

Technical Appendix

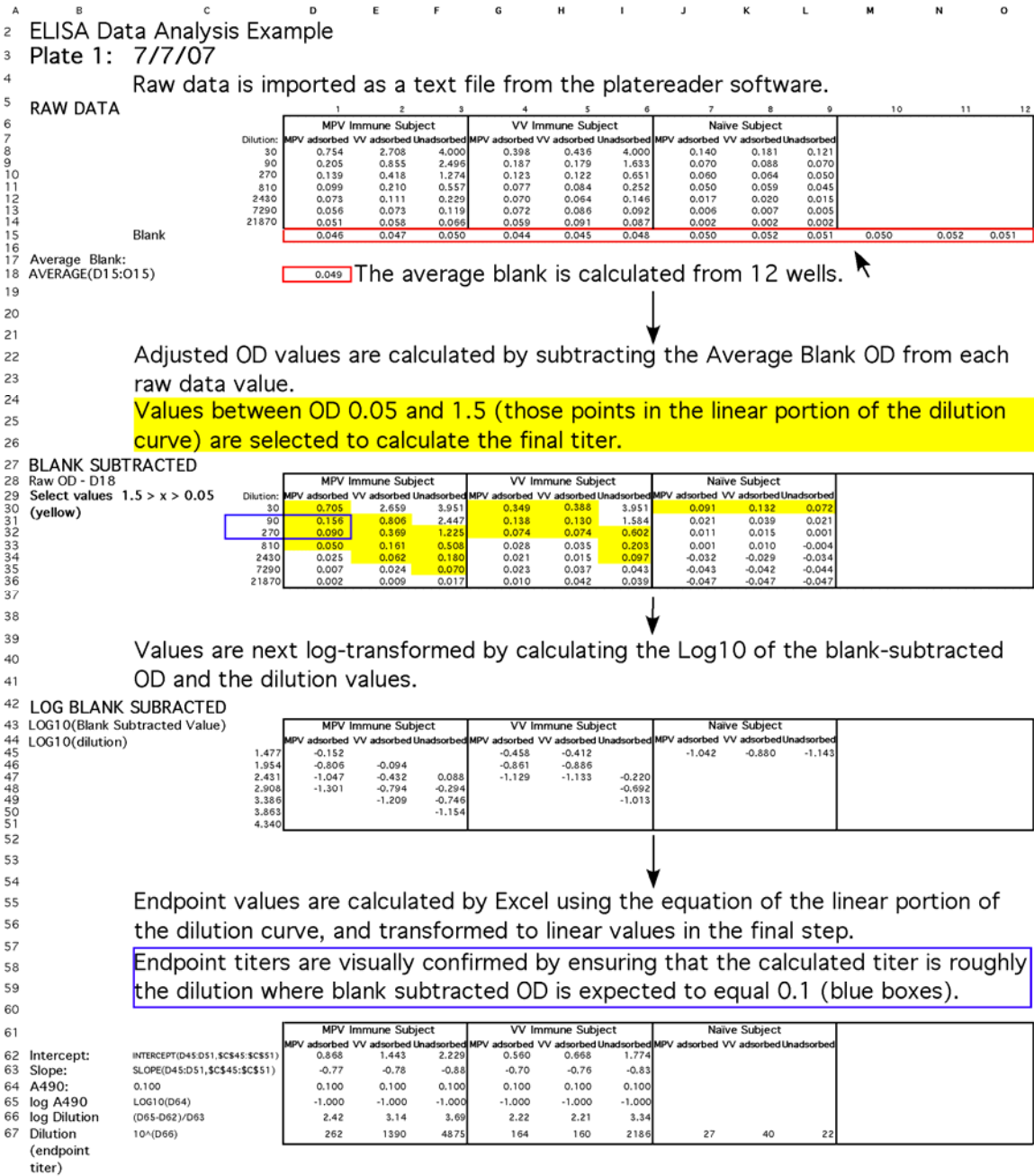


Figure 1. Illustration of ELISA data analysis. Optical density values at 490 nm (OD₄₉₀) values were imported directly into Excel (Microsoft, Redmond, WA) from the ELISA microplate reader (VersaMax; Molecular Devices, Sunnyvale, CA, USA). The average OD₄₉₀ of 12 blank wells (Line 18) was then subtracted from the raw OD₄₉₀ obtained for each sample well. These values were transformed to logarithmic scale to create a log-log curve. We use linear OD₄₉₀ values between 1.5 and 0.05 because these typically fall within the linear portion of the curve and are used to determine the endpoint titer. The slope and intercept of the linear portion of the curve were determined by a standard $y = mx + b$ calculation, and the dilution at which OD₄₉₀ = 0.1 was transformed to a linear value to give a final endpoint titer.

