

**DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE
(JAPC)**

**GUIDANCE ON THE PREVENTION, DIAGNOSIS AND MANAGEMENT OF
VITAMIN D DEFICIENCY IN PRIMARY CARE**

This guidance is based on national recommendations from NICE (PH56), the National Osteoporosis Society, and the government's Scientific Advisory Committee on Nutrition.

JAPC continues to support the prescribing of high-dose vitamin D, usually as a short-course treatment, for the correction of diagnosed deficiency for adults and children.

For all other vitamin D requirements, the patient is encouraged to make lifestyle changes such as increasing dietary intake of vitamin D, increasing safe sun exposure and to purchase a supplement over the counter from a local pharmacy, health food shop or supermarket.

See [position statement on the prescribing of vitamin D](#) for further advice
Local [Patient information leaflet](#) (available in several languages)

Summary

- Prescribers should note local variation of definition. For example NICE classify low vitamin D as <25nmol/litre of 25 hydroxyvitamin D whereas Derbyshire use <30nmol/litre by local endocrinologist agreement.
- Almost a fifth of the UK population is estimated to have a low vitamin D status. For this reason:
 - Routine screening of vitamin D blood levels is not recommended.
 - Lifestyle advice and use of over the counter vitamin D preparations are recommended for prevention. (See appendix 1 for patient information)
 - The government [Healthy Start](#) Scheme offers free vitamin supplements (containing vitamin D) to eligible patients. Commercial vitamin supplements are available to buy for those people not eligible for the Healthy Start Scheme. (see appendix 2)
 - Prescribing of vitamin D preparations should be reserved for treatment of patients with symptoms AND diagnosed deficiency, usually as a short course of treatment.
- Vitamin D products should be prescribed by its brand name so that the most cost effective licenced product is dispensed. Only use liquid options if capsules or tablets are not suitable. Use a suitable licensed alternative if preferred products are not available.

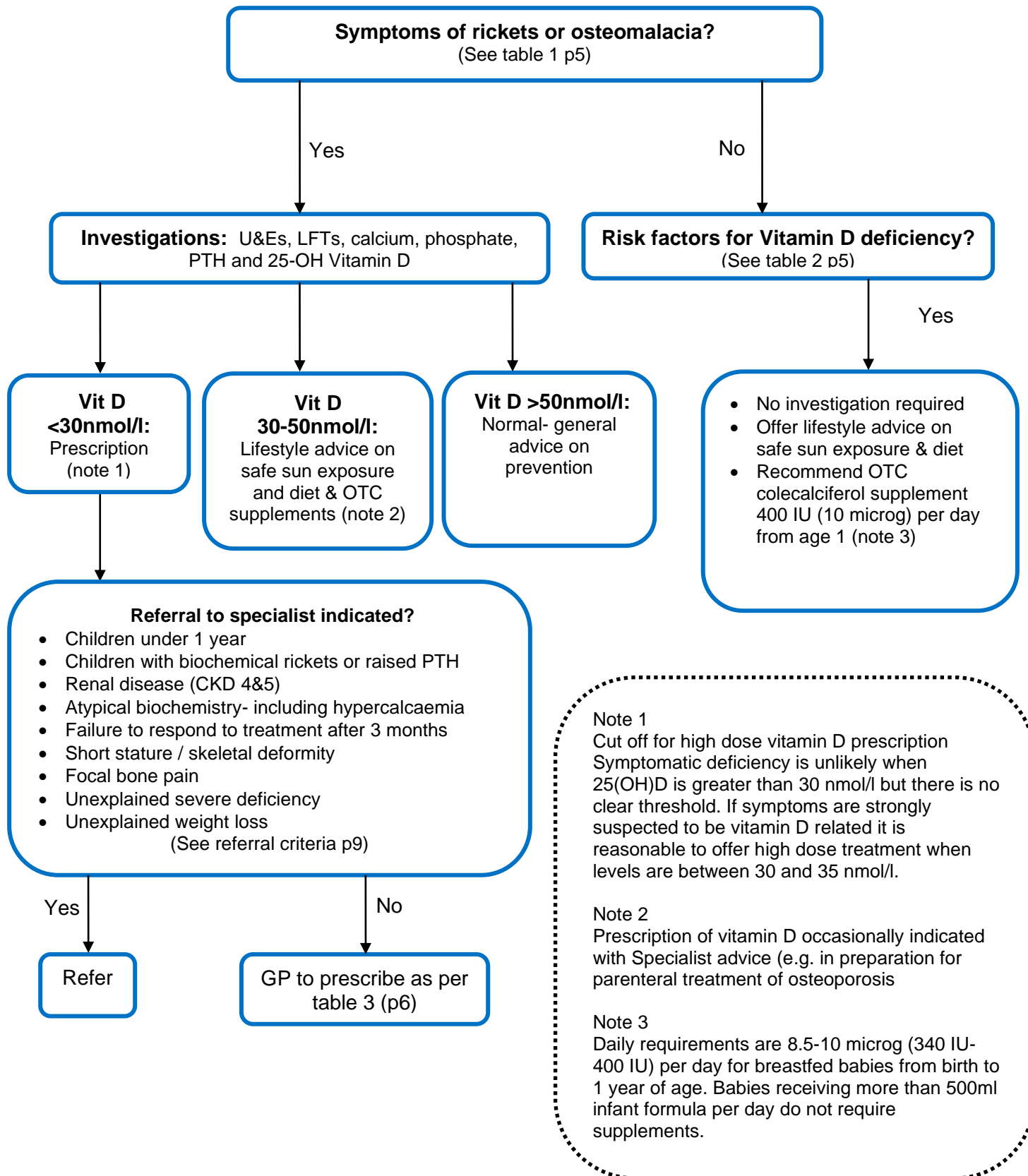
- **Local formulary choice for treatment of deficiency:**

