



# Trichloroethylene Health Risk Assessment: Synthesis and Characterization

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National Center for Environmental Assessment-Washington Office  
Office of Research and Development  
U.S. Environmental Protection Agency  
Washington, DC

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## ABSTRACT

This assessment presents EPA's most current evaluation of the potential health risks from exposure to TCE (trichloroethylene). TCE exposure is associated with several adverse health effects, including neurotoxicity, immunotoxicity, developmental toxicity, liver toxicity, kidney toxicity, endocrine effects, and several forms of cancer. Mechanistic research indicates that TCE-induced carcinogenesis is complex, involving multiple carcinogenic metabolites acting through multiple modes of action. Under EPA's proposed (1996) cancer guidelines, TCE can be characterized as "highly likely to produce cancer in humans."

For effects other than cancer, an oral RfD of  $3 \times 10^{-4}$  mg/kg-d was based on critical effects in the liver, kidney, and developing fetus. An inhalation RfC of  $4 \times 10^{-2}$  mg/m<sup>3</sup> was based on critical effects in the central nervous system, liver, and endocrine system. Several cancer slope factors were developed, with most between  $2 \times 10^{-2}$  and  $4 \times 10^{-1}$  per mg/kg-d. Several sources of uncertainty have been identified and quantified.

The mechanistic information suggests some risk factors that may make some populations more sensitive. There are suggestions that TCE could affect children and adults differently. In addition, several chemicals have the potential to alter TCE's metabolism and clearance and subsequent toxicity; conversely, TCE exposure can augment the toxicity of other chemicals. Widespread environmental exposure to some of TCE's metabolites makes it important to consider the cumulative effect of TCE along with other environmental contaminants.

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## LIST OF ABBREVIATIONS

ADH	alcohol dehydrogenase
AIRS	Aerometric Information Retrieval System
ALDH	aldehyde dehydrogenase
ATSDR	Agency for Toxic Substances and Disease Registry
AUC	area under the curve
Cal/EPA	California Environmental Protection Agency
CEP	Cumulative Exposure Project
CH	chloral hydrate
CI	confidence interval
CYP2E1	cytochrome P450 2E1
CYP450	cytochrome P450
DCA	dichloroacetic acid, dichloroacetate
DCVC	dichlorovinyl cysteine
DCVG	dichlorovinyl glutathione
DEHP	diethylhexyl phthalate
DHEA	dehydroepiandrosterone
EPA	United States Environmental Protection Agency
GST	glutathione S-transferase
HPT	hypothalamo-pituitary-testis (axis)
LOAEL	lowest-observed-adverse-effect level
mg/kg	milligrams per kilogram body weight
mg/kg-d	milligrams per kilogram body weight per day
mg/L	milligrams per liter
mg/m <sup>3</sup>	milligrams per cubic meter
mM	millimolar (concentration)
mmol	millimoles
mRNA	messenger RNA
N	number (of cases)
NAT	N-acetyl transferase
NCI	National Cancer Institute
NHANES III	Third National Health and Nutrition Examination Survey
NOAEL	no-observed-adverse-effect level
NTP	National Toxicology Program



## LIST OF ABBREVIATIONS (continued)

OR	odds ratio
PDH	pyruvate dehydrogenase
PPAR	peroxisome proliferator activated receptor
ppm	parts per million
RfC	reference concentration
RfD	reference dose
RR	relative risk
RXR	retinoid-X receptor
SHBG	sex hormone binding globulin
TCA	trichloroacetic acid, trichloroacetate
TCE	trichloroethylene
TCOH	trichloroethanol
TEAM	Total Exposure Assessment Methodology
TLV	threshold limit value
TRI	Toxics Release Inventory
ug/L	micrograms per liter
ug/m <sup>3</sup>	micrograms per cubic meter
VHL	von Hippel-Lindau tumor suppressor gene

## PREFACE

This assessment presents EPA's most current evaluation of the potential health risks from exposure to trichloroethylene (TCE). TCE is a chemical solvent used for vapor degreasing of metals and as an intermediate in the manufacture of other chemicals. One of the chemicals most released into the environment, TCE is highly volatile, with most TCE released into the environment finding its way into the air. An important exception occurs when TCE is released into groundwater, where TCE can persist for years because of the limited contact between groundwater and air. When people are exposed to TCE, it is readily absorbed by all exposure routes and is widely distributed throughout the body.

The potential health risks of TCE in the environment have caused it to be listed as a chemical of concern across several environmental programs. TCE is listed as a hazardous air pollutant under the Clean Air Act, a toxic pollutant under the Clean Water Act, a contaminant under the Safe Drinking Water Act, a hazardous waste under the Resource Conservation and Recovery Act, and a hazardous substance under the Comprehensive Environmental Response, Compensation, and Liability Act (Superfund). It is a toxic chemical with reporting requirements under the Emergency Planning and Community Right-to-Know Act, and under the Toxic Substances Control Act certain releases must be reported to the Toxics Release Inventory.

This assessment draws on 16 state-of-the-science papers published as a supplemental issue of *Environmental Health Perspectives* (Wartenberg et al., 2000; Lash et al., 2000a; Pastino et al., 2000; Moore and Harrington-Brock, 2000; Bull, 2000; Green, 2000; Fisher, 2000; Bois, 2000a,b; Clewell et al., 2000; Boyes et al., 2000; Barton and Clewell, 2000; Chen, 2000; Rhomberg, 2000; Wu and Schaum, 2000), plus some other key references. Accordingly, this assessment focuses on analysis and interpretation rather than a compilation of study results. More detailed information on the epidemiologic and experimental studies of TCE can be found in the state-of-the-science papers and in comprehensive reviews compiled by ATSDR (1997) and EPA (1985, 1987).

As this assessment is written, it is being shaped by several new developments in risk assessment. The practice of risk assessment is evolving from a focus on one toxic effect of one pollutant in one environmental medium toward integrated assessments covering multiple effects and multiple media that incorporate information about mode of action, uncertainty, human variation, and cumulative effects of multiple pollutants in different media. This evolution responds to recommendations of the National Research Council (NRC, 1994), which have been embraced in EPA's proposed cancer guidelines (U.S. EPA, 1996).

Mode-of-action information is used throughout this assessment, both to understand the cancer hazard and to suggest common mechanisms with some of the effects other than cancer.

Mode-of-action information is also used to assess the relevance of the animal results and to identify risk factors for sensitive human populations.

Uncertainty analyses are used to quantitatively characterize the range of plausible risk estimates and to guide the choices made during the assessment. Uncertainty analyses can be particularly useful for explicitly characterizing the ability of the data and the models to provide stable, credible risk estimates.

Humans vary in their response to environmental contaminants, and risk assessors have been charged with using mode-of-action information to identify susceptible populations. Of special concern has been the potential for disproportionate risks to children. Executive Order 13045 (1997) requires “each Federal Agency shall make it a high priority to identify and assess environmental health and safety risks that may disproportionately affect children, and shall ensure that their policies, programs, and standards address disproportionate risks that result from environmental health risks or safety risks.”

Human response to an environmental contaminant can be affected by other exposures and conditions that occur in a population. EPA (1997) guidance directs “each office to take into account cumulative risk issues in scoping and planning major risk assessments and to consider a broader scope that integrates multiple sources, effects, pathways, stressors, and populations for cumulative risk analyses in all cases for which relevant data are available.”

This assessment evaluates the potential health risks of TCE in light of the available information and analyses pertinent to mode of action, uncertainty, human variation, and cumulative risks.

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The final draft of this assessment was developed and written by **V. James Cogliano**, **Cheryl Siegel Scott**, and **Jane C. Caldwell** of EPA's National Center for Environmental Assessment (NCEA), a part of the Office of Research and Development. This work, however, would not have been possible without the significant contributions of many others, for which the authors are most appreciative.

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This assessment has benefited from extensive peer involvement. Its conclusions draw from 16 state-of-the-science papers written by experts who have conducted research related to the assessment of TCE's health risks. These papers have been published as a supplemental issue of *Environmental Health Perspectives* (volume 108, supplement 2, May 2000). **Cheryl Siegel Scott** served as editor of this special issue and managed the overall development of the state-of-the-science papers. Funding was provided by EPA, the U.S. Air Force, the Occupational Safety and Health Administration, and private industry. The lead authors, affiliations listed in the state-of-the-science papers, and topics of the state-of-the-science papers include:

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These authors have individually provided many constructive comments and suggestions for this synthesis and characterization, but were not asked for consensus on its overall conclusions.

Peer involvement was also facilitated by an External Involvement Group, composed of nine representatives from private industrial organizations, public interest groups, academic research institutions, and State and Federal agencies. These representatives were asked to (1) propose additional topics for state-of-the-science papers and secure expert scientists as authors, (2) review these additional papers for balance and completeness, (3) propose topics for synthesis and characterization, (4) suggest peer reviewers, and (5) keep scientists from their sector informed. The External Involvement Group includes:

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**Lauren Zeise**, California Environmental Protection Agency.

These representatives have also provided many constructive comments and suggestions for this synthesis and characterization, but were not asked for consensus on its overall conclusions.

**Elizabeth Maull**, **Paul Cammer**, and **Paul Dugard** were instrumental in identifying authors and providing funding for some state-of-the-science papers.

# 1. SUMMARY AND CONCLUSIONS

## 1.1. OVERVIEW OF TCE HEALTH HAZARDS

An extensive database—comprising epidemiologic studies, animal bioassays, metabolism studies, and mechanistic studies—shows that trichloroethylene (TCE) exposure is associated with a wide array of adverse health effects (see Section 3.4). TCE has the potential to induce neurotoxicity, immunotoxicity, developmental toxicity, liver toxicity, kidney toxicity, endocrine effects, and several forms of cancer. Overall, similar effects are seen by oral and inhalation exposures, suggesting that TCE or its active metabolites reach their target sites after absorption from either exposure route. Special attention has been given to investigating TCE's potential to cause cancer. Epidemiologic studies, considered as a whole, have associated TCE exposure with excess risks of kidney cancer, liver cancer, lympho-hematopoietic cancer, cervical cancer, and prostate cancer. TCE has been extensively tested in animals, with mice developing liver tumors, lung tumors, and lymphomas, and rats developing kidney tumors and testicular tumors. The epidemiologic evidence is strongest at sites where the animals develop cancer, with site concordance for kidney cancer (in rats and humans), liver cancer (in mice and humans), and lympho-hematopoietic cancer (in mice and humans). TCE is also associated with cervical cancer and prostate cancer in humans, sites for which there are no corresponding animal models.

Extensive metabolic studies show that exposure to TCE results in internal exposure to a complex mixture of TCE's metabolites (see Section 3.2). Much of TCE-induced toxicity may be attributable to its metabolites, as toxicity tests show that some metabolites cause effects similar to those of TCE and, in some assays, TCE is inactive in the absence of its metabolites. Depending on the effect, the pattern of TCE-induced toxicity does not match any single metabolite, but reflects a mixture. The metabolic studies also show that the pattern of metabolite formation is different at high and low doses of TCE, and that metabolism can be altered by levels of metabolites already in the body.

This last point takes on added significance in view of widespread environmental exposure to some of TCE's metabolites (see Section 2). These exposures can be either direct (for example, TCE's metabolites trichloroacetic acid [TCA] and dichloroacetic acid [DCA] are also major byproducts of drinking water disinfection) or indirect (for example, the dry cleaning solvent perchloroethylene can be metabolized to TCA). These common exposures give rise to a background level of some metabolites through which TCE may act. Accordingly, these other exposures should not be regarded as confounding exposures in the traditional sense. Rather, they may help explain why TCE is associated with toxic effects in one study but not in another. Determining background exposure to TCE and its metabolites is important to understanding TCE-induced toxicity (see Section 1.8).

1 Many of TCE's toxic metabolites are formed through the enzyme system that also  
2 metabolizes ethanol, acetaminophen, and many other drugs and environmental pollutants (see  
3 Section 3.2). Exposure to these chemicals (for example, recent alcohol consumption) can affect  
4 enzyme levels, temporarily altering or enhancing TCE's metabolism and toxicity in a manner  
5 analogous to drug interactions known for many pharmaceuticals (see Sections 1.6 and 3.3). In  
6 addition, enzyme activity can vary significantly between individuals, through both intrinsic  
7 factors (for example, genetics) and acquired factors (for example, disease) (see Sections 1.6 and  
8 3.3). Thus, the effects of TCE can vary, depending on exposures and conditions specific to each  
9 person.

## 10 11 **1.2. MODE OF ACTION**

12 Mechanistic research on a few TCE metabolites has yielded insights into TCE's possible  
13 modes of action.<sup>1</sup> The research to date indicates that TCE-induced carcinogenesis is complex,  
14 involving multiple carcinogenic metabolites acting through multiple modes of action. Past  
15 explanations, such as the hypothesis linking mouse liver tumors to peroxisome proliferation, are  
16 not consistent with the whole of the data, and more complex hypotheses have been formulated  
17 (see Section 3.5).

18 TCE-induced mouse liver tumors may arise through multiple metabolites and multiple  
19 modes of action (see Section 3.5.1). The preponderance of evidence suggests that formation of  
20 TCE's CYP450 metabolites<sup>2</sup> is sufficient to explain the liver tumors caused by TCE (Bull, 2000;  
21 Chen, 2000). Exposure to the CYP450 metabolites chloral hydrate (CH), TCA, or DCA can  
22 cause liver tumors in mice, and DCA can also cause liver tumors in rats. A plausible mode of  
23 action is that TCE induces liver tumors through TCA and DCA modifying cell signaling systems

---

<sup>1</sup>EPA's proposed cancer guidelines define *mode of action* as "a series of key events and processes starting with interaction of an agent with a cell, and proceeding through operational and anatomical changes resulting in cancer formation." A *key event* is "an empirically observed precursor step consistent with a mode of action." "Mode of action" is contrasted with "mechanism of action," which implies a more detailed understanding and description of events, often at the molecular level, than is meant by mode of action. An agent may work by more than one mode of action, both at different sites and at the same tumor site (U.S. EPA, 1996, 1999). Mode-of-action data can be used to (1) assess the relevance of laboratory animal results to human environmental exposures, (2) identify risk factors and sensitive populations, (3) provide insight into the shape of the dose-response curve, and (4) quantify the relative sensitivity of laboratory animals and human populations.

<sup>2</sup>*Cytochrome P450* (CYP450) is a major system of enzymes that metabolize chemicals through oxidation. TCE metabolism is most strongly dependent on activity of one particular enzyme, CYP2E1. CYP2E1 activity has been found to vary among humans through both genetic and acquired factors, leading to differences in metabolism and sensitivity to TCE-induced toxicity. Involvement of CYP2E1 in TCE metabolism also raises the possibility that TCE metabolism and toxicity can be affected by exposure to other chemicals, as CYP2E1 activity can be induced by its role in metabolizing many drugs and environmental pollutants, including ethanol, acetaminophen, benzene, 1,3-butadiene, styrene, methylene chloride, chloroform, carbon tetrachloride, vinyl chloride, vinylidene chloride, and perchloroethylene (Pastino et al., 2000).



1 that control rates of cell division and cell death (Bull, 2000). Tumors from the TCA and DCA  
2 bioassays apparently arise from different mechanisms that can be distinguished from each other  
3 (see Section 3.5.1). Characterizing the tumors from the TCE bioassays as either TCA-mediated  
4 or DCA-mediated is a critical research need that limits understanding of the respective roles and  
5 interaction of TCA and DCA in the TCE-induced tumors (see Section 5).

6 There has been much less investigation of the mode of action of TCE-induced mouse  
7 lung tumors. It has been suggested that the lung tumors arise from rapid CYP2E1 metabolism of  
8 TCE in the Clara cells of the mouse lung that leads to an accumulation of CH and causes cell  
9 damage and compensatory cell replication that in turn leads to tumor formation (Green, 2000).  
10 Although this hypothesis is consistent with the higher level of CYP2E1 in mouse lung, it has not  
11 yet been determined whether accumulation of CH is a key event causing tumors or a coincidental  
12 event unrelated to the tumors (see Section 3.5.3). Moreover, several questions about this  
13 hypothesis remain unresolved. In addition, CH is clearly clastogenic and mutagenic at high  
14 doses (Moore and Harrington-Brock, 2000), raising the possibility of multiple modes of action.

15 TCE-induced rat kidney tumors may arise through multiple modes of action (see Section  
16 3.5.2). The preponderance of evidence suggests that TCE's glutathione-S-transferase (GST)  
17 metabolites<sup>3</sup> are responsible for kidney toxicity and kidney tumors (Lash et al., 2000b).  
18 Although these metabolites have not been tested in cancer bioassays, the GST metabolite  
19 dichlorovinyl cysteine (DCVC) is mutagenic (Moore and Harrington-Brock, 2000). Cytotoxicity  
20 may also be involved, as cytotoxicity is observed in both rats and humans exposed to high levels  
21 of TCE (Lash et al., 2000b). Information is lacking on whether the CYP450 metabolites also  
22 have a role in kidney tumor development.

23 Although these possible modes of action are consistent with much of the mechanistic  
24 research that has been conducted, the explanations so far fall short of identifying the active  
25 metabolites and sequence of key events involved at each cancer site (see Section 3.5). Ambiguity  
26 about active metabolites and key events leads to uncertainty in extrapolating the proposed modes  
27 of action across species. For some suggested modes of action, it is possible that most humans  
28 may be less sensitive than rats or mice, and this differential sensitivity has been addressed in the  
29 dose-response assessment (see Sections 4.5.2, 4.5.3). Species-dependent differences in the  
30 kinetics of TCE's metabolism can bring about a different proportion of metabolites that depends  
31 on dose. This, in turn, can lead to different apparent modes of action across species and across  
32 dose ranges. For example, rat kidney tumors at high experimental doses may involve high-dose  
33 cytotoxicity, while rat and human kidney tumors at lower doses may arise through a mutagenic,

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<sup>3</sup>*Glutathione-S-transferase (GST)* is an enzyme system that produces a minor quantity of TCE's metabolites. The potentially higher toxicity of these metabolites, however, may make them important agents of TCE's toxicity.

1 not cytotoxic, mode of action. Accordingly, it may not be appropriate to assume concordance of  
2 tumor site or mode of action across species or across dose ranges.

3 Recent mechanistic research has begun to investigate a more fundamental level of cellular  
4 activity (see Section 3.5), for example, TCE's effects on cell signaling and carbohydrate  
5 metabolism (Bull, 2000). Effects at this level could indirectly accelerate ongoing tumor  
6 development specific to each species. In this way, TCE could be an "opportunistic carcinogen"  
7 that can contribute to ongoing processes or conditions that induce different forms of cancer in  
8 different species or populations. This would imply that TCE poses a cancer risk to humans,  
9 although mechanism-specific animal models might not predict human cancer risks with much  
10 confidence.

### 11 12 **1.3. WEIGHT OF EVIDENCE UNDER THE PROPOSED AND CURRENT CANCER** 13 **GUIDELINES**

14 Under EPA's proposed (1996, 1999) cancer guidelines, TCE can be characterized as  
15 "highly likely to produce cancer in humans" (see Section 3.6.2). Support for this characterization  
16 is strong, including (1) association of TCE exposure with increased risks of human kidney  
17 cancer, liver cancer, lympho-hematopoietic cancer, cervical cancer, and prostate cancer; (2)  
18 induction of multiple von Hippel-Lindau (VHL) gene mutations in renal cell carcinoma patients  
19 who had been exposed to TCE; (3) induction of kidney tumors and testicular tumors in rats and  
20 liver tumors, lung tumors, and lymphomas in mice; and (4) mechanistic information suggesting  
21 that the animal tumors arise through processes that may be relevant to humans. Under EPA's  
22 current (1986) cancer guidelines, TCE would be classified as a "probable human carcinogen"  
23 (group B1), with "limited" human evidence and "sufficient" animal evidence of carcinogenicity.

24 Two areas of much past discussion are the weight of the human evidence and the  
25 relevance of the animal tumors. Compared with previous TCE assessments, the weight of the  
26 epidemiologic evidence has become stronger with the state-of-the-science analysis by  
27 Wartenberg et al. (2000) (see Sections 3.4, 3.6.1). The epidemiologic studies have recently been  
28 augmented by molecular information, in which multiple mutations of the VHL tumor suppressor  
29 gene,<sup>4</sup> primarily C-to-T changes including nucleotide 454, were found in renal cell carcinoma  
30 patients with high, prolonged TCE exposure (Brüning et al., 1997b) (see Section 3.5.2). The

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<sup>4</sup>The von Hippel-Lindau gene normally suppresses renal cell carcinomas. Mutations to this gene have been noted in kidney cancers and may be an important risk factor and mode of action for chemically induced renal cell cancer (Lash et al., 2000b). To illustrate the difference between "mode" of action and "mechanism" of action, knowledge that VHL gene mutations are involved may be enough to identify a plausible "mode" of action, whereas knowing how such modifications induce subsequent events leading to kidney cancer would be needed to identify the "mechanism" of action.

1 mechanistic research into the mode of action for each animal tumor site has begun to link TCE  
2 with disturbances in cell signaling and carbohydrate metabolism, which can lead to human cancer  
3 and other diseases (see Section 3.5). Subject to dose-response adjustments for relative human-to-  
4 animal sensitivity (see Sections 4.5.2, 4.5.3), this research makes it plausible that TCE acts  
5 through mechanisms that can cause cancer in humans.

6 These characterizations are consistent with recent assessments by other authoritative  
7 health agencies, including IARC, which classifies TCE as a “probable human carcinogen” (IARC  
8 1995) and the National Toxicology Program (NTP), which classifies TCE as “reasonably  
9 anticipated to be a human carcinogen” (NTP, 2000a).<sup>5</sup> The NTP recently considered upgrading  
10 TCE to “known to be a human carcinogen,” making a case for a stronger classification in the  
11 future (NTP, 2000b). Key research to support this classification includes further investigation of  
12 VHL gene mutations in other cohorts exposed to TCE (see Section 5). On the other hand, a  
13 sizable faction of scientists is not convinced of the relevance of the animal tumors or the strength  
14 of the epidemiologic studies, which only recently have accumulated enough power to detect  
15 associations between moderate occupational or residential TCE exposures and some relatively  
16 common cancers. After considering this alternative view, these health agencies have now  
17 converged in their assessment that TCE is “highly likely,” “probable,” or “reasonably anticipated  
18 to be” a human carcinogen.

#### 19 20 **1.4. QUANTITATIVE HEALTH REFERENCE VALUES**

21 For effects other than cancer, an oral reference dose (RfD)<sup>6</sup> of  $3 \times 10^{-4}$  mg/kg-d was based  
22 on critical effects in the liver, kidney, and developing fetus (see Section 4.3.1). These effects  
23 were observed in subchronic studies in mice and rats at doses as low as 1 mg/kg-d (see Section  
24 4.3.2). Because laboratory conditions do not necessarily represent lifetime human environmental  
25 exposure, including sensitive populations, this dose was adjusted from subchronic to lifetime  
26 exposure, from animals to humans, and from a general to a sensitive population (see Section  
27 4.3.3). In addition, humans start higher on the dose-response curve than do animals, as humans  
28 are exposed to TCE’s active metabolites from sources other than TCE, and this cumulative

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<sup>5</sup>IARC’s classification of TCE as a “probable human carcinogen” (their group 2A) is based on “limited evidence” of carcinogenicity in human studies and “sufficient evidence” in animal studies (IARC, 1995). The NTP’s listing of TCE as “reasonably anticipated to be a human carcinogen” is based on “limited evidence of carcinogenicity from studies in humans, sufficient evidence of malignant tumor formation in experimental animals, and convincing relevant information that trichloroethylene acts through mechanisms indicating it would likely cause cancer in humans” (NTP, 2000a).

<sup>6</sup>A *reference dose (RfD)* is an estimate (with uncertainty spanning perhaps an order of magnitude) of a daily exposure to the human population (including sensitive subgroups) that is likely to be without an appreciable risk of deleterious noncancer effects during a lifetime (Barnes and Dourson, 1988).

1 exposure can alter TCE's metabolism and toxicity (see Sections 1.8, 3.3, 4.3.3). Differences  
2 between average and sensitive humans were estimated in an uncertainty analysis to be about 50-  
3 fold, and a further 100-fold overall adjustment was considered appropriate for the other  
4 differences (see Section 4.3.3). This latter 100-fold uncertainty indicates the potential for future  
5 research to reduce uncertainty and improve this assessment's accuracy (see Section 5). In the  
6 end, however, the RfD was calculated by reducing the 1 mg/kg-d dose by a factor of 3,000,  
7 representing the largest divisor used by EPA in the presence of substantial uncertainty (see  
8 Section 4.3.4).

9 An inhalation reference concentration (RfC)<sup>7</sup> of  $4 \times 10^{-2}$  mg/m<sup>3</sup> was based on critical  
10 effects in the central nervous system, liver, and endocrine system (see Section 4.4.1).  
11 Occupational studies showed adverse central nervous system effects in workers at a subchronic  
12 exposure to 7 ppm (38 mg/m<sup>3</sup>) (see Section 4.4.2). To convert this to an RfC for lifetime  
13 exposure, this concentration was divided by a composite uncertainty factor of 1,000, representing  
14 a default of 10 for human variation and 100 for uncertainty in extrapolating from subchronic to  
15 lifetime exposure and effect levels to NOAELs (see Section 4.4.3).

16 The 3,000-fold and 1,000-fold uncertainty factors used in deriving the RfD and RfC,  
17 respectively, are not large, considering that the Agency for Toxic Substances and Disease  
18 Registry (ATSDR) (1997) has characterized the chronic studies as inadequate for supporting  
19 chronic health reference values.<sup>8</sup> The key uncertainty about the RfD and RfC is the relative lack  
20 of chronic studies, necessitating reliance on subchronic studies and the numerous attendant  
21 uncertainties in using subchronic studies to estimate health reference values for lifetime  
22 exposure. This assessment's use of pharmacokinetic modeling and route extrapolation allows  
23 comparison of a wider range of oral and inhalation studies, revealing that critical effects for both

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<sup>7</sup>A *reference concentration (RfC)* is 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 effects during a lifetime (U.S. EPA, 1994).

<sup>8</sup>ATSDR (1997) concluded that the available chronic-duration studies had inadequate characterization of exposure, inadequate quantification of results, and lack of endpoints suitable for deriving chronic levels. ATSDR did calculate an intermediate-duration inhalation level of 0.1 ppm, based on neurologic effects (decreased wakefulness and decreased slow-wave sleep) in rats observed at a LOAEL of 50 ppm for 6 weeks (Arito, 1994). The corresponding human-equivalent concentration (44 ppm) was divided by a composite uncertainty factor of 300 (10 for human variability, 3 for extrapolation from animals to humans, and 10 for use of a LOAEL). ATSDR also calculated an acute-duration inhalation level of 2 ppm, based on neurologic effects (fatigue and drowsiness) in six human volunteers observed at a LOAEL of 200 ppm for 5 days (Stewart, 1970). The corresponding daylong concentration (58 ppm) was divided by a composite uncertainty factor of 30 (10 for human variability and 3 for use of a minimal LOAEL). ATSDR calculated an acute-duration oral level of 0.2 mg/kg-d, based on developmental effects (decreased rearing) in mice observed at a LOAEL of 50 mg/kg-d (Fredriksson, 1993). This was divided by a composite uncertainty factor of 300 (3 for human variability in TCE metabolism, 10 for extrapolation from animals to humans, and 10 for use of a LOAEL).

1 exposure routes fall within a narrow dose range and providing strength to both the RfD and RfC  
2 determinations.

3 Several cancer slope factors<sup>9</sup> were developed, with most slope factors falling between  
4  $2 \times 10^{-2}$  and  $4 \times 10^{-1}$  per mg/kg-d. This range is supported by estimates derived for kidney cancer  
5 and liver cancer from occupational exposure to TCE, non-Hodgkin's lymphoma from exposure  
6 to drinking water contaminated with an average of 23  $\mu\text{g/L}$  TCE, and liver cancer in laboratory  
7 mice exposed to TCE (see Sections 4.5.1, 4.5.2). Because this range is supported by diverse  
8 studies and does not include the highest or lowest estimates that were calculated, it can be  
9 considered rather robust and independent of the results or methods used to analyze any single  
10 study (see Section 4.5.6).

11 The range of cancer slope factors has not been reduced to a single number. A range is  
12 reasonable in view of the risk factors that can modify the effects of TCE in different populations  
13 (see Sections 1.6, 3.3). (Ranges were not developed for the RfD and RfC, because they include  
14 sensitive individuals by applying a factor to cover human variation.) For most cancer risk  
15 factors, however, data that would allow differential risks to be quantified are lacking. Only for  
16 the GST polymorphism that modifies the kidney cancer risk are data available, indicating a  
17 fourfold increased risk for the more sensitive population. Because the modifying effect of most  
18 risk factors cannot be quantified at this time, this assessment proposes instead that risk assessors  
19 use the upper end of the slope factor range for susceptible populations having risk factors for  
20 TCE-induced cancer. Although the extremes of the slope factor range are not based on data from  
21 more- or less-susceptible populations, this approach emphasizes the possibility of different risks  
22 in different circumstances, identifies risk factors that may increase susceptibility to TCE's  
23 effects, and provides a practical way to adjust risk estimates to reflect differential susceptibility.

24 The purpose of a risk assessment can also affect the choice of a value from the slope  
25 factor range. An assessment of maximum individual risk would use the upper end of the slope  
26 factor range, while an assessment of the number of cancer cases in a general population could use  
27 the midpoint of the range. This implies that the high end of the slope factor range is appropriate

---

<sup>9</sup>A *slope factor* is an estimate of a carcinogen's potency, characterized as a plausible upper bound on the increased human cancer risk from lifetime exposure to an average dose of 1 mg/kg-d. That is, the slope factor estimates a bound on the risk per mg/kg-d, accordingly, the slope factor is expressed in units of inverse lifetime-average dose, or  $(\text{mg/kg-d})^{-1}$ . Multiplying a slope factor by a lifetime-average dose (in mg/kg-d) yields a plausible upper bound on the increased probability of developing cancer from exposure to the carcinogen. A *unit risk* is analogous to a slope factor, but expressed in units of inverse lifetime-average ambient air concentration  $(\mu\text{g/m}^3)^{-1}$  or inverse lifetime-average drinking water concentration  $(\mu\text{g/L})^{-1}$  instead of inverse lifetime-average dose  $(\text{mg/kg-d})^{-1}$ . Unit risks are convenient when exposure is expressed in terms of environmental concentrations ( $\text{g/m}^3$  or  $\text{g/L}$ ). Unit risk estimates are based on particular exposure assumptions, specifically, a 70-kg adult drinking 2 L/d and breathing 20  $\text{m}^3/\text{d}$ . When applied to other populations with different exposure factors—for example, children—unit risk estimates should be adjusted accordingly.

1 for susceptible individuals but is less descriptive of the rest of the population. The 20-fold span  
2 of the slope factor range is smaller than the uncertainty in dose estimates from the  
3 pharmacokinetic models (see Table 4-1), suggesting that the range may, in some cases,  
4 underestimate high-end risk.

5 For less-than-lifetime exposure, current risk assessment practice typically assumes that  
6 cancer risk is proportional to exposure duration, for example, exposure for 7 years of a 70-year  
7 human lifespan would carry one-tenth the risk of lifetime exposure.<sup>10</sup> There is some evidence for  
8 TCE to suggest that this practice may underestimate the risk from less-than-lifetime exposures  
9 (see Section 4.5.2). Accordingly, tempering the assumption of duration-proportionality may be  
10 warranted in applications involving less-than-lifetime exposure.

11 The continuing development of revised cancer guidelines (U.S. EPA, 1996, 1999) has  
12 raised expectations that nonlinear approaches<sup>11</sup> may replace the linear extrapolation used to  
13 estimate cancer slope factors for TCE. This assessment has pursued nonlinear approaches for  
14 several tumor sites. The key limitation to the nonlinear analyses is the uncertain identity of the  
15 active metabolites and key events involved in TCE-induced cancer. This assessment's  
16 consideration of potential nonlinear approaches indicates that concern for cancer would extend  
17 down to doses of  $3 \times 10^{-4}$  and  $8 \times 10^{-4}$  mg/kg-d for liver tumors and testicular tumors, respectively  
18 (see Sections 4.5.2, 4.5.5). These doses are comparable to the RfD for effects other than cancer,  
19 indicating the importance of considering all health effects in any risk assessment of TCE.

## 20 21 **1.5. UNCERTAINTY**

22 Several sources of uncertainty have been identified and quantified for TCE.<sup>12</sup>  
23 Consideration of these uncertainties has shaped the choices made in this assessment and

---

<sup>10</sup>Cancer risk is calculated by multiplying the slope factor by the lifetime average daily dose (*LADD*), defined as  $LADD = (C \times IR \times ED) / (BW \times LT)$ , where *C* is the concentration, *IR* the intake rate, *ED* the exposure duration, *BW* the body weight, and *LT* the lifetime (U.S. EPA, 1992a).

<sup>11</sup>Because nonlinear dose-response curves can have substantial *model uncertainty* below the experimental doses, these curves are not extrapolated below the observed data. Instead, the risk assessment discusses current understanding of the phenomena that may be occurring at lower doses. Factors to be considered include (1) nature of the observed response, (2) shape of the observed dose-response curve, (3) human sensitivity compared with experimental animals, (4) human variation in sensitivity, and (5) human exposure (U.S. EPA, 1996, 1999).

<sup>12</sup>Uncertainty arises because study conditions differ from conditions of human environmental exposure. Consequently, risk assessments typically involve several *extrapolations*: from laboratory animals to humans, from experimental doses to environmental levels, from one exposure route to another, from one exposure pattern to another, and from small samples to large, more heterogeneous populations.

One type of uncertainty stems from different interpretations of the available data (known as model uncertainty), another from estimation errors due to incomplete or imprecise data (parameter uncertainty).

An understanding of uncertainty can be used (1) to make more informed choices during the conduct of a risk assessment, and (2) to characterize the range of plausible risk estimates for different populations.

1 described the range of estimates that are consistent with existing data and current scientific  
2 understanding.

### 3 4 **1.5.1. Model Uncertainty**<sup>13</sup>

5 In this assessment, the two major areas of model uncertainty are pharmacokinetics and  
6 low-dose extrapolation.

7 The two pharmacokinetic models (Fisher, 2000; Clewell et al., 2000) reveal the existence  
8 of substantial model uncertainty, with risk estimates that differed by 15-fold (see Table 4-4).  
9 Fitting these models to additional data sets (Bois, 2000a, 2000b) produced calibrated models that  
10 yielded more compatible results and reduced this source of model uncertainty (see Section 4.2.1).

11 The choice between linear and nonlinear extrapolation<sup>14</sup> to low doses creates two distinct  
12 classes of estimates (see Sections 4.5.2, 4.5.3). This dichotomous uncertainty stems from  
13 different strongly held and widely held interpretations of the information on TCE's mode of  
14 action (see Section 3.5). Accordingly, this assessment used both linear and nonlinear  
15 approaches, the former to bound the risks and the latter to demonstrate the extent of uncertainty  
16 and value of further research into mode of action and human variation.<sup>15</sup> In addition, this  
17 assessment made efforts to develop risk estimates from human studies as an alternative to  
18 extrapolating from animal models. Average exposure in one human study was close to the  
19 occupational standard, reducing the uncertainty of high- to low-dose extrapolation.  
20

---

<sup>13</sup>*Model uncertainty* refers to a lack of knowledge needed to determine which scientific theory on which a model is based is correct. In risk assessment, model uncertainty is reflected in alternative choices for model structure, dose metrics, and extrapolation approaches. Other sources of model uncertainty concern whether surrogate data are appropriate, e.g., using data on adults to make inferences about children. The full extent of model uncertainty cannot be quantified, only models that have been analyzed. Model uncertainty is expressed through separate analyses yielding alternative estimates, not as a single estimate or distribution made by combining estimates from incompatible models. Combining results of incompatible models to create hybrid risk estimates can undermine the value of having preferred models (NRC, 1994, p. 174).

<sup>14</sup>*Linear extrapolation* implies that risk decreases proportionally with dose below the experimental data. *Sublinear extrapolation* (often called by the less specific term *nonlinear extrapolation*) implies that risk decreases more than proportionally.

Toxicologists often speak of a *threshold dose* below which an individual does not respond. Risk assessments generally do not use this term, as experimental data are not able to estimate thresholds with much confidence. For example, a response that is not statistically significant does not indicate a threshold, rather it can be consistent with a small risk that falls below the experiment's power of detection.

<sup>15</sup>Mode of action is not the only determinant of the shape of a dose-response curve. *Human variation* also affects the shape by spreading the responses in a heterogeneous population over a wider dose range (see footnotes 17, 21). Another factor is *background exposure*, which determines where to place an incremental environmental exposure on the overall dose-response curve (see footnote 26).

1 **1.5.2. Parameter Uncertainty**<sup>16</sup>

2           Uncertainty analyses and confidence intervals were developed for some of this  
3 assessment’s key pharmacokinetic and dose-response parameters. Each description of parameter  
4 uncertainty assumes that the underlying model is valid.

5           Uncertainty in the pharmacokinetic data was analyzed and used to gauge which  
6 applications could be supported by stable models. Confidence intervals spanned approximately  
7 100-, 5,000-, and 14,000-fold for doses in the liver, kidney, and lung, respectively (see Table 4-1,  
8 Section 4.2.2). The unstable model estimates for kidney and lung resulted in use of default  
9 scaling methods for these sites. For all sites, median dose estimates were used in subsequent  
10 calculations.

11           Uncertainty in the animal dose-response data is reflected by the ratio of ED<sub>10</sub>s to LED<sub>10</sub>s.  
12 These generally do not exceed a factor of 2 (Rhomberg, 2000).

13  
14 **1.5.3. Consideration of Multiple Areas of Uncertainty**

15           How to combine these individual aspects of uncertainty is an unresolved question in risk  
16 assessment. Multiplying the sizes of the individual confidence intervals is not recommended, as  
17 this would yield an overall confidence interval whose extremes are too improbable and whose  
18 range is too wide to be of practical use. There are more defensible statistical approaches for  
19 combining multiple uncertain quantities, but these depend on understanding the interrelationships  
20 between the uncertain quantities and on addressing model uncertainty by assigning numerical  
21 weights to the different models. Because this question is unresolved, this assessment has adopted  
22 EPA’s 3,000-fold limit on uncertainty factors for RfDs and RfCs and has developed a cancer  
23 slope factor range that reflects a middle range of estimates that are supported by several sources  
24 of data and several lines of reasoning. This implies, however, that the range may, in some cases,  
25 underestimate high-end risk.

26           It has been suggested that to facilitate probabilistic risk assessment, slope factors be  
27 replaced by slope factor distributions. The quantifiable uncertainties (for example, the twofold  
28 LED<sub>10</sub>-to-ED<sub>10</sub> range) are less important than others that have not been quantified (for example,  
29 pharmacokinetic model uncertainty and parameter uncertainties). To avoid misleadingly narrow  
30 uncertainty distributions that ignore the most important sources of uncertainty, this assessment  
31 does not recommend distributions based on uncertainties of secondary importance.

---

<sup>16</sup>*Parameter uncertainty* refers to lack of knowledge about the values of a model’s parameters. This leads to a distribution of values for each parameter. Common sources of parameter uncertainty include random measurement errors, systematic measurement errors, use of surrogate data instead of direct measurements, misclassification of exposure status, random sampling errors, and use of an unrepresentative sample. Most types of parameter uncertainty can be quantified by statistical analysis.



1           Consideration of nonlinear dose-response models draws attention to the uncertainty in  
2 estimating the point where the dose-response curve begins to turn sharply upward.  
3 Overestimating the dose where the curve turns sharply upward could lead to the error of  
4 declaring a dose “safe” when the risk actually could be quite high. Another consequence of using  
5 nonlinear dose-response curves is the need to determine background exposure. In the case of  
6 TCE, there is substantial background exposure to some of its toxic metabolites. If their dose-  
7 response curves are steep (as for DCA-induced liver tumors in mice), the incremental risk can be  
8 greater in a population with high background exposure (see Section 1.8).

9           The uncertainties quantified for TCE may be similar to what would be found for other  
10 chemicals if pertinent analyses were performed. Thus, the practical importance of describing  
11 TCE uncertainty is not to decrease confidence in the TCE estimates, but to understand that all  
12 risk estimates are uncertain, and that the true risks can be either higher or lower. This assessment  
13 uses central estimates, not extreme values, for several major sources of uncertainty. The  
14 resulting risk estimates are supported by several sources of data and several lines of reasoning,  
15 providing some measure of confidence that the risk estimates are robust and not likely to be  
16 substantially changed by a single new study or analysis.

## 18 **1.6. HUMAN VARIATION AND SENSITIVE POPULATIONS**

19           The mechanistic information on TCE indicates a potential for considerable human  
20 variation<sup>17</sup> and suggests some risk factors<sup>18</sup> that would make a population more sensitive. Further  
21 research is needed to estimate the magnitude of the increased risk (see Section 5).

### 23 **1.6.1. Metabolic Differences**

24           Because TCE’s metabolites contribute to its toxicity, differences in metabolism can lead  
25 to differences in response (see Sections 3.2, 3.3). TCE’s metabolism is extremely complex, and  
26 variation in one metabolic reaction can shift activity from one metabolic pathway to another,

---

<sup>17</sup>*Human variation* refers to person-to-person differences in *susceptibility* due to differences in exposure or differences in biological *sensitivity*. Differences in biological sensitivity can be linked to inherited factors (e.g., genetics) or acquired factors (e.g., disease). Although human variation and uncertainty both can be characterized as ranges or distributions, they are fundamentally different concepts. Uncertainty can be reduced by further research that supports a model or improves a parameter estimate, but human variation is a fact that can be better characterized, but not reduced, by further research. Fields other than risk assessment use “variation” or “variability” to mean dispersion about a central value, including measurement errors and other random errors that risk assessors address as uncertainty.

<sup>18</sup>A *risk factor* is a condition (e.g., genetics or disease) or exposure (e.g., alcohol or chlorinated solvents) associated with a particular risk. For example, in the context of traffic accidents, known risk factors include alcohol consumption, excessive speed, and bad weather. In a particular case, causation is often attributed to a combination of risk factors.

1 yielding different proportions of metabolites that, in turn, yield different toxicity. Because of this  
2 complexity, metabolic differences may not lead to proportionate differences in risk, but do  
3 indicate a potential for differential risks.

4 For GST metabolism, genetic polymorphisms<sup>19</sup> have been identified and linked to an  
5 increased risk of TCE-induced kidney cancer (see Sections 3.3, 3.4.3). The California  
6 Environmental Protection Agency (Cal/EPA) (1999) has estimated that these may lead to  
7 fourfold differences in kidney cancer risk (see Section 4.5.1). For CYP2E1 metabolism, several  
8 investigators have found up to 50-fold variations in small groups of humans (see Section 3.3).  
9 This suggests a potential for considerable differences in response.

