

Specimen Details

Date collected: 08/05/2019 0845 Local
Date received: 08/05/2019
Date entered: 08/05/2019
Date reported: 08/08/2019 0908 ET

General Comments & Additional Information

Alternate Control Number: B0092691962
Total Volume: Not Provided

Alternate Patient ID: Not Provided
Fasting: Yes

Ordered Items

CBC With Differential/Platelet; Comp. Metabolic Panel (14); Lipid Panel w/ Chol/HDL Ratio; Testosterone, Free and Total; DHEA-Sulfate; TSH; Luteinizing Hormone(LH), S; Prostate-Specific Ag, Serum; IGF-1; Estradiol, Sensitive; Sex Horm Binding Glob, Serum; Venipuncture; Cardiovascular Report

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC With Differential/Platelet					
WBC	4.7		x10E3/uL	3.4 - 10.8	01
RBC	5.25		x10E6/uL	4.14 - 5.80	01
Hemoglobin	15.2		g/dL	13.0 - 17.7	01
Hematocrit	45.1		%	37.5 - 51.0	01
MCV	86		fL	79 - 97	01
MCH	29.0		pg	26.6 - 33.0	01
MCHC	33.7		g/dL	31.5 - 35.7	01
RDW	12.8		%	12.3 - 15.4	01
Platelets	181		x10E3/uL	150 - 450	01
Neutrophils	60		%	Not Estab.	01
Lymphs	30		%	Not Estab.	01
Monocytes	8		%	Not Estab.	01
Eos	2		%	Not Estab.	01
Basos	0		%	Not Estab.	01
Neutrophils (Absolute)	2.8		x10E3/uL	1.4 - 7.0	01
Lymphs (Absolute)	1.4		x10E3/uL	0.7 - 3.1	01
Monocytes (Absolute)	0.4		x10E3/uL	0.1 - 0.9	01
Eos (Absolute)	0.1		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	01
Immature Granulocytes	0		%	Not Estab.	01
Immature Grans (Abs)	0.0		x10E3/uL	0.0 - 0.1	01
Comp. Metabolic Panel (14)					
Glucose	94		mg/dL	65 - 99	01
BUN	29	High	mg/dL	6 - 20	01
Creatinine	1.24		mg/dL	0.76 - 1.27	01
eGFR If NonAfricn Am	76		mL/min/1.73	>59	
eGFR If Africn Am	88		mL/min/1.73	>59	

Patient ID:

Date collected:

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
BUN/Creatinine Ratio	23	High		9 - 20	
Sodium	143		mmol/L	134 - 144	01
Potassium	5.5	High	mmol/L	3.5 - 5.2	01
Chloride	102		mmol/L	96 - 106	01
Carbon Dioxide, Total	25		mmol/L	20 - 29	01
Calcium	9.7		mg/dL	8.7 - 10.2	01
Protein, Total	7.1		g/dL	6.0 - 8.5	01
Albumin	4.8		g/dL	3.5 - 5.5	01
Globulin, Total	2.3		g/dL	1.5 - 4.5	
A/G Ratio	2.1			1.2 - 2.2	
Bilirubin, Total	0.2		mg/dL	0.0 - 1.2	01
Alkaline Phosphatase	91		IU/L	39 - 117	01
AST (SGOT)	45	High	IU/L	0 - 40	01
ALT (SGPT)	49	High	IU/L	0 - 44	01
Lipid Panel w/ Chol/HDL Ratio					
Cholesterol, Total	176		mg/dL	100 - 199	01
Triglycerides	86		mg/dL	0 - 149	01
HDL Cholesterol	59		mg/dL	>39	01
VLDL Cholesterol Cal	17		mg/dL	5 - 40	
LDL Cholesterol Calc	100	High	mg/dL	0 - 99	
T. Chol/HDL Ratio	3.0		ratio	0.0 - 5.0	
Please Note:					01
T. Chol/HDL Ratio Men Women 1/2 Avg.Risk 3.4 3.3 Avg.Risk 5.0 4.4 2X Avg.Risk 9.6 7.1 3X Avg.Risk 23.4 11.0					
Testosterone, Free and Total					
Testosterone, Serum	413		ng/dL	264 - 916	01
Adult male reference interval is based on a population of healthy nonobese males (BMI <30) between 19 and 39 years old. Travison, et.al. JCEM 2017,102;1161-1173. PMID: 28324103.					
Free Testosterone(Direct)	5.7	Low	pg/mL	8.7 - 25.1	02
DHEA-Sulfate	198.8		ug/dL	138.5 - 475.2	01
TSH	2.120		uIU/mL	0.450 - 4.500	01
Luteinizing Hormone(LH), S					
LH	3.6		mIU/mL	1.7 - 8.6	01
Prostate-Specific Ag, Serum					
Prostate Specific Ag, Serum	0.9		ng/mL	0.0 - 4.0	01

