



MAGLUMI® Anti-PR3 IgG (CLIA)

INTENDED USE

The kit is an *in vitro* chemiluminescence immunoassay for the quantitative determination of Anti-PR3 IgG (PR3 IgG) in human serum and plasma using the MAGLUMI series Fully-auto chemiluminescence immunoassay analyzer and Biolumi series Integrated System, and the assay is used for an aid in the diagnosis of individuals with suspected or confirmed granulomatosis with polyangiitis (GPA, formerly: Wegener's granulomatosis(WG)) and other anti-neutrophil cytoplasmic antibody (ANCA) associated vasculitis and assessment of disease activity in individuals with confirmed GPA and other ANCA associated vasculitis.

SUMMARY

Anti-neutrophil cytoplasmic antibodies (ANCA) are predominantly IgG autoantibodies against many cytoplasmic antigens of neutrophils and monocytes^{1, 2}. By indirect immunofluorescence, ANCA can be divided into two types: cytoplasmic anti-neutrophil cytoplasmic antibodies (C-ANCA) and perinuclear anti-neutrophil cytoplasmic antibodies (P-ANCA). The target antigen of C-ANCA is mainly protease 3 (PR3), and the target antigen of P-ANCA is mainly myeloperoxidase (MPO)^{1, 3}. ANCA associated vasculitis (AAV) is a group of autoimmune small vasculitis⁴. Its etiology and pathogenesis have not been fully studied. It is suggested that genetic factors may be the pathogenesis of AAV, while environmental factors such as infection, drugs and inhalation of harmful chemicals are the important inducements⁵⁻⁷. AAV mainly includes microscopic polyangiitis (MPA), granulomatosis with polyangiitis (GPA, formerly known as Wegener's granulomatosis (WG)) and eosinophilic granulomatosis with polyangiitis (EGPA)⁸. AAV is necrotizing vasculitis and its histopathology is characterized by inflammation of the blood vessel wall and fibrinoid necrosis, which eventually damage kidney and other organs^{3, 9}. In WG, PR3-ANCA are crucial in the development of generalized vasculitis¹⁰. PR3-ANCA is thought to be present in 80–95% of GPA cases with the remaining 5–20% exhibiting atypical MPO-ANCA positivity or no ANCA¹¹. Revised 2017 international consensus recommend PR3-ANCA and MPO-ANCA as a high-quality immunoassays aimed at the detection of the ANCA serotype¹². In conclusion, ANCA have been recognized as an important biomarker to aid diagnosis in patients with AAV¹³. Though the mechanism of action of ANCA is still under exploration, ANCA serology is being increasingly used for classification of AAV and revealed in defining various disease subsets associated with different genetic background, clinical features, treatment response, and prognosis¹³.

TEST PRINCIPLE

Indirect chemiluminescence immunoassay. The prediluted sample, buffer, magnetic microbeads coated with PR3 antigen are mixed thoroughly, incubating and performing a wash cycle after a precipitation in a magnetic field. ABEI labeled with anti-human IgG monoclonal antibody are then added and incubated, reacting to form immuno-complexes. After precipitation in a magnetic field, the supernatant is decanted and then a wash cycle is performed. Subsequently, the Starter 1+2 are added to initiate a chemiluminescent reaction. The light signal is measured by a photomultiplier as relative light units (RLUs), which is proportional to the concentration of Anti-PR3 IgG present in the sample.

REAGENTS

Kit Contents			
Component	Description	100 tests/kit	50 tests/kit
Magnetic Microbeads	Magnetic microbeads coated with PR3 antigen (~2.00 µg/mL) in Tris buffer, NaNa ₃ (<0.1%).	2.5 mL	1.5 mL
Calibrator Low	A low concentration of PR3 IgG in PBS buffer, NaNa ₃ (<0.1%).	1.0 mL	1.0 mL
Calibrator High	A high concentration of PR3 IgG in PBS buffer, NaNa ₃ (<0.1%).	1.0 mL	1.0 mL
Buffer	BSA, NaNa ₃ (<0.1%).	17.5 mL	9.5 mL
ABEI Label	ABEI labeled with anti-human IgG monoclonal antibody (~16.7 ng/mL) in Tris-HCl buffer, NaNa ₃ (<0.1%).	22.5 mL	12.0 mL
Diluent	PBS buffer, NaNa ₃ (<0.1%).	25.0 mL	13.5 mL
Control 1	A low concentration of PR3 IgG (10.0 AU/mL) in PBS buffer, NaNa ₃ (<0.1%).	1.0 mL	1.0 mL
Control 2	A high concentration of PR3 IgG (100 AU/mL) in PBS buffer, NaNa ₃ (<0.1%).	1.0 mL	1.0 mL
All reagents are provided ready-to-use.			

