Comparison of four commercially available avidity tests for Toxoplasma-specific IgG antibodies


and the French National Reference Center for Toxoplasmosis Network 9

Running title: Comparison of four Toxoplasma IgG avidity assays

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Abstract

Toxoplasma infection in pregnant women may cause congenital toxoplasmosis. Diagnosis of infection is based on serological tests aimed at detecting IgM and IgG antibodies against *Toxoplasma gondii*. However, IgM antibodies are not an accurate marker for discriminating between acute and latent infection. Detection of residual or persistent IgM may occur months or even years after primary infection, while the IgG avidity test is a rapid means for identifying latent infections in pregnant women who exhibit both IgG and IgM anti-

*Toxoplasma* antibodies on initial testing during pregnancy. In this study, we assessed and compared the performance of four commercially available *Toxoplasma* IgG avidity tests in immunocompetent and immunocompromised patients with acute and latent toxoplasmosis. Positive predictive value of high avidity to confirm latent toxoplasmosis was 100% for all the assays indicating that high avidity is a hallmark of latent infection. However, negative predictive value of high avidity ranged from 99.2% (bioMérieux) to 95.3% (Abbott) indicating that that acute toxoplasmosis could not be reliably diagnosed based on low IgG avidity alone. Thus, the avidity test provides a rapid means for identifying latent *Toxoplasma* infection in immunocompetent pregnant women presenting both IgG and IgM anti-

*Toxoplasma* antibodies on initial testing. In terms of cost-effectiveness, avidity testing is a powerful tool that optimizes screening and follow-up of pregnant women while it minimizes the costs of screening by avoiding subsequent costly maternal and fetal investigation and unnecessary treatment. The cheapest assay, VIDAS® Toxo IgG Avidity, also had the best performance for the diagnosis of latent toxoplasmosis.

**Key words:** Toxoplasmosis, pregnancy, IgG avidity, serological diagnosis
Introduction

Toxoplasmosis is a widespread parasitic disease that usually causes no symptoms. However, infection in pregnant women may result in congenital toxoplasmosis (19). In France, a national program for detection and treatment of toxoplasmosis has reduced the rate and severity of congenital infections (6, 10). Diagnosis of Toxoplasma infection is based on serological tests aimed at detecting IgM and IgG antibodies against Toxoplasma gondii (19, 28). However, these assays have been proven to be poorly reliable for discriminating between recent and latent infections. Indeed, detection of specific IgM antibodies, considered to be acute phase markers, can lead to false-positive results or the detection of residual or persistent IgM months or even years after primary infection, suggesting that IgM does not appear to be an accurate acute phase marker. In the obstetrical setting, determination of the date of infection is crucial given to judge the necessity of antenatal diagnosis of toxoplasmosis (22).

For many years, IgG avidity assays have been used in the serological screening strategy for pregnant women (13, 24). As these assays were shown to be an essential tool for discriminating between acute and latent stages of infectious diseases, they are widely used in expert laboratories. Because in-house tests often lack automation and standardization, the use of commercial IgG avidity tests is highly recommended. For this purpose, most major in vitro diagnostic companies have produced kits based on various approaches, including recombinant antigen-based technology (8, 9, 11, 17, 20). Since 2006, the objective of the French National Reference Center for Toxoplasmosis (NRCT) has been to investigate the methods used for the serological diagnosis of toxoplasmosis, with the aim of reducing the cost of the French screening program (27). In this study, we assessed the performance of four commercially available Toxoplasma IgG avidity tests in defined populations of acute and latent toxoplasmosis in immunocompetent and immunocompromised patients.
Materials and methods

Sera specimens

A total of 206 sera were classified into three groups according to clinical and serological criteria as follows (15):

- **Group 1 - acute toxoplasmosis**: 67 samples from 56 pregnant women (one or two sera) corresponded to acute toxoplasmosis in pregnant women with confirmed seroconversion (appearance of IgG and IgM anti-Toxoplasma specific antibodies after an initial negative sample), and are therefore precisely dated. No immunocompromised patients were included in this group. The first sera were from untreated pregnant women, with all subsequent sera taken from patients treated with spiramycine or pyrimethamine-sulfadiazine.

