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January 22, 2009

M. Sue Kirkman, MD, Vice President, Clinical Affairs
The American Diabetes Association
1701 North Beauregard Street
Alexandria, VA 22311

RE: Formal Notice of Failure to Warn and Responsibility to Amend Incorrect Public Statements

Dear Dr. Kirkman:

My name is Daniel Stockin. I am a career public health professional with a strong background in hazardous materials management and toxics assessment. I am not an attorney, but speak regularly with a growing number of attorney firms concerning legal actions related to harm from drinking fluoridated water. After having been forwarded a copy of a letter sent out by you recently on the subject of water fluoridation, and in light of the attorney conversations I am having, it is clear that you and the American Diabetes Association (ADA) will benefit from reading the specific information provided in this letter. This letter will serve as a formal benchmark notification to you, the ADA, and the rest of ADA's leadership personally of two issues: your and ADA's failure to warn ADA constituents of potential harm to diabetics from fluoridated water, and your and ADA's responsibility to publicly retract incorrect statements made concerning fluoridated water.

This notification and your response to it will be provided to attorneys compiling and examining lists of parties bearing potential liability related to harm from fluorides.

Fluorides are the next "asbestos." In fact, discussions with attorneys and my experience in the asbestos and lead fields indicate to me that fluoride harm represents even larger legal and financial liability than asbestos or lead. Given the sheer number and scope of legal avenues being examined -- including class actions; medical malpractice cases; individual tort actions for professional negligence, negligent misrepresentation, and failure to warn; actions against dentists and a variety of other health care providers; lawsuits against water districts; actions against professional associations and non-profit groups (such as ADA); lawsuits against retailers; and civil rights cases due to harm to minorities -- all of these lead me to hope that some of the legal cases can be avoided and the harm to individuals more quickly stopped if groups such as ADA act quickly. But if organizations do not act in accordance with their publicly disseminated, self-ascribed mission statements and in accord with scientific principles and common sense to help stop harm from fluorides *after the organizations have been documented to have been provided actionable information*, they will have little defense to the upcoming tsunami of public outrage and ensuing lawsuits.

The following are some of the developments requiring your and ADA's immediate action:

1. The National Research Council's 2006 report on fluorides stated that diabetics, kidney patients, and seniors are "susceptible subpopulations" that are particularly vulnerable to harm from ingested fluorides. (See attachments 1a-1d for excerpts from the report concerning susceptible groups.) There has been much "spin" placed on certain statements in the NRC's report by fluoridation proponents wishing to do "damage control" because of the alarming information in the report about fluorides. These statements can be misleading to persons that do not actually read the entire 500+ page report nor understand that the report documented disturbing information about fluorides that is *not* tied only to high naturally occurring fluoride levels in water. ADA should note that the NRC report designated diabetics as a susceptible population group *without respect*

to the concentration of fluoride in the water consumed by diabetics. This means that both diabetics drinking typically-fluoridated water with a 1-part-per-million (ppm) concentration of fluoride and those drinking water with higher fluoride levels are included in the susceptible population designation. See item 3 below for information on overlapping exposures.

2. For American adults, fluorides in drinking water are the largest source of chronic fluoride exposures, and for adults with diabetes mellitus specifically, drinking water at a 1-ppm concentration provides 83% of chronic fluoride exposure. (See attachment 2 - table from the NRC report.) Given that one of the symptoms of diabetes is increased thirst, and that many diabetics have *intersecting risks* for harm from fluorides (risk categories per the NRC, such as being a diabetic, or both a diabetic and a senior, or a diabetic with kidney disease who is a senior), diabetics should be warned that they are a susceptible group and that ingesting fluoridated water, as the largest source of fluoride exposure, may cause or contribute to harm. A search of publicly disseminated educational and journal information from the American Diabetes Association uncovers no fluoride warnings to ADA's constituents or the American public in general. No obvious links or information are visible on the ADA internet web site, and a search on the ADA website under the terms "fluoridated water," "fluoridation," and "fluorides" yields no returned documents. Searching under "fluoride" returns only brief mentions of the term and discussion forum comments.

3. In a letter you sent in December 2008 to a citizen concerned about the issue of fluoridation (attachment 3), you made a number of incorrect statements. I will not address all of the issues in your letter at this time, but I will point out here that you misled the letter's recipient by confusing fluoride concentration in water versus fluoride dose ingested. The "amount of fluoride" you referred to that is "90 - 95% lower" than naturally occurring high fluoride water is related to *concentration* of fluoride in water. This is only one component of an individual's ingested *dose* and is only one aspect of how the fluoride may impact that person's body. If a diabetic consumes 5 liters of 1-ppm fluoridated water daily, he or she consumes 5 mg of fluoride, which is a higher *dose* than someone who drinks one liter of 4-ppm so-called "high naturally occurring fluoride" water or two liters of 2-ppm water. Also, body weight and length of time consuming water are factors affecting *dose*. An individual who weighs 150 pounds who drinks the same amount of 1-ppm water as a 250-pound person is dosed with a higher amount per pound of body weight, and if she or he is a senior, there is more risk due to longer time for retained fluoride to accumulate in the bones and joints.

