Occupational Diseases and Diseases Associated With the Workplace

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Abstract
Workers' diseases are a major concern worldwide and particularly in Nigeria and many workers pose a risk of workplace disease. Precise predictions of occupational diseases can have essential preventive and regulatory information. Work conditions are not adequately diagnosed, however, because they look like illness because of other causes and because most doctors are not well qualified to identify them. Opportunities for prevention and recovery are still skipped. Work history is the most accurate way to diagnose workplace diseases more effectively. This paper provides a brief but comprehensive approach to work history which highlights the legal perspective of occupational diseases from the Nigerian and global perspectives. Various occupational disorders and approaches are also summarized for their classification and diagnosis. The management and prevention of workplace diseases is based on the reduction of hazardous workplace exposures and proper training for workers, industry administrators and physicians.

Introduction

People now spend many years of their adult lives at jobs, where they are exposed to various chemicals, viruses, and other illness-related diseases as a result of population development and dynamic technological advancements. Occupational conditions may arise as a result of risk factors in the workplace (Boschman et. al 2017). As pointed by the World Health Organization 2010 estimate, 50 percent of the world's population is professionally employed (WHO, 2019). According to the International Labour Organization (ILO), there are almost 2.2 million deaths annually, with 1,74 million of those deaths being work-related. In addition, almost 160 million workers are afflicted by workplace diseases. Workplace accident or disease is the leading cause of death at work (ILO, 2019). Occupational illnesses and fatalities are responsible for about 6% of all economic casualties in countries and continents (WHO, 2019).

According to a special report on carcinogenic agents, bladder cancer, leukemia, and rheumatoid and musculoskeletal symptoms of repeated injuries are all present in people who are exposed to benzene, leukemia, and rheumatoid and musculoskeletal symptoms of repeated injuries. For example, in the general population, hypertension, which does not occur in people that may not have a medical problem, contributes to a reduction in life expectancy, productivity, or psychiatric problems, which are more common in some occupations and have an impact on workers" (WHO, 2019). The WHO's Workers' Health Action Plan focuses on improvements in workplace diseases: (WHO, 2007). It is required by statute in every country to ensure the well-being of its workers (Zhang, 2013). As a result, the prevention and treatment of occupational illnesses is an important factor in every operating plan. Defining the positions of employers, social security programs, health institutions, and other labor safety and welfare professionals are only a few of the reasons that help with this (Zhang, 2013).

Identifying occupational disorders, on the other hand, has not been taken into account [Rivère et al. 2014; Bland et al. 2012; Van der Molen et al. 2012]. Previous Spreeuero et al. research (2008) found that noise-induced hearing loss and occupational hearing disability were underdiagnosed and under-controlled. Occupational conditions remain little known, and occupational illnesses are often misdiagnosed as noncompliance. Unspecific disabilities worsen the majority of work-related illnesses. In order to plan and take important instructional measures to prevent and mitigate the occurrence of workplace diseases, it is therefore essential to clarify the causal factors and investigate the problem in its entirety.

Purpose of study

The objectives of this paper are to: 1) examine the legal viewpoints on occupational diseases; 2) classify occupational diseases and their related diseases; and 3) describe the causes that cause occupational diseases.

Literature Review

Occupational Disease Concept

There are some meanings for the word "occupational disorder." The concept "occupational disease" is described as "any disease contracted as a result of an exposure to risk factors resulting from work activity" (Article 1 (b)) for the purposes of the Protocol of 2002 to the International Labour Organization's (ILO) Occupational Safety and Health Convention (ILO, 1981). Occupational diseases are described more clearly in the ILO Employment Injury Benefits Recommendation (1964, Article 6, (1)): “Each Member shall regard diseases known to occur out of exposure to substances and hazardous conditions in operations, trades, or occupations as occupational diseases, under specified conditions.” However, there are two primary components that must be included in both meanings (ILO, 2010).

1. The causal association between infection in a given workplace environment or job operation and the development of a particular disease; and
2. The fact that the illness strikes the subset of people who have been vaccinated at a higher rate than the majority of the country or all workplace groups.