- **Group 2 - latent toxoplasmosis with low IgG and negative IgM**: This group comprises 50 sera from 50 subjects with IgG <50 IU/mL and negative for IgM, with a follow-up sample indicating no increase in IgG nor presence of IgM. Nine of the patients were immunocompromised. In addition, there were 34 sera from subjects with a positive IgG history for >1 year and no IgM detected, including 11 immunocompromised patients.

- **Group 3 - latent toxoplasmosis with positive IgG history for >1 year and positive IgM**: 55 subjects, including 2 immunocompromised patients and 9 pregnant women more than 6 months pregnant, being treated during pregnancy after toxoplasmic seroconversion.

All samples were selected using routine tests, including dye-test in reference laboratories from the NRCT network.
Serological diagnosis
Avidity determination

Four kits that are commercially available in France were tested, according to manufacturers’ recommendations.

ARCHITECT® Toxo IgG Avidity (Abbott)
The ARCHITECT® Toxo IgG Avidity assay, CE approved, is an automated test using a chemiluminescent microparticle immunoassay (CMIA), comprising two single tests that are both two-step immunoassays. One of the aliquots is treated by a blocking agent. The avidity of anti-Toxoplasma IgG in the sample is calculated using the relative light units (RLUs) of both tests. The percentage of avidity is obtained by the ratio of RLUs pretreated with a blocking agent and those obtained from the unblocked sample. The avidity can be determined for samples tested with ARCHITECT® Toxo IgG as \( \geq 1.6 \text{ IU/mL} \). Avidity of specimens are classified as low (<50%), gray zone (50-59.9%), or high (\( \geq 60% \)). According to the manufacturer, an avidity \( \geq 60\% \) permits to exclude an infection of less than 4 months.

VIDAS® Toxo IgG Avidity (bioMérieux)
The VIDAS® Toxo IgG avidity, CE approved, is a semi-automated test, combining a two-step enzyme immunoassay sandwich method with a final fluorescent detection (ELFA). It uses a dissociation agent, such as urea. The avidity can only be determined if the VIDAS® Toxo IgG II are \( \geq 8 \text{ IU/mL} \). Moreover, the Toxo IgG II IgG must be reduced to 15 IU/mL by sample dilution. For IgG titers between 8 and 15 IU/mL, samples can be used undiluted. The avidity is determined by the ratio of the sample treated with dissociated agent to the non-treated sample. This allows the avidity of specimens to be classified as low (<0.2), gray zone (0.2-0.3), or high (\( \geq 0.3 \)). According to the manufacturer, a low avidity is not a proof of recent infection, whereas high avidity strongly suggests an infection of more than 4 months.
LIAISON® Toxo IgG Avidity II (DiaSorin)

The LIAISON® Toxo IgG Avidity II, CE approved, is an automated indirect immunoluminometric (CLIA) test, using urea as the dissociation agent. Responses are measured as RLUs, while the avidity is determined by the ratio of RLUs of urea-treated to non-treated samples. Avidity can be determined only if the LIAISON® IgG II is ≥8.8IU/ml and must be interpreted with caution if the IgG is <15IU/ml. Avidity is classified as low (<0.3), gray zone (0.3-0.4), or high (≥0.4). According to the manufacturer, a low avidity suggests a primary infection acquired within the last 4 months, although latent infection cannot be excluded. In contrast, high avidity excludes primary infection within the last 4 months.

PLATELIA® Toxo IgG Avidity (BioRad)

The PLATELIA Toxo IgG Avidity, CE approved, is an indirect enzyme immunoassay in solid phase, which may be automated on EVOLIS®. It has to be used in association with the PLATELIA® Toxo IgG test. IgG must be ≥9IU/mL in order to determine the avidity. The test is based on a standard measurement of IgG followed by the same test after the addition of urea. The avidity is obtained by the ratio of the optical densities (OD) in the samples with and without urea. It allows the avidity to be classified as low (<0.4), gray zone (0.4-0.5), or high (≥0.5). According to the manufacturer, low avidity suggests recent infection of less than 20 weeks, although the result does not confirm this diagnosis with certitude, whereas high avidity suggests a past infection of over 20 weeks, but does not exclude with certitude a more recent infection.

