Assessment of ACTH assay variability: a multicenter study

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Abstract

Objective: Measurement of plasma ACTH plays a pivotal role in the diagnosis and treatment of several endocrine disorders. Little is known, however, on the variability of ACTH assay results and its impact on clinical practice. The aim of the present study was to assess the performance of routine plasma ACTH measurements.

Design: Twenty-five fresh-frozen plasma samples collected from patients with either high, low, or normal ACTH concentrations were measured using seven different assays by 35 different laboratories. Assay precision, method agreement, and result classification were estimated.

Results: Inter- and intra-assay coefficient of variation varied considerably with some assays achieving <10%, others consistently achieving >20%. Overall method agreement was good (mean ratio versus target value 1.02) but subject to exceedingly large excursion (lower and upper limits of agreement at 0.13 and 1.91 respectively). Both differences between assays and between laboratories contributed to variability of method agreement. Assays correctly classified most patients with normal and high ACTH concentrations (90% (95% CI 82–97%) and 95% (95% CI 86–100%) respectively), whereas only 60% (95% CI 52–67%) of measurements from patients with low ACTH values were assigned correctly.

Conclusions: Field ACTH assays have to be interpreted with caution as they are burdened by high variability and often fail to correctly identify patients with suppressed ACTH secretion. The endocrine community has to include ACTH assays among those requiring standardization.

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performance. Participants (see below for details) had responded to the call of the Study Group on the
Hypothalmo-Pituitary–Adrenal Axis of the Italian Society of Endocrinology. Plasma samples from individ-
uals with high (patients #1–2 and #4–6 with Addison’s disease, patients #3 and #7 adrenalectomized for
Cushing’s disease), normal (normal subjects #8–18), and low ACTH levels (patients #22–24 with auto-
immune diseases on 8–16 mg methylprednisolone daily for at least 4 months; patients #19–20 and #25 with
adrenal Cushing’s syndrome, and patient #21 with isolated ACTH deficiency) were used. In detail, patients
with adrenal Cushing presented urinary free cortisol (UFC) levels ranging from 225 to 645 µg/24 h (normal
range in our laboratory is 10–80 µg/24 h) and cortisol levels after 1 mg dexamethasone between 15.4 and
29 µg/dl. The patient with isolated ACTH deficiency (#21) presented morning serum cortisol levels around
2.3–3.8 µg/dl (normal range 5–25) and UFC levels from 8.7 to 10 µg/24 h.

A large blood sample from each subject/patient was collected into EDTA-containing tubes, centrifuged at
4 °C, plasma-pooled, then aliquoted, and stored at –80 °C. Samples were collected in a single sitting and
shipped to individual laboratories in dry ice within 2 months of collection in order to avoid peptide
deterioration. Laboratories were blinded to patient status, assayed all samples in a single run using their
standard procedure, and returned the results to our center for analysis together with their technical assay
sheets. A single measurement or the mean of two values was used for each patient, for singlicate and duplicate
measurements respectively, as per each laboratory’s procedure. All samples were assayed by every labora-

tory. For intraassay variation, 16 additional replicates of samples from patients #2, #4, #5, and #7 for high
ACTH values, patients #12, #13, #14, and #15 for normal ACTH values, and patients #19 and #20 for low
ACTH values were measured with each assay in a single laboratory. The total number of samples available for
analysis was 1835. The lower limit of detection reported by assay kit manufacturers as the smallest value, which
can be distinguished from zero at the 95% confidence limit or mean ± 2 S.D. is given in Table 1. Samples
yielding ACTH concentrations below or above the calibration curve of a given assay were arbitrarily
assigned the lowest/highest value of said calibration curve. Producers of assays used by participants were
Diagnostic Products Corporation (now Siemens Healthcare Diagnostics; DPC), Los Angeles, CA, USA; Diag-
nostic System Laboratories, Inc. (DSL), Webster, TX, USA; Scantibodies Laboratory, Inc., Santee, CA, USA;
Diasorin, Stillwater, MN, USA; Nichols Institute Diagn-

stics, San Juan Capistrano, CA, USA; and CisBio International, Saclay, France. The study was approved
by the Ethical Committee of the Istituto Auxologico Italiano, and subjects gave their informed consent to
participate in the study.

