European Journal of Clinical Nutrition (2013) **67**, 230–238

www.nature.com/ejcn

REVIEW

# Aluminium in parenteral nutrition: a systematic review

A Hernández-Sánchez, P Tejada-González and M Arteta-Jiménez

Aluminium (Al) toxicity problem in parenteral nutrition solutions (PNS) is decades old and is still unresolved. The aim of this review is to gather updated information about this matter, regarding legislation, manifestations, diagnostics and treatment, patient population at risk and the actions to be taken to limit its accumulation. A structured search using MeSH vocabulary and Title/Abstract searches was conducted in PubMed (http://www.pubmed.gov) up to November 2012. Al is ubiquitous, facilitating its potential for exposure. Nevertheless, humans have several mechanisms to prevent significant absorption and to aid its elimination; therefore, the vast majority of the population is not at risk for Al toxicity. However, when protective gastrointestinal mechanisms are bypassed (for example, parenteral fluids), renal function is impaired (for example, adult patients with renal compromise and neonates) or exposure is high (for example, long-term PNS), Al is prone to accumulate in the body, including manifestations such as impaired neurological development, Alzheimer's disease, metabolic bone disease, dyslipemia and even genotoxic activity. A high Al content in PNS is largely the result of three parenteral nutrient additives: calcium gluconate, inorganic phosphates and cysteine hydrochloride. Despite the legislative efforts, some factors make difficult to comply with the rule and, therefore, to limit the Al toxicity. Unfortunately, manufacturers have not universally changed their processes to obtain a lower Al content of parenteral drug products (PDP). In addition, the imprecise information provided by PDP labels and the high lot-to-lot variation make the prediction of Al content rather inaccurate.

*European Journal of Clinical Nutrition* (2013) **67,** 230–238; doi:10.1038/ejcn.2012.219; published online 13 February 2013

**Keywords:** aluminium; parenteral nutrition; bone disease; metabolic; Food and Drug Administration; toxicity

## INTRODUCTION

Aluminium (Al) toxicity in parenteral nutrition solutions (PNS) has been a problem for decades and is still unresolved. Europe lacks a global legislation about the upper limit for Al contamination. In the United States, in an effort to limit patients' exposure to Al and to prevent cases of Al toxicity, the American Society for Clinical Nutrition (ASCN) and the American Society for Parenteral and Enteral Nutrition (ASPEN) Working Group on standards for Al content in PNS established in 1991 a series of thresholds (upper *safe* limit, *unsafe* limit, and *toxic* limit) for Al intake for patients on long-term PNS.

The United States Food and Drug Administration (FDA) endocrinologic and metabolic drugs advisory panel, in 2004, and after several deferrals, issued a rule governing Al content in large volume parenterals (LVPs) and small volume parenterals (SVPs) used to prepare PNS.

Because this regulation applies to industry only, ASPEN issued a statement in 2010 on Al in PNS that provides some guidance to clinicians.

Despite the legislative efforts, some factors have made difficult to comply with the rules and, therefore, to limit the Al toxicity. In this article, we describe how much has been done to limit the Al content in PNS, and highlight its importance and the actions that should be taken to limit it.

## MATERIALS AND METHODS

A structured search using MeSH vocabulary and Title/Abstract searches was conducted in PubMed (http://www.pubmed.gov) up to November 2012. The language of the publications was restricted to English. The terms used were as follows: (((aluminium(Title/Abstract)) or aluminium (Title/Abstract)) and parenteral nutrition (Title/Abstract), rendering 107 publications. Six were excluded according to language criteria, resulting in 101 articles. References from these articles chosen were browsed, yielding an additional 30 papers for potential consideration.

