



AccuDiag™ Dengue IgG ELISA Kit

REF 8116-P2

IVD See External Label 2°C 96 Tests

Dengue IgG ELISA	
Principle	Indirect ELISA
Detection	Qualitative
Sample	10 µL serum/plasma
Incubation Time	40 minutes
Sensitivity	85.9%
Specificity	100%
Shelf Life	12 Months from the manufacturing date

PRODUCT FEATURES

- Very easy to use with little training
- Highly specific and consistent Assay
- Provides accurate results quickly
- Reading of results both visually and as absorbance data

INTENDED USE

The Dengue Virus ELISA (IgG and IgM) is suitable for the serological detection of an acute or a past dengue virus infection and supplements direct pathogen detection e.g. with the Dengue Virus NS1 ELISA. Seroconversion or a significant increase in the IgG antibody titer indicates an acute infection. Furthermore, the determination of specific antibodies is relevant for epidemiological studies.

SIGNIFICANCE AND SUMMARY

Dengue virus (DENV) is an arbovirus of the genus Flavivirus belonging to the Flaviviridae family. The virus is divided into four related but genetically differing serotypes (DENV 1 to 4) (1, 2). Vectors of DENV are mosquitoes of the

genus Aedes; primates and, most of all, humans are the reservoir hosts [3]. DENV can be transmitted via blood transfusions [4] and vertically [5]. Human-to-human transmission has not yet been observed.

The frequency of dengue fever (DF) has dramatically increased worldwide over the past decades. According to recent estimations there are 390 million dengue virus infections per year, of which 96 million show clinical manifestations [6]. DENV is endemic in more than 100 countries, especially in tropical and subtropical regions. The virus has spread in South East Asia, North and South America, the West Pacific, Africa and the eastern Mediterranean region via continuing outbreaks [1].

DENV infections can either be subclinical or cause a broad spectrum of clinical symptoms, ranging from a mild febrile disease and classic dengue fever (DF) to even lethal haemorrhagic fever (DHF) or dengue shock syndrome (DSS) [7]. After an incubation period of 4 to 7 days DF manifests suddenly with high fever, headache and retrobulbar and lumbosacral pains. These are followed by generalised muscle and joint pains that increase in intensity. Further symptoms include a macular exanthema that spreads from the trunk to the arms, legs and face, anorexia, nausea, vomiting, weakness and dizziness. The temperature curve is often biphasic. After a temporary decline of the fever, it rises again after 1 to 2 days and is accompanied by an exanthema of the entire body, excluding the face [7, 8, 9, 10].

DHF initially shows as DF, but the high fever generally persists for more than 2 to 7 days [8, 9]. In 10 to 15% of cases clinically relevant haemorrhage can be observed; gastrointestinal and cerebral bleeding can be life-threatening. Progression to DSS is very rapid [8].

The lethality of DHF and DSS is 6 to 30%, with particularly high rates in small children. Infection confers a life-long serotype-specific immunity. The course is generally more severe in secondary infection with a different serotype [10, 11, 12].

DF should be differentiated diagnostically from other flavivirus infections, such as Zika or yellow fever, as well as chikungunya fever, leptospirosis, malaria, measles, rubella and typhoid fever [2, 7, 10, 12].

Detection of viral RNA or the virus itself, for instance, in serum or plasma is only possible during the viraemic phase in the first 4 to 5 days after onset of the disease using RT-PCR, virus isolation or culturing [2]. The highly specific non-structural protein NS1 of DENV can be detected in the serum of patients generally from onset of clinical symptoms to day 9 in primary and secondary infections [13].

DENV-specific IgM antibodies can mostly be detected 4 to 5 days after onset of symptoms [1, 12, 13]. Seroconversion or a significant titer increase in a follow-up sample taken at least 2 to 3 weeks later also indicates an acute infection [12]. During secondary infection, the IgG antibody titer increases rapidly and remains at a high level even in the acute phase of the disease. The IgM level can be significantly lower in secondary than in primary infection and may not be detectable at all in some cases [1, 14].

