



The Secretary of the WHO Expert Committee on the  
Selection and Use of Essential Medicines  
Policy, Access and Rational Use  
Department of Medicines Policy and Standards  
World Health Organization (WHO)  
20 avenue Appia  
1211- Genève 27  
Switzerland

Antwerpen, January 12, 2009

RE: Inclusion of NECT onto the WHO Essential Medicine List

By email: emlsecretariat@who.int

To whom it may concern,

We are happy to endorse DNDi's application for the inclusion of NECT, the co-administration of oral nifurtimox with intravenous (IV) eflornithine (DFMO), for the treatment of stage 2 *T. b. gambiense* sleeping sickness onto the WHO Model List of Essential Medicines.

The available clinical data on NECT convincingly demonstrate that NECT is not inferior to DFMO monotherapy in terms of efficacy and safety. The conduct of the NECT pivotal phase-3 trial has been exemplary in terms of quality of follow-up and in terms of respect of GCP standards in a very difficult context.

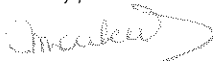
Several years of research on sleeping sickness control in Central Africa have shown us how urgent the need is for novel safer and more efficacious drugs for stage 2 sleeping sickness. A retrospective chart review conducted by our collaborator J. Robays of 4,925 human African trypanosomiasis (HAT) patients treated with melarsoprol in 2001–2003 in Equateur Nord Province of the Democratic Republic of Congo (DRC) showed a treatment failure rate of 19.5%<sup>(1)</sup>. A recently conducted prospective cohort study by Dr D. Mumba in Kasai Province (DRC) points to much higher melarsoprol failure rates (manuscript in preparation), making its use completely obsolete.

The national HAT control program of DRC has recently changed its policy to a two weeks course of IV DFMO in those high resistance areas, but this regimen is very complex, requiring 4 daily infusions (over 2 hours each), and IV-line switches every 2-3 days. Undersigned, E. Bottieau, recently visited HAT treatment centers in Kasai and can testify to the difficulties this regimen poses in the field. For rural treatment wards with about 8 to 10 stage 2 HAT patients staffed by only one nurse, DFMO monotherapy regimen keeps this nurse fully busy on a 24 hour basis changing IV drips, and this raises unavoidably a high risk of suboptimal DFMO administration. In this respect, the NECT regimen presents great value for patients and health workers alike, as it will reduce the intravenous DFMO treatment duration (from two to one week), the DFMO-related toxicity (by halving its total dosage) and also the burden on the nursing staff as well as the logistical constraints posed by DFMO monotherapy. The number of infusions required is reduced from 4 to 2 every day, reducing also the catheter-related infectious risks, with the additional advantage that no nighttime infusions are required. The bulk of goods is also reduced substantially, providing major advantages in transport and storage costs.

Moreover, legitimate concerns have been raised regarding the use of DFMO in monotherapy as first-line treatment because there are no alternatives if resistance to it emerges. The combination regimen proposed in NECT will extend the useful lifespan of DFMO and secure the necessary time for current R&D efforts to deliver on novel compounds for sleeping sickness treatment.

From the evidence available to us, we conclude that NECT is an improved treatment option for stage 2 HAT which can make immediate impact if it is readily adopted and then implemented. We therefore endorse its inclusion in the Essential Medicines Model List.

Yours sincerely,

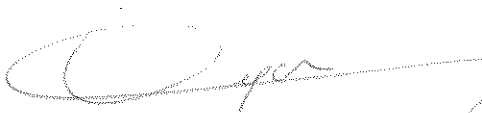


**Prof. Dr. Marleën Boelaert**

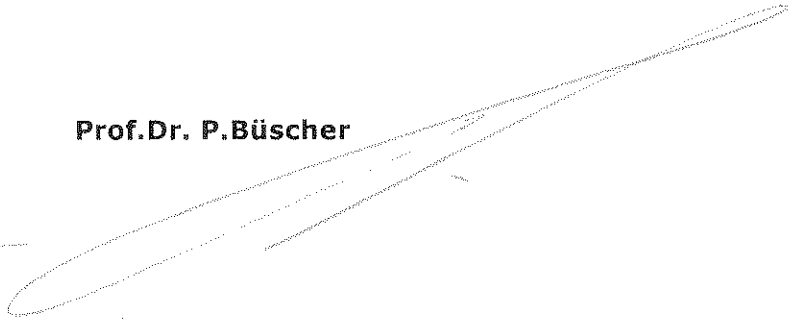


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<sup>(1)</sup> Robays J, Nyamowala G, Sese C, Betu Ku Mesu Kande V, Lutumba P, Van der Veken W, Boelaert M. High failure rates of melarsoprol for sleeping sickness, Democratic Republic of Congo. Emerg Infect Dis. 2008 Jun;14(6):966-7.