

Measurement of vitamin D₃ metabolites in smelter workers exposed to lead and cadmium

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Abstract

Objectives—To investigate the effects of lead and cadmium on the metabolic pathway of vitamin D₃.

Methods—Blood and urinary cadmium and urinary total proteins were measured in 59 smelter workers occupationally exposed to lead and cadmium. In 19 of these workers, the plasma vitamin D₃ metabolites, (25-hydroxycholecalciferol (25(OH)D₃), 24R, 25-dihydroxycholecalciferol (24R,25(OH)₂D₃) and 1α, 25-dihydroxycholecalciferol (1α,25(OH)₂D₃)) were measured together with blood lead. Vitamin D₃ metabolites were measured by radioimmunoassay, (RIA), lead and cadmium by atomic absorption spectrophotometry, and total proteins with a test kit.

Results—Ranges for plasma 25(OH)D₃, 24R,25(OH)₂D₃ and 1α,25(OH)₂D₃ were 1.0–51.9 ng/ml, 0.6–5.8 ng/ml, and 0.1–75.7 pg/ml, respectively. Ranges for blood lead were 1–3.7 μmol/l, (21–76 μg/dl), blood cadmium 6–145 nmol/l, and urinary cadmium 3–161 nmol/l. Total proteins in random urine samples were 2.1–32.6 mg/dl. Concentrations of lead and cadmium in blood showed no correlation (correlation coefficient -0.265) but there was a highly significant correlation between blood and urinary cadmium. Concentrations for 24R,25(OH)₂D₃ were depressed below the normal range as blood and urinary cadmium increased, irrespective of lead concentrations. High cadmium concentrations were associated with decreased plasma 1α,25(OH)₂D₃ when lead concentrations were <1.9 μmol/l and with above normal plasma 1α,25(OH)₂D₃ when lead concentrations were >1.9 μmol/l, Kruskal-Wallis analysis of variance (K-W ANOVA) $\chi^2=10.3$, $p=0.006$. Plasma 25(OH)D₃ was negatively correlated with both urinary total proteins and urinary cadmium, but showed no correlation with plasma 24R,25(OH)₂D₃, 1α,25(OH)₂D₃, blood lead, or blood cadmium.

Conclusion—Continuous long term exposure to cadmium may result in a state of equilibrium between blood and urinary cadmium. Cadmium concentrations in blood could be predicted from the cadmium concentration of the urine, (regression coefficient +0.35 SE 0.077). Exposure to cadmium alone decreased the concentrations of 1α,25(OH)₂D₃ and 24R,25(OH)₂D₃, whereas exposure to both cadmium and lead increased the concentrations of 1α,25(OH)₂D₃. It has been

suggested that cadmium and lead interact with renal mitochondrial hydroxylases of the vitamin D₃ endocrine complex. Perturbation of the vitamin D metabolic pathway by cadmium may result in health effects, such as osteoporosis or osteomalacia, risks which are possibly increased in the presence of lead.

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Keywords: vitamin D₃ metabolites; lead; cadmium; total proteins; blood; urine; smelter workers

This study sought to investigate the effect of exposure to the heavy metals lead and cadmium on the plasma concentrations of vitamin D₃ metabolites and to determine the effects of dual exposure. The metabolic pathway of vitamin D₃, cholecalciferol, involves the gut, liver, kidneys, and bones, all of which are affected by these metals.^{1,2} The liver and kidneys are target organs for lead and cadmium, so that a potential biochemical effect might be found in the vitamin D₃ pathway to explain the changes in bone metabolism found after exposure to lead or cadmium.³⁻⁶ Damage caused by cadmium to the renal tubules^{7,8} was considered especially relevant to the formation of the more active dihydroxy metabolites, 24R, 25-dihydroxycholecalciferol (24R,25(OH)₂D₃) and 1α, 25-dihydroxycholecalciferol, (1α,25(OH)₂D₃).

