

Test Description

The MolQ Germline Cancer Predisposition Panel include genes associated with both common and rare hereditary cancers.

Patient Demographic

Name: Ms. Kratika Singh
Sex: Female
Date of Birth/Age: 33 years
Disease: Asymptomatic

Clinician

Clinician Name: Dr Amit Verma
Medical Facility: Dr AV Institute of Personalized Cancer Therapy and Research
Pathologist: Not Provided

Specimen

Booking ID: 012208150021
Sample Type: Blood
Date of Collection: 15-08-2022
Date of Booking: 15-08-2022

CLINICAL SYNOPSIS

Kratika Singh, has a family history of cancer with her mother diagnosed with carcinoma breast at the age of 40 years and succumbed to it. She has been evaluated for pathogenic variations in the genes listed in Appendix 2.

RESULTS

Variant of Uncertain Significance related to the given phenotype were detected.

Gene (Transcript)#	Location	Variant	Zygoty	Disease (OMIM/Ref)	Inheritance	Classification [§]
<i>MRE11</i> (-) (ENST00000323929.8)	Exon 12	c.1268A>G (p.Glu423Gly)	Heterozygous	[†] Breast cancer	-	Uncertain Significance
<i>RECQL</i> (-) (ENST00000444129.7)	Exon 11	c.1220G>A (p.Arg407Gln)	Heterozygous	[†] Breast cancer	-	Uncertain Significance

[§]Genetic test results are reported based on the recommendations of American College of Medical Genetics.¹

CLINICAL CORRELATION AND VARIANT INTERPRETATION

***MRE11* p.Glu423Gly**
Overall depth: 149X

Variant description: A heterozygous missense variation in exon 12 of the *MRE11* gene (**chr11:g.94460994T>C; Depth: 149x**) that results in the amino acid substitution of Glycine for Glutamic Acid at codon 423 (p.Glu423Gly; ENST00000323929.8) was detected (Table). The observed variation lies in the *Mre11* DNA-binding presumed domain of the MRE11_HUMAN protein². The **p.Glu423Gly** variant has not been reported in the 1000 genomes, gnomAD and reference laboratory internal databases. The *in silico* predictions[#] of the variant are possibly damaging by PolyPhen-2 (HumDiv) and damaging by LRT tools. The reference codon is conserved in mammals.

[†]**Phenotype:** Germline deleterious mutations in the *MRE11/MRE11A* gene have been reported in breast and/or ovarian cancer patients³⁻⁵.

Based on the above evidence[§], **this *MRE11* variation is classified as a variant of uncertain significance and has to be carefully correlated with the clinical symptoms.**

RECQL p.Arg407Gln
Overall depth: 240X

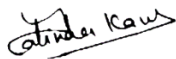
Variant description: heterozygous missense variation in exon 11 of the *RECQL* gene (**chr12:g.21474976C>T; Depth: 240x**) that results in the amino acid substitution of Glutamine for Arginine at codon 407 (**p.Arg407Gln; ENST00000444129.7**) was detected (Table). It lies in the helicase conserved C-terminal domain of the RECQ1_HUMAN protein⁶. It is documented as variant of uncertain significance in the ClinVar database [VCV001312580.3]⁷. The **p.Arg407Gln** variant has not been reported in the 1000 genomes, gnomAD and has a minor allele frequency of 0.001% in reference laboratory internal database. The *in silico* predictions[#] of the variant are damaging by PolyPhen-2 (HumDiv) and damaging by SIFT, LRT and Mutation Taster2 tools. The reference codon is conserved across mammals.

†Phenotype: Germline variations in the *RECQL* gene have been reported in breast cancer patients⁸⁻¹⁰.

Based on the above evidence^{\$}, **this RECQL variation is classified as a variant of uncertain significance and has to be carefully correlated with the clinical symptoms.**

RECOMMENDATIONS

- The *MRE11* gene has a pseudogene in the human genome. Validation of the variant(s) by Sanger sequencing is recommended to rule out false positives.
- **Sequencing the variant(s) in the other affected and unaffected members of the family is recommended to confirm the significance.**
- Genetic counselling is advised for interpretation on the consequences of the variant(s).
- If results obtained do not match the clinical findings, additional testing should be considered as per referring clinician's recommendations.



