930 Agency for Toxic Substances and Disease Registry toxicological profile for Arsenic

http://www.atsdr.cdc.gov/ToxProfiles/tp2.pdf

In vitro toxicology – p. 200

Dermal/inhalation carcinogenicity – p. 194-195

Cardiovascular toxicity – p. 20. 58. 59. 164-166, 274, 282

Inhalation studies – p. 211-212, 225

Reprotoxicity & development toxicity – p. 185-188

Summary of Health Effects

Arsenic is a potent toxicant that may exist in several oxidation states and in a number of inorganic and organic forms. Most cases of arsenic-induced toxicity in humans are due to exposure to inorganic arsenic, and there is an extensive database on the human health effects of the common arsenic oxides and oxyacids . Although there may be some differences in the potency of different chemical forms (e.g., arsenites tend to be somewhat more toxic than arsenates), these differences are usually minor. An exception would be arsine, which is highly toxic. However, because arsine and its methyl derivatives are gases or volatile liquids and are unlikely to be present at levels of concern at hazardous waste sites, health effect data for these compounds are not discussed in this document. Humans may be exposed to organic arseni cals (mainly methyl and phenyl derivatives of arsenic acid) that are used in agriculture and to organic arsenicals found in fish and shellfish (arsenobetaine and arsenocholine). Although the toxicity of organic arsenicals has not been as extensively invest igated as inorganic arsenicals, there are sufficient animal data to evaluate the toxicity of methyl arsenates (e.g., monomethylarsonic acid [MMA] and dimethylarsinic acid [DMA]).

It is generally accepted that the arsenic-carbon bond is quite strong and mo st mammalian species do not have the capacity to break this bond; thus, inorganic arsenic is not formed during the metabolism of organic arsenicals. In most species, including humans, ingested (or exogenous) MMA(V) and DMA(V) undergo limited metabolism, do not readily enter the cell, and are primarily excreted unchanged in

the urine. This is in contrast to inorganic arsenic, which undergoes sequential reduction and methylation reactions leading to the formation of MMA and DMA. Inorganic As(V) is readily reduced to inorganic As(III), which is taken up by the cell. Within the cell (primarily in the liver), As(III) is methylated to form MMA(V), which is reduced to MMA(III); MMA(III) subsequently undergoes oxidative methylations to form DMA(V). DMA(V) is the primary excretion product in humans. Because inorganic and organic arsenicals exhibit distinct toxicokinetic characteristics, the health effects and MRLs are considered separately.

Inorganic Arsenicals. Exposures of humans near hazardous waste sites could involve inhalation of arsenic dusts in air, ingestion of arsenic in water, food, or soil, or dermal contact with contaminated soil or water. Increased risk of lung cancer, respiratory irritation, nausea, skin effects, and neurological effects have been reported following inhalation exposure. There are only a few quantitative data on noncancer effects in humans exposed to inorganic arsenic by the inhalation route. Animal data similarly identify effects on the respiratory system as the primary noncancer effect of inhaled inorganic arsenic compounds, although only a few studies are available. Only limited data on the effects of inhaled organic arsenic compounds in humans or animals are available; these studies are generally limited to high-dose, short-term exposures, which result in frank effects.

Relatively little information is available on effects due to direct dermal contact with inorganic arsenicals, but several studies indicate that the chief effect is local irritation and dermatitis, with little risk of other adverse effects.

The database for the oral toxicity of inorganic arsenic is extensive, containing a large number of studies of orally-exposed human populations. These studies have identified effects on virtually every organ or tissue evaluated, although some end points appear to be more sensitive than others. The available data from humans identify the skin as the most sensitive noncancer target following long-term oral arsenic exposure. Typical dermal effects include hyperkeratinization of the skin (especially on the palms and soles), formation of multiple hyperkeratinized corns or warts, and hyperpigmentation of the skin with interspersed spots of hypopigmentation. Oral exposure data from studies in humans indicate that these lesions typically begin to manifest at exposure levels of about 0.002–0.02 mg As/kg/day, but one study suggests that lesions may appear at even lower levels. At

