

# Genomic damage in children accidentally exposed to ionizing radiation: a review of the literature

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1 **Genomic damage in children accidentally exposed to ionizing radiation: a review of the**  
2 **literature.**

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41 **Abstract**

42 During the last decade, our knowledge of the mechanisms by which children respond to exposures  
43 to physical and chemical agents present in the environment, has significantly increased. Results of  
44 recent projects and programmes focused on children's health underline a specific vulnerability of  
45 children to environmental genotoxicants. Environmental research on children predominantly  
46 investigates the health effects of air pollution while effects from radiation exposure deserve more  
47 attention. The main sources of knowledge on genome damage of children exposed to radiation are  
48 studies performed after the Chernobyl nuclear plant accident in 1986. The present review presents  
49 and discusses data collected from papers analysing genome damage in children environmentally  
50 exposed to ionizing radiation. Overall, the evidence from the studies conducted following the  
51 Chernobyl accident, nuclear tests, environmental radiation pollution and indoor accidental  
52 contamination reveals consistently increased chromosome aberration and micronuclei frequency in  
53 exposed than in referent children.

54 Future research in this area should be focused on studies providing information on: (a) Effects on  
55 children caused by low doses of radiation; (b) effects on children from combined exposure to low  
56 doses of radiation and chemical agents from food, water and air; and (c) specific effects from  
57 exposure during early childhood (radioisotopes from water, radon in homes). Special consideration  
58 should also be given to a possible impact of a radiochemical environment to the development of an  
59 adaptive response for genomic damage. Interactive databases should be developed to provide  
60 integration of cytogenetic data, childhood cancer registry data and information on environmental  
61 contamination. The overall aim is to introduce timely and efficient preventive measures, by means  
62 of a better knowledge of the early and delayed health effects in children resulting from radiation  
63 exposure.

64

65 **Key words:** child, ionizing radiation, environment, chromosome aberration assay, micronucleus  
66 assay, Chernobyl

67 **Introduction**

68 The cancer incidence in children has increased during the last few decades in different parts of the  
69 world [1, 2]. The present occurrence per year is a 1% average annual increase in incidence ( $p <$   
70  $0.0001$ ) has been estimated from the European cancer incidence database, including some 110,000  
71 childhood cancer cases from 63 population based registries [1]. Although this increase may partly  
72 reflect better diagnostics, its aetiology is probably also associated with parental, intrauterine and  
73 postnatal exposure to xenobiotics including low LET ionizing radiation (e.g., X-rays and  $\gamma$ -rays).  
74 [3]

75 Indeed, the occurrence of site specific cancer in children is different than in adults, suggesting that  
76 childhood cancers reflect foetal development and exposure [4,5].

77 Children live in complex radiochemical environments and share all types of exposures with their  
78 parents [Figure 1]. Over the last few decades genotoxicological population studies have mostly  
79 focused on occupational exposures. Exceptions were cases of accidental exposure of the general  
80 population, including children. Recently, genotoxicologists have paid increasing interest in studies  
81 of children addressing the issue of whether they are more susceptible to environmental exposures to  
82 physical and chemical agents than adults [6, 7,8].

83 Based on the available evidence of quantitative health risks associated with radiation exposure,  
84 public dose limits of exposure from mining or nuclear plants are currently set at 1mSv/yr above  
85 background [9], but still there is no specific legislation concerning children, although such exists for  
86 occupational exposure during pregnancy [10].

87 Except for a few studies of children after accidental overexposures, available data on the  
88 consequences of radiation exposure in children are mostly limited to the monitoring of young  
89 victims following April 26, 1986 when the world's worst nuclear power accident occurred at  
90 Chernobyl in the former USSR (now Ukraine). The Chernobyl nuclear disaster affected a vast area  
91 of Europe and may still contribute to genome damage in large areas of Ukraine and Belarus due to  
92 the environmental persistence of some radionuclides [11]. ). Information on genome damage caused

93 by radiation from this and also other nuclear accidents in the former Soviet Union is, however, only  
94 partially available to the scientific community, because scientists of the former USSR still publish  
95 in national rather than international journals.

96 Sixty years ago in Hiroshima and Nagasaki mankind witnessed the first nuclear weapon attack  
97 which for the first time in history had transgenerational consequences. The difference in the type of  
98 exposure in Hiroshima and Nagasaki versus Chernobyl is that while the nuclear bombing resulted in  
99 massive exposure to mixed gamma/neutron radiation, the Chernobyl accident caused an acute  
100 exposure, followed by a long-term internal exposure mostly to low doses of gamma radiation [12].

101 Differences in the type of exposure are reflected in the difference of cancer incidence between these  
102 two nuclear disasters. After the Hiroshima and Nagasaki detonation, ionizing radiation-induced  
103 leukaemia occurred in children 5 to 6 years later, while in adulthood the breast cancer incidence  
104 increased in women who were exposed before puberty [13]. Recent epidemiological reports from  
105 Ukraine and Belarus confirm an increased number of cases of thyroid cancer in children, but not  
106 leukaemia [12]. Thyroid cancer patients aged 15 or younger lived in the most contaminated regions  
107 (the Provinces of Kiev, Chernigov, Zhitomir, Cherkassy, Rovno, and the city of Kiev). The highest  
108 reported incidence was in children who were exposed at the age of five years or younger. [14].

109 However, because of the lack of proper cancer registries in Ukraine and Belarus, and the large  
110 number of people evacuated from the polluted areas that could not be traced through any kind of  
111 demographic records, these findings are considered to be of limited significance [15]. Moreover, in  
112 some regions of Ukraine and Belarus long-term exposure was accompanied by malnutrition,  
113 frequent infections and stress, important confounders that may have had strong impacts on the  
114 reported genome damage [16].

115 A systematic overview of available data of genome damage in children environmentally exposed to  
116 ionizing radiation is missing. Data from scientific papers written in Russian, Byelorussian and  
117 Ukrainian language are not well known in the Western scientific community due to language  
118 barriers. The aim of this study is to present and interpret systematically collected data on genome

119 damage in children exposed to ionizing radiation at the global level (cosmic radiation is excluded).

