



## **A 10-year retrospective comparison of two target sequences, REP-529 and B1, for *Toxoplasma gondii* detection by quantitative PCR**

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27 **Abstract**

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29 This study aimed to evaluate the repeated sequence REP-529 compared to the B1 gene for the  
30 molecular diagnosis of toxoplasmosis by quantitative PCR (qPCR) in routine diagnosis.

31 Over a ten-year period (2003-2013), all patients prospectively diagnosed with a positive REP-529  
32 qPCR result for toxoplasmosis were included. All DNA samples (76 samples from 56 patients) were  
33 simultaneously tested using the two qPCR methods (REP-529 and B1).

34 The mean Ct obtained with the B1 qPCR was significantly higher (+4.71 cycles) than that obtained  
35 with REP-529 qPCR ( $p < 0.0001$ ). Thirty-one out of 69 extracts (45.6%) positive with REP-529 qPCR  
36 were not amplified with the B1 qPCR (relative sensitivity 54.4%, compared to REP-529), yielding false  
37 negative results on 15/28 placentas, 5 cord blood, 2 amniotic fluids, 4 cerebrospinal fluids, 1 aqueous  
38 humor, 2 lymph node punctures and 1 abortion product. This defect in sensitivity would have left  
39 20/56 patients undiagnosed, distributed as follows: 12/40 congenital toxoplasmosis, 4/5 cerebral  
40 toxoplasmosis, 2/8 patients with retinochoroiditis, and both patients with chronic lymphadenopathy.

41 This poor performance of B1 qPCR could be related to low parasite loads, since the mean  
42 *Toxoplasma* quantification in extracts with B1 false negative results was 0.4 parasite/reaction.

43 These results clearly show the superiority of the REP-529 sequence in the diagnosis of toxoplasmosis  
44 by PCR suggest that this target should be adopted as part of standardization of the PCR assay.

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46

## 47 **Introduction**

48

49 Toxoplasmosis is a worldwide parasitic infection due to the intracellular parasite *Toxoplasma gondii*.  
50 The infection is usually asymptomatic in immunocompetent patients, and more rarely result in fever,  
51 lymphadenopathy or retinochoroiditis. By contrast, immunocompromised patients can experiment  
52 severe neurologic, ocular, pulmonary or disseminated disease (1). Yet toxoplasmosis is well-known  
53 for its pathogenicity during pregnancy. Indeed, when primary infection occurs in pregnant women, it  
54 can lead to congenital toxoplasmosis, with a frequency of transmission and a severity of fetal  
55 infection depending on the stage of pregnancy at which infection occurs (2). Diagnosis of  
56 toxoplasmosis is routinely based on serology. In some countries, such as France, seronegative  
57 pregnant women are monitored monthly by serology. In case of seroconversion, detection of  
58 *Toxoplasma gondii* DNA by PCR is a major diagnostic method for congenital toxoplasmosis, and is  
59 performed on amniotic fluid (prenatal diagnosis)(3-5), and placenta or cord blood at birth (postnatal  
60 diagnosis)(6-8). In immunocompromised patients, DNA can also be found in cerebro-spinal fluid  
61 (CSF), broncho-alveolar lavage (BAL) or others samples guided by clinical signs. The 35-fold repeated  
62 B1 gene (9) has been commonly used for this molecular diagnosis since 1989 with acceptable  
63 sensitivity (3, 5, 10), but another sequence (REP-529, Genbank AF146527) was described more  
64 recently, as being 200- to 300-fold repeated (11), leading to better detection of low parasite loads  
65 using spiked specimens (12). Our objective was to evaluate the diagnostic gain resulting from the  
66 routine use of a quantitative PCR (qPCR) targeting REP-529, compared to a qPCR targeting the B1  
67 gene, for the diagnosis of toxoplasmosis in various clinical settings. In this study, we analyzed  
68 retrospectively the qPCRs results of all *T. gondii*-positive DNA samples from patients who benefited  
69 from molecular diagnosis over a 10-year period.

