Hereditary Pancreatic Cancer Panel

Test code: ON0301

The Blueprint Genetics Hereditary Pancreatic Cancer Panel analyzes 22 genes associated with inherited susceptibility to pancreatic cancer.

The Panel is suited for detecting heritable germline mutations and may not be used for the detection of somatic mutations in tumor tissue. This panel is included in the Hereditary Gastrointestinal Cancer Panel and Comprehensive Hereditary Cancer Panel.

About Hereditary Pancreatic Cancer

Pancreatic ductal carcinoma makes up the vast majority (90%) of all pancreatic neoplasms, and remains a disease with very poor prognosis and high morbidity. Familial aggregation has been recognized in approximately 10% of pancreatic cancers. Familial pancreatic cancer is defined as a family with at least one pair of first-degree relatives (parent-child or sibling pair) with pancreatic cancer without an identifiable syndrome in the family. Inherited pancreatic cancer is genetically highly heterogeneous and has been associated with germline mutations in ATM, BRCA2, CDKN2A, PALB2 and BUB1B, among others (PMID: 26658419). Increased susceptibility to pancreatic cancer may also be associated with different cancer syndromes, such as hereditary breast and ovarian cancer syndrome, Lynch syndrome, ataxia telangiectasia, and familial adenomatous polyposis (PMID: 23187834). Genetic diagnosis of familial pancreatic cancer offers opportunities for personalized therapies (PMID: 25719666).

Availability

Results in 3-4 weeks. We do not offer a maternal cell contamination (MCC) test at the moment. We offer prenatal testing only for cases where the maternal cell contamination studies (MCC) are done by a local genetic laboratory. Read more: http://blueprintgenetics.com/faqs/#prenatal

Gene set description

<table>
<thead>
<tr>
<th>Gene</th>
<th>Associated phenotypes</th>
<th>Inheritance</th>
<th>ClinVar</th>
<th>HGMD</th>
</tr>
</thead>
<tbody>
<tr>
<td>APC</td>
<td>Gardner syndrome, Desmoid disease, hereditary, Familial adenomatous polyposis</td>
<td>AD</td>
<td>294</td>
<td>1780</td>
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<tr>
<td>ATM</td>
<td>Breast cancer, Ataxia-Telangiectasia</td>
<td>AD/AR</td>
<td>455</td>
<td>853</td>
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<tr>
<td>BMPR1A*</td>
<td>Polyposis, juvenile intestinal</td>
<td>AD</td>
<td>38</td>
<td>108</td>
</tr>
<tr>
<td>BRCA1*</td>
<td>Pancreatic cancer, Breast-ovarian cancer, familial</td>
<td>AD</td>
<td>2207</td>
<td>2054</td>
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<tr>
<td>BRCA2</td>
<td>Fanconi anemia, Medulloblastoma, Glioma susceptibility, Pancreatic cancer, Wilms tumor, Breast-ovarian cancer, familial</td>
<td>AD/AR</td>
<td>2514</td>
<td>1791</td>
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<tr>
<td>BUB1B</td>
<td>Mosaic variegated aneuploidy syndrome, Premature chromatid separation trait</td>
<td>AD/AR</td>
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<td>22</td>
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<tr>
<td>CDKN2A</td>
<td>Melanoma, familial, Melanoma-pancreatic cancer syndrome</td>
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<tr>
<td>EPCAM</td>
<td>Diarrhea 5, with tufting enteropathy, congenital, Colorectal cancer, hereditary nonpolyposis</td>
<td>AD/AR</td>
<td>15</td>
<td>63</td>
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<tr>
<td>FANCC</td>
<td>Fanconi anemia</td>
<td>AR</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>MEN1</td>
<td>Hyperparathyroidism, familial primary, Multiple endocrine neoplasia</td>
<td>AD</td>
<td>124</td>
<td>699</td>
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</tbody>
</table>

https://blueprintgenetics.com/
**MLH1**  Muir-Torre syndrome, Endometrial cancer, Mismatch repair cancer syndrome, Colorectal cancer, hereditary nonpolyposis  AD/AR  670  1084

**MSH2**  Muir-Torre syndrome, Endometrial cancer, Colorectal cancer, hereditary nonpolyposis, Mismatch repair cancer syndrome  AD/AR  646  1089

**MSH6**  Endometrial cancer, Mismatch repair cancer syndrome, Colorectal cancer, hereditary nonpolyposis  AD/AR  308  426

**NF1**  Watson syndrome, Neurofibromatosis, Neurofibromatosis-Noonan syndrome  AD  261  2607

**PALB2**  Fanconi anemia, Pancreatic cancer, Breast cancer  AD/AR  237  223

**PMS2**  Mismatch repair cancer syndrome, Colorectal cancer, hereditary nonpolyposis  AD/AR  151  266

**SMAD4**  Juvenile polyposis/hereditary hemorrhagic telangiectasia syndrome, Polyposis, juvenile intestinal, Myhre dysplasia, Hereditary hemorrhagic telangiectasia  AD  119  128

