



Dried Urine Test for Comprehensive Hormones



Accession # 00239871

Jane Doe
123 4th St.
Anytown, FL 97155



PRECISION ANALYTICAL INC.
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Last Menstrual Period:

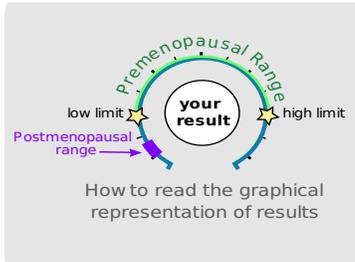
Ordering physician:
Precision Analytical

DOB: 1976-01-03
Age: 40
Gender: Female

Collection Times:
2016-10-01 06:01AM
2016-10-01 08:01AM
2016-10-01 06:01PM
2016-10-01 10:01PM

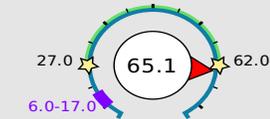
Hormone Testing Summary

All units are given in ng/mg creatinine

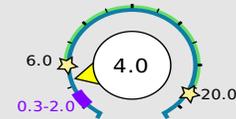


Sex Hormones

See Pages 2 and 3 for a thorough breakdown of sex hormone metabolites



Total Estrogen
(Sum of 8 Estrogen Metabolites)



Progesterone
(Serum Equivalent, ng/mL)

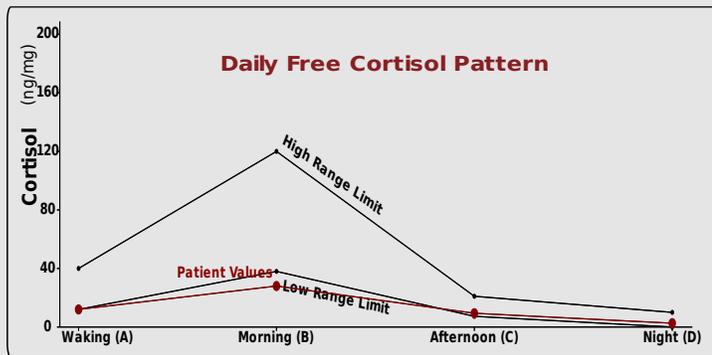


Testosterone

Progesterone Serum Equivalent is a calculated value based on urine pregnanediol.

Adrenal Hormones

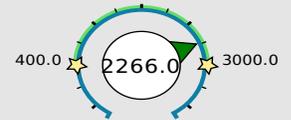
See pages 4 and 5 for a more complete breakdown of adrenal hormones



Free cortisol best reflects tissue levels. Metabolized cortisol best reflects total cortisol production.

Total DHEA Production

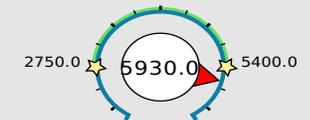
Age	Range
20-30	1000-3000
30-40	800-2000
40-60	530-1550
>60	400-1350



Total DHEA Production
(DHEAS + Etiocholanolone + Androsterone)



24hr Free Cortisol
(A+B+C+D)



Metabolized Cortisol (THF+THE)
(Total Cortisol Production)

Thank you for testing with us!

Please be sure to always read below for any specific lab comments. More detailed comments can be found on page 7.

PLEASE NOTE: We have added a new marker to the DUTCH Complete. See page 5 and provider comments for information on 8-OHdG.

- Because inflammation blocks DHEA being converted to DHEAS, consider inflammation as a potential part of the overall clinical picture when DHEAS is significantly lower than the downstream metabolites of DHEA (Androsterone, Etiocholanolone) as seen in this case (see page3).

Your DUTCH Complete report will include a summary (page 1), a list of all of the hormones tested and their ranges (pages 2,4) as well as a graphical representation of the results (pages 3,5). You will also see a steroid pathway for your reference (page 6) and provider notes. This report is not intended to treat, cure or diagnose any specific diseases.

