Overview

Useful For

Providing a comprehensive genetic evaluation for patients with a personal or family history suggestive of a hereditary bone marrow failure syndrome

Establishing a diagnosis of a hereditary bone marrow failure syndrome associated with known causal genes

Identifying variants within genes known to be associated with heritable bone marrow syndromes, allowing for predictive testing of at-risk family members and/or determination of targeted management (anticipatory guidance, management changes, specific therapies)

Reflex Tests

Test Id	Reporting Name	Available Separately	Always Performed
CULAF	Amniotic Fluid Culture/Genetic Test	Yes	No
_STR1	Comp Analysis using STR (Bill only)	No, (Bill only)	No
_STR2	Add'l comp analysis w/STR (Bill Only)	No, (Bill only)	No
CULFB	Fibroblast Culture for Genetic Test	Yes	No
MATCC	Maternal Cell Contamination, B	Yes	No

Genetics Test Information

This test utilizes next-generation sequencing to detect single nucleotide and copy number variants in 172 genes associated with hereditary bone marrow failure: *ABCB7, ACD, ADA, ADA2, AK2, ALAS2, ANKRD26, AP3B1, AP3D1, ARPC1B, BLOC1S6, BRCA1, BRCA2, BRIP1, CD27, CDAN1, C15orf41 (CDIN1), CEBPA, CLCN7, CLPB, CSF3R, CTC1, CXCR2, CXCR4, CYCS, DDX41, DHFR, DIAPH1, DKC1, DNAJC21, DNMT3B, EFL1, ELANE, EPO, ERCC4, ERCC6L2, ETV6, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, FANCM, FLI1, FYB1, G6PC3, GATA1, GATA2, GFI1, GFI1B, GINS1, GLA, GLRX5, GP1BA, GP1BB, GP9, HAX1, HOXA11, IKZF1, ITGA2B, ITGB3, JAGN1, KDM1A, KIF23, KLF1, LIG4, LPIN2, LYST, MAD2L2, MDM4, MECOM, MPIG6B, MPL, MTHFD1, MYH9, MYSM1, NAF1, NBEAL2, NBN, NHP2, NOP10, OSTM1, PALB2, PARN, PAX5, PGM3, PIK3CD, POT1, PRKACG, PUS1, RAB27A, RAC2, RAD50, RAD51, RAD51C, RBM8A, RECQL4, RFWD3, RMRP, RPA1, RPL11, RPL15, RPL18, RPL26, RPL27, RPL35, RPL35A, RPL5, RPS10, RPS15A, RPS17, RPS19, RPS24, RPS26, RPS27, RPS28, RPS29, RPS7, RTEL1, RUNX1, SAMD9, SAMD9L, SBDS, SEC23B, SLC19A2, SLC25A38, SLC37A4, SLC46A1, SLFN14, SLX4, SMARCAL1, SMARCD2, SNX10, SRC, SRP54, SRP72, STAT3, STIM1, STN1, STXBP2, SYK, TAZ (TAFAZZIN), TCIRG1, TCN2, TERC, TERT, THPO, TINF2, TNFRSF11A, TNFRSF13B, TNFSF11, TP53, TRNT1, TSR2, TUBB1, UBE2T, USB1, VPS13B, VPS45, VWF, WAS, WDR1, WIPF1, WRAP53, XIAP, XRCC2, YARS2,* and *ZCCHC8*. See Targeted Genes and Methodology Details for Inherited Bone Marrow Failure Gene Panel and Method Description for additional

details.

Identification of a disease-causing variant may assist with diagnosis, prognosis, clinical management, recurrence risk assessment, familial screening, and genetic counseling for hereditary bone marrow failure.

Testing Algorithm

Skin biopsy:

For skin biopsy or cultured fibroblast specimens, a fibroblast culture will be performed at an additional charge. If viable cells are not obtained, the client will be notified.

Cord blood:

For cord blood specimens that have an accompanying maternal blood specimen, maternal cell contamination studies will be performed at an additional charge.

