Peutz-Jeghers Syndrome Testing

Procedures addressed

The inclusion of any procedure code in this table does not imply that the code is under management or requires prior authorization. Refer to the specific Health Plan's procedure code list for management requirements.

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What is Peutz-Jeghers syndrome

Definition

Peutz-Jeghers syndrome (PJS) is a genetic disorder characterized by the development of polyps (hamartomas) in the gastrointestinal (GI) tract, most commonly the small intestine. Polyps also occur in the stomach and colon and on occasion in the renal pelvis, urinary bladder, ureters, lungs, nares, and gallbladder.\(^1\) About a third of affected individuals present with polyps by age 10, and by age 20, about half have clinical signs and symptoms.\(^2\)

- Affected people also typically have mucocutaneous pigmented lesions — lip freckling is classic, but pigmentation may also develop in the mouth, gums, nose, perianal area, and on the fingers and toes.\(^1,2\)
- In addition to gastrointestinal polyps and cancer, people with PJS have an increased risk for other cancers, including those of the pancreas, lung, breast, uterus, cervix, ovaries, and testes.\(^1,2\)
- PJS is caused by mutations in the STK11 gene. STK11 is a tumor suppressor gene. Its normal role is to control growth and development of cells in the GI tract. Mutations in STK11 cause cells to grow and divide uncontrollably, leading to the development of polyps and an increased risk for cancer.\(^1\)
- PJS is inherited in an autosomal dominant pattern. Children of an affected person have a 1 in 2 (50%) chance to be affected. “In large series, 60-78% of individuals with PJS had affected relatives and 17-40% of individuals represented isolated cases within their families” \(^1\) The proportion of a new (de novo) mutation is unclear due to variable expressivity and the frequency of subtle signs in parents is unknown.\(^1\)
• Because of the potential early onset of polyp growth, surveillance is complex and involves monitoring at-risk individuals for related cancers, starting with baseline colonoscopy and upper GI endoscopy at age 8.¹⁻⁴

Test information

• Over 200 distinct STK11 gene mutations or deletions have been identified in people with PJS.

  Molecular genetic testing is performed in parallel by two methods:¹

  o **STK11 Sequence Analysis** is used to identify smaller mutations in STK11. Approximately 81% of individuals with PJS will have a mutation detected by this method.

  o **STK11 Deletion/Duplication Analysis** is used to identify larger deletions. Approximately 15% of individuals with PJS will have a mutation detected by this method.

  o Ninety-four to 96% of individuals with PJS will have an STK11 pathogenic variant.⁵,⁶ The detection rate in familial versus sporadic cases is 87% and 97.8%, respectively.⁶

• **STK11 Known Familial Mutation Analysis**: Once an STK11 mutation is identified in an affected person, predictive testing is available for at-risk family members, as is prenatal or preimplantation genetic diagnosis¹ Family members should be tested using the method that can accurately identify the familial mutation.

• A multi-gene panel can also be used to test individuals suspected of having PJS.

Guidelines and evidence

• Evidence-based guidelines for the diagnosis and management of PJS were published in 2010.² These guidelines outline clinical diagnostic criteria for PJS and surveillance recommendations, but do not specifically address the utility of genetic testing.

  o A clinical diagnosis of PJS may be made in an affected person when any ONE of the following is present (directly quoted):

    ▪ Two or more histologically confirmed PJS polyps

    ▪ Any number of PJS polyps detected in one individual who has a family history of PJS in close relative(s)

