Trifunctional Protein Deficiency: \textit{HADHA} & \textit{HADHB} Gene Deletion/Duplication

\textbf{Test Code: GE}  
\textbf{Turnaround time: 2 weeks}  
\textbf{CPT Codes: 81228 x1}

\section*{Condition Description}

Trifunctional protein (TFP) deficiency is an autosomal recessive disorder of fatty acid oxidation \cite{1-2}. Clinical presentation is variable, with three major presentations described. Newborns with the early-onset form can present with poor feeding, severe dilated cardiomyopathy, lactic acidosis, and Reye syndrome-like symptoms of hypoketotic hypoglycemia. A hepatic phenotype is described also in infancy with recurrent hypoketotic hypoglycemia. Patients can also present in the first months of life with recurrent hypoketotic hypoglycemia and lethargy during illness or periods of fasting. In addition, a later onset neuromyopathic form is described in individuals with a later-onset, progressive peripheral neuropathy, muscle weakness, episodic myoglobinuria and high plasma CK concentrations. Developmental delay may be associated with a history of acute metabolic decompensation. A maternal presentation has been reported in women carrying a fetus with TFP deficiency characterized as either HELLP syndrome (hypertension, elevated liver enzymes, low platelets) and AFLP syndrome (acute fatty liver of pregnancy).

TFP is a multi-enzyme complex composed of four alpha-subunits (HADHA), which contains the long-chain 2-enoyl-CoA hydratase and the long-chain L-3-hydroxyacyl-CoA dehydrogenase (LCHAD) domains, and four beta-subunits (HADHB), which contains the long-chain 3-ketoacyl-CoA thiolase (LKT) domain \cite{3-4}. Deficiency of these enzymes can result in diseases of the TFP complex with overlapping clinical symptoms: either the general TFP deficiency (described above) or isolated LCHAD deficiency (LCHADD). General TFP deficiency is defined by reduced activity of all three TFP enzymes. Isolated LCHAD deficiency is defined by reduced LCHAD activity resulting in accumulation of long-chain 3-hydroxy-fatty acids. The other two TFP enzymes might also be affected in LCHADD, but their activities are usually greater than 60% of normal (refer to the LCHAD test description for testing for LCHAD).

The TFP alpha- and beta-subunits are encoded by \textit{HADHA} and \textit{HADHB}, respectively, and genes both located in 2p23 \cite{5}. An isolated LCHAD presentation is associated with the common alpha-subunit mutation 1528G>C (E474Q) that is located directly within the catalytic region of the LCHAD domain, though other genotype-phenotype correlations are limited \cite{7-8}. TFP deficiency due to alpha-subunit mutations has been described more often than cases due to beta-subunit mutations \cite{6}. Gene sequencing is available to test for mutations in the \textit{HADHA} and \textit{HADHB} genes (FZ). For patients with mutations not identified by full gene sequencing, a separate deletion/duplication assay is available using a targeted CGH array (GE).

\textbf{References:}


\section*{Genes}

\textbf{HADHA}, \textbf{HADHB}

\section*{Indications}

This test is indicated for:

- Confirmation of a clinical/biochemical diagnosis of TFP deficiency.
- Carrier testing in adults with a family history of TFP deficiency.

\section*{Methodology}

DNA isolated from peripheral blood is hybridized to a CGH array to detect deletions and duplications. The targeted CGH array has overlapping probes which cover the entire genomic region. Please note that a “backbone” of probes across the entire genome are included on the array for analytical and quality control purposes. Rarely, off-target copy number variants causative of disease may be identified that may or may not be related to the patient’s phenotype. Only known pathogenic off-target copy number variants will be reported. Off-target copy number variants of unknown clinical significance will not be reported.
Detection is limited to duplications and deletions. Array CGH will not detect point mutations or intronic mutations.

Results of molecular analysis must be interpreted in the context of the patient’s clinical and/or biochemical phenotype.

Prevalence: TFP is rare with incidence estimates of 1:250,000 live births [9]. It is inherited in an autosomal recessive manner, therefore the recurrence risk for carrier parents of an affected child is 25%.

**Specimen Requirements**

Submit only 1 of the following specimen types

* Preferred specimen type: Whole Blood

**Type: Whole Blood**

Specimen Requirements:

In EDTA (purple top) tube:
- Infants (2 years): 3-5 ml
- Older Children & Adults: 5-10 ml

Specimen Collection and Shipping: Refrigerate until time of shipment. Ship sample within 5 days of collection at room temperature with overnight delivery.

**Type: Saliva**

Specimen Requirements:

Oragene™ Saliva Collection kit (available through EGL) used according to manufacturer instructions.

Specimen Collection and Shipping: Store sample at room temperature. Ship sample within 5 days of collection at room temperature with overnight delivery.

**Special Instructions**

Please submit copies of diagnostic biochemical test results with the sample. Sequence analysis is required before deletion/duplication analysis by targeted CGH array. If sequencing is performed outside of EGL Genetics, please submit a copy of the sequencing report with the test requisition. Contact the laboratory if further information is needed.

**Related Tests**

- Urine Organic Acids (OA) and Plasma Acylcarnitine Profile (AR) are used in the diagnosis of a patient with TFP deficiency.
- Sequence analysis of the \(HADHA, HADHB\) gene is available and is required before deletion/duplication analysis.
- Prenatal testing is available to couples who are confirmed carriers of mutations. Please contact the laboratory genetic counselor to discuss appropriate testing prior to collecting a prenatal specimen.