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Resolution of, and risk of incident non-alcoholic fatty liver disease with changes in serum 25-hydroxy vitamin D status

Short title: Serum 25(OH)D and NAFLD

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Abbreviation list

25(OH)D, 25-hydroxyvitamin D; BMI, body mass index; BP, blood pressure; CI, confidence interval; CVD, cardiovascular disease; HEPA, health-enhancing physical activity; HOMA-IR, homeostasis model assessment of insulin resistance; HR, hazard ratio; hs-CRP, high-sensitivity C-reactive protein; NAFLD, non-alcoholic fatty liver disease; PY, person-years

Keywords: non-alcoholic fatty liver disease; cohort study; serum 25-hydroxy vitamin D; incidence; resolution

ABSTRACT

Context: A protective or causative role of vitamin D status on the risk of non-alcoholic fatty liver disease (NAFLD) remains inconclusive.

Objective: To evaluate the association between changes in serum 25-hydroxyvitamin D [25(OH)D] status during follow-up and the risk of incident NAFLD and resolution of pre-existing NAFLD

Design: A retrospective cohort study

Setting: Kangbuk Samsung Health Study based on routine health screening examinations

Participants: Korean adults (mean age, 36.8 years; range, 18–96 years) who underwent comprehensive health examinations including assessment of serum 25(OH)D levels

Main Outcome Measures: The main outcomes were a) incidence and b) resolution of NAFLD assessed by liver ultrasound. Cox proportional hazard models were used to estimate hazard ratios (HRs) with 95% confidence intervals (CIs) for outcomes according to serum 25(OH)D levels.

Results: Among 139,599 participants without NAFLD at baseline, 27,531 developed NAFLD during follow-up. Serum 25(OH)D levels were significantly and inversely associated with NAFLD development. Among 48,702 participants with NAFLD at baseline, 13,449 showed NAFLD resolution. Multivariable-adjusted HR (95% CI) for NAFLD resolution comparing 25(OH)D 10–<20, 20–<30, and ≥30 ng/mL to <10 ng/mL were 1.09 (1.03–1.15), 1.13 (1.06–1.21), and 1.21 (1.09–1.35), respectively. Additionally, an increase in 25(OH)D levels between baseline and the subsequent visit (median, 1.8 years) was associated with decreased NAFLD incidence, while persistently adequate 25(OH)D levels over time was associated with decreased incidence and increased resolution of NAFLD.

Conclusions: Maintaining adequate serum 25(OH)D concentrations may be beneficial for both prevention as well as resolution of NAFLD.

INTRODUCTION

Non-alcoholic fatty liver disease (NAFLD) is considered a multisystem disease that is positively associated with cardiovascular disease (CVD) risk factors, CVD mortality, and all-cause mortality (1,2). Despite its burden and impact, the absence of approved pharmaceutical treatment indicates that management of NAFLD consists of lifestyle modifications, which are effective in ameliorating the early stages of liver disease and improving the associated cardiometabolic risk factors (3).

A growing body of evidence has suggested a link between vitamin D deficiency, characterized by low serum levels of 25-hydroxyvitamin D [25(OH)D], and increased risk of various cardiometabolic diseases, including metabolic syndrome (4), coronary artery disease (5), chronic liver disease (6-8), and mortality (9). The therapeutic potential of vitamin D supplementation in NAFLD has been investigated in clinical trials; however, the findings are conflicting and limited by small sample sizes and the short duration of follow-up. A meta-analysis of mainly cross-sectional and case-control studies has demonstrated an association between low vitamin D levels and the presence of NAFLD (10,11). However, we have not identified any previous cohort studies that have investigated the role of vitamin D levels in the development of incident NAFLD, or in the resolution of NAFLD.

The present study aimed to evaluate the association between repeated measurements of serum 25(OH)D levels and both the risk of incident NAFLD and the resolution of pre-existing NAFLD.

METHODS

Study participants

The present study was conducted as part of the Kangbuk Samsung Health Study which is a cohort study of Korean men and women aged ≥18 years who underwent comprehensive

annual or biennial examinations at Kangbuk Samsung Hospital Total Healthcare Center in Seoul and Suwon, South Korea, as previously described. The present cohort study included participants who underwent a comprehensive health examination including serum vitamin D levels between January 2011 and December 2018 and had at least one follow-up visit before 31 December 2019 (n = 251,687)

A total of 112,088 subjects were excluded based on the following criteria shown in **Figure 1**. Exclusion criteria included: excessive alcohol consumption, liver steatogenic medication, medication for hepatitis, history of hepatitis, serologic positivity for hepatitis B virus and hepatitis C virus, liver cirrhosis based on ultrasound, history of cancer, and missing information on alcohol consumption, fatty liver, or serum 25(OH)D levels. Some participants satisfied more than one exclusion criterion, and a total of 139,599 participants with no NAFLD were included in the NAFLD-free cohort, and 48,702 participants with NAFLD were included in the NAFLD cohort. In the analyses regarding the association of 25(OH)D level changes with the risk of incident NAFLD, and with the resolution of existing NAFLD, those who had an initial baseline and subsequent visit and who did not have at least one follow-up visit were further excluded (in addition to the aforementioned exclusion criteria). In addition, subjects with missing data on 25(OH)D, as well as subjects who were diagnosed with NAFLD (for assessing incident NAFLD) and who had NAFLD resolution (for assessing NAFLD resolution) on the second visit were also excluded.

The study was approved by the institutional review board of Kangbuk Samsung Hospital (IRB No. KBSMC 2021-08-045), which waived the requirement for informed consent since de-identified retrospective data from routine health screening were used.

Measurement

Standardized, self-administered questionnaires, diet, physical measurements,

abdominal ultrasonography, and serum biochemical measurements were collected at each visit as part of the basic health check-up program (12,13). The current average alcohol consumption per day was assessed using the frequency of alcohol consumption per week and the amount of alcohol consumed per drinking day. Physical activity levels were assessed using the validated Korean version of the International Physical Activity Questionnaire Short Form (14). Physical activity levels were classified into three categories: inactive, minimally active, and health-enhancing physical activity (HEPA). HEPA was defined as follows: (1) vigorous activity ≥3 days/week with ≥1,500 accumulated metabolic equivalent (MET)-min/week, or (2) a combination of walking, moderate, or vigorous-intensity activities for seven days and accumulating ≥3,000 MET-min/week (14).

Sitting blood pressure (BP), height, weight, and waist circumference were measured by trained nurses. Obesity was defined as a body mass index (BMI) ≥ 25 kg/m^2, the proposed cut-off for the diagnosis of obesity in Asians (15). Hypertension was defined as a systolic BP ≥140 mmHg, diastolic BP ≥90 mmHg, or current use of antihypertensive medications.

Blood and urine specimens were collected after at least 10 h of fasting. Fasting blood sample measurements included: total cholesterol, low-density lipoprotein cholesterol, high-density lipoprotein cholesterol, triglycerides, aspartate aminotransferase (AST), alanine aminotransferase (ALT), gamma-glutamyl transferase (GGT), glucose, hs-CRP, albumin, and platelet count. The serum total cholesterol and triglyceride concentrations were determined using an enzymatic colorimetric assay. High-density lipoprotein and low-density lipoprotein cholesterol levels were directly measured using a homogenous enzymatic colorimetric assay. AST, ALT, and GGT were measured using the modified IFCC method, and serum fasting glucose levels were measured using the hexokinase method on Modular DPP systems (Roche Diagnostics, Tokyo, Japan) until 2015, and the Cobas 8000 c702 (Roche Diagnostics) thereafter. Hemoglobin A1c levels were determined using a turbidimetric inhibition immunoassay on the

Cobas Integra 800 (Roche Diagnostics) until January 2018 and the Cobas 8000 c513 (Roche Diagnostics) thereafter (RRID: AB_2909460 and AB_2909459). Serum insulin levels were measured using an electrochemiluminescence immunoassay with the sandwich principle on the Modular E170 (Roche Diagnostics, Tokyo, Japan) until April 2015, and the Cobas 8000 e801 (Roche Diagnostics) thereafter (RRID: AB_2756877 and AB_2909455). The homeostatic model assessment of insulin resistance (HOMA-IR) index was calculated as follows: fasting blood insulin (mU/mL) × fasting blood glucose (mmol/L)/22.5.

Total 25(OH)D measurement using the Elecsys Vitamin D Total assay demonstrated acceptable performance compared to using liquid chromatography-tandem mass spectrometry, the reference standard for 25(OH)D measurement (16-19). When the analytical performance for precision was evaluated according to CLSI-EP15-A2 guidelines (20), the inter-assay coefficients of variation for quality control specimens of lower and higher levels of total 25(OH)D were 2.01-5.94% and 2.69%-5.03%, respectively, during the study period. The detection limit was determined according to the CLSI EP17-A2 guidelines (21) and was reported to be <3 ng/mL.

To assess serum 25(OH)D status, total 25(OH)D levels, including $25(OH)D_2$ and $25(OH)D_3$, were measured with a competitive immunoassay using an Elecsys Vitamin D Total assay on the Modular E170 (Roche Diagnostics, Tokyo, Japan) until April 2015 and Cobas e801 (Roche Diagnostics) thereafter (18). (RRID: AB_2909604 and AB_2909456)

Serum 25(OH)D levels were categorized as <10, 10-<20, 20-<30, and ≥30 ng/mL (For conversion to SI units: ng/mL×2.5=nmol/L; e.g., <25, 25-<50, 50-<75, and ≥75 nmol/L) (22). Vitamin D insufficiency is defined as serum 25(OH)D level <20 ng/mL; serum 25(OH)D levels ≥20 ng/mL were considered vitamin D sufficient, according to the recommendation for the healthy general population (23-27). The change in 25(OH)D status from baseline to the second visit was analyzed in the following four groups based on the presence/absence of insufficient

serum 25(OH)D (defined as serum 25(OH)D level <20 ng/mL [50 nmol/l]): a) insufficient 25(OH)D level at baseline and follow-up (persistently low); b) insufficient 25(OH)D level at baseline but no insufficiency at follow-up (increased); c) no insufficiency at baseline but insufficiency at follow-up (decreased); and d) no 25(OH)D insufficiency at baseline and also follow-up (persistently adequate).

Diagnosis of hepatic steatosis

Diagnosis of fatty liver was made based on an abdominal ultrasound performed by an experienced radiologist using standard criteria, including a diffuse increase in fine echoes in the liver parenchyma in comparison with the kidney or spleen, deep beam attenuation, and bright vessel walls (28). NAFLD was defined as the presence of mild to severe fatty liver in the absence of excessive alcohol use (<20 and <30 g/day for women and men, respectively) or any other identifiable cause (29). The inter-observer and intra-observer reliability values for hepatic steatosis diagnosis were substantial (kappa statistic of 0.74) and excellent (kappa statistic of 0.94), respectively (13). The severity of hepatic steatosis was also recorded as mild, moderate, or severe steatosis on sonography.

Statistical analyses

Descriptive statistics were used to summarise the participants' characteristics according to 25(OH)D levels as follows: <10, 10–19, 20–29 and ≥30 ng/mL (<25, 25–50, 50–75, and ≥75 nmol/L) based on categories of 25(OH)D levels with adequate levels defined as ≥20 ng/mL (≥50 nmol/L) (22,30). To describe potential linear trends in NAFLD incidence, the four categories were treated as a continuous variable in regression models.

We examined the association between serum 25(OH)D levels and the development and resolution of NAFLD. The primary endpoints were a) the development of NAFLD and b)

NAFLD resolution. The follow-up duration for each participant extended from the baseline examination until the development of the endpoint or the last health examination conducted prior to 31 December 2019; whichever came first. Incidence rates were calculated as the number of incident cases divided by person-years of follow-up. Cox proportional hazard models were used to estimate the hazard ratios (HRs) with 95% confidence intervals (CIs) for the development of incident NAFLD, or resolution of existing NAFLD. We initially adjusted for age and sex. Model 1 was further adjusted for the study center (Seoul, Suwon), year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, and BMI. Model 2 was further adjusted for medications for hyperlipidemia, medications for diabetes, multi-vitamin supplements, 25(OH)D supplements, and calcium supplements. To evaluate the effects of changes in serum 25(OH)D levels and other covariates during the follow-up period, we performed additional analyses by introducing serum 25(OH)D levels, season, BMI, and other factors as time-varying covariates in the models. For each analysis, we further adjusted for HOMA-IR, glucose, and waist circumference, in addition to the variables considered in model 2, and tested the effects of serum 25(OH)D and its change on incident NAFLD or resolution of existing NAFLD. The proportional hazards assumption was assessed via estimated log (-log) survival curves, and no violation of the assumption was found.

To assess the relationship between the serum 25(OH)D as a continuous variable and NAFLD risk, we modelled the serum 25(OH)D as restricted cubic splines with knots at the 5^{th}, 35^{th}, 65^{th}, and 95^{th} percentiles of the sample distribution to provide a flexible estimate of the concentration-response relationship between the serum 25(OH)D concentration and incident NAFLD. Models were adjusted for age, sex, center, year of screening exam, alcohol consumption, smoking, physical activity, total energy intake, education level, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D

supplements, calcium supplements, season, and BMI.

Statistical analyses were performed using STATA version 16.0 (StataCorp LP, College Station, TX, USA). Statistical significance was set at $P < 0.05$.

RESULTS

The baseline characteristics of the study participants are presented according to 25(OH)D levels at baseline and subsequent visits (**Table 1, eTables 1–3)** (31). The mean (SD) age of the subjects was 36.8 (7.3) years. The 25(OH)D levels were positively associated with age, alcohol intake, HEPA, education level, medication use for hyperlipidemia, use of multi-vitamin supplements, vitamin D supplements, calcium supplements, BP, total cholesterol, and ALT (**Table 1**). The baseline characteristics of participants according to NAFLD status are described in **eTables 4** and **5** (31). Compared to those who did not develop NAFLD, those who developed NAFLD were older, more likely to be male, alcohol drinkers, current smokers, obese, have a history of diabetes, hypertension, or CVD, receive glucose-lowering medication or hyperlipidemia medication, and take multi-vitamin supplements; these individuals also had higher BP, total cholesterol, glucose, GGT, ALT, HOMA-IR, and total energy intake (**eTable 4)** (31).

Compared to those with no NAFLD resolution, individuals with NAFLD resolution were more likely to be: older, female, alcohol drinkers, regular exercisers, have higher education levels, take multi-vitamin supplements, and have a higher total energy intake (**eTable 5**) (31).

Table 2 shows the risk of NAFLD development according to 25(OH)D levels among the cohort of people without NAFLD at baseline (n=139,599). Within 581,021 person-years of follow-up (median, 4.1 years; interquartile range, 2.1–6.0 years), 48,702 subjects developed NAFLD (incidence rate, 45.9 per 1,000 person-years). The median (interquartile range) follow-

up frequencies for the NAFLD-free and NAFLD cohorts were 4 visits (3-5) and 4 visits (3-6), respectively. Overall, baseline 25(OH)D levels were inversely associated with the risk of incident NAFLD. After adjusting for age, sex, center, year of screening exam, alcohol consumption, smoking, physical activity, total energy intake, education level, and BMI (Model 1), the HRs (95% CI) for incident NAFLD at baseline 25(OH)D levels of 10–<20, 20–<30, and ≥30 ng/mL compared to <10 ng/mL (reference group) were 0.91 (0.88–0.94), 0.85 (0.81–0.88) and 0.75 (0.70–0.81), respectively. The associations remained significant when the model was further adjusted for medications for hyperlipidemia, medications for diabetes, multi-vitamin supplements, vitamin D supplements, and calcium supplements (Model 2), as well as when 25(OH)D levels, BMI and other potential confounders were treated as time-varying covariates. After further adjustment for glucose and HOMA-IR (**eTable 6**) (31) and waist circumference (**eTable 7**) (31), all associations remained statistically significant. In spline regression models, the NAFLD risk decreased across the range of the 25(OH)D levels (**Figure 2**).

Table 3 presents the association between 25(OH)D levels and resolution of NAFLD. Among 48,702 participants with NAFLD at baseline, 13,449 had resolution of NAFLD. The multivariable-adjusted HRs (95% CI) in subjects with 25(OH)D levels of 10–<20, 20–<30, and ≥30 ng/mL for NAFLD resolution were 1.09 (1.03–1.15), 1.13 (1.06–1.21), and 1.21 (1.09–1.35), respectively, as compared with the reference group (Model 2). All associations were similar after further adjustment for glucose and HOMA-IR (**eTable 6**) (31) and waist circumference (**eTable 7**) (31) as well as when 25(OH)D levels, BMI and other potential confounders were treated as time-varying covariates. When participants were stratified by vitamin D supplement use status, we found significant associations between higher serum 25(OH)D and NAFLD resolution only in vitamin D supplement non-users, whereas the associations were non-significant among vitamin D supplement users (**eTable 8**) (31).

The associations of the changes in 25(OH)D levels from baseline to the second visit

with the risk of incident NAFLD are presented in **Table 4**. The mean interval between the 1st and 2nd visits was 1.8 years (interquartile range, 1.1–2.1 years). The multivariable-adjusted HRs (95% CI) for "decreased", "increased", and "persistently adequate" groups versus "persistently low" group for NAFLD development were 0.92 (0.87–0.98), 0.87 (0.82–0.91), and 0.76 (0.76–0.85), respectively (Model 2). For the association between 25(OH)D level change with NAFLD resolution in subjects with NAFLD at baseline (**Table 5**), the multivariable-adjusted HRs (95% CI) for "decreased", "increased", and "persistently adequate" 25(OH)D groups versus the "persistently low" group for NAFLD development were 0.97 (0.88–1.07), 1.02 (0.94–1.11), and 1.10 (1.01–1.19), respectively. All associations remained materially unchanged after further adjustment for glucose and HOMA-IR (**eTable 9**) (31) and waist circumference (**eTable 10**) (31). In the analysis of the effect of the changes in 25(OH)D levels on NAFLD resolution by vitamin D supplement use status, persistently adequate serum 25(OH)D levels were significantly associated with NAFLD resolution only in the supplement non-users (**eTable 11**) (31).

