

Buruli ulcer and Australian wildlife

Fact Sheet

October 2025

Key points

- *Mycobacterium ulcerans* disease, referred to globally as Buruli ulcer [BU] (also as 'Bairnsdale ulcer' in Vic and 'Daintree ulcer' in Qld) is recognised as one of the world's neglected tropical diseases.
- *Mycobacterium ulcerans* is an environmental bacterium that causes slow-growing, destructive skin ulcers in humans and some Australian mammals.
- Infection typically occurs when puncturing injuries or other wounds introduce the bacteria into the skin and subcutaneous tissues of the host.
- The bacterium is endemic in certain areas of Vic and Far North Qld and has been reported in the NT and Batemans Bay area of NSW.
- In Vic, there is evidence that bacteria are transmitted by both vector-borne (bite from infected mosquitoes) and zoonotic pathways (via faecal contamination from the environment, or rarely, bite from infected possum).
- People who work with wildlife in endemic areas of Australia should consider the possibility of this disease and follow appropriate personal protective measures, especially when handling native mammals with skin ulcers.

Aetiology

Mycobacterium ulcerans [MU] (Family *Mycobacteriaceae*) is a slow growing mycobacterium, closely related to *M. marinum*, and to the mycobacteria that cause tuberculosis and leprosy.

Mycobacterium ulcerans produces mycolactone, a potent destructive toxin that is cytotoxic, immunosuppressive and analgesic, resulting in the characteristic painless ulcers of BU.

One Health implications

Wildlife and the environment: MU can cause disease in a range of native mammal species, however there is no evidence that the disease significantly affects population numbers. Small mammals, particularly ringtail and brushtail possums, are likely reservoirs for the bacterium in Vic.

Domestic animals: MU can cause disease in a range of domestic animals in endemic areas (see below), but cases occur infrequently.

Humans: disease occurs in humans in endemic areas and is notifiable in the state of Vic ^[1]. All age groups are at risk, however severe disease is more common in older patients in Australia ^[2].

Natural hosts

The bacterium has been reported in a range of domestic and wild mammalian species in endemic areas of Australia. Laboratory-confirmed **clinical disease** has been diagnosed in koalas (*Phascolarctos cinereus*)^[3], common ringtail possums (*Pseudocheirus peregrinus*), common brushtail possums (*Trichosurus vulpecula*), a mountain brushtail possum (*T. cunninghami*), a long-footed potoroo (*Potorous longipes*), a black rat (*Rattus rattus*)¹ as well as horses, alpacas, dogs and a cat^[4-7].

The organism has been detected in the faeces of ringtail and brushtail possums, northern brown bandicoots (*Isodon macrourus*) and feral red foxes (*Vulpes vulpes*) in endemic areas of Australia^[8-13].

World distribution

BU has been reported in over 30 countries worldwide. In 2023, cases were reported from 12 countries, across the African region (including Benin, Cote d'Ivoire and Ghana), Americas (including French Guiana), and the Western Pacific, including Japan, Papua New Guinea and Australia (see below). Australia is the only developed country with significant local transmission of *M. ulcerans*.

Occurrences in Australia

BU has been reported in several regions of Australia, including Far North Qld (FNQ) between Mossman and the Daintree River; the Capricorn Coast of Qld; East Gippsland near Bairnsdale, Vic; and the NT^[14].

Since the early 2000s, the BU endemic has been focused around Port Philip Bay in Vic, with most cases being reported in Greater Geelong, the Surf Coast and the Bellarine Peninsula to the west, Melbourne to the north, and Frankston/Bayside and the Mornington Peninsula to the east. The inner Melbourne suburbs of Essendon, Moonee Ponds, Brunswick West, Pascoe Vale South and Strathmore were the first non-coastal locations in Vic identified as being at risk for BU^[15].

In Vic, **human** BU case numbers have increased significantly over the past decade (32 reported human cases in Vic in 2010 compared with 363 cases in 2024, the highest on record^[16]), as have the number of human cases associated with severe disease^[2]. A cluster of BU cases was also recently identified in the Batemans Bay area of NSW, with four cases (two identified retrospectively) believed to have been infected locally since 2021^[17].

