

7. da Costa KA, Badea M, Fischer LM, Zeisel SH. Elevated serum creatine phosphokinase in choline-deficient humans: mechanistic studies in C2C12 mouse myoblasts. *Am J Clin Nutr* 2004;80:163–170.
8. Zeisel SH, Da Costa KA, Franklin PD, et al. Choline, an essential nutrient for humans. *FASEB J* 1991;5:2093–2098.
9. Fischer LM, daCosta KA, Kwock L, et al. Sex and menopausal status influence human dietary requirements for the nutrient choline. *Am J Clin Nutr* 2007;85:1275–1285.
10. Buchman AL, Dubin M, Jenden D, et al. Lecithin increases plasma free choline and decreases hepatic steatosis in long-term total parenteral nutrition patients. *Gastroenterology* 1992;102:1363–1370.
11. Oregon State University. Linus Pauling Institute. Choline. <http://lpi.oregonstate.edu/infocenter/othernuts/choline>. Accessed January 1, 2010.
12. Zhu X, Song J, Mar MH, et al. Phosphatidylethanolamine N-methyltransferase (PEMT) knockout mice have hepatic steatosis and abnormal hepatic choline metabolite concentrations despite ingesting a recommended dietary intake of choline. *Biochem J* 2003;370:987–993.
13. da Costa KA, Kozyreva OG, Song J, et al. Common genetic polymorphisms affect the human requirement for the nutrient choline. *FASEB J* 2006;20:1336–1344.
14. Song J, da Costa KA, Fischer LM, et al. Polymorphism of the PEMT gene and susceptibility to nonalcoholic fatty liver disease (NAFLD). *FASEB J* 2005;19:1266–1271.
15. Zeisel SH. Is there a new component of the Mediterranean diet that reduces inflammation? *Am J Clin Nutr* 2008;87:277–278.
16. Fischer LM, Searce JA, Mar MH, et al. Ad libitum choline intake in healthy individuals meets or exceeds the proposed adequate intake level. *J Nutr* 2005;135:826–829.
17. Davis KL, Hollister LE, Barchas JD, Berger PA. Choline in tardive dyskinesia and Huntington's disease. *Life Sci* 1976;19:1507–1516.
18. Zeisel SH, Wishnok JS, Blusztajn JK. Formation of methylamines from ingested choline and lecithin. *J Pharmacol Exp Ther* 1983;225:320–324.
19. Boyd WD, Graham-White J, Blackwood G, et al. Clinical effects of choline in Alzheimer senile dementia. *Lancet* 1977;2:711.
20. Tamminga C, Smith RC, Chang S, et al. Depression associated with oral choline. *Lancet* 1976;2:905.
21. Food and Nutrition Board. Institute of Medicine. Dietary Reference Intakes for Thiamine, Riboflavin, Niacin, Vitamin B6, Folate, Vitamin B12, Pantothenic Acid, Biotin, and Choline (1998). Washington, DC, National Academy Press, 1998.
22. Morrison LM, Gonzalez WF. Results of treatment of coronary arteriosclerosis with choline. *Am Heart J* 1950;39:729–736.
23. Wurtman RJ, Janowsky DS. Nutritional and precursor control of brain acetylcholine synthesis. *Psychopharmacol Bull* 1978;14(4):53–55.
24. Ho IK, Loh HH, Way EL. Toxic interaction between choline and morphine. *Toxicol Appl Pharmacol* 1979;51:203–208.
25. Agranoff BW, Fox MRS. Antagonism of choline and inositol. *Nature* 1959;183:1259–1260.
26. Zeisel SH, Mar MH, Howe JC, Holden JM. Concentrations of choline-containing compounds and betaine in common foods. *J Nutr* 2003;133:1302–1307.
27. Canty DJ, Zeisel SH. Lecithin and choline in human health and disease. *Nutr Rev* 1994;52:327–339.
28. Hirsch MJ, Growdon JH, Wurtman RJ. Relations between dietary choline or lecithin intake, serum choline levels, and various metabolic indices. *Metabolism* 1978;27:953–960.



## Vitamin C

### Biochemistry

Vitamin C (also called ascorbic acid) functions as an antioxidant and plays a role in immune function. It is essential for the synthesis of collagen (one of the major components of connective tissue) and carnitine. In addition, vitamin C has demonstrated antiviral and antibacterial effects *in vitro*; plays a role in microsomal hydroxylation reactions that catalyze cholesterol catabolism and detoxification of xenobiotic chemicals; and is involved in the metabolism of neurotransmitters.<sup>1</sup>

### Clinical indications

Vitamin C may be useful for preventing and/or treating a wide range of conditions, as listed in Table 22-1.

### Absorption and excretion

Fractional absorption of vitamin C decreases with increasing oral intake. When 15–30 mg of vitamin C was administered, approximately 90% was absorbed. In contrast, less than 50% was absorbed when the dose was increased to 1,250 mg. Clinical observations suggest that the capacity

to absorb vitamin C increases during acute illness (see below, under Dosage and administration). Vitamin C is excreted primarily in the urine, and urinary excretion increases with increasing vitamin C intake.

### Deficiency

Manifestations of severe vitamin C deficiency (scurvy) may include bleeding abnormalities (petechiae, perifollicular and subperiosteal hemorrhage, ecchymoses, purpura, bleeding gums, and hemarthrosis), bone pain, osteoporosis, arthralgias, myalgias, edema, ascites, cardiomegaly, and electrocardiographic abnormalities suggestive of cardiac disease.<sup>2–4</sup> Fatigue, lassitude, and emotional changes (including depression and hypochondriasis) may precede the development of frank scurvy.<sup>5</sup>

Cardiac manifestations may also occur relatively early in the course of vitamin C depletion. Of 10 healthy volunteers (aged 21–34 years) given a vitamin C-deficient diet, 2 developed cardiac emergencies requiring immediate interruption of the experiment and hospitalization. These events occurred in the absence of overt signs of scurvy, and were similar to the observations of James Lind (a pioneer in the

**Table 22-1. Vitamin C may be useful for preventing and/or treating the following conditions**

<b>Cardiovascular</b>	<b>Ear, nose, and throat</b>	<b>Musculoskeletal</b>	<b>Psychiatric</b>
Atherosclerosis/ischemic heart disease	Allergic rhinitis	Herniated disc	Depression
Hypertension	Sinusitis	Muscle cramps	Schizophrenia
Thrombophlebitis	<b>Gastrointestinal</b>	Osteogenesis imperfecta	<b>Other</b>
<b>Dermatological</b>	Constipation	Paget's disease (osteitis deformans)	Asthma
Furuncles	Gallstones	Complex regional pain syndrome	Burns
Herpes simplex	Gastritis	<b>Obstetrical and gynecological</b>	Cancer
Herpes zoster	Peptic ulcer	Dysfunctional uterine bleeding	Critical illness
Immune thrombocytopenic purpura	<b>Infectious disease</b>	Leg cramps of pregnancy	Diabetes
Prickly heat	Acquired immunodeficiency syndrome	Premature rupture of membranes	Gingivitis
Sunburn	Colds	<b>Ophthalmological</b>	Hepatitis
Wrinkles, photoaging	Diphtheria	Conjunctivitis	Hypoadrenalism
	Influenza	Glaucoma	Infertility
	Leprosy	Uveitis	Obesity
	Measles		Opioid addiction
	Infectious mononucleosis		Post-exercise muscle soreness
	Tuberculosis		
	Urinary tract infection		

treatment of scurvy), who wrote in 1757, “Persons that appear to be but slightly scorbutic are apt to be suddenly and unexpectedly seized with some of its worse symptoms. Their dropping down dead upon an exertion of their strength, or change of air, is not easily foretold.”<sup>6,7</sup>

Scurvy can mimic deep vein thrombosis, vasculitis, and systemic bleeding disorders.<sup>8</sup> Because the clinical features of scurvy are no longer well appreciated, scorbutic patients are often extensively evaluated for other disorders.

