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Comparison of serological assays in human Middle East respiratory syndrome (MERS)-coronavirus infection

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Introduction
Middle East respiratory syndrome (MERS) poses a major threat to global public health [1]. Validated serological assays are important for diagnosis and for seroepidemiology to define prevalence and risk factors [2,3]. Serological assays for detecting antibody for MERS-coronavirus (CoV) infection include antibody arrays, enzyme-linked immunosorbent assay (ELISA), immune-fluorescence, microneutralisation (MN), plaque reduction neutralisation (PRNT) and MERS-spike pseudoparticle neutralisation tests (ppNT) [2,4-6]. While data from individual case reports exist [6], there are limited comparative data on serological methods for detecting MERS-CoV antibody in humans, because of a lack of well-characterised sera [7]. We used 95 sera from 17 patients with real-time reverse transcription polymerase chain reaction (RT-PCR) confirmed MERS-CoV infection diagnosed during an outbreak of MERS in South Korea [8,9] to compare PRNT antibody titres using 90% (PRNT 90) and 50% (PRNT 50) plaque reduction end points, MN, MERS-spike ppNT and S1-ELISA tests. The sera were also used to investigate the antigenic similarity of three genetically diverse strains of MERS-CoVs [10]. We had previously reported that early PRNT 50 and S1-ELISA antibody responses in this patient-cohort were associated with improved clinical outcome [9].

Methods
Patients
Patients with RT-PCR confirmed MERS-CoV infections admitted to Seoul National University (SNU) Hospital, SNU Boramae Medical Center and SNU Bundang Hospital within the first 14 days after onset of illness during the outbreak of MERS-CoV between May and June 2015 in South Korea were included. Serial serum samples (n = 95 in total) were collected from 17 patients during the first 39 days of illness or up to time of discharge from hospital. This study was approved by the Institutional Review Board of SNU. Clinical data on these patients have been previously reported [9].

Viruses
The MERS-CoV strains used in the virus neutralisation assays belonged to clade A (MERS-CoV-strain EMC), clade B (dromedary camel MERS-CoV Al-Hasa FKHU13 2013) as well as a virus from a distinct non A and B clade (dromedary camel Egypt NRCE-HKU 270 2013) as previously described [10].

Serology tests
The sera were heat-inactivated for 30 min at 56°C before testing. The PRNT assays were performed in a 24-well format in duplicate for each serum dilution. Twofold serum dilutions were incubated with 40 to 60 plaque-forming units of virus for 1 hour at 37°C. The virus–serum mixture was added onto a Vero cell monolayer and incubated for 1 hr at 37°C in a 5% CO2 incubator. Then, the supernatant was removed and the cells overlaid with 1% agarose (SeaKem LE Agarose, Lonza,
tities of ≥ 1:20 were regarded as positive. Antibody titres were defined as the highest serum dilutions that resulted at ≥ 50% (PRNT<sub>50</sub>) and ≥ 90% (PRNT<sub>90</sub>) reduction in the number of plaques, respectively.

The ppNT assays were performed as previously described, with triplicate serum dilutions [5,11]. MN tests were carried out to determine the highest serum dilution that suppressed virus cytopathic effect in Vero cells following infection with a virus dose of 100 tissue culture infection dose<sub>50</sub> mixed with the respective serum dilution [5]. Serum dilutions were done in quadruplicate. Positive and negative controls and virus back-titrations were included in each assay. Antibody titres of ≥ 1:20 were regarded as positive.

The S1 ELISA E1 2604–9601G kit was purchased from EUROIMMUN Luebeck, Germany for detection of human IgG against MERS-CoV. The test was done on single serum samples in duplicate according to the manufacturer’s instructions. The assay included a calibrator which defined the upper limit of the reference range in non-infected humans and this value was defined as the cut off. The assay was made semi-quantitative by calculating the ratio of the extinction of the patient sample/ extinction of the calibrator. Ratios < 0.8 were considered negative, those ≥ 1.1 as positive and those ≥ 0.8 to < 1.1 regarded as borderline.

**Statistical methods**

Spearman correlation coefficient was calculated to assess the correlations between the different assays.

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**Figure**

Scatter plots comparing antibody titres obtained from different assays in relation to duration (days) after onset of illness due to Middle East respiratory syndrome (MERS)-coronavirus infection.

**Figure A**

PRNT<sub>90</sub> vs PRNT<sub>50</sub> correlation.

**Figure B**

MN vs PRNT<sub>90</sub> correlation.

**Figure C**

MERS-S ppNT vs PRNT<sub>90</sub> correlation.

**Figure D**

ELISA OD ratio vs PRNT<sub>90</sub> correlation.

