



## Donor 4774

### Genetic Testing Summary

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

Last Updated: 02/15/21

Donor Reported Ancestry: Argentine, 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 genotyping of 99 mutations in the CFTR gene	1/300
Spinal Muscular Atrophy (SMA) carrier screening	Negative for deletions of exon 7 in the SMN1 gene	1/610
Hb Beta Chain-Related Hemoglobinopathy (including Beta Thalassemia and Sickle Cell Disease) by genotyping	Negative for 28 mutations tested in the HBB gene	1/290
<b>Special Testing Request:</b>		
Stargardt Disease (ABCA4)	Negative by gene sequencing in the ABCA4 gene	1/2500
Familial Mediterranean Fever (MEFV)	Negative by gene sequencing in the MEFV gene	1/1200

\*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.

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**Ordering Practice:**

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Practice Code: [REDACTED]  
Fairfax Cryobank - [REDACTED]  
[REDACTED]  
[REDACTED]  
Physician: [REDACTED]  
Report Generated: 2016-04-28

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**Donor 4774**

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DOB: [REDACTED]  
Gender: Male  
Ethnicity: Latin American and European  
Procedure ID: 50122  
Kit Barcode: [REDACTED]  
Specimen: Blood, #52669  
Specimen Collection: 2016-04-11  
Specimen Received: 2016-04-12  
Specimen Analyzed: 2016-04-28

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**Partner Not Tested**

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**TEST INFORMATION**

Test: CarrierMap<sup>SEQ</sup> (Genotyping & Sequencing)  
Panel: Custom Panel  
Diseases Tested: 1  
Genes Tested: 1  
Genes Sequenced: 1

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**SUMMARY OF RESULTS: NO MUTATIONS IDENTIFIED**

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Donor 4774 was not identified to carry any pathogenic mutations in the gene(s) tested.

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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](http://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

## 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.

**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

**Stargardt Disease** : Mutations (17): ♂ Genotyping | c.3083C>T (p.A1028V), c.52C>T (p.R18W), c.5338C>G (p.P1780A), c.1018T>G (p.Y340D), c.1715G>A (p.R572Q), c.2461T>A (p.W821R), c.2565G>A (p.W855X), c.3106G>A (p.E1036K), c.3210\_3211insGT (p.S1071Vfs), c.634C>T (p.R212C), c.3113C>T (p.A1038V), c.1622T>C (p.L541P), c.3364G>A (p.E1122K), c.6079C>T (p.L2027F), c.2588G>C (p.G863A), c.1938-1G>A, c.571-2A>G Sequencing | NM\_000350:1-50

## Residual Risk Information

Detection rates are calculated from the primary literature and may not be available for all ethnic populations. Sequencing detection rates and residual risks are reported as “greater than (>)” and “less than (<)” the values for genotyping, respectively, for each disease. More precise values may become available in the future.

Disease	Carrier Rate	Detection Rate	Residual Risk
Stargardt Disease	♂ General: 1/51	18.05%	1/62

**Patient Information**

Name: Donor 4774  
 Date of Birth: [REDACTED]  
 Sema4 ID: [REDACTED]  
 Client ID: [REDACTED]  
 Indication: Carrier Testing

**Specimen Information**

Specimen Type: Semen  
 Date Collected: 01/25/2012  
 Date Received: 01/29/2021  
 Final Report: 02/12/2021

**Referring Provider**

[REDACTED]  
 Fairfax Cryobank, Inc.  
 [REDACTED]  
 [REDACTED]

## Custom Carrier Screen (ECS)

Number of genes tested: 1

### SUMMARY OF RESULTS AND RECOMMENDATIONS

 **Negative**

**Negative for all genes tested: MEFV**

To view a full list of genes and diseases tested  
 please see Table 1 in this report

*AR=Autosomal recessive; XL=X-linked*

**Recommendations**

- Consideration of residual risk by ethnicity after a negative carrier screen is recommended for the other diseases on the panel, especially in the case of a positive family history for a specific disorder. Please note that residual risks for X-linked diseases (including full repeat expansions for Fragile X syndrome) may not be accurate for males and the actual residual risk is likely to be lower.

## Test description

This patient was tested for the genes listed above using one or more of the following methodologies: target capture and short-read sequencing, long-range PCR followed by short-read sequencing, targeted genotyping, and/or copy number analysis. Please note that negative results reduce but do not eliminate the possibility that this individual is a carrier for one or more of the disorders tested. Please view the Table of Residual Risks Based on Ethnicity at the end of this report or at [go.sema4.com/residualrisk](http://go.sema4.com/residualrisk) for gene transcripts, sequencing exceptions, specific detection rates, and residual risk estimates after a negative screening result. With individuals of mixed ethnicity, it is recommended to use the highest residual risk estimate. Only known pathogenic or likely pathogenic variants are reported. This carrier screening test does not report likely benign variants and variants of uncertain significance (VUS). If reporting of likely benign variants and VUS are desired in this patient, please contact the laboratory at 800-298-6470, option 2 to request an amended report.



