

Beyond the Standard Panel: Desk Reference

Additional tests only when clinical context and the decision they could change justify them. Not a universal panel.

Area	Standard test	Order instead / alongside	Why it matters
Diabetes risk	HbA1c, fasting glucose	Fasting insulin + HOMA-IR	Raised fasting insulin with normal glucose is the window: years of compensation before glucose moves
Cardiovascular risk	Standard lipid panel	ApoB; Lp(a) (once)	ApoB tracks particle number, not just cholesterol content. Lp(a) is largely genetic: test once, it informs risk stratification rather than a repeat-monitoring plan
Inflammation	None routine	hs-CRP	Predicts cardiovascular events independent of cholesterol; cheap and on most lab menus
Thyroid	TSH alone	Free T3, free T4, TPO/TgAb antibodies	Antibodies can flag autoimmune thyroid disease years before TSH drifts
Liver	ALT/AST	FIB-4 (calculated from age, ALT, AST, platelets)	No new test: a calculation from values already on a standard panel, worth running routinely
Micronutrients	Usually none	Vitamin D, ferritin, homocysteine	A normal full blood count does not rule any of these out. Homocysteine is a risk marker (association), not a proven treatment target

Interpretation limits

This is a discussion reference, not a universal testing panel or a replacement for standard care. An out-of-range marker does not by itself explain symptoms, identify a cause or prove that treatment will help. Additional testing depends on history, examination, risk and a clear decision it could change.

Fasting insulin and HOMA-IR are surrogate estimates, not diagnostic tests for diabetes. Assays and thresholds vary; routine testing is not generally recommended for most people at risk of diabetes. HbA1c and glucose remain established diagnostic tools.

ApoB reflects atherogenic particle burden rather than a literal particle count. Lp(a) is usually measured at least once in adulthood; repeat testing may be appropriate when clinical circumstances or treatments change. Interpret both within overall cardiovascular risk.

hs-CRP is non-specific: infection, injury and inflammatory conditions can raise it. Interpret in a clinically stable person and consider repeat measurement when indicated. A single result does not diagnose inflammaging or indicate a specific treatment.

A normal TSH is usually informative for primary thyroid disease. Free T4, free T3 and antibodies are selected for specific indications, not automatically ordered together. Positive antibodies with normal thyroid function do not alone require treatment.

FIB-4 estimates risk of advanced liver fibrosis in appropriate at-risk groups; it does not diagnose fatty liver or measure early liver health. Age affects accuracy, including reduced performance below 35 and different thresholds above 65. It is not a routine universal screening test.

Vitamin D, ferritin and homocysteine need a clinical indication and context. Routine vitamin D screening in healthy adults is not generally recommended. Ferritin can rise with inflammation. Lowering homocysteine has not consistently reduced cardiovascular events; an "optimal" range is not a universally validated treatment target.

Full text, sources and evidence notes: www.harleystreetinstitute.com/anti-ageing-longevity-medicine/resources/beyond-the-standard-panel/