

DEPARTMENT OF GENOMICS AND MOLECULAR DIAGNOSTICS

Patient Name	Master SHIVANSH	Visit ID	-	Collection Date	21-04-2024 11:55 AM
Age / Gender	8 Y / MALE	UHID		Registration Date	22-04-2024 11:37 AM

DMD Analysis by MLPA

Referral Reason

I/V/O clinical suspicion, Master Shivansh was referred for deletion/duplication testing by MLPA for *DMD* gene.

Test Result

Hemizygous deletion of exons 17-36 and exons 49 - 50 detected in DMD gene.

Interpretation

The deletion/duplication analysis by MLPA for *DMD* gene in this individual showed **Hemizygous deletion of exons 17-36 and exons 49-50**. The presence of **Hemizygous deletion** is consistent with the diagnosis of Duchenne Muscular Dystrophy (DMD). Clinical correlation is recommended.

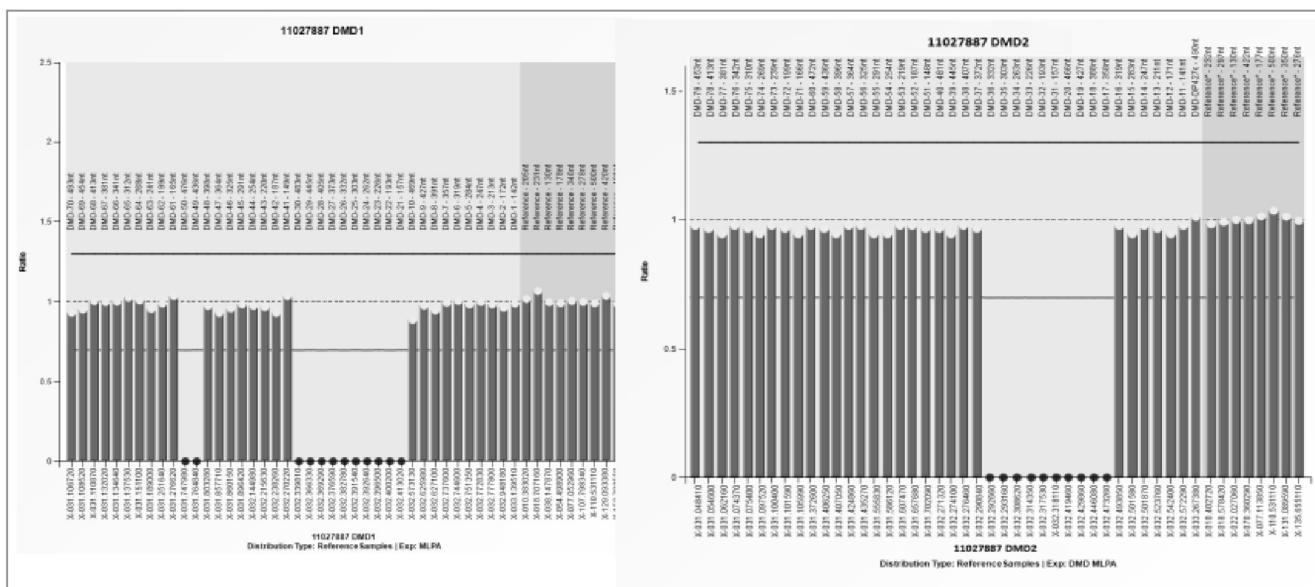


Fig 1: Probe Distribution Ratio for DMD gene _11027887

Approved by

 Kanaka Durga Devi.Y
 Technical Lead -Molecular
 Diagnostics.

Approved by

 A. Radhika
 Co-Head Genomics

Approved by

 Dr. NAUSHAD
 CHIEF SCIENTIFIC OFFICER
 Reg No.: 43432

DEPARTMENT OF GENOMICS AND MOLECULAR DIAGNOSTICS

Patient Name	Master SHIVANSH	Visit ID	-	Collection Date	21-04-2024 11:55 AM
Age / Gender	8 Y / MALE	UHID	-	Registration Date	22-04-2024 11:37 AM

DMD Analysis by MLPA

Recommendations

- Genetic Counselling and clinical correlation is recommended.

Methodology

Multiplex Ligation-dependent probe amplification (MLPA) method is used for detection of deletion and duplication in 79 exons on DMD gene using SALSA MLPA probe mix available from MRC (Holland). Coffalyser.Net software is used for data analysis. The exon numbering used in this P034-B2 DMD-1 and P035-B1 DMD-2 product description is the exon numbering from the RefSeq transcript NM_004006.2, which is identical to the LRG_199 sequence.

Kanaka Durga Devi.Y
Technical Lead -Molecular
Diagnostics.

