Food allergy is linked to season of birth, sun exposure, and vitamin D deficiency

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Abstract

The season of birth and ultraviolet B exposure have been related to the occurrence of food allergy. The levels of vitamin D produced from skin by ultraviolet B exposure might reflect this relationship. Vitamin D is known to induce antimicrobial peptides, protect intestinal flora, enhance the gut epithelial barrier, suppress mast cell activation and IgE synthesis from B cells, and increase the number of tolerogenic dendritic cells and IL-10-producing regulatory T cells. Vitamin D deficiency has been shown to exacerbate sensitization and allergic symptoms in a murine model of food allergy. In clinical situations, contradictory observations have been reported regarding the relationship between food allergy and vitamin D deficiency/supplementation. In this review, we have explored the links between food allergy and vitamin D levels. One explanation for the discrepant findings is confounding factors such as race, age, residency, skin color, and epigenetic changes that contribute to vitamin D levels. In addition, the season of birth influences the development of atop dermatitis, which could lead to food sensitization. Finally, ultraviolet radiation could lead to regulatory T cell expansion and immunosuppression, irrespective of vitamin D status. Based on our current understanding, we believe that correction of vitamin D deficiency by supplementation, appropriate skin care, and sufficient ultraviolet radiation exposure could alter the prognosis of food allergy. To identify potential treatment strategies for food allergy, it is essential to gain a better understanding of the appropriate levels of vitamin D and ultraviolet radiation exposure.

Keywords:
Food allergy
Regulatory T cells
Ultraviolet radiation
Vitamin D
25-Hydroxyvitamin D

Introduction

Food allergy (FA), the incidence of which has been increasing worldwide, is known to affect ~5% of the total population and ~8% of the pediatric population. However, the definite causes and reasons for the increase in incidence of FA remain unclear. Coincident with the rise in FA, cases of vitamin D deficiency have also been increasing worldwide. Further, numerous lines of evidence link vitamin D deficiency with FA. In this comprehensive review, we have focused on the relationships among the season of birth, ultraviolet B (UVB) exposure, vitamin D deficiency, and FA.

Risk factors associated with allergic sensitization and FA

Bjorksten et al., in 1976, were the first to report that reactions to pollen and animal epithelium allergy differed based on the season of birth. Since then, several reports have shown that the rate of allergic sensitization varies according to the month of birth. Subsequently, Kimpen et al. found that cord blood IgE concentration showed a significant cyclic trend, with a peak near the end of April and a trough in late October. Further, the risk of food sensitization was observed to peak among individuals born in winter, while it was the lowest among those born in spring. In Japan, Kuzume et al. showed that total serum IgE levels and egg white-specific IgE levels at 3 months of age were different according to the season of birth—lower in patients born in spring and summer, and higher in those born in autumn and winter. Furthermore, the cumulative solar UV exposure during the 3 months before and after birth was inversely correlated to IgE levels. Previously, we reported the relationship between the season of birth and food sensitization.
and showed that cumulative UV exposure after birth was negatively correlated with food sensitization during infancy. Similar findings showing correlations between food sensitization and the month and season of birth have been reported.1,9

Adrenaline auto-injector prescriptions to treat anaphylaxis mainly caused by foods were higher in northern regions than in southern regions of the United States.10 Similarly, in 5-year-old or younger patients who suffered from FA, food-induced anaphylaxis was more common in those born in autumn or winter than in those born in spring or summer.11,12 Following these reports, similar findings have been described from all over the world.11-16

All these studies indicate that the season of birth, geographical location, and UVB exposure are risk factors associated with allergic sensitization and FA. However, contrasting results were also reported in a study, wherein no association was found between FA in the first year of life and season of birth, ambient UVB levels at birth, or maternal vitamin D supplementation.17 However, this same study did find a correlation between vitamin D deficiency and FA.17

