



anses

Valeurs limites d'exposition
en milieu professionnel

Aluminium et ses composés inorganiques Évaluation des effets sur la santé et des méthodes de mesure

Avis complété de l'Anses
Rapport d'expertise
collective complété

Novembre 2025

Connaître, évaluer, protéger

Le directeur général

Maisons-Alfort, le 19 novembre 2025

AVIS complété¹ **de l'Agence nationale de sécurité sanitaire** **de l'alimentation, de l'environnement et du travail**

relatif à l'expertise en vue de la fixation de valeurs limites d'exposition à des agents chimiques en milieu professionnel

Evaluation des indicateurs biologiques d'exposition en vue de la recommandation de valeurs limites biologiques et de valeur d'imprégnation populationnelle

&

Evaluation des effets sur la santé et des méthodes de mesure des niveaux d'exposition en vue de la fixation de valeurs limites d'exposition pour l'aluminium et ses composés inorganiques en milieu professionnel

L'Anses met en œuvre une expertise scientifique indépendante et pluraliste.

L'Anses contribue principalement à assurer la sécurité sanitaire dans les domaines de l'environnement, du travail et de l'alimentation et à évaluer les risques sanitaires qu'ils peuvent comporter.

Elle contribue également à assurer d'une part la protection de la santé et du bien-être des animaux et de la santé des végétaux et d'autre part à l'évaluation des propriétés nutritionnelles des aliments.

Elle fournit aux autorités compétentes toutes les informations sur ces risques ainsi que l'expertise et l'appui scientifique technique nécessaires à l'élaboration des dispositions législatives et réglementaires et à la mise en œuvre des mesures de gestion du risque (article L.1313-1 du code de la santé publique).

Ses avis sont publiés sur son site internet.

1. CONTEXTE ET OBJET DE LA SAISINE

Dans le cadre du protocole d'accord entre l'Anses et le ministère du Travail pour la mise en œuvre du programme de travail d'expertise scientifique sur les valeurs limites atmosphériques et biologiques pour les expositions professionnelles établi en juillet 2018 et renouvelé en 2023,

¹ Cette version annule et remplace l'avis du 23 mai 2025 afin de pouvoir ajouter les résultats de l'évaluation des méthodes de mesure (les compléments apportés sont tracés en Annexe 1)

la direction générale du travail (DGT) a saisi l'Anses afin de recommander, pour l'aluminium et ses composés inorganiques, des valeurs atmosphériques assorties d'une évaluation des méthodes de mesure disponibles ainsi que des valeurs biologiques, lors de la fixation du programme de travail en 2022.

Actuellement, la France dispose d'une valeur moyenne d'exposition sur 8 heures de 10 mg/m³ pour l'aluminium métal et l'oxyde d'aluminium (alumine) et d'une valeur moyenne d'exposition sur 8 heures de 2 mg/m³ pour les sels solubles d'aluminium, valeurs indicatives fixées par la circulaire du 5 mars 1985², d'une valeur moyenne d'exposition sur 8 heures de 5 mg/m³ pour l'aluminium des fumées de soudage et l'aluminium pulvérulent et de 2 mg/m³ pour les composés alkylés de l'aluminium, valeurs indicatives fixées par la circulaire du 13 mai 1987³.

2. ORGANISATION DE L'EXPERTISE

L'expertise a été réalisée dans le respect de la norme NF X 50-110 « Qualité en expertise – Prescriptions générales de compétence pour une expertise (Mai 2003) ».

L'expertise relève du domaine de compétences du comité d'experts spécialisé (CES) « Valeurs sanitaires de référence » (VSR). Concernant les valeurs biologiques, l'Anses a confié l'expertise au groupe de travail « Indicateurs biologiques d'exposition » (GT IBE).

Les travaux ont été présentés au CES VSR tant sur les aspects méthodologiques que scientifiques entre le 20 mai 2022 et le 27 juin 2024 (mandature 2021-2024) ainsi que les 27 septembre, 8 novembre et 13 décembre 2024 (mandature 2024-2028).

Pour l'évaluation des méthodes de mesure dans l'air des lieux de travail, l'Anses a confié l'expertise au groupe de travail « Métrologie ». Les travaux d'expertise ont été soumis au CES tant sur les aspects méthodologiques que scientifiques. Les travaux ont été présentés au CES VSR sur les aspects méthodologiques le 22 mai 2025 et le 26 juin 2025 (mandature 2024-2028).

Le présent avis se fonde pour les aspects scientifiques sur le rapport intitulé « *Assessment of biomarkers of exposure and recommendation of biological limit values and populational internal exposure levels & assessment of health effects for aluminium and its inorganic compounds* »

Le rapport et l'avis portant sur l'évaluation des indicateurs biologiques d'exposition et l'évaluation des effets sur la santé ont été adoptés par le CES « Valeurs sanitaires de référence » (mandature 2024-2028) réuni le 13 décembre 2024.

Par ailleurs, ces travaux ont été complétés par une évaluation des méthodes de mesure dans l'air des lieux de travail. Cette partie a été adoptée le 25 septembre 2025.

L'Anses analyse les liens d'intérêts déclarés par les experts avant leur nomination et tout au long des travaux, afin d'éviter les risques de conflits d'intérêts au regard des points traités dans le cadre de l'expertise. Le résultat de l'analyse des liens d'intérêts n'a pas mis en évidence de

² circulaire du 5 mars 1985 complétant l'annexe de la circulaire du 19 juillet 1982 relative aux valeurs admises pour les concentrations de certaines substances dangereuses dans l'atmosphère des lieux de travail.

³ circulaire du 13 mai 1987 complétant l'annexe de la circulaire du 19 juillet 1982 relative aux valeurs admises pour les concentrations de certaines substances dangereuses dans l'atmosphère des lieux de travail.

risque de conflit d'intérêts. Cependant, un expert a souhaité se porter en déport. Il ne participe pas à l'examen de la saisine concernée.

Les déclarations d'intérêts des experts sont publiées sur le site internet : <https://dpi.sante.gouv.fr/>.

- **Description de la méthode d'expertise**

Pour la population professionnelle, l'Anses recommande deux types de valeurs de référence : les valeurs limites d'exposition professionnelle (VLEP) et les valeurs biologiques (comprenant les valeurs limites biologiques (VLB) et les valeurs d'imprégnation populationnelle (VIP)).

- **VLEP**

Les VLEP, proposées par le CES VSR, sont des niveaux de concentration de l'agent chimique dans l'atmosphère des lieux de travail à ne pas dépasser sur une période de référence déterminée et en deçà desquels le risque d'altération de la santé est considéré comme négligeable à partir des connaissances scientifiques les plus récentes. Même si des modifications physiologiques réversibles sont parfois tolérées, aucune atteinte organique ou fonctionnelle de caractère irréversible ou prolongée n'est admise à ce niveau d'exposition pour la grande majorité des travailleurs. Ces niveaux de concentration sont déterminés en considérant que la population exposée (les travailleurs) est une population qui ne comprend ni enfants, ni personnes âgées. Ces valeurs s'appliquent à l'ensemble de la population des travailleurs, y compris les populations sensibles.

Trois types de valeurs atmosphériques sont recommandées par le CES : les valeurs limites d'exposition sur 8 heures (VLEP-8h)⁴, les valeurs limites court terme sur 15 minutes (VLCT-15min)⁵ et les valeurs plafond⁶.

Les VLEP sont, idéalement, élaborées à partir de données permettant de caractériser la relation entre les variations de concentrations atmosphériques de l'agent chimique et les effets sanitaires. La construction des VLEP diffère en fonction des connaissances ou des hypothèses formulées sur les mécanismes d'action des substances. Actuellement, l'hypothèse par défaut est de considérer une relation monotone entre la dose d'exposition et l'effet observé. En l'état actuel des connaissances et par défaut, on considère généralement que, pour les effets non cancérogènes, la toxicité ne s'exprime qu'au-delà d'un certain seuil de dose (Anses, à paraître). Pour les effets cancérogènes, il est possible d'établir des VLEP-8h à seuil (correspondant au seuil en dessous duquel il n'est pas attendu la survenue d'effets) ou sans

⁴ valeur limite de la moyenne de la concentration atmosphérique d'un agent chimique prélevé dans la zone de respiration d'un travailleur pondérée par la durée d'un poste de travail, c'est-à-dire 8 heures. Dans l'état actuel des connaissances scientifiques, la VLEP-8h est censée protéger d'effets sur la santé à moyen et long termes les travailleurs exposés régulièrement et pendant la durée d'une vie de travail à l'agent chimique considéré.

⁵ valeur limite de la moyenne de la concentration atmosphérique d'un agent chimique prélevé dans la zone de respiration d'un travailleur pondérée sur une période de référence de 15 minutes. Cette concentration est mesurée pendant le pic d'exposition et ce, quelle que soit sa durée. Elle vise à protéger la santé des travailleurs des effets toxiques aigus en limitant l'intensité des pics d'exposition ou certains effets à long terme dus à la répétition d'expositions de courtes durées.

⁶ valeur limite de la concentration atmosphérique d'un agent chimique dans la zone de respiration d'un travailleur, qui ne doit être dépassée à aucun moment de la période de travail.

La valeur plafond s'applique aux agents chimiques pour lesquels le profil toxicologique montre qu'une exposition peut entraîner, de façon instantanée, un effet grave et potentiellement irréversible et qui ne peut pas être contrôlé par l'application d'une VLEP-8h ou d'une VLCT-15min.

seuil (correspondant à la probabilité de la survenue des effets) selon le mode d'action de l'agent chimique étudié.

En pratique, la proposition de VLEP comprend différentes étapes indiquées en Figure 1.

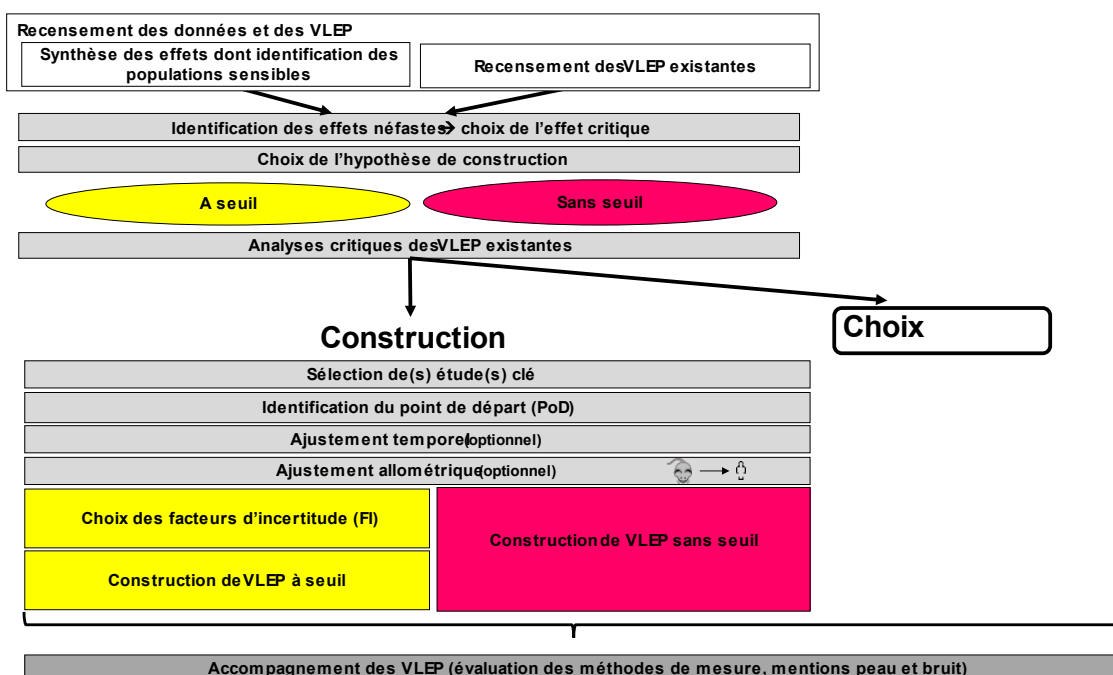


Figure 1 : Schéma des différentes étapes de construction d'une VLEP

Dans le cadre de l'élaboration de VLEP, une valeur pragmatique peut être proposée en l'absence de données pour calculer une VLEP-8h à partir de la VLCT-15 min et inversement. Une valeur plafond pragmatique peut également être déterminée à partir d'une VLCT-15min. La valeur pragmatique est proposée dans un objectif de prévention et n'est pas fondée sur une étude chez l'Homme ou l'animal (Anses, à paraître).

Le CES VSR évalue également la nécessité d'attribuer une mention « peau » lorsqu'une pénétration cutanée significative a été identifiée. Cette mention indique la nécessité de prendre en compte la voie cutanée lors de l'évaluation de l'exposition professionnelle, notamment au travers de la mise en œuvre d'une surveillance biologique des expositions et d'une évaluation de la contamination surfacique au poste de travail. Son attribution rappelle également la nécessité de mettre en œuvre des mesures de prévention comme, par exemple, le port de gants de protection appropriés, et la possibilité de vérifier la non contamination des milieux (prélèvements surfaciques) (Anses, à paraître).

Le CES VSR évalue également la nécessité ou non d'une mention « bruit » signalant un risque d'atteinte auditive en cas de co-exposition au bruit et à l'agent chimique en dessous des limites d'exposition recommandées afin que les préventeurs mettent en place des mesures appropriées (collectives, individuelles et médicales) (Anses, à paraître).

Le CES VSR évalue les méthodes de référence applicables pour la mesure des niveaux d'exposition sur le lieu de travail. La qualité de ces méthodes et leur applicabilité à la mesure des expositions aux fins de comparaison à une VLEP sont évaluées et classées au regard des exigences de performances indiquées notamment dans la norme NF EN 482 (2021) : « Atmosphère des lieux de travail – Exigences générales concernant les performances des modes opératoires de mesurage des agents chimiques » et des critères de décision détaillés dans le rapport méthodologique (Anses, à paraître).

Le classement de ces méthodes est réalisé de la manière suivante (Figure 2) :

- catégorie 1A : méthodes validées (l'ensemble des critères de performance sont satisfaits) ;
- catégorie 1B : méthodes partiellement validées (les critères essentiels de performance sont satisfaits) ;
- catégorie 2 : méthodes indicatives⁷ (des critères essentiels à la validation ne sont pas suffisamment explicités, ou bien la méthode nécessite des ajustements devant faire l'objet d'une validation) ;
- catégorie 3 : méthodes non validées ou non évaluables. Cette catégorie englobe les méthodes inadaptées pour lesquelles des critères essentiels à la validation ne sont pas remplis et les méthodes non évaluables (désignées par la catégorie 3*) pour lesquelles des critères essentiels à la validation ne sont pas documentés.

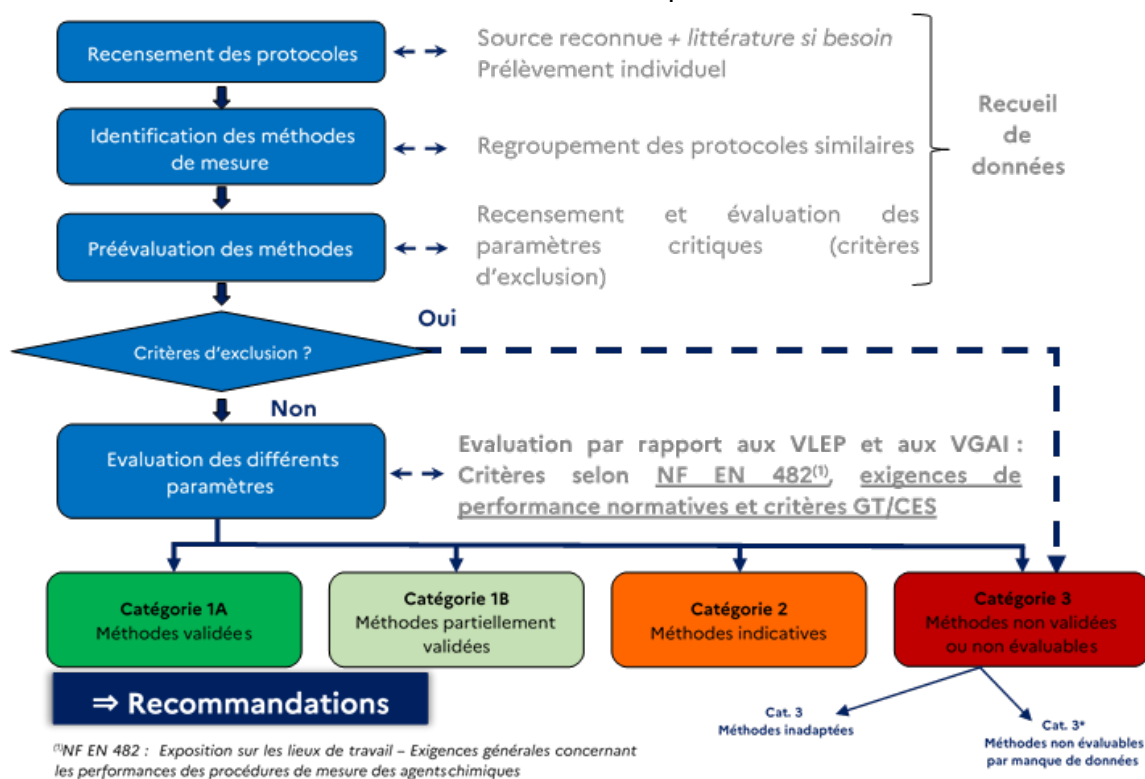


Figure 2 : Principe général de l'évaluation des méthodes de mesure dans l'air (Anses, à paraître)

Une étude comparative et détaillée des méthodes classées en catégorie 1A, 1B et 2 est réalisée au regard des différentes données de validation et de la faisabilité technique, de manière à recommander la ou les méthodes les plus appropriées pour la mesure des concentrations aux fins de comparaison aux VLEP.

- Valeurs biologiques : VLB et VIP

La surveillance biologique et la métrologie atmosphérique sont deux approches complémentaires pour évaluer les niveaux d'exposition des professionnels à des agents chimiques. La surveillance biologique permet de prendre en compte toutes les sources d'exposition, toutes les voies de pénétration dans l'organisme de l'agent d'intérêt, les facteurs individuels et les moyens de protection individuelle éventuellement mis en œuvre. Elle consiste

⁷ Dans le cadre de la réglementation sur la surveillance de l'air ambiant, une méthode indicative désigne une méthode pour laquelle l'incertitude est supérieure à celle de la méthode de référence.

à mesurer les agents chimiques ou leurs métabolites dans des matrices biologiques telles que le sang, l'urine et les autres excréta, les tissus, les phanères, etc., pour évaluer la dose interne, l'exposition des individus et/ou les risques sanitaires. La surveillance biologique des expositions professionnelles est particulièrement utile,

- lorsque les agents chimiques ont un effet systémique et lorsque d'autres voies que l'inhalation contribuent largement à l'absorption ;
- et/ou lorsque l'agent chimique est cumulatif ;
- lorsque les conditions de travail (port d'équipement de protection individuel ou EPI) ou les facteurs interindividuels génèrent une variabilité importante des doses internes qui n'est pas prise en compte par la métrologie atmosphérique.

Un **IBE** à un agent chimique est un paramètre (la substance mère, l'un de ses métabolites, ou le produit fixé sur les cibles ou sur des sites non critiques), mesuré dans une matrice biologique et dont la variation est associée à l'exposition à l'agent et/ou des effets sanitaires. Ce n'est ni un indicateur biologique d'effet précoce, ni un indicateur de susceptibilité/sensibilité.

Les **valeurs limites biologiques (VLB)** recommandées par l'Anses sont des valeurs sanitaires élaborées pour protéger la santé des travailleurs, en considérant une exposition de 8 heures par jour et 5 jours par semaine et ce pendant toute une vie professionnelle.

Plusieurs approches peuvent être utilisées pour dériver ces valeurs, décrites ci-dessous par ordre de priorité en fonction de la disponibilité des données :

- dérivation à partir de données caractérisant la relation entre les variations de concentration de l'IBE et les effets sur la santé (à seuil ou sans seuil) dans les populations exposées ; La VLB correspond au seuil en dessous duquel il n'est pas attendu la survenue d'effets, pour les effets à seuil de dose, ou à la concentration correspondant à une probabilité donnée de leur survenue, pour les effets sans seuil de dose ;
- en l'absence de donnée pour identifier une relation avec les effets sur la santé, détermination sur la base d'une VLEP ou d'un PoD, identifié à partir d'une ou plusieurs études clés. Dans ce cas, il est possible d'extrapoler les concentrations de l'IBE correspondant à une VLEP ou PoD externe à partir de paramètres toxicocinétiques obtenus sur des données humaines ou animales en utilisant (selon les données disponibles) :
 - des mesures d'association entre un indicateur d'exposition externe (ou PoD) et l'IBE (équations de régression),
 - des données toxicocinétiques (modèle PBK⁸ ou approche de conservation de la masse).

La VLB s'accompagne systématiquement d'une recommandation du moment de prélèvement.

Des **valeurs d'imprégnation populationnelle (VIP)** (intitulées précédemment valeurs biologiques de référence ou VBR) sont proposées par le CES pour interpréter les concentrations d'IBE. Elles permettent de situer les concentrations d'un IBE mesurées chez des travailleurs par rapport à celles observées pour le même paramètre dans une population générale d'adultes, en âge de travailler. Les VIP sont fondées sur les résultats d'études

⁸ Description mathématique simulant la relation entre le niveau d'exposition externe et la concentration d'un agent chimique dans les matrices biologiques au fil du temps. Les modèles cinétiques prennent en compte l'absorption, la distribution, le métabolisme et l'élimination de l'agent administré et de ses métabolites (OMS 2010).

d'imprégnation conduites dans un échantillon représentatif de la population générale ou de sa sous-population d'intérêt (Esteban, NHANES, Santé Canada, ...) ou à défaut, quand il s'agit de VIP_T, dans une population à effectif plus restreint et/ou non représentatif de l'ensemble de la population générale sans source d'exposition spécifique à l'agent d'intérêt. La VIP_T doit être exclusivement réservée au suivi des expositions professionnelles. En règle générale, un percentile élevé de la distribution des concentrations de l'IBE dans la population d'intérêt est retenu comme VIP, le plus souvent le 95^{ème} percentile (P95) ou la limite supérieure de son intervalle de confiance à 95 %. Les VIP ne permettent pas une interprétation en termes de risque sanitaire.

Des VIP spécifiques peuvent être attribuées à certains sous-groupes de la population, en fonction du type d'agent chimique, de l'effet et des facteurs influençant les résultats. Il est ainsi possible de recommander des valeurs en fonction du sexe, de l'âge, du tabagisme, etc.

Les VIP sont particulièrement utiles lorsqu'on ne dispose pas de VLB ou pour les agents chimiques dont les effets critiques sont sans seuil de dose. Quand on en dispose et que les concentrations de l'IBE sont inférieures à la VLB, les VIP permettent de situer l'exposition des travailleurs par rapport à celle de la population générale et éventuellement de caractériser un niveau d'exposition en lien avec une activité professionnelle.

Des méthodes analytiques décrites dans la littérature pour la détermination des IBE sélectionnés sont également renseignées. L'objectif n'est pas de recommander une méthode particulière, mais de fournir une description de certains paramètres métrologiques propres aux méthodes analytiques (limite de détection, limite de quantification, coefficient de variation des résultats, etc.) (Anses, à paraître).

- Recherche bibliographique

Afin d'élaborer ces valeurs de référence en population professionnelle, une synthèse des données toxicologiques a été réalisée sur la base des rapports réalisés par des organismes reconnus au niveau international (ATSDR 2008 ; EFSA 2008 ; ACGIH 2008 ; JECFA 2012, DFG 2012 et 2019 ; SCCS 2014, 2020, 2022 et 2023) et a été complétée par une recherche bibliographique sur les effets toxiques de l'aluminium et ses composés inorganiques couvrant la période de 2007 à juillet 2023.

Suite à l'analyse de la littérature, il a été jugé plus pertinent de démarrer les travaux d'expertise par l'évaluation des indicateurs biologiques de l'aluminium avant de réévaluer les valeurs atmosphériques.

3. ANALYSE ET CONCLUSIONS DU CES ET DU GT IBE

3.1. Toxicocinétique

La biodisponibilité de l'aluminium dépend de sa spéciation. Le principal mécanisme d'absorption est probablement la diffusion passive par les voies paracellulaires (ATSDR 2008). Les résultats des études d'absorption *in vivo* et de dissolution *in vitro* montrent que l'aluminium métallique, l'oxyde d'aluminium (Al₂O₃) et l'hydroxyde d'aluminium (Al(OH)₃) sont moins biodisponibles par voies orale et respiratoire que les formes d'aluminium solubles dans l'eau comme l'alun (Al₂(SO₄)₃). Dans des conditions physiologiques normales, l'exposition aux

formes insolubles d'aluminium ne contribue pas de manière significative à la charge corporelle totale d'aluminium (Willhite *et al.* 2021).

Chez l'Homme, l'absorption par inhalation est à la fois dépendante du composé d'aluminium (en particulier sa solubilité) et de la granulométrie de l'aérosol. La fraction absorbée par inhalation est estimée à 1,5-3% de la concentration en aluminium inhalable dans l'air. L'aluminium est faiblement absorbé par ingestion avec une fraction absorbée allant de 0,1 à 0,3% de la dose lorsqu'il provient des aliments et de 0,3% de la dose lorsqu'il provient de l'eau de boisson (Yokel et McNamara 2001). Le Scientific Committee on Consumer Safety (SCCS) a estimé une fraction absorbée, après exposition cutanée, en moyenne de $5,2 \cdot 10^{-4}$ % de la dose d'exposition cutanée (SCCS 2020).

Une fois absorbé, l'aluminium est distribué dans l'ensemble du corps, particulièrement dans les os qui représentent 50% de la charge corporelle. L'accumulation dans les poumons est principalement due à l'inhalation de formes insolubles qui ne sont pas absorbées. Le ratio érythrocyte/plasma de l'aluminium varie d'une publication à l'autre, avec des valeurs comprises entre 0,1 et 0,9 (Riihimäki and Aitio 2012). Quatre-vingt-quinze pour cent (95%) de l'aluminium plasmatique sont liés aux protéines. L'aluminium est également distribué dans la peau, le tractus gastro-intestinal inférieur et les glandes parathyroïdes. De faibles concentrations d'aluminium ont été mesurées dans la plupart des organes des tissus mous. L'aluminium est également capable de traverser la barrière placentaire (ATSDR 2008).

L'aluminium est principalement éliminé dans l'urine (95%) par filtration glomérulaire, tandis que l'aluminium alimentaire non absorbé est excrété dans les fèces. Une voie d'élimination mineure (~ 2%) est l'excrétion biliaire (Krewski *et al.* 2007 ; EFSA 2008). L'aluminium a également été détecté dans le lait maternel dans un intervalle de 9,2 à 49 $\mu\text{g.L}^{-1}$ (ATSDR 2008), dans la salive, dans la sueur et dans le liquide séminal (Krewski *et al.* 2007). Les études de toxicocinétique conduites chez l'Homme indiquent une élimination triphasique avec des demi-vies de 1,4 , 40 et 1727 jours après injection par intra-veineuse. Ces études montrent une grande variabilité des demi-vies apparentes, quelles que soient les voies d'exposition. Cette large gamme de demi-vies pourrait refléter les différences dans la durée et le moment de l'échantillonnage ou même une élimination bi- ou triphasique selon les voies d'exposition. Pour l'heure, plusieurs auteurs ont néanmoins observé une relation linéaire entre les niveaux d'aluminium urinaire après le travail et les niveaux d'aluminium dans l'air au niveau des voies respiratoires des soudeurs au cours du dernier poste ou des postes précédents cumulés (Sjögren *et al.* 1988 ; Letzel, Schaller et Angerer 1996, cités dans ATSDR 2008).

Différents modèles cinétiques pour l'aluminium, avec différents niveaux de complexité, ont été publiés (Nolte *et al.* 2001, Poddalgoda *et al.* 2021, Hethey *et al.* 2021). Les experts considèrent ces modèles comme peu adaptés pour extrapoler des doses externes à partir de concentrations urinaires. L'ensemble des processus de toxicocinétique de l'aluminium est illustré dans la Figure 3.

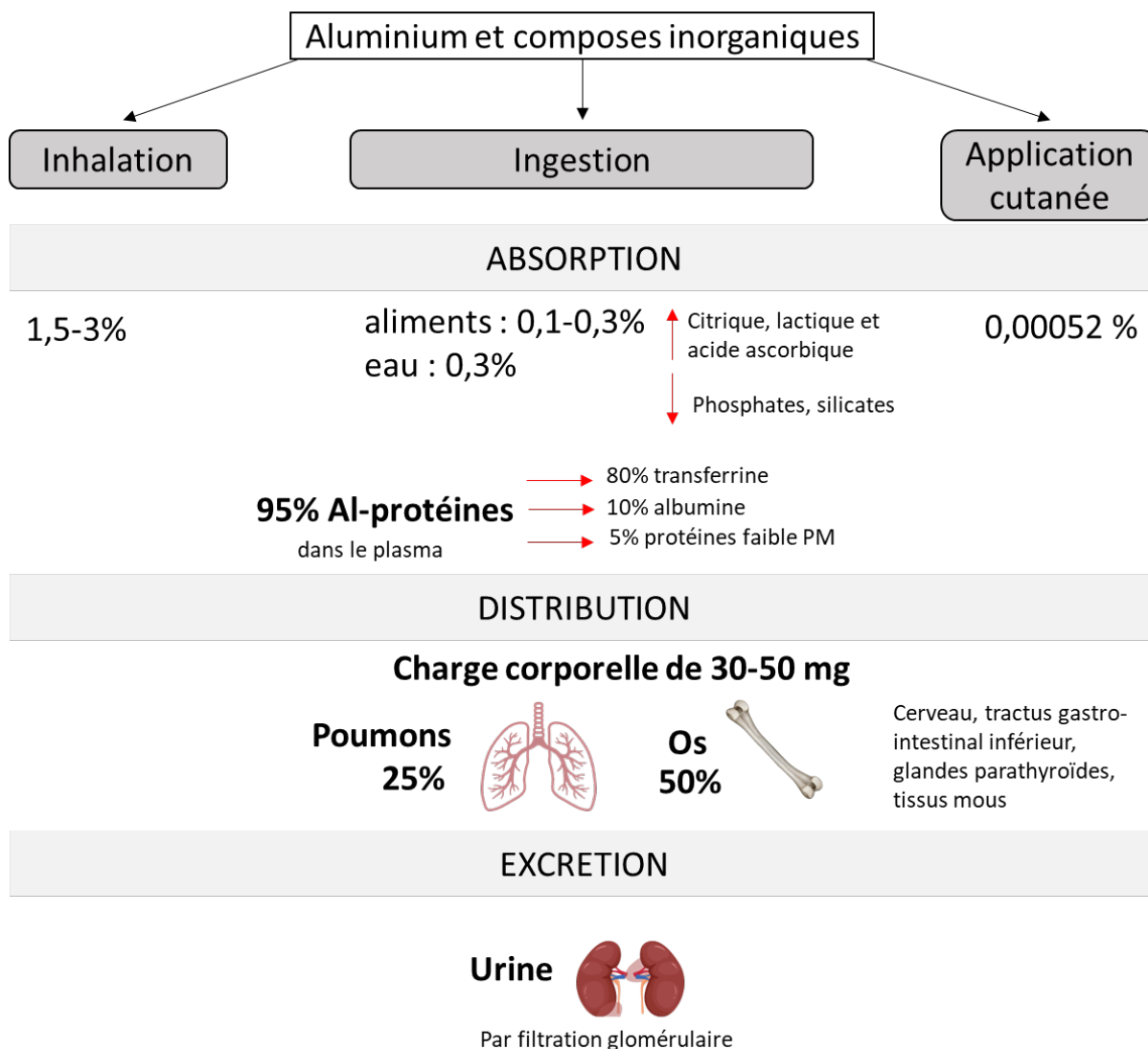


Figure 3 : Schéma de la toxicocinétique de l'aluminium et ses composés inorganiques chez l'Homme

3.2. Indicateurs biologiques d'exposition et biométrie

La recherche dans la littérature scientifique n'a pas permis d'identifier d'indicateurs biologiques d'effets précoces pertinents pour la surveillance de l'exposition à l'aluminium. Par conséquent, ces indicateurs biologiques ne sont pas développés davantage.

L'aluminium peut théoriquement être mesuré dans tous les liquides, tissus ou excréta biologiques (par exemple : le sang, le sérum, l'urine, le liquide céphalorachidien, le sperme, le lait, la salive, les os, les cheveux et les ongles) (ATSDR 2008).

3.2.1. Méthodes analytiques pour la détermination de l'aluminium

Les principales méthodes analytiques pour la mesure de l'aluminium dans le sang et les urines sont décrites dans le Tableau 1 sans pour autant en recommander une. L'objectif est ici d'informer des paramètres métrologiques spécifiques et de présenter les avantages et les limites de chaque méthode.

Tableau 1 : Aperçu des avantages, des limites et des limites de détection / limites de quantification des principales techniques analytiques utilisées pour la mesure de l'aluminium

Méthode analytique	Avantages	Limites	LD	LQ
ETAAS / GFAAS	- Simplicité de préparation des échantillons - Faible volume des échantillons - Peu d'interférences - Sensibilité	- Mesure d'un seul composé à la fois - Gamme analytique limitée	1-2 µg.L ⁻¹ (0,04-0,07 µmol.L ⁻¹)	2 µg.L ⁻¹
ICP-AES	- Simplicité de préparation des échantillons - Faible volume des échantillons - Analyse multi-éléments - Forte spécificité - Large gamme analytique	- Possibles interférences - Faible sensibilité	1-4 µ.L ⁻¹ (LD élevée)	1 µg.L ⁻¹
ICP-MS	- Simplicité de préparation des échantillons - Faible volume des échantillons - Analyse multi-éléments - Très grande sensibilité - Large gamme analytique		0,1–1 µg.L ⁻¹ (0,004–0,04 µmol.L ⁻¹)	0,2-10 µg.L ⁻¹

LD : limite de détection ; LQ : limite de quantification ; ETAAS/GFAAS : Electrothermal Atomic Absorption Spectrometry/ Graphite furnace atomic absorption spectrometry (spectrométrie d'absorption atomique électrothermique/ spectrométrie d'absorption atomique en four graphite) ; ICP-AES : Inductively Coupled Plasma Atomic Emission Spectrometry (spectroscopie d'émission atomique à plasma à couplage inductif) ; ICP-MS : Inductively Coupled Plasma Mass Spectrometry (spectrométrie de masse à plasma à couplage inductif)

3.2.2.Facteurs pouvant influencer l'interprétation des mesures d'aluminium

Certaines pratiques peuvent influencer l'interprétation des mesures d'aluminium en augmentant les niveaux d'aluminium et en rendant les résultats de la biosurveillance difficilement interprétables. Le Tableau 2 présente les facteurs pouvant influencer l'interprétation des mesures d'aluminium dans l'urine et le plasma.

Tableau 2 : Facteurs pouvant influencer l'interprétation des mesures d'aluminium total dans l'urine et le plasma

Traitement médical	La consommation de certains médicaments contenant des sels d'Al comme principe actif ou comme adjuvant pourrait augmenter les niveaux d'Al et devrait être évitée avant le prélèvement (ex. : certains antiacides, aspirines tamponnées, antidiarrhéiques, etc.).
Apport alimentaire	Le contact des aliments avec des emballages en Al, des ustensiles de cuisine et des films en Al dans des conditions acides peut entraîner l'émission d'Al et la contamination des aliments (Krewski et al. 2007). En outre, les jus de fruits (contenant de l'acide citrique qui augmente l'absorption de l'Al) peuvent augmenter les niveaux d'Al urinaire et devraient être évités dans les 2 jours précédant l'échantillonnage (Biotox ⁹).
Tabagisme	Même si des concentrations élevées d'Al dans le tabac sont rapportées, allant de 0,6 à 3,7 mg Al.g ⁻¹ de produit (Exley et al. 2006), le tabagisme n'a pas influencé les concentrations d'Al dans l'urine de sujets non exposés professionnellement

⁹ <https://www.inrs.fr/publications/bdd/biotox.html>, consulté en avril 2024

	(Chiba et Masironi 1992 ; Nisse <i>et al.</i> 2017). Il pourrait donc ne pas y avoir d'impact sur l'interprétation des résultats de la surveillance biologique.
Facteurs physiologiques ou pathologiques	L'Al étant principalement éliminé dans l'urine, les patients dont la fonction rénale est réduite peuvent présenter des niveaux plus élevés d'Al dans le sang en raison de l'absence de clairance normale (ce qui implique des niveaux urinaires réduits). La mesure de l'Al peut être utilisée pour surveiller les patients porteurs de prothèses métalliques (San Martín, Bauçà et Martínez-Morillo 2022). Par ailleurs, l'augmentation des niveaux d'Al peut également être attribuée à l'usure des implants prothétiques à base d'Al.
Co-exposition à une ou plusieurs substances (travailleurs)	N/A
Voie(s) d'exposition, description de la tâche	N/A
Activité physique, effort, ...	N/A
Fréquence et durée d'exposition	N/A

N/A : non applicable ; Al : aluminium

3.2.3. Prélèvement, collecte et stockage des échantillons biologiques

Des précautions strictes doivent être prises lors du prélèvement, de la conservation, de la préparation et de l'analyse des échantillons. Comme pour d'autres agents chimiques omniprésents, le risque de contamination externe apparaît comme un problème dans la détermination de l'aluminium.

Ci-dessous quelques recommandations concernant le prélèvement et la conservation d'échantillons de sang et d'urine en vue de la mesure de l'aluminium. Toutefois, en règle générale, le matériel d'échantillonnage devrait idéalement être fourni par des laboratoires qui ont préalablement vérifié qu'il convenait à l'analyse. En outre, dans le cas d'une exposition professionnelle à des fins de biosurveillance, les échantillons devraient de préférence être prélevés en dehors du lieu de travail et après que le travailleur a retiré ses vêtements de travail et pris une douche. Il est également conseillé de se renseigner, au préalable, auprès du laboratoire effectuant l'analyse, sur les conditions pré-analytiques requises, par exemple : les conditions de stockage et de transport (SFMT 2016).

Les recommandations suivantes sont proposées pour minimiser la contamination et garantir des résultats précis :

- 1) en premier lieu, utiliser des flacons et des consommables étiquetés « sans traces de métaux » et éviter les flacons en verre ;
- 2) si ce n'est pas le cas, le matériel doit être nettoyé avec de l'acide nitrique ultrapur à 10 % (jusqu'à un maximum de 20 %) et trempé pendant une nuit, puis rincé abondamment à l'eau ultrapure ;
- 3) dans tous les cas, tous les consommables doivent être testés pour identifier les éventuelles contaminations en aluminium (test à blanc avec des concentrations de réactifs et d'acides identiques à celles utilisées pour les échantillons). Ce test doit également être effectué après l'étape de nettoyage.

3.2.4.Choix de l'IBE

Le sang et l'urine sont les matrices les plus couramment utilisées pour la biosurveillance de routine de l'exposition à l'aluminium. Pour chacun de ces IBE, des avantages et inconvénients ont été relevés.

Les concentrations d'aluminium dans le sang total, les érythrocytes, le sérum et le plasma sont généralement considérées comme approximativement égales. Ces quatre matrices sanguines pourraient théoriquement être prises en compte pour l'évaluation de l'exposition interne (Poddalgoda et al. 2021). Cependant :

- les études sur la distribution de l'aluminium entre le sérum (ou le plasma) et les érythrocytes ont donné des résultats contradictoires, et les études sur l'association des niveaux d'aluminium dans le sang total ou les érythrocytes avec les effets sur la santé ou l'exposition externe à l'aluminium sont rares. Par conséquent, ces deux matrices ne peuvent pas être retenues actuellement pour la biosurveillance de l'exposition à l'aluminium ;
- les niveaux de sérum et de plasma sont théoriquement équivalents, mais les anticoagulants, tels que l'héparine ou le citrate, peuvent contenir de l'aluminium. Pour cette raison, le sérum doit être préféré au plasma.

La détermination de l'aluminium sérique manque de sensibilité pour révéler les petites variations de l'exposition externe et/ou pour la biosurveillance de la charge corporelle, en particulier dans les situations de faible exposition. Cependant, l'aluminium sérique reste le meilleur biomarqueur de la charge corporelle en aluminium chez les personnes souffrant d'insuffisance rénale, car leur dose interne d'aluminium peut être élevée et que le niveau d'aluminium urinaire n'est pas un indicateur d'exposition validé pour ces personnes.

L'aluminium urinaire est retenu comme IBE car il présente plusieurs avantages :

- il existe des preuves suffisantes d'une association positive entre le niveau d'aluminium urinaire et le risque d'effets sur la santé, avec des NOAEL¹⁰ et LOAEL¹¹ identifiés chez l'Homme ;
- l'aluminium urinaire est un IBE plus sensible que l'aluminium sérique lorsque les changements d'exposition externe sont minimes ($< 5 \text{ mg.m}^{-3}$) ;
- chez les personnes présentant une fonction rénale normale, les variabilités inter- et intra-individuelles sont limitées lorsque les niveaux d'aluminium sont ajustés sur la concentration de créatinine urinaire, la densité spécifique ou l'osmolalité ;
- l'échantillonnage urinaire est non invasif et des méthodes analytiques sont disponibles pour l'analyse.

Le principal inconvénient lié au prélèvement d'aluminium urinaire est le risque élevé de contamination externe lors des échantillonnages et au cours de la préparation et de l'analyse des échantillons.

D'un point de vue pratique, les études permettant de caractériser l'association entre la concentration d'aluminium dans l'urine et les effets sur la santé et d'identifier un NOAEL et un LOAEL ont été conduites en milieu de travail et ont utilisé des échantillons urinaires en fin de poste. Certaines de ces études ont rapporté les résultats des prélèvements en fin de poste et début de poste après plusieurs jours de travail. Elles n'ont montré aucune différence dans les concentrations d'aluminium urinaire à ces deux moments d'échantillonnage. Les concentrations d'aluminium dans les urines de prélèvements de début ou de fin de poste sont

¹⁰ No observed adverse effect level (ou dose sans effet néfaste observé)

¹¹ Lowest observed adverse effect level (ou dose minimale entraînant un effet néfaste observé)

déterminées par la charge corporelle et l'exposition actuelle. La cinétique d'élimination de l'aluminium indique que sa concentration dans des prélèvements urinaires réalisés après quelques jours d'arrêt de l'exposition professionnelle (par exemple, avant le premier poste de la semaine de travail) serait moins influencée par l'exposition actuelle, donc probablement un meilleur indicateur de la charge corporelle. Cependant, les données disponibles ne permettent pas de caractériser l'association de la concentration d'aluminium urinaire avant le premier poste de la semaine de travail et des effets sanitaires.

Ainsi, le CES VSR retient l'aluminium urinaire comme l'IBE pertinent pour la surveillance biologique de l'exposition à l'aluminium, sur la base d'une analyse des avantages et des inconvénients des différents IBE identifiés. En cas d'atteinte de la fonction rénale, l'aluminium urinaire ne peut pas être utilisé comme IBE car cette condition pathologique affecte l'interprétation des résultats de la surveillance biologique.

3.3. Synthèse des données toxicologiques

3.3.1. Toxicité aiguë

Chez l'Homme, aucune étude pertinente mettant en évidence des effets de l'aluminium suite à une exposition aiguë par voie orale ou respiratoire n'a été identifiée.

Plusieurs cas d'encéphalopathie liée à l'aluminium ont été rapportés chez des patients ayant subi une otoneurochirurgie avec reconstruction osseuse à l'aide d'un ciment contenant de l'aluminium (Hantson *et al.* 1995 ; Lévêque *et al.* 1996 ; Reusche *et al.* 2001). Des cas d'encéphalopathie aiguë présentant des taux plasmatiques élevés d'aluminium sont également rapportés, après une irrigation vésicale post-chirurgicale à l'alun. Cependant, dans la plupart de ces cas, l'aluminium n'était probablement pas la seule ou la principale cause des symptômes neurologiques, car des troubles hydroélectrolytiques sévères étaient manifestement ou probablement associés (Phelps *et al.* 1999).

Chez l'animal de laboratoire, des DL₅₀ (doses létales pour 50% des animaux) sont rapportées pour plusieurs composés de l'aluminium chez le rat ; elles sont comprises entre 162 mg Al.kg pc⁻¹ (bromure d'aluminium) et plus de 730 mg Al.kg pc⁻¹ (sulfate d'aluminium). Une exposition par inhalation pendant 4 heures chez le rat à 1000 mg.m⁻³ n'a pas entraîné d'effet léthal mais des microgranulomes multifocaux dans les poumons et des ganglions lymphatiques hilaires ont été détectés (Thomson *et al.* 1986).

3.3.2. Irritation et sensibilisation

Le chlorure d'aluminium anhydre dispose d'une classification et d'un étiquetage harmonisé au niveau européen qui le classe corrosif pour la peau de catégorie 1B.

Selon le SCCS, il n'existe pas de données suffisantes chez l'Homme suggérant que les composés d'aluminium utilisés dans les antiperspirants provoquent des allergies et, compte tenu de leur utilisation répandue, cet effet, s'il existe, semble rare. Les données animales n'indiquent pas d'effet de sensibilisation cutanée des composés d'aluminium utilisés dans ces produits (SCCS 2023).

3.3.3. Toxicités subchronique et chronique

- Données chez l'Homme

De nombreuses études ont documenté des effets respiratoires liés à l'exposition professionnelle à l'aluminium : respiration sifflante, dyspnée, altérations de la fonction pulmonaire, asthme et fibrose pulmonaire. Cependant, le lien entre ces troubles et l'exposition à l'aluminium reste incertain, voire improbable dans de nombreuses études, en raison de facteurs de confusion, notamment la co-exposition à d'autres substances toxiques, en particulier des agents irritants (fluorures, ozone, etc.), des particules ultrafines et de la silice cristalline. Des données contradictoires sont rapportées concernant les effets pulmonaires de la poudre d'aluminium finement broyée : certaines publications font état de cas de fibrose pulmonaire chez des travailleurs exposés, alors que d'autres études ne montrent aucune preuve de fibrose après une exposition prolongée à des particules fines d'aluminium. Cette différence pourrait s'expliquer par le type de lubrifiant utilisé pour empêcher l'oxydation superficielle des particules d'aluminium pendant le broyage (huiles minérales au lieu d'acide stéarique¹²). Des cas sporadiques de pneumoconiose associés à l'exposition professionnelle à l'aluminium sont également signalés (Korogiannos, Babatsikou et Tzimas 1998 ; Kraus et al. 2000 ; Hull et Abraham 2002). Leur faible nombre et les co-expositions à d'autres agents chimiques limitent leur interprétation.

Vingt-cinq études épidémiologiques (21 transversales et 4 longitudinales) ont évalué l'association entre la dose interne d'aluminium (au moins les niveaux d'aluminium dans le sang total, le plasma, le sérum ou l'urine) et les troubles cognitifs chez des travailleurs de différentes industries de l'aluminium. Les principaux troubles cognitifs rapportés dans plusieurs études épidémiologiques sont une baisse de performances dans des tests psychomoteurs et/ou de l'attention. Les études épidémiologiques ne contenaient soit, pas de données, soit des données insuffisantes concernant la concentration d'aluminium dans l'air (pas de mesure individuelle ou de mesure de concentration en poussières dans l'air). En revanche, les concentrations d'aluminium dans le sang (sérum ou plasma) ou les urines y étaient rapportées et des différences de concentration de l'IBE entre les travailleurs exposés et les non exposés ont pu être observées en lien avec des troubles cognitifs, ce qui a permis d'identifier des NOAEL et/ou des LOAEL. Seules les études pour lesquelles un NOAEL et/ou un LOAEL ont été identifiés sont décrites ci-dessous.

Une étude transversale chinoise a comparé 103 travailleurs exposés à l'aluminium et 64 témoins en utilisant la batterie de tests neurocomportementaux recommandée par l'organisation mondiale de la santé (OMS) (Guo et al. 1999). Les travailleurs exposés étaient des employés d'une grande usine de production d'aluminium, travaillant dans les départements d'électrolyse, de fusion ou de soudure depuis au moins cinq ans. Les témoins, travaillant dans d'autres départements, n'étaient pas exposés à l'aluminium et étaient appariés selon l'âge, la durée d'emploi, le niveau d'éducation, la consommation d'alcool et le statut tabagique. Les niveaux d'aluminium urinaire étaient mesurés en fin de poste (jour de la semaine de travail, non précisé) avec des niveaux moyens de 41,8 µg.g⁻¹ de créatinine chez les travailleurs exposés et de 17,7 µg.g⁻¹ de créatinine chez les témoins. Les résultats des

¹² L'acide stéarique est aujourd'hui le lubrifiant le plus couramment utilisé. Il réagit avec l'aluminium en formant un film protecteur superficiel de stéarate d'aluminium. Aucun effet fibrogène n'est signalé lors de l'utilisation de ce procédé. En revanche, l'utilisation antérieure et désormais abandonnée de l'huile minérale comme lubrifiant pour le broyage de l'aluminium a été associée à une fibrose pulmonaire.

tests neurocomportementaux montraient des altérations des performances cognitives incohérentes selon les groupes d'âge.

Une étude longitudinale a été menée dans une usine de production de poudre d'aluminium, en Allemagne, avec, lors du premier examen, 32 travailleurs exposés à la poussière d'aluminium comparés à un groupe témoin de 30 personnes non exposées (Letzel *et al.* 2000). Cinq ans plus tard, lors du deuxième examen, seuls 21 travailleurs exposés et 15 témoins ont accepté de poursuivre l'étude. Les niveaux internes d'aluminium étaient significativement plus élevés dans le groupe exposé lors des deux évaluations (moment d'échantillonnage et méthode d'analyse non spécifiés). En particulier, lors du premier examen, les niveaux médians d'aluminium dans l'urine étaient de $87,6 \mu\text{g.g}^{-1}$ de créatinine chez les travailleurs exposés contre $9,0 \mu\text{g.g}^{-1}$ de créatinine dans le groupe témoin, avec une médiane d'aluminium dans le plasma de $8,7 \mu\text{g.L}^{-1}$ dans le groupe exposé contre $4,3 \mu\text{g.L}^{-1}$ dans le groupe témoin. Lors du second examen, les taux médians d'aluminium urinaire étaient de $19,8 \mu\text{g.g}^{-1}$ de créatinine chez les travailleurs exposés contre $4,5 \mu\text{g.g}^{-1}$ de créatinine dans le groupe témoin, avec un taux médian d'aluminium plasmatique de $6,7 \mu\text{g.L}^{-1}$ dans le groupe exposé contre $4,3 \mu\text{g.L}^{-1}$ chez les témoins. La différence entre les deux examens s'explique par l'amélioration de l'hygiène professionnelle. Aucune relation dose-réponse entre les concentrations plasmatiques ou urinaires d'aluminium, ou la durée d'exposition à l'aluminium et les paramètres psychométriques n'a été observée.

Dans une étude transversale, He *et al.* ont étudié les paramètres neurocomportementaux, la fonction du système nerveux autonome et les sous-populations de lymphocytes chez 33 travailleurs d'une usine d'aluminium chinoise et 34 témoins d'une meunerie (He *et al.* 2003). Les concentrations urinaires moyennes d'aluminium mesurées dans les urines du matin (sans précision de l'horaire par rapport à la prise de poste et du jour de la semaine de travail) étaient respectivement de $40,1$ et $26,8 \mu\text{g.g}^{-1}$ de créatinine chez les travailleurs exposés et les témoins. Une batterie de tests neurocomportementaux comprenant un questionnaire standardisé sur l'état de l'humeur et des tests psychométriques a été réalisée. Le temps de réaction était significativement plus lent chez les travailleurs exposés par rapport aux témoins. Les scores aux tests des symboles numériques et de poursuite étaient significativement plus faibles chez les travailleurs exposés.

Une étude longitudinale a été menée sur 4 ans auprès de soudeurs d'aluminium de l'industrie automobile en Allemagne (Buchta *et al.* 2003 ; Kiesswetter *et al.* 2009). Trois examens ont été effectués en 1999, 2001 et 2003. Quatre-vingt-dix-huit (98) soudeurs d'aluminium en 1999, 97 en 2001 et 92 en 2003, ont été comparés aux 50 mêmes témoins. Les sujets devaient avoir au moins 2 ans d'expérience lors du premier examen. Les personnes ayant des maladies neurologiques non liées à l'exposition, des maladies cérébrovasculaires, du diabète, des blessures à la tête, ou une connaissance insuffisante de la langue allemande étaient exclues. Les concentrations d'aluminium dans le plasma et l'urine étaient mesurées en début et fin de poste, après plusieurs postes. Les évaluations neurocomportementales incluaient des tests standardisés tels que les matrices progressives standard (SPM), un test d'intelligence verbale (WST) et le système européen d'évaluation neurocomportementale (EURO-NES), ainsi que des tests de temps de réaction, de conception de blocs et de performance psychomotrice. Les concentrations urinaires médianes d'aluminium en fin de poste étaient respectivement de $37,87$; $33,57$ et $15,4 \mu\text{g.g}^{-1}$ de créatinine en 1999, 2001 et 2003. La concentration médiane d'aluminium dans l'urine a également été mesurée avant le poste de travail et était de $38,4$; $35,0$ et $12,6 \mu\text{g.g}^{-1}$ de créatinine en 1999, 2001 et 2003. Les concentrations plasmatiques médianes étaient respectivement de $8,3$; $4,1$ et $4,3 \mu\text{g.L}^{-1}$ en 1999, 2001 et 2003. Aucune

différence de symptômes neurologiques et de performances aux tests psychométriques n'a été rapportée entre les deux groupes, à l'exception d'un temps de décision légèrement plus lent et de mouvements moteurs plus rapides chez les soudeurs.

Une autre étude longitudinale a été réalisée sur 4 ans (1999, 2001, 2003) chez 44 soudeurs d'aluminium et 37 témoins non exposés, issus de la même industrie de construction de trains et de camions en Allemagne (Buchta *et al.* 2005 ; Kiesswetter *et al.* 2007). Les concentrations d'aluminium dans le plasma et l'urine en début et fin de poste ont été mesurées, après plusieurs postes. Les évaluations neurocomportementales incluaient des entretiens standardisés, des examens physiques, un test d'intelligence verbale (WST), un test de rappel de chiffres, un test de conception de blocs, une batterie de tests informatisés de performance motrice, un test de temps de réaction simple et le test des matrices progressives standard (SPM). Les concentrations urinaires et plasmatiques d'aluminium en fin de poste étaient respectivement de $97 \mu\text{g.g}^{-1}$ de créatinine et $11,6 \mu\text{g.L}^{-1}$ en 1999, $143,9 \mu\text{g.g}^{-1}$ de créatinine et $14,3 \mu\text{g.L}^{-1}$ en 2001, et $64,5 \mu\text{g.g}^{-1}$ de créatinine et $13,2 \mu\text{g.L}^{-1}$ en 2003. Les concentrations médianes d'aluminium dans l'urine ont également été mesurées avant le poste et étaient de 92,1 ; 90,1 et $58,8 \mu\text{g.g}^{-1}$ de créatinine en 1999, 2001 et 2003. Une diminution des performances a été observée chez les soudeurs par comparaison aux témoins, significative uniquement pour les résultats des tests de conception de blocs. Des diminutions non significatives des performances, étaient observées dans le groupe des soudeurs pour le QI verbal, le test SPM, le test de traçage de pistes, le test de traçage de lignes et les tâches de commutation de l'attention par rapport aux témoins.

- Données chez l'animal

Plusieurs études ont été menées sur des animaux de laboratoire (souris, rats, gerbilles, cobayes et chiens) pour étudier les effets d'une exposition subchronique ou chronique par voie orale ou respiratoire à divers composés aluminiques.

Certaines de ces études chez la souris par voie orale ont montré des effets neurotoxiques, tels qu'une altération de l'apprentissage et de la mémoire, une diminution de la force de préhension des membres antérieurs et postérieurs, une diminution de la réaction de sursaut, une diminution de l'activité locomotrice et du nombre total d'activités, un test de géotaxie négatif réduit et des lésions et diminution de la densité des cellules de l'hippocampe (Golub *et al.* 1989 : NOAEL = $62 \text{ mg Al.kg pc}^{-1}.\text{j}^{-1}$ et LOAEL = $130 \text{ mg Al.kg pc}^{-1}.\text{j}^{-1}$; Cao *et al.* 2016 : NOAEL = $10 \text{ mg Al.kg pc}^{-1}.\text{j}^{-1}$ et LOAEL = $30 \text{ mg Al.kg pc}^{-1}.\text{j}^{-1}$; Yan *et al.* 2017 : NOAEL = $36 \text{ mg Al.kg pc}^{-1}.\text{j}^{-1}$ et LOAEL = $73 \text{ mg Al.kg pc}^{-1}.\text{j}^{-1}$).

Des effets pulmonaires ont été observés chez le rat à la suite d'une exposition respiratoire, tels qu'une augmentation des macrophages alvéolaires et des lésions granulomateuses. Une augmentation du poids relatif des poumons a également été observée (Stone *et al.* 1979 : NOAEL = $0,65 \text{ mg.m}^{-3}$ et LOAEL = $6,5 \text{ mg.m}^{-3}$).

Des effets hématologiques ont été rapportés chez le rat dans certaines études après une administration par voie orale, telles qu'une perturbation de l'homéostasie du fer, une diminution des taux d'hémoglobine, d'hématocrite et d'haptoglobine, une augmentation du compte des réticulocytes. Ces effets ne sont pas systématiquement observés (Gómez *et al.* 1986 : NOAEL = $47 \text{ mg Al.kg pc}^{-1}.\text{j}^{-1}$ et LOAEL = $95 \text{ mg Al.kg pc}^{-1}.\text{j}^{-1}$; Vittori *et al.* 1999 : LOAEL = $230 \text{ mg Al.kg pc}^{-1}.\text{j}^{-1}$).

Toujours chez le rat, des résultats divergents ont été observés dans les études pour les effets sur les os. Une diminution de la densité minérale osseuse ou des changements dans le

contenu minéral des os, ainsi qu'une perturbation de la structure histologique du fémur ont été rapportés (Konishi *et al.* 1996 : NOEL = 90 mg Al.kg pc⁻¹.j⁻¹ ; Sun *et al.* 2015 : LOAEL = 13 mg Al.kg pc⁻¹.j⁻¹).

D'autres effets ont également pu être rapportés comme une réduction du poids corporel, une augmentation du poids de la rate, une augmentation de la pression artérielle systolique et des lésions histopathologiques du foie.

3.3.4.Effets sur la reproduction et le développement

Chez l'Homme, aucune étude des effets sur la reproduction et le développement n'a été identifiée.

Plusieurs études ont porté sur les effets sur la reproduction et le développement suite à une exposition orale à des composés aluminiques chez des animaux de laboratoire (souris, rats, gerbilles, lapins, cobayes et chiens).

Les effets sur la reproduction observés étaient une augmentation de l'incidence des résorptions, une modification de la durée de gestation chez les souris (un jour à deux jours avant terme après comparaison aux contrôles) (Donald *et al.* 1989), une diminution de la qualité spermatique chez les rats (Gosh *et al.* 2021), des modifications morphologiques des glandes para-urétrales et des gonades chez les gerbilles (Da Silva Lima *et al.* 2020 et 2022) et une diminution des concentrations sériques d'œstrogènes, de progestérone, d'hormone folliculo-stimulante (FSH) et d'hormone lutéinisante (LH) chez les rats (Wang *et al.* 2012 ; Fu *et al.* 2014). D'autres études n'ont montré aucun effet de l'exposition à l'aluminium sur l'histologie des tissus de reproduction et la fertilité des souris et rats, mâles et femelles (Golub *et al.* 1992 ; Steinhagen *et al.* 1978 ; Domingo *et al.* 1987).

Différentes études ont observé des effets sur le développement après exposition à l'aluminium par voie orale tels qu'un nombre réduit de portées, la réduction du poids des petits, une mortalité postnatale plus élevée, des changements dans les schémas de développement de la prostate après la naissance, une ossification retardée, un retard de l'ouverture vaginale, la présence de fentes palatines et une augmentation des malformations congénitales et des anomalies mineures. Des effets sur le neurodéveloppement ont également été mis en évidence dans plusieurs études telles que :

- dans une étude menée par Poirier *et al.* (2011) conformément aux bonnes pratiques de laboratoires (BPL) et selon la ligne directrice 426 de l'OCDE exposant des rats au citrate d'aluminium *via* l'eau de boisson à partir du 6^{ème} jour de conception (GD6) jusqu'au 364^{ème} jour postnatal (PND), des précipités blancs ont été observés dans les voies urinaires, entraînant une hydronéphrose, une dilatation de l'uretère et la formation de calculs. Cet effet a été plus particulièrement observé dans le groupe ayant reçu la dose élevée (300 mg Al.kg pc⁻¹.j⁻¹), en particulier chez les petits mâles. Dans le groupe ayant reçu 100 mg Al.kg pc⁻¹.j⁻¹, des lésions des voies urinaires, une diminution du poids corporel, une réaction exagérée au pincement de la queue, un écartement plus étroit des pattes chez les femelles et une diminution de la force de préhension des membres postérieurs et antérieurs chez les petits ont été observés ;
- deux études multigénérationnelles conformes aux BPL ont été conduites par Hirata-Koizumi *et al.* (2011a et b) montrant des effets à la suite de l'administration de sulfate d'aluminium *via* l'eau de boisson tels qu'une diminution du poids corporel avant le sevrage, une diminution du poids du foie, de la rate et du thymus et un retard de l'ouverture vaginale.

Inversement, d'autres études n'ont observé aucun effet sur le poids de naissance, la mortalité péri- et post-natale des petits, aucun signe d'embryotoxicité, y compris aucune anomalie morphologique et aucun retard dans l'ouverture du vagin.

3.3.5. Génotoxicité

Les sels d'aluminium étant capables d'induire un stress oxydatif, ils pourraient éventuellement induire une mutagénicité *in vivo* via ce mécanisme d'action. Les études *in vitro* et *in vivo* indiquent que les composés d'aluminium peuvent induire des effets génotoxiques, principalement à des niveaux d'exposition élevés. Toutefois, des tests supplémentaires, comme le test des micronoyaux sur les érythrocytes de mammifères et le test Comet sur les cellules de mammifères avec l'oxyde d'aluminium, sont nécessaires pour clarifier davantage le potentiel génotoxique des sels d'aluminium.

3.3.6. Cancérogénicité

Selon le centre international de recherche sur le cancer (CIRC), il existe des preuves suffisantes chez l'Homme de la cancérogénicité de la production d'aluminium par le procédé Söderberg¹³. En effet, cette activité est associée à des incidences élevées de cancers de la vessie et du poumon. Les risques de cancer associés à la production d'aluminium résultent principalement de l'exposition aux hydrocarbures aromatiques polycycliques (HAP) plutôt que de l'exposition à l'aluminium ou à ses composés (CIRC 2012).

Sur la base de la quantification d'aluminium dans les tissus du cancer du sein, un lien potentiel entre les anti-perspirants et le cancer du sein a été supposé (SCCS 2023). Cependant, malgré ses potentiels effets génotoxiques, les données existantes provenant d'études animales et épidémiologiques sont actuellement insuffisantes pour établir définitivement une relation de cause à effet entre l'exposition à l'aluminium et le risque de cancer du sein.

3.3.7. Populations sensibles

Les personnes souffrant d'insuffisance rénale constituent la principale population à risque de sur-imprégnation à l'aluminium et sont donc plus sensibles à sa toxicité (Krewski *et al.* 2007 ; ATSDR 2008).

3.4. Proposition de valeurs biologiques

3.4.1. Construction d'une valeur limite biologique (VLB)

L'aluminium urinaire, mesuré en fin de poste après plusieurs journées de travail, est retenu comme IBE pertinent pour le suivi de l'exposition professionnelle à l'aluminium (voir section 3.2.4).

3.4.1.1. Choix de l'effet critique

Le principal effet systémique survenant aux plus faibles concentrations urinaires, rapporté dans les études épidémiologiques sur les travailleurs exposés à l'aluminium, est une baisse

¹³ Production de l'aluminium par électrolyse

des performances cognitives objectivée sous la forme d'une diminution des performances neurocomportementales par rapport aux personnes non exposées (Hosovski et al., 1990 ; Bast-Pettersen et al., 1994 ; Hänninen et al., 1994 ; Guo et al., 1999 ; Riihimäki et al., 2000 ; Bast-Pettersen et al., 2000 ; He et al., 2003 ; Buchta et al., 2005 ; Kiesswetter et al., 2007). Par ailleurs, plusieurs études en population générale ont exploré l'association entre l'exposition à l'aluminium et les performances cognitives (tests neurocomportementaux). Cependant, seuls les niveaux d'aluminium mesurés dans l'eau de boisson y sont rapportés sans mesures correspondantes de l'aluminium dans les matrices biologiques.

Le choix de l'effet critique est également conforté par les études expérimentales : en effet, plusieurs études expérimentales par voie orale chez l'animal ont montré des effets neurotoxiques tels qu'une altération des capacités d'apprentissage et de la mémoire, une diminution de la force de préhension des membres antérieurs et postérieurs, une diminution de la réaction de sursaut, une diminution de l'activité locomotrice et du nombre total d'activités, un test de géotaxie négatif réduit et des lésions et diminution de la densité des cellules de l'hippocampe.

Ainsi, le CES VSR retient les effets neurotoxiques (diminution des performances cognitives objectivée par des tests neurocomportementaux) comme effet critique pour l'élaboration d'une VLB pour l'aluminium urinaire.

3.4.1.2. Choix de l'hypothèse de construction

Pour la plupart des effets non cancérogènes, il est généralement admis, par défaut et dans l'état actuel des connaissances, que la toxicité ne se manifeste qu'au-delà d'un seuil de dose. **Ainsi, le CES VSR considère que la diminution des performances cognitives résulte d'un mécanisme à seuil de dose.**

3.4.1.3. Choix de l'étude clé et du point de départ

Deux études longitudinales, jugées de bonne qualité, portant sur des cohortes distinctes de travailleurs établissant une association entre les concentrations d'aluminium urinaire et la diminution des performances cognitives permettent de déterminer des NOAEL et LOAEL :

- un NOAEL de 38 $\mu\text{g.g}^{-1}$ créatinine (en fin de poste après plusieurs jours de travail) issu d'une étude sur des soudeurs d'aluminium dans la construction automobile (98 travailleurs et 50 contrôles) (Buchta et al., 2003 ; confirmée par l'étude de Kiesswetter et al., 2009) ;
- un LOAEL de 97 $\mu\text{g.g}^{-1}$ créatinine (en fin de poste après plusieurs jours de travail) issu d'une étude sur les travailleurs de la construction de trains et camions (44 travailleurs et 37 contrôles) (Buchta et al., 2005 ; confirmée par l'étude de Kiesswetter et al. de 2007).

Aucune altération des performances cognitives n'a été observée dans une étude longitudinale chez des travailleurs présentant des concentrations plasmatiques d'aluminium comparables à celles observées par Buchta *et al.* (2003) mais des concentrations urinaires plus élevées (87,6 $\mu\text{g.g}^{-1}$ créatinine) suggérant une contamination des échantillons d'urine (Letzel *et al.* 2000).

Des LOAEL plus bas ont été observés dans deux études mais n'ont pas été retenus car les résultats relatifs aux effets sur la performance cognitive étaient équivoques :

- LOAEL de 41,8 $\mu\text{g.g}^{-1}$ créatinine (fin de poste, jour de la semaine non précisé) montrant des altérations des performances cognitives équivoques selon les groupes d'âge (Guo et al. 1999) ;
- LOAEL de 40,1 $\mu\text{g.g}^{-1}$ créatinine (urines du matin, horaire par rapport à la prise de poste et jour de la semaine non précisés) avec un temps de réaction significativement meilleur chez les travailleurs exposés, malgré des scores plus faibles aux tests de symboles numériques et de visée (He et al. 2003).

En conclusion, le CES VSR retient l'étude longitudinale de Buchta et al. de 2003 confirmée par celle de Kiesswetter et al. de 2009 comme étude clé et le NOAEL de 38 $\mu\text{g.g}^{-1}$ créatinine (fin de poste après plusieurs postes) comme PoD.

3.4.1.4. Choix des facteurs d'incertitude

Conformément au guide méthodologique (Anses, à paraître), les facteurs d'incertitude (FI) suivants sont retenus :

- variabilité inter-espèces (FI_A) : 1, car la VLB est basée sur des données humaines ;
- variabilité inter-individuelle (FI_H) : 1, en considérant que la population de travailleurs présente dans l'étude clé est représentative de l'ensemble des travailleurs en terme de variabilité inter-individuelle ;
- transposition subchronique à chronique (FI_S) : 1, car les individus étaient exposés de manière chronique (4 ans de suivi, trois examens) ;
- utilisation d'un PoD (FI_{LB}) : 1, le point de départ retenu étant un NOAEL ;
- insuffisance des données (FI_D) : 1, l'aluminium est un agent chimique dont les effets sont très documentés.

Le facteur d'incertitude global proposé pour dériver la VLB est de 1.

3.4.1.5. Proposition d'une VLB

La VLB est calculée en faisant le rapport entre le PoD et le FI global.

Ainsi, une VLB de 38 $\mu\text{g.g}^{-1}$ de créatinine arrondie à 40 $\mu\text{g.g}^{-1}$ créatinine, fondée sur la neurotoxicité, est proposée pour l'aluminium urinaire avec une mesure effectuée en fin de poste après plusieurs postes.

3.4.2. Valeur d'imprégnation populationnelle (VIP)

En général, lors de la sélection d'une VIP, le 95^{ème} percentile de la distribution dans la population générale d'une étude de référence est utilisé. Dans le cas de l'aluminium, les niveaux urinaires issus de l'étude « ESTEBAN »¹⁴, qui servirait normalement d'étude de référence pour la population française, ne peuvent être interprétés en raison d'une probable contamination externe des échantillons d'urine par l'aluminium. En revanche, l'étude « IMEPOGE » (2008-2010)¹⁵ de Nisse et al. (2017), avec un grand nombre de participants adultes (n = 1920 âgés de 20 à 59 ans), représentative de la population adulte vivant dans le Nord de la France (Hauts-de-France), est retenue comme étude de référence, menant à une

¹⁴ Étude de santé sur l'environnement, la biosurveillance, l'activité physique et la nutrition

¹⁵ L'étude IMEPOGE est une étude transversale descriptive ayant mesuré les concentrations de métaux dans le sang et l'urine de la population générale du Nord de la France entre mai 2008 et septembre 2010.

valeur de référence pour l'exposition à l'aluminium urinaire de $11,5 \mu\text{g.L}^{-1}$ (ou $13,3 \mu\text{g.g}^{-1}$ créatinine), correspondant au 95^{ème} percentile de la distribution des niveaux d'aluminium urinaire dans cette population.

Il convient de noter que la population échantillonnée dans cette étude est probablement représentative non seulement de la région Hauts-de-France, mais aussi de l'ensemble de la population française. En effet, comme indiqué dans l'étude, les niveaux médians d'aluminium collectés à partir des mousses végétales du Nord-Pas-de-Calais étaient même inférieurs à ceux au niveau national, suggérant que la population n'est pas surexposée à l'aluminium dans cette région et que les résultats sont extrapolables au reste de la France. De plus, le 95^{ème} percentile de la concentration d'aluminium urinaire observé dans l'étude de Nisse *et al.* (2017) est cohérent avec ceux des études menées en France par Goullé *et al.* (2005) ($11,2 \mu\text{g.L}^{-1}$, $n = 100$) et en Belgique par Hoet *et al.* (2013) ($9,3 \mu\text{g.L}^{-1}$, ou $7,5 \mu\text{g.g}^{-1}$ créatinine, $n = 1022$).

En conclusion, pour la surveillance biologique des expositions professionnelles, une VIP de $13,3 \mu\text{g.g}^{-1}$ de créatinine, correspondant au 95^{ème} percentile de l'étude « IMEPOGE » (Nisse *et al.* 2017) est proposée pour l'aluminium urinaire.

3.5. Valeurs atmosphériques : VLEP-8h et VLCT-15min

3.5.1. VLEP-8h

3.5.1.1. Choix de l'effet critique

Des effets pulmonaires ont été observés chez les travailleurs après des expositions à des composés de l'aluminium. Cependant, ces effets ne sont pas directement et seulement imputables à l'aluminium, en raison de co-expositions à d'autres agents. Chez des rats exposés au chlorhydrate d'aluminium de manière subchronique par inhalation, seuls des effets pulmonaires (augmentation du poids des poumons, augmentation des macrophages alvéolaires, lésions granulomateuses) ont été observés (Steinhagen et Cavender, 1978 ; Stone *et al.* 1979). Ces effets pourraient être imputables à la fois à l'aluminium, l'ion chlorure et à un effet non spécifique de l'exposition à des poussières. Il n'est pas donc pas possible de distinguer la part attribuable à l'aluminium.

L'exposition à l'aluminium par la voie orale ou respiratoire peut entraîner de nombreux effets systémiques sur la santé, tels que des effets neurotoxiques, neurodéveloppementaux, osseux ou hématologiques. Les effets neurotoxiques apparaissent à la fois chez l'Homme et les animaux de laboratoire aux plus faibles doses testées, par voie orale chez les animaux de laboratoire, ainsi que par voie respiratoire chez des travailleurs.

Ainsi, le CES VSR retient comme effet critique les effets neurotoxiques.

3.5.1.2. Choix de l'hypothèse de construction

Pour la plupart des effets non cancérogènes, il est considéré, par défaut et en l'état actuel des connaissances, que la toxicité ne s'exprime qu'au-delà d'un seuil de dose. Ainsi, **le CES VSR considère que les effets neurotoxiques résultent d'un mécanisme à seuil de dose.**

3.5.1.3. Choix de l'étude clé et du point de départ

Aucune étude épidémiologique en population générale ne renseigne des effets neurotoxiques de l'aluminium après exposition par inhalation ou par voie orale. Les données provenant

d'études épidémiologiques chez les travailleurs ne sont pas adéquates pour caractériser leur exposition par inhalation à l'aluminium. Les études disponibles présentent généralement des niveaux d'aluminium moyennés pour plusieurs catégories de travailleurs ou encore une concentration en poussières dans l'air non pertinente pour cette expertise. Aucune étude animale étudiant la neurotoxicité de l'aluminium par voie respiratoire n'a été identifiée.

Quatre études humaines décrivant une corrélation entre la concentration atmosphérique d'aluminium et les concentrations urinaires d'aluminium chez des travailleurs ont été identifiées (Sjögren et al. 1988, Pierre et al. 1995, Gitelman et al. 1995, Guo et al. 1999). Compte tenu des divergences entre les corrélations linéaires obtenues dans les différentes études, de la diversité des expositions industrielles et des incertitudes dans les mesures atmosphériques, ces corrélations n'ont pas été jugées suffisamment fiables pour établir une VLEP pour l'aluminium. De plus, ces corrélations ne tiennent pas compte des autres voies d'exposition à l'aluminium, en particulier l'ingestion, qui contribue significativement à l'exposition globale à l'aluminium en milieu de travail et, en conséquence, à sa concentration dans l'urine.

Des études récentes ont rapporté des effets neurotoxiques de type cognitif suite à une exposition par voie orale chez l'animal et caractérisé la relation dose-réponse : Cao *et al.* (2016) et Yan *et al.* (2017).

Cao *et al.* ont exposé des rats mâles (n = 30/groupes) à du chlorure d'aluminium pendant 3 mois par gavage à des doses de 0, 10, 30 et 90 mg Al.kg pc⁻¹.j⁻¹. Une diminution significative des capacités d'apprentissage et de mémorisation a été observée (piscine de Morris) à 30 mg Al.kg pc⁻¹.j⁻¹ (LOAEL) permettant d'identifier un NOAEL de 10 mg Al.kg pc⁻¹.j⁻¹.

