The prevalence of aHUS is approximately 9 per 1,000,000. A study by Hofer et al. evaluated 116 aHUS patients and 118 control subjects, and found that homozygous CFHR1 deletion was detected in 32% of the patients with aHUS tested and in 2.5% of controls. CFH antibodies were detected in 82% of patients with aHUS. Absence of CFHR1 and/or CFHR3 was shown to contribute to the defective regulation of complement activation on cell and tissue surfaces. Hofer et al. evaluated 116 aHUS patients and 118 controls. Homozygous deletion in CFHR1 was detected in 32% of the patients with aHUS tested and in 2.5% of controls. CFH antibodies were detected in 82% of patients with aHUS. Antibody-positive patients also received plasma therapy more often. It is noteworthy that disease activity appears to correlate better with immune complex titers than FHAA titers. In 2016, Chalilis and al described novel CFH/CFHR3 hybrid gene in a patient with aHUS secondary to a de novo 6.3-kb deletion that arose through microhomology-mediated end joining rather than nonallelic homologous recombination. Secreted protein product lacked the recognition domain of factor H and exhibits impaired cell surface complement regulation. The fact that the formation of this hybrid gene arose as a de novo event suggests that this cluster is a dynamic area of the genome in which additional genomic disorders may arise (PubMed: 26490391). CFHR1-4 genes In August 25 2017, Blueprint Genetics excluded CFHR1, CFHR2, CFHR3, CFHR4 genes from three diagnostic NGS panels including Primary Immunodeficiency Panel, Complement System Disorder Panel and Hemolytic Uremic Syndrome Panel. This was done due to the fact that the formation of this hybrid gene arose as a de novo event suggests that this cluster is a dynamic area of the genome in which additional genomic disorders may arise (PubMed: 26490391). CFHR1-4 genes In August 25 2017, Blueprint Genetics excluded CFHR1, CFHR2, CFHR3, CFHR4 genes from three diagnostic NGS panels including Primary Immunodeficiency Panel, Complement System Disorder Panel and Hemolytic Uremic Syndrome Panel. This was done due to the fact that the formation of this hybrid gene arose as a de novo event suggests that this cluster is a dynamic area of the genome in which additional genomic disorders may arise (PubMed: 26490391). CFHR1-4 genes In August 25 2017, Blueprint Genetics excluded CFHR1, CFHR2, CFHR3, CFHR4 genes from three diagnostic NGS panels including Primary Immunodeficiency Panel, Complement System Disorder Panel and Hemolytic Uremic Syndrome Panel. This was done due to the fact that the formation of this hybrid gene arose as a de novo event suggests that this cluster is a dynamic area of the genome in which additional genomic disorders may arise (PubMed: 26490391). CFHR1-4 genes In August 25 2017, Blueprint Genetics excluded CFHR1, CFHR2, CFHR3, CFHR4 genes from three diagnostic NGS panels including Primary Immunodeficiency Panel, Complement System Disorder Panel and Hemolytic Uremic Syndrome Panel. This was done due to the fact that the formation of this hybrid gene arose as a de novo event suggests that this cluster is a dynamic area of the genome in which additional genomic disorders may arise (PubMed: 26490391).
caused by this defect (over estimating the effect), we are left with the fact that 99.95% of the individuals with homozygous CFHR1 deletion will never get aHUS. Thus, we consider releasing copy number from CFHR1-4 genes may be misleading, and is not considered helpful in clinical practice. We believe that fusion genes between CFH and CFHR1-4 may be the mechanism that explain the association between CFHR1-4 gene deletions and aHUS. However, this kind of alterations are not reliably detected by targeted sequencing approaches.

