



dutch[®]

INTERPRETIVE GUIDE

Second Edition

Published October 2025



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— INTERPRETIVE GUIDE —

By Precision Analytical Inc.

Second Edition

Published October 2025

**PRECISION
ANALYTICAL INC.**
CREATORS OF THE DUTCH TEST[®]

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Please Note:

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DUTCH Interpretive Guide

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Introduction to DUTCH

Welcome

Thank you for choosing the DUTCH Test™ for your functional endocrinology testing needs. We know you have many options to choose from when it comes to functional endocrinology evaluation, so we strive to offer the best value, the most scientifically-relevant testing parameters and reference ranges, and the greatest clinical and educational support.

The DUTCH Interpretive Guide was written with you, our providers, in mind. DUTCH stands for Dried Urine Test for Comprehensive Hormones. We included the word “comprehensive” to emphasize that the DUTCH Test provides a more complete picture of a person’s hormone health than saliva, 24-hour urine, and serum testing. We also understand that this comprehensiveness can add complexity to test interpretation. To better support our providers in their ability to interpret the DUTCH Test, we have organized all the information that is often discussed during our clinical consults into this handbook. It is our hope that you can use this guide not only to become an expET at DUTCH Test interpretation, but also to acquire a deeper, more extensive understanding of female and male hormone health overall.

This guide is intended to be used in combination with the DUTCH Treatment Guide, the DUTCH Mini Guides, and other DUTCH educational resources. We recommend using the DUTCH Interpretive Guide first to interpret the DUTCH Test results, and then utilizing the DUTCH Mini Guides and DUTCH Treatment Guide to evaluate support considerations.

HOW TO READ A DUTCH TEST

The DUTCH Test uses dials and sliders to visually present the test results. They have been designed to allow for quick and easy evaluation of which hormones are out of range, see **Figure 1.1**.

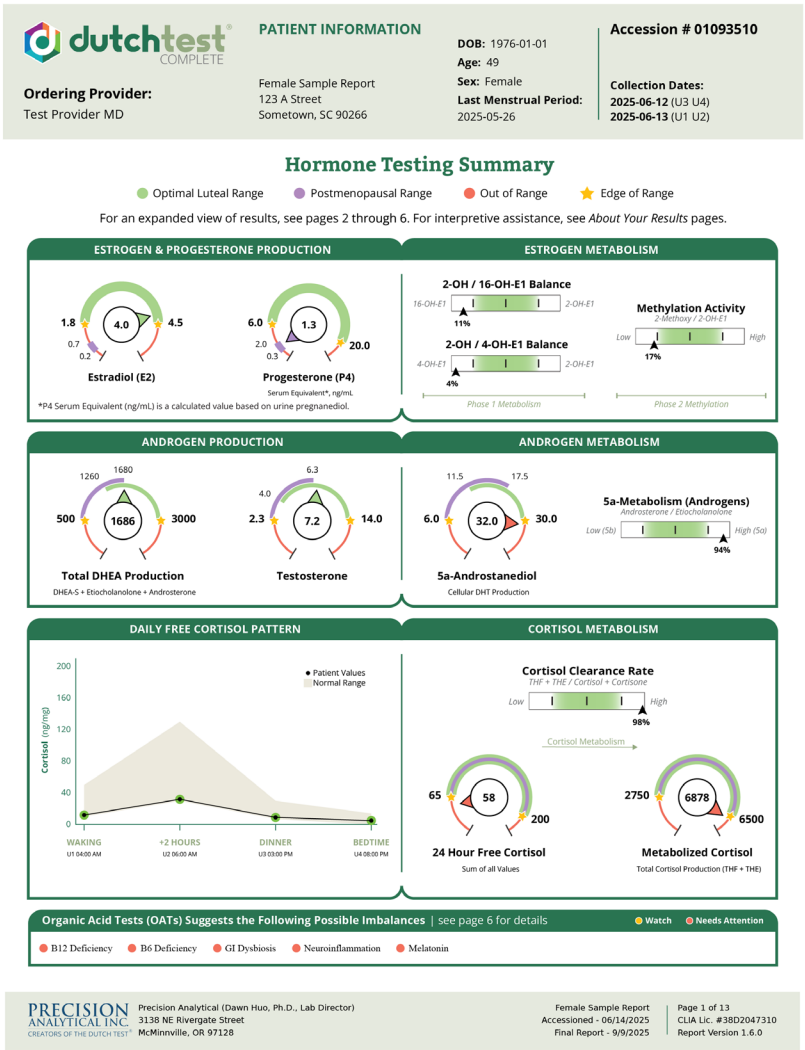


Figure 1.1: Page 1 of an Example DUTCH Complete Report

Sex Hormone Dials on a DUTCH Female Report

The sex hormone dials on the DUTCH female report have two reference ranges, see **Figure 1.2**. On female estrogen and progesterone dials, the green shaded area represents the reference range for the luteal phase of the menstrual cycle. On female androgen dials, the green shaded area represents the premenopausal reference range. For all female sex hormone dials, the purple shaded area represents the postmenopausal reference range.

Androgen Dials on a DUTCH Male Report

The androgen dials on the DUTCH male report have two reference ranges, see **Figure 1.3**. The light green shaded area represents the range for males age 18-40 years, while the dark green shaded area represents the range for males age 41-60+ years.

Regarding all sex hormone dials, these dials represent reference ranges for females 20 years and older and males 18 years and older. Therefore, use caution if interpreting a person's DUTCH Test using these ranges if the female is younger than 20 or if the male is younger than 18.

Androgens naturally decline with age, so referencing the age-dependent ranges offers a better representation of expected levels when interpreting the androgen dials, see **"Reference Range Determination"** on page 56 for more information.

All Other DUTCH Dials

For male estrogen dials and male and female cortisol dials, the arrows on DUTCH dials, see **Figure 1.4**, are shaded according to their position within the established reference ranges:

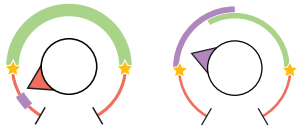
- Results between the stars are shaded green and are considered within the reference range.
- Results below the star on the left or beyond the star on the right and shaded red are considered below and above the reference range, respectively.

Population Sliders

Population sliders on the DUTCH Test visually present the patient's result as a population percentile and provide a visualization of their metabolic preference. The population percentile is plotted on the slider low to high, from left to right, evenly across the slider. The patient's result is shown with a black arrow and their percentile is listed. For example, in **Figure 1.4**, we see the 2OH/4OH ratio is at the 97th percentile. This means that the patient's result is higher than 97% of the population. Since the 2-OH is in the numerator of the ratio, a high result indicates 2-OH is very dominant for this patient.

Figure 1.2: Sex Hormone Dials on a DUTCH Female Report

- ★ Low/high limit of the luteal range
- Luteal/Premenopausal range
- Postmenopausal range
- Below or above range



On the female estrogen and progesterone dials (left), the green shaded area represents the reference range for the luteal phase of the menstrual cycle. On the female androgen dials (right), the green shaded area represents the premenopausal reference range. For all female sex hormone dials, the purple shaded area represents the postmenopausal reference range.

Figure 1.3: Androgen Dials on a DUTCH Male Report

- ★ Low/high limit of normal range
- 18-40 years
- 41-60+ years
- Below or above range



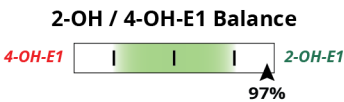
Figure 1.4: All Other DUTCH Dials

- ★ Low/high limit of the normal range
- Within range
- Below or above the range



The arrows on all cortisol and male estrogen dials are shaded according to their position within the established reference ranges.

Figure 1.5: Population Slider



Population sliders on the DUTCH Test visually present the patient's result as a population percentile and provide a visualization of their metabolic preference.

FEMALE QUICKSTART GUIDE

The Female QuickStart Guide will help you understand how to read the DUTCH Test using the **DUTCH Dozen**. The DUTCH Dozen is an interpretive framework that allows clinicians to understand their patients’ DUTCH Test results quickly and comprehensively. We have streamlined the review of the DUTCH Test with a set of **12 assessments** that prioritize the most critical aspects of hormone function, covering estrogens, progesterone, androgens, and cortisol. The DUTCH Dozen allows clinicians to quickly evaluate key hormone markers in the **Hormone Testing Summary** using **page 1 of the report**, making it easier and faster to develop targeted treatment plans. See **page 24** and **page 38** of the DUTCH Interpretive Guide, respectively, for more information about the DUTCH Dozen and to learn about the DUTCH Advanced Insights.

This first page orients you to female reference ranges and the types of graphics used on the DUTCH report.

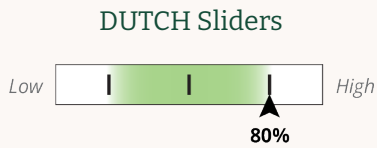
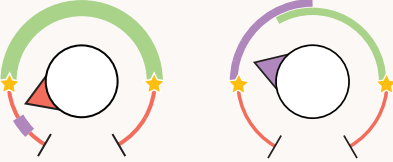
Some dials have one normal range



- In-range results are in green
- Out-of-range results are in red

Sex hormone dials for females have two normal ranges

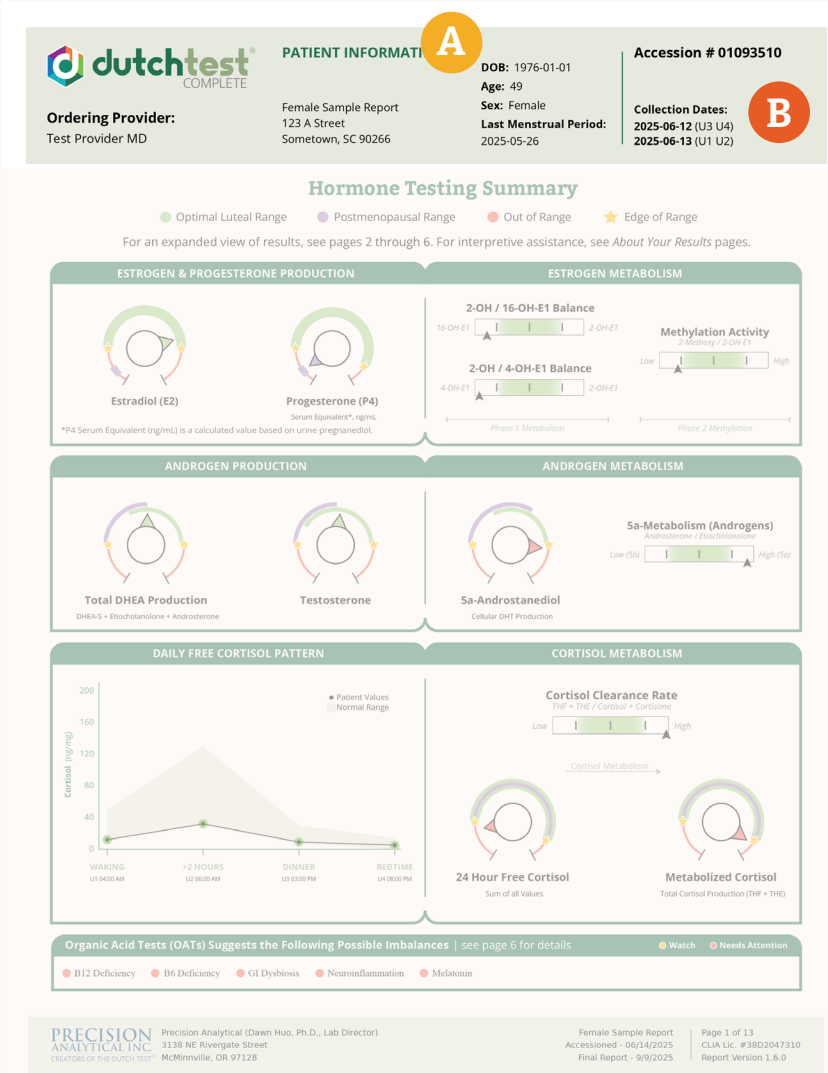
- The luteal range on estrogen and progesterone dials and the premenopausal range on androgen dials are green
- The postmenopausal range is purple
- Out-of-range results are in red



Population sliders are used to report calculated ratios. In this example, the patient’s result is at the 80th percentile, indicating 80% of people have lower values than theirs. The green shaded area is within range (20–80%). The outer white areas are out of range. The patient’s result and the reference ranges are listed on the “table” pages of the report (pages 3 and 5).

Patient and Sample Information

Page 1 of the report: Female Hormone Testing Summary



A Patient information

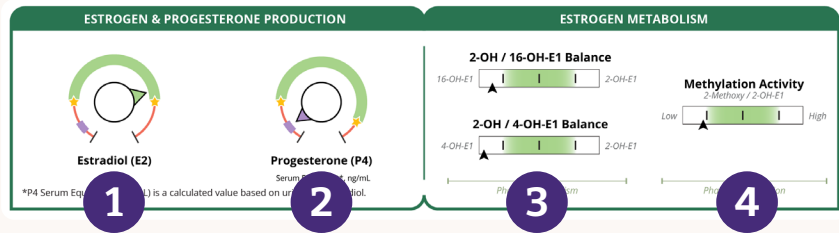
Personal information and last menstrual period. Cycle timing is important for estrogen and progesterone levels.

B Sample information

The date and time each sample was collected. The letter U indicates a urine sample.

DUTCH Dozen – Estrogen and Progesterone

Page 1 of the report: Estrogen and Progesterone section of the Female Hormone Testing Summary



1 Assess estrogen levels given the patient's reproductive status

Are **estrogen** levels normal? Estradiol is the most potent estrogen and thus has more estrogenic activity in the body compared to E1, E3 and the phase 1 and 2 estrogen metabolites.

2 Assess progesterone levels given the patient's reproductive status

Are progesterone levels normal? The progesterone DUTCH Dial reports the **Progesterone Serum Equivalent**. This is a calculated value based on urinary pregnanediol from DUTCH published validation studies. For cycling females in the luteal phase, the Estradiol and Progesterone Serum Equivalent dials can be easily compared on this summary page to assess relative balance.

3 Assess 2-OH preference in phase 1 estrogen metabolism

Is the protective 2-OH pathway preferred?

2-OH-E1

2-OH is the most prominent phase 1 estrogen metabolite. 2-OH metabolite is stable with little-to-no estrogen receptor activity.

16-OH

16-OH is an estrogenic phase 1 metabolite. 2-OH/16-OH-E1 balance slider shows 2-OH-E1 relative to 16-OH-E1. As the arrow moves to the left side of the slider, more 16-OH is present relative to 2-OH.

4-OH

4-OH is a genotoxic metabolite. 2-OH/4-OH-E1 balance slider shows 2-OH-E1 relative to 4-OH-E1. As the arrow moves to the left side of the slider, more 4-OH is present relative to 2-OH.

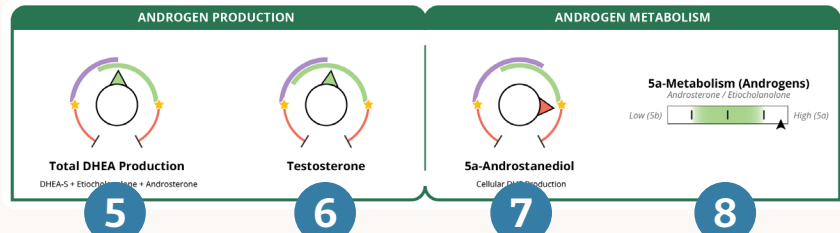
4 Assess methylation of 2-OH estrogens

Are 2-OH estrogens being adequately methylated?

The Methylation Activity slider bar shows the ratio 2-Methoxy/2-OH-E1. 2-Methoxy-E1 is a neutral, stable phase 2 metabolite that is easily excreted from the body. The patient's result is shown by the black arrow. When results are to the left, it indicates lower than average methylation activity, to the right indicates higher than average activity.

DUTCH Dozen – Androgens

Page 1 of the report: Androgen section of the Female Hormone Testing Summary



5 Assess adrenal androgen levels (Total DHEA)

Are adrenal androgen levels normal?

Total DHEA Production is the sum of three urinary DHEA metabolites, DHEA-S, etiocholanolone, and androsterone, and shows the total androgen production from the adrenal glands.

6 Assess testosterone levels

Are testosterone levels normal?

Testosterone on the DUTCH Test reflects the bioavailable conjugated testosterone excreted in urine. For most patients, this result will parallel serum free testosterone.

NOTE: If urinary testosterone is below range, confirm low testosterone levels in the serum before considering treatment.

7 Assess cellular production of 5a-DHT via 5a-androstenediol

Is cellular production and activity of 5a-DHT normal?

5a-DHT

5a-DHT is the most potent androgen and has 4x more androgenic activity than testosterone.

5a-Androstenediol

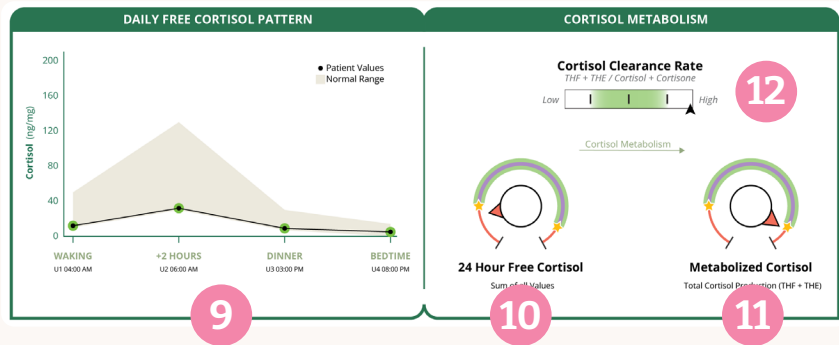
5a-Androstenediol is a metabolite of 5a-DHT. Research shows that 5a-androstenediol best reflects intracellular production and activity of 5a-DHT.

8 Assess if there is a preference for the more potent alpha metabolism of the androgens

Is there a preference for 5a-reductase metabolism of the androgens?

The 5a-Metabolism (Androgens) slider shows the Androsterone (5a) / Etiocholanolone (5b) ratio. Results on the left indicate relatively more inactive 5b metabolites. Results to the right indicate more active 5a metabolites, which typically indicates a higher potential for high androgen symptoms.

Page 1 of the report: Cortisol section of the Female Hormone Testing Summary



9 Assess the daily free cortisol pattern

Is the daily free cortisol pattern optimal?

The graph plots free cortisol measured from the individual urine samples taken throughout the day.

The reference range is shown in the shaded area behind the patient's results, which are shown by the dark line.

The first value reported (Waking A) represents the overnight period. The second value (Morning B) is the peak. Urine samples reflect cortisol levels in the hours before the sample was collected.

10 Assess the daily total of free cortisol in circulation (24hr Free Cortisol)

What is the daily total of free cortisol in circulation?

The 24hr Free Cortisol dial shows a sum of the 4 points on the **Daily Free Cortisol Pattern**.

This dial shows overall cortisol exposure throughout the day.

11 Assess the total cortisol produced by the adrenal glands (Metabolized Cortisol)

What is the total production of cortisol by the adrenals?

Cortisol and cortisone are metabolized in the body into a-THF, b-THF, and b-THE. The sum of these equals the **Metabolized Cortisol** and can give additional insight into total adrenal cortisol output for the day.

12 Assess the rate of cortisol clearance from the body

Is cortisol being cleared from the body at an appropriate rate?

The Cortisol Clearance Rate is the ratio of THF + THE / Cortisol + Cortisone. This can help assess the rate at which cortisol is cleared from the body. Results on the left indicate slower cortisol clearance, and results on the right indicate faster cortisol clearance.

MALE QUICKSTART GUIDE

The Male QuickStart Guide will help you understand how to read the DUTCH Test using the DUTCH Dozen. The **DUTCH Dozen** is an interpretive framework that allows clinicians to understand their patients' DUTCH Test results quickly and comprehensively. We have streamlined the review of the DUTCH Test with a set of **12 assessments** that prioritize the most critical aspects of hormone function, covering estrogens, progesterone, androgens, and cortisol. The DUTCH Dozen allows clinicians to quickly evaluate key hormone markers in the **Hormone Testing Summary using page 1 of the report**, making it easier and faster to develop targeted treatment plans. See **page 24** and **page 38** of the DUTCH Interpretive Guide, respectively, for more information about the DUTCH Dozen and to learn about the DUTCH Advanced Insights.

This first page orients you to male reference ranges and the types of graphics used on the DUTCH report.

Some dials have one normal range

- In-range results are in green
- Out-of-range results are in red

Androgen dials for males have two normal ranges

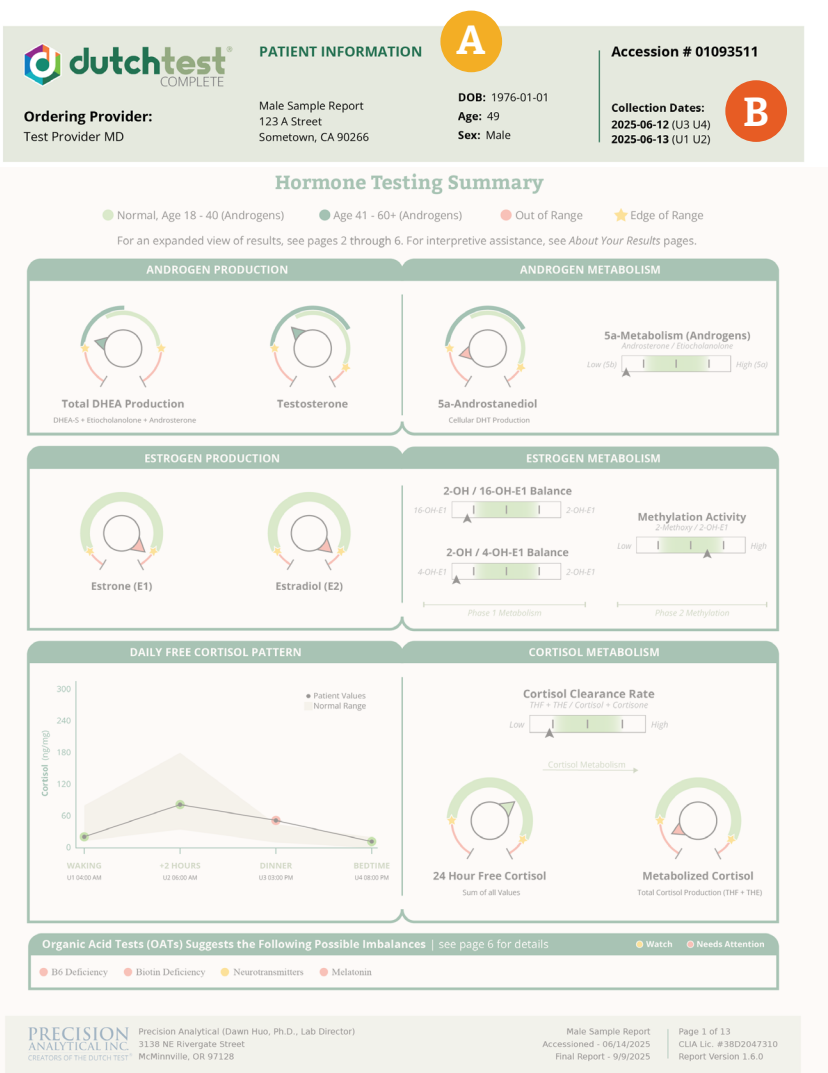
- The normal range for males age 18-40 is in light green
- The normal range for males age 41-60+ is in dark green
- Out-of-range results are in red

DUTCH Sliders

Population sliders are used to report calculated ratios. In this example, the patient's result is at the 80th percentile, indicating 80% of people have lower values than theirs. The green shaded area is within range (20–80%). The outer white areas are out of range. The patient's result and the reference ranges are listed on the "table" pages of the report (pages 8 and 9).

Patient and Sample Information

Page 1 of the report: Male Hormone Testing Summary



A Patient information

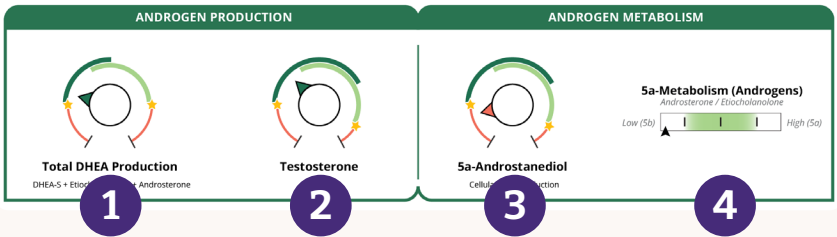
Personal information can be found here.

B Sample information

The date and time each sample was collected. The letter U indicates a urine sample.

DUTCH Dozen – Androgens

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Are adrenal androgen levels normal?

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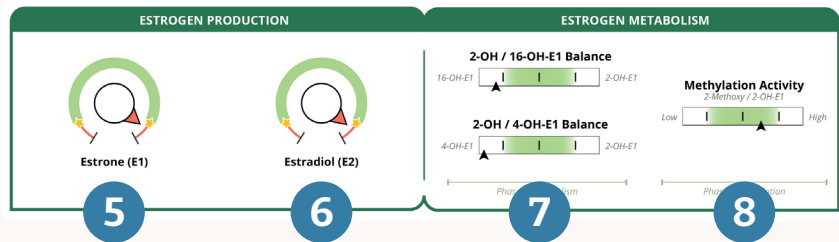
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DUTCH Dozen – Estrogen

Page 1 of the report: Estrogen and Progesterone section of the Male Hormone Testing Summary



5 Assess estrogen levels

Are estrogen levels normal? Estradiol is the most potent estrogen and thus has more estrogenic activity in the body compared to E1, E3 and the phase 1 and 2 estrogen metabolites.

6 Assess the conversion of testosterone to estrogen (via aromatase)

Is testosterone being over converted to estrogen?

Aromatase converts testosterone to E2. Too much estrogen relative to testosterone can be problematic for males.

7 Assess 2-OH preference in phase 1 estrogen metabolism

Is the protective 2-OH pathway preferred?

2-OH-E1

2-OH is the most prominent phase 1 estrogen metabolite. 2-OH metabolite is stable with little-to-no estrogen receptor activity.

16-OH

16-OH is an estrogenic phase 1 metabolite. 2-OH/16-OH-E1 balance slider shows 2-OH-E1 relative to 16-OH-E1. As the arrow moves to the left side of the slider, more 16-OH is present relative to 2-OH.

4-OH

4-OH is a genotoxic metabolite. 2-OH/4-OH-E1 balance slider shows 2-OH-E1 relative to 4-OH-E1. As the arrow moves to the left side of the slider, more 4-OH is present relative to 2-OH.

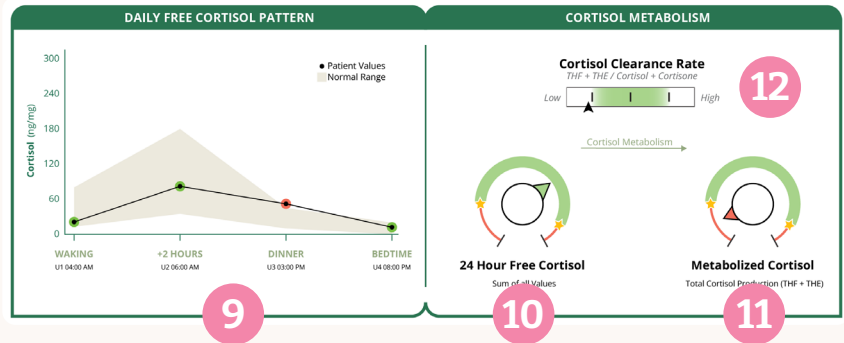
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DUTCH Dozen – Cortisol

Page 1 of the report: Cortisol section of the Male Hormone Testing Summary



9 Assess the daily free cortisol pattern

Is the daily free cortisol pattern optimal?

The **Daily Free Cortisol Pattern** plots free cortisol measured from the individual urine samples taken throughout the day.

The reference range is shown in the shaded area behind the patient's results, which are shown by the dark line.

The first value reported (WAKING) represents the overnight period. The second value (+2 HOURS) is the peak. Urine samples reflect cortisol levels in the hours before the sample was collected.

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What is the daily total of free cortisol in circulation?

The **24hr Free Cortisol** dial shows a sum of the 4 points on the **Daily Free Cortisol Pattern**.

This dial shows overall cortisol exposure throughout the day.

11 Assess the total cortisol produced by the adrenal glands (Metabolized Cortisol)

What is the total production of cortisol by the adrenals?

Cortisol and cortisone are metabolized in the body into a-THF, b-THF, and b-THE. The sum of these equals the **Metabolized Cortisol** and can give additional insight into total adrenal cortisol output for the day.

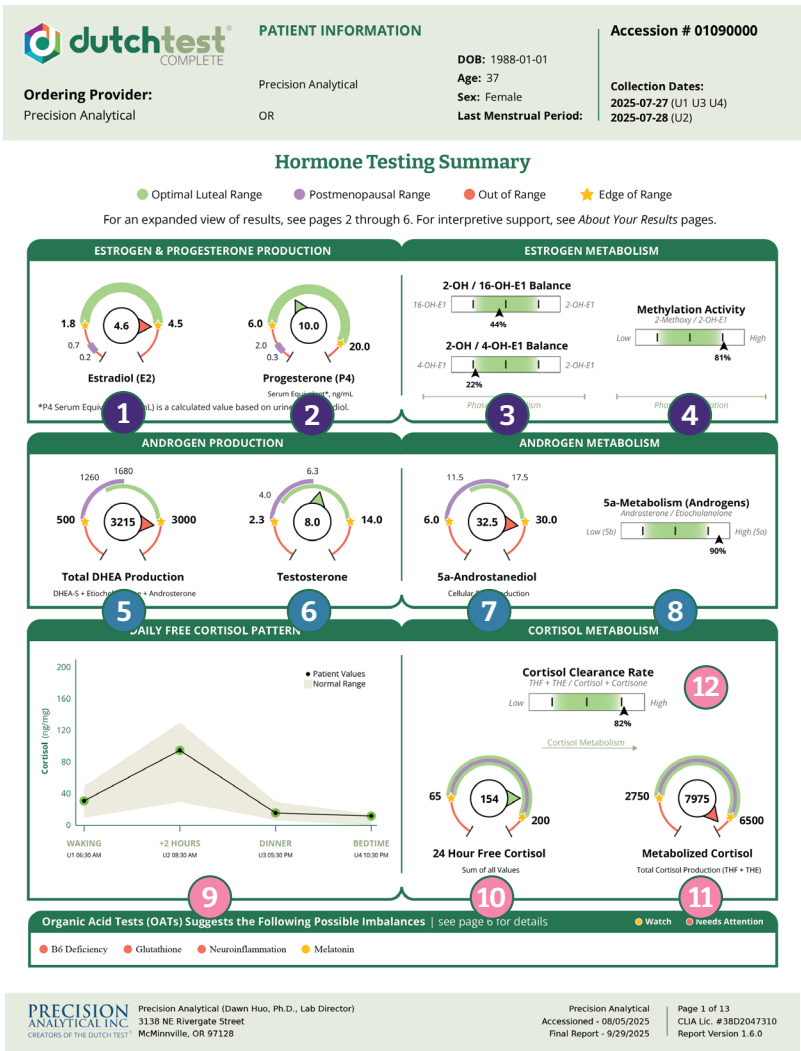
12 Assess the rate of cortisol clearance from the body

Is cortisol being cleared from the body at an appropriate rate?

The **Cortisol Clearance Rate** is the ratio of THF + THE / Cortisol + Cortisone. This can help assess the rate at which cortisol is cleared from the body. Results on the left indicate slower cortisol clearance, and the results on the right indicate faster cortisol clearance.

THE DUTCH DOZEN - FEMALE

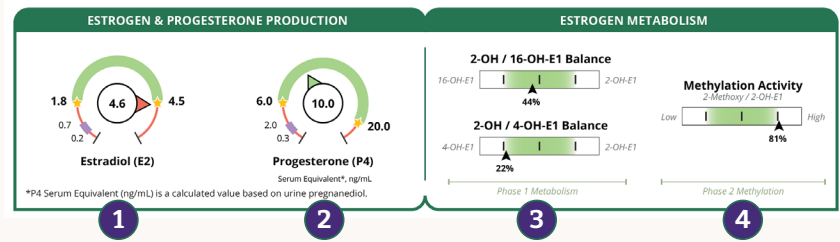
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Page 1 of the report: The Female Hormone Testing Summary Page

DUTCH Dozen Assessments #1-4 – Estrogen and Progesterone

Page 1 of the report: Estrogen and Progesterone section of the Female Hormone Testing Summary Page



1 Assess estrogen levels given the patient’s reproductive status

Are estrogen levels normal? **Estradiol (E2)** is the most potent estrogen and thus has more estrogenic activity in the body compared to E1, E3, and the phase 1 and 2 estrogen metabolites. In the example, the premenopausal patient’s Estradiol (E2) is above the luteal range at 4.6 ng/mg and could result in symptoms of estrogen excess.

See **page 9696 and 118** of the *DUTCH Interpretive Guide* to learn more about estradiol levels for premenopausal and postmenopausal females, respectively. See pages 10-15 of the *DUTCH Treatment Guide* for treatment considerations relating to estradiol.

2 Assess progesterone levels given the patient’s reproductive status

Are progesterone levels normal? Adequate **Progesterone (P4)** is important for opposing estrogen’s proliferative effects, among many other things. In the example, the premenopausal patient’s Progesterone (P4) Serum Equivalent is within the luteal rang at 10 ng/mL. Ovulation occurred but progesterone levels may not be adequate enough to oppose the high estrogen levels.

See **page 102102 and 123** of the *DUTCH Interpretive Guide* to learn more about progesterone levels for premenopausal and postmenopausal females, respectively. See pages 8-9 of the *DUTCH Treatment Guide* for treatment considerations relating to progesterone.

For cycling females in the luteal phase, the **Estradiol (E2)** and **Progesterone (P4) Serum Equivalent** dials can be easily compared to assess relative balance. In the example, there is an estrogen dominance pattern as the Estradiol (E2) dial is pointing relatively higher than the Progesterone (P4) Serum Equivalent dial.

See **page 12098 and 120** of the *DUTCH Interpretive Guide* to learn more about estrogen dominance patterns for premenopausal and postmenopausal females, respectively.

3 Assess 2-OH preference in phase 1 estrogen metabolism

Is the protective 2-OH pathway preferred? The **2-OH estrogen metabolites** are more stable than the other phase 1 estrogen metabolites (16-OH and 4-OH); therefore, a 2-OH preference is favorable.

See **page 34152** of the *DUTCH Interpretive Guide* to learn more about 2-OH and see **page 30** of the *DUTCH Treatment Guide* for treatment considerations relating to 2-OH.

2-OH/16-OH-E1 Balance Slider

16-OH is an estrogenic phase 1 metabolite that can potentially worsen estrogen excess associated symptoms and conditions. The **2-OH/16-OH-E1 Balance** slider shows 2-OH-E1 relative to 16-OH-E1. As the arrow moves to the left side of the slider, more 16-OH is present relative to 2-OH. In the example, the patient's result is within range at the 44th percentile. This result is favorable as she has high estradiol, and a 16-OH preference would further add to the estrogenic activity in the body.

See **page 22153** of the *DUTCH Interpretive Guide* to learn more about 16-OH and see **page 29** of the *DUTCH Treatment Guide* for treatment considerations relating to a 16-OH preference.

2-OH/4-OH-E1 Balance Slider

4-OH is a genotoxic metabolite that has been shown to cause DNA damage and increase risk for breast cancer. The **2-OH/4-OH-E1 Balance** slider shows 2-OH-E1 relative to 4-OH-E1. As the arrow moves to the left side of the slider, more 4-OH is present relative to 2-OH. In the example, the patient's result is within range but at the low end at the 22nd percentile, indicating a 4-OH preference (only 22% of people favor the 4-OH pathway more than they do). This result is not favorable, especially because her 4-OH-E1 and 4-OH-E2 are elevated (in subsequent pages of the report). For the majority of people, it may be less ideal when this percentage is on the low end or below range (low end is <20%-30%; below range is ≤20%).

See **page 22152** of the *DUTCH Interpretive Guide* to learn more about 4-OH and see **page 28** of the *DUTCH Treatment Guide* for treatment considerations relating to a 4-OH preference.

4 Assess methylation of 2-OH estrogens

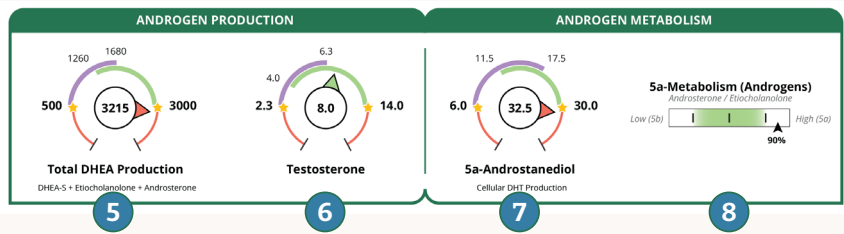
Are 2-OH estrogens being adequately methylated? The majority of 2-OH and 4-OH estrogens are methylated in phase 2 of estrogen detoxification. The **Methylation Activity** slider bar shows the ratio 2-Methoxy/2-OH-E1. 2-Methoxy-E1 is a neutral, stable phase 2 metabolite that is easily excreted from the body. The patient's result is shown by the black arrow. When results are to the left it indicates lower than average methylation activity, to

the right indicates higher than average activity. In the example, the patient's result is at the 81st percentile, indicating significantly high methylation activity (81% of people have slower methylation than they do). This result is favorable, especially with high E1, and E2 levels. For the majority of people, it may be less ideal when this percentage is on the low end or below range (low end is <20%-30%; below range is ≤20%) however, 2-OH, 4-OH, E1, and E2 values also need to be considered. For example, if 2-OH, 4-OH, E1 and E2 are above range, it may be more beneficial for the methylation activity to be >30%.

See **page 60154** of the *DUTCH Interpretive Guide* to learn more about 2-Methoxy-E1 and phase 2 methylation and see **page 30** of the *DUTCH Treatment Guide* for treatment considerations relating to methylation.

DUTCH Dozen Assessments #5-8 – Androgens

Page 1 of the report: Androgen section of the Female Hormone Testing Summary Page



5 Assess adrenal androgen levels (Total DHEA)

Are adrenal androgen levels normal? **Total DHEA Production** is the sum of three urinary DHEA metabolites (DHEA-S, etiocholanolone, and androsterone) and shows the total androgen production from the adrenal glands. In the example, the premenopausal patient's Total DHEA Production is above the premenopausal range at 3,215 ng/mg and could result in symptoms of androgen excess.

See **page 109109 and 130** of the *DUTCH Interpretive Guide* to learn more about DHEA levels for premenopausal and postmenopausal females, respectively. See **pages 22-24** of the *DUTCH Treatment Guide* for treatment considerations relating to DHEA.

6 Assess testosterone levels

Are testosterone levels normal? **Testosterone** on the DUTCH Test reflects the bioavailable conjugated testosterone excreted in urine. For most patients, this result will parallel serum free testosterone. In the example, the premenopausal patient's testosterone is within the premenopausal range at 8.0 ng/mg.

See **page 107106 and 126** of the *DUTCH Interpretive Guide* to learn more about testosterone levels for premenopausal and postmenopausal females, respectively. See pages 16-17 and 20-21 of the *DUTCH Treatment Guide* for treatment considerations relating to testosterone.

NOTE

If urinary testosterone is below range, confirm low testosterone levels in the serum before considering treatment. This is because a genetic deletion polymorphism (UGT2B17) in some patients may cause very low levels of testosterone in urine while levels may be normal (or high) in serum. See page 72 of the *DUTCH Interpretive Guide* to learn more about the UGT2B17 deletion.

7 Assess cellular production of 5a-DHT via 5a-androstenediol

Is cellular production and activity of 5a-DHT normal? 5a-DHT is the most potent androgen and has 4x more androgenic activity than testosterone. **5a-Androstenediol** is a metabolite of 5a-DHT, and research shows that 5a-androstenediol best reflects intracellular production and activity of 5a-DHT. In the example, the premenopausal patient's 5a-androstenediol is above the premenopausal range at 32.5 ng/mg and could result in symptoms of androgen excess.

See **page 132111 and 132** of the *DUTCH Interpretive Guide* to learn more about androgen metabolism for premenopausal and postmenopausal females, respectively. See page 25 of the *DUTCH Treatment Guide* for treatment considerations relating to androgen metabolism (5a/5b Preference).

8 Assess if there is a preference for the more potent alpha metabolism of the androgens

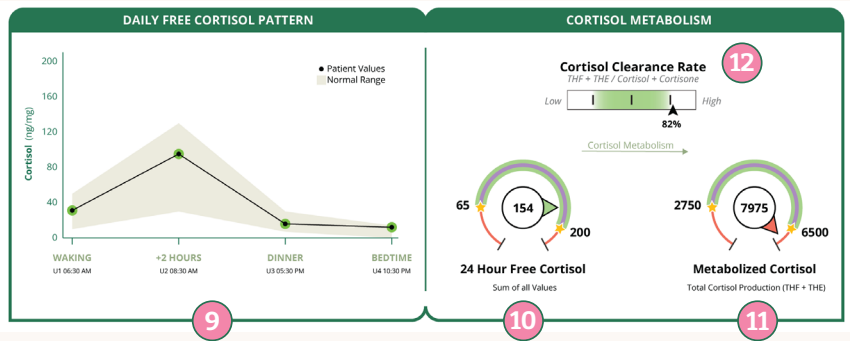
Is there a preference for 5a-reductase metabolism of the androgens? **The 5a-Metabolism (Androgens)** slider shows the Androsterone (5a) / Etiocholanolone (5b) ratio. Results on the left indicate relatively more inactive 5b metabolites. Results to the right indicate more active 5a metabolites, which typically indicates a higher potential for high androgen symptoms. In the example, the premenopausal patient's result is on the high end at the 90th percentile, indicating an alpha preference (90% of people favor the beta pathway more than she does). In this case, the alpha preference is not favorable because 5a-androstenediol is elevated and could result in symptoms of androgen excess. There is no ideal percentile for this slider as androgen levels and symptoms vary. For example, an alpha preference in the absence of androgen-excess symptoms may not need addressing.

See **page 132111 and 132** of the *DUTCH Interpretive Guide* to learn more about androgen metabolism for premenopausal and postmenopausal

females, respectively. See page 25 of the *DUTCH Treatment Guide* for treatment considerations relating to androgen metabolism (5a/5b Preference).

DUTCH Dozen Assessments #9-12 – Cortisol

Page 1 of the report: Cortisol section of the Female Hormone Testing Summary Page



9 Assess the daily free cortisol pattern

Is the daily free cortisol pattern optimal? The **Daily Free Cortisol Pattern** plots free cortisol measured from the individual urine samples taken throughout the day. The reference range is shown in the shaded area behind the patient's results, which are shown by the dark line. The first value reported (WAKING) represents the overnight period. The second value (+2 HOURS) is the peak. Urine samples reflect cortisol levels in the hours before the sample was collected. Saliva samples (on a DUTCH Plus or DUTCH CAR report – not pictured here) reflect cortisol levels at that moment in time. In the example, the patient has a diurnal pattern to their cortisol, and all points are within range. This result is favorable.

See **page 158160** of the *DUTCH Interpretive Guide* to learn more about evaluating cortisol. See pages 34, 36-37, 60-62, and 63 of the *DUTCH Treatment Guide* for general HPA axis support considerations, an herbal support overview, sleep and circadian rhythm support considerations, and stress and parasympathetic activity support considerations, respectively.

10 Assess the daily total of free cortisol in circulation (24hr Free Cortisol)

What is the daily total of free cortisol in circulation? The **24hr Free Cortisol** dial shows the sum of the 4 points on the **Daily Free Cortisol Pattern**. This dial shows overall cortisol exposure throughout the day. In the example, the 24hr Free Cortisol is within range at 154 ng/mg. This result is favorable.

See **page 162** of the *DUTCH Interpretive Guide* to learn more about total free cortisol. See pages 38 of the *DUTCH Treatment Guide* for treatment considerations relating to total free cortisol.

11 Assess the total cortisol produced by the adrenal glands (Metabolized Cortisol)

What is the total production of cortisol by the adrenals? Cortisol and cortisone are metabolized in the body into a-THF, b-THF, and b-THE. The sum of these equals the **Metabolized Cortisol** and can give insight into total adrenal cortisol production for the day. In the example, the patient's Metabolized Cortisol is above the range at 7,975 ng/mg, signifying high production of cortisol from the adrenals on the day of testing. This result is not favorable.

See **page 215167** of the *DUTCH Interpretive Guide* to learn more about metabolized cortisol.

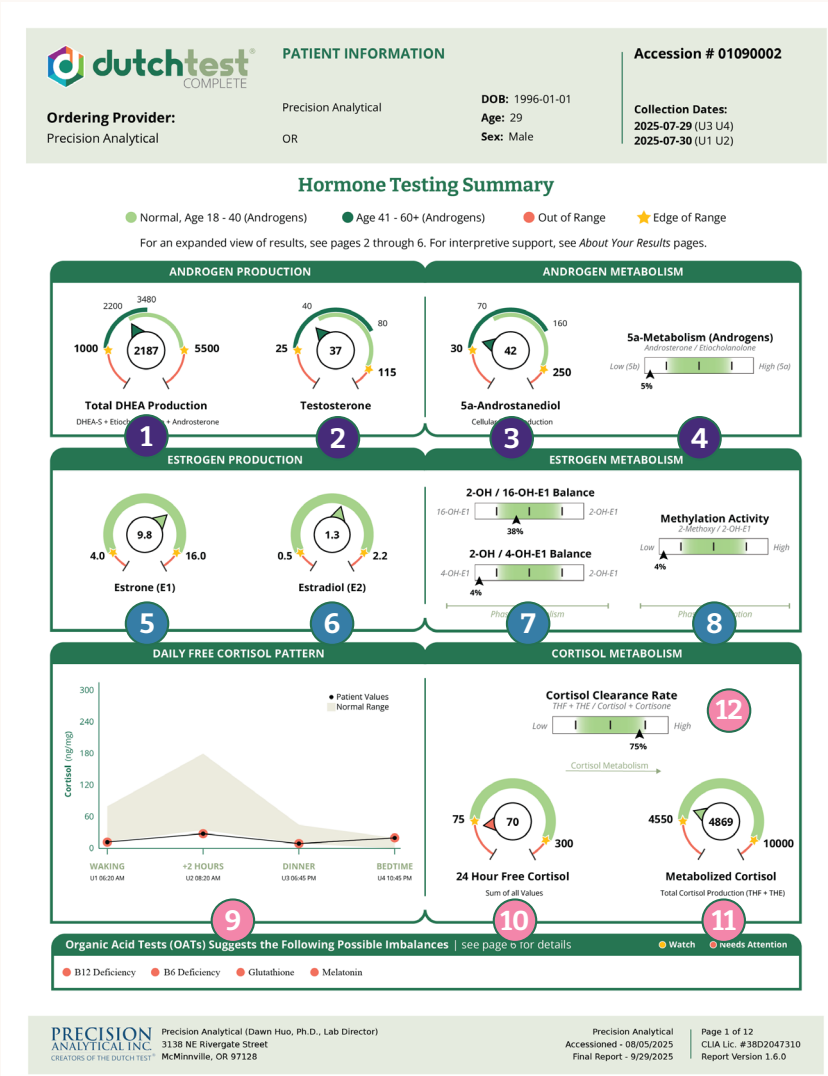
12 Assess the rate of cortisol clearance from the body

Is cortisol being cleared from the body at an appropriate rate? The **Cortisol Clearance Rate (CCR)** is the ratio of THF + THE / Cortisol + Cortisone. This can help assess the rate at which cortisol is cleared from the body. Results on the left indicate slower cortisol clearance, and on the right indicate faster cortisol clearance. A low or high CCR indicates that there is a metabolic component affecting the HPA axis. In the example, the patient's result is at the 82nd percentile, indicating a high (i.e., fast) cortisol clearance rate. This result is not favorable, as it signifies that a hypermetabolic state is affecting the patient's HPA axis. For the majority of people, it is ideal when this percentile is above 20% and below 80%.

See **page 214168** of the *DUTCH Interpretive Guide* to learn more about the CCR and see **page 39** of the *DUTCH Treatment Guide* for treatment considerations relating to the CCR.

THE DUTCH DOZEN - MALE

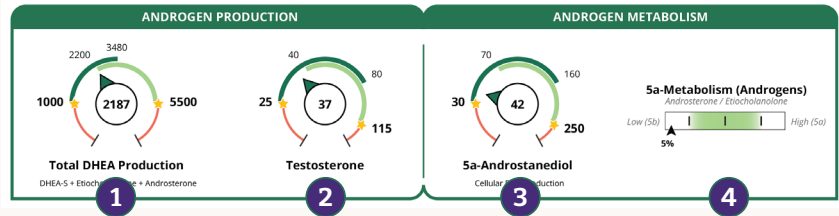
The **DUTCH Dozen** is an interpretive framework that allows clinicians to understand their patients' DUTCH Test results quickly and comprehensively. We have streamlined the review of the DUTCH Test with a set of 12 assessments that prioritize the most critical aspects of hormone function, covering estrogens, progesterone, androgens, and cortisol. The DUTCH Dozen allows clinicians to quickly evaluate key hormone markers in the **Hormone Testing Summary using page 1 of the report**, making it easier and faster to develop targeted treatment plans. For best practice, start with the DUTCH Dozen, then explore details on pages 2, 4, and 6 as needed. For deeper insights, refer to the **DUTCH Advanced Insights** section on **page 38**.



Page 1 of the report: The Male Hormone Testing Summary Page

DUTCH Dozen Assessments #1-4 – Androgens

Page 1 of the report: Androgen section of the Male Hormone Testing Summary Page



1 Assess adrenal androgen levels (Total DHEA)

Are adrenal androgen levels normal? **Total DHEA Production** is the sum of three urinary DHEA metabolites (DHEA-S, etiocholanolone, and androsterone) and shows the total androgen production from the adrenal glands. In the example, the 29-year-old patient's Total DHEA Production is below the 18-40 age range at 2,187 ng/mg and could result in symptoms of androgen deficiency.

See [page 141](#) of the *DUTCH Interpretive Guide* to learn more about DHEA levels for males. See [pages 22-24](#) of the *DUTCH Treatment Guide* for treatment considerations relating to DHEA.

2 Assess testosterone levels

Are testosterone levels normal? **Testosterone** on the DUTCH Test reflects the bioavailable conjugated testosterone excreted in urine. For most patients, this result will parallel serum free testosterone. In the example, the 29-year-old patient's testosterone is below the 18-40 age range at 37 ng/mg and could result in symptoms of androgen deficiency.

See [page 138](#) of the *DUTCH Interpretive Guide* to learn more about testosterone levels for males. See [pages 18-19 and 21](#) of the *DUTCH Treatment Guide* for treatment considerations relating to testosterone.

NOTE

If testosterone is very low on the DUTCH Test, confirm low testosterone levels in the serum before considering treatment. This is because a genetic deletion polymorphism (UGT2B17) in some patients may cause very low levels of testosterone in urine while levels may be normal (or high) in serum. See [page 72](#) of the *DUTCH Interpretive Guide* to learn more about the UGT2B17 deletion.

3 Assess cellular production of 5a-DHT via 5a-androstenediol

Is cellular production and activity of 5a-DHT normal? 5a-DHT is the most potent androgen and has 4x more androgenic activity than testosterone.

5a-Androstenediol is a metabolite of 5a-DHT and research shows that 5a-androstenediol best reflects intracellular production and activity of 5a-DHT. In the example, the 29-year-old patient's 5a-androstenediol is below the 18-40 age range at 42 ng/mg and could result in symptoms of androgen deficiency.

See [page 143](#) of the *DUTCH Interpretive Guide* to learn more about androgen metabolism for males. See [page 25](#) of the *DUTCH Treatment Guide* for treatment considerations relating to androgen metabolism (5a/5b Preference).

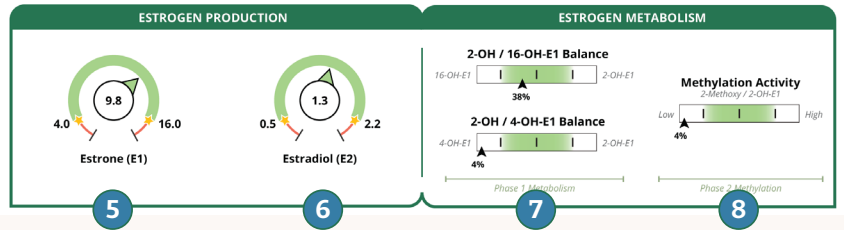
4 Assess if there is a preference for the more potent alpha metabolism of the androgens

Is there a preference for 5a-reductase metabolism of the androgens? **The 5a-Metabolism (Androgens)** slider shows the Androsterone (5a) / Etiocholanolone (5b) ratio. Results on the left indicate relatively more inactive 5b metabolites. To the right indicates more active 5a metabolites, which typically indicates a higher potential for high androgen symptoms. In the example, the patient's result is at the 5th percentile, indicating a significant beta preference (only 5% of people favor the beta pathway more than they do). In this case, the strong beta preference is not favorable because 5a-androstenediol is below range and could result in symptoms of androgen deficiency. There is no ideal percentile for this slider as androgen levels and symptoms vary. For example, an alpha preference in the absence of androgen excess symptoms may not need addressing.

See [page 132](#) and [page 143](#) of the *DUTCH Interpretive Guide* to learn more about androgen metabolism for males. See [page 25](#) of the *DUTCH Treatment Guide* for treatment considerations relating to androgen metabolism (5a/5b Preference).

DUTCH Dozen Assessments #5-8 – Estrogen

Page 1 of the report: Estrogen section of the Male Hormone Testing Summary Page



5 Assess estrogen levels

Are estrogen levels normal? **Estradiol (E2)** is the most potent estrogen and thus has more estrogenic activity in the body compared to E1, E3, and the phase 1 and 2 estrogen metabolites. In the example, the patient's estradiol is within range at 1.3 ng/mg.

See **page 215145** of the *DUTCH Interpretive Guide* to learn more about estradiol levels for males. See pages 12-15 of the *DUTCH Treatment Guide* for treatment considerations relating to estradiol.

6 Assess the conversion of testosterone to estrogen (via aromatase)

Is testosterone being over converted to estrogen? Aromatase converts testosterone to E2. Too much estrogen relative to testosterone can be problematic for males. In the example, the 29-year-old patient may be over-aromatizing his testosterone to estradiol, as his testosterone is below range for his age, but his E2 is within range.

See page 19 of the *DUTCH Treatment Guide* for treatment considerations relating to downregulating aromatase in males.

7 Assess 2-OH preference in phase 1 estrogen metabolism

Is the protective 2-OH pathway preferred? The **2-OH estrogen metabolites** are more stable than the other phase 1 metabolites (16-OH and 4-OH); therefore, a 2-OH preference is favorable.

See **page 34152** of the *DUTCH Interpretive Guide* to learn more about 2-OH and see page 30 of the *DUTCH Treatment Guide* for treatment considerations relating to 2-OH.

2-OH/16-OH-E1 Balance Slider

16-OH is an estrogenic phase 1 metabolite that can potentially worsen estrogen excess associated symptoms and conditions. The **2-OH/16-OH-E1 Balance** slider shows 2-OH-E1 relative to 16-OH-E1. As the arrow moves to the left side of the slider, more 16-OH is present relative to 2-OH. In the example, the patient's result is within range at the 38th percentile (38% of people favor the 16-OH pathway more than they do). A 16-OH preference can be influenced by genetics and medications; however, it also has negative associations (prostate cancer risk, alcohol, smoking, pesticide exposure, autoimmune disease, etc.)

See **page 22153** of the *DUTCH Interpretive Guide* to learn more about 16-OH and see page 29 of the *DUTCH Treatment Guide* for treatment considerations relating to a 16-OH preference.

2-OH/4-OH-E1 Balance Slider

4-OH is a genotoxic metabolite that has been shown to cause DNA damage and increase risk for prostate cancer. The **2-OH/4-OH-E1 Balance slider** shows 2-OH-E1 relative to 4-OH-E1. As the arrow moves to the left side of the slider, more 4-OH is present relative to 2-OH. In the example, the patient's result is low at the 4th percentile, indicating a strong 4-OH preference (only 4% of people favor the

4-OH pathway more than they do). This result is not favorable. For the majority of people, it may be less ideal when this percentage is on the low end or below range (low end is <20%-30%; below range is ≤20%).

See **page 22152** of the *DUTCH Interpretive Guide* to learn more about 4-OH and see page 28 of the *DUTCH Treatment Guide* for treatment considerations relating to a 4-OH preference.

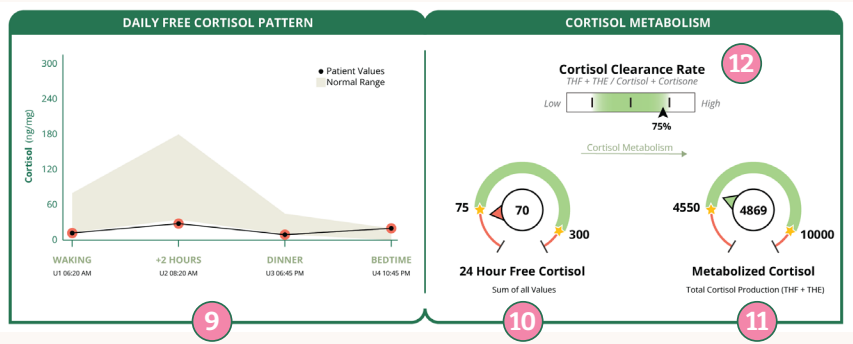
8 Assess methylation of 2-OH estrogens

Are 2-OH estrogens being adequately methylated? The majority of 2-OH and 4-OH estrogens are methylated in phase 2 of estrogen detoxification. The **Methylation Activity** slider bar shows the ratio 2-Methoxy/2-OH-E1. 2-Methoxy-E1 is a neutral, stable phase 2 metabolite that is easily excreted from the body. The patient's result is shown by the black arrow. When results are to the left it indicates lower than average methylation activity, to the right indicates higher than average activity. In the example, the patient's result is low at the 4th percentile, indicating significantly slow methylation activity (only 4% of people have slower methylation than they do). This result is not favorable. For the majority of people, it may be less ideal when this percentage is on the low end or below range (low end is <20%-30%; below range is ≤20%) however, 2-OH, 4-OH, E1, and E2 values also need to be considered. For example, if 2-OH, 4-OH, E1 and E2 are above range, it may be more beneficial for the methylation activity to be >30%.

