NEWPORT CORE CITIES DATA 1995-2004

Supplement to:
CHILDHOOD LEAD POISONING IN RHODE ISLAND: THE NUMBERS 2005 EDITION

Rhode Island Department of Health
Childhood Lead Poisoning Prevention Program
September 2005

Healthy Homes
Healthy Children

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RHODE ISLAND DEPARTMENT OF HEALTH

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INTRODUCTION

The Rhode Island Childhood Lead Poisoning Prevention Program has a strategic plan to eliminate lead poisoning by 2010 (www.health.ri.gov/lead/databook). The main objective of this plan is for each city and town to decrease the proportion of new cases of lead poisoning in children under six years of age to less than 5% without decreasing the availability of lead safe, affordable housing.

Over the past ten years, new cases of lead poisoning in Rhode Island have been concentrated in cities where, according to the 2000 Census, the child poverty rate is greater than 15%. These cities are designated as "core cities" and include Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket. For this reason, we are presenting data specific to each of the core cities so that legislators, community leaders, and the public better understand the extent of the lead poisoning problem in these areas.

ELIMINATING CHILDHOOD LEAD POISONING BY 2010

The Centers for Disease Control and Prevention (CDC) requires all state and local Childhood Lead Poisoning Prevention Programs, including the Rhode Island Program, to develop a strategic plan to eliminate childhood lead poisoning by 2010. As part of that plan, CDC encourages each state to develop a state-specific definition for elimination of lead poisoning based on local data. The elimination goal in Rhode Island is:

"To decrease the proportion of new cases [incidence] of lead poisoning (defined as a blood lead level of 10 µg/dL or more) in children under six years of age to less than 5% in all Rhode Island communities without decreasing the availability of lead safe, affordable housing."

The strategy for elimination is two-fold: reduce incidence and ensure the availability of lead safe, affordable housing. Despite the fact that incidence has been decreasing throughout the state, we will not reach elimination without addressing the housing component.

In July 2004, the Rhode Island Childhood Lead Poisoning Prevention Program (RI CLPPP) created a Plan to achieve this goal called "Rhode Island's Plan to Eliminate Childhood Lead Poisoning by 2010" www.health.ri.gov/lead/databook. The Plan has three main objectives:

1. To support the implementation of the Lead Hazard Mitigation Law in Rhode Island
2. To formulate innovative primary prevention strategies to achieve elimination
3. To maintain and re-evaluate secondary prevention efforts

The Plan describes how progress on each objective can be measured using data in the RI CLPPP database, and, in some cases, data available to the Program from other state and local agencies. The Plan calls for an evaluation of the elimination goal using both of the following components together:

1. Incidence: The incidence of childhood lead poisoning is estimated for each city and town and calculated by dividing the number of new cases of lead poisoning (children with a blood lead level $\geq$ 10 µg/dL for the first time in their lives), by the total number of children screened, who have never had a blood lead level $\geq$10 µg/dL.

2. Lead safe, affordable housing: This measure is still being developed. Measuring the availability of lead safe, affordable housing is a challenge, both with respect to identifying lead safe units and determining how many are affordable. In the last few months, RI CLPPP has been working to develop a feasible way to assess the availability of lead safe, affordable housing. Efforts include:

   a) Forming a RI CLPPP Advisory Committee workgroup to help develop a housing measure. The workgroup will contact the numerous local and state agencies that possess housing data and report back on the availability of these data and the formatting barriers that limit their utility.

   b) Using the report and logic model developed by two students from the Harvard School of Public Health to design a measure to track the availability of lead safe, affordable housing.

   c) Establishing stronger relationships with housing agencies, including the local Lead Hazard Reduction Programs, the Weatherization Program, the Housing Resources Commission, Rhode Island Housing, and the U.S. Environmental Protection Agency (EPA).

   d) Promoting the use of RI CLPPP's public data among lead poisoning prevention advocates. These data include public lists of properties, such as High Risk Premises, Properties with Multiple Poisonings, and Ongoing Violations, and are published on RI CLPPP's web site as required by the Lead Hazard Mitigation Law. These public lists can be found on the web at www.health.ri.gov/lead.

UNDERSTANDING THE LEAD DATA

In Rhode Island, health care providers are required by law to screen their patients between nine months and six years of age for lead poisoning annually. The screening process involves collecting a sample of blood from the child, either from a capillary (fingerstick) or a vein (venous test), and analyzing the blood to determine the amount of lead in the sample. Blood lead levels (BLL) are measured and reported as micrograms of lead per deciliter of blood (µg/dL or mcg/dL).

Although the guidelines recommend that children begin to be screened at nine months of age, some children may be screened earlier if they are at high risk for lead poisoning. The data presented in this report are based on the results of all blood lead tests, both capillary and venous, performed on children from birth to six years of age in the state of Rhode Island.[1] For the incidence and prevalence analyses, each child is represented once per year in which he was screened.

