TEST REPORT

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Beaverton, OR 97008
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ZRT LABORATORY

 # 2022 07 27 400 S

Ordering Provider:
Melissa Parra, CNP

Samples Received
07/27/2022

Samples Collected
Saliva - 07/25/22 07:30

Report Date
08/02/2022

Patient Name: Jennifer S Caspari
Patient Phone Number: 808 778 7253

Gender	Last Menses	Height	Waist
Female	07/03/2022	5 ft 6 in	33 in
DOB	**Menses Status**	**Weight**	**BMI**
5/30/1983 (39 yrs)	Pre-Menopausal	140 lb	22.6

TEST NAME	RESULTS | 07/25/22	RANGE
Salivary Steroids		
Estradiol	1.0 L	1.3-3.3 pg/mL Premenopausal (Luteal)
Progesterone	114	75-270 pg/mL Premenopausal (Luteal)
Ratio: Pg/E2	114	Optimal: 100-500 when E2 1.3-3.3 pg/mL
Testosterone	60 H	16-55 pg/mL (Age Dependent)

<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.

Therapies

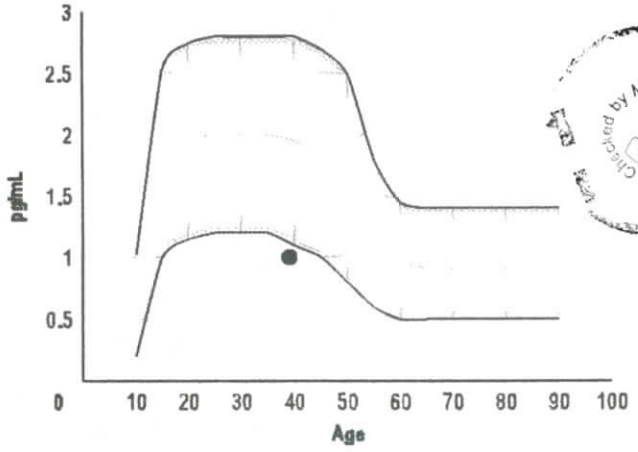
Glutathione; Vitamin C; oral Vitamin D3 (OTC) (1 Days Last Used); Curcumin; Selenium; Zinc; Magnesium; oral B12 (Cobalamin) (OTC) (1 Days Last Used)

Graphs

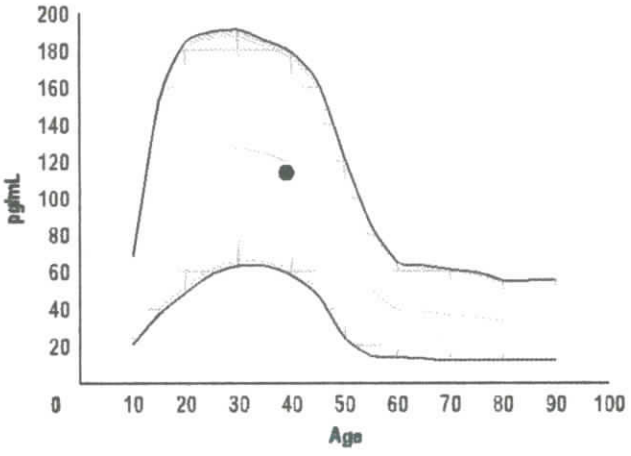
Disclaimer: Graphs below represent averages for healthy individuals not using hormones. Supplementation ranges may be higher. Please see supplementation ranges and lab comments if results are higher or lower than expected.

Average ▼▲ Off Graph

Saliva Estradiol



Saliva Progesterone



The above results and comments are for informational purposes only and are not to be construed as medical advice. Please consult your healthcare practitioner for diagnosis and treatment.

David T. Zava, Ph.D.
Laboratory Director

Alison McAllister, ND.
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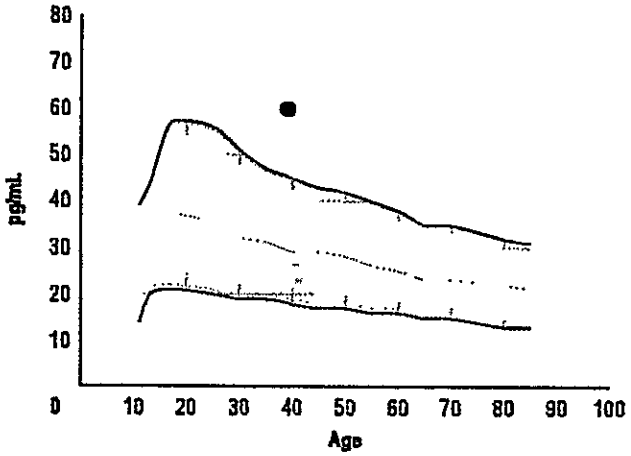
Saliva Testosterone



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Disclaimer: Supplement type and dosage are for informational purposes only and are not recommendations for treatment. For a complete listing of reference ranges, go to www.zrtlab.com/reference-ranges.

