Overview

Useful For
Investigation of immune deficiency due to IgA2 deficiency
Evaluating patients with anaphylactic transfusion reactions

Method Name
Nephelometry

NY State Available
Yes

Specimen

Specimen Type
Serum

Specimen Required
Container/Tube:

Preferred: Red top

Acceptable: Serum gel

Specimen Volume: 1 mL

Specimen Minimum Volume
0.5 mL

Reject Due To

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Gross hemolysis</td>
<td>OK</td>
</tr>
<tr>
<td>Gross lipemia</td>
<td>Reject</td>
</tr>
<tr>
<td>Gross icterus</td>
<td>OK</td>
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</table>

Specimen Stability Information

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Temperature</th>
<th>Time</th>
<th>Special Container</th>
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<tbody>
<tr>
<td>Serum</td>
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<tr>
<td></td>
<td>Ambient</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Frozen</td>
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Clinical and Interpretive
Clinical Information

IgA, the predominant immunoglobulin secreted at mucosal surfaces, consists of 2 subclasses, IgA1 and IgA2. IgA1 is the major (approximately 80%) subclass in serum. IgA2 is the major subclass in secretions such as milk. Although IgA deficiency is a common defect (1 in 700), it is usually asymptomatic. IgA deficiency with or without IgG subclass deficiency, however, can lead to recurrent pulmonary and gastrointestinal infections. Some infections (eg, recurrent sinopulmonary infections with *Haemophilus influenzae*) may be related to a deficiency of IgA2 in the presence of normal total IgA concentrations.

Paradoxically, bacterial infections may also cause IgA deficiency. For example, IgA1 (but not IgA2) can be cleaved and inactivated by certain bacteria, thus depleting the majority of the IgA. In the presence of a concurrent IgA2 deficiency, infection by these organisms results in an apparent IgA deficiency.

IgA deficiency is 1 cause of anaphylactic transfusion reactions. In these situations, IgA-deficient patients produce anti-IgA antibodies that react with IgA present in the transfusion product. While transfusion reactions typically occur in patients who have no detectable levels of IgA, they can occur in patients with measurable IgA. In these situations, the complete deficiency of 1 of the IgA subclasses may be the cause of the transfusion reactions.

Reference Values

IgA

- 0-<5 months: 7-37 mg/dL
- 5-<9 months: 16-50 mg/dL
- 9-<15 months: 27-66 mg/dL
- 15-<24 months: 36-79 mg/dL
- 2-<4 years: 27-246 mg/dL
- 4-<7 years: 29-256 mg/dL
- 7-<10 years: 34-274 mg/dL
- 10-<13 years: 42-295 mg/dL
- 13-<16 years: 52-319 mg/dL
- 16-<18 years: 60-337 mg/dL
- > or =18 years: 61-356 mg/dL

IgA1

- 0-<5 months: 10-34 mg/dL
- 5-<9 months: 14-41 mg/dL
- 9-<15 months: 20-50 mg/dL
- 15-<24 months: 24-58 mg/dL
2-<4 years: 16-162 mg/dL
4-<7 years: 17-187 mg/dL
7-<10 years: 21-221 mg/dL
10-<13 years: 27-250 mg/dL
13-<16 years: 36-275 mg/dL
16-<18 years: 44-289 mg/dL
> or =18 years: 50-314 mg/dL

IgA2
0-<5 months: 0.4-5.5 mg/dL
5-<9 months: 1.5-6.2 mg/dL
9-<15 months: 2.8-7.0 mg/dL
15-<24 months: 3.9-7.7 mg/dL
2-<4 years: 1.3-31.1 mg/dL
4-<7 years: 1.1-39.1 mg/dL
7-<10 years: 1.4-48.0 mg/dL
10-<13 years: 2.6-53.4 mg/dL
13-<16 years: 4.7-55.1 mg/dL
16-<18 years: 6.6-54.3 mg/dL
> or =18 years: 9.7-156.0 mg/dL

**Interpretation**

Low concentrations of IgA2 with normal IgA1 levels suggest an IgA2 deficiency.

Elevated concentrations of IgA2 with normal or low amounts of IgA1 suggest a clonal plasma cell proliferative disorder secreting a monoclonal IgA2.

Increased total IgA levels also may be seen in benign disorders (eg, infection, inflammation, allergy), hyper IgD syndrome with periodic fever and monoclonal gammopathies (eg, myeloma, monoclonal gammopathies of undetermined significance [MGUS]).

**Cautions**

Quantitation of specific proteins by nephelometric means may not be possible in lipemic sera due to the extreme light scattering properties of the specimen. Turbidity and particles in the specimen may result in extraneous light scattering signals, resulting in variable specimen analysis.
Clinical Reference


Performance

Method Description

In this Siemens Nephelometer II method, the light scattered onto the antigen-antibody complexes is measured. The intensity of the measured scattered light is proportional to the amount of antigen-antibody complexes in the sample under certain conditions. If the antibody volume is kept constant, the signal behaves proportionally to the antigen volume.

A reference curve is generated by a standard with a known antigen content on which the scattered light signals of the samples can be evaluated and calculated as an antigen concentration. Antigen-antibody complexes are formed when a sample containing antigen and the corresponding antiserum are put into a cuvette. A light beam is generated with an LED, which is transmitted through the cuvette. The light is scattered onto the immuno-complexes that are present. Antigen and antibody are mixed in the initial measurement, but no complex is formed yet. An antigen-antibody complex is formed in the final measurement.

The result is calculated by subtracting value of the final measurement from the initial measurement. The distribution of intensity of the scattered light depends on the ratio of the particle size of the antigen-antibody complexes to the radiated wavelength. (Unpublished Mayo method; Instruction manual: Siemens Nephelometer II, Version 3, Siemens, Inc., Newark, DE, 2008)

PDF Report

No

Day(s) and Time(s) Test Performed

Monday, Wednesday, Friday; Continuously

Analytic Time

1 day

Maximum Laboratory Time

2 days

Specimen Retention Time

14 days

Performing Laboratory Location

Rochester

Fees and Codes
Fees

- Authorized users can sign in to Test Prices for detailed fee information.
- Clients without access to Test Prices can contact Customer Service 24 hours a day, seven days a week.
- Prospective clients should contact their Regional Manager. For assistance, contact Customer Service.

Test Classification

This test has been cleared, approved or is exempt by the U.S. Food and Drug Administration and is used per manufacturer’s instructions. Performance characteristics were verified by Mayo Clinic in a manner consistent with CLIA requirements.

CPT Code Information

82784

82787 x 2

LOINC® Information

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