



**Cochrane**  
**Library**

Cochrane Database of Systematic Reviews

## Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)

Struyf T, Deeks JJ, Dinnes J, Takwoingi Y, Davenport C, Leeflang MMG, Spijker R, Hooft L, Emperador D, Domen J, Tans A, Janssens S, Wickramasinghe D, Lannoy V, Horn SRA, Van den Bruel A, Cochrane COVID-19 Diagnostic Test Accuracy Group

Struyf T, Deeks JJ, Dinnes J, Takwoingi Y, Davenport C, Leeflang MMG, Spijker R, Hooft L, Emperador D, Domen J, Tans A, Janssens S, Wickramasinghe D, Lannoy V, Horn SR A, Van den Bruel A, Cochrane COVID-19 Diagnostic Test Accuracy Group. Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19. *Cochrane Database of Systematic Reviews* 2022, Issue 5. Art. No.: CD013665.  
DOI: [10.1002/14651858.CD013665.pub3](https://doi.org/10.1002/14651858.CD013665.pub3).

[www.cochranelibrary.com](http://www.cochranelibrary.com)

Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)

Copyright © 2022 The Authors. Cochrane Database of Systematic Reviews published by John Wiley & Sons, Ltd. on behalf of The Cochrane Collaboration.

WILEY

## TABLE OF CONTENTS

ABSTRACT .....	1
PLAIN LANGUAGE SUMMARY .....	3
SUMMARY OF FINDINGS .....	5
BACKGROUND .....	9
OBJECTIVES .....	10
METHODS .....	11
RESULTS .....	12
Figure 1. ....	13
Figure 2. ....	14
Figure 3. ....	15
Figure 4. ....	20
Figure 5. ....	22
Figure 6. ....	24
Figure 7. ....	27
Figure 8. ....	27
Figure 9. ....	28
Figure 10. ....	29
Figure 11. ....	32
Figure 12. ....	33
Figure 13. ....	34
Figure 14. ....	36
Figure 15. ....	37
Figure 16. ....	38
Figure 17. ....	40
Figure 18. ....	41
Figure 19. ....	42
Figure 20. ....	44
Figure 21. ....	45
Figure 22. ....	46
Figure 23. ....	48
Figure 24. ....	50
Figure 25. ....	52
Figure 26. ....	54
Figure 27. ....	55
Figure 28. ....	56
Figure 29. ....	57
DISCUSSION .....	58
Figure 30. ....	59
AUTHORS' CONCLUSIONS .....	61
ACKNOWLEDGEMENTS .....	61
REFERENCES .....	63
CHARACTERISTICS OF STUDIES .....	76
DATA .....	278
Test 1. Cough .....	286
Test 2. Fever .....	286
Test 3. Dyspnoea .....	287
Test 4. Sore throat .....	287
Test 5. Headache .....	288
Test 6. Diarrhoea .....	288
Test 7. Myalgia .....	289
Test 8. Anosmia .....	289

Test 9. Fatigue .....	290
Test 10. Chills/shivers .....	290
Test 11. Chest tightness/pain .....	290
Test 12. Rhinorrhea .....	291
Test 13. Ageusia .....	291
Test 14. Anosmia or ageusia .....	291
Test 15. Abdominal pain .....	291
Test 16. Nasal congestion .....	292
Test 17. Altered mentation/confusion .....	292
Test 18. Conjunctivitis .....	292
Test 19. Nausea or vomiting .....	292
Test 20. Gastrointestinal symptoms (not specified) .....	293
Test 21. Rash .....	293
Test 22. Coryza .....	293
Test 23. Sputum production/productive cough .....	293
Test 24. Asthenia .....	293
Test 25. Odynophagia .....	294
Test 26. Anosmia and ageusia .....	294
Test 27. Arthralgia .....	294
Test 28. Vomiting .....	294
Test 29. Wheeze .....	294
Test 30. Nausea .....	295
Test 31. Dry cough .....	295
Test 32. Malaise .....	295
Test 33. Enlargement of lymph nodes .....	295
Test 34. Anosmia or hyposmia .....	295
Test 35. Anorexia .....	296
Test 36. Fever (subjective) .....	296
Test 37. Haemoptysis .....	296
Test 38. Earache .....	296
Test 39. Systemic soreness (malaise/myalgia/arthralgia) .....	296
Test 40. High fever ( $\geq 38.5$ °C) .....	296
Test 41. Myalgia or arthralgia .....	297
Test 42. Irritability .....	297
Test 43. Sneezing .....	297
Test 44. Anosmia or dysgeusia .....	297
Test 45. Loss of appetite .....	297
Test 46. Pulmonary auscultation: crackling bilateral .....	298
Test 47. Sweating .....	298
Test 48. Nasal symptoms .....	298
Test 49. Rhinitis .....	298
Test 50. Dysgeusia .....	298
Test 51. SCRIPS score, recent case detection rate .....	298
Test 52. SCRIPS score, 0.5*recent case detection rate .....	299
Test 53. Rigors .....	299
Test 54. Cough or dyspnoea .....	299
Test 55. Dysuria .....	299
Test 56. Seizure .....	299
Test 57. Exanthema .....	299
Test 58. Exhaustion .....	300
Test 59. Sinusitis .....	300
Test 60. Hypoxia .....	300

Test 61. Multivariable score cut-off = 5 .....	300
Test 62. Multivariable score cut-off = 8 .....	300
Test 63. Cough and anosmia .....	300
Test 64. Fever and anosmia .....	301
Test 65. Fever and cough and anosmia and dyspnoea and oxygen saturation < 93% .....	301
Test 66. Fever and dyspnoea .....	301
Test 67. Anosmia and dyspnoea .....	301
Test 68. Fever and cough .....	301
Test 69. Weakness or fatigue .....	301
Test 70. Palpitations .....	302
Test 71. Anxiety .....	302
Test 72. Respiratory distress .....	302
Test 73. Hyposmia or anosmia .....	302
Test 74. Diarrhoea and nausea .....	302
Test 75. Isolated fever .....	302
Test 76. Myalgia and asthenia and fever .....	303
Test 77. Cough and fever and sputum production .....	303
Test 78. Cough and fever and sputum production and dyspnoea .....	303
Test 79. Isolated headache .....	303
Test 80. Dyspnoea and cough and fever and low oxygen saturation .....	303
Test 81. Sore throat and nasal congestion and sneezing and mild fever .....	303
Test 82. Low body temperature .....	304
Test 83. Expectoration .....	304
Test 84. Tachypnoea .....	304
Test 85. Cyanosis .....	304
Test 86. Skin lesions .....	304
Test 87. Rhinitis or pharyngitis .....	304
Test 88. Dizziness or syncope .....	305
Test 89. Pulmonary auscultation: crackling unilateral .....	305
Test 90. CSBSS (cut-off = 41.7) .....	305
Test 91. Hyposmia .....	305
Test 92. Hypogeusia .....	305
Test 93. Dizziness .....	305
Test 94. Change to chronic cough .....	306
Test 95. Dysosmia .....	306
Test 96. Myalgia and fatigue .....	306
Test 97. Cough (retrospective data collection) .....	307
Test 98. Fever (retrospective data collection) .....	308
Test 99. Dyspnoea (retrospective data collection) .....	309
Test TST-100. Sore throat (retrospective data collection) .....	310
Test TST-101. Headache (retrospective data collection) .....	310
Test TST-102. Diarrhoea (retrospective data collection) .....	311
Test TST-103. Myalgia (retrospective data collection) .....	311
Test TST-104. Rhinorrhoea (retrospective data collection) .....	312
Test TST-105. Chest tightness/pain (retrospective data collection) .....	312
Test TST-106. Fatigue (retrospective data collection) .....	312
Test TST-107. Anosmia (retrospective data collection) .....	313
Test TST-108. Gastrointestinal symptoms not specified (retrospective data collection) .....	313
Test TST-109. Nasal congestion (retrospective data collection) .....	313
Test TST-110. Nausea or vomiting (retrospective data collection) .....	313
Test TST-111. Abdominal pain (retrospective data collection) .....	314
Test TST-112. Vomiting (retrospective data collection) .....	314

Test TST-113. Myalgia or arthralgia (retrospective data collection) .....	314
Test TST-114. Sputum production/productive cough (retrospective data collection) .....	315
Test TST-115. Chills/shivers (retrospective data collection) .....	315
Test TST-116. Asthenia (retrospective data collection) .....	315
Test TST-117. Anosmia or ageusia (retrospective data collection) .....	315
Test TST-118. Dysgeusia (retrospective data collection) .....	316
Test TST-119. Nausea (retrospective data collection) .....	316
Test TST-120. Arthralgia (retrospective data collection) .....	316
Test TST-121. Anorexia (retrospective data collection) .....	316
Test TST-122. Wheeze (retrospective data collection) .....	316
Test TST-123. Haemoptysis (retrospective data collection) .....	317
Test TST-124. Respiratory symptoms (not specified; retrospective data collection) .....	317
Test TST-125. Skin lesions (retrospective data collection) .....	317
Test TST-126. Tachycardia (retrospective data collection) .....	317
Test TST-127. Nasal symptoms (retrospective data collection) .....	317
Test TST-128. Expectoration (retrospective data collection) .....	318
Test TST-129. Ageusia (retrospective data collection) .....	318
Test TST-130. Positive auscultation findings (retrospective data collection) .....	318
Test TST-131. Tachypnea (retrospective data collection) .....	318
Test TST-132. Anosmia/dysosmia or ageusia/dysgeusia (retrospective data collection)) .....	318
Test TST-133. Earache (retrospective data collection) .....	319
Test TST-134. Sneezing (retrospective data collection) .....	319
Test TST-135. Dizziness (retrospective data collection) .....	319
Test TST-136. Malaise (retrospective data collection) .....	319
Test TST-137. Fever (subjective) (retrospective data collection) .....	319
Test TST-138. Enlargement of lymph nodes (retrospective data collection) .....	319
Test TST-139. Conjunctivitis (retrospective data collection) .....	320
Test TST-140. Hypoxia (retrospective data collection) .....	320
Test TST-141. Pulmonary auscultation: rhonchi (retrospective data collection) .....	320
Test TST-142. Loss of appetite (retrospective data collection) .....	320
Test TST-143. Altered mentation/confusion (retrospective data collection) .....	320
Test TST-144. Presyncope or syncope (retrospective data collection) .....	320
Test TST-145. Stomach ache (retrospective data collection) .....	321
Test TST-146. Odynophagia (retrospective data collection) .....	321
Test TST-147. Anosmia or dysgeusia (retrospective data collection) .....	321
Test TST-148. Weakness or fatigue (retrospective data collection) .....	321
Test TST-149. Objective fever ( $\geq 38^{\circ}\text{C}$ ) or recent fever/chills (retrospective) .....	321
Test TST-150. Body aches or fatigue or dyspnoea or cough or objective fever ( $\geq 38^{\circ}\text{C}$ ) or recent fever/chills (retrospective) .....	321
Test TST-151. Fatigue or dyspnoea or cough or objective fever ( $\geq 38^{\circ}\text{C}$ ) or recent fever/chills (retrospective) .....	322
Test TST-152. Dyspnoea or cough or objective fever ( $\geq 38^{\circ}\text{C}$ ) or recent fever/chills (retrospective) .....	322
Test TST-153. Cough or objective fever ( $\geq 38^{\circ}\text{C}$ ) or recent fever/chills (retrospective) .....	322
Test TST-154. Recent fever or chills (retrospective data collection) .....	322
Test TST-155. Sinusitis (retrospective data collection) .....	322
Test TST-156. Systemic soreness (malaise/myalgia/arthralgia) (retrospective) .....	322
Test TST-157. Malaise or fatigue (retrospective data collection) .....	323
Test TST-158. Lethargy (retrospective data collection) .....	323
Test TST-159. Nausea or vomiting or diarrhoea (retrospective data collection) .....	323
Test TST-160. Respiratory triage score $> 4$ (retrospective data collection) .....	323
Test TST-161. Respiratory triage score $> 5$ (retrospective data collection) .....	323
Test TST-162. Lower respiratory tract symptoms (retrospective data collection) .....	323
Test TST-163. Neurologic symptoms (not specified; retrospective data collection) .....	324
Test TST-164. Upper respiratory tract symptoms (retrospective data collection) .....	324

Test TST-165. Laryngitis/hoarseness/stridor (retrospective data collection) .....	324
Test TST-166. High fever ( $\geq 38.5$ °C) (retrospective data collection) .....	324
Test TST-167. Abdominal distention (retrospective data collection) .....	324
Test TST-168. Aversion to cold (retrospective data collection) .....	324
Test TST-169. Xerostomia (retrospective data collection) .....	325
Test TST-170. Hypersomnia (retrospective data collection) .....	325
Test TST-171. Hyposmia (retrospective data collection) .....	325
Test TST-172. Fever and cough and dyspnoea (retrospective) .....	325
Test TST-173. Fever and cough and sore throat (retrospective) .....	325
Test TST-174. Fever and cough (retrospective data collection) .....	325
Test TST-175. Unconsciousness (retrospective data collection) .....	326
Test TST-176. Rash (retrospective data collection) .....	326
Test TST-177. Fever or cough or dyspnoea (retrospective data collection) .....	326
Test TST-178. Pulmonary auscultation: crackling (retrospective data collection) .....	326
Test TST-179. Dysphonia (retrospective data collection) .....	326
Test TST-180. Dry cough (retrospective data collection) .....	326
Test TST-181. History of fever at home (retrospective data collection) .....	327
Test TST-182. Cough or dyspnoea (retrospective data collection) .....	327
Test TST-183. Anosmia and dysgeusia (retrospective data collection) .....	327
Test TST-184. Palpitations (retrospective data collection) .....	327
Test TST-185. Anosmia or hyposmia (retrospective data collection) .....	327
Test TST-186. Myalgia or fatigue (retrospective data collection) .....	327
Test TST-187. Respiratory distress (retrospective data collection) .....	328
ADDITIONAL TABLES .....	328
APPENDICES .....	339
WHAT'S NEW .....	340
HISTORY .....	340
CONTRIBUTIONS OF AUTHORS .....	340
DECLARATIONS OF INTEREST .....	341
SOURCES OF SUPPORT .....	341
DIFFERENCES BETWEEN PROTOCOL AND REVIEW .....	342
INDEX TERMS .....	342

[Diagnostic Test Accuracy Review]

# Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19

Thomas Struyf<sup>1</sup>, Jonathan J Deeks<sup>2,3</sup>, Jacqueline Dinnes<sup>2,3</sup>, Yemisi Takwoingi<sup>2,3</sup>, Clare Davenport<sup>2,3</sup>, Mariska MG Leeflang<sup>4</sup>, René Spijker<sup>5,6</sup>, Lotty Hooft<sup>6</sup>, Devy Emperador<sup>7</sup>, Julie Domen<sup>8</sup>, Anouk Tans<sup>1</sup>, Stéphanie Janssens<sup>9</sup>, Dakshitha Wickramasinghe<sup>10</sup>, Viktor Lannoy<sup>9</sup>, Sebastiaan R A Horn<sup>8</sup>, Ann Van den Bruel<sup>1</sup>, Cochrane COVID-19 Diagnostic Test Accuracy Group<sup>3</sup>

<sup>1</sup>Department of Public Health and Primary Care, KU Leuven, Leuven, Belgium. <sup>2</sup>Test Evaluation Research Group, Institute of Applied Health Research, University of Birmingham, Birmingham, UK. <sup>3</sup>NIHR Birmingham Biomedical Research Centre, University Hospitals Birmingham NHS Foundation Trust and University of Birmingham, Birmingham, UK. <sup>4</sup>Department of Clinical Epidemiology, Biostatistics and Bioinformatics, Amsterdam University Medical Centers, University of Amsterdam, Amsterdam, Netherlands. <sup>5</sup>Medical Library, Amsterdam UMC, University of Amsterdam, Amsterdam Public Health, Amsterdam, Netherlands. <sup>6</sup>Cochrane Netherlands, Julius Center for Health Sciences and Primary Care, University Medical Center Utrecht, Utrecht University, Utrecht, Netherlands. <sup>7</sup>FIND, Geneva, Switzerland. <sup>8</sup>Department of Primary Care, Faculty of Medicine and Health Sciences, University of Antwerp, Antwerp, Belgium. <sup>9</sup>De Wijkpraktijk, Antwerp, Belgium. <sup>10</sup>Department of Surgery, Faculty of Medicine, University of Colombo, Colombo, Sri Lanka

**Contact:** Ann Van den Bruel, [ann.vandenbruel@kuleuven.be](mailto:ann.vandenbruel@kuleuven.be).

**Editorial group:** Cochrane Infectious Diseases Group.

**Publication status and date:** New search for studies and content updated (conclusions changed), published in Issue 5, 2022.

**Citation:** Struyf T, Deeks JJ, Dinnes J, Takwoingi Y, Davenport C, Leeflang MMG, Spijker R, Hooft L, Emperador D, Domen J, Tans A, Janssens S, Wickramasinghe D, Lannoy V, Horn SR A, Van den Bruel A, Cochrane COVID-19 Diagnostic Test Accuracy Group. Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19. *Cochrane Database of Systematic Reviews* 2022, Issue 5. Art. No.: CD013665. DOI: [10.1002/14651858.CD013665.pub3](https://doi.org/10.1002/14651858.CD013665.pub3).

Copyright © 2022 The Authors. Cochrane Database of Systematic Reviews published by John Wiley & Sons, Ltd. on behalf of The Cochrane Collaboration. This is an open access article under the terms of the [Creative Commons Attribution-Non-Commercial Licence](https://creativecommons.org/licenses/by-nc/4.0/), which permits use, distribution and reproduction in any medium, provided the original work is properly cited and is not used for commercial purposes.

## ABSTRACT

### Background

COVID-19 illness is highly variable, ranging from infection with no symptoms through to pneumonia and life-threatening consequences. Symptoms such as fever, cough, or loss of sense of smell (anosmia) or taste (ageusia), can help flag early on if the disease is present. Such information could be used either to rule out COVID-19 disease, or to identify people who need to go for COVID-19 diagnostic tests. This is the second update of this review, which was first published in 2020.

### Objectives

To assess the diagnostic accuracy of signs and symptoms to determine if a person presenting in primary care or to hospital outpatient settings, such as the emergency department or dedicated COVID-19 clinics, has COVID-19.

### Search methods

We undertook electronic searches up to 10 June 2021 in the University of Bern living search database. In addition, we checked repositories of COVID-19 publications. We used artificial intelligence text analysis to conduct an initial classification of documents. We did not apply any language restrictions.

### Selection criteria

Studies were eligible if they included people with clinically suspected COVID-19, or recruited known cases with COVID-19 and also controls without COVID-19 from a single-gate cohort. Studies were eligible when they recruited people presenting to primary care or hospital

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

1

Copyright © 2022 The Authors. Cochrane Database of Systematic Reviews published by John Wiley & Sons, Ltd. on behalf of The Cochrane Collaboration.

outpatient settings. Studies that included people who contracted SARS-CoV-2 infection while admitted to hospital were not eligible. The minimum eligible sample size of studies was 10 participants. All signs and symptoms were eligible for this review, including individual signs and symptoms or combinations. We accepted a range of reference standards.

### Data collection and analysis

Pairs of review authors independently selected all studies, at both title and abstract, and full-text stage. They resolved any disagreements by discussion with a third review author. Two review authors independently extracted data and assessed risk of bias using the QUADAS-2 checklist, and resolved disagreements by discussion with a third review author. Analyses were restricted to prospective studies only. We presented sensitivity and specificity in paired forest plots, in receiver operating characteristic (ROC) space and in dumbbell plots. We estimated summary parameters using a bivariate random-effects meta-analysis whenever five or more primary prospective studies were available, and whenever heterogeneity across studies was deemed acceptable.

### Main results

We identified 90 studies; for this update we focused on the results of 42 prospective studies with 52,608 participants. Prevalence of COVID-19 disease varied from 3.7% to 60.6% with a median of 27.4%. Thirty-five studies were set in emergency departments or outpatient test centres (46,878 participants), three in primary care settings (1230 participants), two in a mixed population of in- and outpatients in a paediatric hospital setting (493 participants), and two overlapping studies in nursing homes (4007 participants). The studies did not clearly distinguish mild COVID-19 disease from COVID-19 pneumonia, so we present the results for both conditions together.

Twelve studies had a high risk of bias for selection of participants because they used a high level of preselection to decide whether reverse transcription polymerase chain reaction (RT-PCR) testing was needed, or because they enrolled a non-consecutive sample, or because they excluded individuals while they were part of the study base. We rated 36 of the 42 studies as high risk of bias for the index tests because there was little or no detail on how, by whom and when, the symptoms were measured. For most studies, eligibility for testing was dependent on the local case definition and testing criteria that were in effect at the time of the study, meaning most people who were included in studies had already been referred to health services based on the symptoms that we are evaluating in this review.

The applicability of the results of this review iteration improved in comparison with the previous reviews. This version has more studies of people presenting to ambulatory settings, which is where the majority of assessments for COVID-19 take place. Only three studies presented any data on children separately, and only one focused specifically on older adults.

We found data on 96 symptoms or combinations of signs and symptoms. Evidence on individual signs as diagnostic tests was rarely reported, so this review reports mainly on the diagnostic value of symptoms. Results were highly variable across studies. Most had very low sensitivity and high specificity. RT-PCR was the most often used reference standard (40/42 studies).

Only cough (11 studies) had a summary sensitivity above 50% (62.4%, 95% CI 50.6% to 72.9%); its specificity was low (45.4%, 95% CI 33.5% to 57.9%). Presence of fever had a sensitivity of 37.6% (95% CI 23.4% to 54.3%) and a specificity of 75.2% (95% CI 56.3% to 87.8%). The summary positive likelihood ratio of cough was 1.14 (95% CI 1.04 to 1.25) and that of fever 1.52 (95% CI 1.10 to 2.10). Sore throat had a summary positive likelihood ratio of 0.814 (95% CI 0.714 to 0.929), which means that its presence increases the probability of having an infectious disease other than COVID-19.

Dyspnoea (12 studies) and fatigue (8 studies) had a sensitivity of 23.3% (95% CI 16.4% to 31.9%) and 40.2% (95% CI 19.4% to 65.1%) respectively. Their specificity was 75.7% (95% CI 65.2% to 83.9%) and 73.6% (95% CI 48.4% to 89.3%). The summary positive likelihood ratio of dyspnoea was 0.96 (95% CI 0.83 to 1.11) and that of fatigue 1.52 (95% CI 1.21 to 1.91), which means that the presence of fatigue slightly increases the probability of having COVID-19.

Anosmia alone (7 studies), ageusia alone (5 studies), and anosmia or ageusia (6 studies) had summary sensitivities below 50% but summary specificities over 90%. Anosmia had a summary sensitivity of 26.4% (95% CI 13.8% to 44.6%) and a specificity of 94.2% (95% CI 90.6% to 96.5%). Ageusia had a summary sensitivity of 23.2% (95% CI 10.6% to 43.3%) and a specificity of 92.6% (95% CI 83.1% to 97.0%). Anosmia or ageusia had a summary sensitivity of 39.2% (95% CI 26.5% to 53.6%) and a specificity of 92.1% (95% CI 84.5% to 96.2%). The summary positive likelihood ratios of anosmia alone and anosmia or ageusia were 4.55 (95% CI 3.46 to 5.97) and 4.99 (95% CI 3.22 to 7.75) respectively, which is just below our arbitrary definition of a 'red flag', that is, a positive likelihood ratio of at least 5. The summary positive likelihood ratio of ageusia alone was 3.14 (95% CI 1.79 to 5.51).

Twenty-four studies assessed combinations of different signs and symptoms, mostly combining olfactory symptoms. By combining symptoms with other information such as contact or travel history, age, gender, and a local recent case detection rate, some multivariable prediction scores reached a sensitivity as high as 90%.

### Authors' conclusions

Most individual symptoms included in this review have poor diagnostic accuracy. Neither absence nor presence of symptoms are accurate enough to rule in or rule out the disease. The presence of anosmia or ageusia may be useful as a red flag for the presence of COVID-19. The presence of cough also supports further testing. There is currently no evidence to support further testing with PCR in any individuals presenting only with upper respiratory symptoms such as sore throat, coryza or rhinorrhoea.

### Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)



Combinations of symptoms with other readily available information such as contact or travel history, or the local recent case detection rate may prove more useful and should be further investigated in an unselected population presenting to primary care or hospital outpatient settings.

The diagnostic accuracy of symptoms for COVID-19 is moderate to low and any testing strategy using symptoms as selection mechanism will result in both large numbers of missed cases and large numbers of people requiring testing. Which one of these is minimised, is determined by the goal of COVID-19 testing strategies, that is, controlling the epidemic by isolating every possible case versus identifying those with clinically important disease so that they can be monitored or treated to optimise their prognosis. The former will require a testing strategy that uses very few symptoms as entry criterion for testing, the latter could focus on more specific symptoms such as fever and anosmia.

## PLAIN LANGUAGE SUMMARY

### How accurate are symptoms and medical examination to diagnose COVID-19?

#### Key messages

- The results suggest that a single symptom included in this review cannot accurately diagnose COVID-19.
- Loss of sense of taste or smell could be a 'red flag' for the presence of COVID-19. Cough or fever might be useful to identify people who might have COVID-19. These symptoms might be useful to prompt further testing when they are present.
- We need more research to investigate combinations of symptoms and signs with other information such as recent contact or travel history, or vaccination status, and in children, and adults aged 65 years and over.

### What are symptoms or signs of COVID-19?

Symptoms are experienced by patients. COVID-19 symptoms include cough, sore throat, high temperature, diarrhoea, headache, muscle or joint pain, fatigue, and loss of sense of smell and taste.

Signs are measured by healthcare workers during clinical examination. They include lung sounds, blood pressure, blood oxygen level and heart rate.

Symptoms and signs of COVID-19 might be important to help people know whether they and the people they come into contact with should isolate at home, undergo testing with a rapid lateral flow test or PCR (laboratory-based) test, or be hospitalised.

### What did we want to find out?

Symptoms and signs of COVID-19 are varied and may indicate other diseases, not just COVID-19. We wanted to know how accurate diagnosis of COVID-19 is, based on symptoms and signs from medical examination. We were interested in people with suspected COVID-19, who go to their doctor, outpatient test centres or hospital.

### What did we do?

We searched for studies that assessed the accuracy of symptoms and signs to diagnose COVID-19. Studies had to be conducted in general practice, outpatient test centres or hospital outpatient settings only. We only included studies of people in hospital if signs and symptoms were recorded when they were admitted to the hospital, for example through the emergency department.

### What did we find?

We focused on 42 studies with 52,608 participants in this review. The studies assessed 96 separate or combined symptoms and signs. Thirty-five studies were conducted in emergency departments or outpatient COVID-19 test centres (46,878 participants), 3 studies in general practice (1230 participants), 2 studies in children's hospitals (493 in- and outpatients), and 2 studies in nursing homes (4007 participants). The studies were conducted in 18 different countries around the world. Twenty-three studies were conducted in Europe, 8 in North-America, 5 in Asia, and 3 in South-America and 3 in Australia. We didn't find any studies conducted in Africa. Three focused specifically on children, and only 1 focused on adults aged 65 years and over.

Most studies did not clearly distinguish between mild and severe COVID-19, so we present the results for mild, moderate and severe disease together.

Few studies reported individual signs as diagnostic tests, so we focus mainly on the diagnostic value of symptoms. The most frequently reported symptoms were cough, fever, shortness of breath and sore throat.

According to the studies in our review, in a group of 1000 people with suspected COVID-19 of whom 270 (27%) would actually have COVID-19, around 567 people would have a cough. Of these 567, 168 would actually have COVID-19. Of the 433 who do not have a cough, 102 would have COVID-19. In the same 1000 people, around 283 people would have a fever. Of these 283, 102 would actually have COVID-19. Of the 717 people without fever, 168 would have COVID-19.

### Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)

Copyright © 2022 The Authors. Cochrane Database of Systematic Reviews published by John Wiley & Sons, Ltd. on behalf of The Cochrane Collaboration.

---

Someone who has lost their sense of smell or taste is five times more likely to have COVID-19 than someone who hasn't.

Other symptoms, such as a sore throat or runny nose, are more likely to indicate the presence of an infectious disease other than COVID-19. In the same 1000 people as described above, around 362 people would have a sore throat. Of these, only 84 would actually have COVID-19. Of the 638 patients without sore throat, 186 would have COVID-19. We found similar figures for having a runny nose.

**What are the limitations of the evidence?**

The results of this updated review are more reliable than those in previous versions as we included more high-quality studies. However, the accuracy of individual symptoms varied across studies and the diagnostic value of symptoms such as fever, cough or other respiratory symptoms might still be overestimated, as most studies deliberately included participants because they had these symptoms.

The results do not clearly differentiate between people with mild, moderate or severe COVID-19. Only a few studies investigated the symptom-based diagnosis of COVID-19 in children or older adults.

**How up to date is this review?**

This review updates our previous review. The evidence is up to date to June 2021.

## SUMMARY OF FINDINGS

### Summary of findings 1. Symptoms to determine if a patient presenting in primary care or hospital outpatient setting has COVID-19

#### Symptoms to determine if a patient presenting in primary care or hospital outpatient setting has COVID-19

**Patient or population:** people with COVID-19 symptoms

**Setting:** primary care or hospital outpatient departments

**Index test(s):** symptoms of COVID-19

**Target condition:** SARS-CoV-2 infection (symptomatic of any severity); mild or moderate COVID-19; severe or critical COVID-19

**Reference standard:** RT-PCR

Top 10 of most reported symptoms to determine if a patient presenting in primary care or hospital outpatient setting has COVID-19 (prospective cross-sectional studies only). We estimated pooled sensitivity and specificity only for prospective studies with a low risk of bias rating for participant selection.

Symptom	Setting	Number of studies/number of participants	Sensitivity (ranges)	Specificity (ranges)	Strength of evidence  Number of studies with high risk of bias per QUADAS-2 domain:  participant selection/index test/reference standard/flow and timing
Cough	Primary care	2/414	70% to 80%	16% to 30%	2/1/0/0
	Outpatient clinics/ED	25/32,756	14% to 86%	15% to 88%	7/20/1/1
	Mixed: paediatric hospital inpatients/ outpatients	2/493	40% to 47%	29% to 61%	0/2/0/0
	Nursing homes	1/3764	63%	38%	0/1/0/0
	<b>All settings</b>  (only prospective studies with low risk of bias for participant selection)	<b>11/18,702</b>	<b>Summary estimate:</b>  <b>62% (95% CI 51% to 73%)</b>	<b>Summary estimate:</b>  <b>45% (95% CI 34% to 58%)</b>	

<b>Fever</b>	Primary care	1/334	33%	73%	1/1/0/0
	Outpatient clinics/ED	25/40,278	6% to 78%	8% to 99%	6/21/1/1
	Mixed: paediatric hospital inpatients/ outpatients	2/493	47% to 51%	30% to 53%	0/2/0/0
	Nursing homes	1/3771	63%	58%	0/1/0/0
	<b>All settings</b> (only prospective studies with low risk of bias for participant selection)	<b>12/28,495</b>	<b>Summary estimate:</b> <b>38% (95% CI 23% to 54%)</b>	<b>Summary estimate:</b> <b>75% (95% CI 56% to 88%)</b>	
<b>Dyspnoea</b>	Primary care	1/334	15%	82%	1/1/0/0
	Outpatient clinics/ED	24/30,809	6% to 77%	31% to 95%	7/21/1/1
	Mixed: paediatric hospital inpatients/ outpatients	2/493	7% to 16%	86% to 92%	0/2/0/0
	Nursing homes	1/3622	30%	61%	0/1/0/0
	<b>All settings</b> (only prospective studies with low risk of bias for participant selection)	<b>12/19,545</b>	<b>Summary estimate:</b> <b>23% (95% CI 16% to 32%)</b>	<b>Summary estimate:</b> <b>76% (95% CI 65% to 84%)</b>	
<b>Sore throat</b>	Primary care	2/414	19% to 80%	61% to 88%	2/1/0/0
	Outpatient clinics/ED	21/26,470	3% to 77%	21% to 94%	8/19/1/1
	Mixed: paediatric hospital inpatients/ outpatients	2/493	0% to 35%	79% to 89%	0/2/0/0
	Nursing homes	1/2675	10%	86%	0/1/0/0
	<b>All settings</b> (only prospective studies with low risk of bias for participant selection)	<b>10/14,548</b>	<b>Summary estimate:</b> <b>31% (95% CI 20% to 45%)</b>	<b>Summary estimate:</b> <b>62% (95% CI 47% to 75%)</b>	
<b>Headache</b>	Primary care	2/414	11% to 40%	71% to 85%	2/1/0/0
	Outpatient clinics/ED	19/26,135	2% to 93%	9% to 93%	10/16/1/1
	Mixed: paediatric hospital inpatients/ outpatients	2/493	0% to 27%	76% to 95%	0/2/0/0

	Nursing homes	-	-	-	-
	<b>All settings</b>	<b>7/10899</b>		<b>Summary estimate:</b>	<b>Summary estimate:</b>
	(only prospective studies with low risk of bias for participant selection)			<b>36% (95% CI 17% to 60%)</b>	<b>73% (95% CI 53% to 86%)</b>
<b>Diarrhoea</b>	Primary care	1/334	4%	93%	1/1/0/0
	Outpatient clinics/ED	19/24042	10% to 64%	44% to 95%	6/17/1/1
	Mixed: paediatric hospital inpatients/ outpatients	2/493	6% to 20%	90% to 93%	0/2/0/0
	Nursing homes	1/1286	18%	84%	0/1/0/0
	<b>All settings</b>	<b>11/13,669</b>		<b>Summary estimate:</b>	<b>Summary estimate:</b>
	(only prospective studies with low risk of bias for participant selection)			<b>19% (95% CI 16% to 22%)</b>	<b>84% (95% CI 79% to 88%)</b>
<b>Myalgia</b>	Primary care	1/334	26%	81%	1/1/0/0
	Outpatient clinics/ED	17/16,106	20% to 84%	22% to 92%	9/15/0/0
	Mixed: paediatric hospital inpatients/ outpatients	1/319	0%	92%	0/1/0/0
	Nursing homes	-	-	-	-
	<b>All settings</b>	<b>6/2684</b>		<b>Summary estimate:</b>	<b>Summary estimate:</b>
	(only prospective studies with low risk of bias for participant selection)			<b>38% (95% CI 21% to 58%)</b>	<b>75% (95% CI 58% to 87%)</b>
<b>Anosmia</b>	Primary care	2/1150	26% to 41%	88% to 93%	1/2/0/0
	Outpatient clinics/ED	18/18,958	1% to 65%	70% to 99%	9/15/1/2
	Mixed: paediatric hospital inpatients/ outpatients	-	-	-	-
	Nursing homes	-	-	-	-
	<b>All settings</b>	<b>7/9456</b>		<b>Summary estimate:</b>	<b>Summary estimate:</b>

	(only prospective studies with low risk of bias for participant selection)		<b>26% (95% CI 14% to 45%)</b>	<b>94% (95% CI 91% to 97%)</b>	
<b>Fatigue</b>	Primary care	1/334	19%	71%	1/1/0/0
	Outpatient clinics/ED	15/12,369	15% to 90%	18% to 94%	6/14//1/1
	Mixed: paediatric hospital inpatients/ outpatients	2/493	0% to 4%	95% to 97%	0/2/0/0
	Nursing homes	1/1286	22%	87%	0/1/0/0
	<b>All settings</b>	<b>8/7967</b>		<b>Summary estimate:</b>	<b>Summary estimate:</b>
	(only prospective studies with low risk of bias for participant selection)		<b>40% (95% CI 19% to 65%)</b>	<b>74% (95% CI 48% to 89%)</b>	
<b>Chills/shivers</b>	Primary care	2/414	19% to 20%	89% to 93%	2/1/0/0
	Outpatient clinics/ED	10/21,980	26% to 81%	28% to 97%	4/10/0/0
	Mixed: paediatric hospital inpatients/ outpatients	1/174	8%	98%	0/1/0/0
	Nursing homes	-	-	-	-
	<b>All settings</b>	<b>5/14,472</b>		<b>Summary estimate:</b>	<b>Summary estimate:</b>
	(only prospective studies with low risk of bias for participant selection)		<b>25% (95% CI 15% to 39%)</b>	<b>85% (95% CI 72% to 93%)</b>	

**CI:** confidence interval; **ED:** emergency department; **RT-PCR:** reverse transcription polymerase chain reaction

## BACKGROUND

The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus and resulting COVID-19 pandemic present important diagnostic evaluation challenges. These range from, on the one hand, understanding the value of signs and symptoms in predicting possible infection, assessing whether existing biochemical and imaging tests can identify infection and recognise patients needing critical care, and on the other hand, evaluating whether new diagnostic tests can allow accurate rapid and point-of-care testing. Also, the diagnostic aims are diverse, including identifying current infection, ruling out infection, identifying people in need of care escalation, or testing for past infection and immunity.

This review is the second update of a review summarising evidence of the diagnostic accuracy of presenting clinical signs and symptoms for COVID-19. This review is part of a suite of reviews on the diagnosis of SARS-CoV-2 infection and COVID-19 disease, exploring the accuracy of antibody tests (Deeks 2020a), routine laboratory testing (Stegeman 2020), rapid point-of-care tests (Dinnes 2021) and thoracic imaging tests (Islam 2021).

### Target condition being diagnosed

The key target conditions for this suite of reviews are current SARS-CoV-2 infection, current COVID-19, and past SARS-CoV-2 infection.

For current infection, the severity of the disease is of importance. SARS-CoV-2 infection can be asymptomatic (no symptoms); mild or moderate (symptoms such as fever, cough, loss of smell (anosmia) or taste (ageusia), aches, lethargy but without difficulty breathing at rest); severe (symptoms with breathlessness and increased respiratory rate indicative of pneumonia and oxygen need); or critical (requiring intensive support due to severe acute respiratory syndrome (SARS) or acute respiratory distress syndrome (ARDS), shock or other organ dysfunction (NIH 2021)). People with COVID-19 pneumonia (severe or critical disease) require different patient management, which makes it important to distinguish between them and mild or moderate disease.

Thus, there are three target conditions for current infection:

1. SARS-CoV-2 infection (asymptomatic or symptomatic of any severity);
2. mild or moderate COVID-19 disease;
3. COVID-19 pneumonia (severe or critical).

Here we summarise the evidence on signs and symptoms; as a result asymptomatic SARS-CoV-2 and past SARS-CoV-2 infection are out of scope for this review.

### Index test(s)

#### Signs and symptoms

Signs and symptoms are used in the initial diagnosis of suspected COVID-19 disease, and to identify people with COVID-19 pneumonia. Symptoms are what are experienced by patients, for example cough or nausea. Signs are obtained by clinical examination. Signs of COVID-19 examined in this review include lung sounds, blood pressure, blood oxygen level and heart rate.

Key symptoms that have been associated with mild to moderate COVID-19 disease include: troublesome dry cough (for example,

coughing more than usual over a one-hour period, or three or more coughing episodes in 24 hours), fever at examination greater than 37.8°C, diarrhoea, headache, breathlessness on light exertion, muscle pain, fatigue, and loss of sense of smell and taste (Struyf 2021). Signs and symptoms indicating possible pneumonia (severe or critical disease) include breathlessness at rest, loss of appetite, confusion, pain or pressure in the chest, and temperature above 38°C.

### Clinical pathway

Important in the context of COVID-19 is that the pathway is multifaceted because it is designed to care for the diseased individual and to protect the community from further spread. Decisions about patient and isolation pathways for COVID-19 vary according to health services and settings, available resources, and stages of the epidemic. They will change over time if and when effective treatments are identified and populations are increasingly vaccinated. The decision points between these pathways vary, but all include points at which knowledge of the accuracy of diagnostic information is needed to inform rational decision making.

### Prior test(s)

Prior testing will depend on whether people are being investigated for SARS-CoV-2 infection, mild COVID-19 or COVID-19 pneumonia. In this review on signs and symptoms, no prior tests are required because signs and symptoms are used in the initial diagnosis of suspected SARS-CoV-2 infection, and in identifying people with mild COVID-19 or COVID-19 pneumonia.

### Role of index test(s)

Signs and symptoms are used as triage tests, that is, to rule out SARS-CoV-2 infection or COVID-19 disease, but also to identify people with possible COVID-19 who may require further testing, care escalation or isolation.

### Alternative test(s)

We are producing a suite of Cochrane 'living systematic reviews', which will summarise evidence on the clinical accuracy of different tests and diagnostic features, grouped according to the present research questions and settings in the diagnosis of SARS-CoV-2 infection and COVID-19. Summary estimates of accuracy from these reviews will help inform diagnostic, screening, isolation, and patient-management decisions.

New tests are being developed and evidence is emerging at an unprecedented rate during the COVID-19 pandemic. We will aim to update these reviews as often as is feasible to ensure that they provide the most up-to-date evidence about test accuracy.

These reviews are being produced rapidly to assist in providing a central resource of evidence to assist in the COVID-19 pandemic, summarising available evidence on the accuracy of the tests and presenting characteristics.

Other Cochrane diagnostic test accuracy (DTA) reviews in the suite of reviews are addressing the following tests.

- Chest imaging (computed tomography (CT), chest X-ray and ultrasound (Islam 2021))
- Routine laboratory testing, such as for C-reactive protein (CRP) and procalcitonin (PCT) (Stegeman 2020)



- Antibody tests (Deeks 2020a)
- Laboratory-independent point-of-care and near-patient molecular and antigen tests (Dinnes 2021)
- Molecular laboratory tests (in preparation)

## Rationale

It is essential to understand the accuracy of diagnostic features and tests to identify the best way they can be used in different settings to develop effective diagnostic and management pathways. For example, the absence of a highly sensitive sign or symptom is good for ruling out COVID-19, while the presence of a sign or symptom with high specificity is good for ruling in COVID-19 ('red flag').

## OBJECTIVES

To assess the diagnostic accuracy of signs and symptoms to determine if a person presenting in primary care or to hospital outpatient settings, such as the emergency department or dedicated COVID-19 clinics, has COVID-19.

### Secondary objectives

Where data are available, we investigated diagnostic accuracy (either by stratified analysis or meta-regression) according to:

- days since symptom onset;
- population (children, adults, older adults  $\geq$  65 years);
- reference standard;
- study design;
- setting; and
- risk of bias in participant selection (as scored using QUADAS-2)

### Objectives of future updates of this review

This review will no longer be updated in its current form. Objectives of any future updates of this review are:

- to look at a broader approach involving a combination of signs and symptoms with other easy-to-obtain information, for example, point-of-care test results;
- to perform the listed stratified analyses;
- to explore seasonality;
- to investigate people who require respiratory support or intensive care.

### Summary of previous review

In the first update of our review, we found 44 relevant studies with 26,884 participants. Prevalence of COVID-19 disease varied from 3% to 71% with a median of 21%. There were three studies from primary care settings (1824 participants), nine studies from outpatient testing centres (10,717 participants), 12 studies performed in hospital outpatient wards (5061 participants), seven studies in hospitalised patients (1048 participants), 10 studies in the emergency department (3173 participants), and three studies in which the setting was not specified (5061 participants). The studies did not clearly distinguish mild COVID-19 disease from COVID-19 pneumonia, so we presented the results for both conditions together.

Fifteen studies had a high risk of bias for selection of participants because inclusion in the studies depended on the applicable

testing and referral protocols, which included many of the signs and symptoms under study in the review. Five studies only included participants with pneumonia on imaging, suggesting that this is a highly selected population. In an additional 12 studies, we were unable to assess the risk for selection bias. This makes it very difficult to judge the validity of the diagnostic accuracy of the signs and symptoms from these included studies.

None of the studies presented any data on children separately, and only one focused specifically on older adults.

We found data on 84 signs and symptoms. Results were highly variable across studies. Most had very low sensitivity and high specificity. Only cough (25 studies) and fever (7 studies) had a summary sensitivity of at least 50% but specificities were moderate to low. Cough had a sensitivity of 67.4% (95% CI 59.8% to 74.1%) and specificity of 35.0% (95% CI 28.7% to 41.9%). Fever had a sensitivity of 53.8% (95% CI 35.0% to 71.7%) and a specificity 67.4% (95% CI 53.3% to 78.9%). The summary positive likelihood ratio of cough was only 1.04 (95% CI 0.97 to 1.11) and that of fever 1.65 (95% CI 1.41 to 1.93).

Anosmia alone (10 studies), ageusia alone (5 studies), and anosmia or ageusia (6 studies) had sensitivities below 50% but specificities over 85%. Anosmia had a summary sensitivity of 30.5% (95% CI 19.4% to 44.4%) and a specificity of 92.7% (95% CI 87.1% to 96.0%). Ageusia had a summary sensitivity of 29.4% (95% CI 15.1% to 49.5%) and a specificity of 89.0% (95% CI 77.6% to 94.9%). Anosmia or ageusia had a summary sensitivity of 41.0% (95% CI 27.0% to 56.6%) and a specificity of 90.5% (95% CI 81.2% to 95.4%). The summary positive likelihood ratios of anosmia alone and anosmia or ageusia were 4.16 (95% CI 3.10 to 5.60) and 4.31 (95% CI 3.00 to 6.18) respectively, which is just below our arbitrary definition of a red flag, that is, a positive likelihood ratio of at least 5. The summary positive likelihood ratio of ageusia alone was 2.67 (95% CI 1.96 to 3.64).

Only two studies assessed combinations of different signs and symptoms, mostly combining both fever and cough. These combinations had a specificity above 80%, but at the cost of very low sensitivity (< 30%).

We concluded that the majority of individual signs and symptoms included in the review appear to have very poor diagnostic accuracy, although this should be interpreted in the context of selection bias and heterogeneity between studies. Based on the available data, neither absence nor presence of signs or symptoms are accurate enough to rule in or rule out disease. The presence of anosmia or ageusia may be useful as a red flag for the presence of COVID-19. The presence of fever or cough may, given their high sensitivities, be useful as a triage tool for further testing.

### New evidence since previous review

We found more studies on symptoms in people with suspected COVID-19 that used prospective data collection, allowing for more reliable estimation of measures of diagnostic accuracy. Moreover, this update contains new studies on the diagnostic value of 29 different combinations of signs and symptoms.

### Limitations of previous review

The main weakness of the initial review and of the first update was the high risk of selection bias, with many studies including patients



who had already been admitted to hospital or who had presented to hospital settings with the intent to hospitalise.

The lack of data on combinations of signs and symptoms was an important evidence gap. Only two studies presented data on such combinations. The few composite signs and symptoms that were presented in those studies had little added diagnostic value compared to single tests.

## METHODS

### Criteria for considering studies for this review

#### Types of studies

We included published studies of all designs that produce estimates of sensitivity and specificity or provide data from which estimates can be computed. As of this update, we no longer included preprints. If no published version of previously included preprints could be found, we excluded these preprints.

As of this review update, we only included single-gate, cross-sectional designs (studies that recruit from a patient pathway before disease status has been ascertained). We included both studies that used retrospective data collection and studies that used prospective data collection, but the main findings of this review will be based on the prospective studies only, as retrospective studies tend to overestimate the diagnostic accuracy of the index tests (Rutjes 2006).

Studies had to have a minimum sample size of 10 participants.

#### Participants

Studies recruiting people presenting with a clinical suspicion of SARS-CoV-2 infection, based on a symptomatic presentation, were eligible. At least 50% of the study population had to present with COVID-19-compatible symptoms.

#### Index tests

- All signs and symptoms, including:
  - signs such as oxygen saturation, measured by oximetry and blood pressure;
  - symptoms, such as fever or cough.

#### Target conditions

To be eligible, studies had to identify at least one of:

- mild or moderate COVID-19;
- severe or critical COVID-19 (including COVID-19 pneumonia).

Asymptomatic infection with SARS-CoV-2 is out of scope for this review, considering it is by definition not possible to detect this based on signs and symptoms.

#### Reference standards

We anticipated that studies would use a range of reference standards. Although reverse transcription polymerase chain reaction (RT-PCR) is considered the best available test, due to rapidly evolving knowledge about the target conditions, multiple reference standards on their own as well as in combination have emerged.

We expected to encounter cases defined by:

- RT-PCR alone;
- RT-PCR, clinical expertise, and imaging (for example, CT thorax);
- repeated RT-PCR several days apart or from different samples;
- plaque reduction neutralisation test (PRNT) or enzyme-linked immunosorbent assay (ELISA) tests;
- information available at a subsequent time point;
- World Health Organization (WHO) and other case definitions (see Appendix 1).

This list is not exhaustive, and we recorded all reference standards encountered.

### Search methods for identification of studies

The final search date for this version of the review is 10 June 2021.

#### Electronic searches

For this updated review, we used the University of Bern living search database as our primary register. This registry searches PubMed, Embase and preprint archives (medRxiv and bioRxiv) daily for COVID-19 research. The strategies to build the database can be found on the ISPM web site are described here [ispmbern.github.io/COVID-19/](https://ispmbern.github.io/COVID-19/) and in Appendix 2.

Due to the increased volume of literature a specific classifier was built for the review topic in Eppi reviewer. In brief, manual annotations of references on in- or exclusion from repeated retrieval dates from the previous versions of the review were partially used as training data and the remaining for validation and threshold for optimal recall determination. All references from the University of Bern living search database from 15 July 2020 till 10 June 2021 were run against the classifier and references labelled as potentially relevant were screened manually. See Appendix 3.

#### Searching other resources

We also checked our search results against two additional repositories of COVID-19 publications including:

- the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) 'COVID-19: Living map of the evidence' ([eppi.ioe.ac.uk/COVID19\\_MAP/covid\\_map\\_v4.html](https://eppi.ioe.ac.uk/COVID19_MAP/covid_map_v4.html));
- the Norwegian Institute of Public Health 'NIPH systematic and living map on COVID-19 evidence' ([www.nornesk.no/forskningskart/NIPH\\_diagnosisMap.html](https://www.nornesk.no/forskningskart/NIPH_diagnosisMap.html)).

Both of these repositories allow their contents to be filtered according to studies potentially relating to diagnosis, and both have agreed to provide us with updates of new diagnosis studies added. For this iteration of the review, we examined all diagnosis studies from both sources up to 10 June 2021.

We did not apply any language restrictions.

### Data collection and analysis

#### Selection of studies

Pairs of review authors independently screened studies. We resolved disagreements by discussion with a third, experienced review author for initial title and abstract screening, and

through discussion between three review authors for eligibility assessments.

### Data extraction and management

Pairs of review authors independently performed data extraction. We resolved disagreements by discussion between three review authors.

We contacted study authors where we needed to clarify details or obtain missing information.

### Assessment of methodological quality

Pairs of review authors independently assessed risk of bias and applicability concerns using the QUADAS-2 (Quality Assessment tool for Diagnostic Accuracy Studies) checklist, which was common to the suite of reviews but tailored to each particular review (Whiting 2011; Table 1). For this review, we excluded the questions on the nature of the samples as these were not relevant, and we added a question on who assessed the signs. We resolved disagreements by discussion between three review authors.

### Statistical analysis and data synthesis

We presented results of estimated sensitivity and specificity using paired forest plots in [Review Manager 2020](#), and tables as appropriate.

We considered tests to be useful in ruling out a serious infection in ambulatory care if their negative likelihood ratio (LR-) was lower than 0.20; conversely, we considered diagnostic tests useful as red flags for infections when their positive likelihood ratio (LR+) was 5.0 or higher (Jaeschke 1994; Van den Bruel 2010).

We disaggregated data by study design, reporting results from prospective studies separately from studies that used a retrospective design, which we assessed as prone to high risk of bias (Rutjes 2006). We focused on the results of prospective studies in this 2022 update. When interpreting the results, we made sure that the limitations of different study designs were carefully considered, using quality assessment and analysis.

We estimated summary sensitivity and specificity using a bivariate random-effects meta-analysis (Macaskill 2013). We undertook meta-analyses using the lme4 package (R 2020), implemented in MetaDTA ([crsu.shinyapps.io/dta\\_ma/](https://crsu.shinyapps.io/dta_ma/)). We based the decision to pool data on the following criteria: clinically acceptable heterogeneity on visual inspection of the forest and ROC plots, the availability of at least five studies, and low risk of bias for participant selection.

### Investigations of heterogeneity

Sources of heterogeneity that we investigated if adequate data were available are listed in the [Secondary objectives](#), either using stratification (where we believed it was inappropriate to combine studies) or through meta-regression models.

In this version of the review, we have stratified by population (age group) and care setting.

### Sensitivity analyses

We aimed to undertake sensitivity analyses considering the impact of unpublished studies, but this was not possible in this version of the review due to the small number of studies in each meta-analysis.

### Assessment of reporting bias

We aimed to publish lists of studies that we know exist but for which we have not managed to locate reports, and request information to include in updates of these reviews. However, at the time of writing this version of the review, we are unaware of unpublished studies.

### Summary of findings

We have listed our key findings in [Summary of findings 1](#) to determine the strength of evidence for each test and findings, and to highlight important gaps in the evidence.

### Updating

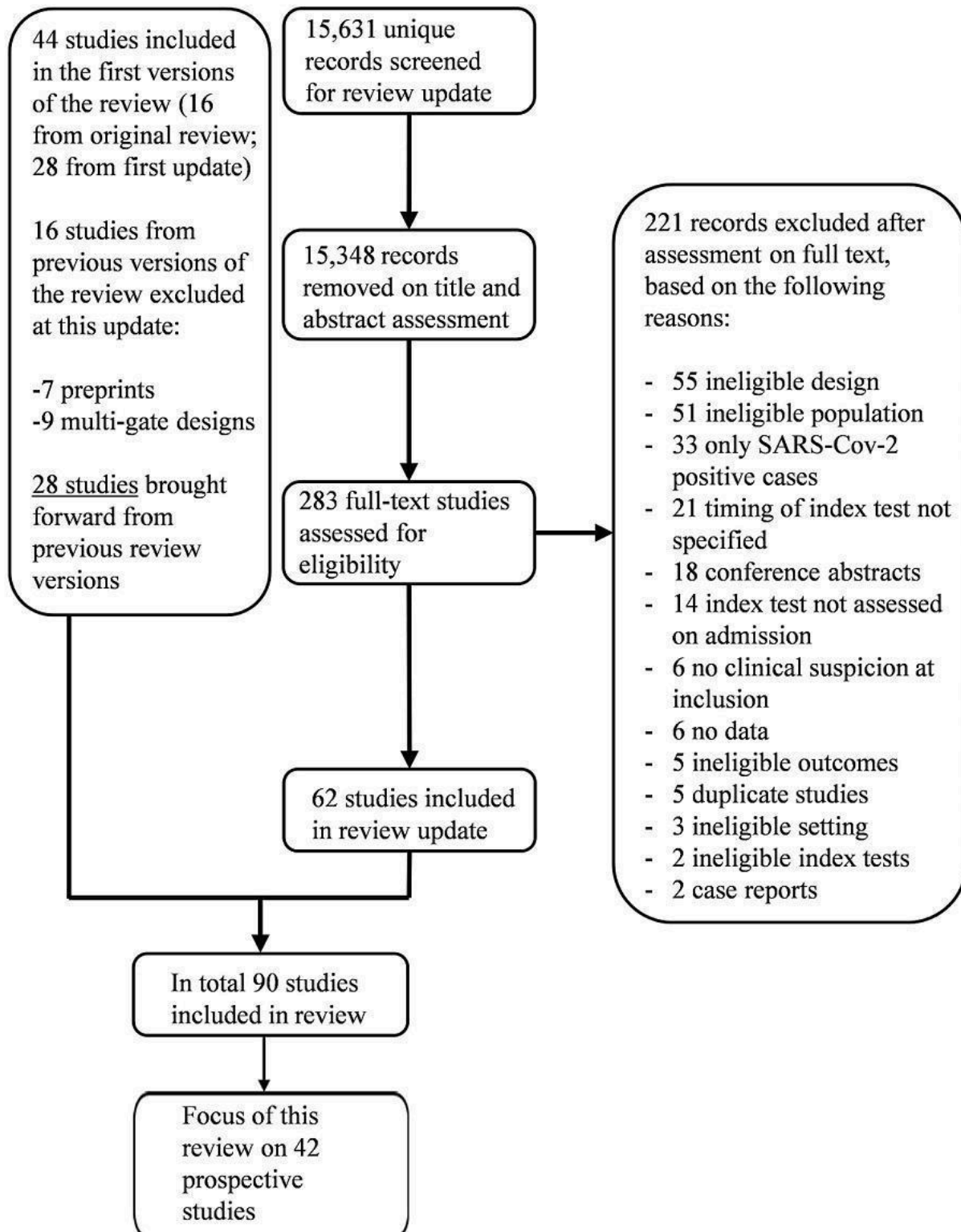
As we will explain in the discussion, this review will no longer be updated in its current form. Resources allowing, we will consider updating this review when sufficient studies of high methodological quality become available examining the combination of signs and symptoms with other, easy-to-obtain information such as demographics, point-of-care test results, prior exposure to an infected person, and recent case detection rate. Another important outcome would be to investigate whether tests exist that identify people requiring respiratory support (SARS or ARDS) or intensive care.

## RESULTS

### Results of the search

The first selection resulted in 23,683 potentially eligible articles. This included the 658 articles that we screened in our initial review and 7394 we screened in the first review update. After screening 15,631 articles on title and abstract for this update, we excluded 15,348 articles, leaving 283 full-text articles to be assessed. We included 90 studies in this version of the review, 28 of which were included in the previous reviews. We excluded 16 studies from the previous review versions from this review because they were either preprints of which no published version was available at the time of our final search (n = 7), or because they were case-control studies (multi-gate designs, n = 9); see [Characteristics of excluded studies](#). The reasons for excluding 221 articles are listed in the flow chart ([Figure 1](#); Moher 2009); reasons for excluding a selected number of studies (n = 143) that Cochrane readers might reasonably expect to find are also listed in [Characteristics of excluded studies](#).

**Figure 1. PRISMA flowchart**



The participants in Zimmerman 2020 and Rutten 2020a were a subset of those included in Chung 2021 and Rutten 2020b, respectively. We included all four studies in this review, but we used only the more complete data from Chung 2021 and Rutten 2020b.

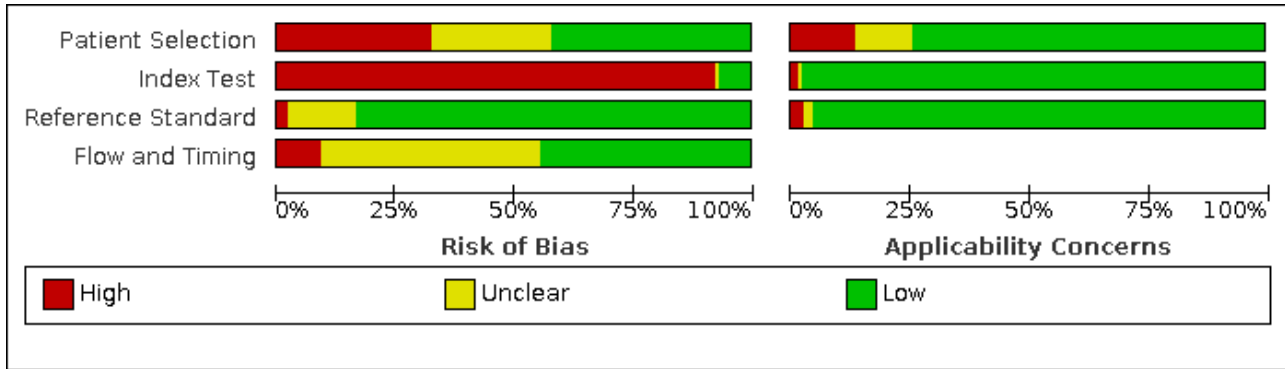
We determined the most appropriate data set in consultation with both study authors.

A summary of the main study characteristics of the prospective studies can be found in [Table 2](#).

**Methodological quality of included studies**

The results of the quality assessment for all 90 included studies are summarised in [Figure 2](#) and [Figure 3](#). Of the 90 single-gate studies included in this review, 42 studies collected their data prospectively. Only one of the 48 retrospective studies applied a nested case-control design ([Tordjman 2020](#)).

**Figure 2. Risk of bias and applicability concerns graph: review authors' judgements about each domain presented as percentages across included studies**



**Figure 3. Risk of bias and applicability concerns summary: review authors' judgements about each domain for each included study**

	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Ahmed 2021	+	-	?	?	+	+	+
Aldobyany 2020	-	-	+	?	+	+	+
Alizadehsani 2021	-	-	?	?	-	+	+
Allegorico 2020	-	-	+	+	?	+	+
Arenas 2020	+	-	+	?	-	+	+
Arslan 2021	+	-	+	?	+	+	+
Barbhaya 2021	?	-	+	+	+	+	+
Bhattacharya 2021	-	?	+	?	+	?	+
Bouzid 2020	-	-	+	?	?	+	+
Brendish 2020	-	-	+	?	+	+	+
Buonafine 2020	-	-	+	?	+	+	+
Chan 2021	+	-	+	?	-	+	+
Cheng 2020	-	-	+	+	-	+	+
Chew 2021	+	-	+	?	+	+	+
Chua 2020	+	-	+	+	?	+	+
Chung 2021	?	-	+	-	+	+	+
Clemency 2020	+	-	+	+	+	+	+
Clifford 2020	+	-	+	?	+	+	+
Cunarro-Lopez 2020	-	-	+	?	-	+	+
Drager 2020	+	+	?	?	+	+	?
Feng 2021	+	-	-	-	+	+	+
Fiel-Ozores 2021	?	-	?	-	?	+	-
Fink 2021	?	+	+	+	?	+	+
Gilbert 2020	-	-	+	+	-	+	+
Haehner 2020	+	+	+	+	+	+	+
Halqa 2021	?	-	+	+	-	+	+

**Figure 3. (Continued)**

Haliga 2021	?	-	+	+	-	+	+
Huang 2020	?	-	+	+	+	+	+
Hüfner 2020	?	-	?	?	+	+	?
Ide 2021	-	-	+	?	+	+	+
Ishii 2021	+	-	+	?	+	+	+
Jeyashree 2021	+	+	+	+	+	+	+
Just 2020	-	-	+	+	+	+	+
Kalayjian 2020	-	-	+	+	-	+	+
Kelen 2021	+	-	+	+	+	+	+
Kempker 2020	+	-	+	?	+	+	+
Kim 2020	+	-	+	+	+	+	+
King 2020	-	-	+	-	+	+	+
Krastinova 2020	?	-	+	?	+	+	+
Langer 2020	+	-	+	+	+	+	+
Lazerini 2021	+	-	?	?	+	+	+
Leal 2020	-	-	?	-	-	-	+
Leung 2021	+	-	+	+	+	+	+
Maechler 2020	+	-	+	+	+	+	+
Mansella 2020	?	-	+	+	+	+	+
Mao 2020	-	-	+	?	+	+	+
Martín-Sánchez 2020	-	-	+	+	+	+	+
Martin-Sanz 2020	+	-	+	?	+	+	+
Nazerian 2021	?	-	+	+	+	+	+
Nitecki 2021	?	-	+	?	+	+	+
O'Reilly 2020a	+	-	+	+	+	+	+
O'Reilly 2020b	?	-	+	?	+	+	+
Olivar Lopez 2020	+	-	+	?	+	+	+
Peng 2020	?	-	+	+	?	+	+
Peyrony 2020	-	-	+	+	?	+	+
Pisapia 2020	+	-	+	?	+	+	+
Pivetta 2020	-	-	-	-	-	+	-






**Figure 3. (Continued)**

Pivetta 2020	-	-	-	-	-	+	-
Pokorska-Śpiewak 2021	+	-	+	?	+	+	+
Porto 2021	?	-	+	?	+	+	+
Raberahona 2020	-	-	+	-	+	+	+
Romero-Gameros 2020	-	-	+	+	+	+	+
Romero-Gameros 2021	-	-	+	?	+	+	+
Rutten 2020a	+	-	?	?	+	+	+
Rutten 2020b	+	-	+	+	+	+	+
Sacks 2020	+	-	+	?	+	+	+
Saegerman 2021	-	-	+	+	+	+	+
Salmon Ceron 2020	?	-	+	+	+	+	+
Shah 2020	+	-	?	+	+	+	+
Simpson 2020	+	-	+	?	+	+	+
Sonoda 2021	?	-	+	?	+	+	+
Sun 2020	?	-	+	+	-	+	+
Tan 2021	-	-	+	?	+	+	+
Tolia 2020	?	-	?	+	+	+	+
Tordjman 2020	+	-	?	?	+	+	+
Trubiano 2020	+	-	+	+	+	+	+
Tudrej 2020	+	-	+	+	+	+	+
Van Loon 2021	+	-	+	?	+	+	+
Van Walraven 2021	+	-	+	+	+	+	+
Vieceli 2020	-	-	+	+	?	+	+
Vilke 2020	?	-	?	?	?	+	+
Villerabel 2021	-	+	+	+	+	+	+
Wee 2020	+	-	+	+	+	+	+
Wei 2020	?	-	+	+	+	+	+
Wernhart 2020	-	+	+	+	+	+	+
Xie 2020	?	-	+	-	-	+	+
Yombi 2020	?	-	+	?	?	+	+
Yonker 2020	+	-	+	+	+	+	+

**Figure 3. (Continued)**

Yonker 2020	+	-	+	+	+	+	+
Zayet 2020a	-	-	+	?	+	+	+
Zhu 2020	+	-	?	?	+	+	+
Zimmerman 2020	?	-	+	?	?	+	+
Zurl 2021	-	-	+	?	+	+	+

 <b>High</b>	 <b>Unclear</b>	 <b>Low</b>
---	--	--

In the next section, we discuss the quality assessment of the 42 prospective studies only (Alizadehsani 2021; Bhattacharya 2021; Bouzid 2020; Brendish 2020; Buonafine 2020; Clemency 2020; Drager 2020; Fink 2021; Gilbert 2020; Haehner 2020; Ishii 2021; Jeyashree 2021; Just 2020; Kalayjian 2020; Kempker 2020; Krastinova 2020; Leal 2020; Maechler 2020; Mansella 2020; Martin-Sanz 2020; Nazerian 2021; O'Reilly 2020a; O'Reilly 2020b; Olivar Lopez 2020; Peyrony 2020; Pivetta 2020; Pokorska-Śpiewak 2021; Porto 2021; Romero-Gameros 2020; Romero-Gameros 2021; Rutten 2020a; Rutten 2020b; Saegerman 2021; Salmon Ceron 2020; Trubiano 2020; Tudrej 2020; Van Loon 2021; Van Walraven 2021; Villerabel 2021; Wee 2020; Wernhart 2020; Yonker 2020).

### Participant selection

Participant selection was at high risk of bias in 12 out of 42 prospective studies. In seven studies (Alizadehsani 2021; Bhattacharya 2021; Brendish 2020; Buonafine 2020; Kalayjian 2020; Peyrony 2020; Romero-Gameros 2021), this was because a high level of preselection was used to decide whether RT-PCR testing was needed. For example, in Alizadehsani 2021, only patients with flu-like symptoms who were referred to the imaging department were included, leading to a preselection of individuals who are more likely to be infected with the SARS-CoV-2 virus and thus to a higher disease prevalence (38.5% in this example). Three studies (Bhattacharya 2021; Gilbert 2020; Just 2020), did not select a consecutive or random sample. Six studies (Leal 2020; Pivetta 2020; Romero-Gameros 2020; Saegerman 2021; Villerabel 2021; Wernhart 2020), excluded individuals while they were part of the study base.

For most studies, testing was dependent on the local case definition and testing criteria that was in effect at the time of the study, meaning all patients who were included in studies had already gone through a referral or selection filter.

### Index tests

We rated all studies except seven (Bhattacharya 2021; Drager 2020; Fink 2021; Haehner 2020; Jeyashree 2021; Villerabel 2021; Wernhart 2020), as high risk of bias for the index tests because there was little to no detail on how, and by whom and when, the signs and symptoms were measured. However, concerns that the index tests, their performance or interpretation deviated from the research question were rated as low in all but one study (Leal 2020), where symptoms were ascertained via telephone assessment by a medical student. Olfactory symptoms

were collected in different ways: interviews by telephone or in person using standardised questionnaires, online surveys, self-reporting at presentation, or systematic assessment by staff at enrolment without standardisation. The standardised questionnaires themselves are rarely reported, and are often newly developed by each research team.

### Reference standard

We rated one study (Pivetta 2020), high risk of bias concerning the reference standard. They used either an RT-PCR or other information including clinical, lab data or imaging. All other studies used RT-PCR or CT scans, depending on the target condition, and we rated them low risk of bias, although some studies provided little detail on blinding. This lack of reporting of blinding of the reference standard did not result in a high risk of bias rating in studies with SARS-CoV-2 infection as the target condition, as we assumed that a lab-based RT-PCR result is not influenced by the index test results. Only one study (Alizadehsani 2021), was at unclear risk of bias because it was unclear whether the radiologist interpreting the CT scans was blinded to the index test results.

### Flow and timing

Patient flow was unclear in 17 studies (Alizadehsani 2021; Bhattacharya 2021; Bouzid 2020; Brendish 2020; Buonafine 2020; Drager 2020; Ishii 2021; Kempker 2020; Krastinova 2020; Martin-Sanz 2020; O'Reilly 2020b; Olivar Lopez 2020; Pokorska-Śpiewak 2021; Porto 2021; Romero-Gameros 2021; Rutten 2020a; Van Loon 2021), either because the timing of recording signs and symptoms and conduct of the reference standard was unclear, or because some patients received a second or third reference standard at unclear time points during hospital admission, or because participant records were deleted when containing missing data. We rated two studies (Leal 2020; Pivetta 2020), high risk of bias concerning patient flow as not all participants received the same reference standard.

### Overall ratings

In summary, we rated 36 of the 42 studies as high risk of bias for the index tests because there was little or no detail on how, by whom and when, the signs and symptoms were measured. Participant selection had a high risk of bias in 12 of the 42 studies. Risk of bias was most often rated low with regard to the implementation of the reference standard, and unclear with regard to flow and



timing. However, the applicability of the study findings to our review question did not often give rise to substantial concerns.

## Findings

### Findings: prospective studies

The main characteristics of all 42 prospective included studies are listed in [Table 2](#).

### Setting

Thirty-five studies were set in emergency departments or outpatient test centres ([Alizadehsani 2021](#); [Bhattacharya 2021](#); [Bouzid 2020](#); [Brendish 2020](#); [Buonafine 2020](#); [Clemency 2020](#); [Drager 2020](#); [Fink 2021](#); [Gilbert 2020](#); [Haehner 2020](#); [Ishii 2021](#); [Jeyashree 2021](#); [Kalayjian 2020](#); [Kempker 2020](#); [Krastinova 2020](#); [Leal 2020](#); [Maechler 2020](#); [Mansella 2020](#); [Martin-Sanz 2020](#); [Nazerian 2021](#); [O'Reilly 2020a](#); [O'Reilly 2020b](#); [Olivar Lopez 2020](#); [Peyrony 2020](#); [Pivetta 2020](#); [Porto 2021](#); [Romero-Gameros 2020](#); [Romero-Gameros 2021](#); [Saegerman 2021](#); [Salmon Ceron 2020](#); [Trubiano 2020](#); [Van Loon 2021](#); [Van Walraven 2021](#); [Villerabel 2021](#); [Wee 2020](#)), three studies in primary care settings ([Just 2020](#); [Tudrej 2020](#); [Wernhart 2020](#)), two studies in a mixed population of in- and outpatients in a hospital setting ([Pokorska-Śpiewak 2021](#); [Yonker 2020](#)), and two overlapping studies in nursing homes ([Rutten 2020a](#); [Rutten 2020b](#)).

### Target conditions

Only one study assessed accuracy of signs and symptoms for the diagnosis of COVID-19 pneumonia ([Alizadehsani 2021](#)), the

remaining studies had SARS-CoV-2 infection as the target condition. The distinction between these two target conditions was not always very clear though, and a degree of overlap is to be assumed and we therefore present the results for both conditions together. All but two studies ([Alizadehsani 2021](#); [Drager 2020](#)) used RT-PCR testing as reference standard, with some variation in the samples that were used. [Alizadehsani 2021](#) used CT scanning for the diagnosis of COVID-19 pneumonia. [Drager 2020](#) did not specify the reference standard.

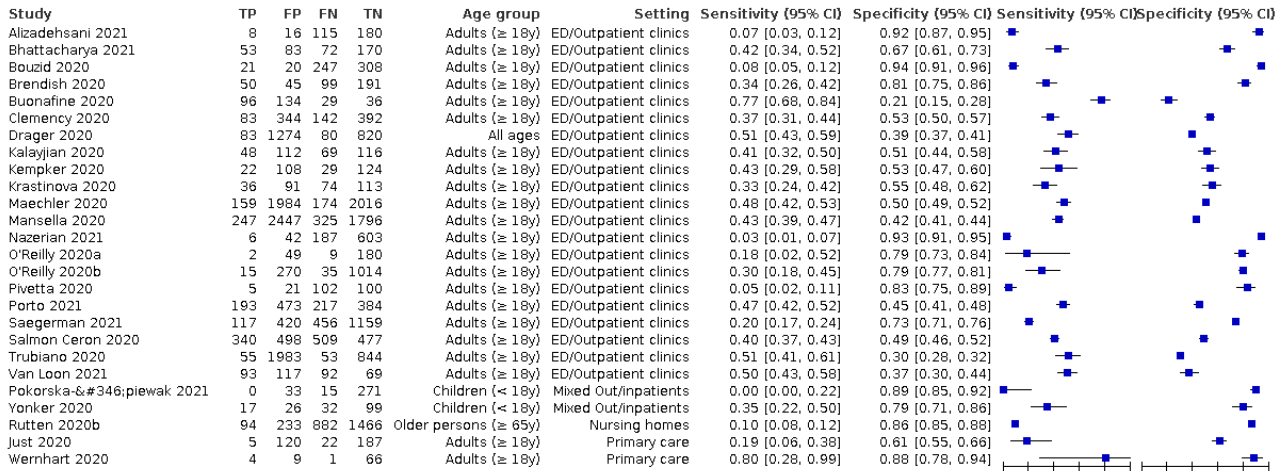
### General results

There were 52,608 participants in all 42 prospective studies, the median number of participants was 553. Prevalence varied from 3.7% to 60.6% with a median of 27.4%.

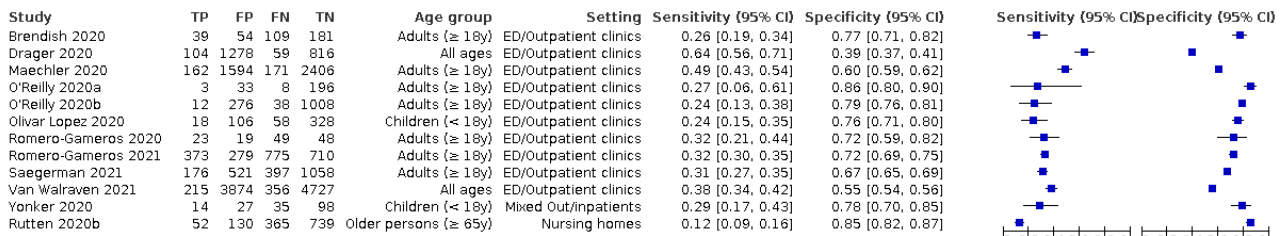
We found data on 96 symptoms, which fall into seven different categories, that is, systemic signs and symptoms, upper respiratory, lower respiratory, olfactory, gastro-intestinal, cardiovascular and multivariable combinations of signs or symptoms. Evidence on individual signs as diagnostic tests was rarely reported, so this review reports mainly on the diagnostic value of symptoms. Results for the prospective cross-sectional studies are presented in forest plots ([Figure 4](#); [Figure 5](#); [Figure 6](#); [Figure 7](#); [Figure 8](#); [Figure 9](#); [Figure 10](#)), and are plotted in ROC (receiver operating characteristic) space ([Figure 11](#); [Figure 12](#); [Figure 13](#); [Figure 14](#); [Figure 15](#); [Figure 16](#); [Figure 17](#); [Figure 18](#); [Figure 19](#)).