In the human, vitamin D₃ is obtained either from the diet^{9,10} or is metabolised from 7-dehydrocholesterol by the epidermis in the presence of sunlight or ultraviolet light.^{11,12} The enzymatic conversion of vitamin D₃ to 25-hydroxycholecalciferol, 25(OH)D₃, takes place in the liver,¹³ whereas the second hydroxylation of 25(OH)D₃ to form the dihydroxy metabolites, 24R,25-(OH)₂D₃ and 1α,25(OH)₂D₃ occurs mainly in the kidney.¹⁴ It has been suggested that this second hydroxylation is catalysed by a single enzyme¹⁵; however, earlier studies identified two membrane bound multiple enzyme complexes in the mitochondria of cells in the proximal convoluted and straight tubular sections of the nephron.^{16,17} Other sites postulated for this hydroxylation include the placenta¹⁸ and the epidermis, especially in the keratinocytes,¹⁹ which are extremely active in psoriatic patients.²⁰

Absorption of calcium from the gut is increased by 1α,25(OH)₂D₃,²¹⁻²³ whereas it has been shown that 24R,25(OH)₂D₃ does not affect this regulation of calcium uptake from the small intestine.²⁴ Both metabolites are implicated in the turnover of calcium in bone, with 1α,25(OH)₂D₃ considered more

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important in the control of osteoclasts,^{25, 26} and 24R,25(OH)₂D₃ more effective on the osteoblasts.²⁷

Dietary lead intake affects the absorption of calcium from the gut²⁸ and interferes with bone formation.^{29, 30} Calcium and lead compete for binding sites on mucosal proteins in the intestine,³¹ although more recent work by these authors suggested that the primary effect was on the cholecalciferol endocrine system, rather than the interaction of calcium and lead at the intestinal level.²⁸ In children with increased lead absorption, a reduction in 1 α ,25(OH)₂D₃ concentrations has been reported,³² which returned to normal once blood lead decreased to <30 μ g/dl (1.4 μ mol/l). It has been suggested that chronic cadmium exposure is linked with the subsequent appearance of osteomalacia and osteoporosis.³³

In smelter workers with a known exposure to both lead and cadmium there was a possibility that if the vitamin D₃ metabolic pathway was affected, this should be apparent in the plasma concentrations of the active dihydroxy metabolites. The effects of exposure to a combination of lead and cadmium were also investigated. In this study, the plasma concentrations of three metabolites of vitamin D₃, 25(OH)₂D₃, 24R,25(OH)₂D₃, and 1 α ,25(OH)₂D₃, blood concentrations of lead and cadmium, and urinary concentrations of cadmium and total proteins were measured.

Materials and methods

BLOOD AND URINARY SAMPLES

During their routine health check, male workers in a large non-ferrous metal smelter took part in a survey of the effects of long term low level cadmium exposure.³⁴ In the five year follow up study^{35, 59} of these workers were available for retesting (follow up group). Blood samples from 19 of these participants collected consecutively, (study group), were stored in conditions suitable for analysing vitamin D₃ metabolites. These blood samples were collected into tubes containing lithium heparin anticoagulant, mixed, and stored at 4°C in light proof containers. Samples were divided into two; one batch was stored at -20°C until analysed for lead and cadmium, whereas the other was centrifuged and the plasma separated and stored in glass vials at -20°C, protected from light, until assayed for vitamin D₃ metabolites. The urine samples were stored in acid washed plastic vials at -20°C. These were spot urine samples, not 24 hour collections, thus all urinary calculations are based on concentration rather than excretion rates. Apart from the difficulty of obtaining collections of 24 hour urine from these volunteers, the probability of cadmium contamination was a deciding factor in collecting spot samples.

CHEMICALS

Tritiated (³H) vitamin D₃ metabolites were obtained from Amersham International, Little Chalfont, Bucks, UK, Sephadex LH20 was from Pharmacia Biotech, St Albans, Herts, UK, 25(OH)₂D₃ binding globulin was prepared in our laboratory from normal rat serum,

1 α ,25(OH)₂D₃ binding protein was kindly donated by Dr S Edelman (Biochemistry Department, Weizmann Institute of Science, Rehovot, Israel), and the control samples for metals in blood and urine were from Behring Diagnostics, Hounslow, Middlesex, UK). All other chemicals and reagents were from Merck BDH, Lutterworth, Leics, UK and were of AnalaR grade unless stated otherwise.