Warnings and Precautions

- For *in vitro* diagnostic use.
- For professional use only.
- Exercise the normal precautions required for handling all laboratory reagents.
- Personal protective measures should be taken to prevent any part of the human body from contacting samples, reagents, and controls, and should comply with local operating requirements for the assay.
- A skillful technique and strict adherence to the package insert are necessary to obtain reliable results.
- Do not use kit beyond the expiration date indicated on the label.
- Do not interchange reagent components from different reagents or lots.
- Avoid foam formation in all reagents and sample types (specimens, calibrators and controls).
- All waste associated with biological samples, biological reagents and disposable materials used for the assay should be considered potentially infectious and should be disposed of in accordance with local guidelines.
- This product contains sodium azide. Sodium azide may react with lead or copper plumbing to form highly explosive metal azides. Immediately after disposal, flush with a large volume of water to prevent azide build-up.
- The safety data sheet is available on request.

Note: If any serious incident has occurred in relation to the device, please report to Shenzhen New Industries Biomedical Engineering Co., Ltd. (Snibe) or our authorized representative and the competent authority of the Member State in which you are established.

Reagent Handling

- To avoid contamination, wear clean gloves when operating with a reagent kit and sample. When handling reagent kit, replace the gloves that have been in contact with samples, since introduction of samples will result in unreliable results.
- Do not use kit in malfunction conditions; e.g., the kit leaking at the sealing film or elsewhere, obviously turbid or precipitation is found in reagents (except for Magnetic Microbeads) or control value is out of the specified range repeatedly. When kit in malfunction conditions, please contact Snibe or our authorized distributor.
- To avoid evaporation of the liquid in the opened reagent kits in refrigerator, it is recommended that the opened reagent kits to be sealed with reagent seals contained within the packaging. The reagent seals are single use, and if more seals are needed, please contact Snibe or our authorized distributor.
- Over time, residual liquids may dry on the septum surface. These are typically dried salts and have no effect on assay efficacy.
- Do not transfer opened reagents between instruments.
- For magnetic microbeads mixing instructions, refer to the Preparation of the Reagent section of this package insert.
- For further information about the reagent handing during system operation, please refer to Analyzer Operating Instructions.

Storage and Stability

- Do not freeze the integral reagents.
- Store the reagent kit upright to ensure complete availability of the magnetic microbeads.
- Protect from direct sunlight.



130217031M:100 tests/kit
130617031M: 50 tests/kit

Stability of the Reagents	
Unopened at 2-8°C	until the stated expiration date
Opened at 2-8°C	6 weeks
On-board	4 weeks

Stability of Controls	
Unopened at 2-8°C	until the stated expiration date
Opened at 10-30°C	8 hours
Opened at 2-8°C	6 weeks
Frozen at -20°C	3 months
Frozen and thawed cycles	no more than 3 times

SPECIMEN COLLECTION AND PREPARATION

Specimen Types

Only the specimens listed below were tested and found acceptable.

Specimen Types	Collection Tubes
Serum	Tubes without additive, or tubes containing clot activator or clot activator with gel
Plasma	K2-EDTA, Li-heparin or Na-heparin

- The sample types listed were tested with a selection of sample collection tubes that were commercially available at the time of testing, i.e. not all available tubes of all manufacturers were tested. Sample collection systems from various manufacturers may contain differing materials which could affect the test results in some cases. Follow tube manufacturers' instructions carefully when using collection tubes.

Specimen Conditions

- Do not use heat-inactivated samples or grossly hemolyzed/hyperlipidaemia specimens and specimens with obvious microbial contamination.
- Ensure that complete clot formation in serum specimens has taken place prior to centrifugation. Some serum specimens, especially those from patients receiving anticoagulant or thrombolytic therapy, may exhibit increased clotting time. If the serum specimen is centrifuged before a complete clotting, the presence of fibrin may cause erroneous results.
- Samples must be free of fibrin and other particulate matter.
- To prevent cross contamination, use of disposable pipettes or pipette tips are recommended.

Preparation for Analysis

- Inspect all specimens for foam. Remove foam with an applicator stick before analysis. Use a new applicator stick for each specimen to prevent cross contamination.
- Frozen specimens must be completely thawed before mixing. Mix thawed specimens thoroughly by low speed vortexing or by gently inverting. Visually inspect the specimens. If layering or stratification is observed, mix until specimens are visibly homogeneous. If specimens are not mixed thoroughly, inconsistent results may be obtained.
- For reliable results, specimens should be free of fibrin, red blood cells, or other particulate matter. Specimens must be centrifuged prior to testing, transfer clarified specimen to a sample cup or secondary tube for testing. For centrifuged specimens with a lipid layer, transfer only the clarified specimen and not the lipemic material.
- The sample volume required for a single determination of this assay is 20 µL.