these exposure levels, peripheral vascular effects are also commonly noted, including cyanosis, gangrene, and, in Taiwa nese populations, the condition known as "Blackfoot Disease. " Other reported cardiovascular effects of oral exposure to inorganic arsenic include increased incidences of high blood pressure and circulatory problems. The use of intravenous arsenic trioxide as therapy for acute promyelocytic leukemia has raised further concerns about the cardiovascular effects of arsenic, including alterations in cardiac QT interval and the development of torsades de pointes. Decrements in lung function, assessed by spirometry, have been reported in subjects exposed to approximately 0.008 –0.04 mg As/kg/day in the drinking water who exhibited skin lesions.

In addition to dermal, cardiovascular, and respiratory effects, oral exposure to inorganic arsenic may result in effects o n other organ systems. Nausea, vomiting, and diarrhea are very common symptoms in humans following oral exposure to inorganic arsenicals, both after acute high-dose exposure and after repeated exposure to lower doses; these effects are likely due to a dire ct irritation of the gastrointestinal mucosa. Acute, high-dose exposure can lead to encephalopathy, with clinical signs such as confusion, hallucinations, impaired memory, and emotional lability, while long-term exposure to lower levels can lead to the development of peripheral neuropathy characterized by a numbness in the hands and feet that may progress to a painful "pins and needles" sensation. Recent studies also have reported neurobehavioral alterations in arsenic-exposed children.

Chronic exposure of humans to inorganic arsenic in the drinking water has been associated with excess incidence of miscarriages, stillbirths, preterm births, and infants with low birth weights. Animal data suggest that arsenic may cause changes to reproductive organs of both sexes, including decreased organ weight and increased inflammation of reproductive tissues, although these changes may be secondary effects. However, these changes do not result in a significant impact on reproductive ability. Animal studies of oral inorg anic arsenic exposure have reported developmental effects, but generally only at concentrations that also resulted in maternal toxicity.

Arsenic is a known human carcinogen by both the inhalation and oral exposure routes. By the inhalation route, the prim ary tumor types are respiratory system cancers, although a few reports have noted increased incidence of tumors at other sites, including the liver, skin, and digestive tract. In humans exposed chronically by

the oral route, skin tumors are the most common type of cancer. In addition to skin cancer, there are a number of case reports and epidemiological studies that indicate that ingestion of arsenic also increases the risk of internal tumors (mainly of bladder and lung, and to a lesser extent, liver, kidney, and prostate).

The Department of Health and Human Services (DHHS) has concluded that inorganic arsenic is known to be a human carcinogen. The International Agency for Research on Cancer (IARC) cites sufficient evidence of a relationship between exposur e to arsenic and human cancer. The IARC classification of arsenic is Group 1. The EPA has determined that inorganic arsenic is a human carcinogen by the inhalation and oral routes, and has assigned it the cancer classification, Group A. EPA has calculated an oral cancer slope factor of 1.5 (mg/kg/day) $^{-1}$ and a drinking water unit risk of 5x10 $^{-5}$ $(\mu g/L)^{-1}$ for inorganic arsenic based on human dose-response data. The inhalation unit risk for cancer is calculated to be 0.0043 ($\mu g/m^3)^{-1}$. The unit risk is the upper -bound excess lifetime cancer risk estimated to result from continuous exposure to an agent at a concentration of 1 µg/L in water or 1 $\mu g/m^3$ in air. EPA is currently revising the assessment for inorganic arsenic; a more detailed discussion of the uncertain ties associated with human cancer risk levels for arsenic is presented in Section 3.2.2.7. The following sections discuss significant effects resulting from exposure to inorganic arsenic in greater detail: dermal, cardiovascular, respiratory, gastrointestinal, neurological, and cancer. Additional information on these effects and on other effects is discussed in Section 3.2.

