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Citation

Published Version
doi:10.1289/ehp.1408605

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Paternal Urinary Concentrations of Parabens and Other Phenols in Relation to Reproductive Outcomes among Couples from a Fertility Clinic

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BACKGROUND: Human exposure to phenols, including bisphenol A and parabens, is widespread. Evidence suggests that paternal exposure to environmental chemicals may adversely affect reproductive outcomes.

OBJECTIVES: We evaluated associations of paternal phenol urinary concentrations with fertilization rate, embryo quality, implantation, and live birth.

METHODS: Male–female couples who underwent in vitro fertilization (IVF) and/or intrauterine insemination (IUI) cycles in a prospective study of environmental determinants of fertility and pregnancy outcomes were included. The geometric mean of males’ specific gravity–adjusted urinary phenol concentrations measured before females’ cycle was quantified. Associations between male urinary phenol concentrations and fertilization rate, embryo quality, implantation, and live birth were investigated using generalized linear mixed models to account for multiple cycles per couple.

RESULTS: Couples (n = 218) underwent 195 IUI and 211 IVF cycles. Paternal phenol concentrations were not associated with fertilization or live birth following IVF. In adjusted models, compared with the lowest quartile of methyl paraben, paternal concentrations in the second quartile were associated with decreased odds of live birth following IUI (adjusted odds ratio = 0.19; 95% CI: 0.04, 0.82).

CONCLUSIONS: To our knowledge, these are some of the first data on the association of paternal phenol concentrations with reproduction and pregnancy outcomes. Although these results do not preclude possible adverse effects of paternal paraben exposures on such outcomes, given the modest sample size, further understanding could result from confirmation using a larger and more diverse population.


Introduction

Humans experience ubiquitous exposure to phenols, including bisphenol A (BPA) and parabens. The National Report on Human Exposure to Environmental Chemicals [Centers for Disease Control and Prevention (CDC) 2013], which is periodically issued by the CDC and uses samples from the National Health and Nutrition Examination Survey (NHANES), detected BPA in 92.6% of a nationally representative sample in 2003–2004 (Calafat et al. 2008). Methyl and propyl paraben were detected in 99.1% and 92.7%, respectively, of 2005–2006 NHANES participants, and butyl paraben was detected in 40% of participants (Calafat et al. 2010), likely reflecting its less common use [Cosmetic Ingredient Review (CIR) Expert Panel 2008].

BPA is polymerized to manufacture polycarbonate plastic products (Biles et al. 1999), dental sealants (Olea et al. 1996), thermal receipt paper (Biedermann et al. 2010), and epoxy resin liners of some canned food containers (Braunrath et al. 2005). Parabens are used largely as antimicrobial preservatives in personal care products and pharmaceuticals (Guo and Kannan 2013). Ingestion is considered the main route of BPA exposure (Vandenberg et al. 2007), whereas dermal absorption is an important route of paraben exposure (CIR Expert Panel 2008). The half-life of BPA is approximately 6 hr, with nearly complete urinary excretion in 24 hr (Völkel et al. 2005); the urinary excretion of butyl paraben peaks 8–12 hr following dermal application (Januja et al. 2008). Urinary concentrations of BPA and parabens can be used as biomarkers of their exposure (Calafat et al. 2010).

Rodent studies have linked phenols with adverse reproductive outcomes. BPA has been linked to increased oocyte aneuploidy (Hunt et al. 2003) and adverse effects on meiotic spindle formation (Can et al. 2005), centrosome dynamics (Lenie et al. 2008), and chromosome alignment and segregation (Machtlinger et al. 2012). Both methyl and propyl parabens have been shown to affect mitochondrial activity (Nakagawa and Moldéus 1998; Prusakiewicz et al. 2007), which affects male fertility (Soni et al. 2002; Tavares et al. 2009), and they have also been shown in rats to bind estrogen receptors (Routledge et al. 1998).

Recent studies have shown that the paternal contribution to a healthy pregnancy is more important than previously thought. Beyond delivering their genome, sperm contribute physical structures necessary for fertilization (Cummins 2001; Sutovsky and Schatten 2000), as well as a variety of spermatozoal RNAs (Östermeier et al. 2002, 2004, 2005). These RNAs are markers and potential effectors of human male infertility (Platts et al. 2007; Yatsenko et al. 2006; Zhao et al. 2007). Thus, paternal phenol exposure may impact sperm with potential implications for couples’ fertility.

