Autosomal Dominant Polycystic Kidney Disease: **PKD2** Gene Deletion/Duplication

**Test Code:** WE  
**Turnaround time:** 2 weeks  
**CPT Codes:** 81228 x1

### Condition Description

Autosomal dominant polycystic kidney disease (ADPKD) is generally a late-onset multisystem disorder characterized by bilateral renal cysts; cysts in other organs including the liver, seminal vesicles, pancreas, and arachnoid membrane; vascular abnormalities including intracranial aneurysms, dilatation of the aortic root, and dissection of the thoracic aorta; mitral valve prolapse; and abdominal wall hernias. Renal manifestations include hypertension, renal pain, and renal insufficiency. Approximately 50% of individuals with ADPKD have end-stage renal disease (ESRD) by age 60 years.

The prevalence of liver cysts, the most common extrarenal manifestation of ADPKD, increases with age and may have been underestimated by ultrasound and CT studies. The prevalence of intracranial aneurysms is higher in those with a positive family history of aneurysms or subarachnoid hemorrhage (22%) than in those without such a family history (6%). Mitral valve prolapse, the most common valvular abnormality, occurs in up to 25% of affected individuals. Substantial variability in severity of renal disease and other extrarenal manifestations occurs even within the same family.

The diagnosis of ADPKD is established primarily by imaging studies of the kidneys. In 85% of individuals with ADPKD, mutations in the **PKD1** gene are causative; in 15%, mutations in the **PKD2** gene (4q21-q23) are causative. Approximately 4% of ADPKD-causing mutations are larger deletions or duplications. About 95% of individuals with ADPKD have an affected parent and about 5% have a de novo mutation. Genetic background and environmental factors account for significant intrafamilial variability in disease severity. **PKD1** mutations are associated with a 20-year earlier onset of ESRD than **PKD2** mutations. In PKD2, males progress to ESRD more rapidly than females; no gender difference is seen in PKD1.

ADPKD is the most common potentially lethal single-gene disorder. Its prevalence at birth is between 1:400 and 1:1,000; and it affects approximately 600,000 persons in the United States.

For patients with suspected ADPKD in whom **PKD1** testing is negative, 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.

Click here for the GeneTests summary on this condition.

### Genes

**PKD2**

### Indications

This test is indicated for:
- Confirmation of a clinical diagnosis of ADPKD in patients with negative **PKD1** testing who have also tested negative for sequence analysis of the **PKD2** gene
- Individuals at-risk for ADPKD due to family history, in whom **PKD1** testing and **PKD2** sequence analysis is negative

### 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

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) or ACD (yellow 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 Emory Genetics Laboratory, please submit a copy of the sequencing report with the test requisition.

Related Tests

- Sequencing analysis of the PKD2 gene is available (WB) and is required before deletion/duplication analysis.
- Prenatal testing is available to individuals who are confirmed carriers of mutations. Please contact the laboratory genetic counselor to discuss appropriate testing prior to collecting a prenatal specimen.