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Genetic Testing Summary

Enclosed are the genetic testing results for

PC 1120

No amount of genetic testing can guarantee that a child will not be affected with a genetic condition. Genetic testing can inform you of the likelihood of passing on the genetic conditions that are tested for, but it cannot eliminate the risk of passing on any genetic condition.

The genetic conditions Cryobio tests for are inherited in an autosomal recessive manner. This means that the child would have to inherit a genetic mutation from both the sperm source and the egg source to be affected with the condition. When both the sperm source and the egg source have undergone genetic carrier screening and the test results are negative, the risk of a child being affected with the conditions tested for is significantly reduced, but it cannot be completely eliminated.

All recipients should discuss both or their own risk for passing on genetic conditions and whether would benefit from genetic counseling and testing with their health care provider. Before using a donor that is a carrier for a specific recessive genetic condition or conditions, we strongly recommend that the recipient (or egg source, if different) consider genetic counseling and testing to determine if they are a carrier for the same genetic condition or conditions as the donor.

Screening and testing have changed dramatically over the years, and so the screening and testing done on each donor may very depending on the testing that was in place when he was actively in Cryobio's donor program. Earlier donors may not have had as extensive testing as later donors. Screening and testing may change again in the future, so please review the results each time before ordering as both the testing done and the results may change.

Patient Information
Name: Pc 1120
Date of Birth: [redacted]
Sema4 ID: [redacted]
Client ID: [redacted]
Indication: Carrier Screening

Specimen Information
Specimen Type: Blood
Date Collected: [redacted]
Date Received: [redacted]
Final Report: [redacted]

Referring Provider
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Expanded Carrier Screen (283 genes)

with Personalized Residual Risk

SUMMARY OF RESULTS AND RECOMMENDATIONS

⊕ Positive	⊖ Negative
Carrier of Bartter Syndrome, Type 4A (AR) Associated gene(s): *BSND* Variant(s) Detected: c.859G>T, p.E287X, Likely Pathogenic, Heterozygous (one copy) **Carrier of Non-Syndromic Hearing Loss (*GJB2*-Related) (AR)** Associated gene(s): *GJB2* Variant(s) Detected: c.109G>A, p.V37I, Pathogenic, Heterozygous (one copy) **Carrier of Smith-Lemli-Opitz Syndrome (AR)** Associated gene(s): *DHCR7* Variant(s) Detected: c.1066delC, p.H356TfsX57, Likely Pathogenic, Heterozygous (one copy)	**Negative for all other genes tested** To view a full list of genes and diseases tested please see Table 1 in this report

AR=Autosomal recessive; XL=X-linked

Recommendations

- Testing the partner for the above positive disorder(s) and genetic counseling are recommended.
- Please note that for female carriers of X-linked diseases, follow-up testing of a male partner is not indicated.
- CGG repeat analysis of *FMR1* for fragile X syndrome is not performed on males as repeat expansion of premutation alleles is not expected in the male germline.
- Individuals of Asian, African, Hispanic and Mediterranean ancestry should also be screened for hemoglobinopathies by CBC and hemoglobin electrophoresis.
- Consideration of residual risk by ethnicity after a negative carrier screen is recommended for the other diseases on the panel, especially in the case of a positive family history for a specific disorder.

Interpretation of positive results

Bartter Syndrome, Type 4A (AR)

Results and Interpretation

A heterozygous (one copy) likely pathogenic premature stop codon, c.859G>T, p.E287X, was detected in the *BSND* gene (NM_057176.2). When this variant is present in trans with a pathogenic variant, it is considered to be causative for Bartter syndrome, type 4A. Therefore, this individual is expected to be at least a carrier for Bartter syndrome, type 4A. Heterozygous carriers are not expected to exhibit symptoms of this disease.

What is Bartter Syndrome, Type 4A?

Bartter syndrome, type 4A is an autosomal recessive disorder caused by pathogenic variants in the gene *BSND*. This pan-ethnic disease is associated with life-threatening health problems present in utero or shortly after birth, including polyhydramnios, which increases the risk for premature birth, failure to thrive, constipation, dehydration, bone weakness, and hardening of kidney tissues. In addition, patients can experience muscle weakness and cramping as well as hearing loss and intellectual disability. With treatment available, life expectancy is not reduced. No genotype-phenotype correlation has been reported.

Non-Syndromic Hearing Loss (*GJB2*-Related) (AR)

Results and Interpretation

A heterozygous (one copy) pathogenic missense variant, c.109G>A, p.V37I, was detected in the *GJB2* gene (NM_004004.5). Please note that this variant has been reported to have a variable penetrance, and some individuals with a pathogenic variant on the opposite allele may not have hearing loss. When this variant is present in trans with a pathogenic variant, it is considered to be causative for non-syndromic hearing loss (*GJB2*-related). Therefore, this individual is expected to be at least a carrier for non-syndromic hearing loss (*GJB2*-related). Heterozygous carriers are not expected to exhibit symptoms of this disease.

What is Non-Syndromic Hearing Loss (*GJB2*-Related)?

Non-syndromic hearing loss (*GJB2*-related) is an autosomal recessive disorder that is caused by pathogenic variants in the gene *GJB2*. It is found in individuals of many different ethnicities, but it more prevalent in individuals of Ashkenazi Jewish descent, as well as Caucasians and Asians. Patients with this form of hearing loss do not experience any other disease manifestations. Hearing loss is usually present from birth and does not progress in severity over time. The level of hearing loss can vary between patients from mild to profound. Patients with two inactivating variants are more likely to have profound hearing loss, whereas patients with two non-inactivating variants are more likely to have mild hearing loss. However, the variability that exists between patients means that it may not be possible to predict the severity of an individual's hearing loss based on their genotype. Life expectancy is not reduced.

Smith-Lemli-Opitz Syndrome (AR)

Results and Interpretation

A heterozygous (one copy) likely pathogenic frameshift variant, c.1066delC, p.H356TfsX57, was detected in the *DHCR7* gene (NM_001360.2). When this variant is present in trans with a pathogenic variant, it is considered to be causative for Smith-Lemli-Opitz syndrome. Therefore, this individual is expected to be at least a carrier for Smith-Lemli-Opitz syndrome. Heterozygous carriers are not expected to exhibit symptoms of this disease.

What is Smith-Lemli-Opitz Syndrome?

Smith-Lemli-Opitz syndrome is an autosomal recessive disease caused by pathogenic variants in the gene *DHCR7*. While it is a pan-ethnic disease, it is identified more frequently in people of Caucasian or Ashkenazi Jewish ancestry. Smith-Lemli-Opitz syndrome is characterized by impaired cholesterol synthesis, which results in congenital abnormalities including a small head, dysmorphic features, cleft palate, extra and/or fused fingers and toes, gastrointestinal anomalies and genital abnormalities in males. Intellectual deficits and behavioral problems, including autistic features, self-harm behaviors and hyperactivity may be present. While most patients have a severe phenotype and are identified at birth, more mildly affected patients who have been diagnosed in childhood or adolescence have been reported. It is thought that many conceptions affected with Smith-Lemli-Opitz syndrome are lost in early embryonic development, as the disease frequency is much rarer than what would be expected based on the frequency of carriers. Life expectancy varies with the severity of disease; it has been reported that approximately 25% of patients die in infancy, while others live to adulthood. A clear genotype-phenotype correlation has not been reported.