Dans l'étude de Yan *et al.*, des rats ont été exposés à du chlorure d'aluminium de l'allaitement (3 semaines) à 14 semaines *via* l'eau de boisson à des doses de 0, 36, 73 et 108 mg Al.kg pc⁻¹.j⁻¹ (n=15/sexe/dose). Une diminution significative des capacités d'apprentissage et de mémorisation a été observée (piscine de Morris) à 36 mg Al.kg pc⁻¹.j⁻¹ (LOAEL) (Yan *et al.* 2017).

Ainsi, en l'absence d'étude pertinente chez l'Homme et d'étude (sub)chronique par voie respiratoire chez l'animal mettant en évidence l'effet critique retenu, une extrapolation voie à voie est proposée pour construire une VLEP-8h. L'étude de Cao *et al.* (2016) étant jugée de bonne qualité (Klimisch 1) et permettant d'identifier le plus faible NOAEL (10 mg.kg pc⁻¹.j⁻¹) pour une altération des performances cognitives, le CES VSR la retient comme étude clé. Une telle extrapolation voie à voie est possible lorsque l'effet critique est un effet systémique.

Les modèles cinétiques disponibles (Poddalgoda *et al.* 2021 ; Hethey *et al.* 2021) n'incluent pas la voie respiratoire et ne peuvent donc pas être utilisés pour réaliser l'extrapolation voie à voie.

Pour réduire l'incertitude sur la variabilité inter-espèces, un ajustement allométrique a été réalisé. Une dose équivalente humaine (HED = Human Equivalent Dose) a été calculée à l'aide de l'équation suivante¹⁶ :

$$\text{Dose équivalente Homme} = \text{Dose animal} \times \left(\frac{\text{Poids animal}}{\text{Poids homme}} \right)^{1/4}$$

¹⁶ Cette équation est issue des recommandations de l'US EPA (US EPA, 2006).

Le poids moyen des rats mâles (Sprague Dawley) de 450 g (issu d'un abaque) a été utilisé pour le calcul et celui de 70 kg pour l'Homme et, comme dose animale, le NOAEL identifié de 10 mg.kg pc⁻¹.j⁻¹.

$$\text{Soit } \text{NOAEL}_{\text{HED}} = 2,83 \text{ mg.kg pc}^{-1}.\text{j}^{-1}$$

3.5.1.4. Ajustements dosimétrique et temporel

L'extrapolation voie à voie a été réalisée à partir de l'étude de Cao et al. (2016), où l'aluminium est administré par gavage sous forme de chlorure d'aluminium qui est l'une des plus biodisponibles. En l'absence de donnée spécifique à ce composé, les valeurs maximales des taux d'absorption des différents composés inorganiques de l'aluminium par voie orale et respiratoire ont été retenues, soit respectivement 0,3 et 3%.

$$\text{NOAEC}_{\text{HEC}} = \frac{\text{NOAEL}_{\text{HED}} \times \text{Absorption}_{\text{orale}} \times \text{PC}}{\text{Volume respiratoire} \times \text{Absorption}_{\text{resp.}}}$$

Avec $\text{NOAEL}_{\text{HED}} = 2,83 \text{ mg.kg pc}^{-1}.\text{j}^{-1}$, le poids corporel (PC) = 70 kg et le volume respiratoire = 20 m³/j.

$$\text{Soit } \text{NOAEC}_{\text{HEC}} = 0,99 \text{ mg.m}^{-3}$$

Un ajustement temporel a ensuite été effectué, en considérant 8 heures de travail par jour (avec des débits respiratoires de 10 m³.jour⁻¹ pendant 8 heures pour un travailleur ayant une activité physique modérée et de 20 m³.jour⁻¹ pendant 24 heures pour un adulte de la population générale), 5 jours par semaine.

$$\text{NOAEC}_{\text{HEC ADJ}} = \text{NOAEC}_{\text{HEC}} \times \frac{7}{5} \times \frac{20}{10}$$

$$\text{NOAEC}_{\text{HEC ADJ}} = 2,77 \text{ mg.m}^{-3}$$

Le CES VSR retient un $\text{NOAEC}_{\text{HEC ADJ}}$ de 2,77 mg.m⁻³ comme PoD après extrapolation de la voie orale vers la voie respiratoire.

3.5.1.5. Choix des facteurs d'incertitude

Conformément au guide méthodologique (Anses, à paraître), les facteurs d'incertitude (FI) suivants sont retenus :

- variabilité inter-espèces (FI_A) : 2,5 pour tenir compte de la variabilité toxicodynamique et d'incertitudes toxicocinétiques résiduelles, un ajustement dosimétrique ayant été réalisé ;
- variabilité interindividuelle (FI_H) : 5 par défaut ;
- transposition subchronique à chronique (FI_S) : $\sqrt{10}$, pour tenir compte de l'extrapolation des données d'une étude subchronique à une exposition chronique ;
- utilisation d'un point de départ (FI_{L/B}) : 1, le PoD étant un NOAEC ;
- insuffisance des données (FI_D) : 1, l'aluminium est un agent chimique dont les effets sont très documentés.

Un facteur d'incertitude global de 40 est donc appliqué pour la construction de la VLEP-8h.

3.5.1.6. Proposition d'une VLEP-8h

La VLEP-8h est calculée en faisant le rapport entre le PoD ajusté et le FI global.

$$\text{VLEP-8h (fraction inhalable)}^{17} = \text{NOAEC}_{\text{ADJ}} / \text{FI} = 2,77/40 = 0,0693 \text{ mg.m}^{-3} \text{ arrondie à } 70 \text{ }\mu\text{g.m}^{-3}$$

3.5.2. Proposition d'une VLCT-15min pragmatique

Aucune étude chez l'Homme n'a été identifiée concernant les effets de l'aluminium suite à une exposition de courte durée par voie respiratoire. Les études animales sur les effets de l'aluminium par inhalation révèlent des effets potentiels sur le système respiratoire : augmentation des macrophages alvéolaires, lésions granulomateuses dans les poumons et augmentation du poids des poumons (Mazzoli-Rocha et al. 2010, Thomson et al. 1986, Drew et al. 1974). Cependant, les effets pulmonaires observés chez les animaux dans ces études pourraient également être liés à une surcharge pulmonaire en poussières plutôt qu'à des effets spécifiques liés à l'aluminium.

En l'absence de donnée permettant l'élaboration d'une VLCT-15min pour l'aluminium, et conformément à sa méthodologie (Anses, à paraître), le CES VSR recommande de ne pas dépasser sur 15 minutes la valeur de 5 fois la VLEP-8h, à savoir **350 $\mu\text{g.m}^{-3}$ (pour la fraction inhalable)**.

3.5.3. Mention « peau »

L'absorption d'aluminium par la peau est estimée à 0,00052% et une étude humaine de quatorze jours sur l'application cutanée d'aluminium n'a pas montré d'impact sur les concentrations d'aluminium dans le sérum ou l'urine.

En l'absence de donnée quantitative sur la perméation cutanée, aucune mention "peau" n'est recommandée pour l'aluminium.

3.5.4. Mention « bruit »

Une seule étude fait état d'une perte d'audition dans une cohorte de travailleurs de l'aluminium par ailleurs co-exposés à un mélange de solvants composé de toluène, de xylène et de méthyléthylcétone (Rabinowitz et al. 2008). Cette perte auditive dans les hautes fréquences pouvant être attribuée à l'exposition à ce mélange de solvants, la mention "bruit" n'est pas recommandée.

3.6. Conclusions et recommandations

Le CES VSR a proposé des valeurs biologiques (une VLB et une VIP) ainsi que des valeurs atmosphériques (une VLEP-8h et une VLCT-15min pragmatique) pour l'aluminium et ses composés inorganiques à partir des données actuellement disponibles.

¹⁷ La mesure de la fraction inhalable est considérée pour la recommandation de la VLEP-8h car elle est jugée plus protectrice

L'utilisation de la VLB de $40 \mu\text{g.g}^{-1}$ de créatinine pour l'aluminium urinaire, mesurée en fin de poste après plusieurs postes, fondée sur des données humaines issues d'expositions professionnelles, est recommandée et permet de protéger les travailleurs d'une diminution des performances cognitives lors d'une exposition professionnelle à l'aluminium et à ses composés inorganiques. En effet, dans le cas d'une substance ubiquitaire telle que l'aluminium, qui présente de multiples sources et voies d'exposition, l'utilisation d'une VLB permet de prendre en compte l'ensemble des sources et des voies d'exposition à l'aluminium lors de l'évaluation des risques pour la santé des travailleurs.

En plus de la VLB recommandée, une VIP de $13,3 \mu\text{g.g}^{-1}$ de créatinine correspondant au 95^{ème} percentile de l'étude « IMEPOGE » (Nisse et al. 2017), étude considérée comme représentative d'une population générale française d'adultes, est proposée pour l'aluminium urinaire. Cette VIP permettra ainsi d'identifier une exposition professionnelle à l'aluminium.

Bien qu'ayant proposé une VLEP-8h et une VLCT-15min pragmatique, pour la fraction inhalable¹⁸ de l'aluminium et de ses composés inorganiques afin de répondre à la saisine, le CES VSR n'en recommande pas l'usage car ces valeurs qui permettent uniquement d'évaluer les expositions professionnelles par inhalation, ne prennent pas en compte les autres voies et sources d'exposition à l'aluminium qui sont, dans la majorité des cas, prédominantes.

Contrairement à la VLB, la VLEP-8h et la VLCT-15min ne peuvent pas être utilisées pour évaluer l'exposition globale des travailleurs. Par ailleurs, le CES VSR recommande, d'une part, la réalisation d'études afin de mieux caractériser les éventuels effets respiratoires de l'aluminium et de ses composés inorganiques, et d'autre part, lors de la conduite d'études visant à caractériser les effets sur les performances cognitives, de mesurer les fractions inhalable et alvéolaire d'aluminium au niveau des voies respiratoires des travailleurs, en même temps que la concentration d'aluminium dans leurs urines afin de pouvoir caractériser les associations entre les concentrations atmosphériques et urinaires d'une part et entre celles-ci et les effets cognitifs, d'autre part.

¹⁸ La justification du choix de la fraction inhalable comme fraction de référence pour la VLEP-8h et la VLCT-15min pour l'aluminium et ses composés inorganiques est son caractère protecteur (comparativement à celui de la fraction alvéolaire)

Tableau 3 : VLEP-8h, VLCT-15min, VLB et VIP

VR	Organisme	Anses			
	Année	2024			
	Nom	VLEP-8h*	VLCT-15min pragmatique*	VLB	VIP
	Valeur	70 $\mu\text{g.m}^{-3}$	Ne pas dépasser la valeur de 5 x la valeur de la VLEP-8h sur une durée de 15 minutes, à savoir 350 $\mu\text{g.m}^{-3}$	40 $\mu\text{g.g}^{-1}$ de créatinine, prélèvement en fin de poste après plusieurs postes	13,3 $\mu\text{g.g}^{-1}$ de créatinine
	IBE	NC	NC	Aluminium urinaire	Aluminium urinaire
Effet critique		Diminution des performances cognitives	Diminution des performances cognitives	Diminution des performances cognitives	NC
Étude clé	Référence	Cao et al. 2016	NC	Buchta et al. 2003 ; Kiesswetter et al. 2009	Etude IMEPOGE (2008 – 2010) (Nisse et al. 2017)
	Population de l'étude ou espèce	Rats	NC	Travailleurs	n = 1920 (population âgée de 20 à 59 ans de la région des Hauts de France)
	Exposition (durée, voie)	3 mois par voie orale (gavage)	NC	4,7 ans $\pm$ 1,6	
Point de départ (PoD)		NOAEL = 10 mg.kg pc ⁻¹ .j ⁻¹	NC	NOAEL = 38 $\mu\text{g.g}^{-1}$ de créatinine	P95 observé
Ajustement temporel		NOAEL _{ADJ} = 2,77 mg Al.kg pc ⁻¹ .j ⁻¹	NC	NA	NC
Ajustement allométrique		NOAEL _{HED} = 2,83 mg Al.kg pc ⁻¹ .j ⁻¹	NC	NA	NC
Extrapolation voie à voie		NOAEC _{HEC} = 0,99 mg.m ⁻³	NC	NC	NC
Facteurs d'incertitude (FI)		40 (FI _A 2,5 ; FI _H 5 ; FI _S $\sqrt{10}$)	NC	1 (FI _A : 1; FI _H : 1; FI _L : 1; FI _S : 1; FI _D : 1)	NC

Avis de l'Anses

Saisines n° 2022-MPEX-0179 et 2022-MPEX-0187

Saisine liée n°2023-MPEX-0137

NA : non appliqué ; NC : non concerné ; NOAEL/C : No Observed Adverse Effect Level/Concentration (dose/concentration n'entraînant pas d'effet néfaste observé) ; HED/C : Human equivalent dose/concentration (dose/concentration équivalente humaine) ; FI : facteur d'incertitude

*Le CES VSR ne recommande pas l'utilisation de la VLEP-8h et de la VLCT-15min pragmatique, étant donné que le respect de ces valeurs ne permet pas de prendre en compte l'ensemble des sources et voies d'exposition à l'aluminium et ses composés inorganiques et donc d'évaluer les risques pour la santé des travailleurs.

3.7. Éléments de proposition pour fixer une méthode de mesure

Cinq méthodes ont été identifiées pour mesurer la concentration en aluminium (fraction inhalable) dans les atmosphères des lieux de travail :

- Méthode A : échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/AES.
- Méthode B : échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse DCP/AES ;
- Méthode C : échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/MS ;
- Méthode D : échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse GFAAS ;
- Méthode E : échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse SAAF.

Ces méthodes, mettant en œuvre une technique d'échantillonnage identique, ont été discriminées selon leur technique d'analyse. Toutes ces méthodes mettent également en œuvre une digestion acide, mais les conditions et mélanges d'acides peuvent être différents d'un protocole à un autre. Les performances sont donc dépendantes des méthodes de digestion utilisées.

En ce qui concerne la technique d'échantillonnage, toutes les méthodes identifiées sont classées en catégorie 2 sous réserve de mettre en œuvre un dispositif d'échantillonnage conforme à la fraction inhalable recommandé dans l'expertise relative aux poussières sans effets spécifiques (Anses 2020). L'évaluation des méthodes identifiées est présentée dans le Tableau 4.

Tableau 4 : Évaluation des méthodes de mesure pour l'évaluation de l'aluminium sur le lieu de travail

Suivi de l'aluminium					
	Méthode	Protocoles	VLEP-8h	VLCT-15min	VLCT-15min
			Contrôle technique réglementaire	Contrôle technique réglementaire	Exposition court-terme
A	Échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/AES	NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005) NIOSH 7300 (2003) NIOSH 7301 (2003) NIOSH 7302 (2014) NIOSH 7303 (2003) NIOSH 7304 (2014) NIOSH 7306 (2015) INRS M-122 (2015) INRS M-124 (2015)	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 1B</i>	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 1B</i>	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 1B</i>

Suivi de l'aluminium					
	Méthode	Protocoles	VLEP-8h	VLCT-15min	VLCT-15min
			Contrôle technique réglementaire	Contrôle technique réglementaire	Exposition court-terme
		INRS M-125 (2016) NF X 43-257 (2016) NF X 43-275 (2002)			
B	Échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse DCP/AES	NF X 43-257 (2016) NF X 43-275 (2002)	Classement global : 3* <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 3*</i>	Classement global : 3* <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 3*</i>	Classement global : 3* <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 3*</i>
C	Échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/MS	IRSST MA-362 (2011) IRSST MA-394 (2018) NF ISO 30011 (2010) IFA 6061 (2024)	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 1B</i>	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 1B</i>	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 1B</i>
D	Échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse GFAAS	INRS M-120 (2015) DGF (MAK) 2718 (2014) NF X 43-257 (2016) NF X 43-275 (2002)	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 1B</i>	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 2</i>	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 1B</i>
E	Échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse SAAF	OSHA ID 121 (2002) INRS M-121 (2015) INSST MTA/MA – 025/A16 (2016) NIOSH 7013 (1994) NF X 43-257 (2016) NF X 43-275 (2002)	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 1B</i>	Classement global : 3 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 3</i>	Classement global : 2 <i>Technique de prélèvement : 2</i> <i>Technique d'analyse : 2</i>

La technique d'analyse de la méthode A (ICP/AES) a été classée en catégorie 1B pour le contrôle technique réglementaire de la VLEP-8h et le suivi des expositions court terme. En effet, les critères essentiels de validation sont satisfaits, mais la limite inférieure de l'intervalle de concentration d'intérêt est atteinte à l'aide de la LOQ. Pour le contrôle technique réglementaire de la VLCT-15min, la technique d'analyse a également été classée en catégorie 1B, car les critères essentiels de validation sont satisfaits mais il est nécessaire d'utiliser un dispositif d'échantillonnage avec un débit de 3,5 L.min⁻¹ ou plus pour couvrir la plage de

concentration requise de 0,1 à 2 fois la VLCT-15min. La technique de prélèvement étant classée en catégorie 2, **la méthode A (englobant le prélèvement et l'analyse) est classée en catégorie 2 pour le contrôle technique réglementaire de la VLEP-8h, de la VLCT-15min et le suivi des expositions court terme.**

La technique d'analyse de la méthode B (DCP/AES) a été classée en catégorie 3* pour le contrôle technique réglementaire de la VLEP-8h, de la VLCT-15min et le suivi des expositions court terme, en raison du manque de données de validation et de l'absence d'information concernant la gamme de concentrations sur laquelle la méthode s'applique. **La méthode B (englobant le prélèvement et l'analyse) est donc classée en catégorie 3* pour le contrôle technique réglementaire de la VLEP-8h, de la VLCT-15min et le suivi des expositions court terme.**

La technique d'analyse de la méthode C (ICP/MS) a été classée en catégorie 1B pour le contrôle technique réglementaire de la VLEP-8h, de la VLCT-15min et le suivi des expositions court terme. En effet, les valeurs des taux de récupération et des incertitudes sont disponibles et conformes aux exigences décrites dans le guide méthodologique de l'Anses (à paraître), même si les données ne sont pas disponibles pour l'ensemble de la gamme de concentrations d'intérêt. La technique de prélèvement étant classée en catégorie 2, **la méthode C (englobant le prélèvement et l'analyse) est classée en catégorie 2 pour le contrôle technique réglementaire de la VLEP-8h, de la VLCT-15min et le suivi des expositions court terme.**

La technique d'analyse de la méthode D (GFAAS) a été classée, sous réserve d'une validation appropriée dans les conditions du protocole DFG (MAK) 2718 (2014), en catégorie 1B pour la surveillance de la VLEP-8h. En effet, les données de validation sont disponibles sur la totalité de la gamme de concentration requise et bien que les incertitudes élargies sont légèrement plus élevées que les exigences décrites dans Anses (à paraître), elles ont été obtenues avec des prélèvements d'une durée de 2 heures et devraient diminuer avec un échantillonnage de 8 heures. Pour le contrôle technique réglementaire de la VLCT-15min, la technique d'analyse de la méthode D est classée dans la catégorie 2 étant donné que les données de validation ne sont pas disponibles pour l'ensemble de la plage de concentration requise. Pour le suivi des expositions court terme, la technique d'analyse est classée dans la catégorie 1B car les incertitudes élargies répondent aux exigences décrites dans Anses (à paraître). La technique de prélèvement étant classée en catégorie 2, **la méthode D (englobant le prélèvement et l'analyse) est classée dans sa globalité en catégorie 2 pour le contrôle technique réglementaire de la VLEP-8h, de la VLCT-15min et la surveillance de l'exposition à court terme.**

La technique d'analyse de la méthode E (SAAF) a été classée en catégorie 1B pour le contrôle technique réglementaire de la VLEP-8h. En effet, les critères essentiels de validation sont satisfaits, mais la limite inférieure de l'intervalle de concentration d'intérêt est atteinte à l'aide de la LOQ. Pour le contrôle technique réglementaire de la VLCT-15min, la technique d'analyse est classée en catégorie 3 car elle n'a pas été validée sur la plage de concentration de 0,1 à 2 fois la VLCT-15min. Pour le suivi des expositions court terme, la technique d'analyse est classée en catégorie 2. En effet les données de validation sont disponibles mais les taux de récupération ont été obtenus en dehors de la plage de concentration requise de 0,5 à 2 fois la VLCT-15min. La technique de prélèvement étant classée en catégorie 2, **la méthode E (englobant le prélèvement et l'analyse) est alors classée en catégorie 2 pour le contrôle technique réglementaire de la VLEP-8h et le suivi des expositions court terme, et en catégorie 3 pour le contrôle technique réglementaire de la VLCT-15min.**

Conclusions et recommandations

Le CES VSR recommande, pour le contrôle technique réglementaire de la VLEP-8h, de la VLCT-15min et le suivi des expositions court terme, les deux méthodes indicatives suivantes :

- échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/AES (méthode A) ;
- échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/MS (méthode C).

Ces méthodes sont recommandées dans les conditions présentées dans le Tableau 5.

Sur les cinq méthodes identifiées, ces deux méthodes sont recommandées car elles mettent en œuvre des techniques analytiques validées de manière plus complète que les autres méthodes, et permettent de contrôler l'ensemble des valeurs limites recommandées.

Le CES VSR attire également l'attention sur la question de la contamination par l'aluminium lors des différentes étapes d'échantillonnage et d'analyse des échantillons d'air. En effet, l'aluminium est ubiquitaire dans les laboratoires et peut être présent dans l'air et dans certains équipements de laboratoire, matériaux et appareils utilisés pour la préparation et l'analyse des échantillons. Il peut représenter une source importante de contamination des échantillons d'air manipulés dans les laboratoires. L'utilisation d'équipements exempts d'aluminium (pinces, spatules, etc.) est donc fortement recommandée. Les caractéristiques et la variabilité des valeurs à blanc des laboratoires pour l'aluminium doivent être vérifiées individuellement dans chaque laboratoire.

Tableau 5 : Méthodes recommandées pour mesurer l'aluminium dans l'air des lieux de travail

Méthode		Échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/AES	Échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/MS
Protocoles		NF ISO 15202-1 (2020); NF ISO 15202-2 (2020); NF ISO 15202-3 (2005); NIOSH 7300 (2003); NIOSH 7301 (2003); NIOSH 7302 (2014); NIOSH 7303 (2003); NIOSH 7304 (2014); NIOSH 7306 (2015); INRS M-122 (2015); INRS M-124 (2015); INRS M-125 (2016); NF X 43-257 (2016); NF X 43-275 (2002)	IRSST MA-362 (2011); IRSST MA-394 (2018); NF ISO 30011 (2010); IFA 6061 (2024)
Pour le contrôle de la VLEP-8h	Classement méthode globale	2 (Prélèvement : 2 / Analyse : 1B)	2 (Prélèvement : 2 / Analyse : 1B)
	Conditions d'utilisation	Applicable en cas d'utilisation d'un échantillonneur actif de la fraction inhalable à membrane ou filtre pouvant atteindre un débit de 2 L.min ⁻¹ recommandé dans l'expertise PSES (Anses, 2020) (tel que CFC avec prise en compte des dépôts muraux, CFC + capsule interne, IOM™, 7-Hole). (durée d'échantillonnage : 8 heures)	Applicable en cas d'utilisation d'un échantillonneur actif de la fraction inhalable à membrane ou filtre pouvant atteindre un débit de 2 L.min ⁻¹ recommandé dans l'expertise PSES (Anses, 2020) (tel que CFC avec prise en compte des dépôts muraux, CFC + capsule interne, IOM™, 7-Hole). (durée d'échantillonnage : 8 heures)

Méthode		Échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/AES	Échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/MS
Pour le contrôle de la VLCT-15min	Classement méthode globale	2 (Prélèvement : 2 / Analyse : 1B)	2 (Prélèvement : 2 / Analyse : 1B)
	Conditions d'utilisation	Applicable en cas d'utilisation d'un échantillonneur actif de la fraction inhalable à membrane ou filtre pouvant atteindre un débit $\geq$ à 3,5 L.min ⁻¹ recommandé dans l'expertise PSES (Anses, 2020) (tel que le GSP-3.5 ou le Button™). (durée d'échantillonnage : 15 minutes)	Applicable en cas d'utilisation d'un échantillonneur actif de la fraction inhalable à membrane ou filtre pouvant atteindre un débit de 2 L.min ⁻¹ recommandé dans l'expertise PSES (Anses, 2020) (tel que CFC avec prise en compte des dépôts muraux, CFC + capsule interne, IOM™, 7-Hole). (durée d'échantillonnage : 15 minutes)
Pour le suivi des expositions court terme	Classement méthode globale	2 (Prélèvement : 2 / Analyse : 1B)	2 (Prélèvement : 2 / Analyse : 1B)
	Conditions d'utilisation	Applicable en cas d'utilisation d'un échantillonneur actif de la fraction inhalable à membrane ou filtre pouvant atteindre un débit de 2 L.min ⁻¹ recommandé dans l'expertise PSES (Anses, 2020) (tel que CFC avec prise en compte des dépôts muraux, CFC + capsule interne, IOM™, 7-Hole). (durée d'échantillonnage : 15 minutes)	Applicable en cas d'utilisation d'un échantillonneur actif de la fraction inhalable à membrane ou filtre pouvant atteindre un débit de 2 L.min ⁻¹ recommandé dans l'expertise PSES (Anses, 2020) (tel que CFC avec prise en compte des dépôts muraux, CFC + capsule interne, IOM™, 7-Hole). (durée d'échantillonnage : 15 minutes)

4. CONCLUSIONS ET RECOMMANDATIONS DE L'AGENCE

L'Agence nationale de sécurité sanitaire de l'alimentation, de l'environnement et du travail endosse les conclusions et recommandations du CES « Valeurs sanitaires de référence » relatives à la recommandation de valeurs limites d'exposition (valeurs biologiques et atmosphériques) pour l'aluminium et ses composés inorganiques.

L'Agence nationale de sécurité sanitaire de l'alimentation, de l'environnement et du travail recommande le recours, en premier lieu, à une surveillance biologique des expositions à l'aluminium et à ses composés plutôt qu'à des mesures dans l'air. En effet, la mesure de l'aluminium urinaire, qui permet de prendre en compte l'ensemble des sources et voies d'exposition, constitue à ce jour l'indicateur le plus pertinent pour évaluer quantitativement les risques sanitaires en lien avec les expositions à l'aluminium et à ses composés inorganiques.

Elle indique que, pour la population générale, c'est également une valeur interne, appelée valeur toxicologique de référence interne (VTR interne) pour l'aluminium urinaire qu'elle recommande en première intention pour évaluer l'exposition à l'aluminium et à ses composés inorganiques.

Dans le cadre du Partenariat européen pour l'évaluation des risques liés aux substances chimiques (PARC), des valeurs guides de biosurveillance humaine (HBM-GV) sont recommandées pour la population générale et les travailleurs. Ces valeurs sont proposées pour des substances d'intérêt prioritaire, telles que l'aluminium et ses composés inorganiques. L'Anses tient à souligner que les valeurs recommandées dans cet avis sont identiques aux valeurs biologiques (HBMGV) actuellement proposées dans le cadre des travaux de PARC.

S'agissant des méthodes de mesure de la fraction inhalable de l'aluminium dans l'air des lieux de travail, l'Anses recommande la méthode consistant à effectuer un échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/AES et la méthode consistant à effectuer un échantillonnage actif de la fraction inhalable sur membrane ou filtre, suivi d'une digestion acide et d'une analyse ICP/MS. Ces méthodes sont indicatives et classées en catégorie 2 pour le contrôle technique réglementaire de la VLEP-8h, la VLCT-15 min pragmatique et le suivi des expositions court terme.

En raison du risque de contamination des échantillons par l'aluminium dans les laboratoires, l'Anses recommande également l'utilisation d'équipements sans aluminium (pinces, spatules, etc.) pendant les différentes étapes de prélèvement et d'analyse des échantillons d'air, ainsi que la vérification individuelle des caractéristiques et de la variabilité des valeurs à blanc dans chaque laboratoire.

Gilles SALVAT

MOTS-CLÉS

Valeurs limites biologiques, valeur d'imprégnation populationnelle, indicateurs biologiques d'exposition, valeurs limites, VLEP, niveaux d'exposition, milieu professionnel, métrologie, méthodes de mesure, agents chimiques, effets sur la santé, aluminium

Keywords

Biological limit values, populational internal exposure level, biomarkers of exposure, limit values, OEL, exposure levels, occupational, metrology, measurement methods, chemical agents, health effects, aluminium

CITATION SUGGÉRÉE

Anses. (2025). Avis complété relatif à l'expertise en vue de la fixation de valeurs limites d'exposition à des agents chimiques en milieu professionnel. Evaluation des indicateurs biologiques d'exposition en vue de la recommandation de valeurs limites biologiques et de valeur d'imprégnation populationnelle & évaluation des effets sur la santé et des méthodes de mesure des niveaux d'exposition en vue de la fixation de valeurs limites d'exposition pour l'aluminium et ses composés inorganiques en milieu professionnel. (saisine 2022-MPEX-0179 et 2022-MPEX-0187). Maisons-Alfort : Anses, 35 p.

ANNEXE 1 : SUIVI DES ACTUALISATIONS DE L'AVIS

Date	Page	Description de la modification
23/05/2025	Version initiale	
17/11/2025	1	Note de bas de page mentionnant la révision de l'avis. Ajout dans le sous-titre d'une mention relative à l'évaluation des méthodes de mesure.
	2	Ajout d'un paragraphe pour préciser l'organisation de l'évaluation des méthodes de mesure. Actualisation de la date de publication et d'adoption du rapport révisé.
	4 - 5	Ajout d'un paragraphe accompagné d'un schéma décrivant la méthode d'évaluation des méthodes de mesure.
	28 - 32	Ajout de la partie « 3.7. Eléments de proposition pour fixer une méthode de mesure ».
	33	Ajout, dans la conclusion de l'Anses, des éléments relatifs aux méthodes de mesure
	34	Modification de l'intitulé de la citation suggérée.
	35	Ajout d'une annexe pour le suivi des actualisations de l'avis.

Expert appraisal on recommending occupational exposure limits (OELs) for chemical agents

**Assessment of biomarkers of exposure and recommendation of biological limit values and populational internal exposure level
&
assessment of health effects and methods for the measurement of exposure levels in workplace atmospheres for

aluminium and its inorganic compounds**

**OEL Permanent Mission
Requests n°2022-MPEX-0179
and n°2022-MPEX-0187
Related request n°2023-MPEX-0137**

Collective expert appraisal REPORT

**Expert Committee on « health reference values »
Working group on « biomarkers of exposure »
Working group on « metrology »**

December 2024 report revised in September 2025¹

¹ This version cancels and replaces the report dated on December 2024, in order to add the assessment results of the measurement methods (see Annex 3)

Suggested citation

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Mots clés

Valeurs limites biologiques, valeur d'imprégnation populationnelle, indicateurs biologiques d'exposition, valeurs limites, VLEP, niveaux d'exposition, milieu professionnel, métrologie, méthodes de mesure, agents chimiques, effets sur la santé, aluminium

Keywords

Biological limit values, populational internal exposure level, biomarkers of exposure, biological indicators of exposure limit values, OEL, exposure levels, occupational, metrology, measurement methods, chemical agents, health effects, aluminium

Presentation of participants

PREAMBLE: Expert members of expert committees, working groups or reviewers are all appointed in a personal capacity, *intuitu personae*, and do not represent their affiliated organization.

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Acronyms and abbreviations

Al	: Aluminium
AAS	: Atomic Absorption Spectrophotometry
ANSES	: Agence nationale de sécurité sanitaire alimentation environnement travail (French agency for food, environmental and occupational health and safety)
ACH	: Aluminium Hexahydrate Chloride
AchE	: Acetylcholinesterase
ACGIH	: American Conference of Governmental Industrial Hygienists
ACP	: Acid phosphatase
Afssaps	: Previous name of the French National Agency for the Safety of Medicines and Health Products (ANSM)
ALP	: Alkaline phosphatase
AOR	: Adjusted Odds Ratio
ATIME	: Average Reaction Time
ATSDR	: Agency for Toxic Substances and Disease Registry
ATP	: Adenosine triphosphate
ATW	: Aluminium-treated drinking water
AVLT	: Auditory Verbal Learning Test
BAT	: Biologischen Arbeitsstoff-Toleranzwerten (Biological Tolerance Value)
BAR	: Biologischer Arbeitsstoff-Referenzwerte (Biological Reference Value)
BDI	: Beck depression inventory
BLV	: Biological limit value
BME	: Biomarker of exposure
BMI	: Body mass index
BMP-2	: Bone morphogenetic protein 2
BDNF	: Brain Derived Neurotrophic Factor
bw	: Body weight
cAMP	: Cyclic adenosine monophosphate
CDC	: US Centers for Disease Control and Prevention
CDT	: Clock Drawing Test
CES	: Expert Committee (comité d'experts spécialisé)
CFC	: Closed-Face Cassette
CFU-E	: Colony-forming units-erythroid
CLP	: Classification, Labelling and Packaging
CNS	: Central Nervous System
COCT	: French Steering Committee on Working Conditions
Col II	: Type II collagen
Cu	: Copper
CX3CL1	: Fractalkine (= a chemokine)
DCP-AES	: Direct-Current Plasma Atomic Emission Spectroscopy
DFG	: Deutsche Forschungsgemeinschaft (German research foundation)
DGT	: Labour General Directorate
DMN	: Default mode network
DSBT	: Digit Span Test backward
DSFT	: Digit Span Test forward
DST	: Digit Span Test
ETAAS	: Electrothermal Atomic Absorption Spectrometry
ECHA	: European chemicals agency

EEG	: Electroencephalography
EFSA	: European Food Safety Authority
ERP	: Event-related potentials
EURO-NES	: European neurobehavioral evaluation system
F1	: First generation bred from a pair of parents
FAAS	: Flame Atomic Absorption Spectrophotometry
Fe	: Iron
FOME	: Fuld Object Memory Evaluation
FSH	: Follicle-stimulating hormone
GerES	: German Environmental Survey
Gd	: Gestational day
GFAAS	: Graphite furnace atomic absorption spectrometry
GFA-P	: Glial fibrillary acidic protein
GHS	: Globally Harmonized System
GSH-PX	: Glutathione peroxidase
HBM4EU	: Human biomonitoring for Europe
HCSP	: Haut Conseil de la Santé Publique
HRV	: Health reference value
HSL	: Health and Safety Laboratory (Buxton, Derbyshire, UK)
IARC	: International Agency for Research on Cancer
CI	: Confidence Interval
ICP-AES	: Inductively Coupled Plasma Atomic Emission Spectrometry
ICP-MS	: Inductively coupled plasma mass spectrometry
INERIS	: Institut national de l'environnement industriel et des risques
INRS	: Institut national de recherche et de sécurité
INSPQ	: Institut national de santé publique du Québec
ip	: Intraperitoneal injection
IQR	: Interquartile range
IRSST	: Institut de recherche Robert-Sauvé en santé et en sécurité du travail
IV	: Intravenous
Ld	: Lactation day
LD50	: Median lethal dose
LDH	: Lactate dehydrogenase
LDH-x	: Lactate dehydrogenase isoenzyme
LH	: Luteinizing hormone
LLNA	: Local lymph node assay
LMW	: Low molecular weight proteins
LOAEL	: Lowest observed adverse effect level
LOD	: Level of detection
LOQ	: Limit of quantification
MCH II	: Major histocompatibility complex class II
MAK Commission	: German Permanent Senate Commission for the Investigation of Health Hazards of Chemical Compounds in the Work Area
MCE	: Mixed Cellulose Ester
MCI	: Mild cognitive impairment
MCT	: Monocarboxylate transporter
MMF	: Macrophagic myofasciitis
MMSE	: Mini-mental state examination
MMSE-AE	: Mini-mental state examination adjusted for age and education
MoCA	: Montreal cognitive assessment basic
N/A	: Not applicable
NCTB	: Neurobehavioral core test battery
NHANES	: National Health and Nutrition Examination Survey
NPC	: Nonparametric test combination
NIOSH	: National Institute for Occupational Safety and Health
NMU	: N-nitroso-N-methylurea

NOAEL	: No observed adverse effect level
NS	: Not specified
NTP	: National toxicology program
OEHHA	: Office of Environmental Health Hazard Assessment (Cal-EPA : California Environmental Protection Agency)
OEL	: Occupational exposure limit
OJ	: Official journal
OR	: Odds ratio
OSHA	: Occupational Safety and Health Administration
PAHs	: Polycyclic aromatic hydrocarbons
P-Al	: Aluminium levels in plasma
PARC	: Partnership for the Assessment of Risks from Chemicals
PBK	: Physiological-based toxicokinetic
PND	: Post natal day
PNR	: Post-rotatory nystagmus
POMS	: Profile of mood states questionnaire
PPM	: Parts per million
PSQI	: Pittsburg sleep quality index
PSS14	: Perceived stress scale
PTFE	: Polytetrafluoroethylene
PVC	: Polyvinyl chloride
QSM	: Quantitative susceptibility mapping
REACH	: Regulation (EC) No 1907/2006 of 18/12/06 concerning the registration, evaluation, and authorisation of chemicals
RT	: Reaction time
S-Al	: Aluminium level in serum
SCCS	: Scientific committee on consumer safety
SDH	: Succinate dehydrogenase
SEM	: Standard error of the mean
SOD	: Superoxide dismutase
SCOEL	: Scientific committee on occupational exposure limits
SPF	: Santé Publique France (French Public Health Agency)
SPM	: Standard progressive matrices test
SRT	: Simple reaction time
SST	: Static steadiness test
TGF-b1	: Transforming growth factor b1
TLV	: Threshold limit value
TNO	: The Netherlands Organisation of Applied Scientific Research
TWA	: Time weighted average
U-Al	: Aluminium levels in urine
UF	: Uncertainty factor
UF _A	: Uncertainty factor for interspecies variability
UF _D	: Uncertainty factor for insufficient data
UF _H	: Uncertainty factor for intra-specie or inter-individual variability
UF _{L/B}	: Uncertainty factor due to the point of departure
UF _s	: Uncertainty factor due to the duration of the key study
US EPA	: United States Environmental Protection Agency
WG	: Working group
VFT	: Verbal fluency test
VMR	: Valeur Minimale Rapportée
WAIS	: Wechsler adult intelligence scale
WMS	: Wechsler memory scale
Zn	: Zinc

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1 Background, purpose and procedure for carrying out the expert appraisal

1.1 Presentation of the issue

The French methodology to establish Occupational Exposure Limits OELs has three clearly distinct phases:

- independent scientific expertise (the phase entrusted to Anses);
- proposal by the Ministry of Labour of a draft regulation for the establishment of limit values, which may be binding or indicative;
- stakeholder consultation during the presentation of the draft regulation to the French Steering Committee on Working Conditions (COCT). The aim of this phase is to discuss the effectiveness of the limit values and if necessary to determine a possible implementation timetable, depending on any technical and economic feasibility.

The organisation of the scientific expertise phase required for the establishment of Occupational Exposure Limits (OELs) was entrusted to the agency in the framework of the French 2005-2009 Occupational Health Plan.

1.2 Purpose of the request

In the scope of the memorandum of agreement between Anses and the Ministry of Labour for the implementation of the scientific expertise work programme on atmospheric and biological limit values for occupational exposure established in 2018, the Labour General Directorate (DGT) requested Anses to carry out the necessary assessment for setting occupational exposure limits, ie. atmospheric and biological limit values, for aluminium and its inorganic compounds.

In addition, under the European Partnership for the Assessment of Risks from Chemicals (PARC), human biomonitoring guidance values (HBM-GVs) are derived for the general population and workers. These values are proposed for priority substances of interest, such as aluminium and its inorganic compounds. HBM-GVs are currently being proposed within PARC.

Currently, France has an indicative 8h-OEL for aluminium metal and aluminium oxide of 10 mg.m⁻³ and of 2 mg.m⁻³ for aluminium soluble salts set by the March 05, 1985 circular², an indicative 8h-OEL of 5 mg.m⁻³ for aluminium in welding fumes and powder aluminium, and of 2 mg.m⁻³ for aluminium alkyl compounds set by the May 13, 1987 circular.³

² Circular of March 05, 1985 supplementing the appendix of circular of July 19, 1982, on the acceptable values for concentrations of certain hazardous substances in workplace atmospheres (not published in the OJ)

³ Circular of May 13, 1987 supplementing the appendix of circular of July 19, 1982, on the acceptable values for concentrations of certain hazardous substances in workplace atmospheres (not published in the OJ).

1.3 Organisation of the expert appraisal

Anses entrusted examination of this request to the Expert Committee on Health Reference Values (HRV Committee). Specifically, the Working Group on Biomarkers of Exposure (BME) was mandated for the assessment of data on biological monitoring in the workplace in order to assess the suitability of recommending one or more biomarkers and elaboration of biological limit values (BLV) for the selected biomarker(s). The « metrology » working group was mandated for the assessment of the measurement methods in workplace air.

The methodological and scientific aspects of the expert appraisal work were regularly submitted to the HRV Committee.

The report produced takes into account the comments and additional information provided by the members of the HRV Committee.

This expert appraisal was therefore conducted by a group of experts with complementary skills. It was carried out in accordance with the French Standard NF X 50-110 “Quality in Expertise Activities”.

This collective expert appraisal work and its conclusions and recommendations were adopted by the HRV Committee on 13 December 2024 and revised with the addition of the metrology section on the 25th of September 2025.

1.4 Prevention of risks of conflicts of interest

ANSES analyses interests declared by the experts before they are appointed and throughout their work in order to prevent potential conflicts of interest in relation to the points addressed in expert appraisals.

The experts' declarations of interests are published on the website <https://dpi.sante.gouv.fr/>.

2 Method

In France, in the scope of occupational risk prevention, two types of limit values for exposure to chemical agents in the workplace are recommended by Anses: air occupational exposure limit values (OELs) and biological values (including biological limit values (BLVs) and populational internal exposure level, formerly known as biological reference values (BRVs)).

■ OELs

The OELs, proposed by the HRV committee, are levels of concentration of the chemical agent in the atmosphere of workplaces not to be exceeded over a given reference period and below which the risk of damage to health is considered negligible on the basis of the most recent scientific knowledge. Even if reversible physiological changes are sometimes tolerated, no irreversible or prolonged organic or functional damage is accepted at this level of exposure for the vast majority of workers. These concentration levels are determined on the basis that the exposed population (workers) does not include children or the elderly. These values apply to the entire population of workers, including sensitive populations.

Three types of atmospheric values are recommended by the HRV committee: 8-hour exposure limit values (8h-OEL)⁴, 15-minute short-term exposure limit values (15min-STEEL)⁵ and ceiling values⁶.

The development of OELs follows a structured approach involving collective assessments by groups of specialists. The construction of OELs differs according to the knowledge or assumptions formulated on the mechanisms of action of the substances. At present, the default assumption is to consider a monotonic relationship between exposure, or dose, and effect, or response. In the current state of knowledge and by default, it is generally considered that, for non-carcinogenic effects, toxicity is only expressed above a certain dose threshold (Anses, to be published). For carcinogenic effects, it is possible to establish an 8h-OEL with a threshold (corresponding to the threshold above which the occurrence of effects is possible) or without a threshold (corresponding to the probability of the occurrence of effects) depending on the mode of action of the chemical agent studied.

In practice, the construction of an OEL involves the following steps (Figure 1).

⁴ limit value of the average atmospheric concentration of a chemical agent sampled in a worker's breathing zone, weighted by the duration of a work shift, i.e. 8 hours. In the current state of scientific knowledge, the 8h-OEL is supposed to protect workers exposed regularly and for the duration of a working life to the chemical agent in question from medium- and long-term health effects.

⁵ limit value of the average atmospheric concentration of a chemical agent sampled in the breathing zone of a worker, weighted over a reference period of 15 minutes. This concentration is measured during the peak of exposure, whatever its duration. Its aim is to protect workers' health from acute toxic effects by limiting the intensity of exposure peaks or certain long-term effects due to the repetition of short-term exposures.

⁶ limit value for the atmospheric concentration of a chemical agent in a worker's breathing zone, which must not be exceeded at any time during the work period.

The ceiling value applies to chemical agents for which the toxicological profile shows that exposure can cause, instantaneously, a serious and potentially irreversible effect and which cannot be controlled by the application of an 8h-OEL or a 15min-STEEL.

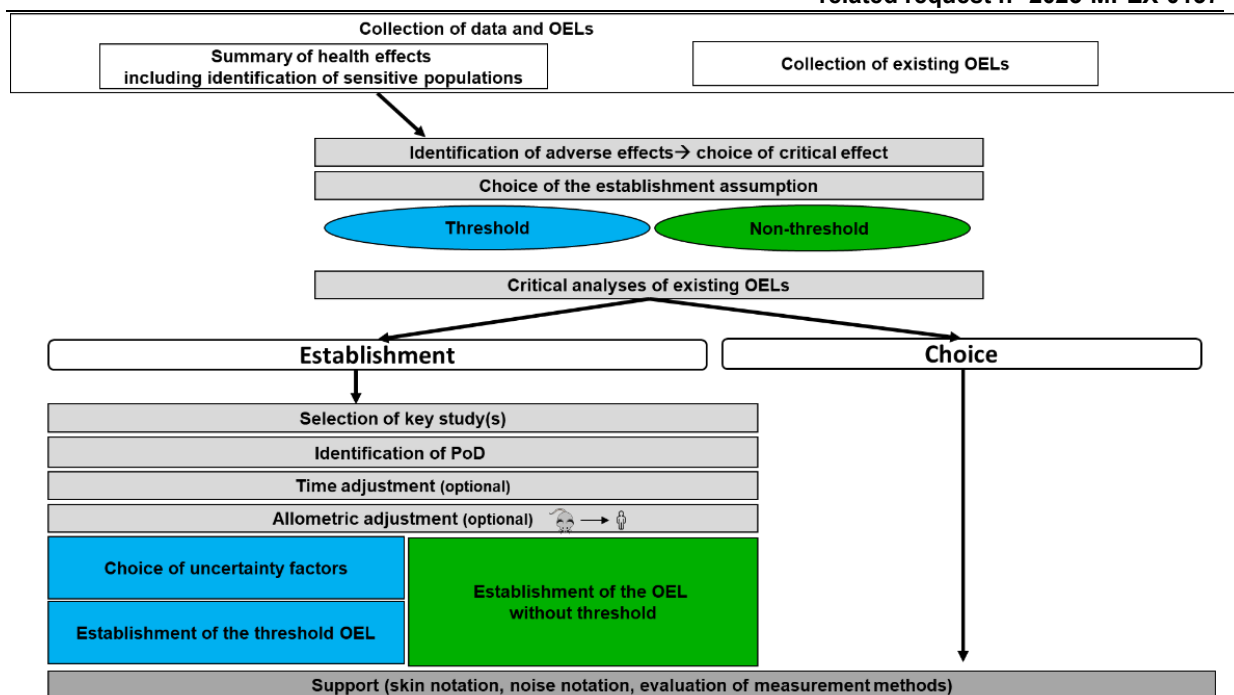


Figure 1. Steps for proposing an OEL (Anses, to be published).

In the context of developing OELs, a pragmatic value can be proposed in the absence of data to calculate an 8h-OEL from the 15min-STEEL and vice-versa. A pragmatic ceiling value can also be determined from a 15min-STEEL. The pragmatic value is proposed for prevention purposes and is not based on a study in humans or animals (Anses, to be published).

In addition to OELs, the HRV Committee assesses the need to assign a “skin” notation, when significant skin penetration is possible. This notation indicates the need to consider the dermal route of exposure in the exposure assessment and, where necessary, to implement appropriate preventive measures (such as wearing protective gloves). Skin penetration of substances is not considered when determining the atmospheric limit levels, although it can potentially cause health effects even when the atmospheric levels are respected.

The HRV committee also assesses the need to assign a “skin” notation when significant skin penetration is possible. This notation indicates the need to take the cutaneous route into account when assessing occupational exposure, in particular through the implementation of biological exposure monitoring and the assessment of surface contamination at the workstation. It is used to remind field specialist to implement preventive measures, such as wearing appropriate protective equipment, and the possibility of verifying that environments are not contaminated (surface sampling) (Anses, to be published).

The HRV Committee also assesses the need to assign a “noise” notation indicating a risk of hearing impairment in the event of co-exposure to noise and the substance below the recommended OELs, to enable OSH experts to implement appropriate measures (collective, individual and/or medical) (Anses, to be published).

(Anses 2017).

The HRV Committee evaluates the applicable reference methods for measuring aluminium exposure levels in the workplace. The quality of these methods and their applicability to the measurement of exposures for the purpose of comparison with an OEL are assessed and classified with regard to the performance requirements indicated in particular in the NF EN 482 (2021) standard: "Atmosphere of the workplace – General requirements concerning the

performance of operating procedures for measuring chemical agents" and the decision criteria detailed in the methodological report (Anses, to be published).

The classification of these methods is carried out as follows:

- category 1A: validated methods (all performance criteria are met);
- category 1B: partially validated methods (essential performance criteria are met);
- category 2: indicative methods (criteria essential to validation are not sufficiently explained, or the method requires adjustments that need to be validated);
- category 3: non-validated or non-evaluable methods. This category includes unsuitable methods for which criteria essential for validation are not met and non-evaluable methods (designated as category 3*) for which criteria essential for validation are not documented.

The objective is not to classify all the methods according to a numerical scoring system but rather to present in a structured and systematic way the criteria enabling the final choice based on a scientific judgement (Figure 2).

The general principle is as follows:

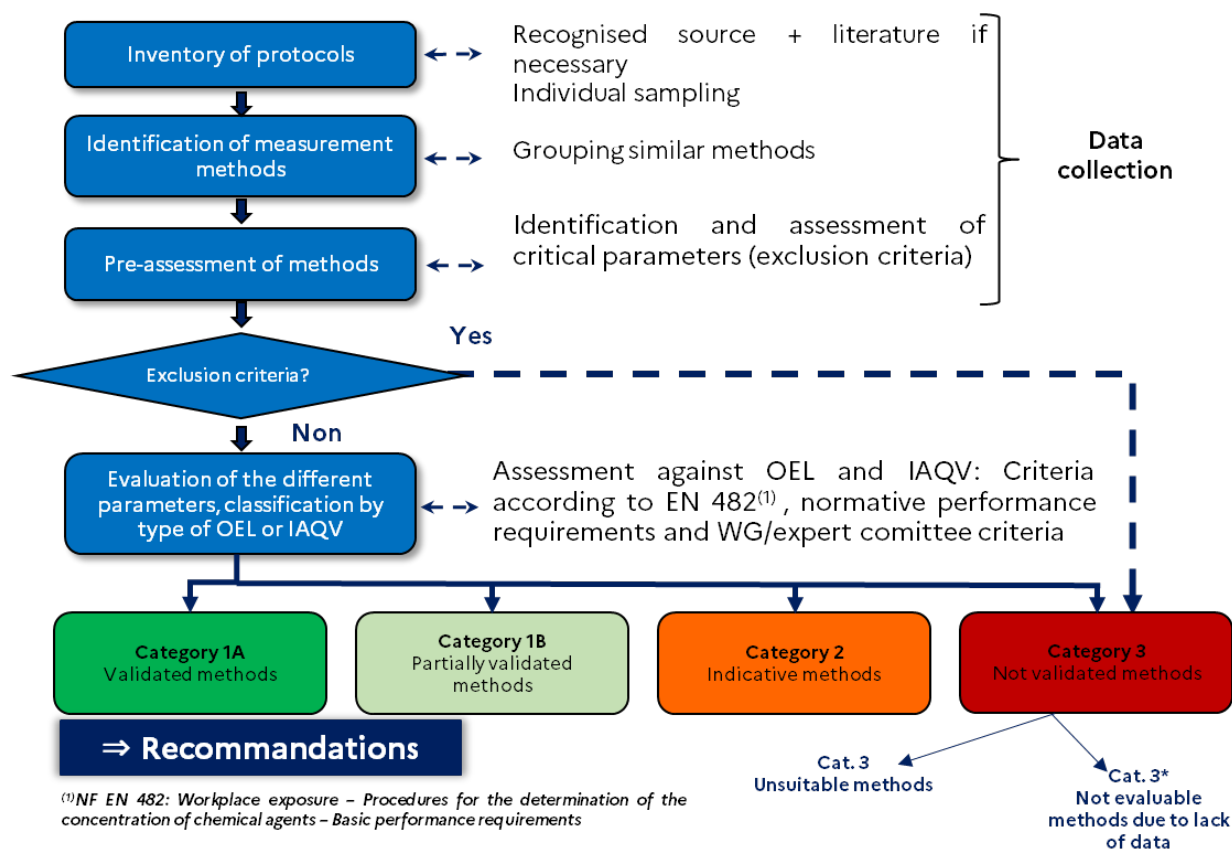


Figure 2. General principle for the classification of analytical methods (Anses, to be published)

■ Biological values: biological limit values and populational internal exposure levels

Biological exposure monitoring is a complementary method to atmospheric metrology for assessing exposure to chemical agents. It involves measuring chemical agents or their metabolites in biological matrices such as urine, blood, excreta, tissues or skin to assess internal dose, exposure and/or health risks. Biological monitoring of occupational exposure is particularly useful when chemical agents have a systemic effect and:

- when routes other than inhalation contribute significantly to absorption;

- and/or when the chemical agent is cumulative;
- when working conditions (wearing of personal protective equipment) or inter-individual factors generate significant variability in internal doses that is not considered by atmospheric metrology.

A biomarker of exposure (BME) to a chemical agent is a parameter (the parent substance, one of its metabolites, or the product bound to targets or non-critical sites), measured in a biological matrix and whose variation is associated with exposure to the agent and/or health effects. It is neither a biological indicator of early effect, nor an indicator of susceptibility/sensitivity.

The BLVs recommended by ANSES are sanitary values designed to protect workers' health, based on exposure for 8 hours a day and 5 days a week over a working life.

Several approaches can be used to derive these values, described below (Figure 2) in order of priority depending on data availability:

- derivation from data characterising the relationship between variations in concentration of the BME (chemical agent of interest or one of its metabolites in the selected matrix) and health effects (threshold or non-threshold) in exposed populations;
- in the absence of data to identify a relationship with health effects, determination on the basis of an OEL or a PoD, identified from one or more key studies. In this case, the BME concentration corresponding to an external OEL/PoD can be extrapolated from toxicokinetic parameters obtained from human or animal data using (depending on the data available):
 - measurements of the association between an external exposure indicator (or PoD) and the BME (regression equations),
 - toxicokinetic data (PBK⁷ model or mass conservation approach).

The BLV is systematically accompanied by a recommendation as to when samples should be taken.

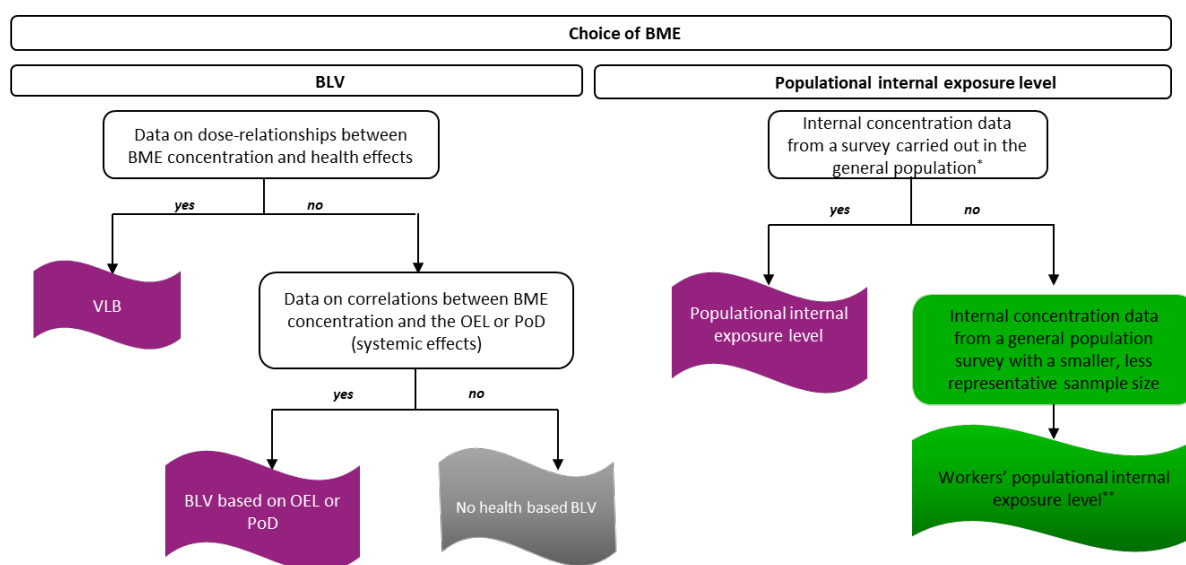
Populational internal exposure levels (previously called biological reference values or BRVs) are proposed by the HRV committee for interpreting BME concentrations. The populational internal exposure levels make it possible to situate the concentrations of a BME measured in workers in relation to those observed for the same parameter in a general population of adults of working age. Populational internal exposure levels are based on the results of impregnation studies conducted in a sample representative of the general population or its sub-population of interest (Esteban, NHANES, Health Canada, etc.) or, failing that, in the case of workers' populational internal exposure levels, in a population with a smaller number of workers and/or not representative of the general population as a whole, without any specific source of exposure to the agent of interest. Workers' populational internal exposure levels should be used exclusively to monitor occupational exposure. As a general rule, a high percentile of the distribution of BME concentrations in the population of interest is selected as the populational internal exposure level, most often the 95th percentile (P95) or the upper limit of its 95% confidence interval, etc.). Populational internal exposure levels cannot be interpreted in terms of health risk.

⁷ Mathematical descriptions simulating the relationship between the level of external exposure and the concentration of a chemical agent in biological matrices over time. Kinetic models take into account the absorption, distribution, metabolism and elimination of the agent administered and its metabolites (WHO 2010).

Specific populational internal exposure levels can be assigned to certain sub-groups of the population, depending on the type of chemical agent, the effect and the factors influencing the results. It is thus possible to recommend values according to sex, age, smoking habits, etc.

Populational internal exposure levels are particularly useful when no BLVs are available, or for chemical agents whose critical effects have no dose threshold. When they are available and the BME concentrations are lower than the BLV, the populational internal exposure levels make it possible to situate the exposure of workers in relation to that of the general population and possibly to characterise a level of exposure linked to an occupational activity.

Analytical methods described in the literature for the determination of the selected BMEs are also provided. The aim is not to recommend a particular method, but to provide a description of certain metrological parameters specific to analytical methods (limit of detection, limit of quantification, coefficient of variation on results, etc.) (Anses, to be published).



* In the working population, the Populational internal exposure levels proposed by ANSES for interpreting BME concentrations enable measured concentrations of a BME in workers to be compared with those observed for the same parameter in the general population of working-age adults.

** Workers' populational internal exposure level are reserved exclusively for monitoring occupational exposure.

BME: biomarker of exposure ; PoD : point of departure ; BLV : biological limit value

Figure 3. Steps to derive BLV and populational internal exposure level.

Before the elaboration of OELs and biological values, a toxicological profile is also systematically drawn up to define the effects, from observations in humans and animals, associated with different types of exposure to a chemical agent, characterised by their duration and route of exposure (oral, respiratory, dermal), as well as the mechanisms of action and sensitive populations. Any beneficial effects of chemical agents are not described in the toxicological profiles.

To this end, for aluminium and its inorganic compounds, a review of the reports provided by ATSDR (ATSDR 2008), EFSA (EFSA 2008), ACGIH (ACGIH 2008), JECFA (JECFA 2012), DFG (DFG 2013 and 2019) and SCCS (SCCS 2014, 2020, 2022 and 2023) was conducted with a search for more recent studies, starting from 2007 on the following databases: PubMed and Scopus.

The scientific articles selected for the evaluation of aluminium biological monitoring data and toxicity data were identified based on the following keywords: “aluminium”, “aluminium compound*”, “toxicity”, “toxicokinetic”, “health effect*”, “biomonitoring”, “biomarker”.

Part A – Report on assessment of health effects

3 Background information

3.1 Substance identification

Aluminium (Al) is a silver-coloured, low-density, malleable and ductile metal (INRS 2021). Ubiquitous, it is the metallic element which is the most widespread in the earth's crust with 8% Al (INERIS 2015), mainly as a silicate. There are many compounds of aluminium. A non-exhaustive list below presents the compounds mostly described in the literature (Table 1).

Table 1. General information on the mostly described aluminium compounds (INERIS 2005; 2015)

Name	CAS Number	EC Number	Physical state	Molecular weight ⁸ (g/mol)
Aluminium (Al)	7429-90-5	231-072-3	Solid	26.98
Aluminium carbonate (Al ₂ (CO ₃) ₃)	14455-29-9	238-440-2	White powder	233.99
Aluminium chloride (AlCl ₃)	7446-70-0	231-208-1	Solid	133.34
Aluminium chloride, basic (Al ₂ (OH) _n Cl _{6-n})	1327-41-9	215-477-2	Aqueous solution	
Aluminium chlorohydrate / Aluminium chloride hydroxide when n=5 (Al ₂ Cl(OH) ₅)	[12042-91-0]	[234-933-1]	Crystallised solid when n=5	174.45
Aluminium citrate (C ₆ H ₅ AlO ₇)	31142-56-0	250-484-4	White crystallised solid	216.08
Aluminium fluoride (AlF ₃)	7784-18-1	232-051-1	Solid	83.98
Aluminium hydroxide (AlH ₃ O ₃)	21645-51-2	244-492-7	Crystallised solid or amorphous powder	78.00
Aluminium lactate (C ₉ H ₁₅ AlO ₉)	18917-91-4	242-670-9	White powder	294.19
Aluminium nitrate (AlN ₃ O ₉)	13473-90-0	236-751-8	Crystallised solid	213.00
Aluminium oxide (Al ₂ O ₃)	1344-28-1	215-691-6	Crystalline	101.96
Aluminium oxide hydroxide, Boehmite (AlOOH)	1318-23-6	215-284-3	Crystalline solid	59.99
Aluminium orthophosphate /	7784-30-7	232-056-9	Powder	121.95

⁸ PubChem: <https://pubchem.ncbi.nlm.nih.gov/>

aluminium phosphate (AlO_4P)				
Aluminium silicate (Al_2SiO_5)	12141-46-7	235-253-8	Crystalline solid	162.05
Aluminium sodium dioxide (AlO_2Na)	1302-42-7	215-100-1	Solid	81.97
Aluminium sulphate ($\text{Al}_2\text{O}_{12}\text{S}_3$)	10043-01-3	233-135-0	Solid and Aqueous solution	342.2

3.2 Physico-chemical properties

Some aluminium salts, for example, aluminium sulphate, aluminium chloride (hydrated) and aluminium nitrate, are readily soluble in water, whereas other aluminium species such as elemental Al, aluminium oxide, aluminium phosphate, and aluminium silicate are very sparsely soluble (Vesa Riihimäki and Aitio 2012). Actually, aluminium citrate is the most soluble and bioavailable aluminium salt (Poirier et al. 2011). The table below (Table 2) presents the solubility of the different aluminium salts in water and in other solvents.

Table 2. Solubility of Al salts in water and other solvents

Name of Al compound	Solubility in water	Solubility in other solvents
Aluminium (Al)	Insoluble in water at 20°C	Soluble in HCl, H_2SO_4 , hot water, and alkalies
Aluminium carbonate ($\text{Al}_2(\text{CO}_3)_3$)	Insoluble	Dissolves in hot HCl or H_2SO_4
Aluminium chloride (AlCl_3)	450-458 g.L ⁻¹ at 20 °C	Soluble in benzene, carbon tetrachloride, chloroform
Aluminium chlorohydrate ($\text{Al}_2\text{Cl}(\text{OH})_5$)	Dissolves in water forming slightly turbid colloidal solutions (up to 550 g.L ⁻¹)	No data
Aluminium citrate ($\text{C}_6\text{H}_5\text{AlO}_7$)	Most soluble	No data
Aluminium fluoride (AlF_3)	5.59 g.L ⁻¹ at 25 °C	Sparingly soluble in acids and alkalies; insoluble in alcohol and acetone
Aluminium hydroxide ($\text{Al}(\text{OH})_3$)	Insoluble in water at 20°C	Soluble in alkaline or acid solutions
Aluminium lactate ($\text{C}_9\text{H}_{15}\text{AlO}_9$)	Freely soluble in water: 206 g.L ⁻¹ at 25 °C	No data
Aluminium nitrate (AlN_3O_9)	Very soluble in water: 637 g.L ⁻¹ at 25 °C	Very soluble in alcohol; very slightly soluble in acetone; almost insoluble in ethyl acetate, pyridine

Aluminium oxide (Al ₂ O ₃)	In cold water, 0.00098 g L ⁻¹ ; insoluble in hot water	Very slightly soluble in acids, alkalies
Aluminium oxide hydroxide (AlO(OH))	No data	No data
Aluminium phosphate (AlO ₄ P)	Practically insoluble in water	Practically insoluble in acetic acid; very slightly soluble in concentrated HCl and HNO ₃ acids
Aluminium silicate (Al ₂ SiO ₅)	Insoluble in water	Insoluble in organic solvents
Aluminium sodium dioxide (AlO ₂ Na)	No data	No data
Aluminium sulphate (Al ₂ O ₁₂ S ₃)	Soluble in water: 360 - 364 g.L ⁻¹ at 20 °C	Insoluble in ethanol

Data from: Krewski et al. 2007; ATSDR 2008; Poirier et al. 2011; INRS 2021

As mentioned in the above table, elemental aluminium is insoluble in water. At acidic pH, below 4, the dominant speciation of aluminium corresponds to its only oxidation state Al³⁺, generally in the form of the hydrated complex Al(H₂O)₆³⁺. At a pH between 5 and 6, the species Al₂(OH)₂⁴⁺ and Al(OH)₅²⁻ dominate. The insoluble form Al(OH)₃ is predominant in the pH range between 5.2 and 8.8. Above a pH of 9, the soluble species Al(OH)₄⁻ is dominant. It is the only species present at pH above 10. Because of the behaviour of its hydroxycomplexes, aluminium is considered amphoteric (INERIS 2005).

3.3 Classification

Elemental aluminium and some of its compounds are subject to harmonised classification under regulation (EC) n° 1272/2008 (ie. CLP regulation). Among the aluminium compounds included in the scope of research (Table 1), an harmonised classification is provided only for aluminium powder (pyrophoric and stabilized) and for anhydrous aluminium chloride (Table 3).

Table 3. Harmonised classification according to Annex VI of the EU Regulation (EC) n° 1272/2008⁹

Name	Classification		Labelling	
	Hazard Class & Category code(s)	Hazard statement code(s)	Pictogram, Signal Word code(s)	Hazard statement code(s)
Aluminium powder (Pyrophoric)	Flam. Sol. 1 Water-react. 2	H250 ^[1] H261 ^[2]	 GHS02 Dgr	H250 ^[1] H261 ^[2]

⁹ <https://echa.europa.eu/information-on-chemicals/cl-inventory-database> (accessed 21 April 2023)

Aluminium powder (stabilised)	Flam. Sol. 1 Water-react. 2	H228 ^[3] H261 ^[2]	 Flame GHS02 Dgr	H261 ^[2] H228 ^[3]
Aluminium chloride, anhydrous	Skin Corr. 1B	H314 ^[4]	 Corrosion GHS05 Dgr	H314 ^[4]

^[1] H250: catches fire spontaneously if exposed to air

^[2] H261: in contact with water releases flammable gas

^[3] H228: flammable solid

^[4] H314: causes severe skin burns and eye damage

According to the International agency for research on cancer (IARC), there is sufficient evidence in humans for the carcinogenicity of aluminium production using the Söderberg process. This activity is associated with elevated incidences of cancers of bladder and lung. The cancer hazards associated with aluminium production mainly result from exposure to polycyclic aromatic hydrocarbons (PAHs) rather than from exposure to aluminium or its related compounds (INRS 2021). Samples of air emitted from aluminium smelters are mutagenic in bacteria; however, mutagenicity studies based on urine from exposed workers, as well as DNA-adducts studies of blood samples from these workers, gave equivocal results. There is sufficient evidence in experimental animals for the carcinogenicity of airborne particulate polynuclear organic matter from aluminium-production plants. Globally, based on both experimental and human studies, there is weak-to-moderate evidence for a genotoxic mechanism underlying the effects of occupational exposures during aluminium production. IARC concluded that occupational exposures during aluminium production are carcinogenic to humans (Group 1) (IARC 2012).

3.4 Sources and major uses

Aluminium production

In 2022, world aluminium production was 69 000 000 tons, the main producers being China (40 000 000 tons), India (4 000 000 tons), Russia (3 700 000 tons), Canada (3 000 000 tons) and the United Arab Emirates (2 700 000 tons) (USGC 2023¹⁰). Aluminium domestic annual production and consumption in France are around 600 000 to 700 000 tons and 1 200 000 to 1 300 000 tons, respectively¹¹.

First fusion aluminium metal is mainly obtained from bauxite or bauxitic laterite. Bauxite is mainly constituted of hydrated alumina, iron oxide (10-20%) and silica (about 5%). Alumina is extracted from bauxite, then transformed into primary aluminium which is refined to the desired degree of purity.

¹⁰ <https://pubs.usgs.gov/periodicals/mcs2023/mcs2023-aluminum.pdf> (accessed on May 2023)

¹¹ <https://www.latribune.fr/entreprises-finance/industrie/industrie-lourde/souverainete-industrielle-et-energetique-le-cas-exemplaire-de-l-aluminium-francais-928225.html#:~:text=La%20production%20nationale%20actuelle%20tourne,importer%20100%25%20de%20ses%20besoins> (accessed on May 2023).

Since the end of the 19th century, the main industrial manufacturing process of aluminium has been electrolysis of alumina dissolved in a molten cryolite (Na_3AlF_6)-based hot bath (also known as the Hall-Héroult process). Alumina in its cryolite bath is introduced into a rectangular steel cell, whose carbon-coated inner walls form the cathode. A direct electric current between 100,000 and 320,000 amperes flows between the anode (either pre-baked or continuously self-baking Söderberg anode) and the cathode in a bath composed of cryolite and alumina. The electric current allows the alumina to react in contact with the carbon anode and to be transformed into aluminium and carbon dioxide which will concentrate at the top of the cell. The aluminium obtained by this method is 99.5% pure. The electrolytic cells are called pots, and the work area is called the potroom. To obtain purer aluminium, it is refined. There are two refining techniques: molten salt electrolysis and fractional crystallisation. These two methods lead to aluminium that is at least 99.99% pure. Casting is the final step in the process where molten aluminium is poured into ingots in the foundry (Health Council of the Netherlands 2010; IARC 2012; INERIS 2015).

The nature and level of contaminants and other agents in the potroom may be influenced by the type of pot (prebake or Söderberg) and design (vertical- or horizontal-stud Söderberg), hooding and hood exhaust rate, building ventilation, size of operation and, electrical current used (cell amperage) (IARC 1984). Actually, pre-baked anodes are produced by moulding petroleum coke and coal-tar pitch binder, which are baked at 1000-1200°C. Söderberg anodes are formed continuously from a paste of petroleum coke and coal-tar pitch. Consequently, both anodes constitute a source of exposure to carcinogenic PAHs. PAHs are formed from partial anode pyrolysis during electrolysis. In a study conducted by Konstantinov and Kuz'minykh (1971), the concentrations of benzo(a)pyrene in the prebake potrooms were found to be lower than in the Söderberg potrooms and, when pre-burned electrodes (presumably prebake) were used, benzo(a)pyrene concentrations were below the level of detection (IARC 1984).

Potential exposures to chemicals other than PAHs and aluminium reported in these occupational settings include fluorides and sulphur dioxide (skin and respiratory irritants), carbon monoxide, carbon dioxide, various trace metals (chromium, nickel, vanadium), asbestos, and also extreme heat and magnetic fields. Exposure to PAH, fluorides and sulphur dioxide have progressively decreased over time (the late 1950s and the late 1980s), as demonstrated by atmospheric measurements and biomonitoring studies. This decrease can be explained by the progressive implementation of improved control technology; the increasing use of both collective and personal protective devices, and the increasing predominance of prebake pot-rooms (IARC 2012).

Coupled atmospheric and biomonitoring studies also demonstrate that inhalation is not the only and generally not the main route of exposure to PAH, aluminium and fluorides in the potroom, and that dermal exposure and ingestion should be taken into account.

Aluminium can be recycled multiple times without losing its original properties (lightness, conductivity, formability, durability, impermeability and multiple recyclability). Actually, aluminium recycled from old and new scraps is equivalent to about 50% of both aluminium production and consumption. It is estimated that 75% of the aluminium produced since 1880 is still in use today. In Europe, recycling rates are over 90% in the automotive and building sectors, and 75% for aluminium cans. The aluminium recycling process requires only 5% of the energy needed to produce the primary metal^{12,13}.

¹² <https://www.aluminium.fr/cycle-de-vie-et-recyclage/> (accessed on June 1, 2023)

¹³ <https://european-aluminium.eu/blog/enabling-the-circular-economy-with-aluminium/> (accessed on June 1, 2023)

Aluminium recycling involves 5 steps¹⁴:

1. Collecting scrap: there are 2 categories of aluminium scrap:
 - new scrap – material that arises during the manufacture and fabrication of aluminium products, up to the point where they are sold to the final consumer;
 - old scrap – material that has been used by the consumer and subsequently discarded (e.g.: used beverage cans, window frames, electrical cabling and car cylinder heads);
2. Sorting scrap – grouping all coated aluminium together and grouping all uncoated aluminium together. Paper, plastic and other non-aluminium recycling needs to be removed;
3. Crushing – by compacting the aluminium scrap, it reduces freight, storage and handling costs;
4. Remelting – uncoated scrap is loaded directly into a large furnace, where it is heated at high temperatures and turned into molten form;
5. Casting – molten aluminium is cast at a temperature of just over 700°C to form ingots.

Employees who process aluminium scrap might be exposed to high levels of aluminium dust during pre-processing steps that involve crushing and/or shredding and drying¹⁵. Thus, aluminium recycling does not involve the use of the Söderberg electrolytic refining process and therefore do not induce co-exposure to carcinogenic PAHs.

Aluminium uses

Aluminium metal and its compounds have many industrial applications (INRS 2021).

In the USA, in 2022, transportation applications (automobile, railway wagons and aircraft parts, signalling panels), accounted for 35% of domestic consumption; in descending order of consumption, the remainder was used in packaging (containers and foils), 23%; building, 16%; electrical, 10%; machinery, 7%; consumer durables, 6%; and other, 3% (U.S. Geological Survey, Mineral Commodity Summaries, January 2023)¹⁶.

The table below (Table 4) presents the different, non-exhaustive, applications of the aluminium compounds (INERIS 2005; 2015; Krewski et al. 2007; INRS 2021) and their production in the European Union (ECHA REACH)¹⁷.