For surveillance purposes in Rhode Island, any child under the age of six with a blood lead level ≥10 µg/dL is considered lead poisoned. As the Centers for Disease Control and Prevention (CDC) states, it is not possible to select a single number to define lead poisoning for various intervention activities. According to guidelines from the CDC, community prevention activities, such as nutritional and educational campaigns, should be implemented at blood lead levels ≥10 µg/dL, and individual prevention activities, such as case management and environmental investigations, should be implemented at blood lead levels ≥15 µg/dL.[2]

[1] Given that calculations in this document are based on screening data rather than population data for all children under the age of six, the numbers presented here are estimates.

[2] Preventing Lead Poisoning in Young Children: A Statement by the Centers for Disease Control- October 1991. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Atlanta, GA 30333.

Occurrences of Lead Poisoning in Rhode Island are broken down into the following action levels:

Action Level	Blood Lead Level (BLL)	Action
Elevated Blood Lead (EBL)	One BLL between 10-14 μg/dL	***Capillary:*** Letter sent to Primary Care Provider recommending venous test to confirm the BLL* ***Venous:*** Letter sent to family inviting them to request a home visit through the Family Outreach Program*
Preventive	One BLL between 15-19 μg/dL	***Capillary:*** Letter sent to Primary Care Provider recommending venous test to confirm the BLL ***Venous:*** Family is referred to a lead center for an in-home lead education visit and some environmental intervention (i.e. temporary lead hazard control measures, window replacement)
Significant	One Venous BLL ≥20 μg/dL or Two BLLs (capillary or venous) ≥15 μg/dL done 90-365 days apart**	Family is referred to a lead center for comprehensive case management and is offered an environmental inspection

* In addition to the actions described, a letter is sent to families living in Providence ONLY informing them that they can contact the city of Providence for a free environmental inspection of their home.
** Two blood lead levels (capillary or venous) ≥15 μg/dL may also be referred to as "persistent lead poisoning."

In 1991, the Centers for Disease Control and Prevention (CDC) defined an elevated blood lead level (also referred to as "level of concern") as a blood test result ≥10 μg/dL, and suggested that children with elevated blood lead levels be monitored and re-tested. Recent research suggests that blood lead levels lower than 10 μg/dL can have harmful health effects.[3,4]

In response to questions about whether to change the "level of concern," CDC has prepared the following statement, which can be found on their website at www.cdc.gov/lead/qanda.htm:

"Recent studies suggest that adverse health effects exist in children at blood lead levels less than 10 μg/dL. In the past the CDC has lowered the level considered elevated in response to similar reports. However, at this time the reasons not to lower the level of concern are as follows:

- No effective clinical interventions are known to lower the blood lead levels for children with levels less than 10 μg/dL or to reduce the risk for adverse developmental effects.
- Children cannot be accurately classified as having blood lead levels above or below a value less than 10 μg/dL because of the inaccuracy inherent in laboratory testing.
- Finally, no evidence exists of a threshold below which adverse effects are not experienced. Thus, any decision to establish a new level of concern would be arbitrary and provide uncertain benefits.

These studies support making primary prevention of childhood lead poisoning a high priority for health, housing, and environmental agencies at the state, local, and federal levels."

[3] Canfield RL, Henderson CR, Cory-Slechta DA, Cox C, Jusko TA, Lanphear BP. Intellectual Impairment in Children with Blood Lead Concentrations below 10μg per Deciliter. New England Journal of Medicine 2003; 348:1517-26.
[4] Selevan SG, Rice DC, Hogan KA, Euling SY, Pfahles-Hutchens A, Bethel J. Blood Lead Concentration and Delayed Puberty in Girls. New England Journal of Medicine 2003; 348:1527-36.

COMPLIANCE WITH LEAD SCREENING GUIDELINES

All Rhode Island children between nine months and six years of age are required by law to be screened for lead poisoning annually. Compliance with these guidelines is assessed by measuring the proportion of children born in a given year (birth cohort) with at least one blood lead test by 18 months of age and the proportion of children born in a given year with at least two blood lead tests by 36 months of age.

