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THE CLINICAL IMPORTANCE OF VITAMIN D (CHOLECALCIFEROL): A PARADIGM SHIFT WITH IMPLICATIONS FOR ALL HEALTHCARE PROVIDERS

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OBJECTIVES

Upon completion of this article, participants should be able to do the following:

1. Appreciate and identify the manifold clinical presentations and consequences of vitamin D deficiency
2. Identify patient groups that are predisposed to vitamin D hypersensitivity
3. Know how to implement vitamin D supplementation in proper doses and with appropriate laboratory monitoring

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While we are all familiar with the important role of vitamin D in calcium absorption and bone metabolism, many doctors and patients are not aware of the recent research on vitamin D and the widening range of therapeutic applications available for cholecalciferol, which can be classified as both a vitamin and a pro-hormone. Additionally, we also now realize that the Food and Nutrition Board's previously defined Upper Limit (UL) for safe intake at 2,000 IU/day was set far too low and that the physiologic requirement for vitamin D in adults may be as high as 5,000 IU/day, which is less than half of the >10,000 IU that can be produced endogenously with full-body sun exposure.^{1,2} With the discovery of vitamin D receptors in tissues other than the gut and bone—especially the brain, breast, prostate, and lymphocytes—and the recent research suggesting that higher vitamin D levels provide protection from diabetes mellitus, osteoporosis, osteoarthritis, hypertension, cardiovascular disease, metabolic syndrome, depression, several autoimmune diseases, and cancers of the breast, prostate, and colon, we can now utilize vitamin D for a wider range of preventive and therapeutic applications to maintain and improve our patients' health.³ Based on the research reviewed in this article, the current authors believe that assessment of vitamin D status and treatment of vita-

min D deficiency with oral vitamin D supplements should become a routine component of clinical practice and preventive medicine. Vitamin D supplementation with doses of 4,000 IU/day for adults is clinically safe and physiologically reasonable since such doses are consistent with physiologic requirements.² Higher doses up to 10,000 IU/day appear safe and produce blood levels of vitamin D that are common in sun-exposed equatorial populations.^{1,2} Periodic assessment of serum 25-OH-vitamin D [25(OH)D] and serum calcium will help to ensure that vitamin D levels are sufficient and safe for health maintenance and disease prevention. Clinical research supporting the use of vitamin D in the management of type 2 diabetes, osteoporosis, osteoarthritis, hypertension, cardiovascular disease, metabolic syndrome, multiple sclerosis, polycystic ovary syndrome, musculoskeletal pain, depression, epilepsy, and the prevention of cancer and type 1 diabetes is presented along with our proposals for the interpretation of serum 25(OH)D laboratory values, for the design of future research studies, and for supplementation in infants, children, adults, and during pregnancy and lactation.

BASIC PHYSIOLOGY OF VITAMIN D

Vitamin D is obtained naturally from two sources: sunlight and dietary consumption. Vitamin D₃ (cholecalciferol) is the form of vitamin D produced in the skin and consumed in the diet. Vitamin D₂ (ergocalciferol), which is produced by irradiating fungi, is much less efficient as a precursor to the biologically active 1,25-dihydroxyvitamin D (calcitriol). Additionally, since ergocalciferol shows altered pharmacokinetics compared with D₃ and may become contaminated during its microbial production, it is potentially less effective and more toxic than cholecalciferol.⁴ Although ergocalciferol is occasionally used clinically and in research studies, cholecalciferol is the preferred form of supplementation and will be implied in this article when supplementation is discussed.

Vitamin D can be described as having two pathways for metabolism: one being "endocrine" and the other "autocrine" (within the cell) and perhaps "paracrine" (around the cell). This elucidation, recently reviewed by Heany,⁵ is vitally important in expanding our previously limited conception of vitamin D from only a "bone nutrient with importance only for the prevention of rickets and osteomalacia" to an extraordinary molecule with far-reaching effects in a variety of cells and tissues. Furthermore, Heany's distinction of "short-latency deficiency diseases" such as rickets from "long-latency deficiency diseases" such as cancer provides a conceptual handle that helps us grasp an understanding of the differences between the acute manifestations of severe nutritional deficiencies and the delayed manifestations of chronic subclinical nutritional deficiencies.⁵

In its endocrine metabolism, vitamin D (cholecalciferol) is formed in the skin following exposure to sunlight and then travels in the blood to the liver where it is converted to 25-hydroxyvitamin D (calcidiol, 25(OH)D) by the enzyme vitamin D-25-hydroxylase. 25(OH)D then circulates to the kidney for its final transformation to 1,25-dihydroxyvitamin D (calcitriol) by 25-hydroxyvitamin D₃-

1-alpha-hydroxylase (1-OHase).⁶ Calcitriol is the most biologically active form of vitamin D and increases calcium and phosphorus absorption in the intestine, induces osteoclast maturation for bone remodeling, and promotes calcium deposition in bone and a reduction in parathyroid hormone (PTH). While increased calcium absorption is obviously important for nutritional reasons, suppression of PTH by vitamin D is also clinically important since relatively lower levels of PTH appear to promote and protect health, and higher levels of PTH correlate with increased risk for myocardial infarction, stroke, and hypertension.^{7,8} Relatedly, Fujita⁹ proposed the "calcium paradox" wherein vitamin D or calcium deficiency leads to elevations of PTH which increases intracellular calcium and may thereby promote a cascade of cellular dysfunction that can contribute to the development of diabetes mellitus, neurologic diseases, malignancy, and degenerative joint disease.

In its autocrine metabolism, circulating 25(OH)D is taken up by a wide variety of cells that contain both 1-OHase as well as nuclear vitamin D receptors (VDR). Therefore, these cells are able to make their own calcitriol rather than necessarily relying upon hematogenous supply. Cells and tissues that are known to contain 1-OHase, and which therefore make their own calcitriol, include the breast, prostate, lung, skin, lymph nodes, colon, pancreas, adrenal medulla, and brain (cerebellum and cerebral cortex).^{3,10} Cells and tissues with nuclear, cytosolic, or membrane-bound VDR include islet cells of the pancreas, monocytes, transformed B-cells, activated T-cells, neurons, prostate cells, ovarian cells, pituitary cells, and aortic endothelial cells.¹¹ Indeed, given the wide range of cells and tissues that metabolize vitamin D in an autocrine manner, we see that there is biological potential for vitamin D to influence function and pathophysiology in a wide range of metabolic processes and disease states.

Since many cells and tissues of the body have the ability to metabolize vitamin D, we should not be surprised that vitamin D plays a role in the function of these cells. Calcitriol is known to modulate transcription of several genes, notably those affecting differentiation and proliferation such as *c-myc*, *c-fos*, and *c-sis*,⁶ and this may partially explain the inverse relationship between sun exposure (eg, vitamin D) and cancer mortality.^{12,13} Vitamin D appears to modulate neurotransmitter/neurologic function as shown by its antidepressant¹⁴ and anticonvulsant¹⁵ benefits. Vitamin D is obviously immunoregulatory as manifested by its ability to reduce inflammation,^{16,17} suppress and/or prevent certain autoimmune diseases,^{18,20} reduce the risk for cancer,¹² and possibly reduce the severity and frequency of infectious diseases, such as acute pneumonia in children.²¹

CLINICAL APPLICATIONS AND THERAPEUTIC BENEFITS OF VITAMIN D

Support for a broad range of clinical applications for vitamin D supplementation comes from laboratory experiments, clinical trials, and epidemiologic surveys. Despite the imperfections of current data, we can still see significant benefits from vitamin D supplementation in a variety of human diseases, as briefly reviewed below.

