CK

Creatine Kinase

cobas®

Order information

REF		CONTENT		Analyzer(s) on which **cobas c** pack(s) can be used
07190794190	07190794500	Creatine Kinase (200 tests)	System-ID 07 7485 5	**cobas c** 311, **cobas c** 501/502, COBAS INTEGRA 400 plus

Materials required (but not provided):

		cobas c 311, **cobas c** 501/502	COBAS INTEGRA 400 plus
10759350190	Calibrator f.a.s. (12 x 3 mL)	Code 401	System-ID 07 3718 6
12149435122	Precinorm U plus (10 x 3 mL)	Code 300	System-ID 07 7999 7
12149443122	Precipath U plus (10 x 3 mL)	Code 301	System-ID 07 8000 6
05117003190	PreciControl ClinChem Multi 1 (20 x 5 mL)	Code 391	System-ID 07 7469 3
05947626190	PreciControl ClinChem Multi 1 (4 x 5 mL)	Code 391	System-ID 07 7469 3
05117216190	PreciControl ClinChem Multi 2 (20 x 5 mL)	Code 392	System-ID 07 7470 7
05947774190	PreciControl ClinChem Multi 2 (4 x 5 mL)	Code 392	System-ID 07 7470 7
04489357190	Diluent NaCl 9 % (50 mL)	System-ID 07 6869 3	n.a.
20756350322	NaCl Diluent 9 % (6 × 22 mL)	n.a.	System-ID 07 5635 0

English

Intended use

In vitro test for the quantitative determination of creatine kinase (CK) in human serum and plasma on **cobas c** and COBAS INTEGRA systems.

Summary

Measurements of creatine kinase (CK), performed with this assay in human serum and plasma, are used as an aid in diagnosis of muscular injuries and diseases.

CK is a dimeric enzyme occurring in four different forms: a mitochondrial isoenzyme and the cytosolic isoenzymes CK MM (skeletal muscle type), CK BB (brain type) and CK MB (myocardial type).[1] Elevated total CK is observed in patients with skeletal and heart muscle injuries and diseases.[2]

The determination of CK and CK isoenzyme activities is utilized in the diagnosis and monitoring of muscular injuries and diseases in the acute (e.g. rhabdomyolysis or acute myocardial injury) and chronic settings (e.g. myopathies such as the progressive Duchenne muscular dystrophy). In acute rhabdomyolysis, for example, serum CK activities above 200 times the upper reference limit may be found. Serum CK activity is elevated in all types of muscular dystrophy.[3] In progressive muscular dystrophy, enzyme activity in serum may be increased long before the disease is clinically apparent.[3]

Following injury to the myocardium, such as occurs with acute myocardial infarction,[1] CK is released from the damaged myocardial cells. In early cases, a rise in the CK activity can be found just 4 hours after an infarction.[1,4] The CK activity reaches a maximum after 12-24 hours and then falls back to the normal range after 3-4 days.[1,4] According to the 4th Universal Definition of Myocardial Infarction, cardiac troponins are the preferred biomarkers for the evaluation of myocardial injury, since other biomarkers are less specific and less sensitive.[5]

The determination of CK levels can also be used for evaluation of drug toxicity. The European Society of Cardiology and the European Atherosclerosis Society recommend measuring CK in patients before initiation of lipid-lowering drug therapy, and in patients on lipid-lowering drugs, presenting with muscle pain and weakness, in order to identify the limited number of patients where treatment is contraindicated.[6]

The assay method using creatine phosphate and ADP was first described by Oliver,[7] modified by Rosalki[8] and further improved for optimal test conditions by Szasz et al.[9] CK is rapidly inactivated by oxidation of the sulfhydryl groups in the active center. The enzyme can be reactivated by the addition of acetylcysteine (NAC).[9] Interference by adenylate kinase is prevented by the addition of diadenosine pentaphosphate[10] and AMP.[9,10]

Standardized methods for the determination of CK with activation by NAC were recommended by the German Society for Clinical Chemistry (DGKC)[10] in 1977 and the International Federation of Clinical Chemistry (IFCC)[11] in 1991. In 2002 the IFCC confirmed their recommendation and extended it to 37 °C.[12,13] The method described here is derived from the formulation recommended by the IFCC and was optimized for performance and stability.

