Test Directory

Oklahoma State Department of Health
Public Health Laboratory
4615 W. Lakeview Rd
Stillwater, Oklahoma 74075
Telephone: (405) 564-7750
Fax: (405) 900-7600
Email: PublicHealthLab@health.ok.gov
Website: http://phl.health.ok.gov
Laboratory Director: Tamar Baruch-Finkel, MD
Federal Tax ID: 736017987
CLIA Number: 37D0656594

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LABORATORY INFORMATION

Hours of Operation

Monday – Friday, 8:00 am - 5:00 pm (Central Time)

The OSDH Public Health Laboratory (PHL) may be reached by email at PublicHealthLab@health.ok.gov. The general email address is monitored by PHL team members that will make sure the inquiry will be answered by the correct service area within two business days. Typical inquiries relate to supply requests, courier information, and providing copies of test results. It is also possible to ask technical questions about specific tests, specimen collection, storage and shipping, and patient test result availability and interpretation.

The OSDH PHL is also closed on Official State Holidays:
- New Year’s Day
- Martin Luther King, Jr. Day
- President’s Day
- Memorial Day
- Independence Day
- Labor Day
- Veterans Day
- Thanksgiving
- Christmas

Generally, when a holiday falls on a non-workday — Saturday or Sunday — the OSDH will be closed on Monday (if the holiday falls on Sunday) or Friday (if the holiday falls on Saturday). For specific dates see https://oklahoma.gov/omes/services/human-capital-management/state-holidays.html.

Contacts

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Email: PublicHealthLab@health.ok.gov
Website: http://phl.health.ok.gov
Laboratory Director: Tamar Baruch-Finkel, MD
Federal Tax ID: 736017987
**Licensure and Accreditations**

The OSDH PHL is has CLIA (Clinical Laboratory Improvement Amendments) certification through CMS (Centers for Medicare & Medicaid Services).

Each laboratory is required to verify that reference laboratories utilized by the laboratory are CLIA-’88-certified for high-complexity testing in the applicable specialty/subspecialty for which testing services are sought. This requirement can be satisfied by obtaining copies of current CLIA certificates from each reference laboratory utilized by the referring laboratory. Since the OSDH PHL serves as a reference laboratory for County Health Departments and other institutions, we have made available a current copy of our CLIA certificate (#37D0656594) at the OSDH PHL website (see Public Health Laboratory/Test Directory) to allow submitting sites to comply with this regulation. If the OSDH PHL forwards submitted specimens to a reference laboratory for additional testing, there is no requirement for the submitting site to obtain verification of CLIA-’88 certification from those reference laboratories; submitting laboratories may rely on our accreditation to ensure compliance with this regulation.
SPECIMEN COLLECTION

Kits/Supplies
The OSDH PHL provides the following collection kits/supplies free-of-charge to OSDH County Health Department sites:

- Enteric Bacteria kit
- TB/Sputum Culture kit
- Ova and Parasite kit
- Virus Transport Medium kit
- Group B Streptococcus kit
- Pertussis kit
- CT/GC Urine Preservative Transport (UPT)
- CT/GC Vaginal Swab kits

The following kits are offered to private clinics and hospitals (fees apply as indicated); check with the OSDH PHL Client Services Department at (405) 271-5070 during regular business hours or submit a Laboratory Supply Order Request Form (see details below) to arrange shipment:

- Enteric Bacteria kit ($18.00)
- TB/Sputum Culture kit ($17.00)
- Virus Transport Medium kit
- Group B Streptococcus kit
- Pertussis kit

Rabies specimens are no longer accepted or processed at the PHL. Animal specimens to be tested for rabies should be submitted to the Oklahoma Animal Disease Diagnostic Laboratory (OADDL) of the OSU College of Veterinary Medicine, located at 1950 W Farm Rd, Stillwater, OK 74078. OADDL can be contacted by telephone at (405) 744-6623. If you suspect a case of human rabies, immediately contact the OSDH Disease and Prevention Services at (405) 271-4060.

Collection kits for Newborn screening and PKU monitoring (ODH #450 Newborn Screening Form) and adult/child hemoglobinopathy (sickle cell) screening (ODH #485 Child/Adult Sickle Cell Screening Kit) are available to birthing centers, County Health Departments, and other healthcare providers at no cost.

All clients can submit Laboratory Supply Order Requests on-line at the OSDH PHL website (Forms, Supply Order Request). Laboratory Supply Order Request Forms can also be faxed to the OSDH PHL at (405) 900-7600. Phone orders for supplies can also be made by calling the OSDH PHL Client Services Department at (405) 271-5070 during regular business hours. In addition, OSDH County Health Department sites can order supplies using the Inventory Supply System.

Supplies are shipped Monday through Thursday.

Instructions for Specimen Collection
Instructions for specimen collection are provided in the description of individual tests within this Test Directory. Further specifics regarding specimen collection can be obtained from technical staff of the OSDH PHL.

All specimens must be collected, labeled, transported, and processed according to procedures indicated in this Test Directory and/or kit instructions. Prior to collection of the specimen, review
the appropriate container type, specimen volume, storage and shipping conditions, and any other special handling requirements needed for optimum analysis. If the guidelines for these processes are not met, the specimen may be rejected or the test results compromised.

To ensure correct patient and specimen identification at the point of collection, personnel involved in the collection of specimens must confirm the patient's identity by checking at least two patient identifiers prior to collection of a specimen, e.g., an inpatient's wristband may be checked for name and unique hospital number or an outpatient's name and birth date may be used. The patient's identity should be verified by asking the patient to identify themselves when it is practical to do so.

Standard precautions to protect against exposure to infectious diseases should always be followed, and barrier protections applied whenever specimens are obtained from patients.

**Labeling Specimens**

The primary specimen container/tube must be labeled with **at least two patient-specific identifiers** (i.e., patient name, date of birth, medical record number, barcode, lab number, or other unique code). Note that use of the patient name alone on the specimen is inadequate to uniquely identify the specimen. Other information may also be required on the specimen container/tube depending on individual test requirements. Some test kits have labels supplied for labeling specimen containers/tubes, otherwise use computer-generated or other labels available at the submitting site. Note that microscope slides submitted for identification purposes (e.g., malaria speciation) are considered primary specimen containers and must be labeled appropriately.

Submissions by Oklahoma County Health Departments:

1. Place unique laboratory barcode label on container/tube. Caution: Do not cover the manufacturer’s expiration date on container/tube. Position label such that the level of blood in the tube is visible.
2. Ensure barcode label on container/tube matches the barcode label on test requisition form prior to submission.
3. Other information may need to be placed on container/tube depending on individual test requirements; refer to collection instructions for specific test.

Submissions by Other Sites:

1. Record patient’s full name or other patient identifier, and date of birth on container/tube. Use a computer-generated label, if available.
2. Ensure information on the container/tube matches that on the test requisition form prior to submission.
3. Other information may need to be placed on container/tube depending on individual test requirements; refer to collection instructions for specific test.

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If multiple labels are used on a specimen, the last applied label will be used as the primary method of identification. It is good practice to place new specimen labels immediately beneath the name/identifier of the patient as it appears on the previous label such that the names/identifiers on both labels can be read.

For instructions on labeling collection kits for newborn screening and PKU monitoring (ODH #450 Newborn Screening Form) and adult/child hemoglobinopathy (Sickle Cell) screening (ODH #485 Child/Adult Sickle Cell Screening Kit), see the Newborn Screening section of this Test Directory.
TEST REQUESTS

Test Requisition Forms

All patient specimens submitted to the OSDH PHL for testing must be accompanied by an appropriately completed test requisition form. Submitters should use a test requisition form appropriate for the specimen being submitted:

- **Laboratory Requisition Form** [ODH #419](#)
  This form is used for submission of patient specimens/isolates other than those associated with newborn screening, PKU monitoring, or child/adult sickle cell screening. OSDH County Health Department sites are able to pre-populate this form electronically within the OSDH PHOCIS system; other sites can access this form at the OSDH PHL website.

- **Newborn Screening Form** [ODH #450](#)
  This form is used for submission of specimens for newborn screening and PKU monitoring, and can be ordered from the OSDH PHL Client Services Department at (405) 271-5070; also, see Kits/Supplies section of this Test Directory.

- **Sickle Cell Screening Form** [ODH #485](#)
  This form is used for screening of children/adults for sickle cell disease and can be ordered from the OSDH PHL Client Services Department at (405) 271-5070; also, see Kits/Supplies section of this Test Directory.

In addition, the OSDH PHL has forms for the submission of specimens for animal rabies testing, and for submission of environmental swabs and food or water samples associated with foodborne outbreak events:

- **Rabies Submission Form** [INSERT LINK TO FORM](#)
  This form must be completed when submitting animal specimens for rabies testing. Specimens may be submitted by a veterinarian, owner of the animal being tested, or a member of the public.

- **Oklahoma Foodborne Taskforce Sample Collection Sheet**
  This form must be completed when submitting environmental swabs, and food or water samples associated with foodborne outbreak events. The form may be requested by contacting the OSDH PHL Client Services Department at (405) 271-5070.

Test requisition forms for patient testing must be completed in their entirety and contain the following information (CLIA Regulation 42 CFR 493.1241) prior to submission:

- Patient’s name or unique patient identifier (e.g., MR#);
- Patient’s sex;
- Patient’s DOB or age;
- Test(s) to be performed;
- Source of the specimen, when appropriate;
- Date and, if appropriate, time of specimen collection;
- Name and address or other suitable identifiers of the authorized person requesting the test, and if appropriate the individual responsible for using the test results, OR name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminently life-threatening laboratory results or panic or alert values;
- Any additional information relevant and necessary for a specific test to ensure accurate and timely testing and reporting of results, including interpretation, if applicable.

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Note: Information provided on the test requisition form will be cross-referenced with information appearing on the last placed label on the specimen container/tube.

All patient-specific identifiers (i.e., patient name, date of birth, MR#, or other unique number or code) provided on the test requisition form must match exactly those provided on the specimen container/tube; any discordance will result in the specimen being deemed unsatisfactory for testing. Therefore, if the name on the requisition is spelled differently from that on the specimen (even by a single letter), it will be deemed unsatisfactory for testing. If a patient’s initials rather than full name are provided on the primary specimen container and the full name is provided on the test requisition, it will be deemed unsatisfactory for testing. Also, even if one patient-specific identifier is concordant between the requisition and specimen but another identifier is discordant, the specimen will be deemed unsatisfactory for testing. The PHL may contact the submitter to resolve such discrepancies in the identifiers provided on the test requisition and specimen.

Also, if other information (e.g., sex, DOC, time of collection) is discordant between the specimen container/tube and test requisition form that potentially affects the acceptability of the specimen, the submitter will be contacted for clarification.

Obvious inconsistencies between multiple labels on the same specimen container/tube will result in the specimen being deemed unsatisfactory for testing.

Information provided on the test requisition may be changed; however, the PHL will not change any information that is provided on a specimen. A corrected requisition form or other suitable documentation must be provided by the submitter before the specimen can be accepted for testing.

For instructions on completion of ODH #450 Newborn Screening Form (for newborn screening and PKU monitoring) and ODH #485 Child/Adult Sickle Cell Screening Form (for adult/child sickle cell screening), see Newborn Screening section of this Test Directory.

Verbal Requests
The OSDH PHL does not accept verbal requests for initial testing; however, it does accept verbal requests for add-on testing to previously submitted specimens, as appropriate (see Add-on Test Requests section below).

Add-on Test Requests
Additional testing may be added subsequent to submission of an original test request, if volume of the original submitted specimen is adequate. Requests for add-on testing may be received verbally, but must be followed with a written request within 30 days of the verbal request. All verbal requests for add-on testing require test order ‘read-back’ to ensure accuracy. Additional testing may be delayed in the absence of a written request. A test report will not be issued for any additional requested testing in the absence of a written request.

STAT Requests
STAT testing is performed only on specimens to determine outbreak status as deemed necessary, and on all credible bioterrorism threat cases. STAT testing requests require notification and approval of the OSDH PHL prior to submission of the specimen.
Medico-legal Test Requests
The OSDH PHL does not perform medico-legal testing.

Test Cancellations
Testing can only be cancelled by the original submitter of the specimen. This can be done verbally or in writing. A report will be issued indicating cancellation of the test.

Referral Testing
When indicated, the OSDH PHL will refer specimens to specific reference laboratories for additional testing. Test results from reference laboratories will be reported to submitting sites by the OSDH PHL.

Specimens submitted to the OSDH PHL for referral to another laboratory for testing (i.e., pass-through testing), including the Centers for Disease Control and Prevention (CDC), requires prior notification and approval by the OSDH PHL.

Specimens referred for testing to a reference laboratory should be submitted using the reference laboratory’s test requisition form, and collected, labeled, stored and shipped as instructed by the reference laboratory. A Specimen Referral Log should be used to track dates, and time as applicable, of collection, shipping and receipt of results for referred specimens. Prior to submitting specimens to a reference laboratory, the referring laboratory must obtain a copy, or have on-hand a copy, of the current CAP accreditation and/or CLIA certificate of the reference laboratory to verify that the reference laboratory is CLIA-‘88 certified for testing in the applicable specialty/subspecialty.
SPECIMEN STORAGE AND SHIPMENT

Following collection, specimens must be appropriately pre-processed and stored (as necessary) then packaged and shipped to ensure that they arrive at the OSDH PHL in a satisfactory state for testing. For detailed information on appropriate pre-processing, storage, packaging and shipping of samples for submission to the OSDH PHL for testing, refer to the individual test descriptions in this Test Directory. Some general guidance on these topics is provided below.

Blood Tubes, CSF, Urine, Culture Tubes, Sputum, and Stool Specimens

1. Specimens must be packaged in a securely sealed, water-tight, primary container appropriate for the specimen being collected (e.g., blood tube, UPT tube, screw-capped plastic tube, etc.). This primary container must be appropriately labeled.

2. The primary container must be placed in a secondary container (zip-lock plastic biohazard bag) that is capable of being closed to form a water-tight seal.
   - The secondary container should contain an absorbent material (e.g., paper toweling or gauze) of sufficient volume to absorb the complete fluid contents of the primary container in case of leakage/breakage of the primary container.
   - OSDH PHL personnel will not open biohazard bags containing specimens that have leaked or broken during transit. If the specimen can be identified without opening the biohazard bag, a report will be issued to the submitter to inform them that the specimen will not be tested. If such specimens cannot be identified, a report will not be generated; therefore, submitting facilities should check their Specimen Referral Log at appropriate intervals to ensure test results have been received accordingly, and contact the OSDH PHL if results have not been received in the expected timeframe.

3. Multiple samples may be placed in a single secondary container but:
   - The total volume of samples in one secondary container must not exceed 50 mL.
   - Sputum samples (for tuberculosis testing), stool samples (for enteric testing), and samples for virus isolation testing should be separated from all other sample types; each specimen type should be packaged separately.
   - When possible, package specimens by test type requested, (e.g., all RPRs in one bag, all HIVs in one bag, etc.).
   - Specimens that require specific transporting conditions (ambient, refrigerated or frozen) must be packaged and shipped separately. It is strongly encouraged to mark the outside of the bag of all secondary containers with “Transport at Room Temperature”, “Transport Refrigerated” or “Transport Frozen”. If such specimens are sent via the OSDH PHL-contracted courier, the courier must be informed that the specimens are to be transported refrigerated on wet ice or frozen on dry ice, as appropriate. Alternatively, samples may be packed in insulated boxes containing cold packs at refrigerated temperatures (for samples requiring refrigerated temperatures during shipping) or with sufficient frozen ice packs or dry ice (for samples that should remain frozen during transport) and given to the courier. Samples that should be transported frozen should be placed directly on frozen ice packs or dry ice to keep them frozen. Do not place specimens that should be transported at refrigerated temperatures directly on frozen ice packs; place cardboard or other insulator between ice packs and these specimens.
• When shipping frozen specimens over long distances, it is best to use a combination of dry ice and frozen gel ice-packs; the gel ice-packs will remain frozen for a day or two after the dry ice has dissipated.

4. Requisitions should be placed in the outer pocket of the plastic biohazard bag. Do not wrap requisitions around individual specimens. Fold requisition such that the test request faces outward and can be read through the bag.

Newborn Screening, PKU Monitoring and Sickle Cell Screening Forms
For instructions on storage and shipping of collection kits for newborn screening, PKU monitoring, and adult/child hemoglobinopathy (sickle cell) screening, see Newborn Screening section of this Test Directory.

Courier Service
The OSDH PHL contracts with a courier service to pick-up specimens from OSDH County Health Departments and other sites for delivery to the central laboratory located in Stillwater. Courier pick-up occurs on a regular schedule Monday through Friday for most sites (weekend pick-up of newborn screening specimens occurs at most birthing facilities). Requests for non-scheduled specimen pick-ups must have prior approval; email PublicHealthLab@health.ok.gov or call the OSDH PHL at 1-405-271-5070. Pick-up occurs at approximately the same time each workday for an individual site. Specimens collected after the designated pick-up time will be picked-up from the site on the following workday. Accordingly, testing of these specimens will not begin until the day following pick-up, at the earliest. Such delays in testing should be considered especially when scheduling specimen collection from patients on Fridays; if the specimen is not picked-up on Friday, pick-up will be delayed until Monday and testing will not occur until Tuesday, at the earliest. For newborn screening specimens picked-up on weekends, testing begins on Monday or the next work day. Similar provisions should be made for holiday closings of the OSDH PHL. Specimens should be stored appropriately from the time of collection to the time of delivery to the OSDH PHL.

Other Delivery Methods
The OSDH PHL-contracted courier is the preferred method for delivery of specimens to the OSDH PHL; however, specimens can also be transported directly to the OSDH PHL via private courier, commercial courier (e.g., FedEx, UPS), or USPS. Note: these alternative services will not be able to deliver specimens to the OSDH on weekends.