Possible cross-reactions with antibodies (due to infection or vaccination) against other flaviviruses, such as Zika, West Nile, Japanese encephalitis, yellow fever or TBE viruses, should be taken into consideration when interpreting results [1, 2].

There is no specific antiviral medication for the treatment of DENV infections. Beside the prevention of mosquito bites, a vaccine has been available for prophylaxis in many endemic countries since 2016. This protects from infection with all four DENV types [8, 15].

ASSAY PRINCIPLE

The test kit contains microplate strips each with 8 break-off reagent wells coated with purified dengue virus antigens. In the first reaction step, diluted patient samples are incubated in the wells. In the case of positive samples, specific IgG antibodies (also IgA and IgM) will bind to the antigens. To detect



the bound antibodies, a second incubation is carried out using an enzyme-labelled anti-human IgG (enzyme conjugate) catalysing a colour reaction.

SPECIMEN PREPARATION & STABILITY

- Samples:** Human serum or EDTA, heparin 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 in sample buffer. For example: dilute 10 µl sample in 1.0 ml sample buffer and mix well by vortexing (sample pipettes are not suitable for mixing). NOTE: The calibrators and controls are prediluted and ready for use, do not dilute them.
- For semiquantitative analysis incubate calibrator 2 along with the positive and negative controls and patient samples. For quantitative analysis incubate calibrators 1, 2 and 3 along with the positive and negative controls and patient samples.

REAGENTS

Materials provided with the kit

Component	Color	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 1 200 RU/ml (IgG, human), ready for use	Dark Red	1 x 2.0 ml	CAL 1
3. Calibrator 2 20 RU/ml (IgG, human), ready for use	Red	1 x 2.0 ml	CAL 2
4. Calibrator 3 2 RU/ml (IgG, human), ready for use	Light Red	1 x 2.0 ml	CAL 3
5. Positive Control (IgG, human), ready for use	Blue	1 x 2.0 ml	POS CONTROL
6. Negative Control (IgG, human), ready for use	Green	1 x 2.0 ml	NEG CONTROL
7. Enzyme Conjugate Peroxidase-labelled anti-human IgG (rabbit), ready for use	Green	1 x 12 ml	CONJUGATE
8. Sample buffer ready for use	Light Blue	1 x 100 ml	SAMPLE BUFFER
9. Wash buffer 10x concentrate	Colorless	1 x 100 ml	WASH BUFFER 10x
10. Chromogen/substrate solution TMB/H ₂ O ₂ , ready to use	Colorless	1 x 12 ml	SUBSTRATE
11. Stop solution 0.5 M sulfuric acid, ready to use	Colorless	1 x 12 ml	STOP SOLUTION
12. Test instruction	---	1 booklet	
13. Certificate of Analysis	---	1 protocol	

Materials required but not provided

- Micropipettes
- Squeeze bottle for washing strips (narrow tip is recommended)
- Reagent grade (DI) water
- Graduated cylinder
- Tubes for sample dilution
- Absorbent paper
- ELISA plate reader with a 450 nm and a 620-650 nm filter (optional if results are read visually)

REAGENT PREPARATION & STABILITY

Note: All reagents must be brought to room temperature (+18°C to +25°C) approx. 30 minutes before use. The reagents can be kept unopened until the specified expiration date if stored at +2°C to +8°C. After opening for the first time, they must still be stored at +2°C to +8°C and protected against contamination. The following table lists the stability of the reagents after first opening. These storage life limits only apply if the indicated storage life is not exceeded

Reagents	Stability
Coated wells	4 months
Calibrators	12 months
Controls	12 months
Enzyme conjugate	12 months
Sample buffer	12 months
Diluted wash buffer	4 weeks
Chromagen/substrate solution	12 months
Stop solution	12 months

- 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).
- 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 deionized or distilled water (1 part reagent plus 9 parts distilled water). For example: For 1 microplate strip, 5 ml concentrate plus 45 ml water.
- Chromagen/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.



