Characterizing Reactivity to *Onchocerca volvulus* Antigens in Multiplex Bead Assays

Karla R. Feeser, Vitaliano Cama, Jeffrey W. Priest, Elizabeth A. Thiele, Ryan E. Wiegand, Thomson Lakwo, Sindew M. Feleke, and Paul T. Cantey

1Division of Parasitic Diseases and Malaria, Center for Global Health, Centers for Disease Control and Prevention, Atlanta, Georgia; 2Division of Foodborne, Waterborne, and Environmental Diseases, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention, Atlanta, Georgia; 3Vector Control Division, Uganda Ministry of Health, Kampala, Uganda; 4Ethiopian Public Health Institute, Addis Ababa, Ethiopia

**Abstract.** Multiplex bead assays (MBAs) may provide a powerful integrated tool for monitoring, evaluation, and post-elimination surveillance of onchocerciasis and co-endemic diseases; however, the specificity and sensitivity of *Onchocerca volvulus* antigens have not been characterized within this context. An MBA was developed to evaluate three antigens (OV-16, OV-17, and OV-33) for onchocerciasis. Receiver operating characteristics (ROC) analyses were used to characterize antigen performance using a panel of 610 specimens: 109 *O. volvulus*-positive specimens, 426 non-onchocerciasis controls with filarial and other confirmed parasitic infection, and 75 sera from patients with no other parasitic infection. The IgG and IgG4 assays for OV-16 demonstrated sensitivities of 95.4% and 96.3%, and specificities of 99.4% and 99.8%, respectively. The OV-17 IgG and IgG4 assays had sensitivities of 86.2% and 76.1% and specificities of 79.2% and 82.8%. For OV-33, the IgG and IgG4 assays had sensitivities of 90.8% and 96.3%, and specificities of 96.8% and 98.6%. The OV-16 IgG4-based MBA had the best assay characteristics, followed by OV-33 IgG4. The OV-16 IgG4 assay would be useful for monitoring and evaluation using the MBA platform. Further evaluations are needed to review the potential use of OV-33 as a confirmatory test in the context of program evaluations.

**INTRODUCTION**

Onchocerciasis, also known as river blindness, is a neglected tropical disease (NTD) caused by the parasitic worm *Onchocerca volvulus*. Recent data from the World Health Organization (WHO) estimate that over 187 million people live at risk for infection by *O. volvulus* primarily in sub-Saharan Africa. Infection can result in visual impairment or blindness, mild to severe dermatitis, and nodules under the skin. Of the over 25 million people estimated to be infected, approximately 300,000 are blind and more than 800,000 suffer visual impairment. Onchocerciasis is targeted for elimination where feasible in Africa by 2025, and the current standard to achieve its elimination is through the mass drug administration (MDA) of ivermectin. This anti-parasitic drug kills microfilariae (MF), a juvenile stage of the parasite, but not the adult worms, which are long lived. Fifteen or more years of MDA may be needed to achieve its elimination. MDA is followed by OV-33 IgG4. The OV-16 IgG4-based MBA had the best assay characteristics, followed by OV-33 IgG4. The OV-16 IgG4 assay would be useful for monitoring and evaluation using the MBA platform. Further evaluations are needed to review the potential use of OV-33 as a confirmatory test in the context of program evaluations.

**METHODS**

**Human samples.** A panel of 610 specimens was assembled for this study: 109 *O. volvulus*-positive specimens (microfilariae positive in skin snips either by microscopy or PCR) and 501 from non-endemic controls (Table 1).
Table 1: Characteristics of the serum specimen panel