Special Instructions

- Informed Consent for Genetic Testing
- Blood Spot Collection Card-Spanish Instructions
- Blood Spot Collection Card-Chinese Instructions
- Informed Consent for Genetic Testing (Spanish)
- Blood Spot Collection Instructions
- Congenital Neutropenia, Bone Marrow Failure, Telomere Defects, and Pulmonary Fibrosis (IPF) Patient Information
- Targeted Genes and Methodology Details for Inherited Bone Marrow Failure Gene Panel

Method Name

Sequence Capture and Amplicon-Based Next-Generation Sequencing (NGS) followed by Droplet Digital Polymerase Chain Reaction (ddPCR)/Quantitative Real-Time Polymerase Chain Reaction (qPCR) and Sanger Sequencing as needed

NY State Available

Yes

Specimen

Specimen Type

Varies

Ordering Guidance

Patients who have had a previous bone marrow transplant from an allogenic donor should not have blood, bone marrow, or saliva submitted for testing, as results generated will reflect the genome of the donor rather than the recipient. Testing on patients who have an active hematologic malignancy or hematologic disorder with clonal proliferation may identify both somatic mutations and germline variants, which may result in test failure or necessitate follow-up testing to determine whether the detected variant is germline or somatic. For these patients, testing a skin biopsy or cultured fibroblasts is recommended. For instructions for testing patients who have received a bone marrow transplant or have an active hematologic disorder, call 800-533-1710. For more information see Cautions.

Customization of this panel and single gene analysis for any gene present on this panel are available. To modify this panel via CGPH, use the Inborn Errors of Immunity/Bone Marrow Failure/Telomeropathy/Pulmonary Fibrosis/Very Early Onset IBD/Pancreatitis disease state for step 1 on the Custom Gene Ordering Tool

Targeted testing for familial variants (also called site-specific or known variants testing) is available for the genes on this panel. See FMTT / Familial Variant, Targeted Testing, Varies. To obtain more information about this testing option, call 800-533-1710.

Specimen Required

Patient Preparation: A previous hematopoietic stem cell transplant from an allogenic donor will interfere with testing. For information about testing patients who have received a hematopoietic stem cell transplant, call 800-533-1710.

Submit only 1 of the following specimens:

Specimen Type: Whole blood
Container/Tube:
Preferred: Lavender top (EDTA) or yellow top (ACD)
Acceptable: Green top (sodium heparin)
Specimen Volume: 3 mL
Collection Instructions:
1. Invert several times to mix blood.
2. Send whole blood specimen in original tube. **Do not aliquot**.
3. Whole blood collected postnatal from an umbilical cord is also acceptable. See Additional Information.
Specimen Stability Information: Ambient (preferred) 4 days/Refrigerated 4 days/Frozen 4 days
Additional Information:
1. Specimens are preferred to be received within 4 days of collection. Extraction will be attempted for specimens received after 4 days, and DNA yield will be evaluated to determine if testing may proceed.
2. To ensure minimum volume and concentration of DNA are met, the requested volume must be submitted. Testing may be canceled if DNA requirements are inadequate.
3. For postnatal umbilical cord whole blood specimens, maternal cell contamination studies are recommended to ensure test results reflect that of the patient tested. A maternal blood specimen is required to complete maternal cell contamination studies. Order MATCC / Maternal Cell Contamination, Molecular Analysis, Varies on both the cord blood and maternal blood specimens under separate order numbers.

Specimen Type: Skin biopsy
Supplies: Fibroblast Biopsy Transport Media (T115)
Container/Tube: Sterile container with any standard cell culture media (eg, minimal essential media, RPMI 1640). The solution should be supplemented with 1% penicillin and streptomycin.
Specimen Volume: 4-mm Punch
Specimen Stability Information: Ambient (preferred) <24 hours/Refrigerated <24 hours
Additional Information:
1. Specimens are preferred to be received within 24 hours of collection. Culture and extraction will be attempted for specimens received after 24 hours and will be evaluated to determine if testing may proceed.

2. A separate culture charge will be assessed under CULFB / Fibroblast Culture for Biochemical or Molecular Testing. An additional 3 to 4 weeks are required to culture fibroblasts before genetic testing can occur.

