RECOMMENDATIONS FOR CONTROL OF BURULI ULCER

Four programmatic targets by 2012

1. By the end of 2014, at least 70% of cases reported from any district or country should have been confirmed by a positive PCR.

2. By the end of 2014, the proportion of category III lesions reported from any district or country should have been reduced from the 2012 average of 33% to below 25%.

3. By the end of 2014, the proportion of ulcerative lesions at diagnosis reported from any district or country should have been reduced from the 2012 average of 84% to a maximum of 60%.

4. By the end of 2014, the proportion of patients presenting with limitation of movement at diagnosis reported from any district or country should have been reduced from the 2012 average of 25% to a maximum of 15% by the end of 2014.

- Target 1 reflects the improvements in the accuracy of clinical diagnosis and correct sampling techniques.
- Targets 2–4 reflect the impact of early detection efforts (village education and active surveillance).

I. Strategic plans

All national control programmes should develop or revise their national strategic plans in 2013, taking into consideration recent developments in Buruli ulcer control and the recommendations of the 2013 meeting so that implementation of new strategic plans can start in 2014.

II. Surveillance

1. All national control programmes should begin to use the revised BU01 and BU02 forms (electronic and paper versions) from January 2014. The new forms should be ready at country level by December 2013. WHO will provide training for countries to introduce the new forms between September and November 2013.

2. Given the apparent decrease in the number of cases reported to WHO in 2012 by some countries, national control programmes are encouraged to conduct limited surveys in selected districts and communities to clarify these trends.
National control programmes should intensify early case-detection efforts and aim to:

- reduce the proportion of category III lesions from the 2012 average of 33% cases to below 25% by the end 2014
- reduce the proportion of ulcerative lesions at diagnosis from the 2012 average of 84% to a maximum of 60% by the end of 2014.

3. WHO should provide technical assistance to Angola, the Democratic Republic of the Congo, Gabon, Liberia, Nigeria, Papua New Guinea and Sierra Leone to determine the extent of the Buruli ulcer situation in 2013 and 2014, and report the results at the next meeting in March 2015.

### III. Clinical diagnosis and laboratory confirmation

1. National control programmes should ensure that health workers are properly trained or retrained in order to improve the accuracy of clinical diagnosis of Buruli ulcer. A facility will soon exist\(^1\) for centres in which Internet access is available to upload clinical data and photographs of lesions for secondary remote confirmation. Countries are strongly encouraged to make use of this facility to improve diagnosis.

2. National control programmes should strengthen laboratory confirmation of cases to ensure that at least 70% of all reported cases are laboratory-confirmed by positive PCR (polymerase chain reaction).

3. All national and international reference and research laboratories\(^2\) involved in the confirmation of Buruli ulcer cases by PCR should participate in the external quality assurance programme.

4. All laboratories of local health facilities implementing direct smear examination as a complement to but not as a substitute for PCR confirmation should participate in internal quality control and external quality assurance programmes for microscopy in collaboration with national tuberculosis control programmes. National Buruli ulcer control programmes should provide the names of such health facilities to WHO.

---

\(^1\) https://who.telederm.org
\(^2\) Global network of laboratories for confirming Buruli ulcer: [http://www.who.int/entity/buruli/Global_network_laboratories_PCR.pdf](http://www.who.int/entity/buruli/Global_network_laboratories_PCR.pdf)
IV. Case management

Drug treatment

1. National control programmes should follow the standard antibiotic regimens recommended by WHO in the new version of its treatment guidelines\(^3\) and ensure strict documentation. National control programmes should also ensure that these new guidelines are made available at all treatment facilities.

2. 100% of new cases of Buruli ulcer patients should be treated according to these guidelines.

3. Governments of endemic countries, partners and WHO are encouraged to support the supply of the recommended antibiotics to guarantee that all patients have access to effective treatment.

Wound management and surgery

1. WHO should develop simple, standard guidelines on wound management for use by national control programmes at reference hospitals as well as decentralized health centres. Such guidelines should also include recommendations for dressing materials.

2. The number of patients requiring surgery has reduced following the introduction of specific antibiotics; however, the capacity (skills and equipment) to do skin grafts should still be maintained or strengthened in selected referral health facilities to ensure that patients who need skin grafting have ready access to this service.

Prevention of disability

1. National control programmes are encouraged to train teams at health facilities involved in the management of Buruli ulcer on the practice of preventive of disability (POD) using the documents developed by the POD sub-group, particularly the concept of the ‘10 tasks’.

2. National control programmes should ensure that at least 50% of these centres are trained or retrained in POD by 2014.

3. National control programmes should further ensure that the proportion of cases diagnosed with initial limitation of movement is reduced from the 2012 average of 25% to 15% by the end of 2014.

\(^3\) Treatment of *mycobacterium ulcerans* disease (Buruli ulcer): guidance for health workers: http://www.who.int/iris/bitstream/10665/77771/1/9789241503402_eng.pdf
**Buruli ulcer and HIV coinfection**

1. WHO should develop provisional guidelines for the management of patients coinfected with Buruli ulcer and the human immunodeficiency virus (HIV).

2. Collaboration between Buruli ulcer and HIV control programmes at all levels is encouraged to ensure optimal management of coinfected patients.

**V. Training of health staff**

In the context of the new momentum generated by WHO on neglected tropical diseases and taking into consideration that control interventions are implemented by the same health workers at district and community levels, it is recommended that:

1. in districts where there is co-endemicity, consideration be given to providing joint training on diseases such as leprosy, Buruli ulcer and yaws, which are easily recognizable skin conditions requiring basic training to enhance surveillance of these diseases.

2. WHO should consider developing integrated training modules in 2013 for use in combined training sessions for these diseases.

**VI. Governments and partners**

Governments of endemic countries and partners are called upon to support national control programmes to implement the above recommendations.

**VII. WHO**

WHO should provide technical support to and monitor the implementation of the above recommendations and report progress at the next meeting in March 2015.