See **page 60154** of the *DUTCH Interpretive Guide* to learn more about 2-Methoxy-E1 and phase 2 methylation and see page 30 of the *DUTCH Treatment Guide* for treatment considerations relating to methylation.

DUTCH Dozen Assessments #9-12 – Cortisol

Page 1 of the report: Cortisol section of the Male Hormone Testing Summary Page



9 Assess the daily free cortisol pattern

Is the daily free cortisol pattern optimal? The **Daily Free Cortisol Pattern** plots free cortisol measured from the individual urine samples taken

throughout the day. The reference range is shown in the shaded area behind the patient's results, which are shown by the dark line. The first value reported (WAKING) represents the overnight period. The second value (+2 HOURS) is the peak. Urine samples reflect cortisol levels in the hours before the sample was collected. Saliva samples (on a DUTCH Plus or DUTCH CAR report – not pictured here) reflect cortisol levels at that moment in time. In the example, the patient's waking, morning, and afternoon cortisol is low but their bedtime cortisol is above range. This result is not favorable.

See **page 158160** of the *DUTCH Interpretive Guide* to learn more about evaluating cortisol. See pages 34, 36-37, 60-62, and 63 of the *DUTCH Treatment Guide* for general HPA axis support considerations, an herbal support overview, sleep and circadian rhythm support considerations, and stress and parasympathetic activity support considerations, respectively.

10 Assess the daily total of free cortisol in circulation (24hr Free Cortisol)

What is the daily total of free cortisol in circulation? The **24hr Free Cortisol** dial shows a sum of the 4 points on the **Daily Free Cortisol Pattern**. This dial shows overall cortisol exposure throughout the day. In the example, the 24hr Free Cortisol is below range at 70 ng/mg, which signifies low total free cortisol in circulation on the day of the test.

See **page 162** of the *DUTCH Interpretive Guide* to learn more about total free cortisol. See pages 38 of the *DUTCH Treatment Guide* for treatment considerations relating to total free cortisol.

11 Assess the total cortisol produced by the adrenal glands (Metabolized Cortisol)

What is the total production of cortisol by the adrenals? Cortisol and cortisone are metabolized in the body into a-THF, b-THF, and b-THE. The sum of these equals the **Metabolized Cortisol** and can give insight into total adrenal cortisol production for the day. In the example, the patient's Metabolized Cortisol is within range but at the low end at 4,869 ng/mg, signifying normal-low production of cortisol from the adrenals on the day of testing. This result is not favorable.

See **page 215167** of the *DUTCH Interpretive Guide* to learn more about metabolized cortisol.

12 Assess the rate of cortisol clearance from the body

Is cortisol being cleared from the body at an appropriate rate? **The Cortisol Clearance Rate (CCR)** is the ratio of THF + THE / Cortisol + Cortisone. This can help assess the rate at which cortisol is cleared from the body. Results on the left indicate slower cortisol clearance, and on the right indicate faster

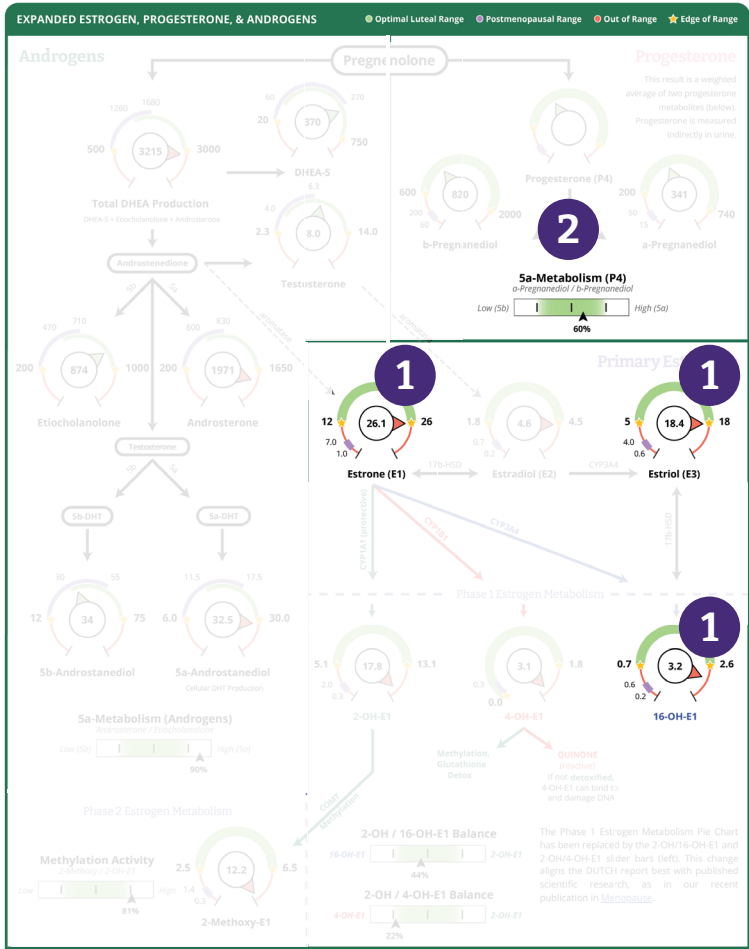
cortisol clearance. A low or high CCR indicates that there is a metabolic component affecting the HPA axis. In the example, the patient's result is within range but at the high end at the 75th percentile, indicating a *slightly* high (i.e., fast) cortisol clearance rate (75% of people have a lower CCR than they do). For the majority of people, it is ideal when this percentile is above 20% and below 80%.

See **page 214168** of the *DUTCH Interpretive Guide* to learn more about the CCR and see page 39 of the *DUTCH Treatment Guide* for treatment considerations relating to the CCR.

THE DUTCH ADVANCED INSIGHTS - FEMALE

While the **Hormone Testing Summary on page 1** of the DUTCH Test and the **DUTCH Dozen** (see **page 24**) provide a comprehensive overview for interpretation, exploring pages 2, 4, and 6 of the DUTCH Test report using the **DUTCH Advanced Insights** may offer additional clarity and a deeper understanding of the results.

DUTCH Advanced Insights Assessments #1-4 – Estrogen and Progesterone



Page 2 of the report: Sex Hormones & Metabolites

1 Assess whether E1, E3, or 16-OH-E1 add more insight into overall estrogenic activity

Do E1, E3, or 16-OH-E1 add more insight into overall estrogenic activity? **E1, E3, and 16-OH-E1** all have estrogenic activity, though less than estradiol (E2). In the example, the premenopausal patient's E1, 16-OH-E1, and E3 are all above range at 26.1, 3.2, and 18.4 ng/mg, respectively, which confirms high estrogen activity.

See **page 96** and **page 118** of the *DUTCH Interpretive Guide* to learn more about estradiol levels for premenopausal and postmenopausal females, respectively, and see **page 153** to learn more about 16-OH. See pages 10-15 and 29 of the *DUTCH Treatment Guide* for treatment considerations relating to estrogen and 16-OH, respectively.

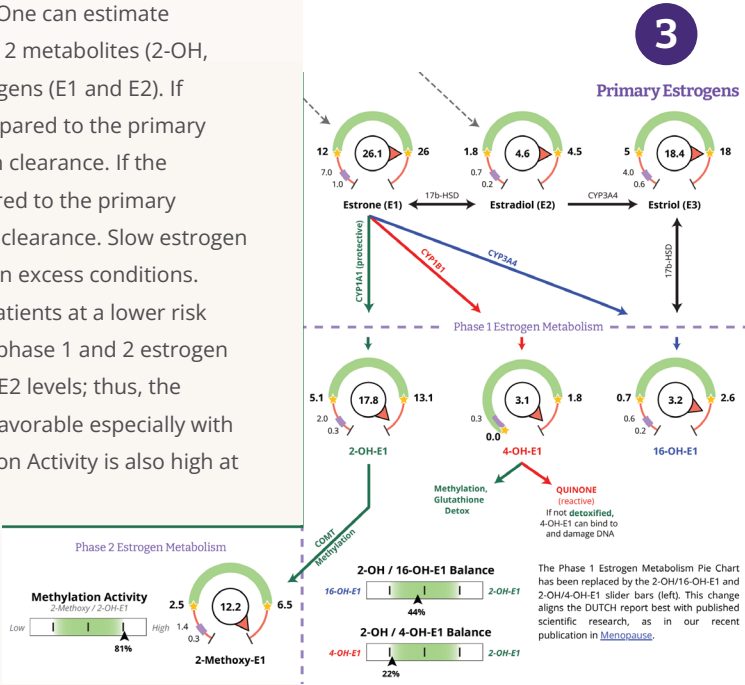
2 Assess if there is a preference for alpha metabolism of progesterone

Does progesterone favor alpha metabolism? **The 5a-Metabolism (P4)** slider is the most effective tool for assessing whether progesterone is primarily metabolized through the alpha pathway (into a-pregnanediol) or the beta pathway (into b-pregnanediol). Understanding this preference can be valuable, as alpha progesterone metabolites, such as allopregnanolone and a-pregnanediol, modulate GABA receptors, potentially supporting mood and sleep. While allopregnanolone has significantly stronger sedating effects than a-pregnanediol, internal DUTCH data shows a strong correlation between their levels. In the example, the premenopausal patient's result is within range at the 60th percentile. Note that an alpha (or beta) preference may not always be clinically significant, especially if progesterone levels are low. This concept may be most relevant for patients using oral progesterone.

See **page 105** and **page 126** of the *DUTCH Interpretive Guide* to learn more about progesterone metabolism for premenopausal and postmenopausal females, respectively. See pages 8-9 of the *DUTCH Treatment Guide* for treatment considerations relating to progesterone.

3 Assess estrogen clearance through phase 1 and 2

How is estrogen clearance through phase 1 and 2? One can estimate **estrogen clearance** by comparing the phase 1 and 2 metabolites (2-OH, 4-OH, 16-OH, 2-Methoxy-E1) with the primary estrogens (E1 and E2). If the phase 1 and 2 metabolites are much lower compared to the primary estrogens, then the patient may have slow estrogen clearance. If the phase 1 and 2 metabolites are much higher compared to the primary estrogens, then the patient may have fast estrogen clearance. Slow estrogen clearance may put patients at higher risk of estrogen excess conditions. On the contrary, fast estrogen clearance may put patients at a lower risk of estrogen excess conditions. In this example, the phase 1 and 2 estrogen metabolite levels look higher relative to the E1 and E2 levels; thus, the estrogen clearance may be relatively fast, which is favorable especially with high E1 and E2 levels. Note, their phase 2 Methylation Activity is also high at the 81st percentile which is favorable.



TEST		RESULT	UNITS	NORMAL RANGE
Nutritional Organic Acids (Urine)				
Vitamin B12 Marker - May be deficient if high Methylmalonate (MMA)	Within range	1.2	ug/mg	0 - 2.5
Vitamin B6 Markers - May be deficient if high Xanthurenate	Above range	2.70	ug/mg	0.12 - 1.2
Kynurenate	Above range	5.3	ug/mg	0.8 - 4.5
Glutathione Marker - May be deficient if high Pyroglutamate				
	Above range	72.0	ug/mg	28 - 58
Gut Marker - Potential gut putrefaction or dysbiosis if high Indican	Within range	50.4	ug/mg	0 - 100
Additional Markers (Urine)				
Oxidative Stress / DNA Damage				
8-Hydroxy-2-deoxyguanosine (8-OHdG)	Within range	2.1	ng/mg	0 - 5.2

Page 6 of the report: Organic Acid Tests (OATs)

Assess whether any of the estrogen-related organic acids are out of range

Are any of the estrogen-related organic acids (MMA, Xanthurenate, Kynurenate, Pyroglutamate, Indican, 8-OHdG) above range?

Methylmalonate (MMA) - High MMA may indicate B12 deficiency. B12 supports optimal methylation.

Xanthurenate and Kynurenate – High Xanthurenate and/ or Kynurenate may indicate B6 deficiency. B6 supports optimal methylation.

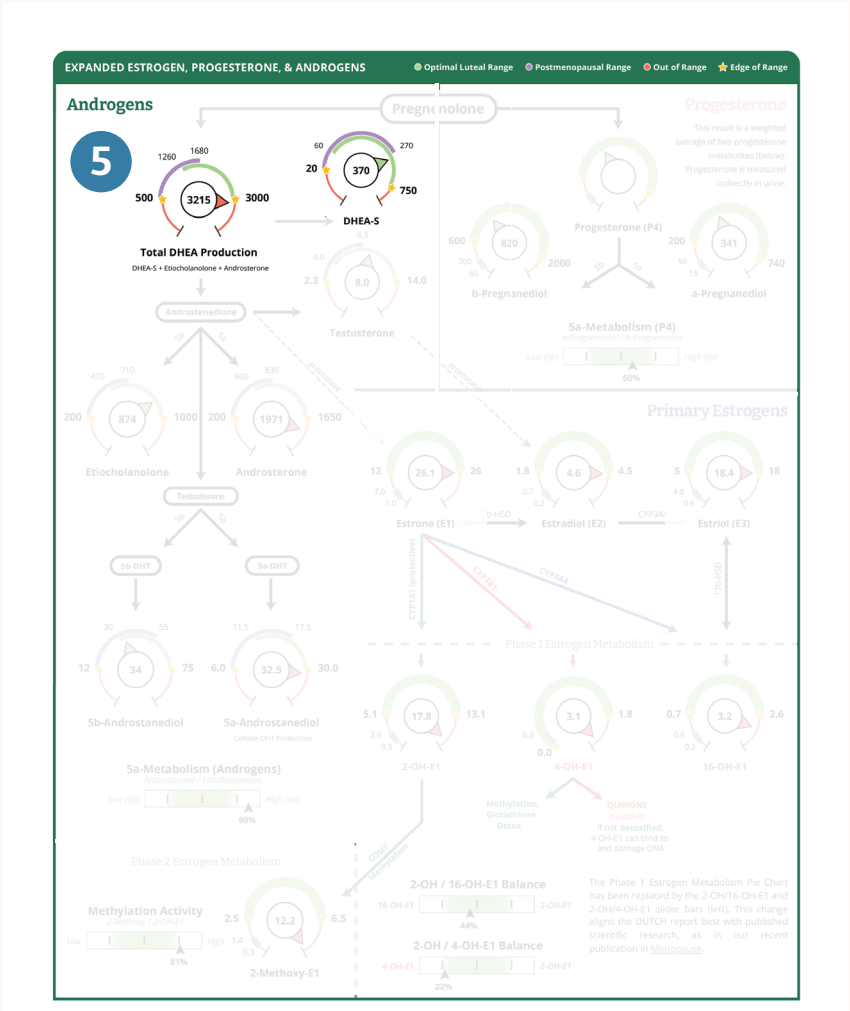
Pyroglutamate – High Pyroglutamate may suggest low glutathione, a key antioxidant that helps protect cells from damage. Low glutathione status is especially significant when the 2-OH/4-OH-E1 Balance slider result is below the optimal range.

Indican – High Indican is a marker of dysbiosis (bacterial imbalance) and intestinal permeability. If paired with high E2 or suboptimal estrogen metabolism, this may contribute to poor estrogen detoxification through the GI tract.

8-Hydroxy-2-deoxyguanosine (8-OHdG) – High 8-OHdG may indicate a higher oxidative stress burden, especially when paired with a high 4-OH-E1 or a low 2-OH/4-OH-E1 ratio.

In the example, the patient’s Xanthurenate, Kynurenate, and Pyroglutamate are all high. Glutathione deficiency is especially significant, as the 2-OH/4-OH-E1 Balance slider result is on the low end and 4-OH-E1 and 4-OH-E2 (on page 3 of the report) are above range.

See **page 176** of the *DUTCH Interpretive Guide* to learn more about the *Organic Acid Tests (OATs)* and see **pages 42-47** of the *DUTCH Treatment Guide* for treatment considerations relating to the *OATs*.

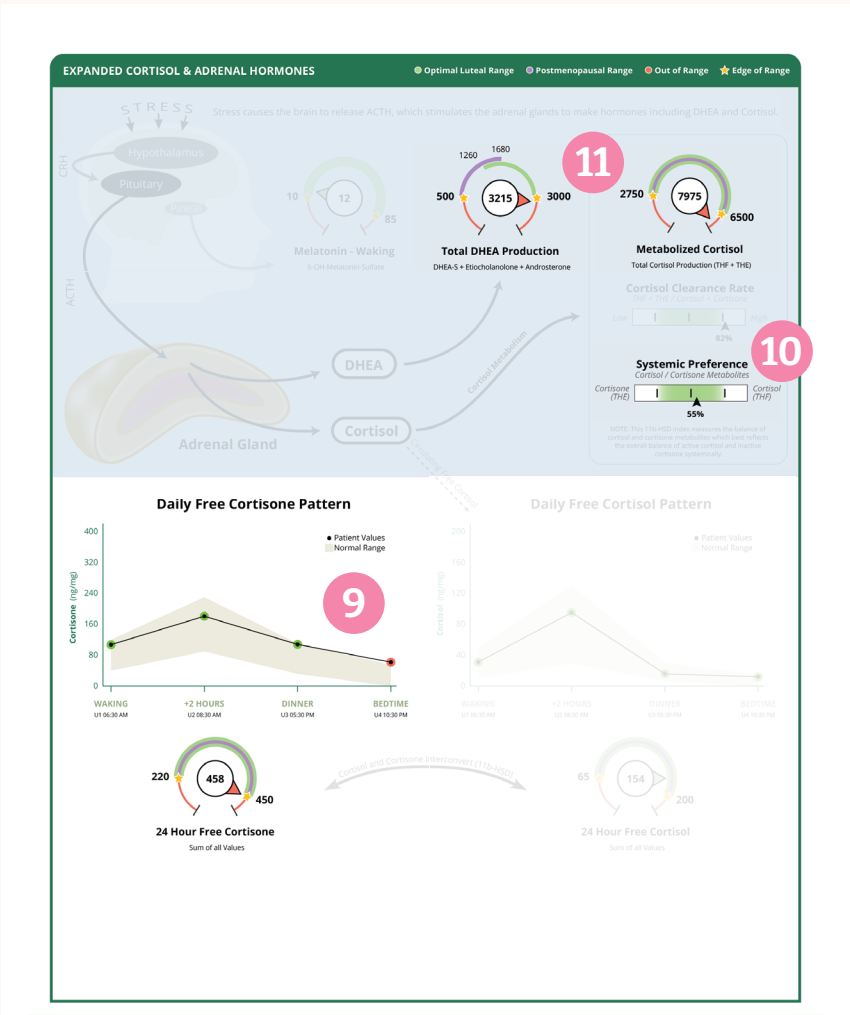


Page 2 of the report: Sex Hormones & Metabolites

Assess if the DHEA-S is relatively lower than the Total DHEA Production

Is **DHEA-S** relatively lower than the **Total DHEA Production** (when each is evaluated against its respective reference range)? When DHEA-S is relatively lower, it may indicate that DHEA is being converted downstream into metabolites like etiocholanolone and androsterone, rather than being sulfated into DHEA-S. Research suggests that low DHEA-S levels in the blood are linked to inflammation, and it is known that inflammation can impair the sulfation process. To assess this, compare the DHEA-S level to the Total DHEA Production. In the example, the patient’s DHEA-S level is lower when compared to their Total DHEA Production when each is evaluated against its respective reference range. This may signify inflammation and/or sulfation issues.

See **page 190** of the *DUTCH Interpretive Guide* to learn more about suboptimal sulfation patterns seen on the *DUTCH Test*. See **page 29** of the *DUTCH Treatment Guide* for treatment considerations relating to suboptimal sulfation.



Page 4 of the report: Adrenal Hormones & Metabolites

9 Assess if cortisone (inactive) adds more insight to the free cortisol assessment

Does free cortisone add more insight to the free cortisol assessment? **Free cortisone (inactive)** in the urine and saliva reflects the free cortisol (active) that entered the kidneys or the saliva glands and was converted to cortisone locally before excretion. This makes free cortisone a secondary marker for free cortisol in circulation. In the example, the patient's Daily Free Cortisone Pattern (and 24hr Free Cortisone) are higher than the Daily Free Cortisol Pattern (and 24hr Free Cortisol); therefore, free cortisol in circulation may be higher than the Daily Free Cortisol Pattern (and 24hr Free Cortisol) imply.

See **page 164** of the *DUTCH Interpretive Guide* to learn more about the *Cortisone Shadow*. See **pages 34, 36-37, 60-62, 63** of the *DUTCH Treatment Guide* for general HPA axis support considerations, an herbal support overview, sleep and circadian rhythm support considerations, and stress and parasympathetic activity support considerations, respectively.

10 Assess if there is a whole-body preference for (inactive) cortisone or (active) cortisol

Is there a systemic preference for (inactive) cortisone or (active) cortisol? **The Systemic Preference** slider on the DUTCH Test is the best way to assess systemic preference. A Cortisol (THF) preference may occur when the body wants more cortisol in the active form (acute stressors) whereas a Cortisone (THE) preference may occur when the body wants less cortisol in the active form (chronic stressors). In the example, Cortisol (THF) and Cortisone (THE) are well-balanced as the Systemic Preference dial is at the 55th percentile.

See **page 170** of the *DUTCH Interpretive Guide* to learn more about *THE* vs *THF* systemic preference. See **pages 38** of the *DUTCH Treatment Guide* for treatment considerations relating to systemic preference.

Assess for anabolic-catabolic balance

11 Is there an **anabolic** or **catabolic** picture present? Compare the Total DHEA Production with the Metabolized Cortisol.

Cortisol > DHEA = Catabolic State

DHEA > Cortisol = Anabolic State

If there is relatively more cortisol than DHEA, the patient may be in a catabolic state. On the other hand, if there is relatively more DHEA than cortisol, the patient may be in an anabolic state. Excessive catabolism can result in the breakdown of body tissues, weakness, impaired tissue repair, and altered immune function. An anabolic state can promote gains in muscle mass from exercise and promote tissue repair. In the example, although the patient's Metabolized Cortisol is above range, their Total DHEA Production is also above range; thus, there is neither a strong anabolic nor catabolic picture present.

Organic Acid Tests (OATs)

TEST		RESULT	UNITS	NORMAL RANGE
Nutritional Organic Acids (Urine)				
Vitamin B12 Marker - May be deficient if high				
Methylmalonate (MMA)	Within range	1.2	ug/mg	0 - 2.5
Vitamin B6 Markers - May be deficient if high				
Xanthurenate	Above range	2.70	ug/mg	0.12 - 1.2
Kynurenate	Above range	5.3	ug/mg	0.8 - 4.5
Neuro-Related Markers (Urine)				
Norepinephrine/Epinephrine Metabolite				
Vanilmandelate (VMA)	Within range	3.7	ug/mg	2.2 - 5.5
Additional Markers (Urine)				
Melatonin - Waking				
6-OH-Melatonin-Sulfate	Low end of range	12.0	ng/mg	10 - 85

Page 6 of the report: Organic Acid Tests (OATs)

12 Assess whether any of the cortisol-related organic acids are out of range

Are any of the cortisol-related organic acids (MMA, Xanthurenate, Kynurenate, Melatonin, VMA) out of range?

Methylmalonate (MMA) - High MMA may indicate B12 deficiency. High cortisol has been associated with reduced B12 in some studies.

Xanthurenate and Kynurenate – High cortisol can impair tryptophan metabolism, causing Kynurenate and Xanthurenate to increase, without requiring B6 deficiency.

Melatonin – Cortisol that is elevated at the end of the day can suppress melatonin production. High waking cortisol is often associated with higher overnight levels of cortisol which may also be suppressive to melatonin. Low melatonin accompanied with low morning cortisol has also been linked to poor sleep.

VMA – During stress, epinephrine is released roughly 10 minutes before cortisol; Therefore, high VMA may be associated with high cortisol.

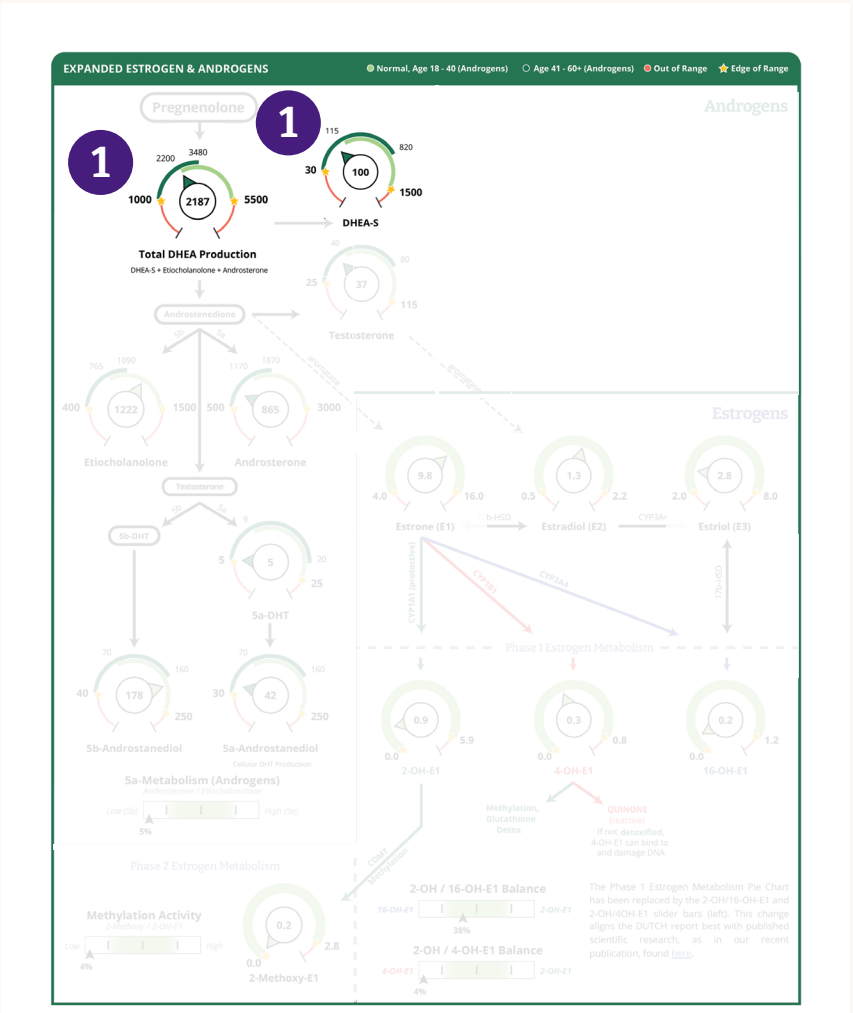
In the example, the patient's Xanthurenate and Kynurenate are both high and Melatonin is low. High bedtime cortisol may be suppressing melatonin production.

See **page 176** of the *DUTCH Interpretive Guide* to learn more about the Organic Acid Tests (OATs) and see **pages 42-47** of the *DUTCH Treatment Guide* for treatment considerations relating to the OATs.

THE DUTCH ADVANCED INSIGHTS - MALE

While the **Hormone Testing Summary** on **page 1** of the DUTCH Test and the **DUTCH Dozen** (see **page 24**) provide a comprehensive overview for interpretation, exploring **pages 2, 4, and 6** of the DUTCH Test report using the **DUTCH Advanced Insights** may offer additional clarity and a deeper understanding of the results.

DUTCH Advanced Insights Assessments #1-4 – Androgens



Page 2 of the report: Sex Hormones & Metabolites

1 Assess if the DHEA-S is relatively lower than the Total DHEA Production

Is **DHEA-S** relatively lower than the **Total DHEA Production** (when each is evaluated against its respective reference range)? When DHEA-S is relatively lower, it may indicate that DHEA is being converted downstream into metabolites, like etiocholanolone and androsterone, rather than being sulfated into DHEA-S. Research suggests that low DHEA-S levels in the blood are linked to inflammation, and it is known that inflammation can impair the sulfation process. To assess this, compare the DHEA-S level to the Total DHEA Production. In the example, the patient's DHEA-S level is relatively

lower than the Total DHEA Production when each is evaluated against its respective reference range. This may signify inflammation and/or sulfation issues.

See **page 190** of the *DUTCH Interpretive Guide* to learn more about suboptimal sulfation patterns seen on the *DUTCH Test*. See **page 29** of the *DUTCH Treatment Guide* for treatment considerations relating to suboptimal sulfation.

[illegible]

Page 3 of the report: Sex Hormones & Metabolites Data

2 Assess the androgen pattern to determine if urine testosterone may not accurately reflect systemic levels (UGT2B17 deletion)

Does the androgen pattern suggest that urine testosterone may not accurately reflect systemic levels? Some people are born with a **genetic deletion polymorphism (UGT2B17)** that causes their testosterone, 5a-DHT, and 5b-androstanediol to be falsely low in the urine but does not affect their 5a-androstanediol or epi-testosterone. For this reason, low and very low urinary testosterone levels should be confirmed with serum testing before treatment. In the example, the androgen pattern does not suggest that urine testosterone may not accurately reflect systemic levels because the testosterone, 5a-androstanediol, and epi-testosterone are all on the low side.

See **page 72** of the *DUTCH Interpretive Guide* to learn more about the UGT deletion.

3 While 5 α -androstane-3 β -diol best represents cellular 5 α -DHT production, assess if 5 α -DHT offers additional insight into androgenic activity

Does 5a-DHT offer additional insight into androgenic activity? **5a-DHT** is the most potent androgen and has 4x more androgenic activity than testosterone. 5a-Androstanediol is a metabolite of 5a-DHT, and research shows that 5a-androstanediol best reflects intracellular production and

activity of 5a-DHT, but it can also be insightful to look at the actual 5a-DHT result. In the example, the patient's 5a-DHT is low end of range at 5.2 ng/mg and confirms low androgen activity.

See **page 132143** of the DUTCH Interpretive Guide to learn more about androgen metabolism males. See page 25 of the DUTCH Treatment Guide for treatment considerations relating to androgen metabolism (5a/5b Preference).

TEST		RESULT	UNITS	NORMAL RANGE
Nutritional Organic Acids (Urine)				
Biotin Marker - May be deficient if high				
b-Hydroxyisovalerate	Within range	8.1	ug/mg	0 - 18
Glutathione Marker - May be deficient if high				
Pyroglutamate	Above range	97.0	ug/mg	38 - 83
Neuro-Related Markers (Urine)				
Additional Markers (Urine)				
Melatonin - Waking				
6-OH-Melatonin-Sulfate	Below range	8.0	ng/mg	10 - 85
Oxidative Stress / DNA Damage				
8-Hydroxy-2-deoxyguanosine (8-OHdG)	Within range	2.3	ng/mg	0 - 8.8

Page 6 of the report: Organic Acid Tests (OATs)

4 Assess whether any of the androgen-related organic acids are out of range

Are any of the androgen-related organic acids (Pyroglutamate, Melatonin, 8-OHdG, b-Hydroxyisovalerate) above range?

Pyroglutamate – Low glutathione status may be linked to high oxidative stress, a state which can impair testicular function and lower testosterone, though the degree to which this may happen varies.

Melatonin – Low melatonin has been associated with increased oxidative stress and poor sleep. Poor sleep and oxidative stress are associated with impaired testicular function and testosterone levels.

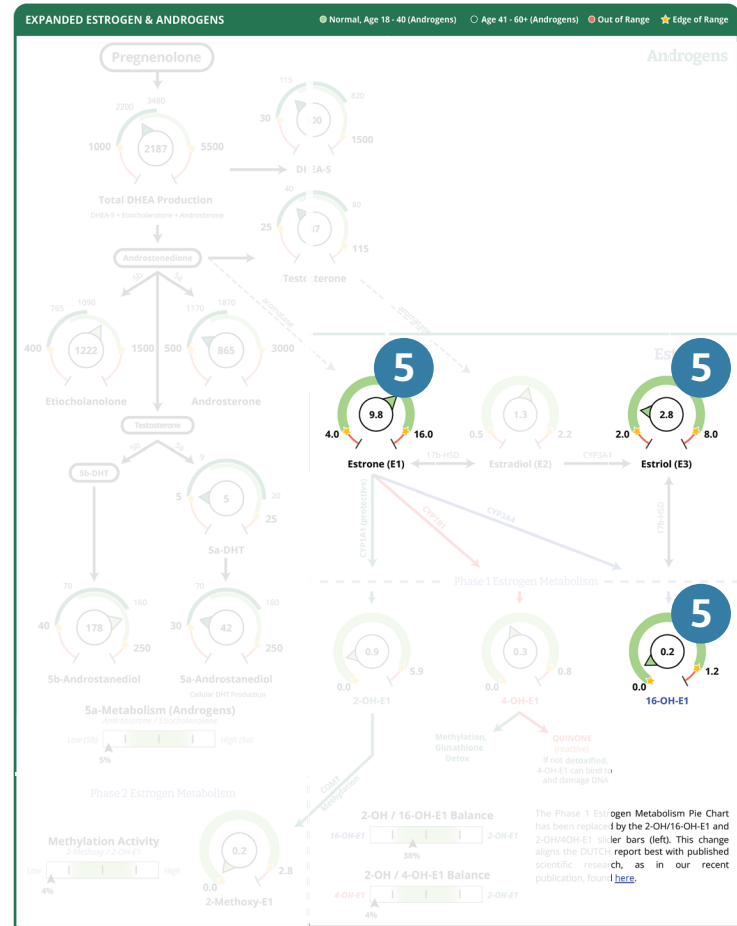
8-Hydroxy-2-deoxyguanosine (8-OHdG) – High 8-OHdG is indicative of high oxidative stress. This can impair testicular function and lower testosterone, though the degree to which this may happen varies.

b-Hydroxyisovalerate – Biotin deficiency can contribute to hair loss. If one of the patient's high androgen complaints includes hair loss, check for elevated b-hydroxyisovalerate.

In the example, the pyroglutamate is high, and melatonin is low, indicating that high oxidative stress (and potentially poor sleep) may be contributing to the patient's low testosterone levels.

See **page 176** of the *DUTCH Interpretive Guide* to learn more about the Organic Acid Tests (OATs) and see **pages 42-47** of the *DUTCH Treatment Guide* for treatment considerations relating to the OATs.

DUTCH Advanced Insights Assessments #5-8 – Estrogen and Progesterone



Page 2 of the report: Sex Hormones & Metabolites

5 Assess whether E1, E3, or 16-OH-E1 add more insight into overall estrogenic activity

Do E1, E3, or 16-OH-E1 add more insight into overall estrogenic activity? **E1, E3, and 16-OH-E1** all have estrogenic activity, though less than estradiol (E2). In the example, the patient's E1 confirms normal E2 levels (E1 is within range at 9.8 ng/mg). E3 and 16-OH-E1 are within range but at the low end (at 2.8 and 0.2 ng/mg, respectively) and therefore do not significantly add to the estrogen activity in the body.

See **page 145** of the *DUTCH Interpretive Guide* to learn more about estradiol levels for males and see **page 22153** to learn more about 16-OH. See pages 12-15 and 29 of the *DUTCH Treatment Guide* for treatment considerations relating to estrogen and 16-OH, respectively.

6

Sex Hormones & Metabolites

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Page 3 of the report: Sex Hormones & Metabolites Data

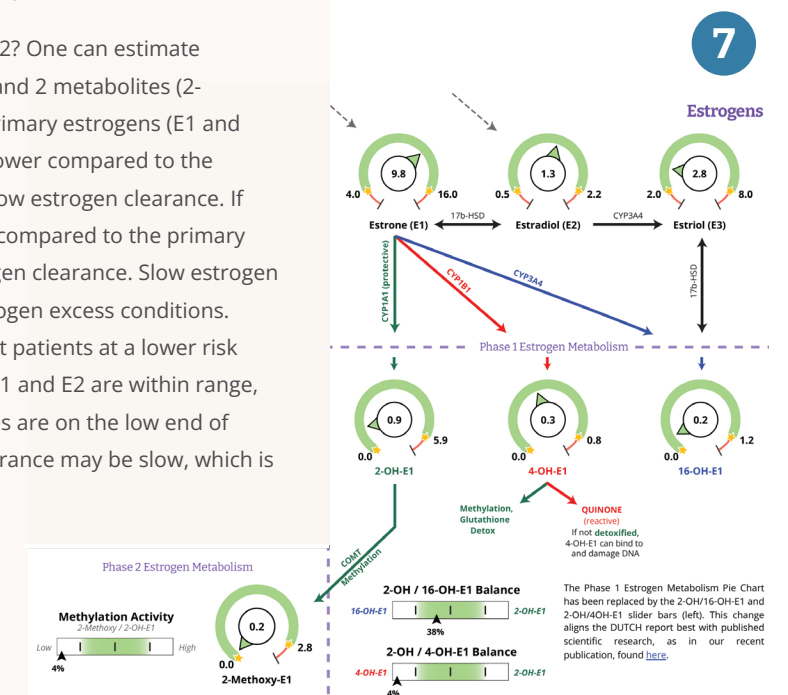
6 Assess progesterone levels

Are progesterone levels normal? **Progesterone** influences sperm and testosterone production and may be neuroprotective. In the example, the patient's b-pregnanediol is within range, though on the high end, and a-pregnanediol is within range. Overall, the progesterone is within range.

See **page 147** of the *DUTCH Interpretive Guide* to learn more about progesterone levels in males. See **page 9** of the *DUTCH Treatment Guide* for treatment considerations relating to progesterone.

7 Assess estrogen clearance through phase 1 and 2

How is estrogen clearance through phase 1 and 2? One can estimate **estrogen clearance** by comparing the phase 1 and 2 metabolites (2-OH, 4-OH, 16-OH, and 2-Methoxy-E1) with the primary estrogens (E1 and E2). If the phase 1 and 2 metabolites are much lower compared to the primary estrogens, then the patient may have slow estrogen clearance. If the phase 1 and 2 metabolites are much higher compared to the primary estrogens, then the patient may have fast estrogen clearance. Slow estrogen clearance may put patients at higher risk of estrogen excess conditions. On the contrary, fast estrogen clearance may put patients at a lower risk of estrogen excess conditions. In this example, E1 and E2 are within range, however, the phase 1 and 2 estrogen metabolites are on the low end of range (except 4-OH-E1); therefore, estrogen clearance may be slow, which is not favorable.



Organic Acid Tests (OATs)

TEST		RESULT	UNITS	NORMAL RANGE
Nutritional Organic Acids (Urine)				
Vitamin B12 Marker - May be deficient if high				
Methylmalonate (MMA)	Above range	4.9	ug/mg	0 - 3.5
Vitamin B6 Markers - May be deficient if high				
Xanthurenate	Above range	2.20	ug/mg	0.2 - 1.9
Kynurenate	Above range	7.8	ug/mg	1 - 6.6
Glutathione Marker - May be deficient if high				
Pyroglutamate	Above range	97.0	ug/mg	38 - 83
Gut Marker - Potential gut putrefaction or dysbiosis if high				
Indican	Within range	67.0	ug/mg	0 - 131
Additional Markers (Urine)				
Oxidative Stress / DNA Damage				
8-Hydroxy-2-deoxyguanosine (8-OHdG)	Within range	2.3	ng/mg	0 - 8.8

Page 6 of the report: Organic Acid Tests (OATs)

Assess whether any of the estrogen-related organic acids are out of range

Are any of the estrogen-related organic acids (MMA, Xanthurenate, Kynurenate, Pyroglutamate, Indican, 8-OHdG) above range?

Methylmalonate (MMA) - High MMA may indicate B12 deficiency. B12 supports optimal methylation.

Xanthurenate and Kynurenate – High Xanthurenate and/ or Kynurenate may indicate B6 deficiency. B6 supports optimal methylation.

Pyroglutamate – High Pyroglutamate may suggest low glutathione, a key antioxidant that helps protect cells from damage. Low glutathione status is especially significant when the 2-OH/4-OH-E1 is below the optimal range.

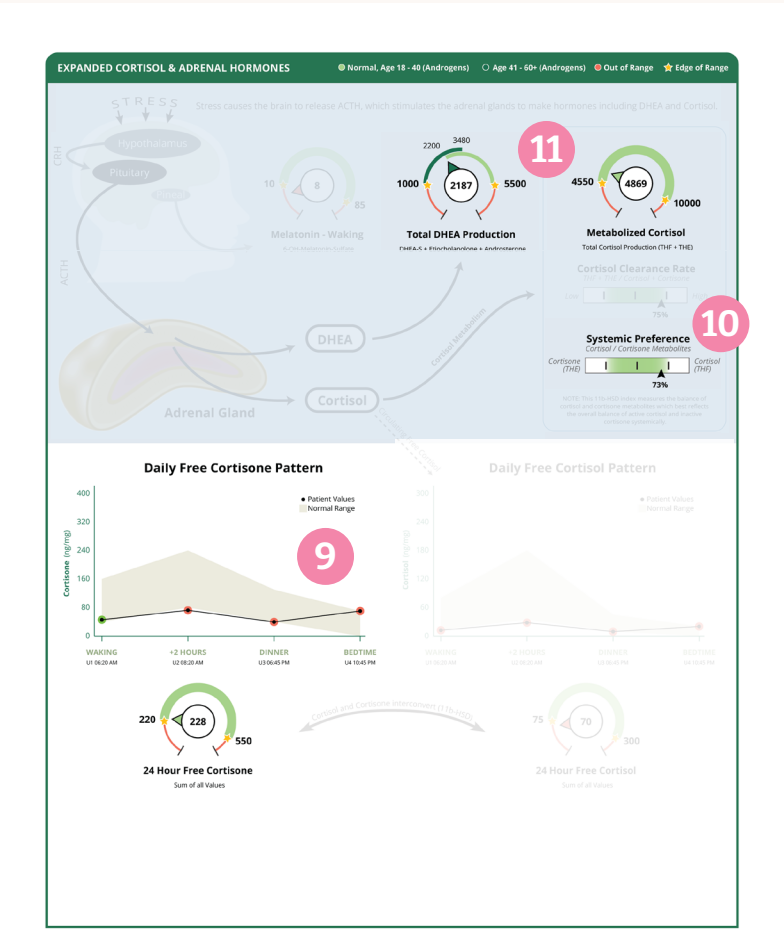
Indican – High Indican is a marker of dysbiosis (bacterial imbalance) and intestinal permeability. If paired with high E2 or suboptimal estrogen metabolism, this may contribute to poor estrogen detoxification through the GI tract.

8-Hydroxy-2-deoxyguanosine (8-OHdG) – High 8-OHdG may indicate a higher oxidative stress burden, especially when paired with a high 4-OH-E1 or a low 2-OH/4-OH-E1 ratio.

In the example, the patient's MMA, Xanthurenate, Kynurenate, and Pyroglutamate are high. B12 and B6 deficiency may be contributing to low methylation activity. Glutathione deficiency is especially significant, as the 2-OH/4-OH-E1 Balance slider result is on the low end at 4%.

See **page 176** of the *DUTCH Interpretive Guide* to learn more about the *Organic Acid Tests (OATs)* and see pages 42-47 of the *DUTCH Treatment Guide* for treatment considerations relating to the OATs.

DUTCH Advanced Insights Assessments #9-12 – Cortisol



Page 4 of the report: Adrenal Hormones & Metabolites

Assess if cortisone (inactive) adds more insight to the free cortisol assessment

Does free cortisone add more insight to the free cortisol assessment? **Free cortisone (inactive)** in the urine and saliva reflects the free cortisol (active) that entered the kidneys or the saliva glands and was converted to cortisone locally before excretion. This makes free cortisone a secondary marker for free cortisol in circulation. In the example, the patient's Daily Free Cortisone Pattern (and 24hr Free Cortisone) are similar to (and thus confirm) the Daily Free Cortisol Pattern (and 24hr Free Cortisol).

See **page 164** of the *DUTCH Interpretive Guide* to learn more about the *Cortisone Shadow*. See pages 34, 36-37, 60-62, 63 of the *DUTCH Treatment Guide* for general HPA axis support considerations, an herbal support overview, sleep and circadian rhythm support considerations, and stress and parasympathetic activity support considerations, respectively.

10

Assess if there is a whole-body preference for (inactive) cortisone or (active) cortisol

Is there a systemic preference for (inactive) cortisone or (active) cortisol? The **Systemic Preference** slider on the DUTCH Test is the best way to assess systemic preference. A Cortisol (THF) preference may occur when the body wants more cortisol in the active form (acute stressors) whereas a Cortisone (THE) preference may occur when the body wants less cortisol in the active form (chronic stressors). In the example, Cortisol (THF) and Cortisone (THE) are well-balanced, though there is a very slight preference for Cortisol (THF) as the Systemic Preference slider is at 73%.

See **page 170** of the *DUTCH Interpretive Guide* to learn more about THE vs THF systemic preference. See *pages 38* of the *DUTCH Treatment Guide* for treatment considerations relating to systemic preference.

11

Assess for anabolic-catabolic balance

Is there an **anabolic** or **catabolic** picture present? Compare the Total DHEA Production with the Metabolized Cortisol.

Cortisol > DHEA = Catabolic State

DHEA > Cortisol = Anabolic State

If there is relatively more cortisol than DHEA, the patient may be in a catabolic state. On the other hand, if there is relatively more DHEA than cortisol, the patient may be in an anabolic state. Excessive catabolism can result in the breakdown of body tissues, weakness, impaired tissue repair, and altered immune function. An anabolic state can promote gains in muscle mass from exercise and promote tissue repair. In the example, although the patient’s Total DHEA Production is slightly below range for their age, their Metabolized Cortisol is also at the low end of range; thus, there is neither a strong anabolic nor catabolic picture present.

Organic Acid Tests (OATs)

TEST		RESULT	UNITS	NORMAL RANGE
Nutritional Organic Acids (Urine)				
Vitamin B12 Marker - May be deficient if high Methylmalonate (MMA)		Above range	4.9	ug/mg 0 - 3.5
Vitamin B6 Markers - May be deficient if high Xanthurenate		Above range	2.20	ug/mg 0.2 - 1.9
Kynurenate		Above range	7.8	ug/mg 1 - 6.6
Norepinephrine/Epinephrine Metabolite Vanilmandelate (VMA)		Within range	5.1	ug/mg 2.5 - 7.5
Additional Markers (Urine)				
Melatonin - Waking 6-OH-Melatonin-Sulfate		Below range	8.0	ng/mg 10 - 85

Page 6 of the report: Organic Acid Tests (OATs)

12

Assess whether any of the cortisol-related organic acids are out of range

Are any of the cortisol-related organic acids (MMA, Xanthurenate, Kynurenate, Melatonin, VMA) out of range?

Methylmalonate (MMA) - High MMA may indicate B12 deficiency. High cortisol has been associated with reduced B12 in some studies.

Xanthurenate and Kynurenate – High cortisol can impair tryptophan metabolism, causing Kynurenate and Xanthurenate to increase, without requiring B6 deficiency.

Melatonin – Cortisol that is elevated at the end of the day can suppress melatonin production. High waking cortisol is often associated with higher overnight levels of cortisol, which may also be suppressive to melatonin. Low melatonin accompanied with low morning cortisol has also been linked to poor sleep.

VMA – During stress, epinephrine is released roughly 10 minutes before cortisol; Therefore, high VMA may be associated with high cortisol.

In the example, the patient’s MMA, Xanthurenate and Kynurenate are all high and Melatonin is low. High bedtime cortisol may be suppressing melatonin production.

See **page 176** of the *DUTCH Interpretive Guide* to learn more about the Organic Acid Tests (OATs) and see *pages 42-47* of the *DUTCH Treatment Guide* for treatment considerations relating to the OATs.

REFERENCE RANGE DETERMINATION

Figure 1.6: Female androgen reference ranges

Menopausal State		
Female Androgens	Pre-	Post-
DHEA-S	60-750	20-270
Etiocholanolone	470-1000	200-710
Androsterone	600-1650	200-830
5a-Androstenediol	11.5-30.0	6.0-17.5
5b-Androstenediol	30-75	12-55
Testosterone	4.0-14.0	2.3-6.3

Androgens naturally decline with age. The female androgen dials include reproductive stage dependent ranges.

Figure 1.7: Male androgen reference ranges

Age Range		
Male Androgens	18 - 40	41 - 60+
DHEA-S	115-1500	30-820
Etiocholanolone	765-1500	400-1090
Androsterone	1170-3000	500-1870
5a-Androstenediol	70-250	30-160
5b-Androstenediol	70-250	40-160
Testosterone	40-115	25-80
5a-DHT	9-25	5-20

Androgens naturally decline with age. The male androgen dials include age-dependent ranges.

OVERVIEW

We aim to make the reference ranges for our tests as clinically appropriate and useful as possible. This includes the testing of thousands of healthy individuals and combing through the data to exclude those who are not considered healthy, or normal, with respect to a particular hormone. As an example, we only use a premenopausal female's data for estrogen range determination if the associated progesterone result is within the luteal range (days 19-21 when progesterone should be at its peak). We exclude females on birth control or with any conditions that may be related to estrogen production.

Regarding all sex hormone dials, these dials represent reference ranges for females 20 years and older and males 18 years and older. Therefore, use caution if interpreting a person's DUTCH Test using these ranges if the female is younger than 20 or if the male is younger than 18.

Androgens naturally decline with age, so referencing the age-dependent ranges offers a better representation of expected levels when interpreting the androgen dials, as seen in **Figure 1.6** and **Figure 1.7**.

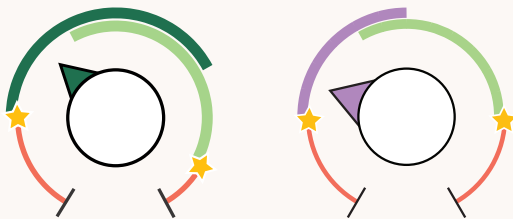


Figure 1.8: Example T dials
The androgen dials on the DUTCH report have two reference ranges. On male androgen dials (left example above), the light green shaded area represents the range for males age 18-40 years, while the dark green shaded area represents the range for males age 41-60+ years. On female androgen dials (right example above), the green shaded area represents the premenopausal reference range, while the purple shaded area represents the postmenopausal reference range.

CLINICAL UTILITY

Over time the database of results for reference ranges has grown quite large. This has allowed us to refine some of the ranges to optimize for clinical utility. The manner in which a metabolite's range is determined can be different depending on the nature of the metabolite. For example, it would not make clinical sense to tell a patient they are deficient in the carcinogenic estrogen metabolite 4-OH-E1, therefore the lower range limit for this metabolite is set to zero for both males and females. Modestly-elevated testosterone is associated with unwanted symptoms in females more so than in men, so the high range limit is set at the 80th percentile in females and the 90th percentile for men.

NOTE

The 90th percentile is defined as a result higher than 90% of a healthy population.

Classic reference ranges for disease determination are usually calculated by determining the average value and adding and subtracting two standard deviations from the average, which defines 95% of the population as being normal. When testing cortisol, for example, these types of two standard deviation ranges are effective for determining if a patient might have Addison's (very low cortisol) or Cushing's (very high cortisol) Disease. Our ranges are set more tightly to be optimally used for functional medicine practices.

HOW DUTCH IS DIFFERENT

For estrogen and progesterone metabolites, our reference ranges don't overlap. This means you can easily determine whether your patients are in the postmenopausal or luteal ranges, or somewhere in between.

"Mind the Gap"

With a significant gap between estrogen sufficiency and deficiency, you'll be able to accurately place your patient between the postmenopausal and luteal ranges in "the gap," see **Figure 1.9**. This gap doesn't exist in available saliva testing and is an important piece of information that can help you prescribe and treat effectively.

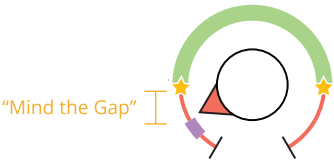
DUTCH Methodology

With an LC/MS assay, the DUTCH Test can more accurately detect nano-level hormone concentrations that show a distinct gap between postmenopausal and luteal reference ranges, improving your ability to precisely characterize your patient's estrogen status. This amount of detail is overlooked by saliva labs and can add more clarity to a patient's hormone status, see **Figure 1.9**.

Clinical Application

The goal of hormone therapy (HT) is often to push a woman's estradiol levels out of the postmenopausal (PMP) range and offer her relief from uncomfortable and troublesome symptoms. This is difficult to accomplish when PMP and luteal levels seem to exist in the same space for many of the most commonly used lab tests. Without meaningful differentiation between these two reference ranges, HT dosing becomes difficult.

Figure 1.9: DUTCH Test Female Estrogen Dials



The female estrogen dials show a distinct gap between postmenopausal and luteal reference ranges, improving your ability to precisely characterize your patient's estrogen status.

Figure 1.10: DUTCH Methodology

- Your Patient
- Luteal range
- Postmenopausal range



DUTCH Testing may improve treatment protocols that involve estrogen therapy because DUTCH uses a highly sensitive LC/MS assay which allows for the clear differentiation between the postmenopausal & luteal reference ranges.

In the graph, see **Figure 1.10**, you can see the clear separation between the reference ranges for luteal and postmenopausal estradiol concentration. We refer to this space between ranges as “the gap”, and its clinical significance is measurable. Providers should “mind the gap” and pay close attention to those patients whose results fall between PMP and luteal reference ranges.

Let’s dive into one of those difficult patient presentations. Imagine a 45-year-old female patient approaches you with symptoms like fatigue, hot flashes, night-sweats, and brain fog. She’s interested in HT to alleviate her symptoms.

The way you proceed with your diagnosis and treatment plan is critical to your patient’s well-being and the health of your practice. If you order the standard salivary immunoassay, you might find that her estradiol results are within the expected range for a postmenopausal female and also for a premenopausal woman. What do you do? Many of these symptoms can have causes other than estrogen deficiency.

Prescribing the right HT dosage (if at all) is nearly impossible in this situation. Without meaningful differentiation between these two ranges (postmenopausal and luteal) you run the risk of misdosing your patient. It’s difficult to move forward confidently with treatment plans when you can’t get definite results from your hormone test.

DUTCH providers have an edge over other clinicians. With superior sensitivity, DUTCH clarifies the blurred lines between menopausal and luteal estradiol reference ranges that other tests can’t define, see **Figure 1.11**. [a]

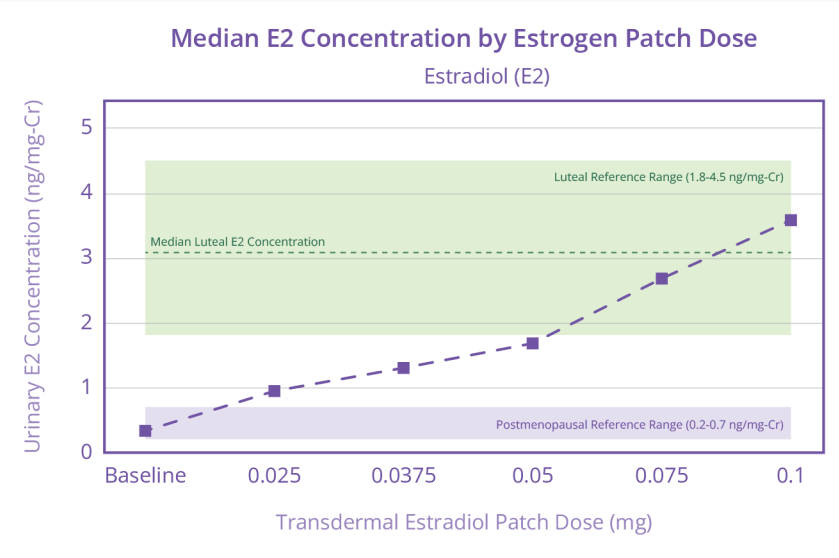


Figure 1.11: Monitoring Estradiol (E2) Patch Therapy
The clear differentiation between the luteal and postmenopausal reference ranges on the DUTCH Test allows for the precise measurement of E2 in women using various patch doses and helps to correlate findings with clinical outcomes.

[a] Mark Newman, MS; Doreen Saltiel, MD, JD; Bryan P. Mayfield, PharmD; Frank Stanczyk, PhD. “Monitoring Estradiol Patch Therapy with a Validated Dried Urine Assay.” Paper presented at TMS, 2021. Washington, DC.

DUTCH BIOMARKER KEY

a-Pregnanediol

Progesterone metabolite that modulates gamma-aminobutyric acid (GABA) receptors in the central nervous system (CNS) and can lead to improvements in mood and sleep.

b-Pregnanediol

Most prominent progesterone metabolite, however, doesn’t modulate GABA receptors.

Estrone (E1)

Moderate strength estrogen.

Estradiol (E2)

Most potent, biologically active estrogen.

Estriol (E3) / 16-Hydroxy-Estradiol (16-OH-E2)

Least potent, weak estrogen derived from estradiol and 16-OH-E1.

2-Hydroxy-Estrone (2-OH-E1)

Phase 1 estrone (E1) metabolite; 2-OH metabolites are the most stable phase 1 metabolites.

2-Hydroxy-Estradiol (2-OH-E2)

Phase 1 estradiol (E2) metabolite; 2-OH metabolites are the most stable phase 1 metabolites.

4-Hydroxy-Estrone (4-OH-E1)

Phase 1 estrone (E1) metabolite; 4-OH metabolites are the most carcinogenic phase 1 metabolites.

4-Hydroxy-Estradiol (4-OH-E2)

Phase 1 estradiol (E2) metabolite; 4-OH metabolites are the most carcinogenic phase 1 metabolites.

16-Hydroxy-Estrone (16-OH-E1)

Phase 1 estrone (E1) metabolite; proliferative estrogen that may contribute to breast tenderness and heavy bleeding, etc.

2-Methoxy-Estrone (2-Me-E1)

Phase 2 metabolite that is much more stable than its precursor 2-OH-E1.

Total Estrogen

Represents the sum of all estrogen markers.

DHEA-S

Sulfated and circulating form of DHEA.

Androsterone

Alpha DHEA metabolite that is roughly seven times weaker than testosterone; can be used to estimate androgen activity in the tissues.

Etiocholanolone

Weak beta DHEA metabolite.

Testosterone

The major circulating androgen.

5a-DHT

Alpha metabolite of testosterone and the most potent androgen; roughly three to four times more androgenic than testosterone.

5a-Androstenediol

The best marker of 5a-DHT formation and activity in the tissues; can be used to estimate androgen activity in the tissues.

5b-Androstenediol

Weak beta androgen metabolite of testosterone that does not contribute to symptoms of androgen excess.