Patient Name

Patient ID:

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
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Roche ECLIA methodology.
According to the American Urological Association, Serum PSA should decrease and remain at undetectable levels after radical prostatectomy. The AUA defines biochemical recurrence as an initial PSA value 0.2 ng/mL or greater followed by a subsequent confirmatory PSA value 0.2 ng/mL or greater.
Values obtained with different assay methods or kits cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

IGF-1

Insulin-Like Growth Factor I	211	ng/mL	88 - 246	02
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Estradiol, Sensitive

10.9	pg/mL	8.0 - 35.0	02
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This test was developed and its performance characteristics determined by LabCorp. It has not been cleared by the Food and Drug Administration.
Methodology: Liquid chromatography tandem mass spectrometry (LC/MS/MS)

Sex Horm Binding Glob, Serum	50.0	nmol/L	16.5 - 55.9	01
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Cardiovascular Report

Interpretation	Note	03
Supplemental report is available.		
PDF Image	.	03

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02	BN	LabCorp Burlington 1447 York Court, Burlington, NC 27215-3361	Dir: Sanjai Nagendra, MD
03	LITIL	Litholink Corporation 2250 West Campbell Park Drive, Chicago, IL 60612-3502	Dir: John Asplin, MD

For inquiries, the physician may contact **Branch: 800-877-5227 Lab: 800-282-7300**

ACCESSION: 22104

DISCLAIMER: These assessments and treatment suggestions are provided as a convenience in support of the physician-patient relationship and are not intended to replace the physician's clinical judgment. They are derived from national guidelines in addition to other evidence and expert opinion. The clinician should consider this information within the context of clinical opinion and the individual patient.

SEE GUIDANCE FOR CARDIOVASCULAR REPORT: Stone NJ et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation* 2014; 129 (suppl 2): S1-S45; Contois et al. *Clin Chem* 2009; 55(3):407-419; Brunzell et al. *Diabetes Care* 2008; 31(4):811-82.

Note: Please refer to your LabCorp Report for all results as well as any test-specific and specimen-specific comments.

Laboratory Director's Notes

Laboratory test values flagged with an asterisk (*) within this report refer to the following commentary from our physicians and quality assurance staff.

COLLECTION DATE	ITEM	RELATED NOTES
08/05/2019	Total Chol:HDL Ratio	T. Chol/HDL Ratio Men Women 1/2 Avg.Risk 3.4 3.3 Avg.Risk 5.0 4.4 2X Avg.Risk 9.6 7.1 3X Avg.Risk 23.4 11.0

Mitchell S. Laks, PhD - Laboratory Director

Current Laboratory Results

Blood Draw Date:	08/05/2019	Date Received:	08/05/2019	Date Completed:	08/06/2019	Fasting:	YES
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Comp. Metabolic Panel (14)

ANALYTE	REF. INTERVAL	LOW		HIGH	RESULT
Glucose mg/dL	65-99		●		94
BUN mg/dL	6-20		●●		29 H
Creatinine mg/dL	0.76-1.27		●		1.24
Sodium mmol/L	134-144		●		143
Potassium mmol/L	3.5-5.2		●●		5.5 H
Chloride mmol/L	96-106		●		102
Carbon Dioxide mmol/L	20-29		●		25
Calcium mg/dL	8.7-10.2		●		9.7
Protein, Total, Serum g/dL	6.0-8.5		●		7.1
Albumin g/dL	3.5-5.5		●		4.8
Globulin, Total g/dL	1.5-4.5		●		2.3
A/G Ratio	1.2-2.2		●		2.1
Bilirubin, Total mg/dL	0.0-1.2		●		0.2
Alkaline Phosphatase, S IU/L	39-117		●		91
AST IU/L	0-40		●●		45 H
ALT IU/L	0-44		●●		49 H
BUN: Creatinine Ratio	9-20		●●		23 H
Anion Gap mmol/L	10 - 18		●		16
estimated GFR mL/min/1.73mE2	> 59		●		76

Albumin testing performed on the Roche Modular using the ALB PLUS assay.

