

Diagnos-Techs, Inc.

Clinical & Research Laboratory
 PO BOX 389662, Tukwila, WA 98138-0662
 Tel: (425) 251-0596
 CLIA License # 50D0630141

Accession # 07-5566

Partial/Preliminary Report, Final Results To Follow

Received : 01/16/2007

NATURAL CHOICES HEALTH CLINIC
 KIM
 12270 SW 2ND ST

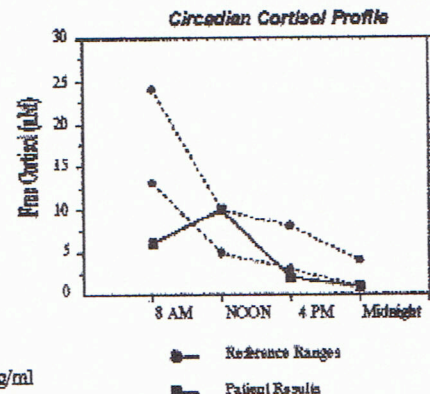
BEAVERTON OR 97005
 USA Tel: 1(503)520-8859 Fax: 1(503)627-0919

Preliminary Results For:

ANNA
 Age: 55 Gender: Female

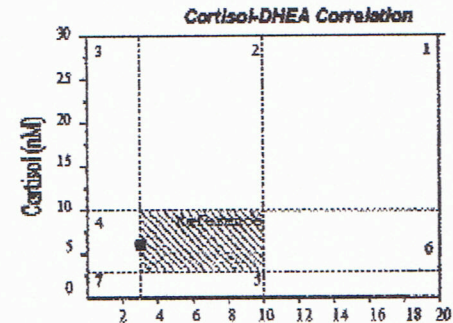
Patient's Tel:
 Specimen Collected: 01/12/2007

Test	Description	Result	Ref Values
<u>NLASI</u>	<u>CUSTOM ASI</u>		
TAP	Free Cortisol Rhythm		
07:00 - 08:00 AM		6 Depressed	13-24 nM
11:00 - Noon		10 Normal	5-10 nM
04:00 - 05:00 PM		2 Depressed	3-8 nM
11:00 - Midnight		1 Normal	1-4 nM
	Cortisol Burden:	19	23 - 42
DHEA	Dehydroepiandrosterone	3 Borderline	Adults (M/F): 3-10 ng/ml



KEY: CORTISOL-DHEA CORRELATION

- Adapted to stress.
- Adapted with DHEA slump.
- Maladapted Phase I.
- Maladapted Phase II.
- Non-adapted, Low Reserves.
- High DHEA.
- Adrenal Fatigue.



Patient Result Interpretations

Depressed morning cortisol, < 13 nM, is suggestive of marginal HPA performance.
 Normal rhythms exhibit highest cortisol value for the day at 7 - 8 AM.
 Morning cortisol augmentation, or 11 Beta HSD inhibitors, as in licorice, worth consideration.
 Minimal cortisol rhythm; cortisol augmentation and anabolic support suggested.

Diagnosis Code: 780.79

Please Note: All examples of patient treatment or therapy are for illustrative and/or educational purpose. Use this report in context of the clinical picture before initiating hormone or other therapies.

COURTESY INTERPRETATION of test and technical support are available upon request, to Physician Only

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PH1. Postmenopausal Hormone panel - Short

Hormone	Result	Notes	Reference Ranges
T1F - Testosterone	5	Borderline Low	Borderline: 5-7 pg/ml Normal: 8-20 pg/ml
E1 - Estrone	54		Normal for Age 50-59: 26-64 pg/ml
E2 - Estradiol	81		Postmenopause-No HRT: 1-4 pg/ml HRT Target Range: 5-13 pg/ml Follicular: 5-13 pg/ml Luteal: 7-20 pg/ml
E3 - Estriol	>100		Postmenopause-No HRT: 7-18 pg/ml HRT Target Range: 14-38 pg/ml Cycling Female: 12-25 pg/ml
P1 - Progesterone	>1000		Postmenopause-No HRT: 5-95 pg/ml HRT Target Range: 100-300 pg/ml Follicular: 20-100 pg/ml Luteal: 65-500 pg/ml

More interpretation and the action plan on following pages.

