Comprehensive Cardiovascular: Sequencing Panel

Test Code: MCAR1
Turnaround time: 6 weeks
CPT Codes: 81413 x1, 81439 x1

<table>
<thead>
<tr>
<th>Condition Description</th>
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<tr>
<td>Arrhythmias</td>
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<td>Arrhythmia is any change from the normal sequence of electrical impulses of the heart. These impulses may happen too fast (tachycardia), too slowly (bradycardia), or erratically. Types of arrhythmias include atrial fibrillation, conduction disorders, premature contraction, ventricular fibrillation, tachycardia, and bradycardia. Arrhythmias can present with a broad spectrum of symptoms including palpitation, a fluttering sensation, fatigue, dizziness, lightheadedness, syncope, rapid heartbeat, shortness of breath, chest pain, and sudden cardiac arrest.</td>
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<td>Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy</td>
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<td>Arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVD/C) is an autosomal dominant condition characterized by abnormalities in cardiac structure and rhythm. The fibrofatty replacement of myocardium can predispose affected individuals to ventricular tachycardia and sudden death in young individuals and athletes. Common presenting features include heart palpitation, syncope, and death. Other diagnostic criteria include right ventricular dilation and reduction of right ventricular function, and right ventricular aneurysms. The phenotype of ARVD/C is highly variable and while it primarily affects the right ventricle, it may involve the left ventricle as well.</td>
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<td>Brugada Syndrome</td>
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<td>Brugada syndrome is characterized by cardiac conduction abnormalities. These cardiac abnormalities can result in sudden death. Often features such as syncope and/or arrhythmias present in adulthood; however, the age of diagnosis ranges from two days to 85 years. Pathogenic variants in eight genes are known to cause Brugada syndrome. Only 25% of individuals with Brugada syndrome have an identifiable pathogenic variant in one of the eight genes known to cause it. Most individuals with Brugada syndrome have an affected parent but approximately 1% of cases are the result of a de novo pathogenic variant</td>
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<tr>
<td>Catecholaminergic Polymorphic Ventricular Tachycardia</td>
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<td>Catecholaminergic polymorphic ventricular tachycardia (CPVT) is characterized by cardiac electrical instability. This instability can be exacerbated by acute activation of the adrenergic nervous system, such as during exercise or extreme emotional events. These episodes have an underlying cause of ventricular tachycardia, which may progress into ventricular fibrillation.</td>
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<tr>
<td>Dilated Cardiomyopathy</td>
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<td>Hereditary dilated cardiomyopathy (DCM) may be inherited in an autosomal dominant, autosomal recessive, or X-linked manner, depending on the gene involved. DCM is characterized by left ventricular enlargement and reduced myocardial contraction force. Typically, DCM presents with one of three features: heart failure, thromboembolic disease, or arrhythmias and/or conduction system disease. Approximately 20-50% of idiopathic dilated cardiomyopathy (those cases not due to acquired causes) are thought to have a genetic cause.</td>
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<tr>
<td>Hypertrophic Cardiomyopathy</td>
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<td>Hereditary hypertrophic cardiomyopathy (HCM) is inherited in an autosomal dominant manner. HCM is characterized by left ventricular hypertrophy in the absence of a predisposing cardiac or cardiovascular condition. The manifestation of HCM is extremely variable, even within the same family, and can range from asymptomatic to progressive heart failure. Other features include syncope, presyncope, shortness of breath, chest pain, orthostasis, and palpitations. The onset of HCM is usually during adolescence or young adulthood; however, it can range from infancy to much later in adult life. The prevalence of HCM is approximately 1 in 500 and ~55-70% of cases are caused by a mutation in one of the genes that encode a part of the sarcomere.</td>
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<tr>
<td>Left Ventricular Noncompaction</td>
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<td>Familial left ventricular noncompaction (LVNC) is an autosomal dominant or X-linked cardiomyopathy. The distinct diagnostic features of LVNC (a thick, bilayered myocardium, deep intertrabecular recesses, and prominent ventricular trabeculations) are secondary to an arrest of myocardial maturation during embryo development. Individuals with LVNC may be symptomatic or asymptomatic. Major complications of LVNC include heart failure, thromboembolic events, arrhythmias, and sudden cardiac death. Diagnosis can occur prenatally through late adulthood. The manifestation of LVNC is extremely variable, even within the same family. Approximately 30% of isolated LVNC are caused by a mutation in a sarcomere gene.</td>
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Long QT Syndrome
Long QT syndrome (LQTS) is characterized by a QT interval that is prolonged on the surface electrocardiogram and a predisposition to early after depolarizations and torsades de pointes. LQTS can present clinically with palpitations, presyncope, syncope, or sudden cardiac death.

