Snibe Diagnostic

CE REF 130203023M:100 tests/kit
130603023M: 50 tests/kit
130703023M: 30 tests/kit

MAGLUMI® TSH (CLIA)

INTENDED USE

The kit is an *in vitro* chemiluminescence immunoassay for the quantitative determination of thyroid-stimulating hormone (TSH) in human serum and plasma using the MAGLUMI series Fully-auto chemiluminescence immunoassay analyzer and Biolumi series Integrated System, and the assay is used for an aid in the diagnosis of individuals with suspected or confirmed pituitary- thyroid disorders.

SUMMARY

Thyroid-stimulating hormone is a molecular weight of approximately 30000 daltons glycoprotein synthesized and secreted from thyrotrophs (basophile cells) of the anterior pituitary gland[1,2]. TSH consists of two noncovalently linked subunits, alpha and beta. It is a member of the glycoprotein hormone family that includes follicle-stimulating hormone (FSH), luteinizing hormone (LH), and human chorionic gonadotropin (hCG). These glycoproteins consist of a common α-subunit and a unique β-subunit, which confers biological specificity to each hormone. TSH expression and biological activity requires a noncovalent association of alpha and beta subunits[1].

The major functions of TSH are to maintain biosynthesis and secretion of the thyroid hormones thyroxine (T4) and 3,5,3′ -triidothyronine (T3)[2]. TSH acts on thyroid follicular epithelium and its secretion is regulated by thyrotropin releasing hormone (TRH)[3]. The thyroid hormones T3 and T4 control the secretion of TRH and TSH by negative feedback to maintain physiological levels of the main hormones of the hypothalamus-pituitary-thyroid axis[4]. Reduction of circulating thyroid hormones levels due to primary thyroid failure results in increased TRH and TSH production, whereas the opposite occurs when circulating thyroid hormones are in excess[4]. Serum TSH remains the primary screening test for thyroid dysfunction[5]. In cases of primary hypothyroidism, T3 and T4 levels are low and TSH levels are significantly increased[6]. Secondary hypothyroidism is less frequent and originates to alterations of the hypothalamus-pituitary axis. Primary hyperthyroidism is characterised by raised serum concentrations of thyroid hormones and depressed or undetectable levels of TSH[7]. When the serum FT4 is low and yet the serum TSH is only minimally elevated, a diagnosis of central hypothyroidism should be considered[8]. TSH alone cannot be used to diagnose central hypothyroidism because current TSH assays measure biologically inactive TSH isoforms[8]. The American Thyroid Association has formally recommended the use of functional sensitivity as the means to quantify the sensitivity of TSH assays[8]. Third generation TSH assays exhibit 20% interassay CVs at <0.02 μIU/mL and are useful in the discrimination of patients with true hyperthyroidism from those with TSH suppression seen in subclinical hyperthyroidism and some non-thyroidal illnesses[6,8]. Laboratory diagnosis of hypothyroidism and hyperthyroidism is supported by FT3, FT4 tests[8,9].

TEST PRINCIPLE

Sandwich chemiluminescence immunoassay.

The sample, buffer, magnetic microbeads coated with anti-TSH monoclonal antibody, ABEI labeled with another anti-TSH monoclonal antibody are mixed thoroughly and incubated, reacting to form sandwich complexes. After precipitation in a magnetic field, the supernatant is decanted and then a wash cycle is performed. Subsequently, the Starter 1+2 are added to initiate a chemiluminescent reaction. The light signal is measured by a photomultiplier as relative light units (RLUs), which is proportional to the concentration of TSH present in the sample.

