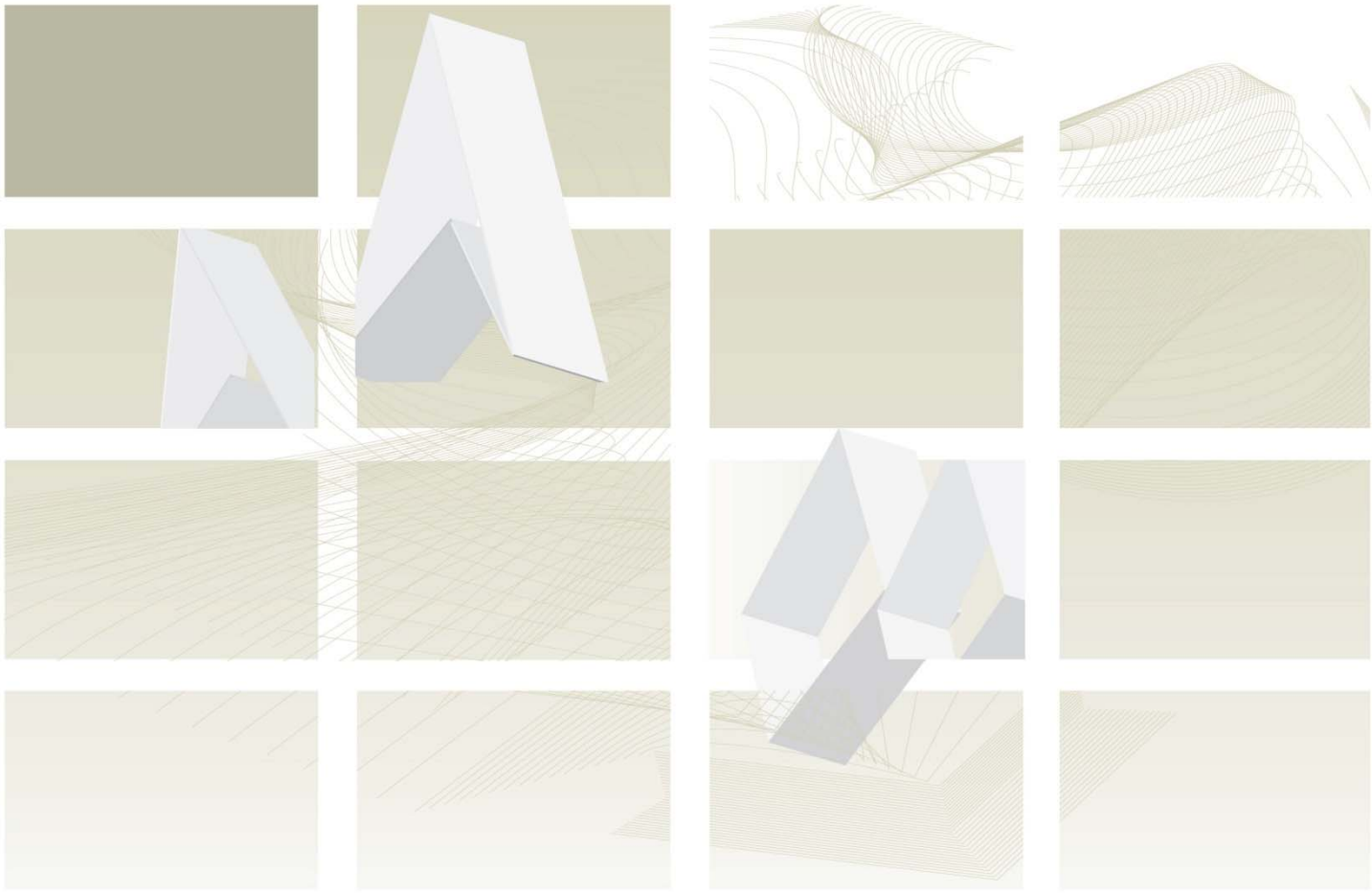
Public Health England

NHS

UK Standards for Microbiology Investigations

Review of users' comments received by Working group for microbiology standards in clinical virology/serology

V 26 Epstein-Barr virus serology



NICE accredited www.nice.org.uk/accreditation

"NICE has renewed accreditation of the process used by **Public Health England (PHE)** to produce **UK Standards for Microbiology Investigations**. The renewed accreditation is valid until **30 June 2021** and applies to guidance produced using the processes described in **UK standards for microbiology investigations (UKSMIs) Development process, S9365', 2016**. The original accreditation term began in **July 2011.**"