This issue of ingested dose (again, not simply concentration in water) has caused the U.S. Dept of Agriculture to create a fluoride-in-foods-and-beverages database and software to begin to measure the acknowledged unknown amount of fluorides Americans are ingesting from numerous sources. (See attachment 4 from the U.S.D.A.) This and the other information I am sharing with you is state of the art knowledge and the ADA has a responsibility to its constituents to warn them and to publicly disagree with the harmful practice of fluoridation.

4. By your own admission in your letter, you state that ADA will modify its non-position on fluoridation if clear evidence emerges "that relates to people with diabetes." *Given that the National Academies of Science's National Research Council says that 83% of fluoride ingestion for diabetic adults is from fluoridated water and that the NRC calls diabetics a susceptible group that is particularly vulnerable to harm from fluorides, you can be assured that juries will believe that you and ADA have actionable clear evidence about fluoridated water that "relates" to people with diabetes.* You also stated that you are monitoring research in this area, and have thereby acknowledged that you have or should have examined the information about risk from fluorides from the USDA, the National Research Council, the National Kidney Foundation, and other research groups and publications. Yet you have elected a) not to share this information with the public, and b) not to modify your position on fluoridation. This situation is all the more disturbing given that the widely disseminated mission statement of ADA says that the organization seeks to "improve the lives of all people affected by diabetes." Shared knowledge is the power for "life improvement," and our experience is that diabetics are understandably upset to learn that ADA has not shared current knowledge about potential harm from fluorides and fluoridated water.

5. ADA states in numerous publications that individuals with diabetes should drink “lots” of water, but fails to share that the water should be unfluoridated. “Lots” of fluoridated water equates to “lots” of fluoride. Fluorides are a cumulative poison known to collect in the bones, joints, and the pineal gland (per the NRC report and other sources). For patients with kidney impairment, increased amounts of fluorides are retained due to reduced ability to excrete them.

6. ADA’s whistleblower program is based on the fact that ADA has both an ethical and a fiduciary responsibility to its donors. After having received this letter, if ADA fails to clearly and openly warn diabetics to avoid fluoridated water and beverages containing fluoridated water, ADA will have violated its responsibility to appropriately steward the funds it receives and will have unethically kept silent about what is clearly a source of potential harm to individuals who have excessive thirst due to diabetes. You will have to defend spending a significant amount of your donated funds on legal costs *when you had the opportunity to avoid doing so*. You will also have to defend the absurd idea that susceptible persons (diabetics) can over a lifetime ingest unmonitored, uncontrolled amounts of fluorides that accumulate in the body, even when those persons may also have other confounding conditions such as low iodine consumption or other nutritional deficiencies, kidney impairment, or occupational exposures to substances that potentiate harm from fluorides. ADA must openly speak out against water fluoridation on behalf of its constituents.

7. There are also a number of other developments you should know. For instance, are you aware that eleven unions of EPA employees, representing 7,000 lab workers, scientists and other EPA employees nationally have *contravened official EPA policy and called for the immediate halt to all fluoridation programs in the country, based on increased risk for osteosarcoma bone cancer?* Also, the Centers for Disease Control has refused to answer specific questions in a formal ethics complaint over CDC’s actions in support of fluoridation. See (<http://www.fluoridealert.org/cdc.ethics.complaint.aug.13.2007.pdf>.) These questions include why CDC has refused to openly show photos of moderate and severe dental fluorosis to black Americans, when blacks are acknowledged by CDC’s own data to be disproportionately harmed by these conditions. (See www.fluoridealert.org/dental-fluorosis.htm and scroll all the way down to see sample photos of moderate and severe dental fluorosis.) As blacks are also disproportionately harmed by kidney disease and kidney patients are known to be susceptible to harm from fluorides, you can look for civil rights cases about harm from fluorides. I have spoken a number of times about fluoridation as a guest on national talk radio programs with large audiences of black Americans and with black radio hosts, and I can tell you from the response to the interviews that the issue of harm to black Americans is going to dramatically mushroom.

I’m sure you’re aware that the National Kidney Foundation has changed its stance on fluorides, now saying that chronic kidney disease patients “should be notified of the potential risk of fluoride exposure.” NKF strangely believed it could change its position on fluorides and quietly put up information on its website without a link or any press release about the subject. This approach will not hold up for much longer. See attachment 5 for a copy of a letter from a former diplomat to the National Kidney Foundation. For learning purposes from a legal and health risk management standpoint, I believe you will find it worthwhile to learn the lessons from reading the letter all the way through.

