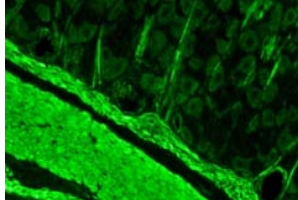
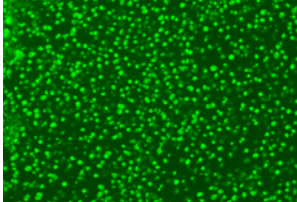


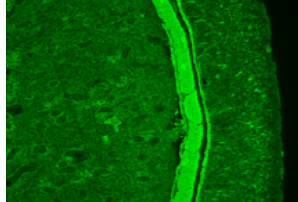
AMA on Mouse Kidney/Stomach



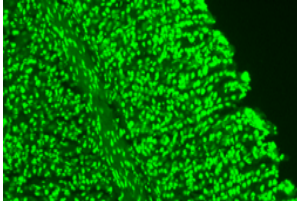
ASMA on Mouse Stomach



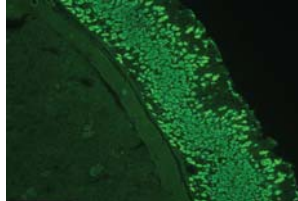
ANA on Mouse Liver



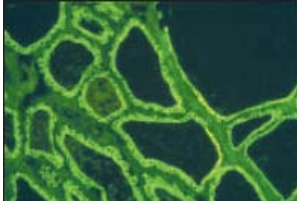
ASMA on Mouse Kidney/Stomach



ANA on Mouse Kidney/Stomach



AGPA on Mouse Kidney/Stomach



ATA on Thyroid Microsomal



Cambridge Life Sciences Ltd. Instructions for Using Immco Slides:

ImmuGlo™ ATS Autoantibody Test

Mouse Kidney/Stomach/Liver Mouse Thyroid Substrate Monkey Thyroid Substrate

IVD For *in vitro* diagnostic use

REF Code: 2144-8 6 Well Substrate Slide

 6 Tests

REF Code: 2152-4 6 Well Substrate Slide

 6 Tests

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INTENDED USE

Indirect immunofluorescence (IF) antibody tests for the detection and quantitation of antinuclear antibodies (ANA), anti-mitochondrial antibodies (AMA), anti-smooth muscle antibodies (ASMA), anti-gastric parietal cell antibodies (AGPA), and anti-thyroid microsomal and thyroglobulin antibodies in human serum.

SUMMARY AND EXPLANATION

Antinuclear antibodies (ANA), detected by indirect immunofluorescence, aid in the diagnosis of connective tissue disorders including systemic lupus erythematosus (SLE), mixed connective tissue disease, Sjögren's syndrome and scleroderma¹⁻⁵. ANA occur in about 95% of SLE patients as well as patients with other connective tissue diseases. ANA may also occur in other disorders such as chronic active hepatitis and primary biliary cirrhosis⁶⁻⁸.

Anti-mitochondrial antibodies (AMA) occur in over 90% of primary biliary cirrhosis cases, 3-11% of chronic active hepatitis patients and are absent in patients with extrahepatic biliary obstruction and in other liver diseases. The universal presence of anti-mitochondrial antibodies in primary biliary cirrhosis and their virtual absence in extrahepatic jaundice makes their detection of considerable value in the differential diagnosis⁶⁻¹².

Anti-smooth muscle antibodies (ASMA) in high titre (>160) occur in the majority of cases of chronic active hepatitis and in intermediate titres (40-80) in acute viral hepatitis. Occasionally they may occur in cases of primary biliary cirrhosis where they are also found in intermediate titres. The significance of titres of 20-40 is doubtful since these titres may occur in normal individuals^{13, 14}.

Anti-gastric parietal cell antibodies (AGPA) are commonly associated with pernicious anaemia and chronic atrophic gastritis where they occur in about 90% and 50% of cases, respectively. However, they are not disease specific as they may occur in low frequency in other disorders. Although healthy individuals may have gastric parietal cell antibodies, this finding may reflect asymptomatic atrophic gastritis. Negative findings for gastric parietal cell antibodies provide strong evidence for excluding pernicious anaemia¹⁵⁻¹⁷.