Medical and/or pathological evidence, occupational history and work research, detection and assessment of occupational risk factors, as well as the position of other risk factors, are all used to determine a causal association (ILO, 2013). In addition, the signs are not distinctive enough to detect an occupational disorder without understanding of the physical, chemical, biochemical, and/or other risk factors found in the course of one's work. Professional decision-making, also known as applied clinical epidemiology, is exemplified by the identification of industrial diseases (ILO, 2013). The anatomy of a disease is not a "exact science," but rather a matter of judgment dependent on a critical examination of all available facts. This may include the intensity of the correlation, continuity, accuracy, time series, or biological gradient (the higher the degree and length of exposure, the worse the diseases or their incidence) (European Commission 2009, ILO, 2010). Work disease is a chronic element which can eliminate life a disease that persists for long time, most work sectors are prone to occupational hazard which is extremely dangerous.

Occupational and work-related diseases are described in more detail.

Occupational diseases that are included in state lists as part of national legislation or regulatory provisions that are compensable and subject to preventive initiatives are known as reportable occupational diseases. Reportable illnesses that have also been through the constitutionally mandated notification procedure are referred to as reported workplace diseases.

A recognized case of an occupational disorder is one that has been acknowledged as such by a responsible national body in the course of an administrative proceeding (Nowak, D., Drexler, H., Kraus, T., Letzel, S., 2013)

Both disorders that may be induced, aggravated, or caused in conjunction with working circumstances are referred to as "work-related diseases." A case of work-related illness does not always imply authority acknowledgment, whereas industrial diseases have a clear or solid link to the profession, usually with only one causal agent, whereas work-related diseases have a more complicated aetiology. Factors resulting from employment and/or the working community play a role in the creation of certain diseases, among their numerous causal agents. Through calculating the attributable fractions, it is possible to make a more accurate differentiation between industrial and work-related diseases. The attributable fraction of workplace diseases is estimated to be greater than 50%, while work-related diseases are estimated to be less than 50%. (Finnish Institute of Occupational health, 2013).

An Overview from a Historical Point Of View

Occupational disorders had a long tradition dating back to the beginning of organized commercial life. Back pain caused by job pressure is mentioned in an Egyptian papyrus, and Hippocrates recalled a case of extreme lead colic. Pliny, among other early authors, recognized the connection between certain illnesses and professions (e.g., mercury poisoning of slaves working as miners).

Common mining accidents and miners' occupational diseases caused by dust inhalation were researched and identified during the Middle Ages, when rudimentary methods of ventilation and personal safety were in use in gold and silver mines. Ramazzini's explanation of the diseases involved with 54 different professions (e.g., Venetian mirror makers' mercury poisoning) offers a concise overview of occupational illnesses.

During the Industrial Revolution of the 18th century, rapid technological advancement and expansion resulted in unsanitary working and living conditions. This was accompanied by an increase in the number of workplace injuries and fatalities due to new equipment and hazardous materials exposure. When a London surgeon named Percivall Pott discovered connections between the prevalence of scrotal cancer in chimney sweeps and the repeated exposure to soot embedded in their blood, he coined the term "occupational cancer."

Classic occupational diseases including lead poisoning and anthrax have decreased in prevalence since the twentieth century, but none have been eradicated. Furthermore, developments in technology and improvements in employment or living environments have resulted in the emergence of new diseases. For instance, radiologists have died as a result of workplace X-ray exposures, asbestos-related diseases, or hemangiosarcoma caused by vinyl chloride monomer (Baxter, P.J., Aw, T-C., Cockcroft, A., Durrington, P., & Harrington, J.M., 2010; Kazantzis, G 2014).

Job-related musculoskeletal disorders, psychosocial problems, and work-related mental health disorders (EU-OSHA – European Agency for Safety and Wellbeing at Work, 2019) are among the new concerns that have emerged at the turn of the third millennium.

National Policy on Occupational Safety and Health (2006)

The National Policy on Occupational Safety and Health, a guide to Occupational Safety and Health in Nigeria, is the government's approach to achieving a national development philosophy of building a united, self-contained and egalitarian economy by minimizing the causes and effects of hazards inherent in the workplace in response to its ratification It came into effect in November 2006 (Nigeria Country Profile on Occupational Safety and Health 2016 Page 22)

The policy objectives are: a) Facilitate enhancement in workplace safety and health outcomes by establishing the basis for participatory occupational safety and health security for employees, especially the most vulnerable communities in all sectors of economic activity.
B) Ensure the harmonization of the security of workers' rights with regional and international norms in a private sector-led economic development, while concentrating the competent authority's role in fostering an enabling atmosphere and regulating various provisions for safeguarding the peace, health and welfare of Nigerian workplaces.
The goals are:

- **a)** Create a general system for improving working and working environments.
- **b)** B) Preventing deaths and wellbeing exits resulting from or during employment.
- **c)** Provide occupational safety and health services to employees in all fields of economic development.