Shipping Regulations
For shipping specimens, specimens should be packaged and labeled in compliance with applicable state, and federal, and international regulations covering the transport of clinical specimens and etiologic agents/infectious substances. Specific rules and regulations set forth by the U. S. Department of Transportation (Code of Federal Regulations 49 (CFR 49) part 173.196, Category A infectious substances and part 173.199, Category B infectious substances) should be followed in order to ensure safe transport of potentially infectious substances.

A *Category A infectious substance* is capable of causing permanent disability, life-threatening or fatal disease in otherwise healthy humans or animals. A *Category B infectious substance* is an infectious substance that does not meet the criteria for inclusion in Category A.
According to The World Health Organization (WHO) Guidance on Regulations for the Transport of Infectious Substances, the proper designation for shipment of Category A substances is “UN 2814 – Infectious Substance, Affecting Humans” and that for Category B substances is “UN 3373 - Biological Substance, Category B”.

If samples are transported by air, the International Civil Aviation Organizations (ICAO) Technical Instructions for the Safe Transport of Dangerous Goods should be followed. The International Air Transportation Association (IATA) provides shipping procedures based on ICAO instructions for shipping hazardous materials by air. These can be found in packing instructions 620 for Category A infectious substances and packing instructions 650 Category B infectious substances.

Contact the OSDH PHL at PublicHealthLab@health.ok.gov for additional information regarding shipping regulations.
SPECIMEN RECEIPT AT OSDH PHL

Specimen Rejection
Specimens will be rejected for the following reasons:

- Inappropriate specimen (e.g., type; patient age; patient gender);
- Inappropriate specimen container or collection device/media;
- Insufficient volume for analysis (i.e., QNS);
- No or illegible patient name or other unique identifier on specimen container;
- No or illegible patient name or other unique identifier on requisition form;
- Inability to match at least one unique identifier between the test requisition form and the specimen container due to absence or illegibility of others;
- No test requisition form;
- Inability to determine address or submitter ID for submitting laboratory/clinic (may be able to obtain information by inquiry, if missing);
- Expired collection device/kit;
- Specimen received outside of timeframe appropriate for testing;
- Specimen handled improperly subsequent to collection (e.g., improper temperature during specimen shipment; specimen container leaked, broke or otherwise compromised during shipping);
- Laboratory accident (e.g., spilled sample during accessioning);
- Other reasons as outlined in the individual test descriptions of this Test Directory.

All specimens deemed unsatisfactory for testing will have a final report generated stating the reason.

Missing Information
When any of the following information is missing from the test requisition form or specimen container, or is otherwise illegible or unclear (e.g., orders are non-specific or non-standard), the submitter will be contacted by the OSDH PHL, as appropriate:

- DOB or age, if appropriate;
- Time of birth (NBS only);
- DOC;
- TOC (NBS only; and only if less than one day difference between date of birth and date of collection);
- Sex (not required for NBS unless 2nd tier CAH testing is required);
- Address of submitter;
- Test requested;
- Source of specimen, if appropriate.

A Request for Missing Information Form will be sent to the submitting site. Specimens with missing information will be held for 7 days or until they have exceeded the appropriate time for testing, whichever is shorter. If missing information is not received from the submitting site within 7 days, the specimen will be deemed unsatisfactory for testing and reported as “Unsatisfactory: Information requested, not received”.

Referred specimens for enteric bacteria testing with missing information and for which requested information is not received, will be tested by the OSDH PHL and test results will be communicated

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to the OSDH Acute Diseases Division for epidemiological purposes only. The submitter will receive a final report that indicates “Unsatisfactory for testing” and will not receive test results, unless deemed necessary.
TEST REPORTS

Issue of Test Reports
Reports are issued via fax and/or US Mail to the submitting facility/healthcare provider using the information provided on the test requisition form. Clients must complete a Facsimile Permission Form prior to receiving reports by fax. To sign-up for this service, call the PHL at (405) 271-5070. OSDH County Health Departments are able to retrieve patient test reports directly using the PHOCIS system.

Newborn Screening results are accessible to authorized healthcare providers through the Newborn Screening Results web-based portal. To sign-up for this service, call the PHL Client Services Department at (405) 271-5070.

Some test results may be reported by telephone to authorized clients (facilities/healthcare providers). HIV test results and abnormal NBS results are not provided by telephone by the OSDH PHL. All results conveyed by telephone require “read-back” confirmation by the client.

No test reports may be picked-up at the OSDH PHL location in Stillwater.

Requests for access to test results for patient specimens tested by the OSDH PHL from non-submitting facilities/healthcare providers will be denied. Such requests should be made directly to the submitting facility/healthcare provider.

Changes to Information on Test Reports
Corrections to test reports, subsequent to original issue of test results to the submitter, may be made by the OSDH PHL, as appropriate. The Corrected Report will indicate the information being changed (i.e., with explicit indication of “from” and “to”) and the need for the change, as appropriate. A request will be made to the submitting facility for the original report to be returned to the OSDH PHL or for it to be destroyed by the submitting facility.

Changes to information presented in a test report may be made at the request of an authorized individual from the submitting facility. Please, call the OSDH PHL at 405-271-5070 and ask to speak to the supervisor of the laboratory responsible for performing the test. Verbal requests for changes to information provided on test reports must be followed by a written request within 30 days. A report will not be issued on such specimens until a written request from the submitting facility is provided to the OSDH PHL. The laboratory supervisor and/or Client Services Department will provide the necessary forms for completion by the submitter in order to fulfill such requests.

Requests for changes in demographic information following issue of a test report will result in issue of a Corrected Report; the information being changed (with explicit indication of “from” and “to”), the person requesting information to be changed, and date/time of the request will be indicated on the Corrected Report. A request will be made to the submitting facility for the original report to be returned to the OSDH PHL or for it to be destroyed by the submitting facility.

The OSDH PHL will not change the name or other unique identifier of a patient on a test report unless the name/unique identifier indicated on the test requisition form or specimen container has been misinterpreted by OSD PHL staff during data entry or a typographical error occurs.

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Patient Access to Laboratory Test Results

On February 6th, 2014, the Centers for Medicare & Medicaid Services (CMS) published a final rule that amended both the Clinical Laboratory Improvement Amendments (CLIA) and the Health Insurance Portability and Accountability Act (HIPAA) in order to provide patients with direct access to laboratory test results. Under the final rule, laboratories that operate as covered entities under HIPAA are required to provide individual patients, or their representatives, with laboratory test results for those tests performed by the laboratory upon the patient's request.

The OSDH PHL in Stillwater is unable to provide laboratory test results directly to individuals presenting at this location. Patients, or their legal representatives, may obtain copies of their laboratory test reports for testing performed at the OSDH PHL by presenting at the County Health Department or other health care facility where medical care was provided. The patient, or their legal representative, will be asked to complete an Oklahoma Standard Authorization Form, provide a photo ID and/or authorization code prior to release of laboratory test results.

Alternatively, patients, or their legal representatives, can contact the OSDH PHL at (405) 271-5070 to obtain laboratory test reports through the mail or electronically. A patient, or their legal representative, may request laboratory test results performed by the OSDH PHL by completing a Request to Release Laboratory Test Results Form.
BILLING

CPT Coding
The OSDH PHL has provided CPT codes for testing that it performs for guidance purposes only. These codes reflect our interpretation of the coding requirements. CPT coding is the sole responsibility of the billing party. Individual facilities should contact the OSDH PHL for information regarding testing methodology and the local Medicare carrier for clarification, as appropriate.
ONSITE TEST LIST

Individual tests that are performed in the PHL in Stillwater are listed alphabetically in the subsequent pages. Be aware that individual tests may be named differently than expected, and keywords have been provided in the title in some instances. If you are having difficulty finding the specific test, try searching the document for keywords.
Chlamydia trachomatis / Neisseria gonorrhoeae – Transcription Mediated Amplification (Gonorrhea)

**Use:**
To screen symptomatic or asymptomatic males and females for the presence of *Chlamydia trachomatis* and/or *Neisseria gonorrhoeae* (CT/GC). This test is not to be used for monitoring therapeutic efficacy.

**Methodology:**
Hologic Aptima Combo 2® *Chlamydia trachomatis* and *Neisseria gonorrhoeae* Assay; Transcription Mediated Amplification (TMA). Amplification of target 23s rRNA of *C. trachomatis* and 16s rRNA of *N. gonorrhoeae*, amplicons hybridize with chemiluminescent probes that are read by the Panther testing platform.

**Clinical Significance:** *Chlamydia trachomatis* and *Neisseria gonorrhoeae* are the most common bacterial causes of sexually transmitted diseases in the U.S. Screening reduces the prevalence of CT/GC and potentially reduces the incidence of severe and debilitating complications associated with symptomatic infections. Further background information, fact sheets, statistics and educational resources may be found at the OSDH Acute Disease Services website.

**Specimen:**

**Type:**
- Urine
- Vaginal Swab
- Unisex Swab

**Volume:**
- 2.0-2.9 mL
- Dry Vaginal Swab in Transport Tube
- Dry Unisex Swab in Transport Tube

**Container:**
- Aptima® Urine Specimen Transport Tube (USTT)
- Aptima® Vaginal Swab Specimen Transport Tube (VSSSTT)
- Aptima® Unisex Swab Specimen Transport Tube (USST)

**Collection:**

**Urine**
1. Collect 20-30 mL of first-void (not mid-stream) urine in sterile collection cup; patient should not have urinated for at least 1 hour prior to collection. Excessive urine collection may dilute rRNA affecting test sensitivity.
2. Label a USTT with two patient identifiers (e.g., Patient’s Name and DOB) and date collected. Place any barcodes along the length of the tube.
3. Twist the cap on the USTT to break the seal.
4. Using transfer pipette provided in kit, transfer urine from cup to USTT until level is between the two lines on the fill window (approx. 2mL). Do not over-fill or under-fill.
5. Urine should be transferred from primary collection device to USTT within 24 hours of collection at 2-30°C.
6. Immediately replace cap and tightly secure.

**Vaginal Swab**
1. Label the VSSSTT with two patient identifiers (e.g., Patient’s Name and DOB) and date collected. Place any barcodes along the length of the tube.
2. Open the swab packaging, being careful not to contaminate the swab.
3. Hold the swab near the middle of the shaft so that your thumb and forefinger touch the score line. Do not hold it between the line and swab tip.
4. Insert the swab approximately 2 inches (5cm) past the introitus and gently rotate the swab, ensuring contact with vaginal walls, for 10 to 30 seconds.
5. Withdraw the swab, making sure to not to touch the skin. Unscrew the cap on the VSST.
6. Place the swab in the collection tube so that the score line is at the top of the tube. Gently flex the shaft against the tube to break at the score line, disposing of the top of the shaft.
7. Tightly secure the cap.

**Unisex Swab**

**Endocervical**
1. Label the USST with two patient identifiers (e.g., Patient’s Name and DOB) and date collected. Place any barcodes along the length of the tube.
2. Using the white shafted cleaning swab, remove excess mucus from the cervical os and surrounding mucosa and discard the cleaning swab. A large-tipped swab may also be used.
3. Insert the blue shafted specimen swab into the endocervical canal. Rotate the swab gently for 10 to 30 seconds.
4. Withdraw the swab, making sure to not touch vaginal mucosa. Unscrew the cap on the USST.
5. Place the swab in the collection tube so that the score line is at the top of the tube. Gently flex the shaft against the tube to break at the score line, disposing of the top of the shaft.
6. Tightly secure the cap.

**Male Urethral**
1. Ensure the patient has not urinated for at least 1 hour before collecting the sample.
2. Label the USST with two patient identifiers (e.g., Patient’s Name and DOB) and date collected. Place any barcodes along the length of the tube.
3. Remove the blue shafted swab from its packaging and gently insert 2 to 4cm into the urethra.
4. Very gently rotate the swab for 2 to 3 seconds.
5. Carefully withdraw the swab from the urethra. Unscrew the cap on the USST.
6. Place the swab in the collection tube so that the score line is at the top of the tube. Gently flex the shaft against the tube to break at the score line, disposing of the top of the shaft.
7. Tightly secure the cap.

**Interferences:** None

**Special Instructions:** None

**Shipping:** Store and ship the appropriate collection tube at refrigerated or ambient temperatures (2-30°C) for delivery within 30 days of collection.

_Last revised 7/1/2022_
Rejection Criteria:
- Patient under 14 years of age
- Specimen transported in container other than the appropriately designated collection device
- Over-filled or under-filled specimen tube
- Raw urine
- Specimens submitted > 30 days from date of collection
- Other criteria as outlined in Specimen Rejection section of this Test Directory

Reported:
Within 7 working days from receipt

CPT Codes:
87491, 87591

<table>
<thead>
<tr>
<th>Normal/Abnormal Results</th>
<th>Chlamydia trachomatis</th>
<th>Neisseria gonorrhoeae</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT Pos</td>
<td></td>
<td>GC Pos</td>
</tr>
<tr>
<td>CT Neg</td>
<td></td>
<td>GC Neg</td>
</tr>
<tr>
<td>CT Equiv</td>
<td></td>
<td>GC Equiv</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Invalid</td>
</tr>
</tbody>
</table>

Interpretation:
- A positive result indicates successful amplification of rRNA for either *C. trachomatis* or *N. gonorrhoeae* by the testing platform.
- A negative result indicates the sample should be presumed negative of rRNA for either *C. trachomatis* or *N. gonorrhoeae*.
- An equivalent result indicates that the testing platform was not able to make a determination of either analyte. A new sample should be collected.
- An invalid result indicates that the instrument encountered issues with the specimen and it was not able to be resulted successfully.

Limitations:
- A negative result does not preclude *C. trachomatis* and/or *N. gonorrhoeae* infection since detection is dependent on adequate specimen collection, absence of inhibitors, and sufficient levels of organisms
- A positive result does not infer viability and/or infectivity for *C. trachomatis* and/or *N. gonorrhoeae* since target DNA for these organisms may persist in the patient in the absence of viable organisms (e.g., following anti-microbial therapy)
- This assay is not appropriate for testing of cases of sexual assault/abuse or cases with other medico-legal implications. Culture is the recommended procedure for diagnosing CT/GC infections in medico-legal cases, testing of conjunctival, rectal and nasopharyngeal specimens, and evaluating gonorrhea treatment failure; Aptima® transport tubes are inappropriate collection devices for culture. Test results may be affected by improper specimen collection, low levels of organisms in the sample, plasmid-free variants of *C. trachomatis*, technical error, specimen mix-up, or concurrent antibiotics. This test cannot be used to assess therapeutic success or failure.

Notes:
This test has been cleared for *in vitro* diagnostic use by the U.S. Food and Drug Administration.
COVID-19 Diagnostic PCR (SARS-CoV-2)

Use:
To screen symptomatic or asymptomatic people for the presence of SARS-CoV-2.

Methodology:
Infinity BiologIX or Thermo TaqPath EUA; Transcription Mediated Amplification (TMA).

Clinical Significance:
COVID-19 is a virus identified as the cause of an outbreak of respiratory illness first detected in Asia in late 2019 that has since spread globally into a pandemic. Symptoms of COVID-19 include fever, cough, and shortness of breath. While roughly 80% of cases report mild symptoms, some progress into severe pneumonia and multi-organ failure and can lead to death. On January 21, 2020, the first set of individuals in the United States tested positive for COVID-19.

Further background information, fact sheets, statistics and educational resources may be found at the OSDH Acute Disease Services COVID-19 website.

Specimen Type:
• Saliva in Spectrum Vial (follow instructions for use)
• NP/OP Swab in Remel M4RT Vial

Saliva
Use Spectrum Saliva kits only.

1. Fill the tube with saliva to the black wavy line. Fill the tube until saliva (not including bubbles) is at or just above the wavy line. DO NOT OVERFILL.
2. Replace the funnel with the fluid cap. Remove the funnel from the tube. Screw on the enclosed cap tightly to release the solution that will stabilize the DNA in the saliva.
3. Firmly screw cap down to release solution and seal tube. You will know it works when the blue solution from the cap is released into the tube. Firmly tighten cap to assure the cap and tube is completely sealed.
4. Shake the tube for at least five seconds. This will ensure the sample mixes thoroughly with the stabilizing solution.
5. Place sample in plastic biohazard bag and insert completed requisition form in outer pouch of the bag. The samples are stable at (2-30°C) for 4 days.
Nasopharyngeal and Oropharyngeal Swabs

**Tip:** If the patient is seated for the procedure, have the patient sit with their head against a wall since patients have a tendency to pull away during the procedure.

**Nasopharyngeal Swab**

1. Label a sterile tube Remel M4RT tube containing 2-3 mL of VTM or other suitable collection media with the patient’s name and date of collection.
2. If the nasal passages have a large amount of mucus, ask the patient to blow their nose before collecting specimen.
3. With the thumb of one hand, elevate the tip of the patient’s nose then gently insert the NP swab into a nostril.
4. Guide the swab straight back (not upwards), along the floor of the nasal passage until it reaches the posterior wall of the nasopharynx; the distance from the nose to the ear gives an estimate of the distance the swab should be inserted.
   **Note:** Do not force the swab – if an obstruction is encountered during insertion, try the other nostril.
5. Rotate the swab by firmly brushing against the nasopharynx several times.
6. Immediately, place swab, tip first, into tube containing VTM or other suitable collection media.
7. Break-off or cut excess shaft of swab so that tube can be capped.
8. Replace the cap of the tube and ensure it is secured.
9. Place tube in plastic biohazard bag and insert completed requisition form in outer pouch of the bag. The samples are stable at (2-30°C) for 4 days.

**Oropharyngeal Swab**

1. Label a sterile tube Remel M4RT tube containing 2-3 mL of VTM or other suitable collection media with the patient’s name and date of collection.
2. Insert swab into the posterior pharynx and tonsillar areas.
3. Rub swab over both tonsillar pillars and posterior oropharynx and avoid touching the tongue, teeth, and gums.
4. Immediately, place swab, tip first, into tube containing VTM or other suitable collection media.
5. Break-off or cut excess shaft of swab so that tube can be capped.
6. Replace the cap of the tube and ensure it is secure.
7. Place tube in plastic biohazard bag and insert completed requisition form in outer pouch of the bag. The samples are stable at (2-30°C) for 4 days.

