

# Vitamin B12

## Advances and Insights



**Rima Obeid (Editor)**



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# Vitamin B12

## Advances and Insights

*Edited by*

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# Dedication

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To my son, Jean-Paul



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# Preface

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Cobalamin(s) (vitamin B12) have been known for 100 years. Key milestones in the study of cobalamin have been through over 10 decades of trial and error, research and discoveries. Remarkable discoveries in the field have saved many lives and were awarded 2 Nobel Prizes; Minot and Murphy (Nobel Prize in Physiology or Medicine 1934) and Dorothy Hodgkin (Nobel Prize in Chemistry 1964). Still, cobalamin constitutes an amazing area of research with many undiscovered facets.

The health relevance of cobalamin became evident long before discovering its chemical entity. Liver extracts containing few micrograms of the healing factor, cobalamin, were used in the 1920s up to the early 1930s as a life-saving medication against fatal pernicious anemia. The purification and production of large quantities of the 'liver factor' were real challenges, but the biggest challenge was for patients to eat these extracts as an alternative to death. Now that cobalamin has become available as over-the-counter supplements, or as injections containing a few micrograms to milligrams, its relevance to health and disease has gained more importance over the time. Cobalamin's 'lifting effect' has been experienced by millions of patients and doctors. Today, the impact of cobalamin on human health has changed from 'treating a severe disease' to 'prevention of a yet not-manifested condition'. The meaning of cobalamin has now taken new dimensions on a population level after implementing modern laboratory diagnosis tests. Using modern biomarkers has shown that subclinical cobalamin deficiency affects many individuals in critical life phases.

'Vitamin B12: advances and insights' is an extract of knowledge of experienced scientists who have been working on nutritional, structural, chemical, and clinical aspects of the vitamin. This book has introduced an innovative and unclassical approach by addressing 'gaps in knowledge' that surround the topic. These gaps are identified by scientists who are very close to the cobalamin epi-center and intended to provide a direction for future research.

The book is an in-depth study on the vitamin from basic science to modern health challenges. Early knowledge on cobalamin in the light of recent scientific discoveries ([Chapter 1](#)); Dietary requirements and nutritional supply ([Chapter 2](#)); Cobalamin uptake and intracellular processing ([Chapter 3](#));



Congenital cobalamin disorders ([Chapter 4](#)); Acquired causes of cobalamin deficiency and clinical consequences ([Chapter 5](#)); Cobalamin deficiency: a public health problem in developing countries ([Chapter 6](#)); The role of cobalamin in the nervous system, its relevance to brain aging, and potential mechanisms surrounding this area ([Chapters 7 and 8](#)); Cobalamin deficiency biomarkers and diagnosis ([Chapter 9](#)); Cobalamin deficiency in critical age phases such as pregnancy, lactation and early life ([Chapters 10 and 11](#)); Cobalamin deficiency in the era of folic acid fortification ([Chapter 12](#)); Cobalamin unexplained extreme values in clinical practice ([Chapter 13](#)); the role of Cobalamin in drug transport and development ([Chapter 14](#)).

The target audience for this book are experts and researchers looking for in-depth knowledge in the above mentioned areas of cobalamin science; health care providers who take part in diagnosis, treatment, and prevention of deficiency conditions; policy makers who can influence implementation of diagnosis tools or nutritional policies on a country and population levels; and stakeholders and pharmaceutical companies who are interested in producing diagnosis tools, supplements, fortified foods or other pharmaceutical products that use cobalamin as a drug carrier.

This book is by no mean a complete documentation of what is going on around the topic. However, it constitutes an attempt to grasp the current knowledge on a few areas related to cobalamin and to provide insights into unexplored questions and issues.

# Contents

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<i>Dedication</i>	v
<i>Preface</i>	vii
<b>1. Milestones in the Discovery of Pernicious Anemia and its Treatment</b> <i>Jörn Schneede</i>	<b>1</b>
<b>2. Nutritional and Biochemical Aspects of Cobalamin Throughout Life</b> <i>Eva Greibe</i>	<b>30</b>
<b>3. Intracellular Processing and Utilization of Cobalamins</b> <i>Luciana Hannibal and Donald W Jacobsen</i>	<b>46</b>
<b>4. Inherited Defects of Cobalamin Metabolism</b> <i>David Watkins and David S Rosenblatt</i>	<b>94</b>
<b>5. Conditions and Diseases that Cause Vitamin B12 Deficiency: From Metabolism to Diseases</b> <i>Emmanuel Andrès</i>	<b>115</b>
<b>6. Vitamin B12 Deficiency in Developing and Newly Industrialising Countries</b> <i>Chittaranjan Yajnik, Urmila Deshmukh, Prachi Katre and Tejas Limaye</i>	<b>131</b>
<b>7. Vitamin B12 in Neurology and Aging</b> <i>Andrew McCaddon and Joshua W Miller</i>	<b>151</b>
<b>8. The Role of Cobalamin in the Central and Peripheral Nervous Systems: Mechanistic Insights</b> <i>Elena Mutti</i>	<b>178</b>
<b>9. Laboratory Markers and Diagnosis of Cobalamin Deficiency</b> <i>Rima Obeid</i>	<b>189</b>
<b>10. Cobalamin During Pregnancy and Lactation</b> <i>Rima Obeid, Pol Solé-Navais and Michelle M Murphy</i>	<b>240</b>

<b>11. Vitamin B12 After Birth and During Early Life</b>	<b>265</b>
<i>Rima Obeid, Pol Solé-Navais and Michelle M Murphy</i>	
<b>12. Cobalamin—Folate Interactions</b>	<b>296</b>
<i>Pol Solé-Navais, Rima Obeid and Michelle M Murphy</i>	
<b>13. Extreme Vitamin B12 Concentrations in Clinical Practice in the Absence of Symptoms or B12 Treatment</b>	<b>317</b>
<i>Rima Obeid</i>	
<b>14. Vitamin B12 and Drug Development</b>	<b>338</b>
<i>Jayne L Workinger and Robert P Doyle</i>	
<b><i>Index</i></b>	<b>365</b>

# 1

## Milestones in the Discovery of Pernicious Anemia and its Treatment

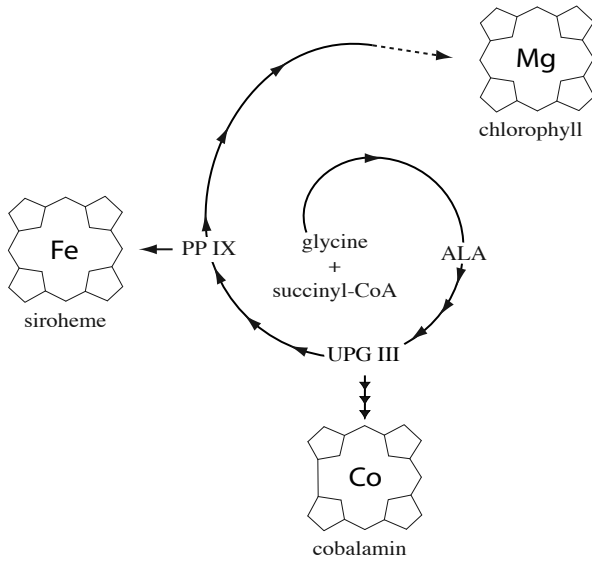
*Jörn Schneede*

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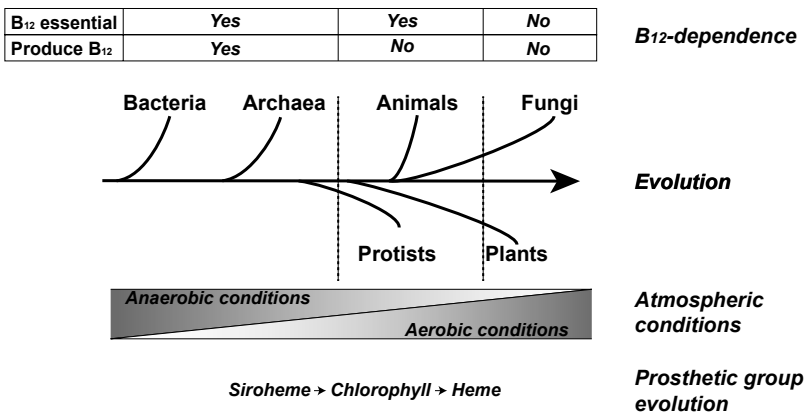
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### OVERVIEW

