



## Donor 5891

### Genetic Testing Summary

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

Last Updated: 10/20/22

Donor Reported Ancestry: German, Scottish, Irish, Chinese

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	1/440
Spinal Muscular Atrophy (SMA) carrier screening	Negative by gene sequencing and for deletions of exon 7 in the SMN1 gene	1/1115
Expanded Genetic Disease Carrier Screening Panel attached- 283 diseases by gene sequencing	<b>Carrier: Non-Syndromic Hearing Loss (GJB2-Related)</b>  Negative for other genes sequenced	Partner testing recommended before using this donor.
<b>Special Testing</b>		
Genes: OTOF, SLC4A1, DUOX2	Negative by gene sequencing	See attached results for residual risks

\*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.

**Patient Information**

Name: Donor 5891  
 Date of Birth: [REDACTED]  
 Sema4 ID: [REDACTED]  
 Client ID: [REDACTED]  
 Indication: Carrier Screening

**Specimen Information**

Specimen Type: Blood  
 Date Collected: 08/23/2021  
 Date Received: 08/24/2021  
 Final Report: 09/12/2021

**Referring Provider**

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

Expanded Carrier Screen Minus TSE (283 genes)  
 with Personalized Residual Risk

**SUMMARY OF RESULTS AND RECOMMENDATIONS**

⊕ Positive	⊖ Negative
<p><b>Carrier of Non-Syndromic Hearing Loss (<i>GJB2</i>-Related) (AR)</b></p> <p>Associated gene(s): <i>GJB2</i></p> <p>Variant(s) Detected: c.235delC, p.L79CfsX3, Pathogenic, Heterozygous (one copy)</p>	<p><b>Negative for all other genes tested</b></p> <p>To view a full list of genes and diseases tested please see Table 1 in this report</p>

AR=Autosomal recessive; XL=X-linked

**Recommendations**

- Testing the partner for the above positive disorder(s) and genetic counseling are recommended.
- Please note that for female carriers of X-linked diseases, follow-up testing of a male partner is not indicated.
- CGG repeat analysis of *FMR1* for fragile X syndrome is not performed on males as repeat expansion of premutation alleles is not expected in the male germline.
- Individuals of Asian, African, Hispanic and Mediterranean ancestry should also be screened for hemoglobinopathies by CBC and hemoglobin electrophoresis.
- 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.

Interpretation of positive results

**Non-Syndromic Hearing Loss (*GJB2*-Related) (AR)**

**Results and Interpretation**

A heterozygous (one copy) pathogenic frameshift variant, c.235delC, p.L79CfsX3, was detected in the *GJB2* gene (NM\_004004.5). When this variant is present in trans with a pathogenic variant, it is considered to be causative for non-syndromic hearing loss (*GJB2*-related). Therefore, this individual is expected to be at least a carrier for non-syndromic hearing loss (*GJB2*-related). Heterozygous carriers are not expected to exhibit symptoms of this disease.

**What is Non-Syndromic Hearing Loss (*GJB2*-Related)?**

Non-syndromic hearing loss (*GJB2*-related) is an autosomal recessive disorder that is caused by pathogenic variants in the gene *GJB2*. It is found in individuals of many different ethnicities, but it more prevalent in individuals of Ashkenazi Jewish descent, as well as Caucasians and Asians. Patients with this form of hearing loss do not experience any other disease manifestations. Hearing loss is usually present from birth and does not progress in severity over time. The level of hearing loss can vary between patients from mild to profound. Patients with two inactivating variants are more likely to have profound hearing loss, whereas patients with two non-inactivating variants are more likely to have



mild hearing loss. However, the variability that exists between patients means that it may not be possible to predict the severity of an individual's hearing loss based on their genotype. Life expectancy is not reduced.

## Test description

This patient was tested for a panel of diseases using a combination of sequencing, targeted genotyping and 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 see Table 1 for a list of genes and diseases tested with the patient's personalized residual risk. If personalized residual risk is not provided, please see the complete residual risk table at [go.sema4.com/residualrisk](https://go.sema4.com/residualrisk). Only variants determined to be pathogenic or likely pathogenic are reported in this carrier screening test.

**Rebekah Zimmerman, Ph.D., FACMG, Laboratory Director**

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

## Genes and diseases tested

The personalized residual risks listed below are specific to this individual. The complete residual risk table is available at [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
<b>⊕ Positive</b>				
<b>Non-Syndromic Hearing Loss (GJB2-Related)</b>	<i>GJB2</i>	AR	Carrier	c.235delC, p.L79CfsX3, Pathogenic, Heterozygous (one copy)
<b>⊖ Negative</b>				
<b>3-Beta-Hydroxysteroid Dehydrogenase Type II Deficiency</b>	<i>HSD3B2</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 3,300
<b>3-Methylcrotonyl-CoA Carboxylase Deficiency (MCCC1-Related)</b>	<i>MCCC1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 930
<b>3-Methylcrotonyl-CoA Carboxylase Deficiency (MCCC2-Related)</b>	<i>MCCC2</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 500
<b>3-Methylglutaconic Aciduria, Type III</b>	<i>OPA3</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 29,000
<b>3-Phosphoglycerate Dehydrogenase Deficiency</b>	<i>PHGDH</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 63,000
<b>6-Pyruvoyl-Tetrahydropterin Synthase Deficiency</b>	<i>PTS</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 1,800
<b>Abetalipoproteinemia</b>	<i>MTTP</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 3,200
<b>Achromatopsia (CNGB3-related)</b>	<i>CNGB3</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 8,600
<b>Acrodermatitis Enteropathica</b>	<i>SLC39A4</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 12,000
<b>Acute Infantile Liver Failure</b>	<i>TRMU</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 9,400
<b>Acyl-CoA Oxidase I Deficiency</b>	<i>ACOX1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 39,000
<b>Adenosine Deaminase Deficiency</b>	<i>ADA</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 5,100
<b>Adrenoleukodystrophy, X-Linked</b>	<i>ABCD1</i>	XL	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 19,000
<b>Aicardi-Goutieres Syndrome (SAMHD1-Related)</b>	<i>SAMHD1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,700
<b>Alpha-Mannosidosis</b>	<i>MAN2B1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 8,000
<b>Alpha-Thalassemia</b>	<i>HBA1/HBA2</i>	AR	Reduced Risk	<i>HBA1</i> Copy Number: 2 <i>HBA2</i> Copy Number: 2 No pathogenic copy number variants detected <i>HBA1/HBA2</i> Sequencing: Negative <b>Personalized Residual Risk:</b> 1 in 380
<b>Alpha-Thalassemia Intellectual Disability Syndrome</b>	<i>ATRX</i>	XL	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 48,000
<b>Alport Syndrome (COL4A3-Related)</b>	<i>COL4A3</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 1,700
<b>Alport Syndrome (COL4A4-Related)</b>	<i>COL4A4</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 510
<b>Alport Syndrome (COL4A5-Related)</b>	<i>COL4A5</i>	XL	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 150,000
<b>Alstrom Syndrome</b>	<i>ALMS1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 3,100
<b>Andermann Syndrome</b>	<i>SLC12A6</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 151,000
<b>Argininosuccinic Aciduria</b>	<i>ASL</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 1,200
<b>Aromatase Deficiency</b>	<i>CYP19A1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 1,200
<b>Arthrogryposis, Mental Retardation, and Seizures</b>	<i>SLC35A3</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 240,000
<b>Asparagine Synthetase Deficiency</b>	<i>ASNS</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 178,000
<b>Aspartylglycosaminuria</b>	<i>AGA</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 13,000
<b>Ataxia With Isolated Vitamin E Deficiency</b>	<i>TTPA</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 20,000
<b>Ataxia-Telangiectasia</b>	<i>ATM</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 540

Autosomal Recessive Spastic Ataxia of Charlevoix-Saguenay	<i>SACS</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,100
Bardet-Biedl Syndrome ( <i>BBS10</i> -Related)	<i>BBS10</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,100
Bardet-Biedl Syndrome ( <i>BBS12</i> -Related)	<i>BBS12</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 9,900
Bardet-Biedl Syndrome ( <i>BBS1</i> -Related)	<i>BBS1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 6,400
Bardet-Biedl Syndrome ( <i>BBS2</i> -Related)	<i>BBS2</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 1,200
Bare Lymphocyte Syndrome, Type II	<i>CIITA</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 35,000
Bartter Syndrome, Type 4A	<i>BSND</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 69,000
Bernard-Soulier Syndrome, Type A1	<i>GP1BA</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 42,000
Bernard-Soulier Syndrome, Type C	<i>GP9</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 1,100
Beta-Globin-Related Hemoglobinopathies	<i>HBB</i>	AR	Reduced Risk	<b>Personalized Residual Risk (Beta-Globin-Related Hemoglobinopathies):</b> 1 in 1,200 <b>Personalized Residual Risk (Beta-Globin-Related Hemoglobinopathies: HbS Variant):</b> 1 in 11,000 <b>Personalized Residual Risk (Beta-Globin-Related Hemoglobinopathies: HbC Variant):</b> 1 in 42,000
Beta-Ketothiolase Deficiency	<i>ACAT1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 3,800
Bilateral Frontoparietal Polymicrogyria	<i>GPR56</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 143,000
Biotinidase Deficiency	<i>BTBD</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 500
Bloom Syndrome	<i>BLM</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 7,400
Canavan Disease	<i>ASPA</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 5,200
Carbamoylphosphate Synthetase I Deficiency	<i>CPS1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 690
Carnitine Palmitoyltransferase IA Deficiency	<i>CPT1A</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 24,000
Carnitine Palmitoyltransferase II Deficiency	<i>CPT2</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 670
Carpenter Syndrome	<i>RAB23</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 21,000
Cartilage-Hair Hypoplasia	<i>RMRP</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 450
Cerebral Creatine Deficiency Syndrome 1	<i>SLC6A8</i>	XL	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 208,000
Cerebral Creatine Deficiency Syndrome 2	<i>GAMT</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,300
Cerebrotendinous Xanthomatosis	<i>CYP27A1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 750
Charcot-Marie-Tooth Disease, Type 4D	<i>NDRG1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 225,000
Charcot-Marie-Tooth Disease, Type 5 / Arts Syndrome	<i>PRPS1</i>	XL	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 114,000
Charcot-Marie-Tooth Disease, X-Linked	<i>GJB1</i>	XL	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 11,000
Choreoacanthocytosis	<i>VPS13A</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 4,700
Choroideremia	<i>CHM</i>	XL	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 125,000
Chronic Granulomatous Disease ( <i>CYBA</i> -Related)	<i>CYBA</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 3,700
Chronic Granulomatous Disease ( <i>CYBB</i> -Related)	<i>CYBB</i>	XL	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 294,000
Citrin Deficiency	<i>SLC25A13</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,200
Citrullinemia, Type 1	<i>ASS1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,500
Cohen Syndrome	<i>VPS13B</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 6,400
Combined Malonic and Methylmalonic Aciduria	<i>ACSF3</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,400
Combined Oxidative Phosphorylation Deficiency 1	<i>GFM1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 8,100
Combined Oxidative Phosphorylation Deficiency 3	<i>TSM</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 21,000
Combined Pituitary Hormone Deficiency 2	<i>PROP1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,800
Combined Pituitary Hormone Deficiency 3	<i>LHX3</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 121,000
Combined SAP Deficiency	<i>PSAP</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 44,000
Congenital Adrenal Hyperplasia due to 17-Alpha-Hydroxylase Deficiency	<i>CYP17A1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 840

