A New Perspective on Vitamin D Deficiency
Meg Mangin, R.N.
Chronic Illness Recovery
May 16, 2013

Abstract

This article reviews basic vitamin D function, explores the controversy surrounding vitamin D recommendations, examines the causes of vitamin D deficiency, critiques the rationale for vitamin D supplementation, explains vitamin D toxicity, proposes a pathogenesis for impaired vitamin D status, and summarizes a strategy to restore normal vitamin D metabolism.

Vitamin D has received much attention in recent years because studies found an association between low serum 25-hydroxyvitamin D (hereafter referred to as 25(OH)D) levels and some disease states. This has caused a heated debate among experts regarding the definition of vitamin D deficiency and the amount of vitamin D necessary for health. Concerns about vitamin D deficiency merit a closer look at the current method of determining vitamin D status. Because the serum level of 25(OH)D doesn’t always reflect the level of the hormone 1,25-dihydroxyvitamin-D (hereafter referred to as 1,25(OH)2D), measuring both of these vitamin D metabolites may provide a better assessment. As analysis of the active metabolite, as well as its inactive precursor, may reveal low 25(OH)D in the presence of elevated 1,25(OH)2D and lead to a diagnosis of abnormal vitamin D endocrine function. The definition of Vitamin D deficiency needs re-evaluation in view of the fact that low serum 25(OH)D is often found in healthy persons. New research contradicts current explanations of vitamin D deficiency and studies used as evidence of the need for vitamin D supplementation are inconclusive. It’s theorized that low vitamin D is a consequence of an inflammatory process and increasing 25(OH)D via supplementation could have negative effects. A bacterial etiology pathogenesis of chronic inflammation appears to provide a rationale for an inflammatory disease process that causes low serum 25(OH)D. There are indications treatment directed at eradicating persistent intracellular infection can correct dysregulated vitamin D metabolism and restore vitamin D metabolites to normal levels.

Keywords: Vitamin D - deficiency - bacteria - D metabolites - VDR - immune system
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A New Perspective on Vitamin D

The five forms of vitamin D are collectively known as calciferol; the primary forms are vitamin D₂ and vitamin D₃. “Vitamin D” is a generic term that can mean either D₂ or D₃ and may also be used to refer to the metabolites formed from calciferol. Chemically, vitamin D is a steroid that functions as a hormone.¹ It was identified as a vitamin when it was discovered early in the 20th century because it cured rickets.² The vitamin moniker is not a complete misnomer, however, because vitamin D is an essential nutrient for those not exposed to adequate sunlight.³ Both vitamin D₂ and D₃ require ultraviolet (UV) radiation. Emissions from the sun include light, heat and UV radiation; 60% of solar UV radiation is received between 10am and 2pm daily. Sunlight is the main source of vitamin D worldwide. Artificial sources also emit UV radiation (e.g., tanning beds, halogen lights, lasers, fluorescent lights).⁴

Vitamin D₂ is photosynthesized in some invertebrates (e.g., yeasts, higher fungi, and phytoplankton, etc.) from ergosterol (an organic molecule in the steroid class). Vitamin D₂ isn’t naturally present in humans because we lack ergosterol. Because it doesn’t come from an animal product, vitamin D₂ is the form of vitamin D supplementation preferred by vegans who aren’t exposed to enough sunlight.⁵ Vitamin D₃ is called the “sunshine vitamin” because it’s photosynthesized, non-enzymatically, in the skin of vertebrates (i.e., animals with backbones) from 7-dehydrocholesterol (a steroid molecule).⁶ Photochemical regulation mechanisms in the skin prevent the formation of toxic levels of vitamin D₃. During prolonged exposure to the sun, the accumulation of previtamin D₃ is limited to about 10 to 15% of the original 7-dehydrocholesterol content because the previtamin photoisomerizes to two biologically inert photoproducts, lumisterol and tachysterol.⁷ Vitamin D₃ is photosynthesized when the UV index
is greater than 3; this occurs daily in the tropics and daily in the spring/summer of temperate regions. Brief casual exposure of the arms and face is equivalent to ingestion of 200 IU/day. 8

Animal products are the primary dietary source of vitamin D3, although there is no dietary requirement for those exposed to adequate sunlight. Fatty fish (e.g., salmon, mackerel, tuna, sardines, herring, etc.) have the highest amounts of D3; other animal products (e.g., eggs, meat, dairy foods, etc.) contain lesser amounts. Vitamin D3 can also be found in processed food that has been synthetically fortified (e.g., milk, cereals, breads, margarine, juices, etc.). 9 Vitamin D3 is available as a dietary supplement. Because the chemical processes that lead to the formation of vitamin D3 are non-enzymatic, they can take place in organic solvents (ex vivo), as well as in vivo. Therefore, vitamin D3 can be synthesized commercially by extracting cholesterol from sheep wool; chemically synthesizing it to 7-dehydrocholesterol and then irradiating it. 10 Supplemental vitamin D3 is also made from fish oil extract. 11

Vitamin D Metabolism

The metabolic processes that convert biologically inactive, parental vitamin D into active metabolites are called the vitamin D endocrine system. The key elements of this system are photo-conversion, the liver, the kidney as an endocrine gland, the vitamin D receptor (VDR) and the vitamin D binding protein (VDBP). This process begins when vitamin D3 is photosynthesized in the skin or ingested (or when D2 is ingested). Vitamin D is then transported to the liver where it’s hydroxylated by the enzyme cytochrome P4502R1 (CYP2R1) to produce 25(OH)D (25-hydroxyvitamin-D). 12 25(OH)D is then transported to the kidneys where it’s hydroxylated by an enzyme (CYP27B1 or 1a-hydroxylase) to produce 1,25(OH)2D (1,25-dihydroxyvitamin-D). 13 25(OH)D (also known as calcidiol) is the primary circulating metabolite. 14 It has a half-life of two to three weeks but it's stored in the liver and fatty tissues for later use. 15 25(OH)D is the pro-hormonal precursor to 1,25(OH)2D. Although 25(OH)D is not an active signaling molecule, it does have some biological activity. 16

1,25(OH)2D (also known as calcitriol), the active metabolite, is the most potent steroid hormone in the human body. 17 Feedback mechanisms regulate production of 1,25(OH)2D in the kidneys via serum levels of parathyroid hormone (PTH), fibroblast-like growth factor-23 (FGF23) calcium and phosphate. 15 1,25(OH)2D has a half-life of four to six hours and is also produced in many other tissues (e.g., skin, macrophages, colon, pancreas, blood vessels, etc.) by enzymatic actions. 18 The VDBP is the transport vehicle. VDBP, which is synthesized in the liver, delivers lipophilic (fat soluble) vitamin D to the liver, 25(OH)D to the kidneys and 1,25(OH)2D to the vitamin D receptor. 19 VDBP also acts as a storehouse for D metabolites and prevent vitamin D deficiency. 20 VDBP maintains stable serum stores of vitamin D metabolites and modulates the rates of its bioavailability, activation, and end-organ responsiveness. These properties may have evolved to stabilize and maintain serum levels of vitamin D in environments with variable D availability. 21

The VDR is the 1,25(OH)2D target. 22 Located in the nucleus of cells, the VDR has been identified in 37 different tissues (e.g., heart, stomach, liver, brain, skin, pancreatic islets (β cells), thyroid, parathyroid, adrenal gland, and immune cells, etc.). 23 The effects of 1,25(OH)2D are
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pleiotropic; it controls expression of over 1000 genes, and transcribes numerous proteins. When 1,25(OH)2D binds to the VDR, it heterodimerizes with the retinoid X receptor (RXR). This duo (VDR/RXR) then binds to cellular DNA (deoxyribonucleic acid) via the vitamin D response element (VDRE) to initiate a cascade of molecular actions. Transcription factors separate the DNA double helix at the correct gene location and make complementary mRNA (messenger RNA). The mRNA then returns to the cytoplasm to be translated into a specific protein by ribosomes. Consequently, genomic expression is usually activated, but it may also be repressed. VDR-activated genomic expression mediates many tissue-specific biological effects. Classical effects (e.g., calcium transport and bone health, etc.) are well known. The non-classical, extra-skeletal effects (e.g., cell differentiation, central nervous system, skin/hair, immune regulation, hormone secretion, etc.) have only been recognized for about 25 years. In addition to the classical VDR-mediated genomic pathway, 1,25(OH)2D also has been shown to elicit rapid responses. The term rapid response is used to describe the biological effects of 1,25(OH)2D that occur within a few minutes after hormone treatment and are considered too rapid to be explained by a VDR-mediated genomic pathway. Rather, the rapid responses are thought to be mediated by a direct action of 1,25(OH)2D on the plasma membrane of target cells stimulating a signal transduction pathway involving the rapid opening of voltage-sensitive Ca2+ channels and activation of protein kinases.