Pernicious anemia (PA) is a serious form of vitamin B12-deficiency. Vitamin B12 belongs together with heme and chlorophyll to the tetrapyrrole family (Figure 1) (Yin and Bauer 2013). Vitamin B12 is an evolutionarily ancient ( $\approx 3.8 \times 10^9$  years old) cofactor that was responsible for energy production through fermentation of small organic molecules in the absence of exogenous electron acceptors in the prokaryotic anaerobic world (Figure 2) (Santander et al. 1997). In the course of evolution siroheme later allowed making use of inorganic electron acceptors, before oxygen production by chlorophyll made aerobic respiration through heme possible. Almost 1% of the genome of *S. typhimurium* is dedicated to vitamin B12 synthesis and transport (Roth et al. 1996). Though being one of the structurally most complex, non-polymeric biomolecules synthesized by nature, eukaryotic organisms do not produce B12 (Figure 2). As a consequence, this vitamin is essential for human metabolism, albeit only required in trace amounts (possibly as low as 1  $\mu\text{g}/\text{d}$ , while the recommended daily allowances in adults are 2.4  $\mu\text{g}/\text{d}$ ) and functions as cofactor in only two enzymes, methionine synthase and (R)-methylmalonyl-CoA mutase (Helliwell et al. 2011). The remarkable discovery of vitamin B12 was only possible and proceeded by the endeavor to find effective



**Figure 1.** Schematic depiction of the evolutionary development of the tetrapyrrole biosynthetic pathways. Synthesis of tetrapyrrols starts with succinyl-CoA and glycine to form 5-aminolevulinic acid (ALA). Uroporphyrinogen III (UPG III) is used for synthesis of cobalamin (vitamin B12), while protoporphyrin IX (PP IX) is the starting point for siroheme and chlorophyll synthesis. Note the different metal ions bound to the corrin rings: Co, Fe and Mg. Compared to (siro-)heme- and chlorophyll, synthesis of cobalamin is far more complicated and complex, involving considerably more enzymatic steps (at least 25 enzymes uniquely involved), ring contraction, insertion of cobalt, modification of the tetrapyrrole ring and insertion of a nucleotide tail. Adapted and modified from (Yin and Bauer 2013).



**Figure 2.** Distribution and dependency on vitamin B12 among different living forms during the evolutionary process and under different atmospheric conditions. Adapted and modified from (Roth et al. 1996).

treatment options for PA, one of the conditions causing severe vitamin B12-deficiency. The scientific progress was, however, slow and stretched over a period of almost 200 years from the first description of PA, to the evolution of theories about possible causes and ultimately the invention of effective treatments. The search for effective treatment options also resulted in the resolution of the pathogenesis of pernicious anemia and ultimately the discovery of B12. Through isolation of an unknown *extrinsic factor* from liver extracts that was accountable for clinical response in pernicious anemia patients it was eventually possible to elucidate the chemical structure of vitamin B12. In parallel, efforts were started to map the production of vitamin B12 in certain bacteria. The elucidation of the chemical pathways of bacterial production of the vitamin finally made the complete synthesis of the vitamin in the laboratory possible. This enterprise has sometimes been called “Mount Everest of biosynthesis” and it was not before in 2013 that the complete anaerobic pathway of B12-synthesis had been charted (Moore et al. 2013). All in all, vitamin B12 research has resulted in two Nobel prizes-so far. Notwithstanding these achievements, synthesis of the vitamin in the laboratory is far too complicated and resource-demanding for commercial purposes and large-scale industrial production of vitamin B12 is still carried out by aerobic fermentation using *Pseudomonas denitrificans* (Xia et al. 2015) (Figure 3).

The course of history of vitamin B12 can arbitrarily be divided into different eras and stages (Figure 4). During this journey different therapeutic approaches for the treatment of vitamin B12-deficiency were developed, first oral therapy with raw liver, then oral or parenteral administration of liver extracts, followed by more refined liver concentrates that could be injected or taken by mouth with and without addition of intrinsic factor isolated from gastric juice. Later, crystalline B12 (cyanocobalamin) was isolated from the liver or produced by bacterial fermentation. With this advance, parenteral therapy with highly concentrated cobalamin preparations became feasible and affordable. In parallel, there was a continuous development of diagnostic tests for detection of vitamin B12-deficiency (Moridani and Ben-Poorat 2006). Parenteral therapy with intramuscular injections was soon considered the most reliable method of treating pernicious anemia (Bethell et al. 1959). However, recent clinical experience and health technology assessments from Sweden and other countries indicate that oral therapy with vitamin B12 tablets is both clinically feasible and more cost-effective than injections (Berlin et al. 1968b; Kolber and Houle 2014).

The following historical review will present a survey over the history of vitamin B12 and changing concepts for the treatment of vitamin B12-deficiency over the last two centuries.



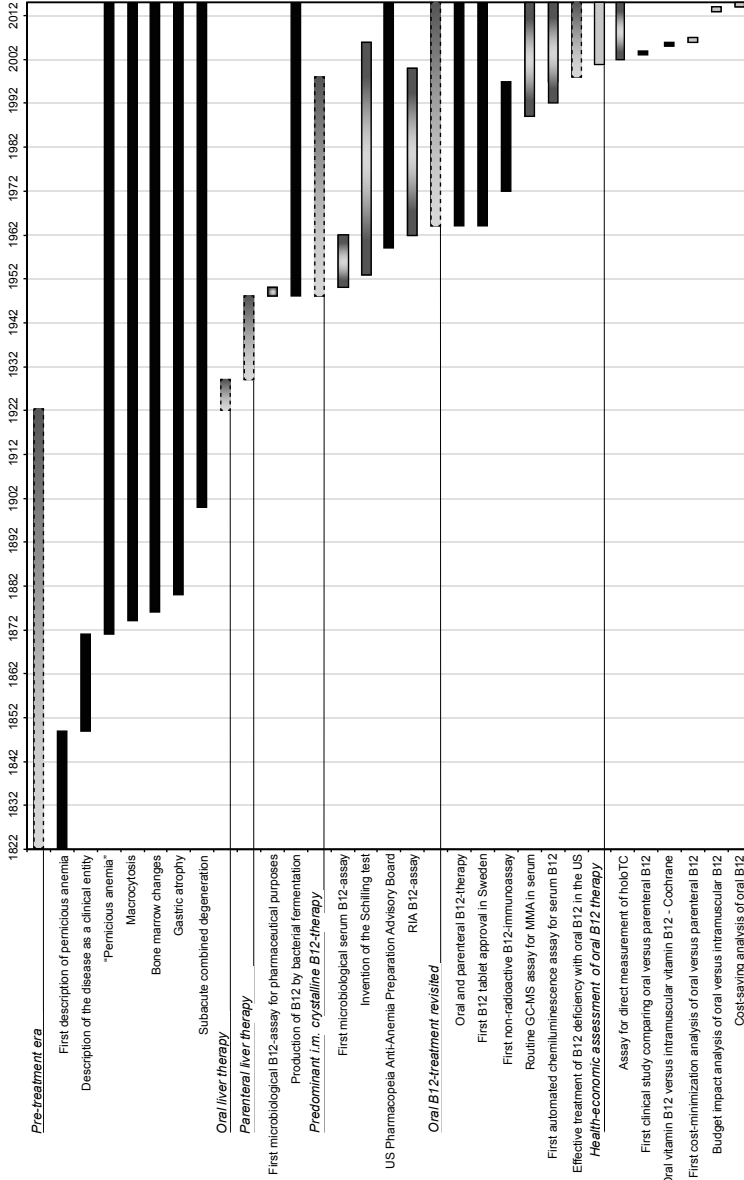
**Figure 3.** Fermenter for pharmaceutical production of vitamin B12. Microbial fermentation still is the most commonly used method for industrial scale production of many vitamins, including vitamin B12 (Xia et al. 2015). The picture shows a fermenter for industrial scale production of vitamin B12 under both aerobic and anaerobic conditions. The tank volume of the depicted fermenter can be up to 6.000 liters. In large scale industrial production fermenters of 120.000 liters can be used yielding up to 198 mg/l of B12 (Xia et al. 2015). Reproduced with permission (INOXPA 2015).