<b>Congenital Adrenal Hyperplasia due to 21-Hydroxylase Deficiency</b>	<i>CYP21A2</i>	AR	Reduced Risk	CYP21A2 copy number: 2 CYP21A2 sequencing: Negative <b>Personalized Residual Risk (Congenital Adrenal Hyperplasia due to 21-Hydroxylase Deficiency (Non-Classic)): 1 in 200</b> <b>Personalized Residual Risk (Congenital Adrenal Hyperplasia due to 21-Hydroxylase Deficiency (Classic)): 1 in 1,200</b>
<b>Congenital Amegakaryocytic Thrombocytopenia</b>	<i>MPL</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 3,100</b>
<b>Congenital Disorder of Glycosylation, Type Ia</b>	<i>PMM2</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 550</b>
<b>Congenital Disorder of Glycosylation, Type Ib</b>	<i>MPI</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 2,100</b>
<b>Congenital Disorder of Glycosylation, Type Ic</b>	<i>ALG6</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 2,300</b>
<b>Congenital Insensitivity to Pain with Anhidrosis</b>	<i>NTRK1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,000</b>
<b>Congenital Myasthenic Syndrome (CHRNA3-Related)</b>	<i>CHRNA3</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 4,100</b>
<b>Congenital Myasthenic Syndrome (RAPSN-Related)</b>	<i>RAPSN</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 2,900</b>
<b>Congenital Neutropenia (HAX1-Related)</b>	<i>HAX1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 82,000</b>
<b>Congenital Neutropenia (VPS45-Related)</b>	<i>VPS45</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 110,000</b>
<b>Corneal Dystrophy and Perceptive Deafness</b>	<i>SLC4A11</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 2,200</b>
<b>Corticosterone Methyltransferase Deficiency</b>	<i>CYP11B2</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,700</b>
<b>Cystic Fibrosis</b>	<i>CFTR</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 440</b>
<b>Cystinosis</b>	<i>CTNS</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 7,100</b>
<b>D-Bifunctional Protein Deficiency</b>	<i>HSD17B4</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 2,700</b>
<b>Deafness, Autosomal Recessive 77</b>	<i>LOXHD1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 2,800</b>
<b>Duchenne Muscular Dystrophy / Becker Muscular Dystrophy</b>	<i>DMD</i>	XL	Reduced Risk	<b>Personalized Residual Risk: 1 in 10,000</b>
<b>Dyskeratosis Congenita (RTEL1-Related)</b>	<i>RTEL1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 3,900</b>
<b>Dystrophic Epidermolysis Bullosa</b>	<i>COL7A1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 900</b>
<b>Ehlers-Danlos Syndrome, Type VIIC</b>	<i>ADAMTS2</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 63,000</b>
<b>Ellis-van Creveld Syndrome (EVC-Related)</b>	<i>EVC</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 4,200</b>
<b>Emery-Dreifuss Myopathy 1</b>	<i>EMD</i>	XL	Reduced Risk	<b>Personalized Residual Risk: 1 in 833,000</b>
<b>Enhanced S-Cone Syndrome</b>	<i>NR2E3</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,700</b>
<b>Ethylmalonic Encephalopathy</b>	<i>ETHE1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 3,400</b>
<b>Fabry Disease</b>	<i>GLA</i>	XL	Reduced Risk	<b>Personalized Residual Risk: 1 in 7,700</b>
<b>Factor IX Deficiency</b>	<i>F9</i>	XL	Reduced Risk	<b>Personalized Residual Risk: 1 in 5,100</b>
<b>Factor XI Deficiency</b>	<i>F11</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 440</b>
<b>Familial Autosomal Recessive Hypercholesterolemia</b>	<i>LDLRAP1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 171,000</b>
<b>Familial Dysautonomia</b>	<i>IKBKAP</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 51,000</b>
<b>Familial Hypercholesterolemia</b>	<i>LDLR</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 260</b>
<b>Familial Hyperinsulinism (ABCC8-Related)</b>	<i>ABCC8</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 240</b>
<b>Familial Hyperinsulinism (KCNJ11-Related)</b>	<i>KCNJ11</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 4,300</b>
<b>Familial Mediterranean Fever</b>	<i>MEFV</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,200</b>
<b>Fanconi Anemia, Group A</b>	<i>FANCA</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,100</b>
<b>Fanconi Anemia, Group C</b>	<i>FANCC</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 12,000</b>
<b>Fanconi Anemia, Group G</b>	<i>FANCG</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,200</b>
<b>Fragile X Syndrome</b>	<i>FMR1</i>	XL	Reduced Risk	FMR1 CGG repeat sizes: Not Performed FMR1 Sequencing: Negative Fragile X CGG triplet repeat expansion testing was not performed at this time, as the patient has either been previously tested or is a male. <b>Personalized Residual Risk: 1 in 19,000</b>
<b>Fumarate Deficiency</b>	<i>FH</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 2,900</b>
<b>GRACILE Syndrome and Other BCS1L-Related Disorders</b>	<i>BCS1L</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 3,900</b>



Galactokinase Deficiency	<i>GALK1</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,600
Galactosemia	<i>GALT</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 390
Gaucher Disease	<i>GBA</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,200
Gitelman Syndrome	<i>SLC12A3</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 230
Glutaric Acidemia, Type I	<i>GCDH</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 2,700
Glutaric Acidemia, Type IIa	<i>ETFA</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 2,100
Glutaric Acidemia, Type IIc	<i>ETFDH</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 260
Glycine Encephalopathy (AMT-Related)	<i>AMT</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 5,700
Glycine Encephalopathy (GLDC-Related)	<i>GLDC</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 240
Glycogen Storage Disease, Type II	<i>GAA</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 280
Glycogen Storage Disease, Type III	<i>AGL</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 5,600
Glycogen Storage Disease, Type IV / Adult Polyglucosan Body Disease	<i>GBE1</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 2,400
Glycogen Storage Disease, Type Ia	<i>G6PC</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 410
Glycogen Storage Disease, Type Ib	<i>SLC37A4</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 3,900
Glycogen Storage Disease, Type V	<i>PYGM</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,400
Glycogen Storage Disease, Type VII	<i>PFKM</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 4,300
HMG-CoA Lyase Deficiency	<i>HMGCL</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 2,700
Hemochromatosis, Type 2A	<i>HFE2</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 740
Hemochromatosis, Type 3	<i>TFR2</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 11,000
Hereditary Fructose Intolerance	<i>ALDOB</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,900
Hereditary Spastic Paraparesis 49	<i>TECPR2</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 116,000
Hermansky-Pudlak Syndrome, Type 1	<i>HPS1</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 3,500
Hermansky-Pudlak Syndrome, Type 3	<i>HPS3</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 22,000
Holocarboxylase Synthetase Deficiency	<i>HLCS</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 6,900
Homocystinuria (CBS-Related)	<i>CBS</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,400
Homocystinuria due to MTHFR Deficiency	<i>MTHFR</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,300
Homocystinuria, cblE Type	<i>MTRR</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 9,600
Hydrolethalus Syndrome	<i>HYLS1</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 52,000
Hyperornithinemia-Hyperammonemia-Homocitrullinuria Syndrome	<i>SLC25A15</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 5,700
Hypohidrotic Ectodermal Dysplasia 1	<i>EDA</i>	XL	Reduced Risk	Personalized Residual Risk: 1 in 22,000
Hypophosphatasia	<i>ALPL</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 790
Inclusion Body Myopathy 2	<i>GNE</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 2,600
Infantile Cerebral and Cerebellar Atrophy	<i>MED17</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 130,000
Isovaleric Acidemia	<i>IVD</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 2,000
Joubert Syndrome 2	<i>TMEM216</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 133,000
Joubert Syndrome 7 / Meckel Syndrome 5 / COACH Syndrome	<i>RPGRIP1L</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,100
Junctional Epidermolysis Bullosa (LAMA3-Related)	<i>LAMA3</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 21,000
Junctional Epidermolysis Bullosa (LAMB3-Related)	<i>LAMB3</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,900
Junctional Epidermolysis Bullosa (LAMC2-Related)	<i>LAMC2</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 28,000
Krabbe Disease	<i>GALC</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 340
Lamellar Ichthyosis, Type 1	<i>TGM1</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,500
Leber Congenital Amaurosis 10 and Other CEP290-Related Ciliopathies	<i>CEP290</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,100
Leber Congenital Amaurosis 13	<i>RDH12</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 5,500
Leber Congenital Amaurosis 2 / Retinitis Pigmentosa 20	<i>RPE65</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 2,100
Leber Congenital Amaurosis 5	<i>LCA5</i>	AR	Reduced Risk	Personalized Residual Risk: 1 in 4,200