Test principle

UV-test

$$\text{Creatine phosphate} + \text{ADP} \xrightarrow{\text{CK}} \text{creatine} + \text{ATP}$$

$$\text{ATP} + \text{D-glucose} \xrightarrow{\text{HK}} \text{ADP} + \text{G6P}$$

$$\text{G6P} + \text{NADP}^+ \xrightarrow{\text{G6PDH}} \text{D-6-phosphogluconate} + \text{NADPH} + \text{H}^+$$

Equimolar quantities of NADPH and ATP are formed at the same rate. The photometrically measured rate of formation of NADPH is directly proportional to the CK activity.

Precautions and warnings

For in vitro diagnostic use for health care professionals. Exercise the normal precautions required for handling all laboratory reagents.

Infectious or microbial waste:
Warning: handle waste as potentially biohazardous material. Dispose of waste according to accepted laboratory instructions and procedures.

Environmental hazards:
Apply all relevant local disposal regulations to determine the safe disposal.

Safety data sheet available for professional user on request.

This kit contains components classified as follows in accordance with the Regulation (EC) No. 1272/2008:

Danger

H360D	May damage the unborn child.

Prevention:

P201	Obtain special instructions before use.
P202	Do not handle until all safety precautions have been read and understood.
P280	Wear protective gloves/ protective clothing/ eye protection/ face protection/ hearing protection.

Response:

P308 + P313	IF exposed or concerned: Get medical advice/attention.

CK

Creatine Kinase

Storage:

P405 Store locked up.

Disposal:

P501 Dispose of contents/container to an approved waste disposal plant.

Product safety labeling follows EU GHS guidance.

Contact phone: all countries: +49-621-7590

Reagent handling

Ready for use

Specimen collection and preparation

For specimen collection and preparation only use suitable tubes or collection containers.

Only the specimens listed below were tested and found acceptable.
Serum: Nonhemolyzed serum is the specimen of choice and also recommended by IFCC.
Plasma: Li-heparin, K_2-, K_3-EDTA plasma.

Please note: Differences in the degree of hemolysis resulting from the blood sampling procedure used can lead to deviating results in serum and plasma.

The sample types listed were tested with a selection of sample collection tubes that were commercially available at the time of testing, i.e. not all available tubes of all manufacturers were tested. Sample collection systems from various manufacturers may contain differing materials which could affect the test results in some cases. When processing samples in primary tubes (sample collection systems), follow the instructions of the tube manufacturer.

Centrifuge samples containing precipitates before performing the assay.

Stability in serum:[14]	2 days at 20-25 °C
	7 days at 4-8 °C
	4 weeks at (-15)-(-25) °C

Freeze only once.

Stability in EDTA/heparin plasma:[15]	2 days at 15-25 °C
	7 days at 2-8 °C
	4 weeks at (-15)-(-25) °C

Freeze only once.

Materials provided

See “Reagents – working solutions” section for reagents.

Materials required (but not provided)

See “Order information” section

General laboratory equipment

Assay

For optimum performance of the assay follow the directions given in this document for the analyzer concerned. Refer to the appropriate operator’s manual for analyzer-specific assay instructions.

The performance of applications not validated by Roche is not warranted and must be defined by the user.

Calculation

The systems automatically calculate the analyte concentration of each sample.

Conversion factor: U/L x 0.0167 = µkat/L

Expected values

Reference intervals strongly depend on the patient group and the specific clinical situation.

