Form Approved
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Case report form: Chromoblastomycosis in the United States
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Patient demographic characteristics

Unique patient ID: _____ (site_####)

Site submitting case: _____

Location of residence for patient (ZIP Code): _____ OR [] Unknown

Age at diagnosis (years): _____

Assigned sex at birth: [] Male [] Female OR [] Unknown

Gender identity: [] Male [] Female [] Transgender, non-binary, or another gender[] Prefer not to answer/Decline OR [] Unknown

Race and/or ethnicity (select all that apply and enter additional details in the spaces provided):

[] American Indian or Alaska Native

Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

_____

[] Asian – provide details below

[] Chinese [] Asian Indian [] Filipino [] Vietnamese [] Korean [] Japanese

Enter, for example, Pakistani, Hmong, Afghan, etc.

_____

[] Black or African American – provide details below

[] African American [] Jamaican [] Haitian [] Nigerian [] Ethiopian [] Somali

Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.

_____

[] Hispanic or Latino – provide details below

[] Mexican [] Puerto Rican [] Salvadoran [] Cuban [] Dominican [] Guatemalan

Enter, for example, Colombian, Honduran, Spaniard, etc.

_____

[] Middle Eastern or North African – provide details below

[] Lebanese [] Iranian [] Egyptian [] Syrian [] Iraqi [] Israeli
Enter, for example, Moroccan, Yemeni, Kurdish, etc.
_____

[] Native Hawaiian or Pacific Islander – provide details below

[] Native Hawaiian [] Samoan [] Chamorro [] Tongan [] Fijian [] Marshallese
Enter, for example, Chuukese, Palauan, Tahitian, etc.
_____

[] White – provide details below

[] English [] German [] Irish [] Italian [] Polish [] Scottish
Enter, for example, French, Swedish, Norwegian, etc.
_____

Monthly household income (USD) _____

Occupation at time of presumed infection: _____

Industry at time of presumed infection: _____

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Underlying medical conditions (active or present in the 2 years before symptom onset)

Diabetes mellitus [] Yes [] No [] Unknown

Chronic kidney disease [] Yes [] No [] Unknown
If yes, on dialysis? [] Yes [] No [] Unknown
If yes, GFR < 60? [] Yes [] No

Liver cirrhosis? [] Yes [] No [] Unknown
Chronic hepatitis without cirrhosis? [] Yes [] No [] Unknown
If yes, [] Hep B [] Hep C

Immunocompromising condition [] Yes [] No [] Unknown
[] HIV infection
[] HIV infection without AIDS (CD4 ≥ 200)
[] HIV infection with AIDS (CD4 < 200) or chart diagnosis of advanced HIV disease
[] Cancer diagnosis, specify _____
[] On chemotherapy, specify _____
Date of cancer diagnosis (mm/dd/yyyy): _____

[] Transplantation,
    [] Solid organ, specify organ _____
    [] Hematologic (stem cell)
    Date of transplantation (mm/dd/yyyy): _____
[] Immunosuppressive therapy, specify _____
[] Other immunocompromised condition, specify _____

Other major underlying condition not listed (specify): _____
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Exposure history

Has patient traveled or lived internationally in their life? [] Yes [] No [] Unknown

- Country 1 _____; Approximate duration of stay (years):
- Country 2 _____; Approximate duration of stay (years):
- Country 3 _____; Approximate duration of stay (years):
- Country 4 _____; Approximate duration of stay (years):
- Country 5 _____; Approximate duration of stay (years):

Did the patient immigrate to the United States? [] Yes [] No [] Unknown

If yes, date of immigration (mm/dd/yyyy): _____ [] Unknown

If yes, country immigrated from: _____ [] Unknown

Any traumatic inoculation recalled? [] Yes [] No [] Unknown

If yes, please describe geographic location (e.g., city, state): _____

If yes, please describe the material involved (e.g., thorns, branches): _____

If yes, please describe any weather events (e.g., hurricane, flood): _____

If yes, please indicate approximate date of traumatic inoculation (mm/dd/yyyy): _____

Most likely source of infection, according to clinician _____

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Diagnosis

Did patient have health care facility visits (health center, hospital, etc.) for mycetoma symptoms before visit with mycetoma diagnosis? [] Yes [] No [] Unknown

If yes, how many visits? _____

Were there misdiagnoses before being diagnosed with mycetoma [] Yes [] No [] Unknown

What misdiagnoses, if any, did this patient have before being diagnosed with mycetoma (in the last 12 months):

- Please list all misdiagnoses: _____

Laboratory testing (associated with diagnosis):

[] Dermoscopy [] Not performed [] Unknown if performed
date of procedure: _____
[] Potassium hydroxide preparation [] Not performed [] Unknown if performed
date of preparation: _____; result: _____
[] Skin or surgical biopsy [] Not performed [] Unknown if performed
date of collection (mm/dd/yyyy): _____; result: _____
[] Fungal culture [] Not performed [] Unknown if performed
date of collection (mm/dd/yyyy): _____; Positive/Negative: _____
Organism(s): _____;