Marfan Syndrome, Thoracic Aortic Aneurysm & Dissection (TAAD), and Related Disorders
Thoracic aortic aneurysm and dissection (TAAD) has a highly variable presentation and age of onset. It is characterized by dilation and dissections of the ascending thoracic aorta and/or ascending aorta. An aneurysm involving the descending thoracic aorta is observed rarely. Without surgical repair of the ascending aorta, individuals with TAAD have continual enlargement of the ascending aorta that leads to an acute aortic dissection. Isolated TAAD is typically inherited in an autosomal dominant manner with variable expression and reduced penetrance. Only about 20% of familial non-syndromic TAAD is attributed to pathogenic variants in known genes.

TAAD can also be present as part of a genetic syndrome. Marfan syndrome, Loeys-Dietz syndrome, Ehlers-Danlos syndrome vascular type, multisystemic smooth muscle dysfunction syndrome, and congenital contractural arachnodactyly all have TAAD as part of their clinical spectrum.

Pulmonary Arterial Hypertension
Pulmonary arterial hypertension (PAH) is increased pulmonary artery pressure in the absence of common causes of pulmonary hypertension, such as lung, heart, or thromboembolic chronic diseases. It is thought that both genetic and environmental factors that alter vascular structure and function contribute to the pathogenesis of PAH.

Familial cases of PAH are usually inherited in an autosomal dominant manner. With the identification of pathogenic variants in genes known to cause PAH, what was previously thought to be idiopathic PAH is now known to be genetic. A pathogenic variant in the BMPR2 gene causes ~70% of hereditary cases of PAH and in 10-40% of idiopathic PAH. Pathogenic variants in the CAV1 gene cause PAH.

Heterozygous pathogenic variants in the ENG and ACVRL1 (previously known as ALK1) genes cause hereditary hemorrhagic telangiectasia (HHT). HHT is an autosomal dominant vascular disorder characterized by acquired cutaneous telangiectasias and arteriovenous malformations that can lead to the development of PAH.

Restrictive Cardiomyopathy
Restrictive cardiomyopathy (RCM) is a primary myocardial disorder in which the main feature, restrictive ventricular physiology, develops early in the disease. RCM is characterized by inadequate ventricular relaxation during diastole. Onset can range from childhood to late adult hood. Major complications of RCM can include congestive heart failure, cerebrovascular accidents, and arrhythmias. Cardiac restriction may occur secondary to many genetic syndromes, such as Pompe disease and Fabry disease.

Short QT Syndrome
Short QT syndrome (SQTS) is characterized by an abnormally short QT interval and susceptibility to both ventricular tachyarrhythmias and atrial fibrillation.

Sudden Cardiac Arrest
Sudden cardiac arrest is the abrupt loss of heart function due to a malfunction in the heart's electrical system, such as an arrhythmia. The individual may or may not have been diagnosed with heart disease.

Note: This test does not detect the retrotransposon insertion in the 3’ UTR of the FKTN gene common in some Asian populations. For patients with suspected Fukuyama congenital muscular dystrophy, testing for the FKTN insertion is recommended. Analysis for the FKTN insertion is available as a separate assay.