REAGENTS

Kit Contents

Component	Description	100 tests/kit	50 tests/kit	30 tests/kit
Magnetic Microbeads	Magnetic microbeads coated with anti-TSH monoclonal antibody (~12.0 μg/mL) in PBS buffer, NaN_3 (<0.1%).	2.5 mL	1.5 mL	1.0 mL
Calibrator Low	A low concentration of TSH antigen in PBS buffer, NaN_3 (<0.1%).	1.5 mL	1.5 mL	1.5 mL
Calibrator High	A high concentration of TSH antigen in PBS buffer, NaN_3 (<0.1%).	1.5 mL	1.5 mL	1.5 mL
Buffer	Tris-HCl buffer, NaN_3 (<0.1%).	5.5 mL	3.5 mL	2.7 mL
ABEI Label	ABEI labeled with anti-TSH monoclonal antibody (~0.25 μg/mL) in Tris-HCl buffer, NaN_3 (<0.1%).	6.5 mL	4.0 mL	3.0 mL
Control 1	A low concentration of TSH antigen (2.00 μIU/mL) in PBS buffer, NaN_3 (<0.1%).	1.5 mL	1.5 mL	1.5 mL
Control 2	A high concentration of TSH antigen (10.0 μIU/mL) in PBS buffer, NaN_3 (<0.1%).	1.5 mL	1.5 mL	1.5 mL
All reagents are provided ready-to-use.				

Warnings and Precautions

- For *in vitro* diagnostic use.
- For professional use only.
- Exercise the normal precautions required for handling all laboratory reagents.
- Personal protective measures should be taken to prevent any part of the human body from contacting samples, reagents, and controls, and should comply with local operating requirements for the assay.
- A skillful technique and strict adherence to the package insert are necessary to obtain reliable results.
- Do not use kit beyond the expiration date indicated on the label.
- Do not interchange reagent components from different reagents or lots.
- Avoid foam formation in all reagents and sample types (specimens, calibrators and controls).
- All waste associated with biological samples, biological reagents and disposable materials used for the assay should be considered potentially infectious and should be disposed of in accordance with local guidelines.
- This product contains sodium azide. Sodium azide may react with lead or copper plumbing to form highly explosive metal azides. Immediately after disposal, flush with a large volume of water to prevent azide build-up. For additional information, see Safety Data Sheets available for professional user on request.

Note: If any serious incident has occurred in relation to the device, please report to Shenzhen New Industries Biomedical Engineering Co., Ltd. (Snibe) or our authorized representative and the competent authority of the Member State in which you are established.

Reagent Handling

- To avoid contamination, wear clean gloves when operating with a reagent kit and sample. When handling reagent kit, replace the gloves that have been in contact with samples, since introduction of samples will result in unreliable results.
- Do not use kit in malfunction conditions; e.g., the kit leaking at the sealing film or elsewhere, obviously turbid or precipitation is found in reagents (except for Magnetic Microbeads) or control value is out of the specified range repeatedly. When kit in malfunction conditions, please contact Snibe or our authorized distributor.
- To avoid evaporation of the liquid in the opened reagent kits in refrigerator, it is recommended that the opened reagent kits to be sealed with reagent seals contained within the packaging. The reagent seals are single use, and if more seals are needed, please contact Snibe or our authorized distributor.
- Over time, residual liquids may dry on the septum surface. These are typically dried salts and have no effect on assay efficacy.
- Use always the same analyzer for an opened reagent integral.
- For magnetic microbeads mixing instructions, refer to the Preparation of the Reagent section of this package insert.
- For further information about the reagent handing during system operation, please refer to Analyzer Operating Instructions.

Storage and Stability

- Do not freeze the integral reagents.
- Store the reagent kit upright to ensure complete availability of the magnetic microbeads.
- Protect from direct sunlight.

Stability of the Reagents	
Unopened at 2-8°C	until the stated expiration date
Opened at 2-8°C	6 weeks
On-board	4 weeks

Stability of Controls	
Unopened at 2-8°C	until the stated expiration date
Opened at 2-8°C	6 weeks
Opened at 15-25°C	6 hours
Frozen at -20°C	3 months
Frozen and thawed cycles	no more than 3 times

SPECIMEN COLLECTION AND PREPARATION

Specimen Types

Only the specimens listed below were tested and found acceptable.