Table 4. Summary of aluminium uses

Name of Al compound	Tonnage	Industrial uses	Uses in pharmaceuticals, food additives, cosmetics and other household products

¹⁴ <https://aluminium.org.au/how-aluminium-is-made/recycling-aluminium-chart/> (accessed on 1 June 2023)

¹⁵ <https://www.osha.gov/sites/default/files/publications/OSHA3348-metal-scrap-recycling.pdf> (accessed on July 2023)

¹⁶ <https://pubs.usgs.gov/periodicals/mcs2021/mcs2021-aluminum.pdf> (accessed on April 2023)

¹⁷ Tonnage: Manufactured in and / or imported to the European Economic Area from: <https://echa.europa.eu/fr/information-on-chemicals> (accessed on April 2023)

Aluminium	≥ 10 000 000 tons per annum	Metal and alloys; foils; in propellant and pyrotechnics. Used in various sectors: aerial electric cables, doors and windows, automobile and aircraft parts, shipbuilding and railways, signaling panels, kitchen utensils paints, explosives and fireworks.	Aluminium foil; colour ingredient; topical drugs, food packaging
Aluminium carbonate	No data		Antacid; phosphate binder
Aluminium chloride	≥ 10 000 to < 100 000 tons per annum	Acid catalyst; as a hydrophobic agent for cotton impregnation, leather tanning, retention agent in paper production; flocculent and clarifying agent in water treatment	Antiperspirant
Aluminium chloride, basic	≥ 100 000 to < 1 000 000 tons per annum		
Aluminium chlorohydrate	≥ 10 000 to < 100 000 tons per annum		Antiperspirant; Astringent; anti-hyperphosphatemic
Aluminium citrate	No data		Antiperspirant
Aluminium fluoride	≥ 100 000 to < 1 000 000 tons per annum	In ceramics; metallurgical flux; inhibitor of fermentation; catalyst; temperature and pH regulator in aluminium production processes; optical coatings and semiconductors	
Aluminium hydroxide	≥ 1 000 000 to < 10 000 000 tons per annum	Adsorbent; emulsifier; dyeing mordant; manufacture of glass; lubricants; detergents; waterproofing fabrics; flame retardant	Antacid; antidiarrheal agents; food colouring agent; topical drugs: diaper rash, antifungal; food packaging ingredient; vaccine adjuvant; opacifying agent in cosmetics and personal care products (e.g.: toothpastes)

Aluminium lactate	≥ 1 000 to < 10 000 tons per annum	Fire extinguishing foam	Antiseptic; in dental impression material
Aluminium nitrate	≥ 1 000 to < 10 000 tons per annum	Tanning agent (for leather); corrosion inhibitor; nitrating agent; extraction of uranium	Antiperspirant
Aluminium oxide	≥ 10 000 000 tons per annum	Adsorbent; abrasive; in lubricants; water-proofing agent	
Aluminium oxide hydroxide	≥ 10 000 to < 100 000 tons per annum		
Aluminium phosphate	≥ 1 000 tons per annum	Cement component; ceramic flux	Antacid; vaccine adjuvant; dental cement
Aluminium silicate	No data	In glass; manufacture of ceramics; semiprecious stones; enamels; paint filler	Dental cement; food packaging ingredient
Aluminium sodium dioxide	≥ 100 000 to < 1 000 000 tons per annum	Water treatment, solidification of the concrete, in the paper industry to increase the opacity, fibre retention and strength of the paper	
Aluminium sulphate	≥ 100 000 tons per annum	Tanning agent (leather); dyeing mordant; fire / waterproofing agent; decolorizing and clarifying agent; flocculating agent in the water purification	Antiperspirant; topical diaper; anti-fungal agent; food additive (in baking powder)

4 Toxicological profile

Treatment doses given in $\text{mg.kg bw}^{-1}.\text{d}^{-1}$ as reported by ATSDR (ATSDR 2008) had been reassessed using the molar mass ratio of aluminium and aluminium compounds (see Table 1).

4.1 Toxicokinetics

4.1.1 Absorption

The bioavailability of aluminium is dependent on the nature and speciation of the aluminium substance. The main mechanism of absorption is probably passive diffusion through paracellular pathways (ATSDR 2008). Results from *in vivo* uptake and *in vitro* dissolution studies show that metallic Al, Al_2O_3 , and $\text{Al}(\text{OH})_3$ are less bioavailable via the oral and inhalation routes compared to water-soluble aluminium forms like alum ($\text{Al}_2(\text{SO}_4)_3$). Under normal physiological conditions, exposures to insoluble aluminium forms do not contribute significantly to total aluminium body burden (Willhite et al. 2021).

4.1.1.1 Absorption by inhalation

Absorption mechanism

The percentage of aluminium absorbed after inhalation is depending on the inhaled compounds (especially, their solubility) and on the granulometry of the aerosol. Insoluble and/or large particles and those not absorbed, are eliminated from the respiratory tract by macrophage entrapment and mainly via mucociliary clearance (and subsequent expectoration or ingestion). Only particles with an aerodynamic diameter under $5\text{ }\mu\text{m}$ can reach alveoli where the soluble aluminium can be absorbed (ATSDR 2008; Klotz et al. 2019).

Human data

In humans, inhalation of aluminium or aluminium compounds is mostly related to occupational exposure. Many studies conducted in the workplace report exposure to aluminium from different sources (fumes, dust). Exposure of the general population essentially occurs through ingestion, including ingestion of indoor or outdoor dust. Possible sources of consumer respiratory exposure are aerosols from antiperspirants or other sprays (ATSDR 2008; SCCS 2020).

In alveoli, aluminium bioavailability increases with the solubility of the inhaled substances with aluminium salts being the more soluble. Studies in workers suggest a mean absorption rate of 1.5-3% of inhaled aluminium (Yokel and McNamara 2001; ATSDR 2008; SCCS 2020).

In a cross-sectional study, pre- and post-shift aluminium serum and urinary levels were measured in 235 workers from 15 different plants employed in areas with potential exposure to aluminium dust, and 44 unexposed workers. In this study, for exposed workers, median aluminium values were 25 and $100\text{ }\mu\text{g m}^{-3}$ for respirable and total particulates in air, respectively. Significant differences were found between exposed and controls for pre-shift serum aluminium only ($4.92\text{ }\mu\text{g.L}^{-1}$ vs $3.60\text{ }\mu\text{g.L}^{-1}$ for exposed workers and controls respectively) and for both pre-shift and post-shift urinary aluminium (pre-shift: $17.11\text{ }\mu\text{g.L}^{-1}$ for workers vs $7.39\text{ }\mu\text{g.L}^{-1}$ for unexposed controls; post-shift: $20.08\text{ }\mu\text{g.L}^{-1}$ for workers vs $7.67\text{ }\mu\text{g.L}^{-1}$ for unexposed controls) and urine aluminium/creatinine ratios (pre-shift: $12.06\text{ }\mu\text{g.g}^{-1}$ vs 6.39

$\mu\text{g.g}^{-1}$ for workers and controls, respectively; post-shift: $13.74 \mu\text{g.g}^{-1}$ vs $5.73 \mu\text{g.g}^{-1}$ for workers and controls, respectively) (Gitelman et al. 1995).

In another study, after an 8hour exposure to $0.3\text{--}10.2 \text{ mg.m}^{-3}$ (mean: 2.4 mg.m^{-3}) aluminium in welding fumes, 3 volunteers (not previously exposed) had urinary aluminium concentrations of $15\text{--}414 \mu\text{g.L}^{-1}$ at the end of shift against less than $3 \mu\text{g.L}^{-1}$ before exposure (Sjögren et al. 1985).

Animal data

ATSDR reported studies showing that aluminium is retained in the lung after exposure to inhalable aluminium oxide (Christie, Mackay, and Fisher 1963; Thomson et al. 1986) and aluminium chlorohydrate (Steinhagen, Cavender, and Cockrell 1978; Stone et al. 1979). There was no significant increase in aluminium levels in tissues other than the lungs or serum (Steinhagen, Cavender, and Cockrell 1978; Stone et al. 1979) (ATSDR 2008).

Results of experimental studies on intranasal aluminium-containing compounds, in either solution or in particulate form, on the absorption through the olfactory pathway in rats, show a low olfactory nerve uptake and subsequent neuronal distribution to the cortex of instilled soluble aluminium compounds. Concerning nanoparticulate aluminium, there are very few studies and the results are controversial, with one study showing some transfer (aluminium nanoparticles) (Kwon et al. 2013) when another did not (nanometric aluminium oxide) (Chalansonnet et al. 2018).

4.1.1.2 Absorption by oral route

Absorption mechanism

Aluminium is poorly absorbed after oral intake. This oral absorption depends on several factors, including the concerned aluminium species, its solubility, and the presence of complexing ligands or competing ions (Affourtit, Bakker, and Pronk 2020). Actually, the bioavailability appears to be generally associated with water solubility; however, there is insufficient data to directly extrapolate from solubility in water to bioavailability (ATSDR 2008). Aluminium's gastrointestinal absorption from aluminium compounds highly depends on its ionic availability in the gut content, which is mainly linked to the prevailing pH, the present complexing ligands which the metal may form absorbable aluminium species with and also the ingested aluminium compound's chemical form. Acid digestion in the stomach is thought to degrade most of the ingested aluminium compounds to generate "free" and soluble Al^{3+} , some of which might be complexed with mono-, di- and tricarboxylic acids like citric acid. The increase in pH during the transition from the stomach to the intestines, leads to successive deprotonations and the formation of complexes of aluminium with hydroxide ion and ultimately, the formation of insoluble aluminium hydroxide at neutral pH. Consequently, when the pH is neutralised in the duodenum, the aluminium ion is progressively converted to aluminium hydroxide and the majority of it is then expected to precipitate in the intestine, with subsequent excretion in the faeces, leaving only a minor fraction available for absorption (EFSA 2011). The large hydration of the Al^{3+} ion can allow it to cross the intestinal epithelium paracellularly, which is probably the main mechanism of absorption. A neutralisation by complexation (e.g. by the anion of the ingested salt), can facilitate the diffusion of the metal through the intestinal membrane. This absorption is therefore generally perceived as a biphasic process involving a fast mucosal uptake, followed by slow transport of aluminium into the blood. On the other hand, a transferrin/vitamin D-dependent active transport is also involved where aluminium shares absorption pathways with other mineral cations (e.g. Mg^{2+} , Fe^{2+}); this hypothesis is incompletely elucidated and complicated by the differences in oxidation states between aluminium and iron ions (Berthon 2002; ATSDR 2008).

Human data

Studies conducted on this topic showed that aluminium present in food and drinking water is poorly absorbed through the gastrointestinal tract.

Based on daily aluminium dietary consumption and urinary daily excretion, the oral global bioavailability of aluminium from the diet has been estimated to be 0.1-0.3 % (Yokel and McNamara 2001; ATSDR 2008; EFSA 2008). Absorption of aluminium from drinking water is estimated to be around 0.3 % (Yokel and McNamara 2001).

Stauber et al. (1999) estimated, on 29 healthy volunteers, the relative bioavailability of aluminium species naturally present in food and in aluminium-treated drinking water (ATW) (aluminium compound not specified) (ATW ; $140 \pm 9 \mu\text{g.L}^{-1}$ of Al). Volunteers drank ATW, during two-day periods, while on a controlled diet. Volunteers' average total intake of aluminium from food and tea contributed about $3,000 \mu\text{g.d}^{-1}$ Al. Aluminium from ATW contributed to $208 \mu\text{g.d}^{-1}$ Al. Only 0.3–0.4% of the aluminium in ATW was absorbed in the digestive tract, a percentage close to that absorbed from food (Stauber et al. 1999). Several studies indicated that simultaneous consumption of citric acid or citrates increases aluminium intestinal absorption. However, though higher than the absorption of most other aluminium compounds, intestinal absorption of aluminium citrate is still low (0.5-5%). In fact, aluminium absorption is probably indirectly facilitated by citrate through binding the Ca^{2+} ions that line the lateral membranes of the intestinal cells and thus, widening the loose junctions between them (Desroches, Daydé, and Berthon 2000). Other carboxylic acids, such as lactic acid or ascorbic acid also enhance aluminium absorption in the digestive tract (ATSDR 2008). Citric acid and other carboxylic acids have the potential to form neutral and more soluble species, making aluminium more available for active-transport pathways (DeVoto and Yokel 1994). On the conversely, some complexing agents (e.g., phosphates or silicates) form insoluble compounds with aluminium, limiting its uptake (DeVoto and Yokel 1994; EFSA 2008; ATSDR 2008).

For oral exposure, there is limited information on the bioavailability of aluminium from sources other than diet and water:

Aluminium in soils being mainly constituted of insoluble species (silicates, oxides, and hydroxides), its bioavailability is expected to be low; this is confirmed by the available studies showing a low oral bioaccessibility¹⁸ of aluminium from soils (median 1.1%; upper limit of the confidence interval of the 95th percentile: 2 %) (Kierulf et al. 2022).

The bioavailability of aluminium hydroxide from antacids is also very low. It was estimated to be 0.004% in volunteers with normal renal function (increasing to 0.2% with concomitant citric acid absorption) (Weberg and Berstad 1986).

Animal data

Several animal studies used [²⁶Al]-aluminium (compound not specified) to estimate aluminium bioavailability from drinking water. In the study by Jouhanneau et al., when aluminium levels in urine, bone, liver, and brain were considered, an absorption rate of 0.1% was estimated in rats (Jouhanneau et al. 1997). Absorption of soluble salts (citrate, nitrate, sulphate) in rats was 0.05%-0.2% compared to 0.02%-0.1% for insoluble compounds (oxide, hydroxide, sodium aluminium silicate) (Priest, Skybakmoen, and Jackson 2021). In the same species, oral absorption was greater for aluminium oxide nanoparticles than for aluminium chloride (a

¹⁸ Bioaccessibility is defined as the fraction of a compound which can be solubilised in the digestive tract. Bioavailability is the fraction of the ingested substance which can be absorbed in the digestive tract, then distributed in the body. For inorganic compounds, bioaccessibility can be considered as a proxy of their bioavailability.

soluble salt); absorption of elemental aluminium nanoparticles was lower but still higher than AlCl_3 absorption (Krause et al. 2020). In rats, the bioavailability of aluminium from tea infusion of ^{26}Al citrate injected tea leaves was estimated to be 0.37 % (Yokel and Florence 2008) and it was 0.1%-0.3% for aluminium from basic aluminium sodium phosphate (a food additive) in biscuit or cheese (Yokel and Florence 2006; 2008). As in humans, numerous studies in animals have shown that the addition of citric acid or lactic acid enhances aluminium absorption through the digestive tract (ATSDR 2008). In a study conducted by Cunat et al., where an *ex vivo* rat gut was used to evaluate the potential of aluminium absorption from different chemical aluminium species, aluminium absorption was positively correlated with the theoretic affinity of aluminium and the anion. The absorption of aluminium after ingestion of organic aluminium compounds was more important than after ingestion of inorganic aluminium compounds, with the following order: aluminium citrate > aluminium tartrate, aluminium gluconate, aluminium lactate > aluminium glutamate, aluminium chloride, aluminium sulphate, aluminium nitrate (Cunat et al. 2000).

4.1.1.3 Absorption by dermal route

Human data

Skin application of personal care and cleaning products appears as one of the main sources of external exposure to aluminium for the general population. In most of the aluminium-containing cosmetics, insoluble species are concerned. Antiperspirants are a notable exception, as they contain soluble aluminium salts (e.g., aluminium chlorohydrate) and their pH is generally low, increasing the bioaccessibility of aluminium. However, when applied to skin, aluminium compounds form inert complexes with basic components of sweat and skin, limiting the bioaccessibility of the element (SCCS 2014). No data were identified regarding dermal exposure of workers in aluminium industries.

Human data on aluminium dermal absorption are limited. Older studies indicate a large range of absorbed fraction values ranging from 0.012% to 10% (SCCS 2014). However, these studies were conducted with a low number of volunteers (1 or 2) or *in vitro*, with skin preparations, and their results should be considered with caution.

A study in 12 volunteers using several exposure scenarios was recently published. It concluded that the aluminium fraction absorbed dermally from antiperspirants was 0.002% to 0.06 % (mean: 0.0094%, standard deviation: 0.0131) (de Ligt et al. 2018). SCCS estimated that this study also suffered from several methodological flaws (gaps in the mass-balance of ^{26}Al and lack of information on how the missing amounts could be accounted for). SCCS asked the cosmetic industry a new study, which was finally performed by the Netherlands organisation for applied scientific research (TNO) and is presented in the SCCS 2020 report (SCCS 2020). This last study with 6 female volunteers showed a mean dermal fraction absorbed of 0.00052 % (min-max: 0.00026%-0.00108%) from a topical application of roll-on formulation, containing aluminium chlorohydrate labelled with [^{26}Al]-aluminium (0.75 g antiperspirant per axilla (total of 1.5 g), ~2,500Bq, nominal dose of ^{26}Al of 3730317 pg). The volunteers were biomonitoring for 11 days by measuring the presence of ^{26}Al in urine and faeces (de Ligt et al. 2022; SCCS 2020). At the same time, they were biomonitoring by taking regular blood samples for up to 7 days. Combined with the aluminium found in the faeces in the same study (0.0014%), this would yield an overall percentage of bioavailable aluminium of 0.00192%. However, De Ligt et al. (2022) argued not to include this additionally recovered test material from faeces. SCCS (2020) agreed to this arguing that no paired faecal samples were collected following intravenous (IV) dosing for relative comparison. Thus, the mean dermal fraction absorbed value of 0.00052% was regarded by SCCS as an appropriate value to use in risk assessment (SCCS 2020).

Fourteen-day use of aluminium-based antiperspirants did not increase plasma or urine aluminium levels in 21 volunteers (Letzel et al. 2020). In this study, shaving habits did not impact the systemic aluminium load.

Animal data

In mice daily percutaneously exposed to 0.1 or 0.4 µg of aluminium chloride for 130 days (i.e. 0.02 - 0.08 µg Al.d⁻¹), Anane et al. reported a significant increase in aluminium levels in urine, serum and brain. This study shows that aluminium was absorbed through the skin of mice. In fact, the concentration of aluminium in serum was 317.5 µg.L⁻¹ (SEM ±63.7) and 380.0 µg.L⁻¹ (SEM ±84.6) when mice were exposed to 0.02 and 0.08 µg Al.d⁻¹ respectively (versus 125.0-227.5 µg.L⁻¹ in the control group). It is noteworthy that, in this study, no measures were taken to prevent animal from licking their fur, and thus, ingesting aluminium (Anane et al. 1995).

4.1.2 Distribution

Once in the body, aluminium ion binds to blood proteins and is distributed to all tissues, especially the bones and lung (Ganrot 1986).

Aluminium erythrocyte/plasma partition ratio varies from one publication to another with values between 0.1 and 0.9 (Riihimäki and Aitio 2012). Around 95% of plasma aluminium is protein-associated, with 80% bound to transferrin at the sites left vacant by iron, 10% bound to albumin, and 5% bound to a low molecular weight protein fraction (Priest 2004). It was demonstrated that aluminium, bound to low molecular weight proteins (LMW-Al), present in spiked human serum of eight healthy volunteers, corresponded to Al-citrate, Al-phosphate and ternary Al-citrate-phosphate complexes (Polak et al. 2001).

It should be emphasized that cellular uptake of aluminium by organs and tissues most likely occurs from the aluminium bound to transferrin. Thus, it is likely that the relative high density of transferrin receptors in different organs influences the distribution of aluminium to organs, with higher aluminium levels present in regions of high transferrin receptor density (ATSDR 2008).

Total aluminium body burden is usually 30-50 mg in healthy adults. In the general population, serum aluminium level is usually 1-3 µg.L⁻¹ and exceptionally above 10 µg.L⁻¹. Half of the total body burden is in the skeleton and about one fourth in the lung (ATSDR 2008).

Aluminium levels in bone tissue of healthy individuals range from 5 to 10 mg.kg⁻¹. They are around 20 mg.kg⁻¹ wet weight in lungs of adults; lung aluminium concentration can be higher in workers after prolonged exposure to aluminium-containing respirable particles, especially when the aluminium species in particles have a low solubility (Ganrot 1986; ATSDR 2008). According to ATSDR, an increase of aluminium concentration with age in lung tissue is due to an accumulation of insoluble aluminium compounds that have entered the body via the airways (Ganrot 1986; ATSDR 2008). Ganrot (1986), have also reported data showing aluminium concentration increasing with age in lung, liver, kidney, bone and brain tissues.

The aluminium concentration levels typically reported in the human brain ranges from 0.25 to 0.75 mg.kg⁻¹, with grey matter containing about twice the concentration found in white matter (ATSDR 2008). Increased brain aluminium level is observed in patients with dialysis encephalopathy. Studies in Alzheimer's disease patients inconsistently showed elevated brain aluminium levels (Krewski et al. 2007). It has been suggested that the aluminium flux through the blood-brain barrier results from transferrin receptor-mediated endocytosis of transferrin-bound aluminium and of transferrin-independent mechanisms involving aluminium citrate. Actually, a study by Yokel et al., showed that the transport of Al citrate across the blood-brain

barrier is carrier-mediated, involving either an uncharacterized monocarboxylate transporter (MCT) isoform expressed in the brain such as MCT7 or MCT8 and/or one of the many members of the organic anion transporting protein family, some of which are known to be expressed at the blood–brain barrier (Yokel et al. 2002).

Aluminium is also present in human skin, lower gastrointestinal tract, parathyroid glands; low aluminium concentrations were measured in most soft tissue organs, other than lungs. Aluminium is also able to cross the placental barrier and to accumulate in foetal tissue (ATSDR 2008).

Distribution following intramuscular injection (case of vaccine):

Aluminium compounds are commonly used as adjuvant in vaccines making the intramuscular route a pathway of exposure to aluminium in the general population. Once injected in tissues, aluminium-containing adjuvants form an extracellular depot; then, they are slowly solubilised (by citrate ions) and can enter blood (Affourtit, Bakker, and Pronk 2020).

A study conducted in 12 preterm infants (mean gestational age: 27.1 weeks, mean weight at birth: 1021 g, mean weight at vaccination: 2254 g) did not show a significant change in serum and urine aluminium levels 24 hours after the routine 2-month vaccination, with vaccines containing a total of 1200 µg of aluminium (Movsas et al. 2013). The administered vaccines were Prevenar 13 (containing aluminium phosphate), PedvaxHIB (containing aluminium hydroxyphosphate sulphate) and Pediarix (containing aluminium hydroxide and aluminium phosphate). This shows that serum aluminium does not significantly increase following vaccination.

However, in animals, after intramuscular administration of ^{26}Al hydroxide or ^{26}Al phosphate vaccine adjuvants in rabbits, increased levels of ^{26}Al were found in the kidney, spleen, liver, heart, lymph nodes, and brain (in decreasing order of aluminium concentration) (Flarend et al. 1997). In this study, aluminium from intramuscular deposits of both solutions appeared in blood as early as 1 hour after injection. The area under the curve showed that during the first 28 days after exposure, three times as much aluminium diffused from the aluminium phosphate deposits than from the aluminium hydroxide deposits; the terminal phase of the blood concentration curve was not reached by that time.

In a study conducted in rats, very low aluminium levels were found in brain after aluminium phosphate or aluminium hydroxide adjuvanted vaccines (adjuvant group means 0.14–0.29 µg.g⁻¹ ww; control 0.13 ± 0.04 µg.g⁻¹ ww), and the authors concluded that the diffusion of aluminium from vaccine deposits to the brain, if there is any, is marginal. In this study, aluminium from both aluminium phosphate and aluminium hydroxide adjuvants and adjuvanted vaccines increased aluminium levels mainly in bone (5–12% of the administered dose). The release from injected muscle was faster for aluminium phosphate than for aluminium hydroxide: 85.5% vs 22.3%, over 80 days. Different rates of absorption were noted, with markedly higher systemic availability from aluminium phosphate than from aluminium hydroxide-adjuvanted vaccines (Weisser et al. 2019).

Other studies conducted in mice have shown that after intramuscular injection, aluminium particles (administered as oxyhydroxide or hydroxide nanodiamonds) were slowly translocated to draining lymph nodes, then to blood, spleen, and liver (Khan et al. 2013; Eidi et al. 2015). Crépeaux et al. in a study conducted in mice, showed that the translocation from muscular deposits to lymph nodes and spleen was very slow, the highest number of particles being observed in these tissues at day 270; in this last study, no translocation of aluminium to brain was observed (Crépeaux et al. 2015).

4.1.3 Metabolism

Aluminium does not undergo metabolism but can be transformed from one species to another. In living organisms, aluminium is thought to exist in four different forms: Al-ions (free and weakly or more strongly bound in salts), as low-molecular-weight complexes (with organic acids, amino acids, nucleotides, phosphates and carbohydrates), as physically bound macromolecular complexes (with proteins, polynucleotides and glycosaminoglycans), and as covalently bound macromolecular complexes (Ganrot 1986; Priest 2004). The free ion, Al^{+3} , is easily bound to many substances and structures; therefore, its fate is determined by its affinity to each of the ligands and their relative amounts and metabolism. The low-molecular-weight (LMW)-complexes are often chelates and may be very stable. The macromolecular complexes are expected to be much less active than the LMW-complexes. Aluminium may also form complexes with macromolecules that are so stable that they are essentially irreversible (Daydé et al. 2003; ATSDR 2008).

4.1.4 Excretion

Aluminium is primarily eliminated in the urine (95%) via glomerular filtration process, while the unabsorbed dietary aluminium is excreted in the faeces. A minor, secondary route (~ 2%) is excretion *via* bile (Krewski et al. 2007; EFSA 2008). Aluminium has also been detected in breast milk at a typical range of 0.0092 to 0.049 mg.L⁻¹ (ATSDR 2008), in saliva, in sweat and in the seminal fluid (Krewski et al. 2007).

Multiple reported values for serum and urine elimination half-lives of aluminium (from hours to years, according to the duration of the period of observation) in humans and animals suggest that there is more than one compartment of aluminium storage, in particular bones and lungs (EFSA 2008; Klotz et al. 2019). Typically, the longer half-life can only be determined with increased duration of sampling, and retention times for aluminium appear to be longer in humans than in rodents. Actually, in most individuals, the largest aluminium reservoir is the skeleton; elimination from bone is very slow with a half-life of several years (Klotz et al. 2019). Slow aluminium elimination coupled with continuous exposure may explain the increasing body burden with age (Affourtit, Bakker, and Pronk 2020).

4.1.4.1 Excretion following inhalation

Human data

Urinary excretion is the primary route of elimination of absorbed aluminium after inhalation exposure (Klotz et al. 2019). Elevated levels of aluminium in urine have been detected in aluminium welders and aluminium flake workers (ATSDR 2008). Exposure studies showed that aluminium excretion is biphasic. As reported in ATSDR 2008, the excretion half-life for the first phase ranged from 7.5 to 9 days among workers exposed to welding fumes or aluminium dust (Sjögren et al. 1985; 1988; Pierre et al. 1995). The half-lives for the second phase ranged from 6.8 to 24 weeks (Sjögren et al. 1988; Schaller et al. 2007). The wide range of apparent half-lives reflects differences in the duration of sampling. Furthermore, several investigators (Sjögren et al. 1988; Letzel, Schaller, and Angerer 1996) have found a linear relationship between post-shift urinary aluminium levels and levels of aluminium in air around welders during the last or the cumulated preceding shifts (ATSDR 2008).

Animal data

No available studies in ATSDR (2008) and since then after literature search.

4.1.4.2 Excretion after oral intake

Human data

An acute exposure of 4 days to 54.3 mg Al.kg⁻¹, as aluminium carbonate, produced peak concentrations ranging from 4- to 10-fold elevation in base-line urinary levels (<200 µg.d⁻¹ (± SEM) on control days vs 380-580 µg.d⁻¹ (± SEM) after aluminium intake) (Recker et al. 1977). In addition, a 40-day balance study was conducted by Greger and Baier, where eight adult males were fed two levels of aluminium, as aluminium lactate: 5 mg.d⁻¹ for 20 days (control diet) and 125 mg.d⁻¹ for 20 days (test diet). Subjects excreted two- to five-fold more aluminium in their urine when fed the test diet (47 to 212 µg Al.d⁻¹; mean 1.71 mg.kg bw⁻¹.d⁻¹) rather than the control diet (24 to 58 µg Al.d⁻¹; mean 0.07 mg.kg bw⁻¹.d⁻¹) (Greger and Baier 1983). Patients taking aluminium hydroxide antacids (1-3 g Al.d⁻¹) had a 3-fold increase in urinary aluminium urine and serum levels, e.g.: a subject excreted 0.098 mg of Al in urine.d⁻¹ before taking Amphogel 90 (aluminium hydroxide) and then excreted 0.282 mg.d⁻¹ Al in urine. Aluminium concentrations in plasma were 36 µg.L⁻¹ and 46 µg.L⁻¹ before and after taking the antacid, respectively (Gorsky et al. 1979).

Animal data

A single oral dose of 11 mg aluminium (administered as aluminium chloride) to healthy Sprague-Dawley rats resulted in a 14-fold increase in urine aluminium levels after 5 days (9.23±2.21 µg.d⁻¹), as compared to baseline levels (0.40±0.54 µg.d⁻¹) (Ittel et al. 1987). Rats administered by gavage a single dose of one of eight aluminium compounds (each one containing 35 mg aluminium) excreted 0.015–2.27% of the initial dose in the urine. In this experiment, 24-hour urine was collected from rats for 2 days before the gavage and 3 days afterwards (Froment et al. 1989). The range of urinary elimination most likely reflects differences in gastrointestinal absorption (ATSDR 2008).

Faecal aluminium results from unabsorbed aluminium and aluminium excreted via bile (ATSDR 2008). In rats receiving a gavage dose of 6.7–27 mg Al.kg bw⁻¹ (administered as aluminium lactate in a sodium citrate aqueous solution to enhance aluminium absorption from the gastrointestinal tract), 1.3-2.8% of the total dose was excreted in urine and 0.06 to 0.14% of the total dose was excreted in bile within 3 hours. Within 15 minutes, the levels of aluminium in bile were significantly higher than in controls (Sutherland and Greger 1998).

4.1.4.3 Excretion after dermal exposure

Human data

No available studies in ATSDR (2008) and since then after literature search.

Animal data

No available studies in ATSDR (2008) and since then after literature search.

4.1.4.4 Excretion after intramuscular injection

In the rabbit study by Flarend et al., the cumulative amount of aluminium eliminated in the urine over 28 days was 6% of the aluminium hydroxide adjuvant dose and 22% of the aluminium phosphate adjuvant dose. Aluminium from both adjuvants was still being excreted at a steady rate on day 28 (Flarend et al. 1997). While this indicates that the body can eliminate the aluminium absorbed from the adjuvants, elimination is slow for the aluminium phosphate

adjuvant and even slower for the aluminium hydroxide adjuvant (Affourtit, Bakker, and Pronk 2020).

4.1.4.5 Excretion after intravenous injection

Two studies conducted in healthy human volunteers described aluminium elimination after intravenous injection of [^{26}Al]-aluminium citrate (Priest et al. 1995; Talbot et al. 1995).

In the study of Priest et al. (1995), a single volunteer received $0.7\ \mu\text{g}\ ^{26}\text{Al}$. After 15 minutes, more than half of ^{26}Al had left blood and the decline continued afterwards, leaving less than 1 % of the injected dose in blood after 2 days. This initial rapid decrease resulted from both distribution and excretion. The proportion of dose that is excreted, estimated up to 13 days after injection, was 83 % in urine and 1.8 % in faeces. The fraction retained in whole body was of 15.2 % at 13 days, and it then slowly declined to around 4 % after 1178 days (3 years) (Priest et al. 1995). A re-analysis of these data in a later publication indicated that they could be adequately interpreted by a three-compartment model with half-lives of 1.4, 40, and 1727 days. This volunteer was re-examined 10 years after the injection, and collected data indicated that the current elimination half-life for this volunteer was very prolonged, in the region of 50 years (Priest 2004).

In the study of Talbot et al., 6 healthy male volunteers received the same injection of [^{26}Al]-aluminium as citrate salt (4 ml containing 84 ng ^{26}Al and 25 mg citrate). Blood concentration decreased by 98 % in one day (mean value of 2% of injection remaining after 1 d); $59 \pm 10\ %$ were excreted in the urine within 24 hours; faecal excretion was negligible during the first 5 days (1 %). Whole-body retention was still $27 \pm 7\ %$ at 5 days (Talbot et al. 1995).

Globally, these two studies reported convergent results, evidencing a rapid excretion of most absorbed aluminium in the urine and a fraction that persists a very long time in the body.

4.1.5 **PBPK model**

Various kinetic models for aluminium, with different levels of complexity, have been published. In the three models developed below, insoluble aluminium compounds are not considered.

The open compartmental model is represented in Figure 4. Open compartmental model for aluminium biokinetics (Nolte et al. 2001)(Nolte et al. 2001). The parameters of this model are based on 4 studies in rats with oral administration of ^{26}Al -chloride and 3 human studies with IV administration of ^{26}Al -citrate. The essential features of the model are a central compartment, three compartments for the digestive tract and three peripheral compartments. The central compartment consists of transferrin-bound aluminium and citrate-bound aluminium in plasma and in the interstitial fluid. The peripheral compartments are used for organs like liver and spleen, muscles and bones. Liver and spleen receive aluminium from the transferrin-bound aluminium in the plasma, the muscles from the transferrin-bound aluminium in the interstitial fluid and the extracellular bone tissue from the citrate-bound aluminium of the interstitial fluid. With regards to the gastrointestinal absorption, aluminium uptake is considered to take place in the duodenum and proximal jejunum. Excretion of incorporated aluminium occurs from the soluble ultrafiltrable phase of the citrate-bound aluminium in the plasma via the kidneys. Measured values of ^{26}Al in serum and urine were used to determine absorption, speciation, distribution, retention, and excretion of aluminium in healthy volunteers and in patients with chronic renal failure following administration of a single oral or IV dose of ^{26}Al (Steinhausen et al. 2004).

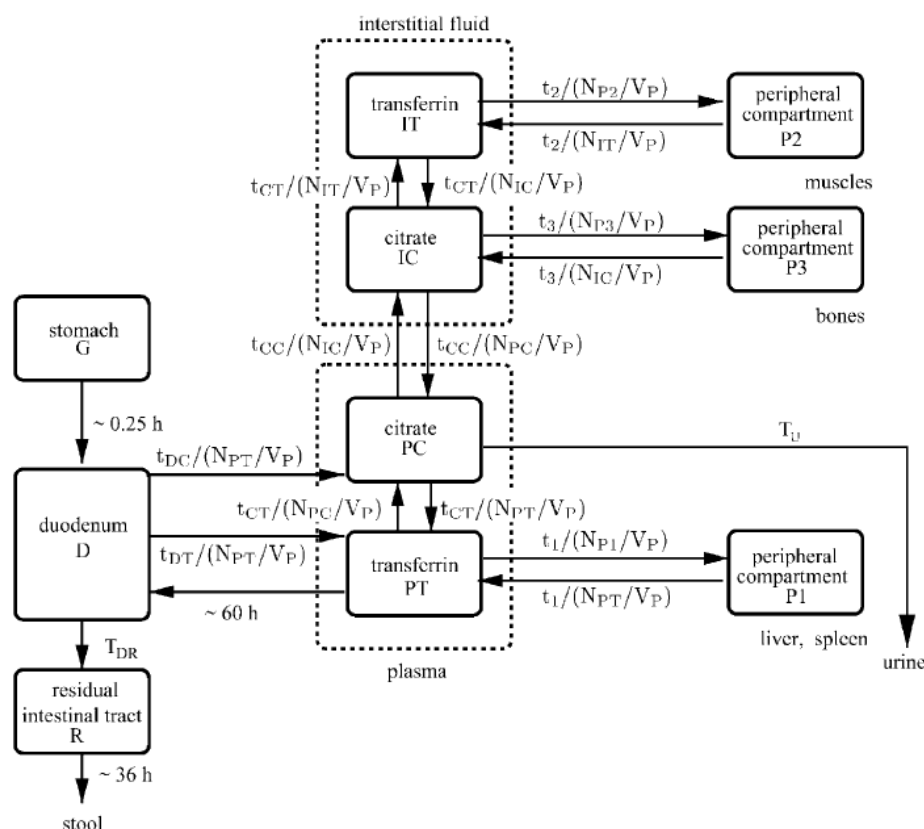


Figure 4. Open compartmental model for aluminium biokinetics (Nolte et al. 2001)

Poddalgoda et al considered a 3-compartment human model (Poddalgoda *et al.* 2021). The model tracks the amount of aluminium in each of three compartments (plasma, rapid and slow tissues) as well as excretion in urine.

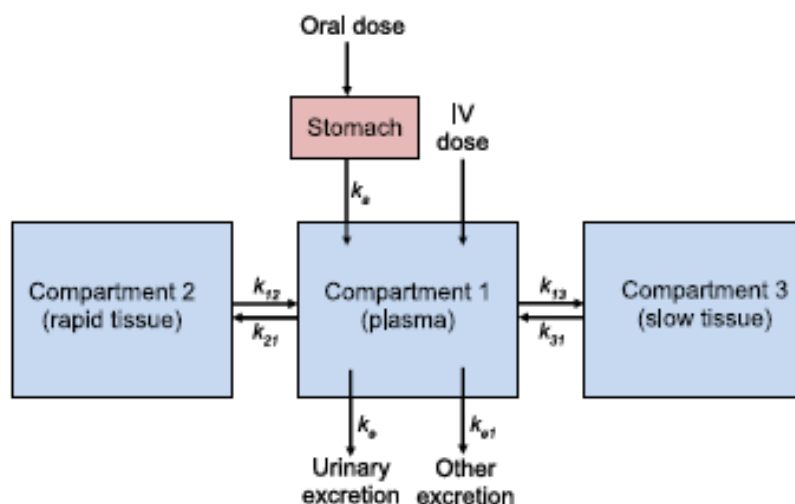


Figure 5. Structure of the three-compartment aluminium pharmacokinetic model (Poddalgoda et al. 2021)

Hethey et al. described a physiological-based toxicokinetic model of aluminium citrate or chloride salts in rats and humans (Figure 6) (Hethey et al. 2021). This PBK model accounts for aluminium kinetics in plasma, blood, liver, spleen, muscle, bone, brain, kidney, and urine. A 'rest of body' compartment describes the sum of the remaining body spaces (carcass,

adipose tissue, lung and sites escaping quantification in before-mentioned tissue homogenates). The organs are in exchange via a central blood compartment that includes the arterio-venous space as well as the vascular space of the tissues. In the figure below, mass transfers are indicated by black arrows. Different aluminium species are considered in the blood compartment: iv-administered citrate, and chloride salts as well as a 'mixed' state, where all aluminium species, including transferrin bound Al, are assumed to be in quasi-steady state. Routes of administration are indicated by red arrows and are intravenous and oral administration. In this model, the amount of aluminium in erythrocytes is assumed to be negligible compared to the amount in plasma. The detailed model structure with three Al states in blood was designed to account for potential differences in renal elimination depending on the route and aluminium salt (citrate or chloride) administered.

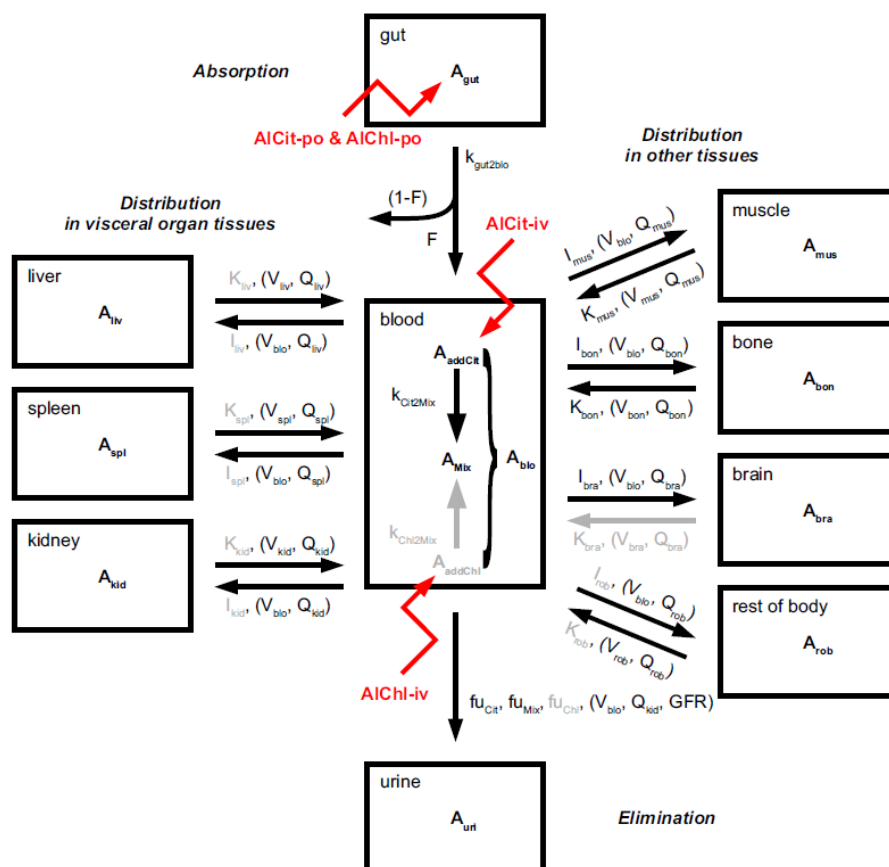


Figure 6. PBK model structure of aluminium (Hethey et al. 2021)

4.1.6 Overview ADE (absorption, distribution, excretion)

The aluminium load in the human body, from daily absorption through the digestive, pulmonary, and even dermal routes, is distributed mainly to the bones (50%) and the lungs (25%); aluminium is also found in small amounts, in the brain, the lower gastrointestinal tract and soft tissue organs other than the lungs. The transport protein of aluminium (as Al^{+3}) is transferrin and the main route of excretion is the urinary route (Figure 6).

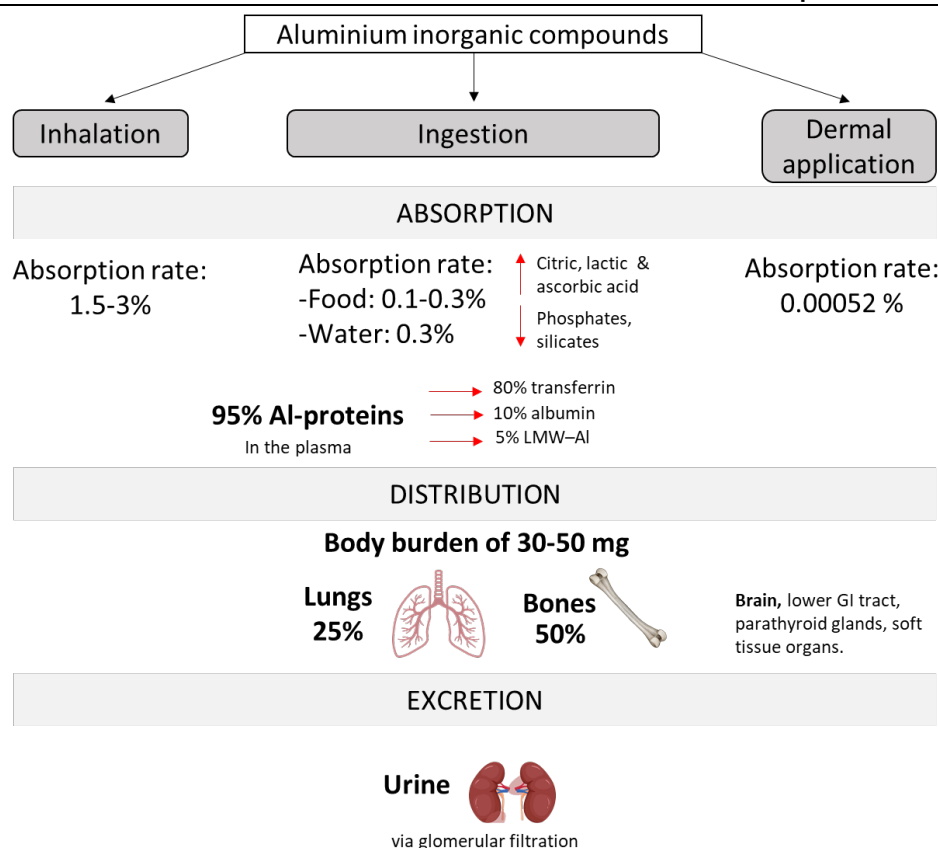


Figure 7: Absorption, distribution and excretion of aluminium inorganic compounds in humans

4.2 Biomarkers of exposure and biomonitoring

The scientific literature search failed to identify any relevant biomarkers of early effects for the biomonitoring of occupational exposure to aluminium. Therefore, biomarkers of early effects will not be developed further.

4.2.1 Measurement of aluminium in biological samples

Aluminium can theoretically be measured in all biological liquids, tissues or excreta (e.g.: blood, serum, urine, cerebrospinal fluid, semen, milk, saliva, bone, hair or even nails) (ATSDR 2008).

4.2.1.1 Analytical methods for aluminium determination

Samples can be analysed after dilution (water, Triton®, EDTA, nitric acid) or after microwave-assisted acidic mineralisation. Nitric acidification is sufficient, for most of the metals present in urine, to ensure good preservation for a few weeks at +4°C.

After sample homogenisation, aliquots are dispensed into clean tubes and either refrigerated (for preservation of less than two weeks) or frozen (at - 20°C, when the preservation time could be of more than 2 weeks) for subsequent analysis. If the sample is frozen, defrosting is followed by homogenisation and centrifugation. The sample must be properly mixed before dosing as,

for example, aluminium phosphate tends to precipitate in urine (WHO 1996; Labat 2010; San Martín, Bauçà, and Martínez-Morillo 2022).

Aluminium determination remains a challenge, regardless of the techniques used or matrices studied, because of the ubiquity of this element and the contamination risks associated with it. In fact, the majority of analytical errors are due to contamination of the sample by aluminium from ambient air, laboratory equipment or reagents used for sampling and sample preparation. It is essential to use high-purity standards and reagents, and type 1 grade ultrapure water.

Blank determination from pre-washed sample containers is recommended to ensure that the cleaning protocols and pre-analytical steps avoided aluminium contamination. The laboratory's environment should be kept as clean as possible.

Numerous analytical methods exist for aluminium concentration measurements in biological materials. Nevertheless, due to their insufficient detection limits or significant number of interferences, some of these techniques are no longer used. These include UV-visible absorption spectroscopy, fluorescence spectroscopy, flame atomic absorption spectrometry, X-ray fluorescence spectrometry, and neutron activation analysis. At present, inductively coupled plasma mass spectrometry (ICP-MS) is the method of choice for measurement of aluminium, as it has shown to offer the best limits of quantification (LOQ), selectivity and robustness (San Martín, Bauçà, and Martínez-Morillo 2022).

The main analytical methods for the measurement of aluminium are described below. It should be noted that the aim of this section is not to recommend an analytical method for the measurement of aluminium, but to inform on specific metrological parameters and to present the advantages and limitations of each method.

Electrothermal atomic absorption spectrometry (ETAAS) or graphite furnace atomic absorption spectrometry (GFAAS)

In this technique, the sample introduced into the graphite furnace undergoes the successive steps of matrix dehydration and mineralisation, element atomization, and pyrolysis. The last step serves to clean the furnace to prevent inter-sample contamination.

To improve selectivity and eliminate interference, this technique requires the use of background correctors, Zeeman correction being the preferred method, preventing molecular interference and conferring high specificity. Alternatively, matrix modifiers are used to displace chlorine atoms and prevent the formation of volatile aluminium chloride in the pre-atomization stages. However, matrix modifiers can be a source of contamination, so their use is not advisable.

One of the main sources of contamination with this technique is atmospheric dust, particularly in the sampler cups, a type of contamination that appears to be almost non-existent with ICP.

Advantages of this technique include its simplicity, sensitivity and low cost. In fact, it does not require sample pre-treatment, and only a small sample volume is required. Detection limits in urine and blood samples are around 1-2 $\mu\text{g.L}^{-1}$ (0.04-0.07 $\mu\text{mol.L}^{-1}$) (ANSES 2003; ATSDR 2008; San Martín, Bauçà, and Martínez-Morillo 2022). The LOQ was reported to be of 2 $\mu\text{g.L}^{-1}$ (INRS Biotox).

Inductively coupled plasma atomic emission spectrometry (ICP-AES)

This technique is based on the production of excited atoms within an argon plasma (partially ionised gas with a temperature ranging from 3000 to 8000 K). The plasma is generated by an electromagnetic field produced by an induction coil connected to a high-frequency generator.

Element identification and quantification are achieved by measuring the intensity of the light emitted by the elements excited in the neutral or ionised state.

While less sensitive than ETAAS, ICP-AES offers several advantages:

- analysis speed (resulting in a significantly reduced need for re-analysis),
- dynamic range (a larger linear range, requiring fewer dilutions),
- specificity (less sensitive to matrix effects, allowing analysis of diverse samples without modifications of the analytical parameters),
- multi-element capability (ANSES 2003).

The limits of detection of aluminium using ICP-AES are about $1\mu\text{g.L}^{-1}$ for urine and $4\mu\text{g.L}^{-1}$ for blood samples (Allain et Mauras 1979 in ATSDR 2008). The lowest LOQ was reported to be of $1\mu\text{g.L}^{-1}$ (INRS Biotox).

Hence, ICP-AES is used when high sensitivity is not required, for the analysis of major components, or when the matrix is highly charged (soils, ores, alloys, etc.). It is easy to use and is faster.

Possible interferences for aluminium by ICP-AES are with Ti, Mo, Zr, Fe, U and Ce (Meggers and Corliss 1961; Burden et al. 1995; ATSDR 2008).

The most commonly used spectral lines, because they are more sensitive, are 167.020 nm (Fe interference) and 396.152 nm (Zr, Ce interferences). Interferences in urine do not seem to be problematic.

Inductively coupled plasma mass spectrometry (ICP-MS)

This technology combines two principles: ICP, a highly efficient source of ion production and mass spectrometry for ion separation. It offers several advantages:

- very high sensitivity,
- enhanced detection limits: $0.1\text{--}1\mu\text{g.L}^{-1}$ ($0.004\text{--}0.04\mu\text{mol.L}^{-1}$) for most of the elements of the periodic table,
- possibility of multi-element and isotopic analysis of trace elements.

Interferences (spectroscopic and non-spectroscopic) must also be controlled (ANSES 2003; ATSDR 2008; San Martín, Bauçà, and Martínez-Morillo 2022). LOQs take into account potential interferences and background noise and the management of interference does not seem problematic.

Generally, LOQ ranged between 0.2 and $10\mu\text{g.L}^{-1}$ (INRS Biotox). In a biomonitoring study, the LOQ of aluminium in urine samples using ICP-MS was of $0.156\mu\text{g.L}^{-1}$ and the limit of detection (LOD) $0.052\mu\text{g.L}^{-1}$ (Bertram et al. 2023).

The advantages and limitations of the analytical methods for aluminium measurement are summarised in Table 5 (ANSES 2003; ATSDR 2008; Wilschefski and Baxter 2019; San Martín, Bauçà, and Martínez-Morillo 2022).

Table 5. Overview of the advantages, limitations and LODs of the main analytical techniques used for aluminium measurement

Analytical method	Advantages	Limitations	Limit of detection	Limit of quantification
ETAAS / GFAAS	• Simplicity of sample preparation • Low sample volume • Few interferences	• Single element technique • Limited analytical range	$1\text{--}2\mu\text{g.L}^{-1}$ ($0.04\text{--}0.07\mu\text{mol.L}^{-1}$)	$2\mu\text{g.L}^{-1}$

	• Sensitivity			
ICP-AES	• Simplicity of sample preparation • Low sample volume • Multi-element analysis • High specificity • Large analytical range	• Possible interferences • Low sensitivity	High detection limit: 1-4 µg.L ⁻¹	1 µg.L ⁻¹
ICP-MS	• Simplicity of sample preparation • Low sample volume • Multi-element analysis • Very high sensitivity • Large analytical range	• Need for high skilled expertise	0.1–1 µg.L ⁻¹ (0.004–0.04 µmol.L ⁻¹)	0.2-10 µg.L ⁻¹

Whatever the analytical technique used, measurement uncertainties are estimated by analytical repeatability and intermediate precision.

Laboratories must indicate the limit of detection and quantification and the uncertainties of the method used when reporting the results of aluminium analysis in the corresponding matrix.

The use of reference material, if available, is recommended for any type of biological matrix. For this end, the procedures recommended within the framework of the European projects DEMOCOPHES, HBM4EU and PARC, concerning the harmonisation of biomonitoring of European populations, can be used (Schindler et al. 2014; Vorkamp et al. 2021; Zare Jeddi et al. 2022).

In fact, reference materials should be incorporated into the analysis process, i.e. samples of the same matrix as the specimen with a well-known amount of biomarker concentration (close to the ones of the specimens). This guarantees reliable results. Control samples are generally commercially available certified samples.

External quality assurance schemes provide a way for laboratories to assess their performance by comparing it to that of other participating laboratories through benchmarking. Different relevant programmes including aluminium are available: the OELM External Quality Program (occupational and environmental laboratory medicine), included matrices are serum, whole blood and urine; the UKNEQAS for Trace Elements (United Kingdom) involving serum, blood, urine, and dialysis water and fluids; and, the QMEQAS of the Centre de Toxicologie du Québec also using several matrices like serum, blood, urine, and hair (ANSES 2003; SOCIETE FRANCAISE DE MEDECINE DU TRAVAIL 2016; San Martín, Bauçà, et Martínez-Morillo 2022; Biotox INRS¹⁹).

The laboratory participation in external quality control programs, and the systematic implementation of internal quality controls are determining points for obtaining COFRAC-ISO 15189 accreditation, which is a guarantee, for users, of laboratory reliability (Nübler et al. 2021).

¹⁹ Biotox INRS : https://www.inrs.fr/publications/bdd/biotox/dosage.html?refINRS=Dosage_1 (accessed on March 2024)

4.2.2 Identification of biomarkers of exposure

Although aluminium can theoretically be measured in different biological liquids, tissues, or excreta, in practice, blood and urine appear as the most commonly used matrices for the routine biomonitoring of aluminium exposure, both in an occupational or an environmental context.

The deferoxamine challenge test (measurement of aluminium excretion after deferoxamine administration) and bone aluminium concentration are probably good indicators of aluminium body burden, but they do not appear adapted for routine surveillance. Indeed, the challenge test is invasive and deferoxamine is not always well tolerated (Yokel 1994). Non-invasive *in vivo* bone aluminium measurement is still in the field of research (Aslam et al. 2009).

Already demonstrated to be of valuable use in forensic for several classes of substances in particular inorganic compounds, hair has multiple advantages for human biomonitoring: it is stable, easy to access for sampling, well tolerated and reflects long-term exposure (Peña-Fernández A, González-Muñoz Mj, and Lobo-Bedmar Mc 2014). Similarly, metal concentration in toenails is a non-invasive biomonitoring tool and early warning indicator that is favoured over fingernails because of the lower risk of external contamination (Di Ciaula et al. 2020). Indeed, the measurement of aluminium in hair and nails has gained considerable interest in recent years. The use of ICP-MS provides high sensitivity and reproducibility in these matrices. However, specifically in the context of environmental exposure, the relevance of aluminium in hair or nails as effective biomarkers of exposure remain to be established, particularly with regard to the prediction of health effects. Indeed, while measurement in these matrices offers the advantage of being non-invasive, it remains challenging to differentiate between aluminium incorporated in the hair (internal exposure) and aluminium deposited on the hair (external exposure), even with advances in technology and especially in the case of aluminium, where the substance itself is measured in the hair and nails and not as a metabolite.

Most of the toxicological studies and data available concern aluminium measured in urine and/or blood. These two matrices will be developed further in the following chapters.

4.2.2.1 Aluminium in urine

Many studies in workers or volunteers have demonstrated that urine aluminium levels measured at the end of a shift and after several shifts is a good biological indicator of the mean exposure of the preceding week (Lauwerys and Hoët 2001; Rossbach et al. 2006; Bertram et al. 2015; Riihimäki and Aitio 2012).

In addition, urine aluminium is possibly a good indicator of aluminium body burden, especially when measured at least 2-3 days after discontinuation of exposure (before the shift) (most of the elimination of the amounts recently absorbed occurring within 2 days). There is no human data validating this hypothesis.

Actually, cross sectional and longitudinal epidemiological studies have shown an increase of the risk of neurotoxic cognitive effects, associated with the elevation of urine aluminium concentration in occupationally exposed workers (see section 6.5.1).

4.2.2.2 Aluminium in blood

Concentrations of aluminium in whole blood, erythrocytes, serum and plasma are usually considered approximately equal and all four blood matrices could theoretically be considered for internal exposure assessment (Poddalgoda et al. 2021). However:

- studies on the distribution of aluminium between serum (or plasma) and erythrocytes gave conflicting results (see section 4.2) and studies on the association of whole-blood or erythrocytes aluminium levels with health effects or aluminium external exposure are scarce.

Consequently, these two matrices cannot be presently considered for aluminium exposure biomonitoring.

- serum and plasma levels are theoretically equivalent, but anticoagulants, such as heparin or citrate, may contain aluminium. For this reason, serum should be preferred over plasma.

When measured at the end of shift with stable chronic exposure (e.g. welding), serum aluminium levels are well correlated with atmospheric exposure (Biotox INRS assessed in April 2024). A good correlation ($r=0.824$) was reported between circulating (serum) and excreted (urine) aluminium concentrations (Riihimäki et al. 2000). However, urinary aluminium is considered as a more sensitive indicator of variations of exposure and/or body burden. Indeed, for low-level occupational exposures (lower than 5 mg.m^{-3} of elemental aluminium), serum aluminium levels are not significantly different from those of the general population, when small variations of exposure are detectable through urinary aluminium monitoring. In addition, after the end of exposure, serum aluminium levels return to normal more rapidly than urinary aluminium concentrations (Riihimäki and Aitio 2012; INRS 2021)

In conclusion, determination of serum aluminium lacks sensitivity for revealing small variations of external exposure and/or for the biomonitoring of the body burden, especially in low exposure situations. However, serum aluminium is still the best biomarker for aluminium body burden in people with renal failure, as their aluminium internal dose can be high and urine aluminium level is not a validated exposure indicator for those people.

Table 6 summarises the advantages and limitations of the most commonly used matrices for the measurement of total aluminium. Other potential matrices are not included in the table as they are rarely used and because of the lack of available literature.

Table 6. Overview of the advantages and limitations of the main matrices used for total aluminium measurement

Analyte	Matrix	Advantages	Limitations
Aluminium	Urine	• Non-invasive • Reflects both aluminium body burden and recent exposure • More sensitive than blood aluminium to changes in external exposure • Association established with risk of neurological effects for urine aluminium levels at the end of a shift after several shifts (see chapter 8)	• Influenced by impaired renal function • Intra- and inter-individual variations in urine concentration (related to water intake and excretion); those variations can be managed through adjustment on urine creatinine level, urine density or urine osmolality • High risk of external contamination of samples, at sampling time and during sample preparation and analysis
Aluminium	Whole blood, Plasma, Serum	• Reflects recent exposure • More reliable than urine aluminium when renal function is not normal	• Invasive • Less sensitive than urine aluminium to changes in external exposure • High risk of external contamination of samples, at sampling time and during sample preparation and analysis
Aluminium	Hair	• Non-invasive, stable, possibility to observed past exposure	• Challenging to differentiate internal and external exposure

			Limited data on the association with health effects
Aluminium	Nails	Non-invasive, easy to access for sampling, well tolerated, possibility to observe past exposure	- Challenging to differentiate internal and external exposure - Limited data on the association with health effects

4.2.3 Factors that may influence the interpretation of aluminium measurements

Certain practices can influence the interpretation of aluminium measurements in workers by increasing aluminium levels and making the occupational exposure not readily interpretable. Table 7 summarises these different factors.

Table 7: Factors that may influence the interpretation of aluminium measurements

Total aluminium in urine or serum	
Medical treatment	Consumption of certain drugs containing aluminium compounds as an active ingredient or as an adjuvant could increase aluminium levels and should be avoided prior to sampling (e.g.: some antacids, buffered aspirins, antidiarrheals, etc.).
Food intake	Food contact with aluminium packaging, kitchen utensils and aluminium films under acidic conditions can allow aluminium emission and food contamination (Krewski et al. 2007). Furthermore, fruit juices (containing citric acid which increases aluminium absorption, see section 4.1.2) can increase urinary aluminium levels and should be avoided in the 2 days prior to sampling (INRS Biotox) ²⁰ .
Smoking	Even though high concentration of aluminium in tobacco are reported, ranging from 0.6 to 3.7 mg Al.g ⁻¹ product (Exley et al. 2006), smoking did not influence aluminium concentrations in plasma and urine of occupationally non-exposed subjects (Chiba and Masironi 1992; Nisse et al. 2017). Thus, it might not impact the biomonitoring result's interpretation.
Physiological or pathological factors	As aluminium is mainly eliminated in the urine (see section 4.4), patients with reduced renal function, might have higher levels of aluminium in blood due to the lack of normal clearance (implying reduced urinary levels). Aluminium-containing prosthetic implants may increase blood and urine aluminium levels (San Martín, Bauçà, and Martínez-Morillo 2022).
Co-exposure to one or more substances (occupationally)	N/A

²⁰ <https://www.inrs.fr/publications/bdd/biotox.html> (accessed in April 2024)

Route(s) of exposure, task description	N/A
Physical activity, effort, ...	N/A
Frequency and duration of exposure	N/A

N/A: not applicable

4.2.4 Sampling, collection and storage of biological specimens

Strict precautions must be taken during sampling, sample preservation, preparation, and analysis. As for other ubiquitous chemicals, the risk of external contamination indeed appears as an issue in aluminium determination.

Below are some recommendations to collect and preserve blood and urine samples for aluminium measurement. However, as a general rule, sampling material should ideally be provided by laboratories that have previously checked their suitability for the analysis. Also, in the case of occupational biomonitoring exposure, samples should preferably be taken outside the workplace and after the worker has removed his work clothes and taken a shower. It is also advisable to enquire in advance, with the laboratory carrying out the analysis, about the pre-analytical conditions required, e.g.: storage and transportation requirements (SFMT 2016).

In general, the working group on biomarkers of exposure suggests the following recommendations to minimise contamination and ensure accurate results:

- 1- In the first instance, vials and consumables labelled “trace metal-free” should be used, and glass vials should be avoided;
- 2- If this is not the case, the equipment should be cleaned with 10% ultra-pure nitric acid (up to a maximum of 20%) and soaked overnight, then rinsed thoroughly with ultra-pure water;
- 3- In all cases, all consumables must be tested for aluminium contamination (blank run with concentrations of reagents and acids identical to those used in the samples). This should also be done after the cleaning step.

■ Urine samples

For aluminium exposed workers, it is generally recommended to carry out urine sampling at the end of the shift and after several shifts (Klotz et al. 2019), as reference health values were produced using such samples, which inform on both aluminium body burden and aluminium exposure during the last days (see chapter 6). Sampling has also been recommended at the beginning of the week, before the start of the first day's work shift (WHO 1996; INRS Biotox²¹). In order to avoid the risk of contamination, samples should be collected at home, using the materials provided by the laboratory or otherwise they must be collected outside the workplace, ideally after showering or at least after washing hands.

²¹ <https://www.inrs.fr/publications/bdd/biotox.html> (accessed in April 2024)

As indicated above, materials used for sampling should be those recommended by the laboratory in charge of the analysis, which should have previously verified that they were free of aluminium (WHO 1996; Labat 2010; San Martín, Bauçà, and Martínez-Morillo 2022). If not, precautions must be taken to avoid aluminium contamination of the material used (wash and soak overnight with 10% (up to a maximum of 20%) nitric acid, then rinsed with ultrapure water and perform a blank test).

The main limitation of urinary aluminium concentration when measured on spot urine sample is the large inter- and intra-individual variability of urine concentration, depending on water intake and loss. The theoretical remedy to this drawback is the adjustment of the urinary aluminium concentration measured on the sample to the concentration of urine (to its water content). The most commonly used adjustment methods are on the osmolality of urine, its relative density (specific gravity) and especially, on the urinary concentration of creatinine. The adjustment on the concentration of creatinine is the one that is, by far, the most used and in particular, in most studies that have sought associations between cumulative exposure to aluminium and health effects. It has been rightly pointed out that adjustment for urinary creatinine concentration is not ideal, because regardless of aluminium exposure and its body burden, the factors of variation in urinary aluminium and creatinine concentrations are not always identical: indeed, urinary creatinine excretion is partly determined by muscle mass, physical effort, consumption of meat-based foods, etc. Even if adjustment on creatinine concentration is not ideal for taking into account variations in urinary flow rate, it is preferable to no adjustment, as the amplitudes of inter- and intra-individual variations are much lower for creatinine excretion than for urine concentration (i.e. water content). This is confirmed by studies showing a stronger association of the urinary excretion of aluminium over a period of 24 hours (as the gold standard) with concentrations in spot samples with adjustment for creatinine concentration rather than with no adjustment (X. Zhang et al. 2017; Y.-X. Wang et al. 2019).

■ **Blood samples**

For workers, blood sampling is also recommended at the end of a shift after several shifts (WHO 1996; INRS Biotox²²). Whereas, for the general population, there is no recommendation on blood sampling time.

Most blood sampling tubes and tools are made of rubber containing aluminium silicate. For this reason, the collection of blood in specific vacuum tubes for trace elements is recommended. The use of separating gel vacuum tubes is permitted, but, as mentioned previously, the use of glass tubes is not. As noted above, materials used for sampling should be those recommended by the laboratory in charge of the analysis, which should have previously verified that they were free of aluminium otherwise, strict precautions must be taken (WHO 1996; Labat 2010; San Martín, Bauçà, and Martínez-Morillo 2022).

For serum measurements, after the blood has been collected and coagulated, it is centrifuged in a closed container (to avoid contamination or evaporation) for 10 minutes at 1,000-1,200 g. Serum is kept in suitable sealed polypropylene or polystyrene tubes for less than 14 days at 4°C (refrigerated) or is frozen at -20°C for prolonged preservation before analysis (WHO 1996; Labat 2010; San Martín, Bauçà, and Martínez-Morillo 2022).

4.2.5 Choice of the biomarker of exposure and of the sampling time

Biomarker of exposure

²² <https://www.inrs.fr/publications/bdd/biotox.html> (accessed in April 2024)

When selecting an exposure biomarker, several criteria are generally taken into account: the association between concentrations of the potential biomarker and health effects and/or external concentrations or doses, the elimination half-life (important for choosing the sampling time), the specificity of the biomarker, the intra-individual and/or inter-individual variability of the association between exposure and the biomarker (in terms of co-exposures, pathologies or predispositions), the sampling conditions and the availability of analytical methods (ANSES, to be released).

As shown in Table 6, urinary aluminium appears to be the biomarker of exposure of choice:

- there is sufficient evidence of a positive association between urinary aluminium level and the risk of health effects, with identified NOAEL and LOAEL in humans (see section 4.7.1);
- urine aluminium is a biomarker of greater sensitivity compared to serum aluminium when external exposure changes are minimal;
- in individuals with normal renal function, inter- and intra-individual variabilities are limited, when aluminium levels are adjusted on urine creatinine concentration, specific gravity or osmolality.

Furthermore, urine sampling is non-invasive and analytical methods are available to conduct the analysis (see above section).

Sampling time

The studies making it possible to characterise the association between urine aluminium concentration and the health effects, and to identify a NOAEL and a LOAEL, have used urinary post-shifts samples. These studies reported the results of post-shift and morning samplings after several working days. They showed no difference on urinary aluminium concentrations at these two sampling times (see section 4.7.1). No data was available for urinary aluminium concentration before the first shift of the working week. As a consequence, the sampling time recommended for the biomonitoring of occupational aluminium exposure is the end of a shift, after several shifts.

In conclusion, urinary aluminium, post-shift after several shifts, is selected as the relevant BME for biological monitoring of occupational exposure to aluminium, on the basis of an analysis of the advantages and disadvantages of the various BMEs identified. In the case of impaired renal function, urinary aluminium cannot be used as BME because this pathological condition affects the interpretation of biomonitoring results.

4.3 Acute and subacute toxicity

4.3.1 Human data

No reliable studies have been identified regarding the effects of acute inhalation or ingestion of aluminium or its compounds in humans.

Several cases of aluminium related encephalopathy were reported in patients who underwent otoneurosurgery with bone reconstruction using an aluminium-containing cement (Hantson et al. 1995; Lévêque et al. 1996; Reusche et al. 2001).

Cases of acute encephalopathy with high aluminium plasma levels are also reported, after post-surgical bladder alum irrigation. However, in most of these cases, aluminium was probably not the only or the main cause of the neurological symptoms, as severe hydroelectrolytic disturbances were obviously or probably associated (Phelps et al. 1999).

4.3.2 Animal data

ATSDR reported several acute toxicity studies in animals following **oral exposure** to aluminium or its compounds (ATSDR 2008).

■ Mice

In mice (Swiss-Webster), LD50s (median lethal doses) were 286, 222 and 164 mg Al.kg bw⁻¹ for aluminium nitrate, aluminium chloride and aluminium bromide, respectively (Llobet et al. 1987). In another mice strain (Dobra Voda), LD50 values were higher, with 770 mg Al.kg bw⁻¹.d⁻¹ for aluminium chloride and 980 mg Al.kg bw⁻¹.d⁻¹ for aluminium sulphate (Ondreicka, Ginter, and Kortus 1966).

■ Rats

The LD50 in rats were 261 mg Al.kg bw⁻¹ for aluminium nitrate, 370 mg Al.kg bw⁻¹ for aluminium chloride, 162 mg Al.kg bw⁻¹ for aluminium bromide and >730 mg Al.kg bw⁻¹ for aluminium sulphate (Llobet et al. 1987).

■ Rabbits

Five female New Zealand rabbits died from a single 540 mg Al.kg bw⁻¹ dose of aluminium lactate administered by gavage (Yokel and McNamara 1985).

Following acute **inhalation**, ATSDR found no study assessing mortality of aluminium or its compounds in animals. However, some respiratory effects following acute and subacute inhalation of aluminium compounds have been reported (ATSDR 2008).

■ Mice

Mice (n=11) whole-body exposed, for one hour, to a suspension of 8 mg.m⁻³ of aluminium dust had a significant higher fraction of alveolar collapse (69.7±1.2%) and influx of polymorphonuclear cells in lung parenchyma (27.5±1.1%) than the control group (n=11) exposed to saline (Mazzoli-Rocha et al. 2010).

■ Rats

In male rats (Fischer-344) whole-body exposed 0, 10, 50 100, 200 or 1000 mg.m⁻³ aluminium flakes (median diameter: 1.58 µm) for (5x) 4 hours, multifocal microgranuloma in the lungs and hilar lymph nodes were detected at the 2 highest concentrations starting 200 mg Al.m⁻³. An increase of lactate dehydrogenase, glucose-6-phosphate dehydrogenase and alkaline phosphatase activities in lavage fluid was observed at 50 mg Al.m⁻³. No respiratory effects were observed at the concentration of 10 mg Al.m⁻³ (NOAEL) (Thomson et al. 1986).

■ Hamsters

In a series of studies on hamsters (Golden Syrian), a 13% increase in lung weight was observed after inhalation (whole-body exposed) of aluminium chlorohydrate for 3 days (4 h.d⁻¹) from the dose of 7 mg Al.m⁻³ (LOAEL), and no significant increase of the lung weight was observed at 3 mg Al.m⁻³ (NOAEL). An alveolar wall thickening, and an increased number of macrophages were observed after a 3-day exposure (4 or 6 hr.d⁻¹) to 31 or 33 mg Al.m⁻³. In this experiment, a progressive decrease in the severity of the pulmonary effects was observed after the end of exposure (Drew et al. 1974).

■ Rabbits

Similar effects were observed in New Zealand rabbits. In this species, a thickening of the alveolar wall, an increase in the number of macrophages and a 65% increase in lung weight were observed after inhalation (whole-body exposed) of aluminium chlorohydrate for 5 days (4hr.d⁻¹) at a LOAEL of 43 mg Al.m⁻³ (Drew et al. 1974).

4.4 Irritation

As indicated in section 3.3, anhydrous aluminium chloride is classified as skin corrosive (category 1B) under the harmonised CLP classification. In addition, ECHA website²³ reports several CLP notifications and information from REACH registration dossiers concerning the skin and/ or ocular irritation effect of other aluminium compounds including, aluminium citrate, aluminium hydroxide, aluminium lactate, aluminium nitrate, aluminium phosphate, aluminium silicate, aluminium sodium dioxide and aluminium sulphate.

In fact, it is predictable that, in contact with a humid environment, partially hydrolysed aluminium salts may cause irritation to the skin and mucous membranes following the liberation of the corresponding acid.

4.4.1 Human data

SCCS mentioned some studies reporting skin irritation following the application of a high dose of aluminium hexahydrate chloride (ACH) in ethanol (20% ACH) in a formulation for the treatment of axillary / palmar hyperhidrosis (Ellis and Scurr 1979; Goh 1990; Reisfeld and Berliner 2008) and following the use of aluminium-containing crystal deodorant (Gallego, Lewis, and Crutchfield 1999). SCCS also explained that, although associations have been reported between axillary irritation and aluminium chloride in antiperspirants for the treatment of hyperhidrosis, the history of use of this compound in antiperspirants shows that this effect is not very common (SCCS 2023).

Furthermore, the review by Krewski et al. reported cases of contact dermatitis and irritant dermatitis in workers following exposure to aluminium alloys and aluminium dust. It was also concluded that aluminium inhalation could cause irritation. This is based on several old studies in the workplace reporting dry cough, dyspnoea and shortness of breath following the exposure to aluminium powder (Krewski et al. 2007).

4.4.2 Animal data

■ Ocular irritation

Conjunctivitis and purulent ophthalmitis were observed following the instillation of potassium alum (aluminium potassium sulphate) (Grekhova et al. 1994) and ammonium alum into rabbit's eyes (Krewski et al. 2007).

■ Dermal irritation

SCCS reported a study (Lansdown 1973) in which epidermal lesions, hyperkeratosis, acanthosis and micro-abscesses were observed in mice, rabbits and pigs after 5 days of dermal application (once.d⁻¹) of aluminium chloride or nitrate (10% [w/v]), but not with aluminium acetate, hydroxide or hydrochloride compounds (SCCS 2023).

4.5 Sensitisation

4.5.1 Human data

ATSDR reported a case described by De Vuyst et al. (1987) where T-helper lymphocyte alveolitis and blastic transformation of peripheral blood lymphocytes in the presence of soluble aluminium compounds *in vitro* were observed in an individual exposed to metallic aluminium and aluminium oxide dust with sarcoid-like epithelioid granulomas (ATSDR 2008).

²³ <https://echa.europa.eu/information-on-chemicals> (accessed on February 2024)

ATSDR (2008) also reported hypersensitivity to aluminium chloride in patch testing in some children and one adult who had previously received injections of vaccines or allergens in aluminium-based vehicles (Böhler-Sommeregger and Lindemayr 1986; Veien et al. 1986).

SCCS specified that there are no sufficient data in humans suggesting that aluminium compounds used in antiperspirants cause allergies and given their widespread use, this effect, if it exists, seems to be rather rare (SCCS 2023).

4.5.2 Animal data

SCCS reports a study conducted by Basketter et al. (1999) where doses up to 25% of aluminium chloride were tested in a murine local lymph node assay (LLNA), with no indications of a skin sensitisation potential. A guinea pig maximisation test with aluminium chlorohydrate dosed at 25 %, was also negative (SCCS 2020).

SCCS confirmed that animal data do not indicate a skin sensitisation effect of the aluminium compounds used in antiperspirants (SCCS 2023).

4.6 Subchronic toxicity

No **human** reliable studies were identified on health effects following subchronic exposure to aluminium compounds.

Among the studies identified in **animals**, seven studies involved administering aluminium chloride to rats via drinking water, at dose levels ranging 0-8.3 mg.kg bw⁻¹.d⁻¹ (Martinez et al. 2017a, 2017b, 2017c, 2018) or by gavage at dose levels ranging 0, 8.3 or 32 mg.kg bw⁻¹.d⁻¹ (Fernandes et al. 2020; Souza-Monteiro et al. 2021; Bittencourt et al. 2022) or 0-100 mg.kg bw⁻¹.d⁻¹ (Martinez et al. 2017a, 2017b, 2017c, 2018). These studies investigated effects on bone mineralisation (Souza-Monteiro, 2021), cardiotoxicity (Martinez et al., 2017a), male reproductive toxicity (Martinez et al., 2017b), and neurotoxicity (Martinez et al. 2017c, 2018; Fernandes et al. 2020; Bittencourt et al. 2022). All the studies referred to human dietary levels of exposure to calculate the doses to be used in rodent studies but the human values used for calculation were not clearly justified and did not refer to benchmark values calculated by regulatory agencies. In addition, the doses received by the animals were not confirmed by analysis of aluminium in drinking water nor supported by drinking water consumption measurement. A high level of uncertainty regarding the doses received by the animals led the experts not to consider these studies for the hazard assessment of aluminium chloride.

