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# **Water Fluoridation and Environmental Justice**

**a report submitted to the**

**Environmental Justice Interagency Working Group**

**from**

**The Fluoride Action Network**

<http://fluoridealert.org/>

**September 25, 2015**

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Do you want them  
drinking a  
neurotoxic chemical ?



**STOP**  
ARTIFICIAL WATER  
FLUORIDATION

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## Water Fluoridation and Environmental Justice

This report was prepared by Neil Carmen, Ellen Connett and Paul Connett, with contributions from other members of the Fluoride Action Network, including David Kennedy, Chris Neurath, John Graham, Tara Blank, and Dan Stockin.

The following individuals and organizations support the sentiments and arguments presented in the Executive Summary and the supporting document:

Audrey **Adams**, Board member, Washington Action for Safe Water, President, King County Citizens Against Fluoridation, Washington  
 Kenji **Akiniwa**, General Secretary, The Japanese Society for Fluoride Research, Japan  
 Phillip **Alexander**, Fluoride Free Charlotte, North Carolina  
**American Environmental Health Science Project, Inc.** (AEHSP), Essex Junction, Vermont  
 James S. **Beck**, MD, PhD, Professor Emeritus of Medical Biophysics, University of Calgary, Canada  
[Jane Beck](#), BSc MBBS, [Thames, NZ](#)  
 Ruth **Bednar** RHN, RNCP, Muskoka Citizens Opposing Fluoridation, Gravenhurst, Ont., Canada  
 Tara **Blank**, PhD, Ridgefield, Washington  
 Jane **Bremmer**, Chair, Alliance for a Clean Environment, Western Australia  
 Mr. Pat **Buckley**, Fluoride Free Wellington, New Zealand  
 Anna Maria **Caldara**, author and activist, Bangor, Pennsylvania  
 Cara L. **Campbell**, Chair, Ecology Party of Florida  
 Suzie **Canales**, Citizens For Environmental Justice, Corpus Christi, Texas  
 Neil **Carman**, PhD, Sierra Club Lone Star Chapter (for I.D. purposes only), Austin, Texas  
 Paul **Carr**, Chairman, Fluoride Free Cumbria, England  
 Liesa **Cianchino**, Concerned Residents of Peel to End Fluoridation, Peel, Ontario, Canada  
**Clean Water California**  
 Stuart **Cooper**, Fluoride Free New Hampshire  
 Ronnie **Cummins**, Organic Consumers Association  
 Todd M. **Davison**, Fluoride Free Nebraska  
 Michael F. **Dolan**, PhD, Public Notice on Water Fluoridation, Amherst, Massachusetts  
 Rev. Dr. Gerald L. **Durley**, Pastor Emeritus, Providence Missionary Baptist Church, Atlanta GA  
 Michael **Finley**, Fluoride Free Illinois  
 Barbara Loe **Fisher**, Co-founder & President, National Vaccine Information Center  
**Fluoride Free Thames**, Thames, NZ  
 Clint **Griess**, Safe Water San Francisco and International Fluoride Free Teleconference  
 Crystal **Harvey**, Arkansas  
 Emeritus Professor C. V. **Howard**, MB. ChB. PhD. FRCPATH., Nano Systems Biology  
 Centre for Molecular Bioscience, University of Ulster, Coleraine, UK  
 Regina **Imburgia**, Fluoride Action North Texas, Dallas, Texas  
 Lynn **Jordan**, New Zealand Health Professionals Opposing Fluoridation  
 Charles **Keil**, PhD, activist, author and music maker, Lakeville, Connecticut  
 Hilton **Kelley**, Executive Director, CIDA Inc., 2011 Goldman Prize winner, Port Arthur, Texas  
 Barry S. **Kendler**, PhD, FACN, CNS.  
 David **Kennedy**, DDS, Fluoride Information Officer for the International Academy of Oral Medicine and Toxicology  
**King County Citizens Against Fluoridation**, Washington

Carol **Kopf**, MS, New York State Coalition Opposed to Fluoridation

Dan **Knapp**, PhD, sociologist and CEO, Urban Ore, Inc., Berkeley, California

Hardy **Limeback**, PhD, DDS, Professor Emeritus, Faculty of Dentistry, University of Toronto

John **Lusk**, MSc., PhD, President, Citizens Against Fluoridation Inc., Port Macquarie, NSW, Australia

Chuck **Matzker**, Fluoride Free Framingham, Framingham, Massachusetts

Donna **Mayne**, Fluoride Free Windsor, Ontario

Howard W. **Mielke**, PhD, Department of Pharmacology, Tulane University, New Orleans, Louisiana

#### **Moms Against Fluoridation**

Peter **Montague**, PhD

Jeffrey **Morris**, PhD, Environmental Economist, Sound Resource Management, Olympia, Washington

Rick **North**, Clean Water Oregon

Rae Nadler **Olenick**, Fluoride Free Austin, Austin, Texas

#### **Organic Consumers Association**

Bill **Osmunson** DDS, MPH

Laura **Pressley**, PhD, Austin, Texas

Jay **Sanders**, Clean Water California, San Francisco, California

Nestor B **Shapka**, BSc, DDS, President of the Canadian Council of Oral Medicine and Toxicology, Joan **Seeman**, Denver, Colorado

Diane **Sprules**, BSc, MSc., Halton Hills, Ontario, Canada

Daniel **Stockin**, MPH, The Lillie Center for Energy and Health Studies, Ellijay, Georgia

**Unifor Durham Regional Environment Council**, Oshawa, Ontario, Canada

Bridget Eileen **Walsh**, Denver, Colorado

Joy **Warren**, BSc. (Hons) Environmental Science, Coordinator of West Midlands Against Fluoridation, UK

**Washington Action for Safe Water**, Washington

**Worldwide Alliance to End Water Fluoridation**

**Fluoride Action Network**

<http://fluoridealert.org/>

September 25, 2015

To the Environmental Justice Interagency Working Group

**Re: Water Fluoridation and Environmental Justice**

We are submitting these comments to the EJ Interagency Working Group in support of the formation and agenda goals of this group. We believe that the attached report (Water Fluoridation and Environmental Justice) gives a clear example of how such an interagency group working cooperatively together can right a bad policy for poor families and communities of color.

Hitherto, water fluoridation has fallen through the cracks as far as regulation by federal agencies has been concerned. The Food and Drug Administration has never regulated fluoridation nor have they ever tested the safety of fluoride. Their position is that fluoride is an “unapproved drug.” The Environmental Protection Agency’s Office of Water, since 1985, has had no jurisdiction over any chemical ADDED to water, only contaminants. The Department of Health and Human Services promotes fluoridation through the Division of Oral Health at the Centers for Disease Control and Prevention.

Here is the nub of the problem that needs correcting by interagency action. The CDC’s Oral Health Division has become a “rogue elephant” as far as this practice is concerned. Their mission is to promote fluoridation – and they do so effectively and aggressively – but the problem is that they have a conflict of interest when it comes to monitoring or even questioning the safety of this practice. That has led them into performing with gross negligence in regards to the adverse effects of fluoridation on the poor and communities of color for several decades. Moreover, the expertise in this department is largely dental. Few if any of their personnel have training in other areas of medicine, toxicology or health risk assessment.

Since 1950, when fluoridation was approved, the role of federal agencies has been only to support the policy and in so doing they have had to dismiss and discredit anyone or any of the thousands of studies that reveal the inherent risks in this anti-science experiment. For over 60 years-American citizens have been treated to Public Relations and propaganda rather than a dispassionate and objective analysis of either the effectiveness or safety of this practice.

Now that serious health effects have been documented – particularly fluoride’s neurotoxic effects - it is time to end this practice. Very seldom can the simple turning off a tap (i.e. the spigot at the public water works) do so much good for so many.

We urge you to continue on the trajectory you have started. Working together you may be able to right many wrongs and in so doing regain the respect and trust of the American people.

Neil Carman, Ellen and Paul Connett  
and other members of the Fluoride Action Network

*“Federal agencies must identify and address, as appropriate, disproportionately high and adverse human health or environmental effects of their programs, policies, and activities on minority populations and low-income populations.”*

(Presidential Executive Order 12898  
of February 11, 1994)

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## WATER FLUORIDATION and ENVIRONMENTAL JUSTICE

### Executive Summary

**Evidence is presented that artificial water fluoridation as promoted by federal agencies has been ineffective in fighting tooth decay and in addition causes “disproportionately high and adverse human health...effects...on minority populations and low-income populations,” in violation of Presidential Executive Order 12898 of February 11, 1994. This problem has been seriously compounded by the failure of these same agencies to warn communities of color of their special vulnerabilities to fluoride exposure in general and the water fluoridation program in particular. The agencies' actions are fueling calls by civil rights and environmental leaders for investigative hearings by Congress.**

**The way the EPA Office of Water is approaching its requirement to establish a safe level of fluoride in drinking water is not scientifically defensible, is politically compromised and makes absolutely no attempt to address numerous environmental justice issues that arise from water fluoridation.**

**There are more positive, effective, and comprehensive ways of fighting tooth decay, which also prevent disproportionate harm to poor families and communities of color and do not violate their civil rights.**

Those who promote fluoridation correctly claim that most of tooth decay is concentrated in low-income families and those from communities of color. That is why it is tragic that 80% of dentists in the U.S. refuse to treat children on Medicaid. The poor need special and focused attention. Putting a toxic substance into everyone's drinking water is a very poor substitute. Water fluoridation has not evened-up the playing field as evidenced by the numerous reports of the dental crises being reported among low-income and communities of color in large U.S. cities that have been fluoridated for over 20 years. Far from helping low-income families and communities of color fluoridation causes them disproportionate harm.

Officials in the US Public Health Service knew as early as 1962 that African-Americans had a higher prevalence of dental fluorosis than whites. Dental researchers have continued to report this over many decades. In 2005 the CDC reported that both Blacks and Hispanic children had higher rates of dental fluorosis particularly in its most disfiguring categories (moderate and severe). However, in all this time neither the CDC nor any other federal agency that promotes water fluoridation has sought to warn communities of color of their particular vulnerability with respect to this permanent visually objectionable injury from systemic exposure to fluoride. Nor have they indicated what this means: their children have been over-exposed to fluoride before their permanent teeth have erupted and this over-exposure might indicate they have been damaged in other ways. This failure to warn communities of color of this problem is a clear example of environmental *injustice*.

When the US Public Health Service endorsed fluoridation in 1950 (before any trial had been completed or any meaningful health study had been published) it quickly fossilized into a policy that was considered beyond debate. Although the FDA has never *approved* any fluoride containing substance intended to be ingested for the purpose of reducing tooth decay it has *rejected* fluoride-containing vitamins stating that, “there is no substantial evidence of drug



effectiveness as prescribed, recommended, or suggested in its labeling.” Drug therapy 1975.

Water fluoridation has never been subjected to an individual-based random control trial (RCT) for either effectiveness or safety. Very few basic health studies have been conducted in fluoridated countries and only in recent years have some of the studies of serious toxic and health effects of fluoride (e.g. lowered IQ) been published, and mainly in non-fluoridated countries.

Fluoride is not an essential nutrient. There is no need to swallow it: fluoride’s beneficial action can be achieved with direct application of fluoridated toothpaste onto the tooth surface. Tooth decay in children from low-income families is not caused by too little fluoride but poor nutrition, including far too much sugar.

The EJ issue goes beyond just dental fluorosis and the failure of the government agencies to warn communities of color about their vulnerability. Fluoridation penalizes families of low-income in the following ways.

- 1) They cannot afford to avoid fluoridated water if they want to do so because both removal equipment and bottled water (for drinking and cooking) is very expensive.
- 2) They cannot afford the expensive treatments to conceal the effects of dental fluorosis (a discoloration and mottling of the enamel).
- 3) Dental fluorosis rates are higher in fluoridated communities especially in Black and Hispanic populations than White.
- 4) Fluoride’s toxicity is made worse by poor nutrition.
- 5) Lactose intolerance is more frequent among Blacks and other ethnic groups than white, and less consumption of dairy products means lower exposure to calcium, which helps to protect against absorption of fluoride from the gut.
- 6) Low-income families from communities of color are less likely to breast-feed their children. Low fluoride ready-to-feed formula is more expensive as is distilled water therefore when baby formula is made up with fluoridated water, the baby gets over 100 times more fluoride than a breast-fed child.
- 7) Fluoride has been associated with lowered IQ in children in 45 studies (as of Sept 2015).
- 8) Children living in the inner cities are more likely to be exposed to lead from flaking old paint, air pollution, etc. leading to cognitive damage. Exposure to fluoride adds to this toxic burden. Research from the University of North Carolina demonstrated that the chemicals used in fluoridation increase the leaching of lead from brass plumbing fixtures into drinking water.
- 9) Communities of color have a greater incidence of kidney disease. Because poor kidney function makes it more difficult for the body to get rid of fluoride kidney patients must avoid as much exposure to fluoride as possible.
- 10) Communities of color have a greater incidence of diabetes, which can lead to increased consumption of water, which in turns leads to a greater consumption of fluoride.

Two strategic goals in the Interagency Working Group on environmental justice (EJ IWG) action agenda for fiscal years 2016- 2018, create a very positive framework within which we can move forward on this issue. These strategic goals are:

- I. Enhance communication and coordination to improve the health, quality-of-life, and economic opportunities in overburdened communities;
- II. Enhance multi-agency support of holistic community-based solutions to solve environmental justice issues;

These goals challenge us to find a plan not just to fight tooth decay in children but also to improve their “health, quality of life and economic opportunities” and to do so with “community-based solutions,” which will involve “multi-agency support.”

We have taken up this challenge in our 5-step alternative plan to water fluoridation.

Our positive, creative and holistic plan aims to fight tooth decay in low-income children but also find ways to improve their health, their fitness, their quality of life, their intellectual development and possibly even their employment within the community. We would like to go further. Our plan also works on other aspects of community development, including its food supply, its discarded resources, its local employment and business opportunities and the need to lower its carbon footprint.

In our 5-step program we are proposing that we start with ending water fluoridation in step 1 and then use the money saved on chemicals, equipment and promotion to finance step 2. This second step involves an educational program for young children modeled after programs in Scotland and Denmark. One aim of this is to reduce sugar consumption. If that is done well it will also help to fight obesity and that over the long-term will produce huge savings in health costs. This should encourage the HHS to provide additional funding needed for step 2 and some of the funding for steps 3 and 4. Here is a summary of the 5 steps:

- 1) **End water fluoridation.** The EPA’s Office of Water could do this swiftly if they were instructed to determine a safe level of fluoride to protect all children from lowered IQ. This would not only remove a threat to children’s intellectual development and future economic potential, but it would also end a number of extra and unnecessary health threats for communities of color, especially for people with poor kidney function; borderline iodine deficiency and diabetes. Never has turning off a tap promised so much.
- 2) **Establish the equivalent of both Scotland’s very successful Childsmile program and the Danish program for pre-schoolers,** in all pre-school programs, kindergarten and primary schools (and possibly churches) and WIC programs in low-income areas.
- 3) **Set up dental clinics either in schools or stand-alone facilities** in the inner city and other low-income areas. In these we should use trained dental nurses to restore decay-damaged teeth and to remove infected ones.
- 4) **Expand these dental clinics into community centers** aimed at improving the child’s overall health. They could support better nutrition, physical fitness and cultural activities. Ideally these community centers would be linked to local community gardens and farms close to the city.

- 5) **Further expand these community centers** into job-creating operations and a foundation for local business opportunities. One concrete way of doing this is to integrate a "reuse and repair" operation into the Zero Waste approach for handling discarded materials.

More than anything else a scientifically balanced approach allows the transition from the politics of "no" to the politics of "yes." Once we get off the shortsighted notion that we can battle tooth decay by putting a neurotoxic chemical into the public drinking water, we can unleash not only the full potential of the children from low-income communities, but also of the communities themselves. The three key words are education, nutrition and justice. We need education (not fluoridation) to fight tooth decay and obesity. We need better nutrition to keep our children and ourselves as healthy as possible and we need Environmental Justice for all.

## 1. Abstract

Evidence is presented that artificial water fluoridation as promoted by federal agencies has been ineffective at helping fight tooth decay in the inner cities and in addition causes *“disproportionately high and adverse human health...effects...on minority populations and low-income populations,”* in violation of Presidential Executive Order 12898 of February 11, 1994. This problem has been seriously compounded by the failure of these same agencies to warn minority populations of their special vulnerabilities to fluoride exposure in general and the water fluoridation program in particular. The current *ongoing* determination by the Environmental Protection Agency’s (EPA) Office of Water of a new Maximum Contaminant Level Goal (MCLG) and the Maximum Contaminant Level (MCL) for fluoride as reported in 2011 is scientifically flawed and betrays an insensitivity to Environmental Justice issues. There are more positive and creative ways of fighting tooth decay in the inner city, which also address other EJ issues in a holistic fashion.

## 2. Introduction

Water fluoridation is the deliberate addition of a fluoride-containing compound to the water supply to produce a concentration of free fluoride ions at about 1 ppm (i.e. 1.0 milligram of fluoride per liter). As of April, 2015 the new recommended level by the U.S. Department of Health and Human Services (HHS) is 0.7 ppm. The stated purpose of this practice is to help fight tooth decay.

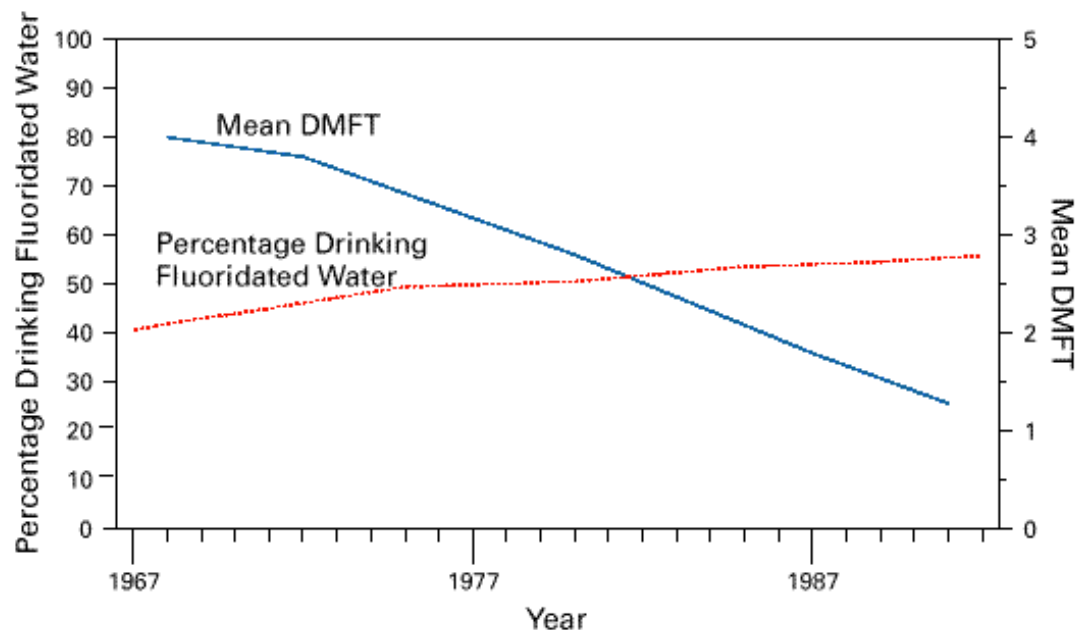
Fluoridation began in the U.S. and Canada in 1945 (see timeline below). This is a very unusual practice as it is the only time that the public water supply has been used as a vehicle to deliver medical or human treatment. All the other chemicals added to water are added to make the water safe or palatable to drink.

While fluoridation is widely practiced in the USA **most countries do not fluoridate their water.** 97% of the European population does not drink fluoridated water (a few countries fluoridate their salt, which allows the consumer the choice of whether to buy it or not). Yet according to World Health Organization (WHO) data (available online) there is little difference in tooth decay in 12-year-olds between fluoridated and non-fluoridated countries today.

In 1999 the CDC published a figure (see Figure 1) that suggests that dental caries was being reduced in 12-year-olds from the 1960’s to the 1990’s as the percentage of the US population drinking fluoridated water had increased.

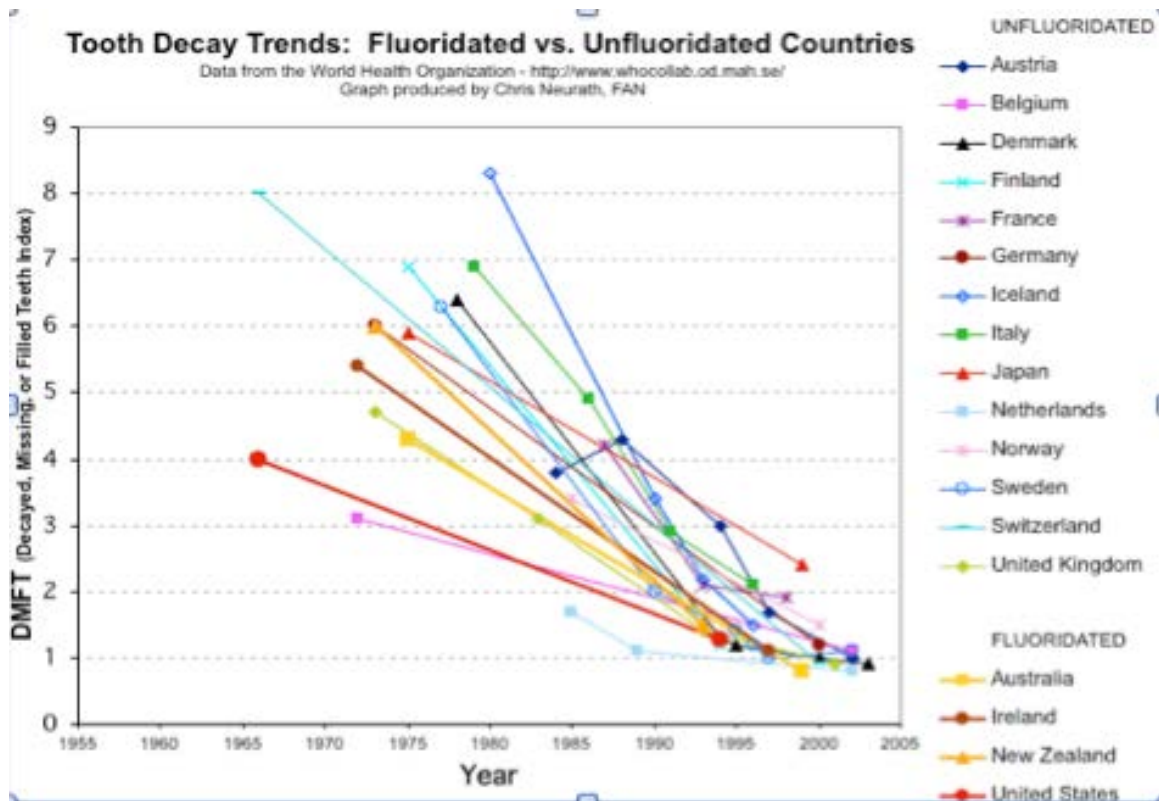
**Figure 1**

**FIGURE 1. Percentage of population residing in areas with fluoridated community water systems and mean number of decayed, missing (because of caries), or filled permanent teeth (DMFT) among children aged 12 years — United States, 1967–1992**



**Figure 1: A copy of Figure 1 in the CDC review, TITLE CDC (1999).**

However, in Figure 2, World Health Organization (WHO) data is plotted for tooth decay in 12-year-olds for both fluoridated and non-fluoridated countries, and it can be seen that the decay rates have been coming down as fast, if not faster, in the non-fluoridated countries as the fluoridated countries. It is surprising therefore the CDC should conclude that the declines in the US have been caused by fluoridation.



**Figure 2: WHO data on tooth decay in 12-year-olds for 18 countries, 4 Fluoridated, 13 non-fluoridated and 1 (UK) partially fluoridated, plotted from the 1960s to 2000's (Graph by Chris Neurath; see FAN, 2012a).**

We would do well to study the ways that European countries have achieved reduction of tooth decay in low-income families without forcing their citizens to swallow fluoride. Of particular interest are the Childsmile program in Scotland and the Nexø Program in Denmark.

### 3. Why are some people opposed to the practice of Water fluoridation?

The arguments given by many citizens and scientists opposed to fluoridation include the following.

- 1) Once added to the water there is no way that the dose each individual receives can be controlled.
- 2) Nor can we control who receives the treatment – it goes to everyone regardless of age, health or nutritional status.
- 3) It violates the individual's right to informed consent to human treatment.
- 4) It is difficult and expensive to avoid, as cheap filters don't remove the fluoride. This makes this doubly unethical for low-income families who don't want this treatment.
- 5) No doctors are overseeing the treatment or monitoring side-effects.
- 6) The Food and Drug Administration (FDA) has never regulated fluoride for ingestion. According to the FDA fluoride is an "unapproved drug".

- 7) Incredibly, after 70 years there has not been one single individually-based randomized control trial (RCT) to demonstrate safety or effectiveness
- 8) Fluoride is not an essential nutrient. No one has ever shown that if an animal is starved of fluoride in its diet that it develops a disease. An individual can have perfectly good teeth without fluoride. Tooth decay is not caused by too little fluoride but by poor dental hygiene and a poor diet, including too much sugar.
- 9) There is not one biological process in the body that needs fluoride to function properly but many that are harmed by it. Fluoride inhibits enzymes and interferes with G-proteins, which carry important messages across cell membranes. See Barbier et al. (2010) for a review of the biochemical mechanisms of fluoride's toxic action.
- 10) Nature in her wisdom has kept fluoride away from the baby. The level in mothers' milk is very low (0.004 ppm, NRC, 2006; 0.004 to 0.008, Sener, 2007) Thus the breast-fed baby is protected from fluoride, but that protection is removed by water fluoridation. A bottle-fed baby where the formula is made up with fluoridated tap water (at the new recommended guideline of 0.7 ppm fluoride) gets over 100 times more fluoride than a breast-fed baby.
- 11) Even promoters of fluoridation now admit the predominant mechanism of fluoride's beneficial action on the teeth is *topical* not *systemic* (CDC, 1999). In other words one does not need to swallow this toxic substance to get the purported benefit. Brushing the teeth with fluoridated toothpaste is a more rational delivery system, which minimizes exposure to other tissues and does not force it on people who don't want it.
- 12) Fluoridation promoters have wildly exaggerated the benefits of swallowing fluoride. A recent Cochrane review (the gold standard for evidence-based medicine) concluded that the scientific studies that have purported to demonstrate effectiveness have been of a very poor quality (Iheozor-Ejiofor et al., 2015) .
- 13) Fluoridation poses many health risks.
- 14) Of particular concern is the large number of animal and human studies that indicate that fluoride is neurotoxic (i.e. it can enter and interfere with brain chemistry) including 45 (out of 51) studies that have associated fairly modest exposure to fluoride and lowered IQ in children.
- 15) The last children in the USA that need their IQ lowered are children from low-income families, who are precisely those who have been targeted by those promoting this practice.
- 16) There are many other health concerns. These include lowered thyroid function (Peckham et al., 2015); accumulation in the human pineal gland (Luke 1997, 2001); ADHD (Malin and Till, 2015); accumulation in the bone (arthritis, NRC, 2006, increased hip fractures in the elderly, Li et al, 2001) and an increased risk of osteosarcoma in young boys when exposed in their 6<sup>th</sup> -8<sup>th</sup> years (Bassin et al, 2006).
- 17) U.S. children are being hugely over-exposed to fluoride from all sources as evidenced by the prevalence of dental fluorosis, which now impacts 41% of 12-15 year olds (Beltrán-Aguilar et al., 2010). The rates are higher for Black and Hispanics (Beltrán-Aguilar et al., 2005).
- 18) Now that it has become clear that low-income and minority communities are more

vulnerable to dental fluorosis and probably fluoride's other toxic effects fluoridation has become a major Environmental Justice issue and needs to be re-assessed from that perspective.

#### 4. Fluoridation and Environmental Justice.

Those who promote fluoridation often do so based upon equity considerations. They correctly claim that most of tooth decay is concentrated in low-income families and especially in communities of color. In the United States, according to Kaste et al. (1996), 25 percent of children and adolescents experience 80 percent of all dental decay occurring in permanent teeth. However, the evidence suggests that promoters were being overly optimistic when they thought that forcing everyone to swallow fluoride would even-up the playing field when it comes to these dental inequalities.

As we explain below fluoridation far from helping low-income families is actually hurting them. In fact fluoridation is a rather graphic example of environmental *injustice*.

Fluoridation penalizes families of low-income, especially communities of color in the following ways.

- 1) Low-income families cannot afford to avoid fluoridated water if they want to do so because both removal equipment and bottled water (for drinking and cooking) is very expensive.
- 2) Low-income families cannot afford the expensive treatments to conceal the damage that fluoride can cause to the enamel (dental fluorosis).
- 3) Dental fluorosis rates are higher in Black and Hispanic communities than White communities especially in the more severe forms that require treatment (Beltrán-Aguilar et al., 2005).
- 4) Fluoride is more toxic when exposure is accompanied by poor nutrition. Poor nutrition is more likely to occur in low-income families than those with higher incomes. This is what was said about this issue in a 1952 article that appeared in the Journal of the American Dental Association:

“The data from this and other investigations suggest that malnourished infants and children, especially if deficient in calcium intake, may suffer from the effects of water containing fluorine while healthy children would remain unaffected...Thus low levels of fluoride ingestion which are generally considered to be safe for the general population may not be safe for malnourished infants and children. Therefore, the nutritional status must be carefully assessed and guarded in areas with endemic fluorosis. Nutritional studies should be included in any comprehensive program of fluoridation of water with special attention to chronically ailing infants and children.” (Massler & Schour 1952).

- 5) Lactose intolerance is more frequent among Blacks and other ethnic groups than white, and less consumption of dairy products typically means lower exposure to calcium. Calcium in the diet helps to a certain extent to protect against absorption of fluoride from the gut.



- 6) Minority families are less likely to breast-feed their children. When baby formula is made up with fluoridated water it leads to over 100 times more exposure to fluoride than breast-feeding.
- 7) Fluoride is neurotoxic and in 45 studies it has been associated with lowered IQ in children. The last children that need their IQ lowered are children from low-income families.
- 8) Low-income and minority groups living in the inner city are likely to have a greater exposure to lead. Fluoride appears to enhance the toxicity of lead. Lead increases the risk of dental fluorosis. Both lead and fluoride are neurotoxic.
- 9) Children from low-income families are more likely to get mercury amalgam fillings than families with higher income. Mercury is neurotoxic. The combined impact of mercury and fluoride on a child's mental development may be greater than either acting alone.
- 10) Minority communities have a greater incidence of kidney disease. Poor kidney function increases fluoride's uptake into the bone, which is likely to increase the rates of arthritis and hip fractures (over a lifetime).
- 11) Minority communities have a greater incidence of diabetes, some forms of which lead to an increased consumption of water, which in turns leads to a greater consumption of fluoride.

Many of these issues are discussed in more detail and documented in the text below.

## **5. The history of the water fluoridation program with a special emphasis on dental fluorosis and environmental justice issues**

### **A timeline from the early 1900's to 2015**

**In the early 1900's** a handful of dentists, particularly Frederick McKay (1916, 1928) and G.V. Black & McKay (1916) were interested in what was causing a condition (which was prominent in both Texas and Colorado), which led to discoloration and marking of the teeth. The condition was called "dental mottling." McKay described dental mottling as "the most poorly constructed enamel of which there is any record in the history of dentistry."

#### **1925**

Norman Ainsworth in a study of 4000 children in Essex County in England reported a lowered prevalence of dental caries in Maldon and Heybridge, which were areas endemic for "dental mottling" (now known as areas with high natural levels of fluoride in the water) – (see Mullen, 2005).

#### **1928**

Frederick McKay (1928) noted that while the discoloration and marking of the teeth in cases of "dental mottling" looked very bad it did not appear to increase the child's susceptibility to tooth

decay, in fact there appeared to be less tooth decay among children with dental mottling than those without.

### 1931

In 1931 three separate research teams (Smith et al., 1931; Churchill et al, 1931 and Vehu, 1931) identified the cause of this condition as fluoride in the drinking water and the name was changed to “dental fluorosis,” which literally means “poisoning of the teeth by fluoride.” It was quickly recognized that dental fluorosis was a “systemic” not a “topical” effect. It can only be contracted *before* the permanent teeth have erupted. It is occasionally seen in the primary teeth (Warren et al., 1999) but it is most frequently observed in the secondary teeth.

