

Coccidioidomycosis

(Rare Disease of Public Health Significance)

1. DISEASE REPORTING

A. Purpose of Reporting and Surveillance

1. To track the emergence of *Coccidioides* in Washington.
2. To differentiate between infection acquired in Washington versus disease acquired outside of Washington.
3. To monitor trends in the epidemiology of disease due to *Coccidioides*.

B. Legal Laboratory Reporting Requirements

1. Health care providers: *Coccidioides* infections notifiable to local health jurisdiction within 24 hours.
2. Health care facilities: *Coccidioides* infections notifiable to local health jurisdiction within 24 hours.
3. Laboratories: *Coccidioides* notifiable to local health jurisdiction within 24 hours; specimen submission required – cultures (2 business days); other specimens upon request.
4. Veterinarians: Animal cases notifiable to Washington State Department of Agriculture (see: <http://app.leg.wa.gov/WAC/default.aspx?cite=16-70>).
5. Local health jurisdictions: notifiable to the Washington State Department of Health (DOH) Office of Communicable Disease Epidemiology (OCDE) within 7 days of case investigation completion or summary information required within 21 days.

C. Local Health Jurisdiction Investigation Responsibilities

1. Identify potential travel-related or local exposures.
2. When possible, request medical records for completion of supplemental CDC case report form. (Note: OCDE will assist in completing the supplemental form).
3. Facilitate transport of specimens to the Washington State Public Health Laboratories (PHL). Please call OCDE prior to submitting specimens (206-418-5500 or 877-539-4344).
4. Report all *confirmed* cases to OCDE (see definition below). Complete the coccidioidomycosis case report form (<http://www.doh.wa.gov/Portals/1/Documents/5100/420-123-ReportForm-Cocci.pdf>). Please fax this form to OCDE (206-418-5515) and enter the relevant data into the Public Health Issues Management System (PHIMS) as “Rare Disease of Public Health Significance.”

2. THE DISEASE AND ITS EPIDEMIOLOGY

Background

Coccidioides (sp. *immitis* or *posadasii*) is an environmental fungus that grows in soil in areas of low rainfall, high summer temperatures and moderate winter temperatures. *Coccidioides* was previously known to occur only in the Southwestern United States and parts of Mexico and Central and South America. Infection with *Coccidioides*, called coccidioidomycosis or more commonly, Valley Fever, is frequently reported from these areas. *Coccidioides immitis* was first recognized as a locally occurring pathogen in Washington State in 2010, when two human cases with no or limited travel history were diagnosed in south-central Washington. Soil samples collected from south-central Washington have also tested positive for the fungus, and specimens from one site were indistinguishable from clinical isolates of one case by whole genome sequencing. Disease can occur in humans and domestic and wild animals (dogs, cats, rodents, etc.).

A. Etiologic Agent

Coccidioides sp. are dimorphic ascomycetes that dwell in the soil. *Coccidioides immitis* is typically found in California and recently in Washington, whereas *Coccidioides posadasii* is generally found in Arizona and other areas of the Southwest. Geographic ranges for *Coccidioides* sp. are still not fully understood. Clinical differences between the two species have not been observed. The *Coccidioides* lifecycle depends on changes in climate; the fungal mycelia require moisture in the soil to grow. The hyphae need a period of dryness to promote desiccation and maturation into fungal spores (arthroconidia), which can be aerosolized and inhaled. Within the lung, the spore changes into a multi-cellular spherule. Both weather patterns and soil composition therefore appear to affect *Coccidioides* infection rates.

B. Description of Illness

Most infections are sub-clinical, with no symptoms or mild flu-like symptoms. Approximately 40% of infections are symptomatic; these cases generally present with fever, fatigue, cough, dyspnea, headache, night sweats, myalgias, and rash. Some people may develop erythema nodosum or erythema multiforme. Primary pulmonary disease is often self-limiting, but some patients fail to recover and develop complications or chronic pulmonary disease, including lung nodules (5-10% of cases). Disseminated disease occurs in about 1% of cases, with bones/joints, soft tissues, and meninges most commonly affected. Men have a higher rate of dissemination than women, and several studies indicate that African Americans and Filipinos are also at higher risk. Increased risk of dissemination also occurs for persons with immune system alterations such as with HIV infection, diabetes, pregnancy, organ transplants, Hodgkin's disease, or chronic corticosteroid therapy.

C. *Coccidioides immitis* in Washington State

In 1997, a dog from King County with no known out-of-state travel was diagnosed with *Coccidioides* infection by culture. Documentation of similar cases includes a horse from Asotin County in 1999 and a dog with unknown residence in 2000.

Between June 2010 and May 2011, physicians in Washington diagnosed three unrelated cases of acute coccidioidomycosis in south-central Washington residents without recent

travel to known endemic areas. Soil samples were collected from suspected exposure sites, and the genotype of one environmental isolate was identical to a clinical isolate from one patient by whole genome sequencing. This is new direct evidence that the infections were acquired in Washington and that *C. immitis* exists in the state's environment. As of January 2015, a total of eight confirmed cases with suspected or confirmed Washington exposure have been identified, all in south-central Washington. Continued environmental sampling efforts have identified the fungus in several Washington counties.

