Summary

Occupational dermatoses are among the most common occupational diseases, with BK 5101 accounting for the largest proportion. Historically, the latter was also the most frequently reported group of occupational diseases within the working age population. More than 80,000 suspected cases of occupational diseases were notified in 2019, of which 19,883 related to BK 5101. In Germany, work-related hand eczema accounts for 90% of all BK 5101 diseases, and consists mainly of contact eczema. Especially young people working in the hairdressing sector, health care, metal, food or construction industries belong to the high-risk group. Diagnosis, therapy and prevention of BK 5101 play an important role, since advanced skin diseases are usually accompanied by a poor prognosis and long periods of inability to work, which can have considerable socio-economic consequences. On January 1st, 2021, with the “Seventh Act amending the Fourth Book of the German Social Code (SGB) and other Laws”, an amendment to the Occupational Diseases Law came into force, with which the obligation to cease work was abolished, thereby fulfilling a decades-long requirement for recognition of BK 5101. As of this year, only the “severe or repeated recurrences” of a skin disease remain as a criterion for the occurrence of an insured event, which will likely result in an increased number of notifications and acknowledged cases of occupational skin diseases.

Introduction

Occupational disease (German: Berufskrankheit, BK) 5101 is the most frequently reported occupational disease in gainfully employable persons in the statutory accident insurance system, and has so far mainly affected young people still at the beginning of their professional careers [1]. A 2010 academic report showed the proportion of confirmed suspected cases of occupational disease among those under 26 years of age in 2006 to be just under one-third [2].

BK 5101 can be manifested both through the novel onset of an exogenous dermatosis (for example contact dermatitis) and by the development or aggravation of a congenital endogenous dermatosis (for instance atopic eczema). Occupational hand eczema, mostly in the form of contact eczema, dominates by far as an occupational disease in the sense of BK 5101 [3]. In the context of occupational activities, chemical (for example, toxic irritants) and physical (for example radiation, temperature, pressure/abrasion, microtrauma) triggers, which can cause a BK 5101 occupational skin disease even after brief exposure, should be considered. However, one of the most common triggers is wet work as in contact with water or occlusion.
The detailed definition of wet work is shown in Table 1. All these environmental factors can cause damage to the epidermal barrier and increase the effect of allergens with simultaneous exposure [4]. Particularly affected sectors are hairdressing, health care, metal processing, food and beverage, and construction, as these account for the majority of suspected reports [3].

In 2019, more than 80,000 notifications of suspected occupational diseases were registered, of which, according to the German Social Accident Insurance, 19,883 were related to BK 5101. However, only 1.93 % of these (383 cases in total) were recognized. The reason for this low number of recognized cases was the insurance law conditions that were valid until December 31, 2020; most of these remained unfulfilled, even when the occupational cause connection could mostly be confirmed. Until the end of last year, the definition of BK 5101 was: “Severe or repeatedly relapsing skin diseases that have necessitated the cessation of all activities that were or may be cause for the development, aggravation or resurgence of the disease”. The greatest obstacle to the recognition of the occupational disease was the lack of objective compulsion to abandon the activity, which could be avoided mainly through the comprehensive preventive measures provided by the dermatologist’s procedure. Further obstacles included unexhausted available preventive measures [5].

The marked disparity between reported and recognized cases of BK 5101 repeatedly gave rise to criticism in the past. Likewise, the definition of eight other occupational diseases included the obligation to cease work, which could not be shown for the vast majority of occupational diseases, so that as of 01/01/2021, as a result of the “Seventh Act to amend the Fourth Book of the Social Code (SGB) and other laws (7th SGB IV-ÄndG)” passed by the German Bundestag, the obligation to cease work was abolished. This is one of the most far-reaching reforms of occupational disease law in recent decades [5].

This involves significant changes in dermatological care and assessment of BK 5101, which are presented in this continuing education article, among others. Likewise, elementary clinical, diagnostics, preventive and legal criteria of the occupational disease are presented.

**Legal definition of an occupational disease**

According to § 9 section 1 of SGB VII on statutory accident insurance, occupational diseases are “diseases which the Federal Government designates as occupational..."
According to § 9 section 1 of SGB VII on statutory accident insurance, occupational diseases are “diseases which the Federal Government designates as occupational diseases by statutory order with the consent of the Bundesrat and which insured persons suffer as a result of an activity giving rise to insurance coverage under §§ 2, 3 or 6”. In addition, occupational diseases are designated under § 9 section 1 as those “which, based on knowledge from medical science, are effected as a result of special influences to which certain groups of persons are exposed to a significantly greater degree than the rest of the population as a result of their insured occupational activity”.

Occupational diseases have been included in the Occupational Diseases List in Annex 1 of the Occupational Diseases Ordinance (BKV) since 1925 and currently include 80 different diseases, each of which has been assigned a corresponding BK number. As a dermatological occupational disease, BK 5101 (severe or repeatedly relapsing skin diseases) is, in terms of numbers, of the greatest importance, followed by BK 5103 (squamous cell carcinomas or multiple actinic keratoses of the skin caused by natural UV radiation).

In the event of a justifiable suspicion of the occurrence of an occupational disease, every physician of any specialty must immediately submit a BK notification to the accident insurance carrier, even without the consent of the insured person [6]. It is also possible for health insurance agencies, companies and insured persons to apply for the initiation of a BK procedure [4].

Causal connection in terms of development or aggravation

In order to be able to assess the existence of an occupational disease, a causal connection between the skin disease and the occupational activity is required. The onset of a skin disease or the aggravation of a congenital disease can establish this causal connection. Competing factors such as common, everyday life events that are stressful to the skin (occasional causes) must be excluded.

BK 5101 diseases

Table 2 provides an overview of some examples of diseases covered by BK 5101. In most cases, these are hand eczemas, the etiopathogenesis of which is based on occupational contact allergens or irritants.

Occupationally caused or aggravated skin diseases that do not fall under the category of BK 5101 are skin cancers (BK 5102 or BK 5103), diseases caused by arsenic or its compounds (BK 1108), diseases caused by ionizing radiation (BK 2402), acquired infectious diseases (such as scabies) resulting from activities in the
health and welfare services or in a laboratory (BK 3101), diseases transmissible from animals to humans (BK 3102) or tropical diseases or typhus (BK 3104).

**Occupational hand eczema**

Occupational hand eczema ranks first among all occupational diseases in many countries [7]. In Germany, 90% of all BK 5101 diseases are due to occupational hand eczema [3]. Acute hand eczema is distinguished from chronic hand eczema, where the former persists for less than three months and does not occur more than once a year, while the latter persists for more than three months and occurs twice or more within twelve months [8].

Hand eczema can be classified according to etiological factors, clinical morphological typology, or a combination of both [9]; however, no internationally accepted classification exists [8]. In terms of etiology, a differentiation can be made between atopic, cumulative-subtoxic/irritant, and contact allergic hand eczema, as well as the rare, special form of protein contact dermatitis that often involves a combination of etiologies; morphologically, it may present as dyshidrosiform, hyperkeratotic-rhagadiform, and nummular.

