Sir,
The commentary by Nigwekar et al. [1] about giving adequate vitamin D to dialysis patients is now just part of a wider prospect, i.e. correction of vitamin D status in CRF patients and even in normal African-Americans. One has only to consider the reviews by Hewison [2] of LA, the Szeto and Li [3] article and that of Baeke et al. [4] from Leuven to realize the need for vital decisions. What form and dosage of the new vitamin D analogues will be required? Unfortunately, FGF23 research has turned out to be a principal but necessary distraction.

No doubt, even the experts are already dazzled by the actions of vitamin D in sustaining podocytes, reducing vascular endothelial dysfunction, potentially reducing atherosclerosis, reducing insulin resistance and decreasing TGFβ expression and renal fibrosis and scarring. Vitamin D action opposes the renin-angiotensin system, thwarts Wnt/β-catenin actions (e.g. on podocytes) and is anti-apoptotic. It is a requisite agent for modulation of innate and adaptive immunity [5]. The health of the respiratory epithelia and of the intestinal homeostasis barrier will be ensured. Regulatory T cells will be able to pursue their vital work. Resistance to tuberculosis will be improved.

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Vitamin D for CRF or for dialysis patients: do we D iscern?


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