



## ALERT FOR CLINICIANS

### Ebola disease outbreak in Central and Eastern Africa

#### KEY POINTS

- An outbreak of Ebola disease caused by Bundibugyo virus in the Democratic Republic of the Congo (DRC) and Uganda has been declared a [Public Health Emergency of International Concern](#) by the World Health Organization. The risk of importation into Australia is **low**.
- At triage or reception, **identify patients with fever**, with or without additional symptoms of Ebola disease, **and travel history** to affected areas of DRC or Uganda in the 21 days prior to symptom onset.
- **Immediately isolate** patients meeting these criteria in a negative pressure isolation room or single room with the door closed. Apply **standard, contact, droplet and airborne precautions**; refer to the viral haemorrhagic fever (VHF) infection prevention and control (IPC) [interim guideline](#) for specific PPE advice.
- **Urgently discuss** with the local [public health physician](#) or call **1800 434 122** if after-hours.
- Asymptomatic **health or aid workers** returning from affected areas should already be known to Public Health for symptom monitoring. Notify [Public Health](#) if **other returned travellers** with high-risk exposures are identified.

#### Epidemiological situation

- As of 26 May 2026, there were 105 confirmed cases in the DRC and seven in Uganda, and over 900 suspected cases including over 220 suspected deaths. True case numbers are likely substantially higher.
- Cases are concentrated in the Bunia, Rwampara, and Mongwalu health zones in Ituri Province, DRC.
- In previous Bundibugyo-associated outbreaks, the case fatality rate was 30% to 50%.

#### Clinical presentation

- Ebolaviruses are transmitted via direct contact (through mucous membranes or broken skin) with the blood or bodily fluids of an infected or deceased person with Ebola disease.
- Onset of Ebola disease is sudden and usually occurs 8-10 days after exposure (range 2-21 days).
- Early symptoms are non-specific, and include fever, fatigue, myalgia, headache and sore throat.
- Illness may progress to include gastrointestinal symptoms (vomiting, diarrhoea, abdominal pain), respiratory symptoms (cough, chest pain), neurological symptoms (confusion), maculopapular rash, multi-organ failure, shock, and in some cases, haemorrhagic manifestations.
- Consider other travel-associated febrile illnesses in returning travellers with compatible symptoms, including malaria, dengue, yellow fever, shigellosis, typhoid fever, and other viral haemorrhagic fevers.

#### Identification and management of potential cases

- At triage or reception, **identify patients with fever**, with or without additional symptoms of Ebola disease, **and travel history** to affected areas of DRC or Uganda in the 21 days prior to symptom onset.
- **Immediately isolate** patients who meet these criteria in a negative pressure isolation room, or if not available, in a single room with ensuite and keep door closed. Consult IPC team if neither is available.
- Apply strict **standard, contact, droplet and airborne precautions**. While ebolaviruses are not spread by aerosols, airborne precautions are recommended due to disease severity and risk of dispersal of droplets or bodily fluids. Refer to the VHF IPC [interim guideline](#) for specific PPE advice.

#### Notification and testing

- **Urgently** phone a **public health physician** (via the local [Public Health Unit](#) or **1800 434 122** if after-hours) to discuss next steps, including whether the patient meets the suspected case definition and testing is required.
- **Do not proceed with any pathology testing** before speaking with [Public Health](#), unless required to urgently stabilise a deteriorating patient. This includes routine haematology and biochemistry, and is due to the high risk of transmission through blood and bodily fluids. [Public Health](#) will undertake a risk assessment and liaise with the PathWest QEII on-call clinical microbiologist.

**Dr Paul Armstrong**

DIRECTOR, COMMUNICABLE DISEASE CONTROL DIRECTORATE

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