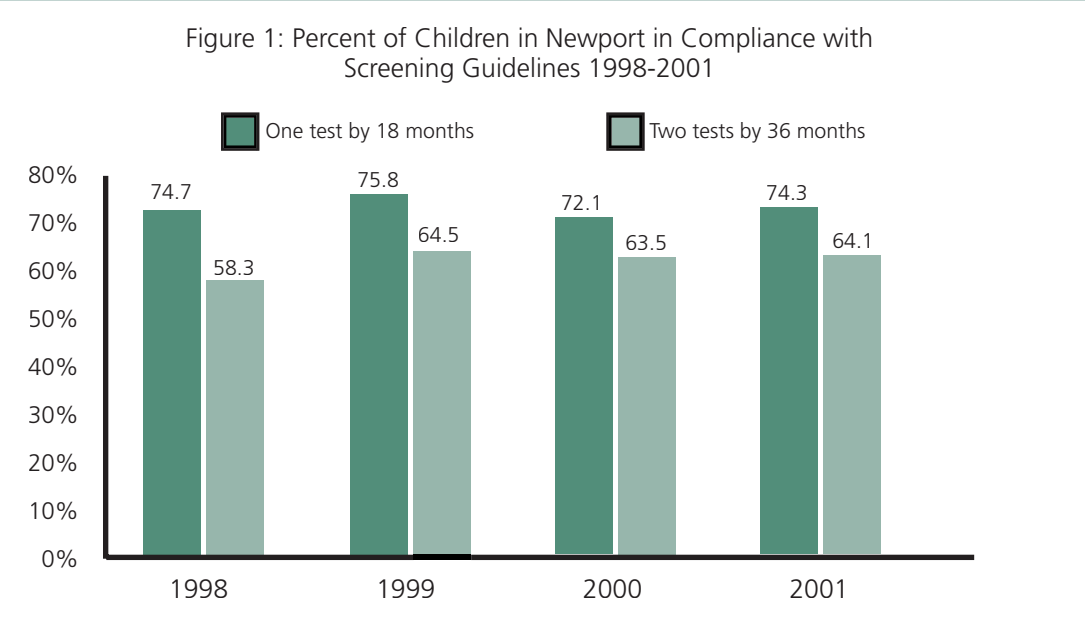


Figure 1: Percent of Children in Newport in Compliance with Screening Guidelines 1998-2001

One Screening Test by 18 Months of Age

Screening children by 18 months of age is important to promptly identify children with elevated blood lead levels and offer interventions. Rhode Island has one of the highest screening rates in the nation. Approximately 75% of children in Rhode Island are screened at least once by 18 months of age. This rate has been consistent between 1998 and 2001, the year for which we have the most recent completed data. The screening rates among children 18 months of age in Newport are consistent with the screening rates statewide.

Two Screening Tests by 36 Months of Age

Compliance with the screening guidelines decreases as children get older. The statewide screening rate drops to approximately 52% when looking at the percent of children with two screening tests by 36 months of age. This rate has been consistent between 1998 and 2001. The average screening rate among children 36 months of age in Newport is 62%, which is about 10% higher than the average statewide screening rate for children in this age group.

A variety of outreach efforts have been made to achieve this high rate of screening, such as sending reminders to parents to have their children tested at the 12 month well-child visit and providing pediatric practices with lists of unscreened children in their practices between the ages of 22 and 24 months. In addition, many pediatric practices have access to KIDSNET, an electronic database containing preventive health information for all children born in the state since 1997. KIDSNET allows doctors to monitor lead screening rates in their practices.

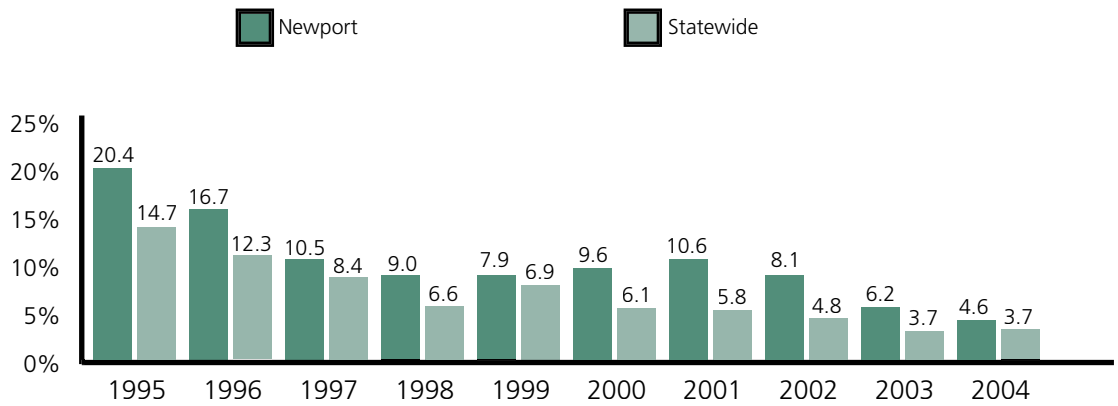
Although the majority of the population is being screened, efforts must continue to focus on screening children after 18 months of age.

* Birth cohorts beyond 2001 are not included here because those children had not yet turned 36 months of age by the time this report was prepared.

