Rapid and reliable routine diagnosis of rotavirus using a commercial monoclonal antibody based immunoassay

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Traditionally, electron microscopy has been used for the detection of faecal viruses associated with gastroenteritis because it is the only “catch all” technique available. As rotaviruses are the most important and common cause of acute gastroenteritis in young children, new assays have been developed for their detection. These assays allow a rapid throughput of large numbers of samples—more suitable for the busy diagnostic laboratory and for third world countries which do not have expensive electron microscopy units. There are a variety of assays currently commercially available including radioimmunoassay, latex agglutination, and solid phase enzyme linked immunoassay systems. These assays are supplemented by rotavirus RNA electrophoretic analysis which also provides invaluable epidemiological data but is too cumbersome for routine diagnostic use.

We describe here the use of a new rotavirus monoclonal based solid phase enzyme linked immunoassay (ELISA) produced by Cambridge Bioscience, Massachusetts, United States of America, and marketed by Boots Celltech Diagnostics Ltd, United Kingdom. We examined stool specimens from all patients up to 7 years of age with symptoms of diarrhoea or gastroenteritis from hospitals and general practitioners in Avon over three months during the winter.

Results obtained using this rotavirus (ELISA) were compared with those for an electron microscopy to evaluate both the specificity and sensitivity of the test. Specimens containing other identified pathogens (bacterial, viral, and parasitic) were also tested by ELISA to establish test specificity. In view of previous reports of false positive results obtained using other enzyme linked immunoassays for rotavirus in stool specimens from neonates results obtained from children less than 2 months old were of particular interest.

We also present our conclusions regarding simplicity of the test system and comment on its potential usefulness in the diagnosis of sporadic cases as well as outbreaks of rotavirus gastroenteritis.

Material and methods

Two hundred and sixty three faecal specimens from children less than 7 years of age were tested. These specimens had been submitted by local paediatric units and health centres from children presenting with acute gastrointestinal symptoms during December 1986 to February 1987. Specimens were examined by electron microscopy after concentration by ammonium sulphate precipitation and by the rotavirus ELISA (Boots Celltech Ltd). All tests were carried out without reference to previous results.

The ELISA was carried out in accordance with the manufacturer’s instructions. It is an antigen capture test provided as a complete kit containing four strips of 12 wells coated with antirotavirus monoclonal antibody, enzyme conjugated monoclonal antibody, substrate/chromogen solution and all necessary controls and diluents. About 10% of faecal emulsions were made in dilution buffer in separate plastic tubes. About 100 μl of each sample was transferred to a single well of the test plate with the disposable pipette.
Technical methods

provided. One hundred μl of enzyme conjugated monoclonal antibody was immediately introduced to each well and allowed to incubate at room temperature for one hour in a moist chamber. Wells were washed with five changes of deionised water. After 10 minutes of incubation with the substrate/chromagen mixture the results were visually recorded, a positive result being indicated by an obvious blue colour in the test well. Acid stopping solution was then added to every well and the absorbence of each determined spectrophotometrically.

The sensitivity of the ELISA was compared with that of electron microscopy by preparing 10-fold dilutions of clarified faecal emulsions in basic Earle’s medium, aliquots of which were tested by both techniques.

Results

The Rotavirus ELISA was simple to use. Visually determined positive results (blue) were distinct from negative wells (colourless). Spectrophotometric measurement of absorbance at 450 nm (A450) after addition of acid stopping solution using the manufacturer’s cut off value of 0.1, produced results concordant with visual determination.

The table shows the results obtained from 263 sequential faecal specimens sent to the laboratory. About 22% of paediatric inpatients with diarrhoea and 10% of those consulting their general practitioner had demonstrable rotavirus antigen in their stool. Two of 21 specimens from neonates (less than 2 months old) were positive for rotavirus antigen by the ELISA, confirmed by electron microscopy.

All samples which were positive for rotavirus by electron microscopy were confirmed by the rotavirus ELISA. Three specimens which were positive by ELISA were not confirmed by electron microscopy. These were all weak positive results by ELISA when judged visually and by spectrophotometric measurement (A450 of 0.1-137, 0.197, and 0.225, respectively). The bulk of positive specimens gave absorbance readings greater than 1.5. Five further specimens gave readings between the manufacturer’s recommended cut off value (0.10) and 1.5, the maximum value measurable by spectrophotometer. The figure shows results obtained from 10-fold dilutions of a faecal specimen for rotavirus examined by ELISA and electron microscopy. There is good correlation between the detection of rotavirus by electron microscopy and the intensity of colour produced in the ELISA.

No false positive results were detected in faecal samples containing Staphylococcus enteriditis, S typhimurium, S bellvue, Shigella sonnei, Campylobacter jejuni, Giardia lamblia, or Cryptosporidium. One of 12 samples containing only adenovirus (shown by electron microscopy) produced a weak positive result by ELISA (A450 0.1-97). Other faecal samples containing astrovirus and small round structured viruses (Norwalk-like) were negative by this assay.

Discussion

The ELISA rotavirus test examined in this study was easy to use and was both sensitive and specific. The relatively small number of neonatal specimens examined did not produce false positive results in contrast to those of previous reports.9 Examination of the titration curve produced from 10-fold dilutions of a positive faecal specimen suggests that this assay will detect antigen below the manufacturer’s cut off value. This is supported by the reproducibility of the mea-

Table  Results of rotavirus ELISA assay of faeces from children in Avon during the winter of 1986–87

<table>
<thead>
<tr>
<th></th>
<th>No of specimens tested</th>
<th>No positive</th>
<th>Per cent</th>
<th>Confirmed by electron microscopy</th>
<th>Per cent confirmed by electron microscopy</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>positive by</td>
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<tr>
<td></td>
<td></td>
<td>ELISA</td>
<td></td>
<td></td>
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<tr>
<td>In patients</td>
<td>118*</td>
<td>26</td>
<td>22</td>
<td>23</td>
<td>88</td>
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<tr>
<td>Outpatients</td>
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<td>14</td>
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<td>263</td>
<td>40</td>
<td>15</td>
<td>37</td>
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</tr>
</tbody>
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*21 specimens from neonates (less than 2 months old).
Letters to the Editor

Fatal infection in neonates caused by *S. milleri* 

With reference to recent papers by Cox *et al.* and Macgowan and Terry* documenting fatal infection in neonates due to Streptococcus milleri,* we report a case of *S. milleri* colonisation in a premature neonate. The 32 year old mother delivered normally after spontaneous rupture of membranes seven days previously. The baby girl was five weeks premature, jaundiced, but otherwise healthy. At delivery a routine infection screen was performed on the baby and a vaginal swab was taken from the mother. A non-haemolytic streptococcus was isolated after overnight incubation on 5% horse blood agar from the baby’s right and left eyes, nose, throat, right and left ears and umbilicus, and from the mother’s high vaginal swab. The organism was identified using the API 20 Strep system (API System SA, Montalieu Vercieu, France) as *S. milleri* biotype III, profile number 5261551. 

The above mentioned articles suggest a link between cervix abnormalities and ascending infection. Our mother had received laser treatment to her cervix in 1982 following abnormal smears. In 1983, 1984, and 1985 she had laparoscopies performed to investigate primary infertility. In 1986 in vivo fertilisation was successfully performed at The Royal Free Hospital, London, resulting in this pregnancy. In this case colonisation did not result in serious infection and both mother and baby were progressing well at the time of writing.

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References