

**BIOHIT HealthCare**

Innovating for Health

# GastroPanel<sup>®</sup> Pepsinogen I

ELISA kit for the measurement of human pepsinogen I in EDTA plasma as part of GastroPanel

## INSTRUCTIONS FOR USE

**GastroPanel<sup>®</sup>**

Product Family  
606 400

**REF** 606 010






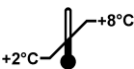











**IVD**

**CE**

For *in vitro* diagnostic use  
Store at 2-8 °C upon receipt

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## EXPLANATION OF THE SYMBOLS USED IN LABELS

	English
	For <i>in vitro</i> diagnostic use
	Catalogue Number
	Batch code
	Use by
	Consult instructions for use
	Storage limitation Store at +2...+8 °C
	96 determinations
	Do not reuse
	CE Mark
	Washing Buffer Concentrate (10x)
	Sample Diluent Buffer
	Calibrator
	Control
	Conjugate
	Substrate
	Stop solution
	Blank solution

# INSTRUCTIONS FOR USE

English

**Note!** Other languages available at [www.biohithealthcare.com](http://www.biohithealthcare.com)

## GastroPanel® Pepsinogen I

Cat. No. 606 010

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## 1. INTRODUCTION TO GASTRO PANEL®

GastroPanel® is the first-line diagnostic test for *Helicobacter pylori* (*Hp*) infection (5-80% of the world population), for the examination of all patients with dyspepsia (20-40% of the Western population), as well as for the screening of atrophic gastritis (AG) with related risks, such as stomach and esophageal cancer (1-3). Atrophic gastritis also enhances the risk of malabsorption of vitamin B12, iron, magnesium, zinc, calcium and some medicines.

GastroPanel consists of key stomach-specific biomarkers representing the key regulators of normal stomach physiology. These four biomarkers include pepsinogen I (PGI), pepsinogen II (PGII), amidated gastrin-17 (G-17), and *Hp* antibodies, designed to give information on both the structure and function of the stomach mucosa (1-6). Most importantly, this panel gives accurate estimates of the capacity of the corpus and antrum mucosa to secrete gastric acid and G-17, respectively, as well as of important gastric pathologies, like inflammation, grade and topography of atrophic gastritis (7-9), which may represent increased risk of gastric cancer (1).

Normal plasma levels of all four biomarkers indicate that the stomach mucosa has normal structure and function, whereas abnormal levels are signs of a non-healthy stomach, reflecting disturbances in the feedback mechanisms between the acid output of the corpus, PGs and G-17. For G-17 assessment, there are two options; G-17 basal (G-17b) values and G-17 stimulated (G-17s) values, the latter being particularly important in distinguishing between functional disturbance of the antrum (G-17s normal) and AG in the antrum (G-17s does not increase in AG) (10,11).

Being the first non-invasive diagnostic test for stomach mucosal health, GastroPanel is unique in that the results are interpreted by a software application (GastroSoft) (<http://www.GastroPanel.com>), specifically designed for this purpose. GastroPanel results are classified into one of five possible diagnostic categories related to stomach morphology: 1) normal mucosa, 2) superficial or non-atrophic (*Hp*) gastritis, 3) AG in the corpus, 4) AG in the antrum, and 5) AG in both antrum and corpus (pan-gastritis) (11,12). Thus, GastroPanel is optimized for use together with the Updated Sydney System (USS) for the classification of gastritis, which is based on these same five diagnostic categories (13). In addition, there are three other marker profiles specific to functional disturbances of the stomach where morphology is normal (details in section 17).

GastroPanel has been validated in several large trials based on biopsy-confirmed gastroscopies (14,15), all included in a meta-analysis of the subject (16). These studies have been exploited to establish the validated reference (cut-off) values for each individual biomarker of the panel for the five histological endpoints. These studies also confirm the high accuracy of GastroPanel in detecting the most important endpoint, moderate-to-severe AG (14-16). Thus, normal values of PGI, PGII and their ratio (PGI/PGII) preclude AG of the corpus with NPV of over 95%. In turn, the values of PGI and PGII as well as their ratio below the established cut-off levels predict moderate-to-severe AG with area under ROC curve (AUC) values of above 0.950 in adequately-powered and USS-validated series (1, 2, 3, 16, 17).

In brief, the levels of PGI decrease in AG of the corpus (and in pan-gastritis), but remain within the normal range in all other conditions. Elevated PGII levels reflect mucosal inflammation, the highest values being detected in *Hp*-associated non-AG. The G-17b values are highest in AG of the corpus, because of the missing negative feedback by the acid output from an atrophic corpus, resulting in uninhibited secretion of G-17b by the normal antral mucosa. The same applies to the situation where acid output is inhibited by prolonged use of PPI medication. By definition,

when antral mucosa is atrophic and the G cells are depleted, G-17 secretion remains very low even after protein stimulation (G-17s)(17).

*Hp* IgG antibodies give significant added diagnostic value to the three biomarkers. IgG antibody level for *Hp* measures two potentially different conditions: 1) an ongoing *Hp* infection, or 2) a previous exposure to *Hp*. As the only abnormal marker, *Hp* implicates an *Hp*-associated superficial gastritis (non-AG), while associated with abnormalities in the other three markers, elevated *Hp* antibody levels confirm the diagnosis of *Hp*-associated AG (antrum or corpus) (1, 3, 18, 19).

**GastroPanel test can detect the following conditions:**

- 1) *H. pylori* infection which is an independent risk factor of both gastric cancer and peptic ulcer disease (gastric- and duodenal ulcer).
- 2) *H. pylori*-induced atrophic gastritis (AG), which in most cases is asymptomatic, as well as the topographic site of AG either in the corpus and/or the antrum. Apart from *H. pylori*, AG in the corpus, with all its clinical sequels, can also develop through an autoimmune mechanism.
- 3) AG of the corpus, leading to low acid output or achlorhydric stomach. This increases the risk of gastric or esophageal cancer, as well as malabsorption of vitamin B12, calcium, magnesium, and zinc. In addition, the absorption of some medicines, such as dipyridamol, some iron preparations and anti-fungal drugs (fluconazol, itraconazol), thyroxin, and atazanovir is impaired due to achlorhydric stomach. Calcium deficiency can cause osteoporosis, and vitamin B12 deficiency can contribute to the development of megaloblastic anemia, Alzheimer's disease, dementia, depression or peripheral neuropathies. Reduced acid output in the stomach can also increase the risk of serious infections in the gastrointestinal- and respiratory tract, including giardiasis, malaria, *Clostridium difficile*, *E. coli* EHEC, and pneumonia.
- 4) AG of the antrum, which increases the risk of peptic ulcer disease and gastric cancer. Co-existent AG of the corpus and antrum is the single most important risk condition for gastric cancer.
- 5) *H. pylori* infection also in subjects with AG, MALT lymphoma or bleeding peptic ulcer, or when taking PPI medication or antibiotics. In these cases, 13C-urea breath tests (UBT) or stool *Hp* antigen tests frequently give false negative results and *H. pylori* infection (with all its consequences) remains undetected.
- 6) High acid output of the gastric mucosa, which predisposes to esophageal reflux disease with potential complications (ulcerative esophagitis, Barrett's esophagus or lower esophageal cancer).

AG, high acid output and symptomatic *H. pylori* infection are indications for gastroscopy.

Globally, gastric cancer remains to be the third most common cause of cancer deaths and achlorhydric stomach is its most important risk factor. According to a recent meta-analysis, chronic use of PPI medication is also associated with an increased risk of gastric cancer (20). The common cause of both these conditions is the carcinogenic (Class I) acetaldehyde borne in achlorhydric stomach (21). Carcinogenicity of acetaldehyde is best documented by a human disease model, i.e., in exposed people who have mutations in the metabolizing enzyme, aldehyde dehydrogenase (ALDH), randomly distributed in some populations (22). This information is important, because disclosure of a specific carcinogenic substance enables taking measures to reduce the exposure of the upper gastrointestinal tract to acetaldehyde on both on population and individual levels (23). To accomplish this protection, it is recommended that all subjects with achlorhydric stomach, AG of the corpus and those on regular

PPI medication should use Acetium capsules to convert the carcinogenic acetaldehyde in the stomach into a harmless compound, thus reducing the risk of gastric and esophageal cancer ([www.acetium.com](http://www.acetium.com)).