**Interferences:** None

_Last revised 7/1/2022_
Special Instructions: None

Shipping: Store and ship the appropriate NP/OP collection tube or Spectrum saliva specimens at ambient (2-30°C) conditions for delivery to the PHL within 4 days of collection.

- Specimen transported in container other than the appropriately designated collection device

Rejection Criteria: • Over-filled or under-filled specimen tube
• Specimens submitted > 4 days from date of collection
• Other criteria as outlined in Specimen Rejection section of this Test Directory

Reported: Within 2 working days from receipt

CPT Codes: 87635

Normal/Abnormal Results: SARS-CoV-2 test results may be negative, positive, or inconclusive.

- Negative results do not preclude SARS-CoV-2 infection and should not be used as the sole basis for patient management decisions. Negative results must be combined with clinical observations, patient history, and epidemiological information.

Interpretation: • Positive results are indicative of the presence of SARS-CoV-2 RNA; clinical correlation with patient history and other diagnostic information is necessary to determine patient infection status. Positive results do not rule out bacterial infection or co-infection with other viruses. The agent detected may not be the definite cause of disease.

Limitations: With any diagnostic test, there is the potential for false negatives or false positives. For existing COVID-19 tests in the U.S., there have been reports of false negative tests in some patients. False negative tests can occur if a specimen was not properly obtained or if a patient was tested too early or too late in their infection. Laboratory error is also a possible cause of false negative test results. Conversely, false positive reports are less common.

Notes: This test is performed in compliance with a US Food and Drug Administration (FDA) Emergency Use Authorization (EUA).

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COVID-19 Sequencing

Use: To determine the lineage and variants of positive COVID-19 specimens.

Methodology: Thermal cyclers and the Illumina SBS chemistry-based platform.

As COVID-19 evolves and new variants of the virus continue to emerge it is important the Oklahoma State Department of Health (OSDH) Public Health Laboratory (PHL) receive COVID-19 specimens to identify variant trends and implement mitigation measures to prevent the continued spread of COVID-19 in Oklahoma.

Clinical Significance: Acceptable specimen types for sequencing and potential virus characterization are the same as for the CDC SARS-CoV-2 diagnostic assays that were authorized by FDA under an Emergency Use Authorization (EUA): upper and lower respiratory specimens, including nasopharyngeal, oropharyngeal, nasal mid-turbinate, and anterior nares (nasal swab) specimens. Additionally, a nasopharyngeal wash/aspirate or nasal wash/aspirate specimen collected by a healthcare professional is acceptable, as is a naturally expectorated sputum. Acceptable specimens will be limited to those collected in media that allow for viral culture (e.g., PBS, VTM). Specimens collected in Hologic Aptima buffer and Molecular Transport Media are excluded from submission.

Specimen Type:

Collection: Not applicable

Interferences: None

Special Instructions: Store specimens at 2–8°C for no more than 96 hours. The 96-hour timeframe is a strict requirement for sequencing to be completed. After the 96-hour timeframe, samples must be frozen at ≤ -70°C and shipped on dry ice for delivery to the PHL.

Shipping: 
- Specimen transported in container other than the appropriately designated collection device
- Over-filled or under-filled specimen tube
- Other criteria as outlined in Specimen Rejection section of this Test Directory

Rejection Criteria: Within 14 working days from receipt to State Epidemiologist

Reported:

CPT Codes: N/A

Normal/Abnormal Results: Due to federal regulation, the PHL is unable to provide result reports for SARS-CoV-2 variant sequencing surveillance to the submitter or patient. SARS-CoV-2 variant surveillance whole genome sequencing is intended for public health surveillance purposes.

Interpretation: N/A

Limitations: Sometimes the positive specimens do not amplify and a variant can’t be determined.

Notes: The Illumina COVIDSeq Test is only for use under the Food and Drug Administration’s Emergency Use Authorization.
Human Immunodeficiency Virus (HIV) - HIV-1/2 Antigen/Antibody EIA with Reflex to HIV-1/2 Antibody Differentiation Test

Use: This test is used to screen for and confirm HIV-1/HIV-2 infection, including acute infection and to differentiate HIV-1 from HIV-2 infection.

Methodology: Sera are initially screened for HIV-1 p24 antigen and HIV-1 and HIV-2 specific antibodies using a 5th generation qualitative Enzyme Immunoassay (EIA). Specimens with an EIA-reactive screen result are repeated in duplicate using the same EIA. If either of the repeated samples is reactive, the specimen is reflexed to a supplemental HIV-1/HIV-2 antibody differentiation test.

Clinical Significance: Two HIV serotypes, designated as HIV-1 and HIV-2, have been identified based on the results of serologic and molecular studies. Both viruses have the same morphology, lymphotropism, and modes of transmission. Following infection with HIV, an individual rapidly (within 4 weeks) develops antibodies to viral proteins, a process known as seroconversion. After seroconversion, HIV-specific antibodies can be readily detected in the blood specimen. The EIA screen detects HIV-1 p24 antigen in addition to HIV-1/HIV-2 antibodies, which allows for earlier detection of HIV in individuals who have not undergone seroconversion. The supplemental differentiation test allows for differentiation between HIV-1/HIV-2 antibodies, which is important in treatment management, since HIV-2 does not respond to some anti-retroviral agents. In acute infections, where patients have not yet seroconverted, the EIA screen may be positive while the differentiation test may be negative; patients with negative or indeterminate results for the supplemental differentiation test require follow-up HIV nucleic acid testing to resolve their infection status. This testing algorithm is consistent with the 2014 CDC Recommended Algorithm for Laboratory Diagnosis of HIV Infection.

Further background information, fact sheets, statistics and educational resources may be found at the OSDH Acute Disease Services website.

Specimen: Whole blood collected in serum separator tube (SST).

- Type: Whole blood collected in serum separator tube (SST).
- Volume: 2 mL serum; draw a sufficient amount of blood to yield the necessary serum volume, around 4mL whole blood. Minimal acceptable volume for testing is 1 mL serum (potential rejection if reflexive testing exhausts sample).
- Container: SST or separated serum poured into sterile, plastic, screw-cap tube
- Collection: Each facility should follow its guidelines for venipuncture collection of blood/serum. Following collection of blood, invert tube gently no more than 8 times then allow blood to clot in an upright position for at least 30 minutes and no more than 60 minutes then centrifuge at 3000 rpm for 10 minutes.
- Interferences: Bacterial contamination; extensive hemolysis; extensive lipemia
- Special Instructions: This test is available for:
  - County Health Departments in Oklahoma
  - Reference sites approved through the OSDH HIV/STD Division

Last revised 7/1/2022
Follow-up nucleic acid testing, as recommended by CDC guidelines, must be approved by the HIV/STD Division. Instructions for submitting specimens for HIV-1 RNA testing or HIV-2 DNA/RNA testing can be found on IRENE (OSDH County Health Departments) and at the OSDH PHL website (Test Directory tab).

**Shipping:**
- Store refrigerated (2-8°C) and ship using ice packs. If transit time will be > 7 days post-collection, pour serum from SST into a sterile, plastic, screw-cap tube and store/ship frozen (-20°C or colder)

**Rejection Criteria:**
- Facility not approved for testing
- Patient younger than 2 years of age
- Blood collected in tube other than SST
- SST received unspun at 2-8°C, and > 2 days from DOC
- Specimen received at ambient temperature and > 24 hours from collection
- Specimen received at 2-8°C and > 7 days from DOC
- SST frozen
- QNS
- Bacterial contamination
- Extensive hemolysis
- Extensive lipemia
- Other criteria as outlined in *Specimen Rejection* section of this Test Directory

**Reported:**
Within 10 working days from receipt

**CPT Codes:**
86701/86689

**Normal/Abnormal Results:**
- Non-reactive: HIV-1 antigen and HIV-1/HIV-2 antibodies not detected; if recent HIV exposure is suspected, consider re-testing
- HIV-1 Reactive: Positive for HIV-1 antibodies; consistent with established HIV-1 infection
- HIV-2 Reactive: Positive for HIV-2 antibodies; consistent with established HIV-2 infection
- HIV Reactive, Undifferentiated: Evidence of HIV infection is present but unable to differentiate antibodies as HIV-1 or HIV-2; recommend referral testing for HIV-1 RNA and HIV-2 RNA or DNA to verify or rule-out dual infection.
- Inconclusive: Reactive HIV-1/HIV-2 screening test result could not be confirmed by the differentiation test; this may be due to an acute/early infection or false positive reaction. Recommend repeat HIV antigen/antibody testing and HIV-1 RNA testing.

**Interpretation:**
The OSDH PHL follows the [CDC-recommended laboratory HIV testing algorithm](#) for serum specimens, which is indicated below:
• Non-Reactive, HIV-1 antigen and HIV-1/HIV-2 antibodies not detected: A non-reactive test result does not exclude the possibility of infection with HIV. Levels of HIV-1 p24 antigen and antibodies to HIV-1 and HIV-2 may be undetectable in early infection. If a recent HIV exposure is suspected, consider re-testing.

• HIV-1 Reactive: Specimens that are HIV-1 reactive with the differentiation test (following a reactive HIV-1/HIV-2 screening result) are considered HIV-1 positive, and no further testing is necessary.

• HIV-2 Reactive: Specimens that are HIV-2 reactive with the differentiation test (following a reactive HIV-1/HIV-2 screening result) are considered HIV-2 positive, and no further testing is necessary.

• HIV Reactive, Undifferentiated: Specimens that are HIV-1 and HIV-2 reactive with the differentiation test (following a reactive HIV-1/HIV-2 screening result) have evidence of HIV infection but the test is unable to differentiate antibodies as HIV-1 or HIV-2, i.e., undifferentiated. HIV-1 RNA testing and HIV-2 RNA or DNA testing is recommended to verify or rule-out dual infection.

• Inconclusive: Specimens that are HIV, HIV-1 or HIV-2 indeterminate (i.e., incomplete pattern of antibodies) or are non-reactive with the differentiation test (following a reactive HIV-1/HIV-2 screening result) could indicate either an acute or early infection or false positive reaction. Recommend submission of additional specimens for repeat HIV antigen/antibody testing and HIV-1 RNA testing or HIV-2 RNA or DNA testing as indicated.

Limitations:

• A person who has antibodies to HIV-1 is presumed to be infected with the virus, except that a person who has participated in an HIV vaccine study may develop antibodies to the vaccine and may or may not be infected with HIV. Clinical correlation is indicated with appropriate counseling, medical evaluation and possibly additional testing to decide whether a diagnosis of HIV infection is accurate.

• Detection of HIV antibodies in infants born to seropositive mothers is not adequate to diagnose HIV infection in the infant, since maternal IgG frequently persists in the infant’s blood for as long as 18 months after birth.
Supplemental assays designed specifically for neonatal specimens may be helpful in resolving such cases.

- Non-reactive, inconclusive and undifferentiated HIV-1/HIV-2 Differentiation Test results should be referred for HIV-1 and/or HIV-2 nucleic acid testing as per CDC guidelines. See *Guidance for HIV Nucleic Acid Testing* on IRENE (OSDH County Health Departments) and at the OSDH PHL website (Test Directory tab).

**Notes:** These tests are approved for *in vitro* diagnostic use by the U.S. Food and Drug Administration.
**Human Papillomavirus, High-risk - Transcription-Mediated Amplification (HPV)**

**Use:** To screen women 25 years and older with atypical squamous cells of undetermined significance (ASC-US) cervical cytology results to determine the need for referral to colposcopy.

Note: High-risk human papillomavirus (hrHPV) testing of standard-risk women aged 21-24 years with ASC-US cervical cytology results is no longer recommended. However, it is acceptable if done. See the updated American Society for Colposcopy and Cervical Pathology (ASCCP) Consensus Screening Guidelines.

To screen women 30-65 years old adjunctively with cervical cytology to assess for the presence/absence of hrHPVs.

Other uses of this test may include those indicated by consensus guidelines for cervical cancer screening and the management of women with abnormal cervical cytology and/or hrHPV results, such as those from the ASCCP; clinical indications must be explicitly documented on the requisition form.

**Methodology:** Transcription-mediated amplification of E6/E7 viral mRNA from 14 hrHPVs: 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68.

**Clinical Significance:** hrHPVs detected by the assay are associated with cervical pre-cancerous and cancerous lesions.

**Specimen:**
- **Type:** ThinPrep® Pap specimens
- **Volume:** 1.0 mL
- **Container:** ThinPrep® Pap Test vials containing PreservCyt® Solution
- **Collection:** Collect cervical specimens in ThinPrep® Pap Test vials containing PreservCyt® Solution with broom-type or cytobrush/spatula collection devices according to the manufacturer's instructions

**Interferences:**
- Personal lubricants containing Polyquaternium 15 at concentrations > 0.025% of test sample
- Anti-fungals containing tioconazole at concentrations > 0.075% of test sample
- Effects of other potential variables such as vaginal discharge, use of tampons, douching, etc. and specimen collection variables have not been evaluated.

**Shipping:** Store and ship ThinPrep® liquid cytology specimens at 2°C to 30°C for delivery within 30 days from collection

**Rejection Criteria:**
- Specimen collection > 30 days prior to receipt
- Patient under 21 years of age
- Patient 21 to 29 years of age without a cytology diagnosis of ASC-US or other prior diagnosis/treatment that would warrant hrHPV testing per consensus guidelines

Last revised 7/1/2022
• Patient 21 to 29 years of age with no cytology diagnosis provided or other prior diagnosis/treatment that would warrant HPV testing per consensus guidelines
• Patient of any age with “HPV Reflex Testing Only” marked on requisition form and without a cytology diagnosis of ASC-US
• QNS: < 1 mL ThinPrep® liquid cytology specimen
• Other criteria as outlined in Specimen Rejection section of this Test Directory

Note: requisitions marked “Co-testing” will be primarily associated with patients 30 years and older; however, if a patient on such a requisition is 25-29 years old and has a prior diagnosis/treatment that would warrant hrHPV testing per consensus guidelines, then the specimen is still acceptable for testing.

Reported: Within 7 working days of receipt
CPT Codes: 87621

Normal/Abnormal Results:
• High-risk HPV Detected
• High-risk HPV Not Detected

Interpretation:
A positive result may be due to the presence of one or more hrHPV types. Infection with HPV is not an indicator of cytologic HSIL or underlying high-grade CIN, nor does it imply that CIN2/3 or cancer will develop; most women infected with hrHPV do not develop CIN2/3 or cancer. False positive results may occur; some cross-reactivity is exhibited with low-risk HPV types 26, 67, 70, and 82. A negative result does not exclude the possibility of, underlying or future cytologic abnormalities, CIN2, CIN3, or cancer, infection with low levels of hrHPV, or other HPV types not detected by this assay. Detection of HPV is dependent on adequate specimen collection and handling, absence of inhibitors, and sufficient levels of virus. Results should be interpreted in conjunction with other laboratory and clinical data. Consensus guidelines for cervical cancer screening and the management of women with abnormal cervical cytology and/or hrHPV results should be followed, such as those from the ASCCP.

Limitations:
This test is not intended for use in cases of suspected sexual abuse or for screening for anal and penile cancers; currently, availability of this test is restricted to County Health Departments in Oklahoma

Notes:
This test is approved for in vitro diagnostic use by the U.S. Food and Drug Administration.
Influenza Virus A and B – PCR

Use: Detection and characterization of influenza virus types A (subtypes H1pdm09, H3, H5, H7), or B (Victoria and Yamagata lineages) in patients with influenza-like symptoms.

Methodology: Specimens are tested using the Human Influenza Virus Real-time Reverse Transcriptase-PCR Diagnostic Panel, which was developed by the CDC to diagnose human infections with seasonal influenza viruses and novel influenza A viruses. Specimens may be initially screened using the Respiratory Pathogen Panel (see this Test Directory), which is able to detect a spectrum of viruses and bacteria associated with respiratory infections, including influenza viruses A and B.

Clinical Significance: Influenza virus types A, B, and C are RNA viruses that cause acute respiratory disease with associated fever, shivering, chills, headache, malaise, dry cough, loss of appetite, body aches and nausea. Severe cases are associated with prostration, hemorrhagic bronchitis, pneumonia and occasionally death, especially in the young and elderly. Most influenza-like infections are not caused by influenza but by other viruses (e.g., rhinoviruses and respiratory syncytial virus, adenoviruses, and parainfluenza viruses).

Further background information, fact sheets, statistics and educational resources may be found at the OSDH Acute Disease Services website.

Specimen:
Type: Nasopharyngeal swab (recommended); Nasal swab; Throat swab
Volume: 1 or 2 swabs
Container: Tube containing viral transport medium (VTM; provided by OSDH PHL) or other appropriate commercial medium (UTM, M4, and M4RT). VTM contains antibiotics and must be stored in the refrigerator prior to and subsequent to specimen collection. Do not use media if cloudy or when past expiration date.

Collection: Respiratory virus diagnosis depends on the collection of high-quality specimens, their rapid transport to the testing laboratory and appropriate storage before testing. Training in specimen collection is highly recommended due to the importance of specimen quality. Specimens should be collected preferably within 3 days of onset of clinical symptoms.

Tip: Have the patient sit with their head against a wall since patients have a tendency to pull away during the procedure.

Nasopharyngeal Swab
1. Label a sterile tube containing 2-3 mL of VTM or other suitable collection media with the patient’s name and date of collection.
2. If the nasal passages have a large amount of mucus, ask the patient
to blow their nose before collecting specimen.

3. With the thumb of one hand, elevate the tip of the patient’s nose then gently insert the NP swab into a nostril.

4. Guide the swab straight back (not upwards), along the floor of the nasal passage until it reaches the posterior wall of the nasopharynx; the distance from the nose to the ear gives an estimate of the distance the swab should be inserted.

**Note:** Do not force the swab — if an obstruction is encountered during insertion, try the other nostril.

5. Rotate the swab by firmly brushing against the nasopharynx several times.

6. Immediately, place swab into tube containing VTM or other suitable collection media.

7. Break-off or cut excess shaft of swab so that tube can be capped.

8. Replace the cap of the tube; tighten and wrap with Parafilm to prevent leakage of contents of tube during transport.

9. Place tube in plastic biohazard bag and insert completed requisition form in outer pouch of the bag.

10. Refrigerate (2-8°C) immediately.

**Nasal Swab**

1. Label a sterile tube containing 2-3 mL of VTM or other suitable collection media with patient’s name and date of collection.

