Questionnaire

1 **Patient Setup**

Patient Setup

Patient Details

You are documenting the following patient:
ID: #u_name#
Year of Birth: #u_birth#
Gender: #u_gender#

Weight / Height
Weight [kg] Height [cm]
Ethnic origin:

Please select
Caucasian (White)
Sub-Saharan African/Afro-American (Black)
Asian
American Indian or Alaska Native
Native Hawaiian or Pacific Islander
Hispanic/Latino
North African
Arabic

Are the inclusion criteria met by this patient?

In case of any uncertainty whether a specific patient can be included, please contact the coordinating physician **Dr. Maria J. G. T. Vehreschild** for Fungiscope and **Jeanna Beth Deermann** for the MSG Phaeohyphomycosis Registry.

Inclusion criteria:

- Fungiscope: Cultural, histopathological, antigen, or DNA evidence of invasive fungal infection
- MSG - Phaeohyphomycosis Registry: Cultural or DNA evidence of invasive fungal infection

- Yes
- No

Are any of the following exclusion criteria met by this patient?

Exclusion criteria

- Infection due to *Aspergillus* spp., *Candida* spp., *Cryptococcus neoformans*, *Pneumocystis jiroveci*
- Any endemic fungal infection such as coccidioidomycosis or histoplasmosis
- Colonisation or other non-invasive infection, including superficial skin infections

- Yes
- No

Documentation of this case in any other registries?

- Yes - please specify:
- No

Case already published?

- Yes - please specify:
- No

Please specify which fungus/fungi caused the infection:

Please specify the **rank of classification** (order, family, genus, species (sp.)). For example, if you have identified a Mucor please specify if you mean a fungus of the genus Mucor (which could be for example *Mucor* sp. but also *Rhizopus* sp.) or do you mean the species *Mucor* sp..

If **several fungi** were involved in the infection, please establish an order based on clinical relevance. In this case, non-rare fungi such as *Aspergillus* spp. and *Candida* spp. may also be listed.

Was the infection imported from another country?

- Yes - please specify:
- No

Please provide the country from where this case is being documented.

Please provide the institution from where this case is being documented.

2 Host Factors

Host Factors

Risk Factors

Which risk factors were present?

Immunosuppression

- ☐ Chemotherapy
- ☐ Hematopoietic stem cell transplantation (HSCT)
- ☐ HIV/AIDS
- ☐ Solid organ transplantation
- ☐ Other disorder requiring any kind of immunosuppression (including steroids):

Trauma/Intervention

- ☐ Burn
- ☐ Major surgery (not including surgey as part of antifungal therapy)
- ☐ Trauma

Chronic disease/behavioral factor

- ☐ Alcoholism
- ☐ Chronic liver disease
- ☐ Chronic pulmonary disease
- ☐ Chronic renal disease
- ☐ Diabetes mellitus
- ☐ IV drug user
- ☐ Premature birth

Other

- ☐ Other risk factor (please specify):
- ☐ No risk factor identified

Was the infection acquired/diagnosed at an ICU?

(if yes please select) If the patient was transferred to the ICU after the definite diagnosis of IFD was made, please check "No".

- ○ Surgical ICU
- ○ Medical ICU
- ○ Anaethesiological ICU
- ○ Neurological/Neurosurgical ICU
- ○ Other ICU (please specify):
- ○ No

2.1.1 Chemotherapy

Chemotherapy

Please specify the underlying disease requiring chemotherapy:

Please specify the type of chemotherapy:

Primary course or relapse?

- ○ Primary course
- ○ First relapse
- ○ Second or later relapse
- ○ not applicable

Was the patient neutropenic within the last four weeks prior to or at diagnosis of the fungal infection?

(Absolute neutrophile count < 500 or leukocytes < 1000)

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Did the patient receive growth factors?

- ☐ Experimental CSF (specify):
- ☐ G-CSF
- ☐ GM-CSF
- ☐ M-CSF
- ☐ Multiple CSF
- ☐ No

Did the patient receive granulozyte transfusion(s)?

- ○ Yes
- ○ No

Which of the following drugs did the patient receive during the last 3 months prior to or at diagnosis of fungal infection?

- ☐ Nucleosid analogues (e.g. Cladribine, Pentostatin)
- ☐ Specific monoclonal antibodies (e.g. Alemtuzumab)
- ☐ T-cell immunusuppressants (e.g. Cyclosporine)
- ☐ TNF-alpha blockers (e.g. Adalimumab, Etanercept, Infliximab)
- ☐ Corticosteroids
- ☐ Other immunosuppressive agent (specify):
- ☐ None of the above

HSCT

HSCT

Please specify the indication for HSCT

- Please select
- Acute lymphoblastic leukemia (ALL)
- Acute myelogenous leukemia (AML)
- Aplastic anemia
- Chronic lymphocytic leukemia (CLL)
- Chronic myelogenous leukemia (CML), accelerated phase or blast crisis
- Myelodysplastic syndrome
- Non-Hodgkin's lymphoma

Other - please specify

Please specify type of HSCT:

- ○ Allogeneic
- ○ Autologous
- ○ Syngeneic

What type of stem cells were used?

- ○ Bone marrow
- ○ Cord blood
- ○ Peripheral blood stem cells (PBSC)
- ○ Other (specify):

Date of most recent stem cell transfusion:

Day	Month	Year
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Was ATG part of the conditioning regimen?

- ○ Yes
- ○ No
- ○ Unknown

Myeloablative conditioning regimen?

