

Vitamin D₂ Is Much Less Effective than Vitamin D₃ in Humans

LAURA A. G. ARMAS, BRUCE W. HOLLIS, AND ROBERT P. HEANEY

Creighton University (L.A.G.A., R.P.H.), Omaha, Nebraska 68131; and Medical University of South Carolina (B.W.H.), Charleston, South Carolina 29425

Vitamins D₂ and D₃ are generally considered to be equivalent in humans. Nevertheless, physicians commonly report equivocal responses to seemingly large doses of the only high-dose calciferol (vitamin D₂) available in the U.S. market.

The relative potencies of vitamins D₂ and D₃ were evaluated by administering single doses of 50,000 IU of the respective calciferols to 20 healthy male volunteers, following the time course of serum vitamin D and 25-hydroxyvitamin D (25OHD) over a period of 28 d and measuring the area under the curve of the rise in 25OHD above baseline.

The two calciferols produced similar rises in serum concentration of the administered vitamin, indicating equivalent absorption. Both produced similar initial rises in serum

25OHD over the first 3 d, but 25OHD continued to rise in the D₃-treated subjects, peaking at 14 d, whereas serum 25OHD fell rapidly in the D₂-treated subjects and was not different from baseline at 14 d. Area under the curve (AUC) to d 28 was 60.2 ng·d/ml (150.5 nmol·d/liter) for vitamin D₂ and 204.7 (511.8) for vitamin D₃ ($P < 0.002$). Calculated AUC_∞ indicated an even greater differential, with the relative potencies for D₃:D₂ being 9.5:1.

Vitamin D₂ potency is less than one third that of vitamin D₃. Physicians resorting to use of vitamin D₂ should be aware of its markedly lower potency and shorter duration of action relative to vitamin D₃. (*J Clin Endocrinol Metab* 89: 5387–5391, 2004)

VITAMIN D DEFICIENCY IS a common problem, especially in older and sick individuals (1, 2). Because most people get most of their vitamin D from sun exposure (3) with a small amount obtained from food and supplements, those at risk for vitamin D deficiency are those with little sun exposure and/or poor dietary intake. Older people are especially at risk because aging lowers the amount of 7-dehydrocholesterol in the skin and the capacity for vitamin D production (4).

Hypovitaminosis D is associated with increased PTH secretion, increased bone turnover, osteoporosis, histological osteomalacia and increased risk of hip and other fractures (5, 6), and, in its most severe expression, clinical osteomalacia (5). Vitamin D deficiency is increasingly being recognized by clinicians and treated, but the treatment guidelines are unclear and available preparations limited. The current adult vitamin D intake recommendation from the Food and Nutrition Board (7) is 200 IU/d up to age 50, 400 IU up to age 70, and 600 IU thereafter. However, it now appears that, if total input were confined to these amounts, only the most severe degrees of vitamin D deficiency would be prevented (3). In any event, these recommendations apply to both ergocalciferol (vitamin D₂) and cholecalciferol (vitamin D₃).

Since the 1930s it has been generally assumed that vitamin D₂ and vitamin D₃ are equally effective in humans. This conclusion was based mainly on anti-rachitic bioassays. With acceptance of serum 25-hydroxyvitamin D concentration as the appropriate functional indicator of vitamin D status (7),

it has become important to reevaluate this assumption of equivalence. Only a few studies have directly compared vitamins D₂ and D₃ using contemporary analytic methods. The limited evidence available indicates that vitamin D₃ is substantially more efficacious than vitamin D₂ (8, 9).

Because ergocalciferol is the only high-dose calciferol on the U.S. market, patients who are severely vitamin D deficient have usually been treated in the U.S. with this form of the vitamin, in a dose of 50,000 IU orally or (in the past) im. Dosing frequencies have varied from one or three times weekly to once every 2 months. Physicians frequently find that such a regimen produces little or no change in serum 25-hydroxyvitamin D (25OHD) concentrations (10). Whether this is because of disease-related abnormalities of vitamin D metabolism in such patients, because of problems with the assay measuring serum 25OHD, or because of nonequivalence of ergocalciferol and cholecalciferol (vitamin D₃) has been unclear. Our sole purpose in this study was to evaluate the relative potency of the two calciferols using research-level assay methods.