2. If the nasal passages have a large amount of mucus, ask the patient to blow their nose before collecting specimen.

3. With the thumb of one hand, elevate the tip of the patient’s nose then gently insert a dry polyester swab into one nostril, keeping swab shaft parallel to the palate.

4. Hold it there for a few seconds then with a rotating motion gently remove it.

5. Using the same swab, repeat the process, inserting the swab in the other nostril.

6. Place swab immediately into VTM or other suitable collection media.

7. Break-off or cut excess shaft of swab so that tube can be capped.

8. Place tube in plastic biohazard bag and insert completed requisition form in outer pouch of the bag.

9. Refrigerate (2-8°C) immediately.

**Interferences:**

Cotton swab; Calcium alginate swab (shown to inhibit PCR); Wooden shaft swab

**Special Instructions:**

Only synthetic (nylon, rayon or Dacron)-tipped swabs with plastic or aluminum shafts are acceptable.

**Note:** Submission of specimens from patients with suspected influenza A/H5 or Eurasian H7 requires OSDH Acute Disease Service pre-approval to verify the patient meets clinical case criteria, including travel history to an area of novel influenza circulation.

**Shipping:**

Store and ship specimens refrigerated (2-8°C) for delivery within 3 days (72 hours) of collection. If delivery will be delayed for more than 72 hours, specimens should be frozen at -70°C or colder and shipped with dry ice.

_Last revised 7/1/2022_
1. Place specimen in round cardboard container and place this in Styrofoam mailer box (both containers are supplied by OSDH PHL for influenza surveillance).

2. Remove frozen cold pack from freezer and place in the mailer with specimen then fill the mailer with packing material.

3. Mailers are returned to submitting sites with fresh tubes of VTM corresponding to the number of specimens submitted. If additional VTM is required, fill-out the order form and return with the specimens in the mailer.

4. Send via OSDH PHL courier service.

Rejection Criteria:
- Incorrect collection device (cotton, wooden, or calcium alginate swab) or media
- Received > 72 hours from time of collection and not frozen at -70°C or colder
- Swab without transport medium
- Specimen at ambient temperature
- Other criteria as outlined in Specimen Rejection section of this Test Directory

Reported:
Within 5 working days of receipt.
Specimens initially screened using the Respiratory Pathogens Panel, and in which influenza virus A and/or B is detected, will be issued a preliminary report pending testing by the Human Influenza Virus rRT-PCR Diagnostic Panel. Specimens in which variant or potential novel influenza viruses are detected by the Human Influenza Virus rRT-PCR Diagnostic Panel will be issued a preliminary report, pending further characterization by the CDC.

CPT Codes:
87502, 87503 (x3)

Normal/Abnormal Results:
- Influenza Not Detected
- Influenza Virus A Detected, Subtype: H1 2009 pandemic strain
- Influenza Virus A Detected, Subtype: H3 strain
- Influenza Virus A Detected, Subtype: H1 2009 pandemic strain; possible co-infection or recent live attenuated influenza virus vaccination
- Influenza Virus A Detected, Subtype: H3 strain; possible co-infection or recent live attenuated influenza virus vaccination
- Influenza Virus A Detected, Subtype: Eurasian H7 strain
- Influenza Virus A Detected, Subtype: Undetermined
- Influenza Virus A Detected, Subtype: Undetermined, referred to CDC for subtyping
- Presumptive Positive for Influenza A/H3N2 variant; referred to CDC for confirmation
- Presumptive Positive for Influenza A/H5; referred to CDC for confirmation
- Influenza Virus B Detected
- Influenza Virus B Detected, Lineage: Victoria
- Influenza Virus B Detected, Lineage: Yamagata
- Influenza Virus B Detected, Lineage: Victoria; possible co-infection or recent live attenuated influenza virus vaccination
- Influenza Virus B Detected, Lineage: Yamagata; possible co-infection or recent live attenuated influenza virus vaccination
- Indeterminate, potential PCR inhibitor/poor sample quality

Interpretation:
When a clinical sample fails to amplify, the sample is reported as

Last revised 7/1/2022
“Indeterminate, potential PCR inhibitor/poor sample quality”. It is recommended that a new sample is submitted for testing.

**Limitations:**

Negative results do not preclude influenza virus infection and should not be used as the sole basis for treatment or other patient management decisions. Positive results do not rule-out other viral or bacterial co-infections. Individuals immunized with live attenuated influenza nasal spray vaccine may be positive for one or more influenza virus targets for several days post-vaccination; vaccination history should be considered when interpreting positive test results, especially early in the flu season. Lineage typing of influenza B is used for epidemiological purposes, and has no bearing on patient treatment. Performance characteristics of this assay may vary in the detection of novel or emerging influenza viruses.

**Notes:**

This test is approved for *in vitro* diagnostic use by the U.S. Food and Drug Administration.

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Newborn Screening (NBS) Panel

Abnormal results from the presumptive screens in the Public Health Lab (PHL) indicate that there may be a metabolic issue in the newborn. These will result in a re-test, which will be the end of the testing process if the test is normal. If the result from the newborn is confirmed to be abnormal, then the newborn is referred for further diagnostic testing by NBS Follow-Up. See “Limitations” below.

| Use: | Screening of newborns for certain metabolic, endocrine, and genetic disorders that can adversely affect a child’s long-term health or survival |
| Methodology: | Tandem mass spectrometry; fluorimetric analysis; isoelectric focusing; polymerase chain reaction amplification |
| Clinical Significance: | The Newborn Screening Panel includes measurement of a number of analytes of newborns that are associated with the following conditions: |
| | • Biotinidase deficiency |
| | • Congenital adrenal hyperplasia |
| | • Congenital hypothyroidism |
| | • Cystic fibrosis |
| | • Galactosemia |
| | • Hemoglobinopathy |
| | • Fatty acid oxidation disorders |
| | • Organic acid disorders |
| | • Amino acid disorders |
| | • X-Linked adrenoleukodystrophy |
| | • Lysosomal storage disorders |
| | • Severe combined immunodeficiency |
| | • Spinal muscular atrophy |

| Specimen: | Dried blood spots prepared by applying fresh whole blood on Whatman 903, Ahlstrom PerkinElmer 226, or equivalent filter paper from infant less than 6 months of age, in accordance with the current CLSI Section NBS01-A6 standards. Specimen must not be applied to filter paper from EDTA, heparin, or citrate collected blood. |
| Type: | 5 filled circles |
ODH #450 Newborn Screening Form and Collection Kit. The submitter must ensure that the newborn screening form kit is not expired, and must complete all information requested by printing legibly.

• Mark if First Screen or Repeat Screen. If repeat screen, enter Previous Lab Number, if known. If unknown, enter Previous Filter Paper Number.
• Mark Reason Not Screened if appropriate. If parent(s)/guardian refused screening, then the NBS Refusal Form must be faxed to Screening and Special Services at 405-900-7556.
• Mark Tests Requested, only if a special test is needed. If this is an initial newborn screen, do not mark any category in this section; if nothing is marked, all tests will be performed.

Infant’s Information:
• Print infant’s Last Name. If baby is being adopted, fill-in BUFA for last name and mark adoption box. Print infant’s First Name or fill-in with Male/Female.
• Mark appropriate Gender.
• Print Date Of Birth.
• Print Time Of Birth using military time.
• Mark appropriate race.
• Print Date of Collection.
• Print Time Of Collection using military time.
• Print Medical Recod Number.
• Print Gestational Age.
• Print Birth Weight in grams.
• If multiple births, indicate birth order (i.e., A, B, C). If not a multiple birth, leave blank.
Mother’s/Guardian’s Information:
If infant is not in mom’s care, put information for person responsible for getting infant to doctor’s appointments (e.g., other family member, case worker, social worker) in the Mother’s/Guardian’s Information section.
- Mark whether infant is in DHS Custody or Up For Adoption if applicable, otherwise leave field blank.
- Print Last and First Names for mother/guardian.
- Print Address and Apartment Number, as applicable; if not applicable, leave field blank.
- Print name of City where mother/guardian resides.
- Print name of State where mother/guardian resides.
- Print Zip Code of city where mother/guardian resides.
- Print Telephone Number for mother/guardian.
- Print Alternate Telephone Number for mother/guardian if available.
- Print mother’s Date of Birth.
- Print mother’s Medicaid Number.
- Print last 4 Digits of Mother’s SSN.

Provider’s Information:
- Print Ordering Physician’s Last and First Names and Provider’s ID Number.
- Print Primary Care/Follow-Up Physician’s Last and First Names and Provider’s ID Number.

Medical/Feeding History:
- Print Transfusion Date and Time, if infant was transfused. If infant was not transfused, leave blank.
- Mark appropriate fields to indicate treatments/health history of infant (i.e., NICU/SCN, TPN/SNAP, Lipids/Carnitine/MCT, Lactose-Free Formula, Meconium Ileus, Family History of CF).

Pulse Oximetry/CCHD Screen:
- Mark appropriate box for CCHD Screen, if the parent(s)/guardian refused screening then NBS Refusal Form must be faxed to Screening and Special Services at 405-900-7556.

Hearing Screening Results:
- Print Date Of Final Hearing Screen
- Mark Pass/Refer for right/left ear.
- Mark Screening Method used to perform hearing test.
- If infant was not screened, mark the Reason Screen not Performed.
- Mark all hearing risk categories that apply to the infant.

Submitter’s Information:
- Print Facility ID Number.

Collection:
Special attention must be paid to the storage and transportation conditions of the dried blood spot samples. Storage of samples in an environment with elevated temperatures and humidity increases the risk of false positive screening results.
1. To prevent specimen contamination do not touch any of the filter paper circles before or after collection.
2. Warm infant’s foot site with a soft cloth, moistened with warm water up to 41°C (105°F) for 3 to 5 minutes.
3. Select puncture site and cleanse with 70% isopropanol and allow heel to air-dry. Black areas shown on image of foot indicate safe areas for puncture site.
4. Keep the heel in a horizontal position (heel-down) at or below the heart level.
5. Use a sterile, disposable lancet or heel incision device to perform a swift clean puncture to the infant’s heel.
6. Use sterile gauze to wipe away first blood drop.
7. Allow a second LARGE blood drop to form.
8. Gently, touch the filter paper against the large drop of blood, allowing a sufficient quantity of the blood to completely fill the pre-printed circle on the filter paper and soak through to the other side. Do not touch the heel to the filter paper. Do not apply multiple drops of blood to the same circle. Apply blood only to one side of the filter paper.

9. Continue filling the other circles with successive single large drops of blood.
10. Allow both sides of blood spots to air-dry at room temperature for at least 3 hours in a horizontal position. Fold the cardboard cover to hold the blood spots off of any surface or place on a rack to dry. Be sure the attached coverslip does not come into contact with the blood until completely dry. NOTE: Do not use artificial heat (lamps, incubators, etc.) to dry the samples. Keep away from direct sunlight. Do not stack wet specimens. Insufficient drying will adversely affect the test results.
11. Replace the coverslip over the blood spots when completely dry.
12. Check the quality of the specimens (see Simple Spot Check below). All specimens are judged for acceptability at the OSDH PHL, and those not acceptable are reported as “Unsatisfactory”.

**Special Instructions:**
Screening requirements for all newborns:
- Collect specimen as early as possible after 24 hours of age or immediately prior to discharge or prior to blood transfusion, whichever comes first.
- If infant is screened at ≤ 24 hours of age, repeat screen at 3-5 days of age (if premature or sick infant, repeat screen at 7-14 days of age).
- All premature and sick infants should have a repeat screen at 14 days of age.

**Shipping:**
- Specimens must be transported within 24 hours after collection but send specimens as soon as possible after drying.

Last revised 7/1/2022
• Transport specimens at ambient temperature of 2–30°C (35–86°F) in a sealed paper envelope or container that will provide protection from moisture, light, heat, and contact with other materials.
  o Never place filter paper specimens in plastic bags.
  o Do not batch specimens from multiple days except for days when there is no courier service.
• Send specimens via OSDH PHL courier service.
  o Courier pick-up occurs daily at most sites.
  o For sites without weekend courier service, specimens collected on the weekend will be picked-up on the next workday.
• Specimens older than 14 days from collection are unsatisfactory for testing and repeat collection will be required.

**Rejection Criteria:**
• Circles not completely filled or not thoroughly saturated
• Uneven saturation of circles or multiple sample applications
• Specimen appears diluted, discolored, or contaminated
• Clotted or caked blood on filter paper
• Peripheral serum rings present on filter paper
• Specimen appears scratched or abraded or filter paper damaged
• No blood applied to filter paper
• Specimen received on incorrect or expired form
• Specimen received more than 14 days from date of collection
• Serial number on form and (detached) filter paper do not match
• Other criteria as outlined in Specimen Rejection section of this Test Directory

**Reported:** Within 5 working days of receipt (7 working days if reflex testing is required)
• Initial normal/abnormal results:
  o Written report sent to baby’s physician and sample collection site
• Repeat of initial abnormal results:
  o Written report to physician and collection site

**Limitations:** Newborn screening is performed as a means to assess risk in clinically asymptomatic newborns for a host of disorders; it is not intended to establish diagnosis. Abnormal biomarker levels, identified through screening and evaluated using cutoffs, only indicate that a newborn may be at increased risk for a screened disorder. The healthcare provider may request additional diagnostic testing to determine if the newborn has the disorder in question. Healthcare providers should understand that in instances where a newborn has a family history of a disease or is symptomatic, additional diagnostic testing is necessary regardless of the NBS result. Even though algorithms are used to determine infants at highest risk, NBS may not detect all affected newborns. A positive (i.e., abnormal) screening result is not a confirmed diagnosis of a disorder, and a negative (i.e., normal) screening result is not a confirmed exclusion of a disorder.
1. Equipment: sterile lancet with tip approximately 3.0 mm, sterile alcohol prep, sterile gauze pad, soft cloth, blood collection form, gloves.

2. Complete ALL information. Do not contaminate filter paper circles by allowing the circles to come in contact with spillage or by touching before or after blood collection. Keep "SUBMITTER COPY" if applicable.

3. Hatched area (mmmmmmmmmmmm) indicates safe area for puncture site.

4. Warm site with soft cloth moistened with warm water up to 41°C, for three to five minutes.

5. Cleanse site with alcohol prep. Wipe DRY with sterile gauze pad.
6. Puncture heel. Wipe away first blood drop with sterile gauze pad. Allow another LARGE blood drop to form.

7. Lightly touch filter paper to LARGE blood drop. Allow blood to soak through and completely fill circle with SINGLE application of LARGE blood drop. (To enhance blood flow, VERY GENTLE intermittent pressure may be applied to area surrounding puncture site. Apply blood to one side of filter paper only.)

8. Fill remaining circles in the same manner as step 7, with successive blood drops. If blood flow is diminished, repeat steps 5 through 7. Care of skin puncture site should be consistent with your institution's procedures.

9. Dry blood spots on a dry, clean, flat non-absorbent surface for a minimum of four hours.

10. Mail completed form to testing laboratory within 24 hours of collection.

Information provided by The New York State Department of Health.
Specific information regarding each newborn screening test is listed below:

Invalid Specimens:

1. Specimen quantity insufficient for testing

2. Specimen appears scratched or abraded.

3. Specimen not dry before mailing.

4. Specimen appears supersaturated.

5. Specimen appears diluted, discolored or contaminated.

6. Specimen exhibits serum rings.

7. Specimen appears clotted or layered.

8. No blood.

Possible Causes:

- Removing filter paper before blood has completely filled circle or before blood has soaked through to second side.
- Applying blood to filter paper with a capillary tube.
- Touching filter paper before or after blood specimen collection with gloved or ungloved hands, hand lotion, etc.
- Allowing filter paper to come in contact with gloved or ungloved hands or substances such as hand lotion or powder, either before or after blood specimen collection.
- Applying blood with a capillary tube or other device.

- Mailing specimen before drying for a minimum of four hours.

- Applying excess blood to filter paper, usually with a device.
- Applying blood to both sides of filter paper.

- Squeezing or “milking” of area surrounding the puncture site.
- Allowing filter paper to come in contact with gloved or ungloved hands or substances such as alcohol, formula, antiseptic solutions, water, hand lotion or powder, etc., either before or after blood specimen collection.
- Exposing blood spots to direct heat.

- Not wiping alcohol from puncture site before making skin puncture.
- Allowing filter paper to come in contact with alcohol, hand lotion, etc.
- Squeezing area surrounding puncture site excessively.
- Drying specimen improperly.
- Applying blood to filter paper with a capillary tube.

- Touching the same circle on filter paper to blood drop several times.
- Filling circle on both sides of filter paper.

- Failure to obtain blood specimen.

Information provided by The New York State Department of Health
Biotinidase Deficiency (NBS)

Use: Determination of biotinidase enzyme activity in blood specimens dried on filter paper as an aid in screening newborns for biotinidase deficiency.

Methodology: The GSP Neonatal Biotinidase assay combines a solution-based enzyme reaction, involving cleavage of the amide bond in europium-labeled biotin by biotinidase (eluted from the dried blood spot [DBS]), followed by a solid phase, time-resolved immunofluorescence reaction. The initial enzyme reaction is stopped by the addition of streptavidin, which binds to both Eu-labeled and free biotin. The streptavidin-biotin complexes are then captured by monoclonal antibodies directed against streptavidin that are immobilized on the walls of 96-well plates. The wells are washed, and then DELFIA® Inducer is used to dissociate the captured complexes into solution where the Eu fluorescence is measured. The measured fluorescence is inversely proportional to the biotinidase activity in the original DBS.