## Requirement

The Recommended Dietary Allowances (RDAs) for vitamin C, as established by the Food and Nutrition Board of the Institute of Medicine, are listed in Table 22-2. The RDAs for cigarette smokers are 35 mg/day higher than those for nonsmokers.<sup>9</sup>

As suggested below, the optimal level of vitamin C intake might be substantially higher than the RDA.

**Table 22-2. Recommended Dietary Allowances for vitamin C.<sup>9</sup>**

Age	Males (mg/day)	Females (mg/day)	Pregnancy (mg/day)	Lactation (mg/day)
0–6 months	40*	40*	—	—
7–12 months	50*	50*	—	—
1–3 years	15	15	—	—
4–8 years	25	25	—	—
9–13 years	45	45	—	—
14–18 years	75	65	80	115
19 years and older	90	75	85	120
Smokers	Smokers require 35 mg/day more vitamin C than nonsmokers.			

\*Adequate Intake

## High-dose vitamin C: the evolutionary perspective

Irwin Stone, Linus Pauling, and others have argued that the level of vitamin C intake needed to promote optimal health is far greater than the RDA, and far greater than the amount found in a typical diet. To support this argument, Stone pointed out that humans are among a small group of species (including monkeys, guinea pigs, and an Indian fruit-eating bat) that are unable to synthesize vitamin C. While the human liver contains the first 3 of the 4 enzymes involved in the biosynthesis of vitamin C from glucose, the fourth enzyme (L-gulonolactone oxidase) is missing or defective.

Stone named this genetic defect hypoascorbemia, in reference to the abnormally low levels of vitamin C that can exist in species that are unable to synthesize vitamin C. He hypothesized that “full correction” of this inborn error of metabolism would require supplying the individual with as much vitamin C as the liver would be synthesizing if the genetic defect were not present. Among animals that synthesize vitamin C, the amounts produced per 70 kg of body weight per day are 1.8–4.9 g for unstressed rats, 15.2 g for stressed rats, 19.3 g for mice, 15.8 g for rabbits, 13.3 g for goats, 2.8 g for dogs, and 2.8 g for cats.<sup>10–14</sup> These amounts are 30–200 times greater than the RDA of 90 mg/day for adult males. It is possible that some benefit can be derived from having the blood and tissues saturated with vitamin C and from large amounts of the vitamin being excreted in the urine and sweat. For example, because vitamin C has antiviral and antibacterial activity, excretion of large amounts in the urine and sweat might help prevent urinary tract and cutaneous infections.

It might seem counterintuitive that mutants unable to synthesize vitamin C would have a survival advantage over those who were capable of synthesizing the vitamin. How-

ever, studies in bacteria have shown that, in the presence of an ample supply of a particular essential nutrient, a mutant that is unable to synthesize the nutrient will win the competition for survival against the wild type that is capable of synthesizing the nutrient. That is because the mutant's cellular machinery has become streamlined by the elimination of unnecessary biosynthetic machinery.<sup>15</sup> There is evidence that before the development of agriculture, humans consumed primarily greens, which provided about 2.3 g/day or more of vitamin C. In this ascorbate-rich prehistoric metaphorical Garden of Eden, the loss of the capacity to synthesize vitamin C may indeed have been a survival advantage.

In reality, full correction of defective vitamin C biosynthesis is not possible, because one cannot duplicate with oral supplementation the steady release of large amounts of vitamin C from the liver into the bloodstream. As compared with maximum hepatic synthesis and release of vitamin C, oral administration of large doses of the vitamin probably results in lower serum vitamin C levels and more pronounced interactions (primarily in the gastrointestinal tract) with nutrients such as iron and copper. Nevertheless, the concept of hypoascorbemia as a genetic defect provides a theoretical framework to support the clinical observations of many practitioners that megadoses of vitamin C are useful for preventing and treating a wide range of health conditions.

Researchers skeptical of the value of high-dose vitamin C have pointed out that when vitamin C intake is high, further increases in intake produce only small increases in plasma or tissue levels of the vitamin. For example, increasing vitamin C intake from 200 mg/day to 2,500 mg/day raised the mean plasma vitamin C level by only 25%.<sup>16</sup> In addition, doubling the plasma vitamin C level increased the vitamin C concentration in the brain by only 10%.<sup>17</sup> However, as suggested by Pauling, the human body might be sensitive to small changes in plasma or tissue vitamin C levels. There are many examples of substances in body fluids for which a 10–25% change in concentration has clinical consequences (e.g., glucose, sodium, calcium, chloride, and hemoglobin).<sup>18</sup> Therefore, the absence of dramatic changes in plasma and tissue vitamin C levels does not rule out the possibility that large doses of the vitamin can be beneficial.

Furthermore, vitamin C might have positive effects that are unrelated to an increase in plasma or tissue levels of the vitamin. It has been suggested that high intake of vitamin C induces the formation of enzymes that promote the metabolism of vitamin C to other compounds, some of which may be beneficial. For example, oxidation products of vitamin C were found to have a greater anticancer effect in mice than vitamin C itself.<sup>19</sup>

## Vitamin C nutritional status

Of 7,277 individuals (aged 6 years or older) participating in the National Health and Nutrition Examination Survey

(NHANES) 2003–2004, 7.1% had vitamin C deficiency, as determined by serum vitamin C levels.<sup>20</sup> In NHANES III (1988–1991), median vitamin C intake among adults (aged 20–59 years) was 85 mg/day for men and 67 mg/day for women.<sup>21</sup> Thus, more than half of the adults surveyed were consuming less than the RDA for vitamin C.

Children less than 1 year of age,<sup>22</sup> the elderly (particularly those living in nursing homes), cigarette smokers, and low-income individuals are at increased risk of having low vitamin C status. People with gastroesophageal reflux may also be susceptible to developing vitamin C deficiency because of an aversion to acidic foods that are rich in vitamin C.<sup>23</sup>

## Assessment of vitamin C status

Methods available to assess vitamin C status include dietary history and measurement of vitamin C levels in serum, leukocytes, and urine.<sup>24–26</sup> In patients who are not severely deficient, none of the laboratory tests by themselves are entirely reliable, and combining measurements may be more informative. Considering the low cost and safety of vitamin C, a therapeutic trial is appropriate in many instances in lieu of laboratory testing.