1,25(OH)2D regulates the immune system. VDR are present in most cell types of the immune system, particularly in antigen-presenting cells (APCs) such as monocyte, macrophages and dendritic cells. The influence of 1,25(OH)2D on the immune system is one of its most important roles. In general, the innate system is enhanced and the adaptive system is inhibited by 1,25(OH)2D. Many cells outside the kidneys contain VDR and express CYP27B1, the enzyme that catalyzes 25(OH)D to 1,25(OH)2D. In monocytes and macrophages (innate immune system), synthesis of 1,25(OH)2D from 25(OH)D promotes an antibacterial response to infection. Monocytes sense pathogen-associated molecular patterns (PAMPs) by utilizing pattern-recognition receptors (PRR), such as toll-like receptors (TLRs). Induction of CYP27B1 occurs following PAMP-sensing by TLR2/1. The inflammatory cytokine interferon γ (IFNγ) also stimulates expression of CYP27B1 by macrophages. As a result, 1,25(OH)2D production is increased in response to a pathogen immune challenge. 1,25(OH)2D activates the VDR to express antimicrobial peptides (AMPs) such as cathelicidin and beta defensins which attack pathogens. VDR immune system regulation also involves cell proliferation, differentiation and apoptosis. The VDR is also expressed in both B and T white blood cells (lymphocytes). 1,25(OH)2D modulates the adaptive immune system by inhibiting dendritic cell maturation, reducing T helper (Th) cells, and shifting Th1/Th17 cells to the Th2 and T regulatory pathways. In addition, 1,25(OH)2D inhibits Th1 cytokines that support cell-mediated immunity and promotes Th2 cytokines that support humoral immunity (antibodies circulating in bodily fluids).

Vitamin D Deficiency

The realization that vitamin D is vital for so many essential biological functions has prompted a number of current trends. There’s been an explosion in vitamin D research; more
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scientific articles have been published about vitamin D in the 21st century than about any other vitamin (there were 28,047 listed in MedLine between January 1, 2000 and December, 2012). An Internet search reveals over 600 clinical trials currently underway concerning vitamin D. Research has led to concerns about vitamin D deficiency and increased use of serum 25(OH)D testing. Karen Lusky reported, in the June 2009 Cleveland Clinic newsletter, an increase from 1,500 tests/month in 2006 to 12,000/month in 2009. Another trend is the increased use of vitamin D supplements, as reported by Alex Williams April 4, 2009 in the New York Times.

Concerns about vitamin D deficiency arose when studies showed patients with autoimmune diseases have lower levels of serum 25(OH)D and study subjects given vitamin D had lower rates of autoimmune diseases and fewer markers of inflammation. Although more people are being tested, there is no consensus on the definition of vitamin D deficiency or insufficiency and experts haven’t agreed on the significance of low 25(OH)D. In the U.S., the leading authority regarding medical research is the Institute of Medicine (IOM). Established in 1970 by the National Academy of Sciences, the IOM is an independent, non-government, non-profit organization with over 1700 volunteer members who provide evidence-based information on science, medicine, and health. IOM committees are carefully composed to assure expertise, avoid bias or conflict of interest; and their reports are reviewed by external experts. In a New York Times article on August 25, 2011, Gardiner Harris wrote, “The IOM is the most esteemed and authoritative adviser on issues of health and medicine, and its reports can transform medical thinking around the world.”

Vitamin D3 levels in human serum are rarely used to estimate cutaneous synthesis of vitamin D, partly because of the transient nature of this blood parameter and the difficulty of measuring the low levels in serum. In 1997, the IOM defined serum 25(OH)D as the functional indicator of vitamin D status. It is a biomarker of exposure and, thus, a reflection of the supply of vitamin D to the body (the net incoming contributions from cutaneous synthesis and total intake). Serum 25(OH)D can be a useful adjunct to examining the intake level of vitamin D if the measure's variability is kept in mind. However, what is not clearly established is the extent to which 25(OH)D levels serve as a biomarker of effect. Does 25(OH)D relate to health outcomes via a causal pathway and can it serve as a predictor of such health outcomes?

In 2006, the Merck Manual listed 25-40 ng/ml as the normal 25(OH)D range. Recently, this range has skyrocketed to 30-74 ng/ml, leading some to declare that half the U.S. non-institutionalized adult population is deficient, with 25(OH)D levels between 12–30 ng/ml. Quest Diagnostics now lists the upper limit of normal 25(OH)D as 100 ng/ml. Laboratory reference ranges for serum 25(OH)D levels have long been based upon average values from populations of healthy individuals but many people are now supplementing with vitamin D. The IOM report emphasized that the current measurements, or cut-off points, of sufficiency and deficiency of 25(OH) D in use by laboratories have not been set using rigorous scientific studies. They suggest that since no central authority has determined which cut-off points to use, reports of deficiency and lab ranges may be skewed and numbers overestimated.
Without a consistent normal range for serum 25(OH)D, the definitions of vitamin D insufficiency and deficiency vary greatly; indeed, some definitions of deficiency for adults are based on 25(OH)D levels associated with rickets in children (<10 ng/ml).

The Institute of Medicine definition of vitamin D insufficiency and deficiency.  
- Risk/deficiency = <12 ng/ml
- Risk/insufficiency = 12-20 ng/ml
- Sufficient = 20 ng/ml
- No benefit >30 ng/ml
- Cause for concern >50 ng/ml

The Endocrine Society definition of vitamin D deficiency and insufficiency (slightly higher).  
- Deficiency = <20 ng/ml
- Insufficiency = 20 to 29 ng/ml

The Vitamin D Council definition of deficiency and insufficiency (much higher).  
- Deficient: 0-40 ng/ml
- Sufficient: 40-80 ng/ml
- High Normal: 80-100 ng/ml
- Undesirable: > 100 ng/ml
- Toxic: > 150 ng/ml

The IOM responded to the Endocrine Society guideline, stating in part that, "aspects are not well supported and [are] in need of reconsideration." The Vitamin D Council guideline is worrisome because it is so high and refers to both adults and children. Some laboratories quote the IOM definition of deficiency in their reports but list a higher range; according to the IOM, the extent of vitamin D deficiency among the North American population has been overestimated because of inflated cut-points for serum 25(OH)D. Measurements of serum 25(OH)D also have limitations. Samples sent to different labs may yield a wide variation in results, depending on the assay used; ELISA or RIA (both are cheaper) or chromatography (reduces assay drift but isn’t standardized). Interpretation of serum 25(OH)D levels must consider factors such as diet, light exposure, illness and the potential for genetic variations (DBP, VDR, and CYP27B1) to influence the physiological and clinical impact. Most importantly, 25(OH)D may not always reflect the level of 1,25(OH)2D (the active metabolite). Measuring only 25(OH)D, and accepting it at face value, may result in a false diagnosis of vitamin D deficiency which could lead to inappropriate, and possibly toxic, supplementation.

Vitamin D recommendations. There is no recommended daily allowance (RDA) of vitamin D because it is not an essential nutrient (i.e., a substance the body can’t make). Instead, the recommendation for vitamin D is stated as adequate intake (AI) and the need for an AI is based on the absence of adequate sunlight and the presence of adequate calcium. An IOM committee met in 1997 and set the AI standard of 400 IU of vitamin D per day for adults. In 2010, after an extensive, evidence-based review of the data from all pertinent vitamin D studies, the IOM raised the recommendation:
- 600 IU daily for ages 1-70
The 2010 IOM consensus report on vitamin D was endorsed by many organizations such as the American Society for Bone and Mineral Research. Hector DeLuca, one of the most respected vitamin D researchers in the world and a member the National Academy of Scientists, agrees with the IOM guidelines but support is not universal. Proponents of vitamin D supplementation lobbied the IOM, unsuccessfully, to raise the AI much higher (2,000-10,000 IU/day) but their request was denied because the IOM saw many problems with the vitamin D research they reviewed.

Vitamin D Studies

High quality human studies of vitamin D are difficult to conduct because of the difficulty in eliminating the con-founding factor of photosynthesis. Most in vivo studies (taking place in a living organism) are murine (mouse); however, there are significant differences between murine and human biological responses. A recent analysis revealed that genomic responses in mouse models poorly mimic human immune system responses, making it difficult to study basic pathophysiological mechanisms. Using knockout mice (genetically altered to lack a functional VDR or CYP27B1) improves the study quality. The IOM noted that most vitamin D studies are observational; few are randomized or well-controlled. They’re short-term and serum 25(OH)D is used as a surrogate marker (i.e., not a true health outcome). No biological plausibility is given to explain study conclusions and often the evidence is ambiguous. Confounding variables (e.g., health consciousness, sick people remain indoors, access to medical care, etc.) are often not taken into account. The studies only show a link between low 25(OH)D and illness; researchers and clinicians understand that correlation does not equal causation. In a widely studied example, numerous epidemiological studies showed that women who were taking combined hormone replacement therapy (HRT) also had a lower-than-average incidence of coronary heart disease (CHD), leading doctors to propose that HRT was protective against CHD. But randomized controlled trials showed that HRT caused a small but statistically significant increase in risk of CHD. Re-analysis of the data from the epidemiological studies showed that women undertaking HRT were more likely to be from higher socio-economic groups, with better-than-average diet and exercise regimens. The use of HRT and decreased incidence of coronary heart disease were coincident effects of a common cause (i.e. the benefits associated with a higher socioeconomic status), rather than cause and effect, as had been supposed.

At the 15th European Congress of Endocrinology April 27 - May 1, 2013 in Copenhagen, Denmark, Mark Cooper, M.D., from the University Hospital, Birmingham, UK, a leading expert in the field of vitamin D, noted that the supposed benefits of vitamin D are exclusively reported in observational studies and there is a huge sector of the scientific community which is "evangelical" in its pro–vitamin-D stance. He commented,
We really need some robust evidence. Physicians have been here before, with many other nutrients that subsequently, in large intervention trials, turned out to have a null effect or even be harmful. In fact, there is already evidence of risks with supplements of vitamin D from randomized clinical trials, with no evidence of benefit. There have been lots of randomized controlled trials, different doses of vitamin D, different groups, all well-designed, all in major journals, and all negative. At least 1 in 20 of these studies should be positive just by chance, but we haven't seen that yet.