Clinical Significance: Biotinidase-deficient newborns have an inborn error of metabolism characterized by the inability to utilize dietary protein-bound vitamin or to recycle endogenous biotin derived from the turnover of carboxylases. Biotin deficiency develops progressively, resulting in deficiency of the biotin-dependent carboxylases: propionyl-CoA carboxylase, 3-methylcrotonyl-CoA carboxylase, and pyruvate carboxylase. The disorder is autosomal recessive. Individuals lacking biotinidase activity exhibit a variety of symptoms, which are frequently not present at birth, thus making it difficult to diagnose the disease by clinical observation. Symptoms and the time of onset vary greatly. Profound biotinidase deficiency, the more severe form of the condition, occurs when the activity of biotinidase is reduced to < 10% of normal and usually manifests itself in infants between two and six months of age. By contrast, partial biotinidase deficiency, the milder form of the condition, occurs when biotinidase activity is reduced to between 10 and 30% of normal, and presents later in life. Affected infants between two and six months of age usually develop hypotonia, ataxia, seizures, breathing difficulties, and display developmental delay. Cutaneous abnormalities (skin rash, alopecia) also may be manifested. Treatment with biotin is effective; however, if the therapy is delayed, neurological damage may not be completely reversed.

Interferences: Abnormal neonatal conjugated bilirubin levels (> 2.5 mg/dL) or triglycerides (≥ 250 mg/dL) may decrease biotinidase activity measured using this assay (i.e., produce a false positive reaction), while elevated glutathione (> 30.0 mg/dL), unconjugated bilirubin (10 mg/dL), sulfisoxazole (≥ 7.5 mg/dL) and ampicillin (≥ 1.4 mg/dL) can increase biotinidase activity measured using this assay (i.e., produce false negative reaction). High heat and humidity can cause rapid loss of biotinidase activity in DBS. The following conditions may also cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, contamination of filter paper.

Reported: Within 5 working days after receipt

CPT Codes: 82261

Last revised 7/1/2022
Reference Interval: BIO ≥ 57 U

Interpretation:
- BIO ≥ 57 U/dL: Not consistent with biotinidase deficiency.
- BIO 25.0–56.9 U/dL (first abnormal biotinidase result): Decreased biotinidase enzyme observed; submit repeat specimen as soon as possible
- BIO 25.0–56.9 U/dL (second abnormal biotinidase result): Possible biotinidase deficiency; recommend immediate confirmatory testing
- BIO < 25.0 U/dL: Consistent with biotinidase deficiency; recommend immediate confirmatory testing

Limitations: This is a screening test only. It should not be used to distinguish partial from profound biotinidase deficiency. A diagnostic procedure should be used to confirm a diagnosis of biotinidase deficiency.

Notes: This test is approved for in vitro diagnostic use by the U.S. Food and Drug Administration.
Congenital Adrenal Hyperplasia (CAH, NBS)

Use: Quantitative determination of human 17 β-OH-progesterone (17-OHP) in blood specimens dried on filter paper as an aid in screening newborns for congenital adrenal hyperplasia (CAH). If the 17-OHP value is elevated, the specimen is referred for 2nd tier MS/MS steroid profiling.

Methodology: The GSP Neonatal 17α-OH-progesterone (17-OHP) is a solid phase, time-resolved fluoroimmunoassay based on the competitive reaction between europium-labeled 17-OHP and sample 17-OHP for a limited amount of binding sites on 17-OHP specific polyclonal antibodies (derived from rabbit). Danazol facilitates the release of 17-OHP from the binding proteins. A second antibody, directed against rabbit IgG, is coated to the solid phase, giving convenient separation of the antibody-bound and free antigen. DELFIA Inducer dissociates europium ions from the labeled antigen into solution where they form highly fluorescent chelates with components of the Enhancement Solution. The fluorescence in each well is then measured. The fluorescence of each sample is inversely proportional to the concentration of 17-OHP in the sample.

Clinical Significance: There are various congenital enzyme defects of the steroid biosynthesis, which cause CAH. They are genetically different, but are all transmitted in an autosomal recessive manner. The most frequent types are 21 β-hydroxylase deficiency (about 80% of all cases) and 11 β-hydroxylase deficiency (about 15% of all cases). CAH due to 21 β-hydroxylase deficiency is characterized by a deficiency in the hormones cortisol and aldosterone and an over-production of androgen. Serious loss of body salt and water can result in death. In girls, the genitalia may appear like that of a male, and can result in incorrect sex assignment. Symptoms of adrenal insufficiency include: emesis, excessive weight loss relative to birth weight, diaphoresis, hyperventilation, pallor, dry mucosa, and lethargy. 17-OHP, a precursor of cortisol, is increased in both 21 and 11 β-hydroxylase deficiency. Its determination is thus useful as a screening method for the two most frequent types of CAH or about 95% of all cases.

Interferences: Do not use EDTA or citrate tubes or capillaries to collect blood, as these anticoagulation reagents will affect the assay by chelating the europium label. Treatment of the mother or the child with dexamethasone, hydrocortisone or prednisone may result in false-negative results. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

Reported: Within 5 working days after receipt
Within 7 working days after receipt if 2nd tier steroid profile is required

CPT Codes: 83498

Reference Interval: 17-OHP < 28.0 ng/mL if birth weight is ≥ 2500 grams
17-OHP < 75.0 ng/mL if birth weight is < 2500 grams
**Interpretation:**
- 17-OHP ≥ 28.0 ng/mL, steroid profile normal, and birth weight ≥ 2500 grams: CAH screening inconclusive. Confirmatory testing recommended
- 17-OHP ≥ 75.0 ng/mL, steroid profile normal, and birth weight < 2500 grams: CAH follow-up recommended if clinically indicated, or if family history indicators are present
- 17-OHP greater than reference range and steroid profile abnormal: Consistent with CAH. Immediate confirmatory testing recommended

**Limitations:**
- This is a screening test only. A diagnostic procedure should be used to confirm a diagnosis of CAH
- Late onset, non-classic CAH is not accurately detected by newborn screening
- Newborn screening for CAH is not intended to detect mild cases, although some are detected
- Despite adjusting 17-OHP cut-off concentrations for birth weight, preterm or low birth weight and samples taken at ≤ 24 hours of age are major factors for false-positive results

**Notes:** This test is approved for in vitro diagnostic use by the U.S. Food and Drug Administration.
Congenital Hypothyroidism (TSH, NBS)

Use: Quantitative determination of human thyroid stimulating hormone (hTSH) in blood specimens dried on filter paper as an aid in screening newborns for congenital (neonatal) hypothyroidism.

Methodology: The GSP Neonatal hTSH assay is a solid phase, two-site fluoroimmunometric assay based on the direct sandwich technique in which two monoclonal antibodies are directed against two separate antigenic determinants on the hTSH molecule. Standards, controls and test specimens containing hTSH are reacted simultaneously with immobilized monoclonal antibodies directed against a specific antigenic site on the β hTSH subunit and europium-labeled monoclonal antibodies (directed against a different antigenic site located partly on the β subunit and partly on the α subunit) in assay buffer. The assay buffer elutes hTSH from the dried blood spots. DELFIA Inducer dissociates europium ions from the labeled antibody into solution where they form highly fluorescent chelates with components of the DELFIA Inducer. The fluorescence in each well is then measured. The fluorescence of each sample is proportional to the concentration of hTSH in the sample.

Clinical Significance: Congenital hypothyroidism is usually caused by abnormal development or absence of the thyroid gland. An elevated hTSH concentration in infant blood is the earliest available laboratory manifestation of primary hypothyroidism. Due to its high specificity and sensitivity, hTSH testing is the screening method of choice for the detection of neonatal hypothyroidism. Since a clinical diagnosis is difficult to establish and since the condition needs early medical attention, large scale laboratory screening programs have been implemented in many countries to detect neonatal hypothyroidism.

Interferences: Do not use EDTA or citrate tubes or capillaries to collect blood, as these anticoagulation reagents will affect the assay by chelating the europium label. Heterophilic antibodies in the sample may interfere with the assay. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

Reported: Within 5 working days after receipt

CPT Codes: 84443

Reference Interval: TSH < 27.0 µIU/mL serum

Interpretation:

- TSH ≥ 27.0 to < 50 µIU/mL serum (first abnormal TSH result): Submit repeat specimen within 48 hours or perform serum TSH and free-T4 tests at 12 to 15 days of life
- TSH ≥ 27.0 to < 50 µIU/mL (second abnormal TSH result): Possible congenital hypothyroidism; recommend immediate serum TSH and free-T4 confirmatory testing
- TSH ≥ 50 µIU/mL: Consistent with hypothyroidism; recommend immediate serum TSH and free-T4 confirmatory testing
Limitations: This is a screening test only. A diagnostic procedure performed on a serum sample should be used to confirm a diagnosis of congenital hypothyroidism.

Notes: This test is approved for *in vitro* diagnostic use by the U.S. Food and Drug Administration.
Cystic Fibrosis (CF, NBS)

Use: Quantitative determination of human immunoreactive trypsinogen (IRT) in blood specimens dried on filter paper is used as an aid in the screening of newborns for Cystic Fibrosis (CF). Specimens with elevated IRT values are reflexed to 2nd tier CFTR gene mutation analysis. Newborns identified with meconium ileus or family history of CF also undergo CFTR mutation analysis.

Methodology:
IRT Assay:
The GSP Neonatal IRT kit is a solid phase, two-site fluoroimmunometric assay based on the direct sandwich technique in which two monoclonal antibodies (mAbs) are directed against two separate antigenic determinants on the IRT molecule. Standards, controls and patient dried blood spot specimens containing IRT are reacted simultaneously with anti-IRT mAbs immobilized on the walls of reaction wells in a 96-well plate and to europium-labeled anti-IRT mAbs in assay buffer. The assay buffer elutes IRT from the dried blood on the filter paper disks, which is then captured onto the walls of the reaction wells by the unlabeled mAbs and reacts with the europium-labeled mAbs in the assay buffer. Delfia Inducer then dissociates europium from the captured IRT-mAb complexes to form highly fluorescent chelates with components of the solution. The fluorescence of each sample is proportional to the concentration of IRT in the sample.

CFTR Mutation Analysis:
The xTag Cystic Fibrosis 39 kit v2 is a PCR-bead array based genotyping assay that identifies a panel of 39 mutations and 6 variants in the CFTR gene, including those currently recommended by the American College of Medical Genetics and American College of Obstetricians and Gynecologists (ACMG/ACOG), plus some of the world’s most common and North American-prevalent mutations (see table below).

Table: Mutations (* denotes ACMG/ACOG panel) and 6 variants (italicized and purple text) included in the xTAG Cystic Fibrosis 39 Kit v2

<table>
<thead>
<tr>
<th>Mutation</th>
<th>Description</th>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F508del*</td>
<td>1717-1G&gt;A*</td>
<td>W1282X*</td>
<td>2307insA</td>
</tr>
<tr>
<td>I507del*</td>
<td>R560T*</td>
<td>1078delT</td>
<td>Y1092X</td>
</tr>
<tr>
<td>G542X*</td>
<td>R553X*</td>
<td>394delTT</td>
<td>M1101K</td>
</tr>
<tr>
<td>G85E*</td>
<td>G551D*</td>
<td>Y122X</td>
<td>S1255X</td>
</tr>
<tr>
<td>R117H*</td>
<td>1898+1G&gt;A*</td>
<td>R347H</td>
<td>3876delA</td>
</tr>
<tr>
<td>621+1G&gt;T*</td>
<td>2184delA*</td>
<td>V520F</td>
<td>3905insT</td>
</tr>
<tr>
<td>711+1G&gt;T*</td>
<td>2789+5G&gt;A*</td>
<td>A559T</td>
<td>5T/7T/9T</td>
</tr>
<tr>
<td>N1303K*</td>
<td>3120+1G&gt;A*</td>
<td>5549N</td>
<td>F508C</td>
</tr>
<tr>
<td>R334W*</td>
<td>R1162X*</td>
<td>S549R</td>
<td>I507V</td>
</tr>
<tr>
<td>R347P*</td>
<td>3659delC*</td>
<td>1898+5G&gt;T</td>
<td>I506V</td>
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<tr>
<td>A455E*</td>
<td>3849+10kB&gt;C&gt;T*</td>
<td>2183AA&gt;G</td>
<td></td>
</tr>
</tbody>
</table>

Clinical Significance: CF is the most common recessive genetic disorder found in Caucasians with an incidence of 1 in 2,500 live births. The main clinical symptoms are characterized by functional abnormalities in the airway epithelium, the exocrine pancreas, the gastrointestinal tract, and the secretory duct of the sweat gland, leading to pancreatic and pulmonary insufficiency. Early detection of CF can decrease the
risk of malnutrition, failure to thrive, zinc deficiency, fat-soluble vitamin (A, D, E and K) deficiency-related disorders of the eye, bone, heart, and immune and nervous systems, and chest infections. Trypsinogen, one of the principle enzyme precursors produced by the pancreas, is abnormally increased in the blood of CF infants at birth due to obstructive pancreatic damage, making it a suitable marker for neonatal screening for CF. Heterozygous carriers of CF can also have elevated blood IRT values; therefore, it is not diagnostic in isolation.

Generally, CF is characterized as “pancreatic insufficient” (PI) or “pancreatic sufficient” (PS), based on whether the individual has enough pancreatic function to grow and maintain health without supplemental pancreatic enzyme therapy (PERT). PI is the result of obstructive destruction of exocrine pancreatic tissue. About 85% of CF patients are PI before the age of 1 year. PI correlates closely with the specific CFTR mutations found in the individual. Individuals with 2 severe CFTR mutations (classes I, II, III, and VI) tend to have early PI, often beginning at birth, while those with 2 mild CFTR mutations (classes IV and V) or with one severe and one mild mutation tend to be PS at birth. However, there is considerable variation in genotype/phenotype correlates, indicating the critical role for environmental factors and modulatory genetic elements in clinical outcomes. CF individuals born PS may become PI at any age, and without symptoms initially, emphasizing the importance of constant monitoring.

**Interferences:**
Do not use EDTA, citrate, or heparin tubes or capillaries to collect blood. EDTA and citrate will affect the assay by chelating the europium label. Heparin is also an inhibitor of the PCR used to detect CFTR mutations. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

**Reported:**
IRT within 5 working days after receipt
IRT and CFTR mutation analysis within 7 working days after receipt

**CPT Codes:**
83516

**Reference Interval:**
IRT < 57 ng/mL (Neonatal IRT); No mutations detected (CFTR mutation analysis)

**Interpretation:**
- IRT ≥ 57 ng/mL and no CFTR mutations detected: Not consistent with cystic fibrosis, unless symptomatic, or if there is a family history of cystic fibrosis
- IRT ≥ 57 ng/mL and 1 CFTR mutation detected: Refer for sweat testing and genetic counseling. Mutation(s) detected - &lt;&lt;list mutation(s)/variant(s)&gt;&gt;
- IRT ≥ 57 ng/mL and 2 CFTR mutations detected: Consistent with cystic fibrosis. Refer for sweat testing and genetic counseling. Mutation(s) detected - &lt;&lt;list mutation(s)/variant(s)&gt;&gt;

Refer to the Physicians Guide to CFTR Test Results at the Oklahoma State Department of Health Public Health Laboratory website https://www.ok.gov/health/Prevention_and_Preparedness/Public_Health_Laboratory/Test_Directory/index.html for further details on interpretation of CFTR mutation analysis

**Limitations:**
The GSP Neonatal IRT assay is a screening test only. Other diseases may mimic PI CF, including other causes of PI, intestinal malabsorption, and some behavioral problems. Therefore, a diagnostic procedure should be used to confirm a diagnosis of CF. The Cystic Fibrosis 39 kit v2 assay can be used to
confirm abnormal IRT values when two mutations are present in either homozygous or compound heterozygous states. However, because this kit only detects a subset of CFTR mutations, albeit common mutations for the US population, individuals with CFTR mutations may be missed. Testing of individuals with an expanded CFTR mutation panel that includes other less common mutations may be indicated if the initial panel of mutations demonstrates a single mutation, or is suspected of having CF. A sweat chloride test should be an early step in the differential diagnosis of PI or malabsorption in newborns, and remains the “gold standard” for diagnosis of CF.

Notes: False negative IRT values are known to occur in some CF newborns that present with meconium ileus. If an infant has meconium ileus or there is a family history of CF, it is important to mark the appropriate area of the NBS collection form, so CFTR mutation analysis will be performed even if the IRT level is < 57 ng/mL.

Both the Neonatal IRT assay and the xTag® Cystic Fibrosis 39 kit v2 assay are approved for in vitro diagnostic use by the U.S. Food and Drug Administration.
Galactosemia (GALT, NBS)

**Use:** Quantitative determination of total galactose (galactose and galactose-1-phosphate) in blood specimens dried on filter paper as an aid in screening newborns for classic galactosemia (GALT), galactokinase deficiency (GALK), and galactoepimerase deficiency (GALE). Specimens with elevated total galactose are reflexed to analysis of galactose-1-phosphate uridyl transferase (GALT) enzyme activity. Newborns identified as receiving lactose-free formula also undergo GALT enzyme testing.

**Methodology:** The GSP Neonatal Total Galactose kit quantitatively measures total galactose, i.e., both galactose and galactose-1-phosphate, in dried blood spot specimens based on a fluorescent galactose oxidase method.

**Clinical Significance:** Galactosemia is an autosomal recessive disorder that is characterized by elevated concentrations of galactose in the blood resulting from the absence or dysfunction of any of the three enzymes responsible for the transformation of galactose to glucose, i.e., D-galactose-1-phosphotransferase, α-D-galactose-1-phosphate-uridylyltransferase, or UDP-glucose-4-epimerase. If not diagnosed and treated within the newborn period, galactosemia can lead to diarrhea, dehydration, jaundice, hepatic failure, hypoglycemia, cataracts, developmental retardation and death within a few weeks. Sepsis due to *Escherichia coli* seems to be particularly frequent among galactosemic neonates and is usually the cause of death. Treatment of the disease consists of withdrawal of all foods containing lactose and galactose from the diet.

