Assessment of immunoglobulin-M immunosorbent agglutination assay (ISAGA) for detecting toxoplasma specific IgM

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SUMMARY An immunoglobulin-M immunosorbent agglutination assay (ISAGA) was introduced to detect toxoplasma specific IgM. This assay incorporates μ chain capture and use of entire toxoplasma trophozoites as an antigen source. The performance of the ISAGA was compared with that of a double sandwich enzyme linked immunosorbent assay (DS-ELISA) currently used in the Public Health Laboratory Service Toxoplasma Reference Laboratories. The ISAGA was found to be more sensitive than DS-ELISA but there was no demonstrable difference in the specificity or reproducibility between the two assays.

The ISAGA is suitable for the diagnosis of acute toxoplasmosis in immunocompetent patients and as a screening test for recent infection in pregnant women. The persistence of ISAGA reactivity, however, is such that additional serological assessment is required to define the risk of congenital infection.

Acute toxoplasma infection in immunocompetent patients is usually asymptomatic. The few who develop a clinical illness present with non-specific signs and symptoms such as malaise and lymphadenopathy.1 In clinical practice the diagnosis of toxoplasmosis is based on serological findings. Measurement of specific IgM antibody is of known value,2 and several detection methods have been developed, including the indirect immunofluorescent antibody test (IFAb),3 latex agglutination assay,4 and the enzyme linked immunosorbent assay (ELISA).5 The double sandwich enzyme linked immunosorbent assay (DS-ELISA) has been shown to be more sensitive than IFAb or conventional ELISA methods.6 Furthermore, the initial μ chain capture reduces the incidence of false negative reactions associated with the presence of excess toxoplasma IgG and false positive results due to rheumatoid factor or antinuclear antibody which are known hazards of the conventional ELISA or IFAb test.7

The IgM latex agglutination assay, IFAb test, ELISA and DS-ELISA use disrupted toxoplasma organisms as an antigen source. French workers have proposed that toxoplasma serology tests should use whole toxoplasma trophozoites as antigens.8 They suggest that the presentation of the organism in its entirety is an accurate reflection of the antigenic stimulation of the immune system induced in acute infection. Consequently, assays based on whole toxoplasma trophozoites may prove superior for the detection of the human antibody response in toxoplasmosis. The immunoglobulin-M immunosorbent agglutination assay (ISAGA) is routinely used in France for the diagnosis of acute toxoplasmosis and congenital infection.8 This assay uses a monoclonal antibody to the CH2 domain of the human μ chain, allowing IgM capture, while avoiding cross reactivity with IgG, IgA, or IgE.9 Specific IgM is then shown by the agglutination of whole toxoplasma trophozoites.10 As the ISAGA has recently become available in this country we undertook a study to compare the performance of this assay with that of the DS-ELISA currently used in our laboratory for detection of toxoplasma specific IgM.

Material and methods

The immunosorbent agglutination assay (ISAGA) detects human IgM antibodies to toxoplasma. An anti-human IgM monoclonal antibody is used to capture human IgM in serum or cerebrospinal fluid. The addition of toxoplasma trophozoites shows the presence of specific toxoplasma IgM.

The kit consists of a 4 ml suspension of formalin-treated Toxoplasma gondii trophozoites obtained
The results (negative) in a trophozoites forming toxoplasma placed was washed twice strips. The apparatus used for this was a moist chamber. The strips were placed on a clean paper towel. The toxoplasma antigen was diluted to 1:20 with BABS buffer and added to the wells, as previously described. The strips were then covered, placed in a moist chamber, and left at 37°C overnight. Agglutination patterns were determined using a mirrored plate reader.

A negative reaction resulted in sedimentation of the toxoplasma trophozoites forming a compact button. The results were marked on a scale of 0 to 4. Total sedimentation in a button similar to the antigen (negative) control, with no agglutination, was given a value of 0, a large button a value of 1, medium sized button 2, very small button 3, and no visible sediment 4. Each well was scored and the total for the three wells was called the “ISAGA index”. The ISAGA index was interpreted as follows: 0 to 5, negative reaction; 6 to 8, borderline; 9 to 12, positive reaction.

Methods for the DS-ELISA, the dye test (DT), latex agglutination test (LAT), and direct agglutination test (DAT) were used as previously described. Toxoplasma specific IgM measurements were performed on routine serum samples producing a DT result of > 31 units, or when the LAT or DAT findings were suggestive of acute infection. ISAGA and DS-ELISA were also performed on samples from patients who were human immunodeficiency virus (HIV) positive, transplant recipients or who suffered from retinochoroiditis, and mother and baby samples in cases of possible congenital infection.

The results of the ISAGA and DS-ELISA were defined in the following way: if both assays were positive IgM was positive; if both were negative IgM was negative. Where one assay gave positive results and the other negative these were termed “mismatches”. Both assays were then repeated. Where one assay produced a borderline or equivocal result and the other a clear positive or negative result, these were not regarded as “mismatches”.