Clinical BU can occur in a range of **animal** species, but to date has only been reported from endemic areas of Vic^[8, 11], where human cases have also occurred. Possums are the most reported wildlife species with clinical disease, with ringtail possums representing 80% of animal cases reported in Vic from 2022 to the end of August 2025^[18]. There appears to be a significant disease burden in ringtail possums in some areas with adult animals most commonly affected. Ringtail possums appear more

¹ National wildlife health information system (eWHIS) data.

likely to have persistent lesions and to suffer from systemic disease associated with BU than other infected marsupials ^[11].

Epidemiology

The global distribution of BU is highly focal, with cases restricted to well-defined geographic clusters ^[10]. The long incubation period in humans and frequently delay in diagnosis have hindered a deeper understanding of the epidemiology. The epidemiology of MU transmission appears to be changing in south-east Australia, with increasing numbers of human cases and expansion into new geographic areas ^[2]. The reasons for the change in epidemiology are not known. Most recent Australian studies have focused on endemic and emerging-endemic areas in Vic. More information is available at <https://www.health.vic.gov.au/infectious-diseases/local-government-areas-surveillance-report>.

The **incubation period** is unknown in animals, but in humans it can range between a few weeks and over nine months (median 4.5 months) ^[19].

The **mode of transmission** is unconfirmed, but it is likely to vary with different geographic and epidemiological scenarios ^[20] and there may be differences in virulence across geographically separate bacterial strains. MU is considered an environmental pathogen and is very rarely transmitted from person-to-person (only one case of human-to-human transmission has been documented, in a West African child bitten by a playmate ^[21]). Humans encounter the pathogen only in specific geographic areas, frequently near water bodies – either along coastal areas, or inland near slow flowing rivers, swamps and lakes. In Vic, the presence of environmental water does not appear to be as clear a risk factor as in West Africa ^[13]. Reports indicate people may become infected after spending as little as two hours in an endemic area in Vic ^[19]. Despite extensive environmental sampling, research has not yet identified a likely environmental origin of MU in Vic.

Infection is believed to occur primarily via penetrating skin injuries, such as punctures, cuts or scratches, which introduce bacteria from the environment into the host's subcutaneous tissues ^[22]. In Australia, BU is both **vector-borne** and **zoonotic**. Here, infection can follow bite wounds from infected small mammals, such as possums (there is one case report describing direct transmission of MU from a ringtail possum to a human in Australia ^[23]), and insects such as mosquitoes ^[22, 24-27].

Research has investigated a potential role for a **mammalian reservoir or amplifying host**. In Vic, common ringtail and common brushtail possums from endemic areas, both with and without clinical disease, have been shown to shed large numbers of MU in their faeces ^[8, 10, 11, 13, 28-30]. Studies in Vic have found an association between cases in humans and the presence of ringtail possums with MU positive faeces in the same area ^[8, 13, 29], and have developed epidemiological models that can use possum faecal surveys to predict the risk of BU occurrence in humans ^[13, 28]. This suggests that in Vic, possums ingest MU from the environment, amplify it within their digestive tract and shed it in the faeces, which then provides an environmental source of infection for people and other animals. MU was also found in the faeces of feral red foxes in Vic, and it is thought that these common and widespread predators may consume MU-infected possums and contribute to the geographic spread of the bacteria ^[13, 31].

Aedes notoscriptus mosquitoes are likely **vectors** in Vic, where they have been shown to carry MU and to sequentially feed from possums and humans [29].

The epidemiological model in **Qld** appears to be different to south-east Australia, with outbreaks occurring sporadically, possibly associated with heavy rainfall and associated environmental changes. In these areas MU has been found in northern brown bandicoot faeces, indicating a possible role for this species in the ecology of MU disease [9].

Clinical signs

Slow-growing destructive skin ulcers are typically observed in humans and other domestic animals. Most cases of BU in wildlife exhibit cutaneous ulcerative lesions, sub-cutaneous nodules or swelling of paws, limbs or digits. There may be an undermined skin ulcer, with necrotic fat frequently visible at the base (Fig. 1).