	Daily regime	Weekly regime
Adult	Strivit D3 20,000 IU daily for 15 days (Contains Gelatin. Gelatin in capsule is Kosher and Halal compliant. Suitable for people with nut allergy)	InVita D3 50,000 IU weekly for 6 weeks
Children	Thorens 10,000 unit/ml oral drops 1-5 months: 3,000 IU (15 drops=0.3ml) daily 6 months- 11 years: 6,000 IU (30 drops= 0.6ml) daily 12-17 years: 10,000 IU daily (50 drops =1 ml) daily Course length 8-12 weeks	

- Monitoring following a treatment course for deficiency
 - Adults- check calcium, phosphate & ALP after six weeks. Only repeat vitamin D level if symptoms persist.
 - Children- check calcium, phosphate, ALP and PTH at 1 month (or 1 week if symptomatic hypocalcaemia. Repeat 3 monthly until treatment stopped.

Algorithm for diagnosis and management of Vitamin D deficiency in primary care

Population screening by measuring Vitamin D levels is unnecessary (see section on diagnosis for more information).



Diagnosis and management of Vitamin D deficiency in primary care

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Introduction

Vitamin D is essential for skeletal growth and bone health. Severe deficiency can result in rickets (among children) and osteomalacia (among children and adults). It is estimated that almost a fifth of the UK population are deficient in vitamin D (< 25nmol/litre).

Examples of people that may be at particular risk include:

- Infants and children aged under 5
- Pregnant and breastfeeding women, particularly teenagers and young women.
- People over 65.
- People who have low or no exposure to the sun, for example, those who cover their skin for cultural reasons, who are housebound or confined indoors for long periods.
- People with darker skin, for example. People of African, African-Caribbean or South Asian family origin.

This guideline has been revised following the publication of the NICE public health guidance on vitamin D supplementation in at risk groups. Other sources of information include the National Osteoporosis Society 'Vitamin D and Bone Health' document and a useful summary of vitamin D prescribing from UKMi. Amendments have also been made in line with the 'Vitamin D and Health' document published by the Scientific Advisory Committee on Nutrition 2016.

The document provides information on vitamin D- including diagnosis and management of deficiency, and advice for patients with insufficiency.

1. Vitamin D physiology:

What is Vitamin D?

