POLICY STATEMENT

Pesticide Exposure in Children

ABSTRACT

This statement presents the position of the American Academy of Pediatrics on pesticides. Pesticides are a collective term for chemicals intended to kill unwanted insects, plants, molds, and rodents. Children encounter pesticides daily and have unique susceptibilities to their potential toxicity. Acute poisoning risks are clear, and understanding of chronic health implications from both acute and chronic exposure are emerging. Epidemiologic evidence demonstrates associations between early life exposure to pesticides and pediatric cancers, decreased cognitive function, and behavioral problems. Related animal toxicology studies provide supportive biological plausibility for these findings.

Recognizing and reducing problematic exposures will require attention to current inadequacies in medical training, public health tracking, and regulatory action on pesticides. Ongoing research describing toxicologic vulnerabilities and exposure factors across the life span are needed to inform regulatory needs and appropriate interventions. Policies that promote integrated pest management, comprehensive pesticide labeling, and marketing practices that incorporate child health considerations will enhance safe use.

INTRODUCTION

Pesticides represent a large group of products designed to kill or harm living organisms from insects to rodents to unwanted plants or animals (e.g., rodents), making them inherently toxic (Table 1). Beyond acute poisoning, the influences of low-level exposures on child health are of increasing concern. This policy statement presents the position of the American Academy of Pediatrics on exposure to these products. It was developed in conjunction with a technical report that provides a thorough review of topics presented here: steps that pediatricians should take to identify pesticide poisoning, evaluate patients for pesticide-related illness, provide appropriate treatment, and prevent unnecessary exposure and poisoning. Recommendations for a regulatory agenda are provided as well, recognizing the role of federal agencies in ensuring the safety of children while balancing the positive attributes of pesticides. Repellents reviewed previously (e.g., N,N-diethyl-meta-toluamide, commonly known as DEET; picaridin) are not discussed.

SOURCES AND MECHANISMS OF EXPOSURE

Children encounter pesticides daily in air, food, dust, and soil and on surfaces through home and public lawn or garden application, household insecticide use, application to pets, and agricultural product
residues. For many children, diet may be the most influential source, as illustrated by an intervention study that placed children on an organic diet (produced without pesticide) and observed drastic and immediate decrease in urinary excretion of pesticide metabolites. In agricultural settings, pesticide spray drift is important for residences near treated crops or by take-home exposure on clothing and footware of agricultural workers. Teen workers may have occupational exposures on the farm or in lawn care. Heavy use of pesticides may also occur in urban pest control.

Most serious acute poisoning occurs after unintentional ingestion, although poisoning may also follow inhalational exposure (particularly from fumigants) or significant dermal exposure.

**ACUTE PESTICIDE TOXICITY**

**Clinical Signs and Symptoms**

High-dose pesticide exposure may result in immediate, devastating, even lethal consequences. Table 2 summarizes features of clinical toxicity for the major pesticides classes. It highlights the similarities of common classes of pesticides (e.g., organophosphates, carbamates, and pyrethroids) and underscores the importance of discriminating among them because treatment modalities differ. Having an index of suspicion based on familiarity with toxic mechanisms and taking an environmental history provides the opportunity for discerning a pesticide role in clinical decision-making. Pediatric care providers have a poor track record for recognition of acute pesticide poisoning. This reflects their self-reported lack of medical education and self-efficacy on the topic. More in-depth review of acute toxicity and management can be found in the accompanying technical report or recommended resources in Table 3.

The local or regional poison control center plays an important role as a resource for any suspected pesticide poisoning. There is no current reliable way to determine the incidence of pesticide exposure and illness in US children. Existing data systems, such as the American Association of Poison Control Centers' National Poison Data System or the National Institute for Occupational Safety and Health's Sentinel Event Notification System for Occupational Risks, capture limited information about acute poisoning and trends over time.