Recommendations are listed as ACCEPT/ PARTIAL ACCEPT/DEFER/ NONE or PENDING

Consultation: 25/05/2018 – 08/06/2018

Version of document consulted on: V 26dd+

Proposal for changes

Comment number	1		
Date received	04/06/2018	**Lab name/Professional body**	Laboratory
Section	Various		
What do you think of the new format and structure of the webpage. Is the information easy to navigate?			
Yes, easy, however, would like to be able to see whole document in final print view.			
What do you think of the new template and content layout of V 26 Epstein barr virus serology' you are commenting on?			
Seems standard.			
Please suggest any improvements you would like to see			
Not completed.			
General comments			
a. Heterophile antibody arm- please define child age cut-off. Also mention in footnote that heterophile antibody may remain detectable for over a year [Blake, J. M. et al 1976. Measurement of heterophile antibody and antibodies to EB viral capsid antigen IgG and IgM in suspected cases of infectious mononucleosis. J. Clin. Pathol. 29:841-847. and if isn't in there, the re fis mentioned in the clin micro review article Clin Microbiol Rev. 2011 Jan; 24(1): 193â€“209.] b. Algorithm for specific serology reports as no evidence of current or past if all tests negative but personal observation (and as in the table row 1) is that patients may be DNA positive alone at onset of illness. c. Table- if acute is up to 4 weeks ago, is past more than 4 weeks ago? As EBV serology is fraught with variable seroconversion periods, maybe this could be mentioned. d. Row 3 decodes as recent infection which is within last 4 weeks, but it can take much longer to seroconvert for EBNA IgG.			
Evidence			
Not completed.			
Financial barriers			
Not completed.			
Health benefits			
If EBV serology were that simple, the world of clinical virology would be a better place,			

but maybe not as intriguing.	
Recommended action	a. **ACCEPT** Child age cut-off added (4 years). b. **NONE** Testing EBV DNA is occasional and not part of a routine diagnostic algorithm as it is not generally helpful. Furthermore this is a serology testing algorithm. c. **NONE** There is no serological evidence of present or past infection. Furthermore we do not define at which point there is sero-conversion and we should not define. Delete the sentence “recent infection covers infection in the last 2-4 weeks”, situated above the reporting table. d. **NONE** This would be responded by the removing the above mentioned Note.

Comment number	2		
Date received	07/06/2018	**Lab name/Professional body**	Professional body
Section	Section 6: Laboratory Diagnosis of acute EBV infection		
What do you think of the new format and structure of the webpage. Is the information easy to navigate?			
Yes, very user friendly.			
What do you think of the new template and content layout of V 26 Epstein barr virus serology' you are commenting on?			
Very clear and easy to navigate. Like the flow chart in section 6 and table in section 7.			
Please suggest any improvements you would like to see			
Would be useful to have some indications for testing. Although EBV serology is usually requested for 'Glandular fever', often also requested as part of hepatitis screen in adults including elderly patients (>75 yrs of age). Is there any point in doing EBV testing for hepatitis/deranged LFTs in immunocompetent adults, and if so, what is the best investigation?			
General comments			
Section 6: a. Footnotes a) Some laboratories choose not to routinely test patients above a specific age as the positive predictive value of any test set will be low for diagnosis of acute infection: Are there any age specific criteria or evidence for such to make local recommendations			

b. b): Heterophile antibody tests are not appropriate for testing children and immunocompromised individuals due to a high false negative rate.-Will be useful to have some age cut-off and definition for immunocompromised. NICE CKS recommends EBV-specific serology for children under 12 yrs and monospot for >12 yrs for glandular fever.	
Evidence	
https://cks.nice.org.uk/glandular-fever-infectious-mononucleosis#!diagnosissub:1	
Financial barriers	
No.	
Health benefits	
No.	
Recommended action	a. **NONE** We encourage laboratories to use their local data interpretation as there is no published data to define the exact age of adults that are not tested for EBV. b. **NONE** After checking the evidence provided, the tests suggested are for diagnosing mononucleosis and it is a detailed clinical algorithm which is divergent from the scope of this document: Serology of EBV.

Respondents indicating they were happy with the contents of the document

Overall number of comments: 2			
Date received	05/06/2018	**Lab name/Professional body**	Laboratory
Health benefits			
No.			
Date received	08/06/2018	**Lab name/Professional body**	Professional body
Health benefits			
Not completed.			