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## Rapid diagnostic tests for infectious diseases in the emergency department

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► **To cite this version:**

Donia Bouzid, Marie-Céline Zanella, Solen Kerneis, Benoit Visseaux, Larissa May, et al.. Rapid diagnostic tests for infectious diseases in the emergency department. *Clinical Microbiology and Infection*, 2021, 27 (2), pp.182-191. 10.1016/j.cmi.2020.02.024 . hal-02499280

**HAL Id: hal-02499280**

**<https://univ-rennes.hal.science/hal-02499280>**

Submitted on 27 Apr 2020

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1 **Rapid diagnostic tests for infectious diseases in the emergency**  
2 **department**

3

4 Running title: RDTs in the ED

5

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8

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31

32 Keywords: Rapid diagnosis; Infections; RDT; POC test; ED; Clinical impact.

33

34 Word count: Abstract: 242 words; Text = 2,509 words; 2 Tables; 80 References.

35

## 36 **Abstract**

37 Background: Rapid diagnostic tests (RDTs) for infectious diseases, with a turn-around time  
38 <2 hours, are promising tools that could improve patient care, antimicrobial stewardship and  
39 infection prevention in the emergency department (ED) setting. Numerous RDTs have been  
40 developed but not necessarily for the ED environment. Their successful implementation in  
41 the ED relies on their performance and impact on patient management.

42 Objectives: The aim of this narrative review is to provide an overview of currently available  
43 RDTs for infectious diseases in the ED.

44 Sources: PubMed was searched through August 2019 for available studies on RDTs for  
45 infectious diseases. Inclusion criteria included: commercial tests approved by the FDA or CE-  
46 IVD with data on clinical samples, ability to run on fully-automated systems and result  
47 delivery within 2 hours.

48 Content: A non-exhaustive list of representative commercially available FDA or CE approved  
49 assays was categorized by clinical syndrome: pharyngitis and upper respiratory tract  
50 infection, lower respiratory tract infection, gastrointestinal infection, meningitis and  
51 encephalitis, fever in the returning traveler and sexually-transmitted infection including HIV.  
52 The performance of tests was described based on clinical validation studies. Further, their  
53 impact on clinical outcomes and anti-infective use was discussed with a focus on ED-based  
54 studies.

55 Implications: Clinicians should be familiar with the distinctive features of each RDT and  
56 individual performance characteristics for each target. Their integration into ED workflow  
57 should be pre-planned considering local constraints of given settings. Additional clinical  
58 studies are needed to further evaluate their clinical and cost effectiveness.

## 59 **I. Introduction**

60 Rapid diagnostic tests (RDTs) for infectious diseases have recently been implemented in  
61 many laboratories and emergency departments (EDs) with the goal of expediting the  
62 diagnosis of infectious diseases, infection prevention, appropriate initial management, and  
63 to facilitate antimicrobial stewardship in the ED where rapid clinical decisions must be  
64 undertaken in the context of overcrowding and time pressures [1]. Even though multiple  
65 RDTs are currently available, their successful implementation in the ED requires careful  
66 assessment of performance characteristics, potential benefits to patient care and cost  
67 considerations, as well as a well-organized implementation plan to optimize their impact [2].  
68 The goal of this narrative review is to provide an overview of currently available RDTs for  
69 infectious diseases in the ED with a detailed description of their performance and to discuss  
70 their impact on patient care.

71

## 72 **II. Methods**

73 A comprehensive PubMed search was conducted through August 2019 to identify studies on  
74 RDTs for infectious diseases in ED department using the following MeSH and keywords:  
75 "RDT", "Point of care", "Panel", "Turnaround time <2hrs", "ED", "Emergency service",  
76 "Pharyngitis", "Respiratory tract infection", "URTI", "LRTI", "Influenza", "RSV", "Urinary  
77 antigen", "Pneumococcal urinary antigen", "Legionella urinary antigen", "Gastrointestinal  
78 infection", "Central nervous system infection", "Meningitis", "encephalitis", "Fever returning  
79 traveller", "Sexually transmitted infection" and "STI".

80 Inclusion criteria were: commercial tests approved by the FDA or CE-IVD with data published  
81 on clinical samples, ability to run on fully-automated systems and result delivery within 2  
82 hours, as supported by Drancourt et al. [3].

83 Assay performance characteristics including sensitivity and specificity are outlined based on  
84 published clinical validation studies, whenever available. In the absence of test comparison  
85 against a gold standard assay, the reported positive and negative percent agreement in  
86 identified clinical studies or manufacturer performance data were not reported to avoid any  
87 misinterpretation.

88

### 89 **III. Overview of available tests**

90 A non-exhaustive list of representative commercially available FDA or CE approved RDTs is  
91 provided in Table 1 [4-39]. Of note, all assays discussed in this review are qualitative assays.  
92 When available, we describe the evidence for impact of tests on clinical outcomes and anti-  
93 infective use in the ED (Table 2) [6, 32, 40-55].