You and I have been told that fluoridation is one of the most thoroughly researched and documented-to-be-safe public health endeavors. Well, like many other things we were told are “safe,” now it turns out not to be so. CDC says that more than 60 years of research shows fluoride’s safety. But take a look at excerpts of the fluoride research recommendations from the 2006 National Research Council report (see attachment 6). How could CDC claim fluoridation is safe when such fundamental, basic research as that described in the list has never been accomplished? Here is how: fluoride has been the proverbial “sacred cow.” It’s been presumed innocent since its inception, a subject not to be questioned or studied. But now the cat is out of the bag, and the chairman of the National Research Council’s committee on fluorides had this to say in the January 2008 Scientific American: “In the scientific community, people tend to think this is settled. I mean, when the U.S. Surgeon General comes out and says this is one of the 10 greatest achievements of the 20th century, that’s a

hard hurdle to get over. But when we looked at the studies that have been done, we found that many of these questions are unsettled and we have much less information than we should, considering how long this (fluoridation) has been going on.”

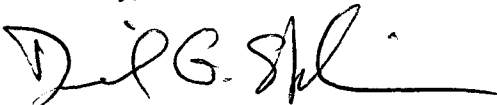
I can tell you that health providers, government health program managers, professional trade associations, and others are afraid of this issue. They are afraid of public embarrassment and afraid of lawsuits. Frankly, they should be, especially those groups that are documented to have been given the latest information but chose to stay quiet and hope the issue would just go away. Now that attorney firms are beginning to grasp the sheer magnitude of the harm that is being done by fluorides, and journalists are getting wind of the developments, the legal nightmare is beginning. In the past, legal arguments against fluorides have not benefited from the specific information now admitted by credible government agencies, but now there is ample data and there are expert witnesses available to support a host of legal avenues.

Thus far in the conversations I’ve had with attorney firms, ADA has not been targeted to be named as a potentially liable party. There is a window of opportunity for ADA to act. But with this letter, that window will in the not-distant future close. I’ve taken the time to compose and send you this letter because I am hopeful that ADA will quickly grasp and honestly respond to the severe threat that fluorides pose for diabetics. CDC and other vested-in-fluoride groups will not pay your legal costs nor respond to angry diabetics who will want to know why you did not call for an end to fluoridation. I hope you will choose to help the people you say in your logo that you are “committed” to: diabetics who simply want to be healthy and who do not care that it may not be politically easy for you to contradict the opinion of the CDC. CDC employees have the luxury to ask you to “take their word for it,” but ADA does not benefit from governmental immunity. The undeniable fact is this: Fluoride harm is about total dose ingested, not concentration in water. Diabetics are likely to drink large amounts of water due to increased thirst, and with fluoridation, no one can control the dose ingested.

I suggest ADA release the following brief, easily defensible statement: “The American Diabetes Association is aware of the historical reasons for the use of fluoridated water to help prevent cavities. However because persons with diabetes often experience increased thirst and may ingest and retain significant quantities of fluorides from fluoridated water and foods made with it, and because it is not possible to control the dose ingested nor guarantee that the fluorides may not be consumed in excessive or harmful quantities, acting on behalf of its constituents ADA issues this statement that it calls for an end to the practice of water fluoridation.”

I will also make this offer: if you would like me to come speak to a group of ADA administrators, I am open to that possibility if you would like to call me to discuss it.

Sincerely,



Daniel G. Stockin, MPH
Senior Operations Officer

CC: Larry Hausner, CEO; George J. Huntley, CPA, Board Chair; attorney firms; diabetes patients

NOTE: Please disseminate a copy of this letter to all ADA senior executives, legal counsel, and board members

information (if any) given on the labels or provided by the manufacturer. Private water sources (e.g., wells and cisterns) probably are even more variable in fluoride content, with some regions of the country being especially high and others very low. A number of authors have pointed out the difficulty doctors and dentists face in ascertaining individual fluoride intakes, just from drinking water (from all sources), for the purpose of prescribing appropriate fluoride supplementation (Nowak and Nowak 1989; Chan et al. 1990; Stannard et al. 1990; Levy and Shavlick 1991; Weinberger 1991; Dillenberg et al. 1992; Jones and Berg 1992; Levy and Muchow 1992; Toumba et al. 1994; Duperon et al. 1995; Van Winkle et al. 1995; Heller et al. 1999; Bartels et al. 2000; Lalumandier and Ayers 2000; Johnson and DeBiase 2003; Zohouri et al. 2003).