VITAMIN D₃ METABOLITES

Figure 1 shows the analytical procedures, which were based on the methods developed by Edelman (personal communication). Extraction methods were based on the procedure described by Lidor *et al.*³⁶ Trace amounts of all three tritiated metabolites were added to all samples to monitor the recovery of the metabolites throughout the procedure. An adjustable rack supplied by Ilacon, Tonbridge, Kent, UK, that held the vials in a water bath at 35°C while a stream of nitrogen was directed at each individual vial, was used to evaporate all samples to dryness when changing solvents or reducing sample volumes. For high pressure liquid chromatography (HPLC), a Waters M45 HPLC solvent delivery system was used with a μ Porasil 27477 column, Waters, Watford, Herts, UK, calibrated with ³H-25(OH)₂D₃, ³H-24R,25(OH)₂D₃, and ³H-1 α ,25(OH)₂D₃, run separately to establish the positions of the three peaks. The eluting solvent was isopropanol:hexane (1:9), degassed under vacuum.

The radioimmunoassay (RIA) was a modified protein binding method, with activated dextran/charcoal separation and ³H-25(OH)₂D₃ or ³H-1 α ,25(OH)₂D₃.³⁶ For 25(OH)₂D₃ and 24R,25(OH)₂D₃ the binding protein was vitamin D₃ binding globulin from rat serum³⁷ and for 1 α ,25(OH)₂D₃ cytosol from the duodenum of rachitic chicks was used. Samples, standards, controls, and blanks were dissolved in absolute ethanol, each sample was assayed in duplicate, and each standard in quadruplet. Barbitone buffer, pH 8.6, was used in the assay for 25(OH)₂D₃ or 24R,25(OH)₂D₃ and TRIS-molybdate buffer, pH 7.4, for the 1 α ,25(OH)₂D₃. Assays were left overnight at 4°C, dextran/charcoal suspension was added and after 30 minutes on ice, the assay samples were filtered into counting vials with an Ilacon filter unit. Radioactivity was measured with a Packard Tricarb β -counter, Packard Instruments, Caversham, Berks, UK. Standard curves were calculated with log/logit transformation, the sample concentrations were calculated, and the values were adjusted for percentage recovery. Matched volumes of a plasma pool used as a laboratory quality control were included in each run. The RIA for vitamin D₃ metabolites had minimum detection limits of 0.5 ng/tube for 25(OH)₂D₃ and 24R,25(OH)₂D₃ and 0.5 pg/tube for 1 α ,25(OH)₂D₃. The working concentration ranges were 30–200 ng/ml for 25(OH)₂D₃ and 24R,25(OH)₂D₃ and 20–300 pg/ml for 1 α ,25(OH)₂D₃ calculated from the relevant precision profile. Control ranges for vitamin D₃ metabolites measured in this laboratory in adults with no known exposure to lead or cadmium were as follows, 25(OH)₂D₃ 12.2–26.2 ng/ml, 24R,