- ○ Yes
- ○ No

Allogeneic HSCT

Allogeneic HSCT

Please specify the HLA-matching:

- ○ Haploidentical transplantation
- ○ Matched related donor (MRD)
- ○ Matched unrelated donor (MUD)

- ○ Mismatched unrelated donor (mMUD) - single mismatch
- ○ Mismatched unrelated donor (mMUD) - 2 mismatches
- ○ Mismatched unrelated donor (mMUD) - 3 or more mismatches
- ○ Other (specify):
- ○ Unknown

Please specify the CMV status of the DONOR:

- ○ positive
- ○ negative
- ○ unknown

Please specify the CMV status of the RECIPIENT:

- ○ positive
- ○ negative
- ○ unknown

Prophylaxis for GvHD after the most recent HSCT:
Multiple checks allowed

- ☐ Adalimumab
- ☐ Ciclosporin A
- ☐ Corticosteroids
- ☐ Daclizumab
- ☐ Etanercept
- ☐ Extracorporeal UV photophoresis
- ☐ Infliximab
- ☐ Mycophenolate Mofetil
- ☐ Plasmapheresis
- ☐ Rituximab
- ☐ Sirolimus
- ☐ Tacrolimus
- ☐ Other (specify):
- ☐ Unknown

Did the patient receive treatment for GvHD?

- ○ Yes
- ○ No
- ○ Unknown

If yes, please specify the course of action. Please mention all immunosuppressives used during the course and give a rough timeline.

2.3.1 **Solid Organ Transplantation**

Solid Organ Transplantation

Solid Organ Transplantation

Please enter the date of most recent solid organ transplantation:

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Please name organ(s) transplanted:

Maximum severity of rejection during or up to two months prior to fungal infection:

- ○ none
- ○ mild
- ○ moderate
- ○ severe
- ○ not applicable

Which of these immunosuppressive drugs were administered to PREVENT rejection during the last two months before diagnosis of fungal infection?

- ☐ Azathioprine
- ☐ Cyclosporine A
- ☐ Corticosteroids
- ☐ Mycophenolic acid / mycophenolate mofetil
- ☐ Sirolimus
- ☐ Tacrolimus
- ☐ Other
- ☐ None

Which of these immunosuppressive drugs were administered to TREAT rejection during the last two months before diagnosis of fungal infection?

- ☐ Azathioprine
- ☐ Cyclosporine A
- ☐ Corticosteroids
- ☐ Mycophenolic acid / mycophenolate mofetil
- ☐ Sirolimus
- ☐ Tacrolimus
- ☐ Other
- ☐ None

2.4.1 **HIV/AIDS**

HIV/AIDS

HIV/AIDS

CDC clinical category at hospital admission:
Click **here** for an overview on the classification categories. In brief, categories are determined as follows:

- **Category A**: Acute HIV infection, asymptomatic or generalized lymphadenopathy
- **Category B**: Bacillary angiomatosis, mucosal candidiasis, cervical dysplasia, idiopathic thrombocytopenic purpura, fever (>38.5°C) or diarrhea lasting >1 month, PNP, Herpes zoster (shingles)

- **Category C**: Recurring bacterial pneumonia, candidiasis other than oral or vaginal, HIV related tumors, coccidioidomycosis, cryptococcosis, cryptosporidiosis, cytomegalovirus disease, encephalopathy, Kaposi sarcoma, Tuberculosis, PCP, PML, toxoplasmosis, wasting syndrome

- ○ A - patient asymptomatic
- ○ B - patient symptomatic
- ○ C - AIDS defining symptoms
- ○ not assessed

CDC lymphocyte category at hospital admission:

- ○ 1: > 500 CD4+/µl
- ○ 2: 200-500 CD4+/µl
- ○ 3: < 200 CD4+/µl
- ○ not assessed

Was the CD4 count assessed?
If yes, please specify.

- ○ No
- ○ Yes (cells/mm³):

Was the CD4/CD8 ratio assessed?
If yes, please specify.

- ○ No
- ○ Yes:

Was the HIV-RNA copy count assessed?
If yes, please specify.

- ○ No
- ○ Yes (copies/ml):

Please state the HIV virus type

- ○ HIV 1
- ○ HIV 2
- ○ Not assessed
- ○ Other (specify):

2.5.1 **ICU/Trauma**

ICU/Trauma

Intensive Care Unit (ICU)

ICU stay

	Day	Month	Year
Admission	please select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	please select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

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Patient condition during ICU stay

- ☐ Central venous catheter
- ☐ Liver failure
- ☐ Mechanical Ventilation
- ☐ Parenteral nutrition
- ☐ Renal failure/Dialysis
- ☐ Sepsis/Blood stream infection
- ☐ None of the above

Please elaborate upon the reason for the ICU stay and any important occurrences

Please state the highest APACHE II Score before or at diagnosis of fungal disease:

2.6.1 **Major surgery**

Major surgery

Major Surgery

Which of theses invasive procedures did the patient undergo during the last two months prior to diagnosis of invasive fungal infection?
Please check which kind of operation was performed and provide details in the text box.

Visceral
☐

Neurosurgical
☐

Orthopedical
☐

Thoracical
☐

Urogenital
☐

Other surgery
☐

Date of surgery most relevant to the development of the fungal infection

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Was the surgery most relevant to the development of the fungal infection:

- Elective
- Emergency
- Unknown

2.7.1 **Major surgery**

Major surgery

Trauma

Did the patient suffer any trauma during the last two months prior to diagnosis of invasive fungal infection?

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What kind of trauma did the patient suffer? Which organs were affected?

Did the patient undergo trauma-related surgery?

