produce similar irritant dusts, fumes or gases need to be evaluated for small-airway disease that could result in similar serious impairment.

References


http://content.nejm.org/cti/content/full/347/5/339/F1

Work-related injury is a daily concern for many occupational physicians, whether advising on prevention, management or for rehabilitation purposes, or assessing fitness. However, in relative terms, work is an infrequent cause of injury in those of working age. A study by Plugge et al. [1] in Journal of Public Health Medicine of 8888 adults of working age found that 16% reported an injury requiring medical attention in the previous 12 months. Five per cent were disabled for >1 month and a further 5% reported long-standing disability as a result of injury. Sport was found to be the commonest cause of all injuries and of disabling injuries. Accidents at work were the fourth most common overall cause of injury, after sport, home and other causes. For males aged between 55 and 64 years, work became a more important cause, presumably as participation in sport declined. The authors also found a dose–response relationship between vigorous exercise and injury.

As if to demonstrate this, Marshall et al. [2], in International Journal of Epidemiology, reported a study comparing injury rates in American football and New Zealand club rugby union. In particular, they wished to investigate the effects of the different use of protective equipment in the two sports. They found the injury rate in American football to be one-third of that in rugby, the head being the site with the greatest differential in injury incidence. Rugby players were nine times more likely to suffer head injury, whilst the incidences of ankle and knee injury were similar in both sports. The authors conclude that regulations which make protective equipment mandatory reduce the incidence of injury and that further research is required into head protection for rugby players.

References


How many times have you been in noisy workplaces and seen workers whose earplugs are clinging precariously to the external auditory meatus? How many of us routinely stop to advise the wearer on the correct method of insertion? And if we do, does it make any difference? A study in the August edition of Annals of Occupational Hygiene suggests that it does make a difference and that we should make the effort to advise on correct insertion. Toivonen et al. [1] divided 54 male subjects into two groups, and gave one group a lecture and training on earplug insertion. They measured effectiveness using two different methods (microphone in real ear and real ear at threshold) and also by visual evaluation using a 0–3 scale. The trained group had an averaged A-weighted noise attenuation 10 dB greater than the untrained group, while attenuation at 1000 Hz was 6dB greater than in the untrained group. On visual evaluation, the trained group scored 2.6, against 1.9 for the untrained group. The authors suggest that training in earplug insertion is important for good attenuation.

References


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