From vitamin D to hormone D: fundamentals of the vitamin D endocrine system essential for good health

Anthony W Norman

ABSTRACT

New knowledge of the biological and clinical importance of the steroid hormone 1α,25-dihydroxyvitamin D₃ \([1\alpha,25(\text{OH})_2 \text{D}_3]\) and its receptor, the vitamin D receptor (VDR), has resulted in significant contributions to good bone health. However, worldwide reports have highlighted a variety of vitamin D insufficiency and deficiency diseases. Despite many publications and scientific meetings reporting advances in vitamin D science, a disturbing realization is growing that the newer scientific and clinical knowledge is not being translated into better human health. Over the past several decades, the biological sphere of influence of vitamin D₃ as defined by the tissue distribution of the VDR, has broadened at least 9-fold from the target organs required for calcium homeostasis (intestine, bone, kidney, and parathyroid). Now, research has shown that the pluripotent steroid hormone 1α,25(OH)₂D₃ initiates the physiologic responses of ≥36 cell types that possess the VDR. In addition to the kidney’s endocrine production of circulating 1α,25(OH)₂D₃, researchers have found a paracrine production of this steroid hormone in ≥10 extrarenal organs. This article identifies the fundamentals of the vitamin D endocrine system, including its potential contributions to good health in 5 physiologic arenas in which investigators have clearly documented new biological actions of 1α,25(OH)₂D₃ through the VDR. As a consequence, the nutritional guidelines for vitamin D₃ intake (defined by serum hydroxyvitamin D₃ concentrations) should be reevaluated, taking into account the contributions to good health that all 36 VDR target organs can provide. Am J Clin Nutr 2008;88(suppl):491S–9S.

INTRODUCTION

Vitamin D₃ is essential for life in higher animals. Research has shown, for example, that vitamin D₃ is one of the primary biological regulators of calcium homeostasis. Vitamin D₃’s important biological effects occur only as a consequence of its metabolism into a family of daughter metabolites, including the key kidney-produced metabolite 1α,25-dihydroxyvitamin D₃ \([1\alpha,25(\text{OH})_2 \text{D}_3]\). Researchers consider 1α,25(OH)₂D₃ to be a steroid hormone and believe that it functions the same way as other steroid hormones—by interacting with its cognate vitamin D receptor (VDR) (1).

The role of vitamin D₃ as a vitamin or essential dietary component, in concert with the biological and clinical importance of the steroid hormone 1α,25(\text{OH})₂D₃ and the VDR, has achieved increasing prominence over the past 3 to 4 decades in the public health arena because of its contributions to good health in the general public. However, despite the plethora of publications and scientific meetings focusing on advances in vitamin D science, there is the disturbing realization that all is not “well” with the translation of the newer scientific and clinical knowledge into the achievement of better health. Scientists and nutrition experts at the 13th Vitamin D Workshop held in 2006 agreed in a consensus statement that “about half of the elderly in North America and two-thirds of the rest of the world are not getting enough vitamin D to maintain healthy bone density, lower their risks for fractures and improve tooth attachment. Such vitamin D insufficiency also decreases muscle strength and increases the risk for falls and is even associated with increased risk for colorectal and other major cancer” (2).

The purpose of this article is to identify the fundamentals of the vitamin D endocrine system and the actions of 1α,25(\text{OH})₂D₃ that are essential for good health, keeping in mind that the totality of their contributions depends on the adequate availability of 25-hydroxyvitamin D₃ [25(OH)D₃], which in turn depends on appropriate vitamin D nutritional status as determined by ultraviolet (UV) radiation exposure and dietary intake of vitamin D₃.