94

#### 95 *II.1. Pharyngitis and upper respiratory tract infections*

96 Upper respiratory tract infection is the leading infectious cause of visits in the ED. In patients  
97 with pharyngitis, clinical scoring systems and rapid tests are recommended to target  
98 antibiotic use.

99 For group A streptococcus (GAS) pharyngitis diagnosis an immunofluorescence-based assay  
100 recently demonstrated higher diagnostic performances compared to an  
101 immunochromatographic rapid antigen detection test (RADT) in pediatric patients  
102 presenting with pharyngitis with a Mclsaac score  $\geq 2$ ; the negative predictive value (NPV) of

103 the immunofluorescence-based assay was also higher (92%) in this pediatric population with  
104 a GAS prevalence of 37% [4].

105 In patients with a high likelihood of streptococcal infection, guidelines recommend the use  
106 of RDTs as they are associated with decreased antibiotic use in pediatric ED populations [56].  
107 However, the utility of clinical scores in children appears to be lower than for adults due to  
108 the different clinical presentation of sore throat in infants and young children. Point-of-care  
109 PCR assays demonstrated improved performance compared to culture or RADT as well  
110 reduced unnecessary antibiotic use in a pediatric study [5-7].

111 In patients with ILI (influenza-like illness), implementation of the FILMARRAY® multiplex PCR  
112 respiratory panel in the ED was associated with shorter times to diagnosis for all respiratory  
113 viruses, shorter duration of antibiotic use, decreased hospitalization rates, shortened length  
114 of stay (LOS), and reduced costs [41, 45]. A recent meta-analysis evaluated the clinical  
115 impact of molecular RDTs for respiratory viruses by analyzing 56 individual test accuracy  
116 studies and showed that, in comparison to conventional molecular assays, RDTs did not  
117 reduce antibiotic use and duration, isolation measures or admission rates, but increased use  
118 of oseltamivir in influenza positive cases and reduced LOS [57].

119

## 120 *II.2. Lower respiratory tract infections*

121 The most frequent LRTIs seen in the ED include: acute bronchitis, community-acquired  
122 pneumonia (CAP), ILI and acute COPD (chronic obstructive pulmonary disease) exacerbation.

123 Current guidelines recommend that urinary antigen tests for *Streptococcus pneumoniae* and  
124 *Legionella pneumophila* serogroup 1 antigens should be performed for CAP patients with  
125 severe illness and for legionellosis when clinically or epidemiologically suspected. Rapid

126 multiplex PCR tests from nasopharyngeal swabs for atypical bacteria and respiratory viruses  
127 should also be considered.

128

#### 129 *II.2.1. RDTs performed on urine specimens*

130 Rapid urine antigen tests are widely used for the diagnosis of *S. pneumoniae* and  
131 *L. pneumophila* respiratory infections. Rapid tests for *S. pneumoniae* detection present  
132 sensitivities ranging from 62 to 66% as compared to blood or sputum culture [8]. The  
133 performance of *L. pneumophila* urinary antigen detection tests varies according to several  
134 factors [9, 58]: (i) assay type, with improved performance for immunofluorescence tests; (ii)  
135 sample type, clinical vs. simulated urine samples prepared with strains of *L. pneumophila*  
136 serogroup 1 are best detected; (iii) pre-analytic sample processing; (iv) serogroup, with  
137 higher sensitivities for *L. pneumophila* serogroup 1. False-positive results can be due to  
138 recent *L. pneumophila* or *S. pneumoniae* past infection or pneumococcal vaccination,  
139 respectively, warranting cautious interpretation in the absence of concomitant cultures.

140 According to guidelines, antibiotic treatment should be initiated immediately after CAP  
141 diagnosis and include empiric therapy of *S. pneumoniae*. Rapid microbiologic confirmation  
142 theoretically offers the opportunity for antibiotic de-escalation. However, in practice, the  
143 poor sensitivity and specificity of urinary antigen testing for *S. pneumoniae* [48,59] do not  
144 allow such de-escalation, and a large proportion of patients remain treated with broader-  
145 spectrum antibiotics [49,60,61].

#### 146 *II.2.2 RDTs performed on respiratory specimens*

147 Among panels developed for broad respiratory virus detection from nasopharyngeal  
148 samples, several are now available on a fully automatized system with turn-around times  
149 (TAT) around 1 hour (Table 1). They allow the detection of all the most common respiratory



150 viruses and some atypical bacteria: *Bordetella pertussis*, *Bordetella parapertussis*,  
151 *Chlamydomphila pneumoniae* and *Mycoplasma pneumoniae*. Analytical performance  
152 characteristics, compared to reference PCR assays, are good to excellent (sensitivity and  
153 specificity from 80 to 100% for all targets). Of note, some bacterial targets have been  
154 validated with fewer than 10 positive samples, and performance characteristics of bacterial  
155 PCR have sometimes been reported to be lower than those of viral PCR [19], highlighting the  
156 need for caution when interpreting cumulative performance results. Furthermore, the  
157 performance of some panels (Table 1) only consist of percent agreement, which represents a  
158 strong- and maybe underappreciated – limitation.