## **1. History of Vitamin B12**

### ***1.1 The era before treatment of pernicious anemia was possible***

#### ***1.1.1 Discovery of pernicious anemia as a first step in identification of vitamin B12***

Pernicious anemia, an extreme form of vitamin B12-deficiency, was most likely first portrayed in 1822 by James Combe (1793–1860), a Scottish physician from Edinburgh (Combe 1824). He described the disease history of a 47-year-old man, Alexander Haynes, who suffered from a peculiar, rather



**Figure 4.** Time lines of different eras in the history of vitamin B12-deficiency and its treatment. The graph portrays an arbitrary division of the history of vitamin B12-deficiency into different eras and milestones of discoveries. Treatment-related accomplishments are depicted by grey gradient bars with dashed-lined borders, major diagnostic achievements by central gradient bars with solid-lined borders and health-economic evaluations of oral vitamin B12 treatment are illustrated by grey bars with solid-lined borders. For about 100 years after the first description of pernicious anemia it was a virtually untreatable, fatal disease. For detailed references see [Table 1](#).



rapidly progressing condition of severe anemia combined with gastrointestinal symptoms. Haynes finally deceased in a state of pulmonary edema within a period of less than seven months after the first contact with Combe. Combe recommended “*chalybeates,<sup>1</sup> tonics and a nourishing diet*” to treat the condition, with no success.

After the first description of PA as a clinical entity it would take over 100 years before an effective treatment strategies became available. During this period, PA was considered an untreatable and inevitably lethal (“pernicious”) disease. The exact cause of the disease remained obscure for even many more years to come. This disease harvested many casualties. Before effective treatment became available, PA accounted for the death of more than 50,000 people per year in the US alone (Ahrens 1993; Jarcho and Brown 1977).

The constantly fatal outcome of this disease accompanied by lack of conclusive autopsy findings must indeed have been an agonizing experience for doctors at that time, but also spurred scientific efforts to find the cause and potential therapies of this disease. In 1855, Thomas Addison (1793–1860), a London physician, described more details about the disease from observations in 11 patients who were admitted to Guy’s Hospital in London (Pearce 2004). Addison reported:

*“a very remarkable form of general anaemia occurring without any discernable cause whatever.”* The patients had “*no previous loss of blood, no exhausting diarrhoea, no chlorosis, no purpura, no renal, splenic, miasmatic, glandular, strumous or malignant disease.*”

Addison’s observations of this “idiopathic anemia” initially received little attention in the scientific community. In 1872, however, Anton Biermer, a German internist working at that time in Zürich, gave a comprehensive description of this disorder during a meeting and used for the first time the expression “progressive pernicious anemia”. He chose the phrase “pernicious anemia” (PA) as the disease had an insidious onset with slow progress and because it was deemed to be untreatable and lethal at that time. This time, the disorder received more interest worldwide, which resulted in a large number of publications during the years to follow (Cohnheim 1876; Ehrlich 1880; Eichhorst 1878; Fenwick 1880; Lichtheim 1887). As an acknowledgment of the contribution of both Addison and Biermer, PA is also called “Addison-Biermer disease” (Ewing 1901).

During the years to come the morphological characteristics of PA were identified and described in more detail. Cohnheim (1839–1884) observed increased cellularity in the bone marrow (Cohnheim 1876) and Paul Ehrlich (1854–1915) discovered the occurrence of megaloblasts in the peripheral blood of PA patients in 1880 (Ehrlich 1880). In 1900, Russell described spinal cord

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<sup>1</sup> Water from a mineral spring with a high content of iron.

involvement in PA and coined the term “subacute combined degeneration of the spinal cord” (Russell et al. 1900). Moreover, gastric atrophy was detected in PA patients (Fenwick 1880). It was noted that hematologic abnormalities in PA patients resembled tropical sprue, which normally responded to a diet containing milk, meat, cod-liver oil and oranges. This may be the reason why similar treatments were used for patients with PA in the early days (Wills 1948).

Thus, in the period from 1876 to 1900, it became clear that PA was not solely a hematological disease, but also had gastrointestinal and nervous system components (Table 1).

Because of the treacherous start and slow progression of PA, this disease was often misinterpreted, and initial symptoms were often attributed to normal or premature ageing processes (Tobin and Cargnello 1993). Consequently, the disease was often identified at a late stage and many patients only had a short time to live after diagnosis (Combe 1824).

Nowadays it is difficult to imagine the seriousness of untreated pernicious anemia. However, thanks to William P Murphy, one of three laureates sharing the Nobel Prize in Physiology or Medicine in 1934, we are still able to watch a motion picture giving a vivid picture of the graveness of the disease in historic PA patients before and under treatment with liver extracts. The motion picture was presented during Murphy’s Nobel Lecture, December 12, 1934 (Murphy 1934). This motion picture has been recently made available to the general public through the Blood journal’s website (Kumar et al. 2006).

An overview over the milestones in the discovery of pernicious anemia and vitamin B12 is given in Table 1.

## 2. Early Treatment Approaches of PA

The first therapeutic approaches to a disease of an unknown cause and pathogenesis were highly experimental and arbitrary, and quite often obscure. Until the discovery that liver contains important nutrients and factors for hematopoiesis, the methods intended to treat pernicious anemia only had temporary effects and were on the whole unsuccessful (Combe 1824; Sinclair 2008). Around 1900 a renowned textbook of hematology considered iron being contraindicated for the treatment of certain forms of anemia where megalocytes with increased hemoglobin content appeared in the peripheral blood. Instead arsenic was supposed to exert almost specific effects and would result in increasing numbers of red cells and in stimulating the production of more uniformly distributed Hb (Ewing 1901). In the eighth edition of Sir William Osler’s *“THE PRINCIPLES AND PRACTICE OF MEDICINE—DESIGNED FOR THE USE OF PRACTITIONERS AND STUDENTS OF MEDICINE”* from 1915, one of the most authoritative text books at that time, it was suggested—among other remedies—to try Fowler’s Solution, sodium cacodylate or *Atoxyl*. Fowler’s Solution was an arsenical preparation, which may well have accelerated the death of many PA patients. Also *Atoxyl*, a

**Table 1.** Historical track record of discovery and treatment of pernicious anemia that later lead to the discovery of vitamin B12.

