

Risk of Autism Associated With Hyperbilirubinemia and Phototherapy

Yvonne W. Wu, MD, MPH,^{a,b,c} Michael W. Kuzniewicz, MD, MPH,^{b,c} Lisa Croen, PhD,^c Eileen M. Walsh, RN, MPH,^c Charles E. McCulloch, PhD,^d Thomas B. Newman, MD, MPH^{b,c,d}

abstract

OBJECTIVE: Whether neonatal hyperbilirubinemia and/or phototherapy increase the risk of autism spectrum disorder (ASD) is unclear. We sought to quantify the risk of ASD associated with elevated total serum bilirubin (TSB) levels and with phototherapy.

METHODS: In a retrospective cohort study of 525 409 infants born at ≥ 35 weeks' gestation in 15 Kaiser Permanente Northern California (KPNC) hospitals, 1995–2011, we obtained all TSB levels and determined which infants received phototherapy. From the KPNC Autism Registry, we identified patients with ASD diagnosed at a KPNC Autism Center, by a clinical specialist, or by a pediatrician. We calculated Cox proportional hazard ratios (HRs) for time to diagnosis of ASD, adjusting for confounding factors.

RESULTS: Among infants in the birth cohort, 2% had at least 1 TSB level ≥ 20 mg/dL, and 8% received phototherapy. The rate of ASD was 13 per 1000 births. Crude analyses revealed an association between TSB ≥ 20 and ASD (relative risk: 1.4; 95% confidence interval [CI]: 1.1–1.6), and between phototherapy and ASD (relative risk: 1.7; 95% CI: 1.5–1.8). After adjusting for confounders, TSB ≥ 20 (HR: 1.09; 95% CI: 0.89–1.35) and phototherapy (HR: 1.10; 95% CI: 0.98–1.24) were no longer significantly associated with ASD. Independent risk factors for ASD included maternal and paternal age; maternal and paternal higher education; male sex; birth weight < 2500 g or ≥ 4200 g; and later year of birth.

CONCLUSIONS: After adjustment for the effects of sociodemographic factors and birth weight, neither hyperbilirubinemia nor phototherapy was an independent risk factor for ASD.

FREE

Departments of ^aNeurology, ^bPediatrics, and ^dEpidemiology and Biostatistics, University of California, San Francisco, California; and ^cDivision of Research, Kaiser Permanente Northern California, Oakland, California

Dr Wu performed data analysis and interpretation of data, and drafted the initial manuscript; Dr Kuzniewicz assisted with obtaining funding, supervised data management and creation of Kaiser Permanente Northern California (KPNC) data sets, and reviewed and revised the manuscript; Dr Croen supervised data management and creation of KPNC autism data sets and reviewed and revised the manuscript; Ms Walsh coordinated the study and reviewed the manuscript; Dr McCulloch provided statistical and design consultation, assisted with obtaining funding, and reviewed and revised the manuscript; Dr Newman conceptualized, designed, and led efforts to obtain funding for the study, analyzed data, and reviewed and critically revised the manuscript; and all authors approved the final manuscript as submitted.

DOI: 10.1542/peds.2016-1813

Accepted for publication Jul 11, 2016

Address correspondence to Yvonne W. Wu, MD, MPH, Department of Neurology, University of California, San Francisco, Box 0663, 675 Nelson Rising Lane, Suite 411, San Francisco, CA 94143. E-mail: wuy@ucsf.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2016 by the American Academy of Pediatrics

WHAT'S KNOWN ON THIS SUBJECT: The etiology of autism spectrum disorder (ASD) is poorly understood. Neonatal jaundice has been associated with ASD in some previous studies. Whether this association is causal, and whether phototherapy modifies the risk of ASD, is unknown.

WHAT THIS STUDY ADDS: Hyperbilirubinemia and phototherapy were both associated with increased risk of ASD on bivariate analysis. However, after adjustment for the confounding effects of sociodemographic factors, neither hyperbilirubinemia nor phototherapy was a significant independent risk factor for ASD.

To cite: Wu YW, Kuzniewicz MW, Croen L, et al. Risk of Autism Associated With Hyperbilirubinemia and Phototherapy. *Pediatrics*. 2016;138(4):e20161813

Autism spectrum disorder (ASD) is a neurodevelopmental disorder characterized by deficits in social interaction, deficits in verbal and nonverbal communication, and restricted and stereotyped interests and behaviors. The etiology of ASD is complex, involving both genetic and environmental risk factors. It is hypothesized that environmental insults occurring during early brain development can lead to ASD among infants who are genetically vulnerable.¹⁻⁴

Neonatal hyperbilirubinemia, or jaundice, has been implicated as a potential environmental risk factor for ASD.^{5,6} Hyperbilirubinemia is associated with a 43% increased risk of ASD, based on a meta-analysis of 13 studies (odds ratio: 1.43; 95% confidence interval [CI]: 1.22–1.67).⁵ Yet previous studies of hyperbilirubinemia and ASD have important limitations. Past studies relied on administrative diagnoses or parental report of jaundice instead of analyzing total serum bilirubin (TSB) levels⁷⁻¹¹; evaluated a dichotomous hyperbilirubinemia variable based on traditional cutoffs or infant weight¹²⁻¹⁵; did not control for confounding^{9,11,16,17}; were not population-based^{9,16,17}; or included a relatively small sample ($N < 120$) of children with ASD.^{10,16,17} Thus, the heterogeneity ($P = .002$)⁵ and limitations of previous studies limit the conclusions that can be drawn.

Phototherapy is the standard treatment of neonatal hyperbilirubinemia. Yet in vivo and in vitro studies suggest that phototherapy can lead to DNA damage, altered cytokine levels, and increased oxidative stress,¹⁸⁻²⁰ mechanisms suggested in the pathophysiology for ASD. Whether phototherapy impacts the risk of ASD has not been studied. It is important to determine whether this common treatment reduces the risk of ASD, or may in fact contribute to an increased ASD risk. In a large population

of term and near-term infants, we set out to quantify the excess risk of ASD in newborns exposed to hyperbilirubinemia, and to determine whether phototherapy is independently associated with ASD.

METHODS

We performed a retrospective cohort study as part of the Late Impact of Getting Hyperbilirubinemia or Phototherapy study.^{21,22} The Late Impact of Getting Hyperbilirubinemia or Phototherapy study includes 525 409 infants born at ≥ 35 weeks' gestation at 15 Kaiser Permanente Northern California (KPNC) hospitals between January 1, 1995, and December 31, 2011. KPNC is an integrated community medical care delivery system that serves 3.9 million members, constituting $\sim 40\%$ of the insured population of Northern California. The study was approved by the California Committee for Human Subjects (for birth certificate data), and by the institutional review boards at KPNC and University of California, San Francisco.

We excluded infants who died during the birth hospitalization ($N = 344$, 0.07%), whose birth hospitalization ended with a transfer out of the KPNC system ($N = 891$, 0.17%), or who were followed < 60 days ($N = 24\,532$, 4.7%). We further excluded infants with at least 2 inpatient or outpatient physician diagnoses of the following *International Classification of Diseases, Ninth Revision* (ICD-9) conditions: Down syndrome (758.0, $N = 531$), other chromosomal abnormalities (758.1–758.9, $N = 680$), or congenital anomalies diagnosed at < 15 days (740–759.9 except 743.65 [nasolacrimal passage anomaly], $N = 41\,388$). After these exclusions, the final study cohort consisted of 457 855 infants.

Predictors

We obtained all TSB levels from electronic medical records up to age

30 days. We assumed that the 49% of infants who did not receive any TSB measurements did not have significant jaundice, and grouped them with those with TSB < 10 mg/dL. We classified the highest single TSB value for each infant into the following categories: TSB < 10 mg/dL or not measured; 10 to 14.9 mg/dL; 15 to 19.9 mg/dL; or ≥ 20 mg/dL. We excluded TSB levels in which the direct or conjugated bilirubin measurement constituted over 50% of the total, because such levels suggest liver disease and because the conjugated bilirubin would not be expected to cross the blood brain barrier.

We determined which infants received in-hospital or home phototherapy. For the 80% of children born before implementation of the Epic (Verona, WI) electronic medical record, we identified those who received inpatient phototherapy from procedure codes (99.82 and 99.83) for admissions before age 30 days. For children born after implementation of EPIC, we classified infants as having received inpatient phototherapy if they had either a phototherapy nursing flow sheet or both a procedure code and an order for phototherapy. Use of home phototherapy was determined from the KPNC durable medical equipment database.

From KPNC electronic data sources, we abstracted covariates including maternal age, maternal race/ethnicity, infant sex, gestational age, birth weight, 5-minute Apgar score, year, and hospital of birth. From linked birth certificate data, we collected information regarding paternal age, and maternal and paternal education.

Outcome

We used the KPNC Autism Registry^{12,23-25} to identify subjects who had been diagnosed with ASD either by an ASD evaluation center, by a clinical ASD specialist outside

TABLE 1 Sociodemographic Factors Associated With Hyperbilirubinemia

	Maximum TSB Level, %		<i>P</i>
	≥20 mg/dL, <i>N</i> = 8677	<20 mg/dL, <i>N</i> = 449 178 ^a	
Race/ethnicity			
White	34	42	<.0005
Asian	34	18	<.0005
African American	4	8	<.0005
Hispanic	22	24	<.0005
Other or missing	6	7	.03
Maternal age ≥30 y	54	50	<.0005
Maternal college education ^b	70	65	<.0005
Male sex	60	50	<.0005
Gestational age <38 wk	26	11	<.0005

^a TSB <20 mg/dL or not measured.

^b Includes some college or more.

the ASD center (ie, psychiatrist, psychologist, or developmental pediatrician), or by a general pediatrician. ASD was defined as a diagnosis of autism (ICD-9 299.0), Asperger syndrome (ICD-9 299.8), or pervasive developmental disorder not otherwise specified (ICD-9 299.9). The ASD centers provide evaluation, diagnosis, and treatment planning for KP children and adolescents. Children suspected of having an ASD are generally referred by their pediatrician to an ASD center, where they are evaluated by using a standardized protocol, including the Autism Diagnostic Observation Schedule,²⁶ by a multidisciplinary clinical team including child and adolescent psychiatrists and psychologists, general and developmental pediatricians, and speech and occupational therapists. We retrieved all ASD diagnoses made during the years January 1, 1995–June 30, 2015. Thus all children in the birth cohort were at least 3.5 years of age at the time that we abstracted data from the Autism Registry.

Statistical Analysis

We calculated crude incidence rates by dividing ASD cases by person-years of follow-up, and CIs for comparing incidence rate ratios by using exact binomial calculations. Follow-up for each study subject began at birth and ended at the date of first diagnosis of ASD, death, or

last date of membership within the health plan through June 30, 2015, whichever came first.

We used a Cox proportional hazards model to evaluate the independent associations between hyperbilirubinemia and ASD, and phototherapy and ASD. We calculated hazard ratios (HRs) and exact 95% CIs for categories of TSB and for phototherapy, adjusting for potential confounders. In sensitivity analyses, we ran separate models in which hyperbilirubinemia was defined as follows: TSB >25, and TSB > American Academy of Pediatrics 2004 phototherapy treatment threshold for age and risk group, based on gestational age and direct antiglobulin test results, as previously described.²⁷ In addition, we examined the effect of phototherapy by using a phototherapy propensity score among only infants who had a TSB level within 3 mg/dL of the American Academy of Pediatrics phototherapy threshold, as previously described.²⁸ This allowed us to adjust for TSB levels before but not after phototherapy, thus allowing us to investigate whether phototherapy might reduce the risk of autism by preventing hyperbilirubinemia. We performed all analyses by using Stata version 12 (Stata Corp, College Station, TX).

RESULTS

Among 457 855 infants in the birth cohort, 2% had a maximum TSB level ≥20 mg/dL. The remaining infants had a maximum TSB level <10 mg/dL or not measured (70%), 10 to 14.9 mg/dL (16%), or 15 to 19.9 mg/dL (12%). Infants with a TSB ≥20 mg/dL were more likely to be male, Asian, <38 weeks' gestational age, and to be born to a mother who was over 30 years old and who had at least some college education (Table 1).

Hyperbilirubinemia decreased in frequency in the later years of the study; that is, a TSB level ≥20 mg/dL was present in 2.1% of infants born in 1995–2000, 2.0% in 2001–2006, and 1.5% in 2007–2011. This was expected because of the adoption of universal bilirubin screening within KPNC between 2004 and 2007, which led to increased recognition and treatment of elevated bilirubin levels, resulting in a lower rate of significant hyperbilirubinemia during the later years of the study.²⁹

Phototherapy was used to treat 8% of all patients in the birth cohort. The rate of phototherapy varied by maximum TSB level as follows: TSB <10 mg/dL or not measured: 0.4%; TSB 10 to 14.9 mg/dL: 14%; TSB 15 to 19.9 mg/dL: 31%; TSB ≥20 mg/dL: 69%. Use of phototherapy increased during the study years as follows: 3% in 1995–2000; 7% in 2001–2006; and 13% in 2007–2011.

Overall incidence of ASD in the birth cohort was 13 per 1000 births. Increasing TSB levels and phototherapy were both significantly associated with risk of ASD in bivariate analyses (Table 2).

After adjusting for potential confounders, TSB ≥20 (HR: 1.09; 95% CI: 0.89–1.35) and phototherapy (HR: 1.10; 95% CI: 0.98–1.24) were no longer significantly associated with ASD (Table 3). Independent risk factors for ASD included increasing maternal and paternal age; higher degrees of maternal and paternal

TABLE 2 Crude Incidence Rate Ratios for Autism Based on Maximum TSB Levels, Phototherapy, and Sociodemographic Characteristics, in a 1995–2011 California Birth Cohort

	<i>N</i> at Risk	<i>N</i> With Autism	Incidence per 1000	Incidence per 1000 Person-Years	Crude Incidence Rate Ratio	95% CI Lower	95% CI Upper	<i>P</i>
Total population	457 855	5979	13	1.63	—	—	—	—
Highest TSB, mg/dL ^a								
Not done or <10	322 246	3952	12	1.29	Ref	—	—	—
10–14.9	71 593	1033	14	1.82	1.41	1.31	1.51	<.0005
15–19.9	55 339	848	15	1.89	1.47	1.36	1.58	<.0005
≥20	8677	146	17	1.74	1.35	1.14	1.59	.001
Phototherapy								
No	423 403	5399	13	1.38	Ref	—	—	—
Yes	34 452	580	17	2.32	1.7	1.54	1.834	<.0005
Maternal age, y								
<30	230 858	2448	11	1.16	Ref	—	—	—
≥30	226 997	3531	16	1.72	1.48	1.40	1.55	<.0005
Paternal age, y								
<40	379 677	4641	12	1.34	Ref	—	—	—
≥40	58 196	1097	19	2.08	1.55	1.45	1.66	<.0005
Maternal education								
High school or less	154 449	1508	10	1.14	Ref	—	—	—
College or more	281 620	4255	15	1.85	1.63	1.54	1.72	<.0005
Paternal education								
High school or less	175 611	1830	10	1.20	Ref	—	—	—
College or more	255 982	3867	15	1.85	1.54	1.46	1.62	<.0005
Race/ethnicity								
White	192 954	2678	14	1.51	Ref	—	—	—
Asian	85 713	1262	15	1.64	1.09	1.02	1.16	.02
African American	36 037	414	11	1.16	0.78	0.70	0.86	<.0005
Hispanic	110 933	1202	11	1.20	0.80	0.75	0.86	<.0005
Other or missing	32 218	423	13	1.61	1.07	0.96	1.19	.20
Infant sex								
Female	226 885	1112	5	0.54	Ref	—	—	—
Male	230 970	4867	21	2.33	4.35	4.08	4.65	<.0005
Gestational age, wk								
<38	53 158	799	15	1.40	1.2	1.13	1.31	<.0005
≥38	404 697	5180	13	1.71	Ref	—	—	—
Birth weight, g								
<2500	14 577	222	15	1.71	1.22	1.06	1.40	.005
2500–4199	413 143	5239	13	1.40	Ref	—	—	—
≥4200	30 135	518	17	1.83	1.31	1.19	1.45	<.0005
Apgar at 5 min								
<7	3660	63	17	1.95	1.36	1.05	1.75	.02
7–10	454 195	5916	13	1.43	Ref	—	—	—
Year of birth								
1995–2000	155 088	1806	12	0.91	Ref	—	—	—
2001–2006	164 410	2329	14	1.59	1.8	1.65	1.87	<.0005
2007–2011	138 357	1844	13	2.60	2.86	2.68	3.06	<.0005

^a To convert to μmol/L, multiply by 17.1.

education (ie, some college or more); male infant; abnormally low and high birth weight; and later year of birth. In contrast, infants born to mothers of African American, Hispanic, and Asian race/ethnicity had a reduced risk of ASD after adjusting for confounders (Table 3).

Separate multivariate models performed as part of sensitivity

analyses confirmed that alternative definitions of hyperbilirubinemia (ie, TSB >25 mg/dL and TSB above the American Academy of Pediatrics phototherapy threshold) were also not independent risk factors for ASD after adjusting for confounders. Propensity-adjusted models revealed neither benefit nor harm from phototherapy (HR: 1.09; 95% CI: 0.95–1.24). Entering maternal and

paternal education in 4 categories (ie, eighth grade or less, some high school, some college, postgraduate) did not change the results appreciably.

DISCUSSION

In this large retrospective cohort study, elevated TSB levels and phototherapy were both associated

TABLE 3 Multivariate HRs for Autism in a 1995–2011 Birth Cohort

Variable ^a	HR	Lower	Upper	P
Highest TSB, mg/dL ^b				
Not done or <10	Ref	—	—	—
10–14.9	1.06	0.98	1.14	.14
15–19.9	1.07	0.98	1.17	.14
≥20	1.09	0.89	1.35	.41
Phototherapy	1.10	0.98	1.24	.12
Maternal age, y	1.02	1.01	1.02	<.0005
Paternal age, y	1.02	1.01	1.02	<.0005
Maternal college education ^c	1.22	1.13	1.31	<.0005
Paternal college education ^c	1.13	1.05	1.21	.001
Race/ethnicity, maternal				
White	Ref	—	—	—
Asian	0.86	0.80	0.93	<.0005
African American	0.89	0.79	1.00	.048
Hispanic	0.82	0.76	0.89	<.0005
Other	0.86	0.77	0.96	.01
Male sex	4.29	4.01	4.59	<.0005
Gestational age <38 wk	1.07	0.98	1.17	.13
Birth weight, g				
<2500	1.22	1.05	1.42	.01
2500–<4200	Ref	—	—	—
≥4200	1.16	1.05	1.27	.003
Apgar <7 at 5 min	1.18	0.90	1.54	.22
Year of birth				
1995	Ref	—	—	—
1996	1.03	0.86	1.22	.78
1997	1.10	0.93	1.31	.27
1998	1.33	1.12	1.57	.001
1999	1.41	1.12	1.67	<.0005
2000	1.50	1.27	1.78	<.0005
2001	1.60	1.36	1.90	<.0005
2002	1.81	1.54	2.14	<.0005
2003	2.16	1.84	2.54	<.0005
2004	1.83	1.55	2.17	<.0005
2005	2.13	1.81	2.51	<.0005
2006	2.15	1.82	2.53	<.0005
2007	2.00	1.69	2.38	<.0005
2008	2.79	2.36	3.29	<.0005
2009	2.82	2.38	3.34	<.0005
2010	3.54	2.99	4.20	<.0005
2011	3.85	3.22	4.60	<.0005

^a Cox model includes all variables in the table, as well as hospital of birth.

^b To convert to $\mu\text{mol/L}$, multiply by 17.1.

^c Includes some college or more.

with ASD in bivariate analyses. However, after adjustment for the confounding effects of sociodemographic factors, neither hyperbilirubinemia nor phototherapy remained a significant independent risk factor for ASD.

ASD is a growing public health concern whose underlying pathogenesis is poorly understood. The lifetime cost to support an individual with ASD in the United States is \$1.4 to \$2.4 million, amounting to a total societal cost

of \$61 billion per year.³⁰ Although genetic factors play an important role, a recent study suggests that environmental factors explain over half of the liability for ASD.³¹ Potential epigenetic changes^{2–4} induced by environmental in utero stressors such as exposure to medications,^{32,33} hazardous air pollutants,^{34,35} and excessive smoking in early pregnancy³⁶ constitute an active area of ASD etiologic research.

Neonatal hyperbilirubinemia is a potentially modifiable factor.

Concerns have been raised that elevated bilirubin may increase the risk of a child developing the social and communication deficits that characterize autism.^{5,37–39} A recent review of 18 relevant clinical studies identified 7 publications that revealed a significant association between hyperbilirubinemia and ASD on bivariate analysis.³⁷ Our findings suggest that these previously reported associations may not represent a true causal relationship.⁴⁰ That is, factors that increase the risk of both hyperbilirubinemia and ASD, such as male sex and lower gestational age, are likely responsible for the previously described link between hyperbilirubinemia and ASD. Among 13 studies that were combined in a meta-analysis that suggested a link between jaundice and ASD, only 6 studies controlled for potential confounders, and 5 of these 6 studies were limited by either no TSB values available, jaundice definitions based on birth weight, or recall bias due to the use of parental questionnaires to determine the presence of jaundice.⁵

Our findings corroborate several known sociodemographic risk factors for ASD, including advanced parental age and education, male sex, lower gestational age, and low birth weight.^{41–44} After adjusting for confounders such as maternal age and education, the rate of ASD was lower in Asians, African Americans, and Hispanics than in whites. Others have also reported a lower rate of ASD in African Americans and Hispanics.^{16,41,42,45} It remains unclear whether this reflects a true disparity in the occurrence of ASD, or whether there are differences in diagnostic practices and access to services leading to decreased and delayed recognition of ASD in some racial/ethnic groups,⁴⁶ thus providing an underestimate of ASD in certain groups.

The rate of ASD increased almost fourfold between 1995 and 2011.

This trend is consistent with other reports. Prevalence estimates of ASD have grown exponentially from ≤ 0.5 per 1000 in the 1970s and 1980s, to 1 to 2 per 1000 in the 1990s,⁴⁷ to 14.7 per 1000 based on the latest US active surveillance data from 2010.⁴¹ Some studies suggest that changes in the definition of ASD, an increased public awareness of this condition, and increased availability of specialized services for ASD leading to a preferential diagnosis of ASD over other diagnoses such as mental retardation (ie, intellectual disability) and learning disabilities, together account for much of this dramatic rise in ASD over the past 2 decades.^{48–50} In addition, KPNC established 3 regional ASD evaluation centers in 2004–2008, and an early developmental screening program initiated in selected facilities in 2009 became fully implemented by 2012. These 2 programs resulted in more children being diagnosed with ASD at earlier ages.

Although neonatal hyperbilirubinemia is almost always benign, extremely high bilirubin levels can cause cerebral palsy and sensorineural hearing loss.^{51–53} The lack of evidence in our study that hyperbilirubinemia causes ASD is an important finding because neonatal jaundice is a common occurrence that may produce anxiety among parents and clinicians, especially when caring for an infant who already carries an increased genetic

risk of ASD (eg, having a sibling with ASD⁵⁴). It is similarly reassuring that phototherapy does not appear to be associated with an increased risk of ASD, based on our data.

Strengths of our study include the large study population; the availability of comprehensive measurements of TSB and lack of recall bias; the ability to adjust for multiple sociodemographic confounders; the evaluation of hyperbilirubinemia using different cutoffs and definitions; and the ability to separate the effects of hyperbilirubinemia from phototherapy, which is possible because of variability in the treatment of hyperbilirubinemia within KPNC.

A limitation of our study was the reliance on physician diagnoses of ASD, as opposed to using a systematic and standardized diagnostic assessment across the entire population. However, 62% of children with ASD were diagnosed at a KPNC ASD center, and among those who were diagnosed outside of an ASD center, ASD was documented in their KPNC medical record on 2 or more occasions in 60%. Based on a large study of 1272 KP members <18 years of age, 2 or more ASD diagnoses recorded in the medical record was a strong predictor of a valid ASD diagnosis, with a positive predictive value of 87%.⁵⁵

We lacked data regarding dose of phototherapy, and the measured

maximum TSB levels are only estimates of the true peak exposure levels. Our study is also subject to residual confounding by factors such as breastfeeding. Although breastfeeding is a known risk factor for hyperbilirubinemia, definitive evidence is lacking for an association between breastfeeding and ASD.⁵⁶ However, if breastfeeding were protective of ASD, then not including it in the multivariable analysis would lead to an underestimate of the effect of hyperbilirubinemia on ASD.

CONCLUSIONS

Within a large US birth population, we found no evidence that hyperbilirubinemia or phototherapy play a role in the pathogenesis of ASD.

ACKNOWLEDGMENTS

The authors thank Yinge Qian, PhD, for his help with data management and database creation, and Elysa Marco, MD, for her critical review of the manuscript.

ABBREVIATIONS

ASD: autism spectrum disorder
CI: confidence interval
HR: hazard ratio
ICD-9: *International Classification of Diseases, Ninth Revision*
KPNC: Kaiser Permanente Northern California
TSB: total serum bilirubin

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: Supported by grant R01HS020618 from the Agency for Healthcare Research and Quality. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality. The funder played no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; and preparation, review, or approval of the manuscript.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

REFERENCES

1. Stoltenberg C, Schjølberg S, Bresnahan M, et al; ABC Study Group. The Autism Birth Cohort: a paradigm for gene-environment-timing research. *Mol Psychiatry*. 2010;15(7):676–680
2. Newschaffer CJ, Croen LA, Daniels J, et al. The epidemiology of autism spectrum disorders. *Annu Rev Public Health*. 2007;28:235–258
3. Tordjman S, Somogyi E, Coulon N, et al. Gene × Environment interactions in autism spectrum disorders: role of epigenetic mechanisms. *Front Psychiatry*. 2014;5:53
4. Loke YJ, Hannan AJ, Craig JM. The role of epigenetic change in autism spectrum disorders. *Front Neurol*. 2015;6:107
5. Amin SB, Smith T, Wang H. Is neonatal jaundice associated with Autism Spectrum Disorders: a systematic

- review. *J Autism Dev Disord*. 2011;41(11):1455–1463
6. Gardener H, Spiegelman D, Buka SL. Perinatal and neonatal risk factors for autism: a comprehensive meta-analysis. *Pediatrics*. 2011;128(2):344–355
 7. Maimburg RD, Bech BH, Vaeth M, Møller-Madsen B, Olsen J. Neonatal jaundice, autism, and other disorders of psychological development. *Pediatrics*. 2010;126(5):872–878
 8. Froehlich-Santino W, Londono Tobon A, Cleveland S, et al. Prenatal and perinatal risk factors in a twin study of autism spectrum disorders. *J Psychiatr Res*. 2014;54:100–108
 9. May-Benson TA, Koomar JA, Teasdale A. Incidence of pre-, peri-, and post-natal birth and developmental problems of children with sensory processing disorder and children with autism spectrum disorder. *Front Integr Neurosci*. 2009;3:31
 10. Deykin EY, MacMahon B. Pregnancy, delivery, and neonatal complications among autistic children. *Am J Dis Child*. 1980;134(9):860–864
 11. Mason-Brothers A, Ritvo ER, Pingree C, et al. The UCLA-University of Utah epidemiologic survey of autism: prenatal, perinatal, and postnatal factors. *Pediatrics*. 1990;86(4):514–519
 12. Croen LA, Yoshida CK, Odouli R, Newman TB. Neonatal hyperbilirubinemia and risk of autism spectrum disorders. *Pediatrics*. 2005;115(2). Available at: www.pediatrics.org/cgi/content/full/115/2/e135
 13. Jangaard KA, Fell DB, Dodds L, Allen AC. Outcomes in a population of healthy term and near-term infants with serum bilirubin levels of ≥ 325 micromol/L (≥ 19 mg/dL) who were born in Nova Scotia, Canada, between 1994 and 2000. *Pediatrics*. 2008;122(1):119–124
 14. Maimburg RD, Vaeth M, Schendel DE, Bech BH, Olsen J, Thorsen P. Neonatal jaundice: a risk factor for infantile autism? *Paediatr Perinat Epidemiol*. 2008;22(6):562–568
 15. Vandborg PK, Hansen BM, Greisen G, Mathiasen R, Kasper F, Ebbesen F. Follow-up of extreme neonatal hyperbilirubinaemia in 5- to 10-year-old children: a Danish population-based study. *Dev Med Child Neurol*. 2015;57(4):378–384
 16. Juul-Dam N, Townsend J, Courchesne E. Prenatal, perinatal, and neonatal factors in autism, pervasive developmental disorder-not otherwise specified, and the general population. *Pediatrics*. 2001;107(4). Available at: www.pediatrics.org/cgi/content/full/107/4/e63
 17. Finegan JA, Quarrington B. Pre-, peri-, and neonatal factors and infantile autism. *J Child Psychol Psychiatry*. 1979;20(2):119–128
 18. Gathwala G, Sharma S. Oxidative stress, phototherapy and the neonate. *Indian J Pediatr*. 2000;67(11):805–808
 19. Sirota L, Straussberg R, Gurary N, Aloni D, Bessler H. Phototherapy for neonatal hyperbilirubinemia affects cytokine production by peripheral blood mononuclear cells. *Eur J Pediatr*. 1999;158(11):910–913
 20. Ramy N, Ghany EA, Alsharany W, et al. Jaundice, phototherapy and DNA damage in full-term neonates. *J Perinatol*. 2016;36(2):132–136
 21. Wu YW, Kuzniewicz MW, Wickremasinghe AC, et al. Risk for cerebral palsy in infants with total serum bilirubin levels at or above the exchange transfusion threshold: a population-based study. *JAMA Pediatr*. 2015;169(3):239–246
 22. Wickremasinghe AC, Risley RJ, Kuzniewicz MW, et al. Risk of sensorineural hearing loss and bilirubin exchange transfusion thresholds. *Pediatrics*. 2015;136(3):505–512
 23. Croen LA, Matevia M, Yoshida CK, Grether JK. Maternal Rh D status, anti-D immune globulin exposure during pregnancy, and risk of autism spectrum disorders. *Am J Obstet Gynecol*. 2008;199(3):234–236
 24. Croen LA, Grether JK, Yoshida CK, Odouli R, Van de Water J. Maternal autoimmune diseases, asthma and allergies, and childhood autism spectrum disorders: a case-control study. *Arch Pediatr Adolesc Med*. 2005;159(2):151–157
 25. Rosen NJ, Yoshida CK, Croen LA. Infection in the first 2 years of life and autism spectrum disorders. *Pediatrics*. 2007;119(1). Available at: www.pediatrics.org/cgi/content/full/119/1/e61
 26. Lord C, Risi S, Lambrecht L, et al. The autism diagnostic observation schedule-generic: a standard measure of social and communication deficits associated with the spectrum of autism. *J Autism Dev Disord*. 2000;30(3):205–223
 27. Newman TB, Kuzniewicz MW, Liljestrand P, Wi S, McCulloch C, Escobar GJ. Numbers needed to treat with phototherapy according to American Academy of Pediatrics guidelines. *Pediatrics*. 2009;123(5):1352–1359
 28. Newman TB, Wickremasinghe AC, Walsh EM, Grimes BA, McCulloch CE, Kuzniewicz MW. Retrospective cohort study of phototherapy and childhood cancer in northern California. *Pediatrics*. 2016;137(6):e20151354
 29. Kuzniewicz MW, Escobar GJ, Newman TB. Impact of universal bilirubin screening on severe hyperbilirubinemia and phototherapy use. *Pediatrics*. 2009;124(4):1031–1039
 30. Buescher AV, Cidav Z, Knapp M, Mandell DS. Costs of autism spectrum disorders in the United Kingdom and the United States. *JAMA Pediatr*. 2014;168(8):721–728
 31. Hallmayer J, Cleveland S, Torres A, et al. Genetic heritability and shared environmental factors among twin pairs with autism. *Arch Gen Psychiatry*. 2011;68(11):1095–1102
 32. Bromley RL, Mawer G, Clayton-Smith J, Baker GA; Liverpool and Manchester Neurodevelopment Group. Autism spectrum disorders following in utero exposure to antiepileptic drugs. *Neurology*. 2008;71(23):1923–1924
 33. da Silva Dal Pizzol T, Knop FP, Mengue SS. Prenatal exposure to misoprostol and congenital anomalies: systematic review and meta-analysis. *Reprod Toxicol*. 2006;22(4):666–671
 34. Windham GC, Zhang L, Gunier R, Croen LA, Grether JK. Autism spectrum disorders in relation to distribution of hazardous air pollutants in the San

- Francisco bay area. *Environ Health Perspect*. 2006;114(9):1438–1444
35. Kalkbrenner AE, Schmidt RJ, Penlesky AC. Environmental chemical exposures and autism spectrum disorders: a review of the epidemiological evidence. *Curr Probl Pediatr Adolesc Health Care*. 2014;44(10):277–318
 36. Hultman CM, Sparén P, Cnattingius S. Perinatal risk factors for infantile autism. *Epidemiology*. 2002;13(4):417–423
 37. Guinchat V, Thorsen P, Laurent C, Cans C, Bodeau N, Cohen D. Pre-, peri- and neonatal risk factors for autism. *Acta Obstet Gynecol Scand*. 2012;91(3):287–300
 38. Mamidala MP, Polinedi A, P T V PK, et al. Prenatal, perinatal and neonatal risk factors of Autism Spectrum Disorder: a comprehensive epidemiological assessment from India. *Res Dev Disabil*. 2013;34(9):3004–3013
 39. Duan G, Yao M, Ma Y, Zhang W. Perinatal and background risk factors for childhood autism in central China. *Psychiatry Res*. 2014;220(1-2):410–417
 40. Newman TB, Croen LA. Jaundice-autism link unconvincing. *Pediatrics*. 2011;127(3). Available at: www.pediatrics.org/cgi/content/full/127/3/e858
 41. Developmental Disabilities Monitoring Network Surveillance Year 2010 Principal Investigators; Centers for Disease Control and Prevention (CDC). Prevalence of autism spectrum disorder among children aged 8 years - autism and developmental disabilities monitoring network, 11 sites, United States, 2010. *MMWR Surveill Summ*. 2014;63(2):1–21
 42. Windham GC, Anderson MC, Croen LA, Smith KS, Collins J, Grether JK. Birth prevalence of autism spectrum disorders in the San Francisco Bay area by demographic and ascertainment source characteristics. *J Autism Dev Disord*. 2011;41(10):1362–1372
 43. Grether JK, Anderson MC, Croen LA, Smith D, Windham GC. Risk of autism and increasing maternal and paternal age in a large North American population. *Am J Epidemiol*. 2009;170(9):1118–1126
 44. Kuzniewicz MW, Wi S, Qian Y, Walsh EM, Armstrong MA, Croen LA. Prevalence and neonatal factors associated with autism spectrum disorders in preterm infants. *J Pediatr*. 2014;164(1):20–25
 45. Kogan MD, Strickland BB, Blumberg SJ, Singh GK, Perrin JM, van Dyck PC. A national profile of the health care experiences and family impact of autism spectrum disorder among children in the United States, 2005–2006. *Pediatrics*. 2008;122(6). Available at: www.pediatrics.org/cgi/content/full/122/6/e1149
 46. Mandell DS, Listerud J, Levy SE, Pinto-Martin JA. Race differences in the age at diagnosis among Medicaid-eligible children with autism. *J Am Acad Child Adolesc Psychiatry*. 2002;41(12):1447–1453
 47. Williams JG, Higgins JP, Brayne CE. Systematic review of prevalence studies of autism spectrum disorders. *Arch Dis Child*. 2006;91(1):8–15
 48. Fombonne E. Epidemiology of pervasive developmental disorders. *Pediatr Res*. 2009;65(6):591–598
 49. Shattuck PT. The contribution of diagnostic substitution to the growing administrative prevalence of autism in US special education. *Pediatrics*. 2006;117(4):1028–1037
 50. Wing L, Potter D. The epidemiology of autistic spectrum disorders: is the prevalence rising? *Ment Retard Dev Disabil Res Rev*. 2002;8(3):151–161
 51. Wu YW, Kuzniewicz MW, Wickremasinghe AC, et al. Risk for cerebral palsy in infants with total serum bilirubin levels at or above the exchange transfusion threshold: a population-based study. *JAMA Pediatr*. 2015;169(3):239–246
 52. Watchko JF, Tiribelli C. Bilirubin-induced neurologic damage—mechanisms and management approaches. *N Engl J Med*. 2013;369(21):2021–2030
 53. Shapiro SM. Chronic bilirubin encephalopathy: diagnosis and outcome. *Semin Fetal Neonatal Med*. 2010;15(3):157–163
 54. Ozonoff S, Young GS, Carter A, et al. Recurrence risk for autism spectrum disorders: a Baby Siblings Research Consortium study. *Pediatrics*. 2011;128(3). Available at: www.pediatrics.org/cgi/content/full/128/3/e488
 55. Coleman KJ, Lutsky MA, Yau V, et al. Validation of autism spectrum disorder diagnoses in large healthcare systems with electronic medical records. *J Autism Dev Disord*. 2015;45(7):1989–1996
 56. Husk JS, Keim SA. Breastfeeding and autism spectrum disorder in the National Survey of Children’s Health. *Epidemiology*. 2015;26(4):451–457

Risk of Autism Associated With Hyperbilirubinemia and Phototherapy
Yvonne W. Wu, Michael W. Kuzniewicz, Lisa Croen, Eileen M. Walsh, Charles E. McCulloch and Thomas B. Newman
Pediatrics 2016;138;; originally published online September 26, 2016;
DOI: 10.1542/peds.2016-1813

Updated Information & Services	including high resolution figures, can be found at: /content/138/4/e20161813.full.html
References	This article cites 56 articles, 18 of which can be accessed free at: /content/138/4/e20161813.full.html#ref-list-1
Subspecialty Collections	This article, along with others on similar topics, appears in the following collection(s): Developmental/Behavioral Pediatrics /cgi/collection/development:behavioral_issues_sub Autism/ASD /cgi/collection/autism:asd_sub Fetus/Newborn Infant /cgi/collection/fetus:newborn_infant_sub Hyperbilirubinemia /cgi/collection/hyperbilirubinemia_sub
Permissions & Licensing	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: /site/misc/Permissions.xhtml
Reprints	Information about ordering reprints can be found online: /site/misc/reprints.xhtml

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2016 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Risk of Autism Associated With Hyperbilirubinemia and Phototherapy

Yvonne W. Wu, Michael W. Kuzniewicz, Lisa Croen, Eileen M. Walsh, Charles E. McCulloch and Thomas B. Newman

Pediatrics 2016;138;; originally published online September 26, 2016;

DOI: 10.1542/peds.2016-1813

The online version of this article, along with updated information and services, is located on the World Wide Web at:
</content/138/4/e20161813.full.html>

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2016 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

