



Research Letter



Screening for Mutations Causing ACOX2 Deficiency-associated Hypertransaminasemia in Patients with Cryptogenic Liver Injury

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Elevation of serum transaminases is a frequent cause of consultation in hepatology departments.¹ The most common causes of hypertransaminasemia are alcoholic and metabolic dysfunction-associated steatotic liver disease, viral infections, autoimmune liver disease, celiac disease, iron overload, Wilson's disease, and exposure to toxic compounds, including drugs.² Although serum biochemistry, serological methods, functional approaches, imaging techniques, and liver biopsy can help to identify the etiology of liver damage, up to 15% of hypertransaminasemia cases in adults³ and 13% in children⁴ remain idiopathic.

Since the first case of acyl-CoA oxidase 2 (ACOX2) deficiency-associated hypertransaminasemia (ADAH) was reported at the International Liver Congress™ – EASL (April 2016; Barcelona, Spain),⁵ several cases caused by different mutations in the ACOX2 gene have been identified by our group^{5–8} and others.^{9,10} This has led to the speculation that some cryptogenic liver damage may be related to ADAH.

In this context, in recent years, a relatively high number of cases of severe pediatric idiopathic acute hepatitis (PIAH) have been described in children under 14 years of age in different European countries, requiring hospital admission and, in some patients, liver transplantation. As the etiology was not defined, several causes were considered to explain these conditions. This included infection by adenoviruses, as well as by specific strains of SARS-CoV-2. However, despite some

clues have been reported,^{11,12} the exact etiology of this condition remains unclear.¹³

The hypothesis of this study was that mutations in the ACOX2 gene leading to peroxisomal dysfunction in cholesterol side-chain shortening could favor the accumulation of toxic intermediate metabolites of bile acid synthesis and act as a predisposing factor. This would induce mild liver damage on its own but markedly increase liver vulnerability to factors such as adenovirus infections or other infectious agents capable of triggering more serious liver injury. Accordingly, the aim was to determine the presence of mutations in the ACOX2 gene in a relatively large number of samples from patients with PIAH. For comparison, we also included in this screening potential cases of ADAH from two small cohorts with different pathological conditions associated with liver injury that mainly affect adults and whose etiology has long been under investigation, namely, hepatocellular carcinoma (HCC) arising in non-cirrhotic liver¹⁴ and drug-induced liver injury (DILI). DILI cases can be classified as intrinsic, which is predictable and associated with known dose-dependent drug toxicity, and idiosyncratic, in which the damage is unexpected for the administered drug and implies enhanced liver susceptibility.^{15,16} All cases included in this study were idiosyncratic DILI. Patients were classified at the time of diagnosis using the updated Roussel method at the time of diagnosis using the updated Roussel Uclaf Causality Assessment Method (RUCAM).¹⁷ However, for inclusion in this study, we did not differentiate between hepatocellular, cholestatic, or mixed types of idiosyncratic DILI.¹⁸

Plasma and white blood cell samples were collected from adults with HCC or DILI at the Hospital Universitario de Navarra (Spain) and from children with PIAH reported at the Centro Nacional de Microbiología (Majadahonda, Madrid, Spain). The research protocol adhered to the ethical guidelines of the 2024 Declaration of Helsinki. The use of genetic information was approved by the Human Ethics Committees of the participating institutions. Blood samples were collected after overnight fasting. Bile acid concentrations in plasma

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Described Mutations			Novel Mutations		Pediatric Idiopathic Acute Hepatitis (PIAH)						
Exon	ADAH	Non-Pathogenic			Exon	3	4	5	6	7	8
3	c.256C>T				PIAH1	+/+	+/+	+/+	+/+	+/+	+/+
4	c.456_459del				PIAH2	+/+	+/+	+/+	+/+	+/+	+/+
6	c.673C>T	c.632C>T	c.778T>C		PIAH3	+/+	+/+	+/+	+/+	+/+	+/+
8	c.935C>A				PIAH4	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH5	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH6	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH7	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH8	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH9	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH10	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH11	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH12	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH13	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH14	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH15	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH16	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH17	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH18	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH19	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH20	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH21	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH22	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH23	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH24	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH25	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH26	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH27	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH28	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH29	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH30	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH31	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH32	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH33	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH34	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH35	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH36	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH37	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH38	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH39	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH40	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH41	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH42	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH43	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH44	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH45	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH46	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH47	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH48	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH49	+/+	+/+	+/+	+/+	+/+	+/+
					PIAH50	+/+	+/+	+/+	+/+	+/+	+/+