### 1930 and 40’s

Under the leadership of H. Trendley Dean the US Public Health Service (PHS) studied the occurrence of this condition throughout the USA. In addition to this mapping exercise Dean subsequently published his famous classification of the different levels of severity of this condition: very mild, mild, moderate and severe. According to Dean et al. (1934, 1935):

**Very mild** ranged from white patches on the cusp of the teeth to up to 25% of the enamel impacted.

**Mild** impacted between 25 and 50% of the enamel.

**Moderate** impacted 100% of the enamel.

**Severe** impacted 100% of enamel with pitting and chipping.

Pictures illustrating these four levels of dental fluorosis are given in Figure 3



“Very Mild”



“Mild”



“Moderate”



“Severe”

Figure 3. Pictures of the four levels of dental fluorosis. (Photographs by Dr. Hardy Limeback and Dr. Iain Pretty, et al. - see [more photos](#))

#### 1942.

In 1941-1942, Dean and his colleagues published his famous 21-city study which purported to show that as the fluoride level in the water went from about 0.1 to 2.6 ppm tooth decay fell. Most of reduction occurred between 0.1 and 0.9 ppm, with only a modest further decrease occurring between 0.9 and 2.6 ppm. He further noted that there was little noticeable dental fluorosis occurring below 1 ppm. Thus was born the notion that the “optimal level” for reducing tooth decay while minimizing the risk of dental fluorosis was 1 ppm. Dean later indicated that at 1 ppm only about 10% of children would have dental fluorosis and only in the *very mild* category. Dean later testified in the US Congress that *mild* dental fluorosis would not be an acceptable trade off for lowered tooth decay. This is what he said to the Delaney Committee in 1952:

“We don’t want any ‘mild’ [fluorosis] when we are talking about fluoridation. We don’t want to go that high...I don’t want to recommend any fluoridation where you get any ‘mild’”. (Connett et al., 2010, page 110).

All the children in Dean's 21-City study were white: there were no Blacks or Hispanics in the 7,257 children studied.

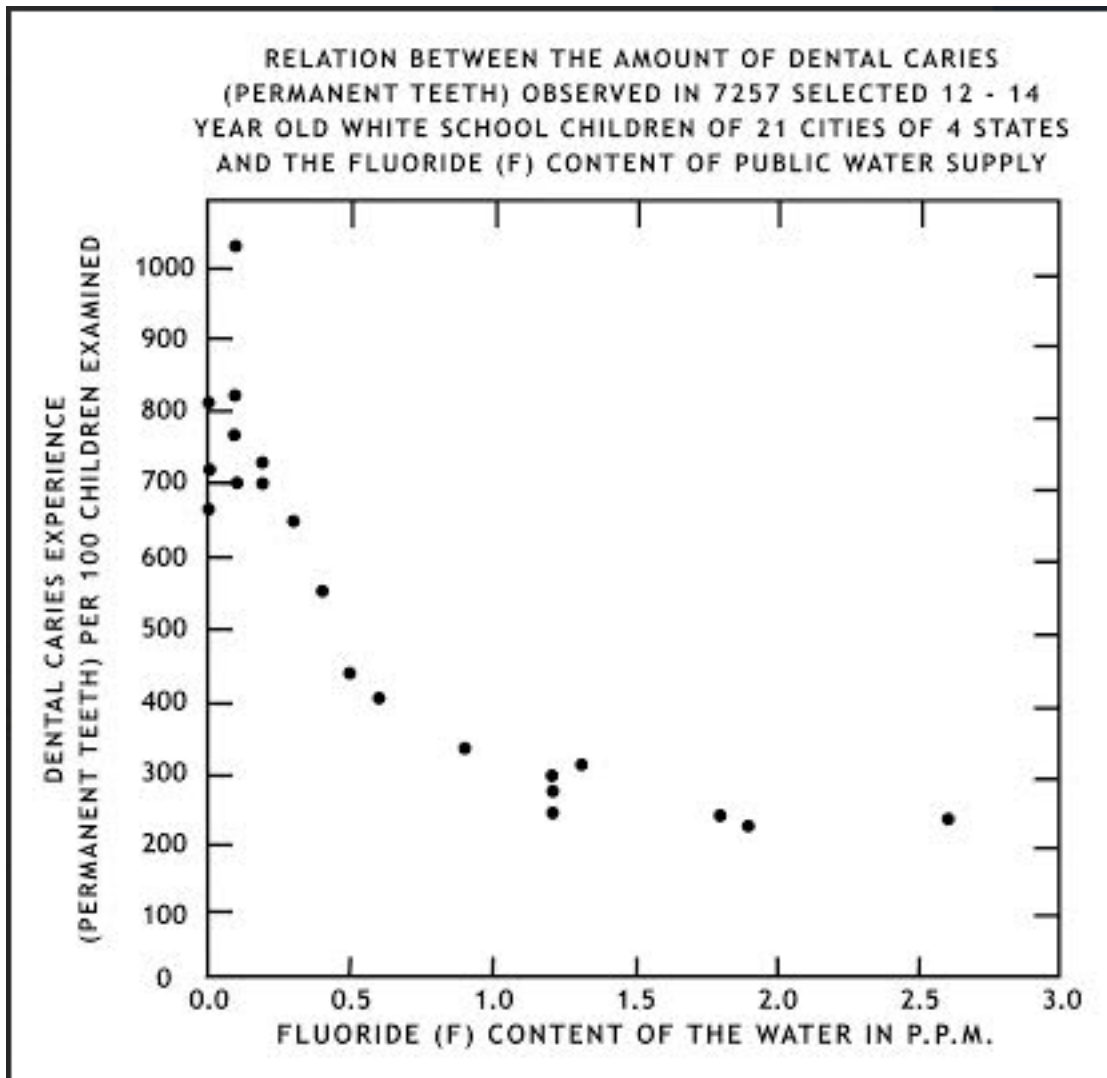


Figure 4: Dean's famous 21-city plot of Dental caries experience in each community versus the concentration of fluoride in the community's water supply in ppm (Dean et al., 1941, 1942)

## 1945

By 1945 Dean and others were convinced that natural levels of fluoride in the water lowered tooth decay and there were no side effects other than dental fluorosis. The question became: could one deliberately add a fluoride-containing compound to the public water supply and achieve the same result? The PHS decided to run a series of experiments to check this out. Instead of these experiments being conducted in the form of randomized control trials on

individual volunteers they were launched on whole cities. In their discussions the early promoters did not want to use the word experiment because as they said, "people don't like to be experimented upon!" They also saw them more as demonstrations – demonstrating that what they had seen with natural fluoride could be reproduced with artificial fluoride. These fluoridation experimental trials began in 1945 in Grand Rapids, MI; Newburgh, NY and Brantford, Ontario, Canada using sodium fluoride at 1 ppm (1 mg fluoride/liter of water). Most now agree that the methodology used in these experiments would not be acceptable by modern epidemiological standards but nevertheless they provided the foundation for the widely accepted belief in this practice for many decades. Dr. Philip Sutton wrote two monographs and a whole book on the inadequacies of these experimental trials, and his arguments have never been successfully rebutted by proponents (Sutton, 1959, 1960, 1996).

### 1950

The trials were meant to last for 10 years, but before any of them had been completed the PHS endorsed fluoridation in 1950 and over the next two years with little science on the table it was endorsed by nearly every dental, public health and medical body in the country. Despite their lack of science these endorsements have been used heavily by promoters ever since.

### 1956

In 1956, Schlesinger et al. published the health findings for the Newburgh, NY (control city Kingston, NY) experiment. They reported that young men in fluoridated Newburgh had a significantly greater number of cortical bone defects than non-fluoridated Kingston (about 2 to 1). There was no follow-up on this finding, which is surprising because the cortical bone is the outside layer of the bone and protects against fracture. However, Dr. Caffey who examined the X-rays said in 1955 that the age, sex and anatomical distribution of these defects were remarkably similar to osteosarcoma. 20 years later this comment prompted the National Academy of Science (NAS) in 1977 to recommend that researchers check to see if there was an increase in osteosarcoma in young men under 30 in fluoridated communities (NAS, 1977). The other finding by Schlesinger was that young girls were menstruating on average 5 months earlier in the fluoridated community than in the non-fluoridated one. This observation was not considered important at the time but today it is intriguing in the context of Luke's findings, a) that fluoride accumulates in the human pineal gland (Luke, 2001) and b) lowers melatonin production in animals and shortens the time to puberty (Luke, 1997).

### 1962

A January 10, 1962 internal memorandum, from a top PHS official, F.J. Maier, in connection with the first fluoridation trial, revealed that, "negroes in Grand Rapids had twice as much [dental] fluorosis than others." Based on this, Maier asked, "In a community with a larger number of negroes (say in Dekalb County, Georgia) **would this tend to change our optimum fluoride levels?**" (Maier, 1962).

### 1983

In 1983 the U.S. Surgeon General convened a panel to review the literature as part of the process of determining a safe drinking water standard for fluoride (the MCL, or Maximum

Contaminant level). One member of the panel on reviewing pictures of dental fluorosis stated that, “You would have to have rocks in your head to allow your child much more than two parts per million (Grossman, 1990 – see Appendix A)...” Over-exposure to fluoride damages teeth as the photos of the various stages of dental fluorosis above, also known as enamel fluorosis, clearly show.

## 1985

When the EPA published its rationale for both a MCL and MCLG (goal) at the very high level of 4 ppm they did not include dental fluorosis as an *adverse health effect* but as a “cosmetic effect” (for which they produced a non-enforceable secondary standard of 2 ppm). Instead of dental fluorosis the EPA used skeletal fluorosis as the health effect of concern – even so, they did not use the first signs of skeletal fluorosis (which are identical to arthritis) but the terminal stages in which the patient is crippled, i.e. crippling skeletal fluorosis. Choosing the gross end point of the problem conflicts with the normal way that the EPA comes up with protective standards. Normally they determine the Lowest Observable Adverse Effect Level (LOAEL) and then apply safety factors to that. Note also that U.S. standard of 4 ppm is about three times the WHO guideline of 1.5 ppm, which is the standard adopted by Canada, Mexico and most of the rest of the world.

Professionals at the EPA who witnessed this process have stated that the level of 4 ppm was chosen for political not scientific reasons. It was chosen to accommodate concerns of states like South Carolina which did not want to spend a lot of money removing high natural fluoride levels from drinking water if a lower level were chosen (Grossman, 1990 in Appendix A; and FAN, 2007).

## 1985

In a Texas survey, published in 1985, Butler et al. reported that the prevalence of dental fluorosis among African-American children was greater than for Hispanic and non-Hispanic white children. The reported Odds Ratio was 2.3.

## 1986-7

The National Institute of Dental Research (NIDR) conducted one of the largest surveys of tooth decay and dental fluorosis ever carried out in the USA. They looked at the teeth of approximately 39,000 children in 84 communities. The *dental caries* results were reported in 1990 by Brunelle and Carlos but the *dental fluorosis* data was not reported until 1997 by Heller et al. The latter reported 29.9% of the children living in communities with fluoride levels between 0.7 and 1.2 ppm had some form of dental fluorosis. Of these 22.5 % had very mild, 5.8% had mild, 1.3% had moderate and none were in the severe category.

As far as dental caries was concerned Brunelle & Carlos found that for children aged 5-17, who had lived all their lives in a fluoridated versus a non-fluoridated community, the *average* saving in tooth decay was 0.6 of one tooth surface (see their Table 6). There are 4 and 5 surfaces for the “cutting” and “chewing” teeth respectively, and by the time all the child’s teeth have erupted there are a total of 128 tooth surfaces. Even this very modest saving of 0.6 of one tooth

surface was not shown by the authors to be statistically significant, but this did not stop them declaring:

“The results show that water fluoridation has played a dominant role in the decline of caries and must continue to be a major prevention methodology.”

Brunelle and Carlos also noted that, “Contrary to some earlier observations, however, white children had lower mean DMFS scores than non-whites (blacks and all others) at most ages (Fig. 7).”

## 1988

In 1988, Bette Hileman, in an important review in *Chemical and Engineering News* reported disagreements among dental researchers as to whether dental fluorosis rates were increasing among children in the U.S.:

“Dennis Leverett, chairman of the department of community dentistry at the Eastman Dental Center in Rochester, N.Y., claims that the prevalence of dental fluorosis today in communities with fluoridated water is twice the level that H. Trendley Dean, a dental surgeon in the Public Health Service, reported in 1942 ... In contrast, William S. Driscoll, acting chief of the disease prevention and health promotion branch at the National Institute of Dental Research (NIDR), and his coworkers report that surveys in 1980 “suggest that no important changes in the prevalence and severity of fluorosis have taken place” since **Dean’s studies**. However, Driscoll did find eight children with either moderate or severe fluorosis in a community with a fluoride level of 1 ppm...” (Hileman, 1988)

## 1990

In 1990, Williams and Zwemer in a study from Georgia, reported that dental fluorosis was more severe among African-American children than white children. As the following table shows, 16.7% of black children in Augusta, Georgia had moderate/severe fluorosis versus 9.1% of white children. In Richmond County, the respective rates were 3.3% vs 0% (see Table 1)

Table 1. **Dental Fluorosis Rates in Augusta & Richmond County, Georgia**

Residence/Race	No Fluorosis (TSIF Score = 0)	Very Mild/Mild Fluorosis ( <a href="#">TSIF Score = 1 - 3</a> )	Moderate/Severe Fluorosis ( <a href="#">TSIF Score = 4 - 7</a> )
City/ <b>Black</b>	19.6%	63.7%	<b>16.7%</b>
City/White	18.2%	72.7%	9.1%
County/ <b>Black</b>	47.8%	48.9%	<b>3.3%</b>
County/White	44.9%	55.1%	0%

SOURCE: Williams JE, Zwemer JD. (1990).

In 1990 the long-awaited animal cancer study (requested by Congress) was published by the National Toxicology Program (NTP, 1990). This report caused great consternation because the authors reported a statistically significant increase in a bone cancer (osteosarcoma) in the male rats, which was “equivocal” evidence that fluoride was carcinogenic.

## 1991

Soon after the 1990 NTP study was published a cover story was published in the *Journal of the American Dental Association* speculating that fluoridation may actually be *protective* against cancer (McGuire et al., 1991). It was clear from the comments in this article that the authors were more worried that a finding that fluoride caused cancer would end water fluoridation, than it might be killing a few young men each year. They wrote:

“An incorrect inference implicating fluoride carcinogenicity and its removal from our water systems would be detrimental to the oral health of most Americans...a disruption in the delivery of fluoride through municipal water systems would increase decay rates over time...Linking of fluoride ingestion and cancer initiation could result in a large-scale defluoridation of municipal water systems under the Delaney clause.” (Connett et al., 2010, p. 187)

One of the authors of this report was Professor Chester Douglass, chairman of the Harvard dental department. In 1994 he received a large grant from the National Institute of Environmental Health Sciences to investigate the possible connection between fluoridation and osteosarcoma. This raises serious questions about why an investigation that had the potential to end fluoridation was given a) to a dental school and b) to a dental professor who was known to be pro-fluoridation and was simultaneously a consultant for Colgate (FAN, 2006).

Despite these doubts in 2001, Douglass’s graduate student, Elise Bassin, as part of her doctoral thesis, discovered in a carefully matched case control study that young boys exposed to fluoridated water in their 6<sup>th</sup>, 7<sup>th</sup> or 8<sup>th</sup> years had a 5-7-fold increased risk of succumbing to osteosarcoma by the age of 20. Over the next three years, Douglass – given several opportunities - hid this finding from his peers, his funders and the National Research Council of the National Academies (NRC) review panel. Bassin’s thesis (2001) was not “found” until 2004. For the rest of this intriguing story see the Harvard/Bone Cancer files (FAN, 2006); Harvard Crimson, 2006; Connett et al., 2010, chapter 18.

## 1997

Heller et al. (1997) paper published (see above)

1997 also saw the publication of **a controversial report from the Institute of Medicine (IOM)**. The title of the report included fluoride in a list of well-known nutrients needed for healthy bone growth: calcium, magnesium, phosphate and vitamin D (IOM, 1997). In response to a letter from a number of scientists complaining about this false classification of fluoride as a nutrient, Dr. Bruce Alberts, President of the National Academies, and Dr. Kenneth Shine, President of the IOM, wrote:



First, let us reassure you with regard to one concern. Nowhere in the report is it stated that fluoride is an essential nutrient. If any speaker or panel member at the September 23rd workshop referred to fluoride as such, they misspoke. As was stated in *Recommended Dietary Allowances 10th Edition*, which we published in 1989: “These contradictory results do not justify a classification of fluoride as an essential element, according to accepted standards. Nonetheless, because of its valuable effects on dental health, fluoride is a beneficial element for humans.” (Alberts and Shine, 1998).

We return to this story in section 26 where we challenge the EPA Office of Water for using the IOM report to support their false claim that fluoride is a nutrient in a 2010 report (EPA, 2010b, page 39).

### 1999 - 2000

Kumar et al. (1999) reported that “African-American children studied [in Newburgh and Kingston, NY] in 1995 were at higher risk for dental fluorosis than children of other racial groups. . . . The higher risk for dental fluorosis observed among African-American children is consistent with several other studies.”

In 2000 Kumar et al. noted, “The results support our earlier findings that African-American children were at **higher risk for dental fluorosis** in the fluoridated area. Even in the nonfluoridated area, there was a suggestion that African-American children were at higher risk. Whether this higher risk for African-American children is the result of their lower threshold for fluoride or due to other unknown sources of fluoride is not known. It has been reported that African-American children in the United States drink more water and less milk compared to white children. In Newburgh, this difference in the fluid consumption may have resulted in a higher prevalence of fluorosis in African-American children. . . . Because a race fluorosis association could have important policy implications, a large-scale study in a representative sample should be conducted to test specifically the hypothesis that African-American children are at higher risk for fluorosis.”

### 2003 -2006

The US EPA Office of Water asked the National Research Council of the National Academies to review their safe water standards for fluoride. A 12-membered panel (unusually for official reviews on fluoride, the panel was balanced with 3 pro-fluoridation, 3 anti-fluoridation and 6 undeclared) was appointed by the National Research Council of the National Academies to do this. The panel reported back in 2006 with a landmark 500-page review (NRC, 2006).

The NRC panel concluded that the safe drinking water goal and standard for fluoride in water (MCLG and MCL) of 4 ppm was not protective of health and a new risk assessment needed to be performed to determine a new MCLG (maximum contaminant level goal).

The panel had this to say on dental fluorosis:

“Severe enamel fluorosis is characterized by dark yellow to brown staining and discrete and confluent pitting, which constitutes enamel loss... Severe enamel fluorosis compromises that health-protective function by causing structural damage to the tooth.

The damage to teeth caused by severe enamel fluorosis is a toxic effect that is consistent with prevailing risk assessment definitions of adverse health effects...

“Severe enamel fluorosis occurs at an appreciable frequency, approximately 10% on average, among children in U.S. communities with water fluoride concentrations at or near the current MCLG [maximum contaminant level goal] of 4 mg/L. Thus, the MCLG is not adequately protective against this condition...

“The committee finds that it is reasonable to assume that some individuals will find *moderate* enamel fluorosis on front teeth to be detrimental to their appearance and that it could affect their overall sense of well-being. However, the available data are not adequate to categorize moderate enamel fluorosis as an adverse health effect on the basis of structural or psychological effects.

“Since 1993, there have been no new studies of enamel fluorosis in U.S. communities with fluoride at 2 mg/L in drinking water. Earlier studies indicated that the prevalence of moderate enamel fluorosis at that concentration could be as high as 15%...” (NRC, 2006)

However, even though the NRC panel concluded that **severe** dental fluorosis constituted an adverse health effect no federal or state agency has gone to any lengths to inform the public that this is the case. Nor have they warned the African-American and Mexican American communities with a total population of 101 million people (Colby & Ortman, U.S. Census, Table 2, 2015) that they are particularly vulnerable to this condition,

## 2005

In 2005, the Centers for Disease Control and Prevention (Beltrán-Aguilar et al. See Table 2 below) acknowledged for the first time publicly that the black community has higher rates of dental fluorosis than the white community. It took a Freedom of Information Act request, however, to learn the full extent of this disparity. **58% of black children** were diagnosed with dental fluorosis in CDC’s 1999-2004 national survey, versus 36% of white children. (Gracia, 2011; see also Stockin, 2015).

**Table 2: A copy of Table 23. Enamel fluorosis\* among persons aged 6- 39 years, by selected characteristics United States, National Health and Nutrition Examination Survey, 1999- 2002.**

**Source: Beltrán-Aguilar et al., 2005 (CDC, 2005)**

<http://fluoridealert.org/content/table-23-enamel-fluorosis-among-persons-aged-6-39-mmwr-2005/>

Characteristic	Unaffected		Questionable		Very mild		Mild		Moderate/Severe	
	% <sup>†</sup>	SE <sup>§</sup>	%	SE	%	SE	%	SE	%	SE
<b>Age group (yrs)</b>										
6–11	59.81	4.07	11.80	2.50	19.85	2.12	5.83	0.73	2.71	0.59
12–15	51.46	3.51	11.96	1.84	25.33	1.98	7.68	0.93	3.56	0.59
16–19	58.32	3.30	10.21	1.70	20.79	1.78	6.65	0.67	4.03	0.77
20–39	74.86	2.28	8.83	1.23	11.15	1.22	3.34	0.58	1.81	0.39
<b>Sex</b>										
Male	67.65	2.63	9.99	1.45	15.65	1.52	4.58	0.54	2.12	0.39
Female	66.97	2.84	9.83	1.34	15.58	1.36	4.84	0.61	2.78	0.49
<b>Race/Ethnicity<sup>¶</sup></b>										
White, non-Hispanic	69.69	3.13	10.43	1.62	14.09	1.56	3.87	0.60	1.92	0.48
Black, non-Hispanic	56.72	3.30	10.40	2.16	21.21	2.16	8.24	0.82	3.43	0.54
Mexican-American	65.25	3.89	8.95	1.29	15.93	2.24	5.05	0.72	4.82**	1.81
<b>Poverty status<sup>††</sup></b>										
<100% FPL	68.02	3.21	10.67	1.64	14.28	1.73	4.07	0.69	2.97	0.66
100%–199% FPL	66.92	2.91	9.11	1.79	16.11	1.46	5.21	0.78	2.65	0.56
≥200% FPL	66.88	2.75	10.73	1.33	15.56	1.56	4.83	0.50	2.00	0.37
<b>Total</b>	<b>67.40</b>	<b>2.65</b>	<b>9.91</b>	<b>1.35</b>	<b>15.55</b>	<b>1.37</b>	<b>4.69</b>	<b>0.49</b>	<b>2.45</b>	<b>0.40</b>

\* Using Dean's index. All estimates are adjusted by age (single years) and sex to the U.S. 2000 standard population, except sex, which is adjusted only by age.

† Weighted prevalence estimates.

§ Standard error.

¶ Calculated using "other race/ethnicity" and "other Hispanic" in the denominator.

\*\* Unreliable estimate: the standard error is 30% the value of the point estimate, or greater.

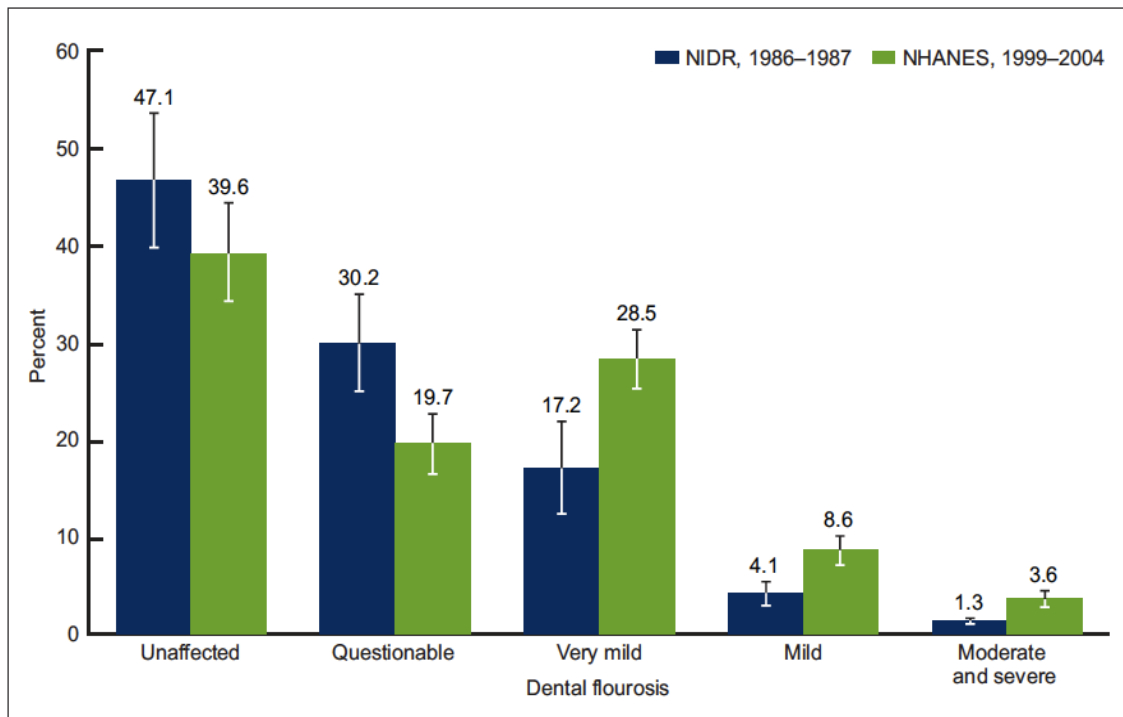
†† Percentage of the Federal Poverty Level (FPL), which varies by income and number of persons living in the household.

According to attorney Michael Connett and Special Projects Director for the Fluoride Action Network (FAN): "The epidemic of fluorosis now seen in the black community is the visible legacy of the government's failure to act on what it knew. They knew in 1962 that '**negroes in Grand Rapids had twice as much [dental] fluorosis than others**' (Maier, 1962)."

## 2010

In 2010 another report from the CDC revealed that **41% of U.S. children** between the ages of 12 and 15 had some form of dental fluorosis. This total included children from both fluoridated and non-fluoridated communities. No breakdown was given for race and ethnicity. A breakdown of the 41% total showed that **28.5 % has very mild, 8.6% had mild, and 3.6 % had either moderate or severe dental fluorosis** (Beltrán-Aguilar et al., 2010).

Figure 3. Change in dental fluorosis prevalence among children aged 12–15 participating in two national surveys: United States, 1986–1987 and 1999–2004



NOTES: Dental fluorosis is defined as having very mild, mild, moderate, or severe forms and is based on Dean's Fluorosis Index. Percentages do not sum to 100 due to rounding. Error bars represent 95% confidence intervals.

SOURCES: CDC/NCHS, National Health and Nutrition Examination Survey, 1999–2004 and National Institute of Dental Research, National Survey of Oral Health in U.S. School Children, 1986–1987.

Figure 6: Change in dental fluorosis prevalence among children aged 12-15 participating in two national surveys: United States, 1986-1987 and 1999-2004, 3 from Beltrán -Aguilar et al. (2010).

2011

On January 7 the U.S. Department for Health and Human Services and EPA held a joint press conference in Washington, DC (HHS, 2011a). The HHS announced its proposal to lower its recommended fluoride level in water to fight tooth decay from a range of 0.7 – 1.2 ppm to 0.7 ppm, largely because of the escalating prevalence of dental fluorosis among US children.

At this same press conference EPA's Office of Water announced that it had begun its determination of a new safe drinking water standard for fluoride (recommended by the NRC panel in March of 2006). While stating that they wanted to find a safe level for fluoride in drinking water (their federal responsibility), they also stated that they were interested in protecting children's teeth (*not* their federal responsibility). According to EPA Assistant Administrator for the Office of Water Peter Silva.

“EPA's new analysis **will help us make sure that people benefit from tooth decay prevention** while at the same time avoiding the unwanted health effects from too much fluoride (HHS, 2011a).” (our emphasis)

EPA at this juncture threw away its objectivity in the setting of a “safe” Maximum Contaminant Level goal (MCLG) for fluoride in drinking water. In other words they were indicating that they were going to select the safe level for fluoride as a contaminant that would not conflict with the HHS recommended level for fluoride in the fluoridation program. Clearly that is a political judgment. However, from a legal point of view no consideration of any perceived benefit of a contaminant should be allowed to interfere with the EPA’s obligation to determine a **safe** Maximum Contaminant Level Goal (MCLG). According to the Safe Drinking Water Act the MCLG should be determined based on a known or reasonably anticipated harmful effect, with appropriate safety factors applied to protect everyone in society, including vulnerable subsets. **Such calculations should be scientifically determined and should not be compromised by accommodating some perceived benefit.**

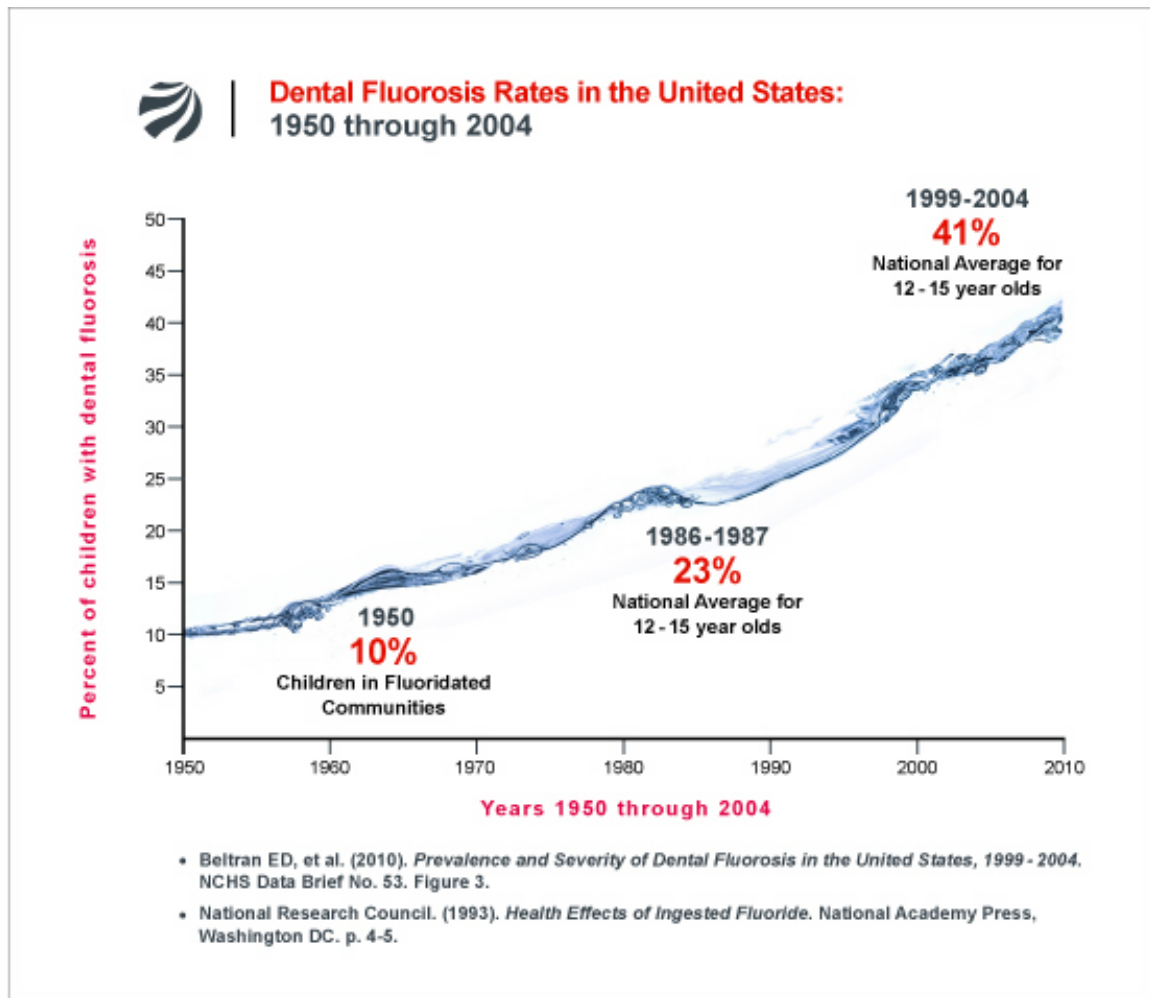
## 2015

**The HHS formally announced its new recommended level of 0.7 ppm fluoride in water claiming that it would lower tooth decay, while minimizing the prevalence of the more objectionable stages of dental fluorosis (HHS, 2015).** In so doing they continued their 60-year plus denial of any other potential health effect other than dental fluorosis at the doses experienced by any American, including the most vulnerable, drinking fluoridated water and getting fluoride from other common sources such as dental products (see section 25 for our response to this).

## SUMMARY: DENTAL FLUOROSIS IN THE U.S. 1945-2015

In 1945 Dean estimated that about 10% of children would develop dental fluorosis in communities fluoridated at 1 ppm. Since then children are being exposed to fluoride not only in fluoridated water but also from all the beverages and processed foods made with fluoridated water, and from many other sources including dental products, and pesticide residues on food, including EPA permitted fluoride residues – from the fumigant sulfuryl fluoride – of 900 ppm fluoride in powdered eggs, 130 ppm fluoride in wheat flour, and 70 ppm fluoride in 99.99% of all processed food (FAN, 2005). As a result the rates of dental fluorosis are getting significantly worse across the U.S. However, the CDC’s Division of Oral Health continues to promote artificial water fluoridation despite its disproportionate impact on communities of color and low-income groups. Studies sponsored by this CDC division in 2005 and 2007 confirm the growing epidemic of dental fluorosis in minority populations. It is an open question as to whether reducing the fluoride levels from a range of 0.7 to 1.2 ppm across the country to a single value of 0.7 ppm, will have a major effect on decreasing the prevalence of this condition in general or in minority communities in particular. A larger question is whether the level of 0.7 ppm will cause other health problems, but for the CDC’s Division of Oral Health that is a mute question since they adamantly deny that any other tissue is harmed by water fluoridation or from all sources combined.