Retrospective study on the use of avidity assays in 16 French University and General Hospitals
We performed a retrospective study during one year to evaluate the use of avidity assays in patients presenting with positive *Toxoplasma* IgG and IgM among 16 laboratories of our network. We have evaluated the amount of avidity assays performed and their results.

**Statistical analysis**

For the acute toxoplasmosis population, in an off-label use of the reagents, we have estimated i) the proportion of low avidity results (sensitivity), ii) the positive predictive value (PPV) and the negative predictive value (NPV) of a low avidity result, iii) the Youden index measuring the accuracy of the test to detect acute toxoplasmosis (negative index: ineffective test; index close to 1: effective test), and iv) the Yule’s Q coefficient measuring the correlation of the IgG avidity index and acute toxoplasmosis (the closer the coefficient to 1, the stronger the correlation). For the latent toxoplasmosis population, in an approved use, similar biostatistical results were calculated using the proportion of high avidity results. For all patients, equivocal or intermediate values were considered false-negatives in subjects with acute toxoplasmosis and false-positives in subjects with latent toxoplasmosis.

**Results**

**Comparison of the sensitivity of the four IgG avidity immunoassays for acute toxoplasmosis**

The IgG kinetics, performed in parallel for the determination of IgG avidity of each kit, followed a similar course with all kits (Fig. 1A). It should be born in mind that the kinetics of IgG avidity varied considerably between individuals. Abbott showed an increase of IgG avidity of 82.8% (23.8 at 2-4 weeks to 43.5% at 17-36 weeks post-infection). bioMérieux revealed an increase of 56.3% (0.064 to 0.1), BioRad 42.1% (0.19 to 0.27), and DiaSorin 30.1% (0.165 to 0.216). None of the sera exhibited high avidity even at 36 weeks post-infection (a late stage of infection). However, we have to bear in mind that all the sera taken
from 6-8 to 17-36 weeks post-infection were from pregnant women treated for acute toxoplasmosis (Fig. 1B).

The slow growth avidity maturation shortly post-infection was evident when the avidities were depicted for individual patients (Fig. 2). However, the existence of equivocal data showed differences between the four immunoassays (Table 1 and Fig. 2): 6 equivocal results for Abbott, 1 for bioMérieux, 2 for BioRad, and 3 for Diasorin. If these equivocal data were considered false negative for detecting acute toxoplasmosis, then bioMérieux had the most appropriate capacity to recognize an acute toxoplasmosis with a 98.2% sensitivity, followed by BioRad (96.4%), Diasorin (94.6%) and finally Abbott (89.3%). Notably, no high avidity results were found in this group, thus confirming the good sensitivity of these assays for the diagnosis of acute toxoplasmosis. It must be remembered that none of these kits is recommended for use in diagnosing acute toxoplasmosis.

Comparison of the sensitivity for latent toxoplasmosis

Considering all patients with latent toxoplasmosis, the proportion of high-avidity results was 87.7% with bioMérieux, 87.1% with Abbott and Diasorin, and 74.8% with BioRad (Table 2, Figures 3 and 4). However, better results were obtained in the group of patients without specific IgM in serum (group 2) with proportion of high-avidity results reaching 94% for bioMérieux, 91.7% for Abbott and Diasorin, and 83.3% for BioRad. If the equivocal results were interpreted as low avidity results, the sensitivity was greatly diminished for each test, especially in the case of BioRad, where a high number of equivocal results was observed. These false negative results were mainly accounted for immunocompromised patients. Indeed, if only immunocompetent patients were considered, the sensitivity increased substantially from 87.1% to 92.5% for Abbott, 87.7% to 91.6% for bioMérieux, 87.1% to 88.8% for Diasorin, and 74.8% to 83.2% for BioRad (Table 2).
Comparison of the diagnostic efficacy of avidity assays

When comparing the PPV for acute toxoplasmosis, there was a large variation between kits, ranging from 61.1% for BioRad to 77.5% for bioMérieux (Table 3). In contrast, the NPV was more than 99% for bioMérieux and BioRad, but lower for Abbott and Diasorin, being 95.3% and 96.8%, respectively. These discrepancies resulted in a large variation in the Youden index, which measures the accuracy of the assay, ranging from 0.73 to 0.87. However, the Yule index, measuring the relationship of IgG avidity with acute toxoplasmosis, was acceptable, exceeding 0.9 for all of the assays and ranging from 0.96 to 1 for bioMérieux.

