CLINICAL STUDY

Plasma 1,25(OH)2D levels decrease in postmenopausal women with hypovitaminosis D

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Abstract

Objective: Although calcitriol (1,25(OH)2D) is considered the biologically active vitamin D metabolite, several studies have shown that calcidiol (25OHD) is the vitamin D metabolite that is most closely linked to parathyroid function and indices of calcium homeostasis. Moreover, low levels of 25OHD have been associated with increased risk of different diseases including cancer, diabetes, and myopathy.

Design: Cross-sectional study.

Methods: We studied relations between plasma concentrations of 25OHD, 1,25(OH)2D, and parathyroid hormone (PTH) in fasting plasma samples from 315 healthy postmenopausal women randomly selected from the local background population.

Results: P-1,25(OH)2D levels varied in a concentration-dependent manner with P-25OHD levels (P<0.001). Thus, P-1,25(OH)2D levels were the lowest in women with vitamin D insufficiency, i.e., P-1,25(OH)2D levels were reduced by approximately one-third in subjects with P-25OHD levels below 25 nmol/l compared with levels above 80 nmol/l (P<0.01). The association was most pronounced at P-25OHD concentrations below 80 nmol/l, whereas no major increase in P-1,25(OH)2D was observed at P-25OHD concentrations above 80 nmol/l. In multiple regression analysis, PTH was a minor although significant predictor of P-1,25(OH)2D levels.

Conclusions: In normal postmenopausal women, the conversion of 25OHD to active vitamin D depends on the substrate concentration. Our data support that vitamin D insufficiency should be considered at P-25OHD levels below 80 nmol/l.

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Introduction

Vitamin D is either absorbed from the diet or synthesized in the skin in response to ultra-violet type B rays (UVB) exposure. Subsequently, vitamin D is hydroxylated to 25-hydroxyvitamin D (25OHD) in the liver. Often, 25OHD is considered biologically inert, as it needs to be activated to calcitriol (1,25(OH)2D) by a specific 1alpha-hydroxylase before it activates the vitamin D receptor (1). Parathyroid hormone (PTH) and 1,25(OH)2D are the principal regulators of calcium homeostasis and both hormones affect the synthesis of each other. Thus, PTH stimulates the renal 1alpha-hydroxylase and 1,25(OH)2D downregulates the synthesis of PTH (2). Circulating 1,25(OH)2D is produced in the proximal tubuli of the kidney by a renal 1alpha-hydroxylase. In addition to PTH, the 1alpha-hydroxylase is activated by hypophosphatemia and hypocalcemia, whereas it is inhibited by its own product (1,25(OH)2D). Moreover, kidney diseases is a well-recognized cause of decreased 1,25(OH)2D levels.

Plasma 25OHD (P-25OHD) is considered to mirror the individual ‘vitamin D status’ since it reflects the sum of vitamin D absorbed from the intestine and produced in the skin. Although 25OHD is considered biologically inactive, a large amount of studies have shown that P-25OHD is an important determinant of several biological functions including bone mineralization and muscle function (2, 3). In addition, circulating levels of PTH are more closely inversely related to P-25OHD than P-1,25(OH)2D (4). Finally, an impaired vitamin D status has been associated with an increased risk of cancer and several chronic disorders, including diabetes, multiple sclerosis, periodontal disease, and cardiovascular diseases (2, 5). Recently, it has been shown that the biological effects associated with circulating 25OHD may be explained by the conversion of 25OHD to 1,25(OH)2D in many different tissues, including parathyroid glands, malignant cells, immune competent cells, smooth muscle cells, and pancreatic beta-cells (3).

