

RCIGM Genome Report

PATIENT NAME	Baby Boy	ORDERING PHYSICIAN	Dr. Jane Doe	RCIGM CASE ID	CSXXXX_INXXXX
SEX	Male	ORDERING PROVIDER	Dr. John Doe	REPORT DATE	02/11/2023
DATE OF BIRTH	01/21/2023	HOSPITAL	Children's Hospital		
MRN	H0000000	SPECIMEN	Dried blood spot		
INDICATION FOR TESTING	Research Subject IRB#	COLLECTED	01/27/2023		
TEST TYPE	Solo Whole Genome Sequencing	RECEIVED	01/30/2023		

PATIENT PHENOTYPE

Hydronephrosis; Encephalopathy; Patent ductus arteriosus; Patent foramen ovale; Anemia; Poor suck; Hypotension; Neonatal respiratory distress; Tachypnea; Hypokalemia; Abnormal renal collecting system morphology; Intraventricular hemorrhage; Elevated circulating 17-hydroxyprogesterone

TEST RESULT: NO VARIANTS REPORTED

RECOMMENDATIONS

- Clinical correlation is recommended.
- Clinical molecular testing should be interpreted in the context of the patient's clinical presentation and the prior probability of the clinical signs and symptoms being associated with known single gene disorders (i.e. defects in the identified gene).
- Genetic counseling is recommended to assess the specific implications of these results relative to an individual's clinical context.
- Additional testing may be appropriate to evaluate for other types of variants not evaluated by this test.
- As knowledge increases, periodic re-evaluation of the clinical implications of variants is appropriate. Please contact RCIGM_rWGS@rchsd.org for questions about the RCIGM re-analysis policy.
- Mitochondrial DNA disorders can be sporadic or maternally inherited. If the reported mtDNA variant is found in the mother, the testing of appropriate matrilineal relatives is recommended.
- If there is a strong clinical suspicion of mitochondrial disease, additional testing of different tissue types may be warranted.

METHODOLOGY

Sequence via next generation sequencing (NGS) technology is generated from genomic DNA. PCR-free library preparation is performed prior to whole genome sequencing (WGS). An average genomic coverage of at least 35x, and/or at least 90% of OMIM genes will achieve 100% of coding base coverage of >10x for each proband. This ensures robust and uniform genome coverage. The current version of this test assesses single nucleotide variants (SNVs), small deletions and insertions, larger deletions and duplications, the mitochondrial genome, SMN1 and SMN2 copy number analysis, and repeat expansions in PHOX2B and DMPK. Alignment and variant calling are performed using the Illumina



Clinical Genome Center

7910 Frost Street, Suite 240
San Diego, CA 92123

RCIGM_rWGS@rchsd.org

P: 858 / 966-8127
F: 858 / 966-8092

CLIA ID# 05D2129627
CAP ID# 9487427

DRAGEN pipeline using the official reference build 37.1 (hg19). Copy number variation (CNV) calling is performed using a combination of CNV callers. Interpretation of CNVs is focused on variants that overlap or have a boundary that lies within 1 kb of an exon in all coding genes. Repeat expansion calling for PHOX2B and DMPK only are performed using Expansion Hunter (v.4.0.2) in DRAGEN 3.10.4. Repeat expansions in PHOX2B may also be detected by the DRAGEN 3.10.4 SNVs & Indels analysis pipeline.

Orthogonal Confirmation Policy

Reported sequencing variants are confirmed by Sanger sequencing, but may not be confirmed using orthogonal technologies if the following criteria are met: 1) the coverage at the variant's position is $\geq 20x$; 2) the allelic balance for heterozygous calls is between 0.3-0.7; 3) the allelic balance is 0 (wild type allele as reference) for homozygous and hemizygous calls; 4) no systematic sequencing errors or local alignment problems are observed; 5) the call is not located in difficult sequence context (highly homologous and repetitive regions); 6) the call is not a complex insertion/deletion call resulting from nearby variants that may be difficult to align. If specific protocols require orthogonal confirmations of all reported variants, confirmations will be performed. If the case is ordered as proband-only and parental samples are available, targeted inheritance studies will be conducted for selected variants of interest.

