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Evidence-Based Consensus and Systematic Review on Reducing the Time to Diagnosis of Duchenne Muscular Dystrophy

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Duchenne muscular dystrophy (DMD) is a severe, progressive, X-linked, recessive neuromuscular disease that affects approximately 1 in 5000 live male births.1 Patients with DMD experience progressive muscle weakness, owing to the absence of functional dystrophin protein, and typically experience delayed walking, difficulty running or climbing stairs, and frequent falls.2,3 However, several nonmotor signs and symptoms (eg, behavioral issues, neurocognitive deficits, and speech delay) also can be associated with the disease.3 Boys with DMD are generally diagnosed between 4 and 5 years of age, when their physical development begins to diverge more clearly from that of their peers,3,4 and, with corticosteroid treatment, typically lose ambulation at a median age of about 12.0-14.0 years.5 However, this can vary by country.

The accurate and early diagnosis of DMD plays a crucial role in the effective management of patients: it has the potential to lead to earlier intervention; appropriate genetic counseling; treatment with mutation-specific therapies (where applicable); and appropriate assignment to clinical trials. However, reports indicate that significant delays in diagnosis of DMD persist.4-8 It has been shown that in the absence of a family history of DMD, there is a delay of approximately 1 year from onset of earliest symptoms to the first assessment by a healthcare professional.4 A further delay of approximately 1 year from this first assessment to referral to a neurologist or a neuromuscular specialist is observed (mean age at diagnosis ± SD: 4.9 ± 1.7 years).4 Findings by Vry et al8 suggest that this could be shorter, with a mean delay of just over 1 year from first symptoms to diagnosis (mean delay ± SD: 1.3 ± 1.8 years). Overall, these findings suggest that, on average, there has been little to no reduction in the age at diagnosis for patients with DMD over the last 30 years.9,10

Once DMD is suspected, genetic testing is required to obtain a complete diagnosis.3,11,12 However, results from a recent survey of 41 delegates from Europe, Turkey, and India (primarily child neurologists and clinical/molecular geneticists) revealed that there may be issues relating to the genetic diagnosis for DMD.

For example, although 100% of delegates understood the importance of genetic testing for DMD, more than 10% did not perform additional genetic testing if deletion/duplication testing was negative.11 Survey results from the 2017 and 2018 TREAT-NMD Expert Masterclasses on DMD, attended by more than 100 delegates combined (primarily from pediatrics and neurology backgrounds from 27 and 20 countries, respectively), showed that some delegates experienced difficulties interpreting DMD genetic test results (Table I; available at www.jpeds.com) and subsequently were not always aware of whether patients were eligible for treatment with mutation-specific therapies. Together, these issues highlight the need for shorter times to diagnosis for patients with DMD and clearer recommendations for DMD genetic testing to ensure complete genetic assessment is performed to reach an accurate genetic diagnosis. This review, supported by a systematic literature search, presents expert consensus on ways of reducing the time to diagnosis of DMD.

Methods

The Delphi Consensus Initiative presented here is focused on how to reduce the time to diagnosis of DMD. The development process for this initiative is summarized in Figure 1. The steering committee comprised 3 experts in the field of human genetics, specializing in the diagnosis of DMD and/or interpretation of genetic mutations: S. F. Nelson (nonvoting chair), A. Aartsma-Rus (voting co-chair), and M. Hegde (voting co-chair). After an initial meeting of the steering committee, 14 experts in the field were invited to form the expert voting panel. The panel comprised primarily medical geneticists specializing in the diagnosis of patients with DMD; however, 2 child neurologists, 1 patient advocate, and 1 genetic counselor also were invited. All members of the expert voting panel and the 2 voting co-chairs voted anonymously on the statements to reach consensus. A systematic literature review was also performed to support development of the consensus statements.

Detailed affiliations, funding, and conflicts of interest disclosure available at www.jpeds.com

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The evidence was graded using the Grading of Recommendations Assessment, Development, and Evaluation system (Figure 1). Further information regarding the development process is provided in the Appendix (available at www.jpeds.com). The grading of evidence for the statements was reviewed and agreed on by the expert voting panel (Table III).

Discussion

Consensus Statements

The 15 consensus statements are presented in Table III. A summary of the supporting information is provided herein, with a full discussion included in the Appendix. Several other more general statements were discussed, but only those most pertinent to reducing the time to diagnosis of DMD are presented here.

Section 1: Reducing the Time to Diagnosis of DMD

Signs and symptoms of DMD (motor and nonmotor) are presented in the 2018 care guidelines for DMD. The consensus group agreed on a series of motor signs and symptoms (Table III) that are typically observed in patients with DMD (supported by the literature; Statement 1). It also should be noted that patients are sometimes referred because of elevated alanine transaminase or aspartate transaminase levels, and that this finding also should require a high index of suspicion from physicians. The consensus group agreed on a number of nonmotor signs and symptoms that may also act as indicators of DMD (autism spectrum disorder, delayed speech/cognitive deficits, and gross motor delay; Statement 2) but are not always associated with the disease and may need wider clinical assessment. As such, these symptoms may sometimes be overlooked, and as a result, patients could be referred incorrectly, for example to a physical, occupational, or speech therapist. As a result, the time to diagnosis for these patients can be delayed. The consensus group therefore agreed that for patients presenting with cognitive or developmental deficits, DMD should be considered as part of the differential diagnosis.

Patients presenting with the motor and nonmotor signs and symptoms of DMD as per Statements 1 and 2 should immediately have their serum creatine kinase (CK) levels tested and be referred to a child neurologist or a neuromuscular specialist. A marked increase in serum CK, defined as >2000 IU/L, should prompt further investigation for DMD. However, elevated CK levels within the range of approximately 500-1200 U/L (1.5 times the upper limit of normal for men), even if asymptomatic, may be indicative of other neuromuscular disorders that require further assessment. It has been shown that once a patient has had a serum CK test, the time to reach a complete diagnosis of DMD is relatively short (mean age ± SD [range] at first CK test, 4.7 ± 1.7 [0.3-8.6] years, n = 151; and at complete diagnosis, 4.9 ± 1.7 [0.3-8.8] years, n = 154).
Table III. Summary of statements and recommendations for reducing the time to diagnosis of DMD