159 For the diagnosis of LRTIs in the ED, a short TAT is a key parameter for relevant therapeutic  
160 measures, when targeted treatments and specific infection-prevention measures exist, such  
161 as for RSV or influenza [62].

162

### 163 *II.3. Gastrointestinal (GI) infections*

164 The rapid diagnosis of *Clostridium difficile* infection (CDI) is often based on a 2- or 3-stage  
165 diagnostic approach using specific GDH antigen with enzyme immunoassays (EIA),  
166 amplification of toxin A/B genes by PCR and detection of toxins A/B by EIA (Table 1). No  
167 other enteric bacteria or virus dispose of sensitive rapid diagnostic method except for  
168 gastrointestinal multiplex PCR panels. Their performances should be considered separately  
169 for each target, and as other syndromic panels, validation studies of some assays were  
170 performed among populations with low prevalence of certain targets including *Vibrio* spp.,  
171 *Entamoeba histolytica*, *Yersinia enterocolitica* [26]; an important consideration for  
172 interpretation of negative results.

173 Very few data have been published on the clinical impact of RDTs for the diagnosis of GI  
174 infections in the ED. Additional research is needed to evaluate their impact and cost  
175 effectiveness, especially for costly, but POC-friendly, rapid multiplex PCR assays [50,51].

176

#### 177 *II.4. Meningitis and encephalitis*

178 Pneumococcal antigen and cryptococcal antigen detection through immunochromatographic  
179 technology are marketed to be used in cerebrospinal fluid samples, with excellent  
180 performance and short TAT [27].

181 To date, only one fully-automatized rapid multiplex PCR system is available, the FilmArray  
182 ME panel (BioFire, bioMérieux), which provides results in about one hour. Common bacteria  
183 and viruses are detected, as well as the yeast *C. neoformans/gattii* (Table 1). Performances  
184 have been evaluated retrospectively [30,63]. Both false positive and false negative results  
185 are possible, and thus all biological and clinical parameters should be taken into account for  
186 result interpretation, especially for uncommon targets such as *Cryptococcus* [64]. These  
187 panels are also not intended to be fully exhaustive of all possible pathogens. Finally *Listeria*  
188 *monocytogenes* was not tested during the clinical validation study, necessitating specific PCR  
189 or cultures if there a high index of suspicion [30].

190 No data are available today on the impact of RDTs on the management of patients with  
191 suspicion of meningitis/encephalitis in the ED. A retrospective analysis of 145 pediatric cases  
192 of meningitis showed that 20% of infants were discharged in <24 h after an enterovirus-  
193 positive result, highlighting some potential benefits of rapid syndromic testing [65]. Further  
194 investigation of this approach is needed, especially in adults.

195

## 196 *II.5. Fever in the returning traveler*

197 Malaria RDTs are critically needed for patients returning from endemic countries. Around  
198 90% of cases occur in the WHO African region with *Plasmodium falciparum* being the most  
199 prevalent species and accounting for nearly all the mortality. Malaria is diagnosed by three  
200 categories of tools: expert light microscopy; immunochromatographic tests (ICTs); and  
201 nucleic acid amplification tests (NAATs) [66]. Light microscopy is widely used but requires  
202 highly-trained staff. ICTs are cheap and have a sensitivity of minimum 95% compared to  
203 microscopy and a specificity of >90% for all *Plasmodium* species [67]. Note that the  
204 BinaxNOW malaria test (Alere), able to detect the four *Plasmodium* species, is the only ICT  
205 approved by the FDA. Currently, no PCR-based RDT is commercially available. Nonetheless, a  
206 LAMP-based molecular test (Malaria LAMP assay; illumigene M; Meridian Biosciences) is  
207 commercially available [68]. In a recent prospective trial in returning travelers, this approach  
208 showed excellent analytical performance vs microscopy with near 100% accuracy [32].  
209 With 96 million dengue infections per year in over 100 tropical and sub-tropical countries  
210 with nonspecific symptoms, rapid and accurate testing is important. Unfortunately, rapid  
211 ICTs detecting both NS1 antigen and IgM have relatively low performance profiles. Their use  
212 should be limited to strong clinical suspicion and confirmed by ELISA or PCR assays [33].  
213 There is a need for “multiplex testing” for other arboviruses, e.g. Zika and Chikungunya,  
214 that have resulted in large outbreaks.

215

## 216 *II.6. Sexually-transmitted infections and HIV infection*

217 Many patients seek to EDs for initial care of sexually transmitted infections (STIs). POC  
218 testing of STIs could allow treating cases during the initial clinical visit and thus improving  
219 adherence to treatment and further transmissions. For syphilis, available RDTs consist of

220 lateral flow immunoassays (LFIAs) detecting treponemal antibodies but unable to distinguish  
221 treated from active infection, leading to the risk of overtreatment. However, they may be  
222 useful in resource limited settings to avoid congenital syphilis, to reduce neonatal mortality  
223 and decrease disease transmissions [69].

