



Donor 5186

Genetic Testing Summary

Fairfax Cryobank recommends reviewing this genetic testing summary with your healthcare provider to determine suitability.

Last Updated: 11/25/19

Donor Reported Ancestry: Irish, English, Polish, Scandinavian, German

Jewish Ancestry: No

Genetic Test*	Result	Comments/Donor's Residual Risk**
Chromosome analysis (karyotype)	Normal male karyotype	No evidence of clinically significant chromosome abnormalities
Hemoglobin evaluation	Normal hemoglobin fractionation and MCV/MCH results	Reduced risk to be a carrier for sickle cell anemia, beta thalassemia, alpha thalassemia trait (aa/-- and a-/a-) and other hemoglobinopathies
Cystic Fibrosis (CF) carrier screening	Negative by gene sequencing in the CFTR gene	1/1250
Spinal Muscular Atrophy (SMA) carrier screening	Negative for deletions of exon 7 in the SMN1 gene	1/632
Standard testing attached- 22 diseases by gene sequencing	Negative for genes sequenced	
Special Testing		
Leigh Syndrome (SURF1)	Negative by gene sequencing in the SURF1 gene	

*No single test can screen for all genetic disorders. A negative screening result significantly reduces, but cannot eliminate, the risk for these conditions in a pregnancy.

**Donor residual risk is the chance the donor is still a carrier after testing negative.

Ordering Practice:

Practice Code: [REDACTED]
Fairfax Cryobank - [REDACTED]
[REDACTED]
Physician: [REDACTED]
Report Generated: 2017-12-11

Donor 5186

DOB: [REDACTED]
Gender: Male
Ethnicity: European
Procedure ID: 107577
Kit Barcode: [REDACTED]
Specimen: Blood, #109364
Specimen Collection: 2017-11-07
Specimen Received: 2017-11-08
Specimen Analyzed: 2017-12-11

Partner Not Tested

TEST INFORMATION

Test: CarrierMap^{SEQ} (Genotyping & Sequencing)
Panel: Fairfax Cryobank Panel V2- Sequencing
Diseases Tested: 22
Genes Tested: 22
Genes Sequenced: 18

SUMMARY OF RESULTS: NO MUTATIONS IDENTIFIED

Donor 5186 was not identified to carry any pathogenic mutations in the gene(s) tested.

No pathogenic mutations were identified in the genes tested, reducing but not eliminating the chance to be a carrier for the associated genetic diseases. CarrierMap assesses carrier status for genetic disease via molecular methods including targeted mutation analysis and/ or next-generation sequencing; other methodologies such as CBC and hemoglobin electrophoresis for hemoglobinopathies and enzyme analysis for Tay-Sachs disease may further refine risks for these conditions. Results should be interpreted in the context of clinical findings, family history, and/or other testing. A list of all the diseases and mutations screened for is included at the end of the report. This test does not screen for every possible genetic disease.

For additional disease information, please visit recombine.com/diseases. To speak with a Genetic Counselor, call [855.OUR.GENES](tel:855.OUR.GENES).

Assay performed by 
Reprogenetics
CLIA ID: 31D1054821
3 Regent Street, Livingston, NJ 07039
Lab Technician: Bo Chu

Recombine CLIA # 31D2100763
Reviewed by Pere Colls, PhD, HCLD, Lab Director

ADDITIONAL RESULTS: NO INCREASED REPRODUCTIVE RISK

The following results are not associated with an increased reproductive risk.

Disease (Gene)	Donor 5186	Partner Not Tested
Spinal Muscular Atrophy: SMN1 Linked (SMN1) *	SMN1 Copy Number: 2 or more copies Method: dPCR & Genotyping	

* SMA Risk Information for Individuals with No Family History of SMA

	Detection Rate	Pre-Test Carrier Risk	Post-Test Carrier Risk (2 SMN1 copies)	Post-Test Carrier Risk (3 SMN1 copies)
European	95%	1/35	1/632	1/3,500
Ashkenazi Jewish	90%	1/41	1/350	1/4,000
Asian	93%	1/53	1/628	1/5,000
African American	71%	1/66	1/121	1/3,000
Hispanic	91%	1/117	1/1,061	1/11,000

For other unspecified ethnicities, post-test carrier risk is assumed to be <1%. For individuals with multiple ethnicities, it is recommended to use the most conservative risk estimate.

Methods and Limitations

Genotyping: Genotyping is performed using the Illumina Infinium Custom HD Genotyping assay to identify mutations in the genes tested. The assay is not validated for homozygous mutations, and it is possible that individuals affected with disease may not be accurately genotyped.

Sequencing: Sequencing is performed using a custom next-generation sequencing (NGS) platform. Only the described exons for each gene listed are sequenced. Variants outside of these regions may not be identified. Some splicing mutations may not be identified. Triplet repeat expansions, intronic mutations, and large insertions and deletions may not be detected. All identified variants are curated, and determination of the likelihood of their pathogenicity is made based on examining allele frequency, segregation studies, predicted effect, functional studies, case/control studies, and other analyses. All variants identified via sequencing that are reported to cause disease in the primary scientific literature will be reported. Variants considered to be benign and variants of unknown significance (VUS) are NOT reported. In the sequencing process, interval drop-out may occur, leading to intervals of insufficient coverage. Intervals of insufficient coverage will be reported if they occur.

