



Nordic Laboratories

PATIENT: **Sample Report**

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

TEST NUMBER: #####

COLLECTED: dd/mm/yyyy

PRACTITIONER: **Nordic Laboratories**

PATIENT NUMBER: #####

RECEIVED: dd/mm/yyyy

ADDRESS:

GENDER: Female

TESTED: dd/mm/yyyy

AGE: 55

DATE OF BIRTH: dd-mm-yyyy

TEST NAME: Menopause Plus™ (G)

# Menopause Plus



## Menopause Plus - Salivary Profile

### Therapeutic Cohort

Hormone	Average † Result	QUINTILE DISTRIBUTION					Therapeutic Range*
		1st	2nd	3rd	4th	5th	
Estradiol (E2)	11.5						2.9-13.7 pmol/L
Estrone (E1)	17.0						5.5-26.1 pmol/L
Estriol (E3)	223						<=135 pmol/L
Testosterone	34						34-183 pmol/L
Progesterone	72,581						174-1,417 pmol/L
P/E2 Ratio	6,311						29-192

\* The therapeutic ranges depicted are for informational purposes only, and were derived from a cohort of peri/menopausal women ranging in age from 37-62 years. They were treated with bioidentical hormone therapy (HT) utilizing combinations of the following: Biest (transdermal); Progesterone (oral micronized); Testosterone (transdermal); and 7-keto-DHEA (oral).

† Patient results with Nordic's standard reference ranges are reported on the following pages.

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## Salivary Hormone Results

Sample	Estrone (E1) (pmol/L)	Estradiol (E2) (pmol/L)	Estriol (E3) (pmol/L)	Progesterone (pmol/L)
1	17.7	7.6	138	111,631
2	17.6	14.2	271	69,081
3	15.8	12.8	259	37,031
Average	17.0	11.5	223	72,581

Average Estradiol ♦ pmol/L

11.5

Reference Range	
Follicular	2.8-8.8 pmol/L
Peak *	4.5-19.1 pmol/L
Luteal	2.8-8.2 pmol/L
Menopausal	3.7-9.4 pmol/L
Male	3.1-7.4 pmol/L
* Peak = Days 11 and 12	

Testosterone ♦ pmol/L

34

Reference Range	
Premenopausal	34-148 pmol/L
Menopausal	34-148 pmol/L
Male	110-513 pmol/L

Average Estrone pmol/L

17.0

Reference Range	
Menopausal	4.7-18.9 pmol/L

Average Progesterone ♦ pmol/L

72,581

Reference Range	
Follicular	120-593 pmol/L
Peak *	328-1385 pmol/L
Luteal	145-797 pmol/L
Menopausal	163-669 pmol/L
Male	141-529 pmol/L
* Peak = Days 18 and 20	

Average Estriol pmol/L

223

Reference Range	
Menopausal	<= 133 pmol/L

P/E2 Ratio

6,311

Reference Range	
Follicular	23-159
Luteal	25-141
Menopausal	33-116

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**Commentary**

*Lab Comments*

*Salivary Melatonin 7am and 3am results confirmed by repeat analysis.  
dd/mm/yyyy mw*

The performance characteristics of all assays have been verified by Genova Diagnostics, Inc. Unless otherwise noted with ♦, the assay has not been cleared by the U.S. Food and Drug Administration.

Please note that hormone results which are absent, NR or begin with "<" or ">" are excluded from the calculation of analyte averages.

Methodology: LIA, EIA and RIA

Commentary is provided to the practitioner for educational purposes, and should not be interpreted as diagnostic or treatment recommendations. Diagnosis and treatment decisions are the responsibility of the practitioner.

Estrogens play a critical role in female sexual development, menstrual function, protein synthesis, cardiovascular function, bone formation and remodeling, cognitive function, emotional balance and other important health factors. The estrogenic potency of estradiol is 12 times that of estrone and 80 times that of estriol. Estradiol is the primary estrogen in premenopausal women. Estrone is the second most potent estrogen compared to estradiol. After menopause, estrone becomes the primary estrogen as the ovary loses its ability to manufacture estradiol, and it is synthesized in the adrenal glands and fat cells. Estriol is considered to be the mildest and briefest-acting of the three estrogens. Estrogen metabolism and synthesis in men appear to remain relatively stable across the life course.

- In women, lower levels of estrogens have been associated with a variety of clinical symptoms: peri/menopausal symptoms (vasomotor symptoms; mood and memory alterations; atrophic vaginitis, a condition associated with decreased vaginal lubrication and thinner vaginal epithelial; lining diminished skin tone); altered lipid metabolism; accelerated rate of bone loss. Excessive estrogen levels have been associated with increased risk of some hormone-dependent cancers.
- In men, low levels of estrogen may be associated with decreased bone density, cognitive decline and cardiovascular disease. Excessive estradiol levels have been associated with greater risk of stroke and cardiovascular disease, as well as BPH, gynecomastia, decreased sexual function and weight gain. A source of elevated estrogen in men may be associated with men who have a higher body fat percentage, as increased aromatization of testosterone to estradiol can occur in adipose tissue.
- In a large, population based study of salivary sex hormone levels in older adults researchers found: Older men and women had similar estradiol concentrations. Estradiol concentrations have been associated with cognition, mood, and memory in women and, in combination with testosterone and other factors, preservation of memory and cognitive function in men.

Progesterone is important for normal reproductive and menstrual function, and influences the health of bone, blood vessels, heart, brain, skin, and many other tissues and organs. As a precursor, progesterone is used by the body to make other steroid hormones, including DHEA, cortisol, estrogen and testosterone. In addition, progesterone plays an important role in mood, blood sugar balance, libido, and thyroid function, as well as adrenal gland health. Progesterone is primarily produced in the ovaries in premenopausal women and in the adrenal cortex in postmenopausal women. Although progesterone is found in both women and men, the physiologic role in men is poorly understood.

- In women, lower levels of progesterone have been associated with dysfunctional uterine bleeding, and may play a role in osteoporosis and impaired neurological function. Excessive amounts can result in problems such as dysglycemia, alopecia, acne and breast tenderness.
- The clinical significance of elevated or low levels in men is poorly understood. Low progesterone levels may be

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**TEST NAME: Menopause Plus™ (G)**

**Commentary**

involved in male infertility. Increased levels of progesterone have been found in states of stress and anxiety in men and women: this may relate to its sedative or stress countering effects.

Testosterone is an androgenic sex steroid/hormone that helps maintain libido, influences muscle mass and weight loss, and plays a role in the production of several other hormones. During the aging process, testosterone levels gradually decline in both sexes, which can lead to loss of bone density. Testosterone concentrations tend to be higher in men versus women.

- In women, imbalances of testosterone have been associated with various forms of coronary heart disease and cardiovascular events, including myocardial infarction in postmenopausal women. Low salivary testosterone levels have also been shown in women with breast cancer compared to age-matched controls. Obese women exhibit higher levels of free salivary testosterone. Excessive amounts are associated with PCOS, acne, oily skin and hirsutism.

- In men, lower levels of testosterone are associated with aortic, peripheral vascular, and cardiovascular disease in middle-aged and older men. In some but not all studies, lower levels of testosterone predict increased incidence of cardiovascular events and mortality. Additionally, elevated testosterone can be associated with CVD risk. Men with excessive testosterone may exhibit aggressive behavior or increased irritability, and hair loss (scalp).

- In men and women, low levels of testosterone have been associated with lower coital frequency and loss of sexual desire in men and women. Low levels are also associated with reduced stamina and lean muscle mass, anxiety, depression and cognitive decline in both men and women.

The P/E2 ratio describes the relationship between progesterone and estradiol levels, and is used clinically to ascertain dominance of one hormone compared to the other.

- An elevated ratio may indicate progesterone dominance, and symptoms may be consistent with progesterone excess.

- A low ratio may indicate estrogen dominance, and symptoms may be consistent with estrogen excess.

