Genetic Testing for PTEN Hamartoma Tumor Syndrome

Effective: July 1, 2017

Next Review: May 2018
Last Review: May 2017

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

The PTEN hamartoma tumor syndrome (PHTS) includes several syndromes with heterogeneous clinical symptoms, which may place individuals at an increased risk of the development of certain types of cancer. PHTS can be diagnosed with the identification of a PTEN mutation.

MEDICAL POLICY CRITERIA

I Genetic testing for PTEN may be considered medically necessary to confirm the diagnosis when a patient has clinical signs of a PTEN hamartoma tumor syndrome. (See Policy Guidelines for clinical diagnostic criteria)

II Genetic testing for PTEN may be considered medically necessary in a first-degree relative of a proband with a known PTEN disease-associated variant. (see Policy Guidelines for testing)

III Genetic testing for PTEN is considered investigational for all other indications.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.
NCCN REVISED PTEN HAMARTOMA TUMOR SYNDROME CLINICAL DIAGNOSTIC CRITERIA

Major Criteria

- Breast Cancer
- Endometrial cancer (epithelial)
- Thyroid Cancer (follicular)
- Gastrointestinal hamartomas (including ganglioneuromas, adenomas, hyperplastic polyps; ≥3)
- Lhermitte-Duclos disease (adult)
- Macrophage (megalocephaly) (i.e. ≥97th percentile, 58 cm in adult woman, 60 cm in adult men)
- Macular pigmentation of glans penis
- Multiple mucocutaneous lesions (any of the following):
  - Multiple trichilemmomas (≥3, at least one biopsy proven)
  - Acral keratoses (≥3 palmoplantar keratotic pits and/or acral hyperkeratotic papules)
  - Mucocutaneous neuromas (≥3)
  - Oral papillomas (particularly on tongue and gingiva), multiple (≥3) OR biopsy proven OR dermatologist diagnosed

Minor Criteria

- Autism spectrum disorder
- Colon cancer
- Esophageal glycogenic acanthoses (≥3)
- Lipomas (≥3)
- Intellectual disability (i.e., IQ ≤75)
- Renal cell carcinoma
- Testicular lipomatosis
- Thyroid cancer (papillary or follicular variant of papillary)
- Thyroid structural lesions (e.g. adenoma, multinodular goiter)
- Vascular anomalies (including multiple intracranial developmental venous anomalies)

Operational Diagnosis in an Individual

Any of the following:

1. Three or more major criteria, but one must include macrocephaly, Lhermitte-Duclos disease, or gastrointestinal hamartomas; or
2. Two major and three minor criteria.

Operational Diagnosis in a Family Where One Individual Meets Revised PTEN Hamartoma Tumor Syndrome Clinical Diagnostic Criteria or Has a PTEN Pathogenic Variant:

1. Any two major criteria with or without minor criteria; or
2. One major and two minor criteria; or
3. Three minor criteria.
TESTING IN A FIRST-DEGREE RELATIVE

When a PTEN pathogenic variant has been identified in the proband, testing of asymptomatic at-risk relatives can identify those family members who have the family-specific variant, for whom an initial evaluation and ongoing surveillance should be performed.

CROSS REFERENCES

1. Genetic Testing for Hereditary Breast and/or Ovarian Cancer, Genetic Testing, Policy No. 02
2. Genetic and Molecular Diagnostic Testing, Genetic Testing, Policy No. 20
3. Evaluating the Utility of Genetic Panels, Genetic Testing, Policy No. 64
4. Genetic Testing for Li-Fraumeni Syndrome, Genetic Testing, Policy No. 82

BACKGROUND

The PTEN (phosphatase and tensin homologue) hamartoma tumor syndrome is characterized by hamartomatous tumors and PTEN germline disease-associated variants. Clinically, PHTS includes Cowden syndrome (CS), Bannayan-Riley-Ruvalcaba syndrome (BRRS), PTEN-related Proteus syndrome (PS), and Proteus-like syndrome (PLS).

CS is a multiple hamartoma syndrome with a high risk for benign and malignant tumors of the thyroid, breast, and endometrium. Affected individuals usually have macrocephaly, trichilemmomas, and papillomatous papules and present by the late 20s. The lifetime risk of developing breast cancer is 25-50%, with an average age of diagnosis between 38 and 46 years. The lifetime risk for thyroid cancer, which is usually follicular carcinoma, is approximately 10%. The risk for endometrial cancer is not well defined, but may approach 5-10%.

