

## Overview

### Useful For

Evaluation of calcium oxalate and calcium phosphate kidney stone risk, and calculation of urinary supersaturation

Evaluation of bone diseases, including osteoporosis and osteomalacia

### Special Instructions

- [Urine Preservatives-Collection and Transportation for 24-Hour Urine Specimens](#)

### Method Name

Photometric

### NY State Available

No

## Specimen

### Specimen Type

Urine

### Necessary Information

**24-Hour volume (in milliliters) and collection duration are required.**

### Specimen Required

**Patient Preparation:** Patient **should not** use a laxative during the 24-hour collection period.

**Supplies:** Sarstedt Aliquot Tube, 5 mL (T914)

**Collection Container/Tube:** 24-hour graduated urine container with no metal cap or glued insert

**Submission Container/Tube:** Plastic, 5 mL tube or a clean, plastic aliquot container with no metal cap or glued insert

**Specimen Volume:** 4 mL

#### Collection Instructions:

1. Collect urine for 24 hours.
2. Refrigerate specimen within 4 hours of completion of 24-hour collection.

**Additional Information:** See [Urine Preservatives-Collection and Transportation for 24-Hour Urine Specimens](#) for multiple collections.

### Forms

If not ordering electronically, complete, print, and send a [Renal Diagnostics Test Request](#) (T830) with the specimen.

### Urine Preservative Collection Options

**Note:** The addition of preservative or application of temperature controls **must occur within 4 hours of completion** of

the collection.

|                           |               |
|---------------------------|---------------|
| Ambient (no additive)     | OK            |
| Refrigerate (no additive) | Preferr<br>ed |
| Frozen (no additive)      | OK            |
| 50% Acetic Acid           | OK            |
| Boric Acid                | OK            |
| Diazolidinyl Urea         | OK            |
| 6M Hydrochloric Acid      | OK            |
| 6M Nitric Acid            | No            |
| Sodium Carbonate          | No            |
| Thymol                    | OK            |
| Toluene                   | No            |

### Specimen Minimum Volume

1 mL

### Reject Due To

All specimens will be evaluated at Mayo Clinic Laboratories for test suitability

### Specimen Stability Information

| Specimen Type | Temperature              | Time     | Special Container |
|---------------|--------------------------|----------|-------------------|
| Urine         | Refrigerated (preferred) | 14 days  |                   |
|               | Ambient                  | 72 hours |                   |
|               | Frozen                   | 30 days  |                   |

## Clinical & Interpretive

### Clinical Information

Calcium is the fifth most common element in the body. It is a fundamental element necessary to form electrical gradients across membranes, an essential cofactor for many enzymes, and the main constituent in bone. Under normal physiological conditions, the concentration of calcium in serum and in cells is tightly controlled. Calcium is excreted in both urine and feces. Ordinarily about 20% to 25% of dietary calcium is absorbed and 98% of filtered calcium is reabsorbed in the kidney. Traffic of calcium between the gastrointestinal tract, bone, and kidney is tightly controlled by a complex regulatory system that includes vitamin D and parathyroid hormone. Sufficient bioavailable calcium is essential for bone health. Excessive excretion of calcium in the urine is a common contributor to kidney stone risk.

### Reference Values

Males: <250 mg/24 h\*

Females: <200 mg/24 h\*

\*Values represent clinical cutoffs above which studies have demonstrated increased risk of kidney stone formation. These values were not determined in a reference range study.

Reference values have not been established for patients who are younger than 18 years.

Reference values apply to 24-hour collection.

### Interpretation

Increased urinary calcium excretion (hypercalciuria) is a known contributor to kidney stone disease and osteoporosis. Many cases are genetic (often termed idiopathic). Previously such patients were often divided into fasting versus absorptive hypercalciuria depending on the level of urine calcium in a fasting versus fed state, but the clinical utility of this approach is now in question. Overall, the risk of stone disease appears increased when 24-hour urine calcium is above 250 mg in men and above 200 mg in women. Thiazide diuretics are often used to reduce urinary calcium excretion. Repeat urine collections can be performed to monitor the effectiveness of therapy.

Known secondary causes of hypercalciuria include hyperparathyroidism, Paget disease, prolonged immobilization, vitamin D intoxication, and diseases that destroy bone (such as metastatic cancer or multiple myeloma).

Urine calcium excretion can be used to gauge the adequacy of calcium and vitamin D supplementation, for example in states of gastrointestinal fat malabsorption that are associated with decreased bone mineralization (osteomalacia).

### Cautions

The interference of intravenously administered gadolinium-containing MRI (magnetic resonance imaging) contrast media was tested (Omniscan, Optimark). For Omniscan, no interference was observed at the therapeutic concentration, but there was interference at higher concentrations. For Optimark, interference was observed at therapeutic and higher concentrations

### Clinical Reference

1. Fraser WD: Bone and mineral metabolism. In: Rifai N, Horvath AR, Wittwer CT, eds: Tietz Textbook of Clinical Chemistry and Molecular Diagnostics. 6th ed. Elsevier; 2018:1438
2. Curhan GC, Willett WC, Speizer FE, Stampfer MJ. Twenty-four-hour urine chemistries and the risk of kidney stones among women and men. *Kidney Int.* 2001;59(6):2290-2298
3. Metz MP. Determining urinary calcium/creatinine cut-offs for the pediatric population using published data. *Ann Clin Biochem.* 2006;43(Pt 5):398-401
4. Pak CY, Britton F, Peterson R, et al. Ambulatory evaluation of nephrolithiasis. Classification, clinical presentation and diagnostic criteria. *Am J Med.* 1980;69(1):19-30
5. Pak CY, Kaplan R, Bone H, Townsend J, Waters O. A simple test for the diagnosis of absorptive, resorptive and renal hypercalciurias. *N Engl J Med.* 1975;292(10):497-500

### Performance

#### Method Description

Calcium ions react with 5-nitro-5'-methyl-BAPTA (NM-BAPTA) under alkaline conditions to form a complex. This complex reacts in the second step with EDTA. The change in absorbance is directly proportional to the calcium concentration and is measured photometrically.(Package insert: CA2, Calcium Gen.2. Roche Diagnostics; V3.0, 08/2023)

**PDF Report**

No

**Day(s) Performed**

Monday through Saturday

**Report Available**

Same day/1 to 3 days

**Specimen Retention Time**

2 weeks

**Performing Laboratory Location**

Mayo Clinic Jacksonville Clinical Lab

**Fees & Codes****Fees**

- Authorized users can sign in to [Test Prices](#) for detailed fee information.
- Clients without access to Test Prices can contact [Customer Service](#) 24 hours a day, seven days a week.
- Prospective clients should contact their account representative. For assistance, contact [Customer Service](#).

**Test Classification**

This test has been cleared, approved, or is exempt by the US Food and Drug Administration and is used per manufacturer's instructions. Performance characteristics were verified by Mayo Clinic in a manner consistent with CLIA requirements.

**CPT Code Information**

82340

**LOINC® Information**

| Test ID | Test Order Name   | Order LOINC® Value |
|---------|-------------------|--------------------|
| CALU    | Calcium, 24 HR, U | 6874-2             |

| Result ID | Test Result Name    | Result LOINC® Value |
|-----------|---------------------|---------------------|
| CA24      | Calcium, 24 HR, U   | 6874-2              |
| TM114     | Collection Duration | 13362-9             |
| VL110     | Urine Volume        | 3167-4              |