Availability

Results in 3-4 weeks

Gene set description

Genes in the Hemolytic Uremic Syndrome Panel and their clinical significance

<table>
<thead>
<tr>
<th>Gene</th>
<th>Associated phenotypes</th>
<th>Inheritance</th>
<th>ClinVar</th>
<th>HGMD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAMTS13</td>
<td>Schulman-Upshaw syndrome, Thrombotic thrombocytopenic purpura, familial</td>
<td>AR</td>
<td>30</td>
<td>183</td>
</tr>
<tr>
<td>C3</td>
<td>Hemolytic uremic syndrome, atypical, Complement component 3 deficiency, Macular degeneration, age-related</td>
<td>AD/AR</td>
<td>6</td>
<td>87</td>
</tr>
<tr>
<td>CD46*</td>
<td>Hemolytic uremic syndrome, atypical</td>
<td>AD/AR</td>
<td>5</td>
<td>81</td>
</tr>
<tr>
<td>CFB</td>
<td>Complement factor B deficiency, Hemolytic uremic syndrome, atypical</td>
<td>AD/AR</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>CFH*</td>
<td>Hemolytic uremic syndrome, atypical, Complement factor H deficiency, Basal laminar drusen</td>
<td>AD/AR</td>
<td>18</td>
<td>305</td>
</tr>
<tr>
<td>CFHR5</td>
<td>Atypical hemolytic-uremic syndrome with anti-factor H antibodies, C3 glomerulonephritis</td>
<td>AD/AR</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>CFI</td>
<td>Hemolytic uremic syndrome, atypical, Complement factor I deficiency</td>
<td>AD/AR</td>
<td>10</td>
<td>143</td>
</tr>
<tr>
<td>DGKE</td>
<td>Nephrotic syndrome</td>
<td>AR</td>
<td>17</td>
<td>38</td>
</tr>
<tr>
<td>THBD</td>
<td>Thrombophilia due to thrombomodulin defect, Hemolytic uremic syndrome, atypical</td>
<td>AD</td>
<td>5</td>
<td>28</td>
</tr>
</tbody>
</table>

*Some regions of the gene are duplicated in the genome. [Read more](https://blueprintgenetics.com/).

# The gene has suboptimal coverage (means <90% of the gene’s target nucleotides are covered at >20x with mapping quality score (MQ>20) reads), and/or the gene has exons listed under Test limitations section that are not included in the panel as they are not sufficiently covered with high quality sequence reads.

The sensitivity to detect variants may be limited in genes marked with an asterisk (*) or number sign (#)

Gene refers to the HGNC approved gene symbol; Inheritance refers to inheritance patterns such as autosomal dominant (AD), autosomal recessive (AR), X-linked (XL), X-linked dominant (XLD) and X-linked recessive (XLR); ClinVar refers to the number of variants in the gene classified as pathogenic or likely pathogenic in this database (ClinVar); HGMD refers to the number of variants with possible disease association in the gene listed in Human Gene Mutation Database (HGMD). The list of associated, gene specific phenotypes are generated from [CGD](https://blueprintgenetics.com/) or [Orphanet](https://blueprintgenetics.com/) 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>
</tr>
</thead>
</table>

[https://blueprintgenetics.com/](https://blueprintgenetics.com/)
Test Strengths

The strengths of this test include:

- CAP accredited laboratory
- CLIA-certified personnel performing clinical testing in a CLIA-certified laboratory
- Powerful sequencing technologies, advanced target enrichment methods and precision bioinformatics pipelines ensure superior analytical performance
- Careful construction of clinically effective and scientifically justified gene panels
- Our Nucleus online portal providing transparent and easy access to quality and performance data at the patient level
- Our publicly available analytic validation demonstrating complete details of test performance
- ~2,000 non-coding disease causing variants in our clinical grade NGS assay for panels (please see 'Non-coding disease causing variants covered by this panel' in the Panel Content section)
- Our rigorous variant classification scheme
- Our systematic clinical interpretation workflow using proprietary software enabling accurate and traceable processing of NGS data
- Our comprehensive clinical statements

Test Limitations

Due to regions of segmental duplications, the genes CFHR1, CFHR2, CFHR3 and CFHR4 cannot be reliably analyzed with NGS technologies. These genes are not included in this Panel. Please see more information on 'about the disease' section. Genes with partial, or whole gene, segmental duplications in the human genome are marked with an asterisk (*) if they overlap with the UCSC pseudogene regions. The technology may have limited sensitivity to detect variants in genes marked with these symbols (please see the Panel content table above).