For more details on the interpretation of the GastroPanel results, please refer to the Table 1 and [www.gastropanel.com](http://www.gastropanel.com).

## 2. PEPSINOGEN I AS PART OF GASTROPANEL®

GastroPanel is a quantitative enzyme-linked immunosorbent assay (ELISA) test panel that measures the blood plasma concentration of four biological markers of gastric mucosal structure and function: pepsinogen I (PGI), pepsinogen II (PGII), gastrin-17 (G-17) and *Helicobacter pylori* IgG antibodies. The indication for use for GastroPanel is to help in the diagnosis of symptomatic (dyspeptic) adult patients and for the screening of asymptomatic subjects to detect the risk groups of gastric cancer, i.e., those with 1) *H. pylori* infection and 2) atrophic gastritis (AG). FOR *IN VITRO* DIAGNOSTIC USE.

## 3. INTENDED USE

The GastroPanel Pepsinogen I (PGI) kit is a microplate-based quantitative enzyme-linked immunosorbent assay (ELISA) for the determination of human pepsinogen I from EDTA plasma samples. The kit is used as part of GastroPanel. FOR *IN VITRO* DIAGNOSTIC USE.

## 4. PEPSINOGEN I BACKGROUND

This biomarker assay is intended to identify patients who have mucosal atrophy (atrophic gastritis) in the gastric corpus, which is a known risk factor for gastric cancer (24, 25). The plasma PGI is an established biomarker of atrophic corpus gastritis (26-29).

Pepsinogen I (PGI) is a precursor enzyme (zymogen) of pepsin, synthesized by the chief cells and neck cells of the gastric corpus (in the so-called oxyntic glands). As a pepsin precursor, the major part of PGI is secreted into the gastric lumen but a minor fraction is excreted into the blood. The circulating PGI concentration closely correlates with the quantity of the chief cells in the corpus mucosa, and any loss of these cells (due to mucosal atrophy) results in a linear decrease in plasma levels of PGI.

For as yet unknown reasons, atrophic gastritis increases the risk of gastric cancer. Compared with a healthy stomach, this risk is 5-fold among patients with advanced atrophic corpus gastritis, but up to 90-fold in patients with advanced atrophy in both the antrum and corpus (i.e., atrophic pan-gastritis) (25).

In the screening of middle-aged (50-69 years) males in Finland, the circulating PGI level was low (<25 µg/l) in 9.8% of the subjects, of whom 4.7% revealed either a gastric cancer or a precancerous lesion on endoscopy (12). Similar results have also been published in several previous studies (8, 30-38).

## 5. PRINCIPLE OF THE TEST

This GastroPanel PGI is based on a sandwich enzyme immunoassay technique with a PGI-specific capture antibody adsorbed on a microplate and a detection antibody labeled with horseradish peroxidase (HRP).

The assay proceeds according to the following reactions:

1. A monoclonal antibody, specific to human PGI, on the polystyrene surface of the wells binds to PGI molecules present in the sample.
2. Wells are washed to remove the residual sample.

3. An HRP-conjugated monoclonal detection antibody is added to the wells and it binds to the PGI molecules that are bound to the PGI capture antibody on the surface of the wells.
4. The wells are washed after incubation and TMB substrate is added. The substrate is oxidized by the enzyme (HRP), resulting in the formation of a blue-colored end product.
5. The enzyme reaction is terminated with the stop solution. The optical density of the developed yellow color is directly related to the PGI concentration of the sample.

## 6. WARNINGS AND PRECAUTIONS

### For *in vitro* diagnostic use.

CAUTION: Handle plasma samples as a potentially biohazardous material.

All samples should be regarded as potentially contaminated and treated as if they were infectious. Please refer to the U.S. Department of Health and Human Services (Bethesda, MD., USA) publication Biosafety in Microbiological and Biomedical Laboratories, 1999, 4th ed. (CDC/NIH) and No. (CDC) 88-8395 on reports of laboratory safety procedures on different diseases, or any other local or national regulation.

This kit contains reagents manufactured from human blood components. The source materials provided in the kit have been tested for the presence of antibodies to hepatitis B and C as well as antibodies to HIV, and found to be negative. However, as no test method can offer absolute assurance that these pathogens are absent; all recommended precautions in the handling of a blood derivative should be observed.

Always use protective gloves when handling patient samples. Use a safety pipetting device for all pipetting. Never pipette by mouth. Read all instructions prior to performing this assay.

Components containing ProClin may cause an allergic skin reaction (see Safety Data Sheet). Dispose of solutions containing ProClin according to local waste management legislation.

## 7. TRACEABILITY OF VALUES

There is no international reference material to Pepsinogen I. The Pepsinogen I calibrator and control values are assigned to Biohit internal master calibrators.

## 8. KIT CONTENTS, REAGENT PREPARATION AND STABILITY FOR MATERIALS PROVIDED

The reagents are sufficient for 96 wells and three separate runs. Reagents of different kit lots should not be mixed.

### 8.1. Microplate

**Contents:** 12 x 8 strips in frame coated with high-affinity, monoclonal anti-human-PGI IgG<sub>1</sub> antibody.

**Preparation:** Ready for use.

**Stability:** Stable until expiry date. Discard the strips after use.

### 8.2. Washing Buffer Concentrate (10x)

**Contents:** 120 ml of 10x phosphate buffer saline (PBS) concentrate containing Tween 20 and 0.1% ProClin 300 as preservative.

**Preparation:** Dilute 1 to 10 (e.g. 100 ml+ 900 ml) with distilled water and mix well.



**Stability:** The concentrate is stable until the expiry date. The diluted solution is stable for two weeks refrigerated (2 - 8 °C).

### **8.3. Sample Diluent Buffer**

**Contents:** 50 ml of phosphate buffer containing casein, Tween 20, 0.1% ProClin 300 as preservative and a red dye.

**Preparation:** Ready for use.

**Stability:** Stable until expiry date.

### **8.4. Blank Solution**

**Contents:** One vial containing 1.5 ml of human serum-based phosphate buffer with 0.1% ProClin 300 as preservative.

**Preparation:** Ready for use.

**Stability:** Stable until expiry date.

### **8.5. Calibrators**

**Contents:** Three vials each containing 1.5 ml of human serum-based calibrators with 0.1% ProClin 300 as preservative. The calibrators have lot-specific PGI values of approximately 25, 100 and 200 µg/l. The exact PGI concentration of the calibrators is labeled on the vials.

**Preparation:** Ready for use.

**Stability:** Stable until expiry date.

### **8.6. Control**

**Contents:** One vial containing 1.5 ml of human serum-based PGI control with 0.1% ProClin 300 as preservative. The expected PGI level of the control is labeled on the vial.

**Preparation:** Ready for use.

**Stability:** Stable until expiry date.

### **8.7. Conjugate**

**Contents:** 15 ml of HRP-conjugated monoclonal anti-human-PGI in stabilizing buffer with 0.02% methylisothiazolone, 0.02% bromonitrodioxne and 0.002% other active isothiazolones as preservatives.

**Preparation:** Ready for use.

**Stability:** Stable until expiry date.

### **8.8. Substrate Solution**

**Contents:** 15 ml of tetramethylbenzidine (TMB) in aqueous solution.

**Preparation:** Ready for use.

**Stability:** Stable until expiry date. Avoid exposure to direct light.

### **8.9. Stop Solution**

**Contents:** 15 ml of 0.1 mol/l sulfuric acid.

**Preparation:** Ready for use.

**Stability:** Stable until expiry date.

### **8.10. Incubation Covers**

Three plastic sheets to cover the microplate during incubation.

### **8.11. Instructions for Use**

Inserted into each kit.

## **9. SPECIMEN COLLECTION AND HANDLING**

It is recommended that the blood sample is drawn after overnight fasting (approximately 10 hours), but at least after 4 hours of fasting, into an EDTA tube without additives. Blood tubes for plasma are mixed immediately by turning them upside down 5-6 times. Plasma is separated by centrifugation immediately or after 2 hours at the latest (e.g. StatSpin® Express 2, centrifugation for 2 minutes at 4440 x g; please refer to centrifuge manufacturer instructions for plasma separation).