Cardiovascular Disease

Deaths from cardiovascular disease are more common in the winter, more common at higher latitudes and more common at lower altitudes, observations that are consistent with vitamin D insufficiency.²² The risk of heart attack is twice as high for those with 25(OH)D levels less than 34 ng/ml (85 nmol/L) than for those with vitamin D status above this level.²³ Patients with congestive heart failure were recently found to have markedly lower levels of vitamin D than controls,²⁴ and vitamin D deficiency as a cause of heart failure has been documented in numerous case reports.²⁵⁻²⁹

Hypertension

It has long been known that blood pressure is higher in the winter than the summer, increases at greater distances from the equator and is affected by skin pigmentation—all observations consistent with a role for vitamin D in regulating blood pressure.³⁰ When patients with hypertension were treated with ultraviolet light three times a week for six weeks their vitamin D levels increased by 162%, and their blood pressure fell significantly.³¹ Even small amounts of oral cholecalciferol (800 IU) for eight weeks lowered both blood pressure and heart rate.³²

Type 2 Diabetes

Hypovitaminosis D is associated with insulin resistance and beta-cell dysfunction in diabetics and young adults who are apparently healthy. Healthy adults with higher serum 25(OH)D levels had significantly lower 60 min, 90 min and 129 min postprandial glucose levels and significantly better insulin sensitivity than those who were vitamin D deficient.³³ The authors noted that, compared with metformin, which improves insulin sensitivity by 13%, higher vitamin D status correlated with a 60% improvement in insulin sensitivity. In a recent clinical trial using 1,332 IU/day for only 30 days in 10 women with type 2 diabetes, vitamin D supplementation was shown to improve insulin sensitivity by 21%.³⁴

Osteoarthritis

Many practitioners know that vitamin D helps prevent and treat osteoporosis, but few know that the progression of osteoarthritis, the most common arthritis, is lessened by adequate blood levels of vitamin D. Framingham data showed osteoarthritis of the knee progressed more rapidly in those with 25(OH)D levels lower than 36 ng/ml (90 nmol/L).³⁵ Another study found that osteoarthritis of the hip progressed more rapidly in those with 25(OH)D levels lower than 30 ng/ml (75 nmol/L).³⁶

Multiple Sclerosis

The autoimmune/inflammatory disease multiple sclerosis (MS) is notably rare in sunny equatorial regions and becomes increasingly prevalent among people who live farther from the equator and/or who lack adequate sun exposure. In a clinical trial with 10 MS patients, Goldberg, Fleming, and Picard³⁹ pre-

scribed daily supplementation with approximately 1,000 mg calcium, 600 mg magnesium, and 5,000 IU vitamin D (from 20 g cod liver oil) for up to two years and found a reduction in the number of exacerbations and an absence of adverse effects. This is one of very few studies in humans that employed sufficient daily doses of vitamin D (5,000 IU) and had sufficient duration (2 years). More recently, Mahon et al³⁷ gave 800 mg calcium and 1,000 IU vitamin D per day for six months to 39 patients with MS and noted a modest anti-inflammatory effect.

Prevention of Type 1 Diabetes

Type 1 diabetes is generally caused by autoimmune/inflammatory destruction of the pancreatic beta-cells. Vitamin D supplementation shows significant preventive and ameliorative benefits in animal models of type 1 diabetes. In a study with more than 10,000 participants, Hypponen et al¹⁸ showed that supplementation in infants (less than one year of age) and children with 2,000 IU of vitamin D per day reduced the incidence of type 1 diabetes by approximately 80%. Relatedly, several studies using cod liver oil as a rich source of vitamin D have also documented significant reductions in the incidence of type 1 diabetes.

Depression

Seasonal affective disorder (SAD) is a particular subtype of depression characterized by the onset or exacerbation of melancholia during winter months when bright light, sun exposure, and serum 25(OH)D levels are reduced. Recently, a dose of 100,000 IU of vitamin D was found superior to light therapy in the treatment of SAD after one month.³⁸ Similarly, in a study involving 44 subjects, supplementation with 400 or 800 IU per day was found to significantly improve mood within five days of supplementation.¹⁴

Epilepsy

Seizures can be the presenting manifestation of vitamin D deficiency.³⁹ Hypovitaminosis D decreases the threshold for and increases the incidence of seizures, and several “anticonvulsant” drugs interfere with the formation of calcitriol in the kidney and further reduce calcitriol levels via induction of hepatic clearance. Therefore, antiepileptic drugs may lead to iatrogenic seizures by causing iatrogenic hypovitaminosis D.⁴⁰ Conversely, supplementation with 4,000–16,000 IU per day of vitamin D₂ was shown to significantly reduce seizure frequency in a placebo controlled pilot study by Christiansen et al.¹⁵

Migraine Headaches

Calcium clearly plays a role in the maintenance of vascular tone and coagulation, both of which are altered in patients with migraine. Thys-Jacobs⁴¹ reported two cases showing a reduction in frequency, duration, and severity of menstrual migraine attacks following daily supplementation with 1,200 mg of calcium and 1,200–1,600 IU of vitamin D in women with vitamin D deficiency.

Polycystic Ovary Syndrome

Polycystic ovary syndrome (PCOS) is a disease seen only in humans and is classically characterized by polycystic ovaries, amenorrhea, hirsutism, insulin resistance, and obesity. Animal studies have shown that calcium is essential for oocyte activation and maturation. Vitamin D deficiency was highly prevalent among 13 women with PCOS, and supplementation with 1,500 mg of calcium per day and 50,000 IU of vitamin D2 on a weekly basis normalized menstruation and/or fertility in nine of nine women with PCOS-related menstrual irregularities within three months of treatment.⁴²

Musculoskeletal Pain

Patients with non-traumatic, persistent musculoskeletal pain show an impressively high prevalence of overt vitamin D deficiency. Plotnikoff and Quigley⁴³ recently showed that 93% of their 150 patients with persistent, nonspecific musculoskeletal pain were overtly deficient in vitamin D. Masood et al⁴⁴ found a high prevalence of vitamin D deficiency in children with limb pain, and vitamin D supplementation ameliorated pain within three months. Al Faraj and Al Mutairi⁴⁵ found vitamin D deficiency in 83% of their 299 patients with low-back pain, and supplementation with 5,000–10,000 IU of vitamin D per day lead to pain reduction in nearly 100% of patients after three months.