Era/Discovery	Year	Discovery/Event	Ref.
Pre-treatment, disease finding era. Characterization of the pernicious anemia and early therapeutic approaches	1822	Unexplained cases of anemia, first description of PA	(Combe 1824)
	1849	PA identified as a clinical entity	(Addison 1849)
	1871	15 cases of PA described—PA gained general interest in the medical community for the first time	(Biermer 1872)
	1874	First blood count in PA—observed large size of cells	(Sørensen 1874)
	1876	Bone marrow examination—increased cellularity	(Cohnheim 1876)
	1878	Comprehensive monograph on progressive PA	(Eichhorst 1878)
	1880	Monograph on atrophy of the stomach	(Fenwick 1880)
	1880	Recognition of megaloblasts in the blood of PA patients	(Ehrlich 1880)
	1887	Neurological components of PA	(Lichtheim 1887)
	1900	Subacute combined degeneration of the spinal cord (SCDC)	(Russell et al. 1900)
Oral and parenteral liver treatment and discovery of the pathogenesis of pernicious anemia	1926	Liver therapy of pernicious anemia	(Minot and Murphy 1926)
	1929	Achylia gastrica (atrophic gastritis) associated with PA—intrinsic factor contained in gastric juice	(Castle 1929)
	1947	First (microbiological) assay for quantification of B12	(Shorb 1947b)
Isolation and characterization of B12; predominantly parenteral treatment with crystalline B12	1948	Isolation and crystallization of B12 from liver	(Fantes et al. 1950; Rickes et al. 1948)
	1949	Production of B12 by bacterial fermentation	(Stokstad et al. 1949)
	1952	Assay of cobalamin in human serum	(Ross 1952)
	1953	Schilling test for evaluation of intestinal absorption of B12	(Schilling 1953)
	1954	Complete structure of B12 resolved	(Brink et al. 1954)
Oral treatment revisited. First B12-tablet approved in Sweden and final elucidation of synthesis pathways of B12	1964	First B12 tablet approved by Swedish Medical Products Agency	(Ågren 1964)
	1965	B12-binding proteins described	(Hall and Finkler 1965)
	1973	Total synthesis of vitamin B12 achieved	(Woodward 1973)
	1994	Entire aerobic pathway of B12 synthesis resolved	(Battersby 1994)
	2013	Elucidation of the entire anaerobic pathway of B12 synthesis	(Moore et al. 2013)

precursor of sulfonamide antibiotics, contained arsenic (Riethmiller 2005), which—together with sodium cacodylate—was used for the treatment of syphilis (Nichols 1911). The following quote from Osler’s textbook illustrates the prevailing ignorance of the medical community about the proper treatment of PA at that time (Osler 1915):

*“There are five essentials: first, a diagnosis; secondly, rest in bed for weeks or even months, if possible (thirdly) in the open air; fourthly, all the good food the patient can take; the outlook depends largely on the stomach; fifthly, arsenic; Fowler’s solution in increasing dosis beginning with m iii or v (0.2 to 0.3 c.c.) three times a day, and increasing to m i each week until the patient takes m xv (1 c.c.) three times a day. Other forms of arsenic may be tried, as the sodium cacodylate<sup>2</sup> or the atoxyl hypodermically. Atoxyl can be given in doses of gr. ss (0.032 gm.) every five days, and the amount is gradually increased. Accessories are oil inunctions; bone-marrow, which has the merit of a recommendation by Galen; in some cases iron seems to do good. Care should be taken of the mouth and teeth. Gastric lavage and irrigations of the colon are useful in some cases.*

*Injections of blood serum and defibrinated blood have been given. The serum is given in small amounts, 10 to 20 c.c., usually into a vein; rabbit serum is perhaps the best. Defibrinated human blood should be given intravenously in large amounts, up to 500 c.c.”* (Osler 1915).

Part of the short-lived effectiveness of arsenic for treatment of PA may be explained by liberation of B12 from the body’s own cells through arsenic-induced cell-lysis (Dunlop 1973; Riedmann et al. 2015; Weber 1932).

### **3. Recovery from PA by Liver Treatment**

#### **3.1 The discovery and development of oral liver therapy**

The First World War triggered research into blood substitutes and ways of improving recovery and hematopoiesis after massive blood loss (Sinclair 2008). This may also have stimulated George Whipple, who was an expert in liver diseases working at the University of California, to examine the liver’s role in hematopoiesis. In 1920 he conducted a series of experiments in dogs that had been made anemic through venesection and investigated the effects of various dietary treatments (Whipple et al. 1920). Interestingly, similar experiments carried out in pancreatectomized dogs resulted in the discovery of insulin by Fredrick Banting and Charles Best at the University of Toronto, Canada, during 1920–1924 (Banting et al. 1991). Whipple later moved to the University of Rochester, School of Medicine and Dentistry in New York State

<sup>2</sup> Chemical compound with the formula  $(\text{CH}_3)_2\text{AsO}_2\text{Na}$  at that time used—together with Salvarsan and Atoxyl—for the treatment of syphilis

and continued his research on the effects of dietary regimes including liver, iron pills, arsenic and germanium dioxide for treatment of chronic anemia. Only liver, and especially raw, uncooked liver turned out to be effective in treatment of anemia (Robscheit-Robbins and Whipple 1925). The finding that raw liver was more effective than cooked liver was pure serendipity. Disobeying the instructions of Whipple, a laboratory technician responsible for the dogs, fed the anemic animals raw liver instead of cooked and a more pronounced hematological effect was observed (Sinclair 2008). We now know that liver is rich in vitamin B12, folate, and other nutrients. Further, vitamin B12 is heat-stable while folate is not. Therefore, the chance finding that raw liver was more effective than cooked liver in restoring hemoglobin levels could indicate that apart from heat-stable vitamin B12 other, heat-labile hematopoietic factors such as folate contained in raw liver might have been responsible for the superior hematological effects in anemic dogs. Still, in 1923 George Minot and William Murphy, two physicians from Boston, took notice of Whipple's discovery in dogs and decided to try raw liver for the treatment of patients with PA (Sinclair 2008). In 1926, Minot and Murphy presented their results of the first 45 patients who had been given a high protein diet that included 100–240 g of liver and 120 g of meat for between six weeks and two years at a meeting of the Association of American Physicians in Boston (Minot and Murphy 1926).

Interestingly, Minot had learnt a method of counting reticulocytes in the meanwhile that allowed him to study early hematological responses to liver treatment (Sinclair 2008). Minot and Murphy observed raised reticulocyte counts within four to ten days after starting the diet (Kumar et al. 2006). Other signs of hematological response such as increased hemoglobin levels and red cell counts and improvement of jaundice in addition to neurological recovery followed later during therapy.

### **3.2 Rather die than being treated with raw liver that tasted dreadful**

Raw liver was assumed to contain a yet unidentified *extrinsic factor* responsible for the clinical effects. However, this diet tasted dreadful. David Hilbert (1862–1943), one of the greatest mathematicians of the first half of the twentieth century and director of the Mathematical Institute of Göttingen (Reid 1996) was diagnosed with pernicious anemia during autumn 1925. The disease had gone undetected for a long time because the first symptoms—taking into account his age of 65 y—had been interpreted as a merely age-related phenomenon. At the time of diagnosis, however, Hilbert was no longer able to leave his house because he was too weak to walk and he taught his students at home. The doctors gave him at best a few months or even weeks to live. A pharmacologist friend in Göttingen by chance read the paper of Minot and Murphy in JAMA from 1926 (Minot and Murphy 1926). By the intervention of Marianne Landau, daughter of the Nobel laureate Paul Ehrlich, contact was established with several Harvard professors in mathematics who finally could convince Minot

to send experimental liver extracts from the United States despite the scarcity of the preparations. Until the arrival of the liver extracts, Hilbert had, however, to follow the original raw liver diet. A colleague of Hilbert, EU Condon, visiting Göttingen in the summer of 1926, heard Hilbert complain that he would rather die than eat that much raw liver. Yet, his condition improved almost immediately upon the liver therapy (Reid 1986).

