Anti-EBV-EA-D ELISA (IgA)
Test instruction

ORDER NO.	ANTIBODIES AGAINST	IG CLASS	SUBSTRATE	FORMAT
EI 2795-9601 A	Epstein-Barr virus early antigen diffuse (EBV-EA-D)	IgA	Ag-coated microplate wells	96 x 01 (96)

Indication: The ELISA test kit provides semiquantitative in vitro determination of human antibodies of the immunoglobulin class IgA against Epstein-Barr virus early antigen diffuse (EBV-EA-D) in serum or plasma to support the diagnosis of a nasopharyngeal carcinoma.

Application: The EUROIMMUN Anti-EBV-EA-D ELISA (IgA) is important for the early identification of nasopharynx carcinoma (NPC) which stimulates the production of IgA antibodies against capsid antigens (CA) and early antigens (EA) of Epstein-Barr virus and represents a useful supplement to the direct pathogen detection (PCR). Primary and past EBV infections can be reliably diagnosed by detection of antibodies of class IgG and/or IgM against EBV-CA and IgG against EBNA-1.

Principles of the test: The test kit contains microtiter strips each with 8 break-off reagent wells coated with EBV-EA-D. In the first reaction step, diluted patient samples are incubated in the wells. In the case of positive samples, specific IgA antibodies (also IgG and IgM) will bind to the antigens. To detect the bound antibodies, a second incubation is carried out using an enzyme-labelled anti-human IgA (enzyme conjugate) catalysing a colour reaction.

Contents of the test kit:

Description	Colour	Format	Symbol
1. Microplate wells coated with antigens 12 microplate strips each containing 8 individual break-off wells in a frame, ready for use	---	12 x 8	STRIPS
2. Calibrator (IgA, human), ready for use	dark red	1 x 2.0 ml	CAL
3. Positive control (IgA, human), ready for use	blue	1 x 2.0 ml	POS CONTROL
4. Negative control (IgA, human), ready for use	green	1 x 2.0 ml	NEG CONTROL
5. Enzyme conjugate peroxidase-labelled anti-human IgA (rabbit), ready for use	orange	1 x 12 ml	CONJUGATE
6. Sample buffer ready for use	light blue	1 x 100 ml	SAMPLE BUFFER
7. Wash buffer 10x concentrate	colourless	1 x 100 ml	WASH BUFFER 10x
8. Chromogen/substrate solution TMB/H_2O_2, ready for use	colourless	1 x 12 ml	SUBSTRATE
9. Stop solution 0.5 M sulphuric acid, ready for use	colourless	1 x 12 ml	STOP SOLUTION
10. Test instruction	---	1 booklet	
11. Quality control certificate	---	1 protocol	

LOT Lot description
IVD In vitro diagnostic medical device
CE
Storage temperature
Unopened usable until

Storage and stability: The test kit has to be stored at a temperature between +2°C and +8°C. Do not freeze. Unopened, all test kit components are stable until the indicated expiry date.

Waste disposal: Patient samples, calibrators, controls and incubated microplate strips should be handled as infectious waste. All reagents must be disposed of in accordance with local disposal regulations.

Preparation and stability of the reagents

Note: All reagents must be brought to room temperature (+18°C to +25°C) approx. 30 minutes before use. After first use, the reagents are stable until the indicated expiry date if stored at +2°C to +8°C and protected from contamination, unless stated otherwise below.

- **Coated wells:** Ready for use. Tear open the resealable protective wrapping of the microplate at the recesses above the grip seam. Do not open until the microplate has reached room temperature to prevent the individual strips from moistening. Immediately replace the remaining wells of a partly used microplate in the protective wrapping and tightly seal with the integrated grip seam (Do not remove the desiccant bag).
  Once the protective wrapping has been opened for the first time, the wells coated with antigens can be stored in a dry place and at a temperature between +2°C and +8°C for 4 months.

- **Calibrator and controls:** Ready for use. The reagents must be mixed thoroughly before use.

- **Enzyme conjugate:** Ready for use. The enzyme conjugate must be mixed thoroughly before use.

- **Sample buffer:** Ready for use.