Dermal Effects. The most characteristic effect of long-term oral exposure to inorganic arsenic compounds is the development of skin l esions; these lesions are often used as diagnostic criteria for arsenicosis. The three lesions most often associated with chronic arsenicosis are hyperkeratinization of the skin (especially on the palms and soles), formation of multiple hyperkeratinized co rns or warts, and hyperpigmentation of the skin with interspersed spots of hypopigmentation. Numerous studies of long-term, low-level exposure to inorganic arsenic in humans have reported the presence of these lesions. In general, they begin to manifest at chronic exposure levels >0.02 mg As/kg/day. Chronic oral studies of lower exposure levels, ranging from 0.0004 to 0.01 mg As/kg/day, have generally not reported dermal effects. However, in a study with detailed exposure assessment, all confirmed cases of skin lesions ingested water containing >100 µg/L arsenic (approximately 0.0037 mg As/kg/day) and the lowest known peak arsenic concentration ingested by

a case was 0.115 µg/L (approximately 0.0043 mg As/kg/day). Another large study reported increased incid ence of skin lesions associated with estimated doses of 0.0012 mg As/kg/day (0.023 mg As/L drinking water). The mechanism(s) by which inorganic arsenic causes dermal effects is not well-understood. Elucidating the mechanism of dermal effects has been parti cularly difficult because the dermal effects common in humans have not been seen in studies in animals.

Dermal effects have also been reported following inhalation exposures to inorganic arsenic, although they are not as diagnostic as for oral exposure. S everal studies of arsenic-exposed workers have reported the development of dermatitis; exposure levels required to produce this condition are not well-established. Altered dermal pigmentation and hyperkeratosis have also been reported in studies of humans exposed to inorganic arsenic by inhalation, although exposure levels have varied considerably. Direct dermal contact with inorganic arsenicals may cause irritation and contact dermatitis. Usually, the effects are mild (erythema and swelling), but may progress to papules, vesicles, or necrotic lesions in extreme cases; these conditions tend to heal without treatment if exposure ceases.

Cardiovascular Effects. A large number of studies in humans have reported cardiovascular effects following oral exposure t o inorganic arsenic compounds. The cardiac effects of arsenic exposure are numerous, and include altered myocardial depolarization (prolonged QT interval, nonspecific ST segment changes), cardiac arrhythmias, and ischemic heart disease. These effects have been seen after acute and long-term exposure to inorganic arsenic in the environment, as well as side effects from intravenous therapy with arsenic trioxide for acute promyelocytic leukemia. Exposure levels for environmental exposures have not been well characterized, but intravenous doses for arsenic trioxide therapy are generally on the order of 0.15 mg As/kg/day.

Chronic exposure to inorganic arsenic has also been shown to lead to effects on the vascular system. The most dramatic of these effects is "Blackfoot Disease," a disease characterized by a progressive loss of circulation in the hands and feet, leading ultimately to necrosis and gangrene. Blackfoot Disease is endemic in an area of Taiwan where average drinking water levels of arsenic range from 0.17 to 0.80 ppm, corresponding to doses of about 0.014–0.065 mg As/kg/day. The results of a another study suggested that individuals with a lower capacity to methylate

inorganic arsenic to DMA have a higher risk of developing peripheral vascular disease in the Blackfoot Disease-hyperendemic area in Taiwan. Arsenic exposure in Taiwan has also been associated with an increased incidence of cerebrovascular and microvascular diseases and ischemic heart disease. While Blackfoot Disease itself has not been repor ted outside of Taiwan, other vascular effects are common in areas with high arsenic exposures, and include such severe effects as increases in the incidences of Raynaud's disease and of cyanosis of fingers and toes as well as hypertension, thickening and v ascular occlusion of blood vessels, and other unspecified cardiovascular conditions. However, while the majority of human studies have reported cardiovascular effects following exposure to inorganic arsenic, some have found no such effects.

Changes in cardiac rhythm and in some vascular end points have also been reported in animal studies of inorganic arsenicals, but generally only at higher exposure levels and not to the degree of severity seen in humans.