<table>
<thead>
<tr>
<th>Consensus statements</th>
<th>Consensus vote</th>
<th>Strength of recommendation</th>
<th>Level of evidence*</th>
<th>Final GRADE score†</th>
<th>Key supporting evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1: Reducing the time to diagnosis of DMD</td>
<td></td>
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</tr>
<tr>
<td>Statement 1: The following signs, symptoms, and characteristics should be considered typical indicators of DMD: calf hypertrophy (pseudohypertrophy); delayed walking; difficulty climbing/descending stairs; difficulty rising from the floor; difficulty running/walking; elevated serum CK levels (including elevated ALT and AST); a family history of DMD; frequent falls; Gowers’ sign; male sex; and muscle weakness.</td>
<td>A + = 93%; A = 7%</td>
<td>Strongly in favor</td>
<td>Moderate</td>
<td>1B</td>
<td>3,4,8,18-22</td>
</tr>
<tr>
<td>Statement 2: Autism spectrum disorder, delayed speech/cognitive deficits, and gross motor delay can be indicators of DMD but are not always associated with the disease.</td>
<td>A + = 93%; A = 7%</td>
<td>Strongly in favor</td>
<td>Moderate</td>
<td>1B</td>
<td>3,4,8,18,21,20-30</td>
</tr>
<tr>
<td>Statement 3: After initial presentation, patients with suspected DMD should have their serum CK levels tested and be referred to a specialist (a child neurologist or neuromuscular specialist).</td>
<td>A + = 93%; A = 7%</td>
<td>Strongly in favor</td>
<td>Moderate</td>
<td>1B</td>
<td>3,4,8,18,31-33</td>
</tr>
<tr>
<td>Statement 4: A lack of awareness of DMD and associated symptoms by the healthcare professional and long waiting times to see a specialist are the primary factors leading to a delay in initial diagnosis.</td>
<td>A + = 67%; A = 33%</td>
<td>Strongly in favor</td>
<td>Low</td>
<td>1C</td>
<td>4.8</td>
</tr>
<tr>
<td>Statement 5: Genetic testing is crucial for obtaining a complete diagnosis of DMD, and should be considered the gold standard.</td>
<td>A + = 94%; A = 6%</td>
<td>Strongly in favor</td>
<td>Low</td>
<td>1C</td>
<td>3,11,10 and expert opinion</td>
</tr>
<tr>
<td>Statement 6: In the majority of cases, a complete genetic diagnosis can be made using MLPA or CGH to detect deletions or duplications in the DMD gene.</td>
<td>A + = 88%; A = 6%; N = 6%</td>
<td>Strongly in favor</td>
<td>Moderate</td>
<td>1B</td>
<td>3,11,12,18,24-44 and expert opinion</td>
</tr>
<tr>
<td>Statement 7: If exon-level deletions/duplications in the DMD gene are not identified, small-scale mutations (by sequencing of exons and flanking regions) should be tested for as the next step.</td>
<td>A + = 93%; A = 7%</td>
<td>Strongly in favor</td>
<td>Low</td>
<td>1C</td>
<td>3,11,35 and expert opinion</td>
</tr>
<tr>
<td>Statement 8: Muscle biopsies with dystrophin staining are generally not needed to obtain a complete diagnosis of DMD, unless DNA testing is negative.</td>
<td>A + = 73%; A = 27%</td>
<td>Strongly in favor</td>
<td>Low</td>
<td>1C</td>
<td>3,11,12,35,43,45,54 and expert opinion</td>
</tr>
<tr>
<td>Statement 9: Delays in the initial clinical diagnosis/referral to a specialist, the sequential nature of the genetic testing process, and incomplete or nonexhaustive genetic testing should be addressed in order to prevent delays in reaching a complete genetic diagnosis for patients with DMD.</td>
<td>A + = 93%; A = 7%</td>
<td>Strongly in favor</td>
<td>Low</td>
<td>1C</td>
<td>4.8,11,19 and expert opinion</td>
</tr>
</tbody>
</table>

| Section 2: Recommendations for next steps following a suspected DMD diagnosis | | | | |
| Statement 10: Patients with signs and symptoms of DMD and elevated serum CK levels should be referred for genetic testing to either a clinical geneticist or a neuromuscular specialist. | A + = 100% | Strongly in favor | Low | 1C | 3,55,56 and expert opinion |
| Statement 11: A medical/clinical geneticist, a child neurologist, or a neuromuscular specialist should request the genetic test and should provide clinical information relevant to the diagnosis as part of the sample submission to the clinical genetics laboratory, and the genetic diagnostic test should be performed by an accredited laboratory. | A + = 100% | Strongly in favor | Low | 1C | 12,27 and expert opinion |
| Statement 12: Educational meetings for physicians and laboratory specialists on topics relating to the genetic diagnosis of DMD would help to improve the understanding of genetic test reports and the interpretation of genetic test results. | A + = 93%; A = 7% | Strongly in favor | Low | 1C | 58-62 and expert opinion |
| Statement 13: Genetic testing is necessary to inform carrier testing, family planning, genetic counseling, prognosis and optimal management strategies, natural history data gathering, and prenatal diagnosis. | A + = 100% | Strongly in favor | Low | 1C | Carrier testing/family planning[11,63-73]; genetic counseling[1,11-14]; prognosis/management[23,75-77]; natural history[78,80]; prenatal diagnosis[12,21]; and expert opinion 11,13-15, carrier testing[64-66,70,73,81-90]; germline mosaicism/de novo mutations[71,74]; family planning/genetic counseling[11,36]; and expert opinion 1,12,21,38-102 and expert opinion |
| Statement 14: After a patient receives a complete genetic diagnosis of DMD, it is mandatory that carrier testing of the mother and other at-risk female family members be offered with appropriate pre- and postgenetic counseling (information regarding germline mosaicism and de novo mutations should also be offered). Similarly, testing of other at-risk male family members should also be offered. | A + = 100% | Strongly in favor | Moderate | 1B | 307 |
| Statement 15: When a family history is present, pre-symptomatic CK testing and prenatal testing can lead to earlier detection and thus management of DMD, which is important for family planning. | A + = 87.5%; A = 12.5% | Strongly in favor | Low | 1C | 307 and expert opinion |

†Consensus: A = strongly agree; A = agree; N = neither agree nor disagree; D = disagree; D = strongly disagree. Grade of recommendation: 1A = strong recommendation, high-quality evidence; 1B = strong recommendation, moderate-quality evidence; 1C = strong recommendation, low-quality or very low-quality evidence; 2A = weak recommendation, high-quality evidence; 2B = weak recommendation, moderate-quality evidence; 2C = weak recommendation, low-quality or very low-quality evidence.

‡Where applicable depending on country-specific legislation on presymptomatic testing of patients aged ≤18 years.

ALT, alanine aminotransferase; AST, aspartate aminotransferase; CGH, comparative genome hybridization; CK, creatine kinase; DMD, Duchenne muscular dystrophy; GRADE, Grading of Recommendations Assessment, Development, and Evaluation.*The level of evidence for most of the statements was graded as either low or moderate, owing to the fact that most of the studies included here are observational in nature rather than randomized controlled trials (due to the nature of this initiative). When there were multiple corroborative supporting observational studies, we have selected “moderate” for quality of evidence.
Indeed, patients who are identified by an incidental finding of elevated CK (before onset of signs and symptoms) can be diagnosed earlier. The consensus group agreed that a lack of awareness of the signs and symptoms of DMD and delays in the time taken to see a specialist are the primary factors contributing to a delay in the initial diagnosis. In support of this, a retrospective chart review of 156 patients without a family history of DMD using the Muscular Dystrophy Surveillance, Tracking and Research Network (MD STARnet) showed, in a subset of patients (n = 127), that 63.8% (81/127) were seen by a pediatrician/family practitioner at their first evaluation and that a CK test was ordered as a result of the first evaluation in only 34.6% (44/127) of cases.4 This finding indicates a need to increase awareness of DMD among front-line healthcare professionals.

The consensus group agreed that genetic testing is crucial to obtain a complete diagnosis of DMD. The DMD gene is one of the largest known human genes (2.2 Mb), containing 79 exons with a relatively high mutation rate (~30% of cases are caused by a de novo mutation).11,45,108 The approximate distribution of mutations in the DMD gene is as follows: deletion of 1 or more exons, 68%; duplication of 1 or more exons, 11%; small-scale mutations, 20% (small-scale deletions, 5%; small-scale insertions, 2%; splice-site, 3%; nonsense, 10%; missense, 0.4%); and deep intronic mutations, 0.3%.35 This distribution is supported by a number of studies.23,36,37,46,106–110 It is therefore practical to test for DMD gene mutations in order of frequency. The consensus group agreed on 3 statements that outline the recommended steps needed to reach a complete genetic diagnosis of DMD (Figure 3).4,35,46 First, multiplex ligation-dependent probe amplification (MLPA) or comparative genome hybridization should be used to screen for deletions or duplications in the DMD gene. These tests are recommended because they can screen all 79 exons of the DMD gene; however, it should be noted that there are several limitations associated with MLPA. For example, point mutations or polymorphisms along the probe hybridization region can present as single-exon deletions when using this method, and thus a second confirmatory test (usually Sanger sequencing) is required.11,12,23 However, if the mutation is identified and correlates with the severity of symptoms (eg, DMD or Becker muscular dystrophy [BMD]), no further genetic testing is typically required. If exonic deletions/duplications in the DMD gene are not identified, small-scale mutations should be tested for by sequencing exons and flanking intronic regions. If clinical signs and genetic testing are conclusive, in most cases, muscle biopsies are not needed. Nevertheless, if no mutation is detected after DNA analysis, it is possible that the patient may have a large rearrangement, such as an inversion (or translocation in females11), a deep intronic mutation that affects splicing, or an alternative diagnosis.32 Inversions and translocations are challenging to detect with most conventional genetic analyses, because they do not affect copy number.111 Deep intronic mutations often can be detected by next-generation sequencing if the full genomic sequence of the gene is available; however, it can be difficult to predict the impact of intronic mutations (or variations) on mRNA. If a muscle biopsy with dystrophin staining confirms dystrophinopathy, mRNA analysis should be performed to identify any impact on mRNA splicing11,12,45,111 that escapes detection by both MLPA and DNA sequencing. RNA analysis is also crucial to determine the consequence of the mutation on the mRNA and can be considered for discordant phenotypes. Muscle biopsy remains a relevant diagnostic tool, especially for mutation types in which the mutation is poorly predictive of disease progression (for instance, a deletion of exons 3-7 can cause both BMD and DMD phenotypes), or for determining dystrophin expression in boys with unexpectedly mild disease progression.11 We note that there are several databases that can help physicians to determine the severity of individual and rare causal mutations in the DMD gene (Appendix). In addition to consulting these databases, physicians entering new data on genotype and phenotype are warranted to help inform future diagnoses.

