Congenital Heart Disease (CHD) is a structural abnormality of the heart and great vessels that is present at birth. It is the most common birth defect, affecting ≈1% of all live-born infants. CHD results from perturbation of the normal program of cardiac development (Figure 1A). Historically, CHD has been categorized based on a combination of final anatomic and physiological phenotypes (Figure 1B), such as conotruncal defects that affect the ventricular septum and outflow tract, defects that lead to obstruction to left ventricular outflow (LVO), defects resulting from abnormal left–right relationships within the heart (heterotaxy), defects affecting the inflow such as the mitral and tricuspid valve abnormalities seen in atrioventricular canal defect, and a broad range of other defects including isolated atrial or ventricular septal defects. Approximately one third of patients with CHD have disease that is categorized as severe (comprising univentricular hearts, heterotaxy, conotruncal defects, atrioventricular canal defects, total anomalous pulmonary venous return, LVO obstruction, and right ventricular outflow obstruction except isolated valvar pulmonary stenosis) and require intervention in the first year of life. Despite progress in medical and surgical treatments, CHD remains the leading cause of mortality.
Evidence supporting the genetic contribution to CHD can be gleaned from several sources. There is greater concordance of CHD in monozygotic than dizygotic twins, although there is evidence that twinning itself increases risk of CHD. The risk of recurrence of related forms of CHD among siblings is elevated, ranging from 3.4 for atrial septal defects (ASDs) to 79.1 for heterotaxy in the Danish national cohort study; there is a smaller, but still significantly increased risk recurrence for discordant CHD. In addition, rare Mendelian forms of CHD, comprising a small fraction of all cases, have been described. These include forms of ASD, heterotaxy, severe mitral valve prolapse, and bicuspid aortic valve (BAV). The increased incidence of CHD in populations with high levels of consanguinity suggests a role for recessive genetic contributions. However, it is striking that a large fraction of CHD, particularly of severely affected subjects, occurs in families with no other history of CHD. This suggests the possibility that a significant fraction of these cases is attributable to de novo genetic events, including chromosomal abnormalities, smaller copy number variants, and point mutations. The severity of CHD in these instances is likely to impair reproductive fitness, limiting transmission of these large-effect mutations, and accounting for the absence of extended pedigrees supporting dominant modes of transmission.

Collectively, these findings point to a major genetic contribution to CHD (Figure 1C). This observational data do not allow insight into whether CHD in individual subjects is attributable to single loci with large effect, a few loci with epistatic or additive interactions, polygenic effects of many loci, or various combinations of these models together. In addition, the possibility of gene–environment interaction is an important consideration. The aggregate of genetic contributions to CHD are likely to not only underlie the structural CHD but also be major contributors to CHD comorbidities, including heart failure, arrhythmia, neurocognitive outcomes, and even to the observation that cancer rates are increasing in patients with CHD. As CHD contributes to an ever-increasing amount of the overall burden of cardiovascular disease, a thorough understanding of the underlying genetics will become ever more important to improved care of patients with CHD.

Established Genetic Contributions to CHD Aneuploidy Aneuploidies were the earliest identified genetic causes of CHD. Estimates of the proportion of CHD associated with cytogenetic abnormalities range from 9% to 18%. The large number of genes that are dysregulated in the setting of aneuploidy results in effects on development that are often pleiotropic and severe, and 98% of fetuses with CHD and cytogenetic abnormalities have at least one extracardiac abnormality. CHD is observed in 35% to 50% of liveborns with trisomy 21, 60% to 80% of liveborns with trisomy 13 and trisomy 18, and 33% with monosomy X. Furthermore, there is a large effect on overall viability, as evidenced by the 33% to 42% incidence of aneuploidy among fetuses with prenatally diagnosed CHD, compared with 9% to 18% among neonates.
Figure 1. A, Outline of human heart development. The x axis displays days of human and mouse gestation. B, The spectrum of congenital heart disease from mild to severe. The lesions indicated as “severe” are expected to require intervention in the first year of life. Classes of CHD based on proposed developmental-genetic mechanisms are indicated in parentheses. C, Genetic causes of CHD identified to date. ASD indicates atrial septal defect; CHD, congenital heart disease; CoA, coarctation of the aorta; CTD, conotruncal defect; HLHS, hypoplastic left heart syndrome; HTX, heterotaxy; LVO, left ventricular outflow obstruction; TGA, transposition of the great arteries; TOF, tetralogy of Fallot; and VSD, ventricular septal defect.
with CHD.\(^2\) The types of CHD associated with specific aneuploidies covers a broad range of CHD phenotypes, although there are lesions that are more prominently associated with specific chromosomal abnormalities, such as atrioventricular septal defects in trisomy 21. The large numbers of genes with dosage disturbance in aneuploidy make it more challenging to pinpoint the underlying genetic and developmental mechanisms. However, insights have been gleaned from studies of patients with rare segmental trisomies affecting chromosome 21 suggesting that DSCAM and COL6A contribute to Down Syndrome–associated CHD.\(^2\) Interestingly, overexpression of both DSCAM and COL6A in mice leads to heart abnormalities, while overexpression of either gene alone does not affect heart development.\(^2\)

**Copy Number Variation**

Copy number variation (CNV) refers to structural aberrations consisting of deletions or duplications ranging in size from 1 kb to several megabases and leading to altered dosage of genes encompassed by the CNV. Low-copy repeats and retrotransposons found throughout the genome form the substrate for CNV formation.\(^3\) CNVs can occur de novo, or be inherited. Millions of single-nucleotide polymorphisms, each typically with population allele frequency \(>1\%\), can be simultaneously genotyped at low cost through dense array-based platforms. This technology permits identification of regions of genome duplication and deletion in both coding and noncoding regions of the genome. More recently, CNVs have also been detected through whole-exome sequencing (WES) and whole-genome sequencing (WGS) data. Comparison of dense array-based platforms with WES showed that each strategy only identified \(\approx 70\%\) of the CNVs that should have been detected, and therefore together may provide substantially complementary information.

