If one or more of the following applies:
• Fragility fracture/osteoporosis/high fracture risk
• Drug treatment for bone disease
• Symptoms suggestive of vitamin D deficiency
• Increased risk of developing vitamin D deficiency e.g.
  • Reduced UV exposure
  • Raised PTH
  • Treatment with anticonvulsants or glucocorticoids
  • Malabsorption

25OH vitamin D (nmol/L)

- >50: Maintain vitamin D through safe sun exposure and current diet/supplement use

- 30–50:
  If one or more of the following applies:
  • Fragility fracture/osteoporosis/high fracture risk
  • Drug treatment for bone disease
  • Symptoms suggestive of vitamin D deficiency
  • Increased risk of developing vitamin D deficiency e.g.
    • Reduced UV exposure
    • Raised PTH
    • Treatment with anticonvulsants or glucocorticoids
    • Malabsorption
  Treat

- <30:
  Treat
  Approximate 300,000 IU vitamin D3 (or D2) by mouth in divided doses over 6–10 weeks
  Commence maintenance vitamin D 4 weeks after loading as per elective correction

TREAT Ensure calcium replete

RAPID

- Symptoms of vitamin D deficiency
- About to start treatment with a potent antiresorptive agent (zoledronate or denosumab)

ROUTINE

- When co-prescribing vitamin D supplements with an oral antiresorptive agent, maintenance therapy may be started without the use of loading doses.
- When co-prescribing vitamin D supplements with an oral antiresorptive agent, maintenance therapy may be started without the use of loading doses.
- 800–2000 IU vitamin D3 daily or intermittently at higher equivalent dose

FOLLOW UP

CAUTION

- Check serum adjusted calcium 4 weeks after treating with loading doses of vitamin D. Vitamin D repletion may unmask primary hyperparathyroidism
- Routine repeat vitamin D testing is not required

Example regimens are given in Appendix 1 of the full practical guide