BRRS is characterized by macrocephaly, intestinal hamartomatous polyposis, lipomas, and pigmented macules of the glans penis. Additional features include high birth weight, developmental delay and mental deficiency (50% of affected individuals), a myopathic process in proximal muscles (60%), joint hyperextensibility, pectus excavatum, and scoliosis (50%).

PS is a complex, highly variable disorder involving congenital malformations and hamartomatous overgrowth of multiple tissues, as well as connective tissue nevi, epidermal nevi, and hyperostoses.

Proteus-like syndrome is undefined but refers to individuals with significant clinical features of PS who do not meet the diagnostic criteria for PS.

CS is the only PHTS disorder associated with a documented predisposition to cancer; however, it has been suggested that patients with other PHTS diagnoses associated with PTEN pathogenic variants should be assumed to have cancer risks similar to those with CS.

CLINICAL DIAGNOSIS

A presumptive diagnosis of PHTS is based on clinical findings (see Policy Guidelines); however, because of the phenotypic heterogeneity associated with the hamartoma syndromes, the diagnosis of PHTS is made only when a PTEN disease-associated variant is identified.

MANAGEMENT

Treatment
Treatment of the benign and malignant manifestations of PHTS is the same as for their sporadic counterparts.

**Surveillance**

The most serious consequences of PHTS relate to the increased risk of cancers, including breast, thyroid and endometrial, and to a lesser extent, renal. Therefore, the most important aspect of management of an individual with a PTEN disease-associated variant is increased cancer surveillance to detect tumors at the earliest, most treatable stages.

**MOLECULAR DIAGNOSIS**

PTEN is a tumor suppressor gene on chromosome 10q23 and is dual specificity phosphatase with multiple but incompletely understood roles in cellular regulation.[1] PTEN pathogenic variants are inherited in an autosomal dominant manner.

Because CS is likely underdiagnosed, the actual proportion of simplex cases (defined as individuals with no obvious family history) and familial cases (defined as ≥2 related affected individuals) cannot be determined. The majority of CS cases are simplex. It is estimated that 50-90% of cases of CS are de novo and approximately 10-50% of individuals with CS have an affected parent.

Because of the phenotypic heterogeneity associated with the hamartoma syndromes, the diagnosis of PHTS is made only when a PTEN disease-associated variant is identified. Up to 85% of patients who meet the clinical criteria for a diagnosis of CS and 65% of patients with a clinical diagnosis of BRRS have a detectable PTEN mutation. Some data suggest the up to 20% of patients with Proteus syndrome and up to 50% of patients with a Proteus-like syndrome have PTEN mutations.

Most of these pathogenic variants can be identified by sequence analysis of the coding and flanking intronic regions of genomic DNA. A smaller number of variants are detected by deletion/duplication or promoter region analysis.

Penetrance: More than 90% of individuals with CS have some clinical manifestation of the disorder by the late 20s. By the third decade, 99% of affected individuals develop the mucocutaneous stigmata, primarily trichilemmomas and papillomatous papules, as well as acral and plantar keratoses.

**REGULATORY STATUS**

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests (LDTs) must meet the general regulatory standards of the Clinical Laboratory Improvement Act (CLIA). Laboratory testing for PTEN variants is available under the auspices of CLIA. Laboratories that offer LDTs must be licensed by CLIA for high-complexity testing. To date, the U.S. Food and Drug Administration has chosen not to require any regulatory review of this test.

**EVIDENCE SUMMARY**

Validation of the clinical use of any genetic test focuses on three main principles:
1. Analytic validity, which refers to the technical accuracy of the test in detecting a pathogenic variant that is present or in excluding a variant that is absent;
2. Clinical validity, which refers to the diagnostic performance of the test (i.e., sensitivity, specificity, positive and negative predictive values) in detecting clinical disease; and
3. Clinical utility, which refers to how the results of the diagnostic test will be used to change management of the patient and whether these changes in management lead to clinically important improvements in health outcomes.