Figure 4. Forest plot of upper respiratory tract symptoms

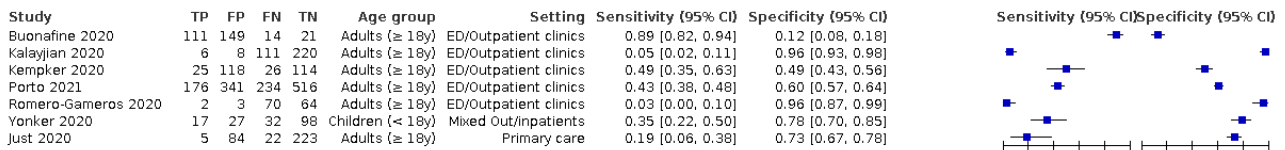
Sore throat



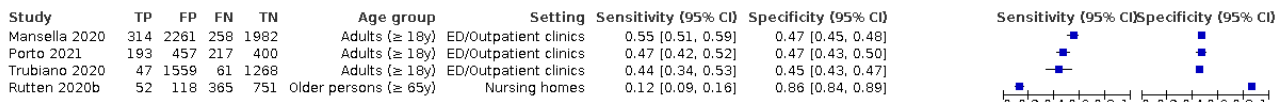
Rhinorrhoea



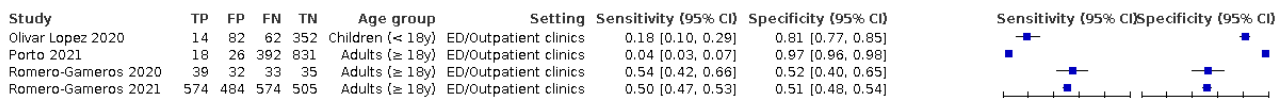
Nasal congestion



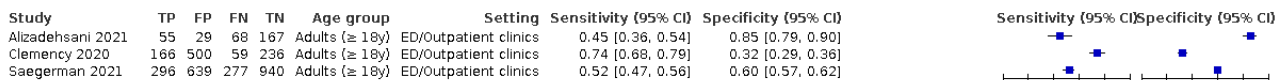
Coryza



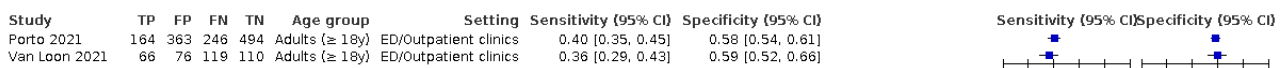
Odynophagia



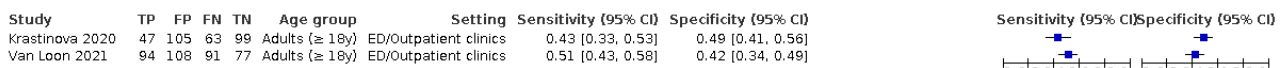
Dry cough



Sneezing



Nasal symptoms



Rhinitis



**Figure 4. (Continued)**

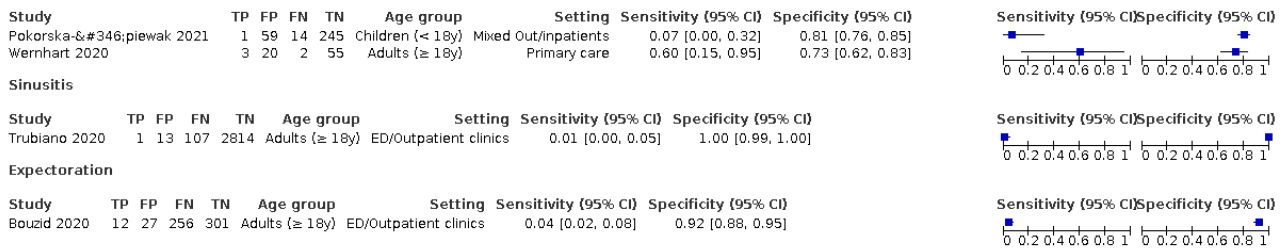
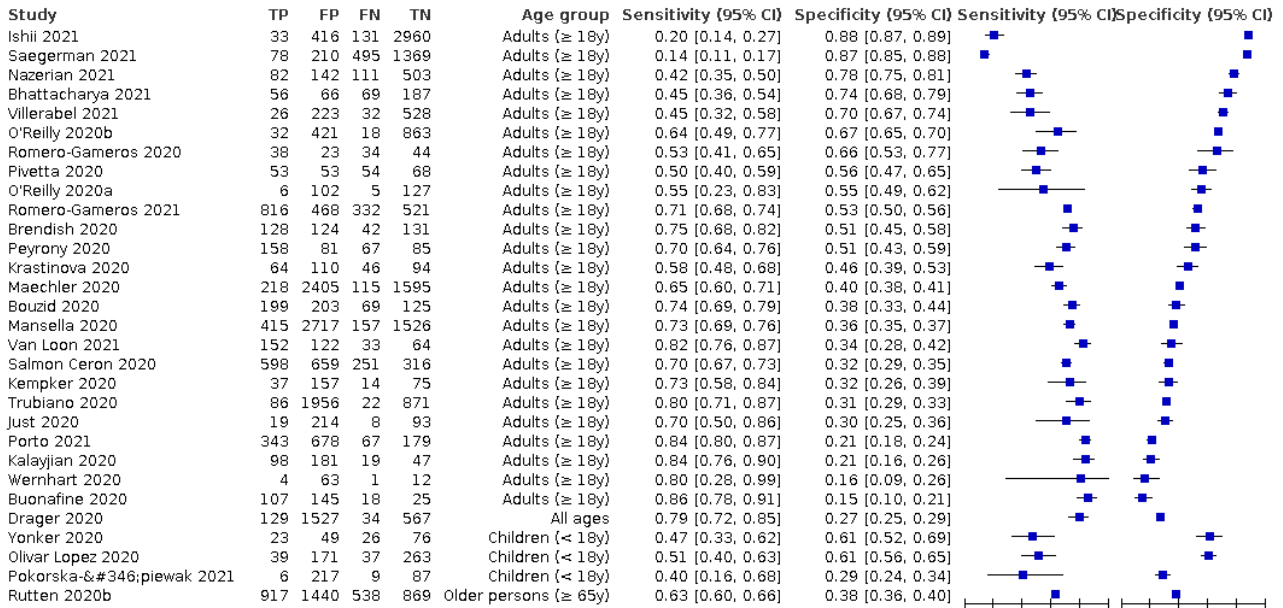
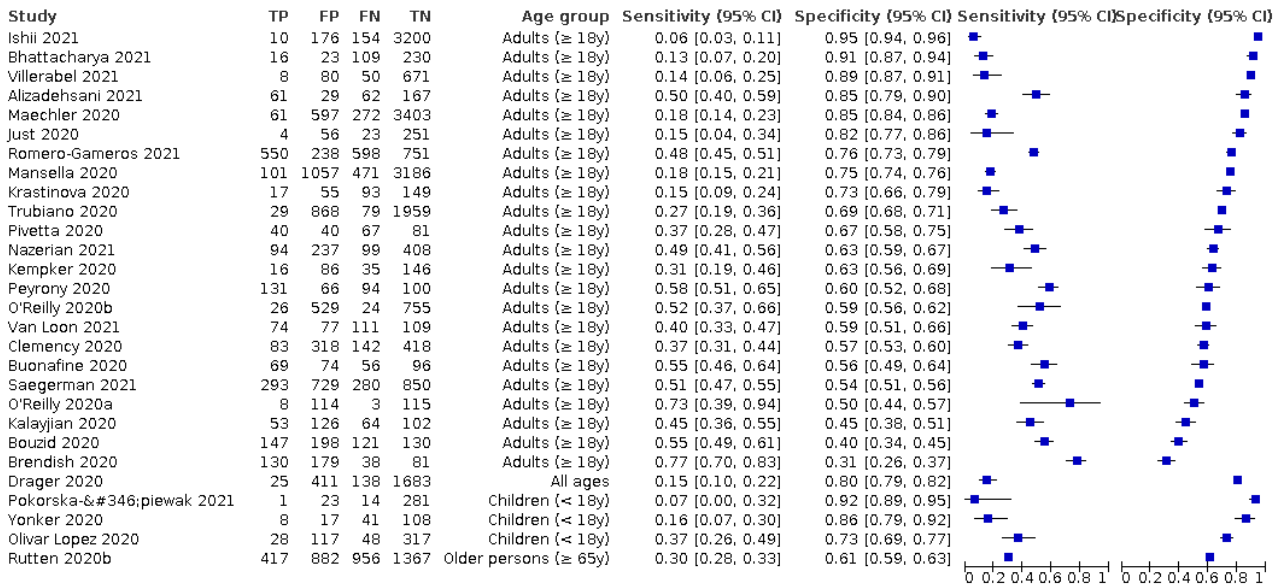


Figure 5. Forest plot of lower respiratory tract symptoms

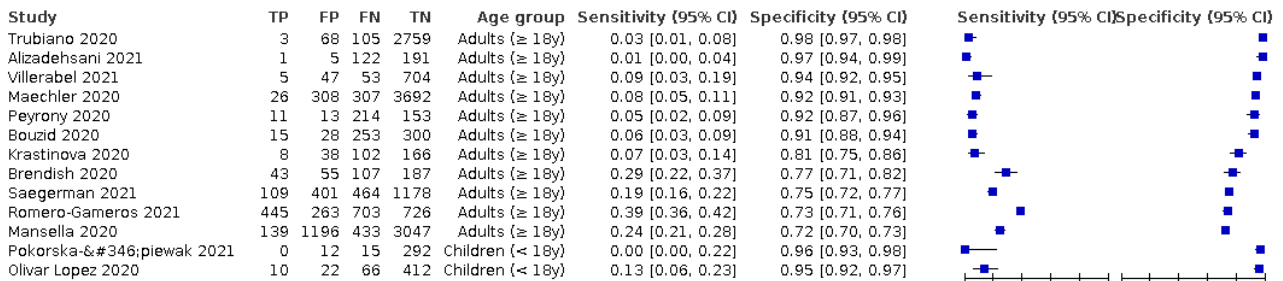
Cough



Dyspnoea



Chest tightness/pain



Sputum production/productive cough

**Figure 5. (Continued)**

**Sputum production/productive cough**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Alizadehsani 2021	2	4	121	192	Adults (≥ 18y)	0.02 [0.00, 0.06]	0.98 [0.95, 0.99]
Porto 2021	32	34	378	823	Adults (≥ 18y)	0.08 [0.05, 0.11]	0.96 [0.94, 0.97]
Clemency 2020	35	111	190	625	Adults (≥ 18y)	0.16 [0.11, 0.21]	0.85 [0.82, 0.87]
Mansella 2020	132	987	440	3256	Adults (≥ 18y)	0.23 [0.20, 0.27]	0.77 [0.75, 0.78]
Brendish 2020	53	56	101	181	Adults (≥ 18y)	0.34 [0.27, 0.42]	0.76 [0.70, 0.82]

**Wheeze**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Peyrony 2020	4	13	221	153	Adults (≥ 18y)	0.02 [0.00, 0.04]	0.92 [0.87, 0.96]
Mansella 2020	42	633	530	3610	Adults (≥ 18y)	0.07 [0.05, 0.10]	0.85 [0.84, 0.86]
Brendish 2020	48	91	102	150	Adults (≥ 18y)	0.32 [0.25, 0.40]	0.62 [0.56, 0.68]

**Dry cough**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Alizadehsani 2021	55	29	68	167	Adults (≥ 18y)	0.45 [0.36, 0.54]	0.85 [0.79, 0.90]
Saegerman 2021	296	639	277	940	Adults (≥ 18y)	0.52 [0.47, 0.56]	0.60 [0.57, 0.62]
Clemency 2020	166	500	59	236	Adults (≥ 18y)	0.74 [0.68, 0.79]	0.32 [0.29, 0.36]

**Haemoptysis**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Peyrony 2020	3	1	222	165	Adults (≥ 18y)	0.01 [0.00, 0.04]	0.99 [0.97, 1.00]
Mansella 2020	4	49	568	4194	Adults (≥ 18y)	0.01 [0.00, 0.02]	0.99 [0.98, 0.99]

**Pulmonary auscultation: crackling bilateral**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Peyrony 2020	80	15	145	151	Adults (≥ 18y)	0.36 [0.29, 0.42]	0.91 [0.86, 0.95]
Bouzid 2020	53	39	215	289	Adults (≥ 18y)	0.20 [0.15, 0.25]	0.88 [0.84, 0.91]

**Hypoxia**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Rutten 2020b	453	820	570	931	Older persons (≥ 65y)	0.44 [0.41, 0.47]	0.53 [0.51, 0.56]

**Respiratory distress**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Porto 2021	94	252	316	605	Adults (≥ 18y)	0.23 [0.19, 0.27]	0.71 [0.67, 0.74]

**Tachypnoea**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Olivar Lopez 2020	23	115	53	319	Children (< 18y)	0.30 [0.20, 0.42]	0.74 [0.69, 0.78]

**Pulmonary auscultation: crackling unilateral**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Peyrony 2020	21	12	204	154	Adults (≥ 18y)	0.09 [0.06, 0.14]	0.93 [0.88, 0.96]

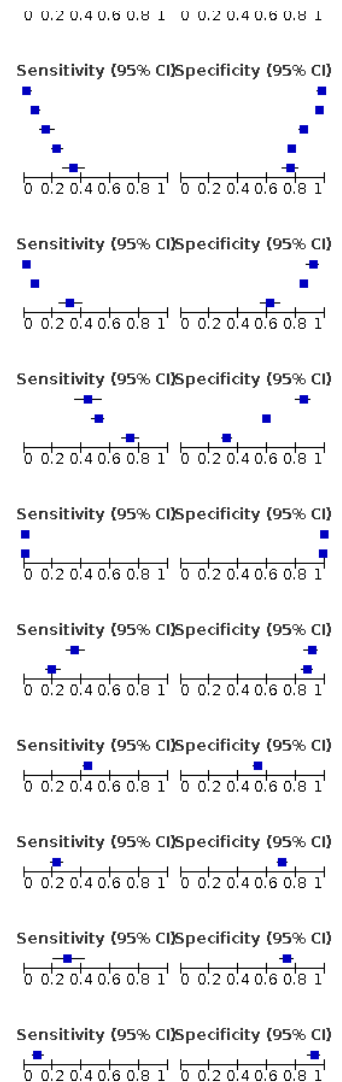
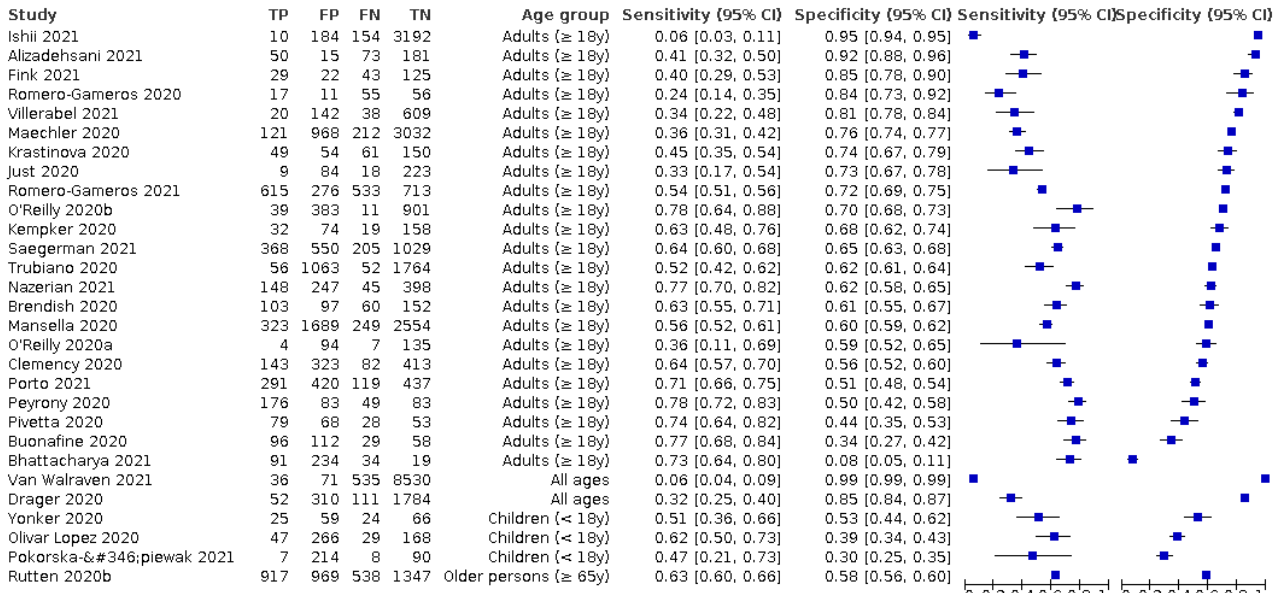
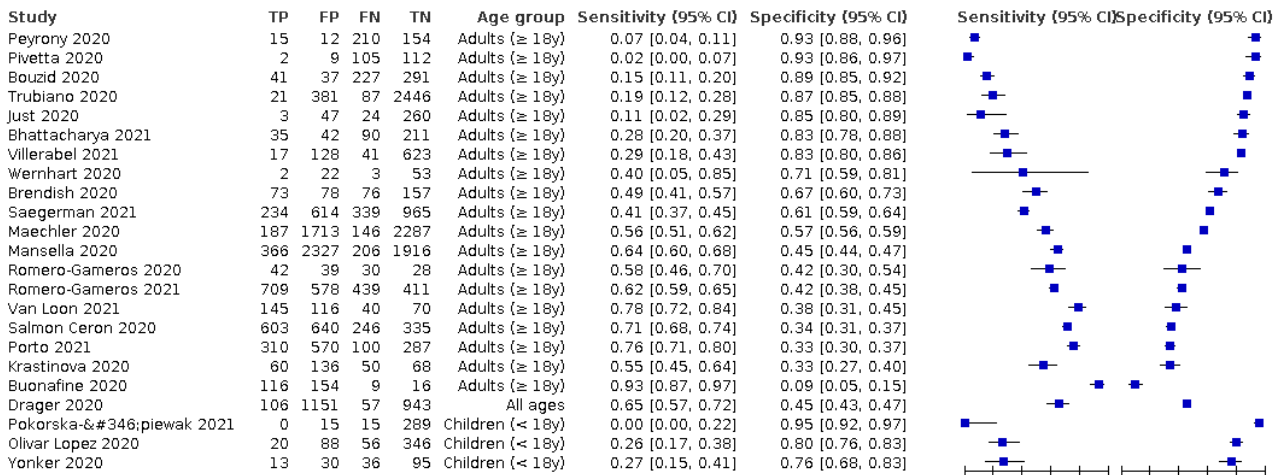


Figure 6. Forest plot of systemic signs and symptoms

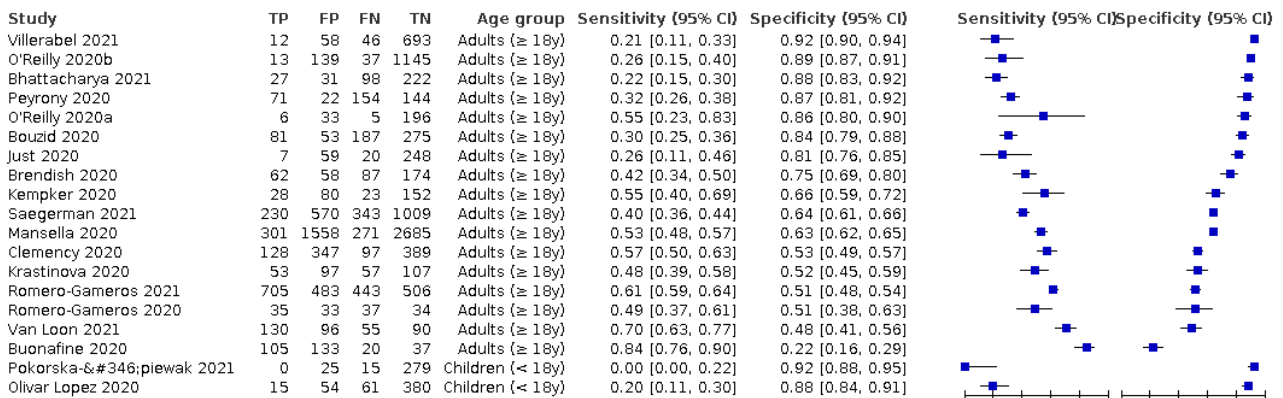
Fever



Headache



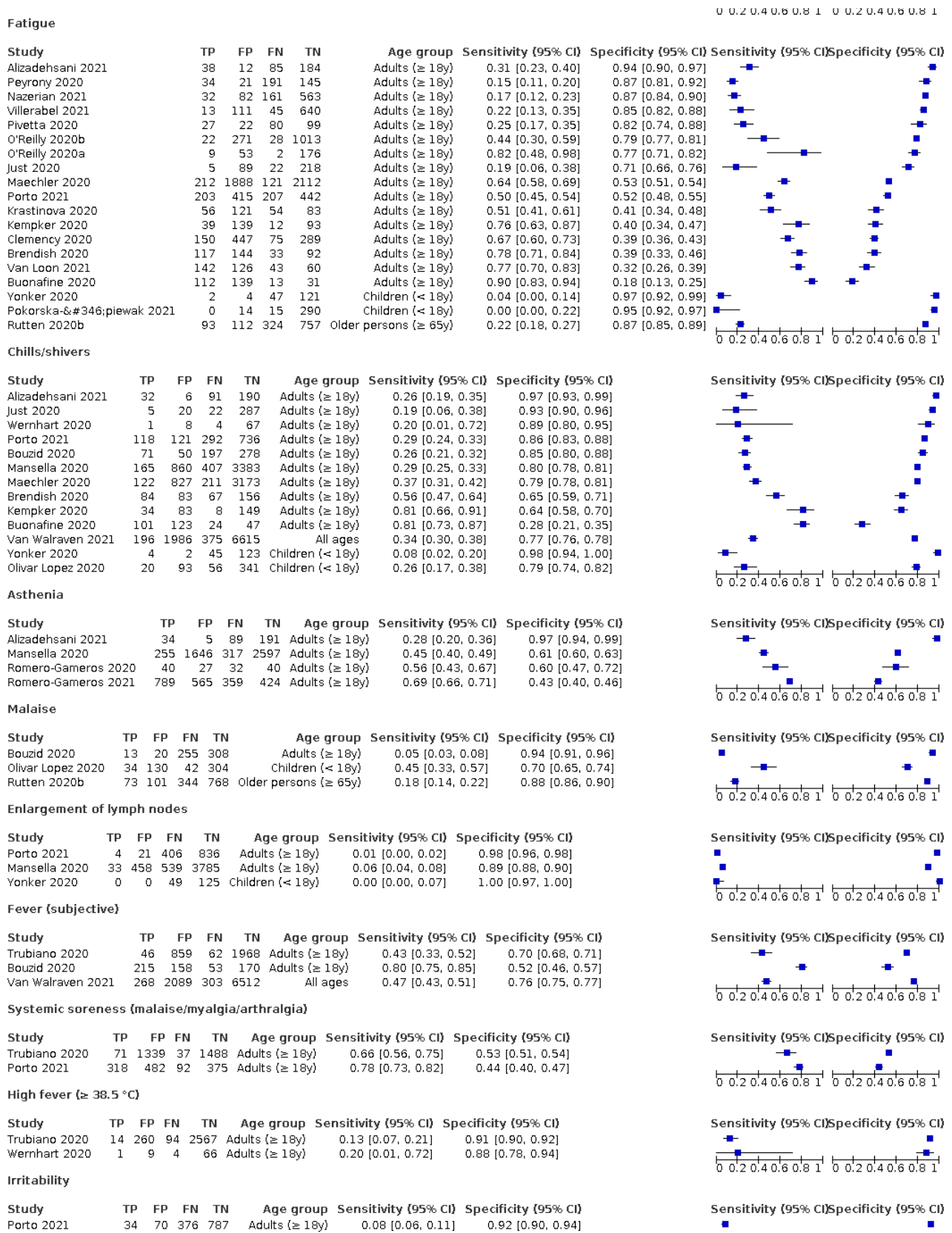
Myalgia



Fatigue



Figure 6. (Continued)



**Figure 6. (Continued)**

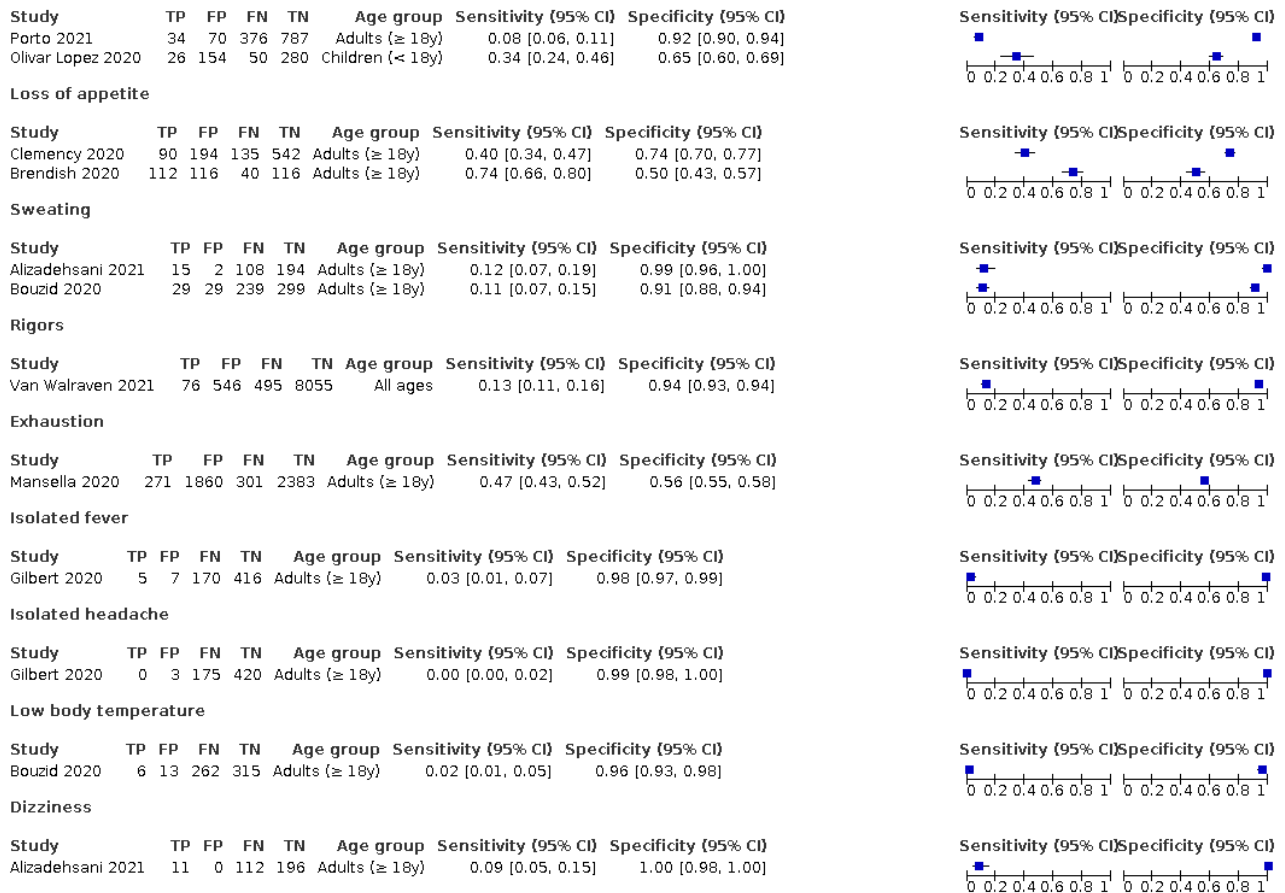
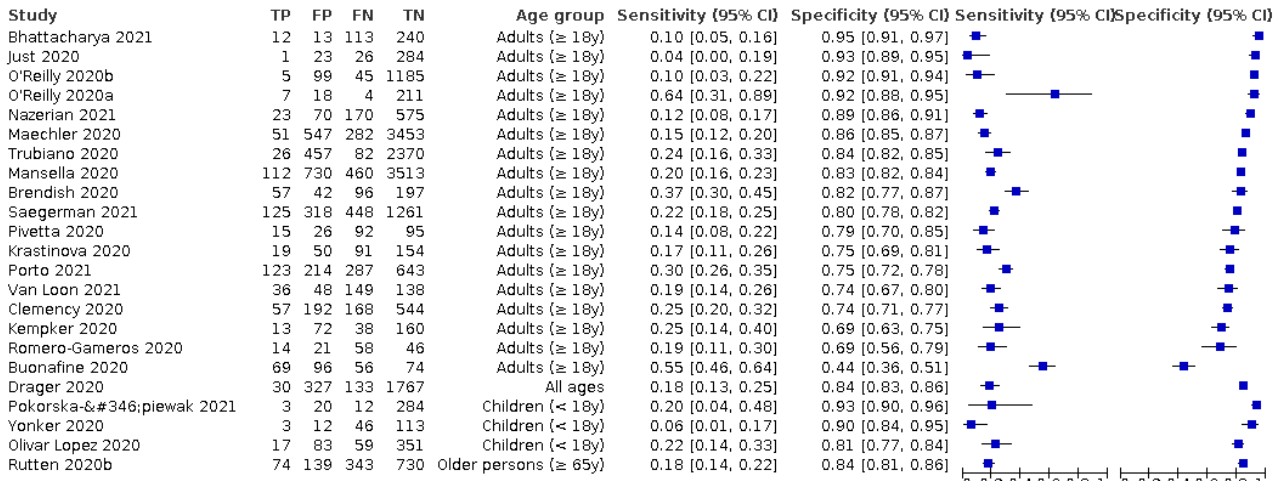


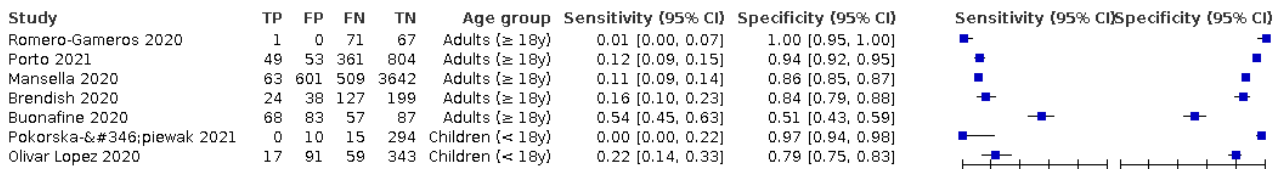


Figure 7. Forest plot of gastrointestinal symptoms

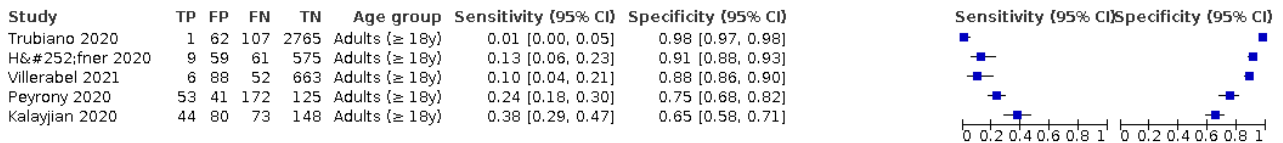
Diarrhoea



Abdominal pain



Gastrointestinal symptoms (not specified)



Vomiting

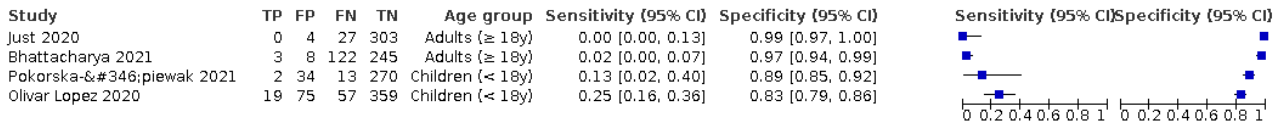
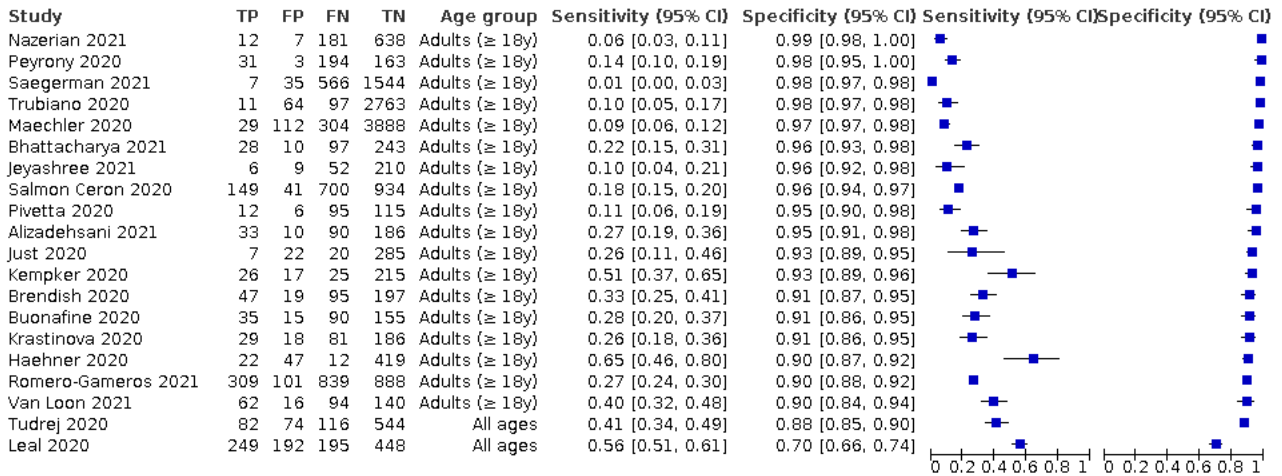


Figure 8. Forest plot of cardiovascular symptoms (palpitations)

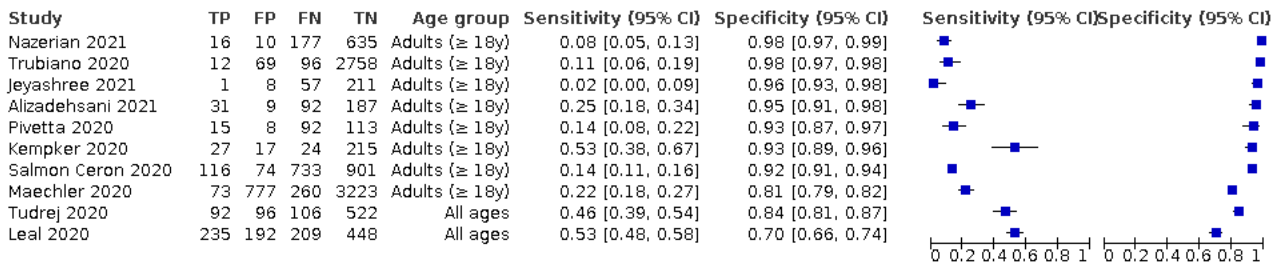


Figure 9. Forest plot of olfactory symptoms

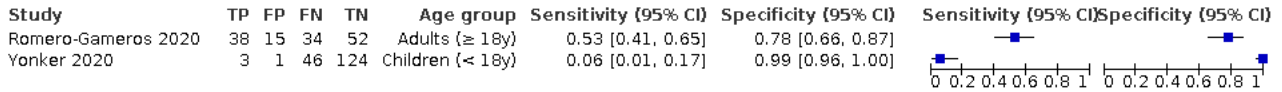
Anosmia



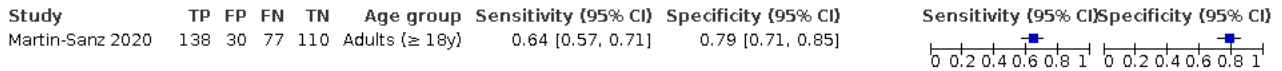
Ageusia



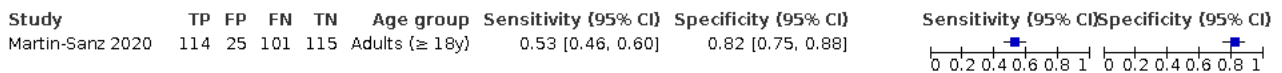
Dysgeusia



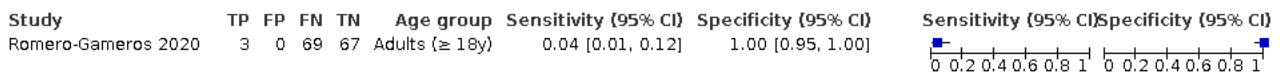
Hyposmia



Hypogeusia

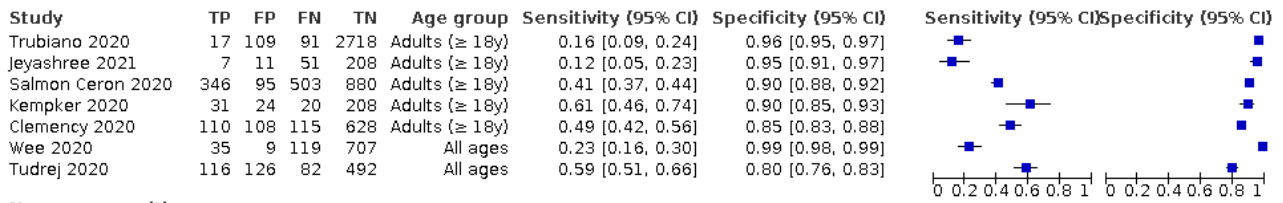


Dysosmia

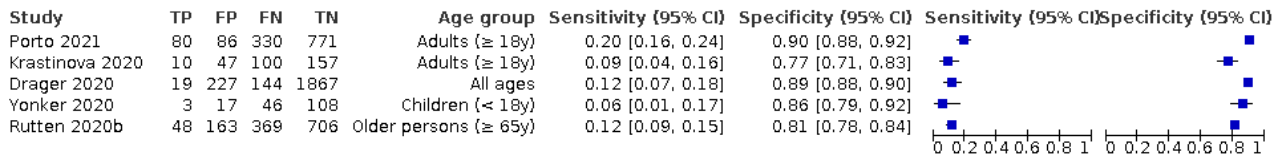


**Figure 10. Forest plot of multivariable combinations of signs and symptoms**

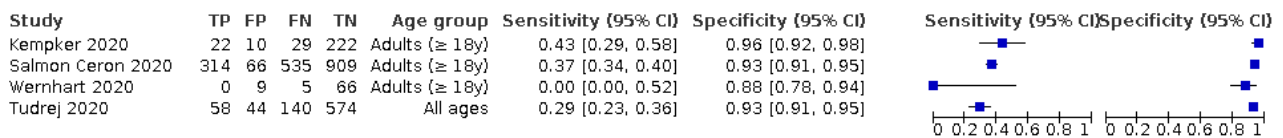
**Anosmia or ageusia**



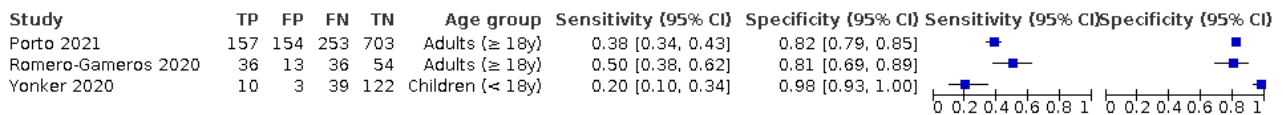
**Nausea or vomiting**



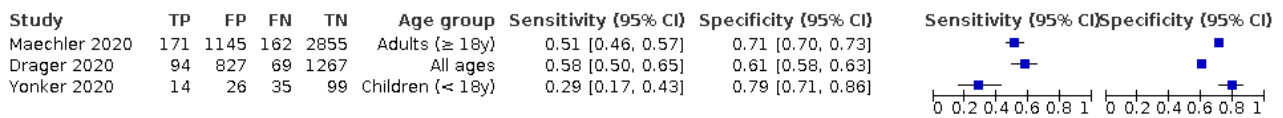
**Anosmia and ageusia**



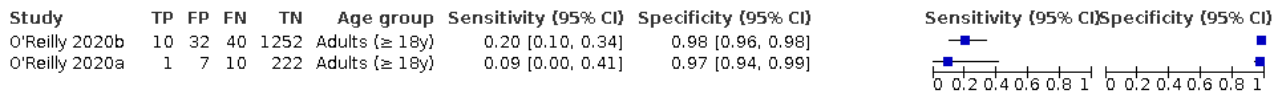
**Anosmia or hyposmia**



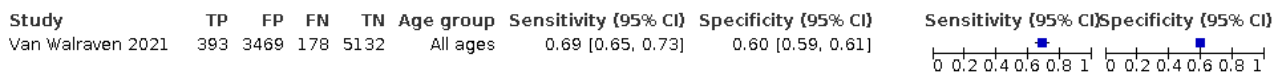
**Myalgia or arthralgia**



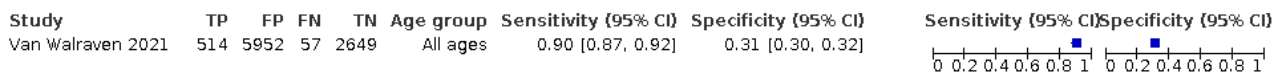
**Anosmia or dysgeusia**



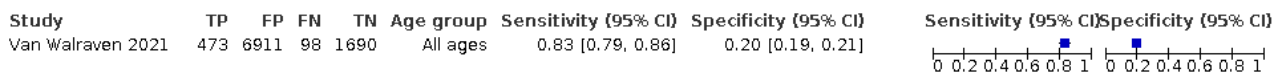
**SCRIPS score, recent case detection rate**



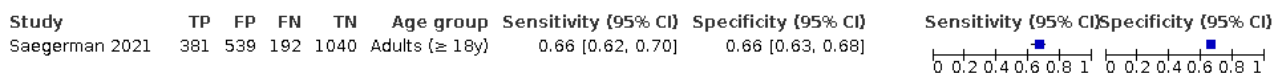
**SCRIPS score, 0.5\*recent case detection rate**



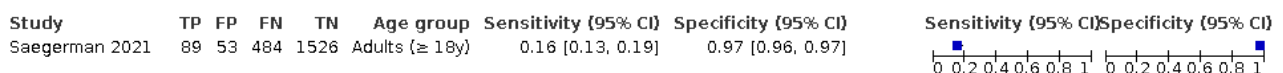
**Cough or dyspnoea**



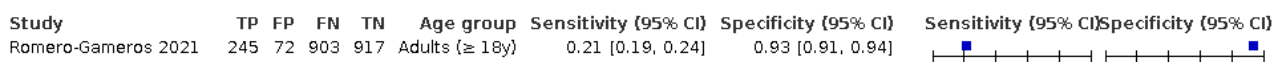
**Multivariable score cut-off = 5**



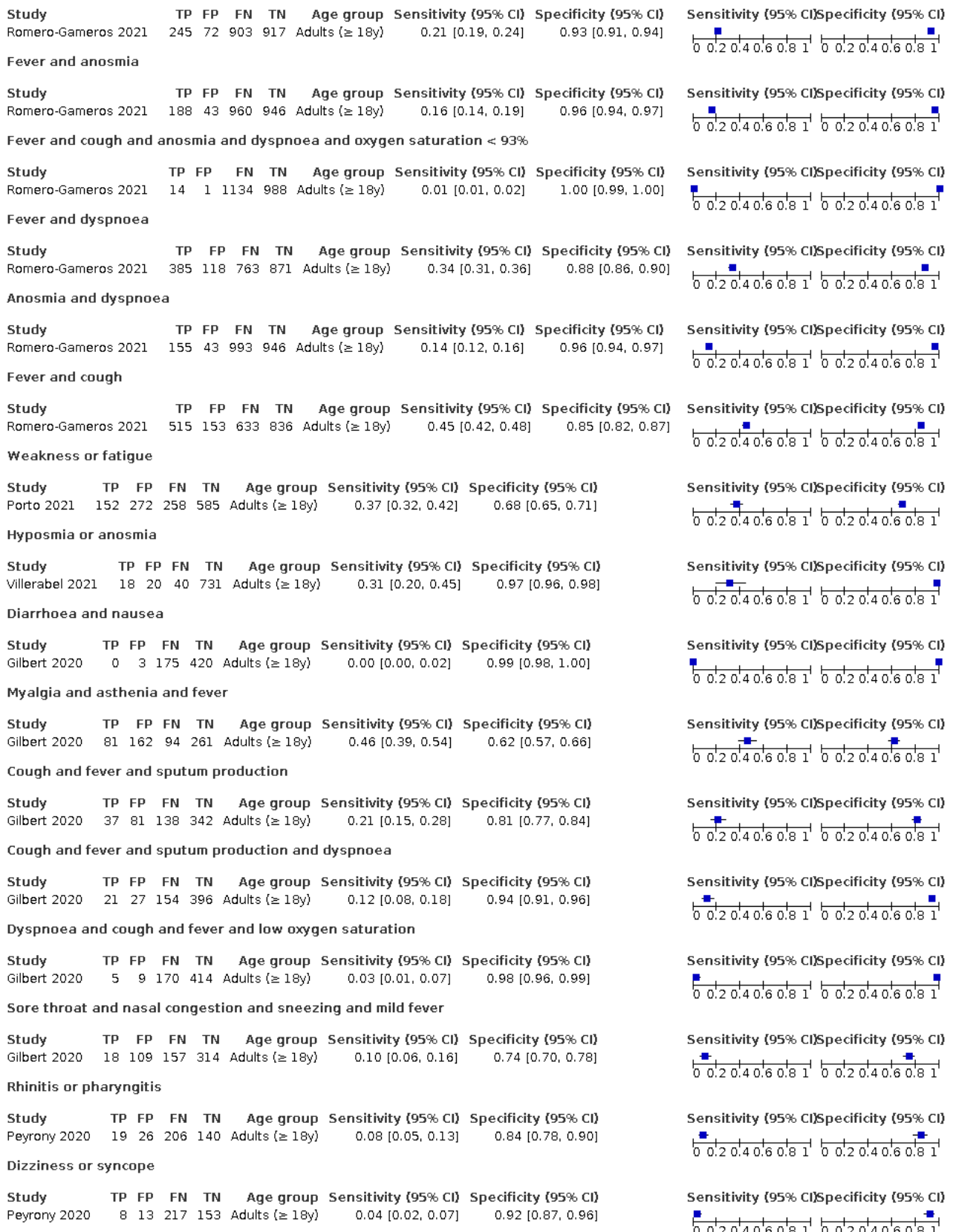
**Multivariable score cut-off = 8**



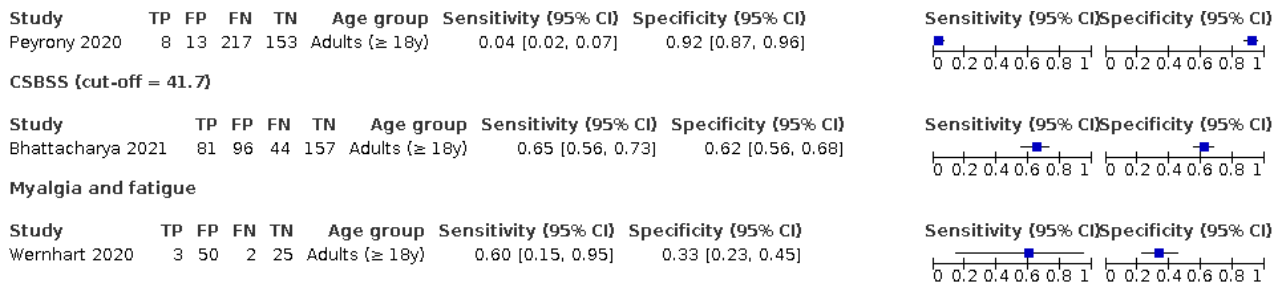
**Cough and anosmia**



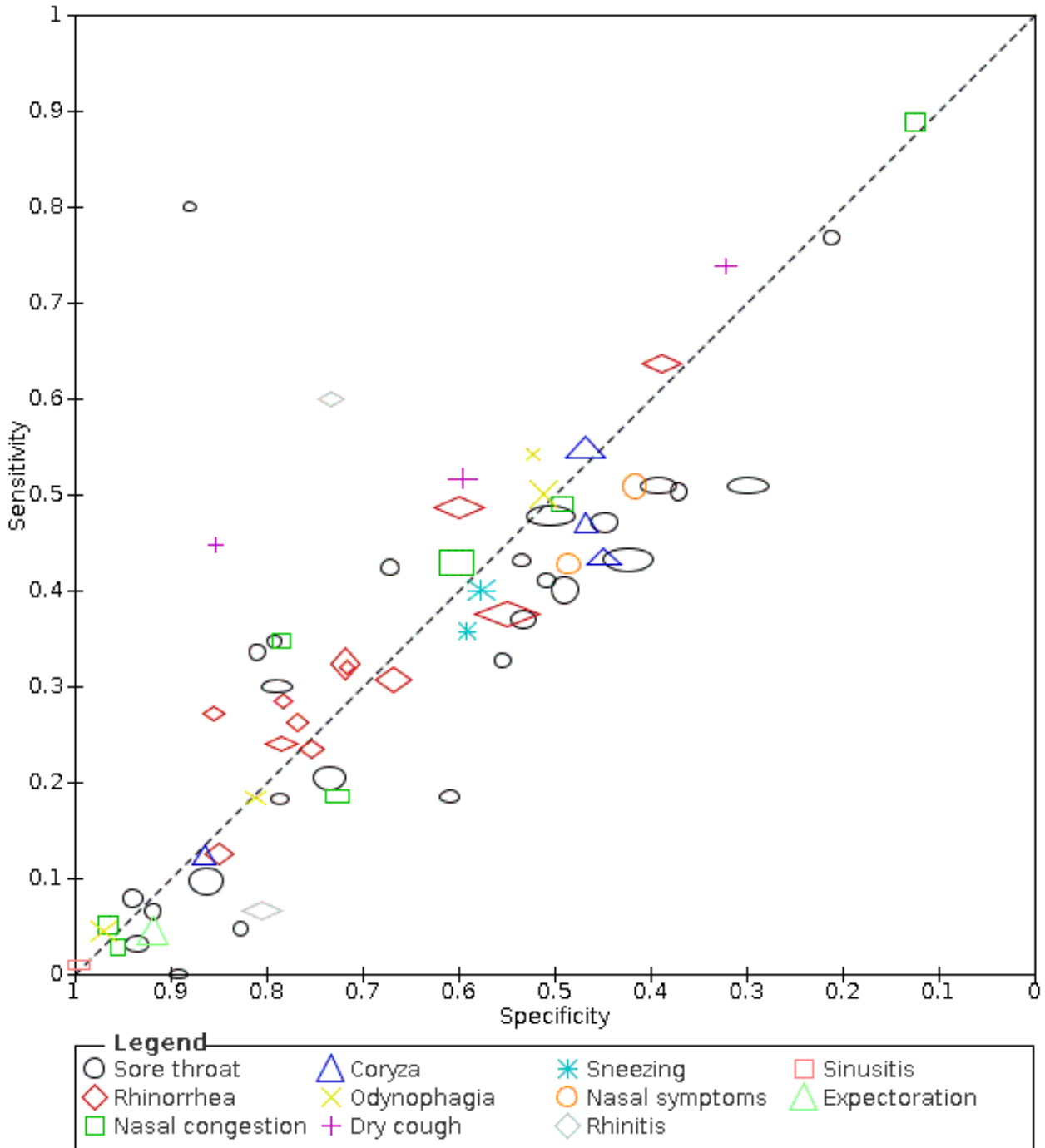
**Figure 10. (Continued)**



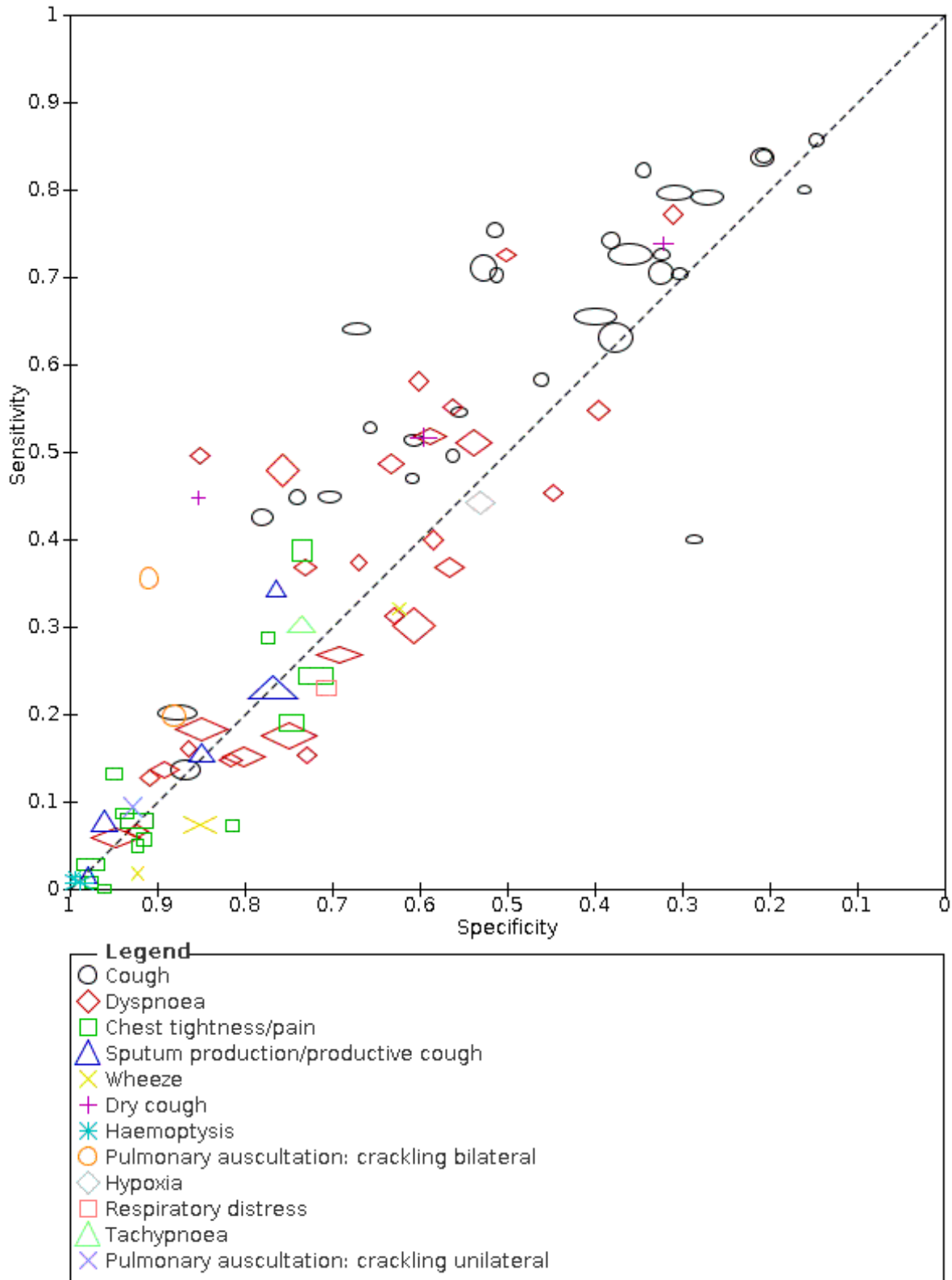
**Figure 10. (Continued)**



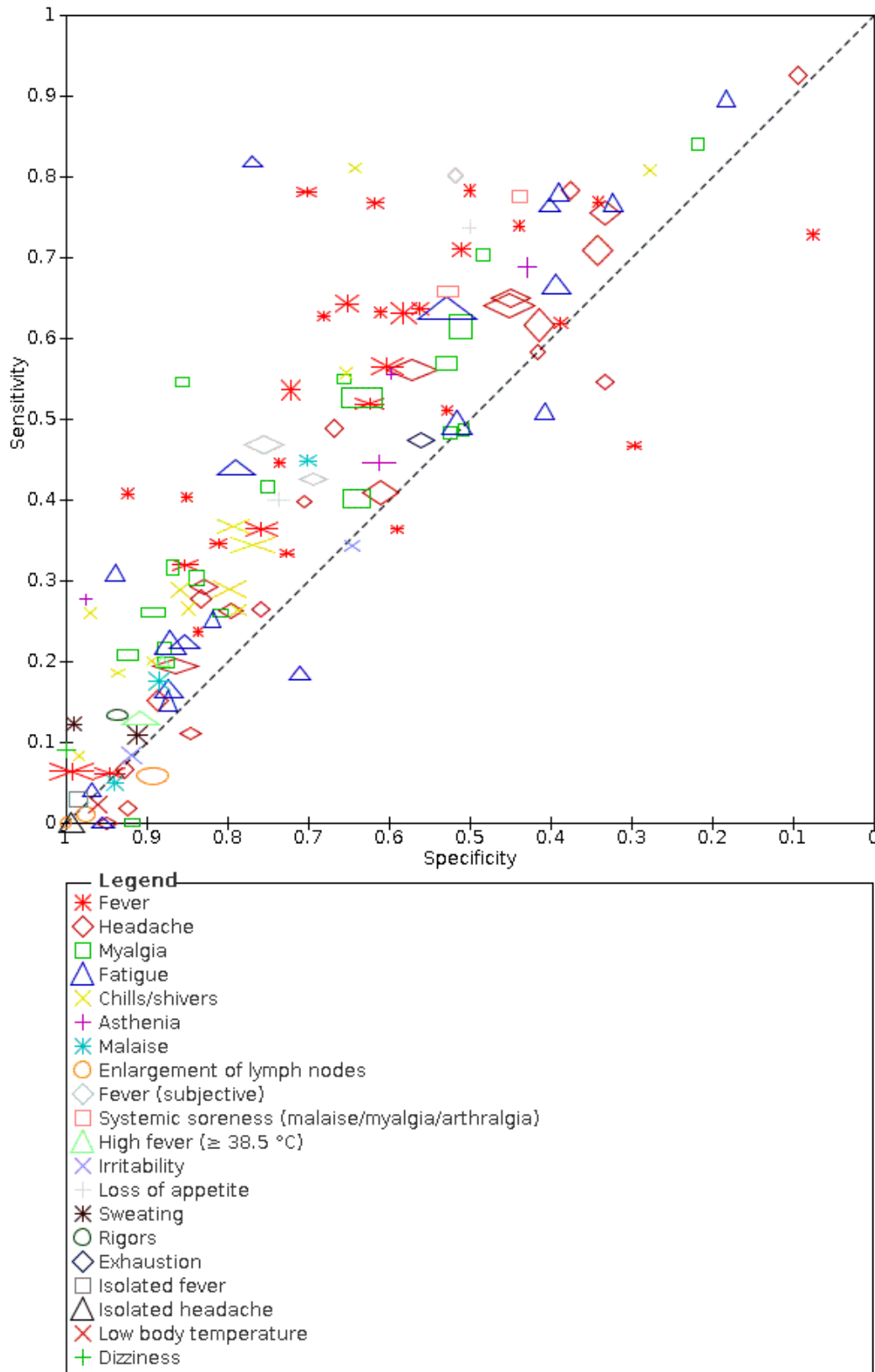
**Figure 11. Summary ROC plot of upper respiratory tract symptoms. The study points (symbols) were scaled according to the sample size**



**Figure 12. Summary ROC plot of lower respiratory tract symptoms. The study points (symbols) were scaled according to the sample size**



**Figure 13. Summary ROC plot of systemic signs and symptoms. The study points (symbols) were scaled according to the sample size**

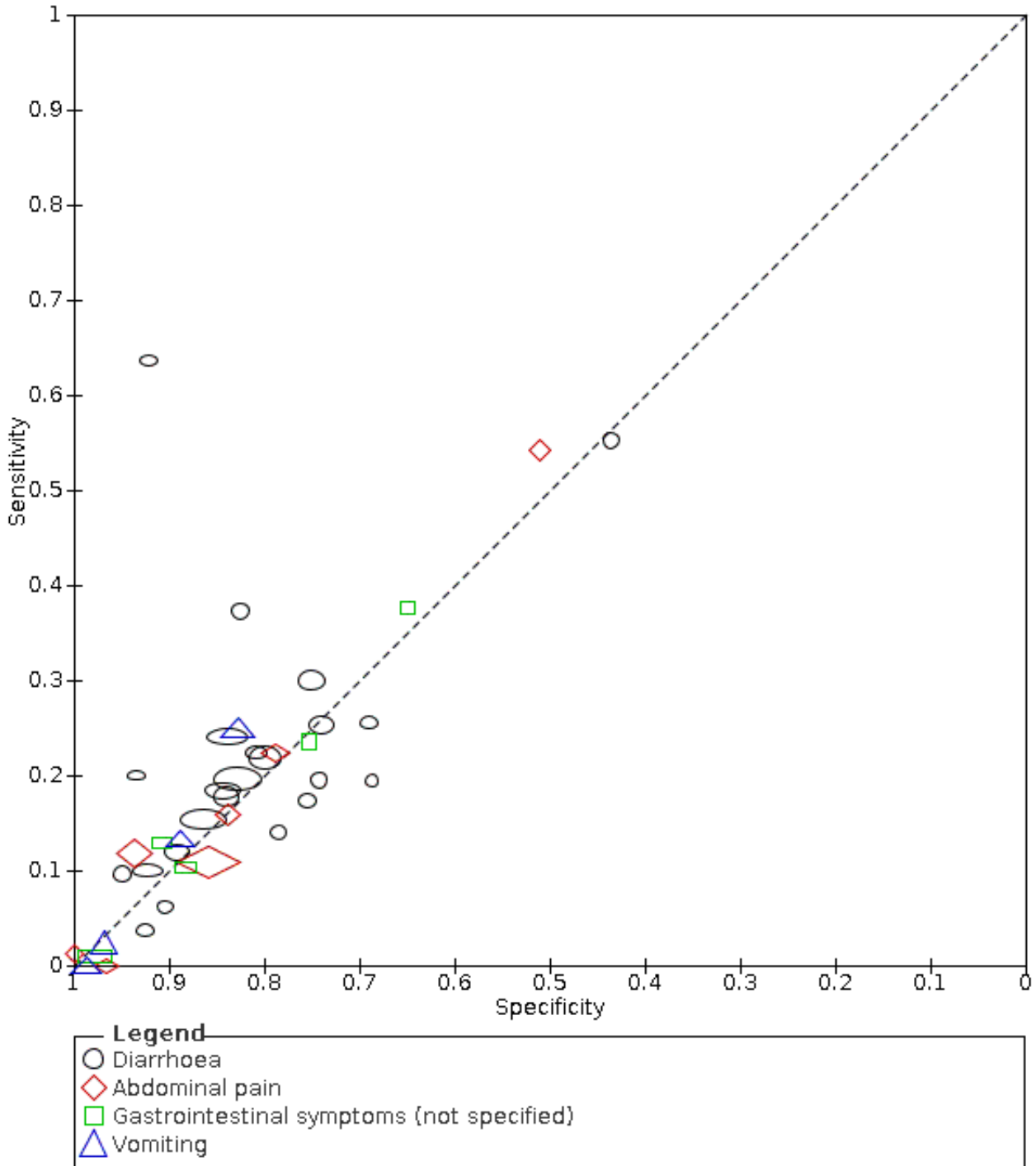




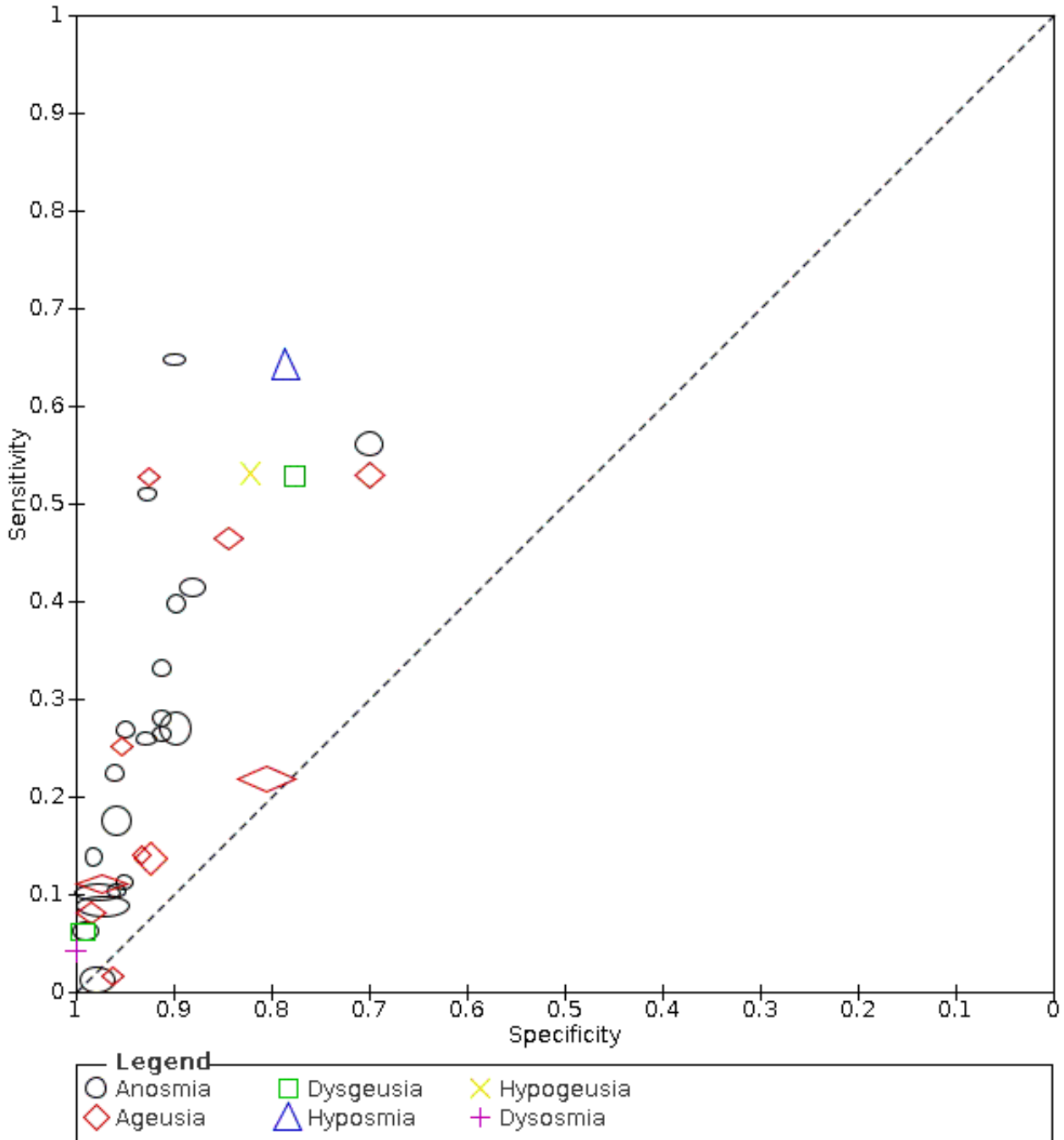
**Figure 13. (Continued)**



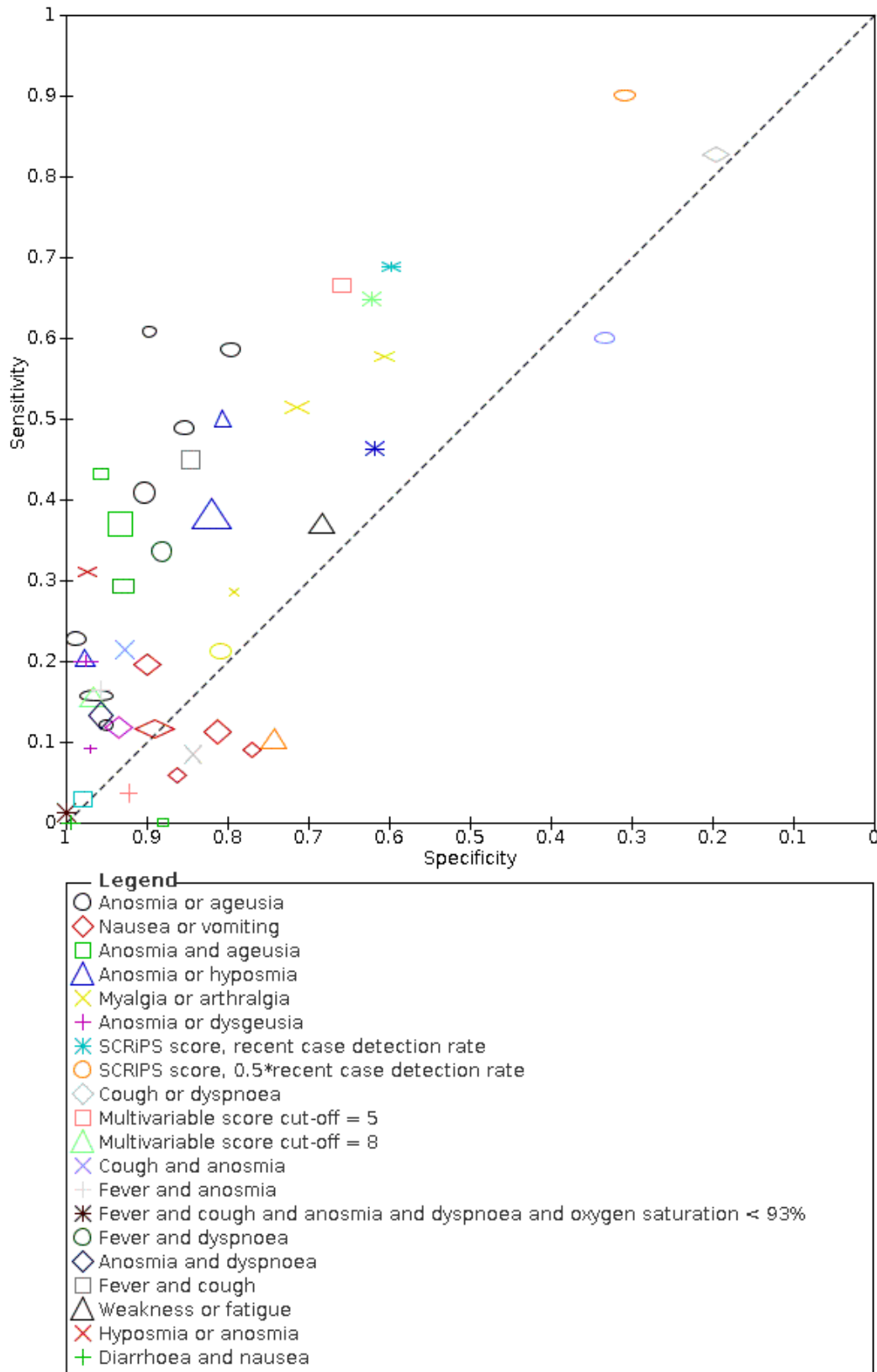
**Figure 14. Summary ROC plot of gastrointestinal symptoms. The study points (symbols) were scaled according to the sample size**



**Figure 15. Summary ROC plot of olfactory symptoms. The study points (symbols) were scaled according to the sample size**



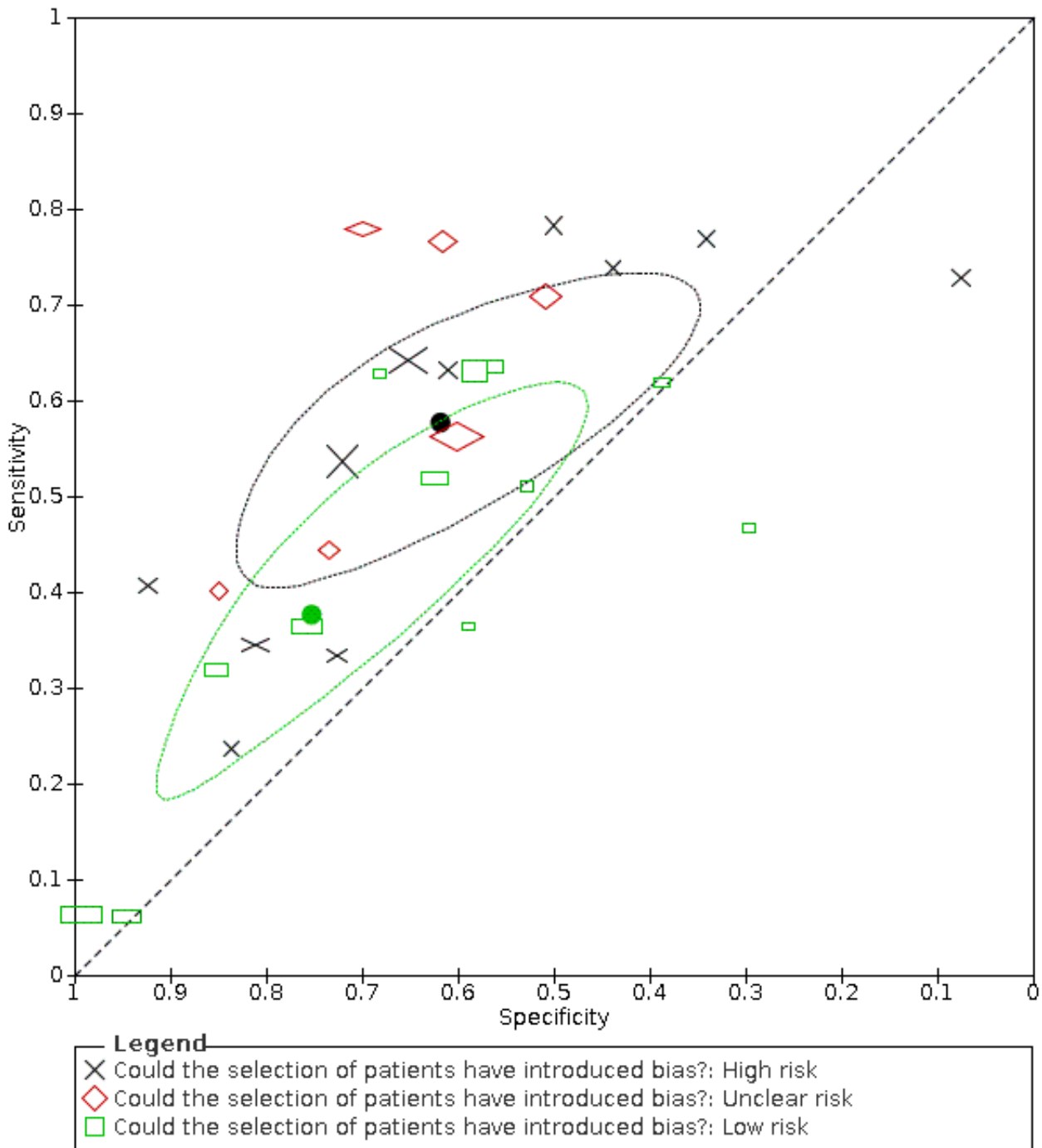
**Figure 16. Summary ROC plot of multivariable combinations of signs and symptoms. The study points (symbols) were scaled according to the sample size**



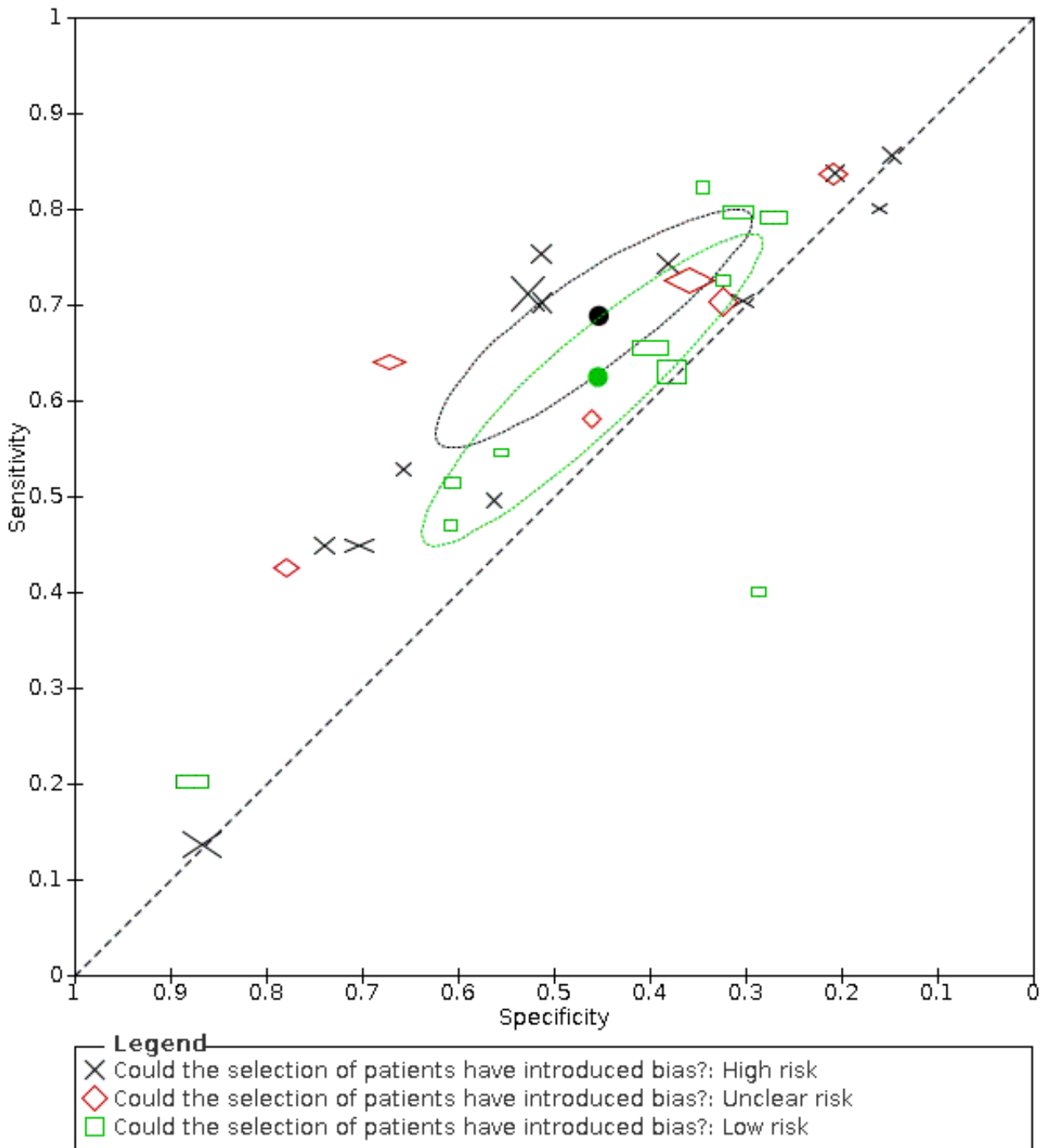
**Figure 16. (Continued)**

- ✕ Hyposmia or anosmia
- + Diarrhoea and nausea
- \* Myalgia and asthenia and fever
- Cough and fever and sputum production
- ◇ Cough and fever and sputum production and dyspnoea
- Dyspnoea and cough and fever and low oxygen saturation
- △ Sore throat and nasal congestion and sneezing and mild fever
- × Rhinitis or pharyngitis
- + Dizziness or syncope
- \* CSBSS (cut-off = 41.7)
- Myalgia and fatigue

**Figure 17. Summary ROC plot of fever by risk of bias concerning participant selection. Summary points and their 95% confidence regions are shown for high and low risk of bias only. The study points (symbols) were scaled according to the sample size**

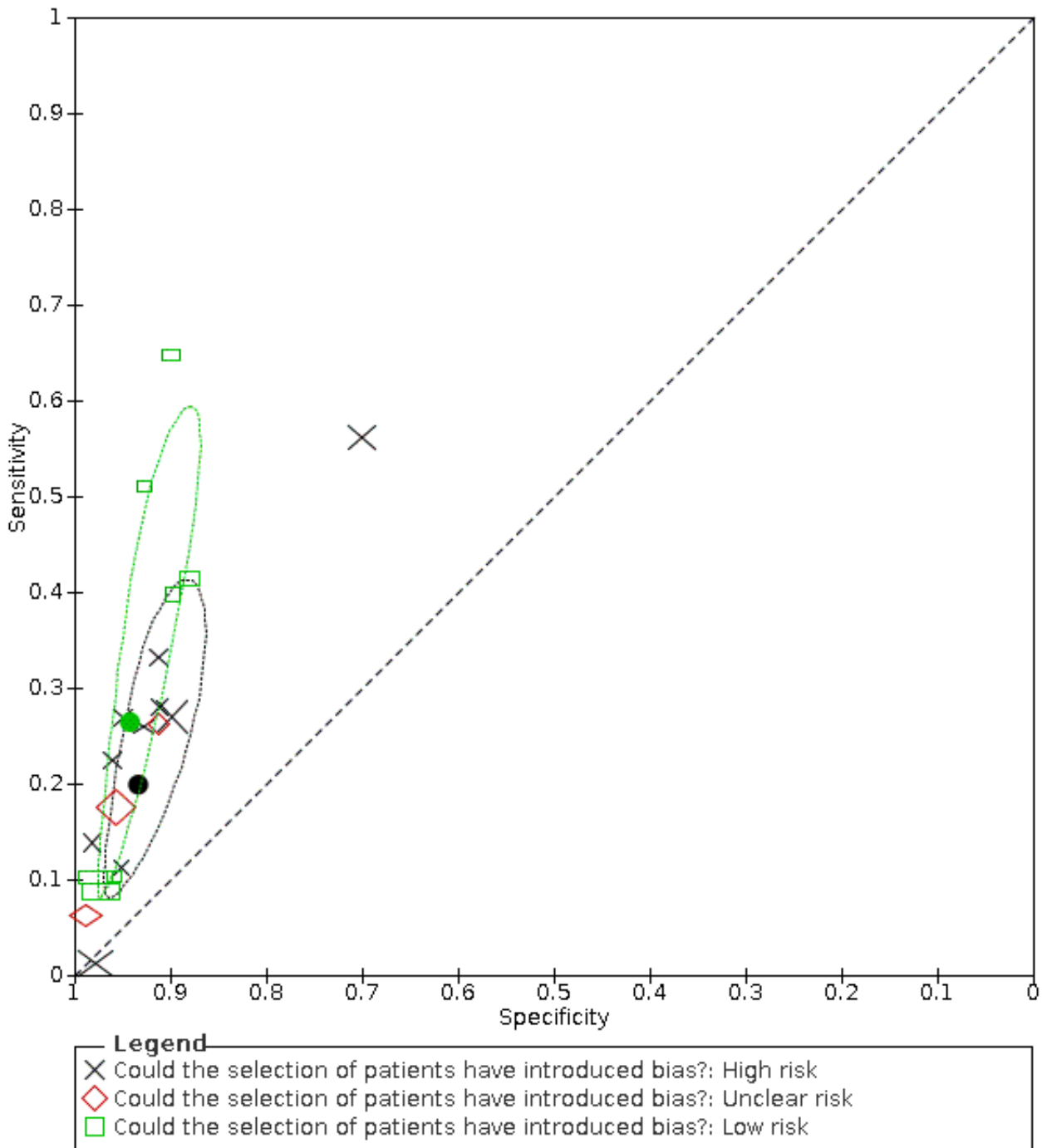


**Figure 18. Summary ROC plot of cough by risk of bias concerning participant selection. Summary points and their 95% confidence regions are shown for high and low risk of bias only. The study points (symbols) were scaled according to the sample size**





**Figure 19. Summary ROC plot of anosmia by risk of bias concerning participant selection. Summary points and their 95% confidence regions are shown for high and low risk of bias only. The study points (symbols) were scaled according to the sample size**



**Summary results**

We conducted meta-analyses for 13 symptoms at presentation (fever, dyspnoea, cough, diarrhoea, sore throat, fatigue, rhinorrhoea, headache, anosmia, anosmia or ageusia, ageusia, myalgia, chills/shivers). The ranges and summary estimates of the sensitivity and specificity of the 13 index tests are listed below,

ordered by decreasing number of studies included. Summary estimates of test accuracy are listed in additional [Table 3](#). They are based on bivariate meta-analyses of prospective studies with low risk of bias for participant selection.

