**Case report form:** Sporotrichosis

======================================================

**Patient demographic characteristics**

Unique patient ID: \_\_\_\_\_\_\_\_\_\_\_ (site\_####)

Site submitting case:

Location of residence for patients (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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

======================================================

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

Diabetes mellitus [] Yes [] No [] Unknown

Chronic Pulmonary Disease [] Yes [] No [] Unknown

History of smoking [] Yes [] No [] Unknown

If yes (select all that apply): [] Tobacco, current [] Tobacco, previous [] E-nicotine delivery system, current [] E-nicotine delivery system, previous

Documented drug use disorder [] Yes (select all that apply) [] No [] Unknown

[] Alcohol

[] Other drug, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] Transplant

[] Solid organ, specify organ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] Hematologic (stem cell)

Date of transplantation (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] Immunosuppressive therapy, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start date of immunosuppressive treatment (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] Other immunocompromised condition, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other major underlying condition not listed (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

======================================================

**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 ever recalled? [] Yes [] No [] Unknown

If yes, what type of traumatic inoculation? [] Sapronotic [] Zoonotic [] Unknown

If sapronotic, source of infection? [] Sphagnum moss [] Rose bushes [] Hay [] Other, specify \_\_\_\_

If zoonotic, did the animal have a clinical or laboratory diagnosis of sporotrichosis? [] Yes [] No [] Unknown

If zoonotic, what type of animal? [] Cat [] Dog [] Armadillo [] Rat [] Other, specify\_\_\_\_\_\_

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): \_\_\_\_\_\_\_\_\_\_\_\_\_

======================================================

**Diagnosis**

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

If yes, how many visits? \_\_\_\_\_\_\_\_\_\_\_\_

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

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

* Please list all misdiagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Laboratory testing (associated with diagnosis)**:

[]Histopathology [] Not performed [] Unknown if performed

Date (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_; Type of stain: \_\_\_\_\_\_\_\_\_\_

Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[]Cytology [] Not performed [] Unknown if performed

Date (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_; Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] Fungal culture [] Not performed [] Unknown if performed

Date of collection (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_; Positive/Negative: \_\_\_\_\_\_\_\_\_\_\_\_\_ Specimen: \_\_\_\_\_\_\_\_\_\_\_\_\_; Organism(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;

[] Serology [] Not performed [] Unknown if performed

Date of collection (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_; Specimen: \_\_\_\_\_\_\_\_\_\_\_\_

Positive/Negative: \_\_\_\_\_\_\_\_\_\_\_\_\_ Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;

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

Date of collection (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_; Type (e.g., 18s, ITS): \_\_\_\_\_\_\_\_\_\_\_\_

Positive/Negative: \_\_\_\_\_\_\_\_\_\_\_\_\_ Organism(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;

======================================================

**Signs and symptoms noted during patient interview**:

Clinical presentation:

[] Fixed cutaneous

[] Lymphocutaneous

[] Multifocal or disseminated cutaneous (≥3 lesions involving 2 different anatomical sites)

[] Extracutaneous

If extracutaneous: [] ocular [] osteoarticular [] pulmonary [] meningitis [] other, specify \_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Signs & Symptoms | Yes/No | Onset Date |
| Ulcer |  |  |
| Nodule |  |  |
| Verrucous lesions |  |  |
| Plaque-like lesions |  |  |
| Granulomatous conjunctivitis |  |  |
| Nodular lymphangitis |  |  |
| Sporotrichoid spread |  |  |
| Pain |  |  |
| Fever |  |  |
| Night sweats |  |  |
| Weight loss |  |  |
| Fatigue |  |  |
| Dyspnea |  |  |
| Cough |  |  |
| Purulent sputum |  |  |
| Hemoptysis |  |  |
| Other symptoms, please describe:\_\_\_\_\_\_\_ |  |  |

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

[] Head or neck

[] Trunk

[] Upper limbs

[] Buttocks, perineum, genitals

[] Lower limbs

Additional comments on anatomical location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Disability | Yes/No | Onset Date | Number of days with disability | Inability to work (Y/N) |
| Mild motor impairment (has some difficulty in moving around but is able to walk without help) |  |  |  |  |
| Moderate motor impairment (has some difficulty in moving around, and difficulty in lifting and holding objects, dressing and sitting upright, but is able to walk without help |  |  |  |  |
| Severe motor impairment (is unable to move around without help, and is not able to lift or hold objects, get dressed or sit upright) |  |  |  |  |

**Treatment**

Was the patient treated for sporotrichosis?

[] 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 local surgical excision of the sporotrichosis lesions: [] Yes [] No [] Unknown

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

Did the patient receive local hyperthermia for treatment of lesions? [] Yes [] No [] Unknown

======================================================

**Complications**:

|  |  |  |  |
| --- | --- | --- | --- |
| Outcome | Yes/No | Onset Date | Notes (e.g., location) |
| Scarring on skin |  |  |  |
| Joint destruction |  |  |  |
| Secondary bacterial infection |  |  |  |
| Amputation |  |  |  |
| Lymphedema |  |  |  |
| Other; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

Did the sporotrichosis infection resolve? [] Yes [] No [] Unknown

If yes, what was the date of clinical resolution (clinical and radiographic cure) (mm/dd/yyyy):: \_\_\_\_\_\_\_\_

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

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

If yes, was sporotrichosis 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?
   1. Very much
   2. A lot
   3. A little
   4. Not at all
2. Over the last week, how embarrassed or self-conscious have you been because of your skin problem?
   1. Very much
   2. A lot
   3. A little
   4. 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?
   1. Very much
   2. A lot
   3. A little
   4. Not at all
   5. Not relevant
4. Over the last week, how much has your skin problem influenced the clothes you wear?
   1. Very much
   2. A lot
   3. A little
   4. Not at all
   5. Not relevant
5. Over the last week, how much has your skin problem affected any social or leisure activities?
   1. Very much
   2. A lot
   3. A little
   4. Not at all
   5. Not relevant
6. Over the last week, how much has your skin problem made it difficult for your to do any sport?
   1. Very much
   2. A lot
   3. A little
   4. Not at all
   5. Not relevant
7. Over the last week, has your skin problem prevented you from working of studying
   1. Yes
   2. No
   3. Not relevant
      1. 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?
   1. Very much
   2. A lot
   3. A little
   4. Not at all
   5. Not relevant
9. Over the last week, how much has your skin problem caused any sexual difficulties?
   1. Very much
   2. A lot
   3. A little
   4. Not at all
   5. 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?
    1. Very much
    2. A lot
    3. A little
    4. Not at all
    5. Not relevant