## FINDINGS

### Al characteristics

Al is the lightest, least dense and third most abundant mineral within the earth's crust (8% by weight) after oxygen and silicon.[1–8] It has no known functions in the human body, although a significant role in biomolecular compaction has been proposed.[5,9] Its wide distribution clearly facilitates the potential for human exposure, which occurs through air, food and water, but it is also present in medical, cosmetic and environmental products.[6,9] Of these, PNS stand out as a substantial source of this toxic metal, as many parenteral drug products (PDP) used to compound them contain Al as a contaminant or as a component of the raw materials.[9,10]

It is estimated that humans ingest between 3 and 20 mg of Al per day.[1,9] Food and beverages provide 2.5–13 mg of Al daily, whereas drinking water may account for 0.2–0.4 mg per day. Drugs such as antacids can contribute up to 500 mg.[6] However, despite this intake, it will not accumulate in the body. Humans have several mechanisms to prevent significant absorption of Al and to aid its elimination; therefore, the vast majority of the population is not at risk for Al toxicity from oral or enteral intake.[9] In healthy people, both the lungs and the skin are very effective at reducing Al absorption, as is the gastrointestinal tract, which

Pharmacy department, Hospital Universitario de Getafe, Getafe, Madrid, Spain. Correspondence: Dr A Hernández-Sánchez, Pharmacy department, Hospital Universitario de Getafe, Carretera A-42, 12,500, 28905 Madrid, Spain.

typically allows <1% of ingested Al into the blood stream.[1,9,11,12] Ninety nine per cent of absorbed Al is lost in the urine and a minor portion being cleared in the bile. Thus, the renal excretion is the primarily via of elimination.[1,2,12,13]

However, when protective gastrointestinal mechanisms are bypassed (for example, parenteral fluids), renal function is impaired (for example, adult patients with renal compromise and neonates) or exposure is high (for example, long-term PNS), Al is prone to accumulate in the body, notably in bone, liver and central nervous system, and also in the spleen, kidneys and other tissues.[1,14] PNS are then one of the parenteral fluids that pose greatest risk for Al accumulation owing to their Al content and their administration directly into the circulation bypassing the gastrointestinal tract.[12]

## Al in PDP

Al is present in all the PDP used to elaborate PNS. Furthermore, product manipulation, containers and administration sets add Al to the mixture.[10,15] Al contamination of PNS has been recognised since the 1980s, although it was higher than it is at present.[9] Previous studies from the 1980s estimated daily intakes of Al from 80 to 100 μg/kg/day, which is almost 50-fold more than the present mean intake. This change is a function of reduced contamination of PNS through its additives.[16]

A high Al content in PNS is largely the result of three PDP: calcium gluconate (CaGluc; up to 81%), inorganic phosphates (especially potassium) and cysteine hydrochloride.[4,8,10,12,17–20]

Historically, replacement of casein hydrolysate with crystalline amino acids, which are very low in Al, substantially reduced the Al load 50–100 times in adult patients receiving PNS. This protein source is no longer available, and thus may no longer be considered a source of Al toxicity.[1,14,16,21] Currently, there are other changes that may lead to Al reduction:

Calcium and phosphorus are prescribed in small amounts but are relevant, as both are important sources of Al and have the potential for developing calcium phosphate precipitates. CaGluc is commonly used in PNS and has replaced calcium chloride (CaCl), because the risk of precipitation with phosphate is lower.[17,22] However, PNS made with CaCl contain significantly less Al compared with those made with CaGluc.[17,23] Another strategy to reduce the risk of calcium phosphate precipitation is to use an organic source of phosphorus, more compatible with CaCl than the inorganic phosphates.[2,3,10] However, although widely used in Europe, they are unavailable in many countries including the United States and Canada. Furthermore, although inorganic phosphates are considered as high Al-content products, potassium phosphate (KPho) usually renders more Al to PNS than sodium phosphate. Therefore, using a sodium or a mixed sodium–KPho solution rather than the potassium salt would significantly reduce Al exposure through PNS.[3,24] Another issue is the under-mineralisation of bone in low-birth-weight infants receiving PNS partly because of the delivery of insufficient amounts of calcium and phosphorus, limited by the low solubility of calcium phosphate. A possible alternative is calcium glycerophosphate, which has confirmed as effective regarding mineral retention as equimolar intakes of calcium and phosphorus from CaGluc and KPho respectively. Also, and higher concentrations of these minerals can be kept in solution when they are provided as calcium glycerophosphate.[25–27]