Subjects and Methods

Subjects

The subjects were 30 men, between ages 20 and 61, in good general health, who habitually consumed less than 16 oz of milk per day and had less than 10 h of sun exposure per week. We excluded those with granulomatous conditions, liver disease, kidney disease, or diabetes and those taking anticonvulsants, barbiturates, or steroids in any form. (There were four subjects who took a multivitamin occasionally, averaging one time per week. They agreed to stop taking this supplement 1 wk before and throughout the study.) Mean (\pm sd) age was 33.06 \pm 11.47, weight was 89.36 \pm 11.59 kg, and body mass index was 27.14 \pm 2.77 kg/m². All subjects were from Omaha, Nebraska, and surrounding communities. The project was approved by the Institutional Review Board of Creighton University, and all subjects gave written informed consent.

Abbreviations: AUC, Area under the curve; DBP, vitamin D-binding protein; 25OHD, 25-hydroxyvitamin D.

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Design

The project was conducted during the month of July, 2003. Subjects were randomly assigned to receive 1) no supplement (the seasonal effect, control group), 2) one tablet labeled to contain 50,000 IU (1.25 mg) ergocalciferol (the vitamin D₂ group), or 3) 10 tablets labeled to contain 5,000 IU (125 μg)/tablet cholecalciferol (the vitamin D₃ group). Because the vitamin D₃ preparation was not a marketed product, we asked the supplier to provide a certificate of analysis. [The 50,000-IU D₂ tablet preparation was supplied by Sidmak Laboratories, Inc. (High Point, NC). The 5,000-IU D₃ tablet preparation was supplied by Tishcon Corp. (Salisbury, MD). The product was assayed on June 12, 2003, and found to contain 5,513 IU/capsule.]

For the control group receiving no vitamin D supplement, serum samples were obtained at d 0 and 28, so as to quantify the midsummer rise in 25OHD that would be expected in all groups. For the two groups receiving a vitamin D supplement, serum samples were obtained at d 0, 1, 3, 5–7, 14, and 28. At the initial visit, each subject's weight and height were measured. Height was measured using a Harpenden stadiometer (Seritex, Inc., Carlstadt, NJ). Blood was obtained for measurement of serum vitamin D and 25OHD. After the baseline blood was obtained, the subjects were observed while they took the assigned vitamin D supplement dose. At each subsequent visit, the subject's weight was measured and blood obtained for measurement of serum vitamin D and 25OHD. The subjects were asked to recall their sun exposure since the previous visit. The subjects were given supplies of sun block lotion, sun protection factor (SPF) 15, to use during out-of-the-ordinary sun exposure.

Analytical methods

Serum ergo- and cholecalciferol concentrations were determined by reversed-phase HPLC, as described elsewhere (11). Serum 25OHD was determined by RIA, using the IDS kit (Nichols Institute, San Clemente, CA). Because it has been reported (12) that the antibody in this kit reacts poorly with 25OHD₂, we measured the samples from the vitamin D₂-treated subjects using both the IDS and the DiaSorin kits (DiaSorin, Stillwater, MN). However, in this group of subjects, there were no significant differences in analyzed 25OHD increments above baseline between the values produced by the two antibodies. Hence, for the values in the D₂-treated participants that we report here, we averaged the results obtained with the two RIAs. Finally, to be certain that the RIAs were adequately detecting both 25OHD₂ and 25OHD₃, aliquots of the serum samples obtained at 0, 3, and 28 d were assayed by HPLC (10) for both 25OHD₂ and 25OHD₃. The mean increment in total 25OHD by HPLC at 3 and 28 d was virtually identical with the mean increment measured by RIA.

Statistical methods

The 25OHD signal produced by the 50,000-IU calciferol dose was analyzed as the increment in total 25OHD concentration above baseline, adjusted for the mean rise in serum 25OHD observed in the untreated controls (0.259 nmol/liter·d). Area under the curve (AUC) of serum 25OHD increments at 14 and 28 d was calculated by the trapezoidal method individually for each subject. AUC_∞ was calculated using pharmacokinetic, biexponential models (PK Solutions, Summit Research Services, Ashland, OH) fitted to the mean 25OHD values at each time point. Mean values for AUC₁₄ and AUC₂₈ for the two calciferols were compared by the usual *t* test for independent samples.