<table>
<thead>
<tr>
<th>Infecting agent</th>
<th>No.</th>
<th>Country of origin</th>
<th>Coinfecting organisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onchocerca volvulus</td>
<td>94</td>
<td>Uganda</td>
<td>Necator americanus (N = 1)</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>Ethiopia</td>
<td>S. stercoralis (N = 2)</td>
</tr>
<tr>
<td>Wuchereria bancrofti</td>
<td>127</td>
<td>Haiti</td>
<td>A. lumbricoides + S. stercoralis (N = 2)</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Kenya</td>
<td>A. lumbricoides, S. mansoni (N = 1)</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Brazil</td>
<td>Entamoeba histolytica (N = 1)</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>India</td>
<td>Trichuris spp. (N = 2)</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Bangladesh</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>Sri Lanka</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Tahiti</td>
<td></td>
</tr>
<tr>
<td>Brugia malayi</td>
<td>3</td>
<td>Sulawesi</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Kalimantan</td>
<td></td>
</tr>
<tr>
<td>Loa loa</td>
<td>21</td>
<td>U.S. expatriates</td>
<td></td>
</tr>
<tr>
<td>Mansonella ozzardi</td>
<td>36</td>
<td>Peru</td>
<td></td>
</tr>
<tr>
<td>Schistosoma mansoni</td>
<td>20</td>
<td>Kenya</td>
<td></td>
</tr>
<tr>
<td>Strongyloides stercoralis</td>
<td>30</td>
<td>Argentina</td>
<td></td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>U.S. expatriates</td>
<td></td>
</tr>
<tr>
<td>Taenia solium</td>
<td>66</td>
<td>Peru</td>
<td></td>
</tr>
<tr>
<td>Toxocara spp.</td>
<td>15</td>
<td>United States</td>
<td>Entamoeba spp. (N = 3)</td>
</tr>
<tr>
<td>Ascaris lumbricoides</td>
<td>6</td>
<td>Brazil</td>
<td>H. nana (N = 1)</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>India</td>
<td>Entamoeba spp. (N = 4)</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Brazil</td>
<td>Giardia intestinalis (N = 1)</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>Brazil</td>
<td>Iodamoeba butschlii (N = 4)</td>
</tr>
<tr>
<td>Hymenolepsis nana</td>
<td>7</td>
<td>Brazil</td>
<td></td>
</tr>
<tr>
<td>Entamoeba spp.</td>
<td>15</td>
<td>Brazil</td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>49</td>
<td>United States</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>India</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Brazil</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Mali</td>
<td></td>
</tr>
</tbody>
</table>

Onchocerciasis-positive specimens were collected in a protocol designed to evaluate diagnostic tests for onchocerciasis in the African context. The objective of the protocol was to find infected individuals, rather than define prevalence of infection, so that various diagnostic tests could be assessed. A convenience sample of 1,000 people was taken in study sites in Uganda and Ethiopia (500 people each site). Ivermectin distribution had consistently occurred for less than 3 years in both sites; the last Ivermectin distribution occurred 5 months before the study. Background information was collected using a standard questionnaire, two skin skips were taken, and venous blood samples (both serum and ethylenediaminetetraacetic acid preserved) were collected from each participant. Skin skips were evaluated in the field by microscopy after incubation for 24 hours in normal saline and by PCR at CDC laboratories. The protocol was approved by ethical review boards in the United States, Ethiopia, and Uganda. Onchocerciasis-positive samples used in the MBA described herein were from people who were enrolled in this protocol and who had MF in skin snips by microscopy and onchocercal DNA by PCR.

Negative control sera were selected from sample sets of projects done in areas not endemic for onchocerciasis in the following countries: Haiti, Kenya, Brazil, India, Bangladesh, Sri Lanka, Tahiti, Indonesia, United States, Peru, Argentina, and Mali. Among these onchocerciasis negative sera, 191 were positive for LF, 57 for other filarial infections, 135 for other NTDs, and 43 for an enteric parasite. These sera originated from individuals whose parasitic infections were confirmed by microscopy or radiologic imaging (e.g., neurocysticercosis). Seventy-five of the onchocerciasis-negative sera were also negative for all of the aforementioned infections (Table 1). All sera were collected under protocols with appropriate ethical clearances.

Antigens. OV-16-GST: This antigen was generated as previously described30,36 in the laboratory of Parasitic Diseases, National Institute of Allergy and Infectious Diseases and kindly provided by Thomas Nutman.

OV-33: A 627-bp fragment of the O. volvulus 33.3 (OV-33) protein coding sequence was amplified from an adult female worm cDNA library in Lambda Uni-ZAP XR (Filariasis Reagent Resource Center at Smith College, Northampton, MA) with primers previously described by Lucius.32 The DNA was amplified and cloned into Rosetta-gamiB(DE3) Escherichia coli (Novagen, Madison, WI). The recombinant GST- and His6-tagged antigen was purified by GST affinity column chromatography (GE Healthcare, Pittsburgh, PA) as previously described.21 It was further purified by dialysis versus 2 L phosphate-buffered saline (PBS) (2× at 4°C), resulting in a 2 mL solution of protein at a concentration of 0.57 mg/mL (BCA microassay, Pierce Biotechnology, Rockford, IL).

