Report from the Meeting of the Buruli ulcer Technical Advisory Group  
World Health Organization, Headquarters, Geneva, Switzerland  
21 March 2017

Present:


Absent: Jacques Grosset

1. Recruitment to the controlled trial of antibiotic therapy for *M. ulcerans* disease (RS vs RC) was closed at the end of December 2016 and preliminary evaluation of the results suggests that the rifampicin clarithromycin combination was not inferior to rifampicin streptomycin. Since streptomycin is currently unavailable it was decided that the WHO recommendation for treatment should be changed to rifampicin clarithromycin pending the full results of the trial.

A non-profit entity in the Netherlands has expressed interest to develop a 2-drug fixed-dose combination (rifampicin and clarithromycin) for Buruli ulcer treatment.

*Action: Tjip van der Werf, Richard Phillips and Kingsley Asiedu to follow up.*

2. The rate of laboratory confirmation of human cases of BU has been unsatisfactory in most endemic countries. Some TAG members expressed frustration at the time taken to deliver results from the laboratory to clinicians managing patients. This must be addressed in the countries by liaison between programme managers and laboratories. The simplicity of AFB detection should not be overlooked when difficulties arise with obtaining PCR results.

*In future, supplies of antibiotics will be linked to the number of laboratory confirmed cases of BU.*

*Action: Kingsley Asiedu to follow up with programme managers.*
3. It was noted that while some countries have made good progress with case detection and management such as in Nigeria, there have been problems in others, notably Congo where a new country coordinator has only recently been appointed after a 3-year lapse. Guinea has reported a number of cases, none of which have been convincingly confirmed on laboratory testing.

*Action: Kingsley Asiedu to continue providing support and encouragement to national programmes.*

4. The importance was stressed of national reference laboratories participating in internal and external quality assurance. The support for the costs involved in these activities remains an issue that should be addressed. The current capacity of the Institute of Tropical Medicine of Antwerp, Belgium, for retesting large volumes of samples is limited. WHO may consider identifying a reference center in the African Region to complement the activities of ITM.

*Action:*

- Kingsley Asiedu and programme managers to follow up with national reference laboratories
- Kingsley Asiedu to help identify a suitable laboratory to serve as a reference facility in the African Region.

5. It was noted that considerable progress has been made towards development of point-of-care laboratory diagnostic tests for BU, particularly in antigen capture and mycolactone detection. However considerable time is still needed to optimize methods and to progress them to field testing. In the meantime, the TAG recommended that the possibility be explored of adapting GeneXpert to detection of *M. ulcerans*.

*Action: Kingsley Asiedu to contact FIND about this and to arrange a further meeting to discuss development of diagnostic tests.*

6. Useful discussions were held during the meeting about integration between Buruli ulcer and other neglected tropical skin diseases including leprosy, yaws, mycetoma, podoconiosis and cutaneous leishmaniasis. There was strong support for this development both in the open meeting and amongst the TAG members. This is a long term project requiring coordination of surveillance data from each disease.

*Action: Kingsley Asiedu to discuss at the WHO.*

Mark Wansbrough-Jones

Chair, WHO Technical Advisory Group on Buruli ulcer

March 24th 2017