CORRESPONDENCE

Occupational asthma in New Zealanders: a population based study

EDITOR,—The community based study of asthma attributable to occupational exposures by Fishwick et al contributes to our appreciation for the types of occupations with increased risk for wheeze, asthma symptoms, and bronchial hyperreactivity (BHR). For computing the proportion of asthma attributable to occupational exposures, the authors took care to initially define the groups that would be considered at risk. Thus, they avoided a positive bias in computing the attributable risk (AR) due to occupational exposures that would occur if the investigators had used a data based criterion for occupational risks—for example, considering occupational groups eventually exposed based on a univariate analysis of the AR of occupational asthma would have been higher for workers with occupational asthma than the AR estimated in the control group. Although the authors noted two key implications for the design of studies to obtain an unbiased measure of AR that applied provided that any misclassification is non-differential: (1) all exposed people must be classified as exposed; and (2) misclassifying unexposed people as exposed does not affect the point estimate of the AR, but does increase its SE.

The New Zealand study clearly shows that narrow definitions of exposure result in underestimated AR. As indicated by the authors, the initial high risk group excluded several occupations with well known risks of asthma including farming, hairdressing, food processing, and woodworking. Of these known high risk groups, farm workers and food processors, were included as exposed, the AR for onset of wheeze after the age 15 increased from 1.9% to 3.1%. Ng et al also used a case-control design to study the AR of asthma due to occupational exposures. However, their study differed from the one of Fishwick et al in that the case definition was based on clinically diagnosed asthma rather than responses to a questionnaire, and Ng et al used a broad definition of exposure to compute the AR of asthma due to occupational exposures. The estimate by Ng et al of AR for Singapore was more than 10 times higher than the AR reported for New Zealand. Although the different AR estimates may be largely due to differences in different exposure prevalences in the two countries and to different methods for ascertaining case status, the definition of exposure may also have contributed to these widely differing results.

The definitions for the control category in the two studies are similar. Therefore, it should be possible to compute the AR with the crude prevalence ratios from data in the tables of Fishwick et al to explore the effect of the narrow definition of exposure. Unfortunately, the tables report all wheeze, not just wheeze with onset after the age of 15. This points to an important problem with the reported odds ratios, which partly reflect the occupations chosen by people with childhood onset asthma rather than risk of asthma from occupational exposures. I have proceeded to compute the AR even with this crude data to make my point, but please note that these results are derived from age, sex, and tobacco smoking, and because they also do not exclude people with childhood onset of wheeze, do not correspond to the AR reported in the paper. The crude AR for wheeze, based on the defined occupational exposures, is 0.63%. However, when all those not in group 1 are considered as potentially exposed, the AR is 2.3%. Thus, had the authors computed the age, sex, and smoking adjusted AR for wheeze onset after age 15 with this broad definition of exposure it is likely that they would have obtained a higher estimate of the risk attributable to occupational exposures.

In contrast to this increase in occupational AR when wheeze defined case status, the AR declined from 1.79% to 0.34% when bronchial hyperreactivity (BHR) defined case status and a broad definition of exposure was used. This reflected the fact that the risk for BHR in several groups, most notably the “other food processing” group, dropped so precipitously that these exposures seemed to be protective for BHR even when they had been significant risk factors for wheeze. These major changes in risk suggest that differential misclassification may have been introduced by two types of selection bias. Firstly is the known bias arising from the significant attrition between the detailed questionnaire and methacholine challenge tests; the attrition was not evenly distributed among occupations. The odds ratio declined in four of the five occupational groups with a more than 40% drop in participation between the questionnaire and the BHR measurement, and in six of the 13 with better participation rates. This may suggest that asthmatic people employed in certain industries were less likely to attend methacholine testing than were asthmatic people in the control group. Although the authors reported that women and ex-smokers were less likely employed in testing BHR than men and non-smokers, they did not comment on the relation between wheeze or the combination of wheeze and occupation and testing BHR. It is also curious that one more spray painter participated in the BHR test than answered the questionnaire.

A low and uneven participation rate may be such that the conditions of non-differential misclassification are not met, and therefore, that Wacholder’s suggestions for unbiased measurements of AR would not apply. This may be especially true in this three stage study from New Zealand where the final participation rate for methacholine challenge was only 38% of the target study population (70% of the 64% who returned the detailed questionnaire were excluded from among the 84% who responded to the initial brief questionnaire).

The second selection bias affecting relative risks and ARs for BHR is that people are unlikely to select occupations independent of their BHR status. Thus, people with pre-existing BHR may be less likely to choose jobs in dusty trades, and so reduce the apparent risk in a study of BHR prevalence. What is really of interest here is the onset of BHR something that cannot be determined from a cross sectional case-control study.

Given the low participation rates and likely selection biases, the authors were correct to report AR only from the first or questionnaire stage of the study, and to compute it based on wheeze onset after the age 15. The use of narrow definitions of exposure may have been justified to defend against the selection bias resulting from the low and variable participation rates across occupations. However, given these limitations, we should not consider these definitive estimates of the attributable risk of asthma from occupational exposures in New Zealand. New study designs involving incident cases and capable of achieving higher participation rates across all occupational groups are needed to give us a clear answer to the question: how much of the asthma among adults is attributable to occupational exposures?