Despite the fact that 25OHD is a precursor for 1,25(OH)2D, and the finding that impaired vitamin D status is very common in the general population, there is a paucity of data on relations between plasma levels of 25OHD and 1,25(OH)2D in normal individuals. It has often been stated that low 25OHD levels cause a compensatory secondary hyperparathyroidism (SHPT).
that increases the renal conversion of 25OHD to 1,25(OH)₂D and thereby maintains normal or slightly increased plasma levels of 1,25(OH)₂D until the vitamin D deficiency is severe enough (frank osteomalacia) to limit the availability of 25OHD and thereby reduce 1,25(OH)₂D production (6). On the other hand, other investigators have reported a positive association between plasma levels of 25OHD and 1,25(OH)₂D (7–11). In order to investigate further whether vitamin D status affects P-1,25(OH)₂D levels we studied the associations between these two vitamin D metabolites in a group of healthy postmenopausal women.

**Subjects and methods**

Through direct mailings, we invited women, randomly selected from the local background population to participate in clinical studies concerning the effects of diuretics on calcium homeostasis and bone metabolism (12–14). The data presented are based on the data from baseline measurements.

To be included, participants were required to be more than 12 months post menopause, and to be healthy as assessed by a standard questionnaire and a biochemical screening program. Subjects with illnesses or taking medications known to affect bone mineral metabolism (including hormone replacement therapy, diuretics, and pharmacological doses of calcium and vitamin D supplements) were excluded. The studies were carried out in accordance with the Declaration of Helsinki II and were approved by the regional Ethical Committee and the Danish National Board of Health. Each individual gave verbal and written informed consent prior to the study.

Blood samples were drawn between 0700 and 0930 h after an overnight fast. Plasma levels of calcium, phosphate, and creatinine were determined by standard laboratory methods. Total plasma calcium was corrected for individual variations in albumin according to the formula: adjusted plasma calcium (mmol/l) = plasma calcium_total (mmol/l) – 0.00086 × (650 – plasma albumin (μmol/l)). Samples for analysis of calcitropic hormones were divided in aliquots and stored immediately at ~80 °C until analysis.

Plasma intact PTH was measured by an IMMULITE automated analyser (Diagnostic Products Corporation, Los Angeles, CA, USA). The total coefficient of variation (CV) was <7%. Plasma 25-hydroxyvitamin D (25-OH)D was measured by an equilibrium RIA procedure (DiaSorin Inc., Stillwater, MN, USA). The inter- and intra-assay CV were 13 and 10% respectively. Plasma 1,25(OH)₂D was measured by a competitive radio-receptor assay (Nichols Institute Diagnostics, San Juan Capistrano, CA, USA). The inter- and intra-assay CV were 10 and 8% respectively.

**Statistical analysis**

Differences between groups were compared by one-way ANOVA or the non-parametric Kruskal–Wallis test, as appropriate, after testing for normal distributions. When indicated, we performed logarithmic transformation of data. Bivariate as well as linear and non-linear regression analysis were used to assess the correlations between variables. Differences between groups were adjusted for using a general linear regression model. Statistical analysis was performed using Statistical Package for Social Sciences (SPSS 14.0, Chicago, Illinois, USA) for Windows.

**Results**

Table 1 shows characteristics of the 315 included subjects. The women had a median age of 64 (range: 50–82) years. In the study group, 39% had vitamin D insufficiency as defined as P-25OHD < 50 nmol/l and 9% had vitamin D deficiency, i.e., P-25OHD < 25 nmol/l, whereas 22% had P-25OHD levels above 80 nmol/l (Table 1).

As shown in Table 2, P-1,25(OH)₂D levels varied with plasma concentrations of its precursor, 25OHD (P < 0.001). P-1,25(OH)₂D levels were the lowest in women with vitamin D deficiency and the highest in women with P-25OHD levels above 80 nmol/l. This was not changed by the adjustment for differences between categories of vitamin D status; i.e., after an adjustment for age, body weight, and plasma creatinine levels, those with P-25OHD levels below 25 nmol/l had lower P-1,25(OH)₂D levels than subjects with P-25(OH)D levels above 25 nmol/l, and the between-group difference remained significant after further adjustment for plasma levels of PTH, calcium, and phosphate (Table 2).

In order to disclose a possible threshold level for further increase in P-1,25(OH)₂D with increasing P-25OHD, we plotted 1,25(OH)₂D concentrations across 10 nmol/l steps of P-25OHD concentrations (Fig. 1).