70

## 71 **Materials and methods**

72

### 73 Patients and sample collection

74 During the study period (2003-2013), all patients with a diagnosis of congenital toxoplasmosis who  
75 benefited from a molecular diagnosis on at least one sample (amniotic fluid, placenta or cord blood)  
76 were included. Congenital toxoplasmosis was defined by a positive prenatal diagnosis for  
77 *Toxoplasma gondii* (molecular diagnosis and/or mouse inoculation) and/or serologic evidence of  
78 antibody synthesis by the newborn at birth or during the one-year serologic monitoring (specific IgM  
79 or IgA detected by ISAGA (BioMérieux, Marcy-l'Etoile, France) or neosynthesized IgG detected by  
80 western-blot (LD-Bio, Lyon, France)). During the study period, routine qPCR molecular diagnosis

81 relied on both gene targets (B1 and REP-529) from 2003-2005, then only REP-529 has been used until  
82 now. All positive samples were re-analyzed with both gene targets in the same qPCR run, to  
83 homogenize parasite quantification, as standard curve had changed meanwhile. Additionally, all  
84 samples from proven congenitally infected infants which had been tested negative in routine  
85 diagnosis with REP-529 were also retested in parallel with the B1 PCR.  
86 Besides, adult patients with clinical signs compatible with toxoplasmosis (lymph nodes with specific  
87 anti-*Toxoplasma* IgM, uveitis, retinochoroiditis, cerebral abscess) and a positive DNA detection with  
88 REP-529 from 2009-2013 were also included, and DNA samples were re-analyzed with both qPCRs.

89

#### 90 Molecular diagnosis

91 On reception of the placenta (PL), several samples were taken from different sites and mixed in a  
92 solution containing 2.5 mg/mL trypsin, penicillin 500 IU/mL, and gentamicin 3.3µg/mL. The  
93 preparation was digested for 2 hours at 37°C under agitation, filtered through gauze and centrifuged  
94 for 10 minutes at 1000 g. The supernatant was discarded and the pellet was washed 3 times. Then,  
95 200µl of prepared placentas and other crushed biopsies (lymph-node or cerebral) were digested  
96 overnight with proteinase K at 56°C prior to extraction. Amniotic fluids (AF) samples (10mL) were  
97 centrifuged at 1500xg for 10 min then supernatant was discarded and 2x200µL samples of the pellet  
98 were used for DNA extraction. Other fluids (CSF, aqueous humor (AH)) were centrifuged at 1500xg  
99 for 10 min, and 200µL of pellet was used for DNA extraction. Routinely, DNA extraction of all samples  
100 was performed using QIAamp DNA mini kit® columns (Qiagen, Courtaboeuf, France) and eluted in  
101 100µL, except for blood (peripheral blood (PB) and cord blood (CB)) samples, which were processed  
102 using 1-2 mL of whole blood and extracted using QIAamp DNA midi kit® columns (Qiagen), and  
103 eluted in 400 µL. Two extracts were performed for amniotic fluids and placentas (only one for other  
104 samples) and amplification was run in duplicate for all samples.

105 The primers and probe used to amplify a 98 pb fragment of the B1 gene were 5'-GAA AGC CAT GAG  
106 GCA CTC CA-3' (forward) and 5' -TTC ACC CGG ACC GTT TAG C- 3' (reverse), and FAM™-5'-CGG GCG  
107 AGT AGC ACC TGA GGA GAT ACA-3'-TAMRA™ (13), and primers and probe targeting REP-529 were  
108 those described previously (6). All samples were re-analyzed by both qPCRs in the same run, using  
109 the following conditions: 25µl reaction mixture containing primers and probe at a final concentration  
110 of 600 nM and 200 nM, respectively, 12.5 µL of TaqMan™ Universal PCR Master mix (Applied  
111 Biosystems, Courtaboeuf, France), and 5 µL of DNA sample. Amplification was performed on a Step  
112 One plus device (Applied Biosystems) for 40 cycles (15 sec 95°C and 1 min 60°C) preceded by 10 min  
113 at 55°C for UNG reaction and 10 min denaturation at 95°C. Appropriate controls were included in  
114 each run (positive and negative controls, internal control of inhibition). Positive samples were

115 quantified using standard curve obtained by serial dilutions of a standardized control (10<sup>5</sup>  
116 *Toxoplasma* RH strain), provided by the National Reference Center for Toxoplasmosis. In the aim to  
117 compare quantification data over the study period, all positive samples were re-analyzed for  
118 quantification using the same standard curve. The cycle threshold (Ct) of positive samples was  
119 recorded for comparison of REP-529 and B1 qPCRs. All Ct results previously acquired during routine  
120 analysis and results acquired after retesting for parasite quantification for the purpose of this study  
121 were compared to ensure that long storage did not alter DNA.

