Congenital Disorder of Glycosylation, \textit{ATP6V0A2}-related: \textit{ATP6V0A2} Gene Deletion/Duplication

\textbf{Test Code:} DATP6  
\textbf{Turnaround time:} 2 weeks  
\textbf{CPT Codes:} 81228 x1

\section*{Condition Description}

Congenital disorders of glycosylation (CDG) are a group of autosomal recessive genetic disorders caused by the alteration in synthesis and structure of protein and lipid glycosylation. In the past decade, over 30 genetic diseases have been identified that alter glycan synthesis, structure and ultimately the function of nearly all organ systems.

CDG type I (CDGI) disorders result from impaired synthesis of the incomplete lipid linked oligosaccharide (LLO) and/or its attachment to the growing polypeptide chain. CDG-Ia is the most common form reported, due to phosphomannomutase deficiency, an enzyme that converts mannose-6-phosphate to mannose-1-phosphate. CDG-Ib (phosphomannose isomerase, MPI deficiency) is the only known treatable form, by giving mannose orally. CDG type II (CDGII) includes defects in processing of N-glycans.

Phenotypes of this disorder are extremely variable. Manifestations range from severe developmental delay and hypotonia with multiple organ system involvement beginning in infancy, to hypoglycemia and protein-losing enteropathy with normal development. Most subtypes have been described in only a few individuals, however, thus understanding of the phenotypes is limited.

The current diagnostic test for CDG is analysis of serum transferrin glycoforms, also called "transferrin isoforms analysis", or "carbohydrate-deficient transferrin analysis." If positive, this testing can be followed by DNA testing to identify mutations in the gene involved.

Individuals with autosomal recessive cutis laxa (ARCL) type II, or wrinkly skin syndrome, have been shown to have a CDG type II pattern on isofocusing of transferrin. Affected individuals have excessive congenital skin wrinkling, a large fontanelle with delayed closure, a typical facial appearance with downslanting palpebral fissures, connective tissue weakness, and varying degrees of growth and developmental delay and neurological abnormalities. Some individuals develop seizures and mental deterioration later in life, and the skin phenotype tends to become milder with age.

Individuals with ARCL type II have been found to have mutations in the \textit{ATP6V0A2} gene (12q24.3). The protein product of this gene is part of a large ATPase protein complex involved in proton transport. The protein complex is embedded in the membrane of endosomes in a compartment overlapping the trans-Golgi network.

For patients with suspected \textit{ATP6V0A2}-related CDG, sequence analysis is recommended as the first step in mutation identification. For patients in whom mutations are not identified by full gene sequencing, deletion/duplication analysis is appropriate.

\section*{References:}

- OMIM: ATPase, H+ Transporting, Lysosomal, V0 Subunit A2

\section*{Genes}

\textit{ATP6V0A2}

\section*{Indications}

This test is indicated for:

- Confirmation of a clinical/biochemical diagnosis of \textit{ATP6V0A2}-related CDG in an individual in whom sequence analysis was negative
- Carrier testing in adults with a family history of \textit{ATP6V0A2}-related CDG in whom sequence analysis was negative

\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.

Disclaimer: This information is confidential and subject to change without notice. It may not be reproduced in whole or part unless authorized in writing by an authorized EGL representative.
Detection

Detection is limited to duplications and deletions. The CGH array will not detect point or intronic mutations. Results of molecular analysis must be interpreted in the context of the patient's clinical and/or biochemical phenotype.

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

Submit copies of diagnostic biochemical test results with the sample, if appropriate. Contact the laboratory if further information is needed.

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.

Related Tests

- Sequence analysis of the ATP6V0A2 gene is available and is required before deletion/duplication analysis.
- Analysis of other CDG genes is also available.
- Biochemical carbohydrate deficient transferrin analysis for CDGs is also available.
- Custom diagnostic mutation analysis (KM) is available to family members if mutations are identified by targeted mutation testing or sequencing analysis.
- Prenatal testing is available to adult couples who are confirmed carriers of mutations. Please contact the laboratory genetic counselor to discuss appropriate testing prior to collecting a prenatal specimen.