The amount of Al leached from glass containers with rubber closures is also a significant contributor of Al.[10] For instance, repackaging CaGluc from glass containers to polyethylene vials reduces the mean Al concentration from 5000 to 195 μg/l (a 96% decrease).[3,10,12] PDP should be stored in containers that do not interact physically or chemically with the preparations. This high chemical resistance is, however, obtained by the addition of mainly boric and Al oxides to glass, consequently turning glass into a source of Al.[28] Low pH favours exchange of metal ions from glass, whereas high-pH solutions promote the dissolution of the glass surface itself.[29] Solutions such as CaGluc, sodium phosphate and sodium acetate form complex anions that dissolve Al from the glass containers during autoclaving.[2,12,24] (Table 1). Table 2 shows the content of Al measured in different PNP as published in several recent studies. Table 3 lists some relevant products currently marketed for PNS preparations in Europe.

## Patient population at risk

As the kidneys are the major route of Al elimination, the patients at greatest risk of accumulation receiving PNS are those with renal compromise and infants with immature renal function, although other patients who receive these Al-contaminated parenterals are also at risk for Al loading.[10,12,14] (Table 4).

- During pregnancy, the foetus is susceptible to Al contamination, as it is transferred transplacentally. Al does not appear to transfer into breast milk in any appreciable. In animal models, less than 2% of a daily dose reached breast milk.[1,13]
- In premature infants, toxicity appears to be negatively correlated with gestational age. In addition to possessing immature renal function, they are more prone to Al toxicity because of their increased calcium and phosphorus requirements, thus exposing them to more contaminants from parenterals that contain these minerals.[1,16] Even intakes of <2 μg/kg/day, the level suggested by the ASCN/ASPEN as being safe, may be toxic in this population.[1] Healthy neonates may be able to handle more Al; however, there are no such studies available upon which we could safely estimate acceptable upper levels of Al from parenteral or injectable sources in healthy children.[11]
- In adults, age represents a risk factor for kidney function impairment, as during normal aging humans lose up to 50% of their glomeruli between 40 and 85 years of age.[11] Elderly patients may also be at a similar risk of Al-related toxicity. However, a study reveals that most patients with acute kidney injury who require PNS do not receive excessive exposure to Al. This was due, in part, to the fact that patients with better renal function received more calcium and smaller doses of phosphorus. Patients with the worst renal function were more apt to have hyperphosphatemia and would therefore receive PNS without phosphorus.[8]
- In geriatric patients, Al absorption becomes more efficient with advancing age; toxicity may not be as dependent on renal function owing to a weakened gastrointestinal protective barrier.[1]
- Other populations at risk for Al toxicity are burn patients who have received large amounts of albumin to maintain oncotic pressure, and plasmapheresis patients who have been given large amounts of albumin.[1]

## Al toxicity manifestations

Reports of Al toxicity from PNS have been cited in the medical literature for several decades.[2,12] Unfortunately, the published literature is primarily limited to studies published in the 1980s and 1990s, and the majority of the literature supporting the need to minimise Al exposure in the PNS-dependent patient is more than 30 years old.[13] Recent publications refer back to these classic papers, and the actual prevalence of Al toxicity in the parenteral nutrition-dependent patients still remains to be unknown and difficult to calculate, as published evidence consists mainly of case reports or small studies.[1]

Signs and symptoms of increased tissue Al levels include possibly neurodegenerative disorders such as dialysis encephalopathy, progressive dementia, impaired neurological development,