After separation of the plasma, add GastroPanel Stabilizer to the sample (50 µl/1 ml plasma; Biohit Oyj, GastroPanel Stabilizer, Cat. Nos. 606 050 and 606 051). The addition of the stabilizer into the plasma sample immediately after separation enables the storage of the sample for 7 days in a refrigerator at 2-8°C and 3 days at room temperature (20-25 °C).

### **9.1 Sample freezing**

Freeze the sample immediately after separation and addition of GastroPanel Stabilizer. For temporary storage, the plasma samples can be stored frozen at –20°C, but in long-term storage of over two weeks, the storage should be at –70°C. Mix the samples thoroughly after thawing. Avoid repeated freezing and thawing of the samples. Grossly hemolyzed, lipemic or turbid specimens should be discarded.

### **9.2 Gastrin-17 stimulation**

When a postprandial, protein-stimulated blood sample is needed, a drink made from protein powder (Biohit Oyj, Cat. No. (601 037 or 601 038) should be taken after fasting for a minimum of 4-10 hours. Twenty minutes after the protein drink is consumed, blood is drawn into an EDTA tube.

## **10. MATERIALS REQUIRED BUT NOT PROVIDED**

### **10.1. Manual method**

Distilled or deionized water, micropipettes and disposable tips to accurately deliver 20 - 1000 µl, pipettes to accurately deliver 1-10 ml, 8-channel pipette delivering 100 µl, 1000 ml graduated cylinder, vortex mixer for sample dilutions, test tubes for specimen dilutions, microplate washer, paper towels or absorbent paper, timer, vertical measurement principle microplate reader 450 nm (39), e. g. plastic blood collection tube for EDTA plasma, container for ice-water bath, plate shaker.

### **10.2. Automates**

Distilled or deionized water for washing buffer dilution. GastroPanel is automation friendly. No additional instruments, accessories or disposables are needed to carry out GastroPanel analysis with commercial ELISA automates with the vertical measurement principle microplate reader (39).

## 11. STORAGE AND STABILITY

Store the GastroPanel Pepsinogen I kit refrigerated (2-8°C). When stored at these temperatures, the kit is stable until the expiration date printed on the box label and the label of each individual kit component. Do not freeze or expose the kit to high temperatures or store at above 8°C when not in use. The substrate solution is sensitive to light. The microplate or individual strips should not be removed from the foil pouch until equilibrated to room temperature (20-25°C). Unused strips must be returned to the foil pouch, sealed, and stored at 2-8°C.

Do not use reagents after the expiration date printed on the label. Do not use reagents from kits with different lot numbers or substitute reagents from kits of other manufacturers. Use only distilled or deionized water. The components of the kit are provided at precise concentrations. Further dilution or other alterations of the reagents may cause incorrect results.

### Indication of kit deterioration

Liquid components should not be visibly cloudy or contain precipitated material. At 2-8°C, the washing buffer concentrate may, however, partially crystallize, but the crystals will dissolve by mixing at room temperature (20-25°C). The diluent buffer is slightly opaque. The calibrators and control may also seem slightly opaque. The substrate solution should be colorless or pale blue. Any other color indicates deterioration of the substrate solution.

## 12. TEST PROCEDURE

### PRELIMINARY PREPARATIONS

Allow all reagents and the microplate to reach room temperature (20-25°C). Dilute the washing buffer concentrate 1 to 10 (e.g. 100 ml + 900 ml) with distilled or deionized water. Frozen samples should be thawed fast in a room temperature water bath with occasional mixing. Once they are almost thawed, place them in a crushed ice bath.

**Read the complete assay procedure before starting. It is recommended that all calibrators and the control are applied on the plate as duplicates. It is necessary to use calibrators and the control in each test run.**

**Mix all reagents and samples well before use.** Note! All incubations may be performed at 20-30°C (=ambient temperature), do not exceed the specified temperature.

### 12.1. Manual method

Follow the sample dilution instructions below for simultaneous analysis of the whole GastroPanel.

#### STEP 1: SPECIMEN DILUTION

The sample diluent buffer, washing buffer, stop solution and substrate can be used interchangeably between the kits, if of the same lot. All other components of the kit are specific to each individual kit.

GastroPanel sample dilutions

Dilution	Analyte
1:5	G-17
1:20	PGI
1:20	PGII
1:400	<i>H. pylori</i>

Make three separate dilutions from the sample. An example of the dilutions is shown below:

1. To make G-17 dilution: dilute the mixed EDTA plasma sample 1:5 (e.g. 100 µl plasma + 400 µl diluent buffer). Mix the tube.
2. To make PGI and PGII dilution: dilute the above-made 1:5 dilution further 1:4 to make a 1:20 dilution (e.g. 180 µl 1:5 dilution + 540 µl diluent buffer). Mix the tube.
3. To make *H. pylori* dilution: dilute the above-made 1:20 dilution further 1:20 to make a 1:400 dilution (e.g. 20 µl 1:20 dilution + 380 µl diluent buffer). Mix the tube.

#### STEP 2: SAMPLE

Mix and pipette 100 µl of the blank solution (BS, for G-17, PGI and PGII) or sample diluent buffer (Blank, for *H. pylori*), calibrators, the control and diluted samples into the microplate wells (see Figure 1 for PGI/PGII, and Figures 2 and 3 for G-17 and *H. pylori*, respectively). You may cover the plate with the incubation cover to avoid splashes. Incubate for 60 minutes at ambient temperature with shaking (750 rpm). Note: It is recommended that the samples are dispensed into the wells of one plate within 20 minutes to avoid assay drift within the plate.

	1	2	3	4
A	BS	BS	etc.	etc.
B	CAL1	CAL1		
C	CAL2	CAL2		
D	CAL3	CAL3		
E	Control	Control		
F	Sample	Sample		
G	Sample	Sample		
H	Sample	Sample		

Figure 1. Pipetting order of PGI and PGII

	1	2	3	4
A	BS	BS	etc.	etc.
B	CAL1	CAL1		
C	CAL2	CAL2		
D	CAL3	CAL3		
E	CAL4	CAL4		
F	Control	Control		
G	Sample	Sample		
H	Sample	Sample		

Figure 2. Pipetting order of G-17

	1	2	3	4
A	Blank	Blank	Sample	Sample
B	CAL 1	CAL 1	etc.	etc.
C	CAL 2	CAL 2		
D	CAL 3	CAL 3		
E	CAL 4	CAL 4		
F	Control	Control		
G	Sample	Sample		
H	Sample	Sample		

Figure 3. Pipetting order of *H. pylori*

#### STEP 3: WASHING

Wash the microplate strips with 3 x 350 µl of the diluted (1 to 10) washing buffer and gently tap the inverted plate a few times on a clean paper towel.

#### STEP 4: CONJUGATE

Note! Each individual kit has its specific conjugate (not interchangeable). Pipette 100 µl of the conjugate solution into the emptied microplate wells with an 8-channel pipette. You may cover the plate with the incubation cover. Incubate for 60 minutes at ambient temperature with shaking (750 rpm).

#### STEP 5: WASHING

Wash the microplate strips with 3 x 350 µl of the diluted (1 to 10) washing buffer and gently tap the inverted plate a few times on a clean paper towel.

#### STEP 6: SUBSTRATE

Pipette 100 µl of the substrate solution into the microplate wells with an 8-channel pipette. Start the incubation time after pipetting the substrate solution into the first microplate strip and continue the incubation for 30 minutes at ambient temperature. Avoid direct exposure to light during incubation.

#### STEP 7: REACTION STOP

Pipette 100 µl of the stop solution with an 8-channel pipette into the microplate wells.

#### STEP 8: MEASURING OF RESULTS BY VERTICAL MEASUREMENT PRINCIPLE

Measure the absorbance of microplate wells at 450 nm within 30 minutes (39).

### 12.2. Automated method

GastroPanel has been designed automation in mind. As soon as test specific protocols have been created and validated for use, running the GastroPanel with a walk-away open ELISA automate saves on resources, and is easy and user friendly, e.g. by avoiding pipetting-induced disorders such as RSI.

The only manual step needed is to prepare 1:10 dilution of the washing buffer concentrate before the next run. The whole assay process, from sample dilution up to the final result calculation and reporting, is performed automatically from start to finish.