- **Wash buffer:** The wash buffer is a 10x concentrate. If crystallisation occurs in the concentrated buffer, warm it to +37°C and mix well before diluting. The quantity required should be removed from the bottle using a clean pipette and diluted with deionised or distilled water (1 part reagent plus 9 parts distilled water).
  For example: For 1 microplate strip, 5 ml concentrate plus 45 ml water.
  The working strength wash buffer is stable for 4 weeks when stored at +2°C to +8°C and handled properly.

- **Chromogen/substrate solution:** Ready for use. Close the bottle immediately after use, as the contents are sensitive to light. ✳ The chromogen/substrate solution must be clear on use. Do not use the solution if it is blue coloured.

- **Stop solution:** Ready for use.

Warning: The calibrator and controls of human origin have tested negative for HBsAg, anti-HCV, anti-HIV-1 and anti-HIV-2. Nonetheless, all materials should be treated as being a potential infection hazard and should be handled with care. Some of the reagents contain sodium azide in non declarable concentration. Avoid skin contact.

Preparation and stability of the patient samples

Samples: Human serum or EDTA, heparin or citrate plasma.

Stability: Patient samples to be investigated can generally be stored at +2°C to +8°C for up to 14 days. Diluted samples should be incubated within one working day.

Sample dilution: Patient samples are diluted **1:101** sample buffer. For example: dilute 10 µl of sample in 1.0 ml sample buffer and mix well by vortexing (sample pipettes are not suitable for mixing).

NOTE: The calibrator and controls are prediluted and ready for use, do not dilute them.

Incubation

(Partly) manual test performance

Sample incubation: (1st step)
Transfer 100 µl of the calibrator, positive and negative controls or diluted patient samples into the individual microplate wells according to the pipetting protocol. Incubate for **30 minutes** at room temperature (+18°C to +25°C).

Washing:
Manual: Empty the wells and subsequently wash 3 times using 300 µl of working strength wash buffer for each wash.
Automatic: Wash the reagent wells 3 times with 450 µl working strength wash buffer (program setting: e.g. TECAN Columbus Washer "Overflow Mode").

Leave the wash buffer in each well for 30 to 60 seconds per washing cycle, then empty the wells. After washing (manual and automated tests), thoroughly dispose of all liquid from the microplate by tapping it on absorbent paper with the openings facing downwards to remove all residual wash buffer.

Note: Residual liquid (> 10 µl) remaining in the reagent wells after washing can interfere with the substrate and lead to false low extinction readings. Insufficient washing (e.g., less than 3 wash cycles, too small wash buffer volumes, or too short residence times) can lead to false high extinction readings.
Free positions on the microplate strip should be filled with blank wells of the same plate format as that of the parameter to be investigated.

Conjugate incubation: (2nd step)
Pipette 100 µl of enzyme conjugate (peroxidase-labelled anti-human IgA) into each of the microplate wells. Incubate for **30 minutes** at room temperature (+18°C to +25°C).

Washing:
Empty the wells. Wash as described above.

Substrate incubation: (3rd step)
Pipette 100 µl of chromogen/substrate solution into each of the microplate wells. Incubate for **15 minutes** at room temperature (+18°C to +25°C) (protect from direct sunlight).

Stopping:
Pipette 100 µl of stop solution into each of the microplate wells in the same order and at the same speed as the chromogen/substrate solution was introduced.

Measurement:
Photometric measurement of the colour intensity should be made at a wavelength of 450 nm and a reference wavelength between 620 nm and 650 nm **within 30 minutes of adding the stop solution**. Prior to measuring, slightly shake the microplate to ensure a homogeneous distribution of the solution.

Test performance using fully automated analysis devices

Sample dilution and test performance are carried out fully automatically using an analysis device. The incubation conditions programmed in the respective software authorised by EUROIMMUN may deviate slightly from the specifications given in the ELISA test instruction. However, these conditions were validated in respect of the combination of the EUROIMMUN Analyzer I, Analyzer I-2P or the DSX from Dynex and this EUROIMMUN ELISA. Validation documents are available on enquiry.
Automated test performance using other fully automated, open-system analysis devices is possible. However, the combination should be validated by the user.