+/+

-/-

+/-

Homozygous Wild-Type

Homozygous Mutated Variant

Heterozygous

Drug-Induced Liver Injury (DILI)

Patients

Exon	3	4	5	6	7	8
DILI1	+/+	+/+	+/+	+/+	+/+	+/+
DILI2	+/+	+/+	+/+	+/+	+/+	+/+
DILI3	+/+	+/+	+/+	+/+	+/+	+/+
DILI4	+/+	+/+	+/+	+/+	+/+	+/+
DILI5	+/+	+/+	+/+	+/+	+/+	+/+
DILI6	+/+	+/+	+/+	+/+	+/+	+/+
DILI7	+/+	+/+	+/+	+/+	+/+	+/+
DILI8	+/+	+/+	+/+	+/+	+/+	+/+
DILI9	+/+	+/+	+/+	+/+	+/+	+/+
DILI10	+/+	+/+	+/+	+/+	+/+	+/+

Patients

Exon	3	4	5	6	7	8
HCC1	+/+	+/+	+/+	+/+	+/+	+/+
HCC2	+/+	+/+	+/+	+/+	+/+	+/+
HCC3	+/+	+/+	+/+	+/+	+/+	+/+
HCC4	+/+	+/+	+/+	+/+	+/+	+/+
HCC5	+/+	+/+	+/+	+/+	+/+	+/+
HCC6	+/+	+/+	+/+	+/+	+/+	+/+
HCC7	+/+	+/+	+/+	+/+	+/+	+/+
HCC8	+/+	+/+	+/+	+/+	+/+	+/+
HCC9	+/+	+/+	+/+	+/+	+/+	+/+
HCC10	+/+	+/+	+/+	+/+	+/+	+/+
HCC11	+/+	+/+	+/+	+/+	+/+	+/+
HCC12	+/+	+/+	+/+	+/+	+/+	+/+
HCC13	+/+	+/+	+/+	+/+	+/+	+/+

Hepatocellular Carcinoma (HCC)

Patients

Exon	3	4	5	6	7	8
HCC1	+/+	+/+	+/+	+/+	+/+	+/+
HCC2	+/+	+/+	+/+	+/+	+/+	+/+
HCC3	+/+	+/+	+/+	+/+	+/+	+/+
HCC4	+/+	+/+	+/+	+/+	+/+	+/+
HCC5	+/+	+/+	+/+	+/+	+/+	+/+
HCC6	+/+	+/+	+/+	+/+	+/+	+/+
HCC7	+/+	+/+	+/+	+/+	+/+	+/+
HCC8	+/+	+/+	+/+	+/+	+/+	+/+
HCC9	+/+	+/+	+/+	+/+	+/+	+/+
HCC10	+/+	+/+	+/+	+/+	+/+	+/+
HCC11	+/+	+/+	+/+	+/+	+/+	+/+
HCC12	+/+	+/+	+/+	+/+	+/+	+/+
HCC13	+/+	+/+	+/+	+/+	+/+	+/+

Patients

Exon	3	4	5	6	7	8
HCC1	+/+	+/+	+/+	+/+	+/+	+/+
HCC2	+/+	+/+	+/+	+/+	+/+	+/+
HCC3	+/+	+/+	+/+	+/+	+/+	+/+
HCC4	+/+	+/+	+/+	+/+	+/+	+/+
HCC5	+/+	+/+	+/+	+/+	+/+	+/+
HCC6	+/+	+/+	+/+	+/+	+/+	+/+
HCC7	+/+	+/+	+/+	+/+	+/+	+/+
HCC8	+/+	+/+	+/+	+/+	+/+	+/+
HCC9	+/+	+/+	+/+	+/+	+/+	+/+
HCC10	+/+	+/+	+/+	+/+	+/+	+/+
HCC11	+/+	+/+	+/+	+/+	+/+	+/+
HCC12	+/+	+/+	+/+	+/+	+/+	+/+
HCC13	+/+	+/+	+/+	+/+	+/+	+/+