Epi-Testosterone

Not an androgenic hormone but produced in approximately the same amount as testosterone by the testes. Can be used to distinguish a truly low testosterone from a falsely low measurement due to the UGT genetic variant, see **“UGT Deletion” on page 72** for more information.

Creatinine

A compound that is produced from the metabolism of creatine from the kidneys and excreted in the urine. In order to provide the most accurate results, the DUTCH Test uses creatinine excretion to control for hydration status.

Free Cortisol Diurnal Pattern

Daily diurnal (circadian) rhythm of active cortisol that is normally highest in the morning and lowest at night.

Free Cortisone Diurnal Pattern

Daily diurnal (circadian) rhythm of inactive cortisone that is normally highest in the morning and lowest at night. The free cortisone diurnal pattern is used in combination with the free cortisol diurnal pattern to evaluate active free cortisol levels throughout the day, see **“The Cortisone Shadow” on page 164** for more information.

Cortisol Awakening Response (CAR)

An HPA axis resiliency marker, an anticipatory marker of upcoming daily events, and a surrogate marker for HPA axis plasticity/reactivity.

Cortisol Clearance Rate (CCR)

Estimated rate that free cortisol and cortisone are cleared from circulation. Represents the ratio of (THF + THE)/(Total Free Cortisol + Total Free Cortisone).

Optional Extra Cortisol Samples (Mid-Sleep and Mid-Day)

Measurement of cortisol in the middle of the day or upon waking at night.

a-Tetrahydrocortisol (a-THF)

Alpha cortisol metabolite.

b-Tetrahydrocortisol (b-THF)

Beta cortisol metabolite.

b-Tetrahydrocortisone (b-THE)

Beta cortisone metabolite.

Metabolized Cortisol (THE + THF)

Sum of all cortisol and cortisone metabolites.

Cortisol Clearance Rate (CCR)

Estimated rate that free cortisol and cortisone are cleared from circulation. Represents the ratio of (THF + THE)/(Total Free Cortisol + Total Free Cortisone).

Methylmalonate (MMA)

Metabolic byproduct of the citric acid cycle that elevates with vitamin B12 deficiency.

Xanthurenate

Metabolic byproduct of tryptophan metabolism that elevates with vitamin B6 deficiency.

Kynurenate

Metabolic byproduct of tryptophan metabolism that elevates with vitamin B6 deficiency and inflammation.

Pyroglutamate

An intermediate in glutathione recycling and production that elevates with glutathione deficiency.

b-Hydroxyisovalerate

Marker associated with biotin deficiency.

Indican

Metabolic byproduct of tryptophan metabolism in the gut that elevates with intestinal dysbiosis.

Homovanillate (HVA)

Primary dopamine metabolite.

Vanilmandelate (VMA)

Primary norepinephrine and epinephrine metabolite.

Quinolate

Metabolic byproduct of tryptophan metabolism and neurotoxin that elevates with neuroinflammation and general inflammation.

Melatonin (6-OH-Melatonin Sulfate)

Melatonin metabolite.

8-Hydroxy-2-Deoxyguanosine (8-OHdG)

Marker associated with oxidative stress and DNA damage.

CAVEATS

TO TEST OR NOT TO TEST?

In some scenarios, DUTCH testing may have limited value. The following list discusses the most common scenarios that cause our providers to ask the question “to test or not to test?” If there is a scenario not listed below, please feel free to contact our lab for further guidance.

MEDICATIONS

Most of the medications listed below have a physiologic effect on the body that can be evaluated using the DUTCH Test. However, a few medications may elevate select DUTCH biomarkers to the point where they are no longer clinically relevant; these are labeled below with an “Affects Clinical Relevancy” tag. In these cases, the DUTCH Test cannot be used to evaluate the biomarkers that are directly affected.

The “time to baseline” refers to the amount of time it may take for a patient’s DUTCH Test markers to return to baseline after stopping a medication or supplement. “Time to baseline” is a rough estimation and may be different for every patient.

5a-Reductase Inhibitors

Finasteride, Dutasteride, etc.

5a-reductase inhibitors inhibit the 5a-reductase enzyme and may lower alpha metabolites (androsterone, 5a-DHT, 5a-androstenediol, 5a-pregnanediol, 5a-THF) from baseline. Time to baseline: 4 weeks.

Amphetamines and Amphetamine-Like Medications and Drugs

Amphetamine, Dextroamphetamine, etc.

Amphetamines and amphetamine-like medications and drugs may increase free cortisol and free cortisone, HVA, and/or VMA from baseline. Time to baseline: These are eliminated from the body within 1 day, but it may take weeks to return to neurochemical baseline.

NOTE

Stimulant withdrawal may alter neurochemistry and result in severe side effects. Medical management of discontinuation is often required.

Antibiotics

Penicillins, Cephalosporins, etc

Infections, acute or chronic, that lead to the use of antibiotics may indirectly alter cortisol levels and cortisol metabolism from baseline. Time to baseline: 2 weeks after the infection has resolved.

Precision Analytical does not recommend that a patient discontinue any medications or supplements prior to collection unless directed by their healthcare provider. Abruptly stopping some of the medications listed below could result in dangerous withdrawal syndromes.

Appetite Suppressants

Semaglutide, Naltrexone-Bupropion, Phentermine-Topiramate, etc.

Appetite suppressants, depending on the medication, may alter cortisol, HVA, and VMA from baseline. Time to baseline: depending on the medication, days to 2+ weeks.

Aromatase Inhibitors

Anastrozole, Letrozole, etc.

Aromatase inhibitors inhibit the aromatase enzyme and may directly lower all estrogens (and estrogen metabolites) and increase testosterone (and testosterone metabolites), and total DHEA from baseline. Time to baseline: 4-6 weeks.

Caffeine

Caffeine may indirectly increase free cortisol and cortisone, and possibly HVA and VMA from baseline. If the patient stops caffeine during collection and experiences a withdrawal effect, this may result in high free cortisol and free cortisone. Thus, if caffeine is a normal part of the patient's daily routine, consider not stopping it during collection (and if doing a DUTCH Plus or DUTCH CAR, drink it after the +60-minute salivary sample). Note that coffee counts towards the total fluids consumed during the collection period. Time to baseline: Caffeine is eliminated from the body within 1 day, but it may take weeks to return to neurochemical baseline.

Clomiphene (Clomid)

In females, clomiphene may increase luteal progesterone, estrogens, and testosterone (and their metabolites) from baseline. In males it may increase testosterone and estrogens (and their metabolites) from baseline. Time to baseline: 3 cycles or 3 months, whichever comes first (cycling females); 5 weeks (males).

Synthetic Corticosteroids (Non-Hydrocortisone)

Time to baseline depends on dose, strength, frequency, and time since last dose.

- **Oral, Intravenous, Intramuscular, Intraarticular Corticosteroids** (e.g., Prednisone, Prednisolone, Methylprednisolone, etc.) Oral corticosteroids lower cortisol to nearly zero values and decrease metabolized cortisol and DHEA significantly from baseline. Time to baseline is 4-12 weeks and depends on dose, strength, frequency, and time since last dose. Most patients' HPA axis function is back to baseline by 6 weeks, but waiting until 12 weeks may be helpful for outliers and for those who have been on higher doses and/or longer courses. **Abruptly stopping oral corticosteroids could result in dangerous withdrawal symptoms.**
- **Topical Corticosteroids** (e.g., Triamcinolone, Clobetasol, Mometasone, etc.) Topical corticosteroids have little to no effect on DUTCH markers, however, occasionally may lower cortisol and DHEA but only if used on large areas of the body that results in high systemic absorption. Time to baseline: 2-6 weeks, depending on extent of use.
- **Inhaled Corticosteroids** (e.g., Fluticasone, Mometasone, Budesonide, Triamcinolone, etc.) Inhaled corticosteroids have little to no effect on DUTCH

markers, however, occasionally may lower cortisol and DHEA. Time to baseline: 1-4 weeks depending on extent of use.

Diabetes Medications

Glucophage, Insulin, etc.

Diabetes medications may indirectly improve androgens, cortisol, cortisol/cortisone balance, Xanthurenate, and kynurenate levels from baseline. Time to baseline: varies depending on the medication, days to 2+ weeks.

Dopamine Reuptake Inhibitors (DRIs)

Wellbutrin/Bupropion, etc.

DRIs may increase HVA and DHEA-S from baseline. It is unknown to what extent medications that affect neurotransmitter levels in the body will affect the neurotransmitter metabolites, HVA and VMA, on the DUTCH Test. Caution is advised regarding interpretation, as these medications may make the HVA and VMA results less clinically significant. Time to baseline: 6+ weeks.

Ephedrine (including Sudafed)

Ephedrine may indirectly increase cortisol and VMA from baseline. Time to baseline: 30-80 hours.

Fertility Medications

- See **Aromatase Inhibitors**, Clomiphene, Follicle Stimulants, hCG, and GnRH Analogs. Time to baseline: 3 cycles or 3 months, whichever comes first (cycling females).
- **Follicle Stimulants** (e.g., Follitropin Beta (Follistim), Follitropin Alfa (Gonal-F), etc.) Follicle stimulants increase estrogen and estrogen metabolites from baseline. Time to baseline: 3 cycles or 3 months, whichever comes first.
- **GnRH Analogs** (e.g., Triptorelin, Goserelin, Leuprorelin, etc.) GnRH analogs may indirectly lower estrogens and estrogen metabolites during treatment. Time to baseline: 3 cycles or 3 months, whichever comes first.

Hormonal Birth Control

Time to baseline: 3 cycles or 3 months, whichever comes first.

- **Combination Contraceptives & Progestin-Only Injections** (e.g., Depo-Provera)
- Combination contraceptives that contain a progestin + ethinyl estradiol:
 - **Combination Oral Contraceptives (COCs)** (e.g., Ortho-Tri Cyclen, Yaz, Yasmin, etc.)
 - **Vaginal Rings** (e.g., NuvaRing)
 - **Birth Control Patches** (e.g., Xulane)

These all suppress the hypothalamic-pituitary-ovarian (HPO) axis, resulting in consistently low endogenous progesterone and estrogen levels. The DUTCH Test does not measure the synthetic hormones in these forms of birth control. You will be able to see estrogen metabolism patterns for endogenous estrogens but not for synthetic estrogen (i.e., ethinyl estradiol). Apart from progesterone and estrogen, the DUTCH Test also includes androgens, cortisol, and organic

Precision Analytical does not recommend that a patient discontinue any medications or supplements prior to collection unless directed by their healthcare provider. Abruptly stopping some of the medications listed below could result in dangerous withdrawal syndromes.

acids, so some females may still benefit from running a DUTCH Plus® or DUTCH Complete™. The DUTCH Cycle Mapping™ does not offer clinically relevant information in females on these forms of birth control.

- **Progestin-Only Pills (POPs – “Minipill”) & Progestin Implants** (e.g., Nexplanon)
These often suppress ovulation and progesterone; however, some females still ovulate. The DUTCH Test does not measure the synthetic progestin in these POPs and implants. Apart from progesterone and estrogen, the DUTCH Test also includes androgens, cortisol, and organic acids, so some females may still benefit from running a DUTCH Plus® or DUTCH Complete™. The DUTCH Cycle Mapping™ may not offer clinically relevant information in females on these forms of birth control if the birth control is suppressing estrogen and progesterone production from the ovaries. POPs that contain drospirenone are more likely to suppress ovulation than ones containing norethindrone.
- **Hormonal IUDs** (e.g., Mirena, Kyleena, Skyla, Liletta, etc.)
These are progestin containing intrauterine devices that sometimes suppress ovulation and progesterone; however, some females still ovulate and cycle regularly with a hormonal IUD. While controversial, we have also seen anecdotally that patients on hormonal IUDs may experience estrogen dominance, and this state can be observed on a DUTCH Test. Some females may benefit from the DUTCH Complete™ or DUTCH Plus®. If the person is still cycling with the hormonal IUD, then the DUTCH Cycle Mapping™ may also have clinical utility, however, keep in mind that the progestin in the IUD can influence progesterone and/or estrogen levels.

Hormone therapy (HT)

See page **page 78** for more information about monitoring HT with DUTCH Testing.
Time to baseline: 7-14 days.

- **Oral Bioidentical Hormones Affect Clinical Relevancy**
Due to the first pass metabolism effect in the gut and liver, oral hormones result in elevated urinary hormone levels that do not reflect circulating hormone levels if taken within 72 hours of sample collection. Thus, adjusting HT dosing based on DUTCH Test results is not advisable as the results are a combination of first-pass metabolites plus the true value in circulation. However, hormone metabolism patterns (as represented by the population sliders and pie chart) are still accurate. For example, a provider may still use the DUTCH test to assess a patient’s a- to b-pregnanediol balance, 2-OH/4-OH-E1 balance, 2-OH/16-OH-E1 balance, methylation activity, and 5a-preference.

NOTE

A note about oral progesterone: When a female patient reports taking oral progesterone within 72 hours of sample collection, we adjust the progesterone reference ranges on a female report to reflect the a-pregnanediol and b-pregnanediol levels that are typically seen when a standard dose of 100-200 mg is taken during collection (and not skipped). Progesterone that is within the oral progesterone reference range does not guarantee that the dose and route of administration (ROA) of progesterone is appropriate for endometrial protection when estrogen therapy (ET) is being used concomitantly. When oral progesterone is supplemented, providers can focus on the a- to b-pregnanediol balance which can offer insights on the role of oral progesterone on mood and sleep.

- **Sublingual Bioidentical Hormones Affect Clinical Relevancy**

The portion of the sublingual hormones that is swallowed will elevate urine hormone metabolites due to the first-pass effect in the gut and liver if the sublingual hormones are taken within 72 hours of sample collection. Subsequently, urine results will not correlate with serum results when sublingual hormones are taken within 72 hours of sample collection. However, hormone metabolism patterns (as represented by the population sliders and pie chart) are still accurate. For example, a provider may still use the DUTCH test to assess a patient’s a- to b-pregnanediol balance, 2-OH/4-OH-E1 balance, 2-OH/16-OH-E1 balance, methylation activity, and 5a-preference.

- **Transdermal (Topically to the Skin) Bioidentical Hormones**

The DUTCH Test results accurately reflect circulating levels of hormones when this route of administration is used.

- **Vaginal Bioidentical Hormones**

The DUTCH Test is unique in that the free hormones are separated from the conjugated hormones prior to analysis allowing for accurate testing even with the use of intravaginal hormones that may contaminate the urine. The DUTCH Test results accurately reflect circulating levels of hormones but may not represent uterine concentrations of these hormones. Note that vaginal bioidentical hormones only affect clinical relevancy of the DUTCH Test results if there is *extreme* contamination of the urine sample paper, which is rare.

- **Bioidentical Hormone Pellets**

The DUTCH Test can be used to monitor estradiol levels when estradiol pellets are used, as urine correlates well with serum. Testosterone pellets increase the DUTCH Test urinary testosterone levels, as expected, but the increase may exceed what is seen in serum testing.

- **Injected Bioidentical Testosterone**

Intramuscular (IM) testosterone injections increase the DUTCH Test urinary testosterone levels, as expected, but the increase may exceed what is seen in serum testing.

Human Chorionic Gonadotropin (hCG)

In females, hCG may increase luteal progesterone, estrogens, and testosterone (and their metabolites) from baseline. In males it may increase testosterone and estrogens (and their metabolites) from baseline. Time to baseline: 3 cycles or 3 months, whichever comes first (cycling females); 1+ weeks (males).

Hydrocortisone

In females, hCG may increase luteal progesterone, estrogens, and testosterone (and their metabolites) from baseline. In males it may increase testosterone and estrogens (and their metabolites) from baseline. Time to baseline: 3 cycles or 3 months, whichever comes first (cycling females); 1+ weeks (males).

- **Hydrocortisone Cream May Affect Clinical Relevancy**

Hydrocortisone cream may affect the clinical relevancy of the free cortisol results if it contaminates the samples. When a person touches the samples with hydrocortisone cream on their hands (even a little), it can contaminate them.

Precision Analytical does not recommend that a patient discontinue any medications or supplements prior to collection unless directed by their healthcare provider. Abruptly stopping some of the medications listed below could result in dangerous withdrawal syndromes.

Cortisol must enter the body in order to be deactivated to cortisone, thus when the samples are contaminated by hydrocortisone cream, the free cortisol will be affected but the free cortisone won't. In these cases, the free cortisone pattern is a better representation of the diurnal pattern. Time to baseline: avoid exposure to and use of on the day(s) of collection to avoid contamination.

• **Hydrocortisone Injections**

Hydrocortisone injections directly increase free cortisol and free cortisone during the 1-2 days after injection, however, after a few days they may result in adrenal suppression and very low cortisol (and lower total DHEA) from baseline. Time to baseline: 6-8 weeks.

• **Oral Hydrocortisone May Affect Clinical Relevancy**

Oral hydrocortisone directly increases free cortisol and free cortisone for 4-6 hours after supplementation and metabolized cortisol (THE + THF) for 10-12 hours after supplementation. Oral hydrocortisone only affects the clinical relevancy of the free cortisol if it contaminates the samples. Cortisol must enter the body in order to be deactivated to cortisone, thus when the samples are contaminated by hydrocortisone, the free cortisol will be affected but the free cortisone won't. In these cases, the free cortisone pattern is a better representation of the diurnal pattern. Time to baseline: 10-12 hours. **Abruptly stopping oral corticosteroids could result in dangerous withdrawal symptoms, depending on the dose and frequency used.**

Levodopa Affects Clinical Relevancy

Levodopa results in elevated HVA (and possibly VMA) levels that are not indicative of high dopamine (or high norepinephrine and epinephrine) in the body. Time to baseline: 48 hours.

Methyltestosterone

Methyltestosterone is a synthetic anabolic steroid that does not show up on the DUTCH Test as testosterone or its metabolites. In males, methyltestosterone is used as a replacement therapy in testosterone deficiency conditions, such as hypogonadism. It suppresses endogenous production of testosterone. Thus, on the DUTCH Test, it may lower testosterone and its metabolites and epi-testosterone from baseline. In females, methyltestosterone is used in cETain types of breast cancer treatment. Time to baseline: females usually test while on methyltestosterone. In males, it is eliminated from the body within 15 hours, however time to true baseline may take weeks.

Opioid Pain Medications

Oxycodone, Hydrocodone, Morphine, etc.

Opioid medications may indirectly decrease sex hormones, DHEA, and cortisol from baseline. Time to baseline: 6-12 weeks (males and non-cycling females); 3 cycles or 3 months, whichever comes first (cycling females). **Note: Opioid withdrawal may alter neurochemistry and result in severe side effects. Medical management of discontinuation is required.**

Selective Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)

Venlafaxine, Desvenlafaxine, Duloxetine, etc.

SNRIs may improve the cortisol awakening response (CAR) from baseline in some patients. It is unknown to what extent medications that affect neurotransmitter levels in the body will affect the neurotransmitter metabolites, HVA and VMA, on the DUTCH Test. Caution is advised regarding interpretation, as these medications may make the HVA and VMA results less clinically significant. Time to baseline: 6+ weeks.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Fluoxetine, Citalopram, SETraline, etc.

SSRIs may improve the cortisol awakening response (CAR) from baseline in some patients. Caveat about fluoxetine: it may decrease CYP3A4 from baseline. It is unknown to what extent medications that affect neurotransmitter levels in the body will affect the neurotransmitter metabolites, HVA and VMA, on the DUTCH Test. Caution is advised regarding interpretation, as these medications may make the HVA and VMA results less clinically significant. Time to baseline: 6+ weeks.

Spironolactone

Spironolactone may lower testosterone and estrogen (and their metabolites) from baseline. It may increase DHEA-S secondary to increasing SHBG and prolactin. Moreover, it may increase 11b-HSD2 activity and increase free cortisone while lowering free cortisol from baseline. Time to baseline: Spironolactone's effects on SHBG and prolactin may be persistent for weeks (perhaps 2-6 weeks). If true baseline is desired, the return of original symptoms (e.g., acne, hirsutism, etc.) may be the clearest sign.

Tamoxifen

Tamoxifen is a **Selective Estrogen Receptor Modulator (SERM)** that may increase estrogens and their metabolites from baseline (mostly seen in premenopausal cycling females). Time to baseline: 10 weeks (non-cycling females); 3 cycles or 3 months, whichever comes first (cycling females).

Thyroid Medication

T3, T4

Patients typically take their thyroid medication as usual during collection.

Tricyclic Antidepressants (TCAs)

Amitriptyline, Nortriptyline, Imipramine, etc.

TCAs may alter HVA and VMA from baseline. It is unknown to what extent medications that affect neurotransmitter levels in the body will affect the neurotransmitter metabolites, HVA and VMA, on the DUTCH Test. Caution is advised regarding interpretation, as these medications may make the HVA and VMA results less clinically significant. Time to baseline: 6+ weeks.

Precision Analytical does not recommend that a patient discontinue any medications or supplements prior to collection unless directed by their healthcare provider. Abruptly stopping some of the medications listed below could result in dangerous withdrawal syndromes.

SUPPLEMENTS

Precision Analytical does not recommend that a patient discontinue any medications or supplements prior to collection unless directed by their healthcare provider.

All the supplements listed below (except DIM and I3C) can elevate select DUTCH biomarkers to the point where they are no longer clinically relevant; these are labeled below with an **“Affects Clinical Relevancy”** tag. DIM and I3C have a physiological effect on the body that can be evaluated using the DUTCH Test.

The “time to baseline” refers to the amount of time it may take for a patient’s DUTCH Test markers to return to baseline after stopping a medication or supplement. “Time to baseline” is a rough estimation and may be different for every patient.

Diindolylmethane/Indole-3-Carbinol (DIM/I3C)

DIM and I3C tend to lower circulating parent estrogen levels (E1 and E2) and encourage more estrogen down the preferred 2-OH pathway. Time to baseline: 24 hours+ (non-cycling females and males); 3 cycles or 3 months, whichever comes first (cycling females).

D,L-Phenylalanine (DLPA) Affects Clinical Relevancy

DLPA results in elevated HVA (and possibly VMA) levels that are not indicative of high dopamine (or high norepinephrine and epinephrine) in the body. Time to baseline: 48 hours.

Hydroxymethylbutyrate (HMB) Affects Clinical Relevancy

HMB results in elevated b-hydroxyisovalerate (the DUTCH Test biotin marker) that is not indicative of a biotin deficiency. Time to baseline: 48 hours.

L-Dopa Affects Clinical Relevancy

L-Dopa results in elevated HVA (and possibly VMA) levels that are not indicative of high dopamine (or high norepinephrine and epinephrine) in the body. Time to baseline: 48 hours.

Melatonin Affects Clinical Relevancy

Oral melatonin directly affects the DUTCH melatonin metabolite, 6-OH-melatonin sulfate. Due to the first pass metabolism effect in the gut and liver, oral melatonin results in elevated urinary melatonin levels that do not reflect circulating melatonin levels. The DUTCH Test cannot be used to determine if the oral melatonin dose is appropriate. The DUTCH melatonin biomarker is only clinically useful as a baseline marker when melatonin is not taken during the night(s) before collection. Time to baseline: depending on dose, 1-3 days.

Mucuna Affects Clinical Relevancy

Mucuna is an herb that contains L-Dopa and results in elevated HVA (and possibly VMA) levels that are not indicative of high dopamine (or high norepinephrine and epinephrine) in the body. Time to baseline: 48 hours.

Phenylalanine Affects Clinical Relevancy

Phenylalanine results in elevated HVA (and possibly VMA) levels that are not indicative of high dopamine (or high norepinephrine and epinephrine) in the body. Time to baseline: 48 hours.

Quercetin Affects Clinical Relevancy

Quercetin results in elevated HVA, which is not indicative of high dopamine in the body. Time to baseline: 48 hours.

Tryptophan Affects Clinical Relevancy

Oral tryptophan results in elevated xanthurenate, kynurenate, and quinolate that are not indicative of a vitamin B6 deficiency or neuroinflammation. Time to baseline: 48 hours.

Tyrosine Affects Clinical Relevancy

Oral tyrosine results in elevated HVA and VMA levels that are not indicative of high dopamine, norepinephrine, and epinephrine in the body. Time to baseline: 48 hours.

DAMP, WET, AND MOLDY URINE SAMPLES

It is important to *completely* dry all DUTCH urine collection strips. When the DUTCH urine collection strips are not properly dried and remain damp, wet, or moldy during transit, analyte stability can decrease. Potential analyte degradation is dependent on the amount of moisture (damp vs. wet), length of time the sample(s) were damp or wet, the degree to which mold has developed, and on the individual urine matrix. Not all analytes degrade in these situations; for example, when urine samples begin to mold, select OATS analytes can degrade, while others can be enhanced. If leaving the samples out to air dry is not possible (not enough time, high humidity, etc.), a hair dryer can be used effectively without using excessive heat settings.

PHYSICAL STATE

Amenorrhea

Females who do not have a period because their ovaries are not cycling likely have low estrogen and progesterone throughout the month. A DUTCH Complete or DUTCH Plus may be helpful in this scenario, and the person can test on any day. The DUTCH Cycle Mapping does not offer clinically relevant information in females with amenorrhea because their hormones do not “cycle.”

Partial Hysterectomy

Females who do not have a period due to a prior hysterectomy (but still have at least one ovary) can still collect for a DUTCH Plus, DUTCH Complete, and/or DUTCH Cycle Mapping. For the DUTCH Complete and DUTCH Plus panels, we suggest collecting 5-7 days after ovulation. Ovulation can be determined by following basal body temperature (BBT) and by using an ovulation predictor kit (OPK).

NOTE

If the patient is postmenopausal, a DUTCH Cycle Mapping test will not offer clinically relevant information (due to the patient no longer cycling).

Complete Hysterectomy

Females who have had a complete hysterectomy (no ovaries remaining) likely have postmenopausal levels of estrogen and progesterone. A DUTCH Complete or DUTCH Plus may offer more clinically relevant information in this scenario. DUTCH Cycle Mapping does not offer clinically relevant information in people who have had a complete hysterectomy.

Pregnancy

The DUTCH Test does not have reference ranges for pregnant women; therefore, clinical utility may be limited if testing during pregnancy.

Illness

Acute illness (common cold, urinary tract infection, etc.) can affect cortisol levels and cortisol metabolism. Testing may be better utilized upon full recovery.

Kidney Disease

Kidney disease can affect the accuracy of DUTCH Test results. If glomerular filtration rate (GFR) and creatinine on serum testing are normal, then DUTCH testing is appropriate. Note that this only pertains to urine samples; a person with kidney disease can still collect accurate data from salivary samples with a DUTCH CAR or DUTCH Plus panel.

UGT DELETION

Some people are born with a genetic deletion that causes their testosterone, 5a-DHT, and 5b-androstenediol to be falsely low in the urine. This genetic difference is known as the UGT2B17 deletion.

The DUTCH Test measures urinary testosterone glucuronide and testosterone sulfate. These testosterone conjugates are formed mostly from bioavailable testosterone that undergoes phase 2 metabolism to make them ready for urinary excretion.

Testosterone in the liver is primarily glucuronidated by the UGT2B17 enzyme, which also produces 5a-DHT and 5b-androstenediol glucuronides. Genetic variants in this enzyme reduce these urinary hormone levels without affecting serum levels.

The genetic UGT2B17 variants vary in the population, with a higher incidence seen in individuals of South Asian descent. The literature continues to evolve, noting a higher incidence in the UGT2B17 variants in non-Asian populations. Heterozygous individuals show milder reductions in urinary testosterone levels than homozygous individuals.

For this reason, low and very low urinary testosterone levels should be confirmed with serum testing before treatment. Serum testing should include total testosterone, free testosterone (either calculated or measured by equilibrium dialysis), and sex hormone binding globulin (SHBG).

Epi-Testosterone May Help Identify the UGT Deletion Pattern

Epi-Testosterone is not androgenic but is included on the DUTCH Test because it may be helpful when assessing the validity of the urinary testosterone result. In males, epi-testosterone is made in the testes in about the same concentration as testosterone. Similarly in females, epi-testosterone is made in the ovaries in about the same concentration as testosterone. Thus, if epi-testosterone is much higher than testosterone, 5a-DHT, and 5b-androstenediol, the UGT deletion may be present, and testosterone should be measured in serum.

Epi-Testosterone can be suppressed if a person is using testosterone therapy (TTh) as TTh can suppress testicular or ovarian production of testosterone (and thus epi-testosterone). In these cases, epi-testosterone can be used to estimate endogenous testosterone production from the testes or ovaries when testosterone is being supplemented.

NOTE

Epi-Testosterone is a less reliable marker of testosterone production in women who are taking oral contraceptives and in women after menopause. Women taking oral contraceptives have been found to have 40% less epi-testosterone in their urine and epi-testosterone drops more sharply than testosterone during the menopause transition.

ADDITIONAL SCENARIOS

Children

DUTCH Test is not intended for prepubescent individuals; the reference ranges are established for adult populations only. Androgen and estrogen levels are often much lower in children. In order to provide the most accurate results, the DUTCH Test uses creatinine excretion to control for hydration status. DUTCH recommends against testing urine samples from children under the age of 12.

NOTE

Children between the ages of 9-12 can still collect accurate data from salivary samples with a DUTCH CAR or DUTCH Plus panel.

Some clinical situations (such as suspected precocious puberty), providers may wish to order a DUTCH urine panel for a child between the ages of 9-12. DUTCH will process these samples but does not have adjusted reference ranges for children in this age range, so interpretation must be completed with that consideration in mind.

Steroid Medications

Steroid medications (e.g., prednisone, budesonide, steroid inhalers, cortisone injections) can suppress the HPA axis. The degree of suppression depends upon the medication strength, dose, frequency of use, duration of use, and time since last use. Adrenal function usually recovers in 4-12 weeks; however, any medication adjustments should be discussed with a physician. The DUTCH Complete, DUTCH Plus and/or DUTCH Cycle Mapping may be helpful to see the extent of adrenal suppression and how adrenal suppression is affecting androgen levels (e.g., DHEA, testosterone, etc.).

CYCLING FEMALES

Cycling females may consider collecting in their midluteal phase, between days 19 and 22 of a 28-day cycle, see **Figure 1.12**. If the cycle is different than 28 days in length, simply subtract 6-9 from the cycle length. For example: collect on days 17-20 for a 26-day cycle. If there are irregular cycles, consider collecting 5-7 days after ovulation. Ovulation can be determined by following BBT and with an OPK, see **Figure 1.13** as well as “**Basal Body Temperature (BBT)**” and “**Ovulation Predictor Kits (OPKs)**” below, to learn how to use BBT and OPKs. It may be helpful to collect in the luteal phase to understand if ovulation has occurred, if the corpus luteum is making adequate progesterone, and if estrogen is well balanced with progesterone.

DUTCH Collection Tips

If the person is not sure they collected at the right time, they can consider air-drying the urine strips for 24 hours and then placing them in their freezer until they get their period. If they’ve successfully collected their samples at the right time in their cycle, then they should get their period no less than 4 days, and no more than 10 days after collection. For example, if they collected on January 1st (and collected at the right time in their cycle), then they should start their period sometime between January 5th and 11th.

Short Cycles

If the person’s cycles are 20 days in length or shorter, they may consider collecting 5-7 days prior to the onset of their menses.

Long Cycles

If someone has very long cycles, they may consider using an ovulation predictor kit (OPK) and start testing for ovulation at any time. They can consider testing daily to see if they get a positive result. If their period starts before they get a positive result, then they can consider resuming OPK testing as soon as their period has stopped, or when the bleeding has slowed down to just spotting. Some females with very long cycles may benefit from testing on any day instead of timing collection with ovulation.

Calculating Cycle Length

A female’s cycle length is the number of days from the day their period starts to the day before their next period starts. For example, if their period starts on January 1st and their next period starts on January 29th, then they had a 28-day cycle.

Cycling Females Without a Period

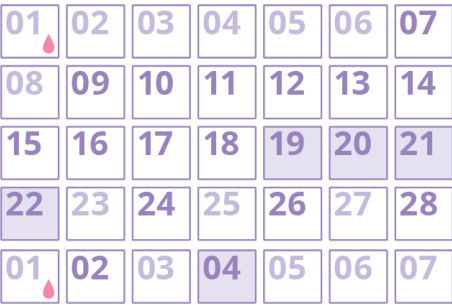
If the patient doesn’t get a period (hysterectomy, Ablation, Etc.) but their ovaries are still cycling, then they can use an OPK to determine when they ovulate. They may consider starting to use the OPK on any day and test daily to see if they get a positive result. Once they get a positive result, they may collect 5-7 days later.

Other Ways to Determine Ovulation

Some females will track their Basal Body Temperature (BBT) to help determine when they ovulate. Other females will monitor for signs of ovulation, such as cervical mucus consistency and the position and firmness of their cervix.

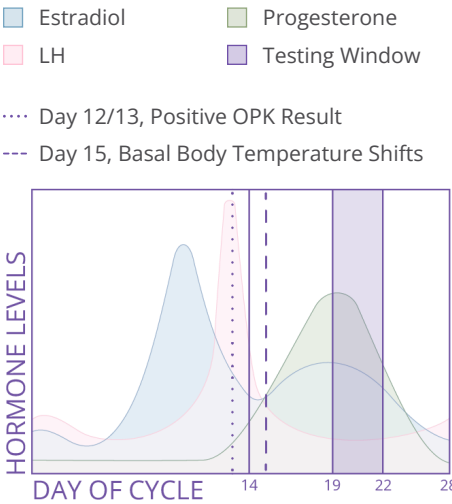
WHEN TO COLLECT

Figure 1.12: Collection Scheduling for Cycling Females



The schedule on which a patient collects depends on the average length of their cycle. If the patient has a standard 28-day cycle, they may consider collecting between days 19 and 22 for a DUTCH Complete or DUTCH Plus. For DUTCH Cycle Mapping, the patient will begin collecting on the seventh day of the cycle, collecting every dark purple day, preferably in the morning. On the fourth day of the new cycle, they will collect the final four samples.

Figure 1.13: Identifying the Testing Window with OPKs or BBT



In a 28-day cycle, it is recommended to collect between days 19 and 22. Ovulation is marked at day 14 after a spike in luteinizing hormone (LH). An Ovulation Predictor Kit (OPK) will have a positive result approximately 1.5 days before ovulation, on day 12 or 13, and Basal Body Temperature (BBT) will shift one day after ovulation, on day 15.

POSTMENOPAUSAL FEMALES

Postmenopausal females can collect on any day. If the DUTCH Test panel includes cortisol, consider collecting on a normal day to best measure typical adrenal function.

MALES

Males can collect on any day. If the DUTCH Test panel includes cortisol, consider collecting on a normal day to best measure typical adrenal function.

OVULATION PREDICTOR KITS (OPKS)

It may be clinically useful for cycling females to collect their DUTCH urine samples during their midluteal phase, about 5-7 days after ovulation. OPKs can help to identify what day ovulation takes place. BBT can also help, see **“Basal Body Temperature (BBT)” on page 77** for more information.

Where to Buy

OPKs can be purchased online or at many grocery stores and pharmacies.

Confirming Ovulation

OPKs detect the presence of luteinizing hormone (LH) in the urine. LH triggers the ovary to release an egg. A strong positive result means that LH is surging, and ovulation will likely happen within the next 8-20 hours.

When to Test

The person should always defer to the OPK’s instructions. However, as a general rule, it is best practice to start the OPK strips 18 days prior to menstruation, taking into account the shortest cycle length. For example, if cycles range from 23-35 days, it is best practice to start OPK strips on cycle day five. To calculate this, we used the shortest cycle length (23 days) and subtracted 18. Always defer to the OPK’s instructions, however research supports collection in the late morning, around 10am.

When to Collect DUTCH Samples

A positive result means that LH is peaking, and the person will likely ovulate within 8-20 hours. Consider collecting the DUTCH urine samples 5-7 days after ovulation, or roughly 5-7 days after a positive OPK result.

Special Considerations

Women with PCOS and perimenopausal females should use caution with OPKs, as they may get a positive result but not ovulate. If someone still decides to utilize OPKs to time their collection, please see **“DUTCH Collection Tips” on page 75** for more information.

Troubleshooting

If the person has tested for 60 days and hasn’t gotten a positive result, they may consider collecting their samples on any day.

BASAL BODY TEMPERATURE (BBT)

It might be clinically useful for cycling females to collect their DUTCH urine samples during their midluteal phase, which is about 5-7 days after ovulation. BBT can help one understand what day ovulation takes place. OPKs can also help, see **“Ovulation Predictor Kits (OPKs)” on page 76** for more information.

Confirming Ovulation

Preovulatory BBTs range from about 97.0 to 97.7 degrees Fahrenheit. After ovulation, BBT rises to about 97.8 degrees or higher. This is because after a female ovulates, the follicle that released the egg turns into the corpus luteum and begins making progesterone. Progesterone is thermogenic meaning it increases body temperature.

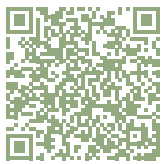
How to Measure

To measure BBT, take your oral temperature with a BBT thermometer each morning upon waking, ideally at the same time each day. A BBT thermometer is a more sensitive thermometer that reads to 2 decimal places and within the normal temperature ranges. Many tech wearables also will measure body temperature, allowing this measurement to occur without any additional effort, such an Oura Ring.

When to Collect DUTCH Samples

A person can consider charting their temperature on paper, or in an app such as Kindara, to look for patterns. It is helpful to look for patterns. Before ovulation, BBT may be lower and then jump up after ovulation and stay higher until the next cycle starts. If a temperature rise occurs for three days straight (especially if it rises by 0.5 degrees), then it is likely that ovulation occurred right before the rise in temperature. Collection of DUTCH samples 5-7 days after ovulation (or about 2-4 days later after the third day of elevated BBT readings) offers best clinical insight.

Figure 1.14: Monitoring Hormone Therapy



More information on HT monitoring can be found on the DUTCH Education page at dutchtest.com. Consider reviewing the HT Testing Matrix by scanning the above QR code (or visiting <https://dutchtest.com/resource/testing-matrix/>) for more information and to compare different lab methods.

OVERVIEW

A common use of the DUTCH Test is to evaluate and monitor patients on HT. HT most commonly consists of estrogen, progesterone, and testosterone, and can come in a variety of forms—some that are FDA-approved prescriptions and others that are custom compounded. To understand how the DUTCH Test can be most useful for HRT, review the following considerations for testing and interpretation.

NOTE

The DUTCH Test is not the best lab tool for all forms of hormone replacement but may offer valuable information regarding hormone metabolism patterns, see Figure 1.14 for more information.

ESTROGEN THERAPY [B]

Using DUTCH for Estrogen Therapy

The best uses of the DUTCH Test with estrogen therapy include:

- 1. Evaluating estrogen detoxification pathways. For example, is estrogen being pushed into the carcinogenic 4-OH estrogen catechols that increase risk for breast cancer? Or is estrogen being pushed into the proliferative 16-OH-E1 metabolites that can contribute to heavy bleeding, breast tenderness, and fibroid growth?
- 2. Monitoring transdermal (TD) estrogen therapies (patches, creams, gels) and pellet therapy, as urine correlates well with serum and aligns with clinical outcomes when these routes of administration are utilized.

Transdermal (TD) Estrogen

The DUTCH Test can be used to monitor estradiol (E2) levels when estrogen is used transdermally, as urinary E2 correlates with serum E2 and aligns with clinical outcomes. Urine additionally provides information about estrogen metabolism patterns and may be a better representation of circulating E2 levels than serum, as it looks at an average over the course of collection and not one point in time.

NOTE

Transdermal estradiol (delivered via gel or cream) dosed between 0.25 – 1.0mg increases urinary E2 concentrations to levels observed with the use of transdermal estradiol patches dosed between 0.025-0.05mg, and urine levels have been shown to parallel serum levels.

[b] Newman MS, Curran DA, Mayfield BP, Saltiel D, Stanczyk FZ. Assessment of estrogen exposure from transdermal estradiol gel therapy with a dried urine assay. Steroids. 2022 Aug; 184:109038. doi: 10.1016/j.steroids.2022.109038. Epub 2022 Apr 26. PMID: 35483542.

DUTCH data for patients on this type of therapy were recently published in the peer-reviewed journal, Steroids, and presented at the 2021 Menopause Society (TMS) meeting, see the data in **Figure 1.15** or find the full-text in **Figure 1.16**.

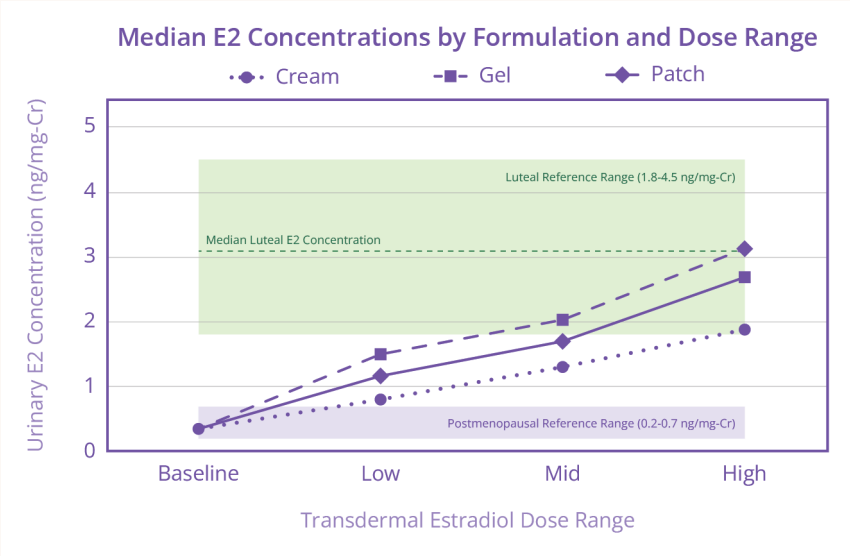


Figure 1.15: Median Estradiol Concentrations by Formulation and Dose Range
Transdermal E2 product doses that increase E2 concentrations above the postmenopausal range are the doses that have been proven to have clinical impact.

Our data shows that transdermal E2 product doses that increase E2 concentrations above the postmenopausal range are the doses that have been proven to have clinical impact. It is not generally necessary to increase levels into the premenopausal (luteal) range to achieve some level of significant clinical change. Therefore, general recommendations for patients on this type of therapy is an E2 value between the postmenopausal and premenopausal range, depending on the clinical goals. A patient whose estrogen levels remain in or below the postmenopausal range for E2 may not have the same level of clinical improvement as a patient with a higher E2 concentration; however, each patient case, along with any risks associated with insufficient or excessive estrogen, should be considered individually.

Response to this type of therapy may vary from person to person as interindividual absorption variability has been shown to be high. This makes testing helpful in assessing an individual's estradiol exposure. Assessing estradiol levels, as well as monitoring downstream metabolites to assess phase I metabolism and methylation is vitally important for optimizing therapy. Precision Analytical does not endorse any particular dose or type of therapy for ET.

Oral Estrogen

If estrogen is supplemented orally within 72 hours of sample collection, urine estrogen metabolites are expected to be elevated due to the first-pass effect in the gut and liver. Subsequently, urine results will not correlate with serum results when this route of administration is used.

Figure 1.16: DUTCH Research



DUTCH data for patients on transdermal estrogen was recently published in the peer-reviewed journal, Steroids, and presented at the 2021 North American Menopause Society (NAMS) meeting. Scan the QR code to find the full text of the manuscripts, or visit: (<https://dutchtest.com/research/>).

NOTE

If a patient is using oral estriol (E3), a portion of the E3 is metabolized into 16-OH-E1 in the gut and liver during first-pass and may result in an elevated 16-OH-E1 percentage relative to the 2-OH-E1 and 4-OH-E1 percentages. In this scenario, use care when interpreting results.

Sublingual Estrogen

If estrogen is supplemented sublingually within 72 hours of sample collection, the portion of the estrogen hormone that is swallowed will elevate urine estrogen metabolites due to the first-pass effect in the gut and liver. Subsequently, like oral estrogen, urine results will not correlate with serum results when sublingual estrogen is taken.

Vaginal Estrogen

There is often the concern that estrogen used vaginally may contaminate the urine and falsely elevate results. DUTCH testing is unique in that free hormones are separated from conjugated hormones prior to analysis allowing for accurate testing even with the use of intravaginal hormones.

The DUTCH results accurately reflect circulating levels of estrogen when the estrogen therapy (ET) is applied labially or inserted in the lower third of the vaginal vault.

NOTE

ET inserted in the upper third of the vaginal vault may excessively elevate endometrial estrogen levels.

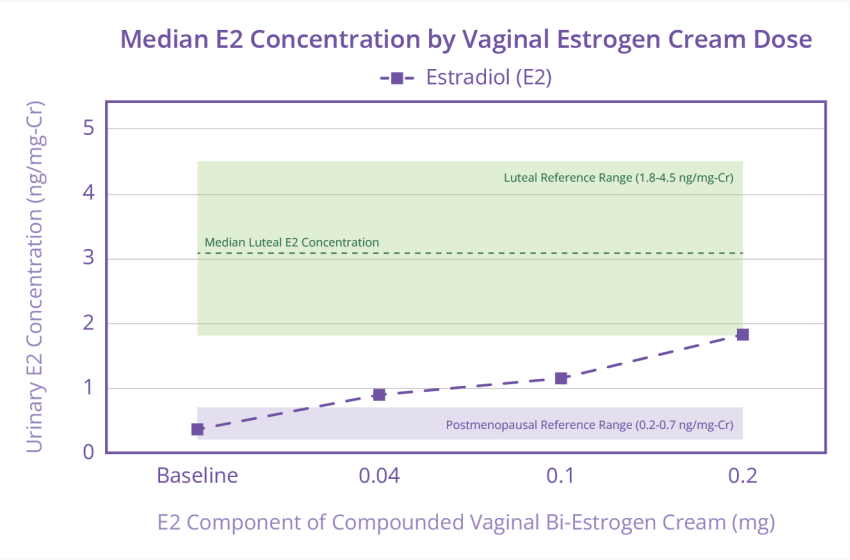


Figure 1.17: Median E2 Concentration by Vaginal Estrogen Cream Dose
Increasing doses of vaginal bi-estrogen cream resulted in a dose-dependent increase in median urinary concentrations of E2.

In a recent Menopause Society (TMS) publication [c], DUTCH showed increasing doses of vaginal estrogen cream resulted in a dose-dependent increase in median urinary concentrations of estrone (E1), estradiol (E2), and estriol (E3), see **Figure 1.17**.

NOTE

If the clinical goal is to provide therapy for a local, vaginal effect (and to avoid meaningful elevations of systemic estrogen), the goal should be for estradiol levels on DUTCH testing to stay within the postmenopausal range.

Estrogen Pellets

The DUTCH Test can be used to monitor estradiol (E2) levels when estrogen pellets are used, as urine correlates well with serum. If on a 3-month dosing schedule, consider testing halfway through dosing intervals (6-8 weeks after insertion) and baseline trough levels (3-4 months after pellet insertion).

Rectal Estrogen

The DUTCH Test urinary estrogen levels may be higher than serum estrogen levels, as some of the estrogen may be transported to the liver via the portal vein and become metabolized.

PROGESTERONE THERAPY

Using DUTCH for Progesterone Therapy

Currently there is no lab testing that can be used to guarantee endometrial protection for patients on progesterone therapy. Studies that have assessed the progesterone dosing and routes of administration (ROA) required to protect the endometrium when concomitant ET is being supplemented use endometrial biopsies to identify and categorize endometrial hyperplasia. As it is not always practical to perform endometrial biopsies on patients to monitor progesterone therapy, which have found that 100 mg of oral progesterone nightly, 200 mg of oral progesterone 12 consecutive days per month, or 100-200 mg vaginal progesterone 12 consecutive days per month protects the endometrium.

Measuring Progesterone

Measuring oral progesterone is difficult because serum progesterone levels rapidly rise and fall within a few hours after dosing. Vaginal progesterone inserted into the upper third of the vaginal vault concentrates in the uterus, and serum levels do not reflect this concentration. Transdermal progesterone creams have not demonstrated the ability to reliably increase serum levels nor provide endometrial protection. Transdermal progesterone gels tend to absorb better than creams, but they also haven't demonstrated the ability to inhibit endometrial proliferation.

Urine progesterone metabolites do not strongly correlate with serum progesterone with many common ROAs (oral, sublingual, topical, vaginal), thus it is not generally recommended to use the DUTCH Test results to monitor circulating progesterone

[c] Mark Newman, MS; Doreen Saltiel, MD, JD; Desmond A Curran. "Approximating Systemic Estrogen Exposure from Vaginal Estrogen Cream Therapy." Poster presented at TMS, 2022. Atlanta, GA.

levels with progesterone therapy. Even a “within range” progesterone result on the DUTCH Test does not ensure endometrial protection.

One unique feature of the DUTCH Test is that it measures progesterone metabolites, which can be useful for assessing other benefits of progesterone therapy. Patients who push progesterone more heavily down the 5a pathway (towards a-pregnenediol) have been shown to make more of the other 5a metabolites like allopregnanolone, which modulate GABA receptors in the brain and can support mood and sleep. See **“Progesterone Metabolism” on page 126** for more information on progesterone alpha vs. beta preference in postmenopausal females.

Oral Progesterone

If progesterone is supplemented orally within 72 hours of sample collection, urine progesterone metabolites are expected to be elevated due to the first-pass effect in the gut and liver. Subsequently, urine concentrations will not correlate with serum concentrations when this route of administration is used.

Orally administered progesterone undergoes several steps of metabolism, including its first steps in the gut when it comes in contact with intestinal bacteria which includes 5b-reductase activity, and then at the gut wall where it has both 5a-reductase activity and conjugation of steroids with glucuronic acid.

As mentioned above, the DUTCH Test measures several of these progesterone metabolites which can offer insights on the role of progesterone on mood and sleep, see **“Progesterone Metabolism” on page 126** for more information.

Progesterone that is within the oral progesterone reference range does not guarantee that the dose and route of administration (ROA) of progesterone is appropriate for endometrial protection when replacement therapy (ET) is being used concomitantly. Research shows that 100 mg of oral progesterone nightly, or 200 mg of oral progesterone 12 consecutive days per month is protective to the endometrium when ET is being used, however, 200 mg oral progesterone may be more appropriate for moderate to high doses of ET.

When a female patient reports taking oral progesterone within 72 hours of sample collection, we adjust the progesterone reference ranges on a female report to reflect the a-pregnenediol and b-pregnenediol levels that are typically seen when a standard dose of 100-200 mg is taken during the test (and not skipped).

NOTE

The serum equivalent value reported on page 1 of the DUTCH Complete and DUTCH Plus reports is a calculated value from the progesterone metabolites and is not accurate when patients take oral or sublingual progesterone.

Sublingual Progesterone

If progesterone is supplemented sublingually within 72 hours of sample collection, the portion of the progesterone hormone that is swallowed will elevate urine progesterone metabolites due to the first-pass effect in the gut and liver. Subsequently, like oral progesterone, urine results will not correlate with serum results when sublingual progesterone is taken. We do not have reference ranges for

sublingual progesterone due to the high variability in the amount of progesterone that is swallowed.

It is not recommended to use the DUTCH Test results to monitor circulating progesterone levels when sublingual/troche progesterone is being supplemented, but instead to monitor how the progesterone is being metabolized, see **“Progesterone Metabolism” on page 126** for more information.

NOTE

The serum equivalent value reported on page 1 of the DUTCH Complete and DUTCH Plus reports is a calculated value from the progesterone metabolites and is not accurate when patients take oral or sublingual progesterone.

Vaginal Progesterone

As with serum, urine testing does not capture endometrial levels. Vaginal progesterone placed in the upper third of the vaginal vault is rapidly absorbed and concentrates higher in the endometrium due to the uterine first-pass effect, thus endometrial progesterone concentrations are often higher than serum progesterone concentrations with this route of administration. Research shows that 100-200 mg of vaginal progesterone 12 consecutive days per month may offer endometrial protection when estrogen therapy (ET) is being used.

Transdermal (TD) Progesterone

Transdermal progesterone typically only increases urine progesterone metabolites slightly on the DUTCH Test. Even high doses of TD progesterone may not elevate urinary progesterone metabolites into the luteal range. In general, laboratory monitoring is not helpful for transdermal (TD) progesterone dosing. TD progesterone has not been well studied, and the studies that are available show that it does not circulate well. TD progesterone has not consistently been shown to protect the endometrium when estrogen therapy (ET) is also being used.

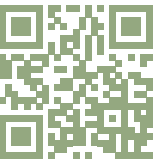
Rectal Progesterone

Urinary progesterone metabolites may be higher than serum results as some of the progesterone may be transported to the liver via the portal vein and become metabolized, though this has not been studied. Rectal progesterone has not demonstrated endometrial protection when estrogen therapy (ET) is used, and the DUTCH Test results should not be assumed to be useful in assessing for endometrial protection.

PREGNENOLONE THERAPY

Like progesterone, pregnenolone is metabolized into a-pregnenediol and b-pregnenediol. However, unlike progesterone, pregnenolone will not elevate circulating progesterone levels. If pregnenolone is supplemented orally within 72 hours of sample collection, urine progesterone metabolites are expected to be elevated due to the first-pass effect in the gut and liver. Subsequently, urine progesterone results will not correlate with serum results when oral pregnenolone is taken.

Figure 1.18: Oral Micronized Progesterone (OMP) Therapy



For access to our references and additional information about OMP, scan the QR code or visit (<https://dutchtest.com/research/>).

TESTOSTERONE THERAPY

Using DUTCH for Testosterone Therapy

The best uses of the DUTCH Test with testosterone therapy include:

1. As a compliment to serum for patients on testosterone therapy.
2. Evaluating androgen metabolism pathways. The alpha androgen metabolites (5a-DHT, 5a-androstenediol and androsterone) best reflect androgen activity at the tissue level, whereas the beta androgen metabolites (5b-androstenediol and etiocholanolone) have little-to-no androgen activity. For example, is testosterone being preferentially metabolized down the more androgenic alpha pathway which could contribute to symptoms of high androgens such as hair loss and irritability? Or is testosterone being preferentially metabolized down the less androgenic beta pathway which could contribute to symptoms of low androgens such as fatigue, low mood, and difficulty losing weight?
3. Monitoring transdermal, intramuscular injection and pellet testosterone therapy, as urine generally correlates with serum. Injections and pellets increase urine testosterone levels, as expected, but the increase may exceed what is seen in serum testing.
4. Evaluating androgen aromatization into estrogens and downstream estrogen metabolism patterns.
5. In men, the addition of epitestosterone as a measured value on the DUTCH test also provides insight into endogenous production of testosterone, as values will reflect (approximately) that of endogenous production of testosterone, and concentrations of epitestosterone are unaffected by administration of exogenous testosterone. This can give you an idea of whether endogenous testosterone production is being suppressed by the testosterone therapy. Based upon our own internal data, if epitestosterone is <10, you can assume there is some testicular suppression and <5 is reflective of complete testicular suppression. In the latter case, you could assume that LH values are very low.

NOTE

Due to the possibility of the UGT deletion (that causes urine testosterone, 5a-DHT and 5b-androstenediol to be falsely low), consider monitoring testosterone therapy (TTh) in the serum and using urine (DUTCH) adjunctively. See “UGT Deletion” on page 72 for more information regarding the UGT genetic variant.

Oral Testosterone

If testosterone is supplemented orally within 72 hours of sample collection, urine testosterone (and downstream metabolites) may be elevated due to the first-pass effect in the gut and liver. Subsequently, urine results may not correlate with serum results when this route of administration is used.

Sublingual Testosterone

If testosterone is supplemented sublingually within 72 hours of sample collection, the portion of the testosterone hormone that is swallowed may elevate urine testosterone (and downstream metabolites) due to the first-pass effect in the gut and

liver. Subsequently, like oral testosterone, urine results may not correlate with serum results when sublingual testosterone is taken.

Vaginal Testosterone

There is often the concern that testosterone used vaginally may contaminate the urine and falsely elevate results. DUTCH testing is unique in that free hormones are separated from conjugated hormones prior to analysis, allowing for accurate testing even with the use of intravaginal hormones. Both serum and DUTCH results show modest increases in testosterone with doses commonly used (~1mg).

It is recommended to evaluate testosterone as well as the downstream metabolites of testosterone: 5a-DHT, 5a-androstenediol, and 5b-androstenediol. If excessive testosterone therapy (TTh) is used, symptoms of androgen excess (facial hair growth, body hair growth, scalp hair loss, acne, mood changes, etc.) will often manifest.

Transdermal Testosterone

Urinary testosterone levels, as reported on the DUTCH Test, generally parallel changes observed in serum testosterone levels as well as with clinical outcomes (including increased muscle mass, erythrocytosis, etc.) in men.

Testosterone Pellets

Pellets increase the DUTCH Test urinary testosterone levels, as expected, but the increase may exceed what is seen in serum testing. If on a 3-month dosing schedule, consider testing halfway through dosing interval (6-8 weeks after insertion) and baseline trough levels (3-4 months after pellet insertion).

We recommend that DUTCH testing be completed about halfway through the dosing window (so 3 months after pellet insertion if pellets are inserted every 6 months), or 3-4 days after a weekly injection.

Intramuscular Testosterone Injections

Intramuscular (IM) testosterone injections increase the DUTCH Test urinary testosterone levels, as expected, but the increase may exceed what is seen in serum testing. Consider testing halfway through the dosing interval.

Rectal Testosterone

The DUTCH Test urine results may be higher than serum results, as some testosterone may be transported to the liver via the portal vein and undergo first-pass metabolism.

DHEA THERAPY

Using DUTCH for DHEA Therapy

The best uses of the DUTCH Test with DHEA therapy include:

1. Evaluating androgen metabolism pathways: the alpha androgen metabolites (5a-DHT, 5a-androstenediol and androsterone) best reflect androgen activity at the tissue level, whereas the beta androgen metabolites (5b-androstenediol and etiocholanolone) have little-to-no androgen activity. For example, is DHEA being preferentially metabolized down the less androgenic beta pathway which could contribute to symptoms of low androgens such as fatigue, low mood, and difficulty losing weight? Or is DHEA possibly being over-aromatized into estrogen?
2. Evaluating androgen aromatization into estrogens and downstream estrogen metabolism patterns.

NOTE

7-keto DHEA does not increase DHEA or its metabolites on the DUTCH Test.