Critical Illness and Autoimmune/Inflammatory Conditions

Deficiency of vitamin D is common among patients with inflammatory and autoimmune disorders and those with prolonged critical illness. In addition to the previously mentioned epidemic of vitamin D insufficiency in patients with MS, we also see evidence of vitamin D insufficiency in a large percentage of patients with Grave's disease,⁴⁶ ankylosing spondylitis,⁴⁷ systemic lupus erythematosus,⁴⁸ and rheumatoid arthritis.²⁰ Clinical trials with proper dosing and duration need to be performed in these patient groups. C-reactive protein was reduced by 23% and matrix metalloproteinase-9 was reduced by 68% in healthy adults following bolus injections of vitamin D that resulted in an average dose of 547 IU per day for 2.5 years.¹⁷ A recent trial of vitamin D supplementation in patients with prolonged critical illness showed a significant and dose-dependent "anti-inflammatory effect" evidenced by reductions in IL-6 and CRP.¹⁶ However, the insufficient dose of only 400 IU per day (administered intravenously) for only ten days precluded more meaningful and beneficial results, and we present guidelines for future studies later in this paper.

Cancer Prevention and Treatment

The inverse relationship between sunlight exposure and cancer mortality was documented by Apperly in 1941.¹³ Vitamin D has anti-cancer effects mediated by anti-proliferative and proapoptotic mechanisms³ which are augmented by modulation of nuclear receptor function and enzyme action,⁴⁹ and limited research shows that synthetic vitamin D analogs may have a role in the treatment of human cancers.⁵⁰ Grant¹² has shown that

inadequate exposure to sunlight, and hence hypovitaminosis D, is associated with an increased risk of cancer mortality for several malignancies, namely those of the breast, colon, ovary, prostate, bladder, esophagus, kidney, lung, pancreas, rectum, stomach, uterus, and non-Hodgkin lymphoma. He proposes that adequate exposure to ultraviolet light and/or supplementation with vitamin D could save more than 23,000 American lives per year from a reduction in cancer mortality alone.

The aforementioned clinical trials using vitamin D in a wide range of health conditions have helped to expand our concept of vitamin D and to appreciate its manifold benefits. However, in light of new research showing that the physiologic requirement is 3,000–5,000 IU/day for adults and that serum levels plateau only after 3-4 months of daily supplementation,² we must conclude that studies using lower doses and/or shorter durations have underestimated the clinical efficacy of vitamin D. Guidelines for the critique and design of clinical trials are proposed later in this article to aid clinicians and researchers in evaluating and designing clinical studies for the determination of the therapeutic efficacy of vitamin D.

ASSESSMENT OF VITAMIN D STATUS WITH MEASUREMENT OF SERUM 25-OH-VITAMIN D

Current laboratory reference ranges for 25(OH)D were erroneously based on average serum levels for the "apparently healthy" nonrachitic, nonosteomalacic American population, a large proportion of which is vitamin D deficient. Currently, laboratories do not report optimal levels so they will mislead the practitioner unless he or she is aware of current research. For the majority of labs, the bottom of the reference range is set too low due to the previous underappreciation of the clinical benefits of and physiologic requirement for higher vitamin D levels, and the top of the range is too low due to previous misinterpretations of the research resulting in an overestimation of vitamin D toxicity.^{1,2,51,52} Therefore, new reference ranges need to be determined based on the current research, and we present our proposals in Figure 1 and in the following outline:

- **Vitamin D Deficiency: less than 20 ng/mL (50 nmol/L).**

Serum 25(OH)D levels below 20 ng/mL (50 nmol/L) are clearly indicative of vitamin D deficiency. However, several authorities note that this level appears to be too low; Heaney⁵ and Holick⁵¹ both state that 25(OH)D levels should always be greater than 30 ng/mL (75 nmol/L).

- **Vitamin D Insufficiency: less than 40 ng/mL (100 nmol/L).**

According to Zittermann,¹¹ hypovitaminosis D, wherein tissue levels are depleted and PTH is slightly elevated, correlates with serum levels of 30–40 ng/mL (75–100 nmol/L). Independently, Dawson-Hughes et al⁵³ showed that serum levels of PTH begin to elevate when 25(OH)D levels fall below 45 ng/mL (110 nmol/L) in elderly men and women, and these findings were supported by Kinyamu et al⁵⁴ who found that optimal PTH status deteriorates when 25(OH)D levels fall below 49

ng/mL (122 nmol/L) in elderly women. Therefore, in order to maintain physiologic suppression of PTH, serum levels of 25(OH)D need to be greater than 40 ng/mL (100 nmol/L).

• **Optimal Vitamin D Status: 40–65 ng/mL (100–160 nmol/L)**

Based on our review of the literature, we propose that the optimal—“sufficient and safe”—range for 25(OH)D correlates with serum levels of 40–65 ng/mL (100–160 nmol/L).⁵⁵ This proposed optimal range is compatible with other published recommendations: Zittermann¹¹ states that serum levels of 40–80 ng/mL (100–200 nmol/L) are “adequate,” and Mahon et al³⁷ recently advocated an optimal range of 40–100 ng/mL (100–250 nmol/L) for patients with multiple sclerosis. The lower end of our proposed range is consistent with suggestions by Mercola^{56,57} who advocates an optimal range of 45–50 ng/mL (115–128 nmol/L) and by Holick⁵¹ who states that levels should be 30–50 ng/mL (75–125 nmol/L). The upper end of our proposed optimal range is modified from the previously mentioned ranges offered by Zittermann¹¹ (up to 80 ng/mL [200 nmol/L]) and Mahon et al³⁷ (up to 100 ng/mL [250 nmol/L]). According to the authoritative monograph by Vieth,¹ there is no consistent, credible evidence of vitamin D toxicity associated with levels below 80–88 ng/mL (200–220 nmol/L). Vieth¹ states, “Although not strictly within the ‘normal’ range for a clothed, sun-avoiding population, serum 25(OH)D concentrations of 220 nmol/L (88 ng/mL) are consistent with certain environments, are not unusual in the absence of vitamin D supplements, and should be regarded as being within the physiologic range for humans.” Similarly, in his very thorough review of the literature, Zittermann¹¹ concludes that serum 25(OH)D concentrations up to 100 ng/mL (250 nmol/L) are subtoxic. Additional support for the safety of this upper limit comes from documentation that sun exposure alone can raise levels of 25(OH)D to more than 80 ng/mL (200 nmol/L)¹ and that oral supplementation with 10,000 IU/day (mimicking endogenous production from sun exposure) in healthy men resulted in serum levels greater than 80 ng/mL (200 nmol/L) with no evidence of toxicity.² Until more data becomes available, we have chosen 65 ng/mL (160 nmol/L) rather than 80 ng/mL (200 nmol/L) as the upper end of the optimal range to provide a safety zone between the optimal level and the level which may possibly be associated with toxicity, and to allow for other factors which may promote hypercalcemia, as discussed below. Long-term prospective interventional studies with large groups and clinical trials involving patients with vitamin D-associated illnesses (listed above) will be needed in order to accurately define the optimal range—the serum level of vitamin D that affords protection from illness but which does not cause iatrogenic complications. In reviewing much of the current literature, we found no evidence of adverse effects associated with a 25(OH)D level of 65 ng/mL (160 nmol/L), and we found that this level is considered normal by some medical laboratories⁵ and that it can be approximated and safely exceeded with frequent full-body exposure to ultraviolet light¹ or oral administration of physiologic doses of 5,000–10,000 IU cholecalciferol per day for 20 weeks.² Prospective studies and