The aim of this study was to examine associations of paternal urinary phenol concentrations (i.e., BPA and parabens) with fertilization rate, embryo quality, implantation, and live birth among couples from a fertility clinic.

Methods

Study participants and data collection. This analysis is part of a larger prospective cohort study, the Environment and Reproductive Health (EARTH) Study, focused on...
environmental and nutritional determinants of fertility among couples from a fertility clinic (Braun et al. 2012; Smith et al. 2012). In 2004, the study began enrolling men 18–51 years and women 18–45 years of age, and at the time of this analysis consisted of 352 men and 579 women. Participants are followed from study entry until they have a live birth or discontinue treatment at the Massachusetts General Hospital (MGH) Fertility Center. All male–female couples whose male partner had phenols measured during his female partner’s cycle(s) in 2004–2012 were included. Up to three intrauterine insemination (IUI) and/or three fresh non-donor in vitro fertilization (IVF) cycles were included. Because a small percentage of men had cycles with missing phenol measurements (n = 18, 4.4%) that were excluded from the analysis, their included cycles were not necessarily consecutive. To account for the total number of treatment cycles each couple undertook, regardless of whether they were included in our analysis, we created a variable for total number of treatment cycles before excluding these cycles. Cycles converted from IUI to IVF or vice versa were excluded because their protocols differed from nonconverted cycles and there were too few cycles to analyze separately. All subjects provided informed consent, and this study was approved by the institutional review boards at the MGH Fertility Center, the Harvard T.H. Chan School of Public Health, and the CDC.

At recruitment, participants completed research nurse–administered and self-administered questionnaires regarding demographics, medical history, occupation, and lifestyle. Clinical information was obtained from the electronic medical record, and infertility diagnoses were classified according to the Society for Assisted Reproductive Technology (SART) definitions (Practice Committee of the American Society for Reproductive Medicine 2006).

Treatment protocols, outcome, and exposure measurements. Couples underwent IUI or IVF following an infertility evaluation. For IUI cycles, women underwent ovulation induction with clomiphene citrate or gonadotropins; cycles without medical induction were excluded because they differ from traditional IUI and there were too few to analyze separately. For IVF, women underwent one of the following three treatment protocols used at the MGH Fertility Center: a) luteal-phase GnRH (gonadotropin-releasing hormone)–agonist protocol using low, regular, and high-dose leuprolide (Lupron), in which pituitary desensitization was initiated in the luteal phase; b) follicular-phase GnRH-agonist/Flare protocol, in which Lupron was begun in the follicular phase on day 2 of menses; or c) GnRH-antagonist protocol, in which GnRH antagonist was initiated when the lead follicle reached 14 mm in size. All IVF cycles were preceded by a cycle of oral contraceptive pills unless contraindicated. On day 3 of menses, exogenous gonadotropins were initiated. Ovulation was induced with hCG (human chorionic gonadotropin) when at least three dominant follicles ≥ 16 mm were noted and peak estradial level was > 600 pg/mL, and oocyte retrieval was performed approximately 36 hr later. Retrieved oocytes were fertilized by insemination or by intracytoplasmic sperm injection (ICSI), which was used for couples with severe male factor infertility and rarely for couples with prior failed fertilization. Embryos were evaluated by an embryologist and selected for transfer on day 2, 3, or 5 of maturation in culture.

For each cycle, men whose female partner was undergoing IVF or IUI provided one spot urine sample at the time of oocyte retrieval or insemination, respectively. Urine was collected in a clean polypropylene specimen cup, and specific gravity (SG) was measured at room temperature using a handheld refractometer (National Instrument Co. Inc., Baltimore, MD) calibrated with deionized water before each measurement. Urine samples were divided into aliquots, frozen, and stored at −80°C. Samples were shipped overnight on dry ice to the CDC, where they were stored at ≤ –40°C until blinded analysis. The urinary concentration of free plus conjugated phenol species (i.e., total concentration) was measured using online solid-phase extraction coupled to isotope dilution–high performance liquid chromatography–tandem mass spectrometry (Ye et al. 2005). Each analytical run included calibration standards, reagent blanks, and quality control materials. The limits of detection (LODs) for BPA and methyl, propyl, and butyl paraben were 0.36–0.40 ng/mL, 1.0 ng/mL, 0.2 ng/mL, and 0.2 ng/mL, respectively. Concentrations below the LOD were assigned a value of 0. LODs for BPA and methyl and propyl parabens were modeled as approximate quartiles. A linear regression was used to model the dichotomous variable as a continuous one. Linear-logistic models were used to model each outcome as a single variable, and models were adapted to include covariates in a stepwise fashion. Logistic regression models were used to assess the association between each quartile and the outcome.