The consensus group agreed that delays in the initial clinical diagnosis or referral to a specialist, the sequential nature of the genetic testing process, and incomplete or nonexhaustive genetic testing should be addressed to prevent delays in diagnosis. In addition, if the ordering physician is not sufficiently informed or trained to understand the hierarchy of tests needed to provide a complete genetic diagnosis for DMD, the testing process could be terminated prematurely (as shown elsewhere).11 It would therefore be helpful if the responsibility for these decisions was integrated with the primary testing laboratory’s operating procedures. The laboratory would thus be obligated to contact the ordering physician to discuss the next level of testing required either to obtain a complete genetic diagnosis of DMD or to exclude DMD from the diagnosis.

**Section 2: Recommendations for Next Steps Following a Suspected DMD Diagnosis**

A patient with signs and symptoms of DMD and elevated CK levels should be referred to a clinical geneticist/neuromuscular specialist during the genetic testing process, because these individuals are best placed to provide accurate interpretation of genetic test results12 and can help to avoid diagnostic delay (Table III).3

In 2010, best practice guidelines for the molecular diagnosis of DMD/BMD were developed using a consensus-building approach.12 More recently, general standards and guidelines for the interpretation of sequence variants have been published by the American College of Medical Genetics and Genomics and the Association for Molecular Pathology.32 The consensus group agreed that a clinical geneticist usually is responsible for the interpretation of the genetic test results but that the process should be shared between the clinical geneticist, the physician who ordered the test (typically a child neurologist or neuromuscular specialist), and/or a genetic counselor.

Although improving the clarity of genetic test reports and directing physicians to the appropriate specialists for assistance would ultimately ensure a quicker and more accurate genetic diagnosis for patients, it is also important for physicians (nongeneticists) to understand genetic test results, because this will have a direct impact on patient management. The
**Figure 3.** Diagnostic steps for reaching a complete diagnosis of DMD. ALT, alanine aminotransferase; AST, aspartate aminotransferase; NGS, next-generation sequencing. *Elevated CK levels within the range of approximately 500-1200 U/L (1.5 times the upper limit of normal for men), even if asymptomatic, may be indicative of other neuromuscular disorders that require further assessment.*

**+**Point mutations or polymorphisms along the probe hybridization region can present as single-exon deletions when using MLPA and thus a second confirmatory test (typically Sanger sequencing) may be required.

**‡**Testing of at-risk (asymptomatic) male relatives will be dependent on country-specific legislation.

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Evidence-Based Consensus and Systematic Review on Reducing the Time to Diagnosis of Duchenne Muscular Dystrophy
consensus group therefore agreed that educational meetings for physicians and laboratory specialists on topics relating to
the genetic diagnosis of DMD would help to improve physi-
cians’ understanding of genetic tests and the interpretation of
the results.

The consensus group also agreed on 3 statements to high-
light the next steps that should be taken after a complete di-
agnosis has been reached. These statements highlight the
importance of carrier testing, genetic counseling, family-
planning decisions, and prenatal diagnosis. It is estimated that
approximately one-third of patients with DMD develop the
disease owing to de novo mutations and that the remaining
two-thirds inherit the mutation from carrier mothers.11,63,64 If
the mutation identified in the affected patient is not carried
by the mother in her somatic cell line, the mother may be a
germine mosaic and should be provided with counseling about
the risk of having a second son with the disease12 or having a
daughter that is a carrier.11 Female carriers are typically as-
symptomatic because DMD is an X-linked inherited disease;
however, carriers can develop mild clinical symptoms, includ-
ing muscle weakness and scoliosis,65,66 and are at an in-
creased risk of cardiomyopathy.67,68 Despite this, approxi-
mately one-third of potential carriers are likely unaware of their carrier
status.84,70 Genetic testing is thus important for family-
planning decisions and counseling of other family members.71,74
Genetic information also is used for genotype–phenotype
correlations,2,75,76,79,114 so that patients can be provided with prog-
nostic information and be offered appropriate medical
management.11,23,77,78

As per the 2010 best practice guidelines for the molecular
diagnosis of DMD/BMD, prenatal testing is advised to be
carried out only for at-risk male pregnancies (those with a
family history of the disease).12 Prenatal screening is not cur-
rently recommended for female fetuses, because it is not yet
possible to determine whether a female heterozygote for a DMD
mutation will exhibit any signs of disease.12 However, the con-
sensus group agreed that when a family history is present, pre-
natal testing leads to earlier detection of DMD and is thus
important for family-planning decisions. Recommendations
regarding prenatal diagnosis will depend on country-specific
legislation.12,31 The consensus group also agreed that in the pres-
ence of a family history of disease, presymptomatic CK testing
would lead to earlier detection and thus earlier management
of patients with DMD, but would be dependent on country-
specific legislation.

The 195th European Neuromuscular Centre International
Workshop (2012) report presented discussions on newborn
screening (NBS) for DMD; the meeting was attended by 21
experts from 7 countries. It was discussed that the introduc-
tion of NBS for DMD using CK testing would help to detect
the disease earlier in patients and reduce the risk of having
additional children with DMD.1 A pilot study in the US
demonstrated the feasibility of a 2-tier NBS system for DMD
using dried blood spots to test CK levels, followed by DMD
gene testing6; however, there are many complexities involved
with NBS programs, some of which are discussed in the
Appendix.

Conclusions

Delays in the diagnosis of DMD have remained relatively un-
changed over the last 30 years,3,10 despite advances in our un-
derstanding of the natural history and improvements in genetic
testing. Delays occur early in the diagnostic pathway, because
of a lack of awareness of DMD and its signs and symptoms
among families, and, more pertinently, among front-line health-
care professionals.4 Issues relating to the understanding of
genetic testing required to obtain a complete diagnosis of DMD
have been highlighted (Table I).11 Patients presenting with the
typical motor signs and symptoms of DMD, as well as the less
well-recognized neurocognitive deficits, developmental delays,
and elevated liver enzymes, should be immediately referred to
a specialist (child neurologist or neuromuscular specialist) and
should have their serum CK levels measured. Patients with a
marked elevation in serum CK should be referred to a cli-
cal geneticist as soon as possible, and the full range of sequen-
tial genetic tests offered to provide a complete diagnosis. After
diagnosis, it is mandatory to offer carrier testing to mothers
and other at-risk female relatives. By highlighting these issues
and providing an in-depth discussion of the DMD diagnos-
pathway, we hope that patients will be diagnosed earlier,
care provided as soon as possible, and personalized interven-
tion provided for eligible patients.