Meta-analysis statistics studies have attempted to make sense of multiple vitamin D studies. An analysis was done in 2012 by Loyola University Chicago Stritch School of Medicine, in which researchers explored all-cause mortality rates, across the spectrum of 25(OH)D levels, over an eighteen-year follow-up, among adults with and without kidney disease. They concluded “while significantly higher mortality rates are noted with 25(OH)D levels less than 12 ng/ml, mortality rates are fairly similar across the range of 25(OH)D levels 20–40 ng/ml.” In other words, they found no benefit to a higher level of 25(OH)D. A retrospective analysis of over 247,000 subjects in Denmark came to a similar conclusion. At the University of Copenhagen, scientists found the lowest mortality rate when 25(OH)D was 20 ng/ml. A 2013 study found parallel results; 25(OH)D in the 20-36 ng/ml range was associated with the lowest risk for mortality and morbidity. Another study found little association with vitamin D deficiency and autoimmune conditions, challenging the assumption that serum levels of 25(OH)D are a sensitive measure of the autoimmune disease state.

Vitamin D proponents

Despite conflicting study results and the IOM recommendation, vitamin D proponents continue to exhort people to take vitamin D supplements. Joe Mercola, the founder and editor of an alternative medicine website visited by thousands of people daily, stated, “A lack of this wonder nutrient can set the stage for no fewer than 33 disorders, including autism, cancer, diabetes and infertility.” Referring to vitamin D as a nutrient is a serious error and Dr. Mercola failed to point out that evidence for his claims is inconclusive. Dr. Michael Holick, a leading vitamin D researcher and director of the Vitamin D, Skin and Bone Research Laboratory at Boston University School of Medicine stated, "There's overwhelming evidence ...that increasing your vitamin D intake can make substantial improvement in your overall health and welfare. There is no downside to increasing your vitamin D intake.” However, it’s premature to claim there is no downside to taking a steroid that has not been studied long-term because the evidence does not yet support vitamin D supplementation. Proponents may also oversell the study findings. For example, Mercola's website headlined an item on a new study this way: "Vitamin D fights Crohn's disease". But the lead researcher, Dr. John White of the Research Institute of McGill University Health Center in Montreal, said the data came from a lab study that "will have to be borne out in the clinic, which may be tricky. Data is coming, but there's a good reason to be skeptical — people have been on this bandwagon before. When it gets into the clinic, it often doesn't work out quite as well."

Thankfully, some experts are advising caution regarding recommendations made based on observational studies. In his August 4, 2009 presentation “Weighing Scientific Evidence” at
the IOM Information Gathering Workshop for Dietary Reference Intakes for Vitamin D and Calcium, Dr. Barry Kramer (Office of Disease Prevention, NIH) urged caution by quoting the Scottish philosopher David Hume (1711-1778) "A wise man proportions his belief to the evidence". In a May 10, 2010 Chicago Tribune article Julie Deardorff quoted two other vitamin D experts. Anastassios Pittas (endocrinologist at Tufts University Medical Center, Boston) stated, "It's premature to go out and make a big deal out of vitamin D supplementation when we don't have the evidence. We've been burned before on nutrition-based interventions." Dr. Ethan Balk (Center for Clinical Evidence Synthesis) cautioned, "There's a potentially large problem with leaping from observational studies to making decisions about interventions." In a Journal of the National Cancer Institute editorial Davis and Dwyer concluded, "While vitamin D may well have multiple benefits beyond bone, health professionals and the public should not, in a rush to judgment, assume that vitamin D is a magic bullet and consume high amounts of vitamin D. More definitive data on both benefits and potential adverse effects of high doses are urgently needed."

Unfortunately, the media have confused the public by only publishing headline-pleasing conclusions instead of reporting the conflicting scientific data surrounding a complicated issue. The Vitamin D Council is the most vocal source of information urging the public to take more vitamin D. This non-profit organization was founded in 2003 by John J. Cannell, M.D., a practicing psychiatrist with a history of activism in various causes. His website (www.vitaminincouncil.org) markets vitamin D₃ as a nutrient and enables him to sell his book on vitamin D, as well as vitamin D supplements and vitamin D test kits. Dr. Len Lichtenfeld (Deputy Chief Medical Officer for the national office of the American Cancer Society) countered Vitamin D Council claims in his online blog with this statement:

When we succumb to making every medical decision solely on the basis of the strongest advocate’s voice, we run the risk of moving medical practice back into an era similar to that from which we are trying to emerge. If the review and research studies confirm Dr. Cannell’s position, that will be welcome. But we need to once and for all establish the science-based evidence that will conclusively answer the question one way or the other, rather than relying on advocacy to establish dietary and medical practice recommendations for the world.

Apparent conflicts of interest are not unusual among the most vocal vitamin D proponents. Some of Holick’s research was supported by the UV foundation which is funded by the tanning bed industry. Dr. Robert Heaney (an endocrinologist at Creighton University in Omaha) has authored vitamin D studies funded by Smith/Kline/Glaxo, spoken on behalf of Proctor & Gamble, and sat on the board of a dairy association. Dr. Reinhold Vieth (a biochemist from Toronto) has co-authored vitamin D studies with vitamin D lobbyists and his wife has a business selling vitamin D supplements. Americans spend $20 billion annually for dietary supplements; it's estimated that if just 1/3 of the Canadian population followed Vieth's recommendation, sales of vitamin D supplements would increase by $2 billion annually. Other vitamin D proponents have more obvious commercial interests. Dairy farmers' associations fund vitamin D studies. Food manufacturers are eager to add vitamin D to their products and promote them as healthier in order to increase sales. Vitamin D is big business; in 1925, the first vitamin D patent made the
University of Wisconsin the richest chemistry department in the world. The Wisconsin Alumni Research Foundation now holds 162 vitamin D patents, which contribute about $45 million per year to the University. Many others are eager to share in the profits; the U.S. patent office has over 1,000 patent entries for vitamin D analogs or vitamin D testing.

**Purported Causes of Vitamin D Deficiency**

Vitamin D proponents reiterate many reasons why they believe the general population is unable to obtain enough vitamin D without the aid of supplementation. These beliefs are often based on outdated or limited studies and can be challenged with more recent research.

**Skin pigmentation.** The ‘early man’ theory of low vitamin D posits that melanin pigmentation evolved in people living near the equator to prevent the excessive production of vitamin D due to constant exposure to sunlight. As people migrated away from the equatorial regions, their sunlight exposure was shortened and, in order to allow adequate production of vitamin D and prevent rickets, the melanin levels in their skin diminished. This evolutionary rationale for low serum 25-D levels is highly speculative. Potts, paleoanthropologist and curator of anthropology at the Smithsonian’s National Museum of Natural History, points out, “The study of human evolution has long sought to explain major adaptations and trends that led to the origin of Homo sapiens. Environmental scenarios have played a pivotal role in this endeavor. They represent statements or, more commonly, assumptions concerning the adaptive context in which key hominin traits emerged. In many cases, however, these scenarios are based on very little if any data about the past settings in which early hominins lived.” Robins disputes the idea that light skin evolved to allow more vitamin D production. Other critics of this hypothesis point out there are no reported cases of hypercalcemia secondary to vitamin D toxicity as a sole consequence of prolonged sun exposure (i.e., photosynthesis of D₃ is stopped at normal levels by a protective regulation mechanism in the skin). Many factors (e.g., protection of sweat glands, sunburn, frostbite, skin cancer, defense against microorganisms, etc.) may have played a role in the evolution of skin color. One study found evidence that low vitamin D levels among Africans may be due to genetic variation tied to African ancestry but genetic studies of Caucasians have found no link to skin pigmentation. Even prominent experts are in seeming disagreement about the role skin pigmentation plays in vitamin D production. Believing our dark-skinned ancestors produced higher 25(OH)D levels than modern man, Heaney opined, “It is highly likely that values of 32-60 ng/ml reflect the status in which human physiology developed.” While Holick reports, “Increases in skin pigmentation markedly diminish the production of vitamin D.”

A number of studies have established the relationship of skin pigmentation to the capacity to produce vitamin D following UVB exposure but the results are not consistent. This study concluded, “…in blacks and whites, UVB exposure produces similar elevations of serum 25(OH)D concentrations and unchanged calcitropic hormones concentrations.” Low 25(OH)D levels in Indians living in India and Chinese in China does not support the hypothesis that low levels seen in people with more pigmentation are due to lack of photosynthesis from the sun at higher latitudes. Other studies have shown that the response to UV dose is non-linear and also dependent on genetic factors, dose of UV exposure, and
baseline serum 25(OH)D levels. Melanin pigmentation is only one factor that determines the amount of vitamin D₃ which is photosynthesized. As early as 1994, it was known “The skin of some vertebrates contains lower quantities of 7-dehydrocholesterol and its photochemical conversion to cholecalciferol is quite inefficient.” In 2010, researchers at the Department of Dermatology in Copenhagen, Denmark measured the baseline serum 25(OH)D and total cholesterol levels of 182 fair-skinned and dark-skinned subjects; and studied the effect of UV radiation on their serum 25(OH)D levels. They found the amount of serum 25(OH)D produced was determined by the amount of cholesterol in the skin, not on skin pigmentation. Most importantly, skin pigmentation doesn’t negatively affect vitamin D status. Persons with dark skin compensate for low 25(OH)D by rapidly converting it to the active 1,25(OH)₂D metabolite, thus allowing them to maintain adequate vitamin D status. Matsuoka et al investigated the effect of racial pigmentation on vitamin D₃ formation, simulating the process with a fixed dose of UVB radiation and concluded that while racial pigmentation has a photo-protective effect, it does not prevent the generation of normal levels of active vitamin D metabolites. The concern about dark skin and vitamin D deficiency appears to be misplaced.

