The Changing Epidemiology of Autism Spectrum Disorders

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Annu. Rev. Public Health 2017. 38:81–102

First published online as a Review in Advance on December 21, 2016

The *Annual Review of Public Health* is online at publhealth.annualreviews.org

https://doi.org/10.1146/annurev-publhealth-031816-044318

Keywords

air pollution, autism, environmental exposures, epidemiology, genetics, gene-environment interaction

Abstract

Autism spectrum disorder (ASD) is a complex neurodevelopmental condition with lifelong impacts. Genetic and environmental factors contribute to ASD etiology, which remains incompletely understood. Research on ASD epidemiology has made significant advances in the past decade. Current prevalence is estimated to be at least 1.5% in developed countries, with recent increases primarily among those without comorbid intellectual disability. Genetic studies have identified a number of rare de novo mutations

and gained footing in the areas of polygenic risk, epigenetics, and gene-by-environment interaction. Epidemiologic investigations focused on nongenetic factors have established advanced parental age and preterm birth as ASD risk factors, indicated that prenatal exposure to air pollution and short interpregnancy interval are potential risk factors, and suggested the need for further exploration of certain prenatal nutrients, metabolic conditions, and exposure to endocrine-disrupting chemicals. We discuss future challenges and goals for ASD epidemiology as well as public health implications.

INTRODUCTION

Autism spectrum disorder (ASD) is a brain-based neurodevelopmental condition characterized and diagnosed by impairments in social communication and social interaction in the presence of restricted, repetitive behaviors or interests (3). Current population prevalence is estimated at ~1.5% in developed countries around the world (11, 34). Though the full range of etiologies underlying ASD remains largely unexplained, progress has been made in the past decade in identifying some neurobiological and genetic underpinnings of, and risk factors for, this complex condition. ASD is highly heritable, but environmental factors are also implicated (76, 146). Multiple lines of evidence suggest the etiology of ASD has prenatal origins (10).

This review covers the changing landscape of the epidemiology of ASD, highlighting the most relevant research over the decade since our last review was published (137), including both descriptive epidemiology and genetic and environmental risk factor investigations.

PHENOTYPE AND DIAGNOSIS

Onset of ASD symptoms typically occurs by age 3, although symptoms may not fully manifest until school age or later, and some research suggests symptoms can emerge between 6 and 18 months of age (174). More severely affected children are more likely to be identified and reliably diagnosed at younger ages than milder cases (201). The hallmark of ASD is impaired social interaction and communication ability, coupled with restricted and repetitive patterns of behaviors or interests. Approximately four males are affected with ASD for every female, though the sex ratio appears to decrease with increasing severity (190). Although this pronounced sex disparity is found in all populations studied and has been historically consistent, differences in symptom presentation in females and potential attendant diagnostic biases (54), even though unlikely to fully explain observed differences, are worthy of additional investigation.

Common ASD-associated impairments include intellectual disability [currently estimated to occur in ~30% of cases (34) and historically estimated at ~70%] and attention deficits (occurring in ~30–40% of cases, though estimates outside this range are common), as well as sensory sensitivities, gastrointestinal problems, immune deficits, anxiety and depression, sleep disturbances, and a range of comorbid medical conditions (41, 131). Up to 15% of cases can be linked to a known genetic cause via monogenic syndromes (such as fragile X syndrome, tuberous sclerosis, and Timothy syndrome) (49).

A clinical diagnosis of ASD relies on expert judgment to detect significant impairment in the core behavioral domains. In 2013, the fifth revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (3) changed ASD diagnostic criteria (123), eliminating diagnostic subtypes (which had included autistic disorder, Asperger's syndrome, and Pervasive Developmental

Disabilities–Not Otherwise Specified) and creating a single category formally designated as ASD. The DSM-5 combined previously distinct social and communication deficit criteria into one domain and incorporated a severity rating. It has also added a new diagnosis, social communication disorder (SCD), outside of ASD (3).

Standardized research assessment tools, most notably the Autism Diagnostic Observation Schedule (ADOS) and the Autism Diagnostic Interview-Revised (ADI-R), have been designed following DSM-IV criteria; however, these tools will likely still prove useful in the research context under DSM-5, given that the changes largely represent a reorganization of the same core constructs (147). More streamlined research case-confirmation approaches are also under development (170).