TEST NAME	WOMEN
Salivary Steroids	
Estradiol	0.5-1.7 pg/mL Postmenopausal (optimal 1.3-1.7); 1.3-3.3 pg/mL Premenopausal (Luteal); 0.8-12 pg/mL Estrogen Rplcmnt (optimal 1.3-3.3); 0.5-2.2 pg/mL (Synthetic HRT, BC); 0.9-2.5 pg/mL Premenopausal (Follicular); 1.1-4.8 Premeno-Ovulatory (2.0-4.8 optimal)
Progesterone	12-100 pg/mL Postmenopausal; 14-48 pg/mL Premenopausal (Follicular); 75-270 pg/mL Premenopausal (Luteal); 30-300 pg/mL Oral, Troche, SL Progesterone (100-300 mg); 200-3000 pg/mL Topical, Vag Pg (10-30mg); 10-53 pg/mL Synthetic Progestins (HRT, BC); 11-59 pg/ml Premeno-Ovulatory
Ratio: Pg/E2	Optimal: 100-500 when E2 1.3-3.3 pg/mL
Testosterone	16-55 pg/mL (Age Dependent)

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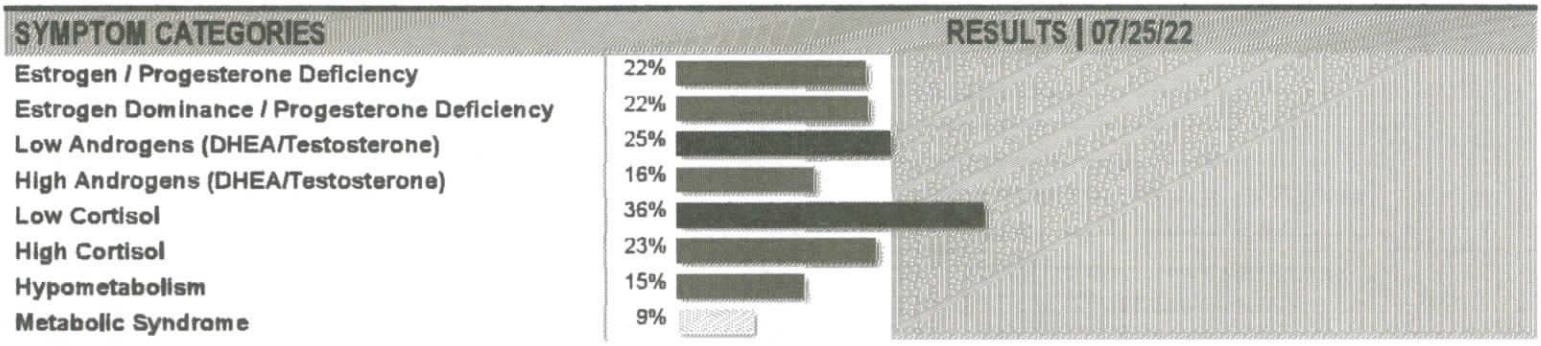
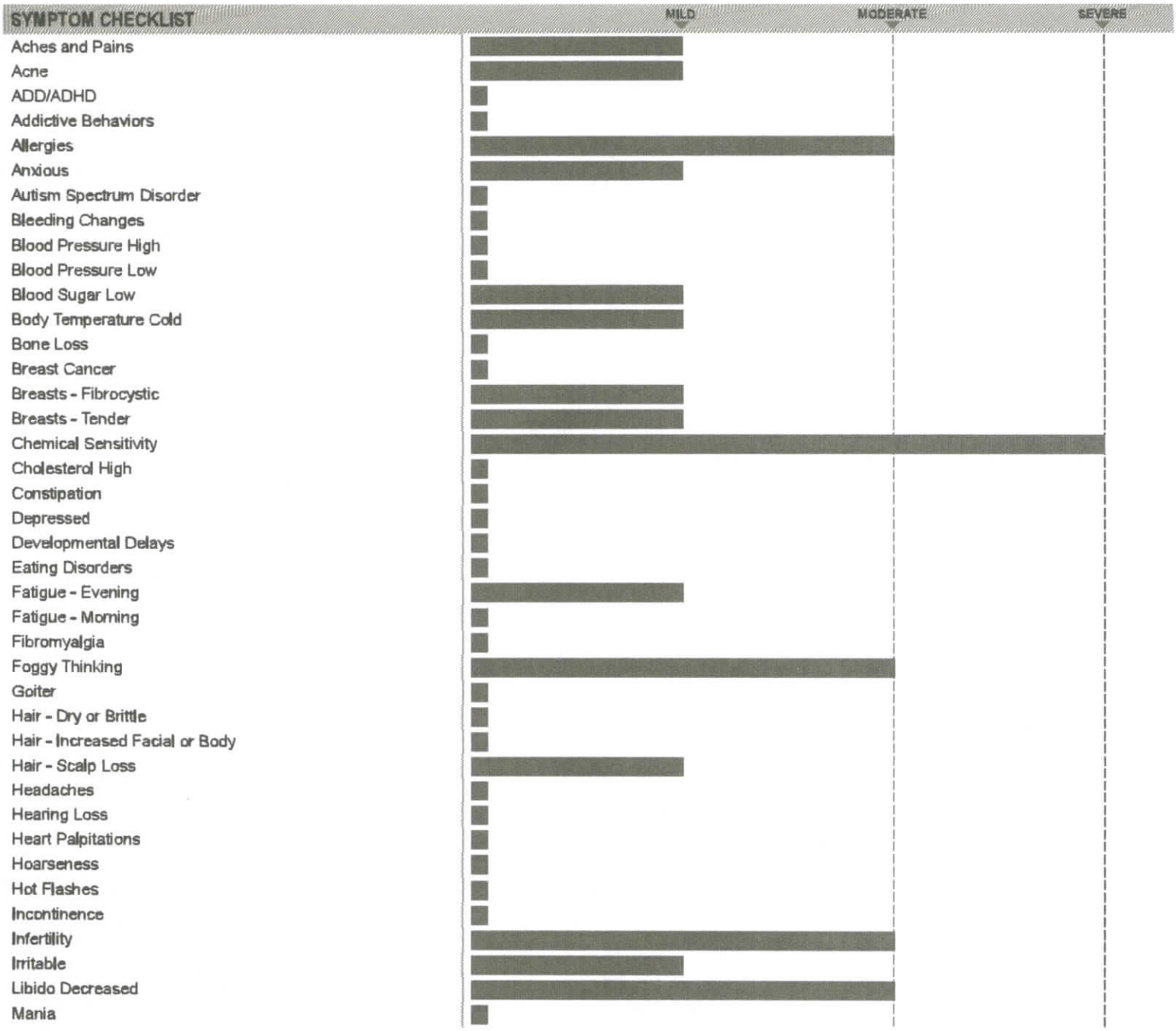
TEST REPORT | Patient Reported Symptoms

