

# ACT Onco<sup>®</sup> + Report

PATIENT		
Name: 林秀華		Patient ID: 48364018
Date of Birth: Oct 11, 1965		Gender: Female
Diagnosis: Small cell carcinoma		
ORDERING PHYSICIAN		
Name: 周德盈醫師		Tel: 886-228712121
Facility: 臺北榮總		
Address: 臺北市北投區石牌路二段 201 號		
SPECIMEN		
Specimen ID: S11111421A	Collection site: Anus	Type: FFPE tissue
Date received: Apr 11, 2022	Lab ID: AA-22-01847	D/ID: NA

## ABOUT ACT Onco<sup>®</sup>+

The test is a next-generation sequencing (NGS)-based assay developed for efficient and comprehensive genomic profiling of cancers. This test interrogates coding regions of 440 genes associated with cancer treatment, prognosis and diagnosis. Genetic mutations detected by this test include small-scale mutations like single nucleotide variants (SNVs), small insertions and deletions (InDels) ( $\leq 15$  nucleotides) and large-scale genomic alterations like copy number alterations (CNAs). The test also includes an RNA test, detecting fusion transcripts of 13 genes.

## SUMMARY FOR ACTIONABLE VARIANTS

### VARIANTS/BIOMARKERS WITH EVIDENCE OF CLINICAL SIGNIFICANCE

Genomic Alterations/Biomarkers	Probable Effects in Patient's Cancer Type		Probable Sensitive in Other Cancer Types
	Sensitive	Resistant	
Not detected			

### VARIANTS/BIOMARKERS WITH POTENTIAL CLINICAL SIGNIFICANCE

Genomic Alterations/Biomarkers	Possibly Sensitive	Possibly Resistant
NRAS G12S	-	Cetuximab, Panitumumab

#### Note:

- The above summary tables present genomic variants and biomarkers based on the three-tiered approach proposed by US FDA for reporting tumor profiling NGS testing. "Variants/biomarkers with evidence of clinical significance" refers to mutations that are widely recognized as standard-of-care biomarkers (FDA level 2/AMP tier 1). "Variants/biomarkers with potential clinical significance" refers to mutations that are not included in the standard of care but are informational for clinicians, which are commonly biomarkers used as inclusion criteria for clinical trials (FDA level 3/AMP tier 2).
- The therapeutic agents and possible effects to a given drug are based on mapping the variants/biomarkers with ACT Genomics clinical knowledge database. The mapping results only provide information for reference, but not medical recommendation.
- Please refer to corresponding sections for more detailed information about genomic alteration and clinical relevance listed above.

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## TESTING RESULTS

### VARIANT(S) WITH CLINICAL RELEVANCE

#### - Single Nucleotide and Small InDel Variants

Gene	Amino Acid Change	Allele Frequency
NRAS	G12S	2.7%

#### - Copy Number Alterations

Chromosome	Gene	Variation	Copy Number
		Amplification not detected	
		Copy number loss cannot be determined because of low tumor purity (<30%)	

#### - Fusions

Fusion Gene & Exon	Transcript ID
	No fusion gene detected in this sample

#### - Immune Checkpoint Inhibitor (ICI) Related Biomarkers

Biomarker	Results
Tumor Mutational Burden (TMB)	Cannot be determined
Microsatellite Instability (MSI)	Cannot be determined

#### Note:

- Loss of heterozygosity (LOH) information was used to infer tumor cellularity. Copy number alteration in the tumor was determined based on <30% tumor purity.
- TMB was calculated by using the sequenced regions of ACTOnco<sup>®</sup> to estimate the number of somatic nonsynonymous mutations per megabase of all protein-coding genes (whole exome). The threshold for high mutation load is set at  $\geq 7.5$  mutations per megabase. TMB, microsatellite status and gene copy number deletion cannot be determined if calculated tumor purity is < 30%.