10 It has been asserted that increases in metabolic rate due to enzyme induction have little  
11 effect on the amount of metabolite formed in the liver (Kedderis, 1997).<sup>20</sup> This assertion was  
12 derived from physiologically based pharmacokinetic modeling exercises reported in a poster  
13 abstract (Kedderis, 1996). A consequence of this assertion is that first-pass metabolism from oral  
14 dosing would be virtually 100%, leaving no TCE to circulate throughout the body. More  
15 complex multiple-pathway pharmacokinetic models (Fisher, 2000; Clewell et al., 2000) show  
16 that this is not the case with concentrations of TCE circulating throughout the body being stored  
17 as fatty tissue. Moreover, even if the total amount of metabolites formed is unchanged, the  
18 balance between the rates of formation of GST metabolites and CYP450 metabolites would  
19 clearly be altered by a relative induction of one enzyme as opposed to another. These  
20 considerations suggest that enzyme induction and inhibition may be involved in susceptibility to  
21 the effects of TCE.

### 22 23 **1.6.2. Disease**

24 Some of TCE's effects may result from its ability to disturb carbohydrate metabolism and  
25 cell signaling (Bull, 2000). Diabetes is a disease caused by such disturbances, and diabetics are  
26 at greater risk for liver cancer, kidney cancer, and many other effects. Further, uncontrolled  
27 diabetes causes induction of CYP2E1, favoring increased formation of toxic metabolites. This  
28 suggests that diabetics may be sensitive to effects from TCE (see Section 3.3).

---

<sup>19</sup>A *polymorphism* is the presence of two or more distinct types due to genetic variation in a population. A familiar example is the polymorphism of blood types O, A, B, and AB. A polymorphism of metabolic enzymes indicates variation in metabolic activity across groups of people. The genetic basis of polymorphisms implies that they can be differently distributed across racial or ethnic groups.

<sup>20</sup>Under this hypothesis, known as *blood flow limitation*, the metabolic rate without enzyme induction is so rapid that all TCE would be metabolized, hence metabolite production would be limited only by the amount of TCE present in the blood flowing into the liver. Increasing the metabolic rate would have no effect, as there would be no TCE left to metabolize.

1 Alcohol, like TCE, is metabolized by CYP2E1, alcohol dehydrogenase (ADH), and  
2 aldehyde dehydrogenase (ALDH). Concurrent exposure to TCE and alcohol can exacerbate the  
3 metabolism and acute effects of both in a manner similar to acute drug-alcohol interactions  
4 known for many pharmaceuticals. More importantly, chronic alcohol consumption can induce  
5 long-term 20-fold increases in CYP2E1 levels, favoring increased formation of toxic metabolites  
6 (see Section 3.3).

### 7 8 **1.6.3. Gender Differences**

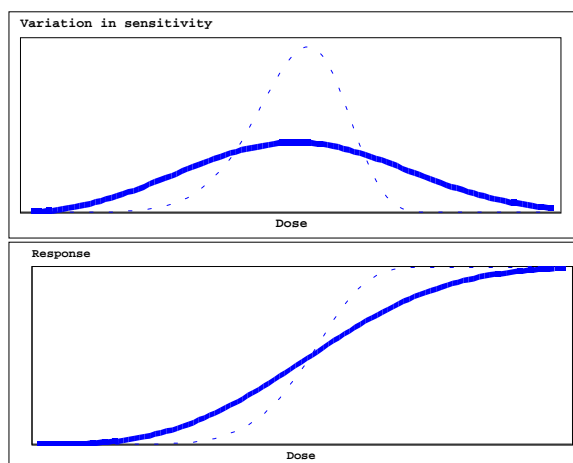
9 TCE exposure has been linked to autoimmune diseases that occur mostly in women. In  
10 addition, recent epidemiologic studies have linked TCE exposure to cervical cancer. These  
11 differences in risk may be related to either pharmacokinetic or pharmacodynamic differences (see  
12 Section 3.3).

### 13 14 **1.6.4. Some Implications**

15 Identifying risk factors that vary across the human population allows us to begin  
16 identifying who is likely to be more sensitive. Human variation is a determinant of the shape of a  
17 population dose-response curve, which can be different from the dose-response curve for an  
18 individual.<sup>21</sup> Understanding the functional relationship between a risk factor and the associated  
19 disease is a critical research need that presently prevents estimating the differential risk faced by  
20 sensitive populations (see Section 5).

---

<sup>21</sup>To illustrate, consider two sensitivity distributions, centered at the same dose, for a homogeneous population (see thin line in upper figure) and a heterogeneous population (see thick line in upper figure). The corresponding population dose-response curves have different shapes, with the curve for the heterogeneous population spread over a wider range (see lower figure). This occurs even when the mode of action suggests a threshold, because the threshold would vary across a heterogeneous population and the population dose-response curve would be indistinguishable from those associated with nonthreshold models. In the human population, genetic and lifestyle factors contribute to variation in sensitivity that spreads the dose-response curve over a wider range (Lutz, 1990).



1 **1.7. DIFFERENTIAL RISKS TO CHILDREN**

2 There are several reasons to suspect that TCE could affect children and adults  
3 differently.<sup>22</sup>

4  
5 **1.7.1. Exposure Differences**

6 Nursing is an exposure pathway unique to children. From its lipophilic nature, TCE  
7 would be expected to be present in milk. Limited data indicate that TCE has been detected in  
8 each of eight samples of human milk from four U.S. urban areas, but levels were not reported  
9 (ATSDR, 1997). Quantification of levels of TCE and its metabolites in milk, in both highly  
10 exposed and relatively unexposed populations, is a critical research need that presently prevents  
11 comparing levels in milk with levels allowed in drinking water (see Section 5). The widely  
12 accepted benefits of nursing highlight the value of minimizing the exposure of nursing mothers  
13 to TCE.

14 The cancer unit risk estimates (see Section 4.5) assume that mg/kg-d is an appropriate  
15 measure of dose and incorporate exposure factors that are based on adults (specifically, 2 L/d  
16 drinking water intake, 20 m<sup>3</sup>/d air intake, and 70 kg body weight). Relative to body weight,  
17 however, children drink more water, eat more food, and breathe more air than do adults (U.S.  
18 EPA, 1999). When assessing risks from less-than-lifetime exposure that occurs during  
19 childhood, good exposure assessment practice would replace these adult exposure factors with  
20 childhood exposure factors (U.S. EPA, 1999).<sup>23</sup>

21  
22 **1.7.2. Pharmacokinetic Differences**

23 Children—especially infants—and adults can have different levels of metabolizing  
24 enzymes (see Sections 3.2, 3.3). CYP2E1 is present in children, although levels are lower than in  
25 adults. The same is true for some enzymes that clear TCE and its metabolites from the body.  
26 Such differences may be responsible for early-life persistence in the body of trichloroethanol  
27 (TCOH), the only TCE metabolite studied in infants, children, and adults. Half-life is 8 days in  
28 adults, 10 days in children, 28 days in full-term infants, and 40 days in preterm infants (Renwick,  
29 1998). This trend runs counter to the general expectation that smaller organisms metabolize and

---

<sup>22</sup>Children are not only a subpopulation, rather childhood is a sequence of life stages that affect the whole population. EPA has long been concerned about environmental risks to children and has identified areas where risks can be different in children and adults (Farland, 1992: (1) different exposures, (2) different remaining life expectancies (early exposures leave more time for latent effects to develop), (3) different internal doses from the same external dose (pharmacokinetic differences), and (4) different responses to the same internal dose (pharmacodynamic differences).

<sup>23</sup>For example, to adjust the drinking water unit risk for a 9-kg infant who drinks 1 L/d (instead of a 70-kg adult who drinks 2 L/d), multiply the unit risk by  $(1 \text{ L/d} / 2 \text{ L/d}) / (9 \text{ kg} / 70 \text{ kg}) = 3.9$ .

1 clear chemicals more rapidly; instead, TCOH persists longer in children than in adults, longer in  
2 infants than in children, and longer in preterm than in full-term infants. These differences do not  
3 necessarily imply greater sensitivity, as we do not know which metabolites are responsible for  
4 each adverse effect, but it does indicate a need for caution, as limited evidence suggests that TCE  
5 metabolism and clearance are different in infants and children compared to adults.

### 6 7 **1.7.3. Pharmacodynamic Differences**

8 TCE's neurotoxic potential suggests an increased risk during childhood, a period of rapid  
9 brain development (see Sections 3.4.1, 3.3). TCE's potential for developmental and endocrine  
10 effects also supports a concern for childhood exposure (see Section 3.4.5). Cancer, too, is an  
11 effect where children may be at higher risk. An accepted concept in carcinogenesis is that young  
12 animals are usually more susceptible to the carcinogenic activity of a chemical than are adults  
13 (McConnell et al., 1992).<sup>24</sup> Because TCE's metabolites can cross the placenta, the period of  
14 concern would extend to prenatal exposure. This concern is supported by a larger risk of  
15 childhood leukemia observed after maternal exposure to TCE-contaminated drinking water  
16 during the prenatal period (MA-DOH, 1997).

### 17 18 **1.7.4. Some Implications**

19 The health reference values developed in this assessment (see Sections 4.3–4.5) do not  
20 address the exposure, pharmacokinetic, and pharmacodynamic considerations discussed here.  
21 For example, the uncertainty factor for human variation is based on data collected in healthy  
22 adults. Some assurance that this assessment does not understate risks to children comes from  
23 consideration of sensitive test systems such as mouse liver. This sensitivity, though, is not  
24 related to the reasons that children and adults may differ. Consequently, it may be appropriate to  
25 consider a further factor to address the potential for differential risks to children (see Section 5).

## 26 27 **1.8. CUMULATIVE RISKS INVOLVING TCE**

28 Several chemicals have the potential to alter TCE's metabolism and clearance and  
29 subsequent toxicity. Much TCE-induced toxicity is attributed to its metabolites, and risks from  
30 TCE exposure can depend on background exposure to its metabolites. Some metabolites are  
31 highly present in the environment (see Section 2), from both direct sources (for example,

---

<sup>24</sup>Although much has been made of the qualitative finding that perinatal exposure rarely induces tumors not found with adult exposures, quantitatively, perinatal exposure in conjunction with adult exposure usually increases the incidence and reduces the latent period of a given tumor. For example, in a survey of 22 chemicals tested for perinatal exposure (TCE and its metabolites have not been so tested), a higher incidence of neoplasms was found when animals were exposed during the last third of pregnancy (McConnell et al., 1992).

1 ingestion of TCA and DCA as byproducts of drinking water disinfection) and indirect sources  
2 (for example, metabolism of other chlorinated solvents to TCA). Hence, these exposures and  
3 conditions can modify the effects of TCE on a population.<sup>25</sup>

4 At the same time, TCE exposure can augment toxicity induced by other chemicals.  
5 Among these, support is strongest for TCE to exacerbate the effects of concurrent exposure to  
6 alcohol or chlorinated solvents by inducing shared metabolic enzymes (see Section 3.3).

7

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<sup>25</sup>Known as *cumulative risk assessment*, this area of inquiry focuses on a population and considers all chemicals and stressors that can affect the population. A cumulative risk assessment goes beyond the effects of each chemical individually to consider (1) how exposure to other chemicals and stressors can alter the toxicity of a chemical, (2) how exposure to a chemical can alter the toxicity of other chemicals and stressors, and (3) how genetics, life stage, lifestyle, diseases, and other conditions in an individual—factors associated with sensitivity—can affect expression of a chemical’s toxicity. In this way, cumulative risk assessments consider human-chemical interactions as well as chemical-chemical interactions.

1 When a nonlinear dose-response curve is assumed, high background exposure can imply  
2 greater susceptibility to incremental exposures.<sup>26</sup> Consequently, an estimate of background  
3 exposure is needed to determine where to place an incremental exposure to TCE on the dose-  
4 response curve, as the size of the increased risk is different in different regions of the dose-  
5 response curve. Finding a safe dose in an otherwise unexposed population does not mean that  
6 that dose is safe when background exposures are considered. This aspect of susceptibility is a  
7 new feature that has not been addressed in past risk assessments, but will become important in  
8 future assessments that consider nonlinear dose-response curves (see Section 5).

9 This assessment has begun to address cumulative risk in several ways:

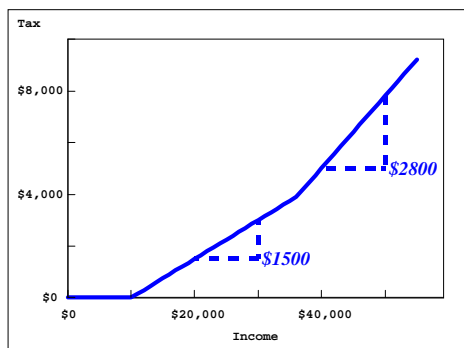
- 10 < Developing a pharmacokinetic model (at EPA’s National Exposure Research Laboratory)  
11 for concurrent exposure to TCE, TCA, and DCA. This will enable risk assessors at  
12 different geographic sites to tailor the model to the cumulative exposures specific to their  
13 sites (see Section 4.2.1).
- 14 < Identifying diseases and other risk factors that may make some individuals more sensitive  
15 to TCE’s effects (see Sections 1.6, 3.3).
- 16 < Including a modifying factor in the RfD to reflect that background exposures to TCE and  
17 its metabolites can be higher in humans than in laboratory animals (see Sections 1.4,  
18 4.3.3). An analogous modifying factor was not used in the RfC because the exposed  
19 workers on which the RfC was based, unlike the laboratory animals on which the RfD  
20 was based, are likely to have had background exposures comparable to those of the  
21 general human population.
- 22 < Developing a range of cancer slope factors to permit risk assessors to choose a slope  
23 factor based on a population’s risk factors and background exposures (see Sections 1.4,  
24 4.5.6).

---

<sup>26</sup>The correlation between background exposure and susceptibility is a property of sublinear dose-response curves in general. A familiar analogy is how federal income tax rates increase with income. For example, the increased tax on \$10,000 additional income can be (see figure at right):

- \$0 if there is no other income.
- \$1500 if added to \$20,000 income.
- \$2800 if added to \$40,000 income.

In this analogy, the same incremental income (“dose”) results in a tax (“effect”) that depends on background income.



## 2. EXPOSURE CHARACTERIZATION

1 This exposure characterization covers TCE, several metabolites of TCE, and other parent  
2 compounds that produce a similar profile of metabolites (see Figure 2-1). Direct exposure to  
3 TCE's metabolites or to parent compounds that produce these metabolites can alter or enhance  
4 TCE's metabolism and toxicity by generating higher internal metabolite concentrations than  
5 would result from TCE exposure by itself.

6 This characterization draws from the state-of-the-science paper on exposure (Wu and  
7 Schaum, 2000). More detailed exposure information can also be found in a supplemental report  
8 (Wu and Schaum, 2001).

### 2.1. ENVIRONMENTAL SOURCES

11 The major use of TCE is as a degreaser for metal cleaning operations. It is also used as a  
12 paint stripper, adhesive solvent, ingredient in paints and varnishes, and in the manufacture of  
13 organic chemicals. Releases from nonanthropogenic activities are negligible. TCE is on the list  
14 for reporting to the Toxics Release Inventory (TRI). Reported releases into air predominate over  
15 other types. Reported releases decreased by a third between 1987 and 1990 and have been stable  
16 since then.

17 TCE's metabolites and their other parent compounds are also generally used in a wide  
18 variety of manufacturing industries. Exceptions to this pattern are TCA and DCA, which are  
19 formed as byproducts of drinking water chlorination; 1,1-dichloroethane, which can be formed  
20 by biodegradation of 1,1,1-trichloroethane in landfills and other anaerobic environments; and  
21 perchloroethylene, whose releases have come primarily from the large number of local dry  
22 cleaning operations.

23 The TRI is the primary source of this information and can be considered recent and well  
24 documented. The major uncertainty is the number of minor releases that occur, which are  
25 exempt from reporting but, collectively, may be important.

### 2.2. ENVIRONMENTAL FATE

28 The chemical properties of TCE are well documented and widely accepted. Because of  
29 its high vapor pressure, TCE in the atmosphere is expected to be present primarily in the vapor  
30 phase rather than adsorbed to particles. Some removal from the atmosphere during wet  
31 precipitation is expected because of the moderate solubility of TCE in water (1.1 g/L). The  
32 major degradation process affecting vapor-phase TCE is photooxidation by hydroxyl radicals  
33 (half-life of 1–11 days).



1 The dominant fate of TCE released to surface soils or surface waters is volatilization to  
2 the air. Because of its moderate water solubility, TCE in soil (for example, landfills) has the  
3 potential to migrate into groundwater. The relatively frequent detection of TCE in groundwater  
4 confirms its mobility in soils. Biodegradation in soil and groundwater is thought to be slow  
5 (half-life on the order of months to years). For releases to surface waters, bioconcentration,  
6 biodegradation, and adsorption to sediments and suspended solids are thought to be insignificant.

### 7 8 **2.3. EXPOSURE CONCENTRATIONS**

9 No statistically based national sampling programs have been conducted that would allow  
10 estimates of true national means for any environmental medium. A substantial amount of air  
11 data, however, has been collected and summarized. TCE has been detected in the air throughout  
12 the United States. Ambient air measurement data can be obtained from the Aerometric  
13 Information Retrieval System (AIRS)<sup>27</sup>, which contains about 1,200 measurements from 25  
14 States during 1985–1998. Air levels in 1998 can be summarized as follows: range=0.01–3.9  
15  $\mu\text{g}/\text{m}^3$ , mean=0.88, median=0.32, 90th percentile=1.76.

16 TCE ambient air concentrations in 1990 were modeled for all census tracts of the  
17 continental United States as part of EPA’s Cumulative Exposure Project (CEP)<sup>28</sup>. The modeling  
18 suggests that 97% of the census tracts have TCE concentrations ranging from 0 to 1.5  $\mu\text{g}/\text{m}^3$ .  
19 The average level was estimated as 0.37  $\mu\text{g}/\text{m}^3$  and the maximum as 32  $\mu\text{g}/\text{m}^3$ . The averages and  
20 percentiles can be interpreted as population-weighted values because all census tracts have  
21 roughly equal populations (but vary in geographic size). The modeling uses population  
22 weighting for its estimates of concentration within each census tract. CEP data suggest a pattern  
23 of generally low TCE levels in rural areas, higher levels in urban areas, and highest levels in  
24 small commercial or industrial sectors across most States. The pattern is consistent with the  
25 monitoring data.

26 These modeled values should be interpreted with caution. They are not as reliable as  
27 measured values for specific locations. AIRS data show an average for 1990 across 59  
28 monitoring stations of 1.84  $\mu\text{g}/\text{m}^3$ . This is much higher than the national average from CEP of  
29 0.37  $\mu\text{g}/\text{m}^3$ . An important difference, though, is that the CEP estimate represents all areas of the  
30 continental United States, whereas the 1990 AIRS data for TCE represent only 59 monitors  
31 located in eight States.

32 TCE has been reported in rainwater, surface water, groundwater, drinking water, and  
33 seawater. ATSDR reports that TCE is the most frequently reported organic contaminant in

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<sup>27</sup> [www.epa.gov/airsdata](http://www.epa.gov/airsdata)

<sup>28</sup> [www.epa.gov/CumulativeExposure/air/air.htm](http://www.epa.gov/CumulativeExposure/air/air.htm)

1 groundwater and has estimated that between 9% and 34% of drinking water supply sources have  
2 some TCE contamination. Most municipal water supplies that do not use contaminated  
3 groundwater, however, are in compliance with the maximum contaminant level of 5 µg/L.

4 TCE has been reported in marine sediments, marine invertebrates, marine mammals,  
5 foods, human milk, and human urine and blood. The food with the highest reported mean  
6 concentration is butter and margarine (73.6 ppb).

7 Biological monitoring is an important supplement to environmental monitoring for  
8 characterizing human exposure, as environmental monitoring data (especially for air) may not be  
9 representative of actual exposures. TCE has been most frequently detected in persons exposed  
10 through occupational degreasing operations. In 1982, TCE was detected in each of eight human  
11 milk samples from four U.S. urban areas. NHANES III reported that, from 1988 to 1994, TCE  
12 levels in whole blood were below the detection limit of 0.01 mg/L for about 90% of the people  
13 sampled.

#### 14 15 **2.4. EXPOSURE PATHWAYS AND LEVELS**

16 Most people are exposed to TCE through drinking water, air, or food. TCE has been  
17 detected in human milk samples from the general population; consequently, nursing infants may  
18 be exposed. Also, because TCE can be present in soil, children may be exposed through  
19 activities such as playing in or ingesting soil.

20 AIRS monitoring data for 1998 indicate a mean outdoor air level of about 0.8 µg/m<sup>3</sup>.  
21 Based on an inhalation rate of 20 m<sup>3</sup>/d, intake by this pathway is about 18 µg/d. This is  
22 consistent with ATSDR, which reported an average daily air intake for the general population of  
23 11–33 µg/d. Total inhalation exposures are likely to be higher, because limited studies suggest  
24 that indoor air may contribute more to overall exposure than outdoor air.

25 A survey of large water utilities in California for 1984 found a median concentration of 3  
26 µg/L. Based on a water consumption rate of 2 L/d, intake by this pathway is about 6 µg/d. This  
27 is consistent with ATSDR, which reported an average daily water intake for the general  
28 population of 2–20 : g/d.

29 TCE can be found in groundwater. It is not known how often TCE reaches levels of  
30 concern, but the highest potential for this to happen would be at wells located near TCE disposal  
31 or contamination sites where leaching occurs. TCE is a common contaminant at Superfund sites.  
32 It has been identified in at least 852 of the 1,416 hazardous waste sites proposed for inclusion on  
33 the EPA National Priorities List. About 41 million people live less than 4 miles from a  
34 Superfund site.

35 TCE exposures may be elevated for people living near waste sites, residents of some  
36 urban or industrialized areas, people exposed at work, and people using products containing TCE

1 with poor ventilation. In addition, TCE is transferred from shower water to air (mean efficiency,  
2 61%); ATSDR reported that a 10-minute shower in TCE-contaminated water could result in  
3 inhalation exposure comparable to that from drinking TCE-contaminated tap water.

4 Table 2-1 presents adult exposure estimates for TCE and several of its metabolites and  
5 other parent compounds that also produce those metabolites. Of special note is that general-  
6 population exposures to TCA and DCA are each approximately 10-fold higher than exposure to  
7 TCE. This indicates that there is a high background level of these metabolites that not only can  
8 alter and enhance the metabolism of TCE, but also have toxic effects themselves. This topic is  
9 further discussed in Section 3.

10 The general population exposure estimates are derived directly from environmental media  
11 data and, therefore, have the same uncertainties as described above. In addition, inhalation  
12 exposures are probably low, because they are based on ambient air measurements, which do not  
13 reflect indoor levels. It is likely that indoor levels are generally higher and contribute more to  
14 inhalation exposure than does outdoor air. For example, the 1987 EPA TEAM (Total Exposure  
15 Assessment Methodology) study shows that the ratio of indoor to outdoor TCE concentrations  
16 for Greensboro, NC, was about 5:1. The prevalence of TCE exposure on the basis of blood  
17 levels is based on NHANES III, which was recent (1988 to 1994) and fairly extensive (644  
18 individuals).

**Table 2-1. Preliminary dose estimates of TCE and TCE-related chemicals**

<b>Chemical</b>	<b>Population</b>	<b>Medium</b>	<b>Range of estimated adult exposures (: g/day)</b>	<b>Range of estimated adult doses (mg/kg/day)</b>	<b>Data sources</b>
Trichloroethylene	General	Air	11 – 33	1.57E-04 – 4.71E-04	(3)
	General	Water	2 – 20	2.86E-05 – 2.86E-04	(3)
	Worker	Air	2,232 – 9,489	3.19E-02 – 1.36E-01	(3)
Tetrachloroethylene	General	Air	80 – 200	1.14E-03 – 2.86E-03	(13)
	General	Water	0.1 – 0.2	1.43E-06 – 2.86E-06	(13)
	Worker	Air	5,897 – 219,685	8.43E-02 – 3.14	(13)
1,1,1-Trichloroethane	General	Air	10.8 – 108	1.54E-04 – 1.54E-03	(16)
	General	Water	0.38 – 4.2	5.5E-06 – 6.00E-05	(16)
1,2-Dichloroethylene	General	Air	1 – 6	1.43E-05 – 8.57E-05	(18)
	General	Water	2.2	3.14E-05	(18)
cis-1,2-Dichloroethylene	General	Air	5.4	7.71E-05	(6)
	General	Water	0.5 – 5.4	7.14E-06 – 7.71E-05	(6)
1,1,1,2-Tetrachloroethane	General	Air	142	2.03E-03	(6)
1,1-Dichloroethane	General	Air	4	5.71E-05	(7)
	General	Water	2.47 – 469.38	3.53E-05 – 6.71E-03	(7)
Chloral	General	Water	0.02 – 36.4	2.86E-07 – 5.20E-04	(6)
Monochloroacetic acid	General	Water	2 – 2.4	2.86E-05 – 3.43E-05	(19)
Dichloroacetic acid	General	Water	10 – 266	1.43E-04 – 3.80E-03	(19)
Trichloroacetic acid	General	Water	8.56 – 322	1.22E-03 – 4.60E-03	(19)

### 3. HAZARD ASSESSMENT AND CHARACTERIZATION

#### 3.1. GENERAL APPROACH

The database for TCE is relatively rich in toxicity information that includes epidemiologic studies, animal bioassays, metabolism studies, genetic toxicity studies, and mechanistic studies. Interpretation of this information, especially the cancer studies, has sparked controversies concerning the strength of the human evidence and the human relevance of the animal responses. These controversies have prompted some new epidemiologic studies and reviews, plus a wealth of mechanistic research committed to developing and supporting hypotheses about TCE's potential modes of action in animals.

To help provide a sound scientific basis for addressing these and other issues, this assessment commissioned a set of state-of-the-science papers that appears in a May 2000 supplement of *Environmental Health Perspectives*. One paper addresses the controversy over the weight of the human evidence. Wartenberg et al. (2000) conducted a joint analysis of the cancer epidemiology studies, using a statistically based weight-of-evidence approach that stratified the available studies into tiers according to how well each study's results can be associated with TCE exposure specifically. Such an analysis affords an opportunity to put differing results in perspective by evaluating whether the positive or the nonpositive results overall have greater weight, and whether the overall result is statistically significant.

Other state-of-the-science papers focus on describing the effects of TCE and its metabolites as well as the human relevance of observed animal responses. Lash et al. (2000a) describe the metabolism of TCE, providing a foundation for the consideration of various metabolites and target sites throughout the body. Pastino et al. (2000) discuss factors that can cause humans to vary in their susceptibility to adverse health effects from TCE exposure and identify populations that are likely to be more susceptible. Moore and Harrington-Brock (2000) discuss the genetic toxicity of TCE and its metabolites, a critical step in understanding TCE's mode of action at different sites. Bull (2000), Green (2000), and Lash et al. (2000b) discuss potential modes of action for tumorigenesis in the liver, lung, and kidney, respectively. These latter papers reflect the considerable research effort that has gone into developing the modes of action for cancer for their respective tumor sites, described as targets in past TCE assessments (U.S. EPA, 1985, 1987). The paper of Barton and Clewell (2000) reviews the evidence in the rodent for effects other than cancer (discussed in this section), and also provides support for the development of an inhalation reference concentration and oral reference dose (see Section 4).

Bull's state-of-the-science paper (Bull, 2000) has turned attention toward cell signaling to give insight into possible modes of action for TCE. This in turn, has helped provide focus for common modes and targets for cancer and other forms of toxicity. Many potential targets of

1 TCE toxicity (e.g., heart, brain, testes, and the developing fetus) may be affected by disturbances  
2 in carbohydrate metabolism and alterations in cell signaling, thus, common themes may  
3 ultimately emerge for different targets and effects. Particularly relevant is the work of Bannasch  
4 (Bannasch et al., 1984, 1986, 1997; Bannasch, 1986, 1996) demonstrating that disturbance of  
5 carbohydrate metabolism and cell signaling may be an early marker and common feature of  
6 carcinogenesis. Discussions with the state-of-the-science authors have also directed attention to  
7 the potential role in the toxicity of TCE of activation of the peroxisomal proliferator-activated  
8 receptor by TCE or its metabolites. They also suggested a focus on the rationale supporting  
9 linear or nonlinear carcinogenic responses in the liver. Accordingly, an expanded mode-of-  
10 action section includes a detailed discussion of potentially relevant epigenetic mechanisms of  
11 carcinogenesis.

12 This hazard assessment focuses on analysis and interpretation rather than a compilation of  
13 study results. More detailed information on the epidemiologic and experimental studies on TCE  
14 can be found in the state-of-the-science papers and in comprehensive reviews compiled by  
15 ATSDR (1997), IARC (1995), and EPA (1985, 1987). Considerable new literature has become  
16 available on TCE's potential toxicity and modes of action, including several effects other than  
17 cancer. Some of the new information postdates the publication of the state-of-the-science papers  
18 and is integrated into this hazard assessment. Thus, the discussion of toxicity and mode of action  
19 is considered more current and the recent references expand the scope beyond cancer. Section  
20 3.2 examines TCE's metabolism and clearance, because TCE-induced toxicity is often attributed  
21 to TCE's metabolites. This leads to a discussion in Section 3.3 of susceptibility, because several  
22 features of TCE metabolism and clearance have been found to be differentially distributed across  
23 the general population, suggesting some potentially susceptible populations. Section 3.4  
24 summarizes the toxic effects reported from TCE exposure. These effects are grouped by organ  
25 system, and for each organ system, cancer and other effects are discussed together. Each  
26 summary of TCE-induced effects is followed by a summary of available information about  
27 similar effects reported in studies of TCE's metabolites. Section 3.5 discusses some potential  
28 modes of action through which TCE may induce these effects. A mode of action can involve  
29 several systems, and conversely, effects in one system may arise from several distinct modes of  
30 action. Much of the research supporting the hypothesized modes of action has concentrated on a  
31 few TCE metabolites rather than on TCE itself.

### 32 33 **3.2. METABOLISM**

34 The state-of-the-science paper by Lash et al. (2000a) discusses the absorption,  
35 distribution, metabolism, and excretion of TCE and its metabolites. TCE is rapidly and  
36 extensively absorbed by all routes of environmental exposure—ingestion, inhalation, and skin

1 contact. Once absorbed, TCE is distributed via the circulatory system throughout the body,  
2 where it can accumulate in fat and other tissues. Storage of TCE in fat represents an internal  
3 source of exposure that can later release TCE again into the circulation. The pathways of  
4 biotransformation observed in humans and animals are thought to be similar qualitatively  
5 (Pastino et al., 2000).

6 TCE is metabolized primarily in the liver, but metabolism can also occur in other tissues.  
7 Metabolism in these other tissues may be important to TCE-induced toxicity. The kidney is the  
8 only other tissue that has been extensively studied to any extent. Metabolism occurs through two  
9 main pathways (oxidation or conjugation with glutathione) (see Figure 3-1). Although several  
10 metabolic products derived from these pathways have been identified for TCE, only a few have  
11 been characterized pharmacokinetically (Lash et al., 2000a). The first major pathway begins with  
12 oxidation of TCE by at least four isozymes of the cytochrome P450 (CYP450) system to CH,  
13 which is then acted upon by ADH and ALDH to form trichloroethanol (TCOH) and TCA,  
14 respectively. CYP450 is also most likely involved in the reduction of CH to TCOH with TCA as  
15 a product. TCOH undergoes glucuronidation and is either excreted in the urine or persists in the  
16 body through enterohepatic recirculation.<sup>29</sup> TCOH can then be excreted from the liver to the  
17 small intestines, where it is reabsorbed into the circulation. In general, enterohepatic  
18 recirculation is more extensive in humans than rodents (Barton and Clewell, 2000), with the  
19 result of a larger area-under-the-curve (AUC) in humans than rodents for an equivalent oral dose.  
20 Overall, the rate-limiting step for this pathway is oxidation of TCE to CH (Lash et al., 2000a).

21 DCA is another metabolite detected in mice and humans, but the source of DCA  
22 formation is not clear. DCA may result from the oxidative pathway by further oxidation of both  
23 TCA and TCOH or by rearrangement directly from dichloroacetyl chloride, from glutathione  
24 conjugation, or, likely, from both pathways (Lash et al., 2000a; Cai and Guengerich, 2000;  
25 Völkel et al., 1998). The estimation of the amount of DCA formed in humans contains  
26 uncertainty because there are problems associated with the analytical methodology, particularly  
27 in the presence of large amounts of TCA, and because of DCA's relatively rapid metabolism to  
28 oxalic acid, monochloroacetic acid, glycolic acid, and glyoxylic acid. Conversion to glyoxylic  
29 acid is thought to be by a newly described isoform of glutathione S-transferase (GST), identified  
30 as GST zeta (GSTZ) (Lash et al., 2000a). GSTZ enzyme activity in vitro differs between rats and  
31 humans and is relatively more sensitive to inhibition by DCA in rats (Cornett et al., 1999). In  
32 general, GSTs are present in multiple forms in mammals and have a large degree of overlapping

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<sup>29</sup>*Enterohepatic recirculation* is the process by which metabolites formed from the biotransformation of the parent compound in the liver are excreted directly into the bile without first entering systemic circulation. From the bile, the metabolites pass into the small intestine and are available for reabsorption (Klaussen, 1980).

1 substrate specificity among the differing forms. They also exhibit polymorphisms and species  
2 differences in expression and catalytic activities. Hence, the further characterization of this  
3 pathway as it relates to TCE is important.

4 The second major pathway of TCE metabolism also involves GST and begins with  
5 glutathione conjugation, primarily in the liver, to S-(1,2-dichlorovinyl)glutathione (DCVG).  
6 DCVG formed in the liver is excreted in the bile and converted in the biliary tract and intestines  
7 to S-(1,2-dichlorovinyl)-L-cysteine (DCVC). DCVC is translocated to the kidneys, where its  
8 concentration modulates the amount of toxic metabolites generated in the kidney. DCVC can be  
9 detoxified by N-acetyltransferase (NAT) in the kidney and excreted in the urine, or it can be  
10 metabolically activated to a thioacetylating agent by  $\beta$ -lyase. Although the capacity of this  
11 pathway is small compared with the CYP450 pathway, the chemically unstable and highly  
12 reactive nature of the metabolites produced by  $\beta$ -lyase metabolism make it likely that relatively  
13 small amounts can induce significant responses (Lash et al., 2000a).

14 Quantitatively, the comparative rate of TCE metabolic reactions between species or  
15 between potential target organs is a complex question. The interspecies relationship of TCE  
16 metabolic pathways has been investigated using pharmacokinetic models (Clewell et al., 2000;  
17 Fisher, 2000) and analyses that look at uncertainty in those models (Bois, 2000a,b). Peak blood  
18 levels of TCE's oxidative metabolites (e.g., TCA) are higher in mice and rats than in humans  
19 administered equivalent doses, whereas blood levels of TCE in humans generally remain for a  
20 longer time period, i.e., longer half-life. Differences in enterohepatic recirculation and  
21 metabolism could be factors in interspecies differences. These factors result in greater  
22 persistence in the body and a larger AUC for some TCE metabolites in humans compared to  
23 rodents. For the GST conjugation pathways in the kidney, in vitro work suggests that DCVG  
24 formation in human liver and kidney was only slightly lower than in the rat, with DCVG  
25 formation in mice shown to be markedly faster than in either humans or rats (Lash et al., 2000a).  
26 However, DCVG formation is only the initial step in the generation of nephrotoxic species, with  
27 additional studies necessary to characterize this metabolic pathway (Lash et al., 2000a). A  
28 gender difference also is apparent, with an overall higher GSH conjugation in male rats than in  
29 female rats (Lash et al., 2000a).

### 31 **3.3. SUSCEPTIBILITY**

32 The state-of-the-science paper by Pastino et al. (2000) discusses physiologic factors (e.g.,  
33 genetics, gender, and age) and acquired factors (e.g., disease, alcohol consumption, and exposure  
34 to other solvents) that may cause humans to vary in their susceptibility to adverse health effects  
35 from TCE exposure. Another way to view the factors that can influence susceptibility to  
36 potential TCE-related toxicity is to categorize them as either intrinsic or extrinsic. Inherent



1 differences in an individual's genetic makeup, gender, age, or disease state may affect  
2 susceptibility intrinsically, whereas coexposure to a pollutant that alters their metabolism or  
3 clearance, or that adds on to background levels of metabolites, may affect susceptibility  
4 extrinsically. Through either mechanism, increased susceptibility to potential TCE-related  
5 toxicity may occur by altering the body burden of TCE or its metabolites, sensitizing the  
6 individual to other agents that act in common metabolic pathways, or augmenting underlying  
7 conditions that share common effects with TCE (e.g., effects on cell signaling).

8         The variation observed for specific metabolic reactions or responses within individual  
9 populations suggests potential for considerable overall differences in response between  
10 individuals in the whole population. It is, however, difficult to describe quantitatively the overall  
11 extent of human variability, as the range of variation in a single process or metabolic reaction, as  
12 well as variation within a specific ethnic group, may not encompass the span of variation across  
13 the entire population or take into account the multiplicity of factors that can determine the  
14 toxicity of TCE. Nonetheless, the variation observed for specific metabolic reactions or groups  
15 not only suggests a potential for considerable overall differences in response between  
16 individuals, but can be used to identify populations and conditions that may be associated with a  
17 higher risk from TCE exposure.

18         Human variation is also a determinant of the shape of a population dose-response curve.  
19 The dose-response curve for a susceptible population can be different and changed when  
20 compared to the dose-response curve for the heterogeneous population. Additionally, direct or  
21 background exposure to some of TCE's metabolites can be considerable and, for individuals with  
22 these exposures, can aggravate the effect of small incremental exposures of TCE. That is,  
23 background and cumulative exposures place the susceptible population on a different part of the  
24 dose-response curve. For example, given a metabolite with an "S"-shaped dose-response curve,  
25 a small dose would induce a minimal response in the absence of background exposure, yet the  
26 same dose could induce a greater response in the presence of background exposure that places an  
27 individual higher on the "S"-shaped curve, in the range where the risk increases rapidly with  
28 dose.

### 30 **3.3.1. Intrinsic Factors Affecting Susceptibility**

#### 31 **3.3.1.1. *Differences in Metabolism and Clearance***

32         Adverse effects resulting from TCE exposure are believed to be attributed mainly to its  
33 metabolites. Hence, individual differences in metabolism can lead to individual differences in  
34 response. The influence of physiologic and acquired factors on metabolism, particularly on

1 CYP2E1,<sup>30</sup> which may be responsible for more than 60% of TCE metabolism, is important  
2 (Lipscomb et al., 1997). Rates for TCE metabolism by the oxidative pathway are believed to  
3 vary across the population. In vitro, an eightfold variation in metabolic activity of TCE via  
4 CYP2E1 was seen in 23 human liver samples (Lipscomb et al., 1997); several investigators have  
5 found activity of CYP2E1, in general, to vary up to 50-fold in humans (Stevens et al., 1994;  
6 Peters et al., 1990; Yoo et al., 1998; Raucy, 1995; Lieber 1997; Pastino et al., 2000).

7 For the GST pathway,<sup>31</sup> genetic polymorphisms may not only influence metabolism of  
8 TCE and its target of toxicity. One epidemiologic study has linked polymorphisms of the GST  
9 pathway (GSTT and GSTM) to increased risk of kidney cancer from TCE exposure (Brüning et  
10 al., 1997a). Additionally, one isozyme, GSTZ, is important to the further metabolism of DCA  
11 (Tong et al., 1998), and in vitro has been shown to be irreversibly inhibited in mice, rats, and  
12 humans with chronic DCA exposure (Tzeng et al., 2000). In vitro studies of cytosolic GST  
13 conjugation of TCE in humans have revealed considerable (3-8 fold) variation in relatively small  
14 samples (Lash et al., 2000a). In general, regulation of GST expression differs among tissues,  
15 such that not all GST isoforms are expressed in every tissue. Partial deletions are also found to  
16 varying degrees in specific ethnic populations (15%–20% of Caucasians and 60% of Asians  
17 having partial deletions). Therefore, it is difficult to accurately predict expression of GST genes  
18 in a given tissue (Eaton and Bammler, 1999).

### 19 20 **3.3.1.2. Disease States**

21 Certain diseases may increase susceptibility to TCE's adverse effects through induction  
22 of metabolic enzymes, favoring increased formation of toxic metabolites of TCE, or by adding to  
23 ongoing physiological processes. For example, uncontrolled diabetes causes induction of  
24 CYP2E1 (Wang, 2000; Nakajima, 2000). Furthermore, diabetics may be a population  
25 susceptible to TCE's adverse effects on the basis of recent mechanistic understanding about the

---

<sup>30</sup>CYP2E1 is one of the CYP450 enzymes and is the primary catalyst of hydrocarbon bioactivation in animals and, most likely, in humans as well (Raucy et al., 1993). CYP2E1 also metabolizes many drugs and environmental pollutants, including ethanol, acetaminophen, benzene, 1,3-butadiene, styrene, methylene chloride, chloroform, carbon tetrachloride, vinyl chloride, vinylidene chloride, and perchloroethylene. Exposure to these chemicals can affect enzyme levels or activity and, in so doing, alter or enhance TCE's toxicity. CYP2E1 is found in greatest concentration in liver, but is also expressed in parenchymal and non-parenchymal cells of the liver (e.g., Kupffer cells) and in many extrahepatic tissues (e.g., kidney, brain, testes, lung, and bone marrow).

<sup>31</sup>GST enzymes are involved in metabolizing many drugs and environmental pollutants, including polycyclic aromatic hydrocarbons, phenolic antioxidants, reactive oxygen species, isothiocyanate, trivalent arsenicals, barbiturates, and synthetic glucocorticoids (Hayes and Pulford, 1995). GST metabolism aids in the clearance of xenobiotics and is generally considered a detoxification process. This is not the case for trichloroethylene, where highly reactive metabolites can be produced.

1 relationship between TCE and its metabolites and carbohydrate handling and cell signaling (Bull,  
2 2000) (see Section 3.5.1).

### 3 4 **3.3.1.3. Gender**

5 Gender-related differences in metabolism may influence susceptibility by shifting  
6 production of metabolites from one toxic pathway to another, or by providing differing targets for  
7 TCE's toxicity. Males have been reported to have higher rates of DCVG formation from acute  
8 exposure (Lash et al., 2000a). There may also be gender-related differences in target organs.  
9 One recent case-control study (Dosemeci et al., 1999) observed an elevated risk among females,  
10 but not males, between kidney cancer and occupational TCE exposure. This study was not able  
11 to address potential gender differences in level of exposure, however. Females have also shown  
12 a greater susceptibility than males to some of TCE's immune system effects (Sanders et al.,  
13 1992; Barton and Clewell, 2000). Moreover, gender-specific organs may be targets of TCE's  
14 effects. TCE exposure has been associated with excess risks of cervical cancer in occupationally  
15 or environmentally exposed women (Blair et al., 1998; Anttila et al., 1995; Burg, 1997), and in  
16 male rats, has been shown to concentrate in the testes (Zenick et al., 1984), decrease serum  
17 testosterone, and alter testicular steroid precursors (Kumar et al., 2000).