**Table 1** Characteristics of included women.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>All subjects (n = 315)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>64 (60–70)</td>
</tr>
<tr>
<td>Body weight (kg)</td>
<td>66.7 (60.0–73.5)</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>25.3 (23.1–27.9)</td>
</tr>
<tr>
<td>Plasma</td>
<td></td>
</tr>
<tr>
<td>Calcium (mmol/l)</td>
<td>2.43 (2.39–2.48)</td>
</tr>
<tr>
<td>Phosphate (mmol/l)</td>
<td>1.0 (1.0–1.2)</td>
</tr>
<tr>
<td>Creatinine (μmol/l)</td>
<td>78 (71–84)</td>
</tr>
<tr>
<td>PTH (pmol/l)</td>
<td>4.8 (3.7–6.2)</td>
</tr>
<tr>
<td>25OHD (nmol/l)</td>
<td>57 (40–78)</td>
</tr>
<tr>
<td>No. with p-25OHD &lt; 25 nmol/l (%)</td>
<td>27 (9%)</td>
</tr>
<tr>
<td>No. with p-25OHD &lt; 50 nmol/l (%)</td>
<td>124 (39%)</td>
</tr>
<tr>
<td>No. with p-25OHD &lt; 80 nmol/l (%)</td>
<td>246 (78%)</td>
</tr>
<tr>
<td>1,25(OH)₂D (pmol/l)</td>
<td>118 (97–147)</td>
</tr>
</tbody>
</table>

Median with interquartile (25–75%) range.
P-1,25(OH)2D levels increased gradually until P-25OHD reached \( \sim 70–80 \) nmol/l with no further increases at concentrations above 80 nmol/l.

A bivariate analysis showed a significant correlation \( (r=0.40, \; P<0.001) \) between P-1,25(OH)2D and P-25OHD levels. As expected, PTH and 25OHD levels also correlated significantly \( (r=0.35; \; P<0.001) \) with increasing PTH levels at P-25OHD < 50 nmol/l. No correlation was found between P-PTH and P-1,25(OH)2D \( (r_p=0.08, \; P=0.14) \). However, in a multiple regression analysis including indices known to affect P-1,25(OH)2D levels, PTH levels did influence P-1,25(OH)2D \( (r_p=0.145, \; P=0.01) \), although the major determinant was P-25OHD levels \( (r_p=0.379, \; P<0.01) \). The results of the multiple regression analysis are shown in Table 3 (model summary: \( r=0.542; \; P<0.001 \)). Finally, we studied the relations between P-25OHD and P-1,25(OH)2D stratified by PTH levels. In our studied subjects, the median P-PTH concentration was 4.8 pmol/l. As shown in Fig. 2, P-1,25(OH)2D decreased significantly with decreasing P-25OHD levels and in accordance with the results from the multiple regression analysis, P-PTH levels only affected the relationship to a minor degree.

### Discussion

In a group of healthy postmenopausal women, we found vitamin D status, as assessed by the measurements of plasma 25OHD levels, to be a major determinant of plasma levels of 1,25(OH)2D. Apparently, at P-25OHD levels above 80 nmol/l, P-1,25(OH)2D levels do not increase further, whereas at levels below 80 nmol/l, P-1,25(OH)2D concentrations decrease with decreasing 25OHD levels.

In previous studies, conflicting results have been reported on the effect of low P-25OHD levels on P-1,25(OH)2D levels. Some studies found no relationship between plasma levels of 25OHD and 1,25(OH)2D \( (15–17) \), while other studies have shown either a positive \( (7–11, \; 18) \) or an inverse association \( (19–21) \). Similar, discrepant results have been reported on the
Table 3 Multiple regression analysis on determinants of plasma 1,25(OH)\textsubscript{2}D levels.

