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**Evaluation of the necessity and the feasibility of the standardization of procalcitonin measurements: activities of IFCC WG-PCT with involvement of all stakeholders**

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**Keywords:** procalcitonin, standardization, harmonization, traceability, reference measurement system

**Abbreviations**

International system (SI)

External quality assessment (EQA)

In vitro diagnostic device (IVD)

Reference measurement procedure (RMP)

Isotope dilution-liquid chromatography tandem mass spectrometry (ID-LC-MS/MS)

Analytical performance specifications (APS)

Isotope dilution mass spectrometry (IDMS)

Stable-isotope-labelled (SIL)

High-resolution mass spectrometry (HRMS)

Reference measurement system (RMS)

**Abstract**

Procalcitonin (PCT) is an important biomarker for sepsis diagnosis and management. To date, there is no higher-order reference measurement procedure (RMP) and certified reference material to achieve global standardization of results and results traceability to the SI units.

Although efforts have been made to harmonize PCT results, a number of correlation studies and external quality assessment (EQA) schemes show conflicting results regarding results comparability and to date, equivalence of PCT results across the assays remains questionable in absence of studies relying on commutable EQA materials. In this context, the IFCC initiated activities to fill these gaps through the creation of the working group on standardization of PCT assays that gathers experts from National Metrology Institutes, calibration laboratories, clinicians, biologists, EQA providers and assay manufacturers. Among the activities, a higher order RMP and commutable reference materials are under development to build a robust reference measurement system (RMS). A commutability study is being organized to identify EQA materials that are fit for purpose to reliably estimate the current comparability of PCT results. This work will make it possible to evaluate the necessity and the feasibility for establishing and maintaining a new RMS for PCT assays, if deemed necessary.

## Introduction

Clinical laboratory tests play an important role across the healthcare continuum to diagnose and monitor patients and to guide treatment decisions. A study based on 72196 patients reported that 56% of patients from the emergency department and 98% of inpatients had at least one laboratory test ordered for diagnosis purpose during their care pathway [1]. Among clinical diagnostic technologies, immunoassay are the most widely used technique in routine laboratory [2]. In response to the high demand for testing, numerous immunoassays have been developed and commercialized. However, the co-existence of in vitro diagnostic medical devices marketed by different vendors may introduce some variability of the results between laboratories equipped with different analyzers. Depending on the purpose of the laboratory test prescription and the use of the test result in clinical management, such a variability could potentially lead to diagnostic errors, inappropriate treatment, and a misleading longitudinal patient monitoring [3]. This variability may have a crucial impact when an inpatient is moving from one unit to another, where different clinical laboratories with potentially different measurement procedures take over the patient follow-up, or when a biomarker has to be monitored for long period where analysis in different laboratories is inevitable. Moreover, from a research perspective as well as clinical decision, the lack of results comparability may impact conclusions and the subsequent definition of clinical practice guidelines and public healthcare strategies based on biomarkers measured values [3]. Thus, not only the precision and accuracy of quantitative methods are fundamental prerequisites for a proper diagnosis and appropriate therapeutic monitoring, but also the comparability and the reliability of the results from different routine assays.

A privileged mean to ensure accuracy and comparability of the results is to establish metrological traceability of results to the International System (SI) of units [3–5]. By definition, metrological traceability is the property of a measurement result whereby the result can be related to a reference through a documented unbroken chain of calibrations, each contributing to the measurement uncertainty [6]. For each measurement procedure used in clinical laboratory for a specific measurand, values associated with the calibrators should be traceable to the available higher-order reference measurement procedure (RMP) and/or reference materials, as requested by ISO 17511:2020 and the European regulation 2017/746 for in vitro diagnostic devices (IVD) that will come into full force on 26<sup>th</sup> May 2022 to replace the 98/79/EC Directive. Although ISO 17511:2020 includes alternative procedures to establish metrological traceability of results (e.g. harmonization protocols based on ISO 21151:2020), the ideal mean to establish metrological traceability of results to the SI Units is to rely on a reference measurement system consisting in higher-order RMP and materials (Figure 1) [7]. In this case, a primary RMP represents the highest metrological order and is used for the value assignment of a primary reference material. This primary reference material is in turn used to calibrate the secondary RMP that is used to assign certified values to secondary reference materials. Assay manufacturers then use these materials to calibrate routine assays and maintain an unbroken chain of calibrations between the primary RMP and the routine assay used to measure patient samples. In that context, standardization of measurement procedures thus ensures metrological traceability to the SI units. However, primary and/or secondary reference materials and procedures are not always available. In such a situation, a common reference measurement system that does not allow establishing results traceability to the SI units could still be agreed as a reference by convention with the objective to obtain equivalent results across the different commercially available assays [3]. This is the concept of harmonization.

