Sullivan Nicolaides PATHOLOGY
Quality is in our DNA

# BROOKE MAGILL

Lab ID 526993830 DOB 02/04/1980 (44 Yrs FEMALE)

Referrer Dr Raymond P Mullen
Your ref.

Address DR R P MULLEN 2/124 STIRLING HWY
NORTH FREMANTLE WA 6159

Address 6 KALKA PDE
JULAGO QLD 4816

Phone

Phone 0419501944

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Requested 30/01/2025

Clinical Notes 44yr old women recurrent

Collected 07/02/2025 15:08

Received 07/02/2025 15:08

## Protein Studies

| | | | |
|---|---|---|---|
| Immunoglobulin G (Total IgG) | 7.24 | 5.76 - 15.36 | g/L |
| Immunoglobulin A (Total IgA) | 1.41 | 1.24 - 4.16 | g/L |
| Immunoglobulin M (Total IgM) | 2.15 | 0.48 - 3.1 | g/L |

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Reported on 08-Feb-25 19:46

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## COVID-19 Serology

| | | |
|---|---|---|
| SARS-CoV-2 IgG/IgM NC (Roche) | Negative | |
| SARS-CoV-2 IgG Spike (Abbott) | **Positive** * | |
| SARS-CoV-2 IgG Quant (Abbott) | 6408 | AU/mL |

**Notifiable result reported to the State Health Department.** *

## Comments

Please note: CoV IgG Spike determination has changed on 7/2/2023 from the Diasorin Liaison XL to Abbott Alinity platform and provides semiquantitation.
Abbott SARS-CoV-2 IgG antibody assay is considered positive at a level >49 AU/mL with an upper reporting range of >25000 AU/mL.
The antigen targets for SARS-CoV-2 include the spike (Abbott Alinity IgG) and nucleocapsid (NC) proteins (Elecsys Roche Total Antibody).
All Australian vaccines generate antibodies against the spike protein, and the detection of spike antibodies may be due to either vaccination, infection or both. Nucleocapsid (NC) antibodies indicate prior SARS-CoV-2 infection. Detection of NC antibodies can be used to confirm previous infection with COVID-19, (e.g. when a nucleic acid amplification test or RAT was not performed at the time of acute illness or where a false-negative RAT result was suspected). Notably NC antibodies wane over time.
Serology is not recommended for the diagnosis of acute infection. Antibodies are usually detectable by day 14 after symptom onset, although they may wane over time.
Molecular tests (e.g PCR) should be considered to rule out acute infection.
Routine post-vaccination testing is not recommended as currently there are no serological correlates of immunity and the majority of the population have now had infection(s).
Final interpretation of these results should consider the epidemiological and clinical evidence of likely infection and also vaccination history.
Immunocompromised patients who have been vaccinated or had COVID-19 may have a delayed antibody response and produce levels of antibody which may not be detectable serologically. Negative results may be observed due to a decline in antibody titer over time.
Passive acquisition of antibody may occur if the patient has recently received blood products. In this case the antibody response will be transient.
All requests for SARS-CoV-2 antibodies are Notifiable on request.
For further information please refer to http://protocols.sonichealthcare.com/shared/IP635.pdf

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