High Intake Population Subgroups

EPA, in its report to Congress on sensitive subpopulations (EPA 2000b), defines sensitive subpopulations in terms of either their response (more severe response or a response to a lower dose) or their exposure (greater exposure than the general population). Hence, it is appropriate to consider those population subgroups whose water intake is likely to be substantially above the national average for the corresponding sex and age group. These subgroups include people with high activity levels (e.g., athletes, workers with physically demanding duties, military personnel); people living in very hot or dry climates, especially outdoor workers; pregnant or lactating women; and people with health conditions that affect water intake. Such health conditions include diabetes mellitus, especially if untreated or poorly controlled; disorders of water and sodium metabolism, such as diabetes insipidus; renal problems resulting in reduced clearance of fluoride; and short-term conditions requiring rapid rehydration, such as gastrointestinal upsets or food poisoning (EPA 2000a). (While the population sample described in Appendix B [Water Ingestion and Fluoride Intakes] included some of these individuals, the study did not attempt to estimate means or distributions of intake for these specific subgroups.)

As shown in Appendix B (Tables B-4 to B-9), some members of the U.S. population could have intakes from community water sources of as much as 4.5-5 L/day (as high as 80 mL/kg/day for adults). Some infants have intakes of community water exceeding 200 mL/kg/day. Heller et al. (1999), using the same data set as EPA (2000a), reported that 21 of 14,640 people (of all ages) had water intakes over 6 standard deviations from the mean (greater than 249 mL/kg/day). Whyte et al. (2005) describe an adult woman who consistently consumed 1-2 gallons (3.8-7.6 L) of fluid per day (instant tea made with well water); no specific reason for her high fluid consumption is given.

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beyond a cosmetic effect to create an adverse psychological effect or an adverse effect on social functioning is not known.

While a few cases of severe enamel fluorosis occasionally have been reported in populations exposed at 2 mg/L, it appears that other sources of exposure to fluoride or other factors contributed to the condition. For example, similar rates of severe enamel fluorosis were reported in populations exposed to negligible amounts of fluoride in drinking water and in populations exposed at 2 mg/L (Selwitz et al. 1995; Kumar and Swango 1999; Nowjack-Raymer et al. 1995). Thus, the committee concludes that the SMCL of 2 mg/L adequately protects the public from the most severe stage of the condition (enamel pitting).

Skeletal Fluorosis

Few new data are available on skeletal fluorosis in populations exposed to fluoride in drinking water at 2 mg/L. Thus, the committee's evaluation was based on new estimates of the accumulation of fluoride into bone (iliac crest/pelvis) at that concentration (on average 4,000 to 5,000 mg/kg ash) and historical information on stage II skeletal fluorosis (4,300 to 9,200 mg/kg ash). A comparison of the bone concentrations indicates that lifetime exposure at the SMCL could lead to bone fluoride concentrations that historically have been associated with stage II skeletal fluorosis. However, as noted above, the existing epidemiologic evidence is insufficient for determining whether stage II skeletal fluorosis is occurring in U.S. residents, so no quantitative conclusions could be made about risks or safety at 2-mg/L exposures.

Bone Fracture

There were few studies to assess bone fracture risk in populations exposed to fluoride at 2 mg/L in drinking water. The best available study was from Finland, which provided data that suggested an increased rate of hip fracture in populations exposed to fluoride at >1.5 mg/L (Kurtio et al. 1999). However, this study alone is not sufficient to base judgment of fracture risk for people exposed to fluoride at 2 mg/L in drinking water. Thus, no quantitative conclusions could be drawn about fracture risk or safety at the SMCL.

Susceptible Subpopulations

Populations in need of special consideration when determining the MCLG and SMCL for fluoride include those at risk because their exposure to fluoride is greater than that of the average person or because they are

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particularly vulnerable to the effects of fluoride. The first category includes people who consume much larger volumes of water than assumed by EPA, such as athletes and outdoor workers, who consume large volumes of water to replace fluids lost because of strenuous activity, and people with medical conditions that cause them to consume excessive amounts of water (e.g., diabetes insipidus). Individuals who consume well over 2 L of water per day will accumulate more fluoride and reach critical bone concentrations before the average water drinker exposed to the same concentration of fluoride in drinking water. In Chapter 2, it was estimated that for high-water-intake individuals, drinking water would contribute 92% to 98% of the exposure to fluoride at 4 mg/L and 86% to 96% at 2 mg/L. Another consideration is individuals who are exposed to other significant sources of fluoride, such as occupational, industrial, and therapeutic sources.

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There are also environmental, metabolic, and disease conditions that cause more fluoride to be retained in the body. For example, fluoride retention might be affected by environments or conditions that chronically affect urinary pH, including diet, drugs, altitude, and certain diseases (e.g., chronic obstructive pulmonary disease) (reviewed by Whitford 1996). It is also affected by renal function, because renal excretion is the primary route of fluoride elimination. Age and health status can affect renal excretion. Individuals with renal disease are of particular concern because their ability to excrete fluoride can be seriously inhibited, causing greater uptake of fluoride into their bones. However, the available data are insufficient to provide quantitative estimates of the differences between healthy individuals and people with renal disease.