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APPENDIX 1: TEST METHODOLOGY

Method

Targeted gene sequencing: Selective capture and sequencing of the protein coding regions of the genome/genes is performed. Mutations identified in the exonic regions are generally actionable compared to variations that occur in non-coding regions. Targeted sequencing represents a cost-effective approach to detect variants present in multiple/large genes in an individual. In this comprehensive hereditary cancer panel, in addition to complete Coding segment (CDS) of 143 genes, promoter regions of relevant genes and critical other non-coding / coding pathogenic variants <100 bp documented in the ClinVar, HGMD, BRCA Exchange and LOVD databases mapping to the targeted genes are also included¹⁻⁴. Additionally, there is an enhanced CNV coverage for better detection of CNVs. This panel provides a comprehensive and robust approach to identify SNV's, Indels and CNVs through single test.

DNA extracted from sample was used to perform targeted gene capture using a custom capture kit. The libraries were sequenced to mean >80- 100X coverage on Illumina sequencing platform. We follow the GATK best practices framework for identification of variants in the sample using Sentieon (v201808.07)⁵. The sequences obtained are aligned to human reference genome (GRCh38.p13) using Sentieon aligner^{5,6} and analyzed using Sentieon for removing duplicates, recalibration and realignment of indels. Sentieon haplotype caller has been used to identify variants which are relevant to the clinical indication. Gene annotation of the variants is performed using VEP program⁷ against the Ensemble release 99 human gene model⁸. Copy number variants (CNVs) are detected from targeted sequence data using the ExomeDepth (v1.1.10) method, a coverage based approach⁹. This algorithm detects rare CNVs based on comparison of the read-depths of the test data with the matched aggregate reference dataset and the overall sensitivity of CNV surveillance through ExomeDepth was found to be 97%¹⁰. In reference laboratory internal validation experiments on MLPA verified samples, >80-90% sensitivity was achieved for detecting CNVs .

Clinically relevant mutations were annotated using published variants in literature and a set of diseases databases - ClinVar, OMIM (updated on 11th May 2020), GWAS, HGMD (v2020.2), LOVD, BRCA Exchange and SwissVar^{1-4, 11-13}. Common variants are filtered based on allele frequency in 1000Genome Phase 3, gnomAD (v3.1), EVS, dbSNP (v151), 1000 Japanese Genome and reference laboratory internal Indian population database¹⁴⁻¹⁸. Non-synonymous variants effect is calculated using multiple algorithms such as PolyPhen-2, SIFT, MutationTaster2 and LRT. Only non-synonymous, splice site and critical non-coding variants found in the hereditary cancer panel genes were used for clinical interpretation. Silent variations that do not result in any change in amino acid in the coding region are not reported.

Total data generated (Gb)	0.6568
Total reads aligned (%)	99.99
Reads that passed alignment (%)	88.78
Data ≥ Q30 (%)	96.82

*The classification of the variations is done based on American College of Medical Genetics as described below¹⁹

Variant	A change in a gene. This could be disease causing (pathogenic) or not disease causing (benign).
Pathogenic	A disease causing variation in a gene which can explain the patient's symptoms has been detected. This usually means that a suspected disorder for which testing had been requested has been confirmed.
Likely Pathogenic	A variant which is very likely to contribute to the development of disease however, the scientific evidence is currently insufficient to prove this conclusively. Additional evidence is expected to confirm this assertion of pathogenicity.
Variant of Uncertain Significance	A variant has been detected, but it is difficult to classify it as either pathogenic (disease causing) or benign (non-disease causing) based on current available scientific evidence. Further testing of the patient or family members as recommended by your clinician may be needed. It is probable that their significance can be assessed only with time, subject to availability of scientific evidence.

#The transcript used for clinical reporting generally represents the canonical transcript, which is usually the longest coding transcript with strong/multiple supporting evidence. However, clinically relevant variants annotated in alternate complete coding transcripts could also be reported.

Variants annotated on incomplete and nonsense mediated decay transcripts will not be reported.