Reported copy number variants are confirmed using orthogonal technologies including Multiplex ligation-dependent probe amplification (MLPA), but may not be confirmed using orthogonal technologies if the following criteria are met: 1) the deletion or duplication event contains robust coverage and/or NGS read support; 2) no systematic sequencing errors or local alignment problems are observed; 3) the call is not located in difficult sequence context (highly homologous, repetitive regions, or segmental duplication regions). If specific protocols require orthogonal confirmations of all reported variants, confirmations will be performed. If the case is ordered as proband-only and parental samples are available, targeted inheritance studies will be conducted for selected variants of interest.

Orthogonal confirmation of the PHOX2B and DMPK expansion variants is performed at an external CAP/CLIA laboratory. Final test results reporting may be affected by turnaround times of CAP/CLIA laboratory.

Reporting Categories

Variants related to patient's phenotype – findings with strong variant pathogenicity evidence and strong evidence that the reported gene-disease association overlaps with the patient's phenotype

Variants possibly related to patient's phenotype - findings that are suggestive of a diagnosis but lacks either conclusive variant pathogenicity evidence or lack conclusive gene-disease association evidence

Variants in genes of uncertain significance – findings in genes that lack strong or supporting evidence for association with human disease

Variants in the mitochondrial genome – findings located within the mitochondrial genome

Incidental findings - findings in genes that do not overlap with the patient's reported phenotype, but may be medically actionable for the patient or tested family members

Test Specifications

The sensitivity and specificity for SNVs (single nucleotide variants) and small insertions and deletions up to 50 base pairs is greater than 99%. The analytical validity of SNVs was assessed using reference samples provided through the Genome in a Bottle (Zook et al. 2019, PMID: 30936564).

The sensitivity for larger deletions and duplications from WGS is estimated to be greater than 85%, although reliable reference data for these types of events are not well established. Deletions and duplications from 1 Kb to whole chromosomal abnormalities are detected with this test.

The sensitivity for detecting GCN trinucleotide repeat expansions within the PHOX2B carboxy terminal polyalanine repeat region by Expansion Hunter on short-read NGS is > 90% for expansions greater than 20 repeats. The sensitivity for detecting 3' UTR DMPK trinucleotide repeat expansion (CTG repeats) is >90% for expansions greater than 50 repeats. However, due to short-read NGS technology's limitations, repeat expansion size cannot be precisely determined and reported (see Test Limitation section of the report). This test is validated for copy number analysis of exons 7 and 8 of the SMN1 and SMN2 genes. Over 95% of pathogenic variation for SMA involves biallelic loss of exon 7 of the SMN1 gene (Prior et al. 2010, PMID: 20057317). Other variation within the SMN1 gene is not detected with this assay. Results will only be reported in the proband if 0 copies of SMN1 are detected. Parental carrier status will be reported for affected patients if samples are available. Results are orthogonally confirmed by Multiplex Ligation-dependent Probe Amplification (MLPA). Whole genome sequencing is unable to determine the phase of SMN1 variants in the absence of parental testing. Therefore, in the absence of phasing, this assay does not exclude the possibility than an individual harbors two copies of SMN1 on the same allele and no copies on the other allele (silent carriers), two pathogenic sequence variants on the same SMN1 allele, two pathogenic sequence variants on opposite SMN1 alleles, and one pathogenic sequence variant and the loss of exon 8 on the opposite SMN1 allele.