Test description

This patient was tested for a panel of diseases using a combination of sequencing, targeted genotyping and copy number analysis. Please note that negative results reduce but do not eliminate the possibility that this individual is a carrier for one or more of the disorders tested. Please see Table 1 for a list of genes and diseases tested with the patient's personalized residual risk. If personalized residual risk is not provided, please see the complete residual risk table at **go.sema4.com/residualrisk**. Only variants determined to be pathogenic or likely pathogenic are reported in this carrier screening test.

Anastasia Larmore, Ph.D., Associate Laboratory Director
Laboratory Medical Consultant: George A. Diaz, M.D., Ph.D

Genes and diseases tested

The personalized residual risks listed below are specific to this individual. The complete residual risk table is available at **go.sema4.com/residualrisk**

Table 1: List of genes and diseases tested with detailed results

	Disease	Gene	Inheritance Pattern	Status	Detailed Summary
⊕	**Positive**				
	Bartter Syndrome, Type 4A	*BSND*	AR	Carrier	c.859G>T, p.E287X, Likely Pathogenic, Heterozygous (one copy)
	Non-Syndromic Hearing Loss (*GJB2*-Related)	*GJB2*	AR	Carrier	c.109G>A, p.V37I, Pathogenic, Heterozygous (one copy)
	Smith-Lemli-Opitz Syndrome	*DHCR7*	AR	Carrier	c.1066delC, p.H356TfsX57, Likely Pathogenic, Heterozygous (one copy)
⊖	**Negative**				
	3-Beta-Hydroxysteroid Dehydrogenase Type II Deficiency	*HSD3B2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,300
	3-Methylcrotonyl-CoA Carboxylase Deficiency (*MCCC1*-Related)	*MCCC1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,400
	3-Methylcrotonyl-CoA Carboxylase Deficiency (*MCCC2*-Related)	*MCCC2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,200
	3-Methylglutaconic Aciduria, Type III	*OPA3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 50,000
	3-Phosphoglycerate Dehydrogenase Deficiency	*PHGDH*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 63,000
	6-Pyruvoyl-Tetrahydropterin Synthase Deficiency	*PTS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,800
	Abetalipoproteinemia	*MTTP*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,200
	Achromatopsia (*CNGB3*-related)	*CNGB3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 8,600
	Acrodermatitis Enteropathica	*SLC39A4*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 12,000
	Acute Infantile Liver Failure	*TRMU*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 9,400
	Acyl-CoA Oxidase I Deficiency	*ACOX1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 39,000
	Adenosine Deaminase Deficiency	*ADA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,100
	Adrenoleukodystrophy, X-Linked	*ABCD1*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 19,000
	Aicardi-Goutieres Syndrome (*SAMHD1*-Related)	*SAMHD1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 10,000
	Alpha-Mannosidosis	*MAN2B1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,200
	Alpha-Thalassemia	*HBA1/HBA2*	AR	Reduced Risk	*HBA1* Copy Number: 2 *HBA2* Copy Number: 2 No pathogenic copy number variants detected *HBA1/ HBA2* Sequencing: Negative **Personalized Residual Risk:** 1 in 10,000
	Alpha-Thalassemia Intellectual Disability Syndrome	*ATRX*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 48,000
	Alport Syndrome (*COL4A3*-Related)	*COL4A3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,800
	Alport Syndrome (*COL4A4*-Related)	*COL4A4*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,800
	Alport Syndrome (*COL4A5*-Related)	*COL4A5*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 150,000
	Alstrom Syndrome	*ALMS1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,800
	Andermann Syndrome	*SLC12A6*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 151,000
	Argininosuccinic Aciduria	*ASL*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,200
	Aromatase Deficiency	*CYP19A1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,400
	Arthrogryposis, Intellectual Disability, and Seizures	*SLC35A3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 454,000
	Asparagine Synthetase Deficiency	*ASNS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 202,000
	Aspartylglycosaminuria	*AGA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 13,000

Ataxia With Isolated Vitamin E Deficiency	*TTPA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 61,000
Ataxia-Telangiectasia	*ATM*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,300
Autosomal Recessive Spastic Ataxia of Charlevoix-Saguenay	*SACS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,600
Bardet-Biedl Syndrome (*BBS10*-Related)	*BBS10*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,700
Bardet-Biedl Syndrome (*BBS12*-Related)	*BBS12*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 9,900
Bardet-Biedl Syndrome (*BBS1*-Related)	*BBS1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,400
Bardet-Biedl Syndrome (*BBS2*-Related)	*BBS2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,200
Bare Lymphocyte Syndrome, Type II	*CIITA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 35,000
Bernard-Soulier Syndrome, Type A1	*GP1BA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 42,000
Bernard-Soulier Syndrome, Type C	*GP9*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,300
Beta-Globin-Related Hemoglobinopathies	*HBB*	AR	Reduced Risk	**Personalized Residual Risk (Beta-Globin-Related Hemoglobinopathies):** 1 in 2,000 **Personalized Residual Risk (Beta-Globin-Related Hemoglobinopathies: HbS Variant):** 1 in 790,000 **Personalized Residual Risk (Beta-Globin-Related Hemoglobinopathies: HbC Variant):** 1 in 2,107,000
Beta-Ketothiolase Deficiency	*ACAT1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,400
Bilateral Frontoparietal Polymicrogyria	*GPR56*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 203,000
Biotinidase Deficiency	*BTD*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 500
Bloom Syndrome	*BLM*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 7,400
Canavan Disease	*ASPA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,000
Carbamoylphosphate Synthetase I Deficiency	*CPS1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,100
Carnitine Palmitoyltransferase IA Deficiency	*CPT1A*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 24,000
Carnitine Palmitoyltransferase II Deficiency	*CPT2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 670
Carpenter Syndrome	*RAB23*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 21,000
Cartilage-Hair Hypoplasia	*RMRP*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 960
Cerebral Creatine Deficiency Syndrome 1	*SLC6A8*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 208,000
Cerebral Creatine Deficiency Syndrome 2	*GAMT*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,100
Cerebrotendinous Xanthomatosis	*CYP27A1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,900
Charcot-Marie-Tooth Disease, Type 4D	*NDRG1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 730,000
Charcot-Marie-Tooth Disease, Type 5 / Arts Syndrome	*PRPS1*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 114,000
Charcot-Marie-Tooth Disease, X-Linked	*GJB1*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 11,000
Choreoacanthocytosis	*VPS13A*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 13,000
Choroideremia	*CHM*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 125,000
Chronic Granulomatous Disease (*CYBA*-Related)	*CYBA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,000
Chronic Granulomatous Disease (*CYBB*-Related)	*CYBB*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 294,000
Citrin Deficiency	*SLC25A13*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 12,000
Citrullinemia, Type 1	*ASS1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,500
Cohen Syndrome	*VPS13B*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,400
Combined Malonic and Methylmalonic Aciduria	*ACSF3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,400
Combined Oxidative Phosphorylation Deficiency 1	*GFM1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 13,000
Combined Oxidative Phosphorylation Deficiency 3	*TSFM*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 27,000
Combined Pituitary Hormone Deficiency 2	*PROP1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,800
Combined Pituitary Hormone Deficiency 3	*LHX3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 140,000
Combined SAP Deficiency	*PSAP*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 44,000
Congenital Adrenal Hyperplasia due to 17-Alpha-Hydroxylase Deficiency	*CYP17A1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,800