Another category of individuals in need of special consideration includes those who are particularly susceptible or vulnerable to the effects of fluoride. For example, children are vulnerable for developing enamel fluorosis, because the condition occurs only when there is exposure while teeth are being formed (the pre-eruption stages). Thus, children up to the age of 8 are the susceptible subpopulation of concern for that end point. The elderly are another population of concern because of their long-term accumulation of fluoride into their bones. There are also medical conditions that can make people more susceptible to the effects of fluoride.

Relative Source Contribution

At the time the MCLG was established for fluoride, a reference dose was not available and the MCLG was calculated directly from available data rather than as an apportioned part of the reference dose. In Chapter 2, the committee shows that at 4 mg/L, drinking water is the primary contributor to total fluoride exposure, ranging from 72% to 94% for average-water-intake individuals and from 92% to 98% for high-water-intake individuals.

TABLE 2-4 Examples of Fluoride Intake from Drinking Water by Members of Selected Population Subgroups Living in Fluoridated Areas^a

Population Subgroup (Weight)	Typical Consumers ^b			High Consumers ^c		
	Water Consumption mL/day	Fluoride Intake ^d mg/day	Fluoride Intake ^d mg/kg/day	Water Consumption mL/day	Fluoride Intake ^d mg/day	Fluoride Intake ^d mg/kg/day
Athletes, workers, military (50 kg)	2,500	1.8-3.0	0.035-0.06	3,500	2.5-4.2	0.049-0.084
Athletes, workers, military (70 kg)	3,500	2.5-4.2	0.035-0.06	4,900	3.4-5.9	0.049-0.084
Athletes, workers, military (100 kg)	5,000	3.5-6.0	0.035-0.06	7,000	4.9-8.4	0.049-0.084
Athletes and workers (120 kg)	6,000	4.2-7.2	0.035-0.06	8,400	5.9-10	0.049-0.084
DM patients (20 kg)	1,000	0.7-1.2	0.035-0.06	2,000	1.4-2.4	0.07-0.12
DM patients (70 kg)	3,500	2.5-4.2	0.035-0.06	4,900	3.4-5.9	0.049-0.084
NDI patients (20 kg)	1,000	0.7-1.2	0.035-0.06	3,000	2.1-3.6	0.11-0.18
NDI patients (70 kg)	3,500	2.5-4.2	0.035-0.06	10,500	7.4-13	0.11-0.18

^aAssumes all drinking water is from fluoridated community (municipal) sources.

^bBased on a typical consumption rate for the population subgroup.

^cBased on a reasonably high (but not upper bound) consumption rate for the population subgroup; some individual exposures could be higher.

^dBased on fluoride concentrations of 0.7-1.2 mg/L.

ABBREVIATIONS: DM, diabetes mellitus; NDI, nephrogenic diabetes insipidus.

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TABLE 2-13 Contributions to Total Fluoride Chronic Exposure at 1 mg/L in Drinking Water

Population Subgroups	Total Exposure, mg/kg/day	% Contribution to Total Exposure			
		Pesticides and Air	Background Food	Tooth-paste	Drinking Water
<i>Modeled average water consumer</i> (Tap water at 1 mg/L, nontap water at 0.5 mg/L; Table 2-11)					
All infants (<1 year)	0.070	4.7	13.6	0	81.7
Nursing	0.030	8.9	15.6	0	70.8
Nonnursing	0.087	4.3	13.2	0	82.5
Children 1-2 years	0.066	9.7	31.7	17.4	41.3
Children 3-5 years	0.060	7.4	30.4	19.1	43.1
Children 6-12 years	0.040	5.4	30.9	18.9	44.8
Youth 13-19 years	0.028	4.9	34.8	12.0	48.3
Adults 20-49 years	0.031	4.0	36.3	4.6	55.1
Adults 50+ years	0.031	4.4	32.4	4.6	58.7
Females 13-49 years ^a	0.031	4.4	34.7	5.3	55.6
<i>EPA default water intake, all water at 1 mg/L</i> (1 L/day for 10-kg child; 2 L/day for 70-kg adult; Table 2-12)					
All infants (<1 year)	0.113	2.9	8.5	0	88.6
Nursing	0.109	2.4	4.3	0	92.0
Nonnursing	0.115	3.2	9.9	0	86.9
Children 1-2 years	0.139	4.6	15.1	8.3	72.0
Adults 20-49 years	0.043	3.0	26.7	3.3	67.0
<i>(High end of high water intake individuals all water at 1 mg/L)</i> (based on intake rates in Table 2-4)					
Athletes and workers	0.084	1.5	13.5	1.7	83.3
DM patients (3-5 years)	0.134	3.3	13.5	8.5	74.7
<u>DM patients (adults)</u>	0.084	1.5	13.5	1.7	<u>83.3</u>
NDI patients (3-5 years)	0.184	2.4	9.9	6.2	81.6
NDI patients (adults)	0.164	0.8	6.9	0.9	91.4

^aWomen of childbearing age.