**Latitude.** An early study done in Boston and Canada is often cited to support the conviction that latitude dramatically influences the amount of solar radiation available to synthesize vitamin D₃. However, authorities who conducted recent studies refute this hypothesis. Kimlin concluded, “It may no longer be correct to assume that vitamin D levels in populations follow latitude gradients.” And Lubin stated, “Geophysical surveys have shown that UV-B penetration over 24 hours, during the summer months at Canadian north latitudes when there are many hours of sunlight, equals or exceeds UV-B penetration at the equator.” In addition, our bodies have mechanisms for preserving the vitamin D we acquire during the summer; which have evolved to stabilize and maintain serum levels of vitamin D in environments with variable vitamin D availability. The DBP optimizes and stores 25(OH)D for later use; it also binds 1,25(OH)₂D, as well as the parental vitamin D itself. DBP sequesters vitamin D sterols in the serum, prolongs their serum half-lives, and provides a circulating store of vitamin D to meet transient periods of deficiency. The IOM states, "Ample opportunities exist to form vitamin D (and store it in the liver and fat) from exposure to sunlight during the spring, summer, and fall months even in the far north latitudes.”

**Clothing and sunscreen.** Clothing is a barrier to ultraviolet radiation but this is an issue only for people who cover themselves from head to toe (e.g., woman who wear a burka may not be exposed to sufficient sunlight). It takes relatively little sunlight exposure to acquire adequate stores of vitamin D and few people wear enough clothes to prevent that from happening. The National Institutes of Health (NIH) advises, “Ten to 15 minutes of sunlight or daylight exposure to a small area of skin (e.g., the forearm or face, etc.) twice a week (without sunscreen) supplies all the vitamin D necessary for health.”

The belief that sunscreen lotion blocks vitamin D production is based on a 1987 study funded by the ultraviolet foundation, which is supported by the tanning bed industry. More accurate information was provided by a 2010 study which concluded: “Emerging evidence suggests that although sunscreens are effective, many may not actually be blocking UV-B because they are improperly or inadequately applied. Thus, sunscreen use may not actually
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diminish vitamin D synthesis in real world use.” As reported by ABC News on May 21, 2009, (according to a survey of 1,000 adults by the Consumer Reports National Research Center) 31 percent of Americans reported not using sunscreen, while 69 percent were occasional users. In the ABC News report, Dr. Michele McDonald, a dermatologist and assistant professor of medicine at Vanderbilt University Medical Center in Nashville, Tenn., stated that recent concerns about regular sunscreen use limiting vitamin D intake are unfounded. "If you're out and you're getting sun, you're getting vitamin D; after 30 to 40 minutes, it's getting through [sunscreen]." Although dermatologists express concern about UV radiation leading to skin cancer, the amount of sun exposure required to produce adequate vitamin D is unlikely to damage skin cells. Vitamin D compounds have a protective effect against DNA photo damage. Dr. Robyn Lucas, an Australian epidemiologist stated, “Far more lives are lost to diseases caused by lack of sunlight than by those caused by too much.”

Pollution, tall buildings, shade and clouds. Although pollution can block some ultraviolet radiation, even in urban areas of high pollution 50% of UV rays reach the ground. This study concluded, "Reductions in atmospheric ozone, due to pollution, are expected to result in higher amounts of UV-B radiation reaching the earth's surface." A significant amount of UV radiation exposure can be obtained in dense metropolitan areas. Tall buildings provide shade but shade gives up to 50% of UV rays. Indoor workers receive 10% to 20% of outdoor workers’ yearly UV exposure; and for many, this may be adequate, especially if sunlight exposure is higher when they are not working. UV radiation is reflected or scattered to varying extents by different surfaces. For example, fresh snow can reflect as much as 80% of UV radiation, sand about 25% and UV radiation is still 40% as intense at half a meter under water. UV radiation levels are highest under cloudless skies but even with cloud cover, UV levels can be high. The scattering and absorption of light by clouds may not significantly reduce natural light exposure because over 90% of UV rays may penetrate clouds. Scattering can have the same effect as the reflectance by different surfaces and thus increase total UV radiation levels. These environmental factors are rarely an impediment to photosynthesis of adequate vitamin D.

Elderly skin and diet. As the skin ages, there is a decline in the cutaneous levels of 7-dehydrocholesterol, resulting in a marked reduction of the skin’s capacity to produce vitamin D3. However, despite the up to fourfold reduction in vitamin D3 production in a 70-year-old compared to a 20-year-old, the skin has such a high capacity to make vitamin D3, elders exposed to sunlight will produce an adequate amount of vitamin D3 to satisfy their vitamin D requirement.
Natural processes favor photosynthesis but, in many developed countries, it’s possible to obtain the recommended vitamin D AI, or a substantial portion of it, from food. A typical Western diet contains many foods that are fortified with vitamin D and some that naturally contain vitamin D (e.g., eggs, fatty fish, cheese, etc.), making it relatively easy to ingest a significant amount. For example, food commonly eaten in one day (3 cups of milk, 1 serving of fortified cereal, 1 cup of fortified juice and 3 ounces of cheese) supplies 600 IU of vitamin D – the AI for those who are not exposed to sunlight in the Spring or Summer.

**Hypovitaminosis-D**

Studies of healthy subjects have found levels of 25(OH)D that, by some vitamin D expert's standards, are declared deficient (hypovitaminosis-D). 109

- In a 2009 meta-analysis of studies on healthy subjects worldwide, the mean 25(OH)D was 21.62 ng/ml. 110
- In a 2006 study, 80% of healthy Bangladeshi women had a 25(OH)D level under 16 ng/ml. 111
- A 2011 study found healthy young female hospital employees in Oman had 25(OH)D levels below 20 ng/ml. 112
- Among healthy young adults in India, a 2011 study found the average level of 25(OH)D was 17.4 ng/ml. 113
- A 1992 study found healthy full-term infants in China had 25(OH)D levels of 5-14 ng/ml and none developed rickets. 114
- A 2012 study of Saudi medical students found the mean 25(OH)D level was 10.74 ng/ml in males and 6.42 ng/ml in females. 115
- The average 25(OH)D level of a cross-section of healthy Calgary citizens, in 2002, was 23 ng/ml. 116

Vitamin D levels that are considered deficient have even been found in persons who are exposed to abundant sunlight. In 2007, a study showed a mean 25(OH)D level of 31.6 ng/ml among healthy young adult Hawaiian surfers. 117 This finding is a good illustration of the action of regulatory mechanisms in the skin which prevent overproduction of vitamin D₃.

**Low Vitamin D May be Normal**

It’s clear that low levels of 25(OH)D are found in both healthy persons and those with autoimmune or chronic inflammatory diseases. Opposing reasoning can be used to explain this contradiction. One explanation reasons that healthy persons with low 25(OH)D will become sick; however, studies don’t support this hypothesis. The more logical explanation may be that, in the absence of disease, low 25(OH)D is normal.

A couple conundrums also support the thesis that low 25(OH)D is normal in healthy persons. Breast milk, unarguably the perfect food, is low in vitamin D and remains relatively low
even when lactating mothers take very high doses of vitamin D. However, the vitamin D biological activity may be higher than the analyzed values, because human milk contains small amounts of 25(OH)D in addition to vitamin D; further, the biological activity of 25(OH)D is approximately 50 percent higher than that of vitamin D. Secondly, studies show “blacks have higher adjusted bone mineral density than whites and a slower age-adjusted annual rate of decline in bone mineral density.” In data from the National Health and Nutrition Examination Survey (NHANES), very few white children aged 1-12 years are vitamin D deficient, using the classic threshold of 15 ng/ml. In contrast, about 10% of non-Hispanic black 1-6 year olds are vitamin D deficient, as are close to 30% of those in the 7-12 years old age bracket. If vitamin D deficiency is rampant in blacks, why do they have greater bone strength and muscle mass, on average, than whites? Perhaps the answer to both these puzzles is that low vitamin D is not a sign of deficiency in healthy individuals.
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Figure 1

Since low 25(OH)D is found in both healthy persons and those with autoimmune or chronic inflammatory diseases, assessing vitamin D status with measurement of an additional clinical marker may be helpful. It is assumed that low levels of 25(OH)D accurately indicate vitamin D status; (i.e., vitamin D storage and VDR-mediated control of calcium metabolism and innate immunity). However, measurement of 1,25(OH)2D often demonstrates a positive correlation of elevated 1,25(OH)2D to inflammatory diseases. This is illustrated by a study, done in Vancouver, of 100 patients with autoimmune and chronic disease which found 85% of subjects had levels of 1,25(OH)2D higher than 46.2 pg/ml without hypercalcemia. Although this serum level may be considered normal by some, lab ranges for 1,25(OH)2 (e.g., 18-72 pg/ml) may have been skewed high by the presence of patients with unrecognized dysregulated vitamin D metabolism. The Danish 1,25-D population data (from a large and reliable study) found the mean value for 1,25-D in a normal
population was 29 pg/ml with a standard deviation of 9.5. More frequent measurement of both D-metabolites in the clinical and research settings, may shed light on the real meaning of low 25(OH)D.

**Vitamin D Supplementation**

In recent years, dietary supplements containing vitamin D have been more frequently consumed. In the United States, vitamin D can now be found in multi-vitamin/multi-mineral formulations as well as a single supplement in a range of dosage levels; including 1,000 to 5,000 IU of vitamin D₃ per dose and even up to 50,000 IU of vitamin D₂ per dose. The impetus for the upsurge in supplementation is the hope that it might protect against a broad range of chronic diseases; including cancer, cardiovascular disease, osteoporosis and autoimmune disease. However, that hope is driven mostly by epidemiologic data, which should be viewed as hypothesis-generating rather than definitive.