Congenital Adrenal Hyperplasia due to 21-Hydroxylase Deficiency	*CYP21A2*	AR	Reduced Risk	*CYP21A2* copy number: 2 *CYP21A2* sequencing: Negative **Personalized Residual Risk (Congenital Adrenal Hyperplasia due to 21-Hydroxylase Deficiency (Non-Classic)):** 1 in 200 **Personalized Residual Risk (Congenital Adrenal Hyperplasia due to 21-Hydroxylase Deficiency (Classic)):** 1 in 1,300
Congenital Amegakaryocytic Thrombocytopenia	*MPL*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,100
Congenital Disorder of Glycosylation, Type Ia	*PMM2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 540
Congenital Disorder of Glycosylation, Type Ib	*MPI*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,600
Congenital Disorder of Glycosylation, Type Ic	*ALG6*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,100
Congenital Insensitivity to Pain with Anhidrosis	*NTRK1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,700
Congenital Myasthenic Syndrome (*CHRNE*-Related)	*CHRNE*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,100
Congenital Myasthenic Syndrome (*RAPSN*-Related)	*RAPSN*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,900
Congenital Neutropenia (*HAX1*-Related)	*HAX1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 82,000
Congenital Neutropenia (*VPS45*-Related)	*VPS45*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 163,000
Corneal Dystrophy and Perceptive Deafness	*SLC4A11*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,600
Corticosterone Methyloxidase Deficiency	*CYP11B2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,500
Cystic Fibrosis	*CFTR*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 440
Cystinosis	*CTNS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 7,700
D-Bifunctional Protein Deficiency	*HSD17B4*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,000
Deafness, Autosomal Recessive 77	*LOXHD1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,700
Duchenne Muscular Dystrophy / Becker Muscular Dystrophy	*DMD*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 10,000
Dyskeratosis Congenita (*RTEL1*-Related)	*RTEL1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 9,800
Dystrophic Epidermolysis Bullosa	*COL7A1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 900
Ehlers-Danlos Syndrome, Type VIIC	*ADAMTS2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 243,000
Ellis-van Creveld Syndrome (*EVC*-Related)	*EVC*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,200
Emery-Dreifuss Myopathy 1	*EMD*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 833,000
Enhanced S-Cone Syndrome	*NR2E3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,600
Ethylmalonic Encephalopathy	*ETHE1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,400
Fabry Disease	*GLA*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 7,700
Factor IX Deficiency	*F9*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 5,100
Factor XI Deficiency	*F11*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,500
Familial Autosomal Recessive Hypercholesterolemia	*LDLRAP1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 136,000
Familial Dysautonomia	*IKBKAP*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 51,000
Familial Hypercholesterolemia	*LDLR*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 280
Familial Hyperinsulinism (*ABCC8*-Related)	*ABCC8*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 450
Familial Hyperinsulinism (*KCNJ11*-Related)	*KCNJ11*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,300
Familial Mediterranean Fever	*MEFV*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,200
Fanconi Anemia, Group A	*FANCA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,100
Fanconi Anemia, Group C	*FANCC*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 12,000
Fanconi Anemia, Group G	*FANCG*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 28,000
Fragile X Syndrome	*FMR1*	XL	Reduced Risk	*FMR1* CGG repeat sizes: Not Performed *FMR1* Sequencing: Negative Fragile X CGG triplet repeat expansion testing was not performed at this time, as the patient has either been previously tested or is a male. **Personalized Residual Risk:** 1 in 19,000
Fumarase Deficiency	*FH*	AR	Reduced Risk	**Personalized Residual Risk** 1 in 2,500
GRACILE Syndrome and Other *BCS1L*-Related Disorders	*BCS1L*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,900

Galactokinase Deficiency	*GALK1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,700
Galactosemia	*GALT*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,200
Gaucher Disease	*GBA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,300
Gitelman Syndrome	*SLC12A3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 290
Glutaric Acidemia, Type I	*GCDH*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,700
Glutaric Acidemia, Type IIa	*ETFA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,700
Glutaric Acidemia, Type IIc	*ETFDH*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,700
Glycine Encephalopathy (*AMT*-Related)	*AMT*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,700
Glycine Encephalopathy (*GLDC*-Related)	*GLDC*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 760
Glycogen Storage Disease, Type II	*GAA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 520
Glycogen Storage Disease, Type III	*AGL*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,600
Glycogen Storage Disease, Type IV / Adult Polyglucosan Body Disease	*GBE1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,400
Glycogen Storage Disease, Type Ia	*G6PC*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,300
Glycogen Storage Disease, Type Ib	*SLC37A4*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 7,300
Glycogen Storage Disease, Type V	*PYGM*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,200
Glycogen Storage Disease, Type VII	*PFKM*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,300
HMG-CoA Lyase Deficiency	*HMGCL*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,700
Hemochromatosis, Type 2A	*HFE2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 12,000
Hemochromatosis, Type 3	*TFR2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 11,000
Hereditary Fructose Intolerance	*ALDOB*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,900
Hereditary Spastic Paraparesis 49	*TECPR2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 116,000
Hermansky-Pudlak Syndrome, Type 1	*HPS1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,500
Hermansky-Pudlak Syndrome, Type 3	*HPS3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 49,000
Holocarboxylase Synthetase Deficiency	*HLCS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,500
Homocystinuria (*CBS*-Related)	*CBS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,400
Homocystinuria due to *MTHFR* Deficiency	*MTHFR*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,300
Homocystinuria, cblE Type	*MTRR*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 9,600
Hydrolethalus Syndrome	*HYLS1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 52,000
Hyperornithinemia-Hyperammonemia-Homocitrullinuria Syndrome	*SLC25A15*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,700
Hypohidrotic Ectodermal Dysplasia 1	*EDA*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 22,000
Hypophosphatasia	*ALPL*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 790
Inclusion Body Myopathy 2	*GNE*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,000
Infantile Cerebral and Cerebellar Atrophy	*MED17*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 129,000
Isovaleric Acidemia	*IVD*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,000
Joubert Syndrome 2	*TMEM216*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 152,000
Joubert Syndrome 7 / Meckel Syndrome 5 / COACH Syndrome	*RPGRIP1L*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 32,000
Junctional Epidermolysis Bullosa (*LAMA3*-Related)	*LAMA3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 21,000
Junctional Epidermolysis Bullosa (*LAMB3*-Related)	*LAMB3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,900
Junctional Epidermolysis Bullosa (*LAMC2*-Related)	*LAMC2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 77,000
Krabbe Disease	*GALC*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 860
Lamellar Ichthyosis, Type 1	*TGM1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,500
Leber Congenital Amaurosis 10 and Other CEP290-Related Ciliopathies	*CEP290*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,100
Leber Congenital Amaurosis 13	*RDH12*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,500
Leber Congenital Amaurosis 2 / Retinitis Pigmentosa 20	*RPE65*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,500
Leber Congenital Amaurosis 5	*LCA5*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 14,000

