

Overview

Useful For

Definitive evaluation of an individual with *JAK2*-negative erythrocytosis associated with lifelong sustained increased red blood cell (RBC) mass, elevated RBC count, hemoglobin, or hematocrit

This test is **not intended for** prenatal diagnosis.

Profile Information

Test Id	Reporting Name	Available Separately	Always Performed
MINT	Molecular Interpretation	No	Yes
EPOR	EPOR Gene, Mutation Analysis, B	No	Yes
HIF2A	HIF2A Gene, Mutation Analysis, B	No	Yes
PHD2	PHD2 Gene, Mutation Analysis, B	No	Yes

Genetics Test Information

This test is a third-order test and should be ordered when the patient meets the following criteria: diagnosis of erythrocytosis and *JAK2* V617F is negative.

Additional Tests

Test Id	Reporting Name	Available Separately	Always Performed
BPGMM	BPGM Full Gene Sequencing	Yes	Yes
VHLE	VHL Gene Erythrocytosis Mutations	No, (Order VHLZZ)	Yes

Testing Algorithm

This evaluation is recommended for patients presenting with lifelong erythrocytosis, usually with a positive family history of similar symptoms. Polycythemia vera should be excluded prior to testing as it is much more common than hereditary erythrocytosis and can be present even in young patients. A *JAK2* V617F or *JAK2* exon 12 variant should not be present. Additionally, testing to exclude the possibility of a high oxygen affinity hemoglobin variant should be performed before ordering this test. See Ordering Guidance.

Additional testing for *BPGM* full gene sequencing and *VHL* gene erythrocytosis variant analysis will always be performed at an additional charge.

For more information see [Erythrocytosis Evaluation Testing Algorithm](#)

Special Instructions

- [Informed Consent for Genetic Testing](#)
- [Erythrocytosis Patient Information](#)
- [Erythrocytosis Evaluation Testing Algorithm](#)
- [Informed Consent for Genetic Testing \(Spanish\)](#)

Method Name

Polymerase Chain Reaction (PCR) Amplification/Sanger Sequence Analysis

NY State Available

Yes

Specimen**Specimen Type**

Whole blood

Ordering Guidance

For a complete evaluation including hemoglobin electrophoresis testing and hereditary erythrocytosis variant analysis in an algorithmic fashion, order REVE2 / Erythrocytosis Evaluation, Blood.

This test does not provide a serum erythropoietin (EPO) level. If EPO testing is desired, order EPO / Erythropoietin, Serum.

Necessary Information

[Erythrocytosis Patient Information](#) (T694) is strongly recommended, but not required, to be filled out and sent with the specimen. This information aids in providing a more thorough interpretation of test results. Ordering providers are strongly encouraged to complete the form and send it with the specimen.

Specimen Required

Container/Tube: Lavender top (EDTA)

Specimen Volume: 3 mL

Collection Instructions: Send whole blood specimen in original tube. **Do not aliquot.**

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 in Special Instructions:

- [Informed Consent for Genetic Testing](#) (T576)
- [Informed Consent for Genetic Testing-Spanish](#) (T826)

2. Erythrocytosis Patient Information (T694)

3. If not ordering electronically, complete, print, and send a [Benign Hematology Test Request Form](#) (T755) with the

specimen.

Specimen Minimum Volume

0.5 mL

Reject Due To

Gross hemolysis	Reject
Gross lipemia	Reject
Gross icterus	Reject
Moderately to severely clotted	Reject

Specimen Stability Information

Specimen Type	Temperature	Time	Special Container
Whole blood	Refrigerated (preferred)	30 days	
	Ambient	14 days	

Clinical & Interpretive**Clinical Information**

Erythrocytosis (ie, increased red blood cell [RBC] mass or polycythemia) may be primary, due to an intrinsic defect of bone marrow stem cells (ie, polycythemia vera: PV), or secondary, in response to increased serum erythropoietin (EPO) levels. Secondary erythrocytosis is associated with a number of disorders including chronic lung disease, chronic increase in carbon monoxide (due to smoking), cyanotic heart disease, high-altitude living, kidney cysts and tumors, hepatoma, and other EPO-secreting tumors. When these common causes of secondary erythrocytosis are excluded, a heritable cause involving hemoglobin or erythrocyte regulatory mechanisms may be suspected.