Anti-thyroid antibodies (ATA). The two thyroid specific autoantibodies most useful for the diagnosis of thyroid disease are microsomal and thyroglobulin antibodies. Thyroid antibodies are commonly associated with Hashimoto's disease and Grave's disease¹⁸⁻¹⁹. Although microsomal and thyroglobulin antibodies occur in a variety of other thyroid disorders, they are more common and found at higher titres in autoimmune thyroid disease. The presence of high titres of thyroid antibodies in an equivocal case would favour a diagnosis of thyroid insufficiency.

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Table 5. Incidence of Anti-Gastric Parietal Cell Antibodies (AGPA) as Detected by Indirect Immunofluorescence on Mouse Stomach Substrate

Clinical Condition	% Positive
Pernicious Anaemia (PA)	85-95
Chronic Atrophic Gastritis without PA	30-60
Gastric Ulcer	25-30
Autoimmune Endocrinopathies	25-33
Sjögren's Syndrome	30
First Degree Relatives of PA Patients	30
Normal Controls	
< 20 years old	2
20-60 years old	6-8
> 60 years old	16

Table 6. Incidence of Thyroglobulin and Microsomal Antibodies

Clinical Condition	% Positive
Hashimoto's disease	80-90
Viral thyroiditis	Transient
Radiation thyroiditis	Transient
Reidel's thyroiditis	Transient
Non-toxic nodular goitre	20
Non-goiterous multifocal thyroiditis	85
Thyroid cancer	20-50
Grave's disease	50-70
Normal Controls	
< 20 years old	2
20-60 years old	6-8
> 60 years old	16

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PRINCIPLES OF PROCEDURE

In the indirect immunofluorescence method used, patients' sera are incubated on mouse kidney/stomach/liver/monkey thyroid sections to allow binding of antibodies to the substrate. Any antibodies not bound are removed by washing. Bound antibodies of the IgG class are detected by incubation of the substrate with fluorescein-labelled, anti-human IgG conjugate. Reactions are observed under a fluorescence microscope equipped with appropriate filters.

The presence of ANA, ASMA, AMA, AGPA and thyroid microsomal and thyroglobulin antibodies is demonstrated by an apple green fluorescence of specific histologic structures in the tissue. The titre (the reciprocal of the highest dilution giving a positive reaction) is then determined by testing serial dilutions¹⁸.

PRODUCT INFORMATION

Storage and preparation

Store all reagents at 2 - 8°C. Reagents are ready for use after equilibration to room temperature.

Materials provided

SORB | SLD | 6

Code: 2144-8 6 well Mouse Kidney/Stomach/Liver, Monkey Thyroid Substrate Slide.

SORB | SLD | 6

Code: 2152-4 6 well Mouse Kidney/Stomach/Liver, Mouse Thyroid Substrate Slide.

