Notes from the Field

Clinical Characteristics of Patients with Ebola Disease Caused by Bundibugyo Virus — Uganda, 2026

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Ebola disease is a viral hemorrhagic fever caused by viruses of the genus *Orthoebolavirus*. Bundibugyo virus (*Orthoebolavirus bundibugyoense*), first identified in 2007 in Bundibugyo District, Uganda, is one of four orthoebolaviruses known to cause Ebola disease in humans (*1*,*2*); only two previous Bundibugyo virus disease (BVD) outbreaks have been documented (*2*). Transmission occurs through direct contact with infectious blood or other body fluids (*3*). Common signs and symptoms include fever, abdominal pain, diarrhea, vomiting, weakness, and bleeding from orifices and injection sites (*1*). Case-fatality rates (CFRs) among confirmed cases in the two previous outbreaks ranged from 32% to 55% (*1*,*4*). No licensed vaccine or specific treatment is available for BVD; clinical management is primarily supportive (*2*). On May 15, 2026, the Uganda Ministry of Health confirmed an outbreak of BVD imported from the neighboring Democratic Republic of the Congo (DRC).

On August 26, 2026, the outbreak was declared over in Uganda with 20 confirmed BVD cases and one probable case reported, although the outbreak in DRC is ongoing. This report describes the clinical and epidemiologic characteristics of all 21 cases. This activity was reviewed by CDC, deemed not research, and conducted consistent with applicable federal law and CDC policy.*

Investigation and Outcomes

Index Case and Identification of BVD Outbreak in Uganda

The index patient in Uganda was a man aged 59 years from Democratic Republic of the Congo (DRC) who traveled to Uganda seeking medical care. He was admitted to a private hospital in Kampala on May 11 with fever, respiratory distress, epigastric pain, and nausea. Despite receiving supportive care, he died in the intensive care unit on May 14.

At the time of his death, the BVD outbreak had not yet been identified in DRC. After the index patient's death, a Congolese resident in Kampala contacted Uganda Ministry of Health officials to alert them about unexplained deaths occurring in DRC, prompting testing of a stored blood sample from the index patient for viral hemorrhagic fever. On May 15, the Central Emergency Response and Surveillance Laboratory in Kampala confirmed the presence of Bundibugyo virus by reverse transcription–polymerase chain reaction. The same day, DRC confirmed the BVD outbreak (*5*).

Characteristics of Patients with BVD

Among the 20 patients with confirmed BVD, the median age was 34 years (range = 1–59 years), and 12 (60%) patients were male. Fifteen (75%) confirmed cases occurred among Congolese nationals who entered Uganda while symptomatic and seeking health care, including 12 persons who were seeking care for suspected BVD. An additional probable case also occurred in a Congolese national. Four (20%) confirmed cases occurred among Ugandan health care workers exposed during the attempted resuscitation of a patient with probable BVD who died and was embalmed before diagnostic testing could be completed. One additional Ugandan case occurred in a driver exposed to the body of one of the Congolese nationals.

The most common signs and symptoms among 18 (90%) patients admitted to the Mulago Hospital Ebola treatment unit (ETU) were fever (100%), headache (83%), and myalgia (78%) (Table). During their initial evaluation, all 18 ETU patients had serum transaminitis with hypoalbuminemia and hyponatremia (Supplementary Table). Among all 21 cases, three patients died (including two with confirmed BVD [CFR = 10%] and one with probable BVD). Among all three patients who died, BVD was only suspected near or after the time of death. All patients who died were bleeding from multiple sites at the time of death; no other patients developed bleeding. Only one of the patients who died (a woman aged 33 years) reached ETU, by which time she was critically ill, and she died 2 days later. She was the only patient with a known comorbidity (decompensated hypertensive heart disease).

Compassionate Use of Remdesivir

Due to the lack of effective antivirals and remdesivir's role as an inhibitor of viral RdRp in COVID-19, remdesivir is now used off-label for the treatment of BDBV in the ongoing outbreaks in DRC and Uganda. Uganda implemented

* 45 C.F.R. part 46.102(l)(2), 21 C.F.R. part 56; 42 U.S.C. Sect 241(d); 5 U.S.C. Sect 552a; 44 U.S.C. Sect 3501 et seq.