For healthy people, according to Klein et al.:[16]

CK	U/L	µkat/L
Men	39-308	0.65-5.14
Women	26-192	0.43-3.21

Consensus values:[17]

CK	U/L	µkat/L
Men	< 190	< 3.20
Women	< 170	< 2.85

Consensus values:[17]

CK-MB	U/L	µkat/L
Men/women	< 25	< 0.42

Myocardial infarction: There is a high probability of myocardial damage when the following three conditions are fulfilled:[18]

		U/L	µkat/L
1	CK_{men}	> 190	> 3.17
	CK_{women}	> 167	> 2.79
2	CK-MB	> 24	> 0.40

3 The CK-MB activity accounts for 6-25 % of the total CK-activity.

According to Tietz:[19]

CK	U/L	µkat/L
Adult males > 19 years	20-200	0.33-3.34
Adult females > 19 years	20-180	0.33-3.01

The reference values according to Klein et al. are based on the 95th percentile of a group of healthy persons (202 men and 217 women) not involved in high-intensity athletic activities.

In order to ensure high sensitivity in the diagnosis of heart diseases the values given by Tietz are recommended. The loss of diagnostic specificity thereby incurred can be compensated for by additionally determining CK-MB and/or troponin T. When myocardial infarction is suspected the diagnostic strategy proposals in the consensus document of European and American cardiologists should in general be followed.[20]

If despite the suspicion of myocardial infarction the values found remain below the stated limits, a fresh infarction may be involved. In such cases, the determinations should be repeated after 4 hours.

CK varies with physical activity level and race in healthy individuals.[19,21]

Each laboratory should investigate the transferability of the expected values to its own patient population and if necessary determine its own reference ranges.

cobas c systems

System information

For **cobas c** 311/501 analyzers:
CK2: ACN 550
For **cobas c** 502 analyzer:
CK2: ACN 8550

Reagents - working solutions

R1 Imidazole buffer: 123 mmol/L, pH 6.5 (37 °C); EDTA: 2.46 mmol/L; Mg^{2+}: 12.3 mmol/L; ADP: 2.46 mmol/L; AMP: 6.14 mmol/L; diadenosine pentaphosphate: 19 µmol/L; $NADP^+$ (yeast): 2.46 mmol/L; N-acetylcysteine: 24.6 mmol/L; HK (yeast): ≥ 36.7 µkat/L; G6PDH (E. coli): ≥ 23.4 µkat/L; preservative; stabilizers; additives.

R2 CAPSO* buffer: 20 mmol/L, pH 8.8 (37 °C); glucose: 120 mmol/L; EDTA: 2.46 mmol/L; creatine phosphate: 184 mmol/L; preservative; stabilizers.

*CAPSO: 3-(cyclohexylamine)-2-hydroxy-1-propanesulfonic acid

R1 is in position B and R2 is in position C.

CK

Creatine Kinase

cobas®

Storage and stability

Shelf life at 2-8 °C:	See expiration date on **cobas c** pack label.
On-board in use and refrigerated on the analyzer:	8 weeks

Application for serum and plasma

cobas c 311 **test definition**

Assay type	Rate A		
Reaction time / Assay points	10 / 16-29		
Wavelength (sub/main)	546/340 nm		
Reaction direction	Increase		
Units	U/L (µkat/L)		
Reagent pipetting		Diluent (H_2O)	
R1	100 µL	–	
R2	20 µL	–	
Sample volumes	*Sample*	*Sample dilution*	
		Sample	*Diluent (NaCl)*
Normal	2.8 µL	–	–
Decreased	2.8 µL	15 µL	150 µL
Increased	2.8 µL	–	–

cobas c 501 **test definition**

Assay type	Rate A		
Reaction time / Assay points	10 / 24-44		
Wavelength (sub/main)	546/340 nm		
Reaction direction	Increase		
Units	U/L (µkat/L)		
Reagent pipetting		Diluent (H_2O)	
R1	100 µL	–	
R2	20 µL	–	
Sample volumes	*Sample*	*Sample dilution*	
		Sample	*Diluent (NaCl)*
Normal	2.8 µL	–	–
Decreased	2.8 µL	15 µL	150 µL
Increased	2.8 µL	–	–

cobas c 502 **test definition**

Assay type	Rate A		
Reaction time / Assay points	10 / 24-44		
Wavelength (sub/main)	546/340 nm		
Reaction direction	Increase		
Units	U/L (µkat/L)		
Reagent pipetting		Diluent (H_2O)	
R1	100 µL	–	
R2	20 µL	–	
Sample volumes	*Sample*	*Sample dilution*	
		Sample	*Diluent (NaCl)*
Normal	2.8 µL	–	–
Decreased	2.8 µL	15 µL	150 µL
Increased	5.6 µL	–	–