Jennifer S Caspari
2022 07 27 400 S

Disclaimer: Symptom Categories below show percent of symptoms self-reported by the patient compared to total available symptoms for each category. For detailed information on category breakdowns, go to www.zrtlab.com/patient-symptoms.





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Lab Comments

Estradiol is slightly lower than the observed range for a premenopausal woman. A lower estradiol can be due to current or recent use of contraceptives (none indicated) but may also result from the consumption of nutritional supplements (e.g. Indole-3-Carbinol, an extract of cruciferous vegetables) and/or soy foods and green leafy vegetables that are natural aromatase inhibitors (the enzyme aromatase is present mostly in fat tissue and converts androgens, such as testosterone, to estrogens). Estrogen deficiency symptoms are minimal and the estradiol is well balanced with progesterone.

Progesterone is within expected range for a premenopausal woman and symptoms of estrogen/progesterone imbalance are minimal. If symptoms of estrogen imbalance become more problematic as menopause approaches it would be worthwhile to consider bio-identical progesterone supplementation. Note: progesterone is often less effective when estradiol is significantly outside the optimal physiological range of 1.3-3.3 pg/ml; therefore, it is important to consider means to reduce the estrogen burden if estradiol is higher than optimal range, and increase estrogen with supplementation if estradiol is lower than optimal range.

Testosterone is high, suggesting excessive production by the ovaries or adrenal glands, testosterone supplementation (none indicated), or exposure to someone using topical testosterone. Chronic high testosterone is usually associated with one or more symptoms of androgen excess (excess facial/body hair, acne, oily skin and hair, weight gain in the waist, increased agitation). These symptoms are not reported as problematic at time of saliva collection suggesting that the exposure to testosterone is acute or some other hormonal imbalance (e.g. high estrogens, high stress hormones such as cortisol or catecholamines) is inhibiting the masculinizing effects of high testosterone.

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