The sensitivity, specificity, and reproducibility of the tests were assessed using separate selected sera. Five sera showing high DS-ELISA results (300–400 enzyme immunoassay units (EIU)) were diluted sequentially in physiological saline to produce a 10% dilution sequence and each dilution tested for specific IgM using ISAGA and DS-ELISA. A selection of sera with the potential to produce false positive IgM reactions were tested by ISAGA and DS-ELISA. Five sera, each positive for antinuclear factor, cytomegalovirus specific IgM, rheumatoid factor, hepatitis A specific IgM, or Epstein-Barr virus specific IgM were processed. Five jaundiced sera, five haemolysed sera, and five sera known to produce negative dye test and latex reactions were also tested. The negative sera were subsequently heat inactivated at 56°C for three hours and retested. Fifty sera previously found to have no detectable toxoplasma specific antibody by dye test or latex agglutination were assayed. Potential false negative reactions were investigated by selecting five sera producing positive DS-ELISA and ISAGA results. Each sample was freeze thawed five times and then retested for specific IgM. The reproducibility of the two assays was assessed by the selection of 10 sera representing a range of IgM DS-ELISA results from negative to high positive (0–400 EIU). Each sample was assayed by DS-ELISA and ISAGA five times. When a patient’s serum was found to give a positive reaction by both IgM assays, repeated samples were requested to document the decline of IgM concentrations by the two tests.

The cost, ease of performance, equipment required and MLSO time necessary for ISAGA and DS-ELISA performance were assessed during the course of the study.

**Results**

A total of 1313 routine samples were processed (table). Of the sera tested, 1032 (79%) samples produced negative results in both the ISAGA and DS-ELISA. Of 145 sera which gave a positive DS-ELISA result, 140 (97%) were confirmed by ISAGA. Of the 222 samples which gave an ISAGA positive result, however, 70 (32%) were negative when tested by DS-ELISA. There were 72 confirmed mismatch results; of these, 70 were DS-ELISA negative/ISAGA positive and only two were DS-ELISA positive/ISAGA negative. The results of 30 samples were designated as “test errors” (defined as changing from positive to
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Table  Comparison of DS-ELISA and ISAGA results

<table>
<thead>
<tr>
<th>DS-ELISA Result</th>
<th>Positive</th>
<th>Borderline</th>
<th>Negative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISAGA results:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>140</td>
<td>12</td>
<td>70</td>
<td>222</td>
</tr>
<tr>
<td>Borderline</td>
<td>3</td>
<td>14</td>
<td>39</td>
<td>56</td>
</tr>
<tr>
<td>Negative</td>
<td>7</td>
<td>11</td>
<td>1032</td>
<td>1035</td>
</tr>
<tr>
<td>Total</td>
<td>154</td>
<td>27</td>
<td>1141</td>
<td>1313</td>
</tr>
</tbody>
</table>

The dye test originated by Sabin and Feldman is the accepted reference assay used for the diagnosis of toxoplasmosis. This test measures both IgG and IgM antibodies, but a positive reaction does not delineate the immunoglobulin class. Although the dye test can be used as a reference value when assessing assays predominantly measuring toxoplasma specific IgG, it is of less value in the context of IgM detection.

Samples showing a seroconversion from negativity to positivity are available in limited numbers only and the non-specific signs and symptoms of acute toxoplasmosis make diagnosis based on clinical findings unreliable. Analysis of antibody response using Western blots has failed to determine criteria for the diagnosis of acute toxoplasmosis while antigen detection and DNA probing techniques remain at the developmental stage. Isolation of the parasite from clinical samples does not differentiate acute from chronic infection. Consequently, there is no definitive reference to which toxoplasma IgM tests may be compared and calculation of predictive values or percentage figures for sensitivity and specificity is not justified.

Although both assay results were most often in agreement, the commonest finding in a confirmed mismatch was that of a positive ISAGA reaction in a sample negative by DS-ELISA testing. Our findings of persistence of ISAGA reactivity at higher serum dilutions and a greater period of time after acquisition of infection than by DS-ELISA suggest a proportion of discordant results will reflect the greater sensitivity of the former assay. Other groups have shown that ISAGA exhibits superior sensitivity compared with commercial ELISA systems or immunofluorescent antibody techniques. French workers found that 80% of patients maintained a positive ISAGA reaction one year after infection compared with 40% positive by commercial ELISA. In clinical practice toxoplasmosis is often considered only when more familiar disease processes have been excluded. Consequently, ISAGA would be useful for the investigation of suspected toxoplasmosis, particularly when the diagnosis is postulated late in the course of the infection.

Experience of ISAGA in Scotland has shown the persistence of reactivity into the second pregnancy following the birth of a congenitally infected infant. The risk of the parasite passing from mother to fetus...
sity of the ISAGA indicate that this test is suitable for the diagnosis of acute toxoplasma infection of immunocompetent subjects. In cases of suspected toxoplasmosis associated with pregnancy the ISAGA may be used as a screening test for recent infection but the persistence of ISAGA reactivity is such that further serological assessment will be required to define the risk of congenital infection. The value of ISAGA testing for the diagnosis of exacerbations of previously latent toxoplasmosis in immunocompromised patients requires evaluation.

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References

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