Respiratory Effects. While case reports and small cohort studies have routinely reported an increase in respiratory symptoms of humans exposed occupationally to inorganic arsenic, dose-response data for these symptoms are generally lacking. The only study that evaluated respiratory effects (changes in ch est x-ray or respiratory performance) and reported an exposure estimate did not report significant changes at an exposure level of 0.613 mg As/m ^{3}. Exposed workers often report irritation of the mucous membranes of the nose and throat, which may lead to lar yngitis, bronchitis, or rhinitis. Increased mortality due to respiratory disease has been reported in some cohort mortality studies of arsenic-exposed workers, but no conclusive evidence of an association of these diseases with arsenic exposure has been pr esented. It is not known whether respiratory effects following inhaled inorganic arsenic compounds are due to a direct effect of arsenic on respiratory tissues, general effects of foreign material in the lungs, or an effect of arsenic on the pulmonary vasc ulature. Similar responses, including rales, labored breathing, and respiratory hyperplasia, have been noted in animal studies of inhaled or instilled inorganic arsenic compounds.

Respiratory effects have also been reported following oral exposure of huma ns to inorganic arsenic. Acute oral exposure to ≥8 mg As/kg may result in serious respiratory effects, including respiratory distress, hemorrhagic bronchitis, and pulmonary edema; however, it is not clear whether these are primary effects or are

the result of damage to the pulmonary vascular system. In general, respiratory effects have not been widely associated with long-term oral exposure to low arsenic doses. However, some studies have reported minor respiratory symptoms, such as cough, sputum, rhinorrhea, and sore throat, in people with repeated oral exposure to 0.03–0.05 mg As/kg/day. More serious respiratory effects, such as bronchitis and sequelae (bronchiectasis, bronchopneumonia) have been observed in patients chronically exposed to arsenic and at autopsy in some chronic poisoning cases. There are few animal data reporting respiratory effects of oral exposure to inorganic arsenic, and those studies generally found effects only at very high dose levels.

Gastrointestinal Effects. Both short-term and c hronic oral exposures to inorganic arsenicals have been reported to result in irritant effects on gastrointestinal tissues. Numerous studies of acute, high-dose exposure to inorganic arsenicals have reported nausea, vomiting, diarrhea, and abdominal pain, although specific dose levels associated with the onset of these symptoms have not been identified. Chronic oral exposure to 0.01 mg As/kg/day generally results in similar reported symptoms. For both acute and chronic exposures, the gastrointestinal effect s generally diminish or resolve with cessation of exposure. Similar gastrointestinal effects have been reported after occupational exposures to inorganic arsenicals, although it is not known if these effects were due to absorption of arsenic from the respiratory tract or from mucociliary clearance resulting in eventual oral exposure.

Neurological Effects. A common effect following both oral and inhalation exposure to inorganic is the development of peripheral neuropathy. Following occupational exposure to inorganic arsenic in pesticide plants or smelters, exposed workers have shown increased incidence of neurological changes, including altered nerve conduction velocities. One study reported that these effects were seen after 28 years of exposure to 0.31 mg As/m ^{3}. In another study, signs and symptoms of sensory and motor polyneuropathy on both upper and lower extremities were reported in workers at a power station in Slovakia. The average length of exposure was 22.3 years (standard deviation [SD] ±8.4 years) and the average arsenic exposure in inhaled air ranged from 4.6 to 142.7 µg/m^3.

Following high-dose (>2 mg As/kg/day) acute oral exposures to inorganic arsenicals in humans, reported effects include headache, lethargy, mental confusion,

hallucination, se izures, and coma. Following longer-term exposure to 0.03 –0.1 mg As/kg/day, peripheral neuropathy, characterized initially by numbness of the hands and feet and a "pins and needles" sensation and progressing to muscle weakness, wrist-drop and/or ankle-drop, diminished sensitivity, and altered reflex action. Histological features of the neuropathy include a dying-back axonopathy and demyelination. Following removal from exposure, the neuropathy is only partially reversible and what recovery does occur is gene rally slow. Reports of neurological effects at lower arsenic levels (0.004 –0.006 mg As/kg/day) have been inconsistent, with some human studies reporting fatigue, headache, depression, dizziness, insomnia, nightmare, and numbness while others reported no ne urological effects. Some studies also have reported that exposure to arsenic may be associated with intellectual deficits in children. Neurological effects have also been reported in oral studies of arsenic toxicity in animals, although these were generall y performed at higher doses (0.4 –26.6 mg As/kg/day) than has been reported in exposed human populations. The mechanism(s) of arsenic-induced neurological changes has not been determined.