On the other hand, the PPV for latent toxoplasmosis attained the maximum of 100% with all kits, while the Yule’s Q coefficient was 1. However, the NPV is lower, ranging from 61.5% for BioRad to 77.8% for bioMérieux. In addition, the Youden index ranged from 0.75 to 0.87 (Table 3).

Distribution of avidity results in the 16 French University and General Hospitals

Among the network, 11 laboratories used bioMérieux assays, 3 BioRad, 2 Abbott and none of them Diasorin. Of 3,885 sera positive for both IgG and IgM, 55.7% exhibited high avidity, 14.8% intermediate affinity, and 29.5% low avidity (Table 4).
Discussion

A number of different methods have been used to determine the avidity of specific IgG antibodies for dating *Toxoplasma* infection. The majority of these methods in use for more than 10 years have involved in-house assays based on the use of protein denaturing agents in washing steps or serum diluents. More recently, assays based on recombinant proteins as blocking agents were introduced (12). The IgG-avidity assays have become generally accepted diagnostic tools with the final goal to exclude a recent infection and a risk for the fetus, which is crucial in the case of pregnant women with suspected acute infection (e.g., IgM positive sera). These assays, evaluated using sera from the biobank developed from the French national screening program, have now been incorporated in decisional algorithms used in national recommendations (28). Today, several commercial IgG avidity assays are available, although few cross-evaluations of their diagnostic performance have been published (1, 3, 14, 17).

One of the primary goals of the French National Center for Toxoplasmosis was to evaluate the performance of the commercialized assays used in the French national screening program for congenital toxoplasmosis (29). Therefore, we evaluated four assays, from Abbott, bioMérieux, BioRad and DiaSorin, which are the most widely used in French biology laboratories and in reference laboratories abroad. These fully automated assays are based on the exclusion of acute infection, with previous expert advice reporting on good performance of these assays.

Considering these assays within the recommended use (exclude acute infection when high avidity antibodies are present), the PPV for confirming latent toxoplasmosis was 100%. The Yule’s Q coefficient was 1, thus confirming the strong relationship between high avidity and latent toxoplasmosis. In our large retrospective study, in the group of pregnant women with both IgG and IgM anti *Toxoplasma* antibodies, 55.7% were considered to have a latent
infection with a single test. Therefore, by measuring IgG avidity in a single first sample in non-treated and immunocompetent patients, we are able to confirm a latent infection and to exclude a recent infection (5, 23).

When we used the above biobank to compare the performance of these four assays in detecting acute toxoplasmosis, noting that they were not designed for this purpose, the kinetics of IgG maturation were variable performance. Abbott was the most dynamic assay, probably because it is based on recombinant proteins (SAG1 and GRA8). In contrast to the conventional BioRad, DiaSorin, and bioMérieux (denaturating) avidity tests, the avidity competition used in Abbott’s ARCHITECT® test detects low avidity IgG by blocking high avidity IgG in the sample with a soluble recombinant antigen (8).

In general, kinetics of avidity maturation were similar for all the assays. The observed decrease in the IgG titers after 12 weeks could be due to the effect of treatment, as all the pregnant women included in this study were treated for acute toxoplasmosis. This could also account for the less dynamic performance of the three “classical” assays based on a native antigen and the conventional denaturing method for determining avidity (4, 16, 25).

In the context of an off-label use, the performance in detection of acute cases were highly variable. When equivocal results were considered as low avidity, all assays reached 100% sensitivity. The results of this study on pregnant women demonstrated that acute toxoplasmosis could not be reliably diagnosed based on low IgG avidity alone. Therefore, only the first sample should be considered a reference sample when interpreting avidity results as after the first determination, all pregnant women were treated with spiramycin according to French recommendations (5, 16). When we considered only the first sample in our group of 56 non-treated pregnant women with acute toxoplasmosis, sensitivity was 100%.

Our results demonstrate also that disequilibrium of host-parasite dynamics due to an impaired immunity or an anti-Toxoplasma treatment probably results in a delay of IgG maturation.
Therefore, results from immunocompromised or Toxoplasma-treated patients should be interpreted with caution. This aspect is clearly indicated only in the VIDAS® booklet.

