



Dr Test Doctor (Test Doctor) Test Clinic. 123 Test Street, Test Suburb Victoria 3125

Patient ID P000060
Ext ID 26241-0005

Test Patient

Sex: Female • 56yrs • 01-Jan-70
123 Home Street, Test Suburb VIC 3125

RECEIVED
29-Aug-26

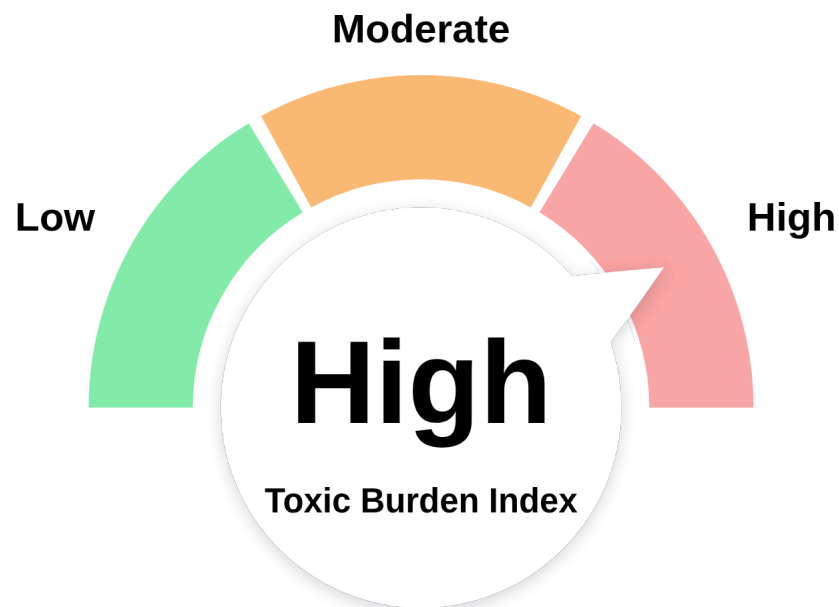
Clinical Notes .

ALL-Tox Environmental Toxins Profile

Specimen type - Urine, Spot

Collected

29-Aug-26

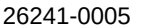


Toxic Burden Comment

Interpretation:

Markedly elevated results suggest significant or chronic toxicant accumulation that may carry clinical relevance. Such elevations warrant investigation of occupational, dietary, or environmental exposures and assessment of detoxification efficiency, mitochondrial status, and organ function. A structured detoxification protocol under clinical supervision is recommended, including source removal, targeted antioxidant and mitochondrial support, and medically guided use of binders or glutathione supplementation. Re-evaluation after intervention is advised to ensure toxin clearance and metabolic recovery.

Nutrient Imbalance	Molds/Metals	Environmental Toxins
Manganese Zinc	Fumonisin B1 Satratoxin G Cadmium Gadolinium Platinum	Quinolinic Acid



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TEST	RESULT	H/L	REFERENCE	UNITS
Aflatoxin B1	1.33		(<3.50)	ng/gCR
Aflatoxin B2	0.62		(<5.30)	ng/gCR
Aflatoxin G1	<DL		(<2.20)	ng/gCR
Aflatoxin G2	<DL		(<6.50)	ng/gCR
Aflatoxin M1	<DL		(<4.70)	ng/gCR
Sterigmatocystin	<DL		(<0.40)	ng/gCR

TEST	RESULT	H/L	REFERENCE	UNITS
Gliotoxin derivative	127.00	●	(<180.00)	ng/gCR

TEST	RESULT	H/L	REFERENCE	UNITS
Ochratoxin A	0.89	●	(<2.20)	ng/gCR

TEST	RESULT	H/L	REFERENCE	UNITS
Diacetoxyscirpenol	<DL		(<2.800)	ng/gCR
HT-2 Toxin	<DL		(<5.20)	ng/gCR
T-2 Toxin	<DL		(<0.500)	ng/gCR

TEST	RESULT	H/L	REFERENCE	UNITS
Deoxynivalenol	<DL		(<15.00)	ng/gCR
Nivalenol	0.66		(<3.70)	ng/gCR

TEST	RESULT	H/L		REFERENCE	UNITS
Roridin A	1.12			(<5.50)	ng/gCR
Roridin E	0.34			(<3.20)	ng/gCR
Roridin H	<DL			(<3.90)	ng/gCR
Roridin L-2	<DL			(<5.70)	ng/gCR
Satratoxin G	0.46	H		(<0.30)	ng/gCR
Satratoxin H	<DL			(<0.40)	ng/gCR
Verrucarin A	0.93			(<1.60)	ng/gCR
Verrucarin J	<DL			(<2.50)	ng/gCR



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ZEARALENONE GROUP

TEST	RESULT	H/L	REFERENCE	UNITS
Zearalenone	0.84		(<1.00)	ng/gCR

MYCOTOXINS GROUP - Other

TEST	RESULT	H/L		REFERENCE	UNITS
Alternariol	0.42			(<1.50)	ng/gCR
Chaetoglobosin A	<DL			(<9.80)	ng/gCR
Citrinin	<DL			(<5.20)	ng/gCR
Enniatin B1	0.16			(<0.50)	ng/gCR
Fumonisin B1	3.15	H		(<2.20)	ng/gCR
Fumonisin B2	2.21			(<2.50)	ng/gCR
Fumonisin B3	0.60			(<4.20)	ng/gCR
Mycophenolic Acid	<DL			(<2.50)	ng/gCR
Patulin	<DL			(<7.50)	ng/gCR

[illegible]

Mycotoxins Comment

TRICHOOTHECENES GROUP ELEVATED (URINE):

Elevated urinary trichothecenes indicate exposure to highly cytotoxic mycotoxins produced by *Fusarium*, *Stachybotrys*, and related species. These compounds are potent inhibitors of protein synthesis and are commonly associated with water-damaged buildings and contaminated grains.

Clinically, trichothecene exposure is associated with prominent inflammatory and neurological symptoms, including headaches, fatigue, cognitive dysfunction, mucosal irritation, gastrointestinal disturbance, and immune dysregulation. Trichothecenes are considered among the more clinically aggressive mycotoxins.

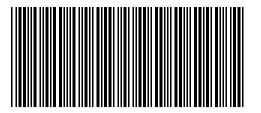
From a functional medicine perspective, management requires urgent identification and removal of environmental exposure, particularly from indoor mould sources. Supportive strategies may include inflammatory modulation, antioxidant support, gut barrier protection, and carefully titrated binders under clinical supervision. Due to their potency, treatment should be individualised and paced to avoid symptom exacerbation.

FUMONISIN B1 (FB1) ELEVATED:

Description: A neurotoxic and hepatotoxic mycotoxin from *Fusarium* species, typically contaminating corn. It disrupts sphingolipid metabolism and cellular membranes.

Symptoms: Neurocognitive symptoms, hepatic enzyme elevations, GI disturbances.

Treatment: Avoid corn-based products, methylation support (B12, folate), liver and neurological detox support.



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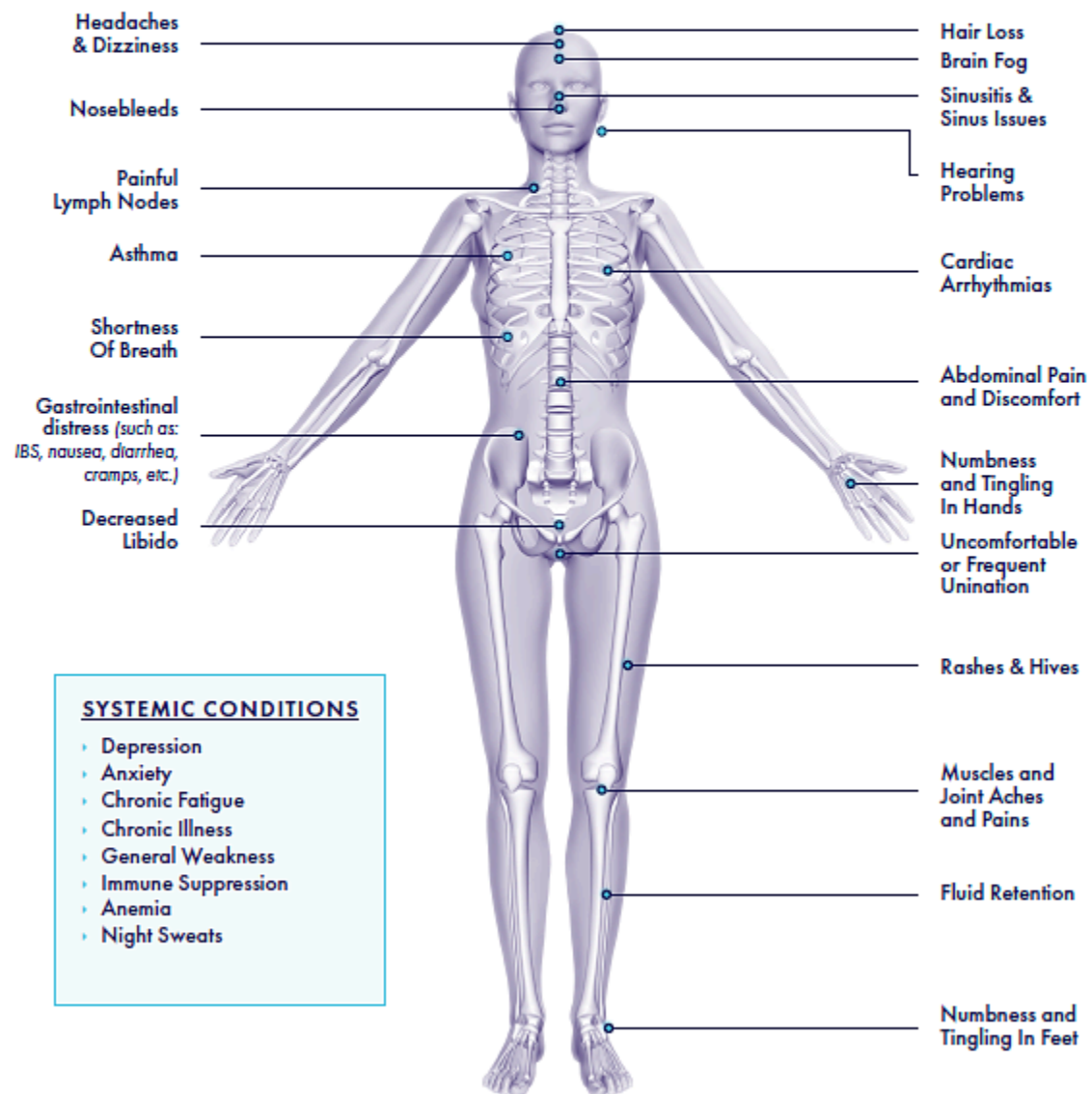
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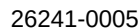
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SYMPTOMS OF **Mycotoxins**





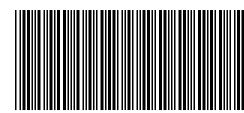
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Amended Report • Issued 18-Sep-26 10:47am • Test Codes: 5044 5 of 1

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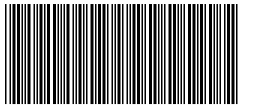
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PHYSIOLOGICAL MINERALS

TEST	RESULT	H/L		REFERENCE	UNITS
● Calcium	127.60			(<450.00)	mg/gCR
● Iron	75			(<80)	ug/gCR
● Magnesium	102.94			(<290.00)	mg/gCR
● Zinc	2000.00	H		(<900.00)	ug/gCR

TRACE MINERALS

[illegible]



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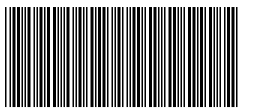
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TOXIC METALS

TEST	RESULT	H/L		REFERENCE	UNITS
Aluminium	10.84			(<40.00)	ug/gCR
Antimony	<DL			(<4.90)	ug/gCR
Arsenic	28.44			(<35.00)	ug/gCR
Barium	0.98			(<9.50)	ug/gCR
Beryllium	0.07			(<0.60)	ug/gCR
Bismuth	<DL			(<1.00)	ug/gCR
Bromine	807			(<7500)	ug/gCR
Cadmium	3.72	H		(<2.98)	ug/gCR
Cesium	1.19			(<10.30)	ug/gCR
Gadolinium	1.14	H		(<0.50)	ug/gCR
Gallium	<DL			(<0.10)	ug/gCR
Lead	0.92			(<38.50)	ug/gCR
Mercury	0.2			(<17.7)	ug/gCR
Palladium	<DL			(<15.00)	ug/gCR
Platinum	2.65	H		(<1.00)	ug/gCR
Silver	<DL			(<0.10)	ug/gCR
Tellurium	<DL			(<0.80)	ug/gCR
Thallium	0.06			(<1.50)	ug/gCR
Tin	<DL			(<4.00)	ug/gCR
Titanium	<DL			(<50.00)	ug/gCR
Tungsten	<DL			(<0.50)	ug/gCR
Uranium	<DL			(<0.30)	ug/gCR
Zirconium	<DL			(<5.00)	ug/gCR



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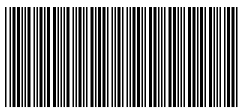
CHELATOR SPECIFIC ORIENTATION RANGES:

The following chelator-specific ranges have been developed based on the fact that each chelator has a specific binding capacity. The ranges were developed based on statistical calculations of a population challenged with one ampoule DMPS or 300mg DMPS.

A urine excretion value/result higher than the Orientation Ranges below, indicates a moderate to high toxic burden.

A test result higher than the normal (pre-chelation) reference range and lower than the Orientation Range indicates a low to moderate toxic burden.

ELEMENT	DMSA (ug/gCR)	EDTA (ug/gCR)	DMPS (ug/gCR)
Toxic Metals			
Aluminium (Al)	< 50	< 100	< 50
Antimony (Sb)	< 10	< 10	< 15
Arsenic (As)	< 100	< 100	< 100
Barium (Ba)	< 10	< 20	< 10
Beryllium (Be)	< 2.0	< 2.0	< 2.0
Bismuth (Bis)	< 10	< 10	< 10
Cadmium (Cd)	< 5.0	< 5.0	< 5.0
Cesium (Cs)	< 30	< 30	< 30
Cobalt (Co)	< 15	< 15	< 15
Gadolinium (Gd)	< 5.0	< 5.0	< 5.0
Lead (Pb)	< 30	< 80	<20
Mercury (Hg)	< 20	< 10	< 40
Nickel (Ni)	< 20	< 30	< 20
Palladium (Pd)	< 15	< 15	< 15
Platinum (Pt)	< 5.0	< 5.0	< 5.0
Silver (Ag)	< 5.0	< 5.0	< 5.0
Thallium (Tl)	< 10	< 10	< 10
Tin (Sn)	< 15	< 20	< 15
Titanium (Ti)	< 50	< 50	< 50
Uranium (U)	< 1.0	< 1.0	< 1.0
Essential Elements			
Manganese (Mn)	< 5.0	< 10	< 5.0
Strontium (Sr)	< 310	< 310	< 310
Tungsten (W)	< 10	< 10	< 10
Vanadium (V)	< 8.0	< 10	< 8.0
Zinc (Zn)	< 1500	< 2000	< 1500



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Nutrient Mineral Comment

MANGANESE ELEVATED (URINE):

Elevated urinary manganese suggests increased manganese exposure and renal excretion. In a first-morning urine sample, this finding reflects recent exposure or mobilisation rather than tissue accumulation.

Clinically, elevated manganese exposure may be associated with non-specific neurological symptoms, fatigue, or mood changes at higher or sustained levels, although mild elevations are often asymptomatic.

From a functional medicine perspective, this result should be interpreted in the context of occupational or environmental exposure (e.g. welding fumes, industrial dust), hepatic function, and iron status, as iron deficiency may increase manganese absorption. Correlation with clinical history and, where indicated, blood manganese may assist interpretation.

Treatment: Identify and eliminate the source of manganese exposure, often in occupational settings like welding or battery manufacturing. In some cases, iron supplementation in conjunction with chelation therapy may lead to improvements in neurological symptoms that chelation alone does not provide.

ZINC ELEVATED (URINE):

Elevated urinary zinc suggests increased zinc excretion, which commonly occurs with supplementation, physiological stress, inflammation, or altered renal handling.

Clinically, excessive zinc loss over time may contribute to copper imbalance, particularly with sustained high zinc intake, although symptoms are often non-specific.

From a functional medicine perspective, this result should be interpreted in the context of supplementation practices, inflammatory status, and copper–zinc balance rather than as an isolated indicator of zinc excess. Correlation with serum zinc and serum copper may assist in assessing systemic balance where clinically appropriate.

Treatment: Evaluate source exposure; elimination through chelation therapy with agents like CaNa2EDTA or ascorbic acid, which form complexes that are then excreted.

Toxic Metals Comment

PLATINUM ELEVATED (URINE):

Elevated urinary platinum suggests increased platinum exposure and renal excretion. Potential sources include occupational contact, environmental exposure, or prior platinum-based chemotherapy.

Clinically, elevated platinum may be associated with hypersensitivity reactions or renal effects depending on exposure context and chronicity.

From a functional medicine perspective, this result should be interpreted in the context of treatment history, occupational exposure, renal function, and cumulative metal burden rather than as an isolated marker of toxicity.

Treatment: Support renal clearance, antioxidant protection (e.g., NAC, selenium), and avoid repeat exposure if possible.

GADOLINIUM ELEVATED (URINE):

Elevated urinary gadolinium suggests recent exposure and renal excretion, most commonly related to prior administration of gadolinium-based contrast agents used in magnetic resonance imaging (MRI). In a first-morning urine sample, this finding reflects clearance following exposure rather than endogenous accumulation.

Clinically, urinary gadolinium may remain detectable for prolonged periods after contrast exposure, particularly in individuals with reduced renal clearance. The clinical significance of low-level persistence remains an area of ongoing research.

From a functional medicine perspective, this result should be interpreted in the context of recent imaging history, renal function, and overall exposure burden, rather than as a marker of toxicity in isolation.

Treatment: Avoid repeat exposure, use binders (e.g., modified citrus pectin, zeolites), and support glutathione metabolism.

CADMIUM ELEVATED (URINE):



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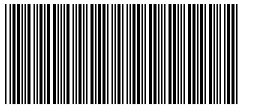
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Elevated urinary cadmium suggests increased cadmium exposure and/or mobilisation with renal excretion. Urinary cadmium is considered a marker of chronic body burden rather than acute exposure.

Clinically, elevated cadmium exposure may be associated with renal tubular stress and bone mineral effects at higher or sustained levels. Smoking remains a common non-occupational source.

From a functional medicine perspective, this finding should prompt assessment of exposure sources (smoking, diet, occupation) and consideration of renal health and antioxidant status, with emphasis on exposure reduction rather than intervention unless clinically indicated.

Treatment: Remove exposure, support zinc and selenium (compete with cadmium), and consider chelation (e.g., EDTA or DMSA).



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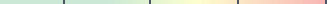
CYSTEINE DERIVATIVES

TEST	RESULT	H/L	REFERENCE	UNITS
N-Acetyl (3,4-Dihydroxybutyl) cysteine (NADB)	<DL		(<250.00)	ug/gCR
N-Acetyl (carbomoylethyl) cysteine	9.66		(<190.00)	ug/gCR
N-Acetyl phenyl cysteine (SPMA)	<DL		(<5.00)	ug/gCR
N-Acetyl (propyl) cysteine (NAPR)	0.76		(<25.00)	ug/gCR

ENVIRONMENTAL PHENOLS

TEST	RESULT	H/L	REFERENCE	UNITS
4-Nonylphenol	<DL		(<3.00)	ug/gCR
Bisphenol A (BPA)	0.48		(<4.00)	ug/gCR
Bisphenol S (BPS)	0.79		(<0.80)	ug/gCR
Triclosan (TCS)	2.64		(<50.00)	ug/gCR

HERBICIDES (Synthetic Auxins)

TEST	RESULT	H/L	REFERENCE	UNITS
● 2,4-Dichlorophenoxyacetic acid (2,4-D)	<DL		(<1.00)	ug/gCR

HERBICIDES (Photosynthetic Inhibitors)

TEST	RESULT	H/L	REFERENCE	UNITS
 Atrazine	<DL		(<0.50)	ug/gCR
 Atrazine mercapturate	<DL		(<0.50)	ug/gCR

HERBICIDES (EPSP Inhibitors)

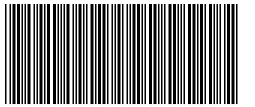
TEST	RESULT	H/L	REFERENCE	UNITS
Aminomethylphosphonic Acid (AMPA)	<DL		(<2.00)	ug/gCR
Glyphosate	0.3		(<1.0)	ppb

METHYLTERT-BUTYL ETHER (MTBE) EXPOSURE

TEST	RESULT	H/L	REFERENCE	UNITS
● 2-Hydroxyisobutyric Acid	1.00		(<2.98)	mmol/molCR

MITOCHONDRIAL MARKERS

TEST	RESULT	H/L	REFERENCE	UNITS
● Tiglylglycine	0.08		(<1.75)	ug/gCR



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PARABENS

TEST	RESULT	H/L	REFERENCE	UNITS
● Benzylparaben	0.07		(<2.00)	ug/gCR
● Butylparaben	0.08		(<1.00)	ug/gCR
● Ethylparaben	0.49		(<7.00)	ug/gCR
● Methylparaben	18.40		(<120.00)	ug/gCR
● 4-Hydroxybenzoic Acid (4-HBA)	0.08		(<0.57)	mmol/molCR
● Propylparaben	0.65		(<35.00)	ug/gCR

PESTICIDES

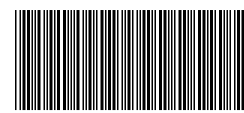
TEST	RESULT	H/L	REFERENCE	UNITS
3-Phenoxybenzoic Acid (3PBA)	<DL		(<3.00)	ug/gCR
Diethyl Phosphate (DEP)	<DL		(<9.00)	ug/gCR
Diethyldithiophosphate (DEDTP)	0.01		(<0.20)	ug/gCR
Diphenyl phosphate (DPP)	0.33		(<2.50)	ug/gCR
Diethylthiophosphate (DETP)	<DL		(<1.00)	ug/gCR

PFA's

TEST	RESULT	H/L	REFERENCE	UNITS
● Perfluorobutanoic acid (PFBA)	0.29		(<1.20)	ug/gCR
● Perfluorooctanoic Acid (PFOA)	<DL		(<0.10)	ug/gCR
● Perfluorooctane Sulphonic Acid (PFOS)	<DL		(<0.60)	ug/gCR

PHTHALATES

TEST	RESULT	H/L		REFERENCE	UNITS
● Butyl Benzyl phthalate (BBP)	0.12			(<1.00)	ug/gCR
● Mono-Benzyl phthalate (mBzP)	1.77			(<3.00)	ug/gCR
● Mono-n-Butyl phthalate (mBP)	4.97			(<55.00)	ug/gCR
● Mono (3-carboxypropyl) phthalate (mCPP)	<DL			(<31.00)	ug/gCR
● Mono-ethyl phthalate (MEtP)	12.11			(<100.00)	ug/gCR
● Mono-2-ethylhexyl phthalate (MEHP)	<DL			(<11.00)	ug/gCR
● Mono-(2-ethy-5-hydroxyhexyl) phthalate (MEHHP)	<DL			(<12.00)	ug/gCR
● Mono-(2-ethy-5-oxohexyl) phthalate (MEOHP)	<DL			(<27.00)	ug/gCR
● Mono-n-octyl phthalate (mOP)	<DL			(<2.00)	ug/gCR
● Phthalic Acid	50.31			(<111.00)	ug/gCR
● Quinolinic Acid	4.40	H		(<3.74)	mmol/molCR