OV-17: Similarly, the OV-17 coding sequence (minus the 51 bp 5’ sequence encoding the 17 amino acid signal peptide) was PCR amplified from an O. volvulus cDNA library31 and cloned into HB101 E. coli cells (Promega, Madison, WI). The GST-tagged recombinant antigen was then purified by GST affinity column chromatography (GE Healthcare). Dialysis of the glutathione-eluted protein against 2 L of PBS (2× at 4°C) yielded approximately
3 mL of protein solution at a concentration of 2.6 mg/mL (BCA microassay, Pierce Biotechnology).

**Bead coupling.** SeroMap beads (Luminex Corporation, Austin, TX) were coupled to the antigens using standard protocols. A total of 30 μg of protein was used for each antigen per 12.5 x 10^6 bead microsphere coupling reaction. PBS (pH 7.2) was used to couple OV-16-GST and GST control protein, whereas 2-(N-morpholino) ethanesulfonic acid (pH 5.0) was used for coupling OV-17-GST and OV-33-GST.25,28

**Multiplex bead assay.** Serum samples were diluted 1:400 in a PBS solution containing 0.5% casein, 0.3% Tween-20, 0.5% polyvinyl alcohol, 0.5% polyvinyl pyrrolidone, 0.2% NaN₃, and incubated overnight at 4°C w ith crude E. coli extract at a final concentration of 3 μg/mL before testing. Coupled beads at 2,500 beads/antigen/well in 50 μL of Buffer A were added to 96-well filtered-bottom plates (Millipore, Bedford, MA) and wash aspirated. Fifty microliters of sample were added in duplicate wells and incubated 1.5 hours at room temperature with gentle shaking.20–26,28 All samples were separately screened for IgG and IgG4 responses. Positive controls for each antigen were calibrated to give an expected mean fluorescent intensity (MFI) signal minus the background (bg) noise of between 8,000 and 15,000 MFI-bg. Antibody binding was detected with biotin-conjugated goat anti-human IgG (Jackson ImmunoResearch Laboratories Inc., West Grove, PA) at 1:15,000, or biotin-conjugated mouse anti-human IgG4 (Life Technologies, Carlsbad, CA) at 1:1,250. Secondary antibodies were allowed to react with 1:200 streptavidin-phycoerythrin (Invitrogen, Carlsbad, CA), and 125 μL of washed beads in PBS were read in a Bio-Plex 200 instrument using BioPlex Manager version 6.1 (Bio-Rad Laboratories, Hercules, CA).

**Statistical analysis.** Threshold values for positive antibody responses, assay characteristics, and 95% confidence intervals (CI) were visualized and analyzed using the pROC package in R version 3.0.1 (R Foundation for Statistical Computing, Vienna, Austria).37,38 CIs were calculated using bootstrap analyses set at 10,000 stratified replicates. Receiver operating characteristics (ROC) curves were compared using Delong’s test for two correlated ROC curves.39

The study was powered to detect differences in accuracy (area under the ROC curve) of at least 0.10 between assays using a two-sided z test. A sample of at least 100 positives and 300 negatives was needed to achieve the required power of >99.9% with a significance level of 0.05. Descriptive analyses were performed using GraphPad Prism version 5.00 for Windows (GraphPad Inc., San Diego, CA).

**RESULTS**

The median MFI-bg among sera from O. volvulus-positive individuals and among sera from O. volvulus-negative individuals are displayed for each of the antigens for both total IgG and for IgG4 in Table 2 along with the results from the ROC analyses.