### 18 19 **3.3.1.4. Age**

20 Several inherent aspects of uptake, distribution, and clearance of TCE in children can  
21 predispose children to its toxicity. In general, children are believed to metabolize and clear  
22 xenobiotics faster than adults, although rate differences vary across chemicals and the patterns of  
23 metabolism may be different from those of adults. In contrast to this general expectation, the  
24 half-life of TCOH in the body has been reported to be 20% higher in children, 3.5-fold higher in  
25 full-term infants, and fivefold higher in preterm infants compared with healthy adults (Renwick,  
26 1998). This finding, which could extend to other TCE metabolites, may be due to differing  
27 enzyme activities in children. For example, glucuronidation does not reach adult levels until 3 to  
28 6 months of age. Individual children may also have low levels of a particular isoform, as shown  
29 by their inability to efficiently carry out glucuronidation and their increased risk for developing  
30 hyperbilirubenemia. Such children may also be less able to glucuronidate TCOH. Furthermore,  
31 ADH activity has been shown to be decreased in the neonate (Pastino et al., 2000). Other life  
32 stage differences, such as the amount of body fat in an organ, can also lead to differences in TCE  
33 distribution and accumulation. The brain of the newborn contains more lipid than that of adults,  
34 thus affecting the distribution of TCE.

35 The prenatal and postnatal periods of development may be critical for TCE's potential  
36 carcinogenic and noncarcinogenic toxicity. Although the modes of action of the carcinogenicity

1 of TCE are unknown, if TCE behaves similarly to the limited number of chemicals tested during  
2 perinatal exposure as well as adult exposure, the carcinogenic potential of TCE may also be  
3 greater in the young (McConnell, 1992). Moreover, TCE exposure to mice during the perinatal  
4 period has been reported to be associated with long-lasting alterations in spontaneous motor  
5 activity (Fredriksson et al., 1993), although this report is only suggestive because of its lack of  
6 statistical analysis on the litter. Exposure during the prenatal period has been shown to induce  
7 toxicity. For example, animal studies report associations between maternal exposure to TCE in  
8 drinking water and cardiac malformations in offspring (Johnson et al., 1998a,b; Dawson et al.,  
9 1993; Epstein et al., 1993). Finally, the longer life expectancy of children compared with adults  
10 may lead to a longer period for expression of toxicity.

### 11 12 **3.3.2. Extrinsic Factors Affecting Susceptibility**

#### 13 **3.3.2.1. *Alteration of Metabolism and Clearance Through Coexposure to Other Chemicals***

14 Exogenous exposures that induce CYP450 enzymes can enhance TCE metabolism and  
15 toxicity. Cytochrome P450, particularly CYP2E1, is important to the metabolism of many  
16 exogenous chemicals, including solvents and ethanol; CYP2E1 is also readily induced by a large  
17 number of these substrates. For example, ethanol is metabolized by CYP2E1, alcohol  
18 dehydrogenase, and aldehyde dehydrogenase. Although interactions have been demonstrated in  
19 the toxicity of both ethanol and TCE given simultaneously at relatively high levels for short  
20 periods, more profound effects on TCE toxicity are liable to occur from chronic ethanol  
21 exposure. Chronic ethanol consumption can result in 20-fold induction of CYP2E1 (Pastino et  
22 al., 2000; Fisher, 2000), significant because large numbers of people consume ethanol. In  
23 addition, ethanol is a weak inducer of peroxisomes, with ethanol consumption linked with  
24 increased risk of liver cancer (Falk, 1982; NIH, 1985). Thus, exposure to both ethanol and TCE  
25 may create conditions that increase risk through shared pathways of metabolism, induction of  
26 metabolic enzymes, and potential targets of toxicity. Methanol is often a concurrent exposure for  
27 TCE and shows affinity for many of the same enzymes. Furthermore, TCE exposure can  
28 increase the toxicity associated with methanol and ethanol exposure by altering not only  
29 metabolism to aldehydes but also their detoxification. For example, TCE exposure has been  
30 reported to induce an “alcohol-flush,” similar to those who possess an inactive ALDH allele (as  
31 seen in half of individuals of Asian heritage), which may be due to TCE’s ability to decrease  
32 ALDH activities at relatively low concentrations (Wang et al., 1999). In addition, the induction  
33 of P450 metabolism or aldehyde clearance by TCE may increase aldehyde production as well  
34 (Wang et al., 1999).

#### 35 36 **3.3.2.2. *Additive Effects from Coexposure to Other Chemicals***

1 The addition of TCE exposure to other background exposure has the potential to increase  
2 susceptibility to TCE's adverse effects. Exposure to perchloroethylene, the dry cleaning solvent,  
3 can be considerable in some populations, and TCA is a primary metabolite of perchloroethylene.  
4 Moreover, TCA and DCA may be found in drinking water, with background exposures to TCA  
5 and DCA each about 10-fold higher than background exposure to TCE (Wu and Schaum, 2000).  
6

### 7 **3.3.2.3. Age**

8 Children and infants may be more susceptible to TCE's toxicity because they may receive  
9 higher exposures via the mother either through systemic circulation during pregnancy or  
10 mother's milk, as well as from pharmacokinetic differences between a developing child and  
11 adult. Limited data collected from residents in U.S. urban areas have indicated that TCE is  
12 present in human milk (ATSDR, 1997); nursing infants may receive a larger exposure to TCE  
13 owing to its presence in mother's milk (Fisher et al., 1989). The fetus may also serve as a  
14 reservoir for maternally derived metabolites; CYP2E1 has been reported to be expressed in full-  
15 term placentas (Vieira et al., 1998). TCA has been reported to accumulate in mouse fetuses and  
16 amniotic fluid (Danielsson, 1990; Ghantous et al., 1986). DCA also readily crosses the placenta  
17 to the fetus (Smith et al., 1992).  
18

## 19 **3.4. TOXICITY**

20 TCE affects many organs and systems of the body, consistent with its lipophilic nature  
21 and ability to distribute widely throughout the body. This section summarizes effects reported  
22 for exposure to TCE and its metabolites, presented by organ system. A discussion of  
23 mechanisms and modes of action are discussed in Section 3.5 because they are, in several cases,  
24 applicable to more than one system.  
25

### 26 **3.4.1. Neurotoxicity**

27 The ability of TCE to cause neurotoxic effects is well established. In general, TCE  
28 produces a "solvent narcosis" that may be related to effects on membrane fluidity and may  
29 include anesthetic effects. TCE was formerly used as a general anesthetic and induces this effect  
30 at about 2,000 ppm (ASTDR, 1997). The array of symptoms observed with TCE exposure is  
31 similar to other solvents, such as alcohol, ethers, petroleum distillates, and other halogenated  
32 solvents.

33 Acute or short-term inhalation of TCE has been associated with dizziness, headache,  
34 sleepiness, nausea, confusion, blurred vision, and weakness in several human studies cited by  
35 Barton and Das (1996). TCE is distributed to the brain, and brain concentrations of TCE in the  
36 rat tend to mimic blood concentrations (Boyes et al., 2000). Acute neurologic effects of TCE in

1 both humans and rats are more closely associated with peak concentrations rather than AUC  
2 (Boyes et al., 2000), but rats require a higher peak concentration to elicit these effects (Bushnell,  
3 1997). Hence, humans appear to be a sensitive species for the neurotoxic effects of TCE.

4 Longer term or chronic inhalation exposure is associated in a number of human studies  
5 with a similar array of neurological symptoms as those observed with acute exposure (ATSDR,  
6 1997). One study (Vandervort et al., 1973), used by Cal/EPA (1999) to derive a reference  
7 exposure level (similar to an RfC), reported eye irritation, drowsiness, heart palpitations, cough,  
8 weakness, and dizziness among workers exposed to a wide range of TCE concentrations. Other  
9 studies of occupational exposure to TCE have reported similar LOAELs (see Table 4-3).  
10 Tremors have been reported in several inhalation studies (Grandjean et al., 1955; Liu et al., 1988;  
11 Bardodej and Vyskocil, 1956) and in one study of a population exposed to a mixture of TCE and  
12 perchloroethylene in drinking water (White et al., 1997). Long-term inhalation exposure at an  
13 average concentration of 44 ppm TCE has also been associated with early nerve function  
14 impairment (Ruitjen et al., 1991).

15 It is not clear whether some of TCE's neurotoxic effects may be attributed to TCE as the  
16 parent or to one of its metabolites such as DCA, which has shown longer term effects on the  
17 central nervous system. A recent study (Moser et al., 1999) in two strains of rats exposed to  
18 DCA for up to 2 years showed neuromuscular toxicity and mild tremors with neurotoxicity being  
19 route, duration, and strain dependent. Drinking water exposure was shown to be more toxic than  
20 gavage, with effects seen at the lowest drinking water dose (16 mg/kg-d). In addition,  
21 neurotoxicity from DCA was described as more pronounced and persistent, and occurring at  
22 lower doses than previously reported (Moser et al., 1999). Subchronic exposures to DCA in  
23 drinking water are associated with brain lesions in dogs at doses of 12.5 mg/kg-d or higher  
24 (Cicmanec et al., 1991) and rats at doses of 125 mg/kg-d or higher (Bhat et al., 1991; Katz et al.,  
25 1981). At much higher doses, focal reactive gliosis—proliferation of reactive astrocytes after  
26 dead neurons have been cleared away—and vacuolization were observed in the brains of DCA-  
27 treated rats (Bhat et al., 1991). DCA given orally is also reported to decrease nerve conduction  
28 velocity in tibial nerves in terms of areas, perimeters, and diameter in rats (Yount et al., 1982)  
29 and, in a human case report, to induce a peripheral neuropathy (Moore et al., 1979).

### 30 31 **3.4.2. Liver**

#### 32 **3.4.2.1. General Hepatotoxicity**

33 TCE can induce hepatotoxicity in humans, as reported in several studies cited by ATSDR  
34 (1997). This is not unexpected, as most metabolism of TCE occurs in the liver. TCE can affect  
35 liver functions not reflected in a standard battery of liver function tests. Workplace exposure to  
36 TCE has been reported to change serum cholesterol and increase bile acids (Nagaya et al., 1993;

1 Driscoll et al., 1992). Alterations of plasma bile acids have been noted in workers at inhalation  
2 exposures of less than 5 ppm (Driscoll et al., 1992; Neghab et al., 1997). Elevations of serum  
3 bile acids, possibly an early sign of liver dysfunction, have also been seen in exposed rats (Wang  
4 and Stacey, 1990; Hamdan and Stacey, 1993). Alterations of cholesterol metabolism have been  
5 observed in workers with low-level chronic TCE exposure, effects that persisted after 2 years  
6 (Nagaya et al., 1993). TCE exposure also can alter insulin and endocrine profiles in  
7 occupationally exposed individuals (mean, 30 ppm) (Chia et al., 1997; Goh et al., 1998), effects  
8 that may be important to responses of the liver.

9 Increased liver weight, primarily resulting from cytomegaly, is one of the most frequently  
10 reported effects in animals dosed chronically with TCE by either the inhalation or oral route.  
11 Barton and Clewell (2000) summarize several studies in which orally administered TCE changed  
12 the liver-weight-to-body-weight ratio in rats and mice. These effects have been observed at  
13 gavage doses as low as 50 mg/kg-d for 14 days (Berman et al., 1995). TCE was reported to  
14 increase cell replication but not cytotoxicity or reparative hyperplasia. TCE metabolites can also  
15 stimulate cell replication; TCA, DCA, and CH have all been associated with increased liver size  
16 (Bull, 2000).

17 Although the state-of-the-science papers have focused on the effects of TCE on  
18 parenchymal cells of the liver, nonparenchymal cells may also have a role in TCE hepatotoxicity.  
19 TCE and DCA have been reported to alter Kupffer cell morphology, indicating activation, in  
20 mice and dogs, respectively (Kjellstrand et al., 1983; Katz et al., 1981). Kupffer cells<sup>32</sup> contain  
21 CYP2E1, which is highly inducible, and have been shown to be critical in the toxicity of ethanol,  
22 acetaminophen, phenobarbital, galactosamine, and carbon tetrachloride (Laskin et al., 1988,  
23 1986, 1995; Knecht et al., 1995; Laskin, 1996; Lieber, 1997).

#### 24 25 **3.4.2.2. Liver Cancer**

26 The review of the TCE cancer epidemiology finds an overall excess incidence of liver  
27 cancer in the tier-I studies (RR=1.9, 95% CI=1.0–3.4, N=12) and the tier-II studies (RR=2.0,  
28 95% CI=1.3–3.3, N=15), with null results in the tier-III studies (Wartenberg et al., 2000).

29 Although none of the tier-I studies achieves statistical significance individually, the relative risks  
30 exceed 1.0 in all three incidence studies, and in the only study that reported mortality for this

---

<sup>32</sup>Kupffer cells, which remove particulate material from the blood and drain the digestive system before it enters systemic circulation, can release potent mediators such as eicosinoids, toxic cytokines, proteolytic enzymes, superoxide anion, and tumor necrosis factor and be involved in hepatotoxicity (Caldwell-Kenkel et al., 1991). Biologically active mediators released by activated macrophages have been implicated in tumor promotion, as well as regulation of CYP450-mediated drug biotransformation (Laskin et al., 1988). Kupffer cells may also have implications for increased toxicity or increased likelihood of tumor progression if their role in immune and endocrine function is altered.

1 specific site. There is a biological gradient seen in the Anttila study (Anttila et al., 1995), as liver  
2 cancer incidence increased with increasing exposure and with increasing time since first  
3 exposure. Among those with the longest time since first exposure, relative risks are large  
4 (RR=6.1, 95% CI=2.8–17.7). A more recent study (Ritz, 1999) supports the observations in the  
5 Anttila study. Although the study was based on few deaths, risks increased with increasing  
6 potential TCE exposure and with increasing time since first exposure. Case-control studies are  
7 supportive, generally, of statistically significant associations with organic solvents as a class.

8 These findings are supported by the well-established and widely acknowledged result that  
9 TCE causes liver tumors in male and female mice (see Table 3-1). The NTP conducted two  
10 gavage studies in B6C3F1 mice (NCI, 1976; NTP, 1990), and Maltoni conducted inhalation  
11 studies in Swiss mice and B6C3F1 mice (Maltoni et al., 1986, 1988). In each study, TCE  
12 exposure caused a statistically significant increased incidence of liver tumors in male and female  
13 mice. Neither series of studies, however, observed liver tumors in rats.

14 Previously, it had been suggested that the liver tumors might be caused by  
15 epichlorohydrin, 1,2-epoxybutane, or other stabilizers present with the TCE (Henschler et al.,  
16 1980). Subsequent testing, however, has ruled this out (Henschler et al., 1984). The state-of-the-  
17 science papers (Lash et al., 2000a; Bull, 2000) suggest that TCE induces liver tumors through its  
18 metabolites. TCA and DCA, as well as CH, have all been shown to cause liver tumors in mice  
19 (Bull, 2000), with DCA also causing liver tumors in rats (DeAngelo et al., 1996).

### 20 21 **3.4.3. Kidney**

#### 22 **3.4.3.1. General Nephrotoxicity**

23 A range of kidney toxicity following human exposure to TCE has been reported in several  
24 studies cited by ATSDR (1997) and Lash et al. (2000b). Tubular damage, as assessed by altered  
25 excretion of urinary proteins, has been noted in occupationally exposed individuals (ATSDR,  
26 1997), as well as in renal cell carcinoma patients with high-level occupational exposure to  
27 trichloroethylene (Brüning et al., 1999a,b). TCE causes dose-related nephrotoxicity in male and  
28 female rats and mice (NTP, 1988, 1990; Maltoni et al., 1986, 1988). The lesions are not the  
29 chronic interstitial nephrosis usually observed in aged rats, but consist of cytomegaly,  
30 kayomegaly, and toxic nephrosis of tubular epithelial cells in the inner renal cortex (Lash et al.,  
31 2000b). As in the liver, TCE can change the kidney-weight-to-body-weight ratio in rats, mice,  
32 and gerbils (Barton and Clewell, 2000; Maltoni et al., 1986, 1988; Kjellstrand et al., 1981, 1983).

#### 33 34 **3.4.3.2. Kidney Cancer**

35 Consistency across epidemiological studies is strongest for an association between TCE  
36 exposure and kidney cancer (Wartenberg et al., 2000). There is an overall excess of kidney



1 cancer incidence in the tier-I studies (RR=1.7, 95% CI=1.1–2.7, N=21) and tier-II studies  
2 (RR=3.7, 95% CI=1.7-8.1, N=6). Mortality was also elevated in the tier-III studies (RR=2.3,  
3 95% CI=1.5–3.50, N=20), but not incidence. The relative risk exceeds 1.0 in three of four  
4 studies in tier 1 that reported incidence, one of which was a follow-up cluster report and achieved  
5 statistical significance individually. It is not obvious that index cases were excluded from these  
6 studies. Supporting the tier-I findings are the tier-II studies and case-control studies of kidney  
7 cancer and TCE (Vamvakas et al., 1998; Dosemeci et al., 1999), degreasers (Schlehofer et al.,  
8 1995), and solvents (Mellempgaard et al., 1994). Dosemeci (Dosemeci et al., 1999) and Blair  
9 (Blair et al., 1998) observed differences in risk between men and women, with higher risk in  
10 women. Dosemeci (Dosemeci et al., 1999) puts forth several hypotheses, including a possible  
11 gender-related difference in the distribution of polymorphisms of the GST metabolic pathway or  
12 differences in level of exposure. The report of Brüning (Brüning et al., 1997a) showed an  
13 increased risk for kidney cancer among individuals with GST isozymes M1 and T1, suggesting  
14 the GST pathway and polymorphisms of this pathway as important contributors to kidney cancer  
15 risk (Lash et al., 2000b).

16 Recently, occupational exposure to TCE has been linked to somatic mutations of the  
17 VHL gene<sup>33</sup> (Brüning, 1997b; Brauch et al., 1999). Thirty-three of the 44 renal cell carcinomas  
18 had one or more mutations in the VHL gene, predominately characterized as changes in cytosine  
19 to thymidine (Brauch et al., 1999). An interesting observation was a mutation in cytosine at a  
20 specific point in the VHL gene, at nucleotide (nt) 454, in 13 of these tumors; none of the 107  
21 renal cell carcinomas from individuals not exposed to TCE displayed this mutation. High levels  
22 of exposure were associated with a higher frequency of tumors with multiple mutations and with  
23 the mutation at nucleotide 454 than lower exposure. This mutation was, moreover, found in  
24 normal kidney tumor tissue that was adjacent to neoplastic tissue in four patients. This  
25 observation suggests that a mutation at nucleotide 454 may precede tumor development. Both  
26 the studies of Brüning (1997b) and Brauch et al. (1999) point to an association of increased  
27 occurrence of mutated sequence in the entire gene for TCE-exposed renal cancer patients, with  
28 the work of Brauch indicating multiple mutations and a specificity in where and how mutations  
29 occurred within the nucleotide sequence of this gene.

30 Another study (Schraml, 1999) assessed the entire genome of 12 renal cell tumors from  
31 individuals with suspected exposure to TCE and other organic solvents (exposure was not  
32 described in this report, nor was an exposure score assigned to individual cases) and observed

---

<sup>33</sup>The VHL gene, consisting of hundreds of nucleotides, normally suppresses renal cell carcinoma. Somatic alterations to the gene are noted in sporadic kidney cancers, and mutation of the VHL gene is considered a risk factor for kidney cancer (Lash et al., 2000b).

1 mutations to genes on several chromosomes besides chromosome 3, the location of the VHL  
2 gene. Mutations found on these other chromosomes included both DNA losses and DNA gains.  
3 There were no differences between TCE and non-TCE exposed renal cell tumors regarding  
4 which chromosomes were affected. Schraml (1999), however, observed a much lower frequency  
5 of mutation of the VHL gene (25%, 4 tumors) among the 12 tumors from TCE-exposed  
6 individuals compared to either the report of Brauch et al. (1999) or to background rates (around  
7 60% of all renal cell carcinomas) (Brauch et al., 1999). This study provides only limited  
8 information because of its absence of complete information on exposure and on tumor stage or  
9 grade, its smaller sample size, and its lower than expected number of tumors with VHL  
10 mutations.

11 The human results are supported by the animal studies, where TCE causes kidney cancer  
12 in rats by both ingestion and inhalation exposure (see Table 3-2). Maltoni observed a  
13 significantly increased incidence of kidney adenocarcinomas in male Sprague-Dawley rats  
14 inhaling TCE (Maltoni et al., 1986, 1988). The NTP conducted parallel corn-oil gavage studies  
15 in ACI, August, Marshall, and Osborne-Mendel rats (NTP, 1988), and a similar study in F344/N  
16 rats (NTP, 1990). The NTP considered the former to be inadequate studies of carcinogenic  
17 activity because of chemically induced toxicity, reduced survival, and deficiencies in the conduct  
18 of the studies. Despite these limitations, however, the NTP concluded that there were tubular  
19 cell neoplasms of the kidney in rats exposed to TCE. Consistent with these results, an earlier  
20 NCI study also reported a tubular adenocarcinoma in one male Osborne-Mendel rat exposed to  
21 TCE for 78 weeks (NCI, 1976).

22 As noted by the NTP (1988), the survival of exposed rats was substantially reduced  
23 compared with controls. Consequently, the tumor incidences tabulated in the NTP report may be  
24 misleading, because animals dying early may not be at full risk of developing tumors. To  
25 ascertain the effect of this reduced survival on the tumor incidences, the individual animal tumor  
26 pathology in the NTP report was used to adjust the tumor incidences to reflect the number of  
27 animals at risk. Animals were discounted if they died before the first kidney tumor was  
28 observed, at 57 weeks. Counting only animals alive at 57 weeks leads to the corrected incidences  
29 reported in Table 3-2.

30 Rhomberg (2000) analyzed the findings of TCE bioassays in rats and suggests that  
31 females are as sensitive as males to TCE-induced renal carcinogenicity. Previously, the kidney  
32 tumors in male rats had received more attention than those in females (ATSDR, 1997).  
33 Consideration of all strains together in Table 3-2, however, reveals that there is virtually no  
34 difference between males and females in the overall incidence of these tumors.

### 3.4.4. Immune and Lympho-Hematopoietic Systems

#### 3.4.4.1. *General Effects on the Immune and Lympho-Hematopoietic System*

Immune system<sup>34</sup> changes have been noted in individuals presumed to have been exposed to TCE and other chlorinated solvents in drinking water (ATSDR, 1997). The ability of TCE to alter immune responses has been observed in mice exposed to TCE via drinking water or inhalation (Khan et al., 1995; Aranyi et al., 1986; Hobara et al., 1984; Parks et al., 1993; Sanders et al., 1982; Tucker et al., 1982). Mice exposed to TCE in drinking water at 0.1 mg/mL and higher showed inhibition of humoral and cell-mediated immunity, as well as effects on macrophage function and monocyte-granulocyte progenitor cells (Sanders et al., 1982). Females showed a greater susceptibility than males to these immunotoxic effects of TCE (Sanders et al., 1982; Barton and Clewell, 2000).

TCE and one of its metabolites have also been shown to affect bone marrow function or components. Sanders et al. (1982) observed an inhibition of stem cell colonization in both male and female mice. Lock et al. (1996) reported that DCVC causes renal toxicity and fatal aplastic anemia in calves at a single dose of 4 mg/kg, a dose much larger than that expected from TCE metabolism, and that toxicity may be related to the  $\beta$ -lyase metabolic pathway (Anderson and Schultze, 1965; Bhattacharya and Schultze, 1967). However, aplastic anemia has not been reported from similar exposures in rat, guinea pig, dog, or cat (Lock et al., 1996).

TCE exposure may also accelerate an autoimmune response. Several studies of occupational exposure have associated TCE and organic solvent exposure with several autoimmune diseases:<sup>35</sup> systemic sclerosis (scleroderma), fasciitis, and systemic lupus erythematosus (SLE) (Lockey et al., 1987; Saihian et al., 1978; Niertert et al., 1998; Bovenzi et al., 1995; Goldman, 1996; Schaeffer et al., 1995; Waller et al., 1994). Furthermore, two studies of populations exposed to TCE and other solvents in drinking water report changes in T-lymphocytes and increased autoantibodies (Byers et al., 1988; Kilburn and Warshaw, 1992). Autoimmune-disease-prone mice exposed to 2.5 or 5.0 mg/mL TCE in drinking water show an increase in autoimmune antinuclear antibodies, elevated serum levels of several immunoglobulins, activation of CD+4, and a cytokine profile consistent with a TH1 type

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<sup>34</sup>Immune cells are derived from stem cells in the bone marrow or fetal liver and are widely distributed throughout the body (Selgrade, 1995). They are also controlled by cytokines. The immune system is highly conserved across species such that organs and cells of the immune system in humans, mice, and rats are similar. In instances where controlled human studies have been possible, results of immune function studies in mice have been accurate predictors of effects in humans.

<sup>35</sup>Autoimmunity can be defined as a loss of self-tolerance that results in an immune reaction against oneself or self-antigens. Autoimmunity appears to have a multifactorial etiology that includes genetic and environmental factors (chemicals and microbes) (D’Cruz, 2000).

1 response<sup>36</sup> (Gilbert, 1999; Griffin et al., 2000a,b). In another recent drinking water study (Griffin  
2 et al., 2000c), these investigators noted many of these same observations, but these effects  
3 occurred at much lower exposures to TCE than previously reported; doses in this latter study  
4 were 0.1 mg/mL, 0.5 mg/mL, and 2.5 mg/mL. An early response to TCE exposure was a dose-  
5 related and significant increase in serum antinuclear antibodies at the lowest exposure (0.1  
6 mg/mL, or 4 mg/kg/d). Furthermore, histopathologic changes that included portal infiltration by  
7 mononuclear cells were seen at the termination of the study, 32 weeks, and were consistent with  
8 the induction of autoimmune disease in the liver (Griffin et al., 2000c). Additionally, hepatocyte  
9 reactive changes were observed at all exposures including the lowest tested dose (0.1 mg/mL, or  
10 4 mg/kg/d).

#### 11 12 **3.4.4.2. Lymphoid Cancer**

13 Overall, an increased incidence of lympho-hematopoietic cancer (RR=1.4, 95%  
14 CI=1.0–2.0, N=40) was noted in tier-I by Wartenberg et al. (2000), primarily a reflection of the  
15 elevated, but not statistically significant, incidence of non-Hodgkin’s lymphoma (RR=1.5, 95%  
16 CI=0.9–2.3, N=22). Null results were seen in the tier-II and tier-III studies (Wartenberg et al.,  
17 2000). Two drinking water studies of ecologic design provide some evidence of an association  
18 between non-Hodgkin’s lymphoma and drinking water that includes TCE and other chemically  
19 similar solvents (Fagliano et al., 1990; Vartianen et al., 1993). Both studies were of ecological  
20 design without individual exposure or residential histories. The case-control studies that  
21 examined occupational exposures were not informative, primarily because of few cases and,  
22 consequently, lower statistical power. However, case-control studies that evaluated lymphoid  
23 cancer (leukemia and non-Hodgkin’s lymphoma) and exposure to drinking water contaminated  
24 with TCE report elevated risks, although not all risks were statistically significant (Cohn et al.,  
25 1994; MA-DOH, 1997). One study of childhood leukemia (MA-DOH, 1997) observed a very  
26 strong association with exposure during pregnancy (OR=13.2, 95% CI=0.9-205.2). For both  
27 leukemia and non-Hodgkin’s lymphoma, these studies report exposure-response gradients  
28 supporting drinking water contamination as the etiologic agent (Cohn et al., 1994; MA-DOH,  
29 1997). Exposures are not sufficiently specific to a single chemical, although TCE is often the  
30 chemical found in highest concentration and the others have similar metabolism and targets.

31 TCE induces malignant lymphomas in mice in a number of inhalation or gavage  
32 bioassays. Mice have been shown to be an excellent immunopathologic model for human

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<sup>36</sup>The profile of cytokines secreted by activated CD4+ T cells is often measured as an indicator of the type of immune response induced by a toxicant. A T-helper type 1 (TH1) type response reflects macrophage activation and inflammation and is marked by an increased secretion of IFN- $\gamma$  with a simultaneous decrease in the secretion of the cytokine IL-4 (Griffin et al., 2000a).

1 lymphoid cancers (Pattengale, 1986, 1994). Henschler found a statistically significant increased  
2 incidence of malignant lymphomas in female Han:NMRI mice exposed by inhalation (Henschler  
3 et al., 1980). The NTP found a significant increase in malignant lymphomas in female B6C3F1  
4 mice exposed by gavage ( $p < 0.05$  by life-table test), although this result was not mentioned in the  
5 abstract or summary of peer review comments (NTP, 1990). Consistent results were found in the  
6 NCI study (NCI, 1976). Lymphosarcomas and malignant lymphomas were just beginning to  
7 appear in exposed mice when the NCI study was terminated at 90 weeks, although the numbers  
8 were too few for statistical significance. For comparison, in the 104-week NTP study only 1 of  
9 the 13 malignant lymphomas in exposed female mice was observed before week 90, at week 85.

### 11 **3.4.5. Developmental and Reproductive Toxicity, Endocrine Effects**

#### 12 **3.4.5.1. Developmental Effects**

13 Epidemiologic studies of women exposed to degreasing solvents, including TCE, have  
14 reported elevated risks for cardiac anomalies in their offspring (Wilson et al., 1998; Goldberg et  
15 al., 1990; Ferencz et al., 1997). Large, statistically significant excesses were observed for  
16 specific cardiac defects: left-sided obstructive defects (OR=6.0, 95% CI=1.7-21.3) and  
17 hypoplastic left heart (OR=3.4, 95% CI=1.6-6.9) with an attributable risk<sup>37</sup> of 4.6% (Wilson et  
18 al., 1998; Ferencz et al., 1997). Neural tube defects have also been noted with either  
19 occupational or drinking water exposure to solvents including TCE (Bove et al., 1992;  
20 Holmberg, 1980a,b, 1982).

21 TCE or its metabolites, TCA and DCA, cause cardiac malformations and eye  
22 malformations (anophthalmia, microphthalmia) in rat pups<sup>38</sup> (Dawson et al., 1993; Smith et al.,  
23 1989, 1992; Johnson et al., 1998a,b; Epstein et al., 1993) given drinking water exposure;  
24 increases for both malformations were dose related (Dawson et al., 1993; Smith et al., 1989,  
25 1992). These malformations have not been reported in inhalation studies, though there is a  
26 question as to whether the ability of the methods or the number of pups in the studies were  
27 adequate to detect these malformations (Barton and Clewell, 2000). The study of Dawson et al.  
28 (1993) raises issues for quantitative analysis because of the wide spacing between low and high  
29 dose (exposure to TCE was at 1.5 ppm and 1,100 ppm) and whether TCE or one of its  
30 metabolites was responsible for the effect reported (Barton and Clewell, 2000).

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<sup>37</sup>*Attributable risk* is the risk or rate difference that may be attributable to the exposure (Rothman, 1986).

<sup>38</sup>Although no battery of animal tests can provide complete assurance in predicting human developmental effects, the similarity in timing and sequencing of events during embryogenesis and organogenesis, particularly cardiogenesis, between humans and rats suggests that the rat is a suitable nonprimate choice for studying developmental effects.

1 Graeter et al. (2000) reported that gavage exposure to TCE, DCA, or TCA did not  
2 produce a statistically significant difference in cardiac malformations in an abstract lacking  
3 information on number of animals examined and exposure levels. DCA exposure, however,  
4 produced a statistically significantly increased number of external malformations, and both DCA  
5 and TCA individually produced lower fetal body weights in Sprague-Dawley rats. TCA also  
6 produced a statistically significant lower mean uterine weight in dams compared with vehicle  
7 controls.

8 Recently Boyer (2000) reported TCE exposure in vitro produces a dose-dependent  
9 inhibition of mesenchymal cell transformation (a critical event in development of the heart) in  
10 progenitors of the valves and septa of the heart, and briefly mentions the findings of a concurrent  
11 study that showed altered gene expression in embryo hearts with maternal exposure to drinking  
12 water with 110 ppm TCE. The concentration in the in vitro study was in the millimolar (mM)  
13 range, comparable to doses of TCE studied in vivo and, because of factors inherent with using an  
14 in vitro paradigm, likely to be much less than those administered to the culture medium (Runyan,  
15 2000). However, although direct quantitative extrapolation of in vitro doses to those studied in  
16 vivo is problematic, these observations support a TCE effect on cardiac development. Moreover,  
17 the finding of cardiac anomalies in rat pups exposed to two TCE metabolites, TCA and DCA,  
18 supports a hazard for this effect with TCE (Smith et al., 1989, 1992; Johnson et al., 1998a,b;  
19 Epstein et al., 1993).

20 Both TCA and DCA induce other effects besides cardiac and eye anomalies in offspring.  
21 Both TCA and DCA exposure were associated with a substantial increase in implantation and  
22 resorption sites<sup>39</sup> and decreased fetal weight (Smith et al., 1989, 1992). These effects were  
23 observed in the absence of maternal toxicity.

24 Exposures to TCE during the prenatal period have been reported to induce  
25 neurobehavioral alterations in rat pups, including changes in long-term exploratory and  
26 locomotor behavior, altered glucose uptake and metabolism in the neonatal brain, and decreases  
27 in myelin (Taylor et al., 1985; Isaacson et al., 1990). In addition, changes in adult behavior are  
28 suggested with perinatal exposure to 50 mg/kg TCE (Fredricksson et al., 1993). Statistical  
29 analysis of the data used individual pups, possibly resulting in an overestimate of the statistical  
30 significance of observed results.

31 Exposure to TCE can potentially modify responses to other chemical exposures, which is  
32 an important consideration because TCE environmental exposure is usually not isolated but also  
33 concurrent with other chemicals. TCE and DEHP (a peroxisome proliferator) together were

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<sup>39</sup>Implantation sites are sites of initial attachment of a fertilized ovum, but with no further growth. Resorption sites are sites of implantation with embryonic growth, but arrest and necrosis during development.

1 reported to have synergistic effects with regard to prenatal loss, pup weight changes, and  
2 anophthalmia (Narotsky et al., 1995a,b).

### 3 4 **3.4.5.2. Endocrine System Effects and Reproductive Toxicity**

5 Reports of TCE-induced effects on human sex hormones and their binding proteins are  
6 just beginning to emerge in the published literature. For the most part, workplace exposure to  
7 TCE has not been reported to change hormones, spermatogenesis, or semen quality in men (Goh  
8 et al., 1998). Recently, however, low-level subchronic TCE exposure (mean 30 ppm) was  
9 associated with changes in insulin and steroid level, decreased serum testosterone, and decreased  
10 sex hormone binding globulin (SHBG<sup>40</sup>) in male workers (Goh et al., 1998). Exposure gradients  
11 were observed for several parameters. In analyses adjusted for age, serum testosterone and  
12 SHBG were observed to decrease whereas free androgen levels increased with increasing  
13 duration of TCE exposure.<sup>41</sup> Moreover, dehydroepiandrosterone (DHEA)<sup>42</sup> increased with years  
14 of TCE exposure (Chia et al., 1997), contradicting expectations as DHEA levels normally  
15 decrease with age (Metzger et al., 1997; Chiu et al., 1999). A more complicated picture was  
16 observed for insulin. Insulin levels were elevated for exposures of less than 2 years, but  
17 decreased to below-normal levels for increasing durations of exposure. The normal  
18 SHBG/insulin relationship appeared to be disturbed with longer durations of exposure (Goh et  
19 al., 1998).

20 TCE exposure has been shown to affect the reproductive system of males; studies in  
21 females are few. In another report of the same population of workers studied above, increase in  
22 urinary levels of TCA was correlated with hyperzoospermia, which has been implicated in  
23 infertility (Chia et al., 1996). A lower percentage of normal sperm, compared to referent values  
24 identified by the World Health Organization, was also observed in this population (Chia et al.,  
25 1996). TCE has been shown to accumulate in the male reproductive tract of rats and to decrease  
26 testosterone levels (Zenick et al., 1984; Kumar et al., 2000). Kumar (2000) recently reported  
27 significant decreases in total epididymal sperm count and motility, with the magnitude of loss  
28 correlated with increased duration of exposure. A concurrent increase in total testicular  
29 cholesterol and decreases in enzyme activities, which are rate limiting in the biosynthesis of  
30 testosterone, was also reported. Of note is the use of young rats (starting weights of 50 g) in this

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<sup>40</sup>SHBG has high affinity but low capacity for testosterone and estradiol 17p, and its level may be related to liver toxicity, as it is produced in the liver.

<sup>41</sup>Free androgen is calculated by the division of testosterone levels by SHBG and is that portion free to be biologically active. A decreased index was achieved by differential rates of reduction of SHBG and testosterone.

<sup>42</sup>DHEA is an adrenal steroid associated with insulin resistance, androgenic effects, peroxisome proliferation, and induction of CYP4A (Mayer, 1998, 1999).

1 subchronic (12 and 24 weeks) study. This report describes results from a preliminary study that  
2 indicated TCE-induced decreases in fertility as well. DCA, a metabolite of TCE, is also a  
3 testicular toxin to rats and to dogs at exposures as low as 12.5 mg/kg-d (Katz et al., 1981,  
4 Cicmanec et al., 1991).

5 One report exists of increased menstrual disorders in female workers exposed to TCE  
6 (Zielinski, 1973).

### 7 8 **3.4.5.3. Cervical, Prostate, and Testicular Cancer**

9 The human studies provide some limited evidence for increased cancer risk for certain  
10 reproductive organs. Cervical cancer, though sparsely reported, is elevated in tier-I incidence  
11 studies (RR=2.4, 95% CI=1.2–4.8, N=8) and in tier-III (dry cleaner) mortality studies (RR=1.7,  
12 95% CI=1.5–2.0, N=43) (Wartenberg et al., 2000). The incidence study by Anttila et al. (1995)  
13 provided the greatest weight for an association and reported a statistically significant elevation of  
14 cervical cancer among those with greatest urinary TCA levels. The comparison with internal  
15 controls in Blair et al. (1998) also is suggestive that TCE may be the etiologic agent, and not  
16 some other confounder such as socioeconomic class. Prostate cancer incidence and mortality are  
17 also elevated in tier-I studies (RR=1.3, 95% CI=1.0-1.6, N=95; RR=1.2, 95% CI=1.0-1.4,  
18 N=131).

19 In an NTP study (NTP, 1988), interstitial cell neoplasms of the testis were reported in  
20 Marshall rats exposed to TCE by gavage. Increased incidences are apparent in the other rat  
21 strains when counting the animals alive when the first testicular tumor was observed. In another  
22 study, (Maltoni et al., 1986, 1988) reported significantly increased incidences of Leydig cell  
23 tumors in male rats exposed to TCE by inhalation. Although testicular cancer is often thought of  
24 as occurring spontaneously in some strains of rats late in life, the testicular cancers reported for  
25 TCE were shown in multiple strains with lower background rates and at earlier times of  
26 appearance (see Table 3-4).

27 DCA at levels of 50 mg/kg-d and higher for 13 weeks produced prostate gland atrophy  
28 and testicular changes that were considered dose dependent (Katz et al., 1981).

### 29 30 **3.4.5.4. Pancreatic Cancer**

31 Pancreatic cancer incidence mortality is statistically significantly elevated in the dry  
32 cleaner (tier-III) studies (RR=1.7, 95% CI=1.2–2.6, N=22; RR=1.3, 95% CI=1.0–1.7, N=42),  
33 with mixed results in tiers I and II (Wartenberg et al., 2000). Disturbances in insulin levels as  
34 noted by Goh et al. (1998) and Kato-Weinstein et al. (1998) and effects on carbohydrate handling  
35 may have a role in the induction of effects on the pancreas by TCE in humans. For example,  
36 diabetics have an increased risk of pancreatic cancer (Calle, 1998). In experimental animals,



1 cancer in this organ has not been well studied in the carcinogenic assays carried out to date. Katz  
2 et al. (1981) reported that DCA causes pancreatitis in dogs.

### 3 4 **3.4.6. Lung**

#### 5 **3.4.6.1. *Pulmonary Effects***

6 There are few human data reporting pulmonary toxicity for TCE (ATSDR, 1997; Barton  
7 and Clewell, 2000). Mice appear to be more sensitive than rats to histopathological changes in  
8 the lung via inhalation; pulmonary effects are also seen in rats with gavage exposure. Lungs of  
9 mice exposed via inhalation to 500 ppm TCE for 30 minutes displayed vacuole formation and  
10 endoplasmic reticulum dilation, specifically in Clara cells of the bronchial tree (Villaschi, 1991).  
11 Additionally, a reduction in pulmonary CYP450 enzyme activity was observed after a 6-hour  
12 exposure to 100 ppm TCE (Odum et al., 1992). TCE administered to rats via gavage at doses  
13 1,000 mg/kg-d and higher caused rales and dyspnea (Narotsky et al., 1995) and pulmonary  
14 vasculitis (NTP, 1990).

15 At relatively high doses (drinking water exposures of 80.5 mM DCA or 45.8 mM TCA),  
16 lung inflammation (perivascular) is seen in rats exposed to both these TCE metabolites, but not  
17 in controls (Bhat et al., 1991). At lower doses, a secondary effect of DCA exposure in dogs has  
18 been reported to be pulmonary inflammation (Katz et al., 1981).

#### 19 20 **3.4.6.2. *Lung Cancer***

21 The epidemiologic studies are not generally supportive of lung cancer; lung cancer  
22 mortality was statistically significantly elevated only in dry cleaners (tier-III) (RR=1.3, 95% CI:  
23 1.1-1.5, N=137) (Wartenberg et al., 2000). TCE has been reported to significantly increase the  
24 incidence of lung tumors in male Swiss mice and female B6C3F1 mice by inhalation (see Table  
25 3-5) (Maltoni et al., 1986, 1988). Another study extended this result to female ICR mice (males  
26 were not tested) (Fukuda et al., 1983). These studies did not observe lung tumors in rats.  
27 Ingested TCE has not been observed to cause lung tumors in either rats or mice. This is the only  
28 tumor site reported to have a positive carcinogenic response by one route but not another.

### 3.4.7. Genetic Toxicity

TCE and a number of its metabolites (CH, DCA, and TCA) have been evaluated in a large number of genotoxic assays.<sup>43</sup> On the basis of the available data, definitive conclusions cannot be drawn as to whether TCE is or is not a genotoxic carcinogen. Taken together, TCE and its metabolites CH, DCA, and TCA are, at most, very poor genotoxicants. There is evidence that the metabolite DCVC is more potent as a potential genotoxic agent. Evidence from a number of different analyses and a number of different laboratories using a fairly complete array of genetic endpoints indicates that TCE may have some potential to be genotoxic. However, the evidence is not convincing that it is genotoxic, and is confounded by the fact that TCE is often stabilized with a very low concentration of epichlorohydrin or 1,2-epoxybutane, both known to be potent mutagens. A series of carefully controlled studies evaluating TCE (without mutagenic stabilizers) found TCE incapable of inducing point mutations in standard *Salmonella* assays. Furthermore, in vitro gross chromosome aberration assays were negative. In vivo, there is some evidence that TCE or its metabolites bind to DNA and can induce single-strand DNA breaks in both hepatic and kidney cells. However, the dose required to cause these DNA breaks was very high (4-10 mM of TCE/kg body weight) and the response was very low. More recent data show TCE to affect DNA methylation in whole-liver preparations at lower exposures with increased expression of the two proto-oncogenes *c-jun* and *c-myc* (Tao et al., 1999). Moore and Harrington-Brock's review of the potential genotoxicity of TCE (Moore and Harrington-Brock, 2000) notes that TCE is negative in a number of standard tests, and furthermore, in those tests where positive responses were observed, the dose was very high and response low. Accordingly, although it is not possible to totally eliminate the possibility that TCE would be a genotoxic carcinogen, it is clear from these evaluations that TCE is not a potent genotoxicant (Moore and Harrington-Brock, 2000).