## Adverse effects

**Gastrointestinal symptoms.** The most common side effects of vitamin C are diarrhea and abdominal pain. These symptoms are dose-related and can be reduced or eliminated by decreasing the total daily dose, taking vitamin C in several divided doses throughout the day, taking the vitamin with food, or using buffered forms of vitamin C (e.g., sodium ascorbate or calcium ascorbate).

**Kidney stones and oxalosis.** It has frequently been claimed that ingestion of large doses of vitamin C can increase the risk of calcium oxalate kidney stones, because vitamin C is converted in part to oxalate. However, the hyperoxaluria associated with use of high-dose vitamin C has been found to be due primarily to a laboratory artifact, resulting from the conversion of vitamin C to oxalate *ex vivo* (i.e., after it has left the body, while it is in the collection bottle). If there is a small increase in urinary oxalate resulting from ingestion of large doses of vitamin C, that increase might be counterbalanced by other effects of the vitamin. For example, vitamin C binds calcium in the urine, potentially reducing the formation of calcium oxalate crystals; produces a small increase in urinary acidity, thereby increasing calcium oxalate solubility; and possibly decreases urinary stasis by promoting diuresis. Observational studies have found either that vitamin C intake is not associated with kidney stone risk or that higher intake is associated with a lower incidence of kidney stones. Moreover, practitioners who have routinely used large doses of vitamin C have not

observed kidney stones as a side effect. These points are discussed in greater detail (with references) in chapter 213.

Despite the apparent safety of vitamin C for the general population with respect to kidney stone risk, there are rare cases in which high-dose vitamin C appeared to cause a substantial increase in urinary oxalate levels. For example, a 25-year-old male with no history of kidney stones had a 350% increase in urinary oxalate excretion (which manifested as hematuria) while ingesting 8 g/day of vitamin C. Oxalate excretion was measured by a method that avoided artifactual increases.<sup>27</sup> This patient may have had a genetic abnormality of oxalate metabolism.

**Triggering or exacerbating renal failure.** Treatment with high-dose vitamin C has been associated with acute renal failure (apparently secondary to the deposition of calcium oxalate crystals) in patients with preexisting renal disease. One patient, who had nephrotic syndrome and renal amyloidosis, developed acute renal failure after intravenous administration of 45 g of vitamin C.<sup>28</sup> Another patient, a 61-year-old man with bilateral ureteral obstruction and renal insufficiency secondary to metastatic prostate cancer, developed acute renal failure after receiving 60 g of vitamin C intravenously over a 2-hour period.<sup>29</sup> A third patient, a 70-year-old man with advanced renal insufficiency (estimated creatinine clearance, 19 ml/minute) became anuric, requiring the initiation of dialysis, after receiving 2.5 g of vitamin C intravenously over a 5-hour period.<sup>30</sup> The adverse effect of a relatively small dose of vitamin C in this patient may have been due to the advanced stage of his renal disease. As noted in chapter 204, even modest doses of vitamin C (such as 500 mg/day orally) can cause hyperoxalemia in patients with end-stage renal disease.

Other reports of vitamin C adversely affecting renal function are less convincing. A 22-year-old woman with extensive small-bowel resection who required home parenteral nutrition developed hyperoxaluria and an elevated serum creatinine level while receiving 1.5 g/day of vitamin C in her parenteral nutrition solution.<sup>31</sup> However, in addition to causing artifactual elevations of oxalate levels, intravenous vitamin C has been reported to cause a false elevation of serum creatinine when measured by certain methods (see below, under Laboratory tests). In another case report, a 31-year-old male developed acute renal failure secondary to acute tubular necrosis after taking 5 g/day of vitamin C for an upper respiratory tract infection.<sup>32</sup> Since certain types of respiratory infections (such as influenza and Legionnaire's disease) have been reported to cause acute tubular necrosis, there is no clear evidence that vitamin C was the causative factor.

**Iron overload.** Because vitamin C increases the absorption of nonheme iron, vitamin C supplementation could worsen iron overload in patients with increased body iron stores. Vitamin C may also increase iron-induced oxidative damage in patients with iron overload.<sup>33</sup>

**Hemolysis in G6PD deficiency.** In case reports, 2 patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency developed acute hemolysis after receiving an intravenous infusion of vitamin C. One patient received a single 80-g infusion and the other patient received 80 g on 2 consecutive days.<sup>34,35</sup> In one of these cases, hemolysis resulted in acute renal failure, which culminated in death. Patients should therefore be tested for G6PD deficiency before they are given large doses of vitamin C intravenously. The highest prevalence of G6PD deficiency is found in African Americans, Asians, and individuals of Mediterranean descent.

While the hemolytic effect of vitamin C in patients with G6PD deficiency is presumably dose-related, it is not known what dosage of intravenous vitamin C would be safe for these individuals. Numerous practitioners administer 1–5 g of vitamin C intravenously as a component of the Myers cocktail (chapter 340) without first testing for G6PD deficiency. Among the many thousands of patients who have received this treatment, there have been no reports of severe hemolytic episodes. However, it is possible that minor episodes of hemolysis have gone unrecognized.

There is also a report of 2 children with G6PD deficiency who developed severe hemolysis after consumption of 8–10 servings of Tang and 2–3 glasses of a lemon-flavored soft drink (providing a total of 3–4 g of vitamin C) over a period of 4–6 hours. The authors of this report attributed the hemolysis to the vitamin C. However, Tang also contains tartrazine (FD&C Yellow #5), which may be metabolized to sulfanilic acid,<sup>36</sup> a precursor in the manufacturing of sulfa drugs. Since sulfa drugs are known to trigger hemolysis in people with G6PD deficiency, sulfanilic acid might have the same effect. In addition, tartrazine cross-reacts with aspirin, another potential cause of hemolysis in people with G6PD deficiency. Therefore, it remains uncertain when oral administration of vitamin C can cause hemolysis.

**“Rebound scurvy.”** When guinea pigs were given large doses of vitamin C and then put on a scorbutic diet, the scurvy was more severe than in guinea pigs fed the scorbutic diet without first giving them large doses of vitamin C.<sup>37</sup> Presumably, there is a lag time before homeostatic mechanisms related to vitamin C absorption, excretion, and metabolism can adjust to an abrupt change in vitamin C intake. It would therefore be prudent for individuals taking large amounts of vitamin C who decide to reduce their dosage to do so gradually. One practitioner stated that patients taking high maintenance doses of vitamin C should not be deprived of the vitamin during emergency hospitalizations, and that they should have a Medic Alert type bracelet describing their increased vitamin C requirement. However, in that practitioner's experience, maintenance doses up to 4 g/day of vitamin C did not seem to create a dependency.<sup>38</sup>

In a report published by Cochrane in 1965, 2 infants in Nova Scotia, Canada, developed scurvy despite consuming

60 mg/day of vitamin C, after their mothers had ingested 400 mg/day of vitamin C during pregnancy. The author of this report suggested that the use of these “large doses” of vitamin C may have resulted in rebound scurvy in the infants.<sup>39</sup> This potential adverse effect of vitamin C has been noted in a number of textbooks and review articles. However, for at least 2 reasons, Cochrane’s conclusion that infantile scurvy was due to maternal ingestion of vitamin C is not credible.

