PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Pesticide Exposure in Children

COUNCIL ON ENVIRONMENTAL HEALTH

Pediatrics 2012;130;e1757; originally published online November 26, 2012;
DOI: 10.1542/peds.2012-2757

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

Pesticide Exposure in Children

COUNCIL ON ENVIRONMENTAL HEALTH

KEY WORDS
pesticides, toxicity, children, pest control, integrated pest management

ABBREVIATIONS
EPA—Environmental Protection Agency
IPM—integrated pest management

www.pediatrics.org/cgi/doi/10.1542/peds.2012-2757

doi:10.1542/peds.2012-2757

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

abstract

FREE

This statement presents the position of the American Academy of Pediatrics on pesticides. Pesticides are a collective term for chemicals intended to kill unwanted insects, plants, molds, and rodents. Children encounter pesticides daily and have unique susceptibilities to their potential toxicity. Acute poisoning risks are clear, and understanding of chronic health implications from both acute and chronic exposure are emerging. Epidemiologic evidence demonstrates associations between early life exposure to pesticides and pediatric cancers, decreased cognitive function, and behavioral problems. Related animal toxicology studies provide supportive biological plausibility for these findings. Recognizing and reducing problematic exposures will require attention to current inadequacies in medical training, public health tracking, and regulatory action on pesticides. Ongoing research describing toxicologic vulnerabilities and exposure factors across the life span are needed to inform regulatory needs and appropriate interventions. Policies that promote integrated pest management, comprehensive pesticide labeling, and marketing practices that incorporate child health considerations will enhance safe use. *Pediatrics* 2012;130:e1757–e1763

INTRODUCTION

Pesticides represent a large group of products designed to kill or harm living organisms from insects to rodents to unwanted plants or animals (eg, rodents), making them inherently toxic (Table 1). Beyond acute poisoning, the influences of low-level exposures on child health are of increasing concern. This policy statement presents the position of the American Academy of Pediatrics on exposure to these products. It was developed in conjunction with a technical report that provides a thorough review of topics presented here: steps that pediatricians should take to identify pesticide poisoning, evaluate patients for pesticide-related illness, provide appropriate treatment, and prevent unnecessary exposure and poisoning.[1] Recommendations for a regulatory agenda are provided as well, recognizing the role of federal agencies in ensuring the safety of children while balancing the positive attributes of pesticides. Repellents reviewed previously (eg, N,N-diethyl-meta-toluamide, commonly known as DEET; picaridin) are not discussed.[2]

SOURCES AND MECHANISMS OF EXPOSURE

Children encounter pesticides daily in air, food, dust, and soil and on surfaces through home and public lawn or garden application, household insecticide use, application to pets, and agricultural product

TABLE 1 Categories of Pesticides and Major Classes

Pesticide category	Major Classes	Examples
Insecticides	Organophosphates	Malathion, methyl parathion, acephate
	Carbamates	Aldicarb, carbaryl, methomyl, propoxur
	Pyrethroids/pyrethrins	Cypermethrin, fenvalerate, permethrin
	Organochlorines	Lindane
	Neonicotinoids	Imidacloprid
	N-phenylpyrazoles	Fipronil
Herbicides	Phosphonates	Glyphosate
	Chlorophenoxy herbicides	2,4-D, mecoprop
	Dipyridyl herbicides	Diquat, paraquat
	Nonselective	Sodium chlorate
Rodenticides	Anticoagulants	Warfarin, brodifacoum
	Convulsants	Strychnine
	Metabolic poison	Sodium fluoroacetate
	Inorganic compounds	Aluminum phosphide
Fungicides	Thiocarbamates	Metam-sodium
	Triazoles	Fluconazole, myclobutanil, triadimefon
	Strobilurins	Pyraclostrobin, picoxystrobin
Fumigants	Halogenated organic	Methyl bromide, Chloropicrin
	Organic	Carbon disulfide, Hydrogen cyanide, Naphthalene
	Inorganic	Phosphine
Miscellaneous	Arsenicals	Lead arsenate, chromated copper arsenate, arsenic trioxide
	Pyridine	4-aminopyridine

residues.[3–9] For many children, diet may be the most influential source, as illustrated by an intervention study that placed children on an organic diet (produced without pesticide) and observed drastic and immediate decrease in urinary excretion of pesticide metabolites.[10] In agricultural settings, pesticide spray drift is important for residences near treated crops or by take-home exposure on clothing and footwear of agricultural workers.[9,11,12] Teen workers may have occupational exposures on the farm or in lawn care.[13–15] Heavy use of pesticides may also occur in urban pest control.[16]

