Effect of a Randomised Controlled Vitamin D Trial on Insulin Resistance and Glucose Metabolism in Patients with Type 2 Diabetes Mellitus

Abstract

The aim of our study was to investigate the influence of a 6-month vitamin D supplementation in patients with noninsulin-requiring type 2 diabetes mellitus. We included 86 patients in a placebo-controlled, randomised, double-blind study. During 6 months patients received Vigantol oil once a week corresponding to a daily dose of 1904 IU or placebo oil, followed by 6 months of follow-up. At start and at 3-month intervals 25OHD, PTH, body mass index, HbA1c, insulin, C-peptide, and homeostasis model assessment-index were measured. The primary outcome was a change in fasting blood glucose and insulin levels. After 6 months of therapy, the verum group’s 25OHD had increased to a median of 35 ng/ml in comparison to the placebo group (median 20 ng/ml, p < 10^-6). PTH tended to decrease in the verum group (25.5 pg/ml vs. 35.0 pg/ml, p = 0.08). After 6 months of therapy, 31 patients (78%) achieved a 25OHD concentration of >20 ng/ml. Their HbA1c was significantly lower at baseline (p=0.008) and after therapy (p=0.009) than in patients with 25OHD below 20 ng/ml. C-Peptide, insulin, and HOMA-index did not change significantly in the verum group but fasting insulin was positively correlated with 25OHD concentrations after 6 months of therapy in both groups. There were no significant effects of vitamin D with a daily dose of 1904 IU on metabolic parameters in type 2 diabetes. However, the correlative findings of this study suggest a link of the 25OHD status and metabolic function in type 2 diabetes. Whether vitamin D therapy with higher doses can improve glucose metabolism needs to be investigated in follow-up trials.

Introduction

According to the International Diabetes Federation, more than 300 million people worldwide are currently affected by diabetes mellitus (http://www.idf.org/diabetesatlas/5e/the-global-burden). A further increase of diabetes prevalence is expected, in particular due to the growing population in developing countries, the increasing industrialisation, urbanisation, and life style changes [1,2]. Diabetes pathophysiology is believed to result from environmental factors on a genetic background, but the causal genes remain complex and exert low hazard risk ratios [3]. The prevalence of type 2 diabetes (T2D) is influenced by multiple environmental factors, one of them may lie in the vitamin D system [4]. During recent years, vitamin D (VD), mainly known for its effects on bone and mineral metabolism, is growingly perceived as a pleiotropic endocrine regulator [5]. The active form of VD, 1α,25(OH)2D or calcitriol, is synthesised from precursor cholesterol by metabolic steps in skin, liver, and kidney. The primary metabolite, 25OHD, is the most abundant form of VD in blood and therefore established for measuring VD status. Various studies have shown an association of VD status and T2D [6]. Low 25OHD is found more often in patients with T2D [7,8] and correlates with a higher risk for T2D [6,9,10]. Furthermore, the 25OHD serum concentration is negatively associated with components of the metabolic syndrome, such as obesity, hyperglycaemia [11–13], and high body mass index (BMI) [9,14–16]. Finally, many studies confirmed an inverse correlation between 25OHD and parameters of insulin resistance: fasting glucose, glucose tolerance, insulin levels, and homeostasis model assessment-index (HOMA-I) [17–24]. In addition, interventional studies showed beneficial effects of VD on glucose status, insulin sensitivity, and insulin resistance [25–27].
However, other investigations did not confirm these findings. They showed neither an association between VD and components of the metabolic syndrome [28–30] nor an influence of VD on glucose metabolism and T2D [31–33]. These studies are difficult to compare due to heterogeneous cohorts and differing outcome parameters. Furthermore, the effects of VD on metabolism have mainly been studied in nondiabetics. In addition intervention times varied greatly and patients were treated with very different doses of VD or even combinations of VD and calcium. Therefore, the aim of our study was to investigate the influence of a 6-month VD supplementation of 1904 IU/d on the metabolism in patients with noninsulin-requiring T2D and to find out how many of the treated individuals would normalise their VD status. Hereby we defined VD deficiency as 25OHD concentrations <20ng/ml, VD insufficiency >20ng/ml and <30ng/ml, the latter being the threshold for VD sufficiency. For group comparisons we divided the verum or placebo treated patients into those with 25OHD levels <20ng/ml (deficient) or >20ng/ml (not deficient; encompassing insufficient and sufficient) [34].