## 13. RESULTS

### 13.1. Quality Control Values

Good Laboratory Practice requires the use of appropriate controls to establish that all the reagents and protocols are performing as designated. The GastroPanel Pepsinogen I is provided with a lot-specific control. Quality control charts within the lot should be maintained to follow the performance of the control. Alternatively, appropriate statistical methods may be used for analyzing internal laboratory control values, which should fall within the appropriate confidence intervals employed in each laboratory. The expected control result must be obtained so that the results can be accepted.

### 13.2. Calculation of the Results

The absorbance readings are converted to PGI concentrations by interpolating unknowns from the best-fit curve of the calibrators. Since the calibrators are ready to use, the concentrations of the patient samples are not multiplied by the dilution factor.

Subtract the mean OD of the blank (BS) from all OD values of the wells. Plot the mean OD of the BS (as 0-calibrator) and the calibrators vs. their respective concentration. A second order polynomial fit is adequate to interpolate the unknown concentrations. A typical calibration curve is shown in Figure 4.

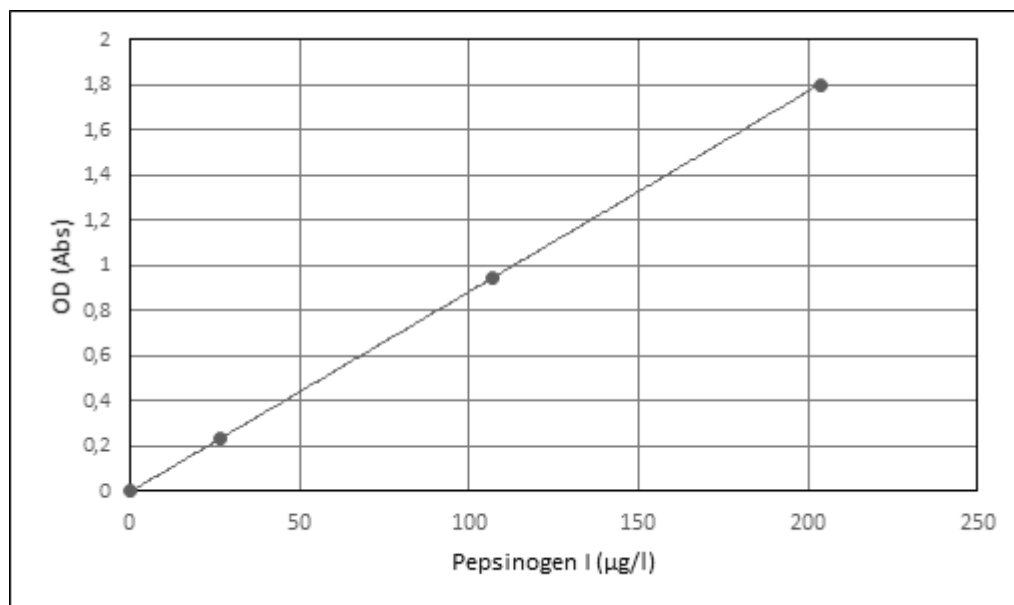


Figure 4. Example of a Typical Calibration Curve.

As the interpretation should be based on all the GastroPanel markers measured from the same patient sample, assay data must be gathered and analyzed together, with optional anamnestic information such as the use of PPI medication and information about *H. pylori* eradication.

Please refer to section 17 regarding interpretation. Should you be willing to automate GastroPanel interpretation, please contact Biohit for more information about the software applications and services. More information is also available on the GastroPanel product site ([www.gastropanel.com](http://www.gastropanel.com)).

### **13.3. Interpretation of the Results**

A low plasma PGI level ( $\text{PGI} < 30 \mu\text{g/l}$ ) indicates advanced (moderate-to-severe) atrophic gastritis of the corpus. PGI levels below this cut-off are an indication for referral to gastroscopy to confirm the diagnosis and to assess the severity of atrophic gastritis.

### **13.4. Biological Reference Interval**

The cut-off value is  $30 \mu\text{g/l}$ , with a reference range of  $30\text{-}160 \mu\text{g/l}$ . The interval is based on 7000 Finnish subjects (Biohit internal report, unpublished data).

## **14. LIMITATIONS OF THE PROCEDURE**

As with any diagnostic procedure, the GastroPanel Pepsinogen I test results must be interpreted together with the patient's clinical presentation and any other information available to the physician.

## **15. ANALYTICAL PERFORMANCE CHARACTERISTICS**

All performance tests were carried out at room temperature ( $20\text{-}25 \text{ }^\circ\text{C}$ ). All samples were analyzed with duplicate microplate wells.

### **Measuring range:**

The measuring range for GastroPanel Pepsinogen I is from  $10 \mu\text{g/l}$  to  $200 \mu\text{g/l}$ .

In this range, the method has been demonstrated to be linear within  $\pm 5\%$  nonlinearity bias, repeatability has been demonstrated to be  $\leq 8 \text{ CV}\%$ , within-assay precision  $\leq 10 \text{ CV}\%$ , and total error at LoQ level  $\leq \pm 20\%$ .

### **Precision:**

The precision studies were performed according to the CLSI EP5-A2 guideline. A panel consisting of six EDTA plasma samples over various levels of low, mid and high pepsinogen I concentrations were run in duplicates for 20 operation days (two runs per day, two repeats per sample per run). Three production lots, seven operators, and two instruments were employed. Statistical analysis was performed in agreement with the CLSI EP5-A2 guideline to determine the estimates of Repeatability and Within-Laboratory precision.

In the repeatability precision for EDTA plasma samples, the range for means was from  $9.9 \mu\text{g/l}$  to  $182.7 \mu\text{g/l}$ , the standard deviations from  $0.4 \mu\text{g/l}$  to  $6 \mu\text{g/l}$ , and the  $\text{CV}\%$  from  $2.7\%$  to  $4.3\%$ .

In the Within-Laboratory precision for EDTA plasma samples, the range for the standard deviations was from  $0.8 \mu\text{g/l}$  to  $12.1 \mu\text{g/l}$ , and the  $\text{CV}\%$  from  $6.6\%$  to  $8.5\%$ .

REPEATABILITY					
Sample	Mean (µg/l)	%CV	Total SD	95% CI SD	n
1	9.9	4.3%	0.43	0.354 to 0.552	80
2	23.0	3.1%	0.70	0.578 to 0.901	80
3	29.4	4.0%	1.17	0.959 to 1.495	80
4	37.0	3.7%	1.36	1.114 to 1.736	80
5	63.8	2.7%	1.75	1.440 to 2.244	80
6	182.7	3.3%	5.95	4.887 to 7.616	80
WITHIN-LABORATORY					
Sample	Mean (µg/l)	%CV	Total SD	95% CI SD	n
1	9.9	8.4%	0.83	0.697 to 1.029	80
2	23.0	8.0%	1.83	1.521 to 2.307	80
3	29.4	8.0%	2.34	1.960 to 2.909	80
4	37.0	8.2%	3.04	2.529 to 3.813	80
5	63.8	8.5%	5.43	4.482 to 6.878	80
6	182.7	6.6%	12.13	10.057 to 15.287	80

**Linearity:**

The linearity of GastroPanel Pepsinogen I was determined in accordance with the CLSI Guideline EP06-A. Three kit lots were tested. A logarithmic transformation of the data was used to correct the data set to be closer to Gaussian distribution.

The method has been demonstrated to be linear from 10.2 µg/l to 199.2 µg/l within +/- 5% nonlinearity bias at this interval.

**Detection limit and quantitation limit:**

The limit of blank (LoB) and the limit of detection (LoD) for GastroPanel Pepsinogen I were determined in accordance with the CLSI Guideline EP17-S with proportions of false positive ( $\alpha$ ) less than 5% and false negatives ( $\beta$ ) less than 5%; based on 120 determinations with 60 blank and 60 low-level samples. Five EDTA plasma samples and three kit lots were used. The LoB was found to be 0.9 µg/l and the LoD 1.5 µg/l.

The limit of quantitation was determined in accordance with the CLSI Guideline EP17-S based on 60 determinations of five EDTA plasma samples with three kit lots. Due to the lack of reference method, the bias estimation was not included in total error calculations.

