Understanding CDC's Blood Lead Reference Value: Laboratory Best Practices & How To Interpret Results

Jennifer A. Lowry, MD, FAAP
Director, Pediatric Environmental Health Specialty Unit – Region 7 PEHSU
Director, Division of Pharmacology, Toxicology and Therapeutic Innovation, Children’s Mercy Kansas City
Professor of Pediatrics, University of Missouri-Kansas City School of Medicine
Disclaimer

This webinar was supported by the Cooperative Agreement Number, NU38OT000282, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the American Academy of Pediatrics, Centers for Disease Control and Prevention or the Department of Health and Human Services.
Objectives

1. Understand what the reference level means to the actions taken in children with elevated blood lead levels
2. Describe laboratory tests used to evaluate blood lead levels
3. Discuss limitations of various methods of blood lead testing and how it impacts decision making in pediatric practices
Reference Value
Reference Value

Source: National Health and Nutrition Examination Survey (NHANES)
CDC Reference Value: What Does it Mean??

- It is a number based on a nationally representative population of children between 1-5 years of age who had lead levels done and 97.5% of children were below that number.
- It does NOT indicate lead “poisoning” or “toxicity”. It is just a reference point based on population data.
- It is NOT indicative of what the clinical laboratory can tell you about the individual child in your practice.
Recommended Actions Taken at Reference Value

<table>
<thead>
<tr>
<th>Blood Lead Level (BLL)</th>
<th>&lt;5 μg/dL</th>
<th>5–9 μg/dL</th>
<th>10–19 μg/dL</th>
<th>20–44 μg/dL</th>
<th>45–69 μg/dL</th>
<th>≥70 μg/dL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine assessment of nutritional and developmental milestones</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hospitalize and commence chelation therapy in conjunction with consultation with a medical toxicologist or a pediatric environmental health specialty unit</td>
</tr>
<tr>
<td>Environmental assessment of detailed history and environmental investigation** including home visit to identify potential sources of lead exposure</td>
<td></td>
<td></td>
<td></td>
<td>Complete history and physical exam</td>
<td>Complete neurological exam including neuro-developmental assessment</td>
<td></td>
</tr>
<tr>
<td>Anticipatory guidance about common sources of lead exposure</td>
<td></td>
<td></td>
<td>Nutritional counseling related to calcium and iron intake; consider</td>
<td>Neurodevelopmental assessment</td>
<td>Environmental investigation of the home and lead hazard reduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Environmental investigation of the home and</td>
<td></td>
<td>Lab work:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Centers for Disease Control and Prevention (CDC); National Center for Environmental Health (NCEH)/Lead
**Recommended Actions Taken at Reference Value**

**Recommendations on Medical Management of Childhood Lead Exposure and Poisoning**

No level of lead in the blood is safe. In 2012, the CDC established a new “reference value” for blood lead levels (5 mcg/dL), thereby lowering the level at which evaluation and intervention are recommended (CDC).

<table>
<thead>
<tr>
<th>Lead level</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| < 5 mcg/dL | 1. Review lab results with family. For reference, the geometric mean blood lead level for children 1-5 years old is less than 2 mcg/dL.  
2. Repeat the blood lead level in 6-12 months if the child is at high risk or risk changes during the timeframe. Ensure levels are done at 1 and 2 years of age.  
3. For children screened at age < 12 months, consider retesting in 3-6 months as lead exposure may increase as mobility increases.  
4. Perform routine health maintenance including assessment of nutrition, physical and mental development, as well as iron deficiency risk factors.  
5. Provide anticipatory guidance on common sources of environmental lead exposure: paint in homes built prior to 1978, soil near roadways or other sources of lead, take-home exposures related to adult occupations, imported spices, cosmetics, folk remedies, and cookware. |
| 5-14 mcg/dL | 1. Perform steps as described above for levels < 5 mcg/dL.  
2. Re-test venous blood lead level within 1-3 months to ensure the lead level is not rising. If it is stable or decreasing, retest the blood lead level in 3 months. Refer patient to local health authorities if such resources are available. Most states require elevated blood lead levels be reported to the state health department. Contact the CDC at 800-CDC-INFO (800-232-4636) or the National Lead Information Center at 800-424-LEAD (5323) for resources regarding lead poisoning prevention and local childhood lead poisoning prevention programs.  
3. Take a careful environmental history to identify potential sources of exposures (see #5 above) and provide preliminary advice about reducing/eliminating exposures. Take care to consider other children who may be exposed. |
Recommended Actions Taken at Reference Value

- Environmental investigations at BLLs 5 – 19 μg/dL vary according to local conditions based on jurisdictional requirements and available resources.
- Providers must know available resources and how to respond to lead level results.
Laboratory Test Available to Evaluate Blood Lead Levels
Commonly Used Available Methods

- **Anodic Stripping Voltammetry (ASV)**
  - Disposable screen printed electrode technologies
  - *(LeadCare® II)*

- **Graphite furnace atomic absorption spectrometry (GFAAS)**
  - Reference method

- **Inductively coupled plasma mass spectrometry (ICP-MS)**
  - Reference method
LeadCare® II