ABBREVIATIONS: DM, diabetes mellitus; NDI, nephrogenic diabetes insipidus.

Although each of these exposure estimates have areas of uncertainty, the average total daily fluoride exposure is expected to fall between them. For the modeling estimates, there are inherent uncertainties in modeling long-term intake rates based on the cross-sectional CSFII dietary survey data. Thus, the exposure from any dietary component, water or other foods, could be underestimated for individuals who have habitually higher intake rates (e.g., water, tea). Specific to the water component, there are also uncertainties regarding the extent the FCID database may include all processed waters (e.g., soft drinks and soups). On the other hand, the EPA

December 19, 2008

Mary Poole
13 Bimini Lane
Bunnell, FL 32110

Dear Mrs. Poole,

Thank you for writing to the American Diabetes Association with your concerns about fluoride in drinking water. Mr. Larry Hausner referred your letter to me, as I am in charge of the Clinical Practice Recommendations of the ADA.

There are really two situations in which fluoride gets in drinking water. The primary concern of several scientific statements, including that of the National Research Council, is a few areas of the country that naturally have very high levels of fluoride in their drinking water (this is estimated to affect about 200,000 people in the U.S.). The second is fluoridation, when municipalities add fluoride to their drinking water to reduce dental cavities. The amount of fluoride in these fluoridated water supplies is 90-95% lower than what is found in the areas that have the naturally occurring very high levels of fluoride.

Fluoride does not harm the kidneys, but the kidneys help the body get rid of fluoride (and related minerals like sodium and potassium). People with advanced kidney disease are at higher risk for problems from fluoride, which include bone and teeth problems from a rare condition called fluorosis. At the American Diabetes Association, we look to groups such as the National Kidney Foundation and the National Kidney Disease Education Program to best advise people with chronic kidney disease. The National Kidney Foundation's recommendations about fluoride are fairly non-specific and do not include a general recommendation against water fluoridation.

The American Diabetes Association bases its positions and recommendations on careful review of the medical and scientific literature. There is no evidence that water fluoridation is specifically harmful or beneficial for people with diabetes compared to those without diabetes. Because of this, currently we don't take a stand either for or against water fluoridation. We will continue to monitor the research in this area and modify our position if clear evidence emerges that relates to people with diabetes.

I am sorry for your loss of your husband. Again, I appreciate your letter, and can assure you that we will continue to keep an eye on this issue as it relates to people with diabetes.

Sincerely,



M. Sue Kirkman, MD
Vice President, Clinical Affairs

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1701 North Beauregard Street
Alexandria, VA 22311
Tel: 703-549-1500

Diabetes Information
call 1-800-DIABETES (1-800-342-2383)
online www.diabetes.org
The Association gratefully accepts gifts through your will.

The Mission of the American
Diabetes Association is to prevent and
cure diabetes and to improve the lives
of all people affected by diabetes.

Attachment 3



National Fluoride Database and Intake Assessment Study



The Nutrient Data Laboratory (NDL), a part of the Agricultural Research Service, and the University of Minnesota Nutrition Coordinating Center (NCC) are collaborating on the National Fluoride Database and Intake Assessment Study (NFDIAS). The NFDIAS was supported by the National Institute of Dental & Craniofacial Research and the National Heart, Lung, & Blood Institute of the National Institutes of Health. The University of Iowa College of Dentistry cooperated with NDL to conduct fluoride analyses for both the USDA National Fluoride Database and for the NCC Software Demonstration Study. The Virginia Polytechnic Institute Food Analysis Laboratory Control Center worked with NDL to receive, composite and ship food and beverage samples for analysis. Fluoride data from other studies and from the scientific literature have been evaluated and incorporated along with analytical data from the NFDIAS study to create the USDA National Fluoride Database of Selected Beverages and Foods released, October 2004, online at USDA-NDL's Web site. The database provides the fluoride level of 400 separate food and beverage items. It will be incorporated into a computer-based food and beverage intake survey tool now being developed by researchers at the University of Minnesota NCC. That tool will be used to assess the amount of fluoride consumed by individuals from dietary and nondietary sources, including fluoride supplements and toothpastes.