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## THERAPEUTIC IMPLICATIONS TARGETED THERAPIES

Genomic Alterations	Therapies	Effect
Level 3A		
<b>NRAS</b> G12S	Cetuximab, Panitumumab	<b>resistant</b>

Therapies associated with benefit or lack of benefit are based on biomarkers detected in this tumor and published evidence in professional guidelines or peer-reviewed journals.

Level	Description
1	FDA-recognized biomarkers predictive of response or resistance to FDA approved drugs in this indication
2	Standard care biomarkers (recommended by the NCCN guideline) predictive of response or resistance to FDA approved drugs in this indication
3A	Biomarkers predictive of response or resistance to therapies approved by the FDA or NCCN guideline in a different cancer type
3B	Biomarkers that serve as inclusion criteria for clinical trials (minimal supportive data required)
4	Biomarkers that show plausible therapeutic significance based on small studies, few case reports, or preclinical studies

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## IMMUNE CHECKPOINT INHIBITORS (ICIs)

No genomic alterations detected to confer sensitivity or lack of benefit to immune checkpoint therapies.

### - Other Biomarkers with Potential Clinical Effects for ICIs

Genomic Alterations	Potential Clinical Effects
Not detected	

Note: Tumor non-genomic factors, such as patient germline genetics, PDL1 expression, tumor microenvironment, epigenetic alterations or other factors not provided by this test may affect ICI response.

## CHEMOTHERAPIES

No genomic alterations detected in this tumor predicted to confer sensitivity or lack of benefit to chemotherapies.

## HORMONAL THERAPIES

No genomic alterations detected in this tumor predicted to confer sensitivity or lack of benefit to hormonal therapies.

## OTHERS

No genomic alterations detected in this tumor predicted to confer sensitivity or lack of benefit to other therapies.

### Note:

Therapeutic implications provided in the test are based solely on the panel of 440 genes sequenced. Therefore, alterations in genes not covered in this panel, epigenetic and post-transcriptional and post-translational factors may also determine a patient's response to therapies. In addition, several other patient-associated clinical factors, including but not limited to, prior lines of therapies received, dosage and combinations with other therapeutic agents, patient's cancer types, sub-types, and/or stages, may also determine the patient's clinical response to therapies.

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## VARIANT INTERPRETATION

### NRAS G12S

#### Biological Impact

The neuroblastoma RAS viral oncogene homolog (NRAS) gene encodes a membrane-associated RAS protein which belongs to the large family of small GTPases. RAS proteins cycle between an active (GTP-bound) and an inactive (GDP-bound) state, to regulate intracellular oncogenic MAPK and PI3K signaling pathways<sup>[1]</sup>. Activated RAS proteins mediate the regulation of cellular proliferation and other cellular functions through the activation of distinct intracellular signaling pathways, including the RAF/MEK/ERK and PI3K/AKT/mTOR pathways. Mutations in NRAS are present in thyroid cancer, ovarian cancers, melanoma and hematological cancers<sup>[2][3][4]</sup>.

NRAS G12S is a hotspot mutation that lies within the GTP-binding region of the NRAS protein (UniProtKB). NRAS G12S is considered as an oncogenic mutation that results in ERK activation, enhanced cell proliferation, and is transforming in vivo<sup>[5]</sup>.

#### Therapeutic and prognostic relevance

Two Phase I clinical studies showed that melanoma and biliary tract cancer patients whose tumor harbored an NRAS mutation were sensitive to MEK1/2 inhibitor trametinib and binimetinib<sup>[6][7]</sup>. In another clinical study, a melanoma patient harboring an ATM mutation and NRAS Q61R demonstrated a partial response and 16-month progression free survival (PFS) when treated with MEK1/2 inhibitor binimetinib<sup>[8]</sup>. Additional in vitro preclinical studies showed that NRAS-mutant lung cancer, liver cancer, ovarian cancer, melanoma and autonomic ganglia cancer cell lines were sensitive to MEK inhibitors, including selumetinib (AZD6244; ARRY-142886) and trametinib<sup>[9][10][11][12]</sup>. In an inducible NRAS Q61K genetically engineered mouse model of melanoma, the combination of MEK and CDK4/6 inhibitors caused tumor regression that paralleled extinction of mutant NRAS<sup>[13]</sup>. An additional preclinical evidence has shown efficacy of MEK1/2 inhibitor selumetinib in NRAS-mutant thyroid cancer model with NF2 loss<sup>[14]</sup>.