Specimen Type: Cultured fibroblasts
Source: Skin or tissue
Container/Tube: T-25 flask
Specimen Volume: 2 Flasks
Collection Instructions: Submit confluent cultured fibroblast cells from a skin or tissue biopsy. Cultured cells from a prenatal specimen **will not be accepted**.
Specimen Stability Information: Ambient (preferred) <24 hours/Refrigerated <24 hours
Additional Information:
1. Specimens are preferred to be received within 24 hours of collection. Culture and extraction will be attempted for specimens received after 24 hours and will be evaluated to determine if testing may proceed.
2. A separate culture charge will be assessed under CULFB / Fibroblast Culture for Biochemical or Molecular Testing. An additional 3 to 4 weeks are required to culture fibroblasts before genetic testing can occur.

Specimen Type: Bone marrow aspirate
Container/Tube:
Preferred: Lavender top (EDTA)
Acceptable: Yellow top (ACD)
Specimen Volume: 2 mL
Collection Instructions:
1. Invert several times to mix bone marrow.
2. Send bone marrow specimen in original tube. **Do not aliquot.**
3. Label specimen as bone marrow.
Specimen Stability Information: Ambient (preferred) 4 days/Refrigerate 4 days/Frozen 4 days
Additional Information:
1. Specimens are preferred to be received within 4 days of collection. Extraction will be attempted for specimens received after 4 days, and DNA yield will be evaluated to determine if testing may proceed.
2. To ensure minimum volume and concentration of DNA are met, the requested volume must be submitted. Testing may be canceled if DNA requirements are inadequate.

Specimen Type: Blood spot
Supplies: Card-Blood Spot Collection (Filter Paper) (T493)
Container/Tube:
Preferred: Collection card (Whatman Protein Saver 903 Paper)
Acceptable: PerkinElmer 226 filter paper or blood spot collection card
Specimen Volume: 2 to 5 Blood spots
Collection Instructions:
1. An alternative blood collection option for a patient older than 1 year is a fingerstick. For detailed instructions, see How to Collect a Dried Blood Spot Sample.
2. Let blood dry on the filter paper at ambient temperature in a horizontal position for a minimum of 3 hours.
3. Do not expose specimen to heat or direct sunlight.
4. Do not stack wet specimens.

5. Keep specimen dry
Specimen Stability Information: Ambient (preferred)/Refrigerated
Additional Information:
1. Blood spot specimens are acceptable but not recommended. Multiple extractions will be required to obtain sufficient yield for supplemental analysis, and there is significant risk for test failure due to insufficient DNA.
2. Due to lower concentration of DNA yielded from blood spot, some aspects of the test may not perform as well as DNA extracted from a whole blood sample. When applicable, specific gene regions that were unable to be interrogated will be noted in the report. Alternatively, additional specimen may be required to complete testing.
3. For collection instructions, see Blood Spot Collection Instructions
4. For collection instructions in Spanish, see Blood Spot Collection Card-Spanish Instructions (T777)
5. For collection instructions in Chinese, see Blood Spot Collection Card-Chinese Instructions (T800)

Specimen Type: Saliva
Patient Preparation: Patient should not eat, drink, smoke, or chew gum 30 minutes prior to collection.
Supplies:
DNA Saliva Kit High Yield (T1007)
Saliva Swab Collection Kit (T786)
Container/Tube:
Preferred: High-yield DNA saliva kit
Acceptable: Saliva swab
Specimen Volume: 1 Tube if using T1007 or 2 swabs if using T786
Collection Instructions: Collect and send specimen per kit instructions.
Specimen Stability Information: Ambient (preferred) 30 days/Refrigerated 30 days
Additional Information: Saliva specimens are acceptable but not recommended. Due to lower quantity/quality of DNA yielded from saliva, some aspects of the test may not perform as well as DNA extracted from a whole blood sample. When applicable, specific gene regions that were unable to be interrogated will be noted in the report. Alternatively, additional specimen may be required to complete testing.

Specimen Type: Extracted DNA
Container/Tube:
Preferred: Screw Cap Micro Tube, 2 mL with skirted conical base
Acceptable: Matrix tube, 1 mL
Collection Instructions:
1. The preferred volume is at least 100 mcL at a concentration of 75 ng/mcL.
2. Include concentration and volume on tube.
Specimen Stability Information: Frozen (preferred) 1 year/Ambient/Refrigerated
Additional Information: DNA must be extracted in a CLIA-certified laboratory or equivalent and must be extracted from a specimen type listed as acceptable for this test (including applicable anticoagulants). Our laboratory has experience with Chemagic, Puregene, Autopure, MagnaPure, and EZ1 extraction platforms and cannot guarantee that all extraction methods are compatible with this test. If testing fails, one repeat will be attempted, and if unsuccessful, the test will be reported as failed and a charge will be applied. If applicable, specific gene regions that were unable to be interrogated due to DNA quality will be noted in the report.