**STK11**  Peutz-Jeghers syndrome  AD  69  399

**TP53**  Colorectal cancer, Li-Fraumeni syndrome, Ependymoma, intracranial, Choroid plexus papilloma, Breast cancer, familial, Adrenocortical carcinoma, Osteogenic sarcoma, Hepatoblastoma, Non-Hodgkin lymphoma  AD  148  391

**TSC1**  Lymphangioleiomyomatosis, Tuberous sclerosis  AD  61  306

**TSC2**  Lymphangioleiomyomatosis, Tuberous sclerosis  AD  141  977

**VHL**  Erythrocytosis, familial, Pheochromocytoma  AD/AR  143  573

*Some regions of the gene are duplicated in the genome leading to limited sensitivity within the regions. Thus, low-quality variants are filtered out from the duplicated regions and only high-quality variants confirmed by other methods are reported out. Read more.*

Gene, refers to HGNC approved gene symbol; Inheritance to inheritance patterns such as autosomal dominant (AD), autosomal recessive (AR) and X-linked (XL); ClinVar, refers to a number of variants in the gene classified as pathogenic or likely pathogenic in ClinVar (http://www.ncbi.nlm.nih.gov/clinvar/); HGMD, refers to a number of variants with possible disease association in the gene listed in Human Gene Mutation Database (HGMD, http://www.hgmd.cf.ac.uk/ac/). The list of associated (gene specific) phenotypes are generated from CDG (http://research.nhgri.nih.gov/CGD/) or Orphanet (http://www.orpha.net/) databases.

### Non-coding disease causing variants covered by the panel

<table>
<thead>
<tr>
<th>Gene</th>
<th>Genomic location HG19</th>
<th>HGVS</th>
<th>RefSeq</th>
<th>RS-number</th>
<th>Comment</th>
<th>Reference</th>
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<tr>
<td>APC</td>
<td>Chr5:112043289</td>
<td>c.-125delA</td>
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<td>c.-190G&gt;A</td>
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<td>APC</td>
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<td>c.-192A&gt;G/T</td>
<td>NM_001127511.2</td>
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<tr>
<td>APC</td>
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<td>c.-195A&gt;C</td>
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<td>ATM</td>
<td>Chr11:108098321</td>
<td>c.-301G&gt;T</td>
<td>NM_000001.3</td>
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<tr>
<td>ATM</td>
<td>Chr11:108141209</td>
<td>c.2839-579_2839-576delAAGT</td>
<td>NM_000001.3</td>
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<td>ATM</td>
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<td>c.5763-1050A&gt;G</td>
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<td>BRCA1</td>
<td>Chr17:41197588</td>
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<td>NM_007294.3</td>
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<td>BRCA1</td>
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<td>c.-19-2A&gt;G</td>
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<td>BRCA1</td>
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<td>c.5277+296_5277+294delAAATCTAGTGTGGTTTTTTTCTCATinsGG</td>
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<td>BRCA1</td>
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<td>CDKN2A</td>
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<td>c.-34G&gt;T</td>
<td>NM_000007.4</td>
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</table>

https://blueprintgenetics.com/
Test performance

Blueprint Genetics offers a comprehensive Hereditary Pancreatic Cancer Panel that covers classical genes associated with ataxia telangiectasia, familial adenomatous polyposis, familial pancreatic cancer, hereditary breast and ovarian cancer syndrome, Li-Fraumeni syndrome, Lynch syndrome, pancreatic cancer, Peutz-Jeghers syndrome and Von Hippel-Lindau disease. The genes are carefully selected based on the existing scientific evidence, our experience and most current mutation databases. Candidate genes are excluded from this first-line diagnostic test. The test does not recognise balanced translocations or complex inversions, and it may not detect low-level mosaicism. The test should not be used for analysis of sequence repeats or for diagnosis of disorders caused by mutations in the mitochondrial DNA.

Analytical validation is a continuous process at Blueprint Genetics. Our mission is to improve the quality of the sequencing process and each modification is followed by our standardized validation process. Average sensitivity and specificity in Blueprint NGS Panels is 99.3% and 99.9% for detecting SNPs. Sensitivity to for indels vary depending on the size of the alteration: 1-10bps (96.0%), 11-20 bps (88.4%) and 21-30 bps (66.7%). The longest detected indel was 46 bps by sequence analysis. Detection limit for Del/Dup (CNV) analysis varies through the genome depending on exon size, sequencing coverage and sequence content. The sensitivity is 71.5% for single exon deletions and duplications and 99% for three exons’ deletions and duplications. We have validated the assays for different starting materials including EDTA-blood, isolated DNA (no FFPE) and saliva that all provide high-quality results. The diagnostic yield varies substantially depending on the used assay, referring healthcare professional, hospital and country. Blueprint Genetics’ Plus Analysis (Seq+Del/Dup) maximizes the chance to find molecular genetic diagnosis for your patient although Sequence Analysis or Del/Dup Analysis may be cost-effective first line test if your patient’s phenotype is suggestive for a specific mutation profile.