### **3.3 Nobel Prize in Medicine in 1934 and development of oral and parenteral liver treatment**

Vitamin B12 research resulted in two Nobel prizes. On December 10, 1934, the Caroline Institute awarded the Nobel Prize in Physiology or Medicine to three American investigators: George R. Minot and William P Murphy of the Harvard Medical School (Boston, MA) and George H Whipple of the University of Rochester School of Medicine and Dentistry (Rochester, NY), “in recognition of their discoveries respecting liver therapy in anaemias.” On December 12, 1934, Murphy presented this motion picture (Murphy 2006) as part of his Nobel lecture (Murphy 1934). He introduced the movie with the following words:

*“Rather than enlarge further upon the details and results of the treatment of pernicious anemia, I shall now present, with your permission, a motion picture which will illustrate many points more clearly than I could discuss them here.”*

The motion picture, made at the Peter Bent Brigham Hospital in Boston emphasizes the superiority of parenteral to oral therapy with liver extract in the treatment of PA. The movie consists of two parts. In the first part hematologic and neurologic signs and symptoms in PA are illustrated and a synopsis of normal hematopoiesis as well as pathology seen in PA is given. Further, different treatment schemes with whole liver, oral liver extracts, and concentrated extracts for intramuscular injections are compared. The second part depicts the improvement in the peripheral smear with liver therapy, and the greater clinical effectiveness of parenteral therapy compared with oral treatment with liver or liver extracts. Even a cost-effectiveness analysis of the parenteral treatment is presented and the importance of maintenance therapy is highlighted. Oral liver therapy was used in clinical practice for a relatively short period of about seven years before it was substituted by parenteral therapy and at the time of the Nobel lecture oral liver therapy had been more or less replaced by intramuscular injections of liver extracts (Figure 4). Liver extraction methods were rather crude at that time (Gänsslen 1930) and preparations certainly contained other hematopoietic factors in addition to vitamin B12 (Okuda 1999). Ironically, improved purification of liver extracts may have removed these additional hematopoietic factors and contributed to the lower potency and greater batch variability of the

preparations during the course of the years between 1940 and 1948 (Mollin 1950). Until that time, the “extrinsic factor” contained in liver and curing PA still remained undiscovered.

#### **4. Isolation and Crystallization of Vitamin B12**

The discovery of the unknown liver factor, i.e., vitamin B12, was delayed because no quantitative *in vitro* tests were available at that time to measure the potency of the different liver extracts. Thus, the only way to evaluate the effectiveness of the extracts was to test them on patients with PA, which was time-consuming (Rickes et al. 1948; Shive 2002; Vora 1956). The discovery of a microbiological assay for the measurement of vitamin B12 activity in 1947 (Shorb 1947a; Shorb 1947b) accelerated the isolation of the *extrinsic factor* contained in liver that was responsible for the alleviating the clinical symptoms. Vitamin B12 in the liver extract was able to enhance the growth of the bacteria, and the growth rate could be used as a measure of the amount of the unknown factor in the extract. Unfortunately, extraction and isolation of crystalline vitamin B12 from liver was highly inefficacious. One and a half tons of beef liver was needed to produce 1 gram of vitamin B12. Finally, in 1948 two independent groups, Folkers and co-workers at Merck, United States, and Lester-Smith and co-workers at Glaxo, England, succeeded in isolating the *extrinsic factor* in 2 different crystalline forms (hydroxyl and cyano-cobalamin) and they named it vitamin B12 (Wagner and Folkers 1963). Vitamin B12 received its name (B12) just after folate (vitamin B9) had been discovered and thus it was given the number 12 in the B-group. The gaps in the numbering of the B-vitamin complex are due to the fact that a number of substances initially mistaken for vitamins were gradually removed from the group of B-vitamins (Elliot 2008).

##### **4.1 Second Nobel Prize in Chemistry in 1955 and the discovery of the chemical structure of vitamin B12**

The final product of the extraction, vitamin B12, turned out to be odor- and tasteless, bright red needle-shaped crystals (Howard 2003). However, it took seven more years before the exact chemical structure was finally resolved through X-ray crystallography by Dorothy Hodgkin in 1955 (Brink et al. 1954; Hodgkin et al. 1955). About ten million calculations had been necessary to clarify the structure of this factor. For this achievement Dorothy Crowfoot Hodgkin received the Nobel Prize in 1964. During the 1950’s studies on isolates of various bacteria and molds primarily used for antibiotic production, and rumen microorganisms revealed that many of these microbes were also able to synthesize vitamin B12 (Halbrook et al. 1950; Johnson et al. 1956).

Still, the complete laboratory chemical synthesis of vitamin B12 was not accomplished before 1972 (Woodward 1973). Total chemical synthesis requires

more than 70 steps and is extremely resource demanding. Microorganisms are far more efficient at synthesis of this vitamin and bacterial fermentation remains the main source of production of vitamin B12 at industrial scale even today (Xia et al. 2015) (Figure 3).

## 5. Oral Treatment Revisited

### 5.1 Oral or parenteral treatment with liver extracts

Even though the exact cause of PA remained unknown for many years to come, involvement of the gastric ventricle in the pathogenesis of this disease was anticipated as early as in 1880 (Fenwick 1880). Gastric atrophy and achlorhydria were common findings in pernicious anemia patients. In 1926, it was clear that liver obviously contained an, at that time, unidentified *extrinsic* (food/liver) *factor* accountable for the clinical response, but for more effective oral treatment in addition an *intrinsic* (gastric) *factor* was needed and this factor was most likely contained in the gastric juice of healthy humans or animals (Castle 1929).

In 1927, Castle performed the first experiments that demonstrated the existence of an additional endogenous gastric substance involved in the pathogenesis of PA, which he called the *intrinsic factor* (Castle 1929).

Castle found that neither normal human gastric juice nor nearly raw hamburger meat alone could induce a reticulocyte response in PA patients. However, hamburger meat that had stayed in Castle's own stomach for 1 h before it was regurgitated and then fed to PA patients via a nasogastric tube triggered a reticulocyte response. Castle stated:

*'that in contrast to the conditions within the stomach of the pernicious anaemia patient, there is found within the normal stomach during digestion of beef muscle some substance capable of promptly and markedly relieving the anaemia of these patients'* (Castle 1929).

Development of processed liver concentrates for oral administration followed. However, oral treatment demanded relatively high doses and was thus very expensive (Ungley 1955). It turned out that the potency of the liver extracts could be improved by adding the yet unidentified *intrinsic factor* (Castle 1953), which was supplied as liquefied stomach contents of a healthy normal person or desiccated hog's stomach (Glass and Boyd 1953). However, all of these preparations tasted dreadful and the period of exclusively oral treatment of PA with liver or liver extracts was soon replaced by more "palatable" parenteral regimes with injectable liver extracts (Schultzer 1934). Parenteral treatment had additional advantages as it was—at that time—considerably cheaper compared to oral therapy due to lower dose-demands and no *intrinsic factor* was needed (Ungley 1950a; Ungley 1950b). However, injectable liver extracts also had serious side effects, sometimes even fatal, and



the potency unfortunately showed considerable variability between vendors as well as over time resulting in many relapses during maintenance therapy (Anonymous 1965; Mollin 1950). Moreover, the cleaner the liver extracts became the poorer was their potency as other potentially active factors such as folate and iron from crude liver extracts gradually disappeared (Conley and Krevans 1955). By the end of the 1940s pure crystalline cyanocobalamin (vitamin B12) was preferred over liver extracts for treatment of PA (Blackburn et al. 1952; Blackburn et al. 1955; Wagner and Folkers 1963).

Since then, parenteral supplementation with crystalline cyanocobalamin has been the mainstay of treatment of most forms of vitamin B12 deficiency in the majority of countries world-wide (Stabler 2013). Adherence to this therapeutic tradition is most likely also a result of the 1959 US Pharmacopeia Anti-Anemia Preparations Advisory Board recommendation, which advised against the use of oral therapy for pernicious anemia, mostly because of its unpredictable efficacy (Bethell et al. 1959). Typically, arguments against oral cyanocobalamin therapy were based on findings of inadequately low serum cobalamin concentrations achieved in patients taking oral vitamin B12 doses of 100–250 µg/d without *intrinsic factor* (Glass and Boyd 1953). According to our current knowledge, when oral doses > 10 µg/d are used, only approximately 1.5% of the dose is expected to be absorbed through passive diffusion, thus explaining the relatively low efficacy of doses < 500 µg/d in treatment of PA.