**Table 1.** Grading quality of evidence

| Study/ date | Purpose | Quality assessment | | | | | Summary of findings | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Design | Quality | Consistency | Directness | Other modifying factors | Sample size | Effect | Quality | Importance |
| *Aluminium in parenteral drug products* | | | | | | | | | | |
| Poole 2011[45] | Determine the least Al-contaminated products to be used when compounding PNS | Observational study | No serious limitations | No important inconsistency | Direct | All products from all manufacturers available in the United States were tested. | Three lots of 16 PNS components | Measured Al concentrations were significantly lower than the labelled concentration. ($P<0.05$)<br>Calcium gluconate, potassium phosphate and sodium phosphate contained the higher Al concentration. | High | Critical |
| Bohrer 2001[28] | To determine the influence of glass packing on the contamination of products by Al | Observational study | No serious limitations | No important inconsistency | Direct | Strong association | 19 amino acid solutions stored in glass type II flask and Al measured at different intervals. | Cysteine (A), cystine (B), aspartic (C) and glutamic acid (D) became contaminated by Al.<br>Measures µg/Al g aa/l) at 15.30 and 60 days:<br>A: 230; 725; 1056.<br>B: 458; 1661; 3026.<br>C: 35; 75; 106.<br>D: 27; 68; 87. | High | Critical |
| Driscoll 2005[19] | To determine the most contaminated components of PNS | Observational study | Limitations[a,b] | No important inconsistency | Direct | None | 16 products | Sodium phosphate, cysteine hydrochloride and Calcium gluconate were the most Al-contaminated componentes | Moderate | Critical |
| Draper 1991[25] | CaGP vs CaGluc and KPho in PNS for Ca and P retention | Clinical trial | Serious limitations[c] | No important inconsistency | Study in piglets | None | 10<br>CaGP ($n=5$)<br>CaGluc & KPho ($n=5$) | Ca and P retention (mean ± s.e.m.)<br>From CaGP to CaGluc and KPho<br>$14.5 \pm 0.2$ vs $2.2 \pm 0.3$ mmol Ca/kg/day ($P<0.01$)<br>$13.3 \pm 0.4$ vs $2.4 \pm 0.1$ mmol P/kg/day ($P<0.01$) | Low | Critical |
| Hanning 1991[26] | Efficacy of CaGP vs CaGluc+KPho on mineral retention | Clinical trial | No serious limitations | No important inconsistency | Direct | Equimolar intakes of Ca and P | 16<br>CaGP ($n=6$)<br>CaGluc+KPho ($n=9$) | Ca and P retention (mean ± s.d.)<br>From CaGluc and KPho to CaGP<br>$1.2 \pm 0.2$ vs $1.0 \pm 0.2$mmol Ca/kg/day<br>$1.1 \pm 0.3$ vs $0.8 \pm 0.3$ mmol P/kg/day | High | Critical |
| Koo 1986[20] | Sources of Al in PNS | Observational study | No serious limitations | No important inconsistency | Direct | Great variety of manufacturers and samples. Samples measured | 123 samples from 16 different PN components | Calcium gluconate, sodium phosphate and potassium phosphate, by this order, were the most heavily contaminated | High | Critical |
| *Aluminium toxicity manifestations* | | | | | | | | | | |
| Fewtrell 2009[24] | To test the hypothesis that neonatal Al exposure also adversely affects long-term bone health | Clinical trial | No serious limitations | No important inconsistency | Direct | The median exposure of 55µg/kg/day of Al as a significant threshold is well above the mean Al exposure from s.d. PNS and the FDA recommendations | 59 patients<br>(mean Al exposure)<br>S: standard-Al PNS [21.3µg/kg/day)($n=26$)<br>AD: Al-depleted PNS (3 µg/kg/day) ($n=33$) | The total Al exposure from PNS as a continuous variable failed to be a significant predictor of adjusted BMC at any site.<br>Patients on intakes over 55µg/kg/day had lower hip BMC by 7.6% (95% CI: 0.12 -13,8) than intakes under that threshold $P=0.02$ | Moderate | Critical |
| Bishop 1997[21] | To investigate the effect of perinatal exposure to intravenous Al on the neurologic development of infants born prematurely | Clinical trial | No serious limitations | No important inconsistency | Direct | Very strong association | 182 premature infants<br>(mean Al exposure of 180 ml/kg/day of PNS)<br>S: standard-Al PNS [45 µg/kg/day)($n=26$)<br>AD: Al-depleted PNS (4-5 µg/kg/day) ($n=$ ) | For patients on S with no neuromotor impairment, increasing Al exposure was associated with a reduction in the mental development index ($P=0.03$) with an adjusted loss of one point per day of intravenous feeding. | High | Critical |