- Fever, 12 studies, 28,495 participants: sensitivity range 6% to 64% (summary 37.6%, 95% CI 23.4% to 54.3%); specificity range 30% to 99% (summary 75.2%, 95% CI 56.3% to 87.8%)
- Dyspnoea, 12 studies, 19,545 participants: sensitivity range 6% to 73% (summary 23.3%, 95% CI 16.4% to 31.9%); specificity range 50% to 95% (summary 75.7%, 95% CI 65.2% to 83.9%)
- Cough, 11 studies, 18,702 participants: sensitivity range 20% to 82% (summary 62.4%, 95% CI 50.6% to 72.9%); specificity range 27% to 88% (summary 45.4%, 95% CI 33.5% to 57.9%)
- Diarrhoea, 11 studies, 13,669 participants: sensitivity range 6% to 64% (summary 18.5%, 95% CI 15.7% to 21.6%); specificity range 69% to 93% (summary 84.1%, 95% CI 79.4% to 87.9%)
- Sore throat, 10 studies, 14,548 participants: sensitivity range 0% to 51% (summary 31.0%, 95% CI 20.2% to 44.5%); specificity range 30% to 89% (summary 61.9%, 95% CI 46.7% to 75.0%)
- Fatigue, eight studies, 7967 participants: sensitivity range 0% to 82% (summary 40.2%, 95% CI 19.4% to 65.1%); specificity range 32% to 97% (summary 73.6%, 95% CI 48.4% to 89.3%)
- Rhinorrhoea, seven studies, 17,972 participants: sensitivity range 12% to 64% (summary 30.3%, 95% CI 18.7% to 45.1%); specificity range 39% to 86% (summary 70.0%, 95% CI 56.8% to 80.6%)
- Headache, seven studies, 10,899 participants: sensitivity range 0% to 78% (summary 35.8%, 95% CI 17.2% to 60.0%); specificity range 38% to 95% (summary 73.0%, 95% CI 53.4% to 86.4%)
- Anosmia, seven studies, 9456 participants: sensitivity range 9% to 65% (summary 26.4%, 95% CI 13.8% to 44.6%); specificity range 88% to 98% (summary 94.2%, 95% CI 90.6% to 96.5%)
- Anosmia or ageusia, six studies, 6142 participants: sensitivity range 12% to 61% (summary 39.2%, 95% CI 26.5% to 53.6%); specificity range 80% to 99% (summary 92.1%, 95% CI 84.5% to 96.2%)
- Myalgia, six studies, 2684 participants: sensitivity range 0% to 70% (summary 37.5%, 95% CI 20.6% to 58.1%); specificity range 48% to 92% (summary 75.4%, 95% CI 58.4% to 87.0%)
- Chills/shivers, five studies, 14,472 participants: sensitivity range 8% to 81% (summary 25.3%, 95% CI 15.1% to 39.3%); specificity range 64% to 98% (summary 85.0%, 95% CI 72.1% to 92.6%)
- Ageusia, five studies, 8644 participants: sensitivity range 2% to 53% (summary 23.2%, 95% CI 10.6% to 43.3%); specificity range 81% to 98% (summary 92.6%, 95% CI 83.1% to 97.0%)

Cough was the only index test with a summary sensitivity above 50%. Its summary specificity was 45.4% (Table 3). Summary specificity was above 90% for anosmia, ageusia and for the presence of anosmia or ageusia (Table 3). However, their summary sensitivity was low (maximum 39.2% for anosmia or ageusia).

The summary positive likelihood ratios (LRs+) of anosmia as a single test or in combination with ageusia ('anosmia or ageusia') was just below our predefined cut-off of 5 for a useful red flag (4.55, 95% CI 3.46 to 5.97) and 4.99, 95% CI 3.22 to 7.75) respectively). The summary negative likelihood ratios (LRs-) were too high to make any of the reported tests useful for ruling out COVID-19. In other words, the absence of the above-mentioned symptoms or signs does not necessarily imply the absence of COVID-19.

### Combinations of signs and symptoms

Twenty-four studies assessed combinations of different signs and symptoms (Figure 10; Figure 16). In total, 29 different combinations

were assessed, of which only six were assessed by more than one study.

Three multivariable prediction scores were reported (Bhattacharya 2021; Saegerman 2021; Van Walraven 2021). Bhattacharya 2021 (378 participants) used a combination of only signs and symptoms (Clinical Symptom-Based Scoring System (CSBSS) based on body temperature, cough, headache, myalgia and anosmia), leading to a sensitivity of 64.8% (95% CI 55.8% to 73.1%) and a specificity of 62.1% (95% CI 55.8% to 68.1%) at the proposed cut-off of 41.7 points. Reducing the cut-off to 10 points led to a sensitivity of 75.0% and a specificity of 42.6%. The Area Under the ROC Curve (AUC) was 0.69 (95% CI 0.62 to 0.76) for the validation dataset.

The other two multivariable prediction score studies combined signs and symptoms with other information: Saegerman 2021 (2152 participants) combined age (> 56.5 years) with the presence of chest pain, sore throat, dry cough or fever, leading to a sensitivity of 66.5% (95% CI 62.5% to 70.4%) and a specificity of 65.9% (95% CI 63.5% to 68.2%) at the lowest cut-off. The AUC of this score was 0.71 (95% CI 0.69 to 0.73). Van Walraven 2021 (9172 participants) developed a score, based on a combination of gender, being a healthcare worker, recent contact with a COVID-19 case, recent travel, the recent local case detection rate, the presence of rhinorrhoea, cough or dyspnoea, and a combination of age and the presence of fever (SARS-CoV-2 Risk Prediction Score (SCRiPS)). The recent local case detection rate was calculated as the proportion of tests from the testing clinic in the previous three days that were SARS-CoV-2-positive. The SCRiPS score using 0.5 times the recent local case detection rate demonstrated the highest sensitivity of all combinations (90.0%; 95% CI 87.3% to 92.4%) at the cost of lower specificity (30.8%, 95% CI 29.8% to 31.8%). The second highest sensitivity was reported by the same study (Van Walraven 2021), using only the presence of cough or dyspnoea. This combination led to a sensitivity of 82.8% (95% CI 79.5% to 85.8%) at a specificity of 19.6% (95% CI 18.8% to 20.5%).

In addition to anosmia or ageusia (see pooled results), some other paired combinations of symptoms were investigated (Figure 10; Figure 16). The following combinations showed a sensitivity of more than 50% in at least one study.

- Anosmia or hyposmia (3 studies): sensitivity from 20% to 50% and specificity from 81% to 98%
- Myalgia or arthralgia (3 studies): sensitivity from 29% to 58% and specificity from 61% to 79%
- Cough or dyspnoea (1 study): sensitivity of 83%, specificity of 20%
- Myalgia and fatigue (1 study): sensitivity of 60%, specificity of 33%

### Positivity rates

Positivity rates (presence of the symptom in the study population) of signs and symptoms depend on prevalence of COVID-19 and population characteristics, especially preselection. As a result, positivity rates were highly variable. In studies with prevalence less than 10%, suggesting little preselection had taken place, positivity rates for fever were between 1.2% and 69.3% (24.7% average), for cough between 12.7% and 83.7% (54.9% average), for anosmia between 2.5% and 13.8% (7.1% average), for ageusia (2 studies) between 2.8% and 19.6% (11.2% average), and for anosmia or ageusia (1 study) 4.3%.

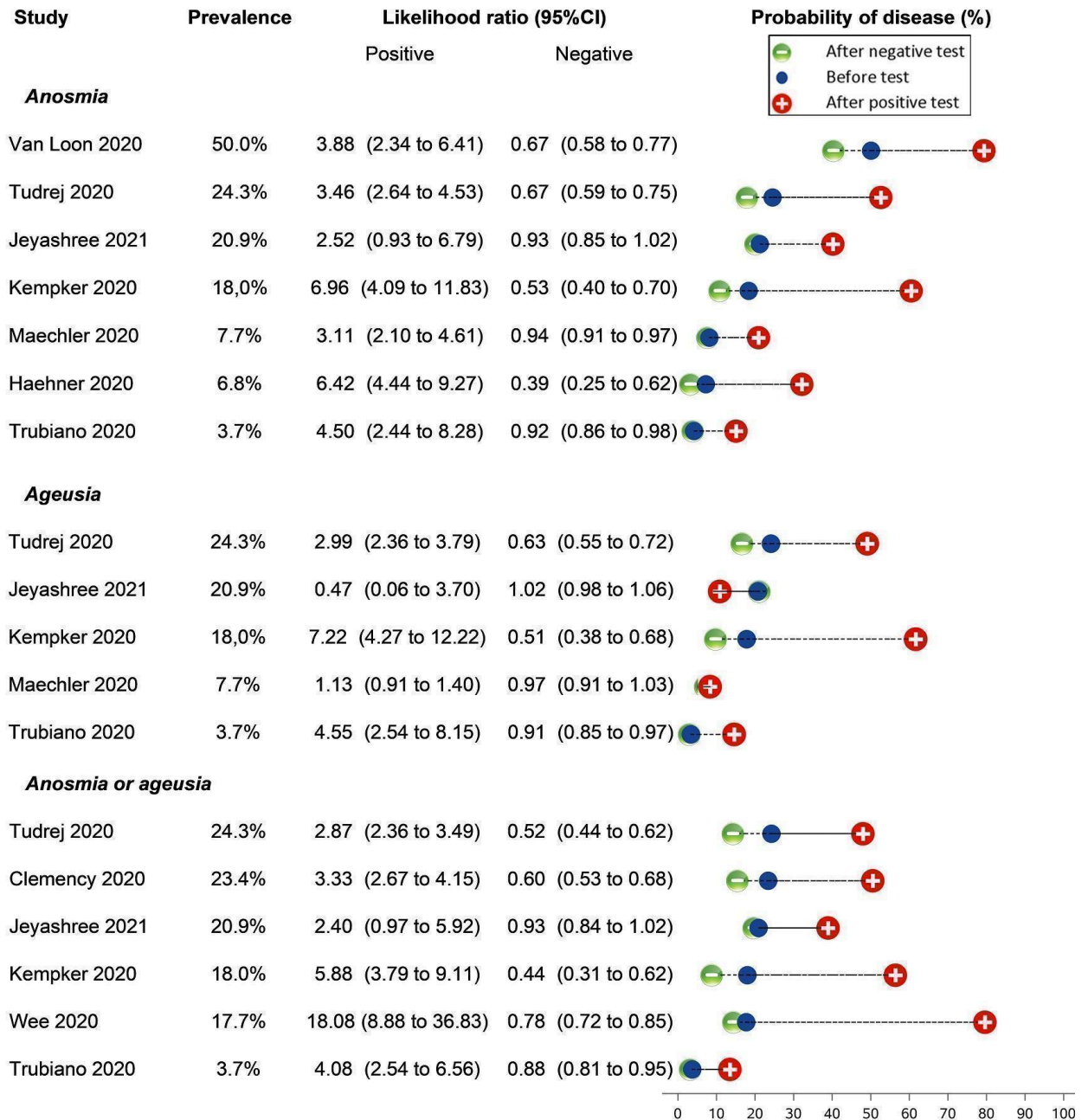
**Stratified analyses**

**Stratification by age group**

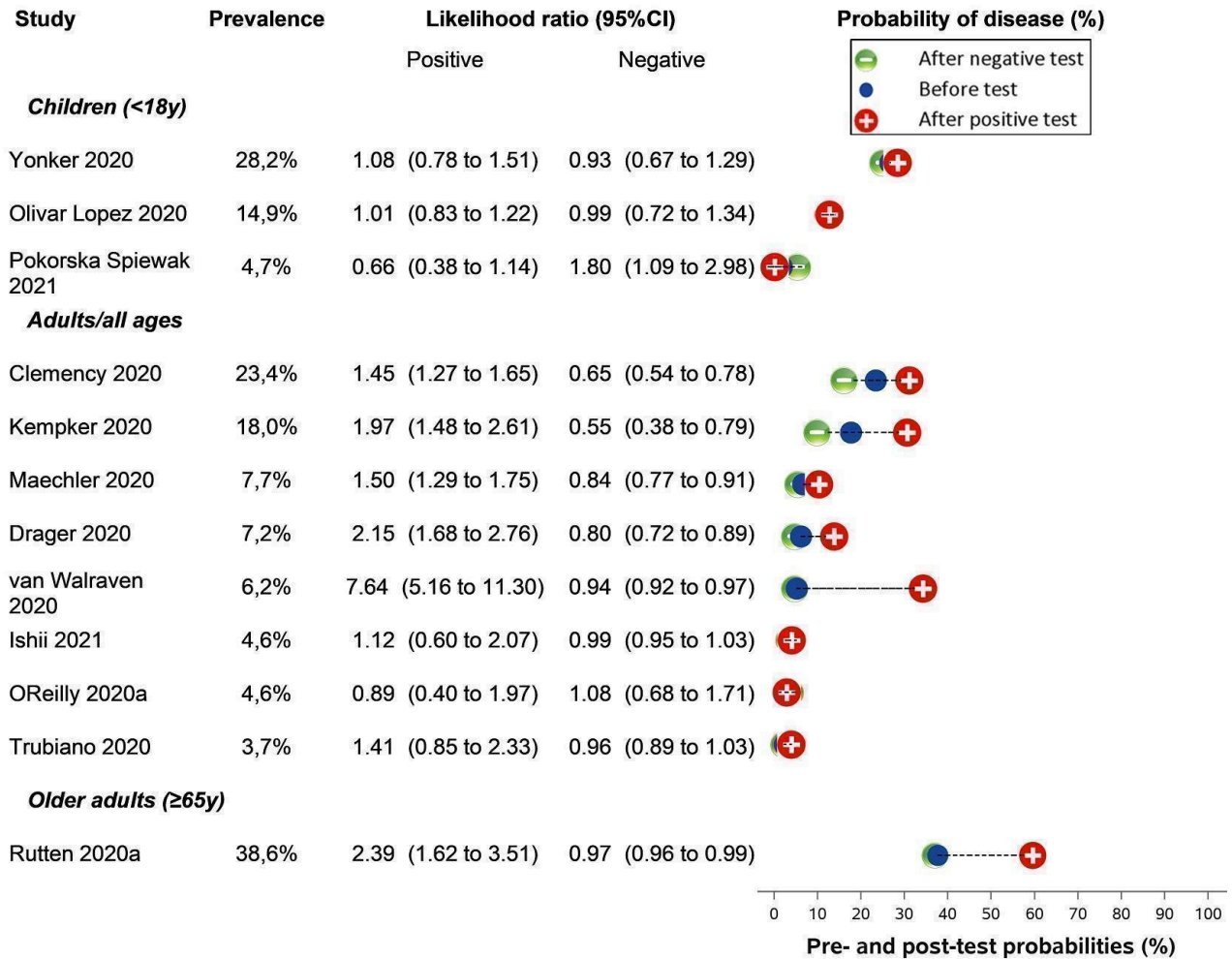
Three prospective studies were performed specifically in children (Olivar Lopez 2020; Pokorska-Śpiewak 2021; Yonker 2020), and two overlapping studies in older people living in a nursing home (Rutten 2020a; Rutten 2020b). All other studies were either performed in

adults or in individuals of all ages. Meta-analysis of data in children or older adults was impossible due to the limited number of studies in these age groups. We therefore limited ourselves to descriptive analyses. All forest plots (Figure 4; Figure 5; Figure 6; Figure 7; Figure 8; Figure 9; Figure 10) and Dumbbell plots (Figure 20; Figure 21; Figure 22) are ordered by age group (adults, all ages, children, older adults (≥ 65 years)).

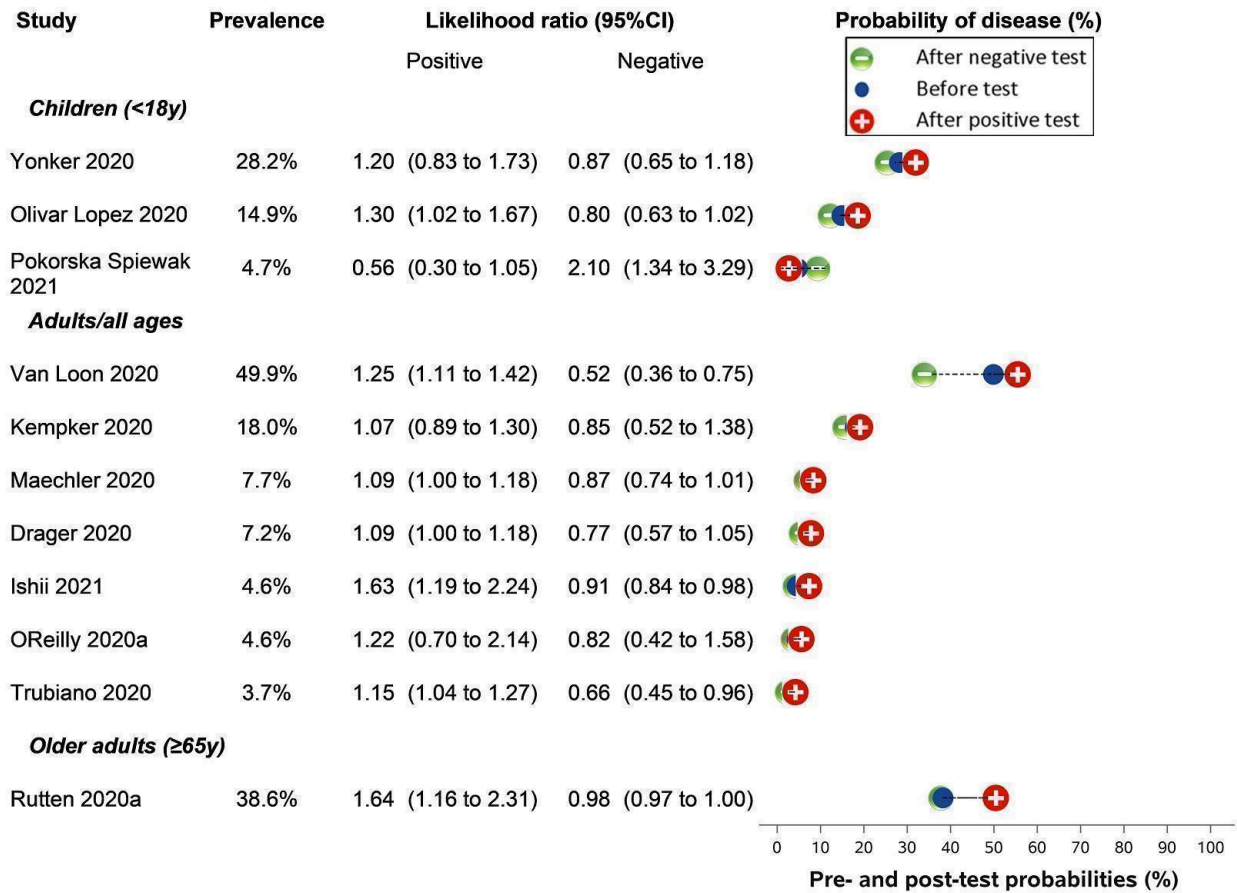
**Figure 20. Dumbbell plot: olfactory symptoms**



**Figure 21. Dumbbell: plot fever. Ordered by age group - children (< 18 years), adults/all ages, older adults (≥ 65 years)**



**Figure 22. Dumbbell plot: cough. Ordered by age group - children (< 18 years), adults/all ages, older adults (≥ 65 years)**



In children, compared to the adult population, the differences in diagnostic accuracy depended strongly on the type of symptom. For example, the sensitivity of fever in children ranged from 47% to 62%, which is higher than the overall summary result for all ages (29%). The specificity of fever in children ranged from 30% to 53%, which is lower than the overall summary result (82.2%). In contrast, we observed lower sensitivity and higher specificity for fatigue, headache and myalgia in children than in the population as a whole.

The results for sore throat, rhinorrhoea, cough, dyspnoea and diarrhoea were comparable with the overall population. Olfactory symptoms were rarely investigated in children. One study (Yonker 2020), investigated the diagnostic value of dysgeusia, observing similar accuracy to in the adult population.

In older adults living in a nursing home, most symptoms showed sensitivities and specificities that were comparable to the overall summary results (Rutten 2020b). The sensitivity of fever appeared to be higher in older people, but this may be due to a strong preselection based on the presence of fever.

**Stratification according to risk of bias in patient selection**

The summary estimates of fever, cough and anosmia from prospective studies that had either a low or a high risk of bias concerning participant selection are presented in ROC curves for comparison (Figure 17; Figure 18; Figure 19). We observed the largest difference between both summary estimates for fever. The differences between the summary estimates between low and high risk of bias concerning participant selection were less pronounced for cough and for anosmia.

**Stratification by care setting**

Stratification according to setting did not explain the observed heterogeneity in diagnostic accuracy.

**Additional analyses**

To further illustrate the ability of a test to either rule in or rule out COVID-19, we constructed dumbbell plots showing pre- and post-test probabilities for anosmia, anosmia or ageusia, fever and cough by age group in each prospective cross-sectional study with a low risk of bias rating for selection of participants (Haehner 2020; Jeyashree 2021; Kempker 2020; Maechler 2020; Trubiano



2020; Tudrej 2020; Van Loon 2021; see Figure 20; Figure 21; Figure 22). For each test, we have plotted the pre-test probability, which is the prevalence of COVID-19 disease in the study (blue dot). The probability of having COVID-19 disease after testing (post-test probability) then changes depending on a positive test result (red dot marked +) or a negative test result (green dot marked -). The plot shows that the presence of anosmia, for example, increased the probability of COVID-19 in all seven studies. Its absence slightly decreased the probability of COVID-19 in three

studies (Kempker 2020; Tudrej 2020; Van Loon 2021), and in the four other studies there was not much difference between pre- and post-test probability (Haehner 2020; Jeyashree 2021; Maechler 2020; Trubiano 2020).

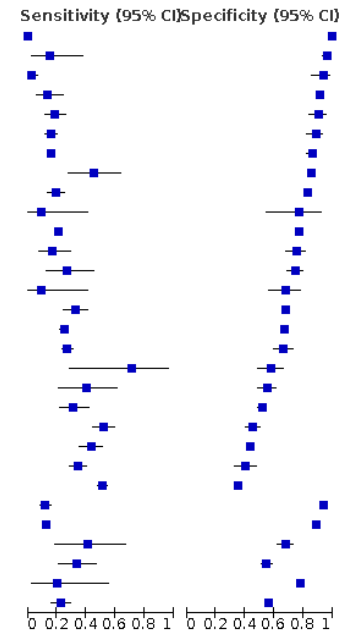
#### **Findings: retrospective studies**

Results of retrospective studies are presented in forest plots (Figure 23; Figure 24; Figure 25; Figure 26; Figure 27; Figure 28; Figure 29).

Figure 23. Forest plot of upper respiratory signs/symptoms (retrospective data collection)

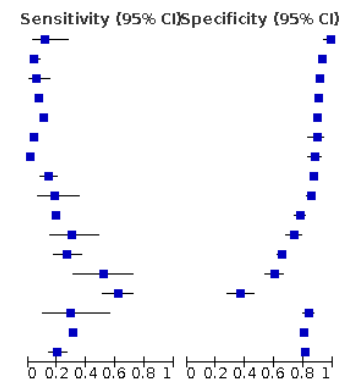
Sore throat (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Wei 2020	1	3	627	305	Adults (≥ 18y)	0.00 [0.00, 0.01]	0.99 [0.97, 1.00]
Haliga 2021	3	9	17	224	Adults (≥ 18y)	0.15 [0.03, 0.38]	0.96 [0.93, 0.98]
Langer 2020	3	5	121	70	Adults (≥ 18y)	0.02 [0.01, 0.07]	0.93 [0.85, 0.98]
H&#252;fner 2020	9	60	56	610	Adults (≥ 18y)	0.14 [0.07, 0.25]	0.91 [0.89, 0.93]
Arslan 2021	25	11	110	103	Adults (≥ 18y)	0.19 [0.12, 0.26]	0.90 [0.83, 0.95]
Huang 2020	54	16	282	123	Adults (≥ 18y)	0.16 [0.12, 0.20]	0.88 [0.82, 0.93]
King 2020	311	67	1676	409	Adults (≥ 18y)	0.16 [0.14, 0.17]	0.86 [0.82, 0.89]
Chew 2021	15	103	18	602	Adults (≥ 18y)	0.45 [0.28, 0.64]	0.85 [0.83, 0.88]
Mao 2020	36	140	152	676	Adults (≥ 18y)	0.19 [0.14, 0.26]	0.83 [0.80, 0.85]
Cheng 2020	1	5	10	17	Adults (≥ 18y)	0.09 [0.00, 0.41]	0.77 [0.55, 0.92]
Nitecki 2021	284	5272	1054	17752	Adults (≥ 18y)	0.21 [0.19, 0.24]	0.77 [0.77, 0.78]
Kim 2020	9	47	45	141	Adults (≥ 18y)	0.17 [0.08, 0.29]	0.75 [0.68, 0.81]
Shah 2020	9	73	24	210	Adults (≥ 18y)	0.27 [0.13, 0.46]	0.74 [0.69, 0.79]
Peng 2020	1	24	10	51	Adults (≥ 18y)	0.09 [0.00, 0.41]	0.68 [0.56, 0.78]
Ahmed 2021	40	545	83	1153	Adults (≥ 18y)	0.33 [0.24, 0.42]	0.68 [0.66, 0.70]
Barbhaya 2021	210	532	636	1093	Adults (≥ 18y)	0.25 [0.22, 0.28]	0.67 [0.65, 0.70]
Chan 2021	139	71	371	140	Adults (≥ 18y)	0.27 [0.23, 0.31]	0.66 [0.60, 0.73]
Feng 2021	5	53	2	72	Adults (≥ 18y)	0.71 [0.29, 0.96]	0.58 [0.48, 0.66]
Ide 2021	10	113	15	139	Adults (≥ 18y)	0.40 [0.21, 0.61]	0.55 [0.49, 0.61]
Leung 2021	27	563	59	609	Adults (≥ 18y)	0.31 [0.22, 0.42]	0.52 [0.49, 0.55]
Yombi 2020	91	197	84	164	Adults (≥ 18y)	0.52 [0.44, 0.60]	0.45 [0.40, 0.51]
Sacks 2020	68	897	89	693	Adults (≥ 18y)	0.43 [0.35, 0.51]	0.44 [0.41, 0.46]
Tan 2021	99	109	188	73	Adults (≥ 18y)	0.34 [0.29, 0.40]	0.40 [0.33, 0.48]
Chung 2021	467	2629	449	1416	Adults (≥ 18y)	0.51 [0.48, 0.54]	0.35 [0.34, 0.36]
Vilke 2020	40	498	290	6126	All ages	0.12 [0.09, 0.16]	0.93 [0.93, 0.94]
Raberahona 2020	162	215	1126	1651	All ages	0.13 [0.11, 0.15]	0.88 [0.87, 0.90]
Sonoda 2021	7	111	10	232	All ages	0.41 [0.18, 0.67]	0.68 [0.62, 0.73]
Sun 2020	18	332	36	402	All ages	0.33 [0.21, 0.47]	0.55 [0.51, 0.58]
Zurl 2021	2	227	8	806	Children (< 18y)	0.20 [0.03, 0.56]	0.78 [0.75, 0.81]
Lazzerini 2021	36	881	123	1108	Children (< 18y)	0.23 [0.16, 0.30]	0.56 [0.53, 0.58]



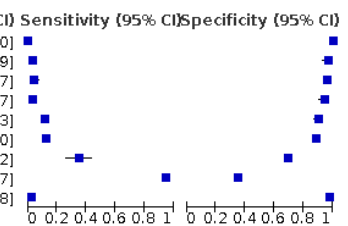
Rhinorrhoea (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Fiel-Ozores 2021	4	1	29	92	Adults (≥ 18y)	0.12 [0.03, 0.28]	0.99 [0.94, 1.00]
Mao 2020	9	59	179	757	Adults (≥ 18y)	0.05 [0.02, 0.09]	0.93 [0.91, 0.94]
H&#252;fner 2020	3	58	50	599	Adults (≥ 18y)	0.06 [0.01, 0.16]	0.91 [0.89, 0.93]
Nitecki 2021	106	2192	1232	20832	Adults (≥ 18y)	0.08 [0.07, 0.10]	0.90 [0.90, 0.91]
Barbhaya 2021	92	166	754	1459	Adults (≥ 18y)	0.11 [0.09, 0.13]	0.90 [0.88, 0.91]
Huang 2020	14	15	322	124	Adults (≥ 18y)	0.04 [0.02, 0.07]	0.89 [0.83, 0.94]
Arslan 2021	3	28	173	200	Adults (≥ 18y)	0.02 [0.00, 0.05]	0.88 [0.83, 0.92]
Sacks 2020	22	204	135	1386	Adults (≥ 18y)	0.14 [0.09, 0.20]	0.87 [0.85, 0.89]
Chew 2021	6	106	27	599	Adults (≥ 18y)	0.18 [0.07, 0.35]	0.85 [0.82, 0.88]
King 2020	383	105	1604	371	Adults (≥ 18y)	0.19 [0.18, 0.21]	0.78 [0.74, 0.82]
Shah 2020	10	74	23	209	Adults (≥ 18y)	0.30 [0.16, 0.49]	0.74 [0.68, 0.79]
Leung 2021	23	412	63	760	Adults (≥ 18y)	0.27 [0.18, 0.37]	0.65 [0.62, 0.68]
Ide 2021	13	100	12	152	Adults (≥ 18y)	0.52 [0.31, 0.72]	0.60 [0.54, 0.66]
Zayet 2020a	59	77	36	45	Adults (≥ 18y)	0.62 [0.52, 0.72]	0.37 [0.28, 0.46]
Sonoda 2021	5	56	12	287	All ages	0.29 [0.10, 0.56]	0.84 [0.79, 0.87]
Raberahona 2020	400	377	888	1489	All ages	0.31 [0.29, 0.34]	0.80 [0.78, 0.82]
Lazzerini 2021	32	372	127	1617	Children (< 18y)	0.20 [0.14, 0.27]	0.81 [0.80, 0.83]



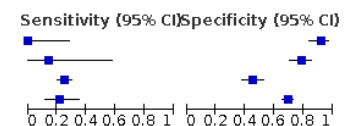
Nasal congestion (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Wei 2020	2	0	626	308	Adults (≥ 18y)	0.00 [0.00, 0.01]	1.00 [0.99, 1.00]
Huang 2020	11	4	325	135	Adults (≥ 18y)	0.03 [0.02, 0.06]	0.97 [0.93, 0.99]
Mao 2020	8	32	180	784	Adults (≥ 18y)	0.04 [0.02, 0.08]	0.96 [0.95, 0.97]
Mart&#237;n-S&#225;nchez 2020	16	13	424	214	Adults (≥ 18y)	0.04 [0.02, 0.06]	0.94 [0.90, 0.97]
King 2020	241	46	1746	430	Adults (≥ 18y)	0.12 [0.11, 0.14]	0.90 [0.87, 0.93]
Barbhaya 2021	110	189	736	1436	Adults (≥ 18y)	0.13 [0.11, 0.15]	0.88 [0.87, 0.90]
Ahmed 2021	43	516	80	1182	Adults (≥ 18y)	0.35 [0.27, 0.44]	0.70 [0.67, 0.72]
Chung 2021	447	1747	27	940	Adults (≥ 18y)	0.94 [0.92, 0.96]	0.35 [0.33, 0.37]
Raberahona 2020	34	42	1254	1824	All ages	0.03 [0.02, 0.04]	0.98 [0.97, 0.98]



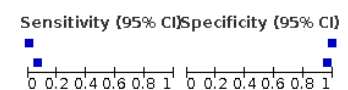
Nasal symptoms (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Peng 2020	0	6	11	69	Adults (≥ 18y)	0.00 [0.00, 0.28]	0.92 [0.83, 0.97]
Feng 2021	1	27	6	98	Adults (≥ 18y)	0.14 [0.00, 0.58]	0.78 [0.70, 0.85]
Tan 2021	72	100	215	82	Adults (≥ 18y)	0.25 [0.20, 0.31]	0.45 [0.38, 0.53]
Sun 2020	12	226	42	508	All ages	0.22 [0.12, 0.36]	0.69 [0.66, 0.73]



Sneezing (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Mao 2020	2	2	186	814	Adults (≥ 18y)	0.01 [0.00, 0.04]	1.00 [0.99, 1.00]
King 2020	132	18	1855	458	Adults (≥ 18y)	0.07 [0.06, 0.08]	0.96 [0.94, 0.98]



Sinusitis (retrospective data collection)



**Figure 23. (Continued)**

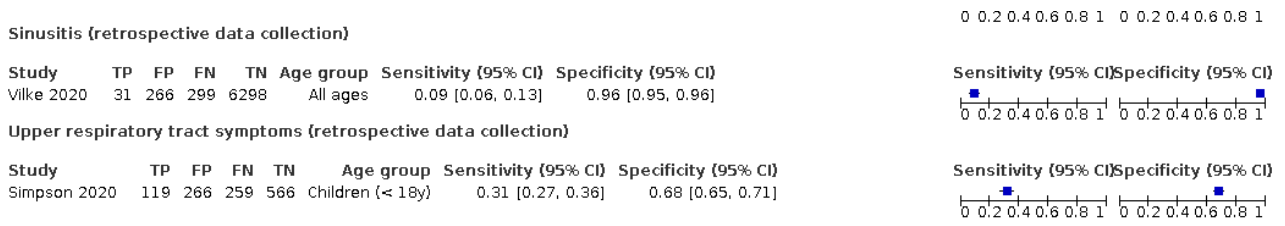
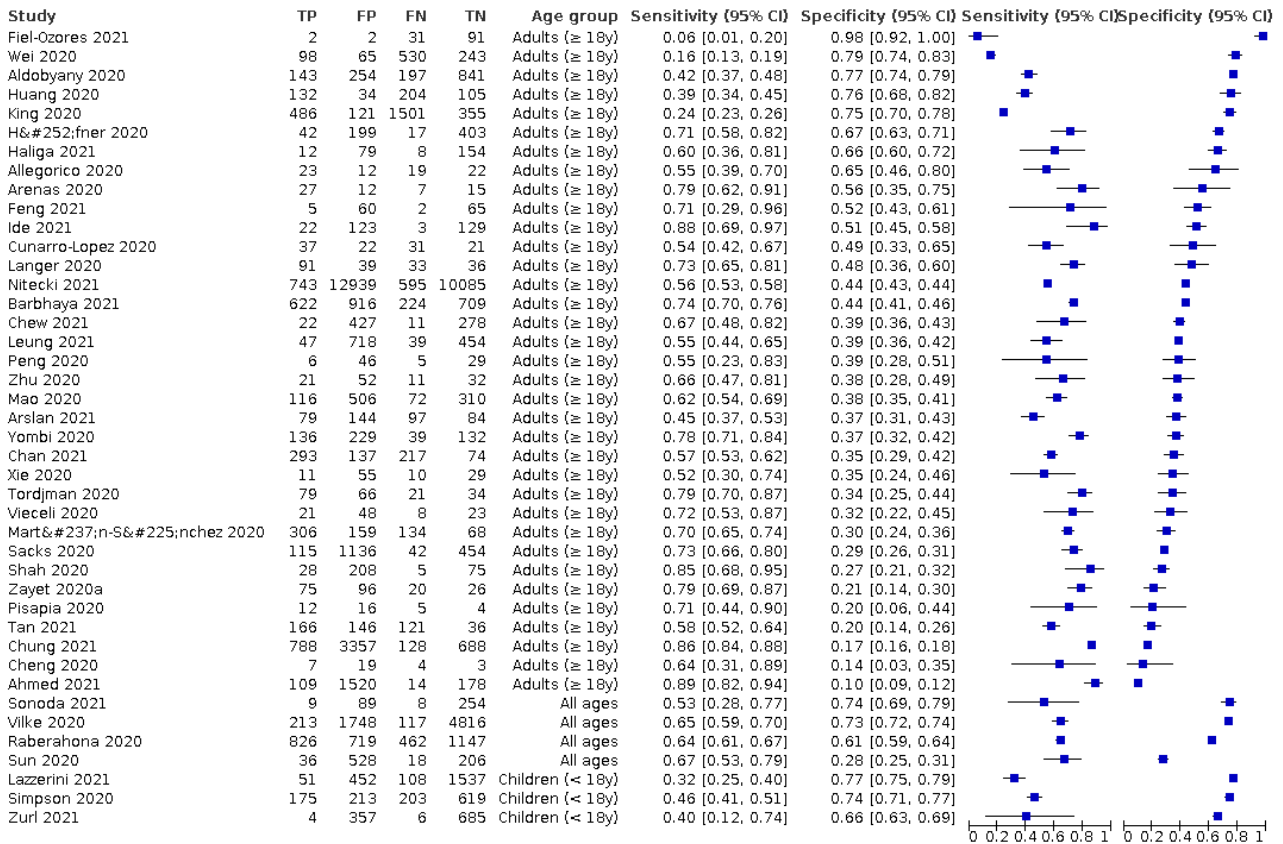


Figure 24. Forest plot of lower respiratory signs/symptoms (retrospective data collection)

Cough (retrospective data collection)



Dyspnoea (retrospective data collection)

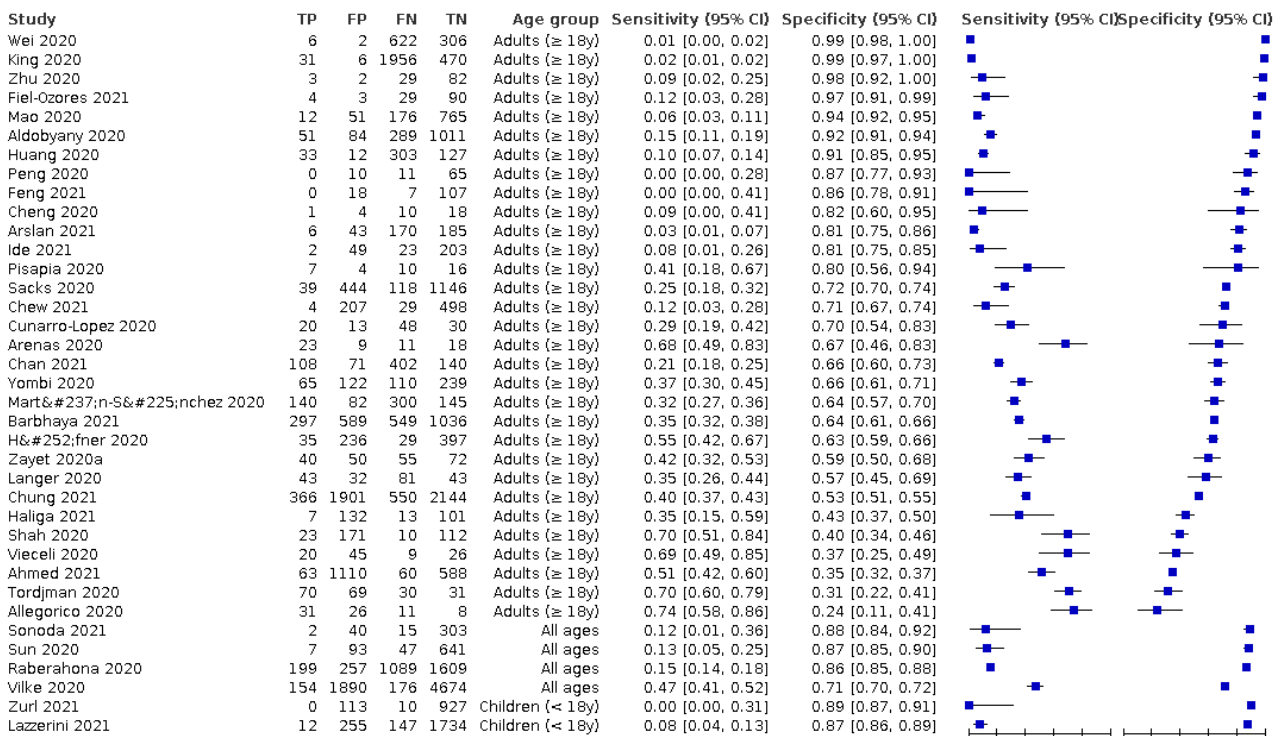


Figure 24. (Continued)

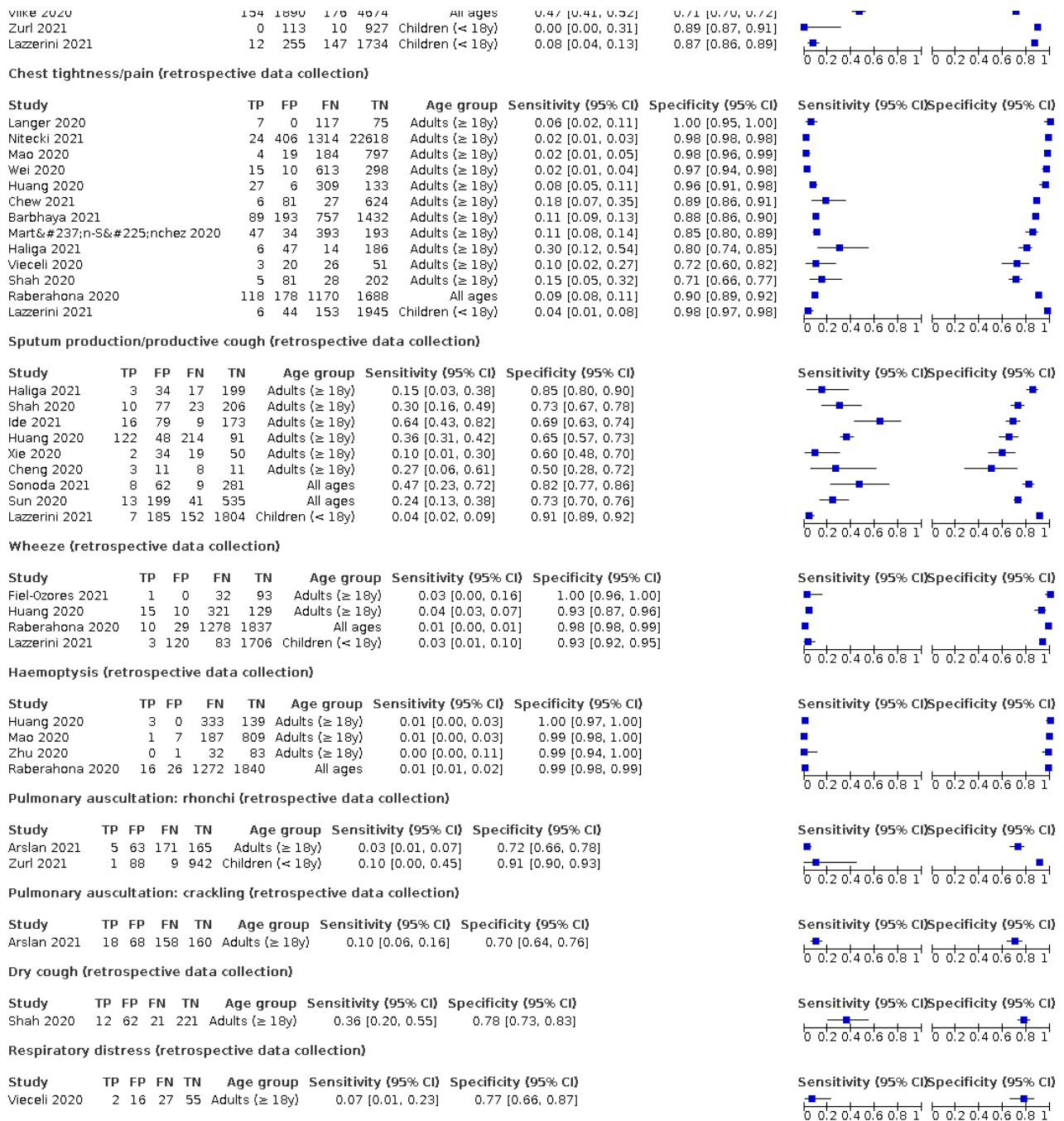
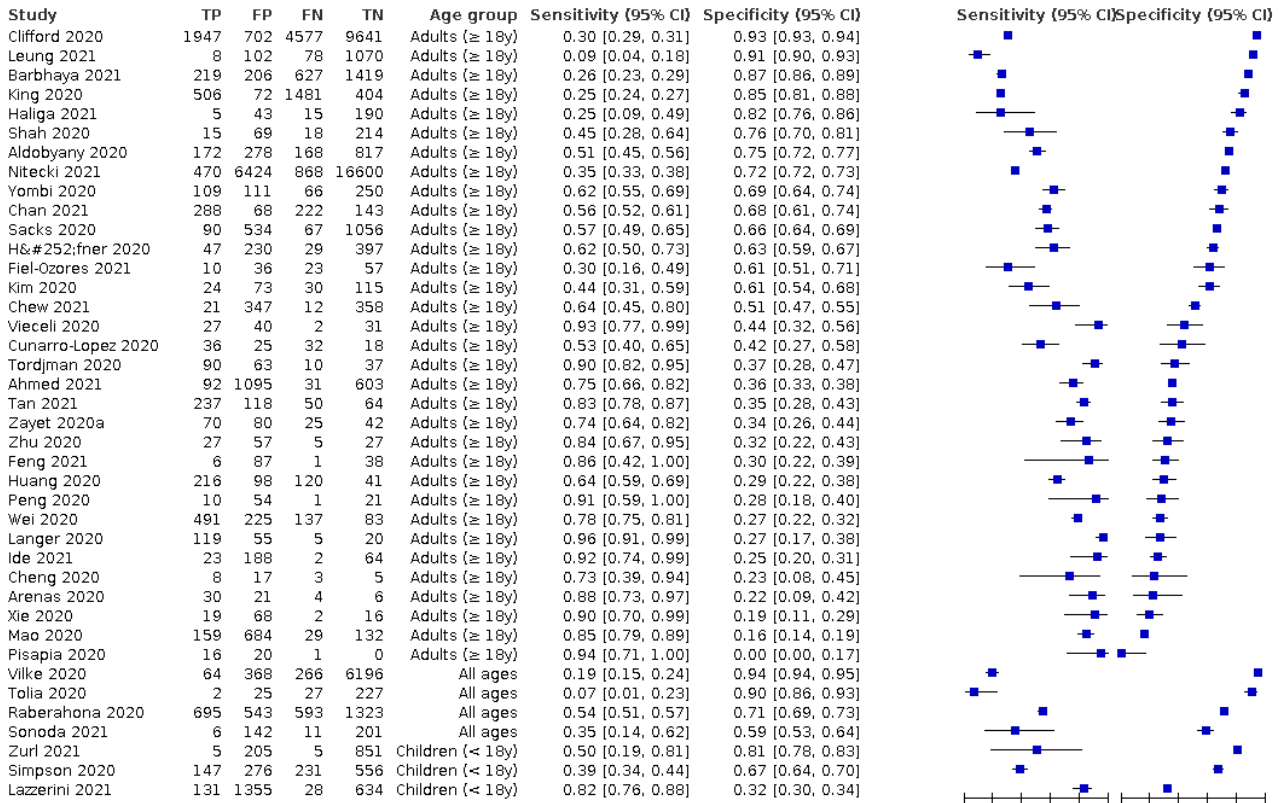
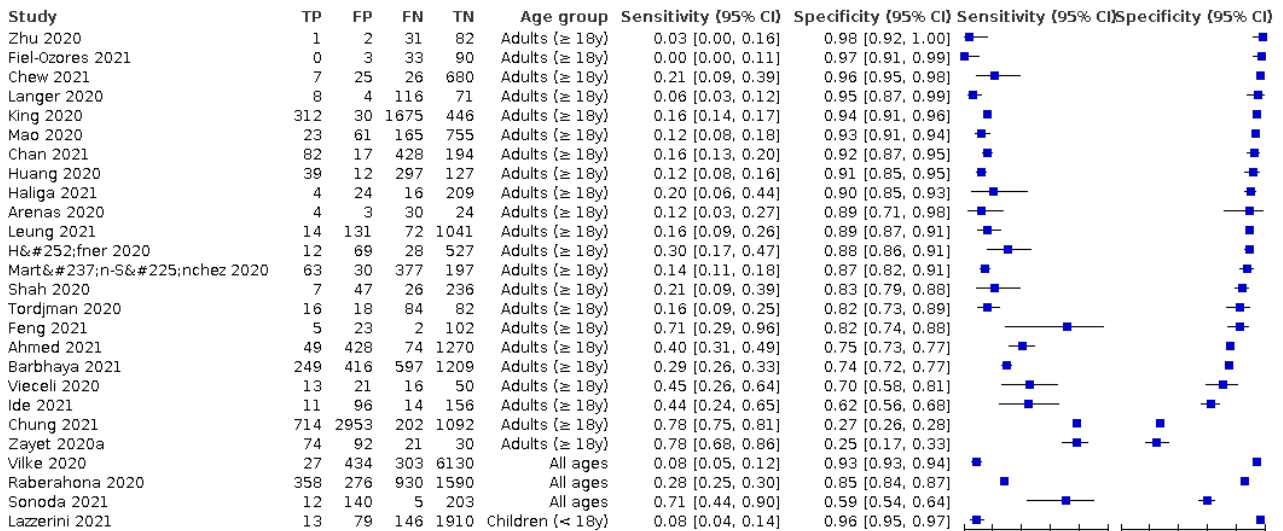


Figure 25. Forest plot of systemic signs/symptoms (retrospective data collection)

Fever (retrospective data collection)



Headache (retrospective data collection)



Myalgia (retrospective data collection)

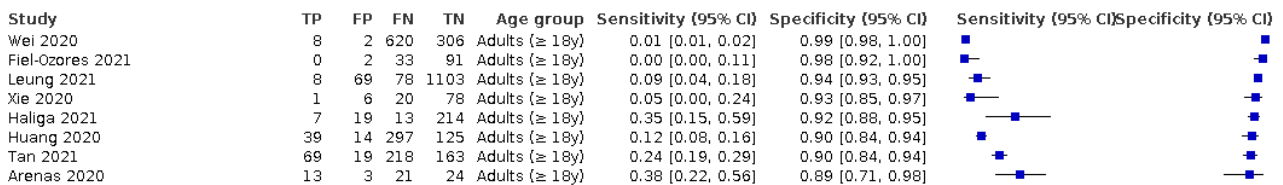
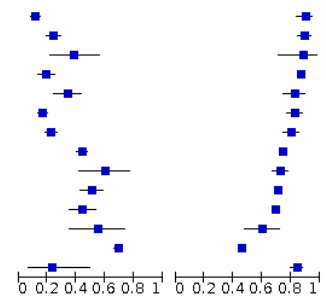


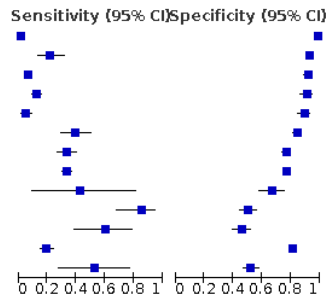
Figure 25. (Continued)

Huang 2020	39	14	297	125	Adults (≥ 18y)	0.12 [0.08, 0.16]	0.90 [0.84, 0.94]
Tan 2021	69	19	218	163	Adults (≥ 18y)	0.24 [0.19, 0.29]	0.90 [0.84, 0.94]
Arenas 2020	13	3	21	24	Adults (≥ 18y)	0.38 [0.22, 0.56]	0.89 [0.71, 0.98]
Mao 2020	36	105	152	711	Adults (≥ 18y)	0.19 [0.14, 0.26]	0.87 [0.85, 0.89]
Tordjman 2020	34	17	66	83	Adults (≥ 18y)	0.34 [0.25, 0.44]	0.83 [0.74, 0.90]
Chan 2021	87	36	423	175	Adults (≥ 18y)	0.17 [0.14, 0.21]	0.83 [0.77, 0.88]
Mart&#237;n-S&#225;nchez 2020	99	44	341	183	Adults (≥ 18y)	0.23 [0.19, 0.27]	0.81 [0.75, 0.86]
Barbhaya 2021	374	417	472	1208	Adults (≥ 18y)	0.44 [0.41, 0.48]	0.74 [0.72, 0.76]
Shah 2020	20	77	13	206	Adults (≥ 18y)	0.61 [0.42, 0.77]	0.73 [0.67, 0.78]
Sacks 2020	80	459	77	1131	Adults (≥ 18y)	0.51 [0.43, 0.59]	0.71 [0.69, 0.73]
Ahmed 2021	55	526	68	1172	Adults (≥ 18y)	0.45 [0.36, 0.54]	0.69 [0.67, 0.71]
Vieceli 2020	16	28	13	43	Adults (≥ 18y)	0.55 [0.36, 0.74]	0.61 [0.48, 0.72]
Chung 2021	632	2184	284	1861	Adults (≥ 18y)	0.69 [0.66, 0.72]	0.46 [0.44, 0.48]
Sonoda 2021	4	54	13	289	All ages	0.24 [0.07, 0.50]	0.84 [0.80, 0.88]



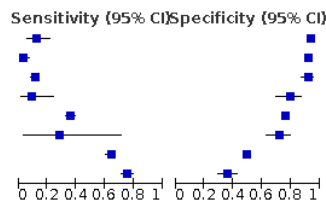
Fatigue (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
King 2020	31	6	1956	470	Adults (≥ 18y)	0.02 [0.01, 0.02]	0.99 [0.97, 1.00]
Leung 2021	19	87	67	1085	Adults (≥ 18y)	0.22 [0.14, 0.32]	0.93 [0.91, 0.94]
Wei 2020	42	24	586	284	Adults (≥ 18y)	0.07 [0.05, 0.09]	0.92 [0.89, 0.95]
Chan 2021	65	19	445	192	Adults (≥ 18y)	0.13 [0.10, 0.16]	0.91 [0.86, 0.94]
Arslian 2021	9	24	167	204	Adults (≥ 18y)	0.05 [0.02, 0.09]	0.89 [0.85, 0.93]
H&#252;fner 2020	36	106	55	573	Adults (≥ 18y)	0.40 [0.29, 0.50]	0.84 [0.81, 0.87]
Mao 2020	63	187	125	629	Adults (≥ 18y)	0.34 [0.27, 0.41]	0.77 [0.74, 0.80]
Barbhaya 2021	286	377	560	1248	Adults (≥ 18y)	0.34 [0.31, 0.37]	0.77 [0.75, 0.79]
Feng 2021	3	41	4	84	Adults (≥ 18y)	0.43 [0.10, 0.82]	0.67 [0.58, 0.75]
Shah 2020	28	140	5	143	Adults (≥ 18y)	0.85 [0.68, 0.95]	0.51 [0.45, 0.56]
Ide 2021	15	137	10	115	Adults (≥ 18y)	0.60 [0.39, 0.79]	0.46 [0.39, 0.52]
Vilke 2020	65	1254	265	5310	All ages	0.20 [0.16, 0.24]	0.81 [0.80, 0.82]
Sonoda 2021	9	164	8	179	All ages	0.53 [0.28, 0.77]	0.52 [0.47, 0.58]



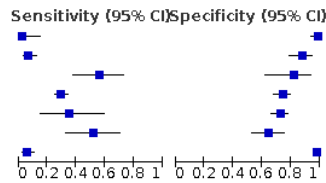
Chills/shivers (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Leung 2021	11	75	75	1097	Adults (≥ 18y)	0.13 [0.07, 0.22]	0.94 [0.92, 0.95]
Mao 2020	7	64	181	752	Adults (≥ 18y)	0.04 [0.02, 0.08]	0.92 [0.90, 0.94]
Chan 2021	59	17	451	194	Adults (≥ 18y)	0.12 [0.09, 0.15]	0.92 [0.87, 0.95]
Fiel-Ozores 2021	3	19	30	74	Adults (≥ 18y)	0.09 [0.02, 0.24]	0.80 [0.70, 0.87]
Barbhaya 2021	306	395	540	1230	Adults (≥ 18y)	0.36 [0.33, 0.40]	0.76 [0.74, 0.78]
Feng 2021	2	35	5	90	Adults (≥ 18y)	0.29 [0.04, 0.71]	0.72 [0.63, 0.80]
Chung 2021	586	2063	330	1982	Adults (≥ 18y)	0.64 [0.61, 0.67]	0.49 [0.47, 0.51]
Mart&#237;n-S&#225;nchez 2020	332	145	108	82	Adults (≥ 18y)	0.75 [0.71, 0.79]	0.36 [0.30, 0.43]



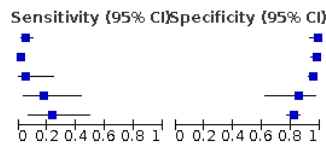
Asthenia (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Fiel-Ozores 2021	1	1	32	92	Adults (≥ 18y)	0.03 [0.00, 0.16]	0.99 [0.94, 1.00]
Langer 2020	9	9	115	66	Adults (≥ 18y)	0.07 [0.03, 0.13]	0.88 [0.78, 0.94]
Arenas 2020	19	5	15	22	Adults (≥ 18y)	0.56 [0.38, 0.73]	0.81 [0.62, 0.94]
Mart&#237;n-S&#225;nchez 2020	131	59	309	168	Adults (≥ 18y)	0.30 [0.26, 0.34]	0.74 [0.68, 0.80]
Haliga 2021	7	64	13	169	Adults (≥ 18y)	0.35 [0.15, 0.59]	0.73 [0.66, 0.78]
Vieceli 2020	15	25	14	46	Adults (≥ 18y)	0.52 [0.33, 0.71]	0.65 [0.53, 0.76]
Lazerini 2021	10	38	149	1951	Children (< 18y)	0.06 [0.03, 0.11]	0.98 [0.97, 0.99]



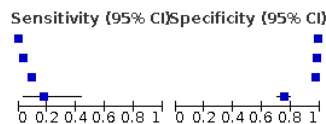
Arthralgia (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Langer 2020	6	1	118	74	Adults (≥ 18y)	0.05 [0.02, 0.10]	0.99 [0.93, 1.00]
Huang 2020	6	3	330	136	Adults (≥ 18y)	0.02 [0.01, 0.04]	0.98 [0.94, 1.00]
Haliga 2021	1	11	19	222	Adults (≥ 18y)	0.05 [0.00, 0.25]	0.95 [0.92, 0.98]
Pisapia 2020	3	3	14	17	Adults (≥ 18y)	0.18 [0.04, 0.43]	0.85 [0.62, 0.97]
Sonoda 2021	4	62	13	281	All ages	0.24 [0.07, 0.50]	0.82 [0.77, 0.86]



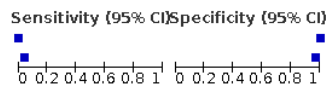
Anorexia (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Wei 2020	3	4	625	304	Adults (≥ 18y)	0.00 [0.00, 0.01]	0.99 [0.97, 1.00]
King 2020	75	10	1912	466	Adults (≥ 18y)	0.04 [0.03, 0.05]	0.98 [0.96, 0.99]
Barbhaya 2021	76	50	770	1575	Adults (≥ 18y)	0.09 [0.07, 0.11]	0.97 [0.96, 0.98]
Sonoda 2021	3	85	14	258	All ages	0.18 [0.04, 0.43]	0.75 [0.70, 0.80]



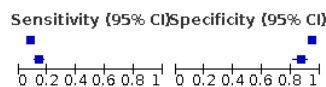
Dizziness (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Wei 2020	1	0	627	308	Adults (≥ 18y)	0.00 [0.00, 0.01]	1.00 [0.99, 1.00]
Barbhaya 2021	36	50	810	1575	Adults (≥ 18y)	0.04 [0.03, 0.06]	0.97 [0.96, 0.98]



Malaise (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
King 2020	165	25	1822	451	Adults (≥ 18y)	0.08 [0.07, 0.10]	0.95 [0.92, 0.97]
Chan 2021	74	28	436	183	Adults (≥ 18y)	0.15 [0.12, 0.18]	0.87 [0.81, 0.91]

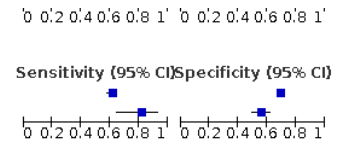


Fever (subjective) (retrospective data collection)

**Figure 25. (Continued)**

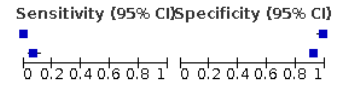
**Fever (subjective) (retrospective data collection)**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Barbhaya 2021	520	498	326	1127	Adults (≥ 18y)	0.61 [0.58, 0.65]	0.69 [0.67, 0.72]
Shah 2020	27	125	6	158	Adults (≥ 18y)	0.82 [0.65, 0.93]	0.56 [0.50, 0.62]



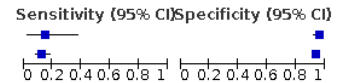
**Enlargement of lymph nodes (retrospective data collection)**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Huang 2020	0	2	336	137	Adults (≥ 18y)	0.00 [0.00, 0.01]	0.99 [0.95, 1.00]
Lazerini 2021	11	158	148	1831	Children (< 18y)	0.07 [0.04, 0.12]	0.92 [0.91, 0.93]



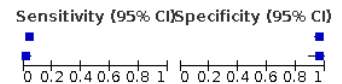
**Loss of appetite (retrospective data collection)**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Haliga 2021	3	10	17	223	Adults (≥ 18y)	0.15 [0.03, 0.38]	0.96 [0.92, 0.98]
Mao 2020	24	55	164	761	Adults (≥ 18y)	0.13 [0.08, 0.18]	0.93 [0.91, 0.95]



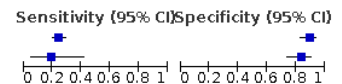
**Presyncope or syncope (retrospective data collection)**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Martinez 2020	21	9	419	218	Adults (≥ 18y)	0.05 [0.03, 0.07]	0.96 [0.93, 0.98]
Langer 2020	2	3	122	72	Adults (≥ 18y)	0.02 [0.00, 0.06]	0.96 [0.89, 0.99]



**Weakness or fatigue (retrospective data collection)**

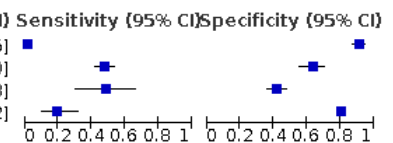
Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Huang 2020	83	15	253	124	Adults (≥ 18y)	0.25 [0.20, 0.30]	0.89 [0.83, 0.94]
Xie 2020	4	14	17	70	Adults (≥ 18y)	0.19 [0.05, 0.42]	0.83 [0.74, 0.91]



**Figure 26. Forest plot of cardiovascular signs/symptoms (retrospective data collection)**

**Tachycardia (retrospective data collection)**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Arslan 2021	3	20	173	208	Adults (≥ 18y)	0.02 [0.00, 0.05]	0.91 [0.87, 0.95]
Tan 2021	137	67	150	115	Adults (≥ 18y)	0.48 [0.42, 0.54]	0.63 [0.56, 0.70]
Shah 2020	16	164	17	119	Adults (≥ 18y)	0.48 [0.31, 0.66]	0.42 [0.36, 0.48]
Lazerini 2021	12	294	49	1195	Children (< 18y)	0.20 [0.11, 0.32]	0.80 [0.78, 0.82]



**Palpitations (retrospective data collection)**

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Feng 2021	0	3	7	122	Adults (≥ 18y)	0.00 [0.00, 0.41]	0.98 [0.93, 1.00]

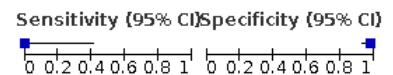
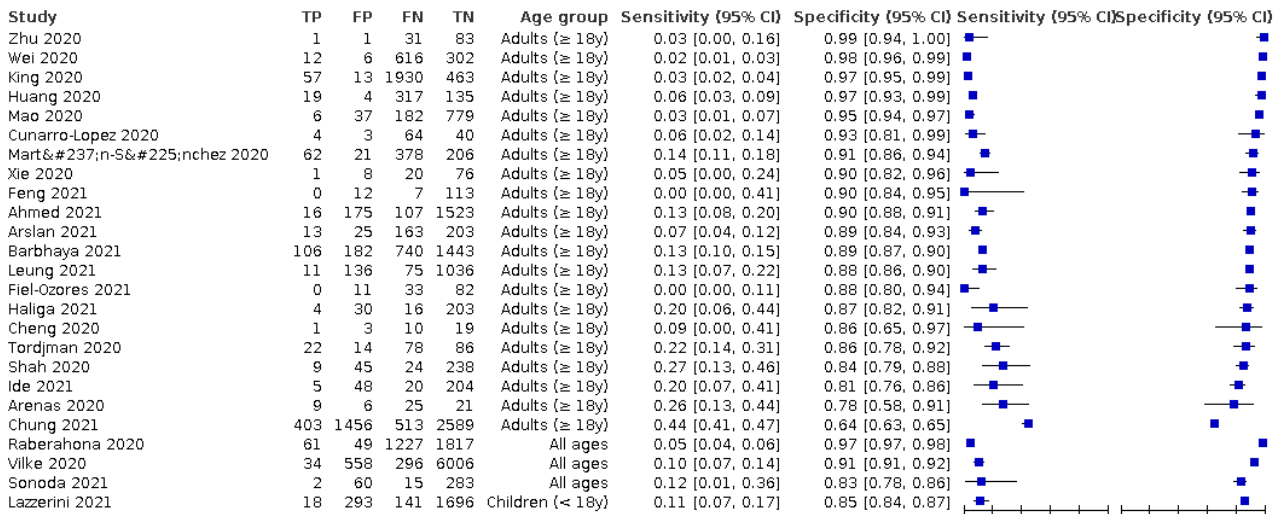


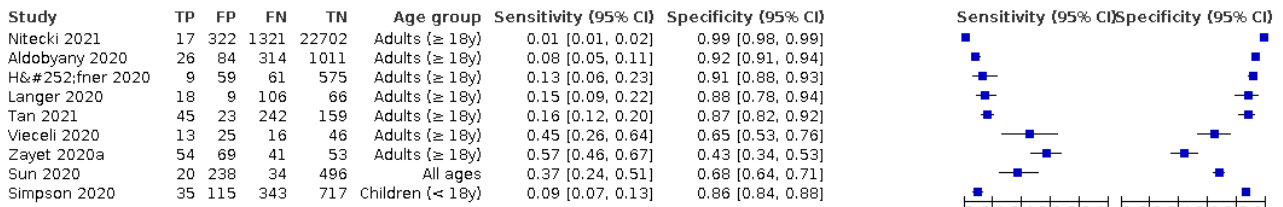


Figure 27. Forest plot of gastrointestinal signs/symptoms (retrospective data collection)

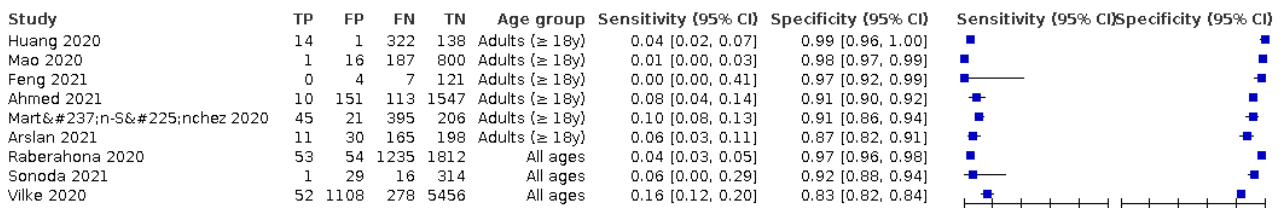
Diarrhoea (retrospective data collection)



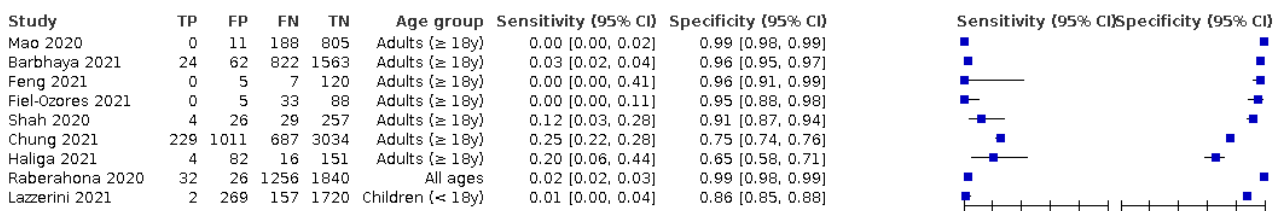
Gastrointestinal symptoms not specified (retrospective data collection)



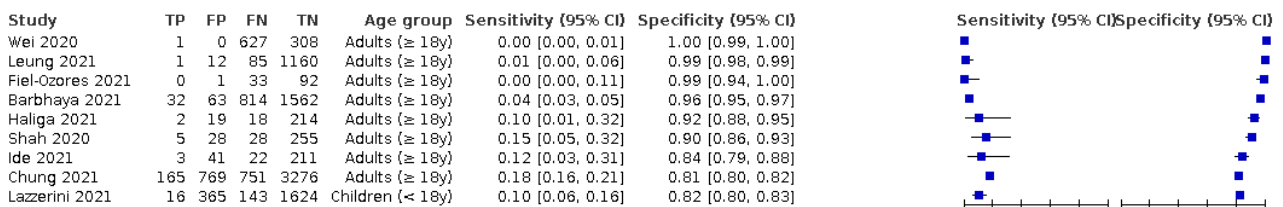
Nausea or vomiting (retrospective data collection)



Abdominal pain (retrospective data collection)



Vomiting (retrospective data collection)



Loss of appetite (retrospective data collection)

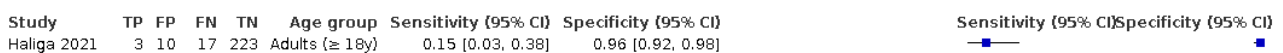




Figure 27. (Continued)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Haliga 2021	3	10	17	223	Adults (≥ 18y)	0.15 [0.03, 0.38]	0.96 [0.92, 0.98]
Mao 2020	24	55	164	761	Adults (≥ 18y)	0.13 [0.08, 0.18]	0.93 [0.91, 0.95]

Stomach ache (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Huang 2020	6	2	330	137	Adults (≥ 18y)	0.02 [0.01, 0.04]	0.99 [0.95, 1.00]
Sonoda 2021	1	37	16	306	All ages	0.06 [0.00, 0.29]	0.89 [0.85, 0.92]

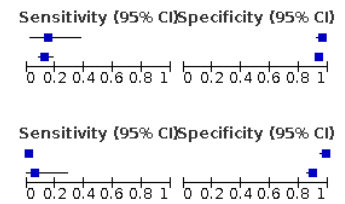
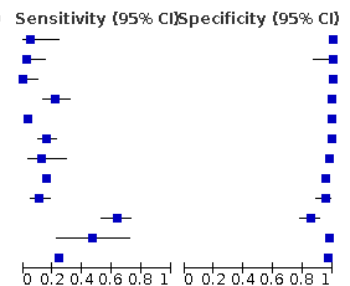


Figure 28. Forest plot of olfactory signs/symptoms (retrospective data collection)

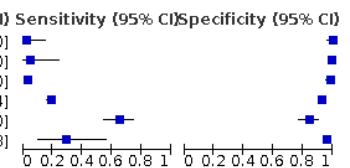
Anosmia (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Haliga 2021	1	0	19	233	Adults (≥ 18y)	0.05 [0.00, 0.25]	1.00 [0.98, 1.00]
Arenas 2020	1	0	33	27	Adults (≥ 18y)	0.03 [0.00, 0.15]	1.00 [0.87, 1.00]
Chew 2021	0	1	33	704	Adults (≥ 18y)	0.00 [0.00, 0.11]	1.00 [0.99, 1.00]
Leung 2021	19	3	67	1169	Adults (≥ 18y)	0.22 [0.14, 0.32]	1.00 [0.99, 1.00]
Mart&#237;n-S&#225;nchez 2020	14	2	426	225	Adults (≥ 18y)	0.03 [0.02, 0.05]	0.99 [0.97, 1.00]
Sacks 2020	25	15	132	1575	Adults (≥ 18y)	0.16 [0.11, 0.23]	0.99 [0.98, 0.99]
Chua 2020	4	14	27	672	Adults (≥ 18y)	0.13 [0.04, 0.30]	0.98 [0.97, 0.99]
Barbhaya 2021	139	79	707	1546	Adults (≥ 18y)	0.16 [0.14, 0.19]	0.95 [0.94, 0.96]
Tordjman 2020	11	5	89	95	Adults (≥ 18y)	0.11 [0.06, 0.19]	0.95 [0.89, 0.98]
Zayet 2020a	60	18	35	104	Adults (≥ 18y)	0.63 [0.53, 0.73]	0.85 [0.78, 0.91]
Sonoda 2021	8	9	9	334	All ages	0.47 [0.23, 0.72]	0.97 [0.95, 0.99]
Raberahona 2020	311	63	977	1803	All ages	0.24 [0.22, 0.27]	0.97 [0.96, 0.97]



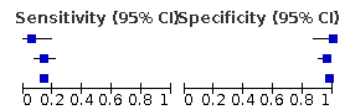
Dysgeusia (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Fiel-Ozores 2021	1	0	32	93	Adults (≥ 18y)	0.03 [0.00, 0.16]	1.00 [0.96, 1.00]
Haliga 2021	1	1	19	232	Adults (≥ 18y)	0.05 [0.00, 0.25]	1.00 [0.98, 1.00]
Mart&#237;n-S&#225;nchez 2020	15	4	425	223	Adults (≥ 18y)	0.03 [0.02, 0.06]	0.98 [0.96, 1.00]
Barbhaya 2021	161	112	685	1513	Adults (≥ 18y)	0.19 [0.16, 0.22]	0.93 [0.92, 0.94]
Zayet 2020a	62	19	33	103	Adults (≥ 18y)	0.65 [0.55, 0.75]	0.84 [0.77, 0.90]
Sonoda 2021	5	13	12	330	All ages	0.29 [0.10, 0.56]	0.96 [0.94, 0.98]