224 Some RDT assays allow the individual or simultaneous detection of *C. trachomatis* and *N.*  
225 *gonorrhoeae*, with varying performance depending on clinical specimen type (Table 1) [34,  
226 35]. Only simultaneous detection will be discussed in this review since dual testing is most  
227 clinically relevant. In the ED context, POC testing significantly decreases overtreatment of  
228 gonorrhea and trichomoniasis compared to NAAT testing [70]. Implementation of rapid  
229 testing for chlamydia and gonorrhea directly from triage using self-collected specimens can  
230 dramatically reduce overtreatment [34, 54]. In the future, to significantly reduce the STI  
231 burden, particularly for *N. gonorrhoeae* and *M. genitalium* infections, a combination of rapid  
232 POC diagnostic and antimicrobial resistance testing will likely be needed.

233 Multiple manufacturers have also developed rapid ICTs for HIV diagnosis. Performance  
234 evaluations are generally carried out on plasma or serum but not finger-stick whole blood.  
235 Their use should also be cautious in the context of patients with primary infection or wide  
236 HIV diversity (HIV-1, HIV-2, HIV-O). Indeed, a recent study demonstrated excellent  
237 performance (sensitivity of 100% and specificity >98.5%) for chronically infected patients but  
238 with inconsistent results for primary infected patients, even for tests detecting both HIV  
239 specific antibodies and p24 antigen [39]. These tests may rarely be falsely negative among  
240 HIV positive patients already on antiretroviral therapy [71,72]. While HIV POC testing in the  
241 ED has no immediate impact on stewardship, it increases screening rates, general disease  
242 awareness and prompt referral to an HIV specialist [73].

243

### 244 **III. Antimicrobial stewardship and health economics**

245 Most EDs face overcrowding, and POC tests may facilitate discharging or admitting patients  
246 more quickly and improving ED throughput while decreasing length of stay (LOS). Various  
247 clinical studies have demonstrated a significant impact on reducing antimicrobial duration  
248 when rapid diagnostic tests are employed in the ED [54, 74-76]. Conversely, others have  
249 failed to obtain such reduction, especially in complex healthcare environments [41, 43]. In  
250 this context, multidisciplinary diagnostic stewardship is essential, which refers to the  
251 appropriate use of laboratory testing to guide patient management, including treatment, in  
252 order to optimize patient outcomes and antibiotic use [77]. Indeed, implementation of new  
253 RDTs should rely on multidisciplinary approaches and high-quality evidence supporting their  
254 clinical validation and impact.

255 Currently, there is limited data on health economic outcomes related to use of POC tests in  
256 the ED, and several of the published studies are based on simulation only [78]. Reductions in  
257 ED LOS, wait time and the number of clinic visits required to receive results were reported  
258 [79].

259

### 260 **IV. Workflow and implementation**

261 Appropriate integration of RDTs into the clinical environment is often an overlooked  
262 component. Pragmatically, successful implementation depends on three key questions: Who  
263 will perform the test? What is the optimal time point of specimen collection? Where should  
264 the sample be processed? Questions on appropriate timing and who should be in charge are  
265 directly related to the ultimate goal of testing. If the primary objectives are prompt isolation  
266 (e.g., POC tests for detection of influenza in patients with ILI), quick administration of anti-

267 infective drugs in critical patients (e.g., malaria in febrile returning traveler) or improved  
268 patient throughput, testing might be performed by triage nurses, based on precise and  
269 simple clinical case definitions. Conversely, other tests require more complex interpretation  
270 or sampling such as LRTI panels and should thus be limited to confirmed pneumonia  
271 patients. Training for assay implementation is strongly required, and additional human  
272 resources may be needed for timely integration into ED workflow. Clinicians also need to  
273 receive regular training on indications and interpretation of RDT results in collaboration with  
274 clinical microbiologists [80]. Finally, with the rapid expansion of RDTs in the ED for both  
275 infectious and noninfectious syndromes, space and time constraints for instruments should  
276 also be anticipated.

277

## 278 **V. Conclusions**

279 This review provides a non-exhaustive overview of currently commercially available FDA and  
280 CE RDTs for infectious diseases in the ED. Most of these assays display adequate analytical  
281 performance yet additional high-quality studies are needed to better assess their impact.  
282 These assays must be appropriately integrated into ED workflow, taking into account local  
283 constraints and priorities. Furthermore, RDTs cannot yet replace conventional methods since  
284 they are not exhaustive, have performance limitations, and provide limited data on  
285 antimicrobial susceptibility profiles. Finally and most importantly, their clinical and economic  
286 impact remains uncertain: there is a need to conduct rigorous studies such as randomized  
287 controlled clinical trials, to determine their actual impact on clinical management and  
288 outcomes such as time to optimal therapy, length of ED or hospital stay, cost effectiveness,  
289 mortality, as well as their role in antimicrobial stewardship interventions.

290

**291 Author's contribution**

292 MCZ, JS and VC conceived the study. DB and MCZ wrote the first draft. All authors  
293 commented on, or edited drafts and approved the final version of the manuscript.