Unlike polycythemia vera, hereditary erythrocytosis is not associated with the risk of clonal evolution and should present with isolated erythrocytosis that has been present since birth. A small subset of cases are associated with pheochromocytoma or paraganglioma formation. Hereditary erythrocytosis is caused by variations in several genes and may be inherited in either an autosomal dominant or autosomal recessive manner. A family history of erythrocytosis would be expected in these cases, although it is possible for new variants to arise in an individual.

The genes coding for hemoglobin, beta globin and alpha globin (high-oxygen-affinity hemoglobin variants), hemoglobin-stabilization proteins (2,3 bisphosphoglycerate mutase: *BPGM*), and the erythropoietin receptor(*EPOR*) and oxygen-sensing pathway enzymes (hypoxia-inducible factor [*HIF/EPAS1*], prolyl hydroxylase domain [*PHD2/EGLN1*], and von Hippel Lindau [*VHL*]) can result in hereditary erythrocytosis (see Table). The true prevalence of hereditary erythrocytosis-causing variants is unknown. The hemoglobin genes, *HBA1/HBA2* and *HBB* are not assayed in this profile.

Table. Genes Associated with Hereditary Erythrocytosis

Gene	Inheritance	Serum EPO
<i>JAK2</i> V617F	Acquired	Decreased
<i>JAK2</i> exon 12	Acquired	Decreased
<i>EPOR</i>	Dominant	Decreased
<i>PHD2/EGLN1</i>	Dominant	Normal level
<i>BPGM</i>	Recessive	Normal level
Beta globin	Dominant	Normal level to increased
Alpha globin	Dominant	Normal level to increased
<i>HIF2A/EPAS1</i>	Dominant	Normal level to increased
<i>VHL</i>	Recessive	Normal to increased

The oxygen-sensing pathway functions through an enzyme, HIF, which regulates RBC mass. A heterodimer protein comprised of alpha and beta subunits, HIF functions as a marker of depleted oxygen concentration. When present, oxygen becomes a substrate mediating HIF-alpha subunit degradation. In the absence of oxygen, degradation does not take place and the alpha protein component is available to dimerize with a HIF-beta subunit. The heterodimer then induces transcription of many hypoxia response genes including *EPO*, *VEGF*, and *GLUT1*. HIF-alpha is regulated by VHL protein-mediated ubiquitination and proteosomal degradation, which requires prolyl hydroxylation of HIF proline residues. The HIF-alpha subunit is encoded by the *HIF2A* (*EPAS1*) gene. Enzymes important in the hydroxylation of HIF-alpha are the prolyl hydroxylase domain proteins, of which the most significant isoform is PHD2, which is encoded by the *PHD2* (*EGLN1*) gene. Variations resulting in altered HIF-alpha, PHD2, and VHL proteins can lead to clinical erythrocytosis. A small subset of variants in *PHD2/EGLN1* and *HIF2A/EPAS1* have also been detected in erythrocytic patients presenting with paragangliomas or pheochromocytomas.

Truncating variants in the *EPOR* gene coding for the erythropoietin receptor can result in erythrocytosis through loss of the negative regulatory cytoplasmic SHP-1 binding domain leading to EPO hypersensitivity. All currently known variants have been localized to exon 8 and are heterozygous truncating variants. *EPOR* variants are associated with decreased EPO levels (see Table).

Reference Values

An interpretive report will be provided.

Interpretation

An interpretive report will be provided and will include specimen information, assay information, and whether the specimen was positive for any variants in the gene. If positive, the variant will be correlated with clinical significance, if known.

Cautions

Polycythemia vera and acquired causes of erythrocytosis should be excluded before ordering this evaluation.

This test will not detect somatic or gonadal mosaicism.

Certain sequence alterations have no clinical manifestations and, in essence, are clinically benign. Correlation with all relevant clinical information is necessary to provide appropriate patient care.

