Pulmonary Arterial Hypertension (PAH) is increased pulmonary artery pressure in the absence of common causes of pulmonary hypertension, such as left heart failure, thromboembolic events, arrhythmias, and sudden cardiac death. Diagnosis can occur prenatally through late adulthood. The manifestation of PAH 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 PAH is usually during adolescence or young adulthood; however, it can range from infancy to much later in adult life.

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 eight genes known to cause it. Most individuals with HCM have an affected parent but approximately 1% of cases are the result of a de novo pathogenic variant.

Dilated Cardiomyopathy
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.

Hypertrophic Cardiomyopathy
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 eight genes known to cause it. Most individuals with HCM have an affected parent but approximately 1% of cases are the result of a de novo pathogenic variant.

Left Ventricular Noncompaction
Familial left ventricular noncompaction (LVNC) is an autosomal dominant or X-linked cardiomyopathy. The distinct diagnostic features of LVNC (a thick, banded 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.

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 afterdepolarizations and torsades de pointes. LOTS 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, Loey-Dietz syndrome, Ehlers-Danlos syndrome vascular type, multisystemic smooth muscle dysfunction syndrome, and congenital contractualarachnodactyly 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 idopathic 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.

**Genes**

**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.

**Copy Number Analysis:** Comparative analysis of the NGS read depth (coverage) of the targeted regions of genes on this panel was performed to detect copy number variants (CNV). The accuracy of the detected variants is highly dependent on the size of the event, the sequence context and the coverage obtained for the targeted region. Due to these variables and limitations a minimum validated CNV size cannot be determined; however, single exon deletions and duplications are expected to be below the detection limit of this analysis.

**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. Results of molecular analysis should be interpreted in the context of the patient's clinical/biochemical phenotype.

Analytical sensitivity for sequence variant detection is ~99%.
Copy Number Analysis: The sensitivity and specificity of this method for CNV detection is highly dependent on the size of the event, sequence context and depth of coverage for the region involved. The assay is highly sensitive for CNVs of 500 base pairs or larger and those containing at least 3 exons. Smaller (< 500 base pairs) CNVs and those that involving only 1 or 2 exons may or may not be detected depending on the sequence context, size of exon(s) involved and depth of coverage.

Specimen Requirements

Submit only 1 of the following specimen types

Type: DNA, Isolated

Specimen Requirements:
Microtainer
15µg
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 72 hours of collection. Do not freeze.

Type: Saliva

Specimen Requirements:
Oragene™ Saliva Collection Kit
Oragene™ Saliva Collection Kit used according to manufacturer instructions. Please contact EGL for a Saliva Collection Kit for patients that cannot provide a blood sample.

Specimen Collection and Shipping:
Please do not refrigerate or freeze saliva sample. Please store and ship at room temperature.

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 TCAP 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.