CH has been extensively studied as a potentially genotoxic agent. It has been evaluated in the recommended battery<sup>44</sup> and several other assays, including genetic alterations in rodent germ cells. CH is weakly positive at very high concentrations in in vitro genotoxicity assays that detect point mutations, chromosomal mutations, and/or aneuploidy. There is a mixture of positive and negative in vivo data, and because there is no reason to weigh any of the studies

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<sup>43</sup>Genetic toxicity can be defined using mutational endpoints, cytogenetic analysis, and evaluation of primary DNA damage with mutagenicity described as the ability to induce heritable mutations (Moore and Harrington-Brock, 2000). Primary DNA damage may occur via adduct formation, strand or chromosomal breakage, and unscheduled DNA synthesis. Mutational damage consists of point mutations, chromosomal rearrangement, deletions, loss or gain of chromosomes (aneuploidy), or changes in whole chromosome complements (polyploidy) (Moore and Harrington-Brock, 2000).

<sup>44</sup>The core battery of recommended tests for genetic toxicity include the *Salmonella* assay, in vitro mouse lymphoma mutation assay, and in vivo cytogenetic assay (Moore and Harrington-Brock, 2000).

1 more than the others, it is not clear whether CH has the potential to be genotoxic in vivo (Moore  
2 and Harrington-Brock, 2000).

3 DCA and TCA have also been extensively studied using a variety of genotoxicity assays,  
4 including the recommended battery. DCA is genotoxic at very high concentrations in the  
5 *Salmonella* assay, the in vitro mouse lymphoma assay, and in vivo cytogenetic and gene mutation  
6 assays. DCA can cause DNA strand breaks in mouse and rat liver cells following in vivo  
7 administration by gavage. As with TCE and CH, the concentration of DCA required to induce  
8 damage is very high and the level of response is generally very low. Therefore, although one  
9 cannot eliminate the possibility that DCA might induce tumors via a mutagenic mode of action,  
10 the weight of the evidence argues that TCE-induced tumors would not be mediated by DCA-  
11 induced mutation. TCA is the least mutagenic of the TCE metabolites discussed so far. It is  
12 negative in the *Salmonella* assay, and although positive in the mouse lymphoma assay, it is  
13 substantially less potent than DCA or CH. It is unclear whether TCA can induce chromosomal  
14 damage in vivo; some assays are positive and some negative. TCOH is negative in the  
15 *Salmonella* assay but has not been evaluated in the other recommended screening assays.  
16 Therefore, it is unclear whether TCOH is genotoxic (Moore and Harrington-Brock, 2000).

17 Cysteine intermediates (DCVC and DCVG) formed by the GST pathway are capable of  
18 inducing point mutations, as evidenced by the fact that they are positive in the *Salmonella* assay.  
19 DCVC is the most potent of the TCE metabolites as a *Salmonella* mutagen; DCVG appears to be  
20 similar in potency to DCA. Although DCVC and DCVG have not been evaluated in the other  
21 EPA-recommended screening assays, there is some indication that they can induce primary DNA  
22 damage in mammalian cells in vitro and in vivo. Long-term DCVC exposure can induce de-  
23 differentiation of LLC-PK1 cell clones, supporting evidence of genetic toxicity (Vamavakas et  
24 al., 1996). DCVC has also been shown to induce the expression to two proto-oncogenes, *c-fos*  
25 and *c-myc* (Lash et al., 2000b). Moreover, chlorothioketenes, which are the intermediates formed  
26 from the further metabolism of DCVC by  $\beta$ -lyase, have been shown in vitro to react with DNA  
27 (Müller et al., 1998a,b) and, in an aqueous solution, to bind with cytosine (Volkel et al., 1998).

### 28 29 **3.5. MODES OF ACTION OF TCE TOXICITY**

30 The previous section identifies TCE and its metabolites as eliciting toxicity in a number  
31 of organs in both humans and laboratory animals. Possible modes of action for these observed  
32 effects are discussed in this section, which focuses primarily on events occurring in the rodent so  
33 as to put into perspective observations in chronic toxicity assays. A discussion of the human  
34 relevance of these possible modes of action is also presented. Much of the discussion focuses on  
35 events that may give rise to rodent liver, kidney, and lung tumors. The epidemiologic analysis,  
36 however, suggests other organ systems may also be targets. Moreover, noncancer toxicity is

1 observed and may arise through a common mode of action with the carcinogenic effects. Mode-  
2 of-action hypotheses for these observations are presented last.

3 An understanding of how TCE may elicit toxicity in a number of organ systems can arise  
4 through the identification of very specific events such as changes in gene regulation and cell  
5 signaling, or through a discussion of more generalized events such as common changes to  
6 physiological processes. Data supporting mode-of-action hypotheses are not uniform across  
7 potential targets of toxicity. Identifying mode(s) of action for TCE toxicity entails obtaining  
8 answers to several key questions concerning the relative amount of metabolites formed between  
9 species, the ability to measure active metabolites in biological samples (e.g., DCA), the  
10 determination of which metabolites may impart adverse effects, the sequence of biological  
11 changes that can lead to tumor development, and the extrapolation of these events from rodents  
12 to humans and from higher level exposure in the bioassay to lower environmental exposure.

13 The carcinogenicity data on TCE are complex in that a consistent site-specific response is  
14 not seen across species. Rather, carcinogenicity is demonstrated in the mouse and the rat, but in  
15 different organs. At the most basic level, the observation of rodent tumors indicates a potential  
16 human cancer hazard, and the epidemiologic data are further suggestive of a cancer hazard.  
17 Mode-of-action data have been generated to explain liver tumor development in the mouse and  
18 are rich compared with observed effects in other organ systems; however, much uncertainty still  
19 exists. In all cases, key pieces of information are still missing. The similarity between  
20 carcinogenic effects induced by parent compound and metabolites supports the conclusion that  
21 TCE metabolites are mostly responsible for the liver and kidney tumors observed in TCE  
22 bioassays. Accordingly, much of the mechanistic data on the liver are derived from experiments  
23 on the oxidative metabolites, TCA and DCA; parallel studies in the parent compound are few,  
24 making it difficult to confidently assign the mode of action to a particular metabolite. The  
25 complexity of TCE metabolism and clearance also complicate the identification of a  
26 metabolite(s) that can be identified as responsible for TCE-induced effects. Not surprisingly,  
27 more than one mode of action may explain TCE-induced carcinogenicity and several hypotheses  
28 are discussed. In all likelihood, a number of events will be significant to tumor development in  
29 the rodent under bioassay conditions. Uncertainty exists, however, as to which events may be  
30 more relevant to human exposure to TCE at environmental levels.

### 31 32 **3.5.1. Liver Cancer**

33 Much attention has focused on understanding the development of liver tumors in the TCE  
34 bioassay and the role of the oxidative metabolites, CH, DCA, and TCA. Each of these  
35 metabolites has induced liver tumors in mice under bioassay conditions; DCA also induces liver  
36 tumors in the rat. Mechanistic studies have concentrated on TCA and DCA. One of the largest

1 uncertainties associated with mode-of-action hypotheses based on these metabolites is the  
2 shortage of parallel evidence with TCE itself. Little experimental evidence is available on CH,  
3 and its rapid metabolism to the haloacetic acids is believed to minimize a direct role of CH in  
4 TCE-induced liver cancer (Bull, 2000). Several hypotheses have been put forth regarding the  
5 development of liver tumors in the mouse. These include the role of the peroxisome proliferator-  
6 activated receptor (PPAR) and peroxisome proliferation, disturbances in cell signaling, and  
7 effects on DNA (Bull, 2000). A short discussion of how these events are consistent with other  
8 physiologic conditions associated with hepatocarcinogenicity is presented at the end of the  
9 section.

### 11 **3.5.1.1. Peroxisome Proliferation**

12 The prevailing view of TCE-induced mouse liver carcinogenesis has been that these  
13 tumors arise in parallel with peroxisome proliferation in the liver by TCE metabolites (Elcombe,  
14 1985; Elcombe et al., 1985; Goldsworthy and Popp, 1987; Melnick et al., 1987; DeAngelo et al.,  
15 1989; Cattley et al., 1998). Specifically, TCA is most closely associated with this hypothesized  
16 mode of action because a sustained response with chronic exposure has been noted, in contrast to  
17 the brief response reported for DCA (Bull, 2000). How tumors may develop from peroxisome  
18 proliferation remains unclear (Bull, 2000; Zhou and Waxman, 1998). It has been proposed that  
19 oxidative damage caused by marked increases in free-radical generating enzymes and  
20 peroxisomal  $\beta$ -oxidation might initiate carcinogenesis. It was generally believed that as  
21 peroxisome proliferation has not been observed in humans, agents that produced this result in the  
22 rodent would not present a carcinogenic hazard to humans.

23 This view had merit in the past; however, emerging data on the peroxisome proliferator-  
24 activated receptor (PPAR) implicate nonperoxisomal events such as PPAR-triggered gene  
25 transcription as having important bearing on liver toxicity and subsequent tumor development.  
26 This position is consistent with the view taken by an expert panel convened by ILSI, which  
27 concluded that the ability to act as a peroxisome proliferator does not exclude the possibility that  
28 other properties independently contribute to the development of cancer (Cattley et al., 1998; Bull,  
29 2000). Moreover, this expert panel determined that there was insufficient basis for concluding  
30 that these compounds did not represent a carcinogenic hazard to humans. More recent  
31 experimental evidence suggests that chemicals that induce peroxisome proliferation also produce  
32 a carcinogenic response in rodents through the activation of the PPAR by the chemical or its  
33 metabolite(s). The activated PPAR will interact with the retinoid-X receptor (RXR) and other  
34 specific response elements, resulting in increased synthesis of peroxisomal enzymes and  
35 promotion of gene transcription including transcription of enzymes important in lipid  
36 metabolism.

1 The PPAR belongs to the steroid hormone receptor superfamily and includes several  
2 distinct types: PPAR $\alpha$ , PPAR $\beta$ , and PPAR $\gamma$ . PPAR $\gamma$  is found in many species including mice,  
3 rats, and humans. It has been mostly identified in the liver of rodents and more recently in the  
4 human liver. PPAR $\gamma$  is also found in other human tissues including muscle, liver, kidney, heart,  
5 and testis (Youseff and Badr, 1999; Schultz et al., 1999). Human liver PPAR $\gamma$  mRNA has been  
6 reported to be 10-fold lower than that of mouse liver, whereas that of skeletal muscle is higher in  
7 humans than in rats (Youseff and Badr, 1999). Interindividual variations are also evident  
8 (Tugwood et al., 1998).

9 TCE and its metabolites have been shown to induce peroxisome proliferation in rodents  
10 and its metabolites (TCA and DCA) to activate PPAR $\gamma$  (Goldsworthy and Popp, 1987; Maloney  
11 and Waxman, 1999; Zhou and Waxman, 1998). However, TCE, TCA, and DCA are considered  
12 as weak peroxisome proliferators compared to the model drug, WY-14643. Recent in vitro  
13 experimental evidence at high concentrations of both TCA and DCA shows activation of human  
14 PPAR $\gamma$  (Maloney and Waxman, 1999). No species differences were noted in the magnitude of  
15 activation, which, for both human and mouse PPAR $\gamma$  activation, appeared to increase with  
16 increasing concentration of either TCA or DCA. High concentrations of TCA, but not DCA,  
17 were further shown to activate PPAR $\alpha$  from mice; no activity was demonstrated for human  
18 PPAR $\alpha$  (Maloney and Waxman, 1999).

19 PPAR activation is likely more important as a possible mode of action for TCA than for  
20 DCA, even though both DCA and TCA are shown to activate mice and human PPAR $\gamma$ . As  
21 discussed more thoroughly in the next section, TCA- and DCA-induced tumors are  
22 characteristically very different. These observations support an inference of differing modes of  
23 action for tumor induction by each of these metabolites. PPAR $\gamma$  activation is seen in vitro with  
24 TCA concentrations in mM range (Issemann and Green, 1990; Maloney and Waxman, 1999),  
25 approximately the same range that would be reached in blood of mice by treatment with TCE at  
26 the doses employed in the in vivo cancer bioassays (Bull, 2000). Like TCA, mM concentrations  
27 of DCA are also shown to activate PPAR $\gamma$ . However, in contrast to TCA, systemic  
28 concentrations of DCA associated with experimental doses that induce liver tumors in mice are  
29 expected to be very small (Barton et al., 1999). Moreover, apoptosis and other effects seen with  
30 DCA exposure (discussed in the following section) are expected to occur at DCA concentrations  
31 much lower than the in vitro concentrations producing PPAR activation. Thus, PPAR activation  
32 and the resulting pleiotrophic responses associated with receptor activation are not expected to  
33 contribute greatly to DCA's carcinogenic mode of action.

34 TCA's ability to activate PPAR $\gamma$  has cross-species relevance. The observations of  
35 Maloney and Waxman (1999) support a qualitative similarity between mice and humans; thus, a  
36 PPAR hypothesized mode of action is relevant to both mice and humans. As identified above,

1 quantitative differences in the expression of PPAR" exist between mice and humans, with  
2 humans in general having a lower expression of PPAR" compared to mice. These quantitative  
3 differences have import to the dose-response analysis of the mouse liver tumors and will be more  
4 rigorously treated in Section 4, Dose-Response Assessment and Characterization.

### 6 **3.5.1.2. Cell Signaling and Effect of Negative Selection and Apoptosis**

7 Bull (2000) suggests that modification of cell signal pathways by TCA and DCA  
8 resulting in alterations in cell replication, selection, and apoptosis (programmed cell death) are  
9 likely important contributions to the hepatocarcinogenicity of TCE and its metabolites. TCA's  
10 ability to activate PPAR and the subsequent cascade of pleiotropic responses, including effects  
11 on gene transcription, is a classic example of cell signaling. DCA exposure has additionally been  
12 shown to influence other cell signaling pathways, and observed perturbations provide insight on  
13 mode-of-action hypotheses regarding induction of DCA tumors.

14 Hepatomegaly, or increase in liver size, is a common feature of TCE, DCA, TCA, and  
15 CH exposure to rodents. Hepatomegaly associated with TCE is observed at experimental  
16 exposures well below those shown to induce liver tumors in mice (Bull, 2000). Hepatomegaly is  
17 influenced by increases in either cell number or cell size. Cell number is affected by cell  
18 replication rates and by rates of apoptosis. There is also some evidence that hepatomegaly  
19 associated with PPAR" activation results from suppressed apoptosis (Roberts et al., 1995);  
20 Kupffer cells have been shown to contribute to this process (Chevalier and Roberts, 1998; Rose  
21 1997). One of the roles of apoptosis appears to be the prevention of damaged cells from dividing  
22 and progressing to tumors.

23 Hepatomegaly seen with TCA and DCA exposure is engendered by different processes.  
24 Hepatomegaly associated with DCA is attributable to cytomegaly, increases in cell size, rather  
25 than increases in cell numbers (Bull, 2000). Hepatocytes stain heavily for glycogen, which  
26 accumulates in cells within 1 to 2 weeks of treatment and becomes more severe over time (Bull,  
27 2000). These observations are quite different from the hepatomegaly induced by TCA. For  
28 TCA, increases in liver weight are observed soon after exposure and are linear with experimental  
29 dose (Bull, 2000); however, this is primarily a reflection of cell number and not cell size.

30 Experimental observations support the inference that DCA and TCA induce tumors that  
31 vary in growth rate and develop from different clones of cells in mouse liver (Bull, 2000).  
32 Tumors produced from DCA and TCA exposure display different characteristics. DCA produces  
33 more benign foci that lead to small adenomas, although larger lesions include carcinomas. TCA  
34 elicits fewer altered foci but more carcinomas. These two metabolites, moreover, show divergent  
35 responses once exposure is terminated (Bull, 2000). Termination of DCA treatment halts  
36 progression of the foci and adenomas to carcinomas. In contrast, carcinomas are still observed

1 after termination of TCA exposure, although fewer in number (Pereira and Phelps, 1996).  
2 Differences are also reported in the immunoreactivity of tumors induced by TCA and DCA in  
3 regard to the proto-oncogenes *c-jun* and *c-fos* (Bull, 2000). DCA- and TCA-induced tumors also  
4 appear to have differences as to the shape of their respective dose-response curves, with the  
5 number of DCA-induced tumors appearing to increase disproportionately with dose while those  
6 of TCA appear to be linear.

7 One possible explanation for these observations is that DCA and TCA may selectively  
8 modify growth rates of different clones of cells. TCE and its metabolites could alter cell  
9 replication and apoptosis rates in altered hepatic foci and preneoplastic foci, and provide a  
10 selective growth advantage for differing clones of cells rather than a generalized proliferative  
11 response. Cells resistant to the downregulation of mitosis induced by a chemical may have  
12 selective growth advantage over other cells in that organ (Bull, 2000).

13 Effects of DCA and TCA on replication rates in foci and normal hepatocytes vary and  
14 appear to be dose dependent in some cases. DCA at higher doses can increase replication rates of  
15 tumor cells (Bull, 2000), whereas only a small stimulatory effect on replication is seen in  
16 extrafocal (normal) hepatocytes. Further, as treatment progresses, an inhibitory effect is  
17 observed in the extrafocal hepatocytes. This suppression of cell replication in extrafocal  
18 hepatocytes is accompanied by a parallel decrease in apoptosis. These observations raise a  
19 question as to which is the driver of the decreased cell turnover in extrafocal hepatocytes seen  
20 with DCA. It is unknown if the decrease in cell turnover would increase the probability of  
21 transformation of hepatocytes to allow clonal expansion of damaged hepatocytes that would  
22 normally be eliminated (Bull, 2000). This possibility is suggested by the modeling of DCA  
23 lesion growth rates by Miller et al. (2000).

24 TCA depresses replication rates in normal hepatocytes with no indication that replication  
25 rate within tumors are modified by TCA treatment (Bull, 2000). TCA appears to be selecting  
26 initiated cells that are more aggressive than those selected by DCA at low doses. The extent to  
27 which replication rates in extrafocal hepatocytes are decreased with longer term TCE exposure  
28 has not been investigated, nor those in foci or tumors.

29 Exposure to DCA has been shown to perturb a number of normal cellular functions  
30 including cell signaling pathways, particularly those associated with carbohydrate handling (Bull,  
31 2000). DCA has more recently been shown to alter serum insulin concentrations in mice  
32 (Kato-Weinstein et al., 1998). Insulin is recognized to be mitogenic in liver (Bull, 2000) and to  
33 have differing effects on apoptosis (Hermann et al., 1999). Further, insulin receptor expression  
34 in extrafocal portions of the liver is suppressed by DCA (Bull, 2000). The principal intracellular  
35 substrate of the insulin receptor, tyrosine kinase, is linked to enzymes regulating glycogen  
36 synthesis. In fact, DCA exposure to mice inhibits the glycogen synthesis enzymes and is also



1 associated with increased glycogen deposition in extrafocal hepatocytes, but not in preneoplastic  
2 foci, which are glycogen poor. DCA can also inhibit pyruvate dehydrogenase kinase, although at  
3 levels higher than those needed for effects on glycogen storage. The dose-response for glycogen  
4 deposition in the liver is in the same range as that seen with liver tumors, raising questions of  
5 whether modification of a same-cell signaling pathway may be responsible for both observations.  
6 Moreover, the accumulation of glycogen in normal hepatocytes may contribute to the differential  
7 effects of DCA treatment on insulin receptor expressed in extrafocal hepatocytes and those in  
8 altered foci (Bull, 2000). DCA thus may alter the insulin signaling pathway and provide a  
9 growth advantage to initiated cells through a signal transduction pathway necessary for tumor  
10 growth (Kato-Weinstein et al., 1998). The precise nature of this pathway, however, has yet to be  
11 fully elucidated.

12 Further, a number of metabolic disturbances are associated with exposure to DCA. A  
13 major site of action of DCA at high doses is pyruvate dehydrogenase (PDH), the rate-limiting  
14 enzyme of glucose oxidation (Stacpoole et al., 1992). DCA exposure has been shown to inhibit  
15 hepatic triglyceride and cholesterol biosynthesis, whereas the stimulation of PDH results in  
16 effects on gluconeogenesis (Stacpoole et al., 1992). Emerging experimental evidence, moreover,  
17 suggests that DCA may interfere with tyrosine catabolism. DCA's further metabolism is  
18 dependent on a glutathione-S-transferase isozyme, GST zeta (GSTZ) (Anderson et al., 1999),  
19 also identified as maleylacetoacetate isomerase (Fernández-Cañón et al., 1998).  
20 Maleylacetoacetate isomerase is one step in the catabolism of tyrosine. Chronic exposure to  
21 DCA causes an irreversible inactivation of GSTZ (Anderson et al., 1999), with the rate of  
22 inactivation greater for rats than for humans; the rate of inactivation in the mouse falls in  
23 between those for the rat and human (Tzeng et al., 2000).

24 The interrelationship between rates of cell replication with rates of cell deaths make it  
25 very difficult to determine if the effects of TCA and DCA are exerted on one process or the other  
26 (Bull, 2000). Although the mechanisms underlying DCA- and TCA-induced alterations in cell  
27 division and death are not yet known, the experimental observations suggest that each metabolite  
28 differentially alters these processes. However, the patterns of effects on the processes of cell  
29 division and death provide a reasonable framework for TCE-induced liver cancer. Moreover,  
30 although it is not yet clear whether DCA-induced effects on carbohydrate handling and on other  
31 metabolic processes are directly related to cancer induction, such effects are consistent with a  
32 hypothesis regarding selection and can be consistent with other physiologic conditions associated  
33 with hepatocarcinogenicity.

### 34 **3.5.1.3. *Effects on DNA***

1 A key question to risk assessment is whether TCE-induced tumors are mediated through  
2 an induced mutational mechanism (Moore and Harrington-Brock, 2000). Examination of tumors  
3 for possible mutation has been carried out for investigation of this potential mode of action. TCE  
4 and its metabolites CH, DCA, and TCA are, at best, very poor genotoxicants (Moore and  
5 Harrington-Brock, 2000). TCE and DCA at high concentrations have been shown to bind to  
6 DNA and proteins, and to induce single-strand breaks (Moore and Harrington-Brock, 2000; Bull,  
7 2000). The magnitude of response, however, is low compared to other more potent  
8 genotoxicants such as MMS and DMN (Moore and Harrington-Brock, 2000). DCA is genotoxic  
9 and has been shown to cause DNA strand breaks in mouse and rat liver cells following high level  
10 in vivo gavage exposure. TCA is the least mutagenic of the TCE metabolites (Moore and  
11 Harrington-Brock, 2000).

12 Mutation frequency and mutation spectra in the *ras* oncogene have been examined in  
13 TCE-, TCA-, and DCA-induced liver tumors from male mice; it is interesting to note that very  
14 few codon 61 *h-ras* mutations are seen in liver tumors from female mice treated with DCA. The  
15 actual amount of mode-of-action information on induced mutational mechanisms from these data  
16 is quite minimal (Moore and Harrington-Brock, 2000). However, the pattern of mutation seen  
17 helps provide insight into the relative contribution of different metabolites to TCE-induced liver  
18 cancer (Bull, 2000). Mutational frequency in DCA and TCE tumors (arising from drinking water  
19 exposure) does not differ significantly from that observed in spontaneous tumors; TCA tumors  
20 show both a higher mutation frequency and a pattern atypical of that found with other  
21 peroxisome proliferators (Bull, 2000; Maronpot et al., 1995). Comparison of nucleotide base  
22 sequences within codon 61 of *h-ras* shows some differences between spontaneous tumors and  
23 DCA and TCE tumors, suggesting a similarity between tumors from DCA and TCE-treated  
24 animals (Moore and Harrington-Brock, 2000). Route of exposure, however, appears important to  
25 mutational frequency associated with TCE-induced liver tumors (Bull, 2000).

26 The similarity between DCA and TCE tumors in terms of frequency of mutation and its  
27 spectra support an inference that DCA contributes an important role in the hepatocarcinogenicity  
28 of TCE. The theoretical modeling of TCE, DCA, and TCA liver tumors of Chen (2000) provides  
29 further support for DCA's contribution to TCE-induced liver cancer, although a role for TCA  
30 cannot be excluded either. As additional supportive evidence, lower doses of DCA that  
31 accompany higher doses of TCA appear to exert a large influence on tumor development.  
32 Female mice initiated with N-methyl-N-nitrosourea followed by promotion with a mixture  
33 containing both DCA and TCA developed tumors that appeared more similar to tumors promoted  
34 by DCA alone than those by TCA alone (Pereira et al., 1997). Moreover, the number of tumors  
35 produced from the mixture was greater than would be achieved by adding together tumor  
36 incidences for the individual exposures.

1 The interaction of TCE and its metabolites to bind directly with DNA may not be as  
2 important at lower exposure levels as effects on gene expression. Specifically, effects on gene  
3 expression, whether through activation of PPAR or other signal pathways, may be more  
4 important to their potential carcinogenic properties than induced mutation. Moreover, effects  
5 such as the mistargeting of covalent modification to the proteins that package DNA (e.g., histone  
6 acetylation) or to DNA itself (e.g., cytosine methylation) may be involved in cancer induction,  
7 not by altering gene sequence, but by modifying transcription of the gene (Wolffe, 1999). For  
8 example, DNA methylation is believed to play a role in the control of gene transcription  
9 (Goodman and Counts, 1993; Counts and Goodman, 1995).

10 TCE and its oxidative metabolites have been shown recently to decrease methylation of  
11 DNA as 5-methylcytosine (5MeC) in addition to demethylation of the promoter regions of two  
12 proto-oncogenes, *c-jun* and *c-myc* (Tao et al., 1998, 1999, 2000a). Moreover, the decreased  
13 methylation and increased expression of *c-jun* and *c-myc* with TCA and DCA exposures also  
14 occurred in the presence of increased DNA methyltransferase activity (Tao et al., 2000b). The  
15 proto-oncogenes, *c-jun* and *c-myc*, participate in the control of cell proliferation and apoptosis  
16 (Tao et al., 2000a). The expression of mRNA for these two genes was shown to be transiently  
17 increased as well (Tao et al., 1999). This is an early observation, seen after 3 days of exposure to  
18 TCE. In fact, cell proliferation is enhanced during the first few weeks of exposure to DCA and  
19 TCA (Bull, 2000). Hypomethylation associated with exposure to DCA appears to be reversed  
20 once exposure is terminated (Tao et al., 1998), in contrast to the extent of hypomethylation  
21 associated with exposure to TCA, which remained elevated upon exposure cessation. These  
22 observations support the hypothesis that DCA, and not some other process or event, is affecting  
23 methylation in the tumors. Tao (2000a) recently suggested that depletion of S-  
24 adenosylmethionine may be responsible for the observed hypomethylation of DNA. The  
25 prevention of DCA-, TCA-, and TCE-induced DNA hypomethylation by the addition of  
26 methionine supports this hypothesis.

27 The relationship between DNA methylation and cancer induction is not well elucidated,  
28 and the events and their sequence, which are important to neoplastic cell transformation, are  
29 lacking. Consequently, at the current time, DNA methylation may be best considered an effect of  
30 exposure rather than a precursor specific to the development of tumors.

#### 31 32 **3.5.1.4. Evaluating Proposed Modes of Action for Liver Carcinogenesis**

33 There are several important questions that arise from the discussion above: which of the  
34 hypothesized modes of action can be judged as more plausible; is there evidence to reason any  
35 one is the mode of action for TCE hepatocarcinogenicity, and if so, is it important to EPA's  
36 proposed cancer guidelines (U.S. EPA, 1999); whether an event considered as a precursor to

1 carcinogenesis can be identified. Hence, insight into these questions can support weight-of-  
2 evidence determinations and approaches that will be used in the quantitative dose-response  
3 assessment presented in Section 4. EPA's proposed cancer guidelines (U.S. EPA, 1996, 1999)  
4 note the necessity to outline the sequence of events leading to cancer, to identify key events that  
5 can be measured, and to weight information to determine whether there is a causal relationship  
6 between events and cancer formation. The validation of a causal relationship between exposure  
7 and cancer risk includes the consideration of a number of factors, many of which have been  
8 borrowed from the epidemiologic literature. These criteria include (1) consideration of the  
9 strength, consistency, and specificity of the association between event and tumor response; (2)  
10 the presence of a dose-response relationship between the key event and tumor endpoint; (3) the  
11 temporal relationship between tumor onset and occurrence of the key event (i.e., the key event  
12 should precede tumor formation); (4) the biological plausibility and coherence of the mode of  
13 action; and (5) consideration of other modes of action. Experimental evidence that can be used  
14 to address these criteria is often derived in the species in which tumors were observed. However,  
15 the ultimate question is the human relevance of the proposed mode of action. Hence, it is  
16 necessary to demonstrate that the sequence of steps leading to tumorigenesis in the rodents will  
17 also occur in humans.

18 Experimental evidence for support of mode-of-action hypotheses in the liver focuses on  
19 two of TCE's oxidative metabolites, TCA and DCA. Few data are available on TCE exposure  
20 directly, and only in studies involving activation of the PPAR, albeit in vitro, experiments of  
21 human hepatic cells. Accordingly, it is difficult to determine which of the metabolites of TCE  
22 may be responsible for its toxicity, what the key events may be, and what is their relevance to  
23 humans. There is enough evidence, however, to suggest that many of the responses to TCE  
24 metabolites are relevant to the ability of TCE to induce cancer of the liver in animals, as well as  
25 to the extrapolation of these observations to humans.

26 TCA and DCA have been shown to induce a number of different events in livers of mice  
27 (discussed in the preceding sections). Both have been shown to activate PPAR" as evidenced by  
28 peroxisomal proliferation; however, a role of PPAR activation as a possible mode of action is  
29 more plausible for TCA than for DCA. TCA induces a more sustained proliferative response  
30 than DCA. Furthermore, DCA induces effects on cell signaling processes and on carbohydrate  
31 handling at lower concentrations than those associated with peroxisome proliferation. Besides  
32 PPAR" , TCA has been shown to activate PPAR( from mice but not humans.

33 The role of PPAR" activation and the sequence of events following activation that are  
34 important to tumorigenesis are not well defined, nor is the contribution of other forms of PPAR  
35 to observed TCE carcinogenicity currently known. Furthermore, extraperoxisomal effects of  
36 activation of transcription by PPAR" may elicit a number of changes in cell signaling that may

1 also be linked to increased cancer risk. Moreover, key events critical to the induction of tumors  
2 and the cross-species relevance of these key events have yet to be identified. Further  
3 investigations regarding activation of PPAR through the use of genetically altered experimental  
4 animals may provide insight regarding the role of PPAR" in the induction of liver tumors by  
5 TCE and the contribution of TCA formation.

6 DCA has the ability to affect other cell signaling processes and to disturb carbohydrate  
7 handling at lower concentrations than those associated with PPAR activation. Specifically, DCA  
8 has been shown to alter cell replication, selection, and apoptosis. The observed disturbances to  
9 insulin signaling and to carbohydrate handling associated with DCA exposure may also be  
10 connected to these alterations. The events that lead to and result in a selective growth advantage  
11 or in depressed apoptosis of altered hepatic foci have yet to be clearly defined. As with  
12 activation of PPAR, critical events important to the induction of liver tumors in mice  
13 administered DCA have yet to be identified.

14 Another potential mode-of-action hypothesis of DCA liver tumor induction recently put  
15 forth by Cornett et al. (1999) involves disturbance of tyrosine catabolism. DCA's inhibitory  
16 effects on GSTZ may also inhibit maleylacetoacetate isomerase. Inhibition of maleylacetoacetate  
17 isomerase activity could consequently lead to a buildup of intermediates of tyrosine catabolism,  
18 several of which have are considered alkylating agents (Cornett et al., 1999). This proposed  
19 mode of action needs further investigation because direct experimental evidence regarding TCE-  
20 induced effects on tyrosine intermediates such as maleylacetoacetate and maleylacetone is  
21 lacking. At the present time, the hypothesis of DCA-induced effects on cell signaling is more  
22 compelling.

23 Another approach for investigating the possible role of TCE metabolites in its toxicity is  
24 to ascertain whether enough of the metabolite is present after administration of the parent  
25 compound to induce tumors at the target of concern. A critical issue is the amount of DCA  
26 produced from chronic exposure to TCE and whether this amount would be sufficient to elicit the  
27 events that have been observed with experimental administration of DCA. Chronic exposure to  
28 DCA has been shown to increase the elimination half-life of subsequent exposures in mice, rats,  
29 and humans, suggesting that chronic exposure to DCA inhibits its own metabolism (Gonzales-  
30 Leon et al., 1999). Moreover, recent reports of irreversible inactivation of DCA by GSTZ  
31 suggest larger internal doses of DCA may occur than previously assumed (Tong et al., 1998;  
32 Tzeng et al., 2000). Thus, factors that may affect the clearance of DCA and the role of a possible  
33 buildup of toxic metabolites are complex and are another uncertainty associated with this  
34 assessment.

35 Nevertheless, Barton et al. (1999) have examined this question for mice by carrying out a  
36 theoretical modeling study of both TCE and DCA pharmacokinetics. This study estimated that

1 the maximum levels of DCA in the serum produced from 1,000 and 2,000 mg/kg gavage doses of  
2 TCE (tumorigenic doses in the bioassay) would be equivalent to internal dose metrics that were  
3 approximately half of those estimated from exposure to 0.5 mg/L DCA in drinking water.  
4 Exposure of mice to 0.5 g/L DCA in drinking water produced a 48% to 63% incidence of  
5 hepatocellular carcinomas and a 75% incidence of combined liver tumors (carcinomas and  
6 adenomas), with an increase in the number of carcinomas per liver compared with livers from  
7 control animals (Daniel et al., 1992; DeAngelo et al., 1999; Bull, 2000). The analysis of Chen  
8 (2000) provides further support that DCA produced by TCE is capable of producing the  
9 carcinogenic response seen in mice from gavage exposure to TCE.

10 Information needed to extrapolate the potential risk of DCA formation from TCE  
11 exposure in regard to human liver cancer induction is more limited. Unfortunately, Barton et al.,  
12 (1999) do not examine the amount of DCA produced in humans from TCE exposure, and only  
13 one study (Fisher, 1998) is available that assayed DCA in serum from 17 human volunteers (9  
14 males and 8 females) exposed via inhalation for 4 hours to 100 ppm TCE. Fisher (1998) noted  
15 low but detectable levels of DCA in serum in five volunteers (three males and two females) with  
16 levels ranging between 4 and 12 ppm. The lack of detection of DCA in the other 12 subjects may  
17 be due to the rapid metabolism of DCA, as inhibition of DCA's metabolism would not be  
18 expected to occur from a 4-hour exposure. Alternatively, but less likely, the absence of DCA in  
19 these human subjects may be from lack of DCA formation from TCE. Only one subject with  
20 detectable DCA levels in serum was exposed to TCE at the lower level of 50 ppm for 4 hours,  
21 and DCA was not detected in this experimental protocol (Fisher, 1998, personal communication  
22 with J. Fisher). Furthermore, DCA has been detected in children and adults who received chloral  
23 hydrate (Henderson et al., 1997; Yan, 1999). These studies together provide support that  
24 humans, like mice, have the potential to produce DCA from either TCE when administered as  
25 parent or from a key TCE metabolite, chloral hydrate.

26 The technical problems with detection of DCA, however, are difficult, particularly in the  
27 presence of large amounts of trichloroacetic acid, and samples are subject to the presence of  
28 DCA as an artifact (Ketcha et al., 1996). Hence, it is not clear whether the reported findings of  
29 DCA in humans are accurate or are a reflection of conversion of TCA to DCA under acidic  
30 conditions. The more recent data of Gonzalez-Leon (1999) and analysis of Barton et al., (1999)  
31 are not subject to analytical artifact; thus, it can be concluded that mice convert DCA from TCE.  
32 Given the large uncertainty associated with the human data, by default, it is reasonable to assume  
33 that humans would similarly produce DCA and observations in mice can be extrapolated across  
34 species to humans.

35 Several lines of reasoning lead to the conclusion that no one metabolite can be identified  
36 as responsible for TCE's carcinogenicity. The modeling studies of Barton et al. (1999) and Chen

1 (2000) support an inference that the concentrations of DCA in mice produced from exposures  
2 experienced in the TCE gavage bioassay are of sufficient quantity to induce hepatic tumors.  
3 Conclusions of Chen (2000) further suggest ambiguity in identifying one metabolite as  
4 explaining TCE hepatocarcinogenicity. Both metabolites may each have their separate modes of  
5 action and may, in fact, work in concert to alter each other's toxicity. This is suggested from the  
6 experimental evidence of joint TCA and DCA exposure by Pereira et al. (1997) and from newly  
7 emerging experimental data of Bull (*personal communication*). Bull (*personal communication*)  
8 has examined the frequency of TCE-induced liver tumors that are *c-jun+*; the frequency of  
9 hepatic tumors in which *c-jun* has been mutated is high in DCA-induced liver tumors.  
10 Preliminary results from Bull suggest a role for DCA, in that many TCE-induced tumors were  
11 *c-jun+* (Bull, *personal communication*). Also noteworthy was a finding of a similar number of  
12 tumors that did not display a mutation to *c-jun* (Bull, *personal communication*); *c-jun* is not  
13 mutated in liver tumors from TCA exposure. These findings suggest that TCA and DCA both  
14 contribute to the hepatocarcinogenicity of TCE.

#### 15 16 **3.5.1.5. Consistency With Other Physiologic Conditions and Associated** 17 **Hepatocarcinogenicity**

18 The consistency in events seen with exposure to TCE metabolites, specifically DCA, and  
19 physiologic conditions associated with several human diseases can provide insight into mode-of-  
20 action hypotheses and may support inferences regarding potential increased human cancer risks.  
21 Many cellular events observed with exposure to DCA, including changes in carbohydrate  
22 handling, are also seen with several diseases such as glycogen storage diseases and diabetes.  
23 Although the pathogenesis of these diseases and what is known about liver tumor induction with  
24 DCA exposure may have distinct differences, disturbances in cell metabolism and in  
25 carbohydrate handling are common events. As discussed below, diabetics and individuals with  
26 glycogen storage diseases are at increased risk for liver cancer. Furthermore, individuals with  
27 tyrosinemia also have an increased risk of liver cancer (Tanguay et al., 1996; Laberge et al.,  
28 1986).

29 Glycogen storage diseases are caused by inherited deficiencies of enzymes that regulate  
30 the synthesis, transport, or degradation of glycogen. Individuals with glycogen storage diseases  
31 store excess glycogen in their livers. This storage resembles that seen in the extrafocal  
32 hepatocytes of DCA-treated livers. The majority of individuals with glycogen storage diseases  
33 develop liver cancer early in life. In fact, multiple hepatocellular neoplasms are often seen in  
34 these individuals. In a similar pattern, DCA exposure induces multiple foci in mice livers.

35 Diabetes is a disease involving insulin disturbances. Poorly controlled diabetes results in  
36 excess glycogen storage in livers as well. Hepatomegaly is seen in both Type I and Type II

1 diabetics (Herrman et al., 1999) and diabetics have an increased risk for liver cancer (LaVecchia  
2 et al., 1994; Adami et al., 1996; Wideroff et al., 1997). It is possible that greater sensitivity of  
3 tumor cells than normal cells to insulin could mimic such disturbance and contribute to DCA  
4 liver tumor induction as well (Bull, 2000).

5 Moreover, observations on cellular changes that include markers in liver tumors resulting  
6 from exposure to TCE, DCA, or TCA overall are consistent with a more generalized description  
7 of hepatocarcinogenesis proposed by Bannasch and others (Bannasch et al., 1986, 1996, 1997; Su  
8 et al., 1997). A number of findings have been reported that suggest the sequence of cellular  
9 changes during hepatocarcinogenesis is in principle identical in humans and experimental  
10 animals (Bannasch et al., 1986, 1996, 1997). For example, Bannasch (1986) notes a correlation  
11 between changes in cell metabolism, carbohydrate handling, and neoplastic cell transformation.  
12

### 13 **3.5.2. Kidney Cancer**

14 Mode-of-action studies investigating kidney tumors induced in gavage and inhalation  
15 bioassays have focused on metabolites, particularly those associated with the glutathione  
16 pathway, where the experimental evidence is more persuasive. There are several lines of  
17 investigation for potential modes of action for TCE in the kidney as cited by Lash et al. (2000b):  
18 peroxisome proliferation, alpha-2u globulin nephropathy, mutagenicity or other genetic toxicity,  
19 formic acid formation, and cytotoxicity-induced damage. The question is which, if any, of these  
20 mechanisms are operative and likely to lead to the development of cancer at doses that were  
21 lower than those used in the bioassays of TCE in animals.  
22

#### 23 **3.5.2.1. Genotoxicity**

24 Cysteine intermediates (DCVC and DCVG) formed in the GST pathway are capable of  
25 inducing point mutations, as evidenced from positive findings in the *Salmonella* assay (Moore  
26 and Harrington-Brock, 2000). DCVC is the most potent of the TCE metabolites as a *Salmonella*  
27 mutagen. DCVG is not as potent as DCVC, but this is consistent with the hypothesis that DCVG  
28 needs to be converted to DCVC to induce point mutations. Although DCVC and DCVG have  
29 not been evaluated in other screening assays, there is some indication that they can induce  
30 primary DNA damage in mammalian cells in vitro and in vivo. Further, formation of covalent  
31 adducts with proteins and other macromolecules in mitochondria have been documented (Lash et  
32 al., 2000b). The covalent binding of DCVC is largely dependent on its metabolism by the  $\gamma$ -  
33 lyase pathway. DCVC has been shown to induce the express of two proto-oncogenes, *c-fos* and  
34 *c-myc* (Lash et al., 2000b). As noted in the liver mode-of-action discussion, *c-myc* is involved in  
35 the control of cell proliferation and apoptosis (Tao et al., 2000a).