120

## 121 **Materials and methods**

122 The scientific literature considered here was selected following an extensive literature search  
123 without any language restriction by using the Med-Line/PubMed database (National Library of  
124 Medicine, National Institutes of Health, Bethesda, MD, USA-<http://www.ncbi.nlm.nih.gov/>  
125 PubMed) covering the time period between January 1, 1980 and December 30th, 2006. Searches  
126 comprised studies of children from newborns to late adolescence (age 0–18 years) exposed to  
127 ionizing radiation. We have excluded case reports, studies without a clear definition of exposure to  
128 ionizing radiation, studies with less than 10 children and/or lacking a referent (unexposed)  
129 population, and studies reporting findings in a conversational style without statistical measures  
130 (e.g., mean and standard deviation) or analysis. Studies written in English, Russian, and Ukrainian  
131 were retrieved and manually reviewed. Studies that were not accessible through online library  
132 systems were obtained by the authors or through interlibrary exchange. Twenty East European  
133 studies of children not available in English but with important information have been recognised  
134 and included in this review. Information about these studies can be obtained upon request. Results  
135 from the following assays of genetic toxicology were considered: chromosome aberration assay  
136 (CA), *in vivo* and *in vitro* micronucleus assay (MN), comet assay, sister chromatid exchange (SCE),  
137 and fluorescent *in situ* hybridization (FISH). In order to simplify the presentation and the  
138 interpretation of the reviewed studies the association between radiation exposure and biomarkers of  
139 DNA damage in children was quantitatively investigated by computing study specific ratios (MRs)  
140 of the mean level of each biomarker detected in radiation exposed and in referent children or  
141 newborns. The computed MR is a point estimate of the relative effect of the exposure on biomarker  
142 level detected in each study taking the value 1 (MR=1) when there is no effect of radiation exposure  
143 on biomarkers level, values greater than 1 (MR>1) or lower than 1 (MR<1) when radiation  
144 exposure is associated with an increased or a decreased levels of the investigated biomarkers,



145 respectively. The MR, as a measure of effect, has the advantage of being independent of the  
146 absolute values of the biomarker mean levels reported by the single studies and is comparable  
147 across the studies and endpoints considered. The main characteristics of the studies considered in  
148 this paper including their findings and the computed MRs, are summarized in Tables 1-3.

149

## 150 **Results**

### 151 **Exposure to ionizing radiation from natural sources**

152 Naturally-occurring radionuclides in food and water are primarily potassium ( $^{40}\text{K}$ ) and the decay  
153 products of Uranium ( $^{238}\text{U}$ ), Thorium ( $^{232}\text{Th}$ ), Carbon ( $^{14}\text{C}$ ) and Rubidium ( $^{87}\text{Rb}$ ) [17]. Radium  
154 ( $^{226}\text{Ra}$ , decay product of  $^{238}\text{U}$  in nature) decays into radon ( $^{219}\text{Rn}$ ,  $^{220}\text{Rn}$ , and the most stable radon  
155 isotope  $^{222}\text{Rn}$ , with half life 3.82 days) which is emitted as a gas in significant quantities and can  
156 reach levels in indoor air up to 15,000 Bq/m<sup>3</sup>. The main intake of  $^{222}\text{Rn}$  is via drinking and  
157 breathing. The European regulations and US environmental action levels are 150-200 Bq/m<sup>3</sup> [18,  
158 19, 20,21].

159 A possible association of radon exposure with adverse health effects, including lung cancer  
160 development, has been recognized relatively recently [22, 23]. Critical environments are poorly  
161 ventilated old dwellings built in karsts-rich areas, geographical areas of irregular limestone where  
162 erosion has produced fissures, caverns and underground streams. Children may be exposed to radon  
163 at kindergarten, school and at home. An additional (although less important) source of exposure to  
164 radon could also be building material such as certain types of concrete and granite tiles [24].

165 Rommens et al 2001 [25] reported European ionizing radiation exposure levels of 2.4 mSv/y for  
166 adults, 2.7 mSv/y for children and 5,4 mSv/y for infants 0-1 years old taking into account all natural  
167 sources such as  $^{222}\text{Rn}$  and  $^{220}\text{Rn}$  (decay product of thorium, commonly named thoron), cosmic  
168 radiation, terrestrial radiation, radionuclides, etc. The total body concentration of radionuclides and  
169 equivalent doses to red bone marrow is age dependent and is higher in children, especially in infants  
170 and adolescents for  $^{226}\text{Ra}$ , lead ( $^{210}\text{Pb}$ ),  $^{228}\text{Th}$ , Polonium ( $^{210}\text{Po}$ ), etc [25, 26,27].

171 As radon daughter products follow the metabolic pathway of calcium, its incorporation into  
172 children's skeleton poses a significant health risk [28]. Due to age dependent developmental stage  
173 of the gastrointestinal system of children, the highest absorption of radon is in newborns and in  
174 children between 13 and 17 years of age [27,29]. This is accompanied with high water intake in  
175 newborns and children in comparison with adults [30]. Children and adolescents are target  
176 populations for intake of water which can be radiocontaminated, due to the increased usage of  
177 bottled water in Europe and its use for production of a number of different drinks favoured by the  
178 youngest. The increased effective dose from radiocontaminated mineral water may be up to seven  
179 times higher in infants and teens than the maximum level recommended by the World Health  
180 Organization (100  $\mu\text{Sv}$ ,) [31]. It has been suggested that this exposure may be specifically relevant  
181 for the hormonal activity of testosterone and oestrogen during puberty when final maturation of  
182 skeleton occurs [32]. Non breast fed infants less than 1 year of age may receive doses up to 0.28  
183 mSv/y if their diet is exclusively prepared with mineral water with elevated radon concentrations  
184 from  $^{226}\text{Ra}$  decay [33]. In addition, such waters contain other radionuclides such as  $^{210}\text{Pb}$  and  $^{222}\text{Ra}$   
185 also contributing to the total received dose [33].

186 The health risk related to indoor radon exposure is still a subject of discussion. It has been shown  
187 that residential radon exposure may contribute to increased cancer incidence. The average radon  
188 exposure of 50  $\text{Bqm}^{-3}$  has been estimated to be responsible for 13-25% of myeloid leukaemia cases  
189 at all ages [34,35]. Indoor exposure at an annual dose of 7-11 mSv from radon has been reported to  
190 be associated with a significantly increased frequency of chromosome aberrations (MR=1.69, Table  
191 1) and micronuclei (MR=1.44, Table 2) in children [36]. To decrease radon levels in the working  
192 and living environment some countries have established programmes for remediation work in  
193 buildings, primarily schools and homes [37].