Several well-characterized large CNVs underlie recognized clinical syndromes that include CHD. Del22q11, a deletion of \(\approx 3\) mB resulting from flanking low-copy repeats, is the most common human microdeletion. It presents with a variable phenotype encompassing CHD, palatal abnormalities, hypocalcemia, immunodeficiency, characteristic facial features, and neurodevelopmental abnormalities including learning disabilities and psychiatric disorders, also known as DiGeorge Syndrome and Velocardio-facial syndrome. Del22q11 includes the T-Box transcription factor TBX1, and haploinsufficiency for TBX1 underlies the cardio-pharyngeal phenotype.\(^3\),\(^4\) Recent work in mice haploinsufficient for Tbx1 delineates regulation of H3K4me1 enrichment, providing an intriguing link between TBX1 and chromatin remodeling in CHD.\(^5\) Other CHD-associated CNVs that are well characterized include del18p23, which includes the cardiac transcription factor GATA4 and manifests with a range of CHD along with developmental delay;\(^6\) del7q11, the cause of William Syndrome, wherein the cardiac disease consists of supravalvar aortic and pulmonary stenosis and results from haploinsufficiency for Elastin;\(^7\),\(^8\) del11q24-25 resulting in Jacobsen Syndrome;\(^9\),\(^10\) Recent analyses of larger cohorts of patients with CHD found several recurrent CNVs associated with CHD, including 1q21.1, 3p25.1, 16p13.11, 15q11.2, and 2p13.3.\(^1\),\(^11\)

Beyond specific syndromes associated with CNVs, their global contribution to CHD has been investigated in several large cohorts of patients with specific CHD: tetralogy of Fallot,\(^1\) heterotaxy,\(^2\) and hypoplastic left heart.\(^3\),\(^4\) all of which show an overrepresentation of rare CNVs, and de novo CNVs, in patients with CHD compared with controls.\(^5\) An increased burden of CNVs was also detected in nonsyndromic patients with mild-to-moderate severity CHD.\(^6\) The availability of chromosomal microarray testing as a standard clinical test has increased the awareness of the contribution of CNVs to CHD, and clinical and research-based testing suggests that CNVs contribute to 10% to 15% of CHD.\(^7\) As previously noted, given the inherent limitations of most commonly used platforms for CNV detection for optimal sensitivity, the contribution of CNVs to disease phenotypes may underestimate their contribution.\(^8\)

**Inherited Point Mutations: Mendelian and Inherited CHD**

Remarkable insights into Mendelian and inherited forms of CHD have emerged from classic linkage analyses, positional cloning and targeted sequencing of CHD candidate genes. Many of the genes first implicated in inherited CHD are members of a core group of cardiac transcription factors that includes NKX2.5, the GATA family of zinc-finger proteins, T-box factors including TBX5 and TBX1 and MEF2 factors.\(^9\)–\(^11\) Mutations in NKX2.5 were one of the first inherited point mutations clearly shown to cause human CHD. NKX2.5 is a transcriptional regulator that interacts with GATA4 to specify cardiac mesoderm, first identified in *Drosophila* mutants that had complete failure to form a heart tube.\(^1\) Evaluation of large pedigrees that included individuals with isolated ASDs, and individuals with ASDs along with abnormalities of the conduction system subsequently identified NKX2.5 mutation underlying both the ASD and conduction system defects. Notably, some affected individuals had the ASD alone, others had the conduction defect alone, and some had both the ASD and the conduction defect.\(^1\) The phenotypic heterogeneity associated with NKX2.5 mutations is remarkable, encompassing a wide range of CHD beyond ASDs, including heterotaxy and TOF.\(^1\) It is interesting to speculate whether the wide spectrum of CHD results from differences in genetic background, or interaction between an at-risk genotype and environmental influences that may include subtle variation in hemodynamics in utero during critical times in cardiac development. GATA4 is a zinc-finger transcription factor essential for cardiogenesis that directly associate with NKX2.5.\(^5\) GATA4 mutations were implicated in two families with CHD with cardiac septal defects.\(^1\)

Mutations in TBX5, a T-box protein, were likewise implicated in two families with Holt–Oram Syndrome, a disease characterized by upper limb malformations and cardiac abnormalities (septation and conduction defects).\(^5\),\(^6\) TBX5 is notably expressed in both the developing forelimb buds and the heart, and similar to other T-box proteins, regulates cell fate and crucial developmental processes. Further evidence of causality has emerged from heterozygous *Tbx5* null mice displaying limb abnormalities, septal defects, deformed hearts, and other complex cardiac malformations.\(^5\)
X-linked ZIC3 mutations were identified in several multigenerational pedigrees and were carried by family members with the mutation, some of whom by chance ended up with either complete situs solitus or complete situs inversus and functionally normal hearts.\(^{19,60,61}\) ZIC3 is a zinc-finger transcription factor that is required to form a functional left–right organizer\(^{62}\) and is required to direct the directionality of heart looping. As the absence of left–right organizer function leads to random heart looping, these pedigrees show striking incomplete penetrance: some affected family members will have normal heart looping and appear phenotypically normal and transmit the disease allele, while others will have situs inversus or heterotaxy and complex CHD.

In addition to cardiac transcriptional regulators, genes coding for a variety of signaling molecules and cellular structural components have been identified in Mendelian inherited CHD. Dominantly inherited NOTCH1 mutations were first described in 2 multigeneration pedigrees that included family members with BAV with only hemodynamic impairment, whereas other family members have complex CHD, including hypoplastic left heart syndrome.\(^{72}\) Since then, NOTCH1 mutations have been found in additional CHD pedigrees,\(^{63}\) and in ≈5% of cases of one of the most common cardiac defects, BAV, which is found in up to 2% of adults.\(^{64}\) Similarly, mutations in JAG1 were mapped to affected family members with Alagille syndrome, a multi-system disorder with diverse malformations to cancer through the analysis of transmission.\(^{62}\) The complete penetrance: some affected family members will have functionally normal hearts.\(^{19,60,61}\) ZIC3 is a zinc-finger transcription factor that results in localization of Notch to the nucleus and downstream activation of target genes. In addition, genes coding for the focal adhesion protein Tns1 (tensin 1) and the planar cell polarity protein Dchs1 (dachsous1) were identified from several large pedigrees of severe mitral valve prolapse.\(^{20,21}\)

Less is known about the impact of recessive inheritance on CHD, although several lines of evidence support a recessive model contributing to some types of CHD. CHD is more prevalent in populations with a high degree of consanguinity.\(^{23}\) Although there is an increase in all types of CHD in consanguineous populations, heterotaxy and the associated complex cardiac malformations are observed at a higher frequency in consanguineous populations.\(^{65}\) Pedigrees of consanguineous families with heterotaxy identified recessively inherited mutations in genes, including SHROOM3\(^{66}\) (cytoskeletal protein), WDR16\(^{67}\) (cilia-associated WD40 repeat-protein), MMP21\(^{68}\) (matrix metalloproteinase 21), and NPHP4\(^{69}\) (nephronphysis 4).