122

### 123 Statistical analysis

124 Before comparing the sensitivity of REP-529 and B1 targets, we verified the quality of DNA samples  
125 stored at -20°C, by using a Wilcoxon paired test to compare the Ct newly obtained with REP-529  
126 qPCR to the Ct previously recorded in routine diagnosis.

127 For the statistical analysis of relative sensitivity between B1 and REP-529 qPCRs, paired Ct obtained  
128 with both qPCRs were compared using the Wilcoxon test. The mean Ct obtained with B1 or REP-529  
129 qPCR per type of sample were also compared using the Mann-Whitney test. Only newly acquired  
130 quantitative results obtained with both PCR simultaneously were taken into account for statistical  
131 analysis. Absolute sensitivity of each PCR for the diagnosis of congenital toxoplasmosis was evaluated  
132 on the whole cohort of congenitally infected infants diagnosed over the study period who benefited  
133 either from prenatal diagnosis or neonatal diagnosis by PCR.

134 Statistical analysis was made using GraphPad® Prism V5 (GraphPad software, USA). P < 0.05 was  
135 considered significant.

136

## 137 **Results**

138

### 139 Patients and samples

140 Forty-one cases of congenital toxoplasmosis were included, consisting of 20 amniotic fluids, 1  
141 abortion product, 35 placentas and 5 cord blood samples. Additionally, 7 cases of reactivation  
142 toxoplasmosis in immunocompromised patients (2 blood samples, 4 CSF, 1 vitreous fluid and 1  
143 cerebral biopsy) and 7 cases of symptomatic toxoplasmosis in immunocompetent patients were  
144 included (2 lymph node biopsy specimens, 5 aqueous humors). Overall, 76 samples from 56 patients  
145 were analyzed. Clinical and biological data of the patients are detailed in Table 1.

146

### 147 Lack of impact of storage on qPCR Ct

Forty-nine samples were retrospectively re-analyzed with B1 qPCR in this work, thus it was essential to verify that long-term storage at -20°C after initial diagnosis had not altered DNA. The mean Ct of REP-529 qPCR obtained on samples before (at time of diagnosis) and after storage were similar ( $31.9 \pm 0.8$  versus  $32.1 \pm 0.8$ ,  $p=0.8347$ ). Additionally, the Ct results were compared using a Wilcoxon paired test, which confirmed that they did not differ ( $p = 0.1631$ , data not shown), thus making possible the interpretation of the data.

#### Comparison of B1 qPCR vs REP529 qPCR

The performance of both qPCR targets was analyzed on 76 samples. Overall, 31 of 69 extracts (45%) tested positive with REP-529 qPCR were not amplified by the B1 qPCR, thus the relative sensitivity of the B1 qPCR was 55%, compared to the REP-529 qPCR (Table 2). Seven false negative results (7 placenta samples) were also observed with REP-529; none was positive with the B1 qPCR. Thus, over the study period, the absolute sensitivity of REP-529 qPCR and B1 qPCR on placenta samples was 80% and 37%, respectively (Tables 1&3). Their absolute specificity for prenatal diagnosis was 100% and 90%, respectively (Table 3). False negative results with the B1 qPCR, compared to REP-529 qPCR, were observed on all sample types, yet mainly on placenta samples (15/28, 54%), blood samples (6/7, 86%), and CSF (4/4, 100%) (Table 2). Overall, the mean Ct obtained with REP-529 qPCR when B1 qPCR was negative was  $36.84 \pm 0.36$  (corresponding to  $0.37 \pm 0.3$  parasites/reaction), underlining the need for a very sensitive qPCR assay. For the 38 samples which could be amplified with both qPCRs, the mean Ct obtained with the B1 qPCR was significantly higher ( $+4.7 \pm 0.3$  Ct) than that obtained with REP-529 qPCR ( $p<0.001$ ) (Table 4). The mean gain in amplification Ct ranged from 3.65 to 4.98 according to the type of sample, and was highly significant for amniotic fluids and placenta samples ( $p<0.001$ , Table 4). The difference was not statistically significant for aqueous humor samples, probably because of a lack of statistical power.