To be used in a calibration hierarchy of one or more end-user measurement procedures and successfully lead to harmonized results, it is crucial that the secondary reference material is commutable for the concerned assays, i.e. that it behaves the same way as patient samples [8–10]. While non-commutability of secondary calibrators breaks the traceability chain and results in the inability to achieve results harmonization [3,9], commutable reference materials are also needed to evaluate accuracy and comparability of routine assays [11–13]. Additionally, commutable reference materials are needed to conduct appropriate post-market vigilance to ensure that standardization has been achieved. Overall, establishing and maintaining a reference system leading to a consistent harmonization level appears demanding and only a limited number of success stories can be found in the field of clinical chemistry [14,15].

To improve global standardization and harmonization of laboratory tests, a wide range of activities are conducted by the Scientific Division of the International Federation of Clinical Chemistry and Laboratory Medicine (IFCC). Within this article, we describe the objectives and activities of the working group on standardization of procalcitonin (PCT) that was created in 2018.

## **1. Procalcitonin and its current measurement procedures**

In the last 20 years, it has been shown that PCT, a 116 amino acids protein, is useful for both diagnosis and antibiotic stewardship in sepsis and lower respiratory tract infections [16–23], two global threats and health priorities [24–27]. Indeed, sepsis affected 48.9 million people, leading more than 11 million deaths worldwide [28], whereas antimicrobial resistance caused approximately 700,000 deaths every year. Without appropriate actions to address this issue, the number of annual deaths caused by antimicrobial resistance could reach 10 million by 2050 [26]. PCT measurement has already supported the clinical community for timely decision to start or terminate antibiotic treatment [29,30] supporting cost-effective patient management [31]. Changes in PCT have been clearly associated with disease outcome in ICU patients [32]. Moreover, elevation of PCT concentration has recently been reported in severe forms of coronavirus disease COVID-19 presenting bacterial coinfection [33,34]. Longitudinal PCT measurement is recommended by IFCC Task Force on COVID-19 to predict its severe form [35]. PCT measurement in COVID-19 patients has been associated with disease severity and mortality [36] but whether can serve as predictor of secondary bacterial infections is still unclear [37], possibly due to variations in PCT measurements that introduce limitations in meta-analyses.

In non-infectious conditions, PCT is cleaved in different products (NProCT, Calcitonin-GKKR-Katacalcin, Calcitonin and Katacalcin). Therefore PCT concentration remains low in the bloodstream ( $\leq 0.05$  ng/mL) (Figure 2) [38]. In infectious conditions, PCT is produced in thyroid C-cells and in various tissues and organs such as liver, lung, pancreas and is directly released into the blood [39]. Therefore, an increase up to 1100 fold of PCT concentration from the basal concentration was observed [39,40]. Moreover, in this condition, it was shown that PCT exists in three different isoforms in the bloodstream (intact PCT (1-116), PCT (2-116) in which the first amino acid is cleaved, PCT (3-116) in which the first two amino acids are cleaved). Among these forms, PCT (3-116) has been reported as the predominant form, but little is known about the relevance of the different forms [41,42].

Interestingly, PCT concentration remains low in the case of viral infections and localized bacterial infections [44,45]. Therefore, PCT concentration has been used to establish clinical guidelines for sepsis stratification and monitoring of antimicrobial therapy [16,17,46]. An example of decision-making process based on PCT concentration is presented in Figure 3.

The use of PCT tests has been gaining widespread in the clinical laboratory settings [48,49]. In consequence, multiple immunoassays measuring PCT concentration in human serum or plasma have been developed to meet the important demand of PCT testing and developments are continuing with new assays commercialized recently (e.g. Architect Brahms PCT assay in 2017, B-R-A-H-M-S PCT direct in 2018, Access PCT assay in 2019, Diasys PETIA PCT assay in 2020) (Table 1). To meet the need for short turnaround times, an increasing number of point-of-care tests for PCT have been developed for a rapid clinical decision and treatment initiation. As underlined previously, the PCT measurement results could vary from one immunoassay to another depending on different factors including detection method, antibody specificity, reagents, instrument platforms or calibrators. Commercially available immunoassays for PCT employ different mechanisms of detection such as chemiluminescence, electroluminescence, time-resolved fluorescence, or immune-turbidimetry whose sensitivity could be different. Moreover, not all immunoassays use the same antibodies. As different antibodies could recognize different epitopes of PCT, this could result in differences in assay specificity and selectivity. Currently, most PCT immunoassays use a pair of antibodies. However, assays like the Diazyme assay employ a single precipitating antibody, and assays like Advia Centaur Brahms, Lumipulse G Brahms and Atellica Brahms assays use a third antibody for the detection. In addition, most immunoassays employ monoclonal antibodies that recognize a single epitope of PCT with high specificity, while the BRAHMS Kryptor assay and Diasys PETIA assay are the only immunoassays using polyclonal antibodies that can potentially recognize multiple epitopes. There is generally limited information available on the PCT isoform(s) being actually measured or on cross reactivity, e.g. with PCT fragments. Liaison Brahms and Lumipulse Brahms assays reported the use of two monoclonal antibodies targeting two epitopes situated in calcitonin and katacalcin segments (Table 1). Furthermore, Brahms PCT LIA, the first commercial kit employed two monoclonal antibodies interacting with two different binding sites: the epitope residues 96-106, part of the katacalcin segment, and residues 70-76, part of the calcitonin segment [50]. However, these assays are not predominantly used in clinical practice.