- ○ Yes
- ○ No

If you checked "yes" , which of theses invasive procedures did the patient undergo?
Please check which kind of operation was performed and provide details in the text box.

- ☐ Visceral
- ☐ Neurosurgical
- ☐ Orthopedical
- ☐ Thoracical
- ☐ Urogenital
- ☐ Other surgery

Date of surgery most relevant to the development of the fungal infection

Day	Month	Year
please select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Was the surgery most relevant to the development of the fungal infection:

- ○ Elective
- ○ Emergency
- ○ Unknown

2.8.1 **Burn**

Burn

Burn

Date of Burn:

Day **Month** **Year**

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Please estimate the extent of the burn in % of total body surface area '); //-->

%

Burn extent: '); //-->

Please select state of burn

Please select
Superficial thickness/First degree burn
Partial thickness - superficial/Second degree burn
Partial thickness - deep/Second degree burn
Full thickness/Third-Fourth degree burn

Involved areas:

Please describe which areas were involved and to what extent

2.9.1 **Other reason for immunosuppression**

Other reason for immunosuppression

You stated *#v_1906#* as reason for immunosuppression. Please provide some details.

Year of first diagnosis:

Status of underlying disease at diagnosis of fungal disease:

- ○ Acute
- ○ Chronic
- ○ Not applicable

Which of these immunosuppressive drugs were administered during the last two months before diagnosis of fungal infection?

- ☐ Azathioprine
- ☐ Cyclosporine A
- ☐ Corticosteroids
- ☐ Mycophenolic acid / mycophenolate mofetil
- ☐ Sirolimus
- ☐ Tacrolimus
- ☐ Other
- ☐ None

2.10.1 **Premature Birth**

Premature Birth

Premature Birth

Date of birth:

Day	Month	Year
please select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Gestational age:

[days]

Weight at birth:

[kg]

Newborn treated with corticosteroids:

- ○ Yes
- ○ No

2.11.1 **Corticosteroids=YES**

Corticosteroids=YES

Corticosteroid Administration

Please enter information on corticosteroid administration during the last three month prior to invasive fungal disease. Please give all dosages as prednisolone equivalents. Click **here** for calculation support.

Duration:

Please enter total number of days corticosteroids were given.

Cumulative steroid dose:

Please give an estimated total steroid dose of the last three months in milligrams.

2.12.1 **Diabetes=Yes**

Diabetes=Yes

Diabetes Mellitus

Year of initial diagnosis:

Does the patient have:

- ○ Insulin dependant diabetes
- ○ Non-insulin dependant diabetes

Did the patiente suffer from ketoacidosis during the last month prior to the fungal infection?

- ○ Yes
- ○ No
- ○ Unknown

Was the HbA1C determined within the last two months before fungal infection?

Please state the highest value in the case of multiple determinations.

2.13.1 **Chronic renal failure=YES**

Chronic renal failure=YES

Chronic Renal Disease

Please enter the year of initial diagnosis:

Dialysis status at diagnosis of fungal disease:

- ○ No dialysis required
- ○ Hemodialysis
- ○ Peritoneal dialysis

Please enter the year of first dialysis, if applicable:

2.14.1 **Chronic liver failure:**

Chronic liver failure:

Chronic Liver Disease

Please help us reconstruct the Child-Pugh score by selecting the appropriate values:

Total bilirubin [µmol/l]

- ○ < 34
- ○ 34 - 50
- ○ > 50
- ○ Not determined

Serum albumin [g/l]

- ○ > 35
- ○ 28 - 35
- ○ < 28
- ○ Not determined

INR - International normalized ratio

- ○ < 1.7
- ○ 1.71 - 2.20
- ○ > 2.20
- ○ Not determined

Ascites

- ○ None
- ○ Suppressed by medication
- ○ Refractory
- ○ Not known

Hepatic encephalopathy

- ○ None
- ○ Grade I-II (or suppressed)
- ○ Grade III-IV (or refractory)
- ○ Not known

2.15.1 **Chronic pulmonary Disease=YES**

Chronic pulmonary Disease=YES

Chronic Pulmonary Disease

Please enter year of initial diagnosis:

Please specify type of chronic pulmonary disease:

What was the last known FEV1% (percentage of normal value) before fungal diagnosis?
FEV1=forced expiratory volume in one second

- ○ 80-100%
- ○ 60-79%
- ○ 40-59%
- ○ Less than 40%
- ○ Not determined

What was the last known VC% (percentage of normal value) before fungal diagnosis?

VC=vital capacity

- ○ 80-100%
- ○ 60-79%
- ○ 40-59%
- ○ Less than 40%
- ○ Not determined

Did the patient use inhalative steroids three months prior to diagnosis?

- ○ Yes
- ○ No
- ○ Unknown

2.16.1 **Other=Yes**

Other=Yes

Other Underlying Condtitions: *#v_1919#*

Please specify other underlying conditions:

2.17.1 **Pathogen ID**

Pathogen ID

This page is for internal use and for your information on pathogen identification, only. Please do not enter or change any data.

Where are the isolates stored?
Multiple selections possible.

- ☐ FungiThek Cologne/Microbiology lab
- ☐ FungiThek ZfMK (Wisplinghoff)
- ☐ FungiThek Innsbruck
- ☐ FungiThek RKI
- ☐ FungiThek Anuradha Chowdary India
- ☐ FungiThek Arunaloke Chakrabarti, NCCPF, Chandigarh, India
- ☐ No isolate stored

Please give specifics on the isolate (material, date income, isolate ID, isolate FungID)

Initial identification at local laboratory:

FungiID
Fungi + laufende Nummer

Preliminary morphological ID:

Final morphological ID (macro- and microscopic ID)

Please describe macro- and microscopic morphology of the fungus.