<b>Leber Congenital Amaurosis 8 / Retinitis Pigmentosa 12 / Pigmented Paravenous Chorioretinal Atrophy</b>	<i>CRB1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 960</b>
<b>Leigh Syndrome, French-Canadian Type</b>	<i>LRPPRC</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 22,000</b>
<b>Lethal Congenital Contracture Syndrome 1 / Lethal Arthrogyrosis with Anterior Horn Cell Disease</b>	<i>GLE1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 5,900</b>
<b>Leukoencephalopathy with Vanishing White Matter</b>	<i>EIF2B5</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 2,300</b>
<b>Limb-Girdle Muscular Dystrophy, Type 2A</b>	<i>CAPN3</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 960</b>
<b>Limb-Girdle Muscular Dystrophy, Type 2B</b>	<i>DYSF</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,100</b>
<b>Limb-Girdle Muscular Dystrophy, Type 2C</b>	<i>SGCG</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 4,900</b>
<b>Limb-Girdle Muscular Dystrophy, Type 2D</b>	<i>SGCA</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 3,500</b>
<b>Limb-Girdle Muscular Dystrophy, Type 2E</b>	<i>SGCB</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 31,000</b>
<b>Limb-Girdle Muscular Dystrophy, Type 2I</b>	<i>FKRP</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 460</b>
<b>Lipoamide Dehydrogenase Deficiency</b>	<i>DLG</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 14,000</b>
<b>Lipoid Adrenal Hyperplasia</b>	<i>STAR</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 3,600</b>
<b>Lipoprotein Lipase Deficiency</b>	<i>LPL</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 800</b>
<b>Long-Chain 3-Hydroxyacyl-CoA Dehydrogenase Deficiency</b>	<i>HADHA</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 4,500</b>
<b>Lysinuric Protein Intolerance</b>	<i>SLC7A7</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 3,000</b>
<b>Maple Syrup Urine Disease, Type 1a</b>	<i>BCKDHA</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 4,000</b>
<b>Maple Syrup Urine Disease, Type 1b</b>	<i>BCKDHB</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,100</b>
<b>Meckel Syndrome 1 / Bardet-Biedl Syndrome 13</b>	<i>MKS1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,700</b>
<b>Medium Chain Acyl-CoA Dehydrogenase Deficiency</b>	<i>ACADM</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,600</b>
<b>Megalencephalic Leukoencephalopathy with Subcortical Cysts</b>	<i>MLC1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 4,300</b>
<b>Menkes Disease</b>	<i>ATP7A</i>	XL	Reduced Risk	<b>Personalized Residual Risk: 1 in 172,000</b>
<b>Metachromatic Leukodystrophy</b>	<i>ARSA</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,000</b>
<b>Methylmalonic Acidemia (MMAA-Related)</b>	<i>MMAA</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 15,000</b>
<b>Methylmalonic Acidemia (MMAB-Related)</b>	<i>MMAB</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 3,700</b>
<b>Methylmalonic Acidemia (MUT-Related)</b>	<i>MUT</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 830</b>
<b>Methylmalonic Aciduria and Homocystinuria, Cobalamin C Type</b>	<i>MMACHC</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,300</b>
<b>Methylmalonic Aciduria and Homocystinuria, Cobalamin D Type</b>	<i>MMADHC</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 172,000</b>
<b>Microphthalmia / Anophthalmia</b>	<i>VSX2</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 40,000</b>
<b>Mitochondrial Complex I Deficiency (ACAD9-Related)</b>	<i>ACAD9</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,800</b>
<b>Mitochondrial Complex I Deficiency (NDUFAF5-Related)</b>	<i>NDUFAF5</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 770</b>
<b>Mitochondrial Complex I Deficiency (NDUFS6-Related)</b>	<i>NDUFS6</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 211,000</b>
<b>Mitochondrial DNA Depletion Syndrome 6 / Navajo Neurohepatopathy</b>	<i>MPV17</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 4,400</b>
<b>Mitochondrial Myopathy and Sideroblastic Anemia 1</b>	<i>PUS1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 333,000</b>
<b>Mucopolysaccharidosis II / IIIA</b>	<i>GNPTAB</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 1,100</b>
<b>Mucopolysaccharidosis III Gamma</b>	<i>GNPTG</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 68,000</b>
<b>Mucopolysaccharidosis IV</b>	<i>MCOLN1</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 6,500</b>
<b>Mucopolysaccharidosis Type I</b>	<i>IDUA</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 630</b>
<b>Mucopolysaccharidosis Type II</b>	<i>IDS</i>	XL	Reduced Risk	<b>Personalized Residual Risk: 1 in 76,000</b>
<b>Mucopolysaccharidosis Type IIIA</b>	<i>SGSH</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 700</b>
<b>Mucopolysaccharidosis Type IIIB</b>	<i>NAGLU</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 900</b>
<b>Mucopolysaccharidosis Type IIIC</b>	<i>HGSNAT</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 3,200</b>
<b>Mucopolysaccharidosis Type IIID</b>	<i>GNS</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 137,000</b>



Mucopolysaccharidosis Type IVb / GM1 Gangliosidosis	<i>GLB1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 1,200
Mucopolysaccharidosis type IX	<i>HYAL1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 63,000
Mucopolysaccharidosis type VI	<i>ARSB</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 1,300
Multiple Sulfatase Deficiency	<i>SUMF1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 69,000
Muscle-Eye-Brain Disease and Other <i>POMGNT1</i> -Related Congenital Muscular Dystrophy-Dystroglycanopathies	<i>POMGNT1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 4,200
Myoneurogastrointestinal Encephalopathy	<i>TYMP</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,100
Myotubular Myopathy 1	<i>MTM1</i>	XL	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 192,000
N-Acetylglutamate Synthase Deficiency	<i>NAGS</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 3,200
Nemaline Myopathy 2	<i>NEB</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 300
Nephrogenic Diabetes Insipidus, Type II	<i>AQP2</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 3,400
Nephrotic Syndrome ( <i>NPHS1</i> -Related) / Congenital Finnish Nephrosis	<i>NPHS1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 980
Nephrotic Syndrome ( <i>NPHS2</i> -Related) / Steroid-Resistant Nephrotic Syndrome	<i>NPHS2</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 780
Neuronal Ceroid-Lipofuscinosis ( <i>CLN3</i> -Related)	<i>CLN3</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 9,200
Neuronal Ceroid-Lipofuscinosis ( <i>CLN5</i> -Related)	<i>CLN5</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 4,300
Neuronal Ceroid-Lipofuscinosis ( <i>CLN6</i> -Related)	<i>CLN6</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 8,600
Neuronal Ceroid-Lipofuscinosis ( <i>CLN8</i> -Related)	<i>CLN8</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 3,100
Neuronal Ceroid-Lipofuscinosis ( <i>MFSD8</i> -Related)	<i>MFSD8</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 6,200
Neuronal Ceroid-Lipofuscinosis ( <i>PPT1</i> -Related)	<i>PPT1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,300
Neuronal Ceroid-Lipofuscinosis ( <i>TPP1</i> -Related)	<i>TPP1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 3,000
Niemann-Pick Disease ( <i>SMPD1</i> -Related)	<i>SMPD1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 1,300
Niemann-Pick Disease, Type C ( <i>NPC1</i> -Related)	<i>NPC1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 690
Niemann-Pick Disease, Type C ( <i>NPC2</i> -Related)	<i>NPC2</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 6,600
Nijmegen Breakage Syndrome	<i>NBN</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 14,000
Odonto-Onycho-Dermal Dysplasia / Schopf-Schulz-Passarge Syndrome	<i>WNT10A</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 900
Omenn Syndrome ( <i>RAG2</i> -Related)	<i>RAG2</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 17,000
Omenn Syndrome / Severe Combined Immunodeficiency, Athabaskan-Type	<i>DCLRE1C</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 5,500
Ornithine Aminotransferase Deficiency	<i>OAT</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 6,900
Ornithine Transcarbamylase Deficiency	<i>OTC</i>	XL	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 103,000
Osteopetrosis 1	<i>TCIRG1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 5,700
Pendred Syndrome	<i>SLC26A4</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 72
Phenylalanine Hydroxylase Deficiency	<i>PAH</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 150
Polycystic Kidney Disease, Autosomal Recessive	<i>PKHD1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 350
Polyglandular Autoimmune Syndrome, Type 1	<i>AIRE</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 4,100
Pontocerebellar Hypoplasia, Type 1A	<i>VRK1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 25,000
Pontocerebellar Hypoplasia, Type 6	<i>RARS2</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 8,600
Primary Carnitine Deficiency	<i>SLC22A5</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 600
Primary Ciliary Dyskinesia ( <i>DNAH5</i> -Related)	<i>DNAH5</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 1,500
Primary Ciliary Dyskinesia ( <i>DNAI1</i> -Related)	<i>DNAI1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 5,000
Primary Ciliary Dyskinesia ( <i>DNAI2</i> -Related)	<i>DNAI2</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 76,000
Primary Hyperoxaluria, Type 1	<i>AGXT</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,400
Primary Hyperoxaluria, Type 2	<i>GRHPR</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 11,000
Primary Hyperoxaluria, Type 3	<i>HOGA1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 2,400
Progressive Cerebello-Cerebral Atrophy	<i>SEPSECS</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 6,400
Progressive Familial Intrahepatic Cholestasis, Type 2	<i>ABCB11</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 390