<table>
<thead>
<tr>
<th>Partial correlation coefficients ($r_p$)</th>
<th></th>
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<tbody>
<tr>
<td>Age (years)</td>
<td>0.094 ($P=0.10$)</td>
</tr>
<tr>
<td>BMI (kg/m\textsuperscript{2})</td>
<td>-0.182 ($P&lt;0.01$)</td>
</tr>
<tr>
<td>Plasma Calcium (mmol/l)</td>
<td>-0.130 ($P=0.02$)</td>
</tr>
<tr>
<td>Phosphate (mmol/l)</td>
<td>-0.186 ($P&lt;0.01$)</td>
</tr>
<tr>
<td>Creatinine (\mu mol/l)</td>
<td>-0.212 ($P&lt;0.01$)</td>
</tr>
<tr>
<td>PTH (pmol/l)</td>
<td>0.145 ($P&lt;0.01$)</td>
</tr>
<tr>
<td>25OHD (nmol/l)</td>
<td>0.379 ($P&lt;0.01$)</td>
</tr>
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</table>

Overall, model summary: $r=0.542; P<0.001$.

Effect of treatment with ergo- or cholecalciferol on P-1,25(OH)\textsubscript{2}D levels. An increase in 1,25(OH)\textsubscript{2}D levels has been reported in patients with vitamin D insufficiency (9, 19, 22), primary hyperparathyroidism (23), and severe osteomalacia (24), whereas no effect has been found in other studies including healthy subjects (25–27) or patients with SHPT due to hypovitaminosis D (28, 29). Moreover, a biphasic response has recently been noted in an Australian study with a positive correlation between plasma levels of 25OHD and 1,25(OH)\textsubscript{2}D if baseline 25OHD is in the normal range, but a negative correlation if baseline 25OHD is subnormal (30). The size of our study is larger than the most previous studies and supports the notion of a positive relationship between plasma levels of 25OHD and 1,25(OH)\textsubscript{2}D. In some prior studies, negative correlations between plasma levels of 25OHD and 1,25(OH)\textsubscript{2}D have been justified by the inclusion of a large proportion of patients with severe vitamin D deficiency, who might have been exposed immediately before the evaluation to vitamin D supplements (31). However, an increase in 1,25(OH)\textsubscript{2}D levels in response to the supplementation with vitamin D may merely be due to a positive association as demonstrated in our study than an inverse relationship.

Previously, it has been suggested that variations within the physiological range of P-25OHD concentrations are of minor importance for the conversion of 25OHD to 1,25(OH)\textsubscript{2}D, as plasma levels are more than 100 times higher for 25OHD than 1,25(OH)\textsubscript{2}D. Our data do not support this hypothesis. Most likely, the 1\alpha-hydroxylase enzyme is set to handle the conversion of 25OHD at the concentrations normally present in plasma, and apparently it has a set point at which it becomes dependent on the concentration of the substrate, i.e., at a P-25OHD concentration of ~80 nmol/l. Nevertheless, despite low P-25OHD concentrations, 1,25(OH)\textsubscript{2}D is still synthesized, although the plasma concentration is reduced by approximately one-third compared with the subjects with P-25OHD levels above 80 nmol/l.

During recent years, increased attention has been paid to the importance of a sufficient vitamin D status and several investigators have sought to determine the plasma levels of 25OHD that is sufficient to meet physiological needs (5). Traditionally, the hallmark for an insufficient vitamin D status is SHPT, and several studies have shown that P-25OHD levels below 50 nmol/l cause increased PTH levels. Accordingly, it has been suggested that vitamin D insufficiency should be defined as P-25OHD concentration below 50 nmol/l (32). However, recent research using other biomarkers than PTH, including biochemical markers of bone turnover, lower extremity function, BMD, risk of falls and fractures, periodontal disease, intestinal calcium absorption, and insulin sensitivity, has indicated that P-25OHD concentrations above 80 nmol/l are needed to ensure an optimal vitamin D status (3, 33). Interestingly, our results suggest that vitamin D insufficiency defined as P-25OHD levels <80 nmol/l is also associated with impaired plasma levels of 1,25(OH)\textsubscript{2}D.