Fluoride is added to many municipal water supplies and, therefore, finds its way into water-based beverages and foods in the United States. Its role in prevention of dental caries is well recognized. Fluoride has an affinity for calcified tissues and attention is being given to fluoride exposure and prevention of bone health, disease, and fracture. Fluoride is among those nutrients for which Dietary Reference Intakes have been established. An Adequate Intake level has been set for fluoride at 3 milligrams (mg) daily for women and 4 mg daily for men. Until now, scant data existed on the quantity of fluoride in the national food supply and, therefore, on overall dietary fluoride intake among individuals. Assessments of fluoride intake are critical to ensure adequacy to prevent dental caries and to prevent excessive fluoride intake resulting in dental and skeletal fluorosis. The fluoride database will, for the first time, enable researchers to estimate consumers' day-to-day fluoride intake. It will also serve as an important data resource for nutrition-related research, planning, and policy nation-wide and when incorporated into NCC's computer-based fluoride intake assessment tool will contribute to assessment studies of fluoride intake in humans including dental and skeletal fluorosis, dental caries, bone health, and osteoporosis.

To access the new database on the Internet, go to: _____ and click on the Special Interest Database "Fluoride" under Food Composition Products.

Read more about the research in the November issue of *Agricultural Research* magazine, on the World Wide Web at:

USDA, Agricultural Research Service
Beltsville Human Nutrition Research Center
Nutrient Data Laboratory
10300 Baltimore Ave.
Bldg 005, Rm 107 BARC-West
Beltsville, MD 20705-2350

For food composition information, access:
www.nal.usda.gov/lnic/foodcomp

Or contact NDL by
telephone: 301-504-0630
fax: 301-504-0632
e-mail: ndlinfo@rbhnrc.usda.gov

March 2005

Attachment 4

November 11, 2008

National Kidney Foundation
30 East 33rd Street
New York, NY 10016

7802 SE 76th Street
Mercer Island, WA 98040
206 / 232-7636

Attention: Dr. Joseph Vassalotti, Chief Medical Officer
The National Kidney Foundation Board of Directors

Dear Dr. Vassalotti and Members of the Board:

I am a senior citizen with compromised renal function. Recently I learned that early in 2008 the NKF quietly changed its stance on fluoridated water for prevention of dental caries, no longer allowing the American Dental Association to use NKF's name to support systemic fluoridation. Because this letter has serious legal ramifications for the NKF, I strongly urge you to discuss it with the Foundation's attorneys for prompt action.

As you well know, the NKF now states that "Individuals with chronic kidney disease should be notified of the potential risk of fluoride exposure." The NKF apparently decided that it would "notify" us by putting information up on NKF's website, but did so without a press release about the new position on fluorides and without any obvious link on its website. One has to enter a search for "fluoridation" or "fluorides" to finally be taken to the information. In short, the data are invisible to the average kidney patient.

One may clearly infer that the NKF realized it hadn't shared with kidney patients the fact that in 2006 the National Research Council had designated us as a "susceptible subpopulation" that is especially vulnerable to harm from ingested fluorides. The NKF certainly knows that it is legally liable to share this with millions of kidney patients and renal health professionals, but obviously did not want to upset the CDC, which supports water fluoridation, partners with the NKF and provides grant money to the NKF.

In your revised position paper, there are glaring examples of apparent attempts to avoid providing the whole story to kidney patients. Saliiently, you say that (compared to sodium and phosphorus intake, etc) "Fluoride intake is a secondary concern;" and then in the next sentence—an obvious non sequitur—say, "Specific recommendations regarding fluoride intake in CKD patients are not possible based on available limited data."

You must realize that it is only a matter of time before a large number of kidney patients find out that, in essence, you are colluding with the CDC to hide the significant damage to their kidneys from fluoridated water and foods that contain it. Similarly, that the full story of your deliberations with the CDC will come out in court cases, as well as the fact that the NKF has left nephrologists, nephrology nurses, water districts, and others in a position of liability in order to not point liability toward the NKF. Even if you believe that you have technically "disclosed" the information; for all practical purposes, millions of mainstream kidney patients haven't heard the news, and your hidden disclosure will be

Attachment 5a.

of small comfort to water districts and physicians who are held accountable for not sharing your statements or incorporating them into their decision-making.

On a personal level, my family and I are furious that you did not share news with us that, by your own admission, we should have heard. We are particularly upset to learn from our research that my negative health condition may well have been caused by the fluoridation of my drinking water. We are further upset to learn that the negative effects of fluoridation can include water that is contaminated with lead, mercury, ARSENIC and radioactive materials!

Beyond possible nervous system effects from lead and unknown effects from ingested radioactive particles, I have another, very real stake in this matter. That is, I have a serious health condition in addition to kidney impairment—metastasized pancreatic cancer. Relatedly, the National Research Council report revealed that there are real concerns over the accumulation of fluorides in the bones. The report also points out the concern that our bones are where immune cells (essential for me fighting cancer) are generated!

I would like a written response from NKF to these two questions: “Can you honestly state that my doctors and I were “notified of the potential risk” from fluorides by your actions?” And, “Will you now publicly and openly oppose water fluoridation for its unknown and uncontrollable-dose risk to kidney patients? “

Yours truly,

[Original signed by]

Lee R. Trousdale

Principal, Strategic Marketing
British Vice-consul Emeritus

Attachment 5b.

