Enzyme Immunoassay for Detection of Antibody-Coated Bacteria

WALTER E. STAMM,* BRUCE E. CUTTER, AND GRADA A. GROOTES-REUVECAMP

Department of Medicine, Division of Infectious Diseases, Harborview Medical Center, University of Washington School of Medicine, Seattle, Washington 98104

To quantitatively evaluate factors potentially affecting antibody coating of bacteria in urine, we developed an assay with enzyme-linked rather than fluorescein-conjugated immunoglobulin. Using the enzyme immunoassay (EIA) in an in vitro system in which concentrations of serotype O44 Escherichia coli and antibody titer to E. coli O44 O antigen were known, we compared specimens run in parallel with a fluorescent antibody (FA) assay. At \( \geq 10^5 \) bacteria per ml, antibody titer to homologous O antigen correlated directly with absorbance in the EIA. Both tests had sensitivities exceeding 95% in specimens containing \( \geq 10^5 \) bacteria per ml, but the FA test detected 23 of 27 positive specimens with \( < 10^5 \) bacteria per ml compared with 21 of 43 detected by EIA (\( P = 0.002 \)). However, nonspecific fluorescence caused false positives in 8% of negative tests run by FA compared with 1% of simultaneous EIA tests (\( P = 0.05 \)). pH alterations and pretreatment of bacteria with antibiotics did not affect either test. Heterologous E. coli strains showed no cross-reactivity with O44 antigen, but all Staphylococcus aureus isolates tested caused false positives in both assays, and one Klebsiella strain repeatedly caused a false-positive FA assay. The EIA appears to be a simple, quantitative, and specific technique for detection of antibody-coated bacteria in this experimental system.

Detection of antibody-coated bacteria (ACB) in urine by the fluorescent-antibody (FA) technique has been used widely for differentiating upper and lower tract urinary infections in epidemiological studies (4–8) and has been used to identify patients most likely to respond to single-dose antimicrobial therapy (2). However, in studies that have directly compared the ACB test with other means of localizing urinary tract infections, up to 33% false positives and 27% false negatives have been reported (4–8). Furthermore, because the ACB test is qualitative rather than quantitative, various factors potentially affecting it have not been evaluated in detail. We have developed an assay for ACB with enzyme-linked rather than fluorescein-conjugated immunoglobulin and found that this method resulted in quantitative and reproducible detection of ACB. Using this assay in parallel with the FA technique, we evaluated five factors potentially affecting the outcome of both tests: (i) concentration of bacteria; (ii) antibody titer; (iii) urinary pH; (iv) pretreatment of bacteria with antibiotics; and (v) cross-reactivity with heterologous Escherichia coli strains and other genera.

(Portions of this paper were presented at the meeting of the American Federation of Clinical Research, Western Section, Carmel, Calif., 8 February 1980.)

MATERIALS AND METHODS

Preparation of ACB. ACB were prepared artificially by suspending colonies from an 18-h culture of E. coli O44 in 1 ml of phosphate-buffered saline (PBS, pH 7.3) with 0.05% Tween (PBST), adding 0.1 ml of E. coli O44 antigen, and incubating for 30 min. At bacterial concentrations \( \geq 10^5 \)/ml and antisera dilutions of \( < 1/1,000 \), this technique produced uniform, strong fluorescence in the FA test, indicating that most bacteria were antibody coated. Rabbit antisera to E. coli O44 O antigen used in all experiments was obtained from the Center for Disease Control (lot 1128, undiluted titer 1:1,280) and was diluted 1:100 in PBST for all experiments unless otherwise specified. Bacterial concentrations were adjusted by measuring absorbance at 340 nm and by using serial 10-fold dilutions in Trypticase soy broth (BBL Microbiology Systems), with aliquots subsequently placed on blood agar plates for colony count determination.

EIA method. For the enzyme immunoassay (EIA) method, previously prepared ACB were washed three times in 1 ml of PBST and were incubated with 1 ml of peroxidase-conjugated goat-anti-rabbit antisem (Cappel Laboratories, Inc., Downingtown, Pa.), diluted 1:1,000 in PBST (pH 7.3) with purified bovine serum albumin in a concentration of 0.5%. After 30 min of incubation at 37°C, the ACB were washed twice in PBST. After washing, 1 ml of freshly prepared
substrate (1 ml of O-phenylenediamine, 1% [wt/vol] in methanol, 0.1 ml of 3% hydrogen peroxide, and 99 ml of PBST) was added, and the tubes were incubated for 30 min in the dark at room temperature. After incubation, the reaction was stopped with 0.125 ml of eight normal sulphuric acid and absorbance was read at 490 nm. Control specimens containing bacteria but no antisera, antisera but no bacteria, and a reagent blank were prepared in all experiments. Results were expressed as sample absorbance minus absorbance of the simultaneous run control containing bacteria only, and positive tests were considered those where absorbance exceeded that of the control by ≥0.02 U. All specimens were coded and run blindly.