Meanwhile, at no time have federal government officials ever taken steps to warn black communities of their heightened fluorosis risk.



(Graph by [Fluoride Action Network](#))

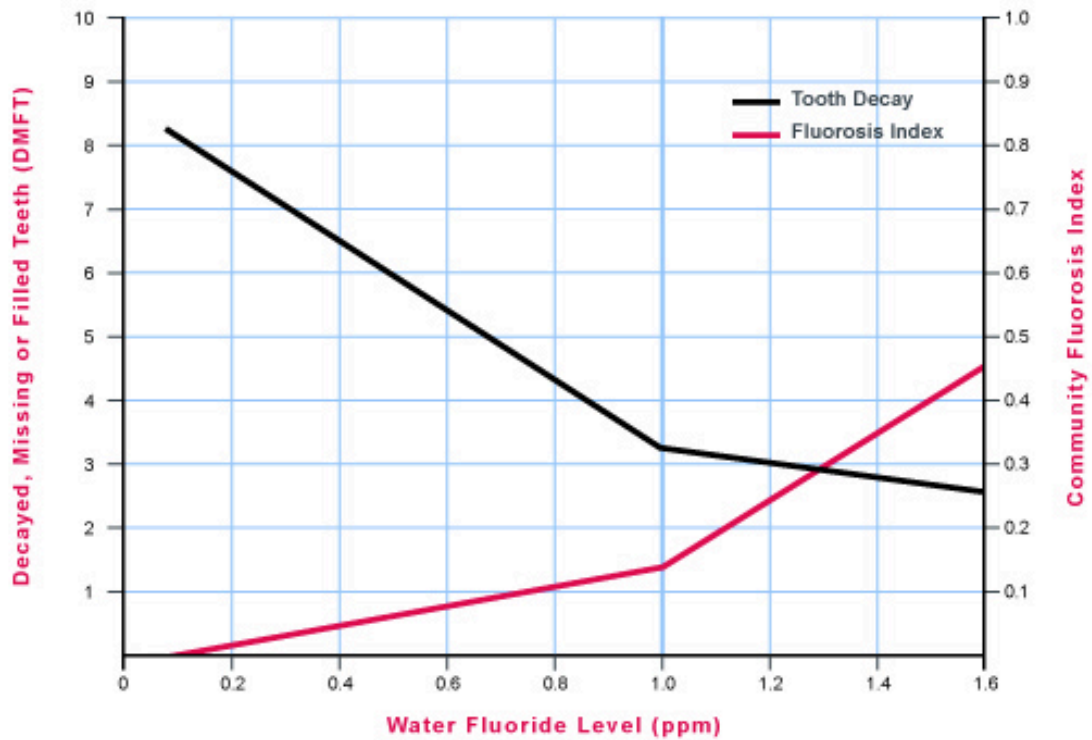
Figure 7: Dental fluorosis rates in the United States: 1950 through 2004 (FAN).

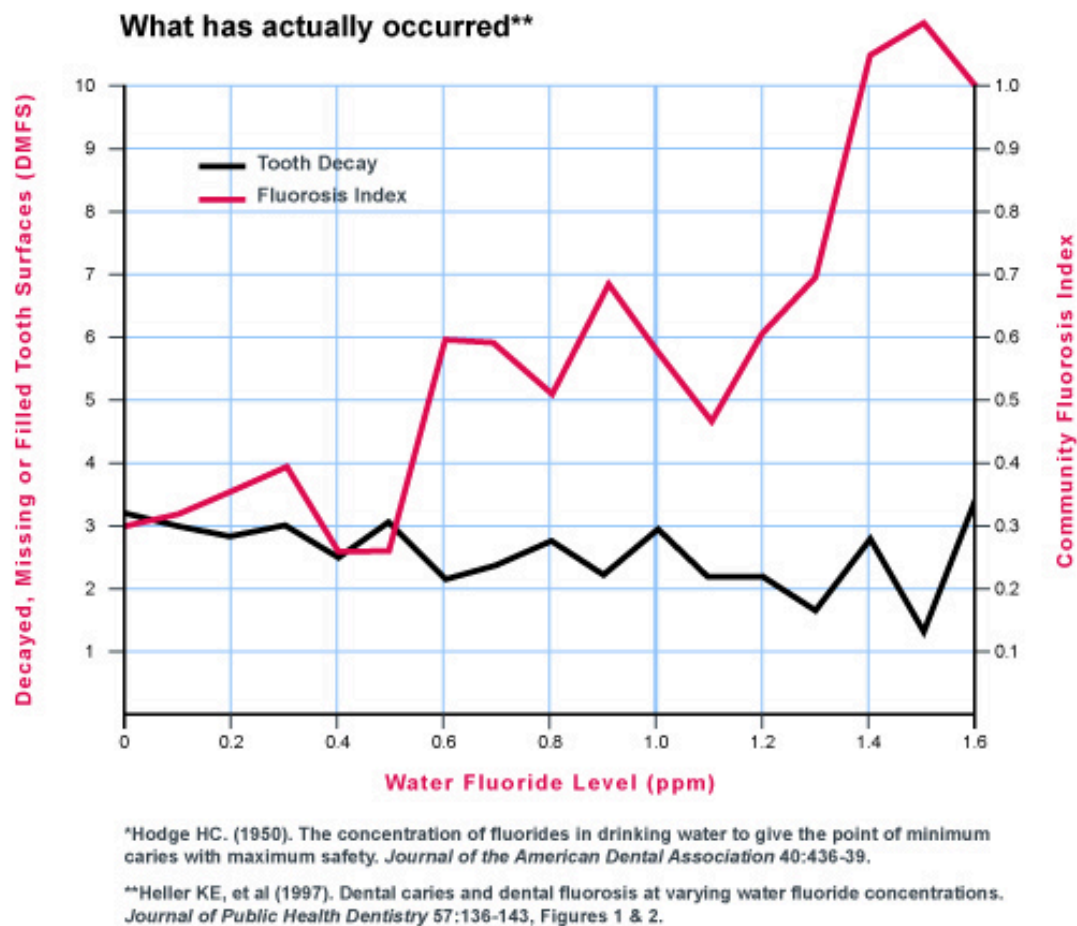


## Fluoridation, Tooth Decay, and Dental Fluorosis

What was predicted vs. what has actually occurred

What was predicted in 1950\*





**Figure 8: What was predicted in 1950 (top graph) vs. What has actually occurred (bottom graph). Legend: Black line is tooth decay measured as DMFT. Red Line is the Community Fluorosis Index. (FAN).**

## 6. Has fluoridation helped reduce tooth decay in the Inner City?

While it is clear that the fluoridation program has failed to limit the prevalence of dental fluorosis to levels anticipated in 1945, what about the other half of the program? Has it reduced tooth decay? And in the context of this discussion has it reduced tooth decay in low-income families and minority communities especially in the inner city?

Despite the laudable aim to reduce the inequalities in dental care, putting fluoride in everyone's water to reduce tooth decay among inner city children has not been the magic bullet it was expected to be. Story after story in the media of major fluoridated cities in the US tell the same story: we still have a dental crisis among America's inner city children especially among poor and minority families. In Table 3 we summarize these reports from New Haven CT; Washington DC; Detroit MI; Boston MA; Concord NH; Manhattan and the Bronx in NY; Cincinnati OH; Pittsburgh PA; and San Antonio TX.



<b>TABLE 3: Communities with water fluoridation and high dental decay</b>	
<b>Fluoridation Status</b>	<b>Detail</b>
<b>CONNECTICUT</b>  <a href="#">Mandatory Fluoridation since 1965 for water systems servicing a population of 20,000 or more</a>  <a href="#">90.3% of the population receive fluoridated water as of 2012</a>	<p>... Peters [director of New Haven Public Schools school health centers] said this past June New Haven Public schools screened 484 Troup students, from kindergarten on up to grade 8, and found that 35 percent had moderate to severe dental needs.</p> <p>“The need for dental care is very clear in Connecticut and New Haven,” Peters said at Troup Wednesday. “Tooth decay is the most common childhood disease. It is five times more common than asthma and its the leading reason for missed school across the state.” ...</p> <p>2015. Markeshia Ricks M. <a href="#">The dentist comes to Troup</a>. New Haven Independent. September 11.</p>
<b>CONNECTICUT</b>  <a href="#">See above</a>	<p>“Dental decay remains the most common chronic disease among Connecticut’s children. Poor oral health causes Connecticut children to lose hundreds of thousands of school days each year. One in four Connecticut children is on Medicaid, but two of three Connecticut children receive no dental care. And DSS continues to exploit the seriously stretched public health providers and the few remaining private providers. There is an oral health crisis in Connecticut.”</p> <p>2005. Slate R. State must fund plan to provide oral health care for the poor. New Haven Register. May 5.</p>
<b>DISTRICT OF COLUMBIA</b>  <a href="#">Fluoridated since 1952</a>	<p>Washington DC has “one of the highest decay rates in children in the country.” The “typical new patient, age 6, has five or six teeth with cavities — a ‘staggering’ number” at the Children’s National Medical Center.</p> <p>2002. Morse S. <a href="#">Bottled Water: Just add Fluoride</a>. Washington Post. March 5.</p>
<b>DISTRICT OF COLUMBIA</b>  <a href="#">Fluoridated since 1952</a>	<ul style="list-style-type: none"> <li>• Low-income Children in Washington, DC are at High Risk for Poor Oral Health and Consequently Inadequate School Readiness</li> <li>• a large proportion (44 percent) of the 144 students examined had a history of dental caries,</li> <li>• Examined students are primarily from some of the most impoverished Wards (5, 6, 7, &amp; 8) and exhibit high caries incidence</li> </ul> <p>2007. <a href="#">Issue Brief: Oral Health is Critical to the School Readiness of Children in Washington, DC</a>. By Altarum Institute.</p>
<b>ILLINOIS</b>	Thousands of low-income children and adults in Illinois suffer from untreated dental disease. They can’t eat or sleep properly, do their best at

<p>Fluoridation is mandatory</p> <p>98.5% of the state's population receive fluoridated water (as of 2012)</p>	<p>school or work or smile and are at risk for other serious health problems...</p> <p>... Illinois has among the lowest rates in the nation for government funded dental care. As a result we face an oral health care crisis... Illinois currently has just one clinic per 8,400 children who rely on government insurance...</p> <p>2009. <a href="#">Support Bill HB 388 for dental care</a>. By Lauri Frichtl, Executive Director, Illinois Head Start. Pioneer Press.</p>
<p><b>INDIANA</b></p> <p>94.8% of the state's population receive fluoridated water (as of 2012)</p>	<p>Results from the 2006 BRFSS also indicated that 47 percent of Hoosiers ages 18 and older have had permanent teeth extracted—a percentage that was significantly higher than the national median of 44 percent (see Figure 2).</p> <p>Groups with the highest prevalence of tooth extractions <b>included blacks; individuals with an annual household income of less than \$35,000; and individuals with lower educational attainment.</b> Prevalence of extractions was highly associated with age – as age increased so did the percentage of Hoosiers who reported having had any permanent teeth extracted.</p> <p>... The elderly, minorities, and low income citizens often face the unfortunate need to have some or all of their teeth extracted.</p> <p>2009. <a href="#">Oral Health Needs in Indiana: Developing an Effective and Diverse Workforce</a>. Center for Health Policy. May.</p>
<p><b>MICHIGAN</b></p> <p><b>Detroit</b> Fluoridated since 1967</p>	<p><b>Excerpt from abstract:</b> To describe the epidemiology of dental caries among low-income African American children 5 years old and younger in the City of Detroit.</p> <p><b>Conclusion: Dental Caries in primary teeth in children 5 years of age and younger in Detroit is a major dental public health problem.</b></p> <p>2006. <a href="#">Severity of Dental Caries Among African American Children in Detroit</a>. By Ismail AI, Tellez M, Sohn W. Presented at the 35th Annual Meeting &amp; Exhibition of the American Assoc. for Dental Research in Orlando, Florida. March.</p>
<p><b>MICHIGAN</b></p> <p><b>Detroit</b> Fluoridated since 1967</p>	<p>From abstract: The aim of this study was to examine the relationship between dietary patterns and caries experience in a representative group of low-income African-American adults. Participants were residents of Detroit, Michigan, with household incomes below 250% of the federally-established poverty level (n = 1,021)... This population had severe caries, poor oral hygiene, and diets that are high in sugars and fats and low in fruits and vegetables. Apart from tap water, the most frequently consumed food item by adults of all ages was soft drinks; 19% of all energy from sugar came from soft drinks alone.</p> <p>2006: <a href="#">Dietary Patterns Related to Caries in a Low-income Adult Population</a>. By Burt BA, Kolker JL, Sandretto AM, et al. Caries Research 40(6):473–80.</p>

<p><b>MASSACHUSETTS</b></p> <p>70.4% of the state residents receive fluoridated water</p>	<p>Children from low-income families and children from certain racial/ethnic groups not only have a much higher prevalence of oral disease but are also less likely to have had their dental caries treated. (Page 4)</p> <p>Significant racial, ethnic and socioeconomic disparities exist within all oral health indicators, at each grade level, and among the state's 14 counties. (page 5)</p> <p>Kindergarten</p> <ul style="list-style-type: none"> <li>• 39.4% of non-Hispanic Black kindergarten children have been affected by dental caries, 1.7 times higher than non-Hispanic white kindergarten children;</li> <li>• 40.9% of Hispanic kindergarten children have been affected by dental caries, 1.8 times higher than non-Hispanic white kindergarten children; and</li> <li>• 41.5% of kindergarten children from low-income families have been affected by dental caries, 1.9 times higher than kindergarten children from families with higher incomes.</li> </ul> <p>2008. <a href="#">The Oral Health of Massachusetts' Children</a>. By White BA, Monopoli MP, Souza BS. Catalyst Institute. January.</p>
<p><b>MASSACHUSETTS</b></p> <p>70.4% of the state residents receive fluoridated water</p>	<p>..."Children are going to school with cavities, gum infections, rotting teeth. I don't think people know how serious a problem it is," said Ms. Cepeda, who has served as coordinator of the volunteer committee.</p> <p>The problem is one that a special state legislative commission last year called an oral health crisis in Massachusetts: Not enough dentists are available for people on MassHealth, the state's health plan that includes Medicaid and the Children's Health Insurance Program...</p> <p>2001. <a href="#">Fluoridated Water Not Preventing Rampant Decay Among Southbridge's Poor</a>. Telegram &amp; Gazette (Massachusetts). October 14.</p>
<p><b>NEW HAMPSHIRE</b></p> <p>Concord Fluoridated since 1978</p>	<p>"It's overwhelming," said Deb Bergschneider, dental clinic coordinator at the Concord center. "Because we serve the uninsured, we see the lower level of the community and the need is just astronomical. ... By the time they get to us, their mouths are bombed out. They are all emergency situations. It's a severe, severe, problem. It's sad."</p> <p>2005. Gerth U. <a href="#">Nothing to smile about</a>. Fosters Daily Democrat, May 22.</p>
<p><b>NEW YORK</b></p> <p>Manhattan Fluoridated since 1965</p>	<p>The level of untreated decay, %d/ dft, was 91%, significantly higher than the US national population which is 76% overall, and 76% for African Americans and Mexican Americans within the US national population.</p> <p><b>CONCLUSIONS:</b> The children in this population have higher caries prevalence and a higher level of untreated caries than the national means as reported in NHANES III. The high level of untreated decay found in this particularly disadvantaged community suggests that enhanced dental services targeting the very young are needed in these communities.</p>

	<p>2002. <a href="#">Dental caries among disadvantaged 3- to 4-year old children in northern Manhattan</a>. By Albert DA, Park K, Findley S, et al. Pediatric Dentistry, May;24(3):229-33. <a href="http://fluoridealert.org/studytracker/19188/">http://fluoridealert.org/studytracker/19188/</a></p>
<p><b>NEW YORK</b></p> <p><b>Bronx</b> Fluoridated since 1965</p>	<p>“Bleeding gums, impacted teeth and rotting teeth are routine matters for the children I have interviewed in the South Bronx. Children get used to feeling constant pain. They go to sleep with it. They go to school with it. Sometimes their teachers are alarmed and try to get them to a clinic. But it’s all so slow and heavily encumbered with red tape and waiting lists and missing, lost or canceled welfare cards, that dental care is often long delayed. Children live for months with pain that grown-ups would find unendurable. The gradual attrition of accepted pain erodes their energy and aspiration. I have seen children in New York with teeth that look like brownish, broken sticks. I have also seen teen-agers who were missing half their teeth. But, to me, most shocking is to see a child with an abscess that has been inflamed for weeks and that he has simply lived with and accepts as part of the routine of life. Many teachers in the urban schools have seen this. It is almost commonplace.”</p> <p>1991. Kozol J. <i>Savage Inequalities</i>. Harper Perennial.</p>
<p><b>OHIO</b></p> <p><b>Cincinnati</b> Fluoridated since 1969-1970</p>	<p>“We cannot meet the demand,” says Dr. Larry Hill, Cincinnati Health Department dental director.</p> <p>“It’s absolutely heartbreaking and a travesty. We have kids in this community with severe untreated dental infections. We have kids with self-esteem problems, and we have kids in severe pain and we have no place to send them in Cincinnati. People would be shocked to learn how bad the problem has become.”</p> <p>... An estimated 43 percent of the city’s 8-year-olds living in low-income homes have significant teeth decay. The rate of infection stood at 37 percent in 1996.</p> <p>2002. Solvig E. <a href="#">Special Report: Cincinnati’s Dental Crisis</a>. The Enquirer (Cincinnati, Ohio). October 6.</p>
<p><b>PENNSYLVANIA</b></p> <p><b>Pittsburgh</b> Fluoridated since 1952</p>	<p>“Nearly half of children in Pittsburgh between 6 and 8 have had cavities, according to a 2002 state Department of Health report. More than 70 percent of 15-year-olds in the city have had cavities, the highest percentage in the state. Close to 30 percent of the city’s children have untreated cavities. That’s more than double the state average of 14 percent.”</p> <p>2005. Law V. Sink your teeth into health care. <i>Pittsburgh Tribune-Review</i> February 13.</p>
<p><b>TEXAS</b></p> <p><b>San Antonio</b></p>	<p>“After 9 years and \$3 million of adding fluoride, research shows tooth decay hasn’t dropped among the poorest of Bexar County’s children it has only increased—up 13 percent this year. One out of two children in the Head</p>

Fluoridated since 2002	<p>Start program who were checked for cavities had some last year.”</p> <p>2011. Conger J. <a href="#">Added to our drinking water: A chemical more toxic than lead?</a> KENS 5. November 11.</p>
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So despite being fluoride-overdosed, it’s not working for poor families and communities of color in the U.S. as they still suffer from higher rates of tooth decay in fluoridated communities (see Table 3 and also FAN, 2013a). Many poor and minority communities suffer from what health officials have called a “silent epidemic” of untreated tooth decay.

According to Kaste et al. (1996), national data indicate that 80% of tooth decay in children is concentrated in 25% of the child population, with low-income children and racial/ethnic minority groups having more untreated decay on average than the U.S. population as a whole.

Little has changed since 1996. According to Dye et al. (2015): “Untreated tooth decay was higher for Hispanic (36%) and non-Hispanic black (42%) adults compared with non-Hispanic white (22%) and non-Hispanic Asian (17%) adults aged 20–64.”

This is not just the opinion of handful of dental researchers it is also the view of the number one promoter of fluoridation in the country: the CDC’s Division of Oral Health. In 2012, according to the CDC, the total population on fluoridated drinking water systems was 210,655,401 Americans or 67.1% of the population (CDC, 2012). Even with this astounding number, dental health disparities continue to thrive for communities of color and society’s poorest – the very groups that fluoridation was meant to serve. In the words of the CDC (2015):

- **Oral health disparities are profound** in the United States. Despite major improvements in oral health for the population as a whole, oral health disparities exist for many racial and ethnic groups, by socioeconomic status, gender, age and geographic location.
- **Overall.** Non-Hispanic blacks, Hispanics, and American Indians and Alaska Natives generally have the poorest oral health of any racial and ethnic groups in the United States.
- **Children and Tooth Decay.** The greatest racial and ethnic disparity among children aged 2–4 years and aged 6–8 years is seen in Mexican American and black, non-Hispanic children.
- **Adults and Untreated Tooth Decay.** Blacks, non-Hispanics, and Mexican Americans aged 35–44 years experience untreated tooth decay nearly twice as much as white, non-Hispanics.

So fluoridation is not working for poor families and communities of color in the U.S.

Why is this the case? The simple truth is that tooth decay is not caused by not enough ingested fluoride but by poor diet and too much sugar as well as too little intervention from dental professionals. This is what the Senate Subcommittee on Primary Health and Aging said about

the lack of access to dental care in 2012. Millions of Americans are “unable to get even the basic dental care they need.”(Sanders, 2012)

Poor nutrition and lack of access to professional dental care goes hand in hand with poverty. ***Sadly 80% of dentists in the US will not treat children on Medicaid because the financial returns are so low (FAN, 2013b).***

Some of the children that need the most care get the least.

Fluoridation simply cannot compensate for poor diet, lack of early professional interventions and poor practices like baby’s sucking on bottles of sugared water, juice, milk and even fizzy drinks for hours on end leading to baby bottle tooth decay (BBTD) which ravages the infant’s first teeth. Such abuse of the primary teeth cannot be prevented with fluoridation but the prevalence can be reduced with better education.

Even though fluoridation promoters know that BBTD cannot be prevented by fluoridation – or should know –that doesn’t stop them using pictures of BBTD as a scare tactic to persuade communities to start or to continue fluoridation. In Figure 9, a Medical Officer of Health from Canada holds up a picture of BBTD falsely implying that fluoridation will address this problem. It won’t. Such propaganda exercises are bad enough in the hands of rabid fluoridation promoters; they are even worse when practiced by civil servants whose salaries are paid for by the taxpayer.



Figure 9: In Canada, Medical Officer of Health Dr. Hazel Lynn holds up a picture of Baby Bottle Tooth decay (BBTD). Lynn claimed in Owen Sound’s Sun Times (Jan 31, 2014) that water fluoridation prevents tooth decay and is a safe practice. The implication is

fluoridation will mitigate against BBTD. It won't! Photo: James Masters/QMI Agency (Langlois, 2014)

## 7. Why are African Americans more sensitive to fluoride's toxicity?

As discussed above African Americans and Hispanics have been shown to be at an increased risk of developing dental fluorosis, and have a higher risk of suffering from the more severe forms of this condition (Russell, 1962; Butler et al., 1985; Williams & Zwemer, 1990; Beltrán-Aguilar et al., 2005, 2010; Martinez-Mier & Soto-Rojas, 2010).

It is not yet known why blacks suffer higher rates of dental fluorosis. According to the CDC, it may be a result of "biologic susceptibility or greater fluoride intake." (Beltrán-Aguilar et al., 2005). Whatever the explanation, it is clear that the black community is being disproportionately harmed by current fluoride policies in the United States.

Here are a few possible explanations:

- 1) African Americans consume significantly more total fluids and plain water, and thus receive more fluoride from drinking water, than white children (Sohn et al., 2009).
- 2) According to CDC, African Americans are less likely to breastfeed than most other racial groups: "non-Hispanic blacks had a lower prevalence of breastfeeding initiation than non-Hispanic whites in all but two states..."-(CDC, 2010). As human milk contains very low levels of fluoride (Ekstrand et al., 1981, 1984; Sener et al., 2007), babies fed formula made with fluoridated water at 0.7 -1.2 mg/L will receive 100 to 200 times more fluoride than a human-fed baby simply through consumption of the water. If the parent reduces the amount of formula in a fluoridated community to save money as many poor parents do (Stein 2008; Egemen et al., 2002; Parraga et al., 1988), and adds more water than recommended, these children will receive even higher levels of fluoride.
- 3) Another possible explanation was suggested by a study by Leite et al. (2011). The authors found that rats treated with both lead and fluoride had worse dental fluorosis than rats treated with fluoride alone. Thus it is possible that children with lead exposure will be more susceptible to developing dental fluorosis. African-Americans in the inner-city have had more exposure to lead than white children. In 1995 Stevens reported, "Of impoverished black children aged three to five living in American inner cities, 90% have elevated blood-lead levels." CDC in 2003 stated, "Of the children reported with confirmed elevated [blood lead levels] between 1997 and 2001, approximately 17% were non-Hispanic whites, 60% were non-Hispanic blacks, 16% were Hispanic, and 7% were of other races or ethnicities. As reported by the MMWR in 2013:

This report summarizes the results of that analysis, which indicated that the percentage of children aged 1–5 years with BLLs at or above the upper reference interval value of 5  $\mu\text{g}/\text{dL}$  calculated using the 2007–2010 NHANES cycle was 2.6%. Thus, an estimated 535,000 U.S. children aged 1–5 years had BLLs  $\geq 5 \mu\text{g}/\text{dL}$  based on the U.S. Census Bureau 2010 count of the number of children in this age group. (MMWR, 2013)

No federal agency has investigated or published studies on the interaction of neurotoxicants such as lead and fluoride on children in fluoridated inner-cities or anywhere else.



4) Fluoride's toxicity is exacerbated by inadequate nutrition, including lower intakes of iodine and calcium (see studies at FAN, 2012).

5) Certain racial groups are more likely to be lactose intolerant than others. Included among these are Central and East Asians (80-100% lactose intolerant; de Vrese et al., 2001), Native Americans (80-100% lactose intolerant; National Institute of Child Health and Human Development, 2006), African Americans (**75% lactose intolerant**), and Southern Indians (70% lactose intolerant; de Vrese et al., 2001). The elevated incidence of lactose intolerance may indicate lower rates of milk consumption, and higher consumption rates of water or other beverages, than Whites (21% lactose intolerant; Scrimshaw, 1988). Thus these groups may be more heavily exposed to fluoride in water and other beverages than are Caucasian Americans, and their calcium intakes may be compromised. Calcium in the diet is partially protective of fluoride because it lowers uptake of fluoride from the gut.

## **8. Reckless assumptions underpin fluoridation promotion**

Dental fluorosis is a clear indicator that the child has been over-exposed to fluoride before their permanent teeth have erupted. This can be compared to the purple-blue line on the gums of those who have been over-exposed to lead. Both markers tell a story. But not all fluoride exposure outcomes are so easily recognizable as dental fluorosis.

One of the most reckless assumptions made by those who endorsed fluoridation in 1950 was the notion that while fluoride was interfering with some biochemical mechanism in the growing tooth cells causing the damage to the enamel which we call dental fluorosis, that it was not causing damage to any other developing tissue in a baby's body.

It was also reckless to ignore the fact that nature provides only a miniscule amount of fluoride in mothers' milk.

It was also reckless to ignore the fact that there is not one biochemical process in the body that needs fluoride to function properly.

It is even more reckless to ignore the fact that fluoride is highly toxic to many fundamental biological processes, see Barbier et al., 2010, *The Biochemical Mechanisms of Fluoride's Toxicity*.

If fluoride limits its toxic effects to the cells laying down the enamel in our teeth (Den Besten & Li, 2011), we have been extremely lucky and undeservedly so considering the recklessness of exposing a huge population to this toxic substance every day of their lives for a whole lifetime with every glass of water they drink.

## **9. Pro-fluoridation governments have undertaken very few studies to seriously investigate fluoride's potential to cause both short-term health effects in children or long-term health effects in adults.**



The consequences of the reckless assumptions discussed in section 8 above have been largely hidden from the public and media because of an atrocious lack of basic research on fluoride's health effects until fairly recent years.

Once the Public Health Service had endorsed fluoridation in 1950 the U.S. government showed little interest in funding studies to investigate the health of fluoridated communities. The same has been true in other (largely English speaking) fluoridated countries.

Based on what has been reported in the scientific literature one would have expected a responsible government that has endorsed the experiment of fluoridation to have carefully investigated a possible association of the following conditions with an increased exposure to fluoride:

- a) Arthritis rates
- b) Decreased thyroid function
- c) Lowered IQ in children
- d) Increased ADHD rates in children.
- e) Reduced time to puberty
- f) Reproductive health
- g) Alzheimer's disease

A responsible government would have also:

Attempted to put the anecdotal reports of people claiming to be sensitive to fluoride on a scientific level using double-blind studies;

Further investigated Bassin et al.'s (2006) suggested age window of vulnerability to osteosarcoma in young boys;

Attempted to reproduce Jennifer Luke's findings of fluoride's accumulation in the human pineal gland and lowered melatonin production in fluoride-treated animals (Luke, 1997, 2001), and

Made a comprehensive effort to monitor fluoride levels in urine, blood and bone to establish a baseline for future research. One simple strategy would have been to have collected the hip-bone of patients undergoing hip replacement (of which there are many thousands each year) and monitored them for fluoride. This was done in one small Canadian study and it was found that the levels were considerably higher in the bones collected in fluoridated Toronto compared to unfluoridated Montreal (Chachra et al., 2010). We need more studies like this.

Used dental fluorosis as a biomarker for exposure to probe any possible correlation with bone fractures, osteosarcoma, age of puberty, even IQ scores.

Most of this research should have started 70 years ago before this reckless fluoridation experiment was begun. But Instead of basic scientific research like this the public has been treated to over 60 years of promotion, propaganda and PR. The central plank of which is the

foolish notion that “the absence of study is the same as the absence of harm.” According to Paul Connett, PhD, retired chemistry professor, **“When policy is king, science becomes a slave.”**

Another way that the pro-fluoridation health establishment in the U.S. has kept western scientists in the dark about fluoride’s toxicity is the exclusion of the journal *Fluoride* from Pub Med, the largest online search engine for biomedical papers and maintained by the National Institutes of Health (NIH). Pub Med refuses to index the only scientific journal dedicated to all aspects of fluoride research. It is published by the International Society for Fluoride Research (ISFR) four times a year, and all issues are available online for free at <http://www.fluorideresearch.org/backissues.pdf> (see section 15 below).

Despite its exclusion from PubMed many studies published in *Fluoride* have been widely cited by scientists in the field — including U.S. government researchers. A review of the references in the landmark report on the toxicology of fluoride by the National Research Council of the National Academies in 2006 reveals an important story: the journal *Fluoride* had the highest number of references -see table 4 for the top 10 journals referenced by the NRC

**Table 4: The top ten journals cited in the NRC (2006) review**

<b>Name of Journal</b>	<b># of Citations</b>
Fluoride	56
Journal of Dental Research	34
Community Dentistry and Oral Epidemiology	31
Journal of Public Health Dentistry	31
Journal of the American Dental Association	23
Journal of Bone and Mineral Research	21
Calcified Tissue Research	19
Caries Research	18
Bone	13
Pediatric Dentistry	12

The feeble excuses offered by the NIH for keeping *Fluoride* out of Pub Med is that the ISFR is anti-fluoridation (and therefore biased). But a) the ISFR has never taken a formal position against fluoridation and b) there is far more to fluoride research than the issue of water fluoridation so why deprive scientists access to that other research? It is true that the editors of *Fluoride* over many years have been anti-fluoridation, but if that is the reason for exclusion from Pub Med the NIH has exercised a glaring double standard here because the editors of every major dental journal are pro-fluoridation but that hasn’t kept their journals out of Pub Med.

## **10. Non-fluoridated countries lead research effort on fluoride’s toxicity**

The understanding of fluoride’s dangers and the potential risks posed by water fluoridation by independent scientists (outside government agencies) in the western world is changing because of research efforts in countries like India, China, Iran, and Mexico. These countries have high natural levels of fluoride in regions of their countries and are genuinely interested in finding out

what level of fluoride in water is safe to drink. Moreover, they do not have a fluoridation program to protect and their researchers are not worried about offending those who promote this practice. (There are also areas in the U.S. where drinking water contains high fluoride levels (FAN, 2007).

A great deal of this research effort was revealed to the Western world by the landmark review of fluoride's toxicity by the U.S. National Research Council of the National Academies report in 2006.

## 11. National Research Council of the National Academies review of 2006

It is hard to overstate the significance of this review titled, *Fluoride in Drinking Water: A Scientific Review of EPA's Standards* (NRC, 2006).

First and foremost the panel put together by the NRC was truly balanced which was most unusual for official reviews of fluoride's toxicity. In the 12-membered panel three were known to be pro-fluoridation, three anti-fluoridation and six undeclared.

Second, the panel was expected to take about one year to complete their review but they ended up spending three and half years on this task.

Third, the panel did not limit themselves to human epidemiological studies, they looked at animal studies, biochemical studies, clinical trials, case studies, epidemiological studies and even theoretical modeling in the case of fluoride's impact on the bone.

In short, they looked at everything that pertained to understanding fluoride's toxicity. Nor did they shun the use of the huge database provided by the journal *Fluoride*, which has published research papers on fluoride since 1968.