Calibration

Calibrators	S1: H_2O
	S2: C.f.a.s.
Calibration mode	Linear
Calibration frequency	2-point calibration • after reagent lot change • as required following quality control procedures

Traceability: This method has been standardized against the IFCC Method for Creatine Kinase.[12]

Quality control

For quality control, use control materials as listed in the "Order information" section.

In addition, other suitable control material can be used.

The control intervals and limits should be adapted to each laboratory's individual requirements. Values obtained should fall within the defined limits. Each laboratory should establish corrective measures to be taken if values fall outside the defined limits.

Follow the applicable government regulations and local guidelines for quality control.

Limitations - interference

Criterion: Recovery within ± 10 % of initial value at a creatine kinase activity of 140 U/L (2.34 µkat/L).

Icterus:[22] No significant interference up to an I index of 60 for conjugated and unconjugated bilirubin (approximate conjugated and unconjugated bilirubin concentration: 1026 µmol/L or 60 mg/dL).

Hemolysis:[22] No significant interference up to an H index of 100 (approximate hemoglobin concentration: 62.1 µmol/L or 100 mg/dL). The level of interference may be variable depending on the exact content of erythrocytes.

Lipemia (Intralipid):[22] No significant interference up to an L index of 1000. There is poor correlation between the L index (corresponds to turbidity) and triglycerides concentration. Highly lipemic specimens (L index > 1000) may cause high absorbance flagging.

Drugs: No interference was found at therapeutic concentrations using common drug panels.[23,24]

Cyanokit (Hydroxocobalamin) at therapeutic concentrations interferes with the test.

In very rare cases, gammopathy, in particular type IgM (Waldenström's macroglobulinemia), may cause unreliable results.[25]

For diagnostic purposes, the results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.

ACTION REQUIRED

Special Wash Programming: The use of special wash steps is mandatory when certain test combinations are run together on **cobas c** systems. The latest version of the carry-over evasion list can be found with the NaOHD-SMS-SmpCln1+2-SCCS Method Sheets. For further instructions refer to the operator's manual. **cobas c** 502 analyzer: All special wash programming necessary for avoiding carry-over is available via the **cobas** link, manual input is required in certain cases.

Where required, special wash/carry-over evasion programming must be implemented prior to reporting results with this test.

Limits and ranges

Measuring range

7-2000 U/L (0.12-33.4 µkat/L)

Determine samples having higher activities via the rerun function. Dilution of samples via the rerun function is a 1:11 dilution. Results from samples diluted by the rerun function are automatically multiplied by a factor of 11.

Lower limits of measurement

Limit of Blank, Limit of Detection and Limit of Quantitation

Limit of Blank	= 7 U/L (0.12 µkat/L)
Limit of Detection	= 7 U/L (0.12 µkat/L)

CK

Creatine Kinase

Limit of Quantitation = 7 U/L (0.12 µkat/L)

The Limit of Blank, Limit of Detection and Limit of Quantitation were determined in accordance with the CLSI (Clinical and Laboratory Standards Institute) EP17-A2 requirements.

The Limit of Blank is the 95th percentile value from n ≥ 60 measurements of analyte-free samples over several independent series. The Limit of Blank corresponds to the concentration below which analyte-free samples are found with a probability of 95 %.

The Limit of Detection is determined based on the Limit of Blank and the standard deviation of low concentration samples. The Limit of Detection corresponds to the lowest analyte concentration which can be detected (value above the limit of blank with a probability of 95 %).
The Limit of Quantitation is the lowest analyte concentration that can be reproducibly measured with a precision of 20 % CV. It has been determined using low concentration creatine kinase samples.