The potential link between vitamin D deficiency and FA

Solar UVB penetrates the skin and converts 7-dehydrocholesterol to previtamin D3, which is then rapidly converted to vitamin D3. In the liver, vitamin D is metabolized to 25-hydroxyvitamin D (25(OH)D), which is the most abundant metabolite of vitamin D and commonly used to determine a patient’s vitamin D status. The 25(OH)D is then metabolized to 1,25-dihydroxyvitamin D \([1,25(OH)_{2}D]\) by the enzyme 25-hydroxyvitamin D-1α-hydroxylase (CYP27B1).18 Extra-renal synthesis of 1,25(OH)₂D occurs in many tissues and cells, including keratinocytes and immune cells such as T cells and dendritic cells (DCs).19 Humans can also obtain vitamin D from their diet.18 However, the main source of vitamin D is sun exposure, contributing to 80–90% of an individual’s serum 25-hydroxyvitamin D levels.20 The solar exposure time required for vitamin D synthesis from sun exposure is longer in winter than in summer, with serum 25(OH)D levels reported to change cyclically with the season.20

Vitamin D deficiency has been identified as a major public health problem, which is continuously increasing across the globe.2,21 Although there is no consensus on the optimal levels of 25(OH)D, vitamin D deficiency is often defined as a level less than 50 nmol/L.22 Surprisingly, 25(OH)D concentration <50 nmol/L was reported to be present in 54% of pregnant women and 75% of newborns globally.23 Correlation was seen between maternal and cord blood 25(OH)D levels, both showing a seasonal distribution.22 Thus, a newborn’s vitamin D status mostly depends on the maternal vitamin D status. During the first year of life, exclusive breastfeeding without adequate sun exposure is an important risk factor for vitamin D deficiency.24 Additionally, an individual’s exposure to sunlight has been limited by changes in lifestyle, such as the use of sunscreens, wearing of clothing that covers the skin, and increasing time spent indoors with closed windows that block UVB, all of which have been linked to an increased risk of vitamin D deficiency.24

Thus, similar to FA, vitamin D deficiency is also affected by seasons and other factors such as maternal vitamin D status. Therefore, we further explored the relationship between vitamin D deficiency and FA.

Season of birth and immune cells

Thysen et al. have shown a birth season-related fluctuation in neonatal immune cell subsets by phenotyping 26 different immune cells and identifying 20 cytokines and chemokines in cord blood. Specifically, summer newborns presented the lowest levels of all cell types and mediators; fall newborns displayed high levels of activated T cells and IL-13; and while winter newborns had the highest levels of innate immune cells, IL-5, and activated T cells.23

Mast cells

Yip et al. have reported that mouse and human mast cells can convert 25(OH)D to 1,25(OH)₂D via CYP27B1 activity.24 Further, they showed that both metabolites could suppress IgE-mediated pro-inflammatory and vasodilatory mediator production from human mast cells in a vitamin D receptor (VDR)-dependent manner. Furthermore, these metabolites significantly reduced IgE-mediated passive cutaneous anaphylaxis reaction.24

Regulatory T cells

Almerighi et al. have reported that 1,25(OH)₂D inhibits CD4₀L-induced pro-inflammation and co-stimulation of CD4⁺ T lymphocytes and enhances IL-10 production by CD4⁺ T cells.25 It has also been shown that 1,25(OH)₂D promotes the development of regulatory T cells (Tregs) expressing cytotoxic T-lymphocyte-associated protein 4 as well as forkhead box P3.26

B cells

B cells can generate 1,25(OH)D, which enhances IL-10 expression of activated B cells by recruiting VDR to the promoter of Il10.27 Naive T cells co-cultured with 1,25(OH)D₃-primed B cells showed reduced expansion, likely triggered by the expression of CD86 on B cells.28 Wittke et al. have reported that IgE serum levels are increased in VDR-knockout (KO) mice.29 Consistently, 1,25(OH)₂D was found to strongly suppress IgE production by human B cells,30 and the IgE response in a type 1 allergy mouse model could be impaired by a VDR agonist.30 Subsequently, this inhibition of IgE production by 1,25(OH)D₂ was found to be mediated by its trans-repressive activity through the VDR-corepressor complex, which affects chromatin compacting around the IκB region.31