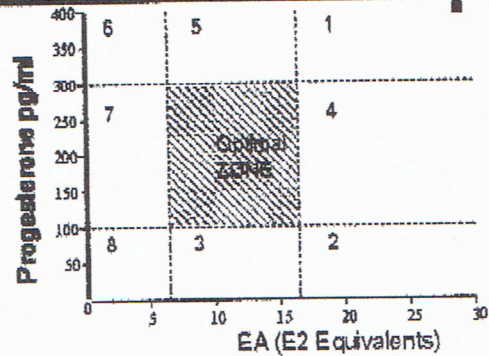
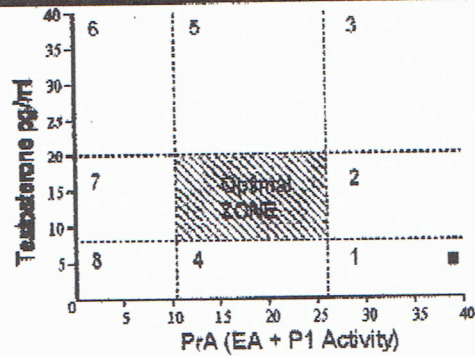
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Uterine Proliferation Index (UPI)TM

Breast Proliferation Index (BPI)TM



Legend

- Patient
- PrA - Proliferative Activity
- EA - Estrogenic Activity

- 1. Enhanced Proliferation.
- 2. High Proliferative Potential.
- 3. Hormone Overload
- 4. Pro-Proliferative.
- 5. Mild Androgen Dominance.
- 6. Frank Androgen Excess.
- 7. Female Hormone Deficit
- 8. Hypogonadism with Atrophy.

- 1. Enhanced Proliferation.
- 2. High Proliferative Potential.
- 3. Potentially Proliferative.
- 4. Accentuated Hormone Imbalance.
- 5. Mild Imbalance.
- 6. Pre-Atrophic.
- 7. Pro-Atrophic.
- 8. Atrophic.

Your hormone values are in Zone 1.

Your hormone values are in Zone 1.

Explanation:

ZONE 1: ENHANCED PROLIFERATION

Zone 1 represents hyperphysiologic hormone levels of the estrogens and estrogen-dependent progesterone that encourage breast tissue proliferation. Insufficient tissue exposure to the anti-proliferative androgen, testosterone, allows unopposed estrogenic proliferation.

Common clinical signs of estrogenic and/or progesterone excess include breast edema, tenderness, hyperplasia and cysts. Furthermore, women with high estrogen activity experience mood dysregulation mostly exaggerated excitatory state of the nervous system e.g. agitation, insomnia, aggressiveness and emotional lability.

What Next?

As applicable, the following general guidelines may help restore hormone balance.

- a) Reduce excessive estrogen or progesterone intake.
- b) Reduce or eliminate soy product intake to minimize pro-estrogenic activity.
- c) Supplement diet with the following items that help reduce re-absorption of estrogens in the enterohepatic cycle:
 - I. Vitamin C, 1,000-3,000 mg/day in divided doses
 - II. Water-soluble dietary fibers, 5-10 grams/day Guar gum or Pectin
- d) If appropriate, augment with androgens or precursors in these cases where anabolic potential is low, i.e. muscle wasting, loss of libido, lethargy and apathy.

Typical Action Plan

- 1. Start with androgen(s) and progesterone augmentation.
- 2. Up protein intake, gradually when applicable.
- 3. Up essential vitamins and minerals.
- 4. Re-test hormones in 4-6 weeks.
- 5. Adjust androgen and progesterone dose.
- 6. Introduce estrogens when applicable.
- 7. Re-test 8 weeks later, then fine tune the doses.
- 8. Follow-up testing recommended annually.

Explanation:

ZONE 1: ENHANCED PROLIFERATION

Zone 1 represents increased proliferative activity. The combination of hyperphysiologic estrogen activity and a high progesterone level encourages uterine tissue proliferation and hypertrophy. Hyper-physiologic levels of progesterone augment the estrogen proliferative activity.

Common findings in Zone 1 include:

- I. Uterine: endometrial thickening, uterine bleeding, fibroids.
- II. Somatic: increased body fat deposition, weight gain and water retention.
- III. Nervous system (CNS) dysfunction: cognitive changes, headaches, anxiety, panic attacks, insomnia and depression with mood swings.

What Next?

- a) Reduce or eliminate soy product intake to minimize pro-estrogenic activity.
- b) Reduce or avoid the intake of exogenous reproductive hormones (estrogens, progesterone and precursors). Enhance Liver Detoxification capacity in the absence of hormone or precursor intake.
- c) Supplement diet with the following items that help reduce re-absorption of estrogens in the enterohepatic cycle:
 - I. Vitamin C, 1,000-3,000 mg/day in divided doses
 - II. Water-soluble dietary fibers, 5-10 grams/day Guar gum or Pectin
- d) Retest hormone levels in 6-8 weeks.

Need a more complete explanation of the indexes? See respective sections on the following page.

BREAST PROLIFERATION INDEX (BPI)**Explanation**

Several reproductive hormones exert trophic effects on the breast tissue i.e. cellular division and differentiation. Unchecked trophic stimulation stimulation can lead to undesired proliferation of the tissue. Over time, breast cysts, hyperplasia and lesions are promoted. Estradiol (E2), Estrin (E3) and Estrone (E1) in descending order of potency exert proliferative influences on breast tissue. Progesterone also exerts a proliferative influence with increasing concentration. On the other hand, testosterone, in the normal to mildly hyper-physiologic range, exerts a significant estrogen antagonizing and anti-proliferative effect which modulates and reduces estrogen proliferative effects.

Notes

Chronic exposure to high concentration of proliferative hormones is usually required to promote the initial proliferative stages of estrogen-sensitive lesions. However, the maintenance of the lesions may not require high concentrations of proliferative hormones. This phenomenon explains the difficulties and prolonged time required to reverse tissue proliferation that has already taken place.

What does the BPI Index mean?

The BPI is a graphical comparison of the proliferative and anti-proliferative hormone activity of the patient. The combined proliferative activity of the three estrogens plus the concentration-dependent contribution of progesterone is represented on the horizontal graph axis (X-axis). The testosterone anti-proliferative activity is represented on the vertical axis (Y-axis).

The BPI graphic grid has 6 distinct numbered zones with an explanatory key below the graph. The patient values of E1, E2, E3, progesterone and testosterone are used to calculate indices and plotted as a solid square that appears one of the numbered zones.

UTERINE PROLIFERATION INDEX (UPI)**Explanation**

It is established that estrogens including Estradiol (E2), Estrin (E3) and Estrone (E1) in descending order of potency can induce proliferative changes in the endometrium at any age. Endometrial hyperplasia with rapid blood vessel formation is one of the major outcomes of estrogen hormone replacement therapy in postmenopausal women. On its own, the estrogen proliferative effect is additive and cumulative over time and is manifested clinically as breakthrough bleeding. Estrogens help organize and capacitate the endometrial cells to respond to progesterone-mediated functionalization with view of constructing an embryo-receptive lining.

Progesterone helps transform the rapidly growing cells into mature ones. It prevents the endometrium from rapidly outgrowing its developing blood supply. Progesterone inhibits uncontrolled endometrial cell growth that otherwise would lead to proliferative lesions.

What does the UPI Index mean?

The UPI is a graphical comparison of the correlation between the proliferative hormone activity (Measured Estrogenic Activity-EA) and the Anti-proliferative activity (Measured Progesterone levels). The EA takes into account the genomic and non-genomic proliferative activity of the three main estrogens. The EA is represented on the horizontal axis (X-axis). The progesterone anti-proliferative activity is represented on the vertical axis (Y-axis).

The UPI graphic grid has 6 distinct numbered zones with an explanatory key below the graph. The patient values of E1, E2, E3 and progesterone are used to calculate indices and appear as a solid square in one of the numbered zones.

Why Choose Grid Analysis over Hormone Ratios?

Proper hormone balance is not achieved at all concentrations. It is only achieved within matched physiologic concentration ranges of the respective hormones. The use of arithmetic ratios of sex hormone concentrations for the purpose of reference range analysis, as used by other laboratories, is usually deceiving. The absolute concentrations of the hormones are extremely important and are not included in arithmetic ratio analysis.

For more accuracy in interpretation, a two dimensional Zoned Grid Method is used in this report. The following example will illustrate the inadequacy of the arithmetic ratio method. At high concentrations of the respective hormones (Zone 3 in the BPI, and Zone 1 in the UPI), you may have a perfect arithmetic ratio between the estrogens and testosterone which other labs consider normal. However, the following adaptive processes may come into play:

- I. At high hormone concentrations, receptor evolution takes place blocking the binding of hormone to receptors. This may lead to unpredictable or paradoxical effects.
- II. At high hormone concentrations there is receptor confusion, i.e. one hormone cross-reacts non-specifically with the receptors of another leading to unpredictable effects.
- III. At high concentrations certain hormones inhibit the synthesis of other antagonistic hormones, or promote the production of synergistic ones.

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 ANNA
 Age: 55 Gender: Female

 Patient's Tel :
 Specimen Collected: 01/12/2007

Code	Test Name	Values	Provisional Ranges
Saliva Thyroid Study			
FT3	Triiodo-thyronine	0.34 Normal	Borderline Low: 0.21-0.27 pg/ml Normal: 0.28-1.10 pg/ml
FT4	L-Thyroxine	0.18 Normal	Normal: 0.17-0.42 ng/dl

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Code	Test Name	Result / Notes	Reference Values/Key
FSH	Follicle Stimulating Hormone	139	Pre-menopause: <125 uIU/mL Post-menopause: 90-500 uIU/mL
LH	Luteinizing Hormone	63	Pre-menopause: 8-30 uIU/mL HRT: 8-30 uIU/mL Post-menopause-No HRT: 25-200 uIU/mL
P17-OH	17-OH Progesterone	15	Adults Optimal: 22-100 pg/ml Borderline: 101-130 pg/ml Elevated: >130 pg/ml

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