A different approach to understanding the recessive contribution to severe CHD was undertaken through an unbiased recessive mutagenesis screen in mouse.\(^{70}\) Here, the offspring of ENU-mutagenized mice were intercrossed, and the pregnancies studied for any severe CHD by fetal ultrasound. This identified 61 genes contributing to recessively inherited CHD. Several notable findings from this landmark study were that, of the 61 genes identified, 34 were cilia-related genes, several of which had previously been identified in human CHD. Furthermore, cilia-related genes contributed to both heterotaxy-type CHD, and CHD not associated with laterality defects. Together, the observations in a limited number of human pedigrees and in model organism suggest that recessive inheritance contributes to CHD, in particular to heterotaxy-type (laterality) CHD.

**Beyond Large Structural Variation and Mendelian CHD: The Impact of Next-Generation Sequencing on CHD Genetics**

The explosion of technological approaches and analysis tools for next-generation sequencing, which has occurred over almost a decade has opened the door for understanding the genetics of complex disease such as CHD. In particular, WES has allowed identification of mutations that were undefinable through traditional genomic methods, such as de novo variation, variants without clear Mendelian inheritance patterns, variants with marked reduced penetrance, and somatic alterations, among others.

**Whole-Exome Sequencing**

The development of robust methods of WES has created new opportunities for genomic discovery.\(^{71,72}\) The complete coding regions of the ≈20000 genes in the human genome plus their flanking splice sites comprises only ≈33 Mb of DNA, ≈1% of the human genome sequence. Unbiased genetic discovery by positional cloning in humans, mice, and fruit flies has demonstrated that the overwhelming majority of phenotypes caused by large-effect mutations are caused by coding sequence mutations. This has identified mutations in ≈3500 genes underlying known Mendelian phenotypes. The recognition that the 20000 human genes are largely conserved across vertebrate phylogeny strongly suggests that mutation of most will lead to phenotypic consequences, although how many of these phenotypes will manifest as disease remains unknown. These observations motivated the development of methods for selective sequencing of this 1% of the genome, which now can be completed at ≈20% of the cost of sequencing complete genomes, affording a significant cost advantage and allowing large cohorts of patients with unexplained phenotypes to be sequenced. Sequential improvements have resulted in virtually complete detection of point mutations in the full-coding region; challenges nonetheless remain in detecting certain CNVs and chromosomal translocations. WES can be used to identify genes that are mutated more often than expected by chance after accounting for sequencing 20000 genes. This has allowed for the identification of novel disease genes for a range of disease phenotypes ranging from autism to congenital malformations to cancer through the analysis of transmitted, de novo and somatic mutations.

**WES Identifies De Novo Mutations in CHD**

The first advance derived from applying next-generation sequencing to the study of CHD was the discovery of the role of de novo mutation in CHD. Most CHD is sporadic: only 2.2% of patients with CHD have affected first-degree relatives.\(^{16}\) That sporadic disease such as CHD has stable incidence, despite low reproductive potential suggests that new mutation occurs as existing mutations are lost because of impaired reproductive fitness and suggests that de novo mutations underlie some CHD.\(^{73}\) De novo mutations are on average more deleterious than inherited mutations, as there has been less evolutionary selection. These mutations occur at ≈1.8×10\(^{-9}\)/nucleotide/generation, resulting in ≈1 de novo mutations per coding-region
As spermatogenesis has many more germ cell divisions than oogenesis, this results in a 3.9:1 ratio of de novo mutations when comparing the paternal allele with the maternal allele. De novo mutations occur throughout the genome, but are not entirely randomly distributed. Factors that influence DNA mutation rate include high CpG density, segmental duplications, maternal age, and mutations conferring advantages during spermatogenesis.

As there is strong evidence for impaired reproductive fitness in a majority of CHD subjects, it is likely that de novo mutations confer a major contribution. This hypothesis has been tested in several studies that used WES of large cohorts of patient–parent trios affected by CHD. The first of these studies analyzed 362 trios with the patient affected by severe CHD. Although the overall rate of de novo mutations was not significantly different between CHD cases and controls, there was a marked enrichment when stratifying for protein-altering de novo mutations in genes highly expressed in the developing heart (top quartile of gene expression in murine hearts at E9.5 and E14.5) in CHD cases. Further stratification by mutation type graded by stringency, from all protein-altering mutations to highly conserved missense and loss of function mutations to loss of function mutations alone, produced a significant rise in odds ratio. De novo mutations were found to collectively contribute to 10% of severe CHD. Moreover, an excess of de novo mutations was identified in chromatin remodeling genes that affected the reading, writing, and removal of two bivalent marks, H3K4 and H3K27 methylation, found at the promoters and enhancers of key developmental genes poised for activation.

Expanding the cohort size from 362 to 1213 CHD trios comprising patients with the complete spectrum of CHD including less complicated CHD such as isolated ASDs, in addition to moderate and severe CHD, reinforced the contribution of de novo mutations to ≈10% of CHD. This cohort included patients with isolated CHD, CHD associated with known syndromes, and CHD with extracardiac malformations or neurodevelopmental abnormalities. More extensive phenotyping coupled with a larger patient cohort demonstrated that de novo mutations disproportionately contributed to CHD in patients with associated syndromes, extracardiac malformations or neurodevelopmental abnormalities. Notably, de novo mutations accounted for at least 20% of CHD with associated extracardiac and neurodevelopmental abnormalities. Although these mutations are more prominently associated with syndromic rather than nonsyndromic CHD, there is a small but measurable contribution to isolated CHD (CHD not associated with a known syndrome, and without any extracardiac malformations or neurodevelopmental abnormalities), which may become more clearly delineated when larger cohorts are analyzed.

**Biological Pathways in CHD**

The genetics underlying CHD have identified critical biological pathways involved in CHD, including chromatin remodeling, Notch signaling, cilia function, sarcomere structure and function, and RAS signaling. These pathways are anticipated to provide direct insights into the mechanism of heart development and to provide insights into potential CHD comorbidities, such as ventricular dysfunction observed in the setting of sarcomere and RAS pathway mutations. Furthermore, identification of common developmental pathways shared between cardiac development and other systems, such as the nervous system in the setting of chromatin modifier mutations and the respiratory system in the setting of cilia mutations, is anticipated to directly inform outcomes and prognosis for patients with CHD. We will outline studies linking three of these pathways to CHD: chromatin remodeling, Notch signaling, and cilia genes.

