**Congenital Disorder of Glycosylation, ATP6V0A2-related: ATP6V0A2 Gene Sequencing**

**Test Code:** SATP6  
**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.

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 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 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.

### References:

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

### Genes

**ATP6V0A2**

### Indications

This test is indicated for:

- Confirmation of a clinical/biochemical diagnosis of ATP6V0A2-related CDG
- Carrier testing in adults with a family history of ATP6V0A2-related CDG

### 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

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) 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

- Deletion/duplication analysis of the \textit{ATP6V0A2} 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.