Leber Congenital Amaurosis 8 / Retinitis Pigmentosa 12 / Pigmented Paravenous Chorioretinal Atrophy	*CRB1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 990
Leigh Syndrome, French-Canadian Type	*LRPPRC*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 32,000
Lethal Congenital Contracture Syndrome 1 / Lethal Arthrogryposis with Anterior Horn Cell Disease	*GLE1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 10,000
Leukoencephalopathy with Vanishing White Matter	*EIF2B5*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,300
Limb-Girdle Muscular Dystrophy, Type 2A	*CAPN3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 960
Limb-Girdle Muscular Dystrophy, Type 2B	*DYSF*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,100
Limb-Girdle Muscular Dystrophy, Type 2C	*SGCG*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,900
Limb-Girdle Muscular Dystrophy, Type 2D	*SGCA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,500
Limb-Girdle Muscular Dystrophy, Type 2E	*SGCB*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 31,000
Limb-Girdle Muscular Dystrophy, Type 2I	*FKRP*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,400
Lipoamide Dehydrogenase Deficiency	*DLD*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 14,000
Lipoid Adrenal Hyperplasia	*STAR*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,600
Lipoprotein Lipase Deficiency	*LPL*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,400
Long-Chain 3-Hydroxyacyl-CoA Dehydrogenase Deficiency	*HADHA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,900
Lysinuric Protein Intolerance	*SLC7A7*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,000
Maple Syrup Urine Disease, Type 1a	*BCKDHA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,100
Maple Syrup Urine Disease, Type 1b	*BCKDHB*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,100
Meckel Syndrome 1 / Bardet-Biedl Syndrome 13	*MKS1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,700
Medium Chain Acyl-CoA Dehydrogenase Deficiency	*ACADM*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,800
Megalencephalic Leukoencephalopathy with Subcortical Cysts	*MLC1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,300
Menkes Disease	*ATP7A*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 172,000
Metachromatic Leukodystrophy	*ARSA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,000
Methylmalonic Acidemia (*MMAA*-Related)	*MMAA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 15,000
Methylmalonic Acidemia (*MMAB*-Related)	*MMAB*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 12,000
Methylmalonic Acidemia (*MUT*-Related)	*MUT*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,300
Methylmalonic Aciduria and Homocystinuria, Cobalamin C Type	*MMACHC*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,800
Methylmalonic Aciduria and Homocystinuria, Cobalamin D Type	*MMADHC*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 219,000
Microphthalmia / Anophthalmia	*VSX2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 40,000
Mitochondrial Complex I Deficiency (*ACAD9*-Related)	*ACAD9*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,800
Mitochondrial Complex I Deficiency (*NDUFAF5*-Related)	*NDUFAF5*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 98,000
Mitochondrial Complex I Deficiency (*NDUFS6*-Related)	*NDUFS6*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 353,000
Mitochondrial DNA Depletion Syndrome 6 / Navajo Neurohepatopathy	*MPV17*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,400
Mitochondrial Myopathy and Sideroblastic Anemia 1	*PUS1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 449,000
Mucolipidosis II / IIIA	*GNPTAB*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,100
Mucolipidosis III Gamma	*GNPTG*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 68,000
Mucolipidosis IV	*MCOLN1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 9,400
Mucopolysaccharidosis Type I	*IDUA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,300
Mucopolysaccharidosis Type II	*IDS*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 76,000
Mucopolysaccharidosis Type IIIA	*SGSH*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,700
Mucopolysaccharidosis Type IIIB	*NAGLU*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 950
Mucopolysaccharidosis Type IIIC	*HGSNAT*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,200
Mucopolysaccharidosis Type IIID	*GNS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 137,000

Mucopolysaccharidosis Type IVb / GM1 Gangliosidosis	*GLB1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,700
Mucopolysaccharidosis type IX	*HYAL1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 149,000
Mucopolysaccharidosis type VI	*ARSB*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,300
Multiple Sulfatase Deficiency	*SUMF1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 69,000
Muscle-Eye-Brain Disease and Other *POMGNT1*-Related Congenital Muscular Dystrophy-Dystroglycanopathies	*POMGNT1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,200
Myoneurogastrointestinal Encephalopathy	*TYMP*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,100
Myotubular Myopathy 1	*MTM1*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 192,000
N-Acetylglutamate Synthase Deficiency	*NAGS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,200
Nemaline Myopathy 2	*NEB*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,400
Nephrogenic Diabetes Insipidus, Type II	*AQP2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,400
Nephrotic Syndrome (*NPHS1*-Related) / Congenital Finnish Nephrosis	*NPHS1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 920
Nephrotic Syndrome (*NPHS2*-Related) / Steroid-Resistant Nephrotic Syndrome	*NPHS2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 780
Neuronal Ceroid-Lipofuscinosis (*CLN3*-Related)	*CLN3*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 9,200
Neuronal Ceroid-Lipofuscinosis (*CLN5*-Related)	*CLN5*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,300
Neuronal Ceroid-Lipofuscinosis (*CLN6*-Related)	*CLN6*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 8,600
Neuronal Ceroid-Lipofuscinosis (*CLN8*-Related)	*CLN8*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,100
Neuronal Ceroid-Lipofuscinosis (*MFSD8*-Related)	*MFSD8*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,200
Neuronal Ceroid-Lipofuscinosis (*PPT1*-Related)	*PPT1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 7,500
Neuronal Ceroid-Lipofuscinosis (*TPP1*-Related)	*TPP1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,300
Niemann-Pick Disease (*SMPD1*-Related)	*SMPD1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,800
Niemann-Pick Disease, Type C (*NPC1*-Related)	*NPC1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 690
Niemann-Pick Disease, Type C (*NPC2*-Related)	*NPC2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,600
Nijmegen Breakage Syndrome	*NBN*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 14,000
Odonto-Onycho-Dermal Dysplasia / Schopf-Schulz-Passarge Syndrome	*WNT10A*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,900
Omenn Syndrome (*RAG2*-Related)	*RAG2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 17,000
Omenn Syndrome / Severe Combined Immunodeficiency, Athabaskan-Type	*DCLRE1C*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,500
Ornithine Aminotransferase Deficiency	*OAT*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,400
Ornithine Transcarbamylase Deficiency	*OTC*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 103,000
Osteopetrosis 1	*TCIRG1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,700
Pendred Syndrome	*SLC26A4*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 390
Phenylalanine Hydroxylase Deficiency	*PAH*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 340
Polycystic Kidney Disease, Autosomal Recessive	*PKHD1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 450
Polyglandular Autoimmune Syndrome, Type 1	*AIRE*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,300
Pontocerebellar Hypoplasia, Type 1A	*VRK1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 25,000
Pontocerebellar Hypoplasia, Type 6	*RARS2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 8,600
Primary Carnitine Deficiency	*SLC22A5*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,500
Primary Ciliary Dyskinesia (*DNAH5*-Related)	*DNAH5*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,500
Primary Ciliary Dyskinesia (*DNAI1*-Related)	*DNAI1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,000
Primary Ciliary Dyskinesia (*DNAI2*-Related)	*DNAI2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 76,000
Primary Hyperoxaluria, Type 1	*AGXT*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,900
Primary Hyperoxaluria, Type 2	*GRHPR*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 11,000
Primary Hyperoxaluria, Type 3	*HOGA1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,400
Progressive Cerebello-Cerebral Atrophy	*SEPSECS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,400
Progressive Familial Intrahepatic Cholestasis, Type 2	*ABCB11*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 950