Cancer. There is clear evidence from studies in humans that exposure to inorganic arsenic by either the inhalation or oral routes increases the risk of cancer. Numerous studies of copper smelters or miners exposed to arsenic trioxide have reported an increased risk of lung cancer. Increased incidence of lung cancer has als o been observed at chemical plants where exposure was primarily to arsenate. Other studies suggest that residents living near smelters or arsenical chemical plants may have increased risk of lung cancer, although the reported increases are small and are no t clearly detectable in all cases. In general, studies reporting long-term exposure to 0.07 mg As/m^3 or greater have shown an increased incidence of lung cancer, while at lower exposure levels, the association has been less clear or not present. There is convincing evidence from a large number of epidemiological studies and case reports that ingestion of inorganic arsenic increases the risk of developing skin cancer. The most common tumors seen are squamous cell carcinomas, which may develop from the hyperkeratotic warts or corns commonly seen as a dermal effect of oral inorganic arsenic exposure. Early studies of populations within the United States did not suggest an increased risk of cancer from oral inorganic arsenic exposure. Later studies have found su ggestive evidence that the possibility of arsenic-induced skin cancers cannot be discounted based on an association between toenail arsenic levels and incidence of skin cancer.

There is increasing evidence that long-term exposure to arsenic can result in the development of bladder cancer, with transitional cell cancers being the most prevalent. While studies have noted statistical dose-response trends in arsenic-induced bladder cancers, reliable quantitative assessments of dose-response relationships have not been presented. Several studies have also shown that chronic oral exposure to arsenic results in the development of respiratory tumors, making lung cancer an established cause of death from exposure to arsenic in drinking water. Exposure levels in studies evaluating respiratory and bladder cancers have been comparable to those in studies evaluating skin tumors. Studies of U.S. populations have not identified an increased risk of bladder or respiratory tumors following oral exposure to inorganic arsenic.

Animal studies of both inhalation and oral exposure to inorganic arsenicals have not resulted in increased incidence of cancer formation in adult animals. However, a series of studies have shown that inorganic arsenic can induce cancer in the offspring from mice exposed to arsenic during gestation (transplacental carcinogen) and acts as a co-carcinogen with UV light and polycyclic aromatic hydrocarbons (PAHs).

Organic Arsenicals. Humans may be exposed to organic arsenicals via inhalation of dusts, ingestion of organic arsenic in water, food, soil, or dermal contact with contaminated soil, water or plants following pesticide application. There are limited data on the toxicity of organic arsenicals following inhalation exposure in humans and animals and these data do not allow for identification of critical effects. Keratosis was observed in workers exposed to 0.065 mg/m ^{3} arsanilic acid (i.e., 4-aminophenyl arsenic acid); no alterations in gastrointestinal symptoms or hematological alterations were observed. In animals, very high concentrations (>3,000 mg/m ^{3}) of DMA results in respiratory distress, diarrhea, and erythematous lesions on the feet and ears. No adverse effects were observed in rats exposed to DMA concentrations as high as 100 mg DMA/m ^{3} for 95 days. Similarly, the available dermal toxicity data do not allow for identification of critical effects. Contact dermatitis was observed in workers applying DMA (and its sodium salt) and mild dermal irritation was observed in a Draize test in rabbits (adverse effect level not reported). Intermediate duration (21 days) exposure studies in rabbits did not result in systemic toxicity or skin irritation following 5 day/week exposure to 1,000 mg/kg/day MMA or DMA. The preponderance of toxicity data for organic arsenicals involves oral exposure. Human

data are limited to three case reports of individuals intentionally ingesting pesticides containing organic arsenicals. Gastrointestinal irritat ion (vomiting, nausea, and diarrhea) were consistently reported in these cases. Animal data has primarily focused on the toxicity of MMA, DMA, and roxarsone; these data suggest that the targets of toxicity may differ between the compounds