NRC's RESEARCH RECOMMENDATIONS:

X "Information is particularly needed on fluoride plasma and bone concentrations in people with small-to-moderate changes in renal function as well as in those with serious renal deficiency." P11

X "The effects of fluoride on various aspects of endocrine function should be examined particularly with respect to a possible role in the development of several diseases or mental states in the United States. Major areas for investigation include the following: thyroid disease (especially in light of decreasing iodine intake by the U.S. population); nutritional (calcium-deficiency) rickets; calcium metabolism (including measurements of both calcitonin and PTH); pineal function (including, but not limited to, melatonin production); and development of glucose intolerance and diabetes." p267

X "More research is needed to clarify fluoride's biochemical effects on the brain." P222

"A systematic study of clinical stage II and stage III skeletal fluorosis should be conducted to clarify the relationship between fluoride ingestion, fluoride concentration in bone, and clinical symptoms. " P12

"The possibility has been raised by the studies conducted in China that fluoride can affect intellectual abilities. Thus, studies of populations exposed to different concentrations of fluoride in drinking water should include measurements of reasoning ability, problem solving, IQ, and short- and long-term memory." P223

"Studies of populations exposed to different concentrations of fluoride should be undertaken to evaluate neurochemical changes that may be associated with dementia. Consideration should be given to assessing effects from chronic exposure, effects that might be delayed or occur late-in-life, and individual susceptibility." P223

"The concentrations of fluoride in human bone as a function of exposure concentration, exposure duration, age, sex, and health status should be studied." P11

"It is paramount that careful biochemical studies be conducted to determine what fluoride concentrations occur in the bone and surrounding interstitial fluids from exposure to fluoride in drinking water at up to 4 mg/L, because bone marrow is the source of the progenitors that produce the immune system cells." P303

"More studies of communities with drinking water containing fluoride at 2 mg/L or more are needed to assess potential bone fracture risk at these higher concentrations." P12

"Carefully conducted studies of exposure to fluoride and emerging health parameters of interest (e.g., endocrine effects and brain function) should be performed in populations in the United States exposed to various concentrations of fluoride." P12

"In addition, studies could be conducted to determine what percentage of immunocompromised subjects have adverse reactions when exposed to fluoride in the range of 1-4 mg/L in drinking water." P303

"Better characterization of exposure to fluoride is needed in epidemiology studies investigating potential effects. Important exposure aspects of such studies would include the following: collecting data on general dietary status and dietary factors that could influence exposure or effects, such as calcium, iodine, and aluminum intakes." P88

"Fluoride should be included in nationwide biomonitoring surveys and nutritional studies; in particular, analysis of fluoride in blood and urine samples taken in these surveys would be valuable." P11

"Additional studies should be carried out to determine the incidence, prevalence, and severity of renal osteodystrophy in patients with renal impairments in areas where there is fluoride at up to 4 mg/L in the drinking water." PP302-303

"To assist in estimating individual fluoride exposure from ingestion, manufacturers and producers should provide information on the fluoride content of commercial foods and beverages." P87

"The possibility of biological effects of SiF_6 , as opposed to free fluoride ion, should be examined." P88

"The biological effects of aluminofluoride complexes should be researched further, including the conditions (exposure conditions and physiological conditions) under which the complexes can be expected to occur and to have biological effects." P88

"Thus, more studies are needed on fluoride concentrations in soft tissues (e.g., brain, thyroid, kidney) following chronic exposure." P102

"More research is needed on bone concentrations of fluoride in people with altered renal function, as well as other potentially sensitive populations (e.g., the elderly, post-menopausal women, people with altered acid-balance), to better understand the risks of musculoskeletal effects in these populations." P180

"the relationship between fertility and fluoride requires additional study." P193

"Further effort is necessary to characterize the direct and indirect mechanisms of fluoride's action on the endocrine system and the factors that determine the response, if any, in a given individual. Such studies would address the following... identification of those factors, endogenous (e.g., age, sex, genetic factors, or preexisting disease) or exogenous (e.g., dietary calcium or iodine concentrations, malnutrition), associated with increased likelihood of effects of fluoride exposures in individuals. P266

"Studies are needed to evaluate gastric responses to fluoride from natural sources at concentrations up to 4 mg/L and from artificial sources." P302

"The effect of low doses of fluoride on kidney and liver enzyme functions in humans needs to be carefully documented in communities exposed to different concentrations of fluoride in drinking water." P303

"Further research on a possible effect of fluoride on bladder cancer risk should be conducted." P338

"in vivo human genotoxicity studies in U.S. populations or other populations with nutritional and sociodemographic variables similar to those in the United States should be conducted." P338-339