**Vitamin D and Cancer**

Evidence for a beneficial effect of vitamin D supplementation in cancer is lacking. In 2011, the U.S. Preventive Services Task Force analyzed 28 observational studies for cancer outcomes and stated, “Evidence is not sufficiently robust to draw conclusions regarding the benefits or harms of vitamin D supplementation for the prevention of cancer.” This statement was based on the results of a variety of cancer and vitamin D studies. The Iowa Womens’ Health study showed protection against breast cancer in the first five years but noted the effect was lost after ten years; illustrating the importance of long-term studies before conclusions are made. The findings of a large prospective study in 2008 do not support the claim that vitamin D is associated with decreased risk of prostate cancer; in fact, higher circulating 25(OH)D concentrations may be associated with increased risk of aggressive disease. On March 5, 2013, the U.S. Food and Drug Administration (FDA) advised that marketing of calcitonin nasal spray for the treatment of osteoporosis be stopped, citing lack of benefit and concerns about a possible cancer risk.

**Vitamin D and Cardiovascular Disease**

There’s no conclusive evidence vitamin D supplementation affords protection against heart disease. A randomized, placebo-controlled study, done at Rockefeller University in New York, found vitamin D supplementation failed to improve lipid profiles and elevated 25(OH)D was associated with carotid and aorta artery plaque in a 2012 study. At a symposium sponsored by the American College of Rheumatology Dr. Lenore Buckley (professor of internal medicine at Virginia Commonwealth University) commented on the study:

One of these concerns is that not all of the extra calcium absorption promoted by boosting vitamin D is going into bone to prevent fractures. Some of it may actually be taken up by atherosclerotic plaque, increasing the risk of cardiovascular events. The
question we have to ask is: What does that low serum vitamin D level mean? Is it the thing that predisposes, or is it somehow a byproduct of illness?

Regarding supplementation to prevent cardiovascular disease, Dr. Whayne (Professor of Medicine-Cardiology, Gill Heart Institute, University of Kentucky, Lexington, KY) concluded, “…potential benefit of supplementation must be weighed against the current absence of definitive outcomes studies.”

**Vitamin D and Rickets**

Rickets is a softening of bones in children due to deficiency or impaired metabolism of vitamin D, phosphorus, or calcium. Hypophosphatemia is the common denominator of all rickets; low calcium intake leads to hyperparathyroidism, which leads to high phosphorus excretion and, thus, phosphorus deficiency. Adequate vitamin D is essential to prevent rickets, but adequate calcium is equally important; if either calcium or vitamin D is deficient, bone health suffers. Rickets is rare in the developed world; however, children in developing countries, who usually photosynthesize enough vitamin D from sunlight, develop rickets if poverty prevents them from eating enough calcium rich food. Studies found rickets occurs in sunny countries due to poor calcium intake and is cured with increased calcium ingestion.

**Vitamin D and Osteoporosis**

Osteoporosis is a bone disease characterized by a decrease in bone mineral density and the appearance of small holes in bones due to loss of minerals. Vitamin D is an important factor in maintaining bone health to avoid osteoporosis. Precise maintenance of the physiologic levels of both extracellular and intracellular ionized calcium is essential to life and 1,25(OH)2D maintains calcium homeostasis between blood, cells and bones by stimulating calcium absorption from the intestines, reabsorption in the kidneys, and resorption in bones. 1,25(OH)2D up-regulates VDR in the small intestine, which then transcribes genes that shuttle calcium and phosphorus through the intestinal epithelium. But mucosal response and calcium/phosphorus absorption is dependent on a competent VDR and elevated 1,25(OH)2D reduces VDR competence. Thus, calcium and phosphorus absorption may be inhibited if VDR function is impaired by elevated 1,25(OH)2D.

Although some studies show vitamin D and calcium supplements increase bone density slightly and decrease the risk of falls and fractures in certain populations, the quality of evidence is poor. A 2013 report by the U.S. Preventive Services Task Force recommends against vitamin D supplementation for the primary prevention of fractures in non-institutionalized, pre or post-menopausal women or older men. The 2005 RECORD study concluded, “…routine supplementation with calcium and vitamin D3, either alone or in combination, is not effective in the prevention of further fractures in people who had a recent low-trauma fracture.” A similar study stated, “We found no evidence that calcium and vitamin D supplementation reduces the risk of clinical fractures in women with one or more risk factors for hip fracture.” A 2008 study found, “Vitamin D supplementation adds no extra short-term skeletal benefit to calcium
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citrate supplementation even in women with vitamin D insufficiency.” 156 And a 2010 study at the Bone Mineral Research Center, Winthrop University Hospital, Mineola, NY showed that “Additional intake of 100 mcg vitamin D₃ did not lower PTH or markers of bone turnover.” 157

**Elevated 1,25(OH)₂D may cause osteoporosis.** In fact, there is ample evidence that elevated 1,25(OH)₂D leads to bone loss. In 1999, Brot et al 158 found “…elevated levels of 1,25(OH)₂D were strongly associated with decreased bone mineral density and content, and increased bone turnover.” When levels are above 42 pg/ml 1,25(OH)₂D stimulates bone osteoclasts. This leads to osteoporosis, dental fractures and calcium deposition into the soft tissues: lungs, breasts, muscle bundles, kidneys.” 159 An earlier study warned, “Vitamin D is a toxic compound, and excessive amounts can cause soft-tissue calcification. There is a narrow leeway between the amount required and that initiating tissue damage.” 160 Kawamori et al 161 found that, “Elevated 1,25(OH)₂D induces increased production of osteoclasts from stem cells.” The EMAS study found that “A combination of high 1,25(OH)₂D and low 25(OH)D is associated with the poorest bone health.” 162 This significant evidence regarding bone loss should motivate medical practitioners and researchers to measure both 25(OH)D and 1,25(OH)₂D to determine vitamin D status.

**Vitamin D and Autoimmune Disease**

The cause of autoimmune disease is unknown; the popular hypothesis states that an overactive immune system produces auto-antibodies against self. A logical alternate hypothesis posits a bacterial etiology in which a persistent intracellular infection causes a cytokine release that induces signals to T cells and B cells, and the antibodies they produce (to the intracellular invader) include some that attack human proteins, as well as target the pathogens. 163 Hintermann explored the second hypothesis: “In theory, a structural similarity or identity between the host and an invading pathogen might cause the immune system of the host to react not only to the pathogen but also to self-components.” 164 Infections can act as environmental triggers inducing or promoting autoimmune disease in genetically predisposed individuals; this study demonstrated how antinuclear antibodies (ANA) are created in response to infectious agents. 165 Microbial and human metabolites often have very similar structures; and interactions between human and bacteria genomes may make it difficult for the body to distinguish “foreign” from “self”. Infections (bacterial, viral and parasitic) are known to induce and exacerbate autoimmune diseases, mainly by the mechanism of molecular mimicry.” 166

Vitamin D reduces autoimmune disease symptoms via immune system suppression. 167 Vitamin D inhibits pro-inflammatory processes by suppressing the enhanced activity of immune cells that take part in the autoimmune reaction. 168 Exposure to ultraviolet light, especially UV-B wavelengths, can impair immune responses in animals and humans. 169 Seasonal variation can have an impact on the immune response; in the summer, when vitamin D₃ is highest, 1,25(OH)₂D down-regulates the immune system. 170 Reduced immunity following exposure of skin to UV radiation may explain the positive latitude gradient measured for a number of autoimmune diseases (decreased incidence of disease with residence at lower latitudes). 171 As a result of vitamin D immuno-suppression inflammation, clinical disease markers and symptoms of autoimmune disease are reduced but this doesn’t treat the underlying cause and relapse is
common. Unfortunately, some researchers believe immuno-suppression is a good thing. Much of current research focuses on finding drugs to suppress inflammation but, according to Francis S. Collins (NIH director), 95% of these studies have failed. It seems clear a better direction is needed.

**Effect of Vitamin D Supplementation**

Despite vitamin D supplementation chronic diseases have increased. More foods than ever before are fortified with vitamin D; the Nutrition Business Journal reported sales of vitamin D supplements have skyrocketed to $425 million in 2009 from just $40 million in 2001. Vitamin D supplement proponents promised double digit declines in chronic disease yet, Between 2000 and 2010, the percentage of adults aged 45-64 (and 65+) with two or more (of nine selected) chronic conditions, increased for both men and women, all racial and ethnic groups examined, and most income groups. As reported by the Partnership to Fight Chronic Disease, more than one in four Americans lives with multiple chronic conditions, including one in 15 children. Almost $2 out of $3 spent on health care in the U.S. is directed toward care for the 27% of Americans with multiple chronic conditions and chronic illness is expected to continue increasing.

The research evidence supports a positive role for vitamin D supplementation in bone health but not in other health outcomes. According to our most respected medical experts, “Outcomes related to autoimmune disorders, cancer, cardiovascular disease and hypertension, diabetes and metabolic syndrome, falls and physical performance, immune functioning, infections, neuropsychological functioning, and preeclampsia could not be linked reliably with calcium or vitamin D intake and were often conflicting.” Genetic findings in those predisposed to longevity cast doubt on whether low levels of vitamin D cause age-related diseases and mortality. A study done at Tufts Medical Center’s Division of Rheumatology concluded, “Vitamin D supplementation for two years at a dose sufficient to elevate 25(OH)D plasma levels to higher than 36 ng/ml, when compared with placebo, did not reduce knee pain or cartilage volume loss in patients with symptomatic knee osteoarthritis.” Subjects supplemented with high doses of vitamin D to increase 25(OH)D levels from 20.9 ng/ml to 40.1 ng/mg, saw “…no improvement in serum lipids, HbA1c, or HS-CRP with high dose vitamin D supplementation. If anything, the effect was negative.”
Vitamin D deficiency or insufficiency can occur in certain situations. Genetic defects in the VDR may result in vitamin D deficiency; a number of mutations have been identified that lead to hereditary vitamin D resistance. Disorders that limit vitamin D absorption and conditions that impair conversion of vitamin D into active metabolites (e.g., certain liver, kidney & hereditary disorders) may cause deficiency. Sick or elderly people who rarely go outdoors and have poor diets are also at risk. Age is a factor, in that synthesis of vitamin D declines with increasing age, due in part to a fall in 7-dehydrocholesterol levels and due in part to alterations in skin morphology. Vitamin D supplementation may be appropriate in these special conditions but the evidence indicates it’s not appropriate to supplement the general population.