In a phase II trial, 47 patients with a refractory solid tumor harboring a codon 12, 13, or 61 NRAS mutation received treatment with binimetinib. The trial demonstrated a limited response to binimetinib monotherapy in NRAS-mutated cancers, and the ORR was 2.1% (1 of 47 patients)<sup>[15]</sup>. Several clinical trials are in progress to evaluate the combination of MEK and mTOR inhibition as a new potential therapeutic strategy in CRC<sup>[16]</sup>, and in patient-derived xenografts of RAS-mutant CRC, inhibition of MEK and mTOR suppressed tumor growth, but not tumor regression<sup>[17]</sup>. Preclinically, cetuximab synergistically triggers apoptotic cell death with MEK1/2 inhibitors in NRAS mutant metastatic colorectal cancer cells<sup>[18]</sup>.

Results from the PRIME and FIRE-3 trials indicated that panitumumab and cetuximab did not benefit patients with KRAS or NRAS mutations and may even have a detrimental effect on these patients<sup>[19]</sup>. Taken together, the National Comprehensive Cancer Network (NCCN) recommended that, cetuximab and panitumumab should only be used if both KRAS and NRAS genes are normal (NCCN guidelines)<sup>[20][21]</sup>.

NRAS mutations have been determined as an inclusion criterion for the trial evaluating cobimetinib or selumetinib efficacy in patients with multiple myeloma, melanoma, thyroid carcinoma, lung cancer, and solid tumor (NCT04109456, NCT03732703, NCT03181100, NCT02639546, NCT02664935)<sup>[22]</sup>.

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## US FDA-APPROVED DRUG(S)

Not Applicable.

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## ONGOING CLINICAL TRIALS

Trials were searched by applying filters: study status, patient's diagnosis, intervention, location and/or biomarker(s). Please visit <https://clinicaltrials.gov> to search and view for a complete list of open available and updated matched trials.

No trial has been found.

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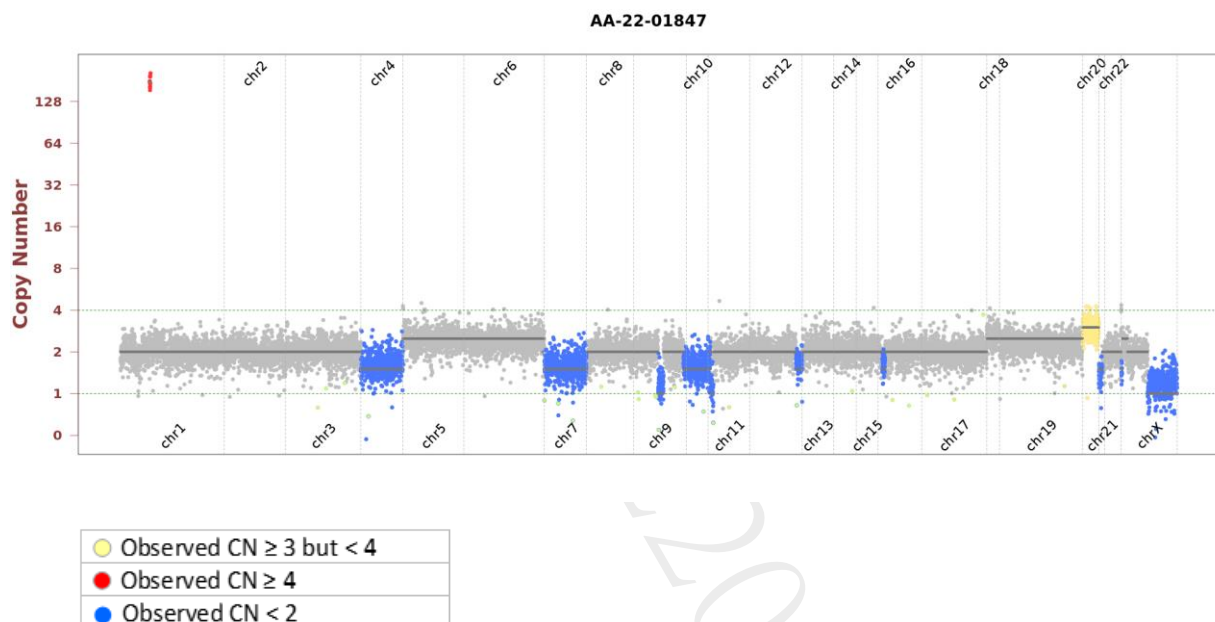
## SUPPLEMENTARY INFORMATION OF TESTING RESULTS DETAILED INFORMATION OF VARIANTS WITH CLINICAL RELEVANCE