SOURCES OF VITAMIN D

Vitamin D is not technically a vitamin, ie, it is not an essential dietary factor; rather, it is a prohormone produced photochemically in the skin from 7-dehydrocholesterol. The molecular structure of vitamin D is closely allied to that of classic steroid hormones (eg, estradiol, cortisol, and aldosterone) in that they have the same root cyclopentanoperhydrophenanthrene ring structure. Technically, vitamin D is a seco-steroid because one of the rings of its cyclopentanoperhydrophenanthrene structure has a broken carbon-carbon bond; in vitamin D₃, this occurs in the 9,10 carbon-carbon bond of ring B (Figure 1). Given that fact as a starting point, the reader must have access to some of the details of the sunlight-mediated photochemical conversion of 7-dehydrocholesterol into vitamin D₃; this information is provided in Figure 1.

The skin produces vitamin D₃ photochemically from the provitamin D₇-dehydrocholesterol, which is present in the epidermis or skin of higher animals, by the action of sunlight in most geographical locations or of artificial UV light. The conjugated double-bond system in ring B (see Figure 1) allows the absorption of light quanta at
VITAMIN D ENDOCRINE SYSTEM

Vitamin D3 does not have any known intrinsic biological activity. It must first be metabolized to 25(OH)D3 in the liver and then to 1α,25(OH)2D3, 24R,25-dihydroxyvitamin D3, or both by the kidney. Researchers have isolated and chemically characterized some 37 vitamin D3 metabolites. Investigators have also established that humans and some other animals can metabolize vitamin D3 to 25(OH)D2 and 1α,25(OH)2D2 and many other similar cognate metabolites.

The steps in the vitamin D endocrine system include the following: (1) the photoconversion of 7-dehydrocholesterol to vitamin D3 in the skin or dietary intake of vitamin D3; (2) metabolism of vitamin D3 by the liver to 25(OH)D3, the major form of vitamin D3 circulating in the blood compartment; (3) conversion of 25(OH)D3 by the kidney (functioning as an endocrine gland) to the hormone 1α,25(OH)2D3; and the candidate hormone 24R,25(OH)2D3; (4) systemic transport of the dihydroxylated metabolites 24R,25(OH)2D3 and 1α,25(OH)2D3 to distal target organs; and (5) binding of 1α,25(OH)2D3 to a nuclear receptor, plasma membrane receptor, or both at the target organs, followed by generation of appropriate biological responses.

The most important regulation point in the classic vitamin D endocrine system occurs through the stringent control of the circulating concentration of the steroid hormone 1α,25(OH)2D3; typically, its production is modulated according to the organism’s calcium and other endocrine needs. The chief regulatory factors are 1α,25(OH)2D3 itself, which down-regulates its own production; parathyroid hormone, which stimulates the renal production of 1,25(OH)2D3; fetal growth factor 23; and serum concentrations of calcium and phosphate.

The pervasive contributions of the VDR in collaboration with its ligand, 1α,25(OH)2D3, to the functioning of the vitamin D endocrine system are illustrated in Figure 3 and listed in Table 1. Thirty-six tissues definitively possess the VDR, which means that the cells in these tissues have the potential to produce biological responses, depending on the availability of appropriate amounts of vitamin D3.
Barbour et al (12) discovered the first extrarenal 25(OH)D3-1α-hydroxylase in 1981 in a hypercalcemic anephric patient with sarcoidosis. Researchers now recognize that in individuals with any of a number of granulomatous diseases, the locally produced 1α,25(OH)2D3 frequently spills over into the general circulation, which results in hypercalcemia. Researchers have shown that the enzyme that converts 25(OH)D3 into 1α,25(OH)2D3, namely the 25(OH)D3-1α-hydroxylase, is present in a paracrine fashion in at least 10 tissues in addition to the proximal tubule of the kidney (Table 2). Thus, cells that express a functional 25(OH)D3-1α-hydroxylase acquire the ability to produce local concentrations of the steroid hormone 1α,25(OH)2D3. This “local” or modest production of 1α,25(OH)2D3 then generates biological responses in the local cellular neighborhood. It is believed that this paracrine-generated 1α,25(OH)2D3 does not normally spill over into the circulatory system; thus, the plasma concentration of 1α,25(OH)2D3 does not increase in a measurable way. The ability of locally produced 1α,25(OH)2D3 to promote cell differentiation in prostate cancer (24) and colon cancer cells (25) are examples demonstrating its potential biological importance.