Pipetting protocol

	1	2	3	4	5	6	7	8	9	10	11	12
A	**C**	**P 6**	**P 14**	**P 22**								
B	**pos.**	**P 7**	**P 15**	**P 23**								
C	**neg.**	**P 8**	**P 16**	**P 24**								
D	**P 1**	**P 9**	**P 17**									
E	**P 2**	**P 10**	**P 18**									
F	**P 3**	**P 11**	**P 19**									
G	**P 4**	**P 12**	**P 20**									
H	**P 5**	**P 13**	**P 21**									

The above pipetting protocol is an example of the **semiquantitative analysis** of antibodies in 24 patient samples (P 1 to P 24).

Calibrator (C), positive (pos.) and negative (neg.) control as well as the patient samples have been incubated in one well each. The reliability of the ELISA test can be improved by duplicate determinations of each sample.
The wells can be broken off individually from the strips. This makes it possible to adjust the number of test substrates used to the number of samples to be examined and minimises reagent wastage.
Both positive and negative controls serve as internal controls for the reliability of the test procedure. They should be assayed with each test run.

Calculation of results

The extinction value of the calibrator defines the upper limit of the reference range of non-infected persons (**cut-off**) recommended by EUROIMMUN. Values above the indicated cut-off are to be considered as positive, those below as negative.

Semiquantitative: Results can be evaluated semiquantitatively by calculating a ratio of the extinction of the control or patient sample over the extinction of the calibrator. Use the following formula to calculate the ratio:

$$\frac{\textbf{Extinction of the control or patient sample}}{\textbf{Extinction of calibrator}} = \textbf{Ratio}$$

EUROIMMUN recommends interpreting results as follows:

Ratio <0.8: **negative**
Ratio ≥0.8 to <1.1: **borderline**
Ratio ≥1.1: **positive**

For duplicate determinations the mean of the two values should be taken. If the two values deviate substantially from one another, EUROIMMUN recommends retesting the samples.

A negative serological result does not exclude an infection. Particularly in the early phase of an infection, antibodies may not yet be present or are only present in such small quantities that they are not detectable. In case of a borderline result, a secure evaluation is not possible. If there is a clinical suspicion and a negative test result, we recommend clarification by means of other diagnostic methods and/or the serological investigation of a follow-up sample. A positive result indicates that there has been contact with the pathogen. In the determination of pathogen-specific IgM antibodies, polyclonal stimulation of the immune system or antibody persistence may affect the diagnostic relevance of positive findings. Significant IgG titer increases (exceeding factor 2) and/or seroconversion in a follow-up sample taken after at least 7 to 10 days can indicate an acute infection. To investigate titer changes, sample and follow-up sample should be incubated in adjacent wells of the ELISA microplate within the same test run. For diagnosis, the clinical picture of the patient always needs to be taken into account along with the serological findings.

Test characteristics

Calibration: As no international reference serum exists for antibodies against EBV-EA-D, results are provided in the form of ratios which are a relative measure for the concentration of antibodies.

For every group of tests performed, the extinction readings of the calibrator and the ratios of the positive and negative controls must lie within the limits stated for the relevant test kit lot. A quality control certificate containing these reference values is included. If the values specified for the controls are not achieved, the test results may be inaccurate and the test should be repeated.

The binding activity of the antibodies and the activity of the enzyme used are temperature-dependent. It is therefore recommended using a thermostat in all three incubation steps. The higher the room temperature (+18°C to +25°C) during the incubation steps, the greater will be the extinction. Corresponding variations apply also to the incubation times. However, the calibrator is subject to the same influences, with the result that such variations will be largely compensated in the calculation of the result.

Antigen: The microplate wells were coated with the recombinant Epstein-Barr virus early antigen diffuse. The protein was expressed in E. coli and the molecular weight is 45 kDa.

Detection limit: The lower detection limit is defined as the mean value of an analyte-free sample plus three times the standard deviation and is the smallest detectable antibody titer. The lower detection limit of the Anti-EBV-EA-D ELISA (IgA) is ratio 0.11.