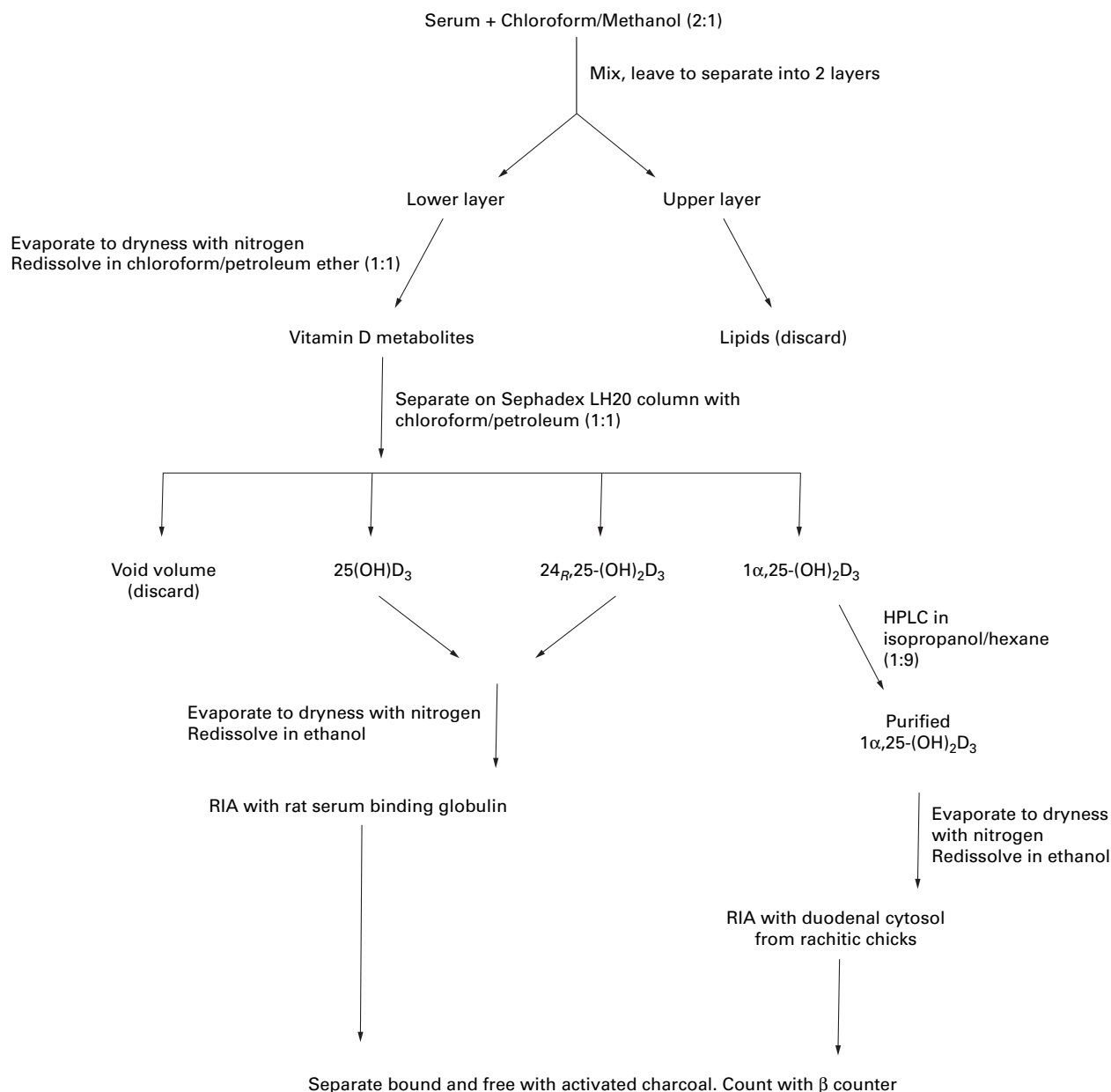


Figure 1 Procedures in the analysis of vitamin D₃ metabolites.

25(OH)₂D₃ 1.3–2.6 ng/ml, and 1α,25(OH)₂D₃ 34.2–42.5 pg/ml.

BLOOD LEAD, AND BLOOD AND URINARY CADMIUM

Samples were analysed for lead and cadmium with an IL Video 11 spectrophotometer and IL 655 furnace atomiser with Fastac II autosampler, Thermo Electron, Warrington, Cheshire, UK. A single matrix matched calibration curve was used to determine concentrations and all samples were analysed in duplicate with two replicates per sample; reproducibility was <10% CV. Control blood samples for metals were used at two concentrations, lead 15 and 40 µg/dl, and cadmium 4.5 and 57.9 nmol/l, control urine samples for cadmium were used at three concentrations 30, 180, and 410 nmol/l. The laboratory participated in external quality assurance schemes for blood lead and for blood and