INCIDENCE OF LEAD POISONING

The Department of Health tracks and reports the number of newly lead poisoned children (blood lead level ≥10 μg/dL) among children less than six years of age who have never had an elevated blood lead level in the past. This is known as the incidence rate.

Figure 2: Incidence of Lead Poisoning in Newport and Statewide 1995-2004



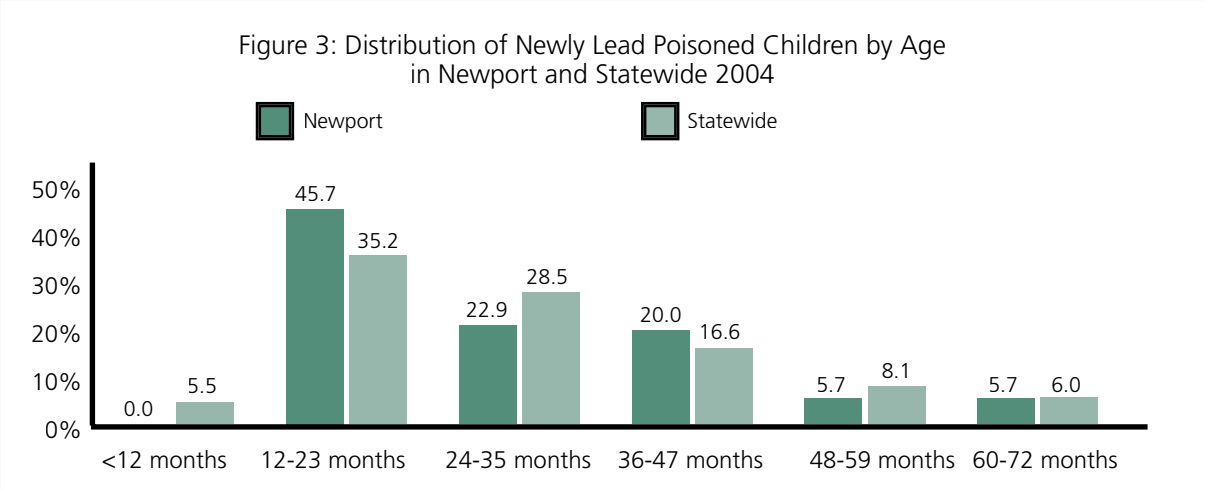
Over the past ten years, the proportion of new cases of lead poisoning among children in Newport has declined from 20.4% in 1995 to 4.6% in 2004. This decline is consistent with the statewide trend over the last ten years. In spite of the considerable decline in incidence over time, 35 children living in Newport were lead poisoned for the first time in 2004.*

*31 of the newly lead poisoned children were screened with a capillary test; 4 were screened with a venous test. As of July 1, 2004, the revised screening guidelines require that all capillary tests ≥10 μg/dL be followed-up with a venous test.

INCIDENCE OF LEAD POISONING BY AGE

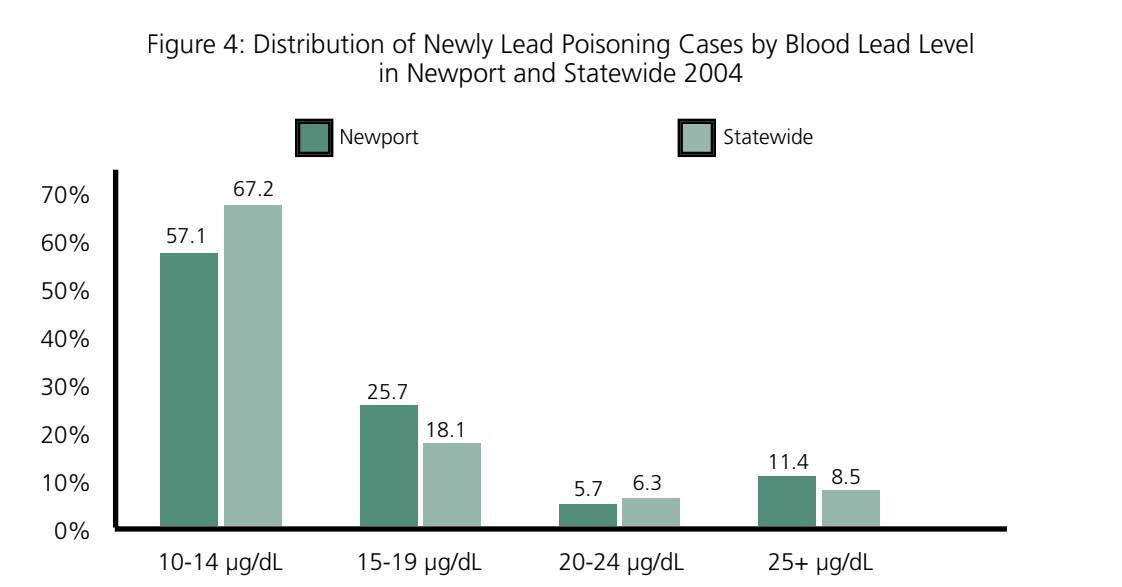
In Newport, no children under 12 months of age were reported to be lead poisoned in 2004, compared to the statewide average of 5.5%. This could suggest that children in other cities and towns across Rhode Island are being poisoned at a younger age than children in Newport, or that residents of Newport are not screening their children for lead before age one. Newport is also below the state average for new cases of lead poisoning among children 24-35 months of age and 48-59 months of age. Newport is similar to the statewide average for new cases of lead poisoning among children 60-72 months of age.