We also performed subgroup analyses stratified by glucose-lowering medication status (no medication usage vs. medication usage) and assessed the association between serum 25(OH)D levels and both NAFLD development and resolution. In this analysis, we found a similar inverse association between 25(OH)D levels and incident NAFLD, and a significant positive association with NAFLD resolution in the "no medication use" group; the trends of these associations remained similar in the "medication use" group, and no significant differences were found between the two groups ($P = 0.674$ for incident NAFLD; $P = 0.152$ for NAFLD resolution) (**eTable 12**) (31). Similarly, the trends of associations observed in the original analyses were mostly retained for both groups when the effects of 25(OH)D changes were assessed, with no significant differences between the groups ($P = 0.944$ for incident NAFLD; $P = 0.490$ for NAFLD resolution) (**eTable 13**) (31).

In analyses after further exclusion of individuals with abnormally high ALT levels (ALT > 35 IU/L (32,33), as the upper limit of normal is usually regarded as 35 IU/L), the main results were similar, showing a significant decrease in the risk of incident NAFLD and an increase in NAFLD resolution with increasing 25(OH)D levels (**eTable 14**) (31). Consistent trends were observed when we assessed the changes in 25(OH)D levels (**eTable 15**) (31). In addition, when the outcome was defined as high ALT level instead of an ultrasonographic diagnosis of NAFLD, the trends were similar, showing decreased risks of high ALT and increased resolution of high ALT with increasing categories of 25(OH)D levels (**eTable 16**) (31). Regarding the changes in 25(OH)D levels, persistently adequate serum 25(OH)D levels were associated with a significantly lower risk of elevated ALT; no significant associations were found between the changes in serum 25(OH)D levels and high ALT (**eTable 17**) (31).

DISCUSSION

In this large cohort study of 139,599 individuals without NAFLD at baseline, serum 25(OH)D levels were inversely associated with the development of NAFLD, while in those with NAFLD at baseline, serum 25(OH)D levels were positively associated with the resolution of NAFLD in a dose-response manner. Importantly, an increase in 25(OH)D from an insufficient level (<20 ng/mL) at baseline to adequate levels (≥20 ng/mL) at subsequent visits; as well as persistently adequate levels of 25(OH)D at both visits, were both associated with a decreased risk of incident NAFLD. In addition, persistently adequate levels of ≥20 ng/mL were also associated with the resolution of NAFLD in subjects with pre-existing NAFLD at baseline. Our study results suggest that maintaining sufficient serum 25(OH)D levels may be an effective approach to both primary and secondary prevention of NAFLD; a strategy that could be easily achieved by the use of supplements (or potentially also by increased sun exposure).

The protective or causative role of vitamin D in the risk of NAFLD has been highly

controversial with conflicting results. It is relatively well established that vitamin D deficiency is prevalent among patients with NAFLD (6,10,34). A recent meta-analysis suggested that low serum vitamin D levels might play a role in NAFLD pathogenesis (11). Although data on the potential effect of vitamin D to prevent NAFLD are scarce, in a recent cross-sectional study, higher levels of serum vitamin D were associated with a decreased prevalence of controlled attenuation parameter-defined NAFLD, compared to low levels of serum vitamin D (35). However, not only are existing studies limited by small sample sizes and a cross-sectional study design, but there is also considerable heterogeneity between existing studies with respect to the prevalence of comorbidities. Our study, the largest cohort study to date, supports the idea that higher serum 25(OH)D levels are prospectively associated with a reduced risk of incident NAFLD in relatively healthy young adults whose mean age was 36.8 years (interquartile range, 31.3-40.5 years), with a much lower prevalence of comorbid conditions than in previous studies. Although outdoor activities and sunlight exposure were not specifically measured in our study, our population predominantly consisted of urban office workers who were likely to spend most of the daytime indoors and whose sun exposure was likely to be particularly insufficient even in the summer (36-38). Moreover, the association of serum 25(OH)D with the risk of NAFLD was not significantly altered and remained significant when we accounted for other, possibly more relevant, factors, such as BMI, physical activity, vitamin D, or calcium supplementation, season during the venesection, and the changing status of 25(OH)D. However, owing to the observational nature of our study, we were not able to establish causality, though our study findings align with a recent Mendelian randomization study of three populations of European descent that reported a significant inverse correlation between genetically predicted serum 25(OH)D levels and NAFLD (39).

We also observed that higher serum 25(OH)D concentration was associated with resolution of NAFLD in people with pre-existing NAFLD at baseline; and to date, there have

been no comparable studies. Several clinical trials have examined the benefits of vitamin D supplementation in individuals with NAFLD, with conflicting results (40-45). These studies are mostly small clinical trials with a short follow-up duration ranging from 4 to 48 weeks. Also, due to the limitations such as heterogeneity of NAFLD at diagnosis, the presence of comorbidities, and the use of biochemical parameters to define NAFLD, such as liver enzyme levels, with sub-optimal specificity and sensitivity, it is difficult to draw a conclusion from these findings (46,47). Large statistical power and longer duration of follow-up in our study allowed us to account for potential confounders and observe the incidence and resolution of hepatic steatosis, and these data suggest potential temporality of the association between 25(OH)D status and NAFLD. Although there remains a possibility of residual confounding due to the observational nature of our study, based on our findings, we suggest that vitamin D may confer therapeutic benefits for those with established NAFLD. Thus, we suggest that our study results highlight that further longer-term studies are still needed to confirm (or refute) whether there are causal associations between serum 25(OH)D levels and NAFLD.

In the present study, both groups of participants whose serum 25(OH)D levels increased from low to adequate levels and those with persistently adequate 25(OH)D levels over time showed a reduced risk of NAFLD development compared to the group with persistently low levels. As many of the previous clinical trials examining the effects of vitamin D did not assess vitamin D levels by repeat measurements (48), the effect of the changes in vitamin D status on NAFLD risk has been uncertain. A strength of our study is that we incorporated the changes in serum measurements of vitamin D status based on repeated measurements at each follow-up visit. Another important consideration is that a substantial proportion (approximately 77%) of our study cohort had sub-optimal 25(OH)D levels (<20 ng/mL) at baseline. This proportion is markedly higher than the prevalence range of 24%–40% in the US and European countries (48). That said, the prevalence of sub-optimal 25(OH)D

levels in our cohort is similar to the nationwide prevalence of suboptimal 25(OH)D levels, reported from the Korea National Health and Nutrition Examination Survey (38,49). The reason for the disparity might be a substantially higher number of indoor office workers or differences in nutrition or patterns of supplement use with respect to other populations. This is likely to be clinically relevant since it underlines the benefit of improving 25(OH)D status in the prevention of NAFLD in a population with a high prevalence of 25(OH)D deficiency. We also observed that people with persistently adequate serum 25(OH)D levels were more likely to experience resolution of NAFLD than those with persistently low levels, whereas those in the "increased group" who had insufficient 25(OH)D levels at baseline but no insufficiency at follow-up, did not. The implication of this observation is not clear, but a previous meta-analysis of randomized-controlled trials has suggested that sufficient duration of vitamin D supplementation is essential in achieving vitamin D levels that can have therapeutic effects on NAFLD (50). Based on our study results, it may be speculated that having an adequate level of serum 25(OH)D, even within a low-normal range, at any point in time may be beneficial in protecting against incident NAFLD, but maintaining the levels for a prolonged duration of time would be needed in order to reverse the disease course in patients with pre-existing NAFLD. Further large-scale observational and interventional studies are warranted to confirm our findings.

The mechanisms by which serum 25(OH)D exerts benefits in NAFLD are not fully understood. Numerous studies have suggested that a pivotal pathway whereby vitamin D improves liver parameters, involves the resolution of insulin resistance and reduction in blood glucose levels (45,51). However, in our study, the associations between 25(OH)D levels and NAFLD were not fully attenuated by adjustment for glucose or insulin resistance. An alternative explanation may involve the anti-inflammatory and immunomodulatory properties of 25(OH)D. In pre-clinical studies in rats, low 25(OH)D levels led to the exacerbation of

hepatic steatosis and lobular inflammation (52). Low serum 25(OH)D levels are implicated in upregulating the hepatic inflammatory response via the effects of adipocytokines, such as adiponectin, leptin, and resistin; which can directly affect the pathogenesis of NAFLD (53). Low serum 25(OH)D levels may also activate the Toll-like receptor signaling pathway as well as downstream inflammatory signaling molecules, subsequently leading to the accumulation of hepatic fat (52). Importantly, it has been reported that activation of vitamin D receptors in liver macrophages by vitamin D ligands ameliorated liver inflammation as well as hepatic steatosis in a mouse model, which may partly explain the resolution of NAFLD (54). Further studies are required to elucidate the mechanisms involved in the benefits of vitamin D in NAFLD pathophysiology.

Several limitations of our study must be considered. First, ultrasonography was used instead of liver biopsy and histology, which is still the reference standard for the diagnosis of NAFLD. However, the use of liver ultrasound to diagnose liver fat is an accepted proxy in large epidemiological studies, and the use of liver biopsy was not feasible or ethically acceptable in the routine health screening setting involving repeat measurements in our cohort study. Second, although we had information on the use of vitamin D or multivitamin supplements, we did not have detailed information on dose, type, frequency of supplementation, outdoor activities, or sunlight exposure, and therefore, the potential for residual confounding remains. Nevertheless, we directly measured serum 25(OH)D levels, which are considered to reflect the overall vitamin D status in the body and the cumulative effect of sunlight exposure and dietary intake of vitamin D. Third, our study participants mainly represent a relatively young and healthy Korean working population. Although this could be perceived as a limitation, it also represents a strength of our study, since relatively few study participants had existing comorbidities that are known to be associated with low levels of serum 25(OH)D. Fourth, detailed information on glucose-lowering medications, such as specific types of medication and their treatment duration,

was not collected. Finally, the generalizability of our findings to other populations with different sociodemographic characteristics and other ethnic groups is limited. The body's capacity to synthesize vitamin D, vitamin D status, and even optimal vitamin D levels may differ across different ethnicities. In addition, genetic polymorphisms, dietary and sociocultural factors, and geographic locations can also influence vitamin D status (55-57). Future investigations should focus on extending our findings to large populations comprising different ethnicities in diverse geographical locations.

Our study has several notable strengths. The longitudinal, prospective design enabled us to examine temporal associations of serum 25(OH)D status and changes in 25(OH)D levels with the risk of incident NAFLD and NAFLD resolution. In addition, we were able to control for the effects of changes with different covariates during follow-up in our time-dependent model in which 25(OH)D levels and other covariates were treated as time-dependent variables. Also, the large sample size, the use of carefully standardized clinical, imaging, and laboratory procedures, the inclusion of lifestyle factors, and repeated measurements allowed us to account for possible confounders such as supplementation use in investigating the associations between change in vitamin D status and both incident NAFLD and resolution of NAFLD.

In conclusion, in this large cohort study, we demonstrated that serum 25(OH)D levels were inversely associated with the risk of incident NAFLD and were positively associated with NAFLD resolution. In addition, maintaining sufficient serum levels of 25(OH)D, even at a low-normal range, had favorable effects not only in prevention but also in the resolution of NAFLD. With the recent prevalence of vitamin D deficiency occurring in parallel with the rising incidence of NAFLD, our findings highlight that improved serum 25(OH)D levels may be beneficial in NAFLD prevention and treatment. These data also emphasize that better-designed, longer term, vitamin D intervention trials are required, in order to prove unequivocally whether inexpensive vitamin D supplements are beneficial in the primary and secondary prevention of

NAFLD, in patients with low levels of vitamin D.

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Data availability statement: The data will not be made available to other researchers for purposes of reproducing the results. However, analytical methods are available from corresponding author on reasonable request.

REFERENCES

1. Byrne CD, Targher G. NAFLD: a multisystem disease. *J Hepatol*. 2015;62(1 Suppl):S47-64.
2. Armstrong MJ, Adams LA, Canbay A, Syn WK. Extrahepatic complications of nonalcoholic fatty liver disease. *Hepatology*. 2014;59(3):1174-1197.
3. Thoma C, Day CP, Trenell MI. Lifestyle interventions for the treatment of non-alcoholic fatty liver disease in adults: a systematic review. *J Hepatol*. 2012;56(1):255-266.
4. Strange RC, Shipman KE, Ramachandran S. Metabolic syndrome: A review of the role of vitamin D in mediating susceptibility and outcome. *World J Diabetes*. 2015;6(7):896-911.
5. El Mokadem M, Boshra H, Abd El Hady Y, Abd El Hameed AS. Relationship of serum vitamin D deficiency with coronary artery disease severity using multislice CT coronary angiography. *Clin Investig Arterioscler*. 2021.
6. Nelson JE, Roth CL, Wilson LA, Yates KP, Aouizerat B, Morgan-Stevenson V, Whalen E, Hoofnagle A, Mason M, Gersuk V, Yeh MM, Kowdley KV. Vitamin D Deficiency Is Associated With Increased Risk of Non-alcoholic Steatohepatitis in Adults With Non-alcoholic Fatty Liver Disease: Possible Role for MAPK and NF-kappaB? *Am J Gastroenterol*. 2016;111(6):852-863.
7. Zhang Y, Jiang X, Li X, Gaman MA, Kord-Varkaneh H, Rahmani J, Salehi-Sahlabadi A, Day AS, Xu Y. Serum Vitamin D Levels and Risk of Liver Cancer: A Systematic Review and Dose-Response Meta-Analysis of Cohort Studies. *Nutr Cancer*. 2020:1-9.
8. Kitson MT, Roberts SK. D-livering the message: the importance of vitamin D status in chronic liver disease. *J Hepatol*. 2012;57(4):897-909.
9. Heath AK, Kim IY, Hodge AM, English DR, Muller DC. Vitamin D Status and Mortality: A Systematic Review of Observational Studies. *Int J Environ Res Public Health*. 2019;16(3).

10. Eliades M, Spyrou E, Agrawal N, Lazo M, Brancati FL, Potter JJ, Koteish AA, Clark JM, Guallar E, Hernaez R. Meta-analysis: vitamin D and non-alcoholic fatty liver disease. *Aliment Pharmacol Ther*. 2013;38(3):246-254.

11. Liu T, Xu L, Chen FH, Zhou YB. Association of serum vitamin D level and nonalcoholic fatty liver disease: a meta-analysis. *Eur J Gastroenterol Hepatol*. 2020;32(2):140-147.

12. Chang Y, Jung HS, Cho J, Zhang Y, Yun KE, Lazo M, Pastor-Barriuso R, Ahn J, Kim CW, Rampal S, Cainzos-Achirica M, Zhao D, Chung EC, Shin H, Guallar E, Ryu S. Metabolically Healthy Obesity and the Development of Nonalcoholic Fatty Liver Disease. *Am J Gastroenterol*. 2016;111(8):1133-1140.

13. Chang Y, Ryu S, Sung KC, Cho YK, Sung E, Kim HN, Jung HS, Yun KE, Ahn J, Shin H, Wild SH, Byrne CD. Alcoholic and non-alcoholic fatty liver disease and associations with coronary artery calcification: evidence from the Kangbuk Samsung Health Study. *Gut*. 2019;68(9):1667-1675.

14. Craig CL, Marshall AL, Sjostrom M, Bauman AE, Booth ML, Ainsworth BE, Pratt M, Ekelund U, Yngve A, Sallis JF, Oja P. International physical activity questionnaire: 12-country reliability and validity. *Medicine and science in sports and exercise*. 2003;35(8):1381-1395.

15. WHO Western Pacific Region, IASO and IOTF. The Asia-Pacific Perspective: Redefining Obesity and Its Treatment. Health Communications Australia Pty Limit: Sdyney, Australia. 2000.

16. Elsenberg E, Ten Boekel E, Huijgen H, Heijboer AC. Standardization of automated 25-hydroxyvitamin D assays: How successful is it? *Clin Biochem*. 2017;50(18):1126-1130.

17. Heijboer AC, Blankenstein MA, Kema IP, Buijs MM. Accuracy of 6 routine 25-hydroxyvitamin D assays: influence of vitamin D binding protein concentration. *Clin*

Chem. 2012;58(3):543-548.

18. Shin SY, Kwon MJ, Song J, Park H, Woo HY. Measurement of serum total vitamin D (25-OH) using automated immunoassay in comparison [corrected] with liquid chromatography tandem-mass spectrometry. *J Clin Lab Anal*. 2013;27(4):284-289.

19. Freeman J, Wilson K, Spears R, Shalhoub V, Sibley P. Performance evaluation of four 25-hydroxyvitamin D assays to measure 25-hydroxyvitamin D2. *Clin Biochem*. 2015;48(16-17):1097-1104.

20. Clinical and Laboratory Standards Institute. EP15-A2: User Verification of Performance for Precision and Trueness; Approved guideline. 2nd ed. Wayne, PA: Clinical and Laboratory Standards Institute.

21. Clinical and Laboratory Standards Institute. EP17-A2: Evaluation of detection capability for clinical laboratory measurement procedures; Approved guideline. 2nd ed. Wayne, PA: Clinical and Laboratory Standards Institute.

22. In: Ross AC, Taylor CL, Yaktine AL, Del Valle HB, eds. Dietary Reference Intakes for Calcium and Vitamin D. Washington (DC)2011.

23. Stokes CS, Lammert F, Volmer DA. Analytical Methods for Quantification of Vitamin D and Implications for Research and Clinical Practice. *Anticancer Res*. 2018;38(2):1137-1144.

24. Ross AC, Taylor CL, Yaktine AL, Del Valle HB. Committee to review dietary reference intakes for vitamin D and calcium. *Food and Nutrition Board*. 2011.

25. Giustina A, Adler RA, Binkley N, Bouillon R, Ebeling PR, Lazaretti-Castro M, Marcocci C, Rizzoli R, Sempos CT, Bilezikian JP. Controversies in Vitamin D: Summary Statement From an International Conference. *J Clin Endocrinol Metab*. 2019;104(2):234-240.

26. Slomski A. IOM endorses vitamin D, calcium only for bone health, dispels deficiency

claims. *JAMA*. 2011;305(5):453-454, 456.

27. Munns CF, Shaw N, Kiely M, Specker BL, Thacher TD, Ozono K, Michigami T, Tiosano D, Mughal MZ, Mäkitie O, Ramos-Abad L, Ward L, DiMeglio LA, Atapattu N, Cassinelli H, Braegger C, Pettifor JM, Seth A, Idris HW, Bhatia V, Fu J, Goldberg G, Sävendahl L, Khadgawat R, Pludowski P, Maddock J, Hyppönen E, Oduwole A, Frew E, Aguiar M, Tulchinsky T, Butler G, Högler W. Global Consensus Recommendations on Prevention and Management of Nutritional Rickets. *J Clin Endocrinol Metab*. 2016;101(2):394-415.

28. Mathiesen UL, Franzen LE, Aselius H, Resjo M, Jacobsson L, Foberg U, Fryden A, Bodemar G. Increased liver echogenicity at ultrasound examination reflects degree of steatosis but not of fibrosis in asymptomatic patients with mild/moderate abnormalities of liver transaminases. *Dig Liver Dis*. 2002;34(7):516-522.

29. Chalasani N, Younossi Z, Lavine JE, Diehl AM, Brunt EM, Cusi K, Charlton M, Sanyal AJ. The diagnosis and management of non-alcoholic fatty liver disease: practice Guideline by the American Association for the Study of Liver Diseases, American College of Gastroenterology, and the American Gastroenterological Association. *Hepatology*. 2012;55(6):2005-2023.

30. Cashman KD. Vitamin D Deficiency: Defining, Prevalence, Causes, and Strategies of Addressing. *Calcif Tissue Int*. 2020;106(1):14-29.

31. Kim Y, Chang Y, Ryu S, Cho IY, Kwon M-J, Sohn W, Kim M-K, Wild S, Byrne C. Supplementary Material (Resolution of, and risk of incident non-alcoholic fatty liver disease with changes in serum 25-hydroxy vitamin D status). Figshare repository. 2022. http://doi.org/10.6084/m9.figshare.19500359.v1.

32. Chang Y, Ryu S, Sung E, Jang Y. Higher concentrations of alanine aminotransferase within the reference interval predict nonalcoholic fatty liver disease. *Clin Chem*.

2007;53(4):686-692.

33. Chang Y, Ryu S, Sung E, Woo HY, Cho SI, Yoo SH, Ahn HY, Choi NK. Weight gain within the normal weight range predicts ultrasonographically detected fatty liver in healthy Korean men. *Gut*. 2009;58(10):1419-1425.

34. Wang X, Li W, Zhang Y, Yang Y, Qin G. Association between vitamin D and non-alcoholic fatty liver disease/non-alcoholic steatohepatitis: results from a meta-analysis. *Int J Clin Exp Med*. 2015;8(10):17221-17234.

35. Heo NJ, Park HE, Yoon JW, Kwak MS, Yang JI, Chung SJ, Yim JY, Chung GE. The Association between Vitamin D and Nonalcoholic Fatty Liver Disease Assessed by Controlled Attenuation Parameter. *J Clin Med*. 2021;10(12).

36. Cinar N, Harmanci A, Yildiz BO, Bayraktar M. Vitamin D status and seasonal changes in plasma concentrations of 25-hydroxyvitamin D in office workers in Ankara, Turkey. *Eur J Intern Med*. 2014;25(2):197-201.

37. Jeong H, Hong S, Heo Y, Chun H, Kim D, Park J, Kang MY. Vitamin D status and associated occupational factors in Korean wage workers: data from the 5th Korea national health and nutrition examination survey (KNHANES 2010-2012). *Ann Occup Environ Med*. 2014;26:28.

38. Park JH, Hong IY, Chung JW, Choi HS. Vitamin D status in South Korean population: Seven-year trend from the KNHANES. *Medicine (Baltimore)*. 2018;97(26):e11032.

39. Yuan S, Larsson SC. Inverse Association Between Serum 25-Hydroxyvitamin D and Nonalcoholic Fatty Liver Disease. *Clin Gastroenterol Hepatol*. 2022.

40. Barchetta I, Del Ben M, Angelico F, Di Martino M, Fraioli A, La Torre G, Saulle R, Perri L, Morini S, Tiberti C, Bertoccini L, Cimini FA, Panimolle F, Catalano C, Baroni MG, Cavallo MG. No effects of oral vitamin D supplementation on non-alcoholic fatty liver disease in patients with type 2 diabetes: a randomized, double-blind, placebo-

controlled trial. *BMC Med*. 2016;14:92.

41. Dabbaghmanesh MH, Danafar F, Eshraghian A, Omrani GR. Vitamin D supplementation for the treatment of non-alcoholic fatty liver disease: A randomized double blind placebo controlled trial. *Diabetes Metab Syndr*. 2018;12(4):513-517.

42. Geier A, Eichinger M, Stirnimann G, Semela D, Tay F, Seifert B, Tschopp O, Bantel H, Jahn D, Marques Maggio E, Saleh L, Bischoff-Ferrari HA, Mullhaupt B, Dufour JF. Treatment of non-alcoholic steatohepatitis patients with vitamin D: a double-blinded, randomized, placebo-controlled pilot study. *Scand J Gastroenterol*. 2018;53(9):1114-1120.

43. Lorvand Amiri H, Agah S, Mousavi SN, Hosseini AF, Shidfar F. Regression of Non-Alcoholic Fatty Liver by Vitamin D Supplement: A Double-Blind Randomized Controlled Clinical Trial. *Arch Iran Med*. 2016;19(9):631-638.

44. Sharifi N, Amani R, Hajiani E, Cheraghian B. Does vitamin D improve liver enzymes, oxidative stress, and inflammatory biomarkers in adults with non-alcoholic fatty liver disease? A randomized clinical trial. *Endocrine*. 2014;47(1):70-80.

45. Barchetta I, Cimini FA, Cavallo MG. Vitamin D and Metabolic Dysfunction-Associated Fatty Liver Disease (MAFLD): An Update. *Nutrients*. 2020;12(11).

46. Zhang Z, Thorne JL, Moore JB. Vitamin D and nonalcoholic fatty liver disease. *Curr Opin Clin Nutr Metab Care*. 2019;22(6):449-458.

47. Moore JB. From sugar to liver fat and public health: systems biology driven studies in understanding non-alcoholic fatty liver disease pathogenesis. *Proc Nutr Soc*. 2019;78(3):290-304.

48. Amrein K, Scherkl M, Hoffmann M, Neuwersch-Sommeregger S, Kostenberger M, Tmava Berisha A, Martucci G, Pilz S, Malle O. Vitamin D deficiency 2.0: an update on the current status worldwide. *Eur J Clin Nutr*. 2020;74(11):1498-1513.

49. Park HY, Lim YH, Park JB, Rhie J, Lee SJ. Environmental and Occupation Factors Associated with Vitamin D Deficiency in Korean Adults: The Korea National Health and Nutrition Examination Survey (KNHANES) 2010-2014. *Int J Environ Res Public Health*. 2020;17(24).

50. Guo XF, Wang C, Yang T, Li S, Li KL, Li D. Vitamin D and non-alcoholic fatty liver disease: a meta-analysis of randomized controlled trials. *Food Funct*. 2020;11(9):7389-7399.

51. Kitson MT, Pham A, Gordon A, Kemp W, Roberts SK. High-dose vitamin D supplementation and liver histology in NASH. *Gut*. 2016;65(4):717-718.

52. Roth CL, Elfers CT, Figlewicz DP, Melhorn SJ, Morton GJ, Hoofnagle A, Yeh MM, Nelson JE, Kowdley KV. Vitamin D deficiency in obese rats exacerbates nonalcoholic fatty liver disease and increases hepatic resistin and Toll-like receptor activation. *Hepatology*. 2012;55(4):1103-1111.

53. Kwok RM, Torres DM, Harrison SA. Vitamin D and nonalcoholic fatty liver disease (NAFLD): is it more than just an association? *Hepatology*. 2013;58(3):1166-1174.

54. Dong B, Zhou Y, Wang W, Scott J, Kim K, Sun Z, Guo Q, Lu Y, Gonzales NM, Wu H, Hartig SM, York RB, Yang F, Moore DD. Vitamin D Receptor Activation in Liver Macrophages Ameliorates Hepatic Inflammation, Steatosis, and Insulin Resistance in Mice. *Hepatology*. 2020;71(5):1559-1574.

55. Hsu S, Hoofnagle AN, Gupta DK, Gutierrez OM, Peralta CA, Shea S, Allen NB, Burke G, Michos ED, Ix JH, Siscovick D, Psaty BM, Watson KE, Kestenbaum B, de Boer IH, Robinson-Cohen C. Race, Ancestry, and Vitamin D Metabolism: The Multi-Ethnic Study of Atherosclerosis. *J Clin Endocrinol Metab*. 2020;105(12):e4337-4350.

56. Levin GP, Robinson-Cohen C, De Boer IH, Houston DK, Lohman K, Liu Y, Kritchevsky SB, Cauley JA, Tanaka T, Ferrucci L. Genetic variants and associations of

25-hydroxyvitamin D concentrations with major clinical outcomes. *Jama*. 2012;308(18):1898-1905.

57. Yeum K-J, Song BC, Joo N-S. Impact of Geographic Location on Vitamin D Status and Bone Mineral Density. *International journal of environmental research and public health*. 2016;13(2):184-184.

Figure 1. Flow chart for the selection of the study participants

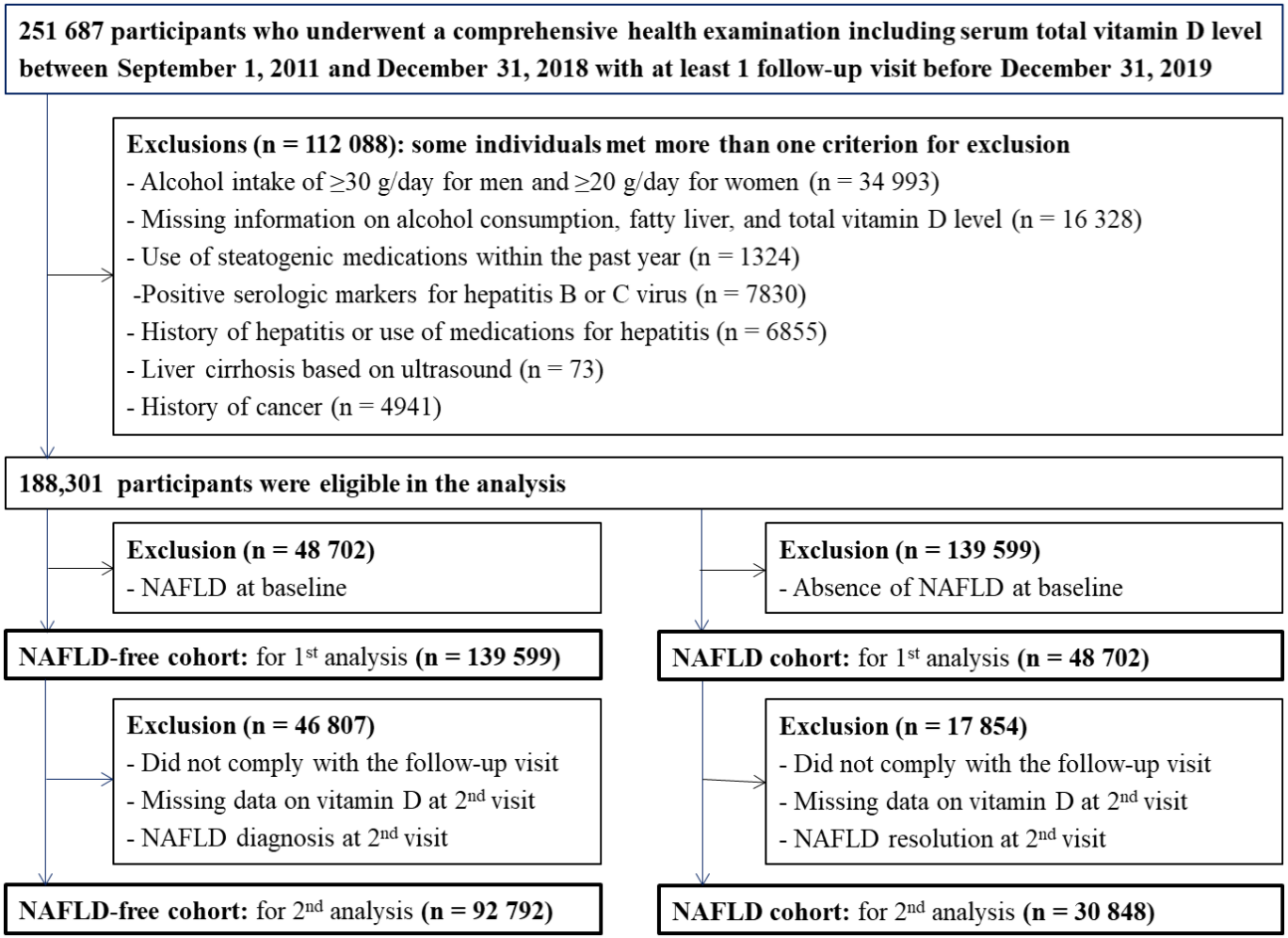

Figure 2. Multivariable-adjusted hazard ratios for NAFLD

Curves represent adjusted hazard ratios for NAFLD based on restricted cubic splines with knots at the 5th, 35th, 65th, and 95th percentiles of serum 25(OH)D distribution.

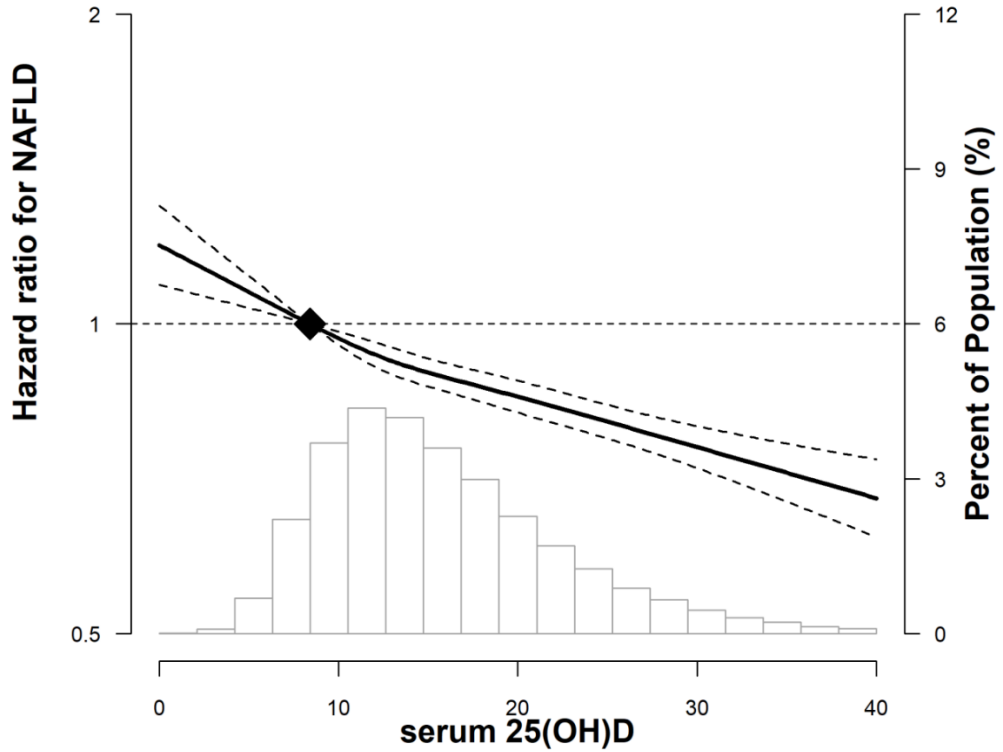

Table 1. Estimated[a] mean values (95% confidence intervals) and adjusted[a] proportion (95% confidence intervals) of baseline characteristics by baseline 25(OH)D levels among participants without NAFLD at baseline (n = 139 599)

Characteristics	Vitamin D levels (ng/mL)				*p*–trend
	<10	10-19	20-29	≥30	
Number of participants	25 975	81 269	26 348	6 007	
Age (years)	35.2 (35.2–35.3)	35.9 (35.8–35.9)	37.1 (37.0–37.2)	39.2 (39.0–39.3)	<0.001
Male (%)	23.0 (22.5–23.5)	42.3 (42.0–42.7)	53.8 (53.2–54.4)	48.0 (46.7–49.3)	<0.001
Alcohol intake (%) [b]	22.6 (22.1–23.2)	24.8 (24.5–25.1)	27.3 (26.8–27.7)	27.5 (26.4–28.5)	<0.001
Current smoker (%)	11.7 (11.2–12.2)	12.6 (12.4–12.9)	14.2 (13.9–14.6)	13.8 (13.1–14.6)	<0.001
HEPA (%)	12.3 (11.9–12.7)	14.5 (14.2–14.7)	17.3 (16.9–17.8)	19.1 (18.1–20.1)	<0.001
Education level (%) [c]	80.6 (80.1–81.1)	84.5 (84.3–84.8)	86.2 (85.7–86.6)	86.5 (85.6–87.3)	<0.001
History of diabetes (%)	0.6 (0.5–0.7)	0.7 (0.6–0.7)	0.7 (0.6–0.8)	0.7 (0.6–0.9)	<0.001
History of hypertension (%)	3.7 (3.4–3.9)	3.4 (3.3–3.5)	3.6 (3.4–3.8)	3.3 (2.9–3.6)	<0.001
History of CVD (%)	0.6 (0.5–0.7)	0.5 (0.5–0.6)	0.6 (0.5–0.7)	0.6 (0.5–0.8)	<0.001
Glucose-lowering medication (%)	0.4 (0.3–0.5)	0.4 (0.4–0.5)	0.4 (0.3–0.5)	0.4 (0.3–0.5)	0.635
Anti-lipid medication use (%)	0.9 (0.8–1.1)	1.0 (0.9–1.0)	1.0 (0.9–1.1)	1.4 (1.2–1.6)	<0.001
Multi-vitamin supplement (%)	6.7 (6.4–7.0)	11.5 (11.3–11.7)	17.9 (17.5–18.4)	22.7 (21.7–23.8)	<0.001
Vitamin D supplement (%)	0.4 (0.3–0.5)	0.9 (0.8–1.0)	2.4 (2.2–2.6)	6.3 (5.7–6.9)	<0.001
Calcium supplement (%)	0.3 (0.2–0.4)	0.7 (0.6–0.8)	1.5 (1.4–1.7)	2.9 (2.5–3.4)	<0.001
Season					
Spring	38.3 (37.7–38.9)	26.9 (26.6–27.2)	16.4 (15.9–16.8)	17.5 (16.5–18.4)	<0.001
Summer	22.1 (21.6–22.6)	31.2 (30.9–31.5)	39.6 (39.0–40.2)	38.4 (37.2–39.7)	<0.001
Fall	20.9 (20.4–21.4)	30.2 (29.9–30.5)	36.5 (36.0–37.1)	34.1 (32.9–35.3)	<0.001
Winter	19.1 (18.6–19.6)	11.7 (11.5–12.0)	7.7 (7.4–8.1)	10.2 (9.3–10.8)	<0.001
Obesity (%) [d]	12.2 (11.7–12.6)	12.8 (12.6–13.0)	13.6 (13.2–14.0)	12.0 (11.2–12.7)	<0.001
BMI (kg/m^2)	21.8 (21.8–21.9)	22.0 (21.9–22.0)	22.0 (22.0–22.0)	21.8 (21.7–21.8)	<0.001
SBP (mmHg)	104.3 (104.1–104.4)	104.6 (104.5–104.7)	104.8 (104.7–104.9)	104.9 (104.7–105.2)	<0.001
DBP (mmHg)	66.6 (66.5–66.7)	66.8 (66.8–66.9)	66.9 (66.9–67.0)	66.9 (66.7–67.1)	<0.001
Glucose (mg/dl)	91.4 (91.3–91.5)	91.5 (91.4–91.6)	91.4 (91.3–91.5)	91.1 (90.9–91.3)	0.075
Total cholesterol (mg/dl)	183.4 (183.1–183.8)	186.8 (186.6–187.1)	188.0 (187.6–188.3)	188.3 (187.5–189.0)	<0.001
GGT (U/L)	19.5 (19.2–19.7)	20.6 (20.4–20.7)	21.7 (21.5–21.9)	21.2 (20.8–21.7)	<0.001
ALT (U/L)	16.6 (16.4–16.7)	17.2 (17.2–17.3)	18.0 (17.8–18.1)	18.5 (18.2–18.8)	<0.001
HOMA-IR	1.21 (1.20–1.22)	1.20 (1.19–1.20)	1.19 (1.18–1.20)	1.18 (1.16–1.20)	<0.001