The conceptualization of ASD as a discrete phenotype, though still represented as such in DSM-5, is being increasingly questioned. The NIMH Research Domain Criteria (RDoC) initiative encourages researchers to deconstruct diagnostic categories and focus on core behavioral and neurobiologic features that cross diagnostic categories in the hopes of improving our understanding of typical versus pathological (46). Tools have been developed to measure the range of behavioral dimensions fundamental to ASD (for example, the Social Responsiveness Scale and the Childhood Autism Spectrum Test), and such assessments are being used more widely. Twin studies that estimate ASD heritability using such measures have suggested similar conclusions regardless of whether autistic traits were assessed discretely or continuously (124, 150). Approaches for creating continuous scores measuring severity among those diagnosed with ASD have also been developed (82). The concept of dimensionality of the ASD-related phenotype also has implications beyond epidemiology, including reshaping the societal response to ASD as part of a neurodiversity continuum rather than as a disorder (97).

PUBLIC HEALTH IMPACT

ASD is one of the most serious neurodevelopmental conditions in the United States, with significant caregiver, family, and financial burdens. The annual total costs associated with ASD in the United States have been estimated to approach $250 billion, with lifetime individual ASD-associated costs in the $1.5 to $2.5 million range (estimates in 2012 US dollars) (25). These costs are likely underestimated due to historical underdiagnosis of ASD in older cohorts—largely because of this, one forecast suggests that total ASD-attributable costs will rise to over $450 billion by 2025 (117). Despite being thought of as a childhood condition, ASD includes impairments that are generally lifelong. In addition to core deficits and associated psychiatric comorbidity (100), ASD has been associated with increased risk of nonbehavioral health outcomes, including injury (89) and elevated mortality risk (80, 158). The amount of research on ASD in adulthood has increased in the past decade, and lifelong decrements in quality-of-life-related outcomes for individuals with ASD have now been empirically documented (178). This has led to calls for greater focus on research that can be more directly translated into improved life course outcomes (165).

PATHOPHYSIOLOGY

The neural mechanisms underlying the impairments observed in ASD remain unknown, though recent work in genetic epidemiology (summarized in the section titled Genetic Epidemiology below), as well as imaging, molecular biology, and gross anatomy investigations have provided insights. Evidence of early brain overgrowth in ASD has been fairly consistently supported, including in a recent meta-analysis (153). Imaging studies have also indicated changes in functional connectivity, and hypoconnectivity across brain structures is common in individuals with ASD (50). Anatomic differences in brain substructures, often within the cerebral cortex and

cerebellum, continue to be found, though the direction and magnitude of differences reported is variable (29, 116). Recently launched longitudinal imaging studies, as well as work examining white matter integrity in specific brain structures, may help to clarify neuroanatomic features influencing behaviors in ASD (56).

Metabolism, gut, and immune function abnormalities have also been frequently described in ASD. Among children with ASD, gastrointestinal symptoms have also been associated with more frequent challenging behaviors (28). However, there is not a clear consensus on the prevalence and potential causes of reported gut pathologies among children with ASD (26). Defects in mitochondrial function, redox sensitive metabolism, and carbon metabolism have also been reported in smaller subsets of ASD cases (152), though it remains to be determined how these multisystem comorbidities may aid understanding of pathophysiology or potential etiologic subgroups.

DESCRIPTIVE EPIDEMIOLOGY

In the United States in 2012, the Centers for Disease Control and Prevention (CDC) estimated that approximately 1.5% of children aged 8 years had an ASD, based on active surveillance and expert review of health and education records (34). The 2012 estimate was similar to that of 2010, marking the first time CDC surveillance prevalence did not exceed a previous estimate since first reported in 2002 as 0.66% (8). However, a large telephone survey relying on parents' report of ASD diagnosis in their children provided a slightly higher US national prevalence estimate (2.2%) for children 3–17 years of age in 2011–2014 (195). Much of the increase in CDC estimates over the last decade has been in milder cases of ASD, with less dramatic changes observed in the prevalence of ASD with co-occurring intellectual disability (9). The inherent complexity of accounting for simultaneous changes in diagnostic practice, coding tendency, and community awareness poses a challenge to efforts to use administrative data to distinguish variation in ASD prevalence due to change in true risk from variation due to other factors (78, 101, 121). Further, prevalence estimates under DSM-5 are not yet widely available, and the prospective impact of the change in diagnostic criteria, including the potential influence of the new SCD diagnosis on prevalence, remains to be seen. Multiple studies have assessed the proportion of individuals diagnosed with ASD according to DSM-IV-TR who meet ASD criteria under DSM-5, with resulting estimates ranging widely (38% to 93%) (171).