Cross reactivity: The quality of the antigen used ensures a high specificity of the ELISA. Sera from patients with infections caused by various agents were investigated with the Anti-EBV-EA-D ELISA (IgA).

Antibodies against	n	Anti-EBV-EA-D (IgA) positive
Adenovirus	10	0%
EBV-CA	10	0%
Enterovirus	10	0%
HEV	10	0%
HSV Pool	10	0%
Influenza A	10	0%
Influenza B	10	0%
Parainfluenza Pool	10	0%
RSV	10	0%
VZV	10	0%

Interference: Haemolytic, lipaemic and icteric samples showed no influence on the result up to a concentration of 10 mg/ml for haemoglobin, 20 mg/ml for triglycerides and 0.4 mg/ml for bilirubin in this ELISA.

Reproducibility: The reproducibility of the test was investigated by determining the intra- and inter-assay coefficients of variation (CV) using 3 samples. The intra-assay CVs are based on 20 determinations and the inter-assay CVs on 4 determinations performed on 6 different test runs.

Intra-assay variation, n = 20		
Sample	**Mean value (Ratio)**	**CV (%)**
1	1.9	3.8
2	2.5	8.0
3	5.7	7.5

Inter-assay variation, n = 4 x 6		
Sample	**Mean value (Ratio)**	**CV (%)**
1	1.9	5.1
2	2.4	6.0
3	5.5	5.2

Reference range: The levels of the anti-EBV-EA-D antibodies (IgA) were analysed with this EUROIMMUN ELISA in a panel of 500 healthy blood donors. With a cut-off ratio of 1.0, 4.8% of the blood donors were anti-EBV-EA-D positive (IgA).

Clinical significance

Epstein-Barr virus (EBV) is one of the most widely distributed human-pathogenic herpes viruses. The virus is transmitted by smear infection, but also by blood transfusions or organ transplants. EBV is the causative agent of infectious mononucleosis (Pfeiffer's disease), a febrile disease usually accompanied by pharyngitis and lymphadenopathy, frequently by hepatosplenomegaly and more rarely by an exanthema. When first infection occurs in childhood the disease often proceeds without symptoms. In industrial countries mainly adolescents or young adults become infected, often leading to manifest disease. EBV infections are also found in connection with the pathogenesis of malignant lymphoma (endemic form of Burkitt's lymphoma in Africa), nasopharyngeal carcinoma (NPC, especially widespread in South-East Asia). NPC is the third most frequent malignant tumour in southern China. Since 2011 the evidence has been increasing that EBV infection is associated with a high risk of multiple sclerosis (MS) or an aggravation of MS.

The main goal of EBV diagnostics in people with a healthy immune system is to differentiate between an acute and a past infection. Various serological methods are used for this. The immune system of healthy persons can quickly suppress a reactivation of the virus. However, in immunosuppressed patients (e.g. those on immunosuppressive therapy after organ transplantation or with an HIV infection) EBV can spread uncontrollably and cause severe lymphoproliferative diseases. In such cases it is diagnostically very important to also determine the viral load, for which PCR (polymerase chain reaction) is normally used.

Infectious mononucleosis must be differentiated from cytomegalic inclusion body disease and toxoplasmosis and, in the case of atypical progress, also from HIV or other infections.

In pregnancy, EBV can cause infection of the placenta, leading to damage to the foetal heart, eyes and liver. In children, accompanying infections of the kidney have been observed with symptoms from microscopic haematuria to acute kidney failure.

The immune response to an EBV infection is characterised by successive formation of antibodies against EBV capsid, EBV nuclear and EBV early antigens.

In the early phase of the disease IgM and IgG antibodies against the viral capsid antigen (CA) can be detected. A positive Anti-EBV-CA (IgM) result is the classical marker of acute infection. IgG antibodies against early antigen are produced later in the acute phase and decrease to a non-detectable level after three to six months. Anti-CA IgG antibody levels persist lifelong. Around six to eight weeks after infection, antibodies against EBNA are produced. The presence of anti-EBNA antibodies indicates a past infection.

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