1 A key question in risk assessment, like that identified in the liver mode-of-action  
2 discussion, is whether TCE-induced kidney tumors are mediated through a compound- or  
3 metabolite-induced mutational mechanism. Two reports provide suggestive evidence for TCE-  
4 induced mutations in the VHL gene of renal cell carcinoma patients (Brüning et al., 1997b;  
5 Brauch et al., 1999). Brauch et al. (1999) expanded the work of Brüning et al. (1997b) and  
6 observed somatic mutations in 75% of the renal cell carcinomas from TCE-exposed individuals.  
7 Many (42%) of the carcinomas taken from TCE-exposed cases had multiple mutations, and  
8 nucleotide base changes were found in five regions. A specific “hot spot” on gene nucleotide  
9 454 was altered in 13 renal cell carcinoma patients with TCE exposure, but this mutation was not  
10 detected in renal cell carcinoma patients without TCE exposure or was carried by healthy  
11 subjects. Brauch et al. (1999) hypothesize that the C>T mutational changes in the VHL gene of  
12 TCE-exposed renal cell carcinoma patients may be associated with alkylation and DNA adduct  
13 formation of the opposite DNA strand. It is probable that these mutations play a role in the  
14 development of these tumors because a function of this gene is to suppress the development of  
15 kidney cancer. These data identify a profile that seems to be specific to TCE exposure. The  
16 finding of the mutation in nucleotide 454 in normal kidney parenchymal tissue from four patients  
17 adds further support that this mutation may precede tumor formation. The halothioketenes,  
18 products from  $\beta$ -lyase cleavage of DCVC, form DNA adducts in vitro and could conceivably  
19 contribute to the induction of these mutations (Müller et al., 1994, 1998a,b). Moreover,  
20 chlorothioketenes have been shown in vitro to form adducts with cytosine in an aqueous solution  
21 (Volkel et al., 1998). There may, however, be alternative mechanisms such as selection of cells  
22 within the mutation, rather than producing the mutation, that may account for or at least  
23 contribute to these observations. Although this is not conclusive proof of a mutagenic  
24 mechanism, it is prudent to consider this as an important and likely mode of action and, at the  
25 minimum, a marker for TCE-induced kidney cancer.

### 26 27 **3.5.2.2. Accumulation of Alpha-2u Globulin**

28 In the past, the production of alpha-2u globulin was considered as contributing to TCE-  
29 induced kidney tumors, with the initiation of several studies to examine this hypothesis.  
30 Alpha-2u globulin accumulation is unique to male rats, and when in excess is associated with  
31 nephropathy, cytotoxicity, cellular proliferation, and consequent renal tumors. Goldsworthy  
32 shows that TCE does not cause an accumulation of alpha-2u globulin in the male (Goldsworthy  
33 et al., 1988; Lash et al., 2000b). Moreover, TCE is a renal toxicant and clearly causes kidney  
34 damage in both male and female rats and in mice (Barton and Clewell, 2000). With respect to  
35 kidney tumors, the analysis of Rhomberg (2000) shows that kidney tumors are found in both  
36 TCE-treated male and female rats. Thus, alpha-2u globulin accumulation does not appear to be a

1 mode of action of TCE-induced kidney toxicity in rats or relevant to human risk (Lash et al.,  
2 2000b).

### 3 4 **3.5.2.3. Peroxisome Proliferation**

5 A potential role of peroxisome proliferation should be included in any mode-of-action  
6 discussion for kidney tumor induction because renal enzymes generate chloroacetates that are  
7 known to induce peroxisome proliferation, and the renal proximal tubular epithelial cells are  
8 relatively rich in peroxisomes. One study specifically has addressed the issue of TCE-induced  
9 peroxisome proliferation in the kidney, with other studies examining the influence of TCE  
10 metabolites on peroxisome proliferation (Lash et al., 2000b). Peroxisome proliferation was  
11 reported to occur in both rat and mouse kidney following exposure to TCE, with mice showing a  
12 greater response, as measured by cyanide-insensitive palmitoyl-CoA oxidation, than that seen in  
13 rats (Goldsworthy and Popp, 1987). TCE and its metabolites have not been shown to induce  
14 kidney cancer in mice, however. Odum et al. (1988), additionally, suggest that TCA-induced  
15 peroxisome proliferation does not play a role in male rat kidney carcinogenicity. A role for  
16 peroxisome proliferation of TCE-induced kidney carcinogenicity is unlikely.

### 17 18 **3.5.2.4. Nephrotoxicity and Cytotoxicity**

19 TCE has been demonstrated to cause nephrotoxicity and to induce persistent changes to  
20 the proximal tubules in both rats and humans. It has been proposed that kidney tumor induction  
21 results from cellular necrosis and activation of repair processes that lead to cellular proliferation.  
22 Most of the studies aimed at elucidating this possible mode of action have focused on DCVG or  
23 DCVC, rather than the parent compound, as it is believed that flux through the GSH conjugation  
24 pathway and the subsequent production of reactive species are responsible for observed  
25 nephrotoxicity (Lash et al., 2000b). The in vivo formation in both animals and humans of these  
26 intermediates from TCE further adds significance to these studies in an assessment of TCE. In  
27 spite of the importance of  $\gamma$ -lyase metabolism in cysteine conjugated-induced nephrotoxicity,  
28 there is evidence in several other studies that suggests additional enzymatic activities may also  
29 bioactivate DCVC and may be important to nephrotoxicity (Lash et al., 2000b).

30 A number of in vivo and in vitro studies support that TCE and its cysteine conjugates are  
31 associated with nephrotoxicity, specifically proximal tubular damage, as measured by elevated  
32 excretion of renal enzymes or by histopathologic examination. Nephrotoxicity has also been  
33 shown in individuals with occupational exposure to high levels of TCE (Lash et al., 2000b;  
34 Brüning et al., 1999a, 1999b). Nephrotoxicity as well as tumors were observed concurrently in  
35 the NTP bioassay (NTP, 1988). The incidence of nephrotoxicity in the rat bioassay was high,  
36 however, and far exceeded the reported incidence of tumors (NTP, 1988). Further,

1 nephrotoxicity appears to correlate with the known sex differences in metabolism rates, males  
2 having a higher metabolic rate than females (Lash et al., 2000b). Exposure to TCE was  
3 associated with a modest increase in lactate dehydrogenase release (a marker of cell injury) in  
4 male rat kidney cells, but not in cells from female rats at similar concentrations (Lash et al.,  
5 2000b).

6 Nephrotoxicity may result from oxidative stress, disturbances in calcium ion homeostasis,  
7 mitochondrial dysfunction, or protein alkylation. A number of studies demonstrate  
8 nephrotoxicity by these process with exposure to TCE or, more so, to DCVC. Both TCE and  
9 DCVC induce an oxidative stress response that includes GSH oxidation or depletion, lipid  
10 peroxidation, and oxidation or alkylation of protein sulfhydryl groups after exposure of renal  
11 cells to these agents. It is likely that oxidative stress plays some role in DCVC-induced  
12 nephrotoxicity, but lipid peroxidation is probably a consequence rather than a cause of cellular  
13 injury (Lash et al., 2000b). DCVC-induced changes in free calcium ion concentrations include  
14 inhibition of mitochondrial metabolism and function, severe mitochondrial damage, poly(ADP)-  
15 ribosylation of nuclear proteins and DNA double-strand breaks, and changes in cytoskeletal  
16 protein structure. The cysteine conjugates, including DCVC, have been shown to covalently bind  
17 with proteins and other macromolecules in mitochondria. Cytosolic proteins are another target of  
18 the reactive metabolites of DCVC, and protein adducts have been observed in vitro in human  
19 proximal tubular cells with exposure to DCVG and DCVC and in rats exposed in vivo to DCVC.  
20 The finding of higher levels of covalent binding in TCE-exposed mice compared to rats suggests  
21 that other factors besides covalent adduct formation must contribute to the induction of renal  
22 carcinogenesis (Lash et al., 2000b).

23 Recently, Green (Green et al., 1998) put forth another hypothesis that urinary excretion of  
24 formic acid leading to decreased pH after TCE exposure may partially explain the observed renal  
25 toxicity in the TCE studies. The excretion of increased levels of formic acid as observed with  
26 exposure to TCE appears to be related to folate deficiency (Dow and Green, 2000). Kidney  
27 toxicity has been reported in humans and rabbits with exposure to formic acid (Jacques, 1982;  
28 Liesivuori and Savolainen, 1986, 1987, 1991, 1992); however, data are lacking on whether  
29 formic acid induces kidney tumors. At the present time there is limited evidence that this  
30 pathway is involved with renal tumorigenesis. Moreover, demonstrating a role for this  
31 mechanism does not detract from a potential contribution to tumorigenesis by other pathways,  
32 e.g., glutathione conjugation and processing to DCVC and subsequent reactive metabolites.

### 33 34 **3.5.2.5. Contribution of Several Modes of Action**

35 It is likely that multiple modes of action may be important in TCE-induced kidney cancer  
36 (Lash et al., 2000b). As in the liver, level of exposure will be an important consideration. The

1 preponderance of the evidence suggests that the cysteine conjugates and reactive metabolites  
2 generated from their  $\beta$ -lyase metabolism are most likely responsible for kidney toxicity and  
3 tumorigenicity (Lash et al., 2000b). These metabolites have not been tested in a chronic bioassay  
4 and the lack of such information is an uncertainty associated with this inference. More  
5 information is also needed regarding any potential role of the oxidative metabolites of TCE and  
6 of formic acid.

7 Separating the contribution of genotoxicity from that of nephrotoxicity and chronic  
8 cellular injury in relation to the development of renal tumors is important to a discussion of  
9 potential modes of action for kidney cancer and TCE. The cysteine metabolites appear to be  
10 inextricably intertwined such that the contribution of these events in tumor development cannot  
11 be evaluated on the basis of data that are available today. As DCVC has been demonstrated to be  
12 mutagenic in *Salmonella*, and mutation in the VHL gene seems to be associated with TCE-  
13 related tumors in epidemiological studies, it is reasonable to regard gene mutation as a potential  
14 mode of action for kidney tumors.

### 15 16 **3.5.3. Lung Cancer**

17 There has been much less investigation into potential modes of action for TCE-induced  
18 lung cancer than for the liver and kidney. Green (2000) suggests that mice may be more sensitive  
19 to the toxic effects of TCE exposure in the lung than are other species tested because of their  
20 increased amounts of CYP2E1 metabolism, specifically in Clara cells, compared to humans and  
21 rats. Lung tumors in mice are thought to arise through an accumulation of CH in the Clara cells  
22 of the lung, causing cell damage and compensatory cell replication, which in turn leads to tumor  
23 formation (Green, 2000). CH is believed to be the etiologic agent because independent studies  
24 have shown that CH when administered alone causes lung lesions identical to TCE-induced  
25 tumors. Neither TCA nor TCOH (metabolites of CH) causes lung lesions.

26 This hypothesis suggests that such a mechanism in mice may not be extrapolated to  
27 humans, as there is little CYP2E1 activity in human lungs as a whole (Green, 2000). However,  
28 activity from whole lungs may give misleading results because of the variety of cell types. High  
29 activity for a few cell types may be diluted by other cells with low activity (Lash et al., 2000b).  
30 While thought to be relatively scarce in the human lung, recently Boers et al. (Boers et al., 1999)  
31 have characterized the number of Clara cells in the normal human airway and show that Clara  
32 cells contribute substantially to cell renewal in normal conducting airway epithelium in humans.  
33 Furthermore, Clara cells have been identified as important to the development of lung  
34 adenocarcinoma in humans (Boers et al., 1999).

35 The hypothesis that CH is responsible for lung tumor induction requires further  
36 confirmation. It would be useful to develop strong connections between metabolism of TCE, the

1 actual tumor cell of origin, and the contribution of other possible mechanisms that CH might  
2 utilize to increase lung tumor incidence. CH is clearly clastogenic and mutagenic at high doses  
3 (Moore and Harrington-Brock, 2000), raising the possibility of genotoxic activity as well as a  
4 mode of action involving simple cytotoxicity and reparative hyperplasia. Moreover, it is not yet  
5 clearly demonstrated that CH is the metabolite responsible for lung tumor development.

#### 6 7 **3.5.4. Toxicity in Other Organs**

8 Mode-of-action information for toxicity in other organs such as the endocrine and  
9 lymphopoietic system, and in the developing fetus, is more limited than that for the liver, kidney  
10 and lung. Data specific to TCE and its metabolites are few, and support for mode-of-action  
11 hypotheses are based on observations of common activities with other agents. In some cases, the  
12 roles of PPAR activation or cell signaling perturbations that are relevant to mode-of-action  
13 discussions for the liver and kidney are applicable to discussions of toxicity observed in these  
14 other organ systems. In other cases, such as lymphoma seen in the human epidemiologic studies,  
15 studies using animal models are lacking or are too few to support the human observations.

16 Endocrine system effects associated with TCE exposure include the development of  
17 testicular (Leydig cell) cancer in rats (Maltoni et al., 1988; NTP, 1988) and hormone  
18 disturbances (SHBG, DHEAS, testosterone) in humans (Chia et al., 1997; Goh et al., 1998).  
19 TCE and its metabolites, TCA and TCOH, have been found to partition in the male reproductive  
20 organs of rats after 6 weeks of inhalation exposure (Zenick et al., 1984). A wide variety of  
21 agents that affect steroid hormone levels, such as testosterone, estradiol, and luteinizing  
22 hormone, will also induce Leydig cell tumors in the rat (Cook et al., 1999). Peroxisome  
23 proliferating chemicals have been shown to induce Leydig cell tumors via a modulation of  
24 growth factor expression by estradiol (Cook et al., 1999). Peroxisome proliferating chemicals  
25 induce hepatic aromatase activity, which can increase serum and testis estradiol levels. The  
26 increased interstitial fluid estradiol levels can modulate growth factors, including TGF $\beta$ , and  
27 stimulate Leydig cell proliferation (Cook et al., 1999).

28 Steroid hormones such as testosterone, estradiol, and luteinizing hormone are regulated  
29 through the hypothalamo-pituitary-testis (HPT) axis in both rats and humans, and agents that induce  
30 Leydig cell tumors in rats by disruption of the HPT axis are thought to pose a hazard to humans  
31 (Cook et al., 1999). Cook et al. (1999) further suggest that Leydig cell tumors induced through  
32 an aromatase activity mode-of-action such as that suggested for peroxisome proliferators are  
33 considered potentially relevant to humans. Although the risk of Leydig cell cancer in humans  
34 may be diminished compared to rats owing to the absence of SHBG, the observation of Leydig  
35 cell tumors in rats exposed to TCE may act as a signal for disturbance of the endocrine system  
36 and be indicative of potential endocrine disturbances in humans. Further, a potential target of

1 testosterone disruption may be the prostate, which in humans is sensitive to testosterone and  
2 other androgens (Shimada et al., 1999; Bosland et al., 1995) and is affected by Leydig cell  
3 function in the rat (Yount et al., 1982). The effects of endocrine disruption in human populations  
4 exposed to TCE are an area for more research.

5 TCE exposure has been associated with effects on immune system functioning and  
6 includes both immune suppression and autoimmunity. Reports of both immune suppression and  
7 autoimmunity may appear paradoxical at first glance; however, these observations are plausible.  
8 Certain elements of the immune system may be differentially affected by a chemical, affecting  
9 the ability to mount well-regulated immune responses to both foreign and self-antigens and  
10 leading to conditions such as autoimmunity via an alteration in the balance between specific  
11 immune components. Immune suppression, furthermore, may play a role in the induction of  
12 cancer; many immune-suppressive agents are human carcinogens (Tomatis et al., 1989).  
13 Additionally, a common event or events may exist in mode-of-action pathways for tumorigenesis  
14 and for autoimmunity (e.g., dysregulation of apoptosis). The observation of an increased risk of  
15 multiple myeloma in patients with autoimmune diseases provides some support for this  
16 hypothesis (Cooper et al., 1999).

17 Organic solvent exposure in general is associated with autoimmune disease such as  
18 scleroderma (systemic sclerosis) (Nietert et al., 1998). Mode-of-action hypotheses for  
19 autoimmunity resulting from environmental agents have been grouped into three broad  
20 categories: (1) a change in the hormonal milieu to favor estrogenic stimulation of the immune  
21 system; (2) suppression of one section of the immune system, which disrupts normal immune  
22 surveillance; and (3) chemical binding to a self-antigen forming a neoantigen, thus breaking  
23 tolerance by inducing immunity to the unmodified native molecule as well as to the modified  
24 antigen (Mayes, 1999). These mechanisms are currently speculative at best, but are supported by  
25 animal models (Mayes, 1999). TCE exposure, specifically, has been shown to induce  
26 autoantibody formation against dichloroacetyl chloride in genetically susceptible autoimmune-  
27 prone mice (Griffin et al., 2000a,b, Khan et al., 1995). Moreover, T-cells were shown to secrete  
28 more interferon- $\gamma$  and less interleukin-4 after TCE exposure (Griffin et al., 2000a). Griffin et al.,  
29 (2000a) note that the pattern of response was consistent with a T-helper Type 1 immune or  
30 inflammatory response. Furthermore, these effects have been shown to contribute to the  
31 development of autoimmune disease in the liver (autoimmune hepatitis) (Griffin et al., 2000c).  
32 Oxidative metabolism is necessary for inducing the inflammatory response because blocking the  
33 CYP450 pathway was shown to primarily inhibit the response (Griffin et al., 2000b). One  
34 epidemiologic study also reported an strong association between TCE exposure and systemic  
35 sclerosis patients with autoantibodies (Nietert et al., 1998). The mode(s) of action for these  
36 observations is not known at this time.

1 The Kupffer cell may also play an important role in autoimmune response. Kupffer cells  
2 have been discussed previously in the liver mode-of-action section. Activated Kupffer cells  
3 release a number of chemicals, including hydrogen peroxide, superoxide ion, and hydrolytic  
4 enzymes, which aid in antigen destruction, and also cytokines, which have immunoregulatory  
5 and inflammatory activity (e.g., interleukins, TGF $\beta$ , and TGF $\alpha$ ). Several of these chemicals  
6 have also been associated with apoptosis (see liver cancer discussion) (Laskin, 1996). Treatment  
7 of mice with TCE for 30 days has been shown to affect Kupffer cells and the production of  
8 inflammatory cells (Kjellstrand et al., 1983). Moreover, peroxisome-proliferating chemicals in  
9 general are also reported to affect Kupffer cell function (Youseff and Badr, 1998), and PPAR  
10 activation may play a role in autoimmune disease.

11 Immune suppression and TCE exposure are areas needing more research. Immune  
12 suppression may play a significant role in the development of non-Hodgkin's lymphoma, as seen  
13 in the epidemiologic studies (Wartenberg et al., 2000) and in the mouse bioassay (Henschler et  
14 al., 1980). Non-Hodgkin's lymphoma is found with a higher frequency among individuals with  
15 compromised immune systems resulting from either viruses or past chemotherapy (Smith, 1996).  
16 Although this is not well studied, one report of TCE exposure to female mice via the drinking  
17 water shows exposure-related inhibition of humoral immunity with effects on bone marrow  
18 function, cell-mediated immune responses, and macrophage function (Sanders et al., 1982).

19 Mode-of-action hypotheses for observed developmental effects seen with TCE, TCA, and  
20 DCA exposure are not well developed, and data specific to TCE exposure are few.  
21 Developmental effects that have been associated with TCE or TCE metabolite exposure include  
22 microphthalmia/anophthalmia (eye anomalies) in rats, cardiac defects in rats and humans and,  
23 more vaguely, neural tube defects in humans. Microphthalmia has been reported in human  
24 offspring with maternal alcohol and retinoic acid exposures. Both retinoic acid and ethanol have  
25 in common peroxisome receptor activity. PPAR $\alpha$  activation may be important to the  
26 development of eye anomalies, although no data currently support this hypothesis. In fact,  
27 another agent that activates PPAR, DEHP, induces pronounced anophthalmia and microphthalmia  
28 in rats (Narotsky et al., 1995a,b).

29 Researchers at the University of Arizona are examining the cardiac teratogenicity of  
30 trichloroethylene. Research is focused on evaluating whether gene expression is affected during  
31 cardiogenesis by altering several molecules which are hypothesized to be critical for normal heart  
32 development. Recently Boyer et al. (2000) have reported that TCE treatment produces a dose-  
33 dependent inhibition of mesenchymal cell transformation (a critical event in development of the  
34 heart) in progenitors of the valves and septa in the heart in vitro. Boyer et al. (2000) also note a  
35 concurrent study that shows alteration of gene expression in rat embryo hearts with maternal  
36 exposure in drinking water of 110 ppm TCE. Although questions may surround the experimental

1 evidence of whether cardiac anomalies observed in the developmental assays are related to TCE,  
2 Boyer et al. (2000) report that TCE can affect events important to the development of the heart,  
3 events which are consistent with an induction of cardiac anomalies. Moreover, the TCE  
4 metabolites, TCA and DCA, both produce cardiac anomalies in rats (Smith et al., 1989, 1992;  
5 Johnson et al., 1998a,b; Epstein et al., 1993). DCA also concentrates in rat myocardial  
6 mitochondria (Kerbey et al., 1976), freely crosses the placenta (Smith et al., 1992), and has  
7 known toxicity to tissues dependent on glycolysis as an energy source (e.g., the testes, lens, and  
8 nervous system in humans and dogs) (Yount et al., 1982; Stacpoole et al., 1979; Katz et al.,  
9 1981; Cicmanec et al., 1991). Mammalian embryos also rely on glycolysis for energy, therefore  
10 suggesting a common vulnerability for toxicity (Smith et al., 1992). However, there is no direct  
11 evidence for DCA to affect glycolysis in the embryo. More research into TCE and its  
12 metabolites is needed to more fully elucidate possible modes of action for the effects observed in  
13 standard developmental protocols.

### 14 15 **3.6. HAZARD CHARACTERIZATION**

#### 16 **3.6.1. Consideration of Causality in the Epidemiologic Evidence**

17 Overall, the epidemiologic studies suggest an association between TCE exposure and  
18 excess risks of kidney cancer, liver cancer, lympho-hematopoietic cancer, cervical cancer, and  
19 prostate cancer (Wartenberg et al., 2000). Determining whether an association is one of cause  
20 and effect involves considering several aspects that are characteristic of cause-and-effect  
21 relationships (Hill, 1965; Rothman, 1986).<sup>45</sup> No aspect is either necessary or sufficient; rather,  
22 they must be weighed to determine whether the most likely explanation of an observed  
23 association is cause and effect.

24 **(1) Strength of the observed association.** The finding of large, precise risks increases  
25 confidence that the association is not likely due to chance, bias, or other factors. A  
26 modest risk, however, does not preclude a causal association and may reflect a lower  
27 level of exposure or an agent of lower potency. For TCE, the observed risks are generally  
28 modest (twofold or less) for cancers of the kidney, liver, and lympho-hematopoietic  
29 system. An exception is the large odds ratio for kidney cancer (OR=10.8, 95% CI=  
30 3.4-34.8) reported by Vamvakas et al. (1998). Differences between cohort and case-

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<sup>45</sup>EPA's proposed cancer guidelines (U.S. EPA, 1999) use this framework to determine whether a cause-and-effect interpretation of the epidemiologic evidence is credible. The proposed guidelines may extend this framework to the separate question of determining whether the mode-of-action information is sufficient to establish cause and effect. For this question, the key aspect of causality is whether experimental evidence in the laboratory demonstrates that a specific sequence of key events leads to the observed tumors and that intervening to prevent a key event will prevent tumor formation.



1 control studies, in part, may reflect exposure differences. The observed risks are not  
2 thought to be attributable to smoking (important in liver cancer) or socioeconomic status  
3 (important in cervical cancer).

4 **(2) Consistency of the observed association.** An inference of causality is strengthened  
5 when a pattern of elevated risks is observed across several independent studies. Some  
6 degree of consistency was observed for associations of TCE exposure with cancers of the  
7 kidney, liver, lympho-hematopoietic system, cervix, and prostate (Wartenberg et al.,  
8 2000). Consistency is strongest for kidney cancer, supported by tier-I, tier-II, and tier-III  
9 mortality (but not tier-III incidence) studies and case-control studies (see Section 3.4.2).  
10 For liver cancer, consistent results were observed in tier-I and tier-II but not tier-III  
11 studies (see Section 3.4.1). For lympho-hematopoietic cancer, associations observed in  
12 the tier-I studies were supported by the ecologic studies of residential drinking water  
13 exposure, though not by the tier-II or tier-III studies (see Section 3.4.4). Cervical cancer,  
14 though sparsely reported, is elevated in tier-I incidence studies and tier-III mortality  
15 studies (see Section 3.4.5). Prostate cancer is elevated in the tier-I studies (see Section  
16 3.4.5).

17 **(3) Specificity of the observed association.** Traditionally, specificity has been defined in  
18 terms of one cause, one disease (Hill, 1965). TCE causes cancer at several sites in rats  
19 and mice; hence, there is no expectation that TCE would be associated with only one  
20 human cancer. Many agents cause cancer at multiple sites, and many cancers have  
21 multiple causes. Evidence of specificity may come from the recent observation of  
22 multiple mutations of the VHL tumor suppressor gene, primarily C>T changes including  
23 nucleotide 454, in renal cell carcinoma patients with high, prolonged TCE exposure  
24 (Brauch et al., 1999; Brüning et al., 1997b) (see Section 3.5.2). Key research related to  
25 specificity would include investigation of VHL gene mutations in other cohorts exposed  
26 to TCE (see Section 5).

27 **(4) Temporal relationship of the observed association.** A causal interpretation is  
28 strengthened when exposure is known to precede development of the disease.  
29 Associations between TCE exposure and several forms of cancer are supported primarily  
30 by cohort and case-control studies, in which the temporal relationship is well described.  
31 All drinking water studies, except the case-control analysis by MA-DOH (1997), are  
32 ecologic or prevalence studies, in which knowledge of the temporal relationship is  
33 lacking. For this reason, the conclusions place greater weight on the cohort and case-  
34 control studies.

1 **(5) Biologic gradient (exposure-response relationship).** A clear exposure-response  
2 relationship strongly suggests cause and effect. For TCE, biologic gradients are only  
3 sporadically observed, though the number of site-specific cancers in a study is often too  
4 small to identify biologic gradients. For kidney cancer, only the studies by Morgan et al.  
5 (1998) and Vamvakas et al. (1998) observed exposure-response relationships.

6 Both the urinary biomarker studies and the Blair et al. (1998) study observed liver cancer  
7 incidence to increase with exposure. Anttila et al. (1995) observed incidence to increase with  
8 time since first exposure, with the largest risk among those with the longest time since first  
9 exposure (SIR=6.1, 95% CI= 2.8-17.7). Similar findings were not observed for liver cancer  
10 mortality; however, liver cancer incidence is considered more definitive because liver cancer  
11 mortality is extensively miscoded on death certificates.

12 Exposure-response analyses presented in the drinking water studies collectively suggest  
13 that greater exposure to drinking water contaminated with TCE and other chlorinated solvents is  
14 associated with lymphatic cancer, particularly leukemia. Studies by Cohn et al. (1994), Fagliano  
15 et al. (1990), and MA-DOH (1997) reported exposure-response relationships between drinking  
16 water exposure to TCE and other chlorinated solvents and the risk of lympho-hematopoietic  
17 cancer, particularly childhood leukemia and non-Hodgkin's lymphoma.

18 For cervical cancer, Anttila et al. (1995) and Blair et al. (1998) observed incidence to  
19 increase with exposure, with a significantly elevated risk among those with the highest urinary  
20 TCA levels in the Anttila study (SIR=4.4, 95% CI= 1.4-10.1). Comparison with internal controls  
21 in the Blair study suggests that TCE may be the etiologic agent rather than a confounder such as  
22 socioeconomic status.

23 **(6) Biologic plausibility.** Section 3.5 discusses the many recent mechanistic studies  
24 investigating TCE's carcinogenic effects in rats and mice and their relevance to humans. The  
25 mechanistic results to date indicate that TCE-induced carcinogenesis is complex, involving  
26 multiple carcinogenic metabolites acting through multiple mechanisms, all of which have  
27 relevance to humans (see Section 3.5).

28 **(7) Coherence.** A cause-and-effect interpretation of the human data does not conflict  
29 with other lines of evidence. The strongest associations between TCE exposure and human  
30 cancer are for the kidney, liver, and lympho-hematopoietic system, sites where TCE causes  
31 cancer in either rats or mice. In both humans and laboratory animals, TCE can cause adverse  
32 effects other than cancer in the kidney, liver, and immune system, and it is biologically plausible  
33 that some of these effects may play a role in the development of cancer of the kidney, liver, and  
34 lympho-hematopoietic system, respectively (see Sections 3.5.2, 3.5.1, 3.5.4). The associations  
35 between human cervical and prostate cancer have no suitable animal models to compare.

1           **(8) Experimental evidence (from human populations).** Experimental evidence is  
2 seldom available from human populations (Rothman, 1986) and exists only when conditions of  
3 human exposure are altered to create a “natural experiment” at different levels of exposure. For  
4 example, leukemia cases became more evenly distributed throughout the town of Woburn after  
5 closure of two wells contaminated with TCE and other solvents (MA-DOH, 1997).

6           **(9) Analogy.** The pattern of effects associated with TCE, particularly in the liver, has  
7 similarities to those of several other chlorinated solvents and to mixed-solvent exposures.

### 8 9 **3.6.1.1. *Synthesis of the Epidemiologic Evidence***

10           Together, these nine aspects of causality suggest that a cause-and-effect association  
11 between TCE exposure and cancer is credible. Among the different tumor sites, support is  
12 strongest for kidney cancer, followed by liver and lympho-hematopoietic cancer and then cervical  
13 and prostate cancer.

14           The strength of this conclusion is tempered by some still-open questions about TCE’s  
15 cancer potential. The statistical significance of the results of the joint epidemiologic analysis  
16 could change with omission of one study or another. Most studies lack quantitative exposure  
17 information. More research is needed on mutations of the VHL gene, particularly in renal cell  
18 carcinoma patients not exposed to TCE. In addition, a nested case-control study could help  
19 resolve questions about causality, as this study design has the potential to examine the effects of  
20 lifestyle factors and exposures to mixtures of solvents that may share common metabolites and  
21 modes of action (see Section 5).

### 22 23 **3.6.2. *Weight of Evidence Under the Current and Proposed Cancer Guidelines***

24           TCE has been extensively tested in animals, with mice developing liver tumors, lung  
25 tumors, and lymphomas, and rats developing kidney tumors and testicular tumors.  
26 Epidemiologic studies, considered as a whole, have associated TCE exposure with excess risks  
27 of kidney cancer, liver cancer, lympho-hematopoietic cancer, cervical cancer, and prostate  
28 cancer. Weight-of-evidence characterizations have had to address issues concerning the strength  
29 of the human evidence and the relevance of the animal tumors to humans.

30           With this assessment, the weight of the epidemiologic evidence of TCE’s potential  
31 carcinogenicity has become stronger than before (see Section 3.4). To bridge the opposing views  
32 of the past, this assessment commissioned a joint analysis of the epidemiologic studies  
33 (Wartenberg et al., 2000). This joint analysis used a statistically based weight-of-evidence  
34 approach that stratified the available studies into tiers according to how well each study’s results

1 can be associated with TCE exposure specifically.<sup>46</sup> Within each tier, study results were  
2 weighted according to inverse variance.<sup>47</sup> The joint analysis found that the most consistent and  
3 compelling results are statistically significant increased incidences of kidney cancer and liver  
4 cancer in workers exposed to TCE. These are followed by lympho-hematopoietic cancer,  
5 cervical cancer, and prostate cancer. There are few studies of highly exposed populations,  
6 consequently, the magnitude of response is generally less than a twofold increase. The joint  
7 analysis leads to a conclusion that these increases are statistically significant, thus, TCE may be  
8 capable of causing cancer in humans at multiple sites.

9 The epidemiologic studies have recently been augmented by molecular information, in  
10 which multiple mutations of the VHL tumor suppressor gene,<sup>48</sup> primarily C>T changes including  
11 nucleotide 454, were found in renal cell carcinoma patients with high, prolonged TCE exposure  
12 (Brüning et al., 1997b) (see Section 3.5.2). A followup study found mutations of the VHL gene  
13 in 75% of TCE-exposed workers with renal cell carcinoma, with an association between number  
14 of mutations and TCE exposure level (Brauch et al., 1999). Adding specificity to this  
15 association, a C>T change at nucleotide 454 was found in 13 of 33 renal cell carcinoma patients  
16 with TCE exposure; this specific mutation was not found in those without identifiable TCE  
17 exposure.

18 The mechanistic research into the mode-of-action for each animal tumor site has begun to  
19 link TCE with disturbances in cell signaling and carbohydrate metabolism, which can lead to  
20 human cancer and other diseases (see Section 3.5). Subject to dose-response adjustments for  
21 relative human-to-animal sensitivity (see Sections 4.5.2, 4.5.3), this research makes it plausible  
22 that TCE acts through mechanisms that can cause cancer in humans.

23 EPA's proposed cancer guidelines provide that molecular information can be used in  
24 choosing a weight-of-evidence descriptor. TCE could be described as "carcinogenic to humans,"  
25 supported by (1) association of TCE exposure with increased risk of human kidney cancer, liver

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<sup>46</sup>Tier I studies are those in which TCE exposure has been inferred for individual study subjects and in which it is best characterized. Tier II studies are those in which there is putative TCE exposure, but individuals are not identified as uniquely exposed to TCE. Tier III studies are the studies of dry cleaning and laundry workers in which subjects are exposed to a variety of solvents including TCE (Wartenberg et al., 2000).

<sup>47</sup>*Inverse variance* gives greater weight to larger studies that yield more precise estimates. Study results are averaged, with each study result weighted (i.e., multiplied) by a factor that is inversely proportional to the study result's variance.

<sup>48</sup>The VHL gene normally suppresses renal cell carcinomas. Mutations to this gene have been noted in kidney cancers and may be an important risk factor and mode-of-action for chemically induced renal cell cancer (Lash et al., 2000b). To illustrate the difference between "mode" of action and "mechanism" of action, knowledge that VHL gene mutations are involved may be enough to identify a plausible "mode" of action, whereas knowing how such modifications induce subsequent events leading to kidney cancer would be needed to identify the "mechanism" of action.

1 cancer, lympho-hematopoietic cancer, cervical cancer, and prostate cancer; (2) induction of  
2 kidney tumors and testicular tumors in rats and liver tumors, lung tumors, and lymphomas in  
3 mice; and (3) induction of multiple VHL gene mutations, primarily C>T changes including  
4 nucleotide 454, in a human population. At this time, however, fuller identification of the mode-  
5 of-action and associated key events is lacking (see Section 5). It is not known whether the C>T  
6 change at nucleotide 454 is a marker of exposure, a key event leading to kidney cancer, or  
7 whether other factors selectively favor the growth of cells with this change. Functional alteration  
8 of the VHL gene can be a mode of kidney cancer induction; whether this is how TCE induces  
9 kidney cancer has not been established.

10 Alternatively, TCE could be described as “likely to be carcinogenic to humans,”  
11 supported by evidence associating TCE exposure with human cancer and strong evidence of  
12 carcinogenicity in animals involving processes that have relevance for humans. Among “likely”  
13 carcinogens, the evidence for TCE is strong and is drawn from several types of information (see  
14 Sections 3.2–3.5).

15 At this time, a strong characterization as “highly likely to be carcinogenic to humans” is  
16 more appropriate, given the still-open questions about TCE’s cancer potential. The statistical  
17 significance of the results of the joint epidemiologic analysis could change with omission of one  
18 study or another. This does not decrease confidence in the results of the joint analysis, but  
19 emphasizes that the TCE studies collectively have only recently accumulated enough power to  
20 begin to detect associations between moderate TCE exposures and some relatively common  
21 cancers. On the other hand, the new evidence associating TCE exposure with a transformation at  
22 nucleotide 454 is striking evidence specific to TCE exposure, putting a “genetic fingerprint” that  
23 associates such kidney tumors with TCE exposure. Replication of this result in another cohort  
24 showing kidney tumors could warrant a future description of TCE as “carcinogenic to humans”  
25 (see Section 5).

26 Under the current (1986) cancer guidelines, TCE would be classified as a “probable  
27 human carcinogen” (group B1), with “limited” human evidence and “sufficient” animal evidence  
28 of carcinogenicity. The principal changes from the controversy of the late 1980s are the stronger  
29 weight of epidemiologic evidence (see Section 3.4) and the new mechanistic information  
30 suggesting that TCE’s modes of action may be relevant to humans (see Section 3.5).

**Table 3-1. Liver tumors in mice exposed to TCE  
Hepatocellular carcinomas and adenomas after 103 weeks gavage exposure, beginning at 8 weeks of age (NTP, 1990)**

Administered dose (mg/kg-d)	Vehicle ctl	1,000
Male B6C3F1 mice **	14/48 (29%)	39/50 (78%)
Female B6C3F1 mice **	6/48 (13%)	22/49 (45%)

**Hepatocellular carcinomas<sup>a</sup> after 90 weeks gavage exposure, beginning at 5 weeks of age (NCI, 1976)**

Dose group	Vehicle ctl	Low dose <sup>b</sup>	High dose <sup>c</sup>
Male B6C3F1 mice **	1/20 (5%)	26/50 (52%)	31/48 (65%)
Female B6C3F1 mice **	0/20 (0%)	4/50 (8%)	11/47 (23%)

**Hepatomas after 78 weeks inhalation exposure, beginning at 11-12 weeks of age (Maltoni et al., 1986)**

Administered daily concentration (mg/m <sup>3</sup> ) <sup>d</sup>	Control	112.5	337.5	675
Male Swiss mice <sup>e</sup> **	4/66 (6%)	2/53 (4%)	8/59 (14%)	13/61 (21%)
Female Swiss mice <sup>e</sup>	0/84 (0%)	0/89 (0%)	0/86 (0%)	1/86 (1%)
Male B6C3F1 mice <sup>f</sup> **	1/59 (2%)	1/31 (3%)	3/38 (8%)	6/37 (16%)
Female B6C3F1 mice <sup>f</sup> **	3/88 (3%)	4/89 (4%)	4/88 (5%)	9/85 (11%)
Male B6C3F1 mice <sup>g</sup>	17/77 (22%)	19/47 (40%)	27/67 (40%)	21/63 (33%)

\*\*Statistically significant by Cochran-Armitage trend test ( $p < 0.05$ ).

<sup>a</sup>Hepatocellular adenomas were not reported.

<sup>b</sup>Low dose is 1,200 mg/kg-d for male mice, 900 mg/kg-d for female mice (5 d/wk).

<sup>c</sup>High dose is 2,400 mg/kg-d for male mice, 1,800 mg/kg-d for female mice (5 d/wk).

<sup>d</sup>Equivalent to 100, 300, 600 ppm (100 ppm=540 mg/m<sup>3</sup>), adjusted for 7 hr/d, 5 d/wk exposure.

<sup>e</sup>Mice alive at week 43, when first hepatoma was observed.

<sup>f</sup>Mice alive at week 33, when first hepatoma was observed (expt BT306).

<sup>g</sup>Mice alive at week 68, when first hepatoma was observed (expt BT306 bis).

Sources: NTP (1990) tables 8, 9; NCI (1976) table VIII; Maltoni et al (1986) IV/VI table 14, IV/VII table 14, IV/VIII table 14.

**Table 3-2. Kidney tumors in rats, adjusted for reduced survival<sup>a</sup>**

**Tubular cell adenomas and adenocarcinomas after 103 weeks gavage exposure, beginning at 6.5-8 weeks of age (NTP, 1988, 1990)**

<b>Administered dose (mg/kg-d)</b>	<b>Untreated ctl</b>	<b>Vehicle ctl</b>	<b>500</b>	<b>1,000</b>
Male ACI rats	0/48 (0%)	0/46 (0%)	1/29 (3%)	0/22 (0%)
Male August rats	0/47 (0%)	0/47 (0%)	2/35 (6%)	1/33 (3%)
Male Marshall rats	2/43 (4%)	0/44 (0%)	1/25 (4%)	1/28 (4%)
Male Osborne-Mendel rats **	0/46 (0%)	0/47 (0%)	6/44 (14%)	2/33 (6%)
Male F344/N rats **	0/48 (0%)	0/46 (0%)	2/46 (4%)	3/33 (9%)
Pooled males **	2/232 (1%)	0/230 (0%)	12/179 (7%)	7/149 (5%)
Female ACI rats	0/46 (0%)	0/43 (0%)	3/36 (6%)	1/31 (3%)
Female August rats	0/47 (0%)	1/47 (2%)	4/42 (10%)	0/34 (0%)
Female Marshall rats	1/48 (2%)	1/49 (2%)	2/44 (5%)	1/32 (3%)
Female Osborne-Mendel rats	1/47 (2%)	0/43 (0%)	0/44 (0%)	1/45 (2%)
Female F344/N rats	0/46 (0%)	0/46 (0%)	0/45 (0%)	1/44 (2%)
Pooled females **	2/234 (1%)	2/228 (1%)	9/211 (4%)	4/186 (2%)

**Renal tubuli adenocarcinomas after 104 weeks inhalation exposure, beginning at 12 weeks of age (Maltoni et al., 1986)**

<b>Administered daily concentration (mg/m<sup>3</sup>)<sup>b</sup></b>	<b>Control</b>	<b>112.5</b>	<b>337.5</b>	<b>675</b>
M Sprague-Dawley rats **	0/120 (0%)	0/118 (0%)	0/116 (0%)	4/122 (3%)
F Sprague-Dawley rats	0/139 (0%)	0/128 (0%)	0/127 (0%)	1/127 (1%)

\*\*Statistically significant by Cochran-Armitage trend test ( $p < 0.05$ ).

<sup>a</sup>ACI, August, Marshall, Osborne-Mendel, and F344/N rats alive at week 57, Sprague-Dawley rats at week 47 (expt BT304) or week 62 (expt BT304 bis).

<sup>b</sup>Equivalent to 100, 300, 600 ppm (100 ppm=540 mg/m<sup>3</sup>), adjusted for 7 hr/d, 5 d/wk exposure. Sources: NTP (1988) Tables A2, C2, E2, G2; NTP (1990) table A3; Maltoni et al. (1986) IV/IV Table 19, IV/V Table 19.

**Table 3-3. Malignant lymphomas in mice exposed to TCE****Malignant lymphomas after 103 weeks gavage exposure, beginning at 8 weeks of age (NTP, 1990)**

<b>Administered dose (mg/kg-d)</b>	<b>Vehicle ctl</b>	<b>1,000</b>
Male B6C3F1 mice	11/50 (22%)	13/50 (26%)
Female B6C3F1 mice	7/48 (15%)	13/49 (27%)

**Lymphosarcomas and reticulum cell sarcomas after 90 weeks gavage exposure, beginning at 5 weeks of age (NCI, 1976)**

<b>Dose group</b>	<b>Vehicle ctl</b>	<b>Low dose<sup>a</sup></b>	<b>High dose<sup>b</sup></b>
Male B6C3F1 mice	1/20 (5%)	4/50 (8%)	2/48 (4%)
Female B6C3F1 mice	1/20 (5%)	5/50 (10%)	5/47 (11%)

**Malignant lymphomas after 78 weeks inhalation exposure (Henschler et al., 1980)**

<b>Administered daily concentration (mg/m<sup>3</sup>)<sup>c</sup></b>	<b>Control</b>	<b>96</b>	<b>480</b>
Male Han:NMRI mice	7/30 (23%)	7/29 (24%)	6/30 (20%)
Female Han:NMRI mice **	9/29 (31%)	17/30 (57%)	18/28 (64%)

\*\*Statistically significant by Cochran-Armitage trend test ( $p < 0.05$ ).

<sup>a</sup>Low dose is 1,200 mg/kg-d for male mice, 900 mg/kg-d for female mice (5 d/wk).

<sup>b</sup>High dose is 2,400 mg/kg-d for male mice, 1800 mg/kg-d for female mice (5 d/wk).