Molecular ID:

Name of fungus identified by MALDI-TOF.

FISH ID:

Biochemical ID (yeasts only):

Other:

Is this case valid? If MSG case please indicate validity through valid (MSG) or not valid (MSG).

○ Valid	○ Not valid	○ Valid (MSG)	○ Not valid (MSG)	○ Test

Validity category
Please select if the case is valid but does not meet Fungiscope inclusion criteria.

- ☐ endemic
- ☐ non-invasive

Reason for invalidity

Classify invasive fungal infection

- ○ Proven
- ○ Probable
- ○ Probable (PCR)
- ○ Possible
- ○ Other; please specify

Was this an infection by multiple fungi?
This includes *Aspergillus* and *Candida* spp.

- ○ Yes
- ○ No

Type of Fungus I

Please select
Mucoromycotina
Fusarium
Yeast
Penicillium/Paecilomyces
Dematiaceae
Scedosporium
Aspergillus
Candida
Other

Type of Fungus II

Please select
Mucoromycotina
Fusarium
Yeast
Penicillium/Paecilomyces
Dematiaceae
Scedosporium
Aspergillus
Candida
Other

Type of Fungus III

Please select
Mucoromycotina
Fusarium
Yeast
Penicillium/Paecilomyces
Dematiaceae
Scedosporium
Aspergillus
Candida
Other

Type of Fungus IV

Please select
Mucoromycotina
Fusarium
Yeast
Penicillium/Paecilomyces
Dematiaceae
Scedosporium
Aspergillus
Candida
Other

Year of infection

Storage for leftover data

Phylum Fungus I

Class Fungus I

Order Fungus I

Family Fungus I

Genus Fungus I

Species Fungus I

Please enter additional information that is not related to the medical history, e.g. who is the corresponding physician if case was documented by the Cologne Team or what was discussed by Email aside from Queries that might be important later

3 Diagnostic Procedures

Diagnostic Procedures

Diagnostic Procedures

Please select which of these procedures were involved in establishing diagnosis of invasive fungal disease (IFD):
The section "ultrasound" includes transesophageal echocardiography.

	Not done	Normal	Abnormal
CT	○	○	○
X-ray	○	○	○
MRT	○	○	○
Ultrasound	○	○	○
Endoscopy	○	○	○

3.1.1 CT-infection

CT-infection

CT Details

Please select which CT was performed and when.

	Day	Month	Year

Cranium

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Abdomen	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Extremities	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Please state all abnormalities:

Please specify, if one of the following findings typical of IFD was present.

- ☐ Pulmonary nodular infiltrate
- ☐ Pulmonary halo sign
- ☐ Pulmonary air crescent sign or cavity within an area of consolidation
- ☐ "Bull's eye lesions"/ target lesions in liver, kidney or spleen
- ☐ None of the above

3.2.1 X-Ray infection

X-Ray infection

X-ray Details

Please select which x-ray was performed and when.

	Day	Month	Year
Cranium	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Thorax	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Abdomen	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Extremities	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Please state all abnormalities:

Please specify, if the following finding typical of IFD was present.

- ○ Pulmonary nodular infiltrate
- ○ None

3.3.1 **MRI-infection**

MRI-infection

MRI Details

Please select which MRI was performed and when.

	Day	**Month**	**Year**

Cranium

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Thorax

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Abdomen	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Extremities	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Please state all abnormalities:

Please specify, if one of the following findings typical of IFD was present.

- ☐ Pulmonary nodular infiltrate
- ☐ Pulmonary halo sign
- ☐ Pulmonary air crescent sign or cavity within an area of consolidation
- ☐ "Bull's eye lesions"/ target lesions in liver, kidney or spleen
- ☐ None of the above

3.4.1 Ultrasound-infection

Ultrasound-infection

Ultrasound Details

Please select which ultrasound was performed and when.

	Day	Month	Year
Abdomen	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Extremities	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Heart

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Please state all abnormalities:

Please specify, if the following finding typical of IFD was present.

- ○ "Bull's eye lesions"/ target lesions in liver, kidney or spleen
- ○ None

3.5.1 **endoscopy -infection**

endoscopy -infection

Endoscopy Details

Please select which endoscopy was performed and when.

	Day	Month	Year
Upper GI-Tract	Please Select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Please Select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Lower GI-Tract

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Respiratory Tract

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Urinary Tract

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Reproductive Systems

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Please explain which mycological evidence was found

4 **Clinical Signs Symptoms**

Clinical Signs Symptoms

Which clinical signs and symptoms attributable to the fungal infection did the patient present?

Fever (>38°C / 100.4 °F)
- ○ Yes
- ○ No

Dyspnea
- ○ Yes
- ○ No

Cough
- ○ Yes
- ○ No

Exanthema
- ○ Yes (please specify, e.g. macular, papular):
- ○ No

Eschars
- ○ Yes
- ○ No

Hemoptysis
- ○ Yes
- ○ No

Soft tissue swelling
- ○ Yes
- ○ No

Please describe any other clinical signs and symptoms.

5 **Site of infection**

Site of infection

Sites of Infection

Wich organs were involved in IFD?
Please check "disseminated" in case of a positive blood culture or involvement of at least two non-adjacent sites.