US prevalence estimates vary by demographic factors; in particular, nonwhite race, Hispanic ethnicity, and low socioeconomic status (SES) have been associated with lower ASD prevalence and delayed diagnosis (34, 101). Disparities in prevalence have narrowed over time in some US regions and are less prominent when ASD is accompanied by intellectual disability (53). In contrast, ASD diagnosis tends to correlate with factors related to lower SES in Scandinavian countries (144).

Regarding international prevalence, the World Health Organization estimated that 0.76% of the world's children had ASD in 2010 (11), though this estimate was based on studies in countries representing only 16% of the global child population (58). Other systematic reviews of prevalence studies internationally have produced similar summary estimates of approximately 0.7% (11, 57), though a review in China reported lower estimates (188). Yet, summary estimates mask considerable variability across geography, methodological approach, and time. The highest recent international prevalence estimate was 2.64% for 7- to 12-year-old children in South Korea in 2005–2009. This estimate was based on a two-stage screening-confirmation approach (99). National registries in Scandinavian countries provide a unique resource for estimating temporal trends. In 2011, ASD prevalence based on registry estimates exceeded 1% in Finland and Sweden and 1.5% in Denmark. These 2011 estimates reflect steady increases in age-specific ASD prevalence across birth year cohorts from 1990 to 2007 (6), mirroring reports in the United States (34). In Sweden, much

of the increase was attributed to improved documentation and, as seen in the CDC data, identification of milder ASD (e.g., without accompanying intellectual disability) (84). However, this and other attempts (77, 133) to dissect causes of secular trends in international ASD prevalence face similar challenges as efforts in the United States. Lastly, reliable prevalence data from developing countries are still sparse, and despite growing interest over the past decade, formal study of the influence of global cultural variations on ASD awareness and diagnosis remains limited (57, 196).

Also worth noting is that virtually all ASD descriptive epidemiology has focused on children. To date, there has been only one rigorous study of ASD prevalence in adults, conducted in England in 2007 (23). This investigation actively sampled adults from the community and used an active two-stage screening-confirmation approach to generate an estimate of 1%. ASD case-finding in population samples of adults is particularly challenging, as efficient sampling frames are far more difficult to develop, nonrisk-related birth cohort effects are magnified, and life course influences increase phenotypic variability.

GENETIC EPIDEMIOLOGY

The genetic contribution to ASD etiology is strongly supported historically by twin and family studies, with recent heritability estimates in the United States and Europe ranging from 50% to 95% (36, 76, 155). Additionally, estimates of recurrence risk among siblings of autistic children range from 3% to 18% (71, 138, 155). Over the past decade, genetic studies have been quite successful at identifying rare genetic variation, including inherited and de novo mutations and copy number variations (CNVs), related to autism or autistic features (18). However, observations of specific rare de novo and inherited CNVs have been limited to a small portion (about 10%) of children with nonsyndromic autism (47). Several strong candidate genes have been identified, including postsynaptic scaffolding genes (e.g., *SHANK3*), contactin genes (e.g., *CNTN4*), neurexin family genes (e.g., *CNTNAP2*), and chromatin remodeling genes (e.g., *CHD2*) (see **https://sfari.org/resources/sfari-gene**). As described in more detail in the section titled Genomics and Neurobiology, evidence is mounting to suggest that genetic risk variants identified among individuals with ASD converge on common genetic pathways. The cumulative effect of multiple common genetic variants, i.e., polygenic risk, is now being recognized as an important indicator of risk for ASD as well as for other psychiatric disorders (47, 65). Common variants contributing to polygenic risk in ASD are also thought to be shared, at least in part, with other neurodevelopmental and psychiatric disorders (42). Large-scale genome-wide ASD and cross-disorder association studies with enough statistical power to estimate small effects from common genetic variants are only now emerging, and they require combining data sets from multiple, large population samples.

Gene-by-Environment Interaction

Although there is a clear genetic contribution to ASD, the considerable phenotypic and genetic heterogeneity supports a multifactorial etiology. There is conflicting evidence about the contribution of environmental factors to the etiology of ASD, with some samples showing a predominant effect of additive genetic influences and others reporting a nearly equal contribution from heritable and nonheritable shared environmental factors (177). In addition, failure to accommodate heterogeneity by environmental exposure could lead to an attenuation of genetic main effect signals in traditional GWAS (genome-wide association studies).