Most serious acute poisoning occurs after unintentional ingestion, although poisoning may also follow inhalational exposure (particularly from fumigants) or significant dermal exposure.[17]

ACUTE PESTICIDE TOXICITY

Clinical Signs and Symptoms

High-dose pesticide exposure may result in immediate, devastating, even lethal consequences. Table 2 summarizes features of clinical toxicity for the major pesticides classes. It highlights the similarities of common classes of pesticides (eg, organophosphates, carbamates, and pyrethroids) and underscores the importance of discriminating among them because treatment modalities differ. Having an index of suspicion based on familiarity with toxic mechanisms and taking an environmental history provides the opportunity for discerning a pesticide's role in clinical decision-making.[18] Pediatric care providers have a poor track record for recognition of acute pesticide poisoning.[19–21] This reflects their self-reported lack of medical education and self-efficacy on the topic.[22–26] More in-depth review of acute toxicity and management can be found in the accompanying technical report or recommended resources in Table 3.

The local or regional poison control center plays an important role as a resource for any suspected pesticide poisoning.

There is no current reliable way to determine the incidence of pesticide exposure and illness in US children. Existing data systems, such as the American Association of Poison Control Centers' National Poison Data System or the National Institute for Occupational Safety and Health's Sentinel Event Notification System for Occupational Risks,[27,28] capture limited information about acute poisoning and trends over time.

There is also no national systematic reporting on the use of pesticides by consumers or licensed professionals. The last national survey of consumer pesticide use in homes and gardens was in 1993 (Research Triangle Institute study).[29]

Improved physician education, accessible and reliable biomarkers, and better diagnostic testing methods to readily identify suspected pesticide illness would significantly improve reporting and surveillance. Such tools would be equally important in improving clinical decision-making and reassuring families if pesticides can be eliminated from the differential diagnosis.

The Pesticide Label

The pesticide label contains information for understanding and preventing acute health consequences: the active ingredient; signal words identifying acute toxicity potential; US Environmental Protection Agency (EPA) registration number; directions for use, including protective equipment recommendations, storage, and disposal; and manufacturer's contact information.[30] Basic first aid advice is provided, and some labels contain a "note for physicians" with specific relevant medical information. The label does not specify the pesticide class or "other"/"inert" ingredients that may have significant toxicity and can account for up to 99% of the product.

Chronic toxicity information is not included, and labels are predominantly available in English. There is significant use of illegal pesticides (especially in immigrant communities), off-label use, and overuse, underscoring the importance of education, monitoring, and enforcement.[31]

TABLE 2 Common Pesticides: Signs, Symptoms, and Management Considerations[a]

Class	Acute Signs and Symptoms	Clinical Considerations
Organophosphate and N-methyl carbamate insecticides	• Headache, nausea, vomiting, abdominal pain, and dizziness • Hypersecretion: sweating, salivation, lacrimation, rhinorrhea, diarrhea, and bronchorrhea • Muscle fasciculation and weakness, and respiratory symptoms (bronchospasm, cough, wheezing, and respiratory depression) • Bradycardia, although early on, tachycardia may be present • Miosis • Central nervous system: respiratory depression, lethargy, coma, and seizures	• Obtain red blood cell and plasma cholinesterase levels • Atropine is primary antidote • Pralidoxime is also an antidote for organophosphate and acts as a cholinesterase reactivator • Because carbamates generally produce a reversible cholinesterase inhibition, pralidoxime is not indicated in these poisonings
Pyrethroid insecticides	• Similar findings found in organophosphates including the hypersecretion, muscle fasciculation, respiratory symptoms, and seizures • Headache, fatigue, vomiting, diarrhea, and irritability • Dermal: skin irritation and paresthesia	• At times have been mistaken for acute organophosphate or carbamate poisoning • Symptomatic treatment • Treatment with high doses of atropine may yield significant adverse results • Vitamin E oil for dermal symptoms
Neonicotinoid insecticides	• Disorientation, severe agitation, drowsiness, dizziness, weakness, and in some situations, loss of consciousness • Vomiting, sore throat, abdominal pain • Ulcerations in upper gastrointestinal tract	• Supportive care • Consider sedation for severe agitation • No available antidote • No available diagnostic test
Fipronil (N-phenylpyrazole insecticides)	• Nausea and vomiting • Aphthous ulcers • Altered mental status and coma • Seizures	• Supportive care • No available antidote • No available diagnostic test
Lindane (organochlorine insecticide)	• Central nervous system: mental status changes and seizures • Paresthesia, tremor, ataxia and hyperreflexia	• Control acute seizures with lorazepam • Lindane blood level available as send out
Glyphosate (phosphonate herbicides)	• Nausea and vomiting • Aspiration pneumonia type syndrome • Hypotension, altered mental status, and oliguria in severe cases • Pulmonary effects may in fact be secondary to organic solvent	• Supportive care • Pulmonary effects may be secondary to organic solvent
Chlorophenoxy herbicides	• Skin and mucous membrane irritation • Vomiting, diarrhea, headache, confusion • Metabolic acidosis is the hallmark • Renal failure, hyperkalemia, and hypocalcemia • Probable carcinogen	• Consider urine alkalinization with sodium bicarbonate in IV fluids
Rodenticides (long-acting anticoagulants)	• Bleeding: gums, nose, and other mucous membrane sites • Bruising	• Consider PT (international normalized ratio) • Observation may be appropriate for some clinical scenarios in which it is not clear a child even ingested the agent • Vitamin K indicated for active bleeding (IV vitamin K) or for elevated PT (oral vitamin K)

