



DRG® *Aspergillus fumigatus* IgG ELISA (EIA-2501)



Revised 17 Sept. 2013 rm (Vers. 5.1)



Please use only the valid version of the package insert provided with the kit.

1 INTENDED USE

Enzyme immunoassay for the qualitative and quantitative determination of IgG antibodies against *Aspergillus fumigatus* in human serum and plasma.

2 SUMMARY AND EXPLANATION

The most common pathogen of the genus *Aspergillus* is *A. fumigatus* occurring in hay, grain, rotten plants and bird faeces. The main opportunistic invasive fungal infections are the candidal mycosis followed by aspergillosis. In general infections with *Aspergillus spp.* are airborne. Because of the ubiquity of *Aspergillus* species it is difficult to decide between contamination by commensalism or a serious infection. Usually infection in humans 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: acute infection (bronchial pneumonia; pneumonia), saprophytic aspergillom (compact reticulum of hyphae in the lungs) and allergic bronchopulmonary aspergillosis (mediated by IgE).

Next to the 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.

3 TEST PRINCIPLE

Solid phase enzyme-linked immunosorbent assay (ELISA) based on the sandwich principle.

The wells are coated with antigen. Specific antibodies of the sample binding to the antigen coated wells are detected by a secondary enzyme conjugated antibody (E-Ab) specific for human IgG. After the substrate reaction the intensity of the color developed is proportional to the amount of IgG-specific antibodies detected. Results of samples can be determined directly using the standard curve.

4 WARNINGS AND PRECAUTIONS

1. For in-vitro diagnostic use only. For professional use only.
2. Before starting the assay, read the instructions completely and carefully. Use the valid version of the package insert provided with the kit. Be sure that everything is understood.
3. In case of severe damage of the kit package please contact your supplier in written form, latest one week after receiving the kit. Do not use damaged components in test runs, but keep safe for complaint related issues.
4. Obey lot number and expiry date. Do not mix reagents of different lots. Do not use expired reagents.
5. Follow good laboratory practice and safety guidelines. Wear lab coats, disposable latex gloves and protective glasses where necessary.
6. Reagents of this kit containing hazardous material may cause eye and skin irritations. See MATERIALS SUPPLIED and labels for details. Material Safety Data Sheets for this product are available upon request.



Revised 17 Sept. 2013 rm (Vers. 5.1)



7. Chemicals and prepared or used reagents have to be treated as hazardous waste according to national biohazard and safety guidelines or regulations.
8. Avoid contact with Stop solution. It may cause skin irritations and burns.
9. Some reagents contain sodium azide (NaN₃) as preservatives. In case of contact with eyes or skin, flush immediately with water. NaN₃ may react with lead and copper plumbing to form explosive metal azides. When disposing reagents, flush with a large volume of water to avoid azide build-up.
10. All reagents of this kit containing human serum or plasma have been tested and were found negative for anti-HIV I/II, HBsAg and anti-HCV. However, a presence of these or other infectious agents cannot be excluded absolutely and therefore reagents should be treated as potential biohazards in use and for disposal.

5 STORAGE AND STABILITY

The kit is shipped at ambient temperature and should be stored at 2 °C - 8 °C. Keep away from heat or direct sun light. The storage and stability of specimen and prepared reagents is stated in the corresponding chapters.

The microtiter strips are stable up to the expiry date of the kit in the broken, but tightly closed bag when stored at 2 °C - 8 °C.

6 SPECIMEN COLLECTION AND STORAGE

Serum, Plasma (EDTA, Heparin)

The usual precautions for venipuncture should be observed. It is important to preserve the chemical integrity of a blood specimen from the moment it is collected until it is assayed. Do not use grossly hemolytic, icteric or grossly lipemic specimens. Samples appearing turbid should be centrifuged before testing to remove any particulate material.

Storage:	2 °C - 8 °C	-20 °C	Keep away from heat or direct sun light. Avoid repeated freeze-thaw cycles.
Stability:	2 days	> 2 days	

7 MATERIALS SUPPLIED

Quantity	Symbol	Component
1 x 12 x 8	MTP	Microtiter Plate Break apart strips. Coated with specific antigen.
1 x 15 mL	ENZCONJ IgG	Enzyme Conjugate IgG Red colored. Ready to use. Contains: anti-human IgG, conjugated to peroxidase, protein-containing buffer, stabilizers.
1 x 4 x 2 mL	CAL A-D	Standard A-D 1; 10; 50; 200 U/mL. Ready to use. Standard A = Negative Control; tandard B = Cut-Off Control Standard C = Weakly Positive Control; Standard D = Positive Control Contains: human serum, IgG antibodies against <i>Aspergillus</i> , PBS, stabilizers.