Specific performance data

Representative performance data on the analyzers are given below. Results obtained in individual laboratories may differ.

Precision

Repeatability and intermediate precision were determined using human samples and controls in accordance with the CLSI (Clinical and Laboratory Standards Institute) EP5 requirements (2 aliquots per run, 2 runs per day, 21 days). The following results were obtained on the **cobas c** 501 analyzer.

Repeatability	*Mean* U/L (µkat/L)	*SD* U/L (µkat/L)	*CV* %
Human serum 1	18.7 (0.31)	0.6 (0.01)	3.0
Human serum 2	137 (2.29)	0.8 (0.01)	0.6
Human serum 3	477 (7.97)	3.0 (0.05)	0.6
Human serum 4	946 (15.8)	5.3 (0.09)	0.6
Human serum 5	1816 (30.3)	9.4 (0.16)	0.5
PCCC Multi 1*	154 (2.57)	0.9 (0.02)	0.6
PCCC Multi 2	301 (5.02)	1.3 (0.02)	0.4

Intermediate precision	*Mean* U/L (µkat/L)	*SD* U/L (µkat/L)	*CV* %
Human serum 1	18.7 (0.31)	0.6 (0.01)	3.2
Human serum 2	137 (2.29)	1.1 (0.02)	0.8
Human serum 3	477 (7.97)	3.1 (0.05)	0.6
Human serum 4	946 (15.8)	5.8 (0.10)	0.6
Human serum 5	1816 (30.3)	10 (0.17)	0.6
PCCC Multi 1	154 (2.57)	1.7 (0.03)	1.1
PCCC Multi 2	301 (5.02)	2.6 (0.04)	0.9

*PCCC = PreciControl ClinChem

The data obtained on **cobas c** 501 analyzer(s) are representative for **cobas c** 311 analyzer(s).

Method comparison

Creatine kinase values for human serum and plasma samples obtained on a **cobas c** 501 analyzer (y) were compared with those determined using the CKL reagent on a COBAS INTEGRA 800 analyzer (x).

Sample size (n) = 132

Passing/Bablok[26]	Linear regression
y = 1.021x + 5.88 U/L	y = 1.006x + 13.6 U/L
τ = 0.980	r = 0.999

The sample activities were between 7.59 and 1946 U/L (0.13 and 32.5 µkat/L).

The data obtained on **cobas c** 501 analyzer(s) are representative for **cobas c** 311 analyzer(s).

COBAS INTEGRA systems

System information

Test **CK2**, test ID 0-045

Reagents - working solutions

R1 Imidazole buffer: 123 mmol/L, pH 6.5 (37 °C); EDTA: 2.46 mmol/L; Mg^{2+}: 12.3 mmol/L; ADP: 2.46 mmol/L; AMP: 6.14 mmol/L; diadenosine pentaphosphate: 19 µmol/L; $NADP^+$ (yeast): 2.46 mmol/L; N-acetylcysteine: 24.6 mmol/L; HK (yeast): ≥ 36.7 µkat/L; G6PDH (E. coli): ≥ 23.4 µkat/L; preservative; stabilizers; additives.

SR CAPSO* buffer: 20 mmol/L, pH 8.8 (37 °C); glucose: 120 mmol/L; EDTA: 2.46 mmol/L; creatine phosphate: 184 mmol/L; preservative; stabilizers.

*CAPSO: 3-(cyclohexylamine)-2-hydroxy-1-propanesulfonic acid

R1 is in position B and SR is in position C.