**294 Transparency declaration**

295 VC reports personal fees from Accelerate Diagnostics, Astellas, bioMérieux, Correvio,  
296 Curetis, Eumédica, Menarini, Mylan, Pfizer and Sanofi. SK reports personal fees from  
297 Accelerate Diagnostics, bioMérieux and MSD. BV reports personal fees from bioMérieux and  
298 Qiagen, and grant from Stat-Dx. LM reports personal fees from Cepheid, Roche, Bio-Rad and  
299 Qvella, and research grants from BioFire Diagnostics and Roche. DB, MCZ and JS report no  
300 conflicts of interest.

**301 Funding information**

302 No external funding was received for this work.

303

304

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**Table 1** : Non exhaustive list of commercially available FDA and CE approved point-of-care tests in infectious diseases, classified according to syndrome (or disease) of interest.

Syndrome or disease	Specific test, duplex or panel	Targeted pathogen(s)	Technique	Clinical specimen types	Trade names of some available assays	Tests performance characteristics†			Reference
						Sensitivity	Specificity	TAT	
<b>Upper respiratory tract infections</b>	Specific	<i>Group A Streptococcus</i>	LFIA	Pharyngeal swabs	Sofia® StrepA FIA	84.9%	96.8%	5min	[4]
	Specific	<i>Group A Streptococcus</i>	LFIA	Pharyngeal swab	TestPack Strep A	75.3%	98.1%	5min	[4]
	Specific	<i>Group A Streptococcus</i>	rPCR	Pharyngeal swabs	AmpliVue® GAS Assay	98.3%	93.2%	60min	[5]
	Specific	<i>Group A Streptococcus</i>	rPCR	Pharyngeal swabs	cobas® Liat Strep A Assay	95.5%	99.3%	15min	[6]
	Specific	<i>Group A Streptococcus</i>	rPCR	Pharyngeal swabs	Xpert® Xpress Strep A	100%	79.3%	25min	[7]
<b>Lower respiratory tract infections</b>	Specific	<i>Streptococcus pneumoniae</i>	LFIA	Urine samples	Sofia® <i>S. pneumoniae</i> FIA	66%	100%	10min	[8]
	Specific	<i>Streptococcus pneumoniae</i>	LFIA	Urine samples	BinaxNow™ <i>Streptococcus pneumoniae</i> Antigen Card	62%	98%	15min	[8]
	Specific	<i>Legionella pneumophila</i>	LFIA	Urine samples	BinaxNOW™ <i>Legionella</i> Urinary Antigen Card	79.7%	97.1%	15min	[9]
	Specific	<i>Mycoplasma pneumoniae</i>	LAMP	Throat swabs	Illumigene Mycoplasma Direct DNA amplification assay	87%	97.9%	60min	[10]
	Specific	Influenza A and B	rRT-PCR	NP swabs	Cobas® Influenza A/B assay	IA: 97.5% IB: 96.9%	IA: 97.9% IB: 97.9%	20min	[11]
	Specific	Influenza A and B	rRT-PCR	NP swabs	ID NOW™ INFLUENZA A & B (formerly Alere™ i. Influenza A & B)	NA	NA	15min	[12]
	Specific	Influenza A and B	LFIA	Nasal swabs, NP swabs, NP aspirate/wash	Sofia® influenza A+B FIA	IA: 82.2% IB: 77.8%	IA: 100% IB: 100%	15min	[13]
	Specific	RSV	rRT-PCR	NP swabs/aspirate	ID NOW™ RSV (formerly Alere™ I RSV)	100%	97%	15min	[14]
	Panel	Influenza A/B, RSV	rRT-PCR	NP swabs	Cobas® Influenza A/B & RSV	NA	NA	20min	[15]
Panel	Influenza A/B, RSV	rRT-PCR	nasal wash fluid samples/aspirates and NP swabs	Xpert® Flu/RSV XC	NA	NA	40min	[16]	

