key points

SELECTED BY

Dr Peter Saul
GP, Wrexham and Associate GP Dean for North Wales

Occupational asthma is induced de novo by an airborne agent encountered in the workplace. The risk of occupational asthma is greater in those with a prior atopic history. Work-exacerbated asthma is the provocation of pre-existing, or coincidental, disease by one or more irritant exposures at work. Distinguishing occupational from work-exacerbated asthma can be difficult but it is important since the two have very different clinical, occupational and legal implications.

Occupational asthma is underrecognised, the disease often develops in young people who are otherwise fit. They may not recognise their symptoms as anything out of the ordinary, or may confuse them with hay fever or a cold. It is sensible to consider occupational and work-exacerbated asthma in every working adult who has asthma or who presents with suggestive symptoms such as rhinitis.

Occupational asthma almost always arises from an immediate-type hypersensitivity reaction to a respiratory sensitising agent in the workplace. The disease has a short latency with symptoms developing 6 to 36 months after employment in a new job. Rhinitis is common and in those working in an environment with airborne proteins the absence of rhinitis effectively rules out occupational asthma. In occupational asthma, symptoms (including nasal symptoms) improve away from work. Once the disease is established symptoms are provoked by even very small exposures at work and begin to be provoked by a wide variety of irritant exposures both at, and away from, work.

It is good practice to enquire into the employment of every working-age adult with asthma, or rhinitis, and particularly in those presenting with new symptoms or symptoms that have become more difficult to manage. Patients should routinely be asked whether their symptoms improve when they are not at work.

Most patients with occupational asthma have to change their work because continuing exposure to the causative agent carries a significant risk of developing intractable disease. Reductions in exposure that are sufficient to eliminate symptoms and airway inflammation are rarely attainable. The diagnosis carries important statutory and legal implications for an employer. The BTS recommends that every patient in whom the diagnosis is suspected should be referred to a respiratory specialist with an interest in occupational lung disease. Investigations will include immunological tests of specific sensitisation and functional tests of an asthma-work relationship, usually through serial measurement of peak flow.

Patients with occupational asthma who subsequently avoid exposure should be followed up to assess any consequent improvement in their disease and to adjust any treatment. Some may choose to continue in the same work and need to know the risk that this entails and be offered suitable advice in relation to protection at work and the appropriate use of standard asthma and allergy treatments.