Fig. 1. Scheme of previously described pathogenic mutations and novel mutations in the ACOX2 mRNA region from exon 3 to exon 8. The table depicts the results of the screening of these mutations in children with pediatric idiopathic acute hepatitis (PIAH, n = 50) and adult patients with idiosyncratic drug-induced liver injury (DILI, n = 10; patients with intrinsic DILI were excluded) or hepatocellular carcinoma (HCC) developed in the absence of liver cirrhosis (n = 13).

were measured by HPLC-MS/MS. All patients included in the study had hypertransaminasemia together with other abnormal liver function parameters, as determined using standard clinical automatic analyzers. Reference normal serum ranges for adults were: alanine aminotransferase 7–55 U/L, aspartate aminotransferase 8–48 U/L, alkaline phosphatase 40–129 U/L, albumin 3.5–5.0 g/dL, total protein 6.3–7.9 g/dL, total bilirubin 0.1–1.2 mg/dL, direct bilirubin <0.3 mg/dL, gamma-glutamyl transferase 8–61 U/L, lactate dehydrogenase 122–222 U/L, and prothrombin time 9.4–12.5 s. These ranges were adapted to pediatric values depending on gender

and age (0 to 14 years).¹⁹ Patients with acute liver failure were excluded. DNA was obtained from total blood samples (DNeasy Blood & Tissue Kit, Qiagen) to amplify the coding sequence of ACOX2 by high-fidelity Polymerase Chain Reaction (PCR).⁶ The amplified fragments containing both the exons and the exon-intron boundaries from at least two PCR reactions per exon were purified by agarose gel electrophoresis. Amplicons were then sequenced in both directions using forward and reverse primers as previously described.⁶ The genetic region analyzed included exons where pathogenic mutations in the coding sequence of ACOX2 have been iden-

tified,^{5–10} i.e., exon 3 to exon 8 (Fig. 1).

The detailed analysis of pathogenic mutations in the ORF of ACOX2 was performed in the cohort of children with PIAH previously reported by Martínez-Laso *et al.*¹¹ Although the global genetic analysis of these patients revealed a relationship between this liver pathology and the presence of specific human leukocyte antigen variants, suggesting an autoimmune predisposition to injury caused by various viruses,¹¹ the pathogenesis of this condition has not yet been fully clarified.¹² Unfortunately, the results of the present screening do not provide a clue to unravel this intriguing question. Among the fifty patients analyzed, only one individual carried a mutation in the analyzed region of the ACOX2 gene (Fig. 1). This was a previously unreported change, c.632C>T in exon 6, which leads to p.S211L. This is a missense mutation resulting in the substitution of serine, a small, polar amino acid capable of hydrogen bonding and often involved in active sites or phosphorylation, with leucine, a larger, non-polar, hydrophobic amino acid that typically contributes to the hydrophobic core of proteins. Although this substitution may have functional consequences, the mutation was found in a heterozygous state. In our experience, even in cases of pathogenic variants, when they appear as a single heterozygous mutation in individuals who are close relatives of ADAH patients, these mutations do not have a phenotypic impact.^{5–8}

Regarding the cohorts of patients with idiosyncratic DILI or HCC developed in non-cirrhotic liver, owing to the limited number of samples, bile acid levels were measured only in patients with DILI. These values showed high variability, ranging from normal (total bile acid concentration below 10 µM, in four patients) to mild elevation (more than 10 µM but below 20 µM, three patients) or even marked hypercholanemia (71–385 µM, three patients). None of the previously described pathogenic mutations (c.256C>T, c.456_459del, c.673C>T, c.935C>A) were found in these cohorts (Fig. 1). In contrast, a novel mutation was identified in one individual from each cohort. This change (c.778T>C, p.F271L) was also located in exon 6 of the ACOX2 gene. The substitution of phenylalanine with leucine represents a missense mutation involving two hydrophobic amino acids. Despite both being nonpolar, phenylalanine contains an aromatic ring, while leucine has an aliphatic side chain. This structural difference might have functional consequences, which could be relevant in the homozygous state. However, in both patients carrying this mutation, it was present only in one allele. As discussed above, no phenotypic repercussions are expected in the heterozygous state of these mutations.