Despite growing interest in evaluating gene-by-environment interaction (G × E) in ASD, only a few such studies have been published to date (132, 161, 183). This is due primarily to the lack

of availability of both genotype and high-quality exposure information within the same data set, combined with the need for large sample sizes in G × E analyses to avoid imprecision and false positive findings. To overcome these challenges and to increase research in this area, several investigations have begun to collect suitable data sets. Additionally, work to develop novel tools that would enable meta-G × E analyses across studies and application of recently established well-powered G × E methods (e.g., 64, 136) is underway. These approaches have had successes in other complex chronic conditions and may generalize well to ASD research.

Although published results have been few, and replication is needed, analysis of both biologically driven and genomic burden–based metrics have shown promise in identifying G × E in ASD. All three of the G × E studies published to date were based on either candidate gene or global CNV burden, as opposed to full genome-wide G × E analyses that would require millions of tests. These reports suggested interactions between the *MET* gene risk variant and prenatal exposure to air pollutants (183), variants in the one carbon metabolism pathway and maternal use of prenatal vitamins (161), and a set of ASD-associated CNVs and maternal prenatal infection (132); however, replication of these findings is necessary.

Epigenetics

Epigenetics is a term used to describe a wide range of molecular information that sits on top of the DNA sequence and regulates a diverse set of cellular processes, including imprinting, gene expression, and organismal development. In recent years, there has been increasing interest in examining epigenetic marks in ASD due to their potential mechanistic involvement in etiology, particularly to explain the effects of environmental exposure or G × E associations with ASD or to serve as biomarkers of previous exposure or disease (108). Studies have shown that DNA methylation (DNAm), a type of epigenetic change, can be controlled by genetic variation (122) and can change with exposure to environmental factors (5, 91, 110). Interestingly, Rett syndrome, fragile X syndrome, and Angelman syndrome are all caused by epigenetic dysregulation (4, 27, 141), and each shares phenotypic overlap with ASD. Epigenetic changes have been found in the brains of individuals with ASD, including hypo- and hypermethylation (109) and spreading of histone 3 lysine 4 trimethylation marks (168), as well as in DNA derived from a range of more accessible tissues. These findings highlight the future potential for epigenetics to serve as a biomarker of disease. Interestingly, rare genetic variants for ASD implicate chromatin remodeling, another aspect of epigenetic regulation. Chromatin structure has not been extensively examined in ASD, given the need for immediate processing of large amounts of biospecimen tissue.

Genomics and Neurobiology

There has been considerable focus recently on leveraging genomics to define common biological processes implicated across genetic discoveries in ASD. Analysis of rare variants linked to ASD has revealed three common biological pathways—chromatin remodeling, synaptic cell adhesion and scaffolding, and neuronal signaling and development (18, 142). Transcriptomics studies considering ASD-associated coexpression patterns in postmortem brain have identified networks of brain development genes (181) implicated in ASD and specified mid-fetal development as a critical period for initiation of ASD neuropathology (192). In addition, these studies have found networks of genes related to immune response (74, 181) and activation of M2 microglia (74) to be differentially coactivated in ASD brains, although questions remain as to whether this has etiologic implications or is a downstream consequence of other events.

ENVIRONMENTAL RISK FACTORS

Prenatal and Perinatal Factors

Systematic reviews and meta-analyses (62, 63, 72, 103) suggest more than 20 individual, familial, and pre-, peri-, and neonatal factors with some level of converging evidence for ASD risk (e.g., significant positive associations across two or more individual studies). The candidate risk factors most commonly identified over the past decade are discussed below.

Parental age. Many studies have examined ASD risk in association with parental age, particularly maternal age, and increased parental age is one of the most consistently identified perinatal risk factors for ASD (72, 85, 154). Advanced maternal and paternal age appear to independently influence ASD risk; there is also evidence for variation in risk across parental age combinations (167), as recently demonstrated in a large multinational study (157). A range of potential mechanisms may underlie these associations, including epigenetic modification, confounding by genetic liability or social determinants of reproductive age, and mediation by age-associated pregnancy risks (115).

Interpregnancy interval. Increases in risk of ASD with a short (<12 months) interpregnancy interval (IPI) have been consistently reported (30, 32, 37, 51, 52, 73, 200), and although evidence is more limited, three studies reported increased risk from long IPI (>60–84 months) (32, 52, 200). The potential mechanisms underlying such associations are unknown but are hypothesized to relate to maternal nutrient depletion, inflammation, stress, infertility, or other reproductive characteristics.

