Low sensitivity of BinaxNOW® RSV in infants.

Roy P. Zuurbier1,2, Louis J. Bont1, Annefleur C. Langedijk1, Mirjam Hamer1, Koos Korsten1, Simon B. Drysdale3, Matthew D. Snape3, Hannah Robinson3, Andrew J. Pollard3, Federico Martinón-Torres4,5, Carmen Rodríguez-Tenreiro Sánchez4, Alberto Gómez-Carballa4,5, Ana Isabel Dacosta-Urbieta4,5, Terho Heikkinen6, Steve Cunningham7, Marlies A. van Houten2, Joanne G. Wildenbeest1, for the RESCEU Investigators

**Affiliations**:

1 Department of Paediatric Immunology and Infectious Diseases, Wilhelmina Children’s Hospital/University Medical Center Utrecht, Utrecht, The Netherlands;

2 Spaarne Gasthuis Academy, Hoofddorp and Haarlem, The Netherlands;

3 Oxford Vaccine Group, Department of Paediatrics, University of Oxford, and the NIHR Oxford Biomedical Research Centre, Oxford, United Kingdom;

4 Translational Pediatrics and Infectious Diseases, Pediatrics Department, Hospital Clínico Universitario de Santiago de Compostela, Santiago de Compostela, Spain.

5 Genetics, Vaccines and Infections Research Group (GENVIP), Instituto de Investigación Sanitaria de Santiago, Santiago de Compostela, Spain.

6 Department of Pediatrics, University of Turku and Turku University Hospital, Turku, Finland;

7 Centre for Inflammation Research, University of Edinburgh, United Kingdom;

## Correspondence to:

Corresponding author

J.G. Wildenbeest, MD, PhD

Department of Paediatric Immunology and Infectious Diseases

Wilhelmina Children’s Hospital/University Medical Center Utrecht

KC.03.063.0, P.O. Box 85090

3508 AB Utrecht, The Netherlands

Email: [j.g.wildenbeest@umcutrecht.nl](mailto:j.g.wildenbeest@umcutrecht.nl)

Tel: +31 88 7563776

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# Abstract

**Background:** Respiratory syncytial virus (RSV) is a major cause of hospitalisation in infants. Early detection of RSV can optimise clinical management and minimise use of antibiotics. BinaxNOW® RSV (BN) is a rapid antigen detection test (RADT) which is widely used. We aimed to validate the sensitivity of BN in hospitalised and non-hospitalised infants against the gold standard of molecular diagnosis.

**Methods:** We evaluated the performance of BN in infants with acute respiratory tract infections (ARTIs) with different degrees of disease severity. Diagnostic accuracy of BN test results were compared to molecular diagnosis as reference standard.

**Results:** 162 respiratory samples from 148 children from October 2017 to February 2019 were studied. Sixty-six (40.7%) samples tested positive for RSV (30 hospitalisations, 31 medically attended episodes not requiring hospitalisation and five non-medically attended episodes). Five of these samples tested positive with BN, leading to an overall sensitivity of BN of 7.6% (95% CI 3.3-16.5%) and a specificity of 100% (95% CI 96.2-100%). Sensitivity was low in all subgroups.

**Conclusion:** We found a low sensitivity of BN for point-of-care (POC) detection of RSV infection. BN should be used and interpreted with caution.

**Clinical Trials Registration:** NCT03627572, NCT03756766

# Keywords

Respiratory syncytial virus, diagnosis, antigen detection, point-of-care test, birth cohort

# Background

Respiratory syncytial virus (RSV) is the most common pathogen identified in young children with acute lower respiratory tract infections (ALRI) [1]. RSV is a major cause of hospital admissions with an estimated hospitalisation rate of 19.19 per 1000 children under the age of one year worldwide [2][3][4].

Reliable rapid diagnostic tests are needed to improve patient management regarding unnecessary use of antibiotics [5,6] and to enable cohorting of hospitalised children in the RSV season. An evolving role for rapid tests is as a companion diagnostic for the development of novel RSV antivirals and evaluation of efficacy of new RSV vaccines, for which it will be important to have both a reliable and rapid RSV test.