**TABLE 2**

<table>
<thead>
<tr>
<th>IgG and IgG4 assay performance by antigen</th>
<th>IgG anti-OV-16</th>
<th>IgG4 anti-OV-16</th>
<th>IgG anti-OV-17</th>
<th>IgG4 anti-OV-17</th>
<th>IgG anti-OV-33</th>
<th>IgG4 anti-OV-33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean MFI-bg (range)</td>
<td>12,423 (14 to 27,024)</td>
<td>21,733 (14 to 31,084)</td>
<td>15,657 (62 to 29,787)</td>
<td>13,062 (3 to 30,104)</td>
<td>23,809 (1,092 to 29,372)</td>
<td>26,522 (2 to 31,806)</td>
</tr>
</tbody>
</table>

**CI = confidence intervals; bg = background; MFI = mean fluorescent intensity.
(CI = 92.7–99.1) and 96.3% (CI = 92.7–99.1) and specificities of 99.4% (CI = 96.4–100) and 99.8% (CI = 99.4–100), respectively (Table 2). For the IgG assay, a high cutoff that captured all of the true negative values (100% specificity) reduced sensitivity to 83.5%, whereas a low cutoff affording 100% sensitivity reduced specificity to 3.4%. Maximizing specificity of the IgG4 assay to 100% reduced sensitivity to 95.4%, whereas maximizing sensitivity to 100% reduced specificity to 1.4%.

Using the optimal threshold, the IgG assay misclassified five (4.6%) sera as negatives and three (0.6%) as positives. The three false positives came from one Wuchereria bancrofti specimen, one Entamoeba spp. specimen, and one U.S. non-traveler specimen, with IgG responses to OV-16 of 777, 795, and 3,451 MFI-bg, respectively. The IgG4 assay misclassified four (3.6%) sera as negatives and one (0.2%) serum as positive. The false positive was a W. bancrofti specimen from India, with an IgG4 response to OV-16 of 48 MFI-bg.

OV-17: ROC analysis produced an AUC of 0.912 for the IgG assay and 0.879 for the IgG4 assay (Figure 1). The optimal cutoffs for the IgG and IgG4 assays were 915 and 603 MFI-bg with sensitivities of 86.2% (CI: 70.6–96.3) and 76.1% (CI = 67.0–94.5) and specificities of 79.2% (CI = 69.7–95.8) and 82.8% (CI = 63.9–92.2), respectively (Table 2). For the IgG assay, a high cutoff resulting in 100% specificity reduced sensitivity to 32.1%, whereas a low cutoff affording 100% sensitivity reduced specificity to 36.5%. Maximizing the specificity of the IgG4 assay to 100% reduced sensitivity to 20.2%, whereas maximizing the sensitivity to 99.1% reduced specificity to 0.2%.

The IgG assay misclassified 15 sera as negative and 104 sera as positive (Table 2). The 104 false-positive specimens included 77 with W. bancrofti (median = 3,693 MFI-bg, range (R) = 969–24,193), 11 with Mansonella ozzardi (median = 1,994 MFI-bg, R = 938–22,607), six with Loa loa (median = 2,529 MFI-bg, R = 1,258–11,067), two with Toxocara spp. (1,050 and 1,155 MFI-bg), one with Schistosoma mansoni (980 MFI-bg), one with B. malayi (2,466 MFI-bg), and six U.S. specimens (median = 2,772 MFI-bg, R = 1,090–20,650).

The IgG4 assay misclassified 26 sera as negatives and 86 sera as positives (Table 2). The false-positive specimens included 74 with W. bancrofti (median = 6,150 MFI-bg,
anti-OV-16 assay (70 and 40 MFI-bg). Both of these specimens were positive for IgG4 anti-OV-16 reactivity in excess 18,000 MFI-bg units (18,812 and 23,238 MFI-bg). No samples had IgG4 reactivity to GST-only beads above the positivity threshold for OV-17 or OV-33.

**Comparison of assays.** There were no significant differences in the AUC between the IgG and IgG4 assays of OV-16 ($P = 0.62$) or for OV-33 ($P = 0.24$). The AUC for the IgG and IgG4 assays of OV-17 was significantly different ($P = 0.002$). No statistically significant difference was found between the ROC curves for the IgG4 assays of OV-16 and OV-33 ($P = 0.44$) nor between the IgG4 assays of OV-16 and OV-33 ($P = 0.73$); however, the IgG4 assay of OV-17 performed significantly worse than the IgG4 assays of both OV-16 ($P < 0.001$) and OV-33 ($P < 0.001$).

