A rapid slide coagglutination test—an alternative to the fluorescent antibody test for the identification of *Neisseria gonorrhoeae*

S SHANKER, DA DALEY, AND TC SORRELL*

*From the Bacteriology Department, Institute of Clinical Pathology and Medical Research, Westmead, and the *Department of Medicine, Infectious Disease Medicine Unit, Westmead Centre, Westmead, New South Wales, Australia

**SUMMARY** The Phadebact(R) Gonococcus Test, a slide coagglutination test, was compared with the Difco fluorescent antibody test for the identification of *Neisseria gonorrhoeae* isolated from 18- to 24-hour primary plates. A total of 316 morphologically characteristic, oxidase-positive, Gram-negative diplococci were tested. Altogether 298 isolates were identified definitively as *N. gonorrhoeae* by a rapid carbohydrate utilisation test; 287 of the 298 isolates of *N. gonorrhoeae* were identified by the coagglutination test, a sensitivity of 96%. The sensitivity of the fluorescent antibody test was 85% (254 of 298 isolates). False-positive results due to cross-reactions with non-gonococcal *Neisseria* were uncommon (1 of 18 non-gonococcal isolates in the coagglutination test, a specificity of 94%; 2 of 18 in the fluorescent antibody test, a specificity of 88%). None of 14 other contaminant organisms seen frequently on primary isolation media gave positive reactions. Interpretation of the coagglutination test proved to be difficult initially. Thirty-two (10%) coagglutination tests had to be repeated; 3 of the 32 (1% of the total isolates tested) remained uninterpretable.

The use of staphylococcal protein A coagglutination tests for the serological identification of various bacteria is well documented. A commercial kit based on the principle of coagglutination has been produced by Pharmacia Diagnostics AB, Uppsala, Sweden, for the identification of *Neisseria gonorrhoeae*. This kit was recently introduced to the Australian market.

At the beginning of our study there had been only two evaluations of this kit, one in Sweden and the other on a prototype of the kit in the United Kingdom. Both studies utilised pure subcultures of confirmed *N. gonorrhoeae* but the results of the two evaluations were not in agreement. We undertook to assess the sensitivity and specificity of the kit available in Australia and to determine if the test could be carried out on primary isolates. This would allow a rapid identification of *N. gonorrhoeae* within 18 to 24 hours of the specimen being taken.

The coagglutination test was compared with a fluorescent antibody test currently used in our laboratory for the routine screening of gonococcal-like organisms isolated from primary plates.

**Material and methods**

Specimens were obtained from patients attending the Veneral Diseases Clinic in Sydney. Over a six-month period 1000 specimens were obtained. These included throat, urethral, and cervical swabs from females, and throat, urethral, and rectal swabs from males.

Swabs were plated directly on to Modified New York City (MNYC) medium at the clinic and incubated overnight at 36°C in BBL jars with CO2 Gaspaks(R). The jars were then transported to the laboratory 18 to 24 hours later. After this period of incubation colonies of *N. gonorrhoeae* measured about 1 mm in diameter.

An oxidase test and a Gram stain were performed on colonies morphologically similar to *N. gonorrhoeae*. Oxidase-positive, Gram-negative diplococci were tested with a fluorescent antibody test and the coagglutination test. Results of these tests were read independently before identification of the organism by the rapid carbohydrate utilisation test described by Young et al.18

Accepted for publication 3 July 1980
A rapid slide coagglutination test—an alternative to the fluorescent antibody test

**Fluorescent Antbody Test**
The fluorescent antibody test was performed using Difco reagents. A culture of *N. gonorrhoeae* was used as a positive control and cultures of *Neisseria meningitidis* and *Enterobacter cloacae* were used as negative controls for each batch of tests.

**Coagglutination Test**
The reagents were supplied as a commercially available test kit, Phadebact® Gonococcus Test, provided by Pharmacia (South Seas) Pty Ltd.

**Reagents**
The test package contained lyophilised ‘gonococcal reagent’, ‘control reagent’, and ‘buffer’ in powderform. The gonococcal reagent consisted of antigonococcal antiserum raised in rabbits and bound to inactivated staphylococci. The control reagent consisted of gammaglobulin from non-immunised rabbits bound to inactivated staphylococci. The reconstituted buffer powder provided a buffer solution of 7.4. This solution was used to reconstitute, wash, and resuspend the gonococcal and control reagents. The reconstituted reagents had a shelf-life of one month at 5°C. The reagents were brought to room temperature before the test.