**EXPANSION OF VITAMIN D KNOWLEDGE**

The consequences that the new knowledge of the vitamin D endocrine system and the various vitamin D metabolites has had on the rate of publication of peer-reviewed articles on vitamin D

**TABLE 1**

| Tissue distribution | 
|---------------------|---|
| Adipose | Muscle, embryonic |
| Adrenal | Muscle, smooth |
| Bone | Osteoblast |
| Bone marrow | Ovary |
| Brain | Pancreas β cell |
| Breast | Parathyroid |
| Cancer cells | Parotid |
| Cartilage | Pituitary |
| Colon | Placenta |
| Eggshell gland | Prostate |
| Epididymis | Retina |
| Hair follicle | Skin |
| Intestine | Stomach |
| Kidney | Testis |
| Liver (fetal) | Thymus |
| Lung | Thyroid |
| Lymphocytes (B & T) | Uterus |
| Muscle, cardiac | Yolk sac (bird) |

1 For reference citations on the distribution of the vitamin D receptor, see reference 8.

**TABLE 2**

<p>| Sites of extrarenal 1α,25-dihydroxyvitamin D3 production in humans1 |
|--------------------------|----------|-----------------|-----------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Tissue</th>
<th>mRNA2</th>
<th>Protein3</th>
<th>Enzymatic activity4</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>(13)</td>
</tr>
<tr>
<td>Dendritic cells</td>
<td>Y</td>
<td>—</td>
<td>—</td>
<td>(14)</td>
</tr>
<tr>
<td>Endothelial cells</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>(15)</td>
</tr>
<tr>
<td>Human brain</td>
<td>—</td>
<td>Y</td>
<td>—</td>
<td>(16)</td>
</tr>
<tr>
<td>Mammary, breast</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>(17)</td>
</tr>
<tr>
<td>Pancreatic islets</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>(18)</td>
</tr>
<tr>
<td>Parathyroid glands</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>(19)</td>
</tr>
<tr>
<td>Placenta, decidua</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>(20)</td>
</tr>
<tr>
<td>Prostate</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>(21)</td>
</tr>
<tr>
<td>Skin, keratinocytes</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>(22, 23)</td>
</tr>
</tbody>
</table>

1 Based on the presence of the 25-hydroxyvitamin D3-1α-hydroxylase enzyme. Hewison and colleagues have studied the tissue localization of the extrarenal 25-hydroxyvitamin D3-1α-hydroxylase enzyme extensively in humans (18, 20).
2 Detection of mRNA for the 1α-hydroxylase and the 1α-hydroxylase protein.
3 Presence of measurable enzymatic activity of the 25-hydroxyvitamin D3-1α-hydroxylase.

FIGURE 3. The vitamin D endocrine system. In this system, the biologically inactive vitamin D3 is activated, first in the liver to produce 25-hydroxyvitamin D3 [25(OH)D3], and the endocrine gland (the kidney) converts it to the hormones 1α,25-dihydroxyvitamin D3 [1α,25(OH)2D3] and 24R,25-dihydroxyvitamin D3 [24R,25(OH)2D3]. Researchers have identified ≥56 target organs, defined by the presence of the vitamin D receptor (VDR), which is the receptor for the steroid hormone 1α,25(OH)2D3; see Table 1 for a list of these target organs. Table 2 lists the 10 extrarenal tissues that investigators have shown possess the 1α-hydroxylase, the enzyme that converts 25(OH)D3 to the steroid hormone 1α,25(OH)2D3. Pi, inorganic phosphate.
is illustrated in Figure 4. In 1975, journals published only \( \approx \) 100 articles per year that included the term vitamin D in the title or abstract; by 2007, the rate of publication had increased to \( > 1400 \) articles per year. Another driving factor for this increased publication rate was the chemical synthesis by academic chemists and by 4 pharmaceutical companies of \( > 2000 \) analogues of \( 1\alpha,25(\text{OH})_2\text{D} \); most of these analogues were targeted toward selective responses in diseases such as osteoporosis, renal osteodystrophy, and psoriasis, and the authors reported their biological properties in a multitude of publications (8, 26).