Spinal Muscular Atrophy: Carrier status for SMA is assessed via copy number analysis by dPCR and via genotyping. Some individuals with a normal number of SMN1 copies (2 copies) may carry both copies of the gene on the same allele/chromosome; this analysis is not able to detect these individuals. Thus, a normal SMN1 result significantly reduces but does not eliminate the risk of being a carrier. Additionally, SMA may be caused by non-deletion mutations in the SMN1 gene; CarrierMap tests for some, but not all, of these mutations. Some SMA cases arise as the result of de novo mutation events which will not be detected by carrier testing.

Limitations: In some cases, genetic variations other than that which is being assayed may interfere with mutation detection, resulting in false-negative or false-positive results. Additional sources of error include, but are not limited to: sample contamination, sample mix-up, bone marrow transplantation, blood transfusions, and technical errors. The test does not test for all forms of genetic disease, birth defects, and intellectual disability. All results should be interpreted in the context of family history; additional evaluation may be indicated based on a history of these conditions. Additional testing may be necessary to determine mutation phase in individuals identified to carry more than one mutation in the same gene. All mutations included within the genes assayed may not be detected, and additional testing may be appropriate for some individuals.

This test was developed and its performance determined by Recombine, Inc., and it has not been cleared or approved by the U.S. Food and Drug Administration (FDA). The FDA has determined that such clearance or approval is not necessary.

Diseases & Mutations Assayed

Alpha Thalassemia (HBA1, HBA2): Mutations (9): ♂ Genotyping | SEA deletion, c.207C>A (p.N69K), c.223G>C (p.D75H), c.22>C, c.207C>G (p.N69K), c.340_351delCTCCCGCCGAG (p.L114_E117del), c.377T>C (p.L126P), c.427T>C (p.X143Qext32), c.*+94A>G

Beta Thalassemia (HBB): Mutations (81): ♂ Genotyping | c.124_127delTTCT (p.F42Lfs), c.17_18delCT, c.20delA (p.E7Gfs), c.217insA (p.S73Kfs), c.223+702_444+342del620insAAGTAGA, c.230delC, c.25_26delAA, c.315+1G>A, c.315+2T>C, c.316-197C>T, c.316-146T>G, c.315+745C>G, c.316-1G>A, c.316-1G>C, c.316-2A>G, c.316-3C>A, c.316-3C>G, c.4delG (p.V2Cfs), c.51delC (p.K18Rfs), c.93-21G>A, c.92+1G>A, c.92+5G>A, c.92+5G>C, c.92+5G>T, c.92+6T>C, c.93-1G>A, c.93-1G>T, c.50A>C, c.-78a>g, c.-79A>G, c.-81A>G, c.52A>T (p.K18X), c.-137c>g, c.-138c>t, c.-151C>T, c.118C>T (p.Q40X), c.169G>C (p.G57R), c.295G>A (p.V99M), c.415G>C (p.A139P), c.47G>A (p.W16X), c.48G>A (p.W16X), c.-80I>a, c.2T>C (p.M11T), c.75T>A (p.G25G), c.444+111A>G, c.-29G>A, c.68_74delAAGTTGG, c.92G>C (p.R31T), c.92+1G>T, c.93-15T>G, c.93-1G>C, c.112delT, c.113G>A (p.W38X), c.114G>A (p.W38X), c.126delC, c.444+113A>G, c.250delG, c.225delC, c.383_385delAGG (p.Q128_A129delGQinsP), c.321_322insG (p.N109fs), c.316-1G>T, c.316-2A>C, c.287_288insA (p.L97fs), c.271G>T (p.E91X), c.203_204delITG (p.V68Afs), c.154delC (p.P52fs), c.135delC (p.F46fs), c.92+2T>A, c.92+2T>C, c.90C>T (p.G30G), c.84_85insC (p.L29fs), c.59A>G (p.N20S), c.46delT (p.W16Gfs), c.45_46insG (p.L16fs), c.36delT (p.T13fs), c.2T>G (p.M1R), c.1A>G (p.M1V), c.-137c>t, c.-136C>G, c.-142C>T, c.-140c>t Sequencing | NM_000518:1-3

Bloom Syndrome (BLM): Mutations (25): ♂ Genotyping | c.2207_2212delATCTGAGinsTAGATTC (p.Y736Lfs), c.2407insT, c.557_559delCAA (p.S186X), c.1284G>A (p.W428X), c.1701G>A (p.W567X), c.1933C>T (p.Q645X), c.2528C>T (p.T843I), c.2695C>T (p.R899X), c.3107G>T (p.C1036F), c.2923delC (p.Q975K), c.3558+1G>T, c.3875-2A>G, c.2074+2T>A, c.2343_2344dupGA (p.781EfsX), c.318_319insT (p.L1107fs), c.380delC (p.L271fs), c.3564delC (p.I188Dfs), c.4008delG (p.I336Rfs), c.947C>G (p.S316X), c.2193+1_2193+9del9, c.1642C>T (p.Q548X), c.3143delA (p.I048NfsX), c.356_357delTA (p.C120Hfs), c.4076+1delG, c.3281C>A (p.S1094X) Sequencing | NM_000057:2-22

Canavan Disease (ASPA): Mutations (8): ♂ Genotyping | c.433-2A>G, c.854A>C (p.E285A), c.693C>A (p.Y231X), c.914C>A (p.A305E), c.71A>G (p.E24G), c.654C>A (p.C218X), c.2T>C (p.M1T), c.79G>A (p.G27R) Sequencing | NM_000049:1-6