**Chromatin Modifiers and Overlapping Biology**

As noted above, one of the most significant findings arising from the recent analysis of large cohorts of patients with CHD by WES is the important role of mutations affecting chromatin-regulating genes in CHD. The first of these studies showed that de novo mutations affecting chromatin-regulating genes contribute to ≈3% of CHD. This observation was reinforced by a larger analysis of 1213 trios, noting loss of function mutations in chromatin-regulating genes in 25/1213 CHD cases, while only 3/900 controls (P=5.7x10^-11). All mutated genes with damaging mutations in cases and their affected chromatin marks are shown in Figure 2A. Genes identified are involved in production, removal or reading of H3K4 methylation (H3K4me), H3K9 methylation (H3K9me), H3K27 methylation (H3K27me), H4K20 methylation (H4K20me), and ubiquitylation of H2BK120, which is required for H3K4 methylation.

Chromatin-regulating genes encompass ≈600 genes that orchestrate dynamic gene expression during development by addition or removal of chemical marks on chromatin or by catalyzing changes in chromatin structure. The biological state of chromatin is controlled by ATP-dependent chromatin modifiers, including the Baf complex and Chd8, and by histone modifiers. Both have been linked to heart development; Baf60c regulates early heart development through cooperation with the GATA4 transcription factor. H3K4me and H3K27me constitute “bivalent” marks that are found on the promoters and enhancers of key cardiac developmental genes poised for activation. A significant burden of haploinsufficient (dominant) de novo mutations within these elements, therefore, indicate dosage sensitivity of the chromatin pathway in heart development. Although relatively rare, chromatin modifiers have been linked to isolated CHD such as the histone methyl transferase PRDM6 which has been associated with nonsyndromic Patent Ductus Arteriosus.

The same control of gene expression required for normal cardiac development is also essential for brain development, and many chromatin-regulating genes have been directly implicated in brain development, including members of the BAF complex, CHD8, HDAC4, and polycomb group protein EZH2. The overlap between specific chromatin regulators required for both heart and brain development remains unclear. Chromatin regulators are widely expressed, and mouse knockout frequently leads to early lethality, precluding analysis of specific brain or heart phenotypes. Heart-specific knockout of Kmt2d, a H3K4 methylase that is associated...
with Kabuki syndrome, results in abnormal hearts with outflow tract septation defects in mice.\(^8\) Mutations in chromatin-modifying genes have been identified in patients with CHD and have been associated with a range of syndromes, including Sotos Syndrome, Kabuki Syndrome, CHARGE (Coloboma, Heart Anomaly, Choanal Atresia, Retardation, Genital and Ear Anomalies), and others (Figure 2B). At the same time, genome-sequencing studies in human neurodevelopmental and psychiatric disorders have identified mutations in chromatin-modifying genes in Kleefstra, Schinzel–Giedion, Claes–Jensen, Weaver, Sotos, and Coffin–Siris syndromes among others. Although neurodevelopmental abnormalities are the most prominent feature, up to 50% of affected patients also have a CHD. These observations indicate that chromatin-regulating mutations result in both cardiac and neurodevelopmental sequelae, and begin to shed light on potential developmental genetic causes of the NDD associated with a subset of patients with CHD.

Notch Pathway Genes

Notch signaling is a highly conserved pathway mediating local intercellular communication that has important roles in a host of developmental processes that are relevant to heart development, including formation of the left–right organizer,\(^9\) blood vessel development,\(^10\) and ventricular chamber development.\(^1\) Notch signaling provides a way for a Notch ligand from one cell to influence a directly neighboring cell via its Notch receptor (Figure 3A) and determines cell fate. On binding of Notch ligand and receptor, signaling requires release of the Notch intracellular domain via a coordinated series of tightly regulated steps, including glycosylation of the receptor, ubiquitylation of the ligands by Mib1, and cleavage of the receptor triggered by Adam17/Tace. Notch intracellular domain can then function as a transcription factor regulating a large number of targets, including SNAIL1, HES, HEY, and NRARP. Notch pathway genes implicated in CHD are outlined in Figure 3B. This
pathway was initially implicated in CHD when \textit{NOTCH1} mutations were identified in families with dominantly inherited BAV and other LVO truct obstructive lesions.\textsuperscript{22} Within a single family, \textit{NOTCH} mutation associated with a range of CHD ranging from BAV to coarctation of the aorta to hypoplastic left heart syndrome. Mutations affecting multiple components of Notch signaling (\textit{NOTCH1}, \textit{MAML1}, and \textit{JAG1}) were significantly enriched in 51 families with

![Figure 3. NOTCH signaling in congenital heart disease (CHD) (A) the outline of NOTCH signaling pathway showing signal-sending cell in yellow and signal receiving cell in green. B, Syndromes and CHD associated with NOTCH pathway gene mutations. BAV indicates bicuspid aortic valve; CoA, coarctation of the aorta; HLHS, hypoplastic left heart syndrome; HTX, heterotaxy-associated defects; NA, not applicable; NICD, Notch intracellular domain; VSD, ventricular septal defect; TA, truncus arteriosus; and TOF, tetralogy of Fallot.](image)

![Figure 4. Cilia in CHD. A, Diagram of a cilium, showing the ciliary axoneme (blue) based on the mother centriole (gray) and linked via the transition zone (orange). B, Syndromes and CHD linked to human cilia mutations. ASD indicates atrial septal defect; CAVC, complete atrio-ventricular canal; CHD, congenital heart disease; CoA, coarctation of the aorta; PCD, primary ciliary dyskinesia; PDA, patent ductus arteriosus; SI, situs inversus; and TGA, transposition of the great arteries.](image)
multiple family members affected by a range of LVO-type CHD. \(^{63}\) NOTCH1 function does not seem to be restricted to left-sided heart development, as additional family studies identified high-impact NOTCH1 mutations in families with both LVO-type CHD and TOF.\(^{63}\)

Furthermore, NOTCH1 and Notch ligand DLL4 mutations are the most common cause of Adams–Oliver Syndrome, a rare syndrome comprising CHD, aplasia cutis of the scalp and limb defects. Alagille syndrome (Arteriohepatic dysplasia) is an autosomal-dominant inherited syndrome characterized by cholestatic liver disease, variable degrees of kidney involvement, and CHD that is most commonly TOF. Mutations in the Notch ligand JAG1 are found in \(\approx90\%\) of patients with Alagille syndrome,\(^{92,93}\) and mutations in the NOTCH2 receptor are found in another 2% of individuals with Alagille syndrome.\(^{94}\) Similar to mutations in other Notch pathway members, JAG1 mutations underlie both syndromic and isolated CHD, most notably TOF.\(^{95}\) Finally, GALNT11, which is required for the S2 cleavage step of Notch receptor processing, has been linked to human heterotaxy by affecting Notch-mediated specification of cilia function at the left–right organizer.\(^{42,89}\)