Currently, the gold standard for RSV diagnosis is laboratory based reverse transcriptase polymerase chain reaction (RT-PCR). This technique is highly sensitive and specific, but is time-consuming, relies on trained laboratory staff and typically has a long lag to provide results to clinical teams (24-48 hours), negating its clinical value. Whilst in recent years point-of-care tests (POCTs) utilising molecular methods have been developed, they remain expensive and consequently are not widely adopted in clinical practice. A range of alternative POCTs are available and used in clinical practice which are fast, easy to use by non-laboratory personnel, and often less expensive compared to routine RT-PCR. The turnaround time of most POCTs is less than one hour. RSV rapid antigen detection tests (RADTs) are POCTs with high specificity, but a wide range in sensitivity, partially depending on viral load [7,8]. Two recent meta-analyses showed a pooled sensitivity of 81% (95% CI, 78% to 84%)[9] and 75.9% (95% CI, 73.1% to 78.5%) for RSV RADTs in general in children compared with RT-PCR[10]. There is large heterogeneity in these studies, which are often sponsored by the tests’ manufacturer. In addition, many studies are performed retrospectively and in hospitalised children, while diagnostics are not evaluated at point-of-care. As a result, sensitivity of individual studies vary considerably from 41.2%[11] to 83% [12].

The aim of the current study was to evaluate for the first time the performance of the RADT BinaxNOW® RSV (BN; Alere Inc., Waltham, MA, USA) [13] to diagnose RSV infection in infants with acute respiratory tract infection (ARTI) in different clinical settings in a large international prospective clinical study.

# Methods

## Study population

The study population consisted of infants (<1 year old) with an acute respiratory tract infection (ARTI) who were participating in the REspiratory Syncytial virus Consortium in EUrope (RESCEU) [14] birth cohort study or the case-control study during two RSV seasons between 1 October 2017 and 28 February 2019. RESCEU is an EU-funded consortium study aiming to define RSV burden of disease in Europe. The current study was performed in the Netherlands, Spain and the United Kingdom. The birth cohort study consists of healthy infants prospective followed up from birth. In their first year of life, during the RSV season(s), a RSV test was performed each time they experienced any symptoms of an ARTI. Infants were tested by a trained member of the study team at home or at the clinic and could be tested during more than one separate episode. The case-control study is a cross-sectional study performed in infants admitted to hospital, attending emergency departments (ED) or general practitioners (GP) with symptoms of ARTI. Details of the study design and procedures can be found at clinicaltrials.gov (NCT03627572, NCT03756766). Informed consent was obtained from the parents of all study participants. All children with ARTI were eligible for RSV POC testing. For practical reasons not all children could be tested with both the BN and the reference test. For this analysis we included only samples on which both BN and a molecular reference test were performed (Figure 1).

Data on age, sex, comorbidities, duration of symptoms of ARTI and level of medical care needed (hospitalised, MA-ARTI and non-MA ARTI) were obtained by completing questionnaires and case report forms (CRF). We defined 3 levels of medical care: infants with ARTI who were hospitalised (including a subgroup of infants who were admitted to the pediatric intensive care unit (PICU), infants with medically attended (MA) ARTI, defined as infants who were seen at the ED or GP, but were not admitted to the hospital, and infants with non-MA ARTIs who did not see any doctor during the entire ARTI episode. In addition the ReSViNET score was used to determine disease severity. (Supplementary Table 1)[15].

**Study procedures**

A nasal flocked swab (FLOQSwab™, Copan diagnostics) was collected by a trained member of the study team and directly stored in one of the following viral transport media: MicroTest™ M4RT® (Remel, 3 ml) or UTM™ (Copan diagnostics, 3 ml). A maximum of 400 μl of the viral transport medium was used for POC testing. Samples were transported at room temperature. BN test was performed within four hours. The remaining sample was stored in aliquots at −80 °C or discarded if RSV was negative (infant case-control study). The molecular reference test was either Xpert® Xpress Flu/RSV assay (Cepheid, Sunnyvale, CA, USA)[16] or Alere™ i RSVassay (Alere Inc., Waltham, MA, USA)[17] depending on availability of the tests at participating sites. The staff had hands-on-training on how to sample patients and how to use the available POC tests before the start of the studies.