Statistical analysis

Imprecision across methods and for individual methods
was determined by Variance Function Program 5.0 (Christchurch, New Zealand). Mean, s.d., and coefficient
of variation (CV) were calculated, and the median of method means (MedMM) (6) for each patient was used
as a target value, as this represents a relative calibrator given that there is no accepted reference method
procedure for quantification of plasma ACTH. For comparisons between standards, MedMM was calcu-
lated from assays using the same reference preparation (RP) (see Table 1). Data were analyzed by nested ANOVA
for repeated measures with methods or standards as between factors and laboratories using the same
method/standard as within factors. Method agreement was established according to Bland–Altman plots
comparing candidate methods with MedMM both in terms of absolute differences and ratio (= method
value/MedMM) with 95% limits of agreement (7). Method alignment was analyzed by weighted Deming
regression using CBstat v.5.1 (Risskov, Denmark), as
measurement error was inconstant over the explored
range (8). Agreement in decision making, i.e. values
interpreted as high, normal, or low, was assessed by
Cohen’s K-statistic (9) using prevalence/bias-adjusted
cappa (P ABAK) values with 95% confidence intervals
since the prevalence was skewed towards the expected
result (10). P ABAK was calculated for agreement
between each of two assays, and then it averaged over
the entire series. P ABAK values >0.6 defined good
agreement (11). Statistical significance was accepted for
\(P < 0.05\).

Results

Samples were assayed by 35 centers, using seven
different assays (Table 1). Figure 1 shows a wide
distribution of ACTH measurements for each individual
with either high, normal, or low ACTH values. For
example, in subject #8, in whom normal ACTH
concentrations were expected, values as low as
7.0 pg/ml and as high as 69.0 pg/ml were reported
across assays and laboratories, whereas in patient #4
with Addison’s disease, values ranged from 955.3 to
11 625 pg/ml. In patient #20 with adrenal Cushing’s
syndrome, results of ACTH assays ranged from < 5 to
34.0 pg/ml.

Method precision

Inter- and intra-assay imprecision profiles are shown in
Fig. 2. Intraassay CV (panel A) was <20% for DPC, Nichols IRMA, Diasorin, and CisBio assays, while
higher values were observed for chemiluminescent
Nichols and DSL. Intraassay evaluation for Scantibodies
could not be performed, as the assay is not distributed in

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Table 1 Features of assays used in the study.