Forms

1. **New York Clients-Informed consent is required.**
Document on the request form or electronic order that a copy is on file. The following documents are available:
-Informed Consent for Genetic Testing (T576)
-Informed Consent for Genetic Testing (Spanish) (T826)
2. Congenital Neutropenia, Bone Marrow Failure, Telomere Defects, and Pulmonary Fibrosis (IPF) Patient Information

Specimen Minimum Volume
See Specimen Required

Reject Due To

All specimens will be evaluated at Mayo Clinic Laboratories for test suitability.

Specimen Stability Information

Specimen Type	Temperature	Time	Special Container
Varies	Varies		

Clinical & Interpretive

Clinical Information
Bone marrow failure (BMF) is characterized by the inadequate production of peripheral blood cells, resulting in single cytopenias or pancytopenia. BMF is associated with a loss, or deficient function, of hematopoietic stem or progenitor cells that may occur from a variety of acquired causes including aplastic anemia, myelodysplasia, environmental factors, drugs, and infections. BMF may also be caused by inherited or *de novo* genetic variants in one or more genes involved in hematopoiesis or bone marrow function.

The genetic landscape of inherited BMF is broad. For instance, some of the commonly recognized forms of inherited BMF include Fanconi anemia (caused by germline variants in one of several genes, such as *FANCA* and *FANCC*), Schwachman-Diamond syndrome (caused by variants in *SBDS*, *DNAJC21*, *EFL1*, *SRP54*), dyskeratosis congenita (caused by variants in one of multiple genes related to telomere biology, such as *DKC1* and *TINF2*), and Diamond-Blackfan anemia (caused by variants in one of multiple genes encoding ribosomal subunits, such as *RPS19*). Other BMF disorders also include GATA2 deficiency (*GATA2)*, MIRAGE (myelodysplasia, infection, growth restriction, adrenal hypoplasia, genital phenotypes, and enteropathy) syndrome (*SAMD9*), ataxia-pancytopenia syndrome (*SAMD9L*), severe congenital neutropenia (*ELANE*, *HAX1*, *G6PC3*, *GFI1*, and others) and congenital amegakaryocytic thrombocytopenia (*MPL*). In addition to these classically recognized BMF syndromes, variants in a broad spectrum of other genes are associated with inherited forms of cytopenias and BMF.

A suspicion for BMF should be raised by the identification of cytopenias with or without related clinical features such as infections, bleeding diathesis, fatigue, pallor, or dyspnea. In addition to hematologic findings, certain inherited BMF syndromes present with additional phenotypic and syndromic features. Importantly, several inherited BMF disorders also confer a predisposition to myeloid malignancies, such as myelodysplastic syndrome and acute myeloid leukemia, as well as other malignancies.

The diagnostic investigation of suspected BMF should include a bone marrow study. Bone marrow findings may be variable yet may include abnormalities in cellularity and dysplastic features. In patients with severely reduced cellularity and apparent aplastic anemia, a genetic etiology should also be considered. The investigation of suspected inherited BMF may also include functional screens, such as assessment of chromosomal breakage and telomere length analysis. Other tests, including viral studies and evaluation for autoimmune conditions or toxins, may also be performed to identify alternate causal factors. Nonetheless, the differential diagnosis of unilineage and multilineage cytopenias is broad, and distinguishing inherited forms of BMF from other underlying etiologies may be challenging. Next-generation sequencing-based genetic panels may be useful in the diagnostic investigation of suspected BMF in concert with the testing and screens described above.