Revised 17 Sept. 2013 rm (Vers. 5.1)



1 x 60 mL	DILBUF	Diluent Buffer Ready to use. Contains: PBS Buffer, BSA, < 0.1 % NaN ₃ .
1 x 60 mL	WASHBUF CONC	Wash Buffer, Concentrate (10x) Contains: PBS Buffer, Tween 20.
1 x 15 mL	TMB SUBS	TMB Substrate Solution Ready to use. Contains: TMB.
1 x 15 mL	TMB STOP	TMB Stop Solution Ready to use. 0.5 M H ₂ SO ₄ .
2 x	FOIL	Adhesive Foil For covering of Microtiter Plate during incubation.
1 x	BAG	Plastic Bag Resealable. For dry storage of non-used strips.

8 MATERIALS REQUIRED BUT NOT SUPPLIED

1. Micropipettes (Multipette Eppendorf or similar devices, < 3% CV). Volumes: 5; 50;100; 500 µL
2. Calibrated measures
3. Tubes (1 mL) for sample dilution
4. 8-Channel Micropipettor with reagent reservoirs
5. Wash bottle, automated or semi-automated microtiter plate washing system
6. Microtiter plate reader capable of reading absorbance at 450 nm (reference wavelength 600-650 nm)
7. Bidistilled or deionised water
8. Paper towels, pipette tips and timer

9 PROCEDURE NOTES

1. Any improper handling of samples or modification of the test procedure may influence the results. The indicated pipetting volumes, incubation times, temperatures and pretreatment steps have to be performed strictly according to the instructions. Use calibrated pipettes and devices only.
2. Once the test has been started, all steps should be completed without interruption. Make sure that required reagents, materials and devices are prepared ready at the appropriate time. Allow all reagents and specimens to reach room temperature (18 °C - 25 °C) and gently swirl each vial of liquid reagent and sample before use. Mix reagents without foaming.
3. Avoid contamination of reagents, pipettes and wells/tubes. Use new disposable plastic pipette tips for each component and specimen. Do not interchange caps. Always cap not used vials. Do not reuse wells/tubes or reagents.
4. Use a pipetting scheme to verify an appropriate plate layout.
5. Incubation time affects results. All wells should be handled in the same order and time sequences. It is recommended to use an 8-channel Micropipettor for pipetting of solutions in all wells.



Revised 17 Sept. 2013 rm (Vers. 5.1)



6. Microplate washing is important. Improperly washed wells will give erroneous results. It is recommended to use a multichannel pipette or an automatic microplate washing system. Do not allow the wells to dry between incubations. Do not scratch coated wells during rinsing and aspiration. Rinse and fill all reagents with care. While rinsing, check that all wells are filled precisely with Wash Buffer, and that there are no residues in the wells.
7. Humidity affects the coated wells/tubes. Do not open the pouch until it reaches room temperature. Unused wells/tubes should be returned immediately to the resealed pouch including the desiccant.

10 PRE-TEST SETUP INSTRUCTIONS

10.1 Preparation of Components

- ⚠ The contents of the kit for 96 determinations can be divided into 3 separate runs.
The volumes stated below are for one run with 4 strips (32 determinations).

Dilute/ dissolve	Component		Diluent	Relation	Remarks	Storage	Stability
20 mL	WASHBUF CONC	200 mL	bidist. water	1:11	Warm up at 37 °C to dissolve crystals, if necessary. Mix vigorously.	2 °C - 8 °C	8 w

10.2 Dilution of Samples

Sample	to be diluted	with	Relation	Remarks
Serum / Plasma	generally	DILBUF	1:101	e.g. 5 µL + 500 µL DILBUF

Samples containing concentrations higher than the highest standard have to be diluted further.