- ☐ Biliary system
- ☐ Blood (if bloodculture positive)
- ☐ Bones
- ☐ CNS
- ☐ Deep soft tissues, e.g. muscles
- ☐ Eyes
- ☐ Gastrointestinal tract
- ☐ Genitourinary tract
- ☐ Kidneys
- ☐ Liver
- ☐ Lungs
- ☐ Paranasal sinus(es)
- ☐ Peritoneum
- ☐ Skin
- ☐ Spleen
- ☐ Other, please specify:
- ☐ Disseminated

6 **Mycological Evidence**

Mycological Evidence

Mycological Evidence

Please select which procedures were performed.

	Not done	Normal	Abnormal
Cytology/Microscopy	○	○	○
Culture	○	○	○
Histology	○	○	○
PCR	○	○	○
Antigen detection	○	○	○
Antibody detection	○	○	○

Was an autopsy performed?

- ○ Yes
- ○ No

6.1.1 **Cytology/Microscopy**

Cytology/Microscopy

Cytology/Microscopy

Cytology/microscopy:
Please enter date of the **first positive** sample acquisition, not the date the results were received:

Day **Month** **Year**

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What type of sample was obtained?

Did staining of sample include fungal stains?

- Yes
- No

Please describe microscopic results:

Please describe any further results after the first positive finding:

6.2.1 **Culture_New**

Culture_New

Culture

Culture:
Please enter date of the **first positive** sample acquisition, not the date the results were received:

Day **Month** **Year**

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What type of sample was obtained?

Please describe cultural results:

Please describe any further cultural results after the first positive finding:

Have you sent a specimen to the Cologne Central Lab?

☐ yes ☐ no

What is the reason in case you can not send the specimen?
e.g. disposal, local laws and regulations

6.3.1 **Histology_New**

Histology_New

Histology

Histology:
Please enter date of the **first positive** sample acquisition, not the date the results were received:

Day **Month** **Year**

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What type of sample was obtained?

Did staining of sample include fungal stains?

- Yes
- No

Did microscopy reveal fungal invasion of the tissue?

- Yes
- No

Please describe microscopic results:

Please describe any further histology results after the first positive finding:

6.4.1 **PCR_New**

PCR_New

PCR

PCR:
Please enter date of the **first positive** sample acquisition, not the date the results were received.

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What type of sample was obtained?

Please describe the type of the PCR that was used.

Please describe PCR results:

Please describe any further PCR results after the first positive finding:

6.5.1 **Antigen detection_new**

Antigen detection_new

Antigen detection

Antigen detection:
Please enter date of the **first positive** sample acquisition, not the date the results were received:

Day **Month** **Year**

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What type of sample was obtained?

Please describe the type of antigen test that was used.

Please describe antigen results:

Please describe any further antigen results after the first positive finding:

6.6.1 **Antibody detection_new**

Antibody detection_new

Antibody detection

Antibody detection:
Please enter date of the **first positive** sample acquisition, not the date the results were received:

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What type of sample was obtained?

Please describe the type of antibody test that was used.

Please describe antibody results:

Please describe any further antibody results after the first positive finding:

7 **Treatment**

Treatment

Treatment

Did the patient receive antifungal prophylaxis:
Please note that prophylaxis does not include mouth washes.
- Yes
- No

Did the patient receive empiric/ pre-emptive treatment:
Please choose "Yes" if the patient was treated without *probable* or *proven* fungal disease according to EORTC/MSG criteria.
- Yes
- No

Did the patient receive targeted antifungal treatment:
- Yes
- No

Did you monitor drug levels in serum, liquor or other tissue samples?
- Yes
- No

Did the patient receive any other treatment for fungal infection:
e.g. surgery, iron chelators, hyperbaric oxygen therapy or any experimental treatment
- Yes
- No

7.1.1 **Prophylaxis=YES**

Prophylaxis=YES

Prophylaxis Details

First prophylaxis:
Agent name:
Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- ○ Liposomal amphotericin B
- ○ Amphotericin B deoxycholate
- ○ Amphotericin B lipid complex
- ○ Flucytosine
- ○ Anidulafungin
- ○ Caspofungin
- ○ Micafungin
- ○ Fluconazole
- ○ Itraconazole
- ○ Voriconazole
- ○ Posaconazole solution
- ○ Posaconazole tablets
- ○ Isavuconazole
- ○ Other; Please specify:

Dosage
Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage	Unit	Frequency

Administration:

- ○ p.o.
- ○ i.v.
- ○ topical
- ○ inhalative

Start date:

Day	Month	Year
please select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	please select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Stop date:

Day	Month	Year

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Was the antifungal prophylaxis continuous?

- Yes
- No

If no, please enter number of days of omitted prophylaxis:

Were there any adverse effects from this treatment, requiring change in therapy?

- No
- Yes, please specify:

Second prophylaxis:

please complete only, if there was another drug given as prophylaxis!

Agent name:

Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- Liposomal amphotericin B
- Amphotericin B deoxycholate
- Amphotericin B lipid complex
- Flucytosine
- Anidulafungin
- Caspofungin
- Micafungin
- Fluconazole
- Itraconazole
- Voriconazole
- Posaconazole solution
- Posaconazole tablets
- Isavuconazole
- Other; Please specify:

Dosage

Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage Unit Frequency

Administration:

- p.o.
- i.v.
- topical
- inhalative

Start date:

Day **Month** **Year**

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Was the antifungal prophylaxis continuous?

- ○ Yes
- ○ No

If no, please enter number of days of omitted prophylaxis:

Were there any adverse effects from this treatment, requiring change in therapy?