Genetic testing for a possible inherited BMF syndrome may be considered in the setting of unexplained peripheral blood cytopenias and bone marrow abnormalities, especially when present during infancy or childhood, although contributory germline variants may be present in adults with BMF as well. The presence of extra hematopoietic features associated with syndromic forms of inherited BMF, such as skeletal abnormalities, leukoplakia, or pancreatic exocrine insufficiency, may also warrant testing. Furthermore, a myeloid malignancy arising at a young age also suggests an underlying genetic etiology, and there is increasing recognition that germline variants in genes associated with inherited forms of BMF also result in predisposition to hematological malignancies in adults. Alternatively, a family history of the clinical features or conditions described above may also suggest an underlying genetic basis for BMF.

In addition to diagnostic considerations, the identification of underlying hereditary variants in BMF carries important management implications. For instance, it may inform surveillance for malignancies and organ dysfunction in the setting of variants in genes associated with a risk for other clinical features and complications. Additionally, several forms of inherited BMF may confer a predisposition to myeloid malignancies that exhibit distinct sensitivity to cytotoxic therapy. Accordingly, the detection of certain germline variants may also guide treatment approaches including the selection of systemic therapy and conditioning regimens for hematopoietic stem cell transplantation. The identification of underlying inherited variants is also important for the optimal choice of donors for transplantation as related donors may share deleterious variants. Finally, detection of germline genetic variants associated with disease allows for familial testing to identify other individuals at risk of developing disease.

Note that testing of peripheral blood in patients with bone marrow failure, particularly in the setting of hematopoietic malignancy, may identify germline genetic variants and/or somatic mutations. This test is unable to definitively differentiate between germline variants and somatic mutations when performed on blood, bone marrow, or saliva specimens; however, testing may be performed on fibroblasts derived from a skin biopsy to aid in this differentiation.

Reference Values

An interpretive report will be provided.

Interpretation

All detected variants are evaluated according to American College of Medical Genetics and Genomics recommendations.(1) Variants are classified based on known, predicted, or possible pathogenicity and reported with interpretive comments detailing their potential or known significance.

Cautions

Clinical Correlations:
Test results should be interpreted in the context of clinical findings, family history, and other laboratory data.

Misinterpretation of results may occur if the information provided is inaccurate or incomplete.

If testing was performed because of a clinically significant family history, it is often useful to first test an affected family member. Detection of a reportable variant in an affected family member would allow for more informative testing of at-risk individuals.

To discuss the availability of additional testing options or for assistance in the interpretation of these results, contact Mayo Clinic Laboratories genetic counselors at 800-533-1710.

Technical Limitations:
Next-generation sequencing may not detect all types of genomic variants. In rare cases, false-negative or false-positive results may occur. The depth of coverage may be variable for some target regions; assay performance below the minimum acceptable criteria or for failed regions will be noted. Given these limitations, negative results do not rule out the diagnosis of a genetic disorder. If a specific clinical disorder is suspected, evaluation by alternative methods can be considered.

There may be regions of genes that cannot be effectively evaluated by sequencing or deletion and duplication analysis as a result of technical limitations of the assay, including regions of homology, high guanine-cytosine (GC) content, and repetitive sequences. Confirmation of select reportable variants will be performed by alternate methodologies based on internal laboratory criteria.

This test is validated to detect 95% of deletions up to 75 base pairs (bp) and insertions up to 47 bp. Deletions-insertions (delins) of 40 or more bp, including mobile element insertions, may be less reliably detected than smaller delins.

This analysis targets single and multi-exon deletions/duplications; however, in some instances single exon resolution cannot be achieved due to isolated reduction in sequence coverage or inherent genomic complexity. Balanced structural rearrangements (such as translocations and inversions) may not be detected.

Deletion/duplication events that extend past the genes included on the panel may occur. In these instances, genes included in the ordered test are provided on the report and interpreted, and genomic breakpoints are reported if they are confirmed. However, copy number variants for genes not listed in the Method Description are typically not reported or interpreted for haploinsufficiency/triplosensitivity. CMACB / Chromosomal Microarray, Congenital, Blood; WESPR / Panel to Whole Exome Sequencing Reflex Test, Varies; or WGSDX / Whole Genome Sequencing for Hereditary Disorders, Varies is recommended for a full interpretation of deletions/duplications predicted to extend past the genes included on the panel.

This test is not designed to detect low levels of mosaicism or to differentiate between somatic mutations and germline variants. If there is a possibility that a detected variant is somatic, additional testing may be necessary to clarify the significance of results.