All tests were performed according to the manufacturer’s instruction. In short, for the BN assay 100 μl of the viral transport medium mixed with the swab was aspirated with the included transfer pipette. The BN card was opened and the entire content of the filled pipette was slowly expelled onto the sample pad of the device. A timer was set at 15 minutes to avoid inaccurate test results. After these 15 minutes test results were read immediately from the BN test card, by visual inspection (Supplementary text).

## Statistical analysis

A positive molecular test for RSV was defined as the reference outcome. BN results were compared with the reference test to measure diagnostic accuracy. Dichotomous variables were compared using chi-square or Fisher’s exact test as appropriate. P values <0.05 were considered statistically significant. Univariate logistic regression analysis was used to determine whether false negative BN tests results were associated with age, duration of symptoms, or ReSViNET score. Statistical analyses were conducted using IBM SPSS Statistics for Windows, Version 25.0 (IBM corp., Armonk, NY, USA).

# Results

In total, 162 nasal swabs from 148 infants with symptoms of ARTI were tested with BN and the reference test. 134 infants were tested once and 14 infants were tested twice during two separate ARTI episodes. Of the 162 samples, 36 (22.2%) were from hospitalised infants, 83 (51.2%) from infants who had a MA ARTI, 41 (25.3%) from infants who had a non-MA ARTI, and two samples were from infants with missing data about level of care. Baseline characteristics are summarised in Table 1. Median age at moment of ARTI was 84 days (IQR, 39 to 178 days). 98 (78.4%) of the swabs were taken within five days after the start of symptoms. Four infants had comorbidities, including: prematurity, cardiomyopathy and congenital bronchomalacia.

There were 66 RSV infections detected in 162 nasal swabs (40.7%) of which five (7.6%) tested positive by BN (Figure 1). All BN positive samples also tested positive by the reference test. One infant had two RSV positive episodes (of which one episode was BN positive). Test characteristics of BN are shown in Table 2. Sensitivity was not significantly related to age, duration of symptoms, disease severity or level of care required (Table 3). Sensitivity was higher in the subgroup of infants admitted to a PICU compared to other infants (22.2% versus 5.3%), although this difference was not statistically significant (p=0.134). Univariate logistic regression analysis confirmed low sensitivity of BN in all subgroups.

## Test procedure

Because sensitivity of BN was lower than previously published, we carefully analyzed our procedures. Uniform standard operating procedures (SOP) regarding sample collection and POC testing with BN was written and distributed to all participating centers prior to the start of the study. In the course of the study, BN test procedure was thoroughly evaluated, including a careful analysis by employees from the manufacturer (Supplementary text). No technical explanation was found for the low sensitivity of BN.

# Discussion

In this study we have shown that the overall sensitivity of BN was only 7.6% (95% CI, 3.3% to 16.5%) in infants with ARTIs of varying clinical severity (hospitalised, MA-ARTI and non-MA ARTI). Highest sensitivity was seen in infants admitted to the PICU, although this was still only 22%. The sensitivity of BN in the current study is remarkably lower than previously reported. Two recent meta-analyses showed a pooled sensitivity of BN of 81% (95% CI, 74% to 87%)[9] and 72.2% (95% CI, 65.2% to 79.1%) [10], respectively. Individual studies showed a sensitivity varying from 41.2% to 83% in children when compared to RT-PCR [7,11,12,18–21]. Characteristics of these studies are shown in Table 4. The sample size of the studies varied between 66 and 720 participants with various age limitations. The 4 larger studies were all performed in children under the age of 3 years with nasopharyngeal aspirate (NPA) or nasal wash (NW) and showed a sensitivity of 63-83% compared to RT-PCR. The 3 other studies were smaller and mainly used nasopharyngeal swab (NPS) as sampling method. The sensitivity of these studies varied between 41% and 80% compared to RT-PCR. The sample size of our study was 162, which is comparable but still smaller than the 4 larger studies. The low sensitivity in our study compared with the other studies is striking and necessitated a thorough analysis of the differences with the other studies and other possible explanations for the low sensitivity observed in our study. One of the differences between our study and the other studies is that we also included infants with non-MA ARTI while other studies evaluated the performance of BN mainly in hospitalised children.