Regarding congenital toxoplasmosis, the B1 qPCR failed to amplify any of the available samples (AF, PL or CB) in 11 out of 40 cases (27.5%) which were positive with REP-529 qPCR. This defect in sensitivity would have had variable consequences according to the results of other biological techniques used. Importantly, prenatal diagnosis would have been falsely negative in two cases (#19 and 31), and fetal infection would have remained unproven in a case of fetal loss (#17). Of note, B1 target also yielded a false negative result on the placenta sample from case #19 (Table 1). In three other cases (#20, 26, 27), where no prenatal diagnosis had been performed because of late maternal infection during the third trimester of pregnancy, the B1 qPCR would have left the newborns undiagnosed, since no serological evidence of infection was observed until several months (Table 1). For the five remaining cases (#8, 11, 15, 22, 30), the consequences of the reduced sensitivity of B1

182 qPCR would have been negligible, as serological markers of congenital infection (specific IgM or IgA  
183 detection, neosynthesized IgG on western-blot) were observed in newborns at birth or during the  
184 first week of live. In case #15, B1 qPCR was falsely negative in both placenta and cord blood. In the  
185 remaining cases, the lack of sensitivity of B1 on placenta samples was moot, since the diagnosis had  
186 been made previously on AF.

187 Regarding ocular toxoplasmosis, one aqueous humor from an immunocompetent patient for whom  
188 Western blot was not contributive, and one blood sample from a HIV+ patient, who did not undergo  
189 aqueous humor puncture (Table 1), were negative with B1, which would have left 2 patients  
190 undiagnosed. Additionally, the B1 target would have left undiagnosed 4 out of 5 (80%) cerebral  
191 toxoplasmosis, and the two patients with chronic lymphadenopathy (Table 2).

192

## 193 **Discussion**

194

195 This study including all positive samples obtained by REP-529 qPCR over a 10-year period, clearly  
196 shows the superiority of the REP-529 target for the diagnosis of toxoplasmosis, whatever the clinical  
197 setting. As previously described in other studies, this can be explained by the difference in the  
198 number of repetitions of this sequence (about 7- to 10 fold more repeated than B1)(11), which  
199 results in a gain of about 4 C<sub>t</sub> (12, 14), as observed here (p<0.001), and allows detection of 10-fold  
200 lower parasite loads (14). However, few studies evaluated the impact in terms of sensitivity of  
201 diagnosis in routine clinical use.

202 Filisetti et al. (15) compared three PCR methods on 23 selected AF samples and 16 CB from 19 cases  
203 of congenital toxoplasmosis, and found that only 5 out of 9 REP-529-positive AF were positive with  
204 the B1 PCR. It must be noted that the overall sensitivity in this study was very low, since only 11 out  
205 of 19 AF (58%) were positive with the reference method used, i.e. rDNA PCR (16), which could be due  
206 to the use of conventional PCR methods in this study. Cassaing et al. (14) included 33 positives  
207 samples (8 AF, 15 PL, 3 AH, 3 CSF, 2 blood samples and 2 BAL), of which 13/15 (87%) PL and 8/8 AF  
208 (100%) tested positive with REP-529 qPCR were also positive with B1 qPCR. No differences in  
209 sensitivity between both targets were observed for AH, CSF and BAL samples, but all samples were  
210 tested in duplicate and in 11 instances, negative results were observed in 1 of the 2 amplifications  
211 with B1 qPCR, whereas one sample was amplified by REP-529 qPCR only once. Additionally, the  
212 authors considered a B1 result as positive, although it was over 40 Ct, in 4 samples. Another study  
213 (17) included prospectively 135 AF samples, of which 27 and 22 were positive with REP-529 and B1  
214 qPCR, respectively. The authors declared that 2 of the 5 presumed false negative B1 results were in  
215 fact false positive REP-529 results, however, no details are provided on the newborns follow-up and



