Trimethylaminuria Test Results

Thank you for initiating your test through MEBO Research, Inc. (“MEBO”).
Your test was performed by,

THE CLEVELAND CLINIC FOUNDATION
The Department of Cardiovascular Medicine
Preventive Cardiology and Rehabilitation
Prevention Research Laboratory

<table>
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<tr>
<th>Last Name</th>
<th>MEBO ID Number</th>
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CLINICAL CHEMISTRY RESULTS

<table>
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<tr>
<th>Parameter</th>
<th>Normal Reference Range*</th>
<th>Comments</th>
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<tbody>
<tr>
<td>TMA (umol/mmol creatinine)</td>
<td>&lt;1.57</td>
<td></td>
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<tr>
<td>TMAO (umol/mmol creatinine)</td>
<td>&lt;766</td>
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<tr>
<td>Creatinine (mmol/L)</td>
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<tr>
<td>TMA/TMAO Ratio</td>
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</table>

* Normal Reference Range established by The Cleveland Clinic

TMA - Trimethylamine / TMAO - Trimethylamine-N-oxide

Comments:
Urine sample was evaluated with Liquid Chromatography / Mass Spectrometry after loading with 1,950 mg choline capsules.

Testing performed at Cleveland Clinic Prevention Research Lab. This is not a medical diagnosis and should not be interpreted as such.

If you have additional questions about your results, please email: tmaresult@meboresearch.org
INTRODUCTION TO TRIMETHYLAMINURIA [TMAU]

Also known as:
- Trimethylaminuria (TMAU)
- Primary TMAU (TMAU1) (Inherited FMO3 deficiency)
- Secondary TMAU (TMAU2)
- Fish Odour Syndrome (FOS) (Fish Malodour Syndrome)
- Primary FOS / Secondary FOS
- Flavin-containing mono-oxygenase type 3 (FMO3) deficiency.

Trimethylaminuria (TMAU) is a metabolic disorder defined by the excessive urinary excretion of the volatile tertiary amine trimethylamine (TMA). This reflects an increase in body fluids which results in TMAU patients exuding the odour of rotten fish (similar to ammonia), as the excess TMA is excreted in sweat. Body odour of rotten fish is not unsurprisingly accompanied by the same odour on the breath of TMAU sufferers.

TMAU is therefore a potentially distressing condition of social exclusion resulting in depression and other psychological problems. Patients may start to show signs of the condition at various ages from infancy to adulthood depending mainly on whether the disorder is inherited or acquired.

PRIMARY TRIMETHYLAMINURIA (TMAU1)

The inherited form of TMAU is known as Primary TMAU or TMAU1. The result of a faulty recessive gene, TMAU1 patients have impaired activity of a liver enzyme known as FMO3 (flavin-containing mono-oxygenase type 3). FMO3 oxidizes chemical compounds and has a wide range of substrates including many drugs. TMA is oxidised to the non-odorous TMA-oxide (TMO) by FMO3, which can then be excreted in the sweat, urine, reproductive fluids, and breath. TMA itself is generated in the large intestine by bacteria which break down compounds such as choline (in meat, liver, eggs and beans/peas), carnitine (meat) and TMO from seafood (hence TMA from rotting fish). TMAU1 therefore results from FMO3 deficiency with an increase in the ratio of TMA to TMO in urine, which can be used for diagnosis.

Due to the low specificity of FMO3 and the large number of drugs detoxified, TMAU1 patients may suffer from adverse drug reactions (eg with codeine; tamoxifen; ketoconazole; nicotine; cimetidine; ranitidine; phenothiazine). Hypertension may result from ingestion of red wine and cheese (and chocolate), which produce the neurotransmitter tyramine, another FMO3 dependent compound. Many people suffer from migraines associated with tyramine containing foods and perhaps FMO3 deficiency may explain some of these cases, but overall this demonstrates the adverse medical consequences as well as the odour related psychosocial aspects.

SECONDARY TRIMETHYLAMINURIA (TMAU2)

The acquired form of TMAU is covered by the term Secondary TMAU or TMAU2 where TMA excretion is high even though FMO3 activity is normal. Most TMAU2 patients produce too much TMA from intestinal bacteria due to excessive bacterial growth of TMA-generating species. The TMA burden is so great that FMO3 oxidation is not enough to convert all the TMA. This problem may be exacerbated by intestinal structural problems, such as ‘blind loops’ or post-operative complications. TMAU2 usually presents in adulthood, although children have been known to
acquire excessive TMA-producing bacteria with the resultant odour. The diagnosis of TMAU2 depends on the
detection of increased urinary TMA and TMO with a normal TMA/TMO ratio indicating normal oxidation by FMO3.
Some TMAU2 patients may have liver or kidney disease, which results in a TMAU1-like pattern of excretion.
Importantly, this may also occur with a urinary tract infection (UTI) which results in TMA being produced directly into
the urine giving a false positive result. Whenever results suggest TMAU1, therefore, UTI must always be excluded by
microbial analysis before a TMAU1 diagnosis is confirmed in a follow-up sample.

ODOR MANAGEMENT PROTOCOL

- **DIET:** Treatment of both TMAU1 and TMAU2 is based on diet to restrict the sources (precursors) of TMA.
  Treatment of manifestations: Dietary restriction of: (1) trimethylamine (present in milk obtained from wheat-fed
cows) and its precursors including choline (present in eggs, liver, kidney, peas, beans, peanuts, soya products,
and brassicas [Brussels sprouts, broccoli, cabbage, cauliflower]), lecithin and lecithin-containing fish oil
supplements, (2) trimethylamine N-oxide (present in seafood [fish, cephalopods, and crustaceans]), (3) inhibitors
of FMO3 enzyme activity such as indoles (found in brassicas)

- **ANTIBIOTICS:** (neomycin, amoxicillin metronidazole) to eliminate the TMA-producing bacteria, and thus
  suppress production of TMA. TMAU2 can well controlled by eradication of the excess bacteria, although stubborn
  colonies may regrow to excess and require further courses of treatment.

- **LAXATIVES:** The use of decrease intestinal transit time. Lactulose adsorbs and eliminates ammonia from the
gut.

- **Riboflavin (Vit B2) supplements** to enhance residual FMO3 enzyme activity. Recommended intake is 30-40mg
taken 3-5 times per day with food.

- **ACID SOAPS:** The use of acid soaps and body lotions are helpful to neutralize TMA chemically while removing
  secreted alkaline trimethylamine by washing. Trimethylamine is a strong base (pH 9.8), thus soaps with pH
closer to that of normal skin help remove the secreted trimethylamine.

- **Odor effects may also be mitigated** with the administration of Activated charcoal taken at a dose of 750mg
twice daily for ten days. Copper chlorophyllin taken at a dose of 60mg three times a day after meals for three
  weeks.to sequester trimethylamine produced in the gut, and copper chlorophyllin complex deodorizing tablets.

TMAU1, as a genetic defect, cannot be completely cured although therapy (dietary and antibiotic) can frequently
successfully control the patient’s TMA to a less odorous level. Patient’s residual enzyme activity is variable
depending on the specific mutation and as such. trials with the cofactor riboflavin have been tried with some
success. Milder TMAU1 patients can, however, reduce their TMA to almost normal values with just diet and periodic
antibiotic therapy.

ADDITIONAL TMAU INFORMATION

Trimethylaminuria. NCBI Bookshelf, A service of the National Library of Medicine, National Institutes of Health
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Suggested Reading