Results

Serum calciferol concentrations were measured at d 0, 1, and 3. The results are shown in Fig. 1. Baseline values of both calciferols were low, with the D₃ concentration higher than the D₂, as would be expected. However, the rise by d 1 was essentially identical for both calciferols, and at d 3 the serum levels of the two had fallen close to baseline and were virtually identical. This behavior indicates that absorption of the two calciferols was approximately equivalent.

The time course for the increment in serum 25OHD is

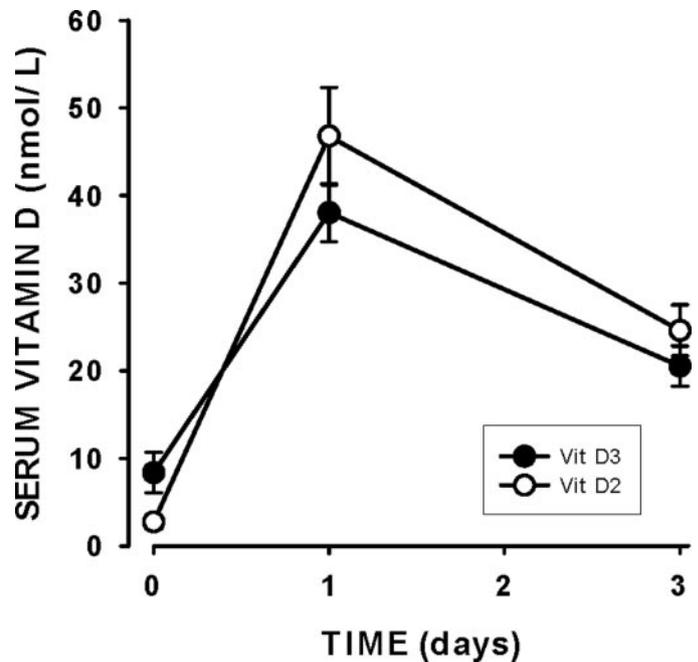


FIG. 1. Time course of serum concentrations of vitamin D after a single oral dose of 50,000 IU of cholecalciferol (vitamin D₃) or ergocalciferol (vitamin D₂) in healthy male subjects (n = 10 for each group). The error bars are 1 SEM. [Copyright Robert P. Heaney, 2004. Used with permission.]

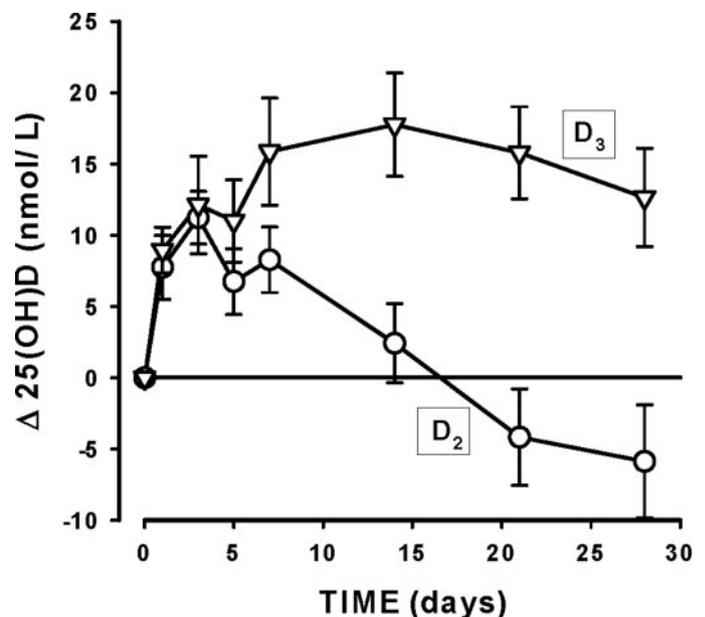


FIG. 2. Time course of the rise in serum 25OHD after a single oral dose of 50,000 IU of either cholecalciferol (vitamin D₃) or ergocalciferol (vitamin D₂) to two groups of 10 normal men each. Error bars are 1 SEM. The zero-change line incorporates a correction for the seasonal rise in 25OHD occurring at the time this study was performed. (To convert from nmol/liter to ng/ml, multiply by 0.4.) [Copyright Robert P. Heaney, 2004. Used with permission.]