216 the criteria that led them to this conclusion. Finally, the most recent study (18) evaluated three qPCR  
217 methods, mainly on AF samples. The authors reported 33 positive results with their B1 qPCR,  
218 compared to 43 with two REP-529 qPCR methods, leading to a relative sensitivity of 77% for B1. Two  
219 cord blood samples tested positive with REP-529 were negative with B1 qPCR. Additionally, they  
220 found that their two REP-529 qPCRs methods and devices (Applied Biosystem and Roche) performed  
221 equally.

222 Our study focused on the evaluation of the relative sensitivity of B1 versus REP-529 PCR targets, thus  
223 all PCR-positive samples were included. Additionally, all samples (AF, PL) from congenitally infected  
224 children with a negative REP-529 qPCR result were retested. No samples with B1-positive and REP-  
225 529-negative results were observed, either prospectively or retrospectively, in cases of proven  
226 congenital toxoplasmosis. The overall relative sensitivity of the B1 qPCR was only 55%, and its  
227 absolute sensitivity was 37% in the setting of congenital toxoplasmosis (Tables 2&3). This defect in  
228 sensitivity was particularly crucial for 3 antenatal diagnoses (2 prenatal diagnoses and 1 early fetal  
229 loss undiagnosed) and 3 neonatal diagnoses. In case of fetal loss, the recognition of the role of  
230 *Toxoplasma* is important, because it allows to eliminate other causes of spontaneous abortion and  
231 avoids useless investigations. On the other hand, the positivity of prenatal diagnosis usually leads to  
232 a change in chemotherapy, using pyrimethamine-sulfonamide combination therapy to treat the  
233 mother (1-2), which would have been missed in the two B1-negative patients here. Finally, the  
234 parasite DNA detection in placenta, even if not yet recognized as a standard criteria for the diagnosis  
235 of congenital toxoplasmosis, was shown to have a positive predictive value over 90% in our hands  
236 (6), and is at least a strong argument to accurately follow the infant and increase the frequency of  
237 serologic testing to confirm infection, with the aim of reducing delay of treatment. We observed here  
238 that parasite DNA detection from placenta was the earliest biological sign of infection in neonates  
239 with neither IgM nor IgA detection, and recall the interest of this sample in patients for whom  
240 antenatal diagnosis was negative or not performed. In 2 cases (#23, 41), both qPCR were negative on  
241 placenta samples, whereas they were positive with mouse inoculation, still underlining the interest  
242 to combine both techniques (Table 1).

243 The B1 qPCR had also poor sensitivity in other clinical settings. The diagnosis of cerebral  
244 toxoplasmosis is difficult, and ancient studies have reported a poor sensitivity of conventional PCR  
245 methods (19-20), probably related to low parasite loads, but no recent studies evaluated new qPCR  
246 methods in this setting. The present study was not designed to answer this question, but we noted  
247 that four patients would have been undiagnosed using B1 qPCR. Besides, the REP-529 qPCR allowed  
248 diagnosing two cases of chronic toxoplasmosis in patients with lymphadenopathy and history of