The LoQ was found to be 8.7 µg/l with a total error of -15.6% with a CV% between measurements of 7.8%.

**Analytical specificity:**

The GastroPanel Pepsinogen I was evaluated for cross-reaction by pepsinogen II by spiking two samples at pepsinogen I levels of approximately 30 µg/l and 100 µg/l. A bias caused by 100 µg/l pepsinogen II was less than 6% (2.4% and 5.5 %, respectively). This was not considered as a significant bias.



As with any assay employing mouse antibodies, the possibility exists for interference by human anti-mouse (HAMA) or heterophilic antibodies in the sample. Patients who have received preparations of mouse monoclonal antibodies for diagnosis or therapy may contain human anti-mouse antibodies (HAMA) and may show either falsely elevated or decreased values when tested.

**Interference:**

The GastroPanel Pepsinogen I was evaluated for interference according to CLSI Guideline EP07-A2. The bias caused by hemoglobin, unconjugated bilirubin, conjugated bilirubin or triglycerides at concentrations of 2 g/l, 5 mg/dl, 15 mg/dl and 500 mg/dl, respectively, was found to be less than 10% at PGI plasma levels of 31 µg/l and 100 µg/l. This was considered as a non-significant interference. Grossly hemolyzed, lipemic, or turbid specimens should be avoided.

**16. DIAGNOSTIC PERFORMANCE**

The cohort of the validation trial consisted of 101 gastroscopy referral patients of Caucasian origin, including 71 women and 30 men. The mean age of the study subjects was 50.1 years, SD=16.7 years, and range 18-83 years.

Concordance\* between the mean values of the biomarkers in the standard pepsinogen I (cat. no. 601 010.01) and the GastroPanel Pepsinogen I test (cat. no. 606 010).

<b>GastroPanel® test version</b>	<b>PGI (M±SD)</b>
Pepsinogen I (cat no. 601 010.01 )	102.9 µg/l (47.4)
GastroPanel® Pepsinogen I (cat.no. 606 010)	89.2 µg/l (42.5)
ICC**	0.966 (0.409-0.990)
Correlation	0.983

\*Calculated by intra-class correlation coefficient (ICC; weighted kappa) and Pearson bivariate correlation tests

\*\*ICC under most stringent conditions (strict parallel two-way random model, absolute agreement, average measures settings).

**17. INTERPRETATION OF THE GASTROPANEL® RESULTS**

GastroPanel is optimized for use in context with the Updated Sydney System (USS) for the classification of gastritis. Both the USS and the GastroSoft® software use five diagnostic categories to classify the biopsy and the GastroPanel results, respectively. These include: 1) normal mucosa, 2) superficial (*Hp*) gastritis, 3) AG in the antrum, 4) AG in the corpus, and 5) AG in both antrum and corpus (pan-gastritis) (13, 40, 41). In addition to these five categories related to stomach morphology, three other marker profiles are possible in GastroPanel being specific for defined functional disturbances with normal stomach morphology. All eight diagnostic categories are depicted in Table 1 and explained in the following.

**17.1 Healthy stomach**

With all four biomarkers within the normal reference range, gastric mucosa functions normally. Given that the function of stomach mucosa is critically dependent on the specific cells responsible for acid output (parietal cells), pepsinogens (chief cells) and G-17 (G cells), normal function necessitates the presence of these cells in normal quantities (1, 3, 9, 11, 19). Thus, stomach function and mucosal structure go hand-in-hand, and by definition, a normal GastroPanel® result is a surrogate marker of a healthy stomach.

## 17.2 High acid output

Gastric acid (HCl) is produced by the highly specialized parietal cells in the corpus. Acid output is controlled, among other things, by the secretion of G-17 in the antrum as a result of a positive feedback loop stimulating acid output after a meal. Acid output results in progressively lower pH in the corpus, and the threshold of pH 2.5 triggers a negative feedback to antral G cells, signaling them to down-regulate the output of G-17. As a result, G-17 output decreases in parallel with the acid content of the corpus (1, 3, 14, 17). When, due to any reason, acid output in the corpus remains abnormally high (other stimulatory mechanisms), the end result is abnormally low G-17b output from the antral G cells. This condition is best diagnosed by the test medication with PPI, when the G-17b should normalize within approximately 2 weeks of therapy. Under these circumstances, postprandial (stimulated) G-17s will be within normal limits, because the G cells are intact and capable of G-17 secretion when properly stimulated (protein powder, Biohit Cat. No. 601038).

## 17.3. Low acid output due to Proton Pump Inhibitor (PPI) medication

The regulation above also works in the other way round. When acid output in the corpus is reduced (for any reason), the positive feedback loop triggers antral G cells to increase their G-17b secretion, resulting in elevated serum levels of G-17b (3, 17). The two conditions with low acid output are 1) AG in the corpus, and 2) long-term use of PPI medication. The former is excluded by the normal (or even elevated) values of PGI, PGII, and normal PGI/PGII ratio, while the latter is best diagnosed by discontinuing PPI medication. In that case, the antral G-17b should be normalized within two weeks (17.8.).

## 17.4. Superficial (non-atrophic), *Helicobacter pylori*-associated gastritis

Like all bacteria, *Helicobacter pylori* will also induce acute inflammation in the gastric mucosa, with the usual onset in the antrum (1, 3, 7, 13, 18, 42). Three different marker profiles can be encountered in association with *Hp* infection.

17.4a In an active *Hp* infection, *Hp* antibody levels are raised, which can be the only abnormal finding in GastroPanel, with all other markers falling within a normal range. Not infrequently, however, an active ongoing *Hp* infection causes a severe inflammatory reaction which, due to increased cell permeability, can lead to increased leakage of PGI, PGII and even G-17 from the cells and result in elevated serum levels of any or all of these three biomarkers (3, 7, 42).

17.4b Successful *Hp* eradication by active treatment should result in normalized values of all three markers, however, with a delay of some weeks to months. *Hp* antibody levels can remain elevated for a longer period of time which is unpredictable and limits the usefulness of GastroPanel<sup>®</sup> as an accurate diagnostic test for the control of *Hp* eradication (42).

17.4c In cases where *Hp* eradication attempt fails, *Hp* antibody levels remain elevated (usually slightly) and PGI and PGI/PGII ratio usually fall within a normal range, whereas PGII and/or G-17b may be slightly elevated due to ongoing inflammatory reaction (see 17.4a). The result can be confirmed after 5-6 months, followed by a new treatment attempt if indicated (3, 42).

## 17.5 Atrophic gastritis of the corpus

By definition, the loss of specific cells (chief cells) in the oxyntic glands of the corpus mucosa as a result of mucosal atrophy will lead to a progressively reduced output of PGI and (to a lesser extent) PGII, which is also produced by the same cells in the antral mucosa. This disproportionate reduction of these two markers will result

in a reduced PGI/PGII ratio, which is another excellent signature of AG in the corpus (1, 3, 5-9, 14, 16). This reduction in the PGI and PGI/PGII ratio is progressive and closely correlated with the severity of corpus atrophy, with total atrophy and acid-free stomach as the end point. In the case of intact (normal) antral mucosa, this leads to markedly increased output and serum levels of G-17b (17, 19). There is no need to test G-17s in such a situation. In chronic cases with a protracted course, *Hp* may disappear, resulting in gradual normalization of *Hp* antibody levels.

### **17.6 Atrophic gastritis of the antrum**

When the mucosal atrophy only affects the antrum, all corpus-specific markers will be within the normal range. By definition, AG in the antrum is caused by *Hp* infection, and *Hp* antibodies are invariably elevated in GastroPanel testing. As a result of antrum atrophy, G cells are reduced in number and finally disappear, leading to progressively reduced plasma levels of G-17b. In severe antrum atrophy, there is no response to protein stimulation of G-17s secretion, because of the lack of (target) G cells in the mucosa (14, 15, 17).

