

Limit of detection	0.2 µg/l by either packed or capillary column GC with ECD
Treatment performance	0.001 mg/l should be achievable using GAC
Guideline value derivation	
• allocation to water	10% of TDI
• weight	60 kg adult
• consumption	2 litres/day
Assessment date	1993
Principal reference	WHO (2003) <i>Chlorophenoxy herbicides (excluding 2,4-D and MCPA) in drinking-water</i>

Chlorophenoxy herbicides, as a group, have been classified in Group 2B (possibly carcinogenic to humans) by IARC. However, the available data from studies in exposed populations and experimental animals do not permit assessment of the carcinogenic potential to humans of any specific chlorophenoxy herbicide. Therefore, drinking-water guidelines for these compounds are based on a threshold approach for other toxic effects. Effects observed in long-term studies with dogs given fenoprop in the diet include mild degeneration and necrosis of hepatocytes and fibroblastic proliferation in one study and severe liver pathology in another study. In rats, increased kidney weight was observed in two long-term dietary studies.

Fluoride¹

Fluorine is a common element that is widely distributed in Earth's crust and exists in the form of fluorides in a number of minerals, such as fluorspar, cryolite and fluorapatite. Traces of fluorides are present in many waters, with higher concentrations often associated with groundwaters. In some areas rich in fluoride-containing minerals, well water may contain up to about 10 mg of fluoride per litre, although much higher concentrations can be found. High fluoride concentrations can be found in many parts of the world, particularly in parts of India, China, Central Africa and South America, but high concentrations can be encountered locally in most parts of the world. Virtually all foodstuffs contain at least traces of fluorine. All vegetation contains some fluoride, which is absorbed from soil and water. Tea in particular can contain high fluoride concentrations, and levels in dry tea are on average 100 mg/kg.

Fluoride is widely used in dental preparations to combat dental caries, particularly in areas of high sugar intake. These can be in the form of tablets, mouthwashes, toothpaste, varnishes or gels for local application. In some countries, fluoride may also be added to table salt or drinking-water in order to provide protection against dental caries. The amounts added to drinking-water are such that final concentrations are usually between 0.5 and 1 mg/l. The fluoride in final water is always present as fluoride ions, whether from natural sources or from artificial fluoridation.

¹ As fluoride is one of the chemicals of greatest health concern in some natural waters, its chemical fact sheet has been expanded.

Total daily fluoride exposure can vary markedly from one region to another. This will depend on the concentration of fluoride in drinking-water and the amount drunk, levels in foodstuffs and the use of fluoridated dental preparations. In addition, fluoride exposure in some areas is considerably higher as a consequence of a range of practices, including the consumption of brick tea and the cooking and drying of food with high-fluoride coal.

Guideline value	1.5 mg/l (1500 µg/l)
Occurrence	In groundwater, concentrations vary with the type of rock through which the water flows but do not usually exceed 10 mg/l; highest natural level reported is 2800 mg/l
Basis of guideline value derivation	Epidemiological evidence that concentrations above this value carry an increasing risk of dental fluorosis and that progressively higher concentrations lead to increasing risks of skeletal fluorosis. The value is higher than that recommended for artificial fluoridation of water supplies, which is usually 0.5–1.0 mg/l.
Limit of detection	0.01 mg/l by ion chromatography; 0.1 mg/l by ion-selective electrodes or the sulfo phenyl azo dihydroxy naphthalene disulfonic acid colorimetric method
Treatment performance	1 mg/l should be achievable using activated alumina (not a “conventional” treatment process, but relatively simple to install filters)
Additional comments	<p>A management guidance document on fluoride is available.</p> <p>In setting national standards for fluoride or in evaluating the possible health consequences of exposure to fluoride, it is essential to consider the intake of water by the population of interest and the intake of fluoride from other sources (e.g. from food, air and dental preparations). Where the intakes from other sources are likely to approach, or be greater than, 6 mg/day, it would be appropriate to consider setting standards at concentrations lower than the guideline value.</p> <p>In areas with high natural fluoride levels in drinking-water, the guideline value may be difficult to achieve, in some circumstances, with the treatment technology available.</p>
Assessment date	2003
Principal references	<p>Fawell et al. (2006) <i>Fluoride in drinking-water</i></p> <p>IPCS (2002) <i>Fluorides</i></p> <p>USNRC (2006) <i>Fluoride in drinking water</i></p> <p>WHO (2004) <i>Fluoride in drinking-water</i></p>

After oral uptake, water-soluble fluorides are rapidly and almost completely absorbed from the gastrointestinal tract, although this may be reduced by complex formation with aluminium, phosphorus, magnesium or calcium. There is no difference in absorption between natural or added fluoride in drinking-water. Fluoride in inhaled particles—from high-fluoride coal, for example—is also absorbed, depending on the particle size and solubility of the fluoride compounds present. Absorbed fluoride is rapidly distributed throughout the body, where it is incorporated into teeth and bones, with virtually no storage in soft tissues. Fluoride in teeth and bone can be

mobilized after external exposure has ceased or been reduced. Fluoride is excreted via urine, faeces and sweat.

