

QuantiFERON®-TB Gold Plus (QFT®-Plus) ELISA Package Insert



2 x 96 (622120)



20 x 96 (622822)

The whole blood IFN- γ test measuring responses to
ESAT-6 and CFP-10 peptide antigens



For in vitro diagnostic use



622120, 622822



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Intended Use

The QuantiFERON-TB Gold Plus (QFT-Plus) assay is an in vitro diagnostic test using a peptide cocktail simulating ESAT-6 and CFP-10 proteins to stimulate cells in heparinized whole blood. Detection of interferon- γ (IFN- γ) by enzyme-linked immunosorbent assay (ELISA) is used to identify in vitro responses to those peptide antigens that are associated with *Mycobacterium tuberculosis* infection.

QFT-Plus is an indirect test for *M. tuberculosis* infection (including disease) and is intended for use in conjunction with risk assessment, radiography, and other medical and diagnostic evaluations.

Summary and Explanation of the Test

Tuberculosis is a communicable disease caused by infection with *M. tuberculosis* (MTB) complex organisms (*M. tuberculosis*, *M. bovis*, *M. africanum*), which typically spread to new hosts via airborne droplet nuclei from patients with respiratory tuberculosis disease. A newly infected individual can become ill from tuberculosis within weeks to months, but most infected individuals remain well. Latent tuberculosis infection (LTBI), a noncommunicable asymptomatic condition, persists in some who might develop tuberculosis disease months or years later. The main purpose of diagnosing LTBI is to consider medical treatment for preventing tuberculosis disease. Until recently, the tuberculin skin test (TST) was the only available method for diagnosing LTBI. Cutaneous sensitivity to tuberculin develops from 2 to 10 weeks after infection. However, some infected individuals, including those with a wide range of conditions hindering immune functions, but also others without these conditions, do not respond to tuberculin. Conversely, some individuals who are unlikely to have *M. tuberculosis* infection exhibit sensitivity to tuberculin and have positive TST results after vaccination with Bacille Calmette-Guérin (BCG) or infection with mycobacteria other than *M. tuberculosis* complex, or undetermined other factors.

LTBI must be distinguished from tuberculosis disease, a reportable condition which usually involves the lungs and lower respiratory tract but may also affect other organ systems. Tuberculosis disease is diagnosed from historical, physical, radiological, histological, and mycobacteriological findings.

QFT-Plus is a test for cell-mediated immune (CMI) responses to peptide antigens that simulate mycobacterial proteins. These proteins, ESAT-6 and CFP-10, are absent from all BCG strains and from most nontuberculous mycobacteria with the exception of *M. kansasii*, *M. szulgai*, and *M. marinum* (1). Individuals infected with MTB-complex organisms usually have lymphocytes in their blood that recognize these and other mycobacterial antigens. This recognition process involves the generation and secretion of the cytokine IFN- γ . The detection and subsequent quantification of IFN- γ forms the basis of this test.

The antigens used in QFT-Plus are a peptide cocktail simulating the proteins ESAT-6 and CFP-10. Numerous studies have demonstrated that these peptide antigens stimulate IFN- γ responses in T cells from individuals infected with *M. tuberculosis*, but generally not from uninfected or BCG-vaccinated persons without disease or risk for LTBI (1–32). However, medical treatments or conditions that impair immune functionality can potentially reduce IFN- γ responses. Patients with certain other mycobacterial infections might also be responsive to ESAT-6 and CFP-10, as the genes encoding these proteins are present in *M. kansasii*, *M. szulgai*, and *M. marinum* (1, 23). QFT-Plus is both a test for LTBI and a helpful aid for diagnosing *M. tuberculosis* complex infection in sick patients. A positive result supports the diagnosis of tuberculosis disease, but infections by other mycobacteria (e.g., *M. kansasii*) could also lead to positive results. Other medical and diagnostic evaluations are necessary to confirm or exclude tuberculosis disease.

QFT-Plus has two distinct TB antigen tubes: TB Antigen Tube 1 (TB1) and TB Antigen Tube 2 (TB2). Both tubes contain peptide antigens from the MTB-complex-associated antigens, ESAT-6 and CFP-10. Whereas the TB1 tube contains peptides from ESAT-6 and CFP-10 that are designed to elicit CMI responses from CD4⁺ T-helper lymphocytes, the TB2 tube contains an additional set of peptides targeted to the induction of CMI responses from CD8⁺ cytotoxic T lymphocytes. In the natural history of MTB infection, CD4⁺ T cells play a critical role in immunological control through their secretion of the cytokine IFN- γ . Evidence now supports a role for CD8⁺ T cells participating in the host defense to MTB by producing IFN- γ and other soluble factors, which activate macrophages to suppress growth of MTB, kill infected cells, or directly lyse intracellular MTB (33–35). MTB-specific CD8⁺ cells have been detected in subjects with LTBI and with active TB disease where IFN- γ producing CD8⁺ cells may be frequently found (36–38). Moreover, ESAT-6 and CFP-10 specific CD8⁺ T lymphocytes are described as being more frequently detected in subjects with active TB disease versus LTBI, and may be associated with a recent MTB exposure (39–41). In addition, MTB-specific CD8⁺ T cells producing IFN- γ have also been detected in active TB subjects with HIV co-infection (42, 43) and in young children with TB disease (44).

Principles of the assay

The QFT-Plus assay uses specialized blood collection tubes, which are used to collect whole blood. Incubation of the blood occurs in the tubes for 16 to 24 hours, after which, plasma is harvested and tested for the presence of IFN- γ produced in response to the peptide antigens.

The QFT-Plus test is performed in two stages. First, whole blood is collected into each of the QFT-Plus Blood Collection Tubes, which include a Nil tube, TB1 tube, TB2 tube, and a Mitogen tube. Alternatively, blood may be collected in a single generic blood collection tube that contains lithium heparin as the anticoagulant, and then transferred to QFT-Plus tubes.

The Mitogen tube is used with the QFT-Plus test as a positive control. This may be important where there is doubt as to the individual's immune status. The Mitogen tube also serves as a control for correct blood handling and incubation.

The QFT-Plus tubes should be incubated at 37°C as soon as possible, and within 16 hours of collection. Following a 16 to 24 hour incubation period, the tubes are centrifuged, the plasma is removed and the amount of IFN- γ (IU/ml) is measured by ELISA.

A QFT-Plus assay is considered positive for an IFN- γ response to either TB Antigen tube that is significantly above the Nil IFN- γ IU/ml value. The plasma sample from the Mitogen tube serves as an IFN- γ positive control for each specimen tested. A low response to Mitogen (<0.5 IU/ml) indicates an indeterminate result when a blood sample also has a negative response to the TB antigens. This pattern may occur with insufficient lymphocytes, reduced lymphocyte activity due to improper specimen handling, incorrect filling/mixing of the Mitogen tube, or inability of the patient's lymphocytes to generate IFN- γ . The Nil tube adjusts for background (e.g., excessive levels of circulating IFN- γ or presence of heterophile antibodies). The IFN- γ level of the Nil tube is subtracted from the IFN- γ level for the TB Antigen tubes and Mitogen tube.

Time required for performing assay

The time required to perform the QFT-Plus ELISA is estimated below; the time of testing multiple samples when batched is also indicated:

37°C incubation of blood tubes: 16 to 24 hours

ELISA: Approx. 3 hours for one ELISA plate

(22 individuals)

<1 hour labor

Add 10 to 15 minutes for each extra plate

Components and Storage

Blood Collection Tubes*		200 tubes	Single Patient Pack	Dispenser Pack	HA 200 tubes	HA Single Patient Pack	HA Dispenser Pack
Catalog no.		622526	622222	622423	623526	623222	623423
Number of tests/pack		50	10	25	50	10	25
QuantiFERON Nil Tube (gray cap, white ring)	Nil	50 tubes	10 tubes	25 tubes			
QuantiFERON TB1 Tube (green cap, white ring)	TB1	50 tubes	10 tubes	25 tubes			
QuantiFERON TB2 Tube (yellow cap, white ring)	TB2	50 tubes	10 tubes	25 tubes			
QuantiFERON Mitogen Tube (purple cap, white ring)	Mitogen	50 tubes	10 tubes	25 tubes			
QuantiFERON Nil HA Tube (gray cap, yellow ring)	Nil HA				50 tubes	10 tubes	25 tubes
QuantiFERON TB1 HA Tube (green cap, yellow ring)	TB1 HA				50 tubes	10 tubes	25 tubes
QuantiFERON TB2 HA Tube (yellow cap, yellow ring)	TB2 HA				50 tubes	10 tubes	25 tubes
QuantiFERON Mitogen HA Tube (purple cap, yellow ring)	Mitogen HA				50 tubes	10 tubes	25 tubes
QFT-Plus Blood Collection Tubes Package Insert		1	1	1	1	1	1

* Not all product configurations are available in every country. Please refer to QIAGEN Customer Care (details on www.qiagen.com) for more information on what configurations are available for ordering.