Propionic Acidemia (PCCA-Related)	PCCA	AR	Reduced Risk	Personalized Residual Risk: 1 in 2,600
Propionic Acidemia (PCCB-Related)	PCCB	AR	Reduced Risk	Personalized Residual Risk: 1 in 920
Pycnodysostosis	CTSK	AR	Reduced Risk	Personalized Residual Risk: 1 in 5,100
Pyruvate Dehydrogenase E1-Alpha Deficiency	PDHA1	XL	Reduced Risk	Personalized Residual Risk: 1 in 139,000
Pyruvate Dehydrogenase E1-Beta Deficiency	PDHB	AR	Reduced Risk	Personalized Residual Risk: 1 in 8,300
Renal Tubular Acidosis and Deafness	ATP6V1B1	AR	Reduced Risk	Personalized Residual Risk: 1 in 7,800
Retinitis Pigmentosa 25	EYS	AR	Reduced Risk	Personalized Residual Risk: 1 in 580
Retinitis Pigmentosa 26	CERKL	AR	Reduced Risk	Personalized Residual Risk: 1 in 4,000
Retinitis Pigmentosa 28	FAM161A	AR	Reduced Risk	Personalized Residual Risk: 1 in 34,000
Retinitis Pigmentosa 59	DHDDS	AR	Reduced Risk	Personalized Residual Risk: 1 in 201,000
Rhizomelic Chondrodysplasia Punctata, Type 1	PEX7	AR	Reduced Risk	Personalized Residual Risk: 1 in 10,000
Rhizomelic Chondrodysplasia Punctata, Type 3	AGPS	AR	Reduced Risk	Personalized Residual Risk: 1 in 620,000
Roberts Syndrome	ESCO2	AR	Reduced Risk	Personalized Residual Risk: 1 in 95,000
Salla Disease	SLC17A5	AR	Reduced Risk	Personalized Residual Risk: 1 in 8,400
Sandhoff Disease	HEXB	AR	Reduced Risk	Personalized Residual Risk: 1 in 680
Schimke Immunoosseous Dysplasia	SMARCAL1	AR	Reduced Risk	Personalized Residual Risk: 1 in 3,800
Segawa Syndrome	TH	AR	Reduced Risk	Personalized Residual Risk: 1 in 3,000
Sjogren-Larsson Syndrome	ALDH3A2	AR	Reduced Risk	Personalized Residual Risk: 1 in 4,100
Smith-Lemli-Opitz Syndrome	DHCR7	AR	Reduced Risk	Personalized Residual Risk: 1 in 750
Spinal Muscular Atrophy	SMN1	AR	Reduced Risk	SMN1 copy number: 2 SMN2 copy number: 2 c.3*80T>G: Negative SMN1 Sequencing: Negative Personalized Residual Risk: 1 in 1,115
Spondylothoracic Dysostosis	MESP2	AR	Reduced Risk	Personalized Residual Risk: 1 in 53,000
Steel Syndrome	COL27A1	AR	Reduced Risk	Personalized Residual Risk: 1 in 93,000
Stuve-Wiedemann Syndrome	LIFR	AR	Reduced Risk	Personalized Residual Risk: 1 in 6,000
Sulfate Transporter-Related Osteochondrodysplasia	SLC26A2	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,800
Tay-Sachs Disease	HEXA	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,400
Tyrosinemia, Type I	FAH	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,900
Usher Syndrome, Type IB	MYO7A	AR	Reduced Risk	Personalized Residual Risk: 1 in 180
Usher Syndrome, Type IC	USH1C	AR	Reduced Risk	Personalized Residual Risk: 1 in 400
Usher Syndrome, Type ID	CDH23	AR	Reduced Risk	Personalized Residual Risk: 1 in 880
Usher Syndrome, Type IF	PCDH15	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,100
Usher Syndrome, Type IIA	USH2A	AR	Reduced Risk	Personalized Residual Risk: 1 in 54
Usher Syndrome, Type III	CLRN1	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,300
Very Long Chain Acyl-CoA Dehydrogenase Deficiency	ACADVL	AR	Reduced Risk	Personalized Residual Risk: 1 in 380
Walker-Warburg Syndrome and Other FKTN-Related Dystrophies	FKTN	AR	Reduced Risk	Personalized Residual Risk: 1 in 390
Wilson Disease	ATP7B	AR	Reduced Risk	Personalized Residual Risk: 1 in 150
Wolman Disease / Cholesteryl Ester Storage Disease	LIPA	AR	Reduced Risk	Personalized Residual Risk: 1 in 3,200
X-Linked Juvenile Retinoschisis	RS1	XL	Reduced Risk	Personalized Residual Risk: 1 in 40,000
X-Linked Severe Combined Immunodeficiency	IL2RG	XL	Reduced Risk	Personalized Residual Risk: 1 in 250,000
Zellweger Syndrome Spectrum (PEX10-Related)	PEX10	AR	Reduced Risk	Personalized Residual Risk: 1 in 6,300
Zellweger Syndrome Spectrum (PEX1-Related)	PEX1	AR	Reduced Risk	Personalized Residual Risk: 1 in 740
Zellweger Syndrome Spectrum (PEX2-Related)	PEX2	AR	Reduced Risk	Personalized Residual Risk: 1 in 77,000
Zellweger Syndrome Spectrum (PEX6-Related)	PEX6	AR	Reduced Risk	Personalized Residual Risk: 1 in 1,500

AR=Autosomal recessive; 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:

### Fragile X CGG Repeat Analysis (Analytical Detection Rate >99%)

PCR amplification using Asuragen, Inc. AmpliDeX<sup>®</sup> *FMR1* PCR reagents followed by capillary electrophoresis for allele sizing was performed. Samples positive for *FMR1* CGG repeats in the premutation and full mutation size range were further analyzed by Southern blot analysis to assess the size and methylation status of the *FMR1* CGG repeat.

### Genotyping (Analytical Detection Rate >99%)

Multiplex PCR amplification and allele specific primer extension analyses using the MassARRAY<sup>®</sup> System were used to identify certain recurrent variants that are complex in nature or are present in low copy repeats. Rare sequence variants may interfere with assay performance.

### Multiplex Ligation-Dependent Probe Amplification (MLPA) (Analytical Detection Rate >99%)

MLPA<sup>®</sup> probe sets and reagents from MRC-Holland were used for copy number analysis of specific targets versus known control samples. False positive or negative results may occur due to rare sequence variants in target regions detected by MLPA probes. Analytical sensitivity and specificity of the MLPA method are both 99%.

For alpha thalassemia, the copy numbers of the *HBA1* and *HBA2* genes were analyzed. Alpha-globin gene deletions, triplications, and the Constant Spring (CS) mutation are assessed. This test is expected to detect approximately 90% of all alpha-thalassemia mutations, varying by ethnicity, carriers of alpha-thalassemia with three or more *HBA* copies on one chromosome, and one or no copies on the other chromosome, may not be detected. With the exception of triplications, other benign alpha-globin gene polymorphisms will not be reported. Analyses of *HBA1* and *HBA2* are performed in association with long-range PCR of the coding regions followed by short-read sequencing.

For Duchenne muscular dystrophy, the copy numbers of all *DMD* exons were analyzed. Potentially pathogenic single exon deletions and duplications are confirmed by a second method. Analysis of *DMD* is performed in association with sequencing of the coding regions.

For congenital adrenal hyperplasia, the copy number of the *CYP21A2* gene was analyzed. This analysis can detect large deletions typically due to unequal meiotic crossing-over between *CYP21A2* and the pseudogene *CYP21A1P*. Classic 30-kb deletions make up approximately 20% of *CYP21A2* pathogenic alleles. This test may also identify certain point mutations in *CYP21A2* caused by gene conversion events between *CYP21A2* and *CYP21A1P*. Some carriers may not be identified by dosage sensitive methods as this testing cannot detect individuals with two copies (duplication) of the *CYP21A2* gene on one chromosome and loss of *CYP21A2* (deletion) on the other chromosome. Analysis of *CYP21A2* is performed in association with long-range PCR of the coding regions followed by short-read sequencing.

For spinal muscular atrophy (SMA), the copy numbers of the *SMN1* and *SMN2* genes were analyzed. The individual dosage of exons 7 and 8 as well as the combined dosage of exons 1, 4, 6 and 8 of *SMN1* and *SMN2* were assessed. Copy number gains and losses can be detected with this assay. Depending on ethnicity, 6 - 29 % of carriers will not be identified by dosage sensitive methods as this testing cannot detect individuals with two copies (duplication) of the *SMN1* gene on one chromosome and loss of *SMN1* (deletion) on the other chromosome (silent 20 carrier) or individuals that carry an intragenic mutation in *SMN1*. Please also note that 2% of individuals diagnosed with SMA have a causative *SMN1* variant that occurred *de novo*, and therefore cannot be picked up by carrier screening in the parents. Analysis of *SMN1* is performed in association with short-read sequencing of exons 2a-7, followed by confirmation using long-range PCR (described below).

The presence of the c.\*380T>G (chr5:70,247,901T>G) variant allele in an individual with Ashkenazi Jewish or Asian ancestry is typically indicative of a duplication of *SMN1*. When present in an Ashkenazi Jewish or Asian individual with two copies of *SMN1*, c.\*380T>G is likely indicative of a silent (20) carrier. In individuals with two copies of *SMN1* with African American, Hispanic or Caucasian ancestry, the presence or absence of c.\*380T>G significantly increases or decreases, respectively, the likelihood of being a silent 20 carrier.

MLPA for Gaucher disease (*GBA*), cystic fibrosis (*CFTR*), and non-syndromic hearing loss (*GJB2/GJB6*) will only be performed if indicated for confirmation of detected CNVs. If *GBA* analysis was performed, the copy numbers of exons 1, 3, 4, and 6 - 10 of the *GBA* gene (of 11 exons total)

were analyzed. If *CFTR* analysis was performed, the copy numbers of all 27 *CFTR* exons were analyzed. If *GJB2/GJB6* analysis was performed, the copy number of the two *GJB2* exons were analyzed, as well as the presence or absence of the two upstream deletions of the *GJB2* regulatory region, del(*GJB6*-D13S1830) and del(*GJB6*-D13S1854).