D. Reservoirs

Coccidioides grows in soil and fungal spores can become airborne when the soil is disturbed by winds, construction, farming, and other activities. Possible animal reservoirs, such as the kangaroo rat and the Arizona pocket mouse, have been proposed, but no zoonotic transmission to humans has been reported.

E. Modes of Transmission

Infection occurs when a fungal spore is inhaled, generally from dust or disturbed soil (e.g. construction, farming, field training, digging, dust storm, or earthquake). Infection from laboratory handling of cultures can also occur, if the cultures are handled outside of appropriate biosafety areas. BSL-2 practices, containment equipment, and facilities are recommended for handling and processing clinical specimens, identifying isolates, and processing animal tissues. BSL-3 practices, containment equipment, and facilities are recommended for propagating and manipulating sporulating cultures already identified as *Coccidioides* sp. and for processing soil or other environmental materials. Laboratory exposures lead to a much higher rate of clinical disease than natural exposures; presumably due to higher infectious dose. Coccidioidomycosis is not transmissible person-to-person.

F. Incubation Period

One to three weeks. Latent or reactivation infection presenting months to years later can also occur in immunosuppressed persons; at least two published case reports indicate coccidioidomycosis can occur early after treatment for HIV infection, during the phase of recovery of the immune system.

G. Period of Communicability

Coccidioidomycosis is not transmitted person-to-person or from animals to humans.

H. Treatment

Coccidioidomycosis can be treated with antifungal therapy. See specific treatment guidance published by the Infectious Disease Society of America (2005): <http://cid.oxfordjournals.org/content/41/9/1217.full.pdf+html>

3. CASE DEFINITIONS

A. Clinical Criteria for Diagnosis

Infection may be asymptomatic or may produce an acute or chronic disease. Although the disease initially resembles influenza-like or pneumonia-like febrile illness primarily

involving the bronchopulmonary system, dissemination can occur to multiple organ systems. An illness is typically characterized by one or more of the following:

- Influenza-like signs and symptoms (e.g., fever, chest pain, cough, myalgia, arthralgia, and headache)
- Pneumonia or other pulmonary lesion, diagnosed by chest radiograph
- Erythema nodosum or erythema multiforme rash
- Involvement of bones, joints, or skin by dissemination
- Meningitis
- Involvement of viscera and lymph nodes

B. Laboratory Criteria for Diagnosis

1. Confirmatory:

- Cultural, histopathologic, or molecular evidence of presence of *Coccidioides* sp.
- Positive serologic test for coccidioidal antibodies in serum, cerebrospinal fluid, or other body fluids by:
 - Detection of coccidioidal immunoglobulin M (IgM) by immunodiffusion, enzyme immunoassay (EIA), latex agglutination, or tube precipitation OR
 - Detection of coccidioidal immunoglobulin G (IgG) by immunodiffusion, EIA, or complement fixation, OR
 - Coccidioidal skin-test conversion from negative to positive after onset of clinical signs and symptoms

C. Case classification (2011)

Confirmed: A case that meets the clinical criteria and is laboratory confirmed.

4. DIAGNOSIS AND LABORATORY SERVICES

A. Diagnosis

Recommended commercially available tests to aid in the diagnosis of coccidioidomycosis include: serology, histopathology with special stains, or fungal culture. IgM antibodies are detectable in ~50% of patients by one week after symptom onset and ~90% by 3 weeks after symptom onset. IgG antibodies are generally detectable by 4-6 weeks post symptom onset, and ~85-90% of patients have detectable IgG by 3 months. However, antibodies generally do not persist longer than several months to a year, occasionally longer in association with a pulmonary cavity or disseminated disease. All serology is generally considered acute testing and a marker for current or recent infection. While false positives are rare, false negatives may occur in up to a third of confirmed cases. Therefore, negative serologic results do not rule out coccidioidal disease. One study reported approximately 5% of immunocompromised patients with coccidioidomycosis are seronegative.

Cerebrospinal fluid (CSF) should be tested for patients with suspected or diagnosed meningitis. Fungal culture can be performed from respiratory secretions (sputum, BAL),

normally sterile fluids (e.g., pleural, peritoneal), tissues (fine needle aspirates or biopsies of the lung, brain, skin), or abscesses. If an isolate is available, submit to PHL to be forwarded to CDC for sequencing. Sequencing can determine if the strain matches or is similar to other strains isolated in south-central Washington or if it is similar to strains found in the Southwest United States.

Other tests that can be performed but are not widely available include urine antigen (available at MiraVista labs only), and PCR testing (not FDA-approved, only done on sputum or tissue).