There is also no national systematic reporting on the use of pesticides by consumers or licensed professionals. The last national survey of consumer pesticide use in homes and gardens was in 1993 (Research Triangle Institute study). Improved physician education, accessible and reliable biomarkers, and better diagnostic testing methods to readily identify suspected pesticide illness would significantly improve reporting and surveillance. Such tools would be equally important in improving clinical decision-making and reassuring families if pesticides can be eliminated from the differential diagnosis.

**The Pesticide Label**

The pesticide label contains information for understanding and preventing acute health consequences: the active ingredient; signal words identifying acute toxicity potential; US Environmental Protection Agency (EPA) registration number; directions for use, including protective equipment recommendations, storage, and disposal; and manufacturer's contact information. Basic first aid advice is provided, and some labels contain a "note for physicians" with specific relevant medical information. The label does not specify the pesticide class or "other"/"inert" ingredients that may have significant toxicity and can account for up to 99% of the product. Chronic toxicity information is not included, and labels are predominantly available in English. There is significant use of illegal pesticides (especially in immigrant communities), off-label use, and overuse, underscoring the importance of education, monitoring, and enforcement.

**TABLE 1 Categories of Pesticides and Major Classes**

<table>
<thead>
<tr>
<th>Pesticide category</th>
<th>Major Classes</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insecticides</td>
<td>Organophosphates</td>
<td>Malathion, methyl parathion, acephate</td>
</tr>
<tr>
<td></td>
<td>Carbamates</td>
<td>Aldicarb, carbaryl, methomyl, propoxur</td>
</tr>
<tr>
<td></td>
<td>Pyrethroids/pyrethrins</td>
<td>Cypermethrin, fenvalerate, permethrin</td>
</tr>
<tr>
<td></td>
<td>Organochlorines</td>
<td>Lindane</td>
</tr>
<tr>
<td></td>
<td>Neonicotinoids</td>
<td>Imidacloprid</td>
</tr>
<tr>
<td></td>
<td>N-phenylpyrazoles</td>
<td>Fipronil</td>
</tr>
<tr>
<td>Herbicides</td>
<td>Phosphonates</td>
<td>Glyphosate</td>
</tr>
<tr>
<td></td>
<td>Chloropyrifos/herbicides</td>
<td>2,4-D, mecoprop</td>
</tr>
<tr>
<td></td>
<td>Dipyridyl herbicides</td>
<td>Diquat, paraquat</td>
</tr>
<tr>
<td></td>
<td>Nonelective</td>
<td>Sodium chloride</td>
</tr>
<tr>
<td>Rodenticides</td>
<td>Anticoagulants</td>
<td>Warfarin, brodifacoum</td>
</tr>
<tr>
<td></td>
<td>Convulsants</td>
<td>Strychnine</td>
</tr>
<tr>
<td></td>
<td>Metabolic poison</td>
<td>Sodium fluoroacetate</td>
</tr>
<tr>
<td></td>
<td>Inorganic compounds</td>
<td>Aluminum phosphide</td>
</tr>
<tr>
<td>Fungicides</td>
<td>Thiocarbamates</td>
<td>Metam-sodium</td>
</tr>
<tr>
<td></td>
<td>Triazoles</td>
<td>Fluocarizole, myclobutanil, triadimefon</td>
</tr>
<tr>
<td></td>
<td>Strobilurins</td>
<td>Pyraclostrobin, picoxystrobin</td>
</tr>
<tr>
<td>Fumigants</td>
<td>Halogenated organic</td>
<td>Methyl bromide, Chloropicrin</td>
</tr>
<tr>
<td></td>
<td>Organic</td>
<td>Carbon disulfide, Hydrogen cyanide, Naphthalene</td>
</tr>
<tr>
<td></td>
<td>Inorganic</td>
<td>Phosphine</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Arsenicals</td>
<td>Lead arsenate, chromated copper arsenate, arsenic trioxide</td>
</tr>
<tr>
<td></td>
<td>Pyridine</td>
<td>4-aminopyridine</td>
</tr>
</tbody>
</table>
Dosing experiments in animals clearly demonstrate the acute and chronic toxicity potential of multiple pesticides. Many pesticide chemicals are classified by the US EPA as carcinogens. The past decade has seen an expansion of the epidemiologic evidence base supporting adverse effects after acute and chronic pesticide exposure in children. This includes increasingly sophisticated studies addressing combined exposures and genetic susceptibility. Chronic toxicity end points identified in epidemiologic studies include adverse birth outcomes including preterm birth, low birth weight, and congenital