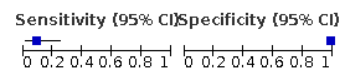
Ageusia (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Arenas 2020	2	0	32	27	Adults (≥ 18y)	0.06 [0.01, 0.20]	1.00 [0.87, 1.00]
Tordjman 2020	14	4	86	96	Adults (≥ 18y)	0.14 [0.08, 0.22]	0.96 [0.90, 0.99]
Raberahona 2020	185	38	1103	1828	All ages	0.14 [0.12, 0.16]	0.98 [0.97, 0.99]



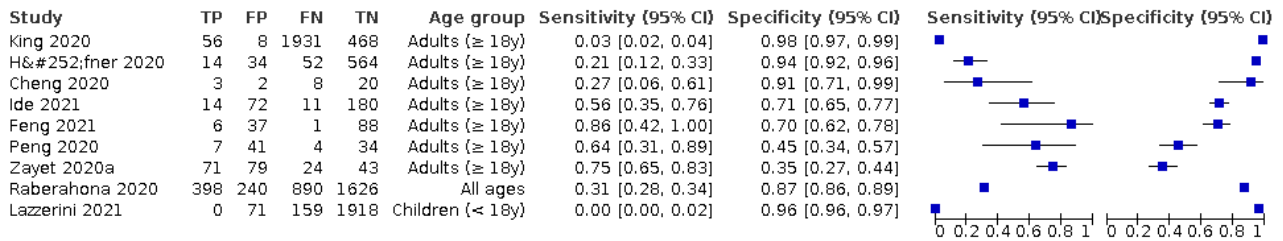
Hyposmia (retrospective data collection)

Study	TP	FP	FN	TN	Age group	Sensitivity (95% CI)	Specificity (95% CI)
Chua 2020	3	8	28	678	Adults (≥ 18y)	0.10 [0.02, 0.26]	0.99 [0.98, 0.99]

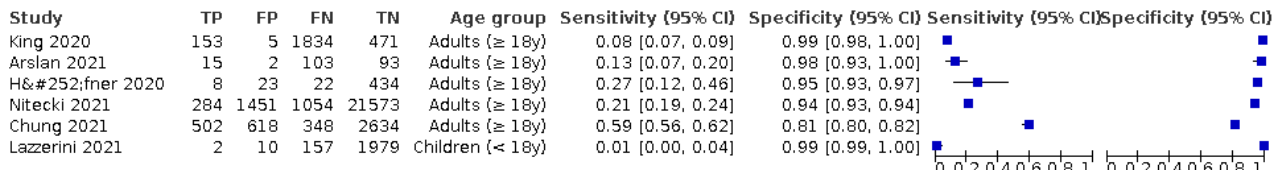


**Figure 29. Forest plot of combinations of signs/symptoms (retrospective data collection)**

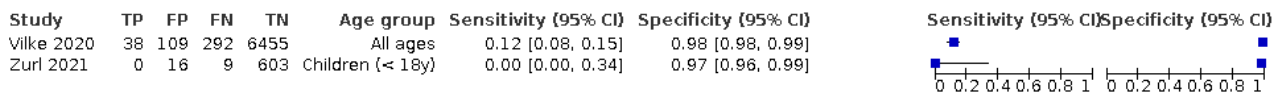
**Myalgia or arthralgia (retrospective data collection)**



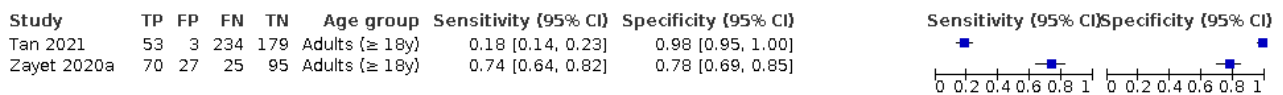
**Anosmia or ageusia (retrospective data collection)**



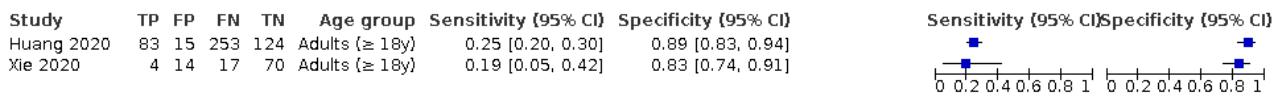
**Anosmia/dysosmia or ageusia/dysgeusia (retrospective data collection)**



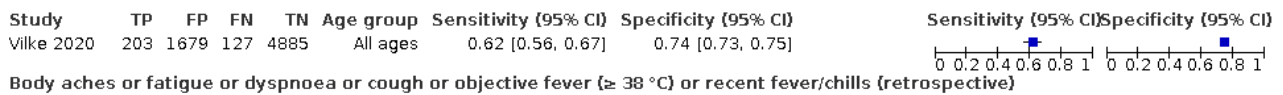
**Anosmia or dysgeusia (retrospective data collection)**



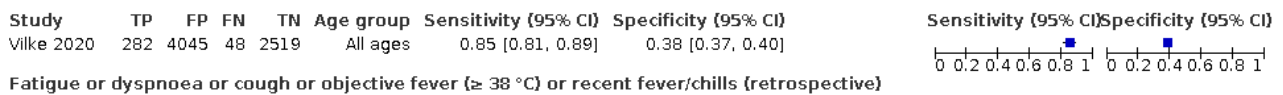
**Weakness or fatigue (retrospective data collection)**



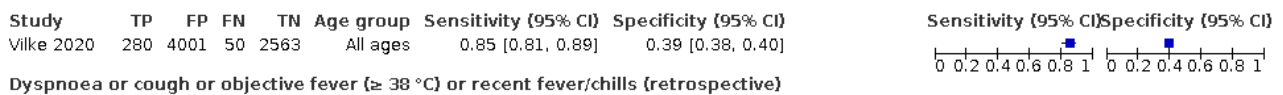
**Objective fever (≥ 38 °C) or recent fever/chills (retrospective)**



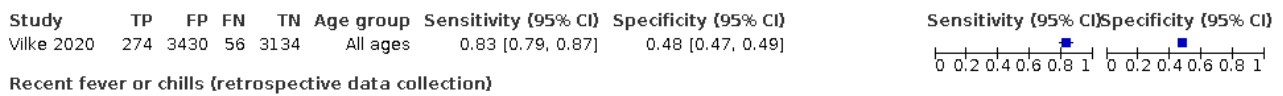
**Body aches or fatigue or dyspnoea or cough or objective fever (≥ 38 °C) or recent fever/chills (retrospective)**



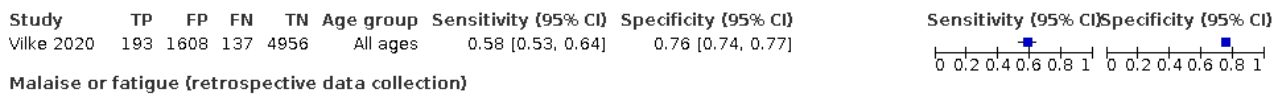
**Fatigue or dyspnoea or cough or objective fever (≥ 38 °C) or recent fever/chills (retrospective)**



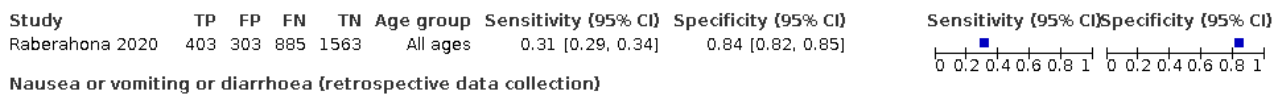
**Dyspnoea or cough or objective fever (≥ 38 °C) or recent fever/chills (retrospective)**



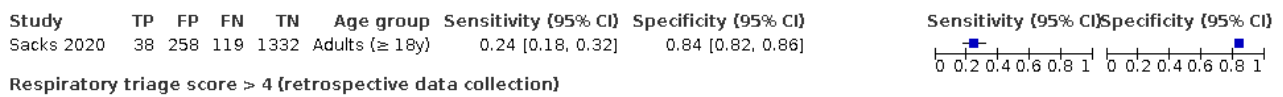
**Recent fever or chills (retrospective data collection)**



**Malaise or fatigue (retrospective data collection)**

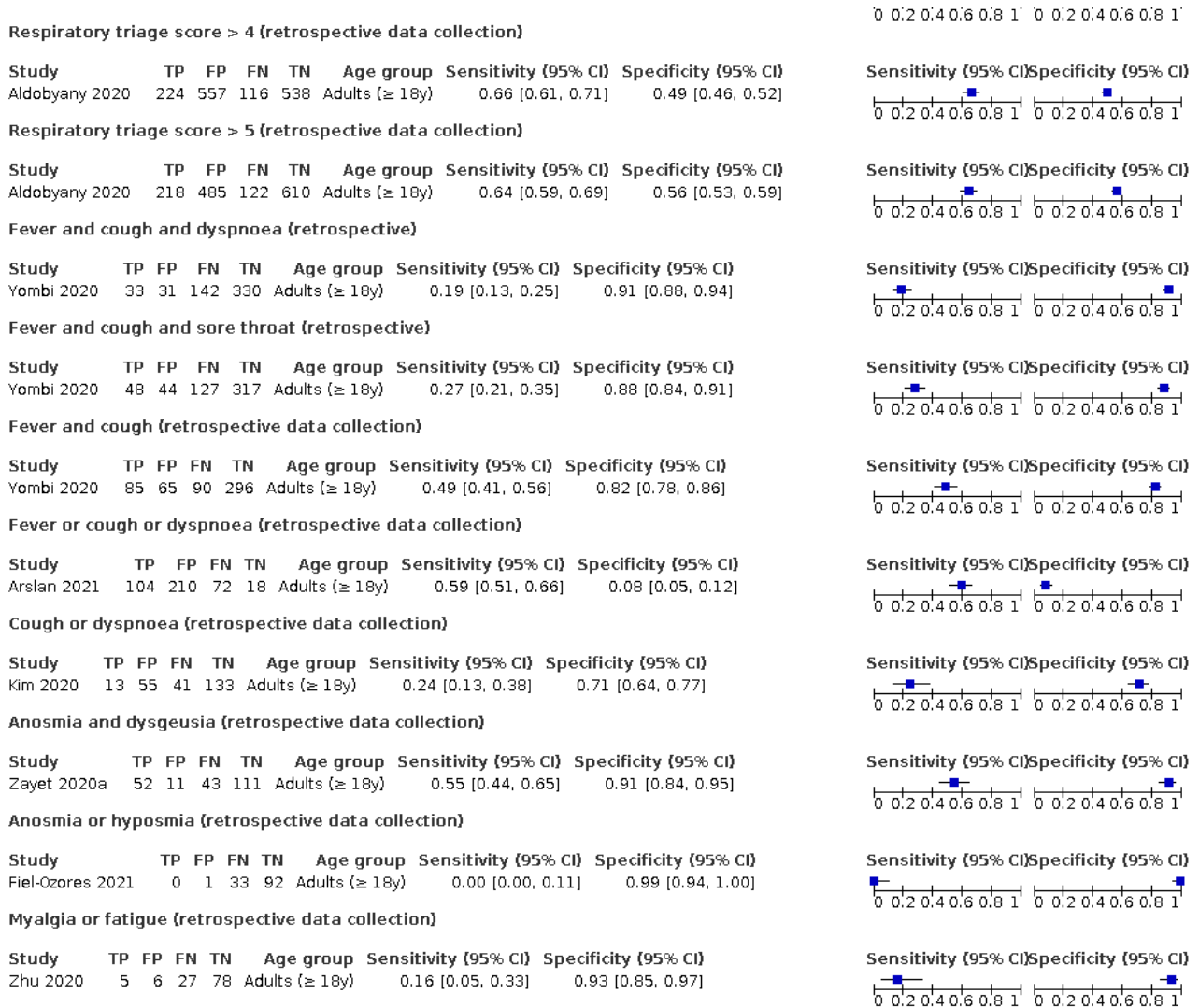


**Nausea or vomiting or diarrhoea (retrospective data collection)**



**Respiratory triage score > 4 (retrospective data collection)**

**Figure 29. (Continued)**



**DISCUSSION**

**Summary of main results**

This is the second update of a living systematic review of signs and symptoms for the diagnosis of COVID-19 in an outpatient setting. For the first time, this update provided a large number of cross-sectional studies using prospective data collection, leading to results that are more reliable than those presented in previous versions of this review. Nevertheless, considerable heterogeneity between study results remains a concern. Our main conclusion remains unchanged: most individual symptoms appear to have poor diagnostic accuracy. Neither absence nor presence of symptoms are accurate enough to rule in or rule out the disease. The presence of anosmia or ageusia may be useful as a red flag for the presence of COVID-19. Some combinations of signs and symptoms may be useful as a tool to triage patients for further testing.

This review update identified more studies on combinations of signs and symptoms, but only six out of 29 different combinations were assessed by more than one study. Some combinations may be useful as a triage tool. For example, in a cohort with a disease prevalence (pre-test probability) of 5%, the presence of either anosmia or ageusia would increase the post-test probability of the presence of COVID-19 to 21%.

The combination of signs and symptoms with other readily available information may prove useful in safely ruling out COVID-19. The multivariable prediction score with the highest sensitivity (90.0%) combined gender, being a healthcare worker, recent contact with a COVID-19 case, recent travel, 0.5 times the recent local case detection rate, the presence of rhinorrhoea, cough or dyspnoea, and a combination of age and the presence of fever (SCRiPS Score, [Van Walraven 2021](#)). This type of score may be especially useful to safely rule out COVID-19, because it achieves a sensitivity that cannot be obtained by combining symptoms alone. For example, using this score, a 35-year old female healthcare worker without chest symptoms but with fever and rhinorrhoea,

who did not have contact with a COVID-19 case recently and who did not travel recently, would have a 1% chance of having COVID-19 if the local recent case detection rate was 5%. An 85-year old man with fever, without any other symptom, who did not travel recently but who did have a recent contact with a COVID-19 case, would have a 46% chance of having COVID-19 at the same local recent case detection rate of 5%. Of course, such a score should ideally be validated externally in other populations before being applied in practice.

The presence of upper respiratory symptoms such as a sore throat, rhinorrhoea or coryza, increases the probability of having an infectious disease other than COVID-19. In a hypothetical cohort of 1000 individuals, at a COVID-19 prevalence of 5%, 16 people with a sore throat would have COVID-19 and there would be 362 people with a sore throat without COVID-19 (false positives). Not using sore throat as an indication to test wouldn't necessarily lead to 16 people with COVID-19 being missed, as some of those individuals would present with other symptoms that would prompt further testing. We found similar figures for rhinorrhoea and coryza. There is currently no evidence to support further testing in all individuals presenting only with upper respiratory symptoms.

Selection bias is present when selective and non-random inclusion and exclusion of patients apply and the resulting association

differs in the selected study population compared to the eligible study population (Rutjes 2006). For the diagnosis of COVID-19, rapidly and constantly changing and widely variable test criteria have influenced who was referred for testing and who was not, both for the presence of infection and disease. Selection in the study of only a fraction of the eligible patients can result in a biased estimate of the true accuracy of the index test when measured against the reference standard and true disease status. Griffith 2020 have reported on the problematic presence of collider stratification bias in the published studies on COVID-19. Appropriate sampling strategies need to be applied to avoid conclusions of spurious relationships, more specific in our case the biased accuracy estimates of signs and symptoms for the diagnosis of both SARS-CoV-2 infection and COVID-19 disease. Selection of patients based on the presence of specific preset symptoms, such as fever and cough, leads to biased associations between these symptoms and to disease and diagnostic accuracy estimates that differ from their true values. The example of collider bias for cough is illustrated in Figure 30. Grouping studies by diagnostic criteria for selection might clarify this issue, but studies do not clearly describe them, with study authors referring to the guidelines in general that were applicable at the time.

**Figure 30. Collider bias**



Figure Directed Acyclic Graph (DAG): the symptom, ‘cough’ is used to enter the study for cough assessment. Both cough and COVID-19 pneumonia (D) result in ascertained diagnosis of SARS-CoV-2 infection (D\*). D\* is a collider on the pathway between cough and COVID-19 pneumonia leading to a biased association between the symptom cough and COVID-19 pneumonia.

Another form of selection bias is spectrum bias, where the patients included in the studies do not reflect the patient spectrum the index test will be applied to. The inclusion of hospitalised patients can

lead to such a bias, when the distribution of signs and symptoms differ in these patients and assessment with the reference standard is differential. In addition, the distribution and severity of

alternative diagnoses may be different in hospitalised populations than in patients presenting to ambulatory care settings. By focusing on prospective studies, spectrum bias was minimised in this review update, as all but two studies, that were performed in a mix of in- and outpatients from paediatric hospitals (Pokorska-Śpiewak 2021; Yonker 2020), were conducted in an outpatient setting.

The observed better sensitivity for cough (and lower specificity) compared to other index tests is unsurprising considering cough was a key feature of COVID-19 that was used in selecting patients for further testing in included studies. As a result, a large proportion of patients in these studies would have a cough, both cases and non-cases. The same applies to fever, for which we observed a large heterogeneity between studies. Some of this heterogeneity was reduced by selecting only studies with a low risk of bias in participant selection for the analyses, but a residual selection bias remained due to preselection based on the presence of fever. The way fever was determined (measured at presentation or self-reported by the patient) and the use of different cut-off levels for fever also contributed to this residual heterogeneity.

### Strengths and weaknesses of the review

Strengths of our review are the systematic and broad search performed to include all possible studies, to gather the largest number of peer-reviewed studies available at this point. Exclusion of retrospective studies, the largest number of the published cohorts of patients with COVID-19, from the data analyses limits the available data but improves the quality of the evidence.

The greatest weakness of the review is the risk of selection bias, as discussed above, with many studies selecting their participants based on the presence of fever or respiratory symptoms. Since individuals may or may not be tested on the basis of symptomatic presentation, this limitation is difficult to avoid completely.

Although we included all studies published until June 2021, all studies reported data from 2020 and over 90% of these data were collected in the first half of 2020. Consequently, no studies reported signs or symptoms of specific viral variants.

We need to assess multiple variables for their possible confounding effect on the summary estimates. Possible confounders include the presence of other respiratory pathogens (seasonality), the phase of the epidemic, exposure to high- versus low-prevalence setting, high or low exposure risk, comorbidity of the participants, or time since infection. Seasonality may influence specificity, because alternative diagnoses such as influenza or other respiratory viruses are more prevalent in winter, leading to more non-COVID-19 patients displaying symptoms such as cough or fever, decreasing specificity. In this version of the review, most studies were conducted during the winter or early spring seasons, suggesting this may still have been at play. However, social distancing policies have shortened this year's influenza season in several countries ([who.int/influenza/surveillance\\_monitoring/updates](http://who.int/influenza/surveillance_monitoring/updates)), which may have led to higher specificity for signs and symptoms than what we may expect in the next influenza season. In future updates of the review, we will explore seasonality effects if data allow. As for time since onset, given that the moment of infection is more likely than not an unrecognisable and unmeasurable variable, time since onset of symptoms can be used as a proxy. Reporting of studies, with presentation of the 2x2 table stratified by time since onset of disease, is informative and might have the potential to

increase accuracy of the signs and symptoms and their diagnostic differential potential.

### Applicability of findings to the review question

In comparison with previous updates, in which many studies included patients who had already been admitted to hospital or who presented to hospital settings with the intent to hospitalise, selection bias was reduced by focusing on prospective studies only. These studies were primarily conducted in outpatient settings, improving the applicability of our findings in comparison with previous review versions.

This review identified only three studies in children. The differences in diagnostic accuracy with adults depended on the type of symptom. The sensitivity of fever in children was higher than the summary estimate across all ages and its specificity was lower. Fever was much more common in children than in adults (higher positivity rate), but often indicated the presence of an infectious disease other than COVID-19 (high proportion of false positives). In contrast, we observed lower sensitivity and higher specificity for fatigue, headache and myalgia in children than in the population as a whole. Olfactory symptoms were investigated by very few studies in children.

Children have been disproportionately underrepresented in studies concerning the diagnosis of SARS-CoV-2 infection. Their absence seems related to the general mild presentation of the disease in the paediatric population and even more frequently the complete asymptomatic course. The full scope of disease presentation in children is however not known. It is important to identify signs and symptoms that can be used to clinically assess children with suspected SARS-CoV-2 infection, especially because non-specific presentations and fever without a source are already common in this age group. Children present as a heterogeneous group, having separate data for neonates, young infants, toddlers, school-aged children and adolescents is of value. Misclassification of children both at their presentation to the healthcare system and in the short term, where children will be asked to remain in quarantine when they present with predefined, but not yet evidence-based symptoms needs to be avoided to decrease the possible damage done to children's health.

Another important patient group that has been neglected in the literature is older adults. They are most at risk of a negative outcome of SARS-CoV-2 infection, especially mortality but also intensive care support. In this version of the review, only two overlapping studies (1 dataset) focused on adults aged 65 years or older. All other studies included adults of all ages and did not present results separately for the older age groups. The lack of a solid evidence base for the diagnosis of COVID-19 in older adults adds to the difficulty in diagnosing serious infections in this age group, in whom other serious infections such as bacterial pneumonia or urinary sepsis also tend to lead to non-specific presentations.

Studies specifically focusing on older adults or children may also enable us to estimate any difference in the diagnostic accuracy of signs and symptoms within these age groups. Given the distinct biological characteristics of children versus younger and versus older adults, these accuracy estimates are likely to be different in different age groups. The current presentation of overall summary estimates may therefore prove too simplistic.



## AUTHORS' CONCLUSIONS

### Implications for practice

The presence of some signs and symptoms may increase the probability of COVID-19 to an extent that is clinically relevant. Within the context of selection bias in most of the studies in this review, the presence of fever, cough, or anosmia/ageusia should be a reason for further testing for COVID-19.

Other symptoms, such as sore throat, rhinorrhoea or coryza, increase the probability of COVID-19 to a much lesser extent. Selecting patients for reverse transcription polymerase chain reaction (RT-PCR) testing based on these minor symptoms will result in large numbers of people who need to be tested and low positivity rates, making such testing strategies more cumbersome, expensive and less efficient.

However, if the main goal of a country's testing strategy remains to detect as many SARS-CoV-2-positive individuals as possible, denying further testing to people based on the absence of major (and even minor) symptoms will result in many missed cases.

In short, the diagnostic accuracy of symptoms for COVID-19 is moderate to low and any testing strategy using symptoms as selection mechanism will result in both large numbers of missed cases and large numbers of people requiring testing. Which one of these is minimised, is determined by the goal of COVID-19 testing strategies, that is, controlling the epidemic by isolating every possible case versus identifying those with clinically important disease so that they can be monitored or treated, or both, to optimise their prognosis. The former will require a testing strategy that uses very few symptoms as entry criterion for testing, the latter could focus on more specific symptoms such as fever and anosmia.

### Implications for research

Our review update reflects the need for a broader diagnostic approach than looking at signs or symptoms alone. Combinations with other, easy-to-obtain information such as patient demographics, the local case detection rate, recent contact with a SARS-CoV-2-positive patient, travel history of the patient, point-of-care test results, vaccination status, and others, may help safely rule out COVID-19 and should be investigated further. Vaccination leads to a reduced rate of asymptomatic infections ([Tande 2022](#)). Whether it also alters the clinical presentation of symptomatic COVID-19 patients is unclear at this time. New variants of the virus might also change the clinical presentation. Given the speed with which these variants emerge, it is difficult to provide up-to-date information from a systematic review regarding the diagnostic value of symptoms for COVID-19.

This review will therefore no longer be updated in its current form. Resources allowing, we will consider updating this review when sufficient studies of high methodological quality examining the combination of signs and symptoms with other clinically relevant information such as contact or travel history, or the local recent case detection rate become available. Another important outcome for future updates would be to investigate whether tests exist that identify people requiring respiratory support (SARS or ARDS) or intensive care.

Studies should report the definition of signs and symptoms more clearly, how they were measured, by whom and when. The

measurement of key symptoms such as anosmia and ageusia could benefit from standardisation, including the severity and nature of the loss of smell or taste. Yet such standardisation should not be overly complicated as signs and symptoms will typically be used by frontline clinicians who will incorporate these in their more holistic assessment of the patient, which includes more than just diagnosis of COVID-19.

Future studies should also include a broader spectrum of patients with studies in the primary healthcare setting to properly evaluate the diagnostic accuracy of signs and symptoms in this setting. Studies aimed at screening for SARS-CoV-2 infections should also be included, as an increased need for screening is to be expected with the relaxation of quarantine measures. Finally, data are needed on specific patient groups with comorbidities with a higher risk of complications or serious illness and a greater impact of missing early diagnosis of SARS-CoV-2 infection, and the paediatric and elderly population should be added.

We would like to recommend that authors adhere to the STARD guidelines when reporting new studies on this topic ([Bossuyt 2015](#)).

## ACKNOWLEDGEMENTS

Members of the Cochrane COVID-19 Diagnostic Test Accuracy Review Group include the following.

- The project team (Deeks JJ, Dinnes J, Takwoingi Y, Davenport C, Leeflang MMG, Spijker R, Hooft L, Van den Bruel A, McInnes MDF, Emperador D, Dittrich S)
- The systematic review teams for each review:
  - molecular, antigen, and antibody tests (Adriano A, Beese S, Dretzke J, Ferrante di Ruffano L, Harris I, Price M, Taylor-Phillips S);
  - signs and symptoms (Struyf T, Domen J, Horn S, Lannoy V, Wickramasinghe D, Janssens S, Tans A);
  - routine laboratory markers (Yang B, Langendam M, Ochodo E, Guleid F, Holtman G, Verbakel J, Wang J, Stegeman I);
  - imaging tests (Salameh JP, McGrath TA, van der Pol CB, Frank RA, Prager R, Hare SS, Dennie C, Jenniskens K, Korevaar DA, Cohen JF, Van de Wijgert J, Damen JAAG, Wang J).
- The wider team of systematic reviewers from University of Birmingham, UK who assisted with title and abstract screening across the entire suite of reviews for the diagnosis of COVID-19 (Agarwal R, Baldwin S, Berhane S, Herd C, Kristunas C, Quinn L, Scholefield B): see [Deeks 2020a](#); [Dinnes 2021](#); [Islam 2021](#); [Stegeman 2020](#)).

Jonathan Deeks is a UK National Institute for Health Research (NIHR) Senior Investigator Emeritus. Yemisi Takwoingi is supported by a NIHR Postdoctoral Fellowship. Jonathan Deeks, Jacqueline Dinnes, Yemisi Takwoingi, Clare Davenport and Malcolm Price are supported by the NIHR Birmingham Biomedical Research Centre. This paper presents independent research supported by the NIHR Birmingham Biomedical Research Centre at the University Hospitals Birmingham NHS Foundation Trust and the University of Birmingham. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care.

We thank Dr Jane Cunningham (World Health Organization) for participation in technical discussions and comments on the review.

Cochrane Infectious Diseases supported the review authors in the development of this second update. The Cochrane Infectious Diseases' editorial base is funded by UK aid from the UK government for the benefit of low- and middle-income countries (project number 300342-104). The views expressed do not necessarily reflect the UK government's official policies.

The following people conducted the editorial process for this review update.

- Sign-off Editor (final editorial decision): Michael Brown, Michigan State University College of Human Medicine, USA
- Managing Editor (selected peer reviewers, collated peer-reviewer comments, provided editorial guidance to authors, edited the update): Joey Kwong, Cochrane Evidence Production & Methods Directorate
- Editorial Assistant (conducted editorial policy checks and supported editorial team): Leticia Rodrigues, Cochrane Evidence Production & Methods Directorate
- Copy Editor (copy-editing and production): Denise Mitchell, Cochrane Copy Edit Support
- Peer-reviewers (provided comments and recommended an editorial decision): Brendan Delaney, Imperial College London (clinical review); Lao-Tzu Allan-Blitz, Division Global Health Equity: Department of Medicine, Brigham and Women's Hospital Department of Pediatrics, Boston Children's Hospital (clinical review); Paul Garner, Liverpool School of Tropical Medicine (clinical review)\*; Jenny Negus (consumer review); Lynda Ware, Cochrane UK (summary versions review); Gianni Virgili and Tanya Walsh, Cochrane Diagnostic Test Accuracy Reviews Editorial Team (methods review); Robin Featherstone, Cochrane Evidence Production & Methods Directorate (search review).  
\*Paul Garner is a member of Cochrane Infectious Diseases and provided peer-review comments on this update, but was not otherwise involved in the editorial process or decision making. One additional peer reviewer provided clinical peer review but chose not to be publicly acknowledged.



## REFERENCES

## References to studies included in this review

**Ahmed 2021** {published data only}

Ahmed SM, Shah RU, Fernandez V, Grineski S, Brintz B, Samore MH, et al. Robust testing in outpatient settings to explore COVID-19 epidemiology: disparities in race/ethnicity and age, Salt Lake County, Utah, 2020. *Public Health Reports* 2021;**136**(3):345-53. [DOI: [10.1177/0033354920988612](https://doi.org/10.1177/0033354920988612)]

**Aldobyany 2020** {published data only}

Aldobyany A, Touman A, Ghaleb N, Alsaggaf R, Murtaza N, Hamada A, et al. Correlation between the COVID-19 Respiratory Triage Score and SARS-CoV-2 PCR test. *Frontiers in Medicine* 2020;**7**(903):605689. [DOI: [10.3389/fmed.2020.605689](https://doi.org/10.3389/fmed.2020.605689)]

**Alizadehsani 2021** {published data only}

Alizadehsani R, Alizadeh SZ, Behjati M, Roshanzamir Z, Hussain S, Abedini N, et al. Risk factors prediction, clinical outcomes, and mortality in COVID-19 patients. *Journal of Medical Virology* 2021;**93**(4):2307-20. [DOI: [10.1002/jmv.26699](https://doi.org/10.1002/jmv.26699)]

**Allegorico 2020** {published data only}

Allegorico E, Buonerba C, Bosso G, Pagano A, Porta G, Serra C, et al. The use of chest ultrasonography in suspected cases of COVID-19 in the emergency department. *Future Science OA* 2020;**7**(1):Fso635. [DOI: [10.2144/fsoa-2020-0127](https://doi.org/10.2144/fsoa-2020-0127)]

**Arenas 2020** {published data only}

Arenas MD, Crespo M, Perez-Saez MJ, Collado S, Redondo-Pachón D, Llinàs-Mallol L, et al. Clinical profiles in renal patients with COVID-19. *Journal of Clinical Medicine* 2020;**9**(8):2665. [DOI: [10.3390/jcm9082665](https://doi.org/10.3390/jcm9082665)]

**Arslan 2021** {published data only}

Arslan G, Aktürk H, Duman M. Clinical characteristics of pediatric COVID-19 and predictors of PCR positivity. *Pediatrics International* 2021;**63**(9):1055-1061. [DOI: [10.1111/ped.14602](https://doi.org/10.1111/ped.14602)]

**Barbhaya 2021** {published data only}

Barbhaya D, Franco S, Gandhi K, Arya R, Neupane R, Foroughi N, et al. Characteristics and outcomes of COVID-19 infection from an urban ambulatory COVID-19 clinic-guidance for outpatient clinicians in triaging patients. *Journal of Primary Care & Community Health* 2021;**12**:21501327211017016. [DOI: [10.1177/21501327211017016](https://doi.org/10.1177/21501327211017016)]

**Bhattacharya 2021** {published data only}

Bhattacharya A, Ranjan P, Kumar A, Brijwal M, Pandey R M, Mahishi N, et al. Development and validation of a clinical symptom-based scoring system for diagnostic evaluation of COVID-19 patients presenting to outpatient department in a pandemic situation. *Cureus* 2021;**13**(3):e13681. [DOI: [10.7759/cureus.13681](https://doi.org/10.7759/cureus.13681)]

**Bouid 2020** {published data only}

Bouid D, Mullaert J, Le Hingrat Q, Laurent O, Duval X, Lescure X, et al. Characteristics associated with COVID-19 or other respiratory viruses' infections at a single-center emergency

department. *PLoS One* 2020;**15**(12):e0243261. [DOI: [10.1371/journal.pone.0243261](https://doi.org/10.1371/journal.pone.0243261)]

**Brendish 2020** {published data only}

Brendish NJ, Poole S, Naidu VV, Mansbridge CT, Norton N, Borca F, et al. Clinical characteristics, symptoms and outcomes of 1054 adults presenting to hospital with suspected COVID-19: a comparison of patients with and without SARS-CoV-2 infection. *Journal of Infection* 2020;**81**(6):937-43. [DOI: [10.1016/j.jinf.2020.09.033](https://doi.org/10.1016/j.jinf.2020.09.033)]

**Buonafine 2020** {published data only}

Buonafine CP, Paiatto BN, Leal FB, de Matos SF, de Moraes CO, Guerra GG, et al. High prevalence of SARS-CoV-2 infection among symptomatic healthcare workers in a large university tertiary hospital in São Paulo, Brazil. *BMC Infectious Diseases* 2020;**20**(1):917. [DOI: [10.1186/s12879-020-05662-8](https://doi.org/10.1186/s12879-020-05662-8)]

**Chan 2021** {published data only}

Chan J, Burke K, Bedard R, Grigg J, Winters J, Vessell C, et al. COVID-19 in the New York City jail system: epidemiology and health care response, March-April 2020. *Public Health Reports* 2021;**136**(3):375-83. [DOI: [10.1177/0033354921999385](https://doi.org/10.1177/0033354921999385)]

**Cheng 2020** {published data only}

Cheng Z, Lu Y, Cao Q, Qin L, Pan Z, Yan F, et al. Clinical features and chest CT manifestations of coronavirus disease 2019 (COVID-19) in a single-center study in Shanghai, China. *American Journal of Roentgenology* 2020;**215**(1):121-6. [DOI: [10.2214/AJR.20.22959](https://doi.org/10.2214/AJR.20.22959)]

**Chew 2021** {published data only}

Chew WM, Loh CH, Jalali A, Fong GS, Senthil Kumar L, Sim RH, et al. A risk prediction score to identify patients at low risk for COVID-19 infection. *Singapore Medical Journal* 2021 Mar 12 [Epub ahead of print]. [DOI: [10.11622/smedj.2021019](https://doi.org/10.11622/smedj.2021019)]

**Chua 2020** {published data only}

Chua AJ, Chan EC, Loh J, Choong Charn T. Acute olfactory loss is specific for COVID-19 at the emergency department. *Annals of Emergency Medicine* 2020;**76**(4):550-1.

**Chung 2021** {published data only}

Chung JR, Kim SS, Jackson ML, Jackson LA, Belongia EA, King JP, et al. Clinical symptoms among ambulatory patients tested for SARS-CoV-2. *Open Forum Infectious Diseases* 2021;**8**(1):ofaa576. [DOI: [10.1093/ofid/ofaa576](https://doi.org/10.1093/ofid/ofaa576)]

**Clemency 2020** {published data only}

Clemency BM, Varughese R, Scheafer DK, Ludwig B, Welch JV, McCormack RF, et al. Symptom criteria for COVID-19 testing of health care workers. *Academic Emergency Medicine* 2020;**27**(6):469-74.

**Clifford 2020** {published data only}

Clifford CT, Pour TR, Freeman R, Reich DL, Glicksberg BS, Levin MA, et al. Association between COVID-19 diagnosis and presenting chief complaint from New York City triage data.

*American Journal of Emergency Medicine* 2020;**46**:520-4. [DOI: [10.1016/j.ajem.2020.11.006](https://doi.org/10.1016/j.ajem.2020.11.006)]

**Cunarro-Lopez 2020** {published data only}

Cuñarro-López Y, Cano-Valderrama Ó, Pintado-Recarte P, Cueto-Hernández I, González-Garzón B, García-Tizón S, et al. Maternal and perinatal outcomes in patients with suspected COVID-19 and their relationship with a negative RT-PCR result. *Journal of Clinical Medicine* 2020;**9**(11):3552. [DOI: [10.3390/jcm9113552](https://doi.org/10.3390/jcm9113552)]

**Drager 2020** {published data only}

Drager S, Kather A, Fricke M, de With K. Corona outpatient clinic at Dresden university hospital: clinical characteristics of SARS-CoV-2 tested patients. *Zeitschrift für Allgemeinmedizin* 2020;**96**(9):343-7. [DOI: [10.3238/zfa.2020.0343-0347](https://doi.org/10.3238/zfa.2020.0343-0347)]

**Feng 2021** {published data only}

Feng C, Wang L, Chen X, Zhai Y, Zhu F, Chen H, et al. A novel artificial intelligence-assisted triage tool to aid in the diagnosis of suspected COVID-19 pneumonia cases in fever clinics. *Annals of Translational Medicine* 2021;**9**(3):201. [DOI: [10.21037/atm-20-3073](https://doi.org/10.21037/atm-20-3073)]

**Fiel-Ozores 2021** {published data only}

Fiel-Ozores A, González-Durán ML, Novoa-Carballal R, Portugués-de la Red MD, Fernández-Pinilla I, Cabrera-Alvargonzález JJ, et al. Differential clinic in children infected by SARS-CoV-2, traceability of contacts and cost-effectiveness of diagnostic tests: cross-sectional observational study [Clínica diferencial en niños infectados por SARS-CoV-2, trazabilidad de contactos y rentabilidad de pruebas diagnósticas: estudio observacional transversal]. *Anales de Pediatría (English Edition)* 2021;**94**(5):318-26. [DOI: [10.1016/j.anpedi.2020.12.001](https://doi.org/10.1016/j.anpedi.2020.12.001)]

**Fink 2021** {published data only}

Fink N, Rueckel J, Kaestle S, Schwarze V, Gresser E, Hoppe B, et al. Evaluation of patients with respiratory infections during the first pandemic wave in Germany: characteristics of COVID-19 versus non-COVID-19 patients. *BMC Infectious Diseases* 2021;**21**(1):167. [DOI: [10.1186/s12879-021-05829-x](https://doi.org/10.1186/s12879-021-05829-x)]

**Gilbert 2020** {published data only}

Gilbert A, Brasseur E, Petit M, Donneau AF, Diep AN, Hetzel Campbell S, et al. Immersion in an emergency department triage center during the COVID-19 outbreak: first report of the Liège University hospital experience. *Acta Clinica Belgica* 2020 Jun 12 [Epub ahead of print]. [DOI: [10.1080/17843286.2020.1778348](https://doi.org/10.1080/17843286.2020.1778348)]

**Haehner 2020** {published data only}

Haehner A, Draef J, Draeger S, de With K, Hummel T. Predictive value of sudden olfactory loss in the diagnosis of COVID-19. *Karger* 2020;**82**(4):175-80. [DOI: [10.1159/000509143](https://doi.org/10.1159/000509143)]

**Haliga 2021** {published data only}

Haliga RE, Sorodoc V, Lionte C, Petris OR, Bologa C, Coman AE, et al. Acute clinical syndromes and suspicion of SARS-CoV-2 infection: the experience of a single Romanian center in the early pandemic period. *Medicina (Kaunas)* 2021;**57**(2):121. [DOI: [10.3390/medicina57020121](https://doi.org/10.3390/medicina57020121)]

**Huang 2020** {published data only}

Huang D, Wang T, Chen Z, Yang H, Yao R, Liang Z. A novel risk score to predict diagnosis with coronavirus disease 2019 (COVID-19) in suspected patients: a retrospective, multicenter, and observational study. *Journal of Medical Virology* 2020;**92**(11):2709-17.

**Hüfner 2020** {published data only}

Hüfner A, Kiefl D, Baacke M, Zöllner R, Loza Mencía, Schellein O, et al. Risk stratification through implementation and evaluation of a COVID-19 score: a retrospective diagnostic study [Risikostratifizierung durch Implementierung und Evaluation eines COVID-19-Scores]. *Medizinische Klinik - Intensivmedizin und Notfallmedizin* 2020;**115** Suppl 3:132-8. [DOI: [10.1007/s00063-020-00754-4](https://doi.org/10.1007/s00063-020-00754-4)]

**Ide 2021** {published data only}

Ide S, Hayakawa K, Yamamoto K, Tsuzuki S, Tanuma J, Ohara K, et al. Positive ratio of polymerase chain reaction (PCR) and validity of pre-screening criteria at an outpatient screening center during the early phase of the COVID-19 epidemic in Japan. *Japanese Journal of Infectious Diseases* 2021;**74**(5):481-6. [DOI: [10.7883/yoken.JJID.2020.813](https://doi.org/10.7883/yoken.JJID.2020.813)]

**Ishii 2021** {published data only}

Ishii T, Kushimoto S, Katori Y, Kure S, Igarashi K, Fujita M, et al. Predictors of SARS-CoV-2 positivity based on RT-PCR swab tests at a drive-through outpatient clinic for COVID-19 screening in Japan. *Tohoku Journal of Experimental Medicine* 2021;**253**(2):101-8. [DOI: [10.1620/tjem.253.101](https://doi.org/10.1620/tjem.253.101)]

**Jeyashree 2021** {published data only}

Jeyashree K, Raju M, Ponnaiah M, Muthappan S, Rozario AG, Raichel R, et al. Self-reported and clinically identified loss of smell and taste among persons tested for COVID-19 in Chennai, southern India, July-August 2020: a cross sectional study. *Clinical Epidemiology and Global Health* 2021;**11**:100718. [DOI: [10.1016/j.cegh.2021.100718](https://doi.org/10.1016/j.cegh.2021.100718)]

**Just 2020** {published data only}

Just J, Puth M-T, Regenold F, Weckbecker K, Bleckwenn M. Risk factors for a positive SARS-CoV-2 PCR in patients with common cold symptoms in a primary care setting - a retrospective analysis based on a joint documentation standard. *BMC Family Practice* 2020;**21**(1):251. [DOI: [doi.org/10.1186/s12875-020-01322-7](https://doi.org/10.1186/s12875-020-01322-7)]

**Kalayjian 2020** {published data only}

Kalayjian BC, Conner K, Butler I, Myers L, Telleria C, Panchang D, et al. Race, heart rate, and temperature are strongly associated with COVID-19 at a community-based clinic in New Orleans. *Mayo Clinic Proceedings: Innovations, Quality & Outcomes* 2020;**4**(6):683-6. [DOI: [doi.org/10.1016/j.mayocpiqo.2020.07.005](https://doi.org/10.1016/j.mayocpiqo.2020.07.005)]

**Kelen 2021** {published data only}

Kelen GD, Swedien D, Hansen J, Klein E, Peterson S, Saheed M, et al. Characterization and impact of COVID-19-tested and infected patients: experience of The Johns Hopkins Health System regional emergency departments. *Journal*

of the American College of Emergency Physicians Open 2021;**2**(1):e12321. [DOI: [10.1002/emp2.12321](https://doi.org/10.1002/emp2.12321)]

**Kempker 2020** {published data only}

Kempker RR, Kempker JA, Peters M, Rebolledo PA, Carroll K, Toomer L, et al. Loss of smell and taste among healthcare personnel screened for coronavirus 2019. *Clinical Infectious Diseases* 2021;**72**(7):1244-6. [DOI: [10.1093/cid/ciaa877](https://doi.org/10.1093/cid/ciaa877)]

**Kim 2020** {published data only}

Kim C, Yeo IH, Kim JK, Cho Y, Lee MJ, Jung H, et al. Confirmation of COVID-19 in out-of-hospital cardiac arrest patients and postmortem management in the emergency department during the COVID-19 outbreak. *Infection & Chemotherapy* 2020;**52**(4):562-72. [DOI: [10.3947/ic.2020.52.4.562](https://doi.org/10.3947/ic.2020.52.4.562)]

**King 2020** {published data only}

King JA, Whitten TA, Bakal JA, McAlister FA. Symptoms associated with a positive result for a swab for SARS-CoV-2 infection among children in Alberta. *CMAJ* 2020;**193**(1):E1-9. [DOI: [10.1503/cmaj.202065](https://doi.org/10.1503/cmaj.202065)]

**Krastinova 2020** {published data only}

Krastinova E, Garrat V, Lecam MT, Coste A, Varon E, Delacroix I, et al. Household transmission and incidence of positive SARS-CoV-2 RT-PCR in symptomatic healthcare workers, clinical course and outcome: a French hospital experience. *Occupational and Environmental Medicine* 2020;**78**(7):479-85. [DOI: [10.1136/oemed-2020-106866](https://doi.org/10.1136/oemed-2020-106866)]

**Langer 2020** {published data only}

Langer T, Favarato M, Giudici R, Bassi G, Garberi R, Villa F, et al. Development of machine learning models to predict RT-PCR results for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in patients with influenza-like symptoms using only basic clinical data. *Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine* 2020;**28**(1):113. [DOI: [10.1186/s13049-020-00808-8](https://doi.org/10.1186/s13049-020-00808-8)]

**Lazzerini 2021** {published data only}

Lazzerini M, Sforzi I, Trapani S, Biban P, Silvagni D, Villa G, et al. Characteristics and risk factors for SARS-CoV-2 in children tested in the early phase of the pandemic: a cross-sectional study, Italy, 23 February to 24 May 2020. *Eurosurveillance* 2021;**26**(14):2001248. [DOI: [10.2807/1560-7917.ES.2021.26.14.2001248](https://doi.org/10.2807/1560-7917.ES.2021.26.14.2001248)]

**Leal 2020** {published data only}

Leal FE, Mendes-Correa MC, Buss LF, Costa SF, Bizario JC, de Souza SR, et al. Clinical features and natural history of the first 2073 suspected COVID-19 cases in the Corona São Caetano primary care programme: a prospective cohort study. *BMJ Open* 2021;**11**(1):e042745. [DOI: [doi.org/10.1136/bmjopen-2020-042745](https://doi.org/10.1136/bmjopen-2020-042745)]

**Leung 2021** {published data only}

Leung WL, Yu EL, Wong SC, Leung M, Lee LL, Chung KL, et al. Findings from the first public COVID-19 temporary test centre in Hong Kong. *Hong Kong Medical Journal* 2021;**27**(2):99-105. [DOI: [10.12809/hkmj208909](https://doi.org/10.12809/hkmj208909)]

**Maechler 2020** {published data only}

Maechler F, Gertler M, Hermes J, Van Loon W, Schwab F, Piening B, et al. Epidemiological and clinical characteristics of SARS-CoV-2 infections at a testing site in Berlin, Germany, March and April 2020—a cross-sectional study. *Clinical Microbiology and Infection* 2020;**26**(12):1685.e7-12. [DOI: [10.1016/j.cmi.2020.08.017](https://doi.org/10.1016/j.cmi.2020.08.017)]

**Mansella 2020** {published data only}

Mansella G, Rueegg M, Widmer AF, Tschudin-Sutter S, Battagay M, Hoff J, et al. COVID-19 triage and test center: safety, feasibility, and outcomes of low-threshold testing. *Journal of Clinical Medicine* 2020;**9**(10):3217. [DOI: [10.3390/jcm9103217](https://doi.org/10.3390/jcm9103217)]

**Mao 2020** {published data only}

Mao B, Liu Y, Chai YH, Jin XY, Lu HW, Yang JW, et al. Assessing risk factors for SARS-CoV-2 infection in patients presenting with symptoms in Shanghai, China: a multicentre, observational cohort study. *Lancet Digital Health* 2020;**2**(6):e323-30.

**Martín-Sánchez 2020** {published data only}

Martín-Sánchez FJ, González Del Castillo J, Valls Carbó A, López Picado A, Martínez-Valero C, Miranda JD, et al. Diagnostic groups and short-term outcomes in suspected COVID-19 cases treated in an emergency department [Categorías diagnósticas y resultados a corto plazo en los pacientes con sospecha de COVID-19 atendidos en un servicio de urgencias]. *Emergencias* 2020;**32**(4):242-52. [1137-6821]

**Martin-Sanz 2020** {published data only}

Martin-Sanz E, Riestra J, Yebra L, Larran A, Mancino F, Yanes-Diaz J, et al. Prospective study in 355 patients with suspected COVID-19 infection: value of cough, subjective hyposmia, and hypogeusia. *Laryngoscope* 2020;**130**(11):2674-9. [DOI: [10.1002/lary.28999](https://doi.org/10.1002/lary.28999)]

**Nazerian 2021** {published data only}

Nazerian P, Morello F, Prota A, Betti L, Lupia E, Apruzzese L, et al. Diagnostic accuracy of physician's gestalt in suspected COVID-19. Prospective bicentric study. *Academic Emergency Medicine* 2021;**28**(4):404-11. [DOI: [10.1111/acem.14232](https://doi.org/10.1111/acem.14232)]

**Nitecki 2021** {published data only}

Nitecki M, Taran B, Ketko I, Geva G, Yosef R, Toledo I, et al. Self-reported symptoms in healthy young adults to predict potential COVID-19 disease. *Clinical Microbiology and Infection* 2021;**27**(4):618-23. [DOI: [10.1016/j.cmi.2020.12.028](https://doi.org/10.1016/j.cmi.2020.12.028)]

**O'Reilly 2020a** {published data only}

O'Reilly GM, Mitchell RD, Rajiv P, Wu J, Brennecke H, Brichko L, et al. Epidemiology and clinical features of emergency department patients with suspected COVID-19: initial results from the COVID-19 Emergency Department Quality Improvement Project (COVED-1). *Emergency Medicine Australasia* 2020;**32**(4):638-45.

**O'Reilly 2020b** {published data only}

O'Reilly GM, Mitchell RD, Mitra B, Akhlaghi H, Tran V, Furyk JS, et al. Epidemiology and clinical features of emergency department patients with suspected and confirmed COVID-19: a multisite report from the COVID-19 Emergency Department



Quality Improvement Project for July 2020 (COVID-3). *Emergency Medicine Australasia* 2020;**33**(1):114-24. [DOI: [10.1111/1742-6723.13651](https://doi.org/10.1111/1742-6723.13651)]

**Olivar Lopez 2020** {published data only}

Olivar-Lopez V, Leyva-Barrera A, Lopez-Martinez B, Parra-Ortega I, Marquez-Gonzalez H. Clinical risk profile associated with SARS-CoV-2 infection and complications in the emergency area of a pediatric COVID-19 center. *Boletín Médico del Hospital Infantil de México* 2020;**77**(5):221-7. [DOI: [10.24875/BMHIM.20000198](https://doi.org/10.24875/BMHIM.20000198)]

**Peng 2020** {published data only}

Peng L, Liu KY, Xue F, Miao YF, Tu PA, Zhou C. Improved early recognition of coronavirus disease-2019 (COVID-19): single-center data from a Shanghai screening hospital. *Archives of Iranian Medicine* 2020;**23**(4):272-6.

**Peyrony 2020** {published data only}

Peyrony O, Marbeuf-Gueye C, Truong V, Giroud M, Rivière C, Khenissi K, et al. Accuracy of emergency department clinical findings for diagnosis of coronavirus disease 2019. *Annals of Emergency Medicine* 2020;**76**(4):405-12.

**Pisapia 2020** {published data only}

Pisapia R, Pisaturo M, Fusco FM, Parrella G, Iodice V, Tambaro O, et al. Differences among confirmed and not-confirmed COVID-19 patients at "D. Cotugno" hospital, Naples (Italy): what we learned from first suspected cases? *Infezioni in Medicina* 2020;**28** Suppl 1:84-8.

**Pivetta 2020** {published data only}

Pivetta E, Goffi A, Tizzani M, Locatelli SM, Porrino G, Losano I, et al. Lung ultrasonography for the diagnosis of SARS-CoV-2 pneumonia in the emergency department. *Annals of Emergency Medicine* 2020;**77**(4):385-94. [DOI: [10.1016/j.annemergmed.2020.10.008](https://doi.org/10.1016/j.annemergmed.2020.10.008)]

**Pokorska-Śpiewak 2021** {published data only}

Pokorska-Śpiewak M, Talarek E, Popielska J, Nowicka K, Otdakowska A, Zawadka K, et al. Comparison of clinical severity and epidemiological spectrum between coronavirus disease 2019 and influenza in children. *Scientific Reports* 2021;**11**(1):5760. [DOI: [10.1038/s41598-021-85340-0](https://doi.org/10.1038/s41598-021-85340-0)]

**Porto 2021** {published data only}

Porto LC, Costa CH, Nunes AS, Bouzas I, Ferreira TF, Porto VM, et al. Clinical and laboratory characteristics in outpatient diagnosis of COVID-19 in healthcare professionals in Rio de Janeiro, Brazil. *Journal of Clinical Pathology* 2021 Feb 10 [Epub ahead of print]. [DOI: [10.1136/jclinpath-2020-206797](https://doi.org/10.1136/jclinpath-2020-206797)]

**Raberahona 2020** {published data only}

Raberahona M, Rakotomalala R, Rakotomijoro E, Rahaingoalidera T, Andry CE, Mamilaza N, et al. Clinical and epidemiological features discriminating confirmed COVID-19 patients from SARS-CoV-2 negative patients at screening centres in Madagascar. *International Journal of Infectious Diseases* 2020;**103**:6-8. [DOI: [10.1016/j.ijid.2020.11.151](https://doi.org/10.1016/j.ijid.2020.11.151)]

**Romero-Gameros 2020** {published data only}

Romero-Gameros CA, Waizel-Haiat S, Mendoza-Zubieta V, Anaya-Dyck A, López-Moreno MA, Colin-Martinez T, et al. Evaluation of predictive value of olfactory dysfunction, as a screening tool for COVID-19. *Laryngoscope Investigative Otolaryngology* 2020;**5**(6):983-91. [DOI: [10.1002/lio2.482](https://doi.org/10.1002/lio2.482)]

**Romero-Gameros 2021** {published data only}

Romero-Gameros CA, Colin-Martínez T, Waizel-Haiat S, Vargas-Ortega G, Ferat-Osorio E, Guerrero-Paz JA, et al. Diagnostic accuracy of symptoms as a diagnostic tool for SARS-CoV 2 infection: a cross-sectional study in a cohort of 2,173 patients. *BMC Infectious Diseases* 2021;**21**(1):255. [DOI: [10.1186/s12879-021-05930-1](https://doi.org/10.1186/s12879-021-05930-1)]

**Rutten 2020a** {published data only}

Rutten JS, Van Loon AM, Joling KJ, Smalbrugge M, Van Buul LW, Hertogh CM. COVID-19 in verpleeghuizen. Een studie naar diagnostiek, ziektepresentatie en ziektebeloop. *Nederlands Tijdschrift voor Geneeskunde* 2020;**164**:D5173. [ntvg.nl/D5173]

**Rutten 2020b** {published data only}

Rutten JJS, Van Loon AM, Van Kooten J, Van Buul LW, Joling KJ, Smalbrugge M, et al. Clinical suspicion of COVID-19 in nursing home residents: symptoms and mortality risk factors. *Journal of the American Medical Directors Association* 2020;**21**(12):1791-7.e1. [DOI: [10.1016/j.jamda.2020.10.034](https://doi.org/10.1016/j.jamda.2020.10.034)]

**Sacks 2020** {published data only}

Sacks CA, Dougan M, McCoy TH Jr, Zheng A, Buonomo G, North CM, et al. The association between symptoms and COVID-19 test results among healthcare workers. *Annals of Surgery* 2020;**272**(6):e329-32. [DOI: [10.1097/SLA.0000000000004483](https://doi.org/10.1097/SLA.0000000000004483)]

**Saegerman 2021** {published data only}

Saegerman C, Gilbert A, Donneau AF, Gangolf M, Diep AN, Meex C, et al. Clinical decision support tool for diagnosis of COVID-19 in hospitals. *PLoS One* 2021;**16**(3):e0247773. [DOI: [10.1371/journal.pone.0247773](https://doi.org/10.1371/journal.pone.0247773)]

**Salmon Ceron 2020** {published data only}

Salmon Ceron D, Bartier S, Hautefort C, Nguyen Y, Nevoux J, Hamel AL, et al. Self-reported loss of smell without nasal obstruction to identify COVID-19. The multicenter Coronosmia cohort study. *Journal of Infection* 2020;**81**(4):614-20.

**Shah 2020** {published data only}

Shah SJ, Barish PN, Prasad PA, Kistler AL, Neff N, Kamm J, et al. Clinical features, diagnostics, and outcomes of patients presenting with acute respiratory illness: a retrospective cohort study of patients with and without COVID-19. *eClinicalMedicine* 2020;**27**:100518. [DOI: [10.1016/j.eclinm.2020.100518](https://doi.org/10.1016/j.eclinm.2020.100518)]

**Simpson 2020** {published data only}

Simpson JN, Goyal MK, Cohen JS, Badolato GM, McGuire M, Ralph A, et al. Results of testing children for SARS-CoV-2 through a community-based testing site. *Journal of Pediatrics* 2020;**231**:157-61.e1. [DOI: [10.1016/j.jpeds.2020.12.030](https://doi.org/10.1016/j.jpeds.2020.12.030)]

**Sonoda 2021** {published data only}

Sonoda S, Kuramochi J, Matsuyama Y, Miyazaki Y, Fujiwara T. Validity of clinical symptoms score to discriminate patients with COVID-19 from common cold out-patients in general practitioner clinics in Japan. *Journal of Clinical Medicine* 2021;**10**(4):854. [DOI: [10.3390/jcm10040854](https://doi.org/10.3390/jcm10040854)]

**Sun 2020** {published data only}

Sun Y, Koh V, Marimuthu K, Ng OT, Young B, Vasoo S, et al. Epidemiological and clinical predictors of COVID-19. *Clinical Infectious Diseases* 2020;**71**(15):786-92. [DOI: [10.1093/cid/ciaa322](https://doi.org/10.1093/cid/ciaa322)]

**Tan 2021** {published data only}

Tan JY, Sim XY, Wee LE, Chua YY, Cherng BP, Ng IM, et al. A comparative study on the clinical features of COVID-19 with non-SARS-CoV-2 respiratory viral infections. *Journal of Medical Virology* 2021;**93**(3):1548-55. [DOI: [doi.org/10.1002/jmv.26486](https://doi.org/10.1002/jmv.26486)]

**Tolia 2020** {published data only}

Tolia VM, Chan TC, Castillo EM. Preliminary results of initial testing for coronavirus (COVID-19) in the emergency department. *Western Journal of Emergency Medicine* 2020;**21**(3):503-6.

**Tordjman 2020** {published data only}

Tordjman M, Mekki A, Mali RD, Saab I, Chassagnon G, Guillo E, et al. Pre-test probability for SARS-CoV-2-related infection score: the PARIS score. *PLoS ONE* 2020;**15**(12):e0243342. [DOI: [doi.org/10.1371/journal.pone.0243342](https://doi.org/10.1371/journal.pone.0243342)]

**Trubiano 2020** {published data only}

Trubiano JA, Vogrin S, Smibert OC, Marhoon N, Alexander AA, Chua KY, et al. COVID-MATCH65 - a prospectively derived clinical decision rule for severe acute respiratory syndrome coronavirus 2. *PLoS One* 2020;**15**(12):e0243414. [DOI: [doi.org/10.1371/journal.pone.0243414](https://doi.org/10.1371/journal.pone.0243414)]

**Tudrej 2020** {published data only}

Tudrej B, Sebo P, Lourdaux J, Cuzin C, Floquet M, Haller DM, et al. Self-reported loss of smell and taste in SARS-CoV-2 patients: primary care data to guide future early detection strategies. *Journal of General Internal Medicine* 2020;**35**(8):2502-4.

**Van Loon 2021** {published data only}

Van Loon N, Verbrugge M, Cartuyvels R, Ramaekers D. Diagnosis of COVID-19 based on symptomatic analysis of hospital healthcare workers in Belgium: observational study in a large Belgian tertiary care center during early COVID-19 outbreak. *Journal of Occupational and Environmental Medicine* 2021;**63**(1):27-31. [DOI: [10.1097/JOM.0000000000002015](https://doi.org/10.1097/JOM.0000000000002015)]

**Van Walraven 2021** {published data only}

Van Walraven C, Manuel DG, Desjardins M, Forster AJ. Derivation and internal validation of a model to predict the probability of severe acute respiratory syndrome coronavirus-2 infection in community people. *Journal of General Internal Medicine* 2021;**36**(1):162-9. [DOI: [10.1007/s11606-020-06307-x](https://doi.org/10.1007/s11606-020-06307-x)]

**Vieceli 2020** {published data only}

Vieceli T, Oliveira Filho CM, Berger M, Saadi MP, Salvador PA, Anizelli LB, et al. A predictive score for COVID-19 diagnosis using clinical, laboratory and chest image data. *Brazilian Journal of Infectious Diseases* 2020;**24**(4):343-8. [DOI: [10.1016/j.bjid.2020.06.009](https://doi.org/10.1016/j.bjid.2020.06.009)]

**Vilke 2020** {published data only}

Vilke GM, Brennan JJ, Cronin AO, Castillo EM. Clinical features of patients with COVID-19: is temperature screening useful? *Journal of Emergency Medicine* 2020;**59**(6):952-6. [DOI: [10.1016/j.jemermed.2020.09.048](https://doi.org/10.1016/j.jemermed.2020.09.048)]

**Villerabel 2021** {published data only}

Villerabel C, Makinson A, Jaussent A, Picot MC, Nègre-Pagès L, Rouvière JA, et al. Diagnostic value of patient-reported and clinically tested olfactory dysfunction in a population screened for COVID-19. *JAMA Otolaryngology-Head & Neck Surgery* 2021;**147**(3):271-9. [DOI: [10.1001/jamaoto.2020.5074](https://doi.org/10.1001/jamaoto.2020.5074)]

**Wee 2020** {published data only}

Wee LE, Chan YZ, Teo NY, Cherng BZ, Thien SY, Wong M, et al. The role of self-reported olfactory and gustatory dysfunction as a screening criterion for suspected COVID-19. *European Archives of Oto-Rhino-Laryngology* 2020;**277**(8):2389-90. [DOI: [10.1007/s00405-020-05999-5](https://doi.org/10.1007/s00405-020-05999-5)]

**Wei 2020** {published data only}

Wei Y, Lu Y, Xia L, Yuan X, Li G, Li X, et al. Analysis of 2019 novel coronavirus infection and clinical characteristics of outpatients: an epidemiological study from a fever clinic in Wuhan, China. *Journal of Medical Virology* 2020;**92**:2758-67.

**Wernhart 2020** {published data only}

Wernhart S, Förster TH, Weihe E. Outpatient management of oligosymptomatic patients with respiratory infection in the era of SARS-CoV-2: experience from rural German general practitioners. *BMC Infectious Diseases* 2020;**20**(1):811. [DOI: [10.1186/s12879-020-05538-x](https://doi.org/10.1186/s12879-020-05538-x)]

**Xie 2020** {published data only}

Xie S, Zhang G, Yu H, Wang J, Wang S, Tang G, et al. The epidemiologic and clinical features of suspected and confirmed cases of imported 2019 novel coronavirus pneumonia in north Shanghai, China. *Annals of Translational Medicine* 2020;**8**(10):637.

**Yombi 2020** {published data only}

Yombi JC, De Greef J, Marsin A-S, Simon A, Rodriguez-Villalobos H, Penaloza A, et al. Symptom-based screening for COVID-19 in health care workers: the importance of fever. *Journal of Hospital Infection* 2020;**105**(3):428-9.

**Yonker 2020** {published data only}

Yonker LM, Neilan AM, Bartsch Y, Patel AB, Regan J, Arya P, et al. Pediatric severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2): clinical presentation, infectivity, and immune responses. *Journal of Pediatrics* 2020;**227**:45-52.e5. [DOI: [10.1016/j.jpeds.2020.08.037](https://doi.org/10.1016/j.jpeds.2020.08.037)]

**Zayet 2020a** {published data only}

Zayet S, Klopfenstein T, Mercier J, Kadiane-Oussou NJ, Lan Cheong Wah L, Royer PY, et al. Contribution of anosmia and dysgeusia for diagnostic of COVID-19 in outpatients. *Infection* 2020;**14**:1-5.

**Zhu 2020** {published data only}

Zhu W, Xie K, Lu H, Xu L, Zhou S, Fang S. Initial clinical features of suspected coronavirus disease 2019 in two emergency departments outside of Hubei, China. *Journal of Medical Virology* 2020;**92**(9):1525-32. [DOI: 10.1002/jmv.25763]

**Zimmerman 2020** {published data only}

Zimmerman RK, Nowalk MP, Bear T, Taber R, Clarke KS, Sax TM, et al. Proposed clinical indicators for efficient screening and testing for COVID-19 infection using Classification and Regression Trees (CART) analysis. *Human Vaccines & Immunotherapeutics* 2020;**17**(4):1109-12. [DOI: doi.org/10.1080/21645515.2020.1822135]

**Zurl 2021** {published data only}

Zurl C, Eber E, Siegl A, Loeffler S, Stelzl E, Kessler HH, et al. Low rate of SARS-CoV-2 infections in symptomatic patients attending a pediatric emergency department. *Frontiers in Pediatrics* 2021;**9**:637167. [DOI: 10.3389/fped.2021.637167]

**References to studies excluded from this review**
**Accorsi 2020** {published data only}

Accorsi TA, Amicis K, Brígido AR, Belfort DS, Habrum FC, Scarpanti FG, et al. Assessment of patients with acute respiratory symptoms during the COVID-19 pandemic by Telemedicine: clinical features and impact on referral. *Einstein (Sao Paulo)* 2020;**18**:eAO6106. [DOI: 10.31744/einstein\_journal/2020AO6106]

**Afshar 2020** {published data only}

Afshar Y, Gaw SL, Flaherman VJ, Chambers BD, Krakow D, Berghella V, et al. Clinical presentation of coronavirus disease 2019 (COVID-19) in pregnant and recently pregnant people. *Obstetrics and Gynecology* 2020;**136**(6):1117-25. [DOI: 10.1097/AOG.0000000000004178]

**Agarwal 2021** {published data only}

Agarwal R, Gupta E, Dubey S, Padhi A, Khodare A, Kumar G, et al. Pooled nasopharyngeal swab collection in a single vial for the diagnosis of SARS CoV-2 infection: an effective cost saving method. *Indian Journal of Medical Microbiology* 2021;**39**(2):231-4. [DOI: 10.1016/j.ijmb.2020.11.002]

**Ai 2020** {published data only}

Ai JW, Zhang HC, Xu T, Wu J, Zhu M, Yu YQ, et al. Optimizing diagnostic strategy for novel coronavirus pneumonia, a multi-center study in Eastern China. *medRxiv [Preprint]* 2020. [DOI: https://doi.org/10.1101/2020.02.13.20022673]

**Akinbami 2021** {published data only}

Akinbami LJ, Petersen LR, Sami S, Vuong N, Lukacs SL, Mackey L, et al. COVID-19 symptoms and SARS-CoV-2 antibody positivity in a large survey of first responders and healthcare

personnel, May-July 2020. *Clinical Infectious Diseases* 2021;**73**(3):e822-5. [DOI: 10.1093/cid/ciab080]

**Akyala 2020** {published data only}

Akyala AI, Awayimbo JR, Elayo MI, Olugbade OT, Akabe EA, Akinyoade A. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection among health care workers in Nasarawa State, Nigeria: implications for infection prevention and control measures. *Pan African Medical Journal* 2020;**37** Suppl 1:21. [DOI: 10.11604/pamj.suppl.2020.37.21.25767]

**Aleebrahim-Dehkordi 2020** {published data only}

Aleebrahim-Dehkordi E, Reyhanian A, Hasanpour-Dehkordi A. Clinical manifestation and the risk of exposure to SARS-CoV-2 (COVID-19). *International Journal of Preventive Medicine* 2020;**11**:86. [DOI: 10.4103/ijpvm.IJPVM\_145\_20]

**Al-Rifai 2021** {published data only}

Al-Rifai RH, Acuna J, Al Hossany FI, Aden B, Al Memari SA, Al Mazrouei SK, et al. Epidemiological characterization of symptomatic and asymptomatic COVID-19 cases and positivity in subsequent RT-PCR tests in the United Arab Emirates. *PLoS One* 2021;**16**(2):e0246903. [DOI: 10.1371/journal.pone.0246903]

**Altınbilek 2020** {published data only}

Altınbilek E, Öztürk D, Atasoy C, Özlem M, Yılmaz F, Kavalci C. Analysis of the patients who admitted to a Turkish emergency department during COVID-19 pandemic. *Acta Biomedica* 2020;**91**(4):e2020201. [DOI: 10.23750/abm.v91i4.10227]

**Andina-Martinez 2021** {published data only}

Andina-Martinez D, Nieto-Moro M, Alonso-Cadenas JA, Añon-Hidalgo J, Hernandez-Martin A, Perez-Suarez E, et al. Mucocutaneous manifestations in children hospitalized with COVID-19. *Journal of the American Academy of Dermatology* 2021;**85**(1):88-94. [DOI: 10.1016/j.jaad.2021.03.083]

**Antonelli 2021** {published data only}

Antonelli M, Capdevila J, Chaudhari A, Granerod J, Canas LS, Graham MS, et al. Optimal symptom combinations to aid COVID-19 case identification: analysis from a community-based, prospective, observational cohort. *Journal of Infection* 2021;**82**(3):384-90. [DOI: 10.1016/j.jinf.2021.02.015]

**Aubert 2021** {published data only}

Aubert J, Durán D, Monsalves MJ, Rodríguez MF, Rotarou ES, Gajardo J, et al. Diagnostic properties of case definitions of suspected COVID-19 in Chile, 2020 [Propiedades diagnósticas de las definiciones de caso sospechoso de COVID-19 en Chile, 2020]. *Revista Panamericana de Salud Pública [Pan American Journal of Public Health]* 2021;**45**:e14. [DOI: 10.26633/RPSP.2021.14]

**Auvinen 2021** {published data only}

Auvinen R, Nohynek H, Syrjänen R, Ollgren J, Kerttula T, Mäntylä J, et al. Comparison of the clinical characteristics and outcomes of hospitalized adult COVID-19 and influenza patients - a prospective observational study. *Infectious Diseases* 2021;**53**(2):111-21. [DOI: 10.1080/23744235.2020.1840623]

**Baghaei 2020** {published data only}

Baghaei P, Nadji SA, Marjani M, Moniri A, Hashemian SM, Sheikhzade H, et al. Clinical manifestations of patients with coronavirus disease 2019 (COVID-19) in a referral center in Iran. *Tanaffos* 2020;**19**(2):122-8.

**Bailey 2020** {published data only}

Bailey L, O'Donoghue A, Martin A. Acute presentations of nursing home residents to hospital during COVID-19 pandemic. *European Geriatric Medicine* 2020;**11** Suppl 1:S52.

**Bailey 2021** {published data only}

Bailey LC, Razzaghi H, Burrows EK, Bunnell HT, Camacho PE, Christakis DA, et al. Assessment of 135 794 pediatric patients tested for severe acute respiratory syndrome coronavirus 2 across the United States. *JAMA Pediatrics* 2021;**175**(2):176-84.

**Bartlett 2020** {published data only}

Bartlett B, Ploog N, Heaton H, Mullan A, Knutson B. 287 likelihood of COVID-19 positive test results in patients who present to the emergency department with key COVID chief symptoms. *Annals of Emergency Medicine* 2020;**76**(4):S111. [DOI: [10.1016/j.annemergmed.2020.09.301](https://doi.org/10.1016/j.annemergmed.2020.09.301)]

**Bastiani 2021** {published data only}

Bastiani L, Fortunato L, Pieroni S, Bianchi F, Adorni F, Prinelli F, et al. Rapid COVID-19 screening based on self-reported symptoms: psychometric assessment and validation of the EPICOV19 Short Diagnostic Scale. *Journal of Medical Internet Research* 2021;**23**(1):e23897.

**Bhatta 2021** {published data only}

Bhatta S, Gandhi S, Saindani SJ, Ganesuni D, Ghanpur AD. Otorhinolaryngological manifestations of coronavirus disease 2019: a prospective review of 600 patients. *Journal of Laryngology and Otology* 2021;**135**(3):206-11.

**Bidkar 2021** {published data only}

Bidkar V, Mishra M, Selvaraj K, Joshi P, Shrikrishna BH, Dabhekar S, et al. Testing olfactory and gustatory dysfunctions among quarantine COVID-19 suspects. *Indian Journal of Otolaryngology and Head & Neck Surgery* 2021;**73**(3):304-9.

**Bonadio 2020** {published data only}

Bonadio W, Bonadio W, Jackson K, Gottlieb L. 379 accuracy of an emergency department clinical protocol for early identification of coronavirus infection. *Annals of Emergency Medicine* 2020;**76**(4):S146.

**Brotos 2020** {published data only}

Brotos C, Serrano J, Fernández D, Garcia-Ramos C, Ichazo B, Lemaire J, et al. Seroprevalence against COVID-19 and follow-up of suspected cases in primary health care in Spain. *medRxiv [Preprint]*. [DOI: <https://doi.org/10.1101/2020.06.13.20130575>]

**Burrell 2021** {published data only}

Burrell S, Hausfater P, Dres M, Pourcher V, Luyt CE, Teyssou E, et al. Co-infection of SARS-CoV-2 with other respiratory viruses and performance of lower respiratory tract samples for the diagnosis of COVID-19. *International Journal of Infectious Diseases* 2021;**102**:10-3.

**Cadegiani 2021** {published data only}

Cadegiani FA, Zimmerman RA, Campello de Souza B, McCoy J, Pereira E, Costa RA, et al. The AndroCoV Clinical Scoring for COVID-19 Diagnosis: a prompt, feasible, costless, and highly sensitive diagnostic tool for COVID-19 based on a 1757-patient cohort. *Cureus* 2021;**13**(1):e12565.

**Cai 2020** {published data only}

Cai X, Jiang H, Zhang S, Xia S, Du W, Ma Y, et al. Clinical manifestations and pathogen characteristics in children admitted for suspected COVID-19. *Frontiers of Medicine* 2020;**14**(6):776-85.

**Calagnan 2020** {published data only}

Calagnan E, Gobbato M, Burba I, Del Zotto S, Toffolutti F, Serraino D, et al. COVID-19 infections in the Friuli Venezia Giulia Region (northern Italy): a population-based retrospective analysis. *Epidemiologia & Prevenzione* 2020;**44**(5-6 Suppl 2):323-9.

**Carignan 2020** {published data only}

Carignan A, Valiquette L, Grenier C, Musonera JB, Nkengurutse D, Marcil-Héguy A, et al. Anosmia and dysgeusia associated with SARS-CoV-2 infection: an age-matched case-control study. *CMAJ* 2020;**192**(26):E702-7.

**Challener 2020** {published data only}

Challener DW, Challener GJ, Gow-Lee VJ, Fida M, Shah AS, O'Horo JC. Screening for COVID-19: patient factors predicting positive PCR test. *Infection Control and Hospital Epidemiology* 2020;**41**(8):968-9.

**Chen 2020** {published data only}

Chen X, Tang Y, Mo Y, Li S, Lin D, Yang Z, et al. A diagnostic model for coronavirus disease 2019 (COVID-19) based on radiological semantic and clinical features: a multi-center study. *European Radiology* 2020;**30**(9):4893-902.

**Chen 2021** {published data only}

Chen R, Xu G, Yang L, Deng Z, Hu Q, Hu H, et al. A new rapid screening program based on risk scores for COVID-19 patients. *Internal and Emergency Medicine* 2021;**16**(4):925-32.

**Concheiro-Guisan 2020** {published data only}

Concheiro-Guisan A, Fiel-Ozores A, Novoa-Carballal R, González-Duran ML, Portugués de la Red M, Martínez-Reglero C, et al. Subtle olfactory dysfunction after SARS-CoV-2 virus infection in children. *International Journal of Pediatric Otorhinolaryngology* 2020;**140**:110539.

**D'Souza 2020** {published data only}

D'Souza G, Springer G, Gustafson D, Kassaye S, Alcaide M L, Ramirez C, et al. COVID-19 symptoms and SARS-CoV-2 infection among people living with HIV in the US: the MACS/WIHS combined cohort study. *HIV Research & Clinical Practice* 2020;**21**(5):130-9.

**Dai 2021** {published data only}

Dai YN, Zheng W, Wu QQ, Hui TC, Sun NN, Chen GB, et al. A rapid screening model for early predicting novel coronavirus



pneumonia in Zhejiang Province of China: a multicenter study. *Scientific Reports* 2021;**11**(1):3863.

**Dantas 2021** {published data only}

Dantas LF, Peres IT, Bastos LS, Marchesi JF, de Souza GF, Gelli JG, et al. App-based symptom tracking to optimize SARS-CoV-2 testing strategy using machine learning. *PLoS One* 2021;**16**(3):e0248920.

**De Angelis 2020** {published data only}

De Angelis G, Posteraro B, Biscetti F, Ianiro G, Zileri Dal Verme L, Cattani P, et al. Confirmed or unconfirmed cases of 2019 novel coronavirus pneumonia in Italian patients: a retrospective analysis of clinical features. *BMC Infectious Diseases* 2020;**20**(1):775.

**Deng 2020** {published data only}

Deng LS, Yuan J, Ding L, Chen YL, Zhao CH, Chen GQ, et al. Comparison of patients hospitalized with COVID-19, H7N9 and H1N1. *Infectious Diseases of Poverty* 2020;**9**(1):163.

**Dixon 2021** {published data only}

Dixon BE, Wools-Kaloustian KK, Fadel WF, Duszynski TJ, Yiannoutsos C, Halverson PK, et al. Symptoms and symptom clusters associated with SARS-CoV-2 infection in community-based populations: results from a statewide epidemiological study. *PLoS One* 2021;**16**(3):e0241875.

**Dreyer 2020** {published data only}

Dreyer NA, Reynolds M, DeFilippo Mack C, Brinkley E, Petruski-Ivleva N, Hawaldar K, et al. Self-reported symptoms from exposure to COVID-19 provide support to clinical diagnosis, triage and prognosis: an exploratory analysis. *Travel Medicine and Infectious Disease* 2020;**38**:101909.

**Duan 2020** {published data only}

Duan J, Liang M, Li Y, Wu D, Chen Y, Gao S, et al. Definition and retrospective application of a clinical scoring system for COVID-19 triage at presentation. *Therapeutic Advances in Respiratory Disease* 2020;**14**:1753466620963019.

**Duque 2021** {published data only}

Duque MP, Lucaccioni H, Costa C, Marques R, Antunes D, Hansen L, et al. COVID-19 symptoms: a case-control study, Portugal, March-April 2020. *Epidemiology and Infection* 2021;**149**:e54.

**Duramaz 2021** {published data only}

Duramaz BB, Turel O, Korkmaz C, Karadogan MT, Yozgat CY, Iscan A, et al. A snapshot of pediatric patients with COVID-19 in a pandemic hospital. *Klinische Pädiatrie* 2021;**233**(1):24-30.

**Elimian 2020** {published data only}

Elimian KO, Ochu CL, Ebhodaghe B, Myles P, Crawford EE, Igumbor E, et al. Patient characteristics associated with COVID-19 positivity and fatality in Nigeria: retrospective cohort study. *BMJ Open* 2020;**10**(12):e044079.

**Escosteguy 2020** {published data only}

Escosteguy CC, Eleuterio TA, Pereira AG, Marques MR, Brandão AD, Batista JP. COVID-19: a cross-sectional study

of suspected cases admitted to a federal hospital in Rio de Janeiro, Brazil, and factors associated with hospital death. *Epidemiologia e Serviços de Saúde* 2020;**30**(1):e2020750.

**Feehan 2021** {published data only}

Feehan AK, Fort D, Velasco C, Burton JH, Garcia-Diaz J, Price-Haywood EG, et al. The importance of anosmia, ageusia and age in community presentation of symptomatic and asymptomatic SARS-CoV-2 infection in Louisiana, USA; a cross-sectional prevalence study. *Clinical Microbiology and Infection* 2021;**27**(4):633.e9-16.

**Fisher 2021** {published data only}

Fisher KA, Olson SM, Tenforde MW, Self WH, Wu M, Lindsell CJ, et al. Symptoms and recovery among adult outpatients with and without COVID-19 at 11 healthcare facilities—July 2020, United States. *Influenza and Other Respiratory Viruses* 2021;**15**(3):345-51.

**Foster 2021** {published data only}

Foster CE, Marquez L, Davis AL, Tocco E, Koy TH, Dunn J, et al. A surge in pediatric coronavirus disease 2019 cases: the experience of Texas Children's Hospital from March to June 2020. *Journal of the Pediatric Infectious Diseases Society* 2021;**10**(5):593-8.

**Gale 2020** {published data only}

Gale J, Clark DA, Bohm C, Canney M, Davis I, LeBlanc JJ, et al. COVID-19 status, symptom burden, and characteristics of dialysis patients residing in areas of community transmission: research letter. *Canadian Journal of Kidney Health and Disease* 2020;**7**:2054358120964178.

**Gerkin 2021** {published data only}

Gerkin RC, Ohla K, Veldhuizen MG, Joseph PV, Kelly CE, Bakke AJ, et al. Recent smell loss is the best predictor of COVID-19 among individuals with recent respiratory symptoms. *Chemical Sense* 2021;**46**:bjaa081.

**Giavedoni 2020** {published data only}

Giavedoni P, Podlipnik S, Pericàs JM, Fuertes de Vega I, García-Herrera A, Alós L, et al. Skin manifestations in COVID-19: prevalence and relationship with disease severity. *Journal of Clinical Medicine* 2020;**9**(10):3261.

**Gibbons 2021** {published data only}

Gibbons C, Hussain M, O'Keeffe DT, Simpkin AJ. An analysis of patient self-reported COVID-19 symptoms during the first wave of the pandemic in Ireland. *Irish Journal of Medical Science* 2021 Mar 25 [Epub ahead of print].

**Gnanasambantham 2020** {published data only}

Gnanasambantham K, Aitken G, Morris B, Simionato J, Chua EH, Ibrahim JE. Developing a clinical screening tool for identifying COVID-19 infection in older people dwelling in residential aged care services. *Australasian Journal on Ageing* 2020;**40**(1):48-57.

**Goel 2020** {published data only}

Goel A, Raizada A, Bansal K, Gaur N, Abraham J, Yadav A. Profile of patients suspected to be COVID-19: a retrospective analysis of early pandemic data. *Cureus* 2020;**12**(8):e10125.



**Gombos 2021** {published data only}

Gombos K, Földi M, Kiss S, Herczeg R, Gyenesei A, Geiger L, et al. Analysis of COVID-19-related RT-qPCR test results in Hungary: epidemiology, diagnostics, and clinical outcome. *Frontiers in Medicine* 2021;**7**:625673.

**Goodacre 2020** {published data only}

Goodacre S, Thomas B, Lee E, Sutton L, Loban A, Waterhouse S, et al. Characterisation of 22445 patients attending UK emergency departments with suspected COVID-19 infection: observational cohort study. *PLoS One* 2020;**15**(11):e0240206.

**Guillén 2020** {published data only}

Martínez AG, Gálvez MA, Rodríguez Sanz S, Hernandez Ruiz P, García Morillas A, Sánchez ET. Incidence of smell and taste disorders and associated factors in patients with mild to moderate COVID-19. *Polish Journal of Otolaryngology* 2020;**75**(2):1-5.

**Gurrola 2021** {published data only}

Gurrola JG 2nd, Chang JL, Roland LT, Loftus PA, Cheung SW. Short-term chemosensory distortions and phantoms in COVID-19. *Laryngoscope Investigative Otolaryngology* 2021;**6**(2):172-6.

**Haddadin 2021** {published data only}

Haddadin Z, Chappell J, McHenry R, Pulido CG, Rahman H, Gu W, et al. Coronavirus surveillance in a pediatric population in Jordan from 2010 to 2013: a prospective viral surveillance study. *Pediatric Infectious Disease Journal* 2021;**40**(1):e12-e7.

**Hamed 2021** {published data only}

Hamed E, Alnuaimi AS, Syed MA, Elhamid MA, Sedeeq ST, Alemrayat B, et al. Clinical characteristics of 51815 patients presenting with positive and negative SARS-CoV-2 swab results in primary health care settings. *Journal of Infection* 2021;**82**(4):84-123.

**Hernández-Cruz 2021** {published data only}

Hernández-Cruz RG, Sánchez-Cobo D, Acevedo-Gallegos S, Helguera-Repetto AC, Rodríguez-Bosch MR, Ramírez-Santes VH, et al. Clinical characteristics and risk factors for SARS-CoV-2 infection in pregnant women attending a third level reference center in Mexico City. *Journal of Maternal-fetal & Neonatal Medicine* 2021:1-5.

**Hosseinzadeh 2021** {published data only}

Hosseinzadeh A, Rezapour M, Rohani-Rasaf M, Emamian MH, Talebi S, Goli S, et al. Epidemiological patterns of syndromic symptoms in suspected patients with covid-19 in Iran: a latent class analysis. *Journal of Research in Health Sciences* 2021;**21**(1):e00508.

**Hosseninasab 2020** {published data only}

Hosseninasab A, Bafti MS, Ebrahimi S, Anjomshoa A, Zerandi FS, Jafari M, et al. Coronavirus disease 2019 in children with acute respiratory infection: a study from southeastern Iran. *Shiraz E Medical Journal* 2020;**21**(12):1-7.

**Hubiche 2021** {published data only}

Hubiche T, Phan A, Leducq S, Rapp J, Fertitta L, Aubert H, et al. Acute acral eruptions in children during the COVID-19 pandemic: characteristics of 103 children and their family clusters. *Annales de Dermatologie et de Vénérologie* 2021;**148**(2):94-100.

**Hurst 2020** {published data only}

Hurst JH, Heston SM, Chambers HN, Cunningham HM, Price MJ, Suarez L, et al. SARS-CoV-2 infections among children in the Biospecimens from Respiratory Virus-Exposed Kids (BRAVE Kids) Study. *Clinical Infectious Diseases* 2020 Nov 03 [Epub ahead of print].

**Indini 2021** {published data only}

Indini A, Cattaneo M, Ghidini M, Rijavec E, Bareggi C, Galassi B, et al. Triage process for the assessment of coronavirus disease 2019-positive patients with cancer: the ONCOVID prospective study. *Cancer* 2021;**127**(7):1091-101.

**Islam 2020** {published data only}

Islam N, Ara Rahman M, Uz Zaman A, Ferdous N, Bin Nazrul F, Tuz Zahura F, et al. Frequency and characteristics of COVID-19 infection in rheumatic patients—an online survey from Bangladesh. *International Journal of Rheumatic Diseases* 2020;**23** Suppl 1:171.

**Jain 2021** {published data only}

Jain A, Kaur J, Rai AK, Pandey AK. Anosmia: a clinical indicator of COVID-19 reinfection. *Ear, Nose, & Throat Journal* 2021;**100**(2 Suppl):180S-181S.

**Karni 2020** {published data only}

Karni N, Klein H, Asseo K, Benjamini Y, Israel S, Nammary M, et al. Self-rated smell ability enables highly specific predictors of COVID-19 status: a case-control study in Israel. *Open Forum Infectious Diseases* 2020;**8**(2):ofaa589.

**Kasiukiewicz 2020** {published data only}

Kasiukiewicz A, Wojszel ZB, Kazberuk M, Sitkiewicz J, Olszewska J. Symptoms and final diagnoses of patients referred to one of the COVID-19 dedicated hospitals in Poland - a cross-sectional study. *European Geriatric Medicine* 2020;**11** Suppl 1:S83.

**Kline 2021** {published data only}

Kline JA, Camargo CA, Courtney DM, Kabrhel C, Nordenholz KE, Aufderheide T, et al. Clinical prediction rule for SARS-CoV-2 infection from 116 U.S. emergency departments 2-22-2021. *PLoS One* 2021;**16**(3):e0248438.

**Lechner 2021** {published data only}

Lechner M, Liu J, Counsell N, Ta NH, Rocke J, Anmolsingh R, et al. Course of symptoms for loss of sense of smell and taste over time in one thousand forty-one healthcare workers during the COVID-19 pandemic: our experience. *Clinical Otolaryngology* 2021;**46**(2):451-7.

**Lee 2020** {published data only}

Lee DJ, Lockwood J, Das P, Wang R, Grinspun E, Lee JM. Self-reported anosmia and dysgeusia as key symptoms of coronavirus disease 2019. *CJEM* 2020;**22**(5):1-8.

**Lee 2021** {published data only}

Lee DJ, Daliyot D, Wang R, Lockwood J, Das P, Zimlichman E, et al. Comparative study of chemosensory dysfunction in COVID-19 in 2 geographically distinct regions. *Ear, Nose & Throat Journal* 2021:1455613211000170.

**Li 2020a** {published data only}

Li Y, Li H, Han J, Yang L. The preliminary comparative results between COVID-19 and non-COVID-19 patients in western China. *BMC Infectious Diseases* 2020;**20**(1):935.

**Li 2020b** {published data only}

Li Y, Shang Y, Yang Y, Wang M, Yu D, Su D, et al. Factors associated with a positive severe acute respiratory syndrome coronavirus 2 testing in suspected cases presenting with pneumonia: a retrospective cohort study in a single medical center. *Respiration* 2020;**99**(9):739-47.

**Li 2021** {published data only}

Li S, Liu SY, Zhao YQ, Li QY, Liu DY, Liu ZC, et al. Spatial and temporal distribution and predictive value of chest CT scoring in patients with COVID-19. *Zhonghua Jie He He Hu Xi Za Zhi* 2021;**44**(3):230-6.

**Liang 2020** {published data only}

Liang Y, Liang J, Zhou Q, Li X, Lin F, Deng Z, et al. Prevalence and clinical features of 2019 novel coronavirus disease (COVID-19) in the fever clinic of a teaching hospital in Beijing: a single-center, retrospective study. *medRxiv [Preprint]*. [DOI: <https://doi.org/10.1101/2020.02.25.20027763>]

**Liu 2021** {published data only}

Liu Y, Chen H, Tan W, Kuang Y, Tang K, Luo Y, et al. Clinical characteristics and outcome of SARS-CoV-2 infection during pregnancy. *Journal of Infection* 2021;**82**(6):e9-10.

**Loftus 2020** {published data only}

Loftus PA, Roland LT, Gurrola JG 2nd, Cheung SW, Chang JL. Temporal profile of olfactory dysfunction in COVID-19. *OTO Open* 2020;**4**(4):2473974X20978133.

**Lu 2020** {published data only}

Lu X, Zhang H, Adu IK, Xiong Z, Zheng Y, Wang J. A retrospective study of the related common factors of COVID-19. *Electronic Journal of General Medicine* 2020;**18**(1):em262.

**Madan 2020** {published data only}

Madan S, Beri S. Conjunctivitis in novel coronavirus disease (COVID-19). *Indian Journal of Occupational and Environmental Medicine* 2020;**24**(2):129-30.

**Makaronidis 2020** {published data only}

Makaronidis J, Mok J, Balogun N, Magee CG, Omar RZ, Carnemolla A, et al. Seroprevalence of SARS-CoV-2 antibodies in people with an acute loss in their sense of smell and/or taste in a community-based population in

London, UK: an observational cohort study. *PLoS Medicine* 2020;**17**(10):e1003358.

**Manley 2020** {published data only}

Manley HJ, Majchrzak KM, Sanders R, Cumber S, Aweh GN, Ladik V, et al. Screening for SARS-CoV-2 (COVID) infection in chronic dialysis patients: a nonprofit provider's experience. *Journal of the American Society of Nephrology* 2020;**31**:32.

**McDonald 2020** {published data only}

McDonald SA, Medford RJ, Basit MA, Diercks DB, Courtney DM. Derivation with internal validation of a multivariable predictive model to predict COVID-19 test results in emergency department patients. *Academic Emergency Medicine* 2020;**28**(2):206-14.

**McGovern 2020** {published data only}

McGovern A, Brooks F, Downs T, Drennan M, Frizzell E, Knox L, et al. Delirium may be the only symptom in older adults with COVID-19 disease. *European Geriatric Medicine* 2020;**11** Suppl 1:S6.

**Medetalibeyoglu 2020** {published data only}

Medetalibeyoglu A, Bahat G, Senkal N, Kose M, Catma Y, Yesil Y, et al. Comparison of clinical characteristics and outcome measures of PCR-positive and PCR-negative patients diagnosed as COVID-19: analyses focusing on the older adults. *European Geriatric Medicine* 2020;**11** Suppl 1:S87.

**Membrilla 2020** {published data only}

Membrilla JA, de Lorenzo Í, Sastre M, Díaz de Terán J. Headache as a cardinal symptom of coronavirus disease 2019: a cross-sectional study. *Headache* 2020;**60**(10):2176-91.

**Mizrahi 2020** {published data only}

Mizrahi B, Shilo S, Rossmann H, Kalkstein N, Marcus K, Barer Y, et al. Longitudinal symptom dynamics of COVID-19 infection. *Nature Communications* 2020;**11**(1):6208.

**Möckel 2021** {published data only}

Möckel M, Stegemann MS, Burst V, Kämpers P, Risse J, Koehler FC, et al. Which parameters support disposition decision in suspected COVID-19 cases in the emergency department (ED): a German clinical cohort study. *BMJ Open* 2021;**11**(3):e044853.

**Moolla 2021** {published data only}

Moolla MS, Parker A, Parker MA, Sithole S, Amien L, Chiecktey R, et al. Staff testing for COVID-19 via an online pre-registration form. *Southern African Journal of Infectious Diseases* 2021;**36**(1):232.

**Muhammad 2021** {published data only}

Muhammad LJ, Algehyne EA, Usman SS, Ahmad A, Chakraborty C, Mohammed IA. Supervised machine learning models for prediction of COVID-19 infection using epidemiology dataset. *SN Computer Science* 2021;**2**(1):11.

**Munblit 2020** {published data only}

Munblit D, Nekliudov NA, Bugaeva P, Blyuss O, Kislova M, Listovskaya E, et al. StopCOVID cohort: an observational study of 3,480 patients admitted to the Sechenov University hospital

network in Moscow city for suspected COVID-19 infection. *Clinical Infectious Diseases* 2020;**73**(1):1-11.

**Murillo-Zamora 2020** {published data only}

Murillo-Zamora E, Aguilar-Sollano F, Delgado-Enciso I, Hernandez-Suarez CM. Predictors of laboratory-positive COVID-19 in children and teenagers. *Public Health* 2020;**189**:153-7.

**Nakajima 2021** {published data only}

Nakajima M, Yamamoto Y, Kaszynski RH, Yamauchi Y, Yamamoto K, Nakajima Y, et al. A comparison on the percentage of polymerase chain reaction positivity for SARS-CoV-2 between Public Health Center referrals and direct walk-in patients: a single center retrospective analysis in Tokyo. *Journal of Infection and Chemotherapy* 2021;**27**(6):852-6.

**Nakanishi 2020** {published data only}

Nakanishi H, Suzuki M, Maeda H, Nakamura Y, Ikegami Y, Takenaka Y, et al. Differential diagnosis of COVID-19: importance of measuring blood lymphocytes, serum electrolytes, and olfactory and taste functions. *Tohoku Journal of Experimental Medicine* 2020;**252**(2):109-19.

**Nayan 2021** {published data only}

Nayan N, Kumar MK, Nair RK, Manral I, Ghosh S, Bhalla S, et al. Clinical triaging in cough clinic alleviates COVID-19 overload in emergency department in India. *SN Comprehensive Clinical Medicine* 2021;**3**:1-6.

**Nobel 2020** {published data only}

Nobel YR, Phipps M, Zucker J, Lebwohl B, Wang TC, Sobieszczyk ME, et al. Gastrointestinal symptoms and coronavirus disease 2019: a case-control study from the United States. *Gastroenterology* 2020;**159**(1):373-5.e2.

**Ortiz 2020** {published data only}

Ortiz Molina E, Hernandez Pailos R, Pola Guillen M, Pascual Pedreno A, Rodriguez Rodriguez E, Hernandez Martinez A. COVID-19 infection in symptomatic pregnant women at the midpoint of the pandemic in Spain: a retrospective analysis. *Ginekologia Polska* 2020;**91**(12):755-63.

**Oshman 2020** {published data only}

Oshman L, Caplan A, Ali R, Singh L, Khalid R, Jameel M, et al. Whom should we test for COVID-19? Performance of a symptom and risk factor questionnaire on COVID-19 test results and patient outcomes in an immediate care setting. *Journal of Primary Care & Community Health* 2020;**11**:2150132720981297.

**Ozcan 2021** {published data only}

Ozcan E, Yavuzer S, Borku Uysal B, Islamoglu MS, Ikitimur H, Unal OF, et al. The relationship between positivity for COVID-19 RT-PCR and symptoms, clinical findings, and mortality in Turkey. *Expert Review of Molecular Diagnostics* 2021;**21**(2):245-50.

**Paar 2021** {published data only}

Paar M, Strumann C, Giesen H. Rate and predictive parameters of novel coronavirus 2019 (SARS-CoV-2) infections in a

German general practice. *Irish Journal of Medical Science* 2021;**191**(1):31-7.

**Pigott 2020** {published data only}

Pigott JS, Jackman C, Lindenberg N, Beaumont L, Patel S, Sun K, et al. Clinical presentation of COVID-19 in older people. *European Geriatric Medicine* 2020;**11** Suppl 1:S5-6.

**Platten 2021** {published data only}

Platten M, Cranen R, Peters C, Wisplinghoff H, Nienhaus A, Bach AD, et al. Prevalence of SARS-CoV-2 in employees of a general hospital in Northrhine-Westphalia, Germany [Prävalenz von SARS-CoV-2 bei Mitarbeitern eines Krankenhauses der Regel-/Schwerpunktversorgung in Nordrhein-Westfalen]. *Deutsche Medizinische Wochenschrift* 2021;**146**(5):e30-8.

**Popovych 2021** {published data only}

Popovych VI, Koshel I, Haman Y, Leschak V, Duplikhin R. Diagnostic accuracy and predictive value of clinical symptoms for the diagnosis of mild COVID 19. *medRxiv [Preprint]*. [DOI: <https://doi.org/10.1101/2021.03.05.21252963>]

**Pullen 2020** {published data only}

Pullen MF, Skipper CP, Hullsiek KH, Bangdiwala AS, Pastick KA, Okafor EC, et al. Symptoms of COVID-19 outpatients in the United States. *Open Forum Infectious Diseases* 2020;**7**(7):ofaa271.

**Quer 2020** {published data only}

Quer G, Radin JM, Gadaleta M, Baca-Motes K, Ariniello L, Ramos E, et al. Wearable sensor data and self-reported symptoms for COVID-19 detection. *Nature Medicine* 2020;**27**(1):73-7.

**Ravani 2020** {published data only}

Ravani P, Saxinger L, Chandran U, Fonseca K, Murphy S, Lang E, et al. COVID-19 screening of asymptomatic patients admitted through emergency departments in Alberta: a prospective quality-improvement study. *CMAJ Open* 2020;**8**(4):E887-94.

**Rentsch 2020** {published data only}

Rentsch CT, Kidwai-Khan F, Tate JP, Park LS, King JT, Skanderson M, et al. COVID-19 testing, hospital admission, and intensive care among 2,026,227 United States veterans aged 54-75 years. *medRxiv [Preprint]*. [DOI: <https://doi.org/10.1101/2020.04.09.20059964>]

**Ronan 2021** {published data only}

Ronan G, Kumar L, Davey M, O'Leary C, McAleer S, Lynch J, et al. Factors associated with SARS-CoV-2 infection in patients attending an acute hospital ambulatory assessment unit. *Journal of Medical Virology* 2021;**93**(7):4488-95.

**Rubel 2020** {published data only}

Rubel K, Sharma D, Campiti V, Yedlicka G, Burgin SJ, Illing EA, et al. COVID-19 status differentially affects olfaction: a prospective case-control study. *OTO Open* 2020;**4**(4):2473974X20970176.

**Sabetian 2021** {published data only}

Sabetian G, Moghadami M, Hashemizadeh Fard Haghghi L, Shahriarirad R, Fallahi MJ, Asmarian N, et al. COVID-19 infection

among healthcare workers: a cross-sectional study in southwest Iran. *Virology Journal* 2021;**18**(1):58.

**Sabetta 2020** {published data only}

Sabetta E, Campagner A, Ferrari D, Ceriotti D, Di Resta C, Colombini A, et al. Development, evaluation, and validation of machine learning models for COVID-19 detection based on complete blood count test from 1,624 patients. *Biochimica Clinica* 2020;**44** Suppl 2:S6-7.

**Sehanobish 2021** {published data only}

Sehanobish E, Barbi M, Fong V, Kravitz M, Matsumura C, Tejera D, et al. Risk factors associated with COVID-19 related anosmia and ageusia. *Journal of Allergy and Clinical Immunology* 2021;**147**(2 Supplement):AB134.

**Senok 2020** {published data only}

Senok A, Alsuwaidi H, Atrah Y, Ayedi OA, Zahid JA, Han A, et al. Saliva as an alternative specimen for molecular COVID-19 testing in community settings and population-based screening. *Infection and Drug Resistance* 2020;**13**:3393-9.

**Shanbehzadeh 2021** {published data only}

Shanbehzadeh M, Nopour R, Kazemi-Arpanahi H. Determination of the most important diagnostic criteria for COVID-19: a step forward to design an intelligent clinical decision support system. *Journal of Advances in Medical and Biomedical Research* 2021;**29**(134):176-82.

**Shayganmehr 2021** {published data only}

Shayganmehr A, Dorosti AA, Saboktakin L, Abbasi M, Khaiatzadeh S, Khoshmaram N, et al. Clinical pediatric screening for COVID-19. *Iranian Journal of Pediatrics* 2021;**31**(1):e107780.

**Sheen 2020** {published data only}

Sheen F, Tan V, Haldar S, Sengupta S, Allen D, Somani J, et al. Evaluating the onset, severity and recovery from smell and taste changes associated with COVID-19 Infection in a Singaporean population: a prospective case controlled study (the COV-OSMIA-19 Trial). *JMIR Research Protocool* 2020;**9**(12):e24797.

**Shoer 2021** {published data only}

Shoer S, Karady T, Keshet A, Shilo S, Rossman H, Gavrieli A, et al. A prediction model to prioritize individuals for SARS-CoV-2 test built from national symptom surveys. *Med (New York, N.Y.)* 2021;**2**(2):196-208.e4.

**Sieber 2021** {published data only}

Sieber P, Flury D, Güsewell S, Albrich WC, Boggian K, Gardiol C, et al. Characteristics of patients with coronavirus disease 2019 (COVID-19) and seasonal influenza at time of hospital admission: a single center comparative study. *BMC Infectious Diseases* 2021;**21**(1):271.

**Song 2020** {published data only}

Song CY, Xu J, He JQ, Lu YQ. COVID-19 early warning score: a multi-parameter screening tool to identify highly suspected patients. *medRxiv [Preprint]*. [DOI: <https://doi.org/10.1101/2020.03.05.20031906>]

**Sorlini 2020** {published data only}

Sorlini C, Femia M, Nattino G, Bellone P, Gesu E, Francione P, et al. The role of lung ultrasound as a frontline diagnostic tool in the era of COVID-19 outbreak. *Internal and Emergency Medicine* 2021;**16**(3):749-56.

**Spangler 2021** {published data only}

Spangler D, Blomberg H, Smekal D. Prehospital identification of COVID-19: an observational study. *Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine* 2021;**29**(1):3.

**Stacevičienė 2021** {published data only}

Stacevičienė I, Burokienė S, Steponavičienė A, Vaičiūnienė D, Jankauskienė A. A cross-sectional study of screening for coronavirus disease 2019 (COVID-19) at the pediatric emergency department in Vilnius during the first wave of the pandemic. *European Journal of Pediatrics* 2021;**180**(7):2137-45.

**Tabacof 2020** {published data only}

Tabacof L, Kellner C, Breyman E, Dewil S, Braren S, Nasr L, et al. Remote patient monitoring for home management of coronavirus disease 2019 in New York: a cross-sectional observational study. *Telemedicine and e-Health* 2020;**27**(6):641-8.

**Taziki 2020** {published data only}

Taziki Balajelini MH, Vakili MA, Saeidi M, Tabarraei A, Hosseini SM. Using anti-SARS-CoV-2 IgG and IgM antibodies to detect outpatient cases with olfactory and taste disorders suspected as mild form of COVID-19: a retrospective survey. *SN Comprehensive Clinical Medicine* 2020;**2**(12):2554-60.

**Ticinesi 2020** {published data only}

Ticinesi A, Nouvenne A, Cerundolo N, Guida L, Chiussi G, Morelli I, et al. Age-related differences in clinical presentation of COVID-19 and factors associated with mortality: a retrospective analysis of patients hospitalized during the pandemic peak. *European Geriatric Medicine* 2020;**11** Suppl 1:S21-2.

**Trevisan 2021** {published data only}

Trevisan C, Noale M, Prinelli F, Maggi S, Sojic A, Di Bari M, et al. Age-related changes in clinical presentation of COVID-19: the EPICVID19 web-based survey. *European Journal of Internal Medicine* 2021;**86**:41-7.

**Verma 2020** {published data only}

Verma RK, Kannaujia S, Khurana N, Singh A, Singh DP, Kumar A. Clinical correlation of severe acute respiratory syndrome-coronavirus-2 cases in selected districts of Uttar Pradesh: a cross-sectional hospital-based study. *Journal of Education and Health Promotion* 2020;**9**:357.

**Viana dos Santos 2021** {published data only}

Viana dos Santos Santana Í, Cm da Silveira A, Sobrinho Á, Chaves E Silva L, Dias da Silva L, Santos DF, et al. Machine learning classification models for COVID-19 test prioritization in Brazil. *Journal of Medical Internet Research* 2021;**23**(4):e27293.



**Visconti 2021** {published data only}

Visconti A, Bataille V, Rossi N, Kluk J, Murphy R, Puig S, et al. Diagnostic value of cutaneous manifestation of SARS-CoV-2 infection. *British Journal of Dermatology* 2021;**184**(5):880-7.

**Vos 2020** {published data only}

Vos ER, den Hartog G, Schepp RM, Kaaijk P, Van Vliet J, Helm K, et al. Nationwide seroprevalence of SARS-CoV-2 and identification of risk factors in the general population of the Netherlands during the first epidemic wave. *Journal of Epidemiology and Community Health* 2020;**75**(6):489-95.

**Weiss 2021a** {published data only}

Weiss JJ, Attuquayefio TN, White EB, Li F, Herz RS, White TL, et al. Tracking smell loss to identify healthcare workers with SARS-CoV-2 infection. *PLoS One* 2021;**16**(3):e0248025.

**Weiss 2021b** {published data only}

Weiss R, Guchlerner L, Loth AG, Leinung M, Wicker S, Kempf VA, et al. Typical symptoms of common otorhinolaryngological diseases may mask a SARS-CoV-2 infection. *European Archives of Oto-Rhino-Laryngology* 2021;**278**(9):3551-8.

**Wells 2020** {published data only}

Wells PM, Doores KJ, Couvreur S, Nunez RM, Seow J, Graham C, et al. Estimates of the rate of infection and asymptomatic COVID-19 disease in a population sample from SE England. *Journal of Infection* 2020;**81**(6):931-6.

**Wu 2020** {published data only}

Wu M, Xie C, Wu R, Shu Y, Wang L, Li M, et al. Epidemiological and clinical characteristics of SARS-CoV-2 infection among healthcare workers in Hubei Province of China. *Infection Control & Hospital Epidemiology* 2020 Nov 18 [Epub ahead of print].

**Xia 2021** {published data only}

Xia Y, Chen W, Ren H, Zhao J, Wang L, Jin R, et al. A rapid screening classifier for diagnosing COVID-19. *International Journal of Biological Sciences* 2021;**17**(2):539-48.

**Yan 2020** {published data only}

Yan CH, Faraji F, Prajapati DP, Boone CE, DeConde AS. Association of chemosensory dysfunction and COVID-19 in patients presenting with influenza-like symptoms. *International Forum of Allergy & Rhinology* 2020;**10**(7):806-13.

**Yang 2020** {published data only}

Yang Z, Lin D, Chen X, Qiu J, Li S, Huang R, et al. Distinguishing COVID-19 from influenza pneumonia in the early stage through CT imaging and clinical features. *medRxiv [Preprint]*. [DOI: <https://doi.org/10.1101/2020.04.17.20061242>]

**Yousef 2021** {published data only}

Yousef M, Showe LC, Ben Shlomo I. Clinical presentation of COVID-19 - a model derived by a machine learning algorithm. *Journal of Integrative Bioinformatics* 2021;**18**(1):3-8.

**Žaja 2021** {published data only}

Žaja R, Kerner I, Macan J, Milošević M. Characteristics of work-related COVID-19 in Croatian healthcare workers: a

preliminary report. *Archives of Industrial Hygiene and Toxicology* 2021;**72**(1):36-41.

**Zavascki 2020** {published data only}

Zavascki AP, Gazzana MB, Bidart JP, Fernandes PS, Galiotto A, Kawski CT, et al. Development of a predictive score for COVID-19 diagnosis based on demographics and symptoms in patients attended at a dedicated screening unit. *medRxiv [Preprint]*. [DOI: <https://doi.org/10.1101/2020.05.14.20101931>]

**Zayet 2020b** {published data only}

Zayet S, Kadiane-Oussou NJ, Lepiller Q, Zahra H, Royer PY, Toko L, et al. Clinical features of COVID-19 and influenza: a comparative study on Nord Franche-Comte cluster. *Microbes and Infection* 2020;**22**(9):481-8.

**Zhao 2020** {published data only}

Zhao D, Yao F, Wang L, Zheng L, Gao Y, Ye J, et al. A comparative study on the clinical features of COVID-19 pneumonia to other pneumonias. *Clinical Infectious Diseases* 2020;**71**(15):756-61.

**Zhao 2021** {published data only}

Zhao J, Grabowska ME, Kerchberger VE, Smith JC, Eken HN, Feng Q, et al. ConceptWAS: a high-throughput method for early identification of COVID-19 presenting symptoms and characteristics from clinical notes. *Journal of Biomedical Informatics* 2021;**117**:103748.

**Additional references**
**Bossuyt 2015**

Bossuyt PM, Reitsma JB, Bruns DE, Gatsonis CA, Glasziou PP, Irwig L, et al. STARD 2015: an updated list of essential items for reporting diagnostic accuracy studies. *BMJ* 2015;**351**:h5527. [DOI: [10.1136/bmj.h5527](https://doi.org/10.1136/bmj.h5527)]

**Deeks 2020a**

Deeks JJ, Dinnes J, Takwoingi Y, Davenport C, Spijker R, Taylor-Phillips S, et al. Cochrane COVID-19 Diagnostic Test Accuracy Group. Antibody tests for identification of current and past infection with SARS-CoV-2. *Cochrane Database of Systematic Reviews* 2020, Issue 6. Art. No: CD013652. [DOI: [10.1002/14651858.CD013652](https://doi.org/10.1002/14651858.CD013652)]

**Dinnes 2021**

Dinnes J, Deeks JJ, Berhane S, Taylor M, Adriano A, Davenport C, et al. Cochrane COVID-19 Diagnostic Test Accuracy Group. Rapid, point-of-care antigen and molecular-based tests for diagnosis of SARS-CoV-2 infection. *Cochrane Database of Systematic Reviews* 2021, Issue 3. Art. No: CD013705. [DOI: [10.1002/14651858.CD013705.pub2](https://doi.org/10.1002/14651858.CD013705.pub2)]

**Griffith 2020**

Griffith G, Morris TT, Tudball M, Herbert A, Mancano G, Pike L, et al. Collider bias undermines our understanding of COVID-19 disease risk and severity. *Nature Communications* 2020;**11**(1):5749. [DOI: [doi.org/10.1038/s41467-020-19478-2](https://doi.org/10.1038/s41467-020-19478-2)]

**Islam 2021**

Islam N, Ebrahimzadeh S, Salameh J-P, Kazi S, Fabiano N, Treanor L, et al. Cochrane COVID-19 Diagnostic Test Accuracy

Group.Thoracic imaging tests for the diagnosis of COVID-19. *Cochrane Database of Systematic Reviews* 2021, Issue 3. Art. No: CD013639. [DOI: [10.1002/14651858.CD013639.pub4](https://doi.org/10.1002/14651858.CD013639.pub4)]

#### Jaeschke 1994

Jaeschke R, Guyatt GH, Sackett DL.Users' guides to the medical literature. III. How to use an article about a diagnostic test. B. What are the results and will they help me in caring for my patients? The Evidence-Based Medicine Working Group. *JAMA* 1994;**271**(9):703-7.

#### Macaskill 2013

Macaskill P, Gatsonis C, Deeks JJ, Harbord RM, Takwoingi Y.Chapter 10: Analysing and presenting results. In: Deeks JJ, Bossuyt PM, Gatsonis C editor(s). *Cochrane Handbook for Systematic Reviews of Diagnostic Test Accuracy* Version 1.0. The Cochrane Collaboration, 2013. Available from [srda.cochrane.org](http://srda.cochrane.org).

#### Moher 2009

Moher D, Liberati A, Tetzlaff J, Altman DG, PRISMA Group.Preferred reporting items for systematic reviews and meta-analyses: the PRISMA Statement. *PLoS Medicine* 2009;**6**(7):e1000097. [DOI: [10.1371/journal.pmed1000097](https://doi.org/10.1371/journal.pmed1000097)]

#### NIH 2021

National Institutes of Health.Clinical Spectrum of SARS-CoV-2 Infection. [www.covid19treatmentguidelines.nih.gov/overview/clinical-spectrum/](http://www.covid19treatmentguidelines.nih.gov/overview/clinical-spectrum/) (accessed 15 February 2022). [<https://www.covid19treatmentguidelines.nih.gov/overview/clinical-spectrum/>]

#### R 2020 [Computer program]

R core team R Foundation for Statistical Computing.Version 3.5.1. Vienna, Austria: R core team, 2020.

#### Review Manager 2020 [Computer program]

Nordic Cochrane Centre, The Cochrane Collaboration Review Manager 5 (RevMan 5).Version 5.4.1. Copenhagen: Nordic Cochrane Centre, The Cochrane Collaboration, 2020.

#### Rutjes 2006

Rutjes AW, Reitsma JB, Di Nisio M, Smidt N, Van Rijn JC, Bossuyt PM.Evidence of bias and variation in diagnostic accuracy studies. *CMAJ* 2006;**174**(4):469476.

#### Stegeman 2020

Stegeman I, Ochodo EA, Guleid F, Holtman GA, Yang B, Davenport C, et al, Cochrane COVID-19 Diagnostic Test Accuracy

Group.Routine laboratory testing to determine if a patient has COVID-19. *Cochrane Database of Systematic Reviews* 2020, Issue 11. Art. No: CD013787. [DOI: [10.1002/14651858.CD013787](https://doi.org/10.1002/14651858.CD013787)]

#### Tande 2022

Tande AJ, Pollock BD, Shah ND, Farrugia G, Virk A, Swift M, et al.Impact of the coronavirus disease 2019 (COVID-19) vaccine on asymptomatic infection among patients undergoing preprocedural COVID-19 molecular screening. *Clinical Infectious Diseases* 2021;**74**(1):59-65. [DOI: [10.1093/cid/ciab229](https://doi.org/10.1093/cid/ciab229)]

#### Van den Bruel 2010

Van den Bruel A, Haj-Hassan T, Thompson M, Buntinx F, Mant D.Diagnostic value of clinical features at presentation to identify serious infection in children in developed countries: a systematic review. *Lancet* 2010;**375**(9717):834-45.

#### Whiting 2011

Whiting PF, Rutjes AW, Westwood ME, Mallett S Deeks JJ, Reitsma JB, et al.QUADAS-2: a revised tool for the quality assessment of diagnostic accuracy studies. *Annals of Internal Medicine* 2011;**155**(8):529-36.

### References to other published versions of this review

#### Deeks 2020b

Deeks JJ, Dinnes J, Takwoingi Y, Davenport C, Leeflang MM, Spijker R, et al.Diagnosis of SARS-CoV-2 infection and COVID-19: accuracy of signs and symptoms; molecular, antigen, and antibody tests; and routine laboratory markers. *Cochrane Database of Systematic Reviews* 2020, Issue 4. Art. No: CD013596. [DOI: [10.1002/14651858.CD013596](https://doi.org/10.1002/14651858.CD013596)]

#### Struyf 2020

Struyf T, Deeks JJ, Dinnes J, Takwoingi Y, Davenport C, Leeflang M, et al, Cochrane COVID-19 Diagnostic Test Accuracy Group.Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 disease. *Cochrane Database of Systematic Reviews* 2020, Issue 7. Art. No: CD013665. [DOI: [10.1002/14651858.CD013665](https://doi.org/10.1002/14651858.CD013665)]

#### Struyf 2021

Struyf T, Deeks JJ, Dinnes J, Takwoingi Y, Davenport C, Leeflang MMG, et al, Cochrane COVID-19 Diagnostic Test Accuracy Group.Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19. *Cochrane Database of Systematic Reviews* 2021, Issue 2. Art. No: CD013665. [DOI: [10.1002/14651858.CD013665.pub2](https://doi.org/10.1002/14651858.CD013665.pub2)]

## CHARACTERISTICS OF STUDIES

### Characteristics of included studies [ordered by study ID]

#### Ahmed 2021

##### Study characteristics

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to compare demographic characteristics of patients who received positive and negative test

**Ahmed 2021** (Continued)

results for SARS-CoV-2 in a population with higher testing rates than among previously published cohorts

**Design:** multicenter cross-sectional cohort study, retrospective data collection

**Recruitment:** all patients tested for SARSCoV-2 in the UHealth system during the study period were eligible for this cohort study. For a random subset of patients tested during 10-31 March 2020, symptom data were manually extracted from medical records from 24 h before and 24 h after SARS-CoV-2 testing. Medical records were selected to include at least 20% of patients tested on each day, for a total of 1821 patients.

**Sample size:** n = 1821 (123 cases) 2021

**Inclusion criteria:** all patients tested for SARS-CoV-2 in the UHealth system during the study period. Test eligibility required at least 1 of the following symptoms - cough, fever, shortness of breath, or a high risk of exposure given recent travel or contact with a person who tested positive.

**Exclusion criteria:** none specified

---

 Patient characteristics and setting

**Facility cases:** positive SARS-CoV-2 test. Primarily outpatient settings

**Facility controls:** negative SARS-CoV-2 test. Primarily outpatient settings

**Country:** Utah, USA

**Dates:** 10 March 2020-31 March 2020

**Symptoms and severity:** not specified. Primarily mild to moderate severity

**Demographics:** median age cases: 38.2 years controls: 39.6 years. Gender: % female cases: 45.8%, controls: 56.7% (entire cohort)

**Exposure history:** previous exposure: 56% of cases, 28% of controls; travel: 45% of cases, 25% of controls

---

 Index tests

- Cough
- Fever
- Shortness of breath
- Lethargy
- Myalgia
- Headache
- Sore throat
- Nasal symptoms
- Diarrhoea
- Nausea/vomiting

---

 Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: RT-PCR for SARS-CoV-2 (specimen not specified)

---

 Flow and timing

Time interval not specified

---

 Comparative

---

 Notes

Funding: supported by the National Institute of Allergy and Infectious Diseases (R01 AI135114 to D.T.L.) and the National Heart, Lung, and Blood Institute (K08 HL13650 to R.U.S.) of the National Institutes of Health; and the Centers for Disease Control and Prevention (5U01CK000555-02 to M.H.S. and 5U01CK000538-03 to M.H.S. and L.T.K.)



**Ahmed 2021** (Continued)

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Unclear		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Unclear		

**Ahmed 2021** (Continued)

Did all patients receive the same reference standard?	Unclear
Were all patients included in the analysis?	No
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Aldobyany 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to determine the diagnostic performance characteristics of the COVID-19 respiratory triage score</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all participants presenting to a tertiary hospital (presenting to ED or clinic) and tested for COVID-19: participants either self-presenting due to symptoms (&gt; 50%), or active screening of contacts to COVID-19 patients or recently travelled (mostly asymptomatic group)</p> <p><b>Sample size:</b> n = 1435 (340 cases)</p> <p><b>Inclusion criteria:</b> all participants presented to King Abdullah Medical City and tested for COVID-19</p> <p><b>Exclusion criteria:</b> participants who did not have a documented COVID-19 respiratory triage score, or presented prior to 2 April 2020</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> Saudi-Arabia</p> <p><b>Dates:</b> 02 April 2020-12 September 2020 (date of submission article)</p> <p><b>Symptoms and severity:</b> mostly asymptomatic, mild or moderate severity</p> <p><b>Demographics:</b> age: controls mean 39.3 years, cases mean 38.7 years M%/F%: cases 68.5/31.5, controls 55.4/44.6</p> <p><b>Exposure history:</b> not specified, &gt; 70% of participants were HCW</p>
Index tests	<ul style="list-style-type: none"> <li>• Saudi CDC COVID-19 respiratory triage score (exposure risks + fever or recent history of fever, cough (new or worsening), shortness of breath (new or worsening), nausea, vomiting, and/or diarrhoea)</li> <li>• Fever</li> <li>• Cough</li> <li>• Dyspnoea</li> <li>• GI symptoms</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasopharyngeal swab)</li> </ul>

**Aldobyany 2020** (Continued)

Flow and timing Timing not specified

Comparative

Notes

Setting unclear

Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern

**Aldobyany 2020** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Alizadehsani 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of COVID-19 pneumonia; to identify risk factors for disease and mortality</p> <p><b>Design:</b> cross-sectional cohort, prospective data collection</p> <p><b>Recruitment:</b> all patients referred to the imaging department through the ED on suspicion of COVID-19 (with flu-like symptoms)</p> <p><b>Sample size:</b> n = 319 (123 cases)</p> <p><b>Inclusion criteria:</b> patients with flu-like symptoms referred to the imaging department</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> patients with positive findings on lung CT</p> <p><b>Facility controls:</b> patients with negative lung CT</p> <p><b>Country:</b> Iran</p> <p><b>Dates:</b> 01 March 2020-08 April 2020</p> <p><b>Symptoms and severity:</b> not specified. 1/3 had COVID-19 pneumonia</p> <p><b>Demographics:</b> mean age cases: 52.0 years controls: 44.1 years M%/F%: cases 40.8/59.2, controls 50.4/49.6</p> <p><b>Exposure history:</b> travelling in past 3 months: cases 4.9%, controls 3.1%</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Dyspnoea</li> <li>• Weakness</li> <li>• Shivering</li> <li>• Fatigue</li> <li>• Dry cough</li> <li>• Anorexia</li> <li>• Anosmia</li> <li>• Ageusia</li> <li>• Dizziness</li> </ul>

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Alizadehsani 2021** (Continued)

	<ul style="list-style-type: none"> <li>Sweating</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: COVID-19 pneumonia</li> <li>RS: thin-slice high-resolution multi-slice spiral CT scan in a supine position, and high-resolution CT images of all patients were reviewed by a radiologist with &gt; 14 years of experience in chest imaging</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	No		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			High
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Unclear risk	

**Alizadehsani 2021** (Continued)

**Are there concerns that the target condition as defined by the reference standard does not match the question?**

Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?      Unclear

Did all patients receive the same reference standard?      Yes

Were all patients included in the analysis?      Yes

**Could the patient flow have introduced bias?**      Unclear risk

**Allegorico 2020**
**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to explore the value of lung ultrasonography to predict RT-PCR test results

**Design:** cross-sectional cohort study, retrospective data collection

**Recruitment:** consecutive ED patients were included if they had either fever (body temperature > 37.5 °C) and/or history of cough and/or dyspnoea within the previous 48 h as assessed on day 1

**Sample size:** n = 79 (42 cases)

**Inclusion criteria:** all patients with fever (body temperature > 37.5 °C measured using infrared thermometer) and of cough and/or dyspnoea

**Exclusion criteria:** patients with missing clinical, biochemistry and radiological data (thoracic ultrasound, CT scan)

Patient characteristics and setting

**Facility cases:** positive RT-PCR for SARS-CoV-2

**Facility controls:** negative RT-PCR for SARS-CoV-2

**Country:** Italy

**Dates:** 01 March 2020-30 April 2020

**Symptoms and severity:** not specified. 75% of all participants had dyspnoea

**Demographics:** median age cases 68.5 years, controls 67.5 years

M%/F%: cases 69.0/31.0, controls 67.6/32.4

**Exposure history:** not specified

Index tests

- Body temperature
- Cough
- Dyspnoea
- Respiratory rate

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Allegorico 2020** (Continued)

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasal swab)</li> </ul>
Flow and timing	Index tests and RS both taken on day 1
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern



**Allegorico 2020** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Yes

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Low risk

**Arenas 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe the clinical features of kidney transplant (KT) and maintenance haemodialysis (MHD) patients, comparing confirmed and suspected non-confirmed COVID-19 cases</p> <p><b>Design:</b> cross-sectional multicenter cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all KT recipients and MHD patients who were studied in the Hospital del Mar for suspected COVID-19 infection</p> <p><b>Sample size:</b> n = 61 (34 cases)</p> <p><b>Inclusion criteria:</b> any patients admitted in that 40-day period with COVID-19-compatible signs, fever was the main symptom leading to suspicion of COVID-19 and testing</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Definition cases:</b> all KT and MHD patients admitted with a single positive RT-PCR test for SARS-CoV-2 (1 case with first a negative and later on a positive test)</p> <p><b>Definition controls:</b> negative RT-PCR test for SARS-CoV-2 (17/27 got a consecutive negative test)</p> <p><b>Country:</b> Spain</p> <p><b>Dates:</b> 12 March 2020-21 April 2020</p> <p><b>Symptoms and severity:</b> inclusion based on potential COVID-symptoms 30/34 cases pneumonia, 5/27 controls had pneumonia</p> <p><b>Demographics:</b> age: controls mean 62.1 years, cases mean 69.0 years M%/F%: cases 70.6/29.4, controls 78.8/21.2</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Cough</li> <li>• Dyspnoea</li> <li>• Asthenia</li> <li>• Myalgia</li> </ul>

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Arenas 2020** (Continued)

- Diarrhoea
- Headache
- Ageusia
- Anosmia

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, nasopharyngeal swabs or bronchoalveolar lavage</li> </ul>
Flow and timing	Unclear time interval. Symptoms recorded on admission. Timing of reference test not specified
Comparative	
Notes	KT and MHD patients: very specific population at higher risk of infection  Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			High
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		

**Arenas 2020** (Continued)

Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Arslan 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to identify the clinical findings and outcomes of children with COVID-19 and factors predicting RT-PCR positivity</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all suspected COVID-19 patients (children) admitted to and treated in the ED, inpatient clinic, or paediatric ICU of a tertiary hospital (suspected if a child had contact with a confirmed COVID-19 case, lived in an epidemic area where COVID-19 case(s) were reported, or had any family member hospitalised due to a respiratory infection or experiencing symptoms such as cough, fever, or shortness of breath in the last 2 weeks and if the children had respiratory or GI symptoms)</p> <p><b>Sample size:</b> n = 404 (176 cases)</p> <p><b>Inclusion criteria:</b> children between 1 month and 18 years of age presenting to the ED, inpatient clinic, or paediatric ICU, suspected of COVID-19</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive SARS-CoV-2 test</p> <p><b>Facility controls:</b> negative SARS-CoV-2 test</p> <p><b>Country:</b> Turkey</p> <p><b>Dates:</b> 20 March 2020-31 May 2020</p> <p><b>Symptoms and severity:</b> asymptomatic: 33.5% of cases; mild: 53.4% of cases; moderate: 12.5% of cases; severe: 0.0% of cases; critical: 0.6% of cases</p> <p><b>Demographics:</b> median age cases 79 months, controls 30.5 months</p>

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Arslan 2021** (Continued)

M%/F%: cases 55.7/44.3, controls 59.2/40.8

**Exposure history:** previous exposure to SARS-CoV-2-infected person: cases 93%, controls 23%

Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Shortness of breath</li> <li>• Fatigue</li> <li>• Sore throat</li> <li>• Rhinorrhoea</li> <li>• Nausea/vomiting</li> <li>• Diarrhoea</li> <li>• Smell/taste loss</li> <li>• Tachypnoea</li> <li>• Tachycardia</li> <li>• Low oxygen saturation (&lt; 92%)</li> <li>• Crackle</li> <li>• Rhonchus</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasopharyngeal swab)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Arslan 2021** (Continued)

<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern
<b>DOMAIN 3: Reference Standard</b>	
Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Barbhaya 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to investigate and characterise mild to moderate COVID-19 and risk factors</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> patients presenting to a dedicated ambulatory COVID-19 clinic in Washington DC</p> <p><b>Sample size:</b> n = 2471 (846)</p> <p><b>Inclusion criteria:</b> patients from the community and hospital associates; PCR tested, prescreened for symptoms or exposure; decisions for testing made according to CDC guidelines in place at the time of each encounter, most often only if the patient was symptomatic</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive SARS-CoV-2 test</p> <p><b>Facility controls:</b> negative SARS-CoV-2 test</p>

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Barbhaya 2021** (Continued)

**Country:** USA

**Dates:** 11 March 2020-14 June 2020

**Symptoms and severity:** mild to moderate disease 88.9%, severe disease (= hospitalisation) 11.1%

**Demographics:** mean age cases 43.2 years, controls 43.5 years

M%/F%: cases 47.8/52.0, controls 35.5/64.4, 0.1% not specified

**Exposure history:** exposure to patient with COVID-19 58.7%

Index tests	<ul style="list-style-type: none"> <li>• Anosmia</li> <li>• Subjective fever</li> <li>• Change in taste</li> <li>• Anorexia</li> <li>• Objective fever</li> <li>• Myalgias</li> <li>• Cough</li> <li>• Chills</li> <li>• Fatigue/malaise</li> <li>• Dizziness</li> <li>• Headache</li> <li>• Nausea</li> <li>• Diarrhoea</li> <li>• Rhinorrhoea</li> <li>• Vomiting</li> <li>• Shortness of breath</li> <li>• Chest pain</li> <li>• Abdominal pain</li> <li>• Sore throat</li> <li>• Congestion</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasopharyngeal and mid-turbinate swab)</li> </ul>
Flow and timing	Index tests and RS both taken at presentation
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Barbhaya 2021** (Continued)

Did the study avoid inappropriate inclusions?	Unclear	
<b>Could the selection of patients have introduced bias?</b>		Unclear risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Low risk

**Bhattacharya 2021**
**Study characteristics**

## Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to evaluate the clinical symptoms among patients with suspected COVID-19 presenting to screening outpatient clinics to develop and validate a clinical symptom-based scoring system

**Design:** cross-sectional cohort study, prospective data collection



**Bhattacharya 2021** (Continued)

**Recruitment:** patients presenting to an outpatient clinic at a tertiary care hospital

**Sample size:** n = 378 (125)

**Inclusion criteria:** patients who were suspected of having COVID-19 and tested, provided informed consent and were contacted successfully by phone, from 1066 suspected patients who were tested during this period, 384 patients were enrolled in the study based on the availability of informed consent and successful telephonic communication). Suspicion was based on the testing advisory developed by the Indian Council of Medical Research (ICMR), Version 5, dated 18 May 2020. "ILI symptoms", defined as acute respiratory infection with fever  $\geq 38$  °C AND cough.

**Exclusion criteria:** no PCR test result

## Patient characteristics and setting

**Facility cases:** positive SARS-CoV-2 test

**Facility controls:** negative SARS-CoV-2 test

**Country:** India

**Dates:** 17 June 2020-1 July 2020

**Symptoms and severity:** not specified, mostly mild to moderate severity

**Demographics:** mean age overall 35.6 years

M%/F% overall: 65.1/34.9

**Exposure history:** not specified

## Index tests

- Body temperature (cutoff fever  $>37.8$ °C)
- Sore throat
- Cough
- Headache
- Myalgia
- Breathlessness
- Nausea
- Vomiting
- Diarrhoea
- Loss of smell

## Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: RT-PCR for SARS-CoV-2 (nasal + throat swab)

## Flow and timing

Index tests and RS both at presentation, phone interview after test was taken but before result was generated

## Comparative

## Notes

Funding: none declared

**Methodological quality**
**Item**
**Authors' judgement**
**Risk of bias**
**Applicability concerns**
**DOMAIN 1: Patient Selection**
**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Bhattacharya 2021** (Continued)

Was a consecutive or random sample of patients enrolled?	No	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Did the study avoid inappropriate inclusions?	No	
<b>Could the selection of patients have introduced bias?</b>		High risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	Yes	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		Unclear risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Unclear
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	No	
<b>Could the patient flow have introduced bias?</b>		Unclear risk

## Bouzid 2020

### Study characteristics

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to identify clinical or biological characteristics to help distinguish SARS-CoV-2 from other respiratory viruses</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> all consecutive patients admitted through the ED and presenting with respiratory symptoms</p> <p><b>Sample size:</b> n = 596 (268 cases) (from 03 March 2020)</p> <p><b>Inclusion criteria:</b> all consecutive patients presenting with an influenza-like illness (ILI: fever with a temperature &gt; 38.5 °C, malaise, headache, and myalgia; and 1 respiratory symptom (cough, sore throat, and dyspnoea)) and admitted to the hospital through the ED</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive SARS-CoV-2 test</p> <p><b>Facility controls:</b> negative SARS-CoV-2 test</p> <p><b>Country:</b> France</p> <p><b>Dates:</b> 03 March 2020-30 March 2020</p> <p><b>Symptoms and severity:</b> not specified, all patients presented with ILI, 13% needed ICU admission, 13% died</p> <p><b>Demographics:</b> median age cases 59 years, controls 62 years</p> <p>M%/F%: cases 71.0/29.0, controls 50.0/50.0</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Feverishness</li> <li>• Hypothermia</li> <li>• Chills</li> <li>• Sweats</li> <li>• Headaches</li> <li>• Myalgia</li> <li>• Malaise</li> <li>• Cough</li> <li>• Sore throat</li> <li>• Dyspnea</li> <li>• Expectoration</li> <li>• Chest pain</li> <li>• Bilateral cracklings</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: depending on kit availability, viral investigations were conducted either with the QIAstat-Dx Respiratory SARS-CoV-2 Panel (Qiagen, Hilden, Germany), allowing for the detection of respiratory pathogens plus SARS-CoV-2, or with a combination of the RT-PCR RealStar SARS-CoV-2 Kit RUO (Altona Diagnostics, Hamburg, Germany) and rapid multiplex PCR FilmArray RP2 (BioFire, BioMerieux, Marcy-L'Etoile, France), specimen not specified</li> </ul>

**Bouzid 2020** (Continued)

Flow and timing Index tests and RS both taken at ED admission

Comparative

Notes

Conflicts of interest: DB and BV declare having received past personal fees and grant from Qiagen (Hilden, Germany)

Funded by the AP-HP (Assistance Publique – Hôpitaux de Paris). This study was supported by Qiagen in the form of a grant funding the data management of the RespiFast2 study targeting to assess the impact of respiratory viruses and of discounted equipment and consumables in the context of the COVID-19 outbreak.

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		

**Bouzid 2020** (Continued)

<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	No
Were all patients included in the analysis?	Unclear
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Brendish 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to examine and compare the clinical characteristics, symptoms, and outcomes of adult patients presenting to the ED or Acute Medicine Unit (AMU), testing positive and negative for COVID-19</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection from a large, controlled, non-randomised trial of molecular POC testing vs laboratory RT-PCR for SARS-CoV-2</p> <p><b>Recruitment:</b> all consecutive patients presenting to the ED or AMU or other admissions area of Southampton, with an acute respiratory illness or otherwise clinically suspected of having COVID-19 (= all patients included in the CoV-19 POC trial)</p> <p><b>Sample size:</b> n = 1054 (352 cases)</p> <p><b>Inclusion criteria:</b> all consecutive adults (<math>\geq 18</math> years old), presenting to the ED or AMU or other admissions area of Southampton, with an acute respiratory illness or otherwise clinically suspected of having COVID-19</p> <p><b>Exclusion criteria:</b> not fulfilling all the inclusion criteria; declines nasal/pharyngeal swabbing; consent declined or consultee consent declined; already recruited to the study in the last 14 days</p>
Patient characteristics and setting	<p><b>Facility cases:</b> PCR-positive patients by either molecular POC testing or laboratory RT-PCR</p> <p><b>Facility controls:</b> PCR-negative patients by either molecular POC testing or laboratory RT-PCR</p> <p><b>Country:</b> UK</p> <p><b>Dates:</b> 20 March 2020-29 April 2020</p> <p><b>Symptoms and severity:</b> mild to moderate to severe</p> <ul style="list-style-type: none"> <li>• 20% of cases received supplemental oxygen, 10% of controls</li> </ul>

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Brendish 2020** (Continued)

- 18% of cases admitted to ICU, 6% of controls
- 25% of cases died within 30 days, 12% of controls

**Demographics:** median age cases 68 years, controls 69 years

M%/F%: cases 57.4/42.6, controls 51.7/48.3

**Exposure history:** not specified, 21% of cases a HCW, 5% of controls

Index tests	<ul style="list-style-type: none"> <li>• Sore throat</li> <li>• Rhinorrhoea</li> <li>• Wheeze</li> <li>• Shortness of breath</li> <li>• Pleuritic chest pain</li> <li>• Cough</li> <li>• Sputum</li> <li>• Fever (body temperature <math>\geq 37.8</math> °C)</li> <li>• Chills</li> <li>• Fatigue</li> <li>• Reduced appetite</li> <li>• Headache</li> <li>• Myalgia</li> <li>• Diarrhoea</li> <li>• Abdominal pain</li> <li>• Anosmia</li> <li>• Heart rate</li> <li>• Respiratory rate</li> <li>• Systolic BP</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: either laboratory RT-PCR or molecular POC testing (QIAGEN) for SARS-CoV-2 (nasopharyngeal swab)</li> </ul>
Flow and timing	Index tests and RS both taken at admission
Comparative	
Notes	<p>Unclear how decision was made which patients received which RS.</p> <p>Funding: the CoV-19 POC trial was funded by University of Southampton and University Hospital Southampton NHS Foundation Trust. NJB is supported by a National Institute of Health Research (NIHR) Clinical Lecturer post. TWC is supported by a NIHR Fellowship (PDF 2016-09-061).</p>

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		

**Brendish 2020** (Continued)

Did the study avoid inappropriate exclusions?	No	
Did the study avoid inappropriate inclusions?	Yes	
<b>Could the selection of patients have introduced bias?</b>		High risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	No	
Were all patients included in the analysis?	Yes	



**Brendish 2020** (Continued)

**Could the patient flow have introduced bias?**

Unclear risk

**Buonafine 2020**
**Study characteristics**

## Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to investigate the prevalence and clinical characteristics of HCWs with COVID-19 symptoms

**Design:** cross-sectional cohort study, prospective data collection

**Recruitment:** HCW from the Santa Casa de São Paulo Hospital were defined as symptomatic and invited to participate in the study if presented with self-reported fever or symptoms suspicious of COVID-19

**Sample size:** n = 295 (125 cases)

**Inclusion criteria:** HCW with self-reported fever or any of the following: acute respiratory symptoms (cough, nasal congestion, sore throat, shortness of breath), loss or changed sense of smell or taste, ocular symptoms, headache, arthralgia, myalgia, fatigue, diarrhoea, nausea, and vomiting

**Exclusion criteria:** none specified

## Patient characteristics and setting

**Facility cases:** RT-PCR-positive for SARS-CoV-2

**Facility controls:** RT-PCR-negative for SARS-CoV-2

**Country:** Brazil

**Dates:** 21 March 2020-22 May 2020

**Symptoms and severity:** mild to moderate to severe: 7% hospitalised 2% died, 91% of included individuals had headache, 88% nasal congestion, 85% cough, 85% fatigue, 81% myalgia

**Demographics:** mean age cases 35 years, controls 34 years

M%/F%: cases 40.0/60.0, controls 23.6/76.4

**Exposure history:** all HCW. Close contact with confirmed COVID-19: cases 73%; controls 74%

## Index tests

- Headache
- Nasal congestion
- Cough
- Fatigue
- Myalgia
- Sore throat
- Chills
- Ocular pain
- Fever
- Arthralgia
- Diarrhoea
- Abdominal pain
- Shortness of breath

**Buonafine 2020** (Continued)

- Cutaneous rash
- Anosmia

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasopharyngeal and oropharyngeal swab)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	

**Buonafine 2020** (Continued)

**Are there concerns that the target condition as defined by the reference standard does not match the question?**

Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?      Unclear

Did all patients receive the same reference standard?      Yes

Were all patients included in the analysis?      Yes

**Could the patient flow have introduced bias?**      Unclear risk

**Chan 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease)</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all patients aged <math>\geq 18</math> years in custody in a New York City jail facility or hospital units housing patients from the jail system who were tested for COVID-19</p> <p><b>Sample size:</b> n = 721 (510 cases)</p> <p><b>Inclusion criteria:</b> all patients aged <math>\geq 18</math> (as of 11 March 2020) in custody in a New York City jail facility or hospital units housing patients from the jail system and tested for COVID-19</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> RT-PCR positive for SARS-CoV-2</p> <p><b>Facility controls:</b> RT-PCR negative for SARS-CoV-2</p> <p><b>Country:</b> New York, USA</p> <p><b>Dates:</b> 11 March 2020-28 April 2020</p> <p><b>Symptoms and severity:</b> mild to moderate to severe: 8% hospitalised, 1% ICU admission, 1% died</p> <p><b>Demographics:</b> median age cases 37 years, controls 33 years M%/F%: cases 91.0/9.0, controls 92.0/8.0</p> <p><b>Exposure history:</b> not specified, all participants in custody in the New York City jail system during a COVID-19 outbreak</p>
Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Fever</li> <li>• Sore throat</li> <li>• Shortness of breath</li> </ul>

**Chan 2021** (Continued)

	<ul style="list-style-type: none"> <li>• Myalgia</li> <li>• Malaise</li> <li>• Headache</li> <li>• Fatigue</li> <li>• Chills</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasopharyngeal swab)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Very specific population Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			High
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		

**Chan 2021** (Continued)

<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Cheng 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> to identify the clinical features and CT manifestations of COVID-19 and compare them with those of pneumonia occurring in patients who do not have COVID-19</p> <p><b>Design:</b> cross-sectional, single-centre, retrospective study</p> <p><b>Recruitment:</b> pneumonia patients who presented at a fever observation department in Shanghai</p> <p><b>Sample size:</b> n = 33 (11 cases)</p> <p><b>Inclusion criteria:</b> patients with clinical and radiological features of pneumonia, and a normal or reduced total leukocyte count or total lymphocyte count, plus an epidemiologic history that included travel or a history of residence in Hubei Province or other areas where continuous transmission of local cases occurred within 14 days before onset of symptoms, a history of contact with patients who had fever or respiratory symptoms and were from Hubei Province or other areas with continuous transmission of local cases within 14 days before onset of the disease, or clustering or epidemiologic association with the new coronavirus infection</p> <p><b>Exclusion criteria:</b> not defined</p>
Patient characteristics and setting	<p><b>Facility cases:</b> confirmed case: positive RT-PCR test result obtained by a throat swab. Test was repeated when the first test was negative</p> <p><b>Facility controls:</b> pneumonia patients confirmed not to be infected by SARS-CoV-2 (2 PCR tests)</p> <p><b>Country:</b> China</p> <p><b>Dates:</b> 19 January 2020-6 February 2020</p> <p><b>Symptoms and severity:</b> pneumonia was defined as patients with at least 1 clinical symptom (i.e. cough, sputum, fever, dyspnoea, or pleuritic chest pain), a finding of either coarse crackles on auscultation or elevated inflammatory biomarkers, and observation of a new pulmonary opacification on chest CT</p>

**Cheng 2020** (Continued)

**Demographics:** median age  $\pm$  SD cases 50.36  $\pm$  15.5, controls 43.59  $\pm$  16.02, gender distribution cases (M/F: 8/3), controls (M/F: 7/15)

**Exposure history:** cases 8/11, controls 7/22 (in the last 14 days with patients with fever or respiratory symptoms or with known cases)

Index tests	<ul style="list-style-type: none"> <li>Fever</li> <li>Cough</li> <li>Sputum</li> <li>Shortness of breath</li> <li>Muscle ache</li> <li>Diarrhoea</li> <li>Sore throat</li> <li>Peak body temperature</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: COVID-19 pneumonia</li> <li>RS: RT-PCR testing on throat swab specimens</li> </ul> <p>Tests were repeated if the first test was negative</p>
Flow and timing	Time interval not specified, reference test at day 0 (or later when the first test was negative), index tests were questionnaire at day 0 for the presence of symptoms in the past period of time
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	No		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			High
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**



**Cheng 2020** (Continued)

<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern
<b>DOMAIN 3: Reference Standard</b>	
Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Chew 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to develop a prediction model to identify patients who are at low risk of having COVID-19</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all patients admitted to the Pneumonia and Acute Respiratory Infection (PARI) wards of Changi General Hospital</p> <p><b>Sample size:</b> n = 1228 (52 cases)</p> <p><b>Inclusion criteria:</b> all patients admitted to PARI wards</p> <p><b>Exclusion criteria:</b> none specified, for patients with multiple admissions during the study period, analysis was limited to the first PARI admission</p>
------------------	--

**Chew 2021** (Continued)

Patient characteristics and setting	<p><b>Facility cases:</b> RT-PCR-positive for SARS-CoV-2</p> <p><b>Facility controls:</b> RT-PCR-negative for SARS-CoV-2</p> <p><b>Country:</b> Singapore</p> <p><b>Dates:</b> 10 February 2020-30 April 2020</p> <p><b>Symptoms and severity:</b> not specified, mild to moderate severity</p> <p><b>Demographics:</b> median age cases 48 years, controls 64 years</p> <p>M%/F%: total cohort 59.9/40.1</p> <p><b>Exposure history:</b> contact with people with acute respiratory infection, cases 36%, controls 4%; travel history: cases 3%, controls 2%</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Cough</li> <li>• Sore throat</li> <li>• Rhinorrhoea</li> <li>• Anosmia</li> <li>• Breathlessness</li> <li>• Headache</li> <li>• Chest discomfort</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasopharyngeal and oropharyngeal swab)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			

**Chew 2021** (Continued)

Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear
If a threshold was used, was it pre-specified?	No
<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern
<b>DOMAIN 3: Reference Standard</b>	
Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Chua 2020**
**Study characteristics**

## Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to evaluate the utility of acute olfactory loss as a risk-stratifying tool for COVID-19

**Design:** retrospective cohort study

**Recruitment:** chart review was performed for all patients who presented with acute respiratory symptoms, and in those who fulfilled the prevailing Ministry of Health suspect or surveillance case definition, at ED of tertiary hospital

**Sample size:** n = 688 (24 cases)

**Inclusion criteria:** all patients with suspected SARS-CoV-2 infection (suspicion based on presence of acute respiratory symptoms, and fulfilling the prevailing Ministry of Health suspect or surveillance case definition)

**Chua 2020** (Continued)

	<p><b>Exclusion criteria:</b> patients with pre-existing olfactory loss, and those who were unable to give a history of olfactory loss reliably (e.g. those with cognitive impairment)</p>
Patient characteristics and setting	<p><b>Facility cases:</b> suspected patients with a positive PCR test</p> <p><b>Facility controls:</b> suspected patients with a negative PCR test</p> <p><b>Country:</b> Singapore</p> <p><b>Dates:</b> 23 March 2020-04 April 2020</p> <p><b>Symptoms and severity:</b> not specified</p> <p><b>Demographics:</b> age: not specified gender: not specified</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>Hyposmia</li> <li>Anosmia</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> <li>RS: RT-PCR (oropharyngeal swab)</li> </ul>
Flow and timing	RS and index tests both taken at presentation
Comparative	
Notes	

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

108

**Chua 2020** (Continued)

**Are there concerns that the index test, its conduct, or interpretation differ from the review question?** Low concern

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition? Yes

Were the reference standard results interpreted without knowledge of the results of the index tests? Unclear

**Could the reference standard, its conduct, or its interpretation have introduced bias?** Low risk

**Are there concerns that the target condition as defined by the reference standard does not match the question?** Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Yes

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Low risk

**Chung 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease) - compare symptoms and characteristics of people with and without laboratory-confirmed SARS-CoV-2 infection</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> research staff screened for study eligibility among people of all ages who had sought medical care (e.g. tele health, primary care, urgent care, and EDs) and/or COVID-19 testing for an acute respiratory illness</p> <p><b>Sample size:</b> n = 4961 (916 cases)</p> <p><b>Inclusion criteria:</b> reported acute illness with fever/feverishness, cough, or shortness of breath/difficulty breathing and had a respiratory specimen collected for SARS-CoV-2 testing within 10 days of illness onset</p> <p><b>Exclusion criteria:</b> people tested by antigen detection assays alone; swabbed, tested, or interviewed &gt; 10 days after symptom onset; inconclusive RT-PCR results</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive SARS-CoV-2 test</p> <p><b>Facility controls:</b> negative SARS-CoV-2 test</p> <p><b>Country:</b> USA</p>

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

109

**Chung 2021** (Continued)

**Dates:** 26 March 2020-15 August 2020

**Symptoms and severity:** not specified, mostly mild to moderate

**Demographics:** age groups ≤ 4 years: cases 1% controls 6%; 5-17 years: cases 4% controls 8%; 18-49 years: cases 65% controls 56%; 50-64 years: cases 21% controls 22 years; ≥ 65 years: cases 9% controls 9%

M%/F%: cases 61.0/39.0, controls 67.0/33.0

**Exposure history:** previous exposure to person with known COVID-19: cases 59%, controls 18%

Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Fever/feverishness</li> <li>• Shortness of breath</li> <li>• Loss sense of taste/smell</li> <li>• Headache</li> <li>• Muscle aches</li> <li>• Nasal congestion</li> <li>• Chills</li> <li>• Sore throat</li> <li>• Diarrhea</li> <li>• Abdominal pain</li> <li>• Vomiting</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasal or nasopharyngeal swab)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: supported through cooperative agreements funded by the US Centers for Disease Control and Prevention and, at the University of Pittsburgh, by infrastructure funding from the National Institutes of Health (UL1 TR001857).