11 TEST PROCEDURE

1. Pipette **100 µL** of each **Standard and diluted sample** into the respective wells of the Microtiter Plate. In the qualitative test only Standard B is used.
2. Cover plate with adhesive foil. Incubate **60 min** at **18 °C - 25 °C**.
3. Remove adhesive foil. Discard incubation solution. Wash plate **3 x** with **300 µL** of **diluted Wash Buffer**. Remove excess solution by tapping the inverted plate on a paper towel.
4. Pipette **100 µL** of **Enzyme Conjugate** into each well.
5. Cover plate with new adhesive foil. **Incubate 30 min** at **18 °C - 25 °C**.
6. Remove adhesive foil. Discard incubation solution. Wash plate **3 x** with **300 µL** of **diluted Wash Buffer**. Remove excess solution by tapping the inverted plate on a paper towel.
7. For adding of Substrate and Stop Solution use, if available, an 8-channel Micropipettor. Pipetting should be carried out in the same time intervals for Substrate and Stop Solution. Use positive displacement and avoid formation of air bubbles.
8. Pipette **100 µL** of **TMB Substrate Solution** into each well.
9. Incubate **20 min** at **18 °C - 25 °C** in the dark (without adhesive foil).
10. Stop the substrate reaction by adding **100 µL** of **TMB Stop Solution** into each well. Briefly mix contents by gently shaking the plate. Color changes from blue to yellow.
11. **Measure** optical density with a photometer at **450 nm** (Reference-wavelength: 600-650 nm) within **60 min** after pipetting of the Stop Solution.

12 QUALITY CONTROL

The test results are only valid if the test has been performed following the instructions. Moreover the user must strictly adhere to the rules of GLP (Good Laboratory Practice) or other applicable standards/laws. All standards/controls must be found within the acceptable ranges as stated on the QC Certificate. If the criteria are not met, the run is not valid and should be repeated. Each laboratory should use known samples as further controls.

It is recommended to participate at appropriate quality assessment trials.

In case of any deviation the following technical issues should be proven: Expiration dates of (prepared) reagents, storage conditions, pipettes, devices, incubation conditions and washing methods.



Revised 17 Sept. 2013 rm (Vers. 5.1)



13 CALCULATION OF RESULTS

The evaluation of the test can be performed either quantitatively or qualitatively.

13.1 Qualitative Evaluation

The Cut-off value is given by the optical density (OD) of the Standard B (Cut-off standard). The Cut-off index (COI) is calculated from the mean optical densities of the sample and Cut-off value. If the optical density of the sample is within a range of 20 % around the Cut-off value (grey zone), the sample has to be considered as borderline. Samples with higher ODs are positive, samples with lower ODs are negative.

For a quantification, the Cut-off index (COI) of the samples can be formed as follows:

$$COI = \frac{OD \text{ Sample}}{OD \text{ Standard B}}$$

13.2 Quantitative Evaluation

The obtained OD of the standards (y-axis, linear) are plotted against their concentration (x-axis, logarithmic) either on semi-logarithmic graph paper or using an automated method. A good fit is provided with cubic spline, 4 Parameter Logisites or Logit-Log.

For the calculation of the standard curve, apply each signal of the standards (one obvious outlier of duplicates might be omitted and the more plausible single value might be used).

The concentration of the samples can be read directly from the standard curve.

The initial dilution has been taken into consideration when reading the results from the graph. Results of samples of higher predilution have to be multiplied with the dilution factor.

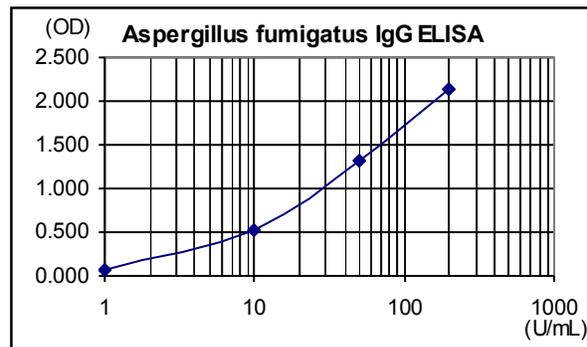
Samples showing concentrations above the highest standard to be diluted as described in PRE-TEST SETUP INSTRUCTIONS and reassayed.

have

Typical Calibration Curve

(Example. Do not use for calculation!)

Standard	U/mL	OD _{Mean}
A	1	0.06
B	10	0.52
C	50	1.31
D	200	2.14





DRG® Aspergillus fumigatus IgG ELISA (EIA-2501)



Revised 17 Sept. 2013 rm (Vers. 5.1)



14 INTERPRETATION OF RESULTS

Method	Range	Interpretation
Quantitative (Standard curve)	< 8 U/mL	negative
	8 - 12 U/mL	equivocal
	> 12 U/mL	positive
Qualitative (Cut-off Index, COI)	< 0.8	negative
	0.8 – 1.2	equivocal
	> 1.2	positive

The results themselves should not be the only reason for any therapeutical consequences. They have to be correlated to other clinical observations and diagnostic tests.