### - Single Nucleotide and Small InDel Variants

Gene	Amino Acid Change	Exon	cDNA Change	Accession Number	COSMIC ID	Allele Frequency	Coverage
NRAS	G12S	2	c.34G>A	NM_002524	COSM563	2.7%	1137

### - Copy Number Alterations

Observed copy number (CN) for each evaluated position is shown on the y-axis. Regions referred to as amplification or deletion are shown in color. Regions without significant changes are represented in gray.





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## OTHER DETECTED VARIANTS

Gene	Amino Acid Change	Exon	cDNA Change	Accession Number	COSMIC ID	Allele Frequency	Coverage
ARID1B	M960T	9	c.2879T>C	NM_017519	-	58.1%	1643
ARID2	K90fs	3	c.269_270del	NM_152641	-	44.4%	1291
ATM	Q95K	4	c.283C>A	NM_000051	COSM7346277	46.3%	315
BRCA2	C315S	10	c.943T>A	NM_000059	-	49.3%	515
BRCA2	H523R	10	c.1568A>G	NM_000059	COSM9110800	51.5%	1033
BRD4	T249M	5	c.746C>T	NM_058243	-	36.8%	133
FAT1	Q2699E	10	c.8095C>G	NM_005245	-	37.5%	753
JAK3	A306T	7	c.916G>A	NM_000215	-	59.8%	752
NOTCH4	D66E	3	c.198C>G	NM_004557	-	39.3%	634
PDGFRB	Splice region	-	c.2463+5G>A	NM_002609	-	21.8%	616
PDIA3	K500A	13	c.1498_1499delinsGC	NM_005313	-	26.5%	1059
PIK3R3	P41S	2	c.121C>T	NM_003629	-	49.2%	760
POLD1	R682W	17	c.2044C>T	NM_001256849	COSM5856440	38.4%	349
POLE	R2165H	46	c.6494G>A	NM_006231	-	62.7%	1195
POLE	I238F	7	c.712A>T	NM_006231	-	58.4%	1458
PPARG	V343I	6	c.1027G>A	NM_015869	-	23.0%	985
PRKDC	Splice region	27	c.3045T>C	NM_006904	-	50.7%	1323
SYNE1	R7412H	122	c.22235G>A	NM_182961	-	34.9%	1713
SYNE1	D8294Y	137	c.24880G>T	NM_182961	-	61.5%	2447