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern

**Chung 2021** (Continued)

**DOMAIN 2: Index Test (All tests)**

Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear
If a threshold was used, was it pre-specified?	No
<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
<b>Could the patient flow have introduced bias?</b>	High risk

**Clemency 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to develop symptom-based criteria for screening of HCW for SARS-CoV-2</p> <p><b>Design:</b> prospective observational cohort</p> <p><b>Recruitment:</b> HCW with symptoms concerning for COVID-19 infection were evaluated for potential testing through a centralised nurse call centre and referred to outpatient drive-through testing sites if any suspicion of infection</p> <p><b>Sample size:</b> n = 961 (225 cases)</p>
------------------	--

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**



**Clemency 2020** (Continued)

**Inclusion criteria:** all HCW tested for SARS-CoV-2, based on symptom-based triage ("symptoms concerning for COVID-19 infection")

**Exclusion criteria:** none specified (141 excluded because symptoms were not documented, 12 excluded because test results not available)

Patient characteristics and setting	<p><b>Facility cases:</b> all consecutive HCW with a single positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> all consecutive HCW with a single negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> New York, USA</p> <p><b>Dates:</b> 26 March 2020-16 April 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity, inclusion based on presenting symptoms</p> <p><b>Demographics:</b> mean age not presented; gender not presented</p> <p><b>Exposure history:</b> not presented (likely a high rate of exposure, because HCW)</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Fatigue</li> <li>• Dry cough</li> <li>• Loss of appetite</li> <li>• Myalgia</li> <li>• Difficulty breathing</li> <li>• Coughing up phlegm</li> <li>• Sore throat</li> <li>• Diarrhoea</li> <li>• Loss of taste or smell</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: (single) RT-PCR, nasopharyngeal or oropharyngeal swabs</li> </ul>
Flow and timing	HCW referred for reference test after index test, but exact time interval not specified
Comparative	
Notes	Funding: supported by the National Center for Advancing Translational Sciences of the National Institutes of Health under award UL1TR001412 to the University at Buffalo

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		

**Clemency 2020** (Continued)

Did the study avoid inappropriate exclusions?	Yes	
Did the study avoid inappropriate inclusions?	Yes	
<b>Could the selection of patients have introduced bias?</b>		Low risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	Unclear	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Low risk

**Clifford 2020**
**Study characteristics**

**Clifford 2020** (Continued)

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to investigate the association between different triage chief complaints and COVID-19 status</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all adult ED visits (structured data) of patients who underwent nasopharyngeal swab RT-PCR testing</p> <p><b>Sample size:</b> n = 11992 (6524 cases)</p> <p><b>Inclusion criteria:</b> all adult patients undergoing RT-PCR at the ED</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> RT-PCR-positive for SARS-CoV-2</p> <p><b>Facility controls:</b> RT-PCR-negative for SARS-CoV-2</p> <p><b>Country:</b> New York, USA</p> <p><b>Dates:</b> 01 March 2020-13 May 2020</p> <p><b>Symptoms and severity:</b> mild to moderate to severe; hospital admission cases 65% controls 47%; mortality cases 20% controls 4%; intubation and ventilation cases 16% controls 4%</p> <p><b>Demographics:</b> median age cases 62 years, controls 54 years</p> <p>M%/F%: cases 55.5/44.5, controls 48.5/51.5</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Shortness of breath</li> <li>• Cough</li> <li>• Weakness/fall/altered mental status</li> <li>• Endocrine</li> <li>• Other viral symptoms</li> <li>• GI complaints</li> <li>• Genitourinary complaints</li> <li>• Neurological deficit or cerebrovascular accident, stroke-like symptoms, or seizures</li> <li>• Chest pain</li> <li>• Abdominal pain</li> <li>• Orthopedic complaints</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasopharyngeal swab)</li> </ul>
Flow and timing	Timing of RS not specified
Comparative	
Notes	Funding: none declared
<b>Methodological quality</b>	

**Clifford 2020** (Continued)

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Unclear		
Did all patients receive the same reference standard?	Yes		
Were all patients included in the analysis?	Yes		
<b>Could the patient flow have introduced bias?</b>		Unclear risk	

**Cunarro-Lopez 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to examine maternal-perinatal outcomes in pregnant women with suspected COVID-19 according to the result of a RT-PCR test and to investigate possible variables that could be useful for predicting a negative RT-PCR result</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> obstetrics patient (pregnant, in labour or puerperium) with suspected COVID-19 who attended the hospital</p> <p><b>Sample size:</b> n = 111 (68 cases)</p> <p><b>Inclusion criteria:</b> all obstetrics patients (pregnant, in labour or puerperium) with suspected COVID-19 who attended the hospital</p> <p><b>Exclusion criteria:</b> non-conclusive RT-PCR result, those patients who did not undergo obstetric follow-up in the hospital and asymptomatic patients with SARS-CoV-2 infections</p>
Patient characteristics and setting	<p><b>Facility cases:</b> RT-PCR positive for SARS-CoV-2</p> <p><b>Facility controls:</b> RT-PCR negative for SARS-CoV-2</p> <p><b>Country:</b> Spain</p> <p><b>Dates:</b> 10 March 2020-12 May 2020</p> <p><b>Symptoms and severity</b></p> <ul style="list-style-type: none"> <li>• cases: mild 52%, moderate 28%, severe 12%, critical 6%</li> <li>• controls: mild 79%, moderate 16%, severe 5%, critical 0%</li> </ul> <p><b>Demographics:</b> mean age cases 34 years, controls 32 years</p> <p>M%/F%: cases 0.0/100.0, controls 40.0/100.0</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Cough</li> <li>• Shortness of breath</li> <li>• Diarrhoea</li> <li>• Body temperature</li> <li>• Breathing frequency</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasal or pharyngeal swab)</li> </ul>
Flow and timing	Timing of RS not specified
Comparative	
Notes	Funding: by University of Alcalá (COVID-19 UAH 2019/00003/016/001/023) and by (FIS-PI18/00912) the Instituto de Salud Carlos III (Plan Estatal de I

**Cunarro-Lopez 2020** (Continued)

+ D+I 2013-2016) and co financed by the European Development Regional Fund

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			High
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Unclear		

**Cunarro-Lopez 2020** (Continued)

Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Drager 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to analyse clinical characteristics of patients with SARS-CoV-2 suspicion</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> all symptomatic patients presenting at the Corona outpatient clinic at the Carl Gustav Carus University hospital of Dresden</p> <p><b>Sample size:</b> n = 2257 (163 cases)</p> <p><b>Inclusion criteria:</b> all patients presenting themselves at the outpatient clinic: patients with symptoms (not further specified) + high-risk contacts or returning from a high-risk area where tested for SARS-CoV-2</p> <p><b>Exclusion criteria:</b> non specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> RT-PCR-positive for SARS-CoV-2</p> <p><b>Facility controls:</b> RT-PCR-negative for SARS-CoV-2</p> <p><b>Country:</b> Germany</p> <p><b>Dates:</b> 09 March 2020-31 March 2020</p> <p><b>Symptoms and severity:</b> mostly cough and upper airway symptoms, mild to moderate, no hospitalisations specified</p> <p><b>Demographics:</b> median age overall 39 years</p> <p>overall 45% male 55% female</p> <p>32% had pre-existing illness</p> <p><b>Exposure history:</b> 5% tested based on epidemiology (returning from high-risk area), 27% had exposure to COVID-19-positive patient(s)</p>
Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Headache</li> <li>• Nasal congestion</li> <li>• Muscle pains</li> <li>• Sore throat</li> <li>• Fever</li> <li>• Diarrhoea</li> <li>• Shortness of breath</li> </ul>



**Drager 2020** (Continued)

	<ul style="list-style-type: none"> <li>Vomiting/nausea</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> <li>RS: not specified (throat swab)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Yes		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		Low risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Unclear		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Unclear

**Drager 2020** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?      Unclear

Did all patients receive the same reference standard?      Yes

Were all patients included in the analysis?      Yes

**Could the patient flow have introduced bias?**      Unclear risk

**Feng 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of COVID-19 pneumonia</p> <p><b>Design:</b> cross-sectional, retrospective, single-centre study</p> <p><b>Recruitment:</b> patients admitted to ED with history of exposure to COVID-19</p> <p><b>Sample size:</b> n = 132 (cases = 7)</p> <p><b>inclusion criteria:</b> all patients admitted to the fever clinic of the ED of the First Medical Center, Chinese People's Liberation Army General Hospital (PLAGH) in Beijing with the epidemiological history of exposure to COVID-19 according to WHO interim guidance</p> <p><b>Exclusion criteria:</b> &lt; 14 years old, no other criteria specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> among clinically suspected patients: those with a positive RT-PCR</p> <p><b>Facility controls:</b> clinically non-suspected patients + suspected patients with negative RT-PCR</p> <p><b>Country:</b> China</p> <p><b>Dates:</b> 14 January 2020-9 February 2020</p> <p><b>Symptoms and severity:</b> all patients admitted, with exposure history to COVID-19, so all levels of severity; days from illness onset until admission (median, IQR): 2.0 (1.0-5.0); patient population with general mild disease and limited presence of co-morbidities (range 0%-2.3% (COPD))</p> <p><b>Demographics:</b> age: controls median 40.0 years (IQR 32.5-54.5), cases median 39.0 years (IQR 37.0-41.5)</p> <p>M%/F%: cases 71.4/28.6, controls 63.2/36.8</p> <p><b>Exposure history:</b> epidemiological history of exposure to COVID-19 (as per WHO guidance)</p>
Index tests	<ul style="list-style-type: none"> <li>• Heart rate</li> <li>• Diastolic BP</li> <li>• Systolic BP</li> <li>• Fever (former: median only on all and cases - no control median given)</li> <li>• Highest temperature</li> <li>• Cough</li> </ul>

**Feng 2021** (Continued)

- Shortness of breath
- Muscle ache
- Headache
- Sore throat
- Rhinorrhoea
- Diarrhoea
- Nausea
- Vomiting
- Chills
- Shiver
- Expectoration
- Abdominal pain
- Fatigue
- Palpitation

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: COVID-19 pneumonia</li> <li>• RS: in-house RT-PCR (E-gene) - at 4 institutions</li> </ul>
Flow and timing	Index test and RS both taken on admission
Comparative	
Notes	Funding: supported by grants from the PLA Science and Technology Project (14CXZ005, AWS15J004, 16BJZ19), National Key R&D Program of China (2019 yearsFF0302300), Construction Project of Key Disciplines in the 13th Five-Year Plan of the PLA (Traumatic Surgery in the Battlefield, 2019-126, 2019-513), Beijing Science and Technology New Star Project (XX2018019/Z181100006218028), the PLA General Hospital Science and technology Project (2019XXJSYX20, 2018XXFC-20, ZH19016)

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			

**Feng 2021** (Continued)

Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		High risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	No	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		High risk

**Fiel-Ozores 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease) - to identify the main differential clinical features of infection by SARS-CoV-2</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> every paediatric patient (ages 0-15 years) that had undergone a RT-PCR test for detection of SARS-CoV-2 in a nasopharyngeal sample due to suspected infection was invited for a serology test and interview, setting unclear</p> <p><b>Sample size:</b> n = 126 (33 cases)</p>
------------------	---

**Fiel-Ozores 2021** (Continued)

**Inclusion criteria:** patients aged 0-15 years who underwent RT-PCR test due to clinical suspicion of SARS-CoV-2 during the period under study whose parents/legal guardians provided consent and did not meet any of the exclusion criteria

**Exclusion criteria:** patients with serum immunoglobulin (Ig) deficiency. Patients who underwent the RT-PCR test when asymptomatic in the context of contact tracing. Study period: March-May 2020, the months that followed the declaration of the state of alert and the population-wide lock down

## Patient characteristics and setting

**Facility cases:** RT-PCR-positive for SARS-CoV-2

**Facility controls:** RT-PCR-negative for SARS-CoV-2

**Country:** Spain

**Dates:** March 2020-May 2020

**Symptoms and severity:** not specified, mild to moderate severity

**Demographics:** mean age cases 8.4 years, controls 6.5 years M%/F%: cases 66.7/33.3, controls 59.1/40.9

**Exposure history**

- cases: 66.7% had close contact with a positive person (pos RT-PCR test), 81.8% had relatives with symptoms
- controls: 19.4% had close contact with a positive person (pos RT-PCR test), 9.7% had relatives with symptoms

## Index tests

All registered at onset of symptoms and during the course of disease

- Fever
- Headache
- Cough
- Asthenia
- Diarrhoea
- Myalgia
- Breathing difficulty
- Cutaneous manifestations
- Odynophagia
- Chills
- Wheezing
- Anosmia/hyposmia
- Rhinorrhoea
- Dysgeusia
- Abdominal pain
- Vomiting

## Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: RT-PCR for SARS-CoV-2 (nasopharyngeal swab) + serology: IgA and IgG antibodies 3-4 weeks after the RT-PCR test (blood)

## Flow and timing

Timing not specified

## Comparative

## Notes

Median time elapsed to the PCR was 8 days and to the first antibody test was 51 days, but interviews were done at time of serology testing (asking about onset of

**Fiel-Ozores 2021** (Continued)

symptoms and evolution); unclear which test (PCR or serology) was eventually used as RS

Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Unclear		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			High

**Fiel-Ozores 2021** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Unclear
<b>Could the patient flow have introduced bias?</b>	High risk

**Fink 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease) - to define clinical and radiological characteristics of COVID-19 patients within a cohort with respiratory infections in the emergency department</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> patients who presented at the ED of the University Hospital, LMU Munich with signs of a respiratory infection suspicious for COVID-19</p> <p><b>Sample size:</b> n = 219 (72 cases)</p> <p><b>Inclusion criteria:</b> patients who presented at ED with signs of a respiratory infection suspicious for COVID-19 and received radiological imaging (chest radiographs/chest X-ray and/or CT) as well as RT-PCR for SARS-CoV-2</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> Germany</p> <p><b>Dates:</b> 16 March 2020-12 April 2020</p> <p><b>Symptoms and severity:</b> mild to moderate to severe. ICU admission: cases 27%, controls 14%. Deaths: cases 5%, controls 3%</p> <p><b>Demographics:</b> age: controls mean 59.5 years, cases mean 60.0 years</p> <p>M%/F%: cases 68.1/31.9, controls 56.5/43.5</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>Fever (&gt; 38 °C)</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> </ul>



**Fink 2021** (Continued)

- RS: RT-PCR for SARS-CoV-2 (nasopharyngeal and oropharyngeal swab)

Flow and timing	RS and index test both taken at presentation
Comparative	
Notes	Funding: open access funding enabled and organised by Projekt DEAL

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		Low risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern

**Fink 2021** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Yes

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Low risk

**Gilbert 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease)</p> <p><b>Design:</b> prospective cohort, including consecutive patients with suspected SARS-CoV-2 infection</p> <p><b>Recruitment:</b> all patients presenting to the ED triage centre with symptoms suggestive of COVID-19</p> <p><b>Sample size:</b> n = 598 (175 cases)</p> <p><b>Inclusion criteria:</b> all consecutive patients suspected of SARS-CoV-2 infection and directed to the triage centres located close to the EDs and subjected to SARS-CoV-2 testing; suspicion = respiratory symptoms and/or fever in a healthcare provider, an immunosuppressed patient or a nursing home resident, and all patients who required admission to the hospital</p> <p><b>Exclusion criteria:</b> none</p>
Patient characteristics and setting	<p><b>Facility cases:</b> RT-PCR-positive patients</p> <p><b>Facility controls:</b> RT-PCR-negative patients</p> <p><b>Country:</b> Belgium</p> <p><b>Dates:</b> 02 March 2020-23 March 2020</p> <p><b>Symptoms and severity:</b> consecutive patients (selection based on PCR testing), mild to moderate severity (83% sent home for self-isolation, 1.9% ICU, 15% hospital admission)</p> <p><b>Demographics:</b> mean age (all): 41.1 years gender: % female (all): 59.0%</p> <p><b>Exposure history:</b> travel to endemic country: cases 5.1%, controls 12.5% contact with positive patients: cases: 10.9%, controls 9.0%</p>
Index tests	<ul style="list-style-type: none"> <li>• Flu-like symptoms (myalgia, asthenia, fever)</li> <li>• Mild lower respiratory tract infection symptoms (cough, fever, sputum)</li> <li>• Moderate lower respiratory tract infection symptoms (cough, fever, sputum, dyspnoea)</li> <li>• Upper respiratory tract infection symptoms (sore throat, nasal congestion, sneezing, mild fever)</li> <li>• Respiratory distress signs/symptoms (dyspnoea, cough, fever, low oxygen saturation)</li> </ul>

**Gilbert 2020** (Continued)

- Isolated fever
- Isolated headache
- Digestive symptoms (diarrhoea, nausea)

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, nasopharyngeal swabs (&gt; 1 if deemed necessary)</li> </ul>
Flow and timing	Index tests followed by reference standard
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	No		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			High
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		

**Gilbert 2020** (Continued)

<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Haehner 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to investigate the frequency of olfactory loss in an outpatient population who presented to a coronavirus testing centre. To evaluate the diagnostic value of the symptom "sudden smell loss" for screening procedures</p> <p><b>Design:</b> cross-sectional cohort study (prospective data collection)</p> <p><b>Recruitment:</b> patients who presented with symptoms of a common cold to a coronavirus testing centre and fulfilled coronavirus testing criteria</p> <p><b>Sample size:</b> n = 500 (cases 34)</p> <p><b>Inclusion criteria:</b> patients with common cold complaints who met the criteria for SARS-CoV-2 testing to WHO recommendations</p> <p><b>Exclusion criteria:</b> none</p>
Patient characteristics and setting	<p><b>Facility cases:</b> RT-PCR for SARS-CoV-2-positive</p> <p><b>Facility controls:</b> RT-PCR for SARS-CoV-2-negative</p> <p><b>Country:</b> Germany</p> <p><b>Dates:</b> not specified</p> <p><b>Symptoms and severity:</b> olfactory loss</p> <p><b>Demographics:</b> mean age: 41.3 years gender % female: 54.6%</p> <p><b>Exposure history:</b> not specified</p>
Index tests	Olfactory loss
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> </ul>

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Haehner 2020** (Continued)

- RS: RT-PCR, samples from throat swabs

Flow and timing	RS and index test taken on the same day
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		Low risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			

**Haehner 2020** (Continued)

Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Haliga 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease) - to analyse whether the evaluation of clinical symptoms and signs upon admission to hospital can be useful for the differentiation of patients with acute medical pathology and suspicion of SARS-CoV-2 infection</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> unclear, adult patients presenting to an ED, cohort of patients admitted to our internal medicine clinic at the emergency clinical county hospital; admission through ED, only RT-PCR for patients who were hospitalised</p> <p><b>Sample size:</b> n = 253 (20 cases)</p> <p><b>Inclusion criteria:</b> &gt; 18 years of age, irrespective of gender, admitted to ED due to an acute medical illness as a consequence of exacerbation of their chronic illness as well as symptoms or clinical signs included in the case definition of suspected cases of SARS-CoV-2 infection</p> <p><b>Exclusion criteria:</b> no informed consent, acute pathology requiring specific emergency treatment or PCR already positive at presentation</p>
Patient characteristics and setting	<p><b>Facility cases:</b> RT-PCR-positive for SARS-CoV-2</p> <p><b>Facility controls:</b> RT-PCR-negative for SARS-CoV-2</p> <p><b>Country:</b> Romania</p> <p><b>Dates:</b> 01 April 2020- 31 May 2020</p> <p><b>Symptoms and severity:</b> not specified, mild to moderate to severe: 236 admitted to the clinic and 17 admitted to ICU</p> <p><b>Demographics:</b> mean age overall 64 years M%/F% overall 57.7/42.3</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• History of fever at home</li> <li>• Fever at presentation</li> <li>• Asthenia</li> <li>• Headache</li> <li>• Dry cough</li> <li>• Sputum production</li> <li>• Chest pain</li> <li>• Dyspnoea</li> </ul>

**Haliga 2021** (Continued)

- Myalgia
- Dysphonia
- Sore throat
- Anosmia
- Dysgeusia
- Nausea
- Vomiting
- Abdominal pain
- Diarrhoea
- Loss of appetite
- Arthralgia

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasopharyngeal swab)</li> </ul>
Flow and timing	Index tests and RS both taken on admission
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			High
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern



**Haliga 2021** (Continued)

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Huang 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to explore a novel risk score to predict diagnosis with COVID-19 among all suspected patients at admission</p> <p><b>Design:</b> retrospective, multicentric observational study</p> <p><b>Recruitment:</b> retrospective chart review of patients admitted into 26 COVID-19 designated hospitals in Sichuan Province, China</p> <p><b>Sample size:</b> n = 475 (336 cases)</p> <p><b>Inclusion criteria:</b> patients with suspected COVID-19 (suspected case is defined as having exposure history and 2 clinical manifestations. Patients without epidemiological exposure histories could also be seen as "suspected COVID-19" only if 3 clinical manifestations were present.</p> <p><b>Exclusion criteria:</b> none</p>
Patient characteristics and setting	<p><b>Facility cases:</b> suspected patients with a positive RT-PCR test</p> <p><b>Facility controls:</b> suspected patients with a negative RT-PCR test. If the first test was negative, at least a second test was done, 24 h apart.</p> <p><b>Country:</b> China</p> <p><b>Dates:</b> 21 January 2020-07 February 2020</p>

**Huang 2020** (Continued)

**Symptoms and severity:** mild to moderate severity, all suspected patients included

**Demographics:** mean age, cases: 43 years, controls: 34 years. Gender: % female cases 45.8%, controls: 41.0%

**Exposure history:** epidemiological exposure history: cases: 69.6%, controls 12.9%

Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Headache</li> <li>• Rhinorrhoea</li> <li>• Dyspnoea</li> <li>• Wheeze</li> <li>• Dry cough</li> <li>• Haemoptysis</li> <li>• Diarrhoea</li> <li>• Earache</li> <li>• Rash</li> <li>• Enlargement of lymph nodes</li> <li>• Weakness/fatigue</li> <li>• Myalgia</li> <li>• Stuffy nose</li> <li>• Sore throat</li> <li>• Chest pain</li> <li>• Productive cough</li> <li>• Stomach ache</li> <li>• Nausea/vomiting</li> <li>• Arthralgia</li> <li>• Skin ulcer</li> <li>• Unconsciousness</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR (if negative, a second test taken at least 24 h apart), sample type not specified</li> </ul>
Flow and timing	RS and index tests both taken on admission
Comparative	
Notes	Funding: Emergency Response Project for New Coronavirus of Science and Technology Department of Sichuan Provincial, Grant/Award Numbers: 2020YFS0005, 2020YFS0009; Special Funds for COVID-19 Prevention and Control of West China Hospital of Sichuan University, Grant/Award Number: HX- 2019-nCoV-068; Science and Technology Benefit People Project of Chengdu Municipality, Grant/Award Number: 2016-HM02-00099-SF

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		

**Huang 2020** (Continued)

Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Did the study avoid inappropriate inclusions?	Yes	
<b>Could the selection of patients have introduced bias?</b>		Unclear risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	Unclear	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Low risk

**Hüfner 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease) - to identify patients in the ED early using a score so that they can be isolated pre-emptively</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all patients who presented at 1 of 3 ED's</p> <p><b>Sample size:</b> n = 697 (64 cases)</p> <p><b>Inclusion criteria:</b> all patients presenting at one of the participating EDs and scoring at least 1 item of the COVID score</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> Germany</p> <p><b>Dates:</b> 9 March 2020-30 April 2020</p> <p><b>Symptoms and severity:</b> all symptomatic patients, 79.7% of cases hospitalised, 53.1% of controls</p> <p><b>Demographics:</b> age: controls mean 54.7 years, cases mean 60.3 years</p> <p>M%/F%: cases 68.8/31.2, controls 46.9/53.1</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever &gt; 37.3 ° C and/or chills</li> <li>• (Irritant) cough with/without sputum</li> <li>• Impairment of the sense of smell or taste</li> <li>• Sore throat</li> <li>• Fatigue (malaise, tiredness)</li> <li>• Headache</li> <li>• Body aches (muscles, joints)</li> <li>• Runny nose</li> <li>• GI symptoms (unspecific abdominal complaints, diarrhoea, vomiting)</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (nasopharyngeal and oropharyngeal swab) or chest X-ray or CT</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

**Hüfner 2020** (Continued)

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Unclear		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Unclear
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Unclear		
Did all patients receive the same reference standard?	No		
Were all patients included in the analysis?	Unclear		
<b>Could the patient flow have introduced bias?</b>		Unclear risk	

Ide 2021

**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease) - to evaluate the SARS-CoV-2-positive ratio among mildly ill patients in Tokyo, Japan, their characteristics, the Ministry of Health, Labour and Welfare criteria, and to identify better criteria</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> patients who underwent SARS-CoV-2 PCR testing at the National Center for Global Health and Medicine in Tokyo (= outpatient screening centre)</p> <p><b>Sample size:</b> n = 277 (25 cases)</p> <p><b>Inclusion criteria:</b> those who met <math>\geq 1</math> of the following criteria were eligible: patients who have fever or symptoms (e.g. respiratory, fatigue, headache, myalgia); patients who had exposure to COVID-19 patient; patients who did not meet 1) or 2) but referred by another physician due to possible exposure to COVID-19 patient or travel history.</p> <p><b>Exclusion criteria:</b> patients who were non-ambulatory upon presentation (referred to the infectious disease clinic for further evaluation)</p>
Patient characteristics and setting	<p><b>Facility cases:</b> RT-PCR-positive for SARS-COV-2</p> <p><b>Facility controls:</b> RT-PCR-negative for SARS-COV-2</p> <p><b>Country:</b> Japan</p> <p><b>Dates:</b> 09 March 2020-29 March 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity</p> <p><b>Demographics:</b> age: controls median 38.9 years, cases median 44.1 years M%/F%: cases 88.0/12.0, controls 52.0/48.0</p> <p><b>Exposure history:</b> exposure to case: cases 52%, controls 7%; travel: cases 72%, controls 20%</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever (<math>&gt; 37.5^{\circ}\text{C}</math>)</li> <li>• Nasal discharge</li> <li>• Sore throat</li> <li>• Cough</li> <li>• Sputum</li> <li>• Dyspnoea</li> <li>• Fatigue</li> <li>• Headache</li> <li>• Myalgia/joint pain</li> <li>• Diarrhoea</li> <li>• Vomiting</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, nasopharyngeal swabs</li> </ul>
Flow and timing	Timing not specified

**Ide 2021** (Continued)

Comparative

Notes Funding: grant for International Health Research from the Ministry of Health Labor and Welfare of Japan (grant no. 20A2003D)

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			



**Ide 2021** (Continued)

Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Ishii 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to identify the predictors of SARS-CoV-2 test positivity for more efficient and evidenced selection of suspected individuals</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> all consecutive individuals, tested in a drive-through outpatient test centre during the first 7 months of the testing programme</p> <p><b>Sample size:</b> n = 3540 (164 cases)</p> <p><b>Inclusion criteria:</b> all consecutive participants who underwent drive-through nasopharyngeal swab testing at an outpatient clinic. Reason for testing: upon request of the participant or participants who had been confirmed to have contacted COVID-19 patients based on contact tracing. No clinical suspicion needed per se, but 54% of individuals were symptomatic, suggestive of COVID-19</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> Japan</p> <p><b>Dates:</b> 16 July 2020-31 January 2021</p> <p><b>Symptoms and severity:</b> not specified, 54% of individuals presented with symptoms suggestive of COVID-19, mostly mild severity</p> <p><b>Demographics:</b> age: controls median 27 years, cases median 25 years M%/F%: cases 63.4/36.6, controls 49.4/50.6</p> <p><b>Exposure history:</b> history of close contact with COVID-19 patient: cases 44%, controls 26%</p>
Index tests	<ul style="list-style-type: none"> <li>• Body temperature (fever defined as <math>\geq 38.0</math> °C)</li> <li>• Cough</li> <li>• Dyspnoea</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, nasopharyngeal swab</li> </ul>

**Ishii 2021** (Continued)

 Flow and timing Timing not specified

Comparative

 Notes No clinical suspicion needed for testing  
Funding: none declared
**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern

**Ishii 2021** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Unclear

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Unclear risk

**Jeyashree 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe the symptom profile of people who underwent testing for COVID-19</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> all consecutive adults who visited COVID-19 testing centres in Chennai city in Southern India</p> <p><b>Sample size:</b> n = 277 (58 cases)</p> <p><b>Inclusion criteria:</b> all consenting adults aged 18-80 years belonging to any gender, who visited COVID-19 testing centres in Chennai city in Southern India</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> India</p> <p><b>Dates:</b> not specified (2020)</p> <p><b>Symptoms and severity:</b> not specified, mild to moderate severity</p> <p><b>Demographics:</b> overall age: mean 40.7 years</p> <p>M%/F%: cases 51.7/48.3, controls 63.5/36.5</p> <p><b>Exposure history:</b> history of close contact with COVID-19 patient: cases 9%, controls 5%</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Headache</li> <li>• Cough</li> <li>• Runny nose</li> <li>• Joint pain</li> <li>• Muscle aches</li> <li>• Sore throat</li> <li>• Fatigue/malaise</li> <li>• Loss of smell or taste</li> </ul>

**Jeyashree 2021** (Continued)

- Loss of smell
- Loss of appetite
- Chills
- Loss of taste
- Vomiting
- Altered conscious
- Bleeding
- Diarrhoea
- Conjunctivitis
- Wheezing
- Chest pain
- Skin rash
- Pain abdomen
- Shortness of breath

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, nasopharyngeal swab</li> </ul>
Flow and timing	Index tests were collected on same day of the specimen collection, and prior to the declaration of COVID-19 test results
Comparative	
Notes	Funding: supported by the Indian Council of Medical Research- National Institute of Epidemiology (ICMR-NIE)

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Yes		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		Low risk	

**Jeyashree 2021** (Continued)

**Are there concerns that the index test, its conduct, or interpretation differ from the review question?** Low concern

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition? Yes

Were the reference standard results interpreted without knowledge of the results of the index tests? Unclear

**Could the reference standard, its conduct, or its interpretation have introduced bias?** Low risk

**Are there concerns that the target condition as defined by the reference standard does not match the question?** Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Yes

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Low risk

**Just 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to identify predictive risk factors for a positive SARS-CoV-2 RT-PCR result in a primary care setting</p> <p><b>Design:</b> multicentre, cross-sectional cohort study</p> <p><b>Recruitment:</b> 26 office-based specialists for internal and/or general medicine with a full primary care mandate from 14 different locations participated in the study. Suspected COVID-19 patients for whom a PCR was taken were included.</p> <p><b>Sample size:</b> n = 374 (40 cases)</p> <p><b>Inclusion criteria:</b> convenience sample of patients who received PCR in the participating GPs' practices within the study period</p> <p><b>Exclusion criteria:</b> patients whose tests had been carried out for procedural reasons and did not correspond to a specific clinical indication were excluded (e.g. testing of recovered patients after end of quarantine). There were no other exclusion criteria.</p>
Patient characteristics and setting	<p><b>Facility cases:</b> suspected patients with a positive PCR test</p> <p><b>Facility controls:</b> suspected patients with a negative PCR test</p> <p><b>Country:</b> Germany</p>

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

Just 2020 (Continued)

**Dates:** 24 March 2020-17 April 2020

**Symptoms and severity:** mild to moderate severity

**Demographics:** median age: cases: 52.0 years, controls: 43.5 years gender: % female cases: 65.0%, controls: 57.2%

**Exposure history:** first grade contact (with symptoms): cases: 35.0%, controls 17.4%

Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Sore throat</li> <li>• Fatigue</li> <li>• Fever</li> <li>• Nasal congestion</li> <li>• Muscle pain</li> <li>• Dyspnoea</li> <li>• Headache</li> <li>• Anorexia</li> <li>• Anosmia</li> <li>• Diarrhoea</li> <li>• Chills</li> <li>• Nausea</li> <li>• Vomiting</li> <li>• Other</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, sample type not specified</li> </ul>
Flow and timing	RS and index tests both taken on admission
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	No		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern

**Just 2020** (Continued)

**DOMAIN 2: Index Test (All tests)**

Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	Unclear	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Low risk

**Kalayjian 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to assess the rate of COVID-19 positivity in a community-based health centre, evaluate the clinical symptoms, and follow patient outcomes</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> clients entering the health centre (walk-in clinic) were screened for symptoms and triaged to the COVID-19 clinic. Testing was performed for patients with a documented or subjective fever within the past 72 h.</p> <p><b>Sample size:</b> n = 345 (117 cases)</p>
------------------	---

**Kalayjian 2020** (Continued)

**Inclusion criteria:** people  $\geq$  17 years old, screened for COVID-19 symptoms and triaged, a documented or subjective fever within the past 72 h

**Exclusion criteria:** none specified

## Patient characteristics and setting

**Facility cases:** patients with a positive Labcorp's nucleic-acid amplification nasopharyngeal swab for SARS-CoV-2

**Facility controls:** patients with a negative Labcorp's nucleic-acid amplification nasopharyngeal swab for SARS-CoV-2

**Country:** Louisiana, USA

**Dates:** 16 March 2020-10 April 2020

**Symptoms and severity:** walk-in clinic for people with COVID-19 symptoms; 9 required ED assessment of whom 6 were admitted to hospital; all patients had to have fever in the past 72 h

**Demographics:** age: controls mean 44.4 years, cases mean 42.3 years

M%/F%: cases 49.6/50.4, controls 46.5/50.4 (3.1% "other")

**Exposure history:** not specified

## Index tests

- Body temperature
- Heart rate
- Oxygen saturation
- Cough
- Shortness of breath
- Sore throat
- Nasal congestion
- GI symptoms

## Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: Labcorp's nucleic-acid amplification, threshold not specified, nasopharyngeal swabs

## Flow and timing

Index tests and reference standard taken at the same clinical encounter

## Comparative

## Notes

Only feverish patients included

Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**



**Kalayjian 2020** (Continued)

Did the study avoid inappropriate inclusions?	No	
<b>Could the selection of patients have introduced bias?</b>		High risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		High
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	Unclear	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	No	
<b>Could the patient flow have introduced bias?</b>		Low risk

**Kelen 2021**
**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to understand the impact of COVID-19 on EDs

**Design:** cross-sectional cohort study, retrospective data collection

**Kelen 2021** (Continued)

	<p><b>Recruitment:</b> consecutive: all patients of at least 15 years of age presenting at ED with symptoms suggestive of COVID-19 or with high acuity</p> <p><b>Sample size:</b> n = 11402 (2484 cases)</p> <p><b>Inclusion criteria:</b> at least 15 years old and symptoms suggestive of COVID-19 symptoms or high acuity</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> USA</p> <p><b>Dates:</b> 16 March 2020-15 May 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity; acuity triage score 1 (highest) 4.7%; 2 22.9%; 3 55.3%; 4 14.1%; 5 1.6%; not listed 1.3%</p> <p><b>Demographics:</b> age overall: 15-24 years: 31.8%, 25-34 years: 33.7%, 35-44 years: 39.3%, 45-54 years: 42.1%, 55-64 years: 45.2%, 65-74 years: 48.1%, 75+ years: 52.6%</p> <p>M%/F%:overall (all those tested) 40.7/59.3</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Constitutional symptom</li> <li>• Pulmonary</li> <li>• Hypotension</li> <li>• Shortness of breath</li> <li>• Altered mental status</li> <li>• Weakness</li> <li>• Syncope</li> <li>• Headache</li> <li>• Nausea/vomiting/diarrhoea</li> <li>• Obstetric/gynaecological symptoms (pregnancy related)</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, nasopharyngeal swabs</li> </ul>
Flow and timing	Index test and RS both taken upon arrival at ED
Comparative	
Notes	Funding: none declared
<b>Methodological quality</b>	
<b>Item</b>	<b>Authors' judgement</b> <b>Risk of bias</b> <b>Applicability concerns</b>
<b>DOMAIN 1: Patient Selection</b>	

**Kelen 2021** (Continued)

Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Did the study avoid inappropriate inclusions?	Yes	
<b>Could the selection of patients have introduced bias?</b>		Low risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Low risk

**Kempker 2020**
**Study characteristics**
**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Kempker 2020** (Continued)

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe the most common and distinguishing clinical symptoms among HCWs who underwent screening for COVID-19

**Design:** cross-sectional cohort study, prospective data collection

**Recruitment:** HCW with a viral-like illness, triaged to the employee health services staff for a virtual clinical assessment and then scheduled for SARS-CoV-2 testing

**Sample size:** n = 283 (51 cases)

**Inclusion criteria:** HCW with symptoms consistent with a viral-like illness

**Exclusion criteria:** none specified

Patient characteristics and setting

**Facility cases:** HCW with positive RT-PCR test for SARS-CoV-2

**Facility controls:** HCW with negative RT-PCR test for SARS-CoV-2

**Country:** Georgia, USA

**Dates:** 18 March 2020-14 April 2020

**Symptoms and severity:** not specified, mild to moderate severity (from table)

**Demographics:** age: not specified

M%/F%: overall 19/81

**Exposure history:** patient contact in general: cases: 96%, controls 88%. Contact with COVID-19 patients: cases 33%, control 36%

Index tests

- Fever
- Fatigue
- Chills
- Myalgia
- Cough
- Dyspnoea
- Nasal congestion
- Sore throat
- Diarrhoea
- Anosmia
- Ageusia

Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: RT-PCR, nasopharyngeal swab

Flow and timing

Not specified

Comparative

Notes

Funding: none declared

**Methodological quality**

**Kempker 2020** (Continued)

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Unclear		
Did all patients receive the same reference standard?	Yes		
Were all patients included in the analysis?	Yes		
<b>Could the patient flow have introduced bias?</b>		Unclear risk	

## Kim 2020

**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to develop a prediction rule for COVID-19</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> consecutive: all patients &gt; 18 years visiting ED who had undergone COVID-19 testing</p> <p><b>Sample size:</b> n = 242 (54 cases)</p> <p><b>Inclusion criteria:</b> &gt; 18 years and visit to one of the EDs</p> <p><b>Exclusion criteria:</b></p> <ul style="list-style-type: none"> <li>- if initial signs and symptoms were not recorded</li> <li>- in the case of a revisit</li> </ul>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> South Korea</p> <p><b>Dates:</b> 1 March 2020-21 March 2020</p> <p><b>Symptoms and severity:</b> mild to moderate to severe: admission to ward: cases 48.1% controls 0%        Admission to ICU cases 11.5% controls 0%, in-hospital death cases 20.4% controls 0%</p> <p><b>Demographics:</b> age: controls median 43.5 years, cases median 70.0 years M%/F%: cases 55.6/44.4, controls 45.2/54.8</p> <p><b>Exposure history:</b> any exposure risk: 37.2% overall</p>
Index tests	<ul style="list-style-type: none"> <li>• Systolic BP</li> <li>• Diastolic BP</li> <li>• Pulse rate</li> <li>• Respiratory rate</li> <li>• Body temperature</li> <li>• Oxygen saturation</li> <li>• Mild fever <math>\geq 37.5</math></li> <li>• Tachypnoea</li> <li>• Oxygen saturation <math>\leq 94\%</math></li> <li>• Fever</li> <li>• Cough or dyspnoea</li> <li>• Sore throat</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, nasopharyngeal swabs</li> </ul>
Flow and timing	Index test and RS both taken upon arrival at ED
Comparative	

**Kim 2020** (Continued)

Notes

Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Yes		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Yes		
Did all patients receive the same reference standard?	Yes		
Were all patients included in the analysis?	No		

Kim 2020 (Continued)

Could the patient flow have introduced bias?

Low risk

King 2020

**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to assess symptom patterns among children tested for SARS-CoV-2

**Design:** cross-sectional cohort study, retrospective data collection

**Recruitment:** database study (Alberta Health Services Communicable Disease Outbreak Management database), including data on children with a positive test result or children tested for contact with a case or in an outbreak

**Sample size:** n = 3249 (2264 cases), after exclusions: n = 2463 (1978 cases)

**Inclusion criteria:** patients < 18 years with a positive PCR test or were tested for being in a high-risk group (close contact with a case or in an outbreak)

**Exclusion criteria:** second tests or patients tested prior to 13 April 2020. Children who were tested for symptoms and were negative, were not contacted for the symptom questionnaire.

Patient characteristics and setting

**Facility cases:** positive RT-PCR test for SARS-CoV-2

**Facility controls:** negative RT-PCR test for SARS-CoV-2

**Country:** Canada

**Dates:** 13 April 2020-30 September 2020

**Symptoms and severity:** mild to moderate severity

**Demographics:** age: controls mean 8.4 years, cases mean 9.8 years; M%/F %: cases 49.4/50.6, controls 53.6/46.4

**Exposure history:** not specified

Index tests

- Anosmia/ageusia
- Nausea/vomiting
- Headache
- Decreased appetite/anorexia
- Sneezing
- Fever or feverish chills
- Muscle/joint pain
- Malaise
- Nasal congestion
- Fatigue
- Difficulty breathing/dyspnoea
- Sore throat
- Diarrhoea
- Cough
- Rhinorrhoea
- Chest pain



**King 2020** (Continued)

- Conjunctivitis

Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: RT-PCR, nasal, nasopharyngeal, throat, or other swabs

Flow and timing

Maximum 5 days between index tests and RS (RS came first in some cases)

Comparative

Notes

Funding: FM was funded by an Alberta Health Services Chair in Cardiovascular Outcomes Research; project was funded by the Alberta Strategy for Patient Oriented Research Support Unit

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	No		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	No		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	No		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	

**King 2020** (Continued)

**Are there concerns that the target condition as defined by the reference standard does not match the question?**

Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? No

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? No

**Could the patient flow have introduced bias?** High risk

**Krastinova 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe infection rates, clinical characteristics, occupational exposure, living conditions and household transmission of symptomatic HCWs</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> symptomatic HCWs in 1 hospital were tested on a voluntary basis (ED/outpatient setting)</p> <p><b>Sample size:</b> n = 314 (110 cases)</p> <p><b>Inclusion criteria:</b> symptomatic HCWs, defined as the presence of fever and/or respiratory symptoms</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Definition cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Definition controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> France</p> <p><b>Dates:</b> 17 March 2020-20 April 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity, 0% of controls hospitalised, 8% of cases hospitalised</p> <p><b>Demographics:</b> age: controls mean 40.2 years, cases mean 40.3 years M%/F%: cases 20.0/80.0, controls 18.0/82.0</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<p>At illness onset:</p> <ul style="list-style-type: none"> <li>• fever</li> <li>• cough</li> <li>• dyspnoea</li> <li>• tiredness</li> </ul>

**Krastinova 2020** (Continued)

- sore throat
- rhinorrhoea/nasal congestion
- headache
- muscle pain
- chest pain/pressure
- nausea, vomiting
- diarrhoea
- anosmia

At screening:

- heart rate
- oxygen saturation
- fever
- cough
- dyspnoea
- tiredness
- sore throat
- rhinorrhoea/nasal congestion
- headache
- muscle pain
- chest pain and/or pressure
- nausea and/or vomiting
- diarrhoea
- anosmia

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, nasopharyngeal swabs</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern

**Krastinova 2020** (Continued)

**DOMAIN 2: Index Test (All tests)**

Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear
If a threshold was used, was it pre-specified?	No
<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Langer 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to develop a model to predict the results of RT-PCR</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all patients admitted to ED with symptoms compatible with COVID-19</p> <p><b>Sample size:</b> n = 199 (124 cases)</p> <p><b>Inclusion criteria:</b> all patients presenting with symptoms compatible with COVID-19</p> <p><b>Exclusion criteria:</b> &lt; 12 years, no leukocyte formula</p>
------------------	---

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Langer 2020** (Continued)

Patient characteristics and setting

**Definition cases:** positive RT-PCR test for SARS-CoV-2

**Definition controls:** negative RT-PCR test for SARS-CoV-2

**Country:** Italy

**Dates:** 22 February 2020-16 March 2020

**Symptoms and severity:** inclusion based on potential COVID-19 symptoms, mostly mild to moderate symptoms, oxygen supplementation needed in 22% of cases and 32% of controls

**Demographics:** age: controls median 66 years, cases median 65 years

M%/F%: cases 62.9/37.1, controls 65.3/34.7

**Exposure history:** not specified

Index tests

- Arthralgia
- Asthenia
- Chest pain
- Cough
- Dyspnoea
- Fever
- GI symptoms
- Headache
- Sore throat
- Syncope
- Glasgow coma scale
- Body temperature
- Systolic BP
- Diastolic BP
- Heart rate
- Sinus rhythm
- Respiratory rate

Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: RT-PCR, specimen not specified, repeated after 48 h if negative

Flow and timing

Index tests and RS both on admission, but in case of a negative PCR the test was repeated after 48 h

Comparative

Notes

Funding: none declared

**Methodological quality**
**Item**
**Authors' judgement**
**Risk of bias**
**Applicability concerns**
**DOMAIN 1: Patient Selection**

Was a consecutive or random sample of patients enrolled?

Yes

**Langer 2020** (Continued)

Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Did the study avoid inappropriate inclusions?	Yes	
<b>Could the selection of patients have introduced bias?</b>		Low risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Low risk

**Lazzerini 2021**
**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe characteristics and risk factors for COVID-19 in children

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

Copyright © 2022 The Authors. Cochrane Database of Systematic Reviews published by John Wiley &amp; Sons, Ltd. on behalf of The Cochrane Collaboration.

**Lazzerini 2021** (Continued)

**Design:** cross-sectional cohort study, retrospective data collection

**Recruitment:** all children aged 0-18 years tested for SARS-CoV-2 at 1 of 20 paediatric centres across Italy because of symptoms/signs suggestive of COVID-19

**Sample size:** n = 2148 (159 cases)

**Inclusion criteria:** children (0-18 years) tested because of symptoms suggestive of COVID-19

**Exclusion criteria:** none

Patient characteristics and setting

**Definition cases:** positive RT-PCR test for SARS-CoV-2

**Definition controls:** negative RT-PCR test for SARS-CoV-2

**Country:** Italy

**Dates:** 23 February 2020-24 May 2020

**Symptoms and severity:** inclusion based on potential COVID-symptoms, mostly mild to moderate symptoms, among the cases, only 2.1% required respiratory support and 1.1% were admitted to intensive care; all recovered

**Demographics:** age: < 6 months: cases 12%, controls 8%; 6-24 months: cases 10.7%, controls 23.7%; 2-9 years: cases 23.3%, controls 42%; 10-18 years: cases 54.1%, controls 26%

M%/F%: cases 48.4/51.6, controls 55.8/44.2

**Exposure history:** contact with person having COVID-19: cases 79.2%, controls 6.1%; relatives with respiratory symptoms: cases 72.3%, controls 11.5%

Index tests

- Symptoms and signs at presentation:
  - fever
  - respiratory symptoms, any
  - respiratory distress
  - rhinorrhoea
  - dry cough
  - productive cough
  - sore throat
  - pharyngitis
  - conjunctivitis
  - apnoea
  - thoracic pain
- GI symptoms, any:
  - vomiting
  - diarrhoea
- Neurological symptoms, any:
  - asthenia
  - headache
  - anosmia/ageusia
  - convulsion
  - hyperactivity
- Cutaneous presentations, any:
  - skin manifestation
  - vasculitis

**Lazzerini 2021** (Continued)

- Unspecific influenza-like presentations, any:
  - muscle or joint pains
  - nausea
  - inappetence
  - lymphadenitis
- Other symptoms, any:
  - abdominal pain
  - oral manifestations (gingivostomatitis, aphthae)
  - dental problems
  - urogenital disorder
  - ear problems
  - other
- Tachycardia
- Tachypnoea
- Oxygen saturation
- Lung auscultation findings

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, nasal or nasopharyngeal swab</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**



**Lazzerini 2021** (Continued)

<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern
<b>DOMAIN 3: Reference Standard</b>	
Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Unclear risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Leal 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe the clinical features predictive for SARS-CoV-2 infection in primary care</p> <p><b>Design:</b> prospective population-based cohort</p> <p><b>Recruitment:</b> residents of the municipality aged <math>\geq 12</math> years with suspected COVID-19 symptoms were encouraged to contact the dedicated platform via the website or phone. They were invited to complete an initial screening questionnaire. Participants were then called by a medical student to complete a risk assessment.</p> <p><b>Sample size:</b> n = 1583 (444 cases (only the PCR-positive patients))</p> <p><b>Inclusion criteria:</b> patients meeting the suspected COVID-19 case definition (having at least 2 of the following symptoms: fever, cough, sore throat, coryza or change in/loss of smell (anosmia); or 1 of these symptoms plus at least 2 other symptoms consistent with COVID-19</p>
------------------	---

**Leal 2020** (Continued)

	<p><b>Exclusion criteria:</b> all pregnant women, and patients meeting pre-defined triage criteria for severe disease</p>
Patient characteristics and setting	<p><b>Facility cases:</b> patients with suspected COVID-19 who tested positive (RT-PCR, testing at home)</p> <p><b>Facility controls:</b> patients with suspected COVID-19 who tested negative (RT-PCR, testing at home)</p> <p><b>Country:</b> Brazil</p> <p><b>Dates:</b> 13 April 2020-13 May 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity, severe cases were excluded</p> <p><b>Demographics:</b> all age groups represented from <math>\geq 10</math> years. Gender: % female cases: 55.0%, controls: 66.5%</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Headache</li> <li>• Myalgia</li> <li>• Cough</li> <li>• Fatigue</li> <li>• Anosmia</li> <li>• Ageusia</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, some negative patients were offered antibody testing as of 19 May 2020 (IgG/IgM combined); self-collected oropharyngeal swabs, collected under supervision of trained HCWs), but results of the antibody testing were not used for this review (only RT-PCR)</li> </ul>
Flow and timing	Swabs were taken within 5 days of symptom onset
Comparative	
Notes	Funding: the municipal health department of São Caetano do Sul funded the establishment and implementation of the platform. Plus award from FAPESP (2018/14389-0) and the UK Medical Research Council (MR/S0195/1) to the Brazil-UK Centre for Arbovirus Discovery

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		

**Leal 2020** (Continued)

<b>Could the selection of patients have introduced bias?</b>		High risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		High
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	Unclear	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		High
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Unclear	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Unclear risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	No	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		High risk

**Leung 2021**
**Study characteristics**

**Leung 2021** (Continued)

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to review the characteristics and outcomes of individuals who attended a testing centre</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all patients attending the testing centre (temporary outpatient testing centre at the AsiaWorldExpo)</p> <p><b>Sample size:</b> n = 1258 (86 cases)</p> <p><b>Inclusion criteria:</b> all patients presenting to the testing centre</p> <p><b>Exclusion criteria:</b> missing data and immediate referral to regional ED</p>
Patient characteristics and setting	<p><b>Definition cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Definition controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> Hong Kong (China)</p> <p><b>Dates:</b> 20 March 2020-19 April 2020</p> <p><b>Symptoms and severity:</b> 96% of all participants symptomatic, mostly mild severity, acutely ill patients were immediately referred to ED</p> <p><b>Demographics:</b> age: controls mean 27.1 years, cases mean 30.6 years M%/F%: cases 53.5/46.5, controls 51.7/48.3</p> <p>Non-Chinese ethnicity overall 10%</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Documented fever</li> <li>• Reported fever</li> <li>• Chills</li> <li>• Cough</li> <li>• Runny nose</li> <li>• Sore throat</li> <li>• Vomiting</li> <li>• Diarrhoea</li> <li>• Fatigue</li> <li>• Myalgia</li> <li>• Headache</li> <li>• Anosmia</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, pooled nasopharyngeal and throat swabs</li> </ul>
Flow and timing	<p>Timing not specified, but both index tests and RS taken at outpatient test centre, so all tests and assessments should have been done at the time of presentation</p>
Comparative	
Notes	<p>Funding: none declared</p>

**Leung 2021** (Continued)

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Unclear		
Did all patients receive the same reference standard?	Yes		
Were all patients included in the analysis?	No		
<b>Could the patient flow have introduced bias?</b>		Low risk	

## Maechler 2020

### Study characteristics

#### Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe epidemiological and clinical characteristics; to identify risk factors for SARS-CoV-2 infection

**Design:** cross-sectional cohort study, prospective data collection

**Recruitment:** symptomatic patients presenting at the test site. Subgroups not by testing criteria at that time: (1) high-risk contacts at a nightclub (26/94 positive). (2) Charité employees 125 asymptomatic.

**Sample size:** n = 4333 (333 cases)

**Inclusion criteria:** until 24 March 2020: symptomatic patients with high-risk contacts or return from high-risk area. From 24 March: also symptomatic people with risk factors and if the test capacity allowed also only symptomatic patients. Plus 2 subgroups of high-risk patients in a nightclub and Charité employees

**Exclusion criteria:** none specified

#### Patient characteristics and setting

**Facility cases:** patients with a positive RT-PCR for SARS-CoV-2 infection

**Facility controls:** patients with a negative RT-PCR for SARS-CoV-2 infection

**Country:** Germany

**Dates:** 03 March 2020-13 April 2020

**Symptoms and severity:** mild to relatively more severe. Asymptomatic: 12 cases, 431 controls

**Demographics:** age: controls median 34.0 years, cases mean 34.0 years

M%/F%: cases 56.8/43.2, controls 48.5/51.5

**Exposure history:** high-risk contact: cases 56.8%, controls 36.4%

#### Index tests

- Fever
- Dyspnoea
- Chest tightness/pain
- Chills
- Fatigue
- Body aches
- Cough
- Rhinorrhoea
- Diarrhoea
- Sore throat
- Headache
- Anosmia
- Ageusia

#### Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: SARS-CoV-2 RT-PCR test (combined oro- and nasopharyngeal swab)

**Maechler 2020** (Continued)

Flow and timing Index tests and reference standard both at presentation

Comparative

Notes Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			

**Maechler 2020** (Continued)

Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Mansella 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to evaluate safety and feasibility of low-threshold testing process; to identify clinical predictors for severe acute COVID-19</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> all patients presenting at the test centre with respiratory symptoms (such as shortness of breath), other flu-like symptoms (fever, sore throat, cough) and self-reported exposure to COVID-19</p> <p><b>Sample size:</b> n = 4815 (572 cases)</p> <p><b>Inclusion criteria:</b> all patients presenting at the test centre with respiratory symptoms, flu-like symptoms and self-reported exposure to COVID-19</p> <p><b>Exclusion criteria:</b> no informed consent, no nasopharyngeal swab and missing data</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> Switzerland</p> <p><b>Dates:</b> 19 March 2020-19 April 2021</p> <p><b>Symptoms and severity:</b> mostly mild to moderate severity, 41/4815 (0.9%) participants were hospitalised</p> <p><b>Demographics:</b> age: controls median 41.2 years, cases median 45.7 years</p> <p>M%/F%: cases 50.5/49.5, controls 44.8/55.2</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Measured/reported</li> <li>• Fever</li> <li>• Chills</li> <li>• Myalgia</li> <li>• Lymphadenopathy</li> <li>• Headache</li> <li>• Seizure</li> <li>• Confusion</li> <li>• Nausea</li> <li>• Conjunctivitis</li> </ul>



**Mansella 2020** (Continued)

- Exanthema
- Coryza
- Otagia
- Sore throat
- Dyspnoea
- Wheezing
- Cough
- Productive cough
- Haemoptysis
- Chest pain
- Abdominal pain
- Diarrhoea
- Dysuria
- Exhausted
- Weakness

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, 2 swabs from naso- and oropharyngeal sites combined into 1</li> </ul>
Flow and timing	Index tests and RS probably both at presentation, but not specified
Comparative	
Notes	Funding: supported by Scientific funds from the University Hospital Basel Switzerland

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear		
If a threshold was used, was it pre-specified?	No		

**Mansella 2020** (Continued)

<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern
<b>DOMAIN 3: Reference Standard</b>	
Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
<b>Could the patient flow have introduced bias?</b>	Low risk

**Mao 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to ascertain the effectiveness of the screening strategy and provide insight for early diagnosis of COVID-19</p> <p><b>Design:</b> multicenter, retrospective, observational cohort study</p> <p><b>Recruitment:</b> all patients visiting the fever clinics within the study period</p> <p><b>Sample size:</b> n = 1004 (cases = 188)</p> <p><b>Inclusion criteria:</b> all patients visiting the fever clinics within the study period. Patients with fever (body temperature &gt; 37.5 °C), or patients with pulmonary symptoms and epidemiological exposure history were requested to visit the fever clinics. All patients visiting the fever clinics during the study period were included.</p> <p><b>Exclusion criteria:</b> patients with missing data</p>
Patient characteristics and setting	<b>Facility cases:</b> RT-PCR-positive patients

Mao 2020 (Continued)

**Facility controls:** RT-PCR-negative patients

**Country:** China

**Dates:** 17 January 2020-16 February 2020

**Symptoms and severity:** not specified

**Demographics:** median age: cases 46 years, controls 39 years. Female; gender %: cases 50%, controls 47%

**Exposure history:** recent visit to epidemic region: cases 51%, controls 28%; contact with infected person: cases 34%, controls 13%

Index tests	<ul style="list-style-type: none"> <li>Fever (body temperature &gt; 38.5 °C)</li> <li>Chills</li> <li>Cough</li> <li>Sore throat</li> <li>Nasal congestion</li> <li>Rhinorrhoea</li> <li>Sneezing</li> <li>Shortness of breath</li> <li>Haemotysis</li> <li>Chest pain</li> <li>Fatigue</li> <li>Headache</li> <li>Abdominal pain</li> <li>Diarrhoea</li> <li>Nausea/vomiting</li> <li>Poor appetite</li> <li>Myalgia</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> <li>RS: RT-PCR (specimen not specified)</li> </ul>
Flow and timing	RS and index tests taken on the same day
Comparative	
Notes	Funding: National Natural Science Foundation of China

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Unclear		

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

174

**Mao 2020** (Continued)

<b>Could the selection of patients have introduced bias?</b>	High risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>	Low concern
<b>DOMAIN 2: Index Test (All tests)</b>	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
If a threshold was used, was it pre-specified?	Unclear
<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern
<b>DOMAIN 3: Reference Standard</b>	
Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Martín-Sánchez 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild to severe COVID-19 disease); to describe the clinical characteristics and 30-day mortality rates in ED patients with COVID-19 in different diagnostic groupings</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> COVID-19 suspects treated in the emergency room</p>
------------------	---

**Martín-Sánchez 2020** (Continued)

	<p><b>Sample size:</b> n = 1417 (1190 cases) (after exclusion of all participants without an RT-PCR)</p> <p><b>Inclusion criteria:</b> all suspicious cases of COVID-19 served in the ED of the San Carlos Clinical Hospital</p> <p><b>Exclusion criteria:</b> patients with a positive PCR test prior to assessment in the ED</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> Spain</p> <p><b>Dates:</b> 28 February 2020-31 March 2020</p> <p><b>Symptoms and severity:</b> 30-day mortality was 11.5% (56.5% in hospitalised cases and 19.6% in cases classified as severe)</p> <p><b>Demographics:</b> age: controls median 50.7 years, cases median 61.5 years</p> <p>M%/F%: cases 53.5/46.5, controls 37.4/62.6</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Dystermic sensation</li> <li>• Dyspnoea</li> <li>• Thoracic pain</li> <li>• Diarrhoea</li> <li>• Nausea/vomiting</li> <li>• Headache</li> <li>• Confusion</li> <li>• Anosmia</li> <li>• Dysgeusia</li> <li>• Myalgia</li> <li>• Asthenia</li> <li>• Odynofagia</li> <li>• Nasal congestion</li> <li>• Cutaneous lesions</li> <li>• Syncopes</li> <li>• Body temperature</li> <li>• Pulse</li> <li>• Oxygen saturation</li> <li>• BP</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (nasal- and oropharyngeal swabs)</li> </ul>
Flow and timing	Index tests and reference standard both taken at the ED
Comparative	
Notes	Strong preselection of participants, unclear why some were not tested, very high disease prevalence

**Martín-Sánchez 2020** (Continued)

Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	No		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Yes		
Did all patients receive the same reference standard?	Yes		
Were all patients included in the analysis?	Yes		

**Martín-Sánchez 2020** (Continued)

**Could the patient flow have introduced bias?**

Low risk

**Martin-Sanz 2020**

**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to evaluate the incidence of certain symptoms in a population of HCWs (exposed to COVID-19-positive patients)

**Design:** cross-sectional cohort study, prospective data collection

**Recruitment:** HCW of the University Hospital of Getafe (Madrid, Spain) with suspicion of COVID-19 infection

**Sample size:** n = 355 (215 cases)

**Inclusion criteria:** HCW with suspicion of COVID-19 infection. Suspicion of COVID-19 was determined by the presence of either cough, fever (> 37.5 °C), headache, or breathlessness, regardless of contact with a COVID-19 patient

**Exclusion criteria:** inconclusive PCR results

Patient characteristics and setting

**Facility cases:** positive RT-PCR for SARS-CoV-2

**Facility controls:** negative RT-PCR for SARS-CoV-2

**Country:** Spain

**Dates:** 15 March 2020-07 April 2020

**Symptoms and severity:** mild to moderate severity (only 14 patients (3.94%) developed pneumonia or severe symptoms that required hospitalisation)

**Demographics:** age: overall mean 42.9 years (SD = 0.67)

M%/F%: cases 20.5/79.5, controls 17.1/82.9

**Exposure history:** not specified

Index tests

- Cough + hyposmia
- Hyposmia
- Dysthermia + hyposmia
- Hypogeusia
- Dysthermia
- Cough
- Myalgia
- Asthenia
- Rhinorrhoea
- Back pain
- Chest pain
- Dyspnoea
- Diarrhoea
- Headache
- Sore throat

**Martin-Sanz 2020** (Continued)

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 next-generation sequencing or real-time PCR methods (nasal and pharyngeal swabs)</li> </ul>
Flow and timing	Not specified
Comparative	
Notes	<p>Article states that it is a case-control study, while it is not (all consecutive suspected HCW's enrolled and tested)</p> <p>Funding: none declared</p>

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	



**Martin-Sanz 2020** (Continued)

**Are there concerns that the target condition as defined by the reference standard does not match the question?**

Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?      Unclear

Did all patients receive the same reference standard?      Unclear

Were all patients included in the analysis?      Yes

**Could the patient flow have introduced bias?**      Unclear risk

**Nazerian 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to formally evaluate the diagnostic testing characteristics of physicians' gestalt for COVID-19</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> patients with suspected COVID-19 were prospectively enrolled in 2 EDs</p> <p><b>Sample size:</b> n = 838 (193 cases)</p> <p><b>Inclusion criteria:</b> age ≥ 18 years, presence of any sign or symptom for COVID-19 and first evaluation at ED during the study period</p> <p><b>Exclusion criteria:</b> known diagnosis of COVID-19, loss to follow-up and refusal to participate</p>
Patient characteristics and setting	<p><b>Definition cases:</b> positive RT-PCR test for SARS-CoV-2 or suggestive symptoms plus chest imaging of acute interstitial lung disease in the absence of an alternative diagnosis taking into account all 30-day follow-up data including medical data and a structured telephone interview</p> <p><b>Definition controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> Italy</p> <p><b>Dates:</b> 01 April 2020-30 April 2020</p> <p><b>Symptoms and severity:</b> mostly mild to moderate severity, need of oxygen supplementation or ventilation: cases 37%, controls 25%</p> <p><b>Demographics:</b> age: controls median 70 years, cases mean 69 years</p> <p>M%/F%: cases 52.3/47.7, controls 49.5/50.5</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Cough</li> <li>• Pharyngodynia</li> </ul>

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

180

**Nazerian 2021** (Continued)

- Dyspnoea
- Anosmia
- Ageusia
- Fatigue
- Diarrhoea
- Symptom duration

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, positive result within 5 days after ED presentation, or suggestive symptoms plus chest imaging (showing acute interstitial lung disease in the absence of an alternative diagnosis), or panel adjudication (for 3 cases without a positive PCR); any respiratory specimen</li> </ul>
--	---

Flow and timing	Max 5 days for PCR test, up to 30 days for clinical information
-----------------	---

Comparative	
-------------	--

Notes	Funding: none declared
-------	------------------------

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Yes		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			

**Nazerian 2021** (Continued)

Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	No
Were all patients included in the analysis?	No
<b>Could the patient flow have introduced bias?</b>	Low risk

**Nitecki 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to assess the utility of self-reported symptoms in identifying positive COVID-19 cases among predominantly healthy young adults in a military setting</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all individuals who were deemed eligible for COVID-19 testing by the Israel Defence Forces COVID Centre, including those voluntarily calling to report symptoms, those actively addressed following epidemiological investigation</p> <p><b>Sample size:</b> n = 24362 (1338 cases)</p> <p><b>Inclusion criteria:</b> all individuals who were deemed eligible for COVID-19 testing by the Israel Defence Forces COVID Centre (suspicious symptoms, those quarantined), including those voluntarily calling to report symptoms, those actively addressed following epidemiological investigation</p> <p><b>Exclusion criteria:</b> no informed consent, no nasopharyngeal swab and missing data</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> Israel</p> <p><b>Dates:</b> 26 March 2020-02 August 2020</p>

**Nitecki 2021** (Continued)

**Symptoms and severity:** mostly mild to moderate severity, mostly cough (56.1%) and fever (28.3%)

**Demographics:** age: controls median 21 years, cases median 21 years

M%/F%: cases 61.1/38.9, controls 59.0/41.0

**Exposure history:** suspected exposure 50.1% (defined as close contact with a confirmed COVID-19 patient or recent (< 14 days) international travel)

Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Fever</li> <li>• Sore throat</li> <li>• Rhinorrhoea</li> <li>• Loss of taste or smell</li> <li>• Chest pain</li> <li>• GI symptoms</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR, nasopharyngeal swabs</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		

**Nitecki 2021** (Continued)

<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern
<b>DOMAIN 3: Reference Standard</b>	
Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**O'Reilly 2020a**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to determine the clinical and epidemiological predictors of a positive SARS-CoV-2 test result and the requirement for intensive respiratory support</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> adult patients who meet testing criteria for COVID-19 and have a SARS-CoV-2 PCR test requested in the ED</p> <p><b>Sample size:</b> n = 240 (cases = 11)</p> <p><b>Inclusion criteria:</b> all adults who met the testing criteria for COVID-19 and who presented at the ED</p> <p><b>Exclusion criteria:</b> patients who attended the screening clinic and did not present for medical assessment in the ED (no clinical data available)</p>
Patient characteristics and setting	<b>Facility cases:</b> positive RT-PCR for SARS-CoV-2

**O'Reilly 2020a** (Continued)

**Facility controls:** negative RT-PCR for SARS-CoV-2

**Country:** Australia

**Dates:** 01 April 2020-14 April 2020

**Symptoms and severity:** moderate to severe

**Demographics:** mean age: cases 51 years, controls 61 years

M%/F%: cases 72.0/28.0, controls 55.0/45.0

**Exposure history:** contact with infected person: cases 56%, controls 7%

Index tests	<ul style="list-style-type: none"> <li>• Shortness of breath</li> <li>• Cough</li> <li>• Change to chronic cough</li> <li>• Anosmia/dysgeusia</li> <li>• Sore throat</li> <li>• Runny nose</li> <li>• Fever</li> <li>• Fatigue</li> <li>• Myalgia</li> <li>• Diarrhoea</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (specimen not specified)</li> </ul>
Flow and timing	RS and index tests taken on the same day
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			

**O'Reilly 2020a** (Continued)

Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Low risk

**O'Reilly 2020b**
**Study characteristics**

## Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe the epidemiology and clinical features of patients presenting to the ED with suspected and confirmed COVID-19

**Design:** cross-sectional cohort study, prospective data collection

**Recruitment:** all adult patients who met criteria for "suspected COVID-19" and underwent testing for SARS-CoV-2 were eligible for inclusion. "Testing criteria are guided by the various health jurisdictions and have evolved throughout the project."

**Sample size:** n = 1334 (50 cases)

**Inclusion criteria:** adult patients who had a SARS-CoV-2 PCR test requested in the ED and were managed as "suspected COVID-19"

**O'Reilly 2020b** (Continued)

	<p><b>Exclusion criteria:</b> patients who underwent testing for surveillance purposes</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> Australia</p> <p><b>Dates:</b> 01 July 2020-31 July 2020</p> <p><b>Symptoms and severity:</b> all levels of severity, mostly mild to moderate</p> <p><b>Demographics:</b> mean age: cases 53 years, controls 56 years</p> <p>M%/F%: cases 48.0/52.0, controls 50.0/50.0</p> <p><b>Exposure history:</b> 50% reported close contact with a confirmed case of COVID-19 or a positive SARS-CoV-2 PCR swab result in the 14 days prior to their ED presentation</p>
Index tests	<ul style="list-style-type: none"> <li>• Shortness of breath</li> <li>• Cough</li> <li>• Anosmia or dysgeusia</li> <li>• Sore throat</li> <li>• Runny nose</li> <li>• Fever</li> <li>• Fatigue</li> <li>• Myalgia</li> <li>• Diarrhoea</li> <li>• Body temperature</li> <li>• Fever recorded</li> <li>• Oxygen saturation (SaO2)</li> <li>• Hypoxia (cut-off SaO2 &lt; 92%)</li> <li>• Systolic BP</li> <li>• Diastolic BP</li> <li>• Hypotension</li> <li>• Abnormality on chest auscultation</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (nasopharyngeal swab)</li> </ul>
Flow and timing	Index tests and reference standard both taken at presentation in the ED
Comparative	
Notes	<p>Thresholds only specified for vital parameters, not for most symptoms</p> <p>Funding: none declared</p>

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			



**O'Reilly 2020b** (Continued)

Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Did the study avoid inappropriate inclusions?	Unclear	
<b>Could the selection of patients have introduced bias?</b>		Unclear risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	No	
<b>Could the patient flow have introduced bias?</b>		Unclear risk

**Olivar Lopez 2020**

**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe the profile of patients < 18 years of age treated at a paediatric COVID centre and its association with test confirmation, endotracheal intubation and death

**Design:** cross-sectional cohort study, prospective data collection

**Recruitment:** all patients < 18 years who presented with a clinical picture compatible with COVID-19 (= fever, respiratory symptoms or general malaise) at the ED of a COVID paediatric reference hospital

**Sample size:** n = 510 (79 cases)

**Inclusion criteria:** all patients < 18 years with symptoms compatible with COVID-19 (= fever, respiratory symptoms or general malaise), and who underwent PCR testing

**Exclusion criteria:** unreported test results, insufficient or poorly taken samples

Patient characteristics and setting

**Facility cases:** positive RT-PCR test for SARS-CoV-2

**Facility controls:** negative RT-PCR test for SARS-CoV-2

**Country:** Mexico

**Dates:** March 2020-June 2020

**Symptoms and severity:** mild to moderate to severe, 12.3% of controls and 19.3% of cases intubated

**Demographics:** age: controls mean 5 years, cases mean 4.9 years

M%/F%: cases 59.5/40.5, controls 51.7/48.3

**Exposure history:** contact with case: 57.9% of cases, 27.6% of controls

Index tests

- Fever
- Cough
- Odynophagia
- Dyspnoea
- Irritability
- Diarrhoea
- Chest pain
- Shivers
- Headache
- Myalgia
- Arthralgia
- General malaise
- Rhinorrhoea
- Polypnoea
- Vomiting
- Abdominal pain
- Conjunctivitis
- Cyanosis

**Olivar Lopez 2020** (Continued)

	<ul style="list-style-type: none"> <li>Sudden onset</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> <li>RS: RT-PCR, nasopharyngeal swabs</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern

**Olivar Lopez 2020** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Peng 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> analyse the clinical features and imaging manifestations of COVID-19</p> <p><b>Design:</b> cross-sectional, single-centre, retrospective study</p> <p><b>Recruitment:</b> clinically suspected cases who were sent to hospital for screening</p> <p><b>Sample size:</b> n = 86 (n = 11)</p> <p><b>Inclusion criteria:</b> clinically suspected patients</p> <p><b>Exclusion criteria:</b> not specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR via nasopharyngeal swab</p> <p><b>Facility controls:</b> negative RT-PCR via nasopharyngeal swab (once)</p> <p><b>Country:</b> China</p> <p><b>Dates:</b> 23 January 2020-16 February 2020</p> <p><b>Symptoms and severity:</b> fever, cough, dyspnoea, sore throat, fatigue, systemic soreness, runny nose</p> <p><b>Demographics:</b> M/F: total 39/47, cases: 5/6, controls 34/40</p> <p>Case group: mean age 40.73 ± 11.32 years, 5 men. Control group: mean age 39.67 ± 13.90 years, 34 men</p> <p><b>Exposure history:</b> 7/11 COVID-19 patients (63.6%) had a history of travel to Hubei (5 Wuhan, 1 Huanggang, 1 Xiaogan), 2 patients had close contact with the COVID-19 patients, and 2 taxi drivers</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Cough</li> <li>• Dyspnoea</li> <li>• Sore throat</li> <li>• Fatigue</li> <li>• Systemic soreness</li> <li>• Runny nose</li> </ul>

**Peng 2020** (Continued)

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR (nasopharyngeal swab)</li> </ul>
Flow and timing	Time interval not specified
Comparative	
Notes	Funding: supported by the Key Discipline of Pudong Area, Shanghai

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Unclear		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern

**Peng 2020** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Peyrony 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to assess utility of clinical parameters, physician clinical judgment, and lung ultrasonography to accurately identify SARS-CoV-2-infected patients at ED presentation</p> <p><b>Design:</b> prospective cohort study</p> <p><b>Recruitment:</b> cohort of all adult (<math>\geq 18</math> years) patients with suspected COVID-19 who were tested for SARS-CoV-2 prospectively enrolled at university ED (not every patient was tested for SARS-CoV-2: testing was left to the clinician's discretion)</p> <p><b>Sample size:</b> n = 391 (225 cases)</p> <p><b>Inclusion criteria:</b> no predefined inclusion criteria. Testing was mostly performed in patients who had severe symptoms such as dyspnoea, reported shortness of breath, presented with comorbidities, or were <math>&gt; 70</math> years. Some patients without COVID-19 symptoms were also tested when they needed admission to hospital.</p> <p><b>Exclusion criteria:</b> patients who attended the ED more than once (only the last visit was included). There were no other exclusion criteria.</p>
Patient characteristics and setting	<p><b>Facility cases:</b> all patients who tested positive for SARS-CoV-2 by RT-PCR</p> <p><b>Facility controls:</b> all patients who tested negative for SARS-CoV-2 by RT-PCR</p> <p><b>Country:</b> France</p> <p><b>Dates:</b> 09 March 2020-04 April 2020</p> <p><b>Symptoms and severity:</b> moderate to mild severity, inclusion based on signs and symptoms suggestive of SARS-CoV-2 infection, 82% of included patients with comorbidities; not all included patients had COVID-19 symptoms</p> <p><b>Demographics:</b> all included patients (pos + neg): median age: 62 years % female: 38.4%</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Cough</li> <li>• Dyspnoea</li> <li>• Myalgia</li> </ul>

**Peyrony 2020** (Continued)

- Rhinitis/pharyngitis
- Anosmia
- Headache
- GI symptoms
- Fatigue
- Chest pain
- Dizziness/syncope
- Haemoptysis
- Oxygen saturation

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR for SARS-CoV-2 (negatives re-tested after 48 h), nasal swab</li> </ul>
Flow and timing	RS and index tests both taken at presentation
Comparative	
Notes	

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	No		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			

**Peyrony 2020** (Continued)

Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Pisapia 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to compare the characteristics at hospital admission of confirmed and not-confirmed COVID-19 patients, in the early phase of the epidemic</p> <p><b>Design:</b> retrospective cohort study</p> <p><b>Recruitment:</b> all patients consecutively admitted in selected medical wards (ED + lab) of the mono-specialist infectious diseases referral centre because of clinical suspicion of COVID-19</p> <p><b>Sample size:</b> n = 37 (17 cases)</p> <p><b>Inclusion criteria:</b> all patients consecutively admitted in the selected medical wards because of clinical suspicion of COVID-19. No specification of 'suspicion'</p> <p><b>Exclusion criteria:</b> none</p>
Patient characteristics and setting	<p><b>Facility cases:</b> suspected cases with a positive RT-PCR (second test after 24 h if first negative)</p> <p><b>Facility controls:</b> suspected cases with a negative RT-PCR (2 negative tests)</p> <p><b>Country:</b> Italy</p> <p><b>Dates:</b> 10 February 2020-10 March 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity</p>



**Pisapia 2020** (Continued)

**Demographics:** median age cases: 49 years controls: 29 years. Gender: % female cases: 35%, controls: 35%

**Exposure history:** travel to affected area: cases 35%, controls 95%. Contact with a confirmed case: cases 47%, controls: 0%. Contact with people from affected area: cases: 12% controls: 0%

Index tests	<ul style="list-style-type: none"> <li>Fever</li> <li>Cough</li> <li>Dyspnoea</li> <li>Arthralgia</li> <li>Conjunctivitis</li> <li>Other</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> <li>RS: RT-PCR, different tests used: targeted to different genomic region (regions RdRp, N and E) (commercial kits used during study changed), negatives re-tested after 24 h, nasopharyngeal swab</li> </ul>
Flow and timing	RS and index tests both taken on admission
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	

**Pisapia 2020** (Continued)

**Are there concerns that the index test, its conduct, or interpretation differ from the review question?** Low concern

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition? Yes

Were the reference standard results interpreted without knowledge of the results of the index tests? Unclear

**Could the reference standard, its conduct, or its interpretation have introduced bias?** Low risk

**Are there concerns that the target condition as defined by the reference standard does not match the question?** Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Yes

Did all patients receive the same reference standard? No

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Unclear risk

**Pivetta 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of COVID-19 pneumonia; to explore whether the integration of lung ultrasound and clinical evaluation increases the sensitivity of the diagnosis of COVID-19 pneumonia</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> all adult patients visiting an ED and screened positive for SARS-CoV-2-associated symptoms</p> <p><b>Sample size:</b> n = 228 (107 cases)</p> <p><b>Inclusion criteria:</b> all adults (<math>\geq 18</math> years) who screened positive for acute symptoms associated with SARS-CoV-2 infection at triage (= fever, dyspnoea, new or worsening cough, sore throat, diarrhoea, ageusia, anosmia and asthenia)</p> <p><b>Exclusion criteria:</b> patients known to be infected by SARS-CoV-2, requiring an urgent psychiatric assessment, or already intubated at arrival, no attending physician with expertise in lung ultrasonography available</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR test for SARS-CoV-2, 1 test in patients with an initial positive PCR result, 2 tests in patients with an initial negative PCR result when clinical, sonographic, lab or imaging results were suggestive of COVID-19</p>

**Pivetta 2020** (Continued)

**Facility controls:** negative RT-PCR test for SARS-CoV-2 and all other test results are concordant

**Country:** Italy

**Dates:** 01 April 2020-20 April 2020

**Symptoms and severity:** ED outcome: home discharge 25.2% cases, 78.5% controls, ward admission 60.8% cases, 20.7% controls, ICU admission 7.5% cases, 0.8% controls, ED death 6.5% cases, 0% controls

**Demographics:** age: controls median 50.3 years, cases median 62.8 years

M%/F%: cases 54.1/45.9, controls 43.7/56.3

**Exposure history:** not specified

Index tests	<ul style="list-style-type: none"> <li>• Ageusia</li> <li>• Anosmia</li> <li>• Cough</li> <li>• Diarrhoea</li> <li>• Fatigue</li> <li>• Fever</li> <li>• Headache</li> <li>• Shortness of breath</li> <li>• Sore throat</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR (nasopharyngeal swabs), and in some cases other information including clinical, lab, imaging</li> </ul>
Flow and timing	Maximum 72 h between index tests and RS
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			High

**Pivetta 2020** (Continued)

**DOMAIN 2: Index Test (All tests)**

Were the index test results interpreted without knowledge of the results of the reference standard? Yes

If a threshold was used, was it pre-specified? No

**Could the conduct or interpretation of the index test have introduced bias?** High risk

**Are there concerns that the index test, its conduct, or interpretation differ from the review question?** Low concern

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition? Yes

Were the reference standard results interpreted without knowledge of the results of the index tests? No

**Could the reference standard, its conduct, or its interpretation have introduced bias?** High risk

**Are there concerns that the target condition as defined by the reference standard does not match the question?** High

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Yes

Did all patients receive the same reference standard? No

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** High risk

**Pokorska-Śpiewak 2021**
**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to compare clinical severity and epidemiological spectrum between COVID-19 and influenza in children

**Design:** cross-sectional cohort study, prospective data collection

**Recruitment:** all consecutive paediatric patients referred to a tertiary healthcare department

**Sample size:** n = 319 (15 cases)

**Pokorska-Śpiewak 2021** (Continued)

	<p><b>Inclusion criteria:</b> clinical symptoms (WHO definition) of the disease or positive epidemiological history (international travel or contact with infected person)</p> <p><b>Exclusion criteria:</b> not specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> Poland</p> <p><b>Dates:</b> 01 February 2020-15 April 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity, hospitalisation needed in 73% of cases and 37% of controls, none needed mechanical ventilation</p> <p><b>Demographics:</b> age: controls median 84 months, cases median 128 months</p> <p>M%/F%: cases 53.3/46.7, controls 50.7/49.3</p> <p><b>Exposure history:</b> household contacts with confirmed positive patient: 100% of cases, 9.2% of controls; history of travel: 6.7% of cases, 25.3% of controls</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Cough</li> <li>• Shortness of breath</li> <li>• Diarrhoea</li> <li>• Vomiting</li> <li>• Rhinitis</li> <li>• Abdominal pain</li> <li>• Sore throat</li> <li>• Headache</li> <li>• Myalgia</li> <li>• Chest pain</li> <li>• Fatigue</li> <li>• Conjunctivitis</li> <li>• Skin rash</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR (nasopharyngeal swabs)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared
<b>Methodological quality</b>	
<b>Item</b>	<b>Authors' judgement</b> <b>Risk of bias</b> <b>Applicability concerns</b>
<b>DOMAIN 1: Patient Selection</b>	

**Pokorska-Śpiewak 2021** (Continued)

Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Did the study avoid inappropriate inclusions?	Yes	
<b>Could the selection of patients have introduced bias?</b>		Low risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Unclear risk

**Porto 2021**
**Study characteristics**
**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Porto 2021** (Continued)

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to identify the symptoms associated with early stage SARS-CoV-2 (COVID-19) infections in HCWs using both clinical and laboratory data

**Design:** cross-sectional cohort study, prospective data collection

**Recruitment:** all patients presenting themselves at a polyclinic (a designated diagnostic site for personnel working in the Brazilian public health system, for screening of COVID-19)

**Sample size:** n = 1297 (410 cases)

**Inclusion criteria:** all patients presenting at the Piquet Carneiro Polyclinic, test indication not specified, but high proportion of symptomatic individuals in recruited population

**Exclusion criteria:** none specified

Patient characteristics and setting

**Facility cases:** positive RT-PCR test for SARS-CoV-2

**Facility controls:** negative or inconclusive RT-PCR test for SARS-CoV-2

**Country:** Brazil

**Dates:** 19 March 2020-08 April 2020

**Symptoms and severity:** not specified, mostly symptomatic presentation (mild to moderate severity)

**Demographics:** age: overall 42 years

M%/F%: overall 28.2/71.8

**Exposure history:** confirmed contact with SARS-CoV-2 infected person: 43.8% of cases 43.3% in controls

Index tests

- Cough
- Headache
- Body ache
- Fever
- Sore throat
- Coryza
- Tiredness
- Sneeze
- Nasal congestion
- Prostration
- Respiratory difficulty
- Diarrhoea
- Anosmia or hyposmia
- Chills
- Anxiety
- Nausea or vomiting
- Eye conjunctiva congestion
- Palpitations
- Irritability
- Abdominal pain
- Sputum production
- Difficulty swallowing

**Porto 2021** (Continued)

- Mental confusion
- Lymph node enlargement
- Skin rash

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR (nasopharyngeal swabs)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: the Laboratory of Histocompatibility and Cryopreservation received a thermo cycler and a -80 °C freezer from COVID-19 donation open account for Pedro Ernesto University Hospital. Rio de Janeiro Health Secretary provided nucleic acid extraction and RT-PCR

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Unclear		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		



**Porto 2021** (Continued)

Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Raberahona 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to identify clinical signs and symptoms and epidemiological features that could help discriminate confirmed cases of COVID-19 from SARS-CoV-2-negative patients</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> patients visiting the screening centre</p> <p><b>Sample size:</b> n = 3154 (1288 cases)</p> <p><b>Inclusion criteria:</b> patients visiting the screening centre</p> <p><b>Exclusion criteria:</b> PCR unknown or inconclusive result</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> Madagascar</p> <p><b>Dates:</b> 06 May 2020-01 July 2020</p> <p><b>Symptoms and severity:</b> mostly mild to moderate severity, 27.8% asymptomatic</p> <p><b>Demographics:</b> age: controls median 31 years, cases median 39 years</p> <p>M%/F%: cases 48.6/51.4, controls 51.1/48.9</p>

**Raberahona 2020** (Continued)

**Exposure history:** self-reported contact cases 19.2%, controls 26.2%

Index tests	<ul style="list-style-type: none"> <li>Fever or history of fever</li> <li>Cough</li> <li>Haemoptysis</li> <li>Sore throat</li> <li>Rhinorrhoea</li> <li>Otalgia</li> <li>Ageusia</li> <li>Anosmia</li> <li>Nasal obstruction</li> <li>Abdominal pain</li> <li>Wheezing</li> <li>Chest pain</li> <li>Myalgia/arthralgia</li> <li>Malaise/fatigue</li> <li>Dyspnoea</li> <li>Headache</li> <li>Nausea/vomiting</li> <li>Diarrhoea</li> <li>Signs of pneumonia</li> <li>Acute respiratory distress</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> <li>RS: RT-PCR, nasopharyngeal swabs</li> </ul>
Flow and timing	Not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			

**Raberahona 2020** (Continued)

Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	No	
<b>Could the patient flow have introduced bias?</b>		High risk

**Romero-Gameros 2020**
**Study characteristics**

## Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to determine the diagnostic yield of a self-assessment questionnaire on smell alterations and the psychophysical olfactory test as screening instruments for COVID-19

**Design:** cross-sectional cohort study, prospective data collection

**Recruitment:** patients who sought a respiratory triage assessment at ED of tertiary care hospital due to COVID-19 suspicion

**Sample size:** n = 139 (72 cases)

**Inclusion criteria:** > 18 years, nasopharyngeal swab taken, present with mild to moderate form of the disease

**Romero-Gameros 2020** (Continued)

**Exclusion criteria:** > 65 years, Parkinson or Alzheimer's history, chronic rhino sinusitis, allergic rhinitis, no SARS-CoV-2 PCR result, requiring hospitalisation

## Patient characteristics and setting

**Facility cases:** positive RT-PCR test for SARS-CoV-2

**Facility controls:** negative RT-PCR test for SARS-CoV-2

**Country:** Mexico

**Dates:** 25 May 2020-30 June 2020

**Symptoms and severity:** mild to moderate severity, patients in need of hospitalisation were excluded

**Demographics:** age: controls mean 39.2 years, cases mean 38.9 years

M%/F%: cases 37.5/62.5, controls 35.8/64.2

Medium-high academic level: 99%

**Exposure history:** not specified

## Index tests

- Headache
- Abdominal pain
- Cough
- Asthenia
- Fever
- Myalgia
- Arthralgia
- Conjunctivitis
- Diarrhoea
- Rhinorrhoea
- Dysosmia
- Nasal obstruction
- Hyposmia - anosmia
- Odynophagia
- Dysgeusia

(Self-assessment questionnaire of smell disorders, pocket smell test)

## Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: RT-PCR (nasopharyngeal swabs)

## Flow and timing

RS taken at presentation, after ENT team assessment of symptoms

## Comparative

## Notes

Funding: none declared

**Methodological quality**
**Item**
**Authors' judgement**
**Risk of bias**
**Applicability concerns**
**DOMAIN 1: Patient Selection**

**Romero-Gameros 2020** (Continued)

Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	No
Did the study avoid inappropriate inclusions?	Yes
<b>Could the selection of patients have introduced bias?</b>	High risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>	Low concern
<b>DOMAIN 2: Index Test (All tests)</b>	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
If a threshold was used, was it pre-specified?	Unclear
<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern
<b>DOMAIN 3: Reference Standard</b>	
Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Romero-Gameros 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to evaluate and establish the diagnostic performance of symptoms and signs in patients with suspected COVID-19</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> patients who came to the ED for suspected COVID-19. Patients were selected through a non probabilistic sampling of consecutive cases according to the order of arrival at the ED</p> <p><b>Sample size:</b> n = 2137 (1148 cases)</p> <p><b>Inclusion criteria:</b> &gt; 17 years, high clinical probability of SARS-CoV-2, confirmatory RT-PCR available</p> <p><b>Exclusion criteria:</b> no RT-PCR test done</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> Mexico</p> <p><b>Dates:</b> 14 April 2020-21 July 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity, high prevalence (&gt; 50%) of symptoms such as cough, asthenia, myalgia and headache; oxygen saturation &lt; 93% in 11% of cases and 4% of controls</p> <p><b>Demographics:</b> age: controls mean 42.8 years, cases mean 48.6 years M%/F%: cases 55.7/44.2, controls 46.8/53.1</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever (&gt; 38 °C)</li> <li>• Cough</li> <li>• Odynophagia</li> <li>• Thoracic pain</li> <li>• Asthenia</li> <li>• Myalgia</li> <li>• Rhinorrhoea</li> <li>• Headache</li> <li>• Anosmia</li> <li>• Conjunctivitis</li> <li>• Dyspnoea</li> <li>• Temperature</li> <li>• Heart rate</li> <li>• Respiratory rate</li> <li>• Systolic BP</li> <li>• Diastolic BP</li> <li>• Oxygen saturation (median)</li> <li>• Oxygen saturation &lt; 93%</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR (nasopharyngeal swabs)</li> </ul>

**Romero-Gameros 2021** (Continued)

Flow and timing Timing not specified

Comparative

Notes Funding: supported by the Mexican Institute of Social Security

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	No		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Unclear		

**Romero-Gameros 2021** (Continued)

Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Rutten 2020a**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); describing (a)typical symptoms and disease course in confirmed COVID-19 patients</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> all patients in a nursing home that were suspected of COVID-19 underwent a diagnostic test</p> <p><b>Sample size:</b> n = 1969 (857 cases)</p> <p><b>Inclusion criteria:</b> patients with at least 2 of the following symptoms: fever/feverish feeling, cough and shortness of breath - later on (from 10 April 2020) patients with atypical symptoms were added.</p> <p><b>Exclusion criteria:</b> patients who didn't undergo a diagnostic test. Patients with unknown results</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> the Netherlands</p> <p><b>Dates:</b> 18 March 2020-15 April 2020</p> <p><b>Symptoms and severity:</b> mild, moderate and severe cases, 30-day mortality almost 50% in the cases</p> <p><b>Demographics:</b> mean age: cases 84 years, controls 83 years</p> <p>M%/F%: cases 35.0/65.0, controls 39.0/61.0</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Fever</li> <li>• Shortness of breath</li> <li>• Confusion</li> <li>• Sore throat</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (specimen not specified), execution and analysis of a RT-PCR test differed per nursing home organisation</li> </ul>
Flow and timing	Timing not specified

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

211



**Rutten 2020a** (Continued)

Comparative

Notes Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Yes		
Did all patients receive the same reference standard?	Yes		

**Rutten 2020a** (Continued)

Were all patients included in the analysis?

Yes

**Could the patient flow have introduced bias?**

Unclear risk

**Rutten 2020b**
**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); describing (a) typical symptoms and disease course in confirmed COVID-19 patients

**Design:** cross-sectional cohort study, prospective data collection

**Recruitment:** all patients in a nursing home that were suspected of COVID-19 (based on the physician's assessment)

**Sample size:** n = 4007 (1538 cases)

**Inclusion criteria:** all nursing home residents with a clinical suspicion of COVID-19 based on the physician's assessment and for whom they had the result of the RT-PCR

**Exclusion criteria:** residents of whom results of follow-up diagnostics were not (yet) available

Patient characteristics and setting

**Facility cases:** positive RT-PCR for SARS-CoV-2

**Facility controls:** negative RT-PCR for SARS-CoV-2

**Country:** the Netherlands

**Dates:** 18 March 2020-13 May 2020

**Symptoms and severity:** decreased oxygen saturation in 44% of cases and 47% of controls, 30- day mortality 3 times higher in cases (42%) than in controls

**Demographics:** mean age: cases 84 years, controls 83 years

M%/F%: cases 36.0/64.0, controls 39.0/61.0

**Exposure history:** not specified

Index tests

- Cough
- Shortness of breath
- Fever
- Sore throat
- Delirium or confusion or drowsiness
- Fatigue
- Diarrhoea
- Malaise
- Rhinorrhoea
- Nausea/vomiting
- Common cold
- Decreased oxygen saturation
- Temperature (categories)

**Rutten 2020b** (Continued)

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (specimen not specified)</li> </ul>
Flow and timing	Index tests and RS taken at same visit
Comparative	
Notes	Data overlap with <a href="#">Rutten 2020a</a> Funding: supported by the Dutch Ministry of Health, Welfare, and sport

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern

**Rutten 2020b** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Sacks 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to determine whether and which specific symptoms are associated with a positive COVID-19 test result</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> mandatory, large-scale programme with onsite capacity to test all HCWs with acute symptoms that were potentially consistent with COVID-19 on an outpatient basis</p> <p><b>Sample size:</b> n = 1747 (157 cases)</p> <p><b>Inclusion criteria:</b> all HCWs with symptoms including fever, myalgia, GI symptoms, runny nose, cough, shortness of breath, sore throat, and anosmia</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> Massachusetts, USA</p> <p><b>Dates:</b> 13 March 2020-02 April 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity</p> <p><b>Demographics:</b> mean age overall cohort: 39 years</p> <p>M%/F%: cases 32.0/68.0, controls 26.0/74.0</p> <p><b>Exposure history:</b> 69% reported direct patient contact as part of their routine work, 15% reported known contact inside or outside the hospital with someone who had been diagnosed with COVID-19</p>
Index tests	<ul style="list-style-type: none"> <li>• Anosmia</li> <li>• Fever</li> <li>• Myalgia</li> <li>• Nausea or vomiting or diarrhoea</li> <li>• Runny nose</li> <li>• Cough</li> <li>• Shortness of breath</li> </ul>

**Sacks 2020** (Continued)

	<ul style="list-style-type: none"> <li>Sore throat</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> <li>RS: SARS-CoV-2 RT-PCR test (nasopharyngeal swab)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funded by Mass CPR Grant and the Massachusetts General Hospital Executive Committee on Research (Carney Family Foundation Award to CAS and Steve and Deborah Gorlin Research Scholars Award to RPW).

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	

**Sacks 2020** (Continued)

**Are there concerns that the target condition as defined by the reference standard does not match the question?**

Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?      Unclear

Did all patients receive the same reference standard?      Yes

Were all patients included in the analysis?      Yes

**Could the patient flow have introduced bias?**      Unclear risk

**Saegerman 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to develop a clinical decision support tool for diagnosis of COVID-19 in hospitals</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> all patients directed to the triage centres of 2 university hospital EDs</p> <p><b>Sample size:</b> n = 2152 (573 cases)</p> <p><b>Inclusion criteria:</b> all suspected patients directed to the triage centres (no definition of 'suspected')</p> <p><b>Exclusion criteria:</b> patient with missing data in clinical records or missing RT-PCR result</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> Belgium</p> <p><b>Dates:</b> 02 March 2020-15 June 2020</p> <p><b>Symptoms and severity:</b> not specified, clinical suspicion at presentation</p> <p><b>Demographics:</b> mean age: cases 58 years, controls 52 years M%/F%: cases 48.7/51.3, controls 42.2/57.8</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Dyspnoea</li> <li>• Chest pain</li> <li>• Rhinorrhoea</li> <li>• Sore throat</li> <li>• Dry cough</li> </ul>

**Saegerman 2021** (Continued)

- Wet cough
- Diarrhoea
- Headache
- Myalgia
- Fever
- Anosmia

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (specimen not specified)</li> </ul>
Flow and timing	Index tests and RS both taken at presentation
Comparative	
Notes	Funded by the Liège University Hospital

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		

**Saegerman 2021** (Continued)

Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk

**Salmon Ceron 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); second part of the study: to assess the diagnostic accuracy of olfactory/gustatory dysfunction for SARS-CoV-2 infection in the overall population tested for SARS-CoV-2</p> <p><b>Design:</b> prospective cohort study</p> <p><b>Recruitment:</b> all consecutive patients who were tested for SARS-CoV-2 in the Paris-based screening centre for COVID-19</p> <p><b>Sample size:</b> n = 1824 (849 cases)</p> <p><b>Inclusion criteria:</b> (second part of the study): all consecutive patients with a suspicion of SARS-CoV-2 infection, independent of loss of smell no specification of 'suspicion'</p> <p><b>Exclusion criteria:</b> (second part of the study): none</p>
Patient characteristics and setting	<p><b>Facility cases:</b> all suspected patients with a positive RT-PCR</p> <p><b>Facility controls:</b> all suspected patients with a negative RT-PCR</p> <p><b>Country:</b> France</p> <p><b>Dates:</b> 17 March 2020-25 March 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity</p> <p><b>Demographics:</b> not specified for second part of this study</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Self-reported loss of smell and/or taste: loss of smell only, loss of taste only, loss of smell and taste, loss of smell and/or loss of taste</li> <li>• Cough</li> <li>• Headache</li> </ul>



**Salmon Ceron 2020** (Continued)

	<ul style="list-style-type: none"> <li>Sore throat</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> <li>RS: RT-PCR test, nasopharyngeal swabs</li> </ul>
Flow and timing	RS and index tests both taken at presentation
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Unclear		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern

**Salmon Ceron 2020** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Yes

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Low risk

**Shah 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe characteristics, diagnostics and outcomes of patients with respiratory illness, comparing patients with and without COVID-19 disease</p> <p><b>Design:</b> retrospective cohort</p> <p><b>Recruitment:</b> all patients presenting to an ED with an acute respiratory illness and tested for SARS-CoV-2</p> <p><b>Sample size:</b> n = 316 (33 cases)</p> <p><b>Inclusion criteria:</b> all patients <math>\geq</math> 18 years who underwent testing for COVID-19 within 24 h of presentation to the ED. Patients with acute respiratory symptoms, influenza-like illness</p> <p><b>Exclusion criteria:</b> not specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> California, USA</p> <p><b>Dates:</b> 03 February 2020-31 March 2020</p> <p><b>Symptoms and severity:</b> not specified</p> <p><b>Demographics:</b> median age: cases 63, controls 62. %. Female: cases 36%, controls 50%</p> <p><b>Exposure history:</b> travel in last 21 days or known COVID exposure: cases 46%, controls 11%</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever (patient-reported)</li> <li>• Fatigue/malaise</li> <li>• Cough (dry, productive)</li> <li>• Myalgia</li> <li>• Dyspnoea</li> <li>• Chest pain</li> <li>• Sore throat</li> <li>• Nasal congestion/rhinorrhoea</li> <li>• Diarrhoea</li> </ul>

**Shah 2020** (Continued)

- Nausea
- Vomiting
- Abdominal pain
- Headache
- Altered mental status
- Tachycardia (> 100 beats/min)
- Low mean arterial pressure (< 60 mmHg)
- Tachypnoea (respiratory rate > 20 breaths/min)
- Fever

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR test, oropharyngeal and/or nasopharyngeal swabs</li> </ul>
Flow and timing	RS performed maximum 24 h later than index tests
Comparative	
Notes	Funding: supported by the National Center for Advancing Translational Sciences, the National Heart Lung Blood Institute, National Institute of Allergy and Infectious Diseases, the Chan Zuckerberg Biohub, the Chan Zuckerberg Initiative

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Yes		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern

**Shah 2020** (Continued)

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Unclear risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Simpson 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe the demographics, clinical features, and test results of children referred from their primary provider for SARS-CoV-2 testing in the community setting</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> all children (0-22 years) who were referred by paediatricians to an outpatient paediatric testing site</p> <p><b>Sample size:</b> n = 1210 (378 cases)</p> <p><b>Inclusion criteria:</b> children presenting with mild symptoms, children who were at high risk for serious infection, children who lived with high-risk household members, or children who lived with household members whose work status would be impacted by the presence of infection</p> <p><b>Exclusion criteria:</b> patients were excluded from the geospatial analysis if they had invalid addresses (n = 12)</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> USA</p> <p><b>Dates:</b> 21 March 2020-16 May 2020</p>

**Simpson 2020** (Continued)

**Symptoms and severity:** mostly mild symptoms

**Demographics:** median age overall: 8 years

M%/F%: cases 47.6/49.3 controls: 52.0/47.8

**Exposure history:** not specified, self-reported high-risk contacts vs no high-risk contacts: OR = 1.6

Index tests	<ul style="list-style-type: none"> <li>• Upper respiratory tract symptoms (e.g. sore throat or nasal congestion)</li> <li>• Cough</li> <li>• Lower respiratory tract symptoms (e.g. difficulty breathing)</li> <li>• GI symptoms (e.g. vomiting or diarrhoea)</li> <li>• Neurologic symptoms (e.g. headache)</li> <li>• Systemic symptoms (e.g. fever)</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (naso- or oropharyngeal swab)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	

**Simpson 2020** (Continued)

**Are there concerns that the index test, its conduct, or interpretation differ from the review question?** Low concern

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition? Yes

Were the reference standard results interpreted without knowledge of the results of the index tests? Yes

**Could the reference standard, its conduct, or its interpretation have introduced bias?** Low risk

**Are there concerns that the target condition as defined by the reference standard does not match the question?** Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Unclear

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? No

**Could the patient flow have introduced bias?** Unclear risk

**Sonoda 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to investigate the clinical symptoms to discriminate between COVID-19 and non-COVID-19 cases among outpatients in GP clinics</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> outpatients visiting the screening centre (GP clinic)</p> <p><b>Sample size:</b> n = 360 (17 cases)</p> <p><b>Inclusion criteria:</b> patients visiting the centre with suspicion of COVID-19 (no definition of 'suspicion')</p> <p><b>Exclusion criteria:</b> patients who didn't receive a RT-PCR test</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> Japan</p> <p><b>Dates:</b> 01 August 2020-14 August 2020</p> <p><b>Symptoms and severity:</b> clinical spectrum of cases (n = 17) was 14 moderate, 2 moderate and 1 severe illness</p>

**Sonoda 2021** (Continued)

**Demographics:** mean age: cases 39.6 years, controls 41.2 years

M%/F%: cases 58.8/41.2, controls 50.7/49.2

**Exposure history:** close contact to patients with COVID-19: cases 13.3%, controls 8.1%

Index tests	<ul style="list-style-type: none"> <li>• Body temperature</li> <li>• Headache</li> <li>• Sore throat</li> <li>• Dysgeusia</li> <li>• Anosmia</li> <li>• Nasal discharge</li> <li>• Cough</li> <li>• Sputum production</li> <li>• Nausea/vomiting</li> <li>• Diarrhoea</li> <li>• Stomach ache</li> <li>• Fatigue</li> <li>• Shortness of breath</li> <li>• Joint pain</li> <li>• Myalgia</li> <li>• Lack of appetite</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (nasal swab or saliva specimen)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			

**Sonoda 2021** (Continued)

Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Unclear risk

**Sun 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> algorithm development for estimating risk of COVID-19</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> patients presenting at the designated national outbreak screening centre and tertiary care hospital in Singapore for SARS-CoV-2 testing. Patients were either self-referred, referred from primary care facilities, or were at-risk cases identified by national contact tracing efforts (recruited n = 991)</p> <p><b>Sample size:</b> n = 788 (n = 54)</p> <p><b>Inclusion criteria:</b> patients presenting to the centre:</p> <ul style="list-style-type: none"> <li>• self-referred</li> <li>• referred from primary care facilities</li> <li>• at-risk cases identified by national contact tracing efforts</li> </ul>
------------------	--



Sun 2020 (Continued)

**Exclusion criteria:** PCR results not available at time of data collection - no electronic medical records - unavailable vital sign records

## Patient characteristics and setting

**Facility cases:** positive SARS-CoV-2 RT-PCR test

**Facility controls:** all SARS-CoV-2 RT-PCR results were negative (minimum 2 test negatives in high-risk patients, minimum 1 test low-risk patients)

**Country:** Singapore

**Dates:** 26 January 2020-16 February 2020

**Symptoms and severity:** 252 (33.2%) symptoms > 5 days at presentation, 75 (9.5%) any comorbidity

**Demographics:** median age 34 years, range 7 years-98 years, IQR 27-45; cases median 42 years, range 16-79; controls 34 years, range 7-98

M/F: 48.3%/51.7% F (cases M: 88 (88.9%))

**Exposure history:** contact with a known COVID-19 case (20.1% (32/54 cases (59.3%)); 126/734 controls (17.2%), contact with travellers from China (22.1%, 15/54 cases (27.8%); 42/734 controls (5.7%)), recent travel history, and visit to hospital in China within 14 days prior to symptom onset (0.8%)

## Index tests

- Body temperature
- Heart rate
- Respiratory rate
- Systolic BP
- Diastolic BP
- Cough
- Sputum production
- Shortness of breath
- Rhinorrhoea or nasal congestion
- Sore throat
- Auscultation finding of pneumonia
- Other respiratory symptoms
- GI symptoms

## Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: SARS-CoV-2, 2 commercial assays 2-target (1 assay: Orf1ab and N - other unclear) RT-PCR

## Flow and timing

Time interval not specified

## Comparative

## Notes

Funding: supported by the following grants from Singapore Ministry of Health's National Medical Research Council: collaborative Solutions Targeting Antimicrobial Resistance Threats in Health Systems (CoSTAR-HS) [NMRC CGAug16C005], NMRC Clinician Scientist Award [MOH-000276] and NMRC Clinician Scientist Individual Research Grant [MOH-CIRG18nov-0006].

**Methodological quality**
**Item**
**Authors' judgement**
**Risk of bias**
**Applicability concerns**
**DOMAIN 1: Patient Selection**

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

228

**Sun 2020** (Continued)

Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Did the study avoid inappropriate inclusions?	Unclear	
<b>Could the selection of patients have introduced bias?</b>		Unclear risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		High
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	

Sun 2020 (Continued)

**Could the patient flow have introduced bias?**

Low risk

**Tan 2021**
**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to describe the differences in clinical presentation between COVID-19 and other respiratory viruses and to determine independently associated clinical features with COVID-19

**Design:** cross-sectional multicenter cohort study, retrospective data collection

**Recruitment:** all patients who fulfilled the hospital's COVID-19 suspect criteria were admitted and tested for both SARS-CoV-2 and non-SARS-CoV-2 respiratory viruses. The hospital's suspect criteria were based on a combination of clinical symptoms, and a constant changing criteria for a history of (international) travel based on the current epidemiological risks

**Sample size:** n = 469 (287 cases) (18 asymptomatic patients excluded from the analysis)

**Inclusion criteria:** patients who were positive for either SARS-CoV-2 or a non-SARS-CoV-2 respiratory virus

**Exclusion criteria:** testing negative for both SARS-CoV-2 and a non-SARS-CoV-2 respiratory virus; co-infection of SARS-CoV-2 and another non-SARS-CoV-2 respiratory virus; asymptomatic patients (screening)

Patient characteristics and setting

**Facility cases:** positive RT-PCR for SARS-CoV-2 (2, if first was negative)

**Facility controls:** negative RT-PCR for SARS-CoV-2

**Country:** Singapore

**Dates:** 17 January 2020-15 April 2020

**Symptoms and severity:** mild to moderate severity, some severe to death

**Demographics:** mean age: ≤ 30 years: cases 32.4%, controls 37.9%; 31-60 years: cases 56.1%, controls 48.9%; > 60 years: cases 11.5%, controls 13.2%

M%/F%: cases 81.2/18.8, controls 56.6/43.4

**Exposure history:** exposure to possible COVID-19-positive case: cases 54%, controls 46.2% Exposure to confirmed COVID-19-positive case: cases 24.7%, controls 11%. Resides in foreign worker dormitory: cases 51.6%, controls 17%. Positive contact with a person with acute respiratory infection symptoms: cases 17.4%, controls 27.5%

Index tests

- Fever
- Sore throat
- Cough
- Rhinorrhea or congested nose
- Myalgia
- Anosmia and/or dysgeusia
- GI symptoms (including abdominal pain, nausea, vomiting diarrhoea)
- Tachycardia (> 100 beats/min)

**Tan 2021** (Continued)

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (oropharyngeal and/or nasopharyngeal swabs)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

231

**Tan 2021** (Continued)

**Are there concerns that the target condition as defined by the reference standard does not match the question?**

Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?      Unclear

Did all patients receive the same reference standard?      Yes

Were all patients included in the analysis?      Yes

**Could the patient flow have introduced bias?**      Unclear risk

**Tolia 2020**
**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of acute SARS-CoV-2 infection

**Design:** cross-sectional cohort, retrospective data collection

**Recruitment:** all patients presenting to 1 of 2 EDs, located at an urban teaching hospital, and academic quaternary medical centre, within the same healthcare system who had targeted testing based on clinician's decision during the initial 10 days of test availability

**Sample size:** n = 283 (29 cases)

**Inclusion criteria:**

- patients presenting with symptoms related to COVID-19 infection (fever and cough or shortness of breath)
- travel within 14 days to countries with high rates of infection (at that time China, Iran, Italy, Japan and South Korea) or
- risk factors for infection complications (including age or comorbid conditions) or
- the patient was a HCW who could potentially expose others at risk and clinician made decision for testing

**Exclusion criteria:** not specified

Patient characteristics and setting

**Facility cases:** positive SARS-CoV-2 test

**Facility controls:** negative SARS-CoV-2 test, visiting the same EDs and being tested

**Country:** USA (San Diego, CA)

**Dates:** 10 March 2020-19 March 2020

**Symptoms and severity:** not specified, all patients presenting with symptoms related to COVID-19 infection (fever and cough or shortness of breath)

**Tolia 2020** (Continued)

**Demographics:** age (< 18 years: 0.7%, 18-64 years: 83.4%, > 65 years: 15.9%); gender: cases M/F%: 55.2/44.8; controls M/F%: 52.8/47.2; all M/F%: 53.0/47.0

**Exposure history:** recent travel (5.5%), 90.6% symptom-based criteria for testing, no known exposure history based

Index tests	<ul style="list-style-type: none"> <li>Fever</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> <li>RS: commercial RT-PCR test - ePLex SARS-CoV-2 test (nasopharyngeal swab)</li> </ul>
Flow and timing	Probably no time interval between index test and RS, but not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			

**Tolia 2020** (Continued)

Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Unclear risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Tordjman 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of COVID-19 pneumonia; to determine the effectiveness of a pre-test probability score for SARS-CoV-2 infection</p> <p><b>Design:</b> cross-sectional cohort, retrospective data collection</p> <p><b>Recruitment:</b> a retrospective cohort of 200 patients with both RT-PCR and CT scan results available with a 1:1 patient:control inclusion ratio from ED at Cochin Hospital (Paris, France) with a suspicion of SARS-CoV-2 infection: 100 consecutive infected patients and 100 consecutive controls + a validation cohort: consecutive recruitment of outpatients suspected with COVID-19 (different from derivation cohort) at Cochin Hospital, Ambroise Paré and Raymond Poincaré hospitals</p> <p><b>Sample size:</b> n = 605 (361) (no clinical data available from validation cohort)</p> <p><b>Inclusion criteria:</b> clinical suspicion of SARS-CoV-2 infection, and both RT-PCR and CT scan available, 'suspicion' not defined</p> <p><b>Exclusion criteria:</b> absence of confirmed diagnosis (diagnosis still under investigation); lack of blood test including complete white blood cell count and serum electrolytes; absence of reported clinical characteristics)</p>
Patient characteristics and setting	<p><b>Facility cases:</b> suspected patients with a positive RT-PCR or positive CT scan (positive signs of COVID-19 pneumonia: usually bilateral and peripheral ground-glass and consolidated pulmonary opacities)</p> <p><b>Facility controls:</b> suspected patients with a negative RT-PCR and negative findings on CT scan</p> <p><b>Country:</b> France</p>

**Tordjman 2020** (Continued)

**Dates:** 10 March 2020-30 April 2020

**Symptoms and severity:** not specified, mild to moderate severity

**Demographics:** median age: cases 60.8 years, controls 54.1 years. Female %: cases 40%, controls 50%

**Exposure history:** not specified

Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Fever</li> <li>• Shortness of breath</li> <li>• Diarrhoea</li> <li>• Myalgia</li> <li>• Headache</li> <li>• Anosmia</li> <li>• Ageusia</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection and COVID-19 pneumonia</li> <li>• RS: RT-PCR (specimen not specified) or CT scan lungs</li> </ul>
Flow and timing	RS and index tests both taken at first presentation
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	No		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**



**Tordjman 2020** (Continued)

**Are there concerns that the index test, its conduct, or interpretation differ from the review question?** Low concern

**DOMAIN 3: Reference Standard**

Is the reference standards likely to correctly classify the target condition? Yes

Were the reference standard results interpreted without knowledge of the results of the index tests? Unclear

**Could the reference standard, its conduct, or its interpretation have introduced bias?** Unclear risk

**Are there concerns that the target condition as defined by the reference standard does not match the question?** Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Yes

Did all patients receive the same reference standard? Unclear

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Unclear risk

**Trubiano 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease)</p> <p><b>Design:</b> prospective cohort study</p> <p><b>Recruitment:</b> data on all patients presenting at a COVID-19 rapid assessment screening clinic were prospectively collected in an electronic database. Only those patients who met the DHHS (Victorian Department of Health and Human Services) criteria for SARS-CoV-2 testing had nasopharyngeal swab collected for SARS-CoV-2 nucleic acid detection by PCR</p> <p><b>Sample size:</b> n = 2935 (108 cases)</p> <p><b>Inclusion criteria:</b> all people meeting DHHS criteria for testing: fever or chills in the absence of an alternative diagnosis that explains the clinical presentation or acute respiratory infection symptoms (e.g. cough, sore throat, shortness of breath, runny nose, loss of smell or loss of taste)</p> <p><b>Exclusion criteria:</b> pending or intermediate results</p>
Patient characteristics and setting	<p><b>Facility cases:</b> patients with suspected COVID-19 with a positive RT-PCR for SARS-CoV-2</p>

**Trubiano 2020** (Continued)

**Facility controls:** suspected patients with a negative RT-PCR for SARS-CoV-2

**Country:** Australia

**Dates:** 11 March 2020-22 April 2020

**Symptoms and severity:** mild to moderate severity

**Demographics:** median age: cases 51 years, controls 38 years. Female %: cases 49.1%, controls 64.1%

**Exposure history:** overseas health facility exposure: cases 1.9%, controls 4.0%. Australian health facility exposure: cases 11.1%, controls 31.5%. Contact with known COVID-19-positive patient: cases 57.4%, controls 15.8%

Index tests	<ul style="list-style-type: none"> <li>• Any fever</li> <li>• Fever &gt; 38 °C</li> <li>• Subjective fever</li> <li>• Sore throat</li> <li>• Cough</li> <li>• Shortness of breath</li> <li>• Chest pain</li> <li>• Anosmia</li> <li>• Ageusia</li> <li>• Anosmia or ageusia</li> <li>• Coryza</li> <li>• Diarrhoea</li> <li>• Other GI symptoms</li> <li>• Malaise/myalgia/arthritis</li> <li>• Headache</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR (nasopharyngeal swab)</li> </ul>
Flow and timing	RS and index tests both taken at presentation
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		

**Trubiano 2020** (Continued)

<b>Could the selection of patients have introduced bias?</b>	Low risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>	Low concern
<b>DOMAIN 2: Index Test (All tests)</b>	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
If a threshold was used, was it pre-specified?	Unclear
<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern
<b>DOMAIN 3: Reference Standard</b>	
Is the reference standards likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Low risk

**Tudrej 2020**
**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to diagnose SARS-CoV-2 infection in primary care settings based on signs and symptoms

**Design:** cross-sectional cohort study, prospective data collection

**Tudrej 2020** (Continued)

	<p><b>Recruitment:</b> recruitment in 2 clinical laboratories in Lyon (France) to which GPs refer patients with suspected COVID-19 for a nasopharyngeal smear (RT-PCR)</p> <p><b>Sample size:</b> n = 816 (198 cases)</p> <p><b>Inclusion criteria:</b> all consecutive patients referred by GPs for PCR testing</p> <p><b>Exclusion criteria:</b> none specified</p>		
Patient characteristics and setting	<p><b>Facility cases:</b> all suspected patients with a positive RT-PCR</p> <p><b>Facility controls:</b> all suspected patients with a negative RT-PCR</p> <p><b>Country:</b> France</p> <p><b>Dates:</b> 24 March 2020-14 April 2020</p> <p><b>Symptoms and severity:</b> not specified</p> <p><b>Demographics:</b> all included patients: median age: 45 years, % female: 65%</p> <p><b>Exposure history:</b> not specified, 37% of participants were health-care professionals</p>		
Index tests	<ul style="list-style-type: none"> <li>• Anosmia or hyposmia</li> <li>• Ageusia or hypogeusia</li> <li>• Fever</li> <li>• Asthenia</li> <li>• Headache</li> <li>• Cough</li> <li>• Dyspnoea</li> <li>• Chest pain</li> <li>• Myalgia</li> <li>• Diarrhoea</li> <li>• Dry nose</li> <li>• Stuffy nose</li> <li>• Dry throat</li> <li>• Sore throat</li> </ul>		
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR (nasopharyngeal swab)</li> </ul>		
Flow and timing	RS specimen taken right after index tests, at presentation		
Comparative			
Notes	Funding: none declared		
<b>Methodological quality</b>			
<b>Item</b>	<b>Authors' judgement</b>	<b>Risk of bias</b>	<b>Applicability concerns</b>
<b>DOMAIN 1: Patient Selection</b>			

**Tudrej 2020** (Continued)

Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Did the study avoid inappropriate inclusions?	Yes	
<b>Could the selection of patients have introduced bias?</b>		Low risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	Unclear	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Low risk

**Van Loon 2021**
**Study characteristics**
**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Van Loon 2021** (Continued)

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to identify early symptoms of SARS-CoV-2 infection among HCWs</p> <p><b>Design:</b> single-centre, cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> all hospital HCWs self-reporting mild symptoms of an acute upper or lower respiratory tract infection were tested in a large non-academic hospital</p> <p><b>Sample size:</b> n = 373 (185 cases)</p> <p><b>Inclusion criteria:</b> HCWs with respiratory complaints and fever, according to the national guidelines for PCR-testing for SARS-CoV-2 by Scienzano, based on those of the WHO and the European Center for Disease Control (ECDC).</p> <p><b>Exclusion criteria:</b> inconclusive PCR results</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2 (2, if first was negative)</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> Belgium</p> <p><b>Dates:</b> 09 March January 2020-17 April 2020</p> <p><b>Symptoms and severity:</b> mild symptoms of an acute upper or lower respiratory tract infection</p> <p><b>Demographics:</b> mean age: &lt; 30 years: total 20.4%, controls 60.5%; 30-39 years: total 30.0 %, controls 41.4%; 40-49 years: total 27.3%, controls 49.5%; 50-59 years: total 17.4%, controls 56.9%; ≥ 60 years: cases 4.8%, controls 33.3%</p> <p>M%/F%: cases 53.1/46.9, overall 22.2/77.8</p> <p><b>Exposure history:</b> HCWs in a hospital with a high number of admitted COVID-19 patients</p>
Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Sore throat</li> <li>• Runny or stuffy nose</li> <li>• Headache</li> <li>• Myalgia</li> <li>• Diarrhoea</li> <li>• Fatigue</li> <li>• Shortness of breath</li> <li>• Sneezing</li> <li>• Anosmia</li> <li>• Fever</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (nasopharyngeal swab)</li> </ul>
Flow and timing	Timing not specified
Comparative	

**Van Loon 2021** (Continued)

Notes

Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Unclear		
Did all patients receive the same reference standard?	Yes		

**Van Loon 2021** (Continued)

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Unclear risk

**Van Walraven 2021**
**Study characteristics**

**Patient Sampling** **Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to derive and assess a model to predict the risk of SARS-CoV-2 in community-based people

**Design:** cross-sectional study, prospective data collection

**Recruitment:** all people who were tested between 13 March and 21 April 2020 at a community-based COVID-19 testing centre

**Sample size:** n = 9172 (571 cases)

**Inclusion criteria:** presence of symptoms including rhinorrhoea; fever symptoms including rigor, chills, perceived fever, or documented fever at home or at the screening clinic; cough; and shortness of breath. Any infection risk factor including close contact with a person with known or presumed COVID-19 disease or recent travel outside of Canada. In the absence of these indications, HCWs (or people cohabiting with a HCW) were included if they had symptoms of sore throat, sputum production, or rhinorrhoea. In the event of extenuating circumstances or if the person was referred to the screening clinic by public health officials for testing

**Exclusion criteria:** result not known, people with previous testing

**Patient characteristics and setting**

**Facility cases:** positive RT-PCR for SARS-CoV-2

**Facility controls:** negative RT-PCR for SARS-CoV-2

**Country:** Canada

**Dates:** 13 March 2020-21 April 2020

**Symptoms and severity:** severity not specified. Mostly symptomatic presentation: cough or shortness of breath was present in > 80% of cases and controls

**Demographics:** mean age: cases 45.4 years, controls 42.5 years

M%/F%: cases 44.5/55.5, controls 43.3/56.7

**Exposure history:** contact %: 72.5 cases, 47 controls travel %: 25.7 cases, 24.2 controls

**Index tests**

- Rhinorrhoea
- Fever symptoms (temp > 38 °C at screening, feverishness, chills, rigor, temp > 38 °C at home)
- chest symptoms (cough, shortness of breath)
- multivariable prediction rule (combination of sex + HCW + contact with case + rhinorrhoea + chest symptoms (cough or dyspnoea) + recent travel + recent case detection rate + age)

**Target condition and reference standard(s)**

- TC: SARS-CoV-2 infection
- RS: SARS-CoV-2 RT-PCR test (nasopharyngeal and throat swabs)



**Van Walraven 2021** (Continued)

Flow and timing Timing not specified, likely both at presentation

Comparative

Notes Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	

**Van Walraven 2021** (Continued)

**Are there concerns that the target condition as defined by the reference standard does not match the question?**

Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Unclear

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?**

Low risk

**Vieceli 2020**
**Study characteristics**

Patient Sampling

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to develop a tool to identify patients with higher probability of COVID-19 diagnosis at admission

**Design:** cross-sectional cohort study, retrospective data collection

**Recruitment:** the first 118 consecutive patients aged  $\geq 18$  admitted to the hospital due to suspected COVID-19 were assessed

**Sample size:** n = 100 (29 cases)

**Inclusion criteria:** aged  $\geq 18$  years and suspected of COVID-19

**Exclusion criteria:** patients discharged within 24 h of admission

Patient characteristics and setting

**Facility cases:** positive RT-PCR for SARS-CoV-2 (2, if first was negative)

**Facility controls:** negative RT-PCR for SARS-CoV-2

**Country:** Brazil

**Dates:** 17 March January 2020-10 April 2020

**Symptoms and severity:** mild to severe

**Demographics:** mean age: cases 62 years, controls 54 years

M%/F%: cases 51.7/48.3, controls 39.4/60.6

**Exposure history:** no patients in the negative group (controls) had travelled in the previous 3 weeks, compared to 8 (28.6%) patients in the confirmed (cases) group

Index tests

- Fever
- Dyspnoea
- Cough
- Expectoration

**Vieceli 2020** (Continued)

- Chest pain
- Headache
- Myalgia
- Asthenia
- Upper respiratory tract symptoms
- GI symptoms (not specified)
- Respiratory distress

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (nasal and throat swabs)</li> </ul>
Flow and timing	Index tests and reference standard both on admission
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		

**Vieceli 2020** (Continued)

Were the reference standard results interpreted without knowledge of the results of the index tests? Unclear

**Could the reference standard, its conduct, or its interpretation have introduced bias?** Low risk

**Are there concerns that the target condition as defined by the reference standard does not match the question?** Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Yes

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Low risk

**Vilke 2020**
**Study characteristics**

**Patient Sampling**

**Purpose:** diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to assess the frequency of fever and other symptoms associated with COVID-19 among patients presenting to ED

**Design:** cross-sectional study, retrospective data collection

**Recruitment:** all patients presenting to 1 of 2 EDs, who were tested for acute COVID-19 while in the ED or within 2 h of their triage temperature

**Sample size:** n = 6894 (330 cases)

**Inclusion criteria:** all patients presenting to the ED who were tested for acute COVID-19 infection while in the ED or within 2 h of their triage temperature (if they were admitted and tested after they left the ED)

**Exclusion criteria:** none specified

**Patient characteristics and setting**

**Facility cases:** positive test on rapid antigen test for SARS-CoV-2 or positive RT-PCR for SARS-CoV-2

**Facility controls:** negative test on rapid antigen test for SARS-CoV-2 or negative RT-PCR for SARS-CoV-2

**Country:** USA (California)

**Dates:** 10 March 2020-30 June 2020

**Symptoms and severity:** severity not specified. Mostly symptomatic presentation: cough was present in 64.5% of cases and 26.6% of controls, fever at presentation in 19.4% of cases and 5.6% of controls

**Demographics:** not specified

**Exposure history:** not specified

**Vilke 2020** (Continued)

Index tests	<ul style="list-style-type: none"> <li>• Presenting fever (<math>\geq 38^{\circ}\text{C}</math>)</li> <li>• Cough</li> <li>• Recent fever or chills</li> <li>• Shortness of breath</li> <li>• Fatigue</li> <li>• Body aches</li> <li>• Nausea or vomiting</li> <li>• Sore Throat</li> <li>• Loss or change in taste or smell</li> <li>• Diarrhoea</li> <li>• Sinus problem</li> <li>• Headache</li> <li>• Presenting fever (<math>\geq 38^{\circ}\text{C}</math>) or recent fever/chills</li> <li>• Cough or presenting fever (<math>\geq 38^{\circ}\text{C}</math>) or recent fever/chills</li> <li>• Shortness of breath or cough or presenting fever (<math>\geq 38^{\circ}\text{C}</math>) or recent fever/chills</li> <li>• Fatigue or shortness of breath or cough or presenting fever (<math>\geq 38^{\circ}\text{C}</math>) or recent fever/chills</li> <li>• Body aches or fatigue or shortness of breath or cough or presenting fever (<math>\geq 38^{\circ}\text{C}</math>) or recent fever/chills</li> </ul>		
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: rapid antigen test or SARS-CoV-2 RT-PCR test (nasal, nasopharyngeal and throat swabs)</li> </ul>		
Flow and timing	RS was taken within 2 h after the triage temperature		
Comparative			
Notes	Funding: none declared		
<b>Methodological quality</b>			
<b>Item</b>	<b>Authors' judgement</b>	<b>Risk of bias</b>	<b>Applicability concerns</b>
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Unclear		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			

**Vilke 2020** (Continued)

Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear
If a threshold was used, was it pre-specified?	No
<b>Could the conduct or interpretation of the index test have introduced bias?</b>	High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>	Low concern
<b>DOMAIN 3: Reference Standard</b>	
Is the reference standards likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>	Unclear risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>	Low concern
<b>DOMAIN 4: Flow and Timing</b>	
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	No
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Villerabel 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to evaluate the diagnostic value of a semi-objective olfactory test in patients with self-reported chemosensory dysfunction before COVID-19 testing; to describe the diagnostic value of suggestive patient-reported COVID-19 symptoms</p> <p><b>Design:</b> cross-sectional study, prospective data collection</p> <p><b>Recruitment:</b> all HCWs and adult patients presenting themselves at the COVID-19 screening facility of the university hospital of Montpellier</p> <p><b>Sample size:</b> n = 809 (58 cases)</p>
------------------	---

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Villerabel 2021** (Continued)

**Inclusion criteria:** all HCW or outpatients with symptoms or with close contact with an index case presenting at the screening facility

**Exclusion criteria:** prior chemosensory dysfunction, testing inability, or contraindications

## Patient characteristics and setting

**Facility cases:** positive test on rapid antigen test for SARS-CoV-2 or positive RT-PCR for SARS-CoV-2

**Facility controls:** negative test on rapid antigen test for SARS-CoV-2 or negative RT-PCR for SARS-CoV-2

**Country:** France

**Dates:** 23 March 2020-22 April 2020

**Symptoms and severity:** severity not specified. Mild to moderate symptoms: 42.0% of patients presenting were asymptomatic, most common symptoms were cough, fever, headache, signs of upper respiratory tract infection and fatigue

**Demographics:** mean age: cases 43.6 years, controls 41.7 years

M%/F%: cases 32.8/67.2, controls 25.8/74.2

**Exposure history:** 71.1% had contact with COVID-19 cases

## Index tests

- Arthralgia
- Chest pain
- Cough
- Rash
- Dyspnoea
- Fatigue
- Fever
- GI tract disorders
- Headache
- Myalgia
- Upper respiratory tract infection
- Olfactory dysfunction
- Flavour (gustatory dysfunction)
- Taste (gustatory dysfunction)
- Olfactory dysfunction and/or gustatory dysfunction
- CODA (Clinical Olfactory Dysfunction Assessment)

## Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: SARS-CoV-2 RT-PCR test (nasopharyngeal swabs)

## Flow and timing

Index tests and RS within 10 min

## Comparative

## Notes

Funding: none declared

**Methodological quality**
**Item**
**Authors' judgement**
**Risk of bias**
**Applicability concerns**
**DOMAIN 1: Patient Selection**
**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

250

**Villerabel 2021** (Continued)

Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	No	
Did the study avoid inappropriate inclusions?	Yes	
<b>Could the selection of patients have introduced bias?</b>		High risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	Yes	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		Low risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	No	
<b>Could the patient flow have introduced bias?</b>		Low risk



## Wee 2020

**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to analyse OTDs as a diagnostic criterion for COVID-19</p> <p><b>Design:</b> cross-sectional, prospective single-centre study</p> <p><b>Recruitment:</b> all suspected cases presenting to the ED</p> <p><b>Sample size:</b> n = 870 (cases = 154)</p> <p><b>Inclusion criteria:</b></p> <ul style="list-style-type: none"> <li>presence of respiratory symptoms and suspicious epidemiological links or travel history or</li> <li>new onset OTD</li> </ul> <p><b>Exclusion criteria:</b> not specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for COVID-19</p> <p><b>Facility controls:</b> negative RT-PCR for COVID-19</p> <p><b>Country:</b> Singapore</p> <p><b>Dates:</b> 26 March 2020-10 April 2020</p> <p><b>Symptoms and severity:</b> loss of sense of smell/taste</p> <p><b>Demographics:</b> not specified</p> <p><b>Exposure history:</b> close contact of a confirmed COVID-19 case: cases 42/112, controls 37/679</p>
Index tests	<ul style="list-style-type: none"> <li>Loss of sense of smell/taste</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>TC: SARS-CoV-2 infection</li> <li>RS: RT-PCR (oropharyngeal swabs)</li> </ul>
Flow and timing	Time interval: same day
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Yes		

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Wee 2020** (Continued)

<b>Could the selection of patients have introduced bias?</b>		Low risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Low risk

**Wei 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); diagnosis of SARS-CoV-2 in outpatients visiting a fever clinic</p> <p><b>Design:</b> retrospective cohort study</p> <p><b>Recruitment:</b> all febrile patients visiting the fever clinic of Tongji Hospital</p> <p><b>Sample size:</b> n = 936 (628 cases)</p>
------------------	---

**Wei 2020** (Continued)

	<p><b>Inclusion criteria:</b> all febrile patients visiting the fever clinic</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> all febrile patients with a positive RT-PCR for SARS-CoV-2 (tested twice in 24 h)</p> <p><b>Facility controls:</b> all febrile patients with a negative RT-PCR for SARS-CoV-2 (tested twice in 24 h)</p> <p><b>Country:</b> China</p> <p><b>Dates:</b> 30 January 2020-04 February 2020</p> <p><b>Symptoms and severity:</b> cases: 88.1% mild, 11.5% severe, 0.5% critical; controls: 90.3% mild, 9.1% severe, 0.7% critical</p> <p><b>Demographics:</b> median age: cases: 53 years, controls: 49 years. Gender: % female cases: 52.9%, controls: 53.9%</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Cough</li> <li>• Fatigue</li> <li>• Chest tightness</li> <li>• Muscle ache</li> <li>• Diarrhoea</li> <li>• Dyspnoea</li> <li>• Anorexia</li> <li>• Rhinobyon</li> <li>• Vomiting</li> <li>• Sore throat</li> <li>• Aversion to cold</li> <li>• Nausea</li> <li>• Hypersomnia</li> <li>• Expectoration</li> <li>• Dizziness</li> <li>• Xerostomia</li> <li>• Chest pain</li> <li>• Abdominal distention</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: RT-PCR twice with a 24-h interval (throat swab specimens from the upper respiratory tract)</li> </ul>
Flow and timing	RS and index tests both taken at presentation
Comparative	
Notes	Funding: supported by the National Natural Science Foundation of China [Grants 81874149, 81974456, and 81530024]; the Clinical Research Physician Program of Tongji Medical College, Huazhong University of Science and Technology [Grant 5001540075]; SARS-CoV-2 Pneumonia Emergency Technology Public Relations Project [2020FCA009]

**Methodological quality**

## Wei 2020 (Continued)

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Yes		
Did all patients receive the same reference standard?	Yes		
Were all patients included in the analysis?	Yes		

**Wei 2020** (Continued)

**Could the patient flow have introduced bias?**

Low risk

**Wernhart 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to compare methods of outpatient management and testing strategies</p> <p><b>Design:</b> cross-sectional study, prospective data collection</p> <p><b>Recruitment:</b> all patients with respiratory symptoms reporting to 3 rural GP offices in North Rhine-Westphalia, Germany</p> <p><b>Sample size:</b> n = 489; only 80 people RT-PCR tested (5 cases)</p> <p><b>Inclusion criteria:</b> all patients from 3 GP offices reporting symptoms of respiratory tract infection</p> <p><b>Exclusion criteria:</b> none specified, only 80 suspected patients tested of the 489, following the strict test criteria of the Robert Koch Institute (RKI)</p>
Patient characteristics and setting	<p><b>Facility cases:</b> patients receiving a smear test according to the RKI criteria and testing RT-PCR-positive</p> <p><b>Facility controls:</b> patients receiving a smear test according to the RKI criteria and testing RT-PCR-negative</p> <p><b>Country:</b> Germany</p> <p><b>Dates:</b> 27 January 2020-20 April 2020</p> <p><b>Symptoms and severity:</b> severity not specified. Mild to moderate symptoms: rhinopharyngitis in 40% and acute bronchitis in 60% of cases</p> <p><b>Demographics:</b> mean age all patients 52.69 years; mean age of tested patients 47.03 years.</p> <p>Gender not specified</p> <p><b>Exposure history:</b> not specified</p>
Index tests	<ul style="list-style-type: none"> <li>• Cough</li> <li>• Sore throat</li> <li>• Myalgia and fatigue</li> <li>• Headache</li> <li>• Rhinitis</li> <li>• Fever</li> <li>• Smell and taste dysfunction</li> <li>• Chills</li> <li>• Earache</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (nasopharyngeal swabs)</li> </ul>

**Wernhart 2020** (Continued)

Flow and timing	Index tests and RS both on the same day (patients referred directly to the smear centre)
-----------------	--

Comparative

Notes	Funding: none declared
-------	------------------------

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Yes		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		Low risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			

**Wernhart 2020** (Continued)

Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
<b>Could the patient flow have introduced bias?</b>	Low risk

**Xie 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of COVID-19 pneumonia; to compare the epidemiological, clinical, laboratory and radiological characteristics, treatment and outcomes between patients with confirmed COVID-19 pneumonia and those with suspected COVID-19 infection (71% of SARS-CoV-2-positive patients had CT-confirmed pneumonia)</p> <p><b>Design:</b> retrospective 2-centre cohort</p> <p><b>Recruitment:</b> patients in whom a RT-PCR test was performed at 2 Shangai hospitals</p> <p><b>Sample size:</b> n = 105 (21 cases)</p> <p><b>Inclusion criteria:</b> not specified</p> <p><b>Exclusion criteria:</b> not specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> patients with a positive RT-PCR test for SARS-CoV-2</p> <p><b>Facility controls:</b> patients with a negative RT-PCR test for SARS-CoV-2</p> <p><b>Country:</b> China</p> <p><b>Dates:</b> 01 January 2020-15 February 2020</p> <p><b>Symptoms and severity:</b> 72% of all participants were hospitalised, 71% of the cases had pneumonia, 88% of controls had pneumonia ("clinical symptoms usually mild")</p> <p><b>Demographics:</b> mean age: cases: 54.0 years, controls: 41.6 years. Gender: % female cases: 38.1%, controls: 51.2%</p> <p><b>Exposure history:</b> recently been to Wuhan: cases: 42.9%, controls: 17.9%. Contact with people from Wuhan: cases: 14.3%, controls: 0%. Recently been to supermarkets and groceries: cases: 28.6%, controls: 34.5%. Recently travelled: cases: 14.3%, controls: 47.6%</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Cough</li> <li>• Sputum production</li> <li>• Myalgia</li> <li>• Weakness</li> <li>• Diarrhoea</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: COVID-19 pneumonia</li> </ul>

Xie 2020 (Continued)

- RS: RT-PCR testing on throat swab and sputum specimens, patients preselected on the presence of pneumonia (radiological findings)

Flow and timing	RS and index tests both taken at admission
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Unclear		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Unclear		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			High
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

259



**Xie 2020** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
<b>Could the patient flow have introduced bias?</b>	High risk

**Yombi 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); diagnosis of SARS-CoV-2 infection, using clinical signs in HCWs</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> period 1: (before 30 March 2020) HCWs were tested only if they had fever and respiratory symptoms (some physicians were tested without fever); period 2 (after 30 March 2020), HCWs were tested if they had respiratory symptoms with or without fever</p> <p><b>Sample size:</b> n = 536 (175 cases)</p> <p><b>Inclusion criteria:</b> not specified (all suspected HCWs)</p> <p><b>Exclusion criteria:</b> not specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> all suspected HCWs with a positive RT-PCR</p> <p><b>Facility controls:</b> all suspected HCWs with a negative RT-PCR</p> <p><b>Country:</b> Belgium</p> <p><b>Dates:</b> 16 March 2020-24 April 2020</p> <p><b>Symptoms and severity:</b> not specified (from tables: mild to moderate severity)</p> <p><b>Demographics:</b> % age &lt; 45 years: cases: 56.6%, controls: 62.3% gender: % female cases: 67.4%, controls: 73.1%</p> <p><b>Exposure history:</b> not specified (all HCWs)</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Cough</li> <li>• Shortness of breath</li> <li>• Sore throat</li> <li>• Fever + cough</li> <li>• Fever + cough + shortness of breath</li> <li>• Fever + cough + sore throat</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> </ul>

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

260

**Yombi 2020** (Continued)

- RS: PCR for SARS-CoV-2 (sample not specified)

Flow and timing	Not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Unclear		
Did the study avoid inappropriate inclusions?	Unclear		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			

**Yombi 2020** (Continued)

Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Unclear
<b>Could the patient flow have introduced bias?</b>	Unclear risk

**Yonker 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease) in children; to describe the paediatric impact of COVID-19, specifically focusing on viral burden, susceptibility to disease and immune responses</p> <p><b>Design:</b> cross-sectional cohort study, retrospective data collection</p> <p><b>Recruitment:</b> paediatric patients ≤ 22 years of age presenting to Infection Control clinics for medical evaluation of symptoms concerning for COVID-19 or admitted for acute symptoms related to COVID-19 or multisystem inflammatory syndrome in children (MIS-C) were offered enrolment in the paediatric COVID-19 bio repository</p> <p><b>Sample size:</b> n = 174 (49 cases), excluding 18 MIS-C patients</p> <p><b>Inclusion criteria:</b> children ages 0-22 years; symptoms concerning for COVID-19 or admitted for acute symptoms related to COVID-19 or MIS-C; informed consent, and if appropriate, assent, were verbally obtained by the patients or parent/guardian</p> <p><b>Exclusion criteria:</b> none specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> positive RT-PCR for SARS-CoV-2</p> <p><b>Facility controls:</b> negative RT-PCR for SARS-CoV-2</p> <p><b>Country:</b> Massachusetts, USA</p> <p><b>Dates:</b> not stated (before 29 July 2020 (date of article submission))</p> <p><b>Symptoms and severity:</b> asymptomatic to mild symptoms to MIS-C</p> <p><b>Demographics:</b> mean age: cases 12.7 years, controls 9.6 years</p> <p>M%/F%: cases 46.9/53.1, overall 53.6/46.4</p> <p><b>Exposure history:</b> household exposures cases: mother: 40.8%, father: 26.5%, sibling: 18.4%, other: 18.4%, no household exposure: 18.4%</p> <p>Household exposures controls: mother: 16.8%, father: 8.8%, sibling: 6.4%, other: 15.2%, no household exposure: 56.0%</p>
Index tests	<ul style="list-style-type: none"> <li>• Nasal congestion</li> <li>• Rhinorrhea</li> <li>• Anosmia or hyposmia</li> <li>• Headache</li> <li>• Myalgia or arthralgia</li> <li>• Sore throat</li> <li>• Cough</li> </ul>

**Yonker 2020** (Continued)

- Fever
- Rash
- Nausea or vomiting
- Diarrhoea
- Anorexia
- Chills
- Dyspnoea
- Fatigue
- Dysgeusia
- Altered mental status
- Lymphadenopathy

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: SARS-CoV-2 RT-PCR test (nasopharyngeal or oropharyngeal swabs)</li> </ul>
--	--

Flow and timing	Index tests and reference standard both taken at presentation
-----------------	---

Comparative	
-------------	--

Notes	<p>MIS-C patients were excluded for our analyses</p> <p>Funding: Supported by the National Heart, Lung, and Blood Institute (5K08HL143183 to L.Y.), the Cystic Fibrosis Foundation (YONKER18Q0 to L.Y.), the National Institute of Child Health and Human Development (K08 HD094638 [to A.N.] and R01HD100022 [to A.E.]), Mark and Lisa Schwartz (to J.L.), the National Institute of Diabetes and Digestive and Kidney Diseases (DK039773, DK072381 [to J.B.] and DK104344 [to A.F.]), the National Institute of Allergy and Infectious Disease (K24AI141036 to I.B.), the Centers for Disease Control and Prevention (U01CK000490 to E.R.), and the Department of Pediatrics and the Department of Obstetrics/Gynecology at Massachusetts General Hospital (to L.Y. and A.E.)</p>
-------	---

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			

**Yonker 2020** (Continued)

Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
If a threshold was used, was it pre-specified?	No	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Low risk

**Zayet 2020a**
**Study characteristics**

Patient Sampling	<b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to compare the symptoms of patients with positive and negative SARS-CoV-2 RT-PCR results and to determine the sensitivity, specificity, positive predictive value and negative predictive value for each of these symptoms in regard to SARS-CoV-2 RT-PCR
------------------	--

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

**Zayet 2020a** (Continued)

	<p><b>Design:</b> retrospective cohort study</p> <p><b>Recruitment:</b> all adult patients (<math>\geq 18</math> years) who presented for possible COVID-19 at the outpatient department</p> <p><b>Sample size:</b> n = 217 (95 cases)</p> <p><b>Inclusion criteria:</b> all adult patients (<math>\geq 18</math> years) who presented for possible COVID-19 at the outpatient department</p> <p><b>Exclusion criteria:</b> pregnant women, children (&lt; 18 years) and patients with dementia (unable to report functional symptoms)</p>
Patient characteristics and setting	<p><b>Facility cases:</b> patients with suspected COVID-19 with a positive RT-PCR</p> <p><b>Facility controls:</b> patients with suspected COVID-19 with a negative RT-PCR</p> <p><b>Country:</b> France</p> <p><b>Dates:</b> 30 March 2020-03 April 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity</p> <p><b>Demographics:</b> mean age: cases: 39.8 years, controls: 39.6 years. Gender: % female cases: 83.2%, controls: 86.9%</p> <p><b>Exposure history:</b> not specified (mostly HCWs)</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Myalgia/arthralgia</li> <li>• Headache</li> <li>• Cough</li> <li>• Dyspnoea</li> <li>• Dysgeusia</li> <li>• Anosmia</li> <li>• Rhinorrhea</li> <li>• GI symptoms</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: PCR for SARS-CoV-2 (nasopharyngeal swabs)</li> </ul>
Flow and timing	Not specified
Comparative	
Notes	Funding: none declared
<b>Methodological quality</b>	
<b>Item</b>	<b>Authors' judgement</b> <b>Risk of bias</b> <b>Applicability concerns</b>
<b>DOMAIN 1: Patient Selection</b>	
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes

**Zayet 2020a** (Continued)

Did the study avoid inappropriate exclusions?	No	
Did the study avoid inappropriate inclusions?	Yes	
<b>Could the selection of patients have introduced bias?</b>		High risk
<b>Are there concerns that the included patients and setting do not match the review question?</b>		Low concern
<b>DOMAIN 2: Index Test (All tests)</b>		
Were the index test results interpreted without knowledge of the results of the reference standard?	Unclear	
If a threshold was used, was it pre-specified?	Unclear	
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>		Low concern
<b>DOMAIN 3: Reference Standard</b>		
Is the reference standards likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>		Low concern
<b>DOMAIN 4: Flow and Timing</b>		
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
<b>Could the patient flow have introduced bias?</b>		Unclear risk

**Zhu 2020**
**Study characteristics**

Patient Sampling	<b>Purpose:</b> description of initial clinical features in patients with suspected and confirmed SARS-CoV-2 infection
	<b>Design:</b> cross-sectional cohort, retrospective data collection

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

Zhu 2020 (Continued)

**Recruitment:** all patients with suspected COVID-19 who presented to the ED of the First Affiliated Hospital of USTC and the Infectious Hospital of the First Affiliated Hospital of USTC for the first time

**Sample size:** n = 116 (32 cases)

**Inclusion criteria:**

- patients defined as suspected SARS-CoV-2 infection based on guidelines for the diagnosis and treatment of pneumonia caused by novel coronavirus infection (trial version III)
- presentation to, clinical observation and quarantine in ED
- nucleic acid amplification test performed in the ED

**Exclusion criteria:** transfer from another hospital or previous visit to First Affiliated Hospital and previous diagnosis of COVID-19

Patient characteristics and setting

**Facility cases:** positive nucleic acid amplification test on admission or 24 h later

**Facility controls:** SARS-CoV-2 PCR test negative

**Country:** China, Anhui

**Dates:** 24 January 2020-20 February 2020

**Symptoms and severity:** all suspected COVID-19 patients included; days since onset of symptoms median 5 (IQR 2-7)

**Demographics:** median age: all: 40 years (IQR 27-53), cases: 46 years (IQR 35-52), controls: 35 years (IQR 27-53); gender distribution M%/F%: all 46/54, cases 47/53, controls 46/54

**Exposure history:** no specific exposure history common to all patients with suspected disease: 8 (25%) diagnosed patients had visited Wuhan in the previous 2 weeks and 12 (38%) had been exposed to patients with infection in the previous 2 weeks

Index tests

- Fever
- Cough
- Myalgia or fatigue
- Expectoration
- Chest stuffiness (congestion)
- Haemoptysis
- Headache
- Diarrhoea

Target condition and reference standard(s)

- TC: SARS-CoV-2 infection
- RS: nucleic acid amplification test not further specified (twice in case-negatives) (samples: swabs, origin not specified)

Flow and timing

Index tests and RS both taken on admission or after 24 h

Comparative

Notes

Funding: none declared

**Methodological quality**



## Zhu 2020 (Continued)

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Yes		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Low risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern
<b>DOMAIN 4: Flow and Timing</b>			
Was there an appropriate interval between index test and reference standard?	Yes		
Did all patients receive the same reference standard?	Yes		
Were all patients included in the analysis?	Yes		

**Zhu 2020** (Continued)

**Could the patient flow have introduced bias?**

Unclear risk

**Zimmerman 2020**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to develop a data-driven set of clinical indicators for COVID-19 that would help to identify outpatient symptoms and those who most benefit from limited testing availability</p> <p><b>Design:</b> cross-sectional cohort study, prospective data collection</p> <p><b>Recruitment:</b> symptomatic individuals who had either exposure to a case of COVID-19 or a typical respiratory illness symptom were scheduled at a centralised outpatient COVID-19 testing facility</p> <p><b>Sample size:</b> n = 736 (55 cases)</p> <p><b>Inclusion criteria:</b> either exposure to a case of COVID-19 or a typical respiratory illness symptom</p> <p><b>Exclusion criteria:</b> asymptomatic individuals</p>
Patient characteristics and setting	<p><b>Facility cases:</b> adult patients testing positive for SARS-CoV-2 infection</p> <p><b>Facility controls:</b> adult patients testing negative for SARS-CoV-2 infection</p> <p><b>Country:</b> Pennsylvania, USA</p> <p><b>Dates:</b> 29 March 2020-26 April 2020</p> <p><b>Symptoms and severity:</b> mild to moderate severity</p> <p><b>Demographics:</b> not specified</p> <p><b>Exposure history:</b> contact with COVID-19 case: cases: 70%, controls: 21%</p>
Index tests	<ul style="list-style-type: none"> <li>• Fever</li> <li>• Chills</li> <li>• Cough</li> <li>• Sore throat</li> <li>• Shortness of breath</li> <li>• Muscle aches</li> <li>• Abdominal pain</li> <li>• Nausea/vomiting</li> <li>• Diarrhoea</li> <li>• Headache</li> <li>• Decrease or loss of taste or smell</li> </ul>
Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: PCR for SARS-CoV-2 (specimen not specified)</li> </ul>
Flow and timing	Not specified

**Zimmerman 2020** (Continued)

Comparative

Notes

Funding: supported through a co-operative agreement with the Centers for Disease Control and Prevention (CDC) through grant number U01 IP000467 and the National Institutes of Health grant number 1UL1 TR001857. The US Flu VE Network is supported through co-operative agreements funded by CDC.

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	Yes		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		Unclear risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Unclear
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	Unclear		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	
<b>Are there concerns that the target condition as defined by the reference standard does not match the question?</b>			Low concern

**Zimmerman 2020** (Continued)

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard? Unclear

Did all patients receive the same reference standard? Yes

Were all patients included in the analysis? Yes

**Could the patient flow have introduced bias?** Unclear risk

**Zurl 2021**
**Study characteristics**

Patient Sampling	<p><b>Purpose:</b> diagnosis of SARS-CoV-2 infection (mild COVID-19 disease); to analyse the infection rate in symptomatic children</p> <p><b>Design:</b> cross-sectional cohort, retrospective data collection</p> <p><b>Recruitment:</b> children presenting at university hospital's children's ED</p> <p><b>Sample size:</b> n = 1105 (10 cases)</p> <p><b>Inclusion criteria:</b> children with symptoms and anamnestic details according to national criteria for suspicion of SARS-CoV-2, and no alternative diagnosis</p> <p><b>Exclusion criteria:</b> not specified</p>
Patient characteristics and setting	<p><b>Facility cases:</b> SARS-CoV-2 PCR test-positive</p> <p><b>Facility controls:</b> SARS-CoV-2 PCR test-negative</p> <p><b>Country:</b> Austria</p> <p><b>Dates:</b> 19 March 2020-15 August 2020</p> <p><b>Symptoms and severity:</b> not specified, mostly mild to moderate severity, 50% of cases requiring hospital admission, 32.4% of controls</p> <p><b>Demographics:</b> median age: cases: 8.4 years, controls: 3.2 years gender M%/F%: cases 50/50, controls 52.1/47.9</p> <p><b>Exposure history:</b> known contact with a case: cases 0%; controls 1.4%</p>
Index tests	<ul style="list-style-type: none"> <li>• Sore throat</li> <li>• Respiratory signs and symptoms (all)             <ul style="list-style-type: none"> <li>◦ laryngitis/hoarseness/stridor</li> <li>◦ cough</li> <li>◦ bronchitis/rhonchi</li> <li>◦ dyspnoea/shortness of breath</li> <li>◦ tachypnoea (age adapted)</li> </ul> </li> </ul>

## Zurl 2021 (Continued)

- Temperature  $\geq 37.5$  °C
  - temperature  $\geq 37.5$  °C reported prior to admission
  - temperature  $\geq 37.5$  °C measured at admission
- Sudden onset of anosmia and or a-/dysgeusia

Target condition and reference standard(s)	<ul style="list-style-type: none"> <li>• TC: SARS-CoV-2 infection</li> <li>• RS: PCR for SARS-CoV-2 (naso- or oropharyngeal swabs)</li> </ul>
Flow and timing	Timing not specified
Comparative	
Notes	Funding: none declared

**Methodological quality**

Item	Authors' judgement	Risk of bias	Applicability concerns
<b>DOMAIN 1: Patient Selection</b>			
Was a consecutive or random sample of patients enrolled?	Unclear		
Was a case-control design avoided?	Yes		
Did the study avoid inappropriate exclusions?	No		
Did the study avoid inappropriate inclusions?	Yes		
<b>Could the selection of patients have introduced bias?</b>		High risk	
<b>Are there concerns that the included patients and setting do not match the review question?</b>			Low concern
<b>DOMAIN 2: Index Test (All tests)</b>			
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes		
If a threshold was used, was it pre-specified?	No		
<b>Could the conduct or interpretation of the index test have introduced bias?</b>		High risk	
<b>Are there concerns that the index test, its conduct, or interpretation differ from the review question?</b>			Low concern
<b>DOMAIN 3: Reference Standard</b>			
Is the reference standards likely to correctly classify the target condition?	Yes		
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear		
<b>Could the reference standard, its conduct, or its interpretation have introduced bias?</b>		Low risk	

**Zurl 2021** (Continued)

**Are there concerns that the target condition as defined by the reference standard does not match the question?**

Low concern

**DOMAIN 4: Flow and Timing**

Was there an appropriate interval between index test and reference standard?      Unclear

Did all patients receive the same reference standard?      Yes

Were all patients included in the analysis?      Yes

**Could the patient flow have introduced bias?**      Unclear risk

**BP:** blood pressure; **CDC:** Centre for Disease Control; **COPD:** constructive obstructive pulmonary disease; **COVID-19:** coronavirus disease 2019; **CT:** computed tomography; **ED:** emergency department; **ENT:** ear, nose and throat; **F:** female; **F<sub>IO<sub>2</sub></sub>:** fraction of inspired oxygen; **GI:** gastrointestinal; **GP:** general practitioner; **HCW:** healthcare workers; **ICU:** intensive care unit; **IgM:** immunoglobulin M; **IQR:** interquartile range; **M:** male; **NCP:** novel coronavirus pneumonia; **OTD:** olfactory and taste disorder; **PaO<sub>2</sub>:** partial pressure of oxygen; **POC:** point-of-care; **RS:** reference standard; **RT-PCR:** reverse transcription polymerase chain reaction; **SARS-CoV-2:** severe acute respiratory syndrome coronavirus 2; **SD:** standard deviation; **SpO<sub>2</sub>:** oxygen saturation; **TC:** target condition; **WBC:** blood white blood cell; **WHO:** World Health Organization; **2019-nCoV:** 2019 novel coronavirus

**Characteristics of excluded studies** [ordered by study ID]

Study	Reason for exclusion
<a href="#">Accorsi 2020</a>	Ineligible population
<a href="#">Afshar 2020</a>	Ineligible design
<a href="#">Agarwal 2021</a>	Ineligible design
<a href="#">Ai 2020</a>	Preprint
<a href="#">Akinbami 2021</a>	Ineligible population
<a href="#">Akyala 2020</a>	Ineligible population
<a href="#">Aleebrahim-Dehkordi 2020</a>	Conference abstract
<a href="#">Al-Rifai 2021</a>	Only SARS-CoV-2-positive patients
<a href="#">Altınbilek 2020</a>	Ineligible outcomes
<a href="#">Andina-Martinez 2021</a>	Only SARS-CoV-2-positive patients
<a href="#">Antonelli 2021</a>	Index test not assessed on admission
<a href="#">Aubert 2021</a>	Ineligible design
<a href="#">Auvinen 2021</a>	Ineligible population
<a href="#">Baghaei 2020</a>	Ineligible outcomes

Study	Reason for exclusion
Bailey 2020	No data
Bailey 2021	Ineligible outcomes
Bartlett 2020	Conference abstract
Bastiani 2021	Ineligible design
Bhatta 2021	Only SARS-CoV-2-positive patients
Bidkar 2021	Ineligible population
Bonadio 2020	Conference abstract
Brotans 2020	Preprint
Burrell 2021	Ineligible outcomes
Cadegiani 2021	Ineligible design
Cai 2020	Timing of index test not specified
Calagnan 2020	Ineligible design
Carignan 2020	Ineligible design
Challener 2020	Ineligible design
Chen 2020	Ineligible design
Chen 2021	Ineligible population
Concheiro-Guisan 2020	Index test not assessed on admission
D'Souza 2020	No clinical suspicion at inclusion
Dai 2021	Timing of index test not specified
Dantas 2021	Ineligible population
De Angelis 2020	Ineligible population
Deng 2020	Ineligible population
Dixon 2021	Index test not assessed on admission
Dreyer 2020	Ineligible population
Duan 2020	No data
Duque 2021	Ineligible design
Duramaz 2021	Only SARS-CoV-2-positive patients
Elimian 2020	Timing of index test not specified

Study	Reason for exclusion
<a href="#">Escosteguy 2020</a>	Ineligible population
<a href="#">Feehan 2021</a>	Ineligible population
<a href="#">Fisher 2021</a>	Index test not assessed on admission
<a href="#">Foster 2021</a>	Ineligible design
<a href="#">Gale 2020</a>	Ineligible population
<a href="#">Gerkin 2021</a>	Ineligible design
<a href="#">Giavedoni 2020</a>	Only SARS-CoV-2-positive patients
<a href="#">Gibbons 2021</a>	Index test not assessed on admission
<a href="#">Gnanasambantham 2020</a>	Ineligible design
<a href="#">Goel 2020</a>	Ineligible index test
<a href="#">Gombos 2021</a>	No data
<a href="#">Goodacre 2020</a>	Ineligible population
<a href="#">Guillén 2020</a>	Only SARS-CoV-2-positive patients
<a href="#">Gurrola 2021</a>	Only SARS-CoV-2-positive patients
<a href="#">Haddadin 2021</a>	Ineligible population
<a href="#">Hamed 2021</a>	Ineligible design
<a href="#">Hernández-Cruz 2021</a>	Ineligible population
<a href="#">Hosseinzadeh 2021</a>	Ineligible design
<a href="#">Hosseninasab 2020</a>	Timing of index test not specified
<a href="#">Hubiche 2021</a>	Conference abstract
<a href="#">Hurst 2020</a>	No data
<a href="#">Indini 2021</a>	Ineligible population
<a href="#">Islam 2020</a>	Conference abstract
<a href="#">Jain 2021</a>	Case report
<a href="#">Karni 2020</a>	Ineligible design
<a href="#">Kasiukiewicz 2020</a>	Conference abstract
<a href="#">Kline 2021</a>	Ineligible design
<a href="#">Lechner 2021</a>	Ineligible design



Study	Reason for exclusion
Lee 2020	Ineligible design
Lee 2021	Only SARS-CoV-2-positive patients
Li 2020a	Timing of index test not specified
Li 2020b	Timing of index test not specified
Li 2021	Ineligible outcomes
Liang 2020	Preprint
Liu 2021	Ineligible design
Loftus 2020	Index test not assessed on admission
Lu 2020	Ineligible population
Madan 2020	Ineligible design
Makaronidis 2020	Ineligible population
Manley 2020	Conference abstract
McDonald 2020	Ineligible design
McGovern 2020	Conference abstract
Medetalibeyoglu 2020	Conference abstract
Membrilla 2020	Only SARS-CoV-2-positive patients
Mizrahi 2020	Ineligible design
Möckel 2021	Ineligible design
Moolla 2021	Index test not assessed on admission
Muhammad 2021	Ineligible design
Munblit 2020	Only SARS-CoV-2-positive patients
Murillo-Zamora 2020	Ineligible index test
Nakajima 2021	Ineligible design
Nakanishi 2020	Ineligible design
Nayan 2021	No data
Nobel 2020	Ineligible design
Ortiz 2020	Only SARS-CoV-2-positive patients
Oshman 2020	Ineligible outcomes

Study	Reason for exclusion
Ozcan 2021	No data
Paar 2021	Ineligible population
Pigott 2020	Conference abstract
Platten 2021	No clinical suspicion at inclusion
Popovych 2021	Ineligible population
Pullen 2020	Ineligible design
Quer 2020	Ineligible design
Ravani 2020	No clinical suspicion at inclusion
Rentsch 2020	Preprint
Ronan 2021	No data
Rubel 2020	Index test not assessed on admission
Sabetian 2021	Only SARS-CoV-2-positive patients
Sabetta 2020	Ineligible outcomes
Sehanobish 2021	Index test not assessed on admission
Senok 2020	Ineligible design
Shanbehzadeh 2021	Ineligible design
Shayganmehr 2021	Ineligible population
Sheen 2020	No data
Shoer 2021	No clinical suspicion at inclusion
Sieber 2021	Ineligible population
Song 2020	Preprint
Sorlini 2020	Ineligible design
Spangler 2021	Ineligible outcomes
Stacevičienė 2021	Ineligible design
Tabacof 2020	Only SARS-CoV-2-positive patients
Taziki 2020	Index test not assessed on admission
Ticinesi 2020	Conference abstract
Trevisan 2021	Ineligible design

Study	Reason for exclusion
Verma 2020	Index test not assessed on admission
Viana dos Santos 2021	Ineligible design
Visconti 2021	Ineligible design
Vos 2020	Ineligible design
Weiss 2021a	Ineligible design
Weiss 2021b	Ineligible population
Wells 2020	No clinical suspicion at inclusion
Wu 2020	Only SARS-CoV-2-positive patients
Xia 2021	Ineligible population
Yan 2020	Ineligible design
Yang 2020	Preprint
Yousef 2021	Ineligible design
Žaja 2021	Only SARS-CoV-2-positive patients
Zavascki 2020	Preprint
Zayet 2020b	Ineligible design
Zhao 2020	Ineligible design
Zhao 2021	Ineligible design

## DATA

Presented below are all the data for all of the tests entered into the review.