Another source of variability across PCT assays lies in the use of different reagents such as biotin, streptavidin, ruthenium, acridinium, as described in Table 1. As demonstrated for other biomarkers, the use of different reagents may have a significant effect on measurement reliability [51–55]. As a consequence, these technical differences could potentially contribute to a lack of comparability across results provided by different immunoassays.

**Table 1.** Characteristics of the current commercially available immunoassays for PCT

Immunoassay (Company)	Date of first market authorization	Market authorization	Predicate Device	Instrument	Assay principle	Antibodies and reagents	Sample volume Sample matrix	Measuring range (ng/mL)
BRAHMS PCT LIA (BRAHMS Diagnostica)	2005	FDA 510(k) - CE marked	Endotoxin Activity Assay	Luminometer	Immunoluminometric assay - non automated	Two mouse anti-PCT mAb	20 µL Se, P	0.3-500
BRAHMS PCT Sensitive Kryptor (BRAHMS diagnostica)	2009	FDA 510(k) – CE marked	BRAHMS PCT LIA	Kryptor Test System	Time-resolved amplified cryptate emission (TRACE) immunoassay	Sheep anti-PCT pAb cryptate labelled Mouse anti-PCT mAb XL665 labelled	50 µL Se, H, E	0.02-50
Architect BRAHMS PCT (Abbott)	2017	FDA 510(k) – CE marked	BRAHMS PCT Sensitive Kryptor	Architect i2000SR Analyzer	Chemiluminescent microparticle immunoassay (CMIA)	Rat anti-PCT mAb microparticles coated Mouse anti- PCT mAb acridinium-labelled conjugate	100 µL Se, L, K2	0.02-100
Vidas BRAHMS PCT (Biomérieux)	2009	FDA 510(k) – CE marked	BRAHMS PCT LIA	Vidas	Enzyme-linked fluorescent immunoassay (ELFA)	Mouse anti-PCT mAb microwells coated Mouse anti- PCT mAb alkaline phosphatase-labelled	200 µL Se, L	0.05-200
Liaison BRAHMS PCT II Gen (Diasorin)	2015	FDA 510(k) – CE marked	BRAHMS PCT Vidas	Liaison analyzer	Chemiluminescence Immunoassay (CLIA)	Mouse anti katacalcin PCT mAb magnetic particle coated. Mouse anti calcitonin PCT mAb isoluminol labelled	225 µL Se, L	0.02-100
Lumipulse G BRAHMS PCT (Fujirebio)	2016	FDA 510(k) – CE marked	BRAHMS PCT Sensitive Kryptor	Lumipulse G system	Chemiluminescence Enzyme Immunoassay	Mouse anti PCT mAb Mouse anti calcitonin PCT mAb coated particles Mouse anti katacalcin PCT mAb alkaline phosphatase labelled	60 µL Se, N, L, K2	0.02-100
Elecsys BRAHMS PCT (Roche Diagnostics)	2009	FDA 510(k) – CE marked	BRAHMS PCT Sensitive Kryptor	Cobas e 411 analyzer	Electrochemiluminescence immunoassay (ECLIA)	Streptavidin-coated microparticles Mouse anti-PCT mAb biotinylated Mouse anti-PCT mAb ruthenium labelled	30 µL Se, K2, K3, L	0.02-100
Atellica IM BRAHMS PCT (Siemens healthcare)	2018	FDA 510(k) – CE marked	BRAHMS PCT Sensitive Kryptor	Atellica IM Analyzer	CLIA	Mouse anti-fluorescein mAb paramagnetic particles coated Mouse anti-PCT mAb acridinium ester labelled Mouse anti-PCT mAb fluorescein labelled	100 µL Se, E, L, N	0.04-50