Chronic hand eczema often presents as atopic, irritant or allergic contact eczema.

| Contact dermatitis (mostly on the hands) |
|-----------------------------------------|
| allergic                                 |
| irritative/subtoxic cumulative           |
| protein contact dermatitis               |

| Exacerbation of an endogenous dermatosis |
|-----------------------------------------|
| atopic (hand-)eczema                    |
| psoriasis                               |
| lupus erythematosus                     |
| genodermatoses (e.g. Darier’s disease)  |

| Other skin diseases                     |
|-----------------------------------------|
| Contact urticaria                        |
| Cold-induced skin damage (e.g. chilblains) |
| Heat-induced skin damage                |
| Photodermatoses                         |
| Fungal infections (due to work in humid environments/heavy sweating) |
| Acne (due to work with tar, pitch, oils, fats, organic chlorine compounds) |

Table 2  Beispiele für Hauterkrankungen im Sinne der BK 5101.
than in men, perhaps due to a greater exposure of women to wet work (such as cleaning, hairdressing, nursing) [15].

Predisposing endogenous factors play a significant role in the development of occupational hand eczema in addition to disease-causing external agents in the workplace. In this regard, an atopic disposition, especially atopic skin diathesis, is the best known and most significant predisposing factor and is found in one third to one half of people with occupational hand eczema [16]. It is not uncommon to have a combination of irritant, allergic and endogenous factors, explaining both the chronic course and the often unsatisfactory therapeutic response [17].

Numerous treatment options are available for occupational hand eczema. Which treatment method is ultimately chosen depends on the severity of the hand eczema, the clinical type, and the cause [18]. For acute eczema therapy, a differentiated local therapy is required [1]. Regarding the management of hand eczema, a staged regimen is recommended, with therapy depending on the morphology and severity of hand eczema. Therapy includes consistent basic care (for example, with urea, lactic acid derivatives, glycine), glucocorticosteroid-containing topicals (potency I-IV), topical calcineurin inhibitors (tacrolimus, pimecrolimus), ultraviolet phototherapy (mostly cream-PUVA therapy) and other physical therapies (for example, tap water iontophoresis) and, in the case of severe hand eczema, additional systemic therapy (for example, oral glucocorticosteroids, altretinoin, ciclosporin, or azathioprine or methotrexate as an off-label application) [18]. The highest priority over the long term, upon identification of an irritant or origin for the contact allergy, is to avoid or reduce exposure to the causative agent/allergen [19].

Eczema of the hands can significantly impair daily life and severely limit a patient’s quality of life. Hand eczema is a socioeconomically significant disease due to its high prevalence, morbidity, and the associated loss of income [20]. Non-negligible manual disabilities, psychological suffering and financial losses for both the individual and society may result [7]. In 70 % of those affected, the disease leads to medical consultations, in about 20 % to a loss of work (> 7 days), and in about 10 % to a change of job [21]. In Germany, production losses caused by occupational hand eczema carry a yearly economic cost of 1.8 billion euros [22].

Medical history, clinical and allergological diagnostics

For the diagnosis of BK 5101, a detailed medical history is required. Table 5 (online Supporting Information) shows which aspects in particular should be included in the medical history for assessment by an evaluator. For the determination of atopic diathesis, which is found as a significant cofactor in 40 % of occupational skin diseases [4], an atopy score should be obtained in combination with a prick test covering the most common inhalation allergens and adapted for occupation-specific allergens. For the determination of atopic diathesis, which is found as a significant cofactor in 40 % of occupational skin diseases [4], an atopy score should be obtained in combination with a prick test covering the most common inhalation allergens and adapted for occupation-specific allergens [4]. Allergies of the immediate type, such as those involving natural rubber latex or certain food allergens, can usually be detected in this manner, as can protein contact dermatitis if required [4]. Subsequently, a thorough clinical examination with explicit inspection of hands, feet and the rest of the integument is necessary. A mycologic examination may also be required for the initial diagnosis and even histological confirmation may be necessary in the case of occupational hand dermatosis as in psoriasis or other diseases requiring a differential diagnosis [4]. Serological allergy diagnostics, if necessary with specific IgE determination and suitable diagnostic procedures such as the epicutaneous test (ECT), should then be performed to identify the cause of the occupational dermatosis. With its standardized test series, ECT represents the gold standard for identification of a type IV sensitization as trigger for allergic contact dermatitis.
ECT is indicated for all patients with eczematous skin findings over more than three months [8]. Proven type IV sensitization requires subsequent relevance assessment. Where required, an inspection of the workplace is indicated to confirm or exclude allergen exposure and to establish whether alternatives are available for replacement of problematic occupational substances [4]. If photoallergic contact dermatitis is suspected, an exposed ECT should be performed [4]. In general, the testing procedure should follow the guideline of the German Contact Allergy Group (DKG), and the test series recommended therein for frequently affected occupational groups should also be applied [23]. In this regard, there are occupations in which several test substances are available for the allergens, such as for the hairdressing profession, although here, too, only a small section of the allergen spectrum is reflected. However, in certain occupations (for example, metalworkers), the responsible allergens are often unknown or no commercial test substances are available, resulting in extensive epicutaneous testing with occupational substances found in the workplace and, consequently, few standardized substances [4]. The current composition of the DKG test series is available on the website (https://dkg.ivdk.org/testreihen.html). Overall, the diagnostic procedure requires extensive allergological experience and expertise on the part of the performing physician [1].

Prevention of BK 5101

Since an advanced occupational dermatosis often has a very unfavorable prognosis, despite the (now no longer necessary) cessation of the occupational activity, and since it leads to long periods of incapacity for work with far-reaching socioeconomic consequences, prevention assumes an important role [1]. The type and extent of work-related skin stresses essentially determine the severity of a skin disease and thus also the associated risk that a BK 5101 will develop, reappear or worsen [24]. According to § 3 section 1 of the Occupational Diseases Ordinance, it is the task of the accident insurance carriers to counteract this imminent danger by “all means appropriate”.

To fulfil this task, measures have been developed in Germany to both counter the development and progression of occupational dermatoses and to minimize their consequences [25]. They are divided into measures of primary, secondary and tertiary prevention, whereby primary and secondary prevention are often congruent and often not clearly distinguishable in practice [3].

In 2015, the Austrian General Accident Insurance Institution (AUVA), in cooperation with the Medical University of Graz, introduced a prevention model for patients with occupational skin diseases, which is essentially based on the system successfully established in Germany for many years [26].

Primary prevention is aimed at the healthy population - especially those working in high-risk occupations - and mainly seeks to substitute or eliminate potential sources of danger.