#The *in-silico* predictions are based on Variant Effect Predictor, Ensembl release 99 (SIFT version - 5.2.2; PolyPhen - 2.2.2); bdNSFPv4.0 (LRT version - December 5, 2019) and Mutation Taster2 (MT2). MutationTaster2 predictions are based on NCBI/Ensembl 66 build (GRCh38 genomic coordinates are converted to hg19 using UCSC LiftOver and mapped to MT2).

For any further technical queries please contact contact@molq.in.

DISCLAIMER

- Interpretation of variants in this report is performed to the best knowledge of the laboratory based on the information available at the time of reporting. The classification of variants can change over time and MolQ cannot be held responsible for this. Please feel free to contact MolQ Laboratory (contact@molq.in) in the future to determine if there have been any changes in the classification of any variations. Re-analysis of variants in previously issued reports in light of new evidence is not routinely performed, but may be considered upon request, provided the variant is covered in the current panel.
- The sensitivity of this assay to detect large deletions/duplications of more than 10 bp or copy number variations (CNV) is 80-90%. The CNVs detected have to be confirmed by alternate method.
- Due to inherent technology limitations of the assay, not all bases of the exome can be covered by this test. Accordingly, variants in regions of insufficient coverage may not be identified and/or interpreted. Therefore, it is possible that certain variants are present in one or more of the genes analyzed, but have not been detected. The variants not detected by the assay that was performed may/ may not impact the phenotype.
- It is also possible that a pathogenic variant is present in a gene that was not selected for analysis and/or interpretation in cases where insufficient phenotypic information is available.
- Genes with pseudogenes, paralog genes and genes with low complexity may have decreased sensitivity and specificity of variant detection and interpretation due to inability of the data and analysis tools to unambiguously determine the origin of the sequence data in such regions.
- The mutations have not been validated/confirmed by Sanger sequencing.
- Incidental or secondary findings (if any) that meet the ACMG guidelines²⁰ can be given upon request.
- The report shall be generated within turnaround time (TAT), however, such TAT may vary depending upon the complexity of test(s) requested. MolQ Laboratory under no circumstances will be liable for any delay beyond afore mentioned TAT.
- It is hereby clarified that the report(s) generated from the test(s) do not provide any diagnosis or opinion or recommends any cure in any manner. MolQ Laboratory hereby recommends the patient and/or the guardians of the patients, as the case may be, to take assistance of the clinician or a certified physician or doctor, to interpret the report(s) thus generated. MolQ Laboratory hereby disclaims all liability arising in connection with the report(s).
- In a very few cases genetic test may not show the correct results, e.g. because of the quality of the material provided to MolQ Laboratory. In case where any test provided by MolQ Laboratory fails for unforeseeable or unknown reasons that cannot be influenced by MolQ Laboratory in advance, MolQ Laboratory shall not be responsible for the incomplete, potentially misleading or even wrong result of any testing if such could not be recognized by MolQ Laboratory in advance.
- This is a laboratory developed test and the development and the performance characteristics of this test was determined by reference laboratory.

LIMITATIONS

- Genetic testing is an important part of the diagnostic process. However, genetic tests may not always give a definitive answer. In some cases, testing may not identify a genetic variant even though one exists. This may be due to limitations in current medical knowledge or testing technology. Accurate interpretation of test results may require knowing the true biological relationships in a family. Failing to accurately state the biological relationships in {my/my child's} family may result in incorrect interpretation of results, incorrect diagnoses, and/or inconclusive test results.
- Test results are interpreted in the context of clinical findings, family history and other laboratory data. Only variations in genes potentially related to the proband's medical condition are reported. Rare polymorphisms may lead to false negative or positive results. Misinterpretation of results may occur if the information provided is inaccurate or incomplete.
- Structural variants such as deletions/duplications (CNVs) reported through NGS assay needs to be confirmed by orthogonal method to rule out the possibility of false positives. Translocations, repeat expansions and chromosomal rearrangements are not detected through this assay.
- Genetic testing is highly accurate. Rarely, inaccurate results may occur for various reasons. These reasons include, but are not limited to mislabelled samples, inaccurate reporting of clinical/medical information, rare technical errors or unusual circumstances such as bone marrow transplantation, blood transfusion; or the presence of change(s) in such a small percentage of cells that may not be detectable by the test (mosaicism).
- The variant population allele frequencies and *in silico* predictions for GRCh38 version of the Human genome is obtained after lifting over the coordinates from hg19 genome build. The existing population allele frequencies (1000Genome, gnomAD-Exome) are currently available for hg19 genome version only. This might result in some discrepancies in variant annotation due to the complex changes in some regions of the genome.