FA method. The FA test was performed with slides prepared from washed sediments of artificially coated bacteria. One drop of a 1:20 dilution of fluorescein-conjugated goat-anti-rabbit antisera (Cappel Laboratories, Inc., Downingtown, Pa.) was placed on each slide and incubated for 30 min at room temperature in the dark and then rinsed with 0.02 M PBS (pH 7.3). Slides were then soaked in the same PBS solution for 15 min, dried, and read in a fluorescent microscope. Specimens showing five or more fluorescing bacteria per 100 fields examined were considered positive.

Conditions for individual experiments. (i) Effects of bacterial concentration. E. coli O44 organisms were coated with antibody (1:100 dilution) as outlined above and were diluted with PBST to concentrations of 10⁵ to 10⁶ bacteria per ml as determined by measuring absorbance at 340 nm. Control specimens consisted of E. coli O44 without antisera exposure and E. coli O44 antisera (dilution 1:100 to 1:1,000) in PBST. After preparation, specimens and controls were tested in the EIA and the FA assay as described above.

(ii) Effects of antisera dilution. Serial 10-fold dilutions of E. coli O44 antisera were incubated with 10⁸ E. coli O44 per ml to prepare ACB. After preparation, specimens and controls were tested in the EIA and FA assay as described above.

(iii) Effects of pH or pretreatment of bacteria with antibiotics. E. coli O44 (10⁸ bacteria per ml) and O44 antisera (1:100 dilution) were incubated in PBST previously adjusted to pH 4, 5, 6, 7, or 8 by addition of 0.1 N hydrochloric acid or 0.1 N sodium hydroxide. After 30 min of incubation, the FA assay and the EIA were performed. To test the effect of antibiotic exposure upon antibody coating, E. coli O44 were exposed to sublethal doses of gentamicin or ampicillin (0.5, 1.0, and 1.5 µg of each drug per ml) for 30 min before incubation with antisera.

(iv) Heterologous E. coli serotypes and non-E. coli strains. Individual E. coli strains of serotypes O1, O4, O6, O7, O25, O75, O50, O15, O77, O126, O115, O102, O137, and three rough strains (10⁹/ml) were tested in the EIA and FA systems after incubation with 1:100 dilution of E. coli O44 antisera for 30 min and after incubation without antisera. All strains were obtained from patients with urinary tract infections. Similarly, strains of Klebsiella (six), Staphylococcus aureus (three), Staphylococcus epidermidis (two), Pseudomonas aeruginosa (two), Proteus mirabilis (one), Enterobacter (one), and enterococci (one) were tested with and without incubation in E. coli O44 antisera.

RESULTS

Effects of bacterial concentration. Increasing concentrations of E. coli O44 from 10⁵ to 10⁶ bacteria per ml produced increasing absorbance in the EIA (Fig. 1). Comparison of the FA and EIA tests with respect to concentrations of bacteria in the prepared suspension showed that both tests were highly sensitive in specimens containing ≥10⁴ bacteria per ml, but in specimens with lower concentrations of bacteria, the FA test detected 23 of 27 positives, whereas the EIA detected only 21 of 43 (P = 0.002; Table 1). In tests with known negative controls (either bacteria without antibody or antibody without bacteria), nonspecific fluorescence caused false positives in 5 of 60 specimens tested by FA but only 1 of 80 in the EIA (P = 0.05, Fisher's exact test, one tailed). Four of the five false positives with the FA test were in specimens containing antibody alone.

Effects of antisera dilution. Using 10⁶ bacteria per ml, dilution of antisera to the E. coli O44 antigen correlated directly with absorbance in the EIA (Fig. 2). FA results paralleled those of the EIA, with both tests becoming negative at antisera dilutions of between 1:1,000 and 1:10,000 (Fig. 2).

Effects of pH or pretreatment of bacteria with antibiotics. Incubation of E. coli O44 and antisera was carried out at pH values ranging from 4 to 8. No significant difference in absorbance obtained with the EIA was found over this range of pH values, and FA tests remained positive at all pH's tested.

Experiments performed after pretreating bacteria with 0.5, 1.0, and 1.5 µg of gentamicin or ampicillin per ml before their exposure to antisera had no effect upon either test.