#### 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>XT Low Input 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. Libraries were pooled and sequenced on the Illumina NovaSeq 9000 platform, using paired-end 100 bp 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. These regions, which are described below, 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.

#### Next Generation Sequencing for SMN1

Exonic regions and intron/exon splice junctions of *SMN1* and *SMN2* were captured, sequenced, and analyzed as described above. Any variants located within exons 2a-7 and classified as pathogenic or likely pathogenic were confirmed to be in either *SMN1* or *SMN2* using gene-specific long-range PCR analysis followed by Sanger sequencing. Variants located in exon 1 cannot be accurately assigned to either *SMN1* or *SMN2* using our current methodology, and so these variants are considered to be of uncertain significance and are not 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 arrayCGH 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 >30,000 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.

#### Personalized Residual Risk Calculations

Agilent SureSelect<sup>TM</sup>XT Low-Input technology was utilized in order to create whole-genome libraries for each patient sample. Libraries were then pooled and sequenced on the Illumina NovaSeq platform. Each sequencing lane was multiplexed to achieve 0.4-2x genome coverage, using paired-end 100 bp reads. The sequencing data underwent ancestral analysis using a customized, licensed bioinformatics algorithm that was validated in house. Identified sub-ethnic groupings were binned into one of 7 continental-level groups (African, East Asian, South Asian, Non-Finnish European, Finnish, Native American, and Ashkenazi Jewish) or, for those ethnicities that matched poorly to the continental-level groups, an 8<sup>th</sup> "unassigned" group, which were then used to select residual risk values for each gene. For individuals belonging to multiple high-level ethnic groupings, a weighting strategy was used to select the most appropriate residual risk. For genes that had insufficient data to calculate ethnic-specific residual risk values, or for sub-ethnic groupings that fell into the "unassigned" group, a "worldwide" residual risk was used. This "worldwide" residual risk was calculated using data from all available continental-level groups.

#### 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.

Please note these tests were developed and their performance characteristics were determined by Mount Sinai Genomics, Inc. They have not been cleared or approved by the FDA. These analyses generally provide highly accurate information regarding the patient's carrier or affected status. Despite this high level of accuracy, it should be kept in mind that there are many potential sources of diagnostic error, including misidentification of samples, polymorphisms, or other rare genetic variants that interfere with analysis. Families should understand that rare diagnostic errors may occur for these reasons.

**Exceptions:**

Gene	Transcript	Exceptions
ABC D1	NM_000333	Exons 8 and 9
ADA	NM_000222	Exon 1
ADA MTS 2	NM_014244.4	Exon 1
AGP S	NM_003659.3	chr2:178,257,512 - 178,257,649 (partial exon 1)
ALM S1	NM_015120.4	chr2:73,612,990 - 73,613,041 (partial exon 1)
CEP 290	NM_025114.3	Exon 5, exon 7, chr12:88,519,017 - 88,519,039 (partial exon 13), chr12:88,514,049 - 88,514,058 (partial exon 15), chr12:88,502,837 - 88,502,841 (partial exon 23), chr12:88,481,551 - 88,481,589 (partial exon 32), chr12:88,471,605 - 88,471,700 (partial exon 40)
CFT R	NM_000492.3	Exon 10
COL 4A4	NM_000924	chr2:227,942,604 - 227,942,619 (partial exon 25)
CYP 11B2	NM_000498.3	Exons 3 - 7
DNA I2	NM_023036.4	chr17:72,308,136 - 72,308,147 (partial exon 12)
EVC	NM_153717.2	Exon 1
FH	NM_000143.3	Exon 1
GA MT	NM_000156.5	Exon 1
GLD C	NM_000170.2	Exon 1
GNP TAB	NM_024312.4	chr17:4,837,000 - 4,837,400 (partial exon 2)
GNP TG	NM_032520.4	Exon 1
HGS NAT	NM_152419.2	Exon 1
IDS	NM_000202.6	Exon 3
LIFR	NM_002310.5	Exon 19
NEB	NM_001271208.1	Exons 82 - 105



NPC 1	NM_00 0271.4	chr18:21,123,519 - 21,123,538 (partial exon 14)
PUS 1	NM_02 5215.5	chr12:132,414,446 - 132,414,532 (partial exon 2)
RPG RIP1 L	NM_01 5272.2	Exon 23
SGS H	NM_00 0199.3	chr17:78,194,022 - 78,194,072 (partial exon 1)
SLC 6A8	NM_00 5629.3	<p>Exons 3 and 4</p> <p><b>SELECTED REFERENCES</b></p> <p><b>Carrier Screening</b> Grody W et al. ACMG position statement on prenatal/preconception expanded carrier screening. <i>Genet Med.</i> 2013 15:482-3.</p> <p><b>Fragile X syndrome:</b> Chen L et al. An information-rich CGG repeat primed PCR that detects the full range of Fragile X expanded alleles and minimizes the need for Southern blot analysis. <i>J Mol Diag</i> 2010 12:589-600.</p> <p><b>Spinal Muscular Atrophy:</b> Luo M et al. An Ashkenazi Jewish SMN1 haplotype specific to duplication alleles improves pan-ethnic carrier screening for spinal muscular atrophy. <i>Genet Med.</i> 2014 16:149-56.</p> <p><b>Ashkenazi Jewish Disorders:</b> Scott SA et al. Experience with carrier screening and prenatal diagnosis for sixteen Ashkenazi Jewish Genetic Diseases. <i>Hum. Mutat.</i> 2010 31:1-11.</p> <p><b>Duchenne Muscular Dystrophy:</b> Flanigan KM et al. Mutational spectrum of DMD mutations in dystrophinopathy patients: application of modern diagnostic techniques to a large cohort. <i>Hum Mutat.</i> 2009 30:1657-66.</p> <p><b>Variant Classification:</b> 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. <i>Genet Med.</i> 2015 May;17(5):405-24</p> <p>Additional disease-specific references available upon request.</p>

**Patient Information**

Name: Donor 5891  
 Date of Birth: [REDACTED]  
 Sema4 ID: [REDACTED]  
 Client ID: [REDACTED]  
 Indication: Carrier Screening

**Specimen Information**

Specimen Type: Blood  
 Date Collected: 08/23/2021  
 Date Received: 08/24/2021  
 Final Report: 09/07/2022

**Referring Provider**

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

Unmask Additional Gene(s) (2 genes)  
 with Personalized Residual Risk

**SUMMARY OF RESULTS AND RECOMMENDATIONS**

⊖ Negative

Negative for all genes tested: *OTOF*, and *SLC4A1*  
 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 see Table 1 for a list of genes and diseases tested with the patient's personalized residual risk. If personalized residual risk is not provided, please see the complete residual risk table at [go.sema4.com/residualrisk](http://go.sema4.com/residualrisk). 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

The personalized residual risks listed below are specific to this individual. The complete residual risk table is available at [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				
<b>Deafness, Autosomal Recessive 9</b>	<i>OTOF</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 370
<b>Distal Renal Tubular Acidosis and other <i>SLC4A1</i>-related Disorders</b>	<i>SLC4A1</i>	AR	Reduced Risk	<b>Personalized Residual Risk:</b> 1 in 910

AR=Autosomal recessive; 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:

### Fragile X CGG Repeat Analysis (Analytical Detection Rate >99%)

PCR amplification using Asuragen, Inc. AmplideX<sup>®</sup> *FMR1* PCR reagents followed by capillary electrophoresis for allele sizing was performed. Samples positive for *FMR1* premutations and full mutations greater than 90 CGG repeats in length were further analyzed by Southern blot analysis or methylation PCR to assess the size and methylation status of the *FMR1* CGG repeat. Additional testing to determine the status of AGG interruptions within the *FMR1* CGG repeat will be automatically performed for premutation alleles ranging from 55 to 90 repeats. These results, which may modify risk for expansion, will follow in a separate report.

### Genotyping (Analytical Detection Rate >99%)

Multiplex PCR amplification and allele specific primer extension analyses using the MassARRAY<sup>®</sup> System were used to identify certain recurrent variants that are complex in nature or are present in low copy repeats. Rare sequence variants may interfere with assay performance.

### Multiplex Ligation-Dependent Probe Amplification (MLPA) (Analytical Detection Rate >99%)

MLPA<sup>®</sup> probe sets and reagents from MRC-Holland were used for copy number analysis of specific targets versus known control samples. False positive or negative results may occur due to rare sequence variants in target regions detected by MLPA probes. Analytical sensitivity and specificity of the MLPA method are both 99%.

For alpha thalassemia, the copy numbers of the *HBA1* and *HBA2* genes were analyzed. Alpha-globin gene deletions, triplications, and the Constant Spring (CS) mutation are assessed. This test is expected to detect approximately 90% of all alpha-thalassemia mutations, varying by ethnicity. Carriers of alpha-thalassemia with three or more *HBA* copies on one chromosome, and one or no copies on the other chromosome, may not be detected. With the exception of triplications, other benign alpha-globin gene polymorphisms will not be reported. Analyses of *HBA1* and *HBA2* are performed in association with long-range PCR of the coding regions followed by short-read sequencing.

For Duchenne muscular dystrophy, the copy numbers of all *DMD* exons were analyzed. Potentially pathogenic single exon deletions and duplications are confirmed by a second method. Analysis of *DMD* is performed in association with sequencing of the coding regions.

For congenital adrenal hyperplasia, the copy number of the *CYP21A2* gene was analyzed. This analysis can detect large deletions typically due to unequal meiotic crossing-over between *CYP21A2* and the pseudogene *CYP21A1P*. Classic 30-kb deletions make up approximately 20% of *CYP21A2* pathogenic alleles. This test may also identify certain point mutations in *CYP21A2* caused by gene conversion events between *CYP21A2* and *CYP21A1P*. Some carriers may not be identified by dosage sensitive methods as this testing cannot detect individuals with two copies (duplication) of the *CYP21A2* gene on one chromosome and loss of *CYP21A2* (deletion) on the other chromosome. Analysis of *CYP21A2* is performed in association with long-range PCR of the coding regions followed by short-read sequencing.