There is a series of videos in our video library at dutchtest.com that you may find useful in understanding the report. The following videos (which can also be found on the website under the listed names) may be particularly helpful in aiding your understanding:

[DUTCH Complete Overview \(quick overview\)](#)
[Estrogen Tutorial; Androgen Tutorial; Cortisol Tutorial](#)



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Sex Hormones and Metabolites

Last Menstrual Period:

Ordering physician:
Precision Analytical

DOB: 1976-01-03
Age: 40
Gender: Female

Collection Times:
2016-10-01 06:01AM
2016-10-01 08:01AM
2016-10-01 06:01PM
2016-10-01 10:01PM

Category	Test	Result	Units	Normal Range
Progesterone Metabolites				
	b-Pregnanediol	Below premenopausal range	200.0	ng/mg 450 - 2300
	a-Pregnanediol	Low end of range	120.0	ng/mg 120 - 740
Androgen Metabolites				
	DHEAS	Low end of range	26.0	ng/mg 23 - 350
	Androsterone	High end of range	1560.0	ng/mg 400 - 1700
	Etiocholanolone	Within range	680.0	ng/mg 260 - 950
	Testosterone	Within range	7.7	ng/mg 4 - 14
	5a-DHT	High end of range	7.5	ng/mg 0 - 8.8
	5a-Androstanediol	Above range	42.0	ng/mg 12 - 30
	5b-Androstanediol	Within range	32.0	ng/mg 20 - 75
	Epi-Testosterone	Below range	2.0	ng/mg 4.5 - 22.3
Estrogen Metabolites				
	Estrone(E1)	Above range	28.2	ng/mg 12 - 26
	Estradiol(E2)	Above range	5.1	ng/mg 1.8 - 4.5
	Estriol(E3)	Above range	22.5	ng/mg 5 - 18
	2-OH-E1	Below premenopausal range	3.6	ng/mg 4.6 - 14.4
	4-OH-E1	Within range	0.7	ng/mg 0 - 1.8
	16-OH-E1	Above range	4.7	ng/mg 1 - 3.5
	2-Methoxy-E1	Below premenopausal range	0.8	ng/mg 2 - 5.5
	2-OH-E2	Within range	0.71	ng/mg 0 - 1.2

Normal Ranges	Luteal	Postmenopausal	Follicular	Ovulatory
Estrone (E1)	12-26	3.0-7.0	4.0-12.0	22-68
Estradiol (E2)	1.8-4.5	0.3-0.9	1.0-2.0	4.0-12.0
Estriol (E3)	5-18	1.5-4.0	N/A	N/A
2-OH-E1	4.6-14.4	0.4-2.0	N/A	N/A
4-OH-E1	0-1.8	0-0.3	N/A	N/A
16-OH-E1	1-3.5	0.2-0.6	N/A	N/A
2-Methoxy-E1	2-5.5	0.5-1.4	N/A	N/A
Oral Pg (100mg)				
a-Pregnanediol	120-740	15-50	580-3000	25-100 25-100
b-Pregnanediol	450-2300	60-200	2000-9000	100-300 100-300

HOW TO READ YOUR RESULTS: Hormones are presented on this page graphically in the order the body metabolizes them. Arrows represent conversion from one hormone to another. The stars represent the low and high limits of the reference ranges (see example, right). The number in the middle is your result.



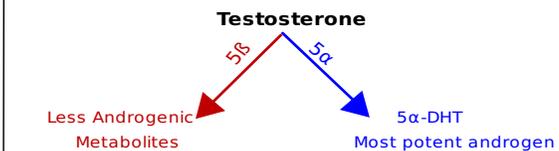
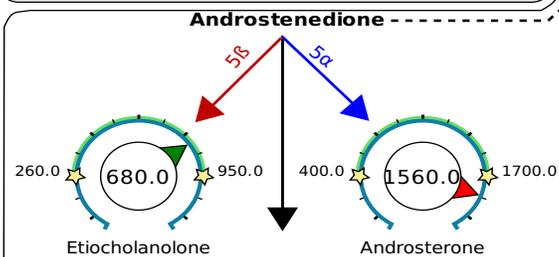
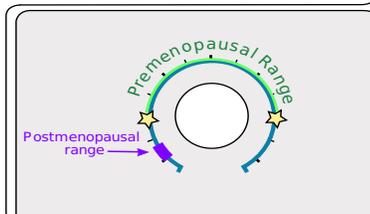
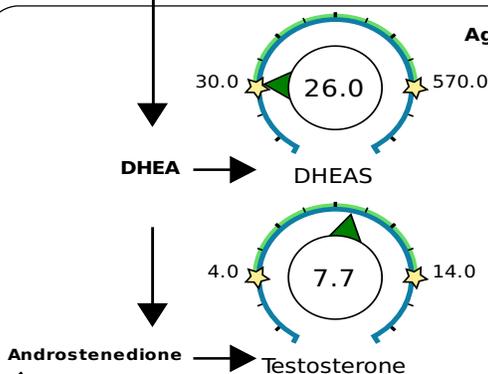
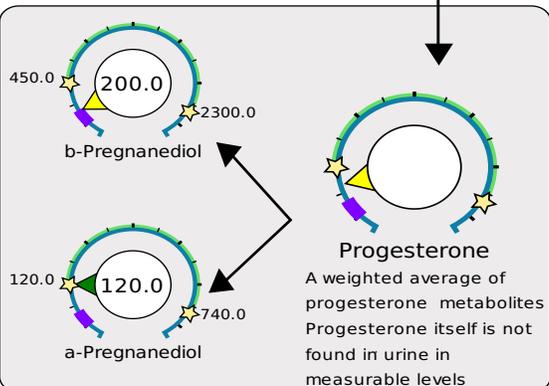
Progesterone Metabolism female

Pregnenolone

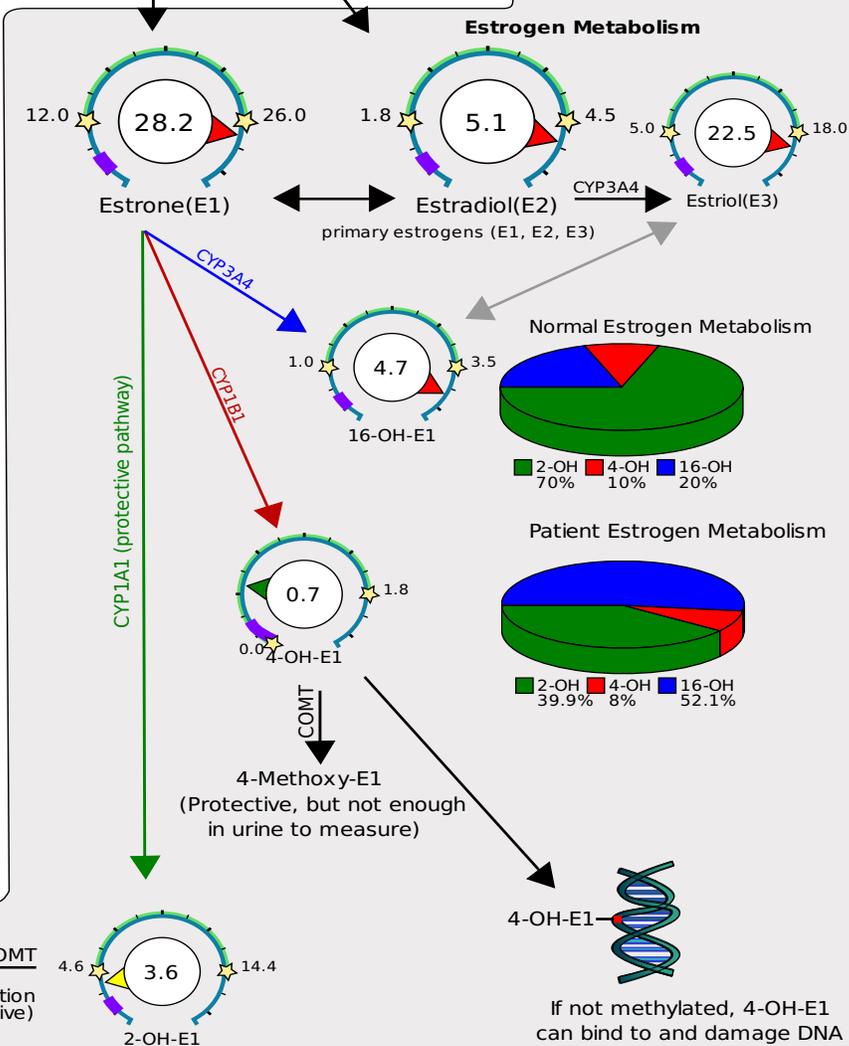
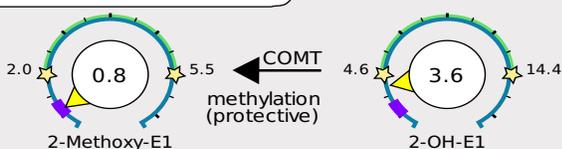
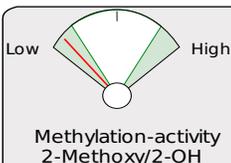
Androgen Metabolism

Age-Dependent DHEAS Ranges

Age	DHEAS
20-30	50-570
30-40	30-280
40-60	20-150
>60	15-115



5α-metabolism makes androgens more androgenic, most notably 5α-DHT is the most potent testosterone metabolite (~3x more potent than testosterone itself). 5α-Reductase activity is assessed using the ratio of Androsterone (5α) to Etiocholanolone (5β).