4.6.1 Neurotoxicity

4.6.1.1 Human data

No human reliable studies were identified on neurotoxic effect following subchronic exposure to aluminium compounds.

4.6.1.2 Animal data

Several animal studies (mice and rats) reported neurotoxicity effects after subchronic exposure to aluminium compounds. These studies are described below and summarised in Table 8.

■ Mice

Swiss-Webster female mice (dams) exposed to aluminium lactate from Gestational day (Gd) 1 to Lactation day (Ld) 21 through diet did not show signs of toxicity in the neurobehavioral test battery (fore and hindlimb grip strength, temperature sensitivity, negative geotaxis, air puff startle reflex, auditory startle reflex, foot splay) when they were exposed to 25 (control), 500 or 1000 $\mu\text{g Al.g}^{-1}$ diet (Donald et al. 1989). The NOAEL was 1000 $\mu\text{g.g}^{-1}$ diet equivalent to 330 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$, referring to the highest tested dose.

Female Swiss-Webster mice (8-12 weeks of age) were exposed to aluminium lactate for 6 weeks in the diet at doses of 25 (control), 500 or 1000 $\mu\text{g Al.g}^{-1}$ diet. In the high dose group, there was a significant reduction in total activity counts and counts of vertical movement and a significantly lower percent of activity in the highest activity level category (Golub et al. 1989). The NOAEL was 500 $\mu\text{g.g}^{-1}$ diet, or 62 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$ and the LOAEL 1000 $\mu\text{g.g}^{-1}$ diet, or 130 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$.

Swiss-Webster female mice (dams) exposed to aluminium lactate in the diet at doses of 25 (control) or 1000 $\mu\text{g Al.g}^{-1}$ diet, during gestation or lactation or both, did not show effects of aluminium exposure in the neurobehavioral test battery performed at time of weaning (Golub, Keen, and Gershwin 1992a). The NOAEL was 1000 $\mu\text{g.g}^{-1}$ diet, or 250 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$, referring to the highest tested dose.

Golub et al. administered aluminium lactate (25 mg (control) or 1000 mg Al.kg^{-1} diet) to female Swiss-Webster (3-4 weeks old) mice through diet for 13 weeks. In the high dose group, decreased forelimb and hindlimb grip strengths and startle response, a decreased in total activity counts, horizontal activity counts and in the percentage of intervals with high activity counts were reported (Golub et al. 1992b). The LOAEL for this study was 1000 mg.kg^{-1} diet, or 195 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$.

Aluminium chloride was also given to 42-day-old female Swiss Webster mice through the diet for 5-7 weeks at dose of 3 (control) or 1000 mg Al.kg^{-1} diet. A decrease in forelimb and hind limb grip strength was reported at the high dose (Oteiza et al. 1993). The LOAEL for this study was 1000 mg.kg^{-1} diet, or 195 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$.

Aluminium ammonium sulphate was administered in drinking water to C57BL/6J female mice at 0 or 0.075 g.L^{-1} from 4 weeks old to 9 weeks old of age (20 per group) or to male and female mice at 0 or 1 g.L^{-1} from Gd 11 until 9 weeks old of age (20 per group). Behavioural effects were observed in mice from the low dose group (increase in total arm entries in the elevated plus maze test, initial decrease followed by increase in immobility in the forced swim test, decreased freezing in the fear conditioning test 1 month after the conditioning session compared with controls). However, considering that only one dose was tested in each experiment and that these effects were not observed in the high dose Al-treated mice, it appears that the observations were probable false positives, even if the exposure protocols were not identical at the lower and the higher doses. Indeed, these behavioural differences did not reach a statistically significant level after correction for multiple testing. In the high dose experiment, increased social contacts, impaired reference memory performance, decreases in pre-pulse inhibition and in correct responses in the working memory task were observed. The differences in any of the behavioural measures, in this second experiment did not reach the significance level after correction for multiple testing (Shoji et al. 2018).

■ Rats

When aluminium lactate was administered through gavage to Wistar rats, from PND 5 to PND 14, at doses of 0, 100, 200 or 300 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$, no effects were observed regarding the grasping reflex. Results of negative geotaxis test was significantly reduced at 200 and 300 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$ compared to the control group and significant differences were observed in the suspension test (reduced time of suspension) and the locomotor coordination test (increase

time to put the 4 feet on the platform) between the control group in the 300 mg Al.kg bw⁻¹.d⁻¹ dose group (Bernuzzi, Desor, and Lehr 1989b). The LOAEL was 200 mg Al.kg bw⁻¹.d⁻¹ and the NOAEL 100 mg Al.kg bw⁻¹.d⁻¹.

Increased brain aluminium levels with decreased choline acetyltransferase activity and general activity were reported at a LOAEL of 200 mg Al.kg bw⁻¹.d⁻¹ in Wistar rats also orally exposed to aluminium lactate through gavage from Post Natal Day (PND) 5 To PND 14 at doses of 0, 100, or 200 mg Al.kg bw⁻¹.d⁻¹ (Cherroret et al. 1992). The NOAEL was 100 mg Al.kg bw⁻¹.d⁻¹.

Male rats (16 days old and 18 months- strain not specified) were exposed to aluminium nitrate for 100 days in drinking water at doses of 0 or 100 mg Al.kg bw⁻¹.d⁻¹ (citric acid was added to water). No significant effects of aluminium exposure on behaviour (motor activity in an open-field apparatus and learning using passive avoidance test) could be detected between groups. The total number of synapses in the left CA1 fields of hippocampal formation was decreased in the aluminium aged group compared to the aluminium young group (Colomina et al. 2002). The NOAEL was 100 mg Al.kg bw⁻¹.d⁻¹, the highest tested dose.

In the study by Mameli et al., Wistar rats (n= 270) at 3, 10- and 24-months age, were exposed through drinking water to aluminium chloride (0.5, 1, 2 g.L⁻¹ in drinking solution providing 11.1, 21.5, 43.1 mg Al.kg bw⁻¹.d⁻¹) for 90 days. The study also included a control group (Mameli et al. 2006). Rats were tested at 30, 60 and 90 days of exposure. Considering the amount of aluminium present in the diet, they were approximatively exposed to 20, 30 or 52 mg Al.kg bw⁻¹.d⁻¹ (EFSA 2008). Results of this study showed significant impairment of post-rotatory nystagmus (PRN) parameters (delayed onset latency of PRN, decrease in jerk frequency and jerk amplitude), regardless of animal age, in rats exposed to 52 mg Al.kg bw⁻¹.d⁻¹ (LOAEL). NOAEL was considered to be 30 mg Al.kg bw⁻¹.d⁻¹.

Twelve months aged male Wistar rats (12-13 per group) received 0, 2 or 20 ppm of aluminium in their drinking water, as aluminium chloride, which resulted in an exposure of total aluminium of 0.4, 0.5 and 1.7 mg Al.kg bw.d⁻¹, respectively, considering aluminium from the feed. From 6 months old, rats were trained to perform a rewarded continuous alternation T-maze task. Performance scores on T-maze task were analysed from 16 months old onwards. Among the rats who survived for at least 28 months, (0/10 low-dose group, 2/10 mid-dose group and 7/10 high-dose group), had significant lower scores in old age (> 28 months old) compared to middle age (12-24 months old) rats. Rats with impaired performance had significant higher aluminium serum levels and a larger percentage of aluminium-loaded pyramidal cells in their entorhinal cortex (ie a multi-sensory area, important for memory and navigation), compared to rats with intact T-maze performance. Furthermore, functionally impaired rats had aberrant behaviours including inability to focus attention on their task, perseverative activity and incontinence while in the T-maze. LOAEL for impaired cognitive function was 0.5 mg Al.kg bw⁻¹.d⁻¹ (Walton 2009). JECFA considered this study difficult to interpret because, among other considerations, rats had an unusual feeding regimen (JECFA 2012).

In another study, Wistar rats also received aluminium chloride in their drinking water at 0 or 3 g.L⁻¹ during 4 months in adulthood (at 3 months old). There was a significant increase of glial fibrillary acidic protein (GFA-P)-immunoreactive astrocytes in brains of aluminium treated rats, that also had a significant reduced locomotor activity compared to controls (Erazi et al. 2010). The LOAEL was 3g.L⁻¹ in water, or 55 mg Al.kg bw⁻¹.d⁻¹.

In another study, Wistar rats (15 per group) were administered aluminium chloride at 0, 0.18, 0.72 or 3.6 g AlCl₃.L⁻¹ in drinking water during 6, 12 and 18 months. A significant increase in aluminium concentration in plasma and brain was observed in a dose dependent and time dependent manner. Exposure to aluminium chloride caused a significant decrease in body weight (highest dose, month 18) and brain weight (mid and highest dose at 18 months); a significant correlation was confirmed between body and brain weight during 12 and 18 months. Aluminium chloride produced, at all doses, lesions of sub-granular and granular layers

(significant at month 18) (Hichem et al. 2014). The LOAEL was 0.18 g.L⁻¹ aluminium chloride in water, or 2 mg Al.kg bw⁻¹.d⁻¹.

In a study by Cao et al., aluminium chloride was administered, through gavage, to Sprague-Dawley rats (30 per group) for 90 days at doses of 0, 50, 150 or 450 mg AlCl₃.kg bw⁻¹.d⁻¹. Increased mRNA levels of IL-1b, IL-6, TNF-a and MCH II, decreased mRNA levels of CX3CL1 and BDNF, and decreased density of dendritic spine and impaired learning and memory were reported following aluminium chloride exposure in a dose dependent manner but were significant from the mid dose exposure (Cao et al. 2016). The NOAEL was 50 mg AlCl₃.kg bw⁻¹.d⁻¹, or 10 mg Al.kg bw⁻¹.d⁻¹ and the LOAEL was 150 mg AlCl₃.kg bw⁻¹.d⁻¹, or 30 mg Al.kg bw⁻¹.d⁻¹.

Wistar rats (30 per group) were orally exposed to aluminium chloride, from birth until 3 months and a half of age (early exposure via maternal milk for 3 weeks, then after weaning, exposure via spontaneous drinking of water (post-natal 3 weeks to 14 weeks) at doses of 0.015, 0.030 or 0.045 mol.L⁻¹ i.e., 2, 4, 6 g.L⁻¹. Following aluminium chloride exposure, aluminium concentration in blood increased in a dose-dependent manner, morphology of the hippocampus and neuronal ultrastructure were aberrant, the escape latency and distance travelled became longer in the Morris water maze test and intracellular Ca²⁺ and cAMP levels in hippocampus cells declined significantly (Yan et al. 2017). The LOAEL was 2 g.L⁻¹ aluminium chloride equivalent to 36 mg Al.kg bw⁻¹.d⁻¹ for impaired learning and memory performances.

Neurotoxicity of aluminium was also assessed in 3-month-old male Wistar rats (6 per group) administered aluminium chloride over 60 days at doses of 0, 1.5 or 8.3 mg Al.kg bw⁻¹.d⁻¹ through drinking water or over 42 days at doses of 0 or 100 mg Al.kg bw⁻¹.d⁻¹ by gavage. Impaired results on object recognition memory were reported in all treated groups. Reactive oxygen species (from low dose) and lipid peroxidation (from 8.3 mg.kg bw⁻¹) were increased and, AChE activity and hippocampal antioxidant capacity were decreased in all treated groups (Martinez et al. 2017c). Martinez et al. also conducted another study where Wistar rats (8 per group) were administered 0 or 8.3 mg Al.kg bw⁻¹ (dose similar to human dietary levels) through drinking water for 60 days or 0 or 100 mg Al.kg bw⁻¹ through gavage for 42 days. In all treated groups, the development of mechanical allodynia, catalepsy, increased inflammation in the sciatic nerve and systemic oxidative stress were reported. Aluminium was also able to be retained in the sciatic nerve (Martinez et al. 2018). The LOAEL was of 1.5 mg Al.kg bw⁻¹.d⁻¹ for the first study and of 8.3 mg Al.kg bw⁻¹.d⁻¹ for the second one.

Wistar rats (10 per group) received, by gavage, aluminium chloride solutions at doses of 0, 8.3 or 32 mg.kg bw⁻¹.d⁻¹ for 60 days. At the high dose group, aluminium level increased significantly in hippocampal parenchyma. Aluminium at both concentrations affected long-term memory and induced oxidative stress in prefrontal and hippocampus but did not affect short-term memory (Fernandes et al. 2020). The LOAEL was 8.3 mg mg.kg bw⁻¹.d⁻¹ of aluminium chloride, or 1.7 mg Al.kg bw⁻¹.d⁻¹.

In another study, male Wistar rats (12 per group) received through gavage either 0 or 8.3 mg.kg bw⁻¹.d⁻¹ of aluminium chloride for 60 days. Aluminium exposed rats had a significantly increased learning deficiency and spatial memory, deregulation of proteins expression, essentially the ones regarding the regulation of the cytoskeleton, cellular metabolism, mitochondrial activity, redox regulation, nervous system regulation and synaptic signalling and, reduced hippocampal cell body density in CA1, CA3, and hilus (Bittencourt et al. 2022). The LOAEL was 8.3 mg.kg bw⁻¹.d⁻¹ of aluminium chloride, or 1.7 mg Al.kg bw⁻¹.d⁻¹.

In another study by Massand et al., male Wistar rats (6 per group) were orally exposed, through gavage, to aluminium chloride at 0, 100 or 300 mg.kg bw⁻¹.d⁻¹ for 30 days. Results showed that rats exposed to aluminium chloride had a significant damage in all hippocampus regions compared to the control group. At 300 mg.kg bw⁻¹.d⁻¹, marked neuronal damage in CA1 and CA3 were reported, in comparison with the group exposed to the lower aluminium dose

(Massand et al. 2022). The LOAEL was 100 mg.kg bw⁻¹.d⁻¹ aluminium chloride, or 20 mg Al.kg bw⁻¹.d⁻¹.

Table 8. Animal studies on aluminium neurotoxicity

Strain	Duration route exposure	and of	Dose	Al compound	Endpoint	NOAEL	LOAEL	Reference
Mice								
Swiss-Webster (n= 16 per group)	Gd1 to Ld 21 In the diet		25 (control), 500 or 1000 µg Al.g ⁻¹ diet	Aluminium lactate	Neurobehavioral test battery No effect was observed at the highest dose	330 mg Al.kg bw ⁻¹ .d ⁻¹		Donald et al. (1989)
Swiss-Webster (n= 5 per group)	6 weeks In the diet		25 (control), 500 or 1000 µg Al.g ⁻¹ diet	Aluminium lactate	Reduced total activity counts, counts of vertical movement and a lower percent of activity in the highest activity level category	62 mg Al.kg bw ⁻¹ .d ⁻¹	130 mg Al.kg bw ⁻¹ .d ⁻¹	Golub et al. (1989)
Swiss-Webster (Control: n = 14; Al: n = 9)	Gd1-Gd21 or Ld1- Ld21 or Gd1-Ld21 In the diet		25 (control) or 1000 µg Al.g ⁻¹ diet	Aluminium lactate	Neurobehavioral test battery No effect observed at the highest dose	250 mg Al.kg bw ⁻¹ .d ⁻¹		Golub et al. (1992a)
Swiss-Webster (n= 12 per group)	13 weeks In the diet		25 (control) or 1000 mg Al.kg ⁻¹ diet	Aluminium lactate	Decreased forelimb and hindlimb grip strengths and startle response, decreased total activity counts		195 mg Al.kg bw ⁻¹ .d ⁻¹	Golub et al. (1992b)
Swiss Webster (n= 10 per group)	5-7 weeks In the diet		3 (control) or 1000 mg Al.kg ⁻¹ diet	Aluminium chloride	Decrease in forelimb and hind limb grip strength		195 mg Al.kg bw ⁻¹ .d ⁻¹	Oteiza et al. (1993)
Rats								
Wistar (n= 25-25-29-38 respectively)	PND 5 to PND 14 Gavage		0, 100, 200 or 300 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium lactate	Reduced negative geotaxis test	100 mg Al.kg bw ⁻¹ .d ⁻¹	200 mg Al.kg bw ⁻¹ .d ⁻¹	Bernuzzi, Desor & Lehr (1989b)

Wistar (n= 4 per group)	PND 5 to PND 14 Gavage	0, 100, or 200 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium lactate	Increased brain aluminium levels with decreased choline acetyltransferase activity and general activity	100 mg Al.kg bw ⁻¹ .d ⁻¹	200 mg Al.kg bw ⁻¹ .d ⁻¹	Cherret et al. (1992)
(NS) (n= 16 per group)	100 days In water	0 or 100 mg Al.kg bw ⁻¹ .d ⁻¹ (+citric acid added)	Aluminium nitrate	Motor activity in an open-field apparatus and learning using passive avoidance test No effect was observed	100 mg Al.kg bw ⁻¹ .d ⁻¹		Colomina et al. (2002)
Wistar (n= 20-30 per group)	90 days In water	11.1, 21.5, 43.1 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Impairment of post-rotatory nystagmus parameters	30 mg Al.kg bw ⁻¹ .d ⁻¹	52 mg Al.kg bw ⁻¹ .d ⁻¹	Mameli et al. (2006)
Wistar (n= 5 per group)	4 months In water	0 or 3 g.L ⁻¹	Aluminium chloride	Reduced locomotor activity		55 mg Al.kg bw ⁻¹ .d ⁻¹	Erazi et al. (2010)
Wistar (n =15 per group)	6, 8 and 12 months In water	0.18, 0.72 or 3.6 g .L ⁻¹	Aluminium chloride	Lesions of sub-granular and granular layers in hippocampus		2 mg Al.kg bw ⁻¹ .d ⁻¹	Hichem et al. (2014)
Sprague Dawley (n= 30 per group)	90 days Gavage	0, 50, 150 or 450 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Impaired learning and memory	10 mg Al.kg bw ⁻¹ .d ⁻¹	30 mg Al.kg bw ⁻¹ .d ⁻¹	Cao et al. (2016)
Wistar (n=30 per group)	Birth to 14 weeks of age Lactation then in water	2, 4, 6 g.L ⁻¹	Aluminium chloride	Morphological injury of the hippocampus and neuronal ultrastructure longer escape latency and distance travelled the Morris water maze test		36 mg Al.kg bw ⁻¹ .d ⁻¹	Yan et al. (2017)
Wistar (n= 6 per group)	60 days in water	0, 1.5 or 8.3 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Impaired results on object recognition memory		1.5 mg Al.kg bw ⁻¹ .d ⁻¹	Martinez et al. (2017c)
	42 days Gavage	0 or 100 mg Al.kg bw ⁻¹ .d ⁻¹					
Wistar	60 days in water	0 or 8.3 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Development of mechanical allodynia, catalepsy		8.3 mg Al.kg bw ⁻¹ .d ⁻¹	

(n= 8 per group)	42 days Gavage	0 or 100 mg Al.kg bw ⁻¹ .d ⁻¹					Martinez et al. (2018)
Wistar (n=10 per group)	60 days Gavage	0, 8.3 or 32 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Impairment of long-term memory		1.7 mg Al.kg bw ⁻¹ .d ⁻¹	Fernandes et al. (2020)
Wistar (n= 12 per group)	60 days Gavage	0 or 8.3 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Increased learning deficiency and spatial memory and, reduced hippocampal cell body density		1.7 mg Al.kg bw ⁻¹ .d ⁻¹	Bittencourt et al. (2022)
Wistar (n= 6 per group)	Gavage 30 days	0, 100 or 300 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Damage in hippocampus regions		20 mg Al.kg bw ⁻¹ .d ⁻¹	Massand et al. (2022)

4.6.2 Respiratory toxicity

4.6.2.1 Human data

No human reliable studies on respiratory toxicity were identified following subchronic exposure to aluminium compounds.

4.6.2.2 Animal data

Some animal studies (rats, hamsters and guinea pigs) demonstrating respiratory toxicity following subchronic exposure to aluminium compounds have been identified. These studies are described below and summarised in Table 9.

■ Rats

The inhalation of aluminium chlorohydrate by rats (Fischer- 344), 0.25, 2.5 or 25 mg.m⁻³ (whole body) over six months (5d.wk⁻¹ and 6hr.d⁻¹) led to an increase in alveolar macrophages and to granulomatous lesions in lung at the medium and high concentrations. The LOAEL of 2.5 mg.m⁻³ Al chlorohydrate, corresponds to a concentration of 0.65 mg Al.m⁻³; this increase was dose related. Histological alterations or changes in lung weights did not occur at 0.065 mg Al.m⁻³ (Steinhagen, Cavender, and Cockrell 1978).

In another study, Fischer-344 rats were exposed (whole body) to aluminium chlorohydrate for 6 months (5d.wk⁻¹ and 6hr.d⁻¹), at doses of 0.25, 2.5 or 25 mg.m⁻³. A statistically significant increase in relative lung weight was observed in both sexes at the highest concentration (LOAEL 25 mg.m⁻³, corresponding to 6.5 mg.m⁻³ Al; NOAEL 2.5 mg.m⁻³, corresponding to 0.65 mg.m⁻³ Al). In male rats, the same effect was observed from the mid concentration (LOAEL = 0.65 mg Al.m⁻³ and NOAEL=0.065 mg Al.m⁻³ (Stone et al. 1979).

No organ weight or histological changes were observed in the lungs of Sprague-Dawley rats exposed to 70 mg.kg bw⁻¹.d⁻¹ Al as aluminium chloride in drinking water for 30, 60, or 90 days (base dietary aluminium was not reported) (Dixon, Sherins, and Lee 1979).

Sprague-Dawley rats exposed to aluminium nitrate through water over one month at doses of 0, 375, 750 or 1500 mg.kg bw⁻¹.d⁻¹ had also no organ weight or histological changes of the lungs (Gómez et al. 1986). The NOAEL was 1500 mg.kg bw.d⁻¹ of aluminium nitrate, equivalent to 190 mg Al.kg bw⁻¹.d⁻¹ (the highest tested dose).

■ Hamsters

In Hamsters (Golden Syrian) inhaling (whole body exposed) 10 mg Al.m⁻³ as aluminium chlorohydrate over 5 or 6 weeks (5d.wk⁻¹ and 6hr.d⁻¹), granulomatous nodules and thickening of alveolar walls due to infiltration of macrophages and heterophils were observed (Drew et al. 1974).

■ Guinea pigs

The inhalation (whole body exposed) of aluminium chlorohydrate by guinea pigs (Hartley) over six months (5d.wk⁻¹ and 6hr.d⁻¹) led to an increase in alveolar macrophages and to granulomatous lesions in lung at a dose of 0.65 mg Al.m⁻³ (LOAEL), this increase was dose related. Histological alterations or changes in lung weights did not occur at 0.065 mg Al.m⁻³ (Steinhagen, Cavender, and Cockrell 1978).

Guinea pigs were exposed to aluminium chlorohydrate (whole body exposed) for 6 months (5d.wk⁻¹ and 6hr.d⁻¹), at concentrations of 0.25, 2.5 or 25 mg.m⁻³. A statistically significant increase in relative lung weight was observed in both sexes at the higher concentration

(LOAEL 25 mg.m⁻³, corresponding to 6.5 mg.m⁻³ Al; NOAEL 2.5 mg.m⁻³, corresponding to 0.65 mg.m⁻³ Al) (Stone et al. 1979).

Table 9. Animal studies on aluminium sub-chronic exposure respiratory toxicity

Strain	Al compound	Duration and exposure route	Concentration	Endpoint	NOAEL	LOAEL	Reference
Rats							
344-Fischer (n= 20 per group)	Aluminium chlorohydrate	6 months (5d/wk and 6hr.d ⁻¹) Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	Increase in alveolar macrophages, granulomatous lesions in lung	0.065 mg Al.m ⁻³	0.65 mg Al.m ⁻³	Steinhagen et al. (1978)
344-Fischer (n≈ 17 per group)	Aluminium chlorohydrate	6 months (5d/wk and 6hr.d ⁻¹) Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	Increase in relative lung weight	M: 0.065 mg Al.m ⁻³ F: 0.65 mg.m ⁻³ Al	M: 0.65 mg Al.m ⁻³ F: 6.5 mg.m ⁻³ Al	Stone et al. (1979)
Sprague-Dawley (n= 31 per group)	Aluminium chloride	30, 60 or 90 days Water	0, 5, 50 or 500 mg Al.L ⁻¹	No histological changes in lungs	70 mg.kg bw ⁻¹ .d ⁻¹		Dixon et al. (1979)
Sprague-Dawley (n= 10 per group)	Aluminium nitrate	1 month Water	0, 375, 750 or 1500 mg.kg bw ⁻¹ .d ⁻¹	Weight and histological changes in lungs No effect observed at the highest dose	190 mg Al.kg bw ⁻¹ .d ⁻¹		Gómez et al. (1986)
Hamsters							
Golden Syrian	Aluminium chlorohydrate	5 or 6 weeks (5d/wk and 6hr.d ⁻¹) Inhalation	10 mg Al.m ⁻³	Alveolar thickening, increased number of foci of macrophages and heterophils	-	10 mg Al.m ⁻³	Drew et al. (1974)

Guinea pigs							
Hartley (n= 20 per group)	Aluminium chlorohydrate	6 months (5d/wk and 6hr.d ⁻¹) Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	Increase in alveolar macrophages, granulomatous lesions in lung	0.065 mg Al.m ⁻³	0.65 mg Al.m ⁻³	Steinhagen et al. (1978)
Hartley (n= 15 per group)	Aluminium chlorohydrate	6 months (5d/wk and 6hr.d ⁻¹) Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	Increase in relative lung weight	0.65 mg Al.m ⁻³	6.5 mg Al.m ⁻³	Stone et al. (1979)

M: male ; F: female.

4.6.3 Haematological effects

4.6.3.1 Human data

No adverse haematological effects were noted in a group of seven workers after 6 months of exposure to aluminium fumes or dust (Mussi et al. 1984). Exposure levels ranged from 1 to 6.2 mg.m⁻³ Al, predominantly as aluminium oxide. No other human study was found regarding this effect.

4.6.3.2 Animal data

Some animal studies (mice, rats, guinea pigs and dogs) have been identified regarding haematological effects after subchronic exposure to aluminium compounds. These studies are described below and summarised in Table 10.

■ Mice

Female Swiss-Webster mice were exposed to aluminium chloride for 5-7 weeks, in the diet at doses of 3 (control) or 1000 µg Al.g⁻¹ diet. No alteration in haematocrit levels was observed (Oteiza et al. 1993). The NOAEL is 1000 mg.kg bw⁻¹.d⁻¹ Al chloride, or 195 mg Al.kg bw⁻¹.d⁻¹ (the highest tested dose).

■ Rats

Rats (Fischer-344) exposed over 6 months (5d.wk⁻¹, 6hr.d⁻¹), whole body exposed, to aluminium chlorohydrate 0, 0.25, 2.5 or 25 mg.m⁻³ did not present haematological adverse effects (Steinhagen, Cavender, and Cockrell 1978) leading to a NOAEL of 25 mg.m⁻³ Al chlorohydrate corresponding to 6.5 mg Al.m⁻³ (the highest tested dose).

In the study by Stone et al., rats (Fisher-344) were exposed over 6 months (5 d.wk⁻¹, 6 hr.d⁻¹) to 0.25, 2.5 or 25 mg.m⁻³ of aluminium chlorohydrate (whole body exposed). At necropsy, peripheral blood was collected for haematological determinations (total red cells count, total white cells count, haematocrit, mean corpuscular volume and total haemoglobin). The authors did not report any haematological effect following this exposure (Stone et al. 1979). The NOAEL is 25 mg.m⁻³ Al chlorohydrate corresponding to 6.5 mg Al.m⁻³ (the highest tested dose).

In the study by Gómez et al., Sprague-Dawley rats were exposed to aluminium nitrate through water over one month at doses of 0, 375, 750 or 1500 mg.kg bw⁻¹.d⁻¹. A hyperaemia in the red pulp of the spleen was observed in the 750 and 1500 mg.kg bw⁻¹.d⁻¹ groups; it was also observed in the liver at the highest dose (Gómez et al. 1986). The LOAEL was 750 mg.kg bw⁻¹.d⁻¹ Al nitrate corresponding to 95 mg Al.kg bw⁻¹.d⁻¹ and the NOAEL was of 375 mg.kg bw⁻¹.d⁻¹ corresponding to 47 mg Al.kg bw⁻¹.d⁻¹.

In a study by Domingo et al., Sprague-Dawley rats were exposed to aluminium nitrate over 100 days at doses of 0, 360, 720 or 3600 mg.kg bw⁻¹.d⁻¹ through drinking water. Rats exposed to aluminium did not show a difference in haematocrit or haemoglobin levels compared to controls (Domingo et al. 1987b). The NOAEL for haematological effects is 3600 mg.kg bw⁻¹.d⁻¹ of aluminium nitrate equivalent to 468 mg Al.kg bw⁻¹.d⁻¹ (highest tested dose).

Rats (Sprague-Dawley) exposed to aluminium citrate over 8 months, through drinking water (80 mmol.L⁻¹), presented decreased haemoglobin, haematocrit and haptoglobin levels, increased reticulocyte levels, and inhibition of colony-forming units-erythroid (CFU-E) proliferation compared to controls (Vittori et al. 1999). The corresponding LOAEL is 230 mg Al.kg bw⁻¹.d⁻¹. Anisocytosis, anisochromia and poikilocytosis were also observed in aluminium

exposed rats. Furthermore, in this study, rats exposed to aluminium were not iron depleted (normal range of plasma iron concentration and total iron binding capacity). However, there was a decrease in iron uptake and iron incorporation into haem by the bone marrow cells.

In a study by Zhang et al., male Wistar rats (n=50 per group) received aluminium chloride in their drinking water for up to 150 days at 0 or 430 mg Al.L⁻¹ (approximately 0 and 67-100 mg Al.kg bw⁻¹.d⁻¹ respectively). Body weight of aluminium treated rats was significantly decreased from day 60, transferrin and total iron binding capacity were significantly higher than in the control group from day 90, and soluble transferrin receptor levels and erythrocyte counts were lower than controls from day 60 (Zhang et al. 2011). The LOAEL was 67 mg Al.kg bw⁻¹.d⁻¹.

■ Guinea pigs

Guinea pigs exposed over 6 months (5d.wk⁻¹, 6hr.d⁻¹) to 0, 0.25, 2.5 or 25 mg.m⁻³ aluminium chlorohydrate (whole body exposed) did not present haematological adverse effects (Steinhagen, Cavender, and Cockrell 1978), resulting in a NOAEL of 6.5 mg Al.m⁻³ (the highest tested dose).

In the study by Stone et al., guinea pigs were exposed over 6 months (5d.wk⁻¹, 6hr.d⁻¹) to 0.25, 2.5 or 25 mg.m⁻³ of aluminium chlorohydrate (whole body exposed). At necropsy, peripheral blood was collected for haematological determinations (total red cells, total white cells, haematocrit, mean corpuscular volume, and total haemoglobin). The authors did not report any haematological effect following this exposure (Stone et al. 1979). The NOAEL was 25 mg.m⁻³ Al chlorohydrate, corresponding to 6.5 mg Al.m⁻³ (the highest tested dose).

■ Dogs

Beagle dogs exposed to aluminium phosphate for 6 months through their diet (dietary concentrations of 0, 0.3, 1.0 or 3.0% of sodium aluminium phosphate) had no haematological effects (Katz et al. 1984). In this study haematology, urinalysis and blood chemistry tests were performed in addition to prothrombin and activated partial thromboplastin time measurements. The NOAEL is 88 mg Al.kg bw⁻¹.d⁻¹. The same goes for Pettersen et al., with beagle dogs exposed to aluminium phosphate over 26 weeks through the diet (0, 0.3%, 1% and 3% of sodium aluminium phosphate). In this study, haematocrit, haemoglobin concentration, erythrocyte, leukocyte and platelet counts were determined but no haematological effects related to the aluminium treatment were observed (Pettersen et al. 1990). The NOAEL is 75 mg Al.kg bw⁻¹.d⁻¹.

Table 10. Animal studies on aluminium subchronic exposure haematological toxicity

Strain	Al compound	Duration and exposure route	Doses	Endpoint	NOAEL	LOAEL	Reference
Mice							
Swiss-Webster (n= 10 per group)	Aluminium chloride	5-7 weeks Diet	3 (control) or 1000 µg Al.g ⁻¹ diet	No alteration in haematocrit levels at the highest dose	195 mg Al.kg bw ⁻¹ .d ⁻¹		Oteiza et al. (1993)
Rats							
Fischer-344 (n= 20 per group)	Aluminium chlorohydrate	6 months (5d/wk, 6hr.d ⁻¹) Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	No haematological adverse effects at the highest dose	6.5 mg Al.m ⁻³		Steinhagen et al. (1978)
Fischer-344 (n≈ 17 per group)	Aluminium chlorohydrate	6 months (5d/wk, 6hr.d ⁻¹) Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	No haematological adverse effects at the highest dose	6.5 mg Al.m ⁻³		Stone et al. (1979)
Sprague-Dawley (n= 10 per group)	Aluminium nitrate	1 month Water	0, 375, 750 or 1500 mg.kg bw ⁻¹ .d ⁻¹	Hyperaemia in the red pulp of the spleen	47 mg Al.kg bw ⁻¹ .d ⁻¹	95 mg Al.kg bw ⁻¹ .d ⁻¹	Gómez et al. (1986)
Sprague-Dawley (n= 10 per group)	Aluminium nitrate	100 days Water	0, 360, 720 or 3600 mg.kg bw ⁻¹ .d ⁻¹	Haematocrit or haemoglobin levels / No effect was observed at the highest dose	468 mg Al.kg bw ⁻¹ .d ⁻¹		Domingo et al. (1987b)
Sprague-Dawley	Aluminium citrate	8 months Water	0, 80 mmol.L ⁻¹	Decreased haemoglobin, haematocrit & haptoglobin levels, increased reticulocyte levels, and		230 mg Al .kg bw ⁻¹ .d ⁻¹	Vittori et al. (1999)

(Control: n=8; Al group: n= 10)				inhibition of CFU-E proliferation			
Wistar (n= 50 per group)	Aluminium chloride	150 days Water	0 and 67-100 mg Al.kg bw ⁻¹ .d ⁻¹	Disruption of iron homeostasis		67 mg Al.kg bw ⁻¹ .d ⁻¹	Zhang et al. (2011)
Guinea pigs							
Hartley (n= 20 per group)	Aluminium chlorohydrate	6 months (5d/wk, 6hr.d ⁻¹) Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	No haematological adverse effects at the highest dose	6.5 mg Al.m ⁻³		Steinhagen et al. (1978)
Hartley (n= 15 per group)	Aluminium chlorohydrate	6 months (5d/wk, 6hr.d ⁻¹) Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	No haematological adverse effects at the highest dose	6.5 mg Al.m ⁻³		Stone et al. (1979)
Dogs							
Beagle (n= 12 per group)	Aluminium phosphate	6 months Diet	0, 0.3%, 1% and 3% of sodium Al phosphate	No haematological adverse effects at the highest dose	88 mg Al.kg bw ⁻¹ .d ⁻¹		Katz et al. (1984)
Beagle (n= 8 per group)	Aluminium phosphate	26 weeks Diet	0, 0.3%, 1% and 3% of sodium Al phosphate	No haematological adverse effects at the highest dose	75 mg Al.kg bw ⁻¹ .d ⁻¹		Pettersen et al. (1990)

4.6.4 Bone related effects

4.6.4.1 Human data

No reliable human studies on bone related effects were identified following subchronic exposure to aluminium compounds.

4.6.4.2 Animal data

Some animal studies (rats and guinea pigs) have been identified regarding bone related effects after subchronic exposure to aluminium compounds. These studies are described below and summarised in Table 11.

■ Rats

In the study conducted by Steinhagen et al., rats (Fischer-344) exposed through inhalation (whole body exposed) to aluminium chlorohydrate (0, 0.25, 2.5 or 25 mg.m⁻³) over 6 months (5 d.wk⁻¹, 6hr.d⁻¹) did not present histological changes in the muscle or bone (Steinhagen, Cavender, and Cockrell 1978). The NOAEL was 6.5 mg Al.m⁻³ (the highest tested dose).

Male STD Wistar rats exposed to aluminium lactate in the diet (1 000 µg Al.g⁻¹ diet) for 10 weeks did not show pathological changes of bones (Konishi et al. 1996). The NOAEL was 90 mg Al.kg bw⁻¹.d⁻¹ (the only tested dose).

In a study by Li et al., four-week-old Wistar rats were exposed to 0 or 430 mg Al.L⁻¹ as aluminium chloride in drinking water over 150 days. Every 30 days, 10 rats were sacrificed in each group. From day 60, the body weight of aluminium-treated rats was significantly lower than the control group. In the aluminium treated group, aluminium levels in bone were significantly higher, calcium and magnesium levels in bone were significantly lower from days 120-150 and phosphorus levels were significantly lower from day 150 compared to the control group. Levels of zinc, iron, copper, manganese, boron, strontium and selenium in bone also decreased significantly in the aluminium treated group, from day 60. Finally, bone mineral density of the femur metaphysis on days 120 and 150 was significantly lower in the aluminium-treated group from day 120 (Li et al. 2011). The LOAEL is 430 mg Al.L⁻¹ equivalent to 38.7 mg Al.kg bw⁻¹.d⁻¹ (the only tested dose).

Male Wistar rats were exposed to 0 or 0.4 g.L⁻¹ of aluminium chloride (resulting in doses of 0 and 64 mg.kg bw⁻¹ AlCl₃.d⁻¹) in drinking water for up to 120 days. From day 60, body weights of aluminium-treated rats were significantly lower compared to control group. Aluminium levels in serum and in the femur were significantly higher following aluminium treatment compared to controls. The bone mineral densities of the proximal and the distal femoral metaphysis were significantly lower from day 120 compared to controls and the histological structure of the bone was disrupted from day 90. Aluminium chloride exposure also inhibited the Wnt/β-catenin signalling pathway as the mRNA expression of Wnt3a, Fzd2, LRP-5, β-catenin, Tcf4, cyclin D1 and c-Myc, the protein levels of Wnt3a and β-catenin and the activities of Fzd2 and LRP-5 were decreased in the aluminium-treated rats (Sun et al. 2015). The LOAEL of 64 mg.kg bw⁻¹.d⁻¹ of Al chloride is equivalent to 13 mg Al.kg bw⁻¹.d⁻¹ (the only tested dose).

In another study by Zhang et al., male Wistar rats received aluminium chloride for 120 days at doses of 0, 0.4, 0.8 or 1.6 g.L⁻¹ AlCl₃ in drinking water (resulting in 64, 128, 256 mg.kg bw⁻¹ AlCl₃.d⁻¹). Body weights were decreased in all aluminium-treated groups compared to the control. Rats treated with aluminium had a significant higher content of aluminium in serum and in the cartilage and a significant higher level of C-telopeptide of type II collagen in serum. Serum levels of type II collagen (Col II) and alkaline phosphatase (ALP), and the mRNA

expressions of TGF- β 1, BMP-2, ALP and Col II were all decreased following aluminium treatment (Fan Zhang et al. 2017). Cartilage histological structure was also disrupted following aluminium treatment. The LOAEL is $64 \text{ mg.kg bw}^{-1} \text{ AlCl}_3.\text{d}^{-1}$ is equivalent to $13 \text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$.

Aluminium chloride was administered to male Wistar rats by gavage at doses of 0 or $8.3 \text{ mg.kg bw}^{-1}.\text{d}^{-1}$ for 60 days (dose chosen as per the dietary aluminium consumption of humans. d^{-1}). Results of this study showed that aluminium can induce changes in the mineral content and in the mineralised bone microstructure associated with alveolar bone loss (Souza-Monteiro et al. 2021). The LOAEL of $8.3 \text{ mg.kg bw}^{-1} \text{ AlCl}_3.\text{d}^{-1}$ corresponds to $1.68 \text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$.

■ Guinea pigs

In the study conducted by Steinhagen et al., Hartley guinea pigs exposed through inhalation (whole body exposed) to aluminium chlorohydrate (0, 0.25, 2.5 or 25 mg.m^{-3}) over 6 months (5 d.wk^{-1} , 6 hr.d^{-1}) did not present histological changes in the muscle or bone (Steinhagen, Cavender, and Cockrell 1978). The NOAEL was 6.5 mg Al.m^{-3} (the highest tested dose).

Table 11. Animal studies on aluminium sub-chronic exposure musculo-skeletal toxicity

Strain	Al compound	Duration or exposure route	Doses	Endpoint	NOAEL	LOAEL	Reference
Rats							
Fischer-344 (n= 20 per group)	Aluminium chlorohydrate	6 months (5d/wk, 6hr.d ⁻¹) Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	No effect observed at the highest dose	6.5 mg Al.m ⁻³		Steinhagen et al. (1978)
STD Wistar (n= 4-5 per group)	Aluminium lactate	10 weeks Diet	0, 1000 µg Al.g ⁻¹ diet	No effect observed at the highest dose	90 mg Al.kg bw ⁻¹ .d ⁻¹		Konishi et al. (1996)
Wistar (n=50 per group)	Aluminium chloride	150 days Water	0 or 430 mg Al.L ⁻¹	Lower bone mineral density of the femur		38.7 mg Al.kg bw ⁻¹ .d ⁻¹	Li et al. (2011)
Wistar (n=80 per group)	Aluminium chloride	120 days Water	0, 64 mg.kg bw ⁻¹ .d ⁻¹	Lower bone mineral density and disruption of histological structure of femora		13 mg Al.kg bw ⁻¹ .d ⁻¹	Sun et al. (2015)
Wistar (n=20 per group)	Aluminium chloride	120 days Water	0, 0.4, 0.8 or 1.6 g.L ⁻¹	Inhibition of cartilage stimulatory growth factors expressions, disruption of cartilage histological structure		13 mg Al.kg bw ⁻¹ .d ⁻¹	Zhang et al. (2017)
Wistar (n=8 per group)	Aluminium chloride	60 days Gavage	0 or 8.3 mg.kg bw ⁻¹ .d ⁻¹	Changes in the mineral content and mineralised bone microstructure, alveolar bone loss		1.68 mg Al.kg bw ⁻¹ .d ⁻¹	Souza-Monteiro et al. (2021)
Guinea pigs							
Hartley (n= 20 per group)	Aluminium chlorohydrate	6 months (5d/wk, 6hr.d ⁻¹) Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	No effect observed at the highest dose	6.5 mg Al.m ⁻³		Steinhagen et al. (1978)

4.6.5 Other effects

4.6.5.1 Human data

No reliable human studies on systemic toxicity were identified following subchronic exposure to aluminium compounds.

4.6.5.2 Animal data

Several animal studies (mice, rats, guinea pigs and dogs), reporting systemic toxicity after subchronic exposure to aluminium compounds, have been identified. These studies are described below and summarised in Table 12.

■ Mice

No effects on the body weight were observed:

- in Swiss-Webster mice exposed to 25, 500 or 1000 $\mu\text{g Al.g}^{-1}$ diet as aluminium lactate from Gd1 until Ld21 (NOAEL of 1000 mg.g^{-1} diet corresponding to 330 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$ in dams) (Donald et al. 1989);
- in Swiss-Webster mice exposed to 25 (control), 500, or 1000 $\mu\text{g Al.g}^{-1}$ diet as aluminium lactate over 6 weeks (NOAEL of 1000 mg.g^{-1} diet, corresponding to 130 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$) (Golub et al. 1989),
- and in Swiss-Webster mice exposed to 25 (control) or 1000 $\mu\text{g Al.g}^{-1}$ diet as aluminium lactate for 90 days (NOAEL of 195 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$) (Golub et al. 1992b).

A decreased body weight in lactating mice was reported in the study of Golub Keen, and Gershwin, where mice were fed with 25 (control) or 1000 $\mu\text{g Al.g}^{-1}$ diet as aluminium lactate during gestation and from day 1 to day 21 of lactation (LOAEL of 250 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$) (Golub, Keen, and Gershwin 1992a).

In the study by Oteiza et al., female Swiss-Webster mice exposed to aluminium chloride for 5-7 weeks, in the diet at doses of 3 (control) or 1000 $\mu\text{g Al.g}^{-1}$ diet did not have alterations in body, brain and liver weight (Oteiza et al. 1993). The NOAEL of 1000 $\mu\text{g/g}$ diet corresponds to 195 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$ (the highest tested dose).

In a study by Golub et al., Swiss-Webster mice were exposed to 6 (control) or 1025 $\mu\text{Al.g}^{-1}$ diet as aluminium lactate from conception to 6 months of age. Results showed that aluminium exposed mice presented a 19% increase in spleen weights, depressed spleen cell concentrations of IL-2, INF-g and TNF-a and a deficit of CD4+ cells in T-cell populations (Golub et al. 1993). The LOAEL is 200 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$.

Pregnant Swiss-Webster mice were exposed through the diet to 25 (control), 500 or 1000 $\mu\text{g Al.g}^{-1}$ diet as aluminium lactate, during gestation and lactation (6 weeks) then, dams and one male and female per litter were inoculated with *Listeria monocytogenes* and were kept on the same diet for 10 days during which they were monitored. The mortality rate was significantly higher in the dams exposed to aluminium compared to the control group and the cumulative deaths were lower in mice treated with 500 $\mu\text{Al.g}^{-1}$ diet compared to the ones treated with 1000 $\mu\text{g Al.g}^{-1}$ diet. In the offsprings challenged after weaning, there was no difference in the mortality between the diet groups (Yoshida et al. 1989). In this same study, virgin female mice exposed to the same amount of aluminium in diets did not have a change in susceptibility to bacterial infection (no statistical significance in mortality).

■ Rats

In the study by Steinhagen et al., no histological or organ weight changes were observed in the heart, liver, kidneys, reproductive and gastrointestinal tissues, adrenal, thyroid or pituitary

glands, skin and eyes, and in the body weight of rats (Fischer-344) exposed over 6 months (5d.wk^{-1} , 6hr.d^{-1}) to 0.25, 2.5 or 25 mg.m^{-3} aluminium chlorohydrate (whole body exposed) (NOAEL : 25 mg.m^{-3} aluminium chlorohydrate, corresponding to 6.5 mg Al.m^{-3}) (Steinhagen, Cavender, and Cockrell 1978).

In the study by Stone et al. (1979), no effects on the body weight of Fischer-344 rats were observed following the inhalation of 0.25, 2.5 or 25 mg.m^{-3} aluminium chlorohydrate over 6 months (whole body exposed), even at the high dose exposure (Stone et al. 1979). The NOAEL was 25 mg.m^{-3} corresponding to 6.5 mg Al.m^{-3} . In the study conducted by Gómez et al., no organ weight or histopathological changes were observed in the heart, kidney and gastrointestinal tissues and no effect on the body weight of Sprague-Dawley rats exposed to the highest dose of aluminium nitrate through water ($1500\text{ mg.kg bw}^{-1}.\text{d}^{-1}$) over one month, equivalent to $190\text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$. In the liver, a hyperaemia was reported with periportal monocytic infiltrate at the highest dose only (Gómez et al. 1986). Thus, the NOAEL for hepatic effects was considered to be 750 mg.kg bw^{-1} of aluminium nitrate equivalent to $95\text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$.

No effects on the body weight were observed in male STD Wistar rats exposed to aluminium lactate in the diet ($1000\text{ }\mu\text{g Al.g}^{-1}$ diet) for 10 weeks (Konishi et al. 1996) which corresponds to a NOAEL of $90\text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$.

Following oral intake of aluminium nitrate through water at doses of 0, 360, 720 or $3600\text{ mg.kg bw}^{-1}.\text{d}^{-1}$ over 100 days in female rats (Sprague-Dawley), Domingo et al., reported no organ weight or histopathological changes in the heart, liver, kidney and no effect on the body weight (Domingo et al. 1987b). The NOAEL of $3600\text{ mg Al nitrate.kg bw}^{-1}.\text{d}^{-1}$ corresponds to of $468\text{ mg Al nitrate.kg bw}^{-1}.\text{d}^{-1}$.

Rats (21 days old and 18 months old) were exposed to aluminium nitrate in water at dose of 0 or $100\text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$ (citric acid was added to the water) for 100 days. A decrease in the body weight gain was reported in the aged group (Colomina et al. 2002). The LOAEL is $100\text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$.

Male Wistar rats ($n=10$ per group) were administered 0, 0.4, 0.8 or 1.6 g.L^{-1} of aluminium chloride in their drinking water over a 120-day period. There was a decrease in the superoxide dismutase (SOD) activity of kidney significant only at the highest dose group and a dose dependent decrease in the glutathione peroxidase (GSH-PX) activity of kidney. A dose dependent increase in malondialdehyde, β_2 -microglobulin and cystatin C concentrations was also observed. Authors concluded that aluminium chloride induces oxidative stress and suppresses kidney function (Liu et al. 2016).

In a study by Zhang et al., aluminium chloride was intragastrically administered to male Wistar rats at doses of 0, 64.18, 128.36 or $256.72\text{ mg.kg bw}^{-1}$ of aluminium chloride for 120 days. There was dose dependent increase in the systolic and mean arterial blood pressure (significant in from the mid dose group), an increase of osmotic fragility of the erythrocyte (significant at high dose only), a decrease in the percentage of the membrane protein (significant from the mid dose for some and at high dose for all), a decrease in activities of $\text{Na}^{(+)}/\text{K}^{(+)}$ -ATPase, $\text{Mg}^{(2+)}$ -ATPase, $\text{Ca}^{(2+)}$ -ATPase, CAT, SOD and GSH-pX (from the low dose) and an increased malondialdehyde content of erythrocyte membrane (Zhang et al. 2016). In this study, the NOAEL and LOAEL are 64.18 and $128.36\text{ mg.kg bw}^{-1}$ Al chloride. d^{-1} corresponding to 12.8 and $25.7\text{ mg.kg bw}^{-1}\text{ Al.d}^{-1}$, respectively.

Male Wistar rats, received aluminium chloride in drinking water, at doses of 0, 0.4, 0.8 or 1.6 mg.mL^{-1} aluminium chloride (resulting in the doses of AlCl_3 at 0, 64, 128, and $256\text{ mg.kg bw}^{-1}.\text{d}^{-1}$) for 120 days. Results showed dose-dependent histopathological lesions in the liver. Aluminium exposure reduced the electron transport chain complexes I–V activities and adenosine triphosphate (ATP) level in the liver mitochondria of aluminium-treated rats. The mitochondria DNA transcript levels (measured by measured ND1, ND2, Cyt-b, COX1, COX3

and ATPase6 mRNA expressions) also decreased in the liver following aluminium exposure. Accumulation of reactive oxygen species decreased S activity and increase in 8-OHdG levels in mitochondria were also observed in the aluminium group (Xu et al. 2017). LOAEL was 64 mg.kg bw⁻¹ Al chloride.d⁻¹ corresponding to 13 mg.kg bw⁻¹ aluminium.d⁻¹.

Male Wistar rats were administered aluminium chloride over 60 days at doses of 0 or 8.3 mg Al.kg bw⁻¹.d⁻¹ through drinking water or over 42 days at doses of 0 or 100 mg Al.kg bw⁻¹.d⁻¹ by gavage. There was a significant increase in systolic blood pressure in the high and low dose group at the third week (but not at the end for the low dose), an increased ROS production from NAD(P)H oxidase, an increase in contractile prostanoids mainly from COX-2 following aluminium exposure, thus inducing vascular dysfunction and increasing blood pressure (Martinez et al. 2017a).

■ Guinea pigs

No histological or organ weight change were observed in the heart, liver, kidneys, reproductive and gastrointestinal tissues, adrenal, thyroid or pituitary glands, skin and eyes, and in the body weight of guinea pigs exposed over 6 months, whole body exposed, (5d.wk⁻¹, 6hr.d⁻¹) to 0.25, 2.5 or 25 mg.m⁻³ aluminium chlorohydrate (NOAEL = 25 mg.m⁻³ Al chlorohydrate corresponding to 6.5 mg Al.m⁻³) (Steinhagen, Cavender, and Cockrell 1978).

In the study by Stone et al., no effects on the body weight of guinea pigs were observed following the inhalation of a 0.25, 2.5 or 25 mg.m⁻³ aluminium chlorohydrate (whole body exposed) over 6 months, even at the high dose exposure. The NOAEL was 25 mg.m⁻³ Al chlorohydrate, corresponding to 6.5 mg Al.m⁻³ (Stone et al. 1979).

■ Dogs

Following dietary exposure (in the feed) to aluminium phosphate, the NOAEL for some systemic effects in dogs were 75 and 88 mg Al.kg bw⁻¹.d⁻¹, respectively in the study of Pettersen et al. (exposure for 26 weeks, no difference in organ weight of the heart, kidneys, thyroid, adrenals) and the one of Katz et al. (exposure for 6 months, no difference in organ weight or histopathological changes in the heart, liver, kidneys, pituitary, thyroid, adrenals and no ocular changes) (Katz et al. 1984; Pettersen et al. 1990).

Table 12. Animal studies on aluminium sub-chronic exposure systemic toxicity

Strain	Al compound	Duration and exposure route	Doses	Endpoint	NOAEL	LOAEL	Reference
Mice							
Swiss-Webster (n= 16 per group)	Aluminium lactate	Gd1-Ld21 Diet	25 (control), 500 or 1000 µg Al.g ⁻¹ diet	Body weight of dams / No effect observed at the highest dose	330 mg Al.kg bw ⁻¹ .d ⁻¹		Donald et al. (1989)
Swiss-Webster (n= 5 per group)	Aluminium lactate	6 weeks Diet	25 (control), 500 or 1000 µg Al.g ⁻¹ diet	Body weight / No effect observed at the highest dose	130 mg Al.kg bw ⁻¹ .d ⁻¹		Golub et al. (1989)
Swiss-Webster (n= 12 per group)	Aluminium lactate	90 days Diet	25 (control) or 1000 µg Al.g ⁻¹ diet	Body weight / No effect observed at the highest dose	195 mg Al.kg bw ⁻¹ .d ⁻¹		Golub et al. (1992b)
Swiss-Webster (Control: n= 14; Al group: n= 9)	Aluminium lactate	Gd1-Ld21 Diet	25 (control) or 1000 µg Al.g ⁻¹ diet	Body weight of lactating mice		250 mg Al.kg bw ⁻¹ .d ⁻¹	Golub et al. (1992a)
Swiss-Webster (n= 10 per group)	Aluminium chloride	5-7 weeks Diet	3 (control) or 1000 µg Al.g ⁻¹ diet	Body, brain and liver weight / No effect observed at the highest dose	195 mg Al.kg bw ⁻¹ .d ⁻¹		Oteiza et al. (1993)
Swiss-Webster	Aluminium lactate	Gd0- PND 180 Diet	6 (control) or 1025 µAl.g ⁻¹ diet	Increased spleen weights, Depressed spleen cell		200 mg Al.kg bw ⁻¹ .d ⁻¹	Golub et al. (1993)

(n=10-11 per group)				concentrations of IL-2, IFN- γ and TNF- α and a deficit of CD4 ⁺ cells in T-cell populations			
Rats							
Fischer-344 (n= 20 per group)	Aluminium chlorohydrate	6 months Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	Histological / weight change of heart, liver, kidneys, reproductive and gastrointestinal tissues, adrenal, thyroid, pituitary glands, skin and eyes and in the body weight / No effect observed at the highest dose	6.5 mg Al.m ⁻³		Steinhagen et al. (1978)
Fischer-344 (n≈ 17 per group)	Aluminium chlorohydrate	6 months Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	Body weight / No effect observed at the highest dose	6.5 mg Al.m ⁻³		Stone et al. (1979)
Sprague-Dawley rats (n= 10 per group)	Aluminium nitrate	1 month Water	0, 375, 750, 1500 mg.kg bw ⁻¹ .d ⁻¹	Weight or histopathological changes in the heart, kidney and gastrointestinal tissues and body weight	190 mg Al.kg bw ⁻¹ .d ⁻¹		Gómez et al. (1986)
				Hyperaemia with periportal monocyctic infiltrate in the liver	95 mg Al.kg bw ⁻¹ .d ⁻¹	190 mg Al.kg bw ⁻¹ .d ⁻¹	
STD Wistar (Control: n= 5; Al group: n= 4)	Aluminium lactate	10 weeks Diet	0 or 1000 μ g Al.g ⁻¹ diet	No effect on the body weight at the highest tested dose	90 mg Al.kg bw ⁻¹ .d ⁻¹		Konishi et al. (1986)
Sprague-Dawley (n= 10 per group)	Aluminium nitrate	100 days Water	0, 360, 720 or 3600 mg.kg bw ⁻¹ .d ⁻¹	No weight or histopathological changes in the heart, liver, kidney and the body weight at the highest tested dose	468 mg Al.kg bw ⁻¹ .d ⁻¹		Domingo et al. (1987b)

(NS) (n=16 per group)	Aluminium nitrate	100 days Water	0 or 100 mg.kg bw ⁻¹ .d ⁻¹ + citric acid added	Decreased body weight		100 mg Al.kg bw ⁻¹ .d ⁻¹	Colomina et al. (2002)
Wistar (n= 20 per group)	Aluminium chloride	120 days Gavage	0, 64.18, 128.36 or 256.72 mg.kg bw ⁻¹ .d ⁻¹	Increase in the systolic and mean arterial blood pressures	12.8 mg Al.kg bw ⁻¹ .d ⁻¹	25.7 mg Al.kg bw ⁻¹ .d ⁻¹	Zhang et al. (2016)
Wistar (n=10 per group)	Aluminium chloride	120 days Water	0, 64, 128, and 256 mg.kg bw ⁻¹ .d ⁻¹	Histopathological lesions in the liver		13 mg Al.kg bw ⁻¹ .d ⁻¹	Xu et al. (2017)
Wistar (n=10 per group)	Aluminium chloride	42 days High dose Gavage	0 or 100 mg Al.kg bw ⁻¹ .d ⁻¹	Increase in systolic blood pressure		8.3 mg Al.kg bw ⁻¹ .d ⁻¹	Martinez et al. (2017a)
		60 days Low dose Water	0 or 8.3 mg Al.kg bw ⁻¹ .d ⁻¹				
Guinea pigs							
Hartley (n= 20 per group)	Aluminium chlorohydrate	6 months Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	No histological / weight change of heart, liver, kidneys, reproductive and gastrointestinal tissues, adrenal, thyroid, pituitary glands, skin and eyes and in the body weight at the highest dose tested	6.5 mg Al.m ⁻³		Steinhagen et al. (1978)
Hartley (n= 15 per group)	Aluminium chlorohydrate	6 months Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	No effect on the body weight at the highest tested dose	6.5 mg Al.m ⁻³		Stone et al. (1979)
Dogs							

Beagle (n= 12 per group)	Aluminium phosphate	6 months Feed	0, 0.3%, 1% and 3% of sodium Al phosphate	No effect on organ weight or changes in the heart, liver, kidneys, pituitary, thyroid, adrenals or ocular changes at the highest dose	88 mg Al.kg bw ⁻¹ .d ⁻¹		Katz et al. (1984)
Beagle (n= 8 per group)	Aluminium phosphate	26 weeks Feed	0, 0.3%, 1% and 3% of sodium Al phosphate	No effect on organ weight of the heart, kidneys, thyroid, adrenal at the highest dose	75 mg Al.kg bw ⁻¹ .d ⁻¹		Pettersen et al. (1990)

4.7 Chronic toxicity

4.7.1 Neurotoxicity

4.7.1.1 Human data

Epidemiological studies assessing internal aluminium dose (at least aluminium levels in whole blood, plasma, serum or urine) and cognitive impairment are described here. A total of 21 cross-sectional and 4 longitudinal studies were identified, all of which focused on occupational exposure in different aluminium industries. Epidemiological studies provided insufficient data on aluminium concentrations in the air.

It is worth noting that most, if not all, of the studies conducted in China were carried out in the same aluminium plant, and that little information was given on the crossover of volunteers between these studies (Guo et al. 1999; He, Qiao, and Sheng 2003; Yang et al. 2015; Meng et al. 2019; Wang et al. 2020; Lu et al. 2021; Zhang et al. 2021; Shang et al. 2021; Z. Y. Zhang et al. 2022; Zhao et al. 2022).

Hosovski et al. (1990):

One-hundred-and-forty-seven (147) workers from an aluminium foundry were included in a cross-sectional study conducted in Poland (Hosovski et al. 1990). The exposed workers had a cumulative exposure of at least 6 years (12 ± 4.5) and a job seniority of 18.9 ± 6.9 years, which is comparable to the non-exposed workers group ($n=60$). Aluminium concentrations at workplaces had been measured for each worker separately during winter and summer. Concentrations were ranging from 4.6 to 11.5 mg.m^{-3} . Number and size of dust particles were also measured, the number of particles was of 329 to 1020 cm^{-3} and 65.6% of dust particles measured up to $1 \text{ }\mu\text{m}$ and 26.6% 1 to $5 \text{ }\mu\text{m}$.

All workers were hospitalized for 5 days, during which time aluminium concentrations in whole blood and urine were determined by flameless atomic absorption spectrometry. Psychomotor performance was assessed using the Turners apparatus, by recording the number of errors and speed of test execution. Intellectual performance was assessed using the Wechsler test, and a quotient of verbal intelligence, performance intelligence and total intelligence was established. The use of alcohol and psychotropic drugs in the month prior to testing was considered an exclusion criterion, and no other confounding factors were considered.

Mean whole blood aluminium concentration in exposed workers was $136.85 \pm 103.15 \text{ }\mu\text{g.L}^{-1}$ and mean urine aluminium concentration $45.38 \pm 55.01 \text{ }\mu\text{g.L}^{-1}$, while in the unexposed group, whole blood aluminium concentration was $58.09 \pm 74.73 \text{ }\mu\text{g.L}^{-1}$ and urine aluminium concentration $7.25 \pm 7.82 \text{ }\mu\text{g.L}^{-1}$. The high blood aluminium levels measured both in exposed workers and in controls are probably indicative of an external contamination of the samples (or of faulty analysis).

Aluminium-exposed workers showed significant dissociation in oculomotor coordination, prolonged complex reaction times and slower psychomotor abilities. The results of the Wechsler test of intellectual ability showed impaired memory, coding, image completion and object assembling, associated with aluminium exposure.

Bast-Pettersen et al. (1994):

A cross-sectional study was conducted in a Norwegian primary aluminium plant (Bast-Pettersen et al. 1994). It included 22 workers exposed to aluminium (14 potroom workers and 8 foundry workers) and 16 controls from other departments of the same plant and never directly exposed to aluminium. All participants were 61-66 years-old and had been employed for at least 10 years in the plant (and exposed for at least 10 years to aluminium for participants from the exposed group). In both groups, exclusion criteria were: occupational exposure to other neurotoxicants, personal history of neurological disease or diabetes.

Measurements of aluminium in serum and urine and administration of psychometric tests were performed just before or soon after retirement. The methods used for aluminium analysis are not specified in the published article.

Disturbances of subjective well-being were assessed by a symptom questionnaire (Q16). A comprehensive neuropsychological exploration was performed to assess psychomotor function. It included the evaluation of static steadiness, simple visual reaction time, Wechsler adult intelligence scale (WAIS) digit symbol substitution test, trail making test, Benton visual retention test, WAIS digit span, Words learning and retention, WAIS information test, WAIS similarities test, WAIS vocabulary test, WAIS picture completion test and WAIS block design test.

Mean urine aluminium levels were 12.6 $\mu\text{g.L}^{-1}$ in potroom workers, 9.9 $\mu\text{g.L}^{-1}$ in foundry workers and 7.8 $\mu\text{g.L}^{-1}$ in controls. The corresponding values for serum aluminium were 3.6 $\mu\text{g.L}^{-1}$, 4.1 $\mu\text{g.L}^{-1}$ and 2.9 $\mu\text{g.L}^{-1}$.

Exposed workers reported more neuropsychiatric symptoms. The results also suggest increased risk of impaired visuo-spatial organisation in exposed workers but the differences with controls did not attain statistical significance, possibly due to the low numbers of exposed and control participants.

Guo et al. (1999):

A Chinese cross-sectional study compared 103 aluminium-exposed workers and 64 controls, using the WHO recommended Neurobehavioral Core Test Battery (NCTB). Exposed workers were employees of a large aluminium production plant, working in the electrolysis, smelting or welding departments for at least 5 years. Controls worked in other departments, were not exposed to aluminium and were matched on age, duration of employment, education level, drinking status and smoking status.

Urinary aluminium was measured using graphite furnace absorption spectrometry, in post-shift samples (any day of the workweek). The mean (range) levels of aluminium in the exposed and control groups were 41.8 $\mu\text{g.g}^{-1}$ creatinine (14-9-116.2 $\mu\text{g.g}^{-1}$ creatinine) and 17.7 $\mu\text{g.g}^{-1}$ creatinine (3.5-42.8 $\mu\text{g.g}^{-1}$ creatinine) respectively.

The NCTB includes a Profile of mood states (POMS) questionnaire. The mean scores of the 5 negative mood variables (tension, depression, anger, fatigue and confusion) of the POMS questionnaire were higher in workers exposed to aluminium and the difference was statistically significant for tension, depression, anger and fatigue for the older (45-60 years) participants. The scores of the psychometric tests were inconsistently impaired: significant differences between exposed workers and the referent group were observed: for the digit span test, only in 25-34 year-old participants; for the digit symbol test, only in 35-44 year-old participants; for the pursuit aiming test both in 35-44 and 45-60 year-old participants (Guo et al. 1999).

Sjögren et al. (1996) ; Iregren et al. (2001):

Iregren et al. summarised data from three different studies conducted in Sweden, in order to assess the effects of aluminium exposure on the nervous system in groups of aluminium workers in different industries including aluminium potroom and foundry workers (n=119), aluminium welders (n=38) and workers exposed to aluminium in the production of flake powder (n=16). Data for these groups were compared with those of mild steel welders without exposure to aluminium (n=39). Both the welders and the smelters were significantly older and had been employed for longer periods. Alcohol consumption and habits did not differ between the groups; educational level was not reported for all the groups.

Measurements of aluminium concentrations in blood and urine were performed by GFAAS (detection limit < 1 µg.L⁻¹). The concentrations of aluminium in urine of the welders after the shift were calculated according to an equation determined in a previous study (Ljunggren et al. 1991). All biological samples from the smelter workers were collected at least 16 hours after their latest exposure. The samples from most of the flake powder production workers were collected after 5 exposure free days. Concentrations of neurotoxic metals manganese and lead in blood were also measured as they might confound the study results.

A questionnaire on exposure was carried out in addition to other rating scales to measure symptoms and mood. Performance was assessed in all four groups by a couple of tests including: simple reaction time, finger tapping speed, finger tapping endurance, digit span, vocabulary, tracking, and symbol digit coding and the Luria-Nebraska motor scale and a board test (cylinders) for motor function assessment. Some neuro-physiological examinations have also taken place (diadochokinesometric measurements and electroencephalography (EEG)).

Age differences between the groups were controlled by forcing age into the regression before entering the group variables simultaneously.

The median aluminium concentration in urine was 4.7 µg.g⁻¹ creatinine in the reference group and 4.2, 59.0 and 24.0 µg.g⁻¹ creatinine for the smelters, flake powder exposed workers and welders, respectively. In blood (not specified if whole blood, serum or plasma), median concentrations of aluminium were 1.0 (range LOD-11), 1.0 (LOD-18), 9.0 (LOD-21) and 3.0 (LOD-27) µg.L⁻¹ in the reference group, smelters, flake powder exposed workers and welders, respectively.

The regression analyses showed a higher prevalence of CNS symptoms for the group exposed to flake powder and the smelters compared with the steel welders. Significant group differences were found for the peg board test (cylinders), the tracking task, and the simple reaction time between aluminium smelters and mild steel welders. Workers exposed to flake powders had also a significantly different result of the tracking task compared to the reference group; their performances in the cylinder peg board test and the simple reaction time were also altered but the differences did not attain statistical significance, possibly due to a lack of power resulting of the low number of flake powder workers (n=12). In any case, there were no correlations between aluminium concentrations in urine or blood and the outcome measures. Thus, the differences between steel welders and aluminium smelters can be explained by other factors than aluminium since the groups are not comparable (Iregren et al. 2001; Sjögren et al. 1996).

Akila et al. (1999):

Akila et al. conducted a cross-sectional study among 51 asymptomatic aluminium welders, in Finland. The control group was constituted of 28 age-matched mild steel welders. The mean age of the 79 male workers was 38.4 (range 22–58). Aluminium was measured in serum and urine, using graphite furnace absorption spectrometry, with Zeeman background correction. On the basis of urinary aluminium concentrations, welders were classified into three exposure groups: reference group (n=28) <1 µmol.L⁻¹ (mean=0.46 µmol.L⁻¹) ; < 27 µg.L⁻¹ (mean=12.4

$\mu\text{g.L}^{-1}$), low exposure group ($n=27$) $1.1\text{--}4.0 \mu\text{mol.L}^{-1}$ (mean= $2.25 \mu\text{mol.L}^{-1}$); $27\text{--}108 \mu\text{g.L}^{-1}$ (mean= $60.7 \mu\text{g.L}^{-1}$) and high exposure group ($n=24$) $>4.1 \mu\text{mol.L}^{-1}$ (mean= $9.98 \mu\text{mol.L}^{-1}$); $>108 \mu\text{g.L}^{-1}$ (mean= 269.3). Age was positively correlated with both urinary ($r=0.267$, $p=0.017$) and serum ($r=0.349$, $p=0.002$) aluminium. Alcohol consumption correlated with urinary aluminium ($r=0.264$, $p=0.019$).

A comprehensive neuropsychological exploration was performed to assess psychomotor function. Five main cognitive domains were investigated with different tests: psychomotor functions (Finger tapping speed, Santa Ana dexterity test, Simple visual reaction time (RT)), attention (WAIS: digit span task, WAIS-R: digit symbol substitution test, Stroop colour word test, Dual task), verbal abilities (WAIS Similarities, Synonyms), visuospatial skills (Embedded figures, WAIS: block design test) and memory and learning (Wechsler memory scale (WMS): paired associates, Memory for designs, Interference recall, Similarities recall, Digit symbol recall).

Aluminium welders showed no impairment on the finger tapping, Santa Ana dexterity, simple visual reaction times, any of the verbal memory tasks, the similarities subtest of Wechsler adult intelligence scale, or the Stroop task.

An exposure-dependent impairment of the performance was observed in the welders of the high exposure group for the memory for Digit symbol substitution test ($p=0.025$, $p=0.035$ after controlling for age), Item selection time ($p=0.027$) and Block design ($p=0.036$). For Embedded figure task, the effect was close to the significance threshold ($p=0.055$) but not significant. For memory design task, welders from the high exposure group performed lower ($p=0.036$) but the effect was not exposure dependent.

For the dual task, an impairment of Backward counting ($p=0.016$) was observed also with the higher exposure group but both in dual and single task conditions, with an exposure-dependent effect.

The authors conclude that the neuropsychological exploration showed that the effects of aluminium appeared circumscribed. Neuropsychological tasks were investigated to precise the cognitive structures impaired. It was observed that performance deficiencies were mainly detected in tasks requiring working memory, particularly those involving visuospatial information. It was also shown that such impairments were more readily found in time-limited tasks involving visually presented material, in which effective visual scanning combined with control of working memory is demanded (Akila, Stollery, and Riihimäki 1999).

Hänninen et al. (1994); Riihimäki et al. (2000):

In a Finnish cross-sectional study, the relationship between elevated internal aluminium load and central nervous system function was studied in 65 aluminium welders and a referent group of 25 mild steel welders. Aluminium was measured in serum and urine, using graphite furnace absorption spectrometry, with Zeeman background correction. Sampling was performed on Monday morning before the 1st shift of the week. In the referent group, serum aluminium ranged from 0.04 to $0.12 \mu\text{mol.L}^{-1}$ ($1\text{--}3.2 \mu\text{g.L}^{-1}$) and urine aluminium from 0.1 to $1.3 \mu\text{mol.L}^{-1}$ ($2\text{--}35.1 \mu\text{g.L}^{-1}$), median values were $0.08 \mu\text{mol.L}^{-1}$ ($2.2 \mu\text{g.L}^{-1}$) and $0.4 \mu\text{mol.L}^{-1}$ ($10.8 \mu\text{g.L}^{-1}$), respectively. A low and a high exposure groups of aluminium welders were defined, according to serum and urine aluminium levels: median (and range) values for serum aluminium concentrations, in the low and high exposure groups were $0.14 \mu\text{mol.L}^{-1}$ ($0.07\text{--}0.24 \mu\text{mol.L}^{-1}$; $3.8 \mu\text{g.L}^{-1}$ ($1.9\text{--}6.5 \mu\text{g.L}^{-1}$)) and $0.46 \mu\text{mol.L}^{-1}$ ($0.27\text{--}1.00 \mu\text{mol.L}^{-1}$; $12.4 \mu\text{g.L}^{-1}$ ($7.3\text{--}27 \mu\text{g.L}^{-1}$)), respectively. The corresponding values for urine aluminium concentrations were $1.8 \mu\text{mol.L}^{-1}$ ($0.3\text{--}5.7 \mu\text{mol.L}^{-1}$; $48.6 \mu\text{g.L}^{-1}$ ($8.1\text{--}153.9 \mu\text{g.L}^{-1}$)) and $7.1 \mu\text{mol.L}^{-1}$ ($3.2\text{--}27.3 \mu\text{mol.L}^{-1}$; $191.7 \mu\text{g.L}^{-1}$ ($86.4\text{--}737.1 \mu\text{g.L}^{-1}$)).

Disturbances of subjective well-being were assessed by a symptom questionnaire. A comprehensive neuropsychological exploration was performed to assess psychomotor function. Five main cognitive domains were investigated with different tests: psychomotor functions (Finger tapping speed, Santa Ana dexterity test, Simple visual RT), attention (WAIS: digit span task, WAIS-R: digit symbol substitution test, Stroop colour word test, Bourdon Wiesma cancellation test, Dual task), verbal abilities (WAIS Similarities, Synonyms), visuospatial skills (Embedded figures, WAIS: block design test) and memory and learning (WMS: paired associates, Memory for designs, Homogeneous interference, Similarities recall, Digit symbol recall). Quantitative electroencephalography was also recorded, and P300 auditory event-related potentials were studied.

There was an exposure-related increase in reported fatigue, mild depression and memory or concentration problems. Neuropsychological testing revealed exposition-related impairments of cancellation accuracy in the Bourdon-Wiesma test, of backwards counting, of both components of the dual task, of synonyms and of memory for designs; those impairments were detectable in both the low and high exposure groups and increased with the exposure. Significant, age-adjusted correlations were observed between impairments in Digit symbol test, counting backwards, Dual task cancellation speed and Dual task counting speed, on one hand and urine aluminium concentration on the other hand. Visual EEG analysis revealed mild diffuse abnormalities only in aluminium welders. No statistically significant differences were observed between the groups in the quantitative analysis. No significant association was observed between serum or urine aluminium concentration and P300 amplitude or latency (Hänninen et al. 1994; Riihimäki et al. 2000).

Bast-Pettersen et al. (2000):

In a Norwegian cross-sectional study, 20 aluminium welders (mean age 33 years), who had been exposed to aluminium for an average of 8.1 years, were tested for tremor and simple reaction time and screened for neuropsychiatric symptoms. They were compared with 20 construction workers matched for age. Exclusion criteria in both groups were diseases affecting the CNS and exposure to solvents.

Urinary aluminium was measured using graphite furnace absorption spectrometry, with Zeeman background correction, in pre-shift and post-shift samples. Subjective symptoms were recorded by means of the self-administered Q16 questionnaire. Hand steadiness was measured by the Klove-Matthews Static Steadiness Test (SST). Reaction times were measured by two computerised test (Simple reaction time and Continuous performance test).