According to the Occupational Health and Safety Act, employers are responsible for primary prevention measures [27]. Likewise, health insurance companies in Germany are responsible for health promotion and non-medical primary prevention [28]. However, in the case of an already existing allergic or irritant contact dermatitis, this measure can also serve in secondary prevention by preventing an allergen or irritant exposure, and it is essential for the desired healing process. Thus patients must be comprehensively informed about the type and occurrence of contact allergens or irritants [4].

“Relational prevention” involves the application of technical and organizational measures if it is not possible to completely eliminate a source of danger.
“Relational prevention” involves the application of technical and organizational measures if it is not possible to completely eliminate a source of danger in advance [25]. Examples of such measures are the automation of work processes, non-touch techniques (for example, the use of tongs or cleaning machines) or the uniform distribution of hazardous activities to reduce the individual burdens. The final element of this hierarchy of measures according to the STOP principle is adequate personal protective equipment (PPE), which the employer must provide for hazardous substances. The employer must also instruct employees on the correct use of this equipment, and skin protection plans should be made available as an additional aid [25]. In particular, PPE includes suitable protective gloves, and compatible material should be used to avoid irritant or allergic contact dermatitis [8]. When liquid-tight gloves are worn for prolonged periods, inner cotton gloves are recommended to reduce the occlusive effect, with regular changes when they become soaked [29].

In the context of “behavioral prevention”, concrete advice should also be given on skin protection and skin care measures (taking into account any already known allergies) and mild cleaning products and disinfectants should be used [25].

The main goal of secondary prevention is the early treatment of occupational skin diseases, resulting in healing or at least a symptom-free, continued occupational activity.

The sequence of primary preventive measures to be taken according to the STOP principle is shown in Table 3.

The responsibility for secondary prevention arises for the statutory accident insurance and until the end of 2020 was indicated if the occupational dermatosis had already appeared, but did not meet the criteria for BK 5101. This preventive measure will play an essential role in the future due to the BK legal reform, as it will now also be used after recognition of a BK 5101 – that is, also at times when secondary prevention has not yet been fully exhausted. The main goal of secondary prevention is the early treatment of occupational skin diseases, resulting in healing or at least a symptom-free, continued occupational activity.

### Table 3 Primary prevention according to the STOP-principle.

| Substitution/Elimination                                                                 | Substitution of substances that are hazardous to the skin/potentially allergenic substances with less hazardous substances (for example the use of gloves made of synthetic material in case of natural rubber latex allergy) | Designing work procedures that avoid skin hazards |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Technical measures                                                                     | Automation of work processes (for example, automatic cleaning machines, automated gluing processes) | Non-touch techniques (e.g. use of tongs or forceps) | Technical ventilation systems/suction |
| Organisational measures                                                                | Skin protection plans                                                                                                           | Internal rotation to more skin-friendly positions | Equal distribution of tasks between employees |
|                                                                                       | Training on skin-friendly work techniques                                                                                       | Cleaning of contaminated work equipment and surfaces | Regular change of gloves |
|                                                                                       | Equal distribution of tasks between employees                                                                                   | Regular change of contaminated work clothes and proper cleaning | Regular change of gloves |
|                                                                                       | Cleaning of contaminated work equipment and surfaces                                                                            | Spatial separation of workplaces that are hazardous to the skin from those that are gentle on the skin | Equal distribution of tasks between employees |
|                                                                                       | Regular inspection of the implemented measures by the employer                                                                |                                                                                           | Regular change of contaminated work clothes and proper cleaning |
| Personal protective equipment                                                          | Adequate gloves                                                                                                                 | Safety goggles and face shield where required | Suitable skin protection products |
|                                                                                       | Long-sleeved protective clothing                                                                                                 | Safety shoes/foot protection                                                                   | Regular inspection of the implemented measures by the employer |
Where required, an inspection of the workplace is indicated to confirm or exclude allergen exposure and to establish whether alternatives are available for replacement of problematic occupational substances.

For outpatient therapy-resistant occupational skin diseases, tertiary individual prevention comes into play, the aim of which is to increase the chance of remaining at work.

The intention of the legislator to introduce the obligation to cease work was, among other things, to exclude petty cases from compensation and to verify the causality of the skin disease.

or at least a symptom-free, continued occupational activity [30]. In this regard, in 1972, pursuant to §§ 41–43 of the “Vertrag Ärzte/Unfallversicherungsträger” (Contract between Physicians and Accident Insurance Carriers), the dermatologist’s procedure, which is unique worldwide, was introduced in order to avoid a chronic and recurring course of disease [3]. In addition to specialized dermatological diagnostics and therapy, the dermatologist’s procedure allows for optimization of protective measures in the workplace, sound occupational dermatological advice within the framework of seminars on secondary individual prevention (SIP) in special skin protection centers or in training and advisory centers of the accident insurance carriers, and even interdisciplinary, modified inpatient curative procedures lasting approximately three weeks if the occupational skin disease proves to be particularly persistent and resistant to outpatient therapy [3]. In the latter case, tertiary individual prevention comes into play, the aim of which is to increase the chances that the affected person can remain at work and generally achieve an improvement in the skin condition. In addition to intensive therapy of the occupationally caused skin disease, it is accompanied by health education and psychological instruction of the patient [25].

Background to the introduction of the obligation to cease work

Since 1925, occupational diseases have been covered by the statutory accident insurance scheme, which has existed since 1884. With skin cancer caused by “soot, tar, pitch and similar substances” (today BK 5102), a skin disease was already included in the first Occupational Diseases Ordinance of 1925 [31]. The origins of the obligation to cease work date back to 1936, when occupational skin diseases were defined in the 3rd Occupational Diseases Ordinance as “severe or repeatedly relapsing occupational skin diseases which compel a change of occupation or the abandonment of any gainful employment.” However, the wording “change of occupation or abandonment of any gainful work” resulted in the problem that a learned occupation was a prerequisite for compensation and recognition of the occupational disease, regardless of cases in which gainful work was abandoned. Therefore, in 1961, in the 6th Occupational Diseases Ordinance, a correction was made to the wording, as follows: “severe or repeatedly relapsing occupational skin diseases that compelled the abandonment of occupational employment or any gainful work” [6]. The consequence of this change was that unskilled labor was also taken into account and the actual abandonment of the activity became a prerequisite for the occurrence of the insured event and thus for recognition - the mere compulsion to abandon the disease-causing activity was no longer sufficient [6]. This resulted in a failure to recognize the disease if the occupational activity was continued and paused possible pension entitlement if the occupational activity was resumed after recognition [6]. The definition of BK 5101, which was valid until the end of 2020 and known to dermatologists in Germany for decades, was introduced with the 7th Occupational Diseases Ordinance in 1976: “Severe or repeated relapsing skin diseases that have forced the cessation of all activities that were or may be causative for the development, aggravation, or resurgence of the disease.” This satisfied the prevention concept according to § 3 section 1 of the Occupational Diseases Ordinance “to counteract by all appropriate means” the danger of the development, aggravation and/or resurgence of an occupational disease, because before it came to the “cessation of all activities”, all possible preventive measures had to be exhausted [6]. Other objectives pursued through the obligation to cease
work were “on the one hand, to bring about the necessary extension of insurance coverage within objectively justified and health-based limits, and on the other hand, to compensate for only those diseases designated as chronic skin diseases according to their course and duration, as well as to limit as far as possible the extraordinary difficulties that lie in clarifying the causes of the disease in each individual case” [32].

