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➔  **Fact sheet No 199: Buruli Ulcer - July 1998 (WHO, 1998, 2 p.)**  
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## BURULI ULCER

**Buruli ulcer is an emerging disease caused by *Mycobacterium ulcerans* - from the family of bacteria which causes tuberculosis and leprosy. It occurs in tropical and sub-tropical humid environments. It destroys skin and underlying tissues and causes deforming lesions. These occur mainly in the limbs.**

**Buruli ulcer is estimated to be the third most common mycobacterial infection in the world after tuberculosis and leprosy. It was first detected in 1948 among farmers in Australia (where it is known as Bairnsdale ulcer). However, cases were described as early as 1897. Most patients are women and children who live in rural areas near rivers or wetlands. Little is known about the mode of transmission to human beings.**

**Prevalence: Buruli ulcer, named after an area of Uganda which was the site of**

**many cases in the 1960s, is most common in West Africa. All countries along the Gulf of Guinea are now affected. In Cte d'Ivoire, approximately 10,000 cases have been recorded since 1978 where up to 16 percent of the population in some villages are affected. In Benin, 2,300 cases have been recorded since 1989; in Ghana up to 22 per cent of villagers are affected in some areas.**

**It is found in marshy parts of the tropical and sub-tropical regions of Africa, Asia, Latin America and the Western Pacific. Cases have been reported in Angola, Australia, Benin, Bolivia, Cameroon, China, Congo, Cte d'Ivoire, Democratic Republic of Congo, French Guyana, Gabon, Ghana, Guinea, India, Indonesia, Liberia, Malaysia, Mexico, Papua New Guinea, Peru, Sierra Leone, Sri Lanka, Sudan, Suriname, Togo and Uganda.**

**Symptoms: The disease starts as a painless swelling in the skin. A nodule develops beneath the skin's surface teeming with mycobacteria. Unlike other mycobacteria, *M ulcerans* produces a toxin, which destroys tissue and suppresses the immune system. Massive areas of skin and sometimes bone are destroyed causing grossly deforming ulcers, unique to Buruli ulcer and easy to recognise. When lesions heal, scarring may cause restricted movement of limbs and other permanent disabilities.**

**Prevention: BCG (Bacille Calmette Gurin) vaccination appears to offer some short-term protection from the disease and reduces the number of new cases. However, it is unclear to what extent it can control Buruli ulcer.**

**Treatment: Treatment of Buruli ulcer with antibiotics has been unsuccessful to date. The only treatment available is surgery to cut out the lesion, with a skin**

**graft if necessary. This is both costly and dangerous, leading to the loss of organs and/or permanent disability. Early detection and surgical removal of small nodules could prevent complications.**

**Social and economic implications: Access to health services is restricted in endemic areas. Patients often seek treatment late. Complications are frequent and severe. Hospitalization is then prolonged and costly. Treatment cost per patient far exceeds per capita health spending. With an increasing number of cases, and associated complications, the long-term economic and social impact of Buruli ulcer on rural populations could be substantial.**

### **WHO's response**

**Recognizing Buruli ulcer as an emerging public health threat, the World Health Organization (WHO) has established the *Global Buruli Ulcer Initiative (GBUI)* to coordinate control and research efforts world-wide. As part of the GBUI, a Buruli Ulcer Advisory Committee was established in 1998 to guide the Organization's work. From 6 to 8 July 1998, WHO held an international conference in Yamoussoukro, Cte d'Ivoire to share information and further develop a global strategy for Buruli ulcer control and research. At that conference, representatives from more than 20 countries signed the Yamoussoukro Declaration on Buruli Ulcer as a pledge to control the disease (<http://www.who.ch/inf/pr/1998/pr98-50.html>).**

### **The GBUI seeks to:**

- **advocate for increased international commitment and financial resources**

**to combat the disease;**

- **develop partnerships with NGOs to assist endemic countries;**
- **assess local health services and resources currently available for the diagnosis and treatment of Buruli ulcer in endemic areas as well as upgrading surgical facilities and improving laboratories;**
- **improve surveillance systems, in conjunction with the strengthening of surveillance systems for other diseases such as tuberculosis, leprosy and Guinea worm, to increase early detection and referral for treatment;**
- **improve health education and staff training in communities most affected;**
- **stimulate essential research on toxin, vaccine and drug development, rapid diagnostic methods and environmental changes that favour the emergence of the disease.**

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