Subjects and Methods

We invited patients with T2D from the city and region of Frankfurt am Main, Germany, to participate in the study. Out of 101 interested individuals, we recruited 86 patients in a randomised, double-blind, placebo-controlled trial: patients with diagnosed T2D aged 18–80 years without VD supplementation for at least 3 months before baseline. Patients who took bisphosphonates, calcimimetics, glucocorticoids, phenytoin, glycosides, or benzodiazepines, or in which therapy with one of these drugs was planned during study time were excluded. Further exclusion criteria were carcinomas, HIV infection, psychiatric diseases affecting participation, renal or hepatic dysfunction, hypercalcemia, nephrolithiasis, and sarcoidosis. Women were only included if they were not pregnant or breast-feeding and, if premenopausal, with effective double barrier contraception.

At baseline all participants were randomised into parallel groups (50 % placebo, 50 % verum). Study time was 12 months for each patient. During the first 6 months the verum group’s patients received 20 drops Vigantol oil once a week, corresponding to a daily dose of 1904 IU/d. The placebo group’s patients received placebo oil consisting of medium chain triglycerides once a week. This was followed by 6 months of follow-up. Study visits were at 3-month intervals. At each visit body weight, BMI, and blood pressure were recorded. Laboratory investigations included calcium, phosphate, fasting glucose, and HbA1c. Furthermore, 25OHD concentrations and 1a-25OHD were measured by 125I-radioimmunoassay. PTH, insulin, and C-peptide were measured by a solid-phase chemiluminescence immunometric assay. Finally the homeostasis model assessment-index (HOMA-I) was calculated by using the formula: HOMA-I = fasting insulin [μU/ml]× fasting glucose (mg/dl)/405.

Main outcome parameters of the trial were changes in blood glucose and insulin levels with HOMA-I over the course of treatment by either verum or placebo. Power calculations indicated that 82 subjects (half treated by verum and half by placebo) will suffice to have more than 80% power in order to detect a true difference in the means of 1.25 difference for HOMA-I. The calculations were performed by using the program Power and Sample Size Calculations 3.0. [35].

### Table 1 Baseline characteristics of patients; age and duration are medians.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>All patients</th>
<th>Verum</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>86</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>Age (range, years)</td>
<td>60 (30–78)</td>
<td>61 (36–78)</td>
<td>60 (30–78)</td>
</tr>
<tr>
<td>Men</td>
<td>48</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Women</td>
<td>38</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Duration of DM (range, years)</td>
<td>3 (1–4)</td>
<td>2 (1–4)</td>
<td>3 (1–4)</td>
</tr>
</tbody>
</table>

### Results

**Clinical and biochemical parameters over the trial period**

After 3 months of VD therapy, the verum group’s (n = 40) 25OHD concentration had increased to 37.3 ng/ml, after 6 months of therapy the verum group’s (n = 40) 25OHD had increased to a median of 35 ng/ml, significantly higher than in the placebo group (median 20 ng/ml, p < 10⁻⁶, Table 3). After VD therapy 37/40 (93 %) patients of the verum group achieved 25OHD levels of >20 ng/ml, but only 29/40 (73 %) reached 25OHD concentration in the sufficient range (>30 ng/ml).

In contrast, the placebo group showed VD deficiency through the entire study period. In addition the 25OHD concentrations varied with the seasonal timing of study visits in both groups (Fig. 1). After VD therapy 37/40 (93 %) patients of the verum group achieved 25OHD levels of >20 ng/ml, but only 29/40 (73 %) reached 25OHD concentration in the sufficient range (>30 ng/ml).

The PTH tended (p = 0.08) to decrease more in the verum group until the end of therapy (Δ = 9.50 pg/ml). No association between PTH and any other parameter was seen. Both, calcium and phosphate were always in the normal range and nearly constant during the study period. All patients showed calcium levels between

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2.39 and 2.43 mmol/l and phosphate levels between 3.40 and 3.60 mg/dl.