- Vitamin D is a group of fat soluble vitamins that is essential for bone formation in all age groups. The 2 main forms are D₂ (ergocalciferol), predominantly from plants and D₃ (colecalciferol), mainly from animal sources. Both have similar actions. Vitamin D is activated in the liver to 25-hydroxycolecalciferol and then in the kidney to 1,25-dihydroxycolecalciferol (active vitamin D). The most well established action of vitamin D is to promote calcium absorption by the GI tract.
- 90% of our daily vitamin requirement is obtained by the action of UVB sunlight on the skin (only during April to September in the United Kingdom). Between October and early March we do not obtain any vitamin D from the action of sunlight on the skin.
- 10% is obtained through diet such as oily fish (sardines, salmon), liver, egg yolks, fortified margarine and fortified breakfast cereals)

Does Vitamin D have other functions?

Research has identified epidemiological links between vitamin D levels and various disease states. It remains unclear whether vitamin D could offer pharmacological benefit for any of these conditions. At the present time the indications for vitamin D treatment relate to maintenance of calcium homeostasis and bone health via the primary mode of action to aid absorption of calcium at the gut.

2. Diagnosis:

Vitamin D deficiency is best assessed by measurement of serum 25-OH vitamin D. Measurement of other vitamin D metabolites or sub-fractions adds nothing further and is not recommended.

NICE recommends that health professionals should NOT routinely test people's vitamin D status unless:

- they have symptoms of deficiency - see table 1.
- they are considered to be at particular high risk of deficiency (for example, they have very low exposure to sunlight) – see table 2.
- there is a clinical reason to do so (for example, they have osteomalacia or have had a fall).

Table 1: Clinical features of Vitamin D deficiency

Children	Adults
<ul style="list-style-type: none"> • Poor growth, skull softening with frontal bossing and delayed fontanelle closure • Muscular weakness (e.g. difficulty climbing stairs, waddling gait, difficulty rising from a chair or delayed walking) • Tender or swollen joints, classically the wrists or costochondral junctions • Deformed bones (progressive bow legs or knock knees) • Bone pain (for >3 months) or tenderness • Muscle pain or proximal myopathy • Delayed eruption of teeth, or enamel hypoplasia • Carpopedal spasm, tetany, seizures or irritability due to hypocalcaemia & requiring urgent treatment • Infantile cardiomyopathy 	<ul style="list-style-type: none"> • Gradual onset & persistent bone pain without preceding mechanical injury (frequently in back, ribs or lower limb) • Fragility fracture • Proximal muscle weakness (difficulty with stairs, getting up off the floor or standing after sitting in a low chair, waddling gait) or muscle pain • Carpopedal spasm, tetany, seizures or irritability due to hypocalcaemia & requiring urgent treatment

GPs should consider a diagnosis of vitamin D deficiency in a patient with risk factors (table 2) who presents with chronic musculoskeletal (MSK) pain.

NB. The relationship between chronic MSK pain and vitamin D deficiency is not clear and treatment does not necessarily resolve symptoms.

Table 2: Examples of risk factors for Vitamin D deficiency

Age Groups	Poor exposure to UVB light	Poor dietary intake	Metabolic risk
<ul style="list-style-type: none"> • ≥65years • <5 years • Pregnant women • Breastfeeding women • Children & young people with family members with proven vitamin D deficiency 	<ul style="list-style-type: none"> • Pigmented skin • Occlusive garments • Housebound • Use of sun blocking creams • Disabled & young people who spend very little time outdoors 	<ul style="list-style-type: none"> • Vegetarian or fish-free diet • Malabsorption including post bariatric surgery • Cholestatic liver disease • Breast fed infants • Children & young people with diet low in calcium or with generally poor diet 	<ul style="list-style-type: none"> • Elderly (reduced synthesis) • Liver disease (reduced stores) • Renal disease (reduced synthesis of active vitamin D) • Obese (excess storage in fat) • Drugs: Rifampicin, Antiretrovirals, anticonvulsants, cholestyramine, glucocorticoids

Investigations (to be arranged by primary care):

- U&Es, LFTs, calcium, phosphate and 25-OH Vitamin D
- PTH should be measured when the adjusted calcium is significantly low (<2.15)
- Children: In addition, albumin & PTH should be measured routinely in children (refer if PTH high)
- The findings in osteomalacia are a low/ normal calcium, low/normal phosphate, raised alkaline phosphatase, low vitamin D and raised PTH (secondary hyperparathyroidism)

Vitamin D levels are expressed as nmol/L (ng/ml x 2.5 = nmol/L).

