KIT Molecular Testing

Molecular testing for KIT mutations is relevant for various types of cancer and can provide diagnostic, prognostic, and predictive information for systemic mastocytosis (SM), gastrointestinal stromal tumors (GIST), melanoma, and acute myeloid leukemia (AML) associated with inv(16) or t(8;21), also known as core-binding factor (CBF) AML. For GIST and melanoma, PDGFRA testing is also often relevant.

Disease Overview

Core-Binding Factor Acute Myeloid Leukemia

- KIT mutation testing is important for prognostication
- KIT mutations are associated with higher incidence of relapse and lower survival
- KIT mutations may be detected in:
  - inv(16) or t(16;16) AML
  - t(8;21) AML

Mastocytosis

KIT mutation testing is important for:

- Diagnosis (presence of mutation is a minor criteria for SM)
- Prediction of response to targeted therapy

Gastrointestinal Stromal Tumors

- KIT and PDGFRA mutation testing is important for prediction of response to targeted therapy and should be performed in all patients considered for targeted therapy
- Mutation presence and type determine if the patient will benefit from targeted therapy
- Detection of secondary resistance mutations in patient already treated with targeted therapy may guide the use of other therapeutic agents
- Mutation testing may be occasionally used to aid in establishing GIST diagnosis in difficult cases (unusual location, morphology, or immunoprofile)
- Immunohistochemistry for c-kit (CD117) is useful for diagnostic purposes but should not be used to predict response to targeted therapy

Melanoma

- KIT mutation testing is important for prediction of response to targeted therapy
- Immunohistochemistry for c-kit (CD117) should not be used to predict response to targeted therapy

Genetics

Gene

KIT

Tests to Consider

KIT Mutations in AML by Fragment Analysis and Sequencing 2002437
Method: Polymerase Chain Reaction/Fragment Analysis/Sequencing

Prognostication in CBF AML

KIT (D816V) Mutation by ddPCR, Quantitative 3002956
Method: Droplet Digital Polymerase Chain Reaction

- Aids in the diagnosis of mastocytosis in peripheral blood and bone marrow specimens
- The D816V mutation is a diagnostic marker for systemic mastocytosis
- The D816V mutation confers resistance to imatinib

Gastrointestinal Stromal Tumor Mutation 2002674
Method: Massively Parallel Sequencing

- Detects activating mutations in KIT and PDGFRA
- Predicts response to targeted therapy

KIT Mutations, Melanoma 2002695
Method: Massively Parallel Sequencing

- Detects activating mutations in KIT and PDGFRA
- Predicts response to targeted therapy

Related Tests

Myeloid Malignancies Mutation Panel by Next Generation Sequencing 2011117
Method: Massively Parallel Sequencing

- Assesses for multiple gene mutations, including substitutions and smaller insertions and deletions that may have prognostic and/or therapeutic significance

Acute Myeloid Leukemia Panel by FISH 2011132
Method: Fluorescence in situ Hybridization (FISH)

- Identifies prognostically important abnormalities in newly diagnosed AML
Structure/Function

- Maps to 4q12
- Receptor tyrosine kinase (type III)
- Important in hematopoiesis for regulation of cell proliferation and maturation

Mutations

A variety of >500 mutations have been described, most commonly in juxtamembrane region (exon 11), extracellular region (exons 8, 9), and kinase domain (exons 13, 17). These mutations are commonly detected in patients with:

- CBF AML
  - Detected in ~20% of AML with KIT mutations, including inv(16)
  - Detected in 20-25% of AML with t(8;21) (particularly the D816V mutation)
- Mastocytosis
  - Adults
    - D816V mutation detected in 95% of patients with SM
    - Rare juxtamembrane mutations
  - Children
    - D816V mutation detected in 30-40% of patients with SM
    - ~40% carry KIT mutations that reside outside exon 17 (mainly exons 8 and 9)
  - Mutations other than D816V may be detected in SM-associated hematologic neoplasm (AHN)
- GIST
  - KIT mutations present in ~85% of cases
    - Primary mutations most common in exon 11 (~70% of cases) and exon 9 (~10-15% of cases); much less common in other exons
    - Secondary resistance mutations occur in exons 13, 14, 17, and 18
  - PDGFRα mutations present in ~5% of cases
    - Primary mutations most common in exon 18 (~5% of cases)
    - Primary mutations much less common in other exons
- Melanoma
  - KIT mutations present in 2.8% of cases overall (more common in mucosal and acral melanomas)
  - Most common in:
    - Exon 11 (70% of KIT mutated cases)
    - Exon 13 (20% of KIT mutated cases)
  - Much less common in other exons