**Anastasia Larmore, Ph.D., Associate Laboratory Director**

Laboratory Medical Consultant: George A. Diaz, M.D., Ph.D.

## Genes and diseases tested

For specific detection rates and residual risk by ethnicity, please visit [go.sema4.com/residualrisk](https://go.sema4.com/residualrisk)

**Table 1: List of genes and diseases tested with detailed results**

Disease	Gene	Inheritance Pattern	Status	Detailed Summary
⊖ Negative				
Familial Mediterranean Fever	MEFV	AR	Reduced Risk (see table below)	

AR=Autosomal recessive; XL=X-linked

**Table 2: Residual Risk by ethnicity for negative results**

Disease (Inheritance)	Gene	Ethnicity	Carrier Frequency	Detection Rate	Residual Risk	Analytical Detection Rate
Familial Mediterranean Fever (AR) NM_000243.2	MEFV <sup>†</sup>	African	1 in 230	74%	1 in 870	99%
		Ashkenazi Jewish	1 in 8	99%	1 in 720	
		East Asian	1 in 141	96%	1 in 3,400	
		Finnish	1 in 29	99%	1 in 2,800	
		European (Non-Finnish)	1 in 40	97%	1 in 1,200	
		Native American	1 in 74	95%	1 in 1,500	
		South Asian	1 in 56	95%	1 in 1,000	
		Worldwide	1 in 40	97%	1 in 1,200	
		Sepharic Jewish	1 in 14	99%	1 in 1,300	
		Armenian	1 in 5	99%	1 in 400	
Turkish	1 in 5	75%	1 in 17			

\* Carrier detection by HEXA enzyme analysis has a detection rate of approximately 98% (Applies to *HEXA* gene testing only).

† Carrier frequencies include milder and reduced penetrance forms of the disease. Therefore, carrier frequencies may appear higher than reported in the literature (Applies to *BTD*, *Fg*, *GJB2*, *GJB1*, *GLA*, and *MEFV* gene testing only).

‡ Please note that *GJB2* testing includes testing for the two upstream deletions, del(GJB6-D13S1830) and del(GJB6-D13S1854) (PMID:11807148 and 15994881) (Applies to *GJB2* gene testing only).

AR: Autosomal recessive; N/A: Not available; XL: X-linked

## Test methods and comments

Genomic DNA isolated from this patient was analyzed by one or more of the following methodologies, as applicable:

### Next Generation Sequencing (NGS) (Analytical Detection Rate >95%)

NGS was performed on a panel of genes for the purpose of identifying pathogenic or likely pathogenic variants.

Agilent SureSelect<sup>TM</sup>QXT technology was used with a custom capture library to target the exonic regions and intron/exon splice junctions of the relevant genes, as well as a number of UTR, intronic or promoter regions that contain previously reported mutations. Samples were pooled and sequenced on the Illumina HiSeq 2500 platform in the Rapid Run mode or the Illumina NovaSeq platform in the Xp workflow, using 100 bp paired-end reads. The sequencing data was analyzed using a custom bioinformatics algorithm designed and validated in house.

The coding exons and splice junctions of the known protein-coding RefSeq genes were assessed for the average depth of coverage (minimum of 20X) and data quality threshold values. Most exons not meeting a minimum of >20X read depth across the exon are further analyzed by Sanger sequencing. Please note that several genomic regions present difficulties in mapping or obtaining read depth >20X. The exons contained within these regions are noted within Table 1 (as "Exceptions") and will not be reflexed to Sanger sequencing if the mapping quality or coverage is poor. Any variants identified during testing in these regions are confirmed by a second method and reported if determined to be pathogenic or likely pathogenic. However, as there is a possibility of false negative results within these regions, detection rates and residual risks for these genes have been calculated with the presumption that variants in these exons will not be detected, unless included in the MassARRAY<sup>®</sup> genotyping platform.

This test will detect variants within the exons and the intron-exon boundaries of the target regions. Variants outside these regions may not be detected, including, but not limited to, UTRs, promoters, and deep intronic areas, or regions that fall into the Exceptions mentioned above. This

technology may not detect all small insertion/deletions and is not diagnostic for repeat expansions and structural genomic variation. In addition, a mutation(s) in a gene not included on the panel could be present in this patient.