Oral DHEA

If DHEA is supplemented orally within 48 hours of sample collection, urine DHEA-S (and downstream metabolites) may be elevated due to the first-pass effect in the gut and liver. Subsequently, urine results may not correlate with serum results when this route of administration is used.

Sublingual DHEA

If DHEA is supplemented sublingually within 48 hours of sample collection, the portion of the DHEA hormone that is swallowed may elevate urine DHEA-S (and downstream metabolites) due to the first-pass effect in the gut and liver. Subsequently, like oral DHEA, urine results may not correlate with serum results when sublingual DHEA is taken.

NOTE

Sublingual/troche DHEA has not been extensively researched.

Transdermal DHEA

The DUTCH test measures predominantly DHEA-S, and because transdermal application bypasses the liver (where much of the DHEA is sulfated to DHEA-S), transdermal DHEA may not increase urinary DHEA-S much.

It is recommended to monitor the androgens (like testosterone, 5a-DHT, 5a-androstenediol, androsterone, and etiocholanolone) and the estrogens (estrone, estradiol, estriol, phase 1 estrogen metabolites, and 2-methoxy-E1) that are downstream of DHEA to evaluate how the supplemented DHEA may be affecting the patient's sex hormone profile.

Vaginal DHEA

As vaginal DHEA has been shown to increase downstream metabolites such as testosterone, the DUTCH Test has proven to be an excellent tool for evaluating DHEA's effects with this route of administration.

It is recommended to monitor the androgens (like testosterone, 5a-DHT, 5a-androstenediol, androsterone, and etiocholanolone) and the estrogens (estrone, estradiol, estriol, phase 1 estrogen metabolites, and 2-methoxy-E1) that are downstream of DHEA to evaluate how the supplemented DHEA may be affecting the patient's sex hormone profile.

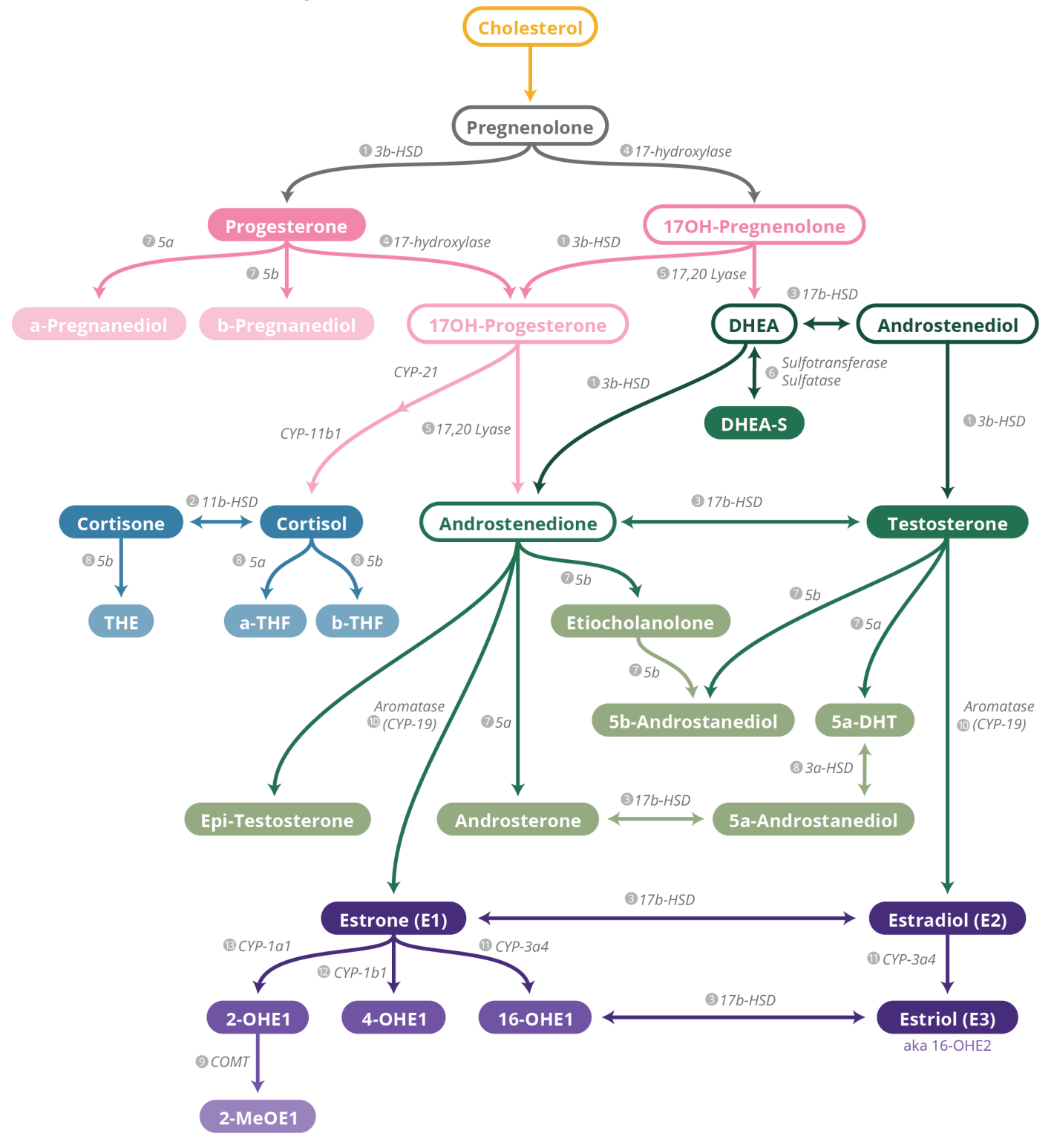


Figure 1.19: The DUTCH Steroid Pathway

Follow the arrows to see how cholesterol is metabolized into the various sex hormones and cortisol.

THE DUTCH STEROID PATHWAY

OVERVIEW

The DUTCH Steroid Pathway is a summary depicting where hormones come from and how they form through various cells in the body. It includes supplements, nutrients, herbs, and medications shown in the literature to increase or decrease particular enzymes affecting these hormones. This is a general steroid pathway and does not specifically differentiate from cells in the ovaries, adrenal glands, or testes.

HOW TO READ THE CHART

Begin at the top of the page, see **Figure 1.19**, with cholesterol and follow the arrows downstream to see the conversion of cholesterol into various steroid hormones. Hormones depicted with a solid color bubble are measured by the DUTCH Test, while hormones depicted with an outline are not. The outlined hormones are too far upstream to test directly with our methodology. Instead, we test the downstream metabolites of that hormone.

Hormones are color-coded for convenient reading:

- Cholesterol
- Pregnenolone
- Cortisol
- Progesterone
- Androgens
- Estrogen

Next to each arrow on the steroid pathway chart is the name of the enzyme responsible for moving each hormone further downstream. These enzymes are important because they can be targeted with lifestyle changes and supplementation to improve symptoms associated hormone imbalances.

CONTRIBUTING FACTORS

Use the corresponding number next to a protein to find the list of contributing factors that may be affecting the results of a DUTCH Test. See **Figure 1.20** for access to our references and additional information about these findings.

1 3b-HSD

May be increased by: Fenugreek, high ACTH/hyperadrenalism, PCOS.

May be decreased by: Isoflavonoids/phytoestrogens, phthalates, organochlorines, BPA, ketoconazole, finasteride, dutasteride.

2 11b-HSD

May push to cortisol: EGCG, PCOS, curcumin, 7-keto-DHEA, progesterone, coffee, holy basil, bitter melon, hyperthyroidism, high estrogens, glucocorticoids.

May push to cortisol: Insulin resistance, obesity, inflammation, hypothyroidism, licorice root, phthalates, organotoxins, alkylphenols, mother's diet during pregnancy.

Figure 1.20: Steroid Pathway Resources & References



For access to our references and additional information, scan the QR code or visit (<https://dutchtest.com/steroid-pathway-resources/>).

3 17b-HSD

Type 1 (Converts E1 to E2)

May be increased by: High carbohydrate diet

May be decreased by: Flavones, flavanones, isoflavones, genistein, biochanin A, hesperidin, luteolin, tea, citrus, Apiaceous vegetables (carrots, celery, parsley, parsnips, cumin, etc.), red pepper, melatonin, omega-3 fatty acids.

Type 2 (Converts E2 to E1)

May be increased by: Endogenous progesterone, progestins (e.g., in birth control pills).

May be decreased by: Flavones, bioflavonoids, phytoestrogens, rutin, quercetin, myricetin, polyphenols (e.g., Kaempferol)

Type 5 (Converts Androstenedione to Testosterone)

May be increased by: Alcohol

May be decreased by: Coumestrol, biochanin A, quercetin, 18b-glycyrrhetic acid (licorice), apigenin

NOTE

There may be significant overlap in how substances affect the back and forth activity of these enzymes.

4 17-hydroxylase

May be increased by: Hyperglycemia, hyperinsulinemia.

May be decreased by: Ketoconazole, spironolactone, apigenin, polyphenols.

5 17, 20 Lyase

May be increased by: PCB exposure, DHEA supplements, obesity.

May be decreased by: Licorice root, spironolactone, azole antifungals, hyperglycemia, apegenin.

6 DHEA & DHEA-S

DHEA convETs to DHEA-S with hydroxysteroid sulfotransferase while DHEA-S convETs to DHEA with steroid sulfatase; these interconvET in different locations within the body.

DHEA-S may be increased by: Spironolactone, dexamethasone, bile acid, St. John’s Wort, forskolin.

DHEA-S may be decreased by: Low cysteine, inflammation, LPS, ketoconazole, progestin, licorice.

7 5a-Reductase & 5b-Reductase

5a-Reductase is best known because it makes androgens like testosterone more potent. It is also responsible for metabolizing progesterone and cortisol. If up-regulated, it may cause high androgen symptoms in men (thinning hair, prostate) and women (as in PCOS, thinning hair, acne, facial hair growth). 5b-Metabolites are less androgenic (weaker). 5b-Reductase may be affected by some of the listed things for 5a as well (often to a lesser degree). This same enzyme also metabolizes cortisol, see “**Cortisol Metabolism/Clearance**” below for more detail.

5a may be increased by: Insulin resistance, obesity, DHEA supplementation, PCOS.

5a may be decreased by: Saw palmetto and beta-sitosterol, reishi, nettle root, pygeum africanum, polyunsaturated fats (PUFAs), and EGCG.

5b may be increased by: Insulin resistance, high triglycerides, PCOS.

5b may be decreased by: Licorice.

8 Cortisol Metabolism/Clearance

Cortisol is metabolized by 5a/5b-reductase (and 3a-HSD) to a/b-THF & THE for excretion. Metabolism may be increased in obesity, high insulin and hyperthyroid. It may be slowed in cases of hypothyroidism, anorexia, cholestasis, or poor liver function. This same enzyme metabolizes testosterone, androstenedione, and progesterone, see “**5a-Reductase & 5b-Reductase**” above for more detail.

9 COMT

May be increased by: S-adenosyl-L-methionine (SAmE), magnesium, choline, B6, B12, folate, betaine/TMG (cofactors).

May be decreased by: Estradiol, phthalate esters, rhodiola rosea, quercetin, catechin, epicatechin.

10 Aromatase (CYP-19)

May be increased by: Obesity and inflammation, high insulin, forskolin, quercetin, genistein (bioflavonoids), white peony, licorice root, atrazine, rutin.

May be decreased by: Enterolactone, apigenin, genistein, chrysin and other flavonoids, white button mushrooms, grape seed extract, red wine procyanidin dimers, PCOS, antifungal medications, metformin, glyphosate, aromatase inhibitors (letrozole, anastrozole).

11 CYP-3a4

Many common medications induce CYP-3a4, including but not limited to, phenobarbitol, phenytoin, rifampicin, and glucocorticoids.

Many common medications interfere with or competitively inhibit CYP-3a4, including but not limited to, cimetidine, tamoxifen, quinolones, and fluoxetine.

May be increased by: St. John's Wort, pesticides, caffeine, smoking, PAHs, moderate alcohol consumption, obesity.

May be decreased by: Grapefruit, resveratrol, rosemary, wild yam, peppermint oil, azole antifungals.

12 CYP-1b1

May be increased by: Inflammation, smoking, PAHs.

May be decreased by: Flavonoids, resveratrol.

13 CYP-1a1

May be increased by: Cruciferous vegetables, DIM/IC3, caffeine, soy, fish oil, rosemary extract, thyroxine, flaxseed.

May be decreased by: High sugar diet, moderate alcohol consumption, resveratrol, pterostilbene.

Sex Hormones: Cycling Female

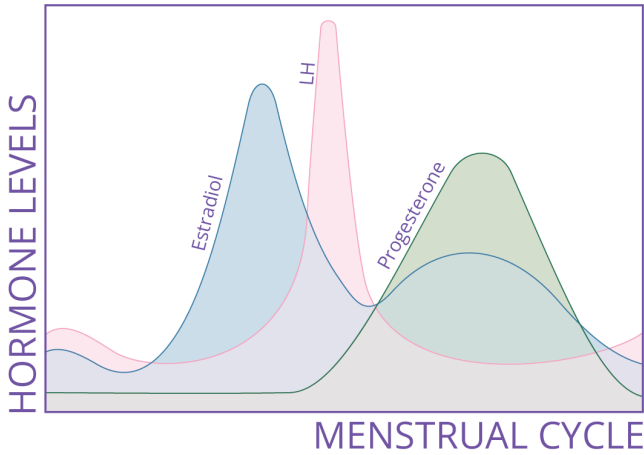


Figure 2.1: Hormones Throughout the Menstrual Cycle
Estrogen and progesterone levels fluctuate significantly during the follicular, ovulatory, and luteal phases of the menstrual cycle.

The Menstrual Cycle

The menstrual cycle is made up of the follicular phase, the ovulatory phase, and the luteal phase, see **Figure 2.1**.

Day one of the menstrual cycle (and day one of the follicular phase) is marked by the onset of menses. During the follicular phase, follicle stimulating hormone (FSH) stimulates multiple follicles to grow within the ovary. While this is happening, luteinizing hormone (LH) stimulates ovarian theca cells to make androgens and FSH stimulates the aromatase enzyme to convert these androgens to estrogens in the ovarian granulosa cells. A single, dominant follicle is selected around cycle days 5-7. This selected follicle will go on to release an egg later in the cycle. The other follicles that were not selected degenerate.

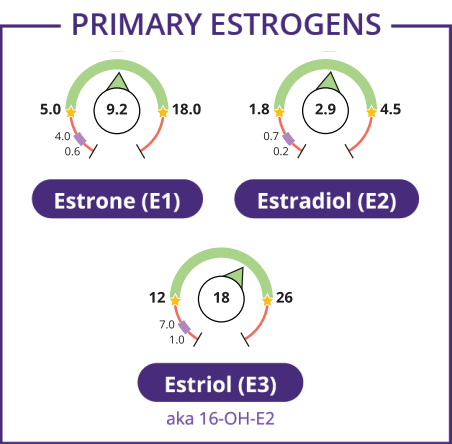
The follicular phase is followed by the ovulatory phase. During the ovulatory phase, surging estradiol released by the dominant follicle signals the pituitary to release a large amount of LH. About 10-12 hours after LH peaks, ovulation occurs, and an egg is released from the follicle. The remaining part of the follicle becomes the corpus luteum, a temporary endocrine structure that produces progesterone through the end of the menstrual cycle. If pregnancy occurs, the corpus luteum will continue to make progesterone until the placenta takes over at the end of the 1st trimester. If there is no pregnancy, then estradiol and progesterone levels decrease, triggering menstrual bleeding and starting the next cycle.

NOTE

A healthy luteal phase is 13-15 days in length and a normal menstrual cycle is typically 24-35 days in length for adults.[d]

[d] Taylor HS, et al. Speroff's Clinical Gynecological Endocrinology and Fertility. Ninth edition. Wolters Kluwer; 2020; 137-173.

Figure 2.2: Measuring Estrogen



The DUTCH Test measures the three primary estrogens: Estrone, Estradiol, and Estriol.

OVERVIEW

The DUTCH Test measures the three primary estrogens: Estrone (E1), Estradiol (E2), and Estriol (E3), see **Figure 2.2**.

Estradiol has the strongest stimulatory effect on estrogen receptors while estriol has the weakest effect. Estrone and estradiol can interconvert via 17b-HSD and estriol is an estradiol and 16-OH-E1 downstream metabolite.

Estrogen’s Role in Cycling Females

In cycling females, estradiol builds the endometrium for possible pregnancy. It is also beneficial for bone health, insulin sensitivity, healthy weight management, neurotransmitter balance, sleep, mood, concentration, memory, hair, skin, vaginal pH and lubrication, and cardiovascular health. Estradiol excess, or estradiol that is not well balanced with progesterone, may have adverse health consequences, which include endometrial cancer, gallstones, clotting issues, heavy bleeding, menstrual cramping, tender or fibrocystic breasts, mood disturbances, acne, fibroids, headaches, and weight gain. See **“Estrogen Dominance Patterns” on page 98** for more information about the progesterone to estrogen balance in cycling females.

Estradiol and the Hypothalamic-Pituitary-Adrenal (HPA) Axis

Studies evaluating interactions between the provoked HPA axis and estradiol are limited in both healthy and diseased individuals. The available data on cortisol and estradiol in cycling females states that estradiol can impact the HPA axis, and the HPA axis can impact estradiol levels. With HPA axis dysfunction, the hypothalamic-pituitary-gonadal (HPG) axis may be suppressed, thus decreasing estradiol levels. [e]

Estrogen Production in Cycling Females

In cycling females, estradiol is predominantly made in the ovaries. Estradiol levels are highest during the ovulatory phase and lowest in the early follicular phase.

ESTRADIOL IS LOW

Signs & Symptoms

Low E2 in cycling females may result in hot flashes, night-sweats, insomnia, joint pain, skin issues, low sex drive, mood disturbance, brain fog, vaginal dryness, weight gain, decreased bone mineral density, and increased cardiovascular disease risk.

Potential Root Causes

Low E2 in cycling females is often associated with high stress (HPA axis dysfunction), thyroid disorders, high prolactin, breastfeeding, perimenopause, downregulated aromatase activity¹, improper timing of DUTCH sample collection, e.g., collecting in the first week of the cycle rather than the last half of the cycle², medications³, and diindolylmethane (DIM)/I3C⁴. Less common associations include anorexia, extreme

[e] Chrousos GP, et al. Interactions between the hypothalamic-pituitary-adrenal axis and the female reproductive system: clinical implications. Ann Intern Med. 1998 Aug 1;129(3):229-40.

exercise, low body weight, low androgens, decreased ovarian blood flow (i.e., surgery or smoking, and poor ovarian cell health.

Potential Support Considerations

In addition to assessing and treating the underlying root cause, other support considerations include herbal and dietary estradiol support, HPA axis support, androgen support if low and promoting regular cycles and ovulation. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

ESTRADIOL IS ELEVATED

Signs & Symptoms

In cycling females, estradiol excess, or estradiol that is not well balanced with progesterone, may have adverse health consequences, which include heavy bleeding, fibroid growth, menstrual cramping, tender or fibrocystic breasts, mood disturbances, fatigue, acne, headaches, weight gain, clotting issues, and gallstones. E2 that is not balanced with Pg may increase endometrial hyperplasia and cancer risk, and elevated endogenous estrogen is a risk factor for breast cancer.

Potential Root Causes

Elevated E2 in cycling females may be normal or may be associated with obesity, insulin resistance, diabetes, inflammation, stress, PCOS, elevated androgens, perimenopause, poor detoxification, endocrine disrupting chemicals (EDCs), high alcohol intake, gut dysbiosis, DHEA/T/E2 supplementation, upregulated aromatase activity⁵, or improper timing of DUTCH sample collection, e.g., if samples are collected during the ovulatory E2 surge⁶. Interpret results with caution if oral or sublingual hormones are being supplemented⁷.

Potential Support Considerations

In addition to assessing and treating the underlying root cause, other support considerations include supporting estrogen detoxification and healthy metabolism patterns, supporting the HPA axis, lowering inflammation, regulating blood sugar, weight loss (if appropriate), lowering androgens if elevated, and general liver support to further encourage hormone detoxification. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

ESTRADIOL IS WITHIN RANGE

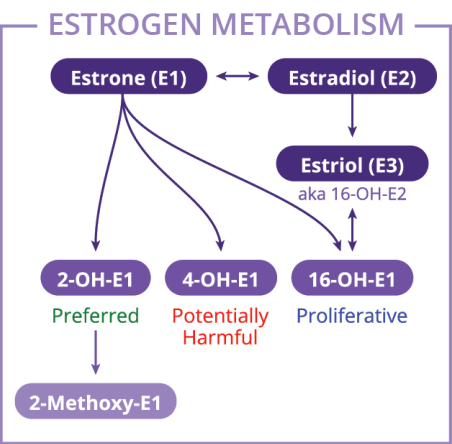
Consider confirming that Pg is within the reference range and balanced with estradiol, especially if the person reports symptoms that are cyclical in nature.

NOTE

Estrogen excess symptoms may have causes other than elevated estradiol relative to progesterone. It is also possible for estradiol to be above the reference range during other times in a female’s cycle (outside of the luteal phase measurement period). In this case, a DUTCH Cycle Mapping may be clinically useful. In all cases, ensure healthy phase 1 and phase 2 estrogen metabolism.

ESTROGEN DOMINANCE PATTERNS

Figure 2.3: Estrogen Metabolism



The DUTCH Test measures the three primary estrogens (E1, E2, E3), as well as some important metabolites, including: 2-OH-E1, 4-OH-E1, 16-OH-E1 and 2-MeOE1.

OVERVIEW

The DUTCH Test measures the three primary estrogens, as well as some important metabolites, see **Figure 2.3**. For a more complete view of metabolism, see **“The DUTCH Steroid Pathway” on page 89**.

“Estrogen dominance” is a term used to describe the hormonal imbalance that arises when estrogen levels are relatively higher than progesterone levels in the body. Estrogen dominance can occur when progesterone is low, estrogen is in excess, or when both are within range, but estrogen is relatively higher than progesterone. Overall, when someone is said to be “estrogen dominant,” their progesterone to estrogen (Pg/E2) ratio tends to be low. People can become symptomatic if they do not have enough progesterone to balance the estrogen activity in their bodies. While estrogen dominance is most commonly considered in cycling females, it can also occur in peri- and postmenopausal females. See **“Estrogen Dominance Patterns” on page 120** for examples of estrogen dominance in postmenopausal females.

B-pregnanediol/E2 ratio reference ranges for cycling females: 50-300 in the follicular phase, <100 during ovulation, and 100-500 in the luteal phase.

Some signs and symptoms of estrogen dominance include:

- Heavy bleeding
- Menstrual cramping
- Breast tenderness
- Mood swings
- PMS
- Irritability
- Anxiety
- Sleep issues
- Irregular cycles
- Weight gain
- Acne
- Fertility issues
- Fatigue
- Gallstones
- Headaches
- Clotting issues

PATTERN EXAMPLES

Estrogen dominance may be observed in various patterns on the DUTCH Test, see **Figures 2.4–2.8** for examples.

Estrogen is Elevated but Progesterone is Not

Estrogen dominance can occur with estrogen excess, see **Figure 2.4**.

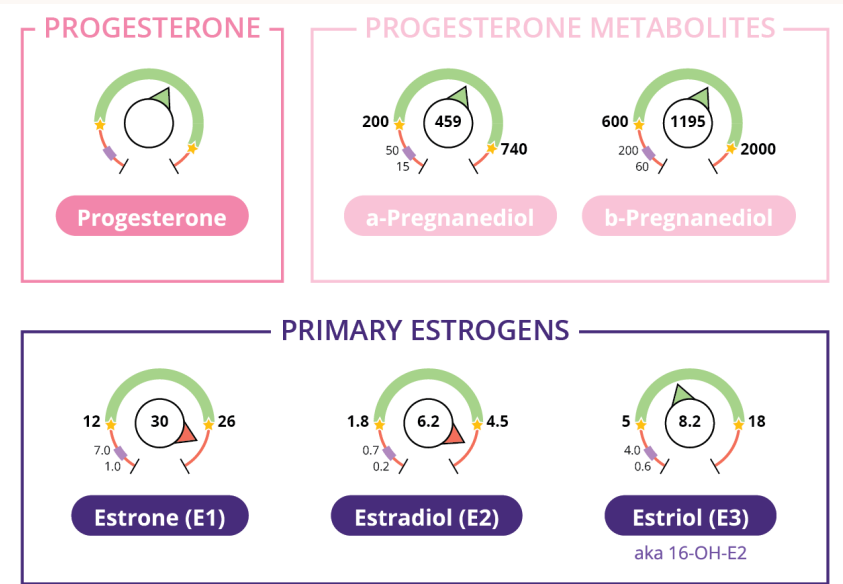


Figure 2.4: Estrogen is Elevated but Progesterone is Not

Estrogen is Within Range but Progesterone is Below Range

Estrogen dominance can occur with low progesterone, see **Figure 2.5**.

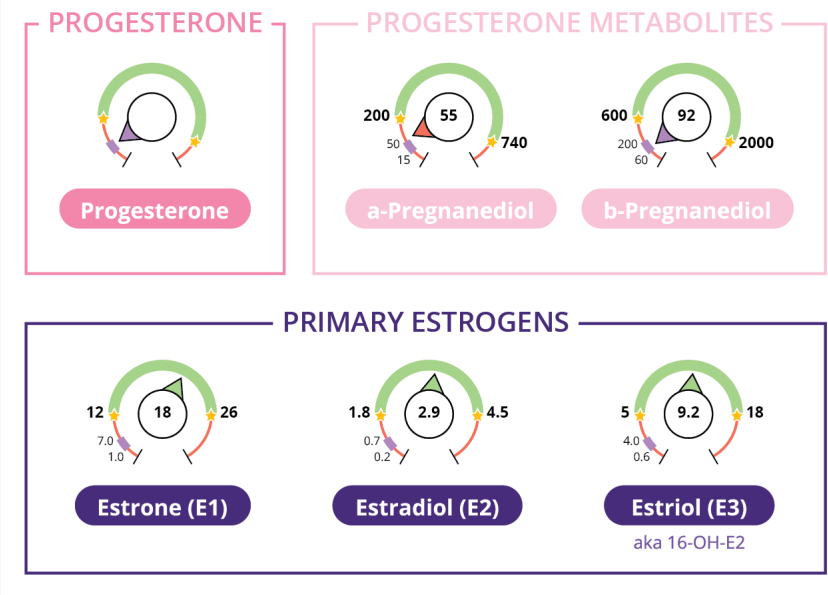


Figure 2.5: Estrogen is Within Range but Progesterone is Below Range

Estrogen is Relatively Higher than Progesterone

Estrogen dominance can occur when both estrogen and progesterone are within range, but estrogen is relatively higher than progesterone, see **Figure 2.6**.

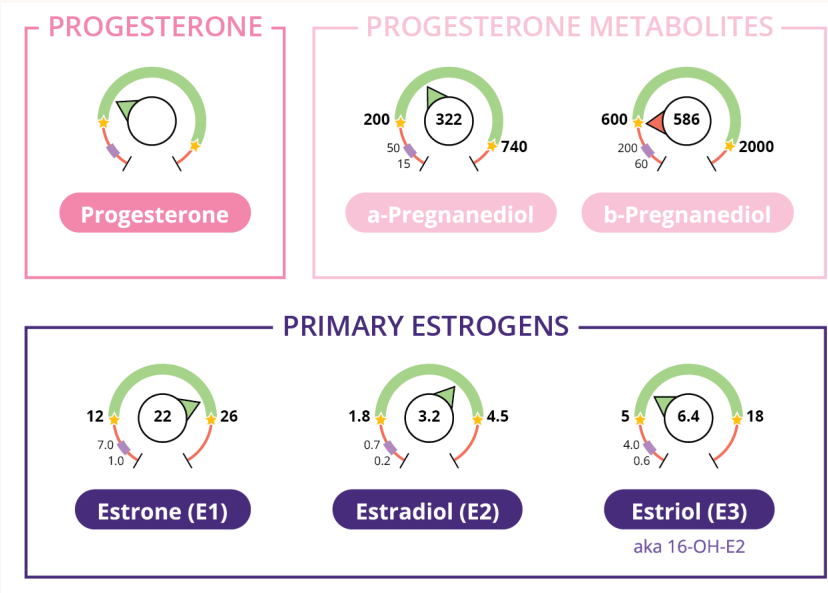


Figure 2.6: Estrogen is Relatively Higher than Progesterone

Phase 1 Estrogen Metabolism is Elevated

Estrogen dominance can also arise when progesterone and the parent estrogens, estradiol (E2), and estrone (E1), are balanced but phase 1 estrogen metabolites are elevated. This is because the 2-OH, 4-OH, and 16-OH phase 1 estrogen metabolites can actively bind to estrogen receptors, see **Figure 2.7**.

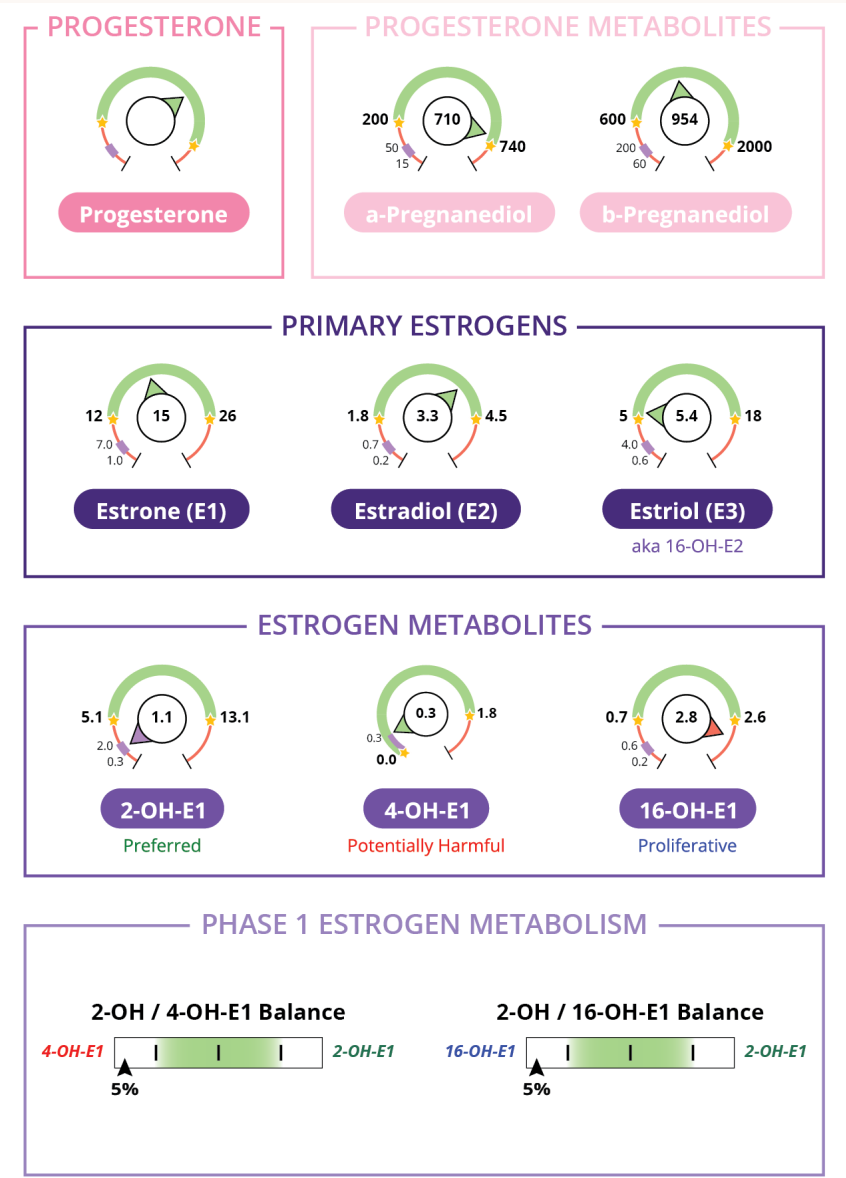


Figure 2.7: Phase 1 Estrogen Metabolism is Elevated

Estrogen is Elevated During Ovulatory Phase

Even if estrogen is well balanced with progesterone during the luteal phase in a cycling woman, estrogen dominance can arise when estrogen surges above range during the ovulatory phase, see **Figure 2.8**.

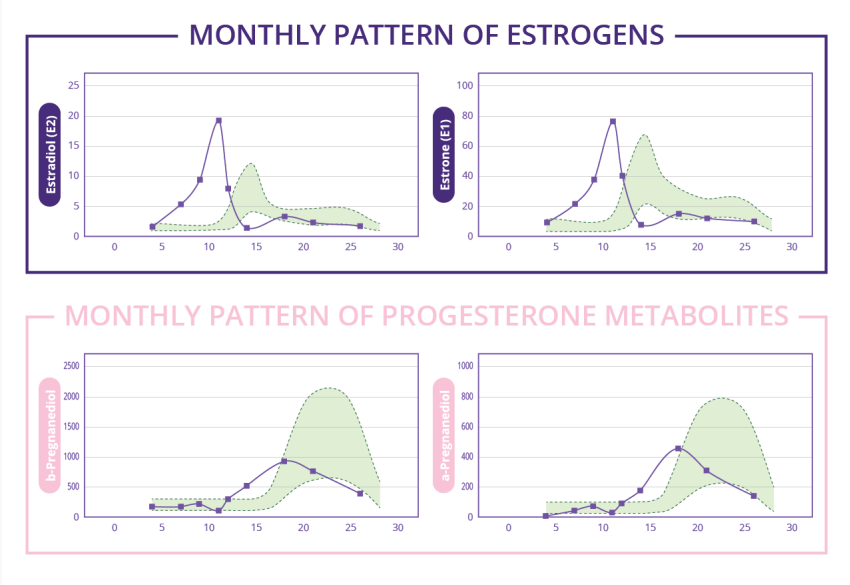
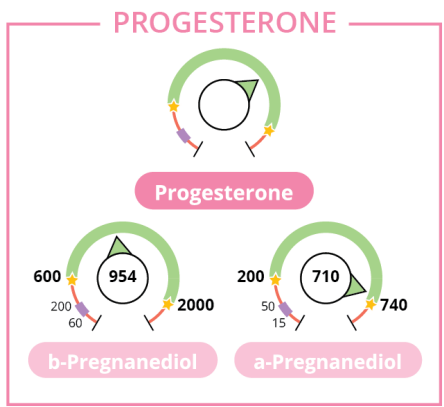


Figure 2.8: Estrogen is Elevated During Ovulatory Phase

Figure 2.9: Measuring Progesterone



The DUTCH Test measures progesterone (Pg) indirectly by taking the weighted average of two metabolites, a-pregnanediol and b-pregnanediol.

OVERVIEW

The DUTCH Test measures two progesterone metabolites in the urine: a-pregnanediol and b-pregnanediol, see **Figure 2.9**.

a-Pregnanediol modulates GABA receptors in the central nervous system (CNS) and can lead to improvements in mood and sleep. b-Pregnanediol is the major progesterone metabolite, but unlike a-pregnanediol, it does not modulate GABA receptors. These progesterone metabolites in urine strongly correlate to serum progesterone. [f] This is not true when oral or sublingual progesterone is used (see medications section).

Progesterone’s Role in Cycling Females

In cycling females, progesterone’s primary role is to stabilize the endometrium for conception, but also supports sleep, mood, and memory. In premenopausal and postmenopausal females, progesterone also protects against endometrial cancer, osteoporosis, and cardiovascular disease.

Progesterone and the HPA Axis

Studies evaluating interactions between the provoked HPA axis and progesterone are limited in both healthy and diseased individuals. The available data on cortisol and progesterone in cycling females is mixed. However, there is literature documenting that with HPA axis dysfunction; the HPG axis may be suppressed, thus decreasing estradiol and as a result, corpus luteum progesterone. Adrenal progesterone increases in response to stress and increased cortisol output. [g] [h]

Progesterone Production in Cycling Females

In cycling females, progesterone is predominantly made in the ovaries by the corpus luteum during the luteal phase.

PROGESTERONE IS LOW

Signs & Symptoms

Low Pg in cycling females may contribute to fatigue, insomnia, irritability, anxiety, weight gain, infertility, and increase endometrial cancer risk. When Pg is low relative to E2 (relative estrogen dominance), some females may experience PMS, heavy bleeding, and breast tenderness.

[f] Newman M, et al. Evaluating urinary estrogen and progesterone metabolites using dried filter paper samples and gas chromatography with tandem mass spectrometry (GC-MS/MS). BMC Chem. 2019; 13(1): 20.

[g] Chrousos GP, et al. Interactions between the hypothalamic-pituitary-adrenal axis and the female reproductive system: clinical implications. Ann Intern Med. 1998 Aug 1; 129(3):229-40.

[h] Herrera AY, et al. Stress-induced increases in progesterone and cortisol in naturally cycling women. Neurobiol Stress. 2016 Feb 11; 3:96-104.

Potential Root Causes

Low Pg in cycling females is commonly associated with anovulation, stress, breastfeeding, perimenopause, PCOS, thyroid disorders, high prolactin, medications⁸, and improper timing of DUTCH sample collection outside the midluteal phase⁹.

Less common associations include anorexia, low body weight, extreme exercise, decreased ovarian blood flow (e.g., surgery or smoking), decreased ovarian cell health, premature ovarian insufficiency, hypopituitarism, and hypogonadism.

Potential Support Considerations

In addition to assessing and treating the underlying root cause, other considerations include HPO axis support with chasteberry extract, maca, evening primrose oil or borage oil, B6, stress reduction, antioxidant support, or bioidentical Pg. Antioxidant support has also been shown to improve Pg levels by improving ovarian cell health. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

PROGESTERONE IS ELEVATED

Signs & Symptoms

Elevated Pg in cycling females may be normal and asymptomatic or can result in fatigue, increased appetite, irritability, premenstrual dysphoric disorder (PMDD), breast tenderness, and bloating before menses. Slightly elevated progesterone is typically not problematic.

Potential Root Causes

High Pg is often normal, but is also commonly associated with pregnancy, progesterone/pregnenolone supplementation¹⁰, inflammation, obesity, insulin resistance, endocrine disrupting chemicals (EDCs), and stress. Less common associations include congenital adrenal hyperplasia (CAH), nonclassical congenital adrenal hyperplasia (NCAH), and theca cell tumors (rare). With oral or sublingual Pg, high DUTCH Test Pg metabolites (relative to the luteal range) are expected.

Potential Support Considerations

In addition to assessing and treating the underlying root cause, other support considerations include reducing inflammation, regulating blood sugar, weight loss (if appropriate), and general liver support to encourage hormone detoxification. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

PROGESTERONE IS WITHIN RANGE

Consider confirming that estradiol is within the luteal range and balanced with progesterone, especially if a person reports symptoms that are cyclical in nature.

ORAL PROGESTERONE REFERENCE RANGES

Oral micronized progesterone (OMP) reference ranges for females:

- a-Pregnanediol: 2,000-9,000 ng/mg
- b-Pregnanediol: 580-3,000 ng/mg

Urinary progesterone metabolite levels strongly correlate with serum progesterone only when progesterone is not being supplemented.

When a person reports taking oral progesterone within 72 hours of sample collection, we adjust the progesterone reference ranges to reflect the a-pregnanediol and b-pregnanediol levels that are typically seen when a standard dose of 100mg is taken during the test and not skipped.

Progesterone that is within the oral progesterone reference range does not guarantee that the dose and route of administration (ROA) of progesterone is appropriate and thus does not guarantee endometrial protection when estrogen is also being supplemented. The primary information that can be gained from DUTCH for patients taking oral progesterone is the relative metabolism of progesterone in the gut. If the patient metabolizes with preference down that 5a-pathway, it is likely that the patient is making large quantities of the sedating, analgesic metabolites like a-pregnanediol and a-pregnanolone, which can act on GABA receptors and help with sleep and mood. Observing the patient’s metabolic preference may help optimize treatment or the recommended dose in some cases.

Serum equivalent values reported on page 1 of the DUTCH Complete and DUTCH Plus reports will be higher than reality when progesterone is taken orally or sublingually.

PROGESTERONE METABOLISM

OVERVIEW OF 5-ALPHA VS 5-BETA

The DUTCH Test measures progesterone indirectly by taking the weighted average of a-pregnanediol and b-pregnanediol, see **Figure 2.10**. For a more complete view of metabolism, see **“The DUTCH Steroid Pathway” on page 89**.

Progesterone is metabolized into a-pregnanediol by 5a-reductase and b-pregnanediol by 5b-reductase. It may be helpful to know if there is a 5a or 5b preference because the alpha progesterone metabolites modulate GABA receptors and may help with mood and sleep. When assessing for an alpha or beta preference, look at the 5a-Metabolism (P4) slider.

5a-Reductase and 5b-reductase are also involved in androgen (i.e., DHEA and testosterone) and cortisol metabolism. Therefore, the body’s overall preference towards alpha or beta metabolism can be further assessed by comparing alpha vs. beta metabolite levels. Alpha metabolites on the DUTCH Test include a-pregnanediol, androsterone, 5a-DHT, 5a-androstanediol, and a-THF. Beta metabolites on the DUTCH Test include b-pregnanediol, etiocholanolone, 5b-androstanediol, b-THF, and b-THE.

CLINICAL SIGNIFICANCE

a-Pregnanediol Preference

a-Pregnanediol is a GABA receptor modulator that supports mood and sleep. However, in some cycling females it exerts a paradoxical effect that has been associated with PMDD¹¹. There is some evidence that a a-pregnanediol preference may increase breast cancer risk, however, more studies are needed to clarify this relationship.

Increased 5a-reductase activity is associated with inflammation, insulin resistance, obesity, DHEA supplementation, PCOS, and certain genetic makeups. Females supplementing with oral Pg may see greater improvements in mood and sleep if they favor the alpha pathway.

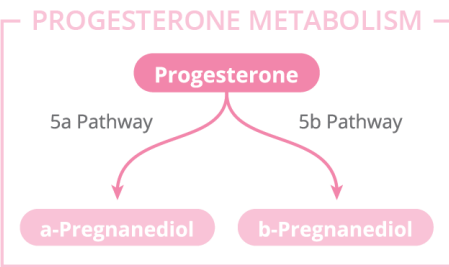
b-Pregnanediol Preference

b-Pregnanediol is the major progesterone metabolite, but unlike a-pregnanediol, it does not exert calming effects in the brain through GABA receptor modulation.

5b-Reductase activity is increased by insulin resistance, high triglycerides, PCOS, and certain genetic makeups. People may also favor the beta pathway if they are taking a prescription 5a-blocker (finasteride, dutasteride, etc.)¹² or natural 5a-blockers.

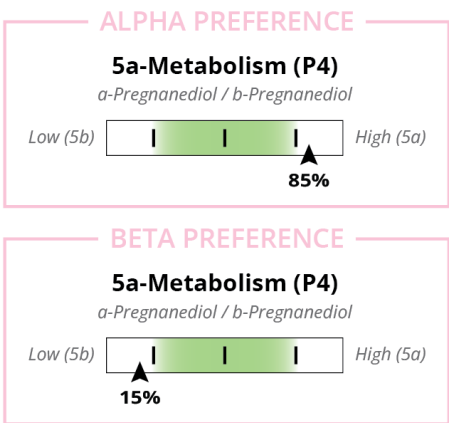
When oral Pg is supplemented, females favoring the beta pathway may need a higher Pg dose than females favoring the alpha pathway to see similar improvements in mood and sleep. In these cases, GABA support may also be considered. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

Figure 2.10: Progesterone Metabolism



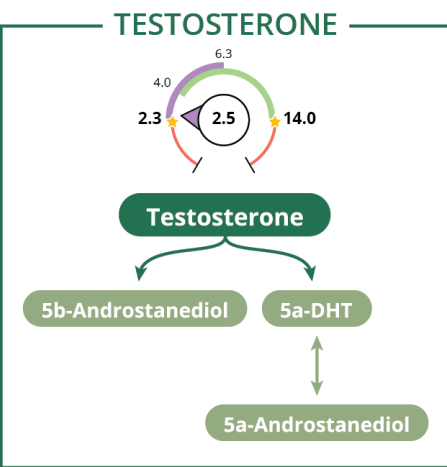
It may be helpful to know if there is a 5a or 5b preference, because the alpha progesterone metabolites modulate GABA receptors and may help with mood and sleep.

Figure 2.11: 5a vs 5b Progesterone Preference



Alpha progesterone metabolites modulate GABA receptor activity and may help to improve mood and sleep. The patient on oral progesterone (OMP) who favors alpha progesterone metabolism (top) may experience more calming GABA effects than the patient on OMP who favors beta progesterone metabolism (bottom), however this also depends on overall progesterone levels.

Figure 2.12: Measuring Testosterone



The DUTCH Test reflects bioavailable testosterone, as well as its downstream metabolites: 5a-DHT, 5a-androstanediol, and 5b-androstanediol.

OVERVIEW

The DUTCH Test reflects bioavailable testosterone. Testosterone’s activity may be evaluated by looking at its downstream metabolites, 5a-DHT, 5a-androstanediol, and 5b-androstanediol, see **Figure 2.12**.

In target tissues, testosterone is activated to 5a-DHT by the enzyme 5a-reductase. 5a-DHT is three times more potent than testosterone and is made and metabolized locally in the tissues to 5a-androstanediol. Therefore, urinary 5a-androstanediol may be a better marker of tissue 5a-DHT activity than urinary 5a-DHT. In addition to the 5a-DHT and 5a-androstanediol, the downstream alpha metabolite of DHEA (androsterone) can be used to evaluate tissue androgen activity.

NOTE

Some 5a-DHT and 5a-androstanediol can also be formed from DHEA. Thus, if 5a-DHT and/or 5a-androstanediol are elevated, it may be helpful to compare total DHEA and testosterone to better understand where the excess androgens are originating from (the adrenals or the ovaries). In females, if DHEA-S or total DHEA is high, the source of excess androgens is likely the adrenal glands. Conversely, if these are within range, but testosterone and its metabolites are high, the source may be ovarian.

Testosterone can also be metabolized down the less androgenic beta pathway. The enzyme 5b-reductase is concentrated in the liver (as opposed to target tissues) and converts testosterone into 5b-androstanediol. This testosterone metabolite does not correlate with classic androgen symptoms such as body hair, libido, muscle mass, and acne due to the low androgenic potential of beta metabolites.

NOTE

Certain genetic profiles can cause testosterone to be falsely low in the urine, see **“UGT Deletion” on page 72** for more information.

Testosterone’s Role in Cycling Females

In cycling females, testosterone supports muscle, strength, stamina, healthy weight, bone, skin, hair, mood, memory, sexual function, fertility, cardiovascular health, and estradiol levels (though it contributes to estradiol levels more in postmenopausal females).

Testosterone Production in Cycling Females

In cycling females, testosterone is made in the ovaries (about 25%) and the adrenals (about 25%), and the remaining 50% is aromatized in peripheral tissues (primarily fat) from androstenedione and DHEA. Testosterone production peaks in the third and fourth decades of life (20s and 30s) and declines thereafter.

Testosterone age-dependent reference ranges for females:

- Premenopausal: 4-14 ng/mg
- Postmenopausal: 2.3-6.3 ng/mg

TESTOSTERONE IS LOW

NOTE

Individuals with a UGT deletion (genetic variant) may have falsely low urinary testosterone, 5a-DHT, and 5b-androstanediol. Please see **“UGT Deletion” on page 72** for more information on this genetic deletion and the impact on DUTCH testing.

Signs & Symptoms

Low testosterone in cycling females may be associated with fatigue, weight gain, difficulty building muscle mass, bone loss, mood issues, brain fog, low libido, and sexual dysfunction.

Potential Root Causes

Low testosterone in cycling females may be associated with aging, elevated sex hormone binding globulin (SHBG), low adrenal output (HPA axis dysfunction), poor ovarian production, surgically removed ovaries, diabetes, hypothyroidism, sleep disturbances, endocrine disrupting chemicals (EDCs), zinc deficiencies, certain medications¹³, and upregulated aromatase activity¹⁴.

Low testosterone in females is less commonly associated with traumatic brain injuries, prolactinoma, extremely low body fat percentage, extremely low calorie intake, stress, overexercising, low cholesterol (LDL < 40mg/dL), and suboptimal mitochondrial function.

Potential Support Considerations

In addition to treating the underlying cause, obtain serum total, free, and bioavailable testosterone levels and if low consider zinc, herbal testosterone support, HPA axis support, blood sugar regulation, improving sleep, DHEA¹⁵, and/or testosterone replacement therapy¹⁶. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

NOTE

If E1 and E2 are elevated, consider natural aromatase inhibition¹⁷.

TESTOSTERONE IS ELEVATED

Signs & Symptoms

Elevated testosterone in cycling females has been associated with acne, oily skin, increased body/facial hair, thinning scalp hair, androgenic alopecia, and mood disturbance (aggression, irritability, etc.).

Mildly elevated androgens that are not accompanied with symptoms of androgen excess may be normal for some women.

Potential Root Causes

Elevated testosterone cycling in females may be associated with PCOS, low SHBG, downregulated aromatase activity¹⁸, stress, obesity, blood sugar dysregulation,

inflammation, testosterone and/or DHEA supplementation¹⁹, transference (from a partner, the gym, etc.), medications²⁰, or sample contamination²¹.

Less common associations include thyroid issues, NCAH, virilizing tumors.

Potential Support Considerations

In addition to treating the underlying cause, other considerations include addressing inflammation, regulating blood sugar, weight loss if appropriate, supporting the HPA axis, supporting liver detoxification, flaxseeds, myo-inositol, herbal anti-androgens, and medications such as metformin and spironolactone, if appropriate. See “Appendix B: Potential Support Considerations” on page 191 for more information.

TESTOSTERONE IS WITHIN RANGE

When testosterone is within range, take the alpha androgen levels (5a-DHT, 5a-androstanediol, and androsterone) into consideration, as these also have androgenic actions in the body. If there are androgen excess symptoms, but all these androgens are within range or low, consider other causes for these symptoms, such as hypothyroidism, stress, autoimmune issues, mineral deficiencies, etc.

Always confirm DUTCH results with serum testosterone before treatment, as the UGT genetic variant can result in falsely low urinary testosterone, 5a-DHT, and 5b-androstanediol. Please see “UGT Deletion” on page 72 for more information on this genetic deletion and the impact on DUTCH testing.

OVERVIEW

The DUTCH Test measures three DHEA metabolites: DHEA-S, etiocholanolone, and androsterone, see **Figure 2.13**.

DHEA is considered a pro-hormone, as most is converted at the tissue level to more potent androgens and estrogens. DHEA in the adrenal gland is sulfated to DHEA-S, a form that is more stable in serum and can act as a DHEA reserve. The best way to assess the total adrenal androgen production is to add up the DHEA-S, etiocholanolone, and androsterone metabolites to equal the total DHEA production, also known as the total adrenal androgen production. It is our experience that total DHEA production may correlate most strongly with serum DHEA-S.

NOTE

Total DHEA = DHEA-S + etiocholanolone + androsterone

DHEA's Role in Cycling Females

DHEA supports muscle, bone, sexual function, fertility, brain health, immune function, and cardiovascular health.

DHEA's Production in Cycling Females

In cycling females, DHEA is primarily made in the adrenal zona reticularis (about 80%) and the rest is made in the ovaries (about 10%) and brain (about 10%). 100% of DHEA-S is made in the adrenals. DHEA production peaks in young adulthood (20s) and then declines with age.

Total DHEA age-dependent reference ranges for cycling females:

- Premenopausal: 60-750ng/mg
- Postmenopausal: 20-270ng/mg

DHEA IS LOW

Signs & Symptoms

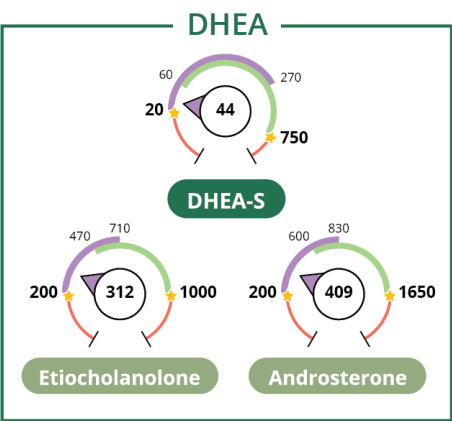
Low DHEA in cycling females may be associated with fatigue, low libido, depression, infertility, diabetes, heart disease, inflammation, and immune disorders.

Potential Root Causes

Low DHEA in cycling females may be associated with older age, decreased adrenal synthesis (HPA axis dysfunction) secondary to chronic stress, inflammation and inflammatory syndromes, blood sugar dysregulation, hypothyroidism, and medications such as glucocorticosteroids, opioids, budesonide inhalers, and metformin.

Higher DHEA-S relative to lower total DHEA may be associated with upregulated SULT2A1 activity (which sulfates DHEA) or a lower STS enzyme activity (removes the “S” from DHEA-S).

Figure 2.13: Measuring DHEA



The DUTCH Test measures three DHEA metabolites including: DHEA-S, etiocholanolone, and androsterone.

Potential Support Considerations

In addition to treating the underlying cause, other considerations include DHEA replacement therapy²², addressing chronic inflammation, regulating blood sugar, supporting liver detoxification, HPA axis support, and stress reduction, which may include calming herbal support, parasympathetic nervous system (PNS) support, and GABA support. See “Appendix B: Potential Support Considerations” on page 191 for more information.

DHEA IS ELEVATED

Signs & Symptoms

Elevated DHEA in cycling females has been associated with androgen excess symptoms including oily skin, acne, sleep problems, headaches, and mood disturbances.

Potential Root Causes

Elevated DHEA in cycling females may be associated with DHEA supplementation²³, stress, high adrenal cortisol output (HPA axis dysfunction), inflammation, blood sugar dysregulation, alcohol, nicotine, PCOS, testosterone supplementation²⁴, and medications such as Alprazolam, Anastrozole, Methylphenidate, Amlodipine, Diltiazem, and Bupropion.

Less common associations include NCAH, hyperprolactinemia, and an adrenal tumor.

Potential Support Considerations

In addition to treating the underlying cause, other considerations include addressing chronic inflammation, regulating blood sugar, supporting liver detoxification, HPA axis support, and stress reduction, which may include calming herbal support, PNS support, and GABA support. See “Appendix B: Potential Support Considerations” on page 191 for more information.

ANDROGEN METABOLISM

OVERVIEW OF 5-ALPHA VS 5-BETA

The DUTCH Test measures bioavailable testosterone, DHEA-S, and their metabolites, see Figure 2.14. For a more complete view of metabolism, see “The DUTCH Steroid Pathway” on page 89.

Regarding androgen metabolism, a person may favor the more androgenic alpha pathway, the less androgenic beta pathway, or a balance between the two pathways.

5a-Reductase converts DHEA and testosterone into the alpha androgen metabolites: androsterone, 5a-DHT, and 5a-androstanediol. 5a-DHT is testosterone’s active metabolite. It is three times more potent than testosterone, and if elevated, may contribute to androgen excess symptoms. 5a-DHT is a peripheral hormone, and research shows that 5a-androstanediol may be a better marker of 5a-DHT tissue activity. [i]

5b-Reductase converts DHEA and testosterone into the beta androgen metabolites: etiocholanolone and 5b-androstanediol. The beta androgen metabolites are generally less androgenic than the alpha androgen metabolites and are formed in the liver, not the tissues. Therefore, these beta metabolites are less likely to contribute to androgen excess symptoms. For example, a person who has elevated testosterone may not experience androgen excess symptoms if they metabolize most of their testosterone down the less androgenic beta pathway.

NOTE

The slider on the DUTCH Test, see Figure 2.15, shows the relative ratio of 5a to 5b metabolites but does not express the absolute value of 5a-DHT and 5a-androstanediol, or if 5a-reductase inhibition is or is not indicated. Consider symptoms and look at the 5a-DHT, androsterone, and 5a-androstanediol results if high androgen symptoms are a concern.

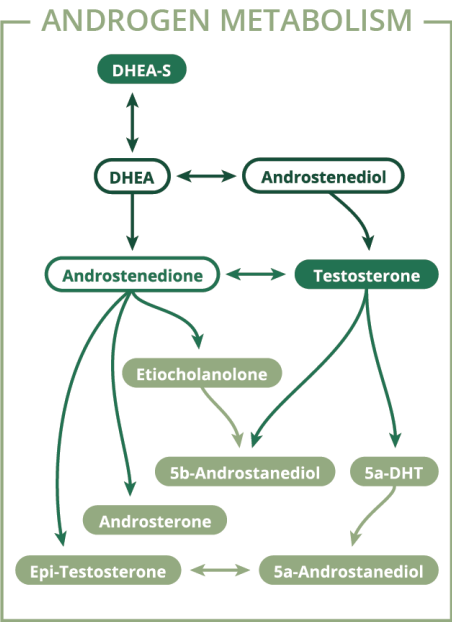
5a-reductase and 5b-reductase are also involved in androgen (i.e., DHEA and testosterone) and cortisol metabolism. Therefore, the body’s overall preference towards alpha or beta metabolism can be further assessed by comparing alpha vs. beta metabolite levels. Alpha metabolites on the DUTCH Test include a-pregnanediol, androsterone, 5a-DHT, 5a-androstanediol, and a-THF. Beta metabolites on the DUTCH Test include b-pregnanediol, etiocholanolone, 5b-androstanediol, b-THF, and b-THE.

CLINICAL SIGNIFICANCE

5a-Reductase Preference

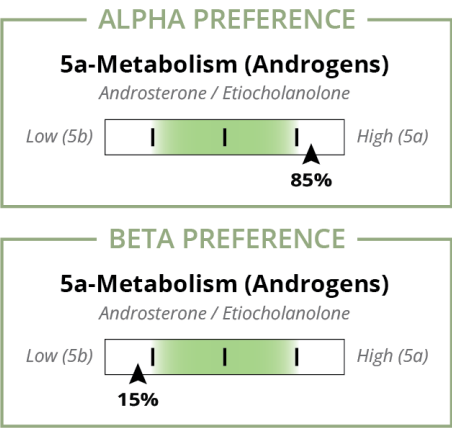
A metabolic preference for the alpha pathway may lead to elevated androsterone, 5a-DHT, 5a-androstanediol, and excess androgen symptoms. Inflammation, high

Figure 2.14: Androgen Metabolism



The DUTCH Test measures several androgenic metabolites that stem from testosterone and DHEA, to provide a more complete picture of a patients’ metabolic health.