Specimen Types	Collection Tubes
Serum	Tubes without additive/accessory, or tubes containing clot activator or clot activator with gel.
Plasma	K2-EDTA

- The sample types listed were tested with a selection of sample collection tubes that were commercially available at the time of testing, i.e. not all available tubes of all manufacturers were tested. Sample collection systems from various manufacturers may contain differing materials which could affect the test results in some cases. Follow tube manufacturers' instructions carefully when using collection tubes.

Specimen Conditions

- Do not use heat-inactivated samples or grossly hemolyzed/hyperlipidaemia specimens and specimens with obvious microbial contamination.
- Ensure that complete clot formation in serum specimens has taken place prior to centrifugation. Some serum specimens, especially those from patients receiving anticoagulant or thrombolytic therapy, may exhibit increased clotting time. If the serum specimen is centrifuged before a complete clotting, the presence of fibrin may cause erroneous results.
- Samples must be free of fibrin and other particulate matter.
- To prevent cross contamination, use of disposable pipettes or pipette tips are recommended.

Preparation for Analysis

- Inspect all specimens for foam. Remove foam with an applicator stick before analysis. Use a new applicator stick for each specimen to prevent cross contamination.
- Frozen specimens must be completely thawed before mixing. Mix thawed specimens thoroughly by low speed vortexing or by gently inverting. Visually inspect the specimens. If layering or stratification is observed, mix until specimens are visibly homogeneous. If specimens are not mixed thoroughly, inconsistent results may be obtained.
- Specimens should be free of fibrin, red blood cells, or other particulate matter. Such specimens may give reliable results and must be centrifuged prior to testing. Transfer clarified specimen to a sample cup or secondary tube for testing. For centrifuged specimens with a lipid layer, transfer only the clarified specimen and not the lipemic material.
- The sample volume required for a single determination of this assay is 100 μL.

Specimen Storage

Specimens removed from the separator, red blood cells or clot may be stored up to to 8 hours at 15-25°C, or 7 days at 2-8°C, or stored up to 30 days frozen at -20°C or colder. Frozen specimens subjected to up to 1 freeze/thaw cycle have been evaluated.

Specimen Shipping

Package and label specimens in compliance with applicable local regulations covering the transport of clinical specimens and infectious substances.
Do not exceed the storage limitations listed above.

Specimen Dilution

- Samples, with TSH concentrations above the analytical measuring interval, can be diluted with manual dilution procedure. The recommended dilution ratio is 1:20. The concentration of the diluted sample must be >5.0 μIU/mL.
- For manual dilution, multiply the result by the dilution factor.
- Please choose applicable diluents or ask Snibe for advice before manual dilution.

PROCEDURE

Materials Provided

TSH (CLIA) assay, control barcode labels.

Materials Required (But Not Provided)

- General laboratory equipment.
- Fully-auto chemiluminescence immunoassay analyzer Maglumi 600, Maglumi 800, Maglumi 1000, Maglumi 2000, Maglumi 2000 Plus, Maglumi 4000, Maglumi 4000 Plus, MAGLUMI X3, MAGLUMI X6, MAGLUMI X8, or Integrated System Biolumi 8000 and Biolumi CX8.
- Additional accessories of test required for the above analyzers include Reaction Module, Starter 1+2, Wash Concentrate, Light Check, Tip, and Reaction Cup. Specific accessories and accessories' specification for each model refer to corresponding Analyzer Operating Instructions.
- Please use accessories specified by Snibe to ensure the reliability of the test results.

Assay Procedure

Preparation of the Reagent

- Take the reagent kit out of the box and visually inspect the integral vials for leaking at the sealing film or elsewhere. If there is no leakage, please tear off the sealing film carefully.
- Open the reagent area door; hold the reagent handle to get the RFID label close to the RFID reader (for about 2s); the buzzer will beep; one beep sound indicates successful sensing.
- Keeping the reagent straight insert to the bottom along the blank reagent track.
- Observe whether the reagent information is displayed successfully in the software interface, otherwise repeat the above two steps.
- Resuspension of the magnetic microbeads takes place automatically when the kit is loaded successfully, ensuring the magnetic microbeads are totally resuspended homogenous prior to use.