Specimen Storage

Specimens removed from the separator, red blood cells or clot may be stored up to 6 hours at 10-30°C or 7 days at 2-8°C, or 3 months frozen at -20°C. Frozen specimens subjected to up to 3 freeze/thaw cycles have been evaluated.

Specimen Shipping

- Package and label specimens in compliance with applicable local regulations covering the transport of clinical specimens and infectious substances.
- Do not exceed the storage limitations listed above.

Specimen Dilution

- Samples, with PR3 IgG concentrations above the analytical measuring interval, can be diluted with Diluent either by following automated dilution protocol or manual dilution procedure. The recommended dilution ratio is 1:10(sample volume:total volume). The concentration of the diluted sample must be >40 AU/mL.
- For manual dilution, multiply the result by the dilution factor. For dilution by the analyzers, the analyzer software automatically takes the dilution into account when calculating the sample concentration.

PROCEDURE

Materials Provided

Anti-PR3 IgG (CLIA) assay, control barcode labels.

Materials Required (But Not Provided)

- General laboratory equipment.
- Fully-auto chemiluminescence immunoassay analyzer Maglumi 600, Maglumi 800, Maglumi 2000, Maglumi 2000 Plus, Maglumi 4000 Plus, MAGLUMI X3, MAGLUMI X6, MAGLUMI X8, MAGLUMI X10 or Integrated System Biolumi CX8.
- For Reaction Module, Starter 1+2, Wash Concentrate, Light Check, Tip and Reaction Cup, please refer to corresponding Analyzer Operating Instructions for catalogue number.
- Please use accessories specified by Snibe to ensure the reliability of the test results.

Assay Procedure

Preparation of the Reagent

- Take the reagent kit out of the box and visually inspect the integral vials for leaking at the sealing film or elsewhere. If there is no leakage, please tear off the sealing film carefully.
- Open the reagent area door; hold the reagent handle to get the RFID label close to the RFID reader (for about 2s); the buzzer will beep; one beep sound indicates successful sensing.
- Keeping the reagent straight insert to the bottom along the blank reagent track.
- Observe whether the reagent information is displayed successfully in the software interface, otherwise repeat the above two steps.
- Resuspension of the magnetic microbeads takes place automatically when the kit is loaded successfully, ensuring the magnetic microbeads are totally resuspended homogenous prior to use.

Assay Calibration

- Select the assay to be calibrated and execute calibration operation in reagent area interface. For specific information on registering calibrations, refer to the calibration section of Analyzer Operating Instructions.
- Execute recalibration according to the calibration interval required in this package insert.

Quality Control

- When new lot used, check or edit the quality control information.
- Scan the control barcode, choose corresponding quality control information and execute testing. For specific information on registering quality controls, refer to the quality control section of the Analyzer Operating Instructions.

Sample Testing

After successfully loading the sample, select the sample in interface and edit the assay for the sample to be tested and execute testing. For specific information on registering samples, refer to the sample section of the Analyzer Operating Instructions.

To ensure proper test performance, strictly adhere to Analyzer Operating Instructions.

Calibration

Traceability: This method has been standardized against the Snibe internal reference standard.
Test of assay specific calibrators allows the detected relative light unit (RLU) values to adjust the master curve.
Recalibration is recommended as follows:

- Whenever a new lot of Reagent or Starter 1+2 is used.
- Every 28 days.
- The analyzer has been serviced.
- Control values lie outside the specified range.

Quality Control

Controls are recommended for the determination of quality control requirements for this assay and should be run in singlicate to monitor the assay performance. Refer to published guidelines for general quality control recommendations, for example Clinical and Laboratory Standards Institute (CLSI) Guideline C24 or other published guidelines¹⁴.

Quality control is recommended once per day of use, or in accordance with local regulations or accreditation requirements and your laboratory's quality control procedures, quality control could be performed by running the Anti-PR3 IgG assay:

- Whenever the kit is calibrated.
- Whenever a new lot of Starter 1+2 or Wash Concentrate is used.

The first seven digits of the lot number on the controls must match those of the corresponding reagent kit. For each target value and range refer to the label. The performance of other controls should be evaluated for compatibility with this assay before they are used. Appropriate value ranges should be established for all quality control materials used.

