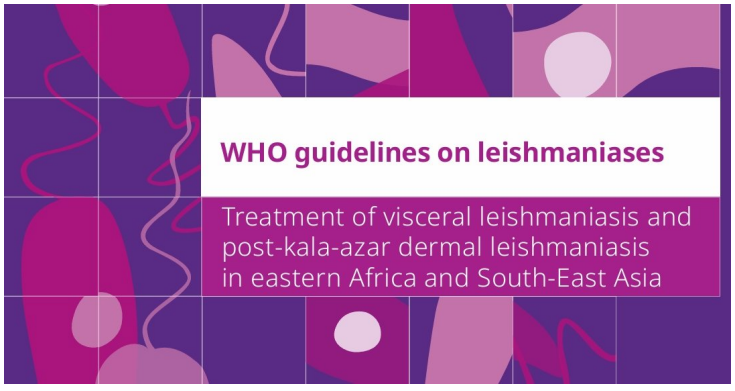
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WHO updates treatment guidelines on visceral and post-kala-azar dermal leishmaniasis

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Countries affected by visceral leishmaniasis and post-kala-azar dermal leishmaniasis are expected to incorporate them into their own national treatment protocols soon



The World Health Organization (WHO) has issued major updates to its leishmaniasis treatment guidelines for eastern Africa and South-East Asia, recommending new regimens that significantly improve patient care. The new WHO guidelines, released today, are applicable for visceral leishmaniasis (VL, also called kala-azar), a deadly disease, and for post-kala-azar dermal leishmaniasis (PKDL).

The updated guidelines include (i) alternative, shorter and safer treatment of primary VL in eastern Africa; (ii) new, shorter, effective and safer treatments for PKDL in eastern Africa and South-East Asia; and (iii) relapse management in immunocompetent VL patients in South-East Asia. Additionally, it updates the safety profile of miltefosine, incorporating the recommendations of the WHO Advisory Committee on the Safety of Medicinal Products, and provides allometric dosing for miltefosine.

For a long time, treatment in Africa relied on an injectable drug called sodium stibogluconate (SSG), which requires lengthy treatments and painful daily injections and caused severe side effects.

For the first time, WHO recommends SSG-free regimens. However, this medicine remains in use for patients who are not eligible for the newly recommended treatment options. In eastern Africa, an oral drug, miltefosine, is recommended for the treatment of both VL and PKDL in combination with paromomycin injection. In South-East Asia, new, safer, shorter combination therapies using liposomal amphotericin B infusion alone or in combination with oral miltefosine are recommended for people living with PKDL.

The new VL treatment in eastern Africa is given over 14 days with one injection less and with less toxicities over the current administration of two injections of sodium stibogluconate and paromomycin over 17 days.

In eastern Africa, chronic cases of PKDL used to be treated with toxic sodium stibogluconate given for 30–60 days or with liposomal amphotericin B over 20 days, whereas in South-East Asia, a 12-week regimen of miltefosine was in practice. New recommendations will replace these lengthy and cumbersome treatments. It is expected that almost half of the primary VL and all PKDL patients will potentially benefit from these life-changing recommendations. In addition, the subset of VL patients who relapse will also benefit from the newer, clearer recommendations for its management in South-East Asia. For the remaining VL patients in Africa, who are not eligible for miltefosine combination, they will still have to rely on older regimens, till new therapies are available.

Many of the new therapies now recommended by WHO were developed by the non-profit medical research organization Drugs for Neglected Diseases initiative (DNDi) and partners.