194

195 **Exposure to high-dose ionizing radiation**

196 **The Chernobyl nuclear accident.**

197 After the 1986 Chernobyl nuclear power plant accident, populations of Ukraine, Belarus and Russia  
198 were exposed to Iodine ( $^{131}\text{I}$ ), Caesium ( $^{137}\text{Cs}$ ,  $^{134}\text{Cs}$ ), Strontium ( $^{90}\text{Sr}$ ) and to a wide spectrum of  
199 short-lived isotopes which were not measured by physical dosimetry [11]. Later on, exposure  
200 became continuous with constant intake of radionuclides via food and water, including  $^{90}\text{Sr}$  which is  
201 incorporated in the skeleton of children at 4-6 fold higher rates than in adults [38]. It has been  
202 estimated that following the Chernobyl accident approximately 160,000 children aged 7 years or  
203 less were exposed to a variety of radioactive isotopes [39]. The explosion of the Chernobyl-4  
204 reactor core led to the release of radioactivity that was deposited in the surrounding area as dust and  
205 debris, while the lighter material was carried by wind over the Ukraine, Belarus, Russia and to some  
206 extent over Europe, with radioactive fallout in Scandinavia, Austria and Switzerland [17]. Some 15  
207 to 23 kg of plutonium were released, the majority within an area of 80 km radius around the nuclear  
208 plant [40]. Immediately after the accident, a first zone with more than 40 Ci/km<sup>2</sup> (the 10 km range  
209 zone) and a second one with more than 15 Ci/km<sup>2</sup> (range of 30 km) were identified. A third area of  
210 145,000 km<sup>2</sup> was contaminated with more than 1 Ci/km<sup>2</sup>. After the accident 135,000 people were  
211 evacuated from the first zone and after some time 210,000 more subjects were evacuated. An  
212 unidentified number of evacuated subjects were sent to different parts of Russia, Israel or other  
213 European countries, for varying periods of time. Today, about 3.8 million people live in the area  
214 with more than 1 Ci/km<sup>2</sup>. The effective human annual dose is in the range between 54 μSv and 3.1  
215 mSv [41, 42]. Efforts to reduce the exposure of the population through altering their diet were not  
216 very successful [40]. In affected area increased incidence of thyroid cancer in children [43] and  
217 recently breast cancer have been reported [26, 27]. Breast cancer could be expected to follow  
218 thyroid cancer since the mammary gland is derived embryogenetically from primitive iodide-  
219 concentrating ectoderm [26, 30, 44, 45, 46]

220 **Chromosome aberrations.** Cytogenetic studies of the children population in Ukraine started in 1988

221 [47]. Studies reported in [47] were performed on peripheral lymphocytes and only *in vivo* MN assay  
222 was performed on reticulocytes. Results revealed dose-dependent increased levels of CA, with MRs  
223 of 3.22 and 1.98, in children exposed to  $^{137}\text{Cs}$  at levels between 18 and  $55 \times 10^{10}\text{Bq/km}^2$  and lower  
224 than  $1 \times 10^{10} \text{Bq/km}^2$ , respectively (Table 1). Repeated measurements of chromosome aberrations  
225 within a 4 year period after accidental overexposure in children living in contaminated areas [48]  
226 revealed a 53% increased average level of genome damage as measured by the chromosome  
227 aberration (CA) assay (Table 1). The follow-up of several exposed and evacuated groups of  
228 children born before and after the nuclear accident by highly experienced cytogenetic centres such  
229 as those in St. Petersburg (Russia) or in Pisa (Italy) also showed the persistence of the genome  
230 damage. An age related radiosensitivity was detected in children from Belarus who were sampled  
231 three months after the Chernobyl accident. A significant difference was found in the number of  
232 dicentrics between young (6-10 years) and older (11-15 years) children (Table1), with 1.17% and  
233 0.67% dicentrics, respectively [49]. Up to 10 years after the accident children were still suffering  
234 from internal contamination: CA frequencies were up to 4 times higher in exposed than in reference  
235 children (Table 1) [50, 51, 52, 53]. In exposed children the frequency of dicentrics was 0.44%  
236 compared to 0.02% observed in unexposed children (Table 1) [54]. Such an alarming situation  
237 feeds speculations about an accumulation of stable genome damage in these children and potentially  
238 related adverse health effects that may occur later in life. Cytogenetic studies also showed that even  
239 the areas which are considered as unpolluted are actually contaminated with radionuclides at levels  
240 that are capable of increasing genome damage in children [47]. The impact of internal  
241 contamination was seen as a presence of rogue cells (specific type of multiaberrant cells) detected  
242 in children living in contaminated areas [55]. In this study 328 Belarussian children were analysed  
243 by the CA assay. The majority of the children (321 subjects) were exposed postnatally. In six  
244 children exposed *in utero* one or two rogue cells were detected in 200 analysed metaphases.  
245 Detected rogue cells contained up to 9 dicentrics, up to three tracentrics or/and rings and  
246 quadricentrics.

247 ***In utero exposure.*** The Chernobyl accident affected also pregnant women who were exposed to  
248 different levels of radiation before being evacuated. A study using G banding was performed on two  
249 groups of children exposed *in utero* and during childhood to ionizing radiation [56]. Children born  
250 by mothers who were pregnant at the time of the accident and evacuated shortly afterwards were  
251 exposed to radiation levels ranging between 10 and 376 mSv while children exposed *in utero* and  
252 chronically during the childhood experienced a cumulative dose of 19-52 mSv. An increased  
253 frequency of CA was detected in newborns from both groups of women. As shown in Table 1 mean  
254 frequencies of  $9.07\% \pm 1.34$  and  $7.63\% \pm 2.92$  of CA were measured in the group of intrauterine  
255 exposed children and in children exposed *in utero* and after birth, respectively, compared to a  
256 frequency of  $2.47\% \pm 0.4$  detected in referent children (MR= 3.67 and 3.08). Translocations,  
257 inversions and deletions represented almost 80% and 70% of chromosome type aberrations in  
258 intrauterine exposed and continuously exposed children, respectively [56]. Non random distribution  
259 of chromosome damage was detected: the most frequently involved chromosomes were  
260 chromosome 1, 3, 5, 7, 9, 11, 13, 21 and 22 [56]. On the background of the available scientific  
261 evidence, this predominant localization of break points correlates with diagnostics markers of  
262 neoplastic disease as summarized in Table 4 [57]. All detected bands at which chromosome  
263 breakage was present are non-random and related with the described neoplasias.

264 ***Parental exposure.*** A high frequency of aberrant cells ( $1.12 \pm 0.37\%$ ) was measured in children  
265 exposed *in utero* to 2.0-2.5 cSv, in those born between 1987-1991 ( $1.24 \pm 0.4$ ) as well as in children  
266 born between 1994-1998 ( $1 \pm 0.2$ ) compared to children born before the Chernobyl accident ( $0.59 \pm$   
267  $0.3\%$ ), with MRs of 1.90, 2.1, and 1.69, respectively [58]. A long-term follow-up study of  
268 populations living in a contaminated area of 15, Ci/km<sup>2</sup> [58] showed increased genome damage in  
269 children of irradiated parents (Table 1). The highest frequency of aberrant cells ( $1.24 \pm 0.4\%$ ) was  
270 measured in children born by mothers who were continuously exposed to ionizing radiation  
271 following the Chernobyl accident (MR=2.1).