Thus, an enormous body of scientific literature currently exists for vitamin D. PUBMED (National Library of Medicine, Bethesda, MD) lists \( > 20 \) 700 publications that use the term vitamin D in either the title or abstract from 1950 to the present. This total includes articles that combine the use of vitamin D with one of the following terms: bone (> 6300 articles), deficiency (> 2900), cancer (> 1500), renal failure (> 700), intestine (> 700), cardiovascular/heart (> 600), diabetes (> 470), insulin (> 450), or brain (> 270). Finally, PUBMED lists > 4500 publications with the term vitamin D in the title or abstract, > 660 articles with vitamin D, and > 2600 articles with calcitriol [a synonym for \( 1\alpha,25(\text{OH})_2\text{D} \)].

Unfortunately, the proliferation of published articles on vitamin D occurred at the same time as the use by many authors of less precise terminology to describe 3 key vitamin D molecules, with one of the following: vitamin D, vitamin D2, and vitamin D3. Figure 2 emphasizes the structural differences between vitamins D1 and D2 and provides a clear description and comparison of the biological properties of these 2 key molecules. This figure shows that 1) vitamin D3 is the only naturally occurring form of vitamin D in humans and other animals and 2) vitamin D2 has only one-third the biological activity of vitamin D1 in humans (7). Given the significant differences in the biological activity of vitamin D3 and vitamin D2, describing a clinical trial by writing that “the patients received 10 \( \mu \)g (400 IU) of vitamin D” is not a best practice when the patients actually received vitamin D2, whose biological activity is equivalent to only 3.25 \( \mu \)g (130 IU) vitamin D3.

Another frequent error occurs when authors use vitamin D as a synonym for \( 1\alpha,25(\text{OH})_2\text{D} \), sometimes even in the methods sections of articles. The very significant structural and biological differences between \( 1\alpha,25(\text{OH})_2\text{D} \) and vitamin D1 are emphasized in Figure 5, which clearly shows why authors must not use vitamin D to refer to \( 1\alpha,25(\text{OH})_2\text{D} \). If, for example, a reader sees the following statement in the results or discussion section of an article, “the animals or subjects received a standard vitamin D dose that would not cause hypercalcemia,” he or she would make a serious error of interpretation if he or she had not carefully read the methods section to learn that “all subjects received a dose of 1.5 micrograms of \( 1\alpha,25(\text{OH})_2\text{D} \).”

MODE OF ACTION OF \( 1\alpha,25(\text{OH})_2\text{D} \): GENOMIC ACTIONS

The steroid hormone \( 1\alpha,25(\text{OH})_2\text{D} \) and many other steroid hormones (eg, estradiol, progesterone, testosterone, cortisol, and aldosterone) generate biological responses both by regulating gene transcription (the classic genomic responses) and by rapidly activating a variety of signal transduction pathways at or near the plasma membrane (rapid or nongenotropenic responses) (27). The genomic responses to \( 1\alpha,25(\text{OH})_2\text{D} \) result from its stereospecific interaction with its nuclear receptor, VDRnuc (Figure 6). The VDRnuc is a protein of 50 kDa, which binds \( 1\alpha,25(\text{OH})_2\text{D} \) with high affinity (\( K_d \approx 0.5 \text{nmol/L} \)). The VDRnuc does not bind the parent vitamin D3, or vitamin D2; \( 25(\text{OH})_2\text{D} \) and \( 1\alpha(\text{OH})_2\text{D} \) only bind \( 0.1–0.3\% \) as well as \( 1\alpha,25(\text{OH})_2\text{D} \). As is true for all nuclear receptors for the steroid hormones involved, the primary amino acid sequence of the VDRnuc consists of 6 functional domains: the variable regions (A and B domains), DNA binding (the C domain), the hinge region (D domain), the ligand-binding region (E domain), and transcriptional activation (domain F) (28). A detailed discussion of the VDRnuc and its participation in the regulation of gene transcription is available elsewhere (28).