Dried Urine Test for Comprehensive Hormones

Advanced Adrenal Assessment

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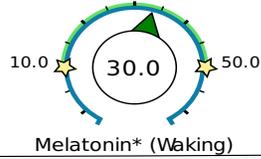
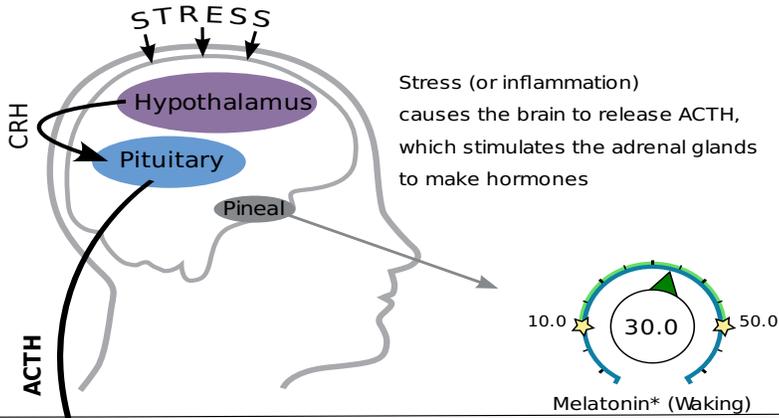
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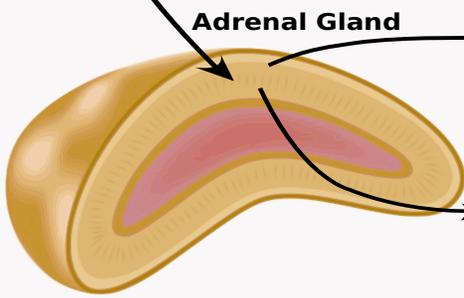
Category	Test	Result	Units	Normal Range
Creatinine				
	Creatinine A (Waking)	Within range	1.1 mg/ml	0.2 - 2
	Creatinine B (Morning)	Within range	0.7 mg/ml	0.2 - 2
	Creatinine C (Afternoon)	Within range	0.8 mg/ml	0.2 - 2
	Creatinine D (Night)	Within range	0.7 mg/ml	0.2 - 2
Daily Free Cortisol and Cortisone				
	Cortisol A (Waking)	Low end of range	12.0 ng/mg	12 - 40
	Cortisol B (Morning)	Below range	28.0 ng/mg	38 - 120
	Cortisol C (Afternoon)	Low end of range	9.4 ng/mg	7.3 - 21
	Cortisol D (Night)	Within range	2.6 ng/mg	0 - 10
	Cortisone A (Waking)	Below range	30.0 ng/mg	40 - 100
	Cortisone B (Morning)	Below range	60.0 ng/mg	90 - 200
	Cortisone C (Afternoon)	Below range	21.4 ng/mg	32 - 80
	Cortisone D (Night)	Within range	16.0 ng/mg	0 - 42
	24hr Free Cortisol	Below range	52.0 ug	80 - 185
	24hr Free Cortisone	Below range	127.0 ug	220 - 400
Cortisol Metabolites and DHEAS				
	a-Tetrahydrocortisol (a-THF)	Above range	400.0 ng/mg	75 - 265
	b-Tetrahydrocortisol (b-THF)	Above range	2500.0 ng/mg	1050 - 2070
	b-Tetrahydrocortisone (b-THE)	High end of range	3030.0 ng/mg	1550 - 3150
	Metabolized Cortisol (THF+THE)	Above range	5930.0 ng/mg	2750 - 5400
	DHEAS	Below range	26.0 ng/mg	30 - 570

DUTCH Complete Extras				
Category	Test	Result	Units	Normal Range
Melatonin (*measured as 6-OH-Melatonin-Sulfate)				
	Melatonin* (Waking)	Within range	30.0 ng/mg	10 - 50
Oxidative Stress / DNA Damage, measured as 8-Hydroxy-2-deoxyguanosine (8-OHdG)				
	8-OHdG (Waking)	Within range	2.3 ng/mg	0 - 4.5



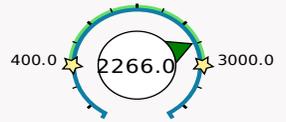
Total DHEA Production

Age	Range
20-30	1000-3000
30-40	800-2000
40-60	530-1550
>60	400-1350



DHEA

A patient's catabolic vs anabolic balance can be estimated by observing relative DHEA (anabolic) vs cortisol (catabolic) production



Total DHEA Production (DHEAS + Etiocholanolone + Androsterone)

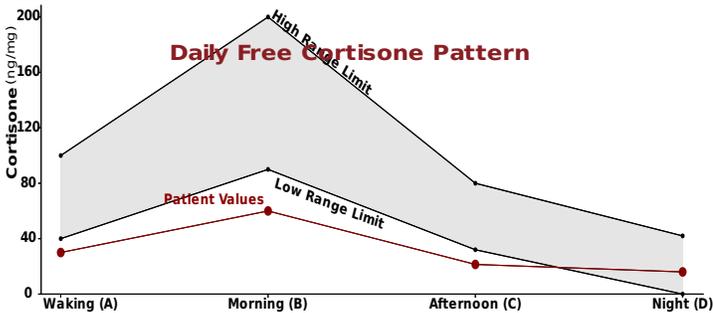
Cortisol

Cortisol Metabolism

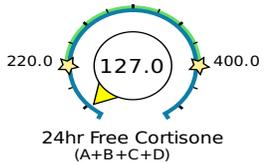
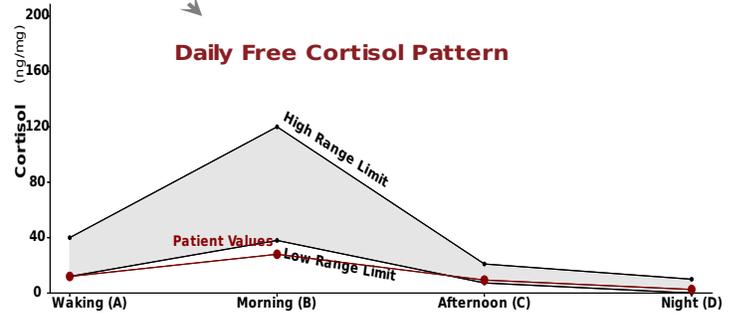
Circulating Free Cortisol



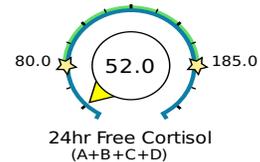
Metabolized Cortisol (THF+THE) (Total Cortisol Production)



Note: "Waking" samples reflect overnight production



Cortisol and Cortisone interconvert (11b-HSD) and are metabolized to THF & THE for excretion



More cortisone metabolites (THE)

More cortisol metabolites (THF)

NOTE: The balance between free cortisol and free cortisone reflects the kidney's conversion of cortisol to cortisone. See below for the overall preference between cortisol and cortisone.

NOTE: This 11b-HSD index measures the balance of cortisol and cortisone metabolites which best reflects the overall balance of active cortisol and inactive cortisone systemically.

Provider Notes

DUTCH welcomes 8-OHdG

8-OHdG (8-hydroxy-2-deoxyguanosine) results can be seen on page 5 of the DUTCH Complete report. It is a marker for estimating DNA damage due to oxidative stress (ROS creation). 8-OHdG is considered pro-mutagenic as it is a biomarker for various cancer and degenerative disease initiation and promotion. It can be increased by chronic inflammation, increased cell turnover, chronic stress, hypertension, hyperglycemia/pre-diabetes/diabetes, kidney disease, IBD, chronic skin conditions (psoriasis/eczema), depression, atherosclerosis, chronic liver disease, Parkinson's (increasing levels with worsening stages), Diabetic neuropathy, COPD, bladder cancer, or insomnia. Studies have shown higher levels in women with breast and prostate cancers. When levels are elevated it may be prudent to eliminate or reduce any causes and increase the consumption of antioxidant containing foods and/or supplements.

Thank you for testing with us! If this is your first report, you are encouraged to watch our educational videos on how to read the report. There are hyperlinks to these videos on the first page of a DUTCH Complete or in these comments (below). The videos can also be seen by going to www.DutchTest.com and visiting the video library. Comments in the report that are specific to the patient ARE IN ALL CAPS or may be **bold**. The other information is general information that we hope you will find useful in understanding the patient's results. These results are not intended to diagnose any specific conditions. Treatments based on results should be made by a qualified healthcare provider.

THE PATIENT REPORTS IRREGULAR MENSTRUAL CYCLES.

THE PATIENT REPORTED SYMPTOMS OF EXCESS ESTROGEN. THIS CAN BE CAUSED BY EXCESS ESTROGEN OR PROGESTERONE DEFICIENCY. RESULTS SHOULD BE CAREFULLY REVIEWED. WE DO NOT REPORT A PROGESTERONE TO ESTROGEN RATIO. HOWEVER, YOU CAN INVESTIGATE THIS ISSUE BY LOOKING AT THE RELATIVE LEVEL OF THESE TWO HORMONES ON THEIR RESPECTIVE GAUGES.

THE PATIENT REPORTED SIGNIFICANT SYMPTOMS OF EXCESS ANDROGEN LEVELS.

THE PATIENT REPORTED SIGNIFICANT FATIGUE IN BOTH THE AM AND PM.

Progesterone Metabolism: The primary role of progesterone is to balance the strong effects of estrogen. Progesterone metabolites are measured and reflect progesterone levels well because very little progesterone is found in urine, so b-Pregnanediol is typically used a surrogate marker because it is the most abundant metabolite, but we also test the corresponding a-pregnanediol. The average of the two metabolites is reported for progesterone. If levels are in the lower part of the reference range compared to estrogen levels, symptoms of too much estrogen may occur. When ordering the DUTCH Complete, you will see Progesterone Serum Equivalent on the summary page 1. The urine metabolites of progesterone have been proven to correlate strongly enough to serum progesterone to provide this value. The correlation is the strongest for values within the premenopausal luteal range. Urine metabolites can at times result in somewhat higher serum equivalent results in the postmenopausal range. For this reason the postmenopausal Serum Equivalent range is slightly higher than typical serum ranges. NOTE: If progesterone is taken orally (also with sublingual), these metabolites are elevated from gut metabolism and results do NOT accurately reflect serum levels.

Androgen Metabolism: This group of hormones is typically thought of as "male" hormones, but they play a key role for women as well. Testosterone is made in the ovaries as well as the adrenal glands. In postmenopausal women, the adrenal glands are the primary source of testosterone. a-DHT (a-dihydrotestosterone) is the most potent androgen (3X more than testosterone), but it is primarily made within the liver and target cells (it is a paracrine hormone) and not by the gonads. a-DHT is subsequently deactivated to a-androstenediol within target tissues and then excreted. Only a fraction of a-DHT formed actually enters circulation as a-DHT (Toscano, 1987). The corresponding beta metabolites (for example b-DHT) are not androgenic. Looking at the balance of androsterone (alpha) and etiocholanolone offer the best approximation of how readily DHT will be made. Elevated androgens can cause general and sexual aggression, increased muscle mass, increased facial/body hair, reduction of fat deposition, and increased libido. Androgen deficiency can lead to decreased sexual function, vaginal dryness, fatigue, depression, and bone loss.

5a-Reductase Activity: The competing enzymes 5a and 5b-reductase act on the androgens androstenedione (creating androsterone and etiocholanolone located under the progesterone picture) and testosterone (creating a-DHT and b-DHT). They also metabolize progesterone, and cortisol. The alpha metabolites of androstenedione and testosterone are far more androgenic than their beta counterparts. Consequently, increased 5a-reductase activity may be accompanied by clinical signs of androgenicity (excess facial hair growth, scalp hair loss, acne, irritability, oily skin, prostate issues in men...etc). If the patient heavily favors the 5a pathway and there are concerns of excess androgenicity (or prostate cancer risk), this may be worth addressing.

Estrogen Metabolism: There are two primary issues with respect to estrogens. 1) Estrogen production (is the patient deficient, sufficient, or in excess?) and 2) Estrogen metabolism (is the metabolism of estrogen favorable or unfavorable when looking at the phase 1 hydroxylation and phase 2 methylation pathways?)

While estradiol (E2) is the most potent estrogen, levels of estrone (E1) and estriol (E3) should also be considered when evaluating the patient's estrogen production. It is important to compare the patient's distribution of metabolites from the pie chart (2nd pie chart) to "Normal Estrogen Metabolism" pie chart. If they are making considerably less of the protective 2-OH estrogens, consider something to improve this metabolism (DIM, I-3-C, etc). Be advised that increasing 2-OH metabolism will

likely lower E1 and E2 as well which may not be warranted if E1 and E2 are already low. It is our position that the ratio of 2:16 OHE1 is not as relevant as has been thought historically (Obi, 2011). Providers may still wish to use this index and it can be calculated by simply dividing the two numbers. A female reference range for the ratio with our methodology is 2.4-6.0.

The methylation index will show you how effectively the patient is turning 2 and 4-OH estrogens into methoxy estrogens. Methylation protects against potentially harmful 4-OH estrogens (carcinogenic) made in phase 1 detoxification. Supporting the methylation pathway should be considered if this index is low.

PATIENTS TYPICALLY METABOLIZE A MUCH HIGHER PERCENTAGE OF THEIR ESTROGENS DOWN THE MORE PROTECTIVE 2-OH PATHWAY IN PHASE 1 DETOXIFICATION. DIINDOLYLMETHANE (DIM) OR INDOLE-3-CARBINOL CONTAINING PRODUCTS CAN HELP MOVE ESTROGENS MORE EFFICIENTLY DOWN THIS PATHWAY. BE AWARE THAT THIS TYPICALLY LOWERS MOST OF THE OTHER ESTROGENS, INCLUDING E1 AND E2 AS WELL. IF PATIENTS ARE TAKING OR CONSIDERING HORMONE REPLACEMENT THERAPY, THESE PRODUCTS MAY BE CONSIDERED BUT A HIGHER DOSE OF ESTROGEN MAY BE NEEDED FOR THE SAME CLINICAL EFFECT IF TAKEN AT THE SAME TIME.

DUTCH Adrenal: The HPA-Axis refers to the communication and interaction between the hypothalamus (H) and pituitary (P) in the brain down to the adrenal glands (A) that sit on top of your kidneys. When a physical or psychological stressor occurs, the hypothalamus tells the pituitary to make ACTH, a hormone. ACTH stimulates the adrenal glands to make the stress hormone, cortisol and to a lesser extent DHEA and DHEA-S. Normally, the HPA-axis production follows a daily pattern in which cortisol rises rather rapidly in the first 10-30 minutes after waking in order to help with energy, then gradually decreases throughout the day so that it is low at night for sleep. The cycle starts over the next morning. Abnormally high activity occurs in Cushing's Disease where the HPA-axis is hyper-stimulated causing cortisol to be elevated all day. The opposite is known as Addison's Disease, where cortisol is abnormally low because it is not made appropriately in response to ACTH's stimulation. These two conditions are somewhat rare. Examples of more common conditions related to less severely abnormal cortisol levels include fatigue, depression, insomnia, fibromyalgia, anxiety, inflammation and more.

Only a fraction of cortisol is "free" and bioactive. This fraction of cortisol is very important, but levels of metabolized cortisol best represents overall production of cortisol therefore both should be taken into account to correctly assess adrenal function.

The Daily Free Cortisol Pattern: In healthy adrenal function, cortisol levels are expected to rise in the early morning and fall throughout the day, reaching the lowest point around 1am and peaking 30-60min after waking. The waking sample represents the total of free cortisol throughout the sleeping period. Cortisone is the inactive form of cortisol. Its pattern is of secondary importance, but at times can give additional clarity and is provided on the adrenal page. Typical urine testing (24-hour collection) averages the daily production of cortisol. This approach is not able to properly characterize individuals whose cortisol patterns do not fit the typical rise then fall pattern through the day. Dysfunctional diurnal patterns have been associated with health-related problems such as fatigue and insomnia.

The daily total of free cortisol is approximated by summing the four measurements. This calculated value correlates to a 24-hour free cortisol value. It is helpful to compare the relative level of 24-hr free cortisol with metabolized cortisol to understand HPA-axis activity. The total of free cortisol for the day only represents about 1-3% of the total production. The total of the metabolites is a better marker for overall cortisol production.

WHILE FREE CORTISOL LEVELS ARE LOW, THESE RESULTS CAN BE SOMEWHAT MISLEADING IN THIS CASE. OVERALL CORTISOL PRODUCTION IS BEST APPROXIMATED BY LEVELS OF METABOLIZED CORTISOL, WHICH ARE ELEVATED. THIS IMPLIES THAT OVERALL HPA-AXIS ACTIVITY IS ELEVATED. CORTISOL CLEARANCE IS UP-REGULATED IN THIS PATIENT, LEAVING THEM WITH LOW LEVELS OF FREE CORTISOL. THE PATIENT'S CORTISOL STATUS MAY BE DIFFERENT DEPENDING ON LOCATION WITHIN THE BODY. FOR EXAMPLE, THE CONVERSION FROM NORADRENALINE TO ADRENALINE IS DRIVEN BY CORTISOL AND TAKES PLACE WITHIN THE ADRENAL MEDULLA. IN THIS CASE, THIS AREA IS LIKELY FLOODED WITH HIGH LEVELS OF CORTISOL FORCING CONVERSION TO ADRENALINE, WHEREAS THE BRAIN (WHERE CORTISOL HAS NEGATIVE FEEDBACK ON ACTH PRODUCTION) MAY BE CORTISOL DEFICIENT. EFFORTS TO INCREASE HPA-AXIS ACTIVITY MAY EXACERBATE SOME SYMPTOMS. CALMING THE HPA-AXIS, WHILE SUPPORTING IT IN WAYS THAT ARE NOT EXCITATORY, MAY BE THE BEST COURSE OF ACTION.