ASSAY PROCEDURE

(Partly) Manual Test Performance

Sample incubation:

Transfer 100 µl of the calibrator, positive and negative controls or diluted patient samples into the individual microplate well 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:

Pipette 100 µl of enzyme conjugate (peroxidase- labelled anti-human IgG) 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:

Pipette 100 µl of chromagen/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 DAI may deviate slightly from the specifications given in the ELISA instructions for use. However, these conditions were validated in respect of the combination of the DAI Analyzer I and the DAI Analyzer I-2P and this DAI 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	C2	P 6	P 14 P 22	P 23			C 1	P 4	P 12 P 20			
B	Pos.	P 7	P 15 P 23	P 24			C 2	P 5	P 13 P 21			
C	Neg.	P 8	P 16 P 24				C 3	P 6	P 14 P 22			
D	P 1	P 9	P 17				Pos.	P 7	P 15 P 23			
E	P 2	P 10	P 18				Neg.	P 8	P 16 P 24			
F	P 3	P 11	P 19				P 1	P 9	P 17			
G	P 4	P 12	P 20				P 2	P 10	P 18			
H	P 5	P 13	P 21				P 3	P 11	P 19			

The pipetting protocol for microplate strips 1 to 4 is an example for the semiquantitative analysis of 24 patient samples (P 1 to P 24).

The pipetting protocol for microplate strips 7 to 10 is an example for the quantitative analysis of 24 patient samples (P 1 to P 24).

The calibrators (C 1 to C 3), the positive (pos.) and negative (neg.) controls, and the patient samples have each been incubated in one well. The reliability of the ELISA test can be improved by duplicate determinations for 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 minimizes 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.

RESULTS

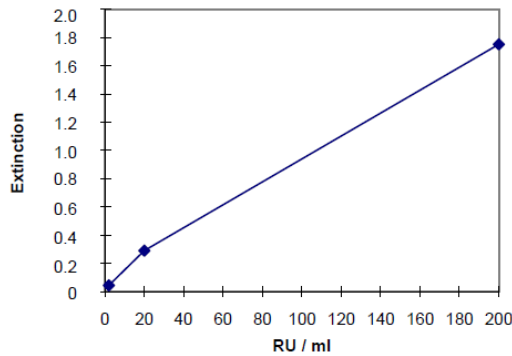
Semiquantitative: Results can be evaluated semiquantitatively by calculating a ratio of the extinction of the control or patient sample over the extinction of the calibrator 2. Calculate the ratio according to the following formula:

$$\frac{\text{Extinction of the control or patient sample}}{\text{Extinction of calibrator 2}} = \text{Ratio}$$

DAI recommends interpreting results as follows:

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

Quantitative: The standard curve from which the concentration of antibodies in the patient samples can be taken is obtained by point-to-point plotting of the extinction readings measured for the 3 calibration sera against the corresponding units (linear/linear). Use "point-to-point" plotting for calculation of the standard curve by computer. The following plot is an example of a typical calibration curve. Please do not use this curve for the determination of antibody concentrations in patient samples.



If the extinction for a patient sample lies above the extinction of calibrator 1 (corresponding to 200 RU/ml), the result should be reported as ">200 RU/ml". It is recommended that the sample be re-tested in a new test run at a dilution of e.g. 1 :400. The result in RU/ml read from the calibration curve for this sample must then be multiplied by factor 4.

The upper limit of the normal range of non-infected persons (**cut-off value**) recommended by DAI is **20 relative units (RU)/ml**. DAI recommends interpreting results as follows:

<16 RU/ml: **negative**
 ≥16 to <22 RU/ml: **borderline**
 ≥22 RU/ml: **positive**

For duplicate determinations the mean of the two values should be taken. If the two values deviate substantially from one another, DAI 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.

PERFORMANCE CHARACTERISTICS

Calibration: As no international reference serum exists for antibodies against dengue virus, the calibration is performed in relative units (RU).