<table>
<thead>
<tr>
<th>Manufacturer</th>
<th>Diagnostic Product Corporation</th>
<th>Nichols</th>
<th>Nichols</th>
<th>CisBio</th>
<th>DiaSorin</th>
<th>Scantibodies</th>
<th>Diagnostic System Laboratories</th>
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<td>Catlog #</td>
<td>LKAC (Immulite) 62–7004</td>
<td>40–2195</td>
<td>ELSA–ACTH 27 065</td>
<td>27 130</td>
<td>3KG100</td>
<td>DSL–1500</td>
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<td></td>
<td>L2KAC (Immulite 2000)</td>
<td>60–4175</td>
<td>6–51 pg/ml (LKAC)</td>
<td>9 pg/ml (L2KAC)</td>
<td>5–1250 pg/ml</td>
<td>10–86 pg/ml</td>
<td>6–2000 pg/ml</td>
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<td>Method</td>
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<td>CLS</td>
<td>IRMA</td>
<td>IRMA</td>
<td>IRMA</td>
<td>IRMA</td>
<td>IRMA</td>
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<td>Lower limit of detection</td>
<td>5 pg/ml (LKAC)</td>
<td>1 pg/ml</td>
<td>2 pg/ml</td>
<td>1.5 pg/ml</td>
<td>1 pg/ml</td>
<td>1.5 pg/ml</td>
<td>1 pg/ml</td>
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<td>Standard curve range</td>
<td>2–1350 pg/ml</td>
<td>5–1400 pg/ml</td>
<td>18–1950 pg/ml</td>
<td>9.9–1330 pg/ml</td>
<td>5–1250 pg/ml</td>
<td>6–56.7 pg/ml</td>
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<td>Normal range</td>
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<td>Reference preparation</td>
<td>Purified ACTH (NHPP)</td>
<td>Purified ACTH (NHPP)</td>
<td>Purified ACTH (NHPP)</td>
<td>Purified ACTH (WHO 74/555)</td>
<td>Purified ACTH (WHO 74/555)</td>
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<td>Coefficient of variation (%)</td>
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<tr>
<td>Intra</td>
<td>&lt; 10</td>
<td>&lt; 5</td>
<td>&lt; 4</td>
<td>&lt; 7</td>
<td>&lt; 6</td>
<td>&lt; 6</td>
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<td>&lt; 6</td>
<td>&lt; 6</td>
<td>&lt; 7</td>
<td>&lt; 9</td>
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<td><strong>Data obtained from the present study</strong></td>
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<td>Number of laboratories using the assay</td>
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<td>7</td>
<td>7</td>
<td>3</td>
<td>2</td>
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<tr>
<td>Difference relative to MedMM</td>
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<td></td>
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<td>Mean ratio</td>
<td>0.84</td>
<td>0.99</td>
<td>1.04</td>
<td>1.2</td>
<td>1.23</td>
<td>1.12</td>
<td>0.85</td>
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<td>95% limits of agreement</td>
<td>0.40; 1.28</td>
<td>0.52; 1.46</td>
<td>0.35; 1.73</td>
<td>0.31; 2.07</td>
<td>0.61; 1.86</td>
<td>0.58; 1.66</td>
<td>0.35; 1.90</td>
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<td>Alignment with MedMM</td>
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<tr>
<td>Slope (95% CI)</td>
<td>0.95 (0.93; 0.98)*</td>
<td>0.98 (0.93; 1.02)</td>
<td>1.36 (1.29; 1.44)*</td>
<td>1.39 (1.34; 1.46)*</td>
<td>1.07 (1.04; 1.12)*</td>
<td>1.02 (0.75; 1.23)</td>
<td>0.76 (0.67; 0.87)*</td>
</tr>
<tr>
<td>Intercept (95% CI)</td>
<td>−0.56 (−0.69; −0.43)*</td>
<td>−0.07 (−0.27; 0.11)</td>
<td>−4.57 (−6.22; −2.92)*</td>
<td>−5.38 (−9.23; −1.53)*</td>
<td>0.72 (0.40; 1.05)*</td>
<td>−0.19 (−3.93; 3.78)</td>
<td>−5.76 (−8.64; −2.89)*</td>
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<tr>
<td>Coefficient of variation (%)</td>
<td></td>
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<tr>
<td>Intra</td>
<td>1–6</td>
<td>2–34</td>
<td>2–19</td>
<td>1–17</td>
<td>2–12</td>
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<tr>
<td>Inter</td>
<td>6–46</td>
<td>9–26</td>
<td>5–82</td>
<td>9–45</td>
<td>6–42</td>
<td>9–84</td>
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<td>Decision making (% correctly identified values)</td>
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<td>Low ACTH</td>
<td>81</td>
<td>65</td>
<td>84</td>
<td>41</td>
<td>3</td>
<td>78</td>
<td>31</td>
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<td>Normal ACTH</td>
<td>95</td>
<td>82</td>
<td>75</td>
<td>100</td>
<td>97</td>
<td>92</td>
<td>94</td>
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<tr>
<td>High ACTH</td>
<td>98</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
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</table>

CLS, chemiluminescent immunometric assay; NHPP, National Hormone Pituitary Program. *P<0.01 versus MedMM.
Italy any more. Of note, maximal acceptable intraassay CV for ACTH assays is 15.5%, according to the College of American Pathologists (12); thus, the majority of assays present adequate repeatability. Interassay imprecision was greater than intraassay imprecision for all assays, as expected; precision profiles (Fig. 2, panel B) spanned 20–40% for most assays, although higher values were observed for Scantibodies and CisBio assays. DSL interassay imprecision could not be evaluated as the assay was used only in one laboratory. Overall, these precision profiles were worse than those reported in technical sheets, reflecting the difficulty in achieving manufacturer evaluation performance under routine workload conditions and considerable between-laboratory variability (Table 1).