IV, intravenous; PT, prothrombin time.

[a] Expanded version of this table is available in the accompanying technical report.[1]

CHRONIC EFFECTS

Dosing experiments in animals clearly demonstrate the acute and chronic toxicity potential of multiple pesticides. Many pesticide chemicals are classified by the US EPA as carcinogens. The past decade has seen an expansion of the epidemiologic evidence base supporting adverse effects after acute and chronic pesticide exposure in children. This includes increasingly sophisticated studies addressing combined exposures and genetic susceptibility.[1]

Chronic toxicity end points identified in epidemiologic studies include adverse birth outcomes including preterm birth, low birth weight, and congenital

TABLE 3 Pesticide and Child Health Resources for the Pediatrician

Topic/Resource	Additional Information	Contact Information
Management of acute pesticide poisoning		
Recognition and Management of Pesticide Poisonings	Print: fifth (1999) is available in Spanish, English; 6th edition available 2013	http://www.epa.gov/pesticides/safety/healthcare/handbook/handbook.htm
Regional Poison Control Centers		1 (800) 222-1222
Chronic exposure information and specialty consultation		
The National Pesticide Medical Monitoring Program (NPMMP)	Cooperative agreement between Oregon State University and the US EPA. NPMMP provides informational assistance by E-mail in the assessment of human exposure to pesticides	npmmp@oregonstate.edu or by fax at (541) 737-9047
Pediatric Environmental Health Specialty Units (PEHSUs)	Coordinated by the Association of Occupational and Environmental Clinics to provide regional academically based free consultation for health care providers	www.aoec.org/PEHSU.htm; toll-free telephone number (888) 347-AOEC (extension 2632)
Resources for safer approaches to pest control		
US EPA		
Citizens Guide to Pest Control and Pesticide Safety	Consumer information documents • Household pest control • Alternatives to chemical pesticides • How to choose pesticides • How to use, store, and dispose of them safely • How to prevent pesticide poisoning • How to choose a pest-control company	www.epa.gov/oppfead1/Publications/Cit_Guide/citguide.pdf
Controlling pests	Recommended safest approaches and examples of programs	www.epa.gov/pesticides/controlling/index.htm
The University of California Integrative Pest Management Program	Information on IPM approaches for common home and garden pests	www.ipm.ucdavis.edu
Other resources		
National research programs addressing children's health and pesticides	• NIEHS/EPA Centers for Children's Environmental Health & Disease Prevention Research • The National Children's Study	www.niehs.nih.gov/research/supported/centers/prevention www.nationalchildrensstudy.gov/Pages/default.aspx
US EPA	Pesticide product labels	www.epa.gov/pesticides/regulating/labels/product-labels.htm#projects
The National Library of Medicine "Tox Town"	Section on pesticides that includes a comprehensive and well-organized list of web link resources on pesticides	http://toxtown.nlm.nih.gov/text_version/chemicals.php?id=23

anomalies, pediatric cancers, neurobehavioral and cognitive deficits, and asthma. These are reviewed in the accompanying technical report. The evidence base is most robust for associations to pediatric cancer and adverse neurodevelopment. Multiple case-control studies and evidence reviews support a role for insecticides in risk of brain tumors and acute lymphocytic leukemia. Prospective contemporary birth cohort studies in the United States link early-life exposure to organophosphate insecticides with reductions in IQ and abnormal behaviors associated with attention-deficit/hyperactivity disorder and autism. The need to better understand the health implications of ongoing pesticide use practices on child health has benefited from these observational epidemiologic data.[32]

EXPOSURE PREVENTION APPROACHES

The concerning and expanding evidence base of chronic health consequences of pesticide exposure underscores the importance of efforts aimed at decreasing exposure.