For spinal muscular atrophy (SMA), the copy numbers of the *SMN1* and *SMN2* genes were analyzed. The individual dosage of exons 7 and 8 as well as the combined dosage of exons 1, 4, 6 and 8 of *SMN1* and *SMN2* were assessed. Copy number gains and losses can be detected with this assay. Depending on ethnicity, 6 - 29 % of carriers will not be identified by dosage sensitive methods as this testing cannot detect individuals with two copies (duplication) of the *SMN1* gene on one chromosome and loss of *SMN1* (deletion) on the other chromosome (silent

2+0 carrier) or individuals that carry an intragenic mutation in *SMN1*. Please also note that 2% of individuals diagnosed with SMA have a causative *SMN1* variant that occurred de novo, and therefore cannot be picked up by carrier screening in the parents. Analysis of *SMN1* is performed in association with short-read sequencing of exons 2a-7, followed by confirmation using long-range PCR (described below).

In individuals with two copies of *SMN1* with Ashkenazi Jewish, East Asian, African American, Native American or Caucasian ancestry, the presence or absence of c.3+80T>G significantly increases or decreases, respectively, the likelihood of being a silent 2+0 silent carrier.

MLPA for Gaucher disease (*GBA*), cystic fibrosis (*CFTR*), and non-syndromic hearing loss (*GJB2/GJB6*) will only be performed if indicated for confirmation of detected CNVs. If *GBA* analysis was performed, the copy numbers of exons 1, 3, 4, and 6 - 10 of the *GBA* gene (of 11 exons total) were analyzed. If *CFTR* analysis was performed, the copy numbers of all 27 *CFTR* exons were analyzed. If *GJB2/GJB6* analysis was performed, the copy number of the two *GJB2* exons were analyzed, as well as the presence or absence of the two upstream deletions of the *GJB2* regulatory region, del(*GJB6*-D13S1830) and del(*GJB6*-D13S1854).

#### 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™XT Low Input 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. Libraries were pooled and sequenced on the Illumina NovaSeq 6000 platform, using paired-end 100 bp 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. These regions, which are described below, 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® genotyping platform.

**Exceptions:** *ABCD1* (NM\_000033.3) exons 8 and 9; *ACADSB* (NM\_001609.3) chr10:124,810,695-124,810,707 (partial exon 9); *ADA* (NM\_000022.2) exon 1; *ADAMTS2* (NM\_014244.4) exon 1; *AGPS* (NM\_003659.3) chr2:178,257,512-178,257,649 (partial exon 1); *ALDH7A1* (NM\_001182.4) chr5:125,911,150-125,911,163 (partial exon 7) and chr5:125,896,807-125,896,821 (partial exon 10); *ALMS1* (NM\_015120.4) chr2:73,612,990-73,613,041 (partial exon 1); *APOPT1* (NM\_032374.4) chr14:104,040,437-104,040,455 (partial exon 3); *CDAN1* (NM\_138477.2) exon 2; *CEP152* (NM\_014985.3) chr15:49,061,146-49,061,165 (partial exon 14) and exon 22; *CEP290* (NM\_025114.3) exon 5, exon 7, chr12:88,519,017-88,519,039 (partial exon 13), chr12:88,514,049-88,514,058 (partial exon 15), chr12:88,502,837-88,502,841 (partial exon 23), chr12:88,481,551-88,481,589 (partial exon 32), chr12:88,471,605-88,471,700 (partial exon 40); *CFTR* (NM\_000492.3) exon 10; *COL4A4* (NM\_000092.4) chr2:227,942,604-227,942,619 (partial exon 25); *COX10* (NM\_001303.3) exon 6; *CYP11B1* (NM\_000497.3) exons 3-7; *CYP11B2* (NM\_000498.3) exons 3-7; *DNAI2* (NM\_023036.4) chr17:72,308,136-72,308,147 (partial exon 12); *DOK7* (NM\_173660.4) chr4:3,465,131-3,465,161 (partial exon 1) and exon 2; *DUOX2* (NM\_014080.4) exons 6-8; *EIF2AK3* (NM\_004836.5) exon 8; *EVC* (NM\_153717.2) exon 1; *F5* (NM\_000130.4) chr1:169,551,662-169,551,679 (partial exon 2); *FH* (NM\_000143.3) exon 1; *GAMT* (NM\_000156.5) exon 1; *GLDC* (NM\_000170.2) exon 1; *GNPTAB* (NM\_024312.4) chr17:4,837,000-4,837,400 (partial exon 2); *GNPTG* (NM\_032520.4) exon 1; *GHR* (NM\_000163.4) exon 3; *GYS2* (NM\_021957.3) chr12:21,699,370-21,699,409 (partial exon 12); *HGSNAT* (NM\_152419.2) exon 1; *IDS* (NM\_000202.6) exon 3; *ITGB4* (NM\_000213.4) chr17:73,749,976-73,750,060 (partial exon 33); *JAK3* (NM\_000215.3) chr19:17,950,462-17,950,483 (partial exon 10); *LIFR* (NM\_002310.5) exon 19; *LMBRD1* (NM\_018368.3) chr6:70,459,226-70,459,257 (partial exon 5), chr6:70,447,828-70,447,836 (partial exon 7) and exon 12; *LYST* (NM\_000081.3) chr1:235,944,158-235,944,176 (partial exon 16) and chr1:235,875,350-235,875,362 (partial exon 43); *MLYCD* (NM\_012213.2) chr16:83,933,242-83,933,282 (partial exon 1); *MTR* (NM\_000254.2) chr1:237,024,418-237,024,439 (partial exon 20) and chr1:237,038,019-237,038,029 (partial exon 24); *NBEAL2* (NM\_015175.2) chr3:47,021,385-47,021,407 (partial exon 1); *NEB* (NM\_001271208.1) exons 82-105; *NPC1* (NM\_000271.4) chr18:21,123,519-21,123,538 (partial exon 14); *NPHP1* (NM\_000272.3) chr2:110,937,251-110,937,263 (partial exon 3); *OCRL* (NM\_000276.3) chrX:128,674,450-128,674,460 (partial exon 1); *PHKB* (NM\_000293.2) exon 1 and chr16:47,732,498-47,732,504 (partial exon 30); *PIGN* (NM\_176787.4) chr18:59,815,547-59,815,576 (partial exon 8); *PIP5K1C* (NM\_012398.2) exon 1 and chr19:3637602-3637616 (partial exon 17); *POU1F1* (NM\_000306.3) exon 5; *PTPRC* (NM\_002838.4) exons 11 and 23; *PUS1* (NM\_025215.5) chr12:132,414,446-132,414,532 (partial exon 2); *RPGRIP1L* (NM\_015272.2) exon 23; *SGSH* (NM\_000199.3) chr17:78,194,022-78,194,072 (partial exon 1); *SLC6A8* (NM\_005629.3) exons 3 and 4; *ST3GAL5* (NM\_003896.3) exon 1; *SURF1* (NM\_003172.3) chr9:136,223,269-136,223,307 (partial exon 1); *TRPM6* (NM\_017662.4) chr9:77,362,800-77,362,811 (partial exon 31); *TSEN54* (NM\_207346.2) exon 1; *TYR* (NM\_000372.4) exon 5; *VWF* (NM\_000552.3) exons 24-26, chr12:6,125,675-6,125,684 (partial exon 30), chr12:6,121,244-6,121,265 (partial exon 33), and exon 34.

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.

#### Next Generation Sequencing for *SMN1*

Exonic regions and intron/exon splice junctions of *SMN1* and *SMN2* were captured, sequenced, and analyzed as described above. Any variants located within exons 2a-7 and classified as pathogenic or likely pathogenic were confirmed to be in either *SMN1* or *SMN2* using gene-specific long-range PCR analysis followed by Sanger sequencing. Variants located in exon 1 cannot be accurately assigned to either *SMN1* or *SMN2* using our current methodology, and so these variants are not 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 arrayCGH 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. Deletions and duplications near the lower limit of detection may not be detected due to run variability.

#### 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. Please note that in rare cases, allele drop-out may occur, which has the potential to lead to false negative results. For *CYP21A2*, a certain percentage of healthy individuals carry a duplication of the *CYP21A2* gene, which has no clinical consequences. In cases where multiple copies of *CYP21A2* are located on the same chromosome in tandem, only the last 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. A *CYP21A1P/CYP21A2* hybrid gene detected only by MLPA but not by long-range PCR will not be reported when the long-range PCR indicates the presence of two full *CYP21A2* gene copies (one on each chromosome), as the additional hybrid gene is nonfunctional. Classic 30-kb deletions are identified by MLPA and are also identified by the presence of multiple common pathogenic *CYP21A2* variants by long-range PCR. Since multiple pseudogene-derived variants are detected in all cases with the classic 30kb deletion, we cannot rule out the possibility that some variant(s) detected could be present in trans with the chimeric *CYP21A1P/CYP21A2* gene created by the 30kb deletion. 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 >30,000 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.

### Personalized Residual Risk Calculations

Agilent SureSelect™XT Low-Input technology was utilized in order to create whole-genome libraries for each patient sample. Libraries were then pooled and sequenced on the Illumina NovaSeq platform. Each sequencing lane was multiplexed to achieve 0.4-2x genome coverage, using paired-end 100 bp reads. The sequencing data underwent ancestral analysis using a customized, licensed bioinformatics algorithm that was validated in house. Identified sub-ethnic groupings were binned into one of 7 continental-level groups (African, East Asian, South Asian, Non-Finnish European, Finnish, Native American, and Ashkenazi Jewish) or, for those ethnicities that matched poorly to the continental-level groups, an 8<sup>th</sup> "unassigned" group, which were then used to select residual risk values for each gene. For individuals belonging to multiple high-level ethnic groupings, a weighting strategy was used to select the most appropriate residual risk. For genes that had insufficient data to calculate ethnic-specific residual risk values, or for sub-ethnic groupings that fell into the "unassigned" group, a "worldwide" residual risk was used. This "worldwide" residual risk was calculated using data from all available continental-level groups.