**Procedure**
Drops of each of the gonococcal and control reagents were placed approximately 3 cm apart on a clean, dry glass slide. Four or five suspected gonococcal colonies were picked from the primary MNYC plate, and two thin smears were made adjacent to the drops of reagents. Each smear was mixed well with the corresponding drop of reagent. The slide was then held close to a source of warmth, for example, a desk lamp, rocked for 2 minutes, and viewed under transillumination against a dark background.

**Interpretation**
A positive reaction was identified by the development of fine powdery particles—coagglutination—in the drop containing gonococcal reagent. The drop of control reagent remained as a thin milky suspension. A negative reaction was one in which there was no coagglutination in the drop of gonococcal reagent. A non-interpretable result was one in which coagglutination was evident in both gonococcal and control drops. Where results were not interpretable, the following two methods were used:

1. A drop of a 0.1% solution of trypsin was applied to the dried smears before the addition of the test reagents. This modification of the method was suggested by Menck, who claimed it reduced considerably the number of non-interpretable results.

2. As recommended by the manufacturer, a 0.5 ml aqueous suspension of several colonies was heated in a water bath at 80°C for 20 minutes and cooled to room temperature. Drops of the aqueous suspension were used for retesting.

The specificity of the coagglutination test was evaluated by testing other *Neisseria* spp and non-*Neisseria* commonly encountered on primary isolation plates.

**Rapid Carbohydrate Utilisation Test**
The test, based on work done by Kellog and Turner and Young et al. measures the action of preformed enzymes on specific substrates: glucose, sucrose, fructose, lactose, and maltose. As the test requires a heavy inoculum, all rapid carbohydrate utilisation tests were carried out on pure, 24-hour subcultures of suspect colonies that were oxidase-positive, Gram-negative diplococci.

**Reagents**
*Stock carbohydrate solutions.* 10% (w/v) stock solutions of glucose, sucrose, fructose, lactose, and maltose* were prepared in distilled water, dispensed in 4-ml amounts, and stored at −20°C.

*Phosphate buffered salt solution.* A solution of pH 7.1-7.15, consisting of 40 ml 0·1 m K₂HPO₄, 12 ml 0·1 m KH₂PO₄, 100 ml 8% (w/v) KCl, 10 ml 1% (w/v) aqueous phenol red, and 838 ml sterile distilled water was prepared; 300-μl aliquots were dispensed into bijou bottles and stored at −20°C.

Of the carbohydrate solutions 20-μl aliquots were dispensed into the wells of BBL Minitek® trays; 100 μl of the phosphate buffered salt solution were then added to each of the wells. The wells were labelled and sealed, and the trays were stored at −20°C.

**Procedure**
The respective solutions were thawed immediately before use, and a heavy emulsion of the inoculum was prepared using the 300 μl buffer solution; 20 μl of this emulsion were then inoculated into each carbohydrate-containing well in the Minitek® tray. The trays were incubated in a 37°C water bath for 3 hours. A pH change, indicated by a colour change from red to yellow in the wells, showed the presence of preformed enzyme for the specific substrate.

**Results**
Of the 1000 plates screened, 316 isolates were identified presumptively as *N. gonorrhoeae* by their

*Maltose—extra pure (BDH Chemicals Ltd, UK).*
characteristic morphology, positive oxidase reaction, and Gram stain. A total of 298 isolates (94%) were confirmed as *N. gonorrhoeae* by our rapid carbohydrate utilisation test; 18 isolates were identified as non-gonococcal *Neisseria* species (Table 1). Of 298 proven gonococcal isolates, 286 were identified by the coagglutination test and 252 by the fluorescent antibody test, a sensitivity of 96% and 85%, respectively. These differences were significant (*p* < 0.0005, *χ²* test). The specificity of the test (percentage of non-gonococcal *Neisseria* yielding a negative result) was 94% for the coagglutination test (17 of 18 isolates) and 88% for the fluorescent antibody test (16 of 18 isolates) (*p* > 0.5, *χ²* test). No false-positive results were obtained with non-*Neisseria* species which commonly contaminate primary isolation plates (Table 2). False-negative results were obtained in 9/298 coagglutination tests compared with 46/298 fluorescent antibody tests (*p* < 0.0005, *χ²* test).

The results of 32 (10%) coagglutination tests were not interpretable on initial testing. Use of the alternative method recommended by the manufacturer led to interpretation of all but three of the tests. These three isolates were later identified as *N. gonorrhoeae*. The modification of Menck⁹ failed to discriminate results not interpretable by coagglutination testing.