[] Broad range sequencing [] Not performed [] Unknown if performed

date of collection (mm/dd/yyyy): _____; Type (e.g., 18s, ITS): _____

Positive/Negative: _____ Organism(s): _____;

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Signs and symptoms noted in medical chart:

Signs & Symptoms	Yes/No	Onset Date
Warty lesions		
Raised and crusted lesions		
Tumors		
Infiltrative plaques		
Nodules		
Polymorphic lesions		
Migraines		
Pain		
Itching		
Edema		
Syncope		
Vomiting		
Other symptoms, please describe:_____		

Please indicate the specific location(s) of the body of the chromoblastomycosis lesions (check all that apply):

[] Head and neck

[] Trunk

[] Upper limbs

[] Buttocks, perineum, genitals

[] Lower limbs

Additional comments on anatomical location: _____

Disease severity:

[] Mild (solitary plaque or nodule less than 5 cm in diameter)

[] Moderate (single or multiple lesions with nodular, verrucous or plaque morphology, less than 15 cm in diameter, and involving a single or two adjacent skin areas)

[] Severe (extensive involvement of adjacent or nonadjacent skin areas)

Did mycetoma cause any form of disability: [] Yes [] No [] Unknown

If yes, please fill out the table below:

Disability	Yes/No	Onset Date	Number of days with disability
Inability to walk			
Impacts mobility/ability to walk			
Inability to work			

Treatment

Was the patient treated for chromoblastomycosis?
[] Yes [] No [] Unknown [] Missing/Not documented

If yes, list all therapeutic agents (e.g., antifungals, immune response modulators, antibiotics, steroids) in the table below:

Therapeutic Agent Name	Max Daily dose (mg/day)	Route (e.g., IV, PO, IT)	Start Date	Duration of Therapy	Therapy ongoing at time of abstraction	Discontinued due to toxicity. **If yes, describe toxicity**	Therapeutic Drug Monitoring (e.g., serum level of antifungal)
			___ / ___ / _____	_____days	[] Yes [] No	[] Yes [] No --- ---	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value

			____ / ____ / ________	______days	[] Yes [] No	[] Yes [] No --------------------- ---------------------	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value
			____ / ____ / ________	______days	[] Yes [] No	[] Yes [] No --------------------- ---------------------	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value
			____ / ____ / ________	______days	[] Yes [] No	[] Yes [] No --------------------- ---------------------	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value
			____ / ____ / ________	______days	[] Yes [] No	[] Yes [] No --------------------- ---------------------	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value
			____ / ____ / ________	______days	[] Yes [] No	[] Yes [] No --------------------- ---------------------	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value

Notes about treatment:

_____

_____

Did the patient undergo surgical excision of the chromoblastomycosis lesion(s): [] Yes [] No [] Unknown

If yes, date of surgical excision (mm/dd/yyyy): _____

Did the patient have cryotherapy: [] Yes [] No [] Unknown

Did the patient have heat therapy: [] Yes [] No [] Unknown

Did the patient have light-based therapy: [] Yes [] No [] Unknown

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Complications:

Outcome	Yes/No	Onset Date	Notes (e.g., location)
Tissue fibrosis			
Secondary bacterial infection			
Squamous cell carcinoma			
Internal organ involvement			
Amputation			
Lymphedema			

Did the chromoblastomycosis infection resolve? [] Yes [] No [] Since

If yes, what was the date of clinical resolution (disappearance of cutaneous manifestations with the exception of atrophic scarring) (mm/dd/yyyy):

If no, what was date of last follow-up (mm/dd/yyyy):

Did this patient die within 2 years after the chromoblastomycosis diagnosis? [] Yes [] No [] Unknown

If yes, was chromoblastomycosis a contributing factor in patient's death? [] Yes [] No [] Unknown

Additional comments:

_____

_____

Appendix 2: Dermatology Life Quality Index Tool

Dermatology Life Quality Index Questionnaire:

1. Over the last week, how itchy, sore, painful, or stinging has your skin problem been?
    a. Very much
    b. A lot
    c. A little

    d. Not at all
2. Over the last week, how embarrassed or self-conscious have you been because of your skin problem?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
3. Over the last week, how much has your skin problem interfered with you going shopping or looking after your home or garden?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
4. Over the last week, how much has your skin problem influenced the clothes you wear?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
5. Over the last week, how much has your skin problem affected any social or leisure activities?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
6. Over the last week, how much has your skin problem made it difficult for your to do any sport?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
7. Over the last week, has your skin problem prevented you from working of studying
    a. Yes
    b. No
    c. Not relevant
        i. If no, over the last week how much has your skin problem been a problem at work or studying?
            1. A lot
            2. A little
            3. Not at all
8. Over the last week, how much has your skin problem created problems with your partner or any of your close friends or relatives?
    a. Very much

b. A lot
c. A little
d. Not at all
e. Not relevant

9. Over the last week, how much has your skin problem caused any sexual difficulties?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
10. Over the last week, how much of a problem has the treatment for your skin problem been, for example by making your home messy, or by taking up time?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant