



# Novocastra™ Liquid Mouse Monoclonal Antibody Blood Coagulation Factor XIIIa

**Product Code: NCL-L-FXIIIa**

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## **Instructions for Use**

Please read before using this product.

**Check the integrity of the packaging before use.**

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**Rx Only**



# Novocastra™ Liquid Mouse Monoclonal Antibody Blood Coagulation Factor XIIIa

## Product Code: NCL-L-FXIIIa

### Intended Use

For *in vitro* diagnostic use.

NCL-L-FXIIIa is intended for the qualitative identification by light microscopy of human blood coagulation factor XIIIa in paraffin sections. The clinical interpretation of any staining or its absence should be complemented by morphological studies using proper controls and should be evaluated within the context of the patient's clinical history and other diagnostic tests by a qualified pathologist.

**NCL-L-FXIIIa is recommended for the assessment of blood coagulation factor XIIIa protein expression in normal and neoplastic tissues.**

### Summary and Explanation

The first immunohistochemical technique was reported by Nakane and Pierce.<sup>1</sup> Since then many developments have occurred, leading to increased sensitivity over earlier techniques. A recent development has been the use of polymeric labeling. This technology has been applied to both primary antibodies<sup>2</sup> and detection systems. The Novolink™ Polymer Detection Systems utilize a novel controlled polymerization technology to prepare polymeric HRP-linker antibody conjugates. Therefore, the problem of non-specific staining that can occur with Streptavidin/Biotin detection systems due to endogenous biotin does not occur.

### Principle of Procedure

Immunohistochemical (IHC) staining techniques allow for the visualization of antigens via the sequential application of a specific antibody to the antigen (primary antibody), a secondary antibody to the primary antibody and an enzyme complex with a chromogenic substrate with interposed washing steps. The enzymatic activation of the chromogen results in a visible reaction product at the antigen site. The specimen may then be counterstained and coverslipped. Results are interpreted using a light microscope and aid in the differential diagnosis of pathophysiological processes, which may or may not be associated with a particular antigen.

### Reagent

NCL-L-FXIIIa is a liquid tissue culture supernatant containing sodium azide as a preservative.

### Clone

E980.1

### Immunogen

Prokaryotic recombinant protein corresponding to a portion of the C-terminus of the blood coagulation factor XIIIa molecule.

### Specificity

Human blood coagulation factor XIIIa.

### Ig Class

IgG1

### Total Protein Concentration Total Protein

Refer to vial label for lot specific total protein concentration.

### Antibody Concentration

Greater than or equal to 264 mg/L. Refer to vial label for lot specific Ig concentration.

### Warnings and Precautions

This reagent has been prepared from the supernatant of cell culture. As it is a biological product, reasonable care should be taken when handling it.

This reagent contains sodium azide. A Material Safety Data Sheet is available upon request or available from [www.LeicaBiosystems.com](http://www.LeicaBiosystems.com)

Consult federal, state or local regulations for disposal of any potentially toxic components.

Specimens, before and after fixation, and all materials exposed to them, should be handled as if capable of transmitting infection and disposed of with proper precautions.<sup>3</sup> Never pipette reagents by mouth and avoid contacting the skin and mucous membranes with reagents and specimens. If reagents or specimens come in contact with sensitive areas, wash with copious amounts of water. Seek medical advice.

Minimize microbial contamination of reagents or an increase in non-specific staining may occur.

Incubation times or temperatures, other than those specified, may give erroneous results. Any such changes must be validated by the user.

### Storage and Stability

Store at 2–8 °C. Do not freeze. Return to 2–8 °C immediately after use. Do not use after expiration date indicated on the vial label.

Storage conditions other than those specified above must be verified by the user.

The signs indicating contamination and/or instability of NCL-L-FXIIIa are: turbidity of the solution, odor development, and presence of precipitate.

### Specimen Preparation

The recommended fixative is 10% neutral-buffered formalin for paraffin-embedded tissue sections.

## Recommendations On Use

Immunohistochemistry on paraffin sections.

**Heat Induced Epitope Retrieval (HIER):** Please follow the instructions for use in Novocastra Epitope Retrieval Solution pH6.

**Suggested dilution:** 1:200 for 30 minutes at 25 °C. This is provided as a guide and users should determine their own optimal working dilutions.

**Visualization:** Please follow the instructions for use in the Novolink™ Polymer Detection Systems. For further product information or support, contact your local distributor or regional office of Leica Biosystems, or alternatively, visit the Leica Biosystems Web site, [www.LeicaBiosystems.com](http://www.LeicaBiosystems.com)

The performance of this antibody should be validated when utilized with other manual staining systems or automated platforms.