Data analysis. Univariable analyses were performed with the use of appropriate tests for each outcome; these tests included the log-rank test for Kaplan–Meier survival analysis. The relative risks for each quartile were estimated, and the results of the Cox proportional hazards model were presented for each outcome. Statistical significance was assessed using the log-rank test with a p-value of 0.05. All statistical analyses were performed using Stata software (StataCorp, College Station, TX).
et al. 2003), given their small number, underweight women were combined with normal-weight women. We considered the following as potential mediators of the relationship between paternal phenol concentration and IVF cycles outcomes: any diagnosis of male factor infertility, IVF treatment protocol (flare/antagonist vs. luteal phase), number of oocytes retrieved, use of ICSI, number of embryos transferred, and embryo transfer day. The only potential mediator considered for IUI cycles was any diagnosis of male-factor infertility. Potential confounders were evaluated in univariate models adjusted for maternal age at cycle start due to its biological relevance. The median urinary phenol concentration for each quartile was modeled as a continuous exposure, and potential confounders or mediators that changed the estimate for the male phenol concentration by 10% on the log odds scale and had a p-value < 0.2 were included in the adjusted models. Potential mediators were subsequently evaluated individually in models adjusting for confounders that met inclusion criteria for the model, as well as maternal age. Models are presented as unadjusted, adjusted for confounders, and adjusted for confounders and mediators. All analyses were conducted with SAS version 9.3 (SAS Institute Inc., Cary, NC), and two-sided p-values < 0.05 were considered to indicate statistically significant associations.

Results
A total of 218 couples underwent 406 (195 IUI and 211 IVF) cycles. The number of first, second, and third IUI cycles were 102, 66, and 27, respectively; the numbers for IVF cycles were 152, 40, and 19, respectively. Fifty-three percent of couples underwent IVF only, 30% underwent IUI only, and 17% underwent IUI before undergoing IVF. Subsequent IUI cycles occurred approximately 4 weeks apart, whereas subsequent IVF cycles occurred approximately 16 weeks apart. At baseline, the mean ages of men and their female partners were 36.7 and 35.0 years, respectively (Table 1). Regarding primary SART diagnosis among the 218 couples, 32% had ovarian dysfunction, diminished ovarian reserve, or other female factor, 33% had male factor, and 35% had explainable infertility. Thirty-nine percent of couples had either a primary or secondary diagnosis of male factor infertility. Two-thirds of women (67%) had a BMI < 25 kg/m², and five (2.3%) were underweight. Among men, 30% were normal weight, and none were underweight (Table 1). Compared to the full cohort, our subsample of men was representative in terms of age, BMI, race, and smoking status (data not shown).

Cycles were nearly evenly split between IVF (52%) and IUI (48%) (Table 2). The majority of IVF cycles (70%) used luteal-phase stimulation, roughly half (56%) used ICSI, and 43% resulted in live birth. Among IUI cycles, 12% resulted in live birth, 79% resulted in no pregnancy, 8.2% resulted in pregnancy loss, which included chemical pregnancy, ectopic pregnancy, and spontaneous abortion, and 1.0% had an unknown outcome (Table 2).