urinary cadmium. The results obtained were as follows, Blood Lead Proficiency Testing, Centers for Disease Control, Atlanta, Georgia, State Laboratory of Hygiene, all concentrations were within target ranges; UK National External Quality Assessment Scheme (NEQAS) for lead and cadmium in blood, Queen Elizabeth Hospital, Birmingham, the mean running variance index score, (MRVIS) for lead was MRVIS=24, (MRVIS=44 for all participants), for cadmium MRVIS=23 (MRVIS=57 for all participants); trace element quality assessment scheme (TEQAS), Analytical Unit, Robens Institute, University of Surrey, UK, for blood lead and blood and urinary cadmium, all the cumulative scores (CUSUM) were above the acceptable concentration of CUSUM=20, blood lead CUSUM=85.8, blood cadmium CUSUM=71, urinary cadmium CUSUM=36.4.

Table 1 Vitamin D₃ metabolites, lead, cadmium, and total proteins in study and follow up groups

	Study group (n=19)			Follow up group (n=55)			Normal values
	AM (range)	Median	Skewness	AM (range)	Median	Skewness	
Plasma 25 (OH)D ₃ (ng/ml)	28.6 (1.0–51.9)	28.4	-0.194				8–45 *
Plasma 24R,25- (OH) ₂ D ₃ (ng/ml)	1.7 (0.6–5.8)	1.3	2.218				2–5 *
Plasma 1α,25- (OH) ₂ D ₃ (pg/ml)	32.2 (0.1–75.7)	35.0	-1.686				15–40 *
Blood lead (μmol/l)	2.2 (1.0–3.6)	2.1	0.235				<1.4 †
(μg/dl)	47 (21–76)	40.0	0.235				<25 †
Blood cadmium (nmol/l)	37 (11–145)	32.0	3.324	30 (6–74)	27.0	3.386	<27 ‡
Random urinary cadmium (nmol/l)	32 (6–160)	15.0	2.499	30 (3–161)	18.0	2.567	<8 ‡
Random urinary total protein (mg/dl)	9.7 (3.2–21.7)	9.2	1.239	10.2 (2.1–32.6)	8.9	1.459	<200 mg/24 h§ (-12.5–20 mg/dl)

Sources quoted for normal values were as follows: vitamin D metabolites* Rosen *et al.*⁴⁰; blood lead† Brody *et al.*⁴¹; blood and urinary cadmium‡ Staessen *et al.*⁴²; urinary total proteins§ Macart *et al.*³⁹

URINARY TOTAL PROTEINS

These were measured with a BioRad total protein test kit, BioRad Laboratories, Watford, Herts, UK, based on Macart's modification of the Bradford method^{38, 39} in which protein in the urine is bound to an acidified dye reagent (Coomassie brilliant blue (G250) dye). The observed change in absorbance was proportional to the protein concentration and the test was linear up to 150 mg/dl with a sensitivity of 1.1 mg/dl. Assays were carried out at room temperature in glass tubes and all measurements were in duplicate. Saline solution, 0.9%, was used as the reagent blank and extra control standards were prepared with a mixture of human albumin and globulin in a 1:1 ratio. Dye/protein colour was stable for 60 minutes and all samples were read within that time with a Varian Techtron spectrophotometer, series 634, Varian, Walton on Thames, Surrey, KT12 2QF, UK.

STATISTICAL ANALYSIS

The statistical package SPSS for Windows was used for all calculations. Frequency distributions were measured for all variables and log transformations used for skew variables. Correlation coefficients and regression analyses were calculated. The non-parametric Kruskal-Wallis one way analysis of variance (K-W one way ANOVA) was used to measure the relation between 1α,25(OH)₂D₃ and cadmium with lead.