As a result the NRC's final report, which is 507 pages long, with over 1100 references, is a veritable textbook on the toxicology on fluoride. What they did not do was to review the practice or the purported benefits of water fluoridation, which they were asked not to do by the EPA. They described their mission as follows,

The committee was charged to review toxicologic, epidemiologic, and clinical data on fluoride—particularly data published since the NRC's previous (1993) report—and exposure data on orally ingested fluoride from drinking water and other sources.

On the basis of its review, the committee was asked to evaluate independently the scientific basis of EPA's MCLG of 4 mg/L and SMCL (secondary maximum contaminant level—a concentration intended to avoid cosmetic damage) of 2 mg/L in drinking water, and the adequacy of those guidelines to protect children and others from adverse health effects. The committee was asked to consider the relative contribution of various fluoride sources (e.g., drinking water, food, dental-hygiene products) to total exposure. The committee was also asked to identify data gaps and to make recommendations for future research relevant to setting the MCLG and SMCL for fluoride. *Addressing questions of artificial fluoridation, economics, risk-benefit assessment, and water-treatment technology was not part of the committee's charge* [emphasis added] (see

also Donahue, 2003).

The enormous breadth covered by this panel is revealed by the chapter titles:

1. Introduction
2. Measures of Exposures to Fluoride in the United States
3. Pharmacokinetics of Fluoride
4. Effects of Fluoride on Teeth
5. Musculoskeletal effects
6. Reproductive and Development Effects of Fluoride
7. Neurotoxicity and Neurobehavioral Effects
8. Effects on the Endocrine System
9. Effects of the Gastrointestinal, Renal, Hepatic and Immune Systems
10. Genotoxicity and Carcinogenicity
11. Drinking Water Standards for Fluoride

This important publication can be searched online without charge at

<http://www.nap.edu/catalog/11571/fluoride-in-drinking-water-a-scientific-review-of-epas-standards>

Based on this massive review the NRC panel concluded that the current MCLG (the maximum contaminant level goal) and MCL (maximum contaminant level) for fluoride (4 ppm) was not protective of health and recommended that the EPA's Office of Water (that commissioned the review) conduct a new risk assessment for fluoride to determine a new (and safer) MCLG.

The MCLG is supposed to be the safe level based upon the best science available on harmful effects with the application of appropriate safety factors to protect everyone including vulnerable subsets of the population from "known and reasonably anticipated" harm. The MCLG is an ideal goal. Once the MCLG has been identified the MCL (a federally enforceable standard) is determined and takes into account the economic costs of reaching this standard in a situation where there are high natural levels in the water, either naturally or from industrial pollution.

The NRC recommendation was made in March 2006, but as of September 2015 the determination of the MCLG (and hence the MCL) has still not been completed by the EPA Office of Water (OW) and the U.S. continues to operate with an unsafe standard nearly three times higher than the WHO recommended safe level of 1.5 ppm, which has been adopted by nearly every other country in the world.

While not discounting any of the other health concerns revealed in the eleven chapters of the report, the authors singled out three clinical conditions that they believed triggered the need for

a new health risk assessment:

1. Clinical stage II skeletal fluorosis: “The committee judges that stage II is also an adverse health effect, as it is associated with chronic joint pain, arthritic symptoms, slight calcification of ligaments, and osteosclerosis of cancellous [porous] bones.”
2. Bone fractures: “The majority of the committee concluded that the MCLG is not likely to be protective against bone fractures.”
3. Severe dental fluorosis: “After reviewing the collective evidence, including studies conducted since the early 1990s, the committee concluded unanimously that the present MCLG of 4 mg/L for fluoride should be lowered. Exposure at the MCLG clearly puts children at risk of developing severe enamel fluorosis.”

In addition to these end points the NRC panel pointed to many gaps in the literature and recommended numerous research questions that needed to be addressed. An independent observer should wonder why after over 60 years of fluoridation (as of 2006) there should be so many gaps in the literature. We have attempted to answer that question in section 9 above. This is what the chairman of the NRC panel had to say about this in a *Scientific American* article in January 2008:

“What the committee found is that we’ve gone with the status quo regarding fluoride for many years—for too long really—and now we need to take a fresh look . . . In the scientific community people tend to think this is settled. I mean, when the U.S. surgeon general comes out and says this is one of the top 10 greatest achievements of the 20th century, that’s a hard hurdle to get over. But when we looked at the studies that have been done, we found that many of these questions are unsettled and we have much less information than we should, considering how long this (fluoridation) has been going on.” (Fagin, 2008)

On the day that the NRC (2006) was published the American Dental Association (ADA) rushed in to deny its relevance to fluoridation and six days later the CDC’s Division of Oral Health did the same. This was an extraordinary position to take because in chapter 2 the NRC panel provided an exposure analysis, which clearly demonstrates that certain subsets of the population are exceeding the EPA’s safe reference dose for fluoride (0.06 mg/kg/day) drinking fluoridated water. These subsets included high water drinkers, people with poor kidney function, people with borderline iodine deficiency and bottle-fed babies. The latter case is illustrated by figure 2.8 that appears on page 85 of the report.

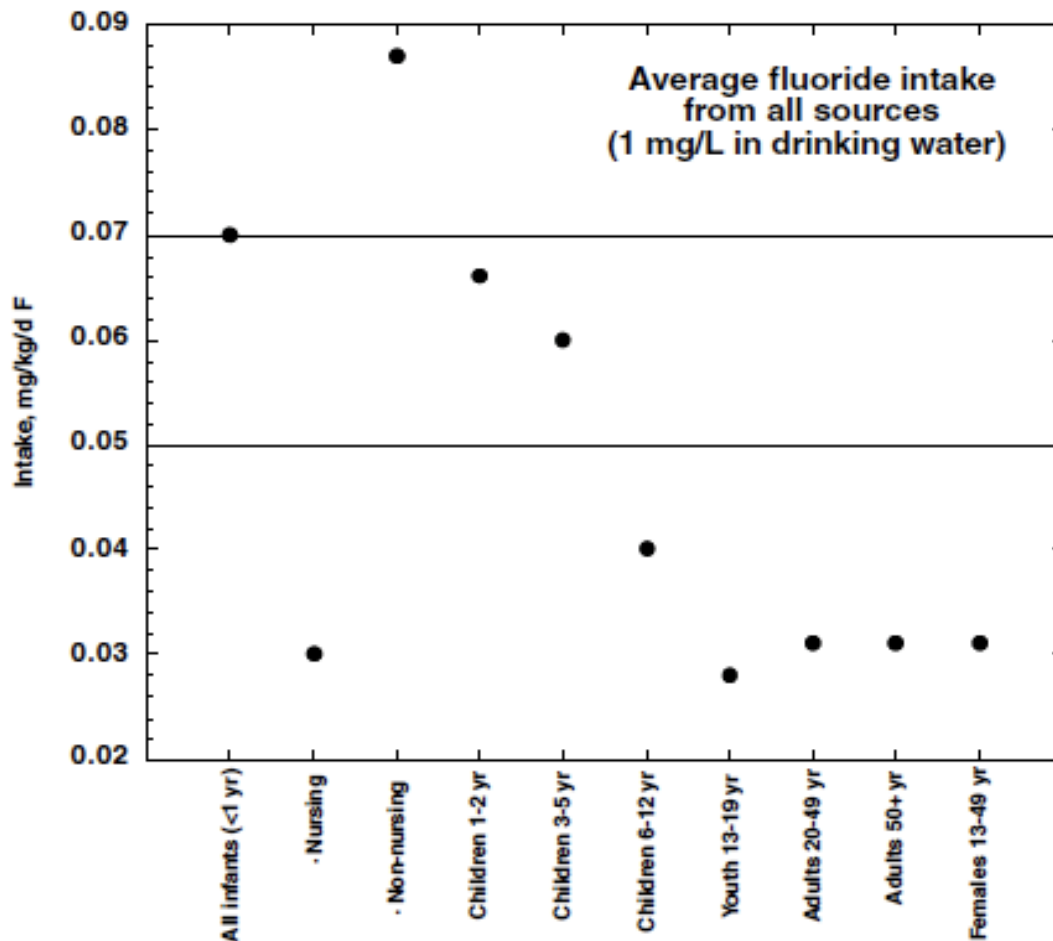


FIGURE 2-8 Estimated average intake of fluoride from all sources, at 1 mg/L in drinking water (based on Table 2-11). Horizontal lines indicate an intake of 0.05-0.07 mg/kg/day.

Figure 10: Copy of Figure 2-8 in NRC (2006), p.85.

### More studies since 2006

Because of the huge delay in the EPA Office of Water completing the recommended risk assessment – its now been 9 years - more studies have been published since 2006, which further underline the need and urgency for a new more protective MCLG. These include many more studies on neurotoxicity, a key study on thyroid function, another on ADHD and an important study on osteosarcoma. Had these been available at the time of the NRC review it is more than likely that these would have been added to the list of endpoints cited above by the panel that should be considered in a new risk assessment.

The EPA's Office of Water in 2011 claimed that the end point of severe dental fluorosis will also protect against arthritic symptoms, bone fractures and harm to any other tissue.

Here we will start with some of the findings in the NRC review and update them with more recent studies.

## 12. NRC and Endocrine Disruption

The NRC panel labeled fluoride an endocrine disruptor. The authors state:

“The chief endocrine effects of fluoride exposures in experimental animals and in humans include decreased thyroid function, increased calcitonin activity, increased parathyroid hormone activity, secondary hyperparathyroidism, impaired glucose intolerance, and possible effects on the timing of sexual maturity. Some of these effects are associated with fluoride intake that is achievable at fluoride concentrations in drinking water of 4 mg/L or less, especially for young children or for individuals with high water intake. (p. 8, NRC 2006)

“In summary, evidence of several types indicates that fluoride affects normal endocrine function or response; the effects of the fluoride-induced changes vary in degree and kind in different individuals. Fluoride is therefore an endocrine disruptor in the broad sense of altering normal endocrine function or response, although probably not in the sense of mimicking a normal hormone.” (p. 266, NRC 2006)

The 2006 NRC report notes that six prior major reviews (1991, 1993, 1999, 2000, 2002, 2003) of the health effects of fluoride did not consider the endocrine system in detail apart from the reproductive system.

## 13. NRC on Thyroid Function

On thyroid function, the NRC panel reported: “Fluoride exposure in humans is associated with elevated TSH concentrations, increased goiter prevalence, and altered T4 and T3 concentrations; similar effects in T4 and T3 are reported in experimental animals, but TSH has not been measured in most studies.” (p. 262)

The panel also indicated that affects on the thyroid have been observed at very low levels. They state that, “In humans, effects on thyroid function were associated with fluoride exposures of 0.05-0.13 mg/kg/day when iodine intake was adequate and 0.01-0.03 mg/kg/day when iodine intake was inadequate (Table 8-2).” (p. 263, NRC 2006).

To reach these dosages (which depend on bodyweight) it takes remarkably little fluoride. For those with borderline iodine deficiency it would only take the consumption of 0.1 to 0.3 mg of fluoride per day for a 10 kg infant and 0.7 to 2.1 mg/day for a 70 kg adult. These are easily exceeded in a fluoridated community. For someone whose iodine levels are adequate for a 10 kg infant it would take between 0.5 and 1.3 mg /day and for a 70 kg adult it would take 3.5 mg to 9.1 mg/day. The lower end of these ranges would be reached by some people in a fluoridated community.

These statements have been recently buttressed by new research conducted in the UK and published in 2015.

## 14. Hypothyroid and fluoride study from UK

This study by Peckham et al., 2015 used the records of over 98% of the General practices in England on the numbers of patients treated for hypothyroidism and examined the prevalence of this condition as a function of the fluoride levels in the local drinking water supplies. The authors noted that:

“Approximately, six million people (10%) in England live in areas where drinking water contains natural fluoride or which has been artificially fluoridated at a target concentration of 1 ppm (1 mg/L). Using prevalence data from the UK QOF, an analysis was undertaken to determine whether prevalence was affected by practice populations being situated in fluoridated areas at >0.7 mg/L and areas with lower levels of fluoride. While there are other sources of fluoride in people’s diet (e.g., tea), drinking water is the most significant source of ingested fluorides in the UK.” (Peckham et al, 2015)

The UK research team found that higher levels of fluoride in drinking water was a useful predictor of the prevalence of hypothyroidism. They found that general medical practices located in the West Midlands (a wholly fluoridated area) are nearly twice as likely to report high hypothyroidism prevalence in comparison to Greater Manchester (non-fluoridated area). (Peckham et al, 2015)

They concluded:

“In many areas of the world, hypothyroidism is a major health concern and in addition to other factors—such as iodine deficiency— fluoride exposure should be considered as a contributing factor. The findings of the study raise particular concerns about the validity of community fluoridation as a safe public health measure.” (Peckham et al, 2015)

It is hard to overstate the significance of these findings.

First, Peckham’s findings are not totally unexpected. Scientific and medical research stretching back to the 1920s has shown that fluoride can affect the thyroid. In fact from the 1930s to the 1950s doctors in Argentina, France and Germany used fluoride to lower thyroid function in hyperactive thyroid patients. The levels of fluoride used overlap with the levels of exposure known to occur in some people drinking artificially fluoridated water today (Galletti & Joyet, 1958).

Second, hypothyroidism is a very common disorder in the US. In fact, one of the most prescribed drugs in the USA is synthroid, which is used to treat hypothyroidism. It can have serious adverse health effects. For a further discussion of the extent and concern about hypothyroidism in the USA see Appendix B.

Third, race may be a factor in sensitivity to certain thyroid diseases, which may make communities of color more vulnerable to fluoride’s impacts on thyroid function (see Appendix C).

Fourth, reduced thyroid function in pregnant women is linked to reduced IQ in their children and there is accumulating evidence that fluoride, at levels within the range to which fluoridated populations are exposed, is associated with lowered IQ. Fluoride’s effect on thyroid function



might be the mechanism by which it lowers IQ.

## 15. Fluoride and brain function

Whether or not the mechanism for fluoride's ability to lower IQ is caused by fluoride's interference with thyroid function in pregnant women or not, there is a huge body of evidence from animal, fetal and human studies that fluoride is a potent developmental neurotoxin (see <http://fluoridealert.org/issues/health/brain/>). The NRC examined some of that evidence in 2006 but much more has been published (or translated) since then. For example, in 2006 the NRC panel reviewed 5 IQ studies, there have been – as of Sept 2015 - 45 studies (out of 52 studies) that have found an association between lowered IQ and exposure to fairly modest levels of fluoride.

27 of these IQ studies were subjected to a meta-analysis by a team from Harvard University, which included Philippe Grandjean (Choi et al., 2012). While they noted that many of the studies had weaknesses (particularly control of a number of conflicting variables) they also noted that the results were remarkably consistent considering the investigations had been conducted in different countries (China and Iran) in widely different geographical areas, at different times and by different research teams. 26 out of the 27 studies found a lowered IQ in the “high-fluoride” village compared with the low-fluoride village. The average lowering was 7 IQ points. Such a downward shift in a large population would have huge ramifications. It would halve the number of geniuses and double the number of mentally handicapped. This in turn would have enormous social and economic consequences.

In a press release from Harvard University that accompanied the Choi et al., 2012 meta-analysis, co-author Philippe Grandjean was quoted as saying that, “Fluoride seems to fit in with lead, mercury, and other poisons that cause chemical brain drain.”

When one considers the pains that our society has taken to either eliminate or drastically reduce the use of lead and mercury (e.g. banning lead in paint, solder, and gasoline and the phasing out the use of mercury in industrial switches, thermometers and other medical equipment, as a fungicide in paint, use in alkaline batteries, limiting emissions from coal-fired power stations and incinerators, fish advisories and in some countries the use in dental fillings) all in the name of protecting children and pregnant women from known neurotoxins, it is absolutely bizarre that we should continue to knowingly add this neurotoxin (i.e. fluoride) every day to the drinking water of over 200 million people.

In a radio debate with Dr. Howard Pollick, a well-known promoter of fluoridation, Grandjean was more succinct when he said:

"Because I've worked in this field long enough to know that with time, we have always found that lead, mercury and pesticides were more toxic than we originally thought. I am not willing to sit here and say, OK, let's expose the next generation's brains and just hope for the best." (WBUR, 2015)

Fluoridation promoters have done their best to dismiss the Choi et al. 2012 findings claiming

that the fluoride concentrations in the High-Fluoride villages made the findings irrelevant to artificial water fluoridation programs. It is true that in two of the studies the fluoride concentrations ranged as high as 11 and 11.5 ppm, but this was the exception not the rule. Table 5 gives the fluoride concentrations in the 20 studies where the fluoride exposure was from water not coal and for which the concentrations was given.

**Table 5: A listing of the Fluoride concentrations in the “high-fluoride” villages in 20 of the 27 studies subjected to a meta-analysis by Choi et al., 2012. The data was compiled by Paul Connett from Table 1 in the Choi paper.**

Author/year	ppm in High F village
Chen 1991	4.55
Lin 1991	0.88
An 1992	2.1 – 7.6 (mean = 4.9)
Xu 1994	1.8
Yang 1994	2.97
Li 1995	1.81 – 2.69 (mean = 2.25)
Yao 1996	2 – 11 (mean = 6.5)
Zhao 1996	4.12
Yao 1997	2
Lu 2000	3.15
Hang 2001	2.90
Wang 2001	2.97
Xiang 2003	0.57 – 4.5 (mean = 2.54 )
Seraj 2006	2.5
Wang 2006	5.44 +/- 3.88 (1.52 – 9.32 )
Fan 2007	1.14 - 6.09 (mean = 3.62 )
Wang 2007	3.8 – 11.5 (mean = 7.65)
Li 2010	2.47 +/- 0.75 (1.72 – 3.22 )
Poureslami 2011	2.38
Wang 1996	>1- 8.6 (mean = 4.8)

Mean of 20 results (using means) = 70.49 / 20 = 3.52

Taken from Choi et al, 2012 – Table 1, pp 24-26.

From Table 5 it can be seen that many of the studies had fluoride concentrations less than 3 ppm and that the mean for all the studies combined was 3.52 ppm, which is lower than the current safe drinking water standard in the USA (4 ppm). Such levels offer **no adequate margin of safety** to protect all children in a large population drinking fluoridated water (and getting fluoride from other sources) sufficient to protect against this serious harmful effect.

Such a conclusion becomes even more obvious when we look at the details of one particularly well-conducted study (Xiang et al. 2003a,b.).

Xiang controlled for iodine intake (Xiang et al, 2003a) and lead exposure (Xiang 2003,b) and retrospectively for arsenic. The average level of fluoride in the well water for the Low-fluoride village was 0.36 ppm (range 0.18 -0.76 ppm) and the average level in the High Fluoride was 2.5

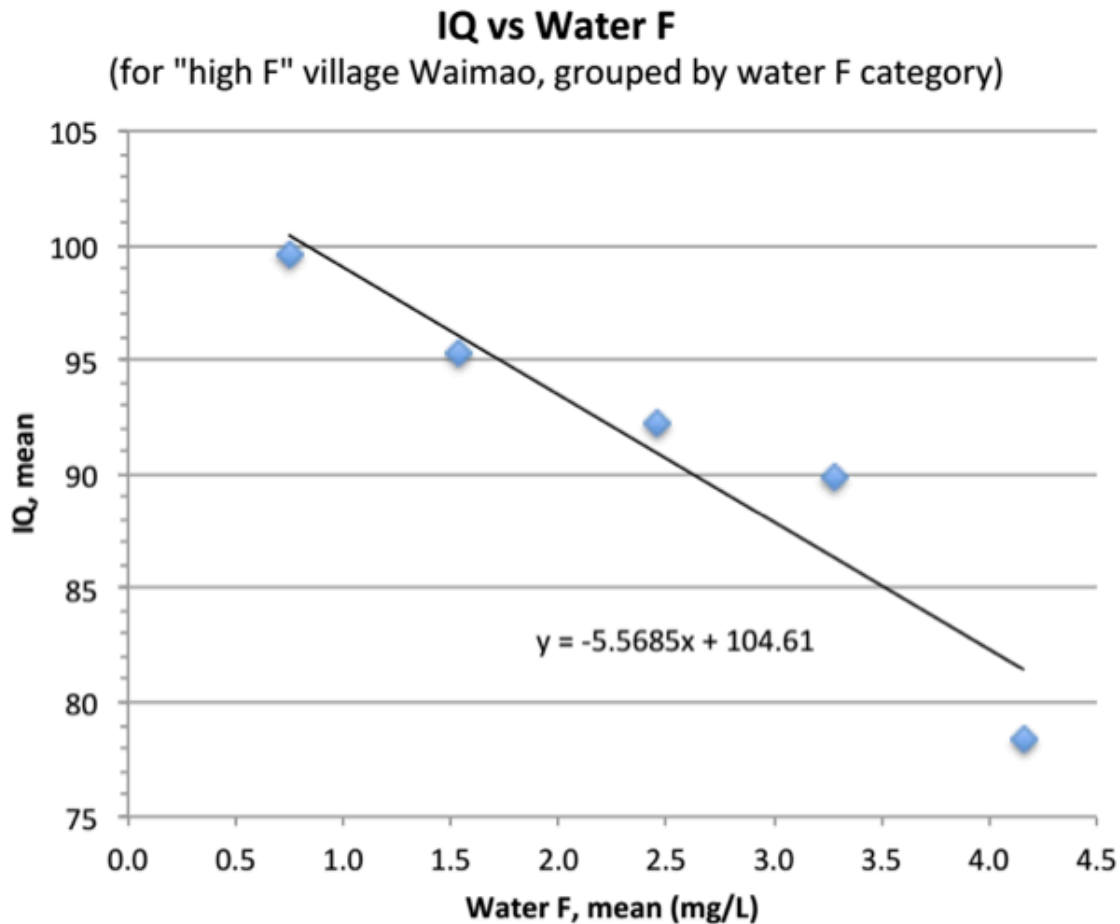
ppm (range 0.57- 4.5 ppm). The average drop in IQ was 5-10 IQ points across the whole age range. Xiang et al also sub-divided the High- Fluoride village into 5 sub-groups (A,B,C,D and E) with mean fluoride concentrations of 0.75, 1.53, 2.46, 3.28 and 4.16 ppm. As can be seen from his Table 8 (reproduced below as our Table 6) as the fluoride concentration increases in these 5 sub-groups the mean IQ decreases in an apparent linear fashion (see the results plotted graphically in Figure 11.

**Table 6: A reproduction of Table 8 in Xiang et al., 2003a**

**Table 8. Level of fluoride in drinking water and children's IQs**

Village	F in drinking water (mg/L)			No. children	IQ and rate of retardation	
	Group	No. samples	Water F level (Mean±SD)		IQ (Mean±SD)	Rate of IQ<80 (%)
Xinhuai	F	290	0.36±0.15	290	100.41±13.21	6.55
Wamiao	A	9	0.75±0.14	9	99.56±14.13	0.00
	B	42	1.53±0.27	42	95.21±12.22*	9.52
	C	111	2.46±0.30	111	92.19±12.98 <sup>†</sup>	14.41*
	D	52	3.28±0.25	52	89.88±11.98 <sup>†</sup>	21.15 <sup>†</sup>
	E	8	4.16±0.22	8	78.38±12.68 <sup>†</sup>	37.50 <sup>†</sup>

\* $p < 0.05$ . <sup>†</sup> $p < 0.01$  compared with group F.



**Figure 11: A plot of the mean IQ versus the mean IQ in the 5 sub-groups (A- E) in the high fluoride village, data taken from Table 8 in Xiang et al, 2003a.**

From this plot one can see that IQ was lowered at a concentration somewhere between 0.75 and 1.5 ppm. This overlaps the range at which communities are fluoridated in the U.S. (0.7 to 1.2 ppm). This finding offers NO margin of safety to protect all children drinking fluoridated water from this serious end point. To make matters worse still according to the authors the children in these rural Chinese villages are unlikely to be using fluoridated toothpaste nor are they likely to be bottle-fed. Thus if we take into account these two sources many American children will be getting more fluoride *from all sources combined* than these Chinese children whose IQ was lowered.

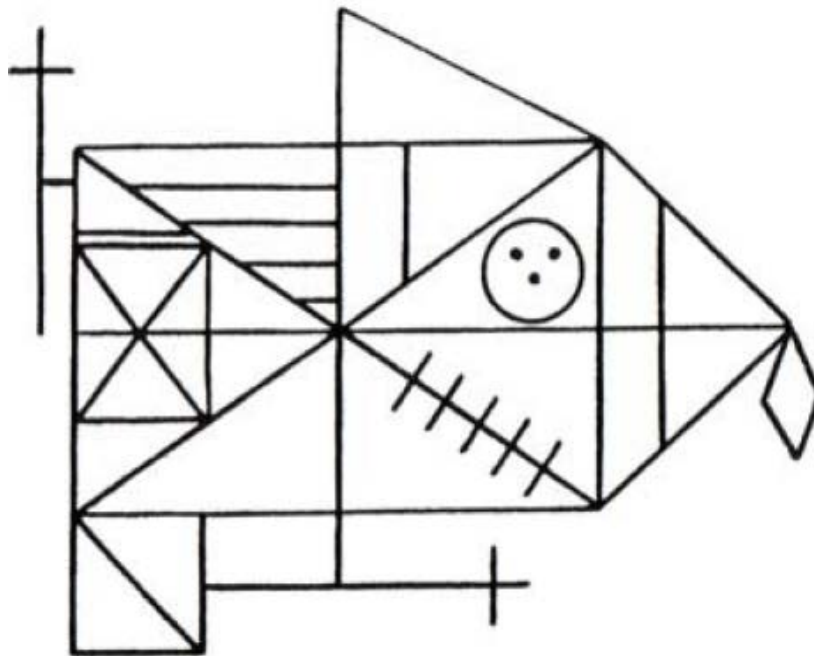
Xiang also found that as the fluoride concentration went up in the 5 sub-groups the percentage of children with an IQ less than 80 (note that an IQ 70 -80 is borderline mentally handicapped and below 70 is outright mentally handicapped) increases dramatically from 0% (at 0.75 ppm) to 37.5% at 4.16 ppm (see Xiang's Table 8 reproduced above in Table 6 ).

By sub-dividing the children in the high-fluoride village Xiang eliminated any confounding factors that may have existed between the low and high-fluoride villages.

### ***Other studies demonstrating fluoride's neurotoxicity***

The evidence that fluoride is neurotoxic does not rest entirely on the 45 IQ studies. These findings are consistent with many animal studies that show that fluoride can enter the brain and alter brain chemistry in several ways. Of particular relevance are the 31 (out of 33) studies that show that when animals are placed in mazes they learn and memorize simple tasks less well when exposed to fluoride (see <http://fluoridealert.org/issues/health/brain/> ).

There are also other human studies that have been conducted on very young children (too young to undertake IQ tests). One of these techniques tests the child's ability to copy and reproduce from memory drawings with a multiple of simple features. These have also shown that child's cognitive function is impaired by fluoride exposure. One example of this was a well-designed study from Mexico by Rocha Amador et al. (2009). They used the Rey-Osterrieth Complex Test (see Figure 12 below). They found that approximately **9 out of 10 children exposed to fluoride** were unable to copy the ROCF as expected for their age. For Immediate Recall, almost **6 out of 10 children** were unable to draw the figure as expected for their age.



**Figure 12: The Rey-Osterrieth Complex Figure Test used in the Rocha Amador et al. (2009) study.**

There have also been four studies of aborted fetuses from China, which show that those from endemic fluorosis areas have impaired brain structures compared to non-fluorosis areas (Yu, 1996; Dong, 1989; Du, 1992; He, 1989).

**The last children that need their IQ lowered in the US are children from low-income and minority families**

## **16. Fluoridation and ADHD.**

Attention Deficit Hyperactivity Disorder (ADHD) has become one of the most commonly diagnosed childhood behavioral disorders. Its basic characteristics are inattention, hyperactivity and impulsivity. “ADHD often continues into adolescence and adulthood, which can lead to medication dependency and a lifetime of treatment (Maddox, 2003).”

In early 2015 a study was published that examined the relationship between exposure to fluoridated water and ADHD prevalence among children and adolescents, ages 4-17, in the United States. The authors found that, “[s]tate prevalence of artificial water fluoridation in 1992 significantly positively predicted state prevalence of ADHD in 2003, 2007 and 2011, even after controlling for socioeconomic status. A multivariate regression analysis showed that after socioeconomic status was controlled each 1% increase in artificial fluoridation prevalence in 1992 was associated with approximately 67,000 to 131,000 additional ADHD diagnoses from 2003 to 2011. Overall state water fluoridation prevalence (not distinguishing between fluoridation types) was also significantly positively correlated with state prevalence of ADHD for all but one year examined.” (Malin & Till, 2015). See figure 13 below

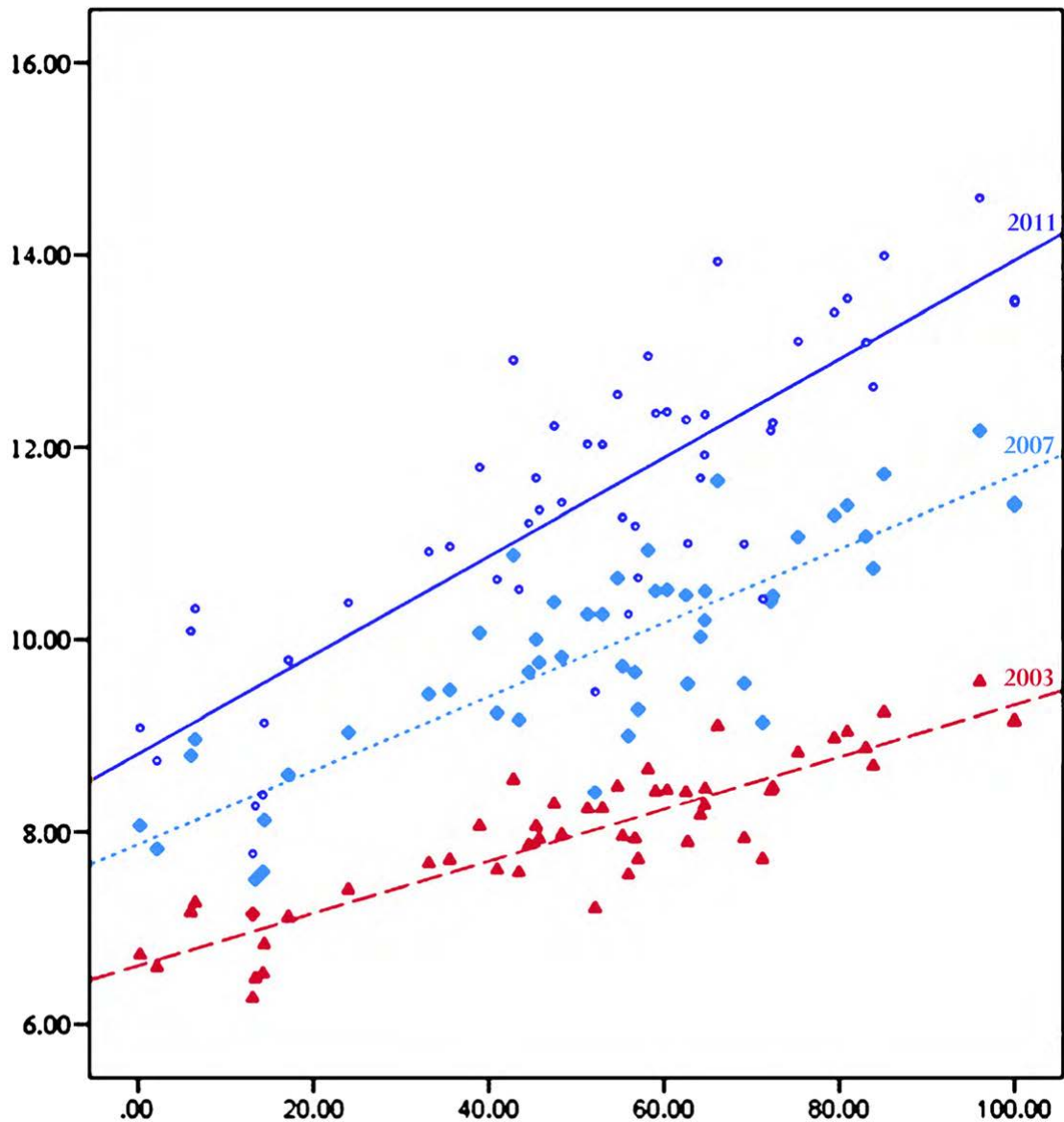


Figure 13: Percent of children with ADHD (by U.S. state) for 2003, 2007 and 2011 plotted against the % of population in each state fluoridated in 1992 (Malin & Till, 2015)

## 17. African Americans suffer greater exposure to other neurotoxins (lead and mercury)

### LEAD

Lead exposure and lead poisoning have been concerns for decades in African American communities. The Huffington Post cites a CDC report that says that lead poisoning is a disease that primarily impacts African-Americans. According to the CDC (Jones et al.), children of color whose families are poor and who live in housing built before 1950 have the highest lead poisoning risk:

On average, between 1999 and 2004, **black children were 1.6 times** more likely to test positive for lead in their blood than white children. And among children who tested positive for extremely high lead levels ( $\geq 10$  micrograms per deciliter), the disparity was even more stark. Black children were nearly three times more likely than white children to have highly elevated blood-lead levels, the type of lead poisoning where the most damaging health outcomes occur. (Jones et al., 2009).