Clinical Reference

1. Patnaik MM, Tefferi A: The complete evaluation of erythrocytosis: congenital and acquired. *Leukemia*. 2009 May;23(5):834-844. doi: 10.1038/leu.2009.54
2. McMullin MF: The classification and diagnosis of erythrocytosis. *Int J Lab Hematol*. 2008 Dec;30(6):447-459. doi: 10.1111/j.1751-553X.2008.01102.x
3. Percy MJ, Lee FS: Familial erythrocytosis: molecular links to red blood cell control. *Haematologica*. 2008 Jul;93(7):963-967. doi: 10.3324/haematol.13250
4. Huang LJ, Shen YM, Bulut GB: Advances in understanding the pathogenesis of primary familial and congenital polycythaemia. *Br J Haematol*. 2010 Mar;148(6):844-852. doi: 10.1111/j.1365-2141.2009.08069.x
5. Maran J, Prchal J: Polycythemia and oxygen sensing. *Patho Biol*. 2004 Jun;52(5):280-284. doi: 10.1016/j.patbio.2004.02.006
6. Lee F: Genetic causes of erythrocytosis and the oxygen-sensing pathway. *Blood Rev*. 2008 Nov;22(6):321-332. doi: 10.1016/j.blre.2008.04.003
7. Merchant SH, Oliveira JL, Hoyer JD, Viswanatha DS: Erythrocytosis. In: His ED, ed. *Hematopathology*. 2nd ed. Elsevier Saunders; 2012:22-723
8. Zhuang Z, Yang C, Lorenzo F, et al: Somatic *HIF2A* gain-of-function mutations in paraganglioma with polycythemia. *N Engl J Med*. 2012 Sep 6;367(10):922-930. doi: 10.1056/NEJMoa1205119
9. Ladroue C, Carcenac R, Leporrier M, et al: *PHD2* mutation and congenital erythrocytosis with paraganglioma. *N Engl J Med*. 2008 Dec 18;359(25):2685-2692. doi: 10.1056/NEJMoa0806277
10. Lorenzo FR, Yang C, Ng Tang Fui M, et al: A novel *EPAS1/HIF2A* germline mutation in congenital polycythemia with paraganglioma. *J Mol Med*. 2013 Apr;91(4):507-512. doi: 10.1007/s00109-012-0967-z
11. Tarade D, Robinson CM, Lee JE, Ohh M: HIF-2alpha-pVHL complex reveals broad genotype-phenotype correlations in HIF-2alpha-driven disease. *Nat Commun*. 2018 Aug;9(1):3359. doi: 10.1038/s41467-018-05554-1
12. Oliveira JL: Algorithmic evaluation of hereditary erythrocytosis: Pathways and caveats. *Int J Lab Hematol*. 2019 May;41 Suppl 1:89-94. doi: 10.1111/ijlh.13019

Performance**Method Description**

DNA is extracted from whole blood and amplified in 7 separate polymerase chain reaction (PCR) to cover *EPOR* exon 8, *HIF2A* exons 9 and 12, and *PHD2* exons 1 through 5. PCR products are then sequenced by the Sanger sequencing method and analyzed with sequencing software. Patient sequence results are compared with the genomic reference sequences and the single nucleotide variants known to occur in the genes. If a variant is detected, the messenger RNA reference sequence will be used to determine the amino acid number and resulting amino acid change, if there is one. (Percy MJ, McMullin MF, Roques AW, et al: Erythrocytosis due to a mutation in the erythropoietin receptor gene. *Br J Haematol*. 1998 Feb;100:407-410. doi: 10.1046/j.1365-2141.1998.00550.x; Martini M, Teofili L, Cenci T, et al: A novel heterozygous HIF2a[M535I] mutation reinforces the role of oxygen sensing pathway disturbances in the pathogenesis of familial erythrocytosis. *Haematologica*. 2008;93[7]:1068-1071. doi: 10.3324/haematol.13210; Percy MJ, Zhao Q, Flores A, et al: A family with erythrocytosis establishes a role for prolyl hydroxylase domain protein 2 in oxygen homeostasis. *PNAS* 2006;103[3]:654-659. doi: 10.1073/pnas.0508423103; Oliveira JL, Coon LM, Frederick LA, et al: Genotype-phenotype correlation of hereditary erythrocytosis mutations, a single center experience. *Am J Hematol*. 2018 May 23. doi: 10.1002/ajh.25000)

10.1002/ajh.25150)

PDF Report

No

Day(s) Performed

Monday through Friday

Report Available

10 to 25 days

Specimen Retention Time

Whole blood: 2 weeks; Extracted DNA: 3 months

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

81479

LOINC® Information

Test ID	Test Order Name	Order LOINC® Value
HEMP	Hereditary Erythrocytosis Mut, B	105351-1

Result ID	Test Result Name	Result LOINC® Value
34645	EPOR Gene Sequencing Result	82939-0
34646	PHD2 Gene Sequencing Result	82939-0
34647	HIF2A Gene Sequencing Result	82939-0
34648	Molecular Interpretation	69047-9
35000	Reviewed By	18771-6