Propionic Acidemia (*PCCA*-Related)	*PCCA*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 2,600
Propionic Acidemia (*PCCB*-Related)	*PCCB*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 12,000
Pycnodysostosis	*CTSK*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,100
Pyruvate Dehydrogenase E1-Alpha Deficiency	*PDHA1*	XL	Reduced Risk	**Personalized Residual Risk:** 1 in 139,000
Pyruvate Dehydrogenase E1-Beta Deficiency	*PDHB*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 15,000
Renal Tubular Acidosis and Deafness	*ATP6V1B1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,600
Retinitis Pigmentosa 25	*EYS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,800
Retinitis Pigmentosa 26	*CERKL*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 13,000
Retinitis Pigmentosa 28	*FAM161A*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 34,000
Retinitis Pigmentosa 59	*DHDDS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 601,000
Rhizomelic Chondrodysplasia Punctata, Type 1	*PEX7*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 10,000
Rhizomelic Chondrodysplasia Punctata, Type 3	*AGPS*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 620,000
Roberts Syndrome	*ESCO2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 139,000
Salla Disease	*SLC17A5*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 8,400
Sandhoff Disease	*HEXB*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,800
Schimke Immunoosseous Dysplasia	*SMARCAL1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,800
Segawa Syndrome	*TH*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,100
Sjogren-Larsson Syndrome	*ALDH3A2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 5,500
Spinal Muscular Atrophy	*SMN1*	AR	Reduced Risk	*SMN1* copy number: 2 *SMN2* copy number: 2 c.*3+80T>G: Negative *SMN1* Sequencing: Negative **Personalized Residual Risk:** 1 in 1,107
Spondylothoracic Dysostosis	*MESP2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 382,000
Steel Syndrome	*COL27A1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 93,000
Stuve-Wiedemann Syndrome	*LIFR*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 6,000
Sulfate Transporter-Related Osteochondrodysplasia	*SLC26A2*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,800
Tay-Sachs Disease	*HEXA*	AR	Reduced Risk	Tay-Sachs disease enzyme: Non-carrier White blood cells: Non-carrier • Hex A%: 61.5% (Non-carrier : 55.0 - 72.0%; Carrier: <50%) • Total hexosaminidase activity: 1687 nmol/hr/mg Plasma: Non-carrier • Hex A%: 70.1 (Non-carrier : 58.0 - 72.0%; Carrier: <54%) • Total hexosaminidase activity: 473 nmol/hr/ml *HEXA* Sequencing: Negative **Personalized Residual Risk:** 1 in 1,400
Tyrosinemia, Type I	*FAH*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,900
Usher Syndrome, Type IB	*MYO7A*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,000
Usher Syndrome, Type IC	*USH1C*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,600
Usher Syndrome, Type ID	*CDH23*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,400
Usher Syndrome, Type IF	*PCDH15*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 3,800
Usher Syndrome, Type IIA	*USH2A*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 290
Usher Syndrome, Type III	*CLRN1*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 1,300
Very Long Chain Acyl-CoA Dehydrogenase Deficiency	*ACADVL*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 920
Walker-Warburg Syndrome and Other *FKTN*-Related Dystrophies	*FKTN*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 4,200
Wilson Disease	*ATP7B*	AR	Reduced Risk	**Personalized Residual Risk:** 1 in 350

Wolman Disease / Cholesteryl Ester Storage Disease	*LIPA*	AR	Reduced Risk	**Personalized Residual Risk**: 1 in 3,200
X-Linked Juvenile Retinoschisis	*RS1*	XL	Reduced Risk	**Personalized Residual Risk**: 1 in 40,000
X-Linked Severe Combined Immunodeficiency	*IL2RG*	XL	Reduced Risk	**Personalized Residual Risk**: 1 in 250,000
Zellweger Syndrome Spectrum (*PEX10*-Related)	*PEX10*	AR	Reduced Risk	**Personalized Residual Risk**: 1 in 6,300
Zellweger Syndrome Spectrum (*PEX1*-Related)	*PEX1*	AR	Reduced Risk	**Personalized Residual Risk**: 1 in 2,000
Zellweger Syndrome Spectrum (*PEX2*-Related)	*PEX2*	AR	Reduced Risk	**Personalized Residual Risk**: 1 in 77,000
Zellweger Syndrome Spectrum (*PEX6*-Related)	*PEX6*	AR	Reduced Risk	**Personalized Residual Risk**: 1 in 1,600

AR=Autosomal recessive; XL=X-linked

Test methods and comments

Genomic DNA isolated from this patient was analyzed by one or more of the following methodologies, as applicable:

Fragile X CGG Repeat Analysis (Analytical Detection Rate >99%)

PCR amplification using Asuragen, Inc. AmplideX® *FMR1* PCR reagents followed by capillary electrophoresis for allele sizing was performed. Samples positive for *FMR1* CGG repeats in the premutation and full mutation size range were further analyzed by Southern blot analysis to assess the size and methylation status of the *FMR1* CGG repeat.

Genotyping (Analytical Detection Rate >99%)

Multiplex PCR amplification and allele specific primer extension analyses using the MassARRAY® System were used to identify certain recurrent variants that are complex in nature or are present in low copy repeats. Rare sequence variants may interfere with assay performance.

Multiplex Ligation-Dependent Probe Amplification (MLPA) (Analytical Detection Rate >99%)

MLPA® probe sets and reagents from MRC-Holland were used for copy number analysis of specific targets versus known control samples. False positive or negative results may occur due to rare sequence variants in target regions detected by MLPA probes. Analytical sensitivity and specificity of the MLPA method are both 99%.

For alpha thalassemia, the copy numbers of the *HBA1* and *HBA2* genes were analyzed. Alpha-globin gene deletions, triplications, and the Constant Spring (CS) mutation are assessed. This test is expected to detect approximately 90% of all alpha-thalassemia mutations, varying by ethnicity. carriers of alpha-thalassemia with three or more *HBA* copies on one chromosome, and one or no copies on the other chromosome, may not be detected. With the exception of triplications, other benign alpha-globin gene polymorphisms will not be reported. Analyses of *HBA1* and *HBA2* are performed in association with long-range PCR of the coding regions followed by short-read sequencing.

For Duchenne muscular dystrophy, the copy numbers of all *DMD* exons were analyzed. Potentially pathogenic single exon deletions and duplications are confirmed by a second method. Analysis of *DMD* is performed in association with sequencing of the coding regions.

For congenital adrenal hyperplasia, the copy number of the *CYP21A2* gene was analyzed. This analysis can detect large deletions typically due to unequal meiotic crossing-over between *CYP21A2* and the pseudogene *CYP21A1P*. Classic 30-kb deletions make up approximately 20% of *CYP21A2* pathogenic alleles. This test may also identify certain point mutations in *CYP21A2* caused by gene conversion events between *CYP21A2* and *CYP21A1P*. Some carriers may not be identified by dosage sensitive methods as this testing cannot detect individuals with two copies (duplication) of the *CYP21A2* gene on one chromosome and loss of *CYP21A2* (deletion) on the other chromosome. Analysis of *CYP21A2* is performed in association with long-range PCR of the coding regions followed by short-read sequencing.

For spinal muscular atrophy (SMA), the copy numbers of the *SMN1* and *SMN2* genes were analyzed. The individual dosage of exons 7 and 8 as well as the combined dosage of exons 1, 4, 6 and 8 of *SMN1* and *SMN2* were assessed. Copy number gains and losses can be detected with this assay. Depending on ethnicity, 6 - 29 % of carriers will not be identified by dosage sensitive methods as this testing cannot detect individuals with two copies (duplication) of the *SMN1* gene on one chromosome and loss of *SMN1* (deletion) on the other chromosome (silent 2+0 carrier) or individuals that carry an intragenic mutation in *SMN1*. Please also note that 2% of individuals diagnosed with SMA have a causative *SMN1* variant that occurred *de novo*, and therefore cannot be picked up by carrier screening in the parents. Analysis of *SMN1* is performed in association with short-read sequencing of exons 2a-7, followed by confirmation using long-range PCR (described below).

The presence of the c.*3+80T>G (chr5:70,247,901T>G) variant allele in an individual with Ashkenazi Jewish or Asian ancestry is typically indicative of a duplication of *SMN1*. When present in an Ashkenazi Jewish or Asian individual with two copies of *SMN1*, c.*3+80T>G is likely indicative of a silent (2+0) carrier. In individuals with two copies of *SMN1* with African American, Hispanic or Caucasian ancestry, the presence or absence of c.*3+80T>G significantly increases or decreases, respectively, the likelihood of being a silent 2+0 silent carrier.

MLPA for Gaucher disease (*GBA*), cystic fibrosis (*CFTR*), and non-syndromic hearing loss (*GJB2/GJB6*) will only be performed if indicated for confirmation of detected CNVs. If *GBA* analysis was performed, the copy numbers of exons 1, 3, 4, and 6 - 10 of the *GBA* gene (of 11 exons total)

were analyzed. If *CFTR* analysis was performed, the copy numbers of all 27 *CFTR* exons were analyzed. If *GJB2/GJB6* analysis was performed, the copy number of the two *GJB2* exons were analyzed, as well as the presence or absence of the two upstream deletions of the *GJB2* regulatory region, del(*GJB6*-D13S1830) and del(*GJB6*-D13S1854).

Next Generation Sequencing (NGS) (Analytical Detection Rate >95%)

NGS was performed on a panel of genes for the purpose of identifying pathogenic or likely pathogenic variants.

Agilent SureSelect^{TM}XT Low Input technology was used with a custom capture library to target the exonic regions and intron/exon splice junctions of the relevant genes, as well as a number of UTR, intronic or promoter regions that contain previously reported mutations. Libraries were pooled and sequenced on the Illumina NovaSeq 9000 platform, using paired-end 100 bp reads. The sequencing data was analyzed using a custom bioinformatics algorithm designed and validated in house.

The coding exons and splice junctions of the known protein-coding RefSeq genes were assessed for the average depth of coverage (minimum of 20X) and data quality threshold values. Most exons not meeting a minimum of >20X read depth across the exon are further analyzed by Sanger sequencing. Please note that several genomic regions present difficulties in mapping or obtaining read depth >20X. These regions, which are described below, will not be reflexed to Sanger sequencing if the mapping quality or coverage is poor. Any variants identified during testing in these regions are confirmed by a second method and reported if determined to be pathogenic or likely pathogenic. However, as there is a possibility of false negative results within these regions, detection rates and residual risks for these genes have been calculated with the presumption that variants in these exons will not be detected, unless included in the MassARRAY® genotyping platform.

***Exceptions**: ABCD1* (NM_000033.3) exons 8 and 9; *ADA* (NM_000022.2) exon 1; *ADAMTS2* (NM_014244.4) exon 1; *AGPS* (NM_003659.3) chr2:178,257,512 - 178,257,649 (partial exon 1); *ALMS1* (NM_015120.4) chr2:73,612,990 - 73,613,041 (partial exon 1); *CEP290* (NM_025114.3) exon 5, exon 7, chr12:88,519,017 - 88,519,039 (partial exon 13), chr12:88,514,049 - 88,514,058 (partial exon 15), chr12:88,502,837 - 88,502,841 (partial exon 23), chr12:88,481,551 - 88,481,589 (partial exon 32), chr12:88,471,605 - 88,471,700 (partial exon 40); *CFTR* (NM_000492.3) exon 10; *COL4A4* (NM_000092.4) chr2:227,942,604 - 227,942,619 (partial exon 25); *CYP11B2* (NM_000498.3) exons 3 - 7; *DNAI2* (NM_023036.4) chr17:72,308,136 - 72,308,147 (partial exon 12); *EVC* (NM_153717.2) exon 1; *FH* (NM_000143.3) exon 1; *GAMT* (NM_000156.5 exon 1; *GLDC* (NM_000170.2) exon 1; *GNPTAB* (NM_024312.4) chr17:4,837,000 - 4,837,400 (partial exon 2); *GNPTG* (NM_032520.4) exon 1; *HGSNAT* (NM_152419.2) exon 1; *IDS* (NM_000202.6) exon 3; *LIFR* (NM_002310.5) exon 19; *NEB* (NM_001271208.1) exons 82 - 105; *NPC1* (NM_000271.4) chr18 21,123,519 - 21,123,538 (partial exon 14); *PUS1* (NM_025215.5) ; chr12:132,414,446 - 132,414,532 (partial exon 2); *RPGRIP1L* (NM_015272.2) exon 23; *SGSH* (NM_000199.3) chr17:78,194,022 - 78,194,072 (partial exon 1); *SLC6A8* (NM_005629.3) exons 3 and 4.

This test will detect variants within the exons and the intron-exon boundaries of the target regions. Variants outside these regions may not be detected, including, but not limited to, UTRs, promoters, and deep intronic areas, or regions that fall into the Exceptions mentioned above. This technology may not detect all small insertion/deletions and is not diagnostic for repeat expansions and structural genomic variation. In addition, a mutation(s) in a gene not included on the panel could be present in this patient.

Variant interpretation and classification was performed based on the American College of Medical Genetics Standards and Guidelines for the Interpretation of Sequence Variants (Richards et al, 2015). All potentially pathogenic variants may be confirmed by either a specific genotyping assay or Sanger sequencing, if indicated. Any benign variants, likely benign variants or variants of uncertain significance identified during this analysis will not be reported.

Next Generation Sequencing for SMN1

Exonic regions and intron/exon splice junctions of *SMN1* and *SMN2* were captured, sequenced, and analyzed as described above. Any variants located within exons 2a-7 and classified as pathogenic or likely pathogenic were confirmed to be in either *SMN1* or *SMN2* using gene-specific long-range PCR analysis followed by Sanger sequencing. Variants located in exon 1 cannot be accurately assigned to either *SMN1* or *SMN2* using our current methodology, and so these variants are considered to be of uncertain significance and are not reported.

Copy Number Variant Analysis (Analytical Detection Rate >95%)

Large duplications and deletions were called from the relative read depths on an exon-by-exon basis using a custom exome hidden Markov model (XHMM) algorithm. Deletions or duplications determined to be pathogenic or likely pathogenic were confirmed by either a custom arrayCGH platform, quantitative PCR, or MLPA (depending on CNV size and gene content). While this algorithm is designed to pick up deletions and duplications of 2 or more exons in length, potentially pathogenic single-exon CNVs will be confirmed and reported, if detected.

Exon Array (Confirmation method) (Accuracy >99%)

The customized oligonucleotide microarray (Oxford Gene Technology) is a highly-targeted exon-focused array capable of detecting medically relevant microdeletions and microduplications at a much higher resolution than traditional aCGH methods. Each array matrix has approximately 180,000 60-mer oligonucleotide probes that cover the entire genome. This platform is designed based on human genome NCBI Build 37 (hg19) and the CGH probes are enriched to target the exonic regions of the genes in this panel.