The scope of the policy covers both the formal and informal economic sectors; the protection of all categories of workers from undue persecution, effective communication and cooperation among all stakeholders; the prevention and control of hazards from all forms of occupational exposure; the provision of health surveillance and emergency medical services; occupational health training;

The Policy empowered the Federal Ministry of Labor and Employment as the Statutory Authority, i.e. the "Competent Authority," which would be responsible for implementing the Policy around the country and specifically specified the statutory authority's duties in this regard. The policy further established the Federal Ministry of Health's supporting duties in the field of the country's workplace deaths, disabilities, and diseases data collection and submission and control of occupational health activity. It also clarified the responsibilities of the following stakeholders—employers, employees, suppliers, transporters, OSH commissions, and the media—to successfully enforce this policy. Establishing a National Commission on Occupational Safety and Health as a coordination body as well as setting up, among other strategies, an Institute for Occupational Safety and Health was intended to help comprehensive policy enforcement. The statutory authority shall review the policy every three (3) years.

The Rate of Work-Related Disease

There is no accurate data on the number of cases of workplace disease around the world. Occupational disease monitoring systems have been identified as "fragmented, inefficient, and 70 years behind the times" by public health officials (Committee on Government Operations, 1984). According to the President's Report on Occupational Safety and Health from 1972, 390,000 new cases of work-related disease are diagnosed each year in the United States, with 100,000 deaths. Investigators in New York looked at death certificate records to develop a more current measure of the level of workplace illness (Markowitz, 2002). They calculated the number of deaths that could be attributed to occupation in each of the six major categories. Occupational disease reports in Nigeria are incomplete, owing to factories' failure to register cases to the appropriate government department. Conjunctivitis, chronic bronchitis, dermatitis, musculoskeletal disorders, and injuries, according to a review of occupational diseases published in the literature, are common workplace health problems (Omokhodion, 2009).
Factors that predispose to workplace illnesses
The proximal causes are those that specifically increase an individual's chance of contracting an occupational disease. These proximal factors do not guarantee that an occupational disease will occur, but they do indicate that a worker may be at risk of developing one at some point in the future. The following are some of them:

Hazardous materials – Employees who work with hazardous materials, such as chemicals, expose themselves to the risk of contracting diseases. When dealing with such materials, it is critical that these individuals have the necessary training and equipment.
Noisy environments – Construction workers and engineers, for example, frequently work in noisy environments. Drills, heavy equipment, and hammering can both be harmful to one's health. Constant pressure on the eardrums can result in permanent hearing loss.
Workplaces that aren't well-ventilated – Employees deserve the freedom to work in environments that are well-ventilated. Dust and gases can be harmful to their health while they work underwater or in enclosed spaces. This will have a physical impact and result in health issues. (2016) (Perecman)

THE MOST COMMON TYPES OF OCCUPATIONAL DISEASE

Toxic environmental exposures have been linked to diseases in a variety of organ systems. Rutstein and colleagues (1983) created the idea of the "sentinel health case (occupational)" to aid clinicians in recognizing these connections. "An unnecessary illness, injury, or untimely death that is occupationally associated," according to the definition of a sentinel health occurrence (occupational). The following is a list of these illnesses. Physicians may detect work-related ailments or exposures that may arise in their patients, as well as professions and fields that may be relevant to their specialty populations, by searching through this catalog of occupational diseases, which includes Musculoskeletal Disorders, Cancer, Occupational Lung Diseases, Neurological and Psychological Diseases.
Musculoskeletal Disorders are a group of diseases that affect the joints and muscles
Musculoskeletal illnesses are more common in the workplace than any other disorder or occupational condition (MOEL, 2014a and Leroyer et al., 2006). The use of desktop computers, especially the use of static pose, has been shown to affect a musculoskeletal disorder common among office employees. When using a mouse or keyboard, the visual devices should be located in such a way that the user's convenience is not jeopardized. The shoulders are the most often affected areas (Seo, 2007; Lee et al., 2007). (Sim et al., 2009).
In a computerized work environment, excess workload, psychosocial tension, and behavioral responses mix and exacerbate each other, according to Feyerstein and his colleagues (1997). These covariates are linked to a higher rate of musculoskeletal symptoms in the upper body. Long-term use of VDTs, as well as a very busy career, have been found to be significant risk factors for musculoskeletal pain in studies (Marcus and Gerr, 1996). They also discovered that prolonged device use is one of the leading causes of musculoskeletal disorders. The use of keyboards, according to Palmer et al. (2001), is important for neck and upper-limb pain. Upper arms, knees, and hands were the areas of the body that were most affected. In the knees, though, the degree of relatedness was smaller. Medical complaints such as headaches, back pain, weak muscles, and overall exhaustion have been shown to increase with the amount of time spent using machines without warning, according to a data collection (Nakazawa et al., 2002). Wrist effects were more common in people who used machines for longer periods of time (Jensen, 2003; Lassen, 2004; Kryger et al., 2003). A systematic analysis found a connection between the amount of hours spent on a simulator and musculoskeletal problems (IJmker et al., 2007). Although machine use has been linked to wrist symptoms in many publications, the link to carpal tunnel syndrome remains unknown (Andersen et al., 2003).