Variant interpretation and classification was performed based on the American College of Medical Genetics Standards and Guidelines for the Interpretation of Sequence Variants (Richards et al, 2015). All potentially pathogenic variants may be confirmed by either a specific genotyping assay or Sanger sequencing, if indicated. Any benign variants, likely benign variants or variants of uncertain significance identified during this analysis will not be reported.

#### **Copy Number Variant Analysis (Analytical Detection Rate >95%)**

Large duplications and deletions were called from the relative read depths on an exon-by-exon basis using a custom exome hidden Markov model (XHMM) algorithm. Deletions or duplications determined to be pathogenic or likely pathogenic were confirmed by either a custom array CGH platform, quantitative PCR, or MLPA (depending on CNV size and gene content). While this algorithm is designed to pick up deletions and duplications of 2 or more exons in length, potentially pathogenic single-exon CNVs will be confirmed and reported, if detected.

#### **Exon Array (Confirmation method) (Accuracy >99%)**

The customized oligonucleotide microarray (Oxford Gene Technology) is a highly-targeted exon-focused array capable of detecting medically relevant microdeletions and microduplications at a much higher resolution than traditional aCGH methods. Each array matrix has approximately 180,000 60-mer oligonucleotide probes that cover the entire genome. This platform is designed based on human genome NCBI Build 37 (hg19) and the CGH probes are enriched to target the exonic regions of the genes in this panel.

#### **Quantitative PCR (Confirmation method) (Accuracy >99%)**

The relative quantification PCR is utilized on a Roche Universal Library Probe (UPL) system, which relates the PCR signal of the target region in one group to another. To test for genomic imbalances, both sample DNA and reference DNA is amplified with primer/probe sets that specific to the target region and a control region with known genomic copy number. Relative genomic copy numbers are calculated based on the standard  $\Delta\Delta C_t$  formula.

#### **Long-Range PCR (Analytical Detection Rate >99%)**

Long-range PCR was performed to generate locus-specific amplicons for *CYP21A2*, *HBA1* and *HBA2* and *GBA*. The PCR products were then prepared for short-read NGS sequencing and sequenced. Sequenced reads were mapped back to the original genomic locus and run through the bioinformatics pipeline. If indicated, copy number from MLPA was correlated with the sequencing output to analyze the results. For *CYP21A2*, a certain percentage of healthy individuals carry a duplication of the *CYP21A2* gene, which has no clinical consequences. In cases where two copies of a gene are located on the same chromosome in tandem, only the second copy will be amplified and assessed for potentially pathogenic variants, due to size limitations of the PCR reaction. However, because these alleles contain at least two copies of the *CYP21A2* gene in tandem, it is expected that this patient has at least one functional gene in the tandem allele and this patient is therefore less likely to be a carrier. When an individual carries both a duplication allele and a pathogenic variant, or multiple pathogenic variants, the current analysis may not be able to determine the phase (cis/trans configuration) of the *CYP21A2* alleles identified. Family studies may be required in certain scenarios where phasing is required to determine the carrier status.

#### **Residual Risk Calculations**

Carrier frequencies and detection rates for each ethnicity were calculated through the combination of internal curations of >28,000 variants and genomic frequency data from >138,000 individuals across seven ethnic groups in the gnomAD database. Additional variants in HGMD and novel deleterious variants were also incorporated into the calculation. Residual risk values are calculated using a Bayesian analysis combining the *a priori* risk of being a pathogenic mutation carrier (carrier frequency) and the detection rate. They are provided only as a guide for assessing approximate risk given a negative result, and values will vary based on the exact ethnic background of an individual. This report does not represent medical advice but should be interpreted by a genetic counselor, medical geneticist or physician skilled in genetic result interpretation and the relevant medical literature.

#### **Sanger Sequencing (Confirmation method) (Accuracy >99%)**

Sanger sequencing, as indicated, was performed using BigDye Terminator chemistry with the ABI 3730 DNA analyzer with target specific amplicons. It also may be used to supplement specific guaranteed target regions that fail NGS sequencing due to poor quality or low depth of coverage (<20 reads) or as a confirmatory method for NGS positive results. False negative results may occur if rare variants interfere with amplification or annealing.

### **SELECTED REFERENCES**

#### **Carrier Screening**

Grody W et al. ACMG position statement on prenatal/preconception expanded carrier screening. *Genet Med*. 2013;15:482-3.

#### **Variant Classification:**

Richards S et al. Standards and guidelines for the interpretation of sequence variants: a joint consensus recommendation of the American College of Medical Genetics and Genomics and the Association for Molecular Pathology. *Genet Med*. 2015 May;17(5):405-24



Additional disease-specific references available upon request.