In terms of cost-effectiveness, avidity testing is a powerful tool allowing optimization of screening and follow-up of pregnant women (2, 7, 26). This point is confirmed by our retrospective study among the French network that shows that half of cases with detection of both IgM and IgG antibodies were identified as latent toxoplasmosis, therefore avoiding unnecessary subsequent maternal and fetal investigation and treatment. For this reason, the assay price should also be considered. In our study, the price for one run of each reagent (not considering external and internal quality control sera) for the determination of IgG avidity were 11.63 € for ARCHITECT® (Abbott), 5.50 € for VIDAS® (bioMérieux), 8.16 € for PLATELIA® Toxo IgG avidity (BioRad), and 6.44 € for LIAISON® (DiaSorin). The cheapest assay, VIDAS® (bioMérieux), also had the best performance for the diagnosis of latent toxoplasmosis. Regardless, avidity testing remains expensive according to the economic evaluations of Stillwagon et al. (26). Thus, we recommend sending inconclusive sera to an expert laboratory that uses these complementary methods (28). Of interest, the ARCHITECT® assay, which employs recombinant antigens provided the best performance for detecting latent infection in the presence of persistent IgM. This means that the use of recombinant antigens for toxoplasmosis assays could be extended in the future, considering that the type of antigen used in antibody recognition is crucial. For example, IgG against antigens recognized early (i.e., GRA7, GRA8, and ROP1) mature significantly earlier than those directed against later antigens (i.e., SAG1 and MAG1) (21).

In conclusion, the avidity test provides a rapid means for identifying latent Toxoplasma infection in pregnant women who show both IgG and IgM anti-Toxoplasma antibodies on initial testing during pregnancy. However, there are some limitations in the use of this method. Avidity assays are not conclusive in some immunocompromised patients and those
treated for toxoplasmosis. Overall, optimal diagnostic performance is achieved by using appropriate combinations of serological, culture-based, and PCR techniques.
The authors declare to have no competing financial interests in this study.

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References


Figure legends

Figure 1: The kinetics (mean) of IgG levels (1A) and IgG avidity values (1B) with four immunoassays in 67 sera of 56 pregnant women with acute toxoplasmosis.

Figure 2: Kinetics of IgG avidity for the four immunoassays in 67 samples taken from 56 pregnant women with acute toxoplasmosis and confirmed seroconversion. All the women were treated for acute toxoplasmosis after the first serum tested. Horizontal lines represent the upper and lower cut-offs of the gray zone for each assay.

Figure 3: IgG avidity Results with the four immunoassays in IgG and IgM positive sera in latent toxoplasmosis (n=55). Black squares represent treated or immunocompromised patients. Horizontal lines represent the upper and lower cut-offs of the gray zone for each assay.

Figure 4: IgG avidity results with the four immunoassays in IgG positive and IgM negative sera in the latent toxoplasmosis population (n=84). Black squares represent treated or immunocompromised patients. Horizontal lines represent the upper and lower cut-offs of the gray zone for each assay.
Table 1: Comparison of the sensitivity of four IgG avidity immunoassays in 56 patients with acute toxoplasmosis (Group 1) according to the classification of equivocal results.

<table>
<thead>
<tr>
<th>Immunoassay</th>
<th>Equivocal data considered low avidity</th>
<th>Equivocal data considered high avidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott</td>
<td>100% (56/56)</td>
<td>89.3% (50/56)</td>
</tr>
<tr>
<td>bioMérieux</td>
<td>100% (56/56)</td>
<td>98.2% (55/56)</td>
</tr>
<tr>
<td>BioRad</td>
<td>100% (56/56)</td>
<td>96.4% (54/56)</td>
</tr>
<tr>
<td>DiaSorin</td>
<td>100% (56/56)</td>
<td>94.6% (53/56)</td>
</tr>
</tbody>
</table>
Table 2: Comparison of the sensitivity of four IgG avidity immunoassays in patients with latent toxoplasmosis (Group 2: IgG positive and IgM negative; Group 3: IgG and IgM positive). Equivocal avidity was considered low avidity.