Control values must lie within the specified range, whenever one of the controls lies outside the specified range, calibration should be repeated and controls retested. If control values lie repeatedly outside the predefined ranges after successful calibration, patient results must not be reported and take the following actions:

- Verify that the materials are not expired.
- Verify that required maintenance was performed.
- Verify that the assay was performed according to the package insert.
- If necessary, contact Snibe or our authorized distributors for assistance.

If the controls in kit are not enough for use, please order Anti-PR3 IgG (CLIA) Controls (REF: 160201185MT) from Snibe or our authorized distributors for more.

RESULTS

Calculation

The analyzer automatically calculates the PR3 IgG concentration in each sample by means of a calibration curve which is generated by a 2-point calibration master curve procedure. The results are expressed in AU/mL. For further information please refer to the Analyzer Operating Instructions.

Interpretation of Results

The expected range for the PR3 IgG assay was obtained by testing 219 patients with Wegener's granulomatosis (WG) and 219 apparently healthy individuals, gave the following expected value by ROC curve:

- Non-reactive: A result less than 20.0 AU/mL (<20.0 AU/mL) is considered to be negative.
- Reactive: A result greater than or equal to 20.0 AU/mL (≥20.0 AU/mL) is considered to be positive.

Results may differ between laboratories due to variations in population and test method. It is recommended that each laboratory establish its own reference interval.

LIMITATIONS

- Results should be used in conjunction with patient's medical history, clinical examination and other findings.
- If the PR3 IgG results are inconsistent with clinical evidence, additional testing is needed to confirm the result.
- Specimens from patients who have received preparations of mouse monoclonal antibodies for diagnosis or therapy may contain human anti-mouse antibodies (HAMA). Such specimens may show either falsely elevated or depressed values when tested with assay kits which employ mouse monoclonal antibodies^{15, 16}. Additional information may be required for diagnosis.
- Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with *in vitro* immunoassays. Patients routinely exposed to animals or animal serum products can be prone to this interference and anomalous values may be observed¹⁷.
- Bacterial contamination or heat inactivation of the specimens may affect the test results.

SPECIFIC PERFORMANCE CHARACTERISTICS

Representative performance data are characterized in this section. Results obtained in individual laboratories may vary.

Precision

Precision was determined using the assay, samples and controls in a protocol (EP05-A3) of the CLSI (Clinical and Laboratory Standards Institute): duplicates at two independent runs per day for 5 days at three different sites using three lots of reagent kits (n = 180). The following results were obtained:

Sample	Mean (AU/mL) (n=180)	Within-Run		Between-Run		Reproducibility	
		SD (AU/mL)	%CV	SD (AU/mL)	%CV	SD (AU/mL)	%CV
Serum Pool 1	5.024	0.195	3.88	0.073	1.46	0.357	7.10
Serum Pool 2	20.379	0.640	3.14	0.495	2.43	1.278	6.27
Serum Pool 3	204.996	5.608	2.74	5.397	2.63	12.414	6.06
Plasma Pool 1	4.725	0.190	4.02	0.076	1.61	0.330	6.99
Plasma Pool 2	20.213	0.613	3.03	0.628	3.11	1.246	6.16
Plasma Pool 3	201.401	5.176	2.57	2.876	1.43	12.355	6.13
Control 1	9.527	0.374	3.93	0.192	2.01	0.629	6.61
Control 2	102.827	2.718	2.64	3.049	2.96	6.508	6.33

Based on internal testing on the MAGLUMI and Biolumi systems, the overall repeatability (% CV) is estimated to be ≤ 8% for samples tested, the overall reproducibility (%CV) is estimated to be ≤ 10%. Performance of the assay at individual laboratories may vary.

Linear Range

2.00-400 AU/mL (defined by the Limit of Quantitation and the maximum of the master curve).

Reportable Interval

1.00-4000 AU/mL (defined by the Limit of Detection and the maximum of the master curve×Recommended Dilution Ratio).

Analytical Sensitivity

Limit of Blank (LoB) =0.50 AU/mL.

Limit of Detection (LoD) =1.00 AU/mL.

Limit of Quantitation (LoQ) ≈2.00 AU/mL.

Analytical Specificity

Interference

Interference was determined using the assay, three samples containing different concentrations of analyte were spiked with potential endogenous and exogenous interferents in a protocol (EP7-A2) of the CLSI. The measurement deviation of the interference substance is within ±10%. The following results were obtained:

Interference	No interference up to	Interference	No interference up to
Hemoglobin	1000 mg/dL	HAMA	40 ng/mL
Intralipid	3000 mg/dL	ANA	398 AU/mL
Bilirubin	90 mg/dL	Rheumatoid factor	2500 IU/mL

High-Dose Hook

No high-dose hook effect was seen for PR3 IgG concentrations up to 8000 AU/mL.