    ▪ Characteristic mucocutaneous pigmentation in an individual who has a family history of PJS in close relative(s)
- Any number of PJS polyps in an individual who also has characteristic mucocutaneous pigmentation
  - “No clear genotype-phenotype correlation has been demonstrated in PJS, and no clear differences found between cases with STK11 mutation and in those in whom no mutation has been detected.”
- The National Comprehensive Cancer Network (2018) guidelines outline similar clinical diagnostic criteria and provide some guidance on surveillance, but do not address the use of genetic testing.
  - “A clinical diagnosis of PJS can be made when an individual has two or more of the following features:”
    - “Two or more Peutz-Jeghers-type hamartomatous polyps of the small intestine”
    - “Mucocutaneous hyperpigmentation of the mouth, lips, nose, eyes, genitalia, or fingers”
    - “Family history of PJS”
  - “The majority of cases occur due to mutations in the STK11 (LKB1) gene and clinical genetic testing is available.”
  - Screening procedures and intervals are outlined for breast, colon, stomach, pancreatic, small intestine, cervical, ovarian, uterine, and testicular cancers.
- Clinical diagnostic criteria have been validated by genetic testing in one series of 71 patients. Of 56 patients who met clinical criteria for PJS, 94% had an STK11 mutation found by a combination of sequencing and deletion/duplication analysis. Twelve patients had only a “presumptive diagnosis” of PJS based on the presence of hyperpigmentation or isolated PJS polyps, with no known family history. No STK11 mutations were found in those 12 patients.
- A 2016 expert-authored review states:
  - “Testing of at-risk asymptomatic adults for Peutz-Jeghers syndrome is available after the disease-causing STK11 mutation has been identified in an affected family member.”
  - “Testing for the disease-causing mutation in the absence of definite symptoms of the disease is predictive testing. At-risk asymptomatic adult family members may seek molecular genetic testing in order to make personal decisions regarding medical surveillance, reproduction, financial matters, and career planning.”
  - “Because early detection of at-risk individuals who have an STK11 mutation affects medical management, particularly surveillance, testing of at-risk individuals during childhood is beneficial.”
• The American Society of Clinical Oncologists (ASCO) position statement on genetic testing (originally published 1996\(^8\); revised/affirmed in 2003\(^9\), 2010\(^{10}\), and 2015\(^{11}\)) outlines general recommendations for genetic testing for hereditary cancer syndromes and specifically addresses issues around genetic testing in at-risk children:
  
  o “Indications for Genetic Testing: ASCO recommends that genetic testing be offered when 1) the individual has personal or family history features suggestive of a genetic cancer susceptibility condition, 2) the test can be adequately interpreted, and 3) the results will aid in diagnosis or influence the medical or surgical management of the patient or family members at hereditary risk of cancer.”
  
  o “Special Issues in Testing Children for Cancer Susceptibility: ASCO recommends that the decision to offer testing to potentially affected children should take into account the availability of evidence-based risk-reduction strategies and the probability of developing a malignancy during childhood. Where risk-reduction strategies are available or cancer predominantly develops in childhood, ASCO believes that the scope of parental authority encompasses the right to decide for or against testing.”
  
  o “Tests for high-penetrance mutations in appropriate populations have clinical utility, meaning that they inform clinical decision making and facilitate the prevention or amelioration of adverse health outcomes.”

**Criteria**

STK11 (LKB1) gene testing may be considered for individuals with a suspected or known clinical diagnosis of Peutz-Jeghers syndrome, or a known family history of a STK11 (LKB1) mutation.

**PJS Known Familial Mutation Analysis**

• Genetic Counseling:
  
  o Pre and post-test genetic counseling by an appropriate provider (as deemed by the Health Plan policy), AND

• Previous Testing:
  
  o No previous STK11 gene testing that would have detected the family mutation, AND

• Diagnostic and Predisposition Testing:
  
  o Known family mutation in the STK11 gene identified in 1st degree relative(s). (Note: 2nd or 3rd degree relatives may be considered when 1st degree relatives are unavailable or unwilling to be tested), AND

• Rendering laboratory is a qualified provider of service per the Health Plan policy.
STK11 Sequencing:

• Genetic Counseling:
  o Pre and post-test genetic counseling by an appropriate provider (as deemed by the Health Plan policy), AND

• Previous Testing:
  o No previous STK11 gene sequencing, and
  o No known familial STK11 mutation, AND

• Diagnostic Testing for Symptomatic Individuals:
  o A clinical diagnosis of PJS based on at least two of the following features:
    ▪ At least two PJS-type hamartomatous polyps of the gastrointestinal tract, or
    ▪ Mucocutaneous hyperpigmentation of the mouth, lips, nose, eyes, genitalia, or fingers, or
    ▪ A family history of PJS, AND

• Predisposition Testing for Presymptomatic/Asymptomatic Individuals:
  o Member is a 1st degree relative of someone with a clinical diagnosis of PJS who has had no previous genetic testing (Note that testing in the setting of a more distant affected relative will only be considered if the 1st degree relative is unavailable or unwilling to be tested), AND

• Rendering laboratory is a qualified provider of service per the Health Plan policy.

STK11 Deletion/duplication testing

• Genetic Counseling:
  o Pre and post-test genetic counseling by an appropriate provider (as deemed by the Health Plan policy), AND

• Previous Testing:
  o No previous STK11 deletion/duplication analysis has been performed, and
  o Above criteria for STK11 full gene sequencing are met, and
  o STK11 sequencing was previously performed and no mutations were found, and

• Rendering laboratory is a qualified provider of service per the Health Plan policy.
References