	Panel	Human adenovirus, human metapneumovirus, rhinovirus/enterovirus, influenza A, B, parainfluenza, RSV, <i>Bordetella pertussis</i> , <i>Chlamydomphila pneumoniae</i> , <i>Mycoplasma pneumoniae</i>	r(RT-)PCR	NP swabs	BIOFIRE® FILMARRAY® Respiratory Panel	NA	NA	65min	[17, 18]
	Panel	Human adenovirus, Coronavirus, human metapneumovirus, rhinovirus/enterovirus, Influenza A, B, parainfluenza, RSV, Mers-Cov, <i>Bordetella pertussis</i> , <i>Chlamydomphila pneumoniae</i> , <i>Mycoplasma pneumoniae</i> , <i>Bordetella parapertussis</i>	r(RT-)PCR	NP swabs	BIOFIRE® FILMARRAY® Respiratory Panel2 plus (RP2plus)	NA <i>M. pneumoniae</i> : 95.8%	NA <i>M. pneumoniae</i> : 99.7%	45min	[19]
	Panel	Human adenovirus, Coronavirus, human metapneumovirus, human rhinovirus/enterovirus, influenza A, B, parainfluenza, RSV-A/-B, <i>Chlamydia pneumoniae</i> , <i>Mycoplasma pneumoniae</i>	r(RT-)PCR	NP swabs	ePlex® Respiratory Pathogen (RP) Panel	NA	NA	90min	[20]
<b>Gastro-intestinal infections</b>	Specific	<i>C. difficile</i>	rPCR	Stool samples	Xpert® C. difficile BT	21.5%	100%	47min	[21,22]
	Specific	<i>C. difficile</i>	rPCR	Stool samples	Cobas® Cdiff test	92.9%	98.7%	20min	[23]
	Specific	<i>C. difficile</i>	EIA	Stool samples	Xpect™ C. difficile Toxin A/B Test	48%	84%	20min	[24]
	Specific	<i>C. difficile</i>	EIA	Stool samples	VIDAS® C. difficile GDH and VIDAS® C. difficile Toxin A & B	80-89.8%	96.7-97.3%	50min	[25]
	Panel	<i>Campylobacter (jejuni, coli &amp; upsaliensis)</i> , <i>Clostridium difficile (Toxin A/B)</i> , <i>Plesiomonas shigelloides</i> , <i>Salmonella</i> , <i>Yersinia enterocolitica</i> , <i>Vibrio (parahaemolyticus, vulnificus, cholerae)</i> , <i>E. coli O157</i> , <i>Enterococci</i> , <i>E. coli (EAEC)</i> , <i>Enteropathogenic E. coli (EPEC)</i> , <i>Enterotoxigenic E. coli (ETEC) It/st</i> , <i>Shiga-like toxin-producing E. coli (STEC) stx1/stx2</i> , <i>E. coli O157</i> , <i>Shigella/Enteroinvasive E.</i>	rPCR	Stool samples	Biofire® FILMARRAY® GI Panel	100% for 12/22 targets ≥94.5% for an additional 7/22 targets	≥97.1% for all panel targets	60min	[26]

		<i>coli (EIEC)</i> , Adenovirus F 40/41, Astrovirus, Norovirus G1/GII, Rotavirus A, Sapovirus (I,II, IV, and V), <i>Cryptosporidium</i> , <i>Cyclospora cayetanensis</i> , <i>Entamoeba histolytica</i> , <i>Giardia lamblia</i>								
<b>Central nervous system infections</b>	Duplex	<i>Cryptococcus neoformans</i> , <i>Cryptococcus gattii</i>	LFIA	Serum, CSF samples	CrAg <sup>®</sup> LFA	100%	99.8%	20min	[27]	
	Specific	<i>S. pneumoniae</i>	LFIA	CSF samples	BinaxNow™ <i>Streptococcus pneumoniae</i> Antigen Card	95.4%-100%	100%	15min	[28]	
	Specific	<i>Enterovirus</i>	rRT-PCR	CSF samples	NucliSENS EasyQ <sup>®</sup> Enterovirus vl.1	NA	NA	120min	[29]	
	Panel	<i>E. coli</i> K1, <i>H. influenzae</i> , <i>L. monocytogenes</i> , <i>N. meningitidis</i> , <i>S. pneumoniae</i> , <i>S. agalactiae</i> , enterovirus, HSV-1/2, VZV, CMV, HHV-6, human parechovirus, <i>Cryptococcus neoformans</i> / <i>C. gattii</i>	r(RT-)PCR	CSF samples	BIOFIRE <sup>®</sup> FILMARRAY <sup>®</sup> Meningitis/Encephalitis (ME) Panel	<i>E.coli</i> K1: 100% <i>H.influenza</i> : 100% (n=1) <i>L.monocytogenes</i> : NA <i>N.meningitidis</i> : NA <i>S.agalactiae</i> : 0% (n=1) <i>S.pneumoniae</i> : 100% NA	<i>E.coli</i> K1: 99.9% <i>H.influenza</i> : 99.9% <i>L.monocytogenes</i> : 100% <i>N.meningitidis</i> : 100% <i>S.agalactiae</i> : 99.9% <i>S.pneumoniae</i> : 99.2% NA	65min	[30]	
<b>Fever in the returning traveler</b>	Specific	<i>Plasmodium spp.</i>	LFIA	Whole blood samples	BinaxNOW <sup>®</sup> Malaria	All patients 84.2% Patients without antimalarial therapy : 92.9%	99.8%	15min	[31]	
	Specific	<i>Plasmodium spp.</i>	LAMP	Whole blood samples	illumigene Malaria DNA amplification assay	98.1%	97.6%	10min	[32]	
	Specific	Dengue virus	EIA	Plasma, serum samples	NS1 Ag detection*					[33]
					- Denge NS2 Ag Strip <sup>®</sup>	52%	77%	30min		
					- OnSite Dengue Ag Rapid Test	40%	76%	30min		
					- Dengue Early Rapid Test	60%	75%	20min		
					- SD Bioline Dengue Duo <sup>®</sup>	59%	78%	20min		
					IgM detection					
					- Dengue IgG/IgM Rapid Test Device	63%	91%	20min		
					- OnSite Dengue IgG/IgM Combo	46%	86%	30min		
					- SD Bioline Dengue Duo <sup>®</sup>	89%	80%	20min		
<b>Sexually transmitted infections</b>	Duplex	<i>C. trachomatis</i> , <i>N. gonorrhoeae</i>	rPCR	Vaginal/endocervical and urine samples	Xpert <sup>®</sup> CT/NG	<i>C. trachomatis</i> in female endocervical, vaginal, urine samples : 97.4%, 98.7%, 97.6% <i>C. trachomatis</i> in male urine samples : 97.5% <i>N. gonorrhoeae</i> in females in endocervical, vaginal, urine samples : 100%, 100%, 95.6% <i>N. gonorrhoeae</i> in males urine	<i>C. trachomatis</i> in female and male samples : ≥99.4% <i>N. gonorrhoeae</i> in female and male samples : ≥99.8%	90min	[34]	