### **17.7 Atrophic gastritis of the antrum and corpus**

The most severe form of AG is known as atrophic pan-gastritis, affecting both the antrum and corpus. As an end result, the specified cells (chief cells) in the corpus and antrum (G cells) disappear, leading to a biomarker expression pattern where both pepsinogens (PGI, PGII) and G-17 are substantially reduced (1, 3, 5-9, 14, 16, 17, 19). This applies to both G-17b and G-17s, which remain low even after stimulation because of the missing G cells. Like in AG of the corpus (17.5), *Hp* antibody levels can be normal or elevated. This is because in chronic AG, *Hp* can disappear in the atrophic mucosa, and in the absence of antigen stimulus, a normal decay of IgG antibodies will reduce the *Hp* antibody level below the 30 EIU cut-off level.

### **17.8 PPI medication**

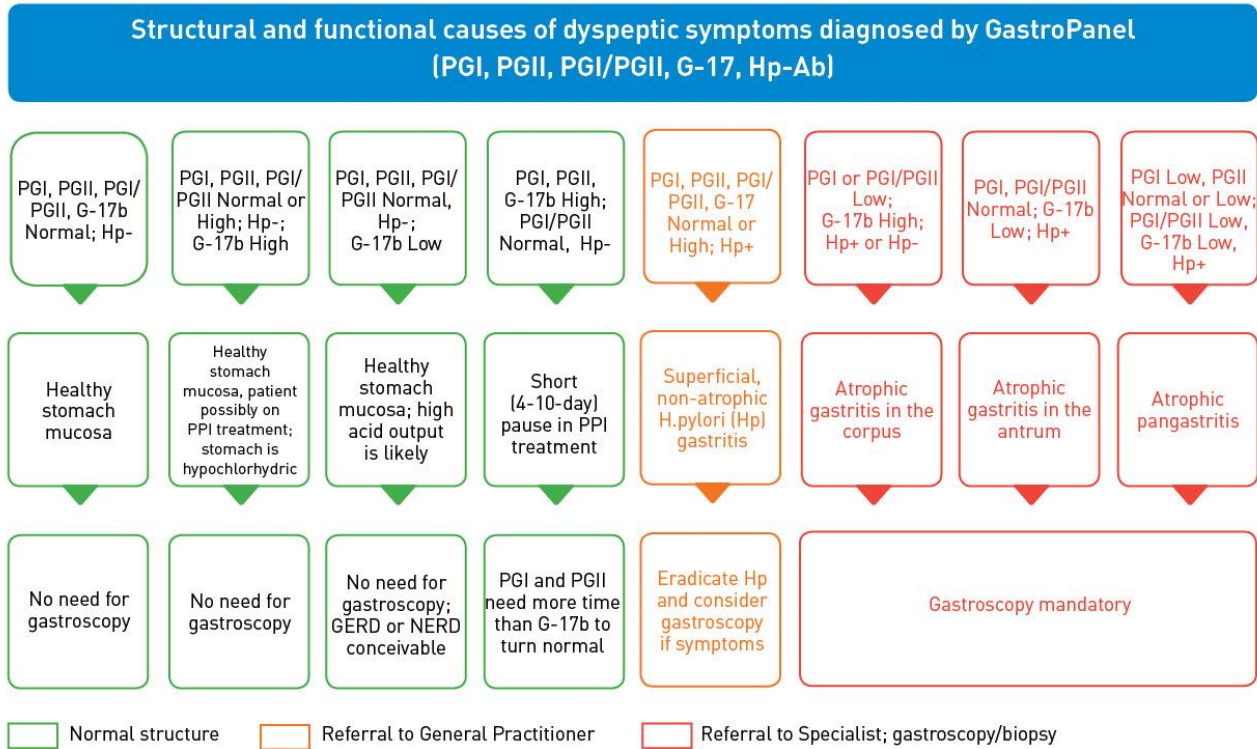
If the patient uses any PPI gastric acid suppression medication, please contact the person taking the samples. Moreover, enter the information in the patient's case history, as it will be included in the GastroSoft printout. Proton pump inhibitors (PPI) reduce gastric acid production in the stomach. This increases the production of gastrin-17, increasing pepsinogen levels. Once the PPI treatment is completed, it takes approximately 4–10 days for hydrochloric acid production and gastrin-17 levels to return to normal. However, pepsinogen levels will remain high for a relatively long period. The cessation of long-term PPI acid suppression is typically followed by rebound acid hypersecretion (within 7–10 days), which means heartburn symptoms will return in force and gastrin-17 levels will be very low. (1, 3, 11, 17)

Table 1. The eight diagnostic categories of GastroPanel

	GastroPanel® Biomarkers						Interpretation
	Pepsinogen I (30-160 µg/l) <sup>®</sup>	Pepsinogen II (3-15 µg/l)	PGI/PGII ratio (3-20)	Gastrin-17b (1-7 pmol/l)	Gastrin-17s (3-30 pmol/l)	<i>H. pylori</i> IgG Antibody level (<30 EIU)	
1	N	N	N	N	N	N	Healthy mucosa (no atrophy, no <i>H. pylori</i> infection)
2	N	N	N	L*	N	N	Healthy mucosa. High acid output in the corpus
3	N or H <sup>^</sup>	N or H <sup>^</sup>	N	H**	N	N	Healthy mucosa. Low acid output due to, e.g., PPI medication
4a	N or H <sup>^</sup>	N or H <sup>^</sup>	N	N or H <sup>^</sup>	ND	H	Active <i>H. pylori</i> infection, not treated
4b	N	N	N	N	ND	N or H <sup>†</sup>	<i>H. pylori</i> infection successfully eradicated
4c	N	H	N	H	ND	H	<i>H. pylori</i> eradication failed
5	L	L	L	H	ND	N <sup>^^</sup> or H	Atrophic gastritis in the corpus
6	N	N	N	L	L	H	Atrophic gastritis in the antrum
7	L	L	L	L	L	N <sup>^^</sup> or H	Atrophic gastritis in the antrum and corpus (pan-gastritis)
8	H	H	N	H	ND	N	Short (4-10day) break in PPI treatment

N=normal; L=low; H=high; \*Test PPI medication for two weeks, G17b should normalize; \*\*Stop PPI medication, G-17b should normalize in two weeks; ND, no need for testing; <sup>^</sup>PGI, PGII and G-17 can be elevated due to mucosal inflammation; <sup>^^</sup>*H. pylori* antibodies can disappear in mucosal atrophy with prolonged course; <sup>®</sup>Pepsinogen I cut-off value 30 µg/l is consonant with moderate/severe atrophic gastritis; <sup>†</sup>*H.pylori* antibody levels can remain elevated for months after successful eradication of *H.pylori*.

## GastroPanel® – interpretation guide snapshot



*H. pylori* infection- or autoimmune atrophic gastritis (AG), with associated risk of gastric cancer and other sequels, or the level of acid output in the stomach, cannot be diagnosed by the conventional tests used for the diagnosis of dyspepsia and *H. pylori* infection, e.g., 13C-urea breath test (UBT) stool antigen test, or antibody test. In subjects with AG, MALT lymphoma, or bleeding peptic ulcer, and in those on PPI medication or antibiotics, the UBT or stool antigen tests frequently give false negative results, and *H. pylori* infection (with all its risks) remains undetected (43-47)([www.biohithealthcare.com/additional-information](http://www.biohithealthcare.com/additional-information)).

GastroPanel is capable of diagnosing atrophic gastritis affecting either the corpus or antrum or both. As compared with gastroscopy, accurate diagnosis of atrophic gastritis is not always possible in a few small biopsy specimens representing only a minimal sample of the adult gastric mucosal area. In addition, the mucosal atrophy (mild atrophy in particular) is a subjective diagnosis, with substantial inter-observer variation among pathologists. Similarly, the accuracy of gastroscopy is dependent on the experience and competence of the gastroscopist. GastroPanel is devoid of these shortcomings, because it is an automated ELISA-based laboratory assay. In fact, endoscopic biopsy histology is not a reliable gold standard (48), albeit currently used as such. As compared with serum biomarkers, its limitations in diagnostic accuracy should be kept in mind (2, 49).

When performed by skillful gastroenterologists and pathologists, the agreement between GastroPanel and gastric biopsy histology is very good, exceeding 0.8 (the limit of almost perfect) by weighted kappa test (14). Importantly, the diagnosis of gastric atrophy is highly subjective without use of gastric biopsies, i.e., on the basis of gastroscopy alone (50). When GastroPanel indicates that gastric mucosa is healthy (no *H. pylori* infection and/or no atrophic gastritis), the clinical symptoms are often caused by functional dyspepsia or other functional disturbance without an organic disease in the gastric mucosa.