Disclaimer

The Delphi Consensus statements presented here are based on
the opinions of carefully selected experts in the field and are
for information and educational purposes only. The state-
ments may reflect gaps in current knowledge, but, where pos-
able, have been supported by relevant literature. These
statements do not reflect clinical practice guidelines or legal
standards of care and, as such, do not include all potential di-
gnostic or management steps. The responsible physician, in
light of all of the circumstances presented by the individual
patient, must determine the appropriate treatment, diagno-
sis, and management.

Endorsements

Endorsed by the European Paediatric Neurology Society
(EPNS), the Muscular Dystrophy Association (MDA),
Duchenne Parent Project Italy, Parent Project Muscular Dys-
trophy (PPMD), and TREAT-NMD.
References


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A.A-R. is employed by Leiden University Medical Center (LUMC), which has patents on exon skipping technology, some of which have been licensed to BioMarin and subsequently sublicensed to Sarepta Therapeutics. As co-inventor of some of these patents, A.A-R. is entitled to a share of royalties. Remuneration for consultancy is paid to LUMC. LUMC also received speaker honoraria from BioMarin Pharmaceuticals and PTC Therapeutics. M.H. is employed by PerkinElmer Genetics and receives royalty payments from Agilent Technologies and Oxford Gene Technologies for next-generation sequencing products and has received speaker honoraria from BioMarin, Genzyme, Pharmaceuticals, and PTC Therapeutics. F.B. is a community pharmacy owner, has acted as a consultant for PTC Therapeutics and Santhera Pharmaceuticals, and has received honoraria related to advisory board participation or speaker activities. A.F. received honoraria via the Ferrara Hospital for participation in clinical trials and also served as a PTC Diagnostic Board member and a Sarepta European Scientific Board member, and received honoraria related to the board participation or speaker activities. R.H. receives speaking fees from Sanofi-Genzyme. E.L. served on a scientific advisory board for PTC Therapeutics Inc in France and also received honoraria related to speaker activities. A.M. received speaker honoraria from BioMarin and Sarepta Therapeutics. A.P-C. is employed by the Medical University of Warsaw and received honoraria for lectures or consultancy from Allergan, Biogen, Kedrion, Novo-Nordisk, PTC Therapeutics (clinical trial investigator), Sanofi-Genzyme, and Teva Pharmaceutical Industries. J.S. received research funding from PTC Therapeutics. W.S. received honoraria for serving as a consultant from PTC Therapeutics and Santhera Pharmaceuticals. T.S. received research grants from Sanofi-Genzyme, and honoraria for lectures or consultancy from Biogen, BioMarin, PTC Therapeutics, and Sanofi-Genzyme. S.T-G. served on a scientific advisory board for PTC Therapeutics Inc in France, and remuneration for this activity was paid to the University of Montpellier. The University of Montpellier also received speaker honoraria from PTC Therapeutics Inc. Z.U. received honoraria from PTC Therapeutics Inc. L.W. is an employee of PharmaGenesis London, London, United Kingdom, and was funded by PTC Therapeutics Inc to provide medical writing and editorial support (including to perform the systematic review of the literature) for this initiative under the guidance of the steering committee. S.N. is employed by UCLA and received honoraria from PTC Therapeutics, Sanofi-Genzyme, Sarepta Therapeutics, and Solid Biosciences for DMD-related advisory panels. T.B-O, P.G., and S.Y. declare no conflicts of interest.
Appendix

Introduction
Example survey results from the 2017 and 2018 TREAT-NMD Expert Masterclasses regarding the genetic diagnosis of patients with DMD are presented in Table I, available at www.jpeds.com.

Methods
Systematic Literature Searches. Search terms were identified by the steering committee and literature searches performed in Ovid (2017 Ovid Technologies, Inc, New York, New York) by PharmaGenesis London, London, United Kingdom, to screen the MEDLINE and EMBASE databases. Search terms (title/abstract) were: Duchenne muscular dystrophy, DMD or Duchenne AND any of the following search terms: symptom; creatine kinase; transaminase; diagnostic; gene; genetic test; genetic report; genetic counselor; delay; screen; carrier; mutation; sequenc; comparative genome hybridization; CGH; multiplex ligation-dependent probe amplification; MLPA; multiplex polymerase chain reaction; multiplex PCR; biops; prenatal; neonatal; female; family planning; germ line mosaicism; de novo; practitioner; pediatrician; pediatric neurologist; neuromuscular specialist. The “?” and “*” functions searched for spelling variations and variations of the word ending, respectively. Search results were limited to: articles published from January 1, 2010, to April 8, 2018; English; studies of humans; and full journal articles. The full electronic search strategy is provided in Table II, available at www.jpeds.com. PharmaGenesis London exported the initial raw results and highlighted articles of potential relevance using a traffic light system (red—unlikely to be relevant; amber—potentially relevant; green—likely to be relevant). The 3 members of the steering committee then reviewed the relevance of the supporting literature. Any articles included by the authors that were not identified by the systematic literature review were categorized as ad hoc in the PRISMA flow diagram in Figure 2, available at www.jpeds.com. Data were then extracted by PharmaGenesis London, and used, under the guidance of the steering committee, to draft questions to aid the development of the Consensus Statements.

Development of the Consensus Statements via Iterative Voting. Voting round 1 included 29 questions drafted by the steering committee based on initial review of the literature, to which the consensus group provided free-text responses. The results were collated by PharmaGenesis London to ensure voter anonymity, and the anonymized results were reviewed by the nonvoting chair. During each voting round, the consensus group was encouraged to comment on the wording and content of the questions, themes, and statements. After each round, the steering committee made changes to the statements to reflect the feedback received.

Voting round 2 included 20 questions formulated using the responses from round 1. The consensus group then rated the importance of, or agreement with, the themes identified during round 2 (using a ranking or 5-point Likert scale). Voting rounds 1 and 2 were conducted using SurveyMonkey (https://www.surveymonkey.co.uk/). Voting round 3 was developed in advance of a 1-day consensus meeting held in May 2017 in Copenhagen, Denmark, and the draft statements were circulated to the consensus group before the meeting. This round comprised 24 statements for which the consensus group had to rate their level of agreement using a 5-point Likert scale (“strongly agree” [A+]; “agree” [A]; “neither agree nor disagree” [N]; “disagree” [D]; or “strongly disagree” [D+] Figure 1.4) using anonymized electronic keypads. Consensus was defined a priori as at least 75% agreement (either “strongly agree” [A+] or “agree” [A]). Each question was introduced by the nonvoting chair. If consensus was not reached after the first round of voting, alterations to the statement were made based on discussions before the next round of voting was conducted.

The 3 members of the steering committee then graded the level of evidence and strength of recommendations supporting each statement using the Grading of Recommendations Assessment, Development, and Evaluation system (Figure 1). The grading was reviewed and agreed on by the expert voting panel (Table III).

Additional Supporting Information for the Consensus Statements. Additional supporting information from the systematic literature review for each consensus statement is detailed below.

Section 1: Reducing the Time to Diagnosis of DMD (Table III).

Statement 1. The following signs, symptoms, and characteristics should be considered typical indicators of DMD: calf hypertrophy (pseudohypertrophy); delayed walking; difficulty climbing/descending stairs; difficulty rising from the floor; difficulty running/walking; elevated serum CK level (including elevated alanine transaminase and aspartate transaminase); a family history of DMD; frequent falls; Gowers’ sign; male sex; and muscle weakness.

Vote: A+ = 93%; A = 7%; grade of recommendation: 1B

Discussion
In support of this statement (Table III), a retrospective chart review of 156 boys with DMD (no family history of disease) using the Muscular Dystrophy Surveillance, Tracking, and Research Network (MD STARnet) assessed the range of signs and symptoms first reported to healthcare providers by patients who were later diagnosed with DMD (n = 111).3 In patients aged 3 to <5 years, the signs and symptoms included calf hypertrophy, 7.1%; difficulty rising from the floor, 23.8%; difficulty climbing, 31.0%; frequent falls/clumsiness, 33.3%; difficulty running/walking, 38.1%; and muscle weakness, 40.5%. These symptoms, with the exception of muscle weakness, difficulty running/walking, and difficulty climbing, were the most frequently reported within this age range compared
with younger or older patients with DMD. Muscle weakness and difficulty climbing were reported more frequently in older patients (≥5 years old), and difficulty running/walking was more frequently reported in patients aged 1.5 to <3 years and patients aged ≥5 years, as the symptom(s) first reported to healthcare providers.