**Table 1.** (Continued)

| *Study/ date* | *Purpose* | *Quality assessment* | | | | | *Summary of findings* | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | *Design* | *Quality* | *Consistency* | *Directness* | *Other modifying factors* | *Sample size* | *Effect* | *Quality* | *Importance* |
| *Estimating aluminium loading* | | | | | | | | | | |
| Migaki 2012([17]) | Calculated vs measured Al concentrations in PNS containing CaCl + NaPhos vs CaGluc & KPho | Observational study | Limitations[a] | No important inconsistency | Direct | Strong association in B and C | 12 PNS samples (4 each)<br>CaCl + NaPhos (A)<br>CaGluc + NaPhos(B)<br>CaGluc + KPhos(C) | Measured vs calculated Al concentration (μg/dl)<br>A: 6 vs 6.3<br>B: 22.9 vs 54.9<br>C: 31.5 vs 73.3 | Moderate | Critical |
| Poole 2010([12]) | To compare calculated vs measured Al contamination in PNS and ascertain wether the actual Al exposure exceeds the FDA recommendations | Observational study | No serious limitations | No important inconsistency | Direct | Very strong association | 40 neonatal PNS | The calculated Al contamination was twice as much as the actual measured Al content<br>Calculated 5–10 times the FDA limit<br>Measured: 3–5 times the FDA limit | High | Critical |
| Poole 2008([2]) | To determine patient's daily Al load delivered from PNS | Observational study | Limitations[b] | No important inconsistency | Direct | Products used with the lowest content available | 13 384 PNS | Calculated average Al exposure is 23.14 μg/kg/day.<br>Meeting the FDA recommendations only possible on patients weighing > 50 kg. | Moderate | Critical |
| Brown 2008([8]) | To determine the potential for Al toxicity caused by PNS in acute kidney injury adults | Observational study | Limitations[b] | No important inconsistency | Direct: adults with acute renal injury (sCr ≥ 1.5 times that of admission) | None | 36 PNS | 29/36 had safe calculated aluminium exposure (< 5 μg/kg/day) | Moderate | Critical |
| Driscoll 2005([19]) | Calculating Al content in PNS | Observational study | Limitations[a, b] | No important inconsistency | Direct | None | 5 typical adult PNS of 40–80 kg | 40 kg: 14.3 μg/kg/d<br>50 kg: 11.6 μg/kg/day<br>60 kg: 9.8 μg/kg/day<br>70 kg: 8.4 μg/kg/day<br>80 kg: μg/kg/day. | Moderate | Critical |
| Advenier 2003([16]) | To determine the Al contamination of children on long-term PNS | Observational study | No serious limitations | No important inconsistency | Direct | None | 10 children | Mean Al daily intake<br>2.16 ± 0.81 μg/kg/day | Moderate | Critical |
| *Deferoxamine therapy* | | | | | | | | | | |
| Kan 2010([34]) | Efficacy of standard vs low dose of DFO in haemodialysis and serum Al 20 μg/l participants. | Clinical trial | No serious limitations | No important inconsistency | Direct | None | 42<br>Low-dose group: 2.5 mg/kg/week ($n = 21$)<br>Standard dose: 5 mg/kg/week ($n = 21$) | Successful treatment response (sAl rise < 50 μg/l after DFO test)<br>Low dose: 62%vs standard dose 57% ($P = 0.75$) | High | Critical |

Abbreviations: AD, Alzheimer's disease; Al, aluminium; BMC, bone mineral content; CaGP, calcium glycerophosphate; CaGluc, calcium gluconate; CI, confidence intervals; DFO, deferoxamine; FDA, Food and Drug Administration; KPho, potassium phosphate; PNS, parenteral nutrition solution; sCr: serum creatinine. **Quality:High** = Further research is very unlikely to change our confidence in the estimate of effect. **Moderate** = Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate. **Low** = Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate. [a]Only one manufacturer tested. [b]Calculation of Al concentration through the quantity expressed on the label tends to overestimate the intoxication. [c]CaGP was in a concentration that provided 3.6 and 7.1 as much calcium and phosphorus, respectively, to the PNS than CaGP and Kphos, as its solubility its better solubility allow higher concentrations. [d]The Al intake from PNS was not measured through the actual PNS but its components.

