Role of Signal-to-Cutoff Ratios in Hepatitis C Virus Antibody Detection

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We reviewed results from 12,800 samples tested for hepatitis C virus (HCV) antibody detection in our laboratory by screening (Ortho chemiluminescence immunoassay [CIA]) and supplemental tests (Chiron recombinant immunoblot assay [RIBA]). We found that a signal-to-cutoff (S/Co) ratio of 10.3 was, in our setting, the most efficient cutoff point to improve the diagnostic algorithm of HCV infection.

Hepatitis C virus (HCV) infection is a major public health concern (2, 12): about 3% of the world’s population has been infected, and there are more than 170 million chronic carriers (17).

HCV infection can lead to end-stage liver disease, cirrhosis, and hepatocellular carcinoma, and mortality will continue to increase over the next 2 decades (1, 10).

The diagnosis of HCV infection is based on serological assays that detect specific antibodies to HCV (anti-HCV) and molecular assays that detect viral nucleic acid (HCV RNA) (14). Testing for the presence of anti-HCV antibodies is recommended for initial identification of persons with HCV infection (3, 7, 16). Anti-HCV detection by immunoassay screening tests is generally the first step in clinical diagnosis and screening of asymptomatic subjects. Screening tests have high false-positive rates, particularly among populations with a low (<10%) prevalence of HCV infection (4).

Chiron RIBA is a qualitative enzyme immunoblot assay for the detection of antibodies against recombinant antigens (c33c and NS5) and HCV-encoded synthetic peptides (c22, c100, and 5-1-1). The anti-HCV reactivity of specimens is determined by visually comparing each HCV band to the intensity of the low- and high-human-IgG internal control bands blotted onto each strip. A negative, indeterminate, or positive interpretation is based on the reaction pattern present on the strip.

The CDC guidelines (4) for laboratory testing reported that screening test positive results are classified as having high S/Co ratios if their ratios are at or above a predetermined value that predicts a supplemental test positive result ≥95% of the time, regardless of the anti-HCV prevalence or characteristics of the population being tested.

The CDC on its website (5) gives S/Co ratios predictive of a true positive ≥95% of the time for each screening test available. For Ortho CIA, high S/Co ratios are defined as ratios of ≥8.0.

Several studies have been published about the ability of this screening test to predict the supplemental test result (9, 11, 14, 15). Lai et al. (14) concluded that for Ortho CIA, it is not necessary to confirm negative or positive values if the S/Co ratio is <3.0 or ≥20.0 because of the high rate of true-negative and true-positive

TABLE 1

<table>
<thead>
<tr>
<th>CIA S/Co ratio</th>
<th>No. (%) of RIBA results:</th>
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<tbody>
<tr>
<td></td>
<td>Negative</td>
</tr>
<tr>
<td>≥3.0 (43)</td>
<td>31 (72.1)</td>
</tr>
<tr>
<td>3.01–8.0 (26)</td>
<td>8 (30.8)</td>
</tr>
<tr>
<td>8.01–20.0 (36)</td>
<td>4 (11.1)</td>
</tr>
<tr>
<td>&gt;20.01 (208)</td>
<td>2 (1.0)</td>
</tr>
<tr>
<td>Total (313)</td>
<td>45</td>
</tr>
</tbody>
</table>

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The objective of the present study was to evaluate in our setting the relationship between Ortho CIA-positive S/Co samples and Chiron RIBA results to assess if our diagnostic algorithm might be modified in order to reduce unnecessary supplementary tests.

We retrospectively reviewed results from a database of 12,800 serum samples that were tested from 1 July 2008 to 31 December 2010. Of these, 7,000 samples (54.7%) were from hospitalized patients and 5,800 (45.3%) were from outpatients.

All samples were analyzed for anti-HCV antibodies screening detection using the Ortho CIA, and all positive sera were evaluated with the Chiron RIBA as a supplemental test.

