Aspergillus Fumigatus IgG ELISA Kit

Prod. No.: DEIA312
Pkg. Size: 96T

INTENDED USE

The Aspergillus fumigatus IgG Antibody ELISA Test Kit has been designed for the detection and the quantitative determination of specific IgG antibodies against Aspergillus fumigatus in serum and plasma. Further applications in other body fluids are possible and can be requested from the Technical Service. This assay is intended for in-vitro diagnostic use only. Laboratory results can never be the only base of a medical report. The patient history and further tests have additionally to be taken into account.

GENERAL DESCRIPTION

Aspergillus species of known pathogenicity to man are Aspergillus fumigatus, A. flavus, A. niger, A. terreus and A. nidulans. The most common pathogen of this genus is A. fumigatus which occurs in hay, grain, rotten plants and birds faeces. The main opportunistic invasive fungal infections are the candidal mycosis followed by aspergillosis. Generally infections with Aspergillus spp. are airborne. Because of the ubiquity of Aspergillus species it renders more difficult to decide between contamination by commensals or a serious infection. Usually infection in man occurs in already damaged tissues only. Aspergillus spp. can cause a chronic infection of paranasal sinus, eyes or lungs.

Three types of lung-aspergillosis can be distinguished:

a: Acute infection (bronchial pneumonia; pneumonitis) Aspergillus pneumonia is mostly found in patients with neutropenia (decrease of neutrophil granulocytes), after a long-time therapy with glucocorticoids, in immunosuppressed patients (after organ transplantation) and in alcoholics.
b: Saprophytic aspergillosis (compact reticulum of hyphae in the lungs) Preformed cavities in the lung due to a previous tuberculosis give place to a colonisation of Aspergillus species.
c: Allergic bronchopulmonary aspergillosis This clinical picture is not due to an infectious disease but a hypersensitive reaction of the bronchial system (mediated by IgE) after inhalation of aspergillus spores. Subsequently the bronchial system produces highly viscous secretions, that may block the bronchial lumen. The patient develops difficulties of breathing and a fibrosis. Next to ELISA the indirect Aspergillus hemagglutination test (Aspergillus HAT) can be performed to detect specific IgG and IgM antibodies. The HAT is not suitable as a screening test, however, because of its low sensitivity. In some high-risk patients it shows only low antibody titers. For a better diagnosis of invasive aspergillosis the brain or lung of these patients should be examined by a biopsy.

These assays are most sensitive for the detection of rheumatoid factor that is of the IgM isotype because of its multivalent structure. These tests provide a dilution which is difficult to standardize and have laborious processing and poor reproducibility. In contrast to these assays modern ELISA tests are characterized by a higher sensitivity and by the possibility to differentiate between IgA, IgG and IgM Rheumatoid Factors.

PRINCIPLE OF THE TEST

The Aspergillus fumigatus IgG antibody test kit is based on the principle of the enzyme immunoassay (EIA). Aspergillus antigen is bound on the surface of the microtiter strips. Diluted patient serum or ready-to-use standards are pipetted into the wells of the microtiter plate. A binding between the IgG antibodies of the serum and the immobilized Aspergillus antigen takes place. After a one hour incubation at room temperature, the plate is rinsed with diluted wash solution, in order to remove unbound material. Then ready-to-use anti-human-IgG peroxidase conjugate is added and incubated for 30 minutes. After a further washing step, the substrate (TMB) solution is pipetted and incubated for 20 minutes, inducing the development of a blue dye in the wells. The color development is terminated by the addition of a stop solution, which changes the 4 ILE ASP01_en color from blue to yellow. The resulting dye is measured spectrophotometrically at the wavelength of 450 nm. The concentration of the IgG antibodies is directly proportional to the intensity of the color.