These findings are supported by several other studies. First, a mixed-methods study of parents’ and patients’ experiences of the diagnosis of DMD in Australia reported that the initial symptoms noted by parents (n = 62) (by ≥20% of parents) were calf hypertrophy, 42%; complaining of tired legs, 26%; difficulties with walking, 35%; frequent falls, 44%; tiring easily, 37%; difficulties running, 65%; and difficulties climbing stairs, 61.6. Similarly, a case note review of 20 boys with DMD in the United Kingdom showed that 20% (8/40) of boys reported “difficulty with steps,” and 20% (8/40) of boys experienced “falls” as part of their initial symptom profile. Three of the 20 boys experienced delayed first walking (later than the 18-month milestone), and 4 of the boys were diagnosed from an incidental finding of elevated serum CK level. A retrospective review of 24 patients with DMD in Korea reported that their initial symptoms were: difficulty rising from the floor, 16.7%; lower-extremity muscle weakness, 90.0%; family history of DMD, 29.2%; and calf hypertrophy, 87.5%. Mean serum CK levels also were elevated (14 144 IU/L). In addition, a study of patients with DMD from eastern India showed that of the 81 patients assessed, 100% had lower-limb weakness, 97.5% had neck-muscle weakness, 93.8% had calf hypertrophy, 70.4% exhibited Gowers’ sign, and 27.1% had a family history of DMD. Lastly, a retrospective study of medical records for 540 patients in the US with DMD showed that patients with a family history of disease are typically seen and diagnosed at an earlier age than those without a family history (with family history vs without family history: age at initial evaluation, 30.8 months vs 56.8 months; P <.001; age at CK measurement, 35.1 months vs 64.0 months; P < .001). Age at genetic testing did not differ significantly between the 2 groups (56.2 months vs 64.3 months, respectively).

Commentary

The consensus group agreed that patients were sometimes identified inadvertently as a result of high serum CK levels, detected as part of routine screening or assessments unrelated to a diagnosis of DMD. It also was discussed that a family history of DMD would act as a strong indicator of DMD, particularly in a male patient presenting with signs and symptoms of the disease.

Statement 2. Autism spectrum disorder, delayed speech/ cognitive deficits, and gross motor delay can be indicators of DMD but are not always associated with the disease.

Vote: A+ = 93%; A = 7%; grade of recommendation: 1B

Discussion

In support of this statement, a European study of 4 centers found that 26% (34/130) of patients with DMD were reported to have an intellectual disability. Of 87 patients who completed the full neurodevelopmental assessment, 21% (18/87) scored in the autistic spectrum disorder range, 24% (21/87) showed clinical hyperactivity, and 44% (38/87) had severe difficulties in attention. Similarly, a study in Germany of 263 patients with DMD showed that 30% of patients experienced a delay in gross motor development and that approximately 40% of patients showed cognitive impairment (learning difficulty, 26%; intellectual disability, 17%). A smaller case note review of 20 boys with DMD (without a family history of disease) in the United Kingdom showed that speech delay was a presenting feature in 25% of the cohort and that this was identified in 45% of the patients at the time of diagnosis. A study of patients with DMD from eastern India showed that approximately one-third of boys with DMD had mild intellectual disability (IQ 38–63). A recent study of 209 caregivers of boys with DMD identified through MD STARnet showed that cognitive deficits were reported in 38.4% of boys. Furthermore, a chart review study of 179 boys with DMD (1989–2012) showed that delayed walking and cognitive impairment were correlated (P ≤ .0001). It also has been shown that boys with DMD have a reduced rate of implicit learning compared with boys with typical development, even in the absence of global intellectual disability.

The location of the DMD gene mutation also has been shown to correlate with the severity of cognitive impairment. For example, an observational study of 47 Italian boys with DMD showed that Full-Scale IQ scores correlated with the location of the dystrophin gene mutation; mutations in the distal region of the DMD gene were associated with more severe cognitive deficits. Patients with point mutations in the DMD gene exhibited a higher degree of cognitive impairment than those with deletions or duplications (P = .005). In addition, patients with mutations in the distal region of the DMD gene had lower IQ levels than those who had mutations in the proximal region. Additional information is presented in a recent review of the literature examining neuropsychological and neurobehavioral functioning in patients with DMD.

These neurocognitive deficits and developmental delays can sometimes be overlooked; as a result, patients with DMD can be referred to the incorrect specialist. This was exemplified in a retrospective chart review of 156 boys with DMD using MD STARnet, which showed that although 16.5% (21/127) of patients were correctly referred to either a neurologist or a neuromuscular specialist, 15.7% (20/127) were referred to a physical, occupational, or speech therapist as a result of their first evaluation.

Commentary

No additional supporting information is included.

Statement 3. After initial presentation, patients with suspected DMD should have their serum CK tested and be referred to a specialist (a pediatric neurologist or neuromuscular specialist).

Vote: A+ = 93%; A = 7%; grade of recommendation: 1B
**Discussion**

Serum CK level was first recognized as a marker of muscular dystrophy approximately 60 years ago. Levels of serum CK are elevated in patients with muscular dystrophy; this is caused by leakage of cytoplasmic CK from damaged muscle fiber cells into the blood circulation. Findings from a retrospective case note review of 20 boys with DMD (with a family history of the disease) in the United Kingdom showed that a delay in requesting a serum CK level test accounted for the majority of the delay experienced by patients (mean [range] diagnostic delay from first visit with a healthcare professional to diagnosis of DMD, 8.8 [0-50] months; delay in CK level test, 7.2 [0-49] months; and time from CK test result available to genetic diagnosis, 1.6 [0-4] months). The mean (range) age at diagnosis for these patients was 51.7 (10-91) months; however, in 4 boys who had been diagnosed based on incidental serum CK level findings as part of an unrelated illness, the age at diagnosis was greatly reduced (35.3 [10-57] months).

**Commentary**

The consensus group agreed that a serum CK level test plays a pivotal role in the diagnostic process for DMD and that this should be requested immediately or as soon as possible by primary care physicians, along with referral to a specialist (a pediatric neurologist or a neuromuscular specialist), for any patient presenting with associated signs and symptoms of the disease. Overall, 87% of consensus group members (13/15) indicated that the request for a serum CK level test should be made “immediately” or “as soon as possible” after the patient presents with initial symptoms; the remaining 13% (2/15) indicated that this should be done within 1 week. Similarly, the majority (75% [9/12]) of consensus group members also agreed that referral to a specialist should occur immediately or as soon as possible after receiving a positive CK test result; the remaining 25% (3/12) indicated that this should occur within 1 week.

**Statement 4.** A lack of awareness of DMD and associated symptoms by the healthcare professional and long waiting times to see a specialist are the primary factors leading to a delay in initial diagnosis.

Vote: A+ = 67%; A = 33%; grade of recommendation: IC

**Discussion**

In support of this statement, a retrospective chart review of 156 patients without a family history of DMD using MD STARnet showed that there is a delay of approximately 1 year from first evaluation by the healthcare professional to referral to a neurologist or neuromuscular specialist (mean age of patient ± SD [range]: first evaluation, 3.6 ± 1.7 [0.2-8.0] years; first neurology/neuromuscular specialist visit, 4.6 ± 1.7 [0.3-8.6] years). This highlights a significant delay in the time from first assessment to seeing a specialist. Several patients also were referred incorrectly (eg, to a speech therapist), demonstrating a lack of awareness of some of the signs and symptoms associated with DMD among front-line healthcare professionals. Similarly, a retrospective case note review of 20 boys with DMD (with a family history of the disease) in the United Kingdom showed that in 19 of the boys, the serum CK level test was performed in secondary care, thus delaying the time to diagnosis (10-50 months, n = 15; <10 months, n = 4). The 1 boy whose serum CK level test was requested by a general practitioner had a minimal delay in the time to diagnosis (<10 months), highlighting the importance of recognizing symptoms early. Furthermore, an Australian mixed-methods study has shown that parents visit a range of healthcare professionals in their search for a diagnosis, and 51% of the parents surveyed (29/57) felt that their child could have been diagnosed earlier.