Alinity I BRAHMS PCT (Abbott)	n/a	FDA 510(k) – CE marked	BRAHMS PCT Sensitive Kryptor	Alinity i analyzer	Chemiluminescent microparticle immunoassay (CMIA)	Rat anti-PCT mAb microparticles coated Mouse anti- PCT mAb acridinium- labelled conjugate	100 µL Se, L, K2	0.02-100
Advia Centaur BRAHMS PCT (Siemens)	2011	CE marked	BRAHMS PCT Sensitive Kryptor	Advia centaur XP and CP analyzers	CLIA	Mouse anti-fluorescein mAb paramagnetic particles coated Mouse anti-PCT mAb acridinium ester labelled Mouse anti-PCT mAb fluorescein labelled	100 µL Se, E, H	0.02-75
Vitros BRAHMS PCT (Ortho Clinical Diagnostics)	2020	FDA 510(k) - CE marked	BRAHMS PCT Sensitive Kryptor	VITROS 3600	Luminescence immunoassay	Streptavidin-coated wells Anti-PCT mAb biotin labelled Anti-PCT mAb horseradish peroxidase labelled	30 µL Se, E, L	0.03-100
Access PCT (Beckman Coulter)	2019	FDA 510(k) – CE marked	BRAHMS PCT Vidas	UniCel DXI or Access 2	CLIA	Anti-PCT mAb paramagnetic particles coated (does not use biotin- streptavidin particle) Anti-PCT mAb alkaline phosphatase conjugate	35 µL Se, L, E	0.01-100
Diazyme PCT (Diazyme Laboratories)	2017	FDA 510(k) – CE marked	BRAHMS PCT Vidas	Olympus Beckman AU400 chemistry analyzer	Latex-enhance immunoturbidimetric assay	Anti-human PCT mAb latex particles coated	15 µL Se, E, L	0.2-52
Diasys PCT FS (Diasys Diagnostic GmbH)	2020	CE marked	BRAHMS PCT Sensitive Kryptor	Cobas c501 chemistry analyzer	Latex-enhance immunoturbidimetric assay	Anti-human PCT pAb latex particles coated	10 µL Se, L	0.2-50
Maglumi PCT (Shenzhen)	n/a	CE marked	n/a	Analyzer Maglumi	CLIA	Mouse anti-PCT mAb nano magnetic microbeads coated Mouse anti-PCT mAb ABEI labelled	40 µL Se, E, Ewb	0.13-100

mAB : monoclonal antibody ; pAb : polyclonal antibody ;

Se : serum ; P : plasma ; H : heparin plasma ; E : EDTA plasma ; L : lithium heparin plasma ; K2 : K2EDTA plasma ; N : sodium heparin plasma ; K3 : K3EDTA plasma ; Ewb : EDTA whole blood



To assess the comparability of PCT measurement results, a number of correlation studies have been conducted but these have shown conflicting results. Indeed, some studies showed significant differences between PCT concentration obtained from different immunoassays, whereas other studies reported the opposite [56–59]. In addition, the evaluation of different external quality assessment (EQA) schemes results has shown a substantial discrepancy across the different EQA schemes: while some highlighted quite good agreement between the different assays, other EQA schemes showed the contrary [60]. Although substantial variations in the PCT concentration measured by different immunoassays were reported in several correlation studies and EQA schemes, the current clinical decision for diagnosis of sepsis and therapy monitoring is based on common clinical cutoff values regardless of the immunoassay employed for PCT measurements. Even if a good clinical concordance at clinical cutoffs has been reported in the different correlation studies [60], several studies came up to the conclusion that it would be preferable to compare results obtained from the same immunoassay when interpreting serial evaluation of PCT concentration for a given patient [61–63].

The current situation regarding the comparability of PCT measurement results may be explained either by differences in assays selectivity or a calibration issue caused by the lack of higher-order reference materials for PCT measurement and thus a lack of traceability to the SI Units. It should be noted that manufacturers offering a PCT assay belonging to the Brahms-like family participate in a harmonization program through the use of the Brahms Kryptor assay as surrogate reference method in absence of any higher order RMP and certified reference materials. However, not all assays commercially available take part in this harmonization effort, thus there is currently no commonly agreed reference material for all available PCT immunoassays at the international level. Therefore, the need for a new reference system based on higher order reference materials and/or a higher-order reference method to achieve global standardization/harmonization of PCT results worldwide has been pointed out in a number of studies [56–59,64,65].

## **2. IFCC working group on standardization of PCT assays (IFCC WG-PCT)**

To address the question of PCT measurements reliability and comparability and more specifically to evaluate the need and the feasibility for standardization or harmonization, a dedicated IFCC working group was created in 2018. This working group gathers clinicians, biologists, in vitro diagnostic manufacturers, EQA providers and metrology institutes. The participation of all concerned stakeholders is of utmost importance for the successful implementation of a reference measurement system. Within this working group, the efforts focused on five terms of reference (Figure 4): the development of a reference measurement system (reference materials and procedures), the evaluation of the variability of results provided by the different commercially available PCT assays, the evaluation of the need and the feasibility for standardization of PCT assays, and the implementation of standardization of PCT assays if deemed needed and feasible.