First, while Cochrane did not mention how old his 2 patients were when they developed scurvy, an evaluation of 69 cases of infantile scurvy that were reported to the Canadian Pediatric Society around the same time period revealed that none developed the disease before 4 months of age.<sup>40</sup> Although vitamin C levels decline rapidly after abrupt discontinuation of the vitamin, they increase again within 10 days. If the infants described by Cochrane truly had “rebound scurvy,” one would have expected them to become ill shortly after they were born, not many months later. Second, millions of women have consumed more than 400 mg/day of vitamin C during pregnancy (through diet and supplements) since 1965. During that time, not a single new case of rebound scurvy has been reported. Moreover, one practitioner who prescribed large doses of vitamin C to thousands of patients over a 23-year period did not see any cases of scurvy in the infants of mothers who took vitamin C during pregnancy.<sup>41</sup>

The most likely explanation why these children developed scurvy is that their mothers boiled the infant formula, thereby destroying most of the vitamin C.<sup>42</sup> Beginning in the early part of the twentieth century, physicians encouraged parents to heat-sterilize cow’s milk in order to prevent summer diarrhea, which was one of the major causes of death in infants. Conscientious mothers, concerned about the dangers of germs for their baby, would in some cases re-boil even the sterilized milk they had purchased, just to “make quite sure.” It was not appreciated that heat-sterilization of milk destroys most of the vitamin C. Infantile scurvy was an important public-health problem in Canada in the 1950s and 1960s, largely because many parents were feeding their infants nothing but evaporated milk, which is deficient in vitamin C. Some pediatricians recommended liquid vitamin C supplements, but these supplements were apparently added to the reconstituted milk, which may have then been boiled prior to giving it to the infant.

Thus, there is no convincing evidence that maintaining high vitamin C intake during pregnancy is detrimental to the infant.

**Uricosuria and gout.** Some, but not all, studies have found that vitamin C supplementation increases urinary excretion of uric acid and lowers serum uric acid levels (chapter 151). It has been hypothesized that vitamin C, like other uricosuric agents, could precipitate gout attacks in susceptible individuals by causing rapid migration of uric acid

from the tissues. However, practitioners who have administered large doses of vitamin C to thousands of patients to treat various medical conditions have not encountered any cases of vitamin C-induced gout. In addition, a 20-year prospective study found that higher intake of vitamin C from food and supplements was associated with a lower incidence of gout. To obviate the theoretical concern that vitamin C could trigger a gout attack, when considering the use of high-dose vitamin C for a patient with a history of gout, it would be reasonable to begin with relatively modest doses and build up gradually.

**Dental erosion.** Chewing ascorbic acid tablets or otherwise allowing ascorbic acid to have direct contact with the teeth can result in erosion of dental enamel.<sup>43–45</sup> Therefore, ascorbic acid tablets should not be chewed, and the use of chewable ascorbic acid preparations is discouraged. In addition, the teeth should be rinsed after ingestion of ascorbic acid crystals or powder. While one might expect that buffered forms of vitamin C would not erode dental enamel, there has not apparently been any research addressing that issue.

**Treatment of cancer patients.** There is one case report of tumor necrosis, hemorrhage, and subsequent death occurring in a cancer patient after a single intravenous dose of 10 g of vitamin C. Further information and precautions related to the use of high-dose vitamin C in cancer patients is presented in chapter 325.

## Drug interactions

Note: References for some of the information below are provided in chapter 342.

**Aluminum-containing antacids.** Co-administration of 2 g of vitamin C and aluminum hydroxide (an antacid), as compared with administration of aluminum hydroxide by itself, increased urinary excretion of aluminum, presumably because of an increase in intestinal aluminum absorption. In rats given aluminum hydroxide, co-administration of vitamin C increased the concentration of aluminum in liver, brain, and bone. These observations raise the possibility that vitamin C increases the absorption of other forms of aluminum as well. Since aluminum may play a role in the pathogenesis of osteoporosis and Alzheimer’s disease, vitamin C should not be taken at the same time as aluminum-containing antacids.

**Anesthetic agents.** Interactions between vitamin C and anesthetic agents are discussed in chapter 336.

**Antipsychotics (neuroleptics).** Administration of vitamin C (500 mg twice a day) to a man with low vitamin C levels who was receiving the neuroleptic drug, fluphenazine, for bipolar disorder resulted in a 25% decrease in plasma fluphenazine levels and a deterioration of his clinical condition. In case reports, supplementation with vita-

min C (2 g 3 times per day) appeared to reverse amenorrhea and irregular menses associated with neuroleptic use.

**Aspirin.** Aspirin has been reported to increase urinary excretion of vitamin C and to decrease platelet vitamin C concentrations. Vitamin C supplementation may therefore be beneficial for people on long-term aspirin therapy.

**Contraceptives, oral.** Some, but not all, studies found that the use of oral contraceptives decreased plasma vitamin C levels.

**Doxorubicin.** In guinea pigs, administration of vitamin C prevented the development of doxorubicin (Adriamycin)-induced cardiomyopathy. Vitamin C had no effect on the antitumor activity of doxorubicin in mice with experimentally induced tumors (chapter 325).

**Glucocorticoids.** In patients receiving large doses of glucocorticoids, administration of 2 g/day of vitamin C corrected glucocorticoid-induced defects in polymorphonuclear neutrophil function, an effect that might help prevent the increase in susceptibility to infections associated with long-term glucocorticoid use.

**Indinavir.** Supplementation with 1,000 mg/day of vitamin C has been reported to decrease by 14–20% the steady-state plasma concentration of indinavir (chapter 309).

**Interleukin-2.** Treatment with interleukin-2 has been reported to cause a marked decrease in plasma vitamin C levels. In one study, plasma vitamin C fell by 80% after the first phase of treatment and became undetectable in 8 of 11 patients as treatment progressed (chapter 325). The effect of vitamin C supplementation on the anticancer effect of interleukin-2 has not been investigated.

**Levodopa.** In a case report, supplementation with vitamin C appeared to enhance the efficacy of levodopa (chapter 139).

**Opioid narcotics.** Interactions between vitamin C and opioid narcotics, and the use of vitamin C to treat opioid addiction, are discussed in chapter 276.

**Propranolol.** In healthy volunteers, administration of 2 g of vitamin C 30 minutes before a dose of propranolol significantly reduced the bioavailability of the drug. This effect appeared to be due to a combination of decreased drug absorption and an alteration in drug metabolism.

**Proton pump inhibitors.** Treatment with proton pump inhibitors decreased plasma vitamin C levels in healthy volunteers.

**Ribavirin.** In patients with chronic hepatitis C, supplementation with 2,000 mg/day of vitamin C and 2,000 IU/day of vitamin E prevented ribavirin-induced hemolytic anemia during combination therapy with ribavirin and interferon alpha-2b, without compromising the efficacy of the treatment (chapter 122).

**Tetracyclines.** Administration of 500 mg of vitamin C along with 250 mg of tetracycline increased the blood level of tetracycline after 2 hours by 3- to 15-fold, compared with the level after administration of tetracycline alone. Similar effects were seen with oxytetracycline and chlortetracycline.

