WHO resolution on access to palliative care

On Jan 23, WHO's Executive Board introduced a resolution urging member states to integrate palliative care services into their health-care systems. They described provision of such care as an "ethical responsibility", and added that, when needed, palliative care is "fundamental" to improve quality of life, wellbeing, comfort, and human dignity. In May, the resolution will be presented to the World Health Assembly, but ratification should be a formality.

This WHO resolution is the first to explicitly address palliative care and access to pain medication. It tackles a huge issue. "5·5 billion people (83% of the world's population) live in countries with low to non-existent access to controlled medicines and have inadequate access to treatment for moderate to severe pain", according to WHO. The organisation estimates that at least 40 million people worldwide require some kind of palliative care every year, about a third of whom have cancer. Every year in countries of low and middle income, 5·5 million patients with terminal cancer do not receive adequate pain management. Predictably, the need is greatest in countries of low and middle income.

"It is an extraordinarily strong resolution", Diederik Lohman (Human Rights Watch, New York, USA) stated. "It has very specific calls to member states on integrating palliative care into their health budgets and on training health-care workers", he commented, adding that poor training has been a crucial issue in the rolling out of palliative care.

The importance of opioid analgesics for pain management has been stressed. "We hope that countries will start taking active measures to critically look at how they deal with controlled medication at a national level", said WHO's Kees de Joncheere. He noted that, in many places, various barriers prevent patients from accessing these drugs. A 2010 report from the International Narcotics Control Board described the use of opioid analgesics as "very inadequate" in more than 100 countries worldwide.

The next step, Lohman said, is to implement the recommendations. WHO has issued several guidance documents about pain management, and will provide technical support. Questions remain about how much funding will come from WHO and how much from individual states. Still, the resolution is an important step. "We hope that this [resolution] will create a momentum to really take palliative care seriously", concluded de Joncheere. "We know what needs to happen, now we need to turn the words into practice."

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For the **WHO resolution** visit http://apps.who.int/gb/ebwha/pdf_files/EB134/B134_R7-en.pdf

For more on **access to controlled medicines** see http://www.who.int/medicines/areas/quality_safety/ACMP_BrNote_Genrl_EN_Apr2012.pdf

For the **International Narcotics Control Board report** see https://www.incb.org/documents/Publications/AnnualReports/AR2010/Supplement-AR10_availability_English.pdf

Idelalisib: targeting PI3Kδ in B-cell malignancies

Idelalisib—a first-in-class selective inhibitor of phosphoinositide-3-kinase delta, which is expressed only in haemopoietic cells—has been shown to be effective for treatment of B-cell malignancies in two clinical trials.

First, in a single-group phase 2 study, researchers enrolled 125 patients with refractory, indolent non-Hodgkin lymphoma. Idelalisib (150 mg orally, twice daily) induced an objective response in 71 patients (57%), of whom seven (6%) achieved a complete response. Median progression-free survival was 11 months. Responses were reported for patients with all subtypes of indolent non-Hodgkin lymphoma studied, including marginal-zone lymphoma and lymphoplasmacytic lymphoma with or without Waldenström macroglobulinaemia.

"Patients had disease that was refractory to both rituximab and alkylating agents", said author Ajay Gopal (Fred Hutchinson Cancer Research Center and University of Washington, Seattle, WA, USA). "The most remarkable part of this study was efficacy without major toxicity. Side-effects were very manageable." Gopal added that, for disease that is managed rather than cured with chemotherapy, the aim should be to "maintain quality of life and effectively manage the disease for long periods of time". He further commented: "One could envision—if future studies support this—using idelalisib up front instead of using toxic chemotherapy".

In a phase 3 study, idelalisib plus rituximab was compared with placebo plus rituximab for treatment of 220 patients with relapsed chronic lymphocytic leukaemia (CLL) who could not tolerate standard chemotherapeutic agents. Compared with patients receiving rituximab alone, more patients receiving idelalisib plus rituximab achieved overall response (81% *vs* 13%) and overall survival at 12 months (92% *vs* 80%). Median progression-free survival was also increased (not reached *vs* 5·5 months).

Author Richard Furman (Weill Cornell Medical College, New York, NY, USA) said: "This placebo-controlled trial met its efficacy endpoints at the first interim data analysis, resulting in the data safety monitoring board halting the trial and moving everyone from placebo to active agent". He added that "idelalisib is a paradigm-changing drug for patients with CLL", with responses far better than he imagined. On Dec 6, 2013, an application was filed with the Food and Drug Administration, and idelalisib for relapsed CLL was given Breakthrough Therapy designation.

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For the **phase 3 study** see *N Engl J Med* 2014; published online Jan 22. DOI:10.1056/NEJMoa1315226