Fabry Disease Service

Contact details:
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Sample Required:
Adult: 5mls blood in EDTA
Paediatric: at least 1ml EDTA (preferably >2ml)

Samples should be accompanied by a FULLY completed request form available to download at www.nbt.nhs.uk/genetics or from the laboratory.

Please include details of test, family history, address and POSTCODE, NHS number, referring clinician and unit/hospital.

Prenatal testing MUST be arranged with the laboratory well in advance.

Consent and DNA Storage:
All genetic testing requires consent. It is the responsibility of the referring clinician to ensure that appropriate consent has been obtained.

DNA is stored from all patients unless consent for this is specifically denied.

Stored samples may be used for quality assurance purposes and may be used anonymously for the development of new tests for the disorder in question.

Clinical Background and Genetics
- Fabry Disease (OMIM# 301500) is an X-linked lysosomal storage disease caused by deficient or absent activity of the lysosomal enzyme α-galactosidase A (α-Gal A). The α-Gal A enzyme is a lysosomal exoglycosidohylase.

- Hemi-zygous males and most heterozygous females are affected; although the onset of classical symptoms may be later in females. Males with classical Fabry Disease have little or no residual enzyme activity, whereas females have variable levels of residual activity, which may be in the normal range. It is recommended that females with symptoms of Fabry Disease should be offered screening.

- The symptoms of classical Fabry Disease, which can begin in childhood or early adolescence, include episodic painful crises (acroparethesia), hypohidrosis, eye changes, heat and cold intolerance, gastrointestinal symptoms and angiokeratoma. Cerebrovascular, cardiac and renal manifestations may develop later in life. Later onset atypical variants (cardiac or renal) have been described. These patients reach adulthood with no classical Fabry Disease symptoms but present with a specific phenotype later in life and have reduced, but not abolished α-Gal A levels.

- The incidence of classical Fabry Disease is reported to be 1:50,000 males (Fabry Disease is a pan-ethnic disorder), however newborn screening studies suggest that the incidence particularly for variant Fabry Disease, is much higher.

- The gene involved in Fabry Disease is GLA, has 7 exons and is located at X.q22.1 (OMIM#300644). The coding region spans 1.3kb and encodes a 429 amino acid protein of which the first 31 residues are a signal peptide.

- Over 600 different disease-causing GLA mutations have been reported, distributed throughout all exons. There are a few mutations which have been seen in multiple families e.g. c.644A>G, p.(Asn215Ser) commonly associated with the cardiac variant of Fabry Disease.

Service Offered
- Full GLA gene screening by direct sequence analysis (sensitivity 95%).
- Testing for familial mutations in family members as appropriate.

Referrals
- Diagnostic Testing: Clinically affected males should have their diagnosis confirmed by biochemical analysis prior to genetic testing. This analysis can be arranged through Vicki Powers, Department of Biochemistry, Bristol Royal Infirmery (Tel: 0117 342 2590) or through your local Clinical Biochemistry Service (see www.metbio.net). Females with a suspected diagnosis of Fabry Disease can proceed directly to genetic testing, due to the unreliability of biochemical analysis. This protocol should also apply to patients with possible variant Fabry Disease.
- Carrier Testing: Once a mutation has been found in a patient, the laboratory can offer carrier testing for the mother and other at-risk relatives.
- Prenatal Testing: May be offered for heterozygous females on a case by case basis. Referrals must come through Clinical Genetics or a Metabolic Consultant.

Target reporting Time & Cost
Diagnostic screen: 56 days
Known Mutation: 28 days
Urgent: 3 days (please contact the lab prior to sending)

Quality
BGL participates in the following external quality assurance schemes:
UKNEQAS Fabry disease scheme, EMON DNA Sequencing scheme and UKNEQAS pathogenicity of sequence variants scheme.

Advice
For clinical advice contact one of the national paediatric or adult centres for inherited metabolic disease. In Bristol contact Dr Germaine Pierre, Paediatric Metabolic Consultant, Bristol Royal Hospital for Children, Bristol, BS2 8BJ (Tel: 0117 3421694)
For laboratory enquiries, please contact: Mary.Gable@nbt.nhs.uk (tel: 0117 414 6164)