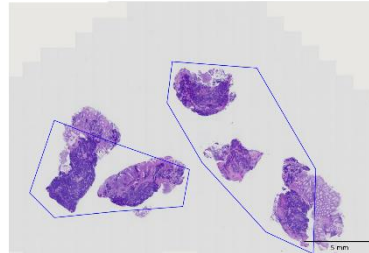
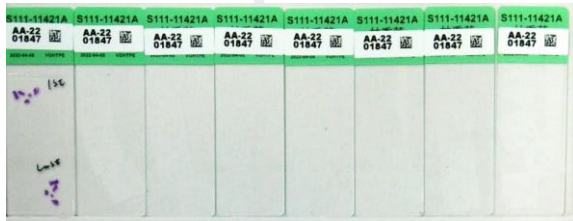
### Note:

- This table enlists variants detected by the panel other than those with clinical relevance (reported in Testing Result section). The clinical impact of a genetic variant is determined according to ACT Genomics in-house clinical knowledge database. A negative result does not necessarily indicate absence of biological effect on the tumor. Some variants listed here may possibly have preclinical data or may show potential clinical relevance in the future.

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## TEST DETAILS

### SPECIMEN RECEIVED AND PATHOLOGY REVIEW



- Collection date: Mar 2022
- Facility retrieved: 臺北榮總
- H&E-stained section No.: S11111421A
- Collection site: Anus
- Examined by: Dr. Chien-Ta Chiang
  1. The percentage of viable tumor cells in total cells in the whole slide (%): 25%
  2. The percentage of viable tumor cells in total cells in the encircled areas in the whole slide (%): 40%
  3. The percentage of necrotic cells (including necrotic tumor cells) in total cells in the whole slide (%): 0%
  4. The percentage of necrotic cells (including necrotic tumor cells) in total cells in the encircled areas in the whole slide (%): 0%
  5. Additional comment: NA
- Manual macrodissection: Performed on the highlighted region
- The outline highlights the area of malignant neoplasm annotated by a pathologist.

## RUN QC

- Panel: ACTOnco<sup>®</sup>+

### DNA test

- Mean Depth: 1035x
- Target Base Coverage at 100x: 95%

### RNA test

- Average unique RNA Start Sites per control GSP2: 107

## LIMITATIONS

1. This test does not provide information of variant causality and does not detect variants in non-coding regions that could affect gene expression. This report does not report polymorphisms and we do not classify whether a mutation is germline or somatic. Variants identified by this assay were not subject to validation by Sanger or other technologies.
2. The possibility cannot be excluded that certain pathogenic variants detected by other sequencing tools may not be reported in the test because of technical limitation of bioinformatics algorithm or the NGS sequencing platform, e.g. low coverage.
3. This test has been designed to detect fusions in 13 genes sequenced. Therefore, fusion in genes not covered by this test would not be reported. For novel fusions detected in this test, Sanger sequencing confirmation is recommended if residue specimen is available.

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## NEXT-GENERATION SEQUENCING (NGS) METHODS

### DNA test

Extracted genomic DNA was amplified using primers targeting coding exons of analyzed genes and subjected to library construction. Barcoded libraries were subsequently conjugated with sequencing beads by emulsion PCR and enriched using Ion Chef system. Sequencing was performed according to Ion Proton or Ion S5 sequencer protocol (Thermo Fisher Scientific).

Raw reads generated by the sequencer were mapped to the hg19 reference genome using the Ion Torrent Suite. Coverage depth was calculated using Torrent Coverage Analysis plug-in. Single nucleotide variants (SNVs) and short insertions/deletions (InDels) were identified using the Torrent Variant Caller plug-in. VEP (Variant Effect Predictor) was used to annotate every variant using databases from Clinvar, COSMIC and Genome Aggregation database. Variants with coverage  $\geq 25$ , allele frequency  $\geq 5\%$  and actionable variants with allele frequency  $\geq 2\%$  were retained. This test provides uniform coverage of the targeted regions, enabling target base coverage at  $100\times \geq 85\%$  with a mean coverage  $\geq 500\times$ .

Variants reported in Genome Aggregation database with  $> 1\%$  minor allele frequency (MAF) were considered as polymorphisms. ACT Genomics in-house database was used to determine technical errors. Clinically actionable and biologically significant variants were determined based on the published medical literature.