Dendritic cells

Széles et al. have reported that an abundance of 25(OH)D causes dendritic cells (DCs) to turn on 1,25(OH)₂D sensitive genes, and activation of VDR by 1,25(OH)₂D reprograms the DCs to become tolerogenic.32 When monocytes were treated with vitamin D3, DCs became semi-mature, expressing intermediate levels of co-stimulatory and major histocompatibility complex (MHC) class II molecules and could convert CD4⁺ T cells to IL-10-secreting Tregs.33 While vitamin D has insignificant effects on DC maturation and only weakly primes DCs to induce suppressive T cells, 25(OH)D not only exerts an inhibitory effect on DC maturation but also primes the DCs to promote Tregs to produce suppressive IL-10.34

Intestinal mucosal immunity

Toll-like receptor activation of human macrophages up-regulates expression of VDR and vitamin D-1-hydroxylase genes, leading to induction of the antimicrobial peptide cathelicidin.35 Kong et al. have reported that 1,25(OH)₂D enhances tight junctions by increasing the levels of tight junction proteins and trans-epithelial electric resistance.36 The expression of E-cadherin on gut epithelial and tolerogenic DCs was suppressed in CYP27B1-KO and VDR-KO mice compared to that in the wild type, leading to dysbiosis of the gut microbiota.37

When mice were fed a vitamin D-deficient diet, genes encoding the antimicrobial angiogenin-4 protein were down-regulated and
levels of bacteria in the colonic tissue were elevated 50-fold compared with that in controls.48 Assa et al. have also shown that vitamin D deficiency altered the composition of the fecal microbiota and reduced transepithelial electrical resistance and permeability of the intestine.49

Thus, vitamin D deficiency could cause inadequate production of antimicrobial peptides, dysbiosis of the gut microbiota, and impairment of the mucosal barrier.

Animal studies of vitamin D deficiency and allergies

Heine et al. have reported that 25(OH)D deficiency promotes the development of type I sensitization and that correction of its serum concentrations enhances the benefit of specific immunotherapy in a murine model of allergic airway inflammation.40 We showed that vitamin D deficiency exacerbated sensitization and allergic diarrhea in a murine FA model; the model was sensitized by both intraperitoneal and oral OVA administration and symptoms were induced by oral administration of OVA. We also confirmed that IL-4 expression in mesenteric lymph nodes was significantly elevated in vitamin D-deficient mice compared with that in control mice, which might be related to the mechanism underlying the exacerbation of sensitization and FA symptoms.41 Maternal and early-life vitamin D deficiency also notably influenced the susceptibility to FA in another murine model.42 Additionally, vitamin D deficiency also decreases the expression of the tight junction protein between adjacent epithelial cells and the percentages of CD4+CD25+Foxp3+ Tregs in the spleen and mesenteric lymph nodes.42

Thus, there are a large number of studies providing clear evidence that vitamin D has several immunomodulatory effects that could be linked to FA. Vitamin D deficiency exacerbated allergic sensitization and FA symptoms in the murine model. In addition, as elaborated below, there have been clinical studies showing a direct relationship between vitamin D and FA.

Vitamin D deficiency and sensitization in clinical situations

Using data from a national health and nutritional survey, it was found that in children and adolescents, allergic sensitization to 11 of 17 allergens, including foods, was more common in those with 25(OH)D deficiency. However, no consistent associations were seen between 25(OH)D levels and allergic sensitization in adults.43 Beak et al. also found that low levels of 25(OH)D could be related to polysensitization of food allergens.44 Low 25(OH)D levels in cord blood and maternal blood before delivery have been associated with a higher risk of food sensitization throughout childhood in Taiwan.45,46 In contrast, Xin et al. reported that there was no association between low vitamin D levels in cord blood and food sensitization, but that persistence of a low vitamin D status at birth and early childhood could increase the risk of sensitization.47

Vitamin D deficiency and FA in clinical cases

The antenatal and cord blood 25(OH)D levels are positively associated with risk of FA in children within the first 2 years of life, based on a birth cohort study of 378 mother–child pairs.22 The same study also found that 25(OH)D levels were negatively correlated with Treg cell numbers. A higher incidence of food-induced anaphylaxis was seen in regions with lower annual mean solar radiation and lower vitamin D levels in South Korea.26 Neeland et al. reported that children with persistent egg allergy demonstrated higher rates of vitamin D deficiency than children with transient egg allergy. Moreover, serum vitamin D levels were inversely correlated with proportions of myeloid DCs and classical monocytes.49 Lower vitamin D levels were found in infants with cow’s milk allergy who were exclusively or predominantly breast-fed than in the control group.50 On the other hand, Molloy et al. reported that there was no evidence that vitamin D deficiency during the first 6 months of infancy is a risk factor for FA at 1 year of age.41

