

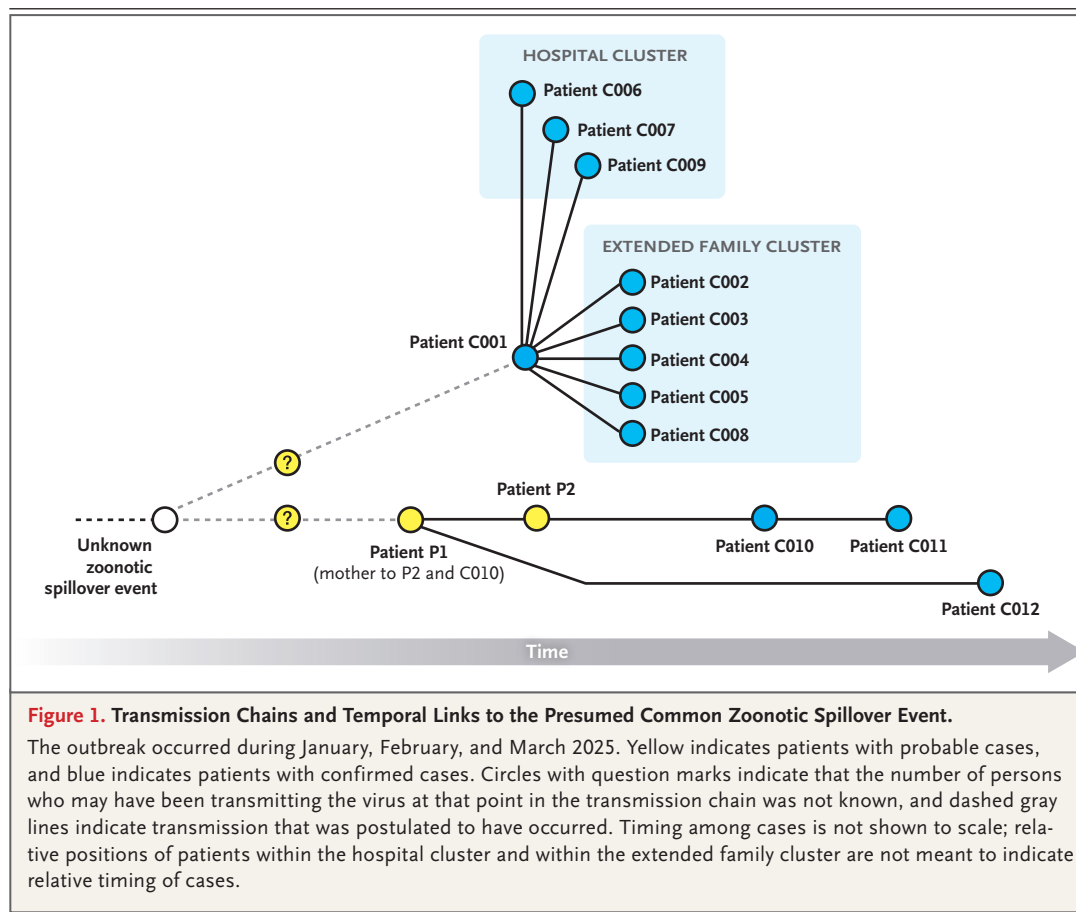
CORRESPONDENCE

Sudan Virus Disease in Uganda, 2025

TO THE EDITOR: On January 30, 2025, the Uganda Ministry of Health notified the World Health Organization of an outbreak of Sudan virus disease (SVD)^{1,2} — the fifth outbreak in Uganda out of eight outbreaks reported on the continent.¹ Here we describe the evolution of the SVD outbreak, which propagated in three transmission chains in geographically distinct regions. Ethics review was not required, because this effort was part of the routine national public health response.

The outbreak was detected at the Mulago National Referral Hospital (NRH) in the capital city of Kampala and subsequently spread to isolated districts to the east and west of Kampala

(Fig. S1 in the Supplementary Appendix, available with the full text of this letter at NEJM.org). Transmission involved three distinct chains with 12 cases confirmed by reverse-transcriptase-polymerase-chain-reaction (RT-PCR) testing, 2 probable cases (in persons who died from suspected SVD, each of whom had an epidemiologic link to a confirmed case but did not undergo testing and had no laboratory confirmation of disease), and 4 fatalities (case fatality rate, 29%) (Fig. 1). The first known transmission cycle, as determined by RT-PCR testing, began with the index patient (Patient C001), a 32-year-old man with SVD that was detected at autopsy and reported through an existing mortality surveillance framework² at



Mulago NRH. Before the infection, the man had worked in three private health clinics in the suburbs of Kampala. We suspect that the infection was transmitted from the index patient to four close relatives — his wife, mother, brother, and a toddler son — plus a household worker (Patients C002 through C005 and C008) through interactions during his illness. The infection was also transmitted from the index patient to three health care workers (Patients C006, C007, and C009) in a hospital cluster. Although the index patient received care in the intensive care unit within the Mulago NRH for 12 hours, none of the health care workers who attended to him reported any signs or symptoms of SVD or tested positive for SVD by RT-PCR.

The second transmission chain involved a child who was 4 and a half years of age (Patient C010), the son of a woman with a probable case of SVD (Patient P1); the infection was transmitted from Patient C010 to a family relative (Patient C011). Patient P1 was a 32-year-old postpartum mother who died from an acute febrile hemorrhagic illness 7 days after giving birth, 3 days before the death of the index patient (Patient C001). Patient P2 — Patient P1's 14-day-old infant, who was thought to have transmitted the virus to Patient C010 — also died from a probable case of SVD. A third transmission chain started with Patient P1 as she cared for sick persons in her household, which resulted in an additional case (in Patient C012).

The three transmission chains — resulting in two family clusters and a hospital cluster — were dispersed in seven districts across the country. All the patients with secondary cases received supportive care (Table S1). This SVD outbreak, which had an unusually low case fatality rate,³ was managed through a response that extended beyond the traditional control measures⁴ (active surveillance, case finding, and community engagement) to preemptive engagement through simultaneous deployment of new response tools. Additional details of the response, including institutional quarantine of contacts, intra-epidemic serologic assessment, use of cellular telephones for data geopositioning, genomic surveillance, experi-

mental antiviral administration in confirmed cases, and administration of a candidate vaccine to contacts under clinical trial conditions, are provided in the Supplementary Appendix.

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Disclosure forms provided by the authors are available with the full text of this letter at NEJM.org.

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