272 The paternal transferability of possible genome damage has been investigated in children born after

273 their fathers were exposed as liquidators at the Chernobyl nuclear plant. Genome damage was  
274 measured in 15 children born after evacuation using the CA assay [59]. A clear increase in CA  
275 (MR=1.64, Table 1) was detected in children of Chernobyl liquidators who suffered with radiation  
276 burns of 1<sup>st</sup> and 2<sup>nd</sup> degree (2.38%±1.9) compared to referents (1.45%±0.2).

277 Six years after the accident children who were evacuated at different times following the accident  
278 and children born after cessation of their father's exposure were analysed for CA. Evacuated  
279 children had spent between 2 days and 2 years in contaminated areas. As it is shown in Table 1,  
280 clearly increased frequencies of CA were detected in children of exposed liquidators (2.8%±0.2)  
281 and in evacuated children (2.5%±0.1) compared to referents (1.8%±0.2). Noteworthy, evacuated  
282 children still had almost ten times more dicentric and ring chromosomes than controls (0.19% and  
283 0.02%, respectively, data not shown). Such increased values of these types of CA could reflect  
284 genomic instability, a phenomenon of increased rate of acquisition of alterations in the mammalian  
285 genome proposed to be a driving force in carcinogenesis [53]. Indeed, germline mutation  
286 frequencies at human minisatellite loci among children born in polluted area and receiving doses of  
287 about 0.18 Gy were shown [60] to be two times higher when compared with a control population  
288 (mutation rate per band 0.03 versus 0.01, respectively). The measurement of new fragments using  
289 multi-site DNA fingerprinting showed that liquidators' children born after the Chernobyl accident  
290 had a seven-fold increased level of new bands that were not present in their sibs conceived before  
291 the Chernobyl accident [61, 62].

292 ***Micronucleous Assay, Comet Assay, FISH, and SCE.*** Among the *in vitro* studies conducted on  
293 children exposed following the Chernobyl accident (Table 2), the one by Mikhalevich et al 2000  
294 [49] failed to detect a difference in the frequency of MN in binucleated lymphocytes of those living  
295 in contaminated areas for 9 years after the accident and being chronically irradiated by internal  
296 contamination, compared to referents (MR=0.83). The study reported a clearly increased frequency  
297 of MN in mononucleated lymphocytes (MR=2.48) in chronically irradiated children (Table 2). Two  
298 studies [63,64] reported a twofold increased frequency of micronucleated cells in radiation exposed

299 compared to referent children while another [65] detected similar levels of micronuclei in exposed  
300 and referents (Table 2). Using the *in vivo* micronucleus assay, liquidators from Chernobyl and their  
301 children evacuated following the nuclear accident [66] were observed to express significantly  
302 increased mean micronuclei levels in peripheral lymphocytes compared to referent children (0.19‰  
303 and 0.012‰ micronucleated cells, respectively, MR=15.8). This is the only available study on a  
304 population environmentally exposed to radiation monitored by the *in vivo* MN assay.

305 The Comet assay has been used to estimate genome damage levels in children from Belarus 10  
306 years after the Chernobyl accident [67]. An increased genome damage was still present in their  
307 lymphocytes (Table 3), a finding that could be explained as a “clastogenic factor” present in 19% of  
308 these children [67]. When the translocation frequency was measured using FISH (Table 3) in a  
309 group of exposed children and in age matched referents, higher levels of translocation were found in  
310 the former (0.65%±0.1) than in the latter group (0.14%±0.05) corresponding to an MR of 4.64 [68].  
311 In the same study higher MN frequencies were found in exposed children than in exposed adults  
312 (0.06‰), a finding that is suggestive of a higher sensitivity of children to ionising radiation induced  
313 cytogenetic damage, since it seems unlikely that the children were exposed to higher levels of  
314 radiation than their parents.

#### 315 **Antioxidants and lipid peroxidation.**

316 Several studies (not included in any table) have investigated the association between radiation  
317 exposure, lipid peroxidation disorders, and cytogenetic damage. Analyses of children born by  
318 mothers who were exposed to low doses of radiation before pregnancy showed that in regions  
319 contaminated by radionuclides, these children suffered from lipoperoxidase disorders and that the  
320 levels of essential antioxidants such as vitamin A and E were low. For mothers on a diet  
321 supplemented with these vitamins during pregnancy, the chromosome aberration frequency in their  
322 newborns was significantly lower in comparison with children born by mothers without such  
323 vitamin supplemented diet [69]. The complexity of interaction between the organism in  
324 development and radiation is also illustrated by a bimodal pattern of distribution of the glutathione

325 system [70, 71] in children born by mothers exposed to different dose levels. In children born by  
326 mothers exposed to doses between 0.8 and 30 cSv, increased levels of reduced plasma glutathione  
327 (up to 90  $\mu\text{M}$ ) could be detected, while in mothers exposed to doses between 30 cSv and 60 cSv,  
328 severe decrease (5  $\mu\text{M}$ ) was detected. Glutathione mediates a reduction of at least two vitamins,  
329 alfa-tocopherol and ascorbic acid which are critical in prevention of lipid peroxidation. Additional  
330 consequences of exposure to ionizing radiation and disturbances of glutathione level are seen in  
331 cases of combined radiochemical exposure. Increased levels of polycyclic aromatic carbons (PAH)-  
332 DNA adducts are found in human placenta of mothers exposed to both ionizing radiation and  
333 environmental PAH, suggesting a possibly higher health risk for the foetus in a case of complex  
334 exposure than would be expected exclusively from PAH concentrations in air [72].

### 335 **Radiation induced adaptive response.**

336 An adaptive response of subjects exposed to low doses of chemical agents or radiation has  
337 frequently been investigated by Russian and Ukrainian scientists. The existence of radiation  
338 associated hormesis (i.e. the concept that small doses of radiation may reduce the damage to levels  
339 even lower than those observed in unexposed controls) is still debated in the literature. The adaptive  
340 response is a characteristic feature of both mammalian and plant cells in their response to various  
341 mutagenic agents [73]. This phenomenon occurs when cells are treated with a low dose of a  
342 clastogen; such a pre-treatment may then reduce the effect of a subsequent treatment with a higher  
343 dose of the same or a similar agent (the challenging treatment). Adaptation can be measured by the  
344 challenge assay in which lymphocytes isolated from exposed and control subjects are treated with  
345 either 1 Gy or a combination of 0.05 Gy and 1 Gy. Compared to children living in Moscow's urban  
346 polluted areas, increased micronuclei frequencies were reported among children from the Chernobyl  
347 area exposed to radiation by living in areas with contamination levels ranging between 5 and 40  
348  $\text{Ci}/\text{km}^2$ . Lymphocytes of children from these radiocontaminated areas showed increased frequencies  
349 of chromosome aberrations and micronuclei in the challenge assay, suggesting that, in this exposed  
350 population, subjects express a radiosensitivity with no indication of an adaptive response. These



351 results may show that a routine application of chromosome aberration and/or micronucleus assay  
352 without also employing a challenge assay may not be sufficient for the detection of genomic  
353 instability [63]. By comparing this radiosensitivity with the observations of adaptive response in the  
354 adult and children populations from Ural (internal exposure with <sup>90</sup>Sr from the Techa River) and the  
355 Chernobyl regions, some common features were apparent. In both groups of exposed children,  
356 individuals with high radiosensitivity were recognized after a challenging dose of 1 Gy and using  
357 MN as the endpoint. Among referent children from the Moscow region, inter-individual differences  
358 in MN frequencies were significantly lower after challenge assay than in exposed group. Based on  
359 such data it is suggested that adaptive response is not developed and will not be expressed in  
360 adulthood if a person is exposed as a child to elevated levels of radiation or other xenobiotics [74,  
361 75].