- **The first term of reference** consists in the development and validation of a RMP for PCT absolute quantification by stable isotope dilution-liquid chromatography-tandem mass spectrometry (ID-LC-MS/MS) in order to establish metrological traceability of measurement results to the SI Units. The standardization of PCT tests could only be implemented if the following prerequisites are met to achieve results comparability independent of time, location and measurement procedures [3]. First, a proper

definition of the measurand should be established, i.e. clearly define what entity is intended to be measured. Then, the selectivity of the different assays should be close enough, i.e. measure the same entity. Finally, a reference measurement system enabling to establish results traceability to the SI units should be established. This includes availability of primary reference materials, commutable secondary reference materials and a higher-order RMP meeting analytical performance specifications (APS) that are fit for purpose to meet the medical need (e.g. sufficiently small measurement uncertainties, high precision, high selectivity and high accuracy).

**Definition of the clinically relevant measurand:** , Measurand is defined by the International Vocabulary of Metrology as a quantity intended to be measured [6]. Defining the measurand comes down to respond to the question “What is being measured?”. At first sight the answer may seem simple, however that may be difficult to answer according to the complexity of analyte, particularly in case of proteins [8]. Indeed, proteins could be subjected to heterogeneity and present as a mixture of different molecular species in biological fluids such as it has been shown for human growth hormone [66], human cardiac Troponin I [8,67], brain natriuretic peptide (BNP) and N-terminal fragment of the BNP [68,69]. Thus, for an accurate quantitative analysis and implementation of a reference measurement system, the isoforms of interest should be clearly defined as it has been performed for HbA1c [70]. In the case of PCT, there is currently no assay that detects the whole form of PCT, particularly the N-terminal side of the sequence to discriminate the three different PCT isoforms. Therefore, the most practical solution has been to define the measurand as total serum PCT, including PCT (1-116), PCT (2-116) and PCT (3-116) isoforms.

### **Selection and development of candidate reference measurement system**

Isotope Dilution Mass spectrometry (IDMS) is widely applied for protein absolute quantification [66,71–79]. Thanks to its high selectivity and the use of stable-isotope-labelled (SIL) compounds as internal standards, IDMS allows accurate quantification of the measurand with low measurement uncertainties and is recognized as a primary reference method by the Consultative Committee for Amount of Substance of BIPM (Bureau International des Poids et Mesures). In a number of Reference Measurement Systems, IDMS successfully serves as higher-order reference method and a number of IDMS-based RMPs are listed as such in JCTLM database [80]. Still, validation of an IDMS-based RMP remains a challenge for different reasons, including the need to extensively characterize purity of primary calibrators, to obtain stable-isotope-labelled (SIL) compounds which behavior is close enough to the endogenous compound to make them suitable for use as internal standards, and to reach sufficiently low limit of quantification with sufficiently small measurement uncertainties while achieving high accuracy and high precision.

In a healthy state or in the absence of infection, plasma or serum concentration of PCT is below 0.05 ng/mL. Due to ion suppression phenomena occurring in mass spectrometry-based analysis, the sample preparation is critical for PCT absolute quantification in a complex serum matrix by mass spectrometry. For sample preparation, an antibody-free approach based on the physicochemical properties of PCT was preferred in contrast to immuno-affinity approaches, which are currently employed in commercially available immunoassays. After optimized sample purification, PCT is then digested into peptides with trypsin. Peptides are then quantified using high-resolution mass spectrometry in order to reduce interferences.

The ID-LC MS/MS analysis consists in the separation, the fragmentation and the detection of PCT-related peptides generated by the digestion of the protein. The different strategies for targeted quantification of proteins by ID-LC MS/MS are described in Figure 5. As the selected bottom-up strategy provides an indirect detection of PCT through the quantification of peptides derived from tryptic digestion, it is crucial to select PCT-related peptides that are unique representatives of PCT protein (proteotypic peptides). Two PCT-related peptides, located in two different segments of PCT amino acid sequence, were selected to improve the specificity of the quantitative method by discriminating the different PCT cleavage forms such as NProCT, Calcitonin-GKKR-Katacalcin, Calcitonin and Katacalcin.

