NOTIFICATION

There are reports of an increased incidence of the fungal disease, mucormycosis, in the country against the backdrop of Covid pandemic. Mucormycosis is known to cause a recalcitrant infection leading to deep tissue damage and even sometimes to death.

Considering the gravity of the situation and also taking MOHFW DO No. T18015/051/2021-IDSP dated 19.05.2021 in the view, the undersigned in exercise of the power conferred in terms of Epidemic Diseases Act, 1897 and Covid-19 Regulations 2020, declares mucormycosis as a ‘notifiable disease’ with immediate effect.

Whenever a health facility or a practitioner in any of the health care sectors diagnoses or finds a case of confirmed or suspected mucormycosis, it will have to be mandatorily notified to the respective district health authority according to the location/site of practice of the facility/practitioner. Within the jurisdiction of Kolkata District, the information is to be sent to the Jt. DHS, PH & CD Branch at the State headquarter.

The case notification will include sharing of all related information inclusive of patient’s personal details, history, examination & investigation findings and also outcome data in case of death. Format for case notification is annexed.

Secretary
Healthy & Family Welfare

Copy forwarded for information & necessary action to:-

1. The Secretary (PHP) and Mission Director, NHM, Govt. of West Bengal.
2. The Director of Health Services, Govt. of West Bengal, Swasthya Bhawan.
3. The Director of Medical Education, Govt. of West Bengal, Swasthya Bhawan.
4. The Spl. Secretary (MERT), Govt. of West Bengal, Swasthya Bhawan.
5. The Director, IPGME&R/STM, Kolkata.
6. The Principal .........................................................Medical College (all).
8. The Dy. DHS (HA), Govt. of West Bengal, Swasthya Bhawan.
9. The CMOH ................................................. (all districts) for wide circulation.
## Format for notification of case(s) of mucormycosis

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Date of case notification</th>
<th>Patient's name</th>
<th>Age in years</th>
<th>Gender (M/F/O)</th>
<th>Detailed address</th>
<th>District</th>
<th>Contact phone no.</th>
<th>Duration of illness</th>
<th>If admitted, where</th>
<th>Date of admission</th>
<th>Confirmed/ Suspected</th>
<th>Confirmed by which test</th>
<th>Currently Covid/ Post-Covid/ No</th>
<th>Diabetic (Y/N)</th>
<th>Recently treated with steroid (Y/N)</th>
<th>If immunocompromised, reason</th>
<th>Present status</th>
<th>If died, date of death</th>
<th>Facility/ place where died</th>
<th>Remarks (if any)</th>
</tr>
</thead>
</table>

Date of submission: ______________

Signature of the reporting Practitioner/ Official on behalf of the Health Facility:

Name of the Practitioner/ Health Facility:

Designation:

Contact phone no.:

E-mail address:

Seal: