APPENDIX A. ATSDR MINIMAL RISK LEVEL WORKSHEETS

MRLs are derived when reliable and sufficient data exist to identify the target organ(s) of effect or the most sensitive health effect(s) for a specific duration for a given route of exposure. An MRL is an estimate of the daily human exposure to a hazardous substance that is likely to be without appreciable risk of adverse noncancer health effects over a specified route and duration of exposure. MRLs are based on noncancer health effects only; cancer effects are not considered. These substance-specific estimates, which are intended to serve as screening levels, are used by ATSDR health assessors to identify contaminants and potential health effects that may be of concern at hazardous waste sites. It is important to note that MRLs are not intended to define clean-up or action levels.

MRLs are derived for hazardous substances using the NOAEL/uncertainty factor approach. They are below levels that might cause adverse health effects in the people most sensitive to such chemical-induced effects. MRLs are derived for acute (1–14 days), intermediate (15–364 days), and chronic (≥365 days) durations and for the oral and inhalation routes of exposure. Currently, MRLs for the dermal route of exposure are not derived because ATSDR has not yet identified a method suitable for this route of exposure. MRLs are generally based on the most sensitive substance-induced endpoint considered to be of relevance to humans. Serious health effects (such as irreparable damage to the liver or kidneys, or birth defects) are not used as a basis for establishing MRLs. Exposure to a level above the MRL does not mean that adverse health effects will occur.

MRLs are intended only to serve as a screening tool to help public health professionals decide where to look more closely. They may also be viewed as a mechanism to identify those hazardous waste sites that are not expected to cause adverse health effects. Most MRLs contain a degree of uncertainty because of the lack of precise toxicological information on the people who might be most sensitive (e.g., infants, elderly, nutritionally or immunologically compromised) to the effects of hazardous substances. ATSDR uses a conservative (i.e., protective) approach to address this uncertainty consistent with the public health principle of prevention. Although human data are preferred, MRLs often must be based on animal studies because relevant human studies are lacking. In the absence of evidence to the contrary, ATSDR assumes that humans are more sensitive to the effects of hazardous substance than animals and that certain persons may be particularly sensitive. Thus, the resulting MRL may be as much as 100-fold below levels that have been shown to be nontoxic in laboratory animals.

APPENDIX A

Proposed MRLs undergo a rigorous review process: Health Effects/MRL Workgroup reviews within the Division of Toxicology and Human Health Sciences, expert panel peer reviews, and agency-wide MRL Workgroup reviews, with participation from other federal agencies and comments from the public. They are subject to change as new information becomes available concomitant with updating the toxicological profiles. Thus, MRLs in the most recent toxicological profiles supersede previously published MRLs. For additional information regarding MRLs, please contact the Division of Toxicology and Human Health Sciences, Agency for Toxic Substances and Disease Registry, 1600 Clifton Road NE, Mailstop S102-1, Atlanta, Georgia 30329-4027.

APPENDIX A

MINIMAL RISK LEVEL (MRL) WORKSHEET

***Chemical Name*:** 1,2-Diphenylhydrazine
CAS Numbers: 122-77-6
Date: December 1990
March 2017—Updated literature search
Profile Status: Draft 5
Route: Inhalation
Duration: Acute

MRL Summary: There are insufficient data for derivation of an acute-duration inhalation MRL.

Rationale for Not Deriving an MRL: No acute-duration inhalation studies were identified for 1,2-diphenylhydrazine.

Agency Contact (Chemical Manager): Sam Keith, M.S., C.H.P.

APPENDIX A

MINIMAL RISK LEVEL (MRL) WORKSHEET

***Chemical Name*:**	1,2-Diphenylhydrazine
CAS Numbers:	122-77-6
Date:	December 1990
	March 2017—Updated literature search
Profile Status:	Draft 5
Route:	Inhalation
Duration:	Intermediate

MRL Summary: There are insufficient data for derivation of an intermediate-duration inhalation MRL.

Rationale for Not Deriving an MRL: No intermediate-duration inhalation studies were identified for 1,2-diphenylhydrazine.

Agency Contact (Chemical Manager): Sam Keith, M.S., C.H.P.

APPENDIX A

MINIMAL RISK LEVEL (MRL) WORKSHEET

***Chemical Name*:**	1,2-Diphenylhydrazine
CAS Numbers:	122-77-6
Date:	December 1990
	March 2017—Updated literature search
Profile Status:	Draft 5
Route:	Inhalation
Duration:	Chronic

MRL Summary: There are insufficient data for derivation of a chronic-duration inhalation MRL.

Rationale for Not Deriving an MRL: No chronic-duration inhalation studies were identified for 1,2-diphenylhydrazine.

Agency Contact (Chemical Manager): Sam Keith, M.S., C.H.P.

MINIMAL RISK LEVEL (MRL) WORKSHEET

***Chemical Name*:** 1,2-Diphenylhydrazine
CAS Numbers: 122-77-6
Date: May 2019
Profile Status: Final, Draft for Public Comment
Route: Oral
Duration: Acute

MRL Summary: There are insufficient data for derivation of an acute-duration oral MRL.

Rationale for Not Deriving an MRL: The acute-duration oral database was not considered suitable for derivation of an MRL because lethality was the only adverse effect observed in the available studies.

The Dodd et al. (2012) study of 1,2-diphenylhydrazine is the only acute oral toxicity study that evaluated endpoints other than lethality. The study found no adverse alterations in body weight, liver weight, liver enzymes, or liver histopathology in rats treated with 1,2-diphenyhydrazine for 5 days or 2 weeks at doses as high as 15.5 mg/kg/day.

Agency Contact (Chemical Manager): Sam Keith, M.S., C.H.P.

APPENDIX A

MINIMAL RISK LEVEL (MRL) WORKSHEET

***Chemical Name*:** 1,2-Diphenylhydrazine
CAS Numbers: 122-77-6
Date: May 2019
Profile Status: Final, Draft for Public Comment
Route: Oral
Duration: Intermediate
***MRL*:** 0.05 mg/kg/day (provisional)
Critical Effect: Hepatic effects
Reference: Dodd et al. 2012
Point of Departure: NOAEL of 4.8 mg/kg/day
Uncertainty Factor: 100
LSE Graph Key: 6
Species: Rat

MRL Summary: A provisional intermediate oral MRL of 0.05 mg/kg/day was derived for 1,2-diphenyl-hydrazine. The provisional MRL is based on a NOAEL of 4.80 mg/kg/day for hepatic effects in rats exposed to 1,2-diphenylhydrazaine in the diet for 13 weeks (Dodd et al. 2012). This NOAEL was divided by an uncertainty factor of 100 (10 for animal to human extrapolation and 10 to account for intra-human variation).

Selection of the Critical Effect: Three studies have evaluated toxicity of 1,2-diphenyhydrazine following intermediate-duration oral exposure. Effects identified include death, gastrointestinal effects, and hepatic effects (Dodd et al. 2012; Marhold et al. 1968; NCI 1978). Increases in mortality were observed in rats at 54 mg/kg/day (NCI 1978) and in mice exposed to 390 mg/kg/day (NCI 1978). An increase in intestinal hemorrhage was reported in mice exposed to 390 mg/kg/day for 4 weeks (NCI 1978); gastrointestinal effects were not observed in similarly exposed rats. Dodd et al. (2012) reported significant increases in the incidences of hypertrophy, eosinophilic granular cytoplasm, and bile duct duplication in the livers of rats exposed to ≥10.3 mg/kg/day for 13 weeks, but not after 4 weeks of exposure. At 15.5 mg/kg/day, macrovesiculation was also observed in the liver of rats exposed for 13 weeks (Dodd et al. 2012). No other intermediate-duration studies included histological examination of the liver. Based on the limited available data, the liver appears to be the most sensitive target of toxicity. This is supported by liver effects (fatty metamorphosis or coagulative necrosis) in rats and mice chronically exposed to 1,2-diphenylhydrazine in the diet (NCI 1978).

Selection of the Principal Study: Due to incomplete details of study design and lack of histopathology data in the 4-week dose-finding study (NCI 1978) and the Marhold et al. (1968) study, derivation of the provisional MRL for hepatic effects is based on findings in the multi-dose study by Dodd et al. (2012). The selected study provides the best available data for characterizing the dose-response relationship for liver effects in laboratory animals orally exposed to 1,2-diphenylhydrazine for intermediate durations and it identified the lowest reliable LOAEL value.

Summary of the Principal Study:

Dodd DE, Pluta LJ, Sochaski MA, et al. 2012. Subchronic hepatotoxicity evaluation of hydrazobenzene in Fischer 344 rats. Int J Toxicol 31: 564-571.

Groups of male Fischer 344 rats (minimum 10/group) were exposed to 0, 5, 20, 80, 200, or 300 ppm 1,2-diphenylhydrazine in the diet for 4 or 13 weeks. Mean administered doses, calculated from weekly food consumption and analytic diet concentration data, were reported to be 0, 0.32, 1.26, 4.80, 10.3, and

15.5 mg/kg/day. Endpoints evaluated included clinical observations, body weight, food consumption, serum chemistry, liver weights, gross pathology, and liver histopathology. Significant, but marginal decreases in body weights (up to ~6% decrease, compared with control values) beginning at 8 weeks occurred in animals exposed to 15.5 mg/kg/day. There were no clinical signs of toxicity or gross pathology throughout the study or at necropsy. Microscopic alterations in the liver, including slight/mild hypertrophy, minimal eosinophilic granular cytoplasm, multifocal bile duct duplications, and multifocal macrovesiculation, an indicator of lipid accumulation within hepatocytes, were observed only at 13 weeks at doses ≥10.3 mg/kg/day; the incidences of these lesions are presented in Table A-1. Relative liver weights also significantly increased (7.7 and 4.4%) at 4 and 13 weeks in 10.3 mg/kg/day rats, and showed concentration dependence, with increases of 8.5 and 10.7% at the same time points after treatment with 15.5 mg/kg/day. No consistent changes in serum alanine aminotransferase, total bilirubin, or lactate dehydrogenase were observed at any dose, but serum aspartate aminotransferase decreased by 26% at 13 weeks after treatment with 15.5 mg/kg/day. Decreases in serum alkaline phosphatase occurred beginning at a dose of 1.26 mg/kg/day at 13 weeks, but were also observed at earlier time points at higher doses; the toxicological significance of the decreases in alkaline phosphatase is not known. The investigators noted that the decreases were unexpected and did not correlate with other liver effects (Dodd et al. 2012).

Table A-1. Incidences of Liver Lesions in Rats Exposed to 1,2-Diphenylhydrazine in the Diet for 13 Weeks

	Dose (mg/kg/day)					
	0	0.32	1.26	4.80	10.3	15.5
Slight/mild hypertrophy (diffuse)	0/12	0/10	0/10	0/10	10/10	10/10
Slight/mild macrovesiculation (multifocal)	0/12	0/10	0/10	0/10	1/10	10/10
Minimal eosinophilic granular cytoplasm	0/12	0/10	0/10	0/10	10/10	9/10
Minimal to slight/mild bile duct duplication (multifocal)	0/12	0/10	0/10	0/10	8/10	10/10

Source: Dodd et al. 2012

Selection of the Point of Departure for the Provisional MRL: Data were not amenable to benchmark dose modeling due to the steep dose-response curve and the lack of information between the extremes of the control incidence (0%) and the maximal response (≥80%). Using a NOAEL/LOAEL approach, the NOAEL of 4.8 mg/kg/day was selected as the basis of the provisional MRL

Adjustment Intermittent Exposure: Not applicable.

Uncertainty Factor: The NOAEL of 4.8 mg/kg/day was divided by a total uncertainty factor of 100:

- 10 for animal to human extrapolation
- 10 for human variability

Other Additional Studies or Pertinent Information: In a chronic-duration study, dietary exposure to 1,2-diphenylhydrazine resulted in interstitial inflammation in the lungs, hyperkeratosis/acanthosis in the stomach, and fatty metamorphosis in the liver of rats exposed for 78 weeks (NCI 1978). Coagulative necrosis was also observed in the livers of female mice exposed to 52 mg/kg/day (NCI 1978). The results of the NCI (1978) study support the selection of the liver lesions as the most sensitive effect.

Agency Contact (Chemical Manager): Sam Keith, M.S., C.H.P.

MINIMAL RISK LEVEL (MRL) WORKSHEET

***Chemical Name*:** 1,2-Diphenylhydrazine
CAS Numbers: 122-77-6
Date: December 1990
March 2017—Updated literature search
Profile Status: Draft 5
Route: Oral
Duration: Chronic

MRL Summary: The available chronic oral data (NCI 1978) were not considered adequate for derivation of a chronic oral MRL.

Rationale for Not Deriving an MRL: The only available chronic-duration oral study was not considered suitable for derivation of an MRL due to the long duration (28–30 weeks) between exposure termination and histological examination and methodological problems with the only available study.

The NCI (1978) bioassay of 1,2-diphenylhydrazine provides the only sufficient chronic oral toxicity data for this chemical. In this study, rats and mice were exposed to 1,2-diphenylhydrazine in the diet for 78 weeks followed by a 28–30-week observation period. The facilities supplying the rats, the diet, and the bedding used for low-dose rats and their controls differed from those used for the high-dose rats and their controls. Additionally, the low-dose control group and low- and high-dose exposed rats were housed in a different room than the high-dose control group. Similar differences in animal husbandry were noted for the mice. All animals, regardless of time or reason for death, whether due to lethality, sacrifice when moribund, or at study termination, were necropsied and were included in histopathological incidence evaluations. Significant increases in mortality were observed in female rats exposed to 9.2 mg/kg/day and in male and female mice exposed to 69 mg/kg/day; times and causes of death were not provided (NCI 1978). Non-neoplastic alterations included interstitial lung inflammation, acanthosis of the stomach, hyperkeratosis of the stomach, and fatty metamorphosis in the liver; the NOAEL and LOAEL values for these effects are presented in Table A-2. Although the study identifies 3.7 mg/kg/day as the lowest LOAEL for interstitial lung inflammation and acanthosis of the stomach in female rats, there is some uncertainty with this categorization, since the incidences of these lesions were not significantly increased at the higher dose level (9.2 mg/kg/day). Adding to the uncertainty is the inconsistency of these effects between the low dose control group and the high dose control group; for example, incidences of lung interstitial inflammation was 0/47 for the low dose female controls and 6/50 in the high dose female controls (in males, the incidences were 0/47 and 4/48 in low- and high-dose controls). In addition to these non-neoplastic lesions, increases in the incidence of neoplastic lesions were observed, including hepatocellular carcinomas in male rats exposed to ≥6.3 mg/kg/day and female mice exposed to 69 mg/kg/day, neoplastic nodules in the livers of female rats exposed to 9.2 mg/kg/day, combined squamous cell carcinomas/papillomas in the ear canal, Zymbal's gland, and skin of the ear in male rats exposed to 24 mg/kg/day, adrenal gland pheochromacytomas in male rats exposed to 24 mg/kg/day, and mammary gland adenocarcinomas in female rats exposed to 9.2 mg/kg/day (NCI 1978).

Table A-2. Summary of Relevant NOAEL and LOAEL Values in Rats and Mice Following Chronic-Duration Oral Exposure to 1,2-Diphenylhydrazine[a]

	Males		Females	
	NOAEL (mg/kg/day)	LOAEL (mg/kg/day)	NOAEL (mg/kg/day)	LOAEL (mg/kg/day)
Fischer 344 rats				
Increased mortality				9.2
Decreased body weight gain	6.	24	3.7	9.2
Interstitial lung inflammation		6.3		3.7[b]
Acanthosis of stomach	6.3	24		3.7[b]
Hyperkeratosis of stomach	6.3	24	9.2	
Fatty metamorphosis in liver	6.3	24	3.7	9.2[c]
B6C3F1 mice				
Increased mortality		69		69
Decreased body weight	14	69	6.9	69
Coagulative hepatic necrosis			6.9	69

[a]Rats and mice were exposed for 78 weeks followed by a 28–30-week observation period.
[b]This effect was not observed in rats exposed to 9.2 mg/kg/day.
[c]Incidence higher than low-dose control group, but not high-dose control group.

Source: NCI 1978

The NCI (1978) study was not considered suitable for the derivation of a chronic-duration oral MRL due to the lack of dose-response for effects observed at the lowest dose tested, the long recovery period, and some methodological issues with the study design. As summarized in Table A-3, significant increases in the incidence of interstitial lung inflammation and acanthosis of the stomach were observed in female rats at the lowest dose tested (3.7 mg/kg/day), but were not observed at the highest dose (9.2 mg/kg/day). In male rats, an increase in interstitial lung inflammation was observed in male rats at 6.3 and 24 mg/kg/day. Stomach lesions were observed in males at 24 mg/kg/day, but not at 6.3 mg/kg/day. The lack of dose-response relationships increases the uncertainty in assessing whether the effects are due to 1,2-diphenyl-hydrazine exposure. Differences in the source of the animals, housing, and diet between the low-dose controls and exposed animals and the high-dose controls and exposed animals may have also contributed to the observed differences. In addition, the long recovery period complicates the identification of the NOAELs and LOAELs because it is not known if effects occurred at lower doses and the damage was repaired prior to examination.

Table A-3. Incidence of Lung and Stomach Lesions in Rats Following Chronic-Duration Oral Exposure to 1,2-Diphenylhydrazine[a]

	Low dose		High dose	
Female rats	Controls	3.7 mg/kg/day	Controls	9.2 mg/kg/day
Interstitial lung inflammation	0/47 (0%)	29/50[b] (58%)	6/50 (12%)	7/50 (14%)
Acanthosis of stomach	0/46 (0%)	6/50[b] (12%)	2/48 (4%)	5/44 (11%)
	Low dose		High dose	
Male rats	Controls	6.3 mg/kg/day	Controls	24 mg/kg/day
Interstitial lung inflammation	0/47 (0%)	12/49[b] (24%)	4/48 (8%)	16/48[b] (33%)
Acanthosis of stomach	0/47 (0%)	4/49 (8%)	1/49 (2%)	17/47[b] (36%)

[a]Rats were exposed for 78 weeks followed by a 28–30-week observation period.
[b]Statistically significant differences ($p<0.05$); Fisher Exact Test conducted by ATSDR.

Source: NCI 1978

Agency Contact (Chemical Manager): Sam Keith, M.S., C.H.P.

APPENDIX B. LITERATURE SEARCH FRAMEWORK FOR 1,2-DIPHENYLHYDRAZINE

The objective of the toxicological profile is to evaluate the potential for human exposure and the potential health hazards associated with inhalation, oral, or dermal/ocular exposure to 1,2-diphenylhydrazine.

B.1 LITERATURE SEARCH AND SCREEN

A literature search and screen was conducted to identify studies examining health effects, toxicokinetics, mechanisms of action, susceptible populations, biomarkers, chemical interactions, and regulations/ guidelines data for 1,2-diphenylhydrazine. ATSDR primarily focused on peer-reviewed articles without publication date or language restrictions. Non-peer-reviewed studies that were considered relevant to the assessment of the health effects of 1,2-diphenylhydrazine have undergone peer review by at least three ATSDR-selected experts who have been screened for conflict of interest. The inclusion criteria used to identify relevant studies examining the health effects of 1,2-diphenylhydrazine are presented in Table B-1.

Table B-1. Inclusion Criteria for the Literature Search and Screen

- Health Effects
  - Species
    - Human
    - Laboratory mammals
  - Route of exposure
    - Inhalation
    - Oral
    - Dermal (or ocular)
    - Parenteral (these studies will be considered supporting data)
  - Health outcome
    - Death
    - Systemic effects
    - Body weight effects
    - Respiratory effects
    - Cardiovascular effects
    - Gastrointestinal effects
    - Hematological effects
    - Musculoskeletal effects
    - Hepatic effects
    - Renal effects
    - Dermal effects
    - Ocular effects
    - Endocrine effects
    - Immunological effects
    - Neurological effects
    - Reproductive effects
    - Developmental effects

Table B-1. Inclusion Criteria for the Literature Search and Screen

Other noncancer effects
Cancer
Toxicokinetics
Absorption
Distribution
Metabolism
Excretion
PBPK models
Biomarkers
Biomarkers of exposure
Biomarkers of effect
Interactions with other chemicals

B.1.1 Literature Search

The current literature search was intended to update the health effects sections of the existing toxicological profile for 1,2-diphenylhydrazine (ATSDR 1990), thus, the literature search was restricted to studies published between January 1988 to March 2017. The following main databases were searched in March 2017:

- PubMed
- National Library of Medicine's TOXLINE
- Scientific and Technical Information Network's TOXCENTER

The search strategy used the chemical names, Chemical Abstracts Service (CAS) numbers, synonyms, and Medical Subject Headings (MeSH) terms for 1,2-diphenylhydrazine. The query strings used for the literature search are presented in Table B-2.

The search was augmented by searching the Toxic Substances Control Act Test Submissions (TSCATS), NTP website, and National Institute of Health Research Portfolio Online Reporting Tools Expenditures and Results (NIH RePORTER) databases using the queries presented in Table B-3. Additional databases were searched in the creation of various tables and figures, such as the TRI Explorer, the Substance priority list (SPL) resource page, and other items as needed. Regulations applicable to 1,2-diphenylhydrazine were identified by searching international and U.S. agency websites and documents.

Review articles were identified and used for the purpose of providing background information and identifying additional references. ATSDR also identified reports from the grey literature, which included unpublished research reports, technical reports from government agencies, conference proceedings and abstracts, and theses and dissertations.

Table B-2. Database Query Strings

Database search date	Query string
PubMed	
03/2017	((1G3CS09TUK[rn] OR 122-66-7[rn] OR "1,2-diphenylhydrazine"[supplementary concept] OR "1,2-diphenylhydrazine"[nm]) AND (1988/01/01 : 3000[dp] OR 1988/01/01 : 3000[mhda])) OR (("(sym)-Diphenylhydrazine"[tw] OR "1,1'-Hydrazodibenzene"[tw] OR "1,2-Diphenylhydrazine"[tw] OR "1,1'-hydrazobis-Benzene"[tw] OR "hydrazodi-Benzene"[tw] OR "1,2-diphenyl-Hydrazine"[tw] OR "Hydrazobenzene"[tw] OR "N, N'-Bianiline"[tw] OR "N, N'-Diphenylhydrazine"[tw] OR "Symmetrical diphenyl hydrazine"[tw]) AND (1988/01/01 : 3000[dp] OR 1988/01/01 : 3000[crdat] OR 1988/01/01 : 3000[edat]))
Toxline	
03/2017	(" (sym) -diphenylhydrazine" OR "1 1'-hydrazodibenzene" OR "1 2-diphenylhydrazine" OR "1 1'-hydrazobis-benzene" OR "hydrazodi-benzene" OR "1 2-diphenyl-hydrazine" OR "hydrazobenzene" OR "n n'-bianiline" OR "n n'-diphenylhydrazine" OR "symmetrical diphenyl hydrazine" OR 122-66-7 [rn]) AND 1988:2017 [yr] AND (ANEUPL [org] OR BIOSIS [org] OR CIS [org] OR DART [org] OR EMIC [org] OR EPIDEM [org] OR HEEP [org] OR HMTC [org] OR IPA [org] OR RISKLINE [org] OR MTGABS [org] OR NIOSH [org] OR NTIS [org] OR PESTAB [org] OR PPBIB [org]) AND NOT PubMed [org] AND NOT pubdart [org]
Toxcenter	
03/2017	FILE 'TOXCENTER' ENTERED AT 16:44:37 ON 16 MAR 2017 CHARGED TO COST=EH011.13.01.01 L49 292 SEA 122-66-7 L50 280 SEA L49 NOT TSCATS/FS L51 260 SEA L50 NOT PATENT/DT L52 169 SEA L51 AND PY>=1988 ACTIVATE TOXQUERY/Q --------- L53 QUE (CHRONIC OR IMMUNOTOX? OR NEUROTOX? OR TOXICOKIN? OR BIOMARKER? OR NEUROLOG?) L54 QUE (PHARMACOKIN? OR SUBCHRONIC OR PBPK OR EPIDEMIOLOGY/ST,CT, IT) L55 QUE (ACUTE OR SUBACUTE OR LD50# OR LD(W)50 OR LC50# OR LC(W)50) L56 QUE (TOXICITY OR ADVERSE OR POISONING)/ST,CT,IT L57 QUE (INHAL? OR PULMON? OR NASAL? OR LUNG? OR RESPIR?) L58 QUE ((OCCUPATION? OR WORKPLACE? OR WORKER?) AND EXPOS?) L59 QUE (ORAL OR ORALLY OR INGEST? OR GAVAGE? OR DIET OR DIETS OR DIETARY OR DRINKING(W)WATER?) L60 QUE (MAXIMUM AND CONCENTRATION? AND (ALLOWABLE OR PERMISSIBLE)) L61 QUE (ABORT? OR ABNORMALIT? OR EMBRYO? OR CLEFT? OR FETUS?) L62 QUE (FOETUS? OR FETAL? OR FOETAL? OR FERTIL? OR MALFORM? OR OVUM?) L63 QUE (OVA OR OVARY OR PLACENTA? OR PREGNAN? OR PRENATAL?) L64 QUE (PERINATAL? OR POSTNATAL? OR REPRODUC? OR STERIL? OR TERATOGEN?)

Table B-2. Database Query Strings

Database search date	Query string
	L65 QUE (SPERM OR SPERMAC? OR SPERMAG? OR SPERMATI? OR SPERMAS? OR SPERMATOB? OR SPERMATOC? OR SPERMATOG?)
	L66 QUE (SPERMATOI? OR SPERMATOL? OR SPERMATOR? OR SPERMATOX? OR SPERMATOZ? OR SPERMATU? OR SPERMI? OR SPERMO?)
	L67 QUE (NEONAT? OR NEWBORN? OR DEVELOPMENT OR DEVELOPMENTAL?)
	L68 QUE (ENDOCRIN? AND DISRUPT?)
	L69 QUE (ZYGOTE? OR CHILD OR CHILDREN OR ADOLESCEN? OR INFANT?)
	L70 QUE (WEAN? OR OFFSPRING OR AGE(W)FACTOR?)
	L71 QUE (DERMAL? OR DERMIS OR SKIN OR EPIDERM? OR CUTANEOUS?)
	L72 QUE (CARCINOG? OR COCARCINOG? OR CANCER? OR PRECANCER? OR NEOPLAS?)
	L73 QUE (TUMOR? OR TUMOUR? OR ONCOGEN? OR LYMPHOMA? OR CARCINOM?)
	L74 QUE (GENETOX? OR GENOTOX? OR MUTAGEN? OR GENETIC(W)TOXIC?)
	L75 QUE (NEPHROTOX? OR HEPATOTOX?)
	L76 QUE (ENDOCRIN? OR ESTROGEN? OR ANDROGEN? OR HORMON?)
	L77 QUE (OCCUPATION? OR WORKER? OR WORKPLACE? OR EPIDEM?)
	L78 QUE L53 OR L54 OR L55 OR L56 OR L57 OR L58 OR L59 OR L60 OR L61 OR L62 OR L63 OR L64 OR L65 OR L66 OR L67 OR L68 OR L69 OR L70 OR L71 OR L72 OR L73 OR L74 OR L75 OR L76 OR L77
	L79 QUE (RAT OR RATS OR MOUSE OR MICE OR GUINEA(W)PIG? OR MURIDAE OR DOG OR DOGS OR RABBIT? OR HAMSTER? OR PIG OR PIGS OR SWINE OR PORCINE OR MONKEY? OR MACAQUE?)
	L80 QUE (MARMOSET? OR FERRET? OR GERBIL? OR RODENT? OR LAGOMORPHA OR BABOON? OR CANINE OR CAT OR CATS OR FELINE OR MURINE)
	L81 QUE L78 OR L79 OR L80
	L82 QUE (NONHUMAN MAMMALS)/ORGN
	L83 QUE L81 OR L82
	L84 QUE (HUMAN OR HUMANS OR HOMINIDAE OR MAMMALS OR MAMMAL? OR PRIMATES OR PRIMATE?)
	L85 QUE L83 OR L84

	L86 125 SEA L52 AND L85
	L87 6 SEA L86 AND MEDLINE/FS
	L88 3 SEA L86 AND BIOSIS/FS
	L89 102 SEA L86 AND CAPLUS/FS
	L90 14 SEA L86 NOT (MEDLINE/FS OR BIOSIS/FS OR CAPLUS/FS)
	L91 117 DUP REM L87 L88 L90 L89 (8 DUPLICATES REMOVED)
	L*** DEL 6 S L86 AND MEDLINE/FS
	L*** DEL 6 S L86 AND MEDLINE/FS

Table B-2. Database Query Strings

Database search date	Query string
	L92 6 SEA L91 L*** DEL 3 S L86 AND BIOSIS/FS L*** DEL 3 S L86 AND BIOSIS/FS L93 2 SEA L91 L*** DEL 102 S L86 AND CAPLUS/FS L*** DEL 102 S L86 AND CAPLUS/FS L94 95 SEA L91 L*** DEL 14 S L86 NOT (MEDLINE/FS OR BIOSIS/FS OR CAPLUS/FS) L*** DEL 14 S L86 NOT (MEDLINE/FS OR BIOSIS/FS OR CAPLUS/FS) L95 14 SEA L91 L96 111 SEA (L92 OR L93 OR L94 OR L95) NOT MEDLINE/FS SAVE TEMP L96 DIPHEN/A D SCAN L96

Table B-3. Strategies to Augment the Literature Search

Source	Query and number screened when available
TSCATS[a]	
03/2017	Compound searched: 122-66-7
NTP	
03/2017	122-66-7 1,1'-Hydrazodibenzene 1,2-Diphenylhydrazine Hydrazobenzene
NIH RePORTER	
05/2017	Active projects "(sym)-Diphenylhydrazine" OR "1,1'-Hydrazodibenzene" OR "1,2-Diphenylhydrazine" OR "1,1'-hydrazobis-Benzene" OR "hydrazodi-Benzene" OR "1,2-diphenyl-Hydrazine" OR "Hydrazobenzene" OR "N,N'-Bianiline" OR "N,N'-Diphenylhydrazine" OR "Symmetrical diphenyl hydrazine"
Other	Identified throughout the assessment process

[a]Several versions of the TSCATS database were searched, as needed, by CASRN including TSCATS1 via Toxline (no date limit), TSCATS2 via https://yosemite.epa.gov/oppts/epatscat8.nsf/ReportSearch?OpenForm (date restricted by EPA receipt date), and TSCATS via CDAT (date restricted by 'Mail Received Date Range'), as well as google for recent TSCA submissions.

The 2017 results were:

- Number of records identified from PubMed, TOXLINE, and TOXCENTER (after duplicate removal): 175
- Number of records identified from other strategies: 34
- Total number of records to undergo literature screening: 209

B.1.2 Literature Screening

A two-step process was used to screen the literature search to identify relevant studies on 1,2-diphenylhydrazine:

- Title and abstract screen
- Full text screen

Title and Abstract Screen. Within the reference library, titles and abstracts were screened manually for relevance. Studies that were considered relevant (see Table B-1 for inclusion criteria) were moved to the second step of the literature screening process. Studies were excluded when the title and abstract clearly indicated that the study was not relevant to the toxicological profile.

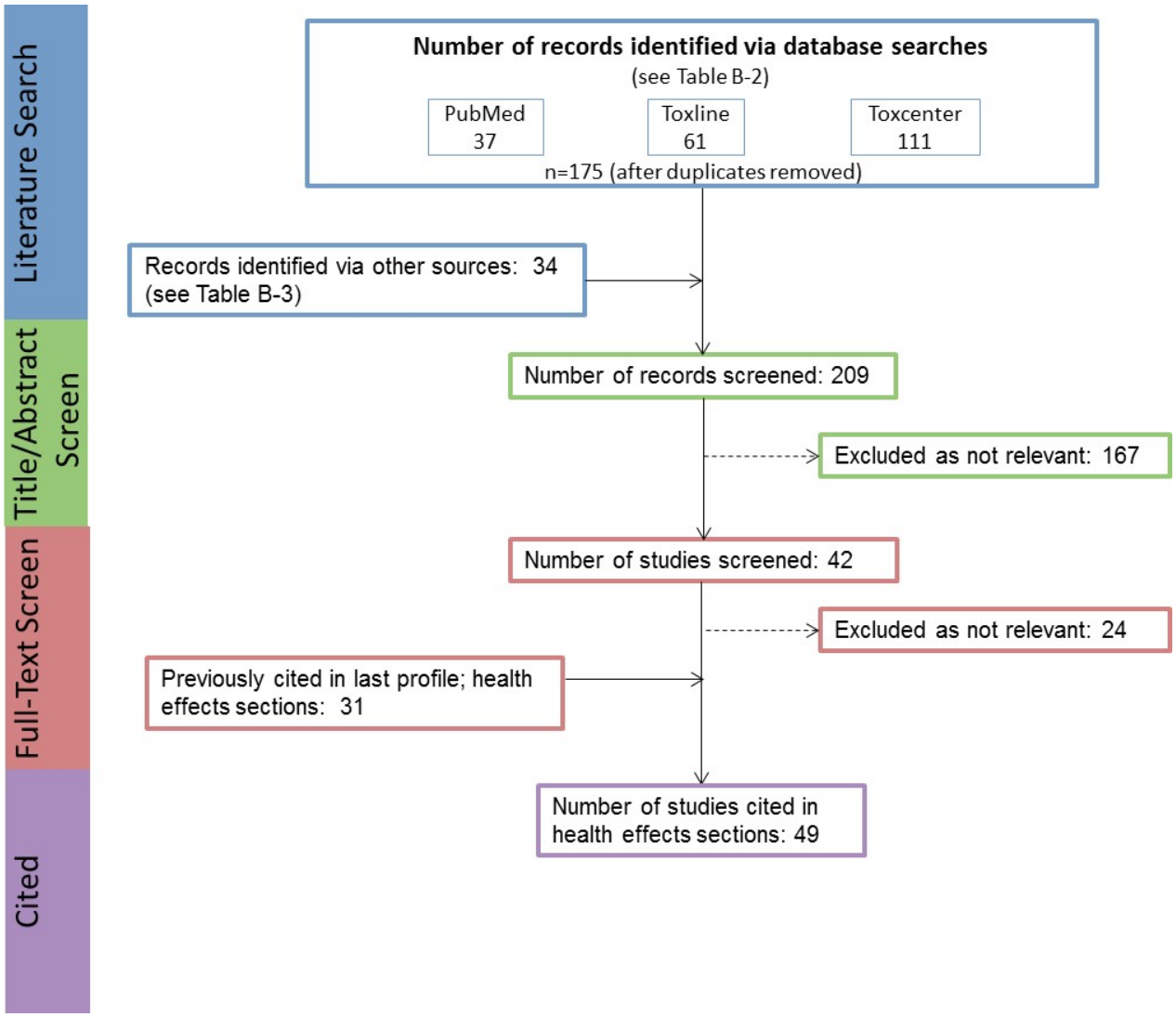
- Number of titles and abstracts screened: 209
- Number of studies considered relevant and moved to the next step: 42

Full Text Screen. The second step in the literature screening process was a full text review of individual studies considered relevant in the title and abstract screen step. Each study was reviewed to determine whether it was relevant for inclusion in the toxicological profile.

- Number of studies undergoing full text review: 42
- Number of studies cited in the health effects sections of the existing toxicological profile (December,1990): 31
- Total number of studies cited in the health effects sections of the updated profile: 49

A summary of the results of the literature search and screening is presented in Figure B-1.

Figure B-1. March 2017 Literature Search Results and Screen for 1,2-Diphenylhydrazine



APPENDIX C. FRAMEWORK FOR ATSDR'S SYSTEMATIC REVIEW OF HEALTH EFFECTS DATA FOR 1,2-DIPHENYLHYDRAZINE

To increase the transparency of ATSDR's process of identifying, evaluating, synthesizing, and interpreting the scientific evidence on the health effects associated with exposure to 1,2-diphenyl-hydrazine, ATSDR utilized a slight modification of NTP's Office of Health Assessment and Translation (OHAT) systematic review methodology (NTP 2013, 2015; Rooney et al. 2014). ATSDR's framework is an eight-step process for systematic review with the goal of identifying the potential health hazards of exposure to 1,2-diphenylhydrazine:

- Step 1. Problem Formulation
- Step 2. Literature Search and Screen for Health Effects Studies
- Step 3. Extract Data from Health Effects Studies
- Step 4. Identify Potential Health Effect Outcomes of Concern
- Step 5. Assess the Risk of Bias for Individual Studies
- Step 6. Rate the Confidence in the Body of Evidence for Each Relevant Outcome
- Step 7. Translate Confidence Rating into Level of Evidence of Health Effects
- Step 8. Integrate Evidence to Develop Hazard Identification Conclusions

C.1 PROBLEM FORMULATION

The objective of the toxicological profile and this systematic review was to identify the potential health hazards associated with inhalation, oral, or dermal/ocular exposure to 1,2-diphenylhydrazine. The inclusion criteria used to identify relevant studies examining the health effects of 1,2-diphenylhydrazine are presented in Table C-1.

Data from human and laboratory animal studies were considered relevant for addressing this objective. Human studies were divided into two broad categories: observational epidemiology studies and controlled exposure studies. The observational epidemiology studies were further divided: cohort studies (retrospective and prospective studies), population studies (with individual data or aggregate data), and case-control studies.

C.2 LITERATURE SEARCH AND SCREEN FOR HEALTH EFFECTS STUDIES

A literature search and screen was conducted to identify studies examining the health effects of 1,2-diphenylhydrazine. The literature search framework for the toxicological profile is discussed in detail in Appendix B.

Table C-1. Inclusion Criteria for Identifying Health Effect Studies

Species
Human
Laboratory mammals
Route of exposure
Inhalation
Oral
Dermal (or ocular)
Parenteral (these studies will be considered supporting data)
Health outcome
Body weight effects
Respiratory effects
Cardiovascular effects
Gastrointestinal effects
Hematological effects
Musculoskeletal effects
Hepatic effects
Renal effects
Dermal effects
Ocular effects
Endocrine effects
Immunological effects
Neurological effects
Reproductive effects
Developmental effects
Other noncancer effects

C.2.1 Literature Search

As noted in Appendix B, the literature search to update the existing toxicological profile for 1,2-diphenylhydrazine (ATSDR 1990) was restricted to studies published between January 1988 and March 2017. See Appendix B for the databases searched and the search strategy.

A total of 174 unique records relevant to all sections of the toxicological profile were identified from the database queries (Table B-2) and 34 items were identified using additional literature search strategies (Table B-3).

C.2.2 Literature Screening

As described in Appendix B, a two-step process was used to screen the literature search to identify relevant studies examining the health effects of 1,2-diphenylhydrazine.

Title and Abstract Screen. In the Title and Abstract Screen step, 209 records were reviewed; 40 studies were considered to meet the health effects inclusion criteria in Table B-1 and were moved to the next step in the process.

Full Text Screen. In the second step in the literature screening process for the systematic review, a full text review of the 40 health effects studies identified in the update literature was performed. Additionally, 31 studies cited in the existing profile were included in the full study screen bringing the total number of studies for the qualitative review to 71. Of the 71 studies undergoing Full Text Screen, 62 studies did not meet the inclusion criteria in Table C-1; some of the excluded studies were used as background information on toxicokinetics or mechanisms of action or were relevant to other sections of the toxicological profile.

C.3 EXTRACT DATA FROM HEALTH EFFECTS STUDIES

Relevant data extracted from the individual studies selected for inclusion in the systematic review were collected in customized data forms. A summary of the type of data extracted from each study is presented in Table C-2. For references that included more than one experiment or species, data extraction records were created for each experiment or species.

Table C-2. Data Extracted from Individual Studies

Citation
Chemical form
Route of exposure (e.g., inhalation, oral, dermal)
Specific route (e.g., gavage in oil, drinking water)
Species
Strain
Exposure duration category (e.g., acute, intermediate, chronic)
Exposure duration
Frequency of exposure (e.g., 6 hours/day, 5 days/week)
Exposure length
Number of animals or subjects per sex per group
Dose/exposure levels
Parameters monitored
Description of the study design and method
Summary of calculations used to estimate doses (if applicable)
Summary of the study results
Reviewer's comments on the study
Outcome summary (one entry for each examined outcome)
No-observed-adverse-effect level (NOAEL) value
Lowest-observed-adverse-effect level (LOAEL) value
Effect observed at the LOAEL value

A summary of the extracted data for each study is presented in the Supplemental Document for 1,2-Diphenylhydrazine and overviews of the results of the oral and dermal exposure studies (no inhalation exposure studies were identified) are presented in Sections 2.2–2.18 of the profile and oral data are summarized in the Levels Significant Exposures table in Section 2.1 of the profile (Table 2-1).

C.4 IDENTIFY POTENTIAL HEALTH EFFECT OUTCOMES OF CONCERN

Overviews of the potential health effect outcomes for 1,2-diphenylhydrazine identified in animal studies (no human studies were identified) are presented in Table C-3. Animal studies examined a number of endpoints following oral exposure (dermal study only examined cancer endpoints). These studies examined most endpoints and reported respiratory, gastrointestinal, and hepatic effects. Studies examining these potential outcomes were carried through to Steps 4–8 of the systematic review.

Table C-3. Overview of the Health Outcomes for 1,2-Diphenylhydrazine Evaluated in Experimental Animal Studies

	Body weight	Respiratory	Cardiovascular	Gastrointestinal	Hematological	Musculoskeletal	Hepatic	Renal	Dermal	Ocular	Endocrine	Immunological[a]	Neurological[a]	Reproductive[a]	Developmental	Other Noncancer	Caner
Inhalation studies																	
Acute-duration																	
Intermediate-duration																	
Chronic-duration																	
Oral studies																	
Acute-duration	2	0		0			2										
	0	0		0			0										
Intermediate-duration	5			1			2										
	0			1			1										
Chronic-duration	2	2	2	2		2	2	2	2	2	2	2	2	2	2		2
	2	2	0	0		0	2	0	0	0	0	0	0	0	0		2
Dermal studies																	
Acute-duration																	
Intermediate-duration																	
Chronic-duration																	1
																	1

Number of studies examining endpoint	0	1	2	3	4	5-9	≥10
Number of studies reporting outcome	0	1	2	3	4	5-9	≥10

[a]Number of studies examining endpoint includes study evaluating histopathology, but not evaluating function.

C.5 ASSESS THE RISK OF BIAS FOR INDIVIDUAL STUDIES

C.5.1 Risk of Bias Assessment

The risk of bias of individual studies was assessed using OHAT's Risk of Bias Tool (NTP 2015). The risk of bias questions for animal experimental studies are presented in Table C-4. Each risk of bias question was answered on a four-point scale:

- **Definitely low risk of bias (++)**
- **Probably low risk of bias (+)**
- **Probably high risk of bias (-)**
- **Definitely high risk of bias (– –)**

In general, "definitely low risk of bias" or "definitely high risk of bias" were used if the question could be answered with information explicitly stated in the study report. If the response to the question could be inferred, then "probably low risk of bias" or "probably high risk of bias" responses were typically used.

Table C-4. Risk of Bias Questionnaire for Experimental Animal Studies

Selection bias
Was administered dose or exposure level adequately randomized?
Was the allocation to study groups adequately concealed?
Performance bias
Were experimental conditions identical across study groups?
Were the research personnel blinded to the study group during the study?
Attrition/exclusion bias
Were outcome data complete without attrition or exclusion from analysis?
Detection bias
Is there confidence in the exposure characterization?
Is there confidence in outcome assessment?
Selective reporting bias
Were all measured outcomes reported?

After the risk of bias questionnaires were completed for the health effects studies, the studies were assigned to one of three risk of bias tiers based on the responses to the key questions listed below and the responses to the remaining questions.

- Is there confidence in the exposure characterization? (only relevant for observational studies)
- Is there confidence in the outcome assessment?
- Does the study design or analysis account for important confounding and modifying variables? (only relevant for observational studies)

First Tier. Studies placed in the first tier received ratings of "definitely low" or "probably low" risk of bias on the key questions **AND** received a rating of "definitely low" or "probably low" risk of bias on the responses to at least 50% of the other applicable questions.

Second Tier. A study was placed in the second tier if it did not meet the criteria for the first or third tiers.

Third Tier. Studies placed in the third tier received ratings of “definitely high” or “probably high” risk of bias for the key questions **AND** received a rating of “definitely high” or “probably high” risk of bias on the response to at least 50% of the other applicable questions.

The results of the risk of bias assessment for the different types of 1,2-diphenylhydrazine health effects studies in animal experimental studies are presented in Table C-5.

Table C-5. Summary of Risk of Bias Assessment for 1,2-Diphenylhydrazine—Experimental Animal Studies

	Risk of bias criteria and ratings								
	Selection bias		Performance bias		Attrition/ exclusion bias	Detection bias		Selective reporting bias	
Reference	Administered dose or exposure level adequately randomized?	Allocation to study groups adequately concealed?	Experimental conditions identical across study groups?	Research personnel blinded to the study group during the study?	Outcome data complete without attrition or exclusion from analysis?	Confidence in exposure characterization?	**Confidence in outcome assessment?***	All measured outcomes reported?	Risk of bias tier
Outcome: Respiratory Effects									
Oral chronic exposure									
NCI 1978 (rat)	+	+	+	+	++	+	+	+	First
NCI 1978 (mouse)	+	+	+	+	++	+	+	+	First
Outcome: Gastrointestinal Effects									
Oral intermediate exposure									
NCI 1978 (mouse, 4-week)	+	+	+	+	+	-	+	-	First
Oral chronic exposure									
NCI 1978 (rat)	+	+	+	+	++	+	+	+	First
NCI 1978 (mouse)	+	+	+	+	++	+	+	+	First
Outcome: Hepatic Effects									
Oral acute exposure									
Dodd et al. 2012 (5-day)	++	+	+	+	++	+	+	++	First
Dodd et al. 2012 (2-week)	++	+	+	+	++	+	+	++	First
Oral intermediate exposure									
Dodd et al. 2012 (4-week)	++	+	+	+	++	+	+	++	First
Dodd et al. 2012 (13-week)	++	+	+	+	++	+	+	++	First

Table C-5. Summary of Risk of Bias Assessment for 1,2-Diphenylhydrazine—Experimental Animal Studies

	Risk of bias criteria and ratings								
	Selection bias		Performance bias		Attrition/ exclusion bias	Detection bias		Selective reporting bias	
Reference	Administered dose or exposure level adequately randomized?	Allocation to study groups adequately concealed?	Experimental conditions identical across study groups?	Research personnel blinded to the study group during the study?	Outcome data complete without attrition or exclusion from analysis?	Confidence in exposure characterization?	**Confidence in outcome assessment?***	All measured outcomes reported?	Risk of bias tier
Oral chronic exposure									
NCI 1978 (rat)	+	+	+	+	++	+	**+**	+	First
NCI 1978 (mouse)	+	+	+	+	++	+	**+**	+	First

++ = definitely low risk of bias; + = probably low risk of bias; – = probably high risk of bias; – – = definitely high risk of bias; na = not applicable
*Key question used to assign risk of bias tier

C.6 RATE THE CONFIDENCE IN THE BODY OF EVIDENCE FOR EACH RELEVANT OUTCOME

Confidences in the bodies of human and animal evidence were evaluated independently for each potential outcome. ATSDR did not evaluate the confidence in the body of evidence for carcinogenicity; rather, the Agency defaulted to the cancer weight-of-evidence assessment of other agencies including DHHS, EPA, and IARC. The confidence in the body of evidence for an association or no association between exposure to 1,2-diphenylhydrazine and a particular outcome was based on the strengths and weaknesses of individual studies. Four descriptors were used to describe the confidence in the body of evidence for effects or when no effect was found:

- **High confidence:** the true effect is highly likely to be reflected in the apparent relationship
- **Moderate confidence:** the true effect may be reflected in the apparent relationship
- **Low confidence:** the true effect may be different from the apparent relationship
- **Very low confidence:** the true effect is highly likely to be different from the apparent relationship

Confidence in the body of evidence for a particular outcome was rated for each type of study: case-control, case series, cohort, population, human-controlled exposure, and experimental animal. In the absence of data to the contrary, data for a particular outcome were collapsed across animal species, routes of exposure, and exposure durations. If species (or strain), route, or exposure duration differences were noted, then the data were treated as separate outcomes.

C.6.1 Initial Confidence Rating

In ATSDR's modification to the OHAT approach, the body of evidence for an association (or no association) between exposure to 1,2-diphenylhydrazine and a particular outcome was given an initial confidence rating based on the key features of the individual studies examining that outcome. The presence of these key features of study design was determined for individual studies using four "yes or no" questions, which were customized for epidemiology, human controlled exposure, or experimental animal study designs. Separate questionnaires were completed for each outcome assessed in a study. The key features for experimental animal studies are presented in Table C-6. The initial confidence in the study was determined based on the number of key features present in the study design:

- **High Initial Confidence:** Studies in which the responses to the four questions were "yes".

- **Moderate Initial Confidence:** Studies in which the responses to only three of the questions were "yes".

- **Low Initial Confidence:** Studies in which the responses to only two of the questions were "yes".

- **Very Low Initial Confidence:** Studies in which the response to one or none of the questions was "yes".

Table C-6. Key Features of Study Design for Experimental Animal Studies

A concurrent control group was used
A sufficient number of animals per group were tested
Appropriate parameters were used to assess a potential adverse effect
Appropriate statistical analyses were performed and reported or the data were reported in such a way to allow independent statistical analysis

The presence or absence of the key features and the initial confidence levels for studies examining body weight, respiratory, gastrointestinal, and hepatic effects observed in the animal experimental studies are presented in Table C-7.

Table C-7. Presence of Key Features of Study Design for 1,2-Diphenylhydrazine—Experimental Animal Studies

	Key feature				
Reference	Concurrent control group	Sufficient number of animals per group	Appropriate parameters to assess potential effect	Adequate data for statistical analysis	Initial study confidence
Outcome: Respiratory Effects					
Oral chronic exposure					
NCI 1978 (rat)	Yes	Yes	No	Yes	Moderate
NCI 1978 (mouse)	Yes	Yes	No	Yes	Moderate
Outcome: Gastrointestinal Effects					
Oral intermediate exposure					
NCI 1978 (mouse, 4-week)	Yes	No	No	No	Very Low
Oral chronic exposure					
NCI 1978 (rat)	Yes	Yes	No	Yes	Moderate
NCI 1978 (mouse)	Yes	Yes	No	Yes	Moderate
Outcome: Hepatic Effects					
Oral acute exposure					
Dodd et al. 2012 (5-day)	Yes	Yes	Yes	Yes	High
Dodd et al. 2012 (2-week)	Yes	Yes	Yes	Yes	High
Oral intermediate exposure					
Dodd et al. 2012 (4-week)	Yes	Yes	Yes	Yes	High
Dodd et al. 2012 (13-week)	Yes	Yes	Yes	Yes	High
Oral chronic exposure					
NCI 1978 (rat)	Yes	Yes	No	Yes	Moderate
NCI 1978 (mouse)	Yes	Yes	No	Yes	Moderate

A summary of the initial confidence ratings for each outcome is presented in Table C-8. If individual studies for a particular outcome and study type had different study quality ratings, then the highest confidence rating for the group of studies was used to determine the initial confidence rating for the body of evidence; any exceptions were noted in Table C-8.

Table C-8. Initial Confidence Rating for 1,2-Diphenylhydrazine Health Effects Studies

	Initial study confidence	Initial confidence rating
Outcome: Respiratory Effects		
Oral chronic exposure		
Animal studies		
NCI 1978 (rat)	Moderate	Moderate
NCI 1978 (mouse)	Moderate	
Outcome: Gastrointestinal Effects		
Oral intermediate exposure		
Animal studies		
NCI 1978 (mouse, 4-week)	Very Low	Very Low
Oral chronic exposure		
Animal studies		
NCI 1978 (rat)	Moderate	Moderate
NCI 1978 (mouse)	Moderate	
Outcome: Hepatic Effects		
Oral acute exposure		
Animal studies		
Dodd et al. 2012 (5-day)	High	High
Dodd et al. 2012 (2-week)	High	
Oral intermediate exposure		
Animal studies		
Dodd et al. 2012 (4-week)	High	High
Dodd et al. 2012 (13-week)	High	
Oral chronic exposure		
Animal studies		
NCI 1978 (rat)	Moderate	Moderate
NCI 1978 (mouse)	Moderate	

C.6.2 Adjustment of the Confidence Rating

The initial confidence rating was then downgraded or upgraded depending on whether there were substantial issues that would decrease or increase confidence in the body of evidence. The nine properties of the body of evidence that were considered are listed below. The summaries of the assessment of the confidence in the body of evidence for body weight, respiratory, gastrointestinal, and hepatic effects are presented in Table C-9. An overview of the confidence in the body of evidence for all health effects associated with 1,2-diphenylhydrazine exposure is presented in Table C-10.

Table C-9. Adjustments to the Initial Confidence in the Body of Evidence

	Initial confidence	Adjustments to the initial confidence rating	Final confidence
Outcome: Respiratory Effects			
Animal studies	Moderate	-1 inconsistency, -1 imprecision	Very Low
Outcome: Gastrointestinal Effects			
Animal studies	Moderate	-1 inconsistency	Low
Outcome: Hepatic Effects			
Animal studies	High	No adjustments	High

Table C-10. Confidence in the Body of Evidence for 1,2-Diphenylhydrazine

Outcome	Confidence in body of evidence	
	Human studies	Animal studies
Respiratory effects	No data	Very Low
Gastrointestinal effects	No data	Low
Hepatic effects	No data	High

Five properties of the body of evidence were considered to determine whether the confidence rating should be downgraded:

- **Risk of bias.** Evaluation of whether there is substantial risk of bias across most of the studies examining the outcome. This evaluation used the risk of bias tier groupings for individual studies examining a particular outcome (Table C-5). Below are the criteria used to determine whether the initial confidence in the body of evidence for each outcome should be downgraded for risk of bias:
    - No downgrade if most studies are in the risk of bias first tier
    - Downgrade one confidence level if most studies are in the risk of bias second tier
    - Downgrade two confidence levels if most studies are in the risk of bias third tier

- **Unexplained inconsistency.** Evaluation of whether there is inconsistency or large variability in the magnitude or direction of estimates of effect across studies that cannot be explained. Below are the criteria used to determine whether the initial confidence in the body of evidence for each outcome should be downgraded for unexplained inconsistency:
    - No downgrade if there is little inconsistency across studies or if only one study evaluated the outcome
    - Downgrade one confidence level if there is variability across studies in the magnitude or direction of the effect
    - Downgrade two confidence levels if there is substantial variability across studies in the magnitude or direct of the effect

- **Indirectness.** Evaluation of four factors that can affect the applicability, generalizability, and relevance of the studies:
    - Relevance of the animal model to human health—unless otherwise indicated, studies in rats, mice, and other mammalian species are considered relevant to humans

- Directness of the endpoints to the primary health outcome—examples of secondary outcomes or nonspecific outcomes include organ weight in the absence of histopathology or clinical chemistry findings in the absence of target tissue effects
- Nature of the exposure in human studies and route of administration in animal studies—inhalation, oral, and dermal exposure routes are considered relevant unless there are compelling data to the contrary
- Duration of treatment in animal studies and length of time between exposure and outcome assessment in animal and prospective human studies—this should be considered on an outcome-specific basis

Below are the criteria used to determine whether the initial confidence in the body of evidence for each outcome should be downgraded for indirectness:

- No downgrade if none of the factors are considered indirect
- Downgrade one confidence level if one of the factors is considered indirect
- Downgrade two confidence levels if two or more of the factors are considered indirect

- **Imprecision.** Evaluation of the narrowness of the effect size estimates and whether the studies have adequate statistical power. Data are considered imprecise when the ratio of the upper to lower 95% CIs for most studies is ≥10 for tests of ratio measures (e.g., odds ratios) and ≥100 for absolute measures (e.g., percent control response). Adequate statistical power is determined if the study can detect a potentially biologically meaningful difference between groups (20% change from control response for categorical data or risk ratio of 1.5 for continuous data). Below are the criteria used to determine whether the initial confidence in the body of evidence for each outcome should be downgraded for imprecision:
  - No downgrade if there are no serious imprecisions
  - Downgrade one confidence level for serious imprecisions
  - Downgrade two confidence levels for very serious imprecisions

- **Publication bias.** Evaluation of the concern that studies with statistically significant results are more likely to be published than studies without statistically significant results.
  - Downgrade one level of confidence for cases where there is serious concern with publication bias

Four properties of the body of evidence were considered to determine whether the confidence rating should be upgraded:

- **Large magnitude of effect.** Evaluation of whether the magnitude of effect is sufficiently large so that it is unlikely to have occurred as a result of bias from potential confounding factors.
  - Upgrade one confidence level if there is evidence of a large magnitude of effect in a few studies, provided that the studies have an overall low risk of bias and there is no serious unexplained inconsistency among the studies of similar dose or exposure levels; confidence can also be upgraded if there is one study examining the outcome, provided that the study has an overall low risk of bias

- **Dose response.** Evaluation of the dose-response relationships measured within a study and across studies. Below are the criteria used to determine whether the initial confidence in the body of evidence for each outcome should be upgraded:
  - Upgrade one confidence level for evidence of a monotonic dose-response gradient
  - Upgrade one confidence level for evidence of a non-monotonic dose-response gradient where there is prior knowledge that supports a non-monotonic dose-response and a non-monotonic dose-response gradient is observed across studies

- **Plausible confounding or other residual biases.** This factor primarily applies to human studies and is an evaluation of unmeasured determinants of an outcome such as residual bias towards the null (e.g., "healthy worker" effect) or residual bias suggesting a spurious effect (e.g., recall bias). Below is the criterion used to determine whether the initial confidence in the body of evidence for each outcome should be upgraded:
    - Upgrade one confidence level for evidence that residual confounding or bias would underestimate an apparent association or treatment effect (i.e., bias toward the null) or suggest a spurious effect when results suggest no effect

- **Consistency in the body of evidence.** Evaluation of consistency across animal models and species, consistency across independent studies of different human populations and exposure scenarios, and consistency across human study types. Below is the criterion used to determine whether the initial confidence in the body of evidence for each outcome should be upgraded:
    - Upgrade one confidence level if there is a high degree of consistency in the database

C.7 TRANSLATE CONFIDENCE RATING INTO LEVEL OF EVIDENCE OF HEALTH EFFECTS

In the seventh step of the systematic review of the health effects data for 1,2-diphenylhydrazine, the confidence in the body of evidence for specific outcomes was translated to a level of evidence rating. The level of evidence rating reflected the confidence in the body of evidence and the direction of the effect (i.e., toxicity or no toxicity); route-specific differences were noted. The level of evidence for health effects was rated on a five-point scale:

- **High level of evidence:** High confidence in the body of evidence for an association between exposure to the substance and the health outcome
- **Moderate level of evidence:** Moderate confidence in the body of evidence for an association between exposure to the substance and the health outcome
- **Low level of evidence:** Low confidence in the body of evidence for an association between exposure to the substance and the health outcome
- **Evidence of no health effect:** High confidence in the body of evidence that exposure to the substance is not associated with the health outcome
- **Inadequate evidence:** Low or moderate confidence in the body of evidence that exposure to the substance is not associated with the health outcome OR very low confidence in the body of evidence for an association between exposure to the substance and the health outcome

A summary of the level of evidence of health effects for 1,2-diphenylhydrazine is presented in Table C-11.

Table C-11. Level of Evidence of Health Effects for 1,2-Diphenylhydrazine

Outcome	Confidence in body of evidence	Direction of health effect	Level of evidence for health effect
Human studies			
Respiratory effects	No data		No data
Gastrointestinal effects	No data		No data
Hepatic effects	No data		No data
Animal studies			
Respiratory effects	Very Low	Health effect	Inadequate
Gastrointestinal effects	Low	Health effect	Low
Hepatic effects	High	Health effect	High

C.8 INTEGRATE EVIDENCE TO DEVELOP HAZARD IDENTIFICATION CONCLUSIONS

The final step involved the integration of the evidence streams for the human studies and animal studies to allow for a determination of hazard identification conclusions. For health effects, there were four hazard identification conclusion categories:

- **Known** to be a hazard to humans
- **Presumed** to be a hazard to humans
- **Suspected** to be a hazard to humans
- **Not classifiable** as to the hazard to humans

The initial hazard identification was based on the highest level of evidence in the human studies and the level of evidence in the animal studies; if there were no data for one evidence stream (human or animal), then the hazard identification was based on the one data stream (equivalent to treating the missing evidence stream as having low level of evidence). The hazard identification scheme is presented in Figure C-1 and described below:

- **Known:** A health effect in this category would have:
  - High level of evidence for health effects in human studies **AND** a high, moderate, or low level of evidence in animal studies.
- **Presumed:** A health effect in this category would have:
  - Moderate level of evidence in human studies **AND** high or moderate level of evidence in animal studies **OR**
  - Low level of evidence in human studies **AND** high level of evidence in animal studies
- **Suspected:** A health effect in this category would have:
  - Moderate level of evidence in human studies **AND** low level of evidence in animal studies **OR**
  - Low level of evidence in human studies **AND** moderate level of evidence in animal studies
- **Not classifiable:** A health effect in this category would have:
  - Low level of evidence in human studies **AND** low level of evidence in animal studies

Other relevant data such as mechanistic or mode-of-action data were considered to raise or lower the level of the hazard identification conclusion by providing information that supported or opposed biological plausibility.

Two hazard identification conclusion categories were used when the data indicated that there may be no health effect in humans:

- **Not identified** to be a hazard in humans
- **Inadequate** to determine hazard to humans

If the human level of evidence conclusion of no health effect was supported by the animal evidence of no health effect, then the hazard identification conclusion category of "not identified" was used. If the human or animal level of evidence was considered inadequate, then a hazard identification conclusion category of "inadequate" was used. As with the hazard identification for health effects, the impact of other relevant data was also considered for no health effect data.

The hazard identification conclusions for 1,2-diphenylhydrazine are listed below and summarized in Table C-12.

Presumed Health Effects

- Hepatic effects
  - No human data are available on the potential hepatic effects of 1,2-diphenylhydrazine.
  - High level of evidence from intermediate (Dodd et al. 2012) and chronic (NCI 1978) oral studies in rats and chronic oral studies in mice (NCI 1978). No liver effects were observed at exposures of less than 13 weeks in rats (Dodd et al. 2012; NCI 1978) or mice (NCI 1978).

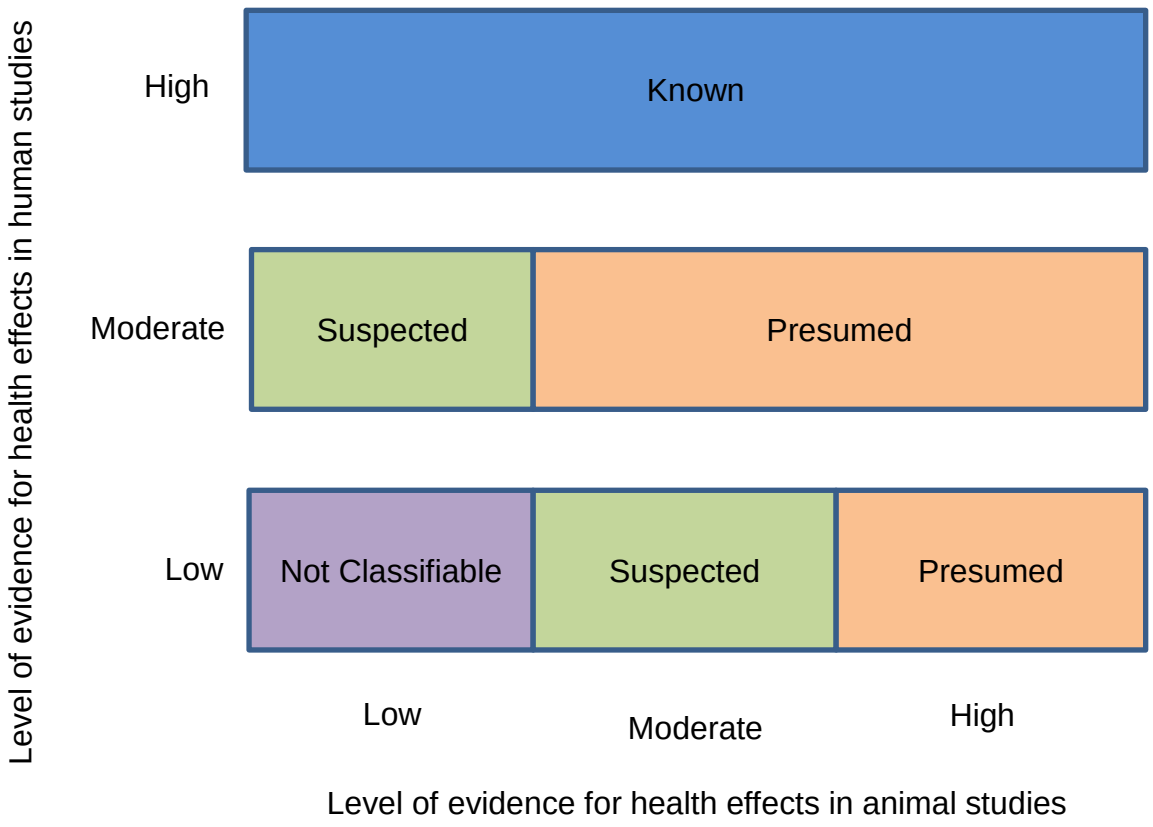
Not Classifiable Effects

- Respiratory effects
  - No human data are available on the potential respiratory effects of 1,2-diphenyl-hydrazine.
  - There is inadequate evidence in animal studies that chronic oral exposure will result in respiratory effects. Interstitial lung inflammation was observed in male rats (NCI 1978); in female rats the incidence was not dose-related. Respiratory effects were not observed in mice following chronic oral exposure (NCI 1978).
- Gastrointestinal effects
  - No human data are available on the potential gastrointestinal effects of 1,2-diphenyl-hydrazine.
  - Low evidence in animals from an intermediate oral study which reported intestinal hemorrhage in mice (NCI 1978) and from a chronic oral study in rats that reported hyperkeratosis and/or acanthosis in rats (NCI 1978); no gastrointestinal effects were observed in mice following chronic oral exposure.

Table C-12. Hazard Identification Conclusions for 1,2-Diphenylhydrazine

Outcome	Hazard identification
Respiratory effects	Not classifiable
Gastrointestinal effects	Not classifiable
Hepatic effects	Presumed

Figure C-1. Hazard Identification Scheme



APPENDIX D. USER'S GUIDE

Chapter 1. Relevance to Public Health

This chapter provides an overview of U.S. exposures, a summary of health effects based on evaluations of existing toxicologic, epidemiologic, and toxicokinetic information, and an overview of the minimal risk levels. This is designed to present interpretive, weight-of-evidence discussions for human health endpoints by addressing the following questions:

1. What effects are known to occur in humans?

2. What effects observed in animals are likely to be of concern to humans?

3. What exposure conditions are likely to be of concern to humans, especially around hazardous waste sites?

Minimal Risk Levels (MRLs)

Where sufficient toxicologic information is available, ATSDR derives MRLs for inhalation and oral routes of entry at each duration of exposure (acute, intermediate, and chronic). These MRLs are not meant to support regulatory action, but to acquaint health professionals with exposure levels at which adverse health effects are not expected to occur in humans.

MRLs should help physicians and public health officials determine the safety of a community living near a hazardous substance emission, given the concentration of a contaminant in air or the estimated daily dose in water. MRLs are based largely on toxicological studies in animals and on reports of human occupational exposure.

MRL users should be familiar with the toxicologic information on which the number is based. Section 1.2, Summary of Health Effects, contains basic information known about the substance. Other sections, such as Section 3.2 Children and Other Populations that are Unusually Susceptible and Section 3.4 Interactions with Other Substances, provide important supplemental information.

MRL users should also understand the MRL derivation methodology. MRLs are derived using a modified version of the risk assessment methodology that the Environmental Protection Agency (EPA) provides (Barnes and Dourson 1988) to determine reference doses (RfDs) for lifetime exposure.

To derive an MRL, ATSDR generally selects the most sensitive endpoint which, in its best judgement, represents the most sensitive human health effect for a given exposure route and duration. ATSDR cannot make this judgement or derive an MRL unless information (quantitative or qualitative) is available for all potential systemic, neurological, and developmental effects. If this information and reliable quantitative data on the chosen endpoint are available, ATSDR derives an MRL using the most sensitive species (when information from multiple species is available) with the highest no-observed-adverse-effect level (NOAEL) that does not exceed any adverse effect levels. When a NOAEL is not available, a lowest-observed-adverse-effect level (LOAEL) can be used to derive an MRL, and an uncertainty factor of 10 must be employed. Additional uncertainty factors of 10 must be used both for human variability to protect sensitive subpopulations (people who are most susceptible to the health effects caused by the substance) and for interspecies variability (extrapolation from animals to humans). In deriving an MRL, these individual uncertainty factors are multiplied together. The product is then divided into the inhalation concentration or oral dosage selected from the study. Uncertainty factors used in developing a

substance-specific MRL are provided in the footnotes of the levels of significant exposure (LSE) tables that are provided in Chapter 2. Detailed discussions of the MRLs are presented in Appendix A.

Chapter 2. Health Effects

Tables and Figures for Levels of Significant Exposure (LSE)

Tables and figures are used to summarize health effects and illustrate graphically levels of exposure associated with those effects. These levels cover health effects observed at increasing dose concentrations and durations, differences in response by species and MRLs to humans for noncancer endpoints. The LSE tables and figures can be used for a quick review of the health effects and to locate data for a specific exposure scenario. The LSE tables and figures should always be used in conjunction with the text. All entries in these tables and figures represent studies that provide reliable, quantitative estimates of NOAELs, LOAELs, or Cancer Effect Levels (CELs).

The legends presented below demonstrate the application of these tables and figures. Representative examples of LSE tables and figures follow. The numbers in the left column of the legends correspond to the numbers in the example table and figure.

TABLE LEGEND

See Sample LSE Table (page D-5)

(1) Route of exposure. One of the first considerations when reviewing the toxicity of a substance using these tables and figures should be the relevant and appropriate route of exposure. Typically, when sufficient data exist, three LSE tables and two LSE figures are presented in the document. The three LSE tables present data on the three principal routes of exposure (i.e., inhalation, oral, and dermal). LSE figures are limited to the inhalation and oral routes. Not all substances will have data on each route of exposure and will not, therefore, have all five of the tables and figures. Profiles with more than one chemical may have more LSE tables and figures.

(2) Exposure period. Three exposure periods—acute (<15 days), intermediate (15–364 days), and chronic (≥365 days)—are presented within each relevant route of exposure. In this example, two oral studies of chronic-duration exposure are reported. For quick reference to health effects occurring from a known length of exposure, locate the applicable exposure period within the LSE table and figure.

(3) Figure key. Each key number in the LSE table links study information to one or more data points using the same key number in the corresponding LSE figure. In this example, the study represented by key number 51 identified NOAELs and less serious LOAELs (also see the three "51R" data points in sample LSE Figure 2-X).

(4) Species (strain) No./group. The test species (and strain), whether animal or human, are identified in this column. The column also contains information on the number of subjects and sex per group. Chapter 1, Relevance to Public Health, covers the relevance of animal data to human toxicity and Section 3.1, Toxicokinetics, contains any available information on comparative toxicokinetics. Although NOAELs and LOAELs are species specific, the levels are extrapolated to equivalent human doses to derive an MRL.

(5) Exposure parameters/doses. The duration of the study and exposure regimens are provided in these columns. This permits comparison of NOAELs and LOAELs from different studies. In this case (key number 51), rats were orally exposed to “Chemical X” via feed for 2 years. For a

more complete review of the dosing regimen, refer to the appropriate sections of the text or the original reference paper (i.e., Aida et al. 1992).

(6) Parameters monitored. This column lists the parameters used to assess health effects. Parameters monitored could include serum (blood) chemistry (BC), behavioral (BH), biochemical changes (BI), body weight (BW), clinical signs (CS), developmental toxicity (DX), enzyme activity (EA), food intake (FI), fetal toxicity (FX), gross necropsy (GN), hematology (HE), histopathology (HP), lethality (LE), maternal toxicity (MX), organ function (OF), ophthalmology (OP), organ weight (OW), teratogenicity (TG), urinalysis (UR), and water intake (WI).

(7) Endpoint. This column lists the endpoint examined. The major categories of health endpoints included in LSE tables and figures are death, body weight, respiratory, cardiovascular, gastrointestinal, hematological, musculoskeletal, hepatic, renal, dermal, ocular, endocrine, immunological, neurological, reproductive, developmental, other noncancer, and cancer. "Other noncancer" refers to any effect (e.g., alterations in blood glucose levels) not covered in these systems. In the example of key number 51, three endpoints (body weight, hematological, and hepatic) were investigated.

(8) NOAEL. A NOAEL is the highest exposure level at which no adverse effects were seen in the organ system studied. The body weight effect reported in key number 51 is a NOAEL at 25.5 mg/kg/day. NOAELs are not reported for cancer and death; with the exception of these two endpoints, this field is left blank if no NOAEL was identified in the study.

(9) LOAEL. A LOAEL is the lowest dose used in the study that caused an adverse health effect. LOAELs have been classified into "Less Serious" and "Serious" effects. These distinctions help readers identify the levels of exposure at which adverse health effects first appear and the gradation of effects with increasing dose. A brief description of the specific endpoint used to quantify the adverse effect accompanies the LOAEL. Key number 51 reports a less serious LOAEL of 6.1 mg/kg/day for the hepatic system, which was used to derive a chronic exposure, oral MRL of 0.008 mg/kg/day (see footnote "c"). MRLs are not derived from serious LOAELs. A cancer effect level (CEL) is the lowest exposure level associated with the onset of carcinogenesis in experimental or epidemiologic studies. CELs are always considered serious effects. The LSE tables and figures do not contain NOAELs for cancer, but the text may report doses not causing measurable cancer increases. If no LOAEL/CEL values were identified in the study, this field is left blank.

(10) Reference. The complete reference citation is provided in Chapter 8 of the profile.

(11) Footnotes. Explanations of abbreviations or reference notes for data in the LSE tables are found in the footnotes. For example, footnote "c" indicates that the LOAEL of 6.1 mg/kg/day in key number 51 was used to derive an oral MRL of 0.008 mg/kg/day.

FIGURE LEGEND

See Sample LSE Figure (page D-6)

LSE figures graphically illustrate the data presented in the corresponding LSE tables. Figures help the reader quickly compare health effects according to exposure concentrations for particular exposure periods.

(13) Exposure period. The same exposure periods appear as in the LSE table. In this example, health effects observed within the chronic exposure period are illustrated.

(14) Endpoint. These are the categories of health effects for which reliable quantitative data exist. The same health effect endpoints appear in the LSE table.

(15) Levels of exposure. Concentrations or doses for each health effect in the LSE tables are graphically displayed in the LSE figures. Exposure concentration or dose is measured on the log scale "y" axis. Inhalation exposure is reported in mg/m^3 or ppm and oral exposure is reported in mg/kg/day.

(16) LOAEL. In this example, the half-shaded circle that is designated 51R identifies a LOAEL critical endpoint in the rat upon which a chronic oral exposure MRL is based. The key number 51 corresponds to the entry in the LSE table. The dashed descending arrow indicates the extrapolation from the exposure level of 6.1 mg/kg/day (see entry 51 in the sample LSE table) to the MRL of 0.008 mg/kg/day (see footnote "c" in the sample LSE table).

(17) CEL. Key number 59R is one of studies for which CELs were derived. The diamond symbol refers to a CEL for the test species (rat). The number 59 corresponds to the entry in the LSE table.

(18) Key to LSE figure. The key provides the abbreviations and symbols used in the figure.

Table 2-X. Levels of Significant Exposure to [Chemical X] – Oral (1)

Figure key[a] (3)	Species (strain) No./group (4)	Exposure parameters (5)	Doses (mg/kg/day) (5)	Parameters monitored (6)	Endpoint (7)	NOAEL (mg/kg/day) (8)	Less serious LOAEL (mg/kg/day) (9)	Serious LOAEL (mg/kg/day) (9)	Effect
CHRONIC EXPOSURE (2)									
51	Rat (Wistar) 40 M, 40 F	2 years (F)	M: 0, 6.1, 25.5, 138.0 F: 0, 8.0, 31.7, 168.4	CS, WI, BW, OW, HE, BC, HP	Bd wt	25.5	138.0		Decreased body weight gain in males (23–25%) and females (31–39%)
					Hemato	138.0			
					Hepatic		6.1[c]		Increases in absolute and relative weights at ≥6.1/8.0 mg/kg/day after 12 months of exposure; fatty generation at ≥6.1 mg/kg/day in males and at ≥31.7 mg/kg/day in females, and granulomas in females at 31.7 and 168.4 mg/kg/day after 12, 18, or 24 months of exposure and in males at ≥6.1 mg/kg/day only after 24 months of exposure
Aida et al. 1992 (10)									
52	Rat (F344) 78 M	104 weeks (W)	0, 3.9, 20.6, 36.3	CS, BW, FI, BC, OW, HP	Hepatic	36.3			
					Renal	20.6	36.3		Increased incidence of renal tubular cell hyperplasia
					Endocr	36.3			
George et al. 2002									
59	Rat (Wistar) 58M, 58F	Lifetime (W)	M: 0, 90 F: 0, 190	BW, HP	Cancer		190 F		Increased incidence of hepatic neoplastic nodules in females only; no additional description of the tumors was provided
Tumasonis et al. 1985									

[a]The number corresponds to entries in Figure 2-x.

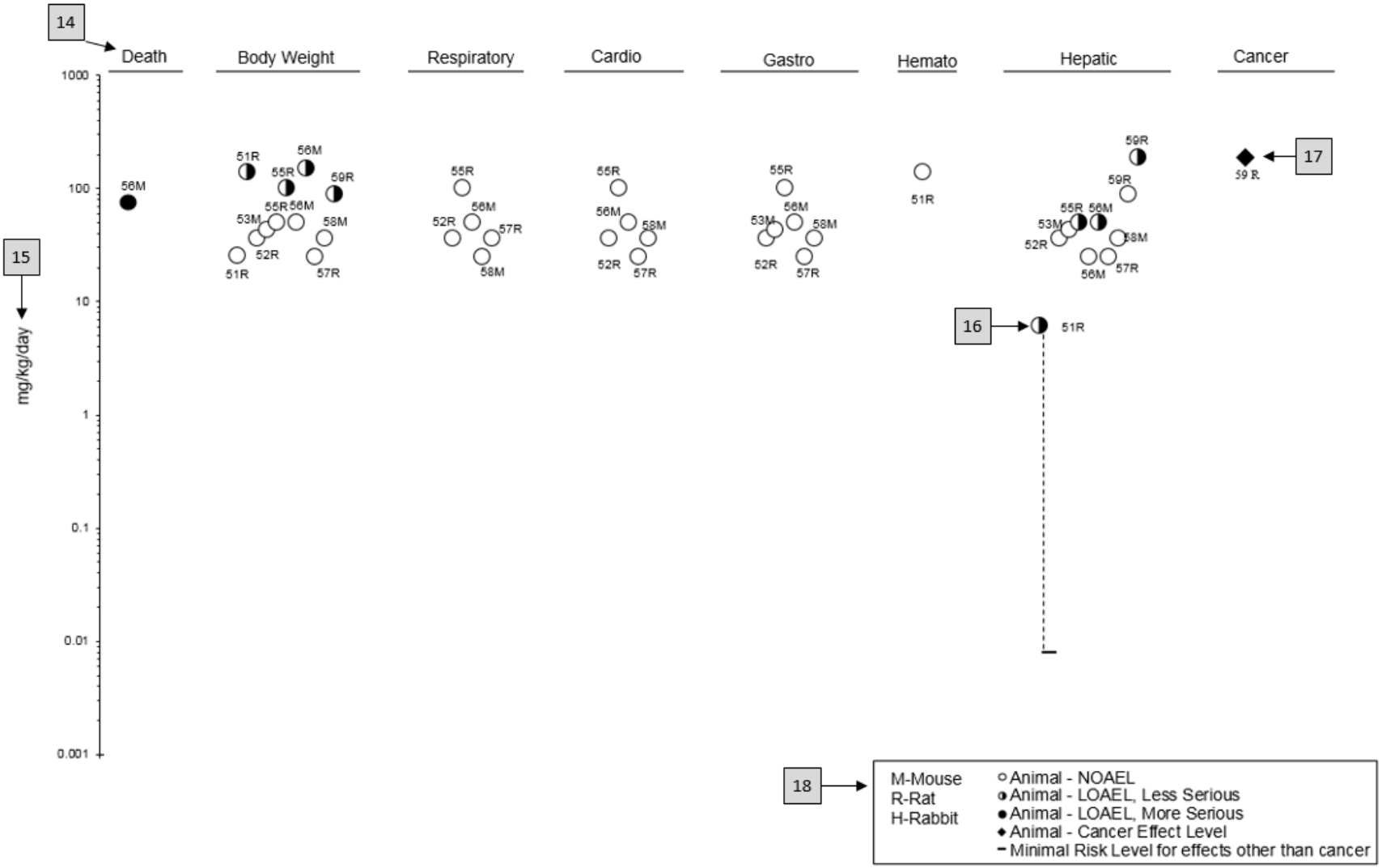
(11) [b]Used to derive an acute-duration oral minimal risk level (MRL) of 0.1 mg/kg/day based on the $BMDL_{05}$ of 10 mg/kg/day and an uncertainty factor of 100 (10 for extrapolation from animals to humans and 10 for human variability).

[c]Used to derive a chronic-duration oral MRL of 0.008 mg/kg/day based on the $BMDL_{10}$ of 0.78 mg/kg/day and an uncertainty factor of 100 (10 for extrapolation from animals to humans and 10 for human variability).

APPENDIX D

Figure 2-X. Levels of Significant Exposure to [Chemical X] - Oral

13 → Chronic (≥365 days)



APPENDIX E. QUICK REFERENCE FOR HEALTH CARE PROVIDERS

Toxicological Profiles are a unique compilation of toxicological information on a given hazardous substance. Each profile reflects a comprehensive and extensive evaluation, summary, and interpretation of available toxicologic and epidemiologic information on a substance. Health care providers treating patients potentially exposed to hazardous substances may find the following information helpful for fast answers to often-asked questions.

Primary Chapters/Sections of Interest

Chapter 1: Relevance to Public Health: The Relevance to Public Health Section provides an overview of exposure and health effects and evaluates, interprets, and assesses the significance of toxicity data to human health. A table listing minimal risk levels (MRLs) is also included in this chapter.

Chapter 2: Health Effects: Specific health effects identified in both human and animal studies are reported by type of health effect (e.g., death, hepatic, renal, immune, reproductive), route of exposure (e.g., inhalation, oral, dermal), and length of exposure (e.g., acute, intermediate, and chronic).
NOTE: Not all health effects reported in this section are necessarily observed in the clinical setting.

Pediatrics:
Section 3.2 Children and Other Populations that are Unusually Susceptible
Section 3.3 Biomarkers of Exposure and Effect

ATSDR Information Center

Phone: 1-800-CDC-INFO (800-232-4636) or 1-888-232-6348 (TTY)
Internet: http://www.atsdr.cdc.gov

The following additional materials are available online:

Case Studies in Environmental Medicine are self-instructional publications designed to increase primary health care providers' knowledge of a hazardous substance in the environment and to aid in the evaluation of potentially exposed patients (see https://www.atsdr.cdc.gov/csem/csem.html).

Managing Hazardous Materials Incidents is a three-volume set of recommendations for on-scene (prehospital) and hospital medical management of patients exposed during a hazardous materials incident (see https://www.atsdr.cdc.gov/MHMI/index.asp). Volumes I and II are planning guides to assist first responders and hospital emergency department personnel in planning for incidents that involve hazardous materials. Volume III—*Medical Management Guidelines for Acute Chemical Exposures*—is a guide for health care professionals treating patients exposed to hazardous materials.

Fact Sheets (ToxFAQs™) provide answers to frequently asked questions about toxic substances (see https://www.atsdr.cdc.gov/toxfaqs/Index.asp).

Other Agencies and Organizations

The National Center for Environmental Health (NCEH) focuses on preventing or controlling disease, injury, and disability related to the interactions between people and their environment outside the workplace. Contact: NCEH, Mailstop F-29, 4770 Buford Highway, NE, Atlanta, GA 30341-3724 • Phone: 770-488-7000 • FAX: 770-488-7015 • Web Page: https://www.cdc.gov/nceh/.

The National Institute for Occupational Safety and Health (NIOSH) conducts research on occupational diseases and injuries, responds to requests for assistance by investigating problems of health and safety in the workplace, recommends standards to the Occupational Safety and Health Administration (OSHA) and the Mine Safety and Health Administration (MSHA), and trains professionals in occupational safety and health. Contact: NIOSH, 395 E Street, S.W., Suite 9200, Patriots Plaza Building, Washington, DC 20201 • Phone: 202-245-0625 or 1-800-CDC-INFO (800-232-4636) • Web Page: https://www.cdc.gov/niosh/.

The National Institute of Environmental Health Sciences (NIEHS) is the principal federal agency for biomedical research on the effects of chemical, physical, and biologic environmental agents on human health and well-being. Contact: NIEHS, PO Box 12233, 104 T.W. Alexander Drive, Research Triangle Park, NC 27709 • Phone: 919-541-3212 • Web Page: https://www.niehs.nih.gov/.

Clinical Resources (Publicly Available Information)

The Association of Occupational and Environmental Clinics (AOEC) has developed a network of clinics in the United States to provide expertise in occupational and environmental issues. Contact: AOEC, 1010 Vermont Avenue, NW, #513, Washington, DC 20005 • Phone: 202-347-4976 • FAX: 202-347-4950 • e-mail: AOEC@AOEC.ORG • Web Page: http://www.aoec.org/.

The American College of Occupational and Environmental Medicine (ACOEM) is an association of physicians and other health care providers specializing in the field of occupational and environmental medicine. Contact: ACOEM, 25 Northwest Point Boulevard, Suite 700, Elk Grove Village, IL 60007-1030 • Phone: 847-818-1800 • FAX: 847-818-9266 • Web Page: http://www.acoem.org/.

The American College of Medical Toxicology (ACMT) is a nonprofit association of physicians with recognized expertise in medical toxicology. Contact: ACMT, 10645 North Tatum Boulevard, Suite 200-111, Phoenix AZ 85028 • Phone: 844-226-8333 • FAX: 844-226-8333 • Web Page: http://www.acmt.net.

The Pediatric Environmental Health Specialty Units (PEHSUs) is an interconnected system of specialists who respond to questions from public health professionals, clinicians, policy makers, and the public about the impact of environmental factors on the health of children and reproductive-aged adults. Contact information for regional centers can be found at http://pehsu.net/findhelp.html.

The American Association of Poison Control Centers (AAPCC) provide support on the prevention and treatment of poison exposures. Contact: AAPCC, 515 King Street, Suite 510, Alexandria VA 22314 • Phone: 701-894-1858 • Poison Help Line: 1-800-222-1222 • Web Page: http://www.aapcc.org/.

APPENDIX F. GLOSSARY

Absorption—The process by which a substance crosses biological membranes and enters systemic circulation. Absorption can also refer to the taking up of liquids by solids, or of gases by solids or liquids.

Acute Exposure—Exposure to a chemical for a duration of ≤14 days, as specified in the Toxicological Profiles.

Adsorption—The adhesion in an extremely thin layer of molecules (as of gases, solutes, or liquids) to the surfaces of solid bodies or liquids with which they are in contact.

Adsorption Coefficient (K_{oc})—The ratio of the amount of a chemical adsorbed per unit weight of organic carbon in the soil or sediment to the concentration of the chemical in solution at equilibrium.

Adsorption Ratio (Kd)—The amount of a chemical adsorbed by sediment or soil (i.e., the solid phase) divided by the amount of chemical in the solution phase, which is in equilibrium with the solid phase, at a fixed solid/solution ratio. It is generally expressed in micrograms of chemical sorbed per gram of soil or sediment.

Benchmark Dose (BMD) or Benchmark Concentration (BMC)—is the dose/concentration corresponding to a specific response level estimate using a statistical dose-response model applied to either experimental toxicology or epidemiology data. For example, a BMD_{10} would be the dose corresponding to a 10% benchmark response (BMR). The BMD is determined by modeling the dose-response curve in the region of the dose-response relationship where biologically observable data are feasible. The BMDL or BMCL is the 95% lower confidence limit on the BMD or BMC.

Bioconcentration Factor (BCF)—The quotient of the concentration of a chemical in aquatic organisms at a specific time or during a discrete time period of exposure divided by the concentration in the surrounding water at the same time or during the same period.

Biomarkers—Indicators signaling events in biologic systems or samples, typically classified as markers of exposure, effect, and susceptibility.

Cancer Effect Level (CEL)—The lowest dose of a chemical in a study, or group of studies, that produces significant increases in the incidence of cancer (or tumors) between the exposed population and its appropriate control.

Carcinogen—A chemical capable of inducing cancer.

Case-Control Study—A type of epidemiological study that examines the relationship between a particular outcome (disease or condition) and a variety of potential causative agents (such as toxic chemicals). In a case-control study, a group of people with a specified and well-defined outcome is identified and compared to a similar group of people without the outcome.

Case Report—A report that describes a single individual with a particular disease or exposure. These reports may suggest some potential topics for scientific research, but are not actual research studies.

Case Series—Reports that describe the experience of a small number of individuals with the same disease or exposure. These reports may suggest potential topics for scientific research, but are not actual research studies.

Ceiling Value—A concentration that must not be exceeded.

Chronic Exposure—Exposure to a chemical for ≥365 days, as specified in the Toxicological Profiles.

Clastogen—A substance that causes breaks in chromosomes resulting in addition, deletion, or rearrangement of parts of the chromosome.

Cohort Study—A type of epidemiological study of a specific group or groups of people who have had a common insult (e.g., exposure to an agent suspected of causing disease or a common disease) and are followed forward from exposure to outcome, and who are disease-free at start of follow-up. Often, at least one exposed group is compared to one unexposed group, while in other cohorts, exposure is a continuous variable and analyses are directed towards analyzing an exposure-response coefficient.

Cross-sectional Study—A type of epidemiological study of a group or groups of people that examines the relationship between exposure and outcome to a chemical or to chemicals at a specific point in time.

Data Needs—Substance-specific informational needs that, if met, would reduce the uncertainties of human health risk assessment.

Developmental Toxicity—The occurrence of adverse effects on the developing organism that may result from exposure to a chemical prior to conception (either parent), during prenatal development, or postnatally to the time of sexual maturation. Adverse developmental effects may be detected at any point in the life span of the organism.

Dose-Response Relationship—The quantitative relationship between the amount of exposure to a toxicant and the incidence of the response or amount of the response.

Embryotoxicity and Fetotoxicity—Any toxic effect on the conceptus as a result of prenatal exposure to a chemical; the distinguishing feature between the two terms is the stage of development during which the effect occurs. Effects include malformations and variations, altered growth, and *in utero* death.

Epidemiology—The investigation of factors that determine the frequency and distribution of disease or other health-related conditions within a defined human population during a specified period.

Excretion—The process by which metabolic waste products are removed from the body.

Genotoxicity—A specific adverse effect on the genome of living cells that, upon the duplication of affected cells, can be expressed as a mutagenic, clastogenic, or carcinogenic event because of specific alteration of the molecular structure of the genome.

Half-life—A measure of rate for the time required to eliminate one-half of a quantity of a chemical from the body or environmental media.

Health Advisory—An estimate of acceptable drinking water levels for a chemical substance derived by EPA and based on health effects information. A health advisory is not a legally enforceable federal standard, but serves as technical guidance to assist federal, state, and local officials.

Immediately Dangerous to Life or Health (IDLH)—A condition that poses a threat of life or health, or conditions that pose an immediate threat of severe exposure to contaminants that are likely to have adverse cumulative or delayed effects on health.

Immunotoxicity—Adverse effect on the functioning of the immune system that may result from exposure to chemical substances.

Incidence—The ratio of new cases of individuals in a population who develop a specified condition to the total number of individuals in that population who could have developed that condition in a specified time period.

Intermediate Exposure—Exposure to a chemical for a duration of 15–364 days, as specified in the Toxicological Profiles.

***In Vitro*—**Isolated from the living organism and artificially maintained, as in a test tube.

***In Vivo*—**Occurring within the living organism.

Lethal Concentration$_{(LO)}$ (LC_{LO})—The lowest concentration of a chemical in air that has been reported to have caused death in humans or animals.

Lethal Concentration$_{(50)}$ (LC_{50})—A calculated concentration of a chemical in air to which exposure for a specific length of time is expected to cause death in 50% of a defined experimental animal population.

Lethal Dose$_{(LO)}$ (LD_{Lo})—The lowest dose of a chemical introduced by a route other than inhalation that has been reported to have caused death in humans or animals.

Lethal Dose$_{(50)}$ (LD_{50})—The dose of a chemical that has been calculated to cause death in 50% of a defined experimental animal population.

Lethal Time$_{(50)}$ (LT_{50})—A calculated period of time within which a specific concentration of a chemical is expected to cause death in 50% of a defined experimental animal population.

Lowest-Observed-Adverse-Effect Level (LOAEL)—The lowest exposure level of chemical in a study, or group of studies, that produces statistically or biologically significant increases in frequency or severity of adverse effects between the exposed population and its appropriate control.

Lymphoreticular Effects—Represent morphological effects involving lymphatic tissues such as the lymph nodes, spleen, and thymus.

Malformations—Permanent structural changes that may adversely affect survival, development, or function.

Metabolism—Process in which chemical substances are biotransformed in the body that could result in less toxic and/or readily excreted compounds or produce a biologically active intermediate.

Minimal Risk Level (MRL)—An estimate of daily human exposure to a hazardous substance that is likely to be without an appreciable risk of adverse noncancer health effects over a specified route and duration of exposure.

Modifying Factor (MF)—A value (greater than zero) that is applied to the derivation of a Minimal Risk Level (MRL) to reflect additional concerns about the database that are not covered by the uncertainty factors. The default value for a MF is 1.

Morbidity—The state of being diseased; the morbidity rate is the incidence or prevalence of a disease in a specific population.

Mortality—Death; the mortality rate is a measure of the number of deaths in a population during a specified interval of time.

Mutagen—A substance that causes mutations, which are changes in the DNA sequence of a cell's DNA. Mutations can lead to birth defects, miscarriages, or cancer.

Necropsy—The gross examination of the organs and tissues of a dead body to determine the cause of death or pathological conditions.

Neurotoxicity—The occurrence of adverse effects on the nervous system following exposure to a hazardous substance.

No-Observed-Adverse-Effect Level (NOAEL)—The dose of a chemical at which there were no statistically or biologically significant increases in frequency or severity of adverse effects seen between the exposed population and its appropriate control. Although effects may be produced at this dose, they are not considered to be adverse.

Octanol-Water Partition Coefficient (K_{ow})—The equilibrium ratio of the concentrations of a chemical in *n*-octanol and water, in dilute solution.

Odds Ratio (OR)—A means of measuring the association between an exposure (such as toxic substances and a disease or condition) that represents the best estimate of relative risk (risk as a ratio of the incidence among subjects exposed to a particular risk factor divided by the incidence among subjects who were not exposed to the risk factor). An odds ratio that is greater than 1 is considered to indicate greater risk of disease in the exposed group compared to the unexposed group.

Permissible Exposure Limit (PEL)—An Occupational Safety and Health Administration (OSHA) regulatory limit on the amount or concentration of a substance not to be exceeded in workplace air averaged over any 8-hour work shift of a 40-hour workweek.

Pesticide—General classification of chemicals specifically developed and produced for use in the control of agricultural and public health pests (insects or other organisms harmful to cultivated plants or animals).

Pharmacokinetics—The dynamic behavior of a material in the body, used to predict the fate (disposition) of an exogenous substance in an organism. Utilizing computational techniques, it provides the means of studying the absorption, distribution, metabolism, and excretion of chemicals by the body.

Pharmacokinetic Model—A set of equations that can be used to describe the time course of a parent chemical or metabolite in an animal system. There are two types of pharmacokinetic models: data-based and physiologically-based. A data-based model divides the animal system into a series of compartments, which, in general, do not represent real, identifiable anatomic regions of the body, whereas the physiologically-based model compartments represent real anatomic regions of the body.

Physiologically Based Pharmacodynamic (PBPD) Model—A type of physiologically based dose-response model that quantitatively describes the relationship between target tissue dose and toxic endpoints. These models advance the importance of physiologically based models in that they clearly describe the biological effect (response) produced by the system following exposure to an exogenous substance.

Physiologically Based Pharmacokinetic (PBPK) Model—A type of physiologically based dose-response model that is comprised of a series of compartments representing organs or tissue groups with realistic weights and blood flows. These models require a variety of physiological information, including tissue volumes, blood flow rates to tissues, cardiac output, alveolar ventilation rates, and possibly membrane permeabilities. The models also utilize biochemical information, such as blood:air partition coefficients, and metabolic parameters. PBPK models are also called biologically based tissue dosimetry models.

Prevalence—The number of cases of a disease or condition in a population at one point in time.

Prospective Study—A type of cohort study in which a group is followed over time and the pertinent observations are made on events occurring after the start of the study.

Recommended Exposure Limit (REL)—A National Institute for Occupational Safety and Health (NIOSH) time-weighted average (TWA) concentration for up to a 10-hour workday during a 40-hour workweek.

Reference Concentration (RfC)—An estimate (with uncertainty spanning perhaps an order of magnitude) of a continuous inhalation exposure to the human population (including sensitive subgroups) that is likely to be without an appreciable risk of deleterious noncancer health effects during a lifetime. The inhalation RfC is expressed in units of mg/m^3 or ppm.

Reference Dose (RfD)—An estimate (with uncertainty spanning perhaps an order of magnitude) of the daily oral exposure of the human population to a potential hazard that is likely to be without risk of deleterious noncancer health effects during a lifetime. The oral RfD is expressed in units of mg/kg/day.

Reportable Quantity (RQ)—The quantity of a hazardous substance that is considered reportable under the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA). RQs are (1) $\geq$1 pound or (2) for selected substances, an amount established by regulation either under CERCLA or under Section 311 of the Clean Water Act. Quantities are measured over a 24-hour period.

Reproductive Toxicity—The occurrence of adverse effects on the reproductive system that may result from exposure to a hazardous substance. The toxicity may be directed to the reproductive organs and/or the related endocrine system. The manifestation of such toxicity may be noted as alterations in sexual behavior, fertility, pregnancy outcomes, or modifications in other functions that are dependent on the integrity of this system.

Retrospective Study—A type of cohort study based on a group of persons known to have been exposed at some time in the past. Data are collected from routinely recorded events, up to the time the study is undertaken. Retrospective studies are limited to causal factors that can be ascertained from existing records and/or examining survivors of the cohort.

Risk—The possibility or chance that some adverse effect will result from a given exposure to a hazardous substance.

Risk Factor—An aspect of personal behavior or lifestyle, an environmental exposure, existing health condition, or an inborn or inherited characteristic that is associated with an increased occurrence of disease or other health-related event or condition.

Risk Ratio/Relative Risk—The ratio of the risk among persons with specific risk factors compared to the risk among persons without risk factors. A risk ratio that is greater than 1 indicates greater risk of disease in the exposed group compared to the unexposed group.

Short-Term Exposure Limit (STEL)—A STEL is a 15-minute TWA exposure that should not be exceeded at any time during a workday.

Standardized Mortality Ratio (SMR)—A ratio of the observed number of deaths and the expected number of deaths in a specific standard population.

Target Organ Toxicity—This term covers a broad range of adverse effects on target organs or physiological systems (e.g., renal, cardiovascular) extending from those arising through a single limited exposure to those assumed over a lifetime of exposure to a chemical.

Teratogen—A chemical that causes structural defects that affect the development of an organism.

Threshold Limit Value (TLV)—An American Conference of Governmental Industrial Hygienists (ACGIH) concentration of a substance to which it is believed that nearly all workers may be repeatedly exposed, day after day, for a working lifetime without adverse effect. The TLV may be expressed as a Time-Weighted Average (TLV-TWA), as a Short-Term Exposure Limit (TLV-STEL), or as a ceiling limit (TLV-C).

Time-Weighted Average (TWA)—An average exposure within a given time period.

Toxicokinetic—The absorption, distribution, metabolism, and elimination of toxic compounds in the living organism.

Toxics Release Inventory (TRI)—The TRI is an EPA program that tracks toxic chemical releases and pollution prevention activities reported by industrial and federal facilities.

Uncertainty Factor (UF)—A factor used in operationally deriving the Minimal Risk Level (MRL), Reference Dose (RfD), or Reference Concentration (RfC) from experimental data. UFs are intended to account for (1) the variation in sensitivity among the members of the human population, (2) the uncertainty in extrapolating animal data to the case of human, (3) the uncertainty in extrapolating from data obtained in a study that is of less than lifetime exposure, and (4) the uncertainty in using lowest-observed-adverse-effect level (LOAEL) data rather than no-observed-adverse-effect level (NOAEL) data. A default for each individual UF is 10; if complete certainty in data exists, a value of 1 can be used; however, a reduced UF of 3 may be used on a case-by-case basis (3 being the approximate logarithmic average of 10 and 1).

Xenobiotic—Any substance that is foreign to the biological system.

APPENDIX G. ACRONYMS, ABBREVIATIONS, AND SYMBOLS

AAPCC	American Association of Poison Control Centers
ACGIH	American Conference of Governmental Industrial Hygienists
ACOEM	American College of Occupational and Environmental Medicine
ACMT	American College of Medical Toxicology
ADI	acceptable daily intake
ADME	absorption, distribution, metabolism, and excretion
AEGL	Acute Exposure Guideline Level
AIC	Akaike's information criterion
AIHA	American Industrial Hygiene Association
ALT	alanine aminotransferase
AOEC	Association of Occupational and Environmental Clinics
AP	alkaline phosphatase
AST	aspartate aminotransferase
atm	atmosphere
ATSDR	Agency for Toxic Substances and Disease Registry
AWQC	Ambient Water Quality Criteria
BCF	bioconcentration factor
BMD/C	benchmark dose or benchmark concentration
BMD_X	dose that produces a X% change in response rate of an adverse effect
$BMDL_X$	95% lower confidence limit on the BMD_X
BMDS	Benchmark Dose Software
BMR	benchmark response
BUN	blood urea nitrogen
C	centigrade
CAA	Clean Air Act
CAS	Chemical Abstract Services
CDC	Centers for Disease Control and Prevention
CEL	cancer effect level
CERCLA	Comprehensive Environmental Response, Compensation, and Liability Act
CFR	Code of Federal Regulations
Ci	curie
CI	confidence interval
cm	centimeter
CPSC	Consumer Products Safety Commission
CWA	Clean Water Act
DHHS	Department of Health and Human Services
DNA	deoxyribonucleic acid
DOD	Department of Defense
DOE	Department of Energy
DWEL	drinking water exposure level
EAFUS	Everything Added to Food in the United States
ECG/EKG	electrocardiogram
EEG	electroencephalogram
EPA	Environmental Protection Agency
ERPG	emergency response planning guidelines
F	Fahrenheit
F1	first-filial generation
FDA	Food and Drug Administration
FIFRA	Federal Insecticide, Fungicide, and Rodenticide Act

FR	Federal Register
FSH	follicle stimulating hormone
g	gram
GC	gas chromatography
gd	gestational day
GGT	γ-glutamyl transferase
GRAS	generally recognized as safe
HEC	human equivalent concentration
HED	human equivalent dose
HHS	Department of Health and Human Services
HPLC	high-performance liquid chromatography
HSDB	Hazardous Substance Data Bank
IARC	International Agency for Research on Cancer
IDLH	immediately dangerous to life and health
IRIS	Integrated Risk Information System
Kd	adsorption ratio
kg	kilogram
kkg	kilokilogram; 1 kilokilogram is equivalent to 1,000 kilograms and 1 metric ton
K_{oc}	organic carbon partition coefficient
K_{ow}	octanol-water partition coefficient
L	liter
LC	liquid chromatography
LC_{50}	lethal concentration, 50% kill
LC_{Lo}	lethal concentration, low
LD_{50}	lethal dose, 50% kill
LD_{Lo}	lethal dose, low
LDH	lactic dehydrogenase
LH	luteinizing hormone
LOAEL	lowest-observed-adverse-effect level
LSE	Level of Significant Exposure
LT_{50}	lethal time, 50% kill
m	meter
mCi	millicurie
MCL	maximum contaminant level
MCLG	maximum contaminant level goal
MF	modifying factor
mg	milligram
mL	milliliter
mm	millimeter
mmHg	millimeters of mercury
mmol	millimole
MRL	Minimal Risk Level
MS	mass spectrometry
MSHA	Mine Safety and Health Administration
Mt	metric ton
NAAQS	National Ambient Air Quality Standard
NAS	National Academy of Science
NCEH	National Center for Environmental Health
ND	not detected
ng	nanogram
NHANES	National Health and Nutrition Examination Survey

NIEHS	National Institute of Environmental Health Sciences
NIOSH	National Institute for Occupational Safety and Health
NLM	National Library of Medicine
nm	nanometer
nmol	nanomole
NOAEL	no-observed-adverse-effect level
NPL	National Priorities List
NR	not reported
NRC	National Research Council
NS	not specified
NTP	National Toxicology Program
OR	odds ratio
OSHA	Occupational Safety and Health Administration
PAC	Protective Action Criteria
PAH	polycyclic aromatic hydrocarbon
PBPD	physiologically based pharmacodynamic
PBPK	physiologically based pharmacokinetic
PEL	permissible exposure limit
PEL-C	permissible exposure limit-ceiling value
pg	picogram
PEHSU	Pediatric Environmental Health Specialty Unit
PND	postnatal day
POD	point of departure
ppb	parts per billion
ppbv	parts per billion by volume
ppm	parts per million
ppt	parts per trillion
REL	recommended exposure level/limit
REL-C	recommended exposure level-ceiling value
RfC	reference concentration
RfD	reference dose
RNA	ribonucleic acid
SARA	Superfund Amendments and Reauthorization Act
SCE	sister chromatid exchange
SD	standard deviation
SE	standard error
SGOT	serum glutamic oxaloacetic transaminase (same as aspartate aminotransferase or AST)
SGPT	serum glutamic pyruvic transaminase (same as alanine aminotransferase or ALT)
SIC	standard industrial classification
SMR	standardized mortality ratio
sRBC	sheep red blood cell
STEL	short term exposure limit
TLV	threshold limit value
TLV-C	threshold limit value-ceiling value
TRI	Toxics Release Inventory
TSCA	Toxic Substances Control Act
TWA	time-weighted average
UF	uncertainty factor
U.S.	United States
USDA	United States Department of Agriculture
USGS	United States Geological Survey

USNRC	U.S. Nuclear Regulatory Commission
VOC	volatile organic compound
WBC	white blood cell
WHO	World Health Organization
>	greater than
≥	greater than or equal to
=	equal to
<	less than
≤	less than or equal to
%	percent
α	alpha
β	beta
γ	gamma
δ	delta
μm	micrometer
μg	microgram
q_1^*	cancer slope factor
–	negative
+	positive
(+)	weakly positive result
(–)	weakly negative result