We reflected on possible explanations for the low sensitivity observed in our study. We considered that reduced disease severity could be linked to lower viral loads in infants recruited [22] and subsequently a lower sensitivity. However, even in the group of infants with severe disease who were admitted to hospital, sensitivity was less than 10%. Other factors that might influence sensitivity are age and duration of symptoms as both are probably related to viral load. False negative results are more often seen with an increasing age [20] or longer duration of symptoms [7,20,21,23]. However, all children in our study were younger than 1 year of age and the majority (78.4%) were tested within 5 days after the start of symptoms, thus this could not explain the low sensitivity.

We also considered sampling methods as a cause of the low sensitivity in our study. Compared to the other published studies we used nasal flocked swabs in 3 ml UTM or M4RT instead of NPS in 1 or 1.5 ml viral transport medium or NW/NPA. We have previously shown that nasal aspirates are associated with higher sensitivity than non-flocked swabs to detect RSV by PCR [24]. Other studies have shown that sensitivity was comparable between NW or NPA, and NPS with flocked swabs for detection of viruses by PCR [25,26]. In addition, Blaschke et al. [27] showed that midturbinate (nasal) flocked swabs are comparable to NPS for quantitative detection of RSV in infants, showing similar viral loads. While no studies have previously compared the performance of rapid antigen testing in nasal swabs compared to aspirates or washes, we do not think that sampling methods fully explain the low sensitivity of BN. Temporal evolution of the binding site of the RSV fusion protein may have changed over time with loss of binding to the BN antibody, ultimately resulting in decreased sensitivity. We have limited information on viral sequences in our patient population. Since most of the known antigenic sites of the RSV fusion protein are generally well conserved we believe this explanation for the low sensitivity of BN is unlikely[28]. Taken together, we have not found a methodological or biological explanation for the low sensitivity of BN in our study compared to previous reports.

A strength of our study is that it is part of a large prospective clinical study with a well-defined study population performed in different centers across Europe. Our study is based on clinical endpoints rather than virological, ensuring a low risk of bias. Another strength is that we evaluated the performance in different clinical settings with a wide range of disease severity. This enabled us to evaluate test performance not only in a hospital setting, but also in primary care and emergency departments. As the availability of POCTs is increasing, these tests might also be introduced into outpatient settings. Our study added valuable information about the sensitivity in different clinical settings, which is important to know before implementing POCTs in these settings. Lastly, we evaluated the test procedure of BN thoroughly during the study period to avoid any bias due to incorrect handling of the tests (see Supplemental text). We also worked closely with the manufacturer of BN to ensure we used the correct procedure.

There are several limitations to our study. First, we did not compare viral loads between true positive and false negative test results. Alere i and Xpert Xpress are qualitative tests. RADT sensitivity depends on viral load [7,8] while viral load is positively associated with disease severity [22]. In our study, sensitivity in the infants who were admitted to the PICU was higher, but this was still only 22% and not statistically significant higher compared to other clinical settings. Second, in our study we used the Alere i RSV and Xpert Xpress Flu/RSV as reference standards while RT-PCR has been used as the gold standard in some other studies [7,11,12,18–20]. These new molecular assays are reported to have a sensitivity (93%-100%) and specificity (96%-100%) comparable with RT-PCR[29–34]. Third, we have not subtyped RSV. RSV genotype-B infection has been associated previously with false-negative results of RADT [20]. Fourth, we used nasal swabs and not nasopharyngeal swabs. Viral loads could be lower in this anterior nasal region and thus affect sensitivity. However, midturbinate flocked swabs have shown to be comparable for quantitative detection of RSV in infants [27]. Last, we have not analysed why BN performed sub-optimally. It is possible that both transport media used in this study, although recommended by the manufacturer, had some form of inhibitory effect on the test.

In conclusion, we have performed the first international prospective population-based study to define the sensitivity of a rapid antigen detection test for RSV infection. We showed that BN has low sensitivity in infants with ARTI in different clinical settings when collected with a nasal flocked swab in UTM or M4RT transport medium. Even in infants with most severe disease sensitivity was only 22%. Our study indicates that BN should be used and interpreted with caution. More studies are needed to determine variation in sensitivity with different sampling methods. Physicians should consider using more sensitive molecular assays for RSV POC testing.