**Statement 5.** Genetic testing is crucial for obtaining a complete diagnosis of DMD and should be considered the gold standard.

Vote: A+ = 94%; A = 6%; grade of recommendation: IC

**Discussion**

Full characterization of the mutation affecting the DMD gene is required to determine its predicted effect on the
reading frame. This is important because mutations that cause a frame-shift, or that change an amino acid codon into a stop codon, generally result in a more severe phenotypic presentation of the disease (ie, DMD), owing to the premature termination of translation. This results in truncated, nonfunctional dystrophin protein. In contrast, mutations that do not disrupt the reading frame typically result in a less severe form of the disease (ie, BMD), owing to the production of a shorter but partly functional version of the dystrophin protein.

At this time, there are 2 mutation-specific therapies with a form of approval. Ataluren has received conditional approval from the European Medicines Agency for the treatment of ambulatory patients with nonsense mutation DMD. Eteplirsen has received accelerated approval from the US Food and Drug Administration for the treatment of patients with DMD who have a mutation in the DMD gene amenable to mRNA reframing by exclusion of exon 51 from mature mRNA.

**Commentary**

No additional supporting information is included.

**Statement 6.** In the majority of cases, a complete genetic diagnosis can be made using MLPA or comparative genome hybridization (CGH) to detect deletions or duplications in the DMD gene.

Vote: A+ = 88%; A = 6%; N = 6%; grade of recommendation: 1B

**Discussion**

There are several databases that can be accessed to obtain information on DMD gene mutations:

- The Leiden Open Variation Database is an online open source that currently contains more than 10 000 DMD gene mutations (www.dmd.nl).
- The UMD-TREAT-NMD database was recently set up as part of an international effort to provide up-to-date information about DMD gene mutations worldwide (http://umd.be/TREAT_DMD/); data from more than 30 national registries are collated here.
- The Human Gene Mutation Database (HGMD) is a database for human inherited diseases and is maintained by the Institute of Medical Genetics in Cardiff, United Kingdom (http://www.hgmd.cf.ac.uk/ac/index). Owing to the fact that approximately 80% of all DMD mutations are either large deletions or duplications, it is practical to screen for these mutations as the first step toward reaching a complete genetic diagnosis of DMD. Multiplex polymerase chain reaction (PCR) using the Chamberlain and colleagues, and Beggs and colleagues primer sets, along with more recent primer sets, can be used to detect approximately 98% of all DMD gene deletions; however, these assays do not characterize the boundaries of these mutations, do not screen all 79 exons of the DMD gene, and are unable to detect duplications. MLPA and CGH are quantitative assays and can characterize all of the mutations not detected by multiplex PCR; these tests can also be used for carrier testing in females.

**Multiplex Ligation-Dependent Probe Amplification.** Lalic et al designed and validated the MLPA assay to screen all 79 exons of the DMD gene for deletions and duplications. The MLPA assay was then used to test samples from 123 unrelated patients with DMD or BMD who had already been screened by multiplex PCR. The study showed that MLPA was able to detect all previously identified deletions, as well as a number of new mutations that were previously not detected (new deletions, n = 7; new duplications, n = 9; new point mutation, n = 1 [note: point mutations are detected by MLPA only when the mutation lies within the binding site of the MLPA probe]). MLPA also was able to determine the precise genetic rearrangement, which is important for determining the effect on the reading frame.

Ultimately, the study showed that MLPA outperformed the Beggs and Chamberlain multiplex PCR test (detecting ~13% more mutations). In light of this, the authors recommended that MLPA be considered the method of choice for initial DNA analysis of patients with suspected DMD or BMD. The improved detection rate of MLPA compared with multiplex PCR is supported by a number of other studies. However, the MLPA assay has a number of limitations: it is unable to provide information regarding the location of intronic breakpoints and point mutations or nonpathogenic polymorphisms in the probe binding site can present as single-exon deletions when using this method. A second confirmatory test, generally Sanger sequencing of the involved exons, should therefore be performed for these false-positive test results. In addition, false-negative test results may occur if there is a partial exonic deletion that is not coincident with the ligation site of the MLPA probe. Despite this, MLPA is a commercially available test and is currently the most widely used.

**Comparative Genome Hybridization.** Soon after the development of MLPA, a novel DMD-CGH array covering the full genomic region of the DMD gene was tested. The assay was able to detect all previously identified deletions and duplications (4/4) and was able to provide the location of intronic breakpoints for these patients. The CGH assay also was able to identify the causative mutations in 3 of 8 of the patients with DMD who had previously tested negative by MLPA. CGH provides a high-resolution assay that has enabled the detection of complex genomic rearrangements and intronic breakpoints and therefore has a slightly greater mutation detection rate than MLPA. This is supported by several other studies. Ultimately, if deletion/duplication testing is positive, and the mutation is fully characterized and correlates with the severity of symptoms (eg, DMD or BMD), then no further genetic testing is required. In some cases, patients with a BMD phenotype have been found to have an out-of-frame DMD gene deletion according to MLPA analysis. An explanation for this discrepancy is that with MLPA, only a portion of the exon is
analyzed, and there have been some rare cases reported where the deletion extends to the splice site of the adjacent exon but not the MLPA target site.

**Commentary**
In the near future, newer assays such as next-generation sequencing (NGS) will be able to evaluate deletions, duplications, and point mutations in a single assay. However, because routine NGS is not yet widely available, it was not included as part of this consensus statement.

**Statement 7.** If exon-level deletions/duplications in the *DMD* gene are not identified, small-scale mutations (by sequencing of exons and flanking regions) should be tested for as the next step.

**Vote:** A+ = 93%; A = 7%; grade of recommendation: 1C

**Discussion**
If deletion/duplication testing is negative, it is possible that the patient may have a small-scale mutation in the *DMD* gene (these account for ~20% of all *DMD* gene mutations). Despite these findings, a recent survey of 41 individuals (primarily pediatric neurologists and clinical geneticists) from Europe, Turkey, and India at the 2015 TREAT-NMD Expert Masterclass on DMD showed that >10% of respondents did not perform additional tests if deletion/duplication testing was negative. The reasons for this included the cost of Sanger sequencing and the need for shipping of samples to other laboratories for analysis. This was further supported by survey results from the 2017 and 2018 TREAT-NMD Expert Masterclasses on DMD (Table I, available at www.jpeds.com), in which 18.8% and 11.1% of the delegates, respectively, did not know the correct next steps following a negative MLPA test result.

Small-scale mutations (single-nucleotide variants) typically are identified using Sanger sequencing of all individual exons; however, because it is becoming more cost- and time-effective, it is likely that in the near future, this methodology will be replaced by next-generation whole-exome sequencing.

**Commentary**
No additional supporting information is included.

**Statement 8.** Muscle biopsies with dystrophin staining are generally not needed to obtain a complete diagnosis of DMD, unless DNA testing is negative.

**Vote:** A+ = 73%; A = 27%; grade of recommendation: 1C

**Discussion**
A deep intronic mutation can cause part of an intron to be incorporated into the dystrophin mRNA if it is recognized as an exon by the splice-site machinery (such sequences are known as cryptic or pseudo-exons). The inclusion of intronic sequences can disrupt the reading frame and generate stop codons. Intrinsic mutations detected by NGS have been reported in a number of cases of DMD, and muscle biopsies have also been used to confirm the presence of aberrant dystrophin mRNA in patients with DMD. In addition to cases of deep intronic mutations, muscle biopsies may also be considered if the patient presents with a discordant phenotype (ie, the genotype would predict DMD, but the patient presents with BMD, or vice versa); however, obtaining this information will not ultimately change the disease course or the patient is managed.

