

Work in brief



Keith Palmer, Editor



AIR POLLUTION AND DOCTORS' HOUSE CALLS

Most studies of air pollution have taken mortality and admission to hospital as their main health-end points. Fewer have been set in primary care, but Chardon *et al*¹ add to the growing number of publications by investigating doctors' house calls in the greater Paris area. Some 53 000 consultations for lower respiratory tract disease and 75 000 for upper respiratory tract disease were studied, as well as about 8000 visits for asthma. A time-series analysis considered the relation of lagged exposures to air pollutants and of daily house calls, adjusted for seasonal factors. An increase of 10 $\mu\text{g}/\text{m}^3$ in mean PM_{10} and $\text{PM}_{2.5}$ in the previous three days led to an increase of 3% in calls for upper respiratory tract symptoms and 6% in those for lower respiratory tract complaints. No associations were found with NO_2 or for asthma with any measures of air pollution. The authors suggest that medical visits for respiratory disease may represent a more sensitive indicator of health effects than other commonly studied end-points.

PREVENTING NECK AND UPPER LIMB DISORDERS

In economic, social and medical terms the burden of work-related musculoskeletal disease is considerable and the need to identify effective preventive and management strategies is correspondingly high. Boocock *et al*² have conducted a systematic review to assess the published evidence on primary, secondary and tertiary interventions. Among 31 relevant studies published recently, the authors evaluated interventions aimed at a variety of targets (mechanical solutions, altered production systems and organisational cultural interventions). Only limited evidence of benefit was found and the review identified no uni- or multi-dimensional strategy with promise of effectiveness across occupational settings. In an accompanying editorial, Bongers³ investigates this sorry position, calling for more and better evidence to aid the policy-making and purchasing decisions of stakeholders.

FIT FOR WORK — HOW DO WE DECIDE?

Most occupational physicians, as part of their routine practice, have to make judgements on workers' fitness for work. But at present there appears to be more art than science to the process. Serra *et al*⁴ question how we define fitness for work; when we assess it; by what criteria and with what assessment tools; and how we report it. The findings of their systematic review highlight confusion over the decision-making processes and a disturbing lack of empirical evidence setting out the criteria and methods to be employed. They point to a relative shortage of standard, validated, off-the-peg methodologies for general use by professionals.

ELSEWHERE IN THE JOURNAL

This month's Journal also includes a consensus report on the classification of neck and upper limb disorders;⁵ a study that compares self-reports of work-related exacerbation of asthma with the reference standard of serial peak flow measurements;⁶ and an education article with tips on how to undertake a systematic review in the occupational setting.⁷

REFERENCES

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