### 362 **Hiroshima and Nagasaki**

363 The Chernobyl disaster resulted primarily in radiation via internal contamination, whereas after the  
364 Hiroshima and Nagasaki bombings the primary source was gamma radiation and fast neutrons. This  
365 represents different types of exposures, which are also associated with different cancer incidence  
366 distributions [76]. Two to three years after the bombing, leukemia was the first cancer to be linked  
367 with exposure with the highest incidence of leukemia detected in people exposed during their  
368 childhood [77]. Besides the increase in leukemia, elevated rates of solid cancers such as cancers of  
369 the breast, lung, and colon have been reported which seem to be larger among subjects exposed  
370 during their childhood than among those exposed as adults [78].

371 Cytogenetic analyses of exposed populations started 15 years after the bombing [79] due to the fact  
372 that cytogenetic methods were not introduced until the 60's. A number of different research teams  
373 have been involved in studying health consequences in survivors and studies are still on going  
374 among children of exposed subjects. [80]

## 375 **Nuclear plants**

376 Epidemiological studies have reported clusters and increased risks of leukaemia in subjects living in  
377 areas adjacent to nuclear power plants [81, 82, 83, 84, 85, 86, 87, 88]. A significant excess of  
378 leukaemia cases in the general population living in the proximity of nuclear plants has also been  
379 reported [82, 89, 90] along with a possible association for children whose father were employed at a  
380 nuclear plant [90].

**Comment [dfm1]:** I've moved refs for krummel here to get rid of reiterations seen by Gunnar

381 A systematic review of leukemia incidence and mortality cohort studies in children living in the  
382 proximity of nuclear facilities found that the majority of studies reported elevated rates [91]. This  
383 meta-analysis confirmed an increased risk of childhood leukemia near nuclear facilities with the  
384 highest contribution of excess cases and deaths from children aged < 10 years and living within 15  
385 km from the nuclear site.

386 A few studies using cytogenetic methods have been conducted in Europe with children living close  
387 to nuclear plants or downstream of rivers from which water is used for cooling of reactors [90, 92].  
388 Between 1988 and 1995 *in vitro* chromosome aberration assays were performed with peripheral  
389 lymphocytes from 5 healthy siblings of the leukemia cases and in 10 control children from the  
390 Elbmarsch Municipality [93 ??], 42 children from the Elbmarsch Municipality and 30 children from  
391 a control region [92], and 25 adults including 7 parents of children diagnosed with leukemia and 14  
392 inhabitants near the Krummel nuclear plant and in 25 healthy adults (control subjects) living in the  
393 city of Bremen about 100 km southwest of Hamburg [94]. While two studies [93, 94] reported a  
394 significant fourfold higher rate of dicentric and/or ring chromosomes in peripheral blood  
395 lymphocytes in subjects living near the plant compared to control subjects, one study [92] failed to  
396 detect any such difference between exposed and control children.

## 397 **Nuclear weapons fallouts, and nuclear accidents**

398 During the period 1948-1967 three nuclear accidents took place in the Soviet nuclear weapon  
399 industry known as «Mayak Complex» established on the Techa River near Chelyabinsk, in the  
400 Southern Urals. During this period beta/gamma radioisotopes were released into the Techa River.

401 Several studies have been conducted on the population of 280,000 dwellings living in the area [95].  
402 It has been estimated that about 8% of this population (124,000 people) were exposed to radioactive  
403 isotopes such as  $^{137}\text{Cs}$ ,  $^{106}\text{Ru}$ ,  $^{95}\text{Zr}$ ,  $^{89}\text{Sr}$ ,  $^{90}\text{Sr}$ , and that these received total accumulated doses above  
404 1.0 Sv [96]. The increased frequency of CA that was observed in exposed children from this area  
405 ( $0.56\pm 0.08$ ) compared to referents ( $0.29\pm 0.07$ ), resulting in an  $\text{MR}= 1.93$  (Table 1), was  
406 accompanied by a 1.7-fold increase in minisatellite mutation rate in the germline of exposed fathers  
407 than in referents from rural areas (data not included in Table 1) [97]. Contrary to Hiroshima,  
408 Nagasaki, and Chernobyl, the general population was exposed to short-lived radionuclides through  
409 food, water and air in the period 1949-1963 due to the nuclear tests at the Semipalatinsk,  
410 Kazakhstan (former Soviet Union), just south of the Altai region of Siberia. An impact of radiation  
411 exposure during childhood was suggested by studies of adults living in this region. The area was  
412 contaminated from 450 nuclear tests until 1989 of which 100 were atmospheric [98,99]. Cytogenetic  
413 analysis of two or three generations within a family showed a presence of dicentric and ring  
414 chromosomes in children born after the nuclear tests had ceased, suggesting family genomic  
415 instability [100]. At the time of atmospheric bomb tests in 1949, about 25,000 people received doses  
416 between 10 mSv and 1,500 mSv [96]. Studies of this population detected germ line mutations in  
417 adults born between 1926 and 1960 and exposed to nuclear fall-out between 1949 and 1956, during  
418 their childhood [101, 102].

419 There are special living conditions in Western Siberia where, in a large geographical area, mines,  
420 chemical and nuclear industries are located. A follow-up study of 289 children [103] showed  
421 significant deviations (including multi-aberrant cells) even in the “referent” population. Indeed,  
422 because of the level of radiation pollution in this region, no unexposed children could be included in  
423 the study and children in the lowest exposure group were used as referents [103, 104]. Despite the  
424 acknowledged exposure misclassification, increased CA levels were reported for children exposed  
425 to 0.6 cSv compared to those exposed to 0.05 cSv ( $3.94\pm 0.44$  and  $2.58\pm 0.59$ , respectively;  
426  $\text{MR}=1.53$  Table 1).

