Name:	**NA**	Booking ID:	**NA**
Age:	**NA**	Sample Type:	**NA**
Sex:	**NA**	Sample Receipt Date:	**NA**
Referring Clinician:	**NA**	Reporting Date:	**NA**
Test Requested:	**Von Willebrand Factor (vWF) Gene Analysis**		

CLINICAL INFORMATION/HISTORY

NA

Previous Investigations: NA

RESULT SUMMARY

No Pathogenic, Likely Pathogenic, or Variants of Uncertain Significance related to the reported phenotype were found

VARIANTS RELEVANT TO INDICATION FOR TESTING

No variants were found in the sequence data which may be associated with the clinical history of the patient.

Gene & Transcript	Variant	Zygosity	Location	Disorder	Inheritance	ACMG Classification
No significant variant related to phenotype was detected.						

COPY NUMBER VARIANTS (CNVs) STATUS IN THE GENES RELATED TO DISEASE

No significant copy number variants were detected for the provided clinical indication.

FINDINGS UNRELATED TO PHENOTYPE

This section provides information on variants identified which are unrelated to the provided phenotype.

ACMG Secondary Findings

No clinically relevant variants associated with the ACMG recommended secondary list of genes were found in the sequence data.

Incidental Findings

No variants were detected as incidental findings in the sequenced data which may not be associated with the diagnostic indication for which the sequencing test was performed.

Carrier Status in the genes related to disease

No Pathogenic or Likely Pathogenic variants were detected.

RECOMMENDATIONS

Based on the clinical features and the observed genetic findings the following have been recommended:

1. Genetic counseling is recommended to discuss the potential clinical implications of this result.
2. **Re-analysis of hereditary spastic paraplegia gene panel data can be done if additional phenotype is provided, and results may change/differ on re-analysis depending on the provided phenotype.**
3. **If the clinician suspects copy number variations as a cause of the patient's phenotype, then additional testing with chromosomal microarray is recommended with better sensitivity and specificity for the detection of copy number variants.**
4. If the above results do not correlate completely with patient phenotype, additional testing is advised based on the clinician' s recommendation.

REPORTED VARIANTS STATISTICS:

Gene/Transcript	Variant	Depth	Allelic Depth	Alternate Allele Fraction	dbSNP rsID
No variant statistics to report					

DATA STATISTICS

Total data generated (Gb)	**NA**
Reads that passed alignment (%)	**NA**
Data > Q30 (%)	**NA**

METHODOLOGY

Sequencing of the protein coding regions of approximately 41Mb of the human exome (targeting approximately 99% of regions in CCDS and RefSeq) was performed using Illumina NovaSeq platform at a mean depth of 100-150X and >90% of bases covered at 30X depth >90% in the target region. The individual's DNA was extracted and fragmented, with fragments from the coding regions of the selected gene panel targeted for amplification and sequencing. Reads from the sequence output were aligned to the human reference genome (GRCh38) using the Burrows-Wheeler Aligner (BWA). Duplicate reads identification and removal, base quality recalibration and re-alignment of reads based on indels were done using inbuilt DRAGEN bio-IT pipeline. Variants to the reference were called using the Genomic Analysis Tool Kit (GATK). The variants were annotated and filtered using the **Golden Helix VarSeq** and **Varsome** analysis workflow implementing the ACMG guidelines for interpretation of sequence variants. This includes comparison against the gnomAD population catalogue of variants in 123,136 exomes, the 1000 Genomes Project Consortium's publication of 2,500 genomes, the NCBI ClinVar database of clinical assertions on variant's pathogenicity and multiple lines of computational evidence on conservation and functional impact. All variants with minor allele frequency (MAF) of less than 1% in gnomAD database, and disease-causing variants reported in **HGMD**, in ClinVar are considered. The investigation for relevant variants is focused on coding exons and flanking +/-10 intronic nucleotides of genes with clear gene-phenotype evidence (based on OMIM information). All potential modes of inheritance patterns are considered. In addition, provided family history and clinical information are used to evaluate identified variants with respect to their pathogenicity and causality. This test has not been cleared or approved by the U.S. Food and Drug Administration (FDA). The FDA has determined that such clearance or approval is not necessary.

VARIANT ASSESSMENT PROCESS

The following databases and in-silico algorithms are used to annotate and evaluate the impact of the variant in the context of human disease: 1000 genomes, gnomAD, ClinVar, OMIM, dbSNP, NCBI RefSeq Genes, ExAC Gene Constraints, VS-SIFT, VS-PolyPhen2, PhyloP, GERP++, GeneSplicer, MaxEntScan, NNSplice, PWM Splice Predictor. Analysis was reported using the HGVS nomenclature (www.hgvs.org/mutnomen) as implemented by the VarSeq transcript annotation algorithm. The reported transcript matches those used most frequently by the clinical labs submitting to ClinVar.

LIMITATIONS

It should be noted that this test is limited to a limited number of genes and does not include all intronic and non-coding regions. This report only includes variants that meet a level of evidence threshold for cause or contribution to disease. Certain classes of genomic variants are also not covered using the NGS testing technology, including triplet repeat expansions, copy number alterations, translocations and gene fusions or other complex structural rearrangements. More evidence for disease association of genes and causal pathogenic variants is discovered every year, and it is recommended that genetic variants are re-interpreted with updated software and annotations periodically.

VARIANT CLASSIFICATION BASED ON ACMG RECOMMENDATIONS

Genetic test results are reported based on the recommendations of American College of Medical Genetics (ACMG) as described below [1]

Variant	A change in a gene. This could be disease causing (pathogenic) or not disease causing (benign).
Pathogenic	A disease-causing variation in a gene which can explain the patients' symptoms.
Likely pathogenic	A variant which is very likely to contribute to the development of disease. However, the scientific evidence is currently insufficient to prove this conclusively. Additional evidence is expected to confirm this assertion of pathogenicity
Variant of uncertain significance	A variant which is difficult to classify either as pathogenic (disease causing) or benign (non-disease causing) based on current available scientific evidence.