Quantitative PCR (Confirmation method) (Accuracy >99%)

The relative quantification PCR is utilized on a Roche Universal Library Probe (UPL) system, which relates the PCR signal of the target region in one group to another. To test for genomic imbalances, both sample DNA and reference DNA is amplified with primer/probe sets that specific to the target region and a control region with known genomic copy number. Relative genomic copy numbers are calculated based on the standard ΔΔCt formula.

Long-Range PCR (Analytical Detection Rate >99%)

Long-range PCR was performed to generate locus-specific amplicons for *CYP21A2*, *HBA1* and *HBA2* and *GBA*. The PCR products were then prepared for short-read NGS sequencing and sequenced. Sequenced reads were mapped back to the original genomic locus and run through the bioinformatics pipeline. If indicated, copy number from MLPA was correlated with the sequencing output to analyze the results. For *CYP21A2*, a certain percentage of healthy individuals carry a duplication of the *CYP21A2* gene, which has no clinical consequences. In cases where two copies of a gene are located on the same chromosome in tandem, only the second copy will be amplified and assessed for potentially pathogenic variants, due to size limitations of the PCR reaction. However, because these alleles contain at least two copies of the *CYP21A2* gene in tandem, it is expected that this patient has at least one functional gene in the tandem allele and this patient is therefore less likely to be a carrier. When an individual carries both a duplication allele and a pathogenic variant, or multiple pathogenic variants, the current analysis may not be able to determine the phase (cis/trans configuration) of the *CYP21A2* alleles identified. Family studies may be required in certain scenarios where phasing is required to determine the carrier status.

Residual Risk Calculations

Carrier frequencies and detection rates for each ethnicity were calculated trough the combination of internal curations of >30,000 variants and genomic frequency data from >138,000 individuals across seven ethnic groups in the gnomAD database. Additional variants in HGMD and novel deleterious variants were also incorporated into the calculation. Residual risk values are calculated using a Bayesian analysis combining the *a priori* risk of being a pathogenic mutation carrier (carrier frequency) and the detection rate. They are provided only as a guide for assessing approximate risk given a negative result, and values will vary based on the exact ethnic background of an individual. This report does not represent medical advice but should be interpreted by a genetic counselor, medical geneticist or physician skilled in genetic result interpretation and the relevant medical literature.

Personalized Residual Risk Calculations

Agilent SureSelect^{TM}XT Low-Input technology was utilized in order to create whole-genome libraries for each patient sample. Libraries were then pooled and sequenced on the Illumina NovaSeq platform. Each sequencing lane was multiplexed to achieve 0 4-2x genome coverage, using paired-end 100 bp reads. The sequencing data underwent ancestral analysis using a customized, licensed bioinformatics algorithm that was validated in house. Identified sub-ethnic groupings were binned into one of 7 continental-level groups (African, East Asian, South Asian, Non-Finnish European, Finnish, Native American, and Ashkenazi Jewish) or, for those ethnicities that matched poorly to the continental-level groups, an 8th "unassigned" group, which were then used to select residual risk values for each gene. For individuals belonging to multiple high-level ethnic groupings, a weighting strategy was used to select the most appropriate residual risk. For genes that had insufficient data to calculate ethnic-specific residual risk values, or for sub-ethnic groupings that fell into the "unassigned" group, a "worldwide" residual risk was used. This "worldwide" residual risk was calculated using data from all available continental-level groups.

Sanger Sequencing (Confirmation method) (Accuracy >99%)

Sanger sequencing, as indicated, was performed using BigDye Terminator chemistry with the ABI 3730 DNA analyzer with target specific amplicons. It also may be used to supplement specific guaranteed target regions that fail NGS sequencing due to poor quality or low depth of coverage (<20 reads) or as a confirmatory method for NGS positive results. False negative results may occur if rare variants interfere with amplification or annealing.

Tay-Sachs Disease (TSD) Enzyme Analysis (Analytical Detection Rate ≥98%)

Hexosaminidase activity and Hex A% activity were measured by a standard heat-inactivation, fluorometric method using artificial 4-MU-β-N-acetyl glucosaminide (4-MUG) substrate. This assay is highly sensitive and accurate in detecting Tay-Sachs carriers and individuals affected with TSD. Normal ranges of Hex A% activity are 55.0-72.0 for white blood cells and 58.0-72.0 for plasma. It is estimated that less than 0.5% of Tay-Sachs carriers have non-carrier levels of percent Hex A activity, and therefore may not be identified by this assay. In addition, this assay may detect individuals that are carriers of or are affected with Sandhoff disease. False positive results may occur if benign variants, such as pseudodeficiency alleles, interfere with the enzymatic assay. False negative results may occur if both *HEXA* and *HEXB* pathogenic or pseudodeficiency variants are present in the same individual.

Please note these tests were developed and their performance characteristics were determined by Sema4 Opco, Inc. They have not been cleared or approved by the FDA. These analyses generally provide highly accurate information regarding the patient's carrier or affected status. Despite this high level of accuracy, it should be kept in mind that there are many potential sources of diagnostic error, including

misidentification of samples, polymorphisms, or other rare genetic variants that interfere with analysis. Families should understand that rare diagnostic errors may occur for these reasons.

SELECTED REFERENCES

Carrier Screening

Grody W et al. ACMG position statement on prenatal/preconception expanded carrier screening. *Genet Med.* 2013 15:482-3.

Fragile X syndrome:

Chen L et al. An information-rich CGG repeat primed PCR that detects the full range of Fragile X expanded alleles and minimizes the need for Southern blot analysis. *J Mol Diag* 2010 12:589-600.

Spinal Muscular Atrophy:

Luo M et al. An Ashkenazi Jewish SMN1 haplotype specific to duplication alleles improves pan-ethnic carrier screening for spinal muscular atrophy. *Genet Med.* 2014 16:149-56.

Ashkenazi Jewish Disorders:

Scott SA et al. Experience with carrier screening and prenatal diagnosis for sixteen Ashkenazi Jewish Genetic Diseases. *Hum. Mutat.* 2010 31:1-11.

Duchenne Muscular Dystrophy:

Flanigan KM et al. Mutational spectrum of DMD mutations in dystrophinopathy patients: application of modern diagnostic techniques to a large cohort. *Hum Mutat.* 2009 30:1657-66.

Variant Classification:

Richards S et al. Standards and guidelines for the interpretation of sequence variants: a joint consensus recommendation of the American College of Medical Genetics and Genomics and the Association for Molecular Pathology. *Genet Med.* 2015 May;17(5):405-24

Additional disease-specific references available upon request.

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KLEBERG CYTOGENETICS LABORATORY

Name: 1120 PC
Date of birth: [redacted]
Gender: M
Hospital/MR #:
Accession #:
Sample Type: BLOOD
Test Code: 8600
Indication: Karyotype Screening - Sperm Donor

Lab Number: [redacted]
Family #:
Date Collected:
Date Received:
Date Reported:

Pittsburgh Cryobank
Tel. No.: 412-687-0335
Fax No: 412-687-0358

Chromosome Analysis - Blood

[redacted]

METHOD OF ANALYSIS:
GTG-Banding

Cultures:	2	***No. of images:***	9
Cells counted:	30	***Cells karyotyped:***	3
Cells analyzed:	5	***Band resolution:***	600

RESULTS:
46,XY

INTERPRETATION :
Normal male chromosome analysis. Analysis of 30 cells rules out 10% mosaicism at the 95% confidence level.