Method agreement
The Bland–Altman plot showing the difference in individual measurements versus the target value (i.e. MedMM) reveals a proportional error, i.e. an increasing difference in ACTH values at higher ACTH concentrations (Fig. 3, panel A); therefore, agreement was re-assessed using the ratio of individual measurements versus the target value (i.e. ratio of MedMM to achieve normal distribution) revealed significant differences in assay measurements by repeated-measures ANOVA (data were analyzed as the ratio of MedMM to achieve normal distribution) revealed significant differences in assay results between standards ($F=47.65$, $P<0.001$), between methods ($F=9.625$, $P<0.01$), and between laboratories ($F=4.65$, $P<0.01$); thus, all items contribute to the lack of agreement.

Decision making
ACTH measurements from patients were related to the reference range reported by individual laboratories and classified as high/normal/low ACTH values (Table 1). Overall, 85.1% (95% CI 83.0–87.2%) of values were interpreted correctly, with high and normal ACTH values achieving correct interpretation in 98.4% (95% CI 86.0–100%) and 89.6% (95% CI 81.8–97.4%) of measurements respectively, whereas only 59.5% (95% CI 52.3–66.8%) of measurements in patients in whom ACTH was expected to be suppressed were classified correctly. Of note, the vast majority of ACTH values in patients with suppressed ACTH (i.e. adrenal Cushing’s syndrome, prolonged steroid treatment, and isolated ACTH deficiency) were deemed ‘normal’ by the DiaSorin assay, as were 60–70% of values measured by CisBio and DSL. In fact, even the best performing assays yielded 15–20% misclassifications (Table 1).
On balance, overall agreement in decision making among assays was good, as mean $P_{ABA}$ equaled 0.88 (95% CI 0.86–0.90) due to the high agreement between values measured in patients with high ACTH concentrations (mean $P_{ABA}$ 0.95 (95% CI 0.89–1.00)) and good agreement for patients with normal ACTH (mean $P_{ABA}$ 0.79 (95% CI 0.71–0.86)). However, agreement in result assignment for patients with low ACTH values was poor (mean $P_{ABA}$ 0.28 (95% CI 0.17–0.38)).

**Discussion**

Wide variations between hormone measurements is a problem that plagued clinicians in the past, when RIA measurements were most common and nowadays, even with automated immunoassays, it still hampers reliable across-laboratory precision and, hence, the correct diagnosis. Low interlaboratory reproducibility and accuracy are being reported for several hormones, most notably serum testosterone (1), GH (2), and 25-hydroxyvitamin D (3), and attributed to a variety of causes, including different antibody epitope specificity (3) or calibrants (2), heterogeneity of circulating isoforms (13, 14), interference with binding proteins (15) and variable recovery after extraction (16, 17). Interlaboratory variability becomes particularly relevant if specific thresholds for hormonal concentrations are used for clinical decision making, be it diagnosis of acromegaly with oral glucose load (18) or GH deficiency after provocative testing (19), adrenal insufficiency (20), or screening for hypothyroidism (21) or for hypovitaminosis D (3).

As regards the hypothalamo-pituitary–adrenal axis, validation studies for serum and urinary cortisol, as well as other steroids, yielded variable results, with some investigators reporting acceptable interassay precision (6) and others reporting large intermethod variation (16), especially for serum cortisol levels after dexamethasone suppression (22) or Synachten stimulation (20) and salivary cortisol (23). Measurement of plasma ACTH evolved from bioassays on guinea pig or rat adrenal cells (24) through the milestone RIA of Berson & Yalow in 1968 (5) to radioactive or non-isotopic immunometric assays. The development and marketing of new ACTH assays usually led to comparison studies with existent assays and commonly revealed good correlation and comparable clinical sensitivity (25–27), although widely different results or limited agreement between two assays have also been observed (28, 29).