shown in Fig. 2, which presents the mean changes in values at each visit for total 25OHD (*i.e.* the sum of 25OHD₂ and 25OHD₃). These values were corrected for the change we measured in 25OHD levels in our control population because

of summer sun exposure. Both vitamin D₂ and vitamin D₃ produced initial rises in 25OHD levels during the first 3 d that did not differ significantly from one another. The mean 25OHD concentration in the D₂-treated subjects then began to fall until, by d 14, it was not different from baseline. By contrast, 25OHD concentration in the D₃-treated subjects continued to rise through d 14 and by d 28 was still higher than the peak value for the D₂-treated group.

The best measure of total exposure of the organism to an administered agent is given by AUC of the serum concentration against time. Here the greater potency of D₃ was dramatically evident. AUC₂₈ was 60.2 ± 23.4 ng·d/ml (150.5 ± 58.5 nmol·d/liter) for D₂ and 204.7 ± 32.4 ng·d/ml (511.8 ± 80.9 nmol·d/l) for D₃ ($P < 0.002$). This is a more than 3-fold difference in potency. AUC_∞ is actually the preferable pharmacokinetic measure of total exposure, and if AUC_∞ is used instead, the values for D₂ and D₃ are, respectively, 112.8 and 1072.8 ng·d/ml (282 and 2682 nmol·d/liter), for a nearly 10-fold difference in potency. Because, as it turned out, 28 d was not long enough to get a firm estimate of the elimination phase in the D₃-treated subjects, the AUC_∞ for D₃ must be considered uncertain. In any event, it is clear that the AUC₂₈ values understate the contrast and that the potency difference must lie somewhere between 3- and perhaps 10-fold.

An initially unanticipated finding was the decline in 25OHD₃ concentration in the ergocalciferol-treated men, as shown by HPLC (Fig. 3). Whereas 25OHD₃ in the untreated

control group rose by 3 ng/ml (7.5 nmol/liter), presumably because of ongoing sun exposure, the vitamin D₂-treated group experienced a fall in 25OHD₃ of nearly 4 ng/ml (10 nmol/liter) ($P < 0.01$).

Discussion

To our knowledge, this is the first study comparing vitamins D₃ and D₂ by mapping the time course of serum 25OHD after a single dose. We showed that vitamin D₃ raises and maintains 25OHD levels to a substantially greater degree than does vitamin D₂, with a differential potency of at least 3-fold, and more likely closer to 10-fold.

The two treated groups had the same baseline 25OHD levels. With the dose of 50,000 IU of vitamin D₂ and vitamin D₃, the respective vitamin D levels rose in parallel, showing that both forms of vitamin D were absorbed comparably. And the rise in serum 25OHD was virtually the same for the first 3 d of the study for both vitamins D₂ and D₃, indicating comparable conversion to the 25-hydroxy metabolite. The much more rapid decline of serum 25OHD in the vitamin D₂-treated subjects after 3 d would seem to reflect substantially more rapid metabolism or clearance of the vitamin D₂ metabolite. Other studies (13, 14) have suggested either differences in affinity of the vitamin D-binding protein (DBP) for the two calciferols or higher affinity of the hepatic 25-hydroxylase for vitamin D₃ than vitamin D₂. The latter seems improbable from our data, because the initial rise in 25OHD concentration was the same for the two calciferols. The former offers a more plausible explanation. 25OHD₂ has been shown to have a lesser affinity for DBP than does 25OHD₃ (15), which would result in a shorter circulating half-life for 25OHD₂ vs. 25OHD₃. The relative binding of vitamin D and its metabolites to DBP determines the circulating half-lives of these substances (16). [That is why vitamin D and 1,25(OH)₂D possess much shorter circulating half-lives than 25OHD (17). Similarly, the reason birds cannot use vitamin D₂ as a feed supplement is because 25OHD₂ will not bind to the avian DBP and is thus rapidly eliminated from the circulation (18).]