The median (range) urinary aluminium concentrations were 0.15 µmol/mmol creatinine (0.06-0.43 µmol/mmol creatinine; 35.8 µg.g⁻¹ creatinine; 14.3-109.9 µg.g⁻¹ creatinine). Urinary aluminium was not measured in controls.

Aluminium welders reported significantly more symptoms than controls did. Although they globally performed better than controls on the tremor test, years of exposure (but not age) was associated with poorer performance (Bast-Pettersen et al. 2000).

Letzel et al. (2000):

A longitudinal study consisting of two successive cross-sectional studies was conducted at a German aluminium powder-producing plant to evaluate possible exposure-related nervous system effects. In the first examination, 32 workers exposed to aluminium dust were compared to a control group of 30 unexposed persons; groups did not differ in age, sex, level of education or professional training. No exclusion criteria are reported. Five years later, in the second examination, only 21 of the exposed workers and 15 controls agreed to continue the study;

this selection led to a difference in age and educational level between the two evaluations. Assessments mainly included biomonitoring, standardised medical history, neuropsychological tests (vocabulary test, three subtests of the Wechsler Adult Intelligence Survey (digit span, digit symbol, and block design), the trail making test, the syndrome short test and a visual discriminative reaction task. An event-related P300 potential was also measured. The methods for aluminium measurements in plasma and urine are not presented in the article. There was no concurrent intake of aluminium-containing medications, but two individuals in the initial assessment had a history of drug abuse or brain contusion, and high alcohol consumption was reported in some individuals in both groups.

Internal aluminium levels were significantly higher in the exposed group in both assessments (sampling time and analytical method not specified). Notably, in the first examination, median urine aluminium levels were $87.6 \mu\text{g.g}^{-1}$ creatinine in exposed workers vs $9.0 \mu\text{g.g}^{-1}$ creatinine in the control group, with median plasma aluminium of $8.7 \mu\text{g.L}^{-1}$ in the exposed group versus $4.3 \mu\text{g.L}^{-1}$ in the controls. In the second examination, median urine aluminium levels were $19.8 \mu\text{g.g}^{-1}$ creatinine in exposed workers vs $4.5 \mu\text{g.g}^{-1}$ creatinine in the control group, with median plasma aluminium of $6.7 \mu\text{g.L}^{-1}$ in the exposed group vs $4.3 \mu\text{g.L}^{-1}$ in the controls (with no significant difference in this latter group). The difference between both examinations is explained by improved occupational hygiene. Regarding the psychometric tests and the P300 potentials, there was no significant exposure-related differences in any of the two cross-sectional studies. There was also no dose-response relationship between plasma or urinary aluminium concentrations, or aluminium exposure length on one hand and psychometric or P300 parameters, on the other hand (Letzel et al. 2000).

Polizzi et al. (2002):

A cross-sectional case-control study was carried out in 64 former Italian aluminium dust-exposed workers and in 32 unexposed controls. All participants were retired for at least 10 years. The control group included workers (from other industries), with a similar profile of age, education level, socio-economic status and clinical features. Subjects taking aluminium-containing drugs or drugs acting on the central nervous system, with kidney problems, or with a history of head trauma or psychological, sleep or neurological disorders, were excluded.

Serum aluminium was measured by GFAAS. Serum concentrations of copper and zinc and whole blood concentrations of iron, lead and manganese were simultaneously assessed. The cognitive assessment included a standardised occupational and medical questionnaire and the MMSE (Mini-Mental State Examination) test and the CDT (Clock Drawing Test, testing visuospatial, abstraction, language and memory abilities). Auditory evoked event-related potentials (ERP-P300) were also measured.

There was a significant difference ($p < 0.001$) between the mean serum aluminium concentrations in the workers' group ($14.1 \pm 3.50 \mu\text{g.L}^{-1}$) and the control group ($8.2 \pm 1.17 \mu\text{g.L}^{-1}$). It should be noted that blood iron levels were also higher in the workers' group. The results of the neuropsychological tests were also significantly different between the 2 groups, with a negative correlation between serum aluminium and the MMSE, MMSE-AE (adjusted for age and education) and CDT scores, and a positive correlation between serum aluminium and the MMSE and CDT times, confounders being taken into account. ERP-P300 latency was also found to correlate positively with serum aluminium concentration (Polizzi et al. 2002).

He et al. (2003):

In a cross-sectional study, He et al. (2003) studied neurobehavioral parameters, autonomic nervous function and lymphocyte subsets in 33 workers from a Chinese aluminium plant and

34 controls from a flour mill. Exclusion criteria were history of neurological disease, heart disease, hypertension, diabetes or renal disease, alcohol consumption ≥ 500 mL/week or cigarette smoking ≥ 40 /j.

Urinary aluminium was measured using graphite furnace absorption spectrometry, in “morning” samples. Neurobehavioral test battery included a standardised questionnaire on mood state, and psychometric tests: Simple reaction time measurement, digital symbol test, Santa Ana dexterity test, digital span test, Benton visual retention test, and pursuit aiming.

Mean urine aluminium concentrations in the exposed workers and the control group were $40.1 \mu\text{g.g}^{-1}$ creatinine and $26.8 \mu\text{g.g}^{-1}$ creatinine, respectively. Reaction time was significantly slower in exposed workers. Also, the scores of the digital symbol test, the pursuit aiming were significantly lower in the aluminium-exposed group (He, Qiao, and Sheng 2003).

Buchta et al. (2003); Kiesswetter et al. (2009):

A longitudinal study, involving aluminium welders from a car-body construction industry in Germany who were not exposed to other possible neurotoxic substances, was conducted over 4 years during which three examinations were carried out, separated by 2 years, in 1999, 2001 (Buchta et al. 2003) and 2003 (Kiesswetter et al. 2009). A total of 98 aluminium welders in 1999, 97 in 2001 and 92 in 2003 were compared to a demographically similar control group of 50 subjects from the same industry (age, level of education and level of carbohydrate-deficient transferrin in plasma). At the first examination, included subjects had at least 2 years of Al-welding time. Subjects with neurological diseases not due to the exposure, cerebrovascular diseases, diabetes, head injuries, insufficient knowledge of the German language were excluded.

Aluminium concentrations were measured in personal air, as well as in plasma and in urine, in pre-shift and post-shift samples after several shifts, by GFAAS. Workers were examined during the day shift between 08:00 and 13:00 h, only if they had worked on the morning or afternoon shift the week before. Neurobehavioral assessments used a standardised interview, the Standard Progressive Matrices test (SPM) (only in the 1st examination), a verbal intelligence test (WST), and the European neurobehavioral evaluation system (EURO-NES) (these 3 tests, only for the last 2 examinations), a simple reaction time test, the block design test, the trail making test, four psychomotor performance tests (testing for steadiness, line tracing, aiming and tapping, and a recall of digits test (HAWIE) (the last test, performed in the 3 examinations).

There was no significant difference of total dust load when welding aluminium between the three examinations ($p = 0.35$), the same applies for the pre- and post-shift internal Al-loads in exposed welders across examinations. In welders, median (min, max) aluminium urine concentration (post-shift) was 37.87 (7.0 – 120.5) $\mu\text{g.g}^{-1}$ creatinine (1999), 33.57 (9.0 – 230.11) $\mu\text{g.g}^{-1}$ creatinine (2001) and 15.4 (0.7 – 94.9) $\mu\text{g.g}^{-1}$ creatinine (2003). Median plasma aluminium (post-shift) was 8.3 (2.3 – 42.3) $\mu\text{g.L}^{-1}$ (1999), 4.1 (0.72 – 11.7) $\mu\text{g.L}^{-1}$ (2001) and 4.3 (1.8 – 15.6) $\mu\text{g.L}^{-1}$ (2003). Median (min-max) aluminium urine concentration in control group was 5.2 (1.7 – 30.3) $\mu\text{g.g}^{-1}$ creatinine (1999), 6.0 (1.6 – 390.0) $\mu\text{g.g}^{-1}$ creatinine (2001) and 5.0 (0.2 – 40.3) $\mu\text{g.g}^{-1}$ creatinine (2003), and median (min-max) plasma concentration was 4.4 (1.4 – 31.6) $\mu\text{g.L}^{-1}$ (1999), 2.3 (0.7 – 5.9) $\mu\text{g.L}^{-1}$ (2001) and 3.8 (1.6 – 10.0) $\mu\text{g.L}^{-1}$ (2003).

Welders and controls did not report significantly more symptoms in the modified questionnaire Q16. Furthermore, no significant differences in psychomotor performance and other neurobehavioral tasks, except for reaction time, were seen between welders and non-welders. Aluminium welders were slightly slower than controls in their reactions (decision time) but quicker in their motor movements. The corresponding multivariate analysis of covariance for repeated measurements included both test parameters in one model. This model indicates a significant group difference ($p = 0.015$). There was a significant influence of age ($p < 0.001$). As

the only abnormal results in all 3 examinations were for simple reaction time and puzzling (the lower performance in one test component being compensated by better performance in the other test component), as these effects did not increase with exposure duration and as confounding factors were present, the authors conclude that their study shows no adverse neurobehavioral effect of aluminium exposure.

Buchta et al. (2005); Kiesswetter et al. (2007):

In a longitudinal study (Buchta et al. 2005; Kiesswetter et al. 2007), exposure and neurobehavioral data of 44 aluminium exposed male welders and 37 controls from the same five German companies in the train and truck construction industry were examined for 4 years (1999, 2001 and 2003) and compared. Pre-shift and post-shift aluminium measurements were performed in the plasma and urine after several shifts, using graphite furnace absorption spectrometry (GFAS). Neurobehavioral assessments used standardised interview, physical examination, a verbal intelligence test (WST), the German version of Q16 questionnaire; a recall of digits test, a block design test, a computerised test battery for motor performance, a simple reaction time measurement, a German version of the standard progressive matrices test, a trail making test, and the EURO-NES.

In welders, median urinary and plasma post-shift levels were 130 $\mu\text{g.L}^{-1}$ or 97 $\mu\text{g.g}^{-1}$ creatinine ($n=31$) and 11.6 $\mu\text{g.L}^{-1}$ ($n=31$) in 1999, 145.5 $\mu\text{g.L}^{-1}$ or 143.9 $\mu\text{g.g}^{-1}$ creatinine ($n=25$) and 14.3 $\mu\text{g.L}^{-1}$ ($n=25$), in 2001, and 93.7 $\mu\text{g.L}^{-1}$ or 64.5 $\mu\text{g.g}^{-1}$ creatinine ($n=20$) and 13.2 $\mu\text{g.L}^{-1}$ ($n=20$) in 2003. The corresponding mean values were: 210 $\mu\text{g.L}^{-1}$ or 135.5 $\mu\text{g.g}^{-1}$ creatinine and 14.8 $\mu\text{g.L}^{-1}$ in 1999; 191.5 $\mu\text{g.L}^{-1}$ or 153 $\mu\text{g.g}^{-1}$ creatinine and 18.6 $\mu\text{g.L}^{-1}$ in 2001; 155.7 $\mu\text{g.L}^{-1}$ or 113.5 $\mu\text{g.g}^{-1}$ creatinine and 17.8 $\mu\text{g.L}^{-1}$ in 2003. In the control group, median values were 5.8 $\mu\text{g.L}^{-1}$ or 4 $\mu\text{g.g}^{-1}$ creatinine in urine and 3.5 $\mu\text{g.L}^{-1}$ in plasma, in 1999; 6 $\mu\text{g.L}^{-1}$ or 4.5 $\mu\text{g.g}^{-1}$ creatinine in urine and 2.8 $\mu\text{g.L}^{-1}$ in plasma, in 2001; 8.3 $\mu\text{g.L}^{-1}$ or 8.5 $\mu\text{g.g}^{-1}$ creatinine in urine and 4.5 $\mu\text{g.L}^{-1}$ in plasma, in 2003.

In 2003, the aluminium welders who had been working in this profession for an average of 15 years had no increased symptom level. The only significant difference between welders and controls was observed for block design test scores, the welders revealing significantly lower scores than controls. It should be observed that verbal IQ (WST), performances in the SPM test, in the trail making test, in the line tracing test and in switching attention tasks were also lower in welders though the intergroup differences were not statistically significant. Regression and covariance analyses showed no correlation between biomonitoring parameters and cognitive performance variables. As only 20 welders and 12 controls were included in the 2003 analysis, these negative (statistically non-significant) results could be due to the low power of the study. The authors also discussed the possibility of a healthy worker effect, workers developing symptoms might have left the plant.

Giorgianni et al. (2014):

Giorgianni et al. looked for an association between serum aluminium level and cognitive impairment in 86 male aluminium welders from an Italian shipyard and in 90 controls from the administrative department of the same company. Serum aluminium concentration was measured using atomic absorption spectrometry. Serum concentrations of chromium, lead manganese and zinc were simultaneously measured. Neuropsychological evaluation used the WMS (form I), the Colour-Word test (Stroop test), the Attention Matrixes test. Mean ages of controls and exposed welders were 38.29 ± 7.14 years and 38.45 ± 6.34 years, respectively. All participants were non-smokers. Duration of aluminium exposure was 15.79 ± 6.50 years in welders. Mean serum aluminium concentration was $24.19 \pm 9.99 \mu\text{g.L}^{-1}$ in welders and $6.93 \pm 1.95 \mu\text{g.L}^{-1}$ in controls. The authors used a nonparametric test combination (NPC) to compare

the stratified volunteers between welders and controls. The stratification was done at two levels, age and length of service, using 38 years and 22 years respectively as threshold values.

Decreased performances were observed in all cognitive tests for the welders' group, the WMS test and the Stroop test showing a greater sensitivity than the Test of Attention Matrixes, according to the authors. Only "partial" results of the NPC test should be considered as combined values seems to overestimate impact of aluminium exposure on neuropsychological evaluation, in the attention Matrixes test, attention deficit is observed only for individuals over 38 years old and with more than 22 years of service (Giorgianni et al. 2014).

Yang et al. (2015):

Yang et al. (2015) assessed the association of cognitive impairment and aluminium exposure in 366 aluminium potroom workers (age 40-60 years old and 21.2 ± 6.5 years of exposure time). The exclusion criteria were the consumption of aluminium-containing or psychotropic drugs, a personal history of mental or neurological disorders or of any severe disease. People with poor vision or hearing were also excluded. Serum aluminium concentration was measured using GFAAS (LOD: $1 \mu\text{g.L}^{-1}$). Cognitive function was assessed with the MMSE. Mild cognitive impairment (MCI) was diagnosed using MMSE scores (cut-offs not specified) followed by confirmation from "professional clinicians".

Median serum aluminium concentration was $48.99 \mu\text{g.L}^{-1}$ (range $6.63\text{--}158.8 \mu\text{g.L}^{-1}$). Analyses were conducted after distributing the participants in three groups based on 25th and 75th percentiles of serum aluminium concentration, $0\text{--}34.02 \mu\text{g.L}^{-1}$, $34.03\text{--}61.42 \mu\text{g.L}^{-1}$ and $\geq 61.43 \mu\text{g.L}^{-1}$ respectively.

The total MMSE score decreased when serum aluminium concentration increased. There were 43 (/366) MCI cases and their rate increased with serum aluminium concentration ($p < 0.001$). The association between aluminium exposure and the risk of MCI was assessed using a logistic regression model, with adjustment for possible confounders (age, education, smoking, and drinking). Cognitive impairment was significantly associated with high aluminium exposure (OR = 2.57; IC95% 1.5-4.41) (Yang et al. 2015).

Meng et al. (2019):

A large-scale case study was conducted in an aluminium factory in China. It included 853 male workers provided with protective equipment, excluding those with a history of cognitive problems or any disease that might induce them, as well as any family history of dementia or those taking aluminium-containing medication or psychotropic drugs, as well as those using cookware or consuming fried food daily; people with poor vision or hearing were also excluded.

This study comprised of a biomonitoring study measuring plasma aluminium by ICP-MS (detection limit of $0.39 \mu\text{g.L}^{-1}$) as well as a 2-step questionnaire to assess cognitive impairment; the first stage being the MMSE and CDT tests. To increase the sensitivity and specificity of diagnosis, cognitive impairment was defined as a MMSE score of 26 or less (of 22 or less in workers whose education level is less than middle school, of 19 or less in workers whose education level is under primary school) or a CDT score of 2 or less. Participants with low MMSE or CDT scores and those complaining of memory impairment were referred to neurologists of the local university hospital for further explorations.

In all, 334 workers passed phase 2, of whom 53 (39.16%) were diagnosed with MCI, mainly on delayed recall (81.13%) and visuospatial executive ability (56.60%). For each case, 4 controls were matched by age randomly with no difference in marital status, income, smoking or drinking status; the mean age for cases and controls were between 45.04 and 44.71 years, respectively. The median (P25-P75) plasma aluminium concentration in the 53 MCI patients

(18.17 (10.39, 34.96) $\mu\text{g.L}^{-1}$) was significantly higher than in the controls (12.02 (6.35, 20.86) $\mu\text{g.L}^{-1}$, $p=0.001$). People with MCI were found to have a lower level of education ($p=0.001$). Conditional logistic regression was used to explore the influential factors of mild cognitive impairment. This showed that a high level of plasma aluminium increased the risk of cognitive problems (AOR= 2.24 95% CI 1.17-4.26 $p=0.014$), whereas a more advanced educational level was more of a protective factor (AOR: 0.36 95% CI 0.18-0.7 $p=0.003$) (Meng et al. 2019).

Mohammed et al. (2020):

A cross-sectional study was conducted in an Egyptian aluminium foundry and included 75 exposed workers who wore gloves only, without mask or other protective equipment, and 75 “unexposed” controls from the administrative department of the same plant, to study the effect of exposure on cognitive performance. The two groups were matched in terms of age, gender, socioeconomic status, demographics and habits affecting health. People taking aluminium-containing or psychotropic drugs and those with a personal history of mental or neurological disorders were excluded. Serum aluminium level was measured (together with serum levels of lead, manganese and zinc), using atomic absorption spectrophotometry (AAS) (LOD: 1 $\mu\text{g.L}^{-1}$). Serum free tau protein was also quantified, using the Western blot technique. This protein is commonly found in the axons of neuronal cells and may be released into peripheral blood during neuronal damage. Cognitive functions were assessed using the Montreal cognitive assessment Basic (MoCA) test. The cutoff value retained for the definition of mild cognitive impairment was 24(/30). Occupational stress was also assessed using the perceived stress scale (PSS14) in its Arabic version. Quality of sleep was evaluated by the Arabic version of the Pittsburgh sleep quality index (PSQI). The Beck depression inventory (BDI) was administered to detect depression.

The exposed group had a significantly ($p<0.001$) higher serum aluminium level (mean $\pm$ SD: 560 $\mu\text{g.L}^{-1} \pm 180$) than the control group (360 $\mu\text{g.L}^{-1} \pm 110$), as did the tau protein (1.53 ± 0.58 for exposed vs. 1.03 ± 0.44 for controls, $p<0.001$).

The MoCA test showed a significantly lower performance in the exposed group (score 24.4 ± 3.4 vs 28.4 ± 1.3 , $p<0.001$). Regression analysis showed that cognitive performance was negatively correlated with serum aluminium and tau protein levels ($r=-0.341$ and $p<0.003$, $r=-0.250$ and $p<0.03$ respectively). Exposed individuals were more stressed than controls, but this had no impact on cognitive performance. It should be noted that there was co-exposure to other metals, since serum lead and manganese levels were also higher in workers than in controls (Mohammed et al. 2020).

Wang et al. (2020):

Wang et al. (2020) conducted a cross-sectional study in 831 male workers (20-59 years old) exposed to aluminium in an aluminium factory (at least one year). Exclusion criteria were all causes of cognitive impairment, family history of neurodegenerative disease, long-term treatment with aluminium-containing drugs, poor vision or hearing. Plasma aluminium level was measured by ICP-MS. The participants were categorised into four quartiles based on their plasma aluminium concentrations, specifically, 0-8.28 $\mu\text{g.L}^{-1}$ (Q1), 8.28-15.26 $\mu\text{g.L}^{-1}$ (Q2), 15.26-27.02 $\mu\text{g.L}^{-1}$ (Q3), and ≥ 27.02 $\mu\text{g.L}^{-1}$ (Q4) subgroups. Cognitive function was measured using the MMSE and the CDT. Multidomain cognition was assessed through sub-tests of the MMSE and the CDT. There was no statistical difference in MMSE scores between groups.

When adjusted for age, education, income, marital status, type of work, and smoking and drinking habits and stratified by age (threshold of 40 years), a positive association was observed between plasma aluminium concentration and the risks of global cognitive

impairment and multi-domain cognitive impairments. Considering total CDT scores, the results were as follow: Q3 vs Q1 (OR=2.26, IC95% 1.25-4.11) and Q4 vs Q1 (OR=3.49, 1.85-6.59) but only for individuals older than 40 years. The same association was observed for executive/visuospatial abilities (OR Q3 vs Q1 = 1.77, IC95% 1.03-3.04; OR Q4 vs Q1 = 2.44, IC95% 1.35-4.41) and CDT-position errors in individuals over 40 years old (OR Q3 vs Q1 = 1.75, IC95% 1.00-3.09; OR Q4 vs Q1 = 2.22, IC95% 1.22-4.10) (Wang et al. 2020).

Lu et al. (2021):

Lu et al. conducted a longitudinal study that included 2 cognitive evaluations one carried out in 2014 and then another 2 years after. A measurement of plasma aluminium concentration was performed using an ICP-MS (detection limit of 0.39 $\mu\text{g.L}^{-1}$ and standard deviation of 0.03%-0.08%) on 276 men workers in an aluminium plant in northern China. Log10 transformed plasma aluminium concentrations were used in this analysis. All workers used the same protective equipment and were exposed to aluminium metal and fluoride salt during the process of electrolytic aluminium with no other metal exposure. Information on background and health was collected by means of an employee health questionnaire, and status on smoking, alcohol consumption, age and sex, level of education and work history as well as diseases were collected. The cognitive assessment was established by an internationally recognised cognitive test questionnaire and the following tests: MMSE, VFT (Verbal Fluency Test), SRT (Simple Reaction Time), FOME (Fuld Object Memory Evaluation, evaluating delayed memory ability), DST (Digit Span Test, testing auditory linguistic memory ability), CDT, testing visuospatial, abstraction, language and memory abilities).

Participants were divided into 3 tertiles according to plasma aluminium (P-Al) concentration: T1 ($<17.6 \mu\text{g.L}^{-1}$) T2 ($17.6-37.3 \mu\text{g.L}^{-1}$) T3 ($\geq 37.3 \mu\text{g.L}^{-1}$). No significant differences were found among participants in terms of age, education, smoking and drinking status, or marital status. After adjusting for covariates, there was a reduction in the FOME (2014) and MMSE (2016) scores with increasing tertiles of P-Al concentrations. Also, there was negative association between P-Al concentration and most of the cognitive scores in 2014 and 2016. However, this association was statistically significant only for MMSE and FOME scores, in 2016. In 2016, each 10-fold increase in P-Al concentration was significantly associated with a 0.53-point decrease in MMSE score ($p=0.002$) and a 0.93-point decrease in FOME score ($p=0.008$). For each 10-fold increase in P-Al concentration, there was a 0.38- point decrease in MMSE score 2016-2014 ($P=0.044$) and a 1.20-point decrement in FOME score 2016-2014 ($P=0.001$). Concerning the average annual change, it was statistically different for the MMSE and FOME with the P-Al concentration increase ($P<0.05$): MMSE scores declined in each tertile, with annual decline rates of 0.58%, 0.61%, and 1.84%, respectively. The decrease in FOME scores only appeared in the T2 and T3 groups, which were 0.34% and 3.33%, respectively. The trend test indicated that there was a dose-response relationship between the P-Al concentration and the MMSE score ($P=0.009$) but no relationship with the FOME score ($P>0.05$) (Lu et al. 2021).

Xu et al. (2021):

A cross-sectional study was conducted in 2014 at an aluminium plant in China. Ultimately, 1,660 workers were included in this study after eliminating those who had worked for < 1 year, those taking aluminium-containing medications, those with neurological and/or mental disorders, and those with no biomonitoring results. For these 1,660 workers, plasma aluminium concentration was determined by ICP-MS with a LOD of 0.39 $\mu\text{g.L}^{-1}$. Cognitive function was assessed by the following 6 tests: the MMSE, the CDT, Digit span test (DST) forward (DSFT) and backward (DSBT), FOME, VFT, SRT. Multiple linear regression analyses were used to study the correlation between plasma aluminium concentrations and cognitive function, while

taking into account age, education, marital status, smoking and alcoholism and total working hours.

All participants were male. Their average age was 40.42 ± 7.58 years; the average working duration was 17.74 ± 9.04 years. The median plasma aluminium concentration was 34.5 (P25, P75 = 15.0, 42.3) $\mu\text{g.L}^{-1}$ which enabled the participants to be divided into 4 quartiles, Q1 ($\text{Al} < 15.00 \mu\text{g.L}^{-1}$), Q2 ($15.00 \leq \text{Al} < 34.52 \mu\text{g.L}^{-1}$), Q3 ($34.52 \leq \text{Al} < 42.25 \mu\text{g.L}^{-1}$), and Q4 ($\text{Al} \geq 42.25 \mu\text{g.L}^{-1}$). Similarly, participants were divided into 2 further categories: younger group (< 40 years) and middle-aged group (≥ 40 years).

Scores of the different tests: recall, DST, DSBT, FOME, VFT, ATIME, FAS, and SLO were significantly lower in the middle-aged group than in the younger group ($p < 0.05$). Multiple linear regression analysis after adjusting for age, education level, marital status, smoking status, alcohol status and total working time, showed that DST and DSBT test scores were negatively correlated ($p < 0.05$) with plasma aluminium concentration in all participants (even when looking at younger and middle-aged groups). The same negative association was found in Q3 and Q4 of the younger group, whereas in the middle-aged group it was only present in Q4 ($p < 0.05$).

Logistic regression analysis showed that the ORs for cognitive impairment for the DSBT and DST tests for category Q4 in all participants were 9.216 (95% CI, 5.068-16.756) and 2.309 (95% CI, 1.587-3.359), respectively, they were 7.644 (95% CI, 3.846-15.192) and 1.695 (95% CI, 1.062-2.705), respectively, in the middle-aged group, and 15.308 (95% CI, 4.180-56.059) and 3.270 (95% CI, 1.615-6.620), respectively in the younger group (Xu et al. 2021).

Zhang et al. (2021):

Zhang et al. studied the effect of aluminium on cognition. In this study, they collected information from a public health surveillance project in Zhejiang (China) from which they selected 539 aluminium occupationally exposed participants (miners and workers from related factories): mean duration of exposure of $13.2 (\pm 11.3)$ years) and a control group of 1720 unexposed participants from another district. Cognitive function was measured by the MMSE. No aluminium measurement in blood or urine was conducted and, no information about personal or familial history of neurological diseases were brought up in the survey. Socio-demographic factors were compared between both groups, it is to be noted that the exposed group was younger than the unexposed one.

People exposed to aluminium had a significant ($p < 0.001$) lower performance in the MMSE than the control group (mean score of 22.95 for unexposed vs 21.34 for exposed) and a higher risk of cognitive impairment²⁴. A logistic regression model showed that aluminium-exposed group had 6.77 times more risk of cognitive impairment than the unexposed group ($p < 0.001$), adjusted for age, sex, and educational level. The prevalence odds ratio remained high when adjusted for more covariates within another model (8.21, $p < 0.001$). The analysis by logistic regression (covariates included age, sex, and education), showed no significant association between occupational exposure duration and cognition ($p = 0.232$) (Zhang et al. 2021).

Shang et al. (2021):

The cross-sectional study by Shang et al. aimed to assess the relationship between the plasma aluminium levels and cognitive impairment in 187 aluminium workers from departments involved in Al electrolysis (cryolite-alumina molten salt electrolysis in particular) in a Chinese factory. A total of 255 participants was considered for the study and 187 were selected according to the inclusion and exclusion criteria. People with known mental or neurological

²⁴ Not defined in the publication. Probably MMSE score under 26.

disease, or with history of neurodegenerative disease in their immediate family members, or with long-term consumption of psychotropic drugs or of aluminium-containing antacid drugs were excluded, as well as those using aluminium cookware, or with an exposure to strong noise. All the AI workers considered for the study were male workers, had been exposed for more than one year and had an average age of 40.16 ± 7.73 years. Cognitive function was assessed using the Chinese version of the MoCA, which assesses the following performances: 1) executive/visuospatial abilities; 2) naming; 3) attention and calculation; 4) language; 5) abstraction ability; 6) recall; 7) orientation. Results were expressed as a global score, which could have a maximal value of 30, and a score fewer than 26 points was considered as MCI. Plasma aluminium levels were quantified using ICP-MS; plasma levels of eight other elements (chromium, cobalt, copper, iron, lead, lithium, manganese and zinc) were simultaneously measured.

Participants were divided into two groups based on their MoCA scores, consisting of 49 individuals classified as normal (MoCA score ≥ 26) and 138 individuals with mild cognitive impairment (MoCA score < 26). Median (interquartile range) plasma aluminium concentrations were 55.862 (38.701 – 77.012) $\mu\text{g.L}^{-1}$ for the normal group and 72.794 (42.510 – 102.652) $\mu\text{g.L}^{-1}$ for the MCI group. To estimate the relationship between plasma aluminium concentration and MoCA scores while adjusting for confounding factors, the study employed a multivariate generalised linear regression model and Bayesian kernel machine regression (BKMR). The results of the multivariate generalised linear model indicated a significant inverse relationship between plasma aluminium concentration and MoCA total scores (β (95% CI) -0.07 (0.108 , -0.032); $p < 0.001$), after adjustment for age, body-mass index, education level, monthly income, marital status, working duration, shift work, smoking status, drinking status, sleep quality, physical activity, and all other plasma elements concentrations (Shang et al. 2021).

Zhang Z et al. (2022a):

The study aimed to analyse the correlation between Quantitative Susceptibility Mapping (QSM) values, MoCA scores and plasma aluminium levels in 53 AI workers issued from the previous cohort study of Shang et al. (2021). The 53 included workers were male, with an age range of 37-57 years, and were divided into two groups according to the MoCA score. Twenty-eight (28) workers were from the MCI group (MoCA score < 26) and 25 from the “normal” group (MoCA score ≥ 26).

There was no difference in age and educational level, between the two groups. Mean plasma aluminium level was higher in the MCI group ($43.8 \mu\text{g.L}^{-1}$ vs $33.1 \mu\text{g.L}^{-1}$). QSM values of left hippocampus, left dentate nucleus, right substantia nigra and left putamen were higher in the MCI group compared to the “normal” group ($p < 0.05$). No correlation was found between QSM values and plasma Al levels, suggesting that the pathological MCI mechanism is not related to plasma aluminium concentration and aluminium deposition in brain tissue. The authors concluded that, although QSM might be a valuable diagnostic marker for the diagnosis of MCI, no correlation was identified between plasma aluminium levels and QSM in AI workers (Zhang et al. 2022).

Zhao et al. (2022):

In a cohort study including 352 workers from a Chinese electrolytic aluminium workshop (19-55 years old), Zhao et al. (2022) investigated neurocognitive impairment using neuropsychological tests. Exclusion criteria were: age ≥ 60 years, exposure duration < 1 year, education level lower than primary school, familial history of neurodegenerative disease, personal history of neurological or mental disease, long-term use of psychotropic drugs, consumption of aluminium-containing drugs or use of aluminium cookware, exposure to strong

noise and hearing deficiency. The tests performed included MMSE, VFT, FOME (evaluating delayed memory ability), DST (testing auditory linguistic memory ability), CDT (testing visuospatial, abstraction, language and memory abilities). Plasma aluminium concentration was measured using GFAAS. Individuals were distributed into 4 quartiles according to plasma aluminium level (Q1 <17.7 µg.L⁻¹; Q2 17.7-27.85 µg.L⁻¹; Q3 27.85-41.04 µg.L⁻¹; Q4 ≥ 41.04 µg.L⁻¹).

Participants from Q3 and Q4 groups performed poorly to cognitive function tests compared to Q1 participants (DST, DSB, VFT for Q3vsQ1 and DST, DSF, DSB, VFT for Q4vsQ1). After adjustment for age, years of employment, education, income, smoking and drinking status, a significant association was observed between plasma aluminium concentration and a global score of cognitive impairment; it was statistically significant only for Q4 compared to Q1 participants, OR=6.172 (IC95% 2.31-16.488). With each 1µg.L⁻¹ rise in plasma aluminium concentration, there was a 1.051-fold increase in the risk of cognitive impairment (95% CI: 1.031 to 1.072) (Zhao et al. 2022).

Zhang et al. (2022):

Zhang et al. studied a cohort of 392 male workers from an electrolytic workshop in China. Participants have worked for 15±9 years in aluminium plant. All participants had been exposed for more than one year. People with long-term consumption of aluminium-containing antacid drugs were excluded, as well as those using aluminium cookware, or those exposed to aluminium less than one year, or those with high blood pressure or hypotension. Plasma aluminium levels were determined by ICP-MS. Thirty minutes after their blood pressure measurement, participants were interviewed to collect the cognitive function test data. Cognitive functions were assessed using several tests as the MMSE, the VFT, the Average Reaction Time (ATIME), the FOME (evaluating delayed memory ability), the DST (testing auditory breadth and auditory linguistic memory ability), the CDT (testing visuospatial construction, abstract thinking, language and memory abilities). The authors conducted a generalised linear regression model to analyse the relationship between plasma aluminium levels, cognitive functions and blood pressure.

The participants were divided into four groups based on median and quartiles of plasma Al levels: Q1 (<18.08 µg.L⁻¹), Q2 (18.08-28.21 µg.L⁻¹), Q3 (28.21-40.88 µg.L⁻¹), Q4 (> 40.88 µg.L⁻¹). When aluminium concentration was used as a continuous variable, after adjustment for age, education level, marital status, smoking and drinking status, BMI, duration of employment, and family history of hypertension, for every fold increase, the MMSE, VFT, and FOM scores decreased by 1.275, 4.289 and 0.879 units respectively. When the Q4 group was compared to the Q1 group, plasma aluminium increase was associated with an increased ATIME. Plasma aluminium increase was also associated with an increasing risk of hypertension (odds-ratio, OR = 1.630, 95% CI: 1.103–2.407), and with an elevated systolic (OR = 1.578, 95% CI: 1.038–2.399) and diastolic blood pressure (OR = 1.842, 95% CI: 1.153–2.944) (Zhang et al. 2022).

Zhang et al. (2023):

In this study by Zhang et al., the relationship between cognitive impairment and occupational exposure to aluminium, as indicated by plasma levels, was examined. The participants were 54 subjects who were native Chinese male individuals, aged 37-57 years and who have worked in an aluminium factory for a minimum of 10 years. Exclusion criteria were left-handedness, history of major illness, contraindication of MRI scanning, and medical history of current serious medical problems

MoCA and verbal memory evaluated with the Rey Auditory Verbal Learning Test (AVLT) and blood sampling were done before MRI scanning. Out of the 54 subjects, 28 with MoCA scores <26 were assigned to the MCI group whereas the 26 other participants were assigned to the control group with normal cognition (MoCA scores >26). Respective work durations were of 25.07 ± 10.38 years for MCI participants and 27.88 ± 5.03 years for the control group. Plasma aluminium levels were measured at $48.90 \pm 9.21 \mu\text{g.L}^{-1}$ for patients and $32.51 \pm 6.05 \mu\text{g.L}^{-1}$ for the control group, and there was no difference between the two groups.

After adjusting for confounding factors, the study observed an inverse relationship between plasma aluminium concentration and MoCA ($r = -0.278$; $p = 0.036$) and AVLT ($r = -0.287$; $p = 0.035$) scores. Cerebral MRI data were obtained for each participant and analysed using nonnegative matrix factorization. In MCI participants, the grey-matter volume of the default mode network (DMN) was lower than that in controls. Positive correlations were observed between DMN and MoCA scores, as well as between DMN and AVLT scores (Zhang et al. 2023).

Zhao et al. (2023):

Zhao et al. investigated the relationship between plasma aluminium levels, lifestyle and cognitive function of 476 male workers from an electrolytic aluminium workshop and a repair workshop in an aluminium factory in China. Inclusion criteria were: age between 20 and 60 years and good physical condition. Exclusion criteria were: long-term use of aluminium-containing drugs, use of drugs affecting neurological functions during the past week, history of personal or familial neurological or mental disease, high frequency of cooking oil strips. Plasma aluminium concentration was measured by ICP-MS. Cognitive condition was determined using the MoCA. MCI was defined as a MoCA score under 26. Subjects were 43.69 ± 7.41 years old. Only 126 individuals had worked in aluminium industry for at least 10 years. Among them 49 were included in the MCI group and 77 considered as having normal cognitive performances. Despite this discrepancy, all 476 workers were categorised in four quartiles according to their plasma aluminium concentration, respectively Q1 <14.95 $\mu\text{g.L}^{-1}$, Q2 14.95-32.96 $\mu\text{g.L}^{-1}$, Q3 32.96-56.62 $\mu\text{g.L}^{-1}$ and Q4 >56.62 $\mu\text{g.L}^{-1}$.

In this study, plasma aluminium concentration was associated with an increased risk of cognitive impairment for Q2, Q3 (not significant) and Q4 compared with Q1 participants. Derived OR (IC95%) were 2.102 (1.092-4.051), 1.866 (0.955-3.644) and 3.679 (1.928-7.020), respectively. The model was adjusted for income and marital status, education level, smoking status, drinking status, physical activity, daily reading time, daily mobile phone use, daily sleep duration (Zhao et al. 2023).

Meta-analyses

A first meta-analysis was performed in 2007 by Meyer-Baron et al. It included the 9 studies by Hosovski et al. (1990), Bast Pettersen et al. (1994 and 2000), Sjögren et al. 1996, Akila et al. (1999), Guo et al. (1999), He et al. (2003), Buchta et al. (2003 and 2005). These nine studies globally concerned 449 exposed workers and 315 control subjects. The mean urinary aluminium concentrations in the exposed groups ranged from 13 to 133 $\mu\text{g.L}^{-1}$. Six neuropsychological tests yielding 10 performance variables were analysed. A significant overall effect size was characterised for the digit symbol test (measuring speed-related components of cognitive and motor performances). The meta-analysis results also suggest an exposure-response relationship for this variable. This would constitute an argument for impairments of cognitive functions associated with occupational exposure to aluminium, even when urinary aluminium level is under 135 $\mu\text{g.L}^{-1}$. However, the authors pertinently noted that one significant effect size out of 10 analyses could be a chance result, and that uncertainties

remain concerning the confounding factors that should and can be considered (Meyer-Baron et al. 2007).

A second meta-analysis was published in 2021 by Bagepally et al. It includes 23 studies, 1781 exposed and 1186 unexposed individuals. It shows statistically significant impairments of global cognitive scores, memory and working memory, associated with occupational aluminium exposure, but do not try to characterise a NOAEL or a LOAEL for these effects, using indicators of external exposure or biomarkers of exposure (Bagepally et al. 2021).

Vlasak et al. conducted a third meta-analysis of 18 studies of aluminium exposure association with performances in seven cognitive functions. It included 1357 exposed and 1119 control individuals, however, the same longitudinal studies that are described in two separate papers are counted twice which might induce biased results. Results of the meta-analysis are reported using Hedges' g as aggregated effect size to consider small sample sizes of some integrated studies. Overall, exposed workers had impaired performances in the following cognitive outcomes: reaction time, working memory and processing speed. No association could be found between urine aluminium levels (corrected for creatinine or not) and cognitive performance while a linear association with blood aluminium levels is observed (Vlasak, Dujlovic, and Barth 2024).

4.7.1.1.1 Neurodegenerative diseases

Amyloid plaques and neurofibrillary tangles are significant neuropathological indicators of Alzheimer's disease. The presence of aluminium in senile plaques, primarily composed of aggregated β -amyloid peptides, and the occurrence of neurofibrillary tangles in the presence of aluminium offer some support for the link between Alzheimer's disease and aluminium presence in the brain (Bryliński et al. 2023). Considering the conflicting results of studies testing for an association between aluminium in brain and the risk of Alzheimer's disease, the simultaneous observation of these neuropathological features and aluminium in the brain does not establish the causal role of aluminium in Alzheimer's disease.

In a meta-analysis of three epidemiological studies (Virk and Eslick 2015), aluminium occupational exposure was not associated with Alzheimer's disease (OR, 1.00; 95% CI, 0.59 to 1.68). In another meta-analysis of eight epidemiological studies (Wang et al. 2016), including also the three previous studies, an association of aluminium exposure with Alzheimer's disease was found (OR, 1.71; 95% CI, 1.35 to 2.18). When separating exposure through drinking water and occupational exposure, this association was observed only with exposure through drinking water (OR, 1.95; 95% CI, 1.47 to 2.59) while no association with occupational exposure was found (OR, 1.25; 95% CI, 0.80 to 1.94).

Most of the epidemiological studies testing for the association between aluminium concentration in drinking water and the risk of Alzheimer's disease and/or dementia suffer multiple methodological flaws. The main of these are that: 1) exposure to aluminium from water is generally not evaluated from individual repeated sampling of water really consumed by the participants, but from data issued from water distributing companies; they inconstantly take into accounts that the participants did not live at the same place during their whole life; 2) they generally only consider aluminium exposure through water, when it usually represents less than 5 % of the total exposure in the general population; 3) they generally do not take into account the other substances in drinking water (when positive and negative associations are respectively reported with the concentrations of fluorides or silicium in water and the risk of dementia). According to EFSA and WHO, exposure to aluminium through the food, including

drinking water, does not constitute a risk for developing Alzheimer's disease (EFSA 2008; JECFA 2012).

4.7.1.1.2 *Autism spectrum disorder*

Autism spectrum disorder has initially been suggested to be associated with aluminium exposure through vaccines based on ecological studies. The Global Advisory Committee on Vaccine Safety (GACVS 2012) had assessed those studies. They presented limitations such as uncertainties regarding autism spectrum disorder prevalence in different countries or in vaccines schedule. More recently, a meta-analysis comprising 18 case-control studies with aluminium measurement in hair, blood and/or urine was published (Sulaiman, Wang, and Ren 2020). It shows equivocal associations between aluminium levels in biological matrices and autism spectrum disorder. While levels of aluminium in hair and urine were positively associated with autism spectrum disorder, aluminium levels in blood were negatively associated. Overall, these studies address association and cannot be used for causality assessment of the association of aluminium exposure with autism spectrum disorder.

Table 13. Epidemiological studies

Study	Population	Industry	Analytical method	BM	BM results in control group	BM results in workers	NOAEL / LOAEL	Results
Hosovski et al. (1990) Cross-sectional	Yugoslavia 87 Al-exposed workers 60 controls	Al foundry Al concentration in the workplace: 4.6 to 11.5 mg.m ⁻³	Flameless AAS	Blood-Al	Mean: 58.09±74.73 µg.L ⁻¹	Mean: 136.85±103.15 µg.L ⁻¹	Blood-Al LOAEL: 136.85 µg.L ⁻¹ U-Al LOAEL: 45.38 µg.L ⁻¹	Memory disorder, decreased performance in complex reaction tests, complicated manipulations and oculomotor coordination. No confounder considered except for alcohol and psychotropic drugs consumption within one month before the study. Probable massive external contamination of the blood samples
				U-Al	Mean: 7.25±7.82 µg.L ⁻¹	Mean: 45.38±55.01 µg.L ⁻¹		
Bast-Pettersen et al. (1994) Cross-sectional	Norway 22 Al-exposed workers (potroom, foundry) 16 controls (other department)	Primary aluminium plant	Not reported	S-Al	Mean: 2.9 µg.L ⁻¹	Mean: 3.6 µg.L ⁻¹ in potroom workers Mean: 4.1 µg.L ⁻¹ in foundry workers		Exposed workers reported more neuropsychiatric symptoms. Increased risk of impaired visuo-spatial organisation in exposed workers but the differences are not significant with the control group
				U-Al	Mean: 7.8 µg.L ⁻¹	Mean: 12.6 µg.L ⁻¹ in potroom workers Mean: 9.9 µg.L ⁻¹ in foundry workers		
Sjögren et al. (1996) Iregren et al. (2001)	Sweden 173 Al exposed workers	Al foundry and potroom workers, Al welders, workers in	GFAAS	Blood-Al	Median: 1.0 (range LOD-11) µg.L ⁻¹	Median: 1.0 (LOD-18), 9.0 (LOD-21) and 3.0 (LOD-27) µg.L ⁻¹ in smelters, flake		No correlation between Al in urine and the outcomes measures. Groups not comparable.

Cross sectional	39 mild steel welders	production of Al flake powder				powder exposed workers and welders, respectively		
				U-Al	Median: 4.7 $\mu\text{g.g}^{-1}$ creatinine	Median: 4.2, 59.0 and 24.0 $\mu\text{g.g}^{-1}$ creatinine for the smelters, flake powder exposed workers and welders, respectively		
Akila et al. (1999) Cross-sectional	Finland 51 aluminium welders 28 age-matched steel welders	Aluminium welders	GFAAS	S-Al	Not reported	Not reported		Effects of Al are only significant at high exposure group for Digit symbol substitution test, Item selection time, Block design, Backward counting.
				U-Al	<1 $\mu\text{mol.L}^{-1}$ (mean=0.46 $\mu\text{mol.L}^{-1}$) < 27 $\mu\text{g.L}^{-1}$ (mean=12.4 $\mu\text{g.L}^{-1}$)	Low exposure group: 1.1–4.0 $\mu\text{mol.L}^{-1}$ (mean=2.25 $\mu\text{mol.L}^{-1}$); 27-108 $\mu\text{g.L}^{-1}$ (mean=60.7 $\mu\text{g.L}^{-1}$) High exposure group: >4.1 $\mu\text{mol.L}^{-1}$ (mean=9.98 $\mu\text{mol.L}^{-1}$); > 108 $\mu\text{g.L}^{-1}$ (mean=269.3 $\mu\text{g.L}^{-1}$)		

Hänninen et al. (1994) ; Riihimäki et al. (2000) Cross-sectional	Finland 65 Al welders Control: 25 mild steel welders	Aluminium welders	GFAAS	S-Al	Median: 0.08 $\mu\text{mol.L}^{-1}$ (2.2 $\mu\text{g.L}^{-1}$) Range: 0.04 to 0.12 $\mu\text{mol.L}^{-1}$ (1-3.2 $\mu\text{g.L}^{-1}$)	Median (range): Low exposure group: 0.14 $\mu\text{mol.L}^{-1}$ (0.07-0.24 $\mu\text{mol.L}^{-1}$); 3.8 $\mu\text{g.L}^{-1}$ (1.9-6.5 $\mu\text{g.L}^{-1}$) High exposure group: 0.46 $\mu\text{mol.L}^{-1}$ (0.27-1.00 $\mu\text{mol.L}^{-1}$); 12.4 $\mu\text{g.L}^{-1}$ (7.3-27 $\mu\text{g.L}^{-1}$)		Exposition related impairments in cancellation accuracy (Bourdon-Wiesma test), backward counting, both components of dual task, synonyms, and memory for designs. Age-adjusted correlations between U-Al and impairments in Digit symbol test, backward counting, dual task cancellation speed and counting speed. No statistically significant differences between the groups in EEG quantitative analysis. No significant association was observed between serum or urine aluminium concentration and P300 amplitude or latency.
				U-Al	Median: 0.4 $\mu\text{mol.L}^{-1}$ (10.8 $\mu\text{g.L}^{-1}$) Range: 0.1 to 1.3 $\mu\text{mol.L}^{-1}$ (2.7-35.1 $\mu\text{g.L}^{-1}$)	Low exposure group: 1.8 $\mu\text{mol.L}^{-1}$ (0.3-5.7 $\mu\text{mol.L}^{-1}$); 48.6 $\mu\text{g.L}^{-1}$ (8.1-153.9 $\mu\text{g.L}^{-1}$) High exposure group: 7.1 $\mu\text{mol.L}^{-1}$ (3.2-27.3 $\mu\text{mol.L}^{-1}$); 191.7 $\mu\text{g.L}^{-1}$ (86.4-737.1 $\mu\text{g.L}^{-1}$)		
Bast-Pettersen et al. (2000)	Norway 20 Al welders 20 constructi	Aluminium welders	GFAAS	U-Al pre and post shift	Not measured	Median (range): 0.15 $\mu\text{mol/mmol}$ creatinine (0.06-0.43 $\mu\text{mol/mmol}$ creatinine); 35.8 $\mu\text{g.g}^{-1}$ creatinine;		Welders reported significantly more symptoms than controls and years of exposure were associated with poorer performance on the tremor test

Cross-sectional	on workers = control					14.3-109.9 µg.g ⁻¹ creatinine)		
Letzel et al. (2000) Longitudinal study	Germany 32 (E1) and 21 (E2) workers 30 (E1) and 15 (E2) controls	Al powder plant	Not reported	P-Al	Median: 1 st examination: 4.3 µg.L ⁻¹ 2 nd examination: 4.3 µg.L ⁻¹	Median: 1 st examination: 8.7 µg.L ⁻¹ 2 nd examination: 6.7 µg.L ⁻¹	NOAEL: 8.7 µg.L ⁻¹ NOAEL: 87.6 µg.g ⁻¹ creatinine	No significant exposure-related differences regarding performances in the psychometric tests or P300 potentials.
				U-Al	Median: 1 st examination: 9.0 µg.g ⁻¹ creatinine 2 nd examination: 4.5 µg.g ⁻¹ creatinine	Median: 1 st examination: 87.6 µg.g ⁻¹ creatinine 2 nd examination: 19.8 µg.g ⁻¹ creatinine		
Polizzi et al. (2002) Cross sectional study	Italy 64 al-exposed workers 32 controls All participants retired for 10	Foundries	GFAAS	S-Al	Mean: 8.2 ± 1.17 µg.L ⁻¹	Mean: 14.1 ± 3.50 µg.L ⁻¹	LOAEL: 14.1 µg.L ⁻¹	Negative correlation between serum aluminium and the MMSE, MMSE-AE and CDT scores Positive correlation between serum aluminium and the MMSE and CDT times ERP-P300 latency positively correlated with serum aluminium concentration

	years or more							
Buchta et al. (2003) and Kiesswetter et al. (2009) Longitudinal study (4 years)	Germany 98, 97, 92 Al welders 50 controls	Al welders of car-body construction industry	GFAAS	P-Al (post-shift)	Median (min, max): 1 st : 4.4 (1.4–31.6) µg.L ⁻¹ 2 nd : 2.3 (0.7–5.9) µg.L ⁻¹ 3 rd : 3.8 (1.6–10.0) µg.L ⁻¹	Median (min, max): 1 st : 8.3 (2.3–42.3) µg.L ⁻¹ 2 nd : 4.1 (0.72–11.7) µg.L ⁻¹ 3 rd : 4.3 (1.8–15.6) µg.L ⁻¹	P-Al NOAEL: 8.3 µg.L ⁻¹ U-Al NOAEL: 37.87 µg.g ⁻¹ creatinine	No differences in neurological symptoms report and in performances in psychometric tests, except that welders were slightly slower in their decision time but quicker in their motor movements.
				U-Al (post-shift)	Median (min, max): 1 st : 5.2 (1.7–30.3) µg.g ⁻¹ creatinine 2 nd : 6.0 (1.6–390.0) µg.g ⁻¹ creatinine 3 rd : 5.0 (0.2–40.3) µg.g ⁻¹ creatinine	Median (min, max): 1 st : 37.87 (7.0–120.5) µg.g ⁻¹ creatinine 2 nd : 33.57 (9.0–230.11) µg.g ⁻¹ creatinine 3 rd : 15.4 (0.7–94.9) µg.g ⁻¹ creatinine		
Buchta et al. (2005) and Kiesswetter et al. (2007) Longitudinal study (4 years)	Germany 44 Al-welders 37 controls	5 companies in the train body and truck trailer construction industry	GFAAS	P-Al (post-shift)	Median: 1 st : 3.5 µg.L ⁻¹ 2 nd : 2.8 µg.L ⁻¹ 3 rd : 4.5 µg.L ⁻¹	Median: 1 st : 11.6 µg.L ⁻¹ 2 nd : 14.3 µg.L ⁻¹ 3 rd : 13.2 µg.L ⁻¹	P-Al LOAEL: 11.6 µg.L ⁻¹ U-Al LOAEL: 97 µg.g ⁻¹ creatinine	Observed significant difference between welders and controls only for block design test scores. Lowered performances (intergroup differences were not statistically significant) in welders group for verbal IQ, SPM test, trail making test, line tracing test and switching attention tasks.
				U-Al (post-shift)	Median: 1 st : 5.8 µg.L ⁻¹ or 4 µg.g ⁻¹ creatinine	Median: 1 st : 130 µg.L ⁻¹ or 97 µg.g ⁻¹ creatinine		

					2 nd : 6 µg.L ⁻¹ or 4.5 µg.g ⁻¹ creatinine 3 rd : 8.3 µg.L ⁻¹ or 8.5 µg.g ⁻¹ creatinine	2 nd : 145.5 µg.L ⁻¹ or 143.9 µg.g ⁻¹ creatinine 3 rd : 93.7 µg.L ⁻¹ or 64.5 µg.g ⁻¹ creatinine		
Giorgianni et al. (2014) Cross-sectional	Italy 86 Al-welders Control group (from the same plant): 90	Welders in a shipyard using MIG (metal inert gas) technique	Spectrophotometry technique of absorption fitted with a graphite oven	S-Al (Monday morning)	Mean: 6.93±1.95 µg.L ⁻¹	Mean: 24.19±9.99 µg.L ⁻¹	LOAEL: 24.19 µg.L ⁻¹	Impaired scores of exposed workers in all cognitive tests, especially WMS test, Stroop test and attention matrices test
Mohammed et al. (2020) Cross-sectional	Egypt 75 Al exposed workers 75 controls from the same plant	Foundry (exposed to various metals)	Atomic Absorption Spectrometry (AAS)	S-Al	Mean ±SD: 0.36 mg.L ⁻¹ ± 0.11	Mean ±SD: 0.56 mg.L ⁻¹ ± 0.18	LOAEL: 560 µg.L ⁻¹	Significant decline in cognitive performance in the exposed group negatively correlated to S-Al and tau protein level. Probable massive external contamination of the blood samples
Guo et al. (1999) Cross-sectional	China 103 Al-exposed workers	Large aluminium production plant (electrolysis, smelting or welding)	GFAAS	U-Al post-shift	Mean (range): 17.7 µg.g ⁻¹ creatinine (3.5-42.8 µg.g ⁻¹ creatinine)	Mean (range): 41.8 µg.g ⁻¹ creatinine (14.9-116.2 µg.g ⁻¹ creatinine)	LOAEL: 41.8 µg.g ⁻¹ creatinine	Significant higher score of some negative mood variables of the POMS questionnaire in workers and inconsistent impairment in some psychometric tests (age dependent) in the group of workers

	64 controls	departments)						
He et al. (2003) Cross-sectional	China 33 workers from a Chinese Al plant 34 controls from a flour mill.	Chinese aluminium plant	GFAAS	U-Al pre shift	Mean: 26.8 $\mu\text{g.g}^{-1}$ creatinine	Mean: 40.1 $\mu\text{g.g}^{-1}$ creatinine	LOAEL: 40.1 $\mu\text{g.g}^{-1}$ creatinine	Reaction time was significantly slower for exposed workers and scores of the digital symbol test and pursuit aiming test were significantly lower in this group.
Yang et al. (2015) Cross-sectional	China 366 Al potroom workers	Al potroom	GFAAS	S-Al	-	Median (range): 48.99 $\mu\text{g.L}^{-1}$ (6.63-158.8 $\mu\text{g.L}^{-1}$)		Total MMSE score decrease with S-Al increase Risk of mild cognitive impairment (MCI) increase with S-Al increase
Meng et al. (2019) Cross-sectional	China 853 Al-exposed workers from which only 334 were fully evaluated 1336 matched controls	Al factory	ICP-MS	P-Al	Median (P25-P75): (12.02 (6.35, 20.86) $\mu\text{g.L}^{-1}$)	Median (P25-P75) in the 53 MCI patients: 18.17 (10.39, 34.96) $\mu\text{g.L}^{-1}$)		High P-Al increased the risk of cognitive problems, advanced education was a protective factor

Wang et al. (2020) Cross-sectional	China 831 Al-exposed workers	Al factory	ICP-MS	P-Al	-	Four quartiles: Q1: 0-8.28 µg.L ⁻¹ Q2: 8.28-15.26 µg.L ⁻¹ Q3: 15.26-27.02 µg.L ⁻¹ Q4: ≥27.02 µg.L ⁻¹		Positive association between P-Al and cognitive impairments
Lu et al. (2021) Longitudinal study (2 years)	China 276 Al-exposed workers	Al factory	ICP-MS	P-Al	-	3 tertiles: T1: <17.6 µg.L ⁻¹ T2: 17.6-37.3 µg.L ⁻¹ T3: ≥37.3 µg.L ⁻¹)		Observed dose-response negative relationship between P-Al and MMSE score and FOME score
Xu et al. (2021) Cross-sectional study	China 1660 exposed workers	Al plant	ICP-MS	P-Al	-	Median: 34.5 (P25, P75 =15.0, 42.3) µg.L ⁻¹		P-Al negatively correlated with DST and DSBT test scores.
Zhang et al. (2021) Cross-sectional	China 539 Al-exposed workers 1720 unexposed	Aluminium miners and workers from remated factories	No measurement	-	-	-		Exposed people had a significant lower MMSE score (p<0.001) and a higher risk of cognitive impairment (OR 2.21)

Shang et al. (2021) Cross-sectional	China 187 aluminium workers	Aluminium factory	ICP-MS	P-AI	-	Median (IQR): Normal group: 55.862 (38.701–77.012) µg.L ⁻¹ MCI group: 72.794 (42.510–102.652) µg.L ⁻¹ for the MCI group.		Significant inverse relationship between P-AI and MocA total scores
Zhang Z et al. (2022) Cross-sectional	China 53 Al-exposed workers	Al factory	ICP-MS	P-AI	-	Mean level: Normal group: 33.1 µg.L ⁻¹ MCI group: 43.8 µg.L ⁻¹		28 workers had mild MCI P-AI was higher in workers with MCI QSM exploration showed higher values in several brain regions for the MCI group No correlation between P-AI and QSM values.
Zhao et al. (2022) Cross-sectional	China 352 Al-exposed workers	Al factory	GFAAS	P-AI	-	Four quartiles: Q1 <17.7 µg.L ⁻¹ ; Q2 17.7-27.85 µg.L ⁻¹ ; Q3 27.85-41.04 µg.L ⁻¹ ; Q4 ≥ 41.04 µg.L ⁻¹		Association between P-AI increase and decrease of global score of cognitive impairment
Zhang Y et al. (2022) Cross-sectional	China 392 Al-exposed workers	Al factory	ICP-MS	P-AI	-	Four groups based on median and quartiles of plasma Al levels: Q1 (< 18.08 µg.L ⁻¹), Q2 (18.08-28.21 µg.L ⁻¹), Q3 (28.21-40.88 µg.L ⁻¹), Q4 (≥ 40.88 µg.L ⁻¹)		Decrease of MMSE, VFT and FOM scores with P-AI increase

Zhang et al. (2023) Case-control	China 28 Al-exposed workers with MCI 26 controls	Al factory	Not reported	P-Al	32.51±6.05 µg.L ⁻¹	48.90±9.21 µg.L ⁻¹ for patients with MCI		Inverse relationship between P-Al and MocA and ALVL scores Lower grey matter volume in MCI patients at cerebral MRI examination
Zhao et al. (2023) Cross-sectional	China 476 Al-exposed workers	Al factory	ICP-MS	P-Al	-	Four quartiles: Q1 <14.95 µg.L ⁻¹ , Q2 14.95-32.96 µg.L ⁻¹ , Q3 32.96-56.62 µg.L ⁻¹ and Q4 >56.62 µg.L ⁻¹		P-Al increase associated with increased risk of cognitive impairment

Blood-Al: blood aluminium concentration; P-Al: plasma aluminium concentration; S-Al: serum aluminium concentration; U-Al: urinary aluminium concentration.

Urinary aluminium levels reported in the various studies with NOAELs or LOAELs are presented in the histogram below (Figure 8) along with the number of samples (the study by Hosovski et al. 1990 is excluded as it shows limitations and urinary aluminium levels are not in $\mu\text{g}\cdot\text{g}^{-1}$ creatinine).

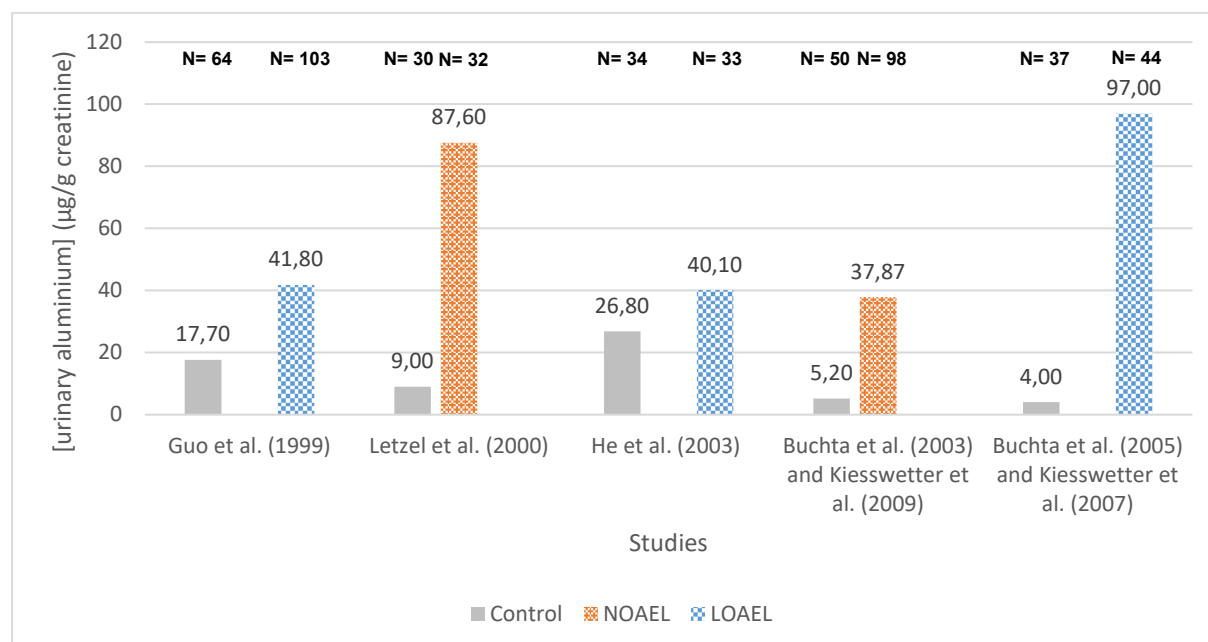


Figure 8. NOAEL and LOAEL extrapolated from median urinary concentrations measured in exposed workers in relation to cognitive impairment.

4.7.1.2 Animal data

No neurotoxicity studies have been found in animals following chronic exposure to aluminium compounds.

4.7.2 Respiratory toxicity

4.7.2.1 Human data

Numerous studies have documented respiratory effects linked to occupational exposure to aluminium, with diverse activities implicated such as aluminium smelting, electrolytic refineries, aluminium powder production and aluminium welding. The spectrum of respiratory disorders includes wheezing, dyspnoea, impaired lung function, asthma, and pulmonary fibrosis. However, the attribution of these disorders to aluminium exposure remains uncertain or even improbable in many studies due to confounding factors, particularly co-exposures to other toxic chemicals, especially irritants. For instance, co-exposure to hydrogen fluoride and other fluorides were reported in electrolytic refineries in cases of potroom asthma or pulmonary fibrosis; co-exposure to ozone and ultra-fine particles in workers exposed to welding fumes; co-exposure to crystalline silica in cases of fibrosis in workers exposed to bauxite (Krewski et al. 2007; ATSDR 2008). Conflicting data are reported concerning the pulmonary effects of finely ground aluminium powder: some publications report on cases of pulmonary fibrosis in exposed workers, when other studies show no evidence of fibrosis after prolonged exposure to aluminium fine particles. It is believed that these differences could be explained by the type of lubricant used to prevent surface oxidation of aluminium particles during milling. Stearic acid is the most commonly used lubricant; it reacts with aluminium forming a protective superficial film of aluminium stearate; no fibrogenic effect is reported when using this process. In contrast,

the previous and now discontinued use of mineral oil, as a lubricant for aluminium milling has been associated with pulmonary fibrosis. Sporadic cases of pneumoconiosis associated with aluminium occupational exposure are also reported (Korogiannos, Babatsikou, and Tzimas 1998; Kraus et al. 2000; Hull and Abraham 2002). Their small number and the co-exposures to other chemical agents limit their interpretation.

4.7.2.2 Animal data

Limited data are available on respiratory effects of aluminium and its compounds following chronic inhalation (ATSDR 2008). Identified studies are described below and summarised in Table 14.

■ Mice

No organ weight or histological changes were observed in the lungs of Swiss mice exposed over lifetime (2-2.5 years) to $1.2 \text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$ as aluminium sulphate in drinking water (Schroeder and Mitchener 1975b) or in mice exposed to $979 \text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$ as aluminium potassium sulphate in the feed for 20 months (Oneda et al. 1994).

■ Rats

No organ weight or histological changes of the lungs were observed in Long-Evans rats exposed over 2 years to $0.6 \text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$ as aluminium sulphate in drinking water (Schroeder and Mitchener 1975a).

Rats (Fischer- 344) exposed over 12-24 months (5d.wk^{-1} and 6hr.d^{-1}) to aluminium chlorohydrate (whole body) at doses of 0.25, 2.5 or 25 mg.m^{-3} presented a 108-274% increase in relative lung weight at 2 years at the high exposure dose (LOAEL= 25 mg.m^{-3} Al chlorohydrate, corresponding to 6.5 mg Al.m^{-3}). No effects on lungs weight were observed at the dose of 2.5 mg.m^{-3} (NOAEL corresponding to $0.65 \text{ mg Al.m}^{-3}$) (Stone et al. 1979).

In a study by Pigott et al., no lung fibrosis was observed in rats (Wistar) following exposure (whole body) to 2.18 or 2.45 mg.m^{-3} alumina fibres (Saffil fibres or Saffil aged fibres, median diameter ranging between $3.0\text{-}3.3 \mu\text{m}$) over 86 weeks (5 d.wk^{-1} and 6hr.d^{-1}) (Pigott, Gaskell, and Ishmael 1981).

■ Guinea pigs

Guinea Pigs (Hartley) exposed, whole body, to aluminium chlorohydrate at doses of 0.25, 2.5 or 25 mg.m^{-3} over 12-21 months (5d.wk^{-1} and 6hr.d^{-1}) showed a 21% increase in relative lung weight at 2 years at the lowest exposure dose (LOAEL corresponding to $0.065 \text{ mg Al.m}^{-3}$) (Stone et al. 1979).

Table 14. Animal studies on aluminium chronic exposure respiratory toxicity

Strain	Al compound	Duration and route of exposure	Doses	Endpoint	NOAEL	LOAEL	Reference
Mice							
Swiss (n= 54 per group)	Aluminium sulphate	Lifetime Water	0 or 5 mg.L ⁻¹	Weight and histological changes in lungs	1.2 mg Al.kg bw ⁻¹ .d ⁻¹		Schroeder and Mitchener (1975b)
B6C3F1 (n= 60 per group)	Aluminium potassium sulphate	20 months Feed	0, 1, 2.5, 5, 10% APS (w/w)	Weight and histological changes in lungs	979 mg Al.kg bw ⁻¹ .d ⁻¹		Oneda et al. (1994)
Rats							
Long- Evans (n=52 of each sex per group)	Aluminium sulphate	2 years Water	0 or 5 mg.L ⁻¹	Weight and histological changes in lungs	0.6 mg Al.kg bw ⁻¹ .d ⁻¹		Schroeder and Mitchener (1975a)
Fischer- 344 (n≈ 17 per group)	Aluminium chlorohydrate	12-24 months Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	Increase in relative lung weight at 2 years	0.65 mg Al.m ⁻³	6.5 mg Al.m ⁻³	Stone et al. (1979)
Wistar (n= 50 per group)	Alumina fibres (Aluminium oxide)	86 weeks Inhalation	2.18 or 2.45 mg.m ⁻³	Lung fibrosis	2.45 mg.m ⁻³		Pigott et al. (1981)
Guinea pigs							
Hartley (n= 15 per group)	Aluminium chlorohydrate	12-21 months Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	Increase in relative lung weight at 2 years		0.065 mg Al.m ⁻³	Stone et al. (1979)

4.7.3 Haematological effects

4.7.3.1 Human data

Elevated aluminium body burden is associated with a reduced erythrocyte lifespan and interferes with haemoglobin synthesis; these factors contribute to the microcytic hypochromic anaemia that develops after prolonged Al exposure in patients with compromised kidney function (Willhite et al. 2014). No human studies were identified regarding haematological effects following chronic environmental or occupational exposure to aluminium compounds of people with normal renal function.

4.7.3.2 Animal data

In a study by Stone et al., rats (Fischer-344) and guinea pigs exposed to 0.25, 2.5 or 25 mg.m⁻³ of aluminium chlorohydrate over 12-24 and 12-21 months respectively did not present haematological effects. The NOAEL of 25 mg.m⁻³ Al chlorohydrate corresponds to 5.4 mg Al.m⁻³ (Stone et al. 1979).

4.7.4 Bone related effects

4.7.4.1 Human data

No human studies were identified related to musculoskeletal effects following chronic exposure to aluminium compounds.

4.7.4.2 Animal data

No animal studies were identified regarding musculoskeletal effects following chronic inhalation or chronic oral exposure to aluminium compounds.

4.7.5 Other effects

4.7.5.1 Human data

No human studies on systemic toxicity were identified following chronic exposure to aluminium compounds.

4.7.5.2 Animal data

Studies reporting systemic effects following chronic exposure to aluminium and its compounds were documented in the ATSDR (2008) report. The studies are described below and summarised in Table 15.

■ Mice

Swiss mice exposed over lifetime to aluminium sulphate via water (5 ppm aluminium) did not show histological changes in the heart, kidney or liver and no effects were observed on the body and organs weights (NOAEL of 1.2 mg Al.kg bw⁻¹.d⁻¹) (Schroeder and Mitchener 1975b).

Swiss-Webster mice were exposed to aluminium lactate for 2 years (from conception to month 24) at 7 (control) or 100 µg Al.g⁻¹ diet. A 20% decrease in body weight gain was reported in females at the dose of 100 mg Al.kg bw⁻¹.d⁻¹ as aluminium lactate (LOAEL). However,

alterations in body weights were not observed in another group of mice similarly exposed (Golub et al. 2000).

■ Rats

Rats (Long-Evans) exposed for 2.5 years to aluminium sulphate via water (5 ppm aluminium) did not show histological changes in the heart, kidney or liver nor effects on the body weight (NOAEL of 0.6 mg Al.kg bw⁻¹.d⁻¹) (Schroeder and Mitchener 1975a).

Fischer-344 rats exposed to the highest dose of aluminium chlorohydrate, whole body, (0, 0.25, 2.5 and 25 mg.m⁻³) had a significant decrease in their body weight at 12 and 24 months of exposure (LOAEL of 25 mg.m⁻³ Al chlorohydrate, equivalent to 6.5 mg Al.m⁻³ and NOAEL of 2.5 mg.m⁻³ Al chlorohydrate equivalent to 0.65 mg Al.m⁻³) (Stone et al. 1979).

Finally, Sprague-Dawley rats exposed from conception to sacrifice (at 1 year or 2 years) to 0, 50 or 100 mg Al.kg bw⁻¹.d⁻¹ as aluminium nitrate through water (+ citric acid to increase aluminium absorption), did not show any adverse body weight effect (Roig et al. 2006). The NOAEL was 100 mg Al.kg bw⁻¹.d⁻¹.

■ Guinea pigs

No effect on the body weight was observed in guinea pigs exposed to 0.25, 2.5 or 25 mg.m⁻³ of aluminium chlorohydrate (whole body) over 12-21 months (NOAEL=25 mg.m⁻³ Al chlorohydrate, equivalent to 6.5 mg Al.m⁻³) (Stone et al. 1979).

Table 15. Animal studies on aluminium chronic exposure systemic toxicity

Strain	Al compound	Duration and route of exposure	Doses	Endpoint	NOAEL	LOAEL	Reference
Mice							
Swiss (n= 54 per group)	Aluminium sulphate	Lifetime Water	0 or 5 mg.L ⁻¹	Histological changes in heart, kidney, liver and the body weight	1.2 mg Al.kg bw ⁻¹ .d ⁻¹		Schroeder and Mitchener (1975b)
Swiss-Webster (n= 18 per group)	Aluminium lactate	Conception- 24 months Diet	7 (control) or 100 µg Al.g ⁻¹ diet	20% decrease in body weight gain in female mice		100 mg Al.kg bw ⁻¹ .d ⁻¹	Golub et al. (2000)
Rats							
Long- Evans (n=52 of each sex per group)	Aluminium sulphate	2 years Water	0 or 5 mg.L ⁻¹	Histological changes in heart, kidney, liver and the body weight	0.6 mg Al.kg bw ⁻¹ .d ⁻¹		Schroeder and Mitchener (1975a)
Fischer- 344 (n≈ 17 per group)	Aluminium chlorohydrate	12-24 months Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	Decrease in the body weight	0.65 mg Al.m ⁻³	6.5 mg Al.m ⁻³	Stone et al. (1979)
Sprague-Dawley (n= 15-21 per group)	Aluminium nitrate + citric acid	Conception- 1 or 2 years olds Water	0, 50 or 100 mg Al.kg bw ⁻¹ .d ⁻¹	No effect on the body weight at the highest tested dose	100 mg Al/bw.d ⁻¹		Roig et al. (2006)
Guinea pigs							
Hartley (n= 15 per group)	Aluminium chlorohydrate	12-21 months Inhalation	0, 0.25, 2.5 or 25 mg.m ⁻³	No effect on the body weight at the highest tested dose	6.5 mg Al.m ⁻³		Stone et al. (1979)

4.8 Toxicity on reproduction and developmental toxicity

4.8.1 Human data

No reliable studies have been identified regarding the reproductive effects and developmental toxicity of aluminium or its compounds in humans.

4.8.2 Animal data

ATSDR (2008) and EFSA (2008) reported some studies regarding reproductive effects and developmental toxicity of aluminium compounds in animals. Identified studies are described below and summarised in Table 16, Table 17 and Table 18.

■ Mice

An increased incidence of resorptions was reported in female BALB/c mice treated with 200 or 300 mg.kg bw⁻¹.d⁻¹ of aluminium chloride, through gavage, on Gds 7-16 (Cranmer et al. 1986). The control group received a saline solution intraperitoneally (ip). The LOAEL for increased resorption is 200 mg.kg bw⁻¹.d⁻¹ AlCl₃ equivalent to 41 mg Al.kg bw⁻¹.d⁻¹.

In female Swiss-Webster mice exposed to aluminium lactate through diet (25 (control), 500 or 1000 µg Al.g⁻¹ diet), during gestation and lactation (Gd1-Ld21), an altered gestational length was observed in the 500 and 1000 µg Al.g⁻¹ groups, where some pups were born on Gd 17, 19 or 20 whereas all pups were born on Gd18 in the control group. The LOAEL for reproductive effects was equivalent to 155 mg Al.kg bw⁻¹.d⁻¹. Furthermore, no effects were observed on the pregnancy rate, litter size, birth weight, peri and post-natal pup mortality, even in the group with the highest exposure approximatively equivalent to 310 mg Al.kg bw⁻¹.d⁻¹ (NOAEL for developmental toxicity). In this study, mice fed with aluminium lactate from conception through weaning had a decrease in forelimb strength (age of 39 days), an increase in hind limb grip strength (age of 25 days) and an increase in foot splay in weanling (age of 21 and 35 days) at the dose of 500 µg Al.g⁻¹ diet (Donald et al. 1989). The LOAEL for neurodevelopmental toxicity was of 500 µg Al.g⁻¹ diet, corresponding to 155 mg Al.kg bw⁻¹.d⁻¹.

