One of the difficulties in occupational health practice is establishing exactly what works and what does not. This month’s Monitor looks at some of the recently published research which has evaluated interventions.

Lanphear et al. [1] looked at the effects of soil abatement on blood lead levels in children living around a former smelting and milling operation in the USA. Soil abatement is the removal and appropriate disposal of a layer of contaminated soil. The investigators conducted two cross-sectional studies, the first in 1989, with a follow-up study in 1998. The first involved a random sample of 6- to 72-month-olds (n = 112). The second included all 6- to 72-month-olds whose parents agreed to participate (n = 215). From 1993 to 1996, soil abatement took place around homes. Blood samples were taken from the children and from house dust, and were tested for lead and arsenic using the same protocol in both surveys. The decline in blood lead between children living near abated and non-abated land was then compared.

There was a statistically significant difference in lead and arsenic concentrations in soil and interior dust between homes which had undergone abatement and those which had not (P < 0.05). After adjustment for potential confounders, the blood lead and arsenic concentrations in children aged 6–72 months had declined 42% faster in children living in abated housing than children who lived in unabated housing (P = 0.14). In children aged 6–36 months, the decline was faster, at 45% (P = 0.03). The study showed that soil abatement was an effective way of reducing the blood lead and arsenic levels of young children.

Knowing what works is useful on a population level, but is also of benefit with regard to individuals. Gossop et al. [2] looked at the relationship between attendance at Alcoholics Anonymous (AA) meetings prior to withdrawing and after leaving treatment, and also looked at changes in clinical outcome following in-patient alcohol treatment. They used a longitudinal study design interviewing participants at admission and 6 months following departure. In total, 150 patients in an in-patients alcohol programme who met the ICD 10 criteria for alcohol dependence were studied. The full sample was interviewed at admission for treatment, and at 6 months after departure from treatment, 120 (80%) were interviewed. Significant improvements in drinking behaviours (frequency, quantity and reported problems), psychological problems and quality of life were reported. Frequent AA attendance was associated with superior outcomes when compared with non-attenders and infrequent attenders. Those who attended AA on a weekly basis or more frequently reported greater reductions in alcohol consumption and more abstinent days, and this finding was sustained after accounting for confounders. The researchers concluded that aftercare was extremely important in alcoholics, but that appropriate funding is often lacking. The findings support the role of AA as a useful aftercare resource, and maybe there is a lesson here for us as occupational physicians—that we should promote membership of AA more enthusiastically to problem drinkers in the workplace.

We are often looking for indicators of disease or surrogates of other conditions which may be present. Janssens et al. [3] looked at cases of gout, and their work provides us with a possible indicator for the need to screen for cardiovascular disease.

They looked at 12,000 patients from four general practices in The Netherlands and followed up cases free of cardiovascular disease at the time of registering their first episode of gout. In all, 261 patients who had had a first episode of gout were recruited, 170 of whom were without prevalent cardiovascular disease. Two control patients were selected for each case, matched for age, sex and practice. In the case–control study, the main outcome measure was the prevalence of cardiovascular morbidity (defined as angina, myocardial infarction, heart failure, CVA, peripheral vascular disease, TIA, diabetes, hypertension or hypercholesterolaemia). In the follow-up study, the main outcome measure was the incidence of cardiovascular morbidity. Gout was found to be associated with cardiovascular disease and with cardiovascular risk indicators, without evidence of it being an independent risk indicator itself. The researchers concluded that a gout attack should indicate the need for the assessment of the cardiovascular risk profile of patients when they seek medical help with their painful joints.

Finally, there is no more sinking a feeling than when a patient proudly says ‘the doctors are completely baffled, so I am seeing another specialist’. Life is so much easier when the patient has a diagnosis. And it is even better when it is a medical-sounding diagnosis!

Evidence has now caught up that feeling and proved it to be correct—both doctors and patients like to have a medical-sounding diagnosis. Ogden et al. [4] conducted a questionnaire survey of 900 consecutive patients attending general practices across England. In total, 740 questionnaires were completed (response rate 82%) by participants, who rated statements on their impact for the patient’s diagnosis. These statements related to their medical condition, whether they were treated appropriately, and whether the diagnosis was consistent with their symptoms or illness. The researchers concluded that a gout attack should indicate the need for the assessment of the cardiovascular risk profile of patients when they seek medical help with their painful joints.
study found that patients attributed greater benefit to the use of medical labels for themselves and that these labels were also of greater benefit to the doctor.

So there we are; it is a case of ‘your osteoarthritis of the lower lumbar vertebrae should not prevent you from working, Mrs Smith’ rather than a much shorter reference to ‘back pain’.

I wonder what the views of our colleagues in human resources would be on this one?

N. R. Williams

References


The list of contents of *Public Health Reports, Alcohol and Alcoholism* and *Family Practice* can be accessed from the OUP website at www.phr.oupjournals.org, www.alcalc.oupjournals.org and www.fampra.oupjournals.org, respectively.

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**ERRATUM**

*Thoracic outlet syndrome—aspects of diagnosis in the differential diagnosis of hand–arm vibration syndrome*

R. A. Cooke


On page 333 of this paper, in the section ‘Neurological presentation’, lines 18 and 23, lateral and medial are the wrong way round. The correct sentences should read as follows:

This is likely to result in pain, sometimes accompanied by paraesthesiae, along the medial (ulnar) border of the forearm, and into the corresponding area of the hands and fingers. Although rare, upper plexus TOS may manifest with symptoms due to the involvement of the C5–C7 nerve roots [19], which may then result in pain or paraesthesiae along the lateral aspect of the arm and forearm, and into the hands and fingers.

The publishers would like to apologize for this error and for any confusion caused.

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