Bioinformatics

The sequencing data generated in our laboratory is analyzed with our proprietary data analysis and annotation pipeline, integrating state-of-the-art algorithms and industry-standard software solutions. Incorporation of rigorous quality control steps throughout the workflow of the pipeline ensures the consistency, validity and accuracy of results. The highest relevance in the reported variants is achieved through elimination of false positive findings based on variability data for thousands of publicly available human reference sequences and validation against our in-house curated mutation database as well as the most current and relevant human mutation databases. Reference databases currently used are the 1000 Genomes Project (http://www.1000genomes.org), the NHLBI GO Exome Sequencing Project (ESP; http://evs.gs.washington.edu/EVS), the Exome Aggregation Consortium (ExAC; http://exac.broadinstitute.org), ClinVar database of genotype-phenotype associations (http://www.ncbi.nlm.nih.gov/clinvar) and the Human Gene Mutation Database (http://www.hgmd.cf.ac.uk). The consequence of variants in coding and splice regions are estimated using the following in silico variant prediction tools: SIFT (http://sift.jcvi.org), Polyphen (http://genetics.bwh.harvard.edu/pph2/), and Mutation Taster (http://www.mutationtaster.org).

Through our online ordering and statement reporting system, Nucleus, the customer can access specific details of the analysis of the patient. This includes coverage and quality specifications and other relevant information on the analysis. This represents our mission to build fully transparent diagnostics where the customer gains easy access to crucial details of the analysis process.

Clinical interpretation

In addition to our cutting-edge patented sequencing technology and proprietary bioinformatics pipeline, we also provide the
customers with the best-informed clinical report on the market. Clinical interpretation requires fundamental clinical and genetic understanding. At Blueprint Genetics our geneticists and clinicians, who together evaluate the results from the sequence analysis pipeline in the context of phenotype information provided in the requisition form, prepare the clinical statement. Our goal is to provide clinically meaningful statements that are understandable for all medical professionals, even without training in genetics.

Variants reported in the statement are always classified using the Blueprint Genetics Variant Classification Scheme modified from the ACMG guidelines (Richards et al. 2015), which has been developed by evaluating existing literature, databases and with thousands of clinical cases analyzed in our laboratory. Variant classification forms the corner stone of clinical interpretation and following patient management decisions. Our statement also includes allele frequencies in reference populations and in silico predictions. We also provide PubMed IDs to the articles or submission numbers to public databases that have been used in the interpretation of the detected variants. In our conclusion, we summarize all the existing information and provide our rationale for the classification of the variant.

A final component of the analysis is the Sanger confirmation of the variants classified as likely pathogenic or pathogenic. This does not only bring confidence to the results obtained by our NGS solution but establishes the mutation specific test for family members. Sanger sequencing is also used occasionally with other variants reported in the statement. In the case of variant of uncertain significance (VUS) we do not recommend risk stratification based on the genetic finding. Furthermore, in the case VUS we do not recommend use of genetic information in patient management or genetic counseling. For some cases Blueprint Genetics offers a special free of charge service to investigate the role of identified VUS.

We constantly follow genetic literature adapting new relevant information and findings to our diagnostics. Relevant novel discoveries can be rapidly translated and adopted into our diagnostics without delay. These processes ensure that our diagnostic panels and clinical statements remain the most up-to-date on the market.

### CPT codes

- **SEQ** 81479
- **DEL/DUP** 81479

### Accepted sample types

- EDTA blood, min. 1 ml
- Purified DNA, min. 5μg
- Saliva (Oragene DNA OG-500 kit)

Label the sample tube with your patient’s name, date of birth and the date of sample collection.

Note that we do not accept DNA samples isolated from formalin-fixed paraffin-embedded (FFPE) tissue.

### Resources

- Ataxia-Telangiectasia Society (UK)
- Pan Care Foundation
- Pancreatic Cancer UK
- Bright Pink
- Fighting Hereditary Breast and Ovarian Cancer
- HBOC Society
- Li-Fraumeni Syndrome Association
- Lynch Syndrome International
- Cancer.Net - Peutz-Jeghers Syndrome
- VHL Alliance
- NORD - Ataxia Telangiectasia
- NORD - Familial Adenomatous Polyposis
- NORD - Peutz Jeghers Syndrome

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- NORD - Von Hippel-Lindau Syndrome
- Gene Reviews - Ataxia-Telangiectasia
- Gene Reviews - BRCA1 and BRCA2 Hereditary Breast and Ovarian Cancer
- Gene Reviews - Li-Fraumeni Syndrome
- Gene Reviews - Lynch Syndrome
- Gene Reviews - Peutz-Jeghers Syndrome
- Gene Reviews - Von Hippel-Lindau Syndrome