ELISA Components[†]	2 Plate Kit ELISA	Reference Lab Pack
Catalog no.	622120	622822
Microplate Strips (12 x 8 wells) coated with murine anti-human IFN- γ monoclonal antibody	2 x 96-well Microplate Strips	20 x 96-well Microplate Strips
IFN- γ Standard, lyophilized (contains recombinant human IFN- γ , bovine casein, 0.01% w/v Thimerosal)	1 x vial (8 IU/ml when reconstituted)	10 x vial (8 IU/ml when reconstituted)
Green Diluent (contains bovine casein, normal mouse serum, 0.01% w/v Thimerosal)	1 x 30 ml	10 x 30 ml
Conjugate 100x Concentrate, lyophilized (murine anti-human IFN- γ HRP, contains 0.01% w/v Thimerosal)	1 x 0.3 ml (when reconstituted)	10 x 0.3 ml (when reconstituted)
Wash Buffer 20x Concentrate (pH 7.2, contains 0.05% v/v ProClin [®] 300)	1 x 100 ml	10 x 100 ml
Enzyme Substrate Solution (contains H ₂ O ₂ , 3,3', 5,5' Tetramethylbenzidine)	1 x 30 ml	10 x 30 ml
Enzyme Stopping Solution (contains 0.5M H ₂ SO ₄)	1 x 15 ml	10 x 15 ml
QFT-Plus ELISA Package Insert	1	1

[†] See page 10 for precautions and hazard statements.

Materials required but not provided

- 37°C ± 1°C incubator*. CO₂ not required
- Calibrated variable volume pipets* for delivery of 10 µl to 1000 µl with disposable tips
- Calibrated multichannel pipet* capable of delivering 50 µl and 100 µl with disposable tips
- Microplate shaker*
- Deionized or distilled water, 2 liters
- Microplate washer (automated washer recommended)
- Microplate reader* fitted with 450 nm filter and 620 nm to 650 nm reference filter

Storage and handling

Blood collection tubes

- Store blood collection tubes at 4°C to 25°C.

Kit reagents

- Store kit reagents at 2°C to 8°C.
- Always protect Enzyme Substrate Solution from direct sunlight.

Reconstituted and unused reagents

For instructions on how to reconstitute reagents, please see page 17.

- The reconstituted kit standard may be kept for up to 3 months if stored at 2°C to 8°C.

Note the date on which the kit standard was reconstituted.

- Once reconstituted, unused Conjugate 100x Concentrate must be returned to storage at 2°C to 8°C and must be used within 3 months.

Note the date on which the conjugate was reconstituted.

- Working strength conjugate must be used within 6 hours of preparation.
- Working strength wash buffer may be stored at room temperature for up to 2 weeks.

* Make sure that instruments have been checked and calibrated according to the manufacturer's recommendations.

Warnings and Precautions

For in vitro diagnostic use

Warnings

- A negative QFT-Plus result does not preclude the possibility of *M. tuberculosis* infection or tuberculosis disease: false-negative results can be due to stage of infection (e.g., specimen obtained prior to the development of cellular immune response), co-morbid conditions that affect immune functions, incorrect handling of the blood collection tubes following venipuncture, incorrect performance of the assay, or other immunological variables.
- A positive QFT-Plus result should not be the sole or definitive basis for determining infection with *M. tuberculosis*. Incorrect performance of the assay may cause false-positive responses.
- A positive QFT-Plus result should be followed by further medical evaluation and diagnostic evaluation for active tuberculosis disease (e.g., AFB smear and culture, chest X-ray).
- While ESAT-6 and CFP-10 are absent from all BCG strains and from most known nontuberculous mycobacteria, it is possible that a positive QFT-Plus result may be due to infection by *M. kansasii*, *M. szulgai*, or *M. marinum*. If such infections are suspected, alternative tests should be investigated.

Precautions

For in vitro diagnostic use only.

When working with chemicals, always wear a suitable lab coat, disposable gloves, and protective goggles. For more information, please consult the appropriate safety data sheets (SDSs). These are available online in convenient and compact PDF format at www.qiagen.com/safety, where you can find, view, and print the SDS for each QIAGEN kit and kit component.



CAUTION: Handle human blood and plasma as if potentially infectious. Observe relevant blood and blood product handling guidelines. Dispose of samples and materials in contact with blood or blood products in accordance with federal, state, and local regulations.

The following hazards and precautionary statements apply to components of the QuantiFERON-TB Gold Plus ELISA.

Hazard Statements



QuantiFERON Conjugate

Contains: boric acid. Danger! May damage fertility or the unborn child. Dispose of contents/container to an approved waste disposal plant. IF exposed or concerned: Get medical advice/attention. Obtain special instructions before use. Store locked up. Wear protective gloves/protective clothing/eye protection/face protection.



QuantiFERON Enzyme Stopping Solution

Contains: sulfuric acid. Danger! Causes severe skin burns and eye damage. May be corrosive to metals. Dispose of contents/container to an approved waste disposal plant. IF IN EYES: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. IF ON SKIN (or hair): Remove/Take off immediately all contaminated clothing. Rinse skin with water/shower. Immediately call a POISON CENTER or doctor/physician. Store locked up. Wear protective gloves/protective clothing/eye protection/face protection.

QuantiFERON Enzyme Substrate Solution

Warning! Causes mild skin irritation. If skin irritation occurs: Get medical advice/attention.



QuantiFERON Green Diluent

Contains: trisodium 5-hydroxy-1-(4-sulphophenyl)-4-(4-sulphophenylazo)pyrazole-3-carboxylate. Warning! May cause an allergic skin reaction. Dispose of contents/container to an approved waste disposal plant. Take off contaminated clothing and wash it before reuse. If skin irritation or rash occurs: Get medical advice/attention. Wear protective gloves/protective clothing/eye protection/face protection.



QuantiFERON IFN- γ Standard

Contains: boric acid. Danger! May damage fertility or the unborn child. Dispose of contents/container to an approved waste disposal plant. IF exposed or concerned: Get medical advice/attention. Obtain special instructions before use. Store locked up. Wear protective gloves/protective clothing/eye protection/face protection.



QuantiFERON Wash Buffer 20x Concentrate

Contains: Mixture of 5-Chloro-2-methyl-4-isothiazolin-3-one and 2-Methyl-2H-isothiazol-3-one (3:1). Warning! May cause an allergic skin reaction. Wear protective gloves/protective clothing/eye protection/face protection.

Precautionary Statements

Obtain special instructions before use. Wear protective gloves/protective clothing/eye protection/face protection. IF ON SKIN (or hair): Remove/Take off immediately all contaminated clothing. Rinse skin with water/shower. **IF IN EYES:** Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. If exposed or concerned: Get medical advice/attention. Immediately call a POISON CENTER or doctor/physician. If skin irritation or rash occurs: Get medical advice/attention. Take off contaminated clothing and wash it before reuse. Store locked up. Dispose of contents/container to an approved waste disposal plant.

Further information

Safety Data Sheets: www.qiagen.com/safety

- Deviations from the *QuantiFERON-TB Gold Plus (QFT-Plus) ELISA Package Insert* may yield erroneous results. Please read the instructions carefully before use.
- Do not use kit if any reagent bottle shows signs of damage or leakage prior to use.
- Do not mix or use the Microplate Strips, IFN- γ Standard, Green Diluent, or Conjugate 100x Concentrate from different QFT-Plus kit batches. Other reagents (Wash Buffer 20x Concentrate, Enzyme Substrate Solution, and Enzyme Stopping Solution) can be interchanged between kits providing the

reagents are within their expiration periods and lot details recorded.
Discard unused reagents and biological samples in accordance with Local, State, and Federal regulations.

- Do not use the QFT-Plus Blood Collection Tubes or ELISA kit after the expiration date.
- Make sure that laboratory equipment has been calibrated/validated for use.

Specimen Collection and Handling

QFT-Plus uses the following collection tubes:

1. QuantiFERON Nil Tubes (gray cap with white ring)
2. QuantiFERON TB1 Tubes (green cap with white ring)
3. QuantiFERON TB2 Tubes (yellow cap with white ring)
4. QuantiFERON Mitogen Tubes (purple cap with white ring)
5. QuantiFERON HA Nil Tubes (gray cap with yellow ring)
6. QuantiFERON HA TB 1 Tubes (green cap with yellow ring)
7. QuantiFERON HA TB2 Tubes (yellow cap with yellow ring)
8. QuantiFERON HA Mitogen Tubes (purple cap with yellow ring)

Follow directions for lithium heparin tubes below.