**Commentary**
For novel or ultra-rare mutations not previously associated with dystrophinopathy, family-based segregation analysis should be recommended (it should be noted that depending on the diagnostic strategies in different countries, segregation analysis is systematically performed).

**Statement 9.** Delays in the initial clinical diagnosis/referral to a specialist, the sequential nature of the genetic testing process, and incomplete or nonexhaustive genetic testing should be addressed to prevent delays in reaching a complete genetic diagnosis for patients with DMD.

**Vote:** A+ = 93%; A = 7%; grade of recommendation: 1C

**Discussion**
Despite improvements in genetic testing, the sequential nature of the genetic testing process has the potential to lead to delays in diagnosis, particularly for patients with rare mutations (ie, those who will be diagnosed at the very end of the diagnostic pathway). However, the availability of NGS will ultimately provide a single-platform test to detect the majority of *DMD* gene mutations and should significantly reduce the time to and cost of diagnosis. As discussed, incomplete or nonexhaustive genetic testing can result in patients not receiving a complete or definitive diagnosis. A survey of 41 healthcare professionals (primarily pediatric neurologists and clinical geneticists) showed that although 100% understood the importance of genetic testing, more than 10% would not request further tests if deletions or duplications were not identified. Furthermore, results from the 2017 and 2018 TREAT-NMD Expert Masterclasses on DMD revealed a lack of understanding of DMD genetics (ie, the sequential steps needed to obtain a complete genetic diagnosis for the patient as shown in Figure 3) and difficulties with the interpretation of genetic test results (Table I, available at www.jpeds.com).

Ultimately, this lack of understanding could result in patients receiving an incomplete or even incorrect genetic diagnosis and prevent them from receiving a mutation-specific therapy for which they are eligible.

**Commentary**
When asked how long it should take from a specialist ordering the genetic test to the patient receiving a complete genetic diagnosis, the majority of consensus group members indicated that this should take no longer than 8 weeks (77% [10/13]).
Section 2: Recommendations for next steps following a suspected DMD diagnosis (Table III).

Statement 10. Patients with signs and symptoms of DMD and elevated serum CK levels should be referred for genetic testing to either a clinical geneticist or a neuromuscular specialist.

Vote: A+ = 100%; grade of recommendation: 1C

Discussion
No additional supporting information is included.

Commentary
No additional supporting information is included.

Statement 11. A medical/clinical geneticist, a pediatric neurologist, or a neuromuscular specialist should request the genetic test and should provide clinical information relevant to the diagnosis as part of the sample submission to the clinical genetics laboratory, and the genetic diagnostic test should be performed by an accredited laboratory.

Vote: A+ = 100%; grade of recommendation: 1C

Discussion
Laboratories should be formally accredited or certified by organizations such as the International Laboratory Accreditation Cooperation,29,60 or be covered by such programs as the Clinical Laboratory Improvement Amendments program.61

Commentary
The consensus group members were asked who performs the genetic testing in their respective countries. Of the 16 members, 14 indicated that this is performed by a molecular genetics laboratory; however, only 4 of these 14 specified that the laboratory had to be accredited. It was therefore felt that this should be specified in the statement, because it is recommended by current guidelines.29,61

Statement 12. Educational meetings for physicians and laboratory specialists on topics relating to the genetic diagnosis of DMD would help to improve the understanding of genetic test reports and the interpretation of genetic test results.

Vote: A+ = 93%; A = 7%; grade of recommendation: 1C

Discussion
In support of this statement, a study of views on genetics training for nongenetic specialists in the United Kingdom showed that of 90 general practitioners surveyed, 90% (81/90) felt that genetics was increasingly important and should be given more attention in their training; 83% (75/90) felt that they did not know all they needed to know about genetics; and 71% (64/90) felt that the training they had received had been insufficient to prepare them for their current role.62 Similarly, a study of 220 interns from 2 academic medical centers in the US showed that 73.7% and 87.1% of interns rated their knowledge of (1) genetics and (2) genetics guidelines as poor, respectively. The interns also acknowledged that they required further training on particular topics (eg, when to order tests, 79.0%; how to counsel patients, 82.0%; how to interpret results, 77.3%).63

Commentary
No additional supporting information is included.

Statement 13. Genetic testing is necessary to inform carrier testing, family planning, genetic counseling, prognosis and optimal management strategies, natural history data gathering, and prenatal diagnosis.

Vote: A+ = 100%; grade of recommendation: 1C

Discussion
Genetic testing is important to inform carrier testing, family planning, and genetic counseling for patients and their families. A qualitative study examined the impact of genetic testing on extended family members. Thirty grandmothers in families with individuals showing fragile X syndrome or DMD were interviewed. The interviews showed that most grandmothers expressed feelings of guilt or responsibility. This highlighted that although genetic counseling is generally focused on family planning, it should also be offered to extended family members because of the psychosocial impact.64 Similarly, a qualitative study on parent communication with siblings of children affected by inherited conditions also highlighted the importance of genetic counseling for unaffected siblings, who are at risk of being carriers.65

Genetic information is also important for natural history data gathering, because such studies can help to provide information on prognosis and risk of complications; for example, it has been shown that patients with deletions flanking exon 44 or a deletion of exons 3-7 lose ambulation later than those with other out-of-frame deletions (hazard ratio [95% CI]: deletion amenable to exon 44 skipping, 0.34 [0.15-0.74]; P = .007; exons 3-7 deletion: 0.24 [0.07-0.82]; P = .02).66-68

Commentary
No additional supporting information is included.

Statement 14. After a patient receives a complete genetic diagnosis of DMD, it is mandatory that carrier testing of the mother and other at-risk female family members be offered with appropriate pre- and postgenetic counseling (information regarding germine mosaicism and de novo mutations should also be offered). Similarly, testing of other at-risk male family members also should be offered.

Vote: A+ = 100%; grade of recommendation: 1B

Discussion
As per the 2010 best practice guidelines, if carrier status has been confirmed in an individual, genetic counseling should be
offered to that individual and to other at-risk family members. Prenatal screening also may be offered, depending on local practices/legislation. If prenatal testing is offered and returns a positive result, the genetic test report should clearly indicate that the male fetus is predicted to have DMD or BMD. If the mutation identified in the affected patient is not carried by the mother in her somatic cell line, the mother may be a germline mosaic and should be provided with counseling about the risk of having a second son with the disease and that daughters are at risk of being a carrier. Similarly, a retro-spective US observational study of 22 female DMD carriers who underwent cardiac magnetic resonance analysis also showed the presence of cardiac involvement: 18% (4/22) had left ventricular ejection fraction <55% and 35% (7/20) were found to have late gadolinium enhancement. These findings are supported by a series of case studies and a prospective study of 15 confirmed female carriers.

Despite these issues, it is thought that approximately one-third of potential carriers could be unaware of their carrier status and may need to be reassessed for risk of carrier status. This is supported by a number of studies. First, a study in the United Kingdom examined levels of carrier testing from 1971 to 2008. In Western Scotland, 843 potential carriers (from 195 families) were tested: of these, 16% and 48% of first-degree and second-degree/more distant relatives had not been tested, respectively. In England, 1223 potential carriers (from 349 families) were tested: of these, 49% of first-degree and 65% of second-degree/more distant relatives had not been tested to determine their carrier status. One study in the Netherlands also showed that of patients registered up to July 1, 2009, 33.7% (35/104) of adult sisters/maternal aunts of patients with DMD who had a 50% risk of being a carrier had not been tested by DNA analysis. This percentage was similar (30.4% [45/148]) for adult sisters with a lower-risk carrier status (4.3% risk). In the US, a recent study by Bogue et al also estimated that 37% of carriers who had an increased risk of cardiomyopathy had never had an echocardiogram and cited that the most commonly identified barrier to carrier testing in the US was the cost of the genetic tests.