15 EXPECTED VALUES

In an in-house study, apparently healthy subjects showed the following results:

Ig Isotype	n	Interpretation		
		positive	equivocal	negative
IgG	88	12.5 %	6.8 %	80.7 %

16 LIMITATIONS OF THE PROCEDURE

Specimen collection has a significant effect on the test results. See SPECIMEN COLLECTION AND STORAGE for details.

For cross-reactivities, see PERFORMANCE.

Azide and thimerosal at concentrations > 0.1 % interfere in this assay and may lead to false results.

The following blood components do not have a significant effect (+/- 20 % of expected) on the test results up to the below stated concentrations:

Hemoglobin	8.0 mg/mL
Bilirubin	0.3 mg/mL
Triglyceride	5.0 mg/mL



Revised 17 Sept. 2013 rm (Vers. 5.1)



17 PERFORMANCE

Analytical Specificity (Cross Reactivity)	No cross-reactivities were found to:		Candida IgG		
Precision	Mean (U/mL)	CV (%)			
	Intra-Assay	47			9.9
	Inter-Assay	47			11.1
Linearity	Range (U/mL)	Serial dilution up to	Range (%)		
	2.6 – 33	1:8	74 - 114		
Recovery	87 – 97 %	% Recovery after spiking (n = 3)			
Method Comparison versus ELISA	Rel. Sensitivity		> 95 %		
	Rel. Specificity		> 95 %		



DRG® *Aspergillus fumigatus* IgG ELISA (EIA-2501)



Revised 17 Sept. 2013 rm (Vers. 5.1)



18 LITERATURE REFERENCES

1. Agarwal R, Allergic Bronchopulmonary Aspergillosis, *Chest* 135: 805-826 (2009)
2. Agin K, Seroprevalence of specific immunoglobulin G antibodies against aspergillus fumigatus among chronic persistent asthma, *Iranian Journal of Clinical Infectious Diseases* 2(2): 61-65 (2007)
3. Boeckh M, Höffken G, Lode H, The spectrum of pulmonary manifestations of aspergillosis, *Dtsch. Med. Wochenschr.* 114(44): 1706-9 (1989)
4. Gupta PR, Vyas A, Meena R C, Sharma S, Khayam N, Subramanian I M, Kanoongo D, Solanki V, Bansal A, Clinical profile of pulmonary aspergilloma complicating residual tubercular cavitations in Northern Indian patients, *Lung India* 27(4): 209-11 (2010)
5. Kousha M, Tadi R, Soubani AO, Pulmonary aspergillosis: a clinical review, *Eur. Respir. Rev.* 20(121): 156-74 (2011)
6. Kurup VP, Kumar A, Immunodiagnosis of aspergillosis *Clin. Microbiol. Rev.* 4(4): 439-56 (1991)
7. Latge J-P, *Aspergillus fumigatus* and Aspergillosis, *Clin. Microbiol. Rev.* 12(2): 310-350 (1999)
8. Patterson R, Greenberger PA, Halwig JM, Liotta L, Roberts M, Allergic bronchopulmonary aspergillosis: natural history and classification of early diagnosis by serologic and roentgenographic studies, *Arch. Intern. Med.* 146(5): 916-18 (1986)
9. Patterson R, Greenberger PA, Harris KE, Allergic bronchopulmonary aspergillosis, *Chest* 118(1): 7-8 (2000)
10. Patterson K, Streck ME, Allergic Bronchopulmonary Aspergillosis, *Proc. Am. Thorac. Soc.* 7: 237-244 (2010)
11. Rüchel R, Diagnosis of invasive mycoses in severely immunosuppressed patients, *Annals of Hematology* 67: 1-11 (1993)
12. Sarma UP, Kurup VP, Madan T, Immunodiagnosis of ABPA, *Frontiers in Bioscience* 8: 1187-1198 (2003)
13. Schaberg T, Mauch H, Lode H, The clinical picture and diagnosis of pulmonary mycoses, *Dtsch. Med. Wochenschr.* 117(44): 1681-84 (1992)
14. Zmeili OS, Soubani AO, Pulmonary aspergillosis: a clinical update, *QJ Med.* 100: 317-334 (2007)

Rev. 09/13/13cc