Cystic Fibrosis (CFTR): Mutations (149): ♂ Genotyping | c.1029delC, c.1153_1154insAT, c.1477delCA, c.1519_1521delATC (p.S07delI), c.1521_1523delCTT (p.S08delF), c.1545_1546delTA (p.Y515Xfs), c.1585-1G>A, c.164+12T>C, c.1680-886A>G, c.1680-1G>A, c.1766+1G>A, c.1766+1G>T, c.1766+5G>T, c.1818del84, c.1911delG, c.1923delCTCAAAATinsA, c.1973delGAAATCAATCTinsAGAAA, c.2052delA (p.K684fs), c.2052insA (p.Q685fs), c.2051_2052delAAinsG (p.K684SfsX38), c.2174insA, c.261delIT, c.2657+5G>A, c.273+1G>A, c.273+3A>C, c.274-1G>A, c.2988+1G>A, c.3039delC, c.3140-26A>G, c.325delTAAinsG, c.3527delC, c.3535delACCA, c.3691delT, c.3717+12191C>T, c.3744delA, c.3773_3774insT (p.L1258fs), c.442delA, c.489+1G>T, c.531delT, c.579+1G>T, c.579+5G>A (IVS4+5G>A), c.803delA (p.N268fs), c.805_806delAT (p.I269fs), c.933_935delCTT (p.S11delF), c.946delT, c.1645A>C (p.S549R), c.2128A>T (p.K710X), c.1000C>T (p.R334W), c.1013C>T (p.T338I), c.1364C>A (p.A455E), c.1477C>T (p.Q493X), c.1572C>A (p.C524X), c.1654C>T (p.Q552X), c.1657C>T (p.R553X), c.1721C>A (p.P574H), c.2125C>T (p.R709X), c.223C>T (p.R75X), c.2668C>T (p.Q890X), c.3196C>T (p.R1066G), c.3276C>G (p.Y1092X), c.3472C>T (p.R1158X), c.3484C>T (p.R1162X), c.349C>T (p.R117C), c.3587C>G (p.S1196X), c.3712C>T (p.Q1238X), c.3764C>A (p.S1255X), c.3909C>G (p.N1303X), c.1040G>A (p.R347H), c.1040G>C (p.R347P), c.1438G>T (p.G480C), c.1558G>T (p.S20F), c.1624G>T (p.G542X), c.1646G>C (p.S549N), c.1646G>T (p.S549N), c.1652G>A (p.G551D), c.1675G>A (p.A559T), c.1679G>C (p.R560T), c.178G>T (p.E60X), c.254G>A (p.G85E), c.271G>A (p.G91R), c.274G>T (p.E92X), c.3209G>A (p.R1070Q), c.3266G>A (p.W1089X), c.3454G>C (p.D1152H), c.350G>A (p.R117H), c.3611G>A (p.W1204X), c.3752G>A (p.S1251N), c.3846G>A (p.W1282X), c.3848G>T (p.R1283M), c.532G>A (p.G178R), c.988G>T (p.G330X), c.1090T>C (p.S364P), c.3302T>A (p.M1101K), c.617T>G (p.L206W), c.14C>T (p.P5L), c.19G>T (p.E7X), c.171G>A (p.W57X), c.313delA (p.I105fs), c.328G>C (p.D110H), c.580-1G>T, c.1055G>A (p.R352Q), c.1075C>A (p.Q359K), c.1079C>A (p.T360K), c.1647T>G (p.S549R), c.1976delA (p.N659fs), c.2290C>T (p.R764X), c.2737_2738insG (p.Y913X), c.3067_3072delATAGTG (p.I1023_V1024delIT), c.3536_3539delCCAA (p.T1179fs), c.3659delC (p.T1220fs), c.54-5940_273+10250del21080bp (p.S18fs), c.4364C>G (p.S1455X), c.4003C>T (p.L1335F), c.2538G>T (p.W846X), c.200C>T (p.P67L), c.4426C>T (p.Q1476X), c.1116+1G>A, c.1986_1989delAACT (p.T663R), c.2089_2090insA (p.R697Kfs), c.2215delG (p.V739Y), c.263T>G (p.L196X), c.3022delG (p.V1008S), c.3908dupA (p.N1303Kfs), c.658C>T (p.Q220X), c.868C>T (p.Q290X), c.1526delG (p.G509fs), c.2908+1085-3367+260del7201, c.11C>A (p.S4X), c.3878_3881delTATT (p.V1293fs), c.3700A>G (p.I1234A), c.416A>T (p.H139L), c.366T>A (p.Y122X), c.3767_3768insC (p.A1256fs), c.613C>T (p.P205S), c.293A>G (p.Q98R), c.3731G>A (p.G1244E), c.535C>A (p.Q179K), c.3368-2A>G, c.455T>G (p.M152R), c.1610_1611delAC (p.D537fs), c.3254A>G (p.H1085R), c.496A>G (p.K166E), c.1408_1417delGTGATTATCG (p.V470fs), c.1585-8G>A, c.2909G>A (p.G970D), c.653T>A (p.L218X), c.1175T>G (p.V392G), c.3139_3139+1delIGG, c.3717+4A>G (IVS22+4A>G) Sequencing | NM_000492:1-27

Familial Dysautonomia (IKBKAP): Mutations (4): ♂ Genotyping | c.2204+6T>C, c.2741C>T