Our study shows a marked variability in assay performance and both constant and proportional bias among tested assays, which encompass major ACTH assay manufacturers. Most assays showed adequate repeatability, i.e. intraassay CV <15%, but assay performance in routine conditions was consistently less than precision profiles reported in assay technical sheets. Furthermore, both a systematic and proportional error was apparent, an effect due to assay RP as well as laboratory differences. These difficulties in ACTH assay agreement are well summarized by Bland–Altman statistics, which shows a good mean agreement with the expected value but an unacceptably large range of agreement for each measurement. From a clinical viewpoint, this translates into an acceptable agreement in the assignment of results obtained in patients with either normal or high ACTH values, where large excursions among measurements do not necessarily alter their clinical significance, but causes poor agreement and frequent result misclassification among patients with low ACTH levels.

Assay performance is a major concern for ACTH assay kits and, in some cases, the reason for assay withdrawal (30). Our study includes assays which are currently off the market but, given their extensive use in the past, for example the Nichols’ assay in the US (26), it provides a good basis for comparison, as diagnostic cut-off values developed by Nichols’ users might require

**Figure 2** Imprecision profiles for each assay calculated according to Variance Function Program 5.0 (Christchurch, New Zealand). Panel A shows intraassay coefficient of variation; panel B shows interassay coefficient of variation.
readjustments. Absolute ACTH values are commonly used for the distinction of ACTH-independent and ACTH-dependent Cushing’s syndrome, for the differential diagnosis of adrenal insufficiency and to assess effects of treatment or during follow-up of patients with adrenal or pituitary disorders. In these contexts, interassay and interlaboratory agreement among ACTH measurements becomes mandatory.

Several causes may contribute to assay variability, starting with the different standards used by individual assays, as not all ACTH (1–39) formulations are equally recognized by assay antibodies. The different potency of ACTH standards had already been observed in the past (31) and is currently difficult to rectify, as there is no International Standard for human ACTH. Indeed, the only International Standard for corticotropin is derived from pig pituitaries (32), and assays use synthetic or pituitary-derived purified preparations. It is also important to recall that ACTH adsorbs to unsiliconized glass tubes and degrades rapidly at room temperature (33); thus, the use of EDTA-coated plastic tubes, rapid sample processing, and cool storage prior to assay is mandatory. These factors were carefully controlled in our study but may play an additional, confounding role in everyday field ACTH measurements.

Incorrect interpretation of low ACTH values and poor agreement in value assignment in these patients are in line with results obtained on a large group of patients.
with adrenal Cushing’s syndrome (4) and other anecdotal observations in patients with ACTH-independent Cushing’s syndrome who do not display suppressed or undetectable ACTH values (34–36), as would be expected. Indeed, diagnostic flowcharts commonly exclude adrenal Cushing’s syndrome if ACTH values are above 1–2 or 5–10 pg/ml (37, 35). The fact that 40% of plasma ACTH measurements fell into the normal range in patients in whom ACTH secretion should be suppressed raises the issue of whether this pattern is due to technical problems or whether the pathophysiology of glucocorticoid negative feedback and secondary adrenal insufficiency should be revisited. Lastly, low plasma ACTH is considered a useful parameter for the diagnosis of subclinical Cushing’s syndrome in patients with an adrenal incidentaloma (38), an ever increasing clinical issue, and the uncertainty in measurement of low ACTH concentrations represents an important obstacle.

In conclusion, notwithstanding the progress in assay automation, our study revealed a considerable variability in field ACTH measurements. This proved particularly relevant for low ACTH values, as up to 40% of results were classified incorrectly. On the basis of this evidence, we recommend that variability among ACTH assays should be kept in mind when dealing with different ACTH assays and low ACTH values should be interpreted with caution; this should be taken into account for both clinical and experimental studies. Endocrinologists should therefore evaluate the performance of their ACTH assays beyond standard laboratory Quality Control testing, and the Endocrinological Community should strive for harmonization of reference materials and re-evaluation of normal ranges as well as cut-off values to be used by commercial ACTH assays.

### Participating laboratories

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### Declaration of interest

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

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