New cases of lead poisoning in Newport occur most frequently among children12-23 months of age. This is 10.5% higher than the statewide average for children between 12-23 months of age (45.7% vs. 35.2%).



INCIDENCE OF LEAD POISONING BY BLOOD LEAD LEVEL

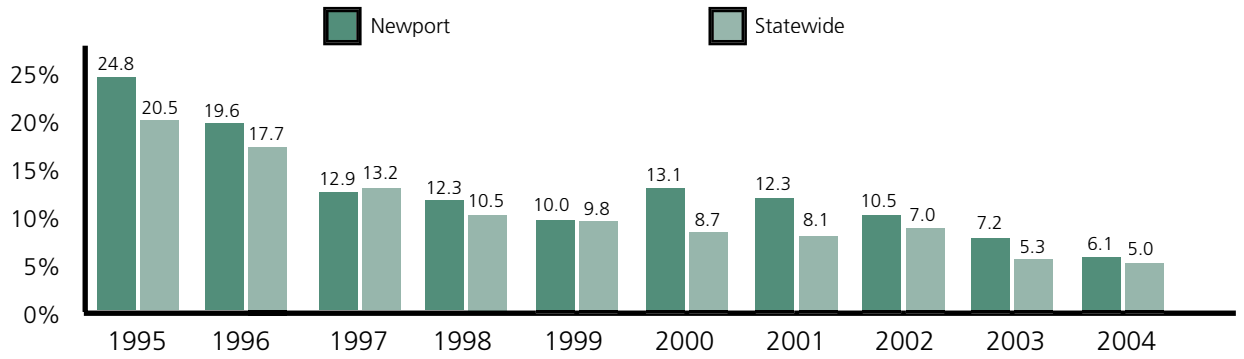
The distribution of newly lead poisoned children by blood lead level in Newport in 2004 follows the same trend as the statewide distribution. In Newport, as well as statewide, lead poisoning is being detected among the majority of children when their blood lead levels are in the 10-14 µg/dL range. This indicates that screening practices are successfully identifying children with elevated blood lead levels before they become highly elevated.



PREVALENCE OF LEAD POISONING

The Rhode Island Department of Health calculates the prevalence of lead poisoning annually. The prevalence rates presented here show the proportion of children with a blood lead level ≥10 μg/dL in a given year and include children who had been lead poisoned in the past.

Figure 5: Percent of Lead Poisoning in Newport and Statewide 1995-2004



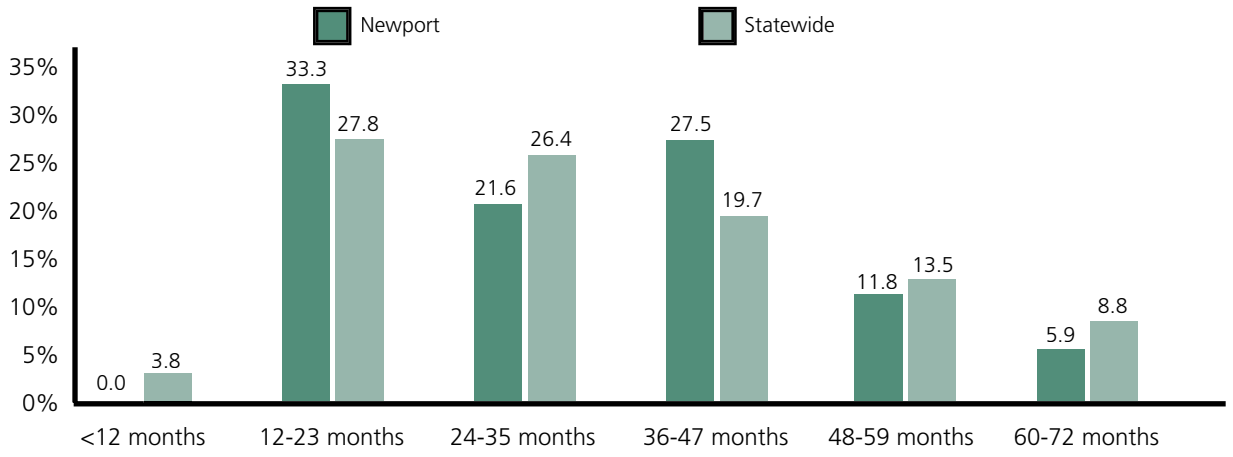
Over the past ten years, the prevalence of lead poisoning among children in Newport has declined from 24.8% in 1995 to 6.1% in 2004. This decline is consistent with the statewide trend over the last ten years, with the exception of the year 2000, where there was an increase in the prevalence of lead poisoning from 10% to 13.1%. Following this increase, the prevalence rates have continued to decline. Despite the decrease, however, a total of 51 children living in Newport had lead poisoning in 2004.