- ○ No
- ○ Yes, please specify:

7.2.1 **Empiric/ pre-empiric Treatment given=YES**

Empiric/ pre-empiric Treatment given=YES

Empiric/Pre-emptive Treatment Details

First empiric/pre-emptive Treatment:
Agent name:

Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- ○ Liposomal amphotericin B
- ○ Amphotericin B deoxycholate
- ○ Amphotericin B lipid complex
- ○ Flucytosine
- ○ Anidulafungin
- ○ Caspofungin
- ○ Micafungin
- ○ Fluconazole
- ○ Itraconazole
- ○ Voriconazole
- ○ Posaconazole solution
- ○ Posaconazole tablets
- ○ Isavuconazole
- ○ Other; Please specify:

Dosage

Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage	Unit	Frequency

Administration:

- ○ p.o.
- ○ i.v.
- ○ topical
- ○ inhalative

Start date:

Day	Month	Year
please select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	please select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Stop date:

Day	Month	Year

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Were there any adverse effects from this treatment, requiring change in therapy?

- ○ No
- ○ Yes, please specify:

Second empiric/pre-emptive treatment:
please complete only, if there was another drug given as empiric/pre-emptive treatment.
Agent name:
Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- ○ Liposomal amphotericin B
- ○ Amphotericin B deoxycholate
- ○ Amphotericin B lipid complex
- ○ Flucytosine
- ○ Anidulafungin
- ○ Caspofungin
- ○ Micafungin
- ○ Fluconazole
- ○ Itraconazole
- ○ Voriconazole
- ○ Posaconazole solution
- ○ Posaconazole tablets
- ○ Isavuconazole
- ○ Other; Please specify:

Dosage
Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage | Unit | Frequency

Administration:

- ○ p.o.
- ○ i.v.
- ○ topical
- ○ inhalative

Start date:

Day **Month** **Year**

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Stop date:

Day	Month	Year

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Were there any adverse effects from this treatment, requiring change in therapy?

- ○ No
- ○ Yes, please specify:

Third empiric/pre-emptive treatment:
please complete only, if there was another drug given as empiric/pre-emptive treatment.
Agent name:
Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- ○ Liposomal amphotericin B
- ○ Amphotericin B deoxycholate
- ○ Amphotericin B lipid complex
- ○ Flucytosine
- ○ Anidulafungin
- ○ Caspofungin
- ○ Micafungin
- ○ Fluconazole
- ○ Itraconazole
- ○ Voriconazole
- ○ Posaconazole solution

- ○ Posaconazole tablets
- ○ Isavuconazole
- ○ Other; Please specify:

Dosage

Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage Unit Frequency

Administration:

- ○ p.o.
- ○ i.v.
- ○ topical
- ○ inhalative

Start date:

Day	Month	Year
please select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	please select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Stop date:

Day	Month	Year
please select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	please select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Were there any adverse effects from this treatment, requiring change in therapy?

- ○ No
- ○ Yes, please specify:

Fourth empiric/pre-emptive treatment:

please complete only, if there was another drug given as empiric/pre-emptive treatment.

Agent name:

Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- ○ Liposomal amphotericin B
- ○ Amphotericin B deoxycholate
- ○ Amphotericin B lipid complex
- ○ Flucytosine
- ○ Anidulafungin
- ○ Caspofungin
- ○ Micafungin
- ○ Fluconazole
- ○ Itraconazole
- ○ Voriconazole
- ○ Posaconazole solution
- ○ Posaconazole tablets
- ○ Isavuconazole
- ○ Other; Please specify:

Dosage

Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage | Unit | Frequency

Administration:

- ○ p.o.
- ○ i.v.
- ○ topical
- ○ inhalative

Start date:

Day	Month	Year
please select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	please select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

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Were there any adverse effects from this treatment, requiring change in therapy?

- ○ No
- ○ Yes, please specify:

7.3.1 **Treatment**

Treatment

Antifungal Treatment Details

First antifungal Treatment:
Agent name:
Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- ○ Liposomal amphotericin B
- ○ Amphotericin B deoxycholate
- ○ Amphotericin B lipid complex
- ○ Flucytosine
- ○ Anidulafungin
- ○ Caspofungin
- ○ Micafungin
- ○ Fluconazole
- ○ Itraconazole
- ○ Voriconazole
- ○ Posaconazole solution
- ○ Posaconazole tablets
- ○ Isavuconazole
- ○ Other; Please specify:

Dosage
Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage | Unit | Frequency

Administration:

- ○ p.o.
- ○ i.v.
- ○ topical
- ○ inhalative

Start date:

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Were there any adverse effects from this treatment, requiring change in therapy?

- ○ No
- ○ Yes, please specify:

Did the patient require change in therapy for discharge home?

- ○ Yes
- ○ No

Did the patient fail therapy?

- ○ Yes
- ○ No

Second antifungal treatment:

please complete only, if there was another drug given as antifungal treatment!

Agent name:

Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- ○ Liposomal amphotericin B
- ○ Amphotericin B deoxycholate
- ○ Amphotericin B lipid complex
- ○ Flucytosine
- ○ Anidulafungin
- ○ Caspofungin

- ○ Micafungin
- ○ Fluconazole
- ○ Itraconazole
- ○ Voriconazole
- ○ Posaconazole solution
- ○ Posaconazole tablets
- ○ Isavuconazole
- ○ Other; Please specify:

Dosage

Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage	Unit	Frequency

Administration:

- ○ p.o.
- ○ i.v.
- ○ topical
- ○ inhalative

Start date:

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Stop date:

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Were there any adverse effects from this treatment, requiring change in therapy?

- ○ No
- ○ Yes, please specify:

Did the patient require change in therapy for discharge home?