**Figure E**

ELISA OD ratio vs PRNT<sub>50</sub> correlation.

Spearman correlation for each comparison is denoted in each panel. Sera collected 1–10, 11–20 and ≥ 21 days from onset of illness are denoted in yellow, green and blue, respectively. The MERS-spike ppNT, MN, PRNT<sub>50</sub>, and PRNT<sub>90</sub> titres have been jittered for better presentation. The negative cut-off titres or OD is denoted in a dotted line.

ELISA: enzyme-linked immunosorbent assay; MN: microneutralisation; OD: optical density; PRNT: plaque reduction neutralisation test; ppNT: pseudoparticle neutralisation test.
Results

Scatter-plots showing correlation between PRNT$_{90}$, PRNT$_{50}$, ppNT, MN and S1-ELISA assays are shown in Figure A-E. As expected, the PRNT$_{50}$ assay was more sensitive than the PRNT$_{90}$ because it uses the less stringent end-point of 50% reduction in the plaque count (Figure A). There was excellent correlation between the PRNT$_{90}$, MN and MERS-spike ppNT titres with Spearman correlations of 0.97–0.98 (Figure B,C). MERS-CoV S1 ELISA was less strongly correlated with the different neutralisation assays with Spearman correlation of 0.86–0.87 (Figure D and E).

Table 1 shows the proportion of sera that were positive in neutralising tests at titres ≥ 1:20 or in ELISA. None of the patients were seropositive in the first 10 days of illness. At 11–15 days of illness, 50% of sera were positive in PRNT$_{50}$ assays, 39% in PRNT$_{50}$ and S1-ELISA assays and 33% positive in ppNT and MN assays. After 21 days of illness, the majority of patients were seropositive. However, even at day 32 of illness, one patient remained seronegative in PRNT$_{50}$, ppNT and MN assays, borderline positive in the S1 ELISA and was only positive in the PRNT$_{50}$ test at a titre of 1:20. She was aged in her mid-fifties with no underlying diseases, and presented with a relatively mild pneumonic illness (reported more fully in [9]).

Twelve patients seroconverted (fourfold increase in antibody titre) by all five assays and one had static high titres (first serum sample of this patient was at day 13 of illness). The woman in her mid-fifties noted above failed to seroconvert by S1 ELISA, MN and PRNT$_{90}$, and only reached PRNT$_{50}$ antibody titre of 1:20 up to day 32 of illness. Three other patients did not seroconvert in any of the assays, but the latest available sera from them was at day 8, 9 and 16, respectively, too early to conclude whether sera of these patients at a later stage of illness would have shown seroconversion.

In order to compare antigenic similarity of genetically diverse MERS-CoV, we selected four sera from two patients. These sera had been sampled early (day 12, 17) and later (day 35, 39) during the course of illness. The antibody titres of each serum to clade A, clade B and the genetically divergent Egyptian camel viruses were within twofold (Table 2).

Discussion

The different virus neutralisation assays (MN; ppNT PRNT$_{50}$; PRNT$_{90}$) all had excellent correlation among them (Spearman correlation ≥ 0.94) (Figure). The PRNT$_{50}$ antibody test was more sensitive in detecting early antibody responses and had higher antibody titres.
ppNT assays can be used in MERS-CoV diagnosis and in conclusion, the different types of neutralisation or antibody titres are not affected by the clade of virus have demonstrated in this, and previous studies, that not available for use in the serology tests. However, we and that a MERS-CoV isolate from these patients was from one outbreak and from one ethnic background from one outbreak and from one ethnic background.

The Korean outbreak was caused by a clade B virus. Limitations of this study are that all the sera tested were from one outbreak and from one ethnic background and that a MERS-CoV isolate from these patients was not available for use in the serology tests. However, we have demonstrated in this, and previous studies, that antibody titres are not affected by the clade of virus used.

In conclusion, the different types of neutralisation or ppNT assays can be used in MERS-CoV diagnosis and seroepidemiology. PRNT$_{50}$ was more sensitive than other assay formats and may be the only assay that can be positive early in the course of infection and in a few patients with poor serologic responses. Genetically diverse MERS-CoV are antigenically homogenous suggesting that future vaccines generated by any MERS-CoV strain will cross-protect against genetically and geographically diverse viruses.

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Conflict of interest

None declared.

Authors’ contributions

MP and MDO conceived, planned and coordinated the study, the study; RAPM carried out the serology assays, RAPMP and LLMP developed the serology assays, WBP, PGC, SJC, JYC, HSO, KJS, JHB, ESK, HBK, SWP, NJK coordinated the clinical studies, EYHL carried out the statistical analysis, and all authors critically reviewed the manuscript.

References


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