Lipid Panel with Chol/HDL Ratio

ANALYTE	REF. INTERVAL	LOW		HIGH	RESULT
Total Cholesterol mg/dL	100-199		●		176
Triglyceride mg/dL	0-149		●		86
HDL-C mg/dL	>39		●		59
VLDL mg/dL	5-40		●		17
LDL(calc) mg/dL	0-99		●●		100 H
non-HDL cholesterol mg/dL	0 - 129		●		117
Total Chol:HDL Ratio ratio units	0.0-5		●		* 3.0

Legend for Abnormal Flags:

L - Below Low Normal
H - Above High Normal

LL - Alert Low
HH - Alert High

< - Panic Low
> - Panic High

A - Abnormal (applies to non-numeric results)
AA - Critical Abnormal (applies to non-numeric results)

Cardiovascular Report

Patient Assessment

Current available clinical information suggests the patient's risk is at least LOW. If the patient has two or more major risk factors, the risk category is intermediate. If the patient has CHD or a CHD risk equivalent, the risk category is high. If patient does not have CHD or a CHD risk equivalent, consider use of the Pooled Cohort Equations to estimate 10-year CVD risk, as individuals with greater than 7.5% risk may warrant more intensive therapy. The calculator can be found at: <http://tools.cardiosource.org/ASCVD-Risk-Estimator/>

Insulin resistance, obesity, excessive alcohol use, smoking, nephrotic syndrome, liver disease, and certain medications can cause secondary dyslipidemia. Consider evaluation if clinically indicated.

Therapeutic lifestyle changes are always valuable to achieve optimal blood lipid status (diet, exercise, weight management).

Lipid Management

Select one patient risk category based upon medical history and clinical judgment. Additional risk factors such as personal or family history of premature CHD, smoking, and hypertension modify a patient's goals of therapy. In CVD prevention, the intensity of therapy should be adjusted to the level of patient risk. MODERATE intensity statin therapy generally results in an average LDL-C reduction of 30% to less than 50% from the untreated baseline. Examples include (daily doses): atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg. HIGH intensity statin therapy generally results in an average LDL-C reduction of 50% or more from the untreated baseline. Examples include (daily doses): atorvastatin 40-80 mg and rosuvastatin 20 mg.

▽ = PATIENT'S RESULT

ANALYTE / RESULT

LDL-C
100 mg/dL

non-HDL
117 mg/dL

Lipid
Assessment

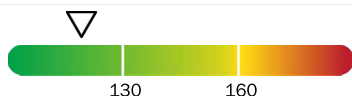
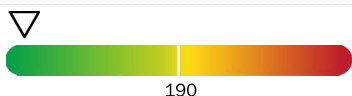
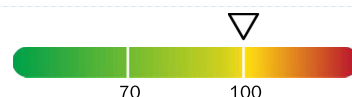
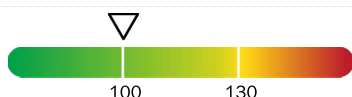
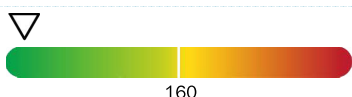
Treatment
Suggestions

Patient Risk Category (select one)

LOW

INTERMEDIATE

HIGH



LDL-C is acceptable, was 110 and now is 100 mg/dL. Non-HDL Cholesterol is optimal, was 128 and now is 117 mg/dL.

LDL-C is acceptable, was 110 and now is 100 mg/dL. Non-HDL Cholesterol is optimal, was 128 and now is 117 mg/dL.

LDL-C is borderline high, was 110 and now is 100 mg/dL. Non-HDL Cholesterol is normal, was 128 and now is 117 mg/dL.

Considerations for use of statin therapy include family history of premature atherosclerotic disease, elevated coronary artery calcium score, ankle-brachial index < 0.9, elevated CRP, or elevated lifetime CVD risk.

Consider measurement of LDL particle number or Apo B to adjudicate need for further LDL lowering therapy. Consider beginning or increasing statin. Factors that may influence statin use include family history of premature atherosclerotic disease, elevated coronary artery calcium score, ankle-brachial index < 0.9, elevated CRP, or elevated lifetime CVD risk. If statin cannot be tolerated or increased, alternatives include use of an intestinal agent (ezetimibe or bile acid sequestrant) or niacin.

