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NOTE:  
A surveillance case definition is a set of uniform criteria used to define a disease for public health surveillance. Surveillance case definitions enable public health officials to classify and count cases consistently across reporting jurisdictions. Surveillance case definitions are not intended to be used by healthcare providers for making a clinical diagnosis or determining how to meet an individual patient’s health needs.  
CSTE Position Statement(s)  
16-ID-02  
Background  
Histoplasmosis is one of the most common endemic mycosis in the United States and encompasses a spectrum of disease ranging from self-limited respiratory illness to disseminated infection (1-2). In the United States, histoplasmosis is caused primarily by  
Histoplasma capsulatum var.  
capsulatum and is endemic in the Ohio and Mississippi River valleys as well as other areas. Another variety of  
H. capsulatum  
(  
var. duboisii  
, sometimes referred to as  
H. duboisii  
), causes a disease known as African histoplasmosis, which has rarely been reported in the United States. Histoplasmosis is typically acquired through inhalation of spores found in soil contaminated with bird or bat droppings. No direct human-to-human transmission has been reported. Symptoms generally develop 3–14 days after exposure, although many infections are asymptomatic (3-5). Acute pulmonary histoplasmosis is the most common form of disease, and symptoms typically include fever, headache, malaise, and cough. Severe pulmonary disease can involve a wide range of complications (3). Several laboratory methods are available for diagnosis of histoplasmosis, including culture, histopathology,and antigen, antibody, and nucleic acid testing (5-6).  
Clinical Criteria  
Clinical presentation includes either:  
At least two of the following clinical findings:  
fever,  
chest pain,  
cough,  
myalgia,  
shortness of breath,  
headache, or  
erythema nodosum/erythema multiforme rash;  
OR  
At least one of the following clinical findings:  
Abnormal chest imaging (e.g., pulmonary infiltrates, cavitation, enlarged hilar or mediastinal lymph nodes, pleural effusion);  
Clinical evidence of disseminated disease:  
gastrointestinal ulcerations or masses;  
skin or mucosal lesions;  
peripheral lymphadenopathy;  
pancytopenia, as evidence of bone marrow involvement;  
enlargement of the liver, spleen, or abdominal lymph nodes; or  
meningitis, encephalitis, or focal brain lesion.  
Laboratory Criteria For Diagnosis  
Confirmatory laboratory criteria:  
Culture of  
H. capsulatum  
from a clinical specimen,  
Identification of characteristic  
H. capsulatum  
&nbspyeast in tissue or sterile body fluid by histopathology,  
≥4-fold rise in  
H. capsulatum  
serum complement fixation antibody titers taken at least 2 weeks apart,  
Detection in serum of H band by  
H. capsulatum  
immunodiffusion antibody test,  
Detection in serum of M band by  
H. capsulatum  
immunodiffusion antibody test after a documented lack of M band on a previous test (i.e., seroconversion),  
Demonstration of  
H. capsulatum  
-specific nucleic acid in a clinical specimen using a validated assay (i.e., polymerase chain reaction (PCR)).  
Non-confirmatory laboratory criteria:  
Identification of characteristic  
H. capsulatum  
yeast in tissue or sterile body fluid by cytopathology,  
Detection in serum or cerebrospinal fluid (CSF) of  
H. capsulatum  
antibodies by single complement fixation titer of 1:32 or greater (e.g., 1:64),  
Detection in serum or cerebrospinal fluid (CSF) of M band by  
H. capsulatum  
immunodiffusion antibody test without a previous negative test,  
Detection of  
H. capsulatum  
antigen in serum, urine, or other body fluid by an enzyme immunoassay test.  
Epidemiologic Linkage  
Epidemiologically linked (e.g.: common environmental exposure) with a confirmed case.  
Criteria to Distinguish a New Case from an Existing Case  
Following acute histoplasmosis, complement fixation titers and M-band on immunodiffusion antibody testing typically remain elevated for several years. People with chronic histoplasmosis may have cultures yielding  
H. capsulatum  
and positive antigen enzyme immunoassay testing for months or more. Distinct repeat infections have also been reported, typically involving acute pulmonary disease in endemic areas. To minimize duplicate counting of chronic infections and missed repeat acute infections, illnesses in a given person should be counted no more than once every 24 months.  
Case Classification  
Probable  
A clinically-compatible case that meets non-confirmatory laboratory criteria\*;  
OR  
A case that meets confirmatory laboratory criteria, but no clinical information is available;  
OR  
A clinically-compatible case that does not meet laboratory criteria, but is epidemiologically linked to a confirmed case.  
\*Illness in a person with compelling evidence (e.g., culture, histopathology, seroconversion) of a different fungal infection, such as blastomycosis or coccidioidomycosis, and meeting only non-confirmatory laboratory criteria for histoplasmosis should not be counted as a case of histoplasmosis since other fungal infections can cause false positive  
H. capsulatum  
antigen and antibody test results.  
Confirmed  
A clinically-compatible case that meets confirmatory laboratory criteria.  
Comments  
The Council of State and Territorial Epidemiologists (CSTE) approved position statement #16-ID-02 which placed histoplasmosis under standardized surveillance, but CSTE did not add this condition to the nationally notifiable disease list. CDC received Office of Management and Budget Paperwork Reduction Act approval to receive data for this condition in February 2018. The CDC program requests that data for this condition be sent to CDC. Refer to the NNDSS event code list for the histoplasmosis event code and the Message Mapping Guide to use for this condition.  
References  
Chu J, Feudtner C, Heydon K, Walsh T, Zaoutis T. Hospitalizations for endemic mycoses: a population-based national study. Clinical Infectious Diseases. 2006;42(6):822-825.  
Manos N, Ferebee S, Kerschbaum W. Geographic variation in the prevalence of histoplasmin sensitivity. Diseases of the Chest. 1956;29(6):649-668.  
Kauffman C. Histoplasmosis: a clinical and laboratory update. Clinical Microbiology Reviews. 2007;20(1):115-132.  
Nett R, Skillman D, Riek L, Davis B, Blue S, Sundberg E, et al. Histoplasmosis in Idaho and Montana, USA, 2012–2013. Emerg Infect Dis. 2015;21(6):1071-1072.  
Wheat L, Freifeld A, Kleiman M, Baddley J, McKinsey D, Loyd J, et al. Clinical practice guidelines for the management of patients with histoplasmosis: 2007 update by the Infectious Diseases Society of America. Clinical Infectious Diseases. 2007;45(7):807-825.  
Guarner J, Brandt M. Histopathologic diagnosis of fungal infections in the 21st century. Clinical Microbiology Reviews. 2011;24(2):247-280.  
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