

## Genomic tests - Overview

	Karyotype <sup>1</sup> FISH	Single gene test <sup>2</sup>	Chromosomal microarray (CMA) <sup>3</sup>	NGS Panel Sequencing	Whole Exome Sequencing (WES)	Whole Genome Sequencing (WGS)
Aneuploidy	+	--	+	--	--	+
Balanced chromosome rearrangements	+	--	--	--	--	+
Unbalanced chromosome rearrangements	+	--	+	--	--	+
Copy number variants (CNV) -Large >5Mb -Small: 0.1-1Mb	+	--	+	--	--	+
	--	--	+	+	#	+
Insertions/deletions (Indels) <100bp	--	+	--	+	+	+
Single nucleotide variants (SNV)	--	+	--	+	+	+
Trinucleotide repeat	--	+	--	--	--	--
Mitochondrial DNA variants (mtDNA)	--	+	--	+	--	+

<sup>1</sup> Karyotype now generally replaced by CMA. Fluorescence *in situ* hybridisation (FISH) detects range of chromosome variants and also single gene copy number and some small changes by using specific probes

<sup>2</sup> For simplicity, several tests have been condensed into this single gene test category; including Sanger sequencing; MLPA; PCR; Methylation studies; Repeat-primed PCR; Southern blot.

<sup>3</sup> SNP-array & CGH-array. SNP-array detects long contiguous sequences of homozygosity (LCSH), indicating consanguinity. CGH-array does not detect LCSH.

+ can be detected / -- not recommended

# can sometimes be detected, but this test not recommended for CNVs.

 Exome sequencing is not an ideal test to identify CNVs. Therefore, CMA is often ordered prior to WES.

## Genomic tests - Overview

	Single Gene* (genetic test)	Chromosomal microarray (CMA)	NGS Panel (multigene panel)	Whole Exome Sequence (WES)	Whole Genome Sequence (WGS)
INDICATION	When you suspect condition caused by variants in one or a small number of genes, e.g. Huntington disease.	Indicated for patients presenting with intellectual disability, developmental delay, multiple congenital anomalies, dysmorphic features.	When patient has a relatively well-defined phenotype and ... When you suspect a condition caused by a variant in one of several genes.	When you suspect a monogenic disorder caused by a variant in one of several genes. Patients may show non-specific phenotype.	When you suspect monogenic disorder caused by a variant in one of several genes. Patients may show non-specific phenotype.
BENEFITS	Very specific and accurate Less chance of incidental or uncertain findings.	Medicare funding for certain indications. Relatively cheap test compared to WES/WGS. Can be performed using saliva, making it quick and easy.	Can provide better coverage of genes of interest compared to exome. Less chance of incidental findings compared to exome/genome. Often cheaper than exome.	Sequencing of the whole exome allows for future re-analysis of other genes as knowledge improves.	Covers non-coding regions; can identify variants not detected by exome, e.g. mtDNA, triplet repeats, deep intronic variants. Costs are declining. New technology increasing speed & accessibility. Can be reanalysed
LIMITATIONS	Limited utility for non-specific phenotype Limited utility for conditions where multiple genes are associated.	Does not identify triplet repeats, balanced translocations, or point mutations.	Sequences only the genes covered on the panel. No capture of other gene sequences so unable to re-analyse (i.e. analyse for other genes) later.	Incomplete coverage of exome - chance of false negatives. Higher chance of incidental and secondary findings. Time consuming variant interpretation.	Clinical use may be limited by cost/availability of services & expertise. Incomplete coverage. Some identified variants not readily interpreted.

\* This table has been simplified for teaching purposes. In particular, we have oversimplified the single gene category (methods including Sanger sequencing, Southern Blot, PCR, MLPA, methylation studies, repeat-primed PCR)