Hemophilia A (F8) 2 Inversions with Reflex to Sequencing and Reflex to Deletion/Duplication

Indications for Ordering

- Detect the causal F8 variant in established cases of hemophilia A
- Determine carrier status for females with a family history of hemophilia A

Test Description

- Inversion analysis of F8 introns 1 and 22A by Bcl1 digest, followed by ligation and polymerase chain reaction (PCR)
  o Products are analyzed by size using eGene
- Bidirectional sequencing of the entire F8 coding region and intron-exon borders
- Multiplex ligation-dependent probe amplification (MLPA) for large deletion/duplication analysis of the F8 gene

Tests to Consider

Typical testing strategy

- Initial testing for hemophilia A
  o Factor VIII activity, von Willebrand factor activity and antigen, and partial thromboplastin time
- Molecular testing
  o Mild to moderate hemophilia A – sequencing followed by deletion/duplication analysis
  o Severe hemophilia A – inversion analysis by PCR followed by sequencing and deletion/duplication analysis

Primary test for severe hemophilia A

Hemophilia A (F8) 2 Inversions with Reflex to Sequencing and Reflex to Deletion/Duplication 2001614

- Detect causal F8 variant in individuals with established severe hemophilia A
- Determine carrier status in at-risk females with severely affected male relatives

Related tests

Initial testing for hemophilia A

- Factor VIII, Activity (Ristocetin Cofactor) 0030095
- von Willebrand Panel 0030125
- Partial Thromboplastin Time 0030235

Molecular testing for hemophilia A

- Hemophilia A (F8) 2 Inversions 2001759
  o Identify causal F8 gene intron 22A or intron 1 variant in individuals with established severe hemophilia A
  o Carrier testing for those with relatives with a known inversion of intron 1 or 22A
- Hemophilia A (F8) 2 Inversions, Fetal 2001755
  o Prenatal testing for hemophilia A caused by a familial F8 gene intron 22A or intron 1 inversion
- Hemophilia A (F8) Sequencing 2001747
  o Identify causal F8 variant in individuals with established mild to moderate hemophilia A
  o Carrier testing for those with a family history of mild to moderate hemophilia A
- Familial Mutation, Targeted Sequencing 2001961
  o Useful when a pathogenic familial variant identifiable by sequencing is known

Disease Overview

Prevalence – 1/4,000-5,000 live male births worldwide; rare in females
Penetrance – 100% in males; 10% in females

Symptoms

Mild hemophilia A

- 6-35% factor VIII activity
- Not usually diagnosed until adulthood
- Abnormal bleeding observed after surgery, tooth extraction, or major injuries
  o Spontaneous bleeding does not occur
- Bleeding frequency may vary from once a year to once in 10 years
- 10% of carrier females are symptomatic
  o Usually mildly affected
  o Carriers should be monitored postpartum for delayed bleeding, unless their baseline factor VIII activity is normal
Moderate hemophilia A
- Characterized by 1-5% factor VIII activity
- Typically diagnosed by age 6 due to prolonged or delayed oozing after minor trauma, with episodic frequency varying from once a month to once a year

Severe hemophilia A
- Defined by <1% factor VIII activity
- Usually diagnosed in first year of life due to spontaneous joint or deep muscle bleeding occurring 2-5 times/month
- Life expectancy for untreated individuals with severe disease is 11 years; when adequately treated, life expectancy increases to 63 years
- Leading cause of death due to bleeding is intracranial hemorrhage
- Major cause of disability from bleeding is joint disease

Diagnostic issues
- Diagnosis of hemophilia A is established by documenting low factor VIII activity with a normal von Willebrand factor antigen and activity.
  - First-line testing in most individuals is not molecular
  - Clinical information and molecular testing is required to distinguish hemophilia A from von Willebrand disease type 2N
- Molecular testing may be helpful in predicting clinical phenotype and risk of developing a factor VIII inhibitor
- Carrier testing cannot be accurately performed by measuring factor VIII activity
  - Molecular studies must be performed

Gene – F8

Inheritance – X-linked recessive

De novo variants
In ~30% of cases that appear to be de novo, the mother is found to be a carrier >80% of the time

Variants
F8 gene variants are the only cause of hemophilia A
- Inversion occurring at intron 22A or intron 1 – 48% and 3% of affected individuals, respectively
- Large gene deletions – 6% of variants
- Smaller point variants – 43% of variants

Test Interpretation

Sensitivity/specificity
- Clinical sensitivity – 51% for inversion testing, 43% for sequencing, and 6% for deletion/duplication analysis (Konkle, 2014)
- Analytical sensitivity/specificity – 99% for sequencing, MLPA, and inversion analysis

Results
- One copy of the F8 intron 22A or intron 1 inversion OR large F8 deletion
  - Predictive of severe hemophilia A disease in males and carrier status in females
    - 10% of carrier females are affected (typically with mild disease)
- Large F8 duplications
  - May result in severe or mild disease, or may be benign depending on the location of the duplication
- Pathogenic variant by sequence analysis
  - Predictive of hemophilia A disease in males and carrier status in females
  - Variants detected by sequencing may result in mild, moderate, or severe disease
- Negative – does not rule out hemophilia A due to the possibility of an undetectable variant in the F8 gene
- Uncertain – sequencing may reveal novel variant(s)
  - Determination of clinical significance (benign or pathogenic) may not be possible

Limitations
- Breakpoints of large F8 deletions/duplications will not be determined
- F8 deep intronic or promoter variants, with the exception of the common intron 1 and 22A inversions, will not be detected
- Rare diagnostic errors may occur due to primer- or probe-site variants
- Deletions/duplications in exon 23 will not be detected

Reference


© 2013 ARUP LABORATORIES | Content review August 2015 | Update September 2018