Thus, the intention of the legislator was to exclude minor cases from compensation, specified by the additional (and still existing) definition of the severity and repeated recurrence of the skin disease [6]. Additionally, the intention was to verify the causality of the skin disease by the omission of the activity. Thus an improvement or even healing after abandonment of the occupation would support the occupational causal connection [5].

Background to the abolition of the obligation to cease work

There has been repeated criticism, especially by trade unions, of the low number of recognized cases of BK 5101 due to the lack of an indication for the obligation to cease work through secondary preventive measures [6]. According to the German Trade Union Confederation, the obligation to cease work is a “relic from the old days” and should be “abolished”. Those affected, especially older employees, had all too often been forced into situations that threatened their existence, as finding a new job or completing retraining programs proved difficult due to their age [33].

Overall, the obligation to cease work often led to unfair disadvantages for the insured in the form of (partial) exclusion from benefits under statutory accident insurance, despite an illness demonstrably caused by work [34].

As early as 2003, the purpose of the obligation to cease work was called into question by the Federal Social Court in a landmark ruling, because “none of the objectives pursued by the obligation can, however, justify not compensating an occupationally acquired illness that has led to a - possibly considerable - reduction in earning capacity, unlike comparable consequences of an occupational accident, merely because the insured person can continue to perform his or her occupational activity thanks to a change in the working conditions that eliminates the causes of the illness”. Another point of criticism was made in 2013 by the German Industrial Union of Metalworkers (IG-Metall) in its “Black Book” on occupational diseases: “The obligation to cease work does not create any prevention incentives, but rather has the effect that those affected are exposed to the burden for even longer”. In addition, the obligation to cease work is described in the same breath as an “imposition” that merely aims to “reduce costs.” In 2016, the German Social Accident Insurance (DGUV) published a white paper recommending that the German government abolish the obligation to cease work in SGB VII, with the following summary justification:

1. In a causality assessment, the observation/evaluation of exposure-free periods (weekends, vacations, incapacity to work) in the case of illnesses that occur in close temporal relation to the workload is an indispensable element anyway.
2. The issue of the prevention purpose overlaps with the regulation of § 3 of the Occupational Diseases Ordinance.
3. The obligation to cease work is not a reliable indicator of the severity of an illness and is therefore not suitable for delimiting petty cases.
It was also noted that, in individual cases, the obligation to cease work would be tantamount to an occupational ban and would be an encroachment on the autonomy of insured persons and their ability to participate in working life. However, in order to counter a future avoidance of preventive measures in the workplace, it was also noted that the abolition of the obligation to cease work should be accompanied by a strengthening of motivation and a legal obligation for insured persons to participate in reasonable preventive measures.

The German federal government followed up on these impulses with new regulations in the 7th SGB IV Amendment Act, which have been effective since 01/01/2021. The obligation to cease work was abolished for all nine occupational diseases affected by it in the definition, with the emphasis that in the case of BK 5101 “trivial diseases” were excluded anyway through the condition that severity and/or repeated recurrence must be fulfilled. The obligation of the insured party to “participate in individual preventive measures of the accident insurance institutions and to cooperate in behavioral prevention measures” was also legally anchored in paragraph 9 section 4 of SGB VII.

7th SGB IV Amendment Act - Consequences with regard to BK 5101

Until now, the cessation of the damaging activity was considered a prerequisite for the occurrence of the insured event and thus constituted a constituent feature of BK 5101. Since January 1, 2021, the obligation to cease work for the recognition of BK 5101 no longer applies and thus the presence of a severe or repeatedly relapsing skin disease is decisive. As a consequence of the retroactive regulation in § 9 section 2a SGB VII, which was also enacted on January 1, 2021, cases of previous non-recognition dating from 1997 are to be reexamined retrospectively to verify whether insured persons may nevertheless have a BK 5101 disease [34]. This is likely to result in an increase in the average age of those affected by BK 5101 diseases in the future. In the past, the indication to refrain from work at first presentation was only rarely given, such as in the case of severe aerogenic contact eczema to epoxy resins. Thus, a medical, objective obligation to cease work could usually only be confirmed when preventive measures appeared to have been exhausted and a desired outcome had failed to materialize. This ultimately prompted the physician to follow up on his BK notification obligation [6]. Henceforth, in the case of a severe skin finding, the only requirement is a six-month examination period for assessing the response to “appropriate” therapeutic and preventive measures, with no necessity to await the conditions with which the objective obligation to cease work would apply [6].

With the amendment of the occupational disease law as enacted on January 1, 2021, physicians are now required to file a BK notification according to § 202 SGB VII if the criterion of “severe” or “repeated recurrence” of an occupationally caused skin disease is fulfilled in an insured person. A BK report must also be submitted for primarily mild skin diseases for which a dermatologist’s report has been prepared, if the skin findings remain unchanged after six months of dermatological therapy in accordance with the guidelines [35]. According to the legal memorandum, the duty falls to the accident insurance carriers to develop targeted preventive measures, provide comprehensive information to insured persons about the potential hazards of the disease-causing activity, and to inform on possible protective measures [6]. It is also the task of the accident insurance institutions to work towards terminating the occupational activity if the insured person can no longer reasonably be expected to pursue it on medical grounds [24].
For the insured person, BK recognition entails a duty to cooperate in individual preventive measures of the accident insurance providers as newly stipulated by law in § 9 section 4 SGB VII, in order to prevent or at least minimize further damage. From the point of view of the legislator, this is a significant advance of the amendment [6]. This means that those affected must implement behavioral preventive measures and take advantage of offered opportunities, such as the implementation of reasonable therapy measures or participation in outpatient skin protection seminars, if the hazardous occupational activity is continued and benefits are to be drawn from the accident insurance [5].

Failure to participate could affect the estimate of the reduction in earning capacity (German: Minderung der Erwerbsfähigkeit, MdE) [6], which the accident insurance providers may assess after requesting the insured person’s medical treatment reports, which contain information on the insured person’s implementation of treatment measures [5]. In addition, after recognition of a BK 5101, the accident insurance institutions may make a more critical distinction between occupationally caused damage and pre-existing endogenous skin disease [6].

Overall, the 7th SGB IV Amendment Act will presumably make future treatment of a recognized BK 5101 easier both for insured persons and their treating physicians, since the statutory accident insurance institutions are now obliged to provide benefits after recognition of the occupational disease for as long as it has not healed or for as long as the aggravating component of a congenital skin disease persists after cessation of the occupational activity [5].