The definition of vitamin D deficiency and insufficiency is based on blood measurements of 25-OH vitamin D:

- >50 nmol/l Satisfactory Vitamin D levels
- 30-50 nmol/l Vitamin D insufficiency
- <30 nmol/l **Vitamin D deficiency**

Note: In patients with a Vitamin D level >30 nmol/l, symptoms are unlikely to be due to Vitamin D deficiency. However, clinicians should use clinical judgment when considering the diagnosis and treatment plan for an individual patient.

3. Management of Vitamin D deficiency (Vitamin D level <30nmol/l)

Patients meeting the above criteria should be managed according to the following principles;

- For the purposes of this document we define ‘treatment’ to be high dose therapy to reverse vitamin D deficiency. This is different from lower doses used as long term daily ‘supplementation’ or as ‘maintenance’ following high dose treatment.
- Available evidence suggests that oral colecalciferol offers greater improvements in serum 25-OH Vitamin D compared with oral ergocalciferol or intramuscular preparations at equivalent doses. As such, **oral colecalciferol is the first line treatment option.**
- Symptomatic patients need high dose colecalciferol treatment to reverse deficiency and eradicate symptoms.
- Asymptomatic patients should be advised to purchase lower doses of colecalciferol of 800units (20microgram) and deficiency will gradually be resolved.
- When indicated, a single course of high dose therapy should be followed by lifestyle advice and maintenance with lower dose supplementation bought over the counter.
- Alfacalcidol and calcitriol are completely inappropriate for treatment of vitamin D deficiency outside of CKD 4-5, due to high risk of toxicity.
- Unlicensed liquid “specials” of vitamin D should NOT be routinely prescribed as cost effective alternatives are available.
- See SPS advice on vitamin D products for patients with [peanut or soya allergy/](#) [vegetarian or vegan](#)

Table 3: Treatment / Maintenance Dosing for Vitamin D

Adults		
Drug	Colecalciferol (oral)	
Treatment Dose	A total of approximately 300,000 units given either as weekly or daily split doses. Consider increasing total dose to 400,000-600,000 units if very low baseline or poor absorption anticipated. Where poor compliance is suspected give supervised stat oral doses (100,000 units colecalciferol for adults) at weekly intervals	
	Daily regimen	Weekly regimen
	20,000 units daily orally for 15 days	50,000 units weekly for 6 weeks
Preferred formulary choice	Strivit D3 20,000 unit capsules one daily for 15 days (Contains highly purified pharmaceutical grade gelatine from a bovine source)	Invita D3 50,000 unit capsules one weekly for 6 weeks (Contains gelatin; Gelatin in capsule is Kosher and Halal compliant; Suitable for people with nut allergy)
	If liquid necessary:	
	Invita D3 25,000 unit/ml oral solution in 1ml single use ampoules daily for 12 days	Invita D3 50,000 unit/ml oral solution in 1ml single use ampoules weekly for 6 weeks (Snap and squeeze single use ampoules; Can be mixed with food e.g. yogurt; Gelatin free; Suitable for vegetarians; suitable for people with nut allergy)
Monitoring	6 weeks- Calcium, phosphate, ALP. Repeat vitamin D levels only if symptoms persist.	
Follow up	No further monitoring or follow up needed.	
Maintenance therapy (This can be used as initial treatment in asymptomatic individuals)	Patients who continue to be at risk following deficiency correction should be encouraged to make lifestyle changes such as increasing dietary intake of vitamin D, increasing safe sun exposure, and to purchase OTC supplement containing colecalciferol 800units (20microg) daily from their local pharmacy, health food shop or supermarket. <i>Note preparations containing 1000 units (25 micrograms) are considerably cheaper to purchase than those containing 400 units (10 micrograms) or 800 units (20 micrograms) and are suitable for maintenance.</i>	
Long term monitoring	No routine monitoring or rechecking of serum 25OHD levels is needed whilst on maintenance therapy. Recheck biochemistry if symptoms return or malabsorption/ poor compliance suspected.	