**Table 2.** Aluminium measured in different parenteral nutrition products according to recent published studies

| *Aluminium μg/l* | *Migaki et al JPEN 2012 (ref.[16])* | *Poole et al. JPPT 2011 (ref.[45])* | *Fewtrell et al. PNS 2011 (ref.[15])* | *Poole et al. JPGN 2010 (ref.[12])* | *Oliveira et al. JPEN 2010 (ref.[46])* | *Brown et al. 2008 (ref.[8])* |
|---|---|---|---|---|---|---|
| Sterile water | 25[a] | <5[b], 5[c], 6.6[a], <5[d], <5[e] | — | <5[e] | 3.8[f] | <1[e] |
| Amino acids solutions | 25[d] | 7[d] | 30[g] | <5[d] | 90.1[g], 124[e] | 3.1[e], 5.9[e] |
| Dextrose | 25[a] | 20[d], 14[a] | | 7[a] | 19.2[h], 17.3[e], 13.5[e], 4.6[g], 17.2[g], 23[f], 20.5[i] | 12.5[e] |
| Lipid emulsions | | 11[g] | 2[g] | 15[g] | 19.7[g], 112.6[g] | 1.3[g] |
| Sodium glicerophosphate | | | | | 263.7[g] | |
| Calcium gluconate | 9400[b] | 2487[b], 2812[c] | 776[j] | 3234[c] | 9205[k], 19400[k] | 278[b] |
| Potassium phosphate | 37000[a] | | 56[j] | 8280[c] | | 223[b] |
| Sodium phosphate | 180[a] | | | 622[b] | | |
| Potassium acetate | | | | 42[a] | | |
| Sodium acetate | 200[a] | | | 83[a] | | |
| Calcium chloride | 1000[a] | | 10[j] | | | |
| Potassium chloride | 100[a] | | | <5[a] | 62[l] | |
| Sodium chloride | | | | <5[a] | 2.9[f], 1.6[l], 62.5[i] | 57[a] |
| Zinc chloride | | | | 41[a] | | |
| Magnesium sulphate | 300[c] | 165[b], 109[c], 122[a] | | 14[a] | 63.1[l], 87.3[f] | |
| Selenium | 2500[b] | | | 87[b] | | |
| Trace elements | | | | | | |
| Paediatric trace elements | | | | 414[b] | | |
| Multi-trace elements | | | | | 1049[m], 2065[m], 1663[m] | 15[b] |
| Vitamins preparations | 6250[b], 30[e] | | 6[g], <2[g], 24[n] | 14[e] | 549[o], 112.1[p], 1509[p] | |
| Cysteina | | | | | | |
| Chromium | | | | | | 25[a] |
| Copper | | | | | | 10[a] |

Abbreviation: JPEN, Journal of Parenteral and Enteral Nutrition; JPGN, Journal of Pediatric Gastroenterology and Nutrition; JPPT, The Journal of Pediatric Pharmacology and Therapeutics; PNS, Proceedings of the Nutrition Society. **Manufacturer:** [a]Hospira. [b]American Regent. [c]APP pharmaceuticals. [d]B. Braun Medical. [e]Baxter. [f]Halex Istar. [g]Fresenius Kabi. [h]Aster. [i]Isofarma. [j]Not specified [k]Hypofarma. [l]Equipex. [m]Darrow. [n]In-house preparation. [o]Cristália. [p]Farmalab.