## **5.2 Oral treatment with crystalline vitamin B12 with and without intrinsic factor**

Parallel with the parenteral use of crystalline vitamin B12, investigators searched for oral alternatives to liver extracts and experimented with oral use of small amounts of crystalline vitamin B12 in combination with *intrinsic factor* from various sources to improve bioavailability (Blackburn et al. 1955). By the end of the 1950s more efficient, large-scale industrial production of vitamin B12 by microbial fermentation was accomplished, securing the supply of inexpensive cyanocobalamin (Mervyn and Smith 1964). This opened up for the use of higher oral doses of cyanocobalamin without *intrinsic factor* despite poor bioavailability (Waife et al. 1963). During the 1950's a large number of dose-finding studies of oral therapy with crystalline B12 were performed with and without addition of intrinsic factor and clinical responses were monitored thoroughly (Brody et al. 1959; Chalmers and Hall 1954; Chalmers and Shinton 1958; Conley and Krevans 1955; Doscherholmen and Hagen 1957; Gaffney et al. 1959; McIntyre et al. 1960; Reisner et al. 1955; Ross et al. 1954; Schwartz et al. 1959; Shinton 1961; Spies et al. 1949; Ungley 1950a; Ungley 1950b; Ungley 1950c; Ungley and Childs 1950; Waife et al. 1963). The required oral doses varied considerably between the studies and ranged from repeated daily doses of 50–100 µg (Brody et al. 1959) to 1000 µg per week (Reisner et al. 1955)

to at highest 3000 µg/d (Ungley 1950a). Consistently, it was found that oral doses needed to be 30–60 times higher than parenteral doses in patients with pernicious anemia (Chalmers and Hall 1954; Spies et al. 1949). In Sweden, during the late 1950's and early 1960's basic research was carried out studying the feasibility of oral treatment of pernicious anemia with tablets containing very high doses of cyanocobalamin without an intrinsic factor (Berlin et al. 1965; Berlin et al. 1966; Berlin et al. 1968b; Berlin et al. 1958; Berlin et al. 1961). Little by little, this research provided convincing evidence from long-term follow-up of pernicious anemia patients, showing that oral treatment with vitamin B12-tablets was indeed possible and reliable (Berlin et al. 1965; Berlin et al. 1968b). Vitamin B12 tablets were approved by the Swedish Medical Products Agency in 1964 (Ågren 1964). Since then, vitamin B12-substitution with tablets has gradually replaced parenteral therapy in Sweden, where vitamin B12 tablets constitute more than 80% of vitamin B12-prescription drugs (Nilsson et al. 2005).

## **6. The Pharmacology of Oral Vitamin B12**

To understand the feasibility of oral vitamin B12-treatment it is necessary to recognize the clinical pharmacology of vitamin B12, which is quite complex. Most of the work on vitamin B12 pharmacokinetics was carried out during the 1960s (Adams et al. 1971; Ardeman et al. 1964; Boddy et al. 1968; Gottlieb et al. 1965; Herbert 1968; Hertz et al. 1964; Heyssel et al. 1966; Skouby 1966). Physiological losses of vitamin B12 through renal and biliary elimination routes are minimal and daily losses in healthy subjects account for only 0.1–0.2% of the total body reserves of 3–5 mg, and merely this portions needs to be replenished (Table 3) (Combs 2008). Therefore, the daily cobalamin requirements in order to maintain normal vitamin status in healthy subjects are extremely low. The recommended daily allowance (RDA) for adults is 2.4 µg/d as set by the US Institute of Medicine in 1998.

### **6.1 Pharmacokinetics**

Absorption, transport and cellular uptake as well as retention in the body depend on a number of transporters, binding proteins and receptors that all have a high specificity for vitamin B12 (Table 2).

The free binding capacity of most of the binding proteins is adapted to the physiologically low vitamin B12-supply and demands. Therefore, the free binding capacity of B12 binders is generally low as regards to both active intestinal absorption and transport in the blood. In line with this, the maximum capacity of active intrinsic factor-mediated absorption of vitamin B12 is only 2.5 to 3.0 µg per serving (Heyssel et al. 1966). It takes about 4–6 hours before maximum active absorption capacity is completely restored (Heyssel et al. 1966). Further, the unsaturated vitamin B12 binding capacity in human plasma

**Table 2.** Main proteins involved in vitamin B12 homeostasis and transport.\*

	Binding proteins or transporters			Receptor proteins		
	IF	HC	TCII	Cubilin/ amnion-less	Megalyn	TC-receptor CD320
<b>Main function:</b>						
Intestinal absorption	x			x		
Blood transport		x	x			
Cellular uptake			x		x	x
Entero-hepatic circulation	x		x	x		
Renal tubular re-absorption			x		x	x
Biliary elimination		x				

\* The table is based on data from the following references (Banerjee et al. 2009; Birn 2006; Fyfe et al. 2004; Grasbeck 2006; Herbert 1994; Kanazawa et al. 1983; Quadros and Sequeira 2013; Schjonsby 1989). IF = intrinsic factor; HC = haptocorrin; TCII = transcobalamin II; TC-receptor = transcobalamin receptor

ranges from 230 to 1380 pmol/l (Herbert 1968), mostly constituted of apo-transcobalamin II (apo TC-II) (Markle 1996; Obeid et al. 2006; Teplitsky et al. 2003). This corresponds to a total binding capacity of only 3 to 5 µg of newly absorbed cobalamin (Gottlieb et al. 1965). Vitamin B12 unbound to transporters or plasma proteins is subject to glomerular filtration and rapid renal excretion (Herbert 1968). This limits maximum (active) absorption and body retention when vitamin B12 is supplemented in pharmacological doses (Table 3). Further, the bioavailability and total body retention of vitamin B12 not only depends on the route of administration, oral or parenteral, the capacity of vitamin B12 binding proteins, but also on the formulation of vitamin B12 preparations (i.e., cyano- and hydroxocobalamin) (Adams et al. 1971; Boddy et al. 1968; Hertz et al. 1964; Skouby 1966) (Table 3). At high doses oral bioavailability or retention of *i.m.* vitamin B12 is very similar in healthy subjects and patients suffering from PA (Table 3, Figure 4).

### 6.1.1 Oral absorption

Gastric dysfunction such as chronic atrophic gastritis is a major cause of reduced oral up-take of cobalamin from food sources (food cobalamin malabsorption) (Nielsen et al. 2012). Interestingly, reduced availability of the intrinsic factor due to gastric atrophy is not a rate-limiting factor in this process. The stomach appears to have a large reserve capacity for *intrinsic factor* secretion and daily production of *intrinsic factor* suffices for uptake of 100–150 µg/d (Ardeman et al. 1964). Only extreme forms of atrophic gastritis and selective destruction of

**Table 3.** Bioavailability and retention of cobalamin.

	Healthy subject		Pernicious anemia patient	
Daily loss*	≈ 1 µg/d		≈ 2 µg/d	
RDA	2.4 µg/d		1000 µg/d p.o. 1000 µg/90 days i.m.	
Bioavailability of a single oral dose µg (% of the dose)				
0.5 µg	0.38 µg (75%)		0.006 µg (1.2%)	
1–2 µg	0.5–1 µg (50%)		0.012–0.024 µg (1.2%)	
10 µg	1.6 µg (16%)		0.12 µg (1.2%)	
50 µg	2.0 µg (4%)		0.6 µg (1.2%)	
500 µg	10 µg (2%)		6 µg (1.2%)	
1000 µg	≈ 14 µg (1.4%)		≈ 12 (1.2%)	
Retention of a single i.m. dose (% of the dose)	CN-Cbl	OH-Cbl	CN-Cbl	OH-Cbl
3 µg	100%	100%	100%	100%
10 µg	97%	98%	98%	98%
25 µg	95%	96%	96%	98%
40 µg	93%	94%	94%	96%
100 µg	55%	90%	60%	94%
500 µg	20%	50%	30%	55%
1000 µg	15%	30%	20%	35%

\* Mainly represented by vitamin excreted in urine and bile. RDA, Recommended Dietary Allowance. This table is a compilation of data from the following studies (Ardean et al. 1964; Berlin et al. 1968a; Heyssel et al. 1966; Scott 1997).