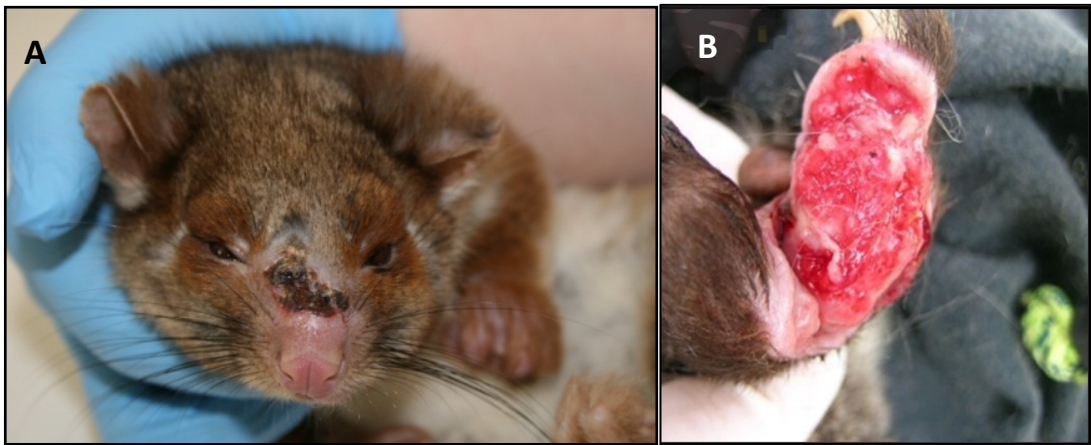


Figure 1. A. Ringtail possum with lesion on nose. B. Mountain brushtail possum with severe paw lesion.

Common ringtail possums appear to be highly susceptible to infection and potentially to more severe disease. Severe deep ulcerative paw lesions, causing extensive tissue necrosis and exposing bones and tendons, have been reported in ringtail possums in Vic [32]. Oedematous forms of BU, often misdiagnosed as bacterial cellulitis, have been reported in possums (and humans) [32-34]. Although less common, these lesions tend to be more severe.

In rare cases, BU lesions have been known to resolve without treatment, as in the case of a mountain brushtail possum from Bellbird Creek and a brushtail possum from Point Lonsdale (unpublished). In severe cases, advanced disease can necessitate euthanasia. Clinical impacts of systemic infection are not known.

Behavioural signs of BU in animals may include lethargy, limited movement and, in the case of koalas, resting on the ground.

Diagnosis

Diagnostic criteria include:

- animal lives in an endemic area
- animal has an ulcer with no other apparent cause, usually on an extremity, and which may have undermined edges
- acid-fast bacilli demonstrated in diagnostic specimens.

Laboratory diagnostic specimens and procedures

Collect:

- swabs (dry or in transport medium)
- fresh tissue
- paraffin-embedded fixed tissue sections.

Diagnostic procedures:

- direct smear examination for acid fast bacilli (AFB)
- culture for *M. ulcerans*
- polymerase chain reaction (PCR)
- histopathology.

PCR is the most rapid, sensitive and specific method for the diagnosis of BU ^[35]. This test is performed at the Victorian Infectious Diseases Reference Laboratory (792 Elizabeth St, Melbourne 3000, phone: 03 9342 9379, www.vidrl.org.au). It is advisable to contact the laboratory prior to sending a specimen for testing.

Pathology

The mycolactone toxin produced by MU has cytotoxic, immunosuppressive and analgesic properties, resulting in the formation of painless ulcers, with often minimal inflammation.

Histopathological examination of cutaneous lesions typically reveals ulcerative necrosis of the skin, muscle and underlying tissues, which in severe cases can extend to adjacent bone. Thick serocellular crusts or necrotic tissue plugs may partially or completely cover the ulcerated surface. Gram-positive and acid-fast bacilli can usually be seen both on the surface and deep within the dermis and underlying tissues. Ulcer margins may be hyperplastic and show varying signs of ongoing cutaneous healing.

MU has been detected in internal organs of severely infected ringtail possums, and pathological changes indicative of pulmonary oedema, hepatitis and pancreatic atrophy were observed ^[11, 32].

Differential diagnoses

Other causes of skin ulcers in Australian mammals include trauma, other mycobacterial and infectious skin ulcers, sarcoptic mange or other external parasite infestations ^[36], poxvirus infections ^[37], fungal infections and exudative dermatitis of possums ^[38] and tularaemia ^[39].

Treatment

Various medical and surgical methods have been used to successfully treat MU disease in domestic animals, including antibiotics, surgical excision and cryosurgery ^[4, 6, 7]. In wildlife, however, these prolonged therapeutic interventions are neither established nor likely to be suitable. Some marsupial species, including ringtail possums, are highly sensitive to adverse effects of antibiotics, and the resultant disruption of the digestive system can prove fatal ^[40].

Human treatment is not addressed in this Fact Sheet.