The median geometric mean of paternal unadjusted BPA among all IVF cycles in our analysis was 1.6 ng/mL ([interquartile range (IQR) = 0.8–2.8 ng/mL], which was slightly lower than the concentrations measured in males in NHANES 2007–2008 (2.20 ng/mL) and 2009–2010 (1.94 ng/mL), though these males include children and older men (CDC 2013). The median geometric mean concentrations of unadjusted paternal methyl and propyl paraben among all IVF cycles in our analysis were 26.1 ng/mL (IQR = 10.3–87.5 ng/mL) and 3.4 ng/mL (IQR = 0.8–15.1 ng/mL), respectively. Although these methyl paraben concentrations were slightly lower than those among males in NHANES 2007–2008 (33.6 ng/mL) and 2009–2010 (31.7 ng/mL), the concentrations of propyl paraben were slightly higher (3.02 ng/mL and 2.77 ng/mL, respectively) (CDC 2013). Among all IVF cycles in our analysis, 60% of paternal urinary butyl paraben measurements were below the LOD (< 0.2 ng/mL), which was similar to NHANES (CDC 2013). For both IVF and IUI cycles, at each cycle number, the medians of the single measurements taken at that cycle (“concurrent measures”) across all men in the analysis were similar to the median geometric means of concentrations measured up to and including that cycle. Additionally, the median paternal SG-adjusted geometric means of the phenols among all IUI cycles in our analysis were similar to those from IVF cycles (see Supplemental Material, Table S1).

Covariates associated with IUI and IVF outcomes. Given univariate models to identify covariates that were associated with the outcomes at the a = 0.20 level and that produced ≥10% change in the log odds, similar to other studies, each additional year of maternal age was associated with decreased odds of live birth following IVF (OR = 0.95; 95% confidence interval (CI): 0.86, 1.01) and IUI (OR = 0.92; 95% CI: 0.82, 1.02). Each additional year of paternal age was marginally associated with decreased odds of implantation (OR = 0.95; 95% CI: 0.89, 1.02) and live birth following IVF (OR = 0.95; 95% CI: 0.89, 1.01), whereas maternal and paternal normal weight were negatively associated with the proportion of high-quality

Table 1. Participant characteristics among 218 male–female couples at enrollment in the Environment and Reproductive Health (EARTH) Study.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Men</th>
<th>Women</th>
<th>Couples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual characteristic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>36.7 ± 5.1</td>
<td>35.0 ± 4.0</td>
<td></td>
</tr>
<tr>
<td>&lt; 37</td>
<td>118 (54.1)</td>
<td>150 (68.8)</td>
<td></td>
</tr>
<tr>
<td>≥ 37</td>
<td>70 (45.9)</td>
<td>52 (21.2)</td>
<td></td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>27.3 ± 4.1</td>
<td>24.2 ± 4.5</td>
<td></td>
</tr>
<tr>
<td>&lt; 25</td>
<td>65 (30.0)</td>
<td>146 (67.0)</td>
<td></td>
</tr>
<tr>
<td>25 to &lt; 30</td>
<td>103 (47.5)</td>
<td>46 (21.1)</td>
<td></td>
</tr>
<tr>
<td>≥ 30</td>
<td>49 (22.6)</td>
<td>26 (11.9)</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>183 (83.9)</td>
<td>178 (81.7)</td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td>5 (2.3)</td>
<td>3 (1.4)</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>16 (7.3)</td>
<td>20 (9.2)</td>
<td></td>
</tr>
<tr>
<td>Native American/Alaska Native</td>
<td>6 (2.8)</td>
<td>3 (1.4)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>7 (3.2)</td>
<td>14 (6.4)</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>1 (0.5)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Smoking status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>145 (66.5)</td>
<td>156 (71.6)</td>
<td></td>
</tr>
<tr>
<td>Ever</td>
<td>73 (33.5)</td>
<td>62 (28.4)</td>
<td></td>
</tr>
<tr>
<td>Former (n)</td>
<td>60</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Current (n)</td>
<td>13</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Couple characteristic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary SART diagnosis at study entry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male factor</td>
<td>71 (32.6)</td>
<td>41 (18.8)</td>
<td></td>
</tr>
<tr>
<td>Ovulatory dysfunction/DOOR</td>
<td>41 (18.8)</td>
<td>29 (13.3)</td>
<td></td>
</tr>
<tr>
<td>Other female factor</td>
<td>77 (35.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained</td>
<td>85 (39.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year of recruitment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004–2006</td>
<td>41 (18.8)</td>
<td>102 (46.8)</td>
<td></td>
</tr>
<tr>
<td>2007–2009</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010–2012 (through April)</td>
<td>75 (34.4)</td>
<td>102 (46.8)</td>
<td></td>
</tr>
</tbody>
</table>

OR, odds ratio; CI, confidence interval; LOD, limit of detection; DOR, diminished ovarian reserve. Values are mean ± SD or n(%).