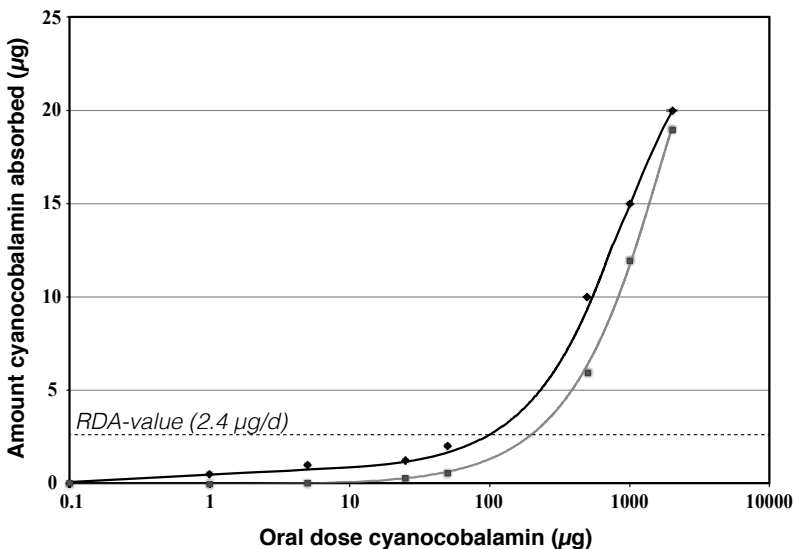
gastric parietal cells by autoantibodies in pernicious anemia can reduce *intrinsic factor* production to a significant level. Nevertheless, atrophic gastritis per se may limit the bioavailability of oral vitamin B-12 through other mechanisms, such as impaired release of the vitamin from food proteins due to impaired acid secretion and reduced digestion by pepsin (Selhub et al. 2000). These restraints do of course not apply for crystalline vitamin B12 tablets. The rate-limiting factor of oral bioavailability of low doses of food vitamin B12 is primarily saturation of ileal receptors, which recognize the cobalamin-*intrinsic factor* complex (Heyssel et al. 1966). The active transport of the cobalamin-*intrinsic factor*-complex is easily saturable. The maximum amount of vitamin B12 that can be absorbed from a single meal is about 2 µg (Scott 1997; Watanabe 2007) and the fractional absorption decreases as oral doses are increased. About 50% of a single oral dose of 1 µg is retained, 20% of a 5 µg dose, and only 5% of a 25 mg dose (Table 3). To improve oral bioavailability of vitamin B12 repeated daily dosing at least 4–6 hours apart without concomitant food intake would appear advantageous (Berlin et al. 1968a; Brody et al. 1959; Heyssel et al. 1966). At oral doses of 500–1000 µg and above a constant fraction of

cobalamin, approximately 1.5 of the dose, is absorbed by simple diffusion from the lumen to the intestinal epithelium independent of *intrinsic factor* (Berlin et al. 1968a). In pernicious anemia active uptake of vitamin B12 through ileal receptors does not occur due to lack of *intrinsic factor*, but passive absorption by simple diffusion is more than adequate to meet the daily requirements for patients without *intrinsic factor* when daily oral dosages of 1000  $\mu\text{g}$  are ingested (Berlin et al. 1968a). When using low oral doses of vitamin B12 a saturation of the plasma total vitamin B12 binding capacity is normally not achieved. However, at oral doses exceeding 1–10 mg significant urinary excretion of newly absorbed vitamin B12 is observed (Berlin et al. 1968a).

At increasing oral doses the absolute and relative difference in vitamin B12 uptake between healthy subjects and patients with pernicious anemia becomes narrower (Berlin et al. 1968a) (Figure 5).

## 6.2 Pharmacodynamics

Vitamin B12 is essential for cell growth and replication and participates in transmethylation reactions during the synthesis of methionine, choline, creatinine and nucleic acids. Vitamin B12 supplements reverse the hematopoietic and, if started timely, neurological symptoms of vitamin B12



**Figure 5.** Schematic representation of estimated vitamin B12-uptake at different oral doses (per serving) in healthy subjects (black color, black diamond symbols) and cyanocobalamin tablets patients with pernicious anemia (grey color, solid grey square symbols) based on data from literature (Doscherholmen and Hagen 1957; Gaffney et al. 1959). The figure illustrates the dual mechanism of active (saturable) and passive absorption of oral cyanocobalamin (Doscherholmen and Hagen 1957) and that similar absolute amounts of cyanocobalamin are absorbed in healthy subjects and patients suffering from PA when very high oral doses are used.

deficiency (Stabler 2013). Vitamin B12 does not exert direct pharmacodynamic activity, but acts as a co-factor in two different forms, methylcobalamin and 5-deoxyadenosinocobalamin, for the enzymes methionine synthase and methylmalonyl-CoA mutase, respectively (Banerjee 2006). In addition, vitamin B12 has repeatedly been proposed as a carrier molecule for up-take and targeting of drugs to certain tissues (Clardy-James et al. 2013).

### 6.3 Side effects

Generally, both oral vitamin B12 and vitamin B12-injections are well tolerated. However, injection site reactions including pain, erythema, pruritus, induration, swelling, and necrosis can occur (2013) causing patient discomfort and inconvenience (van Walraven et al. 2001a; van Walraven et al. 2001b). Oral supplementation reduces the risk of injection complications such as infections or cyst formations and nerve injuries are avoided. In addition, the risk of allergic reactions is lower with oral administration (Bilwani et al. 2005). Finally, oral treatment is preferred to intramuscular injections in patients on anticoagulation therapy as there is increased risk of hematoma formation when i.m. injections have to be performed regularly (Kim and Hyung 2011).

## 7. Diagnostic Achievements in the Course of Discovery of PA

Milestones in the development of diagnostic procedures for vitamin B12-deficiency are depicted by central gradient bars with solid-lined borders in [Figure 4](#). Development of assays for identification and quantification of the putative *extrinsic factor* were crucial for final isolation of vitamin B12 from liver extracts, and measuring its concentration in these extracts (Vora 1956) and later diagnostically in blood samples. Before that, the potency of liver extracts assumed to contain the vital *extrinsic factor* that cured anemia had to be tested on the basis of the hematological response in affected patients, which was very time-consuming and not without risks (Shive 2002; Vora 1956). However, in 1947/48 important observations of Shorb of a linear relationship between the amount of a presumed growth factor for *Lactobacillus lactis* Dorner in liver extracts and the potency of the same factor for the treatment of patients suffering from pernicious anemia resulted in the first microbial vitamin B12-assay (Shorb 1947a; Shorb 1947b; Shorb 1948). Having a quantitative *in vitro* assay that allowed testing the biological activity of the extracts greatly accelerated the successful isolation of vitamin B12 (Ahrens 1993).

Soon, the same principle of microbial assays was found to be useful for measuring of vitamin B12 concentrations in serum and other body fluids. Measuring blood concentrations of vitamin B12 soon became the first step in diagnosing PA (Ross 1952).

However, even microbial assays were laborious had many limitations such as multiple steps and long incubation times, difficulties to automate the assay,

risk of microbial contamination, and suppression of growth by antibiotics and cytotoxic drugs and were relatively soon abandoned from the clinical routine laboratory (O'Sullivan et al. 1992). Today, microbiological assays for vitamin B12 are adapted to microtiter plate format and carried out by robotic workstations and are mainly used for scientific purposes (Molloy and Scott 1997; O'Broin and Kelleher 1992; Taneja et al. 2007).