Several genes have multiple residual risks associated to reflect the likelihood of the tested individual being a carrier for different diseases that are attributed to non-overlapping pathogenic variants in that gene. When calculating the couples' combined reproductive risk, the highest residual risk for each patient was selected.

### 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.

### Tay-Sachs Disease (TSD) Enzyme Analysis (Analytical Detection Rate ≥98%)

Hexosaminidase activity and Hex A% activity were measured by a standard heat-inactivation, fluorometric method using artificial 4-MU-β-N-acetyl glucosaminide (4-MUG) substrate. This assay is highly sensitive and accurate in detecting Tay-Sachs carriers and individuals affected with TSD. Normal ranges of Hex A% activity are 55.0-72.0 for white blood cells and 58.0-72.0 for plasma. It is estimated that less than 0.5% of Tay-Sachs carriers have non-carrier levels of percent Hex A activity, and therefore may not be identified by this assay. In addition, this assay may detect individuals that are carriers of or are affected with Sandhoff disease. False positive results may occur if benign variants, such as pseudodeficiency alleles, interfere with the enzymatic assay. False negative results may occur if both *HEXA* and *HEXB* pathogenic or pseudodeficiency variants are present in the same individual.

Please note that it is not possible to perform Tay-Sachs disease enzyme analysis on saliva samples, buccal swabs, tissue samples, semen samples, or on samples received as extracted DNA.

This test was developed, and its performance characteristics determined by Sema4 Opco, Inc. It has not been cleared or approved by the 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 (CLIA) as qualified to perform high complexity clinical laboratory testing. These analyses generally provide highly accurate information regarding the patient's carrier or affected status. Despite this high level of accuracy, it should be kept in mind that there are many potential sources of diagnostic error, including misidentification of samples, polymorphisms, or other rare genetic variants that interfere with analysis. Families should understand that rare diagnostic errors may occur for these reasons.

## SELECTED REFERENCES

### Carrier Screening

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

### Fragile X syndrome:

Chen L et al. An information-rich CGG repeat primed PCR that detects the full range of Fragile X expanded alleles and minimizes the need for Southern blot analysis. *J Mol Diag* 2010 12:589-600.

### Spinal Muscular Atrophy:

Luo M et al. An Ashkenazi Jewish *SMN1* haplotype specific to duplication alleles improves pan-ethnic carrier screening for spinal muscular atrophy. *Genet Med*. 2014 16:149-56.

### Ashkenazi Jewish Disorders:



Scott SA et al. Experience with carrier screening and prenatal diagnosis for sixteen Ashkenazi Jewish Genetic Diseases. *Hum. Mutat.* 2010 31:1-11.

Akler G et al. Towards a unified approach for comprehensive reproductive carrier screening in the Ashkenazi, Sephardi, and Mizrahi Jewish populations. *Mol Genet Genomic Med.* 2020 Feb 8(2):e1053.

**Duchenne Muscular Dystrophy:**

Flanigan KM et al. Mutational spectrum of *DMD* mutations in dystrophinopathy patients: application of modern diagnostic techniques to a large cohort. *Hum Mutat.* 2009 30:1657-66.

**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.

**Patient Information**

Name: Donor 5891  
 Date of Birth: [REDACTED]  
 Sema4 ID: [REDACTED]  
 Client ID: [REDACTED]  
 Indication: Carrier Screening

**Specimen Information**

Specimen Type: Blood  
 Date Collected: 08/23/2021  
 Date Received: 08/24/2021  
 Final Report: 10/17/2022

**Referring Provider**

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

Unmask Additional Gene(s) (1 gene)  
 with Personalized Residual Risk

**SUMMARY OF RESULTS AND RECOMMENDATIONS**

⊖ Negative

Negative for all genes tested: *DUOX2*  
 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.
- As genetic technologies may improve and variant classifications may change over time, it is recommended to obtain a new carrier screening test or reanalysis when a new pregnancy is being considered.

**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 see Table 1 for a list of genes and diseases tested with the patient's personalized residual risk. If personalized residual risk is not provided, please see the complete residual risk table at [go.sema4.com/residualrisk](http://go.sema4.com/residualrisk). 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.



Ruth Kornreich, Ph.D., FACMG, Laboratory Director

## Genes and diseases tested

The personalized residual risks listed below are specific to this individual. The complete residual risk table is available at [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
<span style="color: green;">⊖</span> <b>Negative</b>				
<b>Thyroid Dysmorphogenesis 6</b>	<i>DUOX2</i>	AR	Reduced Risk	<b>Personalized Residual Risk: 1 in 32</b>

AR=Autosomal recessive; 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:

### Fragile X CGG Repeat Analysis (Analytical Detection Rate >99%)

PCR amplification using Asuragen, Inc. AmpliX<sup>®</sup> *FMR1* PCR reagents followed by capillary electrophoresis for allele sizing was performed. Samples positive for *FMR1* premutations and full mutations greater than 90 CGG repeats in length were further analyzed by Southern blot analysis or methylation PCR to assess the size and methylation status of the *FMR1* CGG repeat. Additional testing to determine the status of AGG interruptions within the *FMR1* CGG repeat will be automatically performed for premutation alleles ranging from 55 to 90 repeats. These results, which may modify risk for expansion, will follow in a separate report.

### Genotyping (Analytical Detection Rate >99%)

Multiplex PCR amplification and allele specific primer extension analyses using the MassARRAY<sup>®</sup> System were used to identify certain recurrent variants that are complex in nature or are present in low copy repeats. Rare sequence variants may interfere with assay performance.

### Multiplex Ligation-Dependent Probe Amplification (MLPA) (Analytical Detection Rate >99%)

MLPA<sup>®</sup> probe sets and reagents from MRC-Holland were used for copy number analysis of specific targets versus known control samples. False positive or negative results may occur due to rare sequence variants in target regions detected by MLPA probes. Analytical sensitivity and specificity of the MLPA method are both 99%.

For alpha thalassemia, the copy numbers of the *HBA1* and *HBA2* genes were analyzed. Alpha-globin gene deletions, triplications, and the Constant Spring (CS) mutation are assessed. This test is expected to detect approximately 90% of all alpha-thalassemia mutations, varying by ethnicity. Carriers of alpha-thalassemia with three or more *HBA* copies on one chromosome, and one or no copies on the other chromosome, may not be detected. With the exception of triplications, other benign alpha-globin gene polymorphisms will not be reported. Analyses of *HBA1* and *HBA2* are performed in association with long-range PCR of the coding regions followed by short-read sequencing.

For Duchenne muscular dystrophy, the copy numbers of all *DMD* exons were analyzed. Potentially pathogenic single exon deletions and duplications are confirmed by a second method. Analysis of *DMD* is performed in association with sequencing of the coding regions.

For congenital adrenal hyperplasia, the copy number of the *CYP21A2* gene was analyzed. This analysis can detect large deletions typically due to unequal meiotic crossing-over between *CYP21A2* and the pseudogene *CYP21A1P*. Classic 30-kb deletions make up approximately 20% of *CYP21A2* pathogenic alleles. This test may also identify certain point mutations in *CYP21A2* caused by gene conversion events between *CYP21A2* and *CYP21A1P*. Some carriers may not be identified by dosage sensitive methods as this testing cannot detect individuals with two copies (duplication) of the *CYP21A2* gene on one chromosome and loss of *CYP21A2* (deletion) on the other chromosome. Analysis of *CYP21A2* is performed in association with long-range PCR of the coding regions followed by short-read sequencing.

For spinal muscular atrophy (SMA), the copy numbers of the *SMN1* and *SMN2* genes were analyzed. The individual dosage of exons 7 and 8 as well as the combined dosage of exons 1, 4, 6 and 8 of *SMN1* and *SMN2* were assessed. Copy number gains and losses can be detected with this assay. Depending on ethnicity, 6 - 29 % of carriers will not be identified by dosage sensitive methods as this testing cannot detect individuals with two copies (duplication) of the *SMN1* gene on one chromosome and loss of *SMN1* (deletion) on the other chromosome (silent 2+0 carrier) or individuals that carry an intragenic mutation in *SMN1*. Please also note that 2% of individuals diagnosed with SMA have a

causative *SMN1* variant that occurred de novo, and therefore cannot be picked up by carrier screening in the parents. Analysis of *SMN1* is performed in association with short-read sequencing of exons 2a-7, followed by confirmation using long-range PCR (described below).

In individuals with two copies of *SMN1* with Ashkenazi Jewish, East Asian, African American, Native American or Caucasian ancestry, the presence or absence of c. \*3+80T>G significantly increases or decreases, respectively, the likelihood of being a silent 2+0 silent carrier.

MLPA for Gaucher disease (*GBA*), cystic fibrosis (*CFTR*), and non-syndromic hearing loss (*GJB2/GJB6*) will only be performed if indicated for confirmation of detected CNVs. If *GBA* analysis was performed, the copy numbers of exons 1, 3, 4, and 6 - 10 of the *GBA* gene (of 11 exons total) were analyzed. If *CFTR* analysis was performed, the copy numbers of all 27 *CFTR* exons were analyzed. If *GJB2/GJB6* analysis was performed, the copy number of the two *GJB2* exons were analyzed, as well as the presence or absence of the two upstream deletions of the *GJB2* regulatory region, del(*GJB6*-D13S1830) and del(*GJB6*-D13S1854).

#### 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™XT Low Input 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. Libraries were pooled and sequenced on the Illumina NovaSeq 6000 platform, using paired-end 100 bp 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. These regions, which are described below, 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® genotyping platform.