The copy number alterations (CNAs) were predicted as described below:

Amplicons with read counts in the lowest 5th percentile of all detectable amplicons and amplicons with a coefficient of variation  $\geq 0.3$  were removed. The remaining amplicons were normalized to correct the pool design bias. ONCOCNV (an established method for calculating copy number aberrations in amplicon sequencing data by Boeva et al., 2014) was applied for the normalization of total amplicon number, amplicon GC content, amplicon length, and technology-related biases, followed by segmenting the sample with a gene-aware model. The method was used as well for establishing the baseline of copy number variations.

Tumor mutational burden (TMB) was calculated by using the sequenced regions of ACTOnco<sup>®</sup> to estimate the number of somatic nonsynonymous mutations per megabase of all protein-coding genes (whole exome). The TMB calculation predicted somatic variants and applied a machine learning model with a cancer hotspot correction. TMB may be reported as "TMB-High", "TMB-Low" or "Cannot Be Determined". TMB-High corresponds to  $\geq 7.5$  mutations per megabase (Muts/Mb); TMB-Low corresponds to  $< 7.5$  Muts/Mb. TMB is reported as "Cannot Be Determined" if the tumor purity of the sample is  $< 30\%$ .

Classification of microsatellite instability (MSI) status is determined by a machine learning prediction algorithm. The change of a number of repeats of different lengths from a pooled microsatellite stable (MSS) baseline in  $> 400$  genomic loci are used as the features for the algorithm. The final output of the results is either microsatellite Stable (MSS) or microsatellite instability high (MSI-H).

### RNA test

Extracted RNA was reverse-transcribed and subjected to library construction. Sequencing was performed according to Ion Proton or Ion S5 sequencer protocol (Thermo Fisher Scientific). To ensure sequencing quality for fusion variant analysis, the average unique RNA Start Sites (SS) per control Gene Specific Primer 2 (GSP 2) should be  $\geq 10$ .

The fusion analysis pipeline aligned sequenced reads to the human reference genome, identified regions that map to noncontiguous regions of the genome, applied filters to exclude probable false-positive events and, annotated previously characterized fusion events according to Quiver Gene Fusion Database, a curated database owned and maintained by ArcherDX. In general, samples with detectable fusions need to meet the following criteria: (1) Number of unique start sites (SS) for the GSP2  $\geq 3$ ; (2) Number of supporting reads spanning the fusion junction  $\geq 5$ ; (3) Percentage of supporting reads spanning the fusion junction  $\geq 10\%$ ; (4) Fusions annotated in Quiver Gene Fusion Database.

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## DATABASE USED

- Reference genome: Human genome sequence hg19
- COSMIC v.92
- Genome Aggregation database r2.1.1
- ClinVar (version 20210404)
- ACT Genomics in-house database
- Quiver Gene Fusion Database version 5.1.18