Assay Calibration

- Select the assay to be calibrated and execute calibration operation in reagent area interface. For specific information on ordering calibrations, refer to the calibration section of Analyzer Operating Instructions.
- Execute recalibration according to the calibration interval required in this package insert.

Quality Control

- When new lot used, check or edit the quality control information.
- Scan the control barcode, choose corresponding quality control information and execute testing. For specific information on ordering quality controls, refer to the quality control section of the Analyzer Operating Instructions.

Sample Testing

- After successfully loading the sample, select the sample in interface and edit the assay for the sample to be tested and execute testing. For specific information on ordering patient specimens, refer to the sample ordering section of the Analyzer Operating Instructions.

To ensure proper test performance, strictly adhere to Analyzer Operating Instructions.

Calibration

Traceability: This method has been standardized against WHO 3rd International Standard 81/565.

Test of assay specific calibrators allows the detected relative light unit (RLU) values to adjust the master curve.

Recalibration is recommended as follows:

- Whenever a new lot of Reagent or Starter 1+2 is used.
- Every 28 days.
- The analyzer has been serviced.
- Control values lie outside the specified range.

Quality Control

Controls are recommended for the determination of quality control requirements for this assay and should be run in singlicate to monitor the assay performance. Refer to published guidelines for general quality control recommendations, for example Clinical and Laboratory Standards Institute (CLSI) Guideline C24 or other published guidelines [10].

Quality control is recommended once per day of use, or in accordance with local regulations or accreditation requirements and your laboratory's quality control procedures, quality control could be performed by running the TSH assay:

- Whenever the kit is calibrated.
- Whenever a new lot of Starter 1+2 or Wash Concentrate is used.

Controls are only applicable with MAGLUMI and Biolumi systems and only used matching with the same top seven LOT numbers of corresponding reagents. For each target value and range refer to the label.

The performance of other controls should be evaluated for compatibility with this assay before they are used. Appropriate value ranges should be established for all quality control materials used.

Control values must lie within the specified range, whenever one of the controls lies outside the specified range, calibration should be repeated and controls retested. If control values lie repeatedly outside the predefined ranges after successful calibration, patient results must not be reported and take the following actions:

- Verify that the materials are not expired.
- Verify that required maintenance was performed.
- Verify that the assay was performed according to the package insert.
- If necessary, contact Snibe or our authorized distributors for assistance.

If the controls in kit are not enough for use, please order TSH (CLIA) Controls (REF: 160201241MT) from Snibe or our authorized distributors for more.

RESULTS

Calculation

The analyzer automatically calculates the TSH concentration in each sample by means of a calibration curve which is generated by a 2-point calibration master curve procedure. The results are expressed in μIU/mL. For further information please refer to the Analyzer Operating Instructions.

Interpretation of Results

The expected range for the TSH assay was obtained by testing 537 apparently healthy individuals in China, gave the following expected value:

0.3-4.5 μIU/mL (2.5th-97.5th percentiles).

Results may differ between laboratories due to variations in population and test method. It is recommended that each laboratory establish its own reference interval.

LIMITATIONS

- Results should be used in conjunction with patient's medical history, clinical examination and other findings.
- If the TSH results are inconsistent with clinical evidence, additional testing is needed to confirm the result.
- The presence of autoantibodies may induce high molecular weight complexes (macro-TSH) which may cause unexpected high values of TSH[11].
- Whether high or low, an abnormal TSH result indicates an excess or deficiency in the amount of thyroid hormone available to the body, but it does not indicate the reason. An abnormal TSH test result is usually followed by additional testing to investigate the cause of the increase or decrease.
- When a doctor adjusts a person's thyroid hormone replacement dosage, it is important to wait at least one to two months before checking the TSH again so that the new dose can have its full effect.
- Extreme stress and acute illness may also affect TSH test results. Results may be low during the first trimester of pregnancy.
- Many medications—including aspirin and thyroid-hormone replacement therapy—may affect thyroid gland function test results and their use should be discussed with the doctor prior to testing.
- Specimens from patients who have received preparations of mouse monoclonal antibodies for diagnosis or therapy may contain human anti-mouse antibodies (HAMA). Such specimens may show either falsely elevated or depressed values when tested with assay kits which employ mouse monoclonal antibodies[12,13]. Additional information may be required for diagnosis.
- Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with *in vitro* immunoassays. Patients routinely exposed to animals or animal serum products can be prone to this interference and anomalous values may be observed[14].
- Bacterial contamination or heat inactivation of the specimens may affect the test results.