Prevention and control

Effective strategies for prevention and control of the disease in wild animals are not considered feasible at present, although vaccination of possums has been proposed as a future control measure that could benefit both animal and public health ^[41]. People working with wildlife in endemic areas of Australia should be alert to the possibility of this disease if they encounter native mammals with skin ulcers. It is recommended that anyone handling possums should implement personal protective measures, such as wearing gloves, and promptly washing and disinfecting any bites or scratches inflicted by possums. Referral of diseased animals for treatment or euthanasia by veterinarians experienced in the diagnosis of this condition is recommended.

Members of the public are advised to adopt a range of precautions in endemic areas, including covering up when outdoors, avoiding insect (especially mosquito) bites, protecting skin wounds with occlusive dressings and promptly disinfecting any new scratches or cuts. Early diagnosis in humans is critical for optimising treatment outcomes ^[42].

More information about BU is available at: www.health.vic.gov.au/infectious-diseases/mycobacterium-ulcerans-infection. Information on mosquito control and bite prevention is available at: www.betterhealth.vic.gov.au/protect-yourself-mosquito-borne-disease. WHA's public health communication guide on Australian possums, with a focus on BU is available at: <https://wildlifehealthaustralia.com.au/Portals/0/ResourceCentre/BiosecurityMgmt/Possum%20Communication%20Guide.pdf>

Research

The World Health Organisation (WHO) has identified six main priorities for research into BU: mode of transmission; development of simple diagnostic tests; drug treatments and new treatment modalities; development of vaccines; social and economic studies; and studies to determine the incidence and prevalence.

In Australia, much research has focused on determining the mode of transmission and environmental source of MU. Further work is needed to gain a better understanding of the role and drivers of ringtail and brushtail possums in transmission, if there are any epidemiological interactions between these two species, and whether the relative population density of ringtail and brushtail possums influences endemicity and/or emergence of BU in humans. Other important knowledge gaps include the prevalence and pathogenesis of MU lesions in possums in BU-endemic areas, the susceptibility of different Australian marsupial species to MU infection, the possibility

and extent of gut amplification in marsupial species and whether BU poses a risk to populations of possums or other marsupial species.

Possum faecal surveys may provide a useful public health monitoring tool by informing modelling that can predict particular times of year and geographical areas at highest risk of MU transmission [28].

Genomic studies could help to explore whether different pathogen strains are associated with different virulence, and whether strains are evolving and changing in virulence over time [2].

Surveillance and management

There is no targeted surveillance program for MU disease in wildlife, and BU is not a notifiable animal disease in any Australian state or territory. A greater awareness of the disease among veterinarians and wildlife carers, particularly in endemic areas of Vic, as well as active case finding as part of research, has led to increased reporting of cases in wildlife and domestic animals.

The WHO Collaborating Centre for MU – based at the Victorian Infectious Diseases Reference Laboratory (VIDRL) in Melbourne – maintains records of all known human and animal cases of MU disease in Australia. In Vic, the Department of Health publishes statistics on notifiable infectious diseases in humans, including MU infection, on its website www.health.vic.gov.au.

Wildlife Health Australia administers Australia's general wildlife health surveillance system, in partnership with government and non-government agencies. Wildlife health data is collected into a national database, the electronic Wildlife Health Information System (eWHIS). Information is reported by a variety of sources including government agencies, zoo-based wildlife hospitals, sentinel veterinary clinics, universities, wildlife rehabilitators, and a range of other organisations and individuals. Targeted surveillance data is also collected by WHA. See the WHA website for more information <https://wildlifehealthaustralia.com.au/Our-Work/Surveillance> and <https://wildlifehealthaustralia.com.au/Our-Work/Surveillance/eWHIS-Wildlife-Health-Information-System>. There are over 30 cases reported in eWHIS from free-living marsupials from endemic areas of Vic, mostly in ringtail possums.

WHA is interested in hearing from anyone with information on this condition in wildlife in Australia, including laboratory reports, historical datasets or survey results that could be added to the National Wildlife Health Information System. If you can help, please contact us at admin@wildlifehealthaustralia.com.au.

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Wildlife Health Australia recognises the Traditional Custodians of Country throughout Australia. We respectfully acknowledge Aboriginal and Torres Strait Islander peoples' continuing connection to

land, sea, wildlife and community. We pay our respects to them and their cultures, and to their Elders past and present.

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