249 *Toxoplasma* seroconversion in the past twelve months, which led to consider this diagnosis and stop  
 250 further exploration aiming at diagnosing a hematological malignancy.  
 251 False negative results targeting B1 had a  $C_t > 34$  (mean  $36.84 \pm 0.36$ ). This poor performance of B1  
 252 qPCR could be related to low parasite loads, a frequently observed situation in congenital  
 253 toxoplasmosis, particularly in France where women are treated all along pregnancy, which probably  
 254 decreases the parasite burden. In the study by Romand et al. (21), 88 positive AF were included, of  
 255 which 35 (40%) were shown to contain less than 10 parasite/mL.  
 256 Besides, the proportion of undetected samples with the B1 qPCR was high for placenta samples (57%  
 257 of REP-529-positive samples) and blood samples (50%). In 12 placenta samples, B1 qPCR was  
 258 negative whereas mouse inoculation was positive, which is unusual. Poor sensitivity on blood and  
 259 placenta samples suggests that inhibitors would more likely interfere with this PCR. Indeed, Chabbert  
 260 et al. (22) nicely showed that the efficacy of PCR on samples spiked with low amounts of parasites  
 261 was lower in placenta or blood, compared to AF, with both sets of B1 primers used.  
 262 After the description of the REP-529 sequence, the B1 target has been still frequently used in parallel  
 263 in most labs, including ours, until it could be demonstrated that the occurrence of B1 positive results  
 264 and REP-529 negative results was never observed (14-15, 18), suggesting that this sequence is  
 265 present in all parasite isolates. However, a recent Brazilian study (23) reported a lower proportion of  
 266 positive amniotic fluids with REP-529 target, than with B1 (36.5% and 87.3%, respectively), with only  
 267 23.8% of samples being positive with both targets. This unusual finding must be verified on other  
 268 series of clinical samples from South America, to check if atypical parasite strains circulating in this  
 269 area could lack the REP-529 sequence or have mutations or modification of the number of  
 270 repetitions, that could lead to a decreased sensitivity of this PCR target, which now appears to be the  
 271 gold standard for European parasite strains.  
 272 Therefore, in view of the results obtained in the present study, we suggest widespread use of the  
 273 REP-529 qPCR target, which should replace B1 target, at least in Western countries, until its value is  
 274 confirmed in South America.

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Table 1: Clinical characteristics and qPCR results for 41 mother-child pairs of congenital toxoplasmosis, 8 cases of ocular toxoplasmosis, 5 cases of cerebral toxoplasmosis and 2 cases of chronic lymphadenopathy

Case N°	Clinical setting	Clinical signs (Pregnancy trimester at maternal infection for CoT)	Sample	qPCR results		Mouse inoculation	Other biological criteria of infection
				B1	Rep-529		
1	CoT	Abnormal neurodevelopment (ultrasound) : Medical termination of pregnancy (T1)	AF	+	+	+	Positive qPCR (REP) on fetal biopsy
			PL	+	+	ND	
2	CoT	Asymptomatic (T3)	AF	+	+	+	IgM detection at 3month in the infant (in another hospital), PL positive by mouse inoculation
3	CoT	Asymptomatic (T3)	PL	+	+	+	Positive prenatal diagnostic in another hospital. Neosynthesized IgG/IgM by WB; IgM and IgA detection at birth
			CB	-	+	ND	
4	CoT	Asymptomatic (T3)	PL	+	+	ND	Neosynthesized IgG/IgM by WB; IgM and IgA detection at 1 month
			CB	-	+	ND	
5	CoT	Asymptomatic (T3)	PL	+	+	+	IgM at birth
6	CoT	Asymptomatic (T2)	AF	+	+	-	Persisting IgG at 1 year of life
			PL	-	+	+	
7	CoT	Ventriculomegaly (ultrasound) : Medical termination of pregnancy (T1)	PL	+	+	+	<i>Toxoplasma</i> detection in AF by mouse inoculation
8	CoT	Asymptomatic (T3)	PL	-	+	+	Neosynthesized IgG/IgM by WB; IgM and IgA detection at birth
9	CoT	Intracerebral calcifications (ultrasound) (T2-3)	AF	+	+	+	Persisting IgG at 1 year of life, <i>Toxoplasma</i> detection in PL by mouse inoculation
10	CoT	Asymptomatic (T2)	PL	+	+	+	Neosynthesized IgG by WB
11	CoT	Seizure after birth (T3)	PL	-	+	+	Positive prenatal diagnostic in another hospital,