<sup>c</sup>Equivalent to 100 and 500 ppm (100 ppm=540 mg/m<sup>3</sup>), adjusted for 6 hr/d, 5 d/wk exposure.

Sources: NTP (1990) tables 8, 9; NCI (1976) table XXXa; Henschler et al (1980) table 3a.



**Table 3-4. Testicular tumors in male rats exposed to TCE, adjusted for reduced survival<sup>a</sup>**

**Interstitial cell tumors after 103 weeks gavage exposure, beginning at 6.5-8 weeks of age (NTP, 1988, 1990)**

<b>Administered dose (mg/kg-d)</b>	<b>Untreated ctl</b>	<b>Vehicle ctl</b>	<b>500</b>	<b>1,000</b>
Male ACI rats	38/45 (84%)	36/44 (82%)	23/26 (88%)	17/19 (89%)
Male August rats	36/46 (78%)	34/46 (74%)	30/34 (88%)	26/30 (87%)
Male Marshall rats **	16/46 (35%)	17/46 (37%)	21/33 (64%)	32/39 (82%)
Male Osborne-Mendel rats	1/30 (3%)	0/28 (0%)	0/25 (0%)	1/19 (5%)
Male F344/N rats	44/47 (94%)	47/48 (98%)	47/48 (98%)	32/44 (73%)

**Leydig cell tumors after 104 weeks inhalation exposure, beginning at 12 weeks of age (Maltoni et al., 1986)**

<b>Administered daily concentration (mg/m<sup>3</sup>)<sup>b</sup></b>	<b>Control</b>	<b>112.5</b>	<b>337.5</b>	<b>675</b>
M Sprague-Dawley rats **	6/114 (5%)	16/105 (15%)	30/107 (28%)	31/113 (27%)

\*\*Statistically significant by Cochran-Armitage trend test ( $p < 0.05$ ).

<sup>a</sup>ACI rats alive at week 70, August rats at week 65, Marshall rats at week 32, Osborne-Mendel rats at week 97, F344/N rats at week 32, Sprague-Dawley rats at week 81 (expt BT304) or week 62 (expt BT304 bis).

<sup>b</sup>Equivalent to 100, 300, 600 ppm (100 ppm=540 mg/m<sup>3</sup>), adjusted for 7 hr/d, 5 d/wk exposure. Sources: NTP (1988) Tables A2, C2, E2, G2; NTP (1990) Table A3; Maltoni et al. (1986) IV/IV Table 21, IV/V Table 21.

**Table 3-5. Lung tumors in mice exposed to TCE**

**Pulmonary adenomas and adenocarcinomas after 78 weeks inhalation exposure, beginning at 11-12 weeks of age (Maltoni et al., 1986)**

<b>Administered daily concentration (mg/m<sup>3</sup>)</b>	<b>Control</b>	<b>112.5</b>	<b>337.5</b>	<b>675</b>
Male Swiss mice **	10/90 (11%)	11/90 (12%)	23/90 (26%)	27/90 (30%)
Female Swiss mice	15/90 (17%)	15/90 (17%)	13/90 (14%)	20/90 (22%)
Male B6C3F1 mice	2/90 ( 2%)	2/90 ( 2%)	3/90 ( 3%)	1/90 ( 1%)
Female B6C3F1 mice **	4/90 ( 4%)	6/90 ( 7%)	7/90 ( 8%)	15/90 (17%)

**Pulmonary adenomas and adenocarcinomas by inhalation (Fukuda et al., 1983)**

<b>Administered daily concentration (mg/m<sup>3</sup>)</b>	<b>Control</b>	<b>56</b>	<b>168</b>	<b>504</b>
Female ICR mice **	6/49 (12%)	5/50 (10%)	13/50 (26%)	11/46 (24%)

**Carcinomas, adenocarcinomas, and adenomas of the lung or alveoli after 90 weeks gavage exposure, beginning at 5 weeks of age (NCI, 1976)**

<b>Dose group</b>	<b>Vehicle ctl</b>	<b>Low dose<sup>a</sup></b>	<b>High dose<sup>b</sup></b>
Male B6C3F1 mice	0/20 (0%)	5/50 (10%)	2/48 ( 4%)
Female B6C3F1 mice	1/20 (5%)	4/50 ( 8%)	7/47 (15%)

\*\*Statistically significant by Cochran-Armitage trend test ( $p < 0.05$ ).

<sup>a</sup>Low dose is 1,200 mg/kg-d for male mice, 900 mg/kg-d for female mice (5 d/wk).

<sup>b</sup>High dose is 2,400 mg/kg-d for male mice, 1,800 mg/kg-d for female mice (5 d/wk).

Sources: Maltoni et al., 1986, Tables 48, 51; Fukuda et al. (1983); NCI (1976) Table XXV.

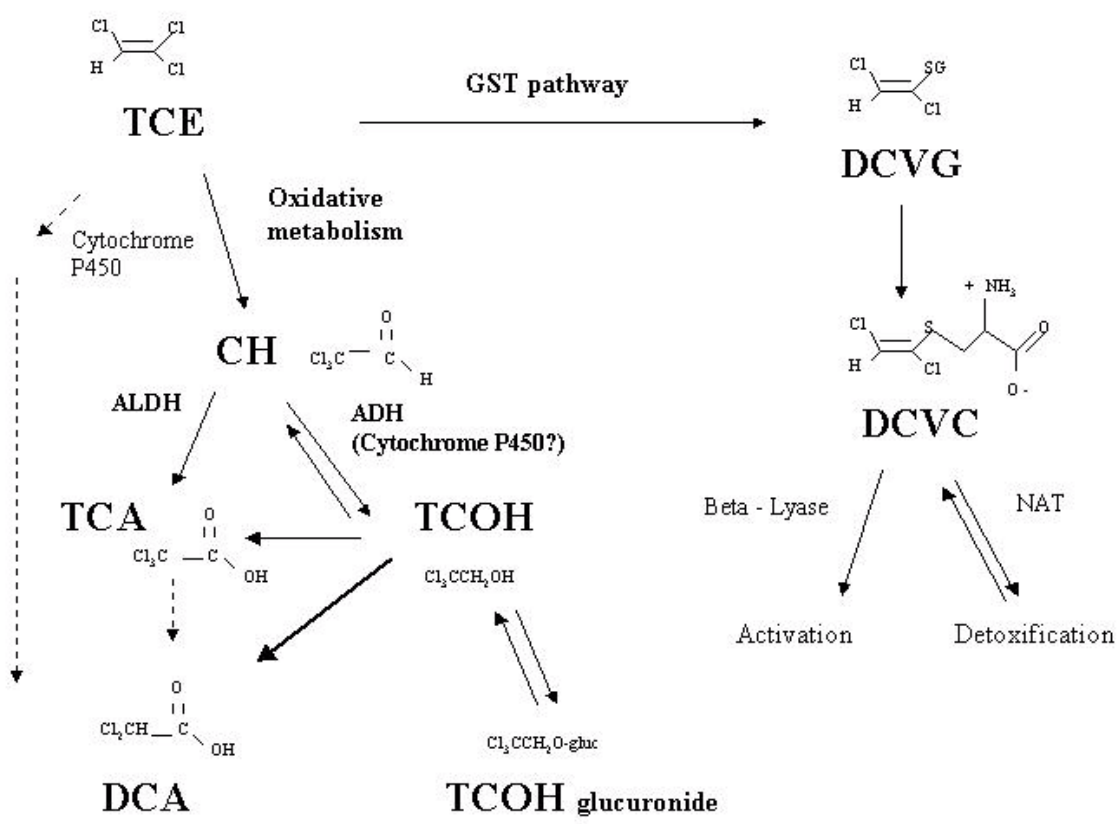


Figure 3-1. Metabolism of Trichloroethylene (TCE).

## 4. DOSE-RESPONSE ASSESSMENT AND CHARACTERIZATION

### 4.1. GENERAL CONSIDERATIONS AND APPROACH

This dose-response assessment updates the cancer slope factor for TCE and develops an oral RfD and an inhalation RfC for effects other than cancer. These effects include neurotoxicity, immunotoxicity, developmental toxicity, liver toxicity, kidney toxicity, endocrine effects, and several forms of cancer (see Section 3.4). The overall approach is to develop alternative estimates using different studies and modeling approaches, then to choose values that are supported by several sources of data and lines of reasoning. This provides a measure of confidence that the risk estimates are robust and not likely to be substantially changed by a new study or analysis.

This dose-response assessment draws from the state-of-the-science papers that appear in volume 1. Pharmacokinetic models<sup>49</sup> were developed to provide dose metrics<sup>50</sup> for the RfD, RfC, and cancer assessments (Fisher, 2000; Clewell et al., 2000). Statistical analyses improved these models by calibrating them to fit more data sets, then quantifying the uncertainty in each dose metric (Bois, 2000a,b). Analyses supporting the RfD and RfC applied pharmacokinetic models and empirical dose-response models<sup>51</sup> whenever suitable data were available (Barton and Clewell, 2000). The cancer assessment pursued several lines of analysis and considered both linear and nonlinear approaches, based on knowledge about mode-of-action at each tumor site (see Section 3.5). Empirical dose-response models were fitted to data on liver tumors and lung tumors in mice and kidney tumors and testicular tumors in rats (Rhomberg, 2000). A mechanism-based dose-response model<sup>52</sup> was developed for testing hypotheses about the mouse liver tumor response (Chen, 2000). Slope factors for kidney tumors, liver tumors, and non-Hodgkin's lymphoma were also developed from the epidemiologic data.

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<sup>49</sup>*Pharmacokinetic models* simulate the relationship between external exposure levels and the biologically effective dose at a target tissue. Pharmacokinetic models take into account absorption, distribution, metabolism, and elimination of the administered chemical and its metabolites. *Pharmacodynamic models* simulate the relationship between a biologically effective dose and the occurrence of a disease response.

<sup>50</sup>*Dose metrics* are alternative ways of describing dose. They involve what is being measured (parent compound, metabolite, or biomarker), where it is measured (whole body, blood, or specific tissue), and how it is measured (cumulative, average, or peak exposure). For example, total administered TCE and average TCA in liver are dose metrics.

<sup>51</sup>An *empirical dose-response model* is one based on fitting a curve to data. (They are sometimes called “curve-fitting” models or “benchmark dose” models.) In contrast to *mechanism-based dose-response models*, an empirical model is not based on specific knowledge about the biological mechanisms leading to disease.

<sup>52</sup>A *mechanism-based dose-response model* (also called a *biologically based dose-response model*) is a pharmacodynamic model whose mathematical structure reflects the ascertained mode-of-action and whose parameters are measured experimentally.

1 The assessment for effects other than cancer follows EPA's methods for developing RfDs  
2 (Barnes and Dourson, 1988) and RfCs (U.S. EPA, 1994). Despite the existence of numerous  
3 studies, however, the database for developing an RfD or RfC is problematic. ATSDR did not  
4 derive analogous chronic-duration levels<sup>53</sup> for TCE, viewing the chronic studies as limited by  
5 inadequate characterization of exposure, inadequate quantification of results, or lack of endpoints  
6 suitable for deriving chronic levels (ATSDR, 1997). This assessment, through modeling and  
7 comparing results for different adverse effects, species, exposure durations, and exposure routes,  
8 has overcome some data gaps and developed an RfD and RfC that are supported by multiple  
9 lines of reasoning.

10 The cancer assessment is consistent with the approach of EPA's proposed cancer  
11 guidelines (U.S. EPA, 1996). These guidelines encourage use of models to incorporate a wider  
12 range of experimental data and use of mode-of-action information to guide modeling and  
13 extrapolation approaches. This assessment develops alternative risk values from many sources  
14 before comparing and reconciling them. Because information about sensitive populations,  
15 children, and cumulative risks indicates the potential for vast human variation in risk, a range of  
16 cancer estimates is described, with guidance on how to choose a particular estimate based on risk  
17 factors in the exposed population and exposure scenario.

## 18 **4.2. DOSIMETRY MODELING**

19 This dose-response assessment begins by expressing doses in common terms to facilitate  
20 better comparisons across studies, health effects, species, exposure durations, and exposure  
21 routes. Reflecting the importance of metabolism to TCE-induced toxicity, doses are estimated  
22 from pharmacokinetic models whenever data are suitable. Otherwise, doses are scaled from  
23 animals to humans based on equivalence of  $\text{mg/kg}^{3/4}\text{-d}$  (U.S. EPA, 1992). Pharmacokinetic  
24 models can account for high- to low-dose nonlinearity and animal-to-human differences in  
25 metabolism. The use of pharmacokinetic modeling and dose scaling in developing RfDs is  
26 relatively new, representing a move toward harmonizing RfD methods with those already in use  
27 for RfCs and cancer assessments.  
28  
29

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<sup>53</sup>ATSDR calls these *minimal risk levels* (MRLs), defined as "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 duration of exposure" (ATSDR, 1997).

### 4.2.1. Pharmacokinetic Modeling

A pharmacokinetic model for ingested TCE in male mice is described in a state-of-the-science paper by Fisher (2000). The model predicts area-under-the-curve<sup>54</sup> in the liver for TCA and DCA. Compartments<sup>55</sup> include TCE in liver, lung, kidney, fat, gut, rapidly perfused tissues, and slowly perfused tissues. Metabolite submodels include CH, TCA, TCOH, TCOG, and DCA in liver, lung, kidney, and the rest of the body; DCVC and DCVG were not modeled. The model simplifies metabolism by modeling it only in the liver. Model parameters were taken from published literature, measured experimentally, or fitted by running the model with data at 1,200 mg/kg. The model was validated against data at 300, 600, and 2,000 mg/kg, suggesting the ability of the model to make predictions below the dose where it was developed. Parameters were scaled according to body weight. This mouse model was then adapted for inhaled TCE in human males and females. The human model does not include CH and DCA, because CH was not detected in experimental subjects and DCA was detected only intermittently.

Another pharmacokinetic model for ingested and inhaled TCE in male mice, rats, and humans is described in a state-of-the-science paper by Clewell et al. (2000). This model predicts metabolite areas-under-the-curve in plasma. Compartments include TCE in liver, lung, tracheobronchial region, fat, gut, rapidly perfused tissues, and slowly perfused tissues. One-compartment metabolite submodels include TCA, TCOH, TCOG, and DCA. The model also includes descriptions of GST metabolism in the kidney, CH metabolism and clearance in the lung, GST metabolism of TCE to DCVC in the liver, activation of  $\beta$ -lyase and clearance by NAT in the kidney, biliary excretion of TCOG, and enterohepatic recirculation of TCOH. Model parameters were taken from published literature or fitted by running the model with selected data sets. Parameters were scaled allometrically.<sup>56</sup>

Statistical analyses of these pharmacokinetic models are discussed in two additional state-of-the-science papers (Bois, 2000a,b). These analyses use a Bayesian<sup>57</sup> statistical framework and

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<sup>54</sup>*Area-under-the-curve* refers to the tissue concentration of a chemical integrated over time. It is a measure of the long-term average concentration of a chemical in a specific tissue.

<sup>55</sup>Pharmacokinetic models specify *compartments* to represent different tissues or groups of tissues, for example, liver, fat, and the rest of the body.

<sup>56</sup>*Allometric scaling* is a method for calculating equivalent doses across species. It scales volumes according to body weight, blood flow rates and metabolic capacities according to the 3/4 power of body weight, and rate constants according to the inverse 1/4 power of body weight.

<sup>57</sup>*Bayesian* statistical methods regard a model's parameters as random variables with a probability distribution. New data can alter what is thought to be the best distribution for describing each parameter. The distribution based only on prior information and assumptions is called the *prior distribution*. Analysis of new data yields a *posterior distribution* that reconciles the prior information and assumptions with the new data.

1 Markov-chain Monte-Carlo<sup>58</sup> simulation to refine the models by using more data sets to estimate  
2 each model's parameters. The result is a set of calibrated models that better fits a wider range of  
3 experimental data. In some cases the calibrated parameters are quite different from the originals,  
4 thus, substantial information has been gained by fitting the models to additional experimental  
5 data sets. Dose estimates from the calibrated models were used in subsequent state-of-the-  
6 science papers (Chen, 2000; Rhomberg, 2000) supporting the cancer assessment, whereas dose  
7 estimates from the Clewell et al. (2000) pharmacokinetic model were used in the state-of-the-  
8 science paper supporting the RfD and RfC (Barton and Clewell, 2000).

9 EPA's National Exposure Research Laboratory is developing a Dose Estimating  
10 Exposure Model, a model architecture that simulates internal doses for different chemicals and  
11 species. As part of this assessment, this model has been configured for TCE, initially following  
12 the structure of the Fisher and Clewell models. This new TCE model is being calibrated by  
13 comparing its predictions to several experimental data sets. A notable feature of this model is its  
14 capacity to simulate simultaneous exposure to TCE, TCA, and DCA. This will be particularly  
15 useful in future site-specific applications (for example, at Superfund sites or in assessing the  
16 safety of a drinking water supply) where people are exposed to TCE along with TCA and DCA  
17 from other solvents or other sources.

#### 18 19 **4.2.2. Uncertainty Analyses**

20 Another product of the statistical analyses is a quantitative description of uncertainty in  
21 the dose estimates (Bois, 2000b). Table 4-1 summarizes distributions of potential dose metrics  
22 for modeling liver, lung, and kidney tumors from the calibrated model (Bois, 2000b) on the basis  
23 of the Clewell et al. (2000) pharmacokinetic model, the only model to calculate estimates outside  
24 the liver. From Table 4-1 it is apparent that lung and kidney dose metrics are quite uncertain,  
25 with 95% confidence intervals spanning more than a 5,000-fold range. This may be due to the  
26 difficulty in measuring and modeling a transient metabolite such as CH, the possibility that  
27 plasma CH may not be a good surrogate for CH accumulated in Clara cells of the lung, or the  
28 poorer database for estimating GST metabolites in the kidney. Whatever the reason, this is more  
29 uncertainty than is generally present in risk analyses supporting public health decisions. One  
30 approach to addressing this uncertainty would be to take lung and kidney dose estimates from the  
31 lower end, perhaps the first percentile, of their distributions; this would effectively increase risk

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<sup>58</sup>*Markov-chain Monte-Carlo simulation* is an iterative process that can be used within a *Bayesian* statistical framework to (1) sample each model's parameters from their *prior distributions*, (2) fit that model with the sampled parameters to several additional experimental data sets, and (3) compare the model's predictions with the experimental results to obtain *posterior distributions* for the model's parameters that improve the model's fit. These steps are repeated thousands of times until each parameter's *posterior distribution* converges to a more robust distribution that reflects a wider database.

1 estimates several hundred-fold above the median. Rather than make such a large adjustment, this  
2 assessment uses default RfC dosimetry models (U.S. EPA, 1994) when modeling lung tumors by  
3 inhalation and the default 3/4-power scaling factor when modeling kidney tumors by ingestion.  
4 Liver dose metrics, in contrast, are less uncertain (see Table 4-1); consequently, the cancer  
5 assessment uses the calibrated model's median dose estimates for the liver. In this way,  
6 uncertainty analysis is used to distinguish between uncertain applications (lung and kidney) and  
7 more robust applications (liver), so that pharmacokinetic modeling is used when the results are  
8 robust and other methods are considered when there is too much uncertainty.

9 The statistical analyses also reveal several differences between males and females.  
10 Females have a significantly lower alveolar ventilation rate (beyond that explained by allometric  
11 scaling), higher TCOH body-to-blood partition coefficient, lower TCA body-to-blood partition  
12 coefficient, higher  $V_{\max}/K_m$  ratio for TCOH glucuronidation, higher conversion of TCOH to  
13 TCA, and higher urinary excretion of TCA (Bois, 2000a). These insights are possible because  
14 Fisher (2000) collected and modeled data from both males and females. The number of variables  
15 with significant differences shows the complexity of overall human variation.

#### 16 17 **4.2.3. Route Extrapolation**

18 Pharmacokinetic models can be used to investigate questions about extrapolation from  
19 one exposure route to another. This can be done by determining oral and inhalation exposures  
20 that yield equal internal doses of the active agent.

21 For this assessment, the pharmacokinetic model developed at EPA's National Exposure  
22 Research Laboratory calculated that chronic oral exposure to TCE at 1 mg/kg-d yields similar  
23 TCA area-under-the-curve as chronic inhalation exposure to TCE at 75 mg/m<sup>3</sup>. This relationship  
24 was investigated at several dose levels near 1 mg/kg-d and found to be approximately linear at  
25 this dose and below. The relationship is different, however, when matching DCA area-under-  
26 the-curve as the internal dose. Chronic oral exposure to TCE at 1 mg/kg-d yields similar DCA  
27 area-under-the-curve as chronic inhalation exposure to TCE at 3 mg/m<sup>3</sup> (instead of 75 mg/m<sup>3</sup>).  
28 This 25-fold uncertainty highlights the importance of further research to identify the appropriate  
29 internal dose metric for each toxic effect (see Section 5).

#### 30 31 **4.3. ORAL REFERENCE DOSE FOR EFFECTS OTHER THAN CANCER**

32 For effects other than cancer, risk assessments have not attempted to describe dose-  
33 response curves in the range of environmental exposures. Rather, the focus has been to estimate  
34 an exposure level where there is little concern for adverse effects. This RfD is derived through a  
35 process of (1) considering all studies and selecting the critical effects that occur at the lowest



1 dose, (2) selecting a dose (or point of departure<sup>59</sup>) at which the critical effect either is not  
2 observed or would occur at a relatively low incidence (for example, 10%), and (3) reducing this  
3 dose by uncertainty factors to reflect differences between study conditions and conditions of  
4 human environmental exposure.

#### 6 **4.3.1. Critical Effects**

7 Many different toxic effects are associated with oral TCE exposure, as TCE can disrupt  
8 fundamental cellular processes through multiple metabolites and mechanisms (see Section 3.4).  
9 At higher doses (above approximately 100 mg/kg-d), targets of oral TCE toxicity include the  
10 liver, kidney, nervous system, reproductive system, and developing fetus (ATSDR, 1997).  
11 Effects have been observed at these sites in acute studies (2 weeks or less), intermediate studies,  
12 or chronic studies (1 year or more). At lower doses (below approximately 100 mg/kg-d), there  
13 are fewer studies, but effects continue to be observed in several systems, often in subchronic  
14 studies. At the lowest doses tested (approximately 1–10 mg/kg-d), effects are observed in the  
15 liver, kidney, and developing fetus. These are considered to be the critical effects of oral TCE  
16 exposure.

#### 18 **4.3.2. Point of Departure**

19 Table 4-2 summarizes the results of oral studies conducted at the lower doses. To  
20 compare studies, doses are expressed in human-equivalent terms. For liver effects,  
21 pharmacokinetic modeling (Clewell et al., 2000) was used to estimate plasma TCA as the dose  
22 metric (Barton and Clewell, 2000). For kidney effects, statistical analyses (Bois, 2000b) revealed  
23 substantial parameter uncertainty in the pharmacokinetic modeling (see Table 4-1), consequently,  
24 human-equivalent doses were based on equivalence of mg/kg<sup>3/4</sup>-d (U.S. EPA, 1992). Response  
25 levels are presented as either a NOAEL,<sup>60</sup> a LOAEL if the study did not identify a NOAEL, or a  
26 modeled LED<sub>10</sub> if the study results were suitable for modeling (Barton and Clewell, 2000).

27 Adverse effects have been observed in several studies at a human-equivalent dose range  
28 of 1–10 mg/kg-d. For the rat kidney there is a chronic NOAEL at 10 mg/kg-d (Maltoni et al.,

<sup>59</sup>*Point of departure* denotes a dose at the lower end of the observed dose-response curve where extrapolation to lower doses begins. For effects other than cancer, the point of departure is either a NOAEL (no-observed-adverse-effect level), a LOAEL (lowest-observed-adverse-effect level) if no NOAEL can be identified, or a modeled point (for example, an LED<sub>10</sub> or LED<sub>01</sub>) if the data are suitable for curve-fitting. For cancer, the point of departure is an LED<sub>10</sub> (or lower point if one can be reliably estimated) for tumors, or for a key tumor precursor when there is information to describe the mode-of-action.

<sup>60</sup>A *NOAEL* (no-observed-adverse-effect level) is the highest experimental dose without a statistically or biologically significant effect. Note that at this dose there may be effects that are not biologically significant (*i.e.*, not judged *adverse*), or there may be biologically significant effects that are not statistically significant. Statistical significance is affected by study design and sample size, consequently, a NOAEL in one study may show a statistically significant adverse effect in another study with a different design or larger sample.

1 1986). For the liver there is a subchronic NOAEL at 1 mg/kg-d in mice (Tucker et al., 1982), a  
2 subchronic LOAEL at 1 mg/kg-d in mice (Buben and O’Flaherty, 1985), and a subchronic LED<sub>10</sub>  
3 of 0.6 mg/kg-d in rats (Berman et al., 1995). Among these liver values, 1 mg/kg-d is chosen as  
4 the point of departure, supported by these three studies as a dose where liver toxicity can begin to  
5 be observed in two species after subchronic dosing. For cardiac anomalies in developing rats,  
6 there is a LOAEL at 34 mg/kg-d and a NOAEL at 0.05 mg/kg-d (Dawson et al., 1993). The 700-  
7 fold difference between this LOAEL and NOAEL reflects the wide dose spacing in this study,  
8 which makes use of this endpoint as a point of departure highly uncertain.

### 10 4.3.3. Uncertainty Factors

11 To address differences between study conditions and conditions of lifetime human  
12 environmental exposure, the point of departure is reduced by *uncertainty factors*<sup>61</sup> that reflect  
13 different areas of uncertainty.

14 Several studies have identified similar points of departure for adverse liver effects,  
15 indicating some degree of confidence in using this effect as a basis for calculating an RfD. There  
16 are several sources of uncertainty in using these studies.

- 17 (a) *Human variation:* The NOAELs, LOAELs, and LED<sub>10</sub>s for adverse liver effects (see  
18 Section 4.3.2, Table 4-2) were estimated using a pharmacokinetic model (Barton and  
19 Clewell, 2000; Clewell et al., 2000). The parameter uncertainty in these modeled dose  
20 estimates (estimated between the 50th and 99th percentiles, see Section 4.2.2, Table 4-1)  
21 is 15-fold if plasma TCA is used as the dose metric and 20-fold if plasma DCA is used

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<sup>61</sup>RfDs apply to lifetime human environmental exposure, including sensitive subgroups. Differences between study conditions and conditions of human environmental exposure may make a dose that appears safe in an experiment not be safe in the environment. *Uncertainty factors* account for differences between study conditions and conditions of human environmental exposure. These include:

- (a) *Variation from average humans to sensitive humans:* RfDs apply to the human population, including sensitive subgroups, but studies rarely target sensitive humans. Sensitive humans could be adversely affected at lower doses than a general study population; consequently, general-population NOAELs are reduced to cover sensitive humans.
- (b) *Uncertainty in extrapolating from animals to humans:* If an RfD is developed from animal studies, the animal NOAEL is reduced to reflect pharmacokinetic and pharmacodynamic factors that may make humans more sensitive than animals.
- (c) *Uncertainty in extrapolating from subchronic NOAELs to chronic NOAELs:* RfDs apply to lifetime exposure, but sometimes the best data come from shorter studies. Lifetime exposure can have effects that do not appear in a shorter study; consequently, a safe dose for lifetime exposure can be less than the safe dose for a shorter period. If an RfD is developed from less-than-lifetime studies, the less-than-lifetime NOAEL is adjusted to estimate a lifetime NOAEL.
- (d) *Uncertainty in extrapolating from LOAELs to NOAELs:* RfDs estimate a dose without appreciable risks, but sometimes adverse effects are observed at all study doses. If an RfD is developed from a dose where there are adverse effects, that dose is adjusted to estimate a NOAEL.
- (e) *Other factors* to reflect professional assessment of scientific uncertainties not explicitly treated above, including completeness of the overall database, minimal sample size, or poor exposure characterization.

1 (Bois, 2000b, Rhomberg, 2000). Not known is whether either of these dose metrics is an  
2 appropriate indicator of liver toxicity. This pharmacokinetic variation is complemented  
3 by pharmacodynamic variation (Renwick, 1998). In the absence of data to quantify  
4 human pharmacodynamic variation, a default factor of  $10^{1/2}$ <sup>62</sup> has been suggested  
5 (Renwick, 1998). Multiplying 15- to 20-fold pharmacokinetic variation by  $10^{1/2}$ -fold  
6 pharmacodynamic variation indicates overall human variation of about 50-fold (rounded  
7 to one significant digit).

8 (b) *Animal-to-human uncertainty*: This aspect of uncertainty can also be viewed in terms of  
9 pharmacokinetic and pharmacodynamic components. Animal-to-human pharmacokinetic  
10 uncertainty is reflected in the 15- to 20-fold factor just discussed. Animal-to-human  
11 pharmacodynamic uncertainty is covered by a default factor of  $10^{1/2}$ , similar to the  
12 practice used for deriving RfCs (U.S. EPA, 1994).

13 (c) *Subchronic-to-chronic uncertainty*: The NOAEL, LOAEL, and  $LED_{10}$  for adverse liver  
14 effects (see Section 4.3.2, Table 4-2) were based on subchronic exposures. When  
15 subchronic studies are used to derive an RfD for lifetime exposure, an uncertainty factor  
16 of up to 10-fold is generally applied. Although duration-response trends are not evident  
17 in the animal studies, recent human studies have found statistically significant duration-  
18 response trends for decreased testosterone, decreased FSH, decreased SHBG, and  
19 increased DHEA (Chia et al., 1997; Goh et al., 1998). Duration-response trends have  
20 also been reported for central nervous system toxicity (Rasmussen et al., 1993; Ruitjen et  
21 al., 1991). These studies suggest that prolonged exposure to TCE can increase the  
22 severity of effects, prompting the use of a partial factor of  $10^{1/2}$  until duration-response  
23 relationships are better characterized in humans.

24 (d) *LOAEL-to-NOAEL uncertainty*: The 1 mg/kg-d point of departure is a subchronic  
25 LOAEL in one study, a NOAEL in another, and an  $LED_{10}$  in a third. When adverse  
26 effects are observed at the point of departure, an uncertainty factor of up to 10-fold is  
27 generally applied. In this case, a reduced factor of  $10^{1/2}$  is appropriate because 1 mg/kg-d  
28 appears to be at the boundary where effects can begin to be observed.

29 (e) *Other factors*: The general population is routinely exposed to many agents that induce  
30 CYP2E1, for example, ethanol, acetaminophen, and many ubiquitous environmental  
31 contaminants. Moreover, several metabolites of TCE are major environmental  
32 contaminants in their own right: for example, TCA and DCA are two principal toxic  
33 byproducts of drinking water disinfection. Thus, humans generally have higher  
34 background exposures to TCE and its metabolites compared to background exposures in

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<sup>62</sup> $10^{1/2}$  denotes the square root of 10. On a logarithmic scale, this represents half of a factor of 10. Numerically,  $10^{1/2}$  is approximately equal to 3.1, which is usually rounded to 3 in a final calculation.

1 test animals; in other words, humans start higher on the dose-response curve than the test  
2 animals. To account for this difference between humans and laboratory animals, a  
3 modifying factor of  $10^{1/2}$  will be applied. This factor appears reasonable in view of the  
4 large numbers of people who are at increased risk because of certain medications (for  
5 example, acetaminophen and barbiturates) or diseases (for example, diabetes and  
6 alcoholism) that affect metabolism and may exacerbate the effects of TCE exposure  
7 (Pastino et al., 2000).

8 This modifying factor to reflect background exposures to TCE and its metabolites is new.  
9 It is meant to address the issue of cumulative risks, thus responding to calls by the risk  
10 assessment and public health communities that risk assessments would be more realistic and  
11 relevant if they address how exposure to other chemicals and stressors can alter a chemical's  
12 toxicity. More than for most other chemicals, the general population is exposed to TCE and its  
13 metabolites from multiple sources (see Section 3). Consideration of a preexisting background  
14 exposure to toxic metabolites is important when these chemicals are assumed to have a sublinear  
15 dose-response curve (see Section 1.8, footnote 26). This modifying factor applies only to  
16 populations that have background exposure to the metabolites that are involved in TCE's  
17 toxicity.

#### 18 19 **4.3.4. Calculation and Characterization of the Oral Reference Dose**

20 For TCE, an RfD can be based on critical effects in the liver, kidney, and developing  
21 fetus. The point of departure is 1 mg/kg-d, a dose where adverse liver effects can begin to be  
22 observed in two species after subchronic dosing. A composite uncertainty factor of 5,000 is  
23 obtained by multiplying factors of 50 for average-to-sensitive human variation,  $10^{1/2}$  for animal-  
24 to-human uncertainty,  $10^{1/2}$  for using subchronic instead of lifetime studies,  $10^{1/2}$  for using a point  
25 of departure where adverse effects have been observed, and a modifying factor of  $10^{1/2}$  to reflect  
26 background exposures to TCE and its metabolites, thus beginning to address the issue of  
27 cumulative risks involving TCE. Dividing the 1 mg/kg-d point of departure by a composite  
28 uncertainty factor of 5,000 would yield an RfD of  $2 \times 10^{-4}$  mg/kg-d.

29 When RfDs are calculated using conventional 10-fold uncertainty factors, EPA limits the  
30 composite factor to 3,000 when human-equivalent doses are used (U.S. EPA, 1994). With this  
31 limitation, the RfD would be  $3 \times 10^{-4}$ . The TCE uncertainty factors are not, for the most part,  
32 conventional 10-fold factors: the 50-fold factor for human variation is based on an uncertainty  
33 analysis, and the other factors are reduced below 10 based on the available data. Each factor is  
34 appropriate at some level, as the RfD is otherwise derived from a dose where adverse effects are  
35 observed in subchronic animal studies, but the size of each factor is an open question.

1 Another perspective on the size of the uncertainty factors is provided by research in  
2 progress at ATSDR (El Masri, 2000), in which a data-derived factor covering human variation  
3 and animal-to-human uncertainty for TCE was 625 (compared with  $50 \times 10^{1/2} = 150$  used in this  
4 assessment). ATSDR's analysis showed more uncertainty for TCE than for the three other  
5 chlorinated solvents that were modeled. This research suggests that an RfD based on a  
6 composite uncertainty factor of 3,000 would leave only a five-fold margin ( $3,000/625=5$ ) to  
7 cover subchronic-to-chronic uncertainty, LOAEL-to-NOAEL uncertainty, and higher cumulative  
8 background exposures in humans. This further indicates the high level of uncertainty inherent in  
9 any RfD currently derivable for TCE.

10 Barton and Clewell (2000) suggest an RfD of 0.06–0.12 mg/kg-d based on subchronic  
11 liver effects in rats and mice.<sup>63</sup> Their RfD is based on increased liver-weight-to-body-weight  
12 ratio, one of the critical effects used here. Their point of departure is equal to the 1 mg/kg-d used  
13 here. The difference is their use of an uncertainty factor only for average-to-sensitive human  
14 variation. This indicates the potential for discussion of alternative RfDs using fewer uncertainty  
15 factors.

16 The argument for omitting the animal-to-human factor would rest on an assertion that  
17 humans are no more sensitive than rats and mice in terms of pharmacodynamic response to TCE.  
18 Although some mechanisms of liver toxicity may be quantitatively less in humans (for example,  
19 PPAR activation), others might not (for example, cell signaling with DCA). TCE's modes of  
20 action are not known, nor is the potential for interaction between modes of action. In addition,  
21 critical effects in the kidney and developing fetus occur at doses only slightly above those  
22 causing liver toxicity. It has not been established that humans are more sensitive than rats and  
23 mice to these other effects.

24 The argument for omitting the subchronic-to-chronic factor would rest on an assertion  
25 that TCE's subchronic effects would not increase over longer durations (the principal studies  
26 supporting liver effects involved exposure for only 14 and 30 days). Such short durations usually  
27 indicate application of a 10-fold factor. In addition, recent human and animal studies have found  
28 statistically significant duration-response trends for several hormone levels, providing further  
29 support for using a subchronic-to-chronic factor.

30 The argument for omitting the LOAEL-to-NOAEL factor would rest on an assertion that  
31 the LOAELs for increased liver-weight-to-body-weight ratio represent a minimal effect level.  
32 This assertion receives some support from the use of "benchmark dose" modeling, which

<sup>63</sup>Barton and Clewell (2000) suggest an oral RfD in the range of 0.06–0.12 mg/kg-d based on liver effects (increased liver-weight-to-body-weight ratio) in rats (Berman et al., 1995) and mice (Buben and O'Flaherty, 1985), obtaining Weibull-model ED<sub>10</sub>s of 308–515 mg/kg-d using modeled TCA area-under-the-curve (Clewell et al., 2000) as the dose metric. The corresponding human-equivalent doses were divided by a composite uncertainty factor of 10 (for human variation).

1 indicates that the LOAELs are comparable to LED<sub>10s</sub>. Benchmark dose modeling, however, does  
2 not mandate rote treatment of LED<sub>10s</sub> as if they were NOAELs. In this case, the observation of  
3 adverse effects at the lowest doses tested after only 14 and 30 days exposure warrants some  
4 concern for effects at still lower doses.

5 This assessment uses partial uncertainty factors of 10<sup>1/2</sup> (approximately threefold) in each  
6 of these areas. This is commensurate with the limited nature of the principal studies, in which  
7 rats and mice dosed for 14 or 30 days, respectively, showed adverse effects at the lowest tested  
8 doses. Further, ATSDR's decision that the database is not strong enough to support a chronic  
9 value indicates the presence of much uncertainty in these areas.

10 Limitations of the database are many. As noted by ATSDR (1997), the chronic-duration  
11 studies are problematic. Epidemiologic studies of TCE-contaminated drinking water are limited  
12 in their ability to quantify dose-response relationships because of difficulties in estimating past  
13 contamination levels and the presence of other solvents with similar metabolic profiles. Most  
14 animal studies focus on liver and kidney, organs where TCE induces tumors; studies assessing  
15 alteration of organ function or enzyme levels are less common. Finally, neither the occupational  
16 studies nor the animal studies provide information about sensitive individuals. In view of these  
17 limitations, the use of several uncertainty factors appears reasonable.

#### 18 19 **4.4. INHALATION REFERENCE CONCENTRATION FOR EFFECTS OTHER** 20 **THAN CANCER**

##### 21 **4.4.1. Critical Effects**

22 For acute inhalation exposure to high concentrations (above approximately 1,000 ppm, or  
23 5,400 mg/m<sup>3</sup>), targets of TCE toxicity include the central nervous system, cardiovascular system,  
24 kidney, and developing fetus (ATSDR, 1997). At lower concentrations (approximately  
25 100–1,000 ppm, or 540–5,400 mg/m<sup>3</sup>), acute exposure still affects these systems, and there are  
26 also intermediate and chronic studies (1 year or more) that show effects on the central nervous  
27 system, kidney, liver, and endocrine system (see Section 3.4). At the lowest concentrations,  
28 effects are observed in the central nervous system, liver, and endocrine system. These are  
29 considered to be the critical effects of inhaled TCE.

##### 30 31 **4.4.2. Point of Departure**

32 Table 4-3 summarizes the results of inhalation studies of lower concentrations.  
33 Concentrations in occupational studies were converted to continuous (24 hr/d, 7 d/wk)  
34 concentrations. Concentrations in animal studies were taken from the analysis of Barton and  
35 Clewell (2000). If pharmacokinetic-adjusted doses were not available, the RfC methodology  
36 (U.S. EPA, 1994) for systemic effects for a water-soluble, perfusion-limited gas was used

1 instead. Response levels are presented as either a NOAEL, a LOAEL if the study did not identify  
2 a NOAEL, or a modeled LEC<sub>10</sub> if the study results were suitable for modeling.

3 Adverse effects have been observed in several studies at a concentration range of 5–16  
4 ppm (27–86 mg/m<sup>3</sup>). These include LOAELs of 7–16 ppm (38–86 mg/m<sup>3</sup>) for signs of central  
5 nervous system toxicity in several occupational studies (Rasmussen et al., 1993; Ruitjen et al.,  
6 1991; Vandervort et al., 1973; Okawa and Bodner, 1973). Also, an LEC<sub>10</sub> of 5 ppm (27 mg/m<sup>3</sup>)  
7 was identified for heart rate and electroencephalographic changes in rats (Arito et al., 1994). For  
8 endocrine effects, a LOAEL of 11 ppm (59 mg/m<sup>3</sup>) was identified for decreased mean levels of  
9 testosterone, decreased FSH, decreased SHBG, and increased DHEA in an occupational study  
10 (Chia et al., 1997; Goh et al., 1998). A pharmacokinetic-model-derived LEC<sub>10</sub> of 5 ppm (27  
11 mg/m<sup>3</sup>) was identified for increased liver-weight-to-body-weight ratio in mice (Kjellstrand et al.,  
12 1983).

13 Together, these studies indicate 5–16 ppm (27–86 mg/m<sup>3</sup>) as the lower end of the range of  
14 concentrations at which adverse effects have been observed. From this range, 7 ppm (38 mg/m<sup>3</sup>)  
15 is chosen as the point of departure. This concentration was identified as a subchronic LOAEL  
16 for central nervous system effects in two occupational studies and is supported by central nervous  
17 system effects in rats at 5 ppm (27 mg/m<sup>3</sup>). This latter dose is also associated with a 10%  
18 increased incidence of liver effects in mice.

#### 19 **4.4.3. Uncertainty Factors**

20 To address differences between study conditions and conditions of human environmental  
21 exposure, the point of departure is reduced by several uncertainty factors.

- 22 (a) *Human variation*: The occupational studies observed healthy adult workers, who do not  
23 reflect the potential for effects in children, the elderly, or those with disease or other  
24 conditions that can increase susceptibility. This supports use of the standard 10-fold  
25 factor for human variation. If human variation for this effect were as large as that for  
26 liver effects (see Section 4.3.3), then this factor would be an underestimate.
- 27 (b) *Animal-to-human uncertainty*: Because the point of departure is supported by human  
28 studies, this factor is not needed.
- 29 (c) *Subchronic-to-chronic uncertainty*: The point of departure is based on subchronic  
30 studies. Duration-response trends have been reported for central nervous system toxicity  
31 (Rasmussen et al., 1993; Ruitjen et al., 1991). These observations suggest that continuing  
32 exposure to TCE can increase the severity of effects, supporting a 10-fold factor to  
33 address the potential for more severe toxicity from lifetime exposure to TCE.  
34 Statistically significant duration-response trends have also been observed for decreased  
35 mean levels of testosterone, decreased follicle-stimulating hormone, decreased SHBG,  
36

1 and increased DHEA in humans (Chia et al., 1997; Goh et al., 1998), plus decreased  
2 testosterone in rats (Kumar et al., 2000).

3 (d) *LOAEL-to-NOAEL uncertainty:* The central nervous system effects and the endocrine  
4 effects observed in occupational studies are LOAELs, supporting a 10-fold factor to  
5 approach the range where a NOAEL could be expected.