### TABLE 2 Common Pesticides: Signs, Symptoms, and Management Considerations

<table>
<thead>
<tr>
<th>Class</th>
<th>Acute Signs and Symptoms</th>
<th>Clinical Considerations</th>
</tr>
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</table>
| Organophosphate and N-methyl carbamate insecticides | - Headache, nausea, vomiting, abdominal pain, and dizziness  
- Hypersecretion: sweating, salivation, lacrimation, rhinorrhea, diarrhea, and bronchorrhea  
- Muscle fasciculation and weakness, and respiratory symptoms (bronchospasm, cough, wheezing, and respiratory depression)  
- Bradycardia, although early on, tachycardia may be present  
- Miosis  
- Central nervous system: respiratory depression, lethargy, coma, and seizures | - Obtain red blood cell and plasma cholinesterase levels  
- Atropine is primary antidote  
- Pralidoxime is also an antidote for organophosphate and acts as a cholinesterase reactivator  
- Because carbamates generally produce a reversible cholinesterase inhibition, pralidoxime is not indicated in these poisonings |
| Pyrethroid insecticides      | - Similar findings found in organophosphates including the hypersecretion, muscle fasciculation, respiratory symptoms, and seizures  
- Headache, fatigue, vomiting, diarrhea, and irritability  
- Dermal: skin irritation and paresthesia | - At times have been mistaken for acute organophosphate or carbamate poisoning  
- Symptomatic treatment  
- Treatment with high doses of atropine may yield significant adverse results  
- Vitamin E oil for dermal symptoms  
- Supportive care |
| Neonicotinoid insecticides | - Disorientation, severe agitation, drowsiness, dizziness, weakness, and in some situations, loss of consciousness  
- Vomiting, sore throat, abdominal pain  
- Ulcerations in upper gastrointestinal tract | - Consider sedation for severe agitation  
- No available antidote  
- No available diagnostic test |
| Fipronil (N-phenylpyrazole insecticides) | - Nausea and vomiting  
- Aphthous ulcers  
- Altered mental status and coma  
- Seizures | - Supportive care  
- No available antidote  
- No available diagnostic test |
| Lindane (organochlorine insecticide) | - Central nervous system: mental status changes and seizures  
- Paresthesia, tremor, ataxia and hyperreflexia | - Control acute seizures with lorazepam  
- Lindane blood level available as send out  
- Supportive care  
- Pulmonary effects may be secondary to organic solvent |
| Glyphosate (phosphonate herbicides) | - Nausea and vomiting  
- Aspiration pneumonia type syndrome  
- Hypotension, altered mental status, and oliguria in severe cases  
- Pulmonary effects may in fact be secondary to organic solvent | - Consider urine alkalinization with sodium bicarbonate in IV fluids  
- Consider PT (international normalized ratio)  
- Observation may be appropriate for some clinical scenarios in which it is not clear a child even ingested the agent  
- Vitamin K indicated for active bleeding (IV vitamin K) or for elevated PT (oral vitamin K) |
| Chlorophenoxy herbicides | - Skin and mucous membrane irritation  
- Vomiting, diarrhea, headache, confusion  
- Metabolic acidosis is the hallmark  
- Renal failure, hyperkalemia, and hypocalcemia  
- Probable carcinogen | |
| Rodenticides (long-acting anticoagulants) | - Bleeding: gums, nose, and other mucous membrane sites  
- Bruising | - Consider PT (international normalized ratio)  
- Observation may be appropriate for some clinical scenarios in which it is not clear a child even ingested the agent  
- Vitamin K indicated for active bleeding (IV vitamin K) or for elevated PT (oral vitamin K) |

IV, intravenous; PT, prothrombin time.