# Notes

## Study group members

The RESCEU investigators are as follows: Roy Zuurbier; Louis Bont; Annefleur Langedijk; Mirjam Hamer; Koos Korsten; Marlies van Houten; Joanne Wildenbeest (University Medical

Center Utrecht); Simon Drysdale; Matthew Snape; Hannah Robinson; Andrew Pollard (University of Oxford);, Federico Martinón-Torres; Carmen Rodríguez-Tenreiro Sánchez; Alberto Gómez-Carballa; Ana Dacosta-Urbieta (Servicio Galego de Saude); Terho Heikkinen (Turku University Central Hospital); Steve Cunningham, Harish Nair, Harry Campbell, (University of Edinburgh); Peter Openshaw (Imperial College London); Philippe Beutels (Universiteit Antwerpen); Eva Molero (Synapse); Adam Meijer (National Institute for Public Health and the Environment); Thea Kølsen Fischer (Statens Serum Institut); Maarten van den Berge (Academisch Ziekenhuis Groningen); Carlo Giaquinto (PENTA Foundation); Mark Esser (AstraZeneca); Charles Knirsch (Pfizer); Amanda Leach (GlaxoSmithKline); Scott Gallichan, (Sanofi Pasteur); Jeroen Aerssens (Janssen); and Brian Rosen (Novavax).

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## Conflict of interests

LJB has regular interaction with pharmaceutical and other industrial partners. He has not received personal fees or other personal benefits; he is also the founding chairman of the ReSViNET Foundation.

MDS, on behalf of the University of Oxford, has acted or acts as a Chief/Principal Investigator on research studies funded or sponsored by vaccine manufacturers including GlaxoSmithKline, Janssen, MCM, Novavax, Medimmune and Pfizer. He receives no personal financial benefit from this work.

AJP is Chair of UK Dept. Health and Social Care’s (DHSC) Joint Committee on Vaccination & Immunisation (JCVI) & the European Medicines Agency (EMA) scientific advisory group, on vaccines and is a member of the WHO’s SAGE. AJP is an NIHR Senior Investigator. The views expressed in this article do not necessarily represent the views of DHSC, JCVI, NIHR or WHO.

FMT received honoraria from GSK, Pfizer, Sanofi Pasteur, MSD, and Janssen for taking part in advisory boards, expert meetings and for acting as speaker in congresses outside the scope of the submitted work. FMT has also acted as principal investigator in RCTs of the above-mentioned companies as well as Seqirus, Ablynx, Regeneron, Abbott, Novavax and Medimmune, with any honoraria being paid to his institution.

SC provides consultancy (including trial development and data monitoring) for which the University of Edinburgh receives payment from Janssen, Ablynx (Sanofi), Pulmocide, ReViral.

All remaining authors declare no competing interests.

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# Supplementary data

**Supplementary text (test procedure BinaxNOW® RSV(BN))**

Uniform standard operating procedures (SOP) regarding sample collection and POC testing with BN was written and distributed to all participating centers prior to the start of the study. The SOP contained a link to a video with detailed instructions how to use BN[13]. BN kits of different lot numbers were used. Positive and negative control swabs were tested before using tests from a new kit and were clearly positive or negative. All centers used microtipped flocked swabs to collect nasal mucus. The swab was immediately transferred into 3 ml virus transport medium (M4RT of UTM), both volume and type of virus transport medium (VTM) were acceptable according to the manufacturer’s instruction. Swabs were rotated vigorously 3 times before breaking off the long end of the swab and leaving the swab in the medium. BN tests were performed within 4 hours after sample collection by slowly pipetting 100 μl from the medium on the card at the indicated point and sealing the card. Test results were read after 15 minutes, by visual inspection. Even a very faint sample line was interpreted as positive (according to the manufacturer’s instructions). BN tests were performed by various researchers and research nurses at the different sites. BN false negative results were retested by another person for a subset of samples with the same results. Alere was contacted and checked the test procedure at location (UMCU), which they approved as being done according to the manufacturer’s instruction. They were not able to explain the low observed sensitivity.