Detection of Human Metapneumovirus Antigens in Nasopharyngeal Secretions by an Immunofluorescent-Antibody Test

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Human metapneumovirus (hMPV), a novel respiratory virus, has recently been recognized as an etiologic agent of respiratory tract infections in children and adults (2, 23, 25). Since hMPV is genetically related to human respiratory syncytial virus (hRSV), hMPV and hRSV are grouped in the same subfamily, subfamily Pneumovirinae, of the family Paramyxoviridae (23). The clinical manifestations and epidemiologies of hMPV and hRSV have been reported to be very similar (3, 21, 24, 27). Both viruses are separated into two groups by genetic differences (12, 14, 23). The seasonality of hMPV infections resembles that of hRSV infections, and the epidemic season of hMPV is from winter to early spring (6, 25). Serological studies have shown that all children are exposed to hMPV by the age of 5 to 10 years (5, 23). Repeated infections with hMPV occur throughout life, even in early childhood (2, 6, 7, 14). Previous studies have indicated that hMPV causes mild respiratory tract infections in healthy adults (2, 22, 25). However, it has been shown that children under 2 years of age, elderly people over 50 years old, and immunocompromised patients are at greater risk of lower respiratory tract infections, such as bronchitis, pneumonia, and bronchiolitis (25). hMPV has been revealed to be associated with acute wheezing in children (6, 13, 25, 29).

Four principal methods are used for the diagnosis of respiratory virus infections: virus isolation by culture, antigen detection, RNA or DNA detection, and serological study. In previous studies (6, 15, 17), virus isolation by culture, reverse transcription-PCR (RT-PCR), and serological study have been used for the diagnosis of hMPV infections. Virus isolation by culture with tertiary monkey (Macaca mulatta) kidney cells, LLC-MK2 cells, or Vero cells is specific and a “gold standard” method (23, 25). However, we could not isolate hMPV by culture from two-thirds of RT-PCR-positive samples (6). Serological study is retrospectively important for differentiation between primary infection and reinfection with hMPV. However, the immunoglobulin G (IgG) and IgM antibody responses to hMPV in the acute phase are not useful for the diagnosis of hMPV infections (6). Therefore, RT-PCR is concluded to be the most sensitive and specific procedure (6, 25). However, RT-PCR can be performed only in special laboratories, and it takes more than 6 h to obtain results.

Two rapid antigen detection methods are available: an immunofluorescent-antibody test and an enzyme-linked immunosorbent assay (ELISA). The ELISA method with mouse polyclonal antibodies to hMPV has been reported to enable detection of hMPV antigens of hMPV-infected cells in culture (28). However, there has been no study on the detection of hMPV antigens in clinical samples. The immunofluorescent-antibody test of respiratory epithelial cells has been shown to be a very useful method to detect other respiratory viruses, such as hRSV, parainfluenza virus, adenovirus, and influenza virus (11). The purpose of this study was to compare the rate of virus detection in nasopharyngeal secretions by an indirect immunofluorescent-antibody test (IFA) with that by RT-PCR.

MATERIALS AND METHODS

Patients and nasopharyngeal swab samples. From April to May 2004 we collected nasopharyngeal swab samples from 48 children who were admitted to Hokkaido Social Insurance Hospital, Kohnan Hospital, Kosei General Hospital, and Tenshi Hospital in Sapporo, Japan, due to respiratory symptoms. Two nasopharyngeal swab samples were collected from each patient. One sample was placed in 2 ml of Eagle’s minimum essential medium for IFA, and the other was placed in 500 µl of RNAzol B (Tel-Test, Inc., Friendswood, Tex.) for RT-PCR. The samples were collected within 7 days after the onset of illness, after the possibility of infection with hRSV or influenza A or B virus was excluded by a rapid antigen detection test. The male-to-female ratio was 1.5 to 1. The mean age of the 48 children was 1.5 years (age range, 1 month to 4.9 years). The final diagnosis for the children are shown in Table 1. All samples were collected after informed consent was obtained from the children’s parents. As negative controls, we collected five samples from healthy adults and three samples from children with infected with hRSV, as confirmed by rapid antigen detection tests.

IFA. Nasopharyngeal swab samples for IFA were gently mixed to create a free cell suspension. The cell suspension was centrifuged, and the cell pellet was
resuspended in 50 to 400 μl of phosphate-buffered saline (PBS). Cell smears were prepared by spotting 1 drop of the cell suspension onto a slide glass. Then, the smears were air dried and fixed in acetone for 10 min. For detection of hMPV antigens by IFA, we used an anti-hMPV mouse monoclonal IgG antibody (monoclonal antibody 1B7) from CHEMICON International, Inc. (Temecula, Calif.), which recognizes hMPV antigens of both groups A and B and of both subgroups 1 and 2. Before the IFA with the monoclonal antibody was started, we took hMPV-infected LLC-MK2 cells for use as hMPV-positive cells for IFA and reacted them with the monoclonal antibody and also with hMPV-positive human serum. Two patterns of IFA staining, granular and diffuse, of the hMPV-infected LLC-MK2 cells with the monoclonal antibody are shown in Fig. 1A and B, respectively. There was no difference between the frequency of hMPV antigen-positive cells obtained with the monoclonal antibody and that obtained with hMPV-positive human serum. Smears were incubated for 30 min at 37°C with the anti-hMPV mouse monoclonal antibody at a dilution of 1:80 and nonimmune mouse antibody as a negative control. They were then incubated for 30 min at 37°C with fluorescein isothiocyanate-conjugated rabbit anti-mouse Igs (Dako, Glostrup, Denmark) at a dilution of 1:40 with 0.001% Evans blue. After incubation, they were washed twice in PBS for 10 min each time, air dried, and mounted with PBS-glycerin (1:1). We confirmed that there were at least more