* Expanded version of this table is available in the accompanying technical report.1

**CHRONIC EFFECTS**

Dosing experiments in animals clearly demonstrate the acute and chronic toxicity potential of multiple pesticides. Many pesticide chemicals are classified by the US EPA as carcinogens. The past decade has seen an expansion of the epidemiologic evidence base supporting adverse effects after acute and chronic pesticide exposure in children. This includes increasingly sophisticated studies addressing combined exposures and genetic susceptibility.1 Chronic toxicity end points identified in epidemiologic studies include adverse birth outcomes including preterm birth, low birth weight, and congenital
anomalies, pediatric cancers, neurobehavioral and cognitive deficits, and asthma. These are reviewed in the accompanying technical report. The evidence base is most robust for associations to pediatric cancer and adverse neurodevelopment. Multiple case-control studies and evidence reviews support a role for insecticides in risk of brain tumors and acute lymphocytic leukemia. Prospective cohort studies in the United States link early-life exposure to organophosphate insecticides with reductions in IQ and abnormal behaviors associated with attention-deficit/hyperactivity disorder and autism. The need to better understand and prevent these associations is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust for evidence base is most robust 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play a role in promotion of development of model programs and practices in the communities and schools of their patients.

RECOMMENDATIONS

Three overarching principles can be identified: (1) pesticide exposures are common and cause both acute and chronic effects; (2) pediatricians need to be knowledgeable in pesticide identification, counseling, and management; and (3) governmental actions to improve pesticide safety are needed. Whenever new public policy is developed or existing policy is revised, the wide range of consequences of pesticide use on children and their families should be considered. The American Academy of Pediatrics, through its chapters, committees, councils, sections, and staff, can provide information and support for public policy advocacy efforts. See http://www.aap.org/advocacy.html for additional information or contact chapter leadership.

Recommendations to Pediatricians

1. Acute exposures: become familiar with the clinical signs and symptoms of acute intoxication from the major types of pesticides. Be able to translate clinical knowledge about pesticide hazards into an appropriate exposure history for pesticide poisoning.
2. Chronic exposures: become familiar with the subclinical effects of chronic exposures and routes of exposures from the major types of pesticides.
3. Resource identification: know locally available resources for acute toxicity management and chronic low-dose exposure (see Table 3).
4. Pesticide labeling knowledge: understand the usefulness and limitations of pesticide chemical information on pesticide product labels.
5. Counseling: Ask parents about pesticide use in or around the home to help determine the need for providing targeted anticipatory guidance. Recommend use of minimal-risk products, safe storage practices, and application of IPM (least toxic methods), whenever possible.
6. Advocacy: work with schools and governmental agencies to advocate for application of least toxic pesticides by using IPM principles. Promote community right-to-know procedures when pesticide spraying occurs in public areas.

Recommendations to Government

1. Marketing: ensure that pesticide products as marketed are not attractive to children.
2. Labeling: include chemical ingredient identity on the label and/or the manufacturer’s Web site for all product constituents, including inert ingredients, carriers, and solvents. Include a label section specific to “Risks to children,” which informs users whether there is evidence that the active or inert ingredients have any known chronic or developmental health concerns for children. Enforce labeling practices that ensure users have adequate information on product contents, acute and chronic toxicity potential, and emergency information. Consider printing or making available labels in Spanish in addition to English.
3. Exposure reduction: set goal to reduce exposure overall. Promote application methods and practices that minimize children’s exposure, such as using bait stations and gels, advising against overuse of pediculicides. Promote education regarding proper storage of product.
4. Reporting: make pesticide-related suspected poisoning universally reportable and support a systematic central repository of such incidents to optimize national surveillance.
5. Exportation: aid in identification of least toxic alternatives to pesticide use internationally, and unless safer alternatives are not available or are impossible to implement, ban export of products that are banned or restricted for toxicity concerns in the United States.
6. Safety: continue to evaluate pesticide safety. Enforce community right-to-know procedures when pesticide spraying occurs in public areas. Develop, strengthen, and enforce standards of removal of concerning products for home or child product use. Require development of a human biomarker, such as a urinary or blood measure, that can be used to identify exposure and/or early health implications with new pesticide chemical registration or reregistration of existing products. Developmental toxicity, including endocrine disruption, should be a priority when evaluating new chemicals for licensing or reregistration of existing products.
7. Advance less toxic pesticide alternatives: increase economic incentives for growers who adopt IPM, including less toxic pesticides. Support research to expand and improve IPM in agriculture and nonagricultural pest control.
8. Research: support toxicologic and epidemiologic research to better identify and understand health risks associated with children’s exposure to pesticides. Consider supporting another national study of pesticide use in the home and garden setting of US households as a targeted initiative or through cooperation with existing research opportunities (eg, National Children’s Study, NHANES).
9. Health provider education and support: support educational efforts to increase the capacity of pediatric health care providers to diagnose and manage acute pesticide
poisoning and reduce pesticide exposure and potential chronic pesticide effects in children. Provide support to systems such as Poison Control Centers to provide timely, expert advice on exposures. Require the development of diagnostic tests to assist providers with diagnosing (and ruling out) pesticide poisoning.