## Variant Analysis:

醫檢師黃靖婷 博士  
Ching-Ting Huang Ph.D.  
檢字第 016511 號

CT Huang

## Sign Off

解剖病理專科醫師王業翰  
Yeh-Han Wang M.D.  
病解字第 000545 號

Yeh

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## GENE LIST SNV & CNV

ABCB1*	ABCC2*	ABCG2*	ABL1	ABL2	ADAMTS1	ADAMTS13	ADAMTS15	ADAMTS16	ADAMTS18	ADAMTS6	ADAMTS9
ADAMTSL1	ADGRA2	ADH1C*	AKT1	AKT2	AKT3	ALDH1A1*	ALK	AMER1	APC	AR	ARAF
ARID1A	ARID1B	ARID2	ASXL1	ATM	ATR	ATRX	AURKA	AURKB	AXIN1	AXIN2	AXL
B2M	BAP1	BARD1	BCL10	BCL2*	BCL2L1	BCL2L2*	BCL6	BCL9	BCOR	BIRC2	BIRC3
BLM	BMPR1A	BRAF	BRCA1	BRCA2	BRD4	BRIP1	BTG1	BTG2*	BTB	BUB1B	CALR
CANX	CARD11	CASP8	CBFB	CBL	CCNA1	CCNA	CCNB1	CCNB2	CCNB3	CCND1	CCND2
CCND3	CCNE1	CCNE2	CCNH	CD19	CD274	CD58	CD70*	CD79A	CD79B	CDC73	CDH1
CDK1	CDK12	CDK2	CDK4	CDK5	CDK6	CDK7	CDK8	CDK9	CDKN1A	CDKN1B	CDKN2A
CDKN2B	CDKN2C	CEBPA*	CHEK1	CHEK2	CIC	CREBBP	CRKL	CRLF2	CSF1R	CTCF	CTLA4
CTNNA1	CTNNB1	CUL3	CYLD	CYP1A1*	CYP2B6*	CYP2C19*	CYP2C8*	CYP2D6	CYP2E1*	CYP3A4*	CYP3A5*
DAXX	DCUN1D1	DDR2	DICER1	DNMT3A	DOT1L	DPYD	DTX1	E2F3	EGFR	EP300	EPCAM
EPHA2	EPHA3	EPHA5	EPHA7	EPHB1	ERBB2	ERBB3	ERBB4	ERCC1	ERCC2	ERCC3	ERCC4
ERCC5	ERG	ESR1	ESR2	ETV1	ETV4	EZH2	FAM46C	FANCA	FANCC	FANCD2	FANCE
FANCF	FANCG	FANCL	FAS	FAT1	FBXW7	FCGR2B	FGF1*	FGF10	FGF14	FGF19*	FGF23
FGF3	FGF4*	FGF6	FGFR1	FGFR2	FGFR3	FGFR4	FH	FLCN	FLT1	FLT3	FLT4
FOXL2*	FOXP1	FRG1	FUBP1	GATA1	GATA2	GATA3	GNA11	GNA13	GNAQ	GNAS	GREM1
GRIN2A	GSK3B	GSTP1*	GSTT1*	HGF	HIF1A	HIST1H1C*	HIST1H1E*	HNF1A	HR	HRAS*	HSP90AA1
HSP90AB1	HSPA4	HSPA5	IDH1	IDH2	IFNL3*	IGF1	IGF1R	IGF2	IKBKB	IKBKE	IKZF1
IL6	IL7R	INPP4B	INSR	IRF4	IRS1	IRS2*	JAK1	JAK2	JAK3	JUN*	KAT6A
KDM5A	KDM5C	KDM6A	KDR	KEAP1	KIT	KMT2A	KMT2C	KMT2D	KRAS	LCK	LIG1
LIG3	LMO1	LRP1B	LYN	MALT1	MAP2K1	MAP2K2	MAP2K4	MAP3K1	MAP3K7	MAPK1	MAPK3
MAX	MCL1	MDM2	MDM4	MED12	MEF2B	MEN1	MET	MITF	MLH1	MPL	MRE11
MSH2	MSH6	MTHFR*	MTOR	MUC16	MUC4	MUC6	MUTYH	MYC	MYCL	MYCN	MYD88
NAT2*	NBN	NEFH	NF1	NF2	NFE2L2	NFKB1	NFKBIA	NKX2-1*	NOTCH1	NOTCH2	NOTCH3
NOTCH4	NPM1	NQO1*	NRAS	NSD1	NTRK1	NTRK2	NTRK3	PAK3	PALB2	PARP1	PAX5
PAX8	PBRM1	PDCD1	PDCD1LG2	PDGFRA	PDGFRB	PDIA3	PGF	PHOX2B*	PIK3C2B	PIK3C2G	PIK3C3
PIK3CA	PIK3CB	PIK3CD	PIK3CG	PIK3R1	PIK3R2	PIK3R3	PIM1	PMS1	PMS2	POLB	POLD1
POLE	PPARG	PPP2R1A	PRDM1	PRKAR1A	PRKCA	PRKCB	PRKCG	PRKCI	PRKCQ	PRKDC	PRKN
PSMB8	PSMB9	PSME1	PSME2	PSME3	PTCH1	PTEN	PTGS2	PTPN11	PTPRD	PTPRT	RAC1
RAD50	RAD51	RAD51B	RAD51C	RAD51D	RAD52	RAD54L	RAF1	RARA	RB1	RBM10	RECQL4
REL	RET	RHOA	RICTOR	RNF43	ROS1	RPPH1	RPTOR	RUNX1	RUNX1T1	RXRA	SDHA
SDHB	SDHC	SDHD	SERPINB3	SERPINB4	SETD2	SF3B1	SGK1	SH2D1A*	SLC19A1*	SLC22A2*	SLC1B1*
SLC1B3*	SMAD2	SMAD3	SMAD4	SMARCA4	SMARCB1	SMO	SOCS1*	SOX2*	SOX9	SPEN	SPOP
SRC	STAG2	STAT3	STK11	SUFU	SYK	SYNE1	TAF1	TAP1	TAP2	TAPBP	TBX3
TEK	TERT	TET1	TET2	TGFBR2	TMSB4X*	TNF	TNFAIP3	TNFRSF14	TNFSF11	TOP1	TP53
TPMT*	TSC1	TSC2	TSHR	TYMS	U2AF1	UBE2A*	UBE2K	UBR5	UGT1A1*	USH2A	VDR*
VEGFA	VEGFB	VHL	WT1	XIAP	XPO1	XRCC2	ZNF217				