Antigens have been dried onto the inner wall of the blood collection tubes so it is essential that the contents of the tubes be thoroughly mixed with blood. The QFT-Plus tubes must be maintained and transported at room temperature ($22^{\circ}\text{C} \pm 5^{\circ}\text{C}$) and be transferred to a 37°C incubator as soon as possible and within 16 hours of collection.

The following procedures should be followed for optimal results:

1. Label tubes appropriately.

Make sure each tube (Nil, TB1, TB2, and Mitogen) is identifiable by its label or other means once the cap is removed.

2. For each patient collect 1 ml of blood by venipuncture directly into each of the QFT-Plus Blood Collection Tubes. This procedure should be performed by a trained phlebotomist.

Important note: Tubes should be between 17°C to 25°C at the time of blood filling.

Standard QFT-Plus Blood Collection Tubes can be used up to an altitude of 810 meters above sea level. High Altitude QFT-Plus Blood Collection Tubes can be used between 1020 meters above sea level to an altitude of 1875 meters above sea level.

As 1 ml tubes draw blood relatively slowly, keep the tube on the needle for 2–3 seconds once the tube appears to have completed filling. This will ensure that the correct volume is drawn.

The black mark on the side of the tubes indicates the validated range of 0.8 to 1.2 ml. If the level of blood in any tube is outside the range of the indicator mark, a new blood sample should be obtained.

If a “butterfly needle” is being used to collect blood, a “purge” tube should be used to ensure that the tubing is filled with blood prior to the QFT-Plus tubes being used.

If using QFT-Plus Blood Collection Tubes at an altitude higher than 810 meters, or if low blood draw volume occurs, users can collect blood with a syringe, and immediately transfer 1 ml to each of the 4 tubes. For safety reasons, this is best performed by removing the syringe needle, ensuring appropriate safety procedures, removing the caps from the 4 QFT-Plus tubes and adding 1 ml of blood to each (to the center of the black mark on the side of the tube label). Replace the caps securely and mix as described below.

Optional single-tube blood collection method: Alternatively, blood may be collected in a single generic blood collection tube containing lithium heparin as the anticoagulant and then transferred to QFT-Plus tubes. **Only use lithium heparin** as a blood anticoagulant because other anticoagulants interfere with the assay. Fill a blood collection tube (minimum volume 5 ml) and gently mix by inverting the tube several times to dissolve the heparin. **Blood should be maintained and transported at room temperature (22°C ± 5°C)** before transfer to QFT-Plus tubes for incubation, which **must** be initiated within 16 hours of blood collection. If blood has been collected in a lithium heparin tube, samples must be **evenly mixed by gentle inversion** before dispensing into QFT-Plus tubes. Dispensing should be performed aseptically, ensuring appropriate safety procedures, removing the caps from the 4 QFT-Plus tubes and adding 1 ml of blood to each (to the center of the black mark on the side of the tube label). Replace the tube caps securely and mix as described below.

- 3. Immediately after filling the tubes, shake them ten (10) times just firmly enough to make sure that the entire inner surface of the tube is coated with blood. This will dissolve antigens on tube walls.**

Important note: Tubes should be between 17°C–25°C at the time of shaking. Overly vigorous shaking may cause gel disruption and could lead to aberrant results.

- 4. Following labeling, filling, and shaking, the tubes must be transferred to a 37°C ± 1°C incubator as soon as possible, and within 16 hours of collection. Prior to incubation, maintain and transport the tubes at room temperature (22°C ± 5°C).**

Directions for Use

Stage 1 – incubation of blood and harvesting of plasma

Materials provided

- QFT-Plus Blood Collection Tubes (Refer to Section 3)

Materials required (but not provided)

- Refer to Section 3

Procedure

1. If the blood is not incubated immediately after collection, re-mixing of the tubes by inverting 10 times must be performed immediately prior to incubation.
2. Incubate the tubes UPRIGHT at $37^{\circ}\text{C} \pm 1^{\circ}\text{C}$ for 16 to 24 hours. The incubator does not require CO_2 or humidification.
3. After incubation at 37°C , blood collection tubes may be held between 4°C and 27°C for up to 3 days prior to centrifugation.
4. After incubation of the tubes at 37°C , harvesting of plasma is facilitated by centrifuging the tubes for 15 minutes at 2000 to 3000 x g RCF (g). The gel plug will separate the cells from the plasma. If this does not occur, the tubes should be re-centrifuged.

It is possible to harvest the plasma without centrifugation, but additional care is required to remove the plasma without disturbing the cells.

5. **Plasma samples should only be harvested using a pipet.**

Important note: After centrifugation, avoid pipetting up and down or mixing plasma by any means prior to harvesting. At all times, take care not to disturb material on the surface of the gel.

Plasma samples can be loaded directly from centrifuged blood collection tubes into the QFT-Plus ELISA plate, including when automated ELISA workstations are used.

Plasma samples can be stored for up to 28 days at 2°C to 8°C or, if harvested, below -20°C for extended periods.

For adequate test samples, harvest at least 150 μl of plasma.

Stage 2 — IFN- γ ELISA

Materials provided

- QFT-Plus ELISA kit (Refer to Section 3).

Materials required but not provided

- Refer to Section 3.

Procedure

1. **All plasma samples and reagents, except for Conjugate 100x Concentrate, must be brought to room temperature ($22^{\circ}\text{C} \pm 5^{\circ}\text{C}$) before use. Allow at least 60 minutes for equilibration.**
2. **Remove strips that are not required from the frame, reseal in the foil pouch, and return to the refrigerator for storage until required.**

Allow at least 1 strip for the QFT-Plus standards and sufficient strips for the number of subjects being tested (refer to Figure 2). After use, retain frame and lid for use with remaining strips.

3. **Reconstitute the IFN- γ Standard with the volume of deionized or distilled water indicated on the label of the vial. Mix gently to minimize frothing and ensure complete solubilization. Reconstitution of the standard to the stated volume will produce a solution with a concentration of 8.0 IU/ml.**

Important note: The reconstitution volume of the kit standard will differ between batches.

Use the reconstituted kit standard to produce a 1 in 2 dilution followed by a 1 in 4 dilution series of IFN- γ in Green Diluent (GD) (see Figure 1). S1 (Standard 1) contains 4.0 IU/ml, S2 (Standard 2) contains 1.0 IU/ml, S3 (Standard 3) contains 0.25 IU/ml, and S4 (Standard 4) contains 0 IU/ml (GD alone). The standards must be assayed at least in duplicate. Prepare fresh dilutions of the kit standard for each ELISA session.

Recommended procedure for duplicate standards

- Label 4 tubes "S1", "S2", "S3", "S4"
- Add **150 μ l** of GD to S1, S2, S3, S4.
- Add **150 μ l** of the kit standard to S1 and mix thoroughly.
- Transfer **50 μ l** from S1 to S2 and mix thoroughly.
- Transfer **50 μ l** from S2 to S3 and mix thoroughly.
- GD alone** serves as the zero standard (S4).

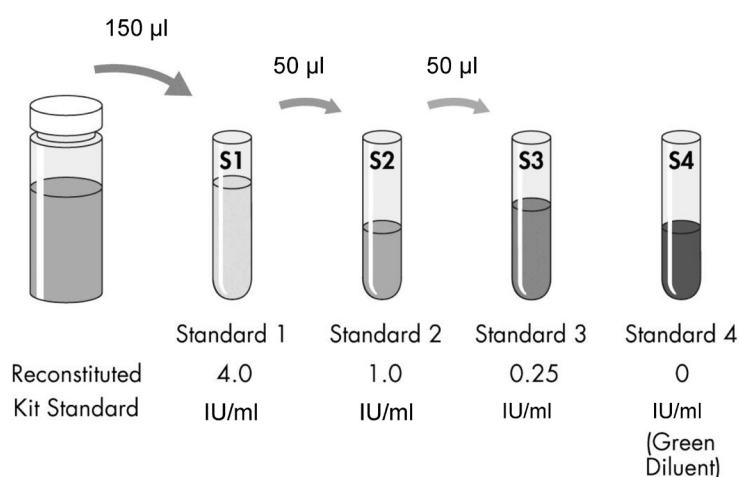


Figure 1. Preparation of standard curve.

- Reconstitute lyophilized Conjugate 100x Concentrate with 0.3 ml of deionized or distilled water. Mix gently to minimize frothing and ensure complete solubilization of the conjugate.**

Working strength conjugate is prepared by diluting the required amount of reconstituted Conjugate 100x Concentrate in Green Diluent (Table 1. Conjugate Preparation). Return any unused Conjugate 100x Concentrate to 2°C to 8°C immediately after use. Use only Green Diluent.