Begin statin. If statin already in use, consider increasing dose to achieve at least a 50% LDL reduction from baseline. Moderate or high intensity statin is preferred. If statin cannot be tolerated or increased, alternatives include use of an intestinal agent (ezetimibe or bile acid sequestrant) or niacin.

DISCLAIMER: These assessments and treatment suggestions are provided as a convenience and are neither comprehensive nor intended to replace the physician's clinical judgment. They do not include information such as family history, personal history, or physical findings as would be obtained by the clinician during patient evaluation because LabCorp does not have access to the complete patient medical record.

Patient Results Summary

Cholesterol comes in different forms and has varying effects on your heart health. Some cholesterol is “good” and not known to cause disease, this is HDL. The rest of cholesterol causes disease by clogging your arteries, this is non-HDL. LDL cholesterol is the largest component of the non-HDL cholesterol. Lowering your levels of “bad” cholesterol will lower your risk for disease.

- **LDL cholesterol (LDL-C)** is the largest component of the non-HDL cholesterol (“bad” cholesterol).
- **non-HDL** is composed of many different types of cholesterol (not just LDL-C) and high levels cause disease.

The level to which your LDL must be lowered depends on the risk for developing heart disease or having a heart attack. The higher your risk for heart disease, the lower your LDL goal.

Contributing Risk Factors For Heart Disease

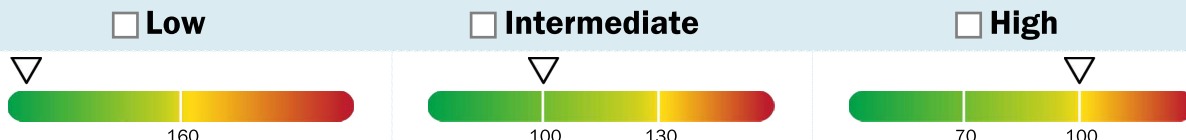
- | | |
|--|---|
| <input type="checkbox"/> Heart and/or vascular disease | <input type="checkbox"/> Cigarette (tobacco) smoking |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low HDL (men less than 40 mg/dL, women less than 50 mg/dL) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Family history of early onset heart disease |
| <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Man over 45 years or woman over 55 years |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Familial Hypercholesterolemia |

Your Heart Disease Risk Category

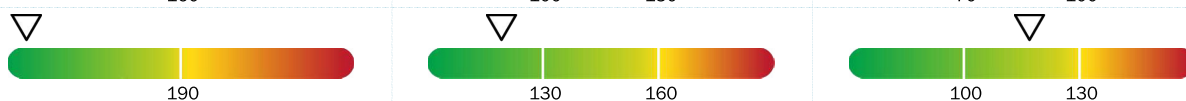
Selected by your physician based upon your risk factors and clinical judgement.

Test /
Your Results

LDL-C
100 mg/dL



non-HDL
117 mg/dL



▽ = Your Result: Left (Green) = Optimal, Center = Acceptable, Right (Red) = High Risk

Your Care Plan (as selected by your physician)

- | | |
|---|---|
| <input type="checkbox"/> Eat less trans fats and saturated fats, red meat, and sugary foods/drinks | <input type="checkbox"/> Control any other medical conditions: such as diabetes, high blood pressure |
| <input type="checkbox"/> Eat more vegetables, fruits, whole grains, low-fat dairy products, poultry, fish, and nuts | <input type="checkbox"/> Visit your doctor as scheduled and obtain all follow-up tests/treatments recommended |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Take all of your medications your doctor(s) have prescribed |
| <input type="checkbox"/> Lose weight | <input type="checkbox"/> |

DISCLAIMER: You should discuss this information with your physician. Litholink does not have a doctor-patient relationship with you, nor does it have access to a complete medical history or a physical examination that would be necessary for a complete diagnosis and comprehensive treatment plan. Neither you nor your physician should rely solely on this guidance. REFERENCES: National Heart, Lung, and Blood Institute's Third Report of the NCEP Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (ATP III) (2002. NIH publication 02-5215); National Heart, Lung, and Blood Institute's Your Guide to Lowering Your Cholesterol with TLC (2005. NIH publication 06-5235); Stone NJ et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2013; 00:000-000.