PREVALENCE OF LEAD POISONING BY AGE

The distribution of children with lead poisoning by age in Newport in 2004 differs from the statewide distribution.

There are no children in Newport identified as lead poisoned under 12 months of age, compared to the statewide rate of 3.8%. In Newport and statewide, the majority of lead poisoned children in 2004 were 12-23 months of age. When compared to the statewide rates, Newport has a higher rate of lead poisoning among children ages 12-23 and 36-47 months, and a lower rate among children ages 24-35 months and 48-72 months.

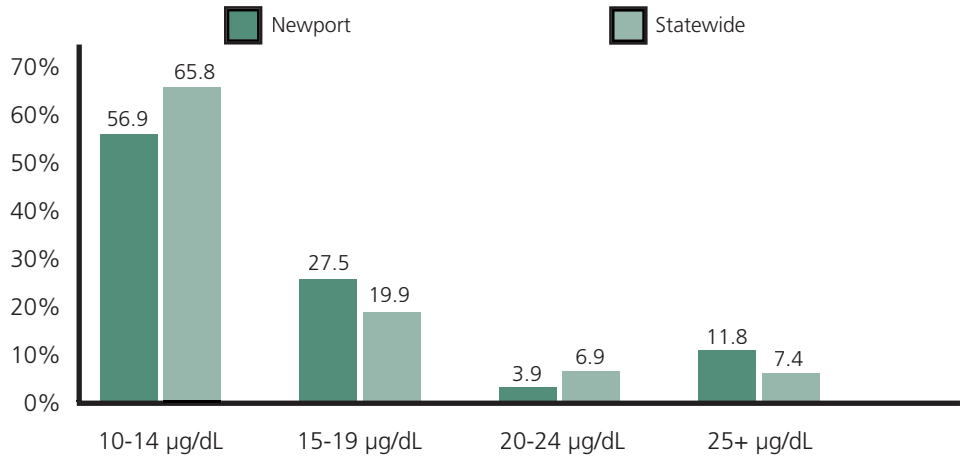
Figure 6: Distribution of Lead Poisoned Children by Age in Newport and Statewide 2004



PREVALENCE OF LEAD POISONING BY BLOOD LEAD LEVEL

The distribution of lead poisoning by blood lead level in Newport in 2004 follows the statewide distribution. Nearly two-thirds of lead poisoned children in Newport, as well as throughout the state, have blood lead levels between 10 and 14 µg/dL. This indicates that among children who are lead poisoned, few have blood lead levels above 14 µg/dL.

Figure 7: Prevalence of Lead Poisoning by Blood Lead Level in Newport and Statewide 2004



ENVIRONMENTAL INSPECTIONS OFFERED

In Rhode Island, comprehensive environmental inspections are offered to families of children who have an environmental intervention blood lead level (EIBLL).* Families are offered an environmental inspection at no cost. The landlord's permission is neither required nor sought for the inspection to occur.

Although inspections are offered to all children with environmental intervention blood lead levels, the inspections may not be performed if the family cannot be located, or they do not respond to letters or phone calls. In addition, inspections are not performed if a child moves or if the family refuses the inspection.

In 2004, five inspections were offered to families in Newport. One family moved and the remaining four inspections were performed. In all inspections performed, lead hazards were found.

For more detailed information about environmental inspections offered between 2000 and 2004, see the table below.

	2000	2001	2002	2003	2004
Inspections Offered	**2**	**7**	**2**	**3**	**5**
Child Moved	0	0	0	0	1
No Response to Letters, Phone Calls	0	0	0	0	0
Inspection Refused	0	2	0	0	0
Pending Inspection	0	0	0	0	0
Inspections Performed	**2**	**5**	**2**	**3**	**4**

*For the purposes of environmental inspections, EIBLL is synonymous with significant lead poisoning.
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STATUS OF ENVIRONMENTAL INSPECTIONS

An environmental case is opened for each child with an environmental intervention blood lead level who receives an inspection. Once the case is opened, the Department of Health works with the property owner until the entire property, including the interior, exterior, and soil, are abated and free of lead hazards. In some instances, cases are closed before abatement is complete. This can occur if the parent of the child is the owner of the property or if the property is no longer regulated, such as illegal apartments that have been dismantled, properties that have been converted to commercial use, or properties that have been razed.