**Warfarin.** In case reports, 2 patients had an increase in their warfarin requirement while taking vitamin C (16 g/day in one case, dose not specified in the other case). In 5 other patients, administration of 1 g/day of vitamin C for 2 weeks had no effect on warfarin requirements. In animals, administration of vitamin C in doses up to 500 mg/kg of body weight per day did not alter the anticoagulant effect of warfarin. The case reports suggesting an interaction between vitamin C and warfarin may have been due to random fluctuations in coagulation parameters, rather than to an effect of vitamin C. However, the possibility that large doses of vitamin C interfere with warfarin cannot be ruled out.

## Nutrient interactions

**Iron.** Vitamin C enhances the absorption of nonheme iron and also reverses the inhibitory effect of some foods on iron absorption (see chapter 30 for references). As little as 50 mg of vitamin C has been found to increase iron absorption in some studies. This interaction is useful for preventing and treating iron deficiency. However, vitamin C supplementation may worsen iron overload in patients with increased body iron stores, and may also increase iron-induced oxidative damage.<sup>33</sup>

**Copper.** In animals, high intake of vitamin C (such as 1% of the diet) inhibited copper absorption and decreased tissue copper levels.<sup>46,47</sup> When the diet was deficient in copper, high vitamin C intake accelerated the development of copper deficiency.<sup>48</sup> In contrast, parenterally administered vitamin C had some supportive and some antagonistic effects on copper metabolism.<sup>49</sup>

In humans, supplementation with 500–600 mg/day of vitamin C had no clear effect on indices of copper status.<sup>50–52</sup> However, based on the results of animal studies, it would seem reasonable to administer a copper supplement (such as 2 mg/day) to individuals taking larger doses of vitamin C for long periods of time.

**Vitamin B<sub>12</sub>.** One investigator reported that the addition of 500 mg of vitamin C destroyed 50–95% of the vitamin B<sub>12</sub> in a homogenized meal *in vitro*. However, another group of researchers found that 500 mg of vitamin C did not destroy vitamin B<sub>12</sub>, and they attributed the earlier findings to artifacts of the method used to measure vitamin B<sub>12</sub> concentrations. One practitioner treated thousands of patients with large doses of vitamin C over a 35-year period and did not see a single case of vitamin B<sub>12</sub> deficiency resulting from the use of vitamin C. In addition, among children taking an average of 1.65 g/day of vitamin C for 2 years

to acidify their urine, there was no significant decrease in serum vitamin B<sub>12</sub> levels (see chapter 20 for references).

An interaction between vitamins C and B<sub>12</sub> may occur when these nutrients are present together in aqueous solution for parenteral administration. This issue is discussed in chapter 20.

**Flavonoids.** Certain flavonoids, such as quercetin and rutin, inhibited the oxidation of vitamin C *in vitro*.<sup>53</sup> In animals fed less than the minimum requirement of vitamin C, supplementation with rutin or quercetin reduced the number of hemorrhages.<sup>54</sup> Thus, certain flavonoids appear to have a sparing effect on vitamin C when vitamin C intake is low.

**Vitamin E.** Vitamins C and E function together as components of the antioxidant defense system. Studies in animals and humans suggest that supplementation with large amounts of either of these nutrients increases the requirement for the other.<sup>55,56</sup>

**Selenium.** Vitamin C appears to convert sodium selenite (a form of selenium used for supplementation) to elemental selenium, making it unavailable for absorption. This interaction occurred when 1 g of vitamin C was taken with sodium selenite on an empty stomach, but not when these nutrients were taken together with a meal.<sup>57</sup> Despite this interaction between sodium selenite and vitamin C supplements, consumption of a diet high in vitamin C was associated with an increased percent absorption of sodium selenite and increased retention of absorbed selenium, when compared with a diet low in vitamin C.<sup>58</sup> Vitamin C does not appear to interact with selenomethionine, another commonly used form of supplemental selenium.<sup>59</sup>

## Other interactions

**Aluminum.** As noted above under Drug interactions, vitamin C may increase the absorption of aluminum. Since aluminum may play a role in the pathogenesis of osteoporosis and Alzheimer's disease, it would be prudent not to take vitamin C at the same time as aluminum-containing antacids or foods or beverages that may be high in aluminum (such as processed cheese, foods that contain baking powder, and beverages stored in aluminum cans).

## Effect of vitamin C on laboratory tests

**Glucose.** Some,<sup>60–62</sup> but not all,<sup>63</sup> studies have found that the glucose oxidase test for glycosuria (Diastix, Clinistix, Tes-tape) was inhibited by the presence of vitamin C in the urine in concentrations that can be achieved by oral administration of 300 mg/day of vitamin C. This test may therefore yield false-negative results in individuals who are taking vitamin C supplements or consuming a diet high in vitamin C. False-negative results can be recognized by adding

1 drop of 0.5% glucose to the negative test area and seeing whether the area remains negative.

The addition of vitamin C to urine *in vitro* to achieve a concentration of 250 mg/dl produced a false-positive glucose test using the copper-reduction method (Clinitest). However, such high concentrations of vitamin C would be difficult to achieve with maximum tolerated oral doses of the vitamin. In healthy volunteers, vitamin C in doses up to 9 g/day did not cause false-positive tests using the copper-reduction method.<sup>64–66</sup>

**Oxalate.** The presence of large amounts of vitamin C in the urine can lead to a falsely elevated value for 24-hour urinary oxalate, because some vitamin C is converted to oxalate *ex vivo* (i.e., in the collection container). This spurious increase in urinary oxalate levels has led to the erroneous assumption that taking large doses of vitamin C causes kidney stones (see above). This *ex vivo* reaction can be prevented by adding 20 ml of concentrated hydrochloric acid to the collection container.<sup>67</sup> The *ex vivo* conversion of vitamin C to oxalate has also been prevented by adding 20–25 mmol (7.44–9.3 g) of disodium EDTA and 0.2–0.6 mmol of sodium thimerosal to the collection container.<sup>68</sup>

**Occult blood tests.** Fecal excretion of as little as 55 mg/day of vitamin C can produce a false-negative stool test for occult blood. Tests that are affected include Hemoccult and similar tests that use guaiac, benzidine, or other diamino compounds as a color indicator. It has been recommended that patients discontinue vitamin C supplements for 48–72 hours prior to testing for occult blood.<sup>69</sup>

Vitamin C at a concentration of 25 mg/dl in urine prevented the detection of occult blood with Multi-Stix when the urine contained 10–20 erythrocytes per high-power field (HPF). At a urinary concentration of 35 mg/dl of vitamin C, occult blood was undetectable when the urine contained greater than 20 erythrocytes per HPF. Thus, vitamin C supplementation can give false-negative results for occult blood in urine.<sup>70</sup> Limiting supplemental vitamin C intake to 100 mg/day for a few days prior to testing the urine would presumably be sufficient to avoid a false-negative result.