Integrated pest management (IPM) is an established but undersupported approach to pest control designed to minimize and, in some cases, replace the use of pesticide chemicals while achieving acceptable control of pest populations.[33] IPM programs and knowledge have been implemented in agriculture and to address weeds and pest control in residential settings and schools, commercial structures, lawn and turf, and community gardens. Reliable resources are available from the US EPA and University of California—Davis (Table 3). Other local policy approaches in use are posting warning signs of pesticide use, restricting spray zone buffers at schools, or restricting specific types of pesticide products in schools. Pediatricians can

play a role in promotion of development of model programs and practices in the communities and schools of their patients.

RECOMMENDATIONS

Three overarching principles can be identified: (1) pesticide exposures are common and cause both acute and chronic effects; (2) pediatricians need to be knowledgeable in pesticide identification, counseling, and management; and (3) governmental actions to improve pesticide safety are needed. Whenever new public policy is developed or existing policy is revised, the wide range of consequences of pesticide use on children and their families should be considered. The American Academy of Pediatrics, through its chapters, committees, councils, sections, and staff, can provide information and support for public policy advocacy efforts. See http://www.aap.org/advocacy.html for additional information or contact chapter leadership.

Recommendations to Pediatricians

1. Acute exposures: become familiar with the clinical signs and symptoms of acute intoxication from the major types of pesticides. Be able to translate clinical knowledge about pesticide hazards into an appropriate exposure history for pesticide poisoning.
2. Chronic exposures: become familiar with the subclinical effects of chronic exposures and routes of exposures from the major types of pesticides.
3. Resource identification: know locally available resources for acute toxicity management and chronic low-dose exposure (see Table 3).
4. Pesticide labeling knowledge: Understand the usefulness and limitations of pesticide chemical information on pesticide product labels.
5. Counseling: Ask parents about pesticide use in or around the home to help determine the need for providing targeted anticipatory guidance. Recommend use of minimal-risk products, safe storage practices, and application of IPM (least toxic methods), whenever possible.
6. Advocacy: work with schools and governmental agencies to advocate for application of least toxic pesticides by using IPM principles. Promote community right-to-know procedures when pesticide spraying occurs in public areas.

Recommendations to Government

1. Marketing: ensure that pesticide products as marketed are not attractive to children.
2. Labeling: include chemical ingredient identity on the label and/or the manufacturer's Web site for all product constituents, including inert ingredients, carriers, and solvents. Include a label section specific to "Risks to children," which informs users whether there is evidence that the active or inert ingredients have any known chronic or developmental health concerns for children. Enforce labeling practices that ensure users have adequate information on product contents, acute and chronic toxicity potential, and emergency information. Consider printing or making available labels in Spanish in addition to English.
3. Exposure reduction: set goal to reduce exposure overall. Promote application methods and practices that minimize children's exposure, such as using bait stations and gels, advising against overuse of pediculicides. Promote education regarding proper storage of product.
4. Reporting: make pesticide-related suspected poisoning universally reportable and support a systematic central repository of such incidents to optimize national surveillance.
5. Exportation: aid in identification of least toxic alternatives to pesticide use internationally, and unless safer alternatives are not available or are impossible to implement, ban export of products that are banned or restricted for toxicity concerns in the United States.
6. Safety: continue to evaluate pesticide safety. Enforce community right-to-know procedures when pesticide spraying occurs in public areas. Develop, strengthen, and enforce standards of removal of concerning products for home or child product use. Require development of a human biomarker, such as a urinary or blood measure, that can be used to identify exposure and/or early health implications with new pesticide chemical registration or reregistration of existing products. Developmental toxicity, including endocrine disruption, should be a priority when evaluating new chemicals for licensing or reregistration of existing products.
7. Advance less toxic pesticide alternatives: increase economic incentives for growers who adopt IPM, including less toxic pesticides. Support research to expand and improve IPM in agriculture and nonagricultural pest control.
8. Research: support toxicologic and epidemiologic research to better identify and understand health risks associated with children's exposure to pesticides. Consider supporting another national study of pesticide use in the home and garden setting of US households as a targeted initiative or through cooperation with existing research opportunities (eg, National Children's Study, NHANES).
9. Health provider education and support: support educational efforts to increase the capacity of pediatric health care providers to diagnose and manage acute pesticide

