Campath 1h discarded by Wellcome

Prospects for immunotherapy suffered a blow last week when Wellcome decided to discontinue development of the humanised antibody Campath 1h. The antibody was one of the first immunosuppressive antibodies to be developed by researchers at the University of Cambridge and, because of the way it caused lymphocyte lyis mediated through complement activation and antibody-dependent cytotoxic mechanisms, its future as a therapy in autoimmunity, transplantation, and leukaemia (mainly non-Hodgkin lymphoma and associated lymphocytic leukaemias) was thought to be certain.

Various data from phase II studies have shown that Campath 1h tends to have only low or moderate activity in non-Hodgkin lymphoma and advanced stages of rheumatoid arthritis, and Wellcome felt the product was not commercially viable. However, this decision may not mean the end of Campath 1h. Wellcome's Campath 1h project leader Philip Bedford said that in a pilot study of 12 transplant patients Campath 1h reversed rejection in all cases, and he thinks that a more specialist biotechnology company may develop the antibody. Talks are being held with the co-licenser, the British Technology Group, to discuss whether outlicensing the product is feasible.

Herman Waldman, one of the early researchers into the antibody, believes that it has potential in areas such as bone-marrow transplantation, multiple sclerosis, or renal allografting and agrees that the development of such drugs may be suited to a small specialist company.

Analysts had forecast that Campath 1h would be launched by 1997 with potential annual sales of $250 million. Wellcome's share price dropped £0.06 to £6.75 after the announcement.

Clare Thompson

Prospective look at breast surgery timing

On both sides of the argument over the timing of surgery for breast cancer there is agreement that a prospective study to settle the question is required. Just such an inquiry, the multicentre Intervention, Timing and Survival study, was launched 18 months ago in Yorkshire and has invited participation from interested centres. This study aims to collect prospectively data on frequency and length of menstrual cycle, and no change in surgical practice is envisaged (indeed this would nullify the study). Despite advertisement, only about 100 patients have been entered, mostly from Yorkshire. Why? The initial requirement for collection of blood for hormone analysis at biopsy or mammography and again at the time of surgery can be waived for centres unable to provide such samples, or the analyses can be done centrally if cost is a problem. Mr Richard Sainsbury, from Huddersfield, one of the study's organisers, concludes that "certain groups are more than willing to write to *The Lancet* with retrospective data but are unwilling to contribute to a prospective study". The target number is 600, and anyone interested in having a speedy answer to this important question is invited to contact Philip Melling, YRCO Trials Office, Cookridge Hospital, Leeds LS16 6QB, UK.

David Sharp

Needle-exchange programme against AIDS in Brazil

The number of new AIDS cases in Brazil has stabilised for the first time. The increase for 1992–93 was 2%—there were 11 319 new cases in 1992 and 11 522 in 1993. These data were released by the Ministry of Health, which said that the total number of registered cases by early September this year, since the first person was diagnosed in 1980, is 55 894. Lair Guerra, director of the national programme against sexually transmitted diseases/AIDS, said that there is no information on the number of new cases of HIV infection.

In 1990, a Brazilian person with AIDS would live on average for 5·8 months after diagnosis. The national survey for 1994 is not yet finished, but research done in the southern state of Rio Grande do Sul has shown that patients can expect to live for 12 months after onset of disease. Guerra credits the increase in life-expectancy to improvements in therapy and to the provision of medicines such as zidovudine for free.

The government has also launched a programme of needle and syringe exchange. The US$9·1 million project will be financed both by the Ministry of Health and the United Nations. From November, drug users will be able to exchange used needles and syringes for new ones in five cities out of a list of seven that have been approved by the Ministry of Justice, which include Rio de Janeiro and Santos. Drug users will have to register in health centres and universities, where they will also receive medical and psychological attention.

Claudio Csillag

UK incapacity for work test

From April next year, when the UK's Incapacity for Work Act (1994) comes into force, entitlement to an allowance for inability to work on medical grounds will be based on a new test for assessing incapacity for work.[1,2] With many countries examining their own social security systems there could well be international interest in the development and the effect of the new test. It will also interest insurance underwriters.

The change was prompted by concern about the huge increase in numbers of people receiving invalidity benefit—from 600 000 in 1978/79 to 1·5 million in 1993/94. The rise is attributed to blurring of the original definition of incapacity for work brought about by decisions made by appeal bodies. Under the existing system, the lay adjudicators for entitlement are guided to a large extent by the statements of incapacity made by the claimant's doctor, usually the general practitioner. Fuzziness of the definition enabled some doctors to be charitable in their assessments.

The new system has been designed to exclude the influence of non-medical factors and of the doctor-patient relationship. Developed over the past 2–3 years, the new test of incapacity—for all work—involves a scoring system and will be applied from the 29th week of incapacity. For the first 28 weeks claimants will be assessed against their ability to do their own job, according to current procedures. For the new, test scores are given to "descriptors" in 15 "functional areas" such as walking, sitting, rising from sitting, speech, hearing. The seven descriptors for walking, for example, start with "cannot walk at all", and go on to "cannot walk more than a few steps without severe discomfort", right up to "no walking problem". If total scores exceed a certain threshold, the claimant will qualify for benefit. It is the claimant who identifies the appropriate descriptor. The claimant's doctor will provide medical information but need not give an opinion on capacity for work. Certain categories are exempted from the test. Nobody will be deemed capable of work without a clinical examination.

80 experts drawn from disabled people, their representatives, and the academic and medical communities helped in the development of the functional areas, the descriptors, and the thresholds. Two field evaluations indicated reasonable consistency among claimants, adjudicators, and doctors in their use of the new test. The discrepancies (table) between the new test and the "gold standard" (a comprehensive clinical examination and interview) in the first evaluation pointed to the need for training for Benefits Agency Medical Service doctors and for additional medical criteria to be applied when functional