Table 1. Conjugate Preparation

Number of strips	Volume of Conjugate 100x Concentrate	Volume of Green Diluent
2	10 µl	1.0 ml
3	15 µl	1.5 ml
4	20 µl	2.0 ml
5	25 µl	2.5 ml
6	30 µl	3.0 ml
7	35 µl	3.5 ml
8	40 µl	4.0 ml
9	45 µl	4.5 ml
10	50 µl	5.0 ml
11	55 µl	5.5 ml
12	60 µl	6.0 ml

5. **For plasma samples harvested from blood collection tubes and subsequently stored or frozen, mix samples before addition to the ELISA well.**
Important note: If plasma samples are to be added directly from the centrifuged QFT-Plus tubes, any mixing of the plasma should be avoided. At all times, take care not to disturb material on the surface of the gel.
6. **Add 50 µl of freshly prepared working strength conjugate to the required ELISA wells using a multichannel pipet.**
7. **Add 50 µl of test plasma samples to appropriate wells using a multichannel pipet (refer to recommended plate layout in Figure 2). Finally, add 50 µl each of the standards 1 to 4.**

	1	2	3	4	5	6	7	8	9	10	11	12
A	1 N	3 N	5 N	7 N	9 N	S1	S1	13 N	15 N	17 N	19 N	21 N
B	1 TB1	3 TB1	5 TB1	7 TB1	9 TB1	S2	S2	13 TB1	15 TB1	17 TB1	19 TB1	21 TB1
C	1 TB2	3 TB2	5 TB2	7 TB2	9 TB2	S3	S3	13 TB2	15 TB2	17 TB2	19 TB2	21 TB2
D	1 M	3 M	5 M	7 M	9 M	S4	S4	13 M	15 M	17 M	19 M	21 M
E	2 N	4 N	6 N	8 N	10 N	11 N	12 N	14 N	16 N	18 N	20 N	22 N
F	2 TB2	4 TB1	6 TB1	8 TB1	10 TB1	11 TB1	12 TB1	14 TB1	16 TB1	18 TB1	20 TB1	22 TB1
G	2 TB2	4 TB2	6 TB2	8 TB2	10 TB2	11 TB2	12 TB2	14 TB2	16 TB2	18 TB2	20 TB2	22 TB2
H	2 M	4 M	6 M	8 M	10 M	11 M	12 M	14 M	16 M	18 M	20 M	22 M

Figure 2. Recommended sample layout (22 tests per plate).

- S1 (Standard 1), S2 (Standard 2), S3 (Standard 3), S4 (Standard 4)
- 1 N (Sample 1. Nil plasma), 1 TB1 (Sample 1. TB1 plasma), 1 TB2 (Sample 1. TB2 plasma), 1 M (Sample 1. Mitogen plasma)

8. Cover each plate with a lid and mix the conjugate and plasma samples/standards thoroughly using a microplate shaker for 1 minute. Avoid splashing.

9. Cover each plate with a lid and incubate at room temperature (22°C ± 5°C) for 120 ± 5 minutes.

Plates should not be exposed to direct sunlight during incubation.

10. During the incubation, dilute one part Wash Buffer 20x Concentrate with 19 parts deionized or distilled water and mix thoroughly. Sufficient Wash Buffer 20x Concentrate has been provided to prepare 2 liters of working strength wash buffer.

Wash wells with **400 µl** of working strength wash buffer for at least 6 cycles. An automated plate washer is recommended.

Thorough washing is very important to the performance of the assay. Make sure each well is **completely filled** with wash buffer to the top of the well for each wash cycle. A soak period of at least 5 seconds between each cycle is recommended.

Standard laboratory disinfectant should be added to the effluent reservoir and established procedures should be followed for the decontamination of potentially infectious material.

11. Tap plates face down on absorbent, low-lint towel to remove residual wash buffer. Add 100 µl of Enzyme Substrate Solution to each well, cover each plate with a lid and mix thoroughly using a microplate shaker.

12. Cover each plate with a lid and incubate at room temperature (22°C ± 5°C) for 30 minutes.

Plates should not be exposed to direct sunlight during incubation.

13. Following the 30-minute incubation, add 50 µl of Enzyme Stopping Solution to each well and mix.

Enzyme Stopping Solution should be added to wells in the same order and at approximately the same speed as the substrate in step 11.

14. Measure the Optical Density (OD) of each well within 5 minutes of stopping the reaction using a microplate reader fitted with a 450 nm filter and with a 620 nm to 650 nm reference filter. OD values are used to calculate results.

Calculations and Test Interpretation

QFT-Plus Analysis Software may be used to analyze raw data and calculate results. It is available from www.QuantiFERON.com. Please make sure that the most current version of the QFT-Plus Analysis Software is used.

The software performs a quality control assessment of the assay, generates a standard curve, and provides a test result for each subject, as detailed in the Interpretation of Results section.

As an alternative to using the QFT-Plus Analysis Software, results can be determined according to the following method.

Generation of standard curve

(If QFT-Plus Analysis Software is not used)

Determine the mean OD values of the kit standard replicates on each plate.

Construct a $\log_{(e)}$ - $\log_{(e)}$ standard curve by plotting the $\log_{(e)}$ of the mean OD (y-axis) against the $\log_{(e)}$ of the IFN- γ concentration of the standards in IU/ml (x-axis), omitting the zero standard from these calculations. Calculate the line of best fit for the standard curve by regression analysis.

Use the standard curve to determine the IFN- γ concentration (IU/ml) for each of the test plasma samples, using the OD value of each sample.

These calculations can be performed using software packages available with microplate readers, and standard spreadsheet or statistical software (such as Microsoft® Excel®). It is recommended that these packages be used to calculate the regression analysis, the coefficient of variation (%CV) for the standards, and the correlation coefficient (r) of the standard curve.

Quality control of test

The accuracy of test results is dependent on the generation of an accurate standard curve. Therefore, results derived from the standards must be examined before test sample results can be interpreted.

For the ELISA to be valid:

- The mean OD value for Standard 1 must be ≥ 0.600 .
- The %CV for Standard 1 and Standard 2 replicate OD values must be $\leq 15\%$.
- Replicate OD values for Standard 3 and Standard 4 must not vary by more than 0.040 optical density units from their mean.
- The correlation coefficient (r) calculated from the mean absorbance values of the standards must be ≥ 0.98 .

The QFT-Plus Analysis Software calculates and reports these quality control parameters.

If the above criteria are not met, the run is invalid and must be repeated.

The mean OD value for the Zero Standard (Green Diluent) should be ≤ 0.150 . If the mean OD value is > 0.150 the plate washing procedure should be investigated.

Interpretation of results

QFT-Plus results are interpreted using the following criteria:

Important note: Diagnosing or excluding tuberculosis disease, and assessing the probability of LTBI, requires a combination of epidemiological, historical, medical, and diagnostic findings that should be taken into account when interpreting QFT-Plus results (Table 2).

Table 2. Interpretation of QFT-Plus results

Nil (IU/ml)	TB1 minus Nil (IU/ml)	TB2 minus Nil (IU/ml)	Mitogen minus Nil (IU/ml)*	QFT-Plus Result	Report/Interpretation
≤8.0	≥0.35 and ≥ 25% of Nil value	Any	Any	Positive†	<i>M. tuberculosis</i> infection likely
	Any	≥0.35 and ≥ 25% of Nil value			
	<0.35 or ≥0.35 and <25% of Nil value	<0.35 or ≥0.35 and <25% of Nil value	≥0.5	Negative	<i>M. tuberculosis</i> infection NOT likely
	<0.35 or ≥0.35 and <25% of Nil value	<0.35 or ≥0.35 and <25% of Nil value	<0.5	Indeterminate‡	Likelihood of <i>M. tuberculosis</i> infection cannot be determined
>8.0§	Any				