Total energy intake (kcal/d)[f]	1502 (1494–1511)	1505 (1500–1510)	1471 (1463–1480)	1415 (1396–1433)	<0.001

[a]Adjusted for age and sex; [b] ≥10 g/day; [c] ≥ college graduate; [d] BMI ≥ 25 kg/m^2; [e] waist circumference ≥90 cm for men and ≥85 cm for women; [f] among 103,514 participants with plausible estimated energy intake levels (within three standard deviations from the log-transformed mean energy intake).
Abbreviations: ALT, alanine aminotransferase; BMI, body mass index; CVD, cardiovascular disease; DBP, diastolic blood pressure; GGT, gamma-glutamyl transferase; HEPA, health-enhancing physical activity; hs-CRP, high-sensitivity C-reactive protein; HOMA-IR, homeostasis model assessment of insulin resistance; NAFLD, non-alcoholic fatty liver disease; SBP, systolic blood pressure.

Table 2. Development of non-alcoholic fatty liver disease (NAFLD) by 25(OH)D levels among participants without NAFLD at baseline (n = 139 599)

25(OH)D levels (**ng/mL**)	Person-years (PY)	Incident cases	Incidence density (/ 10^3 PY)	Age sex-adjusted HR (95% CI)	Multivariable-adjusted HR[a] (95% CI)		HR (95% CI)[b] in a model with time-dependent variables
					Model 1	Model 2	
<10	114 688.6	4310	37.6	1.00 (reference)	1.00 (reference)	1.00 (reference)	1.00 (reference)
10-19	343 136.6	16 487	48.0	0.95 (0.92–0.99)	0.91 (0.88–0.94)	0.89 (0.86–0.92)	0.86 (0.83–0.89)
20-29	102 627.3	5740	55.9	0.91 (0.88–0.95)	0.85 (0.81–0.88)	0.81 (0.78–0.85)	0.74 (0.71–0.77)
≥30	20 569.0	994	48.3	0.76 (0.71–0.82)	0.75 (0.70–0.81)	0.72 (0.67–0.77)	0.60 (0.56–0.64)
p–trend				<0.001	<0.001	<0.001	<0.001

[a] Estimated from Cox proportional hazards models. Multivariable model 1 was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, and BMI; model 2: model 1 plus adjustment for medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements.

[b] Estimated from Cox proportional hazard models with quintiles of vitamin D levels, smoking, alcohol consumption, physical activity, total energy intake, BMI, medication for hyperlipidemia, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, season, vitamin D supplements, and calcium supplements as time-dependent variables, baseline age, center, year of screening exam, and education level as time-fixed variables.

Abbreviations: BMI, body mass index; CI, confidence interval; HR, hazard ratio

Table 3. Resolution of non-alcoholic fatty liver disease (NAFLD) by 25(OH)D levels among subjects with NAFLD at baseline (n = 48 702)

25(OH)D levels (**ng/mL**)	Person-years (PY)	Resolution cases	Resolution rate (/ 10^3 PY)	Age sex-adjusted HR (95% CI)	Multivariable-adjusted HR[a] (95% CI)		HR (95% CI)[b] in a model with time-dependent variable
					Model 1	Model 2	
<10	25 318.4	1819	71.8	1.00 (reference)	1.00 (reference)	1.00 (reference)	1.00 (reference)
10-19	118 651.4	8202	69.1	1.12 (1.06–1.18)	1.09 (1.03–1.14)	1.09 (1.03–1.15)	1.07 (1.01–1.12)
20-29	41 262.9	2929	71.0	1.17 (1.10–1.24)	1.13 (1.06–1.20)	1.13 (1.06–1.21)	1.07 (1.01–1.14)
≥30	6140.4	499	81.3	1.23 (1.12–1.36)	1.20 (1.08–1.33)	1.21 (1.09–1.35)	1.03 (0.93–1.13)
p–trend				<0.001	<0.001	<0.001	0.265

[a] Estimated from Cox proportional hazards models. Multivariable model 1 was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, and BMI; model 2: model 1 plus adjustment for medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements.

[b] Estimated from Cox proportional hazard models with quintiles of vitamin D levels, smoking, alcohol consumption, physical activity, total energy intake, BMI, medication for hyperlipidemia, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, season, vitamin D supplements, and calcium supplements as time-dependent variables, baseline age, center, year of screening exam, and education level as time-fixed variables.

Abbreviations: BMI, body mass index; CI, confidence interval; HR, hazard ratio

Table 4. Development of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration at two examinations, in subjects without NAFLD at baseline (n = 92 792)

25(OH)D concentrations (**ng/mL**)		Person-years (PY)	Incident cases	Incidence density (/ 10^3 PY)	Age sex-adjusted HR (95% CI)	Multivariable-adjusted HR[a] (95% CI)	
Visit 1	Visit 2					Model 1	Model 2
<20	<20	215 164.6	8419	39.1	1.00 (reference)	1.00 (reference)	1.00 (reference)
≥20	<20	30 123.8	1390	46.1	0.96 (0.90–1.01)	0.94 (0.89–1.00)	0.92 (0.87–0.98)
<20	≥20	45 558.3	1678	36.8	0.89 (0.84–0.94)	0.87 (0.82–0.91)	0.87 (0.82–0.91)
≥20	≥20	35 618.6	1656	46.5	0.87 (0.82–0.92)	0.82 (0.78–0.87)	0.80 (0.76–0.85)

[a] Estimated from Cox proportional hazards models. Multivariable model 1 was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, and BMI; model 2: model 1 plus adjustment for medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements.
Abbreviations: BMI, body mass index; CI, confidence interval; HR, hazard ratio

Table 5. Resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D levels at two visits, among subjects with NAFLD at baseline (n = 30 848)

25(OH)D concentrations (ng/mL)		Person-years (PY)	Resolution cases	Resolution rate (/ 10^3 PY)	Age sex-adjusted HR (95% CI)	Multivariable-adjusted HR[a] (95% CI)	
Visit 1	Visit 2					Model 1	Model 2
<20	<20	68 831.8	3352	48.7	1.00 (reference)	1.00 (reference)	1.00 (reference)
≥20	<20	11 386.1	521	45.8	0.98 (0.90–1.08)	0.98 (0.89–1.07)	0.97 (0.88–1.07)
<20	≥20	12 970.5	620	47.8	1.02 (0.93–1.11)	1.02 (0.94–1.11)	1.02 (0.94–1.11)
≥20	≥20	14 786.6	772	52.2	1.11 (1.02–1.20)	1.10 (1.02–1.20)	1.10 (1.01–1.19)

[a] Estimated from Cox proportional hazards models. Multivariable model 1 was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, and BMI; model 2: model 1 plus adjustment for medication for hyperlipidemia, glucose-lowering med

ication, multi-vitamin supplements, vitamin D supplements, and calcium supplements.
Abbreviations: BMI, body mass index; CI, confidence interval; HR, hazard ratio

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eTable 1. Estimated mean values (95% confidence intervals) and adjusted[a] proportion (95% confidence intervals) of baseline characteristics by vitamin D levels among subjects with NAFLD at baseline (n = 48 702)

Characteristics	Vitamin D levels (ng/mL)				*p*–trend
	<10	10-19	20-29	≥30	
Number of participants	6445	29 699	10 752	1806	
Age (years)	36.9 (36.7–37.1)	38.4 (38.3–38.4)	39.9 (39.7–40.0)	42.6 (42.2–42.9)	<0.001
Male (%)	62.3 (61.1–63.5)	83.3 (82.9–83.7)	89.3 (88.7–89.8)	88.8 (87.4–90.1)	<0.001
Alcohol intake (%) [b]	33.1 (31.9–34.3)	39.6 (39.0–40.1)	43.3 (42.4–44.1)	43.6 (41.4–45.7)	<0.001
Current smoker (%)	23.1 (22.0–24.3)	26.6 (26.1–27.1)	30.9 (30.1–31.7)	30.5 (28.4–32.5)	<0.001
HEPA (%)	10.7 (10.0–11.5)	12.9 (12.5–13.3)	15.7 (15.0–16.4)	20.4 (18.5–22.2)	<0.001
Education level (%) [c]	85.0 (84.2–85.8)	86.0 (85.7–86.4)	85.5 (84.8–86.1)	85.5 (83.9–87.0)	<0.001
History of diabetes (%)	3.6 (3.1–4.1)	3.8 (3.6–4.0)	3.6 (3.3–4.0)	4.4 (3.6–5.1)	<0.001
History of hypertension (%)	12.0 (11.2–12.9)	12.1 (11.8–12.5)	12.5 (11.9–13.1)	13.8 (12.4–15.2)	<0.001
History of CVD (%)	0.7 (0.5–0.9)	1.0 (0.9–1.1)	1.0 (0.8–1.2)	1.1 (0.7–1.5)	<0.001
Glucose-lowering medication (%)	2.5 (2.1–2.9)	2.8 (2.6–3.0)	2.7 (2.4–3.0)	3.2 (2.5–3.8)	0.339
Anti-lipid medication use (%)	4.4 (3.9–4.9)	3.8 (3.6–4.0)	3.9 (3.6–4.3)	4.0 (3.3–4.7)	<0.001
Multi-vitamin supplement (%)	7.5 (6.9–8.2)	10.8 (10.4–11.1)	16.7 (16.0–17.4)	23.4 (21.5–25.3)	<0.001
Vitamin D supplement (%)	0.3 (0.2–0.4)	0.6 (0.6–0.7)	1.3 (1.1–1.5)	4.6 (3.6–5.5)	<0.001
Calcium supplement (%)	0.3 (0.2–0.4)	0.4 (0.3–0.5)	0.7 (0.6–0.9)	1.4 (0.9–2.0)	<0.001
Season					
Spring	38.4 (37.2–39.6)	25.0 (24.5–25.5)	13.7 (13.1–14.4)	13.3 (11.7–14.9)	<0.001
Summer	19.9 (18.9–20.9)	29.5 (29.0–30.0)	38.1 (37.2–39.0)	38.4 (36.1–40.7)	<0.001
Fall	22.1 (21.1–23.1)	34.1 (41.2–43.1)	42.2 (41.2–43.1)	41.9 (39.6–44.2)	<0.001
Winter	20.4 (19.4–21.4)	11.4 (11.1–11.8)	7.4 (5.9–6.8)	6.9 (5.8–8.1)	<0.001
Obesity (%) [d]	59.0 (57.8–60.2)	61.7 (61.1–62.2)	63.2 (62.3–64.1)	60.5 (58.2–62.7)	<0.001
BMI (kg/m^2)	26.2 (26.1–26.2)	26.2 (26.1–26.2)	26.2 (26.1–26.3)	26.1 (25.9–26.2)	0.805
SBP (mmHg)	114.5 (114.3–114.8)	114.8 (114.6–114.9)	115.3 (115.1–115.5)	115.2 (114.6–115.7)	<0.001
DBP (mmHg)	73.8 (73.6–74.0)	74.1 (73.9–74.2)	74.3 (74.1–74.5)	73.9 (73.5–74.3)	0.013
Glucose (mg/dL)	98.7 (98.2–99.1)	99.1 (98.9–99.3)	99.0 (98.6–99.3)	98.7 (97.9–99.5)	0.987
Total cholesterol (mg/dL)	201.7 (200.8–202.6)	205.2 (204.8–205.6)	206.2 (205.6–206.9)	201.4 (199.7–203.0)	<0.001
GGT (U/L)	41.4 (40.3–42.5)	43.5 (43.0–44.0)	45.7 (44.9–46.6)	44.1 (42.0–46.1)	<0.001
ALT (U/L)	37.7 (36.9–38.4)	37.8 (37.5–38.1)	38.1 (37.6–38.6)	37.5 (36.1–38.8)	0.049
HOMA-IR	2.26 (2.22–2.30)	2.20 (2.18–2.22)	2.19 (2.15–2.22)	2.19 (2.11–2.27)	<0.001
Total energy intake (kcal/d)[f]	1673.7 (1654.8–1692.7)	1667.3 (1658.7–1675.8)	1646.1 (1631.7–1660.6)	1612.6 (1576.8–1648.4)	<0.001

[a]Adjusted for age and sex; [b] ≥10 g/day; [c] ≥ college graduate; [d] BMI ≥ 25 kg/m^2; [e] waist circumference ≥90 cm for men and ≥85 cm for women; [f] among 103 514 participants with plausible estimated energy intake levels (within three standard deviations from the log-transformed mean energy intake).
Abbreviations: ALT, alanine aminotransferase; BMI, body mass index; CVD, cardiovascular disease; DBP, diastolic blood pressure; GGT, gamma-glutamyl transferase; HEPA, health-enhancing physical activity; hs-CRP, high-sensitivity C-reactive protein; HOMA-IR, homeostasis model assessment of insulin resistance; NAFLD, non-alcoholic fatty liver disease; SBP, systolic blood pressure.

eTable 2. Estimated mean values (95% confidence intervals) and adjusted[a] proportion (95% confidence intervals) of baseline characteristics by vitamin D change among subjects without NAFLD at baseline (n = 92 792)

Characteristics	Vitamin D levels (ng/mL)			
	<20 at visit 1 & <20 at visit 2	≥20 at visit 1 & <20 at visit 2	<20 at visit 1 & ≥20 at visit 2	≥20 at visit 1 & ≥20 at visit 2
Number of participants	59 561	8583	13 690	10 958
Age (years)	36.1 (36.1–36.2)	36.9 (36.8–37.1)	35.2 (35.1–35.3)	38.1 (38.0–38.3)
Male (%)	34.6 (34.3–35.0)	49.9 (48.9–51.0)	39.8 (39.0–40.6)	55.5 (54.6–56.4)
Alcohol intake (%) [b]	22.5 (22.2–22.8)	25.0 (24.2–25.8)	24.7 (24.0–25.3)	27.0 (26.3–27.8)
Current smoker (%)	12.0 (11.8–12.3)	14.1 (13.5–14.7)	13.0 (12.5–13.5)	14.0 (13.5–14.5)
HEPA (%)	13.4 (13.1–13.7)	16.5 (15.8–17.3)	14.5 (13.9–15.1)	17.9 (17.2–18.6)
Education level (%) [c]	84.2 (83.9–84.5)	86.9 (86.2–87.6)	86.1 (85.5–86.7)	86.4 (85.7–87.1)
History of diabetes (%)	0.5 (0.4–0.5)	0.4 (0.3–0.5)	0.6 (0.4–0.7)	0.6 (0.5–0.7)
History of hypertension (%)	2.9 (2.7–3.0)	3.0 (2.7–3.3)	2.9 (2.6–3.2)	3.1 (2.8–3.4)
History of CVD (%)	0.4 (0.4–0.5)	0.6 (0.4–0.7)	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Glucose-lowering medication (%)	0.3 (0.3–0.4)	0.2 (0.2–0.3)	0.3 (0.2–0.4)	0.3 (0.2–0.4)
Anti-lipid medication use (%)	0.7 (0.7–0.8)	0.9 (0.7–1.1)	0.7 (0.5–0.8)	0.9 (0.8–1.0)
Multi-vitamin supplement (%)	11.3 (11.1–11.6)	22.6 (21.7–23.5)	11.9 (11.3–12.4)	21.9 (21.1–22.6)
Vitamin D supplement (%)	0.8 (0.7–0.8)	2.7 (2.3–3.0)	1.1 (0.9–1.2)	3.5 (3.1–3.8)
Calcium supplement (%)	0.6 (0.6–0.7)	1.7 (1.4–2.0)	0.8 (0.6–0.9)	2.2 (1.9–2.5)
Season				
Spring	28.2 (27.9–28.6)	14.4 (13.7–15.2)	31.0 (30.2–31.7)	16.0 (15.3–16.7)
Summer	29.7 (29.4–30.1)	41.6 (40.5–42.6)	28.1 (27.3–28.8)	38.4 (37.5–39.3)
Fall	30.4 (30.0–30.8)	38.7 (37.6–39.7)	38.0 (27.2–28.7)	38.7 (37.8–39.6)
Winter	11.6 (11.4–11.9)	5.5 (5.0–6.0)	13.0 (12.4–13.6)	7.1 (6.6–7.6)
Obesity (%) [d]	9.8 (9.6–10.0)	10.5 (9.9–11.1)	10.3 (9.8–10.8)	11.0 (10.5–11.5)
BMI (kg/m^2)	21.7 (21.6–21.7)	21.7 (21.6–21.7)	21.7 (21.6–21.7)	21.8 (21.7–21.8)
SBP (mmHg)	103.7 (103.6–103.8)	103.6 (103.4–103.8)	104.0 (103.9–104.2)	104.3 (104.1–104.4)
DBP (mmHg)	66.4 (66.3–66.4)	66.5 (66.3–66.7)	66.5 (66.4–66.6)	66.6 (66.5–66.8)
Glucose (mg/dL)	91.3 (91.2–91.4)	91.2 (91.0–91.3)	91.3 (91.1–91.4)	91.3 (91.1–91.4)
Total cholesterol (mg/dL)	185.2 (184.9–185.4)	187.1 (186.5–187.7)	185.6 (185.1–186.1)	187.3 (186.8–187.9)
GGT (U/L)	19.4 (19.2–19.5)	20.6 (20.2–21.0)	20.0 (19.7–20.3)	21.4 (21.1–21.8)
ALT (U/L)	16.3 (16.2–16.4)	16.9 (16.7–17.2)	16.8 (16.6–17.0)	17.7 (17.5–17.9)
HOMA-IR	1.14 (1.14–1.15)	1.10 (1.08–1.11)	1.16 (1.14–1.17)	1.12 (1.11–1.13)

Total energy intake (kcal/d)[f]	1546.5 (1540.8–1552.1)	1532.6 (1517.8–1547.4)	1492.5 (1480.8–1504.2)	1506.9 (1493.6–1520.3)

[a]Adjusted for age and sex; [b] ≥10 g/day; [c] ≥ college graduate; [d] BMI ≥ 25 kg/m^2; [e] waist circumference ≥90 cm for men and ≥85 cm for women; [f] among 103 514 participants with plausible estimated energy intake levels (within three standard deviations from the log-transformed mean energy intake).
Abbreviations: ALT, alanine aminotransferase; BMI, body mass index; CVD, cardiovascular disease; DBP, diastolic blood pressure; GGT, gamma-glutamyl transferase; HEPA, health-enhancing physical activity; hs-CRP, high-sensitivity C-reactive protein; HOMA-IR, homeostasis model assessment of insulin resistance; NAFLD, non-alcoholic fatty liver disease; SBP, systolic blood pressure.

eTable 3. Estimated mean values (95% confidence intervals) and adjusted[a] proportion (95% confidence intervals) of baseline characteristics by vitamin D change among subjects with NAFLD at baseline (n = 30 848)

Characteristics	Vitamin D levels (ng/mL)			
	<20 at visit 1 &<20 at visit 2	≥20 at visit 1 & <20 at visit 2	<20 at visit 1 & ≥20 at visit 2	≥20 at visit 1 & ≥20 at visit 2
Number of participants	19 377	3194	3893	4384
Age (years)	37.9 (37.8–38.0)	39.1 (38.9–39.4)	37.5 (37.3–37.7)	40.6 (40.5–40.8)
Male (%)	83.1 (82.5–83.6)	91.9 (90.9–92.8)	88.1 (87.1–89.1)	94.2 (93.5–94.9)
Alcohol intake (%) [b]	39.3 (38.6–39.9)	42.0 (40.4–43.7)	42.7 (41.2–44.2)	46.7 (45.3–48.1)
Current smoker (%)	27.9 (27.3–28.6)	32.4 (30.8–34.0)	30.6 (29.2–32.0)	35.4 (34.0–36.7)
HEPA (%)	11.5 (11.0–11.9)	15.2 (13.9–16.4)	12.9 (11.8–13.9)	15.1 (14.1–16.2)
Education level (%) [c]	87.5 (87.0–87.9)	86.3 (85.1–87.5)	87.8 (86.8–88.9)	86.7 (85.7–87.8)
History of diabetes (%)	3.8 (3.5–4.1)	4.0 (3.4–4.7)	4.0 (3.3–4.6)	4.1 (3.6–4.7)
History of hypertension (%)	11.9 (11.4–12.4)	12.8 (11.7–13.9)	12.7 (11.7–13.8)	12.4 (11.5–13.3)
History of CVD (%)	0.8 (0.6–0.9)	1.0 (0.7–1.3)	0.8 (0.5–1.1)	0.9 (0.6–1.1)
Glucose-lowering medication (%)	2.8 (2.6–3.0)	2.8 (2.3–3.4)	2.8 (2.3–3.4)	3.0 (2.6–3.4)
Anti-lipid medication use (%)	3.9 (3.7–4.2)	3.9 (3.3–4.6)	3.4 (2.8–4.0)	3.3 (2.8–3.8)
Multi-vitamin supplement (%)	10.9 (10.5–11.4)	18.2 (16.9–19.6)	10.6 (9.7–11.6)	18.3 (17.1–19.4)
Vitamin D supplement (%)	0.5 (0.4–0.6)	1.0 (0.7–1.4)	0.8 (0.5–1.1)	1.7 (1.3–2.1)
Calcium supplement (%)	0.3 (0.2–0.3)	0.5 (0.2–0.8)	0.4 (0.2–0.6)	0.8 (0.5–1.1)
Season				
Spring	26.0 (25.4–26.6)	12.1 (11.0–13.3)	29.5 (28.0–30.9)	12.3 (11.3–13.3)
Summer	28.9 (28.3–29.6)	42.3 (39.6–43.0)	25.5 (24.1–26.9)	36.4 (34.9–37.8)
Fall	34.3 (33.6–34.9)	43.4 (41.7–45.1)	32.9 (31.4–34.4)	46.5 (45.0–48.0)
Winter	10.8 (10.4–11.2)	3.4 (2.7–4.0)	12.1 (11.0–13.1)	5.1 (4.4–5.7)
Obesity (%) [d]	63.4 (62.7–64.1)	65.0 (63.3–66.6)	64.7 (63.2–66.2)	65.2 (63.7–66.6)
BMI (kg/m^2)	26.3 (26.2–26.3)	26.3 (26.2–26.4)	26.3 (26.2–26.4)	26.3 (26.2–26.4)
SBP (mmHg)	115.1 (114.9–115.3)	115.4 (115.0–115.8)	115.4 (115.1–115.8)	115.7 (115.4–116.1)
DBP (mmHg)	74.5 (74.4–74.6)	74.7 (74.3–75.0)	74.4 (74.2–74.7)	74.7 (74.4–75.0)
Glucose (mg/dL)	99.5 (99.2–99.7)	99.3 (98.7–99.9)	99.3 (98.7–99.9)	99.2 (98.6–99.7)
Total cholesterol (mg/dL)	206.3 (205.8–206.7)	208.2 (207.0–209.5)	205.0 (203.9–206.1)	205.9 (204.9–207.0)
GGT (U/L)	44.7 (44.2–45.3)	47.5 (46.2–48.9)	46.5 (45.3–47.7)	47.6 (46.4–48.7)
ALT (U/L)	39.7 (39.3–40.1)	39.4 (38.4–40.4)	39.8 (39.0–40.7)	40.0 (39.1–40.8)
HOMA-IR	2.24 (2.22–2.26)	2.16 (2.11–2.22)	2.29 (2.24–2.33)	2.20 (2.16–2.25)

Total energy intake (kcal/d)[f]	1709 (1699–1720)	1706 (1680–1732)	1673 (1650–1696)	1679 (1656–1701)

[a]Adjusted for age and sex; [b] ≥10 g/day; [c] ≥ college graduate; [d] BMI ≥ 25 kg/m^2; [e] waist circumference ≥90 cm for men and ≥85 cm for women; [f] among 103 514 participants with plausible estimated energy intake levels (within three standard deviations from the log-transformed mean energy intake).
Abbreviations: ALT, alanine aminotransferase; BMI, body mass index; CVD, cardiovascular disease; DBP, diastolic blood pressure; GGT, gamma-glutamyl transferase; HEPA, health-enhancing physical activity; hs-CRP, high-sensitivity C-reactive protein; HOMA-IR, homeostasis model assessment of insulin resistance; NAFLD, non-alcoholic fatty liver disease; SBP, systolic blood pressure.

eTable 4. Estimated[a] mean values (95% confidence intervals) and adjusted[a] proportions (95% confidence intervals) of baseline characteristics by development of **NAFLD** among participants without NAFLD at baseline (n = 139 599)

Characteristics	**No incident NAFLD**	**Incident NAFLD**	*P* value
Number of participants	112 068	27 531	
Age (years)	35.9 (35.9-35.9)	37.1 (37.0-37.2)	<0.001
Male (%)	34.6 (34.3-34.8)	67.9 (67.4-68.5)	<0.001
Alcohol intake (%) [b]	24.8 (24.6-25.0)	26.1 (25.7-26.5)	<0.001
Current smoker (%)	12.0 (11.8-12.2)	15.1 (14.8-15.5)	<0.001
HEPA (%)	15.0 (14.8-15.2)	14.3 (13.9-14.7)	0.003
Education level (%) [c]	84.6 (84.4-84.8)	82.0 (81.5-82.5)	<0.001
History of diabetes (%)	0.6 (0.5-0.6)	1.0 (0.9-1.1)	<0.001
History of hypertension (%)	3.1 (3.0-3.2)	4.5 (4.3-4.7)	<0.001
History of CVD (%)	0.5 (0.5-0.6)	0.6 (0.5-0.7)	0.177
Glucose-lowering medication (%)	0.4 (0.3-0.4)	0.6 (0.5-0.7)	<0.001
Anti-lipid medication use (%)	0.9 (0.8-0.9)	1.5 (1.4-1.6)	<0.001
Multi-vitamin supplement (%)	12.2 (12.0-12.4)	13 (12.6-13.4)	<0.001
Vitamin D supplement (%)	1.3 (1.3-1.4)	1.3 (1.1-1.4)	0.732
Calcium supplement (%)	0.9 (0.8-0.9)	0.8 (0.7-0.9)	0.584
Season			
Spring	27.1 (26.8-27.4)	24.3 (23.7-24.8)	<0.001
Summer	31.4 (31.2-31.7)	31.0 (30.5-31.6)	0.246
Fall	29.0 (28.7-29.2)	33.3 (32.8-33.9)	<0.001
Winter	12.5 (12.3-12.7)	11.4 (11.0-11.8)	<0.001
Obesity (%) [d]	9.2 (9.0-9.4)	24.6 (24.1-25.1)	<0.001
BMI (kg/m^2)	21.6 (21.6-21.6)	23.3 (23.3-23.4)	<0.001
SBP (mmHg)	104.2 (104.1-104.2)	106.3 (106.2-106.4)	<0.001
DBP (mmHg)	66.5 (66.5-66.6)	68.0 (67.9-68.1)	<0.001
Glucose (mg/dl)	91.1 (91.1-91.2)	92.8 (92.7-92.9)	<0.001
Total cholesterol (mg/dl)	185.1 (184.9-185.3)	192.0 (191.6-192.4)	<0.001
GGT (U/L)	19.6 (19.5-19.8)	24.5 (24.2-24.7)	<0.001
ALT (U/L)	16.8 (16.7-16.8)	19.5 (19.4-19.7)	<0.001

HOMA-IR	1.14 (1.13-1.14)	1.45 (1.44-1.46)	<0.001
Total energy intake (kcal/d) [f]	1481.9 (1477.7-1486.1)	1545.3 (1536.6-1554.1)	<0.001

[a]Adjusted for age and sex; [b] ≥10 g/day; [c] ≥ college graduate; [d] BMI ≥ 25 kg/m^2; [e] waist circumference ≥90 cm for men and ≥85 cm for women; [f] among 103 514 participants with plausible estimated energy intake levels (within three standard deviations from the log-transformed mean energy intake).
Abbreviations: ALT, alanine aminotransferase; BMI, body mass index; CVD, cardiovascular disease; DBP, diastolic blood pressure; GGT, gamma-glutamyl transferase; HEPA, health-enhancing physical activity; hs-CRP, high-sensitivity C-reactive protein; HOMA-IR, homeostasis model assessment of insulin resistance; NAFLD, non-alcoholic fatty liver disease; SBP, systolic blood pressure.

eTable 5. Estimated[a] mean values (95% confidence intervals) and adjusted[a] proportions (95% confidence intervals) of baseline characteristics by resolution of **NAFLD** among participants with NAFLD at baseline (n = 30 848)

Characteristics	**No NAFLD resolution**	**NAFLD resolution**	*P* value
Number of participants	35 253	13 449	
Age (years)	38.5 (38.4-38.6)	39.1 (38.9-39.2)	<0.001
Male (%)	85.1 (84.7-85.4)	74.7 (73.9-75.4)	<0.001
Alcohol intake (%) [b]	39.2 (38.7-39.7)	41.6 (40.8-42.4)	<0.001
Current smoker (%)	27.6 (27.1-28.0)	26.9 (26.1-27.7)	0.162
HEPA (%)	13.4 (13.0-13.7)	13.9 (13.3-14.5)	0.132
Education level (%) [c]	85.2 (84.9-85.6)	86.9 (86.4-87.4)	<0.001
History of diabetes (%)	4.0 (3.8-4.2)	3.2 (2.9-3.5)	<0.001
History of hypertension (%)	13.1 (12.7-13.4)	10.2 (9.7-10.7)	<0.001
History of CVD (%)	1.0 (0.9-1.1)	1.0 (0.8-1.1)	0.962
Glucose-lowering medication	3.0 (2.8-3.1)	2.2 (2.0-2.5)	<0.001
Anti-lipid medication use (%)	4.1 (3.9-4.3)	3.2 (3.0-3.5)	<0.001
Multi-vitamin supplement (%)	11.6 (11.3-12.0)	13.6 (13.1-14.2)	<0.001
Vitamin D supplement (%)	0.9 (0.8-1.0)	0.9 (0.7-1.0)	0.676
Calcium supplement (%)	0.5 (0.4-0.5)	0.5 (0.4-0.6)	0.516
Season			
Spring	24.2 (23.7-24.6)	22.7 (22.0-23.4)	0.001
Summer	30.5 (30.0-31.0)	30.1 (29.3-30.9)	0.340
Fall	33.9 (33.4-34.4)	36.4 (35.6-37.2)	<0.001
Winter	11.4 (11.1-11.7)	10.9 (10.4-11.4)	0.118
Obesity (%) [d]	65.1 (64.6-65.6)	52.6 (51.7-53.4)	<0.001
BMI (kg/m^2)	26.4 (26.4-26.5)	25.4 (25.4-25.5)	<0.001
SBP (mmHg)	115.3 (115.2-115.4)	113.7 (113.5-113.9)	<0.001
DBP (mmHg)	74.3 (74.2-74.4)	73.4 (73.3-73.6)	<0.001
Glucose (mg/dl)	99.3 (99.1-99.5)	98.2 (97.9-98.5)	0.075
Total cholesterol (mg/dl)	205.3 (204.9-205.6)	203.7 (203.1-204.3)	<0.001
GGT (U/L)	45.2 (44.8-45.7)	39.8 (39.0-40.5)	<0.001
ALT (U/L)	40.5 (40.2-40.8)	30.7 (30.2-31.2)	<0.001

HOMA-IR	2.34 (2.32-2.36)	1.86 (1.83-1.89)	<0.001
Total energy intake (kcal/d) [f]	1656.3 (1648.3-1664.2)	1675.3 (1662.5-1688.2)	<0.001

[a]Adjusted for age and sex; [b] ≥10 g/day; [c] ≥ college graduate; [d] BMI ≥ 25 kg/m^2; [e] waist circumference ≥90 cm for men and ≥85 cm for women; [f] among 103 514 participants with plausible estimated energy intake levels (within three standard deviations from the log-transformed mean energy intake).
Abbreviations: ALT, alanine aminotransferase; BMI, body mass index; CVD, cardiovascular disease; DBP, diastolic blood pressure; GGT, gamma-glutamyl transferase; HEPA, health-enhancing physical activity; hs-CRP, high-sensitivity C-reactive protein; HOMA-IR, homeostasis model assessment of insulin resistance; NAFLD, non-alcoholic fatty liver disease; SBP, systolic blood pressure.

eTable 6. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by 25(OH)D levels after further adjustment for HOMA-IR and glucose

25(OH)D levels (**ng/mL**)	Among participants **without** NAFLD at baseline (n = 139 599)	Among participants **with** NAFLD at baseline (n = 48 702)
	Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD
<10	1.00 (reference)	1.00 (reference)
10-19	0.90 (0.86–0.93)	1.08 (1.02–1.13)
20-29	0.82 (0.78–0.85)	1.11 (1.04–1.18)
≥30	0.73 (0.68–0.78)	1.21 (1.09–1.34)
p–trend	<0.001	<0.001

[a] Estimated from Cox proportional hazards models. Multivariable model 3 was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, calcium supplements, HOMA-IR and glucose.
Abbreviations: BMI, body mass index; HOMA-IR, homeostasis model assessment of insulin resistance; HR, hazard ratio

eTable 7. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by 25(OH)D levels after further adjustment for waist circumference among participants with available waist circumferences

25(OH)D levels (ng/mL)	Among participants **without** NAFLD at baseline (n = 138 962)	Among participants **with** NAFLD at baseline (n = 48 680)
	Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD
<10	1.00 (reference)	1.00 (reference)
10-19	0.89 (0.86–0.92)	1.09 (1.03–1.15)
20-29	0.82 (0.78–0.85)	1.13 (1.06–1.21)
≥30	0.72 (0.67–0.78)	1.21 (1.09–1.34)
p–trend	<0.001	<0.001

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, calcium supplements, and waist circumference.
Abbreviations: BMI, body mass index; HR, hazard ratio

eTable 8. Resolution of non-alcoholic fatty liver disease (NAFLD) by 25(OH)D levels according to vitamin D supplementation among participants with NAFLD at baseline (n = 48 702)

25(OH)D levels (ng/mL)	Multivariable-adjusted HR (95% confidence intervals) [a] for **resolution** of NAFLD		P for interaction
	No vitamin D supplements (n = 48 271)	Vitamin D supplements (n = 431)	
<10	1.00 (reference)	1.00 (reference)	0.719
10-19	1.09 (1.03–1.15)	0.93 (0.44–1.94)	
20-29	1.13 (1.06–1.21)	0.96 (0.45–2.05)	
≥30	1.22 (1.10–1.36)	0.81 (0.36–1.84)	
p–trend	<0.001	0.636	

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, and calcium supplements.
Abbreviations: BMI, body mass index; HR, hazard ratio

eTable 9. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration at two examinations after further adjustment for HOMA-IR and glucose

25(OH)D changes (**ng/mL**)		Among participants **without** NAFLD at baseline (n = 92 792)	Among participants **with** NAFLD at baseline (n = 30 848)
Visit 1	Visit 2	Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD
<20	<20	1.00 (reference)	1.00 (reference)
≥20	<20	0.93 (0.87–0.98)	0.96 (0.88–1.06)
<20	≥20	0.87 (0.82–0.91)	1.02 (0.94–1.12)
≥20	≥20	0.80 (0.76–0.85)	1.09 (1.01–1.19)

[a] Estimated from Cox proportional hazards models. Multivariable model 3 was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, calcium supplements, HOMA-IR and glucose.
Abbreviations: BMI, body mass index; HOMA-IR, homeostasis model assessment of insulin resistance; HR, hazard ratio

eTable 10. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration at two examinations after further adjustment for waist circumference among participants with available waist circumference

25(OH)D changes (ng/mL)		Among participants **without** NAFLD at baseline (n = 92 347)	Among participants **with** NAFLD at baseline (n = 30 835)
Visit 1	Visit 2	Multivariable-adjusted HR (95% confidence intervals) [a] for **incident** NAFLD	Multivariable-adjusted HR (95% confidence intervals) [a] for **resolution** of NAFLD
<20	<20	1.00 (reference)	1.00 (reference)
≥20	<20	0.93 (0.87–0.98)	0.97 (0.88–1.06)
<20	≥20	0.87 (0.82–0.91)	1.02 (0.94–1.12)
≥20	≥20	0.81 (0.77–0.86)	1.10 (1.01–1.19)

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, calcium supplements, and waist circumference.
Abbreviations: BMI, body mass index; HR, hazard ratio

eTable 11. Resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration at two examinations according to vitamin D supplements among participants with NAFLD at baseline (n = 30 848)

25(OH)D changes (ng/mL)		Multivariable-adjusted HR (95% confidence intervals) [a] for **resolution** of NAFLD		*P* for interaction
Visit 1	Visit 2	No vitamin D supplements (n = 30 621)	Vitamin D supplements (n = 227)	
<20	<20	1.00 (reference)	1.00 (reference)	0.638
≥20	<20	0.98 (0.89–1.07)	0.46 (0.11–1.98)	
<20	≥20	1.03 (0.94–1.12)	0.64 (0.19–2.19)	
≥20	≥20	1.10 (1.01–1.19)	1.16 (0.57–2.35)	

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, and calcium supplements.
Abbreviations: BMI, body mass index; HR, hazard ratio

eTable 12. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by 25(OH)D levels according to glucose-lowering medication

25(OH)D levels (ng/mL)	Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD Among participants **without** NAFLD at baseline (n = 139 599)		*P* for interaction	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD among participants **with** NAFLD at baseline (n = 48 702)		*P* for interaction
	No glucose-lowering medication (n = 139 012)	Glucose-lowering medication (n = 587)		No glucose-lowering medication (n = 47 346)	Glucose-lowering medication (n = 1356)	
<10	1.00 (reference)	1.00 (reference)	0.674	1.00 (reference)	1.00 (reference)	0.152
10-19	0.89 (0.86–0.92)	1.01 (0.63–1.63)		1.08 (1.02–1.14)	1.26 (0.84–1.88)	
20-29	0.81 (0.78–0.85)	0.76 (0.46–1.28)		1.13 (1.06–1.20)	1.50 (0.98–2.31)	
≥30	0.72 (0.67–0.77)	0.70 (0.36–1.34)		1.19 (1.07–1.32)	2.04 (1.22–3.41)	
p–trend	<0.001	0.094		<0.001	0.003	

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, multi-vitamin supplements, vitamin D supplements, and calcium supplements.
Abbreviations: HR, hazard ratio

eTable 13. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration at two examinations according to glucose-lowering medication among participants with NAFLD at baseline

25(OH)D changes (ng/mL)		Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD Among participants **without** NAFLD at baseline (n = 92 792)		*P* for interaction	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD among participants **with** NAFLD at baseline (n = 30 848)		*P* for interaction
Visit 1	Visit 2	No glucose-lowering medication (n = 92 519)	Glucose-lowering medication (n = 273)		No glucose-lowering medication (n = 29 971)	Glucose-lowering medication (n = 877)	
<20	<20	1.00 (reference)	1.00 (reference)	0.944	1.00 (reference)	1.00 (reference)	0.490
≥20	<20	0.92 (0.87–0.98)	0.74 (0.29–1.87)		0.96 (0.88–1.06)	1.22 (0.73–2.02)	
<20	≥20	0.87 (0.82–0.91)	0.75 (0.33–1.67)		1.03 (0.94–1.12)	0.73 (0.40–1.34)	
≥20	≥20	0.80 (0.76–0.85)	0.71 (0.40–1.28)		1.10 (1.01–1.19)	1.17 (0.78–1.76)	

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, multi-vitamin supplements, vitamin D supplements, and calcium supplements.
Abbreviations: HR, hazard ratio

eTable 14. Development and resolution of non-alcoholic fatty liver disease (NAFLD) based on 25(OH)D levels among participants with alanine transaminase (ALT) <36 IU/L

25(OH)D levels (ng/mL)	Among participants **without** NAFLD at baseline (n = 132 666)	Among participants **with** NAFLD at baseline (n = 29 829)
	Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD
<10	1.00 (reference)	1.00 (reference)
10-19	0.89 (0.86–0.92)	1.11 (1.05–1.18)
20-29	0.81 (0.78–0.85)	1.12 (1.04–1.20)
≥30	0.73 (0.68–0.79)	1.19 (1.06–1.34)
p–trend	<0.001	0.002

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements

Abbreviations: ALT, alanine transaminase; BMI, body mass index; HR, hazard ratio

eTable 15. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration in two examinations among participants with alanine transaminase (ALT) <36 IU/L

25(OH)D changes (ng/mL)		Among participants **without** NAFLD at baseline (n = 89 021)	Among participants **with** NAFLD at baseline (n = 17 743)
Visit 1	Visit 2	Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD
<20	<20	1.00 (reference)	1.00 (reference)
≥20	<20	0.93 (0.87–0.99)	0.89 (0.80–1.002)
<20	≥20	0.87 (0.82–0.91)	1.05 (0.94–1.16)
≥20	≥20	0.79 (0.75–0.84)	1.04 (0.94–1.15)

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements.
Abbreviations: ALT, alanine transaminase; BMI, body mass index; HR, hazard ratio

eTable 16. Development and resolution of elevated ALT (≥36 IU/L) by 25(OH)D levels

25(OH)D levels (ng/mL)	Among participants with ALT<36 IU/L at baseline (n = 162 495)	Among participants with ALT≥36 IU/L at baseline (n = 25 806)
	Multivariable-adjusted HR (95% confidence intervals)[a] for development of elevated ALT	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of elevated ALT
<10	1.00 (reference)	1.00 (reference)
10-19	0.95 (0.92–0.99)	1.04 (0.98–1.09)
20-29	0.92 (0.88–0.96)	1.07 (1.01–1.13)
≥30	0.89 (0.83–0.95)	1.15 (1.05–1.25)
p–trend	<0.001	0.002

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements

Abbreviations: ALT, alanine transaminase; BMI, body mass index; HR, hazard ratio

eTable 17. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration at two examinations

25(OH)D changes (ng/mL)		Among participants with ALT<36 IU/L at baseline (n = 110 727)	Among participants with ALT≥36 IU/L at baseline (n = 9906)
Visit 1	Visit 2	Multivariable-adjusted HR (95% confidence intervals)[a] for development of elevated ALT	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of elevated ALT
<20	<20	1.00 (reference)	1.00 (reference)
≥20	<20	0.98 (0.92–1.03)	1.05 (0.95–1.15)
<20	≥20	0.96 (0.91–1.01)	0.99 (0.90–1.08)
≥20	≥20	0.95 (0.90–0.99)	1.04 (0.95–1.14)

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements.
Abbreviations: ALT, alanine transaminase; HR, hazard ratio

April 3, 2022

Paul M. Stewart, MD, FRCP, FMedSci
Editor-in-Chief
Journal of Clinical Endocrinology & Metabolism

Dear Dr. Stewart,

Thank you for your constructive suggestions regarding our manuscript #jc.2022-00343 entitled, "**Resolution of, and risk of incident non-alcoholic fatty liver disease with changes in serum 25-hydroxy vitamin D status**." We have revised the manuscript according to the reviewers' recommendations and comments. Furthermore, we have conducted additional analyses that considerably strengthened the validity of our study. These additional analyses do not alter our original conclusions. We are pleased to submit the revised version of the manuscript for publication in *Journal of Clinical Endocrinology & Metabolism*.

In addition to the revised version of the manuscript, we have uploaded a version with track changes and colored text in blue, reflecting the modifications to the manuscript, as well as our point-by-point responses to the reviewers' comments, which detail the changes made in response to the comments.

The authors declare no conflicts of interest related to this manuscript, including financial conflicts. The manuscript has not been submitted for publication elsewhere and is not under consideration by any other journal.

Thank you for your consideration of our manuscript. Please feel free to contact me if you have any questions related to our manuscript. We look forward to hearing from you.

Sincerely,

Seungho Ryu, MD, PhD
Professor of Occupational and Environmental Medicine
Kangbuk Samsung Hospital
Sungkyunkwan University

Reviewer Comments:

Reviewer 1: In this study, Kim Y, et al. investigated the longitudinal association of 25-hydroxy vitamin D (25OHVitD) status with the development and resolution of non-alcoholic fatty liver disease (NAFLD) using a large sample of young Korean individuals. The authors concluded that higher serum 25OHVitD level was associated with a lower risk of developing NAFLD among those without NAFLD at baseline. On the other hand, a higher serum 25OHVitD level was also associated with a higher chance of resolution of NAFLD over time. The availability of repeated measurements, especially serum 25OHVitD levels, is a major strength of the study. However, there are also a few issues which are of concern:

Response: Thank you for your constructive assessment of our manuscript. We have addressed the specific comments and suggestions below.

1) In addition to baseline 25OHVitD levels, how did the participants with incident NAFLD differ from those without? The authors should include a table summarizing the differences in baseline clinical characteristics between participants who developed NAFLD and those who did not. Similarly, a table should be presented to compare the baseline clinical characteristics between participants who had resolved NAFLD and those who did not.

Response: We appreciate your comments. As suggested by the reviewer, we have presented the baseline characteristics of participants, comparing the participants with incident NAFLD and no NAFLD, as well as those with NAFLD resolution and no resolution, and described the findings in the **Results** section.

*"The baseline characteristics of participants according to NAFLD status are described in **eTables 4** and **5** (1). Compared to those who did not develop NAFLD, those who developed NAFLD were older, more likely to be male, alcohol drinkers, current smokers, obese, have a history of diabetes, hypertension, or CVD, receive glucose-lowering medication or hyperlipidemia medication, and take multi-vitamin supplements; these individuals also had higher BP, total cholesterol, glucose, GGT, ALT, HOMA-IR, and total energy intake (**eTable 4).***

*Compared to those with no NAFLD resolution, individuals with NAFLD resolution were more likely to be: older, female, alcohol drinkers, regular exercisers, have higher education levels, take multi-vitamin supplements, and have a higher total energy intake (**eTable 5**)."* ***(Page 11, 2nd paragraph)***

2) Please explain how variables were chosen to be included for adjustments in multivariable Cox regression analyses.

Response: Confounding variables were chosen for inclusion in the multivariable models if they met the following criteria: 1) were associated with the outcome (incident NAFLD or NAFLD resolution) and 2) were associated with the exposure (serum 25(OH)D), but 3) were not intermediate variables in the causal pathway between the exposure (serum 25(OH)D) and the outcome (incident NAFLD or NAFLD resolution).

3) Although higher baseline serum 25OHVitD levels were independently associated with the development of NAFLD, in Table 1, higher serum 25OHVitD levels were also significantly associated with higher serum ALT levels (p<0.001). Please comment.

Response: Thank you for this comment. As the reviewer has mentioned, we observed unexpectedly higher ALT levels with increasing serum concentrations of 25(OH)D, although all levels were within the reference interval and the difference was marginal. However, given that ALT levels are positively associated with fatty liver, and the beneficial effects of vitamin D on liver enzymes have been reported in previous studies (2,3), this finding is somehow counterintuitive.

In analyses excluding individuals with abnormally high ALT levels (ALT >35 IU/L (4,5), where the upper limit of normal is usually regarded as 35 IU/L), a positive association between 25(OH)D and ALT was consistently observed. To minimize the possibility that this was a result of potential misclassification owing to the limited diagnostic accuracy of ultrasonography in identifying NAFLD, we performed analyses after excluding those with high ALT levels, in addition to the pre-existing exclusion criteria. The main results remained unchanged, showing a significant decrease in the risk of incident NAFLD and an increase in NAFLD resolution with increasing 25(OH)D levels (**eTable 14**). Consistent trends were observed when we assessed changes in the 25(OH)D levels (**eTable 15**). When high ALT level, instead of the ultrasonographic diagnosis of NAFLD, was used as an outcome, the trends were similar, showing decreased risk of higher ALT and increased resolution of high ALT with increasing categories of 25(OH)D levels (**eTable 16**).

For the changes in 25(OH)D levels, persistently adequate serum 25(OH)D levels were associated with a significantly lower risk of elevated ALT levels; no significant associations were found between the changes in serum 25(OH)D and high ALT levels (**eTable 17**). Based on the findings from the supplemental analyses, the overall trends were fairly consistent and robust, and the effect of mildly elevated ALT levels in individuals with higher serum 25(OH)D levels in our study did not seem to be substantial in altering the direction of the associations or have any clinical relevance.

Although the difference in ALT levels among the four categories of 25(OH)D levels was very small, with <2 IU/L between the lowest and highest 25(OH)D categories, it remains unclear why we observed a weak but positive association between serum 25(OH)D and ALT levels (within the normal range). This association has also been reported in previous studies (6-8). A cross-sectional study in the U.S. general population (NHANES) found a positive association between serum ALT levels and vitamin D levels, even after excluding individuals with elevated ALT levels of >39 U/L (6). Another study reported a positive association between ALT and vitamin D, although the association was only found in African-American women (7). In our study, it should also be noted that increasing ALT levels were observed only in the NAFLD-free cohort, whereas such a trend was not evident in the NAFLD group. In addition, considering that the upper limit of normal for ALT in the general Korean population is approximately 34 U/L for men and 24 U/L for women (9), the increase in ALT levels across 25(OH)D categories in the non-NAFLD group was within the normal range. As discussed in previous studies, the liver is an important organ in the metabolism of vitamin D. The 25-α hydroxylation of vitamin

D occurs in the liver, and the relationship between vitamin D and ALT may reflect the effect of vitamin D on hepatocytes that release the cytosolic enzyme ALT (6). ALT levels within the normal range may not reflect liver injury; indeed, vitamin D has been found to stimulate cell turnover and cell differentiation (6,10). However, the exact mechanism underlying this finding requires further exploration.

The findings from the supplemental analyses are described in the **Results** section of the revised manuscript as follows:

"In analyses after further exclusion of individuals with abnormally high ALT levels (ALT > 35 IU/L (4,5)*, as the upper limit of normal is usually regarded as 35 IU/L), the main results were similar, showing a significant decrease in the risk of incident NAFLD and an increase in NAFLD resolution with increasing 25(OH)D levels (**eTable 14**) (1). Consistent trends were observed when we assessed the changes in 25(OH)D levels (**eTable 15**) (1). In addition, when the outcome was defined as high ALT level instead of an ultrasonographic diagnosis of NAFLD, the trends were similar, showing decreased risks of high ALT and increased resolution of high ALT with increasing categories of 25(OH)D levels (**eTable 16**) (1). Regarding the changes in 25(OH)D levels, persistently adequate serum 25(OH)D levels were associated with a significantly lower risk of elevated ALT; no significant associations were found between the changes in serum 25(OH)D levels and high ALT (**eTable 17**) (1)." **(Page 14, 1st paragraph)***

4) The sensitivity of identifying mild fatty liver disease (fat content <20%) is low with the use of ultrasound (USG). In Table 1, it appears that those with lower baseline serum 25OVitD levels also had significantly higher calorie intake, more insulin resistant with a higher prevalence of hypertension but similar mean BMI when compared with those with 25OHVitD ≥30 ng/ml. Therefore, it is possible that those with low serum 25OHVitD levels may in fact be harbouring mild fatty liver which is not detectable on USG but are more prone to progress over time.

Response: We appreciate your comment. In fact, those with lower baseline serum 25(OH)D levels were likely to have metabolically unfavorable factors, such as higher insulin resistance and a history of hypertension. However, these individuals also had a lower level of SBP, DBP, or total cholesterol, which are also known risk factors for NAFLD. Even though we present the age- and sex-adjusted mean or proportion, **Table 1** does not reflect an independent association between 25(OH)D and each covariate. To control for this confounding effect, we presented the main results based on the multivariable-adjusted models. However, as the reviewer mentioned, the potential for misclassification remains, due to the limited diagnostic accuracy of ultrasonography in identifying mild NAFLD; the low sensitivity of ultrasound-based diagnosis may have caused measurement errors, which may have caused some individuals with mild hepatic fat to be misclassified into the NAFLD-free cohort. The reliance on ultrasonography for NAFLD diagnosis in our study has been included as a limitation in the **Discussion** section of the original manuscript.

As detailed in the previous response, we performed analyses after further excluding individuals initially categorized as not having NAFLD on ultrasonography, but with abnormally high ALT levels (ALT >35 IU/L). Consistent with the original findings, we observed a significant

decrease in the risk of incident NAFLD and an increase in NAFLD resolution with increasing 25(OH)D levels (**eTable 14**). Similar trends were observed when we assessed changes in the 25(OH)D levels (**Table 15**), although the significance was lost across the 25(OH)D categories for NAFLD resolution. In addition, when the outcome was defined by high ALT levels instead of ultrasonographic diagnosis of NAFLD (**eTable 16** and **eTable 17**), similar trends were observed. Overall, in these sensitivity analyses, the observed patterns were largely consistent with those of the original data, even when a different outcome definition was used.

5) Are waist circumference measurements of the participants available in this study? Will low serum 25OHVitD level just a surrogate marker of central adiposity, which is an established risk factor of NAFLD?

Response: Thank you for this comment. We performed additional analyses in which we made further adjustments for waist circumference using a sample of individuals with waist circumference measurements (n = 138,962 for incident NAFLD analysis; n = 48,680 for NAFLD resolution). The associations between 25(OH)D levels and incident NAFLD, as well as NAFLD resolution, remained virtually unchanged and were still significant across all categories. Similar associations were found when the effects of changes in 25(OH)D levels were assessed. These findings suggest that the associations between serum 25(OH)D levels and the risk of NAFLD or NAFLD resolution cannot be fully explained by waist circumference status. The results are presented in **eTables 7** and **10**, as well as in the **Results** section of the revised manuscript.

6) With regard to the resolution of NAFLD, among the 48702 participants with NAFLD at baseline, there were significantly more users of multivitamin, calcium and vitamin D supplements in those with the highest baseline serum 25OHVitD levels. Their caloric intake was also significantly lower. Will these participants represent a group of individuals with better health-related behaviour, leading to a higher chance of improvements in fatty liver? Subgroup analysis stratifying participants by their use of vitamin D supplements should be helpful to derive more insights in this subject.

Response: Thank you for this insightful suggestion. As pointed out by the reviewer, high serum 25(OH)D levels were mostly observed in supplement users among NAFLD patients. Following the reviewer's suggestion, we performed subgroup analyses stratified by vitamin D supplementation status. Significant associations between higher serum 25(OH)D levels and NAFLD resolution were consistently observed among vitamin D supplement non-users, and there were no significant interactions with vitamin D supplement use (**eTable 8**; *P* for interaction = 0.719). Similarly, persistently adequate serum 25(OH)D levels were significantly associated with NAFLD resolution in non-users (**eTable 11;** *P* for interaction = 0.638), and no significant difference between the groups was observed. Owing to the very small sample size of the vitamin D supplement use group, the results were inconclusive in this group, while the potential for unmeasured confounding effects remains. However, the significant associations observed among supplement non-users, consistent with the original findings, suggest that the effects of 25(OH)D on NAFLD resolution may not be fully explained by increased supplement use. These findings are presented in **eTables 8** and **11**, as well as in the **Results** section of the revised manuscript.

7) In Table 5, compared to participants who remained vitamin D deficient, only those who were vitamin D sufficient in both visits were significantly associated with resolution of NAFLD. Participants who had their vitamin D repleted actually did not significantly increase the chance of NAFLD resolution (95% CI 0.94 - 1.11).

Response: Thank you for this comment. We observed that people with persistently adequate serum 25(OH)D levels were more likely to experience resolution of NAFLD than those with persistently low levels, whereas those in the "increased group" who had insufficient 25(OH)D levels at baseline but no insufficiency at follow-up, did not. The reason for this observation remains unclear. According to a previous meta-analysis of randomized controlled trials, the duration of vitamin D supplementation was important for the therapeutic effects of vitamin D in NAFLD, which implies that a longer duration of vitamin D sufficiency may be needed for the resolution of NAFLD, which may be relevant to our findings (11). Therefore, while having an adequate serum level of 25(OH)D at any point in time may be beneficial in preventing NAFLD development, maintaining the levels for a prolonged duration could be essential to reverse the disease course in patients with pre-existing NAFLD. Further large-scale observational and interventional studies with longer follow-up durations are required to confirm our findings. For clarification, we have revised the part addressing this point in the **Discussion** section **(Page 17, 1st paragraph).**

8) In all multivariable regression analyses, the models were adjusted for "Medications for diabetes" instead of "History of diabetes". However, details of the use of anti-diabetic medications were not presented in Table 1 and supplementary tables 1-3. This is important, as some anti-diabetic medications have been associated with favourable hepatic effects (eg. glitazones, glucagon like peptide 1 receptor agonists, and sodium glucose co-transporter 2 inhibitors), which could have influenced the development and resolution of NAFLD.

Response: Thank you for pointing this out. We agree with the reviewer that there is a potential benefit of certain antidiabetic medications in hepatic physiology (12), and this may have influenced our results. However, in our study, as details of the medication types were not available, we were not able to systematically analyze the effect of glucose-lowering medications, and we have included the lack of information as a limitation in the **Discussion** section of the revised manuscript. As suggested by the reviewer, we have also included the baseline data on the percentage of patients taking glucose-lowering medication in **Table 1**, as well as **eTable 1** through **eTable 5**.

"Fourth, detailed information on glucose-lowering medications, such as specific types of medication and their treatment duration, was not collected." ***(Page 18, 2nd paragraph)***

We also performed subgroup analyses stratified by diabetes medication status (no medication usage vs. medication usage) and assessed the association between serum 25(OH)D levels and NAFLD development and resolution. We have found a similar inverse association between 25(OH)D levels and incident NAFLD, and a significant positive association with NAFLD resolution in the 'no medication use' group; the trends of these associations remained similar in the "medication use" group, and no significant differences were found between the two groups (P = 0.674 for incident NAFLD; P = 0.152 for NAFLD resolution) (**eTable 12)**. Similarly, the trends of associations observed in the original analyses were mostly

retained for both groups when the effects of 25(OH)D changes were assessed, with no significant differences between the groups (*P* = 0.944 for incident NAFLD; *P* = 0.490 for NAFLD resolution) (**eTable 13**). However, the inconclusive results in the "medication use" group are most likely due to the small sample sizes. While our findings seem to fairly consistently indicate that the association between 25(OH)D status and NAFLD, regardless of diabetes medication status, the results need to be confirmed by further studies with larger sample sizes. We have also included these findings in **eTable 12** and **13**.

9) A recent Mendelian Randomization study have shown that genetically predicted higher levels of serum 25OhVitD levels were associated with a decreased risk of NAFLD. (Yuan S et al. Clin Gastroenterol Hepatol 2022) Please include in the discussions +/- introduction.

Response: Thank you for this comment. As per the reviewer's suggestion, we have added these recent findings to the **Discussion** section:

"…Moreover, the association of serum 25(OH)D with the risk of NAFLD was not significantly altered and remained significant when we accounted for other, possibly more relevant, factors, such as BMI, physical activity, vitamin D, or calcium supplementation, season during the venesection, and the changing status of 25(OH)D. However, owing to the observational nature of our study, we were not able to establish causality, though our study findings align with a recent Mendelian randomization study of three populations of European descent that reported a significant inverse correlation between genetically predicted serum 25(OH)D levels and NAFLD.(13)" ***(Page 15, 1st paragraph)***

Some minor comments:

10) Page 12, line 239: the median follow-up frequencies for NAFLD-free cohort and NAFLD cohort were 4 years (?) (3-5) and 4 years (?) (3-6), respectively.

Response: We apologize for this lack of clarity. We have specified the unit for median follow-up frequencies as follows:

"The median (interquartile range) follow-up frequencies for the NAFLD-free and NAFLD cohorts were 4 visits (3-5) and 4 visits (3-6), respectively." ***(Page 12, 1st paragraph)***

11) Please add the seasonal data in Table 1.

Response: As the reviewer suggested, we have included the seasonal data in the baseline tables (**Table 1**, and **eTables 1**–**5**).

Thank you very much for your insightful comment and constructive suggestions.

Reviewer 2

In this retrospective study cohort, the authors investigated the association between changes in serum 25-hydroxyvitamin D status during follow-up and 1) the risk of incident

NAFLD and 2) the resolution of pre-existing NAFLD in a large population of almost 140.000 individuals with US-assessed NAFLD. Thus, the investigators demonstrated that maintaining an adequate vitamin D status was associated with either prevention or regression of NAFLD. This is a well-designed study conducted in a very large population, the statistical procedures are correct. Although the relationship between vitamin D and NAFLD has been broadly investigated, this is still a matter of debate, since studies so far are discordant and finally evidence is inconclusive.

A potential weakness of this investigation is the general applicability of its findings, since this research has been conducted in Asian individuals from a specific geographical region - South Korea- and results might not be applicable for other ethnic groups.

My main concern is about the presence of major interfering factors mediating the relationship between vitamin D status and NAFLD incidence: i.e. were the investigators able to consider changes in BMI overtime in the adjusted model or just basal BMI? We are aware that vitamin D level changes according to BMI, and so liver fat content does.

Response: Thank you for this comment. As the reviewer mentioned, our study findings of exclusively Korean individuals may not be attributable to other populations with different sociodemographic characteristics. We are also aware that the body's capacity to synthesize vitamin D, vitamin D status, and even optimal vitamin D levels may differ across different races and ethnicities. In addition, genetic polymorphisms, dietary and sociocultural factors, and geographic locations can also influence vitamin D status (14-16). However, despite substantial controversies, the beneficial effects of vitamin D in NAFLD have been suggested in various experimental and clinical studies of different ethnic groups in diverse geographical locations (17-19). Importantly, given a recently published Mendelian randomization study of European populations that suggested a potentially causal association between higher genetically predicted vitamin D levels and a reduced risk of NAFLD (13), we believe that the therapeutic potential of vitamin D in NAFLD merits further investigations, which should focus on extending our findings to large populations comprising different races and ethnicities. Accordingly, we have addressed the limited generalizability of our study findings as a limitation in the **Discussion** section of the original manuscript. In the revised manuscript, we have elaborated this point in the limitations section.

"Finally, the generalizability of our findings to other populations with different sociodemographic characteristics and other ethnic groups is limited. The body's capacity to synthesize vitamin D, vitamin D status, and even optimal vitamin D levels may differ across different ethnicities. In addition, genetic polymorphisms, dietary and sociocultural factors, and geographic locations can also influence vitamin D status (14-16). Future investigations should focus on extending our findings to large populations comprising different ethnicities in diverse geographical locations." ***(Page 18, 2st paragraph-Page 19, 1st paragraph)***

For BMI adjustment, we adjusted for baseline BMI as well as changes in BMI over time, along with changes in serum 25(OH)D levels in time-dependent models. After controlling for these variables and the changing status of BMI and other covariates over time, the associations remained significant, suggesting that the observed associations between serum 25(OH)D

level and NAFLD are independent of the mentioned factors, including BMI. To clarify this point, we have revised the part of the Statistical analyses and **Result** section, specifically including BMI as one of time-varying covariates.

Minor points

1) Add age range in the abstract.

Response: As suggested, we have included the age range in the **Abstract**.

2) Methods for biochemistry assessment should be specified.

Response: Thank you for this comment. We have further specified the biochemical assessment in the **Methods** section as follows:

"The serum total cholesterol and triglyceride concentrations were determined using an enzymatic colorimetric assay. High-density lipoprotein and low-density lipoprotein cholesterol levels were directly measured using a homogenous enzymatic colorimetric assay. AST, ALT, and GGT were measured using the modified IFCC method, and serum fasting glucose levels were measured using the hexokinase method on Modular DPP systems (Roche Diagnostics, Tokyo, Japan) until 2015, and the Cobas 8000 c702 (Roche Diagnostics) thereafter. Hemoglobin A1c levels were determined using a turbidimetric inhibition immunoassay on the Cobas Integra 800 (Roche Diagnostics) until January 2018 and the Cobas 8000 c513 (Roche Diagnostics) thereafter (RRID:AB_2909460 and AB_2909459). Serum insulin levels were measured using an electrochemiluminescence immunoassay with the sandwich principle on the Modular E170 (Roche Diagnostics, Tokyo, Japan) until April 2015, and the Cobas 8000 e801 (Roche Diagnostics) thereafter (RRID:AB_2756877 and AB_2909455)." ***(Page 7, 3rd paragraph-Page 8, 1st paragraph)***

3) Many typos have been detected throughout the manuscript. Please, check and correct.

Response: We have carefully reviewed our manuscript and made corrections where necessary.

4) "Serum 25(OH)D level >20 ng/mL is considered sufficient for skeletal health in the healthy general population" skeletal health identifies a clinical condition. Vitamin D sufficiency is a bio-analytic definition. Please revise and re-consider this.

Response: According to the reviewer's suggestion, we have revised the wording of the definition of vitamin D sufficiency and insufficiency relevant to our study. We acknowledge that many controversies exist regarding the optimal cutoff values for serum levels of vitamin D. We used the terms "sufficiency," "insufficiency," and "deficiency" in line with the guideline paper recommendations for the classification of vitamin D status that has recently been published in *the Journal of Clinical Endocrinology & Metabolism* (20,21).

"Vitamin D insufficiency is defined as serum 25(OH)D level <20 ng/mL; serum 25(OH)D levels ≥20 ng/mL were considered vitamin D sufficient, according to the recommendation for the healthy general population(20-24)." ***(Page 8, 4th paragraph)***

Reference

1. Kim Y, Chang Y, Ryu S, Cho IY, Kwon M-J, Sohn W, Kim M-K, Wild S, Byrne C. Supplementary Material (Resolution of, and risk of incident non-alcoholic fatty liver disease with changes in serum 25-hydroxy vitamin D status). Figshare repository. 2022. http://doi.org/10.6084/m9.figshare.19500359.v1.
2. Gad AI, Elmedames MR, Abdelhai AR, Marei AM, Abdel-Ghani HA. Efficacy of vitamin D supplementation on adult patients with non-alcoholic fatty liver disease: a single-center experience. *Gastroenterol Hepatol Bed Bench*. 2021;14(1):44-52.
3. Sakpal M, Satsangi S, Mehta M, Duseja A, Bhadada S, Das A, Dhiman RK, Chawla YK. Vitamin D supplementation in patients with nonalcoholic fatty liver disease: A randomized controlled trial. *JGH Open*. 2017;1(2):62-67.
4. Chang Y, Ryu S, Sung E, Jang Y. Higher concentrations of alanine aminotransferase within the reference interval predict nonalcoholic fatty liver disease. *Clin Chem*. 2007;53(4):686-692.
5. Chang Y, Ryu S, Sung E, Woo HY, Cho SI, Yoo SH, Ahn HY, Choi NK. Weight gain within the normal weight range predicts ultrasonographically detected fatty liver in healthy Korean men. *Gut*. 2009;58(10):1419-1425.
6. Shehata E, Qayyum R. The Effect of Serum Vitamin D on Serum ALT Levels in Healthy Individuals. *J Clin Gastroenterol*. 2016;50(9):e81-84.
7. Ashraf AP, Alvarez JA, Gower BA, Saenz KH, McCormick KL. Associations of serum 25-hydroxyvitamin D and components of the metabolic syndrome in obese adolescent females. *Obesity (Silver Spring)*. 2011;19(11):2214-2221.
8. Nikniaz L, Shirmohammadi M, Tabrizi JS, Sadeghi Bazargani H, Farahbakhsh M. Positive Association Between Serum 25-Hydroxy-Vitamin D and Liver Enzymes Levels in Healthy Individuals: A Population-Based Study from Iran. *Int J Vitam Nutr Res*. 2016;86(3-4):127-132.
9. Sohn W, Jun DW, Kwak MJ, Park Q, Lee KN, Lee HL, Lee OY, Yoon BC, Choi HS. Upper limit of normal serum alanine and aspartate aminotransferase levels in Korea. *J Gastroenterol Hepatol*. 2013;28(3):522-529.

10. Hadjittofi C, Coran AG, Mogilner JG, Pollak Y, Matter I, Sukhotnik I. Dietary supplementation with vitamin D stimulates intestinal epithelial cell turnover after massive small bowel resection in rats. *Pediatr Surg Int*. 2013;29(1):41-50.

11. Guo XF, Wang C, Yang T, Li S, Li KL, Li D. Vitamin D and non-alcoholic fatty liver disease: a meta-analysis of randomized controlled trials. *Food Funct*. 2020;11(9):7389-7399.

12. Lian J, Fu J. Efficacy of Various Hypoglycemic Agents in the Treatment of Patients With Nonalcoholic Liver Disease With or Without Diabetes A Network Meta-Analysis. *Front Endocrinol (Lausanne)*. 2021;12:649018.

13. Yuan S, Larsson SC. Inverse Association Between Serum 25-Hydroxyvitamin D and Nonalcoholic Fatty Liver Disease. *Clin Gastroenterol Hepatol*. 2022.

14. Hsu S, Hoofnagle AN, Gupta DK, Gutierrez OM, Peralta CA, Shea S, Allen NB, Burke G, Michos ED, Ix JH, Siscovick D, Psaty BM, Watson KE, Kestenbaum B, de Boer IH, Robinson-Cohen C. Race, Ancestry, and Vitamin D Metabolism: The Multi-Ethnic Study of Atherosclerosis. *J Clin Endocrinol Metab*. 2020;105(12):e4337-4350.

15. Levin GP, Robinson-Cohen C, De Boer IH, Houston DK, Lohman K, Liu Y, Kritchevsky SB, Cauley JA, Tanaka T, Ferrucci L. Genetic variants and associations of 25-hydroxyvitamin D concentrations with major clinical outcomes. *Jama*. 2012;308(18):1898-1905.

16. Yeum K-J, Song BC, Joo N-S. Impact of Geographic Location on Vitamin D Status and Bone Mineral Density. *International journal of environmental research and public health*. 2016;13(2):184-184.

17. Eliades M, Spyrou E, Agrawal N, Lazo M, Brancati FL, Potter JJ, Koteish AA, Clark JM, Guallar E, Hernaez R. Meta-analysis: vitamin D and non-alcoholic fatty liver disease. *Aliment Pharmacol Ther*. 2013;38(3):246-254.

18. Hariri M, Zohdi S. Effect of Vitamin D on Non-Alcoholic Fatty Liver Disease: A Systematic Review of Randomized Controlled Clinical Trials. *Int J Prev Med*. 2019;10:14.

19. Kwok RM, Torres DM, Harrison SA. Vitamin D and nonalcoholic fatty liver disease (NAFLD): is it more than just an association? *Hepatology*. 2013;58(3):1166-1174.

20. Giustina A, Adler RA, Binkley N, Bouillon R, Ebeling PR, Lazaretti-Castro M, Marcocci C, Rizzoli R, Sempos CT, Bilezikian JP. Controversies in Vitamin D: Summary Statement From an International Conference. *J Clin Endocrinol Metab*. 2019;104(2):234-240.