Cancer caused by one's job

Carcinogens were first identified mostly in the workplace, beginning with Sir Percival Pott's observations in 1775, which linked scrotal cancer in chimney sweepers to soot deposits. Occupational cancer epidemiology is also critical for the discovery of cancer-causing agents in humans, even though it is no longer applicable (Dele, 2017). Epidemiological testing on highly

exposed employees has been the primary source of evidence for human carcinogens. Lung cancer risks were linked to questionable occupational conditions such as nickel refineries, chromate processing, and sheep dip manufacturing in early studies (Siemiatycki, Richardson, Straif, 2004). Industrial agents were studied more thoroughly later, as shown by Sir Richard Doll's quantitative assessment of the connection between asbestos contamination and the risk of lung cancer in 1955. Several initiatives to promote government policy, including the IARC monograph program and the WHO International Program on Chemical Safety's Environmental Health Criteria monographs, were created in the 1970s in response to the broad and increasing body of evidence on environmental carcinogenesis (Krewski&Momoli, 2008).

According to a news release from the World Health Organization, more than 200 000 people died in the workplace from cancer in a single year, the majority of which were from developed countries. In 2007, The Pandey published a book called "The Pandey." According to the WHO, a significant rise in the incidence of occupational cancer can be expected in developing countries in the coming decades as work activities that involve the use of carcinogens migrate to countries with less stringent occupational health regulations. Chemicals like chrysotile and antibiotics, as well as those used in the production of tires and dyes, are examples of these processes. Due to the widespread use of multiple carcinogenic compounds such as blue asbestos, 2-naphthylamine, and benzene 20 to 30 years ago, the industrialized world actually has a higher prevalence of workplace cancer. The use of these known carcinogens in the workplace is now severely restricted in these countries (Pandey, 2007). The carcinogens most often seen at work include asbestos, secondhand smoke, and benzene. The most common cancers caused by occupational exposure to carcinogens include lung cancer, mesothelioma, bladder cancer, and leukemia (Siemiatycki, et al, 2004), Cancer is an abnormal condition or growth of cell's which tend to proliferate in an uncontrolled way. It involve any tissue of the body and have many different forms in each body area, and it is a group of disease that comes together.

Lung Diseases

Occupational lung diseases such as chronic obstructive pulmonary disease (COPD), asthma, and pneumoconiosis have caused a global burden of disease in the last two decades, according to research.

Exposure to airborne particulates is a leading cause of death and disability, especially in developing countries (WHO, 2017). Chronic respiratory diseases account for nearly 10% of all workplace diseases registered in developed countries like the United Kingdom, and they tend to be much higher in rapidly industrializing developing countries like Nigeria (Cherry et al in Jeebhay, 2007)

Pneumoconiosis

Pneumoconiosis is parenchymal lung disease caused by (usually) inorganic dust inhalation at work. Any of these powders are chemically inert but detectable on a chest X-ray or CT scan; thus, although radiologically disturbing, they do not cause a clinical illness or pulmonary function deficiencies (Paul & Peter, 2013). Others – especially asbestos and crystalline silica – are fibrogenic, so the harm they cause is due to inhaled particles rather than the dust itself. Most important are asbestosis—caused by asbestos fibres; silicosis—caused by quartz and other forms of crystalline silica; coal workers' pneumoconiosis—caused by coal dust; mixed dust fibrosis—caused by silica in combination with other dust, usually coal, carbon, or iron oxides; talc pneumoconiosis (talcosis); berylliosis; and hard metal disease—caused by tungsten and cobalt dust. A 10th death from lung cancer is closely linked to occupational complications, and

employees who are heavily exposed to second-hand cigarette smoke at work are twice as likely to experience lung cancer (Pandey, 2007).