A positive skin test (spherulin) indicates prior exposure and infection with the fungus. Because reactivity is lifelong, skin tests are not generally helpful in diagnosing current infection, but can help determine whether a person is at risk of infection. A conversion from negative to positive after onset of symptoms is laboratory evidence of disease.

Whole genome sequencing of the organism provides useful information about the genetic changes and also helps to link coccidioidomycosis cases to south-central Washington or other geographic areas.

B. Testing Available at Washington State Public Health Laboratories (PHL)

PHL do not currently offer testing for *Coccidioides*, but will facilitate transfer of specimens to the Centers for Disease Control and Prevention (CDC) for confirmation of species and for genotyping. **Please submit all clinical isolates to PHL.** Isolates should be sent on slants (room temperature). Petri dishes and paraffin blocks are not accepted. Office of Communicable Disease Epidemiology (OCDE) can also arrange serology or microscopy testing; submit serum or tissue slides with serology form.

Note that PHL require all clinical specimens have two patient identifiers, a name **and** a second identifier (e.g., date of birth) both on the specimen label and on the submission form. Due to laboratory accreditation standards, specimens will be rejected for testing if not properly identified. Also include specimen source and collection date.

In specific situations, other specimens such as pleural fluid, synovial, or ascetic fluid can be tested through the UC Davis Coccidioidomycosis Laboratory; consult with the laboratory and OCDE about case prior to submitting.

5. ROUTINE CASE INVESTIGATION

Interview the case and others who might provide pertinent information.

A. Evaluate the Diagnosis

Review the clinical presentation and use the case report form to itemize signs and symptoms. Collect information on clinical symptoms, whether the patient was hospitalized, date of onset of symptoms thought to be caused by coccidioidomycosis, and any underlying diseases, especially immunocompromising conditions such as HIV infection or organ transplantation. Get copies of laboratory reports that support the diagnosis. Since genotyping is always recommended, secure the isolate, if available.

B. Identify Source of Infection

Ask about recent travel and outdoor activity during the past month, particularly in the Southwestern United States, Mexico, Central or South America, or south-central

Washington. In cases without recent reported travel to a known endemic area, ask about travel in the previous several years (or ever), and consult Office of Communicable Disease Epidemiology about possible in-state acquired cases.

C. Identify Potentially Exposed Persons

Identify others potentially exposed with the case, and ask about flu- or pneumonia-like illness following exposure. Identify and evaluate laboratory personnel handling a *Coccidioides* culture. If a *Coccidioides* culture was handled outside of a biological safety cabinet, a list of all persons present in the room should be collected. See section 6B for management of exposed laboratory personnel.

D. Environmental Evaluation

Notify the local environmental health program of locally acquired cases.

E. Infection Control Recommendations

1. Hospitalized patients should be cared for using standard precautions.
 - a. Risk of respiratory infection from exposure to infected tissue or aerosols of infected secretions is very low.
 - b. Accidental percutaneous inoculation has typically resulted in local granuloma formation.
2. There is no need for patient isolation or work/day care restrictions.

6. MANAGING SPECIAL SITUATIONS

A. *Coccidioides* in an Animal

Consult with the DOH Zoonotic Disease Program (360-236-3385) regarding infections in animals. Confirmatory testing and genotyping is also available at the Centers for Disease Control and Prevention (CDC). Isolates should be submitted to Washington State Public Health Laboratories.

B. *Coccidioides* exposure in a laboratory

If a *Coccidioides* culture is handled outside of a biological safety cabinet, a list should be made of everyone present in the room at the time of exposure. A baseline serum sample should be obtained promptly from persons exposed to *Coccidioides* and these samples should be stored for eventual testing if symptoms develop. These tests may help determine whether there was any prior exposure to *Coccidioides*. All persons deemed to have been exposed should be given a therapeutic dose of either itraconazole or fluconazole orally for 6 weeks, as prophylaxis. During this 6 week period, all exposed persons should be on symptom watch. If illness develops, they should present to a clinician for diagnostic testing. A second serum specimen should be collected 3-12 weeks after symptom onset for comparison with the baseline specimen.

7. ROUTINE PREVENTION

A. Immunization Recommendations

A coccidioidomycosis vaccine is not currently available.

B. Prevention Recommendations

Avoid dusty environments in risk areas. Be alert for symptoms and consult a health care provider for early diagnosis and treatment.

ACKNOWLEDGEMENTS

This document is a revision of the Washington State Guidelines for Notifiable Condition Reporting and Surveillance published in 2002 which were originally based on the Control of Communicable Diseases Manual (CCDM), 17th Edition; James Chin, Ed. APHA 2000. We would like to acknowledge the Oregon Department of Human Services for developing the format of this document.

Resources:

<https://www.vfce.arizona.edu>

<http://cid.oxfordjournals.org/content/41/9/1217.full.pdf+html>

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6320a3.htm>

UPDATES

March 2015: First issued guideline for *Coccidioides*.