\*Analysis of copy number alterations NOT available.

## FUSION

ALK	BRAF	EGFR	FGFR1	FGFR2	FGFR3	MET	NRG1	NTRK1	NTRK2	NTRK3	RET	ROS1
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## APPENDIX

### POSSIBLE THERAPEUTIC IMPLICATIONS FOR HETEROZYGOUS DELETION

Not Applicable.

### SIGNALING PATHWAYS AND MOLECULAR-TARGETED AGENTS

Not Applicable.

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## DISCLAIMER

### 法律聲明

本檢驗報告僅提供專業醫療參考，結果需經專業醫師解釋及判讀。基因突變資訊非必具備藥物或治療有效性指標，反之亦然。本檢驗報告提供之用藥指引不聲明或保證其臨床有效性，反之亦然。本基因檢測方法係由本公司研究開發，已經過有效性測試。

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本公司於提供檢驗報告後，即已完成本次契約義務，後續之報告解釋、判讀及用藥、治療，應自行尋求相關專業醫師協助，若需將報告移件其他醫師，本人應取得該醫師同意並填寫移件申請書，主動告知行動基因，行動基因僅能配合該醫師意願與時間提供醫師解說。

### 醫療決策需由醫師決定

任何治療與用藥需經由醫師在考慮病患所有健康狀況相關資訊包含健檢、其他檢測報告和病患意願後，依照該地區醫療照護標準由醫師獨立判斷。醫師不應僅依據單一報告結果(例如本檢測或本報告書內容)做決策。

### 基因突變與用藥資訊並非依照有效性排序

本報告中列出之生物標記變異與藥物資訊並非依照潛在治療有效性排序。

### 證據等級

藥物潛在臨床效益(或缺乏潛在臨床效益)的實證證據是依據至少一篇臨床療效個案報告或臨床前試驗做為評估。本公司盡力提供適時及準確之資料，但由於醫學科技之發展日新月異，本公司不就本報告提供的資料是否為準確、適宜或最新作保證。

### 責任

本檢驗報告僅提供專業醫療參考，本公司及其員工不對任何由使用本報告之內容引起的直接、間接、特殊、連帶或衍生的損失或損害承擔責任。



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