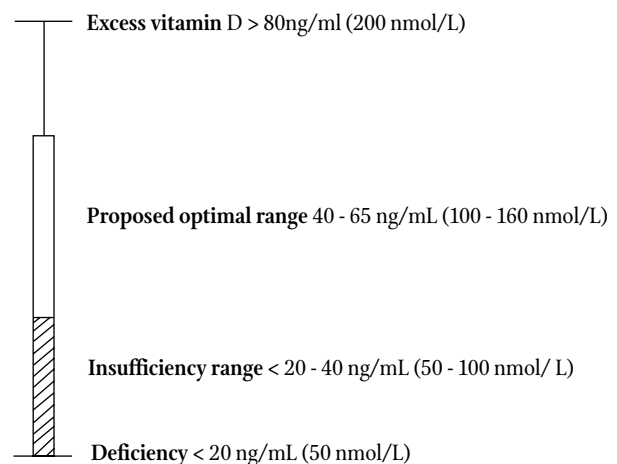
interventional clinical trials comparing different serum levels of 25(OH)D with clinical outcomes are necessary to elucidate the exact optimal range in various clinical conditions. While no acute or subacute risks are associated with the 25(OH)D levels suggested here, research shows clear evidence of long-term danger associated with vitamin D levels that are insufficient.

• **Vitamin D Excess: Serum Levels Greater than 80 ng/mL (200 nmol/L) with Accompanying Hypercalcemia**

Serum levels of 25(OH)D can exceed 80 ng/mL (200 nmol/L) with ultraviolet light exposure in the absence of oral vitamin D supplementation^{1,6} and with oral supplementation with 10,000 IU per day as previously mentioned²—in neither scenario is toxicity observed. 25(OH)D greater than 80 ng/mL (200 nmol/L) are not indicative of toxicity unless accompanied by clinical manifestations and hypercalcemia. Vieth¹ notes that hypercalcemia due to hypervitaminosis D is always associated with serum 25(OH)D concentrations greater than 88 ng/mL (220 nmol/L), and Holick⁵ previously stated, “Vitamin D intoxication does not occur until the circulating levels of 25(OH)D are over 125 ng/mL [312 nmol/L].” Assessment for hypervitaminosis D is performed by measurement of serum 25(OH)D and serum calcium.

MONITORING FOR VITAMIN D TOXICITY WITH 25(OH)D AND SERUM CALCIUM

Hypercalcemia can occur with vitamin D supplementation by either directly causing direct toxicity (rare) or by being associated with a vitamin D hypersensitivity syndrome (more common). If serum calcium becomes abnormally high, then vitamin D supplementation must be discontinued until the cause of the hypercalcemia is identified; however, direct vitamin D toxicity will rarely be the sole cause of the hypercalcemia.



* Modified from: Vasquez A. *Integrative Orthopedics: Concepts, Algorithms, and Therapeutics*. Houston; Natural Health Consulting Corporation. 2004: 417-419 with permission.

FIGURE 1. Proposed normal and optimal ranges for serum 25(OH)D levels based on current research*

The most important indicator of direct vitamin D toxicity is elevated serum calcium associated with a 25(OH)D level greater than 90 ng/ml (225 nmol/L). Elevated 1,25(OH)D levels are commonly—though not always—seen with vitamin D toxicity. Severe vitamin D intoxication is rare and usually seen only with industrial accidents, such as overdosing the fortification of milk, or with long-term administration of more than 40,000 IU of vitamin D per day. Severe hypercalcemia may require urinary acidification and corticosteroids to expedite the reduction in serum calcium.⁵⁸

Induction of vitamin D toxicity generally requires 1–4 months of 40,000 IU per day in infants.⁵⁸ In adults, toxicity generally requires several months of supplementation of at least 100,000 IU per day. Hypercalcemia appears to be the mechanism of vitamin D toxicity (rather than a direct toxic effect of the vitamin), and 25-OH-vitamin D levels may be normal in patients who are vitamin D toxic and hypercalcemic, particularly with vitamin D hypersensitivity syndrome. It has therefore been suggested that serum calcium be measured on a weekly and then monthly basis in patients receiving high-dose vitamin D. Manifestations attributable to hypervitaminosis D and hypercalcemia include anorexia, nausea, and vomiting followed by weakness, nervousness, pruritus, polyuria, polydipsia, renal impairment, and soft-tissue calcifications.

As a cause of hypercalcemia, vitamin D hypersensitivity syndromes are more common than vitamin D toxicity, and they generally arise when aberrant tissue uncontrollably produces the most active form of the vitamin—calcitriol. Primary hyperparathyroidism, granulomatous disease (such as sarcoidosis, Crohn's disease, and tuberculosis) and various forms of cancer may cause the syndrome. 25(OH)D levels are normal or even low in vitamin D hypersensitivity while serum calcium and 1,25(OH)D levels are elevated. Additional causes include adrenal insufficiency, hyperthyroidism, hypothyroidism, and adverse drug effects, particularly with thiazide diuretics. Whatever the cause, patients with persistent hypercalcemia should discontinue vitamin D supplementation and receive a thorough diagnostic evaluation to determine the cause of the problem.

Interventional Strategies to Treat Vitamin D Deficiency by Increasing Serum Vitamin D Levels

Human physiology adapted to and was shaped by a natural environment with ample exposure to sunlight.^{5, 61} Full-body exposure to ultraviolet light on clear days in equatorial latitudes can easily provide the equivalent of 4,000–20,000 IU of vitamin D.^{1, 61} Slightly longer durations of full-body sun exposure of approximately 30 minutes (3x the minimal erythemal dose) will produce 50,000 IU of vitamin D in lightly pigmented persons, while 5x longer durations are required for more darkly pigmented people to attain the same vitamin D production.⁶¹ The oral dose of vitamin D required to obtain adequate blood levels depends on latitude, sun exposure, body weight, skin pigmentation, dietary sources, efficiency of absorption, presence of intestinal disease (eg, intestinal resection or malabsorption), and medication use, for example with the vitamin D-depleting actions of common anticonvulsant drugs.⁴⁰

Past and Future Vitamin D Studies: Critique and Design

Nearly all published clinical trials have suffered from flawed design, including inadequate dosing, inadequate duration, wrong type of vitamin D (ie, ergocalciferol, D2), failure to test serum vitamin D levels, and/or failure to ensure that serum vitamin D levels entered into the optimal range. The following guidelines are provided for clinicians and researchers using vitamin D in clinical practice and research to improve the quality of research and patient care.