(p.P914L), c.2087G>C (p.R696P), c.2128C>T (p.Q710X) Sequencing | NM_003640:2-37

Familial Hyperinsulinism: Type 1: ABCCC Related (ABCCC): Mutations (11): ♂ Genotyping | c.3989-9G>A, c.4159_4161delITC (p.1387delF), c.4258C>T (p.R1420C), c.4477C>T (p.R1493W), c.2147G>T (p.G716V), c.4055G>C (p.R1352P), c.560T>A (p.V187D), c.4516G>A (p.E1506K), c.2506C>T (p.Q836X), c.579+2T>A, c.1333-1013A>G (IVS8-1013A>G) Sequencing | NM_000352:1-39

Fanconi Anemia: Type C (FANCC): Mutations (8): ♂ Genotyping | c.456+4A>T, c.67delG, c.37C>T (p.Q13X), c.553C>T (p.R185X), c.1661T>C (p.L554P), c.1642C>T (p.R548X), c.66G>A (p.W22X), c.65G>A (p.W22X) Sequencing | NM_000136:2-15

Gaucher Disease (GBA): Mutations (6): ♂ Genotyping | c.84_85insG, c.1226A>G (p.N409S), c.1343A>T (p.D448V), c.1504C>T (p.R502C), c.1297G>T (p.V433L), c.1604G>A (p.R535H)

Glycogen Storage Disease: Type IA (G6PC): Mutations (13): ♂ Genotyping | c.376_377insTA, c.79delC, c.979_981delITC (p.327delF), c.1039C>T (p.Q347X), c.247C>T (p.R83C), c.724C>T (p.Q242X), c.248G>A (p.R83H), c.562G>C (p.G188R), c.648G>T, c.809G>T (p.G270V), c.113A>T (p.D38V), c.975delG (p.L326fs), c.724delC Sequencing | NM_000151:1-5

Joubert Syndrome (TMEM216): Mutations (2): ♂ Genotyping | c.218G>T (p.R73L), c.218G>A (p.R73H) Sequencing | NM_001173991:1-5

Maple Syrup Urine Disease: Type 1B (BCKDHB): Mutations (6): ♂ Genotyping | c.1114G>T (p.E372X), c.548G>C (p.R183P), c.832G>A (p.G278S), c.970C>T (p.R324X), c.487G>T (p.E163X), c.853C>T (p.R285X) Sequencing | NM_183050:1-10

Maple Syrup Urine Disease: Type 3 (DLD): Mutations (8): ♂ Genotyping | c.104_105insA, c.685G>T (p.G229C), c.214A>G (p.K72E), c.1081A>G (p.M361V), c.1123G>A (p.E375K), c.1178T>C (p.I393T), c.1463C>T (p.P488L), c.1483A>G (p.R495G) Sequencing | NM_000108:1-14

Mucopolidosis: Type IV (MCOLN1): Mutations (5): ♂ Genotyping | c.-1015_788del6433, c.406-2A>G, c.1084G>T (p.D362Y), c.304C>T (p.R102X), c.244delC (p.L82fsX) Sequencing | NM_020533:1-14

Nemaline Myopathy: NEB Related (NEB): Mutations (2): ♂ Genotyping | c.7434_7536del2502bp, c.8890-2A>G (IVS63-2A>G) Sequencing | NM_001164508:63-66, 86, 95-96, 103, 105, 143, 168-172, NM_004543:3-149

Niemann-Pick Disease: Type A (SMPD1): Mutations (6): ♂ Genotyping | c.996delC, c.1493G>T (p.R498L), c.911T>C (p.L304P), c.1267C>T (p.H423Y), c.1734G>C (p.K578N), c.1493G>A (p.R498H) Sequencing | NM_000543:1-6

Sickle-Cell Anemia (HBB): Mutations (1): ♂ Genotyping | c.20A>T (p.E7V) Sequencing | NM_000518:1-3

Spinal Muscular Atrophy: SMN1 Linked (SMN1): Mutations (19): ♂ Genotyping | DEL EXON 7, c.22_23insA, c.43C>T (p.Q15X), c.91_92insT, c.305G>A (p.W102X), c.400G>A (p.E134K), c.439_443delGAAGT, c.558delA, c.585_586insT, c.683T>A (p.L228X), c.734C>T (p.P245L), c.768_778dupTGTGATGCTT, c.815A>G (p.Y272C), c.821C>T (p.T274I), c.823G>A (p.G275S), c.834+2T>G, c.835-18_835-12delCCTTTAT, c.835G>T, c.836G>T dPCR | DEL EXON 7