In such cases, the benefits received by an insured person from the accident insurance providers are life-long, in contrast to the preventive benefit of the dermatologist’s procedure, which was usually initially limited to six months [5].

The dermatologist’s report and the dermatologist’s procedure

If, in the case of insured persons with severe or repeatedly relapsing skin diseases, there was a possibility that a skin disease might develop, revive or worsen as a result of an occupational activity as defined in the Occupational Diseases Ordinance, then up to now, the dermatologist’s procedure, as developed in 1972, has had priority in terms of prevention.

Based on occupational disease statistics, since its establishment the dermatologist’s procedure has proven its worth, as the obligation to cease work could be prevented in most cases in the past [5].

The first step, with the patient’s consent, was a dermatologist’s report by a dermatologist, occupational physician or company doctor (using form text F6050), followed by the introduction of appropriate measures of secondary individual prevention by the accident insurance carrier [4]. The accident insurance carrier, in return, would cover the costs of the dermatological diagnostics required to clarify the causal relationship between the skin disease and the occupational activity, and the costs of treatment as well, if the cause was confirmed to be work-related [34].

This procedure will remain unchanged in the future if there is already a mere possibility of a work-related skin disease [36]. The obligation to submit a dermatologist’s report in the case of minor skin diseases that have not yet recurred, as agreed in the contract between physicians and accident insurance institutions, continues to apply to dermatologists, occupational physicians or company physicians, as do the subsequent necessary measures for individual prevention. A shift is likely in the future, however, in the “balance between BK reports and
A BK report must be made by every physician if a severe skin disease is already present at initial presentation.

To avoid “prevention gaps”, a dermatologist’s report should be made in accordance with § 41 section 2 of the Contract between Physicians and Accident Insurance Carriers, in parallel with the timely filing of a BK report, if there is a reasonable suspicion of BK 5101.

dermatologist’s reports”, since a BK report must now be prepared by every physician already at initial presentation if a serious skin disease is diagnosed [35].

However, the multi-page dermatologist’s report F6050 provides the accident insurance carrier with a great deal of essential information regarding occupational history, skin findings (with precise information on localization and morphology), therapies already carried out, and precise suggestions for initiating specific preventive measures [4], thus the risk in the earlier filing of the short BK report is that this information may be lost [34]. The process of determining the extent of the disease, which may take months or even years due to extensive investigations, raises the risk of a “prevention gap”, since the social accident insurance carriers are only obliged to pay benefits after recognition of the occupational disease [35]. In order to close this gap, a provision was added to section 2 of § 41 of the Contract between Physicians and Accident Insurance Carriers, which stipulates that even if there is a well-founded suspicion of the existence of a BK 5101, this should be declared with a BK report and together with the F6050 dermatologist’s report [34].

To support the early granting of preventive measures, dermatologists should simultaneously, upon the filing of a BK report (and the simultaneous dermatologist’s report), request that the accident insurance carriers provide a treatment order, pointing out that an aggravation of the occupational disease is imminent in the absence of appropriate measures according to § 3 of the Occupational Diseases Ordinance [35]. In this respect, the valuable time until the end of the determination procedure should be filled with suitable dermatological treatment measures, such as topical, systemic or UV phototherapy [5]. Management of BK 5101 is illustrated in the flow chart in Figure 1.

As usual, a bimonthly progress report (F6052) is to be submitted on the course of the disease, irrespective of whether an occupational disease has been recognized or not [34]. Thus, the dermatologist’s report and the progress report will remain the most important decision-making instruments with regard to initial measures of work-related skin diseases [34].

**Bamberg Recommendation on BK 5101**

In recent decades, the German Working Group for Occupational and Environmental Dermatology (Arbeitsgemeinschaft für Berufs- und Umweltdermatologie, ABD), in interdisciplinary cooperation with statutory accident insurers, has further developed the quality assurance of expert reports in occupational dermatology by continuously revising joint recommendations [37].

While maintaining the highest quality standards, guidelines for the assessment of BK 5101 have been developed since 1987 in the “Bamberger Merkblatt” (now “Bamberger Empfehlung”) to facilitate the assessment by experts, in addition to other dermatological occupational diseases such as BK 5103. With the aid of a summarized presentation of the fundamentals of a homogeneous assessment of work-related skin diseases, these guidelines ensure the constitutionally guaranteed principle of equal treatment of insured persons and render the decisions more comprehensible for the insured persons in question [38].

The recommendations are revised approximately every five years so that they always include the latest findings on diagnostics as well as information on therapy and preventive measures indicated in the guidelines [39].

Thus, the Bamberg Recommendation embodies “an indispensable tool for the dermatological expert and the statutory accident insurance carrier in terms of quality assurance” [40]. With the amendment of the occupational disease law, it is now important to develop precise criteria for the constituent elements of BK 5101 in the
A medical expert opinion is based on sound specialist knowledge and experience of the assessing physician. With consistent neutrality and medical and scientific objectivity, he classifies a medical finding according to uniform and comparable standards and provides a well-founded evaluation of the individual case.

Figure 1 Management of BK 5101 after abolishment of the obligation to cease work.

Bamberg Recommendation and to enable an estimate of the reduction in earning capacity (henceforth referred to as MdE) [6].

**Occupational dermatology expert opinion on BK 5101**

A medical expert opinion is based on sound specialist knowledge and experience of the assessing physician. With consistent neutrality and medical and scientific objectivity, he classifies a medical finding according to uniform and comparable standards and provides a well-founded evaluation of the individual case [41]. The expert must impartially classify medical facts in the legal requirements of social insurance law in order to provide accident insurance carriers and social courts with fundamental decision-making aids [41]. Ensuring equal treatment of the same facts and providing a convincingly reasoned assessment is necessary for the function of an expert opinion [42]. There are no formal requirements, but in the past a standardized structure of occupational dermatology expert opinions has proven successful [37]. After studying the documentation, the personal assessment of the insured person and the diagnostics required to establish the factual situation, a summary of the sources of evidence is provided in the form of an expert opinion.
This should begin with a document excerpt, followed by the medical history and sub-anamneses (personal history, social history, family history, leisure time history, occupational history, specific dermatological history), general and skin findings, if necessary specific clinical scores to determine the risk (e.g. atopy score) and severity (for example SCORAD, PASI) of the skin disease, and a list of the findings of further diagnostics (for example prick test, epicutaneous test) [37]. The main part of the report is the expert opinion, in which the findings are summarized and discussed in relation to the issues at hand [37]. Finally, the questions of the accident insurance carrier should be answered in detail and chronologically, with recourse to the discussion, and provide a concluding overview of the essential assessment points [37].