Storage and stability

Shelf life at 2-8 °C	See expiration date on **cobas c** pack label
On-board in use at 10-15 °C	8 weeks

Application for serum and plasma

Test definition

Measuring mode	Absorbance
Abs. calculation mode	Kinsearch
Reaction mode	R1-S-SR
Reaction direction	Increase
Wavelength A/B	340/552 nm
Calc. first/last	10/45-62
Unit	U/L

Pipetting parameters

		Diluent (H_2O)
R1	100 µL	-
Sample	2.75 µL	2 µL
SR	20 µL	-
Total volume	124.75 µL	

Calibration

Calibrator	Calibrator f.a.s. Use deionized water as zero calibrator.
Calibration mode	Linear regression
Calibration replicate	Duplicate recommended
Calibration interval	Each lot and as required following quality control procedures

Traceability: This method has been standardized against the IFCC Method for Creatine Kinase.[12]

Quality control

Reference range	Precinorm U, Precinorm U plus, Precinorm CK-MB or PreciControl ClinChem Multi 1
Pathological range	Precipath U, Precipath U plus, Precipath CK-MB* or PreciControl ClinChem Multi 2

Control interval	24 hours recommended
Control sequence	User defined
Control after calibration	Recommended

*Not for use in the US

For quality control, use control materials as listed in the "Order information" section. In addition, other suitable control material can be used.

The control intervals and limits should be adapted to each laboratory's individual requirements. Values obtained should fall within the defined limits. Each laboratory should establish corrective measures to be taken if values fall outside the defined limits.

Follow the applicable government regulations and local guidelines for quality control.

Limitations - interference

Criterion: Recovery within ± 10 % of initial value at a creatine kinase activity of 140 U/L (2.34 µkat/L).

Icterus:[22] No significant interference up to an I index of 60 for conjugated and unconjugated bilirubin (approximate conjugated and unconjugated bilirubin concentration: 1026 µmol/L or 60 mg/dL).

Hemolysis:[22] No significant interference up to an H index of 100 (approximate hemoglobin concentration: 62.1 µmol/L or 100 mg/dL). The level of interference may be variable depending on the exact content of erythrocytes.

Lipemia (Intralipid):[22] No significant interference up to an L index of 1000. There is poor correlation between the L index (corresponds to turbidity) and triglycerides concentration. Highly lipemic specimens (L index > 1000) may cause high absorbance flagging.

Drugs: No interference was found at therapeutic concentrations using common drug panels.[23,24]

Cyanokit (Hydroxocobalamin) at therapeutic concentrations interferes with the test.

In very rare cases, gammopathy, in particular type IgM (Waldenström's macroglobulinemia), may cause unreliable results.[25]

For diagnostic purposes, the results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.

ACTION REQUIRED

Special Wash Programming: The use of special wash steps is mandatory when certain test combinations are run together on COBAS INTEGRA analyzers. Refer to the CLEAN Method Sheet for further instructions and for the latest version of the Extra wash cycle list.

Where required, special wash/carry-over evasion programming must be implemented prior to reporting results with this test.

Limits and ranges

Measuring range

7-2000 U/L (0.12-33.4 µkat/L)

Determine samples having higher activities via the rerun function. Dilution of samples via the rerun function is a 1:11 dilution. Results from samples diluted by the rerun function are automatically multiplied by a factor of 11.

Lower limits of measurement

Limit of Blank, Limit of Detection and Limit of Quantitation

Limit of Blank	= 7 U/L (0.12 µkat/L)
Limit of Detection	= 7 U/L (0.12 µkat/L)
Limit of Quantitation	= 7 U/L (0.12 µkat/L)

The Limit of Blank, Limit of Detection and Limit of Quantitation were determined in accordance with the CLSI (Clinical and Laboratory Standards Institute) EP17-A2 requirements.

The Limit of Blank is the 95th percentile value from n ≥ 60 measurements of analyte-free samples over several independent series. The Limit of Blank corresponds to the concentration below which analyte-free samples are found with a probability of 95 %.

The Limit of Detection is determined based on the Limit of Blank and the standard deviation of low concentration samples. The Limit of Detection corresponds to the lowest analyte concentration which can be detected (value above the limit of blank with a probability of 95 %).

The Limit of Quantitation is the lowest analyte concentration that can be reproducibly measured with a precision of 20 % CV. It has been determined using low concentration creatine kinase samples.

Specific performance data

Representative performance data on the COBAS INTEGRA analyzers are given below. Results obtained in individual laboratories may differ.