**Interferences:** Infants that have not ingested breast milk or formula containing lactose prior to the sample collection may have lower total galactose values. Conjugated bilirubin concentrations greater than 16.6 mg/dL and acetaminophen concentrations greater than 2.75 mg/dL in the blood of infants may decrease measured TG concentrations, which may cause false negative results. Exchange transfusions may also lead to a false negative screening test. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

**Reported:** Within 5 working days after receipt

**CPT Codes:** 82760

**Reference Interval:** TG < 10 mg/dL

**Interpretation:**
- TG < 12 mg/dL and GALT enzyme WNL: Not consistent with classic galactosemia
- TG 12 - < 17 mg/dL and GALT enzyme WNL: Not consistent with classic galactosemia; repeat testing at provider’s discretion
- TG ≥ 17 mg/dL and GALT enzyme WNL: Possible variant form of galactosemia, carrier or normal genotype; consult with metabolic specialist
- TG ≥ 10 mg/dL and GALT enzyme Low [2.5 to 3.5 U GALT/g Hb]: Low GALT enzyme; submit repeat specimen as soon as possible

*Last revised 7/1/2022*
• TG ≥ 10 mg/dL and GALT enzyme Absent [< 2.5 U GALT/g Hb]: Consistent with classic galactosemia; recommend immediate confirmatory testing

**Note:** Interpretations and recommendations may differ when screening involves a repeat specimen.

**Limitations:**
This is a screening test only. This test is not designed to screen for GALT heterozygosity. A diagnostic procedure should be used to confirm a diagnosis of galactosemia.

**Notes:**
Samples subjected to heat, light, or moisture may have decreased total galactose levels. Samples stored in warm and/or humid conditions lose GALT activity. Therefore, improper handling and storage of specimens may cause both false positive and false negative galactosemia screening results.

This test is approved for *in vitro* diagnostic use by the U.S. Food and Drug Administration.

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Hemoglobinopathy - Isoelectric Focusing (HGB, NBS)

Use: Qualitative detection of normal and variant hemoglobins in blood specimens dried on filter paper used as an aid in the detection of sickle cell anemia, sickle C disease, S/beta-thalassemia, homozygous C disease, and variant hemoglobinopathies in newborns and children, and in adults.

Methodology: Hemoglobin variants are separated by isoelectric focusing in pH gradient agarose gels. Hemoglobin bands are visualized by staining with o-dianisidine, which is readily oxidized by the heme portion of the hemoglobin molecule in the presence of hydrogen peroxide. The reaction forms an insoluble precipitate that intensifies each band.

Clinical Significance: Detection of hemoglobin variants is important as a diagnostic tool and for genetic counseling. Detecting hemoglobins S, C and E (Hb S, Hb C, and Hb E) is particularly important because each of these variants in their homozygous state produces clinically significant effects. Additionally, these variants are found as double heterozygotes (Hb SC, Hb SE) that also produce disease states. Screening of blood for hemoglobin variants has become important mainly for detection of Hb S. Early treatment of sickle cell anemia (Hb SS) with antibiotics has lessened the infections associated with the disease.

Specimen: Type: Dried blood spot collected from infant in accordance with the current CLSI Section NBS01-A6 standards; or dried blood spot collected from adult of childbearing age (females < 46 years of age, maternity or family planning patients of any age, males of any age). Newborn screening specimen must not be applied to filter paper from EDTA, heparin, or citrate collected blood.

Volume: 5 filled circles (Newborn)
3 filled circles (Adult/Child)

Container: ODH #450 Newborn Screening Form (Newborn)
ODH #485 Child/Adult Sickle Cell Screening Form (Child/Adult)
The submitter must ensure that the expiration date of the screening form has not passed. Legibly print and complete all information requested. See Sample Collection section for detailed instructions on completion of screening form.

Interferences: Older samples may yield “aging bands” due to decomposition and/or oxidation of hemoglobin. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

Reported: Within 5 working days after receipt (Newborn)
Within 10 working days after receipt (Child/Adult)

CPT Codes: 83020-52

Reference Interval: Hb FA (Newborn)
Hb AA (Child/Adult)

Interpretation: • F Only: Submit new filter paper specimen at 2 months of age.
• Consistent with transfusion: Submit new filter paper specimen at 4 months of age
• FA, Bart’s: Recommend CBC with indices at 1 year of age; or at 3 months if of Asian descent
• FAS: Consistent with S trait. Submit new filter paper specimen at 4 months of age
• FAC: Consistent with C trait. Submit new filter paper specimen at 4 months of age
• FA, Other: Consistent with trait. Submit new filter paper specimen at 4 months of age
• FS: Consistent with SS disease. Refer to pediatric hematologist for confirmatory testing
• FC: Consistent with CC disease. Refer to pediatric hematologist for confirmatory testing
• FSC: Consistent with SC disease. Refer to pediatric hematologist for confirmatory testing
• FSA: Consistent with S-thalassemia. Refer to pediatric hematologist for confirmatory testing
• F, Other: Consistent with disease. Refer to pediatric hematologist to confirm

Note: Any variant reported as “F, Other” or “FA, Other” will include an additional comment to convey location of the unidentified variant, e.g., “Other Band in D/G Region” or “Other Band in E/O Region”, etc.

Limitations:
Isoelectric focusing is able to separate hemoglobin variants with isoelectric points (pI) that differ by 0.01 pH units or greater. Variants with the same pI migrate together.
This is a screening test only. A diagnostic procedure should be used to confirm the identity of variant hemoglobins.

Notes:
This test is approved for in vitro diagnostic use by the U.S. Food and Drug Administration.

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Fatty Acid Oxidation Disorders (FAO, NBS)

Use: Quantitative measurement of acylcarnitines C0, C4, C6, C8, C10, C10:1, C14, C16, C16OH, C16:1OH, C18, C18OH, C18:1, C18:1OH, and C18:2 in blood specimens dried on filter paper as an aid in screening newborns for medium-chain acyl-CoA dehydrogenase deficiency and other fatty acid oxidation (FAO) and organic acid disorders, including carnitine uptake defect, short-chain acyl-CoA dehydrogenase deficiency, glutaric acidemia type II, very long-chain acyl-CoA dehydrogenase deficiency, carnitine acylcarnitine translocase deficiency, carnitine palmitoyltransferase I deficiency, carnitine palmitoyltransferase II deficiency, long-chain L-3-hydroxyacyl-CoA dehydrogenase deficiency, and trifunctional protein deficiency.

Methodology: The measurement of free carnitine and acylcarnitines uses an Amino Acids, Acylcarnitines, Lysophospholipids, and Succinylacetone tandem mass spectrometry (MS/MS) kit to extract dried blood spots with a solution containing stable-isotope labeled internal standards with subsequent analysis by MS/MS. The response of each analyte relative to its corresponding stable-isotope labeled internal standard is proportional to analyte concentration.

Clinical Significance: Elevated or decreased free carnitine and elevated acylcarnitine levels in newborn blood can be indicative of one or more of several metabolic disorders. Free carnitine and acylcarnitines are markers for disorders that are generally classified as FAO disorders and organic aciduria (OA) disorders. These disorders are inborn errors of metabolism (or genetic metabolic deficiencies).

In FAO disorders, enzymes necessary for fatty acid breakdown are unavailable or have reduced activity. Breakdown, or oxidation, of fatty acids is necessary for energy production when glucose levels are low. Without this energy supply, some individuals may have recurring incidences of low blood sugar levels. In cases of fasting, often caused by illnesses such as ear infections or flu, there may be metabolic crisis. Affected individuals may show vomiting, diarrhea, lethargy, seizures or coma. Failure to diagnose FAO disorders may result in excessive fat build-up in the liver, heart and kidneys. This build-up can cause a variety of symptoms, ranging from hepatic failure, encephalopathy, heart and eye complications to general problems with muscle development. Many of these clinical symptoms can lead to death. Many deaths due to FAO disorders have been misdiagnosed as Sudden Infant Death Syndrome (SIDS) or Reye’s Syndrome.

Interferences: High nutritional intake of carnitine or medium-chain triglyceride (MCT) oil may interfere with the measurement of acylcarnitines. Variables such as hematocrit, prematurity, and age of infant may affect the interpretation of values produced by the assay. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

Reported: Within 5 working days after receipt

CPT Codes: 82017 (includes organic acid disorders)
**Reference Interval:**

C0 5.51 – 82.99 µmol/L  
C4 < 1.27 µmol/L  
C6 < 0.25 µmol/L  
C8 < 0.40 µmol/L  
C10 < 0.40 µmol/L  
C10:1 < 0.30 µmol/L  
C14 < 0.71 µmol/L  
C14:1 < 0.70 µmol/L  
C16 < 7.46 µmol/L  
C16:OH < 0.16 µmol/L  
C16:10H < 0.47 µmol/L  
C18 < 2.15 µmol/L  
C18:OH < 0.12 µmol/L  
C18:1 < 3.41 µmol/L  
C18:10H < 0.15 µmol/L  
C18:2 < 1.58 µmol/L  
C0/(C16 + C18) ratio < 90  
C4/C2 ratio < 0.06  
C8/C10 ratio < 3.0

**Interpretation:**

- Acylcarnitine pattern consistent with high nutritional intake of carnitine and/or MCT oil: Submit new filter paper specimen at 14 days of age  
- Borderline FAO analyte pattern: Submit repeat specimen as soon as possible  
- Abnormal FAO analyte pattern: Consistent with *specific FAO disorder*. Immediate confirmatory testing recommended

**Limitations:**

This is a screening test only. A diagnostic procedure should be used for confirmation of presumptive abnormal acylcarnitines profiles.

**Notes:**

This test is approved for *in vitro* diagnostic use by the U.S. Food and Drug Administration.
Organic Acid Disorders (NBS)

Use: Quantitative measurement of acylcarnitines C3, C3DC, C4, C5, C5:1, C5DC, C5OH_C4DC, C6DC in blood specimens dried on filter paper as an aid in screening newborns for organic acid disorders, including propionic acidemia (PROP), methylmalonic acidemia (MUT; CBL-C,D; CBL-A,B), malonic acidemia (MAL), isobutyrylglycinuria (IBG), isovaleric acidemia (IVA), 2-methylbutyrylglycinuria (2MBG), 3-methylcrotonyl-CoA carboxylase deficiency (3MCC), 3-methylglutaconic aciduria (3MGA), 3-hydroxy-3-methylglutaric aciduria (HMG), holocarboxylase synthetase deficiency (MCD), 2-methyl-3-hydroxybutyric aciduria (2M3HBA), beta-ketothiolase deficiency (BKT), and glutaric acidemia type 1 (GA1).

Methodology: The measurement of free carnitine and acylcarnitines uses an Amino Acids, Acylcarnitines, Lysophospholipids, and Succinylacetone tandem mass spectrometry (MS/MS) kit to extract dried blood spots with a solution containing stable-isotope labeled internal standards with subsequent analysis by MS/MS. The response of each analyte relative to its corresponding stable-isotope labeled internal standard is proportional to analyte concentration.

Clinical Significance: Elevated acylcarnitine levels in newborn blood can be indicative of one or more of several metabolic disorders. Acylcarnitines are markers for disorders that are generally classified as fatty acid oxidation (FAO) disorders and organic aciduria (OA) disorders. These disorders are inborn errors of metabolism (or genetic metabolic deficiencies).

The metabolic pathways of organic acids are disrupted in OA disorders and thus accumulation of the acids in blood and urine alters the acid-base balance of the body. Resulting modifications or adaptations to intermediary metabolic pathways may cause numerous clinical symptoms, including metabolic acidosis, ketosis, hyperammonemina, failure to thrive, sepsis or coma.

Interferences: Pivalic acid (an antibiotic that may be administered during pregnancy or to the infant) may result in false positive cases for IVA. High nutritional intake of carnitine or medium-chain triglyceride (MCT) oil may interfere with the validity of acylcarnitines concentrations. Variables such as hematocrit, prematurity, and age of infant may affect the interpretation of the values produced. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

Reported: Within 5 working days after receipt

CPT Codes: 82017 (includes MCAD and other fatty acid oxidation disorders)

Reference Interval: C3 < 6.33 µmol/L
C3DC < 0.44 µmol/L
C4 < 1.27 µmol/L
C5 < 0.87 µmol/L
C5:1 < 0.10 µmol/L
C5DC < 0.46 µmol/L
C5OH_C4DC < 0.80 µmol/L
C6DC < 0.27 µmol/L
C3/C2 ratio < 0.25
C5/C2 ratio < 0.05
C5DC/C8 ratio < 4.6
C5DC/C16 ratio < 0.20

**Interpretation:**
- Acylcarnitine pattern consistent with high nutritional intake of carnitine and/or MCT oil: Submit new filter paper specimen at 14 days of age
- Borderline OA analyte pattern: Submit repeat specimen as soon as possible
- Abnormal OA analyte pattern: Consistent with *specific OA disorder* – Immediate confirmatory testing recommended

**Limitations:**
This is a screening test only. A diagnostic procedure should be used for confirmation of presumptive abnormal acylcarnitines profiles.

**Notes:**
This test is approved for *in vitro* diagnostic use by the U.S. Food and Drug Administration.
Amino Acid Disorders (NBS)

Use: Quantitative measurement of phenylalanine, arginine, citrulline, leucine, methionine, tyrosine, and valine in blood specimens dried on filter paper as an aid in screening newborns for phenylketonuria (PKU) and other amino acid disorders including argininemia, argininosuccinic aciduria, citrullinemia type I, citrullinemia type II, homocystinuria, hypermethioninemia, maple syrup urine disease, benign hyperphenylalanemia, biotin defect in cofactor biosynthesis, biotin defect in cofactor regeneration, tyrosinemia type I, tyrosinemia type II, tyrosinemia type III.

Methodology: The measurement of amino acids uses an Amino Acids, Acylcarnitines, Lysophospholipids, and Succinylacetone tandem mass spectrometry (MS/MS) kit to extract dried blood spots with a solution containing stable-isotope labeled internal standards with subsequent analysis by MS/MS. The response of each analyte relative to its corresponding stable-isotope labeled internal standard is proportional to analyte concentration.

Clinical Significance: Elevated amino acids in newborn blood can be indicative of one or more of several metabolic disorders, collectively known as amino acidopathies. In amino acidopathies, enzymes necessary for the metabolism of certain amino acids are unavailable or have reduced activity. As a result, the concentration of the affected amino acids and alternative metabolites increases in the infant’s body. These excesses can have severe deleterious effects on the infant’s health, including death. Some commonly studied amino acidopathies are:

- **PKU** is a disorder of aromatic amino acid metabolism in which phenylalanine cannot be converted to tyrosine. If untreated, PKU leads to various degrees of mental retardation.
- **Hyperphenylalaninemia** leads to mental retardation and muscular rigidity.
- **Homocystinuria** leads to vascular occlusive disease, osteoporosis, accumulation of homocysteine and methionine, and variable developmental delays.
- **Maple Syrup Urine Disease** (MSUD) is caused by a disorder of branched-chain amino acid metabolism resulting in elevated levels of leucine, isoleucine and valine in the blood. If untreated, lethargy progressive to coma, developmental delay, and convulsions will develop.
- **Tyrosinemia type I** (hereditary tyrosinemia) leads to acute hepatic failure or chronic cirrhosis and hepatocellular carcinoma.
- **Citrullinemia** leads to convulsions, anorexia, vomiting and lethargy, followed rapidly by potentially lethal coma.

Interferences: False negative results for some amino acid disorders can be obtained from blood samples that have been collected too soon after birth, i.e., ≤ 24 hours post-partum; or that have been collected from infants who have not received an adequate protein-containing diet within the 24-hour period prior to sample collection. High nutritional intake of amino acids may interfere with the validity of amino acid concentrations. Variables such as hematocrit, prematurity, and age of infant may affect the interpretation of the values produced. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen,
exposure of specimen to high heat and humidity, contamination of filter paper with feces.

**Reported:** Within 5 working days after receipt

**CPT Codes:** 82139

**Reference Interval:**
- Phenylalanine < 150 µmol/L
- Arginine < 100 µmol/L
- Citrulline < 55 µmol/L
- Leucine < 355 µmol/L
- Methionine < 75 µmol/L
- Succinlyacetone < 2.07 µmol/L
- Tyrosine < 400 µmol/L
- Valine < 330 µmol/L
- Phe/Tyr ratio < 2.0
- Cit/Arg ratio < 6.5
- Leu/Phe ratio < 4.8
- Met/Phe ratio < 1.2

**Interpretation:**
- Pattern of multiple amino acid elevations consistent with TPN: Submit new filter paper specimen at 14 days of age
- Borderline amino acid pattern: Submit repeat specimen as soon as possible
- Abnormal amino acid pattern: Consistent with *specific AA disorder*; Immediate confirmatory testing recommended

**Limitations:** This is a screening test only. A diagnostic procedure should be used for confirmation of presumptive abnormal amino acid profiles.

**Notes:** This test is approved for *in vitro* diagnostic use by the U.S. Food and Drug Administration.

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**X-Linked Adrenoleukodystrophy (X-ALD, NBS)**

**Use:** Quantitative measurement of lysophospholipids C26:0 lysophosphatidylcholine (C26:0-LPC) and C24:0 lysophosphatidylcholine (C24:0-LPC) concentrations in blood specimens dried on filter paper as an aid in screening for X-linked adrenoleukodystrophy (X-ALD).

**Methodology:** The measurement of lysophospholipids uses an Amino Acids, Acylcarnitines, Lysophospholipids, and Succinylacetone tandem mass spectrometry (MS/MS) kit to extract dried blood spots with a solution containing stable-isotope labeled internal standards with subsequent analysis by MS/MS. The response of each analyte relative to its corresponding stable-isotope labeled internal standard is proportional to analyte concentration.

**Clinical Significance:** Elevated C26:0-LPC in newborn blood can be indicative of an inborn error of metabolism (or genetic metabolic deficiency). C26:0-LPC is a primary marker for X-ALD, a progressive metabolic condition which affects the adrenal glands and nervous system. When very long chain fatty acids (VLCFAs) cannot be broken down in the body, they accumulate in the plasma and tissues and may disrupt the myelin of nerve cells. The accumulation of VLCFAs has shown to result in an accumulation of C26:0-LPC as well. X-ALD affects males more severely and is more common in males. 20-40% of women who are carriers have symptoms in adulthood.