samples : 98%								
Duplex	<i>C. trachomatis, N. gonorrhoeae</i>	rPCR	Endocervical and urethral samples	Gen-probe PACE2C system for <i>Chlamydia trachomatis</i> and <i>Neisseria gonorrhoea</i>	96.3%	98.8%	95min	[35]
Specific	<i>Treponema pallidum</i>	LFIA	Serum, plasma, whole blood samples	DETERMINE™ SYPHILIS TP	95.6-98.4%	97.3-95.7%	15min	[36]
Specific	<i>Treponema pallidum</i>	LFIA	Serum, plasma, whole blood samples	VisiTect® Syphilis	57%	99%	30min	[37]
Specific	<i>Treponema pallidum</i>	LFIA	Serum, plasma, whole blood samples	Syphicheck®-WB	67.4%	98.4%	15min	[38]
Specific	HIV		Blood samples	Antibody detection (sensitivity for HIV-1 M Ab)				[39]
				- EXACTO® TEST HIV Self-test	100%	98.5%	20 min	
				- Genie™ Fast HIV1/2				
				- INSTI® HIV	100%	100%	30 min	
				- Stat-View® HIV1/2	100%	100%	Immediately	
				- Vikia® HIV1/2	100%	100%	20 min	
				Antibody/antigen detection	99.5%	99.5%	30 min	
				Determine™ HIV-1/2 Ag/Ab	100%	Antigen p24: 99.5%	40 min	
				Combo		Antibodies: 100%		

† The performance characteristics of the assays are described as sensitivity and specificity according to published clinical validation studies when available. In the absence of test comparison against a gold standard assay, the reported positive and negative percent agreement in the clinical studies reviewed were not reported to avoid any misinterpretation by the reader.

\* Sensitivity has been extracted from the “acute infection” population and specificity has been extracted from the “naïve individuals” population described in the corresponding reference.

Abbreviations : TAT : turn around time; r(RT)-PCR : real-time (reverse transcription-)polymerase chain reaction; EIA : enzyme immunoassay; LFIA : lateral flow immunoassay; LAMP : loop-mediated isothermal amplification; CSF : cerebrospinal fluid; NP : nasopharyngeal; SSTI : skin/soft tissue infection; min : minutes; NA : non available; HSV : herpes simplex virus; VZV : varicella zoster virus; CMV : cytomegalovirus; RSV : respiratory syncytial virus; *E. coli* : *Escherichia coli*; *H. influenza* : *Haemophilus influenzae*; *L. monocytogenes* : *Listeria monocytogenes*; *N. meningitides* : *Neisseria meningitides*; *S. pneumoniae* : *Streptococcus pneumoniae*.