1. Dosages of vitamin D must reflect physiologic requirements and natural endogenous production and should therefore be in the range of 3,000–10,000 IU per day

The physiologic requirement for vitamin D appears to be 3,000–5,000 IU per day in adult males.² Full-body exposure to ultraviolet light (eg, sunshine) can produce the equivalent of 10,000–25,000 IU of vitamin D3 per day.¹ Therefore, intervention trials with supplemental vitamin D should use between 4,000 IU/day, which is presumably sufficient to meet physiologic demands, and 10,000 IU/day, which is the physiologic dose attained naturally via full-body sun exposure. Based on these physiologic criteria, we see that the majority of intervention studies in adults have used inadequate, subphysiologic doses of vitamin D. Therefore, studies that failed to identify therapeutic benefits from vitamin D supplementation were flawed due to insufficient therapeutic intervention—the dose of vitamin D was too low.

2. Vitamin D supplementation must be continued for at least 5-9 months for maximum benefit

Since serum 25(OH)D levels do not plateau until after 3-4 months of supplementation,² and we would expect clinical and biochemical changes to become optimally apparent some time after the attainment of peak serum levels, any intervention study of less than 5-9 months is of insufficient duration to determine either maximum benefit or that vitamin D supplementation is ineffective for the condition being investigated. Conversely, since vitamin D supplementation can alter intracellular metabolism within minutes of administration,¹¹ benefits seen in short-term studies should not be inaccurately attributed to statistical error or placebo effect.

3. Supplementation should be performed with D3 rather than D2

Although cholecalciferol (vitamin D3) and ergocalciferol (vitamin D2) are both used as sources of vitamin D, D3 is the human nutrient and is much more efficient in raising and sustaining serum 25[OH]D levels. Vitamin D2 is a fungal metabolite and has been associated with adverse effects due to contamination and altered pharmacokinetics.⁴ The type of vitamin D must always be clearly stated in published research reports.

4. Supplements should be tested for potency

Some products do not contain their claimed amount. This problem was illustrated in the study by Heaney et al² who found that the vitamin D supplement they used in their study, although produced by a well-known company, contained only 83% of its stated value. To ensure accuracy and consistency of clinical trials, actual dosages must be known.

5. Effectiveness of supplementation must include evaluation of serum vitamin D levels

Supplementation does not maximize therapeutic efficacy unless it raises serum 25(OH)D levels into the optimal range. To assess absorption, compliance, and safety, serum 25(OH)D levels must be monitored in clinical trials involving vitamin D supplementation. Assessment of serum levels is important also to determine the relative dose-effectiveness of different preparations of vitamin D, as some evidence suggests that micro-emulsification facilitates absorption of fat-soluble nutrients.^{56,59,60} Measurement of 1,25-dihydroxyvitamin (calcitriol) is potentially misleading and is not recommended for the evaluation of vitamin D status.

6. Serum vitamin D levels must enter the optimal range

The majority of clinical intervention studies using vitamin D have failed to use supplementation of sufficient dosage and duration to attain optimal serum levels of vitamin D. Our proposed optimal range for 25(OH)D is 40–65 ng/mL (100–160 nmol/L) and is presented in Figure 1.

The above-mentioned criteria will aid future researchers in designing interventional studies that can accurately evaluate the relationship between vitamin D status and human illness. Clinicians, who are not conducting research but rather are interested in attaining clinical improvement in their patients, should follow these guidelines as well when using vitamin D supplementation in patients, while remembering to monitor for toxicity with the triad of clinical assessments, serum 25(OH)D, and serum calcium. Clinicians and researchers need to remember, however, that optimal clinical effectiveness often depends on synergism of diet, lifestyle, exercise, emotional health, and other factors. Single intervention studies are a reasonable research tool only for evaluating cause-and-effect relationships based on the presumption of a simplistic, linear model that is generally inconsistent with the complexity and multiplicity of synergistic and interconnected factors that determine health and disease. Thus, single intervention studies with vitamin D supplementation will be useful from an intellectual standpoint insofar as they will help us to further define the role of vitamin D in human physiology and pathophysiology. However, optimal clinical results with individual patients are more easily attained with the use of multicomponent treatment plans that address many facets of the patient's health.⁵⁵

Vitamin D Supplementation in Adults

When 28 men and women were administered 4,000 IU per day for up to five months, in the absence of UVB from the sun, serum 25(OH)D levels reached approximately 40 ng/mL (100 nmol/L), and no toxicity was observed.⁴ When 67 men were administered 5,000 and 10,000 IU of cholecalciferol per day for twenty weeks, again in the absence of UVB from the sun, serum levels of 25(OH)D increased to approximately 60 ng/mL (150 nmol/L) and 90 ng/mL (225 nmol/L), respectively, and no toxicity was observed.² Therefore, given that endogenous vitamin D production following full-body sun exposure at lower latitudes can produce >10,000 IU¹ and that 4,000 IU per day is a safe level of supplementation⁴ that meets physiologic needs in adults,² we recommend at least 4,000 IU per day for adults, with efficacy and safety ensured by periodic measurement of 25(OH)D and serum calcium.

Vitamin D Supplementation in Pregnant Women

In 1966, two case reports and a brief review of the literature showed no adverse effects of 100,000 IU per day of vitamin D in hypoparathyroid pregnant women.⁶² In 1971, a study of 15 hypoparathyroid pregnant women was reported wherein the women received more than 100,000 IU per day of vitamin D with no adverse effects to the mother or child, leading the authors to conclude that there was “no risk from vitamin D in pregnancy.”⁶³ Doses of vitamin D for pregnant women were extensively reviewed by Hollis and Wagner⁶¹ immediately prior to the completion of this article, and the authors concluded that doses of 100,000 IU per day were safe for pregnant women. The authors write, “Thus, there is no evidence in humans that even a 100,000 IU/day dose of vitamin D for extended periods during pregnancy results in any harmful effects.” Data from several placebo-controlled clinical trials with pregnant women show that vitamin D supplementation results in superior health status for the mother and infant. The current daily reference intake (DRI) for vitamin D of 200–400 IU per day is therefore “grossly inadequate,” and administration of less than 1,000 IU vitamin D per day to pregnant women is scientifically unjustifiable and ethically questionable. Hollis and Wagner⁶¹ conclude that up to 4,000 IU per day is necessary for pregnant women, and this conclusion is consistent with previously cited research on physiologic requirements² and endogenous vitamin D production.¹ In order to ensure safety and efficacy in individual patients, we encourage periodic measurement of serum calcium and 25(OH)D levels.

Vitamin D Supplementation in Infants and Children

In Finland from the mid-1950s until 1964, the recommended daily intake of vitamin D for infants was 4,000–5,000 IU, a dose that was proven safe and was associated with significant protection from type 1 diabetes.⁶¹ More recently, in a study involving more than 10,000 infants and children, daily administration of 2,000 IU per day was safe and effective for reducing the incidence of type 1 diabetes by 80%.¹⁸ Thus, for infants and children, doses of 1,000 IU per day are certainly safe, and higher doses should be monitored by serum calcium and 25(OH)D levels.