The study failed to demonstrate a significant effect on the main outcome parameters blood glucose or insulin levels. Neither fasting glucose nor HOMA-1 or HbA1C were significantly affected by the intake of Vigantol, nor were there any changes in systolic blood pressure, or body weight. The median systolic blood pressure during whole study time was 140 mm Hg in all patients. The verum group’s median body weight was 90.4 kg, their fasting glucose 121 mg/dl. In the placebo the median body weight was 83.9 kg, the median fasting glucose 116 mg/dl.

25OHD status indicates metabolic control in T2D patients

In all patients we observed that 25OHD and BMI were inversely related (Table 2, 4) particularly at 6 months of therapy or placebo: those patients with 25OHD levels of < 20 ng/ml had a median BMI of 33 in comparison to those having achieved a

### Table 2 Parameters before and after 6 months of VD-therapy in all study subjects classified according to their 25OHD concentration, which were adjusted for season of blood collection.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Baseline values (all patients n = 86)</th>
<th>After 6 months of therapy (all patients n = 77)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≤ 20</td>
<td>&gt; 20</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>Range</td>
</tr>
<tr>
<td>PTH (pg/ml)</td>
<td>42</td>
<td>4.5–92</td>
</tr>
<tr>
<td>Body weight (kg)</td>
<td>87.1</td>
<td>55.5–140.1</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>30.6</td>
<td>21.1–44.1</td>
</tr>
<tr>
<td>Systolic blood pressure (mm Hg)</td>
<td>140</td>
<td>110–180</td>
</tr>
<tr>
<td>Fasting glucose (mg/dl)</td>
<td>119</td>
<td>69–224</td>
</tr>
<tr>
<td>HbA1c (mmol/mol Hb)</td>
<td>52</td>
<td>34–75</td>
</tr>
<tr>
<td>Insulin (µU/ml)</td>
<td>6.8</td>
<td>2–41</td>
</tr>
<tr>
<td>HOMA-index (µU/ml × mg/dl)</td>
<td>2.0</td>
<td>0.3–14</td>
</tr>
<tr>
<td>C-Peptide (ng/ml)</td>
<td>1.9</td>
<td>0.6–6.8</td>
</tr>
</tbody>
</table>

*Adjusted for season of blood collection

### Table 3 Outcome measures after 6 months of therapy (Visit 3).

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Verum</th>
<th>Placebo</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>25OHD (ng/ml)</td>
<td>35</td>
<td>20</td>
<td>&lt;10⁻⁶</td>
</tr>
<tr>
<td>PTH (pg/ml)</td>
<td>25.5</td>
<td>35</td>
<td>0.080</td>
</tr>
<tr>
<td>Body weight (kg)</td>
<td>90.4</td>
<td>83.9</td>
<td>0.524</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>30.5</td>
<td>31.1</td>
<td>0.856</td>
</tr>
<tr>
<td>Systolic blood pressure (mm Hg)</td>
<td>140</td>
<td>140</td>
<td>0.955</td>
</tr>
<tr>
<td>Fasting glucose (mg/dl)</td>
<td>121</td>
<td>119.5</td>
<td>0.624</td>
</tr>
<tr>
<td>HbA1c (mmol/mol Hb)</td>
<td>51</td>
<td>51</td>
<td>0.681</td>
</tr>
<tr>
<td>Insulin (µU/ml)</td>
<td>7.5</td>
<td>5.6</td>
<td>0.749</td>
</tr>
<tr>
<td>HOMA-index (µU/ml × mg/dl)</td>
<td>1.9</td>
<td>1.5</td>
<td>0.821</td>
</tr>
<tr>
<td>C-Peptide (ng/ml)</td>
<td>2.4</td>
<td>1.9</td>
<td>0.553</td>
</tr>
</tbody>
</table>

*Adjusted for season of blood collection

**Fig. 1** Median 25OHD concentrations in verum and placebo group.
25-OH-D level of >20 ng/ml with a median BMI of 29.9; p=0.098).