Tay-Sachs Disease (HEXA): Mutations (78): ♂ Genotyping | c.1073+1G>A, c.1277_1278insATC, c.1421+1G>C, c.805+1G>A, c.532C>T (p.R178C), c.533G>A (p.R178H), c.805G>A (p.G269S), c.1510C>T (p.R504C), c.1496G>A (p.R499H), c.509G>A (p.R170Q), c.1003A>T (p.I335F), c.910_912delITC (p.305delF), c.749G>A (p.G250D), c.632T>C (p.F211S), c.629C>T (p.S210F), c.613delC, c.611A>G (p.H204R), c.598G>A (p.V200M), c.590A>C (p.K197T), c.571-1G>T, c.540C>G (p.Y180X), c.538T>C (p.Y180H), c.533G>T (p.R178L), c.508C>T (p.R170W), c.409C>T (p.R137X), c.380T>G (p.L127R), c.346+1G>C, c.116T>G (p.L39R), c.78G>A (p.W26X), c.1A>G (p.M1V), c.1495C>T (p.R499C), c.459+5G>A (IVS4+5G>A), c.1422-2A>G, c.535C>T (p.H179Y), c.1141delG (p.V381fs), c.796T>G (p.W266G), c.155C>A (p.S52X), c.426delT (p.F142fs), c.413-2A>G, c.570+3A>G, c.536A>G (p.H179R), c.1146+1G>A, c.736G>A (p.A242T), c.1302C>G (p.F434L), c.778C>T (p.P260S), c.1008G>T (p.Q336H), c.1385A>T (p.E426V), c.964G>A (p.Q322N), c.340G>A (p.E114K), c.1432G>A (p.G478R), c.1178G>C (p.R393P), c.805+1G>C, c.1426A>T (p.R476X), c.623A>T (p.D208V), c.1537C>T (p.Q513X), c.1511G>T (p.R504L), c.1307_1308delTA (p.L436fs), c.571-8A>G, c.624_627delTCTC (p.D208fs), c.1211_1212delITG (p.L404fs), c.621T>G (p.D207E), c.1511G>A (p.S04H), c.1177C>T (p.R393X), c.2T>C (p.M1T), c.1292G>A (p.W431X), c.947_948insA (p.Y316fs), c.607T>G (p.W203G), c.1061_1063delITCT (p.F354_Y355delinsX), c.615delG (p.L205fs), c.805+2T>C, c.1123delG (p.E375fs), c.1121A>G (p.Q374R), c.1043_1046delITCAA (p.F348fs), c.1510delC (p.R504fs), c.1451T>C (p.L484P), c.964G>T (p.Q322Y), c.1351C>G (p.L451V), c.571-2A>G (IVS5-2A>G) Sequencing | NM_000520:1-14

Usher Syndrome: Type 1F (PCDH15): Mutations (7): ♂ Genotyping | c.733C>T (p.R245X), c.2067C>A (p.Y684X), c.7C>T (p.R3X), c.1942C>T (p.R648X), c.1101delT (p.A367fsX), c.2800C>T (p.R934X), c.4272delA (p.L1425fs) Sequencing | NM_001142763:2-35

Usher Syndrome: Type 3 (CLRN1): Mutations (5): ♂ Genotyping | c.144T>G (p.N48K), c.131T>A (p.M120K), c.567T>G (p.Y189X), c.634C>T (p.Q212X), c.221T>C (p.L74P) Sequencing | NM_001195794:1-4

Walker-Warburg Syndrome (FKTN): Mutations (5): ♂ Genotyping | c.1167insA (p.F390fs), c.139C>T (p.R47X), c.748T>G (p.C250G), c.648-1243G>T (IVS5-1243G>T), c.515A>G (p.H172R) Sequencing | NM_006731:2-10

Residual Risk Information

Detection rates are calculated from the primary literature and may not be available for all ethnic populations. The values listed below are for genotyping. Sequencing provides higher detection rates and lower residual risks for each disease. More precise values for sequencing may become available in the future.

Disease	Carrier Rate	Detection Rate	Residual Risk
Alpha Thalassemia	♂ General: 1/48	50.67%	1/97
Beta Thalassemia	♂ African American: 1/75	84.21%	1/475
	♂ Indian: 1/24	74.12%	1/93
	♂ Sardinians: 1/23	97.14%	1/804
	♂ Spaniard: 1/51	93.10%	1/739
Bloom Syndrome	♂ Ashkenazi Jewish: 1/134	96.67%	1/4,020
	♂ European: Unknown	66.22%	Unknown
	♂ Japanese: Unknown	50.00%	Unknown
Canavan Disease	♂ Ashkenazi Jewish: 1/55	98.86%	1/4,840
	♂ European: Unknown	53.23%	Unknown
Cystic Fibrosis	♂ African American: 1/62	69.99%	1/207
	♂ Ashkenazi Jewish: 1/23	96.81%	1/721
	♂ Asian: 1/94	65.42%	1/272
	♂ European: 1/25	94.96%	1/496
	♂ Hispanic American: 1/48	77.32%	1/212
	♂ Native American: 1/53	84.34%	1/338
Familial Dysautonomia	♂ Ashkenazi Jewish: 1/31	>99%	<1/3,100
Familial Hyperinsulinism: Type 1: ABCC8 Related	♂ Ashkenazi Jewish: 1/52	98.75%	1/4,160
	♂ Finnish: 1/101	45.16%	1/184
Fanconi Anemia: Type C	♂ Ashkenazi Jewish: 1/101	>99%	<1/10,100
	♂ General: Unknown	30.00%	Unknown
Gaucher Disease	♂ Ashkenazi Jewish: 1/15	87.16%	1/117
	♂ General: 1/112	31.60%	1/164
	♂ Spaniard: Unknown	44.29%	Unknown
	♂ Turkish: 1/236	59.38%	1/581
Glycogen Storage Disease: Type IA	♂ Ashkenazi Jewish: 1/71	>99%	<1/7,100
	♂ Chinese: 1/159	80.00%	1/795
	♂ European: 1/177	76.88%	1/765
	♂ Hispanic American: 1/177	27.78%	1/245
	♂ Japanese: 1/177	89.22%	1/1,641
Joubert Syndrome	♂ Ashkenazi Jewish: 1/92	>99%	<1/9,200
Maple Syrup Urine Disease: Type 1B	♂ Ashkenazi Jewish: 1/97	>99%	<1/9,700
Maple Syrup Urine Disease: Type 3	♂ Ashkenazi Jewish: 1/94	>99%	<1/9,400
	♂ General: Unknown	68.75%	Unknown
Mucopolipidosis: Type IV	♂ Ashkenazi Jewish: 1/97	96.15%	1/2,522
Nemaline Myopathy: NEB Related	♂ Ashkenazi Jewish: 1/108	>99%	<1/10,800