For every group of tests performed, the readings of the calibrators and the relative units and/or ratios determined for 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 values. Corresponding variations apply also to the incubation times. However, the calibrators are subject to the same influences, with the result that such variations will be largely compensated in the calculation of the result.

Antigen: The antigen source is provided by dengue virus type 2 cultured in Vero cells. The microplate wells were coated with highly purified virus particles. Due to the high structural similarity of dengue virus types 1 to 4 the use of a single virus type is sufficient for the reliable detection of antibodies against all four virus types.

Linearity: The linearity of the Anti-Dengue Virus ELISA (IgG) was determined by assaying at least 4 serial dilutions of different patient samples. The Anti-Dengue Virus ELISA (IgG) is linear at least in the tested concentration range (9 RU/ml to 184 RU/ml).

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-Dengue Virus ELISA (IgG) is 0.6 RU/ml.

Cross-reactivity: The quality of the antigen used ensures a high specificity of the ELISA. Due to the high homologies of the target antigen within the genus of flaviviruses, cross-reactions cannot be completely ruled out. To check the cross-reactivity, sera from patients after vaccination with TBE vaccines and from patients with HCV, West Nile virus or Zika virus infections were investigated. Pronounced cross-reactivities exist mainly with anti-Zika virus IgG and anti-West Nile virus IgG antibodies. However, it should also be taken into account that double infections are possible, especially in endemic regions, or that an infection with another flavivirus may have occurred earlier. Positive findings in these cases do not result from cross-reactivity of the respective antibodies.

Antibodies against	n	Anti-Dengue Virus Elisa (IgG) positive Genus: Flavivirus
Hepatitis C virus (HCV)	20	0%
TBE virus	124	25.8%
West Nile virus (WNV)	53	75.5%
Zika virus (ZIKV)	133	100%

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 in 6 different test runs.

Intra-assay variation, n = 20		
Sample	Mean value (ratio)	CV (%)
1	90	4.7
2	113	4.5
3	114	4.4

Inter-assay variation, n = 4 x 6		
Sample	Mean value (ratio)	CV (%)
1	93	5.5
2	115	4.3
3	120	5.6



Sensitivity and specificity:

Study I: 64 clinically pre-characterised patient samples (INSTAND) were investigated with the DAI Anti-Dengue Virus ELISA (IgG). The sensitivity amounted to 100%, with a specificity of 100%.

n = 64		INSTAND		
		Positive	Borderline	Negative
DAI Anti-Dengue Virus ELISA (IgG)	Positive	35	0	1
	Borderline	0	0	1
	Negative	0	0	29

Study II: 261 pre-characterised patient samples (origin: Europe; reference method: commercially available ELISA of another manufacturer) were investigated with the DAI Anti-Dengue Virus ELISA (IgG). The sensitivity amounted to 98.5%, with a specificity of 95.7%. Borderline results were not included in the calculation.

n = 261		ELISA of another manufacturer		
		Positive	Borderline	Negative
DAI Anti-Dengue Virus ELISA (IgG)	Positive	65	0	8
	Borderline	3	2	0
	Negative	1	2	180

Study III: In another study, 23 samples from patients from a DENV-endemic region (origin: Vietnam) and 23 samples from returned European travellers (origin: Germany) were investigated. The first sample of these patients had been confirmed to be dengue-virus positive using direct detection. Due to this positive pre-characterisation, the follow-up samples were used for sensitivity determination. When considering both immunoglobulin classes (IgG and IgM), the sensitivity of the ELISAs was 100% (IgG 97.8%, IgM 73.8%). Borderline results were excluded from the calculation.

It should be taken into account that patients who have already been in contact with a flavivirus (infection or vaccination) and come into contact with a flavivirus again (secondary flavivirus infection) may produce only small or undetectable amounts of specific IgM antibodies. This means that even if there is an acute infection, no specific IgM antibodies may be detected.