The focus of this review is on evidence from well designed, studies related to the ability of test results to:

- Guide decisions in the clinical setting related to either treatment, management, or prevention; and
- Improve health outcomes as a result of those decisions.

ANALYTIC VALIDITY

According to a large reference laboratory, analytical sensitivity and specificity for polymerase chain reaction (PCR) sequencing PTEN-related disorders is 99%, and analytical sensitivity and specificity of testing for deletions/duplications by MLPA (multiplex ligation-dependent probe amplification) is 90% and 98%, respectively.[2]

CLINICAL VALIDITY

Many reports on the prevalence of the features of Cowden syndrome (CS) and Bannayan-Riley-Ruvalcaba (BRRS) have been based upon data compiled from case reports and studies of small cohorts. Most of these reports were published before adoption of the International Cowden Consortium diagnostic criteria for CS in 1996, and the true frequencies of the clinical features in CS and BRRS are not known.[1]

According to a large reference laboratory, the clinical sensitivity of PTEN-related disorders sequencing is 80% for CS, 60% for BRRS, 20% for PTEN-related Proteus syndrome (PS) and 50% for Proteus-like syndrome (PSL). For PTEN-related deletion/duplication, it is up to 10% for BRRS and unknown for CS, PS, and PSL.[2]

Germline PTEN variants have been identified in ~80% of patients meeting diagnostic criteria for CS and in 50-60% of patients with a diagnosis of BRRS, using PCR-based sequence analysis of the coding and flanking intronic regions of the gene.[3,4] Marsh et al. screened DNA from 37 CS families and PTEN variants were identified in 30 of 37 CS families (81%), including point mutations, insertions, and deletions.[3] The PTEN variant detection rate is much lower in breast cancer patients without other symptoms.[5,6]

Whether the remaining patients have undetected PTEN variants or mutations in other, unidentified genes, is not known.[7]

A study by Pilarski (2011) determined the clinical features that were most predictive of a disease-associated variant in a cohort of patients tested for PTEN variants.[1] Molecular and clinical data were reviewed for 802 patients referred for PTEN analysis by a single laboratory. All of the patients were classified as to whether they met revised International Cowden Consortium Diagnostic criteria. Two hundred and thirty of the 802 patients met diagnostic criteria for a diagnosis of CS. Of these, 79 had a PTEN pathogenic variant, for a detection rate of 34%. The authors commented that this variant frequency was significantly lower than
previously reported, possibly suggesting that the clinical diagnostic criteria for CS are not as robust at identifying patients with germline PTEN variants as previously thought. In contrast, in their study, of the patients meeting diagnostic criteria for BRRS, 23 of 42 (55%) had a pathogenic variant, and 7 of 9 patients (78%) with diagnostic criteria for both CS and BRRS had a mutation, consistent with the literature.

Section Summary

Evidence from several small studies indicated that the clinical sensitivity of genetic testing for PTEN mutations may be highly variable. This may reflect the phenotypic heterogeneity of the syndromes and an inherent referral bias as patients with more clinical features of CS/BRRS are more likely to get tested. The true clinical specificity is uncertain because the syndrome is defined by the variant.

CLINICAL UTILITY

The clinical utility of genetic testing can be considered in the following clinical situations:

1. Individuals with suspected PTEN hamartoma tumor syndrome (PHTS)
2. Family members of individuals with PHTS, and
3. Prenatal testing.

Individuals with Suspected PHTS

The clinical utility for these patients depends on the ability of genetic testing to make a definitive diagnosis and for that diagnosis to lead to management changes that improve outcomes. There is no direct evidence for the clinical utility of genetic testing in these patients as no studies were identified that described how a molecular diagnosis of PHTS changed patient management.

However, for patients who are diagnosed with PHTS by identifying a PTEN pathogenic variant, the medical management focuses on increased cancer surveillance to detect tumors at the earliest, most treatable stages.

- Family members.

  When a PTEN pathogenic variant has been identified in a proband, testing of at-risk relatives can identify those who also have the pathogenic variant and have PTEN hamartoma tumor syndrome (PHTS). These individuals need initial evaluation and ongoing surveillance.

- Prenatal screening.

  Prenatal diagnosis is possible for pregnancies at increased risk, by amniocentesis or chorionic villus sampling; the disease-causing allele of an affected family member must be identified before prenatal testing can be performed.