Disease	Carrier Rate	Detection Rate	Residual Risk
Niemann-Pick Disease: Type A	♂ Ashkenazi Jewish: 1/101	95.00%	1/2,020
Sickle-Cell Anemia	♂ African American: 1/10	>99%	<1/1,000
	♂ Hispanic American: 1/95	>99%	<1/9,500
Tay-Sachs Disease	♂ Argentinian: 1/280	82.35%	1/1,587
	♂ Ashkenazi Jewish: 1/29	99.53%	1/6,177
	♂ Cajun: 1/30	>99%	<1/3,000
	♂ European: 1/280	25.35%	1/375
	♂ General: 1/280	32.09%	1/412
	♂ Indian: Unknown	85.71%	Unknown
	♂ Iraqi Jewish: 1/140	56.25%	1/320
	♂ Japanese: 1/127	82.81%	1/739
	♂ Moroccan Jewish: 1/110	22.22%	1/141
	♂ Portuguese: 1/280	92.31%	1/3,640
	♂ Spaniard: 1/280	67.65%	1/865
	♂ United Kingdom: 1/161	71.43%	1/564
Usher Syndrome: Type 1F	♂ Ashkenazi Jewish: 1/126	93.75%	1/2,016
Usher Syndrome: Type 3	♂ Ashkenazi Jewish: 1/120	>99%	<1/12,000
	♂ Finnish: 1/134	>99%	<1/13,400
Walker-Warburg Syndrome	♂ Ashkenazi Jewish: 1/150	>99%	<1/15,000

PATIENT INFORMATION	SPECIMEN INFORMATION	PROVIDER INFORMATION
5186, Donor ID#: ██████████ DOB: ██████████ Sex: Male	Type: Whole Blood Collected: September 11, 2019 Received: September 13, 2019 PG ID: 2019-256-099	Harvey Stern, MD, PhD Suzanne Seitz, MS Fairfax Cyrobank

**MOLECULAR GENETICS REPORT:
SURF1-Related Leigh Syndrome (LS) via the SURF1 Gene**

SUMMARY OF RESULTS **NEGATIVE**

RESULTS AND INTERPRETATIONS: In this patient, for the *SURF1* gene, we found no sequence variants. This patient is apparently negative for copy number variants (CNVs) within the genomic region encompassing the *SURF1* gene. These results should be interpreted in context of clinical findings, family history and other laboratory data. All genetic tests have limitations. Please see limitations and other information for this test on the following pages.

NOTE: Since this test is performed using exome capture probes, a reflex to any of our exome-based tests is available (PGxome, PGxome Custom Panels).

GENE ANALYZED: *SURF1*

SUMMARY STATISTICS:

Pipeline	Version	Average NGS Coverage	Fraction Bases Covered with NGS
Titanium	1.1.0	227x	88.7%

Minimum NGS coverage is ≥20x for all exons and +/-10bp of flanking DNA, and ≥10x from 11-20bp of flanking DNA.

ENHANCED GENE (Transcript Number - 100% coverage): *SURF1* (NM_003172)

Electronically signed on October 04, 2019 by: Kym Bliven, PhD Human Molecular Geneticist	Electronically signed and reported on October 04, 2019 by: Jerry Machado, PhD, DABMG, FCCMG Clinical Molecular Geneticist
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SUPPLEMENTAL INFORMATION V.18.09 NEXTGEN SEQUENCING

Limitations and Other Test Notes

Interpretation of the test results is limited by the information that is currently available. Better interpretation should be possible in the future as more data and knowledge about human genetics and this specific disorder are accumulated.

When Next Gen or Sanger sequencing does not reveal any difference from the reference sequence, or when a sequence variant is homozygous, we cannot be certain that we were able to detect both patient alleles. Occasionally, a patient may carry an allele which does not capture or amplify, due for example to a large deletion or insertion.

Where applicable (see below), Copy Number Variants (CNVs) of four exons or more in size are detected through analysis of Next Gen sequence data with sensitivity approaching 100%. Sensitivity however varies from gene to gene based on exon size, depth of coverage, and characteristics of the region. Sensitivity for detection of CNVs smaller than four exons is lower (we estimate ~80%).

We sequence coding exons for all available transcripts plus 10 bp of flanking non-coding DNA for each exon. We also sequence other regions within or near genes in which pathogenic variants have been identified at PreventionGenetics or reported elsewhere. Unless specifically indicated, test reports contain no information about other portions of genes.

In most cases, we are unable to determine the phase of sequence variants. In particular, when we find two likely causative mutations for recessive disorders, we cannot be certain that the mutations are on different chromosomes.

Our ability to detect minor sequence variants due to somatic mosaicism is limited. Sequence variants that are present in less than 50% of the patient's nucleated cells may not be detected.