Immune factors. Maternal hospitalization with infection during pregnancy has been associated with increased risk of ASD in a few recent studies (114, 197). Evidence is mixed with regard to the importance of the type (e.g., bacterial versus viral) and timing of infection, but the largest study of more than two million individuals supported increases in risk associated with both bacterial and viral infections during pregnancy (114). These epidemiological results are consistent with animal models that demonstrate that maternal immune activation can result in autism-like phenotypes in offspring (33). As noted above, studies have also reported modification of the effect of prenatal exposure by ASD-associated CNVs (132).

Familial history of autoimmune disease has also been associated with increased risk of ASD (7, 40, 98), and these findings might suggest some shared genetic liability. Maternal immune-mediated conditions (102, 197) and autoimmune reactions could, however, also influence risk of ASD through transfer of antibodies and the impact of immune markers on the developing nervous system. Several small-sample studies have found maternal antifetal brain antibodies in subsets of ASD cases with no evidence of these antibodies in controls, as recently reviewed (61). Animal studies have demonstrated altered neurobehavioral activity in pups of dams injected prenatally with human IgG from women with ASD-affected children (130, 169).

Recent studies assessing biomarker-based evidence of differential immune function during etiologically relevant (i.e., prenatal or neonatal) windows have suggested increased ASD risk associated with altered levels of c-reactive protein (CRP) (22, 198) and other immune markers, including IFN-γ, IL-4, and IL-5 (68), in maternal sera; results for levels of immune markers measured in newborn blood spots are more conflicting (1, 105, 199). Methodological limitations in these studies, including small sample size and high correlation among immune markers, suggest the need for further work to determine the importance of individual immune markers.

Medication use. Beyond historical examples of increased ASD risk following exposure to certain medications with teratogenic properties (137), more recent associations with ASD have been reported for prenatal exposure to antidepressants, antiasthmatics [especially β-2 adrenergic receptor agonists (B2ARs)], and antiepileptics. Although considerably different in pharmacological activity, these drugs all have the ability to cross the placenta and blood–brain barrier. They can also be transferred to the child through breast milk, and animal model evidence supports neurological effects in offspring prenatally exposed (14, 17, 186). Antidepressants, particularly selective serotonin-reuptake inhibitors (SSRIs), are the medications most investigated; however, evidence is conflicting, with six studies reporting increased risk and five finding no association (66). Recent studies of antiepileptics (21, 35, 179) and B2ARs (39, 67) have consistently identified increased risk of ASD or autistic traits with exposure during pregnancy (35, 179).

Other prenatal and perinatal factors. Both lower gestational age/preterm birth (2, 107, 111, 113, 135) and small- or large-size-for-gestation appear to independently increase risk of ASD (2, 135), though these factors may also be markers or mediators of other pregnancy risks. Study results also provide general support for increased ASD risk from maternal metabolic conditions (including gestational weight gain, diabetes, and hypertension) and potentially their interplay; these conditions influence mechanisms relevant to ASD (e.g., chronic inflammation, fetal hypoxia, oxidative stress, insulin resistance) (106, 118, 119, 187).

Other factors recently examined in multiple studies less consistently associated with increased ASD risk include caesarean delivery and assisted conception. A meta-analysis of 21 studies (45) indicated a small increased risk with caesarean delivery, though subsequent studies reported no risk and possible familial confounding (43, 44). The weight of evidence suggests little or no increased ASD risk with assisted conception overall (60, 125), with sociodemographic and suspected mediating perinatal factors playing a large role in the observed modest associations (160). It is possible that risk may be elevated with some specific treatments (12, 83, 156), but adequately powered studies are needed to examine rarer therapies and separate the influence of infertility conditions from the influence of treatment itself (160).

Etiologic implications of pre- and perinatal associations. Recent studies of composite scores combining pregnancy-related conditions (51, 128) are consistent with historical reports showing that increasing numbers of suboptimal conditions in pregnancy generally pose increasing risk of ASD and adverse developmental outcomes (16, 24, 202). A number of key considerations for future research can be drawn from this finding. First, etiologic insights may be gained by investigating the underlying pathogenic mechanisms shared by multiple pre- and perinatal factors (such as immune dysregulation) (93). Further, given the lack of outcome specificity to ASD of many of these factors (143, 159), future inclusion of broader autism phenotype and comorbidity patterns may advance understanding of brain development processes that affect a range of adverse neurodevelopmental outcomes. Finally, directionality and mechanisms of causation across pregnancy risks and obstetric suboptimality, including the roles of confounding by indication (particularly for medications/treatments) and of genetic liability, deserve analytical attention and may prove etiologically informative (16, 202).