Figure 2.15: 5a vs 5b Androgen Preference



It may be helpful to know if there is a 5a or 5b androgen preference, because a beta preference (bottom) may exacerbate signs and symptoms of low androgens (e.g., low libido, fatigue, weight gain), while alpha preference (top) may exacerbate signs and symptoms of high androgens (e.g., scalp hair loss, acne, body hair growth)

[i] Trabert B, et al. Progesterone and Breast Cancer. Endocr Rev. 2020 Apr 1; 41(2):320–44.

stress lifestyles, obesity, and blood sugar dysregulation can upregulate 5a-reductase. Alpha preference is often seen with PCOS.

Consider addressing these root causes if the goal is to decrease the alpha preference. Also consider 5a-reductase herbal blockers and medications such as metformin, spironolactone, or finasteride²⁵, if appropriate. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

NOTE

If DHEA and testosterone are low, a metabolic preference for the 5a-reductase enzyme may not necessarily lead to elevated 5a-DHT levels and symptoms of androgen excess.

5b-Reductase Preference

A metabolic preference for the beta pathway may lead to low androsterone, 5a-DHT, 5a-androstenediol, and low androgen symptoms.

Certain genetic makeups, 5a-reductase herbal blockers, and medications such as spironolactone and finasteride²⁶ may contribute to a beta preference, so consider addressing these root causes if the goal is to decrease the beta preference. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

Consider upregulating 5a-reductase activity with high intensity interval training (HIIT), weight resistance exercises, and supplements such as forskolin and pine pollen. Low androgen symptoms associated with low DHEA and/or testosterone may improve by directly addressing DHEA and testosterone levels.

NOTE

If DHEA and testosterone are elevated, a metabolic preference for the beta pathway may be beneficial, as it may help to keep 5a-DHT within range.

ANNOTATIONS

- 1 Aromatase activity may be downregulated by enterolactone, apigenin, chrysin and other flavonoids, white button mushrooms, grape seed extract, red wine procyanidin dimers, PCOS, antifungal medications, metformin, glyphosate, smoking, antiepileptic drugs, and pharmaceutical aromatase inhibitors. Genetic SNPs in CYP19A1 may also affect aromatase activity.
- 2 Ensure the person collected the samples at the correct time in their cycle, as the DUTCH Test estradiol reference ranges reflect midluteal levels. For proper evaluation of estrogen and progesterone in the luteal phase, it is best if the first day of menses occurs 4-10 days after collection. Ideally, a female will collect 5-7 days after ovulation, or on cycle days 19-22 for a 28-day cycle. If the person did not collect during the midluteal phase, look at “Additional Normal Ranges” on page 2 of the DUTCH Complete and DUTCH Plus, or page 1 of the DUTCH Sex Hormones panel when interpreting the results.
- 3 Medications that can contribute to low estradiol include some forms of hormonal birth control (pill, patch, ring, implant, injection), progestins, gonadotropin-releasing hormone agonists, opioid pain medications, glucocorticoids, and NSAIDS.
- 4 DIM and indole-3-carbinol (I3C) are sometimes used to induce CYP-1a1 (the preferred pathway towards 2-OH), however be mindful that they also tend to lower E1 and E2 which may not be appropriate for every person. When using DIM and/or I3C, it is important that phase 2 detoxification is well supported so that the phase 1 metabolites do not build up in the body and increase propensity for oxidative damage. If on estrogen therapy (ET), a relatively higher dose of estrogen may be needed when used in combination with estrogen-lowering compounds such as DIM and/or I3C to achieve desired clinical outcomes. If on Tamoxifen, note that DIM and I3C may render Tamoxifen less effective.
- 5 Aromatase activity may be upregulated by obesity, inflammation, high insulin, forskolin, quercetin, genistein (bioflavonoids), white peony and licorice root, atrazine, and rutin. Genetic SNPs in CYP19A1 may also affect aromatase activity.
- 6 Ensure the person collected the samples at the correct time in their cycle, as the DUTCH Test estradiol reference ranges reflect midluteal levels. For proper evaluation of estrogen and progesterone in the luteal phase, it is best if the first day of menses occurs 4-10 days after collection. Ideally, a female will collect 5-7 days after ovulation, or on cycle days 19-22 for a 28-day cycle. If the person did not collect during the midluteal phase, look at “Additional Normal Ranges” on page 2 of the DUTCH Complete and

- DUTCH Plus, or page 1 of the DUTCH Sex Hormones panel when interpreting the results.
- 7 Use caution when interpreting estrogen results if estrogen was supplemented orally or sublingually, as the portion that is swallowed undergoes first-pass metabolism and results in elevated urinary estrogen metabolites that do not correlate with serum levels. We suggest stopping oral estrogen 72 hours prior to collection to avoid false elevations in estrogen metabolites. Note that high doses of oral or sublingual DHEA and testosterone may also lead to elevated urinary estrogen metabolites. It may be suggested to stop oral DHEA 48 hours and testosterone 72 hours prior to sample collection.
 - 8 Medications that can contribute to low Pg include some forms of hormone birth control (pill, patch, ring, implant, injection), progestins, gonadotropin-releasing hormone agonists, some fertility medications, opioid pain medications, glucocorticoids, and NSAIDS.
 - 9 Ensure the person collected the samples at the correct time in their cycle, as DUTCH progesterone reference ranges reflect midluteal levels. For proper evaluation of estrogen and progesterone in the luteal phase, it is best if the first day of menses occurs 4-10 days after collection. Ideally, a female will collect 5-7 days after ovulation, or on cycle days 19-22 for a 28-day cycle. If the person did not collect during the midluteal phase, look at the additional reference ranges on page 2 of the DUTCH Complete and DUTCH Plus reports, or on page 1 of the DUTCH Sex Hormones panel when interpreting the results.
 - 10 Urinary progesterone metabolite levels strongly correlate with serum progesterone only when progesterone is not being supplemented. Use caution when interpreting progesterone results if progesterone or pregnenolone was supplemented orally or sublingually within 72 hours of sample collection, as the portion that is swallowed undergoes first-pass metabolism and results in elevated urinary metabolites that do not correlate with serum levels. See “Oral Progesterone Reference Ranges” section above for more information. Note that we do not have reference ranges for sublingual progesterone due to the high variability in the amount of progesterone that is swallowed.
 - 11 In some females, the alpha progesterone metabolites exert a paradoxical effect on the GABA receptors and instead of promoting a sense of calm, they promote anxiety and irritability. This paradoxical effect has been associated with PMDD. Females prone to the paradoxical effect have the most reduction in symptoms when the alpha progesterone metabolites are low (follicular phase levels) or high (above luteal phase levels) and tend to be most symptomatic during their luteal phase. The

- pharmaceutical 5a-reductase inhibitor dutasteride has been shown to significantly improve PMDD symptoms, and some persons see benefits from natural 5a-reductase blockers (saw palmetto/beta-sitosterol, reishi, nettle root, epigallocatechin gallate (EGCG), and Pygeum africanum) due to their effect on lowering the alpha progesterone metabolite levels. Oppositely, increasing progesterone with oral micronized progesterone may increase alpha progesterone metabolites (including allopregnanolone) so much that the GABA receptors become calming again. Note that practitioners may choose to use 5a-reductase blockers OR oral progesterone to impact PMDD symptoms, but usually do not use both at the same time.
- 12 In males and females, the 5a-reductase inhibitors, finasteride and dutasteride, may cause irreversible sexual dysfunction and infertility.
 - 13 Medications that may contribute to low testosterone include glucocorticosteroids, opioids, Accutane, spironolactone, and some oral contraceptive pills.
 - 14 Aromatase activity may be upregulated by obesity, inflammation, high insulin, forskolin, quercetin, genistein (bioflavonoids), white peony and licorice root, atrazine, and rutin. Genetic SNPs in CYP19A1 may also affect aromatase activity.
 - 15 Use caution with oral DHEA supplementation as it may elevate estrogen.
 - 16 Testosterone should always be evaluated and confirmed in the serum before initiating testosterone replacement therapy (TRT) for low testosterone.
 - 17 Aromatase activity may be downregulated by enterolactone, apigenin, chrysin and other flavonoids, white button mushrooms, grape seed extract, red wine procyanidin dimers, PCOS, antifungal medications, metformin, glyphosate, smoking, antiepileptic drugs, and pharmaceutical aromatase inhibitors. Genetic SNPs in CYP19A1 may also affect aromatase activity.
 - 18 Aromatase activity may be downregulated by enterolactone, apigenin, chrysin and other flavonoids, white button mushrooms, grape seed extract, red wine procyanidin dimers, PCOS, antifungal medications, metformin, glyphosate, smoking, antiepileptic drugs, and pharmaceutical aromatase inhibitors. Genetic SNPs in CYP19A1 may also affect aromatase activity.
 - 19 Use caution when interpreting testosterone results if oral or sublingual DHEA or testosterone were supplemented, as these undergo first-pass metabolism which results in elevated urinary metabolites that do not correlate with serum levels.
 - 20 Medications that may contribute to elevated testosterone include aromatase inhibitors, clomiphene citrate (a

- selective estrogen receptor modulator (SERM)), and luteinizing hormone (LH), growth hormone (GH), and gonadotropin-releasing hormone (GnRH) analogs (hCG, gonadorelin, kisspeptin, etc.).
- 21 If testosterone is elevated but the downstream androgen metabolites are not (5a-DHT, androsterone, 5a-androstanediol, etiocholanolone, and 5b-androstanediol) consider the possibility of testosterone sample contamination from someone using TRT (testosterone replacement therapy).
 - 22 Use caution with oral DHEA supplementation, as it may elevate estrogens in addition to increasing testosterone.
 - 23 Use caution when interpreting total DHEA if testosterone replacement therapy (TRT) and/or DHEA was taken. Testosterone can metabolize into and elevate androsterone and etiocholanolone. As total DHEA is calculated by adding up DHEA-S + etiocholanolone + androsterone, TRT (or even high endogenous testosterone) may elevate this calculated marker. Additionally, oral, or sublingual supplemented testosterone, and DHEA undergo first-pass metabolism in the gut and liver, which results in elevated urine metabolites that do not correlate with serum levels. Consider stopping oral DHEA 48 hours prior to testing and oral testosterone 72 hours prior to testing to avoid false elevations.
 - 24 Use caution when interpreting total DHEA if testosterone replacement therapy (TRT) and/or DHEA was taken. Testosterone can metabolize into and elevate androsterone and etiocholanolone. As total DHEA is calculated by adding up DHEA-S + etiocholanolone + androsterone, TRT (or even high endogenous testosterone) may elevate this calculated marker. Additionally, oral, or sublingual supplemented testosterone and DHEA undergo first-pass metabolism in the gut and liver, which results in elevated urine metabolites that do not correlate with serum levels. Consider stopping oral DHEA 48 hours prior to testing and oral testosterone 72 hours prior to testing to avoid false elevations.
 - 25 In males and females, finasteride and dutasteride may cause irreversible sexual dysfunction and infertility.

Sex Hormones: Postmenopausal Female

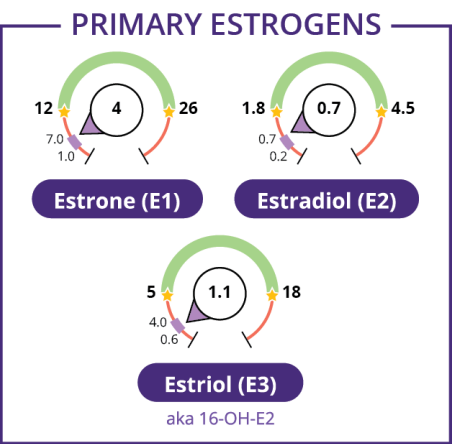
Introduction

Postmenopausal females are the most common type of patient that providers order DUTCH tests for, often as a baseline measure or used in conjunction with monitoring various forms of hormone therapy (HT).

You can gain a lot of knowledge about postmenopausal women from the DUTCH Test. Some of the common reasons for ordering include understanding hormonal symptoms, ensuring that estrogen metabolism is efficient before starting estrogen therapy (ET), evaluation of symptoms of estrogen dominance, and monitoring therapy to ensure that the patient is in an ideal range.

In this section of the guide, we will share with you the most essential information that you need to interpret your postmenopausal female patients' results, including how to interpret each section of their reproductive hormone pages. To understand their HPA axis function, please refer to the separate section in this guide on cortisol and the HPA axis.

Figure 3.1: Measuring Estrogen



The DUTCH Test measures the three primary estrogens: Estrone, Estradiol, and Estriol.

OVERVIEW

The DUTCH Test measures the three primary estrogens: Estrone (E1), Estradiol (E2), and Estriol (E3), see **Figure 3.1**.

Estradiol has the strongest stimulatory effect on estrogen receptors while estriol has the weakest effect. Estrone and estradiol can interconvert via 17b-hydroxy steroid dehydrogenase (HSD) and estriol is an estradiol and 16-OH-E1 downstream metabolite.

Estrogen’s Role in Postmenopausal Females

In postmenopausal females, estradiol is beneficial for bone health, insulin sensitivity, healthy weight management, neurotransmitter balance, sleep, mood, concentration, memory, hair, skin, vaginal pH and lubrication, and cardiovascular health. Estradiol excess, or estradiol that is not well balanced with progesterone, may have adverse health consequences, which includes endometrial cancer, gallstones, clotting issues, breast tenderness, and abnormal uterine bleeding (AUB). See **“Estrogen Dominance Patterns” on page 120** for more information about the progesterone to estrogen balance in postmenopausal females.

Estrogen Production in Postmenopausal Females

In postmenopausal (PMP) females, estrone is the predominant estrogen. Estradiol and estrone are primarily synthesized in fat tissue from adrenal androgen aromatization, e.g., androstenedione to estrone and testosterone to estradiol.

ESTRADIOL IS LOW

Signs & Symptoms

Low E2 in PMP females may result in hot flashes, night-sweats, insomnia, joint pain, skin issues, low sex drive, mood issues, brain fog, vaginal dryness, weight gain, decreased bone mineral density, and increased cardiovascular disease risk.

Potential Root Causes

In PMP females, E2 is made from adrenal androgens, thus low E2 can be associated with low adrenal DHEA and androstenedione production, and downregulated aromatase activity²⁷. It is plausible that low E2 may occur secondary to extremely low body fat percentages, low cholesterol (LDL < 40mg/dL), poor mitochondrial function, or diindolylmethane (DIM)/I3C²⁸.

Potential Support Considerations

In addition to assessing and treating the underlying root cause, other considerations include herbal and dietary E2 support, E2 replacement therapy (ET)²⁹, androgen support if low, and HPA axis support. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

ESTRADIOL IS ELEVATED

Signs & Symptoms

PMP females not on menopausal hormone therapy (MHT), with E2 and estrogen metabolite levels higher than the menopausal reference range, but below a cycling female’s luteal range, may still experience low E2 symptoms (see low E2 symptoms above).

PMP females on estrogen therapy (ET) may experience high E2 symptoms (estrogen dominant symptoms), e.g., AUB, fibroid growth, tender breasts, weight gain, acne, headaches, mood disturbances, swelling, clotting issues, and gallstones.

PMP females with a uterus who are prescribed MHT and have high E2 levels that are not balanced with an appropriate Pg dose may be at increased risk for endometrial cancer.

Potential Root Causes

High E2 in PMP females not on ET may be normal or associated with elevated androgens, obesity, blood sugar dysregulation, inflammation, or upregulated aromatase activity³⁰. In PMP females prescribed DHEA and/or testosterone (T), these hormones may be metabolized to E1 and/or E2, respectively. ET may also elevate systemic E2 levels, but this is dependent on the dose and ROA.

NOTE

Interpret results with caution if oral or sublingual DHEA, testosterone, E2 is being supplemented³¹.

Potential Support Considerations

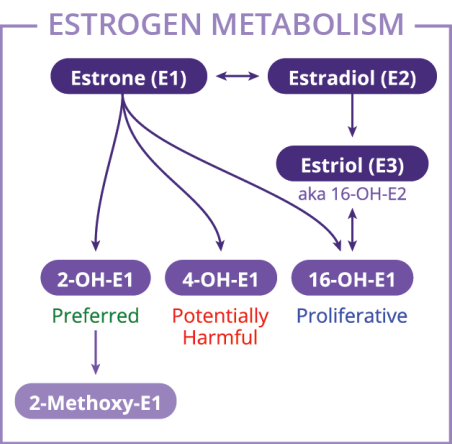
In addition to assessing and treating the underlying root cause, other considerations include supporting estrogen detoxification and healthy metabolism patterns, supporting the HPA axis, lowering inflammation, regulating blood sugar, weight loss (if appropriate), lowering androgens if elevated, and general liver support to further encourage hormone detoxification. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

ESTRADIOL IS WITHIN RANGE

ET³² may still be appropriate on a case-by-case basis even when E2 is within the normal PMP range. E2 improves bone mineral density, menopausal symptoms, and decreases cardiovascular mortality.

ESTROGEN DOMINANCE PATTERNS

Figure 3.2: Estrogen Metabolism



The DUTCH Test measures the three primary estrogens (E1, E2, E3), as well as some important metabolites, including: 2-OH-E1, 4-OH-E1, 16-OH-E1, and 2-MeOE1.

OVERVIEW

The DUTCH Test measures the three primary estrogens, as well as some important metabolites, see **Figure 3.2**. For a more complete view of metabolism, see **“The DUTCH Steroid Pathway”** on page 89.

“Estrogen dominance” is a term used to describe the hormonal imbalance that arises when estrogen levels are relatively higher than progesterone levels in the body. Estrogen dominance can occur in a postmenopausal female when estrogen is in excess, phase 1 estrogen metabolites are elevated, or when a female uses estrogen therapy (ET) without (or inadequate) progesterone therapy. Overall, the progesterone to estrogen (Pg/E2) ratio tends to be low. People can become symptomatic if they do not have enough progesterone to balance the estrogen activity in their bodies.

Some signs and symptoms of estrogen dominance in PMP females include:

- Endometrial hyperplasia
- Abnormal uterine bleeding (AUB)
- Possible fibroid growth
- Breast tenderness
- Mood issues
- Weight gain
- Acne
- Fatigue
- Gallstones
- Headaches
- Clotting issues

PATTERN EXAMPLES

Estrogen is Relatively Higher than Progesterone

Estrogen dominance can occur when estrogen is relatively higher than progesterone, see **Figure 3.3**. Additionally, if all three phase 1 estrogen metabolites are pointing above the PMP range and into the luteal range, it creates a pattern that tends to be seen in postmenopausal females who are overweight with high androgens.

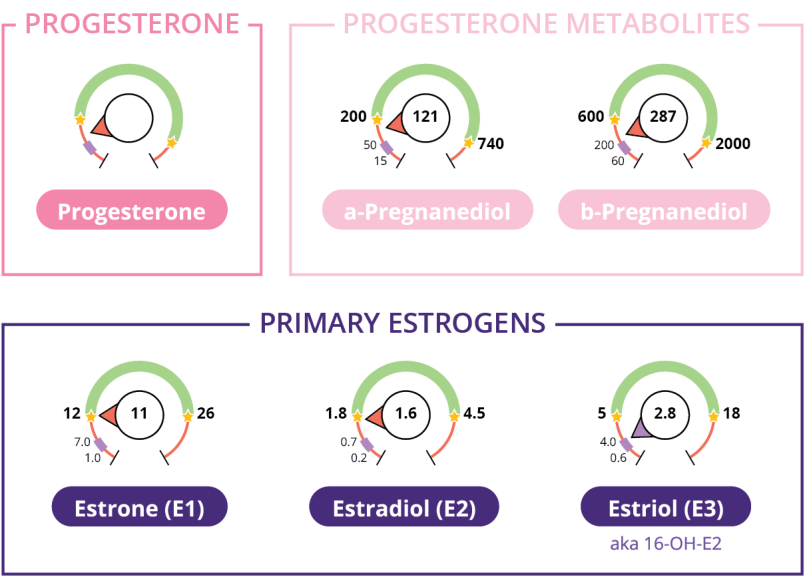


Figure 3.3: Estrogen is Relatively Higher than Progesterone
Estrogen dominance can occur when estrogen is relatively higher than progesterone.

Phase 1 Estrogen Metabolism is Elevated

Estrogen dominance can occur when estrogen (E1, E2) and progesterone are within the PMP range, but phase 1 estrogen metabolites are above the PMP range, see **Figure 3.4**. This is because the 2-OH, 4-OH and 16-OH phase 1 estrogen metabolites can actively bind to estrogen receptors.

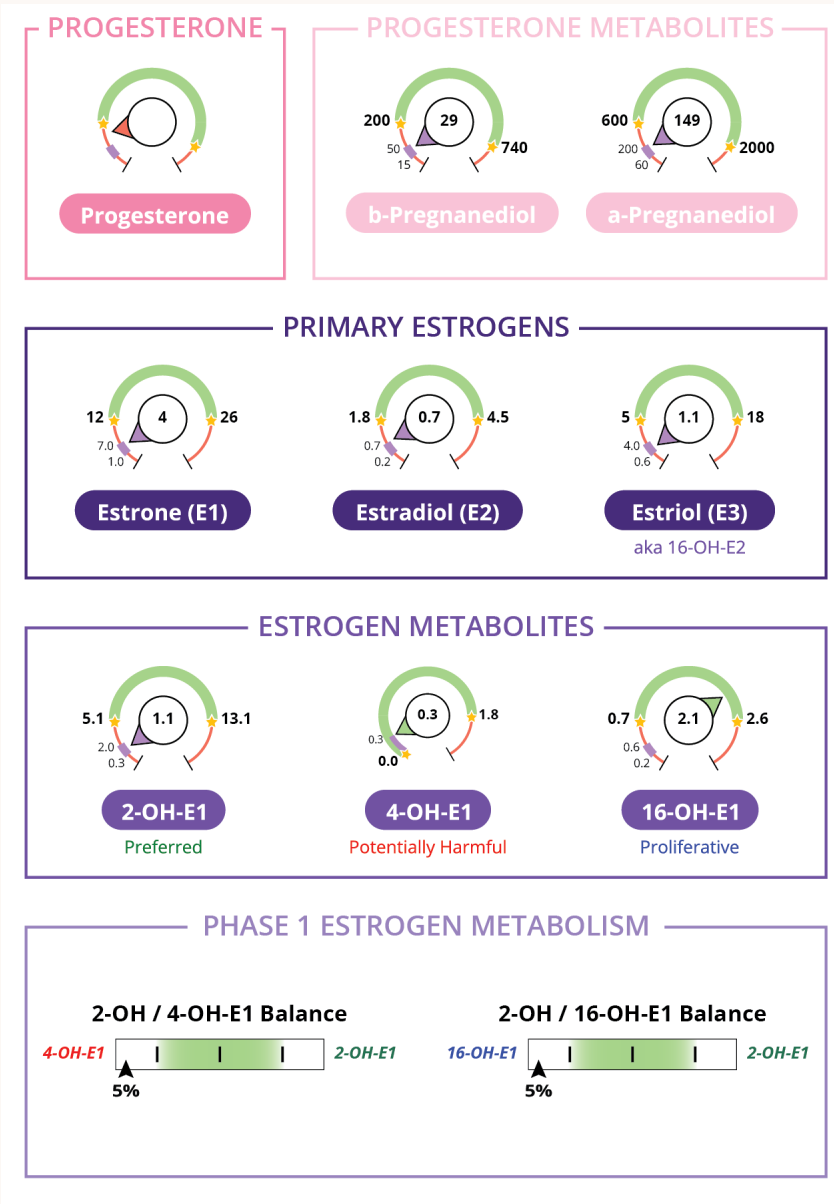


Figure 3.4: Phase 1 Estrogen Metabolism is Elevated
E1, E2, and progesterone metabolites are within the postmenopausal reference range, but the 16-OH-E1 phase 1 estrogen metabolite is above the postmenopausal range. This could contribute to signs and symptoms of estrogen dominance.

Estrogen therapy without Progesterone

Estrogen dominance may be observed when estrogen therapy (ET) is used without (or with inadequate) progesterone therapy. In **Figure 3.5**, the patient was taking a moderately high dose of estradiol (E2) and no progesterone therapy.

NOTE

When a female has a uterus, ET must be used in combination with progesterone to protect the endometrium from hyperplasia and cancer.

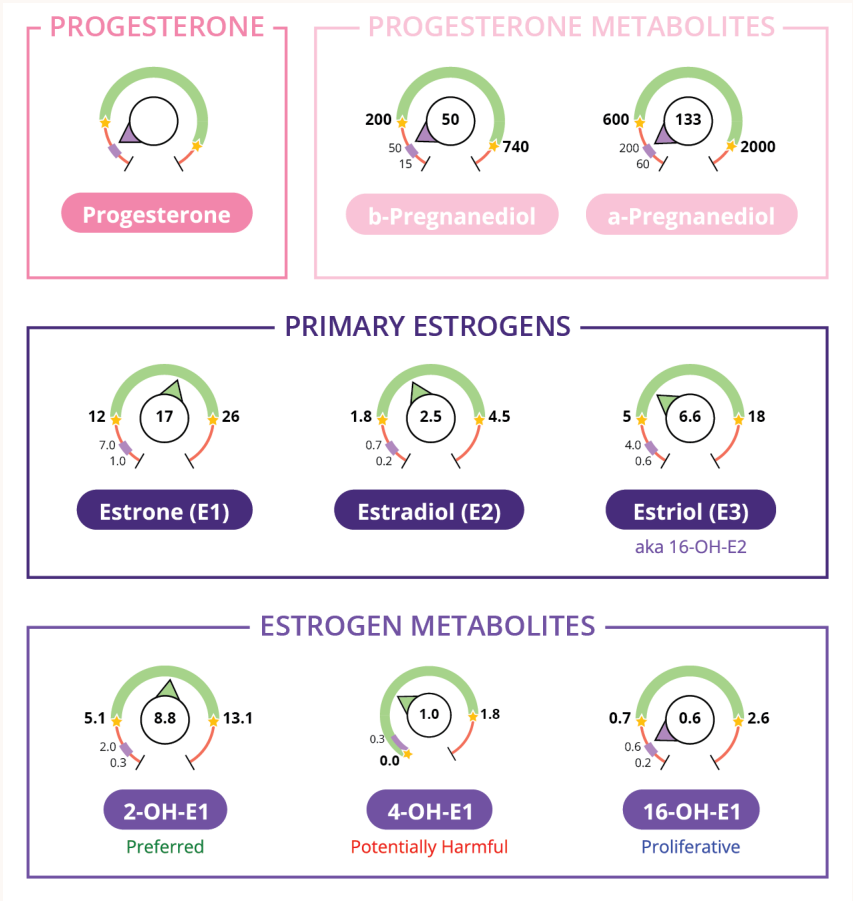


Figure 3.5: Estrogen therapy without Progesterone
Estrogen dominance may be observed when a person takes estrogen therapy (ET) but not (or inadequate) progesterone therapy.

OVERVIEW

The DUTCH Test measures two progesterone metabolites in the urine: a-pregnanediol and b-pregnanediol, see **Figure 3.6**.

Urinary levels of these progesterone metabolites have been shown to strongly correlate with serum progesterone levels when progesterone is not supplemented [j]. a-Pregnanediol modulates GABA receptors in the central nervous system (CNS) and can lead to improvements in mood and sleep. b-Pregnanediol is the major progesterone metabolite, but unlike a-pregnanediol, it does not modulate GABA receptors.

Progesterone’s Role in Postmenopausal Females

In postmenopausal females, progesterone supports sleep, mood, and memory, and protects against endometrial cancer, osteoporosis, and cardiovascular disease. When estrogen therapy is used, oral micronized progesterone (OMP) protects the endometrium without increasing breast cancer risk during the first 5 years of use. Vaginal micronized progesterone (VMP) has also been shown in the research to protect the endometrium.

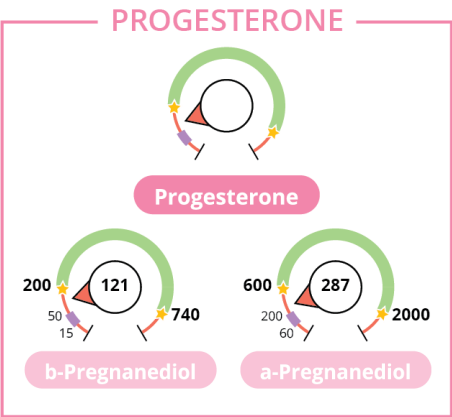
Progesterone and the Hypothalamic-Pituitary-Adrenal (HPA) Axis

Studies evaluating interactions between the provoked HPA axis and progesterone are limited in both healthy and diseased individuals, however it appears that adrenal progesterone increases in response to stress and increased cortisol output. [k]

Progesterone Production in Postmenopausal Females

In postmenopausal females, progesterone is predominantly made in the adrenal glands.

Figure 3.6: Measuring Progesterone



The DUTCH Test measures progesterone (Pg) indirectly by taking the weighted average of two metabolites, a-pregnanediol and b-pregnanediol.

[j] Newman M, et al. Evaluating urinary estrogen and progesterone metabolites using dried filter paper samples and gas chromatography with tandem mass spectrometry (GC-MS/MS). BMC Chem. 2019; 13(1): 20.

[k] Herrera AY, et al. Stress-induced increases in progesterone and cortisol in naturally cycling women. Neurobiol Stress. 2016 Feb; 11(3):96-104.

PROGESTERONE IS LOW

Signs & Symptoms

Low Pg in PMP females who are not prescribed MHT may result in fatigue, insomnia, irritability, anxiety, weight gain, and low bone mineral density.

In PMP females with a uterus who are prescribed MHT, Pg dosing must balance E2's endometrial proliferative effects. When Pg dosing is inadequate, PMP females may be at increased endometrial cancer risk.

Potential Root Causes

In PMP females, Pg is predominantly made by the adrenal glands.

In PMP females who are not prescribed MHT, HPA axis dysfunction may contribute to low Pg levels.

Potential Support Considerations

In addition to assessing and treating the underlying root cause, other considerations include bioidentical Pg supplementation, and/or HPA axis support with adrenal adaptogens, see **“Appendix B: Potential Support Considerations” on page 191** for more information.

PROGESTERONE IS ELEVATED

Signs & Symptoms

PMP females not on MHT, with Pg metabolites that are above the expected PMP range but below a cycling female's luteal range, may still experience low Pg symptoms, i.e., fatigue, insomnia, irritability, anxiety, and weight gain.

Females supplementing with Pg may have high Pg symptoms, i.e., fatigue, mood disturbance, bloating, and breast tenderness.

Potential Root Causes

Pg metabolites in PMP females who are not taking MHT that are above the expected PMP range may be secondary to HPA axis dysfunction (stress).

In PMP females prescribed oral/sublingual Pg or pregnenolone, Pg metabolites are typically elevated above the postmenopausal and premenopausal reference ranges³³.

Potential Support Considerations

As Pg is primarily produced in the adrenal glands in PMP females, HPA axis support may be beneficial, see **“Appendix B: Potential Support Considerations” on page 191** for more information.

PROGESTERONE IS WITHIN RANGE

Bioidentical Pg supplementation may still be appropriate for improving energy, sleep, and/or mood even when Pg is within the expected postmenopausal range. OMP or VMP is necessary to balance E2's proliferative effects, especially in females with a uterus, even without E2 supplementation. OMP or VMP are also necessary for improved bone mineral density.

ORAL PROGESTERONE REFERENCE RANGES

Oral micronized progesterone (OMP) reference ranges for females:

- a-Pregnanediol: 2,000-9,000 ng/mg
- b-Pregnanediol: 580-3,000 ng/mg

Urinary Pg metabolite levels strongly correlate with serum Pg only when Pg is not being supplemented.

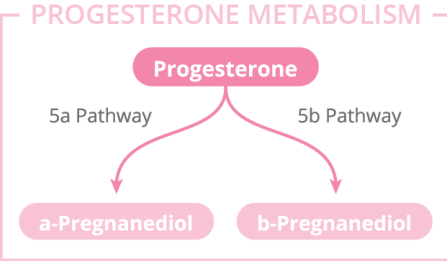
When a female reports taking oral Pg within 72 hours of sample collection, we adjust the Pg reference ranges to reflect the a-pregnanediol and b-pregnanediol levels that are typically seen when a standard dose of 100mg is taken during the test and not skipped.

Pg that is within the oral Pg reference range does not guarantee that the dose and ROA of Pg is appropriate and thus does not guarantee endometrial protection when estrogen is also being supplemented.

Serum equivalent values reported on page 1 of the DUTCH Complete and DUTCH Plus reports will be higher than reality when Pg is taken orally or sublingually.

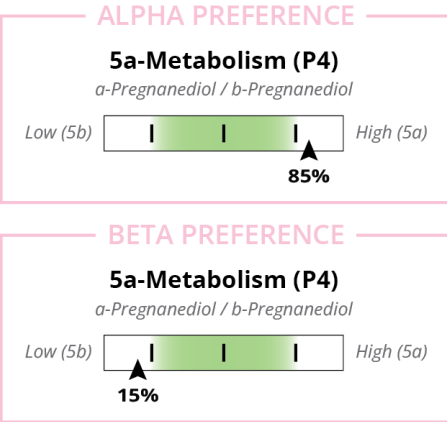
When oral Pg is supplemented, it can be helpful to see if a-pregnanediol is favored, as the alpha Pg metabolites can act on GABA receptors and help with sleep and mood.

Figure 3.7: Progesterone Metabolism



It may be helpful to know if there is a 5a or 5b preference, because the alpha progesterone metabolites modulate GABA receptors and may help with mood and sleep.

Figure 3.8: 5a vs 5b Progesterone Preference



Alpha progesterone metabolites modulate GABA receptor activity and may help to improve mood and sleep. In this example, both postmenopausal patients are taking 100 mg oral progesterone before bedtime. The patient who favors alpha progesterone metabolism (top) may experience more calming GABA effects from the oral progesterone than the patient who favors beta progesterone metabolism (bottom).

OVERVIEW

The DUTCH Test measures progesterone indirectly by taking the weighted average of a-pregnanediol and b-pregnanediol, see **Figure 3.7**. For a more complete view of metabolism, see **“The DUTCH Steroid Pathway” on page 89**.

Progesterone is metabolized into a-pregnanediol by 5a-reductase and b-pregnanediol by 5b-reductase. It may be helpful to know if there is a 5a or 5b preference because the alpha progesterone metabolites modulate GABA receptors when assessing for an alpha or beta preference, look at the 5a-Metabolism (P4) slider, see **Figure 3.8**.

5a-Reductase and 5b-reductase are also involved in androgen (i.e., DHEA and testosterone) and cortisol metabolism. Therefore, the body’s overall preference towards alpha or beta metabolism can be further assessed by comparing alpha vs. beta metabolite levels. Alpha metabolites on the DUTCH Test include a-pregnanediol, androsterone, 5a-DHT, 5a-androstanediol, and a-THF. Beta metabolites on the DUTCH Test include b-pregnanediol, etiocholanolone, 5b-androstanediol, b-THF, and b-THE.

CLINICAL SIGNIFICANCE

a-Pregnanediol Preference

a-Pregnanediol is a GABA receptor modulator that supports mood and sleep. There is some evidence that a a-pregnanediol preference may increase breast cancer risk, however, more studies are needed to clarify this relationship.

Increased 5a-reductase activity is associated with inflammation, insulin resistance, obesity, DHEA supplementation, and certain genetic makeups. Females supplementing with oral Pg may see improvements in mood and sleep if they favor the alpha pathway.

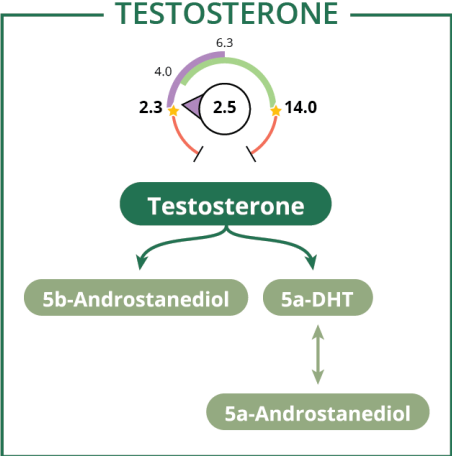
b-Pregnanediol Preference

b-Pregnanediol is the major Pg metabolite, but unlike a-pregnanediol, it does not exert calming effects in the brain through GABA receptor modulation.

5b-Reductase activity is increased by insulin resistance, high triglycerides, and certain genetic makeups. People may also favor the beta pathway if they are taking a prescription 5a-blocker (finasteride, dutasteride, etc.)³⁴ or natural 5a-blockers.

When oral Pg is supplemented, females favoring the beta pathway may need a higher Pg dose than females favoring the alpha pathway to see similar improvements in mood and sleep. In these cases, GABA support can also be considered. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

Figure 3.9: Measuring Testosterone



The DUTCH Test reflects bioavailable testosterone, as well as its downstream metabolites: 5a-DHT, 5a-androstanediol, and 5b-androstanediol.

OVERVIEW

The DUTCH Test reflects bioavailable testosterone. Testosterone’s activity may be evaluated by looking at its downstream metabolites, 5a-DHT, 5a-androstanediol, and 5b-androstanediol, see **Figure 3.99**.

In target tissues, testosterone is activated to 5a-DHT by the enzyme 5a-reductase. 5a-DHT is three times more potent than testosterone and is made and metabolized locally in the tissues to 5a-androstanediol. Therefore, urinary 5a-androstanediol may be a better marker of tissue 5a-DHT activity than urinary 5a-DHT. In addition to 5a-DHE and 5a-androstanediol, the downstream alpha metabolite of DHEA, androsterone, can also be used to suggest tissue androgen activity.

NOTE

Some 5a-DHT and 5a-androstanediol can also be formed from DHEA. Therefore, if 5a-DHT and/or 5a-androstanediol are elevated, it may be helpful to compare total DHEA and testosterone to better understand where the excess androgens are originating from (the adrenals or the ovaries). In females, if DHEA-S or total DHEA is high, the source of excess androgens is likely the adrenal glands. Conversely, if these are within range, but testosterone and its metabolites are high, the source may be ovarian.

Testosterone can also be metabolized down the less androgenic beta pathway. The enzyme 5b-reductase is concentrated in the liver (as opposed to target tissues) and converts testosterone into 5b-androstanediol. This testosterone metabolite does not correlate with classic androgen symptoms such as body hair, libido, muscle mass, and acne due to the low androgenic potential of beta metabolites.

NOTE

Certain genetic profiles can cause testosterone to be falsely low in the urine, see **“UGT Deletion” on page 72** for more information.

Testosterone’s Role in Postmenopausal Females

In postmenopausal females, testosterone supports muscle, strength, stamina, healthy weight, bone, skin, hair, mood, memory, sexual function, cardiovascular health, and estradiol levels.

Testosterone Production in Postmenopausal Females

In postmenopausal females, testosterone is mostly derived from peripheral conversion of androstenedione and DHEA. However, a small amount of androstenedione and DHEA are still synthesized in the ovary and can be peripherally converted to testosterone. Testosterone production peaks in the third and fourth decades of life (20s and 30s) and declines thereafter.

Testosterone age-dependent reference ranges for females:

- Premenopausal: 4-14 ng/mg
- Postmenopausal: 2.3-6.3 ng/mg

TESTOSTERONE IS LOW

NOTE

Individuals with a UGT deletion (genetic variant) may have falsely low urinary testosterone, 5a-DHT, and 5b-androstenediol. Please see “UGT Deletion” on page 72 for more information on this genetic deletion and the impact on DUTCH testing.

Signs & Symptoms

Low testosterone in postmenopausal females may be associated with fatigue, weight gain, difficulty building muscle mass, bone loss, mood issues, brain fog, low libido, and sexual dysfunction.

Potential Root Causes

Low testosterone in postmenopausal females may be associated with aging, elevated SHBG, low adrenal output, HPA axis dysfunction, poor ovarian production, surgically removed ovaries, diabetes, hypothyroidism, and sleep disturbances, endocrine disrupting chemicals (EDCs), zinc deficiencies, cETain medications³⁵, and upregulated aromatase activity³⁶.

Low testosterone in females is less commonly associated with traumatic brain injuries, prolactinoma, extremely low body fat percentage, extremely low calorie intake, stress, overexercising, low cholesterol (LDL < 40mg/dL), and suboptimal mitochondrial function.

Potential Support Considerations

In addition to treating the underlying cause, obtain serum total, free and bioavailable testosterone levels and if low consider zinc, herbal testosterone support, HPA axis support, blood sugar regulation, improving sleep, DHEA³⁷ and/or testosterone replacement therapy³⁸. See “Appendix B: Potential Support Considerations” on page 191 for more information.

NOTE

If E1 and E2 are elevated, consider natural aromatase inhibition³⁹.

TESTOSTERONE IS ELEVATED

Signs & Symptoms

Elevated testosterone postmenopausal in females has been associated with acne, oily skin, increased body/facial hair, thinning scalp hair, androgenic alopecia, and mood disturbance (aggression, irritability, etc.).

Mildly elevated androgens that are not accompanied with symptoms of androgen excess may be normal for some women.

Potential Root Causes

Elevated testosterone in postmenopausal females may be associated with low SHBG, downregulated aromatase activity⁴⁰, stress, obesity, blood sugar dysregulation, inflammation, testosterone and/or DHEA supplementation⁴¹, transference (from a partner, the gym, etc.), medications⁴², or sample contamination⁴³.

Less common associations include thyroid issues, NCAH, virilizing tumors, and ovarian hyperthecosis.

Potential Support Considerations

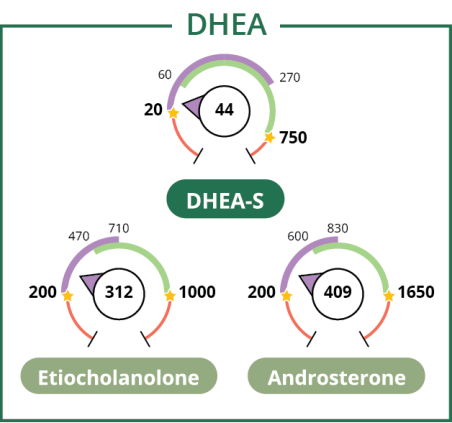
In addition to treating the underlying cause, other considerations include addressing inflammation, regulating blood sugar, weight loss if appropriate, supporting the HPA axis, supporting liver detoxification, flaxseeds, myo-inositol, herbal anti-androgens, and medications such as metformin and spironolactone, if appropriate. See “Appendix B: Potential Support Considerations” on page 191 for more information.

TESTOSTERONE IS WITHIN RANGE

When testosterone is within range, take the alpha androgen levels 5a-DHT, 5a-androstenediol, and androsterone into consideration, as these also have androgenic actions in the body. If there are androgen excess symptoms, but all these androgens are within range or low, consider other causes for these symptoms, such as hypothyroidism, stress, autoimmune issues, mineral deficiencies, etc.

Always confirm DUTCH results with serum testosterone before treatment, as the UGT genetic variant can result in falsely low urinary testosterone, 5a-DHT, and 5b-androstenediol. Please see “UGT Deletion” on page 72 for more information on this genetic deletion and the impact on DUTCH testing.

Figure 3.10: Measuring DHEA



The DUTCH Test measures three DHEA metabolites including: DHEA-S, etiocholanolone, and androsterone.

OVERVIEW

The DUTCH Test measures three DHEA metabolites: DHEA-S, etiocholanolone, and androsterone, see **Figure 3.10.10**.

DHEA is considered a pro-hormone, as most is converted, at the tissue level, to more potent androgens and estrogens. DHEA in the adrenal gland is sulfated to DHEA-S, a form that is more stable in serum and can act as a DHEA reserve. The best way to assess the total adrenal androgen production is to add up the DHEA-S, etiocholanolone, and androsterone metabolites, which equals the total DHEA⁴⁴ production, also known as the total adrenal androgen production.

NOTE

$$\text{Total DHEA} = \text{DHEA-S} + \text{etiocholanolone} + \text{androsterone}$$

DHEA’s Role in Postmenopausal Females

DHEA supports muscle, bone, sexual function, fertility, brain health, immune function, and cardiovascular health.

DHEA Production in Postmenopausal Females

In postmenopausal females, DHEA is primarily made in the adrenal zona reticularis and almost all estrogens and androgens are derived peripherally from this DHEA [1]. DHEA production peaks in young adulthood (20s) and declines with age.

Total DHEA age-dependent reference ranges for females:

- Premenopausal: 1300-3000ng/mg
- Postmenopausal: 500-1200ng/mg

DHEA IS LOW

Signs & Symptoms

Low DHEA in postmenopausal females may be associated with fatigue, low libido, depression, diabetes, heart disease, inflammation, and immune disorders.

Potential Root Causes

Low DHEA in postmenopausal females may be associated with older age, decreased adrenal synthesis (HPA axis dysfunction) secondary to chronic stress, inflammation and inflammatory syndromes, blood sugar dysregulation, hypothyroidism, and medications such as glucocorticosteroids, opioids, budesonide inhalers, and metformin.

Higher DHEA-S relative to lower total DHEA may be associated with upregulated SULT2A1 activity (which sulfates DHEA) or a lower STS enzyme activity (removes the “S” from DHEA-S).

[1] Samaras N, et al. A review of age-related dehydroepiandrosterone decline and its association with well-known geriatric syndromes: is treatment beneficial? Rejuvenation Res. 2013; 16(4): 285-294.

Potential Support Considerations

In addition to treating the underlying cause, other considerations include DHEA replacement therapy⁴⁵, addressing chronic inflammation, regulating blood sugar supporting liver detoxification, HPA axis support, and stress reduction, which may include calming herbal support, parasympathetic nervous system (PNS) support, and GABA support. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

DHEA IS ELEVATED

Signs & Symptoms

Elevated DHEA in postmenopausal females has been associated with androgen excess symptoms including oily skin, acne, sleep problems, headaches, and mood disturbances.

Potential Root Causes

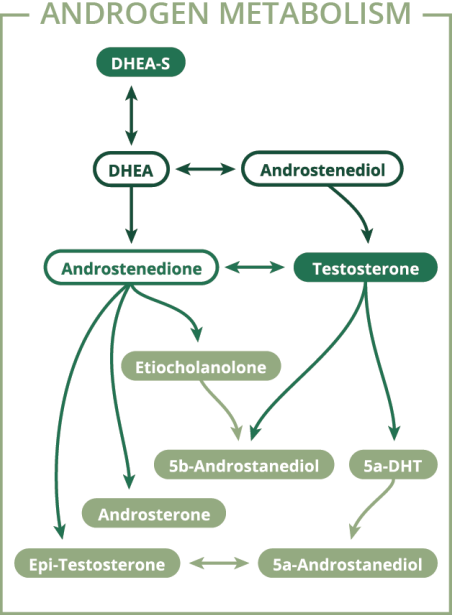
Elevated DHEA in postmenopausal females may be associated with DHEA supplementation⁴⁶, stress, high adrenal cortisol output, HPA axis dysfunction, inflammation, blood sugar dysregulation, alcohol, nicotine, testosterone supplementation⁴⁷, and medications such as Alprazolam, Anastrozole, Methylphenidate, Amlodipine, Diltiazem, and Bupropion.

Less common associations include nonclassical congenital adrenal hyperplasia (NCAH), hyperprolactinemia, and an adrenal tumor.

Potential Support Considerations

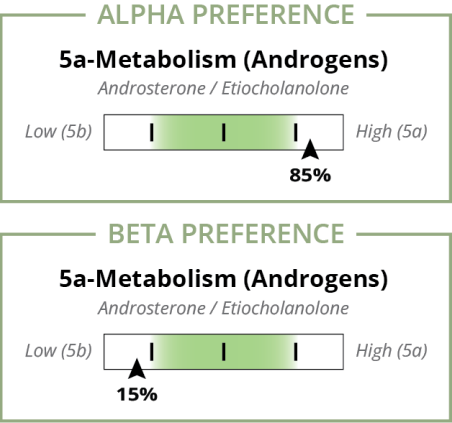
In addition to treating the underlying cause, other considerations include addressing chronic inflammation, regulating blood sugar, supporting liver detoxification, HPA axis support, and stress reduction, which may include calming herbal support, PNS support, and GABA support. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

Figure 3.11: Androgen Metabolism



The DUTCH Test measures several androgenic metabolites that stem from testosterone and DHEA to provide a more complete picture of a patients’ metabolic health.

Figure 3.12: 5a vs 5b Androgen Preference



It may be helpful to know if there is a 5a or 5b androgen preference because a beta preference may exacerbate signs and symptoms of low androgens (e.g., low libido, fatigue, weight gain), while an alpha preference may exacerbate signs and symptoms of high androgens (e.g., scalp hair loss, acne, body hair growth).

OVERVIEW OF 5-ALPHA VS 5-BETA

The DUTCH Test measures bioavailable testosterone, DHEA-S and their metabolites, see **Figure 3.111**. For a more complete view of metabolism, see **“The DUTCH Steroid Pathway” on page 89**.

Regarding androgen metabolism, a person may favor the more androgenic alpha pathway, the less androgenic beta pathway, or a balance between the two pathways.

5a-Reductase converts DHEA and testosterone into the alpha androgen metabolites: androsterone, 5a-DHT, and 5a-androstanediol. 5a-DHT is testosterone’s active metabolite. It is three times more potent than testosterone, and if elevated, may contribute to androgen excess symptoms. 5a-DHT is a peripheral hormone, and research shows that 5a-androstanediol may be a better marker of 5a-DHT tissue activity. [m]

5b-Reductase converts DHEA and testosterone into the beta androgen metabolites: etiocholanolone and 5b-androstanediol. The beta androgen metabolites are generally less androgenic than the alpha androgen metabolites and are formed in the liver, not the tissues. Therefore, these beta metabolites are less likely to contribute to androgen excess symptoms. For example, a person who has elevated testosterone may not experience androgen excess symptoms if they metabolize most of their testosterone down the less androgenic beta pathway.

NOTE

The slider on the DUTCH Test, see **Figure 3.122**, shows the relative ratio of 5a to 5b metabolites but does not express the absolute value of 5a-DHT and 5a-androstanediol, or if 5a-reductase inhibition is or is not indicated. Consider symptoms and look at the 5a-DHT, androsterone and 5a-androstanediol results if high androgen symptoms are a concern.

5a-Reductase and 5b-reductase are also involved in androgen (i.e., DHEA and testosterone) and cortisol metabolism. Therefore, the body’s overall preference towards alpha or beta metabolism can be further assessed by comparing alpha vs. beta metabolite levels. Alpha metabolites on the DUTCH Test include a-pregnanediol, androsterone, 5a-DHT, 5a-androstanediol, and a-THF. Beta metabolites on the DUTCH Test include b-pregnanediol, etiocholanolone, 5b-androstanediol, b-THF, and b-THE.

[m] Trabert B, et al. Progesterone and Breast Cancer. Endocr Rev. 2020 Apr 1; 41(2):320–44.

CLINICAL SIGNIFICANCE

5a-Reductase Preference

A metabolic preference for the alpha pathway may lead to elevated androsterone, 5a-DHT, 5a-androstanediol, and excess androgen symptoms. Inflammation, high stress lifestyles, obesity, and blood sugar dysregulation can upregulate 5a-reductase.

Consider addressing these root causes if the goal is to decrease the alpha preference. Also consider 5a-reductase herbal blockers and medications such as metformin, spironolactone, or finasteride⁴⁸, if appropriate. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

NOTE

If DHEA and testosterone are low, a metabolic preference for the 5a-reductase enzyme may not necessarily lead to elevated 5a-DHT levels and symptoms of androgen excess.

5b-Reductase Preference

A metabolic preference for the beta pathway may lead to low androsterone, 5a-DHT, 5a-androstanediol, and low androgen symptoms.

Certain genetic makeups, 5a-reductase herbal blockers, and medications such as spironolactone and finasteride may contribute to a beta preference, so consider addressing these root causes if the goal is to decrease the beta preference. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

Consider upregulating 5a-reductase activity with high intensity interval training (HIIT), weight resistance exercises, and supplements such as forskolin and pine pollen. Low androgen symptoms associated with low DHEA and/or testosterone may improve by directly addressing DHEA and testosterone levels.

NOTE

If DHEA and testosterone are elevated, a metabolic preference for the beta pathway may be beneficial, as it may help to keep 5a-DHT within range.

27	Aromatase activity can be downregulated by enterolactone, apigenin, chrysin and other flavonoids, white button mushrooms, grape seed extract, red wine procyanidin dimers, PCOS, antifungal medications, metformin, glyphosate, smoking, antiepileptic drugs, and pharmaceutical aromatase inhibitors. Genetic SNPs in CYP19A1 may also affect aromatase activity.	swallowed undergoes first-pass metabolism and results in elevated urinary metabolites that do not correlate with serum levels.
28	DIM and indole-3-carbinol (I3C) are sometimes used to induce CYP-1a1 (the “preferred” pathway towards 2-OH), however be mindful that they also tend to lower E1 and E2 (Newman, M., Smeaton, J. Exploring the impact of 3,3'-diindolylmethane on the urinary estrogen profile of premenopausal women. BMC Complement Med Ther 24, 405 (2024).) which may not be appropriate for every person. When using DIM and/or I3C, it is important that phase 2 detoxification is well supported so that the phase 1 metabolites do not build up in the body and cause oxidative damage. If on ET, sometimes a relatively higher dose of estrogen may be needed when used in combination with estrogenlowering compounds such as DIM and/or I3C in order to achieve desired clinical outcomes. If on Tamoxifen, note that DIM and I3C may render Tamoxifen less effective.	34 In males and females, finasteride and dutasteride may cause irreversible sexual dysfunction and infertility.
29	ET must be balanced with Pg in females with a uterus. In females who have had a hysterectomy (no uterus), progesterone therapy is optional and may provide support for bone mineral density, mood, and sleep.	35 Medications that may contribute to low testosterone include glucocorticosteroids, opioids, Accutane, spironolactone, and some oral contraceptive pills (OCPs).
30	Aromatase activity can be upregulated by obesity, inflammation, high insulin, forskolin, quercetin, genistein (bioflavonoids), white peony and licorice root, atrazine, and rutin. Genetic SNPs in CYP19A1 may also affect aromatase activity.	36 Aromatase activity may be upregulated by obesity, inflammation, high insulin, forskolin, quercetin, genistein (bioflavonoids), white peony and licorice root, atrazine, and rutin. Genetic SNPs in CYP19A1 may also affect aromatase activity.
31	Use caution when interpreting E2 and estrogen metabolite results if oral or sublingual E2, testosterone, and/or DHEA was prescribed, as these undergo first-pass metabolism, which results in elevated urinary metabolites that do not correlate with serum levels. We suggest stopping oral DHEA 48 hours prior to collection and oral testosterone and E2 or Biest (E2 and E3) 72 hours prior to collection.	37 Use caution with oral DHEA supplementation as it may elevate estrogen.
32	Estradiol replacement therapy (ET) must be balanced with progesterone in females with a uterus. In females without a uterus, estradiol and progesterone should also be balanced for optimal bone mineral density and to avoid estrogen dominant symptoms.	38 Testosterone should always be evaluated and confirmed in the serum before initiating TRT for low testosterone.
33	Urinary progesterone metabolite levels strongly correlate with serum progesterone only when progesterone is not being supplemented. Use caution when interpreting progesterone results if progesterone or pregnenolone was supplemented orally or sublingually within 72 hours of sample collection, as the portion that is	39 Aromatase activity may be downregulated by enterolactone, apigenin, chrysin and other flavonoids, white button mushrooms, grape seed extract, red wine procyanidin dimers, PCOS, antifungal medications, metformin, glyphosate, smoking, antiepileptic drugs, and pharmaceutical aromatase inhibitors. Genetic SNPs in CYP19A1 may also affect aromatase activity.
		40 Aromatase activity may be downregulated by enterolactone, apigenin, chrysin and other flavonoids, white button mushrooms, grape seed extract, red wine procyanidin dimers, PCOS, antifungal medications, metformin, glyphosate, smoking, antiepileptic drugs, and pharmaceutical aromatase inhibitors. Genetic SNPs in CYP19A1 may also affect aromatase activity.
		41 Use caution when interpreting testosterone results if oral or sublingual DHEA or testosterone were supplemented, as these undergo first-pass metabolism which results in elevated urinary metabolites that do not correlate with serum levels.
		42 Medications that may contribute to elevated testosterone include aromatase inhibitors, clomiphene citrate (a selective estrogen receptor modulator (SERM)), and luteinizing hormone (LH), growth hormone (GH), and gonadotropin-releasing hormone (GnRH) analogs (hCG, gonadorelin, kisspeptin, etc.).
		43 If testosterone is elevated but the downstream androgen metabolites are not (5a-DHT, androsterone, 5a-androstanediol, etiocholanolone, and 5b-androstanediol), consider the possibility of testosterone sample contamination from someone using TRT (testosterone replacement therapy).
44	Total DHEA is found on the cover and page 5 of a DUTCH Complete and DUTCH Plus report. Note that the Adrenal Only panel measures DHEA-S but not etiocholanolone and androsterone. Total DHEA is calculated by adding together DHEA-S + etiocholanolone + androsterone. For a sex hormone panel, total DHEA is not already calculated; therefore, calculate the total DHEA and use the age-dependent reference ranges above.	
45	Use caution with oral DHEA supplementation, as it may elevate estrogens in addition to increasing testosterone.	
46	Use caution when interpreting total DHEA if testosterone replacement therapy (TRT) and/or DHEA was taken. Testosterone can metabolize into, and elevate, androsterone and etiocholanolone. As total DHEA is calculated by adding up DHEA-S + etiocholanolone + androsterone, TRT (or even high endogenous testosterone) may elevate this calculated marker. Additionally, oral, or sublingual supplemented testosterone and DHEA undergo first-pass metabolism in the gut and liver, which results in elevated urine metabolites that do not correlate with serum levels. Oral DHEA can create false elevations when used during testing.	
47	Use caution when interpreting total DHEA if testosterone replacement therapy (TRT) and/or DHEA was taken. Testosterone can metabolize into, and elevate, androsterone and etiocholanolone. As total DHEA is calculated by adding up DHEA-S + etiocholanolone + androsterone, TRT (or even high endogenous testosterone) may elevate this calculated marker. Additionally, oral, or sublingual supplemented testosterone and DHEA undergo first-pass metabolism in the gut and liver, which results in elevated urine metabolites that do not correlate with serum levels. Oral DHEA can create false elevations when used during testing.	
48	In males and females, finasteride and dutasteride may cause irreversible sexual dysfunction and infertility.	