Runs of mononucleotide repeats (eg (A)_n or (T)_n) with n > 8 in the reference sequence are generally not analyzed because of strand slippage during amplification.

Unless otherwise indicated, DNA sequence data is obtained from a specific cell-type (often leukocytes from whole blood). Test reports contain no information about the DNA sequence in other cell-types.

We cannot be certain that the reference sequences are correct. Genome build hg19, GRCh37 (Feb2009) is used as our reference in nearly all cases.

We have confidence in our ability to track a specimen once it has been received by PreventionGenetics. However, we take no responsibility for any specimen labeling errors that occur before the sample arrives at PreventionGenetics.

Genetic counseling to help to explain test results to the patients and to discuss reproductive options is recommended.

Test Methods

We use a combination of Next Generation Sequencing (NGS) and Sanger sequencing technologies to cover the full coding regions of the listed genes plus ~10 bases of non-coding DNA flanking each exon. As required,

genomic DNA is extracted from the patient specimen. For NGS, patient DNA corresponding to these regions is captured using an optimized set of DNA hybridization probes. Captured DNA is sequenced using Illumina's Reversible Dye Terminator (RDT) platform (Illumina, San Diego, CA, USA). Regions with insufficient coverage by NGS are often covered by Sanger sequencing.

For Sanger sequencing, Polymerase Chain Reaction (PCR) is used to amplify targeted regions. After purification of the PCR products, cycle sequencing is carried out using the ABI Big Dye Terminator v.3.1 kit. PCR products are resolved by electrophoresis on an ABI 3730xl capillary sequencer. In nearly all cases, cycle sequencing is performed separately in both the forward and reverse directions.

Copy number variants (CNVs) are detected from NGS data for tests which utilize the exome backbone. Many but not all of our NGS panels use Exome-based probes; please see the test description on the PreventionGenetics website for details. We utilize a CNV calling algorithm that compares mean read depth and distribution for each target in the test sample against multiple matched controls. Neighboring target read depth and distribution and zygosity of any variants within each target region are used to reinforce CNV calls. All reported CNVs are confirmed using another technology such as aCGH, MLPA, or PCR. On occasion, it will not be technically possible to confirm a smaller CNV called by NGS. In these instances, the CNV will not be included on the report.

Human Genome Variation Society (HGVS) recommendations are used to describe sequence variants (<http://www.hgvs.org>). All differences from the reference sequences are assigned to one of five interpretation categories (Pathogenic, Likely Pathogenic, Variant of Uncertain Significance, Likely Benign and Benign) per ACMG Guidelines (Richards et al. 2015. PubMed ID: 25741868). Rare variants and undocumented variants are nearly always classified as Likely Benign if there is no indication that they alter protein sequence or disrupt splicing. Depending on panel size, Benign or both Benign and Likely Benign variants are not listed in the reports, but are available upon request.

Data Transfer

PreventionGenetics recommends that DNA sequence information from this test be stored in the patient's electronic medical record. This will facilitate reinterpretation of the sequence in future, and will best benefit the patient and family members. Upon request, we will be pleased to transfer the sequence data.

FDA Notes

These results should be used in the context of available clinical findings, and should not be used as the sole basis for treatment. This test was developed and its performance characteristics determined by PreventionGenetics. US Food and Drug Administration (FDA) does not require this test to go through premarket FDA review. This test is used for clinical purposes. It should not be regarded as investigational or for research. This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high complexity clinical laboratory testing.

SUPPLEMENTAL INFORMATION V.18.05

SURF1-RELATED LEIGH SYNDROME (LS) VIA SURF1 GENE SEQUENCING WITH CNV DETECTION

Clinical Features: Leigh Syndrome (LS), also known as subacute necrotizing encephalomyelopathy, is a severe neurodegenerative disorder resulting primarily from defects in the mitochondrial respiratory chain (Ruhoy and Saneto 2014; Zhu et al. 1998; Leigh 1951). The disease incidence for LS is estimated to be around 1:32,000 to 1:40,000 live births (Darin et al. 2001; Rahman et al. 1996).

The hallmark features that characterize this syndrome include elevated levels of lactate in blood and cerebral spinal fluid, and the presence of bilateral symmetric necrotic lesions in the basal ganglia, brain stem, thalamus, and/or spinal cord (Wedatilake et al. 2013; Leigh 1951). Patients also present with isolated or combined mitochondrial complex deficiencies, psychomotor delay or regression, and neurologic manifestations such as hypotonia or ataxia. The term 'Leigh-Like Syndrome (LLS)' is used to describe a similar clinical presentation in which one or more of these diagnostic characteristics is atypical.

Symptomatic onset of this disorder usually occurs shortly after birth or within the first three years of life, although cases of adult-onset LS/LLS have been reported (Ronchi et al. 2011). LS/LLS infants often present with feeding difficulties, gastrointestinal distress, hypotonia, and growth delays, while older children (>1 years) may develop additional symptoms including developmental regression (loss of cognitive or motor skills), dysphagia, hypertrichosis, dystonic posturing, nystagmus, and ophthalmoplegia (Wedatilake et al. 2013).

LS and LLS have been linked to pathogenic variants in over 60 different genes (Rahman 2015). However, while defects in certain genes are more likely to result in classic LS rather than atypical LLS, genotype-phenotype correlations are still poorly understood. In the general population, pathogenic variation in the *SURF1* gene is one of the most frequent causes of LS associated with cytochrome c oxidase (COX) deficiency (Tiranti et al. 1998; Zhu et al. 1998).