In conclusion, although this study was conducted with a limited data set and the findings should be regarded as preliminary, ADAH was not found to be a predisposing condition for PIAH, nor was it present in our cohorts of idiosyncratic DILI or non-cirrhotic HCC. These findings indicate that ADAH is a rare entity scarcely represented in these groups of patients. However, since ADAH patients respond well to treatment with ursodeoxycholic acid (UDCA),⁸ it is advisable to perform serum bile acid profiling by HPLC-MS/MS followed by confirmation through mutational analysis of the ACOX2 gene in patients with hypertransaminasemia of unknown origin, because if they are positive for ADAH, an effective and safe therapy can be recommended.

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Conflict of interest

The authors have no conflict of interest related to this publication.

Author contributions

Conceptualization (JJGM, MJM, EH, JP, AA, LB), funding acquisition (JJGM, AA), investigation, data interpretation (JJGM, EH, MJM, MAP, MMC), methodology (EH, MJM, MAP), supervision (JJGM), writing - original draft (JJGM, EH, MJM), and review & editing (JJGM, EH, MJM, MAP, MMC, JP, AA, LB). All authors read and critically revised the manuscript and approved the final version.

Ethical statement

The research protocol adhered to the ethical guidelines outlined in the 2024 Declaration of Helsinki. The use of genetic information was approved by the Human Ethics Committees of the involved institutions (CEIC: PI81106 and CEI PI 49_2023). Informed consent was obtained from patients entering this study or from their legal representatives.

Data sharing statement

The data that support the findings of this study are available from the corresponding author upon reasonable request. Some data may be subject to ethical or legal restrictions.

References

- [1] Al-Busafi SA, Hilzenrat N. Mild Hypertransaminasemia in Primary Care. *ISRN Hepatol* 2013;2013:256426. doi:10.1155/2013/256426, PMID:27335825.
- [2] Vajro P, Maddaluno S, Veropalumbo C. Persistent hypertransaminasemia in asymptomatic children: a stepwise approach. *World J Gastroenterol* 2013;19(18):2740–2751. doi:10.3748/wjg.v19.i18.2740, PMID:23687411.
- [3] Cacciola I, Scoglio R, Alibrandi A, Squadrito G, Raimondo G, SIMG-Messina Hypertransaminasemia Study Group. Evaluation of liver enzyme levels and identification of asymptomatic liver disease patients in primary care. *Intern Emerg Med* 2017;12(2):181–186. doi:10.1007/s11739-016-1535-2, PMID:27644706.
- [4] Iorio R, Sepe A, Giannattasio A, Cirillo F, Vegnente A. Hypertransaminasemia in childhood as a marker of genetic liver disorders. *J Gastroenterol* 2005;40(8):820–826. doi:10.1007/s00535-005-1635-7, PMID:16143887.
- [5] Monte MJ, Alonso M, Briz O, Herraez E, Macias RIR, Perez MJ, *et al.* Identification of a new inborn error in the peroxisomal steps of bile acid synthesis resulting in accumulation of toxic bile acid intermediates and hepatocellular damage. *J Hepatol* 2016;64:S301. doi:10.1016/S0168-8278(16)00388-3.
- [6] Monte MJ, Alonso-Peña M, Briz O, Herraez E, Berasain C, Argemi J, *et al.* ACOX2 deficiency: An inborn error of bile acid synthesis identified in an adolescent with persistent hypertransaminasemia. *J Hepatol* 2017;66(3):581–588. doi:10.1016/j.jhep.2016.11.005, PMID:27884763.
- [7] Alonso-Peña M, Espinosa-Escudero R, Hermanns HM, Briz O, Herranz JM, Garcia-Ruiz C, *et al.* Impact of Liver Inflammation on Bile Acid Side Chain Shortening and Amidation. *Cells* 2022;11(24):3983. doi:10.3390/cells11243983, PMID:36552746.
- [8] Alonso-Peña M, Espinosa-Escudero R, Herraez E, Briz O, Cagigal ML, Gonzalez-Santiago JM, *et al.* Beneficial effect of ursodeoxycholic acid in patients with acyl-CoA oxidase 2 (ACOX2) deficiency-associated hypertransaminasemia. *Hepatology* 2022;76(5):1259–1274. doi:10.1002/hep.32517, PMID:35395098.
- [9] Vilarinho S, Sari S, Mazzacova F, Bilgüvar K, Esendagli-Yılmaz G, Jain D, *et al.* ACOX2 deficiency: A disorder of bile acid synthesis with transaminase elevation, liver fibrosis, ataxia, and cognitive impairment. *Proc Natl Acad*

