## **FECAL METALS**



LAB#: PATIENT: ID: SEX:

AGE:

POTENTIALLY TOXIC METALS								
	RESULT	REFERENCE	PERCENTILE					
METALS	mg/kg	RANGE	68	3 <sup>th</sup>	95 <sup>th</sup>			
Mercury	0.021	<.05 w/o amalgams*						
Mercury	0.021	<.5 with amalgams*						
Antimony	0.121	< 0.080						
Arsenic	0.18	< 0.30						
Beryllium	0.067	< 0.009						
Bismuth	0.611	< 0.050						
Cadmium	0.69	< 0.50						
Copper	55	< 60						
Lead	1.14	< 0.50						
Nickel	12.9	< 8.0			-			
Platinum	< dl	< 0.003						
Thallium	0.016	< 0.020						
Tungsten	0.338	< 0.090						
Uranium	0.168	< 0.120						

% WATER CONTENT							
	RESULT	EXPECTED		MEAN			
	% H₂O	RANGE	2SD LOW 1SD LOW	72.5%	1SD HIGH 2SD HIGH		
% WATER CONTENT	63.4	60-85%					

## **DISCUSSION**

Analysis of elements in feces provides a comprehensive evaluation of environmental exposure, accumulation and endogenous detoxification of potentially toxic metals. For several toxic elements such as mercury, cadmium, lead, antimony and uranium, biliary excretion of metals into feces is the primary natural route of elimination from the body. Studies performed at DDI demonstrate that the fecal mercury content and number of amalgam surfaces are highly correlated, as is the case for post-DMPS urine mercury levels and amalgam surface area.

Results are reported as mg/kg dry weight of feces to eliminate the influence of variability in water content of fecal specimens. The reference values that appear in this report have been derived from both published data and in-house studies at DDI. \*Due to exposure to mercury in the oral cavity, people with dental amalgams typically have a considerably higher level of mercury in the feces than individuals without dental amalgams; therefore, two reference ranges have been established for mercury.

To provide guidance in interpretation of results, patient values are plotted graphically with respect to percentile distribution of the population base. Since this test reflects both biliary excretion and exposure (metals to which the patient is exposed may not be absorbed), it may not correlate with overt clinical effects. Further testing can assist in determining whether the metals are from endogenous (biliary excretion) or exogenous (oral exposure) sources.

- 1. Bjorkman, L, Sandborgh-Englund, G, and Ekstand, J,. Mercury in Saliva and Feces after Removal of Amalgam Fillings. Toxicology & Applied Pharmacology 144: 156-162 (1997)
- 2. Zalups, R, Progressive Losses of Renal Mass and the Renal and Hepatic Disposition of Administered Inorganic Mercury. Toxicology & Applied Pharmacology 130: 121-131 (1995)
- 3. Adamsson, E., Piscator, M., and Nogawa, K., Pulmonary and Gastrointestinal Exposure to Cadmium Oxide Dust in a Battery Factory. Environmental Health Perspectives, 28: 219-222 (1979)
- 4. Smith, J., et al., The Kinetics of Intravenously Administered Methyl Mercury in Man. Toxicology & Applied Pharmacology 128:251-256 (1994)
- 5. Bass, D., et al., "Measurement of Mercury in Feces", Poster presentation 1999 AACC

SPECIMEN DATA						
Comments:						
Date Collected:	Detoxification Agent:	Dental Amalgams:				
Date Received:		Quantity:				
Date Completed:	Methodology:		V02.00			