21. Munns CF, Shaw N, Kiely M, Specker BL, Thacher TD, Ozono K, Michigami T, Tiosano D, Mughal MZ, Mäkitie O, Ramos-Abad L, Ward L, DiMeglio LA, Atapattu N, Cassinelli H, Braegger C, Pettifor JM, Seth A, Idris HW, Bhatia V, Fu J, Goldberg G, Sävendahl L, Khadgawat R, Pludowski P, Maddock J, Hyppönen E, Oduwole A, Frew E, Aguiar M, Tulchinsky T, Butler

G, Högler W. Global Consensus Recommendations on Prevention and Management of Nutritional Rickets. *J Clin Endocrinol Metab*. 2016;101(2):394-415.

22. Stokes CS, Lammert F, Volmer DA. Analytical Methods for Quantification of Vitamin D and Implications for Research and Clinical Practice. *Anticancer Res*. 2018;38(2):1137-1144.

23. Ross AC, Taylor CL, Yaktine AL, Del Valle HB. Committee to review dietary reference intakes for vitamin D and calcium. *Food and Nutrition Board*. 2011.

24. Slomski A. IOM endorses vitamin D, calcium only for bone health, dispels deficiency claims. *JAMA*. 2011;305(5):453-454, 456.

eTable 4. Estimated[a] mean values (95% confidence intervals) and adjusted[a] proportions (95% confidence intervals) of baseline characteristics by development of **NAFLD** among participants without NAFLD at baseline (n= 139 599)

Characteristics	**No incident NAFLD**	**Incident NAFLD**	*P* value
Number of participants	112 068	27 531	
Age (years)	35.9 (35.9-35.9)	37.1 (37.0-37.2)	<0.001
Male (%)	34.6 (34.3-34.8)	67.9 (67.4-68.5)	<0.001
Alcohol intake (%) [b]	24.8 (24.6-25.0)	26.1 (25.7-26.5)	<0.001
Current smoker (%)	12.0 (11.8-12.2)	15.1 (14.8-15.5)	<0.001
HEPA (%)	15.0 (14.8-15.2)	14.3 (13.9-14.7)	0.003
Education level (%) [c]	84.6 (84.4-84.8)	82.0 (81.5-82.5)	<0.001
History of diabetes (%)	0.6 (0.5-0.6)	1.0 (0.9-1.1)	<0.001
History of hypertension (%)	3.1 (3.0-3.2)	4.5 (4.3-4.7)	<0.001
History of CVD (%)	0.5 (0.5-0.6)	0.6 (0.5-0.7)	0.177
Glucose-lowering medication (%)	0.4 (0.3-0.4)	0.6 (0.5-0.7)	<0.001
Anti-lipid medication use (%)	0.9 (0.8-0.9)	1.5 (1.4-1.6)	<0.001
Multi-vitamin supplement (%)	12.2 (12.0-12.4)	13 (12.6-13.4)	<0.001
Vitamin D supplement (%)	1.3 (1.3-1.4)	1.3 (1.1-1.4)	0.732
Calcium supplement (%)	0.9 (0.8-0.9)	0.8 (0.7-0.9)	0.584
Season			
Spring	27.1 (26.8-27.4)	24.3 (23.7-24.8)	<0.001

Summer	31.4 (31.2-31.7)	31.0 (30.5-31.6)	0.246
Fall	29.0 (28.7-29.2)	33.3 (32.8-33.9)	<0.001
Winter	12.5 (12.3-12.7)	11.4 (11.0-11.8)	<0.001
Obesity (%) [d]	9.2 (9.0-9.4)	24.6 (24.1-25.1)	<0.001
BMI (kg/m^2)	21.6 (21.6-21.6)	23.3 (23.3-23.4)	<0.001
SBP (mmHg)	104.2 (104.1-104.2)	106.3 (106.2-106.4)	<0.001
DBP (mmHg)	66.5 (66.5-66.6)	68.0 (67.9-68.1)	<0.001
Glucose (mg/dl)	91.1 (91.1-91.2)	92.8 (92.7-92.9)	<0.001
Total cholesterol (mg/dl)	185.1 (184.9-185.3)	192.0 (191.6-192.4)	<0.001
GGT (U/L)	19.6 (19.5-19.8)	24.5 (24.2-24.7)	<0.001
ALT (U/L)	16.8 (16.7-16.8)	19.5 (19.4-19.7)	<0.001
HOMA-IR	1.14 (1.13-1.14)	1.45 (1.44-1.46)	<0.001
Total energy intake (kcal/d) [f]	1481.9 (1477.7-1486.1)	1545.3 (1536.6-1554.1)	<0.001

[a]Adjusted for age and sex; [b] ≥10 g/day; [c] ≥ college graduate; [d] BMI ≥ 25 kg/m^2; [e] waist circumference ≥90 cm for men and ≥85 cm for women; [f] among 103 514 participants with plausible estimated energy intake levels (within three standard deviations from the log-transformed mean energy intake).

Abbreviations: ALT, alanine aminotransferase; BMI, body mass index; CVD, cardiovascular disease; DBP, diastolic blood pressure; GGT, gamma-glutamyl transferase; HEPA, health-enhancing physical activity; hs-CRP, high-sensitivity C-reactive protein; HOMA-IR, homeostasis model assessment of insulin resistance; NAFLD, non-alcoholic fatty liver disease; SBP, systolic blood pressure.

eTable 5. Estimated[a] mean values (95% confidence intervals) and adjusted[a] proportions (95% confidence intervals) of baseline characteristics by resolution of **NAFLD** among participants with NAFLD at baseline (n=30 848)

Characteristics	**No NAFLD resolution**	**NAFLD resolution**	*P* value
Number of participants	35 253	13 449	
Age (years)	38.5 (38.4-38.6)	39.1 (38.9-39.2)	<0.001
Male (%)	85.1 (84.7-85.4)	74.7 (73.9-75.4)	<0.001
Alcohol intake (%) [b]	39.2 (38.7-39.7)	41.6 (40.8-42.4)	<0.001
Current smoker (%)	27.6 (27.1-28.0)	26.9 (26.1-27.7)	0.162
HEPA (%)	13.4 (13.0-13.7)	13.9 (13.3-14.5)	0.132
Education level (%) [c]	85.2 (84.9-85.6)	86.9 (86.4-87.4)	<0.001
History of diabetes (%)	4.0 (3.8-4.2)	3.2 (2.9-3.5)	<0.001
History of hypertension (%)	13.1 (12.7-13.4)	10.2 (9.7-10.7)	<0.001
History of CVD (%)	1.0 (0.9-1.1)	1.0 (0.8-1.1)	0.962
Glucose-lowering medication	3.0 (2.8-3.1)	2.2 (2.0-2.5)	<0.001
Anti-lipid medication use (%)	4.1 (3.9-4.3)	3.2 (3.0-3.5)	<0.001
Multi-vitamin supplement (%)	11.6 (11.3-12.0)	13.6 (13.1-14.2)	<0.001
Vitamin D supplement (%)	0.9 (0.8-1.0)	0.9 (0.7-1.0)	0.676
Calcium supplement (%)	0.5 (0.4-0.5)	0.5 (0.4-0.6)	0.516
Season			
Spring	24.2 (23.7-24.6)	22.7 (22.0-23.4)	0.001

Summer	30.5 (30.0-31.0)	30.1 (29.3-30.9)	0.340
Fall	33.9 (33.4-34.4)	36.4 (35.6-37.2)	<0.001
Winter	11.4 (11.1-11.7)	10.9 (10.4-11.4)	0.118
Obesity (%) [d]	65.1 (64.6-65.6)	52.6 (51.7-53.4)	<0.001
BMI (kg/m^2)	26.4 (26.4-26.5)	25.4 (25.4-25.5)	<0.001
SBP (mmHg)	115.3 (115.2-115.4)	113.7 (113.5-113.9)	<0.001
DBP (mmHg)	74.3 (74.2-74.4)	73.4 (73.3-73.6)	<0.001
Glucose (mg/dl)	99.3 (99.1-99.5)	98.2 (97.9-98.5)	0.075
Total cholesterol (mg/dl)	205.3 (204.9-205.6)	203.7 (203.1-204.3)	<0.001
GGT (U/L)	45.2 (44.8-45.7)	39.8 (39.0-40.5)	<0.001
ALT (U/L)	40.5 (40.2-40.8)	30.7 (30.2-31.2)	<0.001
HOMA-IR	2.34 (2.32-2.36)	1.86 (1.83-1.89)	<0.001
Total energy intake (kcal/d) [f]	1656.3 (1648.3-1664.2)	1675.3 (1662.5-1688.2)	<0.001

[a]Adjusted for age and sex; [b] ≥10 g/day; [c] ≥ college graduate; [d] BMI ≥ 25 kg/m^2; [e] waist circumference ≥90 cm for men and ≥85 cm for women; [f] among 103 514 participants with plausible estimated energy intake levels (within three standard deviations from the log-transformed mean energy intake).

Abbreviations: ALT, alanine aminotransferase; BMI, body mass index; CVD, cardiovascular disease; DBP, diastolic blood pressure; GGT, gamma-glutamyl transferase; HEPA, health-enhancing physical activity; hs-CRP, high-sensitivity C-reactive protein; HOMA-IR, homeostasis model assessment of insulin resistance; NAFLD, non-alcoholic fatty liver disease; SBP, systolic blood pressure.

eTable 7. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by 25(OH)D levels after further adjustment for waist circumference among participants with available waist circumferences

25(OH)D levels (ng/mL)	Among participants **without** NAFLD at baseline (n = 138 962)	Among participants **with** NAFLD at baseline (n = 48 680)
	Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD
<10	1.00 (reference)	1.00 (reference)
10-19	0.89 (0.86–0.92)	1.09 (1.03–1.15)
20-29	0.82 (0.78–0.85)	1.13 (1.06–1.21)
≥30	0.72 (0.67–0.78)	1.21 (1.09–1.34)
p–trend	<0.001	<0.001

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, calcium supplements, and waist circumference.

Abbreviations: BMI, body mass index; HR, hazard ratio.

eTable 8. Resolution of non-alcoholic fatty liver disease (NAFLD) by 25(OH)D levels according to vitamin D supplementation among participants with NAFLD at baseline (n=48 702)

25(OH)D levels (ng/mL)	Multivariable-adjusted HR (95% confidence intervals) [a] for **resolution** of NAFLD		P for interaction
	No vitamin D supplements (n = 48 271)	Vitamin D supplements (n = 431)	
<10	1.00 (reference)	1.00 (reference)	0.719
10-19	1.09 (1.03–1.15)	0.93 (0.44–1.94)	
20-29	1.13 (1.06–1.21)	0.96 (0.45–2.05)	
≥30	1.22 (1.10–1.36)	0.81 (0.36–1.84)	
p–trend	<0.001	0.636	

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, and calcium supplements.

Abbreviations: BMI, body mass index; HR, hazard ratio

eTable 10. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration at two examinations after further adjustment for waist circumference among participants with available waist circumference

25(OH)D changes (ng/mL)		Among participants **without** NAFLD at baseline (n = 92 347)	Among participants **with** NAFLD at baseline (n = 30 835)
Visit 1	Visit 2	Multivariable-adjusted HR (95% confidence intervals) [a] for **incident** NAFLD	Multivariable-adjusted HR (95% confidence intervals) [a] for **resolution** of NAFLD
<20	<20	1.00 (reference)	1.00 (reference)
≥20	<20	0.93 (0.87–0.98)	0.97 (0.88–1.06)
<20	≥20	0.87 (0.82–0.91)	1.02 (0.94–1.12)
≥20	≥20	0.81 (0.77–0.86)	1.10 (1.01–1.19)

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, calcium supplements, and waist circumference.

Abbreviations: BMI, body mass index; HR, hazard ratio

eTable 11. Resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration at two examinations according to vitamin D supplements among participants with NAFLD at baseline (n=30 848)

25(OH)D changes (ng/mL)		Multivariable-adjusted HR (95% confidence intervals) [a] for **resolution** of NAFLD		P for interaction
Visit 1	Visit 2	No vitamin D supplements (n = 30 621)	Vitamin D supplements (n = 227)	
<20	<20	1.00 (reference)	1.00 (reference)	0.638
≥20	<20	0.98 (0.89–1.07)	0.46 (0.11–1.98)	
<20	≥20	1.03 (0.94–1.12)	0.64 (0.19–2.19)	
≥20	≥20	1.10 (1.01–1.19)	1.16 (0.57–2.35)	

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, and calcium supplements.

Abbreviations: BMI, body mass index; HR, hazard ratio

eTable 12. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by 25(OH)D levels according to glucose-lowering medication

25(OH)D levels (ng/mL)	Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD Among participants **without** NAFLD at baseline (n = 139 599)		*P* for interaction	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD among participants **with** NAFLD at baseline (n = 48 702)		*P* for interaction
	No glucose-lowering medication (n = 139 012)	Glucose-lowering medication (n = 587)		No glucose-lowering medication (n = 47 346)	Glucose-lowering medication (n = 1356)	
<10	1.00 (reference)	1.00 (reference)	0.674	1.00 (reference)	1.00 (reference)	0.152
10-19	0.89 (0.86–0.92)	1.01 (0.63–1.63)		1.08 (1.02–1.14)	1.26 (0.84–1.88)	
20-29	0.81 (0.78–0.85)	0.76 (0.46–1.28)		1.13 (1.06–1.20)	1.50 (0.98–2.31)	
≥30	0.72 (0.67–0.77)	0.70 (0.36–1.34)		1.19 (1.07–1.32)	2.04 (1.22–3.41)	
p–trend	<0.001	0.094		<0.001	0.003	

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, multi-vitamin supplements, vitamin D supplements, and calcium supplements.

Abbreviations: HR, hazard ratio

eTable 13. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration at two examinations according to glucose-lowering medication among participants with NAFLD at baseline

25(OH)D changes (ng/mL)		Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD Among participants **without** NAFLD at baseline (n = 92 792)		P for interaction	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD among participants **with** NAFLD at baseline (n = 30,848)		P for interaction
Visit 1	Visit 2	No glucose-lowering medication (n = 92 519)	Glucose-lowering medication (n = 273)		No glucose-lowering medication (n = 29 971)	Glucose-lowering medication (n = 877)	
<20	<20	1.00 (reference)	1.00 (reference)	0.944	1.00 (reference)	1.00 (reference)	0.490
≥20	<20	0.92 (0.87–0.98)	0.74 (0.29–1.87)		0.96 (0.88–1.06)	1.22 (0.73–2.02)	
<20	≥20	0.87 (0.82–0.91)	0.75 (0.33–1.67)		1.03 (0.94–1.12)	0.73 (0.40–1.34)	
≥20	≥20	0.80 (0.76–0.85)	0.71 (0.40–1.28)		1.10 (1.01–1.19)	1.17 (0.78–1.76)	

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, multi-vitamin supplements, vitamin D supplements, and calcium supplements.

Abbreviations: HR, hazard ratio

eTable 14. Development and resolution of non-alcoholic fatty liver disease (NAFLD) based on 25(OH)D levels among participants with alanine transaminase (ALT) <36 IU/L

25(OH)D levels (ng/mL)	Among participants **without** NAFLD at baseline (n = 132 666)	Among participants **with** NAFLD at baseline (n = 29 829)
	Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD
<10	1.00 (reference)	1.00 (reference)
10-19	0.89 (0.86–0.92)	1.11 (1.05–1.18)
20-29	0.81 (0.78–0.85)	1.12 (1.04–1.20)
≥30	0.73 (0.68–0.79)	1.19 (1.06–1.34)
p–trend	<0.001	0.002

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements.

Abbreviations: ALT, alanine transaminase; BMI, body mass index; HR, hazard ratio

eTable 15. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration in two examinations among participants with alanine transaminase (ALT) <36 IU/L

25(OH)D changes (ng/mL)		Among participants **without** NAFLD at baseline (n = 89 021)	Among participants **with** NAFLD at baseline (n = 17 743)
Visit 1	Visit 2	Multivariable-adjusted HR (95% confidence intervals)[a] for **incident** NAFLD	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of NAFLD
<20	<20	1.00 (reference)	1.00 (reference)
≥20	<20	0.93 (0.87–0.99)	0.89 (0.80–1.002)
<20	≥20	0.87 (0.82–0.91)	1.05 (0.94–1.16)
≥20	≥20	0.79 (0.75–0.84)	1.04 (0.94–1.15)

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements.

Abbreviations: ALT, alanine transaminase; BMI, body mass index; HR, hazard ratio

eTable 16. Development and resolution of elevated ALT (≥36 IU/L) by 25(OH)D levels

25(OH)D levels (ng/mL)	Among participants with ALT < 36 IU/L at baseline (n = 162 495)	Among participants with ALT ≥ 36 IU/L at baseline (n = 25 806)
	Multivariable-adjusted HR (95% confidence intervals)[a] for development of elevated ALT	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of elevated ALT
<10	1.00 (reference)	1.00 (reference)
10-19	0.95 (0.92–0.99)	1.04 (0.98–1.09)
20-29	0.92 (0.88–0.96)	1.07 (1.01–1.13)
≥30	0.89 (0.83–0.95)	1.15 (1.05–1.25)
p–trend	<0.001	0.002

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements.

Abbreviations: ALT, alanine transaminase; HR, hazard ratio

eTable 17. Development and resolution of non-alcoholic fatty liver disease (NAFLD) by binary categories of 25(OH)D concentration at two examinations

25(OH)D changes (ng/mL)		Among participants with ALT < 36 IU/L at baseline (n = 110 727)	Among participants with ALT ≥ 36 IU/L at baseline (n = 9906)
Visit 1	Visit 2	Multivariable-adjusted HR (95% confidence intervals)[a] for development of elevated ALT	Multivariable-adjusted HR (95% confidence intervals)[a] for **resolution** of elevated ALT
<20	<20	1.00 (reference)	1.00 (reference)
≥20	<20	0.98 (0.92–1.03)	1.05 (0.95–1.15)
<20	≥20	0.96 (0.91–1.01)	0.99 (0.90–1.08)
≥20	≥20	0.95 (0.90–0.99)	1.04 (0.95–1.14)

[a] Estimated from Cox proportional hazards models. Multivariable model was adjusted for age, sex, center, year of screening examination, alcohol consumption, smoking, physical activity, total energy intake, education level, BMI, medication for hyperlipidemia, glucose-lowering medication, multi-vitamin supplements, vitamin D supplements, and calcium supplements.

Abbreviations: ALT, alanine transaminase; HR, hazard ratio