

1 Comparison of Abbott ID Now, Diasorin Simplexa, and CDC FDA EUA methods for the detection  
2 of SARS-CoV-2 from nasopharyngeal and nasal swabs from individuals diagnosed with COVID-  
3 19

4

5 Daniel D. Rhoads<sup>\*1,2</sup>, Sree S. Cherian<sup>1,2</sup>, Katharine Roman<sup>1</sup>, Lisa M. Stempak<sup>1,2</sup>, Christine L.  
6 Schmotzer<sup>1,2</sup>, Navid Sadri<sup>1,2</sup>

7

8 <sup>1</sup> Department of Pathology, University Hospitals Cleveland Medical Center

9 <sup>2</sup> Department of Pathology, School of Medicine, Case Western Reserve University

10

11 \* ddr26@case.edu

12

13 Running Head: Comparison of NAAT methods for the detection of SARS-CoV-2

14

15

16 Dozens of *in vitro* diagnostics (IVDs) have received emergency use authorization (EUA) from the  
17 U.S. Food & Drug Administration (FDA) for the detection of SARS-CoV-2, but little has been  
18 studied to determine how well these assays perform using clinical specimens. This study  
19 compared the positive percent agreement (PPA) of ID Now (Abbott; Chicago, USA) and Simplexa  
20 (Diasorin; Saluggia, Italy) using a modified CDC method as the reference standard (1). All three  
21 methods are used as part of standard of care testing within our hospital system. Ninety-six (96)  
22 remnant clinical specimens from April 2020 that tested positive for SARS-CoV-2 using standard  
23 of care testing were selected based on convenience and retested using the three methods.  
24 Fourteen negative controls (universal transport medium, UTM) were included to control for  
25 carryover contamination. Specimens included 11 supervised self-collected nasal swabs in 2 mL  
26 normal saline and 85 provider-collected nasopharyngeal swabs in 3 mL UTM. The online  
27 Medcalc tool ([https://www.medcalc.org/calc/diagnostic\\_test.php](https://www.medcalc.org/calc/diagnostic_test.php)) was used to determine the  
28 exact Clopper-Pearson 95% confidence intervals (CI). It is well documented that IVDs for SARS-  
29 CoV-2 can return falsely negative results in individuals with COVID-19 (2), and our study did not  
30 attempt to determine the clinical sensitivity of these assays.

31

32 The instructions for use (IFU) were followed for all methods with the exception that nasal swabs  
33 in saline were included, but these specimens are not explicitly described as acceptable in all of  
34 the assays' IFU. Other deviations from the IFU for the CDC method include: (1) using 7500 Fast  
35 instead of 7500 Fast Dx instrument, (2) using an alternate RNA extraction method (Maxwell RSC  
36 instrument with Viral TNA Kit [Cat# AS1330] [Promega, Madison, USA]), and (3) interpreting  
37 "inconclusive" (one positive target) results as "detected."

38

39 The results are in Table 1. The modified CDC assay detected SARS-CoV-2 in all 96 specimens  
40 (range of Ct values: 11.1-39.6). The ID Now assay detected SARS-CoV-2 in 90 of 96 specimens  
41 (PPA 94% [CI 87-98%]). The Simplexa assay detected SARS-CoV-2 in 92 of 96 specimens (PPA  
42 96% [CI 90-99%]) (range of Ct values: 9.3-34.5).

43

44 The modified CDC assay detected both N1 and N2 targets in 94 of 96 specimens. In the other  
45 two specimens, the modified CDC assay detected only one of its two targets at  $\geq 39$  Ct, and  
46 SARS-CoV-2 was not detected using ID Now and Simplexa in these two specimens. In six other  
47 specimens, SARS-CoV-2 was not detected by only one of the assays; both targets in the  
48 modified CDC assay were detected at  $\geq 32$  Ct in these six specimens. Strong correlation of Ct  
49 values was observed when plotting the modified CDC assay N1 and N2 targets against the  
50 Simplexa S and Orf1ab targets ( $R^2=0.89-0.91$ ).

51

52 In summary, the 95% CIs for the PPA was overlapping for the ID Now and Simplexa assays when  
53 using the modified CDC method as the reference standard. The sample size of this study was not  
54 large enough to conclude one of these assays had clearly superior or inferior performance for  
55 the detection of SARS-CoV-2 from upper respiratory specimens in liquid transport media. In  
56 addition to an assay's limit of detection and sensitivity, considerations of other important  
57 variables such as turn-around-time; complexity; cost; workflow; specimen type and stability; and  
58 availability of supplies, reagents, and equipment may influence selection of a health system's  
59 standard of care IVD that is implemented to detect SARS-CoV-2 RNA.

60

61 Acknowledgements: No outside funding was used to support this investigation.

## 62 References

63

64 1. **Biswas B.** 2016. Clinical Performance Evaluation of Molecular Diagnostic Tests. *J Mol*  
65 *Diagn* **18**:803-812.

66 2. **Fang Y, Zhang H, Xie J, Lin M, Ying L, Pang P, Ji W.** 2020. Sensitivity of Chest CT for  
67 COVID-19: Comparison to RT-PCR. *Radiology* doi:10.1148/radiol.2020200432:200432.

68

69

70

71 Table 1. Positive percent agreement (PPA) of the Abbott ID Now and Diasorin Simplexa assays  
72 for the detection of SARS-CoV-2 was determined using a modified CDC assay as the reference  
73 standard

	Detected	Not Detected	PPA (95% CI)
Abbott ID Now	90	6	94% (87-98%)
Diasorin Simplexa	92	4	96% (90-99%)
Modified CDC assay	96	0	Not applicable

74

75

76

77