SPECIFIC PERFORMANCE CHARACTERISTICS

Representative performance data are provided in this section. Results obtained in individual laboratories may vary.

Precision

Precision was determined using the assay, samples and controls in a protocol (EP05-A3) of the CLSI (Clinical and Laboratory Standards Institute): duplicates at two independent runs per day for 5 days at three different sites using three lots of reagent kits (n = 180). The following results were obtained:

Sample	Mean (μIU/mL) (n=180)	Within-Run		Between-Run		Reproducibility	
		SD (μIU/mL)	%CV	SD (μIU/mL)	%CV	SD (μIU/mL)	%CV
Serum Pool 1	0.305	0.010	3.28	0.007	2.30	0.016	5.25
Serum Pool 2	4.537	0.129	2.84	0.098	2.16	0.181	3.99
Serum Pool 3	50.968	1.143	2.24	0.784	1.54	1.696	3.33
Plasma Pool 1	0.299	0.011	3.68	0.004	1.34	0.018	6.02
Plasma Pool 2	4.533	0.150	3.31	0.035	0.77	0.180	4.21
Plasma Pool 3	50.254	1.385	2.76	0.425	0.85	1.894	3.77
Control 1	1.976	0.069	3.49	0.041	2.07	0.100	5.06
Control 2	9.835	0.305	3.10	0.184	1.87	0.480	4.88

Linear Range

0.010 -100 μIU/mL (defined by the Limit of Quantitation and the maximum of the master curve).

Reportable Interval

0.006 -2000 μIU/mL (defined by the Limit of Detection and the maximum of the master curve×Recommended Dilution Ratio).

Analytical Sensitivity

Limit of Blank (LoB) =0.001 μIU/mL.

Limit of Detection (LoD) =0.006 μIU/mL.

Limit of Quantitation (LoQ) =0.010 μIU/mL.

Analytical Specificity

Interference

Interference was determined using the assay, three samples containing different concentrations of analyte were spiked with potential endogenous and exogenous interferents in a protocol (EP7-A2) of the CLSI. The measurement deviation of the interference substance is within ±10%. The following results were obtained:

Interference	No interference up to	Interference	No interference up to
Bilirubin	60 mg/dL	Levothyroxine sodium	72 μg/dL
Hemoglobin	2000 mg/dL	Metoprolol tartrate	24 mg/dL
Intralipid	1000 mg/dL	Dexamethasone	480 μg/dL
HAMA	40 ng/mL	Prednisone	4.8 mg/dL
Rheumatoid factor	1500 IU/mL	Diclofenac Sodium	9 mg/dL
ANA	6(S/CO) strong positive	Ibuprofen	72 mg/dL
Methimazole	14.4 mg/dL	Aspirin	18 mg/dL
Propylthiouracil	144 mg/dL	Paracetamol	9 mg/dL
Hydrocortisone	24 mg/dL	Vitamin B3	48 mg/dL
Propranolol	19.2 mg/dL	Lithium carbonate	90 mg/dL
Sodium iodide	180 mg/dL	Biotin	5 mg/dL

Cross-Reactivity

Cross-reactivity was determined using the assay, three samples containing different concentrations of analyte were spiked with potential cross-reactants in a protocol (EP7-A2) of the CLSI. The measurement deviation of the interference substance is within ±10%. The following results were obtained:

Cross-reactant	No interference up to	Cross-reactant	No interference up to
FSH	1500 mIU/mL	hCG	200 IU/mL
LH	600 mIU/mL		

High-Dose Hook

No high-dose hook effect was seen for TSH concentrations up to 3000 μIU/mL.