Nuclear-receptor–mediated regulation of gene transcription depends on the exquisite structural relation between the unoccupied receptor, which is transcriptionally inactive, and its cognate ligand \( 1\alpha,25(\text{OH})_2\text{D} \). Formation of the ligand-receptor complex, which results in conformational changes in the receptor protein, then allows the ligand-receptor complex to specifically interact with the many proteins that collectively constitute the transcriptional machinery. The complementarity of the ligand shape with that of the interior surface of the nuclear VDR ligand binding domain is key not only to the structural basis of receptor action and its formation of heterodimers and interactions with coactivators (Figure 7), but also to designing new drug forms of vitamin D.
VITAMIN D, 1,25(OH)2D3, VITAMIN D RECEPTOR, AND HEALTH 495S

Determination of Vitamin D Status

As stated in the Introduction, the actions of 1α,25(OH)2D3 are essential for good health, depending on the vitamin D endocrine system. The operation of the vitamin D endocrine system to produce the steroid hormone 1α,25(OH)2D3 depends on the circulating concentration of 25(OH)D3. This key metabolite is the substrate for the 25(OH)D3-1α-hydroxylase enzyme that produces 1α,25(OH)2D3. As is the case for any enzyme, the activity of 1α-hydroxylase depends on the absolute concentration of its substrate. The Km or substrate concentration of 25(OH)D3 required for 50% maximal activity for the 1α-hydroxylase is 700 nmol/L (11). As emphasized in Figure 2, the availability of 25(OH)D3 depends on adequate access to vitamin D3. Thus, determining vitamin D nutritional status becomes a critical issue in optimizing the prospects for those aspects of “good health” that 1α,25(OH)2D3 can mediate or to which it can contribute.

Surprisingly, despite extensive efforts, no routine clinical assay is available for determining the serum concentration of either vitamin D3 or vitamin D2. Furthermore, researchers are unlikely to develop a routine serum vitamin D clinical assay in the future. However, the US Institute of Medicine has endorsed the view that vitamin D nutritional status by determining the serum concentrations of several vitamin D metabolites is presented in Tables 3 and 4. Table 34 presents a tabulation of the circulating serum concentrations of the 3 major vitamin D metabolites: 25(OH)D3, 24,25(OH)2D3, and 1α,25(OH)2D3. The molar ratio of the total (not free steroid) serum concentrations of these metabolites is 830:77:1 for 25(OH)D3 to 24,25(OH)2D3 to 1α,25(OH)2D3. Investigators primarily measure circulating concentrations of 24,25(OH)2D3 for studies of rapid nongenomic actions of 1α,25(OH)2D3 and its analogues show that the VDRnuc preferentially binds a ligand with a 6-s-cis shape (27). This new ligand structure-function relationship will allow chemists to synthesize analogues of 1α,25(OH)2D3 that are selective for either genomic or rapid responses, depending on the ligand’s overall shape.
experimental animal studies or selected clinical studies; such measurements are not available through commercial laboratories. Many, but not all, clinical chemistry laboratories can measure 1α,25(OH)2D3 concentrations. Because serum 1α,25(OH)2D3 values do not correlate with clinical disease status, information on serum 1α,25(OH)2D3 concentration does not usually help with clinical diagnosis and treatment (48).