- **Point of Care testing**
  - Physician’s offices
  - Local health departments
  - Hospitals
- **CLIA waived**
- **Capillary blood samples only**
  - Confirmation testing should be venous blood by a different method
- **Reportable range is 3.3 – 65 µg/dL**
- **State health department reporting is the same as for lab-based tests**
Simulation of sequential blood lead level measurements for person with constant, true blood lead of 5.0 µg/dL

Source: National Center for Environmental Health (NCEH)/ATSDR Board of Scientific Counselors, Semi-Annual Meeting, January 2017
Graphite Furnace Atomic Absorption Spectrometry

- Hospital or reference lab settings
- CLIA: High complexity
- Capillary or venous samples
  - Can be used for venous confirmation on different blood sample
- Reportable range: capable of accurately measuring to 1 µg/dL
Inductively Coupled Plasma – Mass Spectrometry

- Hospital or reference lab settings
- CLIA: High complexity
- Capillary or venous samples
  - Can be used for venous confirmation on different blood sample
- Reportable range: capable of accurately measuring below 1 µg/dL with better precision compared to GFAAS
# Best Estimates of Precision of Blood Lead Measurements at 5 µg/dL

<table>
<thead>
<tr>
<th>Method</th>
<th>95% confidence interval (µg/dL)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>LeadCare II</td>
<td>± 1.8</td>
<td>1469</td>
</tr>
<tr>
<td>GFAAS</td>
<td>± 1.5</td>
<td>908</td>
</tr>
<tr>
<td>ICP-MS</td>
<td>± 0.97</td>
<td>769</td>
</tr>
</tbody>
</table>
Limitations of Laboratory Instruments in Blood Lead Results Based on Reference Value
Procedures for Collecting Samples for Lead Determination

- Capillary blood samples
  - Acceptable only for screening purposes
  - False positives can be frequent but inform the provider on environment
Procedures for Collecting Samples for Lead Determination

- Filter paper collection
  - Varied opinions on reliability and technique
  - Potential for contamination and variable volume
  - Guidelines for methods of measuring lead from filter paper
Procedures for Collecting Samples for Lead Determination

- **Instrument precision**
  - ICP-MS and GFAAS can be reproducible to ± 0.2 µg/dL at low levels
  - Reporting at low levels as clinical value is open to interpretation
  - Quantitation limits
  - Current CLIA regulations within the United States require that the acceptability limits be no larger than ± 4 µg/dL (0.19 µmol/L) below 40 µg/dL (1.93 µmol/L), or ± 10% of the target value above that concentration
  - Repeat testing
Laboratory Reporting

- Prior to reporting patient test results, the laboratory must provide performance specifications
  - Accuracy
  - Precision
  - Reportable Range
  - Reference Intervals
Laboratory Reporting

- **Limit of Detection**
  - Lowest concentration of analyte that the test can detect or distinguish from a blank

- **Limit of Quantification**
  - Lowest quantity that can be accurately measured
Imprecision Increases Non-Linearly Near the Limit of Detection

Adapted from JK Taylor, Quality Assurance of Chemical Measurements, 1987.
Laboratory Reference Interval for Lead

- Different than CDC Reference Value (different meaning)
- Based on LOD and LOQ of instrumentation and what can most accurately be reported
- Current agreement is that precision for measurements made at 3.5 µg/dL will not be better than the current estimates at 5 µg/dL
- CDC changes in reference value will not change laboratory reference levels until better precision can be made
Impact on Patient Care
Interpretation of Results

- There is no known safe level of blood lead for children
- Depending on method used, the actual result should be within ±2 SD knowing the precision is poorer at lower concentrations.
  - For example, a blood lead level of 4.9 µg/dL from LeadCare II could be in a range of 2.9 – 6.9 µg/dL (roughly)
Recommendations for “Action”

- There is no known safe blood lead level
- Local and state regulations guide involvement of health department for case management and home assessments (e.g., blood lead level of 4.9 µg/dL)
- Health care providers must supply education and be involved when the health departments cannot (e.g., blood lead level of 4.9 µg/dL)
  - CDC and Pediatric Environmental Health Specialty Unit (PEHSU) guidance
  - Virtual home assessments
  - Lead questionnaire to help determine source
Additional Testing

- **Confirmatory testing**
  - Capillary “screening” would be considered the first test to determine if the child has an elevated blood lead level.
  - If above 5 µg/dL, this should be repeated with a venous sample by a different method.
  - If venous is below LOR, consider lead may still be in environment and education on sources is still needed for primary prevention.

- **Repeat testing**
  - If child has had EBLL confirmed by venous testing, all further testing should be by venous sampling.

- **Follow testing schedule recommended by CDC and/or PEHSU**
Summary

- **CDC Lead Reference Value (5 µg/dL)**
  - Based on data obtained from a representative population of children in the U.S.
  - This number will change based on the work we do to prevent lead poisoning

- **Laboratory Lead Reference Value (5 µg/dL)**
  - Based on precision testing of methods by laboratories to determine accurate results from LOD and LOQ
  - This number may change as precision in methods improves
Summary

- CDC and Laboratory Reference Values may not always be the same.
- Public health management is based on local and state jurisdictions and availability of resources. They may not be able to provide services at CDC Reference Value.
- Health care providers should understand limitations of methods for lead quantitation and provide appropriate education to families.