This test does not detect the following:

- Complex inversions
- Gene conversions
- Balanced translocations
- Mitochondrial DNA variants
- Repeat expansion disorders unless specifically mentioned
- Non-coding variants deeper than ±20 base pairs from exon-intron boundary unless otherwise indicated (please see above Panel Content / non-coding variants covered by the panel).

This test may not reliably detect the following:

- Low level mosaicism (variant with a minor allele fraction of 14.6% is detected with 90% probability)
- Stretches of mononucleotide repeats
- Indels larger than 50bp
- Single exon deletions or duplications
- Variants within pseudogene regions/duplicated segments

The sensitivity of this test may be reduced if DNA is extracted by a laboratory other than Blueprint Genetics.

For additional information, please refer to the Test performance section and see our Analytic Validation.
Test performance

Our panels are sectioned from our high-quality, clinical grade NGS assay. Please see our sequencing and detection performance table for details regarding our ability to detect different types of alterations (Table).

Assays have been validated for various sample types including EDTA-blood, isolated DNA (excluding from formalin fixed paraffin embedded tissue), saliva and dry blood spots (filter cards). These sample types were selected in order to maximize the likelihood for high-quality DNA yield. The diagnostic yield varies depending on the assay used, referring healthcare professional, hospital and country. Plus analysis increases the likelihood of finding a genetic diagnosis for your patient, as large deletions and duplications cannot be detected using sequence analysis alone. Blueprint Genetics’ Plus Analysis is a combination of both sequencing and deletion/duplication (copy number variant (CNV)) analysis.

Performance of Blueprint Genetics high-quality, clinical grade NGS sequencing assay for panels.

<table>
<thead>
<tr>
<th></th>
<th>Sensitivity % (TP/(TP+FN)</th>
<th>Specificity %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single nucleotide variants</td>
<td>99.89% (99,153/99,266)</td>
<td>&gt;99.9999%</td>
</tr>
<tr>
<td>Insertions, deletions and indels by sequence analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-10 bps</td>
<td>99.2% (7,745/7,806)</td>
<td>&gt;99.9999%</td>
</tr>
<tr>
<td>11-50 bps</td>
<td>99.13% (2,524/2,546)</td>
<td>&gt;99.9999%</td>
</tr>
<tr>
<td>Copy number variants (exon level dels/dups)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 exon level deletion (heterozygous)</td>
<td>100% (20/20)</td>
<td>NA</td>
</tr>
<tr>
<td>1 exon level deletion (homozygous)</td>
<td>100% (5/5)</td>
<td>NA</td>
</tr>
<tr>
<td>1 exon level deletion (het or homo)</td>
<td>100% (25/25)</td>
<td>NA</td>
</tr>
<tr>
<td>2-7 exon level deletion (het or homo)</td>
<td>100% (44/44)</td>
<td>NA</td>
</tr>
<tr>
<td>1-9 exon level duplication (het or homo)</td>
<td>75% (6/8)</td>
<td>NA</td>
</tr>
<tr>
<td>Simulated CNV detection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 exons level deletion/duplication</td>
<td>98.7%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Size range (0.1-47 Mb)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean sequencing depth</td>
<td>143X</td>
<td></td>
</tr>
<tr>
<td>Nucleotides with &gt;20x sequencing coverage (%)</td>
<td>99.86%</td>
<td></td>
</tr>
</tbody>
</table>

The performance presented above reached by Blueprint Genetics high-quality, clinical grade NGS sequencing assay with the following coverage metrics
Bioinformatics