Most researchers agree that the range of the serum concentration of 25(OH)D3 in a population of healthy subjects is the best indicator for assessing the vitamin D status in patients with a vitamin D–related disease. The factors supporting this include: 1) no vitamin D clinical assay is available; 2) vitamin D–related disease. The factors supporting this include: 1) no vitamin D clinical assay is available; 2) the metabolism of vitamin D3 into 25(OH)D3 by the liver vitamin D–25-hydroxylase is not regulated, so the serum concentration of 25(OH)D3 is an accurate “reporter” of both cutaneous UV-stimulated synthesis and dietary intake of vitamin D3; 3) a variety of clinical assays are available to measure 25(OH)D; and 4) the plasma concentrations of 25(OH)D3 correlate with many clinical diseases (6, 46). Hollis et al (41) argued that the relation between vitamin D3 and 25(OH)D3 is not linear, but rather saturable and controlled. They conclude that “optimal vitamin D status was achieved when 25(OH)D3 was > 40 ng/mL or > 100 nmol/L,” which is approximately equivalent to the Km of the 25(OH)D3-1α-hydroxylase.

Presented in Table 4 is a classification of circulating levels of 25(OH)D in relation to vitamin D nutritional status that was largely obtained from clinical studies relating to calcium homeostasis (intestinal calcium absorption, bone mineral density, parathyroid hormone concentrations, etc.). In a large population of vitamin D–replete subjects, the normal range of 25(OH)D was found to be 25–137 nmol/L. But it was also noted that the lower limit of the normal range can vary among populations, ranging from as low as 20 up to 50 nmol/L (5). Undoubtedly, it will ultimately be essential to determine the normal 25(OH)D range in all ethnic groups and geographical populations of the world (at all latitudes to reflect differing UV exposures). I believe that a major goal for the vitamin D field is to agree on the “normal 25(OH)D serum levels that support all 36 VDR-containing target organs in all the world’s population groups.

FUNDAMENTALS OF VITAMIN D AND ITS ENDOCRINE SYSTEM FOR GOOD HEALTH

The purpose of the Adequate Intake recommendations for vitamin D put forth by the Food and Nutrition Board of the Institute of Medicine (5) in 1999 was to provide guidelines of vitamin D2 intake to achieve normal serum levels of 25(OH)D. This was a very difficult goal to achieve, however, given that a quantitative relation of vitamin D’s (ie, operation of the vitamin D endocrine system) contribution to good health was not clearly appreciated by 1997.

Tables 5 and 6 focus on the new biological actions of the steroid hormone 1α,25(OH)2D3 that must be carefully studied to appreciate their dependency on an adequate availability of vitamin D3 to generate biological responses that are mediated by 1α,25(OH)2D3, to be fully compatible with proper health for each individual in the population. The 2 historical roles of vitamin D, namely stimulation of intestinal calcium absorption and increasing the mineral content and the remodeling of bone, are summarized in Table 5. For each process (intestine or bone), historical reference citations are provided to create the foundation that vitamin D is crucial to bone mineral content and intestinal calcium absorption. Thus, between 1922 and 1924, the pioneers Mellanby (54), McCollum (55), and Goldblatt (56) made the separate bone-related discoveries, respectively, that 1) the treatment or prevention of rickets could be mediated by cod liver oil; 2) by feeding a new vitamin, termed vitamin D; or 3) by exposure of skin to UV irradiation. Then in 1937, Nicolaison (49) showed the potent actions of vitamin D3 on stimulating intestinal calcium absorption in rats. Also included in Table 5 are comparable modern observations implicating the participation of the VDR and 1α,25(OH)2D3 in both intestinal calcium absorption and bone remodeling. It is these actions of 1α,25(OH)2D3 and its VDR that were largely addressed in 1999 by the Food and Nutrition Boards’ guidelines for Adequate Intake of vitamin D3.