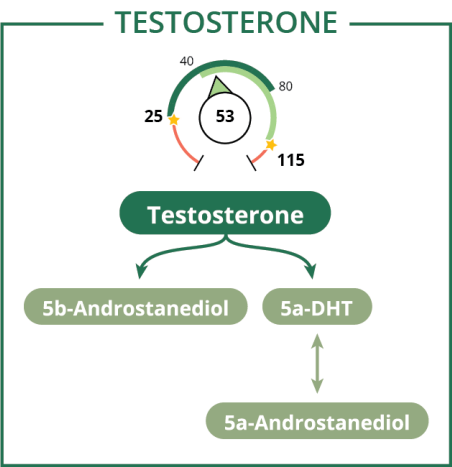
Sex Hormones: Male

Introduction

The DUTCH Test has a breadth of clinical utility in males. While testosterone measurements are best done in serum to obtain quantitative measures, the DUTCH Test offers additional insight into a male’s overall reproductive hormonal picture, as well as androgen metabolites, which often can induce symptoms of excess or be responsible for symptoms of deficiency.

You may be surprised that other hormones affect males as well, including estrogen and estrogen metabolites. In this guide, you will learn about interpretation of the DUTCH Test in males, including how to make sense of elevated or low levels of hormones and metabolites.

Figure 4.1: Measuring Testosterone



The DUTCH Test reflects bioavailable testosterone, as well as its downstream metabolites: 5a-DHT, 5a-androstanediol, and 5b-androstanediol.

OVERVIEW

The DUTCH Test reflects bioavailable testosterone. Testosterone’s activity may be evaluated by looking at its downstream metabolites, 5a-DHT, 5a-androstanediol, and 5b-androstanediol, see **Figure 4.1**.

In target tissues, testosterone is activated to 5a-DHT by the enzyme 5a-reductase. 5a-DHT is three times more potent than testosterone and is made and metabolized locally in the tissues to 5a-androstanediol. Therefore, urinary 5a-androstanediol may be a better marker of tissue 5a-DHT activity than urinary 5a-DHT. In addition to the 5a-DHT and 5a-androstanediol, the downstream alpha metabolite of DHEA (androsterone) can be used to evaluate tissue androgen activity.

NOTE

Some 5a-DHT and 5a-androstanediol can also be formed from DHEA. Therefore, when 5a-DHT and/or 5a-androstanediol are elevated, it may be helpful to compare total DHEA and testosterone to better understand where the excess androgens are originating from (the adrenals or the testes). In males, testosterone is made almost exclusively in the testes, whereas DHEA is made primarily in the adrenal glands. Thus, if DHEA is elevated in a male, the source of excess androgens is likely the adrenals, but if testosterone or its metabolites are elevated, the source is likely the testes.

Testosterone can also be metabolized down the less androgenic beta pathway. The enzyme 5b-reductase is concentrated in the liver (as opposed to target tissues) and converts testosterone into 5b-androstanediol. This testosterone metabolite does not correlate with classic androgen symptoms such as body hair, libido, muscle mass, and acne due to the low androgenic potential of beta metabolites.

NOTE

Certain genetic profiles can cause testosterone to be falsely low in the urine, see **“UGT Deletion” on page 72** for more information.

Testosterone’s Role in Males

In males, testosterone supports muscle, strength, stamina, healthy weight, bone, skin, hair, mood, memory, sexual function, sperm production, fertility, cardiovascular health, and estradiol levels.

Testosterone Production in Males

In males, 95% of testosterone is made by the testes. Testosterone peaks at approximately 20 years of age and starts to decline during the fourth decade of life (30s). Testosterone levels in healthy males vary, so it is critical to consider the person’s symptoms as a point of context when interpreting DUTCH Test results.

Testosterone age-dependent reference ranges for males:

- 18-40 years old: 40-115 ng/mg
- 41-60+: 25-80 ng/mg

TESTOSTERONE IS LOW

NOTE

Individuals with a UGT deletion (genetic variant) may have falsely low urinary testosterone, 5a-DHT, and 5b-androstanediol. Please see **“UGT Deletion” on page 72** for more information on this genetic deletion and the impact on DUTCH testing.

Signs & Symptoms

Low testosterone in males may be associated with fatigue, weight gain, decreased muscle mass, difficulty building muscle, erectile dysfunction, low libido, bone loss, mood issues, brain fog, and gynecomastia (if estradiol is elevated).

Potential Root Causes

Low testosterone in males may be associated with diabetes, obesity, HPA axis dysfunction (high cortisol), hypothyroidism, older age, poor sleep, endocrine disrupting chemicals (EDCs), zinc deficiency, vitamin D deficiency, high alcohol use, regular THC use, recent testosterone supplementation, elevated SHBG, increased aromatization⁴⁹, and certain medications⁵⁰.

Less common associations include traumatic brain injuries, hyperprolactinemia, pituitary and hypothalamic disease, testicular infection, autoimmune antibodies (Leydig cell specific), groin radiation, chemo at-large, and leptin and leptin receptor mutations.

Potential Support Considerations

In addition to treating the underlying cause, obtain a serum total, free, and bioavailable testosterone. If serum testosterone is low, other considerations include high dose DHEA⁵¹ or testosterone replacement therapy (TRT) in males > 50 years old. In young males or older males wanting to maintain fertility, consider clomiphene, gonadorelin, and kisspeptin. HCG may be considered for males with documented fertility issues.

Also consider zinc, herbal testosterone support, HPA axis support, high intensity interval training (HIIT) and weightlifting to increase muscle mass, blood sugar regulation, and improving sleep. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

NOTE

If E1 and E2 are elevated, consider aromatase inhibition with herbal and/or pharmaceutical agents.

TESTOSTERONE IS ELEVATED

Signs & Symptoms

In males, elevated endogenous testosterone has been associated with acne, oily skin, increased body and facial hair, thinning scalp hair, androgenic alopecia, and mood disturbance (aggression, irritability, etc.)

When high testosterone is due to TRT, it may cause low sperm counts (negative feedback), mood swings, aggression, increased hematocrit, and increased E2. Increased HCT (> 50%) and increased E2 levels are associated with increased clotting risk. If elevated testosterone increases DHT, this may increase the likelihood of BPH symptoms.

NOTE

TRT neither increases cardiovascular disease nor prostate cancer risk.

Potential Root Causes

Elevated testosterone in males may be normal, especially in young males, or more commonly due to low SHBG, testosterone and DHEA (high dose) supplementation⁵², sample contamination⁵³, certain medications⁵⁴, and downregulated aromatase activity⁵⁵.

Less common associations include nonclassical congenital adrenal hyperplasia (NCCAH), and virilizing tumors.

Potential Support Considerations

In addition to treating the underlying cause, other considerations include addressing inflammation, regulating blood sugar, weight loss if appropriate, supporting the HPA axis, supporting liver detoxification, flaxseeds, herbal anti-androgens, and medications such as metformin, spironolactone and/or finasteride, if appropriate. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

NOTE

In males, finasteride and dutasteride may cause irreversible sexual dysfunction and infertility.

TESTOSTERONE IS WITHIN RANGE

When testosterone is within range, take into consideration the other DUTCH Test androgen levels (DHEA, 5a-DHT, 5a-androstanediol, 5b-androstanediol, etiocholanolone, and androsterone), as these also have androgenic action in the body. If there are androgen excess or deficiency symptoms but androgens are within range on the DUTCH Test, consider other causes, e.g., hypothyroidism, stress, autoimmune issues, mineral deficiencies, etc. In males, elevated estradiol can mimic low androgen symptoms.

Always confirm serum testosterone results (total testosterone, free testosterone (equilibrium dialysis or calculated), and bioavailable testosterone) before treatment, as the genetic variant UGT deletion can result in falsely low urinary testosterone, 5a-DHT, and 5b-androstanediol. Please see **“UGT Deletion” on page 72** for more information on this genetic deletion and the impact on DUTCH testing.

OVERVIEW

The DUTCH Test measures three DHEA metabolites: DHEA-S, etiocholanolone, and androsterone, see **Figure 4.2**.

DHEA is considered a pro-hormone, as most is converted at the tissue level to more potent androgens and estrogens. DHEA in the adrenal gland is sulfated to DHEA-S, a form that is more stable in serum and can act as a DHEA reserve. The best way to assess the total adrenal androgen production is to add up the DHEA-S, etiocholanolone, and androsterone metabolites, which equals the total DHEA production, also known as the total adrenal androgen production.

NOTE

Total DHEA = DHEA-S + etiocholanolone + androsterone

DHEA's Role in Males

DHEA supports muscle, bone, sexual function, fertility, brain health, immune function, and cardiovascular health.

DHEA Production in Males

In males, most DHEA is produced by the adrenal glands, however about 20% is produced by the testes. The adrenal glands produce 100% of DHEA-S. DHEA production peaks in young adulthood (20s) and declines with age.

Total DHEA age-dependent reference ranges for males:

- 18-40 years old: 3000-5500ng/mg
- 41-60+: 1000-2500ng/mg

DHEA IS LOW

Signs & Symptoms

Low DHEA in males may be associated with fatigue, low libido, depression, diabetes, heart disease, inflammation, and immune disorders.

Potential Root Causes

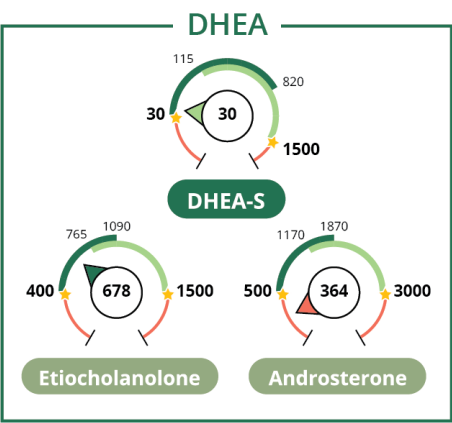
Low DHEA in males may be associated with older age, low adrenal output, HPA axis dysfunction secondary to chronic stress, inflammation, blood sugar dysregulation, hypothyroidism, and medications such as glucocorticosteroids, opioids, budesonide inhalers, and metformin.

Higher DHEA-S relative to lower total DHEA may be due to upregulated SULT2A1 activity (which sulfates DHEA) or lower STS enzyme activity (removes the “S” from DHEA-S).

Potential Support Considerations

In addition to treating the underlying cause, other considerations include DHEA replacement therapy, addressing chronic inflammation, regulating blood sugar, supporting liver detoxification, HPA axis support, and stress reduction, which may include calming herbal support, parasympathetic nervous system (PNS) support, and

Figure 4.2: Measuring DHEA



The DUTCH Test measures three DHEA metabolites including: DHEA-S, etiocholanolone, and androsterone.

GABA support. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

NOTE

Use caution with oral DHEA supplementation, as it may elevate estrogens in males.

DHEA IS ELEVATED

Signs & Symptoms

Elevated DHEA in males may be associated with androgen excess symptoms including oily skin, acne, sleep problems, headaches, and mood disturbances.

Potential Root Causes

Elevated DHEA in a males may be associated with DHEA supplementation⁵⁶, stress, high adrenal cortisol output, HPA axis dysfunction, inflammation, blood sugar dysregulation, alcohol, nicotine, testosterone supplementation⁵⁷, and medications such as Alprazolam, Anastrozole, Methylphenidate, Amlodipine, Diltiazem, and Bupropion.

Less common associations include NCAH, hyperprolactinemia, and an adrenal tumor.

Potential Support Considerations

In addition to treating the underlying cause, other considerations include addressing chronic inflammation, regulating blood sugar, supporting liver detoxification, HPA axis support, and stress reduction, which may include calming herbal support, PNS support, and GABA support. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

ANDROGEN METABOLISM

OVERVIEW OF 5-ALPHA VS 5-BETA

The DUTCH Test measures bioavailable testosterone, DHEA-S and their metabolites, see **Figure 4.3**. For a more complete view of metabolism, see **“The DUTCH Steroid Pathway” on page 89**.

Regarding androgen metabolism, a person may favor the more androgenic alpha pathway, the less androgenic beta pathway, or be balanced between the two pathways, see **Figure 4.4**.

5a-Reductase converts DHEA and testosterone into the alpha androgen metabolites: androsterone, 5a-DHT, and 5a-androstanediol. 5a-DHT is testosterone’s active metabolite. It is three times more potent than testosterone, and if elevated, may contribute to androgen excess symptoms. 5a-DHT is a peripheral hormone, and research shows that 5a-androstanediol may be a better marker of 5a-DHT tissue activity. [n]

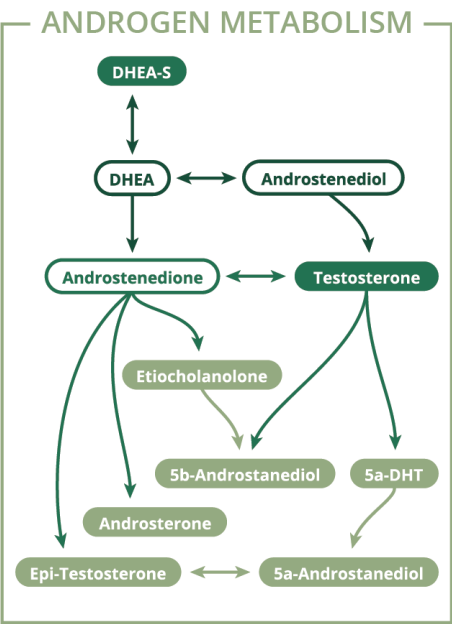
5b-Reductase converts DHEA and testosterone into the beta androgen metabolites: etiocholanolone and 5b-androstanediol. The beta androgen metabolites are generally less androgenic than the alpha androgen metabolites. Therefore, these beta metabolites are less likely to contribute to androgen excess symptoms. For example, a person who has elevated testosterone may not experience androgen excess symptoms if they metabolize most of their testosterone down the less androgenic beta pathway.

NOTE

The slider on the DUTCH Test, see **Figure 4.4**, shows the relative ratio of 5a to 5b metabolites but does not express the absolute value of 5a-DHT and 5a-androstanediol, or if 5a-reductase inhibition is or is not indicated. Consider symptoms and look at the 5a-DHT, androsterone, and 5a-androstanediol results if high androgen symptoms are a concern.

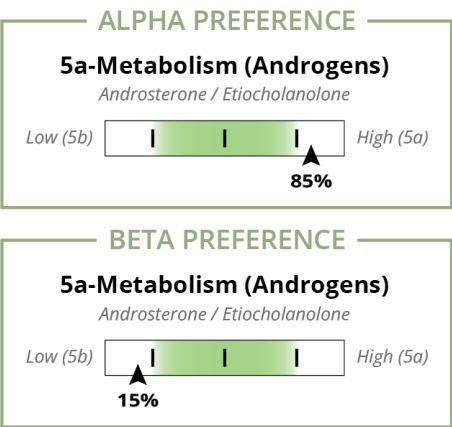
5a-Reductase and 5b-reductase are also involved in androgen (i.e., DHEA and testosterone) and cortisol metabolism. Therefore, the body’s overall preference towards alpha or beta metabolism can be further assessed by comparing alpha vs. beta metabolite levels. Alpha metabolites on the DUTCH Test include a-pregnanediol, androsterone, 5a-DHT, 5a-androstanediol, and a-THF. Beta metabolites on the DUTCH Test include b-pregnanediol, etiocholanolone, 5b-androstanediol, b-THF, and b-THE.

Figure 4.3: Androgen Metabolism



The DUTCH Test measures several androgenic metabolites that stem from testosterone and DHEA to provide a more complete picture of a patients’ metabolic health.

Figure 4.4: 5a vs 5b Androgen Preference



It may be helpful to know if there is a 5a or 5b androgen preference, because a beta preference may exacerbate signs and symptoms of low androgens such as low libido, fatigue, and weight gain.

[n] TrabET B, et al. Progesterone and Breast Cancer. Endocr Rev. 2020 Apr 1; 41(2):320–44.

CLINICAL SIGNIFICANCE

5a-Reductase Preference

A metabolic preference for the alpha pathway may lead to elevated androsterone, 5a-DHT, 5a-androstanediol, and excess androgen symptoms. Inflammation, high stress lifestyle, obesity, and blood sugar dysregulation can upregulate 5a-reductase.

Consider addressing these root causes if the goal is to decrease the alpha preference. Also consider 5a-reductase herbal blockers and medications such as metformin, spironolactone, or finasteride⁵⁸, if appropriate. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

NOTE

If DHEA and testosterone are low, a metabolic preference for the 5a-reductase enzyme may not necessarily lead to elevated 5a-DHT levels and symptoms of androgen excess.

In males, elevated 5a-DHT may lead to BPH, while elevated estradiol, especially in the setting of inflammation, may impact prostate cancer development.

5b-Reductase Preference

A metabolic preference for the beta pathway may lead to low androsterone, 5a-DHT, 5a-androstanediol, and low androgen symptoms.

Certain genetic makeups, 5a-reductase herbal blockers, and medications such as spironolactone and finasteride⁵⁹ may contribute to a beta preference, so consider addressing these root causes if the goal is to decrease the beta preference. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

Consider upregulating 5a-reductase activity with HIIT, weight resistance exercises, and supplements such as forskolin and pine pollen. Low androgen symptoms associated with low DHEA and/or testosterone may improve by directly addressing DHEA and testosterone levels.

NOTE

If DHEA and testosterone are elevated, a metabolic preference for the beta pathway may be beneficial, as it may help to keep 5a-DHT within range.

OVERVIEW

The DUTCH Test measures the three primary estrogens: Estrone (E1), Estradiol (E2), and Estriol (E3), see **Figure 4.5**.

Estradiol has the strongest stimulatory effect on estrogen receptors while estriol has the weakest effect. Estrone and estradiol can interconvert via 17b-hydroxy steroid dehydrogenase (HSD) and estriol is an estradiol and 16-OH-E1 downstream metabolite.

Estrogen's Role in Males

Over the past few decades, research has clarified the importance of healthy estrogen levels and a balanced estrogen to testosterone ratio in males. Estradiol that is well balanced with testosterone is beneficial for bone health, healthy weight-management, mood, concentration, memory, hair, skin, cardiovascular health, libido, and the ability to obtain and maintain an erection.

Estrogen Production in Males

The testes produce approximately 20% of E2 and the remaining 80% is aromatized from androgens in adipose (fat) tissue, muscle, breast, brain, liver, and bone. Therefore, most of the estrogen in males is aromatized from testosterone, androstenedione, and DHEA in the periphery.

ESTRADIOL IS LOW

Signs & Symptoms

Low E2 in males has been associated with an unfavorable lipid profile, decreased bone mineral density (even when total testosterone levels are within the normal range), erectile dysfunction, and infertility.

Low E2 in males may also result in low testosterone symptoms because E2 potentiates testosterone receptors.

Potential Root Causes

Low E2 in males is primarily due to low testosterone production, HPA axis dysfunction (high cortisol), downregulated aromatase activity⁶⁰, and diindolylmethane (DIM)/I3C⁶¹.

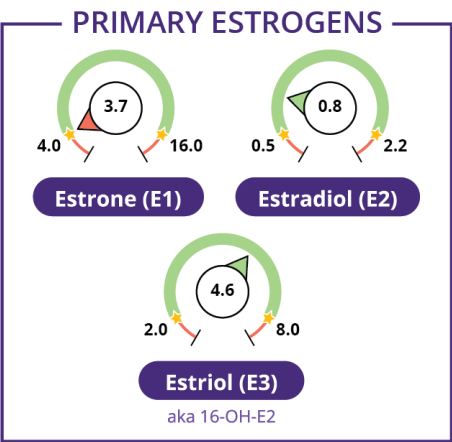
NOTE

Young males with a genetic aromatase polymorphism may present with bone fractures as a consequence of osteopenia/osteoporosis.

In males with either congenital or acquired hypogonadotropic hypogonadism, E2 will be low-normal or low.

ESTROGEN

Figure 4.5: Measuring Estrogen



The DUTCH Test measures the three primary estrogens: Estrone, Estradiol, and Estriol.

Potential Support Considerations

In addition to assessing and treating the underlying root cause, other support considerations include: for males < 50 years old herbal testosterone support, Clomid, peptides, and if fertility is an issue, hCG; TRT for males > 50 years old.

NOTE

Testosterone should always be evaluated and confirmed in the serum before initiating testosterone replacement therapy (TRT).

Additional considerations may also include supporting the HPA axis, and blood sugar regulation, see “Appendix B: Potential Support Considerations” on page 191 for more information.

ESTRADIOL IS ELEVATED

Signs & Symptoms

Elevated E2 levels in males has been associated with breast tissue enlargement, obesity, mood changes, low sex drive, and impaired erectile function.

Potential Root Causes

In males, elevated E2 levels are commonly associated with TRT at supraphysiologic doses, obesity, glucose and insulin dysregulation, inflammation, poor detoxification, endocrine disrupting chemicals (EDCs), upregulated aromatase activity⁶², and high alcohol intake.

Interpret DUTCH results with caution if oral or sublingual hormone therapy (HT) is being supplemented⁶³.

Potential Support Considerations

In addition to assessing and treating the underlying root cause, other support considerations include inhibiting aromatase naturally or with pharmaceutical aromatase inhibitors such as anastrozole, supporting estrogen detoxification and metabolism patterns, supporting the HPA axis, lowering inflammation, regulating blood sugar, weight loss (if appropriate), lowering androgens if elevated, and general liver support to further encourage hormone detoxification. See “Appendix B: Potential Support Considerations” on page 191 for more information.

PROGESTERONE

OVERVIEW

The DUTCH Test measures two progesterone metabolites in the urine: a-pregnanediol and b-pregnanediol, see Figure 4.6.

Urinary levels of progesterone metabolites have been shown to strongly correlate with serum progesterone levels when progesterone is not supplemented. [o] a-pregnanediol is a central nervous system (CNS) GABA receptor modulator and can lead to improvements in mood and sleep. b-Pregnanediol is the major progesterone metabolite, but unlike a-pregnanediol, it does not modulate GABA receptors.

Progesterone’s Role in Males

In males, progesterone’s role is not well understood. Progesterone influences sperm production and activation as well as testicular Leydig cell testosterone biosynthesis. It has neuroprotective properties and may improve sleep and mood through alpha progesterone metabolite modulation of GABA receptors. Elevated progesterone is associated with inflammation and stress.

Progesterone and the Hypothalamic-Pituitary-Adrenal (HPA) Axis

Studies evaluating interactions between the provoked HPA axis and progesterone are limited in both healthy and diseased individuals, however adrenal progesterone increases in response to stress and increased cortisol output. [p]

Progesterone Production in Males

In males, progesterone is primarily made in the adrenal glands, however testicular Leydig cells also synthesize some progesterone.

PROGESTERONE IS LOW

Signs & Symptoms

In males, low Pg may result in infertility.

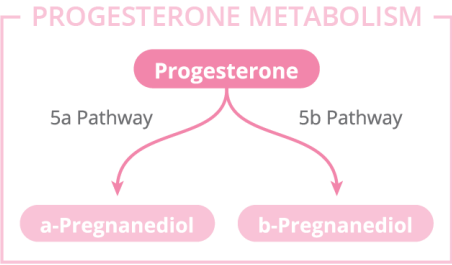
Potential Root Causes

In males the effect of low Pg is not well understood. It is plausible that low Pg may signal low overall adrenal production and/or low testicular Pg production.

Potential Support Considerations

In addition to assessing and treating the underlying root cause, other considerations include herbal testicular support with tongkat ali, ashwagandha, mucuna, Tribulus, fenugreek, and HPA axis support. See “Appendix B: Potential Support Considerations” on page 191 for more information.

Figure 4.6: Measuring Progesterone



The DUTCH Test measures two progesterone metabolites in the urine, a-pregnanediol and b-pregnanediol.

[o] Newman M, et al. Evaluating urinary estrogen and progesterone metabolites using dried filter paper samples and gas chromatography with tandem mass spectrometry (GC-MS/MS). BMC Chem. 2019; 13(1): 20.

[p] Herrera AY, et al. Stress-induced increases in progesterone and cortisol in naturally cycling women. Neurobiol Stress. 2016 Feb 11; 3:96-104.

PROGESTERONE IS ELEVATED

Signs & Symptoms

There is little research on the effect of high Pg in males.

Potential Root Causes

In males, elevated Pg may be associated with elevated cortisol, increased inflammation, and liver disease. High Pg may also be due to pregnenolone/ progesterone supplementation⁶⁴.

Potential Support Considerations

In addition to assessing and treating the underlying root cause, other considerations include stress reduction and HPA axis support. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

ANNOTATIONS

- 49
- Aromatase activity can be upregulated by obesity, inflammation, high insulin, forskolin, quercetin, genistein (bioflavonoids), white peony and licorice root, atrazine, and rutin. Genetic SNPs in CYP19A1 may also affect aromatase activity.
- 50
- Medications that can contribute to lower testosterone include performance steroids, glucocorticosteroids, opioids, Accutane, and anti-androgen therapies.
- 51
- Use caution with oral DHEA supplementation, as it may elevate estrogens (estradiol and estrone) in males.
- 52
- Use caution when interpreting testosterone results if oral or sublingual DHEA or testosterone was supplemented, as these undergo first-pass metabolism, which results in elevated urinary metabolites that do not correlate with serum levels. Androgen supplementation can suppress endogenous testosterone (and epi-testosterone) production in a dose-dependent manner. In these cases, epi-testosterone may provide a rough approximation of endogenous testosterone production.
- 53
- If testosterone is elevated but the downstream androgen metabolites are not (5a-DHT, 5a-androstenediol, 5b-androstenediol), consider the possibility of sample contamination with testosterone from someone in the house or gym using TRT.
- 54
- Medications that may contribute to elevated testosterone include aromatase inhibitors, luteinizing hormone (LH), growth hormone (GH), gonadotropin-releasing hormone (GnRH) analogs (hCG, gonadorelin, kisspeptin, etc.), and clomiphene citrate (a SERM, selective estrogen receptor modulator).
- 55
- Aromatase activity can be downregulated by enterolactone, apigenin, chrysin and other flavonoids, white button mushrooms, grape seed extract, red wine procyanidin dimers, antifungal medications, metformin, glyphosate, smoking, antiepileptic drugs, and pharmaceutical aromatase inhibitors. Genetic SNPs in CYP19A1 may also affect aromatase activity.
- 56
- Use caution when interpreting total DHEA if testosterone replacement therapy (TRT) and/or DHEA was taken. Testosterone can metabolize into, and elevate, androsterone and etiocholanolone. As total DHEA is calculated by adding up DHEA-S + etiocholanolone + androsterone + TRT (or even high endogenous testosterone) may elevate this calculated marker. Additionally, oral, or sublingual supplemented testosterone and DHEA undergo first-pass metabolism in the gut and liver, which results in elevated urine metabolites that do not correlate with serum levels. Oral DHEA can create false elevations when used during testing.

- 57
- Use caution when interpreting total DHEA if testosterone replacement therapy (TRT) and/or DHEA was taken. Testosterone can metabolize into, and elevate, androsterone and etiocholanolone. As total DHEA is calculated by adding up DHEA-S + etiocholanolone + androsterone, TRT (or even high endogenous testosterone) may elevate this calculated marker. Additionally, oral, or sublingual supplemented testosterone and DHEA undergo first-pass metabolism in the gut and liver, which results in elevated urine metabolites that do not correlate with serum levels. Oral DHEA can create false elevations when used during testing.
- 58
- In males and females, finasteride and dutasteride may cause irreversible sexual dysfunction and infertility.
- 60
- Aromatase activity may be downregulated by enterolactone, apigenin, chrysin and other flavonoids, white button mushrooms, grape seed extract, red wine procyanidin dimers, antifungal medications, metformin, glyphosate, smoking, antiepileptic drugs, and pharmaceutical aromatase inhibitors. Genetic SNPs in CYP19A1 may also affect aromatase activity.
- 61
- Diindolylmethane (DIM) and indole-3-carbinol (I3C) are sometimes used in order to induce CYP-1a1 (the “preferred” pathway towards 2-OH), however be mindful that they also tend to lower E1 and E2 (Newman, M., Smeaton, J. Exploring the impact of 3,3’-diindolylmethane on the urinary estrogen profile of premenopausal women. BMC Complement Med Ther 24, 405 (2024).) which may not be appropriate for every patient. When using DIM and/ or I3C, it is important that phase 2 detoxification is well supported so that the phase 1 metabolites do not build up in the body and cause oxidative damage.
- 62
- Aromatase activity can be upregulated by obesity, inflammation, high insulin, forskolin, quercetin, genistein (bioflavonoids), white peony and licorice root, atrazine, and rutin. Genetic SNPs in CYP19A1 may also affect aromatase activity.
- 63
- Use caution when interpreting E2 results if oral or sublingual estrogen, DHEA or testosterone was supplemented, as these undergo first-pass metabolism, which results in elevated urinary metabolites that do not correlate with serum levels. DUTCH suggests stopping oral DHEA 48 hours prior to collection and estrogen and testosterone 72 hours prior to collection.
- 64
- Use caution when interpreting progesterone metabolite results with oral or sublingual progesterone or pregnenolone, as these undergo first pass-metabolism, which results in elevated urinary metabolites that do not correlate with serum levels.

Estrogen Detoxification

Introduction

Healthy estradiol metabolism and clearance is important for regulating estradiol levels and reducing female and male cancer risk (endometrial and prostate, respectively).

NOTE

For a more complete view of metabolism, see “The DUTCH Steroid Pathway” on page 89.

Phase 1 Detox

In phase 1, E1 and E2 are hydroxylated into 2-hydroxy (2-OH), 4-hydroxy (4-OH), and 16-hydroxy (16-OH) metabolites. These intermediate metabolites require further processing to be ready for elimination.

NOTE

If phase 1 metabolites are much lower relative to their parent estrogens (E1 and E2), this implies sluggish phase 1 clearance of estrogens, which can contribute to estrogen excess.

Oppositely, if the phase 1 metabolites are much higher relative to their parent estrogens (E1 and E2), then this implies fast phase 1 clearance of estrogens, which can contribute to estrogen deficiency. Phase 1 detoxification, for example, is upregulated by products containing DIM or I3C. This pattern can also occur with sluggish phase 2 metabolism, however.

Phase 2 Detox

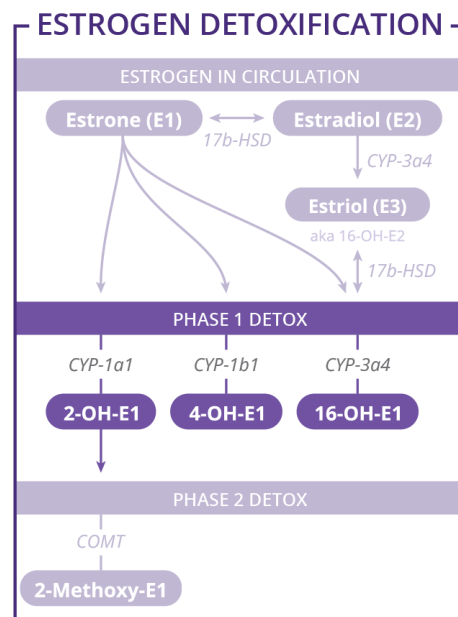
In phase 2, the phase 1 estrogen metabolites are methylated, sulfated, glucuronidated, and conjugated with glutathione. For example, 2-hydroxy-estrone is methylated to 2-methoxy-estrone, a compound that is more stable and ready for excretion from the body.

Phase 3 Detox

In phase 3, estrogens are eliminated in bile (stool) and urine.

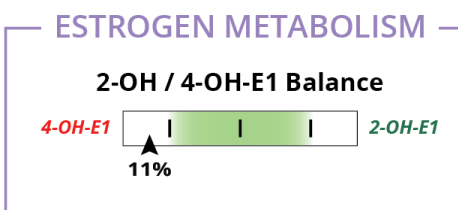
PHASE 1 DETOX

Figure 5.1: Phase 1 Detox



During phase 1, E1 and E2 are hydroxylated into 2-OH, 4-OH, and 16-OH metabolites.

Figure 5.2: 2-OH/4-OH-E1 Balance



This patient has a 2-OH-E1 to 4-OH-E1 ratio of 11% and is an example of a strong 4-OH preference (i.e., low 2-OH preference).

OVERVIEW

During phase 1, E1 and E2 are hydroxylated into 2-OH, 4-OH, and 16-OH metabolites, see **Figure 5.1**. For a more complete view of metabolism, see **“The DUTCH Steroid Pathway” on page 89**.

2-OH catechol estrogens are the most stable of the phase 1 metabolites. The 4-OH pathway is the least stable and can form reactive quinones that bind to DNA, causing damage. This can increase breast cancer risk over time. The 16-OH catechol estrogens have small but significant binding potential on estrogen receptors and are therefore considered estrogenic.

When evaluating phase 1 metabolism, it is important to look at the ratios of 2-OH/4-OH-E1 and 2-OH/16-OH-E1 to see which pathways are metabolically preferred.

2-HYDROXY-ESTRONE (2-OH-E1)

CYP-1a1 is the enzyme responsible for the metabolism of E1 to 2-OH-E1 and E2 to 2-OH-E2. This is the preferred pathway because 2-OH-E1 is the most stable of the three phase 1 estrogen metabolites measured on the DUTCH Test. The 2-OH metabolites have the weakest binding potential to the estrogen receptor when compared to the 4-OH and 16-OH-E1 metabolites.

Like the 4-OH estrogen metabolites, the 2-OH metabolites have the potential to become reactive quinones that bind to DNA and cause DNA damage, especially if they are not adequately methylated. However, unlike the 4-OH estrogen metabolites, when 2-OH metabolites bind to DNA they create stable DNA adducts instead of more damaging (unstable) depurating adducts. Overall, it's best if 2-OH-E1 and 2-OH-E2 are within range.

Potential Support Considerations if Low

If the 2-OH-E1 dial is high, consider supporting phase 2 and phase 3 estrogen detoxification and lowering estrogen if elevated. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

Potential Support Considerations if Elevated

If the 2-OH-E1 dial is high or the 2-OH pie chart percentage is above 80%, consider supporting phase 2 and phase 3 estrogen detoxification and lowering estrogen if elevated. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

4-HYDROXY-ESTRONE (4-OH-E1)

CYP-1b1 is the enzyme responsible for E1 metabolism to 4-OH-E1 and E2 to 4-OH-E2. This pathway is considered the most genotoxic as the 4-OH estrogen metabolites can become reactive quinones that have the potential to bind to DNA and form damaging (unstable) depurating adducts. 4-OH estrogen metabolites may increase breast, endometrial, and prostate cancer risk.

Potential Support Considerations if Elevated

If the 4-OH-E1 dial is high or the pie chart 4-OH percentage is above 11%, consider assessing for CYP-1b1 inducers⁶⁵, lowering estrogen if elevated, supporting CYP-1a1 and the 2-OH preferred pathway, supporting phase 2 and phase 3 estrogen detoxification, and supporting glutathione and antioxidants to help neutralize the reactive quinones and potentially reduce the downstream DNA damage. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

16-HYDROXY-ESTRONE (16-OH-E1)

CYP-3a4 is the enzyme responsible for E1 metabolism to 16-OH-E1, and E2 to 16-OH-E2 (estriol). 16-OH-E1 is a proliferative estrogen, although less estrogenic than estradiol. The 16-OH-E1 metabolites bind most strongly to the estrogen receptor when compared to the 2-OH and 4-OH metabolites, however, its binding potential is still considered weak when compared to E2.

Elevations in 16-OH-E1 may exacerbate estrogen excess symptoms and can contribute to estrogen sensitive tissue proliferation (breast, endometrial, prostate, etc.). 16-OH-E2 (also known as E3, or estriol) is a safer estrogen metabolite, as it is a very weak estrogen and may have protective properties. Both 16-OH-E1 and 16-OH-E2 are important for bone health.

Potential Support Considerations if Low

If the 16-OH-E1 dial is low, consider supporting bone health, as a high 2-OH/16-OH ratio may be less beneficial for bone mineral density. If E2 is within the expected range, then there may be less concern for a lower 16-OH-E1, as E2 is a more potent estrogen than 16-OH-E1 and has the greatest bone-protective effects. Assess for CYP-3a4 inhibitors as these may decrease 16-OH-E1⁶⁶ metabolism, and consider supporting estrogen, if appropriate. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

Potential Support Considerations if Elevated

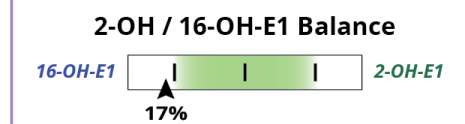
If the 16-OH-E1 dial is high consider assessing for CYP-3a4 inducers⁶⁷, lowering estrogen if elevated, supporting CYP-1a1 and the 2-OH preferred pathway, and supporting phase 2 and phase 3 estrogen detoxification. 16-OH-E1 gets glucuronidated and sulfated in phase 2, see **“Appendix A: DUTCH Test Patterns” on page 190** and **“Appendix B: Potential Support Considerations” on page 191**, for more information.

NOTE

CYP-3a4 is a major detoxification enzyme in the body and is involved in the metabolism of many pharmaceutical medications, so use caution if inhibiting its enzymatic activity.

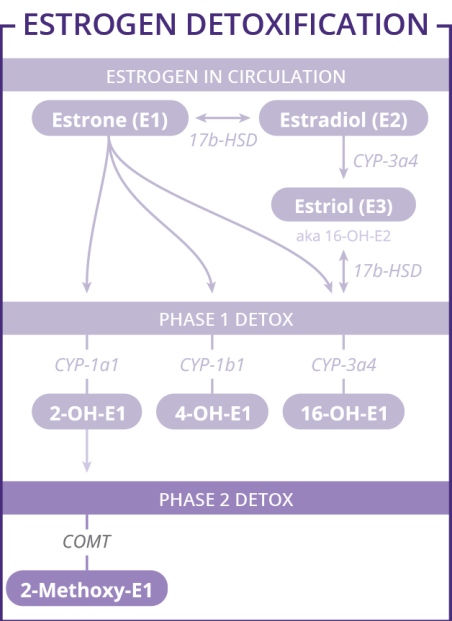
Figure 5.3: 2-OH / 16-OH-E1 Balance

– ESTROGEN METABOLISM



This patient has a 2-OH-E1 to 16-OH-E1 ratio of 17% and is an example of a strong 16-OH preference (i.e., low 2-OH preference).

Figure 5.4: Phase 2 Detox



After phase 1, estrogens go through further transformation through phase 2 detox, where the DUTCH Test measures 2-methoxy-E1.

OVERVIEW

After phase 1, estrogens go through further transformation through phase 2 detox, see **Figure 5.44**. Many phase 1 estrogen metabolites have the potential to cause oxidative damage. Therefore, it's important that the 2-OH and 4-OH catechol estrogens (phase 1 estrogen metabolism products) are efficiently and adequately methylated, sulfated, and glucuronidated in phase 2 and inactivated into more stable, water-soluble compounds like 2-Me-E1.

The DUTCH Test measures the phase 2 estrogen metabolite, 2-methoxy-E1. Phase 2 methylation activity is measured by comparing the relative amount of 2-OH-E1 to 2-Me-E1 in the slider, see **Figure 5.5.5**.

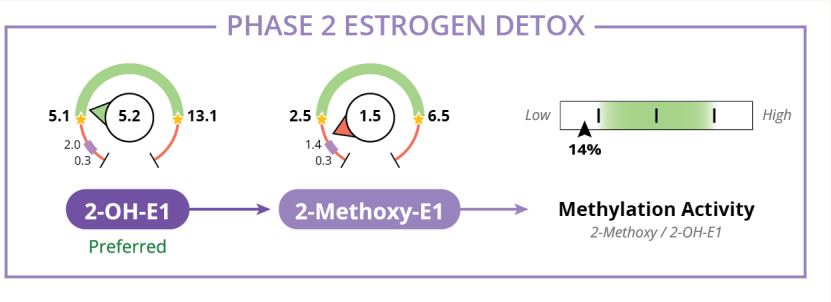


Figure 5.5: Methylation Activity Population Slider
Phase 2 methylation activity is measured by comparing the relative amount of 2-OH-E1 to 2-Me-E1 in the population slider.

2-METHOXY-ESTRONE (2-Me-E1)

Methylation of the 2-OH and 4-OH catechol estrogens in phase 2 is carried out by the COMT (catechol-o-methyltransferase) enzyme. COMT helps metabolize catechols through the liver⁶⁸.

Adequate methylation activity is important for converting reactive phase 1 metabolites into water-soluble, inactive estrogen metabolites that can no longer damage DNA.

The methylation activity slider shows the person's ratio of 2-Me-E1 to 2-OH-E1. The DUTCH Test provides insight into catechol estrogen methylation activity. The methylation gauge does not measure whole body methylation.

We often see that those with COMT SNPs tend to have lower methylation activity reflected on DUTCH testing.

If estrogen methylation is sluggish, then the 2-OH and 4-OH catechol estrogens can become oxidized to form 2- and 4- estrogen reactive quinones. These quinones, especially the 4-OH quinones, can damage DNA and increase cancer risk.

NOTE

If the 2-Me-E1 dial is high: The 2- and 4-methoxy estrogens appear to have anti-cancer benefits, so an elevated 2-methoxy-E1 itself may not be problematic. In contrast, elevated phase 1 metabolites can be problematic and should be assessed.

Methylation Activity is Low

This indicates sluggish 2-OH-E1 methylation. Sluggish methylation can be due to genetics (COMT, MTHFR, etc.)⁶⁹, epigenetics (environmental or lifestyle factors that affect gene expression), decreased precursors, and factors that may inhibit methylation, such as estrogen dominance, gut infections, quercetin, green tea, PCBs, BPA, heavy metals, and nutrient deficiencies.

The rate-limiting nutrients for COMT include vitamin B6 and magnesium. Deficiencies in folate or vitamin B6, B12, glycine, choline, or methionine can cause decreased methyl donors. Consider testing genetic SNPs associated with COMT and MTHFR. See the **“Appendix B: Potential Support Considerations” on page 191** for more information on how to support methylation.

Methylation Activity is Elevated

May suggest quick function of the COMT enzyme for estrogen metabolism. This is much less common than under-methylation and may be due to high intake of methylation supplements or a fast COMT, which can be genetic.

Methylation Activity is Within Range

This indicates that methylation of 2-OH-E1 is not sluggish. In some instances, supporting methylation may still be appropriate (for example, in cases of estrogen excess).

OVERVIEW

Phase 3 of estrogen detoxification describes the excretion of estrogen from the body via bile, stool, and urine. The hormones from phase 2 go through phase 3 estrogen detoxification, where they are eliminated in the bile (via stool) and urine. It is important that phase 3 is functioning optimally.

The DUTCH Test does not include any direct phase 3 estrogen detoxification markers. Measuring the enzyme beta-glucuronidase in stool may be helpful if estrogen is elevated, as elevations in this enzyme can result in estrogens being reabsorbed from the stool and recirculated in the body.

Indican

Indican is a gastrointestinal tract dysbiosis marker, see “**Indican**” on page 181 for more information. Elevated indican may identify people with dysbiosis, which may impact estrogen levels. Consider supporting phase 3 by ensuring adequate bowel movements, hydration, fiber, calcium-d-glucarate, and stress reduction.

- 65

CYP-1b1 inducers include inflammation, polycyclic aromatic hydrocarbons (PAHs), xenoestrogens, alcohol, and smoking. There may also be a genetic predisposition for faster CYP-1b1 activity.
- 66

CYP-3a4 inhibitors include resveratrol, peppermint, rosemary, wild yam, CBD, grapefruit, and various medications. There may also be a genetic predisposition for slower CYP-3a4 activity.
- 67

CYP-3a4 inducers include St. John’s wort, pesticides, caffeine, excess omega-6 fatty acid consumption, inflammatory cytokines (especially in the gut), smoking, polycyclic aromatic hydrocarbons (PAHs), alcohol, obesity, and hypothyroidism. There may also be a genetic predisposition for faster CYP-3a4 activity.
- 68

Catechols include 2-OH and 4-OH estrone and estradiol metabolites, dopamine, norepinephrine and epinephrine, coffee, dark chocolate, and green tea.
- 69

Genetic SNPs in MTHFD1, SHMT1, MTHFR, MTR, MTRR, BHMT, COMT, FUT2 and TCN2 may affect methylation capacity. Note that genetic SNPs in COMT that slow COMT activity can slow methylation activity even in the presence of adequate methyl donors.

Cortisol

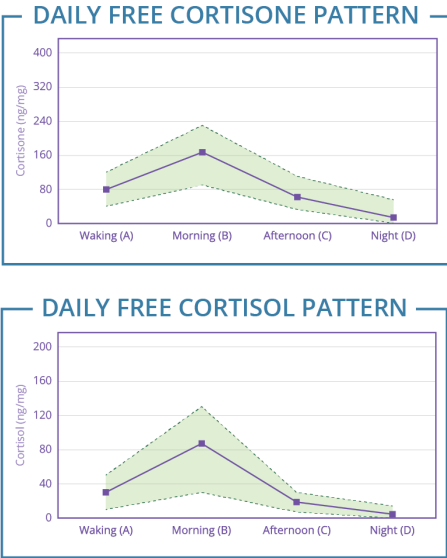
Introduction

Cortisol research is ever changing. The information presented below is extrapolated from the data and research completed at DUTCH and represents our best understanding and interpretation of the existing data on cortisol and its metabolism. We appreciate your understanding as we continue to reach for excellence in updating our resources.

Cortisol is an essential hormone that is released by the adrenal cortex zona fasciculata in small amounts on a daily basis in a circadian rhythm. Cortisol is released in larger amounts in response to stress. Cortisol, a glucocorticoid, helps control blood sugar levels, regulates mood and metabolism, reduces inflammation, and assists with memory formation.

Cortisol production is governed by the HPA axis. The HPA axis is the communication between the hypothalamus and pituitary gland in the brain and the adrenal glands located on the tops of the kidneys. When cortisol is needed in the body, the hypothalamus releases cortisol releasing hormone (CRH) and the pituitary responds by releasing adrenocorticotrophic (ACTH). ACTH signals the adrenal glands to release cortisol, DHEA, DHEA-S, and androstenedione. Assessing these hormones on the DUTCH Test can give insight into HPA axis function and health.

Figure 6.1: Measuring Cortisol



The DUTCH Test measures the diurnal patterns of cortisol and cortisone throughout the day.

OVERVIEW

Cortisol should have a diurnal pattern that is highest in the morning and lowest at night before bedtime. In most instances, daily patterns of free cortisol and free cortisone will be substantially similar, see **Figure 6.1**.

NOTE

Patients are instructed to collect on a typical day to best capture their typical cortisol pattern. Abnormal results should be considered along with the person's symptoms and any unusual occurrences of the day.

In some patients, such as patients with exposure to topical hyrdocortisone cream, cortisol can be significantly elevated, and cortisone daily patterns provide a more accurate representation of HPA axis function and may be used to assess diurnal pattern. See **“Cortisol (Hydrocortisone Cream) Contamination” on page 166** for more information.

USING THE DUTCH TEST

Total Free Cortisol

We can assess cortisol's overall tissue availability by looking at the 24-hour free cortisol and cortisone, see **“Total Free Cortisol” on page 162** for more information.

Daily Free Cortisol & Cortisone Patterns

We can estimate HPA axis function/dysfunction by looking at the free cortisol and free cortisone daily patterns, see **“The Cortisone Shadow” on page 164** for more information.

Metabolized Cortisol

We can estimate the total adrenal cortisol production by assessing metabolized cortisol, see **“Metabolized Cortisol” on page 167** for more information.

Cortisol Clearance Rate

We can estimate the cortisol clearance rate by comparing the 24-hour free cortisol and cortisone with metabolized cortisol, see **“Cortisol Clearance Rate” on page 168** for more information.

THE vs THF Preference

We can estimate the systemic preference for (inactive) cortisone or (active) cortisol by looking at the DUTCH Test THE vs. THF slider, see **“THE vs THF” on page 170** for more information.

SIGNS & SYMPTOMS OF LOW CORTISOL

Low cortisol may be associated with fatigue, burnout, low mood, low motivation, low libido, sleep apnea, orthostatic hypotension, feeling dizzy/weak, and fainting.

Other potential causes for these symptoms include:

- Fatigue/Burnout: Low testosterone, sleep dysregulation, lifestyle/diet choices, infection, autoimmunity, blood sugar dysregulation, nutrient deficiency, neurotransmitter issues, thyroid issues, electrolyte imbalance, high histamine.
- Low Mood/Low Motivation: Neurotransmitter issues, thyroid issues, nutrient deficiency, low or high estrogen, low testosterone, low DHEA.
- Low Libido: Low testosterone, low DHEA, low estrogen, sleep dysregulation, neurotransmitter issues, thyroid issues.
- Sleep Apnea: Overweight, head/neck anatomy, infection (especially sinus), high histamine.
- Orthostatic Hypotension: Dehydration, nutrient deficiency, electrolyte imbalance, POTS, blood sugar dysregulation.
- Feeling Dizzy/Weak/Fainting: Dehydration, nutrient deficiency, electrolyte imbalance, infection, sleep dysregulation, blood sugar dysregulation.

See **“Appendix B: Potential Support Considerations” on page 191** for help targeting these potential root causes.

SIGNS & SYMPTOMS OF ELEVATED CORTISOL

Elevated cortisol may be associated with anxiety, depression, panic attacks, insomnia, weight gain (belly fat), brain fog, inflammation, pain, insulin/blood sugar dysregulation, high blood pressure, and hair loss.

Other potential causes for these symptoms include:

- Anxiety/Depression/Panic Attacks: High estrogen, low progesterone, neurotransmitter issues, thyroid issues, sleep dysregulation, blood sugar dysregulation, nutrient deficiency.
- Insomnia: Blood sugar dysregulation, nighttime blue light exposure, caffeine or alcohol before bed, thyroid issues, gut dysbiosis, low progesterone, low melatonin.
- Weight Gain (Belly Fat): Lifestyle/diet choices, low testosterone, low DHEA, high estrogen, hypothyroidism, blood sugar dysregulation, sleep dysregulation.
- Brain Fog: Low estrogen, nutrient deficiency, neurotransmitter issues, thyroid issues, blood sugar dysregulation.
- Inflammation/Pain: Lifestyle/diet choices, lack of exercise, nutrient deficiency.
- Insulin/Blood Sugar Dysregulation: Lifestyle/diet choices, lack of exercise, nutrient deficiency.
- High Blood Pressure: Kidney disease, nutrient deficiency, cardiovascular issues, age, tobacco use, diabetes, overweight/obesity, lifestyle/diet changes.
- Hair Loss: Thyroid issues, iron deficiency, endocrine disruptors, nutrient deficiency, high androgen (testosterone or DHT).

See **“Appendix B: Potential Support Considerations” on page 191** for help targeting these potential root causes.

OVERVIEW

Total free cortisol⁷⁰ is the best marker to assess overall tissue exposure to cortisol. It is calculated by adding up the four urinary (or five salivary) free cortisol points on the graph. It correlates well with a true 24-hour urine free cortisol; however, it does not consider transitory shifts in cortisol in the late morning and early afternoon.

When considering treatments that affect the entire HPA axis, also look at the metabolized cortisol to get an idea of total cortisol production. Total free cortisol and metabolized cortisol levels don't always agree due to the differences in the cortisol clearance rate. For example, if a person has a fast clearance rate, then their free cortisol may be low while their metabolized cortisol may be above range. Keep in mind that free cortisol only represents about 5% of the total circulating cortisol. The other 95% is bound to cortisol binding globulin (80-90%) and albumin (10%).

NOTE

If the total free cortisone dial points higher than the total free cortisol dial, then the free cortisol in circulation may not be as low as the free cortisol graph implies. See “Special Cases” on page 163 and “The Cortisone Shadow” on page 164, for more information.

When the term “total free cortisol” is used, it is referencing the 24-hour free cortisol for urinary results (DUTCH Complete, Adrenal panel) or the “total salivary cortisol” for salivary results (DUTCH Plus, DUTCH CAR):

- Total free cortisol (urine) = 24-hour free cortisol
- Total free cortisol (saliva) = total salivary cortisol

SIGNS, SYMPTOMS, & ASSOCIATED CONDITIONS

See “Appendix B: Potential Support Considerations” on page 191 for help targeting these potential root causes.

Free Cortisol is Low

Low free cortisol may be associated with fatigue, burnout, low mood, low motivation, low libido, dizziness, weakness, fainting, sleep apnea, orthostatic hypotension, traumatic brain injuries (TBI), concussions, and PTSD. Elevated renal glomerular filtration rate (GFR) can lead to falsely low free cortisol in the urine; however, it does not affect the metabolized cortisol value.

Free Cortisol is Elevated

High free cortisol may be associated with stress, anxiety, panic attacks, depression, insomnia, weight gain (belly fat), brain fog, blood sugar dysregulation, inflammation, pain, high blood pressure, hair loss, and immune suppression. Low urinary creatinine can elevate urinary free cortisol⁷¹. Consider checking in with the person regarding the events that took place during collection day, as cortisol is an acute stress response hormone and results could reflect a high stress state that may not be a daily occurrence. Cortisol can elevate due to low blood sugar, anticipatory stress, anxiety, stressful events, acute inflammation, acute pain, intense exercise and caffeine intake.

Free Cortisol is Within Range

A normal free cortisol reflects a non-stressful environment when testing.

A normal free cortisol may be associated with a healthy blood pressure, blood sugar regulation, reduced inflammation, and improved mood, energy, motivation, focus, and sleep.

SPECIAL CASES

Free Cortisone is Higher Than Free Cortisol

The enzyme 11b-HSD2 deactivates cortisol to cortisone locally in the kidneys and salivary glands. When the activity of this enzyme is increased, more cortisol will show up in the urine or saliva as cortisone. Therefore, if the total free cortisone dial points higher than the total free cortisol dial, then the free cortisol in circulation may not be as low as the free cortisol graph implies.

Free Cortisol is Higher Than Free Cortisone

A free cortisol that is higher than free cortisone suggests an acute stressor when testing and may be associated with acute migraines, high fever, psychological stressor, or injury, to name a few.

However, a free cortisol that is higher than free cortisone may be due to hydrocortisone contamination, see **Figure 6.2**. Hydrocortisone contamination only affects free cortisol, not free cortisone. Despite its name, hydrocortisone is active cortisol. In this setting, use of free cortisone to estimate tissue availability may better represent the diurnal cortisol pattern, see “Cortisol (Hydrocortisone Cream) Contamination” on page 166 for more information.

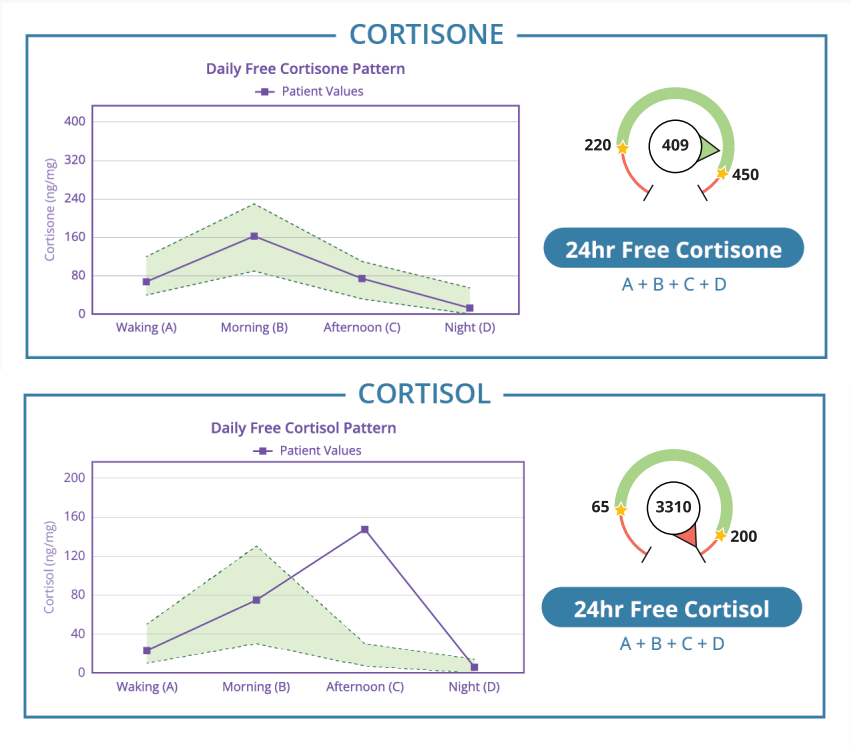
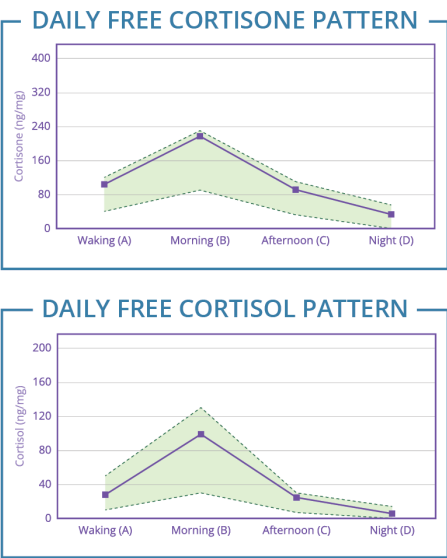


Figure 6.2: Hydrocortisone Contamination

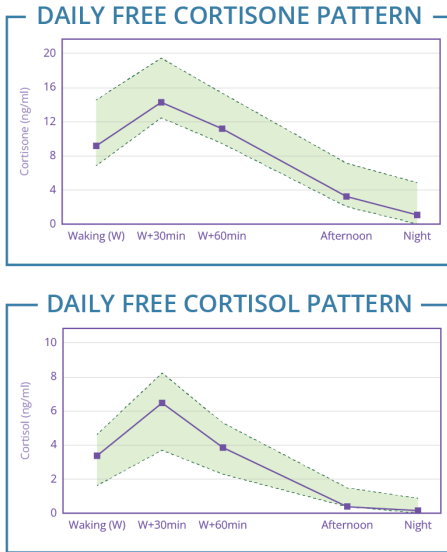
A free cortisol that is much higher than a free cortisone may be due to hydrocortisone contamination.

Figure 6.3: Free Cortisol and Free Cortisone’s Diurnal Pattern in Urine



Both free cortisol and free cortisone have a diurnal pattern in the urine.