PCT concentration is obtained through the measurement of the concentration of the PCT-related proteotypic peptides calculated from a calibration curve that is established by measuring calibrators that are prepared by mixing known amounts of the labeled and non-labelled primary calibrators. Depending on the calibration strategy, the measured concentration of peptides might be negatively biased due to material loss during the different step of the sample preparation, incomplete protein extraction, incomplete proteolysis by trypsin, peptides loss by adsorption) [81]. The two commonly used calibration quantification strategies include peptide-based calibration or protein-based calibration, in which calibrators are prepared with synthetic PCT-related peptides or PCT recombinant protein, respectively (Figure 5). The protein-based calibration approach presents one main advantage: as the protein-based internal standard undergoes the same sample processing as the endogenous protein, incomplete protein extraction, incomplete proteolysis by trypsin and any material loss during sample preparation steps occurring after spiking of the labeled protein are all compensated and do not affect method's accuracy. However, the characterization of protein-based primary calibrator is more challenging than for peptide-based calibrators as protein-based impurities are expected to present, impurity identification and impurities quantification is harder than for peptides. In addition, protein-based calibrators are expensive to produce and can be subject to batch to batch variations. In order to evaluate the most appropriate approach to ensure high accuracy and precision, these two approaches have been employed and compared for the development of a candidate higher-order RMP. Both peptide- and protein-based calibrators were obtained from different providers. The peptides and proteins PCT standards produced from the selected providers were then SI-traceably quantified by the primary RMP composed of amino acid reference method using ID-LC MS and correction of the contribution from impurities containing amino acids (Figure 1). The homogeneity and stability of these materials still need to be evaluated before certification of the primary reference material can be finalized.

**The second term of reference** consists in documenting and understanding the variability of measurement results provided by different commercially available PCT assays. The state of the art of PCT measurement shows conflicting results regarding the comparability of PCT measurement results [60]. Moreover, in almost all correlation studies available in the literature and all EQA programs, no information on the commutability of the study samples is available when the studies are performed using samples other than fresh single donations. However, this is a crucial aspect to accurately document the need for PCT standardization/harmonization. In this respect, agreement and correlation between the different PCT assays will be evaluated through the organization of an interlaboratory comparison involving most popular PCT assays and relying on samples of proven commutability. Thus, the two main tasks of second term of reference consist in the production of candidate EQA materials and the

organization of a commutability study. This will result in the identification of appropriate EQA materials to properly evaluate the comparability of the different PCT assays and evaluate the need for further improving results consistency through calibration standardization.

In a recent review based on data provided from 10 EQA providers of PCT assays, the use of spiked materials was suspected to cause the inability to properly evaluate the comparability between measurement results obtained from the different commercially available PCT assays [60]. Surprisingly, the suitability of EQA materials consisting in pools of fresh unspiked human serum was not evidenced, possibly due to ethical issues and limitations in material stability and challenges to get sample collection, shipment and testing conducted in a sufficiently low period of time [60]. The fact that no data is provided regarding commutability of the materials and the measurement protocol of laboratory participants represents a major limitation to determine what lessons can be learned from such studies. In fact, various modifications/alterations of functional nature could occur during the process to produce commutable candidate material such as lyophilization, freezing, pooling, which could induce matrix effects for all or most of assays. As commutability of a reference material cannot be predicted, it has to be demonstrated against a set of authentic clinical specimens. Different EQA materials will therefore be evaluated to identify the most suitable way to consistently obtain commutable materials. Candidate EQA materials will consist in different matrices, including frozen or lyophilized pools of human serum, artificial matrices, spiked or not with recombinant PCT from different sources. A number of EQA providers already agreed sharing their materials for inclusion in the commutability study. As recommended in the IFCC latest recommendation, commutability of the candidate EQA materials will be evaluated against a set of clinical specimens which PCT concentration brackets that of the EQA materials. Ideally, clinical specimens should consist in fresh unadulterated single donations (i.e. not pooled, not frozen, not spiked with any exogenous substance) because these are commutable by definition. However, maintaining materials stability from sample collection to testing is an important issue, it is challenging to collect within one or two days a set of 30-50 fresh single donations covering the entire concentration range, to ship the materials to all participating laboratories and to get samples tested with a sufficiently short turnaround time to maintain samples stability. It is therefore anticipated that clinical specimens will consist in frozen single donations. In such a case, the absence of freeze-thaw effect should be demonstrated beforehand. As a commutability assessment of a candidate reference material should ideally include all commercially available assays, another challenge lies in the need to collect a sufficiently large volume of each single donation to allow conducting measurements with the different assays with appropriate replication number. Although a commutability assessment should include as many PCT measurement procedures as possible, involved assay should target the same measurand and have adequate APS. The measurement results obtained will be analyzed using the difference in bias approach [82]. An important prerequisite will be to select appropriate acceptance criteria for commutability, ie. to decide what level of non-commutability is acceptable, which is the current topic of the IFCC Working Group on Commutability in Metrological Traceability (WG-CMT). It is expected that results of the commutability will allow identifying the manufacturing process leading to the highest commutability level. An EQA scheme relying on commutable material(s) will allow to accurately document the current state of the art of harmonization of PCT results and consequently to determine whether standardization is needed or not to improve the comparability of the results provided from the different PCT assays used in routine clinical practice.