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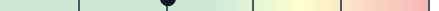
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VOLATILE ORGANIC COMPOUNDS

TEST	RESULT	H/L	REFERENCE	UNITS
2-hydroxyethyl-mercaptopuric acid (HEMA)	<DL		(<5.00)	ug/gCR
Mandelic Acid	145.0		(<267.0)	ug/gCR
Phenylglyoxylic Acid	112.7		(<287.0)	ug/gCR
Mandelic Acid + Phenylglyoxylic Acid	257.7		(<610.0)	ug/gCR

BENZENES EXPOSURE

[illegible]

TOLUENES EXPOSURE

[illegible]

XYLENES EXPOSURE

[illegible][illegible]

Environmental Toxins Comment

ENVIRONMENTAL POLLUTANTS PROFILE:

The reported markers in the Environmental Pollutants Profile commonly originate from industrial/manufacturing products or their associated byproducts. Exposures are often occupationally-related and typically through either inhalation or topical exposure.

Metabolism of these products occurs via the liver detoxification pathways leading to excretion into the urine. Chronic exposures may also lead to build up of these products in fatty tissue deposits.

4-HYDROXYBENZOIC ACID ELEVATED (URINE):

Elevated urinary 4-hydroxybenzoic acid suggests increased exposure to parabens or altered metabolism of aromatic compounds. Parabens are commonly used as preservatives in cosmetics, personal care products, and some pharmaceuticals.

Clinically, elevated 4-hydroxybenzoic acid may be associated with non-specific symptoms such as fatigue, headaches, or endocrine-related concerns, although many individuals remain asymptomatic.

From an organic acid pattern perspective, elevated 4-hydroxybenzoic acid may be seen alongside other aromatic or phenolic metabolites, reflecting cumulative preservative or polyphenol exposure.

From a functional medicine perspective, this finding should be interpreted in the context of environmental and personal care exposures, hepatic conjugation capacity, and cumulative endocrine-disrupting burden, with emphasis on reducing ongoing exposure.



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Treatment: Treatments focus on improving gut health through dietary changes like increasing plant-based foods, fermented foods, and prebiotics while reducing artificial sweeteners and potentially eliminating paraben-containing products.

QUINOLINIC ACID ELEVATED (URINE):

Elevated urinary quinolinic acid suggests increased flux through the kynurenine pathway of tryptophan metabolism, often associated with immune activation or inflammatory signalling. Quinolinic acid is a neuroactive metabolite with excitatory properties.

Clinically, elevated quinolinic acid may be associated with neurocognitive symptoms such as brain fog, mood disturbance, irritability, sleep disruption, or heightened pain sensitivity, although symptom expression varies.

From an organic acid pattern perspective, elevated quinolinic acid is often observed alongside alterations in other tryptophan metabolites, indicating inflammatory diversion of tryptophan metabolism away from serotonin and melatonin pathways.

From a functional medicine perspective, this finding should be interpreted in the context of immune activation, inflammatory burden, and overall balance of tryptophan metabolism rather than as a primary neurological disorder.

Treatment: Treatments for high quinolinic acid focus on reducing its production and counteracting its neurotoxic effects, including dietary changes like increasing vitamin B6 and consuming antioxidants (e.g., sulforaphane, green tea polyphenols, curcumin), and supplements (melatonin, selenium, theanine).

Methodology

Liquid Chromatography-Mass Spectrometry (LC-MS/MS/MS), Automated Chemistry/Immunochemistry, Inductively Coupled Plasma Mass Spectrometry (ICP-MS)