SPECIMEN COLLECTION AND HANDLING

Principally serum or plasma (EDTA, heparin) can be used for the determination. Serum is separated from the blood, which is aspirated by venipuncture, after clotting and centrifugation. The serum or plasma samples can be stored refrigerated (4-8°C) for up to 48 hours, for a longer storage they should be kept at -20 °C. The samples should not be frozen and thawed repeatedly. Lipemic, hemolytic or bacterially contaminated samples can cause false positive or false negative results. For the performance of the test the samples (not the standards) have to be diluted 1:101 with readyto-use sample diluent (e.g. 5 μL serum + 500 μL sample diluent).
REAGENTS PROVIDED

Store kit components at 2-8°C and do not use after the expiry date on the box outer label. Before use, all components should be allowed to warm up to ambient temperature (18-25°C). After use, the plate should be resealed, the bottle caps replaced and tightened and the kit stored at 2-8°C. The opened kit should be used within three months.

**Mikrotiter Strips:** 12 strips with 8 breakable wells each, coated with a Aspergillus fumigatus antigen. Ready-to-use.

**Calibrator A (Negative Control):** 2 mL, protein solution diluted with PBS, contains no IgG antibodies against Aspergillus. Addition of 0.01% methylisothiazolone and 0.01% bromonitrodioxane. Ready-to-use.

**Calibrator B (Cut-Off Standard):** 2 mL, human serum diluted with PBS, contains a low concentration of IgG antibodies against Aspergillus. Addition of 0.01% methylisothiazolone and 0.01% bromonitrodioxane. Ready-to-use.

**Calibrator C (Weak Positive Control):** 2 mL, human serum diluted with PBS, contains a medium concentration of IgG antibodies against Aspergillus. Addition of 0.01% methylisothiazolone and 0.01% bromonitrodioxane. Ready-to-use.

**Calibrator D (Positive Control):** 2 mL, human serum diluted with PBS, contains a high concentration of IgG antibodies against Aspergillus. Addition of 0.01% methylisothiazolone and 0.01% bromonitrodioxane. Ready-to-use.

**Enzyme Conjugate:** 15 mL, anti-human-IgG-HRP (rabbit), in protein-containing buffer solution. Addition of 0.01% methylisothiazolone and 0.01% bromonitrodioxane and 5 mg/L Proclin™. Ready-to-use.

**Substrate:** 15 mL, TMB (tetramethylbenzidine). Ready-to-use.

**Stop Solution:** 15 mL, 0.5 M sulfuric acid. Ready-to-use.

**Sample Diluent:** 60 mL, PBS/BSA buffer. Addition of 0.1% sodium azide. Ready-to-use.

**Washing Buffer:** 60 mL, PBS + Tween 20, 10x concentrate. Final concentration: dilute 1+9 with distilled water. If during the cold storage crystals precipitate, the concentrate should be warmed up at 37°C for 15 minutes.

**Plastic Foils:** 2 pieces to cover the mikrotiter strips during the incubation.

**Plastic Bag:** Resealable, for the dry storage of non-used strips.

MATERIALS REQUIRED BUT NOT PROVIDED

1. 5 μL-, 100 μL- and 500 μL micro- and multichannel pipets
2. Mikrotiter Plate Reader (450 nm)
3. Mikrotiter Plate Washer
4. Reagent tubes for the serum dilution
5. Bidistilled water

ASSAY PROCEDURE

1. **Preparation of Reagents**

**Washing Solution:** dilute before use 1+9 with distilled water.

If during the cold storage crystals precipitate, the concentrate should be warmed up at 37° C for 15 minutes.

1) Strict adherence to the protocol is advised for reliable performance. Any changes or modifications are the responsibility of the user.
2) All reagents and samples must be brought to room temperature before use, but should not be left at this temperature longer than necessary.
3) Standards and samples should be assayed in duplicates.
4) A standard curve should be established with each assay.
5) Return the unused microtiter strips to the plastic bag and store them dry at 4-8°C.