Options for Raising Vitamin D Blood Levels

We have two practical options for increasing vitamin D levels in the body: oral supplementation and/or exposure to ultraviolet radiation. Sunlight is commonly unavailable on rainy or cloudy days, during the winter months, and in particular geographic locations. Topical sunscreens block vitamin D production by 97%-100%. Furthermore, since many people work indoors where sunshine is inaccessible, or they are partially or fully clothed when outside, reliance on sunshine to provide optimal levels of vitamin D is generally destined to provide unsatisfactory and inconsistent biochemical and clinical results. The use of UVB tanning beds can increase vitamin D levels; but this option is more expensive and time-consuming than oral supplementation, and excess ultraviolet radiation exposure expedites skin aging and encourages the development of skin cancer. Given the impracticalities and disadvantages associated with relying on sun exposure to provide optimal levels of vitamin D year-round, for the majority of patients, oral vitamin D supplementation is the better option for ensuring that biochemical needs are consistently met.

Vitamin D is either absent or present in non-therapeutic amounts in dietary sources. One of the only major dietary sources of vitamin D is cod-liver oil, but the amount required to obtain a target dose of 4,000 IU per day would require patients to consume at least three tablespoons of cod-liver oil, or the amount contained in >18 capsules of most commercial preparations.⁵⁵ Clearly this would be unpalatable and prohibitively expensive for most patients, and it would result in very low compliance. Additionally, such a high dose of cod-liver oil may produce adverse effects with long-term use, particularly with regard to excess vitamin A, and perhaps an increased tendency for bleeding and reduced biological activity of gamma-linolenic acid due to the high content of eicosapentaenoic acid.^{55,64} Oral supplementation with "pure" vitamin D supplements allows the dose to be tailored to the individual needs of the patient.

DISCUSSION AND CONCLUSIONS

Vitamin D is not a drug, nor should it be restricted to prescription availability. Vitamin D is not a new or unproven "treatment." Vitamin D is an endogenous, naturally occurring, photochemically-produced steroidal molecule with essential functions in systemic homeostasis and physiology, including modulation of calcium metabolism, cell proliferation, cardiovascular dynamics, immune/inflammatory balance, neurologic function, and genetic expression. Insufficient endogenous production due to lack of sufficient sun exposure necessitates oral supplementation to meet physiologic needs. Failure to meet physiologic needs creates insufficiency/deficiency and results in subtle yet widespread disturbances in cellular function which appear to promote the manifestation of subacute long-latency deficiency diseases such as osteoporosis, cardiovascular disease, hypertension, cancer, depression, epilepsy, type 1 diabetes, insulin resistance, autoimmune disease, migraine, polycystic ovary syndrome, and musculoskeletal pain. In case reports, clinical trials, animal studies, and/or epidemiologic surveys, the provision of vitamin D via sunlight or sup-

plementation has been shown to safely help prevent or alleviate all of the aforementioned conditions.

Vitamin D deficiency/insufficiency is an epidemic in the developed world that has heretofore received insufficient attention from clinicians despite documentation of its prevalence, consequences, and the imperative for daily supplementation at levels above the current inadequate recommendations of 200–600 IU.⁶⁵ For example, at least 57% of 290 medical inpatients in Massachusetts, USA were found to be vitamin D deficient,⁶⁶ and overt vitamin D deficiency was recently found in 93% of 150 patients with chronic musculoskeletal pain in Minnesota, USA.⁴³ Other studies in Americans have shown vitamin D deficiency in 48% of patients with multiple sclerosis,³⁷ 50% of patients with fibromyalgia and systemic lupus erythematosus,⁴⁸ 42% of healthy adolescents⁶⁷ and African American women,⁶⁸ and at least 62% of the morbidly obese.⁶⁹ International studies are consistent with the worldwide prevalence of vitamin D deficiency in various patient groups, showing vitamin D deficiency in 83% of 360 patients with chronic low-back pain in Saudi Arabia,⁴⁵ 73% of Austrian patients with ankylosing spondylitis,⁴⁷ up to 58% of Japanese women with Grave's disease,⁴⁶ more than 40% of Chinese adolescent girls,⁷⁰ and 40%-70% of Finnish medical patients.⁷¹ As a medically valid diagnosis (ICD-9 code: 268.9 Unspecified vitamin D deficiency) with a high prevalence and clinically significant morbidity, vitamin D deficiency deserves equal attention and status with other diagnoses encountered in clinical practice. Given the depth and breadth of the peer-reviewed research documenting the frequency and consequences of hypovitaminosis D, failure to diagnose and treat this disorder is ethically questionable (particularly in pregnant women⁶¹) and is inconsistent with the delivery of quality, science-based healthcare. Failure to act prudently based on the research now available in favor of vitamin D supplementation appears likely to invite repetition analogous to the previous failure to act on the research supporting the use of folic acid to prevent cardiovascular disease and neural tube defects—a blunder that appears to have resulted in hundreds of thousands of unnecessary cardiovascular deaths⁷² and which has contributed to incalculable human suffering related to otherwise unnecessary neural tube defects, cervical dysplasia, cancer, osteoporosis, and mental depression. Currently, Grant¹² estimates that at least 23,000 and perhaps as many as 47,000 cancer deaths⁷³ might be prevented each year in America if we employed simple interventions (ie, sunshine or supplementation) to raise vitamin D levels. Of course, additional lives may be saved and suffering reduced by alleviating the morbidity and mortality associated with hypertension, autoimmune disease, depression, epilepsy, migraine, diabetes, polycystic ovary syndrome, musculoskeletal pain, osteoporosis, and cardiovascular disease. Until proven otherwise, the balance of the research clearly indicates that oral supplementation in the range of 1,000 IU/day for infants, 2,000 IU/day for children, and 4,000 IU/day for adults is safe and reasonable to meet physiologic requirements, to promote optimal health, and to reduce the risk of several serious diseases. Safety and effectiveness of supplementation are assured by periodic monitoring of serum 25(OH)D and serum calcium.