							neosynthesized IgM (WB) at birth
12	CoT	Unknown (T3)	PL	+	+	+	Neosynthesized IgG/IgM by WB
13	CoT	Intrauterine fetal death (T2)	AF	+	+	+	
14	CoT	Asymptomatic (T3)	AF	+	+	+	Neosynthesized IgG/IgM, IgM and IgA detection at birth
			PL	-	+	+	
15	CoT	Asymptomatic (T3)	PL	-	+	-	IgM and IgA detection at 1 week of life
			CB	-	+	ND	
16	CoT	Unknown (T3)	PL	+	+	+	Neosynthesized IgG/IgM by WB; IgM and IgA detection at birth
			CB	-	+	ND	
17	CoT	Termination of pregnancy (T1)	AP	-	+	ND	
18	CoT	Chorioretinitis (T2)	AF	+	+	+	IgM detection at birth
			PL	-	-	-	
19	Co T	Asymptomatic (T3)	AF	-	+	+	Neosynthesized IgG/IgM by WB; IgM and IgA detection at birth
			PL	-	+	+	
20	CoT	Asymptomatic (T3)	PL	-	+	+	IgM (in another hospital) at birth
21	CoT	Asymptomatic (T3)	AF	+	+	+	Neosynthesized IgG/IgM by WB at birth
22	CoT	Asymptomatic (T3)	PL	-	+	+	Positive prenatal diagnostic in another hospital
23	CoT	Asymptomatic (T2)	AF	+	+	+	Neosynthesized IgG/IgM by WB; IgM and IgA detection at birth
			PL	-	-	+	
24	CoT	Chorioretinitis (T2)	AF	+	+	+	IgM and IgA detection at birth and neosynthesized
			PL	-	+	+	IgG/IgM by WB at 1 month
25	CoT	Asymptomatic (T1)	AF	+	+	+	
			PL	-	-	-	
26	CoT	Unknown (T3)	PL	-	+	+	Persisting IgG at 1 year of life
27	CoT	Asymptomatic (T3)	PL	-	+	+	Neosynthesized IgG by WB at 3 months of life
28	CoT	Chorioretinitis (T3)	AF	+	+	+	IgM and IgA detection at birth and neosynthesized IgG (WB) at 1 month of life
			PL	-	+	+	
29	CoT	Asymptomatic (T2)	AF	+	+	+	Neosynthesized IgG at 3 month (WB)

			PL	-	-	-	
30	CoT	Asymptomatic (T3)	PL	-	+	-	Neosynthesized IgG/IgM by WB; IgM and IgA detection at birth
31	CoT	Asymptomatic (T2)	AF	-	+	-	DNA detection by REP-529 qPCR in cord blood (B1 not determined)
			PL	-	-	-	
32	CoT	Asymptomatic (T3)	PL	+	+	+	Neosynthesized IgG/IgM by WB; IgM and IgA detection at birth
			CB	-	+	ND	
33	CoT	Asymptomatic (T3)	AF	+	+	+	IgM and IgA detection at birth, neosynthesized IgG by WB during follow-up
			PL	-	+	+	
34	CoT	Unknown (T3)	PL	+	+	ND	Positive prenatal diagnostic in another hospital
35	CoT	Chorioretinitis and intracerebral calcifications (T2)	AF	+	+	+	Persisting IgG at 1 year of life
			PL	-	-	-	
36	CoT	Asymptomatic (T3)	AF	+	+	+	Neosynthesized IgG/IgM by WB; IgM and IgA detection at birth
			PL	-	+	-	
37	CoT	Asymptomatic (T3)	PL	+	+	+	Neosynthesized IgG/IgM by WB; IgM and IgA detection at birth
38	CoT	Asymptomatic (T3)	AF	+	+	+	
			PL	+	+	+	
39	CoT	Unknown (T3)	AF	+	+	+	Positive serological monitoring in another hospital
40	CoT	Asymptomatic (T3)	PL	+	+	+	Positive prenatal diagnostic in another hospital, IgM at birth
41	CoT	Asymptomatic (T3)	PL	-	-	+	IgM and IgA detection at birth and neosynthesized IgG (WB)
42	OT	Uveitis	AH	+	+	ND	
43	OT	Uveitis	AH	+	+	ND	Neosynthesized IgG in AH (WB)
44	OT	Uveitis and chorioretinitis	AH	+	+	ND	
45	OT	Uveitis	AH	+	+	ND	Neosynthesized IgG in AH (WB)
46	OT	Hyalitis, not treated for toxoplasmosis	AH	-	+	ND	