poisoning and reduce pesticide exposure and potential chronic pesticide effects in children. Provide support to systems such as Poison Control Centers to provide timely, expert advice on exposures. Require the development of diagnostic tests to assist providers with diagnosing (and ruling out) pesticide poisoning.

LEAD AUTHORS

James R. Roberts, MD, MPH
Catherine J. Karr, MD, PhD

COUNCIL ON ENVIRONMENTAL HEALTH EXECUTIVE COMMITTEE, 2012–2013

Jerome A. Paulson, MD, Chairperson
Alice C. Brock-Utne, MD
Heather L. Brumberg, MD, MPH
Carla C. Campbell, MD
Bruce P. Lanphear, MD, MPH
Kevin C. Osterhoudt, MD, MSCE
Megan T. Sandel, MD
Leonardo Trasande, MD, MPP
Robert O. Wright, MD, MPH

FORMER EXECUTIVE COMMITTEE MEMBERS

Helen J. Binns, MD, MPH
James R. Roberts, MD, MPH
Catherine J. Karr, MD, PhD
Joel A. Forman, MD
James M. Seltzer, MD

LIAISONS

Mary Mortensen, MD – *Centers for Disease Control and Prevention/National Center for Environmental Health*
Walter J. Rogan, MD – *National Institute of Environmental Health Sciences*
Sharon Savage, MD – *National Cancer Institute*