All four properties that were inspected in 2004 still contain lead hazards and the cases are open and ongoing with the Department.

For a breakdown of the status of cases opened in 2000-2004, see the table below.

	2000	2001	2002	2003	2004
Closed Cases	**2**	**5**	**2**	**3**	**0**
No Lead Hazards Found	0	0	0	0	0
No Longer Regulated	0	0	0	0	0
Parent is Owner of Property	0	4	0	2	0
Closed Pending Soil	0	0	0	0	0
Abatement Complete	2	1	2	1	0
Ongoing Cases	**0**	**0**	**0**	**0**	**4**
Pending Soil	0	0	0	0	0
Exterior Abated, Interior Pending	0	0	0	0	1
Interior Abated, Exterior Pending	0	0	0	0	0
Enrolled or Enrolling in a HUD Program, Awaiting Abatement	0	0	0	0	0
Various Stages of Abatement	0	0	0	0	4
Total Cases	**2**	**5**	**2**	**3**	**4**

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DATA TABLES

Table 1. Percent of Children in Newport in Compliance with Screening Guidelines 1998-2001

Year Born	Total Number of Children Born	Number of Children Screened at Least Once by 18 Months of Age	Number of Children Screened at Least Twice by 36 Months of Age
1998	288	215 (74.7%)	168 (58.3%)
1999	293	222 (75.8%)	189 (64.5%)
2000	326	235 (72.1%)	207 (63.5%)
2001	315	234 (74.3%)	202 (64.1%)

Table 2A. Incidence of Lead Poisoning in Newport 1995-2004

Year	Number of Children with BLL ≥10 μg/dL for the First Time	Number of Children Screened with No Previous Elevated Blood Lead Level	Incidence
1995	163	798	20.4%
1996	118	706	16.7%
1997	72	686	10.5%
1998	62	687	9.0%
1999	60	764	7.9%
2000	75	780	9.6%
2001	85	804	10.6%
2002	65	804	8.1%
2003	52	845	6.2%
2004	35	761	4.6%

Table 2B. Incidence of Lead Poisoning Statewide 1995-2004

Year	Number of Children with BLL ≥10 μg/dL for the First Time	Number of Children Screened with No Previous Elevated Blood Lead Level	Incidence
1995	4,070	27,642	14.7%
1996	3,368	27,297	12.3%
1997	2,369	28,125	8.4%
1998	1,870	28,170	6.6%
1999	2,025	29,187	6.9%
2000	1,740	28,419	6.1%
2001	1,857	31,848	5.8%
2002	1,535	31,954	4.8%
2003	1,161	31,579	3.7%
2004	1,167	31,610	3.7%

Table 3A. Distribution of New Lead Poisoning Cases by Age in Newport 2004

Age	Number of Children with BLL ≥10 μg/dL for the First Time	Percent of Children with BLL ≥10 μg/dL for the First Time
<12 months	0	0.0%
12-23 months	16	45.7%
24-35 months	8	22.9%
36-47 months	7	20.0%
48-59 months	2	5.7%
60-72 months	2	5.7%
Total	35	100%

Table 3B. Distribution of New Lead Poisoning Cases by Age Statewide 2004

Age	Number of Children with BLL ≥10 μg/dL for the First Time	Percent of Children with BLL ≥10 μg/dL for the First Time
<12 months	64	5.5%
12-23 months	411	35.2%
24-35 months	333	28.5%
36-47 months	194	16.6%
48-59 months	95	8.1%
60-72 months	70	6.0%
Total	1,167	100%

Table 4A. Distribution of New Lead Poisoning Cases by Blood Lead Level in Newport 2004

Blood Lead Level	Number of Children with Elevated Blood Lead Level for the First Time	Percent of Children with BLL ≥10 μg/dL for the First Time
10-14 μg/dL	20	57.1%
15-19 μg/dL	9	25.7%
20-24 μg/dL	2	5.7%
25+ μg/dL	4	11.4%
Total	35	100%

Table 4B. Distribution of New Lead Poisoning Cases by Blood Lead Level Statewide 2004

Blood Lead Level	Number of Children with Elevated Blood Lead Level for the First Time	Percent of Children with BLL ≥10 μg/dL for the First Time
10-14 μg/dL	784	67.2%
15-19 μg/dL	211	18.1%
20-24 μg/dL	73	6.3%
25+ μg/dL	99	8.5%
Total	1,167	100%

