PRACTICAL PEARLS: Vitamin D Screening

INTRODUCTION	• Screening for Vitamin D deficiency (VDD) should be selective: there is no evidence that universal screening is warranted. • Children at risk for VDD include breast-fed infants, kids with obesity, malabsorption syndromes, and chronic glucocorticoid, anticonvulsant, antifungal, and antiretroviral medications. • All breast-fed infants should be supplemented with 400 IU/d. • http://pediatrics.aappublications.org/content/pediatrics/134/4/e1229.full.pdf
INITIAL EVALUATION AND MANAGEMENT BY PRIMARY CARE	• Measure serum 25-OH-D. It is NOT necessary to measure Calcium or PTH; 1,25-OH-D should NOT be measured. • 25-OH-D >20 ng/mL is sufficient. This target is recommended by the IOM, Pediatric Endocrine Society and the European Society for Pediatric Gastroenterology, Hepatology and Nutrition. • If 25-OH-D levels are <20 ng/mL, repeat with Ca, P and PTH levels. Significant VDD is associated with elevated PTH levels; severe VDD may also be associated with low Ca and P levels. • Treatment consists of vitamin D_2 or D_3 2000 IU/d or 50 000 IU/week for 6 weeks followed by a maintenance dose 400-1000 IU/d in infants and toddlers or 600-1000 IU/d in children and teens. 25-OH-D should be re-measured after therapy.
WHEN TO REFER	• Severe VDD (<10) with hypocalcemia or rickets; VDD associated with extremely elevated PTH levels; VDD refractory to therapy after 12 weeks
HOW TO REFER	• (413) 794-KIDS: Pediatric Endocrinology
WHAT TO EXPECT FROM BAYSTATE CHILDREN'S HOSPITAL VISIT	• Comprehensive evaluation and treatment

Author: **Charlotte M. Boney, MD**
Pediatric Endocrinology
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Contact: Baystatechildrenshospital@baystatehealth.org