

## Exome Sequencing

An exome is comprised of ~19,000 genes of known and unknown function. This test entails reanalysis of exome sequencing data from a patient with a suspected genetic disorder to identify the causative variant(s). Submission of control samples from the patient's parents and up to two additional family members believed to be affected with the same condition is encouraged to aid result interpretation.

### Test Overview

Parental specimens are necessary to identify de novo variants and the chromosomal phase of variants and to optimally interpret patient results.

- The exome accounts for 1-2% of the human genome but harbors ~85% of pathogenic variants.
- The function of only ~4,500 genes is currently known.
- Exome sequencing may or may not
  - Determine etiology of patient's medical condition
  - Predict prognosis or severity
  - Guide medical management

### Information Required for Testing

- Completed [Informed Consent for Exome Sequencing](#) form for patient and parents
- Completed [Patient History for Exome Sequencing](#) form for proband and parents
- Three-generation medical pedigree
- Results of genomic microarray, magnetic resonance imaging (MRI) and other relevant tests
- Summary notes from genetic and specialist consultations

## TEST DESCRIPTION

### Clinical Sensitivity

Unpublished internal data

- ~20% when only the proband is sequenced and one or both parental samples are unavailable
- ~35% when only performing targeted sequencing of parental samples based on variants identified by sequencing the proband's exome
- ~45% when the proband and both parents undergo exome sequencing

### Reporting

- Tens of thousands of genetic variants are identified.
  - Variants may be pathogenic, benign, or of unknown clinical significance.
  - American College of Medical Genetics (ACMG) recommends reporting secondary findings in genes not associated with the patient's clinical phenotype. (See [table below](#).)
- Only the following variants are reported:
  - Those predicted to be related to the patient's phenotype
  - De novo and rare compound heterozygous variants in genes of unknown function, if a causative variant is not identified that explains the patient's medical condition
  - Pathogenic variants in genes recommended by ACMG, or other medically actionable incidental variants in non-ACMG genes if elected on the consent form

### Tests to Consider

#### [Exome Sequencing, Trio 2006332](#)

Method: Massively Parallel Sequencing

#### [Exome Sequencing, Familial Control 2006340](#)

Method: Massively Parallel Sequencing

- Exome Sequencing, Trio is the preferred test to diagnose an individual with an unknown Mendelian condition.
- Order control test on patient's parents and up to two additional relatives who are affected with the same condition as the patient. It is performed at no additional cost and increases the detection rate.

#### [Exome Sequencing, Proband 2006336](#)

Method: Massively Parallel Sequencing

#### [Exome Control, Targeted Sequencing 3001114](#)

Method: Massively Parallel Sequencing

- For individuals with a suspected but undiagnosed genetic condition
- Recommended only when obtaining samples from both biological parents is not possible
- Order control test on patient's parents and up to two additional relatives who are affected with the same condition as the patient. It is performed at no additional cost and increases the detection rate.

### Additional Methodology

- Short tandem repeats (STRs) used to confirm familial relationships
- Liquid RNA- or DNA-based probes capture exons and intron/exon junctions of known protein-coding RefSeq genes
- Human reference sequence (Hg19) used for variant identification
- Variants confirmed by Sanger sequencing as needed
- Additional testing, such as X-chromosome inactivation, may be performed to aid variant interpretation

### Related Test

#### [Exome Reanalysis \(Originally Tested at ARUP - No Specimen Required\) 3001457](#)

Method: Bioinformatic Processing and Variant Analysis

- Order on proband when original exome analysis was unable to identify a cause for



- Single disease-causing variants in autosomal recessive ACMG genes are not reported.
- Family members undergoing exome sequencing who complete a consent form requesting ACMG variants will receive a separate report describing pathogenic secondary findings.
- Results are reported in 4-8 weeks.

the patient's condition.

- First reanalysis performed at no charge; additional charges apply for subsequent reanalysis requests.
- New clinical report will be issued using current variant calling pipeline, variant classification, genotype/phenotype knowledge, and updated clinical phenotype.

## Interpretation/Storage/Reanalysis/Data Sharing

- Accurate representation of biological relationships between family members is imperative for correct test interpretation.
- Test interpretation is based on information available at the time of testing and may change in the future.
- Exome sequencing data will be stored for a minimum of 5 years in compliance with ARUP's data retention policy, but many samples are discarded after testing is complete.
- Samples may be stored indefinitely for test validation or education purposes after personal identifiers are removed. All New York samples are discarded 60 days following test completion. Patients may request disposal of their sample by calling ARUP Laboratories at (800) 242-2787 x3301.
- The first request for data reanalysis is available at no cost; subsequent reanalysis requests will be associated with charges.
- De-identified information about genetic variants and clinical findings may be published in international databases unless declined on consent form.
- Patients may also contact ARUP Laboratories at (800) 242-2787, ext. 3301, and request that their test result not be shared with public databases.
- Patients have the opportunity to participate in patient registries and research. For more information, see [www.aruplab.com/genetics/resources](http://www.aruplab.com/genetics/resources).
- Raw exome sequencing data may be requested by the ordering healthcare provider and hospital that submitted the test to ARUP.