Results

Table 1 shows the concentrations obtained for plasma 25(OH)D₃, 24R,25(OH)₂D₃, and 1α,25(OH)₂D₃, blood lead, blood and urinary cadmium, and urinary total proteins. For the follow up group, results for blood and urinary cadmium and urinary total proteins were obtained in 55 of the 59 cases. In the study group, a complete set of concentrations was

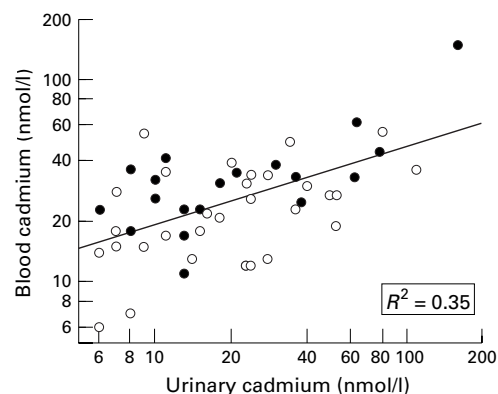


Figure 2 Relation between cadmium concentrations in blood and spot urine samples. Shown as log scales for both axes. ● study group; ○ follow up group.

obtained in all 19 cases. Table 2 shows a correlation matrix with significance levels for all variables.

Figure 2 shows the regression line for log blood cadmium and log urinary cadmium, the regression coefficients being +0.35 (SE 0.077) and the residual SD (in logs to the base 10) was 0.20, corresponding to a 95% prediction width of 2.5-fold. Of the 19 concentrations, 16 (84%) plasma 25(OH)D₃ results were in the normal range, but only six (21%) of the 24R,25(OH)₂D₃ and six (31%) of the 1α,25(OH)₂D₃ results.

The K-W one way ANOVA showed significant differences in the plasma 1α,25(OH)₂D₃ concentrations, $\chi^2=10.3$, df 2, p=0.006, (fig 3), when these were grouped according to the following combination of blood lead and blood or urinary cadmium concentrations: group 1, low Pb/high Cd, blood lead <1.9 μmol/l with urinary cadmium >8 nmol/l or blood cadmium >27 nmol/l; group 2, raised Pb/low Cd, blood lead >1.4 μmol/l with urinary cadmium <8 nmol or blood cadmium <27 nmol/l; group 3, high Pb/high Cd, blood lead >1.9 μmol/l with

Table 2 Correlation matrix for all variables

	Log blood cadmium	Log urinary cadmium	Blood lead	Log			Log urinary proteins
				25(OH)D ₃	24R,25(OH) ₂ D ₃	1α,25(OH) ₂ D ₃	
Log blood cadmium	1.0000						
Log urinary cadmium	0.695**	1.0000					
Blood lead	-0.265	-0.338	1.000				
25(OH)D ₃	0.108	0.388	0.063	1.000			
Log 24R,25(OH) ₂ D ₃	-0.348	-0.496*	0.154	0.379	1.000		
1α,25(OH) ₂ D ₃	0.165	0.337	0.378	-0.086	-0.176	1.000	
Log urinary proteins	-0.183	0.044	-0.075	-0.547*	-0.009	-0.126	1.000

*p<0.05; **p<0.01.

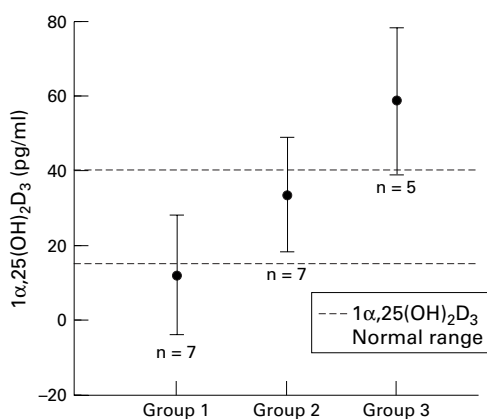


Figure 3 The effect of lead and cadmium on plasma $1\alpha,25(\text{OH})_2\text{D}_3$ concentrations. Error bars show mean and 95% confidence interval (95% CI). Group 1=blood lead $<1.9 \mu\text{mol/l}$ with urinary cadmium $>8 \text{ nmol/l}$ or blood cadmium $>27 \text{ nmol/l}$; group 2=blood lead $>1.4 \mu\text{mol/l}$ with urinary cadmium $<8 \text{ nmol}$ or blood cadmium $<27 \text{ nmol/l}$; group 3=blood lead $>1.9 \mu\text{mol/l}$ with urinary cadmium $>8 \text{ nmol/l}$ or blood cadmium $>27 \text{ nmol/l}$.