Maternal Dietary and Lifestyle Factors

Maternal prenatal diet is known to influence fetal neurodevelopment, with established associations between folic acid and neural tube defects, as well as other adverse neurodevelopmental outcomes

(15). Only recently have maternal dietary factors during pregnancy been considered in association with risk of ASD.

Folic acid and related nutrients. Two studies (one in the United States and the other in Norway) (161, 173) have suggested an approximately 40% reduction in risk for ASD with periconceptional folic acid supplement use. As mentioned above, the US study reported significant G × E interaction, with greater reductions in risk of ASD from prenatal vitamins when the children or their mothers carried gene variants leading to less efficient folate metabolism; the study also found a significant trend of decreasing ASD risk with increasing mean daily folic acid intake (163). However, a third study conducted in Denmark reported no association between preconceptional and prenatal folic acid, multivitamin use, and ASD (180). Only one study to date has measured folate blood concentrations during pregnancy (at 11–21 weeks gestation), and it found no association with ASD traits as measured by SRS scores. Differences across countries in fortification practices (38) and folate levels, genetic backgrounds [particularly of variants along the one carbon pathway previously shown to modify associations between prenatal vitamins and ASD (161)], and timing of exposure assessments could be involved in discrepant findings. Other nutrients involved in one-carbon metabolism and methylation, including vitamin B12, choline, and homocysteine, have not been specifically studied in association with ASD, but could further inform the role of the folate metabolism pathway and its cofactors. Further review of folate and ASD, including discussion of mechanisms, is provided elsewhere (48).

Other prenatal nutrients. Other nutrients have been associated with ASD, but to date their examination during the prenatal period has been extremely limited. One study reported a reduction in risk of ASD for retrospectively measured prenatal maternal iron intake (162); another suggested attention deficits, but not ASD, to be associated with lower prenatal maternal vitamin D levels (191); and another found a significant decrease in risk of ASD with higher prospectively reported prenatal polyunsaturated fatty acid (PUFA) intake (127). Maternal fish intake (127) and fish oil supplements (127, 173) (a source of PUFAs, but the former also of mercury, a known neurotoxicant) have not been associated with ASD, though statistical power was quite limited in one study. Additional epidemiologic research is needed on these and other maternal dietary factors, including more rigorously designed prospective studies incorporating biomarkers.

Alcohol and Smoking

Although smoking and alcohol consumption during pregnancy are known to cause adverse neonatal outcomes, evidence from the existing literature (which has a number of methodological limitations) suggests that maternal prenatal use of these substances does not affect ASD risk. A recent meta-analysis of 15 studies from multiple countries found no evidence that maternal smoking during pregnancy was associated with risk of ASD overall (151). Fewer studies have been conducted regarding maternal prenatal alcohol consumption, though the largest study to date found no association (55).

Environmental Chemicals

Certain environmental chemicals cross the placenta and the blood–brain barrier, accumulate in developing brains, and interfere with normal neurodevelopment. Others disrupt hormone pathways or act on inflammatory pathways that may have downstream effects on brain development. Epidemiologic investigation of environmental chemicals as potential ASD risk factors has increased

over the last decade; most of this work is being done in the areas of air pollution and potential endocrine disrupting chemicals (EDCs), topics on which we focus here.

Air pollution. Over the past decade, prenatal exposure to air pollution has emerged as a candidate risk factor for ASD, with 11 US studies published to date (13, 94, 96, 145, 148, 175, 176, 182, 184, 185, 193). These studies have generally focused on air toxics [also referred to as hazardous air pollutants (HAPs)], criteria air pollutants [including nitrogen dioxide (NO_2), ozone, and particulate matter less than 2.5 or 10 μm in diameter ($PM_{2.5}$ or PM_{10})], and traffic exposure.

The first study of HAPs and ASD, conducted in Northern California, found moderately increased risks of autism with several metals and chlorinated solvents (193). Four subsequent studies conducted in several regions have suggested risks from additional toxics and replicated some results for metals (cadmium, lead, mercury, etc.), solvents, methylene chloride and styrene, and diesel particulate matter (94, 148, 176, 185). However, the data source for these studies (the US National Air Toxics Assessment) is somewhat limited in its spatial and temporal interpretability, creating potential exposure misclassification.

For criteria air pollutants, two studies from California have suggested associations with NO_2, $PM_{2.5}$, and PM_{10} (13, 184). Studies over larger regions in the United States report increased ASD risk with increasing PM_{10} exposure (in North Carolina and Northern California) (96) and with $PM_{2.5}$ exposure (across US regions) (145, 175). Exposure assignment for these studies was based on linkages to the AirNow network, which monitors near-roadway air pollution through dispersion models, traffic density, and distance to roadways. Two of these studies specifically indicated the third trimester of pregnancy as the most important exposure window (96, 145). As mentioned above, one study also found susceptibility to NO_2 exposure to be increased by the presence of a genetic variant near the *MET* gene locus (183).