Reference range: The levels of anti-dengue virus antibodies (IgG) were analysed with this DAI ELISA in a panel of 500 healthy blood donors. With a cut-off of 20 RU/ml, 0.8% of the blood donors were anti-dengue virus positive (IgG). This can also be ascribed to cross reactivities (e.g. antibodies against TBE received through vaccination, see paragraph cross reactivity).

STORAGE CONDITIONS

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.

PRECAUTIONS

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 a non-declarable concentration. Avoid skin contact.

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.

REFERENCES

- Sundaram AK, Lee CRR, Wu SJL **Review of Current Laboratory Diagnostics for Dengue Fever.** Clin Res Infect Dis. 3(5) (2016) 1044-1050
- WHO. **Dengue: guidelines for diagnosis, treatment, prevention and control - New edition.** World Health Organization Geneva (2009)
- Moncayo AC, Fernandez Z, Ortiz D, Diallo M, Sall A, Hartman S, et al. **Dengue Emergence and Adaptation to Peridomestic Mosquitoes.** Emerg Infect Dis. 10(10) (2004) 1790-1796
- Ribas-Silva RC, Eid AA. **Dengue antibodies in blood donors.** Rev Bras Hematol Hemoter. 34(3)(2011) 193-195
- Chye JK, Lim CT, Ng KB, Lim JMH, George R, Lam SK. **Vertical Transmission of Dengue.** Clin Inf Dis. 25(6) (1997) 1374-1377
- Bhatt S, Gething PW, Brady OJ, Messina JP, Farlow AW, Moyes CL, et al. **The global distribution and burden of dengue.** Nature 496(7 446) (2013) 504-507
- Guzman MG, Kouri G. **Dengue diagnosis, advances and challenges.** Int J Inf Dis. 8 (2004) 69-80
- Doerr HW, Gerlich WH. **Medizinische Virologie - Flaviviren.** Georg Thieme Verlag (2010) Kap. 38, 380-396
- Kalayanarooj S. **Clinical Manifestations and Management of Dengue/DHF/DSS.** Trap Med Int Health 39 (4) (2011) 83-87
- Steckbriefe seltener und importierter Infektionskrankheiten - Dengue-Fieber.** Robert-Koch-Institut, Berlin (2011) Kap. 1.2, 10-11
- Pancharoen C, Mekmullica J, Thisyakorn U. **Primary dengue infection: What are the clinical distinctions from secondary infection?** Southeast Asian J Trap Med Public Health 32 (2001) 476-480
- Gubler DJ. **Dengue and dengue hemorrhagic fever.** Clin Microbiol Rev 11 (3) (1998) 480-496
- Alcon S, Talarmin A, Debryne M, Falconar A, Deubel V, Flamand M. **Enzyme-linked immunosorbent assay specific to Dengue virus type 1 nonstructural protein NS1 reveals circulation of the antigen in the blood during the acute phase of disease in patients experiencing primary or secondary infections.** J Clin Microbiol 40(2) (2002) 376-381
- Chanama S, Anantapreecha S, A-nuegoonpipat A, Sa-gnasang A, Kurane I, Sawanpanyalert P. **Analysis of specific IgM responses in secondary dengue virus infections: levels and positive rates in comparison with primary infections.** J Clin Vir 31 (2004) 185-189
- Aguiar M, Stollenwerk N, Halstead SB. **The Impact of the Newly Licensed Dengue Vaccine in Endemic Countries.** PLoS Negl Trap Dis 21 (2016) 1-23



MANUFACTURER AND BRAND DETAILS

ISO 13485:2016



ISO 13485
Quality
Management for
Medical Devices
CERTIFIED



Diagnostic Automation/Cortez Diagnostics, Inc.
21250 Califa Street, Suite 102 and 116,
Woodland Hills, California 91367 USA

Date Adopted	2023-09
Brand Name	AccuDiag™
REF 8116-P2	AccuDiag™ - Dengue IgM ELISA
EC REP	CEpartner4U, Esdoornlaan 13, 3951 DB Maarn, The Netherlands www.cepartner4u.eu
Revision Date: 2019-05-03	