



# Test Definition: CCTR

Calcium/Creatinine Ratio, Random, Urine

## Overview

### Useful For

Calculation of calcium concentration per creatinine concentration

### Method Name

Only orderable as part of a profile. For more information see CACR3 / Calcium/Creatinine Ratio, Random, Urine.

Calculation

### NY State Available

Yes

## Specimen

### Specimen Type

Urine

### Specimen Required

Only orderable as part of a profile. For more information see CACR3 / Calcium/Creatinine Ratio, Random, Urine

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

**Collection Container/Tube:** Clean, plastic 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 a random urine specimen.
2. No preservative.

### 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 physiologic 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**

Only orderable as part of a profile. For more information see CACR3 / Calcium/Creatinine Ratio, Random, Urine

1 month-<12 months: 0.03-0.81 mg/mg creatinine

12 months-<24 months: 0.03-0.56 mg/mg creatinine

24 months-<3 years: 0.02-0.50 mg/mg creatinine

3 years-<5 years: 0.02-0.41 mg/mg creatinine

5 years-<7 years: 0.01-0.30 mg/mg creatinine

7 years-<10 years: 0.01-0.25 mg/mg creatinine

10 years-<18 years: 0.01-0.24 mg/mg creatinine

18 years-83 years: 0.05-0.27 mg/mg creatinine

Reference values have not been established for patients who are less than 1 month of age.

Reference values have not been established for patients who are greater than 83 years of age.

**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 greater than 250 mg in men and greater than 200 mg in women. Thiazide diuretics are often used to reduce urinary calcium excretion, and 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**

[No significant cautionary statements.](#)

**Clinical Reference**

1. Fraser WD. Bone and mineral metabolism. In: Rifai N, Horwath 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, et al. A simple test for the diagnosis of absorptive, resorptive and renal hypercalciurias. N Engl J Med. 1975;292(10):497-500

## Performance

### Method Description

This test is a calculation to provide the calcium per creatinine ratio. This calculation is performed by the laboratory information system, SCC Soft.

### PDF Report

No

### Day(s) Performed

Monday through Sunday

### Report Available

1 to 3 days

### Specimen Retention Time

7 days

### Performing Laboratory Location

Mayo Clinic Laboratories - Rochester Main Campus

## 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

Not Applicable

### LOINC® Information

Test ID	Test Order Name	Order LOINC® Value
CCTR	Calcium/Creat Ratio, Random, U	9321-1

Result ID	Test Result Name	Result LOINC® Value
-----------	------------------	---------------------

# Test Definition: CCTR

Calcium/Creatinine Ratio, Random, Urine

---

CCTR	Calcium/Creat Ratio, Random, U	9321-1
------	--------------------------------	--------