- ○ Yes
- ○ No

Did the patient fail therapy?

- ○ Yes
- ○ No

Third antifungal treatment:

please complete only, if there was another drug given as antifungal treatment!

Agent name:

Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- ○ Liposomal amphotericin B
- ○ Amphotericin B deoxycholate
- ○ Amphotericin B lipid complex
- ○ Flucytosine
- ○ Anidulafungin
- ○ Caspofungin
- ○ Micafungin
- ○ Fluconazole
- ○ Itraconazole
- ○ Voriconazole
- ○ Posaconazole solution
- ○ Posaconazole tablets
- ○ Isavuconazole
- ○ Other; Please specify:

Dosage

Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage Unit Frequency

Administration:

- ○ p.o.
- ○ i.v.
- ○ topical
- ○ inhalative

Start date:

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Were there any adverse effects from this treatment, requiring change in therapy?

- No
- Yes, please specify:

Did the patient require change in therapy for discharge home?

- Yes
- No

Did the patient fail therapy?

- Yes
- No

Fourth antifungal treatment:

please complete only, if there was another drug given as antifungal treatment!

Agent name:

Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- Liposomal amphotericin B
- Amphotericin B deoxycholate
- Amphotericin B lipid complex
- Flucytosine
- Anidulafungin
- Caspofungin
- Micafungin
- Fluconazole
- Itraconazole
- Voriconazole
- Posaconazole solution
- Posaconazole tablets
- Isavuconazole
- Other; Please specify:

Dosage

Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage | Unit | Frequency

Administration:

- p.o.
- i.v.
- topical

Start date:

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Were there any adverse effects from this treatment, requiring change in therapy?

- ○ No
- ○ Yes, please specify:

Did the patient require change in therapy for discharge home?

- ○ Yes
- ○ No

Did the patient fail therapy?

- ○ Yes
- ○ No

Fifth antifungal treatment:

please complete only, if there was another drug given as antifungal treatment!

Agent name:

Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- ○ Liposomal amphotericin B
- ○ Amphotericin B deoxycholate
- ○ Amphotericin B lipid complex
- ○ Flucytosine
- ○ Anidulafungin
- ○ Caspofungin

- ○ Micafungin
- ○ Fluconazole
- ○ Itraconazole
- ○ Voriconazole
- ○ Posaconazole solution
- ○ Posaconazole tablets
- ○ Isavuconazole
- ○ Other; Please specify:

Dosage

Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage	Unit	Frequency

Administration:

- ○ p.o.
- ○ i.v.
- ○ topical

Start date:

Day	Month	Year
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Were there any adverse effects from this treatment, requiring change in therapy?

- ○ No
- ○ Yes, please specify:

Did the patient require change in therapy for discharge home?

- ○ Yes
- ○ No

Did the patient fail therapy?

- ○ Yes
- ○ No

Sixth antifungal treatment:

please complete only, if there was another drug given as antifungal treatment!

Agent name:

Please distinguish between Liposomal amphotericin B, Amphotericin B deoxycholate and Amphotericin B lipid complex if applicable.

- ○ Liposomal amphotericin B
- ○ Amphotericin B deoxycholate
- ○ Amphotericin B lipid complex
- ○ Flucytosine
- ○ Anidulafungin
- ○ Caspofungin
- ○ Micafungin
- ○ Fluconazole
- ○ Itraconazole
- ○ Voriconazole
- ○ Posaconazole solution
- ○ Posaconazole tablets
- ○ Isavuconazole
- ○ Other; Please specify:

Dosage

Please enter dosage, unit and frequency, e.g. 300 ml t.i.d.
qd=once daily, bid=twice daily, tid=three times daily, qid=four times daily

Dosage	Unit	Frequency

Administration:

- ○ p.o.
- ○ i.v.
- ○ topical
- ○ inhalative

Start date:

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Stop date:

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Was there an adverse effect from initial antifungal treatment, requiring change in therapy?

- ○ No
- ○ Yes, please specify:

Did the patient require change in therapy for discharge home?

- ○ Yes
- ○ No

Did the patient fail therapy?

- ○ Yes
- ○ No

7.4.1 **Details other Treatment**

Details other Treatment

Details on Additional Antifungal Treatment

Was surgery carried out for the treatment of IFD?

- ○ No
- ○ Yes, please specify type of surgery

If surgery was carried out as part of the treatment of IFD, please specify the date:

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Please indicate type and duration of additional antifungal treatment, e.g. iron chelators or any other experimental treatment.

7.5.1 **Did you monitored drug levels?**

Did you monitored drug levels?

Drug levels

Agent name:

- Amphotericin B deoxycholate
- Amphotericin B lipid complex
- Liposomal amphotericin B
- Flucytosine
- Anidulafungin
- Caspofungin
- Micafungin
- Fluconazole
- Itraconazole
- Voriconazole
- Posaconazole
- Isavuconazole
- Other; Please specify:

Sample type:

Please select
Serum
Liquor

Other tissue (specify):

please enter in microg/l

Date: drug level:

Date: drug level:

Date: drug level:

Date: drug level:

Date: drug level:

Agent name:

- Amphotericin B deoxycholate
- Amphotericin B lipid complex
- Liposomal amphotericin B

- Flucytosine
- Anidulafungin
- Caspofungin
- Micafungin
- Fluconazole
- Itraconazole
- Voriconazole
- Posaconazole
- Isavuconazole
- Other; Please specify:

Sample type:

Please select
Serum
Liquor

Other tissue (specify):

Date: drug level:

Date: drug level:

Date: drug level:

Date: drug level:

Date: drug level:

Agent name:

- Amphotericin B deoxycholate
- Amphotericin B lipid complex
- Liposomal amphotericin B
- Flucytosine
- Anidulafungin
- Caspofungin
- Micafungin
- Fluconazole
- Itraconazole
- Voriconazole
- Posaconazole
- Isavuconazole
- Other; Please specify:

Sample type:

Please select
Serum
Liquor

Other tissue (specify):

Date: drug level:

Date: drug level:

Date: drug level:

Date: drug level:

Date: drug level:

8 **Outcome**

Outcome

Outcome

Please enter date of last observation:

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Was the patient still alive at last follow up?