### Combined Lead and fluoride exposure

As far we know, no federal agency has published anything on the synergistic effects of exposure to fluoride and lead. The Agency for Toxic Substances and Disease Registry (ATSDR, 2004) produced an “interaction profile” to exposures of the mixture containing uranium, fluoride, cyanide and nitrate. However, no information was available on any interaction.

***There are some experiments that have exposed animals to a combination of lead and fluoride. These have reported the following:***

- Liu et al. (2008) reported that co-exposing rat pups to lead and fluoride resulted in “alterations in testis morphology and sperm quality, including low viability and high abnormality, thereby suggesting that disturbance of energy metabolism may be one of the mechanisms by which F or Pb affects the male reproductive system.”
- In the animal study cited above by Leite et al. (2011), rats treated with both lead and fluoride had worse dental fluorosis than rats treated with fluoride alone.
- Niu et al. (2009) rat study: “Results showed that the learning abilities and hippocampus glutamate levels were significantly decreased by F and Pb individually and the combined interaction of F and Pb. The activities of AST and ALT (markers of lead toxicity) in treatment groups were significantly inhibited, while the activities of GAD were increased, especially in rats exposed to both F and Pb together. These findings suggested that alteration of hippocampus glutamate by F and/or Pb may in part reduce learning ability in rats.”
- Niu et al. (2008) study with adult rats: “From results of the Y-maze test, we can see a significant decrease in learning ability of animals in the HiF+HiPb (High fluoride with high lead) group.”
- Panov et al. (2015) reported the following from a study where rats were exposed to both fluoride and lead:
  - \* Comparison of the values obtained for the groups of separate and combined exposure shows that, for the majority of the toxicodynamic indices, the combined effect is more marked than the effect of fluoride alone or lead alone.
  - \* With a combined exposure of lead and fluoride (but not alone) significant reduction in the thyrotropin level was observed. Thyrotropin is a hormone secreted by the pituitary gland that regulates the production of thyroid hormones.



\* Neither fluoride nor lead produced a reduction in triiodothyronine level, but it was reduced under the combined effect (i.e. overt synergism took place). On the contrary, at exposure to lead alone or in combination with fluoride the level of thyroxine was raised.

In addition to the interaction between lead and fluoride is the additional problem that the chemicals used to fluoridate water appear to interact with chloramine (a common disinfection agent) to increase the dissolution of lead from brass fittings (see Appendix D).

## MERCURY

According to Kaste et al. (1996), national data indicate that 80% of tooth decay in children is concentrated in 25% of the child population, with low-income children and racial/ethnic minority groups having more untreated decay on average than the U.S. population as a whole. This means that they also have greater exposure to mercury via mercury amalgam fillings.

According to the Food & Drug Administration,

Dental amalgam is a mixture of metals, consisting of liquid (elemental) mercury and a powdered alloy composed of silver, tin, and copper. **Approximately 50% of dental amalgam is elemental mercury by weight.** The chemical properties of elemental mercury allow it to react with and bind together the silver/copper/tin alloy particles to form an amalgam.

Dental amalgam fillings are also known as “silver fillings” because of their silver-like appearance. Despite the name, “silver fillings” do contain elemental mercury (FDA, 2015).

According to Counter & Buchanan (2011), “Children are particularly vulnerable to Hg intoxication, which may lead to impairment of the developing central nervous system, as well as pulmonary and nephrotic damage...” Exposures from dental amalgams “release Hg vapors, and Hg<sub>2</sub><sup>+</sup> in tissues... [and] fetal/neonatal Hg exposure from maternal dental amalgam fillings.” The authors state:

It has been known for sometime that dental amalgam is a major source of Hg<sup>0</sup> (elementary mercury) exposure in humans because Hg is the principal metal in most dental fillings (approximately 50% Hg by weight) (Nadarajah et al., 1996). The health effects of dental amalgam Hg have been a subject of considerable debate for years, with no scientific consensus on an association between amalgam Hg exposure and adverse health consequences, either in adults or children (Clarkson, 2002; Ratcliffe et al., 1996). However, questions have been raised regarding a possible association between maternal Hg dental fillings and the health of the developing fetus, neonate, and infant. Significant levels of Hg have been measured in oral vapor, blood, and in organs of animals and humans with Hg containing dental amalgam restorations (Abraham et al., 1984; Snapp et al., 1989; Vimy et al., 1990, 1997). In the oral cavity, Hg<sup>0</sup> vapor is rapidly oxidized to inorganic divalent Hg (Hg<sub>2</sub><sup>+</sup>) in vivo after release from dental amalgam and absorbed through inhalation.

## 18. Association of pre-term births in upstate New York with community water fluoridation

According to the CDC:

In 2012, preterm birth affected more than 450,000 babies—that's 1 of every 9 infants born in the United States. Preterm birth is the birth of an infant before 37 weeks of pregnancy. Preterm-related causes of death together accounted for 35% of all infant deaths in 2010, more than any other single cause. Preterm birth is also a leading cause of long-term neurological disabilities in children. Preterm birth costs the U.S. health care system more than \$26 billion in 2005.

<http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PretermBirth.htm>

In November 2009, Hart et al. presented an abstract at the American Public Health Association on the "Relationship between municipal water fluoridation and preterm birth in Upstate New York." In part, the authors stated:

"The annual incidence of preterm birth (PTB) (<37 weeks gestation) in the United States is approximately 10% and is associated with considerable morbidity and mortality. Current literature suggests an association between periodontal disease and PTB. Domestic water fluoridation is thought to have lessened the burden of dental disease. Theoretically, one would expect water fluoridation to be protective against PTB. The aim of our study was to examine the relationship between municipal water fluoridation and PTB.

**Domestic water fluoridation was associated with an increased risk of PTB (9545 (6.34%) PTB among women exposed to domestic water fluoridation versus 25278 (5.52%) PTB among those unexposed,  $p < 0.0001$ )). This relationship was most pronounced among women in the lowest SES groups (>10% poverty) and those of non-white racial origin.** Domestic water fluoridation was independently associated with an increased risk of PTB in logistic regression, after controlling for age, race/ethnicity, neighborhood poverty level, hypertension, and diabetes (Hart et al., 2009).

In 2013, the Henry J. Kaiser Family Foundation reported that non-Hispanic blacks had the highest rate for *"Preterm Births as a Percent of All Births by Race/Ethnicity."*

16.3% - Non-Hispanic Black

11.3% - Hispanic

10.2% - Non-Hispanic White

<http://kff.org/other/state-indicator/preterm-births-by-raceethnicity/>

## 19. State Oral Health Reports have provided little or no information on dental fluorosis and no warnings to communities of color on their extra vulnerabilities

While the federal government has been grossly negligent about warning communities of color about their findings that they are more vulnerable to dental fluorosis, at least they have provided important dental fluorosis data on the national level which allows interested parties to find out what is going on if they had the time and inclination to do so (Beltrán-Aguilar, 2005, 2010).

However, this has not happened to any significant extent at the state level. Most of the state reports on oral health (many funded by the CDC's Division of Oral Health) have provided no dental fluorosis rates and no racial breakdowns to the public. As a result practically no warnings have emerged at the state level. In Appendix E we have presented what we were able to find on these matters from reviewing **119 state reports published between 2000 and 2015**. Incredibly, 109 of these reports contained not one mention of dental (or enamel) fluorosis. Of the remaining 10 reports only two presented statistics on dental fluorosis. Two reports gave statistics for "white spot lesions" in Head Start children. While no definition of "white spot lesion" was given in the reports, it could include fluorosis as it is seen in the primary teeth (Warren et al., 1999; Hong et al 2006a) but most frequently observed in the secondary teeth.

- The 2011 Washington state report gives the rate for White Spot Lesions in Head Start/ECEAP Preschoolers at 20.5%, with African American children having the highest percent.
- The 2007 Georgia report notes: "20% of 2 to 5 year old Georgia Head Start children surveyed have white spot lesions."

A small non-profit called the Fluoride Action Network, not paid for, or funded by, any federal or state agency working on infant health, childhood health, or oral health, succeeded in getting New Hampshire to become the first state to require notification that infants under 6-months of age should not be routinely fed infant formula mixed with fluoridated water. The law passed in August 4, 2012, *against the opposition of nearly every health and oral-health group in the state (see list below)*, is a proactive approach to reduce fluorosis rates by notifying parents about the risk posed to their infants by fluoridated water so they can take action to prevent a further increase in overexposure to fluoride.

It was passed by the New Hampshire House, 253-23, unanimously by the Senate, and signed by the Governor, the legislation (HB-1416) read:

*"If a public water supply is fluoridated, the following notice shall be posted in the water system's consumer confidence report: 'Your public water supply is fluoridated. According to the Centers for Disease Control and Prevention, if your child under the age of 6 months is exclusively consuming infant formula reconstituted with fluoridated water, there may be an increased chance of dental fluorosis. Consult your child's health care provider for more information.'"*

The law requires the above notice on all annual water consumer confidence reports in fluoridated communities, which must be mailed to all water consumers, be posted on water department websites, and available at city halls.

The legislation was initially introduced in 2011, but was killed in the House Health and Human Services committee, which at the time was chaired by a retired dentist and proponent of fluoridation. In 2012 the bill was sent to a different committee, the House Municipal and Public Works committee, **where it was approved by a 13-2 vote despite the same opposition it had met a year earlier by more than a dozen groups, including the**

**New Hampshire Dental Association**  
**New Hampshire Oral Health Coalition**  
**Delta Dental**  
**American Water Works Association**  
**Municipal Association**  
**Oral Health Advocacy Taskforce**  
**Dental Hygienists' Association**  
**Partners for a Healthier Community**  
**Health Law Advocates**  
**PEW Charitable Trusts**  
**Granite State Children's Alliance (PEW Grantee)**  
**New Hampshire Department of Health and Human Services**

The simplest explanation for this negligence is that those who specialize in oral health are far more interested in promoting water fluoridation, than revealing its downside. However, whatever the explanation, minority communities have every reason to feel let down by those who are paid to protect their health.

In Appendix F we also examine the oral health reports prepared by private entities like the Pew Foundation. Again we find little or no discussion of dental fluorosis or the different prevalence for different races. Clearly their interest is in promoting fluoridation with little desire in undermining their message that fluoridation is “safe and effective” and certainly no desire to draw attention to the disproportionate harm this practice is causing poor and minority communities.

## **20. Civil Rights Leaders mobilize to fight fluoridation because of the increased risks to minority communities.**

Beginning in March 2011 Civil Rights leaders began to speak out publicly about the lack of warning from the CDC and other health agencies about the higher rates of dental fluorosis and extra vulnerability of minority communities to fluoride's toxic effects. Below we provide excerpts of the statements from prominent leaders on this issue. Links to the full text of each statement listed below is in Appendix G.

We present them in chronological order starting with Rev. Durley's letter of March 9, 2011, presented in full.

1) March 9, 2011. Letter from Dr. Gerald L. Durley, Pastor, Providence Baptist Church, to Senator Chip Rogers, Senate Majority Leader, Georgia State Capital, Atlanta. **Re: Repeal of Georgia's Mandatory Fluoridation Law.**

Dear Senator Rogers,

As a citizen, a minister, and a community leader, I am writing to state my opposition to the practice of water fluoridation, and to ask that the current Georgia law mandating water fluoridation throughout our state be repealed.

First and foremost, water fluoridation takes away people's choice. We have a God-given right to not have fluoride forced into our bodies or the bodies of our children. Fluoridation supporters attempt to say that people are not forced to drink fluoridated water, but that is a disingenuous statement that ignores reality. Many families do not have funds to buy an expensive home water fluoride removal system, or to buy unfluoridated bottled water for making their babies' milk formula, so in truth they are forced to drink fluoride in their water simply because of their economic status or household income.

Second, fluoridation disproportionately harms members of the black community. The Centers for Disease Control's own information acknowledges that blacks have significantly more "dental fluorosis" teeth staining than whites. For many, the stains are not simply "barely visible" or "faint" in color, or "just a cosmetic issue" as fluoridation promoters call it. Common sense tells us that if fluorides affect the teeth, which are the hardest surfaces of the body to cause permanent staining, certainly other soft tissue organs in the body are affected. Also, the National Research Council of the National Academy of Science, has designated kidney patients, diabetics, seniors, and babies as "susceptible subpopulations" that are especially vulnerable to harm from ingested fluorides. Black citizens are disproportionately affected by kidney disease and diabetes, and are therefore more impacted by fluorides.

Third, we cannot control the dose of fluoride people ingest if we put fluoride in drinking water. Layered on top of this, we do not know what each person's medical history or nutritional status is. Therefore, the "one size fits all" approach to fluoridation makes no sense at all.

We need to focus on helping people get access to dentists. Lack of fluoride does not cause cavities. Too many sugars on the teeth, lack of access to dental care, and lack of dental health education –these cause cavities.

We also need to know why the full story about harm from fluorides is only just now coming out. I support the holding of Fluoridegate hearings at the state and national level so we can learn why we haven't been openly told that fluorides build up in the body over time, why are government agencies haven't told the black community openly that fluorides disproportionately harm black Americans, and why we've been told that decades of extensive research show fluoridation to be safe, when the National Research Council in 2006 listed volumes of basic research that has never been done. This is a serious issue for all Americans, of every race and in every location.

2) March 29, 2011. Letter from **Ambassador Andrew Young** to Chip Rogers, Senate Majority Leader, Georgia State Capitol, Atlanta, GA.

I am writing to convey my interest in seeing that Georgia's law mandating water fluoridation for Georgia communities be repealed...

I am most deeply concerned for poor families who have babies: if they cannot afford unfluoridated water for their babies milk formula, do their babies not count? Of course

they do. This is an issue of fairness, civil rights, and compassion. We must find better ways to prevent cavities, such as helping those most at risk for cavities obtain access to the services of a dentist

3) April 6, 2011. Letter from **Matt Young, DDS**, President, International Academy of Oral Medicine and Toxicology, to Thomas Frieden, MD, MPH, Director, Centers for Disease Control and Prevention, Atlanta, GA. RE: Disproportionate Harm From Water Fluoridation to Babies, Kidney Patients, and African Americans.

As President of the International Academy of Oral Medicine and Toxicology, I am writing to communicate our organization's concern that the CDC-supported practice of water fluoridation disproportionately harms certain subsets of the population: such as babies, kidney patients, and African Americans.

There is much science we could cite here, but the purpose of this letter is to succinctly summarize the basis for our conclusion that fluoridation must end.

4) June 2011. **Alveda King**, nationally known minister and niece of civil rights leader Martin Luther King Jr.:

"This is a civil rights issue ... No one should be subjected to drinking fluoride in their water, especially sensitive groups like kidney patients and diabetics, babies in their milk formula, or poor families that cannot afford to purchase unfluoridated water. Black and Latino families are being disproportionately harmed."

5) July 1, 2011. A Resolution on fluoridation was passed by the **League of United Latin American Citizens (LULAC)** titled, Civil Rights Violation Regarding Forced Medication.

WHEREAS, minority communities are more highly impacted by fluorides as they historically experience more diabetes and kidney disease; and...

WHEREAS, minorities are disproportionately harmed by fluorides as documented by increased rates of dental fluorosis (disfiguration and discoloration of the teeth); and...

WHEREAS, the CDC now recommends that non-fluoridated water be used for infant formula (if parents want to avoid dental fluorosis – a permanent mottling and staining of teeth), which creates an economic hardship for large numbers of families, minority and otherwise...

6) April 2013. **Portland chapter of the NAACP** voted to oppose the fluoridation of the public water supply.

... Clifford Walker, chair of the branch veteran's committee, says he believes the vote was unanimous. They had been **debating the issue vigorously** for several months," Walker says. "People with **diabetes** would be [affected] by adding fluoride to the water. African-Americans have a higher rate of diabetes." The decision, he says, is "in the best interest of our constituents."

A key narrative of this spring's fluoridation campaign has been that **fluoride supporters had gathered a coalition of 80 groups representing low-income and minority Portlanders**, while the anti-fluoride campaign had none.

WW [reported this morning](#) that the pro-fluoridation campaign, Healthy Kids Healthy Portland, has **rewarded that support with cash payments totaling more than \$119,000**. Groups like the Urban League, the Native American Youth and Family Center and the Latino Network are using that money for "outreach," according to Eryn Mitchell, the campaign manager for Healthy Kids. (Mesh, 2013)

7) November 11, 2014. A Resolution was passed by the **Santa Rosa-Sonoma County NAACP** Opposing Fluoridation of Our Public Water Supply.

Whereas: Studies have found that in fluoridated communities, African-American and Latino children are at greater risk for dental fluorosis (discolored teeth from damaged tooth enamel caused by fluoride exposure) and,

Whereas: Former Ambassador Andrew Young, one of many civil rights leaders opposed to fluoride, has pointed out that: "we...have a cavity epidemic today in our inner cities that have been fluoridated for decades"

8) May 11, 2015: Letter from **Rev. William (Bill) Owens, President of the Coalition of African American Pastors** to Rep. Barry Loudermilk, Chairman, House Subcommittee on Oversight / Science, Space, & Technology Committee, Washington DC:

African Americans should have been told that we are disproportionately harmed by "dental fluorosis," the disfigurement of teeth caused by overexposure to fluorides as a young child. And who among us was told that kidney patients, diabetics, seniors, and children are susceptible subgroups that are especially vulnerable to harm from fluorides? There are more patients with kidney disease and diabetes in the black community, and this is all the more reason federal officials should have told us that kidney patients and diabetics are especially vulnerable to harm. Additionally, low-income families often times lack the resources to purchase unfluoridated water or a filtration system to remove fluoride from drinking water.

## **21. The emergency "fluoridation-defense" meeting held at Morehouse College**

After the statements from civil rights leaders became public (Lillie Center, 2011; FAN, 2011c), Ambassador Young and Rev Gerald Durley were invited to a hastily organized semi-confidential meeting held at Morehouse College on June 1, 2011.

Freedom of Information documents reveal the enormous concern that the pro-fluoridation lobby (both inside and outside government) had about the traction the statements by the Civil Rights leaders were receiving both in the media and on the internet. An extraordinary number of important and influential governmental and professional representatives were brought together for this meeting.

This “army of officials” was a magnified version of the “shock and awe” tactics used to intimidate decision makers should they ever have the temerity to question the wisdom of the fluoridation program. Council chambers are flooded by dentists, dental students, local and state dental and health spokespersons claiming that if they should end fluoridation they would be threatening the future health and well-being of their children.

Those at the Morehouse meeting included the following (FAN, 2015a):

- Dr. David Satcher (former US Surgeon General)
- Dr. John Maupin, Morehouse School of Medicine
- Gwen Keyes Fleming, EPA, Administrator Region IV
- Dr. Ursula Bauer, Director, National Center for Chronic Disease Prevention and Health promotion
- Dr. Scott Presson, CDC program services
- Dr. Gina Thornton-Evans – CDC oral health epidemiologist
- Dr. Desmond Williams, Lead, Chronic Kidney Disease Initiative

#### **Department of Health and Human Services/Office of Minority Health**

- Dr. Garth Graham –Deputy Assistant Director for Minority Health
- Dr. Rochelle Rollins, Director, Division of Policy and Data
- Dr. Arlene Lester, Regional Minority Health Consultant, Georgia State

#### **National Dental Association**

***(The NDA represents over 6,000 Black dentists, and 30 million Black Americans)***

- Dr. Elizabeth Lense, State Dental Director, NDA
- Dr. Sheila Brown, President, NDA
- Dr. Roy Irons, DDS
- Dr. Kim Perry, Chairman of the Board, NDA
- Mr. Robert Johns, ED

#### **American Dental Association (ADA)**

- Dr. Bill Cainon, Pres-Elect, ADA
- Dr. Leon Stanislav, former Chairman NFAC
- Judy Sherman, Washington DC office, ADA

This was a lot of muscle to use against the two Civil Rights leaders who attended this meeting. It is a pity that a fraction of that muscle power has not gone into informing minority communities about the special risks posed to them by fluoride and water fluoridation. Some people might be impressed that so much effort is going into protecting children’s teeth, for others it is disheartening that the rest of their bodies cause so little concern.

## **22. A better way of tackling tooth decay in the inner city and address other EJ issues**

Here we offer a creative and positive holistic approach to address dental decay and other aspects of Environmental Justice in the Inner City. Our suggestions are in line with items I and II



of the “Action agenda on three collective and strategic goals for fiscal years 2016- 2018” of the Inter Agency Working Group on Environment Justice (EJ IWG), namely:

- I. Enhance communication and coordination to improve the health, quality-of-life, and economic opportunities in overburdened communities;
- II. Enhance multi-agency support of holistic community-based solutions to solve environmental justice issues

**Our 5-step alternative plan to water fluoridation for low-income areas and the inner city.**

**1) End water fluoridation.** This could be accomplished swiftly by the US EPA Office of Water (OW). If OW were to determine the safe dose of fluoride that would protect all our children from lowered IQ it would force an immediate end to fluoridation. Such protection against fluoride’s neurotoxic effects would improve the “health, quality-of-life, and economic opportunities” for children and young people in many ways, especially from low-income families.

**2) Establish the equivalent of Scotland’s very successful Childsmile program** in all kindergarten and primary schools (and possibly churches and WIC programs) in low-income areas. In this program involving both teachers and parents, children are taught to brush their teeth properly; are provided more nutritious snacks and beverages and encouraged to reduce sugar consumption. The program also provides annual dental check-ups and treatment if required. This could be combined with a program along the lines of the Danish program for pre-school toddlers – see Appendix I.

**3) Set up dental clinics either in schools or stand-alone facilities in the inner city** and other low-income areas. Recruit dentists, dental hygienists and nutritionists to provide part-time pro bono services to these clinics and support the educational services in step 2.

**4) Expand these dental clinics into community centers** aimed at improving the child’s overall health, nutrition and physical fitness as well as stimulating other health supporting activities. Such a center, depending on local interest and skills could include keep-fit equipment and classes, community gardens, community composting, cooking, nutritional and canning advice. Depending upon demand It might also be linked to local farms..

**5) Expand these communities still further into job creating operations.** One example we know that works well is a “reuse and repair” operation to handle discarded appliances, furniture and other reuseable items from the local and nearby communities. Reuse and repair can also involve job training, skill-sharing, tool sharing, a community workbench and value added enterprises. Such an operation can be linked to a Zero Waste strategy involving source separation, composting, recycling and other waste reduction and prevention initiatives. This strategy not only fights the pollution generated by landfills and incinerators (which are often sited in low-income areas), it also provides many jobs and local business opportunities. One of the authors of this report has lectured and written extensively in this area, see *The Zero Waste Solution: Untrashing the Planet One Community at a Time* by Paul Connett (Chelsea Green, 2013). There are many other creative schemes including

community gardens, a community culinary school that teaches new chefs how to make food that is inexpensive, tasty and nutritious, and many many more.

- 6) It is not difficult to see how many federal and local agencies could be involved with such an ambitious scheme. These could include the HHS as well as the departments of Education and Agriculture and the waste management folks at the EPA. Step 5 could be integrated with the ongoing efforts along these lines in many municipalities. This is one of many ideas that with a little creativity a community can embrace.

More than anything else a holistic approach allows the transition from the politics of “no” to the politics of “yes.” Once we get off the shortsighted notion that we can battle tooth decay by putting a neurotoxic chemical into the public drinking water, we can unleash not only the full potential of the child, but also of our communities and maybe even our civil and professional services. The three key words are education, nutrition and justice. We need education not fluoridation to fight tooth decay and obesity. We need healthy soil, to produce healthy food to produce healthy people to produce a healthy economy and ultimately a healthy planet and we need Environmental Justice for all. A great deal can be achieved with creativity and vision. A threatened community is a strengthened community when people work together to solve their problems in a creative and positive way..

### **23. FAN responds to HHS Jan 7, 2011 announcement proposing to lower recommended level of fluoride in water to fight tooth decay**

In a joint press release issued January 7, 2011, the Department of Health and Human Services and the Environmental Protection Agency’s Office of Water (OW) announced a recommendation to lower the level of fluoride in community water fluoridation schemes to 0.7 mg/L (down from the level set in 1962: 0.7 to 1.2 mg/L) (HHS, 2011). In this announcement Assistant Secretary for Health Howard K. Koh said: **“One of water fluoridation’s biggest advantages is that it benefits all residents of a community...”** Simultaneous with this announcement the public was encouraged to submit **comments** on this new recommendation. On April 19, 2011, the Fluoride Action Network (FAN) responded with two submissions (a,b) and documented the issue of Environmental Justice as it pertains to fluoridation and African Americans (FAN, 2011a).

On April 19, 2011 FAN sent a letter to the then director of HHS Kathleen Sebelius. Subsequently approximately 18,000 people sent in emails in support of this letter. A full copy of the letter can be found in Appendix H. Below is a shortened version.

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Fluoride Action Network  
February 4, 2011

#### **To HHS and Honorable Secretary Sebelius**

In response to your request for comments on the recent change in your recommended level of fluoride added to community drinking water, I respectfully submit the following points

supporting the stance that a reduction in fluoride levels is not sufficient, and that the United States should follow the approach of western Europe and end water fluoridation completely:

- Fluoride is not a nutrient, nor is it essential for healthy teeth...
- Using the water supply to mass medicate the population is unethical...
- The benefit and safety of ingested fluoride has never been proved by accepted medical standards...
- Any benefits of fluoride are primarily topical, not systemic...
- Americans will still be over-exposed to fluoride at 0.7 ppm.,,
- African-American children and low-income children will not be protected...
- HHS has failed to consider fluoride's impact on the brain...
- HHS has failed to consider fluoride as an endocrine disruptor...
- HHS has failed to consider or investigate current rates of skeletal fluorosis in the U.S. ...
- HHS has failed to consider fluoride as a potential carcinogen...
- HHS has failed to confirm the safety of silicofluorides...

Most of the arguments listed above are covered in far more detail in the recently published book "The Case Against Fluoride" by Connett, Beck and Micklem (Chelsea Green, 2010). We urge director Sebelius to appoint a group of experts from HHS, who have not been involved in promoting fluoridation, to provide a fully documented scientific response to the arguments and evidence presented in this book. Were director Sebelius to do this we strongly believe that neither she nor these experts will want to see the practice of water fluoridation continue. The practice is unnecessary, unethical and hitherto the benefits have been wildly exaggerated and the risks minimized. A scientific response to this book from a HHS team would allow the public to judge the cases both for and against fluoridation on their scientific and ethical merits.

#### **24. FAN's critique of the EPA's initial steps to determine a new MCLG for fluoride**

In the timeline above (see section 5) it has already been explained how inappropriate it was for the EPA Office of Water (OW) at the HHS/EPA joint press conference on Jan 7, 2011 to indicate that it was going to take into account the benefits of the water fluoridation program while determining a new MCLG (safe drinking water standard goal) for fluoride in water (HHS, 2011a). Here we will address concerns about the way they have gone about determining the MCLG and indicate a) that it is based upon poor scientific assumptions and b) how it is insensitive to EJ issues.

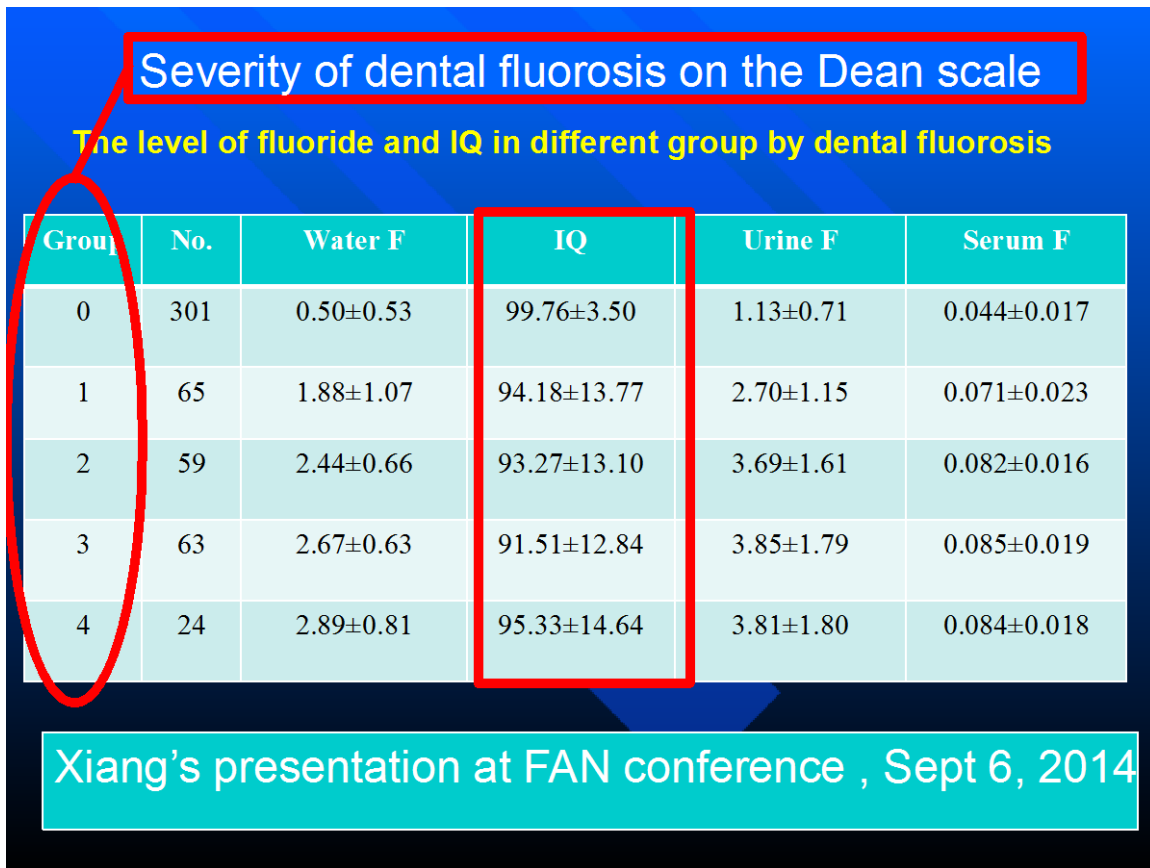
In determining a new MCLG for fluoride the EPA announced that they were going to use **severe**

**dental fluorosis** as the most sensitive health effect for fluoride. They argued that if they found a safe level (safe reference dose or RfD) that protected against severe dental fluorosis it would protect against impacts on all other tissues including bones in adults. In so doing they completely ignored all the scientific evidence sent to them by Fluoride Action Network (FAN, 2011a,b; Thiessen 2011, 2015) and others that fluoride is a neurotoxin that has been associated with lowered IQ in children – a far more serious end point as far as protecting the population is concerned.

In order to support its hypothesis that severe dental fluorosis was the most sensitive outcome to fluoride's toxicity the EPA would have to show that in all the studies where IQ has been lowered (45 studies as of September 2015 at <http://fluoridealert.org/studies/brain01/>) *all the children with lowered IQ* had **severe** dental fluorosis. If any had moderate, mild or very mild dental fluorosis their hypothesis collapses. The EPA has not shown this; instead they have simply ignored all the evidence presented to them on IQ studies. In a delegation to the EPA's OW on Sept 8 2014 FAN provided evidence that children with moderate, mild and even very mild dental fluorosis had a lowered IQ. This evidence came from Xiang's important IQ study from 2003. Xiang was part of the delegation. EPA OW continues to remain silent on this evidence.



**Figure 14: A photo taken of the FAN delegation (from left to right: Quanyong Xiang, Paul Connett, Chris Neurath and Bill Hirzy) outside the EPA's Headquarters after they had met with two top officials at the EPA Office of Water on Sept 8, 2014**



**Figure 15: A copy of a slide in Dr. Quanyong Xiang's presentation at the FAN conference in Crystal City, Sept 6, 2014. The left hand column (0,1,2,3,4) corresponds to Dean's classification of the different levels of dental fluorosis (0 = none, 1 = very mild, 2 = mild, 3 = moderate and 4 = severe. Note by comparing with column 4 that children had lowered IQ who had very mild, mild and moderate dental fluorosis. This refutes the claim by the OW that *severe* dental fluorosis is the most sensitive health effect of fluoride exposure. Lowered IQ is a more sensitive end point.**

The EPA further indicated in the calculations made available simultaneously in the Federal Register (HHS, 2011b) that they were going to use Dean's studies from the 1940's to estimate the threshold level where **severe** dental fluorosis would occur. Having estimated that level they then applied an "uncertainty factor of 1" to protect all the members of society – including the most vulnerable – from this effect.

Normally a factor of 10 is used to extrapolate from the study group to protect a large population to account for the very wide range of sensitivity expected in any large population (this is sometimes referred to as the intra-species variation factor). An uncertainty factor of 1 means 100% certainty that Dean's study in the 1940s was so large and so inclusive that it covered the full range of sensitivity of the total US population of children in the 21<sup>st</sup> century. This is extraordinarily cavalier. In his early studies (from the 1930s) Dean did look at age, sex and color and even mentioned in a 1933 paper, the case of a negro girl with mottled teeth in the bicuspid who used the fluoride water for just three years. However, in his 21-city study from 1942 he focused only on white children. Dean states, "The Study embraced 7,257 **white** urban school

children, aged 12 to 14 years of 21 cities...” (our emphasis).