**Serum cholesterol and triglycerides.** Vitamin C at concentrations within the physiologic range of 30–150 μmol/L caused a small but statistically significant artifactual decrease in total serum cholesterol and triglyceride concentrations, as measured by commonly used peroxidase-linked oxidative colorimetric methods.<sup>71</sup>

**Effect of intravenous vitamin C.** A 61-year-old man received an intravenous infusion of 30 g of sodium ascorbate just prior to the collection of a blood sample. Uric acid, cholesterol, and triglyceride levels were markedly depressed. In addition, serum creatinine was more than 3 times the upper limit of normal, but was normal when tested by a more specific method. Total iron-binding capacity was

also falsely elevated. Serum sodium was elevated, apparently due to the high sodium content of the infusion. Similar laboratory abnormalities have been seen in patients who received lower intravenous doses of vitamin C.<sup>72</sup> Intravenous administration of large amounts of vitamin C produces serum vitamin C concentrations far greater than those attainable with maximum tolerated oral doses. Therefore, except for the small effect on serum cholesterol and triglyceride levels (as noted above), one would not expect oral vitamin C administration to interfere with these laboratory measurements. It has been recommended that patients not have blood tests within 4 hours after receiving intravenous vitamin C.

## Food sources

Good sources of vitamin C include citrus fruits, cantaloupe, broccoli, Brussels sprouts, cauliflower, and potatoes. Substantial amounts of vitamin C in food are lost during high-temperature cooking and during prolonged warming (such as keeping a meal warm at 75 degrees C [167 degrees F] for 4 hours).<sup>73</sup>

## Preparations

Vitamin C is available as ascorbic acid (a weak acid) and in buffered forms (such as sodium ascorbate, calcium ascorbate, and other mineral ascorbates). Sodium ascorbate provides 131 mg of sodium per 1,000 mg of vitamin C, and calcium ascorbate provides 114 mg of calcium per 1,000 mg of vitamin C.<sup>74</sup> For some individuals, gastrointestinal side effects are less likely to occur with buffered vitamin C than with ascorbic acid. However, with large doses, the increased intake of sodium or calcium must be considered. I have often used a 50:50 mixture of ascorbic acid and buffered vitamin C (sodium ascorbate or calcium ascorbate) when administering large oral doses of vitamin C. One practitioner reported that, for some patients, sodium ascorbate was a more effective treatment than ascorbic acid for various allergy-related conditions (including asthma).<sup>75</sup>

One study found that the bioavailability of 500 mg of vitamin C from a natural source (a citrus extract that contained flavonoids and other substances) was somewhat greater than the bioavailability of 500 mg of synthetic vitamin C.<sup>76</sup> In addition to the sparing effect of flavonoids on vitamin C, as noted above under Nutrient interactions, flavonoids may have beneficial effects of their own. However, vitamin C from natural sources is more expensive than synthetic vitamin C, and some vitamin C products advertised as being “natural” contain only token amounts of flavonoids. Therefore, it might be more cost-effective to use synthetic vitamin C for supplementation and to obtain additional flavonoids and other nutrients by consuming more fruits and vegetables.

Ester-C is a proprietary product that contains calcium ascorbate and small amounts of vitamin C metabolites, such as calcium threonate. A comparative trial in healthy volunteers found that Ester-C was not more bioavailable than ascorbic acid.<sup>77</sup>

Ascorbyl palmitate is a fat-soluble form of vitamin C manufactured by esterification of vitamin C to palmitic acid. While this product is promoted as being superior to ascorbic acid, there is no reason to assume that vitamin C is capable of exerting its usual biochemical effects in a fat-soluble environment where it is not normally present. Since other antioxidants (such as vitamin E and vitamin A) are designed to function in fat-soluble environments, it seems illogical to administer vitamin C in the form of ascorbyl palmitate.

## Dosage and administration

For adults, the most frequently used dosages of vitamin C are 100–3,000 mg/day. Some practitioners have recommended much larger, “bowel tolerance” doses to treat certain conditions, such as acute viral infections. The bowel-tolerance dose is the dose just below that which produces diarrhea. It can be determined by taking vitamin C in progressively larger amounts (usually in 3–6 divided doses per day) until diarrhea occurs, and then reducing the dose slightly. According to one practitioner, the benefits of vitamin C become most pronounced as the bowel-tolerance level is approached. Patients are often able to tolerate much larger doses of vitamin C when they are ill than when they are well. As they improve, their bowel-tolerance limit decreases.<sup>38,78</sup>

Vitamin C is better tolerated when taken with food than when taken on an empty stomach. Taking vitamin C in 2 or 3 divided doses per day, as opposed to once a day, may increase the total amount absorbed and minimize the decline in serum vitamin C levels between doses. When administering large amounts of vitamin C, splitting it into multiple doses throughout the day may improve bowel tolerance and allow for a higher total daily dosage.

Information regarding intravenous administration of vitamin C is presented in chapter 341.

## References

1. Ginter E. Optimum intake of vitamin C for the human organism. *Nutr Health* 1982;1:66–77.
2. Singh D, Chan W. Cardiomegaly and generalized oedema due to vitamin C deficiency. *Singapore Med J* 1974;15:60–63.
3. Shafar J. Rapid reversion of electrocardiographic abnormalities after treatment in two cases of scurvy. *Lancet* 1967;2:176–178.
4. Anonymous. Experimental scurvy in a young man. *Nutr Rev* 1986;44:13–15.
5. Kinsman RA, Hood J. Some behavioral effects of ascorbic acid deficiency. *Am J Clin Nutr* 1971;24:455–464.
6. Krumdieck C, Butterworth CE. Ascorbate-cholesterol-lecithin interactions: factors of potential importance in the pathogenesis of atherosclerosis. *Am J Clin Nutr* 1974;27:866–876.
7. Krebs HA. The Sheffield experiment on the vitamin C requirement of human adults. *Proc Soc Exp Biol Med* 1953;12:237–246.