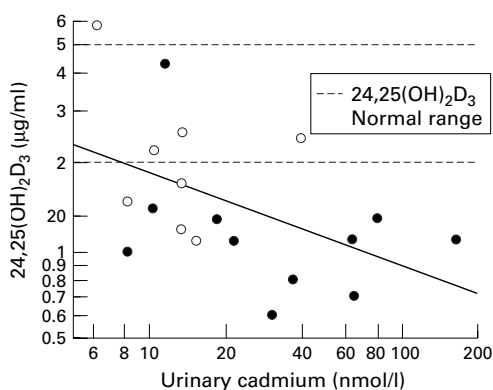


Figure 4 The effect of cadmium on plasma $24\text{R},25(\text{OH})_2\text{D}_3$ concentrations, shown as log scales for both axes. ● Blood CD $>27 \text{ nmol/l}$; ○ Blood CD $<27 \text{ nmol/l}$.

urinary cadmium $>8 \text{ nmol/l}$ or blood cadmium $>27 \text{ nmol/l}$.

Figure 4 shows the effect of urinary cadmium concentrations $>8 \text{ nmol/l}$ and blood cadmium concentrations $>27 \text{ nmol/l}$ on plasma $24\text{R},25(\text{OH})_2\text{D}_3$. There is a decrease in the plasma $24\text{R},25(\text{OH})_2\text{D}_3$ concentrations as the cadmium concentrations increase.

Discussion

These results suggest that increased blood and urinary cadmium and blood lead cause perturbation of the conversion of $25(\text{OH})\text{D}_3$ to $24\text{R},25(\text{OH})_2\text{D}_3$ and $1\alpha,25(\text{OH})_2\text{D}_3$. In the presence of cadmium, lead seems to be associated with increased conversion of $25(\text{OH})\text{D}_3$ to $1\alpha,25(\text{OH})_2\text{D}_3$. Unlike the effect in children,³² in whom the conversion of $25(\text{OH})\text{D}_3$ to $1\alpha,25(\text{OH})_2\text{D}_3$ may be reduced when the blood lead concentration is $>1.4 \mu\text{mol/l}$ ($>30 \mu\text{g/dl}$), in these adults the conversion seemed to be enhanced as blood lead concentrations increased. The negative correlation found in children between blood lead and $1\alpha,25(\text{OH})_2\text{D}_3$ ⁴³ was not found in these adults.

The membrane bound enzyme complexes that catalyse the formation of $24\text{R},25(\text{OH})_2\text{D}_3$ and $1\alpha,25(\text{OH})_2\text{D}_3$ from $25(\text{OH})\text{D}_3$ are

termed $25\text{OH}-\text{D}_3-24\text{R}$ -hydroxylase ($24\text{R}-\text{OHase}$) and $\text{OHD}_3-1\alpha$ -hydroxylase ($1\alpha-\text{OHase}$) respectively.⁴⁴ They are found in the mitochondria of the cells lining the proximal convoluted tubules and the straight tubular segments of the nephron. Phosphorylation of an inactive phosphatase is necessary for the activation of the $1\alpha-\text{OHase}$, which catalyses the formation of $1\alpha,25(\text{OH})_2\text{D}_3$ and a calcium dependant protein kinase converts this enzyme complex to the fully active $24\text{R}-\text{OHase}$. It has been suggested that lead interferes with phosphate linked reactions and that perturbations of calcium mediated processes are an early effect of lead toxicity at the cellular level.⁴⁵ Cadmium induces osteomalacia by a direct action on bone through abnormal calcium homeostasis⁴⁶ and has an effect on bone repair by reduction of alkaline phosphatase activity in osteoblastic cells.⁴⁷