Method Comparison

A comparison of the PR3 IgG assay with a commercially available immunoassay, gave the following correlations (AU/mL):

Number of samples measured: 120

Passing-Bablok: y=1.0011x -0.0234, r=0.967.

The clinical specimen concentrations were between 2.06 and 397.90 AU/mL.

REFERENCES

1. Radice A, Sinico R A. Antineutrophil cytoplasmic antibodies (ANCA)[J]. Autoimmunity, 2005, 38(1):93-103.
2. G. D. Sebastiani. Anticorpi anti-citoplasma dei granulociti neutrofil (ANCA) Antineutrophil cytoplasmic antibodies[J]. reumatismo, 2009.
3. Chen M, Kallenberg C G M. ANCA-associated vasculitides—advances in pathogenesis and treatment[J]. Nature Reviews Rheumatology, 2010, 6(11):653-664.
4. Watts R A, Mooney J, Skinner J, et al. The contrasting epidemiology of granulomatosis with polyangiitis (Wegener's) and microscopic polyangiitis[J]. Rheumatology, 2012, 51(5):926-931.
5. Lyons P A, Rayner T F, Trivedi S, et al. Genetically distinct subsets within ANCA-associated vasculitis[J]. New England Journal of Medicine, 2012, 367(3):214-223.
6. Hogan J J, Markowitz G S, Radhakrishnan J. Drug-induced glomerular disease: immune-mediated injury[J]. Clinical Journal of the American Society of Nephrology, 2015, 10(7): 1300-1310.
7. Lee J W, Myong J P, Choi Y J, et al. Diagnosis of perinuclear anti-neutrophil cytoplasmic antibody-associated microscopic polyangiitis in silicotics: case report[J]. Annals of occupational and environmental medicine, 2016, 28(1): 21.
8. Tervaert J W C, Damoiseaux J. Antineutrophil Cytoplasmic Autoantibodies: How Are They Detected and What Is Their Use for Diagnosis, Classification and Follow-up? [J]. Clinical Reviews in Allergy & Immunology, 2012, 43(3):211-219.
9. Jennette J C, Falk R J, Bacon P A, et al. 2012 Revised international chapel hill consensus conference nomenclature of vasculitides[J]. Arthritis & Rheumatology, 2013, 65(65):1-11.
10. Voswinkel J, Miller A, Lamprecht P .Is PR3-ANCA Formation Initiated in Wegener's Granulomatosis Lesions? Granulomas as Potential Lymphoid Tissue Maintaining Autoantibody Production[J].Annals of the New York Academy of Sciences, 2005, 1051.
11. Gapud P A B .ANCA-Associated Vasculitis Pathogenesis: A Commentary[J].Current rheumatology reports. 2017 Apr; 19(4):15.
12. Kronbichler A, Lee KH, Denicolò S, et al. Immunopathogenesis of ANCA-Associated Vasculitis[J]. International Journal of Molecular Sciences. 2020; 21(19):7319.
13. Fijoeck J, Wiatr E. Antineutrophil cytoplasmic antibodies (ANCA) - their role in pathogenesis, diagnosis, and treatment monitoring of ANCA-associated vasculitis[J]. Central-European journal of immunology, 2020, 45(2):218-227.
14. CLSI. Statistical Quality Control for Quantitative Measurement Procedures: Principles and Definitions. 4th ed. CLSI guideline C24. Wayne, PA: Clinical and Laboratory Standards Institute; 2016.
15. Robert W. Schroff, Kenneth A. Foon, Shannon M. Beatty, et al. Human Anti-Murine Immunoglobulin Responses in Patients Receiving Monoclonal Antibody Therapy[J]. Cancer Research, 1985, 45(2)879-885.
16. Primus F J, Kelley E A, Hansen H J, et al. "Sandwich"-type immunoassay of carcinoembryonic antigen in patients receiving murine monoclonal antibodies for diagnosis and therapy[J]. Clinical Chemistry, 1988, 34(2): 261-264.
17. Boscato L M, Stuart M C . Heterophilic antibodies: a problem for all immunoassays[J]. Clin Chem 1988;34(1): 27-33.

SYMBOLS EXPLANATIONS



Consult instructions for use



Manufacturer



Temperature limit
(Store at 2-8°C)



Use-by date



Contains sufficient for<n> tests



Keep away from sunlight



This way up



Authorized representative in the European Community



In vitro diagnostic medical device



Kit component



Catalogue number



Batch code



CE marking with notified body ID number

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