Vitamin D supplementation and FA

Maternal intake of vitamin D has been inversely associated with sensitization to food allergens at 5 years of age.42 On the other hand, in a double-blinded placebo-controlled trial, maternal vitamin D supplementation for 6 weeks during lactation increased the risk of FA in the offspring up to 2 years of age.51 Tuokkola et al. have reported conflicting data that vitamin D supplementation during pregnancy is associated with an increased risk of FA in their offspring by 3 years of age, whereas vitamin D intake from foods during pregnancy is associated with a decreased risk of FA.52 During a follow-up phase of an interventional trial of high-dose vitamin D given during pregnancy, it was found that food sensitization and FA were not correlated with vitamin D supplementation.57 Thus, the relationship between vitamin D supplementation and FA remains controversial.

Possible factors explaining the discrepancy in the relationship between vitamin D deficiency and FA

As shown above, in clinical situations, conflicting data exist regarding the relationship between vitamin D deficiency and FA. Especially, it is not clear whether vitamin D supplementation can alter the prognosis of FA. Below, we have considered possible explanations for these conflicting data.

The definition of vitamin D deficiency

Willits et al. conducted a systematic review and meta-analysis of vitamin D and FA in children and reported no significant association between 25(OH)D status and risk of FA. Owing to the lack of an established threshold of vitamin D deficiency, they conducted subgroup analysis by stratifying the threshold of vitamin D deficiency. Interestingly, they did not find any significant relationship between FA and vitamin D deficiency when <20 ng/mL of 25(OH)D was considered as deficiency, while they did find an increased relevance of FA when <30 ng/mL of 25(OH)D was considered as deficiency. Therefore, they reported that the study was limited by insufficient knowledge regarding the optimal vitamin D status.56 Considering the increasing health problems associated with vitamin D deficiency, it is critical that we establish universally accepted normal serum 25(OH)D levels.2,20

Excessive vitamin D

Not only deficient but also excessive 25(OH)D levels have been related to high IgE concentrations.57,58 Cairncross et al. reported that vitamin D deficiency was not associated with allergic diseases. In contrast, high 25(OH)D concentrations were associated with a two-fold increased risk of FA in preschool children in New Zealand.57 Thus, both deficient and excessive amounts of vitamin D are potential risk factors associated with FA.

Race

Keet et al. reported that the risk of FA is the greatest among Caucasians, who are most sensitively produce vitamin D from skin via exposure to UVB.14 In fact, darker skin rich in melanin decreases the synthesis of vitamin D in skin.20 In a birth cohort study, it was
Impaired tolerance of the risk of food sensitization among those carrying CC/CT genotypes (SNPs), vitamin D deficiency with food sensitization; however, when examined jointly with single levels and FA.62 They reported that low serum 25(OH)D level at 1 year of age was reported to be associated with increased IgE concentrations.57 Wide association study of a subset of an 18-year-old participants of a cohort study.63 Interestingly, the methylation level was stable from birth until 3 years of age. Lockett et al. reported that autumn birth increased the risk of repeated eczema, and methylation of 92 sites are considered to be the leading causes of FA.65,66 In the case of AD, Aoki et al. reported that more patients aged <1 year were born in autumn than in spring; subsequent studies also reported similar seasonal differences.6,68,69

Although conflicting data exist, Kim et al. reported that vitamin D levels were lower in AD patients and that vitamin D supplementation could be a therapeutic option for AD.10 Some reports showed that fall birth is common among FA subjects, but these observations were no longer significant when infantile eczema was included.4,15 On the other hand, we showed that the frequency of autumn and winter birth in FA patients was significantly higher than that in the control population, irrespective of the presence of infantile eczema.10