![Image 1A](http://jcm.asm.org/)

![Image 1B](http://jcm.asm.org/)

![Image 1C](http://jcm.asm.org/)

![Image 1D](http://jcm.asm.org/)

**FIG. 1.** Typical IFA staining of hMPV-infected LLC-MK2 cells (A, granular staining [white arrow]; B, diffuse staining) and nasopharyngeal epithelial cells (C, IFA-positive staining; D, IFA-negative staining) with the anti-hMPV monoclonal antibody (monoclonal antibody 1B7).

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**TABLE 1. Detection of hMPV by RT-PCR and IFA**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No. of samples that were:</th>
<th>Total no. of samples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RT-PCR and IFA positive</td>
<td>RT-PCR positive and IFA negative</td>
</tr>
<tr>
<td>Wheezy bronchitis</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Laryngotracheitis</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>URTI</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bronchiolitis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>4</td>
</tr>
</tbody>
</table>

*a URTI, upper respiratory tract infection.*
The results for 48 children tested by RT-PCR and IFA are shown in Table 1. All of the children positive for hMPV by either RT-PCR or IFA had lower respiratory tract infections, including wheezy bronchitis, bronchitis, pneumonia, and laryngotracheitis. Fifteen of the 48 children were positive for hMPV by RT-PCR. IFA results were positive for 11 of the 15 RT-PCR-positive children and for 1 of the 33 RT-PCR-negative children. Approximately 0.5 to 2.0% of the cells had specific staining. No specific staining was observed in samples from the healthy adults or the hRSV-infected children. The sensitivity and specificity of IFA were 73.3 and 97.0%, respectively. The rate of agreement of the results between IFA and RT-PCR was 89.6%.

A phylogenetic tree constructed on the basis of the hMPV fusion nucleotide sequences of the 15 hMPV strains is shown in Fig. 2. Positive IFA results were obtained with the hMPV strains of both groups A and B and subgroups 1 and 2, confirming the reactivity of the monoclonal antibody. For the 15 RT-PCR-positive children, the mean ages of the 11 IFA-positive children and the 4 IFA-negative children were 1.2 ± 1.3 years (standard deviation) and 1.8 ± 1.0 years (standard deviation), respectively. There was no significant difference between the mean ages of the two groups (P = 0.44 by Student’s t test).

**DISCUSSION**

We applied IFA to the detection of hMPV antigens in nasopharyngeal secretions for the rapid diagnosis of hMPV infection. The present study showed that IFA with an anti-hMPV mouse monoclonal antibody could detect hMPV antigens in nasopharyngeal secretions with 73.3% sensitivity and 97.0% specificity compared with the results of RT-PCR. We have reported that RT-PCR is a more sensitive method than serological studies and culture for the diagnosis of hMPV infection (6). In a previous study, hMPV was not detected by culture from two-thirds of RT-PCR-positive children. Although we could not perform virus isolation by culture in this study, IFA seemed to be more sensitive than virus isolation by culture.

Four RT-PCR-positive and IFA-negative cases were considered false negative. The false-negative results obtained by IFA might have been caused by technical problems, such as the use of unsuitable smears, and by the sampling period. In general, IFA is less sensitive than RT-PCR for the detection of viruses (4, 10, 19, 20). Furthermore, the sensitivities of various methods for the detection of respiratory viruses decrease in the convalescent phase of illness (6, 8, 9, 26). In fact, additional samples obtained from three RT-PCR-positive children during a period of 8 to 14 days after the onset of illness were RT-PCR positive and IFA negative (data not shown). On the other hand, only one child was RT-PCR negative and IFA positive in the present study. This might have been due to the classification of a misleading nonspecific fluorescence as specific staining.

IFA and ELISA are two major rapid tests for the detection
of virus antigens in nasopharyngeal secretions. In this study, we found that IFA is useful for the diagnosis of hMPV infections. In general, the detection of viral antigens by IFA and ELISA requires sufficient amounts of viral antigens in the clinical samples, including nasopharyngeal secretions. Experimental hMPV infection in cynomolgus macaques has shown that virus antigens are detectable mainly in ciliated epithelial cells throughout the respiratory tract, such as the nasal septum, trachea, and bronchus, and that macaques shed virus in nasopharyngeal secretions at high titers (15). In this study, hMPV antigens were detected in the epithelial cells of the postnasal cavity by IFA, indicating that nasopharyngeal secretions contain sufficient hMPV antigens to be detectable by other immunological detection methods such as ELISA.

IFA and ELISA each has merits and demerits (18). ELISA is easy to perform and provides results more objective than those provided by IFA. Therefore, many antigen detection ELISAs are used as rapid procedures for the diagnosis of respiratory tract infections in clinics. Although IFA requires some special techniques, it enables confirmation that each nasopharyngeal sample contains certain numbers of epithelial cells under a fluorescent microscope. Furthermore, there have been many reports that IFA is more sensitive than ELISA for the detection of respiratory virus antigens (1, 16, 17).

In this study, we showed that IFA is a useful and rapid test for the diagnosis of hMPV infections. However, the development of tests that are easier to perform in clinics, such as ELISA, is necessary for the appropriate treatment of patients.

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REFERENCES