ACMG Criteria for classifying Variants.

Very Strong (PVS1)	
PVS1	Null variant (nonsense, frameshift, canonical ±1 or 2 splice sites, initiation codon, single or multi-exon deletion) in a gene where LOF is a known mechanism of disease.
Strong (PS)	
PS1	Same amino acid change as a previously established pathogenic variant regardless of nucleotide change
PS2	De novo variant (both maternity and paternity confirmed) in a patient with the disease and no family history.
PS3	Well-established in vitro or in vivo functional studies supportive of a damaging effect on the gene or gene product.
PS4	The prevalence of the variant in affected individuals is significantly increased compared with the prevalence in controls.
Moderate (PM)	

PM1	Located in a mutational hot spot and/or critical and well-established functional domain (e.g., active site of an enzyme) without benign variation
PM2	Absent from controls (or at extremely low frequency if recessive) in reputed databases.
PM3	Variant (one of the compound heterozygous), is segregating with a pathogenic variant with known phase after testing of parents.
PM4	An in-frame deletions/insertions in non-repeat region or stop-loss can alter the protein length.
PM5	A novel missense change at the same amino acid residue where a pathogenic missense variant has already been determined.
PM6	De novo, without testing in the family.
Supporting (PP)	
PP1	A variant in known gene for a disease which is co-segregating in multiple affected family members
PP2	Missense variants are a common mechanism of disease in a gene which has low benign missense variants.
PP3	A deleterious effect of the variant is predicted by multiple lines of computational evidence (conservation, evolutionary, splicing impact, etc.)
PP4	Patient's phenotype or family history is highly specific for a disease with a single genetic etiology.
PP5	Reputable source recently reported the variant as pathogenic, but the evidence is not available to the laboratory to perform an independent evaluation.

DISCLAIMER

- In accordance with the Pre-Conception and Pre-Natal Diagnostic Testing (PCPNDT) Act, 2003- Govt. of India; Lab does not disclose the gender of the fetus.
- Prenatal genetic testing or pre-implantation genetic diagnosis is not recommended for the variants reported as variants of uncertain significance (VUS).
- Interpretation of variants in this report is performed to the best knowledge of the laboratory based on the information available at the time of reporting. The classification of variants can change over time and the laboratory cannot be held responsible for this. Re-analysis of variants in previously issued reports considering new evidence is not routinely performed but may be available upon request.
- Negative results do not completely exclude the risk/carrier status for these disorders tested (residual risk)
- The sensitivity of this assay to detect large deletions/duplications of more than 10bp or copy number variations (CNV) is 70-75%. The CNVs detected must be confirmed by an alternate method.
- Due to inherent technological limitations of the assay, not all bases of the exome can be covered by this test. Accordingly, variants in regions of insufficient coverage may not be identified and/or interpreted. Therefore, it is possible that pathogenic variants are present in one or more of the genes analyzed but have not been detected. The variants not detected by the assay that was performed may impact the phenotype.
- It is also possible that a pathogenic variant is present in a gene that was not selected for analysis and/or interpretation in cases where insufficient phenotypic information is available.

- Genes with pseudogenes, paralog genes and genes with low complexity may have decreased sensitivity and specificity of variant detection and interpretation due to inability of the data and analysis tools to unambiguously determine the origin of the sequence data in such regions.
- The mutations have not been validated/confirmed by Sanger sequencing.
- Incidental or secondary findings (if any) that meet the ACMG guidelines [2] can be given upon request.
- The report shall be generated within turnaround time (TAT), however, such TAT may vary depending upon the complexity of test(s) requested. Laboratory under no circumstances will be liable for any delay beyond aforementioned TAT.
- It is hereby clarified that the report(s) generated from the test(s) do not provide any diagnosis or opinion or recommend any cure in any manner. Laboratory hereby recommends the patient and/or the guardians of the patients, as the case may be, to take assistance of the clinician or a certified physician or doctor, to interpret the report(s) thus generated. Laboratory hereby disclaims all liability arising in connection with the report(s).
- In a very few cases genetic tests may not show the correct results, e.g., because of the quality of the material provided to the laboratory. In cases where any test provided by the laboratory fails for unforeseeable or unknown reasons that cannot be influenced by the laboratory in advance, the laboratory shall not be responsible for the incomplete, potentially misleading, or even wrong result of any testing if such could not be recognized by the laboratory in advance.
- This is a laboratory developed test and the development and the performance characteristics of this test was determined by the laboratory.

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CONDITIONS FOR REPORTING

1. It is presumed that the specimen belongs to the patient named or identified, such verification being carried out at the point of generation of said specimen.
2. A test might not be performed due to following reasons:
   a. Specimen quantity not sufficient (Inadequate collection/spillage during transit).
   b. Specimen quality not acceptable (Hemolysis/clotted/lipemic).
   c. Incorrect sample type.
   d. Test canceled either on request of patient or doctor.
3. In any of the above cases a fresh specimen will be required for testing and reporting.
4. The results of the tests may vary from lab to lab, time to time for the same patient.
5. The reported results are dependent on individual assay methods, equipment, method sensitivity, specificity and quality of the specimen received.
6. Partial representation of the report is not allowed.
7. The reported tests are for the notification of the referring doctor, only to assist him/her in the diagnosis and management of the patient.
8. Report with status "Preliminary" means one or more tests are yet to be reported.
9. This report is not valid for Medico Legal Purpose.
10. Applicable Jurisdiction will be of "Delhi" for any dispute/claim concerning the test(s) & results of the test(s).