A. Radhika
Co-Head Genomics

Approved by
Dr. NAUSHAD
CHIEF SCIENTIFIC OFFICER
Reg No.: 43432

DEPARTMENT OF GENOMICS AND MOLECULAR DIAGNOSTICS

Patient Name	Master SHIVANSH	Visit ID	-	Collection Date	21-04-2024 11:55 AM
Age / Gender	8 Y / MALE	UHID	-	Registration Date	22-04-2024 11:37 PM

DMD Analysis by MLPA

Clinical features

The dystrophinopathies include Duchenne muscular dystrophy (DMD, OMIM 310200), Becker muscular dystrophy (BMD, OMIM 300376), and dilated cardiomyopathy, type 3B (CMD3B, OMIM 302045). Duchenne muscular dystrophy is the most common form of congenital muscular dystrophy in all ethnic groups. DMD presents in affected boys in early childhood with difficulty walking and climbing stairs, progressive proximal weakness, pseudohypertrophy of the calves, and greatly elevated serum creatine phosphokinase (CK) levels (Darras et al. 2011). Patients become wheelchair dependent by age 13. Dilated cardiomyopathy and congestive heart failure occur in nearly all patients by their late teens or early 20s. DMD muscle biopsies show a dystrophic process with fibrosis and fatty infiltration. Dystrophin protein content in DMD patients is less than 5% of controls when measured by Western blot or immunohistochemistry (Hoffman et al. 1988).

Becker muscular dystrophy is a relatively mild form of dystrophinopathy with later onset of proximal weakness and preservation of ambulation into the third decade of life. The minimum age for wheelchair dependency in BMD is age 16. As in DMD, cardiomyopathy is a significant cause of morbidity, however, serum CK levels are less elevated than in DMD (Zatz et al. 1991). Dystrophin protein content in BMD patients varies from 20% of control levels to normal levels when measured by Western blot or immunohistochemistry (Hoffman et al. 1988). Both DMD and BMD can be associated with intellectual deficits, involving working memory and executive function (Darras et al. 2011).

DMD-related cardiomyopathy in the absence of skeletal muscle disease is a less common form of dystrophinopathy which presents in affected males between 20 and 40 years of age and later in carrier females (Beggs 1997). In some mild BMD patients, cardiomyopathy can be the presenting feature (Towbin 1998). Females who are heterozygous for a DMD causative mutation are at risk for dilated cardiomyopathy and 70% have slightly elevated CK (Schade van Westrum et al. 2011). Carriers may also present with a myopathy resembling limb-girdle muscular dystrophy (Moser and Emery 1974).

The dystrophinopathies are inherited as X-linked recessive disorders caused by DMD gene located at Xp21 which encodes dystrophin. Heterozygous female carriers are at increased risk for dilated cardiomyopathy. Approximately two-thirds of the mutations in DMD patients are deletions of one or more exons in the DMD gene. The occurrence of deletions is slightly higher in BMD patients. Duplications are found in approximately 10% of DMD patients and 20% of BMD patients. In general, in-frame deletions, which preserve partial functional dystrophin protein, are correlated with a milder (BMD) clinical phenotype (Monaco et al. 1988; Aartsma-Rus et al. 2006).

Limitations: DMD base pair substitutions, small deletions/duplications, deep intronic, and regulatory region mutations will not be detected. Breakpoints for large deletions/duplications will not be determined. Diagnostic errors can occur due to rare sequence variation.

Disclaimer



Kanaka Durga Devi.Y
Technical Lead -Molecular
Diagnostics.



A. Radhika
Co-Head Genomics



Approved by
Dr. NAUSHAD
CHIEF SCIENTIFIC OFFICER
Reg No.: 43432

DEPARTMENT OF GENOMICS AND MOLECULAR DIAGNOSTICS

Patient Name	Master SHIVANSH	Visit ID	-	Collection Date	21-04-2024 11:55 AM
Age / Gender	8 Y / MALE	UHID	-	Registration Date	22-04-2024 11:37 PM

DMD Analysis by MLPA

- Test results should be interpreted in the context of clinical findings, family history, and other laboratory data. Errors in our interpretation of results may occur if information given is inaccurate or incomplete.
- This test doesn't detect SNPs in the DMD gene.
- Although all precautions are taken while conducting these tests, there is a standard error rate of approximate 1% in all genetic tests and this should be taken into consideration before any clinical decision.
- It is presumed that the specimen used to perform the test belongs to the patient specified above, such verification having been carried out at the collection level of sample.
- Diagnostic errors can occur due to rare sequence variations. Regulatory region mutations, large gene deletions/duplications and some deep intronic mutations will not be detected.

References

1. Katharina J Hoff (2009): The effect of sequencing errors on metagenomic gene prediction. *BMCGenomics*, 10:520.
2. Hoffman, E. P. et al. Characterization of dystrophin in muscle-biopsy specimens from patients with Duchenne's or Becker's muscular dystrophy. *N. Engl. J. Med.* (1988). doi:10.1056/NEJM198805263182104
3. Muntoni F. et al. (1993). Deletion of the Dystrophin Muscle-Promotor region associated with X- linked dilated cardiomyopathy. *N Engl J Med* 329:921-925.
4. Dastur RS et al. (2011). Identification of deletions and duplications in the DMD gene and female carrier status in western India using combined methods of multiplex polymerase chain reaction and multiplex ligation-dependent probe amplification. *Neurol India* 59:803-809.
5. McKusick V.A., Mendelian Inheritance in Man. A Catalog of Human Genes and Genetic Disorders. Baltimore: Johns Hopkins University Press (12th edition), 1998

***** End Of Report *****

Suggested clinical correlation & follow up



Kanaka Durga Devi.Y
Technical Lead -Molecular
Diagnostics.



A. Radhika
Co-Head Genomics

Dr. NAUSHAD
CHIEF SCIENTIFIC OFFICER
Reg No. 10432