Non-PCR amplified whole-genome sequencing (WGS) provides a stable, at least ~1,000-fold average, coverage across the entire mitochondrial genome (mtDNA). This test can detect SNVs, small insertions and deletions, as well as large deletions in the mtDNA. For mtDNA SNVs, variants with a heteroplasmy lower than 1% may not be detected. Variants that are classified as pathogenic or likely pathogenic that overlap with the patient's phenotype, with levels of heteroplasmy of >5% will be reported. However, suspicious variants of uncertain clinical significance will only be reported if heteroplasmy levels are >20%. If a patient is identified in having a SNV with heteroplasmy of >20%, Sanger sequencing will be performed for sequence confirmation. Variants with heteroplasmy levels between 1% - 20% will not be confirmed. Variants are considered to be rare if present in asymptomatic adults in fewer than 5 families in mtDB and the RCIGM internal database, combined. The revised Cambridge Reference sequence is used as a reference (rCRS NC_012920). Interpretations are made with the assumption that any information provided on family relationship is accurate.

Both phenotype-informed and phenotype-agnostic analyses are performed. Likely pathogenic and pathogenic variants that may explain the patient's phenotype will be reported as related/possibly related to the patient phenotype. Selected variants of uncertain significance may be reported as well. Should an incidental finding be revealed during genomic analysis for proband, and proband and parents have opted-in to receive incidental findings, it will be included on the proband's report. Parents do not have the option to opt-in for incidental findings if proband has opted-out. Reported variants are curated and classified in accordance with the American College of Medical Genetics and Genomics Guidelines (PMID: 25741868, 21681106, 24071793, 31690835).

Incidental findings may be reported if the patient and/or patient's family do not opt-out of receiving these results. RCIGM's internal incidental finding policy includes the following: 1) variant must be classified as pathogenic per ACMG guidelines and in alignment with the known inheritance pattern of the genetic condition; 2) the variant is located in a gene with a well-established gene-disease relationship; 3) the gene and associated condition is shown to be medically actionable as established by RCIGM policy and in consultation with the RCIGM clinical team. Pathogenic variants included within the ACMG list of 59 secondary findings genes that are identified will be reported as well as other findings that meet the above criteria.

LIMITATIONS

Full coverage of the genome is not currently possible due to technically challenging repetitive elements and duplicated regions within the genome. Thus, not all regions of the genome are sequenced and/or uniquely aligned to the reference genome. Mosaic variant detection is limited using whole genome sequencing. Repeat expansion detection is limited to the DMPK and PHOX2B genes. The exact number of repeats cannot be determined by the current methodology and therefore orthogonal confirmation for precise sizing may be required. Non-diagnostic findings do not rule out the



Clinical Genome Center

7910 Frost Street, Suite 240
San Diego, CA 92123

RCIGM_rWGS@rchsd.org

P: 858 / 966-8127
F: 858 / 966-8092

CLIA ID# 05D2129627
CAP ID# 9487427

diagnosis of a genetic disorder since some genetic abnormalities may be undetectable with the current version of this test. False negative results may occur in the setting of bone marrow transplantation, recent blood transfusion, or suboptimal DNA quality. The chance of false positive or false negative result due to laboratory errors incurred during any phase of testing cannot be completely excluded. This test is set up to evaluate the potential contribution of rare disease-causing variants in known disease genes. It is not designed to evaluate for common variants in genes that might contribute to disease risk or for disorders that have a multigenic inheritance. Based on current knowledge, potential disease-causing variants may not always be recognized at the time of testing.

REGULATORY DISCLOSURES

This test was developed and its performance characteristics determined by the Rady Children’s Hospital and the Rady Children’s Institute for Genomic Medicine. It has not been cleared or approved by the U.S. Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. RCIGM has established and verified the test’s accuracy and precision as outlined in the requirements of CLIA ’88. The test is used for clinical purposes. It should not be regarded as investigational or for research. The Rady Children’s Institute for Genomic Medicine is certified under the Clinical Laboratory Improvement Amendments (CLIA) as qualified to perform high complexity clinical laboratory testing.

Lucia Guidugli, PhD, FACMG, CGMB
Clinical Laboratory Director

Katarzyna (Kasia) Ellsworth, PhD, FACMG
Senior Director of Clinical Operations

Test results reviewed and approved by:
Kasia Ellsworth, PhD, FACMG, CGMB
Senior Director of Clinical Operations
RCIGM_rWGS@rchsd.org