Experts urge caution. More experts are beginning to reconsider vitamin D supplementation among the general population. In the Leiden Longevity study, low levels of 25(OH)D "cast doubt on the causal nature of previously reported associations between low levels of vitamin D and age-related diseases and mortality." This 2009 study found that depressive symptoms were not associated with low vitamin D and researchers have expressed concern that high vitamin D levels in pregnancy and at birth may contribute to a higher risk for food allergy in children. Recommending higher vitamin D intake to large populations carries the potential risk of overdosing certain individuals; for example, vitamin D supplementation increased mortality among institutionalized elderly women.

Excessive vitamin D can be toxic to humans and to animals. This is dramatically illustrated in the use of rodenticides with a high vitamin D content (e.g., True Grit Rampage & Ortho Rat-B-Gone) and when livestock die following ingestion of plants that contain 1,25(OH)2D (e.g., cestrum diurnum). DeLuca et al concluded that 25(OH)D is the metabolite responsible for vitamin D toxicity because high concentrations can bind the VDR and induce transcription of CYP27B1. The immediate effects of vitamin D toxicity (hypervitaminosis-D) are hypercalcemia, hypercalciuria, bone resorption, and calcification of soft tissues. People with high blood calcium or phosphorus levels, heart problems, kidney disease, sarcoidosis, and tuberculosis are at highest risk. It would be difficult to ingest too much vitamin D from food, and natural mechanisms regulate the amount of vitamin D photosynthesized from sunlight; within about 20 minutes of ultraviolet exposure in light-skinned individuals (3–6 times longer for pigmented skin), the concentrations of vitamin D precursors produced in the skin reach an equilibrium, and any further vitamin D that is produced is degraded. However, elevated 25(OH)D and vitamin D toxicity may occur due to vitamin supplementation. Researchers are beginning to realize excess vitamin D may cause other problems in addition to toxicity. Muhammad Amer, M.D., an assistant professor in the division of general internal medicine at the Johns Hopkins University School of Medicine, said “People taking vitamin D supplements need to be sure the supplements are necessary. Those pills could have unforeseen consequences to health even if they are not technically toxic.” When cancer studies (breast and colorectal) from the Womens' Health Initiative, showed no protective effects of vitamin D supplementation, the researchers suggested the dose of vitamin D might have been too low. However, the results of the studies actually showed trends toward potential harmful effects.
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of high vitamin D intake.\textsuperscript{195} Researchers like Dr. Anja Olsen\textsuperscript{196} are concerned that the discussion on potential negative effects of vitamin D supplementation (besides those of toxicity) is very limited. “…the past has shown us (with the history of β-carotene and lung cancer as the scariest lesson) that observational studies on micronutrient blood levels cannot always be extrapolated to positive effects of high-dose supplementation.” Dr. Michael J. Glade\textsuperscript{197} believes 25(OH)D may appear to be low for reasons totally independent of sunlight exposure or vitamin D intake. He expresses concern that local tissue vitamin D intoxication may be present in individuals with much lower serum 25(OH)D concentrations than are currently appreciated and that prolonged routine consumption of megadoses of vitamin D may interfere with the regulation of phosphate homeostasis by fibroblast growth factor-23 (FGF23) and the Klotho gene product, with consequences that are detrimental to health. This 1983 study sounded an early alarm,

The requirement for vitamin D is normally met by its synthesis in the skin. In the United States, various foods are fortified with vitamin D to ensure that deficiencies do not occur. As a result, most individuals consume and synthesize more vitamin D than they require. As most individuals appear to be at risk of obtaining too much vitamin D rather than too little, we suggest that fortification of foods with vitamin D should be curtailed, preferably abolished, that excessive fortification of animal foods be reduced to the level required, and that the use of dietary supplements be restricted. Populations at risk could be monitored closely and counseled to prevent vitamin D deficiency.\textsuperscript{198}

Because adverse effects of vitamin D supplementation may take decades to be realized, more clinicians (mindful of the precept ‘First, do no harm’) are erring on the side of caution and waiting for the results of long-term vitamin D studies.
Cell-wall-deficient (CWD) bacteria invade nucleated cells and use strategies to avoid destruction. Excess 1,25(OH)2D is produced in an effort to up-regulate the VDR to transcribe AMPs; and 25(OH)D is rapidly metabolized in the process, resulting in a low serum level. The resulting elevated 1,25(OH)2D causes chronic, systemic inflammation and its accompanying symptoms.
Putative Etiology of Low Vitamin D

Vitamin D proponents use a disease deficiency model to explain low levels of 25(OH)D. Their hypothesis states low 25(OH)D causes chronic diseases; however, a pathogenesis has not been elucidated. Low serum 25(OH)D in the presence of disease can also be explained with a dysregulated vitamin D model. This hypothesis proposes that low vitamin D is the consequence of a chronic inflammatory process caused by persistent infection.

Bacterial Pathogenesis

The bacterial pathogenesis theorizes that intracellular bacteria cause abnormal vitamin D endocrine function, resulting in low vitamin D. Specifically, cell-wall-deficient (CWD) bacteria invade nucleated cells and use strategies to avoid destruction. Excess 1,25(OH)2D is produced in an effort to up-regulate the VDR to transcribe AMPs; and 25(OH)D is rapidly metabolized in the process, resulting in a low serum level. The resulting elevated 1,25(OH)2D causes chronic, systemic inflammation and its accompanying symptoms. Gerald J Domingue, PhD., Professor Emeritus of Tulane University School of Medicine commented, “This might translate into an etiology for chronic inflammatory diseases, when the stressed bacteria increase in numbers and overwhelm the normal biological functions of the host.” Gabriel Nunez, M.D., Professor of Pathology at the University of Michigan Medical School, was quoted in the university newsletter, "In our study, the presence of bacterial microbes inside the cell is what triggers the immune response." In 2007 French researchers observed, “…the presence of pathogenic invasive bacteria could be the link between innate immune response to invasive bacteria and the development of the inflammation.” Dr. Siobhan O’Connor, assistant to the director of the National Center for Infectious Diseases, stated, “The epidemiologic, clinical, and pathologic features of many chronic inflammatory diseases are consistent with a microbial cause. Infectious agents likely determine more cancers, immune-mediated syndromes, neurodevelopmental disorders, and other chronic conditions than currently appreciated.”

Immune System Suppression

A known effect of vitamin D is suppression of the immune system. In a study of a pro-inflammatory molecule, lipopolysaccharide (LPS), Lemire found elevated 25(OH)D reduced the inflammatory cascade. Low levels (below 30 ng/ml) failed to inhibit the LPS inflammatory cascade but higher levels (30 ng/ml) inhibited inflammatory signaling. The highest levels of inflammatory inhibition occurred at 50 ng/ml. 25(OH)D can also be indirectly immuno-suppressive by being converted to excess 1,25(OH)2D. A 2007 study concluded, “On the whole, vitamin D confers an immunosuppressive effect.” Theoretically, immune system suppression allows parasitic microbes to persist and proliferate in host phagocytes, successfully compete for nutritional resources and displace commensal organisms from their niche.
Intracellular Infection

Bacteria which are capable of invading human cells are known by several names: nanobacteria, pleomorphic, stealth, coccoid bodies, L-forms and cell wall deficient (CWD). CWD bacteria are pleomorphic (i.e., they can change size and shape) and many are smaller than viruses (0.01 microns in diameter). They’re too small to be seen with normal optical microscopes and they can survive under extreme conditions. Diagnosing the presence of CWD bacteria is problematic because they’re very slow-growing and difficult to culture; conditions must be similar to those in the human body (some labs have been successful using blood agar at very specific pH and temperatures). CWD bacteria aren’t detected by antibody tests because they’re able to persist for a long time inside cells (in the presence of inflammation, the life-span of a macrophage may be months) so very few antibodies are created in response to their presence. When the compromised phagocytes die (CWD bacteria use biochemical mechanisms to delay apoptosis) it might be possible to see CWD bacteria with PCR (polymerase chain reaction) testing if the probe sequence is general enough, but there are many limitations. For example, a particular sample may not be infected and the lab may look for a limited number of species (there are many strains of CWD bacteria). The application of PCR to clinical specimens has many potential pitfalls due to the susceptibility of PCR to inhibitors, contamination and experimental conditions. For instance, it’s known that the sensitivity and specificity of a PCR assay is dependent on target genes, primer sequences, PCR techniques, DNA extraction procedures, and PCR product detection methods. Biopsy testing doesn’t usually look for CWD bacteria and they would be difficult to identify because they’re destroyed when taken out of the body; their protective homeostasis is lost and lysosomes in the immune system destroy them.