Precision

Repeatability and intermediate precision were determined using human samples and controls in accordance with the CLSI (Clinical and Laboratory Standards Institute) EP5 requirements (2 aliquots per run, 2 runs per day, 21 days). The following results were obtained on the COBAS INTEGRA 400 analyzer:

Repeatability	*Mean*	*SD*	*CV*
	U/L (µkat/L)	*U/L (µkat/L)*	*%*
Human serum 1	22.1 (0.37)	0.9 (0.01)	3.9
Human serum 2	144 (2.40)	1.4 (0.02)	1.0
Human serum 3	494 (8.25)	4.6 (0.08)	0.9
Human serum 4	980 (16.4)	10 (0.2)	1.0
Human serum 5	1893 (31.6)	19 (0.3)	1.0
PCCC Multi 1*	162 (2.71)	1.5 (0.03)	0.9
PCCC Multi 2	311 (5.19)	2.9 (0.05)	0.9

Intermediate precision	*Mean*	*SD*	*CV*
	U/L (µkat/L)	*U/L (µkat/L)*	*%*
Human serum 1	22.2 (0.37)	1.0 (0.02)	4.6
Human serum 2	145 (2.42)	1.9 (0.03)	1.3
Human serum 3	498 (8.31)	5.7 (0.10)	1.1
Human serum 4	980 (16.4)	12 (0.19)	1.2
Human serum 5	1893 (31.6)	22 (0.36)	1.1
PCCC Multi 1*	161 (2.69)	2.0 (0.03)	1.3
PCCC Multi 2	309 (5.16)	3.6 (0.06)	1.2

*PCCC = PreciControl ClinChem

Method comparison

Creatine kinase values for human serum and plasma samples obtained on a COBAS INTEGRA 400 plus analyzer (y) were compared with those determined using the CKL reagent on a COBAS INTEGRA 800 analyzer (x).

Sample size (n) = 109

Passing/Bablok[26]	Linear regression
y = 0.999x + 12.5 U/L	y = 0.987x + 19.7 U/L
τ = 0.980	r = 0.999

The sample activities were between 11.7 and 1819 U/L (0.20 and 30.4 µkat/L).

References

1 Thomas L, ed. Labor und Diagnose, 8th ed. Bd 1:TH-Books Verlagsgesellschaft 2012.

2 Mauro Panteghini. Serum enzymes. In: Rifai N, Chiu RWK, Young I, Burnham CAD, Wittwer CT, editors. Tietz Textbook of Laboratory Medicine, Saunders Elsevier, Philadelphia, 7th edition, 2023, chapter 32, p. 350-350.e36.

3 Morandi L, Angelini C, Prelle A, et. al. High plasma creatine kinase: review of the literature and proposal for a diagnostic algorithm. Neurol Sci 2006; 27:303-311.

4 Stein W. Laboratory Diagnosis of Acute Myocardial Infarction. Darmstadt: GIT Verlag 1988;34-37.

5 Thygesen K, Alpert JS, Chaitman BR, et al., Fourth Universal Definition of Myocardial Infarction (2018). Glob Heart 2018;13(4):305-338.

6 Catapano AL, Graham I, De Backer G, et al. 2016 ESC/EAS Guidelines for the Management of Dyslipidaemias. Eur Heart J; 37:2999-3058.

7 Oliver IT. A spectrophotometric method for the determination of creatine phosphokinase and myokinase. Biochem J 1955;61:116-122.

8 Rosalki SB. An improved procedure for serum creatine phosphokinase determination. J Lab Clin Med 1967;69:696-705.

9 Szasz G, Gruber W, Bernt E. Creatine kinase in serum: 1. Determination of optimum reaction conditions. Clin Chem 1976;22(5):650-656.

10 Standard method for the determination of creatine kinase activity. J Clin Chem Clin Biochem 1977;15:249-260.

11 Hørder M, Elser RC, Gerhardt M, et al. Approved Recommendation on IFCC Methods for the Measurement of Catalytic Concentration of Enzymes. Part 7. IFCC Method for Creatine Kinase. Eur J Clin Chem Clin Biochem 1991;29:435-456.

