Congenital Disorder of Glycosylation Ib: *MPI* Gene Sequencing

**Test Code:** SMPIX  
**Turnaround time:** 6 weeks  
**CPT Codes:** 81479 x1

### 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.

Cyclic vomiting, profound hypoglycemia, failure to thrive, liver fibrosis, and protein-losing enteropathy, occasionally associated with coagulation disturbances without neurologic involvement, are characteristic of CDG Ib. The clinical course is variable even within families.

In one study, the majority of patients showed a hepatic-intestinal disease with liver fibrosis and protein-losing enteropathy. In one family, the main finding was prolonged episodic vomiting, sometimes associated with diarrhea, while in another family only transient liver disease was present. Symptoms tend to begin between 2 and 12 months with no or transient neurological involvement. Profound deficiency of antithrombin III is often the finding that leads to transferring testing in these patients.

CDG Ib is the only known CDG for which an efficient treatment is available, namely oral D-mannose administration.

Mutations in the *MPI* gene (15q22-qter) cause CDG Ib.

For patients with suspected CDG Ib, 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.

### References:


### Genes

*MPI*

### Indications

This test is indicated for:

- Confirmation of a clinical/biochemical diagnosis of CDG Ib
- Carrier testing in adults with a family history of CDG Ib

### Methodology

PCR amplification of 8 exons contained in the *MPI* gene is performed on the patient's genomic DNA. Direct sequencing of amplification products is performed in both forward and reverse directions, using automated fluorescence dideoxy sequencing methods. The patient's gene sequences are then compared to a normal reference sequence. Sequence variations are classified as mutations, benign variants unrelated to disease, or variations of unknown clinical significance. Variants of unknown clinical significance may require further studies of the patient and/or family members. This assay
does not interrogate the promoter region, deep intronic regions, or other regulatory elements, and does not detect large deletions.

**Detection**

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 will not be detected by this analysis. Results of molecular analysis should be interpreted in the context of the patient’s biochemical phenotype.

Analytical Sensitivity: ~99%

**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**

- Deletion/duplication analysis of the $MGI$ gene by CGH array is available for those individuals in whom sequence analysis is negative.
- 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.