STAFF

Paul Spire

REFERENCES

1. Roberts JR, Karr CK; American Academy of Pediatrics, Council on Environmental Health. Technical report—pesticide exposure in children. *Pediatrics*. 2012:130(6)
2. Katz TM, Miller JH, Hebert AA. Insect repellents: historical perspectives and new developments. *J Am Acad Dermatol*. 2008; 58(5):865–871
3. Lewis RG, Fortune CR, Blanchard FT, Camann DE. Movement and deposition of two organophosphorus pesticides within a residence after interior and exterior applications. *J Air Waste Manag Assoc*. 2001;51(3):339–351
4. Hore P, Robson M, Freeman N, et al. Chlorpyrifos accumulation patterns for child-accessible surfaces and objects and urinary metabolite excretion by children for 2 weeks after crack-and-crevice application. *Environ Health Perspect*. 2005;113 (2):211–219
5. Gurunathan S, Robson M, Freeman N, et al. Accumulation of chlorpyrifos on residential surfaces and toys accessible to children. *Environ Health Perspect*. 1998;106(1):9–16
6. Fenske RA, Black KG, Elkner KP, Lee CL, Methner MM, Soto R. Potential exposure and health risks of infants following indoor residential pesticide applications. *Am J Public Health*. 1990;80(6):689–693
7. Nishioka MG, Lewis RG, Brinkman MC, Burkholder HM, Hines CE, Menkedick JR. Distribution of 2,4-D in air and on surfaces inside residences after lawn applications: comparing exposure estimates from various media for young children. *Environ Health Perspect*. 2001;109(11):1185–1191
8. Coronado GD, Vigoren EM, Thompson B, Griffith WC, Faustman EM. Organophosphate pesticide exposure and work in pome fruit: evidence for the take-home pesticide pathway. *Environ Health Perspect*. 2006;114(7):999–1006
9. Lu C, Fenske RA, Simcox NJ, Kalman D. Pesticide exposure of children in an agricultural community: evidence of household proximity to farmland and take home exposure pathways. *Environ Res*. 2000;84(3): 290–302
10. Lu C, Toepel K, Irish R, Fenske RA, Barr DB, Bravo R. Organic diets significantly lower children's dietary exposure to organophosphorus pesticides. *Environ Health Perspect*. 2006;114(2):260–263
11. Curl CL, Fenske RA, Kissel JC, et al. Evaluation of take-home organophosphorus pesticide exposure among agricultural workers and their children. *Environ Health Perspect*. 2002;110(12):A787–A792
12. Curwin BD, Hein MJ, Sanderson WT, et al. Pesticide contamination inside farm and nonfarm homes. *J Occup Environ Hyg*. 2005; 2(7):357–367
13. Shipp EM, Cooper SP, del Junco DJ, Bolin JN, Whitworth RE, Cooper CJ. Pesticide safety training among adolescent farmworkers from Starr County, Texas. *J Agric Saf Health*. 2007;13(3):311–321
14. Gamlin J, Diaz Romo P, Hesketh T. Exposure of young children working on Mexican tobacco plantations to organophosphorous and carbamic pesticides, indicated by cholinesterase depression. *Child Care Health Dev*. 2007;33(3):246–248
15. Eckerman DA, Gimenes LA, de Souza RC, Lopes Galvão PR, Sarcinelli PN, Chrisman JR. Age related effects of pesticide exposure on neurobehavioral performance of adolescent farm workers in Brazil. *Neurotoxicol Teratol*. 2007;29(1):164–175
16. Landrigan PJ, Claudio L, Markowitz SB, et al. Pesticides and inner-city children: exposures, risks, and prevention. *Environ Health Perspect*. 1999;107(suppl 3):431–437
17. Reigart JR, Roberts JR. *Recognition and Management of Pesticide Poisoning*, 5th ed. Washington, DC: US Environmental Protection Agency; 1999
18. American Academy of Pediatrics, Committee on Environmental Health. Taking an environmental history and giving anticipatory guidance. In: Etzel RA, Balk SJ, eds. *Pediatric Environmental Health*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2003:39–56
19. Sofer S, Tal A, Shahak E. Carbamate and organophosphate poisoning in early childhood. *Pediatr Emerg Care*. 1989;5(4):222–225
20. Zwiener RJ, Ginsburg CM. Organophosphate and carbamate poisoning in infants and children. *Pediatrics*. 1988;81(1):121–126
21. Lifshitz M, Shahak E, Sofer S. Carbamate and organophosphate poisoning in young children. *Pediatr Emerg Care*. 1999;15(2): 102–103
22. Balbus JM, Harvey CE, McCurdy LE. Educational needs assessment for pediatric health care providers on pesticide toxicity. *J Agromed*. 2006;11(1):27–38
23. Kilpatrick N, Frumkin H, Trowbridge J, et al. The environmental history in pediatric practice: a study of pediatricians' attitudes, beliefs, and practices. *Environ Health Perspect*. 2002;110(8):823–871
24. Trasande L, Schapiro ML, Falk R, et al. Pediatrician attitudes, clinical activities, and knowledge of environmental health in Wisconsin. *WMJ*. 2006;105(2):45–49
25. Karr C, Murphy H, Glew G, Keifer MC, Fenske RA. Pacific Northwest health professionals survey on pesticides and children. *J Agromed*. 2006;11(3-4):113–120

26. Roberts JR, Balk SJ, Forman J, Shannon M. Teaching about pediatric environmental health. *Acad Pediatr*. 2009;9(2):129–130
27. Bronstein AC, Spyker DA, Cantilena LR Jr, Green JL, Rumack BH, Dart RC. 2010 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 26th Annual Report. *Clin Toxicol*. 2011;49(10):910–941
28. Baker EL. Sentinel Event Notification System for Occupational Risks (SENSOR): the concept. *Am J Public Health*. 1989;79(suppl):18–20
29. Whitmore RW, Kelly JE, Reading PL, et al. Pesticides in urban environments. *ACS Symp Ser*. 1993;522(3):18–36
30. US Environmental Protection Agency. Pesticide product labels. Available at: www.epa.gov/pesticides/regulating/labels/product-labels.htm#projects. Accessed October 15, 2012
31. US Environmental Protection Agency. Illegal pesticide products. Available at: www.epa.gov/opp00001/health/illegalproducts. Accessed October 15, 2012
32. Kimmel CA, Collman GW, Fields N, Eskenazi B. Lessons learned for the National Children's Study from the National Institute of Environmental Health Sciences/U.S. Environmental Protection Agency Centers for Children's Environmental Health and Disease Prevention Research. *Environ Health Perspect*. 2005;113(10):1414–1418
33. US General Accounting Office. Agricultural pesticides: Management improvements needed to further promote integrated pest management. Available at: www.gao.gov/new.items/d01815.pdf. Accessed October 15, 2012

Pesticide Exposure in Children

COUNCIL ON ENVIRONMENTAL HEALTH

Pediatrics 2012;130;e1757; originally published online November 26, 2012;
DOI: 10.1542/peds.2012-2757