Circulating 1,25(OH)\textsubscript{2}D is synthesized in the kidney by the renal 1\alpha-hydroxylase. Our study, therefore, indicates that the amount of 1,25(OH)\textsubscript{2}D produced by the renal 1\alpha-hydroxylase in postmenopausal women depends on the plasma concentrations of its precursor, 25OHD. However, in addition to the renal synthesis an increasing body of evidence suggests that 1,25(OH)\textsubscript{2}D also is synthesized in a variety of non-renal cells by the action of local 1\alpha-hydroxylase enzymes (34). The non-renal production of 1,25(OH)\textsubscript{2}D may be of major importance to cell function, as 1,25(OH)\textsubscript{2}D is known to enhance cell differentiation and inhibit cell proliferation. The regulation of the non-renal 1\alpha-hydroxylase enzyme is largely unknown. Nevertheless, in vascular smooth muscle cells the local 1-hydroxylase system has been shown to be upregulated by PTH, indicating a hormonal regulation of the local 1-hydroxylase that is similar to the regulation of the renal enzyme (27). Apart from certain diseases (like sarcoidosis and other granulomatose diseases), it is usually believed that this extra-renal produced 1,25(OH)\textsubscript{2}D is used locally and

![Figure 2](http://www.eje-online.org)
does not enter the systemic circulation. Thus, in healthy subjects the extra-renal 1,25(OH)₂D is unlikely to contribute to mineral homeostasis. However, in active sarcoidoses, the amount of 1,25(OH)₂D released to the circulation depends on dietary vitamin D intake and sun exposure, indicating that the production of 1,25(OH)₂D is substrate regulated (35). Further studies should focus on whether this is the case in other tissues. If so, it may help explaining that an impaired vitamin D status is associated with an increased risk of cancer and different chronic disorders, including diabetes and cardiovascular diseases.

Previous studies have shown that the elimination half-time of 25OHD correlates inversely with P-1,25(OH)₂D concentrations (36). The reduced P-1,25(OH)₂D concentrations in subjects with low P-25OHD levels may therefore help preserve P-25OHD levels, and thereby maintain the amount of 25OHD available for conversion in peripheral tissues.

It is well known that PTH has a stimulatory effect on the renal 1α-hydroxylase and that treatment with 1α-hydroxylated vitamin D analogs is needed to normalize plasma calcium levels in patients with hyperparathyroidism (37). In our study, P-PTH did not correlate with P-1,25(OH)₂D levels in the bivariate analysis. However, in our multiple regression analysis, PTH did contribute significantly to the model. This may implicate that PTH is necessary for the synthesis of 1,25(OH)₂D, but in the setting of vitamin D insufficiency the effects of low P-25OHD levels are not compensated for by increased PTH levels.

**Limitations to study**

In our study, we did not measure calcium intake. In the setting of vitamin D insufficiency, daily intake of calcium has been shown to be of importance to P-PTH levels (38) and may as well influence P-1,25(OH)₂D levels (39). Thus, further studies should focus on whether the positive correlation between plasma levels of 25OHD and 1,25(OH)₂D is influenced by calcium intake. Moreover, it should be studied whether age or polymorphisms in the 25-hydroxyvitamin D₃ 1α-hydroxylase gene (CYP27B1) influence the relationship (27, 40). In addition, the cross-sectional design of our study does not allow for causal conclusions, and therefore the relationship between plasma levels of 25OHD and 1,25(OH)₂D should be evaluated further in experimental studies.

**Conclusion**

Our data suggest that the conversion of 25OHD to 1,25(OH)₂D depends on the concentration of the substrate. It seems that the positive correlation is most pronounced at P-25OHD concentrations below 80 nmol/l. This supports the findings by other investigators of an impaired vitamin D status at P-25OHD concentrations below 80 nmol/l. As the conversion of 25OHD to active vitamin D occurs in many tissues, a decreased conversion due to low substrate concentrations may have generalized biological consequences.

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**References**


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