8. Reuler JB, Broudy VC, Cooney TG. Adult scurvy. *JAMA* 1985;253:805–807.
9. National Institutes of Health. Office of Dietary Supplements. Vitamin C. <http://dietary-supplements.info.nih.gov/factsheets/vitaminc.asp#h2>. Accessed March 13, 2010.
10. Stone I. Humans, the mammalian mutants. *Am Lab* 1974(April):32–39.
11. Stone I. On the genetic etiology of scurvy. *Acta Genet Med Gemellol* 1966;15:345–349.
12. Salomon LL, Stubbs DW. Some aspects of the metabolism of ascorbic acid in rats. *Ann N Y Acad Sci* 1961;92:128–140.
13. Burns JJ, Mosbach EH, Schulenberg S. Ascorbic acid synthesis in normal and drug-treated rats, studied with L-ascorbic-1-C14 acid. *J Biol Chem* 1954;207:679–687.
14. Chatterjee IB, Kar NC, Ghosh NC, Guha BC. Aspects of ascorbic acid biosynthesis in animals. *Ann N Y Acad Sci* 1961;92:36–56.
15. Pauling L. Evolution and the need for ascorbic acid. *Proc Natl Acad Sci* 1970;67:1643–1648.
16. Blanchard J, Tozer TN, Rowland M. Pharmacokinetic perspectives on megadoses of ascorbic acid. *Am J Clin Nutr* 1997;66:1165–1171.
17. Spector R. Vitamin homeostasis in the central nervous system. *N Engl J Med* 1977;296:1393–1398.
18. Pauling L. Vitamin homeostasis in the brain and megavitamin therapy. *N Engl J Med* 1977;297:790–791.
19. Tsao CS, Salimi SL. Evidence of rebound effect with ascorbic acid. *Med Hypotheses* 1984;13:303–310.
20. Schleicher RL, Carroll MD, Ford ES, Lacher DA. Serum vitamin C and the prevalence of vitamin C deficiency in the United States: 2003–2004 National Health and Nutrition Examination Survey (NHANES). *Am J Clin Nutr* 2009;90:1252–1263.
21. Levine M, Katz A, Padayatty SJ. Vitamin C. In Shils ME, Shike M, Ross AC, et al (eds.). *Modern Nutrition in Health and Disease*, Tenth Edition. Baltimore, MD, Lippincott Williams & Wilkins, 2006:507–524.
22. Vobecky JS, Vobecky J, Shapcott D, Blanchard R. Vitamin E and C levels in infants during the first year of life. *Am J Clin Nutr* 1976;29:766–771.
23. Hiebert CA. Gastroesophageal reflux and ascorbic acid insufficiency. *Ann Thorac Surg* 1977;24:108–112.
24. Thomas AJ, Briggs RS, Monro P. Is leucocyte ascorbic acid an unreliable estimate of vitamin C deficiency? *Age Ageing* 1984;13:243–247.
25. Barton GMG, Roath OS. Leucocyte ascorbic acid in abnormal leucocyte states. *Int J Vitam Nutr Res* 1976;46:271–274.
26. Burch HB. Methods for detecting and evaluating ascorbic acid deficiency in man and animals. *Ann N Y Acad Sci* 1961;92:268–276.
27. Auer BL, Auer D, Rodgers AL. Relative hyperoxaluria, crystalluria and haematuria after megadose ingestion of vitamin C. *Eur J Clin Invest* 1998;28:695–700.
28. Lawton JM, Conway LT, Crosson JT, et al. Acute oxalate nephropathy after massive ascorbic acid administration. *Arch Intern Med* 1985;145:950–951.
29. Wong K, Thomson C, Bailey RR, et al. Acute oxalate nephropathy after a massive intravenous dose of vitamin C. *Aust N Z J Med* 1994;24:410–411.
30. McAllister CJ, Scowden EB, Dewberry FL, Richman A. Renal failure secondary to massive infusion of vitamin C. *JAMA* 1984;252:1684.
31. Swartz RD, Wesley JR, Somermeyer MG, Lau K. Hyperoxaluria and renal insufficiency due to ascorbic acid administration during total parenteral nutrition. *Ann Intern Med* 1984;100:530–531.
32. Mashour S, Turner JF Jr, Merrell R. Acute renal failure, oxalosis, and vitamin C supplementation: a case report and review of the literature. *Chest* 2000;118:561–563.
33. Slivka A, Kang JO, Cohen G. Ascorbic acid. *N Engl J Med* 1986;315:708–709.
34. Rees DC, Kelsey H, Richards JDM. Acute haemolysis induced by high dose ascorbic acid in glucose-6-phosphate dehydrogenase deficiency. *BMJ* 1993;306:841–842.
35. Campbell GD Jr, Steinberg MH, Bower JD. Ascorbic acid induced hemolysis in G-6-PD deficiency. *Ann Intern Med* 1975;82:810.
36. Pereyo N. Tartrazine compounds. *Arch Dermatol* 1979;115:508.
37. Gordonoff T. Water-soluble vitamins in excessive doses. *JAMA* 1960;174:1672.
38. Cathcart RF III. Vitamin C, titrating to bowel tolerance, anascorbemia, and acute induced scurvy. *Med Hypotheses* 1981;7:1359–1376.
39. Cochrane WA. Overnutrition in prenatal and neonatal life: a problem? *Can Med Assoc J* 1965;93:893–899.
40. Demers P, Fraser D, Goldbloom R, et al. An epidemiological study of infantile scurvy in Canada: 1961–63. *Can Med Assoc J* 1965;93:573–576.
41. Stone I, Hoffer A. The genesis of medical myths. *J Orthomolec Psychiatry* 1976;5:163–168.
42. Carpenter KJ. Vitamin deficiencies in North America in the 20th century. *Nutr Today* 1999;34(6):223–228.
43. Giunta JL. Dental erosion resulting from chewable vitamin C tablets. *J Am Dent Assoc* 1983;107:253–256.
44. Meurman JH, Murtomaa H. Effect of effervescent vitamin C preparations on bovine teeth and on some clinical and salivary parameters in man. *Scand J Dent Res* 1986;94:491–499.
45. Dannenberg JL. Vitamin C enamel loss. *J Am Dent Assoc* 1982;105:172–173.
46. van Campen D, Gross E. Influence of ascorbic acid on the absorption of copper by rats. *J Nutr* 1968;95:617–622.
47. Johnson MA, Murphy CL. Adverse effects of high dietary iron and ascorbic acid on copper status in copper-deficient and copper-adequate rats. *Am J Clin Nutr* 1988;47:96–101.
48. Hunt CE, Carlton WW. Cardiovascular lesions associated with experimental copper deficiency in the rabbit. *J Nutr* 1965;87:385–393.
49. Disilvestro RA, Harris ED. A postabsorption effect of L-ascorbic acid on copper metabolism in chicks. *J Nutr* 1981;111:1964–1968.
50. Jacob RA, Skala JH, Omaye ST, Turnlund JR. Effect of varying ascorbic acid intakes on copper absorption and ceruloplasmin levels of young men. *J Nutr* 1987;117:2109–2115.
51. Finley EB, Cerklewski FL. Influence of ascorbic acid supplementation on copper status in young adult men. *Am J Clin Nutr* 1983;37:553–556.
52. Chenoweth W, Ducey S, Ullrey D. Effect of dietary copper and ascorbic acid supplementation on copper and zinc balances in elderly men. *Fed Proc* 1984;43:683.
53. Clemetson CAB, Andersen L. Plant polyphenols as antioxidants for ascorbic acid. *Ann N Y Acad Sci* 1966;136:341–376.
54. Ambrose AM, DeEds F. The value of rutin and quercetin in scurvy. *J Nutr* 1949;38:305–317.
55. Chen LH. An increase in vitamin E requirement induced by high supplementation of vitamin C in rats. *Am J Clin Nutr* 1981;34:1036–1041.
56. Brown KM, Morrice PC, Duthie GG. Erythrocyte vitamin E and plasma ascorbate concentrations in relation to erythrocyte peroxidation in smokers and nonsmokers: dose response to vitamin E supplementation. *Am J Clin Nutr* 1997;65:496–502.
57. Robinson MF, Thomson CD, Huemmer PK. Effect of a megadose of ascorbic acid, a meal and orange juice on the absorption of selenium as sodium selenite. *N Z Med J* 1985;98:627–629.
58. Martin RF, Young VR, Blumberg J, Janghorbani M. Ascorbic acid-selenite interactions in humans studied with an oral dose of 74SeO3(2-). *Am J Clin Nutr* 1989;49:862–869.
59. Ip C. Interaction of vitamin C and selenium supplementation in the modification of mammary carcinogenesis in rats. *J Natl Cancer Inst* 1986;77:299–303.
60. O’Gorman P, Griffiths PD, Bloxam HR. Ascorbic acid inhibition of the glucose-oxidase test for glycosuria. *Br Med J* 1960;1:603–606.
61. Mayson JS, Schumaker O, Nakamura RM. False negative tests for urinary glucose in the presence of ascorbic acid. *Am J Clin Pathol* 1972;58:297–299.
62. Mayson JS, Schumaker O, Nakamura RM. False-negative tests for urine glucose. *Lancet* 1973;1:780–781.
63. Maguire GA, Price CP. Evidence for interference by ascorbate in the measurement of cerebrospinal fluid glucose by a kinetic glucose oxidase/peroxidase procedure. *Clin Chem* 1983;29:1810–1812.
64. Nahata MC, McLeod DC. Noneffect of oral urinary copper ascorbic acid on reduction glucose test. *Diabetes Care* 1978;1:34–35.
65. Smith D, Young WW. Effect of large-dose ascorbic acid on the two drop Clinitest determination. *Am J Hosp Pharm* 1977;34:1347–1349.
66. Nahata MC, McLeod DC. Lack of effect of ascorbic acid, hippuric acid, and methenamine (urinary formaldehyde) on the copper-reduction glucose test in geriatric patients. *J Am Geriatr Soc* 1980;28:230–233.
67. Wandzilak TR, D’Andre SD, Davis PA, Williams HE. Effect of high dose vitamin C on urinary oxalate levels. *J Urol* 1994;151:834–837.
68. Chalmers AH, Cowley DM, McWhinney BC. Stability of ascorbate in urine: relevance to analyses for ascorbate and oxalate. *Clin Chem* 1985;31:1703–1705.
69. Jaffe RM, Kasten B, Young DS, MacLowry JD. False-negative stool occult blood tests caused by ingestion of ascorbic acid (vitamin C). *Ann Intern Med* 1975;83:824–826.
70. Jaffe RM, Lawrence L, Schmid A, MacLowry JD. Inhibition by ascorbic acid (vitamin C) of chemical detection of blood in urine. *Am J Clin Pathol* 1979;72:468–470.
71. Benzie IFF, Strain JJ. The effect of ascorbic acid on the measurement of total cholesterol and triglycerides: possible artefactual lowering in individuals with high plasma concentration of ascorbic acid. *Clin Chim Acta* 1995;239:185–190.