Genes may be added or removed based on updated clinical relevance. For the most up to date list of genes included in this test and for detailed information regarding gene specific performance and technical limitations, see Method Description or contact a laboratory genetic counselor.

If the patient has had an allogeneic hematopoietic stem cell transplant or a recent non-leukocyte reduced blood transfusion, results of tests performed on blood, bone marrow, or saliva specimens may be inaccurate due to the presence of donor DNA. Test orders for blood, bone marrow, or saliva will be cancelled by the laboratory if there is a history of an allogeneic hematopoietic stem cell transplant. Similarly, blood, bone marrow, and saliva results will be impacted by presence of active hematologic malignancy or hematologic disorder with clonal proliferation. Call Mayo Clinic Laboratories for instructions for testing a skin biopsy or fibroblast culture for patients who have received a bone marrow transplant or have an active hematologic disorder.

Reclassification of Variants**:**
Currently, it is not standard practice for the laboratory to systematically review previously classified variants on a regular basis. The laboratory encourages healthcare professionals to contact the laboratory at any time to learn how the classification of a particular variant may have changed over time. Due to broadening genetic knowledge, it is possible that the laboratory may discover new information of relevance to the patient. Should that occur, the laboratory may issue an amended report.

Variant Evaluation:
Evaluation and categorization of variants are performed using published American College of Medical Genetics and Genomics and the Association for Molecular Pathology recommendations as a guideline.(1) Other gene-specific guidelines may also be considered. Variants are classified based on known, predicted, or possible pathogenicity and reported with interpretive comments detailing their potential or known significance. Variants classified as benign or likely benign are not reported.

Multiple in silico evaluation tools may be used to assist in the interpretation of these results. The accuracy of predictions made by in silico evaluation tools is highly dependent upon the data available for a given gene, and periodic updates to these tools may cause predictions to change over time. Results from in silico evaluation tools should be interpreted with caution and professional clinical judgment.

Rarely, incidental or secondary findings may implicate another predisposition or presence of active disease. These findings will be carefully reviewed to determine whether they will be reported.

Clinical Reference

1. Richards S, Aziz N, Bale 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;17(5):405-424
2. Dokal I, Tummala H, Vulliamy T. Inherited bone marrow failure in the pediatric patient. Blood. 2022;140(6):556-570. doi:10.1182/blood.2020006481
3. DeZern AE, Churpek JE. Approach to the diagnosis of aplastic anemia. Blood Adv. 2021;5(12):2660-2671. doi:10.1182/bloodadvances.2021004345
4. Duncavage EJ, Bagg A, Hasserjian RP, et al. Genomic profiling for clinical decision making in myeloid neoplasms and acute leukemia. Blood. 2022;140(21):2228-2247. doi:10.1182/blood.2022015853
5. Feurstein S, Trottier AM, Estrada-Merly N, et al. Germ line predisposition variants occur in myelodysplastic syndrome patients of all ages. Blood. 2022;140(24):2533-2548. doi:10.1182/blood.2022015790
6. Keel S, Geddis A. The clinical and laboratory evaluation of patients with suspected hypocellular marrow failure. Hematology Am Soc Hematol Educ Program. 2021;2021(1):134-142. doi:10.1182/hematology.2021000244

7. Weinzierl EP, Arber DA. The differential diagnosis and bone marrow evaluation of new-onset pancytopenia. Am J Clin Pathol. 2013;139(1):9-29. doi:10.1309/AJCP50AEEYGREWUZ

Performance

Method Description

Next-generation sequencing (NGS) and/or Sanger sequencing is performed to test for the presence of variants in coding regions and intron/exon boundaries of the genes analyzed, as well as some other regions that have known disease-causing variants. The human genome reference GRCh37/hg19 build was used for sequence read alignment. At least 99% of the bases are covered at a read depth over 30X. Sensitivity is estimated at above 99% for single nucleotide variants, above 94% for deletions/insertions (delins) less than 40 base pairs (bp), above 95% for deletions up to 75 bp and insertions up to 47 bp. NGS and/or a polymerase chain reaction-based quantitative method is performed to test for the presence of deletions and duplications in the genes analyzed. A supplemental droplet digital PCR method is used to detect deletions and duplications in *RPS17*.