Figure 6.4: Free Cortisol and Free Cortisone’s Diurnal Pattern in Saliva



Both free cortisol and free cortisone have a diurnal pattern in the saliva.

OVERVIEW

There are two graphs on the DUTCH adrenal page: one shows the diurnal pattern of free cortisol whereas the other shows the diurnal pattern of free cortisone.

Most clinicians are familiar with reading the first pattern (free cortisol only) and are not sure what to do with the free cortisone graph, especially when the two diurnal patterns don’t match. Please read through this section and look at the images to learn about the significance and importance of using the free cortisone pattern to get a better understanding of free cortisol levels in circulation.

Measuring Cortisone

Cortisone is the inactive form of cortisol and is made directly from cortisol in the kidneys, colon, and saliva glands. (active --> inactive) It is then converted back to cortisol in the liver, fat, etc. (inactive --> active).

Cortisone does not have a diurnal pattern in the serum [q], but it does in urine and saliva, see **Figure 6.3** and **Figure 6.4**.

Free cortisone in the urine and saliva reflects the free cortisol that entered the kidneys or the saliva glands and was converted to cortisone locally before excretion. This makes free cortisone a secondary, confirmatory marker for the up and down diurnal pattern of free cortisol.

NOTE

Studies have found salivary free cortisone to correlate to serum free cortisol better than salivary free cortisol. [r][s]

Some benefits of testing cortisone include:

- It helps to confirm the diurnal pattern of cortisol.
- Sometimes it provides more clinically useful information than the free cortisol pattern (examples later in this section).
- It helps to identify if there is potential cortisol contamination from medications like topical eczema creams that contain hydrocortisone (bioidentical cortisol).

[q] Walker BR, et al. Mineralocorticoid excess and inhibition of 11 beta-hydroxysteroid dehydrogenase in patients with ectopic ACTH syndrome. Clin Endocrinol (Oxf). 1992 ;37(6):483-492.

[r] Blair J, et al. Salivary cortisol and cortisone in the clinical setting. Curr Opin Endocrinol Diabetes Obes. 2017; 24(3):161-168.

[s] Perogamvros I, et al. Salivary Cortisone Is a Potential Biomarker for Serum Free Cortisol. J Clin Endocrinol Met. 2010; 95(11):4951-4958.

HOW TO READ THE FREE CORTISONE PATTERN

First, keep in mind that the goal is to understand the free cortisol pattern in circulation. This is best measured in the serum (via serial blood draws), however this method of measurement is very impractical and stressful for many people, so saliva and urine measurements are more accurate. Fortunately, salivary and urinary cortisone reflect systemic free cortisol.

PATTERN EXAMPLES

Both Free Cortisol & Cortisone Match

When the free cortisol and free cortisone patterns in the urine or saliva match (both high, both low, both normal), cortisone confirms cortisol. In **Figure 6.5**, cortisone and cortisol follow the same pattern. High cortisol in the afternoon and evening is confirmed by high cortisone in the afternoon and evening. Similarly, in **Figure 6.6**, low/flat cortisol throughout the day is confirmed by low/flat cortisone throughout the day.

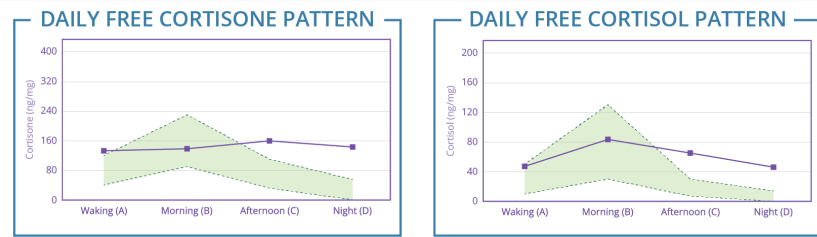


Figure 6.5: Free Cortisol and Free Cortisone Match
In this example the free cortisone pattern confirms the elevated afternoon and evening free cortisol.

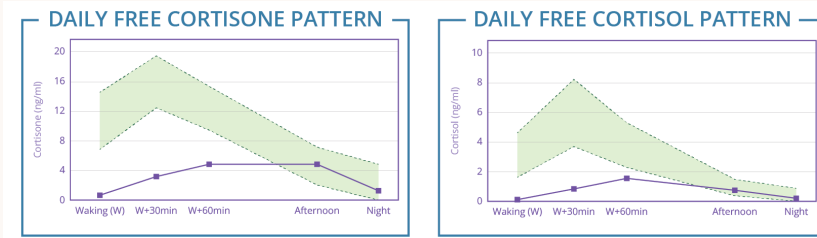


Figure 6.6: Free Cortisol and Free Cortisone are Both Low
In this example, the low free cortisone pattern confirms low free cortisol.

Free Cortisol is Elevated but Cortisone is Not

When free cortisol in the urine or saliva is high but cortisone is not (free cortisone is normal or low), then free cortisol levels may not be quite as high in circulation (serum) as the cortisol levels in the urine or saliva imply.

NOTE

This pattern with elevated free cortisol could be due to hydrocortisone contamination, see **“Cortisol (Hydrocortisone Cream) Contamination” on page 166** for more information.

Free Cortisol is Low, but Cortisone is Not

When free cortisol in the urine or saliva is low but free cortisone is not (free cortisone is normal or elevated), free cortisol levels may not be quite as low in circulation (serum) as the cortisol levels in the urine or saliva imply, and this should influence your approach to symptoms.

In **Figure 6.7**, the free cortisol is lower in the reference range than the free cortisone at each point on the graph. Since free cortisone comes from free cortisol, free cortisone may reflect serum free cortisol better in this case. For unknown reasons, this person's kidneys deactivate cortisol into cortisone more than most. If only free cortisol was tested, this person might be incorrectly treated for very low cortisol. Instead, this person's total free cortisol in circulation is likely on the higher end, as their urine free cortisone total is above range.

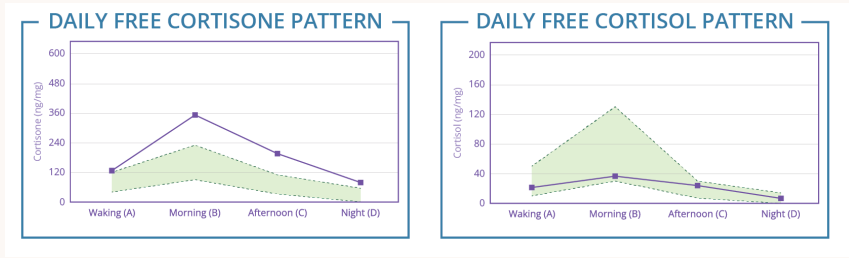


Figure 6.7: Free Cortisol is Low but Free Cortisone is Not
If only free cortisol was tested, this person might be incorrectly treated for very low cortisol.

CORTISOL (HYDROCORTISONE CREAM) CONTAMINATION

Despite its name, hydrocortisone is actually bioidentical active cortisol. When a person touches the sample paper with hydrocortisone cream on their hands (even a little), it can contaminate the sample paper.

Cortisol must enter the body in order to be deactivated to cortisone, thus when the sample paper is contaminated by hydrocortisone cream, the free cortisol will be affected but the free cortisone won't. In these cases, the free cortisol pattern can be ignored, and the free cortisone pattern is more accurate.

In **Figure 6.8**, the patient contaminated their bedtime sample with hydrocortisone cream. Hydrocortisone cream contamination affects the free cortisol graph only, thus the free cortisone graph is a better representation of their true free cortisol diurnal pattern.

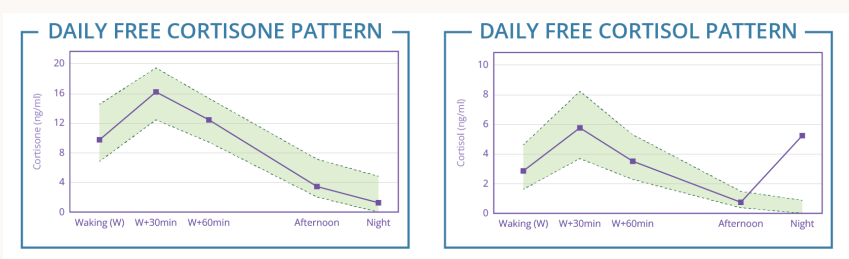


Figure 6.8: Hydrocortisone Contamination in the Saliva
A free cortisol that is much higher than a free cortisone may be due to hydrocortisone contamination.

OVERVIEW

Metabolized cortisol is the sum of a-THF, b-THF, and b-THE (the most abundant cortisol metabolites), see **Figure 6.9**. Metabolized cortisol may be the best marker for assessing total adrenal cortisol production. Remember, this is influenced by HPA axis signaling and cortisol clearance rates.

SIGNS, SYMPTOMS, & ASSOCIATED CONDITIONS

See **“Appendix B: Potential Support Considerations” on page 191** for help targeting these potential root causes.

Metabolized Cortisol is Low

Total cortisol production may be low. Low cortisol production may be associated with long-term stress, poor sleep hygiene, untreated chronic sleep apnea, pituitary or hypothalamic dysfunction, and certain medications known to suppress HPA axis activity⁷². Less common associations may include TBI, NCAH, CAH, and Addison's disease⁷³.

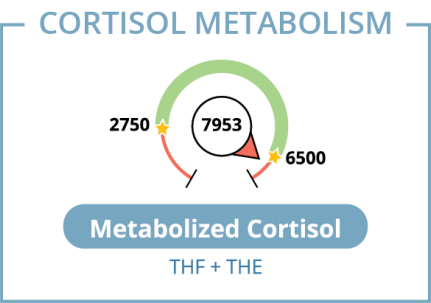
Metabolized Cortisol is High

Total cortisol production may be high. High cortisol production may be associated with stress, anxiety, acute inflammation, infection, pain, caffeine, blood sugar dysregulation, Cushing's syndrome⁷⁴, and oral hydrocortisone supplementation⁷⁵.

Metabolized Cortisol is Within Range

Total cortisol production appears appropriate for the clinical situation⁷⁶. Normal cortisol metabolism and clearance does not rule out conditions that may result in low or high metabolized cortisol, as outlined above.

Figure 6.9: Metabolized Cortisol (Total Cortisol Production)



Metabolized cortisol is the sum of the cortisol metabolites a-THF, b-THF, and b-THE, and may be the best marker for assessing total adrenal cortisol production.

OVERVIEW

We can estimate the cortisol clearance rate (CCR) by comparing the total free cortisol⁷⁷ with the metabolized cortisol.

CCR IS SLOW:
METABOLIZED CORTISOL < FREE CORTISOL

Potential Root Causes

This hypometabolic pattern may indicate that cortisol clearance rate is slow, **Figure 6.10**. Slow cortisol metabolism and clearance may be associated with things that tend to lower the overall metabolic rate, such as hypothyroidism (or insufficient thyroid medication), low calorie intake (anorexia), low bile acid, and poor liver and mitochondrial function.

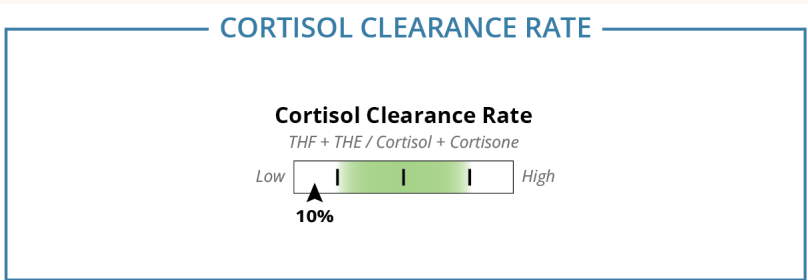


Figure 6.10: Cortisol Clearance Rate is Slow
When metabolized cortisol is relatively lower than free cortisol, it may indicate that the cortisol clearance rate is slow.

Potential Support Considerations

In addition to treating the underlying cause, other evaluations and support considerations may include ordering a full thyroid panel⁷⁸, ensuring sufficient caloric intake, supporting liver function, and supporting mitochondrial function. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

CCR IS FAST:
METABOLIZED CORTISOL > FREE CORTISOL

Potential Root Causes

This hypermetabolic pattern may indicate that the cortisol clearance rate is fast, see **Figure 6.11**. Fast cortisol metabolism and clearance may be associated with obesity, inflammation, blood sugar and insulin dysregulation, hyperthyroidism (or excessive thyroid medication), and long-term stress. In obesity, adipose tissue sequesters cortisol, which in turn may increase cortisol production (metabolized cortisol).

CORTISOL CLEARANCE RATE

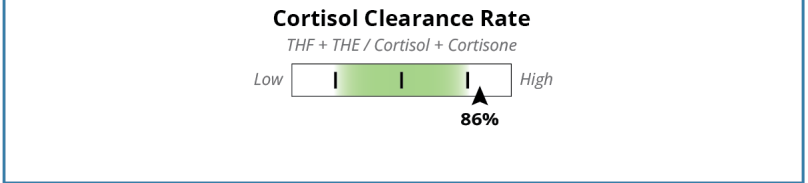


Figure 6.11: Cortisol Clearance Rate is Fast
When metabolized cortisol is relatively higher than free cortisol, it may indicate that the cortisol clearance rate is fast.

Potential Support Considerations

In addition to treating the underlying cause, other evaluations and support considerations may include ordering a full thyroid panel⁷⁹, weight loss if appropriate, reducing inflammation, regulating blood sugar and insulin, reducing stress, which may include supporting the parasympathetic nervous system (PNS), providing herbal calming support and GABA support. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

NOTE

When metabolized cortisol is high but free cortisol and cortisone are low, cortisol levels may be different depending on the location within the body. For example, levels of cortisol may be elevated in the adrenal glands and may result in increased conversion of noradrenaline to adrenaline. Oppositely, levels of cortisol may be low in the brain and may result in increased ACTH secretion. Therefore, use caution with efforts aimed at increasing HPA axis activity as these may exacerbate some symptoms.

CCR IS NORMAL:
METABOLIZED CORTISOL = FREE CORTISOL

This pattern may indicate that the cortisol clearance rate is as expected for the clinical situation, see **Figure 6.12**. Normal cortisol metabolism and clearance does not rule out conditions that may slow down or speed up cortisol metabolism, as outlined above.

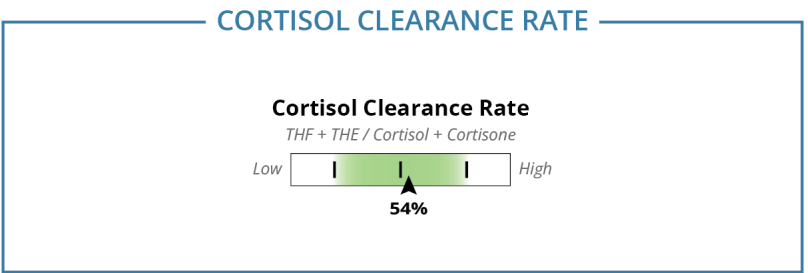
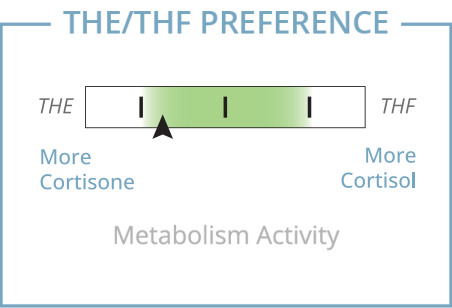


Figure 6.12: Cortisol Clearance Rate is Normal
When metabolized cortisol and free cortisol match, it may indicate that the cortisol clearance rate is as expected for the clinical situation.

Figure 6.13:
Systemic Preference Population
Slider



The THE/THF Preference slider is the best way to assess systemic preference for inactive cortisone (THE) or active cortisol (THF).

ESTIMATING SYSTEMIC⁸⁰ PREFERENCE

The More Cortisone Metabolites (THE) vs More Cortisol Metabolites (THF) slider on the DUTCH Test, see **Figure 6.13**, is the best way to assess systemic preference for inactive cortisone or active cortisol, respectively. Free cortisone is metabolized into b-tetrahydrocortisone (b-THE) by 5b-reductase. Free cortisol is metabolized into a-tetrahydrocortisol (a-THF) by 5a-reductase and b-tetrahydrocortisol (b-THF) by 5b-reductase. Cortisone’s THE metabolites and cortisol’s THF metabolites are inactive and cannot be reactivated.

THE PREFERENCE

A person may have a THE preference if the 11b-HSD2 enzyme is readily deactivating cortisol to cortisone in the kidneys, saliva glands and colon.

Signs & Symptoms

A THE preference may be seen with chronic stress, elevated estrogen levels, glucocorticoid medications, hyperthyroidism (or too much thyroid medication) and during the end stage of infection. With hyperthyroidism, the metabolized cortisol dial tends to point relatively higher than the total free cortisol (and cortisone) dials, as cortisol metabolism and clearance tends to speed up in the presence of increased thyroid activity.

Potential Support Considerations

In addition to treating the underlying cause, other evaluations and considerations may include assessing for chronic adrenal stressors⁸¹, PNS calming support, and licorice root⁸². See **“Appendix B: Potential Support Considerations” on page 191** for more information.

THF PREFERENCE

A person may have a THF preference if the 11b-HSD1 enzyme is readily reactivating cortisone to cortisol in the liver, fat cells, and the periphery.

Signs & Symptoms

A THF preference may be seen with obesity, insulin resistance, inflammation, licorice root supplementation, hypothyroidism (or insufficient thyroid medication), and excessive exposure to, or difficulty detoxifying, specific environmental chemicals such as phthalates, organotoxins, and alkylphenols. With hypothyroidism, the metabolized cortisol dial tends to point lower than the total free cortisol (and cortisone) dials, as cortisol metabolism and clearance may be slow.

Potential Support Considerations

In addition to treating the underlying cause, other evaluations and considerations may include weight loss if appropriate, regulating blood sugar and insulin levels, reducing inflammation, stress reduction, which may include PNS support, herbal calming support, and GABA support. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

OVERVIEW

We can estimate a person’s ability to cope with stress by looking at the cortisol awakening response (CAR) in saliva, see **Figure 6.14**. The CAR may be viewed as a HPA axis resiliency marker, an anticipatory marker of upcoming daily events, and a surrogate marker for HPA axis plasticity/reactivity. The CAR is influenced by several factors including gender, health status, and stress perception.

The CAR is relatively distinct from earlier and later components of circadian cortisol secretion. Studies document that the CAR was found to be unrelated to cortisol levels during the remainder of the day. It is important to remember that the CAR is neither a general HPA axis marker, nor is secreted in response to stress. [t]

Therefore, the CAR and remainder of the diurnal curve should be interpreted separately and then assimilated to determine the presence and severity of HPA axis dysfunction, resiliency, and adaptability. An individual can have a normal CAR, while the remainder of the diurnal pattern may be high, within the reference range, low-normal, or low.

MEASURING THE CAR

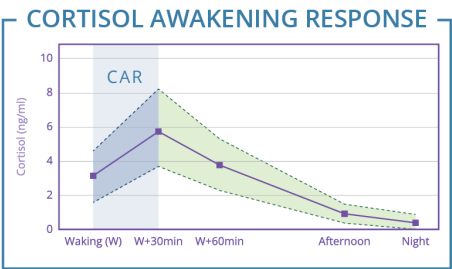
The CAR is measured as the percent difference between the waking and 30-minute free cortisol. In healthy adults (assuming the test is timed correctly) the magnitude of the CAR was found to range between 50-160% or a rise of 1.5-4.0ng/mL. The starting point is the sensation of awakening (S1), then the cortisol increases after awakening (CAR), and then the +30-minute sample (S2). In healthy adults, the +60-minute sample should approximate S1. [u]

An increased CAR has been associated with relapsing-remitting multiple sclerosis, visceral adiposity, metabolic syndrome in females, etc. Conversely, a decreased CAR has been associated with type 2 diabetes, chronic fatigue syndrome, hypertension, and functional gastrointestinal disorders, e.g., irritable bowel syndrome. [v]

Free Cortisone and the CAR

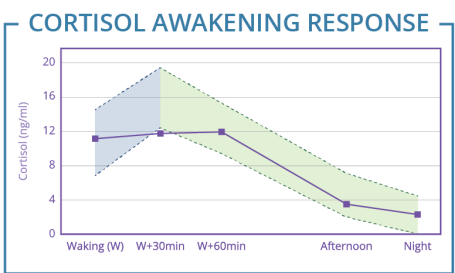
There is no literature assessing cortisone in place of cortisol for assessing the CAR. However, it is not unreasonable to take the cortisone “sense of awakening” sample S1 and the +30 sample into consideration when determining the best overall treatment plan.

Figure 6.14: Daily Free Cortisol with
Cortisol Awakening Response (CAR)



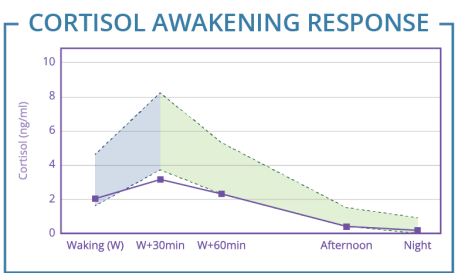
Measuring cortisol can provide valuable insights into hypothalamic-pituitary-adrenal (HPA) axis health.

Figure 6.15: CAR is Absent



In this example there is no increase in cortisol from waking to +30 minutes after waking.

Figure 6.16: CAR is Low



In this example there is a lower than expected increase in cortisol of 1.12 ng/mL or 55.4% from waking to +30 minutes after waking.

CAR IS ABSENT

Potential Root Causes and Associated Conditions

An absent CAR, see **Figure 6.155**, is seen in people with hippocampal atrophy or damage, especially seen in those with memory loss. It is also seen with high adverse childhood events scores (ACEs), obstructive sleep apnea (OSA), and people with chronic low level noise exposure during sleep, such as those living with high traffic noise.

NOTE

An absent CAR is normal in 15% of adults.

Potential Support Considerations

Addressing the root cause. Research supports the use of cognitive behavioral therapy (CBT) for ACE's and continuous positive airway pressure (CPAP) for people with OSA. Consider improving the sleep sound environment (e.g., with ear plugs). See **“Appendix B: Potential Support Considerations” on page 191** for more information.

CAR IS LOW

Potential Root Causes and Associated Conditions

A low CAR, see **Figure 6.1616**, may be associated with type 2 diabetes, chronic fatigue syndrome, hypertension, and functional gastrointestinal disorders, chronic stress or burnout, cardiovascular, autoimmune, atopic, and psychiatric disorders.

Other associations may include awakening in darkness as opposed to light, postpartum depression, major depression, seasonal affective disorder (SAD), PTSD, jet lag insomnia, sleep apnea, poor sleep quality, and taking medications known to suppress HPA axis activity⁸³.

Less common associations may include hippocampal and/or pituitary damage and TBI, and retrograde amnesia.

A person may also have a low CAR if their CAR had already occurred prior to sample collection.

A high waking free cortisol may be associated with stress, low blood sugar, sleep apnea, pain, and alcohol consumption the night prior. A high waking cortisol may be associated with a blunted CAR.

Potential Support Considerations

In addition to treating the underlying cause, other considerations may include foundational HPA axis support, sleep hygiene support, rest, therapy (medication) for mental/emotional distress, cognitive support, light exposure upon waking (sun or full spectrum lighting), aerobic exercise, multivitamin (to address possible vitamin deficiencies), CBT during pregnancy and postpartum, SSRIs for depression, CPAP during sleep for OSA, and stress reduction, which may include PNS support, herbal calming support, or GABA support. See **“Appendix B: Potential Support Considerations” on page 191** for more information.

CAR IS ELEVATED

Potential Root Causes and Associated Conditions

An elevated CAR, see **Figure 6.177**, may be associated with job-related stress, anticipatory stress, relapsing-remitting multiple sclerosis, visceral adiposity, metabolic syndrome in females, inflammation, and white light exposure. The data on anxiety and depression are mixed.

NOTE

A person may have a low sense of awakening cortisol point (S1) and a within-range +30-minute point (S2) resulting in a normal or high CAR. This may be a normal response to the day's anticipated events.

A person may have high waking cortisol if their CAR had already begun prior to sample collection.

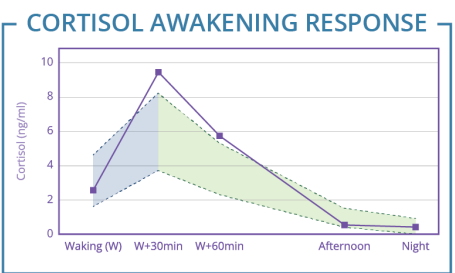
Potential Support Considerations

The key to normalizing an elevated CAR is to address the underlying etiology driving the anticipatory stress. In addition to addressing the above underlying cause(s), other support considerations may include: foundational HPA axis support, PNS support, herbal calming support, GABA support, adaptogenic herbal support, sleep hygiene support, journaling, CBT, CBT for insomnia (CBTI), Rhodiola rosea, and selective serotonin reuptake inhibitors (SSRIs). See **“Appendix B: Potential Support Considerations” on page 191** for more information.

CAR IS WITHIN RANGE

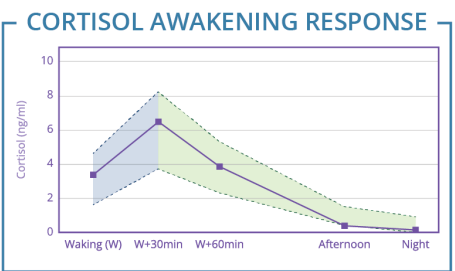
A normal CAR, see **Figure 6.188**, does not rule out conditions that may be associated with a high or low CAR.

Figure 6.17: CAR is Elevated



In this example there is a higher than expected increase in cortisol of 6.9 ng/mL or 269% from waking to +30 minutes after waking.

Figure 6.18: CAR is Within Range



In this example there is an expected increase in cortisol of 3.10 ng/mL or 92.5% from waking to +30 minutes after waking.

- 70
- Total free cortisol is called “24-hour Free Cortisol” for urine samples and “Total Salivary Cortisol” for salivary samples.
- 71
- Note that the free cortisol and free cortisone data can be somewhat less reliable for samples that have very low creatinine (female <0.15; male <0.2; see page 4 of a DUTCH Plus and DUTCH Complete reports or page 1 of a DUTCH Adrenal Only panel).
- 72
- Medications that are suppressive to the HPA axis include glucocorticoids (prednisone, dexamethasone, fluticasone, budesonide, etc.), opioids, NSAIDs, and tricyclic antidepressants (TCAs). These medications can also suppress adrenal hormone production (such as DHEA, androstenedione, testosterone, and mineralocorticoids). The degree of adrenal suppression is dependent upon type of medication used, strength, dose, frequency of use, duration of use and time since last use. It is not known if natural supplements, such as adaptogens, can overcome adrenal suppression from continued glucocorticoid use.
- 73
- In Addison’s disease, free cortisol and cortisone are very low (approaching zero) with no diurnal pattern and metabolized cortisol is < 1,000ng/mg. Further testing is required for diagnosis. Medication-induced HPA axis suppression (for example, with a glucocorticoid like prednisone) may result in a similar pattern.
- 74
- In Cushing’s disease, free cortisol and cortisone are high throughout the day with no diurnal pattern and metabolized cortisol is elevated. Bedtime cortisol is elevated and often more than four times above the upper reference range limit. Further testing is required for diagnosis. Oral hydrocortisone taken throughout the day may result in a similar pattern.
- 75
- Oral hydrocortisone can lead to elevations in urine free cortisol for 4-6 hours after supplementation and elevations in cortisol metabolites (THE and THF) for 10-12 hours after supplementation. Be aware that cortisol metabolites (THE and THF) will lag behind free cortisol levels, so elevations in cortisol metabolites may be due to supplementation that is no longer affecting free cortisol levels if taken the morning of the test. It is important to know when the person last took their hydrocortisone therapy to properly interpret the results.
- 76
- Be sure to assess the free cortisol and free cortisone levels, as the rate of cortisol clearance (comparing 24-hour free cortisol with metabolized cortisol) can affect metabolized cortisol levels. For example, if total free cortisol is elevated and the metabolized cortisol (cortisol production) is within the normal range or low, this suggests that the rate of cortisol clearance is slow.
- 77
- Note that the total free cortisol dial is called 24 Hour Free Cortisol for urine samples or Total Salivary Cortisol for

- salivary samples. If the total free cortisone dial points higher than the total free cortisol dial, then the free cortisol in circulation may not be as low as the free cortisol graph implies. See “**The Cortisone Shadow**” on page 164 for more information.
- 79
- A full thyroid panel often includes TSH, fT4, fT3, rT3, TPO, and thyroglobulin antibodies.
- 80
- Note that it might be helpful to look at the THE vs THF preference and NOT the free cortisol and free cortisone graphs when estimating systemic preference for cortisone and cortisol. This is because the enzyme 11b-HSD2 can affect the local free cortisol and cortisone balance in the kidneys (urine) and salivary glands (saliva).
- 81
- Chronic adrenal stressors may include psychological stress, pain, inflammation, endocrine disrupting chemicals (EDCs), a standard American diet, infection, blood sugar dysregulation, overexercising, overtraining, and poor sleep, etc.
- 82
- Licorice root limits the deactivation of free cortisol into free cortisone and caution is warranted in individuals with hypertension. Licorice root can worsen hypertension. Always monitor blood pressure and electrolyte balance when using licorice root.
- 83
- Medications that are suppressive to the HPA axis include glucocorticoids (prednisone, dexamethasone, fluticasone, budesonide, etc.), opioids, NSAIDs, and tricyclic antidepressants (TCAs). These medications can also suppress adrenal hormone production (such as DHEA, androstenedione, testosterone, and mineralocorticoids). The degree of adrenal suppression is dependent upon type of medication used, strength, dose, frequency of use, duration of use and time since last use. It is not known if natural supplements, such as adaptogens, can overcome adrenal suppression from continued glucocorticoid use.

Organic Acids

Introduction

Organic acids are metabolic byproducts of cellular activity that may provide insight into nutrient status, inflammation, neurotransmitters, etc. The DUTCH Test measures six nutritional organic acids, three neuro-related markers, and two additional markers. These OATs are measured from the first morning collection.

The DUTCH OATs profile is a combination of biomarkers to complement hormone metabolite measurements including a series of organic acids and other select tests. Organic acids related to nutrient deficiencies include biochemical intermediates that are proven to become elevated in the absence of sufficient nutrient status and other biomarkers may indicate oxidative stress, melatonin deficiency, and/or gut dysbiosis, all of which impact patient hormone stories.

Nutritional Organic Acids

These organic acids act as functional markers of nutrient deficiency. When the body has inadequate cellular levels of vitamin B12, vitamin B6 or glutathione, levels of their corresponding organic acid build up and spill into the urine. In some cases, these markers are more effective than measuring the nutrient directly.

Neurotransmitter Metabolites

These organic acids are the primary metabolite of dopamine, norepinephrine, and serotonin. Patients with an imbalance in these neurotransmitters may experience symptoms that are also common with an imbalance in hormones. Hormones (cortisol and estrogen are examples) included in DUTCH testing also directly alter some of these metabolites, so their inclusion provides an even more comprehensive picture of your patient’s hormone health.

METHYLMALONATE (MMA)

Elevated MMA may be seen in vitamin B12 deficiency. MMA is a metabolic byproduct of the citric acid cycle (Krebs cycle). It is converted to succinyl-CoA by methylmalonyl-CoA mutase (MCM). Adenosylcobalamin is a cofactor for MCM, and deficiency in this form of vitamin B12 can cause MMA to build up in the body.

Vitamin B12 is important for estrogen detoxification (phase 2 methylation), neurotransmitter activity, memory, mood, cognition, energy, gait, and red blood cell production.

Signs & Symptoms

Low vitamin B12 may be associated with fatigue, brain fog, memory problems, muscle weakness, unsteady gait, numbness, tingling, depression, anxiety, shortness of breath, low blood pressure, heart palpitations, migraines, headaches, and low blood pressure.

Contributors to Deficiency

Vitamin B12 deficiency may be associated with low dietary intake, poor absorption, low stomach acid, pernicious anemia, genetic SNPs and/or medications such as metformin, H2 acid blockers, proton pump inhibitors (PPIs), and oral birth control (OCPs).

Potential Support Considerations if Elevated

In addition to treating the underlying cause, additional evaluation and support considerations may include:

- Increasing vitamin B12 dietary intake⁸⁴
- Active vitamin B12 supplementation⁸⁵
- Sublingual or injectable vitamin B12 if the individual has low stomach acid while addressing the underlying contributors to low stomach acid⁸⁶
- Genetic SNP testing⁸⁷
- Intrinsic factor antibody testing to rule out pernicious anemia

See “Appendix B: Potential Support Considerations” on page 191 for more information.

XANTHURENATE & KYNURENATE

Elevated xanthurenate and kynurenate may be seen with vitamin B6 deficiency. Xanthurenate and kynurenate are metabolic byproducts of tryptophan metabolism.

Vitamin B6 is involved in over 100 human enzymatic reactions. Vitamin B6 is important for estrogen detoxification (phase 2 methylation), neurotransmitter production, and healthy glutathione levels.

Signs & Symptoms

Low vitamin B6 may be associated with fatigue, PMS, mood issues, tingling and pain in hands and feet, cracked/sore lips, sore tongue, weakened immune function, skin rashes, seizures, and elevated homocysteine.

Contributors to Deficiency

Vitamin B6 deficiency may be associated with low dietary intake, poor absorption, anorexia, suboptimal vitamin B6 activation, pyroluria, chronic alcoholism, and/or medications such as oral contraceptive pills (OCPs) which deplete vitamin B6, and hydrazines (isoniazid, hydralazine, etc.), sulphhydryl compounds (penicillamine, etc.), and substituted hydroxylamines (cycloserine, etc.), which inactivate vitamin B6.

Potential Support Considerations if Elevated

In addition to treating the underlying cause, additional evaluation and support considerations may include:

- Increasing vitamin B6 dietary intake⁸⁸ or supplementing with the active form of vitamin B6 (pyridoxine-5-phosphate (P5P)), especially if both xanthurenate and kynurenate are elevated, as this more likely is associated with low vitamin B6 levels
- Supporting cofactors to vitamin B6, including lysine, zinc, ATP, and vitamin B2
- Further workup around blood sugar and insulin dysregulation, oxidative stress, and inflammation, as elevated xanthurenate and kynurenate may be associated with an increased type 2 diabetes risk⁸⁹, and elevated kynurenate may be associated with oxidative stress and inflammation⁹⁰

See “Appendix B: Potential Support Considerations” on page 191 for more information.

NOTE

Rule out certain food and supplement intake around the time of testing, as tryptophan may elevate both xanthurenate and kynurenate, and bee products (honey, propolis, etc.), white potatoes, broccoli, basil, and thyme may elevate kynurenate.

PYROGLUTAMATE

Elevated pyroglutamate may be associated with glutathione deficiency. Pyroglutamate is an intermediate in glutathione recycling and production. Glutathione is a complex amino acid produced through the transsulfuration pathway via the conjugation of the amino acids cysteine, glycine, and glutamate. Pyroglutamate is leftover after glutathione is reduced. It can bind to more cysteine and recycle back to glutathione. If the body cannot convert pyroglutamate forward to glutathione, it will show up elevated in the urine.

Glutathione is one of the body’s most potent antioxidants. Glutathione may play an important role in cancer prevention by quenching the downstream reactive quinones of the 4-OH and 2-OH estrogen catechols that contribute to breast, endometrial, and prostate tissue DNA damage. Glutathione may become depleted with increased inflammation or when glutathione precursors are deficient.

NOTE

Overall, consider assessing for other patterns of high inflammation found on the DUTCH Test, see “Appendix A: DUTCH Test Patterns” on page 190 for more information.

Potential Support Considerations if Elevated

In addition to treating the underlying cause(s) (inflammation, infection, etc.), additional evaluation and support considerations may include:

- Supporting glutathione precursors and cofactors⁹¹
- Testing genetic SNPs related to glutathione (GPX, GSTP1), and measuring homocysteine and methionine in the serum to ensure adequate levels
- Encouraging healthy estrogen metabolism and clearance to minimize 2-OH and 4-OH conversion to reactive quinones

See “Appendix B: Potential Support Considerations” on page 191 for more information.

NOTE Rule out Italian cheese (parmesan, etc.) consumption around the time of testing as these cheeses may result in elevated pyroglutamate that is not indicative of a glutathione deficiency.

Potential Support Considerations if Low

Low pyroglutamate may be associated with a need for glutathione support, however, the significance of low pyroglutamate in relation to glutathione levels has not yet been established in the scientific literature. See “Appendix B: Potential Support Considerations” on page 191 for more information.

b-HYDROXYISOVALERATE

Elevated b-hydroxyisovalerate may be associated with biotin (vitamin B7) deficiency. Biotin is an important cofactor in mitochondrial function, metabolism of fatty acids, glucose, and protein, as well as reactive oxygen species (ROS) production. Note that when patients supplement with hydroxymethylbutyrate (HMB), it results in elevated b-hydroxyisovalerate that is not indicative of a biotin deficiency. See page 70 for more information.

Signs & Symptoms

Low biotin may be associated with hair loss, fatigue, tingling and burning in hands and feet, cracked mouth corners, skin rashes, dry skin, dry eyes, depression, nausea, loss of appetite, muscle pain, seizures, and difficulty sleeping.

Contributors to Deficiency

Biotin deficiency may be associated with low dietary intake, poor absorption, dysbiosis and gut health issues, long-term and high dose vitamin B5 supplementation, biotinidase deficiency (a rare inherited disorder), other genetic disorders such as PKU (phenylketonuria), and/or medications such as anti-seizure medications and antibiotics.

Potential Support Considerations if Deficient

In addition to treating the underlying cause(s), additional evaluation and support considerations may include:

- Increasing dietary biotin intake⁹²
- Improving gut health
- Supplementing with biotin
- Ordering a stool test

See “Appendix B: Potential Support Considerations” on page 191 for more information.

NOTE Rule out anti-seizure medications and antibiotics that may be associated with biotin deficiency.

INDICAN

Elevated urinary indican has been shown to be a reliable marker for intestinal dysbiosis. Indican levels do not correlate with the severity of dysbiosis; instead, an elevated indican merely shows that dysbiosis is present.

NOTE As dysbiosis can sometimes lead to elevations in circulating estradiol levels by interfering with phase 3 detoxification, see “Phase 3 Detox” on page 156 for more information. The indican marker may be especially helpful when there is estrogen excess. In fact, it is interesting to note that data from DUTCH samples in postmenopausal females and males have shown a small, but statistically significant, positive association between elevated urinary indican levels and estradiol levels.

Signs & Symptoms

Gut dysbiosis may be associated with bloating, gas, abdominal pain, heartburn, acid reflux, food intolerance, chronic fatigue, skin issues, acne, rashes, mood issues, anxiety, depression, trouble focusing, brain fog, joint aches and pains, inflammation, difficulty with urination, etc.

Contributing Factors

High indican may be associated with protein malabsorption because of low stomach acid, poor pancreatic function, Celiac disease, colon anerobic bacteria overgrowth, small intestinal bacterial overgrowth (SIBO), constipation, and medications that interfere with protein absorption, i.e., PPIs, other antacids, or H2 blockers.

Indican is a byproduct of tryptophan putrefaction by bacteria in the gastrointestinal tract. Therefore, keep in mind that indican may be within range even though dysbiosis is present if the person consumes a low-protein (and low tryptophan) diet. The indican test is not diagnostic but suggests that additional gut health testing may be warranted.

Potential Support Considerations if Elevated

In addition to treating the underlying cause, additional evaluation and support considerations may include:

- Supporting gut health and the HPA axis
- Ordering a stool test
- Ensuring adequate daily bowel movements
- Supporting stomach acid production
- Inquiring about medications that can reduce stomach acid, such as PPIs, H2 blockers, and other antacids

See “**Appendix B: Potential Support Considerations**” on page 191 for more information.

HOMOVANILLATE (HVA) & VANILMANDELATE (VMA)

Homovanillate (HVA) is the primary dopamine metabolite and vanilmandelate (VMA) is the primary norepinephrine (NE) and epinephrine (EPI) (adrenaline) metabolite. HVA and VMA do not reflect dopamine and NE/EPI levels in the brain, however, they may provide some insight into overall levels in the body.

Dopamine is a brain and adrenal neurotransmitter that is made from tyrosine with BH4 and iron as cofactors. Dopamine can be converted to NE and then onto EPI. The adrenal medulla makes NE and EPI while the adrenal cortex makes cortisol and DHEA. When adrenal hormone output is low, VMA levels may also be low.

NOTE

If symptoms do not match up with the HVA and VMA results, consider prioritizing treatment based on symptoms.

Signs & Symptoms

Low dopamine may be associated with depression, addictions, cravings, apathy, pleasure-seeking behaviors, increased sleepiness, impulsivity, tremors, low motivation, fatigue, and low mood.

High dopamine may be associated with agitation, insomnia, mania, hyperactivity, hyper-focus, high stress, anxiety, and addictions, cravings, and pleasure seeking to maintain high levels.

Low adrenaline may be associated with addictions, cravings, fatigue, low blood pressure, low muscle tone, intolerance to exercise, depression, and decreased alertness.

High adrenaline may be associated with stress, aggression, violence, impatience, anxiety, panic, excess worry and hypervigilance, insomnia, paranoia, increasing tingling and burning, memory loss, pain sensitivity, high blood pressure, and heart palpitations.

Potential Support Considerations if Both HVA & VMA are Low

In addition to treating the underlying cause, additional evaluation and support considerations may include:

- Assessing, and if appropriate, treating long-term HPA axis stressors (chronic stress, pain, inflammation, blood sugar dysregulation, etc.) that may be associated with lower cortisol production, and subsequently lower adrenal dopamine, NE, and EPI production
- Supporting dopamine, NE, and EPI precursors and cofactors⁹³
- Testing catechol-O-methyltransferase (COMT) and MAO SNPs (as these two enzymes are involved in metabolizing dopamine, NE, and EPI to HVA and VMA)
- Assessing for long-term THC use

See “**Appendix B: Potential Support Considerations**” on page 191 for more information.

Potential Support Considerations if Both HVA & VMA are High

In addition to treating the underlying cause, additional evaluation and support considerations may include:

- Assessing, and if appropriate, treating short-term HPA axis stressors (stress, strenuous exercise, pain, etc. around time of testing) that may be associated with increased cortisol production, and subsequently higher dopamine, NE, and EPI
- Testing COMT and MAO SNPs
- Supporting COMT (methylation)⁹⁴
- Supporting MAO⁹⁵
- Dopamine, NE, and EPI producing tumors⁹⁶
- Ruling out foods, supplements, and medications that can increase HVA and VMA levels⁹⁷

See “**Appendix B: Potential Support Considerations**” on page 191 for more information.

NOTE

Elevated HVA may be associated with Parkinson's disease.

Potential Support Considerations if HVA is High & VMA is Low

In addition to treating the underlying cause, additional evaluation and support considerations may include assessing for factors that slow dopamine beta-hydroxylase (DBH) enzymatic activity, which converts dopamine to NE. These may include low vitamin C and copper (DBH cofactors), and C. difficile infections. If HVA is above range, then also see suggestions under “If HVA and VMA are high” above. See “**Appendix B: Potential Support Considerations**” on page 191 for more information.

Potential Support Considerations if VMA is High & HVA is Low

In addition to treating the underlying cause, additional evaluation and support considerations may include supporting dopamine’s conversion to HVA with B vitamins (vitamin B2, B3, and B6), copper, magnesium, and S-adenosyl-L-methionine (SAME). Also see above suggestions under “If HVA and VMA are high.” See “**Appendix B: Potential Support Considerations**” on page 191 for more information.

QUINOLINATE

Quinolate is a neurotoxin derived from tryptophan. Elevated quinolate may be associated with neuroinflammation, but may also be associated with general inflammation, infection, phthalate exposure, low serotonin, low niacin (vitamin B3), and oral tryptophan use.

Signs & Symptoms

Neuroinflammation may be associated with chronic fatigue, difficulty concentrating, slow cognition, brain fog, memory issues, mood issues, anxiety, depression, irritability, anger, chronic pain, headaches, insomnia, etc.

Contributing Factors

Disorders that may be associated with elevated quinolate include Alzheimer’s disease, Parkinson’s disease, Huntington’s disease, motor neuron diseases, multiple sclerosis, epilepsy, amyotrophic lateral sclerosis (ALS), and major depressive disorder.

Quinolate/Kynurenate Ratio

Another pattern of dysfunction may result from an elevation of quinolate relative to kynurenate, a related metabolite. This is because quinolate is neurotoxic whereas kynurenate is neuroprotective. Above range quinolate that is higher relative to kynurenate may imply the presence of neuroinflammation or other causes for increased quinolate production.

Potential Support Considerations if Elevated

In addition to treating the underlying cause, additional evaluation and support considerations may include:

- Brain support
- Glutathione and other antioxidant support
- Niacin (vitamin B3) supplementation
- Serotonin support⁹⁸
- Identifying and removing sources of phthalate exposure⁹⁹ [w]
- An infection workup
- Evaluating for disorders associated with elevated quinolate, if appropriate

See “Appendix B: Potential Support Considerations” on page 191 for more information.

NOTE

Consider ruling out oral tryptophan consumption within 48 hours of testing, as it can increase quinolate levels in the urine.

[w] Raley E, et al. Chemical Exposures via Personal Care Products and the Disproportionate Asthma Burden Among the U.S. Black Population. J Allergy Clin Immunol Pract. 2021 Sep;9(9):3290-3292.

ADDITIONAL MARKERS

6-OH-MELATONIN SULFATE

Low 6-OH-melatonin sulfate may be associated with low overnight melatonin production. Melatonin is a pineal gland hormone that is involved in sleep and wakefulness cycles, reproductive health, energy metabolism, and more. Though most melatonin is produced in the pineal gland, it can also be synthesized in the gut, and to a lesser extent, in the bone marrow, lymphocytes, epithelial cells, and mast cells. Melanocyte stimulating hormone (MSH) controls the production of melatonin. MSH can be inhibited by mold (for example) and low MSH is associated with insomnia and an increased perception of pain.

The DUTCH Test evaluates overnight production and metabolism of melatonin by measuring 6-OH-melatonin sulfate in the waking sample. Even when a person takes a urine sample in the middle of the night, data strongly suggests that the waking sample alone still correlates best with overnight melatonin production.

Signs & Symptoms

Low melatonin may be associated with insomnia, poor immune response, constipation, weight gain, and increased appetite. High melatonin may be associated with drowsiness, headaches, nausea, dizziness, and mood issues. Elevated melatonin may be associated with chronic fatigue syndrome (CFS).

NOTE

When the DUTCH Test melatonin is above range, it is most commonly due to supplemented oral melatonin, and does not necessarily indicate that the dose is too high. It is not uncommon for supplemental melatonin to cause results to be significantly elevated on testing.

Potential Support Considerations if Low

In addition to treating the underlying cause, additional evaluation and support considerations may include improving sleep hygiene, avoidance of blue light before bedtime, and supplementing with melatonin, tryptophan and/or 5-HTP¹⁰⁰. See “Appendix B: Potential Support Considerations” on page 191 for more information.

Support sulfation, as the melatonin metabolite that DUTCH measures (6-OH-melatonin sulfate), is dependent on sulfation, see “Appendix A: DUTCH Test Patterns” on page 190 for more information.

Potential Support Considerations if Elevated

In addition to treating the underlying cause, additional evaluation and support considerations may include assessing for gastrointestinal inflammation, ruling out oral melatonin supplementation taken around the time of testing¹⁰¹, and ruling out melatonin-containing foods consumed around the time of testing that can result in elevated urinary melatonin levels¹⁰². See “Appendix B: Potential Support Considerations” on page 191 for more information.

NOTE

Elevated melatonin production that is problematic is rare (for example, due to a pineal tumor). Please note that oral melatonin supplementation will result in significantly increased DUTCH Test melatonin levels.

8-HYDROXY-2-DEOXYGUANOSINE (8-OHDG)

Elevated 8-hydroxy-2-deoxyguanosine (8-OHdG) may be associated with oxidative stress and DNA damage. 8-OHdG is considered pro-mutagenic and is a biomarker for various cancer and degenerative disease initiation and promotion states.

Elevated 8-OHdG may be associated with chronic inflammation, chronic stress, COPD, hypertension, hyperglycemia, diabetes, diabetic neuropathy, kidney and liver disease, inflammatory bowel disorders, chronic skin issues (psoriasis, eczema, etc.), atherosclerosis and cardiovascular mortality in people with an acute coronary syndrome, Parkinson's disease, depression, insomnia, breast, bladder, and prostate cancers, and more. [x] A 2019 meta-analysis documented that a low 8-OHdG was associated with a worse breast cancer prognosis. [y]

NOTE

The DUTCH Test 8-OHdG reference range is narrower than the standard laboratory range, because DUTCH uses functional medicine laboratory ranges. Therefore, an elevated 8-OHdG may prompt additional testing especially if results exceed the standard laboratory range of 0-6ng/mg for females and 0-10ng/mg for males.

Signs & Symptoms

Short-term inflammation may be associated with pain, redness, swelling, heat, etc. Long-term inflammation may be associated with fatigue, joint pain, body pain, weight gain, frequent infections, headaches, mood issues, blood sugar dysregulation, sleep issues, gut health issues, acne, etc.

Potential Support Considerations if Elevated

In addition to treating the underlying cause, additional evaluation and support considerations may include increasing antioxidant support with vitamin C, vitamin E, alpha lipoic acid (ALA), NAC, magnesium, taurine, green tea, curcumin, and colorful fruits and vegetables. See “Appendix B: Potential Support Considerations” on page 191 for more information.

Assess for other patterns of high inflammation found on the DUTCH Test, see “Appendix A: DUTCH Test Patterns” on page 190 for more information.

[x] Gohbara M, et al. Clinical impact of admission urinary 8-hydroxydeoxyguanosine level for predicting cardiovascular mortality in patients with acute coronary syndrome. Heart Vessels. 2021; 36(1): 38-47.

[y] Qing X, et al. Prognostic significance of 8-hydroxy-2'-deoxyguanosine in solid tumors: a meta-analysis. BMC Cancer. 2019; 19(1): 997.

ANNOTATIONS

- 84

Good dietary sources of vitamin B12 include grass-fed beef and beef liver, sardines, lamb, wild caught salmon, nutritional yeast, and eggs.
- 85

Active forms of vitamin B12 include methyl, hydroxy, and adenosyl cobalamin.
- 86

Contributors to low stomach acid include stress, older age, H. pylori, SIBO, and certain medications such as H2 blockers, proton pump inhibitors (PPIs), and other antacids.
- 87

SNPs that may affect vitamin B12 levels include fucosyltransferase 2 (FUT2), transcobalamin (TCN), methionine synthase reductase (MTRR), methylmalonyl CoA mutase (MUT), and metabolism of cobalamin associated B (MMAB).
- 88

Good dietary sources of vitamin B6 include grass-fed beef, turkey breast, pinto beans, avocado, pistachios, chicken, sesame seeds, and sunflower seeds.
- 89

Xanthurenate can bind with iron and create a complex that causes oxidative damage in the body. This damage can increase the risk for diabetes and blood sugar/insulin issues and may also result in DNA damage and elevated 8-OHdG.
- 90

Elevated kynurenate may be associated with chronic stress, high cortisol, oxidative damage, inflammation, bacterial lipopolysaccharides (LPS) from gram negative bacteria, estrogen excess, and a ketogenic diet. These conditions can increase the need for vitamin B6. Kynurenate elevations may be associated with schizophrenia, Alzheimer’s disease, cluster headaches, chronic migraines, and psychosis. Kynurenate is neuroprotective, whereas quinolinate is neurotoxic. See “Quinolinate” on page 183 for more information.
- 91

Glutathione precursors and cofactors include protein, glycine, N-acetylcysteine (NAC), vitamin B2, B6, vitamin C, selenium, and zinc.
- 92

Good dietary sources of biotin include egg yolks, organ meats, legumes, lentils, peas, sunflower seeds, seafood, mushrooms, cauliflower, carrots, and barley.
- 93

Dopamine, NE, and EPI production can be supported with adequate dietary protein, tyrosine, B vitamins, vitamin C, healthy iron levels, biopterin, mucuna extract (L-DOPA), and/or D,L-phenylalanine (DLPA). Use caution with mucuna and DLPA when antidepressant medications are being used and avoid DLPA in people with phenylketonuria (PKU).
- 94

Methylation support includes active B vitamins, magnesium, choline, trimethylglycine (TMG or betaine), zinc, methionine, and SAME.
- 95

MAO support includes vitamin B2, vitamin B3, vitamin B6 (active form is P5P), optimizing iron and ferritin,
- magnesium, and lithium orotate. Lithium orotate contains micro doses of lithium, however, it is prudent to make sure thyroid and kidney function are normal before starting. Also consider checking a baseline electrocardiogram (ECG) before starting lithium orotate.
- 96

Tumors are rare and a high HVA and/or VMA alone are not diagnostic of a tumor.
- 97

Foods, supplements, and medications that may be associated with increased HVA and VMA levels include bananas, avocados, fava beans, tyrosine, DLPA, L-Dopa, mucuna, quercetin, Parkinson’s medications, SNRI medications (Wellbutrin/Bupropion is the most common), tricyclic antidepressants, amphetamines/amphetamine-like medications or drugs, appetite suppressants, caffeine, ephedrine (including Sudafed), and opioids.
- 98

Serotonin support may include dietary protein, tryptophan, 5-HTP, and vitamin B6. Use caution with tryptophan and 5-HTP when antidepressant SSRI or SNRI medications are used due to the possibility of serotonin syndrome.
- 99

Phthalates are in hundreds of products, including some shampoos, hair sprays, soaps, deodorants, nail polish, lotions, plastic packaging, garden hoses, medical tubing, vinyl flooring, lubricating oils, carpet backings, adhesives, etc. Phthalates are often added to plastics to make them soft. They are found at higher levels in Black and Hispanic females. They are often found in “fragrances.” Visit the Environmental Working Group’s website at www.EWG.org for more information on cleaner products that are phthalate-free.
- 100

Use caution with tryptophan and 5-HTP when antidepressant SSRI or SNRI medications are being used due to the possibility of serotonin syndrome.
- 101

Due to the first-pass gut and liver effect, oral melatonin results in very high urinary melatonin metabolite levels that do not reflect circulating melatonin levels and cannot be used to determine if the oral melatonin dose is appropriate. The melatonin test is only useful as a baseline marker when melatonin is not taken the night before collecting.
- 102

Melatonin-containing foods include tomatoes, walnuts, barley, rye, strawberries, cherries, red wine, beer, pineapples, bananas, oranges, brown rice, pistachios, and corn. These foods contain small amounts of melatonin that are unlikely to increase circulating levels of melatonin but may increase metabolites in urine due to first pass metabolism.

References

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APPENDIX A: DUTCH TEST PATTERNS

High Inflammation

Inflammation is crucial for protecting the body during injury and infection—however, it can be damaging to tissues if it becomes chronic. Inflammation levels in the body may elevate due to injury, infection, stress, insulin resistance, exposure to pollution or chemicals, autoimmune processes, detoxification issues, standard American diet, poor sleep, sedentary lifestyle, overexercising, and more. Short-term inflammation may be associated with pain, redness, swelling, heat, and loss of function. Long-term inflammation may be associated with fatigue, joint pain, body pain, weight gain, frequent infections, headaches, mood issues, blood sugar dysregulation, sleep issues, gut health issues, acne, etc.

High inflammation is associated with the following results observed on the DUTCH Test:

- 5a-Reductase upregulated
 - Aromatase upregulated (testosterone and androstenedione to E2 and E1, respectively)
 - DHEA-S lower compared to metabolites etiocholanolone and androsterone
 - Estrogen clearance favoring 4-OH and/or 16-OH
 - Elevated cortisol metabolism rate
 - Elevated free cortisol
- Cortisol metabolism favoring THF when acute, and THE when chronic
 - Elevated kynurenate
 - Low or elevated pyroglutamate
 - Elevated indican
 - Elevated quinolinate
 - Elevated 8-OHdG

NOTE

Total DHEA is a calculated by adding DHEA-S + etiocholanolone + androsterone. When assessing if DHEA-S is low relative to total DHEA, compare the direction of the dials, not the numbers in the dials.

Suboptimal Sulfation:

Sulfur is the third most abundant mineral in our body. Sulfation pathways support the detoxification of estrogen (and other hormones), bodily waste products, pharmaceutical drugs, toxic compounds, free radicals, and reactive oxygen species (ROS). Sulfur amino acids, such as methionine and cysteine are paramount for SAMe production and glutathione production. [z]

Suboptimal sulfation is associated with the following results observed on the DUTCH Test:

- Low melatonin. Adequate sulfation is needed to metabolize melatonin into the sulfated metabolite that DUTCH measures (6-OH-melatonin sulfate).
 - Elevated 16-OH-E1 relative to 4-OH-E1 and 2-OH-E1, and elevated E3 relative to E1 and E2 (compare the direction of the dials, not the numbers within the dials). 16-OH-
- E1 and E3 are sulfated and glucuronidated in phase 2. Suboptimal sulfation my result in elevated 16-OH-E1 and E3 urinary levels.

[z] Nimni ME, et al. Are we getting enough sulfur in our diet? Nutr Metab (Lond). 2007 Nov 6; 4:24.

APPENDIX B: POTENTIAL SUPPORT CONSIDERATIONS

For more in-depth potential support considerations, see the DUTCH Treatment Guide.

The information in this handout is provided for informational and educational purposes only and is not medical or treatment advice. Any information and statements regarding dietary or herbal supplements have not been evaluated by the Food and Drug Administration and are not intended to diagnose, treat, cure, or prevent any disease. The use of any information provided in this handout is solely at your own risk. There is limited research on these supplements and their clinical impact.

Adaptogenic Herbs

- Ashwagandha (Withania somnifera)
 - Bacopa (Bacopa monnieri) Cordyceps (Cordyceps sinensis or militaris)
 - Holy basil (Ocimum tenuiflorum)
 - Jujube (Ziziphus jujuba)
 - Licorice root (Glycyrrhiza globra)
- Maca (Lepidium meyenii or peruvianum)
 - Mimosa (Albizia julibrissin or lebbeck)
 - Korean Ginseng (Panax ginseng)
 - Reishi (Ganoderma lucidum)
- Rhodiola (Rhodiola rosea) Shatavari (Asparagus racemosus)
 - Schizandra (Schisandra chinensis)
 - Siberian Ginseng (Eleutherococcus senticosus)
 - Skullcap (Scutellaria lateriflora)

NOTE

Licorice root limits the deactivation of free cortisol into free cortisone and caution is warranted in individuals with hypertension. Licorice root can worsen hypertension. Always monitor blood pressure and electrolyte balance when using licorice root.