Table 4

<table>
<thead>
<tr>
<th>Serum 25(OH)D range</th>
<th>Vitamin D nutritional status</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–49 nmol/L</td>
<td>Sufficiency</td>
<td>(42)</td>
</tr>
<tr>
<td>25–99 nmol/L</td>
<td>Sufficiency</td>
<td>(2, 43)</td>
</tr>
<tr>
<td>100–199 nmol/L</td>
<td>Insufficiency</td>
<td>(44)</td>
</tr>
<tr>
<td>200–499 nmol/L</td>
<td>Deficiency</td>
<td>(43)</td>
</tr>
<tr>
<td>500–999 nmol/L</td>
<td>Severe deficiency</td>
<td>(43)</td>
</tr>
</tbody>
</table>

The classification of 25(OH)D concentrations into sufficiency, insufficiency, deficiency, and severe deficiency represents the author’s interpretation of definitions in the publications listed. Researchers have suggested 2 distinct minimum serum concentrations of 25(OH)D for vitamin D sufficiency: >50 nmol/L and >75 nmol/L. The serum concentrations listed in the table refer to the sums of the concentrations of 25(OH)D2 and 25(OH)D3. Certain methods for measuring 25(OH)D concentration yield information on both 25(OH)D2 and 25(OH)D3 without distinguishing between the two. However, mass spectrometry provides discrete values for each form of 25(OH)D. The use of liquid chromatography–tandem mass spectrometry has made it possible to simultaneously and routinely determine the amount of 25(OH)D2 and 25(OH)D3 in a small blood sample (45–47); the major drawback is that this costs more than $100 per determination. In addition, many physicians cannot interpret differences between 25(OH)D2 and 25(OH)D3 concentrations.

Persons with a 25(OH)D3 concentration <20 nmol/L probably have rickets or osteomalacia (5).

In Table 6 are the 5 physiologic arenas in which new biological actions of 1α,25(OH)2D3 have been implicated, namely 1) promotion of intestinal calcium absorption; 2) maintenance of bone health; 3) bone remodeling; 4) modulation of the immune response; and 5) regulation of extraintestinal calcium absorption.

1 25(OH)D, 25-hydroxyvitamin D; 24R, 25(OH)2D, 24R, 25-dihydroxyvitamin D; 1α, 25(OH)2D, 1α,25-dihydroxyvitamin D3; Vitamin D (both D2 and D3) is quite difficult to measure because of its hydrophobicity, so vitamin D measurements require extensive HPLC (40). A US Institute of Medicine report has endorsed the view that the circulating concentration of 25(OH)D is a functional measure of vitamin D nutritional status (5); see also reference 36.
TABLE 6
Newly identified biological actions of 1α, 25(OH)2D3 with relevance to vitamin D nutritional status and resulting good health

<table>
<thead>
<tr>
<th>VDR-dependent system</th>
<th>VDR present or involved</th>
<th>Observation</th>
<th>Key reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intestinal calcium absorption</td>
<td>Not yet discovered</td>
<td>Vitamin D stimulates intestinal calcium and phosphorus absorption.</td>
<td>(49)</td>
</tr>
<tr>
<td>Intestinal calcium absorption</td>
<td>Yes</td>
<td>1α,25(OH)2D3 stimulates intestinal calcium absorption in chicks and humans.</td>
<td>(50–52)</td>
</tr>
<tr>
<td>Bone formation and resorption (remodeling)</td>
<td>Not yet discovered</td>
<td>Giving the patient a new dietary supplement, called vitamin D, or exposing the skin to ultraviolet irradiation can prevent or treat rickets.</td>
<td>(54–56)</td>
</tr>
<tr>
<td>Bone formation and resorption (remodeling)</td>
<td>VDR</td>
<td>The actions of 1α,25(OH)2D3 on the osteoblast (bone formation) and crosstalk with the osteoclast result in bone resorption and overall bone remodeling.</td>
<td>(53)</td>
</tr>
</tbody>
</table>

VDR, vitamin D receptor; 1α,25(OH)2D3, 1α,25-dihydroxvitamin D3.