Table 5A. Prevalence of Lead Poisoning Cases in Newport 1995-2004

Year	Number of Children with BLL ≥10 μg/dL	Total Number of Children Screened	Prevalence
1995	232	936	24.8%
1996	167	853	19.6%
1997	108	836	12.9%
1998	101	824	12.3%
1999	87	869	10.0%
2000	113	862	13.1%
2001	109	887	12.3%
2002	96	910	10.5%
2003	67	931	7.2%
2004	51	834	6.1%

Table 5B. Prevalence of Lead Poisoning Cases Statewide 1995-2004

Year	Number of Children with BLL ≥10 μg/dL	Total Number of Children Screened	Prevalence
1995	6,835	33,312	20.5%
1996	5,843	32,996	17.7%
1997	4,446	33,647	13.2%
1998	3,437	32,684	10.5%
1999	3,208	32,816	9.8%
2000	2,741	31,382	8.7%
2001	2,813	34,865	8.1%
2002	2,450	34,835	7.0%
2003	1,811	34,130	5.3%
2004	1,685	33,839	5.0%

Table 6A. Prevalence of Lead Poisoning by Age in Newport 2004

Age	Number of Children with BLL ≥10 μg/dL	Percent of Children with BLL ≥10 μg/dL
<12 months	0	0.0%
12-23 months	17	33.3%
24-35 months	11	21.6%
36-47 months	14	27.5%
48-59 months	6	11.8%
60-72 months	3	5.9%
Total	51	100%

Table 6B. Prevalence of Lead Poisoning by Age Statewide 2004

Age	Number of Children with BLL ≥10 µg/dL	Percent of Children with BLL ≥10 µg/dL
<12 months	64	3.8%
12-23 months	469	27.8%
24-35 months	445	26.4%
36-47 months	332	19.7%
48-59 months	227	13.5%
60-72 months	148	8.8%
Total	1,685	100%

Table 7A. Prevalence of Lead Poisoning by Blood Lead Level in Newport 2004

Blood Lead Level	Number of Children with Elevated Blood Lead Levels	Percent of Children with Elevated Blood Lead Levels
10-14 µg/dL	29	56.9%
15-19 µg/dL	14	27.5%
20-24 µg/dL	2	3.9%
25+ µg/dL	6	11.8%
Total	51	100%

Table 7B. Prevalence of Lead Poisoning by Blood Lead Level Statewide 2004

Blood Lead Level	Number of Children with Elevated Blood Lead Levels	Percent of Children with Elevated Blood Lead Levels
10-14 µg/dL	1,108	65.8%
15-19 µg/dL	336	19.9%
20-24 µg/dL	116	6.9%
25+ µg/dL	125	7.4%
Total	1,685	100%

GLOSSARY

BLL: Blood lead level.

EBL: Elevated blood lead. A single blood lead level between 10-14 µg/dL.

EIBLL: Environmental intervention blood lead level. Synonymous with Significant Lead Poisoning.

Incidence: The proportion of new cases of a disease that develops during a specified time period among the population at risk for developing the disease. The population at risk for lead poisoning is defined as Rhode Island children under the age of six who have been screened for lead in a given year, and who have never had an elevated blood lead level.

Lead Hazard Mitigation Law: Legislation passed by the Rhode Island General Assembly in June 2002 that takes effect on November 1, 2005. The Law modified the Lead Poisoning Prevention Act and established standards for the maintenence of pre-1978 rental property in Rhode Island.

NOV: Notice of violation. A notice sent to a property owner after an environmental lead inspection or lead assessment has been performed and environmental lead hazards have been identified. The notice informs the property owner that significant environmental lead hazards exist on his property and requires the owner to abate all identified hazards in accordance with Rhode Island Department of Health regulations.

Persistent Lead Poisoning: A case of a child under age six with two blood lead tests (capillary or venous) done between 90 and 365 days apart that are ≥15 µg/dL.

Prevalence: Proportion of people in a population who have a given disease at a specific point in time.

Preventive Lead Poisoning: A case of a child under age six with a single blood lead level between 15 and 19 µg/dL for the first time.

RI CLPPP: The Rhode Island Childhood Lead Poisoning Prevention Program.

Screening: Mandatory test that involves collecting a blood sample from a child under the age of six, either through a fingerstick or a venipuncture. The sample is then analyzed to determine the amount of lead in the child's blood.

Significant Lead Poisoning: A venous blood lead level ≥20 µg/dL in a child under six years of age, or two blood lead tests (capillary or venous) from a child under six years of age, done between 90 and 365 days apart, with a blood lead level ≥15 µg/dL. Synonymous with EIBLL.

µg/dL: Micrograms per deciliter of whole blood; the measurement used to estimate the amount of lead in a sample of blood. This measure is sometimes represented as mcg/dL.

FOR MORE INFORMATION CONTACT:

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