This study complements the findings of Trang *et al.* (9) who, using daily dosing of 4000 IU for 2 wk, reported an increase in 25OHD 70% greater with vitamin D₃ than for vitamin D₂. (After adjustment for concomitant changes in the control group, the difference between the two groups can be shown to have been approximately 2-fold.) The reason for the larger differential found in our study is unclear. In any case, both studies show that there is a substantial difference in serum 25OHD achieved by the same dose of the two calciferols.

There can be little doubt that the demonstrated lower potency of vitamin D₂ is physiologically/pharmacologically meaningful. Serum 25OHD is the recognized functional status indicator for vitamin D nutrition (7). Recent studies have shown that raising serum 25OHD improves calcium absorption (19), reduces fall frequency (20), and lowers osteoporotic fracture risk (6). Furthermore, lower extremity muscle function improves across virtually the entire range of prevailing serum 25OHD concentrations (21).

It would be desirable to have long-term dosing data as

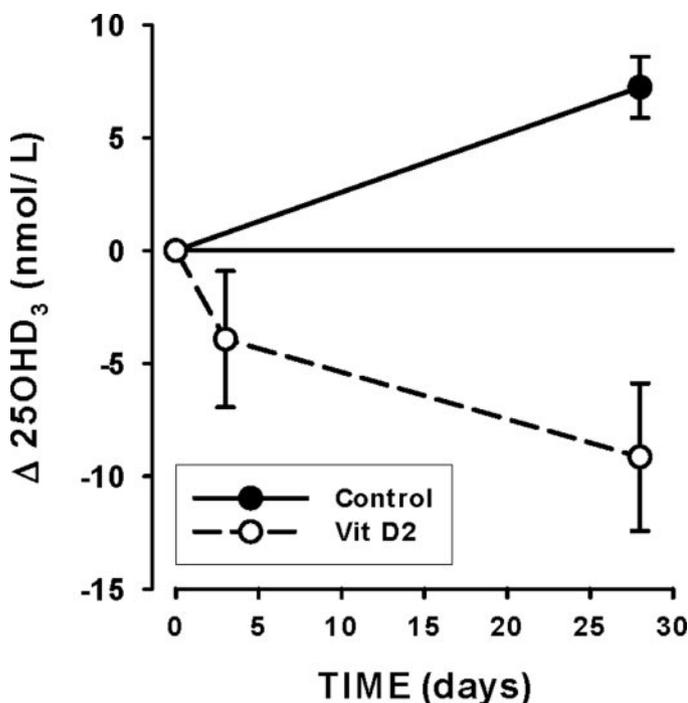


FIG. 3. Changes in serum 25OHD₃ in the subjects treated with vitamin D₂ and in those in the untreated control group over the 28 d of follow-up after a single oral dose of 50,000 IU vitamin D₂. The error bars are 1 SEM. The mean 28-d value in the D₂-treated subjects was significantly lower than both their own baseline values and the corresponding values in the control group (which exhibited the expected summer rise in serum 25OHD). (To convert from nmol/liter to ng/ml, multiply by 0.4.) [Copyright Robert P. Heaney, 2004. Used with permission.]

well, because such information would more closely approximate the situation of actual treatment. However, such information would serve only to define more precisely the magnitude of the difference. It would not be expected to alter the finding of a substantial differential in potency between the two calciferols, because by standard pharmacokinetics, the concentration achieved by multiple doses of a short half-life substance is virtually always lower than the concentration achieved by comparable doses with a long half-life compound. Continuous dosing studies would need to be of several months' duration because Heaney *et al.* (3) have shown, at least for vitamin D₃, that time to equilibrium is approximately 5 months. At 14 d of continuous dosing, Tjelleson *et al.* (8) found a potency difference of nearly three times, which, for the reason just given, must understate the differential.