*One value is missing.
embryos compared with participants who were overweight or obese (RR = 0.58; 95% CI: 0.38, 0.90 and RR = 0.65; 95% CI: 0.41, 1.02, respectively). Each additional cycle number was negatively associated with implantation (OR = 0.79; 95% CI: 0.65, 0.96) and live birth following IVF (OR = 0.86; 95% CI: 0.71, 1.04), because couples requiring more cycles are more likely to have lower fertility. Similarly, maternal ever smoking compared with never smoking was associated with lower proportions of high-quality embryos (RR = 0.73; 95% CI: 0.46, 1.17) and decreased odds of implantation (OR = 0.53; 95% CI: 0.26, 1.08) and live birth following IVF (OR = 0.61; 95% CI: 0.31, 1.21). The use of ICSI was associated with lower odds of implantation (OR = 0.59; 95% CI: 0.31, 1.13), likely because couples using ICSI have poorer fertility, as reflected by prior failures of IVF without ICSI. Live birth following IVF was positively associated with luteal-phase stimulation protocol (OR = 1.85; 95% CI: 0.95, 3.60), a greater number of oocytes retrieved (OR = 1.04; 95% CI: 0.98, 1.10), and day 5 embryo transfer; (OR = 1.86; 95% CI: 0.98, 3.52), but it was negatively associated with a greater number of embryos transferred (OR = 0.70; 95% CI: 0.41, 1.18).

**Paternal urinary phenol concentrations and IUI and IVF outcomes.** Paternal urinary phenol concentrations were not associated with fertilization rate (see Supplemental Material, Table S2), which was evaluated only in IVF cycles, or live birth following IVF (Table 3) in either unadjusted or adjusted models. After adjustment for confounders, male BPA concentrations in the second quartile were associated with a greater proportion of high-quality embryos (adjusted RR (aRR) = 1.92; 95% CI: 1.13, 3.25) in IVF cycles, but higher quartiles showed no association, and no associations were seen with paternal urinary paraben concentrations (see Supplemental Material, Table S3). After adjustment for confounders and mediators, paternal phenol concentrations were not significantly associated with odds of implantation, which was evaluated in IVF cycles (see Supplemental Material, Table S4). After adjusting for confounders, paternal methyl paraben concentrations in the second quartile were associated with decreased odds of live birth following IUI (aOR = 0.19; 95% CI: 0.04, 0.82), and propyl paraben concentrations in the fourth quartile were suggestive of decreased odds (OR = 0.20; 95% CI: 0.04, 1.02; p = 0.053; Table 4).

### Discussion

In this analysis we examined the association of paternal urinary phenol concentrations with couple-level reproductive outcomes. Prior work in this cohort among women undergoing IVF showed that higher maternal urinary BPA concentrations were associated with decreased ovarian response (Mok-Lin et al. 2010), decreased peak serum estradiol, fewer oocytes retrieved, fewer normally fertilized oocytes, and reduced implantation (Ehrlich et al. 2012a, 2012b). In this analysis, paternal concentrations of methyl paraben in the second quartile and propyl paraben in the fourth quartile were significantly associated with and suggestive of decreased odds of live birth following IUI, respectively. However, because there were only three, five, and six live births in the second, third, and fourth quartiles of methyl paraben, respectively, and there were only three live births in the fourth quartile of propyl paraben, these estimates should be interpreted with caution. These results do not clearly indicate or preclude adverse effects of paternal exposure to environmental phenols on reproductive outcomes, and much research remains to further elucidate these potential effects.

It is interesting to note the differences found between IUI and IVF, with null results in IVF cycles and significant and suggestive associations for specific quartiles of methyl and propyl paraben, respectively, in IUI cycles. One possible explanation may be the differing invasiveness of the procedures. For instance, if phenols adversely affect reproductive outcomes, the intensive interventions of IVF may overcome these effects, whereas the less intense IUI may not.