Statistical analysis was carried out with Stata Release statistical software version 11.0 (Stata Corp. LP, College Station, TX) and Visual Basic (VBA) for Windows. A P value of <0.05 was considered significantly different.

Among 12,800 patients tested, 313 (2.4%) resulted positive (S/Co ratio, ≥1.0) by Ortho CIA. The S/Co ratio of positive samples ranged from 1.0 (minimum) to 30.1 (maximum). The mean value was 19.1 (standard deviation [SD], 9.4), and the 5th and 95th percentiles were 1.28 and 28.50, respectively.

Of the 313 Ortho CIA-positive patients, 222 (71.0%), 46 (14.7%), and 45 patients (14.3%) were positive, negative, and indeterminate, respectively, by Chiron RIBA.

We categorized positive samples on the basis of the S/Co ratio and calculated ratios of negative, indeterminate, and positive results by Chiron RIBA (Table 1).

The diagnostic sensitivity and specificity, the positive predictive value (PPV) and negative predictive value (NPV), were calculated at S/Co ratios of 3.0, 8.0, and 20.0, respectively (Table 2). Ordinal regression analysis was performed using the S/Co screening test as the continuous predictive variable and the confirmatory test as the ordinal dependent variable (0, negative; 1, indeterminate; 2, positive). The analysis with ordinal regression shows that the screening test value is strongly associated with the ordinal result of the confirmatory test ($\chi^2 = 226.1, P < 0.0001$), suggesting a strong relationship between screening and supplemental tests. Despite the relationship, there are a statistically significant number of samples with an indeterminate result (Fig. 1).

The values of the S/Co ratios associated with 95% PPV and 95% NPV were 10.3 and 3.0, respectively.

On the basis of our present study and literature data, we modified our algorithm for HCV testing. If the S/Co ratio is <10.3, the Ortho CIA results should be confirmed by supplemental Chiron RIBA.

We decided to report specimens with an S/Co ratio of ≥10.3 without a supplemental test but with an explanatory comment. We declare in the comment that supplemental serological testing was not performed for a sample with an S/Co ratio of ≥10.3 since in these cases, the screening test predicts a true antibody-positive result ≥95% of the time. We inform the test-ordering physician also that more specific testing can be requested if necessary, especially for people being tested for HCV infection for the first time or on the basis of other clinical or laboratory information. For this eventuality, we store the specimens for the supplemental test. Therefore, we suggest performing reverse transcriptase-PCR (RT-PCR)...

### Table 2: Diagnostic performance of the CIA screening test in the prediction of RIBA results

<table>
<thead>
<tr>
<th>Parameter</th>
<th>% correct diagnosis (95% CI) at CIA S/Co ratio of:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>3.0</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>99.5 (97.5–100)</td>
</tr>
<tr>
<td>Specificity</td>
<td>46.2 (35.6–56.9)</td>
</tr>
<tr>
<td>PPV</td>
<td>81.9 (76.7–86.3)</td>
</tr>
<tr>
<td>NPV</td>
<td>97.7 (87.7–99.9)</td>
</tr>
</tbody>
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*a* 95% CI, 95% confidence interval; PPV, positive predictive value; NPV, negative predictive value.

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**FIG 1** Plot of ordinal regression results: relationship between test screening (S/Co ratio) and RIBA results for HCV. The abscissa represents crescent values for screening test (minimum, 1.0; maximum, 30.1), while the horizontal line represents the results of RIBA. RIBA results are symbolized as follows: 0, negative; 1, indeterminate; and 2, positive.
PCR) to detect HCV viremia in positive samples at the screening test and with indeterminate or positive RIBA results.

We believe that implementation of this algorithm will improve the accuracy, efficiency, and utility of anti-HCV testing, providing more reliable results for physicians and their patients, and can reduce unnecessary supplementary testing. We also suggest that this type of validation will need to be done by each laboratory since the population characteristics and the assay used will both have an effect on the cutoff selection.

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REFERENCES