TABLE 5
Roles of vitamin D identified in the early 20th century

<table>
<thead>
<tr>
<th>VDR-dependent system</th>
<th>VDR present or involved</th>
<th>Observation</th>
<th>Key reference</th>
</tr>
</thead>
<tbody>
<tr>
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<td>(53)</td>
</tr>
</tbody>
</table>

VDR, vitamin D receptor; 1α,25(OH)2D3, 1α,25-dihydroxvitamin D3.

clearly documented and which have the capability of contributing to better health through improved vitamin D nutritional status. These include understanding at the molecular level the involvement of the VDR and 1α,25(OH)2D3 (in both genomic and rapid responses) in 1) the functioning of B and T lymphocytes, which constitutes the adaptive immune system; 2) the innate immune system; 3) secretion of insulin by the pancreatic β cell; 4) the multifactorial functioning of the heart and blood pressure regulation; and 5) the multitude of activities of the brain. There are also multiple opportunities to address how the actions of the VDR and 1α,25(OH)2D3 can affect several diseases. These include prevention and treatment of several cancers (breast, colon, and prostate) through prodifferentiation, antiproliferation, or inactivation of growth signals, which constitute the adaptive immune system. Researchers must also understand the role of proper vitamin D nutrition and the molecular actions of the VDR with 1α,25(OH)2D3 for all the steps of fetal development.

The important points made in this presentation are summarized in Figure 7. Researchers must understand the fundamentals of the vitamin D endocrine system, which include 1) vitamin D nutritional status (dietary intake and sunlight exposure), which define the circulating concentration of 25(OH)D3 that is available to 2) the kidney functioning as an endocrine gland, which is complemented by 3) the paracrine 1α-hydroxylase activities in 10 tissues to produce the steroid hormone 1α,25(OH)2D3, which will 4) interact with the VDR in ≥36 target tissues to generate optimal responses in the calcium homeostasis system. Researchers must also understand the 5 new physiologic systems that collectively comprise the vitamin D endocrine system.
One can derive at least 3 important conclusions, one prediction, and one expectation from the discoveries made over the past 30 y pertaining to the wide tissue distribution of both the VDR and the extrarenal 25(OH)D3-1α-hydroxylase.

Conclusions

1) Recent research has shown that vitamin D3’s biological sphere of influence is much broader than researchers originally thought, as shown by the tissue distribution of the VDR, from mediating only calcium homeostasis (intestine, bone, kidney, and parathyroid) to functioning as a pluripotent hormone in 5 physiologic arenas in which researchers have clearly identified additional biological actions of 1α,25(OH)2D3 through the VDR. These physiologic arenas are the adaptive immune system, the innate immune system, insulin secretion by the pancreatic β cell, multifactorial heart functioning and blood pressure regulation, and brain and fetal development.

2) Researchers have also expanded the parent vitamin D3’s nutritional sphere of influence from a focus on bone health to include 5 additional physiologic systems.

3) The nutritional guidelines for vitamin D intake must be carefully reevaluated to determine the adequate intake (balancing sunlight exposure with dietary intake) to achieve good health by involving all 36 target organs rather than just the first 4 target organs (intestine, kidney, bone, and parathyroid gland) that are considered for calcium homeostasis.

Corollary

Given that vitamin D3 is significantly less biologically active in humans than is vitamin D2 (7), its biological use as a dietary supplement in the United States should be discontinued and its use in a high-dose form [eg, 500 000 IU/mL of ergocalciferol (vitamin D2)] in clinical studies (73, 74) and as described in the Physicians Desk Reference (75) should be replaced by a new formulation of high-dose vitamin D3.

Prediction

Given the large expansion of the vitamin D endocrine system, the number of identified diseases or consequences of vitamin D deficiency or insufficiency will greatly increase to reflect the fact that the number of target organs for 1α,25(OH)2D3 has increased ≈9-fold since the discovery of the VDR in intestine, bone, kidney, and parathyroid tissues in the early 1970s.

Expectation or hope

More than ever, we need to increase the amount of research on vitamin D (ie, increase funding from government agencies and pharmaceutical companies) to meet the challenge of maximizing the knowledge of how to use vitamin D in the context of the vitamin D endocrine system to preserve or improve the health of everyone on the planet.

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