There may be regions of genes that cannot be effectively evaluated by sequencing or deletion and duplication analysis as a result of technical limitations of the assay, including regions of homology, high guanine-cytosine (GC) content, and repetitive sequences. See Targeted Genes and Methodology Details for Inherited Bone Marrow Failure Gene Panel for details regarding the targeted genes analyzed for each test and specific gene regions not routinely covered.(Unpublished Mayo method)

Genes analyzed: *ABCB7, ACD, ADA, ADA2, AK2, ALAS2, ANKRD26, AP3B1, AP3D1, ARPC1B, BLOC1S6, BRCA1, BRCA2, BRIP1, CD27, CDAN1, C15orf41 (CDIN1), CEBPA, CLCN7, CLPB, CSF3R, CTC1, CXCR2, CXCR4, CYCS, DDX41, DHFR, DIAPH1, DKC1, DNAJC21, DNMT3B, EFL1, ELANE, EPO, ERCC4, ERCC6L2, ETV6, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, FANCM, FLI1, FYB1, G6PC3, GATA1, GATA2, GFI1, GFI1B, GINS1, GLA, GLRX5, GP1BA, GP1BB, GP9, HAX1, HOXA11, IKZF1, ITGA2B, ITGB3, JAGN1, KDM1A, KIF23, KLF1, LIG4, LPIN2, LYST, MAD2L2, MDM4, MECOM, MPIG6B, MPL, MTHFD1, MYH9, MYSM1, NAF1, NBEAL2, NBN, NHP2, NOP10, OSTM1, PALB2, PARN, PAX5, PGM3, PIK3CD, POT1, PRKACG, PUS1, RAB27A, RAC2, RAD50, RAD51, RAD51C, RBM8A, RECQL4, RFWD3, RMRP, RPA1, RPL11, RPL15, RPL18, RPL26, RPL27, RPL35, RPL35A, RPL5, RPS10, RPS15A, RPS17, RPS19, RPS24, RPS26, RPS27, RPS28, RPS29, RPS7, RTEL1, RUNX1, SAMD9, SAMD9L, SBDS, SEC23B, SLC19A2, SLC25A38, SLC37A4, SLC46A1, SLFN14, SLX4, SMARCAL1, SMARCD2, SNX10, SRC, SRP54, SRP72, STAT3, STIM1, STN1, STXBP2, SYK, TAZ (TAFAZZIN), TCIRG1, TCN2, TERC, TERT, THPO, TINF2, TNFRSF11A, TNFRSF13B, TNFSF11, TP53, TRNT1, TSR2, TUBB1, UBE2T, USB1, VPS13B, VPS45, VWF, WAS, WDR1, WIPF1, WRAP53, XIAP, XRCC2, YARS2,* and *ZCCHC8*

PDF Report

No

Day(s) Performed

Varies

Report Available

28 to 42 days

Specimen Retention Time

Whole blood: 25 days (if available); Saliva: 30 days (if available); Hair root bulb (if available)/Extracted DNA: 3 months; Blood spots: 1 year (if available)

Performing Laboratory Location

Mayo Clinic Laboratories - Rochester Main Campus

Fees & Codes

Fees

- Authorized users can sign in to Test Prices for detailed fee information.
- Clients without access to Test Prices can contact Customer Service 24 hours a day, seven days a week.
- Prospective clients should contact their account representative. For assistance, contact Customer Service.

Test Classification

This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. It has not been cleared or approved by the US Food and Drug Administration.

CPT Code Information

81441

LOINC® Information

Test ID	Test Order Name	Order LOINC® Value
BMFGP	Bone Marrow Failure Gene Panel	112328-0

Result ID	Test Result Name	Result LOINC® Value
621562	Test Description	62364-5
621563	Specimen	31208-2
621564	Source	31208-2
621565	Result Summary	50397-9
621566	Result	82939-0
621567	Interpretation	69047-9
621568	Additional Results	82939-0
621569	Resources	99622-3
621570	Additional Information	48767-8
621571	Method	85069-3
621572	Genes Analyzed	82939-0
621573	Disclaimer	62364-5
621574	Released By	18771-6
MG153	Is this Bone Marrow	31208-2