In this issue of *Occupational Medicine*

Occupational medicine has a strong history rooted in heavy industry and manufacturing. It is disappointing that despite all of our knowledge and advances in technology, ‘classical’ occupational diseases continue to occur.

Walters et al. [1] describe a case series of 14 metal-workers involved in automotive engine valve manufacture who developed cobalt asthma between 1996 and 2005. The workers were predominantly stellite grinders, stellite welders or machine setter-operators. The authors describe a detailed work-up including OASYS computer analysis ([http://www.occupationalasthma.com](http://www.occupationalasthma.com)) of serial peak flow measurements and responses to skin prick tests and inhalation challenges. Whilst cobalt asthma is well recognized and documented in the literature in other occupations, this is the first time a case series of this size, from a single company and involving metal workers has been reported. The paper demonstrates not only the importance of reporting systems to identify such cohorts but also the essential need for specialized services within the National Health Service in order to properly investigate such cases.

The relationship between silicosis and the development of systemic lupus erythematosus (SLE) has been well described but only in cases of acute or accelerated silicosis. Lucas et al. [2] describe a case of SLE in a young male former stone mason with simple silicosis and draw a link between occupational silica exposure and autoimmune disease including SLE, highlighting the importance for clinicians of taking a good occupational history, especially in males developing the condition. Given that it is rheumatologists who are most likely to see potential cases of SLE, there is a clear message for their training in occupational history taking.

The occupational health aspects of influenza present a more recent challenge to occupational physicians. Tsai et al. [3] consider the burden of influenza-like illnesses in the US workforce and calculate that the mean number of hours lost per episode is approximately 24 with around 1.2% of employees experiencing such an episode in 2008–2009. They rightly conclude that this is a considerable disease burden requiring attention and input from both policymakers and health care professionals. So what to do?

An obvious answer is vaccination but uptake of influenza vaccine, even when provided free of charge and conveniently delivered at the workplace, is notoriously poor in some hospitals and businesses. Lewthwaite et al. [4] looked at health care workers’ attitudes after the 2009 flu epidemic and the reasons why they had declined vaccination. They describe some useful insights for anyone planning a future campaign: willingness to be vaccinated increased with age, senior doctors were the occupational group most likely to be vaccinated but where they declined it was because they viewed influenza as trivial. Females were more likely to decline vaccination due to a fear of side-effects—a message regarding the need for myth busting in any campaign. Junior doctors cited the lack of availability of immunization sessions as one of the main reasons why they had not had the vaccination, suggesting flexible availability tailored to work patterns is needed. The paper concludes with a clear message—a one-size-fits-all approach to influenza immunization campaigns does not work, more effort needs to go into tailored campaigns for different genders and groups.

Nerys Williams

*Assistant Editor*

**References**