72. Badrick TC, Campbell B. Effects of intravenous infusion of ascorbate on common clinical chemistry tests. *Clin Chem* 1992;38:2160.
73. Hallberg L, Rossander L, Persson H, Svahn E. Deleterious effects of prolonged warming of meals on ascorbic acid content and iron absorption. *Am J Clin Nutr* 1982;36:846–850.
74. Oregon State University. Linus Pauling Institute. <http://lpi.oregonstate.edu/infocenter/vitamins/vitaminC>. Accessed April 23, 2010.
75. Ruskin SL. Sodium ascorbate in the treatment of allergic disturbances. The role of adrenal cortical hormone-sodium-vitamin C. *Am J Dig Dis* 1947;14:302–306.

76. Vinson JA, Bose P. Comparative bioavailability to humans of ascorbic acid alone or in a citrus extract. *Am J Clin Nutr* 1988;48:601–604.
77. Johnston CS, Luo B. Comparison of the absorption and excretion of three commercially available sources of vitamin C. *J Am Diet Assoc* 1994;94:779–781.
78. Cathcart RF. Vitamin C: the nontoxic, nonrate-limited, antioxidant free radical scavenger. *Med Hypotheses* 1985;18:61–77.



## Vitamin D

### Nomenclature and biochemistry

Vitamin D is a fat-soluble vitamin that functions as a pro-hormone (hormone precursor). Vitamin D<sub>3</sub> (also known as cholecalciferol) occurs naturally in fish and in small amounts in a few other foods (e.g., cheese, egg yolk, and beef liver), and is synthesized in the skin from 7-dehydrocholesterol after exposure to sunlight or other sources of ultraviolet light. Vitamin D<sub>2</sub> (also called ergocalciferol) is produced by irradiation of ergosterol, a sterol present in fungi. While vitamin D<sub>2</sub> is not normally present in the human body and is found only in trace amounts in plants, it has vitamin D activity and has been used for decades to prevent and treat vitamin D deficiency in humans. In this chapter, all references to vitamin D and its metabolites indicate vitamin D<sub>3</sub> unless otherwise specified.

Vitamin D itself is biologically inactive, and must undergo two hydroxylation reactions to become active. Vitamin D is first hydroxylated in the liver to form 25-hydroxyvitamin D (25[OH]D). It is further hydroxylated in the kidney to 1,25-dihydroxyvitamin D (1,25[OH]<sub>2</sub>D), the biologically active form of the vitamin, which functions as a steroid hormone.

Vitamin D enhances the intestinal absorption of calcium and phosphorus, promotes bone mineralization and remodeling, and is involved in regulating serum calcium and phosphorus levels. Vitamin D also plays a role in neuromuscular function and influences cellular growth and differentiation. As a modulator of immune function, vitamin D may help prevent both infections and autoimmune diseases. In addition, vitamin D appears to enhance the secretion and action of insulin.

Throughout most of human history, vitamin D was obtained almost exclusively through cutaneous biosynthesis, since typical diets contained little or no vitamin D. Moreover, people who are exposed to adequate amounts of sunlight do not require a dietary source of the vitamin. For these reasons, it has been debated whether vitamin D should

be classified a nutrient. However, there is no question that vitamin D becomes an essential nutrient when sunlight exposure is inadequate.

### Clinical indications

Vitamin D may be useful for preventing and/or treating the conditions listed in Table 23-1.

### Absorption and excretion

The absorption of vitamin D is enhanced by the presence of bile and fat in the intestinal tract. With advancing age, the increase in the serum 25(OH)D concentration in response to vitamin D supplementation becomes less pronounced. This blunting of the serum 25(OH)D response may be due to an age-related decrease in vitamin D absorption, but it could also reflect a decrease in 25-hydroxylation by the liver.<sup>1</sup> Studies in infants suggest that iron deficiency leads to impaired absorption of vitamin D, and that correction of iron deficiency improves vitamin D absorption.<sup>2</sup> Vitamin D malabsorption may also occur in individuals with chronic liver disease, pancreatic insufficiency, and diseases of the small intestine (e.g., celiac disease, Crohn's disease).

Vitamin D is excreted primarily in the bile, and some vitamin D metabolites are excreted in the urine.

**Table 23-1. Vitamin D may be useful for preventing and/or treating the following conditions**

Back pain	Hearing loss
Breath-holding spells	Influenza
Burns	Myopathy
Cancer	Osteomalacia
Chilblains	Osteoporosis
Colds	Paget's disease
Congestive heart failure	Polycystic ovary syndrome
Critical illness	Rickets
Diabetes	Seasonal affective disorder
Fatigue	Tuberculosis