Recent studies reporting on the clinical features of individuals with a PTEN pathogenic variant have indicated there is insufficient evidence to support the inclusion of benign breast disease, uterine fibroids, or genitourinary malformations as diagnostic criteria. However, there was sufficient evidence identified to include autism spectrum disorders, colon cancer, esophageal glycogenic acanthosis, penile macules, renal cell carcinoma, testicular lipomatosis and
vascular anomalies. These identified clinical features are included in CS testing minor criteria in National Comprehensive Cancer Network guidelines (see Policy Guidelines section above) and described in a recent systematic review.[8,9]

Section Summary

Direct evidence for the clinical utility of PTEN testing is lacking. However, the clinical utility of genetic testing for PTEN variants is that genetic testing can confirm the diagnosis in patients with clinical signs and symptoms of PHTS. Management changes include increased surveillance for the cancers associated with these syndromes.

PRACTICE GUIDELINE SUMMARY

NATIONAL COMPREHENSIVE CANCER NETWORK

The NCCN guidelines on Genetic/Familial High-Risk Assessment: Breast and Ovarian recommend the following for CS/PHTS management (V2.2017):[8]

For Women:

- Breast awareness starting at age 18 years.
- Clinical breast exam every 6-12 months, starting at age 25 years or 5-10 years before the earliest known breast cancer in the family (whichever comes first).
- Breast screening:
  - Annual mammography and breast MRI [magnetic resonance imaging] screening starting at age 30-35 years or 5 to 10 years before the earliest known breast cancer in family (whichever comes first).
  - Age > 75, management should be considered on an individual basis.
  - For women with a PTEN mutation who are treated for breast cancer, screening of remaining breast tissue with annual mammography and breast MRI should continue.
- For endometrial cancer screening, encourage patient education and prompt response to symptoms. Consider annual random endometrial biopsies and/or ultrasound beginning at age 30 to 35 years.
- Discuss option of hysterectomy upon completion of childbearing and counsel regarding degree of protection, extent of cancer risk, and reproductive desires.
- Discuss risk-reducing mastectomy and hysterectomy and counsel regarding degree of protection, extent of cancer risk, and reconstructive options.
- Address psychosocial, social, and quality-of-life aspects of undergoing risk-reducing mastectomy and/or hysterectomy.

For Men and Women:

- Annual comprehensive physical exam starting at age 18 years or 5 years before the youngest age of diagnosis of a component cancer in the family (whichever comes first), with particular attention to thyroid exam.
- Annual thyroid ultrasound, starting at the time of PHTS diagnosis.
- Colonoscopy, starting at age 35 years, unless symptomatic or a close relative with colon cancer before age 40 years, then start 5-10 years before earliest known colon cancer in the family. Colonoscopy should be done every 5 years or more frequently if patient is symptomatic or polyps found.
• Consider renal ultrasound starting at age 40 years, then every 1-2 years.
• Dermatologic management may be indicated for some patients.
• Consider psychomotor assessment in children at diagnosis and brain MRI if there are symptoms.
• Education regarding the signs and symptoms of cancer.

For Relatives:

• Advise about possible inherited cancer risk to relatives, options for risk assessment, and management.
• Recommend genetic counseling and consideration of genetic testing for at-risk relatives

Reproductive options:

• For women of reproductive age, advise about options for prenatal diagnosis and assisted reproduction including preimplantation genetic diagnosis. Discussion should include known risks, limitations, and benefits of these technologies.

**SUMMARY**

There is enough research to show that PTEN genetic testing can help to determine appropriate cancer surveillance, leading to improved health outcomes for patients at high risk for PTEN hamartoma tumor syndrome. Clinical guidelines based on research recommend this testing for certain individuals. Therefore, PTEN genetic testing may be considered medically necessary when a presumptive diagnosis of a PTEN hamartoma tumor syndrome has been made, based on clinical signs, and for first-degree relatives of an individual with a known disease-associated PTEN variant. There is not enough research to show that PTEN genetic testing improves health outcomes for individuals who do not meet the policy criteria. Therefore, genetic testing for a PTEN mutation is considered investigational for all other indications.

**REFERENCES**


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**CODES**

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