Thousands of people employed in the pharmaceutical and diamond industry die from leukaemia caused by benzene contamination, which is commonly used by employers as an industrial solvent in those industries. WHO says avoidance of cancer exposure in the workplace could be the most effective way to avoid cancer. "Control of carcinogens in the workplace should be a key component of every national cancer control program," said Andreas Ullrich, WHO Cancer Control Officer. To protect workers from occupational cancer, WHO recommends stopping the use of asbestos; introducing benzene-free organic solvents and technologies that convert carcinogenic chromium into non-carcinogenic f. This quick measures could avert hundreds of thousands of premature deaths and workplace cancer sufferers. Recently, WHO released an official statement urging countries to avoid using asbestos or face cancer epidemics in the coming years. It proposed using pine fibers in cement construction materials as a suitable solution to asbestos (WHO, 2017).

Working asthma.

Workplace reactions are believed to account for around one in ten recent or chronic adult asthma events. Many general respiratory physicians may be shocked at the extent of this proportion derived from meta-analysis of epidemiological studies that investigated the distribution of asthma in various occupations (Szram, 2012).

There are two broad types of work-related asthma. First, exposure to an airborne sensitizing or irritating agent found at work can cause the disease anew. Occupational asthma may occur from another source in an employee who has or does not have a previous history of asthma. Alternatively, pre-existing asthma can be caused by proximity to workplace 'exaggerating' agents, usually involving irritating fumes or pollen, cool weather and vigorous activity. This is called 'work-induced asthma,' normally manageable with strict attention to preventive equipment and appropriate pharmacological treatment of the underlying occupational disorder. Occupational asthma also always develops as an allergic reaction to an airborne occupational sensitizer. The essence of this 'hypersensitivity' response is such that there is a latent ('sensitizing') multi-month period between initial exposure and symptom growth, accompanied by very low inducer exposure. Presumably representing disparities in latent vulnerability, not all exposed employees can become sensitized, while very large percentages can do so depending on the level of occupational exposure. (Cullinan, Harris, Newman, 2000). In certain occupational asthma caused by airborne proteins, the immune response is characterized by releasing specific IgE antibodies. In cases of exposure to chemical agents, the form of immunological reaction is much less understood. Occupational asthma can also occur—but rarely—from very high respiratory irritants. This reaction cause, initially called 'reactive airway disorder syndrome' (Brooks et al 2005), but now more generally referred to as 'irritant-induced' asthma, is largely non-immunological. Most well-characterized events follow single 'toxic' reactions to agents like chlorine or nitrogen oxides. It is uncertain whether more regular but less acute reactions to occupational irritants can cause asthma, while domestic exposures – cleaning sprays, etc. – have been linked with 'asthmatic' incident symptoms (Zock, Plana, Jarvis et al, 2007). Asthma is a chronic disorder in which inflammation causes bronchi narrow the airways, creating breathing difficulties.

Working COPD (chronic obstructive pulmonary disease)

This is a type of lung disorders that block airflow which prevent breathing, and can lead to asphyxia. Chronic obstructive pulmonary disease (COPD) is the world's fourth leading cause of death, and almost 15% of COPD deaths are due to occupational exposure (Cullinan, 2012 and Jaakkola, 2009). Proof analysis from the National Health and Nutrition Survey showed

that almost 19% of all COPD cases were attributed to multiple occupational exposures (31% of non-smokers) (Jaakkola, 2009). While no official definition of occupational COPD exists, robust data favor non-smoking occupational exposures as a cause (Cullinan, 2012 and Jaakkola, 2009). Non-specific vapors, gases, dusts and fumes are the most often involved in occupational COPD, with more consistent association of dust. It's best for workers exposed to coal tar, silica, cotton dust, or cadmium. (Mistrangelo, 2003).

Neuro-psychological epidemic

Although stress is recognized as an important risk factor, not all people who experience stress, experience impaired mental health. While there is evidence that chronic stress in daily life is a stronger predictor of mental health and well-being (Newnham,Pearson, Stein, & Betancourt, 2014), previous studies focused mostly on traumatic incidents or major life events (e.g. Bosmans, Benight, K). However, assumptions that simply include direct health consequences of stress are inadequate and ignore alternative interfering or mitigating causes contributing to a highly misleading estimate of impact sizes. The extent of the relationship between stress and mental status relies on traits and techniques that distinguish people from each other (Leiva-Bianchi, Baher, & Poblete, 2012). The extent to which the effects of daily stress on mental health through personal characteristics have not yet been examined.