Discussion

Our data indicate that the coagglutination test is a practicable alternative to the fluorescent antibody test in the rapid screening of suspect gonococcal colonies from primary isolation plates. It is more sensitive than the fluorescent antibody test, detecting 96% of isolates identified as *N. gonorrhoeae*, compared to 85% using the fluorescent antibody test. The specificity of the coagglutination test is similar to that of the fluorescent antibody test, 94% of non-gonococcal *Neisseria* yielding a negative result compared to 88% with the fluorescent antibody test. Barnham and Glynn¹⁰ were critical of the lack of specificity of the coagglutination test but they did not use an alternative method for testing organisms giving inconclusive results. Of 35 non-gonococcal *Neisseria* tested by them, 12 were coagglutination positive and 12 were inconclusive. Menck⁹ tested 16 non-gonococcal *Neisseria*. After trypsinisation, 12 were negative and four were inconclusive. We tested 18 non-gonococcal *Neisseria*; 17 were negative and one was positive, a *N. meningitidis* isolated from a throat swab. Pharyngeal colonisation by *N. meningitidis* has been reported in approximately 10% of patients attending a venereal diseases clinic,¹⁵ and in up to 25% of normal males.¹⁶ The organism has also been iso-

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Fluorescent antibody (FA), coagglutination (CoA), and rapid carbohydrate utilisation test (RCUT) results on 316 Gram-negative diplococci that were oxidase positive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Origin of specimen</strong></td>
<td><strong>No. of specimens</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Urogenital</td>
<td>236</td>
</tr>
<tr>
<td>Rectal</td>
<td>60</td>
</tr>
<tr>
<td>Throat</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>316</td>
</tr>
</tbody>
</table>

*Carbohydrate reactions consistent with *N. gonorrhoeae*.¹⁴

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Fluorescent antibody (FA) and coagglutination (CoA) results for other organisms found on primary isolation plates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organism</strong></td>
<td><strong>No. tested</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Neisseria meningitidis</em></td>
<td>15</td>
</tr>
<tr>
<td><em>Neisseria catarrhalis</em></td>
<td>2</td>
</tr>
<tr>
<td><em>Neisseria pharyngis</em></td>
<td>1</td>
</tr>
<tr>
<td>Candida spp.</td>
<td>3</td>
</tr>
<tr>
<td>Escherichia coli</td>
<td>3</td>
</tr>
<tr>
<td>Klebsiella spp.</td>
<td>2</td>
</tr>
<tr>
<td>Staphylococcus albus</td>
<td>2</td>
</tr>
<tr>
<td>Streptococcus faecalis</td>
<td>2</td>
</tr>
<tr>
<td>Streptococcus viridans</td>
<td>2</td>
</tr>
<tr>
<td>Mixed cultures of <em>N. gonorrhoeae</em> and normal flora</td>
<td>10</td>
</tr>
</tbody>
</table>
isolated from genitourinary and anal specimens. As the carriage of *N. meningitidis* and *N. gonorrhoeae* carries different therapeutic implications, it is important to differentiate these two species of *Neisseria*. In our study, other non-gonococcal species of *Neisseria* did not cross-react with *N. gonorrhoeae*.

The coagglutination test costs no more per test than the fluorescent antibody test and it is less time-consuming. The rapidity of the test (less than 2 minutes per test for most isolates) and the fact that expensive laboratory equipment is not required make it attractive for smaller laboratories. The shelf-life of the reconstituted coagglutination reagents, however, is one month when stored at 5°C, and smaller laboratories would process fewer gonococcal isolates during that period.

Clearly, the coagglutination test cannot replace carbohydrate tests for definitive identification of *N. gonorrhoeae* (13/298 (4%) gonococcal isolates defined by rapid carbohydrate utilisation test were identified incorrectly by coagglutination testing). It is sufficiently sensitive and specific to replace the fluorescent antibody test in the rapid screening of suspect colonies from primary isolation plates.

We thank Pharmacia (South Seas) Pty Ltd for supplying us with the Phadebact Gonococcus Test kits. Thanks are also extended to Dr R Munro for her encouragement and assistance during the course of this study.

References


Requests for reprints to: Mr S Shanker, Bacteriology Department, Institute of Clinical Pathology and Medical Research, Old Windsor Road, Westmead 2145, NSW, Australia.
A rapid slid coagglutination test—an alternative to the fluorescent antibody test for the identification of Neisseria gonorrhoeae.

S Shanker, D A Daley and T C Sorrell

doi: 10.1136/jcp.34.4.420

Updated information and services can be found at:
http://jcp.bmj.com/content/34/4/420

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/