6 (e) *Other factors:* These are not being used.  
7

#### 8 **4.4.4. Calculation and Characterization of the Inhalation Reference Concentration**

9 For TCE, an RfC can be based on critical effects in the central nervous system, liver, and  
10 endocrine system. The point of departure is 7 ppm (38 mg/m<sup>3</sup>). This concentration was  
11 identified as a subchronic LOAEL for central nervous system effects in two occupational studies  
12 and is further supported by central nervous system effects in rats and liver effects in mice at 5  
13 ppm (27 mg/m<sup>3</sup>). A composite uncertainty factor of 1,000 is obtained by multiplying factors of  
14 10 for average-to-sensitive human variation, 10 for starting from subchronic instead of lifetime  
15 studies, and 10 for starting from effect levels instead of NOAELs. Dividing the 38 mg/m<sup>3</sup> point  
16 of departure by a composite uncertainty factor of 1,000 yields an RfC of 4×10<sup>-2</sup> mg/m<sup>3</sup>.

17 Barton and Clewell (2000) suggest an RfC of 0.4–1 ppm (2–5 mg/m<sup>3</sup>) based on  
18 subchronic neurological effects in rats.<sup>64</sup> Their RfC is based on one of the studies supporting the  
19 point of departure. The difference is their use of an uncertainty factor for only average-to-  
20 sensitive human variation. This indicates the potential for discussion of alternative RfCs that do  
21 not incorporate uncertainty factors for using a subchronic instead of a lifetime study or for using  
22 an effect level instead of a NOAEL.  
23

#### 24 **4.4.5. Comparison of Reference Dose and Reference Concentration**

25 The similarity of effects by oral or inhalation exposure to TCE suggests using route  
26 extrapolation (see Section 4.2.3):

27 (a) to compare effect levels for oral and inhalation exposure, and

28 (b) to compare the RfD and RfC.

29 The results will depend on the equivalence between oral dose and inhaled concentration  
30 that yields similar internal levels of the active agent causing a particular toxic effect. If TCA  
31 area-under-the-curve is the appropriate dose metric, then ingesting TCE at 1 mg/kg-d yields  
32 similar internal TCA as inhaling TCE at 75 mg/m<sup>3</sup>. On the other hand, if DCA area-under-the-

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<sup>64</sup>Barton and Clewell (2000) suggest an inhalation RfC in the range of 0.4–1 ppm (2–5 mg/m<sup>3</sup>) based on neurologic effects (changes in sleep and wakefulness) in rats (Arito et al., 1994), obtaining an ED<sub>10</sub> of 0.57 ppm using modeled TCOH in blood (Clewell et al., 2000) as the dose metric. The corresponding human-equivalent concentration was divided by a composite uncertainty factor of 10 (for human variation).



1 curve is the appropriate dose metric, then ingesting TCE at 1 mg/kg-d yields similar internal  
2 DCA as inhaling TCE at 3 mg/m<sup>3</sup> (see Section 4.2.3).

3 The oral point of departure is an equivalent human dose of 1 mg/kg-d (see Section 4.3.2).  
4 This corresponds to an inhaled concentration of 75 mg/m<sup>3</sup> if TCA is the appropriate dose metric  
5 for route extrapolation, and 3 mg/m<sup>3</sup> if DCA is the appropriate dose metric. The 25-fold range  
6 between these two concentrations contains the inhalation point of departure of 38 mg/m<sup>3</sup> (see  
7 Section 4.4.2). This suggests a convergence of effect levels for these two exposure routes.

8 Similarly, the oral RfD is 3×10<sup>-4</sup> mg/kg-d (see Section 4.4.4). This corresponds to an  
9 inhaled concentration of 2×10<sup>-2</sup> mg/m<sup>3</sup> if TCA is the appropriate dose metric and 9×10<sup>-4</sup> mg/m<sup>3</sup> if  
10 DCA is the appropriate dose metric.<sup>65</sup> The inhalation RfC of 4×10<sup>-2</sup> mg/m<sup>3</sup> is close to the  
11 concentration that results when TCA is used as the dose metric.

12 Another useful route extrapolation compares TCE exposures in the occupational and  
13 drinking water studies. In the Singapore cohort (Chia et al., 1997; Goh et al., 1998), hormone  
14 disruption was observed in male workers exposed to an average of 30 ppm (162 mg/m<sup>3</sup>) for 8  
15 hr/d. This inhalation exposure yields similar internal TCA as ingesting TCE at 0.71 mg/kg-d,  
16 and this dose corresponds to a drinking water concentration of 25 mg/L for a 70-kg adult  
17 drinking 2 L/d.<sup>66</sup> The corresponding ingested dose (0.71 mg/kg-d) is close to the oral point of  
18 departure (1 mg/kg-d), reiterating the convergence between the oral and inhalation databases and  
19 giving them greater confidence than they would have if analyzed separately. At the same time,  
20 the corresponding drinking water concentration (25 mg/L) greatly exceeds the Safe Drinking  
21 Water Act maximum contaminant level of 5 : g/L for TCE, suggesting that there is much value  
22 in attempting to use drinking water studies to estimate risk and avoid some of the problems of  
23 low-dose extrapolation (see Section 4.5.1).

#### 24 25 **4.5. SLOPE FACTOR AND INHALATION UNIT RISK FOR CANCER**

26 Cancer risk assessments have described dose-response curves in the range of  
27 environmental exposures, conveying an appreciation of how risk decreases as dose decreases.  
28 Past risk assessments have used a dose-response curve that is linear at low doses, implying that

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<sup>65</sup>The calculations are:

$$(2 \times 10^{-4} \text{ mg/kg-d}) \times (75 \text{ mg/m}^3) / (\text{mg/kg-d}) = 1.5 \times 10^{-2} : \text{g/m}^3$$
$$(2 \times 10^{-4} \text{ mg/kg-d}) \times (3 \text{ mg/m}^3) / (\text{mg/kg-d}) = 6 \times 10^{-4} : \text{g/m}^3$$

<sup>66</sup>The calculations are:

$$(162 \text{ mg/m}^3) \times (8 \text{ hr}/24 \text{ hr}) \times (1 \text{ mg/kg-d}) / (75 \text{ mg/m}^3) = 0.71 \text{ mg/kg-d}$$
$$(0.71 \text{ mg/kg-d}) \times (70 \text{ kg}) / (2 \text{ L/d}) = 25 \text{ mg/L}$$

1 risk decreases proportionately with dose.<sup>67</sup> The slope of the dose-response curve at low doses is  
2 called a *slope factor*.

3 EPA's proposed cancer guideline revisions (U.S. EPA, 1996) describe a two-step process  
4 of modeling the observed data followed by extrapolation to lower doses. Extrapolation to lower  
5 doses follows either a linear or a nonlinear approach, depending on what is known about mode-  
6 of-action. Extrapolation begins from a *point of departure* near the lowest doses. When linear  
7 extrapolation is used, the slope factor is determined by the line from the point of departure  
8 toward zero. When the mode-of-action is understood well enough to support nonlinear  
9 extrapolation, a dose-response curve is not estimated below the point of departure. Instead, a  
10 discussion provides information about the distance from the point of departure to a dose where  
11 there would be little concern for cancer.

12 The use of pharmacokinetic and dosimetry models carries an implicit assumption of  
13 tumor site concordance across species; therefore, it is important to assess and consider each  
14 tumor site that may be relevant to human environmental exposure. In this regard, it is important  
15 to note that lack of suitable dose-response data has precluded development of slope factors for  
16 some sites where there might be a cancer risk, notably for cervical cancer and prostate cancer.  
17

#### 18 **4.5.1. Risk Estimates From Cancer Epidemiology Studies**

19 Quantitative risk methods for human studies must be tailored to the type of data available  
20 in each particular case. Of utmost importance is the availability of quantitative exposure data,  
21 which can be the principal determinant of the quality of the risk estimates.  
22

##### 23 **4.5.1.1. Finnish Cohort**

24 One set of risk estimates was derived from a cohort of 2,050 male and 1,924 female  
25 Finnish workers exposed to TCE and other solvents (Anttila et al., 1995). This cohort had  
26 statistically significant increases in non-Hodgkin's lymphoma and, among workers exposed for  
27 more than 20 years, liver cancer. Although kidney cancer was not statistically significantly  
28 increased in this cohort, the observed incidence was used to bound the potential risk identified  
29 qualitatively from the epidemiologic studies as a whole (Wartenberg et al., 2000). For this

---

<sup>67</sup>Low-dose-linear models are appropriate for extrapolation to lower doses when a carcinogen acts in concert with other exposures and processes that cause a background incidence of cancer (Crump et al., 1976; Lutz, 1990). Further, even when the mode-of-action indicates a nonlinear dose-response curve in homogeneous animal populations, the presence of genetic and lifestyle factors in a heterogeneous human population tends to make the dose-response curve more linear (Lutz, 1990). This is because genetic and lifestyle factors contribute to a wider spread of human sensitivity, which extends and straightens the dose-response curve over a wider range. Although these considerations provide a reasonable argument for a model that is linear at low doses, the relation of the low-dose slope to one from the experimental range is uncertain; this uncertainty increases with the distance from the experimental range.

assessment, Anttila made available to EPA urinary TCA measurements and the cancer status for each worker.<sup>68</sup> A separate study of 51 male workers (Ikeda, 1972) was used to derive a relationship between urinary TCA and air concentrations of TCE:

$$\text{Urinary TCA (mg/L)} = 2.956 \times \text{Ambient TCE (ppm, 8 hr/d, 6 d/wk)}$$

Occupational exposure duration, which was not available, was assumed to be 15 years, and each worker's mean urinary TCA measurement was taken as representative for this duration. The resulting inhalation unit risk estimates, adjusted for lifetime exposure to an average of 1 ug/m<sup>3</sup> of TCE in air, are:

Liver cancer:	$1 \times 10^{-7}$ ; upper bound, $9 \times 10^{-7}$
Kidney cancer:	$2 \times 10^{-5}$ ; upper bound, $3 \times 10^{-5}$
Non-Hodgkin's lymphoma:	$5 \times 10^{-5}$ ; upper bound, $9 \times 10^{-5}$
Overall:	$7 \times 10^{-5}$ ; upper bound, $>9 \times 10^{-5}$

These estimates are based on a small number of cancer cases. As with other occupational studies, they are based on healthy adult workers and may not be representative of children or other groups. Moreover, the exposure duration is uncertain. In addition, the workers were exposed to other solvents (albeit solvents with similar metabolic pathways, potential modes of action, and toxic effects), so that attributing all risk to TCE can overestimate the risk from TCE (though not, perhaps, for the combined solvent exposure). On the other hand, the exposure metric is based on biological measurements of a major metabolite of TCE.

#### 4.5.1.2. Hill Air Force Base Cohort

Another analysis considered the cohort of Hill Air Force Base workers exposed to TCE and other chemicals (Blair et al., 1998). This cohort showed nonsignificant increases in mortality from liver cancer, kidney cancer, and non-Hodgkin's lymphoma, cancers that are elevated in the epidemiologic studies overall (Wartenberg et al., 2000). Blair made available to EPA a qualitative exposure index and the cancer mortality status for each worker. The exposure index did not quantify exposure, instead, it classified each job as either high or low peak exposure. Difficulties in converting this exposure index into a credible quantitative estimate include differences between peak exposure and cumulative exposure and the diversity of jobs and exposure levels in the cohort; indeed, Blair (1998) cautioned that the exposure index was not

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<sup>68</sup>The data for each cancer case are as follows:

	Liver cancer				Kidney cancer					Non-Hodgkin's lymphoma								
Average urinary TCA (: mol/L)	15	257	17	112	92	23	77	363	2,217	3	3	48	207	312	422	13	44	21
Age at first TCA measurement	64	50	29	15	52	48	41	40	32	54	54	36	63	34	33	33	18	21
Age at last TCA measurement	65	52	30	25	54	49	42	41	33	55	55	37	64	35	34	34	19	27
Age at end of followup	78	79	56	41	68	62	62	63	49	80	74	61	81	58	62	57	39	43

1 convertible into ppm. Without a quantitative estimate of exposure, it is not possible to derive  
2 risk estimates.

### 3 4 **4.5.1.3. New Jersey Drinking Water Study**

5 Risk estimates were derived from a study of drinking water contamination in a 75-town  
6 area of New Jersey (Cohn et al., 1994). Female residents had increased incidences of leukemia  
7 (RR=1.4, 95% CI=1.1–1.9, N=56) and non-Hodgkin’s lymphoma (RR=1.4, 95% CI=1.1–1.7,  
8 N=87). For homes exceeding the Safe Drinking Water Act maximum contaminant level of  
9 5 µg/L, the average concentration was 23 : g/L and the highest concentration was 67 µg/L.  
10 Using this average from the most-exposed homes, a drinking water unit risk estimate for non-  
11 Hodgkin’s lymphoma from exposure to 1 : g/L of TCE in drinking water is:

$$12 \quad (RR - 1) \times \text{Background risk} / \text{Average concentration} =$$

$$13 \quad (1.4 - 1) \times (6 \times 10^{-4}) / (23 : \text{g/L}) = 1 \times 10^{-5} \text{ per } : \text{g/L}$$

14 where  $6 \times 10^{-4}$  is the background risk of non-Hodgkin’s lymphoma in the United States. This unit  
15 risk can be converted to a slope factor by multiplying by 35,000 (based on a 70-kg adult drinking  
16 2 L/d). The resulting slope factor is  $3.5 \times 10^{-1}$  per mg/kg-d average lifetime exposure to TCE.  
17 The residents were exposed to other drinking water contaminants, so that attributing all risk to  
18 TCE can overestimate the risk from TCE. On the other hand, this risk estimate is derived from  
19 human environmental exposure, avoiding the uncertainties of animal-to-human extrapolation and  
20 high- to low-dose extrapolation. Moreover, using the average concentration from the most-  
21 exposed homes would tend to overestimate exposure and, hence, underestimate unit risks.

### 22 23 **4.5.1.4. German Cohort**

24 The California Environmental Protection Agency (Cal/U.S. EPA, 1999) derived a slope  
25 factor from the increased incidence of kidney cancer in German cardboard workers exposed to  
26 TCE (Henschler et al., 1995). In the absence of exposure data, the German threshold limit value  
27 of 50 ppm (270 mg/m<sup>3</sup>) was used as a surrogate for the average workplace concentration. This  
28 was converted to a lifetime average daily dose, assuming 50% absorption of inhaled TCE:

$$29 \quad 50 \text{ ppm} \times (8 \text{ hr}/24 \text{ hr}) \times (5 \text{ d}/7 \text{ d}) \times (15.2 \text{ yr}/70 \text{ yr}) \times 0.50 \times 5.37 \text{ (mg/m}^3\text{)}/\text{ppm}$$
$$30 \quad \times 20 \text{ m}^3\text{/d} / 70 \text{ kg} = 1.98 \text{ mg/kg-d}$$

31 From the reported kidney cancer incidence (7/169, SIR=13.53 based on East German  
32 background rates), a slope factor was obtained by the following calculation, based on an additive  
33 risk model that is linear in dose:

$$34 \quad (7/169) \times (1 - 1/13.53) / 1.98 \text{ mg/kg-d} = 1.9 \times 10^{-2} \text{ per mg/kg-d}$$

1 By this calculation, Cal/EPA converted the air concentration into mg/kg-d by figuring  
2 gross amount inhaled by a 70-kg adult breathing 20 m<sup>3</sup>/d. Therefore, to convert the slope factor  
3 to an inhalation unit risk, 20 m<sup>3</sup>/d and 70 kg would be removed from the preceding calculations.  
4 The resulting inhalation unit risk is 5×10<sup>-6</sup> per : g/m<sup>3</sup>.

5 To the extent that the workers were exposed to mixed solvents and other risk factors, this  
6 slope factor derived from the Henschler study would tend to overestimate risks from TCE,  
7 because it attributes all kidney cancers to TCE and not to the other risk factors. On the other  
8 hand, to the extent that the threshold limit value of 50 ppm overestimates average workplace  
9 concentration, this slope factor would tend to underestimate risks. Further uncertainty arises  
10 from using an unadjusted incidence (7/169) instead of one based on life-table methods, from  
11 comparing this incidence with East German background rates (the plant was in West Germany,  
12 but West German rates were unavailable), and from treating exposure concentration and  
13 exposure duration as constant across all workers.

14 Variation in human susceptibility was explored by further analyses based on observed  
15 differences in kidney cancer risk attributed to GST polymorphisms (Brüning et al., 1997). The  
16 odds ratio for the combined genotype GSTM/GSTT (found in 40% of Caucasians) was 3.75.  
17 This corresponds to a higher slope factor (3.5×10<sup>-2</sup> per mg/kg-d) for those with the combined  
18 genotype and a lower slope factor (9×10<sup>-3</sup> per mg/kg-d) for the rest of the population (Cal/U.S.  
19 EPA, 1999).

#### 21 **4.5.2. Risk Estimates From Liver Tumors in Mice**

22 TCE causes hepatocellular carcinomas and adenomas in male and female mice exposed  
23 by ingestion or inhalation (see Table 3-1). TCE is also associated with liver cancer in humans  
24 (Wartenberg et al., 2000). Several approaches are explored for estimating these risks.

##### 26 **4.5.2.1. Mechanism-Based Modeling**

27 Chen (2000) developed a mechanism-based dose-response model for mouse liver tumors,  
28 based on mechanistic hypotheses discussed by Bull (2000). The model is a stochastic form of the  
29 two-stage model, in which normal cells can become initiated (the first stage); initiated cells either  
30 die, proliferate into a clone of initiated cells, or are converted to malignancy (the second stage);  
31 and malignant cells either die or progress to a detectable tumor. Dose metrics were area-under-  
32 the-curve of TCA or DCA in the liver, taken from Bois's calibration of Fisher's pharmacokinetic  
33 model (Bois, 2000a). Chen's model assumes that TCE induces liver tumors through TCA and  
34 DCA acting by clonal expansion of preexisting initiated cells. This assumption of action on only

1 preexisting initiated cells implies that TCE-induced liver tumor incidences are proportional to  
2 background liver tumor incidences.

3 In a sequence of applications of the mechanism-based model, (1) a dose-response curve  
4 for DCA-induced liver tumors was developed from bioassays of DCA in mice, (2) this curve was  
5 found to be consistent with bioassays of TCA in mice, considering the rate at which some TCA is  
6 metabolized to DCA, and (3) these curves were found to be consistent with the bioassays of TCE  
7 in mice, considering the rate at which some TCE is metabolized to TCA and DCA (Chen, 2000).  
8 This suggests that TCE produces enough DCA to theoretically explain the mouse liver tumors  
9 induced in the TCE bioassays, though it cannot rule out a role for TCA or other metabolites.  
10 Thus, the relative importance of DCA or TCA in TCE-induced mouse liver tumors is not  
11 resolved by mechanism-based modeling.

12 The mechanism-based model also explored extrapolation to lower doses. Following the  
13 model below the observed range yields an (upper bound) unit risk of  $2.4 \times 10^{-8}$  for oral exposure  
14 to 1 ug/L of TCE in drinking water (Chen, 2000).  
15

#### 16 **4.5.2.2. Empirical Modeling**

17 Rhomberg (2000) fitted empirical dose-response models to the liver tumor data. Dose  
18 metrics were area-under-the-curve of TCA or DCA in the liver or plasma, taken from Bois's  
19 calibrations of Fisher's and Clewell's pharmacokinetic models (Bois, 2000a,b). Table 4-4  
20 presents the modeled  $LED_{10s}$  that provide a point of departure for low-dose extrapolation. These  
21  $LED_{10s}$  reveal substantial model uncertainty between Fisher's and Clewell's models. They also  
22 reveal that Bois's calibrations bring some convergence: harmonic means<sup>69</sup> of  $LED_{10s}$  from the  
23 four experiments span 0.16–25.82 mg/kg-d when dose estimates come from Fisher's and  
24 Clewell's original models, but narrow to 0.5–3.1 mg/kg-d when dose estimates come from Bois's  
25 calibrations of those models. (Bois did not calibrate Fisher's model with DCA as the dose  
26 metric; in this case, only Fisher's original model is considered.) This latter range (0.5–3.1  
27 mg/kg-d) is used as the point of departure for low-dose extrapolation. Although both endpoints  
28 of this range use TCA as the dose metric, this does not imply a preference for TCA over DCA.  
29 The DCA range (1.7–2.5 mg/kg-d) simply falls within the TCA range, moreover, Section 4.5.1  
30 discusses why neither is established as the appropriate dose metric.

31 It is tempting to note that the point-of-departure range for liver tumors (0.5–3.1 mg/kg-d)  
32 includes the point of departure for liver toxicity (a subchronic LOAEL of 1 mg/kg-d for increased  
33 liver-weight-to-body-weight ratio; see Section 4.3.2). This concordance, however, is likely to be

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<sup>69</sup>The *harmonic mean* is computed as  $N/(3 \sum 1/X_i)$ . For this application, this is equivalent to averaging slope factors (which are inversely proportional to  $LED_{10s}$ ), then taking the reciprocal to convert the average slope factor back to a dose.

1 only coincidental, as liver weight change is a nonspecific effect observed in both rats and mice,  
2 but rats have not developed liver tumors from TCE exposure. The liver weight changes,  
3 therefore, are not considered a key event in liver tumor development.

#### 4 5 **4.5.2.3. Extending the Observed Range Using Subchronic-dosing Studies**

6 A key determinant of risk is the shape of the dose-response curve below the point of  
7 departure. One source of information about lower doses is the comprehensive study by Maltoni  
8 et al. (1986), who had the foresight to investigate different exposure durations in parallel  
9 experiments. Groups of Swiss mice inhaled TCE at 100–600 ppm (540–3,240 mg/m<sup>3</sup>), 7 hours  
10 daily, 5 days weekly, for either 8 weeks or 78 weeks; then the experiments continued past 2 years  
11 to ensure that the latent period for tumor development had passed.

12 Table 4-5 and Figure 4-1 show the incidence of hepatomas in male mice (females did not  
13 develop hepatomas). If response is considered as a function of cumulative exposure  
14 (concentration times duration), the 8-week exposure groups can be regarded as extending the  
15 observed range to lower cumulative exposures. Overall, response decreases as cumulative  
16 exposure decreases, but the curve does not appear to be sublinear anywhere in this extended  
17 range. This suggests that exposures must be far below the observable range before the risk drops  
18 appreciably.

19 This finding may be pertinent for risk assessments of less-than-lifetime exposure  
20 durations. If the lifetime average dose is low because the exposure duration is relatively short, it  
21 may be important to consider that risk may not fall proportionately as exposure duration  
22 decreases. That is, cumulative exposure (concentration times duration, or area-under-the-curve)  
23 may not be a good dose metric to use to predict liver tumor risk.

#### 24 25 **4.5.2.4. Extending the Observed Range Using DCA and TCA Studies**

26 Another source of information at lower doses are the studies of DCA- or TCA-induced  
27 liver cancer. Bioassays of these TCE metabolites cover a 100-fold dose range, wider than the  
28 dose range of the TCE bioassays. Chen (2000) analyzed these studies jointly, using area-under-  
29 the-curve of DCA in the liver as a common dose metric.

30 Table 4-6 and Figure 4-2 bring together the dose-response information from the DCA,  
31 TCA, and TCE bioassays. The DCA and TCA studies extend the dose range as much as 100-fold  
32 below the TCE studies. Overall, the responses appear to decrease as dose decreases, but the  
33 dose-response curve does not appear to be sublinear anywhere in this extended range, again  
34 suggesting that exposures must be far below an LED<sub>10</sub> before the risk drops appreciably.

35 Looking at the multiple-dose TCA and DCA bioassays individually, the dose-response  
36 curve for TCA appears linear, whereas the curve for DCA appears sublinear. If we consider

1 tumor multiplicity along with tumor incidence, however, the DCA dose-response curve, too,  
2 becomes linear (DeAngelo et al., 1999). Tumor multiplicity may more closely reflect rates of  
3 underlying carcinogenic processes.

#### 4 5 **4.5.2.5. Extrapolation to Lower Doses**

6 Under EPA's proposed cancer guideline revisions (U.S. EPA, 1996), choice of linear or  
7 nonlinear extrapolation to lower doses is based on what is known about the mode-of-action. The  
8 evidence indicates that TCE-induced liver tumors arise through multiple metabolites and  
9 multiple modes of action (see Section 3.5.1). The preponderance of evidence suggests that the  
10 CYP450 metabolites are sufficient to explain the liver tumors (Bull, 2000; Chen, 2000). CH and  
11 TCA cause liver tumors in mice, and DCA causes liver tumors in mice and rats. A plausible  
12 mode-of-action is that TCE induces liver tumors through TCA and DCA modifying cell signaling  
13 systems that control rates of cell division and cell death (Bull, 2000). Tumors from the TCA and  
14 DCA bioassays arise from different mechanisms and can be distinguished: TCA-induced tumors  
15 are associated with peroxisome proliferation, while DCA-induced tumors are associated with  
16 selectively inhibiting growth of normal hepatocytes and suppressing apoptosis (Bull, 2000).  
17 DCA may also have different modes of action at different doses, possibly involving differential  
18 accumulation of glycogen in normal and initiated liver cells (Bull, 2000). Moreover, DCA is  
19 also weakly mutagenic (Moore and Harrington-Brock, 2000), although this property is not  
20 needed to explain the bioassay results. Characterizing the tumors from the TCE bioassays is a  
21 critical research need that presently limits understanding of the respective roles of TCA and DCA  
22 in TCE-induced tumors (see Section 5). At present, however, the extensive mode-of-action  
23 information still lacks identification of the sequence of key events and a quantitative description  
24 of the doses at which those key events begin to occur. In such cases, EPA's proposed cancer  
25 guideline revisions (U.S. EPA, 1996) support consideration of both linear and nonlinear  
26 extrapolation to lower doses.

27 Linear extrapolation follows a straight line toward the origin, the slope of this line (or  
28 *slope factor*) is  $0.10/\text{LED}_{10}$ . The  $\text{LED}_{10}$  range of 0.5–3.1 mg/kg-d yields slope factors of  $3 \times 10^{-2}$   
29 to  $2 \times 10^{-1}$  per mg/kg-d. Because the pharmacokinetic models allow for a nonlinear relationship  
30 between (external) exposure and (internal) dose, this “straight-line” extrapolation can reflect  
31 nonlinearity in the exposure-dose-response data.

32 Nonlinear extrapolation under the proposed cancer guideline revisions (U.S. EPA, 1996)  
33 does not attempt to describe dose-response curves in the range of environmental exposures,  
34 instead, it examines whether an exposure is small enough to pose little risk of cancer. The goal is  
35 that exposures be small enough that “the key events in tumor development would not occur  
36 among sensitive individuals in a heterogeneous human population, thus representing an actual



1 ‘no effect level’” (U.S. EPA, 1999). A nonlinear analysis considers several factors<sup>70</sup> where the  
2 available data may fall short of this ideal.

3 (a) *Nature of the response:* The point of departure is ideally based on key precursor events.  
4 If tumors are used instead, then the dose is adjusted to bring it into the range where the  
5 key precursor events would not occur (U.S. EPA, 1999). For TCE-induced liver cancer,  
6 further research is needed to identify the key events and the doses at which the key events  
7 begin to occur (see Section 5). These doses will be below the LED<sub>10</sub>s where tumors are  
8 clearly observable, how far below cannot now be determined.

9 (b) *Shape of the observed dose-response curve:* The shape of the dose-response curve can  
10 indicate how fast risk decreases below the point of departure. For TCE-induced liver  
11 cancer, dose-response curves are ambiguous, consistent with either low-dose linearity or  
12 nonlinearity (Rhomberg, 2000). Extending the dose-response curve using information  
13 from subchronic-dosing studies or from DCA and TCA bioassays suggests that the dose-  
14 response curve may remain linear quite far below, perhaps two orders of magnitude  
15 below, the LED<sub>10</sub>s. At still lower doses, the mode-of-action may ultimately be nonlinear;  
16 nonetheless, current data do not identify how far below the LED<sub>10</sub>s sublinearity begins to  
17 prevail. Further research is needed to identify the key precursor events and describe their  
18 dose-response curves (see Section 5).

19 (c) *Human sensitivity compared with experimental animals:* This factor has been viewed as  
20 having pharmacokinetic and pharmacodynamic components (U.S. EPA, 1994). For TCE,  
21 the pharmacokinetic component is addressed by the pharmacokinetic models, which  
22 predict higher internal doses of TCA and DCA in humans than in mice. Little  
23 information is typically available on the pharmacodynamic component, and the proposed  
24 cancer guideline revisions (U.S. EPA, 1996) recommend that humans be considered

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<sup>70</sup>A nonlinear analysis considers the following factors (U.S. EPA, 1999):

- (a) *Nature of the response:* The point of departure is ideally based on key precursor events, not tumors, just as RfDs and RfCs are based on critical (precursor) effects occurring at lower doses than those associated with frank toxicity. Precursor events are likely to occur at doses below those where tumors are observable. If a point of departure is based on tumors, then the point of departure is adjusted to reflect the dose at which key precursor events would begin to occur.
- (b) *Shape of the observed dose-response curve:* If the dose-response curve is steep at the point of departure, then the occurrence of key events declines rapidly in this range. On the other hand, if the dose-response curve is relatively shallow, then the point where the key event no longer occurs may lie far below this range.
- (c) *Human sensitivity compared with experimental animals:* If the point of departure is developed from animal studies, this dose is adjusted to reflect pharmacokinetic and pharmacodynamic factors that may make humans and animals differ in sensitivity.
- (d) *Nature and extent of human variability in sensitivity:* Pertinent information would come from human studies, because animal studies, particularly those using homogeneous animal strains, do not provide information about human variation.
- (e) *Human exposure:* Cancer response can depend on the expected pattern of human exposure, including the magnitude, frequency, and duration of exposure.

1 potentially more sensitive by a default factor of  $10^{1/2}$ . For TCE, however, the prevailing  
2 view is that humans would be quantitatively less sensitive than mice to the PPAR activity  
3 and other processes leading to the mouse liver tumors (Bull, 2000). In this case, an  
4 inverse factor of  $10^{-1/2}$  could be used to reflect the potential lesser sensitivity of humans  
5 (U.S. EPA, 1996).

- 6 (d) *Nature and extent of human variability in sensitivity:* For TCE, this factor can be based  
7 on the statistical uncertainty analyses (Bois, 2000b). A factor of 15–20 reflects the  
8 pharmacokinetic uncertainty in the liver between the 50th and 99th percentiles (see Table  
9 4-1). Coupled with a factor of  $10^{1/2}$  to cover pharmacodynamic differences between  
10 humans, a factor of 50–60 would appear appropriate to reflect human variation in  
11 sensitivity.

12 This discussion of data-derived factors indicates several large uncertainties: 50–60-fold  
13 to reflect human variation, approximately 100-fold to reach a range where the dose-response  
14 curve does not appear linear in some bioassay, an as-yet-undeterminable factor to reflect the  
15 difference in dose between tumors and key precursor events, and a factor of  $10^{-1/2}$  to reflect the  
16 potential for humans to be less sensitive than mice. Overall, then, the composite factor would  
17 appear comparable to the 3000–10,000 that is the maximum for developing a credible RfC or  
18 RfD (U.S. EPA, 1994; Barnes and Dourson, 1988).

#### 19 20 **4.5.2.6. Comparison of Empirical and Mechanism-Based Modeling Results**

21 Mechanism-based modeling yields a unit risk of  $2.4 \times 10^{-8}$  for oral exposure to 1 : g/L in  
22 water (Chen, 2000). This unit risk can be converted to a slope factor by multiplying by 35,000  
23 (based on a 70-kg adult drinking 2 L/d). The resulting slope factor is  $8.4 \times 10^{-4}$  per mg/kg-d. This  
24 result lies below the empirically based slope factor range of  $3 \times 10^{-2}$  to  $2 \times 10^{-1}$ .

25 The mechanism-based slope factor includes a 100-fold reduction attributable to an  
26 assumption that chemically induced tumor rates scale across species in proportion to background  
27 tumor rates, the rate in mice being 100 times that of humans. This difference is not based on any  
28 data for TCE, rather, it is a corollary of the model's assumptions that TCE acts by clonal  
29 expansion of preexisting initiated cells and that there is strict tumor site concordance across  
30 species. If these assumptions, which generally are not used in cross-species extrapolations for  
31 other chemicals, were not used here, then the mechanism-based slope factor would be 100-fold  
32 higher, or  $8 \times 10^{-2}$  per mg/kg-d. This latter result lies within the slope factor range based on  
33 empirical modeling.

#### 34 35 **4.5.3. Risk Estimates From Lung Tumors in Mice**

1 **4.5.3.1. Modeling**

2 TCE causes lung adenomas and adenocarcinomas in mice exposed by inhalation (see  
3 Table 3-5). Pharmacokinetic models (Clewett et al., 2000; Bois, 2000b) were used to estimate  
4 area-under-the-curve and peak concentration of CH in plasma, plasma CH being considered as a  
5 surrogate for CH accumulation in Clara cells of the lung. Bois's uncertainty analysis (Bois,  
6 2000b), however, revealed the presence of substantial parameter uncertainty in the lung dose  
7 estimates (see Table 4-1, Section 4.2.2). Consequently, dosimetry models for deriving inhalation  
8 RfCs were used instead (U.S. EPA, 1994). Rhomberg (Rhomberg, 2000) fitted empirical dose-  
9 response models to the lung data (see Table 4-7). The resulting LEC<sub>10</sub>s are quite similar, ranging  
10 from 1.3×10<sup>5</sup> to 3.6×10<sup>5</sup> : g/m<sup>3</sup>.

11  
12 **4.5.3.2. Extrapolation to Lower Doses**

13 The proposed mode-of-action for TCE-induced lung tumors is that rapid CYP2E1  
14 metabolism of TCE in the Clara cells of the mouse lung leads to an accumulation of CH and  
15 causes cell damage and compensatory cell replication that leads to tumor formation (Green,  
16 2000). Because humans have fewer Clara cells and little CYP2E1 activity in the lung as a whole,  
17 humans may be less sensitive to this particular mode-of-action. (This argument, however,  
18 pertains more to the relative sensitivity of mice and humans than to nonlinearity in either mice or  
19 humans.) Although this hypothesis is consistent with the higher level of CYP2E1 in mouse lung,  
20 it has not yet been determined whether accumulation of CH is a key event causing tumors or a  
21 coincidental event unrelated to tumors. Moreover, several questions about this hypothesis  
22 remain unresolved (see Section 3.5.3). In addition, CH is clearly clastogenic and mutagenic at  
23 high doses (Moore and Harrington-Brock, 2000), raising the possibility of multiple modes of  
24 action. For these reasons, this assessment will pursue both linear and nonlinear extrapolation to  
25 lower doses.

26 Linear extrapolation takes the form of a straight line to the origin; the slope of this line  
27 (or *inhalation unit risk*) is 0.10/LEC<sub>10</sub>. The LEC<sub>10</sub> range of 1.3×10<sup>5</sup> to 3.6×10<sup>5</sup> : g/m<sup>3</sup> yields unit  
28 risks of 3×10<sup>-7</sup> to 8×10<sup>-7</sup> per : g/m<sup>3</sup>.

29 Nonlinear extrapolation under the proposed cancer guidelines (U.S. EPA, 1996) considers  
30 several factors in identifying a dose where there would be little concern for cancer.

31 (a) *Nature of the response:* The proposed key event, CH accumulation in Clara cells, has  
32 been studied only at high doses (450 ppm and above, equivalent to 2,430 : g/m<sup>3</sup>) (Green,  
33 2000) relative to those where lung tumors have been observed (150–300 ppm, or  
34 810–1,620 mg/m<sup>3</sup>). This makes determination of cause-and-effect premature, and it does  
35 not identify doses at which CH accumulation would not occur. Further research is needed

1 to establish the quantitative relationship between CH accumulation and lung tumors so  
2 that a point of departure can be based on the key precursor event.

3 (b) *Shape of the observed dose-response curve:* Dose-response curves for TCE-induced lung  
4 cancer are ambiguous, consistent with either linearity or nonlinearity at low doses  
5 (Rhomberg, 2000). Current data do not identify how far below the LEC<sub>10s</sub> sublinearity  
6 begins to prevail. Further research is needed to link CH accumulation to lung tumors and  
7 describe the dose-response curve for CH accumulation.

8 (c) *Human sensitivity compared with experimental animals:* The pharmacokinetic  
9 component is addressed by inhalation dosimetry models (U.S. EPA, 1994). For the  
10 pharmacodynamic component, if rapid CYP2E1 metabolism leading to CH accumulation  
11 in Clara cells is the key event, humans may be quantitatively less sensitive than mice to  
12 this effect (Green, 2000). In this case, an inverse factor of 10<sup>-1/2</sup> could be used to reflect  
13 the potential lesser sensitivity of humans (U.S. EPA, 1996). Nonetheless, humans may  
14 not necessarily be less sensitive if other CYP450 enzymes play a role or if other lung cell  
15 types are involved.

16 (d) *Nature and extent of human variability in sensitivity:* For TCE in the lung, this factor is  
17 problematic in light of the substantial variation revealed by the uncertainty analysis of the  
18 pharmacokinetic modeling (Bois, 2000b). A factor of more than 300 would be needed to  
19 reflect just the pharmacokinetic uncertainty in the lung between the 50th and 99th  
20 percentiles (see Table 4-1). A further factor would be needed to reflect  
21 pharmacodynamic differences. Clearly, more research is needed in the area of human  
22 variation.

23 In light of these research needs (see Section 5), it is difficult to proceed with nonlinear  
24 extrapolation to establish a dose at which lung tumors would not be of concern.

#### 25 26 **4.5.4. Risk Estimates From Kidney Tumors in Rats**

##### 27 **4.5.4.1. Modeling**

28 TCE causes kidney adenocarcinomas and adenomas in male and female rats by oral  
29 gavage and in male rats by inhalation (see Table 3-2). TCE is also associated with kidney cancer  
30 in humans (Wartenberg et al., 2000). Pharmacokinetic models (Clewell et al., 2000; Bois,  
31 2000b) were used to estimate metabolites in the kidney. Bois's uncertainty analysis (Bois,  
32 2000b), however, revealed the presence of substantial parameter uncertainty in the kidney dose  
33 estimates (see Table 4-1, Section 4.2.2). Consequently, dose estimates for the kidney were based  
34 on equivalence of mg/kg<sup>3/4</sup>-d instead (U.S. EPA, 1992). Rhomberg (2000) fitted empirical dose-  
35 response models to the kidney data (see Table 4-8). Following NTP guidance to combine kidney  
36 adenocarcinomas and adenomas (McConnell et al., 1986), the resulting human-equivalent LED<sub>01</sub>

1 for kidney tumors is 33 mg/kg-d. LED<sub>01</sub>s were calculated instead of LED<sub>10</sub>s because kidney  
2 tumor incidences can be observed below the 10% level.

#### 3 4 **4.5.4.2. Extrapolation to Lower Doses**

5 TCE-induced kidney tumors may arise through multiple modes of action (see Section  
6 3.5.2). The preponderance of evidence suggests that TCE's GST metabolites are responsible for  
7 kidney toxicity and kidney tumors (Lash et al., 2000b). Although these metabolites have not  
8 been tested in cancer bioassays, the GST metabolite DCVC is mutagenic (Moore and  
9 Harrington-Brock, 2000). Involvement of a mutagenic metabolite would indicate use of linear  
10 extrapolation to lower doses (U.S. EPA, 1996). Cytotoxicity may also be involved, as  
11 cytotoxicity is observed in both rats and humans exposed to high levels of TCE.

12 Linear extrapolation from the LED<sub>01</sub> of 33 mg/kg-d yields a slope factor of  $3 \times 10^{-4}$  per  
13 mg/kg-d ( $0.01/33 = 3 \times 10^{-4}$ ).

#### 14 15 **4.5.5. Risk Estimates From Testicular Tumors in Rats**

##### 16 **4.5.5.1. Modeling**

17 Independent studies provide some evidence that TCE causes testicular tumors in rats by  
18 oral gavage and by inhalation (see Table 3-4). Health Canada derived a cancer potency estimate  
19 (a TD<sub>05</sub>, the dose associated with an increased tumor risk of 5%) from the increased incidence of  
20 testicular interstitial cell tumors in Marshall rats exposed to TCE (see Table 3-4). Health  
21 Canada's dosimetry assumed cross-species equivalence of mg/kg-d. Their resulting TD<sub>05</sub> was  
22 200 mg/kg-d.

23 Using EPA's methodology with the same study yields an LED<sub>10</sub> of 25 mg/kg-d. The  
24 eightfold ratio of Health Canada's TD<sub>05</sub> to EPA's LED<sub>10</sub> is attributable to a factor of 3.8 for  
25 EPA's use of 3/4-power scaling and a factor of 2.2 between the lower-bound dose at 10%  
26 response and the central-estimate dose at 5% response.

##### 27 28 **4.5.5.2. Extrapolation to Lower Doses**

29 TCE-induced testicular tumors would likely result from endocrine disturbances (see  
30 Section 3.5.4). There is evidence of endocrine disturbance in both rats (Kumar et al., 2000) and  
31 humans (Chia et al., 1997; Goh et al., 1998). Endocrine disturbance in humans is one of the  
32 critical effects used in developing the RfC, where a subchronic LOAEL of 11 ppm (59 mg/m<sup>3</sup>)  
33 was observed for decreased testosterone, decreased follicle-stimulating hormone, decreased  
34 SHBG, and increased DHEA (see Section 4.4.2). Route extrapolation yields equivalent oral  
35 doses of 0.8 mg/kg-d to 20 mg/kg-d, depending on whether TCA or DCA is used as the dose

1 metric (see Section 4.2.3). As a check for consistency with the tumor data, these precursor doses  
2 lie below the LED<sub>10</sub> for tumors of 25 mg/kg-d.

3 EPA's proposed cancer guidelines (U.S. EPA, 1996) prefer to extrapolate from precursor  
4 data instead of tumor data, using an RfD or RfC for the precursor if the tumors were  
5 demonstrated to occur only subsequently to the precursor. If this is the case, then an RfD for  
6 endocrine-related tumors would be calculated by dividing the point of departure for endocrine  
7 disturbance (0.8 mg/kg-d) by the composite uncertainty factor (1,000, comprising 10 for human  
8 variation, 10 for a subchronic study, 10 for the LOAEL) previously applied to endocrine  
9 disturbance as a critical effect (see Section 4.4.3). The resulting RfD is  $8 \times 10^{-4}$  mg/kg-d.

## 11 **4.5.6. Discussion of Alternative Cancer Risk Estimates**

### 12 **4.5.6.1. Slope Factors**

13 Table 4-9 and Figure 4-3 compile the alternative points of departure and cancer risk  
14 estimates for TCE. Inhalation-to-oral extrapolation of estimates from the Anttila study was  
15 based on internal TCA (see Section 4.2.3), because that study quantified exposure by measuring  
16 urinary TCA. Route extrapolation is also supported by the general similarity of tumor sites from  
17 oral or inhalation exposure (see Section 3.4). Nonetheless, the best approach for route  
18 extrapolation remains a topic for further research (see Section 5).