- Sci U S A 2016;113(40):11289–11293. doi:10.1073/pnas.1613228113, PMID:27647924.
- [10] Ferdinandusse S, Denis S, van Roermund CWT, Preece MA, Koster J, Ebberink MS, *et al*. A novel case of ACOX2 deficiency leads to recognition of a third human peroxisomal acyl-CoA oxidase. *Biochim Biophys Acta Mol Basis Dis* 2018;1864(3):952–958. doi:10.1016/j.bbadis.2017.12.032, PMID:29287774.
- [11] Martinez-Laso J, Cervera I, Munoz-Chimeno M, Casas I, Avellón A. Could the paediatric acute hepatitis of unknown origin be related to a new autoimmune disease? *J Hepatol* 2025;82(4):e176–e177. doi:10.1016/j.jhep.2024.10.006, PMID:39419180.
- [12] Okamoto T, Hatano E. Reply to: Could the paediatric acute hepatitis of unknown origin be related to a new autoimmune disease? *J Hepatol* 2025;82(4):e178–e179. doi:10.1016/j.jhep.2024.11.045, PMID:39617135.
- [13] Stasi C, Pacifici M, Puglia M, Voller F. Severe acute hepatitis of unknown origin in children: Is it still a mystery? What role does adenovirus play? *J Viral Hepat* 2024;31(10):577–581. doi:10.1111/jvh.13978, PMID:39073179.
- [14] Desai A, Sandhu S, Lai JP, Sandhu DS. Hepatocellular carcinoma in non-cirrhotic liver: A comprehensive review. *World J Hepatol* 2019;11(1):1–18. doi:10.4254/wjh.v11.i1.1, PMID:30705715.
- [15] Mosedale M, Watkins PB. Drug-induced liver injury: Advances in mechanistic understanding that will inform risk management. *Clin Pharmacol Ther* 2017;101(4):469–480. doi:10.1002/cpt.564, PMID:27861792.
- [16] Iasella CJ, Johnson HJ, Dunn MA. Adverse Drug Reactions: Type A (Intrinsic) or Type B (Idiosyncratic). *Clin Liver Dis* 2017;21(1):73–87. doi:10.1016/j.cld.2016.08.005, PMID:27842776.
- [17] Danan G, Teschke R. RUCAM in Drug and Herb Induced Liver Injury: The Update. *Int J Mol Sci* 2015;17(1):E14. doi:10.3390/ijms17010014, PMID:26712744.
- [18] Kaufman G. Adverse drug reactions: classification, susceptibility and reporting. *Nurs Stand* 2016;30(50):53–63. doi:10.7748/ns.2016.e10214, PMID:27507394.
- [19] Adeli K, Higgins V, Trajcevski K, White-Al Habeeb N. The Canadian laboratory initiative on pediatric reference intervals: A CALIPER white paper. *Crit Rev Clin Lab Sci* 2017;54(6):358–413. doi:10.1080/10408363.2017.1379945, PMID:29017389.