The “severe” and “repeated recurrence” criterion

Since “severe” and “repeated recurrence” of a skin disease are now decisive for the existence of BK 5101, a clear definition of these characteristics is required. With regard to “severe”, there are as yet no generally binding criteria that allow a clear differentiation from mild skin diseases, so that this decision will continue to depend on the assessment of the examining physician [35]. After a joint consultation of the Bamberg Recommendation Workgroup in July 2020, the following results were published, which will presumably find their way into the Bamberg Recommendation as an amendment. The assessment criterion “severe” is based on:

– the clinical symptoms, morphology and complaints, extent, course and duration of the disease under therapeutic and preventive measures and
– the severity of a work-related allergy [43].

Accordingly, both objective and subjective clinical aspects (morphology, extent and complaints resp.) as well as the time-dependent aspects (course and duration) of the disease must be considered [6].

A severe skin disease as in BK 5101 could, for example, be a chronic eczema affecting the entire skin or a hand eczema with considerable disease value due to deep rhagades, erosions, pronounced infiltration, severe pain and excruciating pruritus [5]. Even if in the latter case the “extent” is limited to the hands only, “severe” would be confirmed based on the subjective impact. Other skin diseases that may meet the “severe” criterion would include occupationally aggravated congenital dermatoses such as atopic eczema or (rarely) psoriasis [5]. Allergic skin diseases with severe reactions, such as generalized contact urticaria syndrome or generalized allergic contact dermatitis with generalized symptoms, would also fall under the “severe” criterion, provided that the disease is caused by sensitization to an occupationally unavoidable substance [43]. Similarly, in the past, “severe” correlated with the duration of a disease according to social court jurisprudence, provided that there was an uninterrupted need for dermatological treatment over a period of at least six months. Here, the disease could even be clinically mild [5]. The decisive factor was a documented, protracted dermatological therapy, regardless of whether this corresponded to appropriate treatment in accordance with guidelines [5].

The joint consultation of the Bamberg Recommendation Workgroup has now decided that for future purposes, a severe skin disease is to be affirmed if there is no significant improvement in the findings after six months of “appropriate” preventive and therapeutic measures in accordance with currently valid standards (for example medical guidelines) [43].
If, on the other hand, an improvement of the skin condition is achieved with appropriate therapy and prevention measures, and if the skin affection is limited, then a mild disease in terms of BK 5101 would exist. However, if the skin findings can only be achieved with “considerable effort” (for example, systemic or inpatient therapy) and “intensified preventive efforts”, use of the term “severe” would be justified even for clinically mild skin diseases. Therefore, detailed documentation of the need for treatment is recommended [43].

The definition of repeated recurrence is simpler. It is present when there are at least three episodes of disease (initial disease and two relapses). This assumes that healing has occurred between the initial illness and the relapses without the need for further treatment, the insured person was employed between the episodes of illness, and a clear occupational connection can be identified [38]. A repeated recurrence exists when the episodes of occupationally-caused skin disease occur as a result of the same insured exposure within a period of twelve months; thus, recurrences that meet the criteria described above but that occur beyond the twelve-month period are not to be considered as repeated recurrences but instead as a new occurrence [43].

(New) Recognition of BK 5101

A BK assessment procedure, initiated by an accident insurance carrier in case of repeated recurrences or severe, work-related skin diseases that arise despite appropriate therapy and prevention measures, should be “objective and neutral, appropriate and simple, expeditious and efficient” in order to support a decision on the recognition of an occupational disease [34]. Here, final clarification of the workplace-related causation as well as factfinding regarding exposure conditions, the skin disease, and competing influences takes place [34].

In terms of numbers, recognition of BK 5101 was previously in counts of less than 400 cases per year - this after elaborate assessments or complex inpatient rehabilitation measures [34].

As a result of the amendment to the BK law, the number of additional reports of suspected BK 5101 is, according to an explanatory memorandum, estimated by the federal government to be around 5700 per year in the first five years and some 2800 per year thereafter, meaning an increase of several thousand recognitions per year.

In addition, there are the recognitions that can now be confirmed due to the current retroactive regulation in the case of previous non-recognition under the new law. Thus, the number of expert opinions on BK 5101 will increase considerably, requiring additional, qualified occupational dermatologists [5].

The increase in recognitions also results in a higher number of pension benefits, the amount of which is determined by the MdE caused by the occupational disease [5]. According to § 56 SGB VII, insured persons are entitled to a pension if, as a result of the insured event, an MdE of at least 20 % can be discerned after the expiry of 26 weeks following the occurrence of the insured event.

Since the recognition of an occupational disease according to BK 5101 can now be affirmed for less severe skin diseases than previously, consideration must be given to whether, in some cases, this may be determined using standardized investigations and a reduced investigatory effort in the future. If so, the questions in the dermatologist’s report would need to be adapted to cover decision-relevant facts [34].
Assessments of the MdE for BK 5101

According to § 56 section 2 of the SGB VII, the value of the MdE is assessed as follows: “The MdE depends on the extent of reduced working possibilities seen over the entire sphere of professional life, that results from the impairment of physical and mental capacity”.

Assessment of the MdE must be made individually in each case, regardless of the insured person’s age, sex, living conditions or previous qualification level [24]. The decisive factor for calculating the MdE is the specific health impairments resulting from the insured event on the general labor market. This means that the mere fact that the previously performed activity can no longer be pursued is not decisive [24]. Furthermore, pre-existing illnesses and disabilities can also affect the level of the MdE, resulting in an increase or decrease of the MdE compared to “healthy” insured persons [24].

Without the effects of an occupational disease, the individual’s gainfully employable capacity is calculated at 100 percent; if medical consequences of an occupational disease are present, the remaining extent of the gainfully employable capacity must be assessed [24]. The difference between the reference value of 100 % and this value is the MdE. Hence, if an individual’s remaining gainfully employable capacity is 90 %, the resulting MdE would be 10 %.

The presence of a BK 5101 disease may impair the individual’s gainfully employable capacity, since certain work opportunities remain closed to the insured person due to unavoidable skin exposure or the effects of an allergy. Therefore, where required, additional health disorders such as considerable pain or disfiguring skin changes must also be taken into account [24]. Accordingly, filtering out which health impairments are present and to what degree of severity is necessary, as are the extent to which these are attributable to the occupational disease, and the extent to which the functional impairment caused by the insured event impairs participation in working life [24]. This is because, in the future, accident insurance will continue to cover only occupationally caused skin changes. Dermatoses caused by the patient’s constitution, such as occupationally aggravated atopic eczema, will only be compensated through accident insurance as long as the non-aggravated initial condition has not been restored [5].

To enable a realistic assessment of the degree of disability, acute skin symptoms should first have subsided as a result of appropriate therapy and preventive measures. This is why, in accordance with § 56 SGB VII, the assessment must not be carried out until after the 26th week following the insured event.