CHILDREN	
Drug	Colecalciferol (oral)
Treatment Dose	<p>NOS recommendations</p> <ul style="list-style-type: none"> • 1 - 5 months 3,000units (15 drops = 0.3ml) daily for 8 – 12 weeks • 6 months – 11 years 6000units (30 drops = 0.6ml) daily for 8 – 12 weeks • 12 – 18 years 10,000units (50 drops = 1ml) daily for 8 – 12 weeks <p><i>The same effect may be achieved by multiplying the dose by seven and giving it weekly if compliance is a concern.</i></p> <p><i>A single or divided oral dose totalling 300,000 units over treatment period can be considered if there is concern about compliance (12-18yrs only).</i></p>
Preferred formulary choice	<p>If liquid is needed consider Thorens 10,000 unit/ml Oral Drops (10ml dropper bottle; 1ml= 50 drops, 1 drop =200units; 1000units = 5 drops) Note-treatment doses above for the licensed preparation are used off-license</p> <p>In children, THORENS can be mixed with a small amount of children's foods, yogurt, milk, cheese or other dairy products. The parents should be warned not to mix THORENS into a bottle of milk or container of soft foods in case the child does not consume the whole portion, and does not receive the full dose. The parents should ensure that their child takes the entire dose. In children who are not breast-feeding, the prescribed dose should be administered with a meal.</p>
Monitoring	<ul style="list-style-type: none"> • Ensure dietary factors improved. • 1 month (or 1 week if symptomatic hypocalcaemia): calcium, phosphate, ALP and PTH. Repeat 3 monthly until treatment stopped. • If ALP does not improve, check compliance • Where treatment continues >6 months, check early morning urine calcium:creatinine <p>Note: If a child's symptoms/signs have not improved despite a satisfactory 25(OH)D concentration, they are unlikely to be related to vitamin D deficiency.</p>
Follow up	Review and investigate family members. Give prevention advice as a minimum.
Maintenance therapy (This can be used as initial treatment in asymptomatic individuals)	<p>Patients who continue to be at risk following deficiency correction, should be encouraged to make lifestyle changes such as increasing dietary intake of vitamin D, increasing safe sun exposure and to take colecalciferol supplement 400-600 units (10-16microg) daily long term.</p> <p>Healthy Start vitamins, Abidec or Dalivit vitamin drops are recommended. Only Children up to the age of 4 years who are entitled through the Healthy Start scheme will continue to receive vitamin supplements through this national scheme.</p> <p>Parents of children >4 years in age (and children not entitled through the Healthy Start scheme) are advised to purchase a Vitamin D containing supplement for maintenance treatment (400 – 600 units daily). Babies that are receiving more than 500ml infant formula a day do not require vitamin D supplementation.</p>
Long term monitoring	No routine monitoring or rechecking of serum 25OHD levels is needed whilst on maintenance therapy. Recheck biochemistry if symptoms return or malabsorption/poor compliance suspected.

4. Management of Vitamin D insufficiency (vitamin D level 30-50nmol/l)

Use of colecalciferol supplements (purchased over the counter) are recommended for patients with 25-OH Vitamin D 30-50 nmol/l, especially if they have one of the following additional factors;

- fragility fracture, osteoporosis or high fracture risk including patients on antiresorptive medications
- increased risk of future deficiency due to e.g. reduced exposure to sunlight, cultural dress code, dark skin
- raised PTH
- regular prescription for antiepileptic drugs or glucocorticoids
- malabsorption

Lifestyle advice for Vitamin D insufficiency (and deficiency)

Sun exposure: Sun exposure is the main source of vitamin D and should be exploited! However, this should be balanced with the risks of excessive exposure. Time required in the sun to make sufficient vitamin D is generally short and less than the time needed for skin to burn. This should be adjusted on an individual basis and safe practices adopted. Little and often is best.