**Cilia Genes**

Mutations affecting cilia structure and function have been identified in patients with CHD, and notably, cilia mutations were the major class of mutations found in a recessive mouse screen for severe CHD.\(^{79}\) Cilia are hair-like organelles found on the surface of most vertebrate cell types and serve a multitude of functions, including signaling, extracellular fluid propulsion, and cell cycle control (Figure 4A). Defects affecting cilia structure and function have been intimately linked to a group of diverse human disorders characterized by pleiotropic phenotypes, including renal, neurological, sensory, and laterality defects coined “ciliopathies”. In heart development, the best understood role for cilia is establishing left–right (LR) asymmetry and determining the direction of heart looping. Here, a highly conserved ciliated LR organizer uses cilia to generate and sense directional flow of extraembryonic fluid and transduce it in a polycystin-dependent manner to a calcium signal.\(^{96-99}\) This triggers asymmetrical gene expression in the lateral plate mesoderm, eventually leading to asymmetrical heart looping. Because of the role of cilia in determining LR patterning, mutations affecting ciliary motility\(^{100}\) and sensing\(^{100}\) machinery result in heterotaxy and CHD.

In mice, mutations in components of the dynein motor complex, such as LR dynein (Dnah11/Lrd) and dynein heavy chain 5 (Dnah5), result in cardiac and visceral LR abnormalities.\(^{102,103}\) Not surprisingly, 6.5% of patients with primary ciliary dyskinesia (PCD), a disorder defined by abnormal ciliary motility in the airway epithelia, also display heterotaxy.\(^{100}\) PCD is genetically highly heterogeneous, and there are currently 35 genes that have been linked to PCD. It remains unknown how many of the PCD genes cause CHD, since a diagnosis of PCD in patients with CHD is made more challenging, due to the difficulty differentiating whether respiratory symptoms are primary or secondary to the underlying cardiac pathology and the medical and surgical interventions required to manage the CHD. Other cilia genes that are not required for cilia motility and LR development, but instead are involved in ciliogenesis or cilia-mediated sensation, are also associated with CHD (Figure 4B). It is interesting to speculate that cilia found in the developing heart and vasculature have a function in cardiac morphogenesis extending beyond their role in LR development,\(^{104,105}\) and that similar to mouse, cilia defects may underlie a broader range of human CHD than suspected to date.

**Future Efforts in CHD Genomics**

**State of the Art Understanding of CHD Genetics**

The genetic basis of CHD has now been established in 1 of 3 affected cases (Figure 1C). These comprise a broad array of genetic alterations in a large, heterogeneous group of genes. Earliest insights arose from aneuploidies in CHD. Likewise, there is a growing catalogue of CNVs in CHD, typified by well-characterized deletions, such as del22q11. Given the large number of genes involved in aneuploidies and CNVs, identification of specific disease-associated genes is challenging. In addition, inherited forms of CHD have been identified through traditional genetic tools, such as linkage. These linkage studies have ranged from mutations in cardiac transcription factors, such as NKX2.5, and GATA4 to signaling molecules and cellular structural components, such as NOTCH1 and JAG1. Through critical advances in next-generation sequencing, our understanding of CHD biology has expanded rapidly over the past decade. Seminal studies have found that 10% of CHD is because of de novo mutations, which increases to >20% when stratifying for CHD with associated extracardiac manifestations or NDD. Indeed, certain biological pathways, including chromatin modification genes, cilia genes, and the Notch signaling pathway, have been implicated in CHD, raising the possibility that environmental perturbations might phenocopy the effects of these mutations. Despite these significant advances, the genetic underpinnings of over 50% of CHD remain unknown. Barriers to a complete understanding of CHD genetics include the extreme genetic heterogeneity coupled with limited genotype–phenotype correlation. Some of the “unexplained CHD cases” could be because of mutations affecting the as of yet underexplored noncoding DNA, somatic mutations, and gene–environment interactions as discussed below. In addition, CHD due to biallelic mutations has been underexplored, and thus far has largely focused on candidate gene analysis and familial CHD.\(^{101}\) As new statistical approaches are coupled with larger CHD cohorts, the inherent challenges in an unbiased analysis of recessive mutations in sporadic CHD can be surmounted.

Most CHD is sporadic, with no affected family members. Beyond the 20% of sporadic CHD caused by de novo CNVs and SNVs, it is likely that some CHD will be secondary to complex inheritance, wherein for example, a heterozygous mutation requires a modifier mutation, or the absence of a protective variant, to manifest as disease. This is supported by incomplete or nonpenetration in extended families carrying mutations in well-characterized CHD genes, including ZIC3 and NOTCH1.\(^{10,61,108}\) Animal models provide an avenue for testing the complex trait hypothesis in a more controlled genetic environment, and for example, the susceptibility to VSDs
in mice heterozygous for mutation in the cardiac transcription factor Nkx2.5 was modified by loci on mouse chromosomes 6, 8, and 10. Another example is provided by the observation that introduction of a null allele for the VEGF-A (vascular endothelial growth factor-A) pathway gene CRELD1 into a mouse model of Down syndrome raises the incidence of atrioventricular septal defects, which supports previous observations on human Down syndrome cohorts. Correspondingly, several large GWAS (genome-wide association) studies in patients with CHD also identified possible loci influencing ventricular septal defects, which supports previous observations. The mouse model of Down syndrome raises the incidence of atrioventricular septal defects, which supports previous observations on human Down syndrome cohorts.

In addition, it is also likely that because heart development appears to be highly dosage sensitive, some CHD may result from convergence of hypomorphic mutations in several components of a single pathway to exceed a threshold and manifest as disease. This model has previously been shown in a mouse model of CHD where the penetrance of the CHD phenotype is increased in mice compound heterozygous for Zic3(+/−); Nodal (+/−). As available gene- and protein-level interactome databases become more robust and comprehensive, it may well become possible to link CHD genomics data with genetic interactome databases to better explore multigenic CHD.

