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Use of Di(2-ethylhexyl) Phthalate–Containing Medical Products and Urinary Levels of Mono(2-ethylhexyl) Phthalate in Neonatal Intensive Care Unit Infants

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OBJECTIVE: Di(2-ethylhexyl) phthahlate (DEHP) is a plasticizer used in medical products made with polyvinyl chloride (PVC) plastic and may be toxic to humans. DEHP is lipophilic and binds non-covalently to PVC, allowing it to leach from these products. Medical devices containing DEHP are used extensively in neonatal intensive care units (NICUs). Among neonates in NICUs, we studied exposure to DEHP-containing medical devices in relation to urinary levels of mono(2-ethylhexyl) phthalate (MEHP), a metabolite of DEHP.

DESIGN: We used a cross-sectional design for this study.

PARTICIPANTS: We studied 54 neonates admitted to either of two level III hospital NICUs for at least 3 days between 1 March and 30 April 2003.

MEASUREMENTS: A priori, we classified the infants’ exposures to DEHP based on medical products used: The low-DEHP exposure group included infants receiving primarily bottle and/or gavage feedings; the medium exposure group included infants receiving enteral feedings, intravenous hyperalimentation, and/or nasal continuous positive airway pressure; and the high exposure group included infants receiving umbilical vessel catheterization, endotracheal intubation, intravenous hyperalimentation, and indwelling gavage tube. We measured MEHP in the infants’ urine using automated solid-phase extraction/isotope dilution/high-performance liquid chromatography/tandem mass spectrometry.

RESULTS: Urinary MEHP levels increased monotonically with DEHP exposure. For the low-, medium-, and high-DEHP exposure groups, median (interquartile range) MEHP levels were 4 (18), 28 (58), and 86 ng/mL (150), respectively (p = 0.004). After adjustment for institution and sex, urinary MEHP levels among infants in the high exposure group were 5.1 times those among infants in the low exposure group (p = 0.03).

CONCLUSION: Intensive use of DEHP-containing medical devices in NICU infants results in higher exposure to DEHP as reflected by elevated urinary levels of MEHP.

KEY WORDS: di(2-ethylhexyl) phthalate, hospital equipment and supplies, mono(2-ethylhexyl) phthalate, neonatal intensive care units, newborn infants.

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from DEHP-containing products, there is additional concern regarding potential health risks because, until 3 months of age, infants have immature glucuronidation pathways. Because glucuronidation, via enzymes such as UDP-glucuronosyltransferase, facilitates urinary excretion of phthalates and other xenobiotics, a reduced potential for glucuronidation may lead to slower MEHP excretion and higher levels of MEHP in neonates than in older children and adults (Leeder and Kearns 1997).

Among neonates in NICUs, we conducted a study to characterize DEHP exposure and to quantitatively relate the use of DEHP-containing products to urinary levels of MEHP, a biologic marker of DEHP exposure.

Materials and Methods

Study population. We studied a convenience sample of 54 infants enrolled from the level III NICUs at two major Boston-area hospitals. Level III NICUs provide all newborn care, including mechanical ventilation, high-frequency ventilation, surgery, and cardiac catheterization. We selected infants to reflect a range of diagnoses (including congenital anomalies and developmental and metabolic abnormalities) and NICU care requirements (including ventilation, enteral feedings, parenteral nutrition, and indwelling catheterization). Infants must have been in the NICU at least 3 consecutive days before enrollment, have had a corrected gestational age of ≤44 weeks, and have been born at or transferred to either hospital between 1 March and 30 April 2003. Concerns regarding the sensitivity of this research led to the design and implementation of a data and sample collection protocol that was based on visual inspection and that did not include inspection of the medical records. The study protocol and methods were approved by the institutional review boards of Harvard School of Public Health, Brigham and Women’s Hospital, and Massachusetts General Hospital.

Assessment of DEHP exposure. Before data collection, we defined three DEHP exposure categories (low, medium, and high) based on a review of medical products typically used in both NICUs and information provided by their manufacturers with respect to DEHP content. Infants classified as having low DEHP exposure were those receiving primarily bottle and/or gavage feedings. The medium-DEHP exposure group included infants receiving enteral feedings by indwelling gavage tubes either continuously or by bolus feedings; intravenous hyperalimentation by indwelling percutaneous intravenous central catheter (PICC) line, broviac, or umbilical vessel catheter (UVC); and/or nasal continuous positive airway pressure by nasal prongs. The high-DEHP exposure group included infants receiving continuous indwelling UVC, endotracheal intubation, intravenous hyperalimentation by the central venous route (i.e., PICC line, broviac, UVC), and an indwelling gavage tube (for gastric decompression).