There are three different typical presentations of X-ALD:
- *Childhood cerebral ALD (cALD)* can present as early as age 2 but more commonly between ages 4-10. Symptoms start with attention deficit disorder/hyperactivity and can progress with worsening nervous system deterioration, seizures, paralysis, and coma. Left untreated, death occurs within a few years of symptoms appearing.
- *Adrenomyeloneuropathy (AMN)* presents in men around 20 years of age or older. Most, but not all, have adrenocortical insufficiency. About 10-20% will have severe brain and nervous system damage causing an early death. Women who are carriers may develop similar symptoms.
- *Adrenal insufficiency or Addison’s disease* occurs in 90% of males with X-ALD and can present as early as 6 months of age. Addison’s can be managed with corticosteroids but can result in adrenal crisis or coma if left untreated.

**Interferences:** Elevated C26:0-LPC concentrations have been measured in newborn blood spots taken from children diagnosed with Aicardi Goutiéres Syndrome (AGS) leading to false positive results in screening. Chlorhexidine digluconate (an antimicrobial agent that can be found in some disinfectant wipes used to wipe the heel prior to specimen) was found to increase the measured C24:0-LPC and C26:0-LPC concentrations. Amounts >0.03% could theoretically cause false positives. Variables such as hematocrit, prematurity, and age of infant may affect the interpretation of the values produced. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

**Reported:** Within 5 working days after receipt
CPT Codes: 82017

Reference Interval:  
- C26:0-LPC < 0.58 µmol/L  
- C24:0-LPC < 1.60 µmol/L  

Interpretation:  
- C26:0-LPC < 0.58 µmol/L & C24:0-LPC < 1.60 µmol/L: Not consistent with X-ALD  
- C26:0-LPC ≥ 0.58 µmol/L & C24:0-LPC < 1.60 µmol/L (first abnormal X-ALD result): Submit repeat specimen as soon as possible.  
- C26:0-LPC ≥ 0.58 µmol/L & C24:0-LPC < 1.60 µmol/L (second abnormal X-ALD result): Consistent with X-ALD; immediate confirmatory testing recommended.  
- C26:0-LPC ≥ 0.58 µmol/L & C24:0-LPC ≥ 1.60 µmol/L: Consistent with X-ALD; immediate confirmatory testing recommended.

Limitations: This is a screening test only. A diagnostic procedure should be used for confirmation of presumptive abnormal C26:0-LPC and C24:0-LPC profiles.

Notes: This test is approved for in vitro diagnostic use by the U.S. Food and Drug Administration.
Lysosomal Storage Disorders (LSD, NBS)

Use: Quantitative measurement of the activity of the enzymes acid-α-glucosidase (GAA) and α-L-iduronidase (IDUA) in blood specimens dried on filter paper as an aid in screening newborns for the lysosomal storage disorders Pompe Disease and Mucopolysaccharidosis Type 1 (MPS 1) Disease.

Methodology: The quantitative measurement of the activities of the lysosomal enzymes deficient in Pompe disease and MPs 1 (GAA and IDUA, respectively) uses a tandem mass spectrometry kit (MS/MS) to measure the product generated when an enzyme reacts with a synthesized substrate to create a specific product. Enzymatic activities are expressed as micromoles (µmol) per hour (h) per Liter (L) calculated from the peak ratio of each measured product and its associated, stable-isotope mass labeled, internal standard using the calculation:

\[
\text{enzyme activity} = \frac{\text{product intensity}}{\text{IS intensity}} \times \frac{(\text{IS concentration} \times \text{IS volume})}{(\text{Blood volume} \times \text{incubation time})} \times RRF
\]

Clinical Significance: Lysosomal storage disorders result from the dysfunction, deficiency, or absence of a lysosomal enzyme. Affected individuals are unable to metabolize the disease specific substrate of the deficient enzyme, leading to accumulation in the lysosomes of tissues.

Pompe is a disease in which complex sugars cannot be broken down in the lysosomes. There are three forms of Pompe which determines the severity of disease and age of onset.

- **Classic infantile-onset Pompe** begins before or shortly after birth with symptoms that include hypotonia (poor muscle tone), failure to thrive, difficulty breathing, trouble feeding, and respiratory infections.
- **Non-classic infantile-onset Pompe** usually presents by age one and affected babies show signs of delayed motor skills, progressive muscle weakness (myopathy), and difficulty breathing.
- **Late-onset Pompe** may develop in childhood, adolescence, or even adulthood. It is also associated with progressive muscle weakness and difficulty breathing. Symptoms are usually milder and progress more slowly. Infantile forms of Pompe may be fatal within the first year of life if untreated. Even with treatment, children with both forms of infantile-onset Pompe usually pass away in early childhood.

Mucopolysaccharidosis Type 1 (MPS 1) is an inherited condition in which complex sugars cannot be broken down in the lysosomes. MPS 1 comprises a wide spectrum and severity and individuals may be categorized anywhere from severe to attenuated. Age of onset, symptoms, and long-term outcome within this spectrum vary widely. Babies with severe MPS 1 usually develop signs and symptoms within the first year of life and have a rapid disease progression. In the attenuated form, symptoms are generally milder and do not appear until later in childhood. Early signs include umbilical or inguinal hernia, macrocephaly, varying degrees of developmental delay and learning disabilities, and hearing loss. Life expectancy is varied, with affected individuals having a reasonably normal life span while severely affected individuals may die before becoming teenagers. The most common cause of death, even with treatment, is heart or respiratory failure.
Interferences: Elevated hemoglobin level at 18.0 g/dL increases IDUA activity which may result in false negative results for MPS 1. Hemoglobin does not interfere at normal (≤15 g/dL) levels. Glucose levels above 0.25 g/dL can interfere by causing decreased measured GAA activity resulting in false positive results for Pompe disease. Preterm infants typically with very low birthweights have a high risk of hyperglycemia due to glucose infusion. Triglyceride (Intralipid®) can interfere by increasing the measured GAA and IDUA activity. Intralipid® ≤0.15 g/dL does not interfere with GAA and ≤ 0.30 g/dL does not interfere with IDUA activity. High triglyceride concentrations in newborns due to medication effects or pathological conditions may cause a false negative newborn screening result for a specimen with measured GAA or IDUA activity close to the cut-off values. Variables such as hematocrit, prematurity, and age of infant may affect the interpretation of the values produced. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

Reported: Within 5 working days after receipt

CPT Codes: 82657

Reference Interval:
- GAA ≥ 2.5 μmol/L/h
- IDUA ≥ 1.3 μmol/L/h

Interpretation:
- GAA ≥ 2.5 μmol/L/h & IDUA ≥ 1.3 μmol/L/h: Not consistent with LSD
- GAA < 2.5 μmol/L/h & IDUA ≥ 1.3 μmol/L/h (first abnormal Pompe result):
  - Pompe – Submit repeat specimen as soon as possible.
- GAA < 2.5 μmol/L/h & IDUA ≥ 1.3 μmol/L/h (second abnormal Pompe result):
  - Pompe – Possible Pompe disease; further testing is required. Recommend referral to clinical geneticist.
- GAA ≥ 2.5 μmol/L/h & IDUA < 1.3 μmol/L/h (first abnormal MPS 1 result):
  - MPS 1 – Submit repeat specimen as soon as possible.
- GAA ≥ 2.5 μmol/L/h & IDUA < 1.3 μmol/L/h (second abnormal MPS 1 result):
  - MPS 1 – Possible Mucopolysaccharidosis disease; further testing is required. Recommend referral to clinical geneticist.
- GAA < 2.5 μmol/L/h & IDUA < 1.3 μmol/L/h: Specimen results inconclusive. Submit new specimen as soon as possible.

Limitations: Certain late onset forms of Pompe disorder may have GAA enzymatic activity in the normal range and result in a false negative newborn screening result. False positives for Pompe and MPS 1 can result by identifying pseudo deficiencies and carriers. This is a screening test only. A diagnostic procedure should be used for confirmation of presumptive Pompe and MPS 1 diseases.

Notes: This test is approved for in vitro diagnostic use by the U.S. Food and Drug Administration.
Severe Combined Immunodeficiency (SCID, NBS)

Use: Semi-quantitative determination of T-Cell Receptor Excision Circles (TRECs) in dried blood spots (DBSs) as an aid in screening newborns for severe combined immunodeficiency (SCID).

Methodology: Real-time, polymerase chain reaction (rt PCR) amplification is used to detect levels of TREC DNA in DBSs collected from newborn infants using a multiplex rt PCR reagent kit that uses target sequence-specific primers and TaqMan™ probes to amplify and detect targets: TREC, SMN1 exon 7, and RPP30 in a single PCR reaction. DNA is extracted from the dried blood spot using a DNA extraction kit. Each TaqMan™ probe has a unique dye linked to their terminal 5'-end allowing the simultaneous detection of each target if present. The amount of each target present in the DNA is determined by the intensity of fluorescence emitted by each dye released by the degraded probe during amplification and detected by a rt PCR thermocycler. The fluorescence signals are measured and converted into comparative quantitative readouts which are expressed as a function of crossing threshold (Ct) values.

Clinical Significance: The initial protective effects afforded by maternal antibodies transferred during pregnancy and nursing can initially mask the inherent immunodeficiency of the SCID infant during the first weeks of life. Subsequently, SCID infants experience recurrent infections, including pneumonia, bronchitis, meningitis, ear infections, thrush, chronic diarrhea, fail to thrive, and often develop a scaly erythematous rash over the entire body. Left undiagnosed, SCID infants usually die from severe infections within the first year of life. Identification of the asymptomatic infant with a primary immunodeficiency during the first few weeks of life is essential for successful treatment, which generally involves immune reconstitution by hematopoietic cell transplantation (HCT), gene therapy or enzyme replacement (for ADA deficiency); thereafter, morbidity from infections makes treatment much less effective.

Interferences: Do not use heparinized tubes or capillaries to collect blood; heparin is a known inhibitor of PCR. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

Reported: Within 5 working days after receipt

CPT Codes: 81479

Reference Interval: Term (gestational age ≥ 37 weeks)
- TREC threshold cycle (Ct) < 33.5 (i.e., > 1290 TREC copies per 10,000 cells)

Preterm (gestational age < 37 weeks)
- TREC Ct < 33.8 (i.e., > 1048 TREC copies per 10,000 cells)
**Interpretation:**

**Term**
- TREC Ct < 33.5: In-range
- TREC Ct 33.5 – 35.4: Submit repeat specimen as soon as possible
- TREC Ct 33.5 – 35.4 (for a previously abnormal term specimen): Consistent with primary immunodeficiency due to two abnormal screen results; immediate confirmatory testing recommended
- TREC Ct ≥ 35.5: Consistent with primary immunodeficiency; immediate confirmatory testing recommended
- RNAseP ≥ 32.0 Ct: Poor DNA amplification; submit repeat specimen as soon as possible

**Preterm**
- TREC Ct < 33.8: In-range
- TREC Ct ≥ 33.8 and ≤ 40: Submit new filter paper specimen at 37 weeks gestational age
- TREC Ct ≥ 40: Consistent with primary immunodeficiency; immediate confirmatory testing recommended
- RNAseP ≥ 32.0 Ct: Poor DNA amplification; submit repeat specimen as soon as possible

**Limitations:**
This is a screening test only. A diagnostic procedure should be used to confirm a diagnosis of SCID

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Spinal Muscular Atrophy (SMA, NBS)

**Use:** Qualitative determination of the exon 7 SMN1 gene in dried blood spots (DBSs) as an aid in screening newborns for spinal muscular atrophy (SMA).

**Methodology:** Real-time, polymerase chain reaction (rt PCR) amplification is used to detect levels of the exon 7 SMN1 gene in DBSs collected from newborn infants using a multiplex rt PCR reagent kit that uses target sequence-specific primers and TaqMan™ probes to amplify and detect targets: TREC, SMN1 exon 7, and RPP30 in a single PCR reaction. DNA is extracted from the dried blood spot using a DNA extraction kit. Each TaqMan™ probe has a unique dye linked to their terminal 5'-end allowing the simultaneous detection of each target if present. The amount of each target present in the DNA is determined by the intensity of fluorescence emitted by each dye released by the degraded probe during amplification and detected by a rt PCR thermocycler. The fluorescence signals are measured and converted into comparative quantitative readouts which are expressed as a function of crossing threshold (Ct) values.

**Clinical Significance:** The SMN1 gene provides the instructions for making the survival motor neuron (SMN) protein. These proteins are important for the maintenance and continued health of motor neurons, specialized nerve cells that control the muscles used for activities such as breathing, crawling, and walking. SMA is a group of inherited (autosomal recessive) conditions that affect these motor proteins due to changes in the SMN1 gene. The loss of motor neurons leads to progressive muscle weakness and atrophy. The four primary forms are classified based on the severity of the condition and the age at which symptoms begin. In general, forms of SMA with an earlier age of onset are more severe and have a greater impact on motor function.

- **SMA type I** is the most common and sever form. Signs and symptoms often begin within the first six months of life. Severe muscle weakness and poor muscle tone leads to significant development delay. Most are unable to support their heads or sit unassisted. Other signs include breathing problems, difficulty swallowing, poor growth, and joint abnormalities.

- **SMA type II** is generally characterized by muscle weakness that develops between six months and two years of age. Affected individuals can typically maintain a seated position but are unable to walk.

- **SMA type III** is often diagnosed between 18 months and three years of age, with some not developing muscle weakness until adolescence. Affected individuals are able to stand and walk independently, but have increasingly limited mobility with age.

- **SMA type IV** is characterized by mild to moderate symptoms that usually don’t develop until adulthood. Mild motor impairment such as gradual muscle weakness, tremor, twitching, and mild breathing problems are common symptoms.

**Interferences:** Do not use heparinized tubes or capillaries to collect blood; heparin is a known inhibitor of PCR. The following conditions may cause anomalous assay results: poorly collected specimen, spot not uniformly saturated with blood, improperly dried specimen, exposure of specimen to high heat and humidity, contamination of filter paper with feces.

*Last revised 7/1/2022*
Reported: Within 5 working days after receipt

CPT Codes: 81479

Reference Interval:

- Exon 7 SMN1 gene present (SMN1 Ct < 28)

Interpretation:

- Exon 7 SMN1 gene present (SMN1 Ct < 28): Not consistent with SMA
- Exon 7 SMN1 gene absent (SMN1 Ct ≥ 28): Consistent with SMA. Immediate confirmatory testing recommended.
- RPP30 CT ≥ 32.0: Poor DNA amplification; submit repeat specimen as soon as possible.

Limitations:

This is a screening test only. A diagnostic procedure should be used to confirm a diagnosis of SMA.

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Respiratory Pathogen Panel (RPP, Flu, Influenza)

**Use:** Detection and identification of nucleic acids from multiple respiratory viral and bacterial pathogens extracted from nasopharyngeal swabs collected from individuals with clinical signs and symptoms of respiratory tract infection.

**Methodology:** Specimens are tested using the NxTAG® Respiratory Pathogen Panel (RPP), a qualitative PCR amplification assay.

**Clinical Significance:** Respiratory pathogens are responsible for an estimated 80% of respiratory tract infections annually. A respiratory tract infection can be the result of one of dozens of viral or bacterial pathogens. The symptoms caused by these different pathogens are nearly indistinguishable, but how a healthcare provider chooses to treat a respiratory infection may depend greatly on a rapid and accurate diagnosis of the responsible pathogen. These infections can range from a mild, self-limiting illness to severe disease that can cause death. More severe disease is seen in the young, the immunocompromised, and the elderly. The frequency of respiratory viral infections is highest in children under 4 years of age. School children become infected, on average, with 5 to 8 respiratory viruses per year, and adults average 2 to 4 respiratory viruses annually. Bacteria that cause respiratory infections represent approximately 10% of all upper respiratory tract infections. In children, respiratory syncytial virus (RSV) is the most common cause of severe lower respiratory tract infection worldwide. Timely detection of these viruses can lead to initiation of proper antiviral treatment, decreased use of unnecessary antibiotics, reduced transmission of disease from person to person and better clinical outcomes. Further background information, fact sheets, statistics and educational resources may be found at the OSDH Acute Disease Services website.

**Specimen:**
- **Type:** Nasopharyngeal swab
- **Volume:** 1 or 2 swabs
- **Container:** Tube containing viral transport medium (VTM; provided by OSDH PHL) or other appropriate commercial medium (UTM, M4, and M4RT). VTM contains antibiotics and must be stored in the refrigerator prior to and subsequent to specimen collection. Do not use media if cloudy or when past expiration date.
Respiratory virus diagnosis depends on the collection of high-quality specimens, their rapid transport to the testing laboratory and appropriate storage before testing. Training in specimen collection is highly recommended due to the importance of specimen quality. Specimens should be collected preferably within 3 days of onset of clinical symptoms.

**Tip:** If the patient is seated for the procedure, have the patient sit with their head against a wall since patients have a tendency to pull away during the procedure.

**Nasopharyngeal Swab**
1. Label a sterile tube containing 2-3 mL of VTM or other suitable collection media with the patient’s name and date of collection.
2. If the nasal passages have a large amount of mucus, ask the patient to blow their nose before collecting specimen.
3. With the thumb of one hand, elevate the tip of the patient’s nose then gently insert the NP swab into a nostril.
4. Guide the swab straight back (not upwards), along the floor of the nasal passage until it reaches the posterior wall of the nasopharynx; the distance from the nose to the ear gives an estimate of the distance the swab should be inserted.
   **Note:** Do not force the swab – if an obstruction is encountered during insertion, try the other nostril.
5. Rotate the swab by firmly brushing against the nasopharynx several times.
6. Immediately, place swab into tube containing VTM or other suitable collection media.
7. Break-off or cut excess shaft of swab so that tube can be capped.
8. Replace the cap of the tube; tighten and wrap with Parafilm to prevent leakage of contents of tube during transport.
9. Place tube in plastic biohazard bag and insert completed requisition form in outer pouch of the bag.
10. Refrigerate (2-8°C) immediately.