In the 1960s, radioimmunoassays, RIAs, were introduced using  $^{57}\text{Co}$ -cyanocobalamin and *intrinsic factor* and R-binder as binders (Moridani and Ben-Poorat 2006; O'Sullivan et al. 1992). RIA tests had the drawback of demanding manual sample pretreatment, radiation exposure risk and costs associated with disposal of the radioimmunoassay components (Kuemmerle et al. 1992; Moridani and Ben-Poorat 2006). By 2007, the manufacturer of the most commonly used RIA-assay, the Bio-Rad RIA, discontinued the production (Yetley et al. 2011). The first automated, non-isotopic chemiluminescence assays for measuring vitamin B12 in serum were developed in the early 1990s (Kuemmerle et al. 1992). Current automated routine assays are mostly based on these non-isotopic procedures using chemiluminescence or more recently electroluminescence detection and exhibit relatively good measuring agreement between the methods (Karmi et al. 2011; Vogeser and Lorenzl 2007).

In parallel, alternative or complementary tests to serum vitamin B12 assays were developed, including more sensitive and specific functional markers of vitamin B12 status such as methylmalonic acid and homocysteine that increase in blood and urine of people with deficiency. By the end of the 1980s and through the 1990s different methods for determination of the functional vitamin B12-marker methylmalonic acid (MMA) became available, including GC-MS, HPLC, capillary electrophoresis, LC-MS and LC-MS-MS techniques (Stabler et al. 1986; Schneede and Ueland 1993; Schneede and Ueland 1995; Windelberg et al. 2005; Lakso et al. 2008). Together with total homocysteine, MMA nowadays represents one of the cornerstones of vitamin B12 deficiency diagnostic tests (Langan and Zawistoski 2011; Remacha et al. 2014; Risch et al. 2015).

During the same period, the concept of holotranscobalamin (holoTC) as a measure of biologically active cobalamin was developed (Carmel 1985; Herbert et al. 1990; Herzlich and Herbert 1988; Lindemans et al. 1983; Remacha et al. 2014). Vitamin B12 in serum is carried by two binding proteins, transcobalamin and haptocorrin. Although the fraction of transcobalamin-bound vitamin B12 (holoTC) in relation to total vitamin B12 is small ( $\approx 20\text{--}30\%$ ), holoTC is considered representing newly absorbed vitamin B12 and being responsible for delivering cobalamin to cells through a receptor mediated up-take. HoloTC is considered being the functionally active fraction of the vitamin (Carmel 2011; Nexö and Hoffmann-Lucke 2011). The first commercial RIA-assay for determination of holoTC became available in 2002 (Ulleland et al. 2002) and has now been replaced by an automated sandwich microparticle enzyme immunoassay that can be run on standard analytical platforms (Brady et al. 2008). The clinical utility of the holo-TC test has been evaluated during the

recent years and its place in vitamin B12-diagnostics is still under debate (Herrmann and Obeid 2013; Remacha et al. 2014; Risch et al. 2015).

Another landmark in revealing the cause of vitamin B12-deficiency through diagnostic test was the Schilling test. The Schilling test was introduced by Schilling in 1953 and was designed to assess the ability of the patient to absorb small oral doses of radioactively labeled vitamin B12 (Schilling 1953). This test remained the mainstay of diagnostic tests for detection and differentiation of potential causes of vitamin B12 deficiency for more than five decades until it was abandoned due to high costs, lack of sensitivity under certain conditions and terminated production of cobalt radioisotopes and labeled cobalamin forms (Moridani and Ben-Poorat 2006; Palmer et al. 2012; Yetley et al. 2011). More recently, a non-radioactive vitamin B12 absorption test (CobaSorb) has been developed, but also this test has several limitations and has not achieved widespread adoption so far (Hardlei et al. 2010; Hvas et al. 2011; Hvas et al. 2007).

## **8. Health-economic Assessments of Oral B12 Treatment**

Vitamin B12-treatment was from the very beginning not just a matter of clinical effectiveness, but also cost-effectiveness (Kumar et al. 2006). Already in 1934 Murphy addressed in his Nobel lecture cost-aspects of liver-treatment and potential savings with liver extracts for intramuscular use compared to peroral treatment (Murphy 1934). The first modern health-economic assessment of oral versus parenteral B12 supplementation that also included a sensitivity analysis was performed in 2001 (Figure 4) (van Walraven et al. 2001a), grey bars with solid-lined borders in Figure 4. Sensitivity analysis indicated that the number of injection-associated physician visits that could be avoided by switching patients to oral therapy had major impact on the cost-effectiveness. Later, publications on cost minimization analyses (Vidal-Alaball et al. 2006) and cost-saving analyses (Houle et al. 2014) as well as budget impact analyses (Masucci and Goeree 2013) performed in the UK, Canada and Spain followed.

Nowadays, the switch to oral vitamin B12 supplementation with tablets is generally considered feasible and a cost-effective alternative to parenteral treatment (Kolber and Houle 2014; Kwong et al. 2005).

## **9. Summary**

Vitamin B12 is an archaic vitamin in many aspects. As other vitamins, vitamin B12 is vital for all higher organisms and functions as cofactor. Humans require dietary supply of these organic micronutrients, but microorganisms and many plants synthesize *de novo* the cofactors they need. Vitamin B12 is also an ancient molecule, as it was first synthesized by prokaryotic cells. Conceivably, the history of vitamin B12 deficiency and PA in humans has to be considerably shorter than the history of the vitamin itself, and can arbitrarily be divided



into different epochs. It is almost 200 years since the first description of PA and the pre-treatment era stretches over 100 years before effective treatment options were developed (Figure 4). Oral treatment with raw or slightly cooked liver or liver extracts followed, but was soon abandoned due to high costs and unacceptable taste. The epoch of oral liver therapy was succeeded by a period of intramuscular administration of liver extracts, which lasted for about 20 years. With the isolation and characterization of the *extrinsic factor* (B12) from liver and the advent of large-scale, cost-effective production of vitamin B12 by bacterial fermentation (Xia et al. 2015) it was possible to use pure crystalline vitamin B12 for intramuscular administration, which still is the predominant treatment option of vitamin B12 deficiency world-wide today. The introduction and approval of high-dose vitamin B12 tablets in Sweden in the early 1960's ushered in the renaissance of oral treatment of vitamin B12-deficiency. The need to diagnose PA and other causes of vitamin B12 deficiency triggered the development of a range of diagnostic tests, some of them now constitute the basis of diagnostic strategies in clinical routine. During the last decade several health-economic assessments have confirmed the cost-effectiveness of oral vitamin B12 treatment over parenteral therapy. Industrial production by bacterial fermentation and the return of oral treatment vitamin B12 deficiency underscore the archaic nature of this precious co-factor. Almost 200 years after discovering PA and after approximately 70 years of efforts to find the cause of PA and to understand the synthesis of vitamin B12, large parts of the puzzle now seem to have been solved, but in fact many questions on vitamin B12 deficiency are still unanswered and warrant further investigations (Gräsbeck 2013).

**Keywords:** Vitamin B12 deficiency, cobalamin, history, management, diagnostics, supplementation, homocysteine, methylmalonic acid, holotranscobalamin, health economics.

## Abbreviations

PA	:	Pernicious anaemia
HC	:	Haptocorrin
TCII	:	Transcobalamin II
HoloTC	:	holotranscobalamin
RDA	:	Recommended Daily Allowance

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## Milestones in the Discovery of Pernicious Anemia and its Treatment

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## Conditions and Diseases that Cause Vitamin B12 Deficiency: Form Metabolism to Diseases

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## Vitamin B12 Deficiency in Developing and Newly Industrialising Countries

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## Vitamin B12 in Neurology and Aging

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# The Role of Cobalamin in the Central and Peripheral Nervous Systems: Mechanistic Insights

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## Cobalamin During Pregnancy and Lactation

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## CobalaminFolate Interactions

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## Extreme Vitamin B12 Concentrations in Clinical Practice in the Absence of Symptoms or B12 Treatment

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## Vitamin B12 and Drug Development

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