The Cortisol-Cortisone Balance: Cortisol, which is the active hormone, can convert into cortisone, the inactive form. They convert back and forth in different parts of the body. We tell which one you make more of by looking at whether cortisol metabolites (aTHF, bTHF) or cortisone metabolites (bTHE) are made more (compared to what is normal) in the gauge at the bottom of the adrenal page. The deactivation of cortisol to cortisone (via enzyme 11b-HSD II) occurs predominantly in the kidneys, colon, and saliva glands. The local formation of inactive cortisone from cortisol in the kidney is strongly reflected in urine. Activation of cortisone to cortisol takes place primarily in the liver, adipose tissue, gonads, brain, and muscle. Within these same tissues (mostly the liver) the free hormones are also converted to their metabolites (cortisol to a/b-THF, cortisone to THE). Balance between the two is usually preferred, but making more cortisol than cortisone is sometimes good to help give you enough cortisol if your levels are low however a preference for the active cortisol is enhanced by central adiposity, hypothyroidism, inflammation, and supplements such as licorice root extract. Cortisone formation is enhanced by growth hormone, estrogen, coffee and hyperthyroidism.

Reading the Report: The first page of the Dutch Complete lab report is a summary page while the second page of the Dutch Complete lab report and first page of the Dutch sex hormone and Dutch adrenal test are a classic lab report showing each result and the respective range of each hormone. Reference ranges shown are those of young healthy individuals with females collecting on days 19-21 (mid-luteal phase) of the menstrual cycle. The graphical representation of results on the page that follows allows the viewing of hormone results within the biochemical flowchart to more easily see the relative level

of each hormone. The gauge format shows the patient result (represented by the "needle" of the gauge) and the area between the stars represents the reference range.

Reference ranges are typically set at the 20th to the 80th percentile of young, healthy individuals (DHEAS for example). This means that a result at the low end of a range is lower than 80 percent of young, healthy individuals. Likewise a result at the high end of a range is higher than 80 percent of the population. Some reference ranges are set more widely. For example, slightly elevated progesterone is not generally considered problematic, so its metabolites have reference ranges that extend further (90th percentile instead of 80th).

The "fan" style gauges are used for indexes/ratios such as on 5a-reductase activity, cortisol/cortisone, and estrogen methylation. Because these values are all based on ratios there are no values or units, but they give a general idea of a particular relationship and can tell you how 'turned up' or 'turned down' a particular process is. The middle of the gauge represents an average value, while the lines towards the edge represent results lower or higher than most (80%) of the population. Being outside of any range is not always considered unfavorable. For example, on the estrogen methylation gauge, an elevated level means someone methylates estrogens very effectively which may have positive consequences.

What is actually measured in urine? In blood, most hormones are bound to binding proteins. A small fraction of the total hormone levels are "free" and unbound such that they are active hormones. These free hormones are not found readily in urine except for cortisol and cortisone (because they are much more water soluble than, for example, testosterone). As such, free cortisol and cortisone can be measured in urine and it is this measurement that nearly all urinary cortisol research is based upon. In the DUTCH Adrenal Profile the diurnal patterns of free cortisol and cortisone are measured by LC-MS/MS.

All other hormones measured (cortisol metabolites, DHEA, and all sex hormones) are excreted in urine predominately after the addition of a glucuronide or sulfate group (to increase water solubility for excretion). As an example, Tajic (Natural Sciences, 1968 publication) found that of the testosterone found in urine, 57-80% was testosterone-glucuronide, 14-42% was testosterone-sulfate, and negligible amounts (<1% for most) was free testosterone. The most likely source of free sex hormones in urine is from contamination from hormonal supplements. To eliminate this potential, we remove free hormones from conjugates (our testing can be used even if vaginal hormones have been given). The glucuronides and sulfates are then broken off of the parent hormones, and the measurement is made. These measurements reflect well the bioavailable amount of hormone in most cases as it is only the free, nonprotein-bound fraction in blood/tissue that is available for phase II metabolism (glucuronidation and sulfation) and subsequent urine excretion.

Disclaimer: the filter paper used for sample collection is designed for blood collection, so it is technically considered "research only" for urine collection. Its proper use for urine collection has been thoroughly validated.