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REFERENCES


An error occurred in this article by Spooner, titled “We Are Still Waiting for Fully Supportive Electronic Health Records in Pediatrics” published in the December 2012 issue of Pediatrics (2012;130[6]:e1674–e1676; originally published online November 19, 2012; doi:10.1542/peds.2012-2724). On page e1674, on line 33, this reads: “The alarming result from the survey was that only 3% of AAP Fellows reported that they had a system that provided all of the items listed by Leu and colleagues.” This should have read: “The alarming result from the survey was that only 9.6% of AAP Fellows reported that they had or planned to adopt within 12 months a system that provided all of the five “pediatric-supportive” items listed by Leu and colleagues.”

doi:10.1542/peds.2013-0134


An error occurred in this article by Auger et al, titled “Medical Home Quality and Readmission Risk for Children Hospitalized With Asthma Exacerbations” published in the January 2013 issue of Pediatrics (2013;131[1]:64–70; doi:10.1542/2012-1055). On page 69, in Table 2 under the heading Adjusted HR, on the line Medicaid, this reads: “0.28 (0.51–1.34).” This should have read: “0.82 (0.51–1.34).”

doi:10.1542/peds.2013-0187


A couple of errors occurred in this AAP Policy Statement titled “Pesticide Exposure in Children” published in the December 2012 issue of Pediatrics (2012;130[6]:e1757–e1763; originally published online November 26, 2012; doi:10.1542/peds.2012-2757). In Table 2, in the second and third columns where glyphosate is discussed, the words “organic solvent” should be replaced with the word “surfactant.” On page e1758, in the first paragraph of the left-hand column, immediately beneath Table 1, the first full sentence should be amended to read: “For many children, diet may be the most influential source, as illustrated by an intervention study that placed children on an organic diet (produced without most conventional pesticides) and observed drastic and immediate decrease in urinary excretion of organophosphate pesticide metabolites.”

doi:10.1542/peds.2013-0576


Several inaccuracies occurred in this AAP Technical Report titled “Pesticide Exposure in Children” published in the December 2012 issue of Pediatrics (2012;130[6]:e1765–e1788; originally published online November 26, 2012; doi:10.1542/peds.2012-2758). On page e1773 and in Tables 1 and 2 where the phosphonate herbicide glyphosate is discussed, changes should be noted. In the first paragraph of the first column on page e1773 about acute glyphosate poisoning, the word “intentional” should be substituted for the word “unintentional.” In this same paragraph as well as in Tables 1 and 2, the word “surfactant” should replace the words “hydrocarbon solvent” and “organic solvent, respectively.”
Pesticide Exposure in Children
COUNCIL ON ENVIRONMENTAL HEALTH

Pediatrics 2012;130;e1757
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The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/130/6/e1757

An erratum has been published regarding this article. Please see the attached page for:
http://pediatrics.aappublications.org/content/131/5/1013.3.full.pdf

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