



PATIENT: **Sample Report**

TEST REF: **TST-##-####**

TEST NUMBER: #####
 PATIENT NUMBER: #####
 GENDER: Male
 AGE: 45
 DATE OF BIRTH: dd-mm-yyyy

COLLECTED: dd/mm/yyyy
 RECEIVED: dd/mm/yyyy
 TESTED: dd/mm/yyyy

PRACTITIONER: **Nordic Laboratories**
 ADDRESS:

TEST NAME: Comprehensive Male I (Saliva: E2, T, DS, Cx4) (Blood Spot: PSA, TSH, FT3, FT4, TPOab)

TEST NAME	RESULTS 10/29/18	10/29/18	RANGE
Salivary Steroids			
Estradiol	0.7		0.5-2.2 pg/mL
Testosterone	97		44-148 pg/mL (Age Dependent)
DHEAS	4.5		2-23 ng/mL (Age Dependent)
Cortisol	3.6 L		3.7-9.5 ng/mL (morning)
Cortisol	1.9		1.2-3.0 ng/mL (noon)
Cortisol	1.6		0.6-1.9 ng/mL (evening)
Cortisol	0.6		0.4-1.0 ng/mL (night)

TEST NAME	RESULTS 10/29/18	RANGE
Blood Spot		
PSA	3.6	<0.5-4 ng/mL (optimal 0.5-2)
Blood Spot Thyroids		
Free T4*	1.3	0.7-2.5 ng/dL
Free T3	3.3	2.4-4.2 pg/mL
TSH	2.1	0.5-3.0 µU/mL
TPOab*	9	0-150 IU/mL (70-150 borderline)

<dL = Less than the detectable limit of the lab. N/A = Not applicable; 1 or more values used in this calculation is less than the detectable limit. H = High. L = Low. * For research purposes only.

Therapies

10/29/2018: Lithium;5mg BID topical Melatonin (OTC) (12 Hours Last Used); Magnesium

10/29/2018: None Indicated



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TEST REPORT | Results *continued*

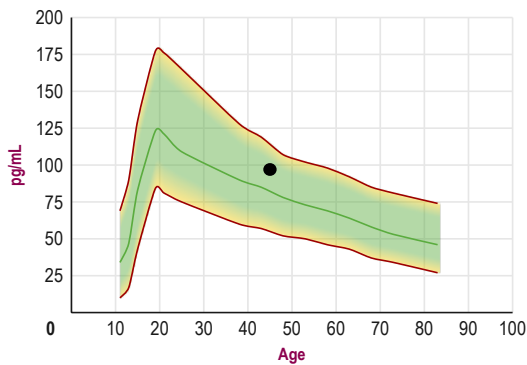
Sample Report

Graphs

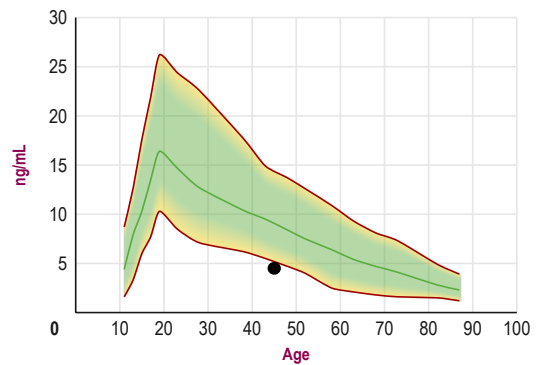
Disclaimer: Graphs below represent averages for healthy individuals not using hormones. Supplementation ranges may be higher. Please see supplementation ranges and lab comments if results are higher or lower than expected.

Average ▼▲ Off Graph

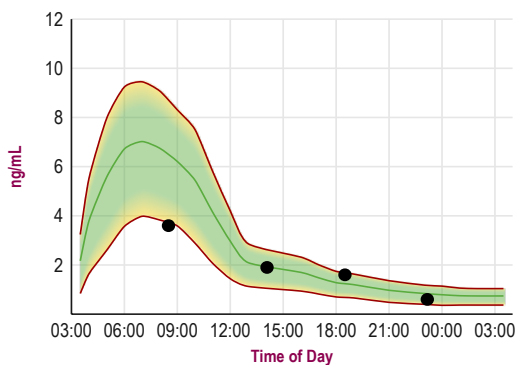
Saliva Testosterone



Saliva DHEAS



Saliva Cortisol



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TEST NAME: Comprehensive Male I (Saliva: E2, T, DS, Cx4) (Blood Spot: PSA, TSH, FT3, FT4, TPOab)

TEST REPORT | Reference Ranges

Sample Report

Disclaimer: Supplement type and dosage are for informational purposes only and are not recommendations for treatment.

TEST NAME	MEN
Estradiol	0.5-2.2 pg/mL
Testosterone	44-148 pg/mL (Age Dependent); 115-3700 pg/mL (5-50 mg topical 12-24 hr)
DHEAS	2-23 ng/mL (Age Dependent)
Cortisol	3.7-9.5 ng/mL (morning); 1.2-3.0 ng/mL (noon); 0.6-1.9 ng/mL (evening); 0.4-1.0 ng/mL (night)
PSA	<0.5-4 ng/mL (optimal 0.5-2)
Free T4	0.7-2.5 ng/dL
Free T3	2.4-4.2 pg/mL
TSH	0.5-3.0 µU/mL
TPOab	0-150 IU/mL (70-150 borderline)

Lab Comments

Estradiol is within expected range for a male.

Testosterone is within mid-normal range. In healthy males from youth to middle age testosterone levels usually range from about 80-120 pg/ml. Healthy testosterone levels drop to about 60-80 pg/ml in men > 60 years of age. Supplementation with physiological amounts of androgens usually raises testosterone to levels seen in young men. Testosterone ranges are age specific. Normal age-dependent testosterone levels are usually associated with few symptoms of androgen deficiency, however, in some individuals with other hormonal problems (e.g. low IGF1, low thyroid, low or high cortisol) symptoms can be similar to androgen deficiency.

DHEAS is within low-normal expected age range. Chronic low DHEAS may suggest HPA axis dysfunction, particularly if cortisol is also low and symptoms are indicative of low adrenal function. DHEAS is highest during the late teens to early twenties (10-20 ng/ml) and drops steadily with age to the lower end of range by age 70-80. Consider adrenal adaptogens or DHEA supplements if symptoms of androgen deficiency are problematic.

Cortisol is low in the morning but recovers to normal levels throughout the remainder of the day. The lower morning cortisol suggests adrenal exhaustion which likely is caused by some form of stressor such as emotional/psychological stress, sleep deprivation, low protein diet, nutrient deficiencies (particularly low vitamins C and B5), physical insults (surgery, injury, diseases, inflammatory conditions), chemical exposure, low cortisol precursors (pregnenolone, progesterone) and pathogenic infections (bacterial, viral, fungal). In a healthy individual the adrenal glands initially respond to stressors by increasing cortisol output. However, if the stressor persists the adrenal glands either continue to meet the demands of the stressor with high cortisol output, or become exhausted, wherein cortisol levels fall below normal, as in these test results. Symptoms commonly associated with chronic low cortisol include fatigue, allergies (immune dysfunction), chemical sensitivity, cold body temp, and sugar craving. Low cortisol is often associated with symptoms of thyroid deficiency as normal physiological levels of cortisol are essential for optimal thyroid function. Adequate sleep and rest, gentle exercise, proper diet (adequate protein), natural progesterone, adrenal extracts, herbs, and nutritional supplements (vitamins C and B5) are some of the natural ways to help support adrenal function. Caution: Thyroid or androgen therapies may further lower cortisol levels and exacerbate symptoms of cortisol deficiency. These therapies are not likely to be successful if cortisol is not first adjusted to normal levels. For additional information about strategies for supporting adrenal gland function and reducing stressors that deplete cortisol, the following books are worth reading: "Adrenal Fatigue", by James L. Wilson, N.D., D.C., Ph.D.; "The Cortisol Connection", by Shawn Talbot, Ph.D.; "The End of Stress As We Know It" by Bruce McEwen; "Awakening Athena" by Kenna Stephenson, MD.

PSA (Prostate Specific Antigen) is slightly above optimal range. A high PSA is usually caused by BPH (Benign Prostatic Hypertrophy), prostate cancer, prostate inflammation or infection, and prostate or perineal trauma. Ejaculation within 48-72 hr of blood collection may also cause a slight elevation in PSA. Prostate surgery can cause a significant rise in PSA outside the normal range and testing for PSA is not recommended for at least three weeks post surgery. Periodic repeat testing for PSA is recommended.

Thyroid hormones (free T4, free T3, and TSH) and thyroid peroxidase antibodies (TPO) are within normal ranges; however, symptoms of thyroid deficiency persist. This suggests that T3 is not functioning normally at the tissue level (i.e., functional thyroid deficiency). Stress is listed as moderate/severe on the requisition form. This often is associated with high cortisol or catecholamines (norepinephrine), which can desensitize target tissues to the actions of T3. Poor response of target tissues to normal circulating levels of T3 may also be caused by heavy metals (particularly mercury), and/or other steroid hormone imbalances (high estradiol, low progesterone, low testosterone). If steroid imbalances are detected by saliva or blood testing, they should be corrected before attempting thyroid therapy. Full evaluation of adrenal cortisol production throughout the day should be performed before attempting thyroid therapy since normal cortisol levels are required for normal thyroid function. Thyroid therapy in individuals with low cortisol levels could result in exacerbation of thyroid deficiency symptoms.

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