The inability of most research labs to culture CWD bacteria has been an obstacle to their acceptance, and reliance on Koch’s postulates has made it difficult to correlate CWD bacteria to specific diseases. But some researchers believe Koch’s postulates may have to be redefined in terms of molecular data when dormant and non-culturable bacteria are implicated as causative agents of mysterious diseases. In Emerging Infectious Determinants of Chronic Diseases, the authors report “microbes can now be irrefutably linked to pathology without meeting Koch’s postulates”… and “…powerful tools of molecular biology have exposed new causal links by detecting difficult-to-culture and novel agents in chronic illness settings”.

CWD bacteria are ubiquitous and easily acquired throughout life. They’re found in water, food, air, soil, and blood products. They may pass the placental barrier and some may be small enough to pass through filters of injectable medications. Acquisition of a variety of CWD bacteria, from a variety of sources, may begin in utero. CWD bacteria grow very slowly but the process may be accelerated by exogenous immuno-suppressants. High levels of stress can also lower immunity by inhibiting lymphocyte populations, natural killer cell activity, and antibody production. The authors of Emerging Infectious Determinants of Chronic Diseases state,

A spectrum of diverse pathogens and chronic syndromes emerges, with a range of pathways from exposure to chronic illness or disability. Complex systems of changing
human behavioral traits superimposed on human, microbial, and environmental factors often determine risk for exposure and chronic outcome.\textsuperscript{203}

CWD bacteria are considered communicable but not contagious; protective immunity depends on an effective cell-mediated immune response.\textsuperscript{223} It’s now well appreciated that pathologic processes caused by infectious agents may emerge clinically after an incubation of decades.\textsuperscript{224} Among the speculated causes of the increase in chronic infection are overuse of Beta-lactam antibiotics (which force bacteria into CWD form)\textsuperscript{225,226} and immuno-suppression via medications or excess vitamin D. Almost 60 L-forms have been identified since they were first discovered in the late nineteenth century and research continues.\textsuperscript{227,228} Many microbiologists now believe at least some, if not all, of the inflammation which drives the chronic disease process is caused by the presence of pathogens.\textsuperscript{229} In a book review John McDougal\textsuperscript{230} writes, “The editors of Infection and Autoimmunity boldly state that reading the chapters in this book brings one to the conclusion that all autoimmune diseases are infectious, until proven otherwise.” A considerable body of experimental and clinical evidence supports the concept that difficult-to-culture and dormant bacteria are involved in latency of infection and that these persistent bacteria may be pathogenic.\textsuperscript{215} The Center for Disease Control and Prevention states, “Evidence now confirms that non-communicable chronic diseases can stem from infectious agents.”\textsuperscript{230}

**Effects of Intracellular Pathogens**

The human body is colonized by a vast number of microbes, and microbial colonies gain many advantages by parasitizing immune cells and altering nuclear receptor activity. Tissue invasion provides a privileged niche with access to host protein and iron; sequestration from immune response and a means for persistence.\textsuperscript{227} Microbicidal mechanisms of macrophages are thought to be responsible for the control and elimination of intracellular pathogens; 1,25(OH)\textsubscript{2}D production and action in human macrophages activates toll-like receptors to increase expression of the AMP cathelicidin and kill the infectious invaders.\textsuperscript{231} As a result, immune defenses are stimulated; Th\textsubscript{17} cells mobilize host immunity and contribute to the development of harmful inflammatory conditions.\textsuperscript{232}

Microbial cells outnumber human cells by a factor of ten\textsuperscript{233} and increasing pathogens in the microbiome may ultimately cause pathogenic interferences between intracellular bacteria and host cells; resulting in various clusters of disease symptoms. Intracellular pathogens have developed innovative strategies to evade immune responses and persist in cellular cytoplasm.\textsuperscript{234} They express proteases that degrade AMPs,\textsuperscript{235} use biofilms as a shield,\textsuperscript{236} and secrete substances that block the VDR.\textsuperscript{237} Genetic foreign and host protein interactions alter gene transcription and translation mechanisms\textsuperscript{238} and many species survive by horizontal gene transfer.\textsuperscript{233} Autoimmune patients acquire a distinct pathogenic microbiota\textsuperscript{239} and multimorbidity often results. Intracellular bacteria modulate cytokine production;\textsuperscript{240} and in human monocytes and macrophages, cytokine activation markedly inhibits 1,25(OH)\textsubscript{2}D/VDR gene transcription.\textsuperscript{241} When the immune system is fighting a persistent microbe, it continually releases inflammatory molecules in an effort to kill the pathogen.\textsuperscript{242} This dysfunctional immunological response produces low-grade inflammation which is a component of many chronic and autoimmune diseases.
Dysregulated Vitamin D Metabolism

The immune system detects and responds to the presence of CWD bacteria by producing more 1,25(OH)2D to activate the VDR and express the crucial endogenous AMPs which allow the innate immune system to target intracellular pathogens. Tissues known to synthesize 1,25(OH)2D include uterine decidua and placenta, bone cells, keratinocytes, colon, breast, prostate, spleen, melanoma cells, synovial, and pulmonary monocytes and macrophages. Extra-renal production of 1,25(OH)2D is regulated by cytokines (e.g., interferon-gamma), lipopolysaccharide, nitric oxide and intracellular VDBP, that activates the enzyme CYP27B1 which stimulates conversion of 25(OH)D to 1,25(OH)2D. In this way, excess production of 1,25(OH)2D may contribute to low levels of 25(OH)D.

Because extra-renal production of 1,25(OH)2D is primarily dependent on the availability of 25(OH)D, supplementation with vitamin D to increase 25(OH)D may promote the production of 1,25(OH)2D in non-renal tissues that are sites of intracellular infection and result in hypervitaminosis-D. Sunlight appears to play a part in this process. The skin (dermal fibroblasts and keratinocytes possess VDR) has the capacity to synthesize 1,25(OH)2D, and represents an important target tissue for 1,25(OH)2D. If keratinocytes in the skin are infected, natural regulation of photosynthesis may be thwarted and solar energy may overstimulate cellular activity, resulting in an increase in cutaneous production of vitamin D3, 25(OH)D and 1,25(OH)2D following sun exposure.

When nuclear cells are parasitized by CWD bacteria, known mechanisms are believed to cause extra-renal production of 1,25(OH)2D to increase, the kidneys to lose control of 1,25(OH)2D production, and pro-hormone 25(OH)D to decrease due to rapid conversion. Several mechanisms may play a part in the process:

- Inflammatory cytokines activate CYP27B1 (formerly 1a-hydroxylase), an enzyme that causes more 25(OH)D to be converted to 1,25(OH)2D.
- The microbial-repressed VDR can't transcribe CYP24A1 (formerly 24-hydroxylase), an enzyme that breaks down excess 1,25(OH)2D.
- Excess 1,25(OH)2D binds the PXR receptor, to inhibit conversion of D3 to 25(OH)D so 25(OH)D is down-regulated.

Thus, low 25(OH)D may be a consequence of the inflammatory process. More studies are concluding that suboptimal circulating levels of vitamin D appear to be caused by the disease process. This 2013 study found serum 25(OH)D was decreased following an acute inflammatory insult (i.e., orthopedic surgery) and concluded “Hypovitaminosis D may be the consequence rather than cause of chronic inflammatory diseases.” Another recent study stated:

…there may be a relationship between inflammatory processes induced by chronic overstimulation of the renin angiotensin system (RAS) and the worldwide vitamin D deficiency… In fact, the pandemic of vitamin D deficiency could be the other face of increased RAS activity, which could potentially cause a lower activity or lower levels of Vitamin D.
The Compromised Immune System

The host immune response has developed many mechanisms to neutralize and remove pathogen bacteria. In turn, pathogenic bacteria have developed mechanisms to alter and evade the host immune response. For example, several studies demonstrate that microbes have the ability to repress the VDR:

- Mycobacterium tuberculosis down-regulates VDR activity.
- Epstein-Barr Virus lowers VDR activity.
- HIV completely shuts down VDR activity.

Studies also point to immune system depression and elevated 1,25(OH)2D in chronic diseases:

- Sarcoidosis patients are deficient in cathelicidin despite healthy vitamin D3 levels.
- 1,25(OH)2D is high (>60 pg/ml) in 42% of Crohn’s patients. “Treatment of the underlying inflammation may improve metabolic bone disease…”
- 1,25(OH)2D is elevated in the synovial fluid of patients with RA.
- Crohn's disease decreases expression of cathelicidin.

Elevated 1,25(OH)2D further reduces VDR competence and suppresses macrophage function. Disabling the immune system via VDR repression and macrophage inhibition would allow intracellular bacteria to persist and increase susceptibility to extracellular co-infections that are commonly found in chronic illnesses (e.g., viruses, fungi, parasites and cell-walled bacteria).

High levels of 1,25-D may result when dysregulation of the VDR by bacterial ligands prevents the receptor from expressing enzymes necessary to keep 1,25-D in a normal range. Elevated 1,25(OH)2D appears to be evidence of the immune system’s attempt to activate the VDR to combat infection.