201  
202     ▪ **The third term of reference** consists in evaluating the need for standardization of PCT  
203 assays through a common calibration with commutable calibrators value assigned with  
204 the ID-LC HRMS RMP. The consultation of the International Consortium for  
205 Harmonization of Clinical Laboratory Results (ICHCLR) has already revealed that  
206 standardization/harmonization of PCT assays is considered as a high priority due to  
207 the growing utilization of PCT and to the implementation and integration in clinical  
208 guidelines and antimicrobial stewardship programs [83]. Moreover, a high medical  
209 impact of this standardization was pointed out by the ICHCLR. The strength of the IFCC  
210 working group on PCT assays, that gathers almost all IVD manufacturers marketing  
211 PCT assays, is particularly relevant for the objective of this term of reference. Indeed,  
212 the consultation of assay manufacturers was initiated with the creation of the working  
213 group and reveals that the need and demand for standardization on PCT assays differ  
214 across assay manufacturers. For some commercially available PCT assays (BRAHMS  
215 licensed assays group), a harmonization system is already in place through the use of  
216 the Kryptor method as a consensus reference method. Thus, for this group of methods,  
217 the recalibration of PCT assays is not perceived as a priority. On the contrary, for PCT  
218 assays other than BRAHMS PCT assays, there is currently no common calibrators nor  
219 reference system. Thus, standardization or harmonization is needed for these assays.  
220 Although views differ, all IFCC WG-PCT members agreed that commutable EQA  
221 materials are needed to accurately estimate between-method agreement (second term  
222 of reference) and thus assess the need for standardization of PCT.

223  
224     ▪ **The fourth term of reference** consists in evaluating the feasibility for standardization  
225 of PCT assays through common calibration with commutable calibrators, value  
226 assigned with the ID-LC HRMS RMP. This activity is highly dependent on the activities  
227 of the first and second terms of reference. Indeed, if a RMP is not available or does not  
228 meet appropriate APS, standardization will not be feasible. When validated, it will be  
229 necessary to evaluate if the candidate reference method by ID-LC MS/MS is robust  
230 enough at PCT concentration of clinical interest and if it enables to properly establish  
231 results traceability to the SI Units with sufficiently low measurement uncertainty. In  
232 addition, a sufficiently strong correlation between the different commercially available  
233 PCT assays and the candidate reference methods by ID-LC HRMS has to be  
234 demonstrated. Finally, the availability of the commutable calibrators has to be ensured.  
235 The feasibility of the standardization of PCT assays will thus be assessed if all these  
236 criteria are met.

237  
238     **The fifth term of reference** consists in implementing the standardization of PCT  
239 assays at the global scale, if it appears desirable and feasible. If all the conditions for  
240 feasibility are met and if discrepant results between the different PCT assays are still  
241 observed from the EQA scheme relying on commutable EQA materials, standardization  
242 of PCT assays could be done either through panels of patient or commutable  
243 secondary calibrators value assigned with the ID-LC HRMS RMP. As recalibration of  
244 commercially available assays for PCT would require important efforts from IVD  
245 manufacturers, there should be strong evidence that standardization is necessary and  
246 feasible. EQA schemes will be needed to assess the accuracy and comparability of  
247 PCT measurement and evaluate the impact of the recalibration. Subsequently, it would  
248 be necessary to assess if the current clinical decision used in clinical practice need to  
249 be reconsidered or not.

## **Conclusion**

Due to the growing threat of antimicrobial resistance and high mortality associated with sepsis, having accurate and comparable PCT results appears of high importance. Still, in absence of neither any higher order reference material nor any accuracy-based program relying on EQA materials of proven commutability, the current state of the art regarding comparability of PCT results across the different commercially available assays remains to be properly documented. In this context, the IFCC Working Group on standardization of PCT assays has initiated activities to fill this gap. A higher order RMP and commutable reference material are under development to evaluate the necessity and the feasibility for establishing and maintaining a new reference measurement system for PCT. As cooperation from all stakeholders is of major importance, the working group gathers experts from National Metrology Institutes, calibration laboratories, clinicians, biologists, EQA providers and assay manufacturers.

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## Figure captions

**Figure 1.** Example of a metrological traceability chain for procalcitonin (PCT) measurement (ISO 17511-2020) relying on the development of a reference measurement system consisting of a hierarchy of different reference materials and reference measurement procedures.