The following advice was given in the New England Journal of Medicine (2007): *“Exposure of arms and legs for 5 to 30 minutes (depending on time of day, season, latitude, and skin pigmentation) between the hours of 10 a.m. and 3 p.m. twice a week is often adequate”*

Note: Use of creams containing sun protection factors reduces vitamin D synthesis by >95%.

Diet: Dietary sources of Vitamin D include:

- Oily Fish – Salmon, Mackerel, Sardines, Herring, Pilchards, Fresh Tuna etc.
- Cod liver oil & other fish oils
- Red meat & Eggs yolk
- Infant formula milk, powdered milk
- Fortified breakfast cereals
- Soya products, fortified margarines, low fat spreads

It is difficult to obtain enough vitamin D from usual diet alone. The average daily intake from a normal diet is just 80-160 units/day (2-4µg). Where supplementation is indicated, the following doses are recommended:

Table 4: Supplement dosing for Vitamin D

Age/ group	Daily requirements
Birth to 1 year of age and partially or exclusively breastfed (babies receiving infant formula do not require supplements if receiving more than 500ml per day)	8.5-10 micrograms (340units - 400units/day)
Aged 1-4 years	10 micrograms (400units/day)
Limited UVB exposure including due occlusive clothing, low levels of exposure or dark skin	10 micrograms (400units/day)
All individuals not otherwise at risk 5 years of age and above, including pregnant women	10 micrograms (400units/day)

NB: There is no benefit in using preparations of vitamin D combined with calcium in most patients. However calcium & vitamin D 400-800 units/day maybe appropriate in the elderly, most people aged 65 years or more taking bisphosphonates, and those taking corticosteroids.

OTC supplementation should be continued long term in most patients unless there is a significant lifestyle change to improve vitamin D status.

5. Prevention of Vitamin D deficiency in the general population:

Most of these patients should be offered lifestyle advice as detailed above and advised to purchase supplementation over the counter (eligible patients can obtain free supplements through the Healthy Start scheme). More information on available products for supplementation and the Healthy Start scheme can be found in appendix 2 (p12).

Recommendation based on SACN guidance and NICE PH56:

Age/ group	Advice
Infants from birth up to 1 year of age (exclusively or partially breastfed)	Should be given a daily supplement containing 8.5-10 micrograms (340 – 400 units) vitamin D. Babies fed infant formula should not be given a vitamin D supplement unless they are receiving less than 500mls (17.6 fl oz or about a pint) of formula a day as it is fortified with vitamin D and no other supplementation is required.
Children ages 1 – 4 years	Parents should be encouraged to purchase a daily supplement containing 10 micrograms (400 units) vitamin D. Some children aged 1 – 4 may be entitled to free Healthy Start vitamin drops.
General population ages 4 years and older including	Should be encouraged to purchase 10 micrograms (400units) vitamin D throughout the year. (NICE PH56, May 2017).
Pregnant and lactating women and populations at increased risk of vitamin D deficiency	Should be encouraged to purchase 10 micrograms (400units) vitamin D throughout the year. (NICE PH56, May 2017). Some pregnant women and new mothers may be entitled to free Healthy Start vitamins
Little or no UVB exposure	Should be encouraged to purchase a daily supplement containing 10 micrograms (400 units) vitamin D throughout the year. They are: <ul style="list-style-type: none">• people who are seldom outdoors such as frail or housebound individuals and those who are confined indoors e.g. in institutions such as care homes• people who habitually wear clothes that cover most of their skin while outdoors.
People from minority ethnic groups with dark skin	e.g. African, African-Caribbean and South Asian origin Should be encouraged to purchase a vitamin D supplement containing 10 micrograms (400 units) throughout the year.

6. Exceptionalities:

Hyperparathyroidism/ hypercalcaemia and development of new hypercalcaemia during vitamin D replacement

Patients with Hyperparathyroidism frequently have vitamin D deficiency. Vitamin D deficiency in hyperparathyroidism may exacerbate bone loss in this condition.