Material required and available from CLS

CONTROL + | ANA

1 x 0.5mL ANA Positive Control, homogeneous pattern. **Code 2201**

CONTROL + | ANA

1 x 0.5mL ANA Low Titre Control, homogeneous pattern. **Code 2201-1**

CONTROL + | ANA

1 x 0.5mL ANA Positive Control, speckled pattern. **Code 2202**

CONTROL + | ANA

1 x 0.5mL ANA Positive Control, nucleolar pattern. **Code 2204**

CONTROL + | ANA

1 x 0.5mL ANA Positive Control, peripheral pattern. **Code 2205**

CONTROL + | AMA

1 x 0.5mL AMA Positive Control, anti-mitochondrial. **Code 2210**

CONTROL + | ATA

1 x 0.5mL Thyroid/Microsomal Positive Control. **Code 2239**

CONTROL -

1 x 0.5mL Negative Control. **Code 2200**

IgG-CONJ FITC

1 x 5mL Anti-human IgG FITC Conjugate. Code 2100X or

IgG-CONJ FITC EB

1 x 5mL Anti-human IgG FITC Conjugate containing Evan's Blue. Code 2100

BUF

1 x 60mL Buffered Diluent. Code 2302

BUF WASH

1 vial Phosphate Buffered Saline (PBS). Dissolve each vial to 1 litre. Code 2301

MOUNTING MEDIUM

1 x 5.0mL Mounting Medium. Do not freeze. Code 2505

EVANS

1 x 1.0mL Evan's Blue Counterstain. Not required if using 2100. Code 2510

Material required but not provided

Fluorescence microscope
 Micropipette or Pasteur pipette
 Serological pipettes
 Staining dish (e.g. Coplin jar)
 Small test tubes (e.g. 13 x 75mm) and test tube rack
 Distilled or deionised water
 1 litre container
 Wash bottle
 Paper towels
 Incubation chamber
 Coverslip

WARNINGS AND PRECAUTIONS

For *in vitro* diagnostic use only.
 For Professional Use only.

All human derived components used have been tested for HbsAg, HCV, HIV-1 and 2 and HTLV-I and found negative by FDA required tests. All human serum specimens and human derived products should be treated as potentially hazardous, regardless of their origin. Follow good laboratory practices in storing, dispensing and disposing of these materials¹⁴.

WARNING - Sodium azide (NaN₃) is present in reagents at <0.1%. Sodium azide may react with lead and copper plumbing to form highly explosive metal azides. Upon disposal of liquids, flush with large volumes of water to prevent azide build-up. Sodium azide may be toxic if ingested. If ingested, report incident immediately to laboratory director or poison control centre.

Instructions should be followed exactly as they appear in this insert to ensure valid results. Do not interchange components with those from other sources

EXPECTED VALUES

As seen in Tables 2, 3, 4, 5 and 6, tests for nuclear antibodies are used to screen for SLE and certain other immunologic disturbances. AMA occurs in over 90% of cases of primary biliary cirrhosis and 3-11% of cases of chronic hepatitis. ASMA occur in the majority of cases of chronic active hepatitis and AGPA are commonly associated with pernicious anaemia and chronic atrophic gastritis.

Table 2: Incidence of Antinuclear Antibodies (ANA) Detected by Indirect Immunofluorescence on Mouse Kidney Substrate

Clinical Condition	No. of Sera	% Positive
SLE	21	95
Scleroderma	17	82
Rheumatoid Arthritis	20	5
Normal Controls	96	0

Table 3: Incidence of Anti-Mitochondrial Antibodies (AMA) Detected by IFA on Mouse Kidney Substrate

Clinical Condition	% Positive
Primary Biliary Cirrhosis	100
Autoimmune Chronic Active Hepatitis	8
HBSAg and Chronic Active Hepatitis	0
Extrahepatic Jaundice and Other Liver Diseases	0
Systemic Lupus Erythematosus (SLE)	3
Rheumatoid Arthritis	0
Normal Controls	0

Adapted from Meyer zum Büschenfelde KH, et al.²¹; Walker JG, et al.²² and Paronetto F and Popper H²³.

Table 4: Incidence of Anti-Smooth Muscle Antibodies (ASMA) as Detected by IFA on Mouse Kidney Substrate

Clinical Condition	% Positive
Chronic Active Hepatitis (Type A)	50 - 87
Primary Biliary Cirrhosis	25
Acute Viral Hepatitis	87
Infectious Mononucleosis	87
Burkitt's Lymphoma	73
Nasopharyngeal Carcinoma	23
Hodgkin's Disease	23
Myeloproliferative Disorder	5
Warts	4
Normal Controls	3 - 18

Adapted from Anderson P, et al.¹³

Table 1. Diagnostic Significance of Antinuclear Antibodies

IF Staining Pattern	Nature of Antigen	Associated Disease
Homogeneous	Deoxyribonucleoprotein	SLE with renal involvement
Peripheral	DNA	SLE
Speckled	RNP	SLE or MCTD*
	Sm	SLE
	SS-A/SS-B	SLE or Sjögren's
	Scl-70	Scleroderma
Nucleolar	4S-6S RNA	Scleroderma
	probably U3 RNA	

*Mixed Connective Tissue Disease

AMA may be observed on both the distal and proximal tubules of the kidney with the distal tubules staining more brightly. Even though the cytoplasm of the gastric parietal cells also stains, AMA should be quantitated on the kidney.