Genetics: Leigh and Leigh-Like Syndromes (LS/LLS) are caused by defects in the mitochondrial oxidative phosphorylation (OXPHOS) complexes or associated proteins, such as OXPHOS assembly factors or the pyruvate dehydrogenase (PDH) complex (for a review, see Rahman 2015). As a result, the LS/LLS phenotypes exhibit significant genetic heterogeneity, and pathogenic variants in over 60 different genes have been reported to be causative for this disorder. Depending on the cellular localization of the affected gene(s), these syndromes may be inherited in an autosomal recessive, maternal, or X-linked recessive manner.

Nuclear genes associated with autosomal recessive inheritance of LS/LLS include: *SURF1*, *BCS1L*, *C12ORF65*, *COX10*, *COX15*, *FOXRED1*, *GFM1*, *LRPPRC*, *NDUFA2*, *NDUFA4*, *NDUFA9*, *NDUFA10*, *NDUFA11*, *NDUFA12*, *NDUFAB2*, *NDUFAB5*, *NDUFAB6*, *NDUFS1*, *NDUFS2*, *NDUFS3*, *NDUFS4*, *NDUFS7*, *NDUFS8*, *NDUFV1*, *PDSS2*, *PET100*, *SCO2*, *SDHA*, *SDHAF1*, *SLC19A3*, *SUCLA2*, *SUCLG1*, *TACO1*, *TTC19*, *UQCRCQ*, *SERAC1*, *NDUFV2*, *MTFMT*, *HIBCH*, *TSFM*, *ECHS1*, *LIAS*, *PNPT1*, *POLG*, *LIPT1*, *DLD*, *TPK1*, and *ETHE1*.

Mitochondrial genes associated with maternal inheritance of LS/LLS include: *MT-ATP6*, *MT-TL1*, *MT-TK*, *MT-TW*, *MT-TV*, *MT-ND1*, *MT-ND2*, *MT-ND3*, *MT-ND4*, *MT-ND5*, *MT-ND6*, and *MT-CO3*.

X-linked genes associated with X-linked recessive inheritance of LS/LLS include: *NDUFA1*, *AIFM1*, *PDHA1*, *PDHB*, and *PDHX*. In this form of inheritance, male patients are more frequently affected, although heterozygous females may present with LS/LLS due to skewed X-inactivation (Patel et al. 2012).

The *SURF1* gene, comprised of nine exons, is thought to encode for an assembly or maintenance factor for the cytochrome oxidase (COX/complex IV) (Zhu et al. 1998; Tiranti et al. 1999). A number of pathogenic variants (>80) have been documented for *SURF1*-associated autosomal recessive LS, although the majority of identified mutations cluster within exons 6-8 (for a review, see Wedatilake et al. 2013). Deletions and/or insertions of one or more nucleotides are a common cause of *SURF1* gene disruption, usually resulting in frameshifts and premature protein termination. A number of missense mutations, some of which abolish existing splice sites, have also been reported, in addition to several duplication events (Tiranti et al. 1998; Wedatilake et al. 2013). One small deletion (c.845_846delCT) is prevalent among patients with Slavic ancestry (Böhm et al. 2006).

Testing Strategy: For this Next Generation Sequencing (NGS) test, sequencing is accomplished by capturing specific regions with an optimized solution-based hybridization kit, followed by massively parallel sequencing of the captured DNA fragments. Additional Sanger sequencing is performed for regions not captured or with insufficient number of sequence reads.

For Sanger sequencing, polymerase chain reaction (PCR) is used to amplify targeted regions. After purification of the PCR products, cycle sequencing is carried out using the ABI Big Dye Terminator v.3.0 kit. PCR products are resolved by electrophoresis on an ABI 3730xl capillary sequencer. In nearly all cases, cycle sequencing is performed separately in both the forward and reverse directions.

Copy number variants (CNVs) are also detected from NGS data. We utilize a CNV calling algorithm that compares mean read depth and distribution for each target in the test sample against multiple matched controls. Neighboring target read depth and distribution and zygosity of any variants within each target region are used to reinforce CNV calls. All CNVs are confirmed using another technology such as aCGH, MLPA, or PCR before they are reported.

This test provides full coverage of all coding exons of the *SURF1* gene, plus ~10 bases of flanking noncoding DNA. We define full coverage as >20X NGS reads or Sanger sequencing.

Since this test is performed using exome capture probes, a reflex to any of our exome based tests is available (PGxome, PGxome Custom Panels).

Indications for Test: *SURF1* sequencing should be considered in patients with a family history of LS or childhood encephalopathy, or patients who present with symptoms consistent with LS. We will also sequence the *SURF1* gene to determine carrier status.

Sensitivity of Test: In the general population, pathogenic variation in the *SURF1* gene is one of the most frequent causes of LS associated with cytochrome c oxidase (COX) deficiency (Tiranti et al. 1998; Zhu et al. 1998). One large cohort study was complicated by the presence of a founder mutation in the affected population, resulting in a high prevalence of *SURF1*-related LS that is likely not representative of the general population (Böhm et al. 2006). Analytical sensitivity of this test is expected to be high, however, as the majority of documented pathogenic variants in *SURF1* are detectable by this sequencing test.

References: Please see the test description for this test on our website (www.preventiongenetics.com) for a full list of complete citations.