For estimation of the MdE in the assessment of an occupational skin disease according to BK 5101, under the old law (according to which the obligation to cease work was still a prerequisite for recognition of the disease), various points of accepted, empirical knowledge which have proven themselves over the years have been gathered, and are presented in tabular form in the Bamberg Recommendation. These take into account both the extent of skin symptoms and the effect of an allergy on the restrictions within the labor market and generally assess an MdE level of up to 30 % (Table 4).

In this context, the fact that stabilization or even improvement of occupationally effected skin symptoms usually ensued after cessation of the occupational activity and the associated absence of exposure, was also taken into account [24]. However, the abolition of the obligation to cease an occupational activity poses a new challenge for the assessment of the MdE, since in the future, a fair assessment of MdE for insured persons who have abandoned an occupational activity, despite this no longer being a prerequisite for the recognition of the occupational disease,
has to be made in comparison to persons who continue to perform the hazardous activity and thus may suffer from more severe skin symptoms [6].

The Bamberg Recommendation Workgroup intends to gather and publish results based on concrete case studies in this regard [24].

The success or failure of suitable therapeutic and preventive measures essentially determines whether and how participation in professional life is still possible, on which basis the recommendation to continue or terminate a potentially skin-damaging activity is made and also determines the MdE level [24]. It is therefore necessary to assess whether the skin condition can be reduced to a medically acceptable level, which is usually attributed an MdE value of 0 %, or whether the continuation of the activity is deemed medically untenable. In the latter case, the accident insurance institution must endeavor to ensure that the insured person refrains from the hazardous occupational activity [24]. In these cases, the MdE values from the previous Bamberg Recommendation remain valid, until the availability of initial results, and regardless of whether the occupational activity is actually abandoned or not [24].

Minor effects of an allergy and a mild extent of skin symptoms are present when individual, occupationally relevant allergens are poorly distributed within the general labor market and the pathological skin changes, which do not occur more than three times per year, heal after adequate dermatological therapy, a merely mildly atrophic skin is present as a result of a protracted occupational eczema or after corticosteroid treatment, or a pathological skin change is documented after intensive skin exposure [38].

Moderate effects of an allergy and a moderate extent of skin symptoms are present when individual, occupationally relevant allergens are somewhat distributed within the general labor market or if a clinically particularly intense sensitization to a single, poorly distributed occupational substance is present and the pathological skin changes, which occur more than three times per year, persist for several weeks after adequate dermatological therapy, a lichenified and easily damaged skin as a result of a protracted occupational eczema or after corticosteroid treatment is present, or a pathological skin change is documented after moderate skin exposure [38].

Severe effects of an allergy and severe skin symptoms are present if several occupationally relevant allergens are widely distributed within the general labor market or if a single allergen is very widely distributed and there are pronounced permanent or chronic, recurrent skin changes associated with a substantial disease value, or if a pathological skin change is documented even after low skin exposure [38].

Table 4 Assessment of the reduced ability to work (according to [38]).

| Effect of an allergy | Extent of skin symptoms, including after irritative damage (MdE-values in percent) |
|---------------------|-----------------------------------------------------------------------------------|
|                     | none | light | average | severe |
| None                | 0    | 10    | 20      | 25     |
| Minimal             | 0    | 10    | 20      | 25     |
| Moderate            | 10   | 15    | 25      | 30     |
| Severe              | 20   | 20    | 30      | > 30   |

In the future, a fair MdE assessment must be made of insureds who have ceased their activity versus those who continue to perform the hazardous activity.

To date, the MdE values of the previous Bamberg Recommendation still apply, regardless of whether the occupational activity is actually abandoned or not.
Conclusions

BK 5101 is one of the most frequently reported occupational diseases and manifests, with few exceptions, in the form of any dermatosis that arises or is aggravated by the effects of occupational activity. In most cases, it presents as hand eczema, often triggered by wet work. The dermatologist’s procedure plays an important role with regard to targeted diagnostics and early preventive and therapeutic measures and should be initiated on the mere suspicion of BK 5101. A well-founded suspicion of BK 5101 should be followed by initiation of the dermatologist’s procedure in parallel with the timely filing of the notification of an occupational disease in order to avoid “preventive gaps”.

The amendment of the Occupational Diseases Law, which came into force on January 1, 2021, abolished the obligation to cease work of the triggering activity, which was necessary for recognition of the condition until the end of 2020. Prospectively, this will result in a significantly increased number of recognized cases of BK 5101, the processing of which will require additional qualified experts. Official recognition can now be gained if there is a severe or repeatedly relapsing skin condition the cause of which is substantially related to the occupational activity.

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1. Welche Aussage zu Feuchtarbeit trifft zu?
   a) Arbeit im feuchten Milieu von mehr als einer Stunde pro Tag.
   b) Okklusion in Schutzhandschuhen von mehr als zwei Stunden pro Tag.
   c) Intensive Reinigung der Hände während der Arbeitszeit fällt nicht unter die Definition „Feuchtarbeit“.
   d) Feuchtarbeit lässt sich nur selten als Ursache von Handekzemen ausmachen.
   e) Das Unterziehen von Baumwollhandschuhen wird bei allen Handschuhen bereits bei kurzen Arbeitszeiten empfohlen.

2. Welche Aussage zur BK 5101 trifft zu?
   a) Die BK 5101 war die am häufigsten anerkannte Berufskrankheit bei Erwerbstätigen der vergangenen Jahre.
   b) Insbesondere Erwerbstätige höheren Alters des Friseurgewerbes, des Gesundheitswesens, der Metallverarbeitung, der Nahrungsmittel- und Genussmittelgewerbe sowie des Baugewerbes waren bislang von der BK 5101 betroffen.
   c) Einschließlich des Hautkrebses fallen unter die BK 5101 alle Krankheiten der Haut oder Hautanhangsgebilde.
   d) Eine beruflich verursachte Akne zählt ebenfalls zur BK 5101.
   e) Lediglich chemische Irritanzien kommen als Verursacher der BK 5101 in Betracht.

3. Welche Aussage zum Ursachenzusammenhang trifft zu?
   a) Bei einer schweren oder wiederholt rückfälligen Hauterkrankung ist eine BK 5101 auch dann zu bestätigen, wenn ein „wesentlicher“ ursächlicher Zusammenhang zwischen der Hauterkrankung und der beruflichen Tätigkeit nicht vorliegt.
   b) Der Ursachenzusammenhang begründet sich in der Entstehung oder Verschlimmerung einer Hauterkrankung.
   c) Eine Verschlimmerung findet sich häufig bei Patienten mit atopischer Diathese, welche bei 60 % der Patienten mit einer „BK 5101-Erkrankung“ nachzuweisen ist.
   d) Bei einer Gelegenheitsursache handelt es sich um gelegentlich auftretende Noxen im Rahmen der beruflichen Tätigkeit.
   e) Um eine BK 5101 bestätigen zu können, ist es ausreichend, dass die berufliche Tätigkeit eine mögliche krankheitsauslösende Ursache, neben weiteren außerberuflichen, die Hauterkrankung wesentlich unterhaltenden Einflüssen, darstellt.