427 The nuclear test site Syevernaya (in the period between 1955 and 1962, about 80 nuclear bomb tests  
428 were performed here) is located in N6vaya Zemlyá, an area of Russia in which the population of the  
429 Tundra Nenets population lives. In this population increased cancer morbidity was detected (100).  
430 Similar to the children population in the Altai region, 20 years after cessation of nuclear tests,  
431 unstable chromosome aberrations such as rings and dicentrics were still detected in newborns [105].  
432 An increased MN frequency (MR=1.4 and MR=1.6 in probably exposed and directly exposed  
433 children compared to referents) was detected in accidentally exposed children in the Goiania, Brazil  
434 radiological accident (Table 2); detected values are within the control values of other studies  
435 presented in Table 1 [106].

#### 436 **Contaminated building materials**

437 In the period between 1982 and 1984 in Taiwan a number of buildings were constructed using  
438 reinforced steel contaminated by <sup>60</sup>Co which had been illegally discarded. The buildings were  
439 residential, schools and kindergartens, and it was estimated that 20% of 897 families were exposed  
440 to radiation doses higher than 5 mSv/year (in addition to background radiation). Several studies  
441 were carried out to estimate the radiation-induced genome damage simultaneously with physical  
442 dosimetry [108, 109, 110]. Although 1,500 subjects aged between 0 and 19 years were studied,  
443 findings for children were not reported separately [109], with the exception of a small study without  
444 a referent population in which the first blood sampling showed a significantly increased CA  
445 frequency (20.6±3.9%) in comparison with a second sampling conducted after evacuation from the  
446 contaminated buildings (8.7±1.5%), resulting in an MR=2.4 (Table 1). The issue of contaminated  
447 steel or other metals is not limited to the Taiwan episode: several reports [111, 112, 113] have  
448 addressed unsolved problems concerning building materials used in construction.

449

#### 450 **Conclusions**

451 In general, genome damage caused by accidental overexposure to ionizing radiation may result  
452 from interactions such as the formation of DNA damage directly or via free radicals, but also from

453 damage to the nuclear membrane, lipid peroxidation, methylation disturbances, activation of a chain  
454 of signal molecules influencing the expression of apoptosis, and other mechanisms including  
455 hormonal, age related bioaccumulation of radionuclides, metabolism and clearance. Other  
456 contributing factors such as stress, malnutrition and infections may play major roles. At present,  
457 such conditions are predominantly found in some specific social environments in Ukraine and  
458 Belarus, but they could easily be envisaged in other parts of the world in conjunction with a nuclear  
459 accident. With respect to the genome damage discussed in this review, the main body of available  
460 data for children exposed to radiation comes from studies that were performed in Russia. Territories  
461 of the ex-Soviet Countries, as well as some other areas of our planet are still polluted as a  
462 consequence of nuclear tests and the nuclear industry. The resulting nuclear waste may lead to  
463 radiation exposure and complex exposures to radiation and chemical pollution, as is the case in a  
464 rocket test area or in spacedroms [114].

465 The studies considered in this systematic review consistently reported an increased frequency of CA  
466 and micronuclei in radiation exposed children compared to referents. Elevated CA levels were  
467 observed also in children exposed to high levels of radiation when compared to those exposed to  
468 lower levels [47,54,49,103]; this interpretation should be made despite the potential exposure  
469 misclassification of referent children for whom radiation exposure levels are hardly ever reported.  
470 Such a differential misclassification of exposure is expected to result in study findings that are  
471 toward the study null hypothesis (i.e., that there is no effect of environmental radiation exposure on  
472 genome damage in children) resulting in underestimated measures effect (MR).

473 The impact of internal contamination was indicated by a presence of rogue cells and by the higher  
474 frequency of dicentrics in exposed than in referent children as reported by several studies.

475 Beside a threat of accidental overexposures children are exposed routinely to ionizing radiation for  
476 diagnostic purposes which doses should be recorded and summarised as a cumulative life long dose.

477 An increased risk of childhood leukaemia was detected in children who reported two or more  
478 postnatal X-rays [115]. The environmental burden during childhood could have a significant

479 influence on the adaptive capacity in adulthood and could be partly responsible for inter-individual  
480 differences in chemo- and radiosensitivity [116]. Additional radiosensitivity time windows should  
481 be investigated which may exist during childhood, e.g. in newborns and teens.

482 Populations suffering from radiological accidents, living in contaminated areas or ex-nuclear testing  
483 sites or close to radiochemical industries, are today subjected to an improved identification and  
484 monitoring, taking place in several medical centres. These groups of people constitute a large cohort  
485 including thousands of subjects and sometimes families with several generations. Local research  
486 centres often have stored biological samples, data on exposure and questionnaire data representing a  
487 valuable source of information that could be used for studying the delayed adverse effects of  
488 radiation on children and the transgenerational transfer of genome damage [96]. Integration and  
489 utilisation of such sources represent a great challenge and will probably be important in future  
490 studies of the consequences of children's exposure to ionizing radiation.

491 In Europe there is a dramatic discrepancy between the number of existing nuclear plants and the  
492 number of field studies on the potentially associated health consequences [117]. Regarding natural  
493 sources of radiation, consumers should be informed about possible health risks associated with the  
494 consumption of bottled mineral waters available on the market [6], in cases where increased  
495 radiation exposure may be significant. As only 5%-15% of childhood cancers seems to be related  
496 with familial and genetic factors [118], the age related sensitivity should be subject to a closer study  
497 in order to avoid, at least, exposure of children during their most susceptible age periods. Similarly,  
498 governments should support reconstruction of dwellings in order to decrease radiation levels in  
499 homes and public buildings where children spend most of their time. Strict control of building  
500 materials for radio contamination should be performed (such as fly ash and steel).  
501 Genotoxicological studies of children living in the proximity of nuclear plants should be set as a  
502 priority in research programmes. At the same time there is a need for an arising preparedness of  
503 medical staff in case of nuclear accidents.

504

505

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510

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**Table 1.** Chromosome aberration frequencies (mean  $\pm$  SE), measured in children exposed to ionizing radiation and in referents, by type and level of exposure. The exposure level, sample size, age of the study groups (range), and the median ratio (MR) are reported for each study. Gaps excluded.