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Author’s reply—We thank Milton for, and read with interest, his comments concerning our recent publication in Occupational and Environmental Medicine. Indeed, the comments concerning our paper are valid and explore the variation in attributable risk (AR) of occupational asthma due to the use of varying definitions of asthma. We would like to respond particularly to two points made by Milton.

Firstly, he suggests that the AR for occupational asthma would have been higher for wheezing if we had adopted a broader definition of occupational exposures classified as being at high risk. In response, we would emphasise that we also expected this, and indeed our estimates of AR are likely to be an underestimate. In fact, we noted that the estimate would have been higher if we had excluded food processors (other than bakers). However, we also reported the findings for the more restricted exposure group, so that they could be compared with the findings of the Spanish group.2

References

Secondly, Milton makes the important point that the AR for bronchial hyperresponsiveness (BHR) dropped when a broader definition of exposure was used, and this may reflect possible types of selection bias. We similarly would agree with the possible biases he raises, but would counter that a further possible explanation could be the differences in the findings for wheezing and BHR due to differences in the findings for the control group (group M)—that is, that group M had a particularly low prevalence of wheezing or a particularly high prevalence of BHR either by chance, or because of unknown selection factors or occupational exposures. We would also comment that Milton is assuming that wheezing and BHR should show the same patterns, but this is not necessarily the case as wheeze, BHR, and asthma are not synonymous.

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NOTICES

Epidemiology and Occupational Risks.
22-24 April 1998. Graz, Austria.

This international conference on the role and importance of epidemiological studies in the prevention of and compensation for occupational accidents and diseases is organised by the occupational health section of the International Social Security Association (ISSA) in cooperation with the main Austrian social insurance against occupational risks, the AUVA.

The objective of the meeting is to review the experience with guides to good practice in epidemiology and to identify further improvements, to consider obstacles and ethical issues in conducting occupational epidemiology, and to discuss approaches for the critical interpretation and synthesis of the results.

The symposium will also review experiences and expectations for the use of epidemiological evidence by those working in prevention, compensation or regulation.

The two main topics of the symposium are:
- Epidemiology: methods, quality criteria and interpretation
- Epidemiology and those working in health and safety at work.

The meeting will be of particular interest to representatives of authorities responsible for the establishment of occupational exposure limits or the definition of lists of occupational diseases, labour medical inspectors and occupational physicians, safety engineers, and representatives of the social partners, social security institutions and occupational epidemiologists.

A round table on cooperation between researchers and practitioners to solve occupational health and safety problems will allow for an in depth discussion on experiences and the possibilities of a fruitful cooperation in the field.

The detailed scientific programme of the symposium including the registration documentation is now available.

Further information from: Office for International Relations and Conferences, Allgemeine Unfallversichersungsanstalt, Adalbert-Stifter-Strasse 65, A-1200 Vienna. Tel: +43-1-33111-537; Fax: +43-1-33111-469; Email: presse@auva.or.at


This conference is being hosted by the Workplace Safety and Health Division of Manitoba Labour and the InterAgency Committee on Agricultural Safety and Health.

The Planning Committee is represented by the Crop Protection Institute of Canada, Manitoba Labour, Manitoba Agriculture, Manitoba Hydro, Peak of the Market, the Prairie Implement Manufacturers’ Association, United Grain Growers, and the Workers Compensation Board of Manitoba.

All sessions and meetings are open to registrants. Children’s and spousal programmes will be provided.

Further information from: Glen G Blahy, 200-401 York Avenue, Winnipeg, MB R3C 0P8, Canada. Tel: 001 204 945 2315; Fax 001 204 945 4556; E mail: Gblahy@labour.gov.mb.ca

BOOK REVIEW

Book review editor: R I. Maynard

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It is difficult to conceive of any book dealing better with the scientific aspects of tuberculosis. This is not entirely surprising, however, given the experience and expertise of the authors who are widely known and respected by clinical and public health bacteriologists. Furthermore, this book is timely as the subject is of increasing importance. Although the incidence of tuberculosis has, until recently, declined in industrialised countries, this has not been so elsewhere. Moreover, the association of the disease with HIV infections and AIDS, as well as multiple drug resistance, has led to what now, with an estimated 5000 deaths daily world wide, is no less than a global emergency.

The authors are to be commended for covering the subject so comprehensively and concisely with excellent illustrations in little more than 100 pages. Despite its brevity, the book is a mine of essential information. After a brief historical introduction, the authors sort out clearly the tangle of mycobacterial nomenclature. Then, after a short clinical section, they describe the role and design of laboratories with special reference to their varying degrees of technical complexity.

There is commendable emphasis on all aspects of safety which include not only the design of the laboratory but also the collection and transport of specimens as well as their handling and processing in the laboratory. The section on training and motivation of staff is excellent. Of great importance also is the part dealing with sterilisation and safe disposal of infected waste material.

Routine technical procedures from the fixation, staining, and microscopical examination of dried smears, through cultural methods, to the identification of isolates and drug susceptibility testing are described clearly in considerable detail. More advanced methods for detecting growth of mycobacteria and testing their drug susceptibility by radiometry and nucleic acid-base techniques are described also. For good measure, the final chapter deals briefly but succinctly with leprosy.

This book can be highly recommended to all students and professionals concerned with the prevention and treatment of tuberculosis as well as those people concerned with the occupational health of laboratory workers. Officers of the Health and Safety Executive would also find it of value. Considering the amount and quality of information together with the sound advice contained in this book, its cost at £25 is not excessive.