Nephronophthisis: INVS Gene Deletion/Duplication

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

### Condition Description

Nephronophthisis, an autosomal recessive cystic kidney disease, is the most frequent monogenic cause of renal failure in childhood. There are four forms of nephronophthisis caused by mutations in four different genes. Clinically, there is a statistically different age at onset at end-stage renal disease: terminal renal failure develops at median ages of 13 years, 1 year, 19 years, and 11-34 years in NPHP1, NPHP2, NPHP3, and NPHP4 respectively. Hallmarks of familial nephronophthisis are tubular basement membrane disruption, interstitiallymphohistiocytic cell infiltration, and development of cysts at the corticomedullary border of the kidneys. The histology in later stages of NPH always merges into a chronic sclerosing tubulointerstitial nephropathy, which is found in chronic renal failure of all origins.

**Nephronophthisis 2**

In one study, individuals with infantile nephronophthisis (NPHP2) presented within the first months of life with severe renal failure and acidosis, which could be associated with hypertension and/or polyuria and/or severe cholestatic liver disease. A renal biopsy, performed in all patients, showed similar features characterized by a diffuse chronic tubulointerstitial nephritis and particularly by the presence of microcystic dilatation of proximal tubules and Bowman space. Progression of the renal disease was extremely rapid and patients can reach end-stage renal failure before the age of 2 years (11 to 22 months).

In another study, phenotypic presentation ranged from a Potter-like syndrome to hydroureteric kidneys, renal insufficiency, hypertension, and hyperkalemia. Affected individuals showed rapid deterioration of kidney function, leading to end-stage renal failure within 3 years. The manifestations range from prenatal fetopathy and oligohydramnios resulting in postnatal respiratory failure and death to postnatal onset of disease later than 30 months of age. None of the postnatally diagnosed patients had a history of either oligohydramnios or neonatal respiratory symptoms. All affected individuals developed anemia, hyperkalemic metabolic acidosis, and increased serum creatine. None of the affected subjects had polyuria, polydypsia, or associated ocular or hepatic complications.

These specific clinical features of this disease are its early onset and rapid progression to end-stage renal failure. Pathologically, it differs from later-onset nephronophthisis by the absence of medullary cysts and thickened tubular basement membranes and by the presence of cortical microcysts. NPHP2 is caused by mutations in the INVS gene (also known as NPHP2) (9q31). The protein product of the INVS gene, nephrocytin, has been shown to interact with that of the NPHP1 gene, nephrocystin.

Click here for the OMIM summary on this condition.

### Genes

**INVS**

### Indications

This test is indicated for:

- Confirmation of a clinical/biochemical diagnosis of infantile nephronophthisis in individuals who have tested negative for sequence analysis
- Carrier testing in adults with a family history of infantile nephronophthisis who have tested negative for sequence analysis

### 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.

### 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**

**Type:** DNA, Isolated

**Specimen Requirements:**

- Microtainer
- 3µg

Isolation using the Perkin Elmer™ Chemagen™ Automated Extraction method or Qiagen™ Puregene kit for DNA extraction is recommended.

**Specimen Collection and Shipping:**

Refrigerate until time of shipment in 100 ng/µL in TE buffer. Ship sample at room temperature with overnight delivery.
Type: Whole Blood (EDTA)

Specimen Requirements:
EDTA (Purple Top)
Infants and Young Children (< 2 years of age to 10 years old): 3-5 ml
Older Children & Adults: 5-10 ml
Autopsy: 2-3 ml unclotted cord or cardiac blood

Specimen Collection and Shipping:
Ship sample at room temperature for receipt at EGL within 24 hours of collection. Do not refrigerate or freeze.

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

- Sequencing analysis of the INVS gene is available and is required before deletion/duplication analysis.
- Custom diagnostic mutation analysis is available to family members if mutations are identified by targeted mutation testing or sequencing analysis.
- Prenatal testing is available to couples who are confirmed carriers of mutations. Please contact the laboratory genetic counselor to discuss appropriate testing prior to collecting a prenatal specimen.