### Table Tests. Data tables by test

Test	No. of studies	No. of participants
1 Cough	30	37427
2 Fever	29	44876
3 Dyspnoea	28	35258
4 Sore throat	26	30052
5 Headache	23	27042

Test	No. of studies	No. of participants
6 Diarrhoea	23	26155
7 Myalgia	19	16759
8 Anosmia	20	20108
9 Fatigue	19	14482
10 Chills/shivers	13	22559
11 Chest tightness/pain	13	20022
12 Rhinorrhea	12	24117
13 Ageusia	10	12937
14 Anosmia or ageusia	7	7966
15 Abdominal pain	7	7733
16 Nasal congestion	7	2837
17 Altered mentation/confusion	5	10073
18 Conjunctivitis	6	9187
19 Nausea or vomiting	5	5298
20 Gastrointestinal symptoms (not specified)	5	5184
21 Rash	5	2864
22 Coryza	4	10303
23 Sputum production/productive cough	5	7753
24 Asthenia	4	7410
25 Odynophagia	4	4053
26 Anosmia and ageusia	4	3003
27 Arthralgia	4	1753
28 Vomiting	4	1541
29 Wheeze	3	5597
30 Nausea	3	5527
31 Dry cough	3	3432
32 Malaise	3	2392
33 Enlargement of lymph nodes	3	6256

Test	No. of studies	No. of participants
34 Anosmia or hyposmia	3	1580
35 Anorexia	3	827
36 Fever (subjective)	3	12703
37 Haemoptysis	2	5206
38 Earache	2	4895
39 Systemic soreness (malaise/myalgia/arthralgia)	2	4202
40 High fever ( $\geq 38.5$ °C)	2	3015
41 Myalgia or arthralgia	3	6764
42 Irritability	2	1777
43 Sneezing	2	1638
44 Anosmia or dysgeusia	2	1574
45 Loss of appetite	2	1345
46 Pulmonary auscultation: crackling bilateral	2	987
47 Sweating	2	915
48 Nasal symptoms	2	684
49 Rhinitis	2	399
50 Dysgeusia	2	313
51 SCRiPS score, recent case detection rate	1	9172
52 SCRiPS score, 0.5*recent case detection rate	1	9172
53 Rigors	1	9172
54 Cough or dyspnoea	1	9172
55 Dysuria	1	4815
56 Seizure	1	4815
57 Exanthema	1	4815
58 Exhaustion	1	4815
59 Sinusitis	1	2935
60 Hypoxia	1	2774
61 Multivariable score cut-off = 5	1	2152

Test	No. of studies	No. of participants
62 Multivariable score cut-off = 8	1	2152
63 Cough and anosmia	1	2137
64 Fever and anosmia	1	2137
65 Fever and cough and anosmia and dyspnoea and oxygen saturation < 93%	1	2137
66 Fever and dyspnoea	1	2137
67 Anosmia and dyspnoea	1	2137
68 Fever and cough	1	2137
69 Weakness or fatigue	1	1267
70 Palpitations	1	1267
71 Anxiety	1	1267
72 Respiratory distress	1	1267
73 Hyposmia or anosmia	1	809
74 Diarrhoea and nausea	1	598
75 Isolated fever	1	598
76 Myalgia and asthenia and fever	1	598
77 Cough and fever and sputum production	1	598
78 Cough and fever and sputum production and dyspnoea	1	598
79 Isolated headache	1	598
80 Dyspnoea and cough and fever and low oxygen saturation	1	598
81 Sore throat and nasal congestion and sneezing and mild fever	1	598
82 Low body temperature	1	596
83 Expectoration	1	596
84 Tachypnoea	1	510
85 Cyanosis	1	510
86 Skin lesions	1	391
87 Rhinitis or pharyngitis	1	391
88 Dizziness or syncope	1	391
89 Pulmonary auscultation: crackling unilateral	1	391

Test	No. of studies	No. of participants
90 CSBSS (cut-off = 41.7)	1	378
91 Hyposmia	1	355
92 Hypogeusia	1	355
93 Dizziness	1	319
94 Change to chronic cough	1	240
95 Dysosmia	1	139
96 Myalgia and fatigue	1	80
97 Cough (retrospective data collection)	42	65180
98 Fever (retrospective data collection)	40	75730
99 Dyspnoea (retrospective data collection)	37	37810
100 Sore throat (retrospective data collection)	30	60871
101 Headache (retrospective data collection)	26	31768
102 Diarrhoea (retrospective data collection)	25	30746
103 Myalgia (retrospective data collection)	19	18051
104 Rhinorrhoea (retrospective data collection)	17	42230
105 Chest tightness/pain (retrospective data collection)	13	36823
106 Fatigue (retrospective data collection)	13	18006
107 Anosmia (retrospective data collection)	12	11843
108 Gastrointestinal symptoms not specified (retrospective data collection)	9	29484
109 Nasal congestion (retrospective data collection)	9	16152
110 Nausea or vomiting (retrospective data collection)	9	14911
111 Abdominal pain (retrospective data collection)	9	14565
112 Vomiting (retrospective data collection)	9	12746
113 Myalgia or arthralgia (retrospective data collection)	9	9174
114 Sputum production/productive cough (retrospective data collection)	9	4755
115 Chills/shivers (retrospective data collection)	8	11340
116 Asthenia (retrospective data collection)	7	3554
117 Anosmia or ageusia (retrospective data collection)	6	33775

Test	No. of studies	No. of participants
118 Dysgeusia (retrospective data collection)	6	4094
119 Nausea (retrospective data collection)	5	6124
120 Arthralgia (retrospective data collection)	5	1324
121 Anorexia (retrospective data collection)	4	6230
122 Wheeze (retrospective data collection)	4	5667
123 Haemoptysis (retrospective data collection)	4	4749
124 Respiratory symptoms (not specified; retrospective data collection)	4	4136
125 Skin lesions (retrospective data collection)	4	3416
126 Tachycardia (retrospective data collection)	4	2739
127 Nasal symptoms (retrospective data collection)	4	1475
128 Expectoration (retrospective data collection)	4	1283
129 Ageusia (retrospective data collection)	3	3415
130 Positive auscultation findings (retrospective data collection)	3	2917
131 Tachypnea (retrospective data collection)	3	1756
132 Anosmia/dysosmia or ageusia/dysgeusia (retrospective data collection))	2	7522
133 Earache (retrospective data collection)	2	3629
134 Sneezing (retrospective data collection)	2	3467
135 Dizziness (retrospective data collection)	2	3407
136 Malaise (retrospective data collection)	2	3184
137 Fever (subjective) (retrospective data collection)	2	2787
138 Enlargement of lymph nodes (retrospective data collection)	2	2623
139 Conjunctivitis (retrospective data collection)	2	2185
140 Hypoxia (retrospective data collection)	2	2045
141 Pulmonary auscultation: rhonchi (retrospective data collection)	2	1444
142 Loss of appetite (retrospective data collection)	2	1257
143 Altered mentation/confusion (retrospective data collection)	2	983
144 Presyncope or syncope (retrospective data collection)	2	866
145 Stomach ache (retrospective data collection)	2	835

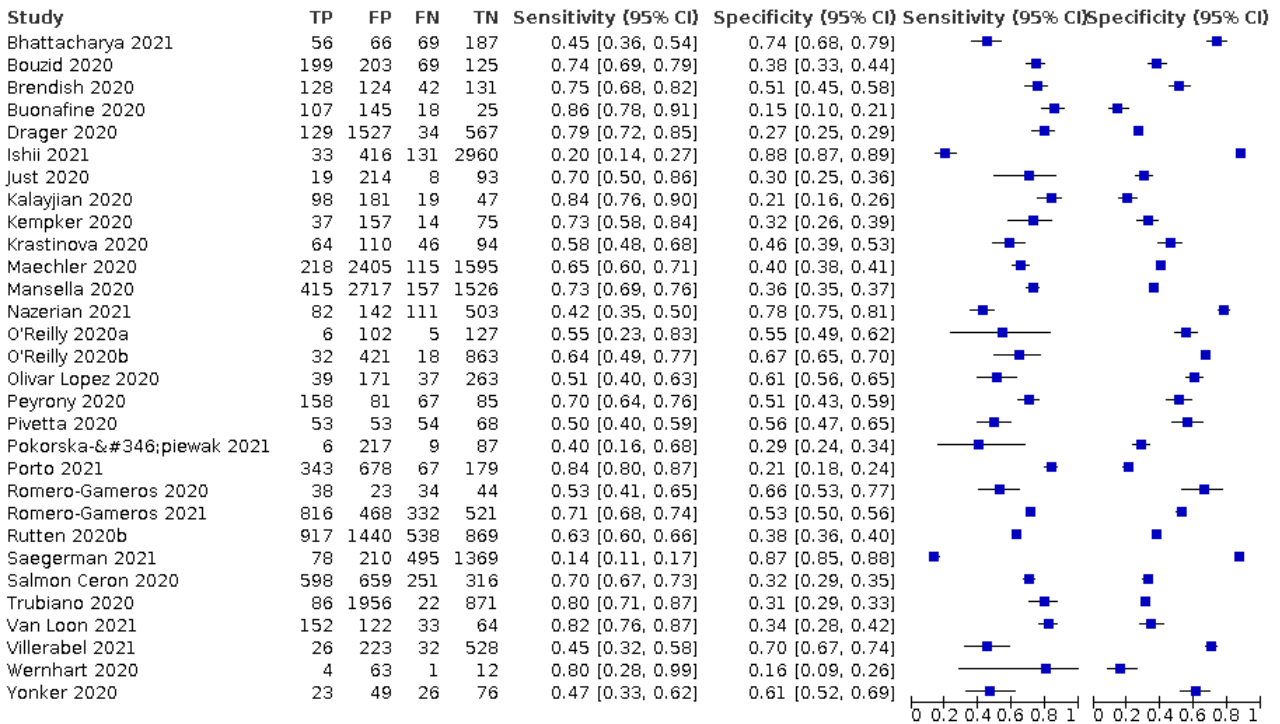


Test	No. of studies	No. of participants
146 Odynophagia (retrospective data collection)	2	793
147 Anosmia or dysgeusia (retrospective data collection)	2	686
148 Weakness or fatigue (retrospective data collection)	2	580
149 Objective fever ( $\geq 38$ °C) or recent fever/chills (retrospective)	1	6894
150 Body aches or fatigue or dyspnoea or cough or objective fever ( $\geq 38$ °C) or recent fever/chills (retrospective)	1	6894
151 Fatigue or dyspnoea or cough or objective fever ( $\geq 38$ °C) or recent fever/chills (retrospective)	1	6894
152 Dyspnoea or cough or objective fever ( $\geq 38$ °C) or recent fever/chills (retrospective)	1	6894
153 Cough or objective fever ( $\geq 38$ °C) or recent fever/chills (retrospective)	1	6894
154 Recent fever or chills (retrospective data collection)	1	6894
155 Sinusitis (retrospective data collection)	1	6894
156 Systemic soreness (malaise/myalgia/arthralgia) (retrospective)	1	6894
157 Malaise or fatigue (retrospective data collection)	1	3154
158 Lethargy (retrospective data collection)	1	1821
159 Nausea or vomiting or diarrhoea (retrospective data collection)	1	1747
160 Respiratory triage score $> 4$ (retrospective data collection)	1	1435
161 Respiratory triage score $> 5$ (retrospective data collection)	1	1435
162 Lower respiratory tract symptoms (retrospective data collection)	1	1210
163 Neurologic symptoms (not specified; retrospective data collection)	1	1210
164 Upper respiratory tract symptoms (retrospective data collection)	1	1210
165 Laryngitis/hoarseness/stridor (retrospective data collection)	1	1051
166 High fever ( $\geq 38.5$ °C) (retrospective data collection)	1	1004
167 Abdominal distention (retrospective data collection)	1	936
168 Aversion to cold (retrospective data collection)	1	936
169 Xerostomia (retrospective data collection)	1	936
170 Hypersomnia (retrospective data collection)	1	936
171 Hyposmia (retrospective data collection)	1	717

Test	No. of studies	No. of participants
172 Fever and cough and dyspnoea (retrospective)	1	536
173 Fever and cough and sore throat (retrospective)	1	536
174 Fever and cough (retrospective data collection)	1	536
175 Unconsciousness (retrospective data collection)	1	475
176 Rash (retrospective data collection)	1	475
177 Fever or cough or dyspnoea (retrospective data collection)	1	404
178 Pulmonary auscultation: crackling (retrospective data collection)	1	404
179 Dysphonia (retrospective data collection)	1	253
180 Dry cough (retrospective data collection)	1	316
181 History of fever at home (retrospective data collection)	1	253
182 Cough or dyspnoea (retrospective data collection)	1	242
183 Anosmia and dysgeusia (retrospective data collection)	1	217
184 Palpitations (retrospective data collection)	1	132
185 Anosmia or hyposmia (retrospective data collection)	1	126
186 Myalgia or fatigue (retrospective data collection)	1	116
187 Respiratory distress (retrospective data collection)	1	100

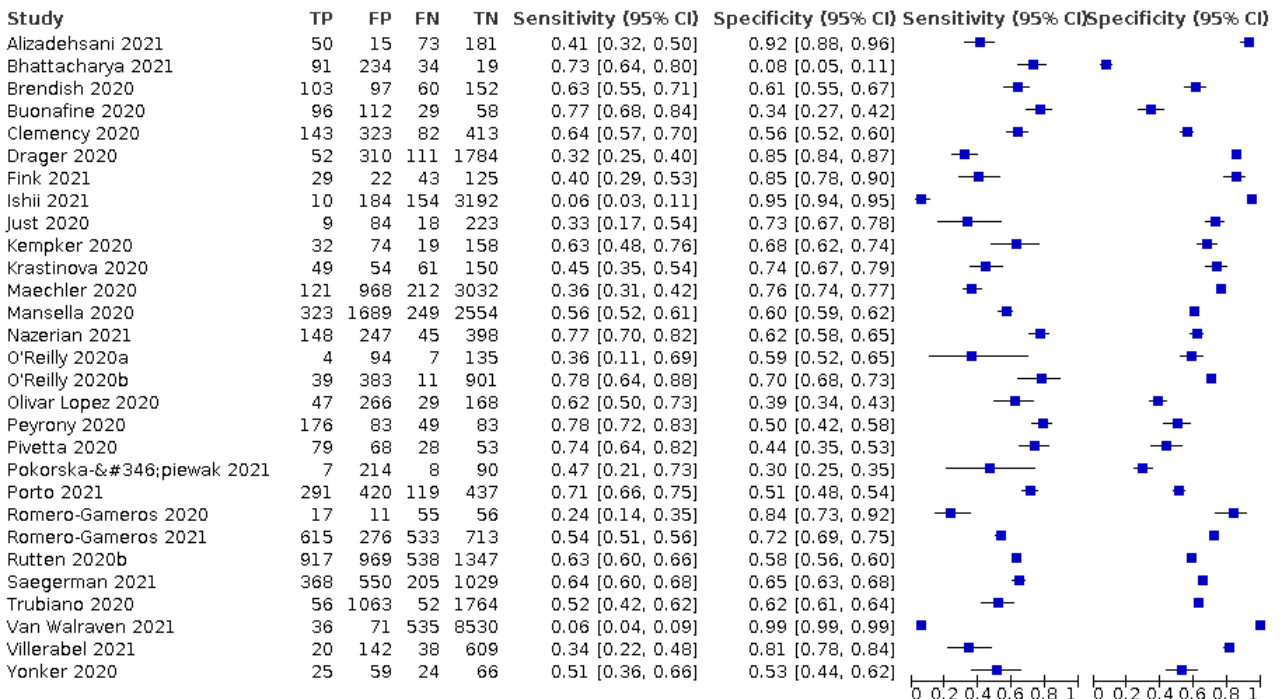
### Test 1. Cough

#### Cough



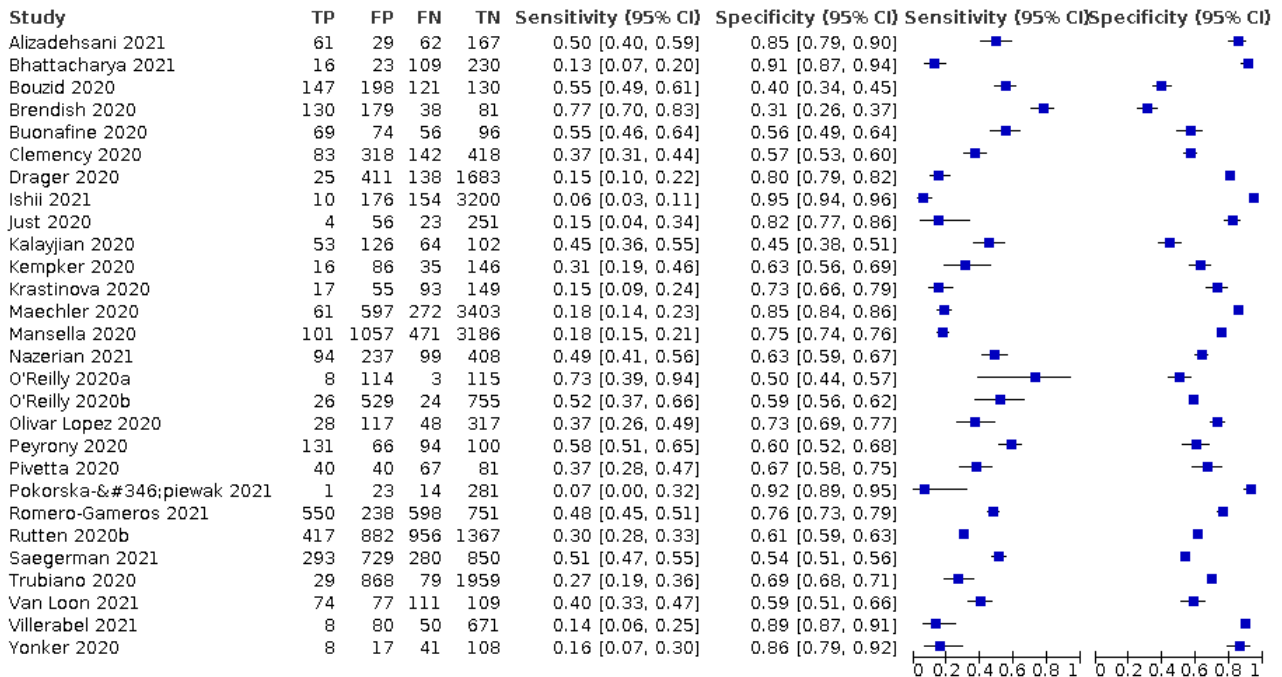
### Test 2. Fever

#### Fever



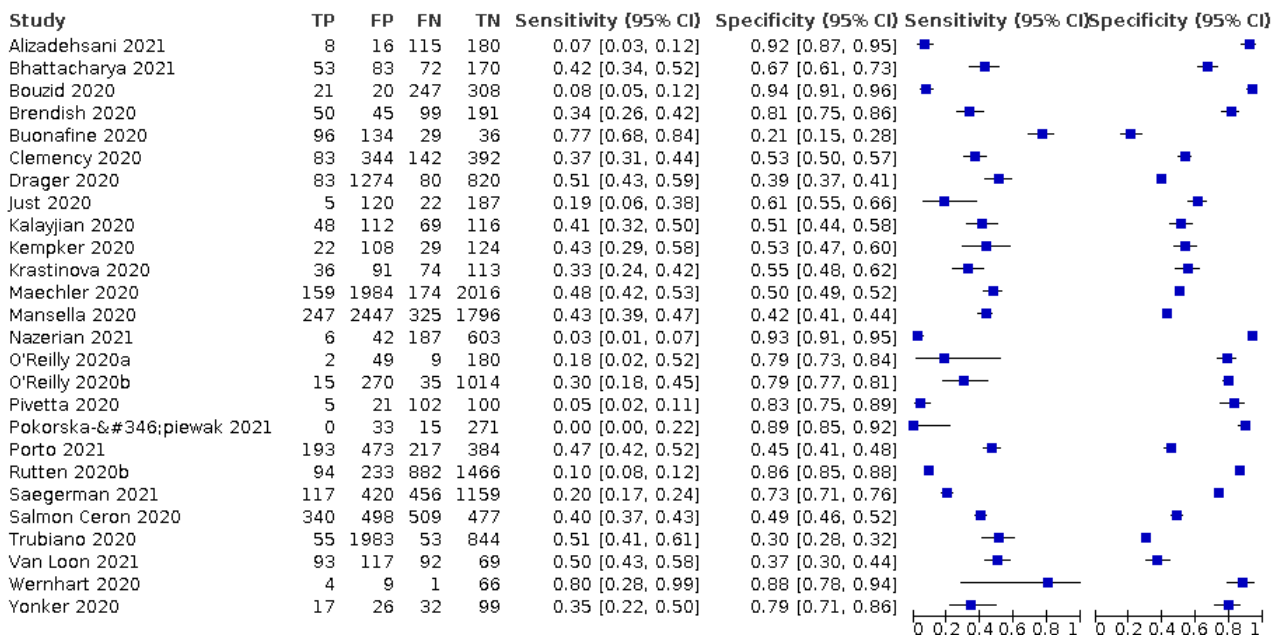
### Test 3. Dyspnoea

#### Dyspnoea



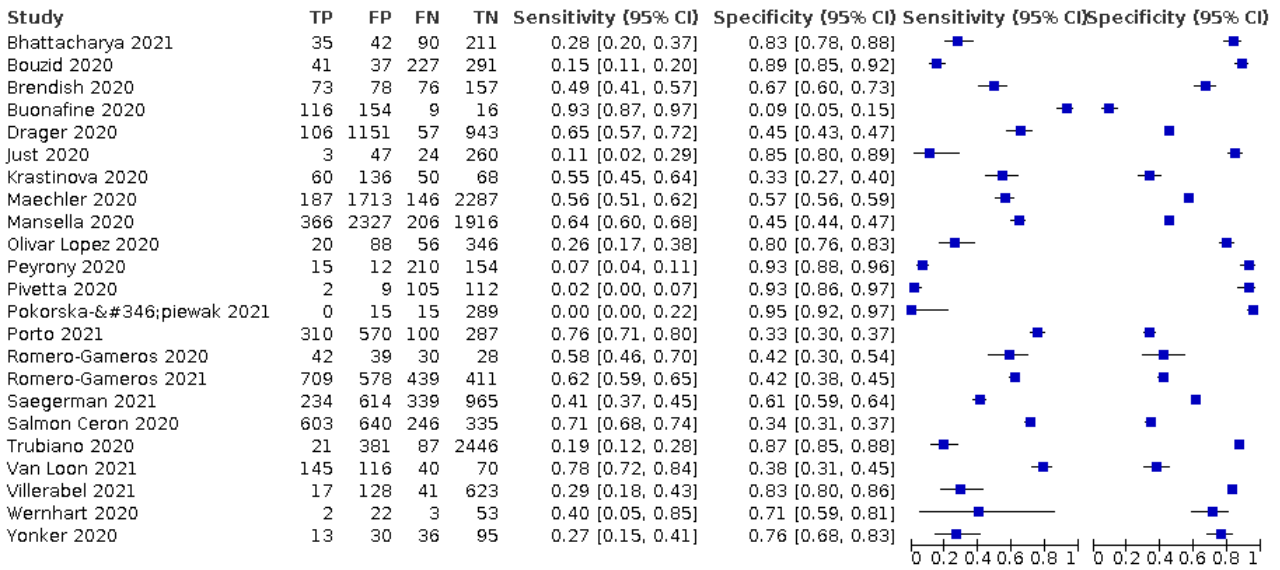
### Test 4. Sore throat

#### Sore throat



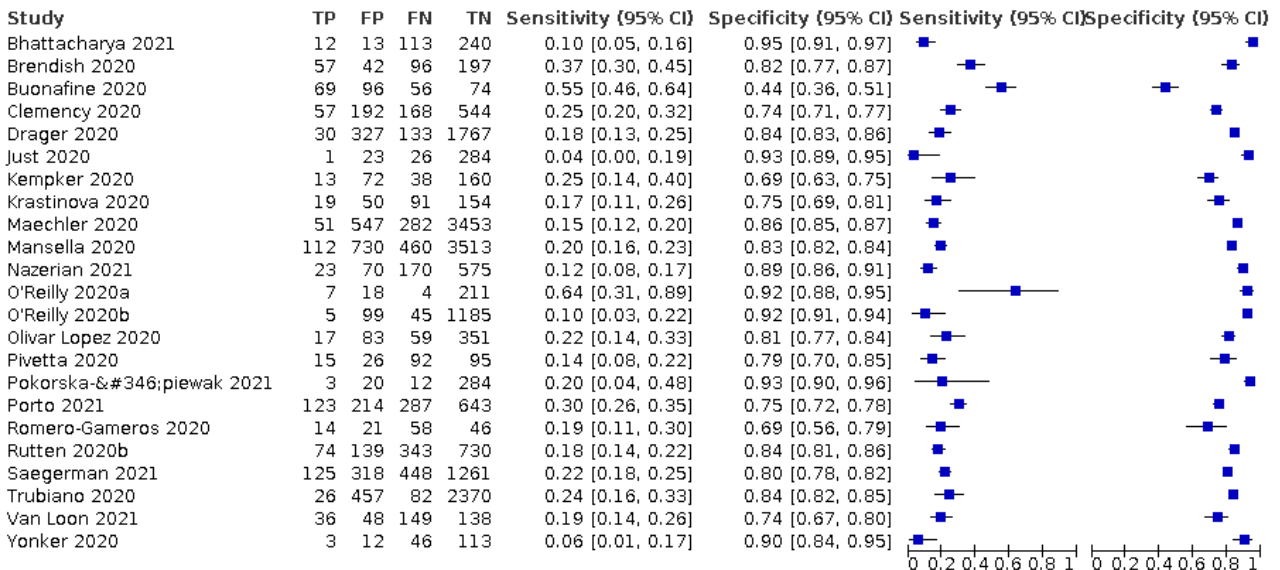
### Test 5. Headache

#### Headache



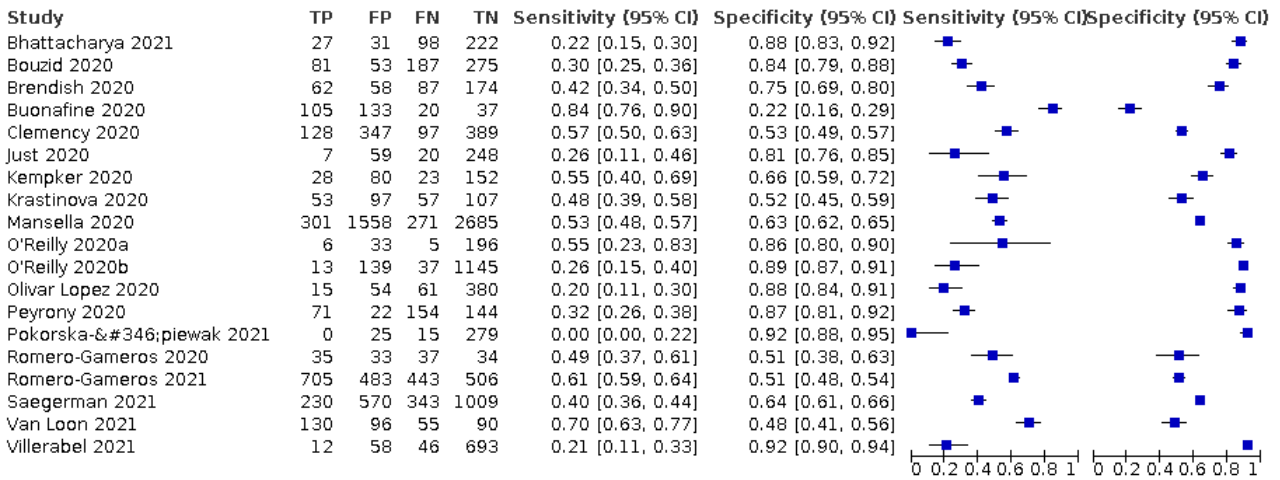
### Test 6. Diarrhoea

#### Diarrhoea



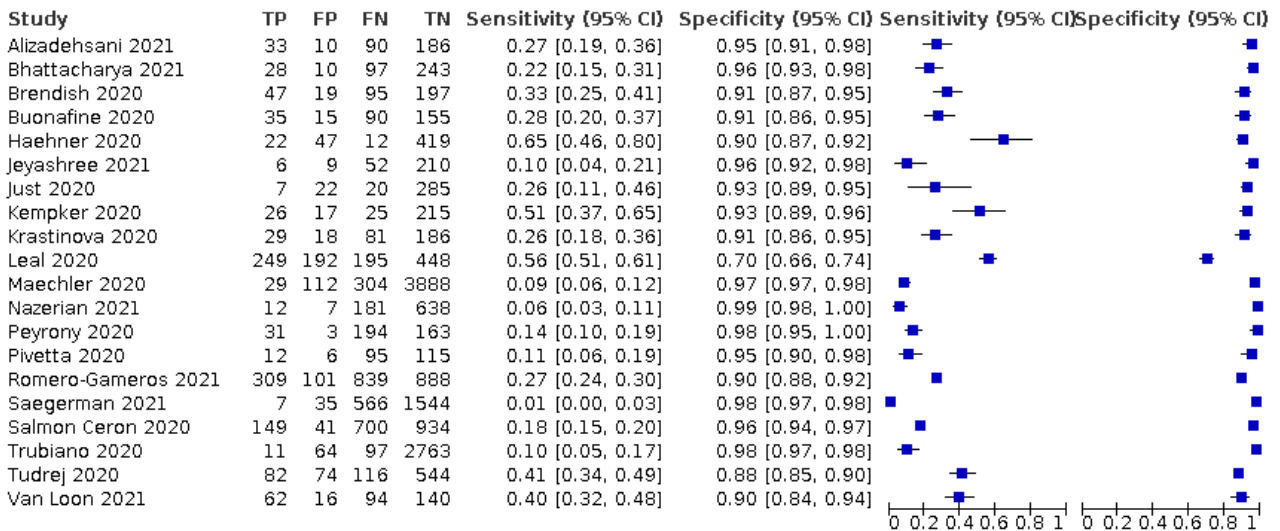
### Test 7. Myalgia

#### Myalgia



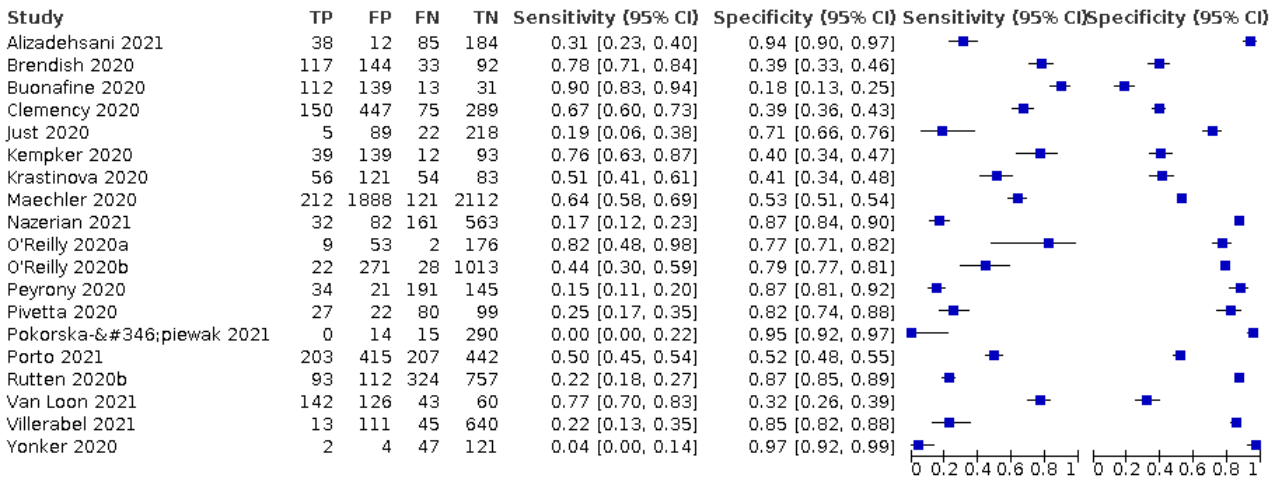
### Test 8. Anosmia

#### Anosmia



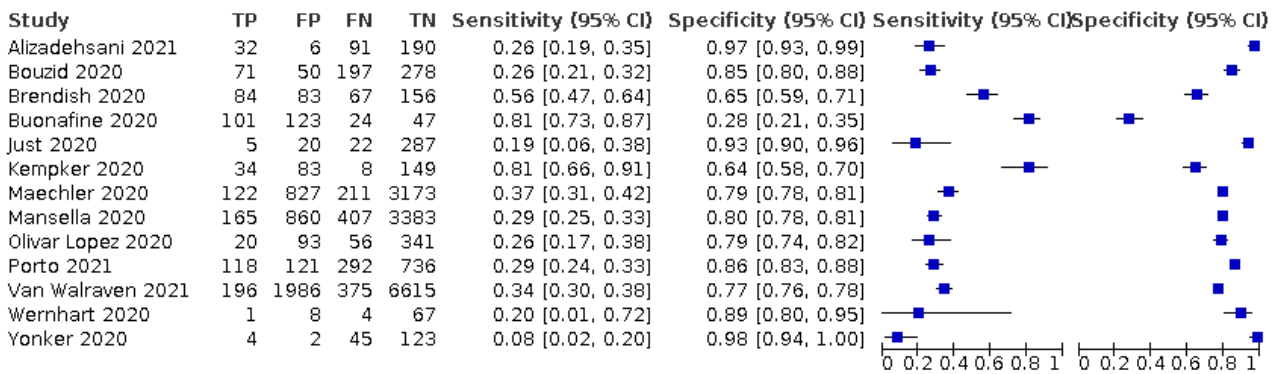
### Test 9. Fatigue

#### Fatigue



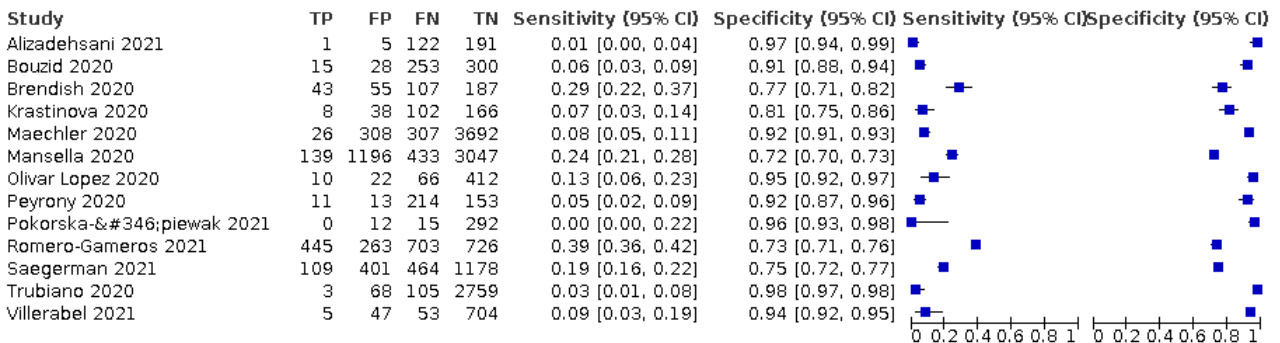
### Test 10. Chills/shivers

#### Chills/shivers



### Test 11. Chest tightness/pain

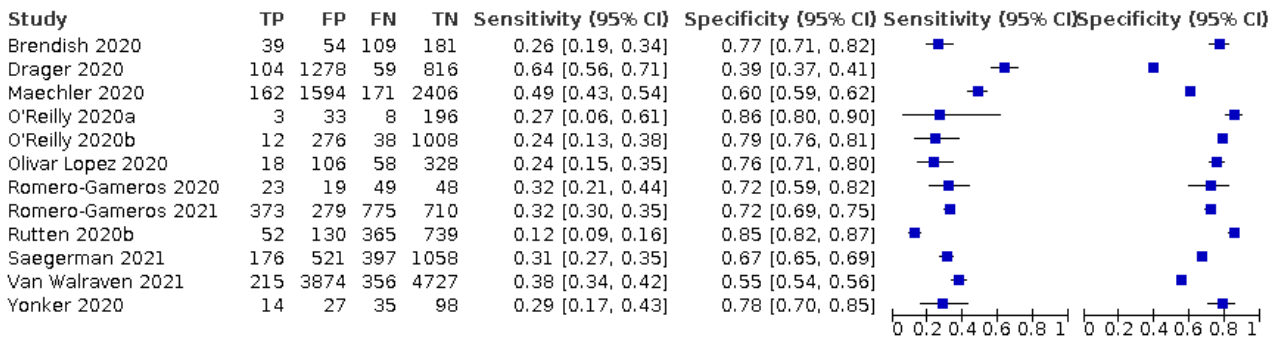
#### Chest tightness/pain





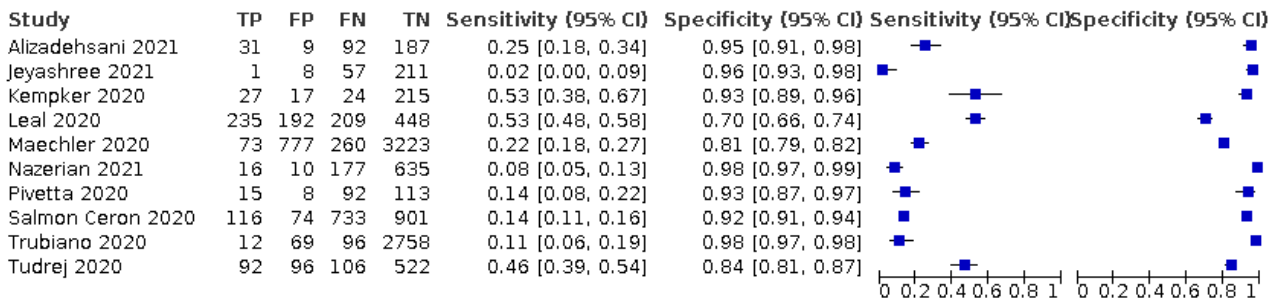
### Test 12. Rhinorrhea

#### Rhinorrhea



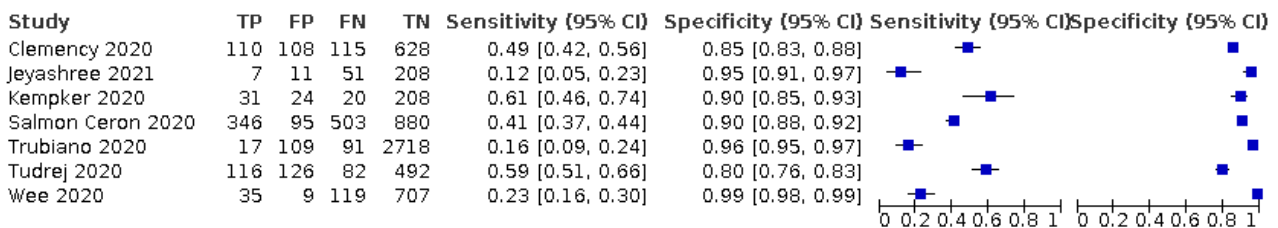
### Test 13. Ageusia

#### Ageusia



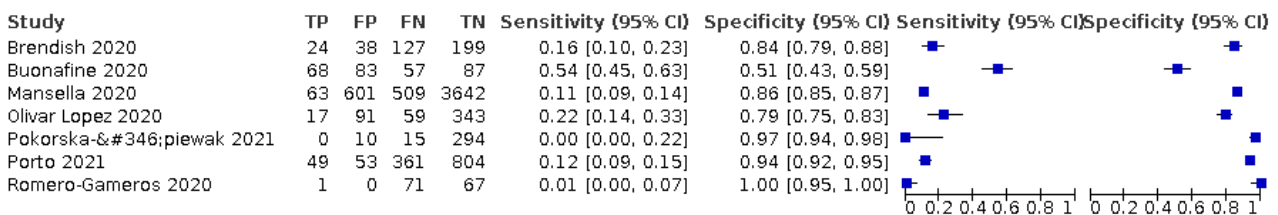
### Test 14. Anosmia or ageusia

#### Anosmia or ageusia



### Test 15. Abdominal pain

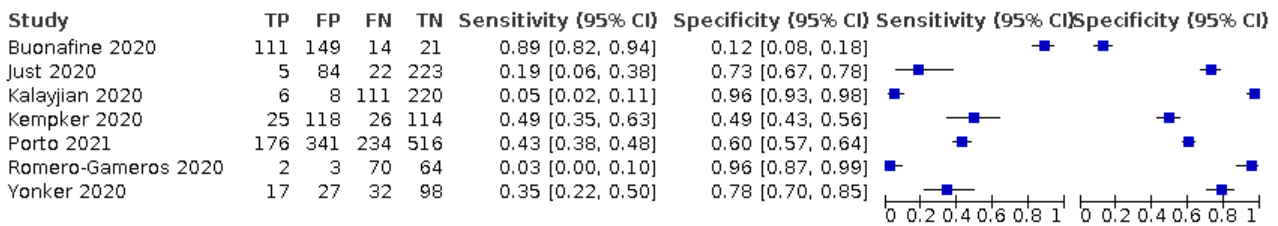
#### Abdominal pain





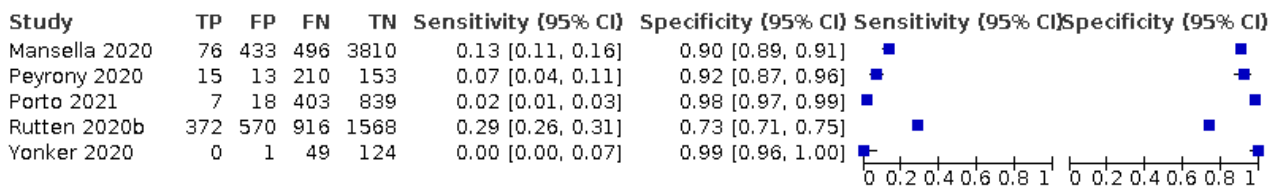
### Test 16. Nasal congestion

#### Nasal congestion



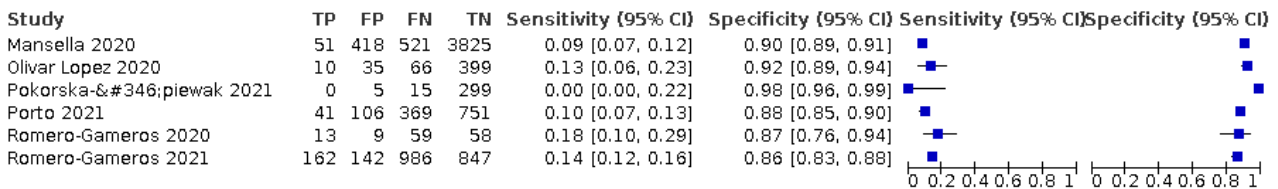
### Test 17. Altered mentation/confusion

#### Altered mentation/confusion



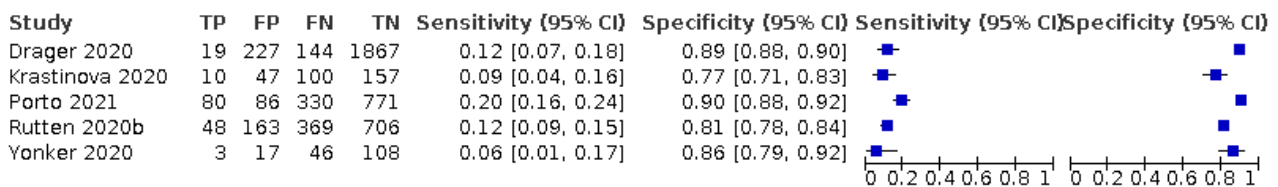
### Test 18. Conjunctivitis

#### Conjunctivitis



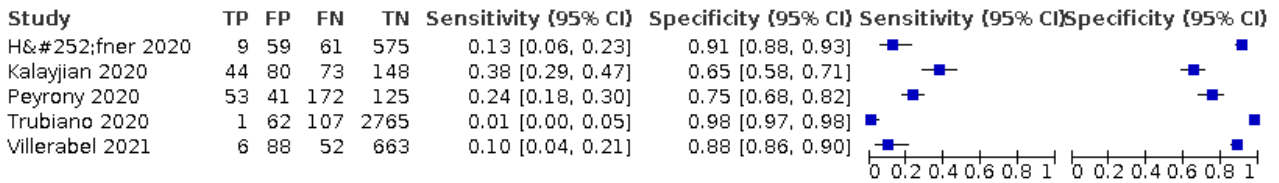
### Test 19. Nausea or vomiting

#### Nausea or vomiting



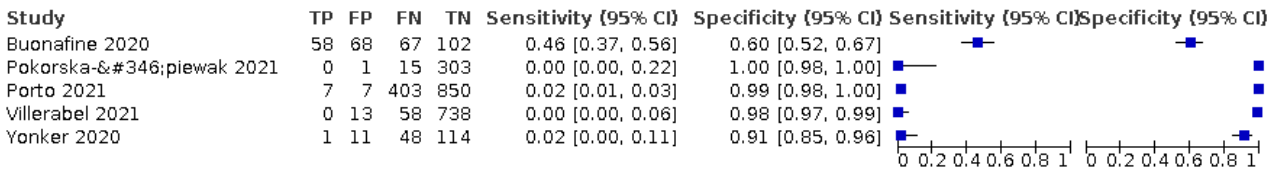
### Test 20. Gastrointestinal symptoms (not specified)

#### Gastrointestinal symptoms (not specified)



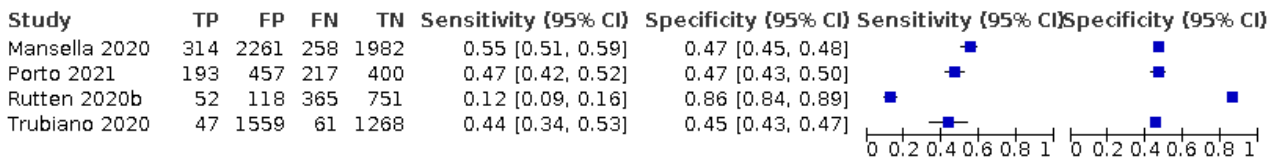
### Test 21. Rash

#### Rash



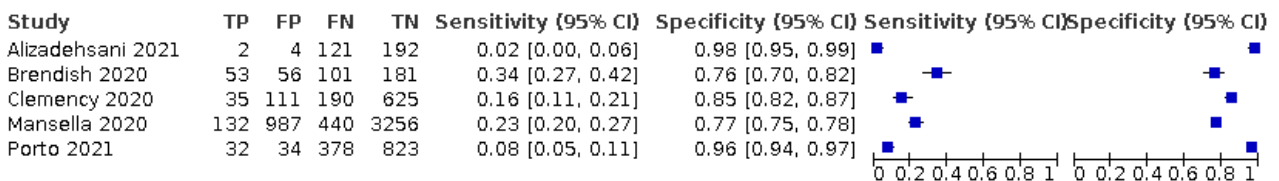
### Test 22. Coryza

#### Coryza



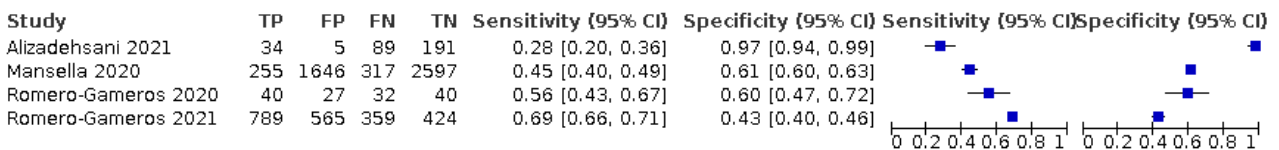
### Test 23. Sputum production/productive cough

#### Sputum production/productive cough



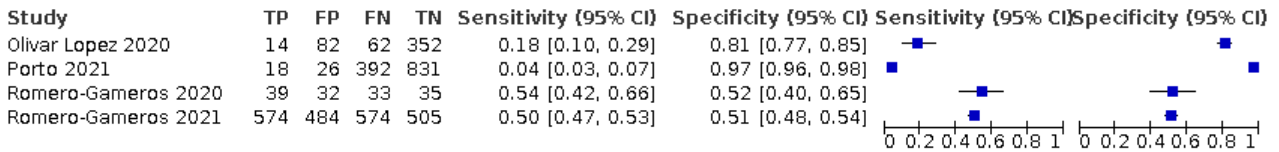
### Test 24. Asthenia

#### Asthenia



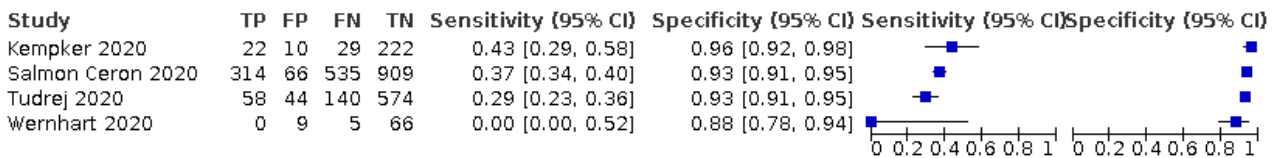
### Test 25. Odynophagia

#### Odynophagia



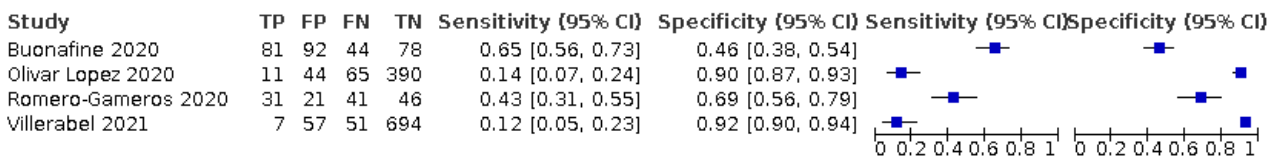
### Test 26. Anosmia and ageusia

#### Anosmia and ageusia



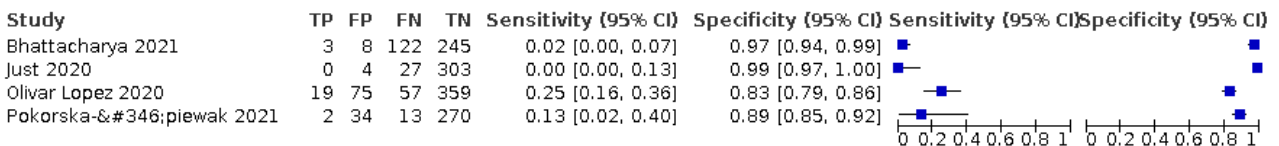
### Test 27. Arthralgia

#### Arthralgia



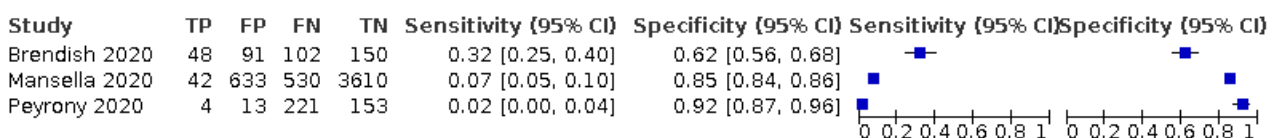
### Test 28. Vomiting

#### Vomiting



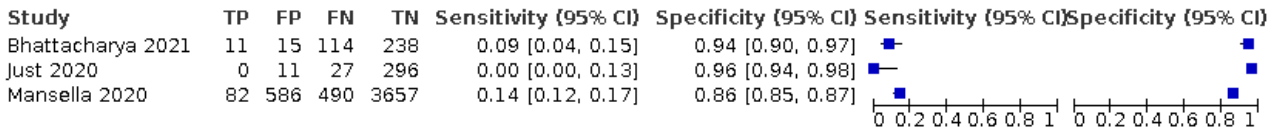
### Test 29. Wheeze

#### Wheeze



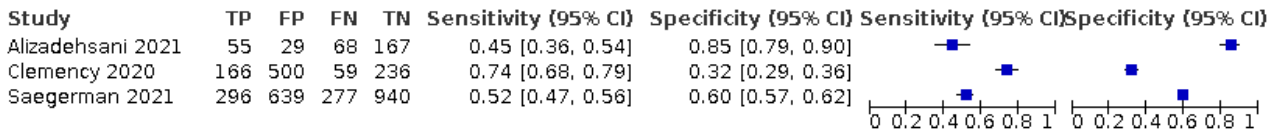
### Test 30. Nausea

#### Nausea



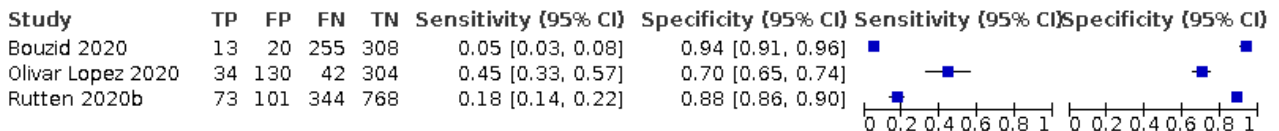
### Test 31. Dry cough

#### Dry cough



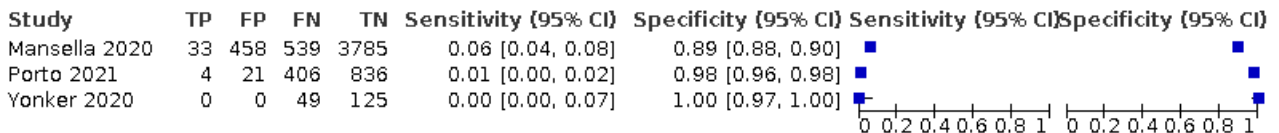
### Test 32. Malaise

#### Malaise



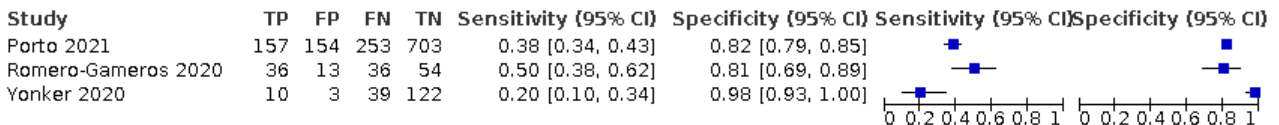
### Test 33. Enlargement of lymph nodes

#### Enlargement of lymph nodes



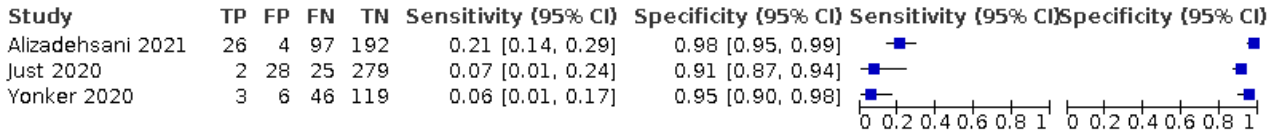
### Test 34. Anosmia or hyposmia

#### Anosmia or hyposmia



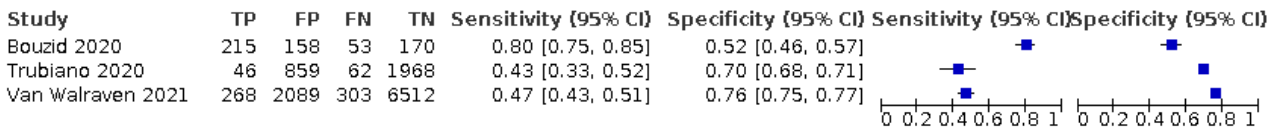
### Test 35. Anorexia

#### Anorexia



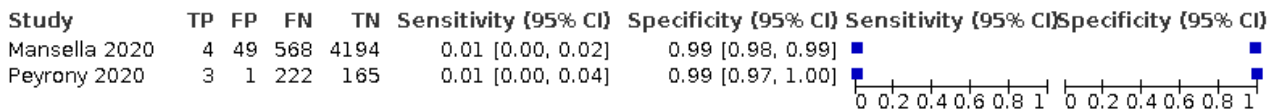
### Test 36. Fever (subjective)

#### Fever (subjective)



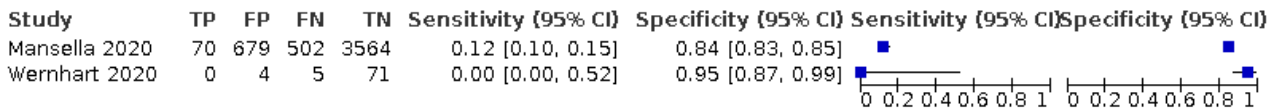
### Test 37. Haemoptysis

#### Haemoptysis



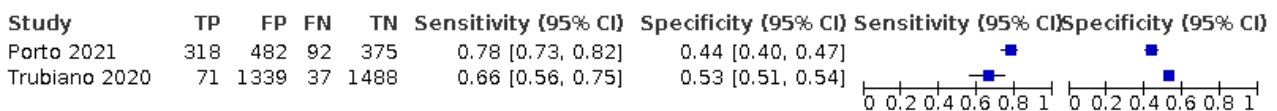
### Test 38. Earache

#### Earache



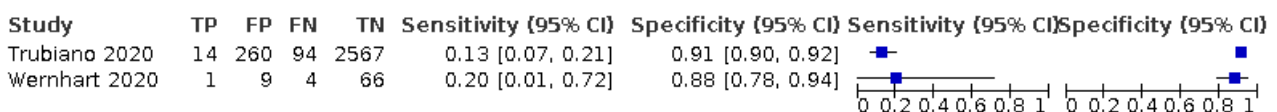
### Test 39. Systemic soreness (malaise/myalgia/arthritis)

#### Systemic soreness (malaise/myalgia/arthritis)



### Test 40. High fever (≥ 38.5 °C)

#### High fever (≥ 38.5 °C)



### Test 41. Myalgia or arthralgia

#### Myalgia or arthralgia

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Drager 2020	94	827	69	1267	0.58 [0.50, 0.65]	0.61 [0.58, 0.63]		
Maechler 2020	171	1145	162	2855	0.51 [0.46, 0.57]	0.71 [0.70, 0.73]		
Yonker 2020	14	26	35	99	0.29 [0.17, 0.43]	0.79 [0.71, 0.86]		

### Test 42. Irritability

#### Irritability

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Olivar Lopez 2020	26	154	50	280	0.34 [0.24, 0.46]	0.65 [0.60, 0.69]		
Porto 2021	34	70	376	787	0.08 [0.06, 0.11]	0.92 [0.90, 0.94]		

### Test 43. Sneezing

#### Sneezing

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Porto 2021	164	363	246	494	0.40 [0.35, 0.45]	0.58 [0.54, 0.61]		
Van Loon 2021	66	76	119	110	0.36 [0.29, 0.43]	0.59 [0.52, 0.66]		

### Test 44. Anosmia or dysgeusia

#### Anosmia or dysgeusia

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
O'Reilly 2020a	1	7	10	222	0.09 [0.00, 0.41]	0.97 [0.94, 0.99]		
O'Reilly 2020b	10	32	40	1252	0.20 [0.10, 0.34]	0.98 [0.96, 0.98]		

### Test 45. Loss of appetite

#### Loss of appetite

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Brendish 2020	112	116	40	116	0.74 [0.66, 0.80]	0.50 [0.43, 0.57]		
Clemency 2020	90	194	135	542	0.40 [0.34, 0.47]	0.74 [0.70, 0.77]		

### Test 46. Pulmonary auscultation: crackling bilateral

#### Pulmonary auscultation: crackling bilateral

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Bouزيد 2020	53	39	215	289	0.20 [0.15, 0.25]	0.88 [0.84, 0.91]		
Peyrony 2020	80	15	145	151	0.36 [0.29, 0.42]	0.91 [0.86, 0.95]		

### Test 47. Sweating

#### Sweating

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Alizadehsani 2021	15	2	108	194	0.12 [0.07, 0.19]	0.99 [0.96, 1.00]		
Bouزيد 2020	29	29	239	299	0.11 [0.07, 0.15]	0.91 [0.88, 0.94]		

### Test 48. Nasal symptoms

#### Nasal symptoms

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Krastinova 2020	47	105	63	99	0.43 [0.33, 0.53]	0.49 [0.41, 0.56]		
Van Loon 2021	94	108	91	77	0.51 [0.43, 0.58]	0.42 [0.34, 0.49]		

### Test 49. Rhinitis

#### Rhinitis

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Pokorska-&#346;piewak 2021	1	59	14	245	0.07 [0.00, 0.32]	0.81 [0.76, 0.85]		
Wernhart 2020	3	20	2	55	0.60 [0.15, 0.95]	0.73 [0.62, 0.83]		

### Test 50. Dysgeusia

#### Dysgeusia

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Romero-Gameros 2020	38	15	34	52	0.53 [0.41, 0.65]	0.78 [0.66, 0.87]		
Yonker 2020	3	1	46	124	0.06 [0.01, 0.17]	0.99 [0.96, 1.00]		

### Test 51. SCRiPS score, recent case detection rate

#### SCRiPS score, recent case detection rate

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Van Walraven 2021	393	3469	178	5132	0.69 [0.65, 0.73]	0.60 [0.59, 0.61]		

**Test 52. SCRIPS score, 0.5\*recent case detection rate**

SCRIPS score, 0.5\*recent case detection rate

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Van Walraven 2021	514	5952	57	2649	0.90 [0.87, 0.92]	0.31 [0.30, 0.32]		

**Test 53. Rigors**

Rigors

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Van Walraven 2021	76	546	495	8055	0.13 [0.11, 0.16]	0.94 [0.93, 0.94]		

**Test 54. Cough or dyspnoea**

Cough or dyspnoea

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Van Walraven 2021	473	6911	98	1690	0.83 [0.79, 0.86]	0.20 [0.19, 0.21]		

**Test 55. Dysuria**

Dysuria

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Mansella 2020	22	162	550	4081	0.04 [0.02, 0.06]	0.96 [0.96, 0.97]		

**Test 56. Seizure**

Seizure

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Mansella 2020	9	77	563	4166	0.02 [0.01, 0.03]	0.98 [0.98, 0.99]		

**Test 57. Exanthema**

Exanthema

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Mansella 2020	20	224	552	4019	0.03 [0.02, 0.05]	0.95 [0.94, 0.95]		



### Test 58. Exhaustion

#### Exhaustion

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Mansella 2020	271	1860	301	2383	0.47 [0.43, 0.52]	0.56 [0.55, 0.58]		

### Test 59. Sinusitis

#### Sinusitis

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Trubiano 2020	1	13	107	2814	0.01 [0.00, 0.05]	1.00 [0.99, 1.00]		

### Test 60. Hypoxia

#### Hypoxia

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Rutten 2020b	453	820	570	931	0.44 [0.41, 0.47]	0.53 [0.51, 0.56]		

### Test 61. Multivariable score cut-off = 5

#### Multivariable score cut-off = 5

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Saegerman 2021	381	539	192	1040	0.66 [0.62, 0.70]	0.66 [0.63, 0.68]		

### Test 62. Multivariable score cut-off = 8

#### Multivariable score cut-off = 8

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Saegerman 2021	89	53	484	1526	0.16 [0.13, 0.19]	0.97 [0.96, 0.97]		

### Test 63. Cough and anosmia

#### Cough and anosmia

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Romero-Gameros 2021	245	72	903	917	0.21 [0.19, 0.24]	0.93 [0.91, 0.94]		

### Test 64. Fever and anosmia

#### Fever and anosmia

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Romero-Gameros 2021	188	43	960	946	0.16 [0.14, 0.19]	0.96 [0.94, 0.97]		

### Test 65. Fever and cough and anosmia and dyspnoea and oxygen saturation < 93%

#### Fever and cough and anosmia and dyspnoea and oxygen saturation < 93%

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Romero-Gameros 2021	14	1	1134	988	0.01 [0.01, 0.02]	1.00 [0.99, 1.00]		

### Test 66. Fever and dyspnoea

#### Fever and dyspnoea

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Romero-Gameros 2021	385	118	763	871	0.34 [0.31, 0.36]	0.88 [0.86, 0.90]		

### Test 67. Anosmia and dyspnoea

#### Anosmia and dyspnoea

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Romero-Gameros 2021	155	43	993	946	0.14 [0.12, 0.16]	0.96 [0.94, 0.97]		

### Test 68. Fever and cough

#### Fever and cough

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Romero-Gameros 2021	515	153	633	836	0.45 [0.42, 0.48]	0.85 [0.82, 0.87]		

### Test 69. Weakness or fatigue

#### Weakness or fatigue

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Porto 2021	152	272	258	585	0.37 [0.32, 0.42]	0.68 [0.65, 0.71]		

### Test 70. Palpitations

#### Palpitations

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Porto 2021	45	102	365	755	0.11 [0.08, 0.14]	0.88 [0.86, 0.90]		

### Test 71. Anxiety

#### Anxiety

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Porto 2021	56	159	354	698	0.14 [0.10, 0.17]	0.81 [0.79, 0.84]		

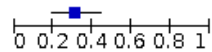
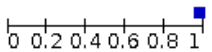
### Test 72. Respiratory distress

#### Respiratory distress

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Porto 2021	94	252	316	605	0.23 [0.19, 0.27]	0.71 [0.67, 0.74]		

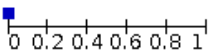
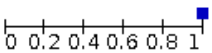
### Test 73. Hyposmia or anosmia

#### Hyposmia or anosmia

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Villerabel 2021	18	20	40	731	0.31 [0.20, 0.45]	0.97 [0.96, 0.98]		

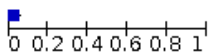
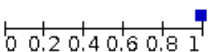
### Test 74. Diarrhoea and nausea

#### Diarrhoea and nausea

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Gilbert 2020	0	3	175	420	0.00 [0.00, 0.02]	0.99 [0.98, 1.00]		

### Test 75. Isolated fever

#### Isolated fever

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Gilbert 2020	5	7	170	416	0.03 [0.01, 0.07]	0.98 [0.97, 0.99]		

### Test 76. Myalgia and asthenia and fever

#### Myalgia and asthenia and fever

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Gilbert 2020	81	162	94	261	0.46 [0.39, 0.54]	0.62 [0.57, 0.66]		

### Test 77. Cough and fever and sputum production

#### Cough and fever and sputum production

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Gilbert 2020	37	81	138	342	0.21 [0.15, 0.28]	0.81 [0.77, 0.84]		

### Test 78. Cough and fever and sputum production and dyspnoea

#### Cough and fever and sputum production and dyspnoea

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Gilbert 2020	21	27	154	396	0.12 [0.08, 0.18]	0.94 [0.91, 0.96]		

### Test 79. Isolated headache

#### Isolated headache

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Gilbert 2020	0	3	175	420	0.00 [0.00, 0.02]	0.99 [0.98, 1.00]		

### Test 80. Dyspnoea and cough and fever and low oxygen saturation

#### Dyspnoea and cough and fever and low oxygen saturation

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Gilbert 2020	5	9	170	414	0.03 [0.01, 0.07]	0.98 [0.96, 0.99]		

### Test 81. Sore throat and nasal congestion and sneezing and mild fever

#### Sore throat and nasal congestion and sneezing and mild fever

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Gilbert 2020	18	109	157	314	0.10 [0.06, 0.16]	0.74 [0.70, 0.78]		

### Test 82. Low body temperature

#### Low body temperature

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Bouzid 2020	6	13	262	315	0.02 [0.01, 0.05]	0.96 [0.93, 0.98]		

### Test 83. Expectoration

#### Expectoration

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Bouzid 2020	12	27	256	301	0.04 [0.02, 0.08]	0.92 [0.88, 0.95]		

### Test 84. Tachypnoea

#### Tachypnoea

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Olivar Lopez 2020	23	115	53	319	0.30 [0.20, 0.42]	0.74 [0.69, 0.78]		

### Test 85. Cyanosis

#### Cyanosis

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Olivar Lopez 2020	5	40	71	394	0.07 [0.02, 0.15]	0.91 [0.88, 0.93]		

### Test 86. Skin lesions

#### Skin lesions

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Peyrony 2020	23	11	202	155	0.10 [0.07, 0.15]	0.93 [0.88, 0.97]		

### Test 87. Rhinitis or pharyngitis

#### Rhinitis or pharyngitis

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Peyrony 2020	19	26	206	140	0.08 [0.05, 0.13]	0.84 [0.78, 0.90]		

### Test 88. Dizziness or syncope

#### Dizziness or syncope

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Peyrony 2020	8	13	217	153	0.04 [0.02, 0.07]	0.92 [0.87, 0.96]		

### Test 89. Pulmonary auscultation: crackling unilateral

#### Pulmonary auscultation: crackling unilateral

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Peyrony 2020	21	12	204	154	0.09 [0.06, 0.14]	0.93 [0.88, 0.96]		

### Test 90. CSBSS (cut-off = 41.7)

#### CSBSS (cut-off = 41.7)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Bhattacharya 2021	81	96	44	157	0.65 [0.56, 0.73]	0.62 [0.56, 0.68]		

### Test 91. Hyposmia

#### Hyposmia

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Martin-Sanz 2020	138	30	77	110	0.64 [0.57, 0.71]	0.79 [0.71, 0.85]		

### Test 92. Hypogeusia

#### Hypogeusia

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Martin-Sanz 2020	114	25	101	115	0.53 [0.46, 0.60]	0.82 [0.75, 0.88]		

### Test 93. Dizziness

#### Dizziness

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Alizadehsani 2021	11	0	112	196	0.09 [0.05, 0.15]	1.00 [0.98, 1.00]		

### Test 94. Change to chronic cough

#### Change to chronic cough

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
O'Reilly 2020a	1	14	10	215	0.09 [0.00, 0.41]	0.94 [0.90, 0.97]		

### Test 95. Dysosmia

#### Dysosmia

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Romero-Gameros 2020	3	0	69	67	0.04 [0.01, 0.12]	1.00 [0.95, 1.00]		

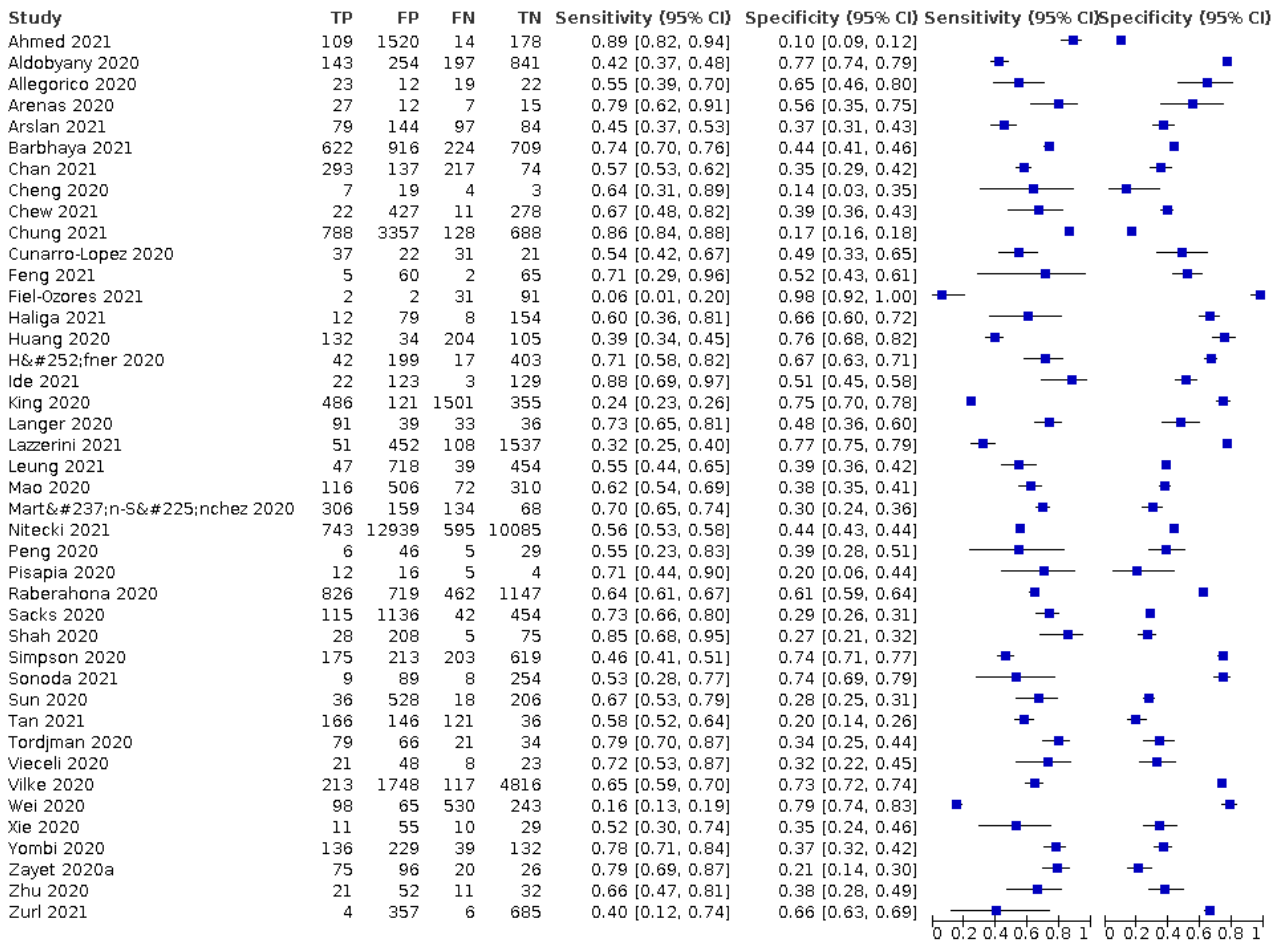
### Test 96. Myalgia and fatigue

#### Myalgia and fatigue

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Wernhart 2020	3	50	2	25	0.60 [0.15, 0.95]	0.33 [0.23, 0.45]		

**Test 97. Cough (retrospective data collection)**

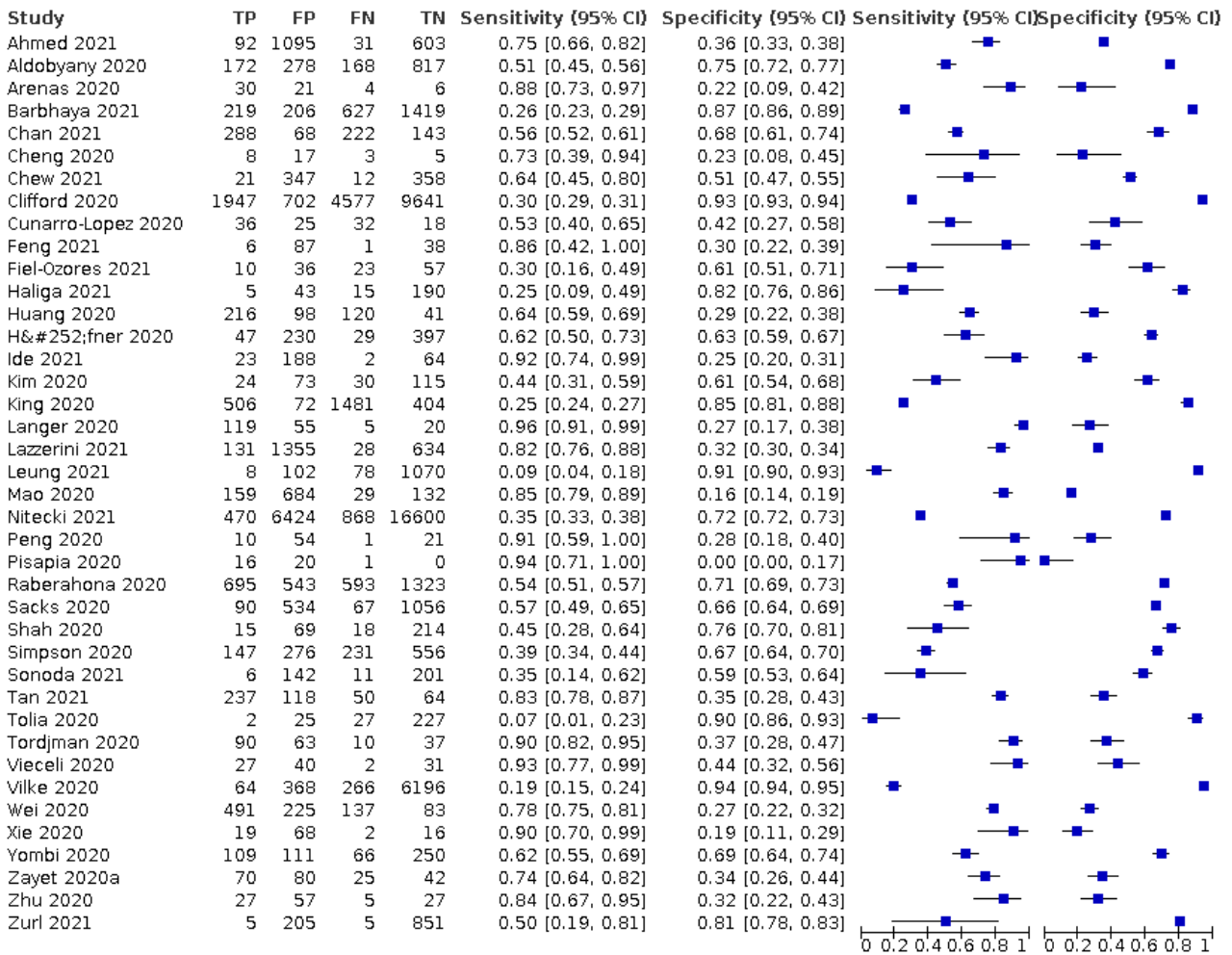
**Cough (retrospective data collection)**