## Materials Provided

See Reagent.

## Materials Required But Not Provided

See Novolink™ Polymer Detection Systems Instructions for Use.

## Quality Control

Differences in tissue processing and technical procedures in the user's laboratory may produce significant variability in results, necessitating regular performance of in-house controls in addition to the following procedures.

Controls should be fresh autopsy/biopsy/surgical specimens, formalin-fixed, processed and paraffin wax-embedded as soon as possible in the same manner as the patient sample(s).

### Positive Tissue Control

Used to indicate correctly prepared tissues and proper staining techniques.

One positive tissue control should be included for each set of test conditions in each staining run.

A tissue with weak positive staining is more suitable than a tissue with strong positive staining for optimal quality control and to detect minor levels of reagent degradation.<sup>4</sup>

Recommended positive control tissue is placenta.

If the positive tissue control fails to demonstrate positive staining, results with the test specimens should be considered invalid.

### Negative Tissue Control

Should be examined after the positive tissue control to verify the specificity of the labeling of the target antigen by the primary antibody.

Recommended negative control tissue is colon (mucosal epithelium).

Alternatively, the variety of different cell types present in most tissue sections frequently offers negative control sites, but this should be verified by the user.

Non-specific staining, if present, usually has a diffuse appearance. Sporadic staining of connective tissue may also be observed in sections from excessively formalin-fixed tissues. Use intact cells for interpretation of staining results. Necrotic or degenerated cells often stain non-specifically.<sup>5</sup> False-positive results may be seen due to non-immunological binding of proteins or substrate reaction products. They may also be caused by endogenous enzymes such as pseudoperoxidase (erythrocytes), endogenous peroxidase (cytochrome C), or endogenous biotin (eg. liver, breast, brain, kidney) depending on the type of immunostain used. To differentiate endogenous enzyme activity or non-specific binding of enzymes from specific immunoreactivity, additional patient tissues may be stained exclusively with substrate chromogen or enzyme complexes (avidin-biotin, streptavidin, labeled polymer) and substrate-chromogen, respectively. If specific staining occurs in the negative tissue control, results with the patient specimens should be considered invalid.

### Negative Reagent Control

Use a non-specific negative reagent control in place of the primary antibody with a section of each patient specimen to evaluate non-specific staining and allow better interpretation of specific staining at the antigen site.

### Patient Tissue

Examine patient specimens stained with NCL-L-FXIIIa last. Positive staining intensity should be assessed within the context of any non-specific background staining of the negative reagent control. As with any immunohistochemical test, a negative result means that the antigen was not detected, not that the antigen was absent in the cells/tissue assayed. If necessary, use a panel of antibodies to identify false-negative reactions.

## Results Expected

### Normal Tissues

Clone E980.1 stained the blood coagulation factor XIIIa protein in the cytoplasm and occasional nuclei of Hofbauer cells and decidua of placenta, histiocytes and lymphocytes in the spleen and stromal cells of prostate. Weak staining was noted in epithelium in the cecum, adrenal gland, exocervix, endocervix and tongue; acinar cells in the pancreas; tubules of the kidney cortex; neurons of the cerebral cortex and hippocampus; squamous epithelium in esophagus; glands of proliferative endometrium; myocytes of skeletal muscle and within soft tissue; neutrophils, lymphocytes & histiocytes of tonsil; alveolar macrophages in lung; hepatocytes in liver; acinar cells in pancreas. Some weak positivity was also observed in neurons in the cerebellum and tunica media of blood vessels. (Total number of normal cases evaluated = 52).

### Abnormal Tissues

Clone E980.1 demonstrated weak staining in 3/4 papillary carcinomas of the thyroid, 1/2 esophageal squamous cell carcinomas, 1/1 squamous cell carcinoma of the larynx, 1/2 infiltrating ductal carcinomas of the breast, 1/4 ovarian tumors (including 1/1 ovarian mucinous cystadenocarcinoma), 2/2 rectal adenocarcinomas, 1/2 skin tumors (including 1/1 squamous cell carcinoma), 2/2 metastatic tumors of unknown origin, 1/2 squamous cell carcinomas of the tongue and 2/4 lung tumors (including 1/1 non small cell carcinoma, 1/1 squamous cell carcinoma).