One of the study investigators (R.G.) observed the care of each infant for 1–4 hr per day for 1–3 days per infant, for a total of 3–12 hr of observation per infant. Observations were made during a single day for 37 infants, on 2 days for 12 infants, and on 3 days for 5 infants. During the observations, the investigator took an inventory of products in use for the care of each infant. This information was used to categorize infants into low-, medium-, and high-DEHP exposure groups. None of the infants changed DEHP exposure groups over the course of observation.

Assessment of urinary MEHP. The observing investigator collected spot urine samples at the end of each infant’s observation period(s). A total of 81 urine samples were collected from 54 infants. Two or more urine samples came from 17 infants, and of these, four samples were collected concurrently with the first samples, and 18 others were collected 6–72 hr after the first samples. We used these repeated samples to assess intra-individual variability in urinary MEHP levels.

Urine samples were collected by either squeezing the urine from a cotton gauze placed in the infant’s diaper at the beginning of the observation period or from the cotton filling of the diaper the infant wore during the period of observation. The cotton gauze or the removed cotton diaper filling was placed into a 3–5 cc polypropylene syringe (Becton-Dickinson, Franklin Lakes, NJ), the plunger was replaced, and the urine was squeezed into a 2- or 4-cc Nunc (Rochester, NY) cryovial. Urine samples were frozen within 4–6 hr at −35°C and shipped on dry ice to the Centers for Disease Control and Prevention (CDC; Atlanta, GA) for analysis.

Urine specimens were analyzed for 10 phthalate monoesters, including three DEHP metabolites [MEHP, mono(2-ethyl-5-hydroxyhexyl) phthalate, and mono(2-ethyl-5-oxohexyl) phthalate], using automated solid-phase extraction/isotope dilution/high-performance liquid chromatography/tandem mass spectrometry at the CDC. Monobutyl phthalate and monobenzyl phthalate were also frequently detected. In this report, we focus on levels of MEHP, because this metabolite has been most studied and is a valid biomarker of DEHP exposure.

The analytical method used for measuring phthalate metabolites in urine has been described in detail previously (Silva et al. 2004). Briefly, the method involved the enzymatic deconjugation of the phthalate metabolites from their glucuronidated form, followed by automated solid-phase extraction. We used reversed-phase high-performance liquid chromatography to separate the phthalate metabolites from other components in the extracted urine. We then quantified the metabolites by isotope dilution/tandem mass spectrometry. Samples, reagent blanks, and quality control (QC) materials were processed identically. QC materials were analyzed along with the study samples to ensure the accuracy and reliability of the data. QC materials with low concentrations (QCL) and high concentrations (QCH) were prepared from a base urine pool, obtained from multiple anonymous donors as described previously (Silva et al. 2004), dispensed in 5-mL aliquots, and stored at −20°C. Each QC material was characterized by repeated measurements, spanned over several weeks, to define the mean concentrations and the 95% and 99% control limits of MEHP. Each analytical run consisted of 50 (5 QCs, 5 blanks, and 40 unknown) samples. The concentrations of the replicate QCH and QCL materials, averaged to obtain one measurement of QCH and QCL for each run, were evaluated using standard statistical probability rules. All MEHP concentrations, reported in nanograms per milliliter of urine, were blank-corrected. However, MEHP is not typically found in the reagent blank samples, and when it is, it is at concentrations near the limit of detection (LOD; 0.87 ng/mL). Specimens with MEHP levels below the LOD were assigned a value of 0.435 ng/mL, the midpoint between 0 and the LOD.

Assessment of other variables. We collected data, as available, on gestational age and length of stay in the NICU. However, data on these variables were incomplete for about half of the infants because, as noted, the sample collection was anonymous and not based on review of medical records. The interpretation of these data is likely to be tenuous because of missing data, and we therefore do not present these results.

Statistical analysis. We used Fisher’s exact test to evaluate differences in sex and institution by DEHP exposure group. To evaluate the intraindividual variability of urinary MEHP levels, we computed Spearman correlations between repeated urine specimens. For unadjusted comparisons of urinary MEHP levels by sex, institution, and DEHP exposure group, we used the Mann-Whitney Kruskal-Wallis non-parametric test. We used multiple linear regression to compare urinary MEHP levels across DEHP exposure groups, adjusting for institution and infants’ sex. Because the distribution of urinary MEHP was skewed, we used log-transformed MEHP values in the regression models. In regression models of log-transformed MEHP, the regression parameters estimated MEHP levels in the medium- and high-DEHP exposure groups as a proportion of MEHP levels in the low-DEHP exposure group. Our primary analyses focused on the MEHP levels in the first urine specimen collected from each infant.
Results

The 54 infants in our study were roughly equally distributed between the two institutions, and 34 (63%) were female (Table 1). Thirteen (24%) had low exposure to DEHP-containing products, 24 (44%) had medium exposure, and 17 (32%) had high exposure. Among the first set of urine samples collected from these infants, 11 (20%) had MEHP levels that were less than the LOD (0.87 ng/mL), and the maximum level was 758 ng/mL (geometric mean = 14 ng/mL; geometric SD = 8.6 ng/mL).