Type of exposure	Level of exposure <sup>a</sup>	Group: Sample Size	Age <sup>b</sup>	Mean $\pm$ SE (%)	MR	Details	Reference
<sup>137</sup> Cs	18-55 x10 <sup>10</sup> Bq/km <sup>2</sup>	Exposed: 103	6-15	2.74 $\pm$ 0.1	<b>3.22</b>		42 Yeliseeva et al.,1994
<i>Chernobyl</i>	0.37-0.74 x10 <sup>10</sup> Bq/km <sup>2</sup>	Exposed: 27		1.68 $\pm$ 0.2	<b>1.98</b>		
	--	Referent: 16		0.85 $\pm$ 0.1	<b>1</b>		
<b>Radionuclides</b>	74-148 Ci/km <sup>2</sup>	Exposed: 11	4-11	4.0 $\pm$ 0.3	<b>1.53</b>	Repeated measurements	43 Bochkov et al.,1991
<i>Chernobyl</i>	--	Referents: 13	4-11	2.6 $\pm$ 0.2	<b>1</b>		
<b>Radionuclides</b>	148 x10 <sup>10</sup> Bq/km <sup>2</sup>	Exposed: 24	10-12	0.62 $\pm$ 0.08	<b>1.87</b>		46 Padovani et al.,1997
<i>Chernobyl</i>	--	Referent: 11	10-12	0.33 $\pm$ 0.08	<b>1</b>		
<b>Radionuclides</b>	40 x10 <sup>10</sup> Bq/km <sup>2</sup>	Exposed: 24	8-10	2.4	<b>4.00</b>	<sup>137</sup> Cs whole-body counter	45 Padovani et al.,1993
<i>Chernobyl</i>	--	Referent: 10	8-10	0.6	<b>1</b>		
<sup>137</sup> Cs	2.43 Bq/day	Exposed: 17	9-14	1.46 $\pm$ na	<b>1.02</b>	Belarus children	44 Barale et al.,1998
<i>Chernobyl</i>	--	Referents: 35	12-16	1.42 $\pm$ na	<b>1</b>	Italian healthy children	
		Exposed: 17	9-14	1.3 $\pm$ na	<b>3.25</b>	%o Dicentrics	
		Referents: 35	12-16	0.4 $\pm$ na	<b>1</b>	%o Dicentrics	
<b>Radionuclides</b>	--	Exposed: 49	1-16	2.5 $\pm$ 0.1	<b>1.38</b>	Evaquated children	47 Vorobtsova al.,1995
<i>Chernobyl</i>	--	Exposed: 35	1-6	2.8 $\pm$ 0.2	<b>1.55</b>	Liquidators' children	
	--	Referent: 25	3-16	1.8 $\pm$ 0.2	<b>1</b>		
<b>Radionuclides</b>	0-6 cSv/y	Exposed: 25	6-15	3.93 $\pm$ 0.2	<b>2.25</b>	Dicentrics = 0.44%	48 Pilinskaya et al.,1992
<i>Chernobyl</i>	0.8 cSv/y	Exposed: 25	6-15	3.78 $\pm$ 0.3	<b>2.17</b>		
	--	Exposed: 25	6-15	2.62 $\pm$ 0.2	<b>1.50</b>		
	--	Referent:25	6-15	1.74 $\pm$ 0.2	<b>1</b>	Dicentrics = 0.02%	

**Table 1 (cont.). Chromosome aberration frequencies** (mean ± SE), measured in children exposed to ionizing radiation and in referents, by type and level of exposure. The exposure level, sample size, average age of the study groups, and the median ratio (MR) are reported for each study.

Type of exposure	Level of exposure <sup>a</sup>	Group: Sample Size	Age <sup>b</sup>	Mean±SE (%)	MR	Details	Reference
<b>Radionuclides</b>	--	Exposed: 15	2-5	2.38±1.9	<b>1.64</b>	Fathers with 1 <sup>st</sup> - 2 <sup>nd</sup> degree burns	51 Stepa. 1993
<i>Chernobyl</i>	--	Referents: 50	2-5	1.45±0.2	<b>1</b>		
<b>Radionuclides</b>	2.0-2.5 cSv	Exposed: 14	15	1.12±0.37	<b>1.90</b>	Exposed in utero	50 Suskov,2001
<i>Chernobyl</i>	1.5-2.5 cSv	Exposed: 18	10-14	1.24±0.4	<b>2.10</b>	Born 1987-1991	
<i>cumulative dose</i>	1.0-1.5 cSv	Exposed: 20	3-7	1.0±0.2	<b>1.69</b>	Born 1994-1998	
	--	Referent: 15	15-19	0.59±0.3	<b>1</b>	Born before 1986	
<b>Radionuclides</b>	10-376 mSv	Exposed: 22	15	9.07±1.34	<b>3.67</b>	Exposed in utero evacuated	67 Stepa.,2002
<i>Chernobyl</i>	19-52 mSv	Exposed: 20	15	7.63±2.92	<b>3.08</b>	Exposed in utero and after birth	
	--	Referent: 15	15	2.47±0.4	<b>1</b>	Living in unpolluted areas	
<sup>137</sup> Cs, <sup>90</sup> Sr	35.9 kBq/m <sup>2</sup>	Exposed: 20	6-10	1.17± na	<b>1.75</b>	% Dicentrics	71 Mikhalevich ,2000,
<i>Chernobyl</i>	2.22 kBq/m <sup>2</sup>	Referents: 10	11-15	0.67± na	<b>1</b>	% Dicentrics	
<b>Nuclear industry</b>	> 1 Sv	Exposed: 15	9-11	0.56±0.08	<b>1.93</b>	Exposed to long-lived radionuclides	82 Testa,1998
<i>Southern Urals</i>	--	Referent: 11	9-11	0.29±0.07	<b>1</b>		
		Exposed: 15	9-11	0.07±0.03	<b>1.4</b>	% dicentrics	
		Referent: 11	9-11	0.05±0.02	<b>1</b>	% dicentrics	
<b>Nuclear Industry</b>	0.6 cSv	Exposed: 289	12-17	3.94±0.44	<b>1.53</b>	children with higher exposure	90 Druz.,1997
<i>Western Siberia</i>	0.05 cSv	Referent: 12	12-17	2.58±0.59	<b>1</b>	children with the lowest exposure	
<b>Nuclear power plant</b>	--	Exposed: 42	9-17	0.43 (0.24,0.7) <sup>c</sup>	<b>0.61</b>	% Dicentrics+ring chromosomes	81 Bruske-Hoh, 2001
<i>Elbmarsch, Germany</i>	--	Referent: 30	9-17	0.706 (0.4,0.1) <sup>c</sup>	<b>1</b>	% Dicentrics+ring chromosomes	
<sup>60</sup> Co (steel rebar)	5 mSv/y	Exposed: 18	4-18	20.6±3.9	<b>2.4</b>	1 <sup>st</sup> phlebotomy	97 Hsieh ,2002
<i>Taiwan, residential</i>	5 mSv/y	Exposed: 18	4-18	8.7±1.5	<b>1</b>	2 <sup>nd</sup> phlebotomy, after evacuation	
<b>Ra (indoor)</b>	>1000 Bq/m <sup>3</sup>	Exposed: 85	8-12	2.03±3.9	<b>1.69</b>	Schools' level	35 Bilban et al.,2001
<i>Slovenia</i>	<400 Bq/m <sup>3</sup>	Referents: 20	8-12	1.2±0.59	<b>1</b>	Schools' level	
		Exposed: 85	8-12	0.08±0.44	--	% dicentrics	
		Referents: 20	8-12	0	<b>1</b>	% dicentrics	

<sup>a</sup>) -- = exposure levels not reported; <sup>b</sup>) range in years; <sup>c</sup>) 95% confidence interval; SE = standard error; na = not available

**Table 2.** In vitro (binucleated and mononucleated lymphocytes) and in vivo (reticulocytes) micronucleus assay data) measured in children exposed to ionizing radiation and in referents, by type and level of exposure. The exposure level, sample size, average age of the study groups, and the median ratio (MR) are reported for each study.