Thus the only children who featured in Dean’s 21-city study were white – so it wasn’t even inclusive of the US population in 1942, let alone in the twenty-first century.

By using studies that did not include low-income families and communities of color clearly makes the EPA’s calculations inappropriate for estimating a level which would protect every child from severe dental fluorosis – **without a safety factor applied to it** - especially in the light of the discussion above that indicates that both Blacks and Hispanics are more sensitive to dental fluorosis than Whites. Choosing an uncertainty factor of one is scientifically indefensible on the one hand, and betrays an insensitivity to EJ issues on the other.

If the EPA is serious about eliminating environmental injustice from its policy decisions this is a classic case to address. In determining a safe reference dose for fluoride and a new MCLG the EPA OW has to do two things:

1) They need to provide evidence that severe dental fluorosis is a more sensitive end point than lowered IQ. The last children in the U.S. who need their IQ lowered are children from low-income families.

2) Even if they use severe dental fluorosis as the end point they need to use a more appropriate database and uncertainty factors to produce a safe reference dose to protect all individuals in society including the most vulnerable.

If they don’t do either of these things it will make a mockery of the Presidential Executive Order of 1994: ***“Federal agencies must identify and address, as appropriate, “disproportionately high and adverse human health or environmental effects of their programs, policies, and activities on minority populations and low-income populations.”*** (Presidential Executive Order 12898 of February 11, 1994)

The above discussion updates our concerns to those we submitted in two formal responses to the OW’s reports, which appeared in the Federal Register at the same time as their press conference of Jan 7, 2011.

FAN’s two formal responses submitted to the EPA’s Office of Water in April 2011 can be accessed online at:

[http://www.fluoridealert.org/wp-content/uploads/epa-2010.dose\\_.pdf](http://www.fluoridealert.org/wp-content/uploads/epa-2010.dose_.pdf)

and

<http://www.fluoridealert.org/wp-content/uploads/fan.exposure.revised.4-22-11.pdf>

Below we have given a skeletal summary of our responses so that readers will have a quick access to the many criticisms we had of OW’s assumptions and calculations in both documents.

**A) A summary of FAN’s Responses to EPA OW’s report, [Fluoride: Dose-Response Analysis For Non-cancer Effects](#).**

***We identified 16 flaws in the  
(safe reference dose)***

*m e t h o d o l o g y   a n d   r*

**We argued that**

- 1) *Consideration of the adverse effects of fluoride should take precedence over any presumed benefits in OW's determination of an RfD and MCLG*
- 2) *OW has failed to offer convincing evidence that severe dental fluorosis should be considered the critical effect associated with exposure to fluoride.*
- 3) *failed to consider potential variation in responses to the different types of fluoride in drinking water.*
- 4) *failed to apply appropriate safety factors.*
- 5) *unnecessarily delayed consideration of the potential carcinogenicity of fluoride.*
- 6) *failed to consider fluoride's effects on the brain.*
- 7) *failed to consider fluoride as an endocrine disruptor.*
- failed to consider the disproportionate impact on a number of susceptible populations in its analysis.***
  - 8) *disregarded pregnant women and embryos/fetuses in its analysis.*
  - 9) *completely ignored infants 0-6 months of age in its analysis, and has failed to consider the disproportionate burden placed on bottle-fed infants.*
  - 10) *failed to consider the disproportionate impact on above-average water consumers, which account for at least 10% of the population.*
  - 11) *failed to consider the disproportionate impact on minority Americans.*
  - 12) *failed to consider the disproportionate burden placed on low-income families.*
  - 13) *failed to consider the disproportionate harm to people with inadequate nutrition.*
  - 14) *failed to consider those with impaired kidney function.*
  - 15) *failed to consider those co-exposed to lead, arsenic, or aluminum.*
  - 16) *failed to consider those with an increased sensitivity to fluoride.*

**B) A summary of FAN's Comments on the EPA OW's Report Fluoride: Exposure and Relative Source Contribution Analysis**

*The policies used to calculate fluoride exposures are flawed, especially when no margin of safety is applied. **FAN identified 12 flaws in their analysis***

- 1) OW's policy of using the 90<sup>th</sup> percentile for water consumption ignores 10% of the U.S. population —nearly 31 million people*
- 2) OW's policy of using the mean drinking water fluoride concentration ignores as much as half of the population whose drinking water has higher fluoride levels.*
- 3) OW's policy of using the average body weight of the population of interest ignores as much as half of the population in the lower 50<sup>th</sup> percentile for weight.*
- 4) OW has failed to consider studies of urinary fluoride excretion as an estimate of total fluoride intake.*
- 5) OW has failed to consider fluoride exposures for several of the most sensitive groups — pregnant women, embryos/fetuses, and infants 0-6 months*
- 6) failed to adequately consider racial, ethnic, regional, and socioeconomic differences in food and beverage consumption patterns*

**OW has ignored several sources of fluoride as contributors to total intake. OW has**

- 8) ignored fluoride exposures from several dental products, including professionally applied topical fluorides, mouthwashes, and various dental devices.*
- 9) failed to consider fluoride exposure from dietary fluoride supplements in its analysis.*
- 10) failed to consider pharmaceuticals and anesthetics that metabolize to the fluoride anion in its exposure analysis.*
- 11) failed to consider ambient air as a source of fluoride in its exposure analysis.*
- 12) does not adequately consider exposure from cigarettes in its analysis.*

## **25. The EPA's false characterization of fluoride as a nutrient.**

In addition to all the other flaws discussed above there is another major misrepresentation that the EPA made in both the documents discussed in section 24 above to which we would like to draw special attention because it is a false claim that is often made by promoters of fluoridation. This is the claim that fluoride is a nutrient. In the case of OW they should not have made this claim in 2011 because twice they were informed in 2003 that the source they were using had rejected the claim. Here are the details.

The EPA states that the source for this claim is the Institute of Medicine (IOM). Here are the exact quotes.



In their report, "[Fluoride: Exposure and Relative Source Contribution Analysis](#)" on page 39 EPA's Office of Water states:

However, it should be recognized that **fluoride is a nutrient** and reconstitution of infant formulas with water containing lower levels of fluoride may result in infants not consuming the Adequate Intake for fluoride (0.5 mg/day) established by the Institute of Medicine (1997).

And in their report, "[Fluoride: Dose-Response Analysis For Non-cancer Effects](#)", on page 95 they state:

The dietary guidelines for fluoride were revised by the Institute of Medicine (IOM) in 1997. The 1997 revisions (see Table 5-1) considered **fluoride as a nutrient** based on its presence and function in bones and tooth enamel. (p. 95)

To appreciate the blatancy of this falsehood a little history is needed. In 1997 the Food and Nutrition Board of the IOM caused considerable consternation among scientists who have taken an interest in the fluoride debate. The IOM produced a report entitled, *Dietary Reference Intakes for Calcium, Phosphorus, Magnesium, Vitamin D, and Fluoride* (IOM, 1997) and held a public meeting in Washington DC, Sept 23, 1997, to discuss a draft of the report. William Hirzy PhD (then with the EPA) and Paul Connett PhD attended this day-long meeting and several times questioned the inclusion of fluoride among a list of well-known nutrients, when there is no scientific study justifying such a characterization for fluoride.

To demonstrate that a substance is an essential nutrient one has to remove the proposed nutrient from an animal's diet and demonstrate that some disease occurs as result. This has never been done for fluoride. Moreover, no one has ever shown that there is any biochemical process in the body that needs fluoride to function properly or any molecule (fat, amino acid, protein, nucleic acid or metabolite) that contains fluoride.

Despite the intervention of Hirzy and Connett the IOM went ahead and finalized its draft retaining fluoride among a list of known nutrients needed for healthy bone growth. About a dozen scientists wrote to the heads of both the Institute of Medicine (Dr. Kenneth Shine) and the National Academies (Dr. Bruce Albert) complaining of this false implication. Alberts and Shine (1998) replied as follows:

First, let us reassure you with regard to one concern. Nowhere in the report is it stated that fluoride is an essential nutrient. If any speaker or panel member at the September 23rd workshop referred to fluoride as such, they misspoke. As was stated in *Recommended Dietary Allowances 10th Edition*, which we published in 1989: "These contradictory results do not justify a classification of fluoride as an essential element, according to accepted standards. Nonetheless, because of its valuable effects on dental health, fluoride is a beneficial element for humans."

Run the clock forward to April 2003 when Paul Connett had a semi-debate at the EPA headquarters in Washington DC as part of their annual science fair. Ed Ohanian of the EPA's Office of Water was present. He didn't formally debate Connett but he did summarize some of

the EPA's activities on fluoride. In these comments he cited the IOM (1997) as characterizing fluoride as a nutrient. Connett corrected him citing the Shine-Alberts letter (1998).

Then in October 2003 before Connett testified before the NRC panel, which was reviewing fluoride's toxicity discussed above (section 11), Joyce Donahue (2003), also of EPA's Office of Water, presented the parameters of the review they wanted from the panel. She also referred to fluoride as a nutrient and used the IOM report to justify that claim. Connett corrected her from the floor again citing the Alberts-Shine letter (1998).

it is extraordinary that the EPA 's Office of Water should try to get away with this false characterization yet again.

## **26. Fluoride has no known role in nutrition or biochemistry (a summary)**

Here is what FAN submitted to the EPA in April 2011 on this point.

Fluoride is not considered by knowledgeable experts to be an essential nutrient for humans, and it has no known, beneficial role in human biochemistry (Nielsen, 1996; Hunt & Stoecker, 1996; NRC, 1989).

The U.S. authority for recommended dietary intakes concluded in 1989 that contradictory studies in rats and mice in the 1970s "do not justify a classification of fluorine [as fluoride] as an essential element, according to accepted standards" (NRC, 1989). (Because animal diets can be more stringently depleted in fluoride than human diets, studies in short-lived rats and mice are considered the best way to discover the possible essentiality of minerals in mammals.)

In its most recent publication on recommended dietary intakes, the same U.S. authority makes no mention of fluoride essentiality in the diets of humans or animals (IOM, 1997).

Human milk is extraordinarily low in fluoride, ranging from 0.007 parts per million (ppm) to 0.011 ppm (IOM, 1997)—100 times less than in fluoridated water in the U.S. (0.7 to 1.0 ppm).

Human milk also has about 3 times less fluoride than the blood of the mothers producing it (Sener et al., 2007).

Thus it seems clear that nature has evolved active mechanisms to limit the transfer of fluoride in humans—both from ingested food and water to blood, and from blood to breast milk.

Thus either by accident or intent mothers' milk protects the baby from more than minimal exposure to fluoride. Water fluoridation removes that protection for bottle-fed babies.

It is well-established that fluoride's toxicity may be exacerbated by poor nutrition. By not accounting for this fluoridation promoters are contributing to the disproportionate

harm fluoride exposure and water fluoridation may be causing both low-income and minority families, who are more likely to suffer from poor nutrition.

However, nutritional factors may enhance fluoride's toxicity. These include deficiencies in iodine, calcium, magnesium, and vitamin C (ATSDR, 1993, p.112), selenium, and vitamin D (e.g. ATSDR, 1993, p.112; NRC, 2006).

Poor nutrition has been found to increase the incidence and severity of dental fluorosis (Pandit et al., 1940; Murray et al., 1948; Littleton et al., 1999) and skeletal fluorosis (Pandit et al., 1940; Marier et al., 1963; Fisher et al., 1989; Teotia et al., 1984; Littleton et al., 1999).

The dose of fluoride at which disturbed endocrine function occurs is reduced in situations of iodine deficiency (NRC, 2006). Lin et al. (1991), in a UNICEF - sponsored study, found that even modest levels of fluoride in the water (0.88 mg/L vs. 0.34 mg/L) resulted in reduced IQ (and increased frequency of hypothyroidism) when combined with low iodine, even more so than with iodine deficiency alone.

The increasing dietary intake of fats in the U.S. may have negative repercussions in terms of fluoride metabolism, as "Diets high in fat have been reported to increase deposition of fluoride in bone and, thus, to enhance toxicity" (HHS, 1991).

***As we have not received a response to our April, 2011 submission (as of Sept 2015), we have yet to hear whether the EPA OW has retracted their claim that fluoride is a nutrient or whether they are going to try to convince the world that it is.***

## **27. Final HHS ruling in 2015 uses sleight of hand to dismiss FAN's input on fluoride's neurotoxicity**

In April 2015 the HHS released its opinion in support of its recommended level of 0.7 mg/L level for water fluoridation programs in the US (DHHS, 2015). ***In this HHS document there is no mention of the Environmental Justice issue and thus no discussion of the adverse potential this recommended level bodes for the children of low-income and minority families.***

The HHS statement was accompanied by a statement from the director of the CDC's Division of Oral Health on the "evidence supporting the safety and effectiveness of fluoridation". In this statement the terms "minority" and "racial" were each used once; the term "poor" was used twice, and all with the same reference to the Surgeon General's report of 2000 (Weno, 2015; Surgeon General's reference) discussed above.

The CDC also rejected our concerns about Fluoride's neurotoxicity. Here is the short section that deals with this:

IQ and other neurological effects

.

The standard letters and approximately 100 unique responses expressed

concern about fluoride's impact on the brain, specifically citing lower IQ in children. Several Chinese studies considered in detail by the NRC review reported lower IQ among children exposed to fluoride in drinking water at mean concentrations of 2.5–4.1 mg/L—several times higher than concentrations recommended for community water fluoridation.

The NRC found that “the significance of these Chinese studies is uncertain” because important procedural details were omitted, but also stated that findings warranted additional research on the effects of fluoride on intelligence.

Based on animal studies, the NRC committee speculated about potential mechanisms for nervous system changes and called for more research “to clarify the effect of fluoride on brain chemistry and function.”

These recommendations should be considered in the context of the NRC review, which limited its conclusions regarding adverse effects to water fluoride concentrations of 2–4 mg/L and did “not address the lower exposures commonly experienced by most U.S. citizens.”

**A recent meta-analysis of studies conducted in rural China, including those considered by the NRC report, identified an association between high fluoride exposure (i.e., drinking water concentrations ranging up to 11.5 mg/L) and lower IQ scores;** study authors noted the low quality of included studies and the inability to rule out other explanations.

A subsequent review cited this meta-analysis to support its identification of “raised fluoride concentrations” in drinking water as a developmental neurotoxicant.

A review by SCHER also considered the neurotoxicity of fluoride in water and determined that there was not enough evidence from well-controlled studies to conclude if fluoride in drinking water at concentrations used for community fluoridation might impair the IQ of children. The review also noted that “a biological plausibility for the link between fluoridated water and IQ has not been established.”

Findings of a recent prospective study of a birth cohort in New Zealand did not support an association between fluoride exposure, including residence in an area with fluoridated water during early childhood, and IQ measured repeatedly during childhood and at age 38 years. (CDC, 2015) **(our emphasis).**

Please note the highlighted section in this excerpt. This statement is referring to the Harvard meta-analysis by Choi et al., 2012 discussed in section above. We have already noted that fluoridation promoters have tried to dismiss the relevance of this review with respect to artificial water fluoridation by referring to the “high concentrations” in the “high-fluoride villages.” However, we saw in table xx that for the 20 studies where the source of fluoride was water and not coal and for which fluoride concentrations were given, the mean value in the “high-fluoride” villages was 3.52 ppm, which is lower than the current safe drinking water standard of 4 ppm. We also noted that a number of studies were lower than 3 ppm, and when we looked at one study (Xiang et al. 2003 a,b) in more detail some of the children had their IQ

lowered at 1.5 ppm, and extrapolating from a linear fit of the data, could possibly have occurred between 0.75 and 1.5 ppm.

To see the “sleight of hand” operating here note the way the CDC authors qualify “high fluoride exposure” as “ **drinking water concentrations ranging up to 11.5 mg/L.**”

When we look at the study in question (Wang, 2007) we find that the 11.5 ppm is one end of a range “3.5 to 11.5 ppm.” Thus this value of 11.5 ppm was not experienced by all the children in this particular study, nor was it typical for all 20 studies, where the mean value was 3.52 ppm, so singling it out is highly misleading. (See Table 5, section 15)

Moreover, as any regulatory toxicologist should know when looking at a table of results like this it is not the *highest* value, which is of concern but the *lowest*. It is the lowest value (i.e. the lowest observable adverse effect level, or LOAEL), which is the starting point for determining the safe reference dose (RfD) needed to protect all the individuals in a large population that may be exposed to this toxic. The RfD is the stepping stone in determining the MCLG in water.

So once again we see the CDC Oral Health Division presenting the data in a way to minimize concerns about the practice they vigorously promote. This is not science but a public relations exercise in the name of protecting its long-standing policy. Once again we see an example of where, “**When policy is king, science becomes a slave.**”

## 28. Summary

Water fluoridation is a very poor and unethical practice, which infringes on the right of every individual to informed consent to human treatment.

It throws an extra burden on poor families and communities of color. These range from an increased risk to dental fluorosis (the first telltale sign that the body has been over-exposed to this toxic substance) to a lowered IQ. The last children in the U.S. who need their IQ lowered are children from poor families and communities of color because their intellectual development is more likely to have been compromised by exposure to other neurotoxins like lead and mercury and because fluoride’s toxicity is made worse by poor nutrition.

While the Oral Health Division of the Centers for Disease Control and Prevention lauds the fluoridation experiment as “One of the top public health achievements of the Twentieth Century” it is probably our greatest public health mistake and needs to be ended as soon as possible.

We believe that it is not enough to say “no” to this program but to say “yes” to a viable and better alternative. We have done this using the challenge of the agenda goals of the EJ IWG for 2016 – 2018 and have a proposed a 5-step plan which addresses these goals (see section 21)

## 29. Recommendations

### The Environmental Justice Interagency Working Group (EJ IWG)

We urge all the agencies involved in the EJ IWG to see how they can become involved in our

proposed 5-step plan. We believe there is a role for every single agency.

### ***The CDC.***

If the CDC's Division of Oral Health resists our 5 step plan, and is going to continue to spend millions of taxpayers' dollars on fluoridation promotion then it should not be spent on propaganda. That should be left to private organizations like the ADA and Pew. The CDC's Division of Oral Health should provide balanced information. As well as providing information on benefits they need to do a better job of providing information on side effects. Such a task should be given over to a different section of the CDC, not the Oral Health Division, whose personnel have little or no training in specialized areas of medicine other than the teeth and no expertise in toxicology and risk assessment.

Meanwhile, the CDC should be warning, those particularly vulnerable to fluoride's toxic actions of their vulnerabilities. These citizens include low-income families and Black and Hispanic Americans.

### ***The EPA***

1) As we have made clear above the EPA Office of Water could end fluoridation tomorrow if it used the best science to determine a safe reference dose (RfD) for fluoride that would protect all our children from lowered IQ. If they use standard procedures and appropriate safety factors the RfD would be so low that an MCLG would have to be set at zero, as is the case for both lead and arsenic. Needless to say, as with arsenic and lead, an MCL (the federally enforceable standard) would have to be chosen, which took into account the costs of removing naturally-occurring fluoride down to some compromise that didn't make removal too cost-prohibitive. The key for the EPA under the Safe Water Drinking Act is to produce a scientifically defensible MCLG for fluoride.

2) The EPA should live up to its self-proclaimed interest in making sure that their decisions take into account EJ issues. In 2011 the EPA stated that:

Environmental Justice is the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies. EPA has this goal for all communities and persons across this Nation. It will be achieved when everyone enjoys the same degree of protection from environmental and health hazards and equal access to the decision-making process to have a healthy environment in which to live, learn, and work.

An excellent place to start making these noble words into a reality would be for the EPA OW to take them into account in their ongoing determination of a safe MCLG for fluoride in water. As of Jan 7 2011 the initial steps they have taken in this determination conflicts with these goals in two fundamental ways:

- A) They have ignored all the evidence that fluoride is neurotoxic falsely claiming that severe dental fluorosis is the most sensitive end point of fluoride's toxicity. If this is uncorrected it will further hurt the interest of children of low-income and communities of color: they are the last children that need their IQ lowered or have their mental development impacted in any way.
- B) Even if severe dental fluorosis is erroneously accepted as the most sensitive end point it is ridiculous for them to use data from the 1930s and 1940s in which the vast majority of the

children were white. This foolishness was compounded by their applying to this outdated and incomplete data an uncertainty factor of one, instead of the normal default value of 10, when extrapolating from a small study that has found harm to produce a reference dose to protect all the individuals in a large population from that harm. The normal safety factor of 10 is used to protect for the full range of sensitivity to any toxic substance expected in a large population (i.e. intra-species variation). This variation in sensitivity is caused by many differences in a large population, including genetics, race, ethnicity, income levels, social circumstances, diet and health status. The fact that one of the factors which influences the prevalence of dental fluorosis – especially in its more severe forms - is race underlines the enormous insensitivity being shown to EJ issues by the EPA in their selection of this uncertainty factor and needs urgent and immediate correction.

3. The EPA should acknowledge that fluoride is not a nutrient unless they can produce science to substantiate this claim.

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## APPENDICES

**APPENDIX A:** Article by Daniel Grossman, *Fluoride's Revenge: Has this cure, too, become a disease?*  
Published in the Progressive, December 1990.

**APPENDIX B:** Hypothyroidism in the USA

**APPENDIX C:** Certain Thyroid-Related Diseases May Vary by Race: Study looked at Graves', Hashimoto's thyroiditis among U.S. military personnel.

**APPENDIX D:** Fluoride chemical species & Lead: No mention by EPA of lead-fluoride-chlorine interactions

**APPENDIX E:** 119 State Reports on Oral Health

**APPENDIX F:** Pro-Fluoridation groups have also downplayed or ignored dental fluorosis

**APPENDIX G:** Civil Rights Leaders have begun to mobilize to end fluoridation's threat to minority communities

**APPENDIX H:** On April 19, 2011 (check date) FAN sent a letter to the then director of HHS Kathleen Sebelius. Subsequently approximately 18,000 people sent in emails in support of this letter

**APPENDIX I:** The Nexø Method from Denmark

## APPENDIX A

### Fluoride's Revenge: Has this cure, too, become a disease?

The Progressive | December 1990 | By Daniel Grossman

([See Photocopy of this article](#))

*Daniel Grossman is a free-lance science writer specializing in environmental and health issues. Research for this article was supported by a grant from the Fund for Investigative Journalism.*

Terry Rich, a Colorado Spring dentist, recently treated Molly, a teenage patient, for an ugly brown stain on her front teeth. "She was dissatisfied with her teeth," he recalls, noting that dark, brown horizontal lines marred an otherwise straight smile. Though his acid-etching treatment failed to remove the stain, Rich hopes to try again with a different formula. Molly is Rich's own child. Like other people across the nation, she suffers from dental fluorosis, an ailment caused by excessive levels of the chemical fluoride in naturally mineral-rich water.



Moderate/Severe Dental Fluorosis (Photograph by BMC Oral Health)

An investigation of the health effects of fluoride, including two Freedom of Information Act requests that pried loose more than 10,000 pages of documentation, shows that a Government regulation intended to prevent fluorosis was [derailed](#) by a decades-old controversy between two agencies over a legally unrelated Government policy.

Officials at the Public Health Service, the Federal Government's all-purpose health agency, stopped the Environmental Protection Agency from issuing a standard to prevent [dental fluorosis](#) because they feared the rule would disrupt their own plans to protect dental health. As a result, what might have been an open public debate became an obscure internecine battle between two bureaucracies, each with its own idea of what makes good public policy. Though dental fluorosis is hardly a life-threatening ailment, this

story demonstrates how a powerful agency, intent upon enforcing its own view of the public good, can suppress anyone who gets in its way.

On October 31, 1985, employees of the EPA were circulating a [memo](#) written by Paul Price, a staff member in the regulatory agency's drinking water program. It was a spoof of an official press release issued that day to announce a new regulation.

"The Office of Drinking Water," it began, "proudly presents their new improved FLUORIDE REGULATION, or 'How We Stopped Worrying and Learned to Love Funky Teeth.'" The takeoff reflected the frustration felt by staff members who had invested years in developing the protective regulation only to see it diluted because of pressure from another agency.

Though fluoride is best known as the chemical added to drinking water and toothpaste to prevent dental decay, it can also cause a variety of harmful ailments, including one that puts brown stains on teeth and may make them brittle and crumbly. The amount of fluoride added to drinking water to prevent tooth decay is about the same as the amount that can cause moderate staining.

Such staining, known as dental fluorosis, was discovered even before the beneficial effects of fluoride were recognized. The convoluted history of fluoride -- perhaps one of America's most bizarre encounters with a chemical contaminant -- holds the secret to why two agencies, each ostensibly concerned about the effects of fluoride on teeth, should clash.

Dental fluorosis was first noted in Colorado Springs at the turn of the century by a young dentist who became obsessed with discovering the cause of the disease, then known as "Colorado Stain." When minute amounts of fluoride dissolved in drinking water were identified as the culprit in 1931, the Public Health Service dispatched H. Trendly Dean, a talented epidemiologist, to determine the concentration at which the disease occurs.

"In moderate cases, all enamel surfaces of the teeth are altered," Dean wrote. "Brown stain is frequently a disfiguring feature." In severe cases, he added, "brown stains are widespread and teeth often present a corroded-like appearance." The disease, researchers later discovered, is caused in children up to the age of eight during the formation of their teeth.

Fluoride would probably be treated today with the same degree of concern as any other contaminant that affects human health, were it not for the fact that Dean also confirmed an observation that changed the course of preventative health care. He showed that people with dental fluorosis had fewer cavities--then considered a public-health scourge. This discovery was greeted with enthusiasm by activists in the dental community, especially in Wisconsin, a stronghold of the Progressive movement, where a small group of energetic dentists campaigned vigorously to add fluoride to drinking water.

Dean and his agency were more circumspect, as were the American Dental Association and the American Medical Association, which preferred to await the results of investigations of the benefits of fluoride. But by the mid-1940s, a few communities began experimenting with fluoridation - as the process of adding fluoride came to be known. By 1950, the Public Health Service, under increasing pressure from advocates, endorsed the process.

As a full-blown campaign to fluoridate the entire country - nourished by the once-skeptical Public Health Service - began to build, grass-roots opposition appeared as well. Some critics questioned the safety and efficacy of fluoridation, and others raised ethical, moral, and philosophical objections to the injection of a potent chemical into a public resource. There were crackpots, too, who countered advocates of fluoridation with McCarthy-era anticommunist and anti-Semitic rhetoric. One activist who gained



notoriety in California claimed that fluoridation would produce "moronic atheistic slaves." It would "weaken the minds of the people," she said, and make them prey to communists. Another called fluoridation a Jewish attempt to "weaken the Aryan race mentally and spiritually."

When the strategy of challenging fluoridation in local referendums began to threaten the nationwide endeavor, proponents responded by tarring all opponents - indeed the very idea of opposition - with this "quack" brush. According to fluoridation advocate G.F. Lull, for example, "We will find in the antifluoridation camp the antivaccinationists, the antivivisectionists, the cultists and quacks of all descriptions: In short, everyone who has a grudge against legitimate scientific progress."

The controversy over fluoridation is no longer as visible as it was in the 1950s, but it continues. The Public Health Service is still trying to make fluoridation universally available, and opponents are still at work with roadblocks and sandbags. Today, proponents note with alarm that fluoridation was actually rejected in about 100 of the more than 150 referendums on the measure in the past decade. With only two-thirds of the public water supplies served by what dentists consider the optimal level of fluoride today, the longstanding Public Health Service goal of 95 per cent by 1990 was recently lowered to 75 per cent by the year 2000.

Though many beneficial chemicals are dangerous when consumed at excessive levels, fluoride is unique because the amount that dentists recommend to prevent cavities is about the same as the amount that causes dental fluorosis. The Public Health Service recommends that about one part of fluoride be added for every million parts of water to prevent tooth decay -- the amount depends on the climate -- while the Environmental Protection Agency says water with as little as 0.7 parts per million of fluoride can cause moderate dental fluorosis in a small percentage of the people who drink it.

Today, according to the EPA, there are 1,300 communities -- mostly rural towns -- serving nearly two million people with water naturally enriched with fluoride in concentrations greater than two parts per million (ppm). And there are 200 communities serving more than a quarter-million people with water exceeding four ppm. At two ppm, according to agency studies, 10 per cent of all children will contract either moderate or severe fluorosis. At four ppm, nearly half the children will be afflicted. The Public Health Service estimates that nearly half a million American schoolchildren suffer from mild or severe dental fluorosis.

The EPA issued a regulation to protect the public from dental fluorosis in 1977, under authority of the then newly enacted Safe Drinking Water Act. The rule prohibited public water suppliers from distributing water with more than two ppm of fluoride, though the deadline for compliance extended until 1984. As the deadline neared, however, none of the offending suppliers moved to comply, since defluoridation equipment costs hundreds of thousands of dollars. Instead, EPA came under increasing pressure to reexamine the rule. The regulation was a temporary standard, promulgated hastily with the expectation that the agency would later issue a permanent rule based on further deliberations.

EPA staff scientists were convinced of the need to prevent fluorosis. "This was the only contaminant up to this time that we knew had a human health effect," recalls David Schnare, an EPA drinking water analyst. Other drinking-water contaminants, he explains, were recognized by the results of animal studies only.

Nevertheless, EPA was besieged by petitions from state governors and [dental officials](#) to weaken the standard or, better yet, replace the legally binding regulation with a less burdensome, voluntary standard. But voluntary standards are typically ignored.

Dental and other public-health officials opposed the binding rule because they feared EPA would encourage the antifluoridation camp and hinder the ongoing effort to [fluoridate](#) the entire country. EPA's



plans to regulate fluoride, said [John Daniel](#), a dental official in South Carolina, "served only to stimulate ardent antifluoridationists in their fanatic quest to associate fluoride with every disease and unpleasantness known to mankind."

But many members of the medical community are cautiously beginning to question forty years of doctrinaire advocacy of fluoridation. Even Public Health Service officials are noting today that fluoride may not be as effective as they once claimed. "Perhaps we have been too much the crusaders," says Canadian dental official Alan Gray in calling on his colleagues to reconsider the benefits of fluoridation.

State governments opposed the binding regulation for another reason: because defluoridation is expensive and therefore politically unpalatable. According to EPA estimates, for instance, a typical family in a community that installed defluoridation equipment could expect an increase in its water bill of between \$20 and \$100 annually.

Though the Public Health Service has long been the chief Federal advocate of fluoridation -- and therefore a less-than-neutral judge -- EPA in 1981 asked Surgeon General C. Everett Koop, a Public Health Service leader, to convene a panel to advise the agency on the relationship between fluoride in drinking water and dental fluorosis. It was an unusual step; according to Joseph Cotruvo, the EPA official directly responsible for drinking-water standards, EPA had never before asked the Surgeon General to conduct such a review of a chemical, nor has it since.

Koop's office assembled a committee of dental researchers in various branches of the Service. Completed in 1982, their [report](#) concluded that dental fluorosis, though "cosmetically objectionable," is not a health hazard. Summarizing the report, [Koop](#) wrote to EPA: "No sound evidence exists which shows that drinking water...in the U.S. has an adverse effect on dental health."

Public Health Service documents verify that the wording of Koop's letter was intended to hinder EPA plans to set a binding fluoride standard. Unless EPA demonstrates that a contaminant has a "health effect," the agency cannot legally set a binding standard.

"If we send this letter," Koop explained in a memo to Edward Brandt, his superior in the Public Health Service, "it means that [EPA] would not be able to publish [binding] drinking-water regulations." Then he advised, "I think we should go with this letter, in spite of the fact that EPA will not like our response."

Still eager to demonstrate the need to regulate fluoride, the EPA asked the Surgeon General to assemble another panel in 1983, this time to consider the nondental effects of fluoride. A [transcript](#) of the panel's two-day meeting shows that, despite its nondental mandate, the panel was especially disturbed by what it learned about dental fluorosis. "You would have to have [rocks in your head](#) to allow your child much more than two parts per million," said Stanley Wallach, then medical-service chief of the Veterans Administration Medical Center in Albany, New York.

In the final draft of its report, panel chair Jay Shapiro concluded, "There was a consensus that... dental fluorosis per se constitutes an adverse health effect that should be prevented." Shapiro wrote a memo warning that "because the report deals with sensitive political issues which may or may not be acceptable to the PHS, it runs the risk of being modified at a higher level or returned for modification." He attached the memo to his draft and sent them on to John Small, a Public Health Service official. Small, in turn, forwarded the draft to Koop.

The [final report](#), which Koop sent the EPA a month later, included none of the Shapiro draft's conclusions about dental fluorosis. Instead, it concluded that it was "inadvisable" for children to drink water

containing high levels of fluoride to prevent the "uncosmetic effect" of dental fluorosis. Koop had again foiled EPA by repeating his conclusion that dental fluorosis is not an "adverse health effect."