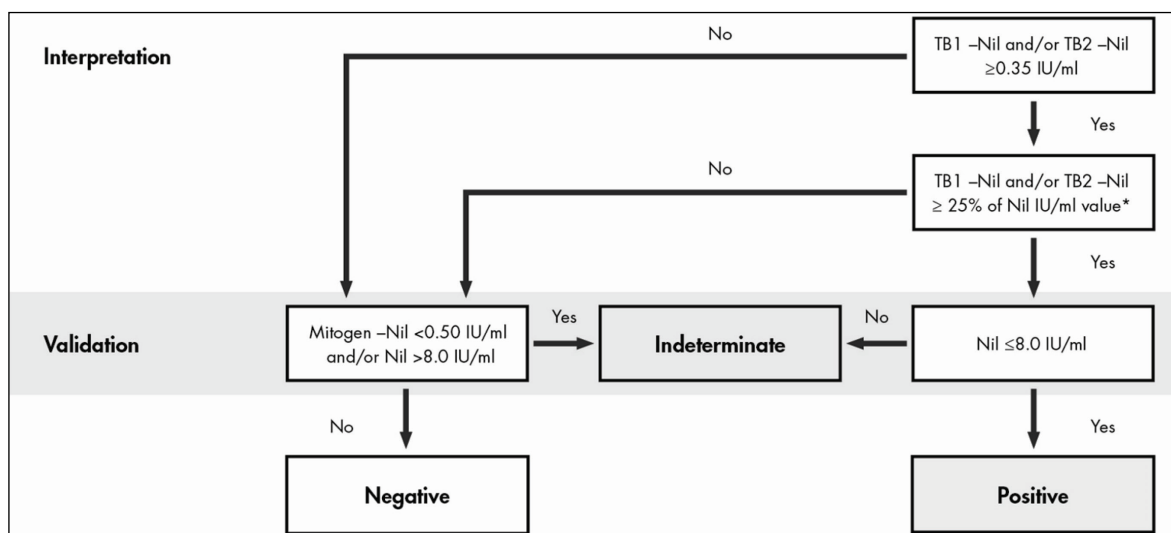
* Responses to the Mitogen positive control (and occasionally TB Antigens) can be outside the range of the microplate reader. This has no impact on test results. Values >10 ml are reported by the QFT-Plus software as >10 IU/ml.

† Where *M. tuberculosis* infection is not suspected, initially positive results can be confirmed by retesting the original plasma samples in duplicate in the QFT-Plus ELISA. If repeat testing of one or both replicates is positive, the individual should be considered test positive.

‡ Refer to the “Troubleshooting” section for possible causes.

§ In clinical studies, less than 0.25% of subjects had IFN- γ levels of >8.0 IU/ml for the Nil value.

The magnitude of the measured IFN- γ level cannot be correlated to stage or degree of infection, level of immune responsiveness, or likelihood for progression to active disease. A positive TB response in persons who are negative to Mitogen is rare, but has been seen in patients with TB disease. This indicates the IFN- γ response to TB Antigen is greater than that to Mitogen, which is possible as the level of Mitogen does not maximally stimulate IFN- γ production by lymphocytes.



* For TB1 minus Nil or TB2 minus Nil to be valid, amount $\geq 25\%$ of Nil IU/ml value must be from the same tube as the original ≥ 0.35 IU/ml result.

Figure 3. QFT-Plus interpretation flowchart.

Limitations

Results from QFT-Plus testing must be used in conjunction with each individual's epidemiological history, current medical status, and other diagnostic evaluations.

Individuals with Nil values greater than 8.0 IU/ml are classed as "Indeterminate" because a 25% higher response to the TB antigens may be outside the assay measurement range.

Unreliable or indeterminate results may occur due to:

- Deviations from the procedure described in this package insert
- Excessive levels of circulating IFN- γ or presence of heterophile antibodies
- Longer than 16 hours between drawing the blood specimen and incubation at 37°C

Performance Characteristics

Clinical studies

As there is no definitive standard test for LTBI, an estimate of sensitivity and specificity for QFT-Plus cannot be practically evaluated. Specificity of QFT-Plus was approximated by evaluating false-positive rates in the persons with low risk (no known risk factors) of tuberculosis infection. Sensitivity was approximated by evaluating groups of patients with culture-confirmed active TB disease.

Specificity

A study evaluating QFT-Plus specificity in 409 subjects was conducted. Demographic information and risk factors for TB exposure were determined using a standardized survey at the time of testing.

In a summary of findings from the 2 groups of patients with low risk (no known risk factors) for tuberculosis infection, the overall specificity of QFT-Plus was 97.6% (399/409) (Tables 3 and 4).

Table 3. QFT-Plus specificity study results by study site

Study	Positive	Negative	Indeterminate	Specificity (95% CI)
Japan	4	203	0	98% (95–100)
Australia	6	196	0	97% (94–99)

Table 4. QFT-Plus specificity study results by TB antigen tube

	TB1	TB2	QFT-Plus
Positive	5	10	10
Negative	404	399	399
Indeterminate	0	0	0
Specificity (95% CI)	98.8% (97.2–99.6)	97.6% (95.6–98.8)	97.6% (95.6–98.8)

Sensitivity for active TB

While there is no definitive standard test for LTBI, a suitable surrogate is the microbiological culture of *M. tuberculosis* because patients with disease are by definition infected. TB suspects from 4 study sites in Australia and Japan who were subsequently confirmed to have *M. tuberculosis* infection by culture were tested to evaluate the sensitivity of QFT-Plus (Tables 5 and 6). The patients had received less than 14 days of treatment prior to the collection of blood for QFT-Plus testing.

In a summary of findings from the 4 groups of *M. tuberculosis* culture-positive patients, the overall sensitivity of QFT-Plus for active TB disease was 95.3% (164/172). In the 4 groups, 159 patients were positive by both TB1 and TB2 tubes, 1 patient was positive by TB1 only, and 4 were positive by TB2 only. A total of 1.1% (2/174) of the results were indeterminate. The TB2 result correctly identified 1 culture-confirmed patient that would have been indeterminate (low Mitogen) by TB1 result alone (see Tables 5 and 6).

Table 5. QFT-Plus sensitivity study results by study site

Study sites	Positive	Negative	Indeterminate	QFT-Plus sensitivity* (95% CI)
Japan site 1	36	7	0	84% (69–93)
Japan site 2	53	1	2	98% (90–100)
Japan site 3	54	0	0	100% (93–100)
Australia site	21	0	0	100% (84–100)

* Sensitivity is based on the total number of valid tests, excluding indeterminate results.

Table 6. QFT-Plus sensitivity study results by TB antigen tube

	TB1	TB2	QFT-Plus
Positive	160	163	164
Negative	11	9	8
Indeterminate	3	2	2
Sensitivity† (95% CI)	93.6% (88.8–96.7)	94.8% (90.3–97.6)	95.3% (90.9–97.9)

† Sensitivity is based on the total number of valid tests, excluding indeterminate results.

Observed response distributions — risk stratified

A range of IFN- γ responses to TB1, TB2, and control tubes were observed in clinical trials and stratified by risk of *M. tuberculosis* infection (Figures 4–7). The mixed risk group consists of subjects representative of a general testing population, including subjects with and without risk factors for TB exposure, and where active TB is unlikely (i.e., LTBI).