Test Interpretation

KIT Mutations in AML by Fragment Analysis and Sequencing

Analytical Sensitivity

Detected mutations in:

- Exon 17 in specimens with at least 30% AML cells harboring the mutation
- Exon 8 in specimens with at least 5% AML cells harboring the mutation

Results

- Detected: KIT exon 8 or 17 mutation
  - Associated with less favorable outcome in CBF AML
TKIs may be useful in conjunction with standard chemotherapy
Not detected: no detectable mutation in KIT exon 8 or 17

Limitations
Not intended to detect minimal residual disease
Mutations outside of exons 8 and 17 are not detected
Mutations below analytical sensitivity will not be detected

KIT (D816V) Mutation by ddPCR, Quantitative

Sensitivity
Clinical: occurs in >80% of SM cases
Analytical: 0.03% variant allele frequency (VAF)

Results
Detected VAF: KIT (D816V) point mutation; allele specific amplification of the c.2447 C>T (D816V)
Results are reported as a percent mutated allele
Supports a diagnosis of SM or SM-associated clonal hematologic nonmast cell lineage disease (SM-AHNMD) in the correct clinical context
Therapeutic implications
Imatinib: ineffective if mutation is present
Dasatinib and Nilotinib: uncertain clinical efficacy
Not detected: no detectable KIT (D816V) point mutation

Limitations
Mutations other than the D816V mutation are not detected, including other D816 variants
Mutations below analytical sensitivity will not be detected

Gastrointestinal Stromal Tumor Mutations and KIT Mutations, Melanoma

<table>
<thead>
<tr>
<th>Variant Class</th>
<th>No. Variant Tested</th>
<th>Positive Percent Agreement (PPA)</th>
<th>PPA, 95% Tolerance at 95% Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNV</td>
<td>177</td>
<td>100%</td>
<td>98.9-100.0%</td>
</tr>
<tr>
<td>MNVs</td>
<td>42</td>
<td>95%</td>
<td>85.6-99.0%</td>
</tr>
<tr>
<td>Small insertions and duplicationsa</td>
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<tr>
<td>Medium insertions and duplicationsb</td>
<td>10</td>
<td>100%</td>
<td>82.9-100.0%</td>
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<tr>
<td>Large insertionsc</td>
<td>1</td>
<td>100%</td>
<td>22.9%-100.0%</td>
</tr>
<tr>
<td>Small deletionsa</td>
<td>80</td>
<td>100%</td>
<td>97.6-100.0%</td>
</tr>
<tr>
<td>Medium deletionsb</td>
<td>14</td>
<td>100%</td>
<td>71.2%-99.2%</td>
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</table>

a≤21 bp
b22-60 bp
c≥61 bp and ≤64bp
d≥61 bp and ≤13547bp
bp, base pair; MNVs, multiple nucleotide variants; SNV, single nucleotide variant
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</tr>
</thead>
<tbody>
<tr>
<td>Large deletions&lt;sup&gt;d&lt;/sup&gt;</td>
<td>22</td>
<td>64%</td>
<td>42.9%-81.1%</td>
</tr>
</tbody>
</table>

<sup>a</sup><sub>&le;21 bp</sub>
<sup>b</sup><sub>22-60 bp</sub>
<sup>c</sup><sub>&le;61 bp and &le;64bp</sub>
<sup>d</sup><sub>&ge;61 bp and &le;13547bp</sub>

bp, base pair; MNVs, multiple nucleotide variants; SNV, single nucleotide variant

Results

- Detected: KIT mutation detected in exons 9, 11, 13, 14, 17, 18
- Detected: PDGFRA mutation detected in exons 12, 14, 18
- Not detected: no mutations detected in KIT and PDGFRA

Limitations

- Mutations outside of targeted exons are not detected
- Test alone cannot be used for diagnosis of malignancy
- Variants below the limit of detection (LOD) of 5% VAF may not be detected
- 10 ng input DNA from extracted tissue sample is minimally required, but 50 ng input DNA is recommended for optimal results
- Large variants (>60bp) may not be detected
- Not intended to detect minimal residual disease
- Does not distinguish between somatic and germline variants

References


Additional Resources