The fall in 25OHD₃ that we observed in the D₂-treated subjects has been reported previously. Using a design similar to that of Trang *et al.* (9), Tjelleson *et al.* (8) described a nearly 70% drop in 25OHD₃ in subjects treated for 2 wk with 4000 IU/d of vitamin D₂. This fall may reflect either competition by D₂ for the 25-hydroxylase or increased metabolic degradation of 25OHD₃ by the mechanisms up-regulated to metabolize vitamin D₂ and its metabolites (or both).

It is worth noting in passing that our subjects were all healthy young men with some sun exposure (not homebound as a nursing home resident or elderly person might be). Their mean baseline 25OHD level was 31.7 ng/ml ± 8.45 (79.19 nmol/liter ± 21.13), nearly at the optimal level of 32 ng/ml (80 nmol/liter) or higher [where calcium absorption plateaus and PTH levels become minimal (22)]. Even so, individual baseline 25OHD levels ranged from 15.2–58.7 ng/ml (37.9–146.8 nmol/liter). Thus, approximately half of the subjects, who would not usually be considered at risk for vitamin D deficiency, nevertheless exhibited suboptimal vitamin D status during the summer. Presumably, their vitamin D levels would be even lower at midwinter. The finding of suboptimal vitamin D levels in those without obvious risk is consistent with other studies that report high prevalence of vitamin D deficiency in general medicine patients at no particular risk for vitamin D deficiency (23).

It is important to note that even in those subjects with high baseline serum 25OHD values, one large dose of vitamin D₃ produces serum 25OHD values well within the safe range of 25OHD [*i.e.* <88 ng/ml (220 nmol/liter) (1)]. The mean rise was only approximately 7 ng/ml (~18 nmol/liter), and the highest observed 25OHD rise was 10.4 ng/ml (26 nmol/liter); the latter produced a value of 69.2 ng/ml (173 nmol/liter) and occurred in the subject with the highest starting value.

As the medical community is becoming more aware of vitamin D deficiency and its effects, both on bones and other body tissues (24–26), there will be more testing of vitamin D levels and interest in treating the deficiency. The goal should be standardized methods of testing and clear recommendations on the level of 25OHD that should be achieved and what form of vitamin D to use, in what amount, and how often (27).

This study addresses some of these issues. Clearly, vitamin D₃ is the preferable form of vitamin D. This is in contrast to

the long-held belief that vitamin D₂ and vitamin D₃ are seen by the body as identical. This nonequivalence makes sense, because the two calciferols are known not to be equivalent in other species, and vitamin D₃ is the form that animals make in response to sunlight.

There are several barriers to the clinician in treating vitamin D-deficient patients. Most published studies were performed using vitamin D₃, and application of their results to patients using vitamin D₂ is not easily possible, as we have shown here. This is not to suggest that vitamin D₂, in the 50,000-IU dosage form, is not efficacious in treating severe vitamin D deficiency. A large body of experience indicates that it can be quite effective. But, as the unitage of the two forms of the vitamin is clearly not equivalent, thinking about dosing must be adjusted to match the product used. The data presented in this paper indicate that the 50,000-IU dosage form of vitamin D₂ should be considered to be equivalent to no more than 15,000 IU of vitamin D₃ and perhaps closer to only 5,000 IU. In any event, the tolerable upper intake level, 2,000 IU/d, published for vitamin D₃ (7), and already judged to be set too low (3), ought not be applied to vitamin D₂.

Another barrier is the lack of a high-potency therapeutic vitamin D₃ preparation in the United States. In Europe, several high-potency preparations are available, some used for "stoss" therapy in clinical trials (6, 28, 29). With the vitamin D₃ that is available mainly by special order in the United States, it would require 25–50 pills (of 1,000 or 2,000 IU each) to achieve a 50,000-IU dose, a regimen that would not be practical or acceptable to most patients.

More needs to be done both to standardize methods of testing 25OHD and to provide a high-potency vitamin D₃ preparation available for clinical use (27). Additional studies are also needed to establish optimal dosing recommendations.

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Address all correspondence and requests for reprints to: Robert P. Heaney, M.D., Creighton University, 601 North 30th Street, Suite 4841, Omaha, Nebraska 68131. E-mail: rheaney@creighton.edu.

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