Treatment with vitamin D has the potential to exacerbate hypercalcaemia and hypercalciuria but is still often indicated. **Specialist advice (Endocrinology) is recommended prior to vitamin D treatment in this context.**

Patients may develop hypercalcaemia during correction of vitamin D deficiency. This can indicate vitamin D toxicity although this would not be expected when using recommended doses. Most other cases are due to underlying and previously undiagnosed Hyperparathyroidism although granulomatous conditions are also relevant (e.g. Sarcoidosis). The diagnosis can be aided by measurement of PTH- and such cases should be referred to Endocrinology for assessment.

Parenteral Osteoporosis treatments

Parenteral treatments for osteoporosis require adequate vitamin D levels in order to be safe and effective. Follow specialist advice.

7. Referral:

The following patients should be referred to secondary care for further investigation:

- Children under 1 year
- Children with biochemical rickets or raised PTH
- Renal disease (CKD 4&5)
- Atypical biochemistry- including hypercalcaemia
- Failure to respond to treatment after 3 months despite good adherence
- Short stature / skeletal deformity
- Focal bone pain
- Unexplained severe deficiency
- Unexplained weight loss
- Children with repeated low serum calcium concentration with or without symptoms (irritability, brisk reflexes, tetany, seizures or other neurological abnormalities)
 - symptomatic: requires immediate referral to A&E if outpatient
 - asymptomatic: discuss treatment with paediatrician
- Children with underlying complex medical disorders (e.g. liver disease, intestinal malabsorption)
- Children with persisting low serum phosphate or low/high alkaline phosphatase

8. References

Based on guidance originally written by S Fitton and Dr G Summers.

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Document control	Date
Strivit D3 20,000 unit caps replaces Fultium D3 20,000 unit caps as cost effective formulary choice	July 2020

Appendix 1: Patient information

A variety of patient information is available nationally including:

- [NHS Choices Vitamin D](#)
- [Patient.co.uk Vitamin D deficiency](#)
- [National Osteoporosis Society: Healthy eating for bones: Facts about food](#)
- National Osteoporosis society: [Vitamin D supplements and tests factsheet](#)
- [Royal National Orthopaedic Hospital: Vitamin D dosage guide for children](#)

Local vitamin D patient information [leaflet](#) (also available in other languages)

Appendix 2: Healthy Start vitamins/ OTC preparations for children

Healthy Start vitamins

Women and children from families who are eligible for the Government's Healthy Start scheme can get supplements which include vitamin D, in the form of tablets for women and drops for children.

- [Vitamin drops](#) contain Vitamins A, C & D (292 units per 5 drops) – dose 5 drops daily
- [Vitamin tablets](#) contain Vitamins C, D (400 units per tablet) and folic acid – dose 1 tablet daily

Women qualify for Healthy Start from the 10th week of pregnancy or if they have a child under four years old, **and** if she or her family receive:

- Income Support, or
- Income-based Jobseeker's Allowance, or
- Income-related Employment and Support Allowance, or
- Child Tax Credit (but not Working Tax Credit unless the family is receiving Working Tax Credit run-on only) **and** has an annual family income of £16,190 or less.

Women under 18 and pregnant also qualify even if not on the above benefits.

To obtain free supplies, present a Healthy Start voucher (sent to Healthy Start recipients every 8 weeks). For further information and application forms, visit <http://www.healthystart.nhs.uk/>

OTC preparations

Healthy Start vitamins are no longer available for sale, but commercial preparations such as Abidec and Dalivit are available to buy from pharmacies, supermarkets, and other health food retailers.

- **Abidec** – contains Vitamins A, B, C & D (400 units per 0.6ml dose):
 - Under 1 year: dose 0.3ml daily;
 - 1-12 years: dose 0.6ml daily.Contains arachis oil: Not suitable for those with peanut allergy.
Contains sugar so place at the back of the tongue to avoid contact with teeth.
- **Dalivit** – contains Vitamins A, B, C & D (400 units per 0.6ml dose) – dose: 6 weeks – 1 year 0.3ml (7 drops) daily; Older children, adults and elderly 0.6ml (14 drops) daily.
Does not contain arachis oil: Suitable for those with peanut allergy.
Contains sugar so place at the back of the tongue to avoid contact with teeth.

NB: Some vitamin D preparations contain soya oil or peanut oil; most vitamin D capsules contain gelatin. Retailers can provide information on the contents and suitability of their products.