TABLE. Characteristics of patients with confirmed Ebola disease caused by Bundibugyo virus — Uganda, 2026

Characteristic	No. (%)
Demographic characteristics	**20 (100)**
Age, yrs, median (range)	34 (1–59)
Sex	
Female	8 (40)
Male	12 (60)
Nationality	
Congolese	15 (75)
Ugandan	5 (25)
Occupation	
Health care worker	4 (20)
Other	16 (80)
Exposure and travel	**20 (100)**
Traveled from DRC into Uganda (exposure in DRC)	14 (70)
Exposed in Uganda	6 (30)
Laboratory abnormalities on admission to ETU	**18 (100)**
Leukopenia	13 (72)
Monocytosis	11 (61)
Thrombocytopenia	5 (28)
Anemia	0 (—)
Hypoalbuminemia	18 (100)
Elevated alanine aminotransferase	14 (78)
Elevated aspartate aminotransferase	18 (100)
Elevated C-reactive protein	11 (61)
Hyponatremia	18 (100)
Hyperkalemia	1 (6)
Elevated urea level	3 (17)
Elevated creatinine level	5 (29)
Elevated creatinine kinase level	3 (17)
Hypoglycemia	3 (16)
Signs and symptoms on admission to ETU	**18 (100)**
Fever	18 (100)
Headache	15 (83)
Myalgia	14 (78)
Arthralgia	13 (72)
Fatigue and asthenia	12 (67)
Epigastric pain	12 (67)
Vomiting	8 (44)
Diarrhea	7 (39)
Bleeding	3 (17)
Reduced level of consciousness	1 (6)
Clinical care and outcome	**20 (100)**
Treated in ETU	18 (90)
Managed in non-ETU areas before definitive diagnosis	2 (10)
Received remdesivir	18 (100)
Died	2 (10)
Recovered	18 (90)

Abbreviations: DRC = Democratic Republic of the Congo; ETU = Ebola treatment unit.

compassionate use[†] of remdesivir (an antiviral medication approved for treatment of COVID-19 and used off-label for BVD) as part of the clinical management of all 18 patients with Ebola virus disease admitted to ETU. One patient experienced severe skin rash and hepatorenal toxicity, resulting in discontinuation of remdesivir after 3 days, followed by resolution of signs and symptoms. The patient later recovered.

[†] Remdesivir is an investigational nucleotide analog antiviral medication with activity against RNA viruses that is approved for treatment of COVID-19 and used off-label for BVD. The medication was made available through Uganda's compassionate use (expanded access) framework. Before medication administration, patients underwent an eligibility assessment in accordance with the Uganda Ministry of Health treatment protocol in the viral hemorrhagic fever handbook. Remdesivir was administered only after obtaining informed consent from patients or their legally authorized representatives. This intervention was implemented as an emergency public health measure in the absence of licensed treatment options. Remdesivir was administered on the day of admission to ETU (median = 5 days and mean = 5.6 days from symptom onset).

Preliminary Conclusions and Actions

The observed 10% CFR among confirmed patients with BVD in Uganda is lower than CFRs in previous BVD outbreaks (*1*,*4*), which might be a result of the patients who sought health care promptly. Communicating with the public about the benefits of seeking care promptly when BVD is suspected might improve patient outcomes. The universal findings of elevated liver enzymes, hypoalbuminemia, and hyponatremia at ETU admission suggest that these abnormalities might be characteristic features of early BVD; a routine laboratory assessment might help guide clinical management. In addition, the low CFR in Uganda (10%) during this outbreak compared with that in DRC's 2026 outbreak (48% as of September 2, 2026) suggests that clinical trials of remdesivir for BVD patients might be warranted in addition to optimized supportive care. Enhancing Ebola disease surveillance in Uganda in border areas and in health care facilities frequented by persons from outbreak-affected communities could also help identify cases and provide early health care. Uganda's response to the BVD outbreak underscores the importance of coordinated multisectoral activities to prioritize early diagnosis, rapid isolation, and infection prevention and control, as well as the potential benefit of remdesivir in treating BVD.

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Summary

What is already known about this topic?

Clinical and epidemiologic descriptions of Bundibugyo virus disease (BVD) are rare; case-fatality rates in previous outbreaks have ranged from 32% to 55%. Effective treatments have not been described.

What is added by this report?

Among the first 21 cases (20 confirmed; one probable) in the 2026 Uganda BVD outbreak, 18 were admitted to the Mulago National Referral Hospital Ebola Treatment Unit (ETU). Among these 18, all had elevated liver enzymes, hypoalbuminemia, and hyponatremia on ETU admission. All 18 received treatment with remdesivir through an off-label, compassionate-use protocol. Among 20 confirmed cases, 18 (90%) patients survived; two deaths occurred among patients with confirmed cases whose infections were recognized late. Seeking care promptly might have reduced the number of deaths.

What are the implications for public health practice?

Communicating with the public about the benefits of seeking health care promptly when BVD is suspected might improve patient outcomes. Clinical trials of remdesivir for patients with BVD might be warranted.

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