Pregnant Swiss mice exposed through gavage during Gd 6 to 15 to aluminium hydroxide at doses of 0, 66.5, 133 or 266 mg.kg bw⁻¹.d⁻¹ corresponding to 0, 23, 46 or 92 mg Al.kg bw⁻¹.d⁻¹ did not present maternal toxicity or signs of embryotoxicity including morphological abnormalities (Domingo et al. 1989). The NOAEL was thus reported to be 92 mg Al.kg bw⁻¹.d⁻¹ (the highest tested dose).

Swiss-Webster mice were exposed to aluminium lactate at doses of 25 (control) or 1000 µg Al.g⁻¹ diet, through the diet, from conception through gestation, or from conception to lactation, or during lactation only (Golub, Keen, and Gershwin 1992a). There was a significant decrease in pup body weight, crown-rump length and forelimb grip strength in the gestation exposed group. There was an increase in hind limb grip strength and in tail withdrawal times in gestation and lactation exposed groups. An increase in negative geotaxis latency was observed in the lactation exposed groups. The LOAEL was 1000 µg.g⁻¹ diet, equivalent to 250 mg Al.kg bw⁻¹.d⁻¹. In this study, no reproductive effects (no effects on litter size, birth weight, crown-rump length, or sex ratio) were seen in female mice dams exposed to aluminium lactate during gestation and lactation. The NOAEL for reproductive toxicity is equivalent to 250 mg Al.kg bw⁻¹.d⁻¹ (the highest tested dose).

In another study, Swiss (CD-1) mice were exposed during Gd 6 to 15, by gavage, to either aluminium lactate (627 mg.kg bw⁻¹ delivering 57.4 mg Al.kg bw⁻¹.d⁻¹) or aluminium hydroxide

(166 mg.kg bw⁻¹ delivering 57.4 mg Al.kg bw⁻¹.d⁻¹) or aluminium hydroxide and lactic acid (570 mg.kg bw⁻¹) or lactic acid or distilled water. It was shown that dams had a reduced body weight gain (not related to food consumption) following exposure to either aluminium lactate or aluminium hydroxide + lactic acid. In addition, exposure to aluminium lactate induced a significant decrease of foetal body weight, cleft palate and delayed foetal ossification (Colomina et al. 1992). The LOAEL for aluminium lactate was 57.4 mg Al.kg bw⁻¹.d⁻¹ and the NOAEL for aluminium hydroxide 57.4 mg Al.kg bw⁻¹.d⁻¹.

Aluminium hydroxide (dose of 300 mg.kg bw⁻¹.d⁻¹ delivering 103 mg Al.kg bw⁻¹.d⁻¹) was also administered to Swiss mice, by gavage, with or without ascorbic acid (85 mg.kg bw⁻¹.d⁻¹) from Gd 6 to Gd 15. The study included a control group receiving distilled water. A significant reduction in maternal food consumption was reported during all the gestational period in the aluminium hydroxide and aluminium hydroxide + ascorbic acid groups. No developmental effects were observed among the groups including the percentage of post implantation loss, foetal body weight and the incidence of minor anomalies and major malformations (Colomina et al. 1994). The NOAEL was 103 mg Al.kg bw⁻¹.d⁻¹.

Swiss-Webster mice were exposed to aluminium lactate in the diet at 7 (control), 500 or 1000 µg Al.g⁻¹ diet from conception until weaning. At 500 µg Al.g⁻¹ diet, there was a decrease in forelimb and hind limb grip strengths and startle response compared to controls (Golub et al. 1995). The LOAEL was 500 µg.g⁻¹ diet, or 155 mg Al.kg bw⁻¹.d⁻¹.

In a study by Golub and Germann, where Swiss-Webster mice were exposed through diet, from conception till PND 35 to aluminium lactate at doses of 7 (control), 500 or 1000 µg Al.g⁻¹ diet, there was no effect of aluminium exposure on the performance of the Delayed Spatial Alternation task (Golub and Germann 1998). The NOAEL was 1000 µg.g⁻¹ diet, or 330 mg Al.kg bw⁻¹.d⁻¹ (the highest tested dose).

In a study where five groups of CD-1 mice were exposed by gavage to aluminium nitrate nonahydrate at a single dose of 995 mg.kg bw⁻¹ (71 mg Al.kg bw⁻¹), at one of the Gds 8 to 12, a reduction of body weight gain and a reduced foetal body weight were observed in all aluminium treated groups compared to controls. In addition, reduced ossification was common due to the exposure to aluminium (in all groups compared to controls). Some female death and abortions were also reported (Albina et al. 2000). The LOAEL was 71mg Al.kg bw⁻¹ in this study.

Furthermore, a chronic exposure to aluminium lactate through diet (at 7 (control) or 1000 µg Al.g⁻¹ diet) over 2 years, from conception until month 24 of age caused a decrease in forelimb and hind limb strength and a decreased thermal activity in aluminium-treated Swiss-Webster mice (Golub et al. 2000). The LOAEL was 1000 µg.g⁻¹ diet equivalent to 100 mg Al.kg bw⁻¹.d⁻¹.

Swiss Webster mice were exposed to aluminium lactate through diet at doses of 7 (control), 100, 500, or 1000 µg Al.g⁻¹ diet from conception to PND 35. From the dose of 500 µg Al.g⁻¹ diet, females showed an impaired performance on the water maze test and males had shorter latency to fall in wire suspension test. At 1000 µg Al.g⁻¹ diet, there was a decrease in hind limb grip strength compared to controls (Golub and Germann 2001). The LOAEL was 500 µg.g⁻¹ diet or 130 mg Al.kg bw⁻¹.d⁻¹ and the NOAEL was 100 µg.g⁻¹ diet, or 26 mg Al.kg bw⁻¹.d⁻¹.

Pregnant Swiss-Webster mice were exposed to 0, 300 or 600 mg Al.kg bw⁻¹.d⁻¹ as aluminium chloride through water from Gd 1 until PND 15. For each experimental group, pups were culled to 8 per dam but stayed with their mothers until PND 22. In male offspring, a significant and dose-dependent deficit was reported in the locomotor activity (PND 22), learning capacity (PND 25) and cognitive behaviours (PND 30-36). In addition, delays in opening of the eyes and appearance of body hair fuzz, and deficits in the sensory motor reflexes of the pups during weaning period were reported (Abu-Taweel, Ajarem, and Ahmad 2012). The LOAEL was 300 mg Al.kg bw⁻¹.d⁻¹.

■ Rats

Fischer-344 rats inhaling 0, 0.065, 0.65 or 6.5 mg Al.m⁻³ as aluminium chlorohydrate over 6 months had no histological changes in their reproductive tissues (Steinhagen, Cavender, and Cockrell 1978). The NOAEL was 6.5 mg Al.m⁻³.

Aluminium chloride was given to Wistar rats, through diet, at doses of 0, 160 or 200 mg Al.kg bw⁻¹.d⁻¹, from Gd 8 until parturition. There was no difference between the aluminium treated groups and the control group regarding food consumption and weight gain of pregnant rats. Aluminium affected postnatal pups' survival but not in a dose dependent manner. The age of appearance of eye opening and mean body weight of pups did not differ between groups except for the body weight that was reduced on the first day postpartum in the treated groups compared to controls (Bernuzzi, Desor, and Lehr 1986). The LOAEL was 160 mg Al.kg bw⁻¹.d⁻¹.

Male Sprague-Dawley rats were exposed to aluminium nitrate nonahydrate through gavage, over 60 days prior to mating, at the following doses: 0, 180, 360 or 720 mg.kg bw⁻¹.d⁻¹. Female rats were exposed to similar doses for 14 days prior to mating (with male rat with the same exposure dose), during gestation, delivery and lactation. No reproductive toxicity was observed in male and female rats (Domingo et al. 1987a). NOAEL regarding male and female fertility was considered to be 720 mg.kg bw⁻¹.d⁻¹ of aluminium nitrate nonahydrate, equal to 52 mg Al.kg bw.d⁻¹.

Domingo et al. administered aluminium nitrate by gavage at doses of 0, 180, 360 or 720 mg.kg bw⁻¹.d⁻¹ (delivering 0, 13, 26 or 52 mg Al.kg bw⁻¹.d⁻¹) to pregnant Sprague Dawley rats (10 per group) from Gd14 to Gd21. Number of litters and number of live pups per litter were lower in all aluminium treated groups compared to controls. However, the decrease was not significantly dose dependent. At the highest dose of aluminium nitrate, the mean pup body weight was lower (Domingo et al. 1987c). The LOAEL was 13 mg Al.kg bw⁻¹.d⁻¹.

In another study, aluminium nitrate was administered to rats (Sprague Dawley, 10 per group), by gavage, from gestational day 6 to gestational day 14, at doses of 0, 180, 360 or 720 mg.kg bw⁻¹.d⁻¹ (delivering 0, 13, 26 or 52 mg Al.kg bw⁻¹.d⁻¹), then, rats underwent caesarean section on Gd20. Results showed that all groups exposed to aluminium nitrate had a significantly reduced body weight gain of dams compared to controls. The number of runt fetuses was higher, in an aluminium dose dependent manner. In addition, foetal body weight was reduced in all aluminium treated groups where severe signs of delayed ossification, increase congenital malformations and minor anomalies were observed (Paternain et al. 1988). The LOAEL was 13 mg Al.kg bw⁻¹.d⁻¹.

Bernuzzi et al. administered aluminium chloride (0, 100, 300 or 400 mg.kg bw⁻¹.d⁻¹ delivering 0, 20, 60 and 80mg Al.kg bw⁻¹.d⁻¹) or aluminium lactate (0, 100, 300 or 400 mg.kg bw⁻¹.d⁻¹ delivering 0, 9, 18 and 36 mg Al.kg bw⁻¹.d⁻¹), through diet, to pregnant Wistar rats from Gd1 to parturition. In the mid and high doses of aluminium chloride and in the high dose of aluminium lactate, a reduction of maternal body weight gain, higher postnatal mortalities and significant reduction of pup weights at birth and during postnatal development were observed compared to controls. Litter size at birth was similar in all the groups (Bernuzzi, Desor, and Lehr 1989a). The NOAEL was 20 mg Al.kg bw⁻¹.d⁻¹ in rats treated with aluminium chloride and 18 mg Al.kg bw⁻¹.d⁻¹ for those treated with aluminium lactate. The LOAEL were 60 and 36 mg Al.kg bw⁻¹, respectively for aluminium chloride and aluminium lactate.

In another study, aluminium lactate was administered through diet at 0 or 400 mg Al.kg bw⁻¹.d⁻¹ to pregnant Wistar rats during Gd1-Gd7 or Gd1-Gd14 or Gd1-parturition. The results showed no effect of aluminium on the litter size, mortality rate or weight of pups. Maternal body weight was significantly decreased on Gd16 and Gd19 in the group of rats treated during the whole

gestational period (Muller et al. 1990). The NOAEL for developmental effects was 400 mg Al.kg bw⁻¹.d⁻¹.

Wistar rats were administered, by gavage, aluminium chloride onGD6 to GD15 at doses delivering 0, 66, 132 or 264 mg Al.kg bw⁻¹.d⁻¹ (divided in two equal administrations.d⁻¹). Dams were killed on day 20 of gestation. No maternal toxicity nor embryotoxicity were reported in all groups (Gomez et al. 1990). The NOAEL was 264 mg Al.kg bw⁻¹.d⁻¹.

Female rats (Sprague-Dawley) were exposed for 15 days prior to mating, then during gestation, lactation and post-weaning period to 0, 50 or 100 mg Al.kg bw⁻¹.d⁻¹ as aluminium nitrate nonahydrate in drinking water (citric acid was added at 335 or 710 mg.kg bw⁻¹.d⁻¹) (Colomina et al. 2005). At 100 mg Al.kg bw⁻¹.d⁻¹, a decrease in the body weight of pups was observed from postnatal day 12 through 21. A delay in vaginal opening was reported from the dose of 50 mg Al.kg bw⁻¹.d⁻¹ and a delay in testes descent was reported from 100 mg Al.kg bw⁻¹.d⁻¹. The LOAEL for developmental toxicity was 50 mg Al.kg bw⁻¹.d⁻¹. In this study, a decrease in forelimb strength of pups was observed at 100 mg Al.kg bw⁻¹.d⁻¹. The LOAEL for neurodevelopmental effects was 100 mg Al.kg bw⁻¹.d⁻¹ for these effects and the NOAEL 50 mg Al.kg bw⁻¹.d⁻¹. Nevertheless, Sprague Dawley rats did not have alterations in performance of water maze test when exposed to 100 mg Al.kg bw⁻¹.d⁻¹ as aluminium lactate (NOAEL) from conception to sacrifice (at 1 year or 2 years old) (Roig et al. 2006). In this study, citric acid was added to the water and aluminium was administered at doses of 0, 50 or 100 mg Al.kg bw⁻¹.d⁻¹.

Wistar rats were exposed to aluminium chloride during gestational and lactation stages and then after weaning in their drinking water (0 or 3 g.L⁻¹ AlCl₃) until the age of 4 months. There was a significant increase of glial fibrillary acidic protein (GFA-P) -immunoreactive astrocytes in brain of aluminium treated rats who also had a significant reduced locomotor activity compared to controls. Also, rats exposed to aluminium preferred to spend more time in the lit compartment of a dark/light box, which indicates increased anxiety; this was not seen in rats only exposed to aluminium at adult age in this same study (Erazi et al. 2010). The LOAEL was 3000 mg aluminium chloride.L⁻¹, or 600 mg Al.L⁻¹.

In a study conducted according to GLP with a design based on OECD Test Guideline 426, Sprague Dawley pregnant rats were exposed to aluminium citrate through drinking water, starting gestational day 6, during gestation, lactation, and to offspring during post-weaning, through to PND 364, at doses delivering 30, 100 or 300 mg Al.kg bw⁻¹.d⁻¹. The study also included two control groups receiving either sodium citrate solution or deionised water. The concentration of aluminium in diet was reported to be less than 9 µg.kg⁻¹. On PND 4, there was a normalisation to 4 males and 4 females per litter assigned per number to each of four sacrifice day groups (day 23, day 64, day 120, day 364) associated with milestone observations and sacrifice. In the offspring, white precipitates were observed in the urinary tracts (test item precipitation) resulting in hydronephrosis, ureteral dilation and stone formation, this effect was considered related to aluminium-treatment and was most prominently observed in the high dose group, particularly in male pups, which resulted in higher mortality and morbidity rate in male pups of the high dose group. The high dose group was considered to be the maximum tolerated dose. In the middle dose group, urinary tract lesions, decreased body weight in males at PND 120, elevated fluid consumption and an exaggerated response to tail pinch and narrower foot splay in females were observed. There was also a decrease in hindlimb and forelimb grip strength in pups (significant in the mid- and high dose) that was dose related, although some of the effects may be secondary to body weight changes. No significant effects were reported for auditory startle response, T-maze tests or the Morris water maze test. The authors concluded a LOAEL of 100 mg Al.kg bw⁻¹.d⁻¹ and a NOAEL of 30 mg Al.kg bw⁻¹.d⁻¹ (Poirier et al. 2011).

Sun and al. conducted a study on male Wistar rats, exposed orally, for 120 days, to 0, 64.18, 128.36 or 256.72 mg.kg bw⁻¹.d⁻¹ of aluminium chloride in drinking water. Aluminium treated male rats had decreased levels of testosterone and luteinizing hormone (LH) when exposed to ≥ 128.36 mg.kg bw⁻¹.d⁻¹ compared to controls. In all aluminium treated groups, follicle-stimulating hormone (FSH) level did not show significant change compared to controls. However, androgen receptor protein expression and mRNA expression were lower than in control group (Sun et al. 2011). The LOAEL was 64.18 mg.kg bw⁻¹.d⁻¹ of aluminium chloride, equivalent to 13 mg Al.kg bw⁻¹.d⁻¹.

Female Wistar rats were administered 0, 64.18, 128.36, or 256.72 mg .kg bw⁻¹.d⁻¹ of aluminium chloride through their drinking water over 120 days. It was shown that aluminium exposed female rats, in the three aluminium exposure groups, had a significant decrease in serum levels of oestrogens, progesterone, FSH and LH in an Al dose-dependent manner, compared to the control group (Wang et al. 2012). The LOAEL was 64.18 mg.kg bw⁻¹.d⁻¹ of aluminium chloride, equivalent to 13 mg Al.kg bw⁻¹.d⁻¹.

Pregnant Wistar rats were divided into four groups: from the first day after birth, they received water containing 0, 0.2, 0.4 or 0.6% of aluminium chloride. Eight litters per group were kept and were exposed to aluminium chloride through lactation from parturition to weaning (3 weeks) and then were administered water containing 0, 0.2, 0.4, 0.6 % of aluminium chloride until 3 months age. Pups exposed to aluminium chloride had higher levels of aluminium in blood and hippocampus than controls and, aluminium caused pathological changes in neuronal and synaptic ultrastructure and impaired spatial memory ability in rats (Zhang et al. 2013). The LOAEL was 0.2 % aluminium chloride in drinking water, or 400 mg Al.L⁻¹.

Wistar male rats were orally exposed to 0, 64.18, 128.36 or 256.72mg.kg bw⁻¹.d⁻¹ of aluminium chloride for 120 days. Findings of this study (Zhu et al. 2014) showed that aluminium caused adverse effects on testicular function; exposed rats had a decrease in Zn and Fe testes content (mid and high dose), sperm count (mid and high dose) and enzyme activities of testicular ACP (acid phosphatase), LDH-x (lactate dehydrogenase isoenzyme) (mid and high dose), SDH (succinate dehydrogenase) and LDH (lactate dehydrogenase) (high dose) with an increase in Al and Cu contents (mid and high dose) and an increase in sperm malformation rate (in all the aluminium-treated groups, 31.24% in the highest exposed group vs 14.93% in the control group). LOAEL was 64.18 mg.kg bw⁻¹.d⁻¹ of aluminium chloride, equivalent to 13 mg Al.kg bw⁻¹.d⁻¹.

In 2014, Fu et al. exposed female Wistar rats to 0, 64, 128 or 256 mg.kg bw⁻¹.d⁻¹ of aluminium chloride in drinking water over 120 days. Results showed that AlCl₃-treated rats had a disruption in their ovary structure (at high dose), a decrease in the activities of ALP, ACP, SDH, Na⁺-K⁺-ATPase, Mg²⁺-ATPase and Ca²⁺-ATPase (from low dose), lower contents of Zn, Fe (from mid dose), lower protein expression of FSHR and LHR (from low dose) and an increase of Cu content (from mid dose) in the ovaries compared to controls. The authors concluded that sub-chronic exposure to aluminium chloride could damage the ovarian structure, suppress energy supply in the ovary, inhibit ovulation and corpus luteum development, resulting in sterility (Fu et al. 2014). LOAEL was 64 mg.kg bw⁻¹.d⁻¹ of aluminium chloride, equivalent to 12.96 mg Al.kg bw⁻¹.d⁻¹.

In a study by Martinez et al., Wistar male rats were orally exposed to aluminium chloride. The study included 2 experiments: experiment 1 with a control group and rats exposed over 60 days to 1.5 or 8.3 mg Al.kg bw⁻¹.d⁻¹ through drinking water and, experiment 2 with a control group and rats exposed over 42 days to 100 mg Al.kg bw⁻¹.d⁻¹. In these experiments aluminium was detected in germinative cells and even low concentrations in testes could alter spermatogenesis and sperm quality. In fact, aluminium increased oxidative stress in the reproductive organs and caused inflammation in testis (Martinez et al. 2017b). The LOAEL was 1.5 mg Al.kg bw⁻¹.d⁻¹.

Male Wistar rats were orally exposed, by gavage, to aluminium chloride at concentrations of 0, 6.7×10^{-5} , 3.35×10^{-4} , 10, and 40 mg.kg bw⁻¹.d⁻¹ for 112 days. In this study, rats exposed to doses from 6.7×10^{-5} mg.kg bw⁻¹.d⁻¹ had lower testis, parenchymal and epididymal weight and lower testosterone concentrations than control rats. No significant difference was reported between the low and the high exposure groups for these parameters. A significant lower sperm motility was observed in the highest dose group (40 mg.kg bw⁻¹.d⁻¹). Aluminium exposure did not alter the histology of testis and epididymis and sperm morphology (Mouro et al. 2018).

In another study, male Wistar rats (n=4 per group) were administered, through gavage for 90 days, 0 or 4.2 mg.kg bw⁻¹.d⁻¹ of aluminium chloride or 1 g ethanol.kg bw⁻¹.d⁻¹ or both. Rats exposed orally to aluminium or ethanol had a loss of normal distribution of spermatogenic cells in the seminiferous tubules and few fragmented sperms in the lumen. More adverse effects were observed in rats exposed concomitantly to ethanol and aluminium and, the authors concluded that ethanol increases the impact of aluminium on testis (Ghosh, Kant Sharma, and Yadav 2021a). LOAEL was 4.2 mg.kg bw⁻¹.d⁻¹ of aluminium chloride, or 0.85 mg Al.kg bw⁻¹.d⁻¹.

In another study of Gosh et al., female Wistar rats (n=4 per group) were also exposed orally and for 3 months, through gavage, to 0 or 4.2 mg.kg bw⁻¹.d⁻¹ of aluminium chloride with or without 1 g ethanol.kg bw⁻¹.d⁻¹. A significant increase of atretic follicles with degenerated ova and vacuolation was seen in the ovary of aluminium treated rats in addition to the rupture of zona pellucida in oocyte. In this study, authors also observed that ethanol increased the impact of aluminium on the ovary (Ghosh et al. 2021b). LOAEL was 4.2 mg.kg bw⁻¹.d⁻¹ of aluminium chloride, equivalent to 0.85 mg Al.kg bw⁻¹.d⁻¹.

Multigeneration studies:

Hirata-Koizumi et al. conducted a multigeneration GLP-compliant study to evaluate the effect of aluminium on reproduction and development. Twenty-four male and 24 female Crl:CD (SD) rats were given, through water, 0, 120, 600 or 3000 mg.L⁻¹ of aluminium sulphate from the age of 5 weeks for 10 weeks prior to mating, during mating and gestation (Generation F0). Males were then sacrificed, and females were also exposed through weaning and then sacrificed. At weaning, 24 male and 24 female pups were considered as generation F1 and were given the aluminium sulphate for 10 weeks prior to mating, during mating and gestation, and, for the females, through weaning, same exposure scheme as F0. Aluminium exposure from the diet and drinking water were reported. At the three aluminium sulphate concentrations, a decrease in water consumption was observed and linked to the pH of water. It was associated with a decrease of food consumption in the 600 and 3000 mg.L⁻¹ groups and a decrease of body weight in the 3000 mg.L⁻¹ group. There was a decrease in preweaning body weight gain in the F1 & F2 pups in the 3000 mg.L⁻¹ group in addition to a decrease in the liver and spleen weight at weaning. In addition, at 3000 mg.L⁻¹ there was a slight delay in the vaginal opening. On another hand, aluminium did not cause changes in other reproductive and developmental parameters and no developmental neurobehavioral toxicity was reported. The NOAEL was considered to be 600 mg.L⁻¹ equivalent to 41 mg.kg bw⁻¹.d⁻¹ of aluminium sulphate. Considering the intake from food and drinking water, NOAEL was 8.06 mg Al.kg bw⁻¹.d⁻¹ (Hirata-Koizumi et al. 2011b). The LOAEL was considered to be 3000 mg.L⁻¹ (188 mg.kg bw⁻¹.d⁻¹) of aluminium sulphate equivalent to 31.2 mg Al.kg bw⁻¹.d⁻¹ considering intake from food and water.

Another two-generation GLP-compliant study was conducted by Hirata-Koizumi et al. and included 24 male and 24 female Crl:CD(SD) rats (F0) who were exposed to either 0, 50, 500 or 5000 mg.L⁻¹ of aluminium ammonium sulphate through drinking water at 5 weeks of age for 10 weeks. Afterwards female rats were mated with males from the same dosage group. F0 male rats were killed after parturition and F0 females were necropsied after weaning of their offsprings but were administrated aluminium ammonium sulphate during mating, gestation and

lactation periods. At weaning, 24 male and 24 female pups were identified to be generation F1 and were exposed as generation F0, to aluminium ammonium sulphate for 10 weeks before mating, during mating and gestation and during weaning for females. Aluminium exposure from diet was reported. A decrease in water consumption was reported in all treated groups but was related to the low pH of drinking water. At 5000 mg.L⁻¹ there was a transient body weight decrease in parental rats. Female and male reproductive performance were not affected by aluminium treatment (oestrous cycle, copulation, fertility index, precoital interval, gestation length, number of implantations, number of pups delivery, delivery index, sperm parameters), changes in reproductive organs were not reported and, in F1 and F2 pups there were no malformations, sex ratio or viability difference with the control group. A decrease in body weight was reported in male and female F1 pups on PND 21 and 14 & 21, respectively and on PND 26 in F2 pups (the reduced preweaning body weight gain might be due to decrease in water consumption). However, there was no difference in body weight at birth between control groups and aluminium treated groups. Vaginal opening was delayed in F1 female pups at 5000 mg.L⁻¹; no differences were reported regarding time of preputial separation in F1 male pups. In F1 and F2 weanlings, there was a decrease in liver, spleen and thymus weight at 5000 mg.L⁻¹ without histopathological changes. There was no aluminium treatment effect on locomotor activity, righting reflex and negative geotaxis reflex. The authors considered the NOAEL to be 500 mg.L⁻¹ of aluminium ammonium sulphate equivalent to 33.5 mg.kg bw⁻¹.d⁻¹ expressed as aluminium 3.81 mg.kg bw⁻¹.d⁻¹. Considering diet aluminium intake, the calculated total aluminium level was 5.35 mg Al.kg bw⁻¹.d⁻¹ (Hirata-Koizumi et al. 2011a). The LOAEL was considered to be 5000 mg.L⁻¹ of aluminium ammonium sulphate; considering combined intake from food and drinking water, LOAEL was 305 mg.kg bw⁻¹.d⁻¹ and 36.3 mg Al.kg bw⁻¹.d⁻¹.

■ Gerbils

A recent study aimed at assessing the effect of prenatal aluminium exposure on gerbils' prostate. Pregnant gerbils (*Meriones unguiculatus*) were orally exposed, by gavage, to 0 or 100 mg.kg bw⁻¹.d⁻¹ of aluminium chloride (delivering 20.2 mg Al.kg bw⁻¹.d⁻¹; 1/35 LD50) during Gd17 to GD24. Following birth, males and female gerbils were separated and euthanized at either PN1 or PN90 (8 pups per group). A decrease in the body weight of PN1 males and females, a reduced anogenital distance of PN1 females, changes in the prostate developmental patterns of PN1 animals causing an increase in proliferative status and a decrease in the immunostaining of androgen receptor were reported in the aluminium exposed groups. These effects were permanent as some were also observed in the adult gerbils (Gomes et al. 2019). The LOAEL was 20.2 mg Al.kg bw⁻¹.d⁻¹.

The authors conducted another study aiming to assess the effect of aluminium neonatal exposure on the male and female paraurethral gland of gerbils. Male and female gerbils (8 per group) were exposed, by gavage, to 0 or 10 mg.kg bw⁻¹.d⁻¹ of aluminium chloride (delivering 2.02 mg Al.kg bw⁻¹.d⁻¹; 1/345 LD50), from day PND1 to PND14. Aluminium caused morphological changes in the ventral male paraurethral gland (intensified prostate branching morphogenesis with greater length, number and area of prostatic epithelial buds and, increased immunostaining of the androgen receptor) and in the female paraurethral gland (up regulation of the androgen receptor and oestrogen receptor α) and altered the prostate hormonal regulation of males and females (Gomes et al. 2020). The LOAEL was 2.02 mg Al.kg bw⁻¹.d⁻¹.

Male and female gerbils (*Meriones unguiculatus*) orally exposed over 30 days to 10 mg.kg bw⁻¹.d⁻¹ to aluminium chloride showed toxic effects on their paraurethral gland and gonads (Da Silva Lima et al. 2020). In another study, with the same exposure design, male gerbils had a paraurethral gland increased cell proliferation, glandular hyperplasia, increased secretory activity and greater androgen receptor immunoreactivity when euthanized one day after the

aluminium treatment. When gerbils were euthanized 30 days after the end of the treatment, a partial recovery of the prostate was observed in males, however, in females, 30 days recovery was not enough for paraurethral glands healing (Da Silva Lima et al. 2022). LOAEL for both studies was $10 \text{ mg.kg bw}^{-1}.\text{d}^{-1}$ of aluminium chloride, equivalent to $2.024 \text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$.

■ Rabbits

Four New Zealand rabbit groups were given through gavage, ascorbic acid ($40 \text{ mg.kg bw}^{-1}.\text{d}^{-1}$) or aluminium chloride ($34 \text{ mg.kg bw}^{-1}.\text{d}^{-1}$) or ascorbic acid & aluminium chloride. Results showed that rabbits exposed to $34 \text{ mg.kg bw}^{-1}.\text{d}^{-1}$ of aluminium chloride over 16 weeks had a significant decrease in feed intake, body weight, relative weights of testes and epididymis, means of semen ejaculated volume, sperm concentration, total sperm output, sperm motility, total sperm ejaculate and libido (Yousef, El-Morsy, and Hassan 2005). LOAEL was $34 \text{ mg.kg bw}^{-1}.\text{d}^{-1}$ of aluminium chloride equivalent to $6.8 \text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$.

■ Guinea pigs

Hartley guinea pigs inhaling 0.065, 0.65 or 6.5 mg Al.m^{-3} as aluminium chlorohydrate over 6 months had no histological changes in their reproductive tissues (Steinhagen, Cavender, and Cockrell 1978). The NOAEL is 6.5 mg Al.m^{-3} .

■ Dogs

Male ($n=4$) and female ($n=4$) beagle dogs were fed diets containing 0, 3 000, 10 000 or 30 000 mg basic sodium aluminium phosphate per kg over 26 weeks. This exposure is equivalent to 4, 10, 27 or 75 and 3, 10, 22 or 80 $\text{mg Al.kg bw}^{-1}.\text{d}^{-1}$ for male and female dogs respectively. In the high dose group, males had a decrease in food consumption and in body weight associated with testicular changes. NOAEL for male dogs was considered to be $27 \text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$ (Pettersen et al. 1990).

Table 16. Animal studies on aluminium reproductive toxicity

Strain	Duration and exposure route	Dose	Al Compound	Endpoint	NOAEL	LOAEL	Reference
Mice							
BALB/c (n≈ 6 per group)	Gd7-Gd16 Gavage	0 (ip), 200, 300 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Increased incidence of resorptions		41 mg Al.kg bw ⁻¹ .d ⁻¹	Cranmer et al. (1986)
Swiss-Webster (n= 16 per group)	Gd1-Ld21 In diet	25 (control), 500 or 1000 µg Al.g ⁻¹ .diet ⁻¹	Aluminium lactate	Altered gestational length from 500 µg Al.g ⁻¹ diet		155 mg Al.kg bw ⁻¹ .d ⁻¹	Donald et al. (1989)
Swiss-Webster (Control: n=14, Al group: n=9)	Gestation and lactation In diet	25 (control) or 1000 µg Al.g ⁻¹ diet	Aluminium lactate	No effects on litter size, birth weight, crown-rump length, or sex ratio	250 mg Al.kg bw ⁻¹ .d ⁻¹		Golub et al. (1992a)
Rats							
Fischer-344 (n=20 per group)	6 months (5d/wk and 6hr.d ⁻¹) Inhalation	0, 0.065, 0.65 or 6.5 mg Al.m ⁻³	Aluminium chlorohydrate	Histological changes in reproductive tissues	6.5 mg Al.m ⁻³		Steinhagen et al. (1978)
Sprague-Dawley (number not reported)	Males: 60 days prior mating Females 14 days prior to mating till end of lactation Gavage	0, 180, 360 or 720 mg.kg bw ⁻¹ .d ⁻¹	Aluminium nitrate nonahydrate	No reproductive toxicity (male and female fertility)	52 mg Al.kg bw ⁻¹ .d ⁻¹		Domingo et al. (1987a)
Wistar (n=10 per group)	120 days Drinking water	0, 64.18, 128.36 or 256.72 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Lower androgen receptor protein expression and mRNA expression		13 mg Al.kg bw ⁻¹ .d ⁻¹	Sun et al. (2011)

Wistar (n=10 per group)	120 days Drinking water	0, 64.18, 128.36, or 256.72 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Decrease in serum levels of oestrogen, progesterone, FSH and LH		13 mg Al.kg bw ⁻¹ .d ⁻¹	Wang et al. (2012)
Wistar (n= 10 per group)	120 days Drinking water	0, 64.18, 128.36 or 256.72 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Increase in sperm malformation rate		13 mg Al.kg bw ⁻¹ .d ⁻¹	Zhu et al. (2014)
Wistar (n= 20 per group)	120 days Drinking water	0, 64, 128 or 256 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Lower protein expression of FSHR and LHR and lower energy supply in the ovary		12.96 mg Al.kg bw ⁻¹ .d ⁻¹	Fu et al. (2014)
Wistar (n= 6 per group)	60 days Drinking water	1.5 or 8.3 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Alteration of spermatogenesis and sperm quality		1.5 mg Al.kg bw ⁻¹ .d ⁻¹	Martinez et al. (2017b)
	42 days Gavage	100 mg Al.kg bw ⁻¹ .d ⁻¹					
Wistar (n= 5 per group)	112 days Gavage	0, 6.7×10 ⁻⁵ , 3.35×10 ⁻⁴ , 10, and 40 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Lower testis, parenchyma and epididymal weight and lower testosterone concentrations		6.7× 10 ⁻⁵ mg.kg bw ⁻¹ .d ⁻¹	Mouro et al. (2018)
Wistar (n=4 per group)	90 days Gavage	0 or 4.2 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Loss of normal distribution of spermatogenic cells in the seminiferous tubules and few fragmented sperms in the lumen		0.85 mg Al.kg bw ⁻¹ .d ⁻¹	Gosh et al. (2021)
Wistar (n=4 per group)	3 months Gavage	0 or 4.2 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Atretic follicles with degenerated ova and vacuolation, rupture of zona pellucida in oocyte		0.85 mg Al.kg bw ⁻¹ .d ⁻¹	Gosh et al. (2021)
Gerbils							
Meriones unguiculatus (n= 20 for	30 days Gavage	0 or 10 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Toxic effect on paraurethral gland and gonads		2.024 mg Al.kg bw ⁻¹ .d ⁻¹	Da Silva Lima et al. (2020)

each sex per group)							
Meriones unguiculatus (n= 20 for each sex per group)	30 days Gavage	0 or 10 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Toxic effect on paraurethral gland		2.024 mg Al.kg bw ⁻¹ .d ⁻¹	Da Silva Lima et al. (2022)
Rabbits							
New Zealand (n= 6 per group)	16 weeks Gavage	34 mg.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Reduced semen quality		6.8 mg Al.kg bw ⁻¹ .d ⁻¹	Yousef et al. (2005)
Guinea pigs							
Hartley (n= 20 per group)	6 months (5d/wk, 6hr.d ⁻¹) Inhalation	0, 0.065, 0.65 or 6.5 mg Al.m ⁻³	Aluminium chlorohydrate	Histological changes in reproductive tissues	6.5 mg Al.m ⁻³		Steinhagen et al. (1978)
Dogs							
Beagle (n= 4 for each sex per group)	26 weeks In diet	4, 10, 27 or 75 and 3, 10, 22 or 80 mg Al.kg bw ⁻¹ .d ⁻¹ for male and female	Aluminium phosphate	Decrease in food consumption and in bw associated with testicular changes	27 mg Al.kg bw ⁻¹ .d ⁻¹	75 mg Al.kg bw ⁻¹ .d ⁻¹	Pettersen et al. (1990)

Table 17. Animal studies on aluminium developmental toxicity

Stain	Duration and exposure route	Dose	Al Compound	Endpoint	NOAEL	LOAEL	Reference
Mice							
Swiss Webster F0 (n= 16 per group) F1 (n= 4/ litter)	Gd1-Ld21 In diet	25, 500 or 1000 mg Al.kg ⁻¹ diet	Aluminium lactate	No effects on birth weight, peri and post-natal pup mortality	310 mg Al.kg bw ⁻¹ .d ⁻¹		Donald et al. (1989)
Swiss F0 (n= 20 per group)	Gd6 to Gd15 Gavage	0, 23, 46 or 92 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium hydroxide	No signs of embryotoxicity including morphological abnormalities	92 mg Al.kg bw ⁻¹ .d ⁻¹		Domingo et al. (1989)
Swiss (DD1) F0 (n= 10-13 per group)	Gd6 to Gd15 Gavage	0 or 57.4 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium lactate	Reduced foetal body weight, cleft palate and delayed foetal ossification		57.4 mg Al.kg bw ⁻¹ .d ⁻¹	Colomina et al. (1992)
Swiss (DD1) F0 (n= 10-13 per group)	Gd6 to Gd15 Gavage	0 or 57.4 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium hydroxide		57.4 mg Al.kg bw ⁻¹ .d ⁻¹		Colomina et al. (1992)
Swiss (number not reported)	Gd6 to Gd15 Gavage	0, 103 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium hydroxide	No developmental effects	103 mg Al.kg bw ⁻¹ .d ⁻¹		Colomina et al. (1994)
CD-1 F0 (n= 10-14 per group)	One day between Gd8-Gd12 Gavage	0 or 71 mg Al.kg bw ⁻¹	Aluminium nitrate	Reduced foetal body weight, reduced ossification		71mg Al.kg bw ⁻¹	Albina et al. (2000)

Rats							
Wistar	Gd 8 until parturition In diet	0, 160 or 200 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Reduced pup weight on PND1		160 mg Al.kg bw ⁻¹ .d ⁻¹	Bernuzzi et al. (1986)
Sprague Dawley	Gd14 to Gd21 Gavage	0, 13, 26 or 52 mg Al.kg bw ⁻¹ .d ⁻¹)	Aluminium nitrate	Reduced number of litters and live pups per litter		13 mg Al.kg bw ⁻¹ .d ⁻¹	Domingo et al. (1987c)
Sprague Dawley F0 (n= 10 per group) F1 (n= more than half of the foetuses)	Gd6 to Gd 14 Gavage	0, 13, 26 or 52 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium nitrate	Higher number of runt foetuses, reduced bw, delayed ossification, increase of congenital malformations and minor anomalies		13 mg Al.kg bw ⁻¹ .d ⁻¹	Paternain et al. (1988)
Wistar F0 (n= 6 to 12 per group)	Gd1 to parturition In the diet	0, 20, 60 and 80mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Reduction of pup weight, higher postnatal mortalities	20 mg Al.kg bw ⁻¹ .d ⁻¹	60 mg Al.kg bw ⁻¹ .d ⁻¹	Bernuzzi et al. (1989a)
Wistar F0 (n= 6 to 10 per group)	Gd1 to parturition In the diet	0, 9, 18 and 36 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium lactate	Reduction of pup weight, higher postnatal mortalities	18 mg Al.kg bw ⁻¹ .d ⁻¹	36 mg Al.kg bw ⁻¹ .d ⁻¹	Bernuzzi et al. (1989a)
Wistar rats F0 (n= 6 to 9 per group)	Gd1-Gd7 or Gd1-Gd14 or Gd1-parturition In the diet	0 or 400 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium lactate	No effect of on the litter size, mortality rate or weight of pups	400 mg Al.kg bw ⁻¹ .d ⁻¹		Muller et al. (1990)
Wistar F0 (n= 18-19 per group)	Gd6 to 15 Gavage	0, 66, 132 or 264 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	No embryotoxicity		264 mg Al.kg bw ⁻¹ .d ⁻¹	Gomez et al. (1990)

Sprague Dawley F0 (n= 11 to 17 per group) F1 (n= 8 per litter)	15-day premating to post-weaning In water	0, 50 or 100 mg Al.kg bw ⁻¹ .d ⁻¹ + citric acid	Aluminium nitrate nonahydrate	Delay in vaginal opening	50 mg Al.kg bw ⁻¹ .d ⁻¹		Colomina et al. (2005)
Crl:CD (SD)	Multigeneratio nal GLP- compliant study In water	0, 120, 600 or 3000 mg.L ⁻¹	Aluminium sulphate	Decrease in preweaning bw, decrease in liver & spleen weight at weaning, delayed vaginal opening	8.06 mg Al.kg bw ⁻¹ .d ⁻¹	31.2 mg Al.kg bw ⁻¹ .d ⁻¹	Hirata- Koizumi et al. (2011b)
Crl:CD (SD)	Multigeneratio nal GLP- compliant study In water	0, 50, 500 or 5000 mg.L ⁻¹	Aluminium sulphate	Delayed vaginal opening in F1 female, decrease in liver, spleen and thymus weight	3.81 mg.kg bw ⁻¹ .d ⁻¹	36.3 mg Al.kg bw ⁻¹ .d ⁻¹	Hirata- Koizumi et al. (2011a)
Gerbils							
Meriones unguiculatus F0 (n=10 per group) F1 (n=8 per group)	Gd 17 to 24 Gavage	0 or 20.2 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Decrease in bw of PN1, changes in the prostate developmental patterns of PN1		20.2 mg Al.kg bw ⁻¹ .d ⁻¹	Gomes et al. (2019)
Meriones unguiculatus (n= 8 of each sex per group)	PND 1 to 14 Gavage	0 or 2.02 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Morphological changes in the ventral male prostate and female prostate		2.02 mg Al.kg bw ⁻¹ .d ⁻¹	Gomes et al. (2020)

Table 18: Animal studies on aluminium neurodevelopmental toxicity

Strain	Duration and exposure route	Dose	Al Compound	Endpoint	NOAEL	LOAEL	Reference
Mice							
Swiss Webster (F0= 16 per group) F1 (n= 4/ litter)	From conception to Ld21 In diet	25 (control), 500 or 1000 µg Al.g ⁻¹ diet	Aluminium lactate	Decreased forelimb, increased hindlimb grip strength, increased foot splay in weanlings		155 mg Al.kg bw ⁻¹ .d ⁻¹	Donald et al. (1989)
Swiss-Webster F0 (n= 9-14 per group) F1 (n= 2 pups per litter)	G: Gd1 -Gd19 or G+ D: Gd1 - Ld21 or L: Ld1-Ld21 In diet	25 (control) or 1000 µg Al.g ⁻¹ diet	Aluminium lactate	Decrease forelimb grip strength (G), increase in hindlimb grip strength and tail withdrawal times (gestation and lactation groups), increase in negative geotaxis latency (L)		250 mg.kg bw ⁻¹ .d ⁻¹	Golub et al. (1992a)
Swiss-Webster (n= 8 males and females per group)	From conception to weaning In diet	7 (control), 500 or 1000 µg Al.g ⁻¹ diet	Aluminium lactate	Decrease in forelimb and hindlimb grip strength and in the startle response		155 mg Al.kg bw ⁻¹ .d ⁻¹	Golub et al. (1995)
Swiss Webster (n= 8 per group)	From conception to PND 35 In diet	7 (control), 500, or 1000 µg Al.g ⁻¹ diet	Aluminium lactate	Performance of the Delayed spatial Alternation task	330 mg Al.kg bw ⁻¹ .d ⁻¹		Golub and Germann (1998)
Swiss Webster (n= 18 per group)	Conception – month 24 of age In diet	7 (control) or 1000 µg Al.g ⁻¹ diet	Aluminium lactate	Decreased forelimb and hindlimb strength, decreased thermal activity		100 mg Al.kg bw ⁻¹ .d ⁻¹	Golub et al. (2000)
Swiss Webster (n = 20 per group)	From conception to PND 35 In diet	7 (control), 100, 500, or 1000 µg Al.g ⁻¹ diet	Aluminium lactate		26 mg Al.kg bw ⁻¹ .d ⁻¹	130 mg Al.kg bw ⁻¹ .d ⁻¹	Golub and German (2001)

Swiss-Webster (n= 21 pups per group)	From Gd1 to PND15 In water	0, 300 or 600 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium chloride	Deficit in locomotor activity, learning capacity and cognitive behaviours		300 mg Al.kg bw ⁻¹ .d ⁻¹	Abu Taweel et al. (2012)
Rats							
Sprague Dawley F0 (n= 11-17 per group) F1 (n= 1 male & 1 female of each litter)	15 days pre mating and from Gd1 to Ld21 In water	0, 50 or 100 mg Al.kg bw ⁻¹ .d ⁻¹ (+citric acid added)	Aluminium nitrate	Decreased forelimb grip	50 mg Al.kg bw ⁻¹ .d ⁻¹	100 mg Al.kg bw ⁻¹ .d ⁻¹	Colomina et al. (2005)
Sprague Dawley (n=17-21 per group)	Conception- 1 or 2 years old In water	0, 50 or 100 mg Al.kg bw ⁻¹ .d ⁻¹ (+citric acid added)	Aluminium lactate	Performance of water maze test	100 mg Al.kg bw ⁻¹ .d ⁻¹		Roig et al. (2006)
Wistar (n= 10 per group)	From conception to 4 months age In water	0 or 3 g.L ⁻¹ AlCl ₃	Aluminium chloride	Increased GFA-P astrocytes in brain, increased anxiety, reduced locomotor activity		600 mg Al.L ⁻¹	Erazi et al. (2010)
Sprague Dawley F0 (n= 20 per group) F1 (n=4 of each sex per litter)	From Gd6 to PND 364 In water	0, 30, 100 or 300 mg Al.kg bw ⁻¹ .d ⁻¹	Aluminium citrate	Decrease in hindlimb and forelimb grip strength (+other effects)	30 mg Al.kg bw ⁻¹ .d ⁻¹	100 mg Al.kg bw ⁻¹ .d ⁻¹	Poirier et al. (2011)
Wistar (n= 8 per group)	From parturition to 3-month age In water	0, 0.2, 0.4 or 0.6% of AlCl ₃	Aluminium chloride	Pathological changes in neuronal and synaptic ultrastructure and impaired spatial memory ability		400 mg Al.L ⁻¹	Zhang et al. (2013)

4.9 Macrophagic myofasciitis

Macrophagic myofasciitis (MMF) is an inflammatory condition characterised by specific muscle lesions infiltrated by macrophages containing aluminium crystal inclusions and was reported for the first time in 1982 (Mrak 1982). This lesion generally results from aluminium adjuvant depots after vaccine injection. Though the duration of this phenomenon after vaccination is not known and could be variable from an individual to another, there is no indication that it is pathologic.

More recently, French authors published from 1998 to 2023, clinical and experimental studies with the aim to establish an association between MMF and a systemic syndrome diversely associating diffuse myalgias, arthralgias, fatigue, muscle weakness, fever and cognitive alterations' (Gherardi et al. 1998; Eickhoff and Myers 2002; HCSP 2013; J.-P. Goullé and Grangeot-Keros 2020). However, the published studies suffer several methodologic flaws: inclusion criteria of the patients in the cohort are not presented; the relative frequencies of the signs and symptoms constituting the syndrome, as well the sex ratio of the patients in the cohort are broadly fluctuating from a publication to another. The cohort is constituted of patients with a biopsy of the deltoid showing a MMF and also complaining for the systemic syndrome described above. There is (as ethically expected) no control group with no systemic complaint and results of a deltoid biopsy.

Finally, MMF as a local reaction after intramuscular injection of an aluminium-adjuvanted vaccine is a largely documented phenomenon. There is no demonstration that it is or can be causally associated with a systemic syndrome or illness. Strong arguments against a causal link are that this association has been quasi-exclusively described in France and by the same authors and rarely in children, though the latter constitute the fraction of the population with the bigger exposure to aluminium adjuvanted vaccines (Gherardi et al. 1998; Eickhoff and Myers 2002; HCSP 2013; J.-P. Goullé and Grangeot-Keros 2020).

Evaluations by Afssaps (2004) Scientific Committee and by HCSP (2013) both concluded that there is no evidence that MMF following intramuscular injection of aluminium-adjuvanted vaccines is causally associated with one or more systemic manifestations (Afssaps 2004; HCSP 2013).

In 2022, the US Centers for Disease Control and Prevention (CDC) acknowledged an observational study in which a possible association between exposure to vaccine aluminium and the subsequent development of persistent asthma in a cohort of children was identified (Daley et al. 2023). This finding is considered by the CDC to be a health signal but does not call into question the assessment of the risk of exposure to aluminium after following the vaccination schedule (Mitkus et al. 2011).

4.10 Genotoxicity

Since the aluminium salts are able to induce an oxidative stress, they could possibly induce mutagenicity *in vivo* using this mechanism of action.

4.10.1 *In vitro* studies

In studies documented in EFSA's report, aluminium ion (Al^{3+}) was proved to interact with DNA *in vitro* by binding to phosphate oxygen. Several aluminium compounds showed negative

results in bacterial mutagenicity assays and in mammalian cells in vitro and, others produced DNA damage (EFSA 2008). These studies are reported below.

Aluminium lactate at concentration of 1.8 - 5.5 $\mu\text{mol/plate}$ gave negative response in the reverse mutation test using various *Salmonella typhimurium* strains (Gava et al. 1989). Negative results were also observed for aluminium fluoride at 0.02-119 $\mu\text{mol/plate}$ (Shimizu et al. 1985), aluminium silicate at 0.96 - 38.5 $\mu\text{mol/plate}$ (Zeiger et al. 1987), sodium aluminium silicate at 0.36 - 108.1 $\mu\text{mol/plate}$ (Prival, Simmon, and Mortelmans 1991), aluminium chloride hexahydrate at 0-100 nmol/plate (Marzin and Phi 1985), aluminium sulphate up to 5000 $\mu\text{g/plate}$ (ECHA, Registration dossier) and aluminium chloride at concentrations of 0.3 and 3.0 mg.L^{-1} in an assay carried out in suspension culture (Ahn and Jeffery 1994).

In other studies, bacterial tryptophan reverse mutation assay using *Escherichia coli* WP2 strain, showed negative responses with aluminium chloride, aluminium fluoride, calcium aluminosilicate and sodium aluminium silicate to induce gene mutations (Seo, and Lee 1993; Shimizu et al. 1985; Prival, Simmon, and Mortelmans 1991).

No mutagenic activity was induced by aluminium oxide, aluminium chloride or aluminium sulphate at concentrations of 1-10 mM in the rec-assay using *Bacillus subtilis* strains (ATSDR 2006).

In L5178Y mouse lymphoma assay, no forward mutations were detected with aluminium chloride at concentrations up to 625 μg aluminium chloride. mL^{-1} (Oberly, Piper, and McDonald 1982).

The induction of micronuclei in human lymphocytes was increased following exposure to aluminium sulphate (exposure for 48 h after PHA stimulation) (Migliore et al. 1999) and to aluminium chloride (with a decrease at high dose correlated to an increase of apoptosis) (Banasik et al. 2005). Paz et al. have also observed a significant increase in the quantity of micronucleus in human lymphocytes (from the peripheral blood) exposed to aluminium chloride at concentrations of 5 μM , 10 μM and 20 μM (Paz et al. 2017).

Effects of aluminium chloride (1, 2, 5, 10 and 25 $\mu\text{g.mL}^{-1}$) on DNA damage and apoptosis in human lymphocytes were assessed using a comet assay. The results showed a dose-dependent increase in DNA damage up to the dose of 10 $\mu\text{g.mL}^{-1}$ of aluminium chloride and decline at 25 $\mu\text{g.mL}^{-1}$ due to increase in apoptosis (Lankoff et al. 2006). The authors then evaluated the effect of aluminium on DNA repair and found that aluminium chloride treated cells had a decreased capacity of DNA repair compared to controls (Lankoff et al. 2006). Lima et al. have also observed aluminium induced DNA damage in human lymphocytes in addition to structural chromosomal aberrations (Lima et al. 2007).

In the study by Tenan et al. (2021), on V79 hamster lung fibroblasts exposed to aluminium, dose-dependent increases in DNA double strand breaks, and chromosome numerical abnormalities (aneuploidy) as well as arrest in the G2/M phase of the cell cycle, were observed. Additionally, during mitosis, abnormal multipolar mitotic spindles were detected (SCCS 2023).

4.10.2 *In vivo* studies

In vivo genotoxicity studies in rodents showed a clastogenic potential of aluminium (EFSA 2008).

In a study by Manna and Das (1972), mice intraperitoneally injected with aluminium chloride exhibited a significant increase in chromosome aberrations in the bone marrow. However, no clear dose-response relationship was observed (ATSDR 2008; EFSA 2008).

As stated in EFSA (2008), the administration of aluminium sulphate (17, 22, 28, 43, 85 or 172 $\text{mg Al}^{3+}.\text{kg bw}^{-1}$) or aluminium potassium sulphate (28 or 43 $\text{mg Al}^{3+}.\text{kg bw}^{-1}$) to rats by gavage,

daily over 21 days, led to a dose-dependent inhibition of cell division and an increase in chromosome aberrations, in the bone marrow (Roy, Sharma, and Talukder 1991). Furthermore, a dose-dependent induction of micronuclei was observed in the bone marrow of mice injected intraperitoneally with aluminium sulphate (2 doses, 24 hours apart). Aluminium sulphate also induced sister chromatid exchanges in the bone marrow of mice injected intraperitoneally, in a dose related manner (Roy, Dhir, and Sharma 1992).

In a study by Paz et al., Swiss mice (n= 8 per group) were orally administered hydrated aluminium chloride at 0, 49, 98 or 161 mg Al.kg bw⁻¹ to assess aluminium's possible genotoxic activity using micronucleus test. The study included a negative control and a positive control group. An increase of micronucleus number was observed in all aluminium concentration groups and significant alterations in all the evaluated organs were identified and verified by the presence of irreversible lesions (Paz et al. 2017).

In another study, Sprague Dawley rats (n= 8 per group) were gavaged with 0 or 2000 mg.L⁻¹ aluminium (as aluminium chloride) 5 days/week for 90 days with or without N-nitroso-N-methyl urea (NMU) induction of breast cancer. A higher number of micronucleus count in peripheral blood erythrocytes was observed following the exposure to +2000Al/-NMU and -Al/+NMU treatments indicating that treatment containing only aluminium can independently cause genotoxicity in rats. Furthermore, comets were observed after 10 and 15 days in the Comet Assay in rats receiving the +2000Al/-NMU treatment (García-Alegría et al. 2020).

As stated in the recent opinion by SCCS, in the study by Mandriota et al. (2020), normal mouse mammary epithelial cells after long-term culture in the presence of aluminium chloride formed tumours and metastases when injected into syngeneic and immunocompetent BALB/cByJ mice. Aluminium chloride rapidly increased chromosomal structural abnormalities in the cultured cells (SCCS 2023).

In the study of Jalili et al., acute exposure to aluminium chloride (25 mg.kg bw⁻¹ through gavage) induced slight but non-significant oxidative DNA damage in peripheral blood lymphocytes of Sprague-Dawley rats (n= 5 per group). No increase of micronuclei in both bone marrow cells and in colon was observed (Jalili et al. 2020).

EFSA (2008) stated that aluminium had genotoxic effects at high level of exposure, not relevant for human exposure through the diet. Nevertheless, an in vivo mammalian erythrocyte micronucleus test combined with in vivo mammalian alkaline comet assay with aluminium oxide has been requested by ECHA, but the test has not been performed yet. The results of this study may better clarify the assessment on the potential of aluminium salts to induce genotoxicity, as stated by SCCS in its latest opinion (SCCS 2023).

4.11 Carcinogenicity

4.11.1 Human data

According to the International agency for research on cancer (IARC), there is sufficient evidence in humans for the carcinogenicity of aluminium production using the Söderberg process. This activity is associated with elevated incidences of cancers of bladder and lung. These cancer hazards associated with aluminium production mainly result from exposure to polycyclic aromatic hydrocarbons (PAHs) rather than from exposure to aluminium or its related compounds (INRS 2021).

Based on the quantification of aluminium in breast cancer tissues, a potential link between antiperspirants and breast cancer was suggested by some authors, alongside observations of a high incidence of breast cancer in the upper outer quadrant, adjacent to the area of typical application of deodorants and/or antiperspirants (Darbre 2005; Exley et al. 2007). Epidemiological studies had assessed the association between exposure to aluminium through cosmetics containing aluminium and the risk of breast cancer but none of them established a causal link between aluminium exposure and breast cancer. It has been suggested that a reverse causal effect cannot be excluded, implying that the breast tumour could accumulate aluminium (Linhart et al. 2017).

The SCCS conducted safety assessments of aluminium exposure through cosmetic products on four occasions since 2014 (in 2014, 2020, 2023, and 2024). It concluded that despite the known genotoxic effects of aluminium, which may potentially contribute to the development of breast cancer, the existing data from both animal and epidemiological studies are presently insufficient to definitively establish a causal relationship between aluminium exposure and the risk of developing breast cancer.

4.11.2 Animal data

No reliable studies regarding cancer effects were identified in animals following acute or intermediate duration inhalation of aluminium or its compounds.

Oneda et al. did not report an increase of tumours incidence or other proliferative lesions in B6C3F1 mice ingesting aluminium potassium sulphate through diet at doses of 1.0, 2.5, 5.0 and 10.0% (w/w) over 20 months (the study included a control group). In this study, hepatocellular carcinoma's incidence was significantly decreased in the group of high-dose males (Oneda et al. 1994).

Following oral exposure of Swiss CD mice to aluminium potassium sulphate in drinking water (5 ppm Al, equivalent to $1.2 \text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$) from weaning through their lifetime (mean lifespans were of 533 days), a significant increase in the incidence of gross tumours was observed in females (46.3% in the aluminium exposed group vs 29.8% in the control group). In addition, the incidence of lymphoma leukaemia was also significantly increased in females (10/41 vs 3/47) (Schroeder and Mitchener 1975b). No significant increase of tumour incidence was observed in male mice.

In another study, Long-Evans rats were exposed to aluminium potassium sulphate in their drinking water (5 ppm Al, equivalent to $0.6 \text{ mg Al.kg bw}^{-1}.\text{d}^{-1}$) from weaning through their lifetime (2 years). Only males presented an increase in the incidence of gross tumours (52% in the aluminium exposed group vs 15% in the control group). Of the tumours, six were malignant in the aluminium exposed group vs 2 in the control group (Schroeder and Mitchener 1975a). No significant increase of tumour incidence was observed in female rats.

In both studies, only one dose of aluminium was used and, the type of tumours and the organs where they were found were not mentioned. Thus, it could not be determined if this incidence increase was dose dependent. The levels of aluminium in the base diet were mentioned but the diet was low in trace elements.

In a study by Pigott et al., male and female rats (Wistar) did not show an increase in cancer rate following whole-body inhalation of $2.18\text{-}2.45 \text{ mg Al.m}^{-3}$ as alumina fibres ($\approx 96\%$ aluminium oxide, Saffil fibres & aged Saffil fibres with a median diameter ranging between $3.0\text{-}3.3 \mu\text{m}$) over 86 weeks (5 d.wk^{-1} and 6 hr.d^{-1}) (Pigott, Gaskell, and Ishmael 1981).

Four groups of female Sprague Dawley rats ($n= 8$ per group) were exposed to 0 or 2000 mg.L^{-1} aluminium (as aluminium chloride) by gavage 5 days/week for 90 days with or without N-nitroso-N-methyl urea (NMU) induction of breast cancer: -Al/-NMU; +2000Al/+NMU;

+2000Al/-NMU; -Al/+NMU. The dose of aluminium is equivalent to 10 mg Al.kg bw⁻¹.d⁻¹. The group +2000Al/-NMU had a significantly higher aluminium concentration in the mammary gland. In the aluminium-treated groups, there was a moderate intraductal cell proliferation (hyperplasia) but no cancer development; cell proliferation was minimal in the -Al/+NMU group (García-Alegría et al. 2020).

4.12 Sensitive population

People suffering from kidney failure are the main population at risk because of the decreased glomerular filtration leading to an increase in internal exposure at the same external dose and are therefore more sensitive to aluminium toxicity (Krewski et al. 2007; ATSDR 2008).

4.13 Synthesis of the toxicological profile

■ Acute toxicity

No relevant studies demonstrating the effects of acute inhalation or ingestion of aluminium or its compounds in humans have been identified.

Several cases of aluminium-related encephalopathy have been reported in patients undergoing otoneurosurgery with bone reconstruction using aluminium-containing cement (Hantson et al. 1995; Lévêque et al. 1996; Reusche et al. 2001). Cases of acute encephalopathy with high plasma aluminium levels have also been reported, following post-surgical bladder irrigation with alum. However, in most of these latter cases, aluminium was probably not the sole or main cause of neurological symptoms, as severe hydroelectrolytic disturbances were obviously or probably associated (Phelps et al. 1999).

In laboratory animals, LD50s have been reported for several aluminium compounds in rats, ranging from 162 mg Al.kg bw⁻¹ (aluminium bromide) to over 730 mg Al.kg bw⁻¹ (aluminium sulphate). A 4-hour inhalation exposure in rats to 1000 mg.m⁻³ was not lethal, but multifocal microgranulomas in the lungs and hilar lymph nodes were detected (Thomson et al. 1986).

■ Irritation and sensitization

Anhydrous aluminium chloride is classified as skin corrosive (category 1B) in the harmonised CLP classification. Several CLP notifications have been received by ECHA concerning the skin and/or eye irritation effect of other aluminium compounds, including aluminium citrate, aluminium hydroxide, aluminium lactate, aluminium nitrate, aluminium phosphate, aluminium silicate, aluminium sodium dioxide and aluminium sulphate.

The SCCS has stated that there are no sufficient data in humans to suggest that aluminium compounds used in antiperspirants cause allergies, and that, given their widespread use, this effect, if it exists, appears to be rare. Animal data do not indicate any skin sensitization effect of aluminium compounds used in antiperspirants (SCCS 2023).

■ Subchronic and chronic toxicity

Numerous studies have documented respiratory effects associated with occupational exposure to aluminium. The spectrum of respiratory disorders includes wheezing, dyspnoea, impaired lung function, asthma and pulmonary fibrosis. However, the attribution of these disorders to aluminium exposure remains uncertain or even improbable in many studies, due to confounding factors including co-exposure to other toxic chemicals, particularly irritants. For

example, co-exposures to hydrogen fluoride and other fluorides have been reported in electrolytic refineries in cases of potroom asthma or pulmonary fibrosis; co-exposure to ozone and ultrafine particles in workers exposed to welding fumes; co-exposure to crystalline silica in cases of fibrosis in workers exposed to bauxite (Krewski et al. 2007; ATSDR 2008). Contradictory data are reported concerning the pulmonary effects of finely ground aluminium powder: Some publications reported cases of pulmonary fibrosis in exposed workers, while other studies showed no evidence of fibrosis after prolonged exposure to fine aluminium particles. Sporadic cases of pneumoconiosis associated with occupational exposure to aluminium have also been reported (Korogiannos, Babatsikou et Tzimas 1998; Kraus et al. 2000; Hull et Abraham 2002). Their low number and co-exposure to other chemical agents limit their interpretation.

The main toxic effects of aluminium reported after exposure in the workplace are cognitive impairments, characterised in several epidemiological studies by reduced performance in psychomotor and/or attention tests. The epidemiological studies either contained no data, or insufficient data, on airborne aluminium concentrations (no personal measurements or airborne dust concentrations). However, aluminium concentrations in blood (serum or plasma) or urine were reported, and differences in the concentration of the biomarker of exposure (BME) between exposed and unexposed workers were observed in relation to cognitive disorders, enabling NOAELs and/or LOAELs to be identified from these studies.

Several studies have been carried out on laboratory animals (mice, rats, gerbils, guinea pigs and dogs) to investigate the effects of sub-chronic or chronic oral or respiratory exposure to various aluminium compounds. Some of these studies showed neurotoxic effects after oral administration. Pulmonary effects have also been reported by inhalation. Haematological effects have also been reported in some studies following digestive administration. Divergent results have been observed concerning bone effects.

■ Reproductive and developmental effects

Several studies have investigated the effects of exposure to aluminium compounds on reproduction and development in laboratory animals (mice, rats, gerbils, rabbits, guinea pigs and dogs).

Reported toxicological effects on reproduction include increased incidence of resorptions, altered gestation length, reduced sperm quality, toxicity to paraurethral glands and gonads, and decreased serum levels of oestrogen, progesterone, FSH and LH. Other studies have shown no effect of aluminium exposure on the histology of reproductive tissues and fertility in males and females.

Various studies have observed developmental effects following aluminium exposure, such as reduced litter size, reduced pup weight, higher postnatal mortality, changes in postnatal prostate development patterns, delayed vaginal opening and increased congenital malformations (notably, cleft palate) and minor anomalies (notably, delayed ossification). Effects on neurodevelopment have also been demonstrated in several studies. Other studies, however, found no effects on birth weight, peri- and post-natal pup mortality, no signs of embryotoxicity, including morphological abnormalities, and no delay in vaginal opening.

■ Genotoxicity

Since aluminium salts are capable of inducing oxidative stress, they could potentially induce mutagenicity in vivo via this mechanism of action. In vitro and in vivo studies indicate that aluminium compounds can induce genotoxic effects, mainly at high exposure levels. EFSA noted that these levels are not relevant for human exposure via food. However, additional tests, such as the mammalian erythrocyte micronucleus assay and the mammalian cell comet

assay with aluminium oxide, are needed to further clarify the genotoxic potential of aluminium salts.

■ Carcinogenicity

According to the International agency for research on cancer (IARC), there is sufficient evidence in humans for the carcinogenicity of aluminium production using the Söderberg process. This activity is associated with elevated incidences of cancers of bladder and lung. The cancer hazards associated with aluminium production mainly result from exposure to polycyclic aromatic hydrocarbons (PAHs) rather than from exposure to aluminium or its related compounds (INRS 2021).

Based on the quantification of aluminium in breast cancer tissues, a potential link between antiperspirants and breast cancer has been assumed. However, despite its potential genotoxic effects, existing data from animal and epidemiological studies are currently insufficient to definitively establish a cause-and-effect relationship between exposure to aluminium and the risk of developing breast cancer.

■ Sensitive populations

People suffering from kidney failure are the main population at risk of aluminium over-impregnation, and are therefore more sensitive to aluminium toxicity (Krewski et al. 2007; ATSDR 2008).

5 Biological values

5.1 Existing biological limit values for workers and populational internal exposure level

■ Existing BLV

In 2019, the MAK commission (Klotz et al. 2019) established a biological tolerance value (BAT) of 50 µg Al.g⁻¹ creatinine as measured in post-shift urine after several shifts. DFG considered an approach based on the relationship between internal dose and health effects. Based on epidemiological observations in workers occupationally exposed to aluminium, cognitive effects were considered as the critical effect corresponding to preclinical neurotoxic effects.

Based on two longitudinal studies, one conducted in train and truck construction industry (Buchta et al. 2005; Kiesswetter et al. 2007) and the other one in automotive engineering (Buchta et al. 2003; Kiesswetter et al. 2009), the MAK commission identified a LOAEL of 100 µg.g⁻¹ creatinine and a NOAEL of 38 µg.g⁻¹ creatinine for aluminium concentration in post-shift urine after several shifts. Significant changes observed at the LOAEL were decreased performances in symbol-digit substitution test, attention-switching test and block design test.

In a second step, DFG analysed data from 12 epidemiological studies of neurocognitive effects in workers exposed to aluminium for the evaluation of the effect size of each study (Hosovski et al. 1990; Bast-Pettersen et al. 1994; Sjögren et al. 1996; Akila, Stollery, and Riihimäki 1999; Guo et al. 1999; Bast-Pettersen et al. 2000; Riihimäki et al. 2000; Buchta et al. 2003; He, Qiao, and Sheng 2003; Buchta et al. 2005; Kiesswetter et al. 2007; Kiesswetter et al. 2009). The effect size for each study was estimated as standardised mean differences (i.e. difference between the mean test results of the exposed group and the control group, divided by the variance in the control group). This approach allowed to demonstrate that a higher effect size was observed in studies with a median urinary concentration higher than 50 µg.g⁻¹ creatinine in exposed workers, while those studies where median urine aluminium concentration in the exposed group was below 50 µg.g⁻¹ creatinine had an effect size considered as small by the MAK Commission. Thus, the BAT value was rounded up to 50 µg.g⁻¹ creatinine from the NOAEL of 38 µg.g⁻¹ creatinine with the recommendation to measure urinary levels at the end of a shift after several shifts.

A summary of the scientific data leading to the biological limit value (ie a biological tolerance value) recommended by DFG is done in Table 19.

Table 19. Summary table of existing biological limit value

BME		Urinary aluminium
Organism		DFG
Year		2019
Reference value	Name	BAT
	Value	50 µg.g⁻¹ creatinine; end of shift after several shifts
Target population		Workers
Applied methodology		Relation internal dose/health effects
Critical effect		Cognitive and motor effects
Key study	Reference	Buchta et al. (2003) ; Kiesswetter et al. (2009)
	Specie	human

	Exposure (duration, route)	4.7 years ± 1.6 Inhalation, ingestion, cutaneous at workplace
PoD		38 µg.g ⁻¹ creatinine (NOAEL)
Adjustment		NA
Uncertainty factor (UF)		1

NA: not applicable

5.2 Derivation of BLV

Urinary aluminium, post-shift after several shifts, is selected as the relevant BME for biological monitoring of occupational exposure to aluminium, on the basis of an analysis of the advantages and disadvantages of the various BMEs identified. In the case of impaired renal function, urinary aluminium cannot be used as BME because this pathological condition affects the interpretation of biomonitoring results (see section 4.2.3).

5.2.1 Choice of critical effect

The systemic effects reported for the lowest exposure in epidemiological studies of workers occupationally exposed to aluminium are cognitive impairments, observed as decreased neurobehavioral performances compared to unexposed individuals. Several epidemiological studies in the general population investigated association between aluminium exposure and neurobehavioral performances. However, only aluminium levels in drinking water were used and urinary aluminium was not measured.

The choice to consider neurotoxic effects as the critical effect is also supported by experimental studies. Indeed, several oral experimental studies in animals have demonstrated neurotoxic effects such as impaired learning and memory, reduced grip strength in forelimbs and hindlimbs, decreased startle response, reduced locomotor activity and total activity counts, impaired negative geotaxis test performance, as well as hippocampal cell damage and decreased cell density.

The HRV committee retains cognitive impairment in exposed workers as the critical effect in relation to urinary levels of aluminium.

5.2.2 Choice of construction hypothesis

For most non-carcinogenic effects, it is generally considered by default and in the current state of knowledge that toxicity is only expressed above a dose threshold.

Thus, the HRV committee considers that the cognitive impairment results from a dose-threshold mechanism.

5.2.3 Choice of key-study and point of departure

Among several studies, only two longitudinal studies, judged to be of good quality, on separate cohorts of workers establishing an association between urinary aluminium concentrations and impairment of cognitive performances make it possible to determine NOAELs and LOAELs:

- NOAEL of 38 $\mu\text{g.g}^{-1}$ creatinine (post-shift, after several shifts) from a study of aluminium welders in car manufacturing (98 workers and 50 controls) (Buchta et al. 2003 and confirmed by the Kiesswetter et al. 2009),
- LOAEL of 97 $\mu\text{g.g}^{-1}$ creatinine (post-shift, after several shifts) from a study of train and truck construction workers (44 workers and 37 controls) (Buchta et al., 2005 and confirmed by the Kiesswetter et al. 2007).

Contrastingly, the longitudinal study conducted by Letzel et al. (2000) did not identify any discernible effects on the cognitive performance of workers compared to controls (32 workers and 30 controls on the first examination, 21 workers and 15 controls on the second one). Although plasma aluminium concentration among workers was comparable to that observed by Buchta et al. (2003), the urinary concentration was notably higher at 87.6 $\mu\text{g.g}^{-1}$ creatinine (sampling time not specified).

Experts also identified studies exhibiting lowest LOAELs. These LOAELs were not considered usable because results on cognitive effects were equivocal:

- LOAEL of 41.8 $\mu\text{g.g}^{-1}$ creatinine post-shift (timing from the start of the shift and day of the work-week not specified) (Guo et al. 1999). Cognitive performances were impaired in an inconsistent manner across age group;
- LOAEL of 40.1 $\mu\text{g.g}^{-1}$ creatinine in “morning” urine samples (day of the work-week, not specified) (He et al. 2003). In this study, exposed workers had a significantly better reaction time than controls despite a significantly lower scores in digital symbol test and pursuit aiming test.

In conclusion, the HRV committee selects the longitudinal study by Buchta et al. in 2003, confirmed by Kiesswetter et al. in 2009, as the key studies, and the NOAEL of 38 $\mu\text{g.g}^{-1}$ creatinine (post-shift, after several shifts) as the PoD.

5.2.4 Application of uncertainty factor

In accordance with the methodological guide (Anses, to be published), no additional uncertainty factor (UF) is considered necessary as the target population correspond to the studied population from the longitudinal study:

- inter-species variability (UF_A): 1, because the internal TRV is based on human data;
- inter-individual variability (UF_H): 1 because the key study corresponds to the target population;
- subchronic to chronic transposition (UF_S): 1, because workers from the reference study were chronically exposed (4 years of follow-up, 3 evaluations)
- use of point of departure ($\text{UF}_{L/L}$): 1, the retained PoD is a NOAEL;
- insufficient data (UF_D): 1, aluminium is a chemical agent whose effects are well documented

The overall UF for deriving the BLV is 1.

5.2.5 Derivation of BLV

The BLV for aluminium is derived from the NOAEL of 38 $\mu\text{g.g}^{-1}$ creatinine with an uncertainty factor of 1, rounded to 40 $\mu\text{g.g}^{-1}$ creatinine.

A BLV of 40 $\mu\text{g.g}^{-1}$ creatinine post-shift after several shifts is proposed for urinary aluminium based on neurotoxicity.

5.3 Urine, blood, serum, plasma and hair aluminium in the general population

Several studies report measurements of aluminium concentration in the general population in urine, blood and hair samples. This data are summarised in Table 20.

Valkonen and Aitio measured aluminium levels in the serum and urine of occupationally non-exposed people (laboratory workers, $n=44$) in three towns of southern Finland using Zeeman graphite furnace atomic absorption spectrophotometer. For serum, samples from 12 women and 9 men (mean age 39.4 years) were analysed and, for urine, samples were collected from 28 women and 16 men (mean age 39.6 years). The 95th percentile of the urinary aluminium results was of $0.63 \mu\text{mol.L}^{-1}$ ($17 \mu\text{g.L}^{-1}$) and for the serum aluminium of $0.09 \mu\text{mol.L}^{-1}$ ($2.4 \mu\text{g.L}^{-1}$).

The findings from the German Environmental Survey (GerES) conducted in 1990/1992, which was a large-scale representative population study, indicated that the 95th percentile of the distribution of hair aluminium concentration was $23.1 \mu\text{g.g}^{-1}$ in the German population aged 6 to 14 years ($n= 638$). Additionally, the 95th percentile of aluminium concentration in scalp hair among the German adult population, aged 25 to 69 years ($n= 3246$), was found to be $14.0 \mu\text{g.g}^{-1}$. Adult males and boys exhibited higher levels of aluminium in their hair compared to adult females and girls, although specific numerical values were not provided. The analysis of hair samples was carried out using ICP-MS with a LOD of $1.0 \mu\text{g.g}^{-1}$ (Seifert et al. 2000; Valkonen and Aitio 1997).

Goullé et al. measured levels of 27-32 elements, including aluminium, in whole blood ($n = 100$), plasma ($n = 100$), urine ($n = 100$) and hair ($n=45$) samples of healthy volunteers using ICP-MS. The 95th percentile of aluminium levels were of $11.2 \mu\text{g.L}^{-1}$, $6.35 \mu\text{g.L}^{-1}$, $17.3 \mu\text{g.L}^{-1}$ and $5.30 \mu\text{g.g}^{-1}$ respectively, in urine, whole blood, plasma and hair (Goullé et al. 2005).