Staining of the stomach muscularis and kidney glomeruli may also be observed with ASMA, but only ASMA seen on the blood vessel walls of the kidney should be reported.

LIMITATION OF THE PROCEDURE

In some cases, sera positive for ANA may either be very weak or negative at the initial screening dilution (prozone phenomenon). In such doubtful cases the sera should be screened at higher dilutions and, if positive, antibody titres determined.

In some cases the presence of two or more antibodies in a serum which are reactive with the same substrate may cause an interference in their detection by immunofluorescence. This interference may cause either failure to detect ANA or suppression of its titre if the interfering antibody has a higher titre than ANA. All ANA reactions should be reported.

The goat anti-human IgG FITC conjugate supplied in this kit is primarily heavy chain specific but has some light chain activity. It reacts primarily with IgG class autoantibodies, but may, to a lesser degree, react with light chains of other classes such as IgM.

A positive ANA should not be considered indicative of SLE by itself. They also occur in patients with other connective tissue diseases and certain drugs such as procainamide and hydralazine may induce a positive ANA¹. Moreover, sera of patients with malignancies and infectious diseases may also have a positive ANA^{2,1}.

other than the same catalogue number from IMMCO/CLS. Do not use beyond expiration date given on the labels.

SPECIMEN COLLECTION AND PREPARATION

Only serum specimens should be used for this procedure. Grossly haemolysed, lipaemic or microbial contaminated specimens may interfere with the performance of this test and should not be used. Store specimens at 2 - 8°C for no longer than one week. For longer storage, serum should be frozen at -20°C. Avoid repeated freezing and thawing of samples.

PROCEDURE

Test Method

A. Screening

1. Dilute each patient serum 1:10 with the Buffered Diluent (20µL serum + 200µL Diluent). **Do not dilute Positive or Negative Controls.** Save the undiluted sera to determine antibody titres if screening tests are found to be positive.
2. Allow pouches containing substrate slides to equilibrate to room temperature for 10 - 15 minutes. Carefully remove the slides without touching the substrate.
3. Label the slides and place them in an incubation chamber lined with paper towels moistened with water to prevent drying.
4. Invert dropper vial and gently squeeze to apply 2 drops (approximately 100µL) of Negative Control to well #1. Similarly apply 2 drops of Positive Control to well #2. Avoid overfilling the wells.
5. Using a micropipette or Pasteur Pipette, apply 2 drops of patient's diluted serum (approximately 100µL) to the other wells. Avoid overfilling the wells.
6. Place the lid on the incubation chamber and incubate slides for 30 minutes at room temperature (18 – 25°C).
7. Remove slide from the incubation chamber. Hold slide at tab end and rinse gently with approximately 10mL PBS using a pipette, or rinse slide in beaker filled with PBS. Do not use wash bottle. Transfer slide immediately into Coplin jar and wash for 10 minutes. Repeat process with all remaining slides.
8. Remove slide(s) from Coplin jar. Blot the edge of the slide on a paper towel to remove excess PBS. Place the slide in the incubation chamber. Immediately invert the Conjugate dropper vial and gently squeeze to apply 2 drops (approximately 100µL) to each well.
9. Replace the lid on the incubation chamber. Incubate for 30 minutes at room temperature (18 – 25°C).

- Remove a slide from incubator. Hold the slide at the tab end and dip the slide in a beaker containing PBS to remove excess conjugate. Place slide(s) in a staining dish filled with PBS for 10 minutes. If desired, 2 - 3 drops of Evans blue counterstain may be added to the final wash. Repeat for the remaining slides.

NOTE: Improper washing may lead to increased background fluorescence.