Moreover, with the understanding that full mental wellbeing is more than just the lack of psychopathological signs (WHO, 2001), the conventional one-dimensional paradigm is no longer adequate. The preventive effect of desirable traits is important to both preventing health issues and boosting well-being. On this basis, mental health can be separated into two dimensions. Positive mental health is characterized as an ideal way of coping and a general sense of well-being (Deci & Ryan, 2008; Keyes, Shmotkin, &Ryff, 2002). Negative mental wellbeing, however, encompasses harmful aspects such as health issues, psychopathology or medical conditions. Nevertheless, these two variables are distinct and may behave reasonably separately (Keyes, 2007; Suldo & Shaffer, 2008; Weich et al., 2011). Therefore, disregarding positive characteristics will minimize the predictive utility of stress

CONTROL OF OCCUPATIONALDISEASE

The control of occupational disease will require a three part program consisting of

(1) Prevention of toxic exposures in the workplace,
(2) Premarket toxicological testing of all new chemicals and technologies, and
(3) Astute clinical diagnosis of occupational diseases.

Prevention in the workplace

Elimination or reduction of toxic exposures is the most important method for preventing workplace disease. Reduced exposure can be achieved by a variety of methods, the most effective of which is the replacement of a less dangerous substance or procedure. Ventilation, process separation, and enclosure are examples of engineering safeguards that limit worker exposure to harmful substances. Total exposure can be regulated by administrative controls such as rotating employees into and out of dangerous environments. The amount of exposure to a threat is not lowered as regulatory restrictions are implemented; rather, the length of human exposure is decreased, and exposure is distributed more uniformly across the workers.

Finally, personal protective equipment (PPE) such as respirators, masks, specialized garments, and ear plugs or muffs may further protect workers. Personal safety, on the other hand, is seldom as effective or as appropriate as engineering controls.

Testing for Toxicity

For the prevention of workplace diseases, premarket toxicologic testing of new chemicals and processes is important.

According to a study conducted by the National Academy of Sciences in 1984, only about 20% of synthetic chemicals had been properly tested for potential human toxicity. Physicians are unable to determine the potential health risks of the chemicals to which their patients are exposed in the absence of toxicity evidence. While the Toxic Substances Control Act mandated that all experimental chemical substances be reviewed, the Environmental Protection Agency's implementation of the legislation has been lax in the United States. New and unexpected pathogens of occupational origin will continue to strike America's workforce until this situation is addressed.

Management and Diagnosis in Clinical Practice

Physicians' accurate diagnosis of occupational diseases, particularly when combined with effective referral to public health authorities, labor union health and safety professionals, or industrial managers, may play a critical role in the remediation and prevention of dangerous workplace exposures.

The clinical identification of workplace diseases serves as a foundation for medical counseling on their hazardous occupational exposures.

The specialist who has diagnosed occupational disorders and determined their causes is in a great position to warn particular people, groups of patients, and populations about the dangers of the workplace.

Occupational History

The most important tool for correctly diagnosing workplace illness is the occupational history. It contains crucial information on workplace hazards. Goldman and Peters also devised a method for collecting an occupational biography that is both succinct and systematic. This method acknowledges that obtaining a complete occupational background for each patient is impossible. The warn clinician, on the other hand, should ask any new patient a brief list of screening questions.

Conclusion

The rising prevalence of workplace hazards and occupational diseases among Nigerian professionals is cause for concern. Risk aversion and the failure to adhere to hierarchical management mechanisms are also risk factors. Technology, administrative, and personal protective equipment (PPE) controls must be implemented and strictly adhered to by the working group and government at all levels in order to eliminate or reduce these risks. Recognition, treatment, and avoidance of workplace diseases are all dependent on the practitioner. Asbestos, silica, and benzene are also well-known workplace risks, and the doctor will be able to detect ailments caused by them. Furthermore, the warn clinician is in a rare role to discover new links between workplace exposures and diseases. The key method for correctly diagnosing occupational disease is based on informal suspicion. Any patient with an occupational disorder should be considered by the warning physician. As a result, for all prospective cases, the practitioner shall receive at least a short history of occupational exposure during the initial screening interview.

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