Diagnosis of Dysregulated Vitamin D Metabolism

Vitamin D status is currently determined by measuring the level of 25(OH)D which, presumably, reflects the levels of other D metabolites (e.g., vitamin D3, vitamin D2 and 1,25(OH)2D, etc.). This measurement may not, however, provide enough information to assess vitamin D endocrine function. Measurement of both the active metabolite and its precursor is essential to diagnose dysregulated vitamin D metabolism; assays of 25(OH)D and 1,25(OH)2D provide valuable tools to assess vitamin D status of patients. Vitamin D status encompasses more than vitamin D intake. 1,25(OH)2D formation isn’t directly regulated by parental vitamin D and may be affected by the same factors that cause a decrease in serum 25(OH)D. 1,25(OH)2D has not been used as a measure associated with vitamin D nutritional status or as an intermediate marker related to health outcomes, or even routinely in vitamin D research. In the context of solving the puzzle of low 25(OH)D, the reasons cited for this lapse fail to consider the possibility of abnormal levels in the presence of chronic inflammation:

- 1,25(OH)2D has a short half-life (hours) and fluctuates rapidly. However, a high result may be discovered even at trough level.
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- 1,25(OH)2D levels are regulated by PTH, calcium, phosphate. *This isn’t true in chronic illness when extra-renal production is prevalent.*
- 1,25(OH)2D doesn’t decrease until 25(OH)D is very low. *A low 25(OH)D may be a sign that 1,25(OH)2D is abnormally high.*
- 1,25(OH)2D is only over-produced in hypercalcemic disease states such as sarcoidosis. *Studies show this isn’t true.*
- 1,25(OH)2D may be elevated as a result of up-regulation of the CYP27B1 enzyme. *This begs the question “why is this enzyme elevated?”*

Measuring both 25(OH)D and 1,25(OH)2D (and PTH, calcium, phosphate when indicated) as clinical markers in chronic disease is more likely to provide a true picture of vitamin D status, than measuring 25(OH)D alone. Measuring 1,25(OH)2D should be considered in patients with low 25(OH)D, abnormal lab results (especially inflammatory markers), a diagnosis of autoimmune disease or other chronic inflammatory illness, or signs of chronic systemic inflammation. Each test has specific parameters that must be followed to ensure accurate results. In written correspondence (2013), vitamin D researcher Martin Hewison (Professor in Residence at the David Geffen School of Medicine UCLA), stated, “I agree that 1,25(OH)2D is a forgotten component of the vitamin D and human health story - I think measurement of serum 1,25(OH)2D will be more common as LC:MS techniques improve.”

### Table 1. D-metabolites Tests

#### Serum 25(OH)D
- CPT code: 82306
- Performed at most labs
- No special handling needed
- Lowest mortality reported at 20 ng/ml
- Immuno-suppression reported when higher than 30 ng/ml

#### Serum 1,25(OH)2D
- CPT code: 82652
- ICD-9 codes:
  - 733.00 Osteoporosis, unspecified
  - 733.90 Osteopenia
  - 780.9 Fatigue
- A specialized lab is required
- Special handling of the sample is necessary - freeze for transport to avoid degradation due to agitation
- A low result may be inaccurate due to sample mishandling
- A high result is always accurate
- Maximum normal = 45 pg/ml
Restoring VDR Competence

The ability to mount an appropriate response to intracellular infection is highly dependent on a competent VDR. When it appears that 1,25(OH)2D is unable to up-regulate the VDR due to microbial activity, another ligand may be able to act as an agonist (an agonist increases the signal transduction activity of a cell when bound to a receptor on that cell) and restore VDR competence. A number of non-vitamin D VDR ligands have been identified: curcumin, omega-6 fatty acids such as arachidonic acid and linoleic acid, and lithocolic acid (LCA). Molecular modeling demonstrated that olmesartan medoxomil, an angiotensin receptor blocker (ARB), has a high affinity for the VDR. In the clinical setting, olmesartan is being used off-label as a novel VDR ligand and it appears to function as a VDR agonist. In patients with autoimmune and inflammatory disorders, olmesartan provokes inflammatory symptoms that suggest the expression of endogenous antimicrobials under VDR control. Olmesartan also lowers angiotensin II (a peptide that’s implicated in the inflammatory process). The endogenous VDR ligand 1,25(OH)2D has a similar effect in that it represses renin gene expression to down-regulate the renin angiotensin system (RAS) and reduce inflammation via the Nuclear Factor-kappa B (NF-kb) pathway. VDR and RAS receptors are distributed in almost the same tissues. This 2013 study found a link between RAS activity and activation of the VDR:

…the inappropriate stimulation of the RAS has been associated with the pathogenesis of hypertension, heart attack, stroke, and hypertrophy of both the left ventricle and vascular smooth muscle cells. Changes in RAS activity and activation of VDR seem to be inversely related, making it possible to speculate that both systems could have a feedback relationship. [The researchers conclude] the combination of RAS blockade and VDR stimulation appears to be more effective than each one used individually.

This is what olmesartan appears to accomplish (blocking angiotensin II and stimulating the VDR) and is consistent with a theory of VDR incompetence. The multiple beneficial effects of olmesartan, including the ability to reduce cardiovascular and kidney disease, prevent migraines, and reduce oxidative stress, suggest it could play a key role in the resolution of chronic systemic inflammation.
Clinical Response to Treatment

Olmesartan causes a dramatic reduction in elevated 1,25(OH)2D within weeks of initiation, which provides further evidence of its ability to up-regulate the VDR. Olmesartan is believed to decrease excess 1,25(OH)2D by several VDR-mediated effects:

- The up-regulated VDR transcribes CYP24A1 and CYP3A4 (enzymes which reduce 1,25(OH)2D production).
- CYP27B1 (the enzyme that hydroxylates 25(OH)D to 1,25(OH)2D) is repressed so less 1,25(OH)2D is made.
- Consequently, renal control of 1,25(OH)2D production is restored and extra-renal production of 1,25(OH)2D is reduced.

A decrease in elevated 1,25(OH)2D means less systemic inflammation, as these studies of olmesartan indicate:
• "Improvement of glycemic control and insulin resistance was only observed in olmesartan group. ...these effects of olmesartan might be mediated by an anti-inflammatory action."

• "Olmesartan treatment ...significantly reduced serum levels of inflammatory markers; h-CRP, h-TNFα, IL-6, MCP-1 after 6 weeks of therapy..."

• Blocking angiotensin-converting enzyme induces potent regulatory T cells and modulates TH1- and TH17-mediated autoimmunity.

Following administration of olmesartan, a Jarisch-Herxheimer reaction (a cascade of reactions including inflammation, cytokine release, and endotoxin release as part of the immune response to microbial death) is usually seen. This suggests a robust immune response and transcription of AMPs by an activated VDR, providing additional evidence that olmesartan is a VDR agonist. The adaptive immune system may also respond to the presence of pathogenic and cellular debris, generating antibodies in the process. Theoretically, olmesartan restores VDR competence and, thus, phagocytosis leads to bacterial death; consequently, inflammation is increased by cytokine reaction to microbial endotoxins and cellular debris from dead host cells and bacteria. The eminent German researcher Friedrich Flachsbart is often quoted regarding this effect, "Jarisch-Herxheimer is in fact the maximum of evidence possible in search of occult microbes." Successful treatment also targets CWD bacteria with the concomitant use of select, sub-inhibitory doses of oral antibiotics, in a pulsed fashion; for their ability to weaken bacterial ribosomes, penetrate cell walls, accumulate in phagocytes, or interfere with folate synthesis. Sunlight exposure, foods high in vitamin D and vitamin D supplements are avoided to maintain serum 25(OH)D at a level (20-30 ng/ml) that isn’t likely to suppress the immune system and inhibit bacterial elimination.

In the absence of clinical trials, the determination of when to use olmesartan and low-dose antibiotics as immunotherapy is made on the basis of diagnosis, severity of symptoms, history, potential disease course, previous treatments attempted, efficacy of traditional treatments and risk versus potential benefit. Treatment requires several years (to avoid intolerable Jarisch-Herxheimer reactions) but dramatic improvement has been seen (e.g., reduction in inflammatory symptoms, normalization of lab work, improvement in bone density and correction of hormonal imbalances) in a wide variety of chronic inflammatory and autoimmune diseases.
Table 2. Key Points

A consensus regarding the definition of vitamin D deficiency has been elusive.

Photosynthesis of vitamin D₃ may provide adequate vitamin D stores for most individuals.

Low levels of 25(OH)D are seen in healthy individuals, as well as those with chronic inflammatory conditions.

Studies are inconsistent regarding the health benefits of increasing vitamin D stores; supplementation may have negative effects.

25(OH)D may not always reflect the level of 1,25(OH)D; accurate assessment of vitamin D status may depend on measuring both metabolites.

Intracellular cell-wall-deficient bacteria may cause impaired immune system function.

A novel non-vitamin D vitamin D receptor ligand appears to restore VDR competence, resolve dysregulated vitamin D metabolism and reduce inflammatory symptoms.

Discussion

Vitamin D is essential for many important biological processes and most people get an adequate supply from exposure to sunlight. Long-term studies are needed to determine if low vitamin D in healthy individuals leads to disease. Evidence that vitamin D supplementation cures or prevents chronic disease is inconsistent; despite increased supplementation chronic inflammatory diseases are on the rise. Attention to the alternate hypothesis - low 25(OH)D is a consequence of the chronic disease process provoked by persistent intracellular infection – may be crucial to reversing this trend.

The prevailing dogma that the 25(OH)D level provides an accurate assessment of vitamin D status needs closer examination. Circulating levels of 25(OH)D may not be an accurate reflection of vitamin D status in those with an autoimmune disease or chronic inflammatory symptoms; 1,25(OH)2D may be elevated, which can lead to osteoporosis and cause immunosuppression (which is contraindicated in the presence of infection). Advocating vitamin D supplementation without adequate evidence of efficacy is, in effect, a mass experiment using the general population without their informed consent. The resulting immunosuppression may promote chronic infection which has been implicated in chronic inflammatory diseases. Pathogenic invasive bacteria may be the root cause of chronic disease and low vitamin D. A treatment which has demonstrated efficacy in reversing vitamin D metabolism dysfunction and reducing inflammatory symptoms is currently being used by clinicians and warrants formal study.
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