To our knowledge, there are few if any studies in experimental animals on pregnancy outcomes following paternal exposure.
Paternal phenols and reproductive outcomes

to phenols, but there is growing evidence of
paternally mediated adverse health effects of
phenols. In one study in which adult male
rats, used as sires, were chronically exposed
to 50 μg/kg/day of dietary BPA, the adult
F1 offspring had decreased acquisition and
retention of spatial memory compared with
unexposed F1 offspring (Fan et al. 2013). In
another study in mice, maternal exposure to
plastics-derived endocrine disruptors, including
BPA, promoted epigenetic transgen-
erational inheritance of adult disease mediated
through the male germline (Manikkam et al.
2013). Finally, in male offspring exposed
during gestation to a mixture of BPA and phthalates,
differential DNA methylation of
the F1 generation sperm promoter epigenome
was identified (Manikkam et al. 2012).

There are few epidemiologic studies on
male-mediated effects of phenols. We reported
an association of urinary BPA with altered
semen quality, as evidenced by declines of
23% in sperm concentration, 8% in motility, and
13% in morphology in a cross-sectional
study of 190 men from the MGH Fertility
Center (Meeker et al. 2010). Poorer semen
parameters were also associated with increased
urinary BPA concentrations in a study of
occupationally exposed Chinese workers (Li
et al. 2011), and a modest reduction in free
testosterone was found among 375 fertile
men (Mendiola et al. 2010). A small study,
similar in design to ours, of 27 couples under-
going IU and embryo transfer day; the model for propyl paraben was also adjusted for
any diagnosis of male factor infertility (yes vs. no); models for methyl, propyl, and butyl paraben were also adjusted for stimula-
tion protocol (luteal phase vs. flare/antagonist); the model for methyl paraben was also adjusted for use of ICSI (yes vs. no).

The p-trend value was calculated using the median of each quartile as a continuous variable. The LOD for butyl paraben was 0.2 ng/mL. The p-value was calculated using above and below the LOD as categorical variables.

Table 4. Associations between live birth among initiated cycles and quartiles of specific gravity–adjusted
urinary phenol concentrations among men whose partner underwent in vitro fertilization.

<table>
<thead>
<tr>
<th>Phenol quartiles (range in ng/mL)</th>
<th>Live births/cycles</th>
<th>Unadjusted OR (95% CI)</th>
<th>Confounder-adjusted aOR (95% CI)</th>
<th>Confounder- and mediator-adjusted aOR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPA 24/195</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (≤ 1.16)</td>
<td>8/48</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>2 (1.17–1.82)</td>
<td>8/49</td>
<td>0.99 (0.32, 3.03)</td>
<td>0.95 (0.31, 2.93)</td>
<td></td>
</tr>
<tr>
<td>3 (1.83–2.96)</td>
<td>2/49</td>
<td>0.21 (0.04, 1.11)</td>
<td>0.24 (0.04, 1.25)</td>
<td></td>
</tr>
<tr>
<td>4 (2.97–32.97)</td>
<td>6/49</td>
<td>0.69 (0.21, 2.28)</td>
<td>0.66 (0.20, 2.21)</td>
<td></td>
</tr>
<tr>
<td>p-Trend</td>
<td></td>
<td>0.43</td>
<td>0.41</td>
<td></td>
</tr>
<tr>
<td>Methyl paraben 24/182</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (≤ 10.66)</td>
<td>10/45</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>2 (10.67–25.15)</td>
<td>3/46</td>
<td>0.25 (0.06, 0.99)</td>
<td>0.19 (0.04, 0.82)</td>
<td></td>
</tr>
<tr>
<td>3 (25.16–78.17)</td>
<td>5/46</td>
<td>0.43 (0.13, 1.42)</td>
<td>0.34 (0.08, 1.21)</td>
<td></td>
</tr>
<tr>
<td>4 (79.48–887)</td>
<td>6/45</td>
<td>0.54 (0.17, 1.70)</td>
<td>0.35 (0.10, 1.25)</td>
<td></td>
</tr>
<tr>
<td>p-Trend</td>
<td></td>
<td>0.92</td>
<td>0.58</td>
<td></td>
</tr>
<tr>
<td>Propyl paraben 24/182</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (≤ 0.90)</td>
<td>7/46</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>2 (0.91–2.66)</td>
<td>7/45</td>
<td>1.04 (0.32, 3.40)</td>
<td>0.78 (0.22, 2.75)</td>
<td></td>
</tr>
<tr>
<td>3 (2.67–11.37)</td>
<td>7/45</td>
<td>1.03 (0.31, 3.42)</td>
<td>0.90 (0.26, 3.14)</td>
<td></td>
</tr>
<tr>
<td>4 (11.38–981)</td>
<td>3/46</td>
<td>0.38 (0.09, 1.68)</td>
<td>0.20 (0.04, 1.02)</td>
<td></td>
</tr>
<tr>
<td>p-Trend</td>
<td></td>
<td>0.14</td>
<td>0.04</td>
<td></td>
</tr>
<tr>
<td>Butyl paraben 24/182</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below the LOD c</td>
<td>15/122</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>Above the LOD c</td>
<td>9/60</td>
<td>1.27 (0.51, 3.18)</td>
<td>1.18 (0.47, 2.97)</td>
<td></td>
</tr>
<tr>
<td>p-Value</td>
<td></td>
<td>0.61</td>
<td>0.73</td>
<td></td>
</tr>
<tr>
<td>aOR, adjusted odds ratio.</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
| *All models were adjusted for maternal age (years); maternal smoking (ever vs. never) was additionally adjusted for in the models for methyl and propyl paraben. *The p-trend value was calculated using the median of each quartile as a continuous variable. The LOD for butyl paraben was 0.2 ng/mL. The p-value was calculated using above and below the LOD as categorical variables. No mediator met the inclusion criteria for any model, so we present a mode adjusted for confounders only.