The few studies conducted outside the United States have reported disparate findings. A recent publication from a joint analysis of four European birth cohorts found no association of NO_2 exposure with ASD traits (75), and examination of the air pollution–autistic traits relationship in a Swedish twin sample yielded null results (69). In contrast, the analysis of a large cohort from Taiwan suggested increased ASD risk with higher exposures to four pollutants, including ozone and NO_2 (92). The greater variability in findings outside the United States could be related to a number of factors. The international studies have assessed ASD or related traits using different methods and at different ages than most US studies. Methods used to assess air pollution exposure were also variable across these studies, though not dissimilar to those used by some work in the United States. The US studies could also be more vulnerable to residual confounding due to social factors that correlate with both air pollution and ASD status (especially for the studies relying on community-acquired ASD diagnoses). Moreover, although these studies examined similar criteria pollutants, the levels and mix of pollutants vary across countries and regions, suggesting that the exposures may not be directly comparable.

This rapidly growing evidence base suggests that further investigation of associations between air pollution and ASD risk is warranted (189). A contemporaneous body of epidemiologic research has also supported associations between prenatal air pollution exposure and more broadly defined early life cognitive and behavioral impairment (172). In vivo and in vitro studies have begun testing potential underlying mechanisms, considering both indirect (i.e., systemic responses like immune activation or oxidative stress) and direct (i.e., small particle deposition in the developing nervous system) effects. Moving forward, epidemiologic research will need to address outcome and exposure measurement issues, as well as potential residual confounding; consider more carefully the effects of mixtures of highly correlated air pollutants; examine windows of vulnerability (which

is a challenge given high correlation in exposure across prenatal time periods); and incorporate exposure to pollutants that are unregulated and less commonly measured, such as PM < 0.1.

Endocrine-disrupting chemicals. At this point, epidemiologic evidence with respect to early life exposure to EDCs (which include environmentally persistent organic pollutants as well as certain nonpersistent chemicals) and ASD risk remains sparse, and findings are inconsistent. However, EDCs are of concern because they interfere with the activity of hormones critical in neurodevelopment (164), may interfere with immune system activity (79), and have been associated with a range of other neurodevelopmental endpoints (70). Further, exposure to EDCs is ubiquitous in developed countries (194).

Several recent studies have investigated prenatal pesticide exposures. Two studies have reported significant increases in risk of ASD traits with prenatal pesticide exposure; one found an association between maternal concentrations of a marker of organophosphate (OP) pesticide exposure and pervasive developmental disorder traits (59); the other reported an association between exposure to trans-nonochlor, an organochlorine (OC) pesticide, and ASD symptoms (19). However, a third study did not see significant associations between ASD and measured prenatal levels of two OC pesticides (126). Residential proximity both to OC pesticide applications during early gestation (149) and to OP pesticides in mid to late pregnancy (166) has been associated with ASD in two studies, though in each investigation, additional pesticides and/or metabolites considered were not statistically associated with ASD risk, producing inconsistent results for this class of chemicals.

Three studies have examined risk of ASD in relation to prenatal levels of poly-chlorinated biphenyls (PCBs). One reported a suggestive association with total PCBs (31); another found an inverse association with PCB-178 and no significant associations with other PCB congeners for autistic behaviors measured by the SRS (20); and the third and largest study found increased risk of ASD with two PCB congeners and suggestions of higher risk with a number of other congeners (126).

For other EDCs, evidence is more limited. Only one or two studies have examined prenatal exposure to measured levels of PBDEs, BPA, phthalates, and perfluorinated compounds [or surrogates of exposure (112, 140)] in association with ASD or autistic behaviors, with inconsistencies in associations both across available studies and within chemical classes (20, 120, 134).

Future studies should address the limitations of previous work by expanding sample size, incorporating data on exposure during different potential etiologic windows, and considering exposure mixtures. In addition, investigations incorporating genomic and epigenomic data might reveal susceptible subgroups, and thoughtful consideration of ASD's sexual dimorphism in the context of these hormonally acting exposures is warranted.