**Exceptions:** *ABCD1* (NM\_000033.3) exons 8 and 9; *ACADSB* (NM\_001609.3) chr10:124,810,695-124,810,707 (partial exon 9); *ADA* (NM\_000022.2) exon 1; *ADAMTS2* (NM\_014244.4) exon 1; *AGPS* (NM\_003659.3) chr2:178,257,512-178,257,649 (partial exon 1); *ALDH7A1* (NM\_001182.4) chr5:125,911,150-125,911,163 (partial exon 7) and chr5:125,896,807-125,896,821 (partial exon 10); *ALMS1* (NM\_015120.4) chr2:73,612,990-73,613,041 (partial exon 1); *APOPT1* (NM\_032374.4) chr14:104,040,437-104,040,455 (partial exon 3); *CDAN1* (NM\_138477.2) exon 2; *CEP152* (NM\_014985.3) chr15:49,061,146-49,061,165 (partial exon 14) and exon 22; *CEP290* (NM\_025114.3) exon 5, exon 7, chr12:88,519,017-88,519,039 (partial exon 13), chr12:88,514,049-88,514,058 (partial exon 15), chr12:88,502,837-88,502,841 (partial exon 23), chr12:88,481,551-88,481,589 (partial exon 32), chr12:88,471,605-88,471,700 (partial exon 40); *CFTR* (NM\_000492.3) exon 10; *COL4A4* (NM\_000092.4) chr2:227,942,604-227,942,619 (partial exon 25); *COX10* (NM\_001303.3) exon 6; *CYP11B1* (NM\_000497.3) exons 3-7; *CYP11B2* (NM\_000498.3) exons 3-7; *DNAI2* (NM\_023036.4) chr17:72,308,136-72,308,147 (partial exon 12); *DOK7* (NM\_173660.4) chr4:3,465,131-3,465,161 (partial exon 1) and exon 2; *DUOX2* (NM\_014080.4) exons 6-8; *EIF2AK3* (NM\_004836.5) exon 8; *EVC* (NM\_153717.2) exon 1; *F5* (NM\_000130.4) chr1:169,551,662-169,551,679 (partial exon 2); *FH* (NM\_000143.3) exon 1; *GAMT* (NM\_000156.5) exon 1; *GLDC* (NM\_000170.2) exon 1; *GNPTAB* (NM\_024312.4) chr17:4,837,000-4,837,400 (partial exon 2); *GNPTG* (NM\_032520.4) exon 1; *GHR* (NM\_000163.4) exon 3; *GYS2* (NM\_021957.3) chr12:21,699,370-21,699,409 (partial exon 12); *HGSNAT* (NM\_152419.2) exon 1; *IDS* (NM\_000202.6) exon 3; *ITGB4* (NM\_000213.4) chr17:73,749,976-73,750,060 (partial exon 33); *JAK3* (NM\_000215.3) chr19:17,950,462-17,950,483 (partial exon 10); *LIFR* (NM\_002310.5) exon 19; *LMBRD1* (NM\_018368.3) chr6:70,459,226-70,459,257 (partial exon 5), chr6:70,447,828-70,447,836 (partial exon 7) and exon 12; *LYST* (NM\_000081.3) chr1:235,944,158-235,944,176 (partial exon 16) and chr1:235,875,350-235,875,362 (partial exon 43); *MLYCD* (NM\_012213.2) chr16:83,933,242-83,933,282 (partial exon 1); *MTR* (NM\_000254.2) chr1:237,024,418-237,024,439 (partial exon 20) and chr1:237,038,019-237,038,029 (partial exon 24); *NBEAL2* (NM\_015175.2) chr3:47,021,385-47,021,407 (partial exon 1); *NEB* (NM\_001271208.1) exons 82-105; *NPC1* (NM\_000271.4) chr18:21,123,519-21,123,538 (partial exon 14); *NPHP1* (NM\_000272.3) chr2:110,937,251-110,937,263 (partial exon 3); *OCRL* (NM\_000027.3) chrX:128,674,450-128,674,460 (partial exon 1); *PHKB* (NM\_000293.2) exon 1 and chr16:47,732,498-47,732,504 (partial exon 30); *PIGN* (NM\_176787.4) chr18:59,815,547-59,815,576 (partial exon 8); *PIP5K1C* (NM\_012398.2) exon 1 and chr19:363,7602-363,7616 (partial exon 17); *POU1F1* (NM\_000306.3) exon 5; *PTPRC* (NM\_002838.4) exons 11 and 23; *PUS1* (NM\_025215.5) chr12:132,414,446-132,414,532 (partial exon 2); *RPGRIP1L* (NM\_015272.2) exon 23; *SGSH* (NM\_000199.3) chr17:78,194,022-78,194,072 (partial exon 1); *SLC6A8* (NM\_005629.3) exons 3 and 4; *ST3GAL5* (NM\_003896.3) exon 1; *SURF1* (NM\_003172.3) chr9:136,223,269-136,223,307 (partial exon 1); *TRPM6* (NM\_017662.4) chr9:77,362,800-77,362,811 (partial exon 31); *TSEN54* (NM\_020734.6.2) exon 1; *TYR* (NM\_000372.4) exon 5; *VWF* (NM\_000552.3) exons 24-26, chr12:6,125,675-6,125,684 (partial exon 30), chr12:6,121,244-6,121,265 (partial exon 33), and exon 34.

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.



Variation 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.

#### Next Generation Sequencing for *SMN1*

Exonic regions and intron/exon splice junctions of *SMN1* and *SMN2* were captured, sequenced, and analyzed as described above. Any variants located within exons 2a-7 and classified as pathogenic or likely pathogenic were confirmed to be in either *SMN1* or *SMN2* using gene-specific long-range PCR analysis followed by Sanger sequencing. Variants located in exon 1 cannot be accurately assigned to either *SMN1* or *SMN2* using our current methodology, and so these variants are not 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 arrayCGH 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. Deletions and duplications near the lower limit of detection may not be detected due to run variability.

#### 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. Please note that in rare cases, allele drop-out may occur, which has the potential to lead to false negative results. For *CYP21A2*, a certain percentage of healthy individuals carry a duplication of the *CYP21A2* gene, which has no clinical consequences. In cases where multiple copies of *CYP21A2* are located on the same chromosome in tandem, only the last 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. A *CYP21A1P/CYP21A2* hybrid gene detected only by MLPA but not by long-range PCR will not be reported when the long-range PCR indicates the presence of two full *CYP21A2* gene copies (one on each chromosome), as the additional hybrid gene is nonfunctional. Classic 30-kb deletions are identified by MLPA and are also identified by the presence of multiple common pathogenic *CYP21A2* variants by long-range PCR. Since multiple pseudogene-derived variants are detected in all cases with the classic 30kb deletion, we cannot rule out the possibility that some variant(s) detected could be present in trans with the chimeric *CYP21A1P/CYP21A2* gene created by the 30kb deletion. 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 >30,000 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.

## Personalized Residual Risk Calculations

Agilent SureSelect™XT Low-Input technology was utilized in order to create whole-genome libraries for each patient sample. Libraries were then pooled and sequenced on the Illumina NovaSeq platform. Each sequencing lane was multiplexed to achieve 0.4-2x genome coverage, using paired-end 100 bp reads. The sequencing data underwent ancestral analysis using a customized, licensed bioinformatics algorithm that was validated in house. Identified sub-ethnic groupings were binned into one of 7 continental-level groups (African, East Asian, South Asian, Non-Finnish European, Finnish, Native American, and Ashkenazi Jewish) or, for those ethnicities that matched poorly to the continental-level groups, an 8<sup>th</sup> "unassigned" group, which were then used to select residual risk values for each gene. For individuals belonging to multiple high-level ethnic groupings, a weighting strategy was used to select the most appropriate residual risk. For genes that had insufficient data to calculate ethnic-specific residual risk values, or for sub-ethnic groupings that fell into the "unassigned" group, a "worldwide" residual risk was used. This "worldwide" residual risk was calculated using data from all available continental-level groups.

Several genes have multiple residual risks associated to reflect the likelihood of the tested individual being a carrier for different diseases that are attributed to non-overlapping pathogenic variants in that gene. When calculating the couples' combined reproductive risk, the highest residual risk for each patient was selected.

### 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.

### Tay-Sachs Disease (TSD) Enzyme Analysis (Analytical Detection Rate ≥98%)

Hexosaminidase activity and Hex A% activity were measured by a standard heat-inactivation, fluorometric method using artificial 4-MU-β-N-acetyl glucosaminide (4-MUG) substrate. This assay is highly sensitive and accurate in detecting Tay-Sachs carriers and individuals affected with TSD. Normal ranges of Hex A% activity are 55.0-72.0 for white blood cells and 58.0-72.0 for plasma. It is estimated that less than 0.5% of Tay-Sachs carriers have non-carrier levels of percent Hex A activity, and therefore may not be identified by this assay. In addition, this assay may detect individuals that are carriers of or are affected with Sandhoff disease. False positive results may occur if benign variants, such as pseudodeficiency alleles, interfere with the enzymatic assay. False negative results may occur if both *HEXA* and *HEXB* pathogenic or pseudodeficiency variants are present in the same individual.

Please note that it is not possible to perform Tay-Sachs disease enzyme analysis on saliva samples, buccal swabs, tissue samples, semen samples, or on samples received as extracted DNA.

This test was developed, and its performance characteristics determined by Sema4 Opco, Inc. It has not been cleared or approved by the 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 (CLIA) as qualified to perform high complexity clinical laboratory testing. These analyses generally provide highly accurate information regarding the patient's carrier or affected status. Despite this high level of accuracy, it should be kept in mind that there are many potential sources of diagnostic error, including misidentification of samples, polymorphisms, or other rare genetic variants that interfere with analysis. Families should understand that rare diagnostic errors may occur for these reasons.

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