References:
- American Heart Association.
- GeneReviews.
- OMIM.
Puregene kit for DNA extraction is recommended.

In-solution hybridization of all coding exons is performed on the patient's genomic DNA. Although some deep intronic and genes.

### Genes

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<td>ABC9C, ACTA2, ACTC1, ACTN2, ACVR1L1, AKAP9, ANK2, ANKRD1, BAG3, BMPR2, BRAF, CACNA1C, CACNB2, CALM1, CASQ2, CAV1, CAV3, CBS, COL3A1, COL5A1, COL5A2, CRYAB, CSRP3, CTNNNA3, DES, DMD, DSG2, DSP, DTA, EMD, ENG, FBN1, FBN2, FHL2, FKTN, FLNA, GAA, GATAD1, GJA5, GLA, GPD1L, HCN4, HRAS, JPH2, JUP, KCN5, KCND3, KCNE1, KCNE2, KCNE3, KCNH2, KCNJ2, KCNJ5, KCNJ8, KCNQ1, KRAS, LAMA4, LAMP2, LDB3, LMNA, MAP2K1, MAP2K2, MED12, MYBPC3, MYH11, MYH6, MYH7, MYL2, MYL3, MYLK2, MYOD2, MYPN, NEBL, NEXN, NKX2-5, NPPA, NRAS, PDLIM3, PKP2, PLN, PRDM16, PRKAG2, PTPN11, RAF1, RANGRF, RBM20, RIT1, RYR2, SCN1B, SCN1B, SCN4B, SCNT, SGC, SIK1, SLC2A5, SLC2A10, SMARTD3, SNTA1, SOST, TAZ, TIE2, TMEM43, TNR, TNNT1, TNNT2, TPM1, TRDN, TRPM4, TN, TTR, VCL</td>
</tr>
</tbody>
</table>

### Indications

This test is indicated for:
- Individuals with a cardiovascular condition.

### Methodology

**Next Generation Sequencing:** In-solution hybridization of all coding exons is performed on the patient's genomic DNA. Although some deep intronic regions may also be analyzed, this assay is not meant to interrogate most promoter regions, deep intronic regions, or other regulatory elements, and does not detect single or multi-exon deletions or duplications. Direct sequencing of the captured regions is performed using next generation sequencing. The patient's gene sequences are then compared to a standard reference sequence. Potentially causative variants and areas of low coverage are Sanger-sequenced. Sequence variations are classified as pathogenic, likely pathogenic, benign, likely benign, or variants of unknown significance. Variants of unknown significance may require further studies of the patient and/or family members.

### Detection

**Next Generation Sequencing:** Clinical Sensitivity: Unknown. Mutations in the promoter region, some mutations in the introns and other regulatory element mutations cannot be detected by this analysis. Large deletions/duplications will not be detected by this analysis. Results of molecular analysis should be interpreted in the context of the patient's clinical/biochemical phenotype.

**Analytical Sensitivity:** ~99%.

### Specimen Requirements

Submit only 1 of the following specimen types

#### 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: Ship sample at room temperature with overnight delivery.

#### Type: Isolated DNA

**Specimen Requirements:**
- In microtainer: 60 ug
- Isolation using the Qiagen™ Puregene kit for DNA extraction is recommended.
- Specimen Collection and Shipping: Refrigerate until time of shipment in 100 ng/ul of TE buffer. Ship sample at room temperature with overnight delivery.

### Related Tests

- Individual gene sequencing analysis and deletion duplication analysis are available for the CAV3, DES, DMD, EMD, GAA, GLA, LAMP2, LMNA, RYR2, SGCD, and TIE2 genes.
- 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 only for known familial mutations to individuals who are confirmed carriers of mutations. Please contact the laboratory genetic counselor to discuss appropriate testing prior to collecting a prenatal specimen.
- Comprehensive Cardiovascular; Deletion/Duplication Panel.