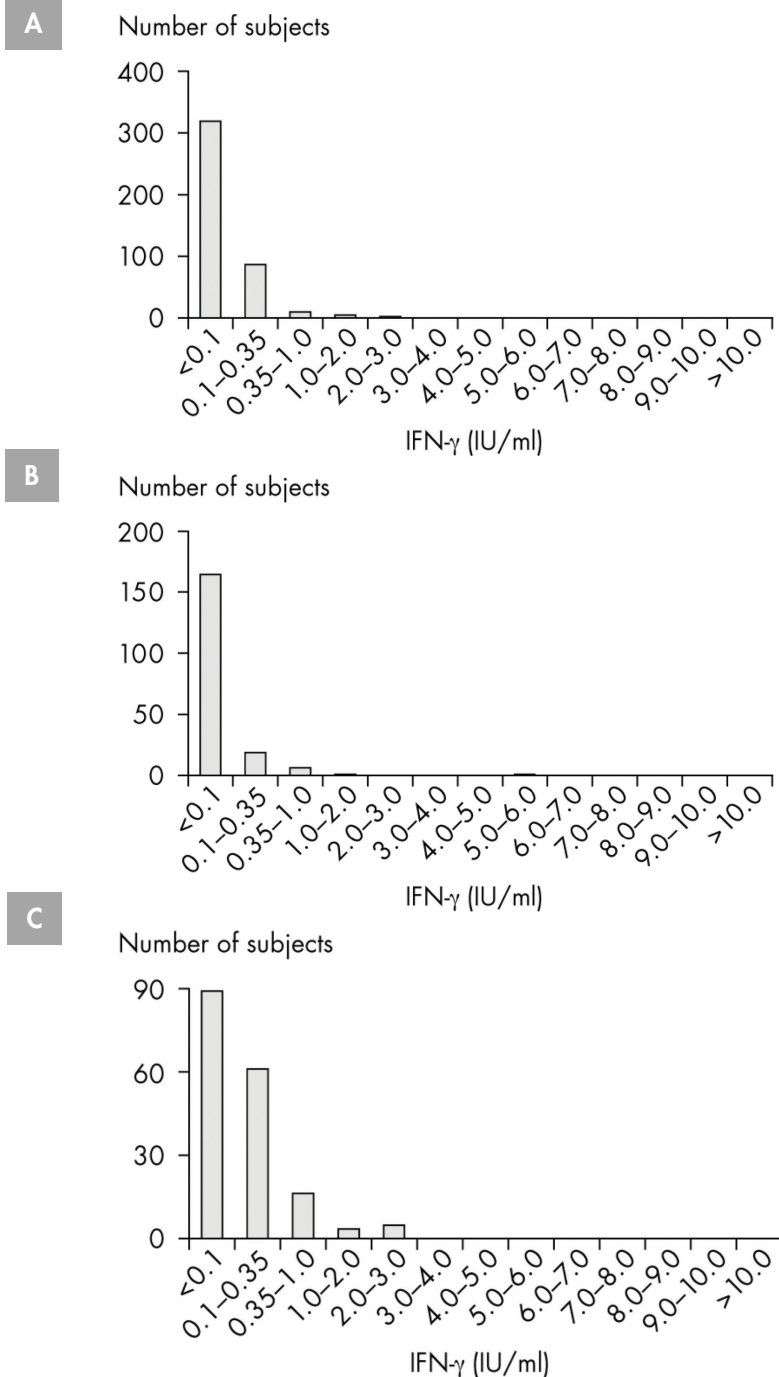


Figure 4. Distribution of Nil. **A.** Distribution of Nil values in a low-risk population (n=409). **B.** Distribution of Nil values in a mixed-risk population (n=194). **C.** Distribution of Nil values in a population with culture-confirmed *M. tuberculosis* infection (n=174).

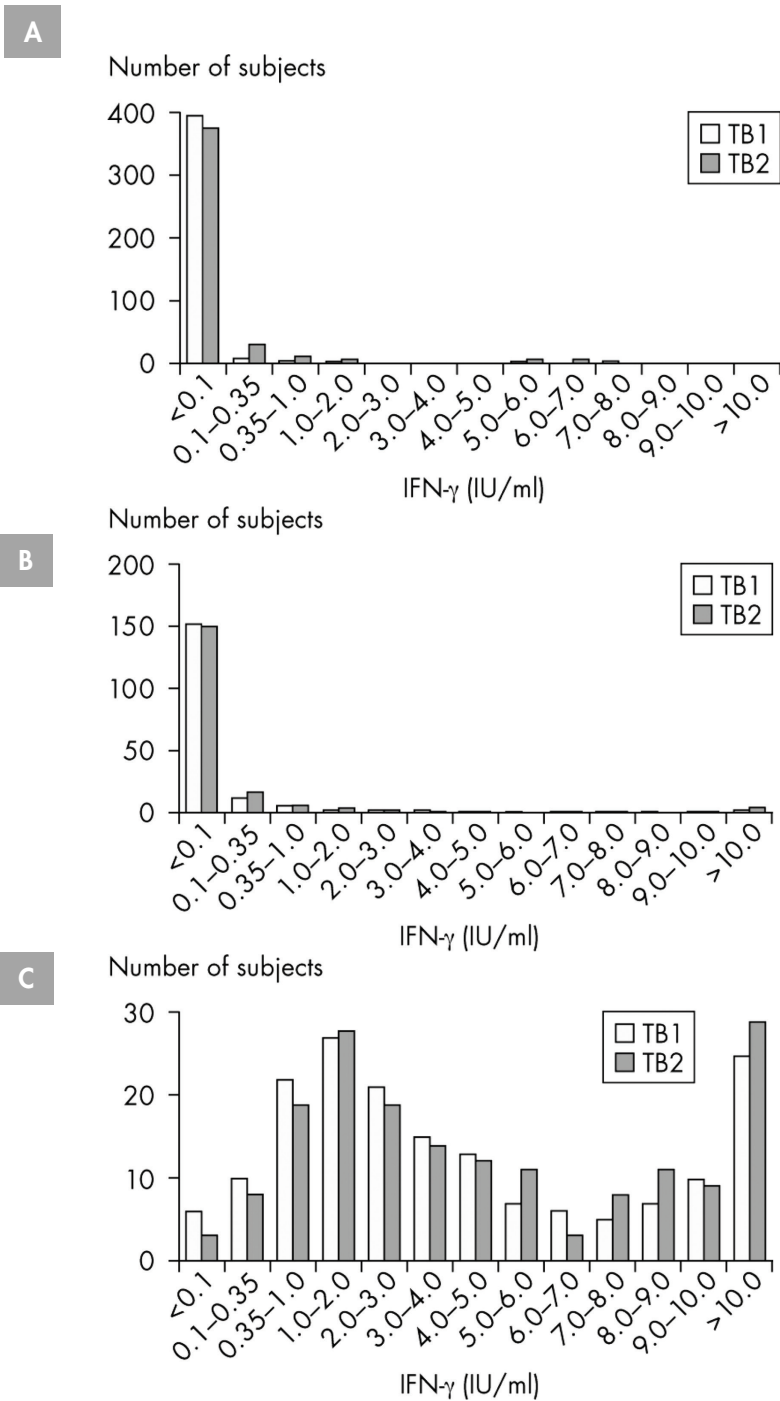


Figure 5. Distribution of TB1 and TB2 (nil subtracted). **A.** Distribution of TB1 and TB2 (nil subtracted) values in a low-risk population (n=409). **B.** Distribution of TB1 and TB2 (nil subtracted) values in a mixed-risk population (n=194). **C.** Distribution of TB1 and TB2 (nil subtracted) values in a population with culture-confirmed *M. tuberculosis* infection (n=174).

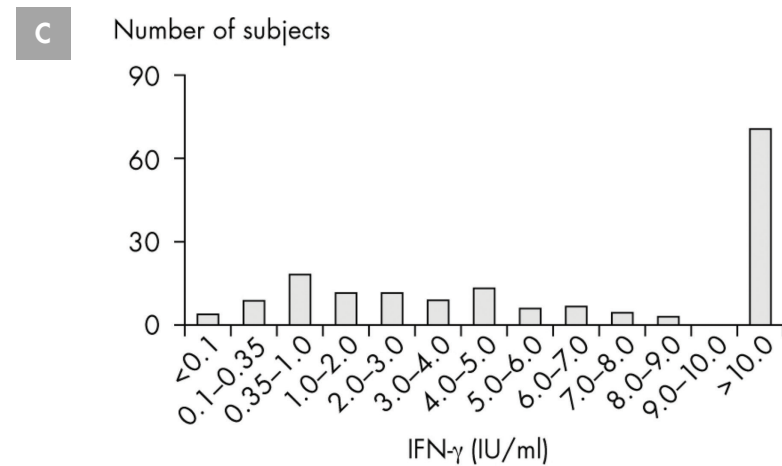
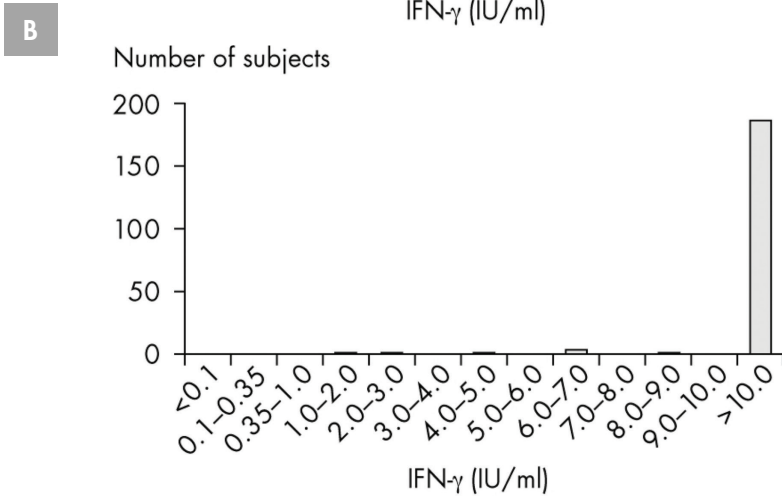
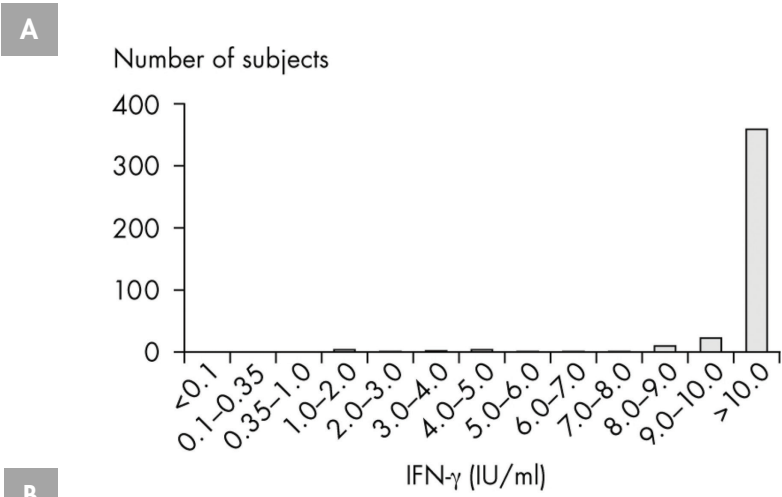


Figure 6. Distribution of Mitogen (nil subtracted). **A.** Distribution of Mitogen (nil subtracted) values in a low-risk population (n=409). **B.** Distribution of Mitogen (nil subtracted) values in a mixed-risk population (n=194). **C.** Distribution of Mitogen (nil subtracted) values in a population with culture-confirmed *M. tuberculosis* infection (n=169).