Hoet et al. conducted a study to determine the reference distribution and the upper reference limit of 26 trace elements, including aluminium, in the urine of the general adult population residing in 10 provinces of Belgium (either in urban, suburban or rural areas). Adults were not occupationally or extra occupationally exposed to the trace elements and were recruited by an occupational health service during their annual medical check-up. Non-fasting spot urine samples were analysed for 460 males and 541 females (age range: 18 – 80 years) by ICP-MS. A 95th percentile value of $9.3 \mu\text{g.L}^{-1}$ ($7.5 \mu\text{g.g}^{-1}$ creatinine) was identified for aluminium (Hoet et al. 2013).

Morton et al. measured levels of 61 elements, including aluminium, in urine samples collected from 132 (50 females and 82 males) occupationally unexposed UK adults aged from 18 to 66 years old, by ICP-MS. The sample was not representative of the whole UK population (staff at the Health and Safety Laboratory (HSL) and friends/relatives). The 95th percentile of urine aluminium levels was of $25.73 \mu\text{g.L}^{-1}$ ($215.19 \mu\text{mol/mol}$ creatinine; $51.4 \mu\text{g.g}^{-1}$ creatinine) (Morton et al. 2014).

A study by Nisse et al. named 'IMEPOGE', evaluated the blood and urinary levels of various metals and metalloids in a representative sample of adults aged 20–59 years from the general population of Northern France, a formerly heavily industrialised area that retains some industrial activity. The study was conducted between 2008 and 2010, a total of 982 men and 1018 women participated, allowing the analysis of 1992 blood and 1910 urine samples using ICP-MS. 95th percentile of aluminium concentrations were $11.5 \mu\text{g.L}^{-1}$ ($13.3 \mu\text{g.g}^{-1}$ creatinine) and $11.2 \mu\text{g.L}^{-1}$ in urine and blood respectively (Nisse et al. 2017).

The Santé Publique France (SpF) Esteban study, identified 95th percentile values of $27.66 \mu\text{g.L}^{-1}$ ($62.36 \mu\text{g.g}^{-1}$ creatinine) in adults (18-74 years old) and $26.5 \mu\text{g.L}^{-1}$ ($34.8 \mu\text{g.g}^{-1}$ creatinine) in children (6-17 years old). The target population for the Esteban study was the general population of mainland France, aged 6 to 74 and living in an ordinary household during the

study period. Participants were included between April 2014 and March 2016, in four successive waves of equal duration to balance inclusions according to the seasonality of environmental and dietary exposures. Urinary metals were analysed by ICP-MS. It is important to note that, in this study, aluminium contamination of the samples could not be dismissed. Indeed, after analysing the control samples (water for injections), they were found to contain boron, aluminium and arsenic. Similarly, six pairs of replicates were blindly introduced into the analytical series, with concordant results for all metals except one for aluminium, suggesting environmental contamination issues. The results should therefore be interpreted with caution (SpF 2021).

No biomonitoring data of aluminium is reported by Health Canada, INSPQ, NHANES and HBM4EU.

Table 20. 95th percentiles of aluminium levels in blood, urine or hair, from various studies

Study, Country	Sampling Year	Population	95 th percentile value
Urine			
Valkonen and Aitio (1997), Finland	-	Mean age 39.6 years n=44	17.01 µg.L ⁻¹ (0.63 µmol.L ⁻¹)
Goullé et al. (2005), France	-	Healthy volunteers n=100	11.2 µg.L ⁻¹
Hoët et al. (2013), Belgium	2010-2011	Adults (18 -80 years old) n=1022	9.3 µg.L ⁻¹ (7.5 µg.g ⁻¹ creatinine)
Morton et al. (2014), UK	-	Adults (18-66 years old) n=132	25.73 µg.L ⁻¹ (215.19 µmol/mol creatinine)
Nisse et al. (2017), France	2008-2010	Adults (20–59 years old) n=1910	11.5 µg.L ⁻¹ (13.3 µg.g ⁻¹ creatinine)
SPF (2021), France	2014-2016	Adults (18-74 years old) n=2419	27.66 µg.L ⁻¹ (62.36 µg.g ⁻¹ creatinine)
SPF (2021), France	2014-2016	Children (6-17 years old) n=1052	26.5 µg.L ⁻¹ (34.8 µg.g ⁻¹ creatinine)
Whole Blood			
Goullé et al. (2005), France	-	Healthy volunteers n=100	6.35 µg.L ⁻¹
Nisse et al. (2017), France	2008-2010	Adults (20–59 years) n=1992	11.2 µg.L ⁻¹
Serum			
Valkonen and Aitio (1997), Finland	-	Mean age 39.4 years n=21	2.43 µg.L ⁻¹ (0.09 µmol.L ⁻¹)
Plasma			
Goullé et al. (2005), France	-	Healthy volunteers n=45	17.3 µg.L ⁻¹
Hair			

Seifert et al. (2000), Germany	1990-1992	German children (6 to 14 years old) n=638	23.1 µg.g ⁻¹
Seifert et al. (2000), Germany	1990-1992	German adult (25 to 69 years old) n= 3246	14.0 µg.g ⁻¹
Goullé et al. (2005), France	-	Healthy volunteers n=45	5.30 ng/mg

5.3.1 Populational internal exposure level

The German Commission for the Investigation of Health Hazards of Chemical Compounds in the Work Area has derived a Biological Reference Value (BAR) of 15 µg.g⁻¹ creatinine in the general population. This value was based on five studies (Valkonen and Aitio 1997; Goullé et al. 2005; Hoet et al. 2013; Morton et al. 2014; Nisse et al. 2017) in which the 95th percentiles for urinary aluminium ranged between 7.5 and 21.4 µg.g⁻¹ creatinine. In fact, the BAR value represents the internal exposure to a substance at a particular time of a reference population of persons of working age who are not occupationally exposed to this substance (Klotz et al. 2020)

Table 21. Summary table of existing populational internal exposure level

BME		Urinary Aluminium
Organism		DFG
Year		2018
Reference value	Name	BAR 15 µg.g⁻¹ creatinine; for long-term exposures: at the end of the shift after several shifts
	Value	
Target population		People of working age in the general population
Applied methodology		P95 of five studies* reporting background exposure of persons in working age not occupationally exposed to aluminium
Key study or campaign	Date of subject recruitment/ campaign	Up to 2010
	Number of subjects	Between 44 and 1910 participants

*The five studies used to establish this BAR value are described in the section above.

5.4 Derivation of a populational internal exposure level

In general, when selecting a populational internal exposure level, the 95th percentile of the distribution in the general population of a reference study is used. In the case of aluminium, urinary levels from the 'ESTEBAN' study, which would normally serve as a reference study for the French population, cannot be interpreted due to the probable external contamination of urine samples by aluminium. On the other hand, the 'IMEPOGE' study (2008-2010) by Nisse et al. (2017), with a large number of adult participants (n = 1920 aged 20 to 59), representative of the adult population living in the north of France (Hauts-de-France), is retained as a reference study, leading to a reference value for exposure to urinary aluminium of 11.5 µg. L⁻¹

(or $13.3 \mu\text{g.g}^{-1}$ creatinine), corresponding to the 95th percentile of the distribution of urinary aluminium levels in this population.

It should be noted that the population sampled in this study is probably representative not only of the Hauts-de-France region, but also of the French population as a whole. Indeed, as indicated in the study, the median aluminium levels collected from plant mosses in the Nord-Pas-de-Calais were even lower than those at national level, suggesting that the population is not overexposed to aluminium in this region and that the results can be extrapolated to the rest of France. In addition, the 95th percentile urinary aluminium concentration observed in the Nisse et al. study (2017) is consistent with those of the studies conducted in France by Goullé et al. (2005) ($11.2 \mu\text{g.L}^{-1}$, $n = 100$) and in Belgium by Hoet et al. (2013) ($9.3 \mu\text{g.L}^{-1}$, or $7.5 \mu\text{g.g}^{-1}$ creatinine, $n = 1022$).

In conclusion, for the biological monitoring of occupational exposure, a populational internal exposure level of $13.3 \mu\text{g.g}^{-1}$ creatinine, corresponding to the 95th percentile of the “IMEPOGE” study (Nisse et al. 2017), is proposed for urinary aluminium.

6 Overview of existing OELs for aluminium and correlations between external and internal exposure

6.1 Existing OELs

At present, there is no European OEL value.

In France, only indicative OELs were established between 1985 and 1987 for aluminium as metal and aluminium oxide (10 mg.m^{-3}), aluminium in welding fumes and powdery aluminium (5 mg.m^{-3}) and as soluble salts (2 mg.m^{-3}) (INRS²⁵).

DFG had assessed effects of exposure to aluminium at workplace through inhalation and has concluded that no data were available from human studies to derive a NOAEL, as epidemiological studies contained only inadequate data regarding aluminium concentration in air. Thus, DFG recommended to apply general threshold MAK value for dust to aluminium, aluminium oxide and aluminium hydroxide, i.e. 4 mg.m^{-3} for the inhalable fraction and 1.5 mg.m^{-3} for the respirable fraction (DFG 2014).

In the USA, ACGIH derived a TLV-TWA of 1 mg.m^{-3} for aluminium metal and insoluble compounds. This value is based on human and laboratory animal evidence. In non-smoking workers (production of aluminium) exposed to cumulative aluminium levels exceeding 100 mg.m^{-3} per year, minimal changes were observed in pulmonary function: reduction in forced expiratory volume in the first second compared to the mean predicted value when workers were exposed at least for 10 years (68 workers) (Townsend et al. 1985). ACGIH considered it to be equivalent to an exposure to 2.5 mg.m^{-3} aluminium over 40 years. Moreover, based on observed abnormalities in psychomotor functions in patients under haemodialysis at $59 \text{ } \mu\text{g.L}^{-1}$ in serum (corresponding to $330 \text{ } \mu\text{g.L}^{-1}$ in urine of healthy individuals, according to authors) and the relation between post shift urinary concentration and number of years of exposure, $330 \text{ } \mu\text{g.L}^{-1}$ urine would correspond to 40 years of exposure to 1.6 mg.m^{-3} aluminium welding fumes (also assumed by authors) (Sjögren and Elinder 1992). Two animal studies were also considered. In a chronic inhalation study of aluminium oxide in rats (25 per sex and per group) for 86 weeks (2.45 mg.m^{-3}), incidence of pulmonary tumours was observed and compared to incidences in non-exposed rats and in asbestos-exposed rats as a positive control. Pulmonary tumours were observed only in asbestos treated rats and ACGIH identified $2.45 \text{ mg Al.m}^{-3}$ as a NOAEL. The second study was a 6-months inhalation study in rats with aluminium chlorohydrate (17 rats per group, 0, 0.25, 2.5 and $25 \text{ mg aluminium chlorohydrate.m}^{-3}$), where an increase in relative lung weight was observed at the highest concentration in female and mid concentration in males (Stone et al. 1979). ACGIH retained 2.5 mg Al.m^{-3} as a NOAEL for aluminium in exposed workers.

²⁵ <https://www.inrs.fr/publications/bdd/vlep.html> (accessed in April 2024)

6.2 Derivation of atmospheric values: 8h-OEL and 15min-STEL

8h-OEL

6.2.1.1 Choice of critical effect

Pulmonary effects were observed in workers, for which a risk of bias is raised due to co-exposures probably causing the effects observed. In rats subchronically exposed by inhalation to aluminium chlorohydrate, only pulmonary effects (increase in lung weight, increase in alveolar macrophages, granulomatous lesions) were observed (Steinhagen and Cavender, 1978; Stone et al. 1979). These effects could be attributable to both aluminium and the chlorohydrate moiety. It is therefore not possible to distinguish the proportion attributable to aluminium.

Exposure to aluminium via the oral or respiratory routes can lead to numerous systemic health effects such as neurotoxic, neurodevelopmental, bone or haematological effects. Neurotoxic effects appear both in humans and laboratory animals at the lowest doses tested, by the oral route in laboratory animals and by the respiratory route in workers.

The HRV committee retains neurotoxic effects as the critical effect.

6.2.1.2 Choice of key study and point of departure

No epidemiological studies in the general population provide information on the neurotoxic effects of aluminium after inhalation or oral exposure. Expert committee assume that to use only the available data on concentrations of aluminium in air in the workplace from epidemiological studies of workers is not adequate to characterise their total occupational exposure to aluminium. Indeed, workers are exposed through different sources and routes of exposure to aluminium in the workplace and inhalation route seems not to be the major source of aluminium. The only categories of workers mainly exposed to aluminium through the respiratory route are welders and workers in aluminium powder production plants. However, available data do not allow the characterisation of the association of health effects with air aluminium levels in these workers. Factually, the available studies generally present aluminium levels averaged over several categories of workers, or an airborne dust concentration that is not relevant for deriving an 8h-OEL. No animal studies investigating the neurotoxicity of aluminium via the respiratory route have been identified.

6.2.1.2.1 *Correlation between air aluminium exposure and urinary levels*

Four human studies have been identified where a correlation between concentration of aluminium in the workplace and workers urinary levels was described.

In the first study, post-shift urinary aluminium levels and air concentration (welding fumes) were measured for 16 welders over 6 hours. Aluminium concentrations (8h-TWA) ranged from 0.2 to 5.3 mg.m⁻³ (median 1.1 mg.m⁻³) in welding fumes and urinary levels ranged from 6 to 322 µg.g⁻¹ creatinine (median 54 µg.g⁻¹ creatinine). A linear correlation was derived between post-shift urinary concentrations and air concentrations of aluminium:

$$UAI = 29.6 + (25.0 \times airAl)$$

where, UAI is the urinary concentration of aluminium in µg Al.g⁻¹ creatinine and airAl is the air concentration in mg Al.m⁻³ ($r = 0.47$) (Sjögren et al. 1988, Sjögren et al. 1992).

The second study was conducted in workers from an aluminium fluoride production plant (2 workers) and from electrolytic production of aluminium plants (14 workers from two plants). Urinary aluminium excretion was measured by collecting 24 h urine with six samples.d⁻¹ over four to seven days. Samples were taken either at home or at workplace before shift, at mid-shift and at the end of the shift. Atmospheric aluminium was measured near the breathing zone of workers. A linear correlation was derived between urinary aluminium post-shift and atmospheric aluminium:

$$UAl = 27.1 + (0.127 \times airAl)$$

Where, UAl is the urinary concentration of aluminium in µg Al.g⁻¹ creatinine and air Al is the air concentration of soluble aluminium in mg Al.m⁻³ ($r = 0.411$) (Pierre et al. 1995). Soluble aluminium concentrations in air ranged between 0.03 and 0.56 mg.m⁻³ and the daily mean aluminium excreted in urine was between 20 and 118 µg.d⁻¹.

In the 3rd study, 279 workers from 15 plants were recruited to assess the relationship between serum, urine and atmospheric aluminium. Forty-four (44) of them were unexposed to aluminium while others were exposed through different processes (reduction, extrusion, powder, paste, forge, cable, alumina and rolling mills). Exposure was assessed for total and respirable particulates based on NIOSH methods (NIOSH 1984). Exposed workers were divided into low and high exposure groups, based on the median concentration of air aluminium (geometric mean 3.7 mg.m⁻³ and 100 mg.m⁻³ respectively, extracted from figure). Urinary aluminium concentrations were of 5.9, 8.9 and 16.8 µg.g⁻¹ creatinine in control, low and high exposure groups respectively. The authors considered a clear relationship between urinary aluminium and air aluminium ($r = 0.43-0.49$), while a weak to no relationship between air and serum aluminium was observed (Gitelman et al. 1995). No correlation equation was presented. The expert committee judged highly uncertain to derive a correlation based on the summary data available in this article.

The 4th study was a cross-sectional study (Guo et al. 1999), with 103 exposed workers compared to 64 unexposed workers using neurobehavioral tests (see Chapter 6.5.1). The mean (range) urinary aluminium levels in the exposed and control groups were 41.8 µg.g⁻¹ creatinine (14.9-116.2 µg.g⁻¹ creatinine) and 17.7 µg.g⁻¹ creatinine (3.5-42.8 µg.g⁻¹ creatinine) respectively. Seventy-six (76) air samples were analysed (36 environmental samplings and 40 personal samplings) and mean air aluminium concentration was 5.31 mg.m⁻³ (range 0.67-10.76 mg.m⁻³). A linear correlation was derived for air aluminium and urinary aluminium:

$$UAl = 22.17 + (7.42 \times airAl)$$

where, UAl is the urinary concentration of aluminium in µg Al.L⁻¹ and airAl is the air concentration in mg Al.m⁻³ ($r = 0.4584$) (Guo et al. 1999). No correlation equation is presented for the association of air aluminium with urinary aluminium expressed in µg.g⁻¹ creatinine.

In the longitudinal studies used to identify the NOAEL for the derivation of the BLV (see Chapter 8.1), only total dust concentrations in air were reported. In the study by Kiesswetter et al. (2009), the median dust load during welding was 0.5 mg/m³ (range: 0.1–6.2 mg/m³, n=50) at the first examination, corresponding to a urinary aluminium concentration of 38 µg/g creatinine. In the latter study, Kiesswetter et al. (2007) reported a higher median dust load of 5.7 mg/m³ (range: 0.0–31.5 mg/m³, n=36) at the first examination, associated with a urinary aluminium concentration of 97 µg/g creatinine.

Given the discrepancies in linear correlations, the diversity of industrial exposures and the uncertainties in atmospheric measurements compared with the actual respirable fraction, these correlations were not considered sufficiently reliable to establish an OEL for aluminium.

Furthermore, these correlations do not take into account other sources of exposure of aluminium, particularly oral ingestion, which could contribute significantly to occupational global aluminium exposure and therefore to aluminium concentration in urine.

6.2.1.2.2 Animal data

No animal studies investigating the neurotoxicity of aluminium by the respiratory route have been identified.

Several oral studies observed neurotoxic effects as diminished cognitive performance in rats, including Cao et al. 2016 and Yan et al. 2017. Based on the impaired learning and memory performances in Morris water maze observed in rats exposed by gavage for 3 months to aluminium chloride, the lowest observed NOAEL is 10 mg Al.kg bw⁻¹.d⁻¹ and the LOAEL 30 mg Al.kg bw⁻¹.d⁻¹ (Cao et al. 2016). Reported data do not gave the basis for a benchmark dose approach.

Thus, in the absence of a relevant study in humans and of a (sub)chronic respiratory study in animals demonstrating the critical effect, a route-to-route extrapolation is proposed to derive an 8h-OEL. As the study by Cao et al. (2016) was judged to be of good quality (Klimisch 1) and enables to identify the lowest NOAEL for impaired cognitive performance, the HRV committee decided to retain it as the key study. Such route-to-route extrapolation is possible when the critical effect is a systemic effect.

6.2.1.2.3 Route-to-route extrapolation

The kinetic models available (Poddalgoda et al. 2021; Hethey et al. 2021) do not include the respiratory route and therefore cannot be used to perform route-to route extrapolation.

The following route-to-route extrapolation is based on the study by Cao et al. (2016), where aluminium is administered by gavage in the aluminium chloride form, which is one of the most bioavailable. In the absence of data specific to this compound, the maximum absorption rates of the various inorganic aluminium compounds by the oral and respiratory routes are taken into account, i.e. 0.3% and 3% respectively.

To reduce the uncertainty of inter-species variability, an allometric adjustment was performed. A Human Equivalent Dose (HED) is calculated using the following equation:

$$Dose_{HED} = Animaldose \times \left(\frac{AnimalBW}{HumanBW} \right)^{\frac{1}{4}}$$

Mean rats body weight (Sprague Dawley) is 450 g (from abacus). The human body weight used for the calculation is 70 kg.

$$NOAEL_{HED} = 2.83 \text{ mg.kg bw}^{-1}.\text{d}^{-1}$$

$$NOAEC_{HEC} = \frac{NOAEL_{HED} \times Absorption_{orale} \times BW}{Respiratory\ volume \times Absorption_{resp.}}$$

Where NOAEL_{HED} = 2.83 mg.kg bw⁻¹.d⁻¹, body weight (BW) = 70 kg and respiratory volume = 20 m³.d⁻¹.

$$NOAEC_{HEC} = 0.99 \text{ mg.m}^{-3}$$

A temporal adjustment is then conducted, considering 8 hours work.d⁻¹ (**with respiratory volumes of 10 m³.d⁻¹ for 8 h for a worker with moderate physical activity and 20 m³ for 24 hours for an adult from the general population**), 5 days per week.

$$NOAEC_{HEC\ ADJ} = NOAEC_{HED} \times \frac{7}{5} \times \frac{20}{10}$$

$$NOAEC_{HEC\ ADJ} = 2.77\ \text{mg.m}^{-3}$$

The HRV committee decided to retain a $NOAEC_{ADJ}$ of 2.77 mg.m⁻³ as PoD after extrapolation from the oral to the respiratory route and temporal adjustment.

6.2.1.3 Application of uncertainty factors

In accordance with the methodological guide (Anses, to be published), the following uncertainty factors (UF) have been retained:

- inter-species variability (UF_A): 2.5, to account for toxicodynamic variability and residual toxicokinetic uncertainties, an allometric adjustment having been made;
- inter-individual variability (UF_H): 5 by default for workers;
- subchronic-to-chronic transposition (UF_S): $\sqrt{10}$, to take account of the transposition from a subchronic study to a chronic exposure;
- use of point of departure (UF_{L/B}): 1, the PoD being a NOAEC, no additional factor is needed;
- insufficient data (UF_D): 1, aluminium is a chemical agent whose effects are well documented.

An overall uncertainty factor of 40 is therefore applied to derive the 8h-OEL.

6.2.1.4 Proposed 8h-OEL

The 8h-OEL was calculated by dividing the adjusted PoD by the overall UF.

$$\text{8h-OEL (inhalable fraction)}^{26} = NOAEC_{ADJ} / UF = 0.0693\ \text{mg.m}^{-3} \text{ rounded to } 70\ \mu\text{g.m}^{-3}$$

6.2.2 Recommended pragmatic 15min-STEEL

The human and animal data currently available do not allow the recommendation of a 15-minute TLV for aluminum. Accordingly to the methodological guide (Anses, forthcoming), the HRV committee recommends that the value of 5 times the 8h-OEL should not be exceeded over 15 minutes.

$$\text{Pragmatic 15min-STEEL (inhalable fraction)} = 8\text{h-OEL} \times 5 = 0.346\ \text{mg.m}^{-3} \text{ rounded to } 350\ \mu\text{g.m}^{-3}$$

6.2.3 Skin notation

Aluminium absorption through skin is estimated to be of 0.00052%, and a fourteen-day human study of aluminium dermal application did not show impact on serum or urine aluminium concentrations.

In the absence of quantitative data on skin permeation, **no "skin" notation is recommended for aluminium.**

²⁶ The measurement of the inhalable fraction is considered for the recommendation of the 8h-OEL as it is considered more protective.

6.2.4 Noise notation

Only one study reports hearing loss in a cohort of aluminium workers who were also co-exposed to a solvent mixture consisting of toluene, xylene and methyl ethyl ketone (Rabinowitz et al. 2008). Since this high-frequency hearing loss can be attributed to exposure to this mixture of solvents, the 'noise' notation is not recommended.

7 Conclusions of the HRV committee

The HRV committee has proposed biological values (a BLV and a populational internal exposure level) as well as atmospheric values (an 8h-OEL and a pragmatic 15min-STEEL) for aluminium and its inorganic compounds based on currently available data.

The use of a BLV of 40 µg.g⁻¹ creatinine for urinary aluminium measured at the end of a shift after several shifts, based on human data from occupational exposures, is recommended and will protect worker from cognitive impairment during occupational exposure to aluminium and its inorganic compounds. Indeed, in the case of an ubiquitous substance such as aluminium, with multiple sources and routes of exposure, the use of a BLV makes it possible to take into account all sources and routes of exposure to aluminium when assessing the risks to workers' health.

In addition to the recommended BLV, a populational internal exposure level of 13.3 µg.g⁻¹ creatinine corresponding to the 95th percentile of the "IMEPOGE" study (Nisse et al. 2017), a study considered to be representative of the general French adult population, is proposed for urinary aluminium. This populational internal exposure level will thus make it possible to identify occupational overexposure to aluminium by comparison with the expected exposure of the general population.

Although an 8h-OEL and a pragmatic 15min-STEEL have been proposed for the inhalable fraction²⁷ of aluminium dust to address the request, the HRV committee does not recommend their uses. These values, which are solely intended to assess occupational exposures via inhalation, fail to account for other routes and sources of aluminium exposure, which are, in most cases, predominant. Unlike the Biological Limit Value (BLV), the 8h-OEL and the pragmatic 15min-STEEL cannot be used to assess workers' overall exposure to aluminium. In addition, the HRV committee recommends, conducting studies to better characterise the potential respiratory effects of aluminium and its inorganic compounds, and to measure the inhalable and alveolar fractions of aluminium in the breathing zone of workers during studies investigating cognitive performance effects with the goals to both provide correlations between air and urine concentrations and better characterised the associations of air and urine aluminium levels with cognitive effects.

²⁷ The justification for the choice of inhalable fraction as reference fraction for the 8h-OEL and the pragmatic 15min-STEEL for aluminium and its inorganic compounds is its protective character (compared to the respirable fraction)

Table 22. Long-term and short-term occupational exposure limit values, BLV and populational internal exposure level

RV	Organism	Anses			
	Year	2024			
	Type	8h-OEL*	15min-STEL*	BLV	Populational internal exposure level
	Value	70 µg.m⁻³	Not to exceed 5 x VLEP-8h, i.e. 350 µg.m ⁻³	40 µg.g ⁻¹ creatinin, post shift sampling and after several shifts	13,3 µg.g ⁻¹ creatinin
	BME	NC	NC	Urinary aluminium	Urinary aluminium
Critical effect		Cognitive impairments	Cognitive impairments	Cognitive impairments	NC
Key study	Reference	Cao et al. 2016	NC	Buchta et al. 2003 ; Kiesswetter et al. 2009	IMEPOGE Study, 2008 – 2010 (Nisse et al. 2017)
	Study population or species	Rats	NC	Workers	n=1920 (population aged 20 to 59 in the Hauts de France region)
	Exposure (duration, route)	3 months, oral (gavage)	NC	4.7 years ± 1.6	
Point of departure (PoD)		NOAEL = 10 mg.kg bw ⁻¹ .d ⁻¹	NC	NOAEL = 38 µg.g ⁻¹ creatinine	P95 observed
Temporal adjustment		NOAEC _{ADJ} = 2.77 mg Al kg bw ⁻¹ .d ⁻¹	NC	NA	NC
Allometric scaling		NOAEL _{ADJ} = 2.83 mg Al.kg bw ⁻¹ .d ⁻¹	NC	NA	NC
Route-to-route extrapolation		NOAEC _{HEC} = 0.99 mg.m ⁻³			
Uncertainty factor (UF)		40 (UF _A 2,5 ; UF _H 5 ; UF _S √10)	NC	1 (UF _A : 1; UF _H : 1; UF _L : 1; UF _S : 1; UF _D : 1)	NC

NA: not applied; NC: not concerned; NOAEL/C: No Observed Adverse Effect Level/Concentration; HED/C: Human Equivalent Dose/Concentration; UF: uncertainty factor.

*** The HRV committee does not recommend the use of the 8h-OEL and the pragmatic 15min-STEEL, since compliance with these values does not make it possible to take into account all the sources and routes of exposure to aluminium and its inorganic compounds, and thus to assess the risks to workers' health**

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Part B – Report on the assessment of methods for measurement of exposure levels in workplace atmospheres

1 Presentation and discussion of methods for measuring aluminium in workplace air

1.1 Mapping measurement methods

Table 23 presents the measurement methods that were identified and evaluated in the present report. Because of the recommended OEL, only methods allowing the sampling of the inhalable fraction have been listed.

Table 23. Summary table of methods for measuring the inhalable fraction of aluminium in workplace air

Methods		Protocols				
	Description	Reference	Sampling device	Support	Mineralisation	Analysis
A	Active sampling of inhalable fraction on membrane or filter – Acid Digestion – ICP-AES Analysis	NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005)	Inhalable fraction sampler	Filter (reference EN 13205-1)	Acid and hotplate or microwave	ICP-AES
		NIOSH 7300 (2003)	Closed-Face Cassette (CFC)	Membrane (0.8-µm, mixed cellulose ester membrane (MCE), or 5.0-µm, polyvinyl chloride (PVC) membrane) 37-mm diameter	Acid and hotplate	
		NIOSH 7301 (2003)			Acid (aqua regia) and hotplate	
		NIOSH 7302 (2014)		Membrane (MCE, 37-mm diameter, 0.8-µm pore size)	Acid and microwave	
		NIOSH 7303 (2003)			Acid and hot plate	
		NIOSH 7304 (2014)		Membrane (PVC, 37-mm diameter, 5.0 µm pore size)	Acid and microwave	
		NIOSH 7306 (2015)	CFC + internal capsule	Cellulose acetate internal capsule + membrane (MCE membrane, 0.8-µm pore size; 37-mm diameter)	Acid and hotplate or microwave	
		INRS MétroPol M-122 (2015)	CFC	Filter (quartz fiber)	Acid and ultrasound	
		INRS MétroPol M-124 (2015)		Membrane (MCE)	Acid and ultrasound	
		INRS MétroPol M-125 (2016)	CFC + internal capsule	AccuCap™ or equivalent + membrane (MCE)	Acid and ultrasound	

Methods		Protocols				
	Description	Reference	Sampling device	Support	Mineralisation	Analysis
		NF X 43-257 (2016) NF X 43-275 (2002)	Inhalable fraction sampler	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)	Acid and ultrasound	
B	Active sampling of inhalable fraction on membrane or filter – Acid Digestion – DCP-AES Analysis	NF X 43-257 (2016) NF X 43-275 (2002)	Inhalable fraction sampler	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)	Acid	DCP-AES
C	Active sampling of inhalable fraction on membrane or filter – Acid digestion – ICP-MS analysis	IRSST MA-362 (2011)	CFC	Membrane (MCE, 37-mm or 25-mm diameter, 0.8-µm pore size)	Acid	ICP-MS
		IRSST MA-394 (2018)	CFC + internal capsule	Solu-Sert™ 25 mm and 37 mm (0.8 µm MCE filter encapsulated 2-piece polypropylene cassette with cellulose backing in a cellulose acetate membrane)	Acid	
		NF ISO 30011 (2010)	Inhalable fraction sampler	Reference NF ISO 15202-1	Acid	
		IFA 6061 (2025)	GSP-10	Filter (cellulose nitrate)	Acid +/- microwave	
D	Active sampling of inhalable fraction on membrane or filter – Acid Digestion – GFAAS Analysis	INRS MétroPol M-120 (2015)	CFC	Filter (quartz fiber)	Acid	GFAAS
		DFG (MAK) 2718 (2014)	GSP-3.5	Filter (Nitrocellulose)	Acid and microwave	
		NF X 43-257 (2016) NF X 43-275 (2002)	Inhalable fraction sampler	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)	Acid	
E	Active sampling of inhalable fraction on membrane or filter – Acid Digestion – FAAS Analysis	OSHA ID 121 (2002)	CFC	Membrane (MCE or PVC)	Acid	FAAS
		INRS MétroPol M-121 (2015)	CFC	Filter (quartz fiber)	Acid	
		INSST MTA/MA – 025/A16 (2016)	Inhalable fraction sampler	Filter or membrane (MCE are most commonly used)	Acid and hot plate / Acid and microwave	
		NIOSH 7013 (1994)	CFC	Membrane (MCE, 0.8-µm pore size, 37-mm diameter)	Acid	

Methods		Protocols				
	Description	Reference	Sampling device	Support	Mineralisation	Analysis
		NF X 43-257 (2016) NF X 43-275 (2002)	Inhalable fraction sampler	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)	Acid	

The main performance criteria for sampling and analytical methods used in the workplace atmosphere are summarised in chapter 1.2.

Details in terms of sampling media, sample processing, analysis and validation data are given in Annex 1 for methods classified as category 2.

1.2 Detailed assessment of the methods

Requirements: considering the 8h-OEL and the 15 min-STEEL recommended by the Committee, methods should be validated in the following concentration range for the inhalable fraction:

- 0.1 to 2 *8h-OEL: 7 – 140 $\mu\text{g}\cdot\text{m}^{-3}$ (for the technical regulatory control)
- 0.1 to 2 *15min-STEEL: 34,6 – 692 $\mu\text{g}\cdot\text{m}^{-3}$ (for the technical regulatory control)
- 0.5 to 2 *15-min-STEEL: 173 – 692 $\mu\text{g}\cdot\text{m}^{-3}$ (for the monitoring of short exposure)

The following table presents the rating of identified methods relevant to measure worker's aluminium exposure (Table 24). The evaluation is described in the following paragraphs.

Table 24. Rating of monitoring methods for workplace aluminium assessment

Aluminium Monitoring					
	Methods	Protocols	8h-OEL	15min-STEEL	15min-STEEL
			Technical regulatory control	Technical regulatory control	Short-term exposure
A	Active sampling of inhalable fraction on membrane or filter – Acid Digestion – ICP-AES Analysis	NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005) NIOSH 7300 (2003) NIOSH 7301 (2003) NIOSH 7302 (2014) NIOSH 7303 (2003) NIOSH 7304 (2014) NIOSH 7306 (2015) INRS M-122 (2015) INRS M-124 (2015) INRS M-125 (2016)	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 1B</i>	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 1B</i>	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 1B</i>

Aluminium Monitoring					
	Methods	Protocols	8h-OEL	15min-STEEL	15min-STEEL
			Technical regulatory control	Technical regulatory control	Short-term exposure
		NF X 43-257 (2016) NF X 43-275 (2002)			
B	Active sampling of inhalable fraction on membrane or filter – Acid Digestion – DCP-AES Analysis	NF X 43-257 (2016) NF X 43-275 (2002)	Global rating: 3* <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 3*</i>	Global rating: 3* <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 3*</i>	Global rating: 3* <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 3*</i>
C	Active sampling of inhalable fraction on membrane or filter – Acid digestion – ICP-MS analysis	IRSST MA-362 (2011) IRSST MA-394 (2018) NF ISO 30011 (2010) IFA 6061 (2025)	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 1B</i>	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 1B</i>	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 1B</i>
D	Active sampling of inhalable fraction on membrane or filter – Acid Digestion – GFAAS Analysis	INRS M-120 (2015) DFG (MAK) 2718 (2014) NF X 43-257 (2016) NF X 43-275 (2002)	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 1B</i>	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 2</i>	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 1B</i>
E	Active sampling of inhalable fraction on membrane or filter – Acid Digestion – FAAS Analysis	OSHA ID 121 (2002) INRS M-121 (2015) INSST MTA/MA – 025/A16 (2016) NIOSH 7013 (1994) NF X 43-257 (2016) NF X 43-275 (2002)	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 1B</i>	Global rating: 3 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 3</i>	Global rating: 2 <i>Sampling technique rating: 2</i> <i>Analytical technique rating: 2</i>

The following figure presents the ranges for which the various methods were tested and their limit of quantification for the 8h-OEL and 15 min-STEEL value recommended by the Committee.

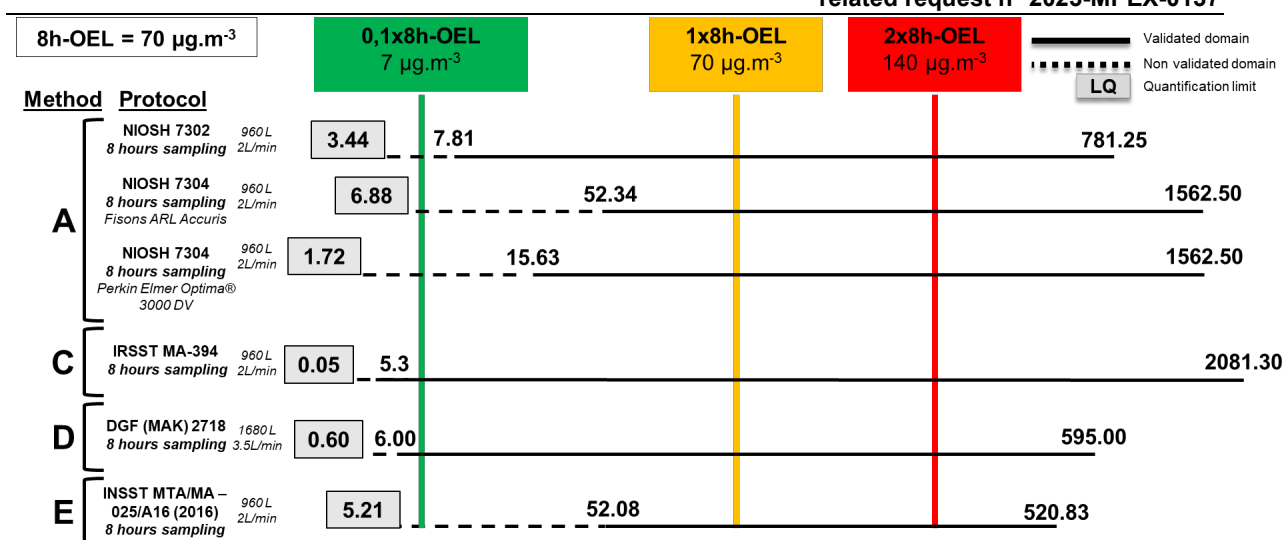


Figure 9. Working range and quantification limit of the different methods classified as 2 compared to the 8h-OEL

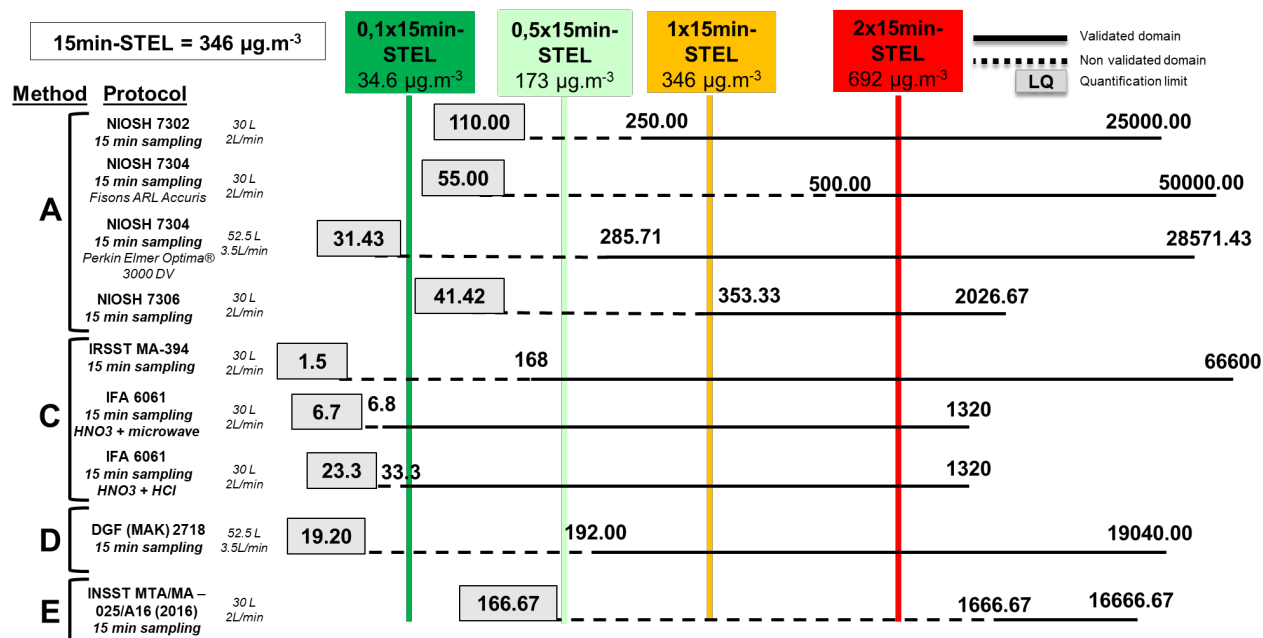


Figure 10. Working range and quantification limit of the different methods classified as 2 compared to the 15min-STEEL

1.2.1 Preliminary remark about the aluminium measurement methods

It should be noted that aluminium contamination of the sample is possible. Indeed, aluminium is ubiquitous in laboratories, and can be found in laboratory air, in the instruments and equipment used. So, when handling the sampler, preparing the sample for analysis, or preparing the standards, care must be taken and good laboratory practice followed and the use of aluminium-free equipment (pincers, spatulas, etc.) is then strongly recommended.

It should also be noted that the IFA 6061 (2025) protocol recommends that the characteristics and variability of laboratory blank values for aluminium should be checked individually in each laboratory, and the suitability of the corresponding measurement methods should also be assessed in the light of the blank value concentrations observed.

1.2.2 Detailed assessment of the sampling technique for methods A to E

The samplers for the inhalable fraction have been evaluated in 2020 (Anses 2020) and thus, the resulting classification provided in the report has been applied to assess the sampling technique for methods A to E.

The sampling methodology is similar for methods A to E, and consists of active sampling of the inhalable fraction on various filters or membranes. The target specification for sampling the inhalable fraction is given in standards NF EN 481 (1993) and NF ISO 7708 (1996) and corresponds to a collection efficiency of 100 % for particles with sizes (aerodynamic diameter) smaller than $\approx 2 \mu\text{m}$, the efficiency drops to 50 % for $100 \mu\text{m}$ sized particles. Particles larger than $100 \mu\text{m}$ are not included in the definition of the inhalable fraction. An inhalable fraction sampler is considered ideal “when a personal sampler carried by the worker gives the same measured dust concentration and aerodynamic distribution as that inhaled by the worker” (Mark and Vincent, 1986). The convention is defined for wind speed inferior to 4 m.s^{-1} (NF EN 481, 1993; NF ISO 7708, 1996). Standard NF EN ISO 13205 (2014) defines the requirements for aerosol samplers, including performance criteria relating to sampling bias with respect to conventions and relative uncertainties.

In methods A to E, the protocols either reference the use of the Closed Face Cassette (CFC) with (NIOSH 7306, 2015; INRS M-125, 2016; IRSST MA-394, 2018) or without internal cap (NIOSH 7300, 2003; NIOSH 7301, 2003; NIOSH 7302, 2014; NIOSH 7303, 2003; NIOSH 7304, 2014; NIOSH 7013, 1994; INRS M-120, 2015; INRS M-121, 2015; INRS M-122, 2015; INRS M-124, 2015; NF X 43-257, 2016; NF X 43-275, 2002; IRSST MA-362, 2011; OSHA ID 121, 2002), specify standards outlining the requirements for samplers (NF ISO 15202-1, 2020; NF ISO 15202-2, 2020; NF ISO 15202-3, 2005; INSST MTA/MA – 025/A16, 2016), or cite a documentation file listing the devices available on the market in 2004. Therefore, all inhalable fraction samplers using membranes or filters recommended by Anses (2020) should be considered suitable for use when the protocol does not specify any particular requirements. The Closed Face Cassette (CFC) consists of a 37 mm diameter filter holder with three plastic parts with a 4 mm opening. The type of filter or membrane depends on the type of subsequent analysis to be carried out, and may require the use of a cellulose fiber support pad. Closed cassettes with a diameter of 25 mm are also available. The sampling is performed using a pump operating from 1.5 to at 4 L.min^{-1} .

The CFC, is a sampling device for the inhalable fraction that is not recommended (classified in category 3) with regard to the criterion of “compliance with the conventional inhalable fraction” (classified in category 3 – Anses 2020). Indeed, CFC, although closest to the conventional fraction for aerosols with particle sizes $< 20\text{-}30 \mu\text{m}$, shows significant under-sampling from $20\text{-}30 \mu\text{m}$, whatever the air speed with a negative bias evaluated to -25 %.

Alternatively, the CFC using an internal cup are classified in category 2 as the underestimation of the conventional fraction begins for particle sizes above $40\text{-}50 \mu\text{m}$, so that the biases observed in conditions close to workplace air (air velocity $\leq 0.5 \text{ m.s}^{-1}$) with respect to the convention are less than those observed with the CFC alone. If the CFC is used without an internal capsule, it is recommended to ensure that any wall deposits are thoroughly rinsed during mineralisation. The use of internal cup for sampling is proposed in method A (NIOSH 7306, 2015 and INRS M-125, 2016) and method C (IRSST MA-394, 2018). Regardless of the sampling device used, standards 15202-1 (2020) and 15202-2 (2020) recommend taking into account or evaluating wall deposits. Several methods are described for taking account of these deposits, such as: dissolving the sample inside the sampler body, recovery by brushing, recovery by wiping the internal surfaces with a moistened wipe. These factors must be taken into account in the assessment of uncertainties. None of the protocols for methods A to E identified in this report proposed a technique for recovering deposits from the walls. However,

rinsing the walls of the cassette at the time of sample mineralisation can be implemented to face this issue.

The sampling supports used in the protocols of methods A to E are polyvinyl chloride (PVC), mixed cellulose ester (MCE), polytetrafluoroethylene (PTFE) membranes, quartz or glass fiber filters. These recommended filters or membranes can be, depending on the protocols, either 25 mm or 37 mm in diameter. The diameter of the filter has no effect on the measurement, as it will be acid-etched during mineralisation.

In the IFA 6061 (2025) protocol, the GSP-10 sampler is used for the inhalable fraction sampling. This device is a sampler using a flow rate of 10 L.min⁻¹. It was not retained as a category 2 inhalable fraction sampler in the previous assessment (Anses 2020) due to a lack of validation data. A literature search (detailed in Annex 3) identified two new articles on this sampling system since the previous assessment. However, these articles contained no information on the validation data that would enable to assess this device in terms of its compliance with the conventional inhalable fraction. Due to this lack of information, GSP-10 has been classified as category 3* and is not a recommended sampling technique for sampling the aluminium inhalable fraction.

In conclusion, regarding the sampling devices for the inhalable fraction using membranes or filters assessed with regard to the criterion “compliance with the conventional inhalable fraction” of methods A to E: the CFC accounting for wall deposits, the CFC + internal capsule, GSP-3.5 or any inhalable fraction sampler (such as the IOM™, the Button™ sampler, the 7-Hole) are classified as category 2 and are recommended for sampling the inhalable fraction, as mentioned in Anses (2020).

1.2.3 Detailed assessment of the extraction technique for methods A to E

Different mineralisation modes are proposed in the protocols/methods listed in the report. These protocols, are nonetheless transposable from one analysis method to another (with a few exceptions, such as the use of HClO₄+HNO₃, which is not recommended for analysis by ICP-MS). Details of the mineralisation methods proposed in the various protocols are shown in Table 25.

The performance of the different protocols, and in particular the limits of quantification/detection, depend on the mineralisation methods used. This is why the evaluation of the different methods will be implicitly linked to the mineralisation modes proposed in the associated protocol. In conclusion, the Limit Of Detection (LOD) and Limit Of Quantification (LOQ) of each protocol are in no way transposable, as they are dependent on a number of factors, including the method of dissolution (heating mode, volumes and nature of acids used, total desorption volume), the sampling medium and, of course, the analysis method (sensitivity of the equipment).

Table 25. Proposed mineralisation modes for ICP-MS and DCP/MS, ICP-AES and SAA methods

ICP-AES methods	ICP-MS or DCP/MS methods	SAA methods
Mineralisation method in NIOSH protocols HNO ₃ HClO ₄ / hot plate / final Vol 25 ml (NIOSH 7300) HNO ₃ and HCl / hot plate / final Vol 25 ml (NIOSH 7301)	Mineralisation method in IRSST protocols HNO ₃ , HClO ₄ , H ₂ O ₂ , HCl /hot plate and add HNO ₃ (IRSST MA-394 and IRSST MA-362)	HCl / micro wave / T = 100°C (DFG MAK 2718)

ICP-AES methods	ICP-MS or DCP/MS methods	SAA methods
HNO ₃ / micro wave / final Vol 25 ml (NIOSH 7302) HNO ₃ et HCl / heating block / final Vol 25 ml (NIOSH 7303) HNO ₃ / micro wave / final vol 50 ml (NIOSH 7304) NIOSH 7306 ≈ 7300, 7301, 7302 or 7303)		
Mineralisation method in NF ISO 15202 HNO ₃ +HCl hot plate HF+HNO ₃ ultra sounds H ₂ SO ₄ +H ₂ O ₂ hot plate HClO ₄ +HNO ₃ hot plate HNO ₃ ± HF micro wave	Mineralisation method in norms NF ISO 30011 refers to NF ISO 15202: HNO ₃ +HCl hot plate HF+HNO ₃ ultra sound H ₂ SO ₄ +H ₂ O ₂ hot plate HClO ₄ +HNO ₃ hot plate (-> non recommended) HNO ₃ ± HF micro wave NF X 43-275: HF+HNO ₃ + HF (for non-soluble element) – ultra sound	
Mineralisation method in INRS protocols HF + HNO ₃ (INRS MétroPol M-122) HClO ₄ + HCl +HNO ₃ (with or without HF) (INRS MétroPol M-124 and INRS MétroPol M-125) HNO ₃ +H ₂ O ₂ +HF micro wave – and at 260°C (INRS MétroPol M-439 (2024)	Mineralisation method in IFA 6061 protocol HNO ₃ + pressure assisted by microwave HNO ₃ + HCl with heat	

1.2.4 Detailed assessment of the analytical technique of method A: Active sampling of inhalable fraction on membrane or filter - Acid digestion - ICP-AES analysis

The method is described by 3 norms ISO NF and 2 norms NF X, 6 NIOSH protocols and 2 INRS protocols. This method involves pumping the inhalable fraction onto a sampling medium using an appropriate sampling device (§1.2.2). After sampling, the support is mineralized in an acid medium (§1.2.3) for determination of aluminium concentration by inductively coupled plasma (ICP) atomic emission spectrometry (AES).

The typical sampling flow rate is comprised between 1 and 4 L.min⁻¹. Atmospheric concentration data presented in this assessment were calculated on the basis of a flow rate of 2 L.min⁻¹ during 8 hours for the 8h-OEL and during 15 minutes for the 15 min-STEL.

It should be noted that two types of validation data are reported in this evaluation for the NIOSH 7304 (2014) protocol. Indeed, this protocol reports validation data obtained on 2 devices: the Fisons ARL Accuris and the Perkin Elmer Optima® 3000 DV. The tables below indicate which device the validation data refers to.

Validation range:

The method was validated by spiking the media with aluminium quantities that varied according to the protocol. Table 26 shows the validation range for each protocol, calculated on the basis of a sample air volume of 960 L and 30 L, corresponding to an 8h and 15 min sampling period at 2 L.min⁻¹, respectively. These air volumes fall within the range of air volumes recommended by each protocol, and this sampling flow rate corresponds to the most common flow rate for inhalable fraction sampling devices, also compatible with CFC alone or with the internal capsule used in the protocols.

The method has been validated across different domains for 6 protocols, as presented in Table 26. The validation ranges identified in protocols of method A are variable and depend on the conditions under which the protocols are implemented.

For the 8h-OEL the NIOSH protocols 7302 (2014) and 7303 (2003) cover 0.1 to 2 times the 8h-OEL range with a sample of 960 L of air. For the 15min-STEEL, none of the protocols covers the 0.1 to 2 times 15min-STEEL concentration range required for technical regulatory control.

The NF ISO 15202-1 (2020), NF ISO 15202-2 (2020), NF ISO 15202-3 (2005), NF X 43-257 (2016), NF X43-275 (2002) and INRS protocols do not specify the studied concentration range.

Table 26. Validation ranges identified in the protocols for method A

Protocol	Sampling support	Sampled volume (L)	Validation range		Fraction of the exposure levels covered	
			(µg/sample)	(µg·m ⁻³)	8h-OEL	15 min-STEEL
NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005)	Filter (reference EN 13205-1)	960	nd	nd	nd	-
		30		nd	-	nd
NIOSH 7300 (2003)	MCE or PVC membrane	960	1.54 – 6.40	1.60 – 6.67	0.02 – 0.10	-
		30		51.33 – 213.33	-	0.14 – 0.62
NIOSH 7301 (2003)	MCE or PVC membrane	960	1.54 – 6.40	1.60 – 6.67	0.02 – 0.10	-
		30		51.33 – 213.33	-	0.14 – 0.62
NIOSH 7302 (2014)	MCE membrane	960	7.50 – 750.00	7.81 – 781.25	0.11 – 11.16	-
		30		250.00 – 25000.00	-	0.72 – 75.25
NIOSH 7303 (2003)	MCE membrane	960	9.25 – 50000	9.63 – 52083.33	0.14 – 744.05	-
		30		308.33 – 1666666.67	-	0.89 – 4816.96
NIOSH 7304 (2014) <i>Fisons ARL Accuris</i>	PVC membrane	960	50.25 – 1500.00	52.34 – 1562.50	0.74 – 22.32	-
		30		1675.00 – 50000.00	-	4.84 – 144.51
NIOSH 7304 (2014)	PVC membrane	960	15.00 – 1500.00	15.63 – 1562.50	0.22 – 22.32	-

Protocol	Sampling support	Sampled volume (L)	Validation range		Fraction of the exposure levels covered	
			(µg/sample)	(µg·m ⁻³)	8h-OEL	15 min-STEEL
<i>Perkin Elmer Optima® 3000 DV</i>		30		500.00 – 50000.00	-	1.45 – 144.51
		52.5		285.71 – 28571.43	-	0.83 – 82.58
NIOSH 7306 (2015)	Internal capsule + MCE membrane	960	10.60 - 60.80	11.04 – 63.33	0.16 – 0.90	-
		30		353.33 – 2026.67	-	1.02 – 5.86
INRS MétroPol M-122 (2015)	Quartz fiber filter	960	nd	nd	nd	-
		30		nd	-	nd
INRS MétroPol M-124 (2015)	MCE membrane	960	nd	nd	nd	-
		30		nd	-	nd
INRS MétroPol M-125 (2016)	Internal capsule + MCE membrane	960	nd	nd	nd	-
		30		nd	-	nd
NF X 43-257 (2016) NF X 43-275 (2002)	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)	960	nd	nd	nd	-
		30		nd	-	nd

nd : not determined in the protocol.

Limit of detection and quantification:

The LOD and LOQ mentioned in the protocols (in bold) or calculated from the LOD (in italics) are summarised in the following Table 27. For the 8h-OEL, LOQs are generally below 0.1 times the 8h-OEL, except for the NIOSH 7303, INRS MétroPol M-122 (2015) and NF X43-275 (2002) protocols. For the 15min-STEEL, only the LOQs of the NIOSH 7300, 7301 protocols are below 0.1 times the 15min-STEEL.

Table 27. Limits of detection and quantification identified in the protocols for method A

Protocol	LOD (µg/sampling support)	LOQ (µg/sampling support)	8h-OEL		15min-STEEL	
			LOD ^(a) (µg·m ⁻³)	LOQ ^{(a)/(b)} (µg·m ⁻³)	LOD ^(a) (µg·m ⁻³)	LOQ ^{(a)/(b)} (µg·m ⁻³)
NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005)	nd	nd	nd	nd	nd	nd
NIOSH 7300 (2003)	0.12	<i>0.38</i>	<i>0.12</i>	<i>0.40</i>	4.05	12.65
NIOSH 7301 (2003)	0.12	<i>0.38</i>	<i>0.12</i>	<i>0.40</i>	4.05	12.65
NIOSH 7302 (2014)	1.00	3.30	1.04	3.44	33.33	110.00

Protocol	LOD ($\mu\text{g}/\text{sampling support}$)	LOQ ($\mu\text{g}/\text{sampling support}$)	8h-OEL		15min-STEEL	
			LOD ^(a) ($\mu\text{g}\cdot\text{m}^{-3}$)	LOQ ^{(a)(b)} ($\mu\text{g}\cdot\text{m}^{-3}$)	LOD ^(a) ($\mu\text{g}\cdot\text{m}^{-3}$)	LOQ ^{(a)(b)} ($\mu\text{g}\cdot\text{m}^{-3}$)
NIOSH 7303 (2003)	2.78	9.17	2.90	9.56	92.67	305.8
NIOSH 7304 (2014) <i>Fisons ARL Accuris</i>	2.00	6.60	2.08	6.88	66.67	220.00
NIOSH 7304 (2014) <i>Perkin Elmer Optima® 3000 DV</i>	0.50	1.65	0.52	1.72	16.67	55.00
NIOSH 7306 (2015)	0.38	1.25	0.39	1.29	12.67	41.42
INRS MétroPol M-122 (2015)	7.40	24.42	7.71	25.44	246.67	814.00
INRS MétroPol M-124 (2015)	nd	nd	nd	nd	nd	nd
INRS MétroPol M-125 (2016)	1.00	3.30	1.04	3.44	33.37	110.00
NF X 43-257 (2016) NF X 43-275 (2002)	7.40	24.42	7.71	25.44	246.67	814.00
In bold: values extracted from the protocol; in italics: calculated values ($\text{LOQ} = 3,3 \cdot \text{LOD}$); nd: not determined in the protocol						
(a) calculated for a 960 L sampling for the 8h-OEL or a 30L sampling for the 15min-STEEL.						
(b) atmospheric concentration – estimated from LOD if not mentioned in the protocol, estimated by $\text{LOQ} = 3,3 \cdot \text{LOD}$.						

Accessible measurement range:

The accessible measurement range depends on the limit of quantification, the validation range identified in the protocols and some adaptations of the measurement method (flow rate, sampling duration...) that can be made to achieve the range required to monitor the recommended 8h-OEL and 15 min-STEEL.

As all the identified methods use a device to collect the inhalable fraction on a membrane, and the validation data were obtained by doping the membrane, this validation data does not take into account the collection efficiency of the device.

Therefore, in order to increase the sample volume and thus reduce the LOQ obtained to cover the accessible range required to monitor an 8h-OEL, a 15min-STEEL or a short-term exposure, it is possible to adapt the method by using a filter or membrane inhalable fraction sampling system with a higher flow rate than that mentioned in the protocols describing the method, provided that it is classified as category 2 with regard to its compliance with the conventional inhalable fraction (see. Section 1.2.2).

The accessible measurement range of Method A covers the domain required to monitor the 8h-OEL under the conditions of the NIOSH 7302 (2014) and NIOSH 7304 (2014) protocols described in Table 28.

Table 28. Method A accessible measurement range for monitoring the 8h-OEL

Protocol	Sampling support	Flow rate ($\text{L}\cdot\text{min}^{-1}$)	Sampling duration (h)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					($\mu\text{g}\cdot\text{m}^{-3}$)	Fraction of 8h-OEL covered
NF ISO 15202-1 (2020)	Filter (reference EN 13205-1)	2	8	960	nd	nd

Protocol	Sampling support	Flow rate (L·min ⁻¹)	Sampling duration (h)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					(µg·m ⁻³)	Fraction of 8h-OEL covered
NF ISO 15202-2 (2020) NF ISO 15202-3 (2005)						
NIOSH 7300 (2003)	MCE or PVC membrane				0.40 – 6.67	0.01 - 0.10
NIOSH 7301 (2003)	MCE or PVC membrane				0.40 – 6.67	0.01 - 0.10
NIOSH 7302 (2014)	MCE membrane				3.44 – 781.25	0.05 – 11.16
NIOSH 7303 (2003)	MCE membrane				9.56 – 52083.33	0.14 – 744.05
NIOSH 7304 (2014) Fisons ARL Accuris	PVC membrane				6.88 – 1562.50	0.10 - 22.32
NIOSH 7304 (2014) Perkin Elmer Optima® 3000 DV	PVC membrane				1.72 – 1562.50.0	0.02 - 22.32
NIOSH 7306 (2015)	Internal capsule + MCE membrane				1.29 – 63.33	0.02 - 0.90
INRS MétroPol M-122 (2015)	Quartz fiber filter				25.44 - nd	0.36 - nd
INRS MétroPol M-124 (2015)	MCE membrane				nd	nd
INRS MétroPol M-125 (2016)	Internal capsule + MCE membrane				3.44 - nd	0.05 - nd
NF X 43-257 (2016) NF X 43-275 (2002)	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)				25.44 - nd	0.36 - nd
In bold: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 8h-OEL for the technical regulatory control. nd : not determined in protocol.						

For short-term exposure monitoring, the NIOSH 7302, 7304 (2014) (using the Perkin Elmer Optima® 3000 DV ICP AES) and 7306 (2015) protocols cover the 0.5 to 2 times 15min-STEEL concentration range required, as shown in Table 29.

For the technical regulatory control of the 15min-STEEL, the NIOSH 7306 (2015) protocol covers 0.12 to 2 times 15min-STEEL, which is very close to the required accessible range (0.1

to 2 times 15min-STEEL). An adaptation by using a sampler with a higher flow rate to reach 0.1 times 15min-STEEL is not possible. Indeed, the NIOSH 7306 (2015) protocol recommends the use of an internal capsule in addition to a MCE membrane and this sampling support is not compatible with higher flow rate samplers such as the GSP-3.5 or the Button™. However, the NIOSH 7304 (2014) protocol using a Perkin Elmer Optima® 3000 DV ICP-AES has an accessible concentration range from 0.16 to 145 times the 15min-STEEL, which is also very close to the required accessible range. As this latter protocol uses PVC membranes, this sampling support is adaptable to a sampling device with a flow rate greater than 3.5 L.min⁻¹ (as mentioned in 1.2.2 such as a GSP-3.5 or a Button™ sampler) which will increase the volume sampled, enabling the accessible concentration range to be lowered, as shown in Table 29. Thus, by using a sampling device with a flow rate greater than 3.5 L.min⁻¹, the range required for regulatory technical monitoring of the 15min-STEEL is covered.

Table 29. Method A accessible measurement range for monitoring the 15min-STEEL

Protocol	Sampling support	Flow rate (L·min ⁻¹)	Sampling duration (min)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					(µg·m ⁻³)	Fraction of the 15 min-STEEL
NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005)	Filter (reference EN 13205-1)	2	15	30	nd	nd
NIOSH 7300 (2003)	MCE or PVC membrane				12.65 – 213.33	0.04 – 0.62
NIOSH 7301 (2003)	MCE or PVC membrane				12.65 – 213.33	0.04 – 0.62
NIOSH 7302 (2014)	MCE membrane				110.00 – 25000.00	0.32 – 75.25
NIOSH 7303 (2003)	MCE membrane				308.33 – 1666666.67	0.89 – 4816.96
NIOSH 7304 (2014) Fisons ARL Accuris	PVC membrane				220.00 – 50000.00	0.64 – 145.51
NIOSH 7304 (2014) Perkin Elmer Optima® 3000 DV	PVC membrane				55.00 – 50000.00	0.16 – 145.51
NIOSH 7306 (2015)	Internal capsule + MCE membrane				41.42 – 2026.67	0.12 – 5.86
INRS MétroPol M-122 (2015)	Quartz fiber filter				814.00 - nd	2.35- nd

Protocol	Sampling support	Flow rate (L·min ⁻¹)	Sampling duration (min)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					(µg·m ⁻³)	Fraction of the 15 min-STEEL
INRS MétroPol M-124 (2015)	MCE membrane				nd	nd
INRS MétroPol M-125 (2016)	Internal capsule + MCE membrane				110.00 - nd	0.32- nd
NF X 43-257 (2016) NF X 43-275 (2002)	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)				814.00 - nd	2.35 - nd
Adaptation of protocols						
<i>NIOSH 7304 (2014)</i> <i>Perkin Elmer Optima® 3000 DV</i>	<i>PVC membrane</i>	<i>3.5</i>	<i>15</i>	<i>52.5</i>	<i>31.43 – 28571.43</i>	<i>0.09 – 82.58</i>
In italics: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 15min-STEEL for short-term exposure; in italics and bold: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 15min-STEEL for the technical regulatory control. nd : not determined in protocol.						

Recovery rates:

Recovery rates were evaluated by doping the supports and are only available in NIOSH protocols, as shown in Table 30. These yields therefore do not take into account capture efficiency and mineralisation yield (soluble deposits). It should be noted that all NIOSH protocols using MCE membranes meet the expected recovery requirements ($\geq 90\%$), while for PVC membranes, only the NIOSH 7304 (2014) protocol using a Perkin Elmer Optima® 3000 DV ICP-AES meets this requirement.

Table 30. Recovery rates identified in the protocols for method A

Protocol	Sampling support	Range in µg Al/filtre	Recovery rates
NIOSH 7300 (2003)	MCE membrane	1.54 – 6.40	105.40 – 101.50
NIOSH 7300 (2003)	PVC membrane	1.56 – 6.40	77.40 – 92.90
NIOSH 7301 (2003)	MCE membrane	1.54 – 6.40	105.40 – 101.50
NIOSH 7301 (2003)	PVC membrane	1.56 – 6.40	77.40 – 92.90
NIOSH 7302 (2014)	MCE membrane	7.50 - 750	92.70 – 98.70
NIOSH 7303 (2003)	MCE membrane	< 50000	90.00 – 110.00^(a)
NIOSH 7304 (2014) Fisons ARL Accuris	PVC membrane	50.25 – 1500.00	89.78 – 100.71
NIOSH 7304 (2014)	PVC membrane	15.00 – 1500.00	115.05 – 105.17

Protocol	Sampling support	Range in µg Al/filtre	Recovery rates
Perkin Elmer Optima® 3000 DV			
NIOSH 7306 (2015)	Internal capsule + MCE membrane	10.60 – 60.80	95.70 – 96.20
^(a) The protocol has obtained the validated status, which means that the method is suitable for samples up to at least 0.0500 g bulk material with recoveries of between 90 and 110 percent. In bold: protocols meeting expected recovery rate requirements (≥ 90 %).			

Linearity of Detection:

Linearity over the calibration range is not indicated in any of the protocols.

Interferences and specificity:

The method is not substance-specific as far as sampling is concerned, but becomes specific through the choice of the analytical method for which aluminium has a specific response.

Spectral interference can be minimized by selecting the least-interfered aluminium wavelength. The wavelengths used in the various protocols are: 167.00 nm (NIOSH 7300, 2003 ; NIOSH 7301, 2003), 308.20 nm axial (NIOSH 7302, 2014 ; NIOSH 7303, 2003 ; NIOSH 7304, 2014), 396.15 nm (NIOSH 7306, 2015) or unspecified (NF ISO 15202, 2020 ; INRS M-122, 2015 ; INRS M-124, 2015 ; INRS M-125, 2016 ; INRS M-439, 2024 ; NF X43-257, 2016 and NF X43-275, 2002). The instrument's control software also allows interference between two elements to be corrected by an inter-element correction factor. Analytical interference has not been specifically studied. In view of the selectivity of the analytical technique, this criterion is not considered a determining factor.

Uncertainties:

Uncertainties are only described in the NIOSH protocols 7302 (2014), 7304 (2014) and 7306 (2015) and were determined by doping the supports. The concentration ranges tested for uncertainties are described in Table 31.

- Data for calculating uncertainty are available in the concentration range of interest for the recommended 8h-OEL in the NIOSH 7302 (2014) and 7304 (2014) protocols;
- For the 15min-STEEL technical regulatory control, the data used for calculating uncertainty are available for part of the concentration range of interest;
- For the short-term exposure monitoring, the NIOSH 7302 (2014) and 7304 (2014) protocols provide data for calculating uncertainty in the concentration range of interest.

Table 31. Uncertainties information identified in protocols for method A

Protocol	Range reported in protocol (µg Al/sampling support)	Range calculated 8h-OEL (µg.m ⁻³) V= 960L	Range calculated 15min-STEEL (µg.m ⁻³) V= 30L	Range calculated 15min-STEEL (µg.m ⁻³) V= 52.5L	Bias	Overall Precision (%)	Accuracy (%)
NIOSH 7302 (2014)	2.50 - 750.00	2.60 - 781.25	83.33 – 25000.00	47.62 – 14285.71	0.0505	1.455	7.41
NIOSH 7304 (2014) Fisons ARL Accuris	5.00 - 1500.00	5.21 – 1562.50	166.67 – 50000.00	95.24 – 28571.42	-0.0318	0.0419	9.90
NIOSH 7304 (2014) Perkin Elmer Optima® 3000 DV	5.00 - 1500.00	5.21 – 1562.50	166.67 – 50000.00	95.24 – 28571.42	0.0833	0.0379	15.1
NIOSH 7306 (2015)	10.60 - 60.80	11.04 – 63.33	353.33 – 2026.67	201.90 – 1158.10	-0.0414	0.050	12.40

For the technical regulatory control of the 8h-OEL method A analytical technique has been validated in the concentration range of interest, in relation to 8h sampling at a flow rate of 2 L.min⁻¹, in the condition of the NIOSH 7302 (2014) protocol. It should be noted that the validated domain does not reach the 0.1 times the 8h-OEL, but the limit of quantification nevertheless allows it which makes it partially adapted. Detailed values for uncertainties are available in the 0.1 to 2 times 8h-OEL concentration range. Therefore, the analytical technique of method A is classified in 1B. As the sampling technique is classified in category 2, method A is globally classified as category 2 for the technical regulatory control of the recommended 8h-OEL.

For the technical regulatory control of the 15min-STEEL, method A analytical technique has not been directly validated in the 0.1 to 2 concentration range of interest. Nevertheless, in the condition of the NIOSH 7304 (2014) protocol using a Perkin Elmer Optima® 3000 DV ICP-AES, an adaptation of the sampling device allows to cover this concentration range by using a sampling device working with a flow rate of at least 3.5 L.min⁻¹, for 15 minutes. In those conditions, detailed values for uncertainties are available and comply with requirements described in Anses (to be published) even though not available for the entire concentration range from 0.1 to 2 times 15min-STEEL concentration range. Therefore, by using a sampling device working at a 3.5 L.min⁻¹ (or at a greater flow rate) during 15 minutes, the analytical technique of method A is classified in 1B. As the sampling technique is classified in category 2, method A is globally classified as category 2 for the technical regulatory control of the recommended 15min-STEEL.

For the short-term exposure control of the recommended 15min-STEEL method A analytical technique has been validated in the 0.5 to 2 concentration range, in relation to a 15 minutes sampling at a flow rate of 2 L.min⁻¹, in the condition of the NIOSH 7302 (2014) and NIOSH 7306 protocols. The validated domain does not reach the 0.5 times 15min-STEEL, but the limit of quantification nevertheless allows it which makes it partially adapted. Detailed values for uncertainties are available in the 0.5 to 2 times 15min-STEEL concentration range under the condition of the NIOSH 7302 (2014) protocol.

Therefore, the analytical technique of method A is classified in 1B for short-term exposure assessment. As the sampling technique is classified in category 2, method A is globally classified as category 2 for the short-term exposure assessment.

1.2.5 Detailed assessment of the analytical technique of the method B: Active sampling of inhalable fraction on membrane or filter - Acid digestion - DCP-AES analysis

The method is described in 2 norms i.e. NF X43-257 (2016) and NF X43-275 (2002). The method consists in sampling inhalable fraction (§ 1.2.2). After sampling, the support is mineralized in an acid medium (§ 1.2.3) for determination of aluminium concentration by direct-current plasma (DCP) atomic emission spectroscopy (AES).

Validation range and available data:

The norms NF X43-257 (2016) and NF X43-275 (2002) does not specify the validation range, moreover, essential validation data are missing, such as limit of quantification, uncertainties, and so on. As a consequence, these norms will not be taken into account in the rest of the assessment.

Due to the lack of validation data and information on the applicable concentration range, method B is classified for the 8h-OEL, 15min-STEEL and short-term exposure monitoring as category 3*. As the sampling technique is classified in category 2, method B is globally classified in category 3* for the control of the 8h-OEL, the 15min-STEEL and short-term exposure.

1.2.6 Detailed assessment of the analytical technique of the method C: Active sampling of inhalable fraction on membrane or filter - Acid digestion - ICP-MS analysis

Method C involves sampling by pumping the inhalable fraction onto a filter or a membrane (§1.2.2). After sampling, the medium is mineralized in an acidic medium (§1.2.3) for aluminium determination by inductively coupled plasma mass spectrometry (ICP-MS). Three protocols (IRSST MA-362, 2011; IRSST MA-394, 2018 ; IFA 6061, 2024) and one standard (ISO 30011, 2010) describe this method.

For the IRSST MA-362 (2011), MA-394 (2018) and the ISO 30011 (2010) protocols, atmospheric concentration data presented in this assessment were calculated based on air sampling at a flow rate of 2 L.min⁻¹ for 8 hours and for 15 minutes.

The IFA 6061 (2025) protocol, recommends a GSP-10, but, as explained in §1.2.2, this sampling device is not recommended to sample the inhalable fraction due to a lack of validation data. However, as explained in the “accessible measurement range” part of section 1.2.4, it is possible to use another membrane inhalable sampling device with an adapted flow rate allowing compliance with the conventional inhalable fraction. Therefore, the validation data provided in the IFA 6061 (2025) protocol, was recalculated on the basis of an 8 hours or 15 minutes sampling at a flow rate of 2 L/min.

It should be noted that different types of validation data are reported in the IFA 6061 (2025) protocol, depending on the mineralization technique. As the objective was to assess the method for measuring aluminium, only data related to the mineralisation type “HNO₃ + microwave-assisted pressure” and “HNO₃ + HCl” were reported. The tables below indicate to

which mineralisation technique the validation data refers.

Validation range:

The method was validated by doping the supports with aluminium in the concentrations presented in Table 37. For the NF ISO 30011 (2010), IRSST MA-362 (2011) and IRSST MA-394 (2018) protocols, the validation range for each protocol is calculated on the basis of a sample air volume of 960 L and 30 L, corresponding to an 8 hours and 15 minutes sampling period at 2 L.min⁻¹, respectively. These air volumes fall within the range of air volumes recommended by each protocol, and this sampling flow rate corresponds to the most common flow rate for inhalable fraction sampling devices, also compatible with CFC alone or with the internal capsule used in the protocols.

For the IFA 6061 (2025) protocol, the validation range is calculated on the basis of a sample air volume of 960 L and 30 L, corresponding to an 8 hours and 15 minutes sampling period at 2 L.min⁻¹, respectively.

The method has been validated across different domains for each protocol, as presented in Table 32. According to Table 32, the validation ranges identified in each protocol are variable and depend on the conditions under which the protocols are implemented.

Table 32. Validation ranges identified in the protocols for method C

Protocol	Sampling support	Sampled volume (L)	Validation range		Fraction of the exposure levels covered	
			(µg/sample)	(µg·m ⁻³)	8h-OEL	15min-STEL
NF ISO 30011 (2010)	Reference NF ISO 15202-1	960	nd	nd	nd	-
		30		nd	-	nd
IRSST MA-362 (2011)	Membrane (MCE, 37-mm or 25-mm diameter, 0.8-µm pore size)	960	1.08 – 19.8	1.1 – 20.6	0.02 – 0.29	-
		30		36.0 - 660	-	0.104 – 1.91
IRSST MA-394 (2018)	Solu-Sert™ 25 mm and 37 mm (0.8 µm MCE encapsulated 2-piece polypropylene cassette with cellulose backing in a cellulose acetate membrane)	960	5.04 – 1998	5.3 – 2081.3	0.01 – 29.73	-
		30		168 – 66600	-	0.49 – 192.49
IFA 6061 (2025) HNO ₃ + microwave-assisted pressure mineralisation	Filter (cellulose nitrate)	960	0.204 – 39.6	0.21- 41.25	0.003 – 0.58	-
		30		6.8 - 1320	-	0.02 – 3.8

Protocol	Sampling support	Sampled volume (L)	Validation range		Fraction of the exposure levels covered	
			(µg/sample)	(µg·m ⁻³)	8h-OEL	15min-STEEL
IFA 6061 (2025) HNO ₃ + HCl mineralisation	Filter (cellulose nitrate)	960	1 – 39.6	1 – 41.25	0.01 – 0.59	-
		30		33.3 - 1320	-	0.1 – 3.81
nd: not determined in the protocol.						