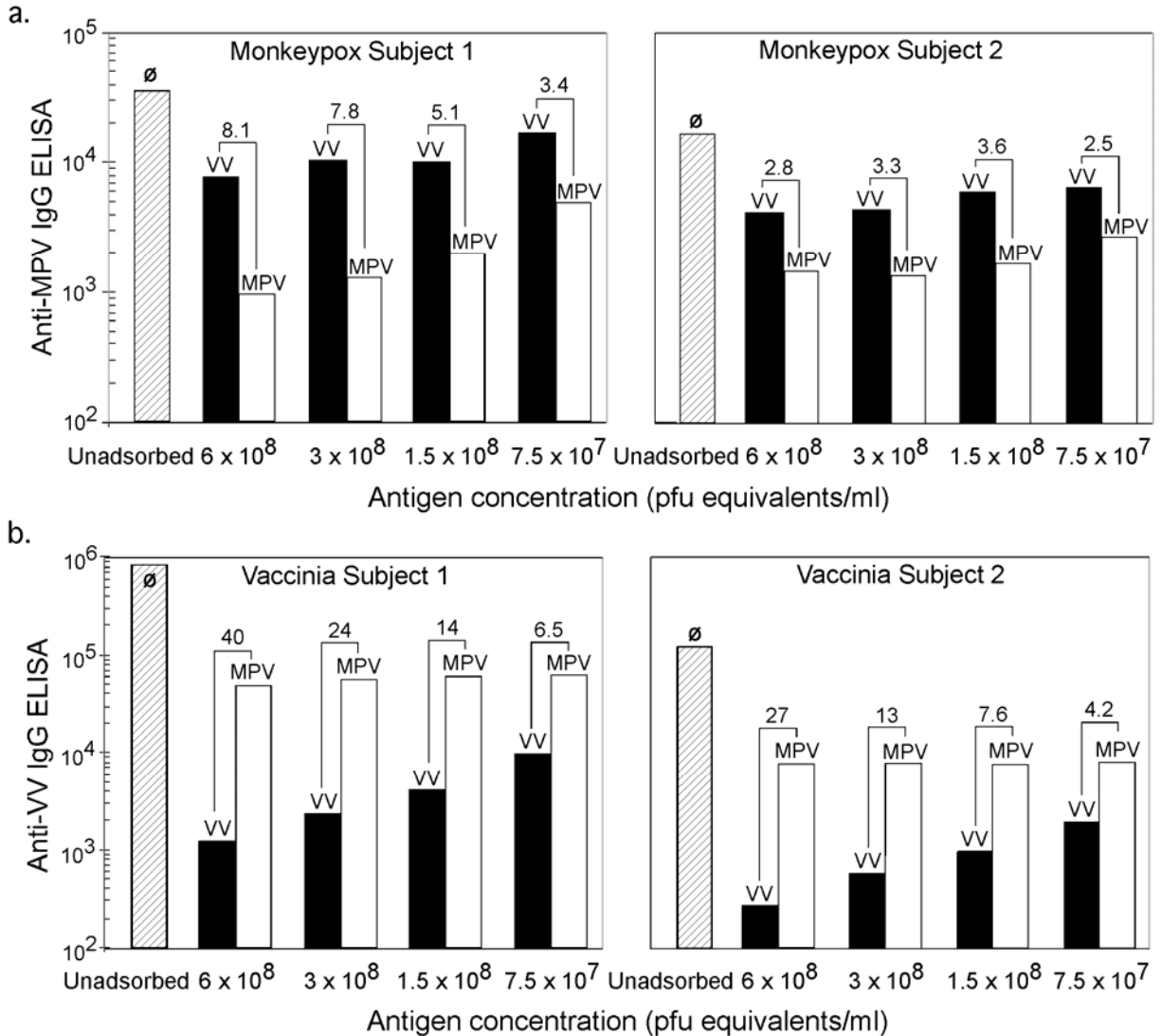


Figure 2. Titration of antigen for postadsorption ELISA. Preliminary experiments were performed to determine the optimal concentration of antigen at which orthopoxvirus infections could be differentiated by postadsorption ELISA. Plasma samples were obtained from a) 2 monkeypox-immune subjects (2–4 months postinfection), or b) 2 vaccinia-immune subjects (21 days postbooster vaccination) and tested on ELISA plates coated with a) inactivated monkeypox antigen or b) inactivated vaccinia antigen. Plasma from each subject was not preadsorbed (hatched bars), preadsorbed with inactivated vaccinia antigen (black bars), or preadsorbed with inactivated monkeypox antigen (white bars) at the indicated antigen concentrations. Values above brackets refer to the fold difference in postadsorption ELISA titers. Postadsorption ELISA may be used for diagnosing monkeypox infection by testing the plasma samples from an unvaccinated monkeypox-infected person (MPV)- or VV-adsorbed plasma on a MPV-coated plate. If the infecting virus is monkeypox (panel a), then MPV antigen is better at reducing MPV immunoglobulin (Ig) G titers than VV antigen. Alternatively, vaccinia infection may be distinguished from monkeypox by testing the adsorbed plasma on a VV-coated plate (panel b). If the infection was caused by vaccinia, then vaccinia antigen is better at reducing anti-VV IgG (i.e., tested on a VV-coated plate) than monkeypox antigen.