2. **Assay Steps**

1) Prepare a sufficient amount of mikrotiter wells for the standards, controls and samples in duplicate as well as for a substrate blank.
2) Pipet 100 μL each of the diluted (1:101) samples and the ready-to-use standards and controls respectively into the wells. Leave one well empty for the substrate blank.
3) Cover plate with the enclosed foil and incubate at room temperature for 60 minutes.
4) Empty the wells of the plate (dump or aspirate) and add 300 μL of diluted washing solution. This procedure is repeated totally three times. Rests of the washing buffer are afterwards removed by gentle tapping of the mikrotiter plate on a tissue cloth.
5) Pipet 100 μL each of ready-to-use conjugate into the wells. Leave one well empty for the substrate blank.
6) Cover plate with the enclosed foil and incubate at room temperature for 30 minutes.
7) Empty the wells of the plate (dump or aspirate) and add 300 μL of diluted washing solution. This procedure is repeated totally three times. Rests of the washing buffer are afterwards removed by gentle tapping of the mikrotiter plate on a tissue cloth.
8) Pipet 100 μL each of the ready-to-use substrate into the wells. This time also the substrate blank is pipetted.
9) Cover plate with the enclosed foil and incubate at room temperature for 20 minutes in the dark (e.g. drawer).
10) To terminate the substrate reaction, pipet 100 μL each of the ready-to-use stop solution into the wells. Pipet also the substrate blank.
11) After thorough mixing and wiping the bottom of the plate, perform the reading of the absorption at 450 nm (optionally reference wavelength of 620 nm). The color is stable for at least 60 minutes.

**EVALUATION**

The mean values for the measured absorptions are calculated after subtraction of the substrate blank value. The difference between the single values should not exceed 10%.

1. **Qualitative Evaluation**
   The calculated absorptions for the patient sera, as mentioned above, are compared with the value for the cut-off standard. If the value of the sample is higher, there is a positive result. For a value below the cut-off standard, there is a negative result. It seems reasonable to define a range of +/-20% around the value of the cut-off as a grey zone. In such a case the repetition of the test with the same serum or with a new sample of the same patient, taken after 2-4 weeks, is recommended. Both samples should be measured in parallel in the same run. The positive control must show at least the double absorption compared with the cut-off standard.

2. **Quantitative Evaluation**
   The ready-to-use standards and controls of the Aspergillus fumigatus antibody kit are defined and expressed in arbitrary units (U/ml). This results in an exact and reproducible quantitative evaluation. Consequently for a given patient follow-up controls become possible. The values for controls and standards in units are printed on the labels of the vials. For a quantitative evaluation the absorptions of the standards and controls are graphically drawn against their concentrations. From the resulting reference curve the concentration values for each patient sample can then be extracted in relation to their absorptions. It is also possible to use automatic computer programs.

**ASSAY CHARACTERISTICS**

<table>
<thead>
<tr>
<th>Assay</th>
<th>IgG</th>
<th>IgA</th>
<th>IgM</th>
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<tbody>
<tr>
<td>Aspergillus fumigatus ELISA</td>
<td>9.9 %</td>
<td>7.5 %</td>
<td>5.9 %</td>
</tr>
<tr>
<td>Intra-Assay-Precision</td>
<td>11.1 %</td>
<td>12.3 %</td>
<td>5.5 %</td>
</tr>
<tr>
<td>Inter-Assay-Precision</td>
<td>3.5 – 16.4 %</td>
<td>4.2 – 14.1 %</td>
<td>1.4 – 3.1 %</td>
</tr>
<tr>
<td>Inter-Lot-Precision</td>
<td>1.08 U/mL</td>
<td>1.14 U/mL</td>
<td>1.04 U/mL</td>
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<tr>
<td>Analytical Sensitivity</td>
<td>87 – 97 %</td>
<td>83 – 93 %</td>
<td>90 – 104 %</td>
</tr>
<tr>
<td>Recovery</td>
<td>74 – 114 %</td>
<td>72 – 118 %</td>
<td>95 – 120 %</td>
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<tr>
<td>Linearity</td>
<td>81 %</td>
<td>99 %</td>
<td>99 %</td>
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<tr>
<td>Clinical Specificity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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Cross-Reactivity: No cross-reactivity to Candida albicans
Interferences: No interferences to bilirubin up to 0.3 mg/mL, hemoglobin up to 8.0 mg/mL and triglycerides up to 5.0 mg/mL

**REFERENCES**