Vitamin D is dispensable for UVB-induced immunosuppression

Yamazaki et al. have reported that exposure to UVB induced the expansion of Treg cells up to 50–60% of the CD4+ T cells in the irradiated skin, which lasted for 2 weeks after exposure.71 When antigen-loaded DCs, differentiated from the bone marrow of UV-irradiated mice, were adoptively transferred into naïve mice or mice pre-sensitized with antigen, the recipients exhibited a reduced immune response following antigen challenge when compared to that in mice without DC transfer.72 Further, UV radiation is reported to inhibit the induction of contact hypersensitivity and induce Tregs, similar to the topical application of 1,25(OH)2D.70 When Langerin+ DCs were depleted, the induction of Tregs was abrogated by both ultraviolet radiation (UVR) and topical application of 1,25(OH)2D. However, VDR-KO mice were equally susceptible to UVR-induced immunosuppression when compared to wild-type controls. Taken together, these observations suggest that 1,25(OH)2D exerts immunosuppressive effects similar to UVR and is dispensable for local UVR-induced immunosuppression.74

Season of birth and AD

Infantile eczema and AD and exposure to food allergens through these sites are considered to be the leading causes of FA.55,65 in the case of AD, Aoki et al. reported that more patients aged <1 year were born in autumn than in spring; subsequent studies also reported similar seasonal differences.6,68,69

In summary, there are numerous data that supports the link between FA and season of birth. The possible mechanisms might

Discussion and conclusion

*Appropriate vitamin D levels are unknown
*Susceptibility of vitamin D deficiency is affected by skin color, race, residency, and epigenetics

Fig. 1. A hypothesis of the link between the season of birth and food allergy (FA). First, fall or winter birth could exacerbate eczema, leading to excessive food antigen exposure and sensitization. Second, inadequate ultraviolet B (UVB) exposure can cause inadequate expansion of regulatory T cells (Tregs), possibly leading to impaired food tolerance. Third, vitamin D deficiency could impair the intestinal epithelial barrier, cause dysbiosis of the intestine, and modulate immune responses related to sensitization. Thus, vitamin D deficiency caused by inadequate UVB exposure shows a strong correlation with FA.
include vitamin D deficiency due to a shortage of UVR exposure. In fact, several in vitro and in vivo experiments suggested that vitamin D deficiency leads to FA. Nonetheless, there are some conflicting data regarding the relationship between vitamin D and FA based on clinical observations.

As to the relationship between season of birth and FA, we propose a hypothesis, as shown in Figure 1. Fall and winter birth could exacerbate eczema, possibly leading to excessive food antigen exposure and sensitization. Eczema and AD were shown to be strongly related to food sensitization and FA. Some studies have successfully shown that skin care early in life could reduce the risk of AD. Therefore, aggressive skin care for fall and winter-born children might reduce the risk of FA.

In addition, a shortage of UVR exposure can cause inadequate Treg expansion, possibly leading to impaired food tolerance irrespective of vitamin D deficiency. Thus appropriate UVR exposure might be necessary to reduce the risk of FA. However, sun protection is emphasized because UVR exposure is known as a risk factor for skin cancer. On the other hand, inadequate UVR exposure is reported to be a risk factor for other diseases such as colorectal cancer, breast cancer, non-Hodgkin lymphoma, multiple sclerosis, cardiovascular disease, metabolic syndrome, and Alzheimer’s disease.

Finally, vitamin D deficiency caused by inadequate vitamin D synthesis from skin could impair the intestinal epithelial barrier and antimicrobial peptides, possibly leading to dysbiosis of the intestine. Further, such deficiency could modulate immune responses including mast cells, DCs, B cells, and T cells, leading to sensitization and impaired food tolerance. Thus, vitamin D deficiency caused by inadequate UVB exposure shows a strong correlation with FA. Correcting vitamin D deficiency might improve the prognosis of FA. A precise definition of vitamin D deficiency and more clinical studies correcting for co-factors such as existing eczema, skin color, race, residency, skin color, sex, and age are warranted.

Acknowledgements

We would like to thank Editage (www.editage.jp) for English language editing. The first author (TM) received the 2017 JSA Best First Author Award (TM) received the 2017 JSA Best First Author Award by the Japanese Society of Allergology for this work.

Conflict of interest

The authors have no conflict of interest to declare.

References