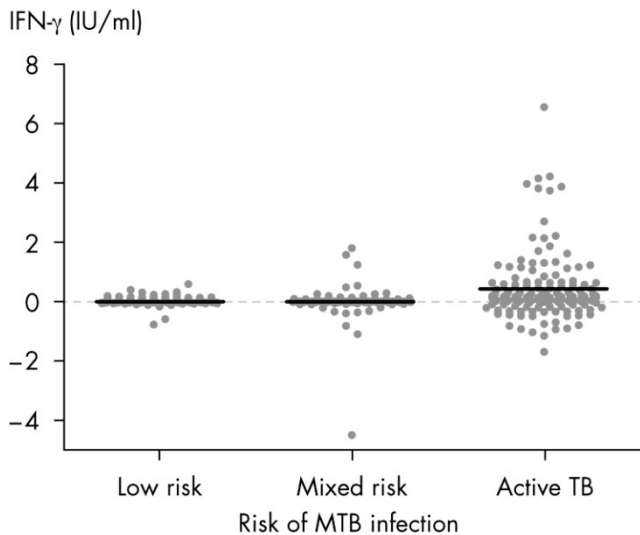


Figure 7. Observed difference between TB1 and TB2 values (nil subtracted), stratified by risk. Low-risk population (n=409), mixed risk population (n=189), and a population with culture confirmed *M. tuberculosis* infection (n=141). TB1 values were subtracted from TB2 values. Subjects with values for TB1 or TB2 of >10.0 IU/ml were excluded because they were outside the linear range of the assay.

Assay performance characteristics

The QFT-Plus ELISA has been demonstrated to be linear by placing 5 replicates of 11 plasma pools of known IFN- γ concentrations randomly on the ELISA plate. The linear regression line has a slope of 1.002 ± 0.011 and a correlation coefficient of 0.99 (Figure 8).

The limit of detection of the QFT-Plus ELISA is 0.065 IU/ml, and there is no evidence of a high-dose hook (prozone) effect with concentrations of IFN- γ up to 10,000 IU/ml.

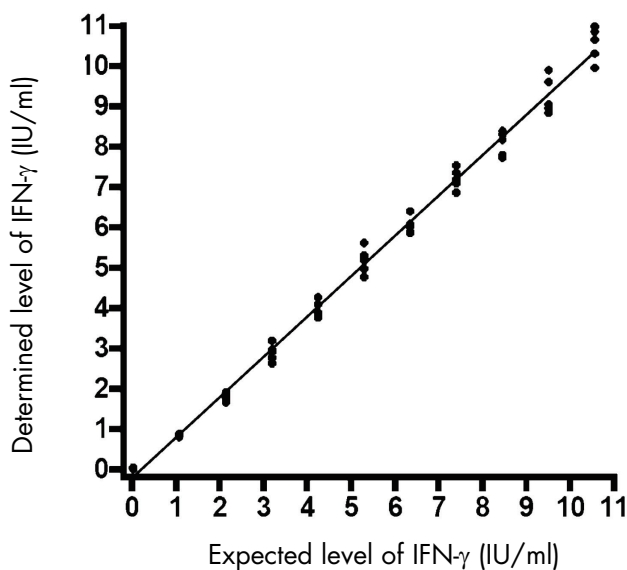


Figure 8. Linearity profile of QFT-Plus ELISA.

Intra- and inter-assay imprecision (% CV) of the QFT-Plus ELISA was estimated by testing 20 plasma samples with varying IFN- γ concentrations in replicates of 3, in 3 different laboratories, on 3 nonconsecutive days, and by 3 different operators. Thus, each sample was tested 27 times in 9 independent assay runs. One sample was a nil control and had a calculated IFN- γ concentration of 0.08 IU/ml (95% CI: 0.07–0.09). Of the remaining 19 plasma samples, concentrations ranged from 0.33 (95% CI: 0.31–0.34) to 7.7 IU/ml (95% CI: 7.48–7.92).

Within run or intra-assay imprecision was estimated by averaging the %CVs for each test plasma containing IFN- γ from each plate run (n=9), and the imprecision ranged from 4.1 to 9.1%CV. The average within run covariance (\pm 95% CI) was 6.6% \pm 0.6%. The average of the zero IFN- γ plasma was 14.1% CV.

Total or inter-assay imprecision was determined by comparing the 27 calculated concentrations of IFN- γ for each test plasma. The inter-assay imprecision ranged from 6.6 to 12.3% CV. The overall average % CV (\pm 95% CI) was 8.7% \pm 0.7%. The zero IFN- γ plasma showed a 26.1% CV. This level of variation is to be expected because the calculated concentration of IFN- γ is low and variation around a low estimate of concentration will be larger than that for higher concentrations.

The reproducibility of the QFT-Plus test was determined using blood samples from 102 subjects with mixed risk factors for *M. tuberculosis* infection. Three different operators and laboratory conditions were assessed.

A total of 3 diagnostic determinations were made for each subject and 306 in total for all subjects. Overall, diagnostic reproducibility was 99% (95% CI: 97.2–99.7), where the diagnostic result was concordant for 303 of 306 determinations. The results of 3 subjects that were close to the cutoff accounted for all variation.

Diagnosis of LTBI

A number of studies have been published that demonstrate the performance of QFT, the precursor for QFT-Plus, in various populations at risk of infection with MTB. The principle findings of some selected studies are shown in Table 7.

Table 7. Selected published studies on QFT.

Population/condition	Outcomes and findings	Total number of published studies
Pediatrics	<p>Proven performance in children, including children less than 5 years of age (45–46) with higher accuracy than the ELISpot-based IGRA (8). Largest study to-date comparing QFT and TST in children from Vietnam, Philippines and Mexico supports the preferential use of QFT over TST for testing foreign-born children for LTBI (46). A limited contacts study shows better predictive value than TST in children (47) and 8-fold higher risk of progression to TB disease within two years among QFT converters compared to non-converters (48). QFT-negative/TST-positive discordance is high in BCG vaccinated children (46, 49), but there was no impact on Mitogen response in children under age 5 (49) and low indeterminate rates during routine screening of immigrant children (46).</p>	152
Pregnancy	<p>In a low-burden setting, QFT performs equally well in each trimester of pregnancy with comparable results to nonpregnant females, is much more specific, at least as sensitive, and may be a better predictor of disease progression than the TST (50). In a high-burden setting, QFT was more stable throughout pregnancy and more closely approximated the background LTBI prevalence compared to the TST, although the authors concluded that pregnancy affects both QFT and the TST (51).</p>	6
HIV/AIDS	<p>Both IGRAs and TST are impacted by HIV infection, and the body of evidence suggests that caution should be taken when interpreting results in those with CD4⁺ counts <200 (52). QFT has been shown to be less affected than the ELISpot-based IGRA and TST (53–55). Single visit of IGRAs overcomes the TST issue of poor return rates in this population (53).</p>	101

Population/condition	Outcomes and findings	Total number of published studies
Immunosuppressive therapies	QFT is less impacted by immunosuppressive therapies than TST and correlates better with TB risk factors (23, 27). QFT has high sensitivity in patients with rheumatic disease (23; 56, 57) and higher specificity than TST, minimizing false positives and reducing unnecessary treatment that would occur with the TST (23, 57, 58).	112
Healthcare workers	Shown to be more specific with fewer false positives than the TST, and more cost-effective than the TST (59–62). Variability around the threshold is an expected finding in serial testing, due to dichotomous cut-point and inherent variability of a biological test (63). Studies have shown higher conversion/reversion rates than TST in serial testing of low-risk healthcare workers (64, 65). The US CDC acknowledges that the lenient criterion to define IGRA conversion may produce more conversion than is observed with the more stringent quantitative criteria of the TST, and retesting strategies have been shown to be effective in managing the conversion/reversion phenomenon (65–68).	111
TB contacts	Higher PPV and NPV than the TST (47); convenience of single visit for those unlikely to return (63), better correlation to exposure (69), which is especially noted in BCG-vaccinated people and populations from BCG vaccinating countries (70, 71).	89
Transplantation	Has been shown to be at least as effective as TST, but less impacted by end-stage organ disease than the TST (22).	23