As previously discussed, genetic counseling also should be offered for siblings of affected patients, and extended family members (such as grandmothers), to manage the psychosocial impact.
During the Canadian NBS program, boys who were diagnosed with DMD were monitored afterwards. In a number of these boys, neurocognitive motor developmental delay was identified at a much earlier age (12-18 months) than would be anticipated. The report also highlighted that physiotherapy and corticosteroid treatment could be implemented earlier as a result of NBS programs. Although only pilot studies have been performed thus far, a NBS program for DMD is being initiated in the Zhejiang Province in China.

Stress and anxiety are often cited as the reasons for not performing NBS for DMD; however, a recent survey of parents of children with DMD, BMD, or spinal muscular atrophy showed that the level of support for NBS for these conditions was >90%. Furthermore, a recent Internet-administered study of 2991 adults showed that participants were more likely to select an optional DMD NBS program when information about this option was presented alongside a mandatory DMD NBS program, highlighting the importance of how these schemes are presented to parents and carers.

A publication by Kwon et al presented a proposed schedule of follow-up visits (and their objectives) for patients identified as having DMD by NBS. The aim of this publication was to provide anticipatory guidance for healthcare professionals, the patients, and the families/guardians to provide effective care for the patient’s lifespan after a diagnosis as a result of NBS.

After a genetic diagnosis has been received, prenatal testing also can be performed (depending on local practices) for any at-risk male fetuses, this can help to inform any family-planning decisions. Preimplantation screening also is offered at a number of specialist centers.

A study from The Netherlands examined the impact of 26 years of prenatal testing for DMD. The study showed that during the period 1984-2009, 635 prenatal diagnoses were made; of these, 51% were male, and 46% of these male fetuses either were affected by DMD or had an increased risk of the disease. As a result of this prenatal testing, 145 male fetuses were aborted, and 174 continued to full term unaffected by DMD. However, in the cohort of boys during 1961-1974 (n = 397), 62% of the boys did not have an affected relative, suggesting that they were the first affected individual in their family. During the period 1993-2002, 88% of boys in the cohort were the first affected with DMD in their family. The fact that current policy recommends not to test female fetuses, and that many female members are not tested for their carrier status (in this study, 78% of girls ≥16 years old who were at risk of being a carrier had not been tested), has likely contributed to the increased incidence of first affected boys being born.

Commentary

When asked whether CK testing should be offered to younger asymptomatic or presymptomatic male siblings at risk of DMD, 100% of consensus group members who responded answered “yes” (13/13). However, it should be noted that genetic testing in asymptomatic minors is not authorized in some countries. For example, the European Society of Human Genetics indicates that testing of asymptomatic minors is less compelling if the therapeutic measure is deferred to a later time.

The consensus group also was asked if NBS for DMD should be performed: 47% (7/15) members answered “yes”; 47% (7/15) answered “not sure”; and one answered “no.” The reason for 47% answering “not sure” was primarily related to the absence of available treatments for patients younger than 5 years of age. However, the earlier treatment of patients with corticosteroids has been shown to be beneficial. Lastly, the consensus group members were asked whether they felt that prenatal testing for DMD should be offered in the absence of a family history of disease. Of the 16 members, 56% (9/16) answered “no,” 31% (5/16) answered “not sure,” and 13% (2/16) answered “yes.”

Further Reading


### Table 1. Example survey results from the 2017 and 2018 TREAT-NMD Expert Masterclasses on DMD regarding the genetic diagnosis of patients with DMD

<table>
<thead>
<tr>
<th>Question</th>
<th>Correct answer</th>
<th>TREAT-NMD</th>
<th>Total number of responses</th>
<th>Number who answered correctly</th>
<th>Number who answered incorrectly</th>
<th>Number who answered “I do not know”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MLPA analysis is negative for a patient with suspected DMD. What is your next step?</strong> (1) Multiplex PCR, (2) Consider another differential diagnosis, (3) Sequencing of all exons and flanking sequences, (4) Muscle biopsy and dystrophin analysis, (5) I do not know.</td>
<td>Sequencing of all exons and flanking sequences</td>
<td>2017</td>
<td>64</td>
<td>51 (79.7)</td>
<td>12 (18.8)</td>
<td>1 (1.6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2018</td>
<td>45</td>
<td>40 (88.9)</td>
<td>5 (11.1)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td><strong>MLPA analysis reveals a deletion of exon 20. What is your next step?</strong> (1) Multiplex PCR, (2) Perform a second test to confirm the finding, (3) Nothing, the diagnosis is confirmed, (4) Muscle biopsy and dystrophin analysis, (5) I do not know.</td>
<td>Perform a second test to confirm the finding</td>
<td>2017</td>
<td>64</td>
<td>31 (48.4)</td>
<td>31 (48.4)</td>
<td>2 (3.1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2018</td>
<td>45</td>
<td>12 (26.7)</td>
<td>31 (68.9)</td>
<td>2 (4.4)</td>
</tr>
<tr>
<td><strong>A patient with a deletion of exon 51 is eligible for which therapy?</strong> (1) Ataluren/stop-codon readthrough, (2) Eteplirsen/exon-51 skipping, (3) No therapy yet available, (4) I do not know.</td>
<td>No therapy yet available</td>
<td>2017</td>
<td>65</td>
<td>18 (27.7)</td>
<td>39 (60.0)</td>
<td>8 (12.3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2018</td>
<td>49</td>
<td>21 (42.9)</td>
<td>20 (40.8)</td>
<td>8 (16.3)</td>
</tr>
<tr>
<td><strong>Multiple analysis reveals the presence of exons 44, 45, and 51, and the absence of exon 50. Is this patient eligible for exon 51 skipping?</strong> (1) Yes, (2) No, (3) I do not know.</td>
<td>I do not know</td>
<td>2017</td>
<td>57</td>
<td>14 (24.6)</td>
<td>43 (75.4)</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>2018</td>
<td>46</td>
<td>12 (26.1)</td>
<td>34 (73.9)</td>
<td>NA</td>
</tr>
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</table>
Figure 2. PRISMA flow diagram of systematic literature searches. The searches were conducted using Ovid to screen the EMBASE and MEDLINE databases. PCR, polymerase chain reaction. *Disease search terms (limited to title/abstract): Duchenne muscular dystrophy, DMD, or Duchenne AND any of the following search terms (limited to title/abstract): sign; symptom; creatine kinase; transaminase; diagnost*; gene*; genetic test*; genetic report*; genetic counsel*; delay*; screen*; carrier; mutation; sequence*; comparative genome hybridization; CGH; multiplex ligation-dependent probe amplification; MLPA; multiplex polymerase chain reaction; multiplex PCR; biops*; prenatal; neonatal; female; family planning; germline mosaicism; de novo; practitioner; pediatrician; pediatric neurologist; neuromuscular specialist. The “?” function was included to search for variations of the spelling; the “*” function was included to search for variations of the word; and search terms were limited to the title or abstract of articles only. The full electronic search strategy is presented in Table II. †Search criteria: articles published from January 1, 2010, to April 8, 2018; English language; studies of humans; full journal articles. ‡Relevant articles older than 2010 (if no newer reference could be found) were identified ad hoc by the steering committee and expert voting panel.
Table II. Electronic search strategy for MEDLINE and EMBASE databases, performed in Ovid (2017 Ovid Technologies, Inc)

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<td>3</td>
<td>Duchenne.tw</td>
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<td>1 or 2 or 3</td>
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<tr>
<td>5</td>
<td>sign.tw</td>
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<td>symptom.tw</td>
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<td>7</td>
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<td>8</td>
<td>transaminase.tw</td>
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<td>multiplex ligation-dependent probe amplification.tw</td>
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<td>Limit 41 to humans</td>
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<td>Remove duplicates from 42</td>
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*The first search was performed from January 1, 2010, to June 21, 2017; an update was then performed from June 22, 2017, to April 8, 2018, using the same strategy. Search results were then exported, and full journal articles selected, using Excel’s filter function.