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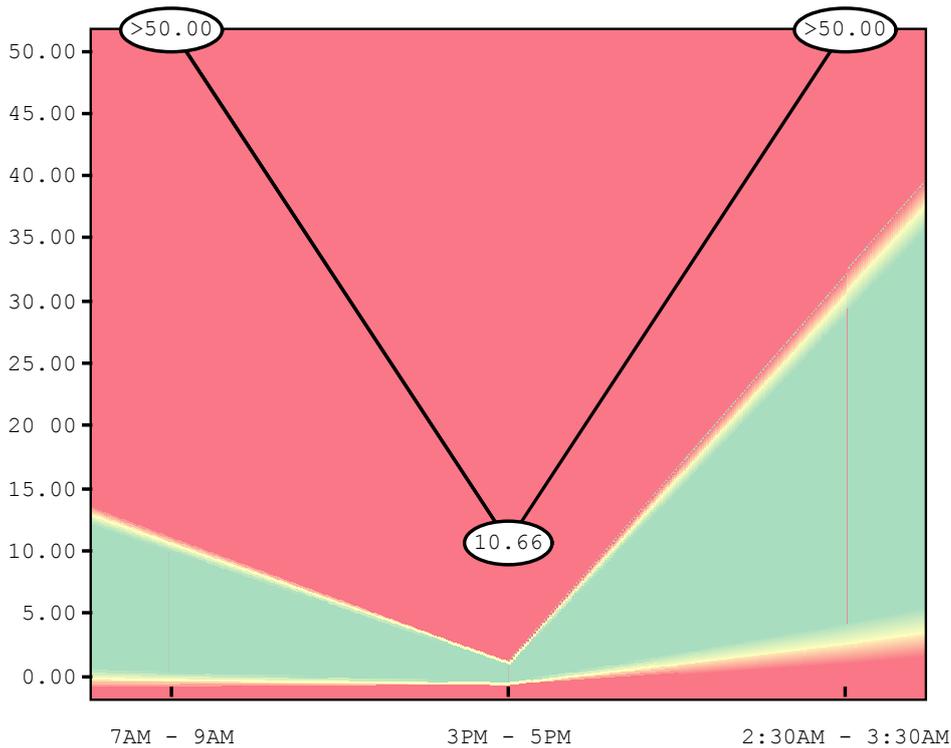
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ADDRESS:

TEST NAME: **Menopause Plus™ (G)**

## Comprehensive Melatonin Profile

### Salivary Melatonin



#### Reference Range

7AM - 9AM: <=10.50 pg/mL

3PM - 5PM: <=0.88 pg/mL

2:30AM - 3:30AM: 2.53-30.67 pg/mL

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**Commentary**

*Lab Comments*

*Salivary Melatonin 7am and 3am results confirmed by repeat analysis.  
dd/mm/yyyy mw*

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Melatonin activity is elevated throughout the sample period.

High morning melatonin levels are often present in individuals with Seasonal Affective Disorder. This may be due to prolonged nocturnal production of melatonin, and/or late onset of its production. High melatonin levels may bring about inhibition of ovulation in women as well as decreased body temperature. High melatonin has been noted in the manic phase of bipolar mood disorder. Many antidepressant drugs may stimulate melatonin production, including fluvoxamine (Luvox), desipramine, and most MAO inhibitors. Prozac may lower melatonin levels.

This profile reveals a disturbance in the circadian rhythm of melatonin. This may influence other hormones such as thyroid, testosterone, and estrogen. As well as playing a crucial role in sleep-wake cycles, melatonin influences other vital functions including cardiovascular and antioxidant protection, endocrine function, immune regulation and body temperature.

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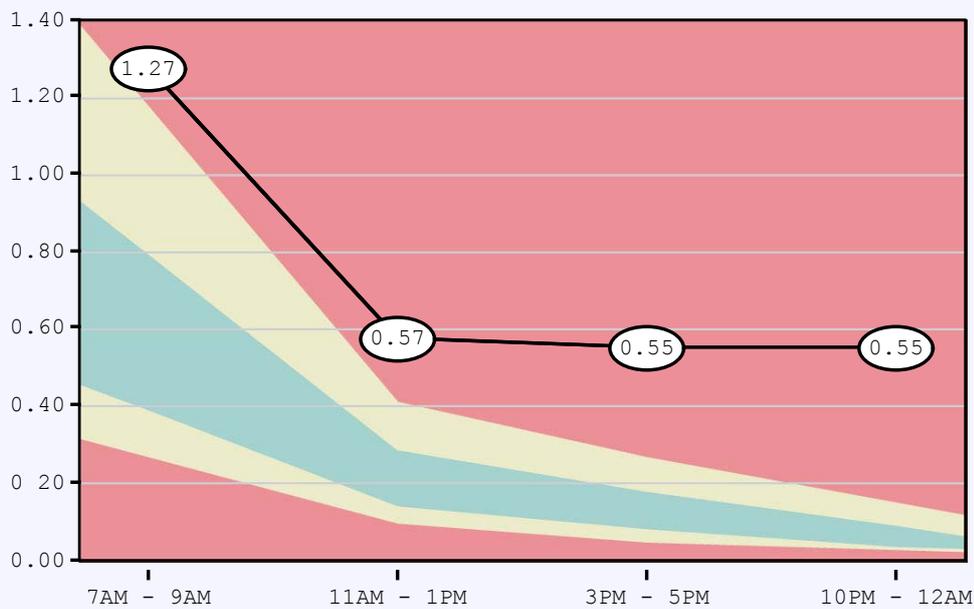
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## Adrenocortex Stress Profile (Saliva)

### Salivary Cortisol and DHEA



**Cortisol** ♦  
 Reference Range  
 1 Hour After Rising  
 7AM - 9AM:  
 0.27-1.18 mcg/dL  
 11AM - 1PM:  
 0.10-0.41 mcg/dL  
 3PM - 5PM:  
 0.05-0.27 mcg/dL  
 10PM - 12AM:  
 0.03-0.14 mcg/dL

Hormone	Reference Range	Reference Range
DHEA 7am - 9am	113	71-640 pg/mL
DHEA: Cortisol Ratio/10,000	89	115-1,188

### Commentary

*Lab Comments*

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**Commentary**

Methodology: EIA and LIA

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For the patient:

This profile measures the levels of cortisol and DHEA and provides an evaluation of how cortisol levels differ throughout the day. Cortisol levels typically peak shortly after rising and are at their lowest after the onset of sleep.

Cortisol is involved in many important functions in your body, including the metabolism and utilization of proteins, carbohydrates and fats, your body's response to physiological or psychological stress, and the control of inflammation and proper blood sugar levels. Cortisol also helps maintain proper blood pressure, normal nerve and brain activity and normal heart and immune function. DHEA also plays a role in the metabolism of protein, carbohydrates and fats, and works with cortisol to help maintain proper blood sugar levels. DHEA helps regulate body weight, blood pressure and immune function, and is used by the body to make the hormones, testosterone and estradiol.

Too much or too little of cortisol or DHEA can lead to illness, and it is important that these two hormones be in balance with each other.

For the physician:

In this profile, the 7-9 AM cortisol level is significantly elevated. Because cortisol levels are typically at their peak shortly after awakening, morning cortisol may be a good indicator of peak adrenal gland function. High morning cortisol levels suggest a degree of adrenal hyperfunction in regard to peak circadian activity, stress being the most common inducer. High cortisol levels cannot be sustained and are often a precursor to adrenal fatigue. Other possible causes of high salivary cortisol include heavy exercise, pregnancy, hypoglycemia, smoking, obesity, depression, alcoholism, and if significantly elevated, adrenal hyperplasia or Cushing's syndrome.

The 11 AM-1 PM cortisol level is above the reference range. Mid-day cortisol levels may be a good indication of adaptive adrenal gland function since they represent the adrenal glands' response to the demands of the first few hours of the day. High mid-day cortisol levels suggest a degree of adrenal hyperfunction with hyper-reactive adaptive response, most commonly to stress. Other possible causes of high salivary cortisol include heavy exercise, pregnancy, hypoglycemia, smoking, obesity, depression, alcoholism, and if significantly elevated, adrenal hyperplasia or Cushing's syndrome.

The 3-5 PM cortisol level is above the reference range. Afternoon cortisol levels may be a good indication of glycemic control exerted by the adrenal gland since they represent a postprandial sample. High afternoon levels suggest a degree of adrenal hyperfunction with increased adrenal assistance in glycemic control. Other possible causes of high salivary cortisol include stress, heavy exercise, pregnancy, smoking, obesity, depression, alcoholism, or if significantly elevated, adrenal hyperplasia and Cushing's syndrome.

The 10 PM-12 AM cortisol level is above the reference range. Late-night cortisol levels may be a good indication of baseline adrenal gland function since they typically represent the lowest level during the day. High late-night cortisol levels suggest a degree of adrenal hyperfunction with regard to baseline circadian activity. Possible causes of elevated late-night cortisol include stress, heavy exercise, pregnancy, hypoglycemia, smoking, obesity, depression, alcoholism, and the use of glucocorticoids. Significantly elevated late-night cortisol levels are considered a reliable indicator of Cushing's syndrome, especially if coupled with a reduced circadian rhythm.

DHEA is within the reference range. Proper levels contribute to the ideal metabolism of proteins, carbohydrates and fats, including efficient glycemic control.

A low DHEA: cortisol ratio is generally associated with chronic stress and hypothalamic-pituitary-adrenal imbalances. While often observed in individuals as they age, it may also be associated with cognitive and mood disorders, anxiety, and depressive symptoms. DHEA levels in women tend to decrease more rapidly with aging (especially between 50-60 years of age) than DHEA levels in men.

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A pattern showing one or more elevated cortisol levels, while the level of DHEA is within reference range, is clinically significant. Elevated cortisol suggests adrenal hyperfunction of the zona fasciculata (the primary source of cortisol). At this time there is no evidence of hyperfunction of the zona reticularis (the primary source of DHEA). This profile may present in the presence of increased physiological or psychological stress, anxiety, hypertension, and/or dysglycemia.

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