Strengths and limitations. To our knowl-
edge, this study is one of the first to examine
associations of paternal preconception urinary
concentrations of BPA and parabens with
pregnancy and early reproductive outcomes.
Another couple-based prospective cohort
study with preconception enrollment, the
Longitudinal Investigation of Fertility and the
Environment (LIFE) Study, has reported
associations between decreased couple fecun-
dity and maternal and paternal exposure to
environmental chemicals (Buck Louis et al.
2012, 2013). The authors found no associa-
tion between maternal or paternal urinary
BPA concentrations and time to pregnancy
(Buck Louis et al. 2014). Our study examined
early reproductive outcomes among couples
undergoing assisted reproduction, and though
these couples differ from the general popu-
lation, they may be a population sensitive
to these exposures. Our subsample of men
was representative of the full cohort with
respect to age, BMI, race, and smoking
status. This subsample excluded men who
participated without their female partner and
men whose urine sample had not yet been
analyzed, but these reasons are unlikely to
introduce any bias.

A limitation is potential exposure misclas-
dification due to the short half-life of phenols,
which can result in high within-individual variability. The intracluster correlation coefficient (ICC) of BPA has been shown to be as low as 0.12 (Braun et al. 2012), though parabens appear to be less variable, particularly among men (ICC > 0.54 and ICC = 0.51 for methyl and propyl paraben, respectively) (Smith et al. 2012). Low ICCs can reduce study power and increase the probability of type 2 error. In our study, the geometric means were similar to concurrent measurements, though we believe using the geometric mean concentration of all samples collected before the cycle minimized this potential bias. Any residual misclassification should be nondifferential, though due to the use of categorical exposure, this could result in bias toward or away from the null. Finally, we adjusted for variables that may be mediators as opposed to confounders. For instance, if phenol exposures adversely affect reproduction, they could reduce the number of viable oocytes available for retrieval, which could also decrease the number of embryos available for transfer, which in turn may affect implantation. When controlling for a mediator, it is possible that the total causal effect of the exposure on the outcome is not consistently estimated; typically, this will bias results toward the null (Schisterman et al. 2009). Thus, these estimates may underestimate the true causal effect. Additionally, race and ethnicity have been shown to be determinants of exposure, particularly for parabens (Calafat et al. 2010). As our population was 83% Caucasian, these phenol concentrations may not be representative of population concentrations.

Conclusions

This study does not exclude the possibility of adverse effects of male phenol exposure on reproductive outcomes in couples undergoing assisted reproduction. Further understanding of these associations could result from replication within a larger and more diverse cohort, and investigations into exposure to mixtures of environmental chemicals, within both individuals and couples, would further elucidate the reproductive effects of these exposures.

References


Dodge et al.