4. Welche Aussage zum Handekzem ist korrekt?
   a) Mit 75 % ist das Handekzem die häufigste Hauterkrankung im Sinne der BK 5101.
   b) Das akute Handekzem persistiert weniger als einen Monat und tritt nicht mehr als einmal pro Jahr in Erscheinung.
   c) Es existiert keine international anerkannte Klassifikation zum Handekzem.
   d) Männer sind häufiger betroffen als Frauen.
   e) Nur in Ausnahmefällen findet sich eine Kombination aus irritativen, allergischen und endogenen Faktoren.

5. Welche Angabe zur Prävention ist richtig?
   a) Gemäß § 9 Abs. 2 der BKV ist es die Aufgabe der UV-Träger, der Gefahr, dass eine BK 5101 entsteht, wieder auflebt oder sich verschlimmert mit „allen geeigneten Mitteln entgegenzuwirken“.
   b) Der Unterlassungszwang ist ein zuverlässiger Indikator für den Schweregrad einer Erkrankung.
   c) Zwei Jahrzehnte lang war der Unterlassungszwang Bestandteil der bis Ende 2020 gültigen Definition der BK 5101.
   d) Der Unterlassungszwang stellte bei 15 weiteren Berufserkrankungen ein Tatbestandsmerkmal dar.
   e) Ursprüngliche Intention des Unterlassungszwangs war es, unter anderem Bagatellfälle von der Entschädigung des UV-Trägers auszuschließen und die Kausalität der Hauterkrankung zu überprüfen.

6. Welche Aussage zum Unterlassungszwang ist zutreffend?
   a) In einem „Gelbbuch“ der Deutschen Gesetzlichen Unfallversicherung wurden Empfehlungen an die Bundesregierung ausgesprochen, den Unterlassungszwang abzuschaffen.
   b) Der Unterlassungszwang ist ein zuverlässiger Indikator für den Schweregrad einer Erkrankung.
   c) Zwei Jahrzehnte lang war der Unterlassungszwang Bestandteil der bis Ende 2020 gültigen Definition der BK 5101.
   d) Der Unterlassungszwang stellte bei 15 weiteren Berufserkrankungen ein Tatbestandsmerkmal dar.
   e) Ursprüngliche Intention des Unterlassungszwangs war es, unter anderem Bagatellfälle von der Entschädigung des UV-Trägers auszuschließen und die Kausalität der Hauterkrankung zu überprüfen.

7. Welche Aussage zum SGB IV-ÄndG trifft zu?
   a) Bei bisheriger Nicht-Anerkennung sollen gemäß der Rückwirkungsregelung von § 9 Abs. 2a SGB VII die vergangenen fünf Jahre auf eine möglicherweise doch vorliegende BK 5101 überprüft werden.
CME-Artikel

8. Eine Hauterkrankung steht im wesentlichen Ursachenzusammenhang mit der beruflichen Tätigkeit des Versicherten. Welches Vorgehen ist richtig?
   a) Sie diagnostizieren ein schwarzes Handekzem und erstatten zunächst nur einen Hautarztbericht.
   b) Die Hauterkrankung ist weder schwer noch wiederholt rückfällig, da aber die bloße Möglichkeit einer BK 5101 gegeben ist, erstatten Sie eine BK-Anzeige.
   c) Die Kosten der Behandlung sind von der gesetzlichen/privaten Krankversicherung zu übernehmen.
   d) Da eine schwere Hauterkrankung vorliegt, hat eine BK-Anzeige zu folgen, die aber nur durch Hautärzte, Arbeitsmediziner oder Betriebsärzte erstattet werden kann.
   e) Sie diagnostizieren eine wiederholt rückfällige Hauterkrankung und erstatten unverzüglich einen Hautarztbericht und eine BK-Anzeige.

9. Welche Aussage zur „Schwere“ und „wiederholten Rückfälligkeit“ trifft zu?
   a) Bei klinisch nicht schweren Hauterkrankungen kann das Vorliegen einer „Schwere“ dennoch bestätigt werden, wenn dies zum Beispiel nur durch eine systemische Therapie erzielt werden kann.
   b) Eine wiederholte Rückfälligkeit kann dann bestätigt werden, wenn im Rahmen einer Arbeitsunfähigkeit zwischen den Episoden der Hauterkrankung zweimalig eine Abheilung eingetreten ist.
   c) Ein auf die Füße beschränktes Ekzem kann nicht das Kriterium der „Schwere“ erfüllen, da hinsichtlich der Ausdehnung mindestens eine weitere Körperregion betroffen sein muss.
   d) Eine wiederholte Rückfälligkeit besteht dann, wenn die Episoden der beruflich verursachten Hauterkrankung innerhalb eines Zeitraumes von zwölf Monaten eintreten, unabhängig davon, ob die versicherte Tätigkeit zwischenzeitlich gewechselt wurde.
   e) Eine schwere Hauterkrankung kann bestätigt werden, wenn nach dreimonatigen „angemessenen“ Präventions- und Therapiemaßnahmen, gemäß aktuell gültigen Standards, keine wesentliche Befundverbesserung zu verzeichnen ist.

10. Welche Aussage zur MdE ist korrekt?
   a) Die Berechnung der MdE erfolgt in Abhängigkeit der spezifischen gesundheitlichen Beeinträchtigungen infolge des Versicherungsfalls in Bezug auf die bisher verrichtete Tätigkeit.
   b) Die Einschätzung der MdE erfolgt abhängig von Alter, Geschlecht, Wohnverhältnis oder dem bisherigen Qualifikationsniveau der versicherten Person.
   c) Schwergradige Auswirkungen einer Allergie liegen vor, wenn auf dem allgemeinen Arbeitsmarkt einzelne beruflich relevante Allergene nur wenig verbreitet sind.
   d) Die MdE-Sätze der bisherigen Bamberger Empfehlung sind seit 01.01.2021 hinfällig.
   e) Versicherte haben Anspruch auf eine Rente, wenn eine MdE infolge des Versicherungsfalls von mindestens 20 % nach Ablauf von 26 Wochen nach dem Eintritt des Versicherungsfalls zu verzeichnen ist.

Lieber Leserinnen und Leser,

der Einsendeschluss an die DDA für diese Ausgabe ist der 30. Juli 2021.
Die richtige Lösung zum Thema „Inhalte und Stellenwert der Rehabilitation in der Dermatologie“ in Heft 2 (Februar 2021) ist: (1a, 2d, 3d, 4c, 5b, 6e, 7c, 8e, 9a, 10b).

Bitte verwenden Sie für Ihre Einsendung das aktuelle Formblatt auf der folgenden Seite oder aber geben Sie Ihre Lösung online unter http://jddg.akademie-dda.de ein.