**Table 3.** Relevant products currently marketed for parenteral nutrition solutions preparations in Europe

| *Brand name* | *Manufacturer* |
|---|---|
| *Amino acid solutions* | |
| Aminofusin | Baxter |
| Aminopaed | Fresenius Kabi |
| Aminoplasmal | B. Braun |
| Aminosteril | Fresenius Kabi |
| Aminoven | Fresenius Kabi |
| Glamin | Fresenius Kabi |
| Nephrotect | Fresenius Kabi |
| Primene | Fresenius Kabi |
| Tauramin | Grifols |
| Throphamine | b. Braun |
| Travasol | Baxter |
| Synthamin | Baxter |
| Vamin | Fresenius Kabi |
| Vaminolact | Fresenius Kabi |
| *Lipid emulsions* | |
| ClinOleic | Baxter |
| Intralipid | Fresenius Kabi |
| Ivelip | Baxter |
| Lipofundin | B. Braun |
| Lipoplus | B. Braun |
| Lipovenos | Fresenius Kabi |
| Omegaven | Fresenius Kabi |
| Smoflipid | Fresenius Kabi |
| Soyacal | Grifols |
| Structolipid | Fresenius Kabi |
| *Vitamins preparations* | |
| Cernevit | Baxter |
| Soluvit | Fresenius Kabi |
| Vitalipid | Fresenius Kabi |
| *Trace elements* | |
| Addamel | Fresenius Kabi |
| Decan | Baxter |
| Peditrace | Fresenius Kabi |

**Table 4.** Patient population at risk of Al accumulation

| *Patient population at risk* | *Causes* |
|---|---|
| Renal compromise | Kidneys are the major route of Al elimination |
| Foetus | During pregnancy Al is transferred transplacentally |
| Premature infants | Al toxicity negatively correlated with gestational age: immature renal function, increased calcium and phosphorus requirements |
| Elderly patients | Weakened GI protective barrier<br>Normal renal function deterioration |
| Burn patients | Al-contaminated albumin to maintain oncotic pressure |

Abbreviations: Al, aluminium, GI, gastrointestinal.

Alzheimer's disease (AD) and Parkinson's disease, as well as metabolic bone disease including impaired bone growth, bone pain, proximal muscle weakness, multiple nonhealing fractures, premature osteoporosis, osteopenia and osteomalacia. Microcytic anaemia and cholestasis have been described as well.[1,2,4,6,11,12,30] (Table 1).

### Impaired neurological development

A key study by Bishop *et al.*[31] that contributed to the FDA rule governing Al contamination compared neurological development in premature infants who received a standard PNS formula (median: 45 μg/kg/day of Al) or an Al-depleted formula (median: 4–5 μg/kg/day of Al) for a period of 5–16 days. The authors estimated that for infants receiving the standard PNS, the expected reduction in the Bayley Mental Development Index score would be 1 point per day of intravenous feeding.[12]

### Alzheimer disease

Al has a direct and active access to the brain, where it accumulates in a region-specific manner that highly implicates its involvement

DOCKET ALARM

# Explore Litigation Insights

Docket Alarm provides insights to develop a more informed litigation strategy and the peace of mind of knowing you're on top of things.

## Real-Time Litigation Alerts

Keep your litigation team up-to-date with **real-time alerts** and advanced team management tools built for the enterprise, all while greatly reducing PACER spend.

Our comprehensive service means we can handle Federal, State, and Administrative courts across the country.

## Advanced Docket Research

With over 230 million records, Docket Alarm's cloud-native docket research platform finds what other services can't. Coverage includes Federal, State, plus PTAB, TTAB, ITC and NLRB decisions, all in one place.

Identify arguments that have been successful in the past with full text, pinpoint searching. Link to case law cited within any court document via Fastcase.

## Analytics At Your Fingertips

Learn what happened the last time a particular judge, opposing counsel or company faced cases similar to yours.

Advanced out-of-the-box PTAB and TTAB analytics are always at your fingertips.

## API

Docket Alarm offers a powerful API (application programming interface) to developers that want to integrate case filings into their apps.

**LAW FIRMS**
Build custom dashboards for your attorneys and clients with live data direct from the court.

Automate many repetitive legal tasks like conflict checks, document management, and marketing.

**FINANCIAL INSTITUTIONS**
Litigation and bankruptcy checks for companies and debtors.

**E-DISCOVERY AND LEGAL VENDORS**
Sync your system to PACER to automate legal marketing.