**DISCUSSION**

In our analysis, the anti-OV-16 MBA had the highest specificity and sensitivity of those antigens tested, followed closely by the anti-OV-33 MBA. Although no statistically significant difference was detected between the IgG and IgG4 assays for OV-16 and OV-33 (Figure 1), the IgG4 assays for both resulted in more false positives than the IgG4 assays (Figure 2). This suggests that IgG4 immunoassays are preferable to IgG assays in the elimination context. WHO guidelines for elimination require seroprevalence < 0.1% to stop MDA. Therefore, even a few false positives could result in unnecessary continuation of MDA. Furthermore, the IgG4 assays for OV-16 and OV-33 are able to maintain much higher sensitivity when the specificity is maximized. Although it would be ideal to have a highly specific test that was also capable of identifying true infections (e.g., detection of fertile adult females), no test is yet available.

OVA16 IgG4 antibody tests are currently available in other formats, including ELISA and a rapid diagnostic test. As such, OV-16 is the antigen most commonly used in serologic testing; however, given the high specificity and sensitivity of the anti-OV-33 IgG4 assay, it has potential for use as a confirmatory test alongside anti-OV-16 in the MBA. The inclusion of two antigens for onchocerciasis in assays for M and E might allow public health practitioners to make rapid determinations in the face of indeterminate or potentially false-positive results. Additionally, M and E programs faced with concerns about missing patent infections, such as when mapping a hypoendemic area, using a combination of tests may reduce the number of missed infections. Furthermore, studies of homologues to OV-33 found in other filarial parasites previously suggested these antigens could be markers of early infection. If found to be an early marker for onchocerciasis, OV-33 may play a role in the detection of recrudescence in areas that have stopped MDA.

The present study tested only a single batch of coupled beads for each antigen. This was done to avoid variance between batches that could affect cutoff thresholds. Cutoff thresholds are dependent on specific coupling conditions and must be recalibrated for each new batch of antigen-bead coupling that is produced. Although cutoff thresholds are expected to change for each new batch of beads, we anticipate that overall performance characteristics will remain consistent across couplings.
MULTIPLEX BEAD ASSAY FOR ONCHOCERCIASIS

MBAs, whether using just anti-OV-16 or both anti-OV-16 and anti-OV-33 antigens, could be used for routine surveillance. Blood was collected to evaluate the impact of other public health programs (e.g., NTD, malaria, vaccination) in river blindness program areas, generating information for multiple diseases in a single assay. They would also be helpful when used in combination in areas that are being evaluated to determine if MDA can be stopped, as multiple antigens of \textit{O. volvulus} could be simultaneously tested. The use of the MBA will require specialized training, particularly to ensure proper coupling and determination of cutoff thresholds. It also requires specialized equipment that many programs do not currently possess. However, the needed equipment is becoming more commonly available as various program take up the technology.

Compared with current surveillance methods for onchocerciasis, the MBA is a more sensitive platform than skin snip microscopy (CDC, unpublished data) and can be a more versatile tool than the IgG4 anti-OV-16 ELISA.\textsuperscript{12} The MBA has advantages both as a research tool and as a surveillance tool. Given the many areas of co-endemicity for onchocerciasis and other NTDs, an integrated monitoring platform would be ideal. As elimination programs move toward integration, it makes sense that M and E efforts for different infections should be integrated; the MBA is one tool that would facilitate an integrated surveillance platform. As demonstrated by this study, both OV-16 and OV-33 can discriminate onchocerciasis from other filarial infections and both antigens are good candidates for inclusion in integrated sero-surveillance of NTDs on the MBA platform.

Received June 24, 2016. Accepted for publication February 16, 2017.

Acknowledgments: We would like to thank the people of the communities of Kitgum/Lamwo in Uganda and Jimma in Ethiopia, and the respective field teams for their generous participation and support. We also would like to thank Dr. Patrick J. Lammie and the NIH/NIAID Filarialis Research Reagent Resource Center (www.filarialiscenter.org) for providing valuable serum samples. This work was funded in part by the Bill and Melinda Gates Foundation, grant OPP1017858.

Disclaimer: The findings and conclusions in this report are those of the original author and source are credited.

REFERENCES