12 Schumann G, Bonora R, Ceriotti F, et al. IFCC Primary Reference Procedures for the Measurement of Catalytic Activity Concentrations of Enzymes at 37 °C – Part 2. Reference Procedure for the Measurement of Catalytic Concentration of Creatine Kinase. Clin Chem Lab Med 2002;40(6):635-642.

13 Klauke R, Schmidt E, Lorentz K. Recommendations for carrying out standard ECCLS procedures (1988) for the catalytic concentrations of creatine kinase, aspartate aminotransferase, alanine aminotransferase and γ-glutamyltransferase at 37 °C. Eur J Clin Chem Clin Biochem 1993;31:901-909.

14 Guder WG, Narayanan S, Wisser H, et al. List of Analytes; Preanalytical Variables. Brochure in: Samples: From the Patient to the Laboratory. Darmstadt: GIT-Verlag 1996.

15 Data on file at Roche Diagnostics.

16 Klein G, Berger A, Bertholf R, et al. Abstract: Multicenter Evaluation of Liquid Reagents for CK, CK-MB and LDH with Determination of Reference Intervals on Hitachi Systems. Clin Chem 2001;47:Suppl. A30.

17 Thomas L, Müller M, Schumann G, et al. Consensus of DGKL and VDGH for interim reference intervals on enzymes in serum. J Lab Med 2005; 29(5):301-308.

18 Stein W. Strategie der klinischen-chemischen Diagnostik des frischen Myokardinfarktes. Med Welt 1985;36:572-577.

19 Wu AHB, editor. Tietz Clinical Guide to Laboratory Tests, 4th edition. St. Louis (MO): Saunders Elsevier 2006;306-307.

20 Myocardial Infarction Redefined - A Consensus Document of the Joint European Society of Cardiology/ American College of Cardiology Committee for the Redefinition of Myocardial Infarction. Eur Heart J 2000;21:1502-1513.

21 Black HR, Quallich H, Gareleck CB. Racial differences in serum creatine kinase levels. Am J Med 1986;81:479-487.

22 Glick MR, Ryder KW, Jackson SA. Graphical Comparisons of Interferences in Clinical Chemistry Instrumentation. Clin Chem 1986;32:470-475.

23 Breuer J. Report on the Symposium "Drug effects in Clinical Chemistry Methods". Eur J Clin Chem Clin Biochem 1996;34:385-386.

24 Sonntag O, Scholer A. Drug interference in clinical chemistry: recommendation of drugs and their concentrations to be used in drug interference studies. Ann Clin Biochem 2001;38:376-385.

25 Bakker AJ, Mücke M. Gammopathy interference in clinical chemistry assays: mechanisms, detection and prevention. Clin Chem Lab Med 2007;45(9):1240-1243.

26 Bablok W, Passing H, Bender R, et al. A general regression procedure for method transformation. Application of linear regression procedures for method comparison studies in clinical chemistry, Part III. J Clin Chem Clin Biochem 1988 Nov;26(11):783-790.

A point (period/stop) is always used in this Method Sheet as the decimal separator to mark the border between the integral and the fractional parts of a decimal numeral. Separators for thousands are not used.

Any serious incident that has occurred in relation to the device shall be reported to the manufacturer and the competent authority of the Member State in which the user and/or the patient is established.

The Summary of Safety & Performance Report can be found here: https://ec.europa.eu/tools/eudamed

Symbols

Roche Diagnostics uses the following symbols and signs in addition to those listed in the ISO 15223-1 standard (for USA: see navifyportal.roche.com for definition of symbols used):

CONTENT	Contents of kit
→	Volume for reconstitution
GTIN	Global Trade Item Number
Rx only	For USA: Caution: Federal law restricts this device to sale by or on the order of a physician.

CE 0123

Roche Diagnostics GmbH, Sandhofer Strasse 116, D-68305 Mannheim
www.roche.com
+800 5505 6606