Correlation between urinary MEHP levels in repeated urine samples. Among the 17 infants with multiple urine samples, urinary MEHP measurements from the same infants were highly correlated. Spearman correlations were 0.9 (p < 0.0001; n = 17) for urinary MEHP levels in the first and second urine specimens, 0.9 (p = 0.04; n = 5) for the second and third specimens, and 0.7 (p = 0.2; n = 5) for the first and third specimens. Although our data were limited, we observed no apparent dissimilarity in the correlation between specimens collected at the same time (correlation coefficient r = 0.80; n = 4) versus those collected at different times (r = 0.88; n = 13 first and second samples only).

Correlates of DEHP exposure group and urinary MEHP. Compared with infants in the two lowest DEHP exposure groups, infants in the high-DEHP exposure group were more likely to be patients at institution B (Table 1). In unadjusted comparisons, urinary MEHP levels were significantly higher among infants at institution B (Mann-Whitney Kruskal-Wallis p = 0.002; Table 2).

Table 1. Characteristics, by DEHP exposure group [n (%)].

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>34</td>
<td>8 (62)</td>
<td>15 (63)</td>
<td>11 (65)</td>
<td>&gt; 0.9a</td>
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<tr>
<td>Male</td>
<td>18</td>
<td>4 (31)</td>
<td>8 (33)</td>
<td>6 (35)</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>1 (8)</td>
<td>1 (4)</td>
<td>0 (0)</td>
<td>0.01</td>
</tr>
<tr>
<td>Institution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>28</td>
<td>11 (85)</td>
<td>12 (50)</td>
<td>5 (29)</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>26</td>
<td>2 (15)</td>
<td>12 (50)</td>
<td>12 (71)</td>
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</table>

Table 2. Median concentrations (and 25th and 75th percentiles) of urinary MEHP, by sex, institution, and DEHP exposure group.

<table>
<thead>
<tr>
<th>Factor</th>
<th>25th percentile</th>
<th>Median</th>
<th>75th percentile</th>
<th>p-Valuea</th>
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<td>Sex</td>
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<td></td>
<td></td>
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<tr>
<td>Female</td>
<td>3</td>
<td>20</td>
<td>64</td>
<td>0.15</td>
</tr>
<tr>
<td>Male</td>
<td>19</td>
<td>39</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Institution</td>
<td></td>
<td></td>
<td></td>
<td>0.002</td>
</tr>
<tr>
<td>A</td>
<td>&lt; LODb</td>
<td>12</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>18</td>
<td>58</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>DEHP exposure group</td>
<td></td>
<td></td>
<td></td>
<td>0.001</td>
</tr>
<tr>
<td>Low</td>
<td>&lt; LODb</td>
<td>4</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>3</td>
<td>28</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>21</td>
<td>86</td>
<td>171</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Relativea urinary MEHP levels (95% CIs), by DEHP exposure group, as a multiple of urinary MEHP in the low-DEHP exposure group (referent = low).

<table>
<thead>
<tr>
<th>DEHP exposure group</th>
<th>Not adjusted</th>
<th>Adjusted for sex</th>
<th>Adjusted for institution</th>
<th>Adjusted for sex and institution</th>
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<tr>
<td>Low</td>
<td>1.0 (Referent)</td>
<td>1.0 (Referent)</td>
<td>1.0 (Referent)</td>
<td>1.0 (Referent)</td>
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<tr>
<td>Medium</td>
<td>3.4 (2.9–3.4)</td>
<td>3.1 (2.8–3.4)</td>
<td>2.2 (1.8–2.7)</td>
<td>2.0 (1.5–2.6)</td>
</tr>
<tr>
<td>High</td>
<td>12.4 (9.3–21.3)</td>
<td>9.7 (7.1–14.3)</td>
<td>6.1 (3.1–12.0)</td>
<td>5.1 (3.0–11.2)</td>
</tr>
</tbody>
</table>

Table 4. Test of overall differences among groups, p-value.

Figure 1. Median and interquartile range of urinary MEHP, by DEHP exposure group, and adjusted for institution and infant sex using quantile regression.
In conclusion, our study demonstrated an association between the use of DEHP-containing medical products and urinary levels of MEHP in NICU infants. This study was designed to evaluate the distribution of exposure to DEHP among NICU neonates only. Additional studies, larger and more comprehensive than the present one, with follow-up of the infants, are needed. Such studies would help determine potential health risks, if any, from DEHP exposure among NICU infants.

**References**


