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**Carrier screening report Donor 12954** Date of Birth: Sema4 ID: 22227137

### **Patient Information**

Name: Donor 12954 Date of Birth: Sema4 ID: 22227137 Client ID: SEATSB-S484719135 Indication: Carrier Screening

#### **Specimen Information**

Specimen Type: Blood Date Collected: 11/08/2022 Date Received: 11/09/2022 Final Report: 11/28/2022

### **Referring Provider**

Jeffrey Olliffe, M.D. Seattle Sperm Bank 4915 25th Avenue NE Suite 204W Seattle, WA, 98105 Fax: 206-466-4696

### Expanded Carrier Screen (502 genes)

with Personalized Residual Risk

### **SUMMARY OF RESULTS AND RECOMMENDATIONS**



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. 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.



## Interpretation of positive results

### **Cystic Fibrosis (AR)**

### **Results and Interpretation**

A heterozygous (one copy) likely pathogenic missense variant, c.1865G>A, p.G622D, was detected in the CFTR gene (NM\_000492.3). Please note that this variant has been reported with varying consequences. Some patients have presented with classic cystic fibrosis, while others have displayed only milder CF-related symptoms or have been asymptomatic. When this variant is present in trans with a pathogenic variant, it is considered to be causative for cystic fibrosis. Therefore, this individual is expected to be at least a carrier for cystic fibrosis. The majority of individuals heterozygous for a variant in this gene are not expected to exhibit symptoms of CFTR-related disorders. However, several studies suggest that carrying a heterozygous CFTR variant may confer an increased risk for certain health conditions including chronic or recurrent pancreatitis. Recent studies estimate the relative risk for chronic pancreatitis is approximately 5-9 times greater in heterozygous carriers compared to the general population (PMID: 31882447).

#### **What is Cystic Fibrosis?**

Cystic fibrosis is an autosomal recessive disorder caused by pathogenic variants in the gene CFTR. It may be diagnosed in individuals worldwide, but has the highest prevalence in the Caucasian population, in individuals with Northern European ancestry. The clinical presentation includes thick mucus accumulation in the lungs leading to breathing difficulties and infection, poor digestion, and male infertility. The average life expectancy is in the 30s. Although some genotype-phenotype correlations exist, individuals with two classic pathogenic variants in CFTR are expected to present with a more severe disease phenotype. Non-classic variants in CFTR may lead to less severe forms of disease or specific phenotypes, such as male infertility as a result of congenital absence or hypoplasia of the vas deferens.

#### **Galactokinase Deficiency (AR)**

#### **Results and Interpretation**

A heterozygous (one copy) likely pathogenic missense variant, c.863C>T, p.T288M, was detected in the GALK1 gene (NM\_000154.1). When this variant is present in trans with a pathogenic variant, it is considered to be causative for galactokinase deficiency. Therefore, this individual is expected to be at least a carrier for galactokinase deficiency. Heterozygous carriers are not expected to exhibit symptoms of this disease.

#### **What is Galactokinase Deficiency?**

Galactokinase deficiency is an autosomal recessive disorder caused by pathogenic variants in the gene GALK1. While it has been diagnosed in individuals worldwide, there is an increased prevalence in the European Roma population. Patients with this disorder cannot break down the sugar in lactose, which accumulates in the eyes and is broken down to a metabolite that causes cataracts during the first months of life. Cataract formation can be prevented with dietary management. Rarely, patients with intellectual disability have been reported. Life expectancy is not reduced. No genotype-phenotype correlation has been reported, and therefore severity of the disease cannot be predicted.

### 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.

Juliatte Halle

**Juliette J. Kahle, Ph.D., FACMG, Assistant 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**











































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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 single-base pair probe extension analyses using the Agena Bioscience iPlex Pro chemistry on a MassARRAY® 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%)**

Conventional MLPA and/or digitalMLPA<sup>®</sup> probe sets and reagents from MRC-Holland were used for copy number variations (CNVs) analysis of specific targets versus known control samples. digitalMLPA® is a semi-quantitative technique, based on the well-established conventional MLPA method, followed by Illumina based sequencing to determine read number for amplicon quantification. False positive or negative results may occur due to rare sequence variants in target regions detected by conventional MLPA or digitalMLPA® probes. Analytical sensitivity and specificity of both the conventional MLPA method and the digitalMLPA<sup>®</sup> method are greater than 99%.

For alpha thalassemia, the copy numbers of the HBA1 and HBA2 genes were analyzed. Alpha-globin gene deletions, duplications, 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 precisely specified without phase analysis. With the exception of duplications, 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. Depending on ethnicity, 6 - 29 % of carriers will not be identified by dosage sensitive methods as this testing cannot distinguish 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 identify intragenic mutation in SMN1. Please also note that 2% of individuals diagnosed with SMA have a causative SMN1 variant that occurred de novo, 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).

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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<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 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

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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 (CNV) Analysis (Analytical Detection Rate >98% for CNVs of 3 exons and larger, >90% for CNVs of 2 exons)**

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. Genomic regions with high homology or highly repetitive sequences are excluded from this analysis.

#### **Exon Array Comparative Genomic Hybridization (aCGH) (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 1,000,000 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 SYBR Green reagents on a LightCycler® 480 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 ∆∆Ct 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 quide 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**

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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 highlevel 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-Nacetyl 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**

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Additional disease-specific references available upon request.

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Ward: SEATSB

### Cytogenetic Report

### **CHROMOSOME ANALYSIS, BLOOD - 14596 Lab:EZ CHROMOSOME ANALYSIS, BLOOD**

Order ID: 22-474808 Specimen Type: Blood Clinical Indication: Encounter of male for testing for disease carrier status for procrea management.

### **RESULT:**

NORMAL MALE KARYOTYPE

#### **INTERPRETATION:**

Chromosome analysis revealed normal G-band patterns within the limits of standard cytogenetic analysis.

Please expect the results of any other concurrent study in a separate report.

#### **NOMENCLATURE:**

46,XY

#### **ASSAY INFORMATION:**

![](_page_19_Picture_191.jpeg)

This test does not address genetic disorders that cannot be detected by standard cytogenetic methods or rare events such as low level mosaicism or subtle rearrangements.

Sibel Kantarci, PhD, FACMG (800) NICHOLS-4307

Electronic Signature: 11/17/2022 4:49 PM

CLIENT SERVICES: 866.697.8378 SPECIMEN: CF147702J

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![](_page_20_Figure_4.jpeg)

## **PERFORMING SITE:**<br>EZ QUEST DIAGNOSTICS/NIC

EZ QUEST DIAGNOSTICS/NICHOLS SJC, 33608 ORTEGA HWY, SAN JUAN CAPISTRANO, CA 92675-2042 Laboratory Director: IRINA MARAMICA,MD,PHD,MBA, CLIA: 05D0643352