When contacted recently, members of the panel assembled by the Public Health Service expressed surprise at their report's conclusions; they never received copies of the final--altered--version. EPA scientist Edward Ohanian, who observed the panel's deliberations, recalled being "baffled" when the agency received its report. But, he added, "it's what they give us in writing that counts."

But William Ruckelshaus, then the administrator of EPA, wanted to set a binding standard to prevent dental fluorosis, so EPA tried one more time. In 1984, Ruckelshaus asked the [National Institute of Mental Health](#) to assemble a panel to examine the psychological effects of dental fluorosis. This time the request was submitted directly to NIMH rather than through the office of the Surgeon General.

Although there was no body of research on the psychological effects of dental fluorosis per se, the panel was guided by numerous studies of facial attractiveness and the behavioral impacts of other dental impairments, such as cleft lip and palate. Panel members were also impressed by photographs they were shown of the teeth of people suffering from severe dental fluorosis. They concluded that people with moderate or severe cases risked "psychological and behavioral problems or difficulties."

EPA staff members were pleased with the results of this study. "The staff response was: Here is our silver bullet," says Paul Price, then an analyst working on the standard. He recalls that the staff was vacillating between recommending a standard of one ppm or two ppm, to prevent the psychological effects of dental fluorosis.

Ruckelshaus was shown a set of pictures of dental fluorosis at a high-level meeting in July 1984, recalls drinking-water analyst Schnare. Ruckelshaus's comment: "That's an adverse health effect." But he stepped down as EPA administrator in January 1985 and was replaced by Lee Thomas, a man less sympathetic to staff concerns about dental fluorosis.

Recent interviews confirm that the staff was preparing at the time to recommend that Thomas issue a one-ppm standard. "It is legally and scientifically indefensible to set the [standard] at a level other than optimum (e.g., 1 ppm)," reads the draft of a memo prepared for Thomas's approval.

A handwritten note scribbled on this draft, however, says a higher-level office, controlled not by staff scientists but by political appointees, preferred a binding standard of four ppm, justified by the threat of skeletal fluorosis, another effect of fluoride, but a much less common one. The note added, "And they have the final say!"

The final draft, completed a few weeks later, concluded that dental fluorosis is merely a "cosmetic effect" and recommends a binding standard of four ppm, and a voluntary one of two ppm. When issued six months later, the standard followed this recommendation.

One drinking water official believes Thomas succumbed to pressure. A native of South Carolina, a state abundantly endowed with fluoride-rich water, Thomas listened not to his staff but to Republican Senator Strom Thurmond, a relentless opponent of the fluoride standard. Edward Groth of the Consumers Union, who wrote a doctoral dissertation on the fluoridation controversy, surmises that Thomas took "the path of least resistance" in following the lead of the Surgeon General.

The technical staff was "devastated" at the decision to go with a standard of four ppm instead of one, according to Paul Price, who managed the writing of the standard and its official justification issued by the EPA. But, he says, once the decision was made, "there were arguments that could be made to justify it."

Price calls the struggle over fluoride regulation "a clash of two different cultures." The Public Health Service, he says, was guided by a 1950s-era attitude that health problems are solved with medication and that doctors know best; anyone questioning this is a crackpot. The Environmental Protection Agency, in contrast, works on the principle -- and is staffed with scientists who believe -- that nothing should be allowed in drinking water unless its safety can be proven. This conviction dictates stringent regulations justified by conservative analyses with ample margins of safety. In the case of fluoride, these two philosophies collide.

In Colorado Springs, where dental fluorosis was first studied almost a century ago, fluoride levels today reach nearly four ppm. Dentist Terry Rich thinks this level is too high, though he concedes the city couldn't afford a treatment plant even if regulators required it.

And he views the high level of fluoride in his city's water as an opportunity for business. "It could be a money-making thing in my practice," he says, musing about treatment for people suffering from dental fluorosis - "if only I could figure out a way to do it."

## APPENDIX B

### Hypothyroidism in the USA

The following is from the **American Thyroid Association**

<http://www.thyroid.org/media-main/about-hypothyroidism/>

#### Prevalence and Impact of Thyroid Disease

More than 12 percent of the U.S. population will develop a thyroid condition during their lifetime.

- An estimated 20 million Americans have some form of thyroid disease.
- Up to 60 percent of those with thyroid disease are unaware of their condition.
- Women are five to eight times more likely than men to have thyroid problems.
- One woman in eight will develop a thyroid disorder during her lifetime.
- Most thyroid cancers respond to treatment, although a small percentage can be very aggressive.
- The causes of thyroid problems are largely unknown.
- Undiagnosed thyroid disease may put patients at risk for certain serious conditions, such as cardiovascular diseases, osteoporosis and infertility.
- Pregnant women with undiagnosed or inadequately treated hypothyroidism have an increased risk of miscarriage, preterm delivery, and severe developmental problems in their children.
- Most thyroid diseases are life-long conditions that can be managed with medical attention.

#### Facts about the Thyroid Gland and Thyroid Disease

The thyroid is a hormone-producing gland that regulates the body's metabolism—the rate at which the body produces energy from nutrients and oxygen—and affects critical body functions, such as energy level and heart rate.

- The thyroid gland is located in the middle of the lower neck.
- Although the thyroid gland is relatively small, it produces a hormone that influences every cell, tissue and organ in the body.
- Hypothyroidism is a condition where the thyroid gland does not produce enough thyroid hormone. Symptoms include extreme fatigue, depression, forgetfulness, and some weight gain.
- Hyperthyroidism, another form of thyroid disease, is a condition causing the gland to produce too much thyroid hormone. Symptoms include irritability, nervousness, muscle weakness, unexplained weight loss, sleep disturbances, vision problems and eye irritation.
- Graves' disease is a type of hyperthyroidism; it is an autoimmune disorder that is genetic and estimated to affect one percent of the population.

## APPENDIX C

### **Certain Thyroid-Related Diseases May Vary by Race:**

#### **Study looked at Graves', Hashimoto's thyroiditis among U.S. military personnel.**

<http://www.webmd.com/women/news/20140415/certain-thyroid-related-diseases-may-vary-by-race>

Race appears to be a factor in determining a person's risk of developing autoimmune thyroid conditions such as Graves' disease or Hashimoto's thyroiditis, a new study in the *Journal of the American Medical Association* (JAMA) says. African Americans and Asians are much more likely to develop Graves' disease than whites are, according to the study published in the April 16, 2014 issue of JAMA. On the other hand, whites have an increased risk of Hashimoto's thyroiditis when compared to other ethnic groups, the researchers found.

The findings are based on analysis of medical records from all United States active duty military personnel aged 20 to 54 from 1997 through 2011. "These stark race differences in the incidence of autoimmune thyroid disease raise the important question of why?" said lead author Donald McLeod, an endocrinologist and researcher at the QIMR Berghofer Medical Research Institute in Queensland, Australia. "If we can work this out, we may unlock the mechanisms of autoimmune thyroid disease, and potentially yield insights into other autoimmune disorders."

The thyroid gland plays a crucial role in regulating the body's metabolism, influencing how quickly a person burns calories, how fast their heart beats, and how alert they feel. Graves' disease occurs when the immune system begins producing an antibody that tricks the thyroid into producing too much hormone. It's the most common cause of hyperthyroidism, and affects about one in every 200 people, according to the U.S. National Institutes of Health (NIH).

Hashimoto's thyroiditis happens when the immune system attacks the thyroid gland itself, causing hormone production to fall and causing hypothyroidism. Hashimoto's affects as many as 5 percent of adults, according to the NIH.

The analysis found that, compared to whites, black women are about twice as likely and black men are about two and a half times more likely to have Graves' disease.

Asian/Pacific Islander women had a 78 percent increased risk of Graves' disease compared to whites, while Asian/Pacific Islander men had a more than threefold increased risk, the study noted. But the risk of Hashimoto's in both blacks and Asian/Pacific Islanders was much lower than the risk among whites, ranging from 67 percent to 78 percent less, the findings showed.

"The findings are striking, that there are so many more African Americans and Asian individuals who are coded as having Graves'," said Dr. James Hennessey, director of clinical endocrinology at Beth Israel Deaconess Medical Center in Boston. He was not involved with the new research.

Study author McLeod demurred when asked about how a person's race could influence their thyroid function. "Our current study can't answer whether racial differences in autoimmune thyroid disease incidence are due to genetics, environmental exposures or a combination of both," McLeod said. "Further work needs to be performed to find the underlying mechanisms of thyroid autoimmunity."

In the paper, the researchers rule out one potential environmental influence -- [smoking](#). Smoking is associated with an increased risk for Graves' and a decreased risk for Hashimoto's. But whites have the highest smoking rates in the U.S. military, which runs counter to their increased risk for Hashimoto's and lower risk for Graves', the study authors added.

## APPENDIX D

### Fluoride chemical species & Lead: No mention by EPA of lead-fluoride-chlorine interactions

Lead poses a health concern in two ways with the addition of fluoride chemicals to public drinking water, and EPA needs to address the lead-fluoride **interactions** and the lead-fluoride-chlorine **interactions**.

1. First, lead is a known toxic contaminant in the industrial fluoride waste byproduct added to water at levels that may exceed the EPA's 15 ppb maximum level and contributes to lead poisoning.
2. Second, fluoride leaches lead salts from any lead-based plumbing systems in older homes common in poor urban areas heavily populated by low income, minority groups. There is a failure by public health officials to adequately monitor for toxic lead that is being leached from the water piping system and plumbing systems in fluoridated cities over decades, since hexafluorosilicic acid (likely the produced intact silicic acid) causes lead to escape from common materials (brass) used in the water supply system (reported as elevated blood lead levels in children that have been linked to fluoride in water (NRC 2006, Coplan et al. 2007).

Research by Masters and Coplan (1999) and Westendorf (1975) provide evidence that fluoride in drinking water increases blood lead levels and lead is a metal that interferes with acetylcholine esterase activity. Acetylcholine esterase is a key enzyme playing a vital role in neurotransmission throughout the human nervous system and one of the most fundamental enzymes in the body. Masters and Coplan (1999) stated referring to the silicofluorides as "Sifts":

Unfortunately, and as surprising as it may seem, neither of these commercial-grade Sifts have been properly (or officially) tested for safety in fluoridating drinking water. Indeed, their use in water fluoridation has even been called an "ideal solution to a longstanding problem"<sup>11</sup> as a way to dispose of a highly toxic by-product that is otherwise an enormous health hazard to the local environment. Meanwhile, our own research has revealed<sup>12</sup> and recently confirmed<sup>13</sup> a statistically significant association between silicofluoride-treated water and elevated blood lead levels, which, in turn, have disturbing implications in relation to their very unwelcome neurological and sociological consequences.

A recent study in rats found a synergistic effect of significantly higher concentrations of lead in both the blood and calcified tissues of animals that were exposed to both silicofluorides and lead (Sawan et al. 2010).

Masters and Coplan (2001) raised further concerns about silicofluorides interference effects on vital biological enzymes such as acetylcholinesterase.

As pointed out in a recent comprehensive review,<sup>10</sup> among the many different enzymes that initiate, control, and terminate various chemical changes in the body, acetylcholinesterase is one of the most fundamental. Therefore, in view of the extensive use of SiFs for water fluoridation (estimated to be 200,000 tons per year in the United States), Westendorf's seminal findings take on added importance in that they reveal that fluorosilicates are more potent in interfering with acetylcholinesterase activity than uncomplexed fluoride. These SiFs are industrial grade materials derived from HF and SiF<sub>4</sub> emissions that are collected in water as toxic by-products in the manufacture of phosphate fertilizers from fluoride-bearing rock phosphate. During that step concentrated aqueous solutions of fluosilicic acid, H<sub>2</sub>SiF<sub>6</sub>, are formed containing residual HF and SiF<sub>4</sub>, together with variable low concentrations of contaminants like lead, arsenic, cadmium, beryllium, and heavy-metal radionuclides.

Recent analysis in Thunder Bay, Ontario, Canada (see below) shows that all 3 fluoride chemicals (H<sub>2</sub>SiF<sub>6</sub> – hexafluorosilicic acid, NaF – sodium fluoride, and Na<sub>2</sub>SiF<sub>6</sub> – sodium silicofluoride) used in artificial water fluoridation, increase the lead content in drinking water when lead pipes are used.

Fluoridation Impacts on Water Chemistry P3-4, Report No. 2009.123, (Thunder Bay, Ontario, 2009):

“The drinking water produced from the Bare Point Water Treatment Plant is taken from Lake Superior and then treated. Water quality testing results of this source water have continually shown that the Lake Superior water is of high quality, is soft, and of low alkalinity. Testing has also demonstrated that the water is very low in dissolved major ions and metals. These characteristics mean that the water is of excellent quality and as a result has little buffering capacity – the ability to resist changes in the water chemistry.

The effects on the water chemistry of three fluoridating agents, hydrofluorosilicic acid, sodium silicofluoride and sodium fluoride, were all tested on Bare Point drinking water in a laboratory controlled setting. The impact the water chemistry with fluoride addition was tested to determine whether the addition of fluoride would have a potential to increase the number occurrences of elevated lead levels in the community.

The results of this preliminary study show that all fluoridating agents, when added to the drinking water at a concentration of 0.7 ppm (the optimal fluoride concentration rate as recommended by an expert panel convened by Health Canada in 2007), increased lead leaching from the lead pipe.”

Research by Maas et al. 2007 in the journal *Neurotoxicology* demonstrate that lead in solder and brass metal in the water pipes, connections and other materials is also leached and released by all fluoride chemicals used in urban artificial water fluoridation. Their synergistic effects with chlorine and/or chloramine were demonstrated to increase the lead levels even further and yet the EPA has no discussion of this lead leaching concern. Maas et al. (2007) found levels of lead leaching from brass when coming in contact with fluorosilicic acid and chloramine:

#### CHLORAMINE, FLUOROSILICIC ACID & LEAD LEACHING FROM BRASS MATERIALS

<b>Chemicals</b>	<b>Median Lead level</b>
Chlorine	145.9 µg/DL (1.5mg/L)
Chloramine *	23.3 orami (0.23mg/L) or 233 ppb
Chlorine & sodium fluoride	185.3 µg/DL (1.85mg/L)
Chloramine* & sodium fluoride	28.1 µg/DL (0.28mg/L)
Chlorine and fluorosilicic acid	362.8 µg/DL (3.63mg/L) doubled
Chloramine* & fluorosilicic acid	42.6 µg/DL (0.43mg/L) doubled
Chloramine** & fluorosilicic acid	83.1 µg/DL (0.83mg/L) quadrupled
* with 100% extra ammonia added, to neutralize effect; note difference of one sample of chloramine without this extra ammonia (at **)	
** without extra ammonia.	





## APPENDIX E

### 119 State Reports on Oral Health

**109 of these reports have no mention of dental or enamel fluorosis**

**10 reports include a mention of dental fluorosis:**

2 reports give limited fluorosis statistics: 2009 California and 2014 Idaho

2 reports cite fluorosis only in a reference citation

The Alabama 2010 report presents the most information on fluorosis, albeit very briefly

Out of the 119 reports, five mention “White Spots” which could be dental fluorosis.

- The 2007 Georgia report notes: "20% of 2 to 5 year old Georgia Head Start children surveyed have white spot lesions."
- The 2011 Washington state report gives the rate for White Spot Lesions in Head Start/ECEAP Preschoolers at 20.5%, with African American children having the highest percent.

State	Oral Health Report
Alabama	2007. <b>Dental Screenings by % W/Decay. In order by Dental District and % W/Decay. 2006-2007.</b> <a href="http://fluoridealert.org/wp-content/uploads/al-2007.pdf">http://fluoridealert.org/wp-content/uploads/al-2007.pdf</a> <b>Note:</b> 7,643 students were screened at 103 schools. <b>No mention of dental fluorosis.</b>
Alabama	2012. <b>The Oral Health of Alabama’s Children, 2010-2012.</b> <a href="http://fluoridealert.org/wp-content/uploads/al-2012.pdf">http://fluoridealert.org/wp-content/uploads/al-2012.pdf</a> <b>No mention of dental fluorosis.</b>
Alabama	2013. <b>The Oral Health of Alabama’s Kindergarten and Third Grade Children Compared to the General U.S. Population and Healthy People 2020 Targets.</b> Alabama Department of Public Health Data Brief February. <a href="http://fluoridealert.org/wp-content/uploads/al-2013.pdf">http://fluoridealert.org/wp-content/uploads/al-2013.pdf</a> <b>No mention of dental fluorosis.</b>
Alaska	Undated. <b>13. Oral Health. Healthy Alaskans 2010 – Volume I.</b> <a href="http://www.fluoridealert.org/wp-content/uploads/ak.report.pdf">http://www.fluoridealert.org/wp-content/uploads/ak.report.pdf</a> <b>A 2 paragraph description of dental fluorosis is given.</b>
Alaska	2007. <b>Alaska Oral Health Plan: 2008-2012.</b> By BJ Whistler. Women’s, Children’s and Family Health, Division of Public Health, Alaska Department of Health and Social Services. Funding for the State Oral Health Plan was provided by the U.S. Centers for Disease Control and Prevention through the Chronic Disease Prevention and Health Promotion Programs Cooperative Agreement (U58/CCU022905). <a href="http://www.fluoridealert.org/wp-content/uploads/ak.2007.pdf">http://www.fluoridealert.org/wp-content/uploads/ak.2007.pdf</a> <b>No mention of dental fluorosis.</b> ◁ <b>"White Spot Lesions" is mentioned on page 12:</b> “Develop or identify education materials for parental/caregiver recognition of early enamel caries, ‘white spot lesions’, in relation to early childhood caries and prevention efforts.”
Alaska	2012. <b>Alaska Oral Health Plan 2012-2016.</b> Alaska Department of Health and Social Services. July. Funding for the State Oral Health Plan was provided by the U.S. Centers for Disease Control and Prevention through the Chronic Disease Prevention and Health Promotion Programs Cooperative Agreement (U58/CCU022905). <a href="http://fluoridealert.org/wp-content/uploads/ak-2012.pdf">http://fluoridealert.org/wp-content/uploads/ak-2012.pdf</a> <b>No mention of dental fluorosis.</b>

	<p>◁ <b>"White Spot Lesions" is mentioned on page 35 using the same language as above.</b></p>
Alaska	<p>2013. <b>Alaska Oral Health Surveillance System.</b> Oral Health Program, Department of Health and Social Services. November 1. Supported by a cooperative agreement with the U.S. Centers for Disease Control and Prevention.  <a href="http://fluoridealert.org/wp-content/uploads/ak-2013.pdf">http://fluoridealert.org/wp-content/uploads/ak-2013.pdf</a>  <b>* Dental fluorosis mentioned once on page 12:</b> "Rates of dental fluorosis, a cosmetic condition in tooth enamel, may increase if fluoride levels in the drinking water are chronically in excess of optimal fluoride levels."</p>
Arizona	<p>2005. <b>The Oral Health of Arizona's Children. Current status, trends, and disparities.</b> Arizona Department of Health Services - Office of Oral Health. November.  <a href="http://fluoridealert.org/wp-content/uploads/az.2005.pdf">http://fluoridealert.org/wp-content/uploads/az.2005.pdf</a>  <b>* Dental fluorosis mentioned once on page 18:</b> "Consistent with recommendations developed by the National Institute of Dental and Craniofacial Research, each tooth surface was scored for decay, restorations, sealants, fluorosis, trauma, premature loss, and eruption status. Additional information was gathered to determine treatment urgency and referral needs."  <b>However, no statistics were given on dental fluorosis</b> even though "More than 13,000 children received dental screenings." and "each tooth surface was scored for decay, restorations, sealants, fluorosis, trauma, premature loss, and eruption status..."</p>
Arkansas	<p>2002. <b>Too Few Visits to the Dentist? The Impact on Children's Health.</b> A Special Report from Arkansas Advocates for Children &amp; Families. February.  <a href="http://www.fluoridealert.org/wp-content/uploads/ar-2002.pdf">http://www.fluoridealert.org/wp-content/uploads/ar-2002.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Arkansas	<p>Undated. <b>Alaska Oral Health Assessment. Summary Report 2004-2005.</b> By the State of Alaska, Department of Health and Social Services, Division of Public Health, Oral Health Program.  <a href="http://fluoridealert.org/wp-content/uploads/ak-2004-2005.pdf">http://fluoridealert.org/wp-content/uploads/ak-2004-2005.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Arkansas	<p>2007. <b>Oral Health in Arkansas.</b> By Mouden LD, Phillips MM, Sledge R, Evans V. Office of Oral Health. August.  <a href="http://fluoridealert.org/wp-content/uploads/ar-2007.pdf">http://fluoridealert.org/wp-content/uploads/ar-2007.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Arkansas	<p>2012. <b>Arkansas Oral Health Plan 2012-2015.</b> Arkansas Department of Health, Office of Oral Health.  "Recommendation 2.8. Provide funding for public health clinic start up and maintenance grants and other safety net programs including community health centers and not-for-profit volunteer programs. Strategy: 1. On an ongoing basis, pursue funding for community health center dental expansion and volunteer community programs through the <b>Tobacco Master Settlement Agreement</b> and other funding mechanisms."  <a href="http://fluoridealert.org/wp-content/uploads/ar-2012.pdf">http://fluoridealert.org/wp-content/uploads/ar-2012.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Arkansas	<p>2013. Office of Oral Health Surveillance Plan. Prepared by Abby Holt and Brian Whitaker. Arkansas Department of Health.  <b>"Community water fluoridation (CWF) is promoted through a CDC cooperative agreement.</b> Activities include presentations on the benefits and costs of CWF internally within the ADH and externally to various governing bodies, community leaders and lay citizens through the distribution of informational packets and campaigns to include</p>

	<p>print and broadcast media. Internal partners include the ADH Section of Engineering and the Office of Communications and Marketing among others.”</p> <p><a href="http://fluoridealert.org/wp-content/uploads/ar-2013.pdf">http://fluoridealert.org/wp-content/uploads/ar-2013.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
California	<p>2006. <b>"Mommy, it hurts to chew."</b> The California Smile Survey. An Oral Health Assessment of California's Kindergarten and 3rd Grade Children. Dental Health Foundation. February.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/ca-2006.pdf">http://fluoridealert.org/wp-content/uploads/ca-2006.pdf</a></p> <p>"During the 2004-2005 school year we surveyed over 21,000 California children in kindergarten or third grade, in nearly 200 randomly-selected schools spread across the State..."</p> <p><b>No mention of dental fluorosis.</b></p>
California	<p>2009. <b>Research and public policy: dental caries and fluoridation.</b> UCSF Dental Public Health Seminar: Part 1. By Howard Pollick. October 6.</p> <p><a href="http://www.fluoridealert.org/wp-content/uploads/pollick-2009.pdf">http://www.fluoridealert.org/wp-content/uploads/pollick-2009.pdf</a></p> <p>* This is not a report published by the state. However, there is a discussion on dental fluorosis and rates are given for "High Schools" 1993-94. It's difficult to read the small chart in the report for the percent of severity of dental fluorosis.</p> <p><b>Percent of dental fluorosis given for 10th graders teeth 1993-94:</b></p> <p><b>Fluoridated Urban: 9.0%</b></p> <p><b>Other Urban: 16.1%</b></p> <p><b>Rural 7.9%</b></p> <p><b>All Regions (lifetime residents): 11.5%</b></p>
California	<p>2009. <b>Dental Health Fact Sheet 2009 [for Santa Clara].</b> By the Santa Clara Public Health Department.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/ca-2009.santa-clara.pdf">http://fluoridealert.org/wp-content/uploads/ca-2009.santa-clara.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
California	<p>2014. <b>Sonoma County Smile Survey. An Oral Health Assessment of Sonoma County's Kindergarten and Third Grade Children.</b> Prepared by Jenny Mercado MPH, Epidemiologist, Sonoma County Department of Health Services. November.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/ca-2014.sonoma-county.pdf">http://fluoridealert.org/wp-content/uploads/ca-2014.sonoma-county.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
Colorado	<p>2000. <b>Addressing the crisis of oral health access for Colorado's children.</b> Colorado Commission Children's Dental Health. A Report to the Honorable Bill Owens Governor, State of Colorado. December 2.</p> <p>"During the Colorado 2000 General Assembly session, <b>through tobacco settlement legislation, funds were designated</b> for the improvement of the Child Health Plan Plus, including the addition of a dental benefit to begin January 1, 2001, providing an 'adequate number of dentists are willing to provide services to eligible children.'"</p> <p><a href="http://www.fluoridealert.org/wp-content/uploads/co-2000.pdf">http://www.fluoridealert.org/wp-content/uploads/co-2000.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
Colorado	<p>2005. <b>Smart Mouths, Healthy Bodies: An Action Plan to Improve the Oral Health of Coloradans.</b> Prepared for Oral Health Awareness Colorado by the Colorado Department of Public Health and Environment, Oral Health Program. Fall.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/co-2005.pdf">http://fluoridealert.org/wp-content/uploads/co-2005.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
Colorado	<p>2011-2015 <b>Colorado Oral Health Surveillance System Plan.</b> The Colorado Department of Public Health and Environment.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/co-2011.pdf">http://fluoridealert.org/wp-content/uploads/co-2011.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
Colorado	<p>2012. <b>Colorado Oral Health Plan.</b> Developed by Oral Health Colorado.</p>

	<a href="http://fluoridealert.org/wp-content/uploads/co-2012.pdf">http://fluoridealert.org/wp-content/uploads/co-2012.pdf</a> <b>No mention of dental fluorosis.</b>
Connecticut	2007. <b>Oral Health in Connecticut.</b> Connecticut Department of Public Health. <a href="http://www.fluoridealert.org/wp-content/uploads/ct.report.2007.pdf">http://www.fluoridealert.org/wp-content/uploads/ct.report.2007.pdf</a> <b>* A definition of dental fluorosis is given:</b> "However, excessive fluoride consumption can cause mottled enamel or fluorosis (i.e. whitish or brownish spots on teeth). Dental fluorosis results from the ingestion of high levels of fluoride during tooth development in children less than 8 years old."
Connecticut	2012. <b>The Oral Health of Connecticut's Children.</b> Connecticut Department of Public Health, Office of Oral Health. October. This publication was supported by the Cooperative Agreement Number 5U58DP001534-04 from The Centers for Disease Control and Prevention <a href="http://www.fluoridealert.org/wp-content/uploads/ct-2012.pdf">http://www.fluoridealert.org/wp-content/uploads/ct-2012.pdf</a> <b>Key findings:</b> -- Dental decay continues to be a significant public health problem for CT's children -- There are significant oral health disparities in CT with minority and low-income children having the highest level of dental disease. <b>No mention of dental fluorosis.</b>
Connecticut	2013. <b>Oral Health Improvement Plan for Connecticut 2013-2018.</b> Connecticut Coalition for Oral Health. This publication was supported by the Cooperative Agreement Number 5U58DP001534-05 from the Centers for Disease Control and Prevention. <a href="http://www.fluoridealert.org/wp-content/uploads/ct-2013.pdf">http://www.fluoridealert.org/wp-content/uploads/ct-2013.pdf</a> <b>No mention of dental fluorosis.</b>
Delaware	2002. <b>Delaware Oral Health Assessment of Third Grade Children.</b> Delaware Health and Social Services, Division of Public Health. May. <a href="http://www.fluoridealert.org/wp-content/uploads/de-2002.pdf">http://www.fluoridealert.org/wp-content/uploads/de-2002.pdf</a> <b>No mention of dental fluorosis.</b>
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	<p><b>Children 2006.</b> Office of Oral Health, Health Systems Bureau, New Mexico Department of Health. Funding was provided by State Oral Health Collaborative Systems Grant, # H47MCO1945, Health Resources Services Administration, US Department of Health and Human Services.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/nm-2006.pdf">http://fluoridealert.org/wp-content/uploads/nm-2006.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
New Mexico	<p><b>2006. New Mexico Oral Health Surveillance System. NMOHSS Special Report on the Border Counties 2006.</b> Office of Oral Health, Health Systems Bureau, New Mexico Department of Health. Funding was provided by State Oral Health Collaborative Systems Grant, # H47MCO1945, Health Resources Services Administration, US Department of Health and Human Services.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/nm-2006-b.pdf">http://fluoridealert.org/wp-content/uploads/nm-2006-b.pdf</a></p> <p><b>* Dental fluorosis is mentioned on page 5. "The EPA- established Maximum Contaminant Level Goal (MCLG) for fluoride is currently 4 mg/L; higher levels increase the risk of severe enamel fluorosis (discoloration, enamel loss, and pitting of the teeth during tooth development in children).</b></p>
New York	<p><b>2005. Oral Health Plan for New York State.</b> By the New York State Department of Health. August. This effort was made possible in part by funding from Centers for Disease Control and Prevention, Division of Oral Health, Cooperative Agreement 03022.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/ny-2005-b.pdf">http://fluoridealert.org/wp-content/uploads/ny-2005-b.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
New York	<p><b>2005. Oral Health Status of Third Grade Children.</b> By Kumar JV, Altshul DL, Cooke TL, Green EL. New York State Oral Health Surveillance System. December 15.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/ny-2005.pdf">http://fluoridealert.org/wp-content/uploads/ny-2005.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
New York	<p><b>2005. Children's Oral Health.</b> By the Schuyler Center for Analysis and Advocacy (Albany NY).</p> <p><a href="http://fluoridealert.org/wp-content/uploads/ny-2005.schuyler-center.pdf">http://fluoridealert.org/wp-content/uploads/ny-2005.schuyler-center.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
New York	<p><b>2012. Oral Health in New York City.</b> A data report from the New York City Department of Health. NYC Vital Signs, Volume 11, No. 5, June 2012.</p> <p><b>No mention of dental fluorosis.</b></p>
New York	<p><b>2014. Oral Health Plan for New York State. December 2014.</b> By the New York State Department of Health. December. This effort was made possible in part by funding from Centers for Disease Control and Prevention, Division of Oral Health, Cooperative Agreement 03022.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/ny-2014.pdf">http://fluoridealert.org/wp-content/uploads/ny-2014.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
North Carolina	<p><b>2013. North Carolina Oral Health Section. Kindergarten and Fifth Grade Oral Health Status. County Level Summary 2012-2013.</b> North Carolina Division of Public Health, Dental Health Section.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/nc-2013.pdf">http://fluoridealert.org/wp-content/uploads/nc-2013.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p>
North Carolina	<p><b>2014. Revised Statewide Oral Health Strategic Plan: Collaboration for Integrated and Comprehensive Oral Health.</b> North Carolina Department of Health and Human Services. February 1.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/nc-2014-ocr.pdf">http://fluoridealert.org/wp-content/uploads/nc-2014-ocr.pdf</a></p> <p><b>No mention of dental fluorosis.</b></p> <p>◀ "WHITE SPOT LESIONS" is mentioned on page 22.</p>
North Dakota	<p><b>2005. North Dakota Oral Health Survey 2004-2005 School Year.</b> Prepared by Kathy Phipps, DrPH, ASTDD Data Coordinator, Morrow Bay, CA.</p> <p><a href="http://fluoridealert.org/wp-content/uploads/nd-2005.pdf">http://fluoridealert.org/wp-content/uploads/nd-2005.pdf</a></p>