References

1. Vieth R. Vitamin D supplementation, 25-hydroxyvitamin D concentrations, and safety. *Am J Clin Nutr.* 1999;69(5):842-56.
2. Heaney RP, Davies KM, Chen TC, Holick MF, Barger-Lux MJ. Human serum 25-hydroxycholecalciferol response to extended oral dosing with cholecalciferol. *Am J Clin Nutr.* 2003;77(1):204-10.
3. Holick MF. Vitamin D: importance in the prevention of cancers, type 1 diabetes, heart disease, and osteoporosis. *Am J Clin Nutr.* 2004;79(3):362-71.
4. Vieth R, Chan PC, MacFarlane GD. Efficacy and safety of vitamin D3 intake exceeding the lowest observed adverse effect level. *Am J Clin Nutr.* 2001;73(2):288-94.
5. Heaney RP. Long-latency deficiency disease: insights from calcium and vitamin D. *Am J Clin Nutr.* 2003;78(5):912-9.
6. Holick MF. Calcium and Vitamin D. Diagnostics and Therapeutics. *Clin Lab Med.* 2000;20(3):569-90.
7. Kamycheva E, Sundsfjord J, Jorde R. Serum parathyroid hormone levels predict coronary heart disease: the Tromso Study. *Eur J Cardiovasc Prev Rehabil.* 2004;11(1):69-74.
8. Sato Y, Kaji M, Metoki N, Satoh K, Iwamoto J. Does compensatory hyperparathyroidism predispose to ischemic stroke? *Neurology.* 2003;60(4):626-9.
9. Fujita T. Calcium paradox: consequences of calcium deficiency manifested by a wide variety of diseases. *J Bone Miner Metab.* 2000;18(4):234-6.
10. Zehnder D, Bland R, Williams MC, McNinch RW, Howie AJ, Stewart PM, Hewison M. Extrarenal expression of 25-hydroxyvitamin d(3)-1 alpha-hydroxylase. *J Clin Endocrinol Metab.* 2001;86(2):888-94.
11. Zittermann A. Vitamin D in preventive medicine: are we ignoring the evidence? *Br J Nutr.* 2003;89(5):552-72.
12. Grant WB. An estimate of premature cancer mortality in the U.S. due to inadequate doses of solar ultraviolet-B radiation. *Cancer.* 2002;94(6):1867-75.
13. Apperly FL. The relation of solar radiation to cancer mortality in North America. *Cancer Res.* 1941;1:191-5.
14. Lansdowne AT, Provost SC. Vitamin D3 enhances mood in healthy subjects during winter. *Psychopharmacology (Berl).* 1998;135(4):319-23.
15. Christiansen C, Rodbro P, Sjo O. "Anticonvulsant action" of vitamin D in epileptic patients? A controlled pilot study. *Br Med J.* 1974;2(913):258-9.
16. Van den Berghe G, Van Roosbroeck D, Vanhove P, Wouters PJ, De Pourcq L, Bouillon R. Bone turnover in prolonged critical illness: effect of vitamin D. *J Clin Endocrinol Metab.* 2003;88(10):4623-32.
17. Timms PM, Mannan N, Hitman GA, Noonan K, Mills PG, Syndercombe-Court D, Aganna E, Price CP, Boucher BJ. Circulating MMP9, vitamin D and variation in the TIMP-1 response with VDR genotype: mechanisms for inflammatory damage in chronic disorders? *QJM.* 2002;95:787-96.
18. Hypponen E, Laara E, Reunanen A, Jarvelin MR, Virtanen SM. Intake of vitamin D and risk of type 1 diabetes: a birth-cohort study. *Lancet.* 2001;358(9292):1500-3.
19. Goldberg P, Fleming MC, Picard EH. Multiple sclerosis: decreased relapse rate through dietary supplementation with calcium, magnesium and vitamin D. *Med Hypotheses.* 1986 Oct;21(2):193-200.
20. Cantorna MT. Vitamin D and autoimmunity: is vitamin D status an environmental factor affecting autoimmune disease prevalence? *Proc Soc Exp Biol Med.* 2000;223(3):230-3.
21. Wayse V, Yousafzai A, Mogale K, Filteau S. Association of subclinical vitamin D deficiency with severe acute lower respiratory infection in Indian children under 5 y. *Eur J Clin Nutr.* 2004;58(4):563-7.
22. Scragg R. Seasonality of cardiovascular disease mortality and the possible protective effect of ultra-violet radiation. *Int J Epidemiol.* 1981;10(4):337-41.
23. Scragg R, Jackson R, Holdaway IM, Lim T, Beaglehole R. Myocardial infarction is inversely associated with plasma 25-hydroxyvitamin D3 levels: a community-based study. *Int J Epidemiol.* 1990;19(3):559-63.
24. Zittermann A, Schleithof SS, Tenderich G, Berthold HK, Korfer R, Stehle P. Low vitamin D status: a contributing factor in the pathogenesis of congestive heart failure? *J Am Coll Cardiol.* 2003;41:105-12.
25. Gulati S, Bajpai A, Juneja R, Kabra M, Bagga A, Kalra V. Hypocalcemic heart failure masquerading as dilated cardiomyopathy. *Indian J Pediatr.* 2001;68(3):287-90.
26. Brunvand L, Haga P, Tangsrud SE, Haug E. Congestive heart failure caused by vitamin D deficiency? *Acta Paediatr.* 1995;84(1):106-8.
27. Kini SM, Pednekar SJ, Nabar ST, Varthakavi P. A reversible form of cardiomyopathy. *J Postgrad Med.* 2003;49(1):85-7.
28. Olgun H, Ceviz N, Ozkan B. A case of dilated cardiomyopathy due to nutritional vitamin D deficiency rickets. *Turk J Pediatr.* 2003;35(2):152-4.
29. Price DI, Stanford LC Jr, Braden DS, Ebeid MR, Smith JC. Hypocalcemic rickets: an unusual cause of dilated cardiomyopathy. *Pediatr Cardiol.* 2003;24(5):510-2.
30. Rostand SG. Ultraviolet light may contribute to geographic and racial blood pressure differences. *Hypertension.* 1997;30(2 Pt 1):150-6.
31. Krause R, Buhning M, Hopfenmuller W, Holick MF, Sharma AM. Ultraviolet B and blood pressure. *Lancet.* 1998;352(9129):709-10.
32. Pfeifer M, Begerow B, Minne HW, Nachtigall D, Hansen C. Effects of a short-term vitamin D(3) and calcium supplementation on blood pressure and parathyroid hormone levels in elderly women. *J Clin Endocrinol Metab.* 2001;86(4):1633-7.
33. Chiu KC, Chu A, Vay LWG, Saad MF. Hypovitaminosis D is associated with insulin resistance and beta cell dysfunction. *Am J Clin Nutr.* 2004;79:820-5.
34. Borissova AM, Tankova T, Kirilov G, Dakovska L, Kovacheva R. The effect of vitamin D3 on insulin secretion and peripheral insulin sensitivity in type 2 diabetic patients. *Int J Clin Pract.* 2003;57(4):258-61.
35. McAlindon TE, Felson DT, Zhang Y, Hannan MT, Aliajadi P, Weissman B, Rush D, Wilson PW, Jacques P. Relation of dietary intake and serum levels of vitamin D to progression of osteoarthritis of the knee among participants in the Framingham Study. *Ann Intern Med.* 1996;125(5):353-9.
36. Lane NE, Gore LR, Cummings SR, Hochberg MC, Scott JC, Williams EN, Nevitt MC. Serum vitamin D levels and incident changes of radiographic hip osteoarthritis: a longitudinal study. Study of Osteoporotic Fractures Research Group. *Arthritis Rheum.* 1999;42(5):854-60.