47	OT	Uveitis, HIV + patient. Treated for toxoplasmosis	VF	+	+	ND	Neosynthesized IgG in VF (WB)
48	OT	Uveitis, HIV + patient. Treated for toxoplasmosis	PB	-	+	ND	Serological reactivation (high levels of IgG and IgM)
49	OT	Retinochoroiditis, HIV+ patient. Treated for toxoplasmosis.	PB	+	+	ND	
50	CeT		CSF	-	+	ND	
51	CeT	Neurological symptoms, HIV+ patient	CSF	-	+	ND	
52	CeT	Immunocompromised patient, 5 cerebral lesions on CT scan	CeB	+	+	ND	DNA detection in CSF in another hospital
53	CeT	Heart transplant patient, neurological symptoms	CSF	-	+	ND	IgM detection in serum
54	CeT	Cerebellar syndrome	CSF	-	+	ND	Serological reactivation (high levels of IgG and IgM)
55	CL	Chronic toxoplasmosis, asthenia	LNP	-	+	ND	History of seroconversion (persisting IgM)
56	CL	Chronic toxoplasmosis, asthenia	LNP	-	+	ND	History of seroconversion 6 month before

348 CoT, congenital toxoplasmosis; AF, amniotic fluid; PL, placenta; CB, cord blood; AP, abortion product; T1, first trimester of pregnancy; T2, second trimester  
349 of pregnancy; T3, third trimester of pregnancy; OT, ocular toxoplasmosis; AH, aqueous humor; PB, peripheral blood; VF, vitreous fluid  
350 CeT, cerebral toxoplasmosis; CSF, cerebro-spinal fluid, CeB, cerebral biopsy  
351 CL, chronic lymphadenopathy; LNP, lymph node puncture; ND, not determined ; WB, Western-blot  
352



353 Table 2: Relative sensitivity of B1 qPCR on samples tested positive with REP-529 qPCR, according to  
 354 the type of sample

Sample	B1 qPCR result
	No positive/Total No (%)
Amniotic fluid	18/20 (90)
Placenta	13/28 (46.4)
Abortion product	0/1 (0)
Cord blood	0/5 (0)
Blood	1/2 (50)
Ocular fluids	5/6 (83)
Cerebrospinal fluid	0/4 (0)
Biopsy (cerebral or lymph node)	1/3 (33)
All samples	38/69 (55)

355

356

357 Table 3: Sensitivity of B1 qPCR and REP-529 qPCR for the diagnosis of congenital toxoplasmosis  
 358 (2003-2013)

Sample	B1 qPCR result	REP-529 qPCR result
	No positive/Total No (%)	No positive/Total No (%)
Prenatal diagnosis (amniotic fluid)	18/20 (90)	20/20 (100%)
Neonatal diagnosis (placenta)	13/35 (37)	28/35 (80%)

359

360

361 Table 4: Mean Cycle threshold (Ct) obtained with B1 qPCR and REP-529 qPCR, according to sample  
 362 type.

363

Sample	Ct B1	Ct Rep 529	$\Delta$ Ct	P value <sup>a</sup>	P value <sup>b</sup>
	(Mean $\pm$ SEM)	(Mean $\pm$ SEM)	(Mean $\pm$ SEM)		
Amniotic fluid (n = 18)	34.80 $\pm$ 0.58	29.87 $\pm$ 0.57	4.93 $\pm$ 1.35	0.0002***	<0.0001***
Placenta (n = 12)	35.86 $\pm$ 0.57	30.87 $\pm$ 0.58	4.98 $\pm$ 2.07	0.0002***	<0.0001***
Ocular fluids (n =5)	32.98 $\pm$ 2.00	29.84 $\pm$ 2.30	3.49 $\pm$ 1.1	0.0625	0.3095
All samples (n = 37)	34.51 $\pm$ 0.56	29.7 $\pm$ 0.53	4.81 $\pm$ 0.31	<0.0001***	<0.0001

364 <sup>a</sup> Wilcoxon test; <sup>b</sup> Mann Whitney test

365 \*\*\*, p<0.001

366