**Interferences:**
Cotton swab; Calcium alginate swab (shown to inhibit PCR); Wooden shaft swab

**Special Instructions:**
Only synthetic (nylon, rayon or Dacron)-tipped swabs with plastic or aluminum shafts are acceptable.

**Note:** Submission of specimens from patients with suspected influenza A/H5 or Eurasian H7 requires OSDH Acute Disease Service pre-approval to verify the patient meets clinical case criteria, including travel history to an area of novel influenza circulation.

**Shipping:**
Store and ship specimens refrigerated (2-8°C) for delivery within 7 days of collection. If delivery will be delayed for more than 7 days, specimens should be frozen at -70°C or colder and shipped with dry ice.
1. Place specimen in round cardboard container and place this in Styrofoam mailer box (both containers are supplied by OSDH PHL for respiratory pathogen surveillance).
2. Remove frozen cold pack from freezer and place in the mailer with specimen then fill the mailer with packing material.

3. Mailers are returned to submitting sites with fresh tubes of VTM corresponding to the number of specimens submitted. If additional VTM is required, fill-out the order form and return with the specimens in the mailer.

4. Send via OSDH PHL courier service.

Rejection Criteria:
- Incorrect collection device (cotton, wooden, or calcium alginate swab) or media
- Nasal swab
- Throat swab
- Swab without transport medium
- Received > 7 days from time of collection and not frozen at -70°C or colder
- Specimen at ambient temperature
- Other criteria as outlined in Specimen Rejection section of this Test Directory

Reported: Within 5 working days of receipt

CPT Codes: 87633, 87581, 87486

Normal/Abnormal Results:
- Pathogen Not Detected
- Adenovirus Detected
- Chlamydophila pneumoniae Detected
- Coronavirus OC43 Detected
- Coronavirus 229E Detected
- Coronavirus HKU1 Detected
- Coronavirus NL63 Detected
- Human Bocavirus Detected
- Human Metapneumovirus Detected
- Influenza Detected; presumptive positive pending additional testing
  o For specimens in which influenza virus is detected by RPP, a preliminary report will be issued, pending testing by the OSDH PHL using the CDC Human Influenza Virus rRT-PCR Diagnostic Panel.
  o For specimens in which variant or potential novel influenza viruses are detected by the Human Influenza Virus rRT-PCR Diagnostic Panel, a preliminary report will be issued, pending further characterization by the CDC.
- Mycoplasma pneumoniae Detected
- Parainfluenza Virus 1 Detected
- Parainfluenza Virus 2 Detected
- Parainfluenza Virus 3 Detected
- Parainfluenza Virus 4 Detected
- Respiratory Syncytial Virus A Detected
- Respiratory Syncytial Virus B Detected
- Rhinovirus/Enterovirus Detected
- Indeterminate, potential PCR inhibitors/poor sample quality; suggest additional sample submission

Interpretation: The RPP test is indicated to aid in the detection and identification of viral and bacterial agents causing respiratory tract infections in symptomatic adult and
pediatric patients, who are either hospitalized, admitted to emergency departments or who are outpatients with suspected respiratory tract infection. The results of this test should not be used as the sole basis for diagnosis, treatment, or other patient management decisions. The use of additional laboratory testing and clinical findings must be taken into consideration in order to obtain the final diagnosis of respiratory tract infection.

**Limitations:**
Negative results in the setting of a respiratory illness may be due to infection with pathogens not detected by this test or lower respiratory tract infection that is not detected by a nasopharyngeal swab specimen. Positive results do not rule out co-infection with other pathogens. The agent(s) detected may not be the definite cause of disease.

**Notes:**
This test is approved for *in vitro* diagnostic use by the U.S. Food and Drug Administration.
Syphilis – Treponemal Screen with Reflex to RPR, with Titer and TP-PA Confirmation, as Indicated

Use: This test comprises a set of serologic treponemal and non-treponemal assays that are used in a “reverse sequence algorithm” as an aid in the diagnosis of syphilis. The BioPlex 2200’s Syphilis Total & RPR Assay qualitatively detects antibodies (IgG and IgM) to *Treponema pallidum* in human serum.

Methodology: The reverse sequence algorithm for syphilis testing initially uses a qualitative treponemal screening assay to detect antibodies (IgG and IgM) to *T. pallidum* in human serum. Screen-reactive specimens are reflexed to a semi-quantitative Rapid Plasma Reagin (RPR) flocculation test for the detection of reagin antibodies and endpoint titer determination. RPR-negative specimens are reflexed to the qualitative *T. pallidum* Particle Agglutination (TP-PA) treponemal test to verify the initial screen-reactive result.

Clinical Significance: *T. pallidum*, the etiological agent of syphilis, induces the production of at least two types of antibodies in human infection: anti-treponemal antibodies that can be detected by treponemal antigen, and anti-non-treponemal antibodies (reagin) produced as the result of reaction to cellular breakdown due to infection that can be detected by RPR antigen. Diagnosis of syphilis relies on the use of two types of serologic tests: non-treponemal and treponemal. The use of only one type of serologic test is generally insufficient for diagnosis because each test has limitations: false-positive RPR results may occur in persons without syphilis and treponemal tests are unable to distinguish between recent and past infections.

Non-treponemal test titers usually correlate with current disease activity, and the results are reported quantitatively. Sequential non-treponemal test endpoint titers can be used to monitor effectiveness of treatment. A 4-fold change in titers (e.g., from 1:16 to 1:4 or from 1:8 to 1:32) is considered necessary to demonstrate a clinically significant difference. Non-treponemal tests usually become non-reactive with time after treatment. In some patients, however, non-treponemal antibodies can persist at a low titer for a long period of time (i.e., "serofast reaction"), sometimes for the life of the patient. By contrast, reactive treponemal tests usually remain reactive for the life of the patient. While rare, non-treponemal tests can also produce false negative results, particularly during tertiary syphilis, due to the “prozone effect” whereby the reaction is overwhelmed by excess antibody.

Traditional serologic screening for syphilis initially uses non-treponemal testing, with confirmation of reactive results using a treponemal test; however, reverse sequence algorithms, which initially use treponemal testing, with confirmation of reactive results using a non-treponemal test, are gaining popularity, and offer certain advantages analytically and clinically.

- Detects early primary and treated infection that might be missed with traditional algorithm
- Automated and lower cost in high-volume settings
- No false negatives as a result of prozone reaction

Because the treponemal screen cannot differentiate active versus previously treated infections, all screen-reactive specimens are reflexed to a non-
treponemal test with titer to define those with active infections. False-positive screen results (i.e., initial reactive treponemal screen with negative reflexed non-treponemal test) are resolved by further testing using a second treponemal test.

Further background information, fact sheets, statistics and educational resources may be found at the OSDH Acute Disease Services website.

**Specimen:**
- **Type:** Whole blood collected in serum separator tube (SST)
- **Volume:** 2 mL serum; draw a sufficient amount of blood to yield the necessary serum volume, around 4mL whole blood. Minimal acceptable volume for testing is 1 mL serum (potential rejection if reflexive testing exhausts sample).
- **Container:** SST or separated serum poured into sterile, plastic, screw-cap tube
- **Collection:** Each facility should follow its guidelines for venipuncture collection of blood/serum. Following collection of blood, invert tube gently no more than 8 times then allow blood to clot in an upright position for at least 30 minutes and no more than 60 minutes then centrifuge at 3000 rpm for 10 minutes.
- **Interferences:** Bacterial contamination, hemolysis, lipemia
- **Special Instructions:** The RPR has utility in monitoring the effectiveness of treatment by comparing sequential RPR titer results. Because treponemal antibodies are generally detectable for the lifetime of the patient after syphilis infection, sera from previously-treated patients will remain reactive by the treponemal screen, and will be automatically reflexed to RPR with titer. Therefore, when monitoring the effectiveness of treatment, specific requests for an RPR titer should not be needed. RPR titer requests on screen-negative specimens require advance notice of the OSDH Public Health Laboratory. Also, such requests must be clearly indicated on the Laboratory Test Requisition Form.

**Shipping:**
- Separated serum (in spun SSTs or poured-off serum) to be received within 5 days of date of collection (DOC) when stored/transported at 2-8°C
- If specimen will be > 5 days from DOC when received at the testing laboratory, pour serum into sterile, plastic, screw-cap tube and freeze at -20°C or colder, then ship on dry ice; specimens may be stored at -20°C or colder for a maximum of 14 days from DOC

**Rejection Criteria:**
- Blood collected in tube other than SST
- SST received unspun at 2-8°C, and > 2 days from DOC
- Specimen received at ambient temperature and > 24 hours from collection
- Specimen received at 2-8°C and > 5 days from DOC
- Specimen received frozen and >14 days from DOC
- SST received frozen
- QNS (1 mL allows for TP-N screen testing only)
- Specimen too old for TP-PA; a TP-PA test cannot be performed after 7 days from DOC regardless of shipping/storage temperatures
- Specimen subjected to > 1 freeze/thaw cycle (TP-PA test only)
- Bacterial contamination
- Extensive hemolysis

Last revised 7/1/2022
• Extensive lipemia
• Other criteria as outlined in Specimen Rejection section of this Test Directory

Reported: Within 7 working days from receipt
CPT Codes: 86592, 86593, 86780

Normal/Abnormal Results:
Treponemal screen:
• Non-reactive
• Reactive
RPR:
• Non-reactive
• Reactive
RPR Titer:
• 1:1 to ≥ 1:256 (at sequential two-fold dilutions)

TP-PA:
• Non-reactive
• Reactive
• Inconclusive

Interpretation:
Treponemal Screen:
• Non- Reactive: A non-reactive treponemal screen result alone suggests the absence of a current syphilis infection; however, it does not exclude the possibility of syphilis infection. T. pallidum antibodies may be undetectable in some stages of infection and in some clinical conditions. If recent exposure is suspected, re-draw sample in 2-4 weeks.
• Reactive: Specimens with reactive treponemal screen results are tested by RPR to determine potential current or past infection.

RPR:
• Reactive: Specimens with reactive RPR results are tested by semi-quantitative RPR to determine the endpoint titer.
• Non- Reactive: Specimens with non-reactive RPR results are tested by TP-PA to confirm the initial treponemal (TP-N) result.

RPR Titer:
• Specimens with endpoint titers ≥ 1.1 are consistent with syphilis infection, either current or past. Patients should be evaluated clinically to identify signs, symptoms, or past history of infection.
• RPR titers can be used to monitor a patient’s response to treatment. RPR titers usually become non-reactive with time, following successful treatment.
  - A ≥ 4-fold decline in titers at 12 months signifies successful treatment.
  - A < 4-fold decline in titers at 12 months indicates treatment failure or re-infection, or “serofast” condition.

TP-PA:
• Reactive: A reactive TP-PA test result, together with a reactive TP-N and non-reactive RPR, is consistent with past or potential early syphilis infection.
• Non- Reactive: A non-reactive TP-PA result, together with a reactive TP-N and non-reactive RPR, is considered inconclusive for syphilis infection, likely signifying a false positive TP-N or potentially an early infection.
• Inconclusive: Patients with reactive TP-N, non-reactive RPR, and inconclusive TP-PA results should have blood drawn in 2-4 weeks for re-testing and/or syphilis testing performed by an alternative method.

Limitations:

Treponemal screening:
• All treponemal tests tend to remain reactive for the life of a treponeme-infected individual, even after treatment. Treponemal antibody titers correlate poorly with disease activity; therefore, they should not be used to evaluate response to therapy. Because of the persistence of reactivity, treponemal tests are of no value in determining relapse or re-infection in a patient who has had a reactive TP-PA result.
• False positives, especially in low prevalence populations, and false negatives may occur.
• Interference may be encountered with certain sera containing non-specific and/or unidentified reactive substances.
• Test results from specimens obtained from immunosuppressed patients should be interpreted with caution.
• Assay interference due to possible circulating antibodies against pinta, yaws, and bejel has not been evaluated.

RPR:
• False negative reactions may occur, particularly in tertiary syphilis but also in early primary and late latent stages.
• Rarely, false negative results arise from a phenomenon called “prozone effect”, whereby the reaction is overwhelmed by excess antibody.
• False positive reactions occur occasionally in samples from individuals with a history of drug abuse, with febrile illness, women who are pregnant or with diseases such as lupus erythematosus, malaria, vaccinia, mononucleosis, leprosy, viral pneumonia, and after smallpox vaccinations.
• Pinta, yaws, bejel and other treponemal diseases produce positive reactions in this test.

TP-PA:
• TP-PA may be reactive in a small percentage (< 1%) of normal or healthy persons; these false positive results are often transient, and their cause is unknown.
• TP-PA may be reactive in persons from areas where yaws or pinta, bejel, and other treponemal diseases were, or are, endemic.
• Samples from patients with HIV, leprosy, toxoplasmosis, H. pylori, cardiovascular disease, and drug addiction may react, on occasion, causing false positive or indeterminate results.
• TP-PA is less sensitive than the fluorescent treponemal antibody absorption (FTA-ABS) test in untreated primary syphilis but compares favorably in all other stages of syphilis.

In accord with all diagnostic methods, a final diagnosis should not be made on the result of a single test, but should be based on a correlation of all laboratory test results with other clinical findings.

Notes:
These tests are approved for in vitro diagnostics use by the U.S. Food and Drug Administration.
Syphilis Reverse Sequence Algorithm

BioPlex 2200 TP-N Treponemal Screen

- Non-reactive
  - If recent exposure is suspected, retest in 2-4 weeks. If patient remains at risk consider re-testing in 3-12 months
- Reactive
  - Confirm with Non-treponemal Rapid Plasma Reagin (RPR)

   Confirm with Non-treponemal Rapid Plasma Reagin (RPR)

   - Reactive
     - Confirm Reactive TP-N Screen by Treponemal TP-PA
   - Non-reactive
     - Syphilis unlikely; stage disease by:
       - Sexual history
       - Syphilis treatment history
       - Physical exam
       - Treat according to CDC guidelines
       - Monitor Treatment Using RPR Endpoint Titers
         - ≥ 4-fold decline in titers at 12 months → Cure
         - < 4-fold decline in titers at 12 months → Treatment failure, re-infection, or serofast condition; follow recommended guidelines

   RPR Endpoint Titer

   - Reactive
     - Syphilis likely; stage disease by:
       - Sexual history
       - Syphilis treatment history
       - Physical exam
       - Treat according to CDC guidelines
       - Monitor Treatment Using RPR Endpoint Titers
         - ≥ 4-fold decline in titers at 12 months → Cure
         - < 4-fold decline in titers at 12 months → Treatment failure, re-infection, or serofast condition; follow recommended guidelines
   - Non-reactive or Inconclusive
     - Syphilis unlikely. Most likely a false-positive reaction. If recent exposure is suspected, re-test in 2-4 weeks.
OUTSOURCED TEST LIST

These individual tests are currently being referred to other laboratories from the Public Health Lab. In some cases, the specimens are collected and sent to the PHL, where they are subsequently sent to the reference lab. In other cases, the submitter will work directly with the reference lab for all phases, including the materials, courier services, analysis and reporting. Reporting times are provided as an approximation only, as the samples require more time for transit between the laboratories. Reference laboratories that are currently performing these tests may have different specimen collection, storage and transport requirements than provided here. For specific testing requirements please email the PHL at PublicHealthLab@health.ok.gov.

Clinical Pathology Laboratories (CPL, https://www.cpllabs.com)

Send specimens directly to CPL using the CPL process.

- Pap Smear, thin prep
- AFB Cultures
  - CPL does all TB smear and cultures from raw specimens. If a raw specimen grows up a culture that is identified as a first time positive MTBC, then they will perform susceptibilities on it.
- Order Code 1374: Blood Film
- Order Code 3745: Malaria Detection /Speciation by PCR
- Order Code 6096: B. Pertussis /Parapertussis by PCR
- Order Code 6126: Acid Fast Smear and Culture (will need to go to Kansas PHL to complete susceptibilities and they will submit to CDC)
- Order Code 5273: MTB PCR, Respiratory
- Order Code 2821: MTB PCR, Non-Respiratory
- Order Code 6127: Isolate Culture, Anaerobic
- Order Code 6010: Culture, Anaerobic
- Order Code 3880: Stool Pathogen Panel by PCR
- Order Code 7045: Culture, Stool with STEC; positive results will need OSDH submission
- Order Code 6118: Shiga toxin-producing E. Coli (STEC) by EIA; positive results will need OSDH submission

Oklahoma Animal Diagnostic Disease Laboratory (OADDL, https://vetmed.okstate.edu/oaddl/index.html)

- Rabies testing
- Submission instructions and forms located at https://vetmed.okstate.edu/oaddl/rabies-testing.html.

Minnesota Public Health Laboratory (https://www.health.state.mn.us/about/org/phl/index.html)

- CRE/CRPA/CRA
- Antibiotic Resistant Infections/ARLN
- Haemophilus influenzae (HAI)
- Neisseria meningitidis (HAI)
Nebraska Public Health Laboratory (https://www.nphl.org)
Gastrointestinal Panel
E. coli Culture; for epidemiological survey (required submission)  GIP
Salmonella Culture; for epidemiological survey (required submission)  HECCU
Campylobacter, Yersinia, Vibrio Culture; for epidemiological survey (required submission)  ORGSS
Organism Archival  ORGISO
Whole Genome Sequencing for PulseNet Organisms  NPHLBK
Whole Genome Sequencing, other  WGS
Bioterrorism Agent Identification from bacterial isolate or viral clinical specimen  WGSHAI
Unknown isolate identification  BTID
Fungal ID  ORGCU
Yeast ID  FUNID
Bordetella PCR  BPD
Simple Isolate Identification  YID
Blood Culture  SIMID

Kansas Health and Environmental Laboratory (https://www.kdhe.ks.gov/908/Laboratories)
Tuberculous Testing – Clinical Specimen
Tuberculous Testing – Isolate

Centers for Disease Control

- West Nile Virus
- St. Louis Encephalitis
- Heartland Bourbon Virus
- Chagas Disease (Blood parasites)