Blood Sugar

Blood sugar balancing substances may include inositol, berberine, chromium, cinnamon, Gymnema, ALA, etc.

Bone Health

Supportive treatments for bone health may include hormone therapy (HT) if appropriate, resistance training, vitamin D3, vitamin K2Mk7, calcium, magnesium, phosphorus, optimizing thyroid function, and optimizing the HPA axis, etc.

Brain

Brain support may include a nutrient-rich diet, movement to improve blood flow to the brain, stress reduction, vagal nerve stimulation, blood sugar regulation, smoking cessation, anemia treatment, hemochromatosis treatment, sleep apnea treatment, neurofeedback, acupuncture, chiropractic, massage, hyperbaric oxygen treatment (HBOT), craniosacral treatment, rosemary, bacopa monnieri, fish oil, ginkgo biloba, cordyceps sinesis, maca lepidium, pyrroloquinoline quinone (PQQ), and optimizing sex hormone levels.

Calming Herbs

Calming herbs may include milky oats, ziziphus (jujube), valerian, passionflower, chamomile, lemon balm, California poppy (may also reduce pain), etc.

Estrogen Detox

General estrogen detox support may include DIM/I3C, broccoli sprouts (contain glucoraphanin/sulforaphane), cruciferous vegetables, apiaceae carrot family vegetables, rosemary, turmeric, calcium-d-glucarate, resveratrol, quercetin, glutathione, NAC, fiber, hydration, and adequate bowel movements.

NOTE

DIM and I3C induce CYP-1a1 (the preferred pathway), however they also tend to lower E1 and E2, which may not be appropriate for every person.

GABA

GABA support may include GABA, L-theanine, pregnenolone, Honokiol (extracted from magnolia off. bark), lemon balm, passionflower, valerian, etc.

Glutathione & Antioxidants

Glutathione and antioxidant support may include glutathione, NAC, sulforaphane (highest in broccoli sprouts), green tea, protein, selenium, vitamins E and C, etc.

Herbal Anti-Androgens

Herbal anti-androgens used in females may include spearmint tea, chaste tree, licorice, white peony, green tea, black cohosh, and red reishi.

NOTE

Licorice root limits the deactivation of free cortisol into free cortisone and caution is warranted in individuals with hypertension. Licorice root can worsen hypertension. Always monitor blood pressure and electrolyte balance when using licorice.

Estrogen Supports

Herbal estrogen support may include maca, black cohosh, dong quai, and ground flaxseeds.

Herbal Support for High Cortisol

High cortisol supportive herbs may include ashwagandha, skullcap, holy basil, cordyceps, jujube, mimosa, chamomile, lemon balm, passionflower, valerian, milky oats, magnolia, and California poppy.

Herbal Support for Low Cortisol

Low cortisol supportive herbs may include ashwagandha, Korean ginseng, rhodiola, cordyceps, schizandra, bacopa, licorice, and panax ginseng.

NOTE

Licorice root limits the deactivation of free cortisol into free cortisone and caution is warranted in individuals with hypertension. Licorice root can worsen hypertension. Always monitor blood pressure and electrolyte balance when using licorice.

Hypothalamic-Pituitary-Adrenal (HPA) Axis

HPA axis support may include B vitamins, vitamin C, adaptogenic herbs, stress reduction, blood sugar regulation, weight loss if appropriate, etc.

Inflammation

Inflammation reducing substances include NAC, turmeric, resveratrol, alpha lipoic acid (ALA), fish oil, EGCG, mushroom therapies, etc. Inflammation can also be reduced with stress reduction, exercise (in moderation), anti-inflammatory diet, autoimmune protocol (AIP) diet, blood sugar regulation, and by limiting exposure to environmental toxic compounds.

Liver

Liver supporting substances may include B vitamins, amino acids, NAC, choline, ALA, dandelion, artichoke, turmeric, milk thistle, etc.

Mitochondria

Mitochondria supporting substances include B vitamins, NADH, vitamin C, vitamin E, L-carnitine, NAC, ALA, curcumin, resveratrol, CoQ10/ubiquinol, PQQ, sulforaphane, glutathione support, selenium, magnesium, manganese, and copper. Mitochondrial function can also be supported by improving a standard American diet, limiting alcohol intake, reducing environmental chemical exposures, treating chronic and acute disease and infections, intermittent fasting, exercise, and cold exposure (ending showers with 30 seconds of cold water for example).

Natural 5a Blockers

Natural 5a blockers may include saw palmetto and beta-sitosterol, reishi, nettle root, Pygeum africanum, polyunsaturated fats (PUFAs), and epigallocatechin gallate (EGCG).

Natural Aromatase Inducers

Natural aromatase inducers may include forskolin (Indian coleus), quercetin, rutin, white peony and licorice.

NOTE

Licorice root limits the deactivation of free cortisol into free cortisone and caution is warranted in individuals with hypertension. Licorice root can worsen hypertension. Always monitor blood pressure and electrolyte balance when using licorice.

Natural Aromatase Inhibitors

Natural aromatase inhibitors may include chrysin, damiana, mangosteen, and Agaricus (white button mushroom), active lifestyle, EGCG, flaxseed, and grape seed extract (GSE).

Parasympathetic Nervous System (PNS)

PNS support may include meditation, prayer, breath work, and vagal nerve stimulation (humming, singing loudly, gargling), etc.

Phase 2 Glucuronidation

Glucuronidation support may include sulforaphane and calcium-d-glucarate.

Phase 2 Methylation

Methylation support may include active B vitamins, magnesium, choline, trimethylglycine (TMG), methionine, zinc, and SAMe.

Phase 2 Sulfation

Sulfation support includes supplementing with the cofactor molybdenum and sulfur donors such as methionine, NAC, methylsulfonylmethane (MSM), taurine, sulforaphane, glutathione, and/or sulfurous vegetables such as onions, garlic, eggs, brassicas, asparagus, arugula, etc. Assess for and lower inflammation, as inflammation is associated with decreased sulfation. Assess for possible hypothyroidism with a full thyroid panel (TSH, fT4, fT3, RT3, TPO and TG antibodies) as hypothyroidism may be associated with poor sulfation.

Testosterone Supports

Herbal testosterone support may include tongkat ali, ashwagandha, Mucuna, Tribulus[aa], Epimedium, maca, damiana, forskolin, and fenugreek. Shatavari is additionally used in females.

[aa] Munir N, et al. Therapeutic Response of Epimedium gandiflorum's Different Doses to Restore the Antioxidant Potential and Reproductive Hormones in Male Albino Rats. Dose Response. 2020 Sep 14; 18(3)

APPENDIX C: DUTCH TEST SAMPLE REPORT

Page 1: Hormone Testing Summary

PATIENT INFORMATION

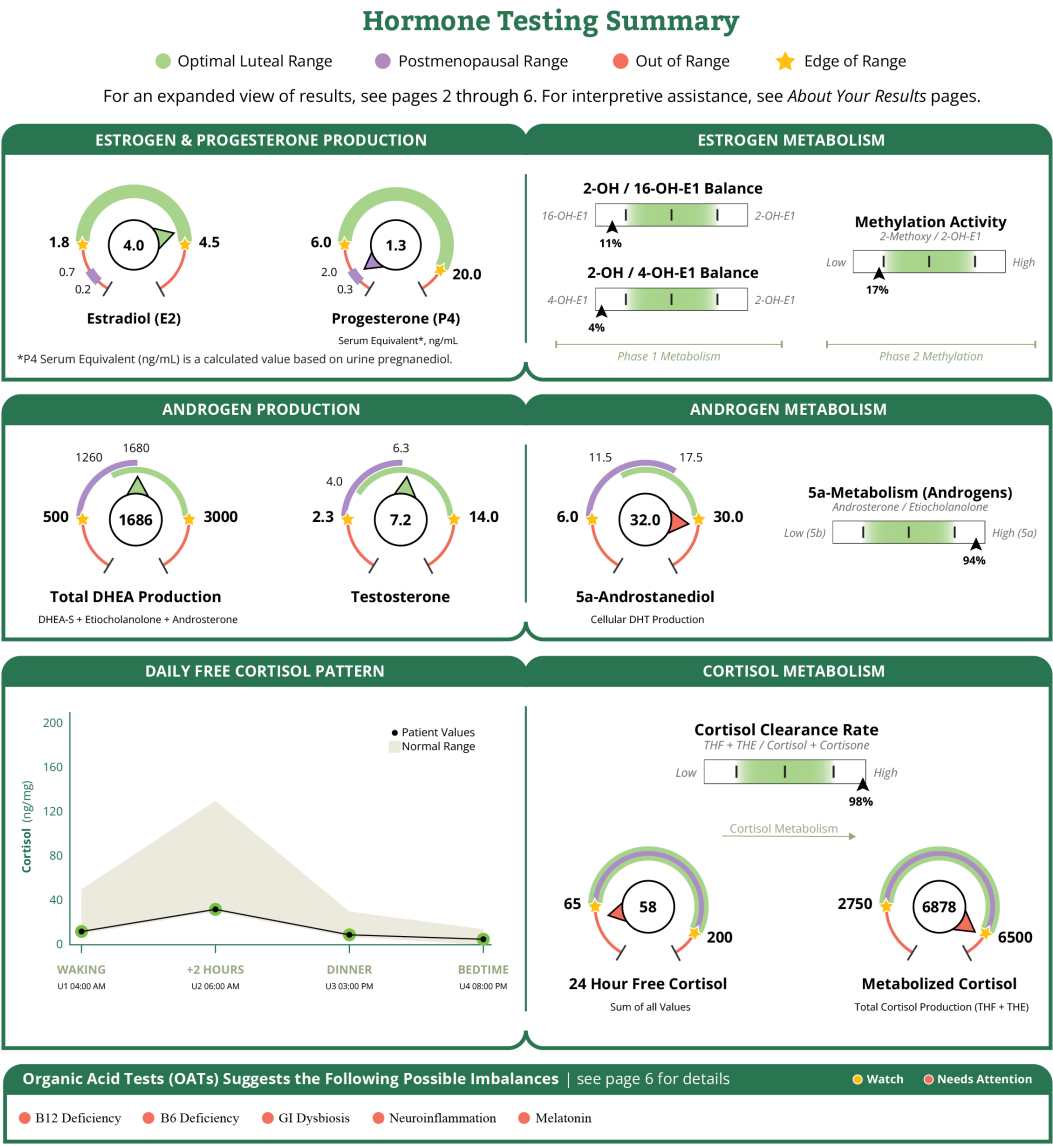
DOB: 1976-01-01
Age: 49
Sex: Female
Last Menstrual Period: 2025-05-26

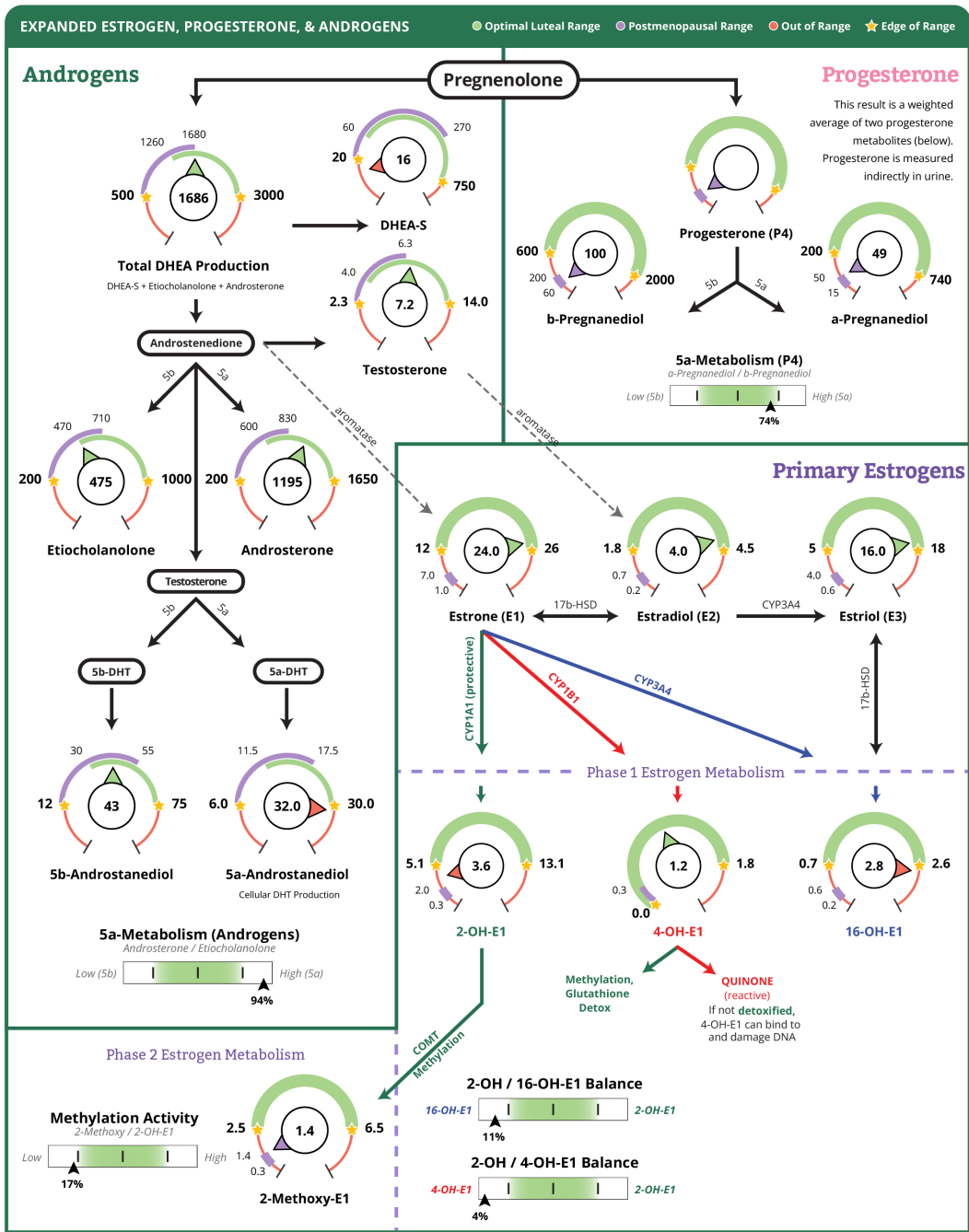
Accession # 01093510

Collection Dates:
2025-06-12 (U3 U4)
2025-06-13 (U1 U2)

Ordering Provider:
Test Provider MD

Female Sample Report
123 A Street
Sometown, SC 90266





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CREATORS OF THE DUTCH TEST[®]

Precision Analytical (Dawn Huo, Ph.D., Lab Director)
3138 NE Rivergate Street
McMinnville, OR 97128

Female Sample Report
Accessioned - 06/14/2025
Final Report - 9/9/2025

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CLIA Lic. #38D2047310
Report Version 1.6.0



Accession # 01093510

Female Sample Report
123 A Street
Sometown, SC 90266

DOB: 1976-01-01

Age: 49

Sex: Female

Last Menstrual Period:

2025-05-26

Collection Times:

2025-06-13 04:00AM (U1)
2025-06-13 06:00AM (U2)
2025-06-12 03:00PM (U3)
2025-06-12 08:00PM (U4)

Ordering Provider:

Test Provider MD

Sex Hormones & Metabolites

TEST		RESULT	UNITS	LUTEAL*	POSTMENOPAUSAL
Progesterone Metabolites (Urine)					
b-Pregnanediol	Below luteal range	100.0	ng/mg	600 - 2000	60 - 200
a-Pregnanediol	Below luteal range	49.0	ng/mg	200 - 740	15 - 50
Estrogens and Metabolites (Urine)					
Estrone (E1)	High end of luteal range	24.01	ng/mg	12 - 26	1.0 - 7.0
Estradiol (E2)	High end of luteal range	4.00	ng/mg	1.8 - 4.5	0.2 - 0.7
Estrinol (E3)	High end of luteal range	16.0	ng/mg	5 - 18	0.6 - 4.0
2-OH-E1	Below luteal range	3.58	ng/mg	5.1 - 13.1	0.3 - 2.0
4-OH-E1	Within luteal range	1.20	ng/mg	0 - 1.8	0 - 0.3
16-OH-E1	Above luteal range	2.80	ng/mg	0.7 - 2.6	0.2 - 0.6
2-Methoxy-E1	Below luteal range	1.35	ng/mg	2.5 - 6.5	0.3 - 1.4
2-OH-E2	Within luteal range	0.74	ng/mg	0 - 3.1	0 - 0.52
4-OH-E2	Within luteal range	0.41	ng/mg	0 - 0.52	0 - 0.12
Total Estrogen	Within range	54.1	ng/mg	35 - 70	3.5 - 15
Metabolite Ratios (Urine)					
2-OH / 16-OH-E1 Balance	Below range	1.28	ratio	2.69 - 11.83	
2-OH / 4-OH-E1 Balance	Below range	2.98	ratio	5.4 - 12.62	
2-Methoxy / 2-OH Balance	Below range	0.38	ratio	0.39 - 0.67	
Androgens and Metabolites (Urine)					
				Range	
DHEA-S	Below range	16.0	ng/mg	20 - 750	
Androsterone	Within range	1195.0	ng/mg	200 - 1650	
Etiocholanolone	Within range	474.6	ng/mg	200 - 1000	
Testosterone	Within range	7.16	ng/mg	2.3 - 14	
5a-DHT	Within range	6.2	ng/mg	0 - 6.6	
5a-Androstanediol	Above range	32.0	ng/mg	6 - 30	
5b-Androstanediol	Within range	42.6	ng/mg	12 - 75	
Epi-Testosterone	Within range	8.6	ng/mg	2.3 - 14	

* The Luteal Range represents the expected premenopausal luteal range, collected menstrual cycle days 19-22 of a 28-day cycle. If your patient noted taking oral progesterone, the reference range represents the expected range on 100 - 200 mg of oral micronized progesterone (OMP). The ranges in the table below represent ranges in other times of the cycle your patient may have collected, such as follicular or ovulatory phases.

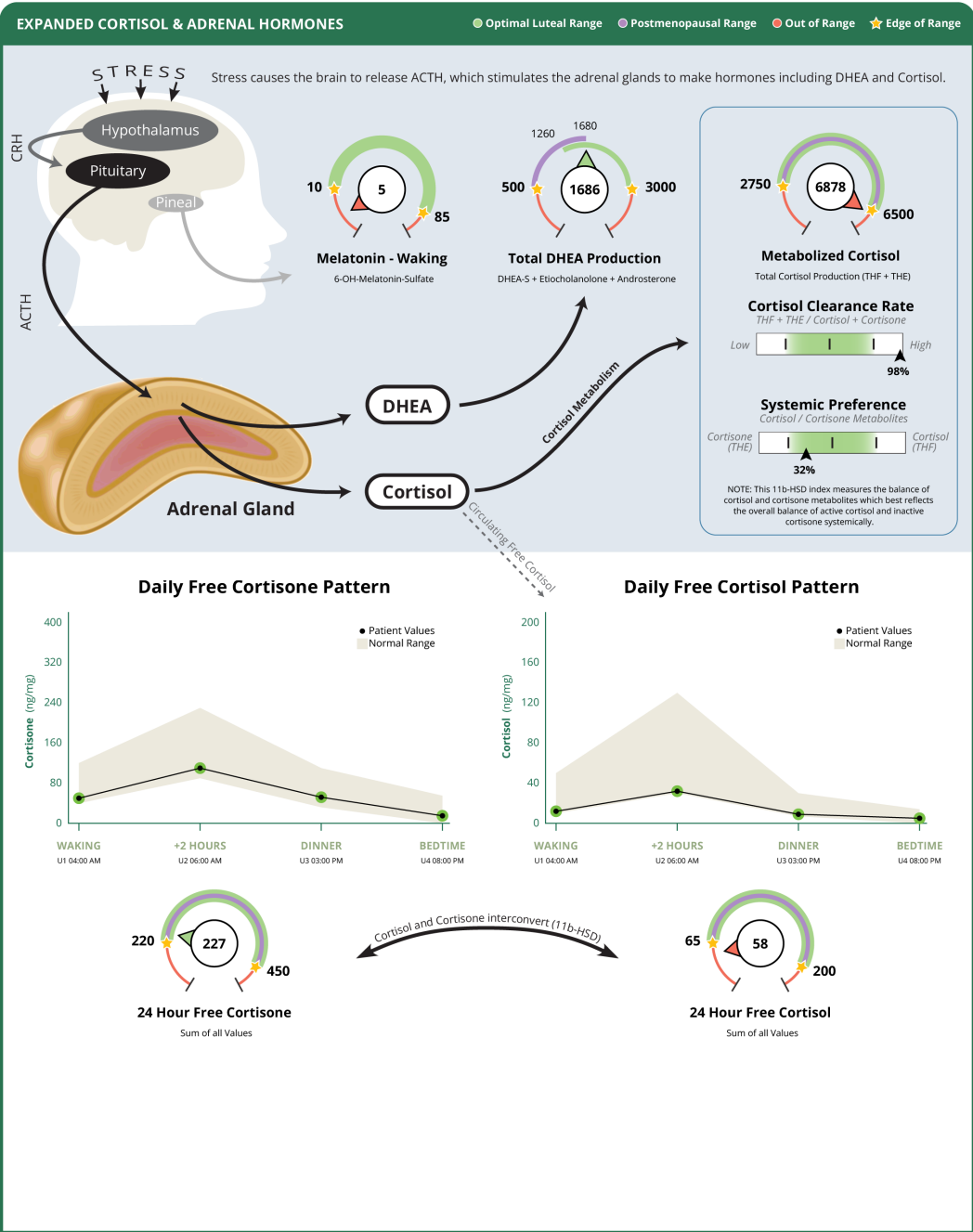
ADDITIONAL NORMAL RANGES	FOLLICULAR	OVULATORY	ON ORAL PG
b-Pregnanediol	100 - 300	100 - 300	2000 - 9000
a-Pregnanediol	25 - 100	25 - 100	580 - 3000
Estrone (E1)	4.0 - 12.0		N/A
Estradiol (E2)	1.0 - 2.0	4.0 - 12.0	N/A

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Accession # 01093510

Female Sample Report
123 A Street
Sometown, SC 90266

DOB: 1976-01-01

Age: 49

Sex: Female

Last Menstrual Period:
2025-05-26

Collection Times:

2025-06-13 04:00AM (U1)
2025-06-13 06:00AM (U2)
2025-06-12 03:00PM (U3)
2025-06-12 08:00PM (U4)

Ordering Provider:

Test Provider MD

Adrenal Hormones & Metabolites

TEST	RESULT	UNITS	NORMAL RANGE
Daily Free Cortisol and Cortisone (Urine)			
Cortisol (U1) - Waking	Low end of range	12.0	ng/mg 10 - 50
Cortisol (U2) - +2 Hours	Low end of range	32.0	ng/mg 30 - 130
Cortisol (U3) - Dinner	Low end of range	9.0	ng/mg 7 - 30
Cortisol (U4) - Bedtime	Within range	5.0	ng/mg 0 - 14
Cortisone (U1) - Waking	Low end of range	50.0	ng/mg 40 - 120
Cortisone (U2) - +2 Hours	Low end of range	110.0	ng/mg 90 - 230
Cortisone (U3) - Dinner	Within range	52.0	ng/mg 32 - 110
Cortisone (U4) - Bedtime	Within range	15.0	ng/mg 0 - 55
24 Hour Free Cortisol (Sum of all Values)	Below range	58.0	ng/mg 65 - 200
24 Hour Free Cortisone (Sum of all Values)	Low end of range	227.0	ng/mg 220 - 450
Creatinine (Urine)			
Creatinine (U1) - Waking	Within range	0.50	mg/ml 0.2 - 2
Creatinine (U2) - +2 Hours	Within range	0.72	mg/ml 0.2 - 2
Creatinine (U3) - Dinner	Within range	0.48	mg/ml 0.2 - 2
Creatinine (U4) - Bedtime	Within range	0.34	mg/ml 0.2 - 2
Cortisol Metabolites and DHEA-S (Urine)			
a-Tetrahydrocortisol (a-THF)	Above range	464.0	ng/mg 75 - 370
b-Tetrahydrocortisol (b-THF)	Within range	2318.9	ng/mg 1050 - 2500
b-Tetrahydrocortisone (b-THE)	Above range	4095.1	ng/mg 1550 - 3800
Metabolized Cortisol (THF + THE)	Above range	6878.0	ng/mg 2750 - 6500
DHEA-S	Below range	16.0	ng/mg 20 - 750
Cortisol Clearance Rate (CCR)	Above range	24.1	6 - 12.5

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PATIENT INFORMATION
DOB: 1976-01-01
Age: 49
Sex: Female
Last Menstrual Period: 2025-05-26

Accession # 01093510
Collection Dates:
2025-06-12 (U3 U4)
2025-06-13 (U1 U2)

Ordering Provider:
Test Provider MD

Female Sample Report
123 A Street
Sometown, SC 90266

Organic Acid Tests (OATs)

TEST		RESULT	UNITS	NORMAL RANGE
Nutritional Organic Acids (Urine)				
Vitamin B12 Marker - May be deficient if high				
Methylmalonate (MMA)	Above range	4.9	ug/mg	0 - 2.5
Vitamin B6 Markers - May be deficient if high				
Xanthurenate	Above range	1.23	ug/mg	0.12 - 1.2
Kynurenate	Above range	5.4	ug/mg	0.8 - 4.5
Biotin Marker - May be deficient if high				
b-Hydroxyisovalerate	Within range	7.9	ug/mg	0 - 12.5
Glutathione Marker - May be deficient if high				
Pyroglutamate	Within range	42.0	ug/mg	28 - 58
Gut Marker - Potential gut putrefaction or dysbiosis if high				
Indican	Above range	114.0	ug/mg	0 - 100
Neuro-Related Markers (Urine)				
Dopamine Metabolite				
Homovanillate (HVA)	Within range	4.4	ug/mg	3 - 11
Norepinephrine/Epinephrine Metabolite				
Vanilmandelate (VMA)	Within range	4.3	ug/mg	2.2 - 5.5
Neuroinflammation Marker				
Quinolinate	Above range	13.2	ug/mg	0 - 9.6
Additional Markers (Urine)				
Melatonin - Waking				
6-OH-Melatonin-Sulfate	Below range	5.3	ng/mg	10 - 85
Oxidative Stress / DNA Damage				
8-Hydroxy-2-deoxyguanosine (8-OHdG)	Within range	2.6	ng/mg	0 - 5.2

Organic Acid Comments:

- The MMA is above the range. This may indicate vitamin B12 or adenosylcobalamin deficiency. B12 is important for phase 2 methylation (estrogen detox), neurotransmitter synthesis, and other key processes.
- Both the Xanthurenate and Kynurenate are above the range. This may indicate vitamin B6 deficiency. B6 is important for phase 2 methylation (estrogen detox), neurotransmitter synthesis, and other key processes. Tryptophan taken within 72 hours before testing can also raise these markers without indicating a true B6 deficiency.
- The indican is above the range. This can indicate gut dysbiosis. Gut dysbiosis can affect estrogen metabolism, inflammation, and malabsorption of nutrients. Further GI testing may be indicated.
- The quinolinate is above the normal range. This increase may be in response to high cortisol and inflammation, potentially contributing to mood and sleep dysregulation through neuroinflammation. Tryptophan taken within 72 hours before testing can also raise quinolinate in the urine without raising it in circulation.
- The waking urinary 6-OH-Melatonin-Sulfate is low. This reflects low overnight production of melatonin. This may be implicated in poor sleep and insomnia.



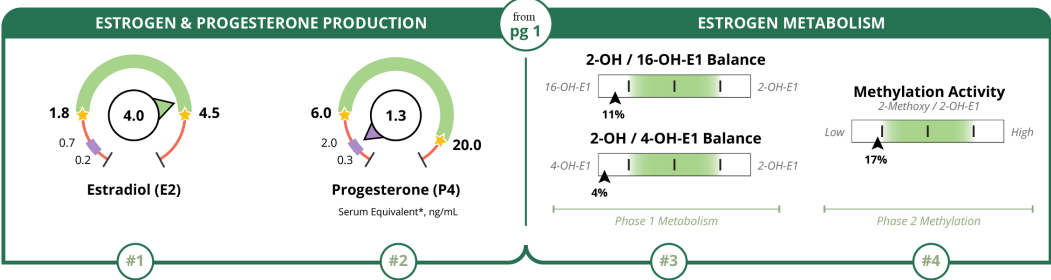
Precision Analytical (Dawn Huo, Ph.D., Lab Director)
3138 NE Rivergate Street
McMinnville, OR 97128

Female Sample Report
Accessioned - 06/14/2025
Final Report - 9/9/2025

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About Your Results Estrogen & Progesterone

The following About Your Results sections include key DUTCH report elements from page 1 to aid your interpretation.



Estrogen-related Patient or Sample Comments:

- The patient reports irregular cycles.
- The patient reported collecting samples on Cycle Day 17. Estrogen and progesterone levels would be expected to reflect luteal phase values if the onset of her next menstrual cycle occurred 4-10 days after sample collection.

#1. Assess estrogen levels given the patient's reproductive status

- Estradiol (the most potent estrogen) is **4.00ng/mg**, which is within the optimal luteal range, but toward the higher end. If paired with other elevated estrogen markers, poor estrogen metabolism, or suboptimal progesterone, this may contribute to estrogen excess symptoms.

#2. Assess progesterone levels given the patient's reproductive status

- The progesterone serum equivalent is **1.30 ng/mL**, which is below the optimal luteal range. If the patient ovulated, progesterone is suboptimal. Confirm that the patient's samples were collected in the luteal phase to interpret this result.

#3. Assess 2-OH preference in phase 1 estrogen metabolism

- The 2-OH/16-OH-E1 is **11.0%**, which is below the optimal range. This indicates a preference for the less desirable 16-OH-E1 metabolite compared to the beneficial 2-OH-E1 metabolite. The 16-OH preference may be associated with estrogenic activity.
- The 2-OH/4-OH-E1 is **4.00%**, which is below the optimal range. This indicates a preference for the less desirable 4-OH-E1 metabolite compared to the beneficial 2-OH-E1 metabolite. The 4-OH preference may be associated with oxidative stress.

#4. Assess methylation of reactive 2-OH catechol estrogens

- The methylation activity is **17.0%**, which is in the optimal range, but towards the low end. This may indicate slightly reduced estrogen methylation capacity.

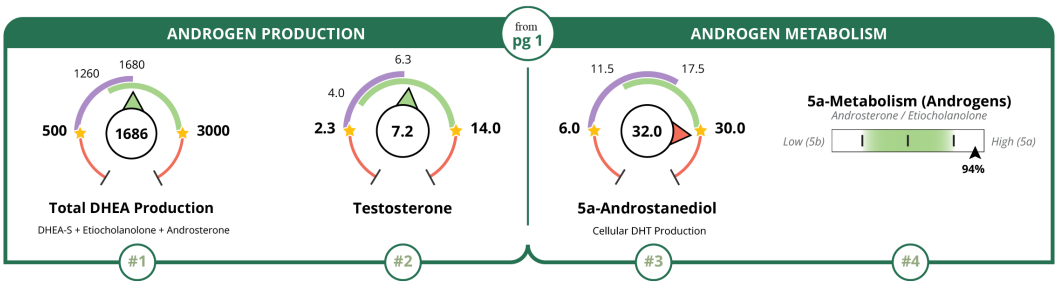


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About Your Results Androgens



Androgen-related Patient or Sample Comments:

- The patient reports high androgen symptoms.

#1. Assess adrenal androgen levels (Total DHEA)

- The total DHEA production is **1,686 ng/mL**, which is within the optimal premenopausal range.

#2. Assess testosterone levels

- Testosterone is **7.2 ng/mL**, which is within the optimal premenopausal range.

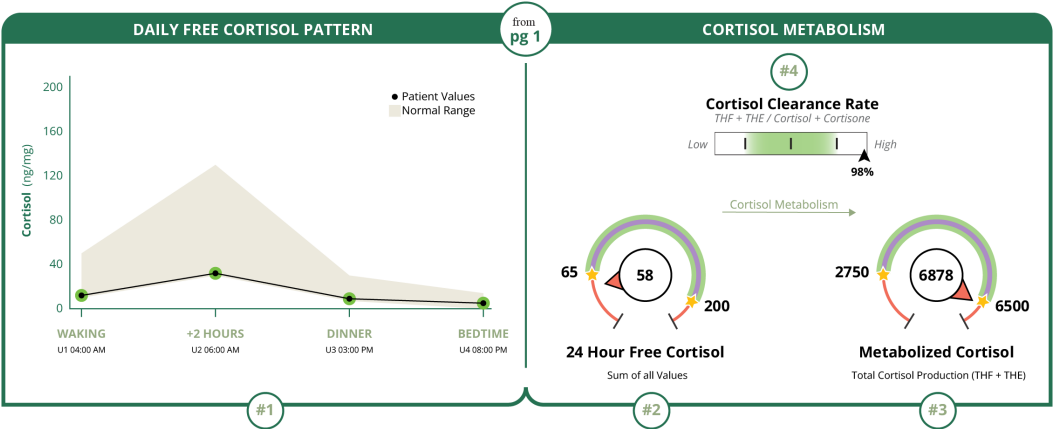
#3. Assess cellular production of 5a-DHT via 5a-androstenediol

- 5a-Androstenediol is **32.0 ng/mL**, which is above the range for women of any age. 5a-Androstenediol reflects the tissue activity of 5a-DHT (the most potent androgen).

#4. Assess if there is a preference for the more potent alpha metabolism of the androgens

- 5a-Metabolism of androgens is **94.0%**, which is above the range. This indicates a preference for the more androgenic pathway.

About Your Results Cortisol



Cortisol-related Patient or Sample Comments:

#1. Assess the daily free cortisol pattern

- All points on the Daily Free Cortisol Pattern are within the optimal range. Cortisol levels should follow a rhythm that is higher in the morning and lower at night.

#2. Assess the daily total of free cortisol in circulation (24hr Free Cortisol)

- The 24hr Free Cortisol (the sum of the 4 points on the Daily Free Cortisol Pattern) is **58.0ng/mg**, which is below the optimal range. This indicates low overall cortisol levels.

#3. Assess the total cortisol produced by the adrenal glands (Metabolized Cortisol)

- The Metabolized Cortisol, which reflects the total cortisol output for the day, is **6,878ng/mg**, which is above the optimal range.

#4. Assess the rate of cortisol clearance from the body

- The Cortisol Clearance Rate is **98.0%**, which is above the optimal range. This indicates that cortisol and cortisone are being metabolized at a faster rate than expected. If paired with low free cortisol, this can contribute to low cortisol symptoms.
- The patient reports that they have a BMI between 25 and 30. A higher BMI is associated with a fast cortisol clearance rate.

About Your Results **Advanced Insights**

The previous "About Your Results" pages look at core insights for the DUTCH report shown on the Hormone Testing Summary page, all of which are worth considering for most patients. Next, "Advanced Insights" cover additional features within the DUTCH test that require reviewing the pages after the summary page. These concepts are more complex but can be highly relevant for some patients. Review the concepts and look for patient-specific comments, when notable, in bullets.

ESTROGEN & PROGESTERONE

#1. Assess whether E1, E3, or 16-OH-E1 add more insight into overall estrogenic activity

- While E2 is the most potent estrogen, other estrogens - such as estrone (E1), 16-hydroxyestrone (16-OH-E1), and estriol (E3) - also contribute to overall estrogenic activity.
- E1 is less potent than E2 but can still impact total estrogenic load and can be converted to E2 as needed. 16-OH-E1 is weaker than E2 but may exert significant estrogenic effects, depending on the tissue in which it is produced. E3 is a weak estrogen with mild estrogenic effects and may have anti-inflammatory properties.
- Higher levels of these additional estrogens relative to E2 may enhance overall estrogenic activity, while lower levels may result in reduced estrogenic effects.

#2. Assess if there is a preference for alpha metabolism of progesterone

- The slider bar for 5a-metabolism of progesterone metabolites reflects the balance between a-pregnanediol and b-pregnanediol. Most progesterone is typically metabolized to b-pregnanediol, but a-pregnanediol is an active metabolite that can bind to GABA receptors in the central nervous system. A higher result on the 5a-metabolism (P4) slider indicates that available progesterone has a greater potential for impact on GABA receptors.

#3. Assess estrogen clearance through phase 1 and 2

- By looking at the parent estrogens (E1, E2) and their breakdown products (2OH, 4OH, 16OH, and 2MeOHE1), we can see how quickly estrogen is being metabolized. If the parent estrogens are higher than the breakdown products, it means estrogen is clearing more slowly, which increases risk of estrogen excess symptoms. Balanced levels show normal clearance, while lower parent estrogens compared to breakdown products suggest faster clearance, decreasing the risk of estrogen excess symptoms.

#4. Assess whether any of the estrogen-related organic acids are out of range

- Estrogen levels, metabolites, and metabolism patterns can be influenced by nutrient status, oxidative stress, and gut health. Check the OATs page for imbalances in glutathione, B12, B6, gut dybiosis, and oxidative stress markers, which may help identify contributing factors affecting estrogens.

ANDROGENS

#1. Assess if the DHEA-S is relatively lower than the Total DHEA

- DHEA-S is primarily produced in the adrenals through sulfation. Inflammation can inhibit sulfation, lowering DHEA-S levels and diverting DHEA metabolism toward 5a- and 5b-reductase pathways, resulting in higher etiocholanolone (5b-metabolite) and Androsterone (5a-metabolite) levels relative to DHEA-S. Review the patient's results to assess if this pattern is present.

#2. Assess the androgen pattern to determine if urine testosterone may not accurately reflect systemic levels (UGT2B17 deletion)

- This advanced topic is only relevant if the patient has low testosterone on the DUTCH Test.

A specific enzyme called UGT2B17, is primarily responsible for the process (glucuronidation) of how testosterone, 5a-DHT, and 5b-Androstenediol are excreted in the urine. Some people have a genetic variation affecting this enzyme which impacts how the body gets rid of those metabolites in urine. This can mean urine tests might show low testosterone levels when actual testosterone levels in the body are normal.

This variation does not mean anything is wrong, it just makes urine results less reliable in some people and serum testing (checking free and total testosterone) should be considered prior to initiating treatment if low testosterone, 5a-DHT, or 5b-androstenediol results are noted on a urinary test. It does not affect epi-testosterone, 5a-androstenediol, or other androgens, as those are processed (glucuronidated) by different enzymes.

#3. While 5a-androstenediol best represents cellular 5a-DHT production, assess if 5a-DHT offers additional insight into androgenic activity

- 5a-DHT is testosterone's active metabolite and is three times more potent than testosterone. If elevated it may contribute to androgen excess syptoms. Research shows 5a-Androstenediol may be a better marker of 5a-DHT tissue activity, but the 5a-DHT result may provide additional insight. Review the 5a-DHT result in context of other androgens and androgenic symptoms for a deeper understanding of the androgen results.

#4. Assess whether any of the androgen-related organic acids are out of range

- Androgen levels can be influenced by inflammation and nutrient status. Check the OATs page for imbalances in B6 and neuroinflammation markers, which may help identify contributing factors affecting androgens.

About Your Results Advanced Insights (continued)

ADRENAL

#1. Assess if cortisone (inactive) adds more insight to the free cortisol assessment

- Cortisol is the active adrenal glucocorticoid, while cortisone is an inactive "storage" form. In the kidney, a significant amount of cortisol is converted to cortisone before excretion into the urine. Therefore, urinary cortisone should be considered a reflection or "shadow" of systemic cortisol. The degree to which this happens in an individual may vary. If free cortisone is significantly higher than free cortisol it may indicate free cortisol levels were higher in circulation (serum) than the urinary free cortisol levels may imply. If free cortisone is lower than free cortisol this may indicate free cortisol levels were not as high in circulation (serum) as urinary free cortisol imply.

#2. Assess if there is a whole-body preference for (inactive) cortisone or (active) cortisol

- The Systemic Preference slider reflects the balance between cortisol (THF) and cortisone (THE) metabolites and is influenced by systemic cortisol needs. As these metabolites are processed through the liver, the body may shift to cortisol (THF) in response to acute stressors (e.g., immune activation or infection), or toward cortisone (THE) with chronic stress (e.g., long-term inflammation or illness). Review the patient's result to determine if they are out of range.

A rightward shift (toward cortisol) paired with elevated free cortisol, may contribute to elevated tissue cortisol. If paired with low free cortisol, it may be helping preserve active cortisol in the systemic tissues.

A leftward shift (toward cortisone) paired with elevated free cortisol may be protective, helping reduce tissue exposure. If paired with low free cortisol it may worsen low cortisol symptoms by inactivating available cortisol.

#3. Assess for anabolic-catabolic balance

- Androgens support tissue growth and repair, while cortisol promotes tissue breakdown. When androgens are significantly higher than cortisol, it may suggest an anabolic state (favoring tissue building and repair). When androgens are significantly lower than cortisol, it may suggest a catabolic state (favoring tissue breakdown).

#4. Assess whether any of the cortisol-related organic acids are out of range

- Cortisol can be impacted by inflammation, nutrient status, and sleep. Check the OATs page for imbalances in B12, B6, melatonin, and neuroinflammation markers, which may help identify contributing factors affecting cortisol.

Reference Range Percentiles

Reference ranges are developed by testing thousands of healthy individuals, while excluding results from outliers or those on impactful medications. A percentile approach is applied, as is done with most labs. Classic reference ranges use the 95th percentile as the upper end of range and the 5th percentile as the lower end of range. Our DUTCH ranges uses the percentiles found in the table below. We feel these ranges reflect the more optimal range sought in functional medicine practices. The table below shows the percentiles used for the reference range of each analyte on the DUTCH report:

Female Reference Ranges (Updated 05.20.2025)									
	Low%	High%	Low	High		Low%	High%	Low	High
b-Pregnanediol	20%	90%	600	2000	Cortisol A (waking)	20%	90%	10	50
a-Pregnanediol	20%	90%	200	740	Cortisol B (morning)	20%	90%	30	130
Estrone (E1)	20%	80%	12	26	Cortisol C (~5pm)	20%	90%	7	30
Estradiol (E2)	20%	80%	1.8	4.5	Cortisol D (bed)	0	90%	0	14
Estriol (E3)	20%	80%	5	18	Cortisone A (waking)	20%	90%	40	120
2-OH-E1	20%	80%	5.1	13.1	Cortisone B (morning)	20%	90%	90	230
4-OH-E1	0	80%	0	1.8	Cortisone C (~5pm)	20%	90%	32	110
16-OH-E1	20%	80%	0.7	2.6	Cortisone D (bed)	0	90%	0	55
2-Methoxy-E1	20%	80%	2.5	6.5	Cortisol Clearance Rate (CCR)	20%	80%	6	12.5
2-OH-E2	0	80%	0	3.1	Melatonin (6-OHMS)	20%	90%	10	85
4-OH-E2	0	80%	0	0.52	8-OHdG	0	90%	0	5.2
2-16-ratio	20%	80%	2.69	11.83	Methylmalonate	0	90%	0	2.5
2-4-ratio	20%	80%	5.4	12.62	Xanthurenate	0	90%	0.12	1.2
2Me-2OH-ratio	20%	80%	0.39	0.67	Kynurenate	0	90%	0.8	4.5
DHEA-S	20%	90%	20	750	b-Hydroxyisovalerate	0	90%	0	12.5
Androsterone	20%	80%	200	1650	Pyroglutamate	10%	90%	28	58
Etiocholanolone	20%	80%	200	1000	Indican	0	90%	0	100
Testosterone	20%	80%	2.3	14	Homovanillate	10%	95%	3	11
5a-DHT	0	80%	0	6.6	Vanilmandelate	10%	95%	2.2	5.5
5a-Androstanediol	20%	80%	6	30	Quinolate	0	90%	0	9.6
5b-Androstanediol	20%	80%	12	75	Calculated Values				
Epi-Testosterone	20%	80%	2.3	14	Total DHEA Production	20%	80%	500	3000
a-THF	20%	90%	75	370	Total Estrogens	20%	80%	35	70
b-THF	20%	90%	1050	2500	Metabolized Cortisol	20%	90%	2750	6500
b-THE	20%	90%	1550	3800	24hr Free Cortisol	20%	90%	65	200
					24hr Free Cortisone	20%	90%	220	450
% = population percentile: Example - a high limit of 90% means results higher than 90% of the women tested for the reference range will be designated as "high."									

APPENDIX D: DUTCH TEST REFERENCE RANGES

FEMALE REFERENCE RANGES (UPDATED 07.01.2022)					
CATEGORY	BIOMARKER	LOW %	HIGH %	LOW LIMIT	HIGH LIMIT
Sex Hormones: Estrogen	Estrone (E1)	20%	80%	12	26
	Estradiol (E2)	20%	80%	1.8	4.5
	Estriol (E3)	20%	80%	5	18
	2-OH-E1	20%	80%	5.1	13.1
	4-OH-E1	0	80%	0	1.8
	16-OH-E1	20%	80%	0.7	2.6
	2-Me-E1	20%	80%	2.5	6.5
	2-OH-E2	0	80%	0	1.2
	4-OH-E2	0	80%	0	0.5
Sex Hormones: Progesterone	a-Pregnanediol	20%	90%	200	740
	b-Pregnanediol	20%	90%	600	2000
Sex Hormones: Androgen	DHEA-S	20%	90%	20	750
	Androsterone	20%	80%	200	1650
	Etiocholanolone	20%	80%	200	1000
	Testosterone	20%	80%	2.3	14
	5a-DHT	0	80%	0	6.6
	5a-Androstenediol	20%	80%	6	30
	5b-Androstenediol	20%	80%	20	75
	Epi-Testosterone	20%	80%	2.3	14
	a-THF	20%	90%	75	370
	b-THF	20%	90%	1050	2500
	b-THE	20%	90%	1550	3800
Organic Acids: Nutritional	Methylmalonate	0	90%	0	2.2
	Xanthurenate	0	90%	0	1.4
	Kynurenate	0	90%	0	7.3
	b-Hydroxyisovalerate	0	90%	0	12.5
	Pyroglutamate	10%	90%	32	60
	Indican	0	90%	0	100
Organic Acids: Neuro-Related	Homovanillate	10%	95%	4	13
	Vanilmandelate	10%	95%	2.4	6.4
	Quinolinate	0	90%	0	9.6
Organic Acids: Additional	Melatonin (6-OHMS)	20%	90%	10	85
	8-OHdG	0	90%	0	5.2

% = Population percentile: Example – a high limit of 90% means results higher than 90% of the women tested for the reference range will be designated as “high.”

FEMALE REFERENCE RANGES (UPDATED 07.01.2022)					
CATEGORY	BIOMARKER	LOW %	HIGH %	LOW LIMIT	HIGH LIMIT
Adrenals: Cortisol	Urinary Cortisol (Waking)	20%	90%	10	50
	Urinary Cortisol (+2 Hours)	20%	90%	30	130
	Urinary Cortisol (Dinner)	20%	90%	7	30
	Urinary Cortisol (Bedtime)	0	90%	0	14
	Salivary Cortisol Waking (W)	20%	90%	1.6	4.6
	Salivary Cortisol (W+30 min.)	20%	90%	3.7	8.2
	Salivary Cortisol (W+60 min.)	20%	90%	2.3	5.3
	Salivary Cortisol (Dinner)	20%	90%	0.4	1.5
	Salivary Cortisol (Bedtime)	0	95%	0	0.9
	Salivary Cortisol (Mid-Sleep)	0	90%	0	0.9
Adrenals: Cortisone	Urinary Cortisone (Waking)	20%	90%	40	120
	Urinary Cortisone (+2 Hours)	20%	90%	90	230
	Urinary Cortisone (Dinner)	20%	90%	32	110
	Urinary Cortisone (Bedtime)	0	90%	0	55
	Salivary Cortisone Waking (W)	20%	90%	6.8	14.5
	Salivary Cortisone (W+30 min.)	20%	90%	12.4	19.4
	Salivary Cortisone (W+60 min.)	20%	90%	9.4	15.3
	Salivary Cortisone Dinner	20%	90%	2	7.1
	Salivary Cortisone Bedtime	0	95%	0	4.8
	Salivary Cortisone (Mid-Sleep)	0	95%	0	4.8
CALCULATED VALUES					
Androgen	Total DHEA Production	20%	80%	500	3000
Estrogen	Total Estrogens	20%	80%	35	70
Adrenal	Metabolized Cortisol	20%	90%	2750	6500
	Urinary 24hr Free Cortisol	20%	90%	65	200
	Urinary 24hr Free Cortisone	20%	90%	220	450
	Salivary Cortisol Total	20%	90%	9.6	19.3
	Salivary Cortisone Total	20%	90%	36	55

% = Population percentile: Example – a high limit of 90% means results higher than 90% of the women tested for the reference range will be designated as “high.”

MALE REFERENCE RANGES (UPDATED 07.01.2022)					
CATEGORY	BIOMARKER	LOW %	HIGH %	LOW LIMIT	HIGH LIMIT
Sex Hormones: Androgen	DHEA-S	20%	90%	30	1500
	Androsterone	20%	80%	500	3000
	Etiocholanolone	20%	80%	400	1500
	Testosterone	20%	90%	25	115
	5a-DHT	20%	90%	5	25
	5a-Androstenediol	20%	90%	30	250
	5b-Androstenediol	20%	90%	40	250
	Epi-Testosterone	20%	90%	25	115
	a-THF	20%	90%	175	700
	b-THF	20%	90%	1750	4000
	b-THE	20%	90%	2350	5800
	Estrone (E1)	10%	90%	4	16
	Estradiol (E2)	10%	90%	0.5	2.2
Sex Hormones: Estrogen	Estriol (E3)	10%	90%	2	8
	2-OH-E1	0	90%	0	5.9
	4-OH-E1	0	90%	0	0.8
	16-OH-E1	0	90%	0	1.2
	2-Me-E1	0	90%	0	2.8
	2-OH-E2	0	90%	0	0.6
	4-OH-E2	0	90%	0	0.3
Sex Hormones: Progesterone	a-Pregnanediol	10%	90%	20	130
	b-Pregnanediol	10%	90%	75	400
Organic Acids: Nutritional	Methylmalonate	0	90%	0	3
	Xanthurenate	0	90%	0	2.1
	Kynurenate	0	90%	0	9.3
	b-Hydroxyisovalerate	0	90%	0	18
	Pyroglutamate	10%	90%	43	85
	Indican	0	90%	0	131
Organic Acids: Neuro-Related	Homovanillate	10%	95%	4.8	19
	Vanilmandelate	10%	95%	2.8	8
	Quinolate	0	90%	0	12.5
Organic Acids: Additional	Melatonin (6-OHMS)	20%	90%	10	85
	8-OHdG	0	90%	0	8.8

% = Population percentile: Example – a high limit of 90% means results higher than 90% of the men tested for the reference range will be designated as “high.”

MALE REFERENCE RANGES (UPDATED 07.01.2022)					
CATEGORY	BIOMARKER	LOW %	HIGH %	LOW LIMIT	HIGH LIMIT
Adrenals: Cortisol	Urinary Cortisol (Waking)	20%	90%	13	80
	Urinary Cortisol (+2 Hours)	20%	90%	35	180
	Urinary Cortisol (Dinner)	20%	90%	10	45
	Urinary Cortisol (Bedtime)	0	90%	0	20
	Salivary Cortisol Waking (W)	20%	90%	1.6	4.6
	Salivary Cortisol (W+30 min.)	20%	90%	3.7	8.2
	Salivary Cortisol (W+60 min.)	20%	90%	2.3	5.3
	Salivary Cortisol (Dinner)	20%	90%	0.4	1.5
	Salivary Cortisol (Bedtime)	0	95%	0	0.9
	Salivary Cortisol (Mid-Sleep)	0	90%	0	0.9
Adrenals: Cortisone	Urinary Cortisone (waking)	20%	90%	40	160
	Urinary Cortisone (+2 Hours)	20%	90%	80	240
	Urinary Cortisone (Dinner)	20%	90%	40	130
	Urinary Cortisone (Bedtime)	0	90%	0	70
	Salivary Cortisone Waking (W)	20%	90%	6.8	14.5
	Salivary Cortisone (W+30 min.)	20%	90%	12.4	19.4
	Salivary Cortisone (W+60 min.)	20%	90%	9.4	15.3
	Salivary Cortisone Dinner	20%	90%	2	7.1
	Salivary Cortisone Bedtime	0	95%	0	4.8
	Salivary Cortisone (Mid-Sleep)	0	95%	0	4.8
CALCULATED VALUES					
Androgen	Total DHEA Production	20%	80%	1000	5500
Estrogen	Total Estrogens	10%	90%	10	34
Adrenal	Metabolized Cortisol	20%	90%	4550	10000
	Urinary 24hr Free Cortisol	20%	90%	75	300
	Urinary 24hr Free Cortisone	20%	90%	220	550
	Salivary Cortisol Total	20%	90%	9.6	19.3
	Salivary Cortisone Total	20%	90%	36	55

% = Population percentile: Example – a high limit of 90% means results higher than 90% of the men tested for the reference range will be designated as “high.”

16-Hydroxy-Estrone (16-OH-E1)

Phase 1 estrone (E1) metabolite; proliferative estrogen that may contribute to breast tenderness and heavy bleeding, etc.

2-Hydroxy-Estrone (2-OH-E1)

Phase 1 estrone (E1) metabolite; 2-OH metabolites are the most stable phase 1 metabolites.

2-Hydroxy-Estradiol (2-OH-E2)

Phase 1 estradiol (E2) metabolite; 2-OH metabolites are the most stable phase 1 metabolites.

2-Methoxy-Estrone (2-Me-E1)

Phase 2 metabolite that is much more stable than its precursor 2-OH-E1.

4-Hydroxy-Estrone (4-OH-E1)

Phase 1 estrone (E1) metabolite; 4-OH metabolites are the most carcinogenic phase 1 metabolites.

4-Hydroxy-Estradiol (4-OH-E2)

Phase 1 estradiol (E2) metabolite; 4-OH metabolites are the most carcinogenic phase 1 metabolites.

5a-Androstenediol

The best marker of 5a-DHT formation and activity in the tissues; can be used to estimate androgen activity in the tissues.

5a-DHT

Alpha metabolite of testosterone and the most potent androgen; roughly three to four times more androgenic than testosterone.

5b-Androstenediol

Weak beta androgen metabolite of testosterone that does not contribute to symptoms of androgen excess.

8-Hydroxy-2-Deoxyguanosine (8-OHdG)

Marker associated with oxidative stress and DNA damage.

a-Pregnanediol

Progesterone metabolite that modulates gamma-aminobutyric acid (GABA) receptors in the central nervous system (CNS) and can lead to improvements in mood and sleep.

a-Tetrahydrocortisol (a-THF)

Alpha cortisol metabolite.

Androsterone

Alpha DHEA metabolite that is roughly seven times weaker than testosterone; can be used to estimate androgen activity in the tissues.

b-Hydroxyisovalerate

Marker associated with biotin deficiency.

b-Pregnanediol

Most prominent progesterone metabolite, however, doesn't modulate GABA receptors.

b-Tetrahydrocortisol (b-THF)

Beta cortisol metabolite.

b-Tetrahydrocortisone (b-THE)

Beta cortisone metabolite.

Cortisol Awakening Response (CAR)

An HPA axis resiliency marker, an anticipatory marker of upcoming daily events, and a surrogate marker for HPA axis plasticity/reactivity.

Cortisol Clearance Rate (CCR)

Estimated rate that free cortisol and cortisone are cleared from circulation. Represents the ratio of (THF + THE)/(Total Free Cortisol + Total Free Cortisone).

Creatinine

A compound that is produced from the metabolism of creatine from the kidneys and excreted in the urine. In order to provide the most accurate results, the DUTCH Test uses creatinine excretion to control for hydration status.

DHEA-S

Sulfated and circulating form of DHEA.

Epi-Testosterone

Not an androgenic hormone but produced in approximately the same amount as testosterone by the testes. Can be used to distinguish a truly low testosterone from a falsely low measurement due to the UGT genetic variant, see **“UGT Deletion” on page 72** for more information.

Estradiol (E2)

Most potent, biologically active estrogen.

Estriol (E3) / 16-Hydroxy-Estradiol (16-OH-E2)

Least potent, weak estrogen derived from estradiol and 16-OH-E1.

Estrone (E1)

Moderate strength estrogen.

Etiocholanolone

Weak beta DHEA metabolite.

Free Cortisol Diurnal Pattern

Daily diurnal (circadian) rhythm of active cortisol that is normally highest in the morning and lowest at night.

Free Cortisone Diurnal Pattern

Daily diurnal (circadian) rhythm of inactive cortisone that is normally highest in the morning and lowest at night. The free cortisone diurnal pattern is used in combination with the free cortisol diurnal pattern to evaluate active free cortisol levels throughout the day, see **“The Cortisone Shadow” on page 164** for more information.

Homovanillate (HVA)

Primary dopamine metabolite.

Indican

Metabolic byproduct of tryptophan metabolism in the gut that elevates with intestinal dysbiosis.

Kynurenate

Metabolic byproduct of tryptophan metabolism that elevates with vitamin B6 deficiency and inflammation.

Melatonin (6-OH-Melatonin Sulfate)

Melatonin metabolite.

Metabolized Cortisol (THE + THF)

Sum of all cortisol and cortisone metabolites.

Methylmalonate (MMA)

Metabolic byproduct of the citric acid cycle that elevates with vitamin B12 deficiency.

Optional Extra Cortisol Sample (Mid-Day and Mid-Sleep)
Measurements of cortisol in the middle of the day and upon waking at night.
Pyroglutamate
An intermediate in glutathione recycling and production that elevates with glutathione deficiency.
Quinolate
Metabolic byproduct of tryptophan metabolism and neurotoxin that elevates with neuroinflammation and general inflammation.
Testosterone
The major circulating androgen.
Total Estrogen
Represents the sum of all estrogen markers.
Vanilmandelate (VMA)
Primary norepinephrine and epinephrine metabolite.
Xanthurenate
Metabolic byproduct of tryptophan metabolism that elevates with vitamin B6 deficiency.

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