- Remove a slide from the staining dish. Blot the edge of the slide on a paper towel to remove excess PBS. **To prevent slide from drying, proceed immediately with next step while slide is still wet.**
- Mount the coverslip by applying 3 drops of Mounting Medium evenly on the coverslip and place coverslip over slide. Avoid applying undue pressure and prevent lateral movement of the coverslip.
- Repeat steps 11 and 12 for each slide.
- Examine for specific fluorescence under a fluorescence microscope at a magnification of 200x or greater.

Slides may be read as soon as prepared. However, because of the presence of antifading agent in the mounting medium, no significant loss of staining intensity occurs if reading is delayed for up to 48 hours. Slides should be stored in the dark at 2 - 8°C.

B. Endpoint Determination (titration)

A serum positive in the screening test may be further tested following steps 5 through 12 to determine the titre. Each test run should include the Positive and Negative Controls. Make serial two-fold dilutions starting at 1:10. The reciprocal of the highest dilution producing a positive reaction is the titre.

Preparation of Serial Dilutions

Number six tubes 1 through 6. Add 1.0mL of Buffered Diluent to tube 1 and 0.2mL to tubes 2 through 6. Pipette 0.1mL of undiluted serum to tube 1 and mix thoroughly. Transfer 0.2mL from tube 1 to tube 2 and mix thoroughly. Continue transferring 0.2mL from one tube to the next after mixing to yield the dilutions depicted in the following table:

Tubes	1	2	3	4	5	6
Serum	0.1mL					
	+					
Buffered Diluent	1.0mL	0.2mL	0.2mL	0.2mL	0.2mL	0.2mL
		⇩	⇩	⇩	⇩	⇩
Transfer		0.2mL	0.2mL	0.2mL	0.2mL	0.2mL
Final dilution	1:10	1:20	1:40	1:80	1:160	1:320 etc

Contact CLS for help with protocols for use with automated IFA instrumentation.

QUALITY CONTROL

Both a Positive and Negative Control should be included with each test run. The Negative Control should show no specific fluorescence of the nuclei, smooth muscle, tubules of the kidney or gastric parietal cells. The AMA Positive Control should have 2+ or greater staining intensity of the tubules of the kidney. The ANA Positive Control should have 2+ or greater staining intensity of the nuclei of the kidney and liver with a predominantly homogeneous pattern.

If expected results are not obtained, the run should be repeated. If inadequate results continue to occur with the controls, these may be due to:

- Turbidity. Discard and use another control
- Problems with the optical system of the fluorescence microscope. These may include: improper alignment, bulb beyond useful life expectancy, etc.
- Allowing the slide to dry during the procedure.

INTERPRETATION OF RESULTS

The results of the tests for ANA, AMA, ASMA, AGPA and ATA antibodies should be reported as negative (< 10) on kidney, stomach and thyroid sections, negative (<20) on liver sections, or alternatively, positive with titre. Read only fields which contain specific staining of the nuclei for ANA, the kidney tubules for AMA, the blood vessel walls for ASMA, gastric parietal cells only for AGPA and thyroid for thyroid microsomal and thyroglobulin antibodies. All other reactions should be reported as negative for ANA, AMA, ASMA, AGPA, and/or ATA.

ANA can be detected on all substrates but should be quantified on the kidney or liver. The nuclear staining patterns observable with the kidney or liver substrate provided include homogeneous, peripheral (rim), speckled and nucleolar. They may be one or a combination of several staining patterns. The latter are due to reactions to several different nuclear antigens.

Homogeneous: The entire nucleus fluoresces evenly with a diffuse staining pattern.

Peripheral (rim): The nuclear membrane stains most intensely with decreasing staining intensity of the nucleoplasm towards the centre of the nucleus.

Speckled: Discrete coarse to fine round speckles fluoresce throughout the nucleus.

Nucleolar: The nucleoli stain as multiple solid bodies within the nucleus.

The specificity of some of the antibodies giving the above staining patterns may be further identified by tests for antibodies to nDNA and to various extractable nuclear antigens. These may be of diagnostic significance as listed in table 1.