DISCLAIMER:
The resolution of analysis for this standard cytogenetic methodology does not routinely detect subtle rearrangements (<5Mb) or low-level mosaicism. Standard cytogenetic analysis cannot detect microdeletions/microduplications that might be diagnosed with Chromosomal Microarray Analysis. These results do not rule out the possibility of genetic conditions not detectable by cytogenetic analysis. Depending upon the clinical indication, additional testing may be warranted.

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ABMG Certified Cytogeneticist and Molecular Geneticist
Medical Director

Ankita Patel, Ph.D.
ABMG Certified Clinical Cytogeneticist
Laboratory Director

genzyme Genetics

Cystic Fibrosis Mutation Analysis

Patient Name: PC 1120, .
Referring Physician: David Prescott, MD
Specimen #: [redacted] **Client #:** [redacted]
Patient ID: [redacted] **Case #:** [redacted]

DOB [redacted]
Sex: M
SSN:

Date Collected: [redacted]
Date Received:
Lab ID:
Hospital ID:
Specimen Type: **BLDPER**

Pittsburgh Cryobank
4415 Fifth Avenue
Suite 161
Pittsburgh PA 15213 USA

Ethnicity: Caucasian

Indication: Carrier test / Gamete donor

RESULTS: Negative for the 97 mutations analyzed

INTERPRETATION

This individual's risk to be a carrier is reduced from 1/25 (4%) to 1/343 (0.3%), based on these results and a negative family history.

COMMENTS:

Mutation Detection Rates among Ethnic Groups Detection rates are based on mutation frequencies in patients affected with cystic fibrosis. Among individuals with an atypical or mild presentation (e.g. congenital absence of the vas deferens, pancreatitis) detection rates may vary from those provided here.

Ethnicity	Carrier risk reduction when no family history	Detection rate	References
African American	1/65 to 1/338	81%	Genet in Med 3:168, 2001
Ashkenazi Jewish	1/25 to 1/854	97%	Am J Hum Genet 51:951, 1994
Asian		Not Provided	Insufficient data
Caucasian	1/25 to 1/343	93%	Genet in Med 3:168, 2001; Genet in Med 4:90, 2002
Hispanic	1/45 to 1/205	78%	Genet in Med 3:168, 2001;www.dhs.ca.gov/pcfh/gdb/html/PDE/CFStudy.htm
Jewish, non-Ashkenazi		Varies by country of origin	Genet Testing 5:47, 2001, Genet Testing, 1:35, 1997
Other or Mixed Ethnicity		Not Provided	Detection rate not determined and varies with ethnicity

This interpretation is based on the clinical and family relationship information provided and the current understanding of the molecular genetics of this condition.

METHOD / LIMITATIONS:

DNA is isolated from the sample and tested for the 97 CF mutations listed. Regions of the *CFTR* gene are amplified enzymatically and subjected to a solution-phase multiplex allele-specific primer extension with subsequent hybridization to a bead array and fluorescence detection. Some mutations are then specifically identified by bi-directional dideoxysequencing. The assay discriminates between ΔF508 and the following polymorphisms: F508C, I506V and I507V. False positive or negative results may occur for reasons that include genetic variants, blood transfusions, bone marrow transplantation, erroneous representation of family relationships or contamination of a fetal sample with maternal cells.

Under the direction of: [redacted] Zhaoqing Zhou PhD, FACMG Date: [redacted]

Zhaoqing Zhou, Ph.D., FACMG
Testing Performed At Genzyme Genetics 3400 Computer Drive Westborough, MA 01581 1-800-255-7357

Integrated GENETICS
LabCorp Specialty Testing Group

SMN1 Copy Number Analysis

Patient Name: . PC 1120
DOB: [redacted] Age [redacted]
SSN #: Gender: Male

Specimen #: [redacted]
Case #: [redacted] Patient ID #: [redacted]
Date Collected: [redacted] Date Received: [redacted]

[redacted]
Pittsburgh Cryobank
4415 Fifth Avenue
Suite 161
Pittsburgh, PA 15213
USA

Referring Physician: David Prescott
Genetic Counselor:

Specimen Type: Peripheral blood

Clinical Data: Carrier Test/Gamete donor

Client Lab ID #:
Hospital ID #:
Specimen ID #:
Specimen(s) Received: 1 - Lavender 7 ml round bottom tube(s)

Ethnicity: Caucasian

RESULTS: SMN1 copy number: 2 (Reduced Carrier Risk)

INTERPRETATION:

This individual has an SMN1 copy number of two. This result reduces but does not eliminate the risk to be a carrier of SMA. Ethnic specific risk reductions based on a negative family history and an SMN1 copy number of two are provided in the Comments section of this report.

COMMENT:

Spinal muscular atrophy (SMA) is an autosomal recessive disease of variable age of onset and severity caused by mutations (most often deletions or gene conversions) in the survival motor neuron (SMN1) gene. Molecular testing assesses the number of copies of the SMN1 gene. Individuals with one copy of the SMN1 gene are predicted to be carriers of SMA. Individuals with two or more copies have a reduced risk to be carriers. (Affected individuals have 0 copies of the SMN1 gene.)

This copy number analysis cannot detect individuals who are carriers of SMA as a result of either 2 (or very rarely 3) copies of the SMN1 gene on one chromosome and the absence of the SMN1 gene on the other chromosome or small intragenic mutations within the SMN1 gene. This analysis also will not detect germline mosaicism or mutations in genes other than SMN1. Additionally, de novo mutations have been reported in approximately 2% of SMA patients.

Carrier Frequency and Risk Reductions for Individuals with No Family History of SMA				
Ethnicity	**Detection Rate[1]**	**Prior Carrier Risk[1]**	**Reduced Carrier Risk for 2 copy result**	**Reduced Carrier Risk for 3 copy result**
Caucasian	94.8%	1:47	1:834	1:5,600
Ashkenazi Jewish	90.5%	1:67	1:611	1:5,400
Asian	93.3%	1:59	1:806	1:5,600
Hispanic	90.0%	1:68	1:579	1:5,400
African American	70.5%	1:72	1:130	1:4,200
Asian Indian	90.2%	1:52	1:443	1:5,400
Mixed or Other Ethnic Background	For counseling purposes, consider using the ethnic background with the most conservative risk estimates.			

METHOD/LIMITATIONS: Specimen DNA is isolated and amplified by real-time polymerase chain reaction (PCR) for exon 7 of the SMN1 gene and the internal standard reference genes. A mathematical algorithm is used to calculate and report SMN1 copy numbers of 0, 1, 2 and 3. Based upon this analysis, an upper limit of 3 represents the highest degree of accuracy in reporting SMN1 copy number with statistical confidence. Sequencing of the primer and probe binding sites is performed on all fetal samples and samples with one copy of SMN1 by real-time PCR to rule out the presence of sequence variants which could interfere with analysis and interpretation. False positive or negative results may occur for reasons that include genetic variants, blood transfusions, bone marrow transplantation, erroneous representation of family relationships or contamination of a fetal sample with maternal cells.

REFERENCES:
1. Sugarman EA, Nagan N, Zhu H, et al. Pan-ethnic carrier screening and prenatal diagnosis for spinal muscular atrophy: clinical laboratory analysis of >72,400 specimens. Eur J Hum Genet 2012; 20:27-32. 2. Prior TW, et al. Technical standards and guidelines for spinal muscular atrophy testing. Genet Med 2011; 13(7): 686-694.

Electronically Signed by: Jane W. Thuo, Ph.D., FACMG, on [redacted]
Reported by: /