As occupational medicine has become more established, the awareness of health problems, either caused or exacerbated by exposures in the workplace, has increased. As a group of disorders, occupational skin disease is certainly very common. The OPRA reporting scheme from 1996 to 1999 showed that work-related dermatological problems accounted for 20% of reports, just overtaken by mental ill-health at 20.9% [1]. Musculo-skeletal problems were the most frequent at 49.1% and respiratory ailments were fourth at 8.1%. However, if one looks at specific disease reporting, then contact dermatitis is the second most frequent occupational condition in the UK. Looking at the diagnostic groups for occupational dermatoses, the most recent figures from EPIDERM [2] from January to March 2003 showed that contact dermatitis represents 83%, contact urticaria 3%, infective causes 4% and neoplasia 10% of cases reported. The three reviews in this issue cover occupational dermatitis, occupational skin cancers and occupational skin infection, respectively, in more detail [3–5]. Other occupational dermatoses, such as halogen acne, chemical depigmentation and work-related connective tissue disease, are recognized but are very rare. Further information on these rare conditions is published elsewhere [6–8].

It has been estimated that 4 million working days are lost due to work-related skin disease and the UK Health & Safety Executive has calculated an associated cost to British industry of £200 million per year. Not only is occupational contact dermatitis very costly, it also has been shown to have an appreciable impact on quality of life [9]. The prognosis after developing occupational contact dermatitis can be poor and lead to loss of occupation [10]. However, there is evidence that, if contact dermatitis is treated early, then the prognosis is improved. Therefore, identifying these patients is important for their future lives and the industries in which they work.

Unfortunately, diagnosing occupational dermatoses is not always easy. Diagnostic difficulties arise from dermatitis. Great care should be taken in making a distinction between contact dermatitis and endogenous eczema and other dermatoses, and between irritant and allergic contact dermatitis, as the aetiologies and implications for the patient are quite different (Figure 1). Not only is dermatological knowledge important, but also the occupational history is vital in making a diagnosis. Lack of knowledge and lack of diagnostic tests often make it difficult to confirm a diagnosis of occupational dermatosis [11]. The following are well-recognized indicators of an occupational origin: occupational contact with an agent known to cause similar skin changes in other individuals; the occurrence of similar dermatosis in fellow workers within the same occupation; a time relationship between exposure and dermatitis; type and site of lesions consistent with occupational exposure; similarity to other post-exposure episodes of dermatitis followed by an improvement and resolution after removal. A detailed history and examination corroborated by patch and/or prick tests results is usually necessary in making the diagnosis as accurately as possible.

With an increase in litigious climate within our society, medico-legal and insurance claims are becoming more frequent. It is therefore crucial for expert witnesses to provide evidence of causal contributory factors at work to the dermatosis and also to document the severity of the
problem and loss of amenity. These three reviews should help provide a framework upon which experts can base their opinions.

As with all areas of medicine, prevention is better than a cure and there is good evidence that if such systematic programmes for prevention are undertaken, then a reduction in the instance of dermatitis will occur [12].

The purpose of these review articles is to improve knowledge in important areas of common occupational dermatoses so that we are better prepared in managing skin disease in the workplace.

References