Other environmental chemicals. Heavy metals such as lead and mercury are established neurotoxicants with documented impacts on cognitive and developmental outcomes; some metals may also act as EDCs (104). ASD risk following prenatal exposure to mercury through fish or other sources has received little study, but it has not been associated with ASD in available evidence (127). Low-level exposure to lead in association with ASD has not been studied in depth, though work examining prenatal levels of these and other chemicals from shed deciduous teeth is emerging. The potential impacts of a range of environmental chemicals, including metals, on risk of ASD is the subject of another review (95).

Epidemiologic evidence to date has consistently shown no increased risk of ASD with vaccines (81, 129). A 2004 Institute of Medicine (IOM) report examined existing evidence (including the later-retracted article based on 12 children that initially raised concerns) and found no support for a causal link between vaccines and autism (86); serious flaws, including very small sample sizes,

lack of control groups and/or use of specialized clinical samples, and lack of confounder-adjusted statistical analyses, were noted in the few small studies with positive findings. Later IOM reports, as well as independent reviews of 67 studies in the United States and in other countries, have also consistently reported that the weight of evidence supports no association between vaccines, including the MMR vaccine or the preservative thimerosal, and ASD (81, 87, 88, 129). Finally, a recent study leveraged a large administrative database to examine MMR immunization and subsequent ASD risk in a cohort of children with ASD-affected siblings, finding no indication of any risk increase associated with vaccination in this genetically susceptible group (200).

FUTURE DIRECTIONS AND CONCLUSIONS

In the United States and the rest of the developed world, ASD is now accepted as one of the most common serious developmental conditions, and the staggering economic burden of ASD throughout the life span is now being quantified. With recent prevalence increases in ASD driven by those without cognitive impairment (9), the population impact of the condition's dimensionality and the need to support individuals with ASD having a range of abilities and disabilities are more fully recognized. The fairly consistent documentation of ASD's prevalence above 1%, combined with the emergence of initial estimates of the substantive societal costs associated with ASD, has prompted public policy responses in the United States, including the proliferation of state insurance coverage mandates for ASD services (90). At the same time, some have issued calls to rethink the perspective adopted in the definition of policies around autism services, in order to view services as more of an investment in the affected individual's future (165). Challenges in ASD descriptive epidemiology for the next decade include characterization of the impact of the shift to DSM-5; deeper exploration of the interplay of race, ethnicity, and SES on ASD distribution and addressing of diagnostic disparities related to these factors as well as to sex; more robust comparisons of ASD characteristics across sexes; and enhanced effort to describe the epidemiology of ASD over the life course and in developing nations around the world. Perhaps also in the coming decade, population-level surveillance efforts could increase tracking of key continuous traits underlying the ASD phenotype (in addition to the condition itself), which could have potentially profound implications for research and public health.

Recent developments continue to reveal complexity in the genetic epidemiology of ASD. Identification of etiologically significant rare variants has proliferated, and the field also seems poised to move into a period of common variant discovery. Although any one variant's associated attributable risk is likely small, the combined knowledge of biologic systems affected downstream contributes to an improved mechanistic understanding of ASD. In addition, given the de novo nature of many of these rare variants, these investigations may also discover modifiable determinants upstream. Initial empirical evidence supporting G × E interaction has emerged over the last decade (132, 161, 183), though replication of individual findings is needed, and combining genomic and environmental exposure information in large data sets needs to be a major research goal.

Epidemiologic investigation of potentially modifiable risk factors has grown markedly over the past decade. Multi-study bodies of evidence have established parental age and preterm birth as true ASD risk factors requiring further mechanistic dissection, and they have newly identified short IPI as a risk factor for ASD. Prenatal air pollution exposure has also emerged as a potentially modifiable risk factor of great interest (189), but one necessitating further investigation to address the gaps described above.

In addition to focused follow-up on modifiable risk factors, and continued efforts to identify new risk factors, the innovation around biomarkers of exposure and exposure response prompted

by increased interest in the field of exposomics might also catalyze further advances in the coming decade (139). The development or synthesis of large epidemiologic cohorts of children containing informative outcome data, relevant biosamples for exposomics, and available genomic data is now being put into practice; however, the extent to which ASD-related outcomes are incorporated into such cohorts and the utility of exposomics technology, including its ability to reach back into the critical windows for ASD etiology, remain to be seen. Equally important will be determining whether and how real-world mixtures of exposures may compound risk as well as identifying individual bad actors or groups of exposures that may be targets for intervention for widespread public health impact.

DISCLOSURE STATEMENT

The authors are not aware of any affiliations, memberships, funding, or financial holdings that might be perceived as affecting the objectivity of this review.

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