	<b>No mention of dental fluorosis.</b>
North Dakota	2012. <b>Oral Health in North Dakota. Burden of Disease and Plan for the Future 2012-2017.</b> North Dakota Oral Health Department, North Dakota Department of Health. Funding for this publication was obtained through cooperative agreement #DP08-802 between the U.S. Centers for Disease Control and Prevention (CDC) and the North Dakota Department of Health (NDDoH). <a href="http://fluoridealert.org/wp-content/uploads/nd-2012.pdf">http://fluoridealert.org/wp-content/uploads/nd-2012.pdf</a> <b>No mention of dental fluorosis.</b>
Ohio	2013. <b>Oral Health Section 2013 Plan.</b> Ohio Department of Health. <a href="http://fluoridealert.org/wp-content/uploads/oh-2013.pdf">http://fluoridealert.org/wp-content/uploads/oh-2013.pdf</a> <b>No mention of dental fluorosis.</b>
Ohio	2014. <b>Ohio Oral Health Surveillance Plan, 2014-2018.</b> Ohio Department of Health. February 1. <a href="http://fluoridealert.org/wp-content/uploads/oh-2014.pdf">http://fluoridealert.org/wp-content/uploads/oh-2014.pdf</a> <b>No mention of dental fluorosis.</b>
Oklahoma	2009. <b>Governors Task Force on Children and Oral Health.</b> August. <a href="http://fluoridealert.org/wp-content/uploads/ok-2009.pdf">http://fluoridealert.org/wp-content/uploads/ok-2009.pdf</a> <b>No mention of dental fluorosis.</b>
Oklahoma	2013. <b>Oklahoma Oral Health Needs Assessment 2013. Third Grade Children.</b> By the Oklahoma State Department of Health, Dental Health Service. <a href="http://fluoridealert.org/wp-content/uploads/ok-2013.pdf">http://fluoridealert.org/wp-content/uploads/ok-2013.pdf</a> <b>No mention of dental fluorosis.</b>
Oregon	2014. <b>Oregon Oral Health Surveillance System 2002-2014.</b> By the Oregon Health Authority, Public Health Division, Oral Health Program. <a href="http://fluoridealert.org/wp-content/uploads/or-2014.pdf">http://fluoridealert.org/wp-content/uploads/or-2014.pdf</a> <b>No mention of dental fluorosis.</b>
Oregon	2014. <b>Strategic Plan for Oral Health in Oregon: 2014-2020.</b> Oregon Oral Health Coalition, Oregon Health Authority, Oregon Health Funders Collaborative. <a href="http://fluoridealert.org/wp-content/uploads/or-2014-b.pdf">http://fluoridealert.org/wp-content/uploads/or-2014-b.pdf</a> <b>No mention of dental fluorosis.</b>
Pennsylvania	2002. <b>Oral Health Strategic Plan for Pennsylvania.</b> Commonwealth of Pennsylvania Department of Health. November 2002. <a href="http://fluoridealert.org/wp-content/uploads/pa-2002.pdf">http://fluoridealert.org/wp-content/uploads/pa-2002.pdf</a> <b>No mention of dental fluorosis.</b>
Rhode island	2011. <b>Rhode Island Oral Health Plan, 2011-2016.</b> Rhode Island Oral Health Commission, Rhode Island Department of Health. January. This publication was made possible in part by funding from the Centers for Disease Control and Prevention, Division of Oral Health, Cooperative Agreement 08802 and the Health Resources and Services Administration, Division of Medicine and Dentistry, Grant #T12HP14663. <a href="http://fluoridealert.org/wp-content/uploads/ri-2011.pdf">http://fluoridealert.org/wp-content/uploads/ri-2011.pdf</a> <b>No mention of dental fluorosis.</b>
Rhode island	2012. <b>Oral Health of Rhode Island's Children.</b> By the Rhode Island Department of Health, Oral Health Program. February. Authored by Junhie Oh, BDS, MPH, Oral Health Epidemiologist/Evaluator; Deborah Fuller, DMD, MS, Dental Sealant Program Coordinator/Public Health Dentist, Oral Health Program. <a href="http://fluoridealert.org/wp-content/uploads/ri-2012.pdf">http://fluoridealert.org/wp-content/uploads/ri-2012.pdf</a> <b>No mention of dental fluorosis.</b>
South Carolina	2008. <b>South Carolina State Oral Health Plan.</b> Update May 26, 2008. <a href="http://fluoridealert.org/wp-content/uploads/sc-2008.pdf">http://fluoridealert.org/wp-content/uploads/sc-2008.pdf</a> <b>No mention of dental fluorosis.</b>
South Dakota	2014. <b>The Oral Health of South Dakota's Third Grade Children Compared to the</b>

	<p><b>General U.S. Third Grade Population.</b> South Dakota Department of Health Data Brief June 2014.  <a href="http://fluoridealert.org/wp-content/uploads/sd-2014.pdf">http://fluoridealert.org/wp-content/uploads/sd-2014.pdf</a>  <b>No mention of dental fluorosis.</b></p>
South Dakota	<p>2015. <b>Oral Health Plan for South Dakota, 2015-2020.</b> South Dakota Oral Health Coalition. Spring.  <a href="http://fluoridealert.org/wp-content/uploads/sd-2015.pdf">http://fluoridealert.org/wp-content/uploads/sd-2015.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Tennessee	<p>2010. <b>Tennessee Smiles: The UT Grassroots Oral Health Outreach Initiative.</b> By Lewis MW, Wasson W, Scarbecz M, Aubertin MA, Woods M, Himel VT. Journal of the Tennessee Dental Association. 91-4.          • See reference 67  <a href="http://fluoridealert.org/wp-content/uploads/tn-2010.pdf">http://fluoridealert.org/wp-content/uploads/tn-2010.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Texas	<p>2008. <b>Oral Health in Texas 2008.</b> By the Texas Department of State Health Service, the Centers for Disease Control and Prevention, and the U.S. Department of Health and Human Services. DSHS OHP acknowledges the funding and technical support received from the Division of Oral Health at the Centers for Disease Control and Prevention, Atlanta, Georgia, in making this document available to the citizens of Texas as provided through Cooperative Agreement No. U58/CCU622789-0.  <a href="http://fluoridealert.org/wp-content/uploads/tx-2008.pdf">http://fluoridealert.org/wp-content/uploads/tx-2008.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Utah	<p>2012. <b>Utah's Plan of Action to Promote Oral Health.</b> A Public-Private Partnership, Utah Oral Health Coalition. December 20.  <a href="http://fluoridealert.org/wp-content/uploads/ut-2012.pdf">http://fluoridealert.org/wp-content/uploads/ut-2012.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Vermont	<p>2014. <b>Vermont Oral Health Plan 2014.</b> By the Vermont Department of Health.  <a href="http://fluoridealert.org/wp-content/uploads/vt-2014.pdf">http://fluoridealert.org/wp-content/uploads/vt-2014.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Virginia	<p>2011. <b>Oral Health in Northern Virginia.</b> A report commissioned by the Northern Virginia Health Foundation. September 2011.  <a href="http://fluoridealert.org/wp-content/uploads/va-2011.northern-va.pdf">http://fluoridealert.org/wp-content/uploads/va-2011.northern-va.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Washington	<p>2009. <b>Washington State Collaborative Oral Health Improvement Plan 2009-2014.</b> Washington State Oral Health Coalition. November. Acknowledgment: Federal funding from HRSA Grant T12HP10687, CFDA 93.236.  <a href="http://fluoridealert.org/wp-content/uploads/wa-20091.pdf">http://fluoridealert.org/wp-content/uploads/wa-20091.pdf</a>  <b>No mention of dental fluorosis.</b></p>
Washington	<p>2011. <b>Smile Survey 2010. The Oral Health of Washington's Children.</b> By the Washington State Department of Health; Delta Dental Washington Dental Service Foundation; Washington State Department of Early Learning. March.  <a href="http://fluoridealert.org/wp-content/uploads/wa-2011.pdf">http://fluoridealert.org/wp-content/uploads/wa-2011.pdf</a>  <b>No mention of dental fluorosis.</b>          ◀ <b>WHITE SPOT Lesions mentioned in Tables 7,8,9,10.</b>  <b>WHITE SPOT LESIONS in Head Start/ECEAP Preschoolers is 20.5%</b>          WHITE SPOT: Head Start/ECEAP Preschoolers by race:          25.3%, African-American          20.7%, Minority          20.6%, White, Non-Hispanic          17.5%, Hispanic</p>
West Virginia	<p>2010. <b>West Virginia Oral Health Plan 2010-2015.</b> By the West Virginia Department of Health &amp; Human Resources. March 2010.</p>

	<a href="http://fluoridealert.org/wp-content/uploads/wv-2010.pdf">http://fluoridealert.org/wp-content/uploads/wv-2010.pdf</a> <b>No mention of dental fluorosis.</b>
Wisconsin	2012. <b>The Health of Dane County. The Oral Health Crisis.</b> Produced by the Public Health Madison & Dane County and the Oral Health Coalition of Dane County. May. <a href="http://fluoridealert.org/wp-content/uploads/wi-2012.dane-county.pdf">http://fluoridealert.org/wp-content/uploads/wi-2012.dane-county.pdf</a> <b>No mention of dental fluorosis.</b>
Wisconsin	2013 - <b>Healthy Smiles / Healthy Growth. Wisconsin's Third Grade Students.</b> By Olson M, Chaffin J, Chudy N, Yang A. The publication was made possible in part by funding from two grants from the Centers for Disease Control and Prevention. The Division of Oral Health, Cooperative Agreement DP08-802 and the Division of Nutrition, Physical Activity and Obesity Cooperative Agreement 5U58DP001494-05. <a href="http://fluoridealert.org/wp-content/uploads/wi-2013.pdf">http://fluoridealert.org/wp-content/uploads/wi-2013.pdf</a> <b>No mention of dental fluorosis.</b>
Wisconsin	2013b. <b>Wisconsin's Roadmap to Improving Oral Health 2013-2018.</b> Wisconsin Oral Health Coalition. This publication was made possible in part by funding from the Centers for Disease Control and Prevention, Division of Oral Health, Cooperative Agreement DP08-802. <a href="http://fluoridealert.org/wp-content/uploads/wi-2013b.pdf">http://fluoridealert.org/wp-content/uploads/wi-2013b.pdf</a> <b>No mention of dental fluorosis.</b>
Wyoming	2010. <b>Oral Health in Wyoming. Final Report.</b> Wyoming Department of Health. <a href="http://fluoridealert.org/wp-content/uploads/wy-2010.pdf">http://fluoridealert.org/wp-content/uploads/wy-2010.pdf</a> <b>No mention of dental fluorosis.</b>

## APPENDIX F

### Pro-Fluoridation groups have also ignored dental fluorosis

The Pew foundation has probably been the most active foundation in promoting community water fluoridation since 2008 by setting up health care coalitions across the country to vigorously support fluoridation. According to Pew's main fluoridation campaigner, Matt Jacob (2012), Pew's outreach to states for community water fluoridation (CWF) included the following:

- Arkansas: "Funded a poll and offered other assistance to pass a state mandate in 2011."
- California: "Provided assistance to a successful campaign to secure CWF in San Jose."
- Kansas: "Assisted oral health advocates in Wichita pass a fluoridation policy."
- Mississippi: "Provided message training for oral health field staff."
- Montana: "Assisted successful effort to preserve CWF in the city of Bozeman."
- New Hampshire: "Helped defeat a statewide ban on CWF."
- Oregon: "Offering funds and research for a campaign [referendum] in Portland."
- Wisconsin: "Provided research and technical assistance to preserve CWF in Milwaukee."

- In May 2011, **The Pew Center on the States**, a major funder of pro-fluoridation groups, published **The State of Children's Health: Making Coverage Matter** (Pew, 2011, <http://fluoridealert.org/wp-content/uploads/pew-2011.pdf>). There is no discussion of dental fluorosis in this report.

- In July 2015, a report titled, **Fluoridation Advocacy: Pew's Contributions and Lessons that Emerge** (<http://fluoridealert.org/wp-content/uploads/pew.july-2015.pdf>) contained one citation on fluorosis (page 3) that came from the CDC's "[FAQs for Dental Fluorosis](#)." The Pew Charitable Trusts commissioned the **Children's Dental Health Project** (CDHP) to prepare this report. CDHP funders include the CDC, DHHS, Colgate-Palmolive and the W.K. Kellogg Foundation. An individual from the American Dental Association is on its board. There was one citation to African-Americans (page 15): "To build this consensus [for working on a referendum for fluoridation], Upstream formed a diverse coalition of Portland organizations called Healthy Kids, Healthy Portland (HKHP). The coalition included the **African Women's Coalition**, the Asian Pacific American Network of Oregon, Familias en Acción, Kaiser Permanente Northwest, Lutheran Community Services and the Oregon Business Association. (See below, *Portland, Oregon: Money given to minority groups to support fluoridation*)

- On the **Children's Dental Health Project (CDHP)** website (<https://www.cdhp.org/>) a search for "fluorosis" had two hits:

- April 27, 2015: "... The updated level for fluoride is expected to help reduce enamel fluorosis. Fluorosis is a change in the appearance of tooth enamel that does *not* affect the health or function of the teeth.[In 2006 the NRC-2006 report stated that severe dental fluorosis was an adverse health effect.] Typically, fluorosis in the U.S. is a mild, cosmetic condition that leaves faint, white spots or streaks on the surface of teeth. The effect is subtle, which is why many people with fluorosis don't even notice it; it often takes a dental professional to recognize it..." <https://www.cdhp.org/blog/316-hhs-updates-fluoride-level>
-



- January 10, 2011: Quote from Burton Edelstein, President of CDHP, “In no way does this adjustment mean that public health authorities are backing off of their commitment to fluoridating water” said Edelstein. “In fact, capping water levels at the newly recommended level (0.7 parts per million) is the best way to meet children’s needs while also reducing the chance that a child will develop fluorosis. Edelstein added that “Parents can take steps to limit the chance of fluorosis from toothpaste by supervising tooth brushing.”  
<https://www.cdhp.org/resources/219-public-health-officials-reconfirm-value-of-water-fluoridation-while-adjusting-recommended-levels>

- On Pew’s website (<http://www.pewtrusts.org/en/projects/childrens-dental-policy>)

**Children’s Dental Policy**, a search for fluorosis gets 2 hits:

-- **Quote from Bill Maas, Advisor, Pew Children's Dental Campaign (and former Director of the Division of Oral Health at the CDC):** “Opponents have also raised concerns about community water fluoridation leading to severe cases of dental fluorosis. Fluorosis is a change in appearance of the tooth’s enamel. Nearly all fluorosis in the U.S. is not harmful and results in white streaks on the teeth that are barely noticeable. Severe fluorosis can cause enamel damage and brown spots, but that problem is rare in our country, afflicting only people on private well water.” -

<http://www.pewtrusts.org/en/research-and-analysis/q-and-a/2011/12/08/bill-maas-water-fluoridation>

-- **FAQ’s:** Q. What is dental fluorosis? Dental fluorosis is a change in the appearance of tooth enamel that occurs when someone is exposed to too much fluoride. In the U.S., fluorosis is typically a minor discoloration of teeth that is usually visible only to a dentist. It does not cause pain, and it does not affect the health or function of the teeth. The new HHS recommendation reflects the fact that Americans today receive fluoride from more sources (toothpaste, mouth rinses, and other products) than they were getting several decades ago. In 2006, the National Research Council examined water sources with a range of naturally occurring fluoride levels and found that severe fluorosis virtually never occurs in levels below 2 parts per million. Public water systems fluoridate at a concentration that’s well below that level. -

<http://www.pewtrusts.org/en/research-and-analysis/q-and-a/2011/11/11/water-fluoridation-frequently-asked-questions>

- In the Pew sponsored **Campaign for Dental Health** website <http://ilikemyteeth.org/> , there were two “hits” for African Americans:

- A 2012 citation to a \$9 million grant to the UCLA School of dentistry to give access to the city’s Latino and African American children (birth to 5 years). - <http://ilikemyteeth.org/million-dollar-grant-aims-increase-dental-care-access-las-youngest/>

- -- Another 2012 citation noting, “U.S. National Health Interview Surveys from 1964 to 2010 showed that the once blatant racial gap in kid’s dental care has been eliminated... African-American kids still have higher rates of cavities, and



there are still children of all races who do not have access to dental care.” -  
<http://ilikemyteeth.org/children-race-dentist/>

There is no mention on the websites of the **Children’s Dental Health Project**, the **Children’s Dental Policy** or Pew’s **Campaign for Dental Health** of another neurotoxin that children are exposed to: **mercury in dental amalgams**. The FDA defines them as, “is a mixture of metals, consisting of liquid (elemental) mercury and a powdered alloy composed of silver, tin, and copper. Approximately 50% of dental amalgam is elemental mercury by weight.” -  
<http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DentalProducts/DentalAmalgam/ucm171094.htm>

## APPENDIX G

### Civil Rights Leaders have begun to mobilize to end fluoridation's threat to minority communities

This section contains the following:

May 21, 2015. **Letter from William Owens, Coalition of African American Pastors**, to Rep. Barry Loudermilk, Chairman, House Subcommittee on Oversight / Science, Space, & Technology Committee, Washington, DC.

<http://fluoridealert.org/wp-content/uploads/owens-may.11.2015.pdf>

November 11, 2014. Resolution of the Santa Rosa-Sonoma County NAACP Opposing Fluoridation of Our Public Water Supply.

<http://fluoridealert.org/wp-content/uploads/sonoma.calif.naACP.nov-2014.pdf>

April 17, 2013. Portland NAACP Opposes fluoridation.

<http://fluoridealert.org/news/portland-naACP-opposes-fluoridation/>

July 1, 2011. **Civil Rights Violation Regarding Forced Medication**. Resolution of the League of United Latin American Citizens.

[http://lulac.org/advocacy/resolutions/2011/resolution\\_Civil\\_Rights\\_Violation\\_Regarding\\_Forced\\_Medication/](http://lulac.org/advocacy/resolutions/2011/resolution_Civil_Rights_Violation_Regarding_Forced_Medication/)

June 22, 2011. **Another King family member speaks out as Fluoridegate scandal builds in Atlanta.**

<http://fluoridealert.org/news/another-king-family-member-speaks-out-as-fluoridegate-scandal-builds-in-atlanta/>

April 6, 2011. Letter from Matt Young, DDS, President, International Academy of Oral Medicine and Toxicology, to Thomas Frieden, MD, MPH, Director, Centers for Disease Control and Prevention, Atlanta, GA.

<http://fluoridealert.org/wp-content/uploads/iaomt-letter-to-cdc-april.6.2011.pdf>

March 29, 2011. Letter from Andrew Young to Chip Rogers, Senate Majority Leader, Georgia State Capitol, Atlanta, GA.

<http://fluoridealert.org/wp-content/uploads/young-andrew.letter-march.29.2011.pdf>

March 9, 2011. Letter from Dr. Gerald L. Durley, Pastor, Providence Baptist Church, to Senator Chip Rogers, Senate Majority Leader, Georgia State Capital, Atlanta. **Re: Repeal of Georgia's Mandatory Fluoridation Law.**

[http://fluoridealert.org/wp-content/uploads/durley\\_2011.pdf](http://fluoridealert.org/wp-content/uploads/durley_2011.pdf)

## APPENDIX H

*On January 7, 2011, the U.S. Department of Health and Human Services (HHS) announced its recommendation to reduce the level of fluoride added to drinking water based on national survey data showing that 41% of American adolescents (ages 12-15) now have dental fluorosis (a tooth defect caused by excess fluoride consumption during childhood). On January 13, 2011, the HHS published a Federal Register notice proposing to reduce the recommended fluoride level from the existing range of 0.7 to 1.2 parts per million (ppm) to 0.7 ppm. HHS solicited public comments on their recommendation. The Fluoride Action Network's submission to HHS is reproduced in full below. Over 18,000 emails were sent to HHS in support of FAN's submission.*

Fluoride Action Network  
February 4, 2011

### To HHS and Honorable Secretary Sebelius

In response to your request for comments on the recent change in your recommended level of fluoride added to community drinking water, I respectfully submit the following points supporting the stance that a reduction in fluoride levels is not sufficient, and that the United States should follow the approach of western Europe and end water fluoridation completely:

- **Fluoride is not a nutrient, nor is it essential for healthy teeth.** No study has ever revealed a diseased state resulting from lack of fluoride, including dental caries. (1,2) No American is, or ever was, "fluoride deficient."
- **Using the water supply to mass medicate the population is unethical.** The public water supply should not be used as a drug-delivery system without regard for an individual's age, weight, health status, or knowledge of how fluoride will interact with other drugs they are taking. No informed consent is requested or given, and no medical follow-up is offered.
- **The benefit and safety of ingested fluoride has never been proved by accepted medical standards.** The HHS has failed to inform the public that there is not a single randomized controlled trial (the gold standard of medical research) that demonstrates the effectiveness of water fluoridation. (3) HHS has also failed to inform the public that the Food and Drug Administration has never studied, or approved, the safety of fluoride supplements and continues to classify all fluoride supplements as "unapproved new drugs." (4, 5) Lastly, HHS has failed to inform the public that tooth decay rates have declined at the same general rate in all western, industrialized countries, irrespective of water fluoridation status. (6)
- **Any benefits of fluoride are primarily topical, not systemic.** The CDC has acknowledged this for over a decade (7). The Iowa Fluoride Study, funded by HHS, has reported little, if any, relationship between individual fluoride intake and caries experience. According to the study (the largest of its kind): "achieving a caries-free status may have relatively little to do with fluoride *intake*, while fluorosis is clearly more dependent on fluoride intake." (8)
- **Americans will still be over-exposed to fluoride at 0.7 ppm.** According to EPA's recent documents "it is likely that most children, even those that live in fluoridated communities, can be over-exposed to fluoride at least occasionally. (9) At present, nearly 41% of American adolescents aged 12-15 have some form of dental fluorosis (10), an outwardly visible sign of fluoride toxicity. Reducing the fluoride levels to 0.7 ppm will *not* remedy this problem as national statistics clearly show that dental fluorosis remains significantly elevated at 0.7 ppm. (11)

Drinking water is just one source of ingested fluoride; others include foods, beverages, dental products and supplements, pesticides and pharmaceuticals. For communities that practice artificial water fluoridation, this is the easiest source of fluoride to remove.

- **Infants will not be protected.** Infants fed formula made with fluoridated tap water—at the reduced level of 0.7 ppm—will still receive up to 175 times more fluoride than a breast-fed infant. In their supporting documents, EPA has not calculated the risks to the bottle-fed infant. In fact, infants from birth to six months of age were completely excluded from any consideration by EPA, despite HHS’s own admission that “The period of possible risk for fluorosis in the permanent teeth...extends from about birth through 8 years of age.” (12) As the most susceptible subpopulation, the potential for long-term, irreparable damage to developing infants must be seriously considered, and should extend beyond just their teeth.
- **African-American children and low-income children will not be protected.** HHS’s reference (p. 2386) to the study by Sohn et al. (13) failed to mention that African-American and low-income children were found to consume significantly more total fluids and plain water, and thus receive more fluoride from drinking water, than white or higher-income children. African-Americans have been shown to have an increased risk of developing dental fluorosis, and are at higher risk for suffering from the more severe forms of this condition. (14) Despite receiving high intakes of fluoride, low-income and minority children living in fluoridated communities continue to suffer from rampant and severe dental decay (15-18)—undermining the common premise that fluoridation will prevent these problems. Additionally, low-income children have a greater risk for suffering from all forms of fluoride toxicity, as poor diet exacerbates the detrimental effects of fluoride. This is clearly, therefore, an environmental justice issue.
- **HHS has failed to consider fluoride’s impact on the brain.** Over 100 animal studies have observed fluoride-induced brain damage (19), 24 human studies have reported lowered IQ in children exposed to various levels of fluoride (20), and at least 6 other studies have found non-IQ neurological effects such as impaired visuo-spatial organization. (21-26) One study of 500 children in China observed reduced IQ at a water fluoride level of 1.9 ppm (27, 28) and another reported a reduction in IQ at even lower (mean=1.3 ppm) water fluoride levels. (29) HHS’s new recommendation of 0.7 ppm offers no adequate margin of safety to protect all of our children, including those with iodine deficiencies (30-32), from experiencing similar neurological damage.
- **HHS has failed to consider fluoride as an endocrine disruptor.** The 2006 NRC report (33) states that fluoride is an endocrine disruptor, and even at low levels can be detrimental to the thyroid gland. Pre- and post-natal babies, people with kidney disease, and above-average water drinkers (including diabetics and lactating women) are especially susceptible to the endocrine disrupting effects of fluoride in drinking water.
- **HHS has failed to consider or investigate current rates of skeletal fluorosis in the U.S.** According to EPA’s supporting document (34), there is a general lack of information on the prevalence of stage II skeletal fluorosis in the U.S. Yet, many of the symptoms of stage II skeletal fluorosis (e.g. sporadic pain, stiffness of the joints) are identical to arthritis (35-40), which affects at least 46 million Americans. People with renal insufficiency are known to be at an elevated risk for developing skeletal fluorosis (33), as crippling stage III skeletal fluorosis with renal deficiency has been documented in the U.S. at water fluoride levels as low as 1.7 ppm. (41) Since skeletal fluorosis in kidney patients has been detected in small case studies, it is likely that systematic studies would detect skeletal fluorosis at even lower fluoride levels.
- **HHS has failed to consider fluoride as a potential carcinogen.** Bassin et al. (42) reported a significantly elevated risk of osteosarcoma in boys living in fluoridated communities, and thus

fluoride may be a carcinogen. Chester Douglass, who has serious conflicts-of-interest concerning fluoride research, has stated that a subsequent study will refute these findings (43), but no publication has appeared in the five years since he made this claim. As EPA has still not completed carcinogenicity testing for fluoride, HHS should not support the addition of a potential carcinogen to our drinking water.

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- **HHS has failed to confirm the safety of silicofluorides.** Despite being used in more than 90% of artificial water fluoridation schemes, no chronic toxicity testing of silicofluorides has ever been completed: "No short-term or subchronic exposure, chronic exposure, cytotoxicity, reproductive toxicity, teratology, carcinogenicity, or initiation/promotion studies were available" for the toxicological summary for silicofluorides, as prepared for the National Institute of Environmental Health Sciences. (44) However, recent epidemiological research has found an association between the use of silicofluoride-treated community water and increased blood lead concentrations in children (45) – a link that is consistent with recent laboratory findings. (46) HHS has failed to inform the American public that the fluoridating agent used in drinking water is a hazardous waste product from the phosphate fertilizer industry, and can be laced with arsenic and radionuclides, (47, 48) which are known carcinogens. HHS should not support the addition of a non-tested substance to our drinking water.

Most of the arguments listed above are covered in far more detail in the recently published book "The Case Against Fluoride" by Connett, Beck and Micklem (Chelsea Green, 2010). We urge director Sebelius to appoint a group of experts from HHS, who have not been involved in promoting fluoridation, to provide a fully documented scientific response to the arguments and evidence presented in this book. Were director Sebelius to do this we strongly believe that neither she nor these experts will want to see the practice of water fluoridation continue. The practice is unnecessary, unethical and hitherto the benefits have been wildly exaggerated and the risks minimized. A scientific response to this book from a HHS team would allow the public to judge the cases both for and against fluoridation on their scientific and ethical merits.

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## APPENDIX I

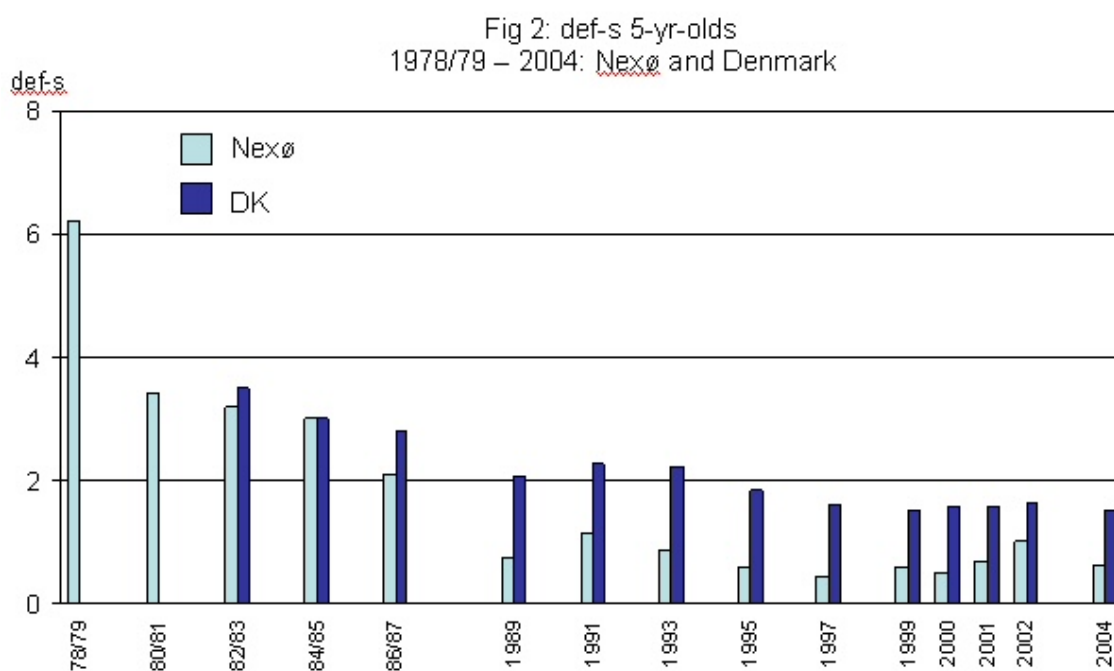
### The Nexø Method

Some information from:

<http://www.nexodent.com>

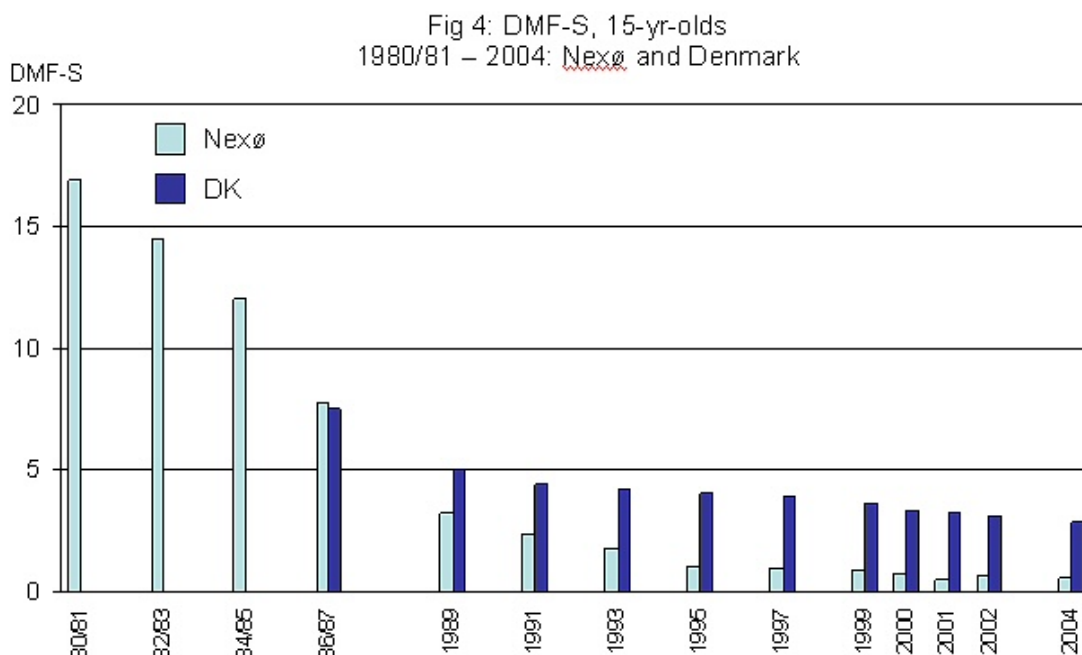
This public health dental program is based on similar principles as the ChildSmile system in Scotland, but is more comprehensive. It was developed in Denmark, with the initial trial in a community named Nexø. The results were so dramatic in rapidly lowering caries rates that the method has been extended to other communities in Denmark and other countries. Today, Denmark has the lowest childhood caries rates in the developed world according to WHO data [WHO 2015], and Denmark has never been fluoridated.

The caries rates over time in Nexø compared to those in the rest of Denmark which was not using Nexø Method, are shown in the graphs below. The first period 1978-1979 was the baseline period before the Nexø program began. The first graph is for primary teeth, dmfs:



<http://www.nexodent.com/2a.jpg>

For permanent teeth in 15 year olds, DMFS:



<http://www.nexodent.com/4.jpg>

When compared to the primary teeth, the permanent teeth took several years before the reduction in caries caught up to the Denmark level. Nexø started out as a high caries area, because it had relatively low SES compared to the rest of Denmark. The slower rate of improvement is likely because the children were already almost 15 years old when the program started. However, by 1995, by which time the 15 year olds had continuous exposure to the method since infancy, the benefit was already very dramatic. The DMFS rate was only 1.03 in Nexø compared to 4.01 in Denmark, for a 400% lowering. The largest difference ever claimed by water fluoridation has been about 70%, and today the claim is typically a 25% lowering of DMFS rates. By 2004 the rate in Nexø was just 0.56 compared to 2.85 in the rest of Denmark, a 500% reduction. These rates are all measures of decay by tooth surface (“S” for surfaces), not “T” for entire tooth, so they are higher than a tooth score.

The success of the Nexø Method has been documented in peer-reviewed scientific papers, both in Denmark and in other countries where it has been tried [Ekstrand 2005].

Here is the brief summary of the Nexø method itself:

A dental health care program based on  
treatment of children and adolescents aged 0-18.  
maintain sound teeth using the fewest resources possible.

-operationalized

The aim of the p

The treatment program is based on 3 principles - dosed at  
recalls according to diagnosis and risk assessment:

individually assess

1. Education of parents, children and adolescents in understanding Dental caries as a localized disease.
2. Intensive training in home-based plaque control.
3. Early professional non-operative intervention.

All parents and children in a community are given free oral hygiene training starting at 8 months age and continuing frequently through age 18. Parents and children are shown how to do proper oral hygiene and are checked to see how they are doing at each visit. If oral hygiene is not adequate or any caries starts developing, the next visit is scheduled sooner. Topical fluoride is given only if oral hygiene is not adequate or caries starts developing. Systemic fluorides are never considered. Even sealants are avoided because they are considered less effective than proper oral hygiene.

If any fillings or dental work is required, they are provided in a timely manner.

The program gets parents and children receiving frequent oral health visits throughout childhood. Dental auxiliaries perform most of the work rather than dentists to save expense.

The economics of the Nexø Method have also been examined using careful scientific and economic analyses [Ekstrand 2005, Vermaire 2013]. They found that the dramatic reduction in caries requiring treatment outweighs any additional cost for more frequent prevention visits. This net economic long-term benefit was found even in the context of an area like Denmark that has relatively low caries rate. For areas with high caries rates, due to low socio-economic status for example, the economic benefit would likely be higher.

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