Exhausting the Coding Region: Number of Genes Contributing to CHD

Analysis of de novo mutations has illuminated the immense genetic heterogeneity underlying CHD pathogenesis. Recent work analyzing de novo mutations in 1213 CHD subjects showed that 392 genes, albeit with wide confidence intervals, collectively contribute to CHD. This estimation of the number of risk genes was performed using a maximum likelihood function, details of the simulation and derivation are noted in the studies by Homsy et al. and Lossifov et al. On the basis of this function in 1213 CHD cases, 392 genes were estimated to contribute to CHD. An approach to identify a greater fraction of the CHD risk genes is to identify additional genes with more than one de novo mutation in patients with CHD. In a cohort double the size (2426 trios), power simulations approximate 61 genes with more than one damaging mutation (≈40 new genes in the additional 1213 trios and 21 previously identified in the original 1213 trios). To identify all 392 CHD genes would require a significant increase in the number of CHD trios analyzed. Furthermore, recent work suggests that WES of 10000 trios would permit ≈80% saturation for detecting genes contributing to haploinsufficient syndromic CHD alone; it is likely that a significantly larger number of trios will have to be analyzed to approach a complete gene set for all CHD. As sequencing continues to become faster and less expensive, it is anticipated that large-scale collaboration of CHD genetics programs, such as the Pediatric Cardiac Genomics Consortium, Pediatric Heart Network, and the UK10K consortium, could allow for capture of the estimated ≈392 CHD risk genes and make a previously daunting task achievable.

Contribution of Somatic Mosaicism in CHD

The wealth of sequencing data at high coverage has prompted the search for genetic mosaicism. Genetic mosaicism is defined as the presence of having multiple populations of genetically distinct cells within an individual. Mosaic de novo variants have been shown to contribute up to 20% of sporadic cases in several developmental disorders, including Sturge–Weber syndrome, facioscapulohumeral muscular dystrophy, and segmental neurofibromatosis. There have also been clinical reports suggesting pathogenic mosaic CNVs in patients with CHD. Small studies using array comparative genomic hybridization have not identified any CNVs with differential presence between cardiac tissue and peripheral whole blood. A recent study identified an excess of extreme allele-specific expression events in cardiac tissue from patients with CHD compared with controls, and as only 15% of the allele-specific expression events were explained by genomic variants, it is possible that some of these were secondary to mosaicism. However, such studies are limited because of sample size, lack of developmentally relevant cardiac tissues, and imperfect statistical tools to detect mosaic variation. Larger cohorts of sequencing data, continued development of analysis tools, and ascertainment of cardiac tissues could help in identification of mosaic mutations, such as (1) de novo mutations with mosaic tissue distributions with involvement of cardiac tissues or precursors that would directly influence heart development and (2) parental mosaicism where the unaffected parents of an affected offspring with CHD harbors mutation in the germline and any somatic tissue not involved in cardiac development, such that the mutation is constitutively transmitted to the affected offspring.

Environmental Phenocopies

Considering the overrepresentation of mutations in certain pathways, such as chromatin modifying genes, in which dosage-sensitive mutations confer CHD, it is possible that environmental triggers phenocopy the effects of these mutations. Many environmental exposures have been studied through observational and epidemiological studies in CHD. A large Canadian population study showed a modest association between folic acid supplementation and reduction in seizures. The effect is independent of whether the mother is affected by type 1 or type 2 diabetes mellitus, and studies of the nonobese diabetic mouse show that CHD in offspring correlates with elevated glucose during embryogenesis. Especially in view of the increasing rates of type 2 diabetes mellitus in the younger population, this represents an important contributor to CHD; for example, maternal diabetes mellitus is thought to contribute to 6% to 8% of hypoplastic left heart syndrome and TOF. The potential for gene–environment interactions highlight the continued need to catalogue environmental exposures within a cohort which also has corresponding DNA sequencing data. This should further expand our understanding of the genetic and nongenetic mechanisms of CHD, and moreover tell us how these two causes may converge.

Contribution of Noncoding Mutations

The prominent role of transcriptional regulation in CHD predicts that mutations affecting regulatory elements will
contribute to CHD. For example, homozygous variation in a TBX5 enhancer was found in a patient with isolated septal defects. An important obstacle of detecting noncoding mutations in CHD is to delineate cardiac-specific regulatory elements and promoters at appropriate developmental time points. Projects, such as ENCODE and the Cardiovascular Genomic Consortium, continue to build these data sets, and thus may be helpful in identifying rare de novo events in these noncoding elements. Other sources of WGS discovery could focus on cis-acting regulatory sequences, allelic selective gene expression in regulatory elements, and identification of epistatic and modifying mutations in diseases with known coding mutations, but with poor penetrance. An example of the latter has been shown in another developmental disorder, craniosynostosis, where rare SMAD6 loss of function mutations modified by a common variant in BMP2 resulted in complete penetrance of this disease. Exploration of the noncoding DNA will require WGS, which provides the most comprehensive view of the genome. Beyond complete determination of mutations outside the coding region, WGS provides more complete coverage of the exome and leads to improved detection of exonic CNVs and translocations. The potential challenges of WGS include greater expense, larger amounts of acquired and stored data, and the greater challenge of interpreting sequence variation in noncoding DNA. At present, evidence that WGS comes close to WES in efficiency of discovery of rare mutations with large effect remains limited. Moreover, the 10-fold lower conservation of enhancer sequences indicates a much lower power to find disease-related mutations and adds to the challenge. One study of patients with severe intellectual disability, however, identified a conclusive cause in 42% of patients by WGS, compared with 27% by WES; it is notable that many of the mutations identified by WGS in this study actually affected the exome. This limitation of WES is progressively being overcome by improved capture technologies that generate progressively more complete coverage of all exonic sequences. The genomic technologies applied to CHD gene discovery and patient with CHD diagnosis are rapidly evolving. Currently, WGS is likely contribute to understanding the genetic cause of CHD, but it is most effective when applied in patients without WES evidence of damaging de novo mutations or likely pathogenic dominant and recessive mutations.

Clinical Impact of CHD Genetics
For CHD genetics to become part of standard care for patients with CHD, there are a few essential considerations. First, testing should be broadly available, and specific testing (chromosomal microarray, karyotype, targeted sequencing, exome sequencing, or genome sequencing) should be tailored to the specific patient’s case with regard to the type of CHD and presence or absence of extracardiac abnormalities. Second, the results of genetic testing for CHD should be actionable, that is, impact management and hopefully contribute to improved outcome. Third, when a genetic cause for CHD can be identified, it becomes possible to provide much more specific information about recurrence risk in other family members; this will become increasingly important as many more patients with CHD reach reproductive age in the context of the growing population of adults with CHD. The extreme heterogeneity and variable expressivity of CHD make it difficult to directly link specific genes to specific outcomes. However, evidence is mounting that defects affecting specific gene ontologies and pathways predispose patients to defined groups of potential complications. These risks may be defined by the genetic defect, in addition to the specific anatomic-physiological cardiac defect. We will focus on two outcomes associated with CHD for which there is mounting evidence that the genetic cause of the CHD is a major contributor: neurodevelopmental abnormalities and surgical outcome focusing on respiratory complications. Other comorbidities such as renal and myocardial dysfunction may also be influenced by genetic findings contributing to the CHD.