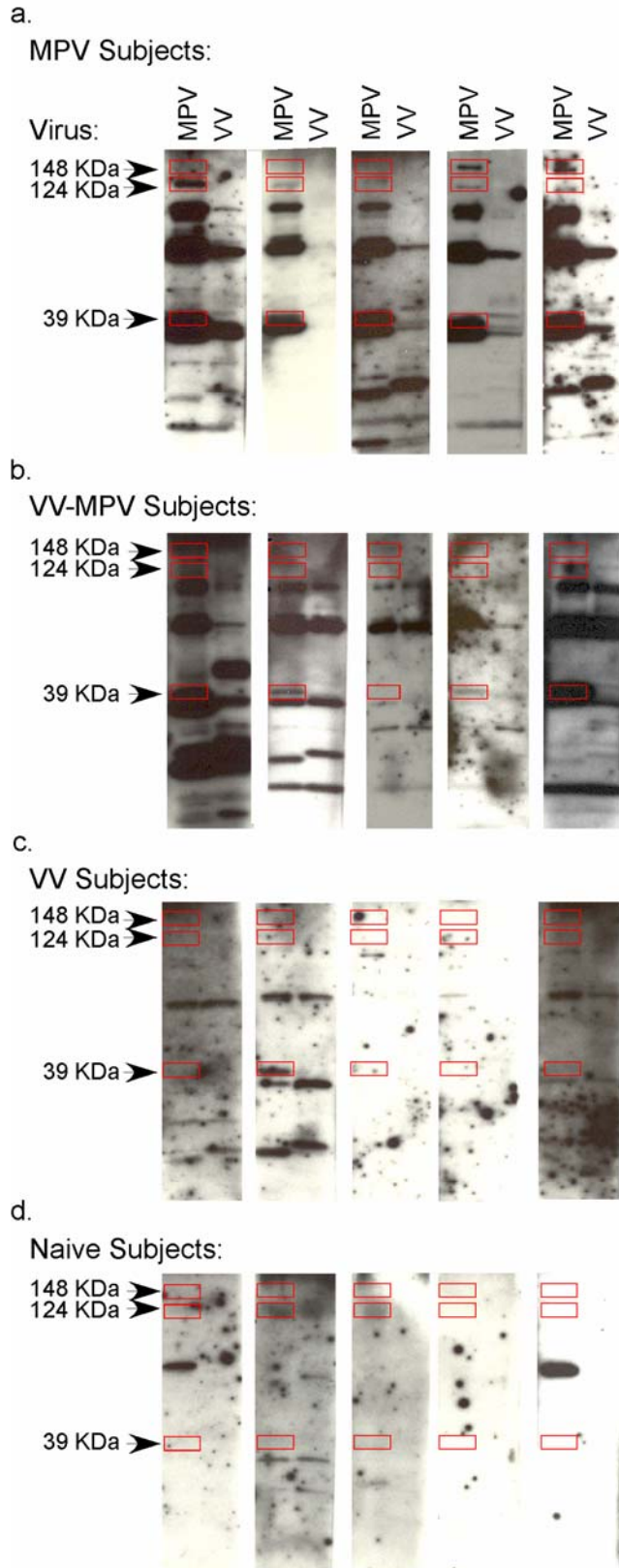


Figure 3. Examples of Western blot analysis of orthopoxvirus infections. Preadsorption of cross-reactive anti-orthopoxvirus antibodies with vaccinia antigen before Western blot analysis provided easier identification of monkeypox-specific bands. Purified monkeypox virus and vaccinia (2 μ g/lane) were separated by sodium dodecyl sulfate–polyacrylamide gel electrophoresis on 4%–20% Tris-glycine gels. Proteins were electrophoretically transferred to polyvinylidene fluoride membranes, and subsequently probed with plasma from a) monkeypox-immune persons, b) vaccinia-monkeypox immune persons, c) vaccinia-immune persons, or d) orthopoxvirus-naive persons after preadsorption of plasma with vaccinia antigen (H_2O_2 -inactivated vaccinia lysate). Immunoreactive bands were detected with peroxidase-conjugated anti-human immunoglobulin G plus chemiluminescent substrate and exposed to x-ray film. Samples from monkeypox virus (MPV), VV (vaccinia virus)–MPV, or VV persons were exposed to film for 15 s to 5 min. Samples from OPV-naive persons were exposed to film for 30 s to 1 h. Arrows and boxes indicate location of diagnostic bands with apparent molecular masses of 148 kDa, 124 kDa, and 39 kDa.