Method Comparison

A comparison of the TSH (CLIA) assay with a commercially available immunoassay, gave the following correlations (μIU/mL):

Number of samples measured: 153.

Passing-Bablok: y=1.0030 x+0.0010, r= 0.991.

The clinical specimen concentrations were between 0.010 and 96.47 μIU/mL.

REFERENCES

1. Szkudlinski M W, Fremont V, Ronin C, et al. Thyroid-Stimulating Hormone and Thyroid-Stimulating Hormone Receptor Structure-Function Relationships [J]. Physiological Reviews, 2002, 82(2):473-502.
2. Professor, Charles, H, et al. Recombinant Human Thyroid-Stimulating Hormone [J]. Biodrugs, 2003.
3. Goel R, Raju R, Maharudraiah J, et al. A Signaling Network of Thyroid-Stimulating Hormone. J Proteomics Bioinform. 2011;4:10.4172/jpb.1000195. doi:10.4172/jpb.1000195
4. Ortiga-Carvalho T M, Chiamolera M I, Pazos-Moura C C, et al. Hypothalamus-Pituitary-Thyroid Axis [M]. Comprehensive Physiology. John Wiley & Sons, Inc. 2016.
5. Esfandiari N H, Papaleontiou M. Biochemical Testing in Thyroid Disorders [J]. Endocrinology & Metabolism Clinics of North America, 2017:S0889852917300324.
6. Okosieme O, Gilbert J, Abraham P, et al. Management of primary hypothyroidism: statement by the British Thyroid Association Executive Committee [J]. Clinical Endocrinology, 2015, 84(6).
7. Simone De Leo, Sun Y Lee, Lewis E Braverman, Hyperthyroidism, The Lancet, Volume 388, Issue 10047, 2016, Pages 906-918, ISSN 0140-6736.
8. Spencer, C. The National Academy of Clinical Biochemistry laboratory support for the diagnosis of thyroid disease. Europe 13, 2002.
9. Taylor P N , Albrecht D , Scholz A , et al. Global epidemiology of hyperthyroidism and hypothyroidism[J]. Nature Reviews Endocrinology, 2018.
10. CLSI. Statistical Quality Control for Quantitative Measurement Procedures: Principles and Definitions. 4th ed. CLSI guideline C24. Wayne, PA: Clinical and Laboratory Standards Institute; 2016.
11. Sakai H, Fukuda G, Suzuki N, et al. Falsely Elevated Thyroid-Stimulating Hormone (TSH) Level Due to Macro-TSH [J]. Endocrine journal, 2009, 56(3):435-440.
12. Robert W. Schroff, Kenneth A. Foon, Shannon M. Beatty, et al. Human Anti-Murine Immunoglobulin Responses in Patients Receiving Monoclonal Antibody Therapy [J]. Cancer Research, 1985, 45(2):879-885.
13. Primus F J, Kelley E A, Hansen H J, et al. "Sandwich"-type immunoassay of carcinoembryonic antigen in patients receiving murine monoclonal antibodies for diagnosis and therapy [J]. Clinical Chemistry, 1988, 34(2):261-264.
14. Boscato L M, Stuart M C. Heterophilic antibodies: a problem for all immunoassays [J]. Clinical Chemistry, 1988, 34 (1):27-33.

SYMBOLS EXPLANATIONS

	Consult instructions for use		Manufacturer
2°C 8°C	Temperature limit (Store at 2-8 °C)		Use-by date
Σ	Contains sufficient for<n> tests		Keep away from sunlight
	This way up	EC REP	Authorized representative in the European Community
IVD	*In vitro* diagnostic medical device	CONTENTS	Kit component
REF	Catalogue number	LOT	Batch code
CE	CE marking		

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