Population/condition	Outcomes and findings	Total number of published studies
Diabetes	<p>Conflicting evidence from a small number of publications with limited numbers of subjects. A study from a low-burden area found that QFT sensitivity is not compromised by diabetes in TB patients (72). A study from Tanzania, a high-burden setting, suggesting a negative impact of diabetes on production of IFN-γ, failed to take into account confounders like HIV and helminth infections (73). In Vietnamese studies, 838 self-reported diabetics suspected of having TB due to abnormal CXRs or confirmed by culture to have active TB (n=128), QFT positivity was equal or greater than the TST cutpoints of 10 and 15 mm (74).</p>	9
End-stage renal disease	<p>QFT-positive results correlate with risk factors for TB better than TST and are less associated with BCG (75).</p>	45
Migrants	<p>Studies demonstrate QFT is unaffected by BCG and age unlike TST (74). QFT shown to be most cost-effective method (76). In low-burden settings the majority of TB coming from foreign born and from reactivation of latent TB after arrival (77). Largest study to-date comparing QFT and TST in immigrant children supports the preferential use of QFT over TST for testing foreign-born children for latent TB infection (46).</p>	29

Technical Information

Indeterminate results

Indeterminate results are uncommon and may relate to the immune status of the individual being tested, but may also be related to a number of technical factors if the above instructions for use are not followed.

If technical issues are suspected with the reagent storage, blood collection, or handling of the blood samples, repeat the entire QFT-Plus test with a new blood specimen. Repeating the ELISA testing of stimulated plasmas can be performed if inadequate washing or other procedural deviation with the ELISA test is suspected. Indeterminate tests that result from low Mitogen or high Nil values would not be expected to change on repeat unless there was an error with the ELISA testing. Indeterminate results should be reported as such. Physicians may choose to redraw a specimen or perform other procedures as appropriate.

Clotted plasma samples

Should fibrin clots occur with long-term storage of plasma samples, centrifuge the samples to sediment clotted material and facilitate pipetting of plasma.

Troubleshooting Guide

This troubleshooting guide may be helpful in solving any problems that may arise. For more information, see also the technical information provided at: www.QuantiFERON.com. For contact information, see the back cover.

ELISA troubleshooting

Nonspecific color development

Possible cause	Solution
a) Incomplete washing of the plate	Wash the plate at least 6 times with 400 µl/well of wash buffer. More than 6 washing cycles may be required depending on the washer being used. A soak time of at least 5 seconds between cycles should be used.
b) Cross-contamination of ELISA wells	Take care when pipetting and mixing sample to minimize risk.
c) Kit/components have expired	Ensure that the kit is used before the expiry date. Ensure reconstituted standard and Conjugate 100x Concentrate are used within three months of the reconstitution date.
d) Enzyme Substrate Solution is contaminated	Discard substrate if blue coloration exists. Ensure clean reagent reservoirs are used.
e) Mixing of plasma in QFT-Plus tubes before harvesting	After centrifugation, avoid pipetting up and down or mixing plasma by any means prior to harvesting. At all times, take care not to disturb material on the surface of the gel.

Low optical density readings for standards

Possible cause	Solution
a) Standard dilution error	Ensure dilutions of the Kit Standard are prepared correctly as per this package insert.
b) Pipetting error	Ensure pipets are calibrated and used according to manufacturer's instructions.
c) Incubation temperature too low	Incubation of ELISA should be performed at room temperature (22°C ± 5°C).
d) Incubation time too short	Incubation of the plate with the conjugate, standards and samples should be for 120 ± 5 minutes. The Enzyme Substrate Solution is incubated on the plate for 30 minutes.

ELISA troubleshooting

- | | |
|---------------------------------------|---|
| e) Incorrect plate reader filter used | Plate should be read at 450 nm with a reference filter between 620 and 650 nm. |
| f) Reagents are too cold | All reagents, with the exception of the Conjugate 100x Concentrate, must be brought to room temperature prior to commencing the assay. This takes approximately one hour. |
| g) Kit/components have expired | Ensure that the kit is used before the expiry date. Ensure reconstituted standard and Conjugate 100x Concentrate are used within 3 months of the reconstitution date. |

High background

- | Possible cause | Solution |
|--|--|
| a) Incomplete washing of the plate | Wash the plate at least 6 times with 400 µl/well of wash buffer. More than 6 washing cycles may be required depending on the washer being used. A soak time of at least 5 seconds between cycles should be used. |
| b) Incubation temperature too high | Incubation of the ELISA should be performed at room temperature (22°C ± 5°C). |
| c) Kit/components have expired | Ensure that the kit is used before the expiry date. Ensure reconstituted standard and Conjugate 100x Concentrate are used within 3 months of the reconstitution date. |
| d) Enzyme Substrate Solution is contaminated | Discard substrate if blue coloration exists. Ensure clean reagent reservoirs are used. |

Nonlinear standard curve and duplicate variability

- | Possible cause | Solution |
|------------------------------------|--|
| a) Incomplete washing of the plate | Wash the plate at least 6 times with 400 µl/well of wash buffer. More than 6 washing cycles may be required depending on the washer being used. A soak time of at least 5 seconds between cycles should be used. |
| b) Standard dilution error | Ensure dilutions of the standard are prepared correctly as per this package insert. |
| c) Poor mixing | Mix reagents thoroughly by inversion or gentle vortexing prior to their addition to the plate. |

ELISA troubleshooting

- | | |
|---|---|
| d) Inconsistent pipetting technique or interruption during assay set up | Sample and standard addition should be performed in a continuous manner. All reagents should be prepared prior to commencing the assay. |
|---|---|

Product information and technical guides are available free of charge from QIAGEN, via your distributor, or by visiting www.QuantiFERON.com.

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A comprehensive list of QFT-Plus and QFT references is located on Gnowee — the QuantiFERON reference library, available at www.gnowee.net.

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Symbols

 2 x 96	Sufficient for 2 x 96 sample preparations
	Legal manufacturer
	CE-IVD marked symbol
	For in vitro diagnostic use
	Batch code
	Catalog number
	Global Trade Item Number
	Use by date
	Temperature limitation
	Consult instructions for use
	Do not reuse
	Keep away from sunlight

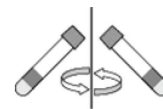
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Abbreviated Test Procedure

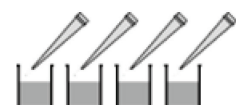
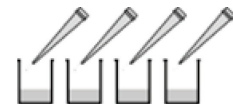
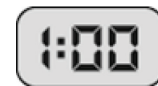
Stage 1 – blood incubation

1. Collect patient blood into blood collection tubes and mix by shaking them ten (10) times just firmly enough to ensure that the entire inner surface of the tube has been coated with blood. This will dissolve antigens on tube walls.
2. Incubate tubes upright at $37^{\circ}\text{C} \pm 1^{\circ}\text{C}$ for 16 to 24 hours.
3. Following incubation, centrifuge tubes for 15 minutes at 2000 to 3000 $\times g$ RCF (g) to separate the plasma and the red cells.
4. After centrifugation, avoid pipetting up and down or mixing the plasma by any means prior to harvesting. At all times, take care not to disturb the material on the surface of the gel.



Stage 2 – IFN- γ ELISA

1. Equilibrate ELISA components, with the exception of the Conjugate 100x Concentrate, to room temperature ($22^{\circ}\text{C} \pm 5^{\circ}\text{C}$) for at least 60 minutes.
2. Reconstitute the kit standard to 8.0 IU/ml with distilled or deionized water. Prepare four (4) standard dilutions.
3. Reconstitute freeze-dried Conjugate 100x Concentrate with distilled or deionized water.
4. Prepare working strength conjugate in Green Diluent and add 50 μl to all wells.
5. Add 50 μl of test plasma samples and 50 μl standards to appropriate wells. Mix using shaker.



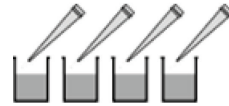
6. Incubate for 120 ± 5 minutes at room temperature.



7. Wash wells at least 6 times with $400 \mu\text{l}$ /well of wash buffer.



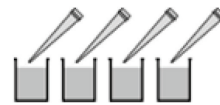
8. Add $100 \mu\text{l}$ Enzyme Substrate Solution to wells. Mix using shaker.



9. Incubate for 30 minutes at room temperature.



10. Add $50 \mu\text{l}$ Enzyme Stopping Solution to all wells. Mix using shaker.



11. Read results at 450 nm with a 620 to 650 nm reference filter.



12. Analyze results.



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