Type of exposure	Level of exposure <sup>a</sup>	Group : Sample Size	Age <sup>b</sup>	Mean ± SE (%)	MR	Comments	Reference
<b>Ra (indoor)</b>	>1000 Bq/m <sup>3</sup>	Exposed: 85	8-12	6.5±2.5	<b>1.44</b>	Schools' level	35 Bilban et al.,2001
<b>Slovenia</b>	<400 Bq/m <sup>3</sup>	Referenst: 20	8-12	4.5±1.9	<b>1</b>	Schools' level	
<sup>137</sup> Cs	--	Exposed: 24	1-18	1.16±na	<b>1.6</b>	Directly exposed	95 da Cruz et al., 94
<b>Accidental, Brazil</b>	--	Exposed: 14	1-18	1.00±na	<b>1.4</b>	Probably exposed	
	--	Referents: 30	1-18	0.73	<b>1</b>		
<b>Radionuclides</b>							
<b>Chernobyl</b>							
<sup>137</sup> Cs	35.9 kBq/m <sup>2</sup>	Exposed: 20	10-17	0.75±0.08	<b>0.83</b>	binucleated lymphocytes	71 Mikhalevich ,2000
<sup>90</sup> Sr	2.22 kBq/m <sup>2</sup>	Referents: 10	10-15	0.90±0.08	<b>1</b>	binucleated lymphocytes	
<sup>137</sup> Cs	35.9 kBq/m <sup>2</sup>	Exposed: 20	10-17	2.71±0.27 <sup>a</sup>	<b>2.48</b>	mononucleated lymphocytes	71 Mikhalevich ,2000
<sup>90</sup> Sr	2.22 kBq/m <sup>2</sup>	Referents: 10	10-15	1.09±0.16 <sup>a</sup>	<b>1</b>	mononucleated lymphocytes	
<b>Radionuclides</b>	2.43 Bq/day	Exposed: 26	9-14	3.61±2.6	<b>1.80</b>	Belarus children	73 Zotti-Martelli.,99
<b>Chernobyl</b>	--	Referents: 30	12-16	2.0±2.1	<b>1</b>	Italian healthy children	
<b>Radionuclides</b>	0-20.2 Bq/kg	Exposed: 25	8-9	0.46±0.3	<b>0.90</b>	USA immigrants	72 Livingston et al,97
<b>Chernobyl</b>	--	Referents: 31	4	0.51±0.2	<b>1</b>		
<b>Radionuclides</b>	5-40 Ci/km <sup>2</sup>	Exposed: 58	7-13	2.3 ±0.1	<b>2.3</b>		63 Pelevina et al.,96
<b>Chernobyl</b>	--	Referents: 136	8-13	1.0±0.06	<b>1</b>		
<b>Radionuclides</b>	--	Exposed: 54	6-16	0.19±na <sup>c</sup>	<b>15.8</b>	Evacuated children	70 Fedoretsova et.,97
<b>Chernobyl</b>	--	Referent: 94	6-16	0.012±na <sup>c</sup>	<b>1</b>		

-- = exposure levels not reported ; <sup>a</sup>) mononucleated lymphocytes; <sup>b</sup>) range in years; <sup>c</sup>) in vivo micronucleous assay; na, not available.

**Table 3.** Comet assay, FISH, and SCE results from measurements in children exposed to ionizing radiation and in referents, by type and level of exposure. The exposure level, sample size, the age range, and the median ratio (MR) are reported for each study.

Type of exposure	Level of exposure <sup>a</sup>	Group: Sample Size	Age	Mean±SE	Unit	MR	Details	Reference
<b>Radionuclides</b> <i>Chernobyl</i>	24x10 <sup>10</sup> Bq/km <sup>2</sup>	Exposed: 16	8-16	26.34±9.55	<b>COMET</b> DNA migration, μm	<b>0.62</b> <b>1</b>	10 years after explosion	59 Frenzilli .,2001
	--	Referents: 39		16.46±4.6				
<b>Radionuclides</b> <i>Chernobyl</i>	--	Exposed: 11	8-19	0.65±0.1	<b>FISH</b> %	<b>4.64</b> <b>1</b>		69 Vorobtsova,2000
	--	Referents: 14	3-19	0.14±0.05				
<b>Radionuclides</b> <i>Chernobyl</i>	2.43 Bq/day	Exposed: 15	9-13	6.0±1.12	<b>SCE</b> %	<b>0.85</b> <b>1</b>	Belarus children Italian healthy children	44 Barale et al.,1998
	--	Referents: 32	12-14	7.0±1.24				

<sup>a</sup>) -- = exposure levels not reported

**Table 4.** Correlation of detected break points (Stepanova 2002) and related disease in intrauterine exposed children.

<b>LOCALIZATION OF BREAK SITES</b>	<b>RELATED DISEASE</b>	<b>LOCALIZATION OF BREAK SITES</b>	<b>RELATED DISEASE</b>
1p35	NB, PV	5q33	ATL, LI, AML, MDS
1p13	AML-M7, PV	5q35	NHL, AML, MDS
1q32	NHL/CLD, MPD	7p15	AML, MPD
1q42	NHL/CLD, MPD	7q33	ALL, AML, CLD, MDS, NHL, PV
2q33	CLL	9q34	ALL, AML, CML, MDS, MPD, NHL
3p21	PA, AC salivary gland, AC/SCC, lung, CLD, NHL, AC kidney	13q32	LI, ALL, MDS, MPD
3q25	AML, MDS, AC kidney	17q21	AML, breast cancer
5p15	ATL, AML	17q25	AML
5p13	ATL	22q13	AML-M7, ALL, MN
5q31	ALL, AML, MDS		

\*\*\* AC Adenocarcinoma, ALL Acute lymphoblastic leukemia, AML Acute myeloid leukemia, subclassified FAB M1 through M7, ATL Adult T-cell leukemia/lymphoma, CLD Chronic lymphoproliferative disorder, CLL Chronic lymphocytic leukemia, LI Lipoma, MDS Myelodysplastic syndrome, MPD Myeloproliferative disorder, NB Neuroblastoma, NHL Non-Hodgkin's lymphoma, subclassified B or T cell lineage, PA Pleomorphic adenoma, PV Polycythemia vera, SCC Small cell carcinoma.