Over all study visits the lowest HbA1c levels were seen in patients with 25OHDF >20 ng/ml. HbA1c was 4 mmol/mol (p=0.008; Table 2) lower at baseline and 4 mmol/mol Hb (p=0.009; Table 2) lower after VD therapy than in patients with 25OHDF <20 ng/ml. Highest HbA1c (p=0.009) by a median of 54 mmol/mol was seen in patients with 25OHDF ≤20 ng/ml at the end of therapy. As depicted in Table 2 all patients with 25OHDF >20 ng/ml showed higher C-peptide (2.2 ng/ml vs. 1.8 ng/ml) and higher insulin (7.8 μU/ml vs. 4.8 μU/ml, p=0.11) after VD therapy, but this was not significant. However, 25OHDF concentrations correlated significantly with the BMI at baseline in all patients and after 6 months of therapy in the placebo group. Furthermore fasting insulin was positively correlated with 25OHDF after 6 months of therapy in both groups (Table 4).

### Discussion and Conclusion

Vitamin D deficiency or insufficiency is highly prevalent and this observation is more profound in patients with type 2 diabetes [36,37]. This global epidemic has been described in several populations of all age groups and evoked interest into the effects of controlled vitamin D supplementation as opposed to uncontrolled self-ingestion as an alimentary component. It is now widely held that vitamin D has multiple extra-skeletal effects, some of which affect metabolism and the endocrine pancreas [38]. In an animal model active vitamin D can increase islet insulin secretion upon glucose stimuli [39].

Whether vitamin D can also affect the human β-cell has been subject to several studies, including interventional trials. A meta-analysis of vitamin D supplementation of patients with type 2 diabetes has recently summarised 15 trials that had included patients for a controlled intervention with vitamin D, its metabolites and placebo, and studied fasting glucose, HbA1c as well as parameters of insulin resistance [40]. The conclusion of their summary was that insufficient evidence supported a recommendation for vitamin D supplementation for improving glucose metabolism or insulin action in patients with diabetes or prediabetes. However, those studies had used both low vitamin D doses as well as higher ones, had been performed on heterogeneous cohorts, and did not address all potential confounders. Furthermore vitamin D acts on several cells and tissues including immunity. Hereby anti-inflammatory effects may indirectly improve cardiovascular and metabolic health in patients with diabetes [38]. Since vitamin D’s immune effects may vary between individuals with variants in their vitamin D system genotypes, intervention trials are needed to address pharmacogenomic differences for potential therapeutic stratification [41].

Our study shows a significantly lower HbA1c with improving 25OHDF status. Furthermore, this randomised, placebo-controlled intervention study with nearly 2000 IU cholecalciferol per day demonstrates that insulin levels correlate significantly after 6 months of VD although the underlying insulin resistance persisted. Although the trial failed to meet endpoints for improved insulin and C-peptide secretion as well as HOMA-index, the correlation of BMI, HbA1c, insulin levels, and the vitamin D status suggests that glucose homeostasis may be positively regulated by vitamin D. The paradox observation that differences were more significant at 6 months of therapy in the placebo group suggests that either the chosen dose is insufficient or that other factors regulate vitamin D’s metabolic effects. A recent placebo-controlled trial with 47 diabetic patients and a lower daily dose (1000IU/d) demonstrated no metabolic effects but a nonsignificant increase in adiponectin and a significant improvement of aortal stiffness [42].

Physiologic and metabolic improvement may be due to direct or indirect VDR-mediated musculoskeletal, hepatic or effects on pancreatic β-cell secretion. Since β-cells express the VDR, some of their pathways involved in insulin secretion are subject to VD actions such as metabolic processing, stress response and DNA repair, as well as epigenetic regulations. These mechanisms have recently been elucidated by microarray analysis of buffy coat cells from a small randomised double-blind clinical trial using 2000IU VD/d [43].

Since vitamin D dosing appears to be safe in this population of preadipose and obese individuals higher VD doses are needed to optimise VD status in more than half of patients. Interventional studies with higher study numbers and higher VD doses are required to verify these findings. However, this study illustrates potential metabolic benefits of VD therapy in type 2 diabetes.

### Acknowledgements

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Conflict of Interest

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

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