**Table 2** : Clinical studies evaluating the clinical impact of RDT use in the ED

Syndrom or disease	Approach and targeted pathogens	Test brand	Population	Study design	Findings	Reference
<b>Upper Respiratory tract infections</b>	Group A Streptococcus (GAS) RADT	QuickVue (Quidel)	Infants (n=223)	Single center Prospective study	After using RADT, antibiotic prescriptions decreased by 42.6%	[40]
	Group A Streptococcus (GAS) PCR	Coba Liat Strep A (Roche)	Infants (n=275)	Single center Prospective study	Compared with RADT, POC PCR resulted in significantly greater appropriate antibiotic use (97.1% vs 87.5%; $p=0.0065$ )	[6]
<b>Lower Respiratory tract infections</b>	mPCR in the ED vs usual tests in central laboratory	FilmArray (Biofire, bioMérieux)	Infants (n=1,136)	Single center Retrospective study	mPCR in the ED decreases the duration of antibiotic use (from 3.2 to 2.8 days $p=0.003$ ), the length of inpatient stay (from 3.4 to 3.2 days $p=0.03$ ).	[41]
	mPCR in the ED vs usual tests in central laboratory	FilmArray (Biofire, bioMérieux)	Adults (n=720)	Single center prospective study	mPCR in the ED decreases the duration of antibiotic use (from 6.5 to 2.9 days, $p=0.0009$ ), the hospital length of stay (from 6.8 to 5.7 days, $p=0.004$ )	[42]
	mPCR in the ED vs usual tests in central laboratory	FilmArray (Biofire, bioMérieux)	Adults (n=606)	Single center Prospective study	No association between respiratory PCR POC testing and length of stay but a reduction in the median time to the first dose of antiviral (from 60.4 to 24h) and appropriate treatment of mycoplasma infection	[43]
	Influenza PCR	Cobas Liat (Roche)	Adults (n=620)	Multicenter Retrospective study	Antivirals were prescribed more often in patients that tested positive by LIAT PCR (82.4%) than in those testing positive by either RIDT or reflex PCR (69.9%; $P < 0.05$ )	[44]
	Influenza PCR	FilmArray (Biofire, bioMérieux)	Adults (n=337)	Single center Retrospective study	Diagnosis of influenza by FilmArray was associated with significantly lower odds ratios (ORs) for admission ( $P = 0.046$ ), length of stay ( $P = 0.040$ ), duration of antimicrobial use ( $P = 0.032$ ), and number of chest radiographs ( $P = 0.005$ ).	[45]
	Influenza RADT	QuickVue (InGen)	Infants (n=170)	Single center prospective study	Positive RIDT enabled a significant decrease in orders for chest X-rays (64.4% vs. 45.8%, $p<0.05$ ) and laboratory tests (71.1% vs. 41.1%, $p<0.05$ ).	[46]
	Influenza immunoassay	Binax NOW (Alere)	Adults + Infants (n=827)	Multicenter Prospective study	For a cohort of 1000 participants, annual estimated non-diagnostic cost savings with Alere® are €215,040.	[47]
	Pneumococcus (SP) and legionella (LP) urinary antigen	Binax NOW (Alere)	Adults (n=1,941)	EPIC study Multicenter Prospective study	IDSA/ATS indications had 61% sensitivity (95% confidence interval [CI] 49-71%) and 39% specificity (95% CI 37-41%) for SP, and 63% sensitivity (95% CI 44-79%) and 35% specificity (95% CI 33-37%) for LP.	[48]
Pneumococcus (SP) and legionella (LP) urinary antigen	Binax NOW (Alere)	Adults (n=1,224)	Single center Retrospective	Only 7 tests led to appropriate antimicrobial modification, and since 972 tests had no impact, we estimate that potential cost savings, if the test had not been used, would have been 26,244 € (972 9 27) during a 3 year period, that is 8748 € per year.	[49]	



<b>Gastrointestinal infections</b>	GI PCR panel	FilmArray (Biofire, bioMérieux)	Adults + infants (n=9,402)	Cross sectional Retrospective study	Patients who received a GI panel were less likely to undergo any endoscopic procedure (8.4% GI panel versus 9.6% stool culture, $P = 0.008$ ) or any abdominal radiology (29.4% GI panel versus 31.7%, $P = 0.002$ ). Within 14 days following stool testing, patients who received a GI panel were less likely to be prescribed any antibiotic (36.2% GI panel versus 40.9%, $p < 0.001$ ).	[50]
	GI PCR panel	FilmArray (Biofire, bioMérieux)	Adults + infants (n=241)	Single center Retrospective study	The GI panel helped reduce the need for other diagnostic tests, reducing unnecessary use of antibiotics, and leading to a reduction in hospital length of stay.	[51]
<b>Central nervous system infections</b>	Meningitis and encephalitis	FilmArray (Biofire, bioMérieux)	Infants (n=145)	Multicenter Prospective study	FilmArray ME panel results may conduct in a decreased length of stay and in less antimicrobial exposure for infants with low-risk viral infection detected.	[52]
<b>Malaria</b>	Malaria testing	Illumigene Malaria (Meridian Bioscience)	Adults (n=298)	Multicenter Retrospective and prospective study	A cost-benefit analysis suggests savings of up to USD\$13 per specimen using a novel algorithm with this test.	[32]
<b>Genital and sexually transmitted infections</b>	HIV RNA testing (PCR)	Xpert (Cepheid)	Adults (n=706)	Single center Prospective study	The addition of Xpert HIV-1 Qual testing led to an increase in confirmed diagnoses by 25% (from 24 to 30 cases).	[53]
	<i>C. trachomatis</i> and <i>N. gonorrhoeae</i> testing (PCR)	Xpert (Cepheid)	Adults (n=70)	Single center RCT	The use of Xpert CT/NG reduced overtreatment and improved adherence.	[54]
	<i>C. trachomatis</i> and <i>N. gonorrhoeae</i> testing (PCR)	Xpert (Cepheid)	Adult women (n=254)	Single center RCT	Xpert CT/NG reduced overtreatment and improved undertreatment of patients tested in the ED.	[55]

GI, Gastrointestinal; mPCR, Multiplex PCR; RADT, Rapid antigen detection test