Clone E980.1 also stained 60/69 soft tissue tumors, (including, 6/6 angiosarcomas, 2/2 malignant hemangiopericytomas, 2/2 epithelioid hemangioendotheliomas, 3/3 hemangioendotheliomas, 1/1 spindle cell hemangioendothelioma, 4/6 capillary hemangiomas, 39/45 cavernous hemangiomas, 2/3 granulomatous hemangiomas and 1/1 phlebitis with thrombus).

No staining was observed in brain tumors (0/2), a thymus tumor (0/1), a venous hemangioma (0/1), stomach tumors (0/2), liver tumors (0/4), kidney tumors (0/2), cervical tumors (0/2), testicular tumors (0/2), colonic tumors (0/2) and soft tissue tumors (0/2). (Total number of tumor cases evaluated =114).

### **General Limitations**

Immunohistochemistry is a multistep diagnostic process that consists of specialized training in the selection of the appropriate reagents; tissue selection, fixation, and processing; preparation of the IHC slide; and interpretation of the staining results.

Tissue staining is dependent on the handling and processing of the tissue prior to staining. Improper fixation, freezing, thawing, washing, drying, heating, sectioning or contamination with other tissues or fluids may produce artifacts, antibody trapping, or false negative results. Inconsistent results may be due to variations in fixation and embedding methods, or to inherent irregularities within the tissue.<sup>6</sup> Excessive or incomplete counterstaining may compromise proper interpretation of results.

The clinical interpretation of any staining or its absence should be complemented by morphological studies using proper controls and should be evaluated within the context of the patient's clinical history and other diagnostic tests by a qualified pathologist.

Antibodies from Leica Biosystems Newcastle Ltd are for use, as indicated, on either frozen or paraffin-embedded sections with specific fixation requirements. Unexpected antigen expression may occur, especially in neoplasms. The clinical interpretation of any stained tissue section must include morphological analysis and the evaluation of appropriate controls.

### **Performance Characteristics**

The performance of NCL-L-FXIIIa has been validated on a range of normal and abnormal tissues. See Results Expected.

### **Bibliography - General**

1. Nakane PK and Pierce GB. Enzyme labeled antibodies : Preparations and applications for the localization of antigens. *Journal of Histochemistry and Cytochemistry*. 1967; 14:929–931.
2. Tsutsumi Y, Serizawa A and Kawai K. Enhanced polymer one-step staining (EPOS) for proliferating cell nuclear antigen and Ki-67 antigen-applications to intraoperative frozen diagnosis. *Pathology International*. 1995; 45(2):108–115.
3. National Committee for Clinical Laboratory Standards (NCCLS). Protection of laboratory workers from infectious diseases transmitted by blood and tissue; proposed guideline. Villanova, P.A. 1991; 7(9). Order code M29-P.
4. Battifora H. Diagnostic uses of antibodies to keratins: a review and immunohistochemical comparison of seven monoclonal and three polyclonal antibodies. *Progress in Surgical Pathology*. 6:1–15. eds. Fenoglio-Preiser C, Wolff CM, Rilke F. Field & Wood, Inc., Philadelphia.
5. Nadji M, Morales AR. Immunoperoxidase, part I: the techniques and pitfalls. *Laboratory Medicine*. 1983; 14:767.
6. Omata M, Liew CT, Ashcavai M, Peters RL. Nonimmunologic binding of horseradish peroxidase to hepatitis B surface antigen: a possible source of error in immunohistochemistry. *American Journal of Clinical Pathology*. 1980; 73:626.
7. Chan J K C, Lamant L, Algar E, et al. ALK+ histiocytosis: a novel type of systemic histiocytic proliferative disorder of early infancy. *Blood*. 2008; 112(7): 2965-2968
8. Mahalingam M, Alter JN and Bhawan J. Multiple cellular neurothekeomas – a case report and review on the role of immunohistochemistry as a histologic adjunct. *Journal of Cutaneous Pathology*. 2006; 33 (1): 51–56.
9. Song Y, Sakamoto F and Ito M. Characterization of factor XIIIa+ dendritic cells in dermatofibroma: Immunohistochemical, electron and immunoelectron microscopical observations. *Journal of Dermatological Science*. 2005; 39(2): 89–96.
10. Deguchi M, Aiba S, Ohtani H, et al. Comparison of the distribution and numbers of antigen-presenting cells among T-lymphocyte-mediated dermatoses: CD1a+, factor XIIIa+, and CD68+ cells in eczematous dermatitis, psoriasis, lichen planus and graft versus host disease. *Archives of Dermatological Research*. 2002; 294(7): 297-302.

### **Amendments to Previous Issue**

Not applicable.

### **Date of Issue**

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