Heterologous E. coli serotypes and non-E. coli strains. We evaluated 16 E. coli strains other than serotype O44 and 16 non-E. coli strains in both the FA and EIA tests. No cross-reactivity with heterologous E. coli strains and O44 antisera was observed. All three S. aureus strains tested caused positive results in both assays irrespective of prior treatment with E. coli O44 antisera. Other strains tested (two strains of S. epidermidis and P. aeruginosa, and one strain each of P. mirabilis, Enterobacter, and enterococci) did not cause false positives, with the exception of one of six Klebsiella strains. This strain was repeatedly positive in the FA but not the EIA test and, like the S. aureus strains, was positive with and without addition of E. coli antisera.
**TABLE 1. Comparison of FA and EIA in positive specimens (E. coli O44 plus homologous antibody)**

<table>
<thead>
<tr>
<th>Concen</th>
<th>FA</th>
<th>EIA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. positive</td>
<td>No. negative</td>
</tr>
<tr>
<td>≥10^6</td>
<td>52</td>
<td>3</td>
</tr>
<tr>
<td>&lt;10^5</td>
<td>23</td>
<td>4</td>
</tr>
</tbody>
</table>

^* P = 0.002, Fisher’s exact test, FA versus EIA.

DISCUSSION

EIA has been widely used for detection of soluble antigens and antibodies in biological fluids, but has not often been employed for detection of antibody attached to bacteria. In the classic EIA technique, antigen is fixed or bound to a plastic support medium, and antibody attached to the bound antigen is detected by enzyme-linked anti-human globulin (1). In our assay, rabbit immunoglobulin attached to bacteria was incubated with enzyme-linked goat-anti-rabbit immunoglobulin, and bound enzyme-linked immunoglobulin was separated from unbound by centrifugation. This method was simple to perform, quantitative, and more specific than the FA assay in detecting E. coli artificially coated with antibody. False positives with the FA test occurred mainly in specimens with antibody but no bacteria and probably resulted from nonspecific adherence of antibody to bacterial contaminants or to debris closely resembling bacteria. Unfortunately, the sensitivity of the EIA fell below 50% in specimens containing <10^5 bacteria per ml, whereas the FA test detected 85% of positives in this group. We suspect that the EIA requires a substantial proportion of bacteria to be antibody coated before enough peroxidase-conjugated immunoglobulin is retained to result in a positive test, whereas the FA test can identify antibody-coated cells even when only a small number are present. Most infected urines actually contain 10^9 to 10^10 bacteria per ml (3), so lack of sensitivity in specimens with <10^5 bacteria per ml may not preclude use of the EIA in clinical specimens. However, the percentage of bacteria coated with antibody in actual upper tract infections may be lower than in our artificial system where at antiserum dilutions of 1:100, most bacteria exhibited fluorescence. We are now examining urines from infected patients with both assays to determine their sensitivity and specificity in...
clinical use.

Since the EIA provides quantitative results, we assessed factors that may cause either false positives or false negatives in the FA test by running both assays in parallel. The direct correlation of EIA absorbance with dilution of antisemur suggests that insufficient antibody will probably cause false-negative tests. In a rabbit model, Smith demonstrated that positive FA tests did not occur until 10 to 14 days after experimental pyelonephritis when sufficient antibody titers had developed (9). Concentration of bacteria in the assay also directly correlated with EIA absorbance. In infections with lower counts of E. coli, false-negative tests may result from this phenomenon. Urinary pH and pretreatment with antibiotics had no apparent effect upon the ACB test or the EIA. However, we examined only brief exposure of bacteria to antibiotics. Longer exposures, as could occur in patients, might produce different results.

Of particular interest were the false-positive FA tests observed with both S. aureus and Klebsiella strains. All S. aureus strains tested caused false-positive tests in both assays with or without the addition of E. coli antisemur. Presumably this phenomenon results from attachment of fluorescein-conjugated or enzyme-linked immunoglobulin to staphylococcal protein A via the FC receptor. False-positive results with one of six Klebsiella strains were unexpected but occurred repeatedly in this strain when tested by FA. This strain did not result in false positives using the EIA. We cannot explain this false-positive test at the present time, but the ACB test may not be as reliable for Klebsiella as for E. coli.

ACKNOWLEDGMENTS

We thank Thomas M. Buchanan and Thomas P. Gillis for their helpful suggestions, and Patra Learning for editorial assistance.

This work was supported in part by a Public Health Service training grant (AI-07044) from the National Institutes of Health.

LITERATURE CITED