## 18. REFERENCES

1. Agréus L, Kuipers EJ, Kupcinskis L, Malfertheiner P, Di Mario F, Leja M, Mahachai V, Yaron N, van Oijen M, Perez Perez G, Rugge M, Ronkainen J, Salaspuro M, Sipponen P, Sugano K and Sung J: Rationale in diagnosis and screening of atrophic gastritis with stomach-specific plasma biomarkers. *Scand J Gastroenterol* 2012;47:136-147.
2. Storskrubb T, Aro P, Ronkainen J, Sipponen P, Nyhlin H and Talley NJ: Serum biomarkers provide an accurate method for diagnosis of atrophic gastritis in a general population: the Kalixanda study. *Scand J Gastroenterol* 2008;43:1448-1455.
3. Wikström M: Assessment of stomach health by "chemical gastroscopy". *Eur Gastroenterol Rev* 2012;1-6.
4. Lomba-Viana R, Dinis-Ribeiro M, Fonseca F, Vieira AS, Bento MJ and Lomba-Viana H: Serum pepsinogen test for early detection of gastric cancer in a European country. *Eur J Gastroenterol Hepatol* 2012;24:37-41.
5. Miki K: Gastric cancer screening using the serum pepsinogen test method. *Gastric Cancer* 2006;9:245-253.
6. Bornschein J, Selgrad M, Wex T, Kuester D and Malfertheiner P: Serological assessment of gastric mucosal atrophy in gastric cancer. *BMC Gastroenterol* 2012;12:10. doi: 10.1186/1471-230X-12-10.
7. Germaná B, Di Mario F, Cavallaro LG, Moussa AM, Lecis P, Liatoupolou S, Comparato G, Carloni C, Bertiato G, Battistelli M, Papa N, Aragona G, Cavestro GM, Iori V, Merli R, Bertolini S, Caruana P and Franzé A: Clinical usefulness of serum pepsinogens I and II, gastrin-17 and anti-*Helicobacter pylori* antibodies in the management of dyspeptic patients in primary care. *Dig Liver Dis* 2005;37:501-508.
8. Miki K, Ichinose M, Shimizu A, Huang SC, Oka H, Furihata C, Matsushima T and Takahashi K: Serum pepsinogens as a screening test of extensive chronic gastritis. *Gastroenterol Jpn* 1987;22:133-141.
9. Samloff IM, Varis K, Ihamaki T, Siurala M and Rotter JI: Relationships among serum pepsinogen I, serum pepsinogen II, and gastric mucosal histology. A study in relatives of patients with pernicious anemia. *Gastroenterol* 1982;83:204-209.
10. Korstanje A, den Hartog G, Biemond I and Lamers CB: The serological gastric biopsy: a non-endoscopic diagnostic approach in management of the dyspeptic patient: significance for primary care based on a survey of the literature. *Scand J Gastroenterol* 2002 236 (Suppl): 22–26.
11. Oksanen A, Sipponen P, Miettinen A, Sarna S and Rautelin H: Evaluation of blood tests to normal gastric mucosa. *Scand J Gastroenterol* 2000;35:791–795.
12. Varis K, Sipponen P, Laxen F, Samloff IM, Huttunen JK, Taylor PR, and the Helsinki Gastritis Study Group: Implications of serum pepsinogen I in early endoscopic diagnosis of gastric cancer and dysplasia. *Scand J Gastroenterol* 2000;35:950–956.
13. Dixon MF, Genta RM, Yardley JH and Correa P: Classification and grading of gastritis. The updated Sydney System. International Workshop on the Histopathology of Gastritis, Houston 1994. *Am J Surg Pathol* 1996;20:1161-1181.
14. Väänänen H, Vauhkonen M, Helske T, et al. Non-endoscopic diagnosis of atrophic gastritis with a blood test. Correlation between gastric histology and serum levels of gastrin-17 and pepsinogen I: a multicenter study. *Eur J Gastroenterol Hepatol* 2003;15:885–891.
15. Telaranta-Keerie A, Kara R, Paloheimo L, Härkönen M and Sipponen P: Prevalence of undiagnosed advanced atrophic corpus gastritis in Finland: an observational study among 4,256 volunteers without specific complaints. *Scand J Gastroenterol* 2010;45:1036-1041.
16. Dinis-Ribeiro M, Yamaki G, Miki K, Costa-Pereira A, Matsukawa M and Kurihara M: Meta-analysis on the validity of pepsinogen test for gastric carcinoma, dysplasia or chronic atrophic gastritis screening. *J Med Screen* 2004;11:141–147.

17. Sipponen P, Ranta P, Helske T, Kääriäinen I, Mäki T and Linnala A. Serum levels of amidated gastrin-17 and pepsinogen I in atrophic gastritis: an observational case-control study. *Scand J Gastroenterol* 2002;37:785–791.
18. Benberin V, Bektayeva R, Karabayeva R, Lebedev A, Akemeyeva K, Paloheimo L, Syrjänen K. Prevalence of *H.pylori* infection and atrophic gastritis among symptomatic and dyspeptic adults in Kazakhstan. A hospital-based screening with a panel of serum biomarkers. *Anticancer Res* 2013;33:4595-4602.
19. Syrjänen KJ, Sipponen P, Härkönen M, Peetsalu A, Korpela S. Accuracy of GastroPanel testing in detection of atrophic gastritis. *Eur J Gastroenterol Hepatol* 2015;27:102-104.
20. Ahn JS, Eom C-S, Jeon CY, Park MS. Acid suppressive drugs and gastric cancer: A meta-analysis of observational studies. *World J Gastroenterol* 2013;19:2560-8.
21. In IARC monographs on the evaluation of carcinogenic risk to humans. Personal habits and indoor combustions volume 100E, 4.3.2 The Role of acetaldehyde in alcohol-induced carcinogenesis, 2012. Pp. 471. Available: <http://monographs.iarc.fr/ENG/Monographs/vol/100E>.
22. Maejima R, Katsunori I, Kaihovaara P, Hatta W, Koike T, Imatani A, Shimosegawa T, Salaspuro M. Effects of ALDH2 genotype, PPI treatment and L-cysteine on carcinogenic acetaldehyde in gastric juice and saliva after intragastric alcohol administration. *PLoS One*. 2015; 10(4): e0120397.
23. Salaspuro M. Acetaldehyde and gastric cancer. *J Dig Dis* 2011; 12:51-59. doi: 10.1111/j.1751-2980.2011.00480.xPMID:21401890.
24. Varis K. Surveillance of pernicious anemia. In *Precancerous Lesions of the Gastrointestinal Tract*. Scherlock P, Morson PC, Barbara L, Veronesi U (eds), Raven Press, New York 1983:189-194.
25. Sipponen P, Kekki M, Haapakoski J, Ihamäki T, Siurala M. Gastric cancer risk in chronic atrophic gastritis: statistical calculations of cross sectional data. *Int J Cancer* 1985; 35:173-177.
26. Varis K, Samloff IM, Ihamäki T, Siurala M. An appraisal of tests for severe atrophic gastritis in relatives of patients with pernicious anemia. *Dig Dis Sci* 1979; 24:187-191.
27. Varis K, Kekki M, Härkönen M, Sipponen P, Samloff IM. Serum pepsinogen I and serum gastrin in screening of atrophic pangastritis with high risk of gastric cancer. *Scand J Gastroenterol* 1991; 186:117-123.
28. Knight T, Wyatt J, Wilson A, Greaves S, Newell D, Hengels K, Corlett M, Webb B, Forman D, Elder J. *Helicobacter pylori* gastritis and serum pepsinogen levels in a healthy population: development of a biomarker strategy for gastric atrophy in high groups. *Br J Cancer* 1996; 73:819-824.
29. Borch K, Axelsson CK, Halgreen H, Damkjaer Nielsen MD, Ledin T, Szesci PB. The ratio of pepsinogen A to pepsinogen C: a sensitive test for atrophic gastritis. *Scand J Gastroenterol* 1989; 24:870-876.
30. Miki K, Ichinose M, Ishikawa KB, Yahagi N, Matsushima M, Kakei N, Tsukada S, Kido M, Ishihama S, Shimizu Y, Suzuki T, Kurokawa K. Clinical application of serum pepsinogen I and II levels for mass screening to detect gastric cancer. *Jpn J Cancer Res* 1993; 84:1086-1090.
31. Hattori Y, Tashiro H, Kawamoto T, Kodama Y. Sensitivity and specificity of mass screening for gastric cancer using the measurement of serum pepsinogens. *Jpn J Cancer Res* 1995; 86:1210-1215.
32. Yoshihara M, Sumii K, Haruma K, Kiyohira K, Hattori N, Tanka S, Kajiyama G, Shigenobu T. The usefulness of gastric mass screening using serum pepsinogen levels compared with photofluorography. *Hiroshima J Med Sci* 1997; 46:81-86.
33. Kodoi A, Yoshihara M, Sumii K, Haruma K, Kajiyama G. Serum pepsinogen in screening for gastric cancer. *J Gastroenterol* 1995; 30: 452-460.
34. Aoki K, Misumi J, Kimura T, Zhao W, Xie T. Evaluation of cut-off levels for screening of gastric cancer using serum pepsinogens and distribution of levels of serum pepsinogen I, II and of PG1/PGII ratios in a gastric cancer case-control study. *J Epidemiol* 1997; 7:143-151.