37. Mahon BD, Gordon SA, Cruz J, Cosman F, Cantorna MT. Cytokine profile in patients with multiple sclerosis following vitamin D supplementation. *J Neuroimmunol.* 2003;134(1-2):128-32.
38. Gloth FM 3rd, Alam W, Hollis B. Vitamin D vs broad spectrum phototherapy in the treatment of seasonal affective disorder. *J Nutr Health Aging.* 1999;3(1):5-7.
39. Johnson GH, Willis F. Seizures as the presenting feature of rickets in an infant. *Med J Aust.* 2003;178(9):467; discussion 467-8.
40. Ali FE, Al-Bustan MA, Al-Busairi WA, Al-Mulla FA. Loss of seizure control due to anticonvulsant-induced hypocalcemia. *Ann Pharmacother.* 2004;38(6):1002-5.
41. Thys-Jacobs S. Vitamin D and calcium in menstrual migraine. *Headache.* 1994 Oct;34(9):544-6.
42. Thys-Jacobs S, Donovan D, Papadopoulos A, Sarrel P, Bilezikian JP. Vitamin D and calcium dysregulation in the polycystic ovarian syndrome. *Steroids.* 1999;64(6):430-5.
43. Plotnikoff GA, Quigley JM. Prevalence of severe hypovitaminosis D in patients with persistent, nonspecific musculoskeletal pain. *Mayo Clin Proc.* 2003;78(12):1463-70.
44. Masood H, Narang AP, Bhat IA, Shah GN. Persistent limb pain and raised serum alkaline phosphatase the earliest markers of subclinical hypovitaminosis D in Kashmir. *Indian J Physiol Pharmacol.* 1989;33(4):259-61.
45. Al Faraj S, Al Mutairi K. Vitamin D deficiency and chronic low back pain in Saudi Arabia. *Spine.* 2003;28(2):177-9.
46. Yamashita H, Noguchi S, Takatsu K, Koike E, Murakami T, Watanabe S, Uchino S, Yamashita H, Kawamoto H. High prevalence of vitamin D deficiency in Japanese female patients with Graves' disease. *Endocr J.* 2001;48(1):63-9.
47. Falkenbach A, Tripathi R, Sedlmeyer A, Staudinger M, Herold M. Serum 25-hydroxyvitamin D and parathyroid hormone in patients with ankylosing spondylitis before and after a three-week rehabilitation treatment at high altitude during winter and spring. *Wien Klin Wochenschr.* 2001;113(9):328-32.
48. Huisman AM, White KP, Algra A, Harth M, Vieth R, Jacobs JW, Bijlsma JW, Bell DA. Vitamin D levels in women with systemic lupus erythematosus and fibromyalgia. *J Rheumatol.* 2001;28(11):2535-9.
49. Banerjee P, Chatterjee M. Antiproliferative role of vitamin D and its analogs—a brief overview. *Mol Cell Biochem.* 2003;253(1-2):247-54.
50. Trouillas P, Honnorat J, Bret P, Jouve A, Gerard JP. Redifferentiation therapy in brain tumors: long-lasting complete regression of glioblastomas and an anaplastic astrocytoma under long term 1-alpha-hydroxycholecalciferol. *J Neurooncol.* 2001;51(1):57-66.
51. Holick MF. Vitamin D deficiency: what a pain it is. *Mayo Clin Proc.* 2003;78(12):1457-9.
52. Wright JV. Vitamin D: Its Role in Autoimmune Disease and Hypertension. *Townsend Letter for Doctors and Patients.* 2004; May #250: 75-78.
53. Dawson-Hughes B, Harris SS, Dallal GE. Plasma calcidiol, season, and serum parathyroid hormone concentrations in healthy elderly men and women. *Am J Clin Nutr.* 1997;65(1):67-71.
54. Kinyamu HK, Gallagher JC, Rafferty KA, Balhorn KE. Dietary calcium and vitamin D intake in elderly women: effect on serum parathyroid hormone and vitamin D metabolites. *Am J Clin Nutr.* 1998;67(2):342-8.
55. Vasquez A. *Integrative Orthopedics: Concepts, Algorithms, and Therapeutics.* Houston; Natural Health Consulting Corporation (www.OptimalHealthResearch.com): 2004. Pages 417-419 and website updates.
56. Mercola J. Available at: <http://www.mercola.com/forms/vitaminD.htm>. Accessed July 23, 2004.
57. Mercola J. Test Values and Treatment for Vitamin D Deficiency. Available at: http://www.mercola.com/2002/feb/23/vitamin_d_deficiency.htm. Accessed July 23, 2004.
58. Berkow R, Fletcher AJ. *The Merck Manual of Diagnosis and Therapy.* Fifteenth Edition. Rahway; Merck Sharp and Dohme Research Laboratories. 1987: 928, 974-5.
59. Bucci LR, Pillors M, Medlin R, Henderson R, Stiles JC, Robol HJ, Sparks WS. Enhanced uptake in humans of coenzyme Q10 from an emulsified form. Third International Congress of Biomedical Gerontology; Acapulco, Mexico; June 1989.
60. Bucci LR, Pillors M, Medlin R, Klenda B, Robol H, Stiles JC, Sparks WS. *Enhanced blood levels of coenzyme Q-10 from an emulsified oral form.* In Faruqi SR and Ansari MS (editors). Second Symposium on Nutrition and Chiropractic Proceedings. April 15-16, 1989 in Davenport, Iowa.
61. Hollis BW, Wagner CL. Assessment of dietary vitamin D requirements during pregnancy and lactation. *Am J Clin Nutr.* 2004;79(5):717-26.
62. O'Leary JA, Klainer LM, Neuwirth RS. The management of hypoparathyroidism in pregnancy. *Am J Obstet Gynecol.* 1966;94(8):1103-7.
63. Goodenay LS, Gordon GS. No risk from vitamin D in pregnancy. *Ann Intern Med.* 1971;75(5):807-8.
64. Horrobin DF. Interactions between n-3 and n-6 essential fatty acids (EFAs) in the regulation of cardiovascular disorders and inflammation. *Prostaglandins Leukot Essent Fatty Acids.* 1991;44(2):127-31.
65. Utiger RD. The need for more vitamin D. *N Engl J Med.* 1998;338:828-9.
66. Thomas MK, Lloyd-Jones DM, Thadhani RI, Shaw AC, Deraska DJ, Kitch BT, Vamvakas EC, Dick IM, Prince RL, Finkelstein JS. Hypovitaminosis D in medical inpatients. *N Engl J Med.* 1998;338(12):777-83.
67. Gordon CM, DePeter KC, Feldman HA, Grace E, Emans SJ. Prevalence of vitamin D deficiency among healthy adolescents. *Arch Pediatr Adolesc Med.* 2004;158(6):531-7.
68. Nesby-O'Dell S, Scanlon KS, Cogswell ME, Gillespie C, Hollis BW, Looker AC, Allen C, Dougherty C, Gunter EW, Bowman BA. Hypovitaminosis D prevalence and determinants among African American and white women of reproductive age: third National Health and Nutrition Examination Survey, 1988-1994. *Am J Clin Nutr.* 2002;76:187-92.
69. Buffington C, Walker B, Cowan GS Jr, Scruggs D. Vitamin D Deficiency in the Morbidly Obese. *Obes Surg.* 1993;3:421-424.
70. Fraser DR. Vitamin D-deficiency in Asia. *J Steroid Biochem Mol Biol.* 2004;89-90:491-5.
71. Kauppinen-Makelin R, Tahela R, Lyytyniemi E, Karkkainen J, Valimaki MJ. A high prevalence of hypovitaminosis D in Finnish medical in- and outpatients. *J Intern Med.* 2001;249(6):559-63.
72. Ellis A. Inertia on folic acid has caused thousands of unnecessary deaths. *BMJ.* 2003;326(7398):1054.
73. Grant WB. Personal communication by email, "My current estimate is 47,000 premature cancer deaths/year." June 3, 2004.