The target region for each gene includes coding exons and ±20 base pairs from the exon-intron boundary. In addition, the panel includes non-coding and regulatory variants if listed above (Non-coding variants covered by the panel). Some regions of the gene(s) may be removed from the panel if specifically mentioned in the 'Test limitations' section above. 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. Our pipeline is streamlined to maximize sensitivity without sacrificing specificity. We have incorporated a number of reference population databases and mutation databases including, but not limited, to 1000 Genomes Project, gnomAD, ClinVar and HGMD into our clinical interpretation software to make the process effective and efficient. For missense variants, in silico variant prediction tools such as SIFT, PolyPhen, MutationTaster are used to assist with variant classification. Through our online ordering and statement reporting system, Nucleus, ordering providers have access to the details of the analysis, including patient specific sequencing metrics, a gene level coverage plot and a list of regions with <20X sequencing depth if applicable. This reflects our mission to build fully transparent diagnostics where ordering providers can easily visualize the crucial details of the analysis process.

Clinical interpretation

We provide customers with the most comprehensive clinical report available on the market. Clinical interpretation requires a fundamental understanding of clinical genetics and genetic principles. At Blueprint Genetics, our PhD molecular geneticists, medical geneticists and clinical consultants prepare the clinical statement together by evaluating the identified variants in the context of the phenotypic information provided in the requisition form. Our goal is to provide clinically meaningful statements that are understandable for all medical professionals regardless of whether they have formal training in genetics.

Variant classification is the corner stone of clinical interpretation and resulting patient management decisions. Our classifications follow the Blueprint Genetics Variant Classification Schemes based on the ACMG guideline 2015. Minor modifications were made to increase reproducibility of the variant classification and improve the clinical validity of the report. Our experience with tens of thousands of clinical cases analyzed at our laboratory allowed us to further develop the industry standard.

The final step in the analysis is orthogonal confirmation. Sequence variants classified as pathogenic, likely pathogenic and variants of uncertain significance (VUS) are confirmed using bi-directional Sanger sequencing when they do not meet our stringent NGS quality metrics for a true positive call. Reported heterozygous and homo/hemizygous copy number variations with a size <10 and <3 target exons are confirmed by orthogonal methods such as qPCR if the specific CNV has been seen and confirmed less than three times at Blueprint Genetics.

Our clinical statement includes tables for sequencing and copy number variants that include basic variant information (genomic coordinates, HGVS nomenclature, zygosity, allele frequencies, in silico predictions, OMIM phenotypes and classification of the variant). In addition, the statement includes detailed descriptions of the variant, gene and phenotype(s) including the role of the specific gene in human disease, the mutation profile, information about the gene's variation in population cohorts and detailed information about related phenotypes. We also provide links to the references, abstracts and variant databases used to help ordering providers further evaluate the reported findings if desired. The conclusion summarizes all of the existing information and provides our rationale for the classification of the variant.

Identification of pathogenic or likely pathogenic variants in dominant disorders or their combinations in different alleles in recessive disorders are considered molecular confirmation of the clinical diagnosis. In these cases, family member testing can be used for risk stratification. We do not recommend using variants of uncertain significance (VUS) for family member risk stratification or patient management. Genetic counseling is recommended.

Our interpretation team analyzes millions of variants from thousands of individuals with rare diseases. Our internal database and our understanding of variants and related phenotypes increases with every case analyzed. Our laboratory is therefore well-positioned to re-classify previously reported variants as new information becomes available. If a variant previously reported by Blueprint Genetics is re-classified, our laboratory will issue a follow-up statement to the original ordering health care provider at no additional cost.

#}
ICD codes

Commonly used ICD-10 codes when ordering the Hemolytic Uremic Syndrome Panel

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>D58.8</td>
<td>Hemolytic uremic syndrome</td>
</tr>
</tbody>
</table>

Accepted sample types

- EDTA blood, min. 1 ml
- Purified DNA, min. 3μg*
- 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

- Atypical HUS Foundation
- GeneReviews
- GeneReviews - Genetic Atypical Hemolytic-Uremic Syndrome
- National Organization for Rare Disorder
- aHUS Alliance
- aHUS Canada