As ISO 30011 (2010) does not specify the validation range, this protocol will not be taken into account in the rest of the assessment.

- IRSST MA-362 (2011):

- between 6.0 and 110 $\mu\text{g}\cdot\text{m}^{-3}$ for 180 L of air sampled is specified in the protocol, that does not cover the 0.1 to 2 times the 8h-OEL. By converting into the quantity on the support (taking into account the 180 L volume) the validation range is 1.08 to 19.8 μg per support. Thus, for a volume of 960 L (8 h at 2 $\text{L}\cdot\text{min}^{-1}$) the domain validated is 1.1 to 20.6 $\mu\text{g}\cdot\text{m}^{-3}$ that is not satisfactory regarding the domain expected (i.e. 7-140 $\mu\text{g}\cdot\text{m}^{-3}$).
- between 36.0 and 660 $\mu\text{g}\cdot\text{m}^{-3}$ for 30 L (2 $\text{L}\cdot\text{min}^{-1}$) of air sampled, that does not cover the 0.1 to 2 times the 15min-STEEL (i.e. 34.6-692 $\mu\text{g}\cdot\text{m}^{-3}$) but covers the 0.5 to 2 times the 15min STEEL which corresponds to the domain to reach to evaluate short term exposure.

- IRSST MA-394 (2018):

- between 28.0 and 11100 $\mu\text{g}\cdot\text{m}^{-3}$ for 180 L of air sampled, that does not cover the 0.1 times the 8h-OEL. By converting a quantity on the support (taking into account the 180 L volume) the validation range is 5.04 to 1998 μg per support. Thus, for a volume of 960 L (8 h at 2 $\text{L}\cdot\text{min}^{-1}$) the domain covered is 5.3 to 2081.3 $\mu\text{g}\cdot\text{m}^{-3}$ covering the 0.1 to 2 times the 8h-OEL concentration range.
- between 336 and 133200 $\mu\text{g}\cdot\text{m}^{-3}$ for 15 L of air sampled (1 $\text{L}\cdot\text{min}^{-1}$), that does not cover neither the 0.1 to 2 times the 15min-STEEL nor the 0.5 to 2 times the 15min-STEEL. By converting a quantity on the support (taking into account the 180L volume) we can calculate 5.04 to 1998 μg per support. Thus, for a volume of 30 L (15 min at 2 $\text{L}\cdot\text{min}^{-1}$) the domain covered is 168.0 to 66600 $\mu\text{g}\cdot\text{m}^{-3}$ covering the 0.5 to 2 times the 15min-STEEL concentration range.

- IFA 6061 (2025):

- for the “HNO₃ + microwave-assisted pressure” mineralisation technique, the validation range is between 0.21 and 41.25 $\mu\text{g}\cdot\text{m}^{-3}$ for 960 L of air sample (2 $\text{L}\cdot\text{min}^{-1}$). This does not cover the 0.1 to 2 times 8h-OEL concentration range.
- for the “HNO₃ + microwave-assisted pressure” mineralisation technique, the validation range is between 6.8 and 1320 $\mu\text{g}\cdot\text{m}^{-3}$ for 30 L of air sample (2 $\text{L}\cdot\text{min}^{-1}$). This covers the 0.1 to 2 times the 15min-STEEL concentration range.

- for the “HNO₃ + HCl” mineralisation technique, the validation range is between 1 and 41.25 µg.m⁻³ for 960 L of air sample (2 L.min⁻¹). This does not cover the 0.1 to 2 times 8h-OEL concentration range.
- for the “HNO₃ + HCl” mineralisation technique, the validation range is between 33.3 and 1320 µg.m⁻³ for 30 L of air sample (2 L.min⁻¹). This covers the 0.1 to 2 times the 15min-STEEL concentration range.

Limit of detection and limits of quantification:

The LOD and LOQ mentioned in the protocols (in bold) or calculated from the LOD (in italics) are summarised in the following Table 33.

Table 33. Limits of detection and quantification identified in the protocols for method C

Protocol	LOD (µg/sampling support)	LOQ (µg/sampling support)	8h-OEL		15min-STEEL	
			LOD ^(a) (µg.m ⁻³)	LOQ ^{(a)(b)} (µg.m ⁻³)	LOD ^(a) (µg.m ⁻³)	LOQ ^{(a)(b)} (µg.m ⁻³)
NF ISO 30011 (2010)	nd	nd	nd	nd	nd	nd
IRSST MA-362 (2011)	0.078	0.261*	<i>0.08</i>	<i>0.27</i>	2.6	2.6
IRSST MA-394 (2018)	0.014	0.046	<i>0.015</i>	<i>0.05</i>	<i>0.47</i>	1.5
IFA 6061 (2025) HNO ₃ + microwave- assisted pressure mineralisation	0.059	0.20	<i>0.06</i>	<i>0.21</i>	1.97	6.66
IFA 6061 (2025) HNO ₃ + HCl mineralisation	0.21	0.70	<i>0.22</i>	<i>0.73</i>	7	23.33

In bold: value extracted from the protocol; in italics: calculated values; nd: not determined in the protocol
 (a) calculated for a 960 L sampling for the 8h-OEL or a 30 L sampling for the 15min-STEEL
 (b) atmospheric concentration – estimated from LD if not mentioned in the protocol, estimated by $LQ = 3 \times LD$
 * A “Valeur Minimale Rapportée” (“VMR”) was available in this protocol but only the LOQ was considered, as no contextual information is available to use the “VMR” value.

- ISO 30011 (2010): the detection limit given in the protocol is 0.23 µg.L⁻¹ - the quantification limit given in the protocol is 0.77 µg.L⁻¹ - The final volume is not given and does not allow to calculate LOD and LOQ.

- IRSST MA-362:

- the detection limit is 7.8 µg.L⁻¹ corresponding to 0.078 µg/sampling support (mineralisation volume of 10 mL) and thus to a detection limit of 0.08 µg.m⁻³ (for 960 L of sampled air) and 2.6 µg.m⁻³ (for 30 L of sampled air). The quantification limit given in the protocol is 26.1 µg.L⁻¹ corresponding to 0.261 µg/sampling support (mineralisation volume of 10 mL) and thus to a quantification limit of 0.27 µg.m⁻³ (for 960 L of sampled air) and 17.4 µg.m⁻³ (for 15 L of sampled air).
- the detection limit is 1.4 µg.L⁻¹ corresponding to 0.014 µg/sampling support (mineralisation volume of 10 mL-dilution 1/10) and thus to a detection limit of 0.015 µg.m⁻³ (for 960 L of sampled air) and 0.47 µg.m⁻³ (for 30 L of sampled air). The quantification limit given in the protocol is 4.6 µg.L⁻¹ corresponding to 0.046 µg/sampling support (mineralisation volume of 10 mL) and thus to a quantification limit of 0.048 µg.m⁻³ (for 960 L of sampled air) and 1.5 µg.m⁻³ (for 30 L of sampled air).

- IFA 6061 (2025):

- for the “HNO₃ + microwave-assisted pressure” mineralisation technique, the detection limit is 0.059 µg/sampling support corresponding to 0.06 µg.m⁻³ (for 960 L of sampled air) and 1.97 µg.m⁻³ (for 30 L of sampled air). The quantification limit is 0.20 µg/sampling support corresponding to 0.21 µg.m⁻³ (for 960 L of sampled air) and 6.66 µg.m⁻³ (for 30 L of sampled air).
- for the “HNO₃ + HCl” mineralisation technique, the detection limit is 0.21 µg/sampling support corresponding to 0.22 µg.m⁻³ (for 960 L of sampled air) and 7 µg.m⁻³ (for 30 L of sampled air). The quantification limit is 0.70 µg/sampling support corresponding to 0.73 µg.m⁻³ (for 960 L of sampled air) and 23.33 µg.m⁻³ (for 30 L of sampled air).

Accessible measurement range:

The accessible measurement range depends on the limit of quantification, the validation range identified in the protocols and some adaptations of the measurement method (flow rate, sampling duration...) that can be made to achieve the range required to monitor the recommended 8h-OEL and 15 min-STEEL. Detailed reasons of adaptations and an adaptation example is explained in the accessible measurement range part of section 1.2.4.

Method C accessible measurement range covers the domain required to monitor the 8h-OEL under the conditions of the IRSST MA-394 (2018) protocol as described in Table 34.

Table 34. Method C accessible measurement range for monitoring the 8h-OEL

Protocol	Sampling support	Flow rate (L·min ⁻¹)	Sampling duration (h)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					(µg·m ⁻³)	Fraction of 8h-OEL covered
NF ISO 30011 (2010)	Reference NF ISO 15202-1	2	8	960	nd	nd
IRSST MA-362 (2011)	Membrane (MCE, 37-mm or 25-mm diameter, 0.8-µm pore size)	2	8	960	0.3 – 26.6	0.004 – 0.38
IRSST MA-394 (2018)	Solu-Sert™ 25 mm and 37 mm (0.8 µm MCE membrane encapsulated 2-piece polypropylene cassette with cellulose backing in a cellulose acetate membrane)	2	8	960	0.05 – 2081	0.0007 – 29.73
IFA 6061 (2025) HNO ₃ + microwave-assisted pressure mineralisation	Filter (cellulose nitrate)	2	8	960	0.21 – 41.25	0.003 – 0.58
IFA 6061 (2025) HNO ₃ + HCl mineralisation	Filter (cellulose nitrate)	2	8	960	0.73 – 41.25	0.01 – 0.59
In bold: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 8h-OEL for the technical regulatory control. nd: not determined in the protocol.						

Method C accessible measurement range covers the domain required to monitor the 15min-STEEL for technical regulatory control and short-term exposure monitoring under the conditions of the IRSST MA-394 (2018) and the IFA 6061 (2025) (using a sampling device recommended in §1.2.2 with a 2 L.min⁻¹ flow rate) protocols described in Table 35.

Table 35. Method C accessible measurement range for monitoring the 15min-STEEL

Protocol	Sampling support	Flow rate (L.min ⁻¹)	Sampling duration (min)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					(µg.m ⁻³)	Fraction of the 15 min-STEEL
NF ISO 30011 (2010)	Reference NF ISO 15202-1	2	15	30	nd	nd
IRSST MA-362 (2011)	Membrane (MCE, 37-mm or 25-mm diameter, 0.8-µm pore size)	2	15	30	2.6 – 660	0.008 – 1.91
IRSST MA-394 (2018)	<i>Solu-Sert™ 25 mm and 37 mm (0.8 µm MCE membrane encapsulated 2-piece polypropylene cassette with cellulose backing in a cellulose acetate membrane)</i>	2	15	30	1.5 – 66600	0.004 – 192.49
<i>IFA 6061 (2025) HNO₃ + microwave-assisted pressure mineralisation</i>	<i>Filter (cellulose nitrate)</i>	2	15	30	6.66 – 1320.00	0.02 – 3.82
<i>IFA 6061 (2025) HNO₃ + HCl mineralisation</i>	<i>Filter (cellulose nitrate)</i>	2	15	30	23.33 – 1320.00	0.07 - 3.82

In italics: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 15min-STEEL for short-term exposure; in italics and bold: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 15min-STEEL for the technical regulatory control. nd: not determined in the protocol.

Recovery rates:

For aluminium, recovery rates of 97.7 % and 102.9 % are reported for the protocols IRSST MA-362 (2011) and IRSST MA-394 (2018), respectively. For the IRSST MA-362 (2011) protocol it was evaluated by subjecting a series of membranes enriched (n=28, 4 concentration levels, 7 membranes per level) with a soluble form of aluminium to the entire analytical procedure.

For the IFA 6061 (2025) protocol, recovery rates depend on the mineralisation technique:

-
- from 102 to 106 % for a mineralisation with HNO₃ and HCl;
 - from 93 to 99 % for a mineralisation with HNO₃ and pressure assisted by microwave.

Storage and Efficiency:

The samples are described as stable at ambient temperature (IRSST MA-394, 2018). The stability of solutions after mineralisation depends on several factors, such as element concentration, test matrix, nature of the storage container and storage conditions. Fresh solutions should be prepared daily, or stored for a maximum period determined from the results of stability experiments (IRSST MA 362). The IFA 6061 (2025) protocol indicates that samples can be stored for up to 4 weeks. Concentrations from 0.6 to 23 µg of Al/sampling support (24 cellulose nitrate filters were spiked for each concentration) were tested after 4 weeks, mean recovery rates between 103 and 104 % were obtained.

Linearity of Detection:

Linearity over the calibration range is given for a range from 200 to 2000 µg.L⁻¹ (IRSST MA-362, 2011). No information about linearity of detection is provided in the IRSST MA-394 (2018) protocol.

Interferences and specificity:

In the IRSST MA-394 (2018) protocol, it is indicated that there are two types of interference: spectral and non-spectral. Non-spectral interferences, generally referred to as matrix effects, originate in the composition of the matrix and result in a physical suppression of the analyte signal. This phenomenon is observed when the matrix is composed of too high level of dissolved salts or too high concentration of acid in the sample. Wherever possible, the matrix effect can be attenuated or eliminated by using an internal standard and/or diluting the sample. Spectral interference comes in two forms: isobaric interference and polyatomic interference. Isobaric interference was avoided by selecting the isotopes of interest. The use of a collision/reaction cell in collision mode reduces or eliminates the presence of polyatomic interference. Al has a single stable isotope (²⁷Al). No isobaric interferences are reported.

The IFA 6061 (2025) protocol indicates that measurement results must always be checked for possible interference and that additional dilution steps must be performed during preparation in case of interferences.

The method is not substance-specific as far as sampling is concerned, but becomes specific through the choice of analytical method for which aluminium has a specific response (irrespective of the compound).

Uncertainties:

The IRSST MA-362 (2011) protocol provides numerous validation data which are determined from doped supports (MCE) i.e.: analytical uncertainties (CVa): 3.8 %; expanded uncertainties (CVe): 12.4 %; accuracy: 94.6 %; replicability: 1.5 % and repeatability: 2.7 %. The analytical measurement uncertainty was calculated using results obtained on 28 spiked membranes (4 concentration levels, 7 membranes per level) subjected to the entire analytical procedure. The expanded measurement uncertainty (CVe) for the assay and sampling as a whole has been calculated, taking into account an estimated CV of 5 % for sampling and a 95 % probability threshold. No information is provided on concentrations tested to determine the analytical uncertainties but the domain of applicability of this protocol for aluminium is indicated. It is presented in Table 36.

The IRSST MA-394 (2018) protocol provides numerous validation data which are determined from doped supports (MCE) i.e.: analytical uncertainties (CVa): 3.2 %; accuracy: 97.6 %; replicability: 3.0 % and repeatability: 3.3 %. The method's analytical measurement uncertainty (CVa) is determined on the basis of individual results obtained on samples subjected to the entire analytical procedure. It does not take into account a probability threshold (e.g. 95 %), nor the contribution of sampling uncertainty. The protocol indicates the domain of applicability for aluminium, but it does not report the concentrations tested to determine the analytical uncertainties. It is presented in Table 36.

The IFA 6061 (2025) protocol reports expanded uncertainties at different levels of concentrations, depending on the mineralisation technique. Details are presented in Table 36.

Table 36. Uncertainties information identified in the method C protocols

Protocol	Range reported in protocol ($\mu\text{g.m}^{-3}$) V = 180 L	Range reported in protocol ($\mu\text{g.m}^{-3}$) V = 1200 L	Range calculated 8h-OEL ($\mu\text{g.m}^{-3}$) V = 960 L	Range calculated 15min-STEEL ($\mu\text{g.m}^{-3}$) V = 30 L	Expanded uncertainties (%)
IRSST MA-362 (2011)	6.00 – 110.00	nd	1.13 – 20.62	36.00 – 660.00	12.40
IRSST MA-394 (2018)	28.00 – 11 100.00	nd	5.25 – 2081.20	168.00 – 66600.00	nd
IFA 6061 (2025) HNO ₃ + microwave- assisted pressure	nd	0.50 – 10.00	0.63 – 12.50	20.00 – 400.00	23.40 – 24.40
IFA 6061 (2025) HNO ₃ + HCl / heat	nd	0.58 – 10.00	0.73 – 12.50	23.20 – 400.00	21.40 – 22.80
nd: not determined in the protocol.					

For the technical regulatory control of the 8h-OEL, method C analytical technique has been validated in the 0.1 to 2 times 8h-OEL concentration range, in relation to 8 hours sampling at a flow rate of 2 L.min⁻¹, in the condition of the IRSST MA-394 (2018) protocol. For the technical regulatory control of the 15min-STEEL and short term exposure monitoring, method C analytical technique has been validated in the 0.1 to 2 times 15min-STEEL concentration range, in relation to 15 minutes sampling at a flow rate of 2 L.min⁻¹, in the condition of the IFA 6061 (2025) protocol. Values for recovery rates, uncertainties are available and comply with requirements described in Anses methodological guide (to be published) even though not available for the entire concentration range from 0.1 to 2 times the 8h-OEL and from 0.1 to 2 times the 15min-STEEL. Therefore, the method C analytical technique is classified as category 1B for the technical regulatory control of the recommended 8h-OEL, 15min-STEEL and short term exposure monitoring.

As the sampling technique (using a sampling device recommended in §1.1.2 with a 2 L.min⁻¹ flow rate) is classified in category 2, method C is globally classified as category 2 for the technical regulatory control of the recommended 8h-OEL, 15min-STEEL and short term exposure monitoring.

1.2.7 Detailed assessment of the analytical technique of the method D: Active sampling of inhalable fraction on membrane or filter - Acid digestion - GFAAS analysis

The method consists of taking an active sample from a filter or a membrane. The support after sampling is mineralized in an acidic medium to perform a determination by electrothermal atomization atomic absorption spectrometry / graphite furnace (SAA-FG).

This method is described by 4 protocols that are very equivalent from a sampling and analysis point of view: DFG (MAK) 2718 (2014), INRS MétroPol M-120 (2015), NF X 43-257 (2016) and NF X 43-275 (2002).

The sample is taken from a quartz fiber or nitrocellulose filter using a CFC (§ 1.2.1). The evaluation of the D method mineralisation technique is provided in paragraph 1.2.2. Regarding validation data, only the DFG (MAK) 2718 protocol (2014) provides detailed information.

Validation range:

The most comprehensive validation data are provided in DFG (MAK) 2718 (2014), as presented in Table 37. The recommended sampling time in this protocol is 2 hours with a flow rate of 3.5 L.min⁻¹ to sample the inhalable fraction, but atmospheric concentration data were also calculated for 8 hours sampling with a flow rate of 3.5 L.min⁻¹ as shown in Table 37.

Table 37. Validation ranges identified in the protocols for method D

Protocol	Sampling support	Sampled volume (L)	Validation range		Fraction of the exposure levels covered	
			(µg/sample)	(µg·m ⁻³)	8h-OEL	15 min-STEL
INRS MétroPol M-120 (2015)	Filter (quartz fiber)	960	nd	nd	nd	-
		30		nd	-	nd
DFG (MAK) 2718 (2014)	Filter (Nitrocellulose)	1680	10.08 – 999.60	6.00 – 595.00	0.09 – 8.50	-
		420		24.00 - 2380.00	0.34 – 34.00	-
		52.5		192.00 – 19040.00	-	0.55 – 55.03
NF X 43-257 (2016)	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)	960	nd	nd	nd	-
NF X 43-275 (2002)		30		nd	-	nd

nd: not determined in the protocol.

Limit of detection and quantification:

DFG (MAK) 2718 (2014): the LOQ is 0.7 µg·m⁻³ for 2 hours sampling at 3.5 L.min⁻¹. The LOQ was determined from a 10-point calibration (based on DIN 32645) for the inhalable fraction and corresponds to 2.4 µg·m⁻³ for a 2 hours sampling at 3.5 L.min⁻¹ and 0.6 µg·m⁻³ for an 8h-sampling at 3.5 L.min⁻¹. The NF X 43-275 (2002) analysis method specifies the LOD is 7.4 µg of aluminium by sampling support but this instrumental detection limit was determined by an ICP

analysis in 1992, which is not the analytical technique of method D. Therefore, the NF X 43-257 LOD is not taken into account into the assessment of method D.

Accessible measurement range:

The accessible measurement range depends on the limit of quantification, validation ranges identified in the protocols and some adaptations of the measurement method (flow rate, sampling duration etc.) that can be made to achieve the range required to monitor the recommended 8h-OEL and 15 min-STEEL. Detailed reasons of adaptations and an adaptation example are explained in the accessible measurement range part of section 1.2.4.

Considering a 2 hours sampling and an 8 hours sampling, method D accessible measurement range covers the domain required to monitor the 8h-OEL under the conditions of the DFG (MAK) 2718 (2014) protocol described in Table 38. As a total sampling duration of 8 hours is required to assess the 8h-OEL, it is strongly recommended to perform a single 8-hour sampling, as conducting four consecutive 2 hours samplings may significantly increase the overall measurement uncertainty.

Table 38. Method D accessible measurement range for monitoring the 8-hour OEL

Protocol	Sampling support	Flow rate (L·min ⁻¹)	Sampling duration (h)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					(µg·m ⁻³)	Fraction of 8h-OEL covered
INRS MétroPol M-120 (2015)	Filter (quartz fiber)	2	8	960	nd	nd
DFG (MAK) 2718 (2014)	Filter (nitrocellulose)	3.5	2	420	2.40 – 2380.00	0.03 – 34.00
			8	1680	0.60 – 595.00	0.01 – 8.50
NF X 43-257 (2016) NF X 43-275 (2002)	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)	2	8	960	nd	nd

In bold: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 8h-OEL for the technical regulatory control. nd: not determined in the protocol.

Method C accessible measurement range covers the domain required to monitor the 15min-STEEL for technical regulatory control and short-term exposure under the conditions of the DFG (MAK) 2718 (2014) protocol described in Table 39.

Table 39. Method D accessible measurement range for monitoring the 15 min-STEEL

Protocol	Sampling support	Flow rate (L·min ⁻¹)	Sampling duration (min)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					(µg·m ⁻³)	Fraction of the 15 min-STEEL
INRS MétroPol M- 120 (2015)	Filter (quartz fiber)	2	15	30	nd	nd
<i>DFG (MAK) 2718 (2014)</i>	<i>Filter (nitrocellulose)</i>	<i>3.5</i>	<i>15</i>	<i>52.5</i>	<i>19.20 – 19040.00</i>	<i>0.06 – 55.03</i>
NF X 43-257 (2016) NF X 43-275 (2002)	Filter (glass fiber, quartz fiber, MCE, PVC, PTFE)	2	15	30	nd	nd

In italics: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 15min-STEEL for short-term exposure; in italics and bold: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 15min-STEEL for the technical regulatory control. nd: not determined in the protocol.

Recovery rates:

In the DFG (MAK) 2718 (2014) protocol, a recovery of aluminium of 97 ± 5 % was obtained in the course of the determination of the precision by spiking of the filters with 3 simulated different concentrations (24, 238 and 2380 µg·m⁻³ for 420 L of air sampling) for n=8 determinations.

This corresponds to a concentration range of 6 to 595 µg·m⁻³ for a 1680 L air sample (8h at the recommended flow rate), covering the required range of 0.1 to 2 times the 8h-OEL. For an air sample of 52.5 L (15 min at the recommended flow rate), this corresponds to a concentration range of 192 to 19 040 µg·m⁻³, which covers the 0.5 to 2 times 15min-STEEL concentration range, but not the 0.1 to 2 times 15min-STEEL concentration range required for regulatory technical control.

Linearity of Detection:

Linearity over the calibration range is not indicated in any of the protocols.

Interferences and specificity:

The method is not substance-specific as far as sampling is concerned, but becomes specific through the choice of the analytical method for which aluminium has a specific response. No further information is indicated in the protocols.

Uncertainties:

DFG (MAK) 2718 (2014): uncertainties were determined using 8 filters loaded with three different aluminium masses (0.01, 0.10 and 1.0 mg). The expanded uncertainty estimate varies between 32.3 % and 37 % (k = 2). The lowest concentration point lies between 0.1 to 0.5 times the 8h-OEL — in this range, the uncertainty requirement can go up to 50 %.

In this context, the atmospheric concentration ranges covered by the method, depending on the sampled air volume, are as follows:

- For a 2 hours sampling at a flow rate of $3.5 \text{ L}\cdot\text{min}^{-1}$ (i.e. a total volume of 420 L): the measurement range extends from 24 to $2380 \mu\text{g}\cdot\text{m}^{-3}$ (not covering 0.1 to 2 times the 8h-OEL).
- For a 15 minutes sampling at a flow rate of $3.5 \text{ L}\cdot\text{min}^{-1}$ (i.e. a total volume of 52.5 L): the measurement range extends from 192 to $19\,040 \mu\text{g}\cdot\text{m}^{-3}$ (covering 0.5 to 2 times the 15min-STEEL).
- For an 8 hours sampling at a flow rate of $2 \text{ L}\cdot\text{min}^{-1}$ (i.e. a total volume of 1680 L): the corresponding measurement range extends from 6 to $595 \mu\text{g}\cdot\text{m}^{-3}$ (covering 0.1 to 2 times the 8h-OEL).

In this case, the point at $238 \mu\text{g}\cdot\text{m}^{-3}$ (over 2 hours, equivalent to $59.5 \mu\text{g}\cdot\text{m}^{-3}$ over 8 hours, which is approximately equal to the 8h-OEL) shows an expanded uncertainty very close to 30 %.

The lowest concentration point lies between 0.1 and 0.5 times the 8h-OEL, a range in which the regulatory requirement allows an expanded uncertainty of up to 50 %. In this context, the point at $60 \mu\text{g}\cdot\text{m}^{-3}$ over 8 hours (i.e. a concentration close to the recommended 8h-OEL) shows an estimated expanded uncertainty of approximately 30 %, which remains very close to the maximum allowable threshold.

Validation data reported in method D were obtained on the whole range of the required 0.1 to 2 times the 8h-OEL concentration. Expanded uncertainties are higher than 30 %, but are very close to the requirements since they vary between 32.3 % to 37 %. It should be noted that these data were obtained with a 2-hour sampling, and that an 8-hour sampling should reduce uncertainties. Given these performances and that other validation data are available and meet the requirements described in Anses (to be published), method D analytical technique is classified as category 1B for technical regulatory control of 8h-OEL, subject to appropriate validation under the conditions of the DFG (MAK) 2718 (2014) protocol.

The sampling technique is classified as category 2. As a result, method D is classified globally as category 2 for the technical regulatory control of the recommended 8h-OEL.

For technical regulatory control of the 15min-STEEL, method D analytical technique is classified as category 2 since validation data were not obtained on all of the required concentration range of 0.1 to 2 times the 15min-STEEL. The sampling technique is classified as category 2. As a result, method D is classified globally as category 2 for the technical regulatory control of the recommended 15min-STEEL.

For short-term exposure monitoring, the analytical technique is classified in category 1B since validation data reported in method D were obtained on the totality of the required 0.5 to 2 times 15min-STEEL concentration range and that the expanded uncertainties are less than 50 %, which meet the requirements described in Anses (to be published). The sampling technique is classified in category 2. As a result, method D is classified overall as category 2 for short-term exposure monitoring.

1.2.8 Detailed assessment of the analytical technique of the method E: Active sampling of inhalable fraction on membrane or filter - Acid digestion - FAAS analysis

Method E involves sampling by pumping the inhalable fraction onto a filter or a membrane (§1.2.2). The sampling is carried out on a quartz fiber filter using a CFC, its evaluation is dealt

with in the 1.2.2 paragraph. After sampling, the medium is mineralized in an acidic medium (§ 1.2.3) for determination by flame atomization atomic absorption spectrometry (FAAS).

This method is described by 6 protocols that are very equivalent from a sampling and analysis point of view:

- OSHA ID 121 (2002)
- INRS M-121 (2015)
- INSST MTA/MA – 025/A16 (2016)
- NIOSH 7013 (1994)
- NF X 43-257 (2016) and NF X 43-275 (2002)

Validation range:

The method has been validated across different domains for 3 protocols, as presented in Table 40. Atmospheric concentration data were calculated on the basis of a flow rate of 2 L.min⁻¹ during 8 hours for the 8h-OEL and during 15 minutes for the 15min-STEEL as shown in Table 40. No information regarding the validation range was provided in norms NF X 43-257 and NF X 43-275 and in the INRS M-121 (2015) protocol.

Table 40. Validation ranges identified in the protocols for method E

Protocol	Sampling support	Sampled volume (L)	Validation range		Fraction of the exposure levels covered	
			(µg/sample)	(µg·m ⁻³)	8h-OEL	15 min-STEEL
OSHA ID 121 (2002)	Membrane (MCE or PVC)	960	100.00 – 500.00	104.17 – 520.83	1.49 – 7.44	-
		30		3333.33 – 16666.67	-	9.63 – 48.17
INRS MétroPol M-121 (2015)	Filter (quartz fiber)	960	nd	nd	nd	-
		30		nd	-	nd
INSST MTA/MA 025/A16 (2016)	Filter or membrane (MCE are most commonly used)	960	50.00 – 500.00	52.08 – 520.83	0.74 – 7.44	-
		30		1666.67 – 16666.67	-	4.82 – 48.17
NIOSH 7013 (1994)	Membrane (MCE, 0.8-µm pore size, 37-mm diameter)	960	50.00 – 1000.00	52.08 – 1041.67	0.74 – 14.88	-
		30		1666.67 – 33333.33	-	4.82 – 96.34
NF X 43-257 (2016) NF X 43-275 (2002)	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)	960	nd	nd	nd	-
		30		nd	-	nd

nd: not determined in the protocol.

Limit of detection and quantification

Regarding the LOD, the OSHA ID 121 (2002) protocol specifies an analytical LOD of $0.3 \mu\text{g.mL}^{-1}$ for a 25 mL volume, which corresponds to a $7.8 \mu\text{g.m}^{-3}$ LOD for the 8h-OEL and a $250 \mu\text{g.m}^{-3}$ LOD for the 15min-STEEL. The NF X 43-275 (2002) analysis method specifies the LOD is $7.4 \mu\text{g}$ of aluminium by filter but this instrumental detection limit was determined by an ICP analysis in 1992, which is not the analytical technique of method E. Therefore, the NF X 43-257 LOD is not taken into account. Other protocols did not specify any LOD.

Regarding the LOQs, the LOQs mentioned in protocols are indicated in the following Table 41. Only the INSST MTA/MA – 025/A16 (2016) LOQs are below 0.1 times the 8h-OEL and 0.5 times the 15min-STEEL. None of the LOQs mentioned are less than 0.1 times the 15min-STEEL value.

Table 41. Limits of detection and quantification identified in the protocols for method E

Protocol	LOD ($\mu\text{g/sampling support}$)	LOQ ($\mu\text{g/sampling support}$)	8h-OEL		15min-STEEL	
			LOD ^(a) ($\mu\text{g.m}^{-3}$)	LOQ ^{(a)(b)} ($\mu\text{g.m}^{-3}$)	LOD ^(a) ($\mu\text{g.m}^{-3}$)	LOQ ^(a) ($\mu\text{g.m}^{-3}$)
OSHA ID 121 (2002)	7.50	24.75	7.81	27.5	250.00	825.00
INRS MétroPol M-121 (2015)	nd	nd	nd	nd	nd	nd
INSST MTA/MA – 025/A16 (2016)	nd	5.00	nd	5.21	nd	166.67
NIOSH 7013 (1994)	nd	50.00	nd	52.08	nd	1666.67
NF X 43-257 (2016) NF X 43-275 (2002)	nd	nd	nd	nd	nd	nd
In bold: value extracted from the protocol; in italics: calculated values; nd: not determined in the protocol. (a) calculated for a 960 L sampling for the 8h-OEL or a 30L sampling for the 15min-STEEL. (b) atmospheric concentration – estimated from LOD if not mentioned in the protocol, estimated by $\text{LOQ} = 3,3 \times \text{LOD}$.						

Accessible measurement Range:

The accessible measurement range depends on the quantification limit, validation ranges identified in protocols and some adjustments of the measurement method (flow rate, sampling duration...) that can be made to achieve the required domain for monitoring the recommended 8h-OEL and 15min-STEEL.

For the 8h-OEL monitoring, method E accessible measurement range covers the domain required to monitor the 8h-OEL under the conditions of the INSST MTA/MA – 025/A16 (2016) protocol described in Table 42.

Table 42. Method E accessible measurement range for monitoring the 8-hour OEL

Protocol	Sampling support	Flow rate (L·min ⁻¹)	Sampling duration (h)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					(µg·m ⁻³)	Fraction of 8h-OEL covered
OSHA ID 121 (2002)	Membrane (MCE or PVC)	2	8	960	27.5 – 520.83	0.39 – 7.44
INRS MétroPol M-121 (2015)	Filter (quartz fiber)				nd	nd
INSST MTA/MA – 025/A16 (2016)	Filter or membrane (MCE are most commonly used)				5.21 – 520.83	0.07 – 7.44
NIOSH 7013 (1994)	Membrane (MCE, 0.8-µm pore size, 37-mm diameter)				52.08 – 1041.67	0.74 – 14.88
NF X 43-257 (2016) NF X 43-275 (2002)	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)				nd	nd
In bold: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 8h-OEL for the technical regulatory control. nd: not determined in the protocol.						

For the 15min-STEEL monitoring, method E accessible measurement range only covers the domain required to monitor short-term exposure under the conditions of the INSST MTA/MA – 025/A16 (2016) protocol described in Table 43. The adaptation of the INSST MTA/MA – 025/A16 (2016) protocol with a sampler having a flow rate of 4 L·min⁻¹ (such as the Button™ sampler) does not allow 0.1 times the 15min-STEEL to be covered.

Table 43. Method E accessible measurement range for monitoring the 15 min-STEEL

Protocol	Sampling support	Flow rate (L·min ⁻¹)	Sampling duration (min)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					(µg·m ⁻³)	Fraction of 15min-STEEL covered
OSHA ID 121 (2002)	Membrane (MCE or PVC)	2	15	30	825.00 – 16667.67	2.38 – 48.17
INRS MétroPol M-121 (2015)	Filter (quartz fiber)				nd	nd

Protocol	Sampling support	Flow rate (L·min ⁻¹)	Sampling duration (min)	Volume (L)	Accessible measurement range (ie LOQ to upper limit of the validation range)	
					(µg·m ⁻³)	Fraction of 15min-STEEL covered
<i>INSST MTA/MA – 025/A16 (2016)</i>	<i>Filter or membrane (MCE are most commonly used)</i>				166.67 – 1666.67	0.48 - 48.17
NIOSH 7013 (1994)	Membrane (MCE, 0.8-µm pore size, 37-mm diameter)				166.67 – 33333.33	4.82 – 96.34
NF X 43-257 (2016) NF X 43-275 (2002)	Filter or membrane (glass fiber or quartz fiber or MCE or PVC or PTFE)				nd	nd
In italics: protocols and conditions with an accessible measurement range that covers the domain required to monitor the 15min-STEEL for short-term exposure. nd: not determined in the protocol.						

Recovery rates:

Only the OSHA ID 121 (2002) protocol specifies a recovery rate: 94.5 % over the 100 to 500 µg range tested which corresponds to 104 to 520 µg·m⁻³ (960 L of air sampled) or to 3333 to 16667 µg·m⁻³ (30 L of air sampled) concentration range. It has to be noted that the recovery rate data was not obtained over all of the 0.1 to 2 times 8h-OEL concentration range, but it remains within this concentration range. For the 15min-STEEL, the recovery rate data was obtained outside of the 0.1 or 0.5 to 2 times 15min-STEEL concentration range. To determine the recovery rate, analytes were spiked onto MCE membranes.

There is no information on the recovery rates for the INSST MTA/MA – 025/A16 (2016) protocol.

Linearity of Detection:

- OSHA ID 121 (2002): Optimization at 50 µg/mL = 0.22 ABS.
- INSST MTA/MA – 025/A16 (2016): Not explicitly detailed, but analysis performed between 250 and 2500 µg/m³.

Interferences and specificity:

The OSHA ID 121 (2002) protocol describes potential interferences that can enhance the aluminium signal: acetic acid, fluoroborate, iron, and titanium. It recommends ionization control by adding an alkali salt (potassium or lanthanum) to samples and standards. Other protocols did not detail any information about interferences or specificity of the method.

Uncertainties:

The INSST MTA/MA – 025/A16 (2016) protocol gives expanded uncertainty determined using the GUM method (k=2): 25.6 %.

For regulatory technical control of the recommended 8h-OEL, method E has been validated in the concentration range of 0.1 to 2 times the 8h-OEL, in relation to sampling for 8 h at a flow rate of 2 L.min⁻¹, under the conditions of INSST protocol MTA/MA - 025/A16 (2016). It should be noted that the validated range does not reach 0.1 times the 8h-OEL, but the limit of quantification allows it, which makes it partially suitable. Validation data are available and meet requirements described in Anses (to be published). Although the recovery data have not been obtained over the entire concentration range from 0.1 to 2 times the 8h-OEL, they remain within this range and therefore meet requirements. Consequently, the method E analytical technique is classified in category 1B. As the sampling technique is classified in category 2, method E is overall classified in category 2 for regulatory technical control of the recommended 8h-OEL.

For regulatory technical control of the recommended 15min-STEEL, method E has not been validated in the concentration range of 0.1 to 2 times the 15min-STEEL. Consequently, method E analytical technique is classified as category 3. As the sampling technique is classified as category 2, method E is overall classified as category 3 for regulatory technical control of the recommended 15min-STEEL.

For short-term exposure monitoring, method E has been validated in the concentration range of 0.5 to 2 times the 15min-STEEL, in relation to sampling for 15 minutes at a flow rate of 2 L.min⁻¹, under the conditions of INSST protocol MTA/MA - 025/A16 (2016). It should be noted that the validated range does not reach 0.5 times the 15min-STEEL, but the limit of quantification allows it, which makes it partially suitable. Validation data is available but the recovery rate information was obtained outside the 0.5 to 2 times 15min-STEEL concentration range. Consequently, method E analytical technique is classified as category 2. As the sampling technique is classified as category 2, method E is overall classified as category 2 for short-term exposure control.

2 Conclusions and recommendations

Five methods have been identified for determining aluminium content in workplace atmospheres:

- Method A: active sampling of inhalable fraction on membrane or filter followed by an acid digestion and an ICP-AES analysis;
- Method B: active sampling of inhalable fraction on membrane or filter followed by an acid digestion and a DCP-AES analysis;
- Method C: active sampling of inhalable fraction on membrane or filter followed by an acid digestion and an ICP-MS analysis;
- Method D: active sampling of inhalable fraction on membrane or filter followed by an acid digestion and a GFAAS analysis;
- Method E: active sampling of inhalable fraction on membrane or filter followed by an acid digestion and a FAAS analysis.

Regarding sampling technique, all the methods identified are classified as category 2 as long as they use a sampling device that has been previously evaluated and classified as category 2 in the dedicated previous report (Anses 2020), as mentioned in section 1.1.2. The detailed assessment of the identified method is presented in Table 24.

Method A has been classified, for its analytical technique, as category 1B for monitoring the 8h-OEL and the short-term exposure. This is due to the fact that the low end of the required range to monitor those limit values is achieved using LOQ. For the technical regulatory control of the 15min-STEEL, method A analytical technique has also been classified as category 1B since the use of a sampling device with a 3.5 L.min⁻¹ (or greater flow rate) covers the required concentration range of 0.1 to 2 times the 15min-STEEL. As the sampling technique is classified as category 2, **method A (including sampling and analysis) is globally classified as category 2 for the technical regulatory control of the 8h-OEL and the 15min-STEEL and the short-term exposure monitoring.**

Method B has been classified, for its analytical technique, as category 3* for the monitoring of the 8h-OEL, the 15min-STEEL and the control of short-term exposure, due to the lack of validation data and the absence of information on the applicable concentration range. **Method B (including sampling and analysis) is globally classified as category 3* for the technical regulatory control of the 8h-OEL and the 15min-STEEL and the short-term exposure monitoring.**

Method C has been classified, for its analytical technique, as category 1B for monitoring the 8h-OEL, the 15min-STEEL and the short term exposure. This is due to the fact that values for recovery rates, uncertainties are available and comply with requirements described in Anses (to be published) even though not available for the entire concentration range from 0.1 to 2 times 8h-OEL. As the sampling technique is classified as category 2, **method C (including sampling and analysis) is globally classified as category 2 for the technical regulatory control of the 8h-OEL and the 15min-STEEL and the short term exposure monitoring.**

Method D has been classified for its analytical technique, subject to appropriate validation under the conditions of the DFG (MAK) 2718 (2014) protocol, as category 1B for the regulatory control of the 8h-OEL. This is due to the fact that validation data are available on the whole concentration range required and that expanded uncertainties slightly higher than the requirements described in Anses (to be published) were obtained with a 2-hours sampling and can be expected to decrease with an 8-hour sampling. For the 15min-STEEL monitoring, method D analytical technique is classified as category 2 since validation data are not available

on the totality of the required concentration range. For short-term exposure monitoring of 15min-STEEL, the analytical technique is classified in category 1B because the expanded uncertainties meet the requirements described in Anses (to be published). As the sampling technique is classified as category 2, **Method D (including sampling and analysis) is globally classified as category 2 for the technical regulatory control of the 8h-OEL and the 15min-STEEL and the short-term exposure monitoring.**

Method E has been classified, for its analytical technique, as category 1B for monitoring the 8h-OEL because the validated range does not reach 0.1 times the 8h-OEL, but the limit of quantification allows it, which makes it partially suitable. For the 15min-STEEL monitoring, method E analytical technique is classified as category 3 since it has not been validated in the concentration range of 0.1 to 2 times the 15min-STEEL. For the short-term exposure monitoring, method E analytical technique is classified as category 2 since the validation data is available but recovery rates were obtained outside the 0.5 to 2 times 15min-STEEL concentration range. As the sampling technique is classified as category 2, **method E (including sampling and analysis) is globally classified as category 2 for the technical regulatory control of the 8h-OEL and the short-term exposure monitoring. Method E is globally classified as category 3 for the technical regulatory control of the 15min-STEEL.**

The HRV Committee recommends for regulatory technical control of 8h-OEL, 15 min-STEEL and monitoring of short-term exposure, the two following indicative methods:

- Active sampling of inhalable fraction on membrane or filter, followed by an acid digestion and an ICP-AES analysis (method A);
- active sampling of inhalable fraction on membrane or filter, followed by an acid digestion and an ICP-MS analysis (method C).

These methods are recommended under the conditions presented in Table 44.

Among the five identified methods, these two methods were recommended because the analytical technique is more extensively validated than other methods. Overall, these two methods enable all recommended limit values to be monitored.

The HRV committee is also drawing attention to the issue of aluminium contamination during the various sampling and analysis stages of air samples. Indeed, aluminium is ubiquitously found in air laboratories, instruments and the equipment used for sample preparation and analysis. It can represent a major source of aluminium contamination of samples in laboratories. The use of aluminium-free equipment (forceps, spatulas, etc.) is therefore strongly recommended. The characteristics and variability of laboratory blank values for aluminium must be checked individually in each laboratory.

Table 44. Recommended method for measuring aluminium in workplace air

Method	Active sampling of inhalable fraction on membrane or filter, followed by an acid digestion and an ICP-AES analysis	Active sampling of inhalable fraction on membrane or filter, followed by an acid digestion and an ICP-MS analysis
Protocols	NF ISO 15202-1 (2020); NF ISO 15202-2 (2020); NF ISO 15202-3 (2005); NIOSH 7300 (2003); NIOSH 7301 (2003); NIOSH 7302 (2014); NIOSH 7303 (2003); NIOSH 7304 (2014); NIOSH 7306 (2015); INRS M-122 (2015); INRS M-124 (2015); INRS M-125 (2016); NF X 43-257 (2016); NF X 43-275 (2002)	IRSST MA-362 (2011); IRSST MA-394 (2018); NF ISO 30011 (2010); IFA 6061 (2025)

Method		Active sampling of inhalable fraction on membrane or filter, followed by an acid digestion and an ICP-AES analysis	Active sampling of inhalable fraction on membrane or filter, followed by an acid digestion and an ICP-MS analysis
For regulatory control of the 8h-OEL	Global method category	2 (Sampling technique: 2 / Analytical technique: 1B)	2 (Sampling technique: 2 / Analytical technique: 1B)
	Conditions of use	using an inhalable fraction active membrane/filter sampler that can achieve a 2 L.min ⁻¹ flow rate (such as CFC with accounting for wall deposits, CFC + internal capsule, the IOM™, the 7-Hole) (sampling duration: 8 hours)	using an inhalable fraction active membrane/filter sampler that can achieve a 2 L.min ⁻¹ flow rate (such as CFC with accounting for wall deposits, CFC + internal capsule, the IOM™, the 7-Hole) (sampling duration: 8 hours)
For regulatory control of the 15min-STEL	Global method category	2 (Sampling technique: 2 / Analytical technique: 1B)	2 (Sampling technique: 2 / Analytical technique: 1B)
	Conditions of use	using an inhalable fraction active membrane/filter sampler that can achieve a ≥ 3.5 L.min ⁻¹ flow rate (such as the GSP-3.5 or the Button™) (sampling duration: 15 minutes)	using an inhalable fraction active membrane/filter sampler that can achieve a 2 L.min ⁻¹ flow rate (such as CFC with accounting for wall deposits, CFC + internal capsule, the IOM™, the 7-Hole) (sampling duration: 15 minutes)
For the short-term exposure monitoring	Global method category	2 (Sampling technique: 2 / Analytical technique: 1B)	2 (Sampling technique: 2 / Analytical technique: 1B)
	Conditions of use	using an inhalable fraction active membrane/filter sampler that can achieve a 2 L.min ⁻¹ flow rate (such as CFC with accounting for wall deposits, CFC + internal capsule, the IOM™, the 7-Hole) (sampling duration: 15 minutes)	using an inhalable fraction active membrane/filter sampler that can achieve a 2 L.min ⁻¹ flow rate (such as CFC with accounting for wall deposits, CFC + internal capsule, the IOM™, the 7-Hole) (sampling duration: 15 minutes)

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ANNEX 1: Technical support: detailed presentation of workplace air aluminium monitoring methods classified as category 2

Annex 1.1: Method A

Table 45. Method A: Descriptive parameters

Method A - Active Membrane Sampling – Acid Digestion – ICP/AES Analysis												
		NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005)	NIOSH 7300 (2003)	NIOSH 7301 (2003)	NIOSH 7302 (2014)	NIOSH 7303 (2003)	NIOSH 7304 (2014)	NIOSH 7306 (2015)	INRS M-122 (2015)	INRS M-124 (2015)	INRS M-125 (2016)	NF X 43-257 (2016) NF X 43-275 (2002)
Gas/vapor - Aerosol - Mix		Aerosol										
Sampling	Active/passive sampling	Active										
	Sampling system	EN 132025-1 compliant Inhalable sampler + quartz fiber filter or MCE membrane or PVC membrane OR PTFE membrane	CFC 37 mm + MCE (0.8 µm pore size) or PVC membrane (5 µm pore size)	CFC 37 mm + MCE (0.8 µm pore size) or PVC membrane (5 µm pore size)	CFC 37 mm + MCE membrane (0.8 µm pore size)	CFC 37 mm + MCE membrane (0.8 µm pore size)	CFC 37 mm + PVC membrane (5 µm pore size)	CFC + internal capsule (MCE) + MCE membrane (0.8µm pore size)	CFC 37 mm + quartz fiber filter	CFC 37 mm + MCE membrane	CFC 37 mm + AccuCap™ 0.8 µm + MCE membrane	CFC 37 mm + quartz fiber filter or membrane filter
	Sampling rate (L.min ⁻¹)	NR: Flowrate according to sampler	1 to 4 L.min-1	1 to 4 L.min-1	1 to 4 L.min-1	1 to 4 L.min-1	1 to 4 L.min-1	1 to 4 L.min-1	2 L.min-1	2 L.min-1	2 L.min-1	2 L.min-1
	Air volume (L)	Not specified	5 - 100 L	5 - 100 L	5 - 100 L	2- 10000 L	5-100 L	< 1 - 330 L	30 - 960 L	30 - 960 L	30 - 960 L	NR
	Sampling time	To adapted to the duration of the limit value	To adapt	To adapt	To adapt	To adapt	To adapt	To adapt	To adapt	15min to 8h	15min to 8h	15min to 8h

Method A - Active Membrane Sampling – Acid Digestion – ICP/AES Analysis												
		NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005)	NIOSH 7300 (2003)	NIOSH 7301 (2003)	NIOSH 7302 (2014)	NIOSH 7303 (2003)	NIOSH 7304 (2014)	NIOSH 7306 (2015)	INRS M-122 (2015)	INRS M-124 (2015)	INRS M-125 (2016)	NF X 43-257 (2016) NF X 43-275 (2002)
Measurement	Sample preparation	Hot acid leaching (37°C water bath) or hot plate or microwave digestion	Acid digestion (conc. HNO ₃ / conc. HClO ₄ (4:1)) - Hot Plate	Acid digestion (Aqua regia (1 HNO ₃ : 3 HCl) - Hot Plate	Acid digestion (20% HNO ₃) - microwave	Acid digestion (5% HCl and 5% HNO ₃ .) - hotblock	Acid digestion (20% HNO ₃) - microwave	Hotplate digestion (NIOSH 7300 or 7301). microwave digestion (NIOSH 7302) or hot block extraction (NIOSH 7303)	HF/HNO ₃ (3:2) digestion - ultrasounds	HClO ₄ then HCl+HNO ₃ (+- HF) digestion - ultrasounds	HClO ₄ then HCl+HNO ₃ (+- HF) digestion - ultrasounds	HF/HNO ₃ (3:2) digestion - ultrasounds (other methods: see ISO 15202-2)
	Analytical technique	ICP AES	ICP AES	ICP AES	ICP AES	ICP AES	ICP AES	ICP AES	ICP AES	ICP AES	ICP AES	ICP AES
	Analytical parameters	standards preparation	167 nm - standards preparation	167 nm - standards preparation	308.2 nm - standards preparation	Not specified	308.22 nm	396.152 nm	Not specified	Not specified	Not specified	Not specified

Table 46. Method A: Validation data

Method A - Active Membrane Sampling – Acid Digestion – ICP/AES Analysis											
	NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005)	NIOSH 7300 (2003)	NIOSH 7301 (2003)	NIOSH 7302 (2014)	NIOSH 7303 (2003)	NIOSH 7304 (2014)	NIOSH 7306 (2015)	INRS M-122 (2015)	INRS M-124 (2015)	INRS M-125 (2016)	NF X 43-257 (2016) NF X 43-275 (2002)
Validated range ($\mu\text{g}\cdot\text{m}^{-3}$)	Not specified - to be determined with standard solutions and spiked filters	The working range of this method is 0.005 to 2.0 mg/m ³ for each element in a 500-L air sample The precision and recovery data were determined between 1.54 to 6.40 μg per filter (MCE) or 1.56 to 6.40 per filter (PVC) (spiked filter with solution)	The working range of this method is 0.005 to 2.0 mg/m ³ for each element in a 500-L air sample - precision and recovery determined between 1.54 to 6.40 μg per filter (MCE) or 1.56 to 6.40 per filter (PVC) (spiked filter with solution)	Use a spike level that is within the range of 10 to 20 times the LOQ - 7.50 to 750 μg /filter	The working range of this method is up to 100 mg/m ³ for each element in a 500-L sample - 9.25 to 50.000 μg /filter	Precision and accuracy date for a range of 5- 1500 μg /sample - spiked filters - Fisons ARL Accuris ICP/AES : 50.25 to 1500 μg /sample Perkin Elmer Optima 3000DV ICP/AES : 15 to 1500 μg	The working range of this method is 4 x 10-5 mg/m ³ to 10 mg/m ³ for each element in a 500-L air sample - 10.6 to 60.8 μg /sample	Not specified	Not specified	Not specified	Not specified
Desorption coefficient / Desorption efficiency / Analytical recovery rate	Not specified	105.4 to 101.5 % (MCE) 77.4 to 92.9% (PVC)	105.4 to 101.5 % (MCE) 77.4 to 92.9% (PVC)	92.7 to 98.7%	Not specified. but the protocol has obtain the "validated status", which means that the method is suitable for samples up to at least 0.0500 g bulk material with recoveries of between 90 and 110 percent.	Perkin Elmer Optima 3000DV ICP/AES : 115.05 % @ 15 μg /sample 105.17 % @ 1500 μg /sample Fisons ARL Accuris ICP/AES : 89.78 % @ 50.25 μg /sample 100.71 % @ 1500 μg /sample	95.7 % to 96.2%	Not specified	Not specified	Not specified	Not specified
Experimental validation data for diffusive sampling rate	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable
Diffusive sampling rate stability data	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable

Method A - Active Membrane Sampling – Acid Digestion – ICP/AES Analysis											
	NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005)	NIOSH 7300 (2003)	NIOSH 7301 (2003)	NIOSH 7302 (2014)	NIOSH 7303 (2003)	NIOSH 7304 (2014)	NIOSH 7306 (2015)	INRS M-122 (2015)	INRS M-124 (2015)	INRS M-125 (2016)	NF X 43-257 (2016) NF X 43-275 (2002)
Backdiffusion	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable
Capacity / Overloading volume	Not specified	< 2 mg total dust per filter	< 2 mg total dust per filter	< 2 mg total dust per filter	< 2 mg total dust per filter	< 2 mg total dust per filter	< 5 mg total dust per filter	Not specified	Not specified	Not specified	Not specified
Detector response linearity	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified
Storage studies	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	The elements removed are stable indefinitely	The elements removed are stable indefinitely	Not specified
Environmental conditions	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified
Selectivity / Interference	Not specified	Spectral interferences minimized by: wavelength. interelement correction factors and background correction.	Spectral interferences minimized by: wavelength. interelement correction factors and background correction.	Spectral interferences minimized by: wavelength. interelement correction factors and background correction.	Spectral interferences minimized by: wavelength. interelement correction factors and background correction.	Spectral interferences minimized by: wavelength. interelement correction factors and background correction.	Spectral interferences minimized by: wavelength. interelement correction factors and background correction.	Not specified	Not specified	Not specified	Not specified
Speciation	Not specified	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8h-OEL	Expanded uncertainty	Not specified	Not specified	Not specified	Estimation of uncertainties and biases RSD = 0.981% to 0.462%	Not specified	On 5-1500 µg/sample: Fisons ARL Accuris ICP/AES : Bias: -0.0318 Precision : 0.0419 Accuracy : 9.9% Perkin Elmer Optima 3000DV ICP/AES : Bias : 0.0833 Precision : 0.0379 Accuracy : 15.1 %	On 10.6 to 60.8 µg/sample: Bias: -0.0414 Precision : 0.050 Accuracy : 12.4 %	Not specified	Not specified	Not specified

Method A - Active Membrane Sampling – Acid Digestion – ICP/AES Analysis												
		NF ISO 15202-1 (2020) NF ISO 15202-2 (2020) NF ISO 15202-3 (2005)	NIOSH 7300 (2003)	NIOSH 7301 (2003)	NIOSH 7302 (2014)	NIOSH 7303 (2003)	NIOSH 7304 (2014)	NIOSH 7306 (2015)	INRS M-122 (2015)	INRS M-124 (2015)	INRS M-125 (2016)	NF X 43-257 (2016) NF X 43-275 (2002)
	Detection limit	Not specified	0.115 µg per filter (MCE or PVC)	0.115 µg per filter (MCE or PVC)	1 µg/sample	0.111 µg/mL for a sample volume of 25 mL. i.e. 2.78 µg/sample	Fisons ARL Accuris ICP/AES : 2 µg/ sample Perkin Elmer Optima 3000DV ICP/AES : 0.5 µg/sample	0.38 µg/sample (obtained with microwave digestion described in NIOSH 7302)	7.4 µg/filter. ie 15 µg.m-3 for 480 L	Not specified	1µg/sample	instrumental detection limit: 7.4 µg/quartz fiber filter
	Quantification limit	Not specified	Not specified	Not specified	Not specified	9.25 µg/sample	Fisons ARL Accuris ICP/AES : 50.25 µg Perkin Elmer Optima 3000DV ICP/AES : 15 µg	Not specified	3.3*7.4 = 24.42 µg/filter. ie 50 µg.m-3 for 480 L	Not specified	Not specified	Not specified
15min-STEL	Expanded uncertainty	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified
	Detection limit	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	7.4 µg/filter. ie 250 µg.m-3 for 30 L	Not specified	Not specified	Not specified
	Quantification limit	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	3.3*7.4 = 24.42 µg/filter. ie 820 µg.m-3 for 30 L	Not specified	Not specified	Not specified
Additional information		-	Protocol not specific to aluminium. No validation data.	-	The working range of this method is 0.005 to 2.0 mg/m3 in a 500-L air sample => 2.5 to 1000 µg/filter	-	The method is suitable for samples up to at least 0.0500 g bulk material with recoveries of between 90 and 110.	-	-	-	-	-

Annex 1.2: Method C

Table 47. Method C: Descriptive parameters

Method C - Active membrane sampling – Acid digestion – ICP/MS analysis					
		IRSST MA-362 (2011)	IRSST MA-394 (2018)	NF ISO 30011 (2010)	IFA 6061 (2024)
Gas/vapor - Aerosol - Mix		Aerosol			
Sampling	Active/passive sampling	Active			
	Sampling system	ECM 0.8µm, 25 and 37mm	2-piece polypropylene cassette with cellulose backing - 0.8 µm ECM encapsulated in cellulose acetate membrane	Sampling techniques adapted to the targeted fraction - CFC and IOM filters quartz, fiberglass, PTFE and PVC	GSP (Respirable Fraction) or FSP (Alveolar Fraction) + Cellulose Nitrate Membrane Filter
	Sampling rate (L.min ⁻¹)	1.5L/min	1.5L/min	Different flow rates depending on the devices to be adapted	10 L/min
	Air volume (L)	180 L	180 L	To be adapted	1200 - 4800 L
	Sampling time	120 min	120 min	Not specified	Minimum 2 hours until 8 hours
Measurement	Sample preparation	Acid digestion HClO ₄ /HCl/HNO ₃ /H ₂ O ₂	Acid digestion of the samples (Solu-Sert™ + collected particles). Samples recovered and volumetric at 10 mL with 1% nitric acid - Dilution 1/10 HNO ₃ 1%	Hot acid leaching (37°C water bath) or microwave digestion	Open acid digestion (HNO ₃ [65%] / HCl [25%], 2:1 v/v +/- heating) or open acid mineralization (HCl [0.1 molar] + heating)
	Analytical technique	ICP/MS	ICP/MS	ICP/MS	ICP/MS

Method C - Active membrane sampling – Acid digestion – ICP/MS analysis				
	IRSST MA-362 (2011)	IRSST MA-394 (2018)	NF ISO 30011 (2010)	IFA 6061 (2024)
Analytical parameters	Plasma Power (Watts): 1200 Argon Flow Rate (L/min): 15 Auxiliary Gas Flow Rate (L/min): 1.2 Gas flow rate at nebulizer (L/min): 0.9 Acquisition mode: Peak hopping Sweeps (per read): 10 Readings (per replicate): 1 Replicates: 3 Analysis mode: Standard and DRC Calibration: External Calibration Detector Mode: Pulse	Injector: 1.5 mL injection loop Pump: Peristaltic pump set at 6 rpm Autosampler: ESI SC-4 DX Self-diluter: PrepFast S400V. Automated calibration curves and QC. Automatic dilution of samples outside the field of analysis. Eluent: Nitric acid 1% Isotope analyzed: 24 Mg, 27 Al, 51 V, 52 Cr, 55 Mn, 57 Fe, 59 Co, 60 Ni, 63 Cu, 66 Zn, 75 As, 111 Cd, 206, 207, 208 Pb Internal Standard: 45 Sc, 89 Y, 72 Ge, 159 Tb Analysis mode: DEC/KED (Kinetic Energy Discrimination). Helium Gas Flow Rate: 3.9 and 4.9 L.min⁻¹ Detector: SimulScan™ dual-stage (pulse counting or analog) Plasma Power: 1600 Watts Argon Gas Flow Rate: 16 L.min⁻¹ Nebulizer flow rate: 1 L.min⁻¹	Not specified	Instrument: ICP quadrupole mass spectrometer, NexION 2000, PerkinElmer LAS (Germany) GmbH Plasma parameters: Optimized for robust plasma conditions with basically unknown Rehearse/Matrices (CeO/Ce ≤ 2.0%; Ce++/Ce ≤ 2.5%) RF Power: 1550 W Atomizer: PFA-ST3 MicroFlow Nebulizer, PerkinElmer LAS (Germany)Ltd Atomizer Chamber: Cooled Cyclone Spray Chamber Made of Quartz Glass Injector: Quartz glass, 2.0 mm inner diameter Flow rates: Sample solution: approx. 0.35 mL/min Atomizer gas flow: approx. 1 L/min Auxiliary gas flow: 1.2 L/min Plasma gas flow: 15 L/min KED-Gasfluss (Helium): approx. 4.6 mL/min (KED = kinetic energy discrimination) Detector: Secondary Electron Multiplier (SEV); Two-stage detector "Dual Stage" Isotop: Aluminium 27 amu Measurement Mode: Kinetic Energy Discrimination (KED) Interference minimization: Potential polyatomic interference (see also section 10.2); Using KED Mode Internal Standard Isotop: Scandium 45 amu

Table 48. Method C: Validation data

	IRSST MA-362 (2011)	IRSST MA-394 (2018)	NF ISO 30011 (2010)	IFA 6061 (2024)
Validated range ($\mu\text{g.m-3}$)	Application Range: 6 to 110 $\mu\text{g.m-3}$	Application range: 28 to 11100 $\mu\text{g.m-3}$	For Al 27: 0,0006 to 0,027 $\mu\text{g/mL}$	Following the digestion procedure (validated at 1.2 m ³): - Microwave-assisted pressure decomposition (HNO(3)[65%]: 0.17 - 33 $\mu\text{g/m}^3$ - Open acid digestion (HNO(3)[65%]/HCl[25%], 2:1, v/v): 0.83 - 33 $\mu\text{g/m}^3$ - Open acid mineralization (HCl [0.1 molar]): 0.83 - 33 $\mu\text{g/m}^3$
Desorption coefficient / Desorption efficiency / Analytical recovery rate	Recovery rate : 97.7%	Recovery rate : 102.9%	Not specified	Following the digestion procedure: - Microwave-assisted pressure decomposition (HNO(3)[65%]: 93-99% - Open acid digestion (HNO(3)[65%]/HCl[25%], 2:1, v/v): 102-106% - Open acid mineralization (HCl [0.1 molar]): 91-96%.
Experimental validation data for diffusive sampling rate	Not suitable	Not suitable	Not suitable	Not suitable
Diffusive sampling rate stability data	Not suitable	Not suitable	Not suitable	Not suitable
Backdiffusion	Not suitable	Not suitable	Not suitable	Not suitable
Capacity / Overloading volume	Not specified	Not specified	Not specified	Not specified
Detector response linearity	Not specified	Not specified	Not specified	Not specified
Storage studies	Not specified	Tested and validated shelf life: Stable at room temperature	Not specified	Storage stability studied: doping from 0.6 to 23 μg of Al/filter. Analyses for 4 weeks. Average recovery of 103% or 104%.
Environmental conditions	Not specified	Not specified	Not specified	If the relative humidity of the air exceeds 50% and if working substances are present in the form of droplet aerosols, it is recommended to use double quartz fiber filters as a sample carrier.
Selectivity / Interference	Spectral and non-spectral interference.	Spectral and non-spectral interferences. Helium is used as a non-reactive gas that allows for the mitigation or elimination of polyatomic interference.	Elementary isobaric interference, sensitivity related to abundance, isobaric interference due to polyatomic ions, physical interference, memory effects.	The measurement results should always be checked for possible interferences. Additional dilution steps should be performed during preparation.
Speciation	Yes	Yes	Yes	Yes

		IRSST MA-362 (2011)	IRSST MA-394 (2018)	NF ISO 30011 (2010)	IFA 6061 (2024)
8h-OEL	Expanded uncertainty	Coefficient of variation of the analytical method: 3.8% Extended measurement uncertainty: 12.4%	Analytical measurement uncertainty: 3.2%	Not specified	Following the digestion procedure: - Microwave-assisted pressure decomposition (HNO ₃)[65%]: 24.4% - Open acid digestion (HNO ₃)[65%]/HCl[25%], 2:1, v/v): 22.8% - Open acid mineralization (HCl [0.1 molar]): 27.6%.
	Detection limit	7,8 µg/L	1,4 µg/L	0,23 µg/L	Following the digestion procedure: - Microwave-assisted pressure decomposition (HNO ₃)[65%]: 0.059 µg/filter - Open acid digestion (HNO ₃)[65%]/HCl[25%], 2:1, v/v): 0.21µg/filter - Open acid mineralization (HCl [0.1 molar]): 0.20µg/filter
	Quantification limit	26,1 µg/L	4,6 µg/L	0,77 µg/L	Following the digestion procedure: - Microwave-assisted pressure decomposition (HNO ₃)[65%]: 0.2 µg/filter - Open acid digestion (HNO ₃)[65%]/HCl[25%], 2:1, v/v): 0.7 µg/filter - Open acid mineralization (HCl [0.1 molar]): 0.68 µg/filter.
15min-STEL	Expanded uncertainty	Not specified	Not specified	Not specified	Following the digestion procedure: - Microwave-assisted pressure decomposition (HNO ₃)[65%]: 24.4% - Open acid digestion (HNO ₃)[65%]/HCl[25%], 2:1, v/v): 22.8% - Open acid mineralization (HCl [0.1 molar]): 27.6%.
	Detection limit	Not specified	Not specified	Not specified	Following the digestion procedure: - Microwave-assisted pressure decomposition (HNO ₃)[65%]: 0.059 µg/filter - Open acid digestion (HNO ₃)[65%]/HCl[25%], 2:1, v/v): 0.21µg/filter - Open acid mineralization (HCl [0.1 molar]): 0.20µg/filter.
	Quantification limit	Not specified	Not specified	Not specified	Following the digestion procedure: - Microwave-assisted pressure decomposition (HNO ₃)[65%]: 0.2 µg/filter - Open acid digestion (HNO ₃)[65%]/HCl[25%], 2:1, v/v): 0.7 µg/filter - Open acid mineralization (HCl [0.1 molar]): 0.68 µg/filter.
Additional information		-	-	-	-

Annex 1.3: Method D

Table 49. Method D: Descriptive parameters

Method D - Active sampling of inhalable fraction on membrane or filter – Acid Digestion – GFAAS Analysis				
		INRS M-120 (2015)	DFG (MAK) 2718 (2014)	NF X 43-257 (2016) NF X 43-275 (2002)
Gas/vapor - Aerosol - Mix		Aerosol		
Sampling	Active/passive sampling	Active		
	Sampling system	Closed cassette 37 mm 3 pieces Pump flow rate 1-3 L/min Quartz filter	GSP-3.5 Closed cassette 37 mm 3 pieces Filter: nitrocellulose (8µm pore - SARTORIUS)	CFC 37 mm + quartz fiber filter or membrane filter
	Sampling rate (L.min ⁻¹)	2 L.min ⁻¹	3.5 L.min ⁻¹	2 L.min ⁻¹
	Air volume (L)	30 to 960 L	420 L	NR
	Sampling time	15min to 8h	2h	15min to 8h
Measurement	Sample preparation	Dissolving the filter/cassette Hydrofluoric acid 3 mL Nitric acid 2 mL Ultrasonic stirring 10 min (Tank 60°C) Rinse 2 times 5 mL of water Fill 20 to 40 mL	Dissolving the filter/cassette Hydrochloric acid 30% Ultrasonic stirring 120 min (100°C tank) Supplement 300 mL of ultrapure water	HF/HNO ₃ (3:2) digestion - ultrasons (other methods: see ISO 15202-2)
	Analytical technique	GFAAS	GFAAS	GFAAS
	Analytical parameters	Not specified	309.3 nm - standards preparation	Not specified

Table 50. Method D: Validation data

Method D - Active Membrane Sampling – Acid Digestion – GFAAS Analysis			
	INRS M-120 (2015)	DFG (MAK) 2718 (2014)	NF X 43-257 (2016) NF X 43-275 (2002)
Validated range (µg.m ⁻³)	Not specified	0.024 to 2.38 mg/m ³	Not specified
Desorption coefficient / Desorption efficiency / Analytical recovery rate	Not specified	Not specified	Not specified
Experimental validation data for diffusive sampling rate	Not suitable	Not suitable	Not suitable
Diffusive sampling rate stability data	Not suitable	Not suitable	Not suitable
Backdiffusion	Not suitable	Not suitable	Not suitable
Capacity / Overloading volume	Not specified	Not specified	Not specified
Detector response linearity	Not specified	Not specified	Not specified
Storage studies	Not specified	Not specified	Protocol to be applied in order to determine it
Environmental conditions	Not specified	Not specified	Wind speed < 0.1 m/s Significant decrease in efficiency beyond 0.5 to 4 m/s Reference to scientific publications
Selectivity / Interference	Not specified	Not specified	Not specified
Speciation	Yes	Yes	Not specified
8h-OEL	Expanded uncertainty	Not specified	32 to 37%
	Detection limit	Calculation with the ICP-AES analytical method For Al: LD=1 µg/support	0.0024 mg/m ³
	Quantification limit	Not specified	0.0042 mg/m ³ (2h)
15min-STEL	Expanded uncertainty	Not specified	Not specified
	Detection limit	Not specified	Not specified
	Quantification limit	Not specified	Not specified
Additional information	-	Better LOD with cellulose ester membranes rather than quartz	-

Annex 1.4: Method E

Table 51. Method E: Descriptive parameters

Method E - Active sampling of inhalable fraction on membrane or filter – Acid Digestion – FAAS Analysis						
		OSHA ID 121 (2002)	INRS M-121 (2015)	INSST MTA/MA – 025/A16 (2016)	NIOSH 7013 (1994)	NF X 43-257 (2016) NF X 43-275 (2002)
Gas/vapor - Aerosol - Mix		Aerosol				
Sampling	Active/passive sampling	Active				
	Sampling system	Closed cassette on 37 mm filter 25 mm cellulose ester filter possible	Closed cassette 37 mm 3 pieces Pump flow rate 1-3 L/min Quartz filter	Closed cassette37 mm 3 pieces Quartz / cellulose ester / fiberglass filter 25 mm possible	Closed cassette37 mm 3 pieces Pump flow rate 1-3 L/min Cellulose ester filter	CFC 37 mm + quartz fiber filter or membrane filter
	Sampling rate (L.min ⁻¹)	2 L.min-1	2 L.min-1	2 L.min-1	1 to 3 L.min-1	2 L.min-1
	Air volume (L)	30 to 960 L	30 to 960 L	200 L	10 to 400 L	Not specified
	Sampling time	15min to 8h	15min to 8h	Not specified, it is indicated "before clogging"	Not specified, it is indicated no more than 2 mg of particles	15min to 8h
Measurement	Sample preparation	Nitric acid digestion (HNO3)	Filter/cassette dissolution Hydrofluoric acid 3 mL Anitric acid 2mL Axonic agitation 10 min (Tank 60°C) Rinse 2 times 5 mL of water Complete 20 to 40 mL	Digestion nitric acid (HNO3) 5ml Heated 140°C Addition of HNO3 10 %	Digestion nitric acid (HNO3) 6 ml Heated 140°C Addition of HNO3 10 % + CsNO3	HF/HNO3 (3:2) digestion - ultrasons (other methods: see ISO 15202-2)
	Analytical technique	FAAS	FAAS	FAAS	FAAS	FAAS
	Analytical parameters	Not specified Adjustment using a solution with an absorbance between 0.25 and 0.30	Not specified	309.3 nm - standards preparation	309.3 nm - standards preparation	Not specified

Table 52. Method E: Validation data

	OSHA ID 121 (2002)	INRS M-121 (2015)	INSST MTA/MA – 025/A16 (2016)	NIOSH 7013 (1994)	NF X 43-257 (2016) NF X 43-275 (2002)
Validated range ($\mu\text{g}\cdot\text{m}^{-3}$)	100 - 500 μg	Not specified	50 to 500 $\mu\text{g}/\text{m}^3$ -> 0.250 to 2.50 mg/m^3	0.5 to 10 mg/m^3 per 100 L of sampling	Not specified
Desorption coefficient / Desorption efficiency / Analytical recovery rate	Al (Soluble Part possible with this method) Recovery rate = 94.5% CV = 0.076	Not specified	Recovery rate > 90%	Not specified	Not specified
Experimental validation data for diffusive sampling rate	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable
Diffusive sampling rate stability data	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable
Backdiffusion	Not suitable	Not suitable	Not suitable	Not suitable	Not suitable
Capacity / Overloading volume	Not specified	Not specified	Not specified	Not specified	Not specified
Detector response linearity	Upper linear range: 50 $\mu\text{g}/\text{mL}$ Sensitivity 1 $\mu\text{g}/\text{mL}$ LOD analytical 0.3 $\mu\text{g}/\text{mL}$	Not specified	Not specified	Not specified	Not specified
Storage studies	Not specified	Not specified	Not specified	Not specified	Not specified
Environmental conditions	Not specified	Not specified	Not specified	Not specified	Not specified
Selectivity / Interference	Acetic acid, fluoroborate, Fe, and Ti increase the Al signal	Not specified	Fe, V, HCl, H ₂ SO ₄ and SO ₄ 2-	Cesium at 1000 $\mu\text{g}/\text{mL}$ controls ionization in the nitrous oxide-acetylene flame. Iron and HCl at greater than 0.2% (w/w) decrease the sensitivity.	Not specified
Speciation	Yes	Yes	Yes	Yes	Not specified
8h-OEL	Expanded uncertainty	Not specified	Not specified	GUM method = 25 at 30%	Not specified
	Detection limit	Not specified	Not specified	1.5 $\mu\text{g}/\text{filter}$	instrumental detection limit : 7.4 $\mu\text{g}/\text{quartz fiber filter}$
	Quantification limit	Not specified	Not specified	5.0 $\mu\text{g}/\text{filter}$	Not specified
15min-STEL	Expanded uncertainty	Not specified	Not specified	Not specified	Not specified
	Detection limit	Not specified	Not specified	Not specified	Not specified
	Quantification limit	Not specified	Not specified	Not specified	Not specified
Additional information	-	-	-	-	-

ANNEX 2: Details of bibliographic queries to identify articles using GSP-10 to measure aluminium

Bibliographic queries

Scopus, 04/06/2025

aerosol AND sampler AND inhalable - from 2020 to 2025

Google Scholar, 04/06/2025

aerosol AND sampler AND inhalable - from 2020 to 2025

List of articles identified in queries

Title	Year	Authors
Review of Workplace Based Aerosol Sampler Comparison Studies, 2004–2020	2021	James Hanlon, Karen S. Galea and Steven Verpaele
Review of Published Laboratory-Based Aerosol Sampler Efficiency, Performance and Comparison Studies (1994–2021)	2022	James Hanlon, Karen S. Galea and Steven Verpaele

ANNEX 3: Tracking report updates

Date	Page	Description of modification
13/12/2024	Initial version	
25/09/2025	1	Footnote mentioning the revision of the notice. Inclusion in the subtitle of a reference to the evaluation of measurement methods. Addition of the 'Metrology' working group. Modification of the date of the report.
	2	Suggested citation modified.
	8 - 9	Addition of the working group "metrology" (2024-2028) list of members.
	11	Addition of names in the scientific coordination, scientific contribution and administration sections.
	22	Addition of the role of the 'metrology' working group in evaluating measurement methods. Amendment to the date of adoption of the report.
	24-25	Addition of a paragraph describing the method for evaluating measurement methods.
	28	Addition of the title 'Part A - Report on assessment of health effects'.
	178 - 217	Addition of the 'Part B - Report on the assessment of methods for measurement of exposure levels in workplace atmospheres'.
	218 - 230	Addition of an annex of technical support with detailed presentation of workplace air aluminium monitoring methods.
	231	Addition of an annex detailing the bibliographic queries.
	232	Addition of an annex to track updates to the report.



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