Lead is initially accumulated in renal tissue and may be taken up by the renal tubular epithelial cells from the basolateral side by active transport as the free ion.⁴⁸ Both the structure and function of mitochondria are very sensitive to lead, which is rapidly taken up by these organelles by an active transport process that may be comparable with the transport process associated with calcium. Granules found in mitochondria exposed to lead are thought to be precipitates of both calcium and lead phosphates.^{49,50} Lead may therefore interfere with both calcium and phosphate metabolism and thus affect enzymatic function in the vitamin D_3 pathway. The kidney matures gradually from infancy and thus these membrane bound enzyme complexes that catalyse the formation of $24\text{R},25(\text{OH})_2\text{D}_3$ and $1\alpha,25(\text{OH})_2\text{D}_3$ from $25(\text{OH})\text{D}_3$ may be more susceptible to the effects of lead in children as opposed to adults. The whole enzyme complex may be affected, inhibiting the $1\alpha-\text{OHase}$ and the $24\text{R}-\text{OHase}$ so that both $1\alpha,25(\text{OH})_2\text{D}_3$ and $24\text{R},25(\text{OH})_2\text{D}_3$ are low in children with raised lead concentrations. Cadmium damage to the renal tubules may affect the folding, cleavage, and reorientation of the active sites of these enzymes.⁴⁴ Therefore cadmium and lead could have a combined effect on this enzyme complex inhibiting the inactivation of the $1\alpha-\text{OHase}$ and its conversion to partially active $24\text{R}-\text{OHase}$. This would subsequently prevent the formation of fully active $24\text{R}-\text{OHase}$, resulting in raised concentrations of $1\alpha,25(\text{OH})_2\text{D}_3$ and depleted concentrations of $24\text{R},25(\text{OH})_2\text{D}_3$.

Concentrations of lead and cadmium in blood are indicators of present or recent exposure to these metals, whereas the concentrations in urine indicate previous or long term exposure.^{42,51} However, a significant correlation has been shown between cadmium concentrations in blood and urine in this study, which suggests that continuous long term exposure to cadmium produces a state of equilibrium. The interrelation between blood and urinary cadmium concentrations and the decrease in $24\text{R},25(\text{OH})_2\text{D}_3$ may have appeared after exposure to cadmium of as yet unknown duration. As these workers were still exposed to

cadmium and were taking part in a five year follow up study, it is possible to state that they had been continuously exposed to cadmium for at least five years. The preferential incorporation of lead rather than calcium into bone and the osteomalacia and osteoporosis found after cadmium ingestion may be linked with decreased 24R,25(OH)₂D₃ concentrations, but this remains unproved. Epidemiological and clinical studies in Japan since 1962 have shown that bone is affected only after very high exposure to cadmium.⁶ However, where there is exposure to both lead and cadmium, as in this report, the effects on bone, mediated through the vitamin D₃ pathway, may possibly be found at lower exposures.

The negative correlation of 25(OH)D₃ with total urinary proteins agrees with that found by Saha,⁵² who also found that patients with heavy proteinuria had abnormal regulation of 1 α ,25(OH)₂D₃ and a dependency on 25(OH)D₃. Chronic renal failure from other causes did not seem to affect 25(OH)D₃ concentrations.⁵³ Nogawa *et al* found that cadmium initially disturbed the hydroxylation of 25(OH)D₃ to 24R,25(OH)₂D₃ but that at higher blood cadmium concentrations the hydroxylation of 1 α ,25(OH)₂D₃ was affected, in participants with poor renal function.⁵⁴

Conclusions

The highly significant correlation between the cadmium concentrations in blood and urine suggested that continuous long term exposure to cadmium can result in an equilibrium between blood and urinary concentrations. In this situation, it is possible to estimate cadmium blood concentrations from the analysis of spot urine samples. Cadmium and lead have an effect on vitamin D₃ metabolism at blood and urinary concentrations below those at which there is clinical evidence of toxicity. Cadmium decreased the concentrations of 1 α ,25(OH)₂D₃ and 24R,25(OH)₂D₃, whereas cadmium and lead increased the concentrations of 1 α ,25(OH)₂D₃. Biochemical changes may occur that could have long term health implications. Although many sources of lead and cadmium have been removed, exposure in industrial situations is still possible. The simultaneous exposure to more than one contaminant may lower threshold levels for the appearance of health effects and this should be taken into account in routine monitoring.

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