Fluoride may be an essential element for humans; however, essentiality has not been demonstrated unequivocally. Meanwhile, there is evidence of fluoride being a beneficial element with regard to the prevention of dental caries.

To produce signs of acute fluoride intoxication, minimum oral doses of about 1 mg of fluoride per kilogram of body weight were required. Many epidemiological studies of possible adverse effects of the long-term ingestion of fluoride via drinking-water have been carried out. These studies clearly establish that high fluoride intakes primarily produce effects on skeletal tissues (bones and teeth). Low concentrations provide protection against dental caries, both in children and in adults. The protective effects of fluoride increase with concentration up to about 2 mg of fluoride per litre of drinking-water; the minimum concentration of fluoride in drinking-water required to produce it is approximately 0.5 mg/l. However, fluoride can also have an adverse effect on tooth enamel and may give rise to mild dental fluorosis (prevalence: 12–33%) at drinking-water concentrations between 0.9 and 1.2 mg/l, depending on drinking-water intake and exposure to fluoride from other sources. Mild dental fluorosis may not be detectable except by specialist examination. The risk of dental fluorosis will depend on the total intake of fluoride from all sources and not just the concentration in drinking-water.

Elevated fluoride intakes can have more serious effects on skeletal tissues. Skeletal fluorosis (with adverse changes in bone structure) may be observed when drinking-water contains 3–6 mg of fluoride per litre, particularly with high water consumption. Crippling skeletal fluorosis usually develops only where drinking-water contains over 10 mg of fluoride per litre. IPCS concluded that there is clear evidence from India and China that skeletal fluorosis and an increased risk of bone fractures occur at a total intake of 14 mg of fluoride per day. This conclusion was supported by a review by the United States National Research Council in 2006. The relationship between exposure and response for adverse effects in bone is frequently difficult to ascertain because of inadequacies in most of the epidemiological studies. IPCS concluded from estimates based on studies from China and India that for a total intake of 14 mg/day, there is a clear excess risk of skeletal adverse effects; and there is suggestive evidence of an increased risk of effects on the skeleton at total fluoride intakes above about 6 mg/day.

Several epidemiological studies are available on the possible association between fluoride in drinking-water and cancer. IPCS evaluated these studies and concluded that, overall, the evidence of carcinogenicity in laboratory animals is inconclusive and that the available evidence does not support the hypothesis that fluoride causes cancer in humans; however, the data on bone cancer are limited. The results of several epidemiological studies on the possible adverse effects of fluoride in drinking-water on pregnancy outcome indicate that there is no relationship between the rates of Down syndrome or congenital malformation and the consumption of fluoridated drinking-water.

There is no evidence to suggest that the guideline value of 1.5 mg/l set in 1984 and reaffirmed in 1993 needs to be revised. Concentrations above this value carry an increasing risk of dental fluorosis, and much higher concentrations lead to skeletal

fluorosis. The value is higher than that recommended for artificial fluoridation of water supplies, which is usually 0.5–1.0 mg/l.

In setting national standards or local guidelines for fluoride or in evaluating the possible health consequences of exposure to fluoride, it is essential to consider the average daily intake of water by the population of interest and the intake of fluoride from other sources (e.g. from food and air). Where the intakes are likely to approach, or be greater than, 6 mg/day, it would be appropriate to consider setting a standard or local guideline at a concentration lower than 1.5 mg/l.

Practical considerations

Fluoride is usually determined by means of an ion-selective electrode, which makes it possible to measure the total amount of free and complex-bound fluoride dissolved in water. The method can detect fluoride concentrations in water well below the guideline value. However, appropriate sample preparation is a critical step in the accurate quantification of fluoride, especially where only the free fluoride ion is measured.

A range of treatment technologies are available for both large and small supplies. Different methods for small supplies are favoured in different countries; these are based on bone charcoal, contact precipitation, activated alumina and clay. However, in some areas with high natural fluoride levels in drinking-water, the guideline value may be difficult to achieve in some circumstances with the treatment technology available. Large supplies tend to rely on activated alumina or advanced treatment processes such as reverse osmosis.

Formaldehyde

Formaldehyde occurs in industrial effluents and is emitted into air from plastic materials and resin glues. Formaldehyde in drinking-water results primarily from the oxidation of natural organic matter during ozonation and chlorination. Concentrations of up to 30 µg/l have been found in ozonated drinking-water. Formaldehyde can also be found in drinking-water as a result of release from polyacetal plastic fittings. Formaldehyde's physicochemical properties suggest that it is unlikely to volatilize from water, so exposure by inhalation during showering is expected to be low.

Reason for not establishing a guideline value	Occurs in drinking-water at concentrations well below those of health concern
Assessment date	2004
Principal references	IPCS (2002) <i>Formaldehyde</i> WHO (2005) <i>Formaldehyde in drinking-water</i>

Rats and mice exposed to formaldehyde by inhalation exhibited an increased incidence of carcinomas of the nasal cavity at doses that caused irritation of the nasal epithelium. Ingestion of formaldehyde in drinking-water for 2 years caused stomach irritation in rats. Papillomas of the stomach associated with severe tissue irritation were observed in one study. IARC has classified formaldehyde in Group 1 (carcinogenic to