- Yes
- No

How many days after diagnosis of IFI was the final response assessed?

8.1.1 **Patient died**

Patient died

Outcome assessment

Notes:

Complete response:
Complete resolution of attributable symptoms of signs of fungal infection, negative culture, PCR and/or antigen tests and at least 90% imaging resolution (assuming positive at day zero).

Partial response:
Complete or near complete resolution of attributable symptoms and signs of fungal infection, negative culture or PCR, major improvement of antigen titer and at least 50% improvement in imaging abnormalities, (assuming positive at day zero).

Stable:
Minor clinical, imaging or laboratory improvement or deterioration, or no change (especially if course of therapy very short)

Deterioration or failure:
Definite clinical, radiological or laboratory evidence of worsening of disease.

Status of fungal disease 14 days after diagnosis:
Please refer to fungal disease only.

- Complete response
- Partial response
- Stable
- Deterioration or failure
- Not applicable
- Unknown

Status of fungal disease 30 days after diagnosis:
Please refer to fungal disease only.

- Complete response
- Partial response
- Stable

- ○ Deterioration or failure
- ○ Not applicable
- ○ Unknown

Status of fungal disease at the most recent follow-up:
Please refer to fungal disease only.

- ○ Complete response
- ○ Partial response
- ○ Stable
- ○ Deterioration or failure
- ○ Unknown

Please indicate the status of the underlying condition (if any) 30 days after diagnosis.
If no underlying disease, please select "not applicable". If death occurred before day 30, please state the status of the underlying condition at the time of death.

- ○ Complete response
- ○ Partial response
- ○ Stable disease
- ○ Disease progression/ uncontrolled disease
- ○ Unknown
- ○ Not applicable

Please indicate if the patient was still neutropenic or receiving immunosuppressants 30 days after diagnosis:
Neutropenia: absolute neutrophile count < 500 or leukocytes < 1000. If death occurred before day 30, please state the patient's status at the time of death.

- ☐ Neutropenic
- ☐ Under immunosuppression
- ☐ Unknown
- ☐ None of the above

Was death attributable to the fungal infection?

- ○ Yes
- ○ No

Please list primary causes of death:

Please enter date of death:

Day	Month	Year
please select 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Please Select Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	please select 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

Was an autopsy performed or a post mortem sample taken?

- ○ Yes
- ○ No

If yes, please enter report:

Case summary:
Please summarize key features of this case with respect to fungal disease

Thank you very much for participating in *Fungiscope*!

8.2.1 **Patient alive**

Patient alive

Outcome assessment

Notes:

Complete response:
Complete resolution of attributable symptoms of signs of fungal infection, negative culture, PCR and/or antigen tests and at least 90% imaging resolution (assuming positive at day zero).

Partial response:
Complete or near complete resolution of attributable symptoms and signs of fungal infection, negative culture or PCR, major improvement of antigen titer and at least 50% improvement in imaging abnormalities, (assuming positive at day zero).

Stable:
Minor clinical, imaging or laboratory improvement or deterioration, or no change (especially if course of therapy very short)

Deterioration or failure:
Definite clinical, radiological or laboratory evidence of worsening of disease.

Status of fungal disease 14 days after diagnosis:
Please refer to fungal disease only.
- ○ Complete response
- ○ Partial response
- ○ Stable
- ○ Deterioration or failure
- ○ Unknown

Status of fungal disease 30 days after diagnosis:
Please refer to fungal disease only.
- ○ Complete response
- ○ Partial response
- ○ Stable
- ○ Deterioration or failure
- ○ Unknown

Status of fungal disease at the most recent follow-up:
Please refer to fungal disease only.
- ○ Complete response
- ○ Partial response
- ○ Stable
- ○ Deterioration or failure
- ○ Unknown

Please indicate the status of the underlying condition (if any) 30 days after diagnosis:
If no underlying disease, please select "not applicable".
- ○ Complete response
- ○ Partial response
- ○ Stable disease
- ○ Disease progression/ uncontrolled disease
- ○ Unknown
- ○ Not applicable

Please indicate if the patient was still neutropenic or receiving immunosuppressants 30 days after diagnosis:
Neutropenia: absolute neutrophile count < 500 or leukocytes < 1000
- ☐ Neutropenic
- ☐ Under immunosuppression
- ☐ Unknown
- ☐ None of the above

Is the patient still receiving antifungal therapy?
- ○ Yes
- ○ No
- ○ Unknown

Outcome of local infection:
Response with sequelae:

- Yes
- No
- Unknown

If yes, please describe sequelae:

Case summary:
Please summarize key features of this case with respect to fungal disease

Thank you very much for participating in *Fungiscope*!

9 Feedback

Feedback

The Fungiscope-Team is continuously trying to make this questionnaire as userfriendly as possible. If you have any suggestions, we would be grateful to know about them!

If you press continue now, you will be logged out of Fungiscope and redirected to www.clinicalsurveys.net.

10 Endseite

Endseite