35. Kikuchi S, Wada O, Miki K, Nakajima T, Nishi T, Kobayashi O, Inaba Y. Serum pepsinogen as a new marker for gastric carcinoma among young adults. Research group on prevention of gastric carcinoma among young adults. *Cancer* 1994; 73:2695-2702.
36. Yoshihara M, Sumii K, Haruma K, Kiyohira K, Hattori N, Kitadai Y, Komoto K, Tanka S, Kajiyama G. Correlation of ratio of serum pepsinogen I and II with prevalence of gastric cancer and adenoma in Japanese subjects. *Am J Gastroenterol* 1998; 93:1090-1096.
37. Farinati F, Di Mario F, Plebani M, Cielo R, Fanton MC, Valiante F, Masiero M, DeBoni M, Della Libera G, Burlin A. Pepsinogen A/Pepsinogen C or Pepsinogen A multiplied by gastrin in the diagnosis of gastric cancer. *Ital J Gastroenterol* 1991; 23:194-206.
38. Nomura AM, Stemmermann GN, Samloff IM. Serum pepsinogen I as a predictor of stomach cancer. *Ann Intern Med* 1980; 93:537-540.
39. [www.biohithealthcare.com/About](http://www.biohithealthcare.com/About) US/History: Aggressive innovation and patenting strategy. [www.biohithealthcare.com/Scientific/Literature/Suovaniemi](http://www.biohithealthcare.com/Scientific/Literature/Suovaniemi) O:Automated instrumentation for clinical and research laboratories.
40. Misiewicz JJ. The Sydney System: a new classification of gastritis. Introduction. *J Gastroenterol Hepatol.* 1991; 6:207–208.
41. Sipponen P, Price AB. The Sydney System for classification of gastritis 20 years ago. *J Gastroenterol Hepatol.* 2011;26: Suppl 1:31-34.
42. Malfertheiner P, Megraud F, O'Morain CA, Atherton J, Axon AT, Bazzoli F, Gensini GF, Gisbert JP, Graham DY, Rokkas T, El-Omar EM, Kuipers EJ. European Helicobacter Study Group. Management of Helicobacter pylori infection - the Maastricht IV/ Florence Consensus Report. *Gut* 2012;61:646-664.
43. Graham DY, Opekun AR, Hammoud F, Yamaoka Y, Reddy R, Osato MS, El-Zimaity HM. Studies regarding the mechanism of false negative urea breath tests with proton pump inhibitors. *Am J Gastroenterol.* 2003;98(5):1005-1009.
44. Savarinoa V, Vignierib S, Cella G. The 13C urea breath test in the diagnosis of Helicobacter pylori infection. *Gut* 1999;45:118-122 doi:10.1136/gut.45.2008.i18
45. Kokkola A, Rautelin H, Puolakkainen P, Sipponen P, Färkkilä M, Haapiainen R, Kosunen TU. Diagnosis of Helicobacter pylori infection in patients with atrophic gastritis: comparison of histology, 13C-urea breath test, and serology. *Scand J Gastroenterol.* 2000;35(2):138-141.
46. Gisbert JP, Esteban C, Jimenez I, Moreno-Otero R. 13C-urea breath test during hospitalization for the diagnosis of Helicobacter pylori infection in peptic ulcer bleeding. *Helicobacter* 2007; 12(3):231-237.
47. Megraud F, Lehours P. Helicobacter pylori detection and antimicrobial susceptibility Testing. *Clin Microbiol Rev.* 2007;20(2):280–322.
48. Iijima K, Abe Y, Kikuchi R, Koike T, Ohara S, Sipponen P, Shimosegawa T. Serum biomarker tests are useful in delineating between patients with gastric atrophy and a normal, healthy stomach. *World J Gastroenterol* 2009;15 (7):853-859.
49. Ren JS, Kamangar F, Qiao YL, Taylor P, Liang H, Dawsey S, Liu B, Fan JH, Abnet C. Serum pepsinogens and risk of gastric and oesophageal cancers in the General Population Nutrition Intervention Trial cohort. *Gut* 2009;58:636–42. doi:10.1136/gut.2008.168641.
50. Yanaoka K, Oka M, Yoshimura N, Mukoubayashi C, Enomoto S, Iguchi M, Magari H, Utsunomiya H, Tamai H, Arii K, Yamamichi N, Fujishiro M, Takeshita T, Mohara O, Ichinose M. Risk of gastric cancer in asymptomatic, middle-aged Japanese subjects based on serum pepsinogen and Helicobacter pylori levels. *Int J Cancer* 2008; 123: 917 – 926.



## **19. DATE OF ISSUE**

GastroPanel® Pepsinogen I kit insert.

Version 4.0, September 2016.

## **20. WARRANTY**

The Manufacturer shall remedy all defects discovered in any Product (the “Defective Product”) that result from unsuitable materials or negligent workmanship and which prevent the mechanical functioning or intended use of the Products including, but not limited to, the functions specified in the Manufacturer’s specifications for the Products. ANY WARRANTY WILL, HOWEVER, BE DEEMED VOID IF FAULT IS FOUND TO HAVE BEEN CAUSED BY MALTREATMENT, MISUSE, ACCIDENTAL DAMAGE, INCORRECT STORAGE OR USE OF THE PRODUCTS FOR OPERATIONS OUTSIDE THEIR SPECIFIED LIMITATIONS OR OUTSIDE THEIR SPECIFICATIONS, CONTRARY TO THE INSTRUCTIONS GIVEN IN THE INSTRUCTION MANUAL.

The period of this warranty for the Distributor is defined in the instruction manual of the Products and will commence from the date the relevant Product is shipped by the Manufacturer. In case of interpretation disputes the English text applies.

This Biohit diagnostic kit has been manufactured according to ISO 9001/ISO 13485 quality management protocols and has passed all relevant Quality Assurance procedures related to this product.

## 21. ORDERING INFORMATION

**GastroPanel®**

Cat. No. 606 400

### **Headquarters**

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## NOTES

## 22. BRIEF OUTLINE OF THE PROCEDURE

Allow all the reagents to reach ambient temperature

**Remember to mix all the reagents and samples well just before pipetting**

\*

After mixing, pipette 100 µl of the blank solution, the calibrators, the control, and diluted (1 to 20) patient samples into the wells

\*

Incubate for **60 min at ambient temperature with shaking (750 rpm)**

\*

Wash the wells 3 times with 350 µl of the diluted washing buffer

\*

Pipette 100 µl of the mixed conjugate solution into the wells

\*

Incubate for **60 min at ambient temperature with shaking (750 rpm)**

\*

Wash the wells 3 times with 350 µl of the diluted washing buffer

\*

Pipette 100 µl of the mixed substrate solution into the wells

\*

Incubate for **30 min** at ambient temperature

\*

Pipette 100 µl of the mixed stop solution into the wells

\*

Read at **450 nm** within 30 minutes