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APPENDIX 2: GENE LIST WITH COVERAGE^

Gene	Percentage of coding region covered	Gene	Percentage of coding region covered	Gene	Percentage of coding region covered
ABRAXAS1	100.00	AIP	100.00	ALK	100.00
APC*	100.00	AR	100.00	ATM	100.00
AXIN2	100.00	BAP1	100.00	BARD1	100.00
BLM	100.00	BMPR1A	100.00	BRCA1	100.00
BRCA2	100.00	BRIP1	100.00	BUB1B	100.00
CBL	100.00	CD82	100.00	CDC73	100.00
CDH1	100.00	CDK12	100.00	CDK4	100.00
CDKN1B	100.00	CDKN1C	100.00	CDKN2A	100.00
CEBPA	100.00	CEP57	100.00	CHEK1	100.00
CHEK2	100.00	CTNNA1	100.00	CYLD	100.00
DDB2	100.00	DICER1	100.00	DIS3L2	100.00
EGFR	100.00	ELAC2	100.00	ENG	100.00
EPCAM	100.00	ERCC2	100.00	ERCC3	100.00
ERCC4	100.00	ERCC5	100.00	EXT1	100.00
EXT2	100.00	EZH2	100.00	FAN1	100.00
FANCA	100.00	FANCB	100.00	FANCC	100.00
FANCD2	100.00	FANCE	100.00	FANCF	100.00
FANCG	100.00	FANCI	100.00	FANCL	100.00
FANCM	100.00	FH	100.00	FLCN	100.00
GALNT12	100.00	GATA2	100.00	GPC3	100.00
HOXB13	100.00	HRAS	100.00	KIF1B	100.00
KIT	100.00	LZTR1	100.00	MAX	100.00
MEN1	100.00	MET	100.00	MITF	100.00
MLH1	100.00	MLH3	100.00	MRE11	100.00
MSH2	100.00	MSH3	100.00	MSH6	100.00
MSR1	100.00	MUTYH	100.00	MXI1	100.00
NBN	100.00	NF1	100.00	NF2	100.00
NSD1	100.00	NTHL1	100.00	PALB2	100.00
PALLD	100.00	PAX5	100.00	PDGFRA	100.00
PHOX2B	100.00	PMS1	100.00	PMS2	94.60
POLD1	100.00	POLE	100.00	POT1	100.00
PPP2R2A	100.00	PRF1	100.00	PRKAR1A	100.00
PRSS1	100.00	PTCH1	100.00	PTCH2	100.00
PTEN	100.00	RAD50	100.00	RAD51B	100.00
RAD51C	100.00	RAD51D	100.00	RAD54L	100.00
RB1	100.00	RECQL	100.00	RECQL4	100.00
RET	100.00	RHBDF2	100.00	RINT1	100.00
RNASEL	100.00	RNF43	100.00	RUNX1	100.00
SBDS	100.00	SDHA	100.00	SDHAF2	100.00
SDHB	100.00	SDHC	100.00	SDHD	100.00
SLC45A2	100.00	SLX4	100.00	SMAD4	100.00
SMARCA4	100.00	SMARCB1	100.00	SMARCE1	100.00
SRGAP1	100.00	STK11	100.00	SUFU	100.00
TERT*	100.00	TGFBR2	100.00	TMEM127	100.00
TP53	100.00	TSC1	100.00	TSC2	100.00

<i>TYR</i>	100.00	<i>VHL</i>	100.00	<i>WRN</i>	100.00
<i>WT1</i>	100.00	<i>XPA</i>	100.00	<i>XPC</i>	100.00
<i>XRCC1</i>	100.00	<i>XRCC3</i>	100.00		

* Promoter regions of these genes are also analyzed. ^ In addition to complete CDS coverage in these genes, critical non-coding variants reported as pathogenic in clinical databases are also analyzed in this assay.