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30-Jul-26

Clinical Notes .

29-Jul-26



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

Patient ID P000060
Ext ID 26211-0702

Test Patient

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

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LIPIIDS PROFILE

TEST	RESULT	H/L		REFERENCE	UNITS
Cholesterol	5.8	H		(<5.5)	mmol/L
Triglycerides	1.7			(<2.0)	mmol/L
HDL (Protective)	1.1			(1.0-2.2)	mmol/L
Non-HDL Cholesterol	4.7	H		(<4.0)	mmol/L
LDL-C (Atherogenic)	3.9	H		(<3.0)	mmol/L
Cholesterol/HDL Ratio	5.3	H		(<5.0)	ratio
LDL/HDL Ratio	3.6	H		(<3.2)	ratio

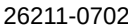
SPECIFIC LIPOPROTEINS

TEST		RESULT	H/L		REFERENCE	UNITS
Apolipoprotein A-1		1.26			(1.10-2.05)	g/L
Apolipoprotein B		1.43	H		(0.60-1.30)	g/L
Ratio (ApoB/Apo-A1)		1.13			(0.35-1.15)	ratio
Lipoprotein (a)		133.0	H		(<75.0)	nmol/L

LIPOSCREEN-LDL SUBFRACTIONS

TEST	RESULT	H/L		REFERENCE	UNITS
Very Low Density Lipoprotein (VLDL)	0.62	H		(<0.60)	mmol/L
Mid Density Lipoprotein (IDL-1)	0.47			(<0.60)	mmol/L
Mid Density Lipoprotein (IDL-2)	0.31			(<0.40)	mmol/L
Mid Density Lipoprotein (IDL-3)	0.62	H		(<0.60)	mmol/L
Low Density Lipoprotein (LDL-1)	1.37			(<1.50)	mmol/L
Low Density Lipoprotein (LDL-2)	0.65			(<0.80)	mmol/L
Low Density Lipoprotein (LDL-3)	0.10			(<0.20)	mmol/L
Low Density Lipoprotein (LDL-4)	<DL			(<0.01)	mmol/L
Low Density Lipoprotein (LDL-5)	<DL			(<0.01)	mmol/L
Low Density Lipoprotein (LDL-6)	<DL			(<0.01)	mmol/L
Low Density Lipoprotein (LDL-7)	<DL			(<0.01)	mmol/L
Mean Particle Size	271			(>268)	Angstrom

LDL Phenotype Pattern Type A - Normal

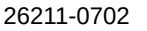


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Legend Not Tested Within Range Out of Range L = Low, LL = Critically Low H = High, HH = Critically High Regulator Enzyme

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TEST	RESULT	H/L		REFERENCE	UNITS
Progesterone (P4)	0.36				nmol/L
Estradiol (E2)	202.0				pmol/L
DHEA Sulphate	11.0	H		(0.3-6.7)	umol/L
Testosterone (TT)	1.10			(0.10-1.42)	nmol/L
Sex Hormone Binding Globulin	29			(27-128)	nmol/L
Calc. Free Testosterone (Vermeulen)	21.0			(1.0-22.0)	pmol/L

HORMONE	Progesterone	Estradiol	Estrone	FSH	LH
UNITS	nmol/L	pmol/L	pg/mL	mIU/mL	mIU/mL
Early Follicular	-	-	15 - 150	-	-
Follicular	0.16 - 0.62	114 -332	-	3.5 - 12.5	2.4 -12.6
Late Follicular	-	-	100 - 250	-	-
Mid-Cycle Peak	-	315 - 1828	-	3.0 - 19.2	10.5 - 85
Ovulation Phase	0.18 - 13.2	222 - 1959	-	4.7 - 21.5	14.0 - 95.6
Luteal Phase	13.1 - 46.3	222 - 854	15 - 200	1.7 - 7.7	1.0 - 11.4
Post Menopause	0.16 - 0.40	18.4 - 505	15 - 55	25.8 - 134.8	7.7 - 58.5
Pregnant (1st Trimester)	35 - 141	563 - 11902	-	-	-
Pregnant (2nd Trimester)	80.8 - 265	5729 - 78098	-	-	-
Pregnant (3rd Trimester)	187 - 679	31287 - 110100	-	-	-
MALE	0.16 - 0.47	41 - 159	-	1.5 - 12.4	1.7 - 8.6

Pregnancy:	59 - 1363 nmol/L
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Renal Function Test Comment

ESTIMATED GFR COMMENT:

eGFR (mL/min/1.73m²) is calculated by the laboratory using the CKD-EPI formula eGFR > 90 mL/min/1.73 sq.m - Normal GFR

Lipids Profile Comment

The National Vascular Disease Prevention Alliance (NVDPA) treatment target levels for high risk people are:

Total Cholesterol <4.0 mmol/L Fasting Triglycerides < 2.0 mmol/L

Non-HDL Cholesterol <2.5 mmol/L HDL-Cholesterol ≥1.00 mmol/L

LDL-Cholesterol <2.0 mmol/L

Increased non-HDL Cholesterol is a significant marker for subclinical atherosclerosis (ref: Cardiology Today 2013; 3(2): pp25-27).

LDL-C COMMENT:

Low levels of HDL cholesterol and high levels of LDL cholesterol are associated with an increased risk of atherosclerotic vascular disease. A LDL Subfractions test may be considered to determine the presence of small, dense (highly atherogenic) LDLs which are a primary cause of Coronary Artery Disease (CAD). The LDL subtypes are not detectable through conventional Lipid Profiles.

APOLIPOPROTEIN B ELEVATED:

Apolipoprotein B levels increase during pregnancy, hypercholesteremia, LDL receptor defect, bile obstruction, hyperlipemia type II, and nephrotic syndrome.

Suspect: Elevated LDL, Hyperlipoproteinemia type 2a or 2b, Hyper-beta-lipoproteinemia, Arterial Stenosis (High Apo B can be associated with carotid or coronary stenosis).

Further testing: Liposcreen LDL subfractions, Lipoprotein-a, Oxidised LDL.

Consider the following actions: Treat as for elevated Cholesterol and Triglycerides, 1 g TID Niacin OR inositol hexaniacinate (non-flush if available), use Psyllium and other water soluble fibres, vegetable-based diet including soy products, Zinc supplementation and Anti-oxidants.

ELEVATED HOMOCYSTEINE:

Elevated homocysteine levels may result from low levels of folic acid, vitamin B6, or vitamin B12, some drugs and renal impairment, as well as several inherited defects. However, an elevated plasma homocysteine may also be due to high protein/Paleo diet.

The following genetic SNPs in CBS, MTHFR, MTR, MTRR may also impact levels of plasma homocysteine.

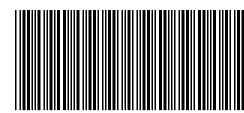
NOTE: Fasting overnight is required for this test. A falsely elevated result can occur if the blood has not been preserved appropriately and there is a delay in separation of the plasma from cells.

Lipoproteins Comment

LIPOPROTEIN(a) ELEVATED:

Consists of an LDL bound to Apolipoprotein component. Causes atherothrombogenesis and strongly associated with peripheral and coronary events. Consider the following possible causes: Genetic predisposition, Excessive intake of partially hydrogenated oils/fats, low-fibre, low vegetable-based diet, Hypothyroidism, Post-Menopausal elevation, Diabetes, particularly with central obesity, Chronic renal insufficiency, Simvastatin Therapy, Compounded likelihood of CVD if also high LDL and/or total Cholesterol.

Consider the following actions: Aerobic Exercise, Dietary modification, 1 g TID Niacin OR inositol hexaniacinate (non-flush if available), CoQ10, L-lysine, proline, HRT if indicated, Magnesium, Coronary vasodilator therapy - as elevated Lp(a) may impair normal vasodilation mechanisms. Vitamin C, L-Lysine and Vitamin E are also beneficial. Increased HDL levels appear to reduce the threat posed by high levels of Lp(a).



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Vitamin B12 levels are considered to be borderline and need to be interpreted with the clinical presentation, folate level, FBE and blood film.

Further investigation to consider: - Intrinsic Factor and Parietal Cell Antibodies (to exclude possible pernicious anaemia). - Gastrin to assess possible hypochlorhydria.

High/Normal Folate levels do not necessarily reflect adequate levels of 5 MTHF (the most readily useable form of folate in the body). If the serum Folate level is low, look at the Homocysteine level which will be elevated, whilst MMA levels will be normal. Further assessments to consider: Folate Metabolism Profile (THF, Folinic Acid, 5-MTHF), MTHFR gene status.

Consider measuring vitamin D by LCMS if the result does not correlate clinically or does not change with vitamin D supplementation.

Non-insulin dependent diabetes mellitus and insulin therapy may also give high levels.

NORMAL - Diabetes mellitus unlikely; GTT not indicated.

≥ 3.1 Severe

Elevated reverse T3 (rT3) reflects increased peripheral conversion of thyroxine (T4) toward the inactive metabolite rT3 rather than the biologically active triiodothyronine (T3). This pattern indicates an alteration in thyroid hormone metabolism at the tissue level and may