Neurodevelopmental Outcomes
One of the most impactful associations with CHD are neurodevelopmental abnormalities. They affect 10% of all patients with CHD and 50% of patients with severe CHD. The spectrum of associated neurodevelopmental abnormalities includes intellectual disability, language deficits, autism spectrum, executive function deficits, deficits in nonverbal skills, including motor skills and social cognition. Attention-deficit hyperactivity disorder is also observed at a prevalence of up to 3× to 4× higher than the general population. Although the incidence of NDD is increased in the setting of complex CHD and CHD in the setting of known genetic syndromes, the underlying causes remain poorly defined. Investigation of risk factors for CHD-associated NDD has focused on the role of complications of cardiopulmonary bypass, effects of abnormal physiology preceding repair (including during fetal life), and complications of hospitalization, including prolonged requirement for intensive care; it is likely that these factors interrelate with the genetic substrate. Thus far, no dominant major contributor to the NDD associated with CHD has been identified, and it remains difficult to identify at-risk children prospectively. Although some studies show a modest correlation with the type of CHD and length of deep hypothermic arrest, the most striking predictor of poor neurodevelopmental outcome at age 2 was preoperative microcephaly. Similarly, preoperative brain magnetic resonance imaging has demonstrated white matter abnormalities in 32% of newborns with D-transposition of the Great Arteries or single ventricle, compared with none of the control infants; both of these observations support the association of CHD with abnormal brain development independent of surgical management.

Although recent recommendations include developmental evaluation in a subset of high-risk patients with CHD, ND risk-stratification for CHD remains difficult. Poor neurodevelopmental outcomes are much more prevalent in CHD patients with a diagnosed genetic syndrome, and a link between genetic factors and weight growth and head circumference has been identified. Genetic analysis of 1213 patients with CHD revealed that de novo risk increases when stratifying for CHD cases with NDD or extracardiac manifestations. Specifically, 10% of patients with CHD and NDD were found to be attributable to damaging de novo mutations, which increased to 20% when looking at patients with both NDD and extracardiac manifestations. These mutations tended to occur in genes that were highly expressed in both the heart and the brain.
Furthermore, within this set of cases, there were 66 genes, which were mutated in both CHD probands and 7 published cohorts ascertained for neurodevelopmental phenotypes. These findings were suggestive of common genetic causes. Common pathways converged on chromatin modification, transcriptional regulations, Notch and Wnt Signaling, among other pathways in cardiac development. These findings open an avenue to identification of patients with CHD who are at risk for neurodevelopmental difficulties early during their clinical course. Several studies show that early interventions affect neurodevelopmental outcomes, such as executive function in at-risk children. Whether these or other interventions could also benefit children with CHD who are at high risk for neurodevelopmental sequelae still needs to be rigorously tested.

**Postoperative and Respiratory Outcomes**

Surgical correction or palliation of even the most complex CHD has been one of the main drivers of the remarkable increase in survival for patients with CHD. One of the challenging aspects of caring for these patients is the variable outcome resulting from surgery for anatomically and physiologically identical CHD. Two of the most significant modulators of postoperative outcome that may be influenced by the genetic underpinnings of the CHD are respiratory complications and myocardial dysfunction, and the ability to identify at-risk patients preoperatively may allow improved surgical and postoperative care that is better tailored to the individual patient. Mutations in cilia genes are known to cause heterotaxy and are also likely contributing to some types of non-heterotaxy CHD. In addition to CHD, cilia mutations cause PCD, a genetically heterogeneous disorder leading to pulmonary dysfunction, male infertility, and organ laterality defects. In the respiratory tract, PCD can result in immotile or dyskinetic cilia that fail to coordinate mucociliary clearance of pathogens and debris from the respiratory tract. Poor mucociliary clearance leads to infection and inflammation that damage the airway, and it is, especially, important to note that patients with ciliary dysfunction depend entirely on cough for mucociliary clearance, a function that is compromised in patients on mechanical ventilatory support, such as postoperative CHD patients. With this in mind, it is not surprising that patients with airway ciliary dysfunction and heterotaxy with CHD have a higher rate of respiratory complication postoperatively compared with patients without airway ciliary dysfunction, these findings suggest that prospective knowledge of which patients have airway ciliary dysfunction could improve postoperative outcome by tailored modifications to their respiratory care.

**Genetic Testing in CHD**

The use of genetic information in tailoring care for the patient with CHD, risk stratification, establishing prognosis, and counseling families affected by CHD is continually expanding as more is learned about the genetic contribution to CHD. Genetic testing is being offered to an increasing portion of CHD families; however, at this time, there is little consensus on the type of testing, the specific clinical indication for testing, and the interpretation of testing results. Increasingly, specialty clinics in CHD genetics where testing can be ordered, and patient counseling provided by geneticists and genetic counselors working together with pediatric cardiologists are being offered to patients. Below, we outline CHD genetic testing available on a clinical basis at the time of this writing; notably, the technology for genetic testing along with the interpretation of results is evolving at an extremely rapid pace, and it is distinctly possible that whole-exome or WGS will become more universally used in the diagnosis and management of CHD in the near future.

The most common clinical genetic tests used in CHD are karyotypes, chromosomal microarray, targeted fluorescence in-situ hybridization (FISH), directed panel sequencing, and more recently WES. The decision on which type of testing is appropriate depends on the clinical presentation. Karyotyping is commonly the first line of testing used. In studies of patients with CHD admitted to a cardiac intensive care unit, or who had surgery in the first year of life, karyotyping yielded a diagnosis in 10.5% to 23% of patients. The majority of the positive results from karyotyping were either Down syndrome or Turner syndrome, both of which are often clinically recognized. Genome-wide microarray provides information on deletions and duplications including common CNVs associated with CHD, such as del22q11 (DiGeorge syndrome) and del7q11 (William syndrome). Microarray has yielded a diagnostic result in 10% to 25% of patients tested, with an additional 8% of patients carrying a variant of unknown significance. Targeted FISH, most commonly focusing on the 22q11 deletion, identifies the presence or absence of the specific target at lower cost and slightly more rapid turnover than genome-wide microarray and had a positive diagnostic rate of 12%. Whether targeted FISH is positively correlated most directly with the specific cardiac lesion being tested, with 25% to 50% of patients with interrupted aortic arch, pulmonary atresia with ventricular septal defect, or truncus arteriosus having a positive 22q11 FISH. It is important to note that the abnormalities detected by targeted FISH will also be detected by genome-wide microarray, and at least one study suggests that except in specific clinical scenarios, microarray testing is more cost effective.