## Limitations

- A negative result does not exclude a genetic cause for the patient's disorder.
- Diagnostic errors can occur due to rare sequence variations.
- Result interpretation may be impacted if this individual has had an allogeneic stem cell transplantation.
- The human exome is not able to be completely analyzed as some genes have not been identified while others, due to technical limitations, cannot either be sequenced or interpreted.
- The following will not be evaluated:
  - Variants outside the coding regions and intron-exon boundaries
  - Large deletions/duplications
  - Mitochondrial DNA (mtDNA)
- The following may not be detected:
  - Deletions/duplications/insertions of any size by massively parallel sequencing
  - Some variants due to the presence of pseudogenes, repetitive, or homologous regions
  - Low-level somatic variants
  - Chromosomal phase of identified variants
  - Pathogenic ACMG variants that cannot be detected by routine exome analysis

## Analytical Sensitivity

The analytical sensitivity of this test is approximately 98% for single nucleotide variants (SNVs) and greater than 93% for insertions/duplications/deletions from 1-10 base pairs in size. Deletions/duplication greater than 10 base pairs may be detected, but the analytical sensitivity may be reduced.

### ACMG Recommends Reporting Secondary Findings for These Genes<sup>1</sup>

Conditions	Associated Genes
Tumors/cancer syndromes	Familial adenomatous polyposis <i>APC</i>
	Familial medullary thyroid cancer Multiple endocrine neoplasia type 2 <i>RET</i>
	Hereditary breast and ovarian cancer <i>BRCA1, BRCA2</i>



Conditions	Associated Genes
Hereditary paraganglioma/pheochromocytoma	<i>SDHD, SDHAF2, SDHC, SDHB</i>
Juvenile polyposis	<i>BMPR1A, SMAD4</i>
Li-Fraumeni syndrome	<i>TP53</i>
Lynch syndrome	<i>MLH1, MSH2, MSH6, PMS2</i>
Multiple endocrine neoplasia type 1	<i>MEN1</i>
<i>MUTYH</i> -associated polyposis	<i>MUTYH</i>
Neurofibromatosis type 2	<i>NF2</i>
Peutz-Jeghers syndrome	<i>STK11</i>
<i>PTEN</i> hamartoma tumor syndrome	<i>PTEN</i>
Retinoblastoma	<i>RB1</i>
Tuberous sclerosis complex	<i>TSC1, TSC2</i>
Von Hippel-Lindau syndrome	<i>VHL</i>
<i>WT1</i> -related Wilms tumor	<i>WT1</i>
<b>Cardiovascular conditions/syndromes</b>	
Arrhythmogenic right-ventricular cardiomyopathy	<i>PKP2, DSP, DSC2, TMEM43, DSG2</i>
Brugada syndrome	<i>KCNQ1, KCNH2, SCN5A</i>
Romano-Ward long QT syndrome types 1, 2, and 3	
Catecholaminergic polymorphic ventricular tachycardia	<i>RYR2</i>
Ehlers-Danlos syndrome, vascular type	<i>COL3A1</i>
Familial hypercholesterolemia	<i>LDLR, APOB, PCSK9</i>
Familial thoracic aortic aneurysms and dissections	<i>SMAD3, ACTA2, MYLK, MYH11</i>
Hypertrophic cardiomyopathy, dilated cardiomyopathy	<i>MYBPC3, MYH7, TNNT2, TNNI3, TPM1, MYL3, ACTC1, PRKAG2, GLA, MYL2, LMNA</i>
Loeys-Dietz	<i>TGFBR1, TGFB2</i>
Marfan syndrome	<i>FBN1</i>
<b>Other conditions</b>	
Malignant hyperthermia susceptibility	<i>RYR1, CACNA1S</i>
Ornithine transcarbamylase deficiency	<i>OTC</i>



Conditions	Associated Genes
Wilson disease	<i>ATP7B</i>

## References

1. Kalia SS, Adelman K, Bale SJ, et al. [Recommendations for reporting of secondary findings in clinical exome and genome sequencing, 2016 update \(ACMG SF v2.0\): a policy statement of the American College of Medical Genetics and Genomics](#) [published correction appears in Genet Med. 2017 Apr;19(4):484]. Genet Med. 2017;19(2):249-255. PubMed
2. Farwell KD, Shahmirzadi L, El-Khechen D, et al. [Enhanced utility of family-centered diagnostic exome sequencing with inheritance model-based analysis: results from 500 unselected families with undiagnosed genetic conditions](#). Genet Med. 2015;17(7):578-586. PubMed

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