**Figure 2.** Amino acid sequence of procalcitonin (PCT) and the different forms of PCT derived products which can be detected at different concentrations in the bloodstream of healthy subjects (figure adapted from Maruna et al 2000 and Becker et al 2004 [38,43])

**Figure 3.** PCT clinical cut-off values for patient stratification (figure adapted from Meisner 2014 [47])

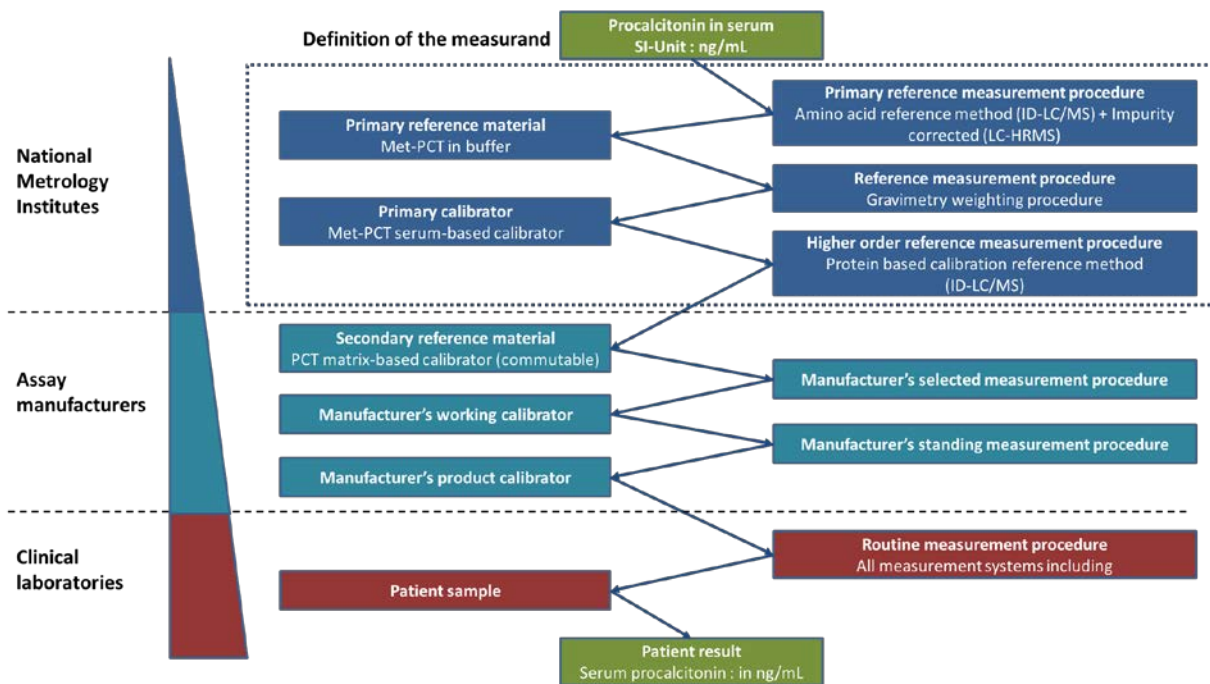
**Figure 4.** Terms of Reference of IFCC working group on Standardization of Procalcitonin (PCT) assays (IFCC WG-PCT)

**Figure 5.** Different calibration strategies for procalcitonin (PCT) targeted quantification by ID-LC MS/MS.

Analyte and internal standard (IS) could be spiked at different steps of the sample preparation process: 1 – before protein purification step; 2 – after protein purification step and before protein digestion step; 3 – after digestion step and before LC-MS/MS analysis. Depending on when analyte and IS are added to calibrators or patient samples, results accuracy could be influenced by various random variabilities during the whole quantification process such as sample handling, inefficient protein purification/digestion, protein/peptides adsorption, LC injection volume or MS ion suppression/enhancement.

Peptide-based calibration: calibrator produced by the addition of peptide analyte and SIL-peptide internal IS after protein digestion step (3)

Protein-based calibration: calibrators produced by the addition of protein analyte and SIL-protein IS before (2) or after (3) protein purification step.





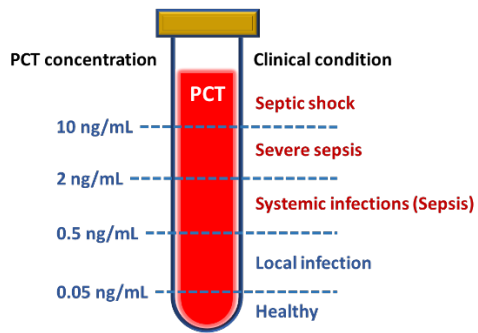
PCT amino acid sequence (NProCT-KR-Mature Calcitonin-GKKR-Katacalcin)

H<sub>2</sub>N-APFRSALESS PADPATLSED EARLLAALV QDYVQMKASE LEQEQUREGS

SLDSPRSKRC GNLSTCMLGT YTQDFNKFHT FPQTAIGVGA PGKKRDMSSD

LERDHRPHVS MPQNaN-COOH

					<u>Concentration</u>
NProCT	-KR-	Mature Calcitonin	-G-KKR-	Katacalcin	0.19 fmol/mL
NProCT					4.15 fmol/mL
		Mature Calcitonin	-G-KKR-	Katacalcin	0.17 fmol/mL
				Katacalcin	3.17 fmol/mL
		Mature Calcitonin			1.84 fmol/mL



## Standardization of Procalcitonin assays (IFCC WG-PCT)