19 Two sets of estimates appear to lie apart from all others. On the low end, rats appear to  
20 be less sensitive than mice or humans. On the high end, estimates from the Anttila study are  
21 rather uncertain, based on a small number of cancer cases and an assumed uniform exposure  
22 duration of 15 years. Setting aside these lowest and highest estimates, there appears to be  
23 convergence of the other estimates, even though they are derived from different sources. The  
24 remaining slope factors, per mg/kg-d, are  $2 \times 10^{-2}$  (derived from occupational inhalation  
25 exposure),  $3 \times 10^{-2}$  to  $2 \times 10^{-1}$  (derived from mice), and  $4 \times 10^{-1}$  (derived from residential drinking  
26 water exposure). Because they are supported by diverse studies and do not reflect the highest  
27 estimates (from the Anttila study) or the lowest estimates (from the rat studies), these remaining  
28 estimates constitute a middle range of risk estimates where confidence is greatest. This middle  
29 range is robust in the sense that it is not likely to be dramatically altered by a new study or by  
30 minor changes in the analysis of existing studies.

31 This new slope factor range,  $2 \times 10^{-2}$  to  $4 \times 10^{-1}$  per mg/kg-d, lies just above EPA's previous  
32 slope factor for TCE,  $1.1 \times 10^{-2}$  per mg/kg-d. The increase can be attributed principally to two  
33 factors: (1) the pharmacokinetic models predict that humans would experience higher internal  
34 doses of TCA and DCA than would mice from similar exposures (Rhomberg, 2000), perhaps due  
35 to more extensive enterohepatic recirculation (Barton and Clewell, 2000); and (2) the generation  
36 of TCA and DCA would be more efficient at the lower doses expected from environmental

1 exposure than from doses used in the bioassays (Rhomberg, 2000). The new slope factor range  
2 also lies just above the recent slope factor used by Cal/EPA,  $1.3 \times 10^{-2}$  per mg/kg-d (Cal/U.S.  
3 EPA, 1999).<sup>71</sup>

#### 4.5.6.2. *Nonlinear Analyses*

4  
5  
6 Nonlinear extrapolations were attempted for liver tumors, lung tumors, and testicular  
7 tumors. For liver tumors, the point of departure was in the range of 0.5–3.1 mg/kg-d, with a dose  
8 reduction of 3,000–10,000 needed to reach a dose where there may be little concern for cancer.  
9 For lung tumors, it was problematic to determine the reduction needed to reach such a dose. For  
10 testicular tumors, an RfD of  $8 \times 10^{-4}$  mg/kg-d was developed.

#### 4.5.6.3. *Joint Consideration of Slope Factors and Nonlinear Analyses*

11  
12  
13 Joint consideration of results from linear and nonlinear extrapolations is an area for which  
14 there has been no guidance. This may prove to be a complex question, as the purpose of linear  
15 extrapolation is to estimate a bound on risk whereas nonlinear extrapolation attempts to make a  
16 qualitative assurance of safety. It would not be appropriate to settle on a single result by  
17 choosing one analysis and ignoring the other.

18 In the meantime, linear and nonlinear analyses can be harmonized somewhat by being  
19 expressed in common units. For example, slope factors can be inverted to obtain *risk-specific*  
20 *doses*.<sup>72</sup> For an increased risk of 1 in 1 million, the slope factor range ( $2 \times 10^{-2}$  to  $4 \times 10^{-1}$  per  
21 mg/kg-d) yields  $2.5 \times 10^{-6}$  to  $5 \times 10^{-5}$  mg/kg-d as a range of risk-specific doses. Similarly, for a  
22 risk of 1 in 10,000, the range is  $2.5 \times 10^{-4}$  to  $5 \times 10^{-3}$  mg/kg-d. Nonlinear extrapolation can be  
23 expressed as a dose where there may be little concern for cancer. For example, for a point of  
24 departure of 1.8 mg/kg-d (the midpoint of 0.5–3.1 mg/kg-d, the point-of-departure range for liver  
25 tumors) and a dose reduction of 6500 (the midpoint of 3000–10,000, the dose-reduction range  
26 developed for mouse liver tumors), a dose where there may be little concern for liver cancer is  
27 roughly  $3 \times 10^{-4}$  mg/kg-d ( $1.8/6500 = 3 \times 10^{-4}$ ). Higher or lower results could be obtained by using  
28 other choices from these two ranges, but the midpoints serve to illustrate the comparison between  
29 linear and nonlinear health benchmarks.

30 Figure 4-3 shows that for TCE the health benchmarks under nonlinear extrapolation are  
31 approximately 10–100 times the doses associated with an increased cancer risk of 1 in 1 million

<sup>71</sup>Cal/EPA's cancer estimates are based on liver tumors in mice (NCI, 1976; Maltoni et al., 1986), modeled to an LED<sub>10</sub> of 7.9 mg/kg-d using total amount of TCE metabolized as the dose metric. Using linear extrapolation to lower doses, their slope factor is  $0.10/\text{LED}_{10} = 1.3 \times 10^{-2}$ . Cal/EPA considered nonlinear extrapolation to be insufficiently supported by the data.

<sup>72</sup>A *risk-specific dose* is calculated by dividing a risk level by a slope factor. For example, if the slope factor is 2 per mg/kg-d, then the risk-specific dose associated with a risk of 1 in 1 million is  $10^{-6}/(2 \text{ per mg/kg-d}) = 5 \times 10^{-7}$  mg/kg-d.

1 under linear extrapolation. In other words, nonlinear extrapolation leads to doses that would be  
2 associated with increased cancer risks of 1 in 100,000 to 1 in 10,000 under linear extrapolation.  
3 This suggests that if confidence increases in the appropriateness of nonlinear extrapolation for  
4 TCE, then levels that we now associate with risks approaching 1 in 10,000 may be considered  
5 virtually safe in the future.

#### 6 7 **4.5.6.4. Sensitive Populations and Cumulative Risks**

8 Information is beginning to emerge about differences in metabolism, disease, and other  
9 factors that make humans vary in their response to TCE, as well as the potential for other  
10 chemicals to alter TCE's metabolism and toxicity. This information indicates that a single risk  
11 value is not appropriate to describe the differential effects of TCE. For this reason, the  
12 alternative slope factors have not been consolidated into a single estimate. Rather, a range of  
13 slope factors has been described. Depending on the characteristics of the exposed population and  
14 the exposure scenario, each risk assessment should select an appropriate slope factor from this  
15 range. Risk assessments involving the presence of risk factors such as diabetes or alcohol  
16 consumption, or high background exposure to TCE or its metabolites, would more appropriately  
17 choose a higher slope factor. Conversely, lower slope factors may be appropriate when these risk  
18 factors and background exposures are not involved.

19 It will be a challenge for future research to quantify the differential risk indicated by each  
20 risk factor or exposure scenario (see Section 5). In this way, nonlinear cancer assessments will  
21 stop resembling single-point RfDs and will move toward risk ranges with the flexibility to  
22 quantitatively accommodate population-specific and site-specific considerations.

#### 23 24 **4.5.7. Sources of Uncertainty in the Dose-Response Assessment**

25 All risk assessments involve uncertainty, as study data are extrapolated to make  
26 inferences about potential effects from human environmental exposure. One type of uncertainty  
27 stems from different interpretations of the available data (known as model uncertainty), another  
28 from estimation errors due to incomplete or imprecise data (parameter uncertainty). An  
29 understanding of uncertainty can be used:

- 30 < To make more informed choices during the conduct of a risk assessment, and
- 31 < To better characterize the range of plausible risk estimates for different populations.

#### 32 33 **4.5.7.1. Model Uncertainty**

34 This assessment's exploration of multiple modeling approaches affords an opportunity to  
35 understand and address different sources of model uncertainty. The full extent of model



1 uncertainty cannot be quantified, only the models that have been analyzed. In this assessment,  
2 several sources of model uncertainty have been discussed:

- 3 < Two pharmacokinetic models initially led to risk estimates that differed by 15-fold (see  
4 Table 4-4). To reduce this uncertainty, the models were fitted to additional data sets  
5 (Bois, 2000a,b). This calibration improved the models and made the models' results  
6 more compatible, reducing this source of model uncertainty (see Section 4.2.1).
- 7 < A mechanism-based model assumption that TCE-induced liver tumor incidences are  
8 proportional to a species' background liver tumor incidence results in 100-fold lower  
9 human risk estimates (see Section 4.5.2). Because current mechanistic understanding  
10 suggests that cross-species extrapolation is far more complex (see Section 3.5.1), this  
11 assessment chose estimates not based on this assumption.
- 12 < Different exposure routes yield different proportions of metabolite formation. Depending  
13 on whether TCA formation or DCA formation is used as the basis of comparison, route  
14 extrapolations can differ by 25-fold (see Section 4.2.3). To convey an appreciation for  
15 this unresolved uncertainty, this assessment has developed estimates using both  
16 approaches.
- 17 < Different exposure patterns<sup>73</sup> may yield different risks, but this has not been well  
18 investigated. In the absence of TCE-specific data, this assessment has followed the  
19 common, neutral practice of assuming that equal risks result from equal cumulative  
20 doses. There are some data, however, to suggest that this approach may underestimate  
21 risks from short-duration exposures (see Section 4.5.2).
- 22 < The choice between linear and nonlinear extrapolation to environmental doses creates  
23 two distinct classes of estimates (see Sections 4.5.2, 4.5.3). This dichotomous uncertainty  
24 stems from different interpretations of the information on TCE's mode-of-action (see  
25 Section 3.5). Some toxicologists maintain that cross-species differences would make  
26 humans less sensitive to TCE according to the modes of action proposed for mice and  
27 rats, suggesting less concern for human cancer. Other scientists maintain that such  
28 conclusions are premature without more specific definition and experimental  
29 confirmation of the active agents and sequences of key events leading to cancer. In  
30 addition, some of TCE's effects on cell signaling may augment ongoing processes and  
31 conditions in some groups of humans, leading to an increased cancer risk for some.  
32 EPA's proposed cancer guidelines take the latter view, that the active agents and key  
33 events be identified in order to establish the mode-of-action. Consequently, this

---

<sup>73</sup>*Exposure patterns* refer to magnitude, frequency, duration, and timing of exposure. For example, exposure to 30 ppm for 10 hr at age 30 and exposure to 300 ppm for 1 hr at age 1 are two different exposure patterns with a total exposure of 300 ppm-hr.

1 assessment has prepared estimates using both linear and nonlinear approaches, the former  
2 to bound the risks and the latter to demonstrate the degree of uncertainty and value of  
3 further mechanistic research. In addition, this assessment has made efforts to develop  
4 risk estimates from human studies as an alternative to extrapolating from animal models.  
5

#### 6 **4.5.7.2. Parameter Uncertainty**

7 Uncertainty analyses and confidence intervals were developed for some of the key  
8 parameters used in this assessment. Each description of parameter uncertainty assumes that the  
9 underlying model is valid.

- 10 < Uncertainty in the pharmacokinetic data is reflected by 95% confidence intervals  
11 spanning approximately 100-fold for the liver, 14,000-fold for the lung, and 5,000-fold  
12 for the kidney (see Table 4-1, Section 4.2.2). Because of this high uncertainty for lung  
13 and kidney, this assessment reverted to default animal-to-human dose-scaling models for  
14 these organs. In all cases, median dose estimates were used in subsequent calculations.
- 15 < Uncertainty in the animal dose-response data is reflected by the ratio of ED10s to  
16 LED10s. These generally do not exceed a factor of 2 (Rhomberg, 2000).

**Table 4-1. Distributions of potential dose metrics from the uncertainty analysis of the pharmacokinetic models**

Dose metric	GSD	Ratio of dose estimate at each percentile to the median <sup>a</sup>							Span of 95% CI <sup>b</sup>
		1	2.5	10	50	90	97.5	99	
Mouse liver TCA AUC	3.2	1/15	1/10	1/4	1	4	10	15	100
Mouse liver DCA AUC	3.6	1/20	1/12	1/5	1	5	12	20	144
Mouse lung CH AUC	11.7	1/300	1/120	1/23	1	23	120	300	14,400
Mouse lung CH max	12.5	1/360	1/140	1/25	1	25	140	360	19,600
Rat kidney thiol	9.0	1/170	1/74	1/17	1	17	74	170	5,476

<sup>a</sup>Assuming lognormally distributed errors.

<sup>b</sup>Ratio of estimate at 97.5 percentile to estimate at 2.5 percentile.

Source: Adapted from Bois, 2000b, Table 5–7; Rhomberg, 2000, Table 15.

**Table 4-2. Oral studies supporting development of an RfD**

Study	Species	Duration; exposure route	Exoerimental doses (mg/kg/day) <sup>1,2</sup>	Organ; effect	Human-equivalent dose <sup>2,3</sup>
Tucker et al. (1982) and Sanders et al. (1982)	Mouse	Subchronic (6 months) Oral - drinking water	0, <u>18</u> <sup>4</sup> , <u>217</u> <sup>5</sup> , 393, 660 (m) 0, <u>18</u> <sup>4</sup> , <u>193</u> <sup>5</sup> , 437, 793 (f)	Liver: liver weight- body weight ratio  Immune system: antibody (plaque)- forming cell assay	NOAEL, PK - adj. 1 mg/kg-d  NOAEL 29 mg/kg-d
Buben and O'Flaherty (1985)	Mouse	Subchronic (6 weeks) Oral - gavage	0, <u>100</u> , 200, 400, 800, 1600, 2400, 3200	Liver: liver weight- body weight ratio	LOAEL, PK - adj. 1 mg/kg-d
Berman et al. (1995) and Moser et al. (1995)	Rat	14 days Oral - gavage	0, <u>50</u> <sup>6</sup> , <u>150</u> <sup>7</sup> , 500, 1500	Liver: liver weight- body weight ratio  Neurobehavioral	LOAEL, PK - adj. 0.3 mg/kg-d BMD <sub>10</sub> , PK - adj. (Weibull) 0.6 mg/kg-d (Power) 0.5 mg/kg-d NOAEL 40 mg/kg-d
Maltoni et al. (1986)	Rat	Chronic bioassay (52 weeks exposure, followed until natural death) Oral - gavage	0, <u>50</u> , 250	Kidney: renal megalonucleocytosis	NOAEL 10 mg/kg-d
Dawson et al. (1993)	Rat	Developmental Oral - drinking water	0, <u>1.5</u> <sup>8</sup> , 1100 ppm • <u>0.18</u> , 129 mg/kg/day	Developmental: cardiac anomalies	LOAEL 34 mg/kg-d NOAEL 0.05 mg/kg-d
Narotsky et al. (1995)	Rat	Developmental Oral - gavage	0, 10, <u>32</u> , 101, 320, 475, 633, 844, 1,125	Developmental: anophthalmia/ microphthalmia	NOAEL 9 mg/kg-d BMD <sub>10</sub> 133 mg/kg-d
Griffin et al. (2000c)	Mouse	Subchronic (4 weeks and 32 weeks) Oral - drinking water	0, <u>21</u> , 100, 400	Immune system/liver: serum antinuclear antibodies (ANA), histopathological changes, serumalanine aminotransferase	LOAEL 4 mg/kg-d

<sup>1</sup> NOAELs or LOAELs are underlined.<sup>2</sup> From Barton and Clewell (1999).<sup>3</sup> Human equivalent doses calculated using RfD methodology (Barnes and Dourson, 1988) and scaling to the ratio of body weights to the 0.75 power.<sup>4</sup> Tucker et al. (1982).<sup>5</sup> Saunder et al. (1982).<sup>6</sup> Berman et al. (1995).<sup>7</sup> Moser et al. (1995).<sup>8</sup> NOAEL.

**Table 4-3. Inhalation studies supporting development of an RfC**

Study	Species	Duration; exposure route	Concentration <sup>1</sup>	Organ; effect	Human-equivalent concentration <sup>2,3</sup>
Kjellstrand et al. (1983)	Mouse	Subchronic (30 days) inhalation	0, <u>37</u> , 75, 150, 300 ppm	Liver: liver weight- body weight ratio	LOAEL,PK-adj. 12 ppm BMD <sub>10</sub> , PK - adj. (f) 5 ppm (m) 9, 11 ppm
Chia et al. (1997) Goh et al. (1998) Chia et al. (1996)	Human	Subchronic (mean =5 years) inhalation	<u>30</u> ppm (mean)	Endocrine/Liver: FSH, testosterone, DHEAS <sup>4</sup> , FAI <sup>4</sup> , SHBG <sup>4</sup> , insulin	LOAEL 11 ppm
Maltoni et al. (1986)	Rat	Chronic bioassay (104 weeks) inhalation	0, <u>100</u> , 300, 600 ppm	Kidney: megalonucleocytosis	NOAEL, PK - adj. 21 ppm
Ruijten et al. (1991)	Human	Subchronic (mean =16 years) inhalation	44 ppm (calculated from mean cumulative exposure)	CNS: massiter reflex latency	LOAEL 16 ppm
Rasmussen et al. (1993)	Human	Subchronic (mean = 7 years) inhalation	40 - 60 mg/1 urinary TCA - • <u>20</u> ppm <sup>5</sup>	CNS: motor dyscoordination	LOAEL 7 ppm
Vandervort and Pelakoff (1973)	Human	Subchronic (8 years) inhalation	<u>32</u> ppm	CNS: drowsiness, fatigue, dizziness, eye irritation	LOAEL 11 ppm
Okawa and Bodner (1973)	Human	Subchronic inhalation	71 mg/1 urinary TCA (average) - • 20 - <u>30</u> ppm <sup>5</sup>	CNS: nausea, headache, dizziness, fatigue, upper respiratory irritation	LOAEL 7-11 ppm
Arito et al. (1994)	Rat	Subchronic (6 weeks) inhalation	0, <u>50</u> , 100, 600 ppm	CNS: heart rate, electroencephalographic changes	LOAEL,PK- adj. 9 ppm BMD <sub>10</sub> , PK - adj. 5 ppm (wakefulness)
Kumar et al. (2000)	Rat	Subchronic (12 weeks and 24 weeks) inhalation	0, <u>376</u> ppm	Endocrine/Reproductive: testosterone, testicular cholesterol, 17 B-hydroxy steroid dehydrogenase, glucose 6-P- dehydrogenase, sperm number and motility	LOAEL 41 ppm

<sup>1</sup> NOAELs or LOAELs are underlined.

<sup>2</sup> Human equivalent doses calculated using RfC methodology (U.S. EPA, 1994) for a category 3 gas, extrathoracic effects.

$NOAEL^*_{[HEC]} (mg/m^3) = NOAEL^*_{[ADJ]} (mg/m^3) \times [(H_{b/g})_A / (H_{b/g})_H]$ .  
The value of 1.0 is used if  $(H_{b/g})_A > (H_{b/g})_H$ .  $(H_{b/g})_A = 15.9$ , mouse (Fisher, 2000); 14, mouse, 18.5, rat (Clewell et al., 2000).  $(H_{b/g})_H = 9.13$ , male, 11.15, female (Fisher, 2000); 9.2 (Clewell et al., 2000).

<sup>3</sup> HECs for mice and rats are from Barton and Clewell (1999).

<sup>4</sup> DHEAS - dihydroepiandrosterone sulphate, FAI - free androgen index, SHBG - sex hormone binding globin.

<sup>5</sup> U-TCA interpolated to atmospheric concentration assuming 50 mg/1 U-TCA is equivalent to 20 ppm (Axelson et al., 1994).

**Table 4-4. Human-equivalent LED<sub>10s</sub> (mg/kg-d) derived from liver tumor incidences in four mouse studies (NTP males or females, NCI males or females), using two dose metrics (TCA area-under-the-curve, DCA area-under-the-curve) and four pharmacokinetic models (Fisher 2000; Bois, 2000a; Clewell et al., 2000; Bois, 2000b)**

	Based on TCA area-under-the-curve				Based on DCA area-under-the-curve			
	Fisher	Bois/ Fisher	Clewell	Bois/ Clewell	Fisher	Bois/ Fisher	Clewell	Bois/ Clewell
Male mice (NTP)	0.19	1.47	0.077	0.23	0.77	NA	12.05	1.15
Female mice (NTP)	0.33	3.03	0.15	0.45	1.39	NA	24.39	2.33
Male mice (NCI)	0.83	4.76	0.24	0.83	3.45	NA	40.00	4.35
Female mice (NCI)	2.63	18.52	1.01	3.57	10.75	NA	169.49	18.18
Mean <sup>1</sup> of 4 exp'ts	0.40	3.14	0.16	0.50	1.67	NA	25.82	2.52

NA = not available.

<sup>1</sup>Harmonic mean =  $N / (\sum 1/X_i)$ ; equivalent to averaging slope factors (which are inversely proportional to LED<sub>10s</sub>), then taking the reciprocal to convert back to a dose.

Source: Adapted from Rhomberg (2000) (LED<sub>10s</sub> are computed as 0.10 divided by slope factors in Rhomberg, 2000, Table 4).

**Table 4-5. Extending the observed range with a study of less-than-lifetime dosing of TCE**

<b>Concentration (ppm)</b>	<b>Duration (wk)</b>	<b>Exposure index (conc × dur)</b>	<b>Hepatoma incidence</b>
0	8	0	1/41 ( 2%)
100	8	800	3/36 ( 8%)
600	8	4,800	4/23 (17%)
0	78	0	4/66 ( 6%)
100	78	7,800	2/53 ( 4%)
300	78	23,400	8/59 (14%)
600	78	46,800	13/61 (21%)

Source: Adapted from Maltoni et al., 1986.

**Table 4-6. Extending the observed range with studies of TCE's metabolites**

<b>Compound</b>	<b>Dose (DCA AUC)</b>	<b>Liver tumor incidence</b>
DCA	1.38	3/21 (14%)
	14.01	1/18 (5%)
	63.66	8/12 (67%)
	88.4	25/30 (83%)
TCA	0.07	2/9 (22%)
	7.12	8/21 (38%)
	40.8	21/24 (88%)
TCE	67	(61%)
	71	(86%)
	67	(65%)

Source: Adapted from Chen, 2000.



**Table 4-7. Human-equivalent LEC<sub>10</sub>s (ug/m<sup>3</sup>) derived from lung tumor incidences in four mouse studies, using RfC dosimetry**

	LEC <sub>10</sub>
Female ICR mice (Fukuda)	1.4×10 <sup>5</sup>
Male Swiss mice (Maltoni)	1.3×10 <sup>5</sup>
Female Swiss mice (Maltoni)	3.6×10 <sup>5</sup>
Male B6C3F1 mice (Maltoni)	2.8×10 <sup>5</sup>
Mean of 4 experiments	1.9×10 <sup>5</sup>

Source: Adapted from Rhomberg, 2000. (LEC<sub>10</sub>s are computed as 0.10 divided by unit risks in Rhomberg, 2000, Table 9).

**Table 4-8. Human-equivalent LED<sub>01</sub>s (mg/kg-d) derived from kidney tumor incidences in rat studies, using 3/4-power scaling**

	<b>Based on cross-species scaling factor of 3/4-power of relative body weight</b>
Male and female rats, 5 strains pooled (NTP), gavage, adenocarcinomas only	6.7×10 <sup>1</sup>
Male and female rats, 5 strains pooled (NTP), gavage, adenocarcinomas and adenomas <sup>1</sup>	3.3×10 <sup>1</sup>
Male Sprague-Dawley rats (Maltoni), inhalation, adenocarcinomas only	N/A

<sup>1</sup>NTP guidance (McConnell et al., 1986) recommends combining adenocarcinomas and adenomas; Rhomberg (2000) Table 12 states that including adenomas yields values about half those for adenocarcinomas alone.

Source: Adapted from Rhomberg, 2000. (LED<sub>01</sub>s are computed as 0.01 divided by slope factors in Rhomberg, 2000, Table 13.)

**Table 4-9. Compilation of cancer estimates**

	Point of departure (mg/kg-d)	Slope factor (mg/kg-d) <sup>-1</sup>	Risk-specific dose <sup>a</sup> (mg/kg-d)
<b>Cancer estimates based on human studies</b>			
Liver cancer			
Finnish cohort <sup>b</sup>	1.4 <sup>c</sup>	7×10 <sup>-2</sup>	1.4×10 <sup>-5</sup>
Kidney cancer			
Finnish cohort <sup>b</sup>	0.05 <sup>c</sup>	2×10 <sup>0</sup>	5×10 <sup>-7</sup>
German cohort	5 <sup>c</sup>	2×10 <sup>-2</sup>	5×10 <sup>-5</sup>
Non-Hodgkin's lymphoma			
Finnish cohort <sup>b</sup>	0.014 <sup>c</sup>	7×10 <sup>0</sup>	1.4×10 <sup>-7</sup>
New Jersey cohort	0.25 <sup>c</sup>	4×10 <sup>-1</sup>	2.5×10 <sup>-6</sup>
<b>Cancer estimates based on mouse studies</b>			
Liver cancer			
Mechanism-based model <sup>d</sup>	Not applicable	8×10 <sup>-4</sup>	1.25×10 <sup>-3</sup>
Mechanism-based model <sup>e</sup>	Not applicable	8×10 <sup>-2</sup>	1.25×10 <sup>-5</sup>
Linear extrapolation	0.5–3.1	3×10 <sup>-2</sup> –2×10 <sup>-1</sup>	0.5–3.1×10 <sup>-5</sup>
Nonlinear extrapolation	0.5–3.1	Not applicable	(3×10 <sup>-4</sup> ) <sup>f</sup>
Lung cancer <sup>g</sup>	1.7–4.8	Not applicable	(Not calculable) <sup>f</sup>
<b>Cancer estimates based on rat studies</b>			
Kidney cancer	33 <sup>h</sup>	3×10 <sup>-4</sup>	3.3×10 <sup>-3</sup>
Testicular cancer	25	Not indicated	(8×10 <sup>-4</sup> ) <sup>f</sup>

<sup>a</sup>Dose associated with an upper-bound increased cancer risk of 1 in 1 million, calculated as 10<sup>-6</sup>/slope factor. When nonlinear low-dose extrapolation is used, this is a dose considered to pose minimal cancer risks, calculated as the point of departure divided by the composite risk reduction factor from a nonlinear dose-response analysis.

<sup>b</sup>For the Finnish cohort, the slope factors are based on route extrapolation from air unit risks, using a correspondence between inhaled and oral doses giving equal TCA area-under-the-curve (75 mg/m<sup>3</sup> ~ 1 mg/kg-d, see Section 5.2.3). Air unit risks for liver cancer, kidney cancer, and non-Hodgkin's lymphoma are 9×10<sup>-7</sup>, 3×10<sup>-5</sup>, and 9×10<sup>-5</sup> per µg/m<sup>3</sup>, respectively.

<sup>c</sup>The point of departure (an LED<sub>10</sub>) is calculated from the slope factor (LED<sub>10</sub>=0.10/slope factor).

<sup>d</sup>From a mechanism-based model, assuming that tumor response is proportional to background liver tumor incidence (Chen, 2000).

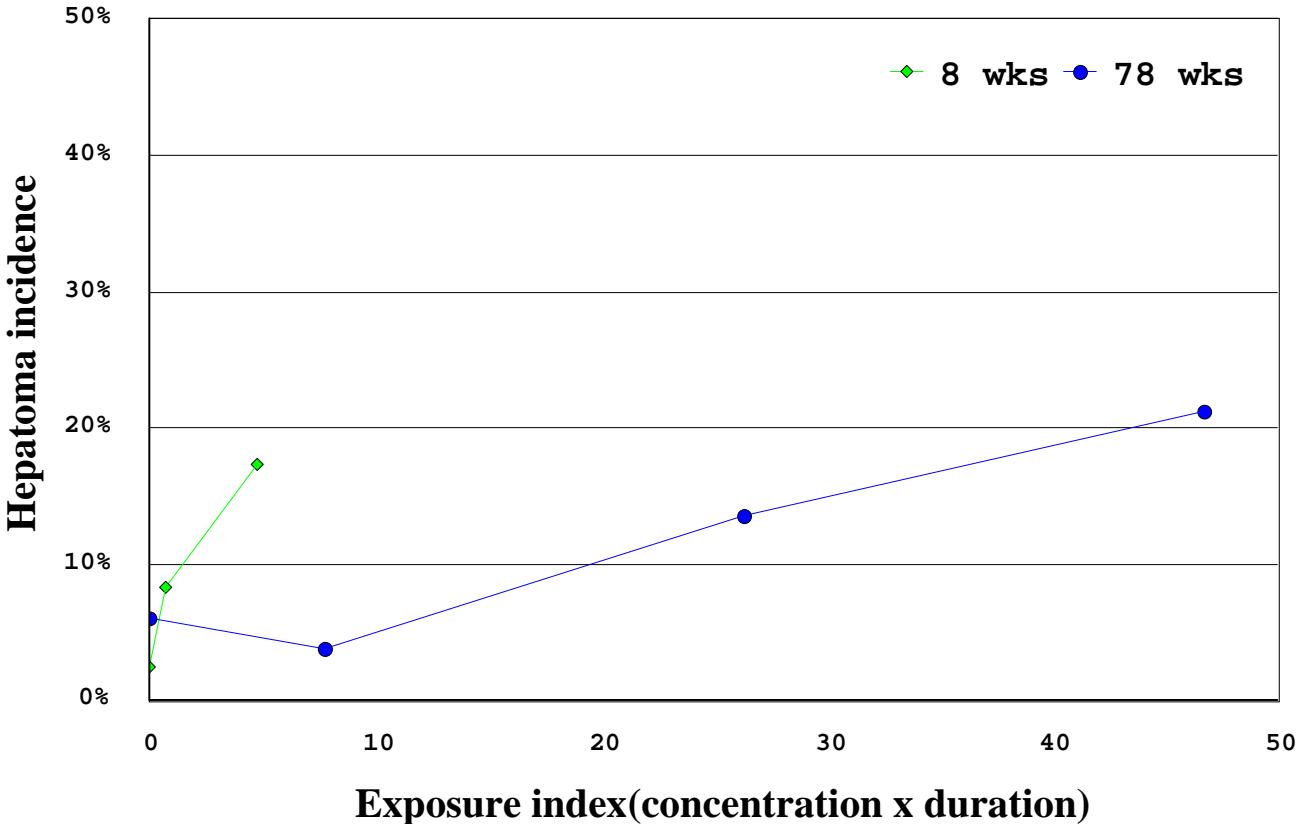
<sup>e</sup>From a mechanism-based model (see note m), without assuming that liver tumor response is proportional to background liver tumor incidence.

<sup>f</sup>This is a dose considered to pose minimal cancer risks, calculated as the point of departure divided by the composite risk reduction factor from a nonlinear dose-response analysis. This is not a dose associated with a 1-in-1 million cancer risk.

<sup>g</sup>The point of departure is based on route extrapolation from the point of departure for an inhalation study in mice using a correspondence between inhaled and oral doses giving equal TCA area-under-the-curve [75 mg/m<sup>3</sup> ~ 1 mg/kg-d, see Section 5.2.3]. The point of departure for mouse lung tumors (an LEC<sub>10</sub>) spans a range of 1.3×10<sup>5</sup> to 3.6×10<sup>5</sup> µg/m<sup>3</sup>.

<sup>h</sup>The point of departure is an LED<sub>01</sub> rather than an LED<sub>10</sub> (see Section 5.5.3).

**Figure 4-1. Extending the observed range with less-than-lifetime dosing**



**Figure 4-2. Extending the observed range with studies of TCE's metabolite**

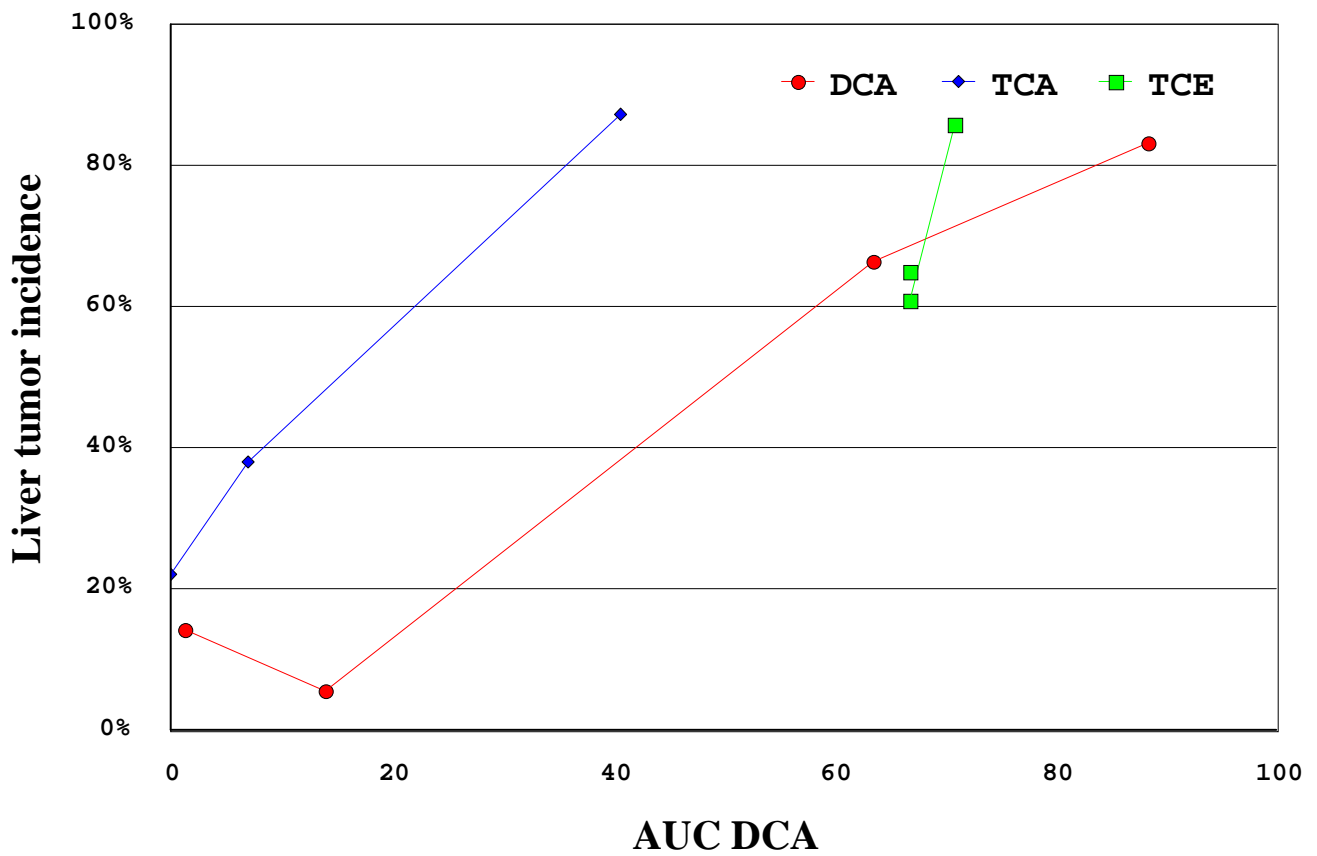
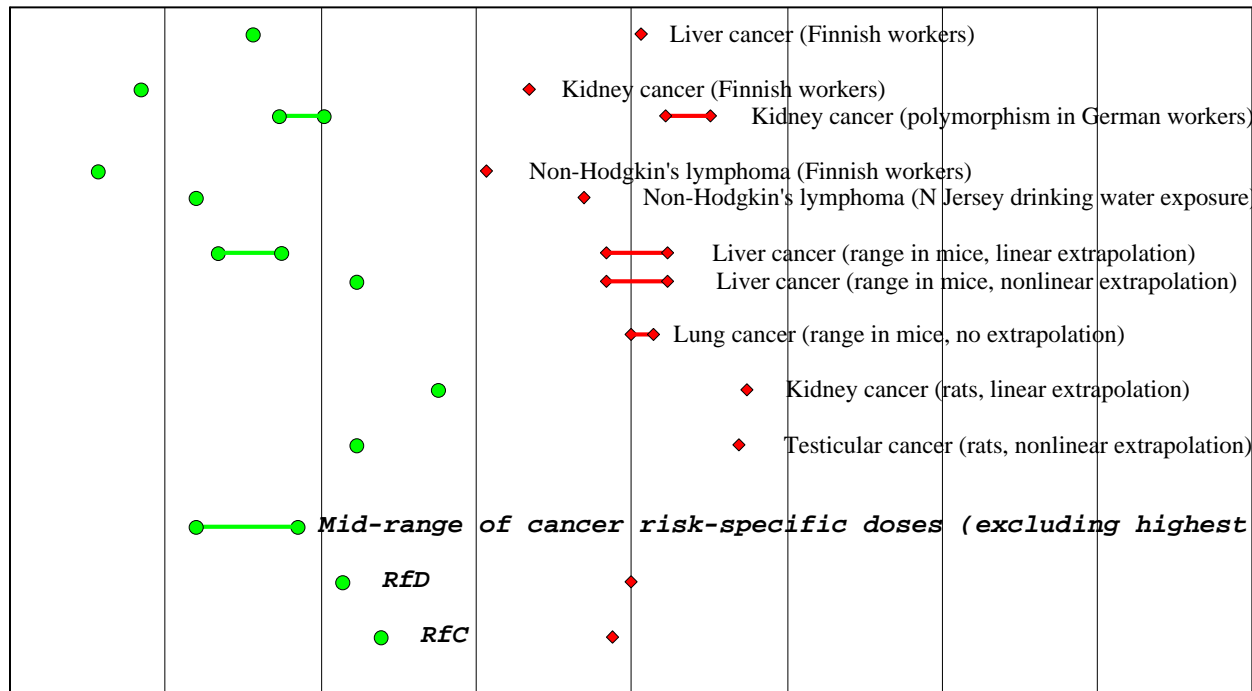


Figure 4-3. TCE health benchmarks

● Risk-specific dose    ◆ Point of departure



1E-8      1E-6      1E-4      1E-2      1E+0      1E+2      1E+4      1E+6      1E+8

TCE dose (mg/kg-d)

## 5. RESEARCH NEEDS

1           Although the database for TCE is rather extensive and much has been learned in recent  
2 years, this is a time when new research could significantly increase understanding and lead to  
3 later refinement of this health risk assessment. Many research needs were discussed in the state-  
4 of-the-science papers that comprise volume 1 of this assessment, and this research promises to  
5 increase understanding of TCE's adverse health effects, the active agents and modes of action for  
6 each effect, and their relevance to human environmental exposure. This section focuses on those  
7 research needs that left this assessment with open questions that were filled by default  
8 assumptions and methods. Further research into these areas could, therefore, have direct bearing  
9 on specific sections of this assessment. The practical importance of describing these research  
10 needs is not to decrease confidence in this assessment, as all assessments have areas that can be  
11 improved by further research, but to be explicit about what specific research could help resolve  
12 the major open questions in this assessment.

### 5.1. RESEARCH NEEDS FOR HAZARD ASSESSMENT

- 14
- 15 (a) TCE's effects other than cancer have not been adequately identified or studied. There is a  
16 lack of definitive chronic studies of effects other than cancer (see Section 3.4).  
17 Investigation into the modes of action for effects other than cancer lags behind what has  
18 been developed for TCE-induced cancer (see Section 3.5).
  - 19 (b) With EPA's proposed cancer guidelines becoming more specific (U.S. EPA, 1999), it is  
20 now apparent that what is needed is a description of the sequence of key events for each  
21 tumor type and the dose levels at which those events begin to occur. Although there has  
22 been much progress in developing and investigating several plausible modes of action,  
23 the active agents and key events have not yet been identified (see Section 3.5).
  - 24 (c) For TCE-induced liver cancer, further research is needed to identify the key events and  
25 the doses at which they begin to occur. Characterizing biological markers of the liver  
26 tumors from the TCE bioassays would promote understanding of the respective roles and  
27 interaction of TCA and DCA in the TCE-induced tumors (see Section 3.5.1).
  - 28 (d) Fuller identification of the mode-of-action and associated key events for kidney tumors,  
29 especially with respect to the potential role of VHL mutations in human kidney cancer,  
30 could affect the description of TCE as either "carcinogenic to humans" or "likely to be  
31 carcinogenic to humans." Replication of recent findings in another cohort showing  
32 kidney tumors could warrant a future description of TCE as "carcinogenic to humans"  
33 (see Section 1.3).
- 34

## 5.2. RESEARCH NEEDS FOR DOSE-RESPONSE ASSESSMENT

- (a) Route extrapolations can differ by 25-fold, depending on whether internal TCA or DCA is used as the dose metric. Further research could identify the appropriate internal dose metric for each toxic effect (see Section 4.2.3).
- (b) There is a need for consensus on a preferred empirical model to be used for each type of data set. This assessment's experience with benchmark dose modeling revealed differences of more than an order of magnitude depending on which empirical model was used. This invites "model shopping" and introduces too much uncertainty for use in risk assessments that support public health decisions (see Section 4.3.2, Table 4-2).
- (c) The RfD includes a data-derived factor of 50 for human variation and default factors of 100 overall for uncertainty in extrapolating from animals to humans, from subchronic studies to lifetime exposure, from effect levels to NOAELs, and from single-chemical toxicity tests to complex exposures involving multiple chemicals. This latter 100-fold factor indicates the potential for future research to reduce uncertainty and improve the assessment's accuracy (see Section 4.3.3, 4.3.4).
- (d) There is considerable pharmacokinetic and pharmacodynamic uncertainty for children. An approach is needed for evaluating the need for and size of an additional factor to ensure that the RfD and RfC are protective of children, while also providing incentives for research to quantify the potential difference in sensitivity between children and adults.
- (e) At low doses, the mode-of-action for liver tumors may be nonlinear; nonetheless, current data do not identify how far below the  $LED_{10s}$  sublinearity begins to prevail. Further research is needed to identify the key precursor events and describe their dose-response curves (see Section 4.5.2).
- (f) The mode-of-action for lung tumors is undeveloped with respect to developing dose-response curves for the key events. In addition, there is substantial parameter uncertainty in current pharmacokinetic estimates of a dose metric in the lung (see Section 4.5.3).
- (g) Similarly, there is substantial parameter uncertainty in current pharmacokinetic estimates of a dose metric in the kidney (see Section 4.5.4).
- (h) This assessment identifies several risk factors that would make a population more sensitive. Further research is needed to estimate the magnitude of the increased risk. Understanding the functional relationship between a risk factor and the associated disease is a critical research need that presently prevents estimating the differential risk faced by sensitive populations (see Sections 2.4, 2.5, 2.6, 4.5.6).
- (i) It may be important to understand the joint effect of several risk factors together. If the effects of several factors are multiplicative, the combined effect could be quite large (see Section 4.5.6).



- 1 (j) Risk assessment guidelines and methods will need to explicitly consider the effect of  
2 background exposures as risk assessments consider the cumulative effect of multiple  
3 chemicals and stressors on an exposed population. Finding a safe dose in an otherwise  
4 unexposed population does not mean that that dose is safe when background exposures  
5 are considered (see Section 1.6).  
6

### 7 **5.3. RESEARCH NEEDS FOR EXPOSURE ASSESSMENT**

- 8 (a) Limited data indicate that TCE has been detected in all of eight samples of human milk  
9 from four U.S. urban areas. Quantification of levels of TCE and its metabolites in milk,  
10 in both highly exposed and relatively unexposed populations, is a critical research need  
11 that presently prevents comparing levels in milk with levels allowed in drinking water  
12 (see Section 1.5).
- 13 (b) As TCE's metabolites have a large role in TCE-induced toxicity, there is a need to  
14 estimate cumulative exposure to these metabolites from all parent compounds, sources,  
15 and pathways (see Section 1.6).

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