Finally, sequencing is increasingly being used to identify genetic causes of CHD at the clinical level. Targeted sequencing is being offered for panels of CHD candidate genes. Two studies using similar sets of 57 genes previously implicated in CHD to test a group of patients from nonsyndromic CHD families with probable dominantly inherited CHD identified likely causative mutations in 25% to 46% of the families. This approach relies on variants segregating with disease within a family, and thus becomes more difficult in nonfamilial CHD, first because the composition of the currently used CHD gene sets in the targeted sequencing approach are biased toward inherited CHD, and second because variant interpretation in an isolated case is more challenging. When there is strong clinical suspicion for CHD associated with a syndrome that has known genetic cause, targeted sequencing of a gene or group of genes associated with that syndrome is indicated, and one study finds that targeted sequencing that is driven by clinical evaluation identified the cause of CHD in 17% of the cases.
In specific syndromes that have been well characterized at the molecular level, such as Noonan syndrome or Marfan syndrome, the diagnostic yield can be as high as 80% (Noonan syndrome) to 90% (Marfan syndrome). Finally, whole-exome or even WGS, which have been extensively used in management of oncology patients, are increasingly being offered as a clinical tool in the care of patients with CHD. Although these methods are more expensive and time-consuming than targeted sequencing, they are unbiased and allow reanalysis when additional clinical or genetic information come to light. WES has been successfully used clinically for almost a decade and is now becoming part of genetic testing for CHD. It provides information for the entire coding region of the genome at a cost of only 2× to 3× the cost of targeted panels. The current clinical approach to WES in CHD is to obtain the data for the entire exome, and then interrogate gene sets that are driven by the clinical phenotype. If there are new pieces of clinical information obtained during the patient’s course, it is possible to reinterrogate and look for mutations in a different set of genes. Furthermore, if new genes are identified as possible causes for the patient’s phenotype, it is possible to obtain patient data for those genes without reobtaining a sample and repeating sequencing. Because of the large amounts of data obtained by WES, the most challenging aspect of this methodology is identifying whether rare variants that are biologically plausible, but have not previously been linked to disease (variants of unknown significance), are actually causal. Because denovo mutations have been associated with CHD, interpretation of clinical WES results is greatly helped by obtaining parental samples; if a variant is not identified in either phenotypically normal parent, the likelihood that it is contributing to the patient’s CHD is much more likely.

Genetic testing for CHD is increasingly becoming part of standard care, especially for severe CHD requiring intervention and for CHD associated with extracardiac abnormalities. Specific testing should be strongly guided by the cardiac and extracardiac phenotype; a proposed strategy for clinical genetic testing in CHD is outlined in Figure 5. Phenotyping and family history are exceptionally important in this scenario, as they inform the type of testing and will help guide the genetic testing laboratory. Equally important will be careful adjudication of those variants that are not known disease-causing variants, but variants of unknown significance. The first step here is to test whether the variant is de novo, which greatly raises the likelihood that the variant is disease causing. Additional information on the likelihood that a given variant is disease causing is provided by the measures of evolutionary conservation of the position at which the variant is occurring and by the biological impact of the resulting amino acid substitution. Computational algorithms that integrate sequence and functional parameters provide indices of whether a given missense variant is predicted to be damaging or benign are also able to add information on the likely pathogenicity of a sequence variant (Meta-SVM, Polyphen-2, SIFT, MutationTaster, and among others). As more and increasingly complex technologies reveal an expanding array of genomic variation, criteria for interpretation of clinical genetic testing are being developed and standardized by workgroups, including the American College of Medical Genetics and Genomics. Finally, the implications of genetic testing for patients with CHD and their families are significant, ranging from prognostic risk factors for neurodevelopmental outcome, to estimates of recurrence risk in siblings, and increasingly as patients with CHD reach reproductive age, to recurrence risk in their own offspring. The increasing awareness of the major genetic contribution to CHD provides a strong argument for providing broad access for patients with CHD and families to specialized cardiac genetics clinics that can provide high-quality genetic counseling, along with training of pediatric and adult cardiologists, and genetic counselors, in CHD genetics.

Summary
Genetics of CHD has made giant leaps forward in parallel with the evolution of genome analysis technologies. The suspicion that CHD is extremely heterogenic has been validated, and the anticipated complexity of CHD genetics further increased by

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**Figure 5.** Outline of proposed clinical genetic testing for patients with congenital heart disease (CHD). WES indicates whole-exome sequencing.
relatively limited observed genotype–phenotype correlations. Even syndromes that were thought to be well-defined clinically, such as CHARGE and Kabuki, are showing tremendous variation in phenotype when they are defined on the basis of the molecular finding. It is distinctly possible that some of the outcome in CHD is substantially influenced by the underlying genetic cause, in addition to the morphology and hemodynamics that underpin the impressively successful medical and surgical management of CHD to date.\(^3\) This observation drives the hope that early identification of genetic causes of CHD will allow more tailored management of CHD and will hopefully improve the outcome, especially, with respect to the many comorbidities of CHD that have a profound impact in quality of life for patients living with CHD. For example, identification of neurodevelopmental risk genes can identify patients who can benefit from early intervention programs long before any clinical signs of NDD, such as learning disabilities become apparent. In addition to the clinical implications of a more complete understanding of CHD genetics, the genes uncovered in human patients have already provided tremendous insights into the basic mechanisms underlying cardiac development.

Going forward, there is still much work to be done. Studies to date have at most defined the cause of 45% to 50% of CHD. Current analysis protocols are possibly underestimating the CNV and SNV contributions because of detection limitations and difficulty predicting whether identified variants are pathogenic or not. In addition, it is highly likely that some CHD is because of multicloic inheritance, and that some is caused by mutations in noncoding DNA. As larger cohorts of patients with CHD are being evaluated with progressively more comprehensive sequencing, it seems ever more likely that we will be able to identify the genetic underpinning of the majority of CHD and to translate these findings into precision medicine for the care of patients with CHD from infants to adults.

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**Disclosures**

None.

**References**


Rebalancing gene haploinsufficiency in vivo by targeting chromatin.


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