<table>
<thead>
<tr>
<th></th>
<th>IgG Pos and IgM Neg</th>
<th>IgG Pos and IgM Pos</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott</td>
<td>91.7% (77/84)</td>
<td>80% (44/55)</td>
<td>87.1% (121/139)</td>
</tr>
<tr>
<td>bioMérieux</td>
<td>94% (79/84)</td>
<td>78.2% (43/55)</td>
<td>87.7% (122/139)</td>
</tr>
<tr>
<td>BioRad</td>
<td>83.3% (70/84)</td>
<td>61.8% (34/55)</td>
<td>74.8% (104/139)</td>
</tr>
<tr>
<td>DiaSorin</td>
<td>91.7% (77/84)</td>
<td>80% (44/55)</td>
<td>87.1% (121/139)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>IgG Pos and IgM Neg</th>
<th>IgG Pos and IgM Pos</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Abbott</td>
<td>95.3% (61/64)</td>
<td>88.4% (38/43)</td>
<td>92.5% (99/107)</td>
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<tr>
<td>bioMérieux</td>
<td>95.3% (61/64)</td>
<td>86% (37/43)</td>
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<tr>
<td>BioRad</td>
<td>92.2% (58/64)</td>
<td>72.1% (31/43)</td>
<td>83.2% (89/107)</td>
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<tr>
<td>DiaSorin</td>
<td>89.1% (57/64)</td>
<td>88.4% (38/43)</td>
<td>88.8% (95/107)</td>
</tr>
</tbody>
</table>
Table 3: Comparison of positive predictive value (PPV), negative predictive value (NPV), Youden index, and Yule’s Q coefficient of four IgG avidity immunoassays for patients with acute or latent toxoplasmosis.

<table>
<thead>
<tr>
<th></th>
<th>Acute Toxoplasmosis*</th>
<th>Latent Toxoplasmosis**</th>
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<tbody>
<tr>
<td></td>
<td>PPV (%)</td>
<td>NPV (%)</td>
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<tr>
<td>Abbott</td>
<td>73.5</td>
<td>95.3</td>
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<td>99.1</td>
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<tr>
<td>DiaSorin</td>
<td>74.3</td>
<td>96.8</td>
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</table>

*For the acute toxoplasmosis population, in an off-label use of the reagents, we have estimated the positive predictive value (PPV) and the negative predictive value (NPV) of a low avidity result.

**For the latent toxoplasmosis population, in an approved use, similar biostatistical results were calculated using the proportion of high avidity results. For all patients, equivocal or intermediate values were considered false-negatives in subjects with acute toxoplasmosis and false-positives in subjects with latent toxoplasmosis.

*** Youden index measures the effectiveness of the test (negative index: ineffective test; index close to 1: effective test)

**** Yule’s Q coefficient measures the relationship to IgG avidity index (the closer the coefficient is to 1, the stronger the relationship)
Table 4: Distribution of avidity results in the 16 University and General Hospitals in patients positive for both IgG and IgM anti-Toxoplasma antibodies.

<table>
<thead>
<tr>
<th>University Hospital</th>
<th>Number of sera</th>
<th>High avidity</th>
<th>Equivocal avidity</th>
<th>Low avidity</th>
<th>Assay used</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>602</td>
<td>60.5%</td>
<td>16.1%</td>
<td>23.4%</td>
<td>bioMérieux</td>
</tr>
<tr>
<td>B</td>
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<td>69.5%</td>
<td>9.5%</td>
<td>21%</td>
<td>bioMérieux</td>
</tr>
<tr>
<td>C</td>
<td>78</td>
<td>38.5%</td>
<td>26.9%</td>
<td>34.6%</td>
<td>bioMérieux</td>
</tr>
<tr>
<td>D</td>
<td>77</td>
<td>58.4%</td>
<td>20.7%</td>
<td>20.7%</td>
<td>bioMérieux</td>
</tr>
<tr>
<td>E</td>
<td>245</td>
<td>59.6%</td>
<td>10.2%</td>
<td>30.2%</td>
<td>bioMérieux</td>
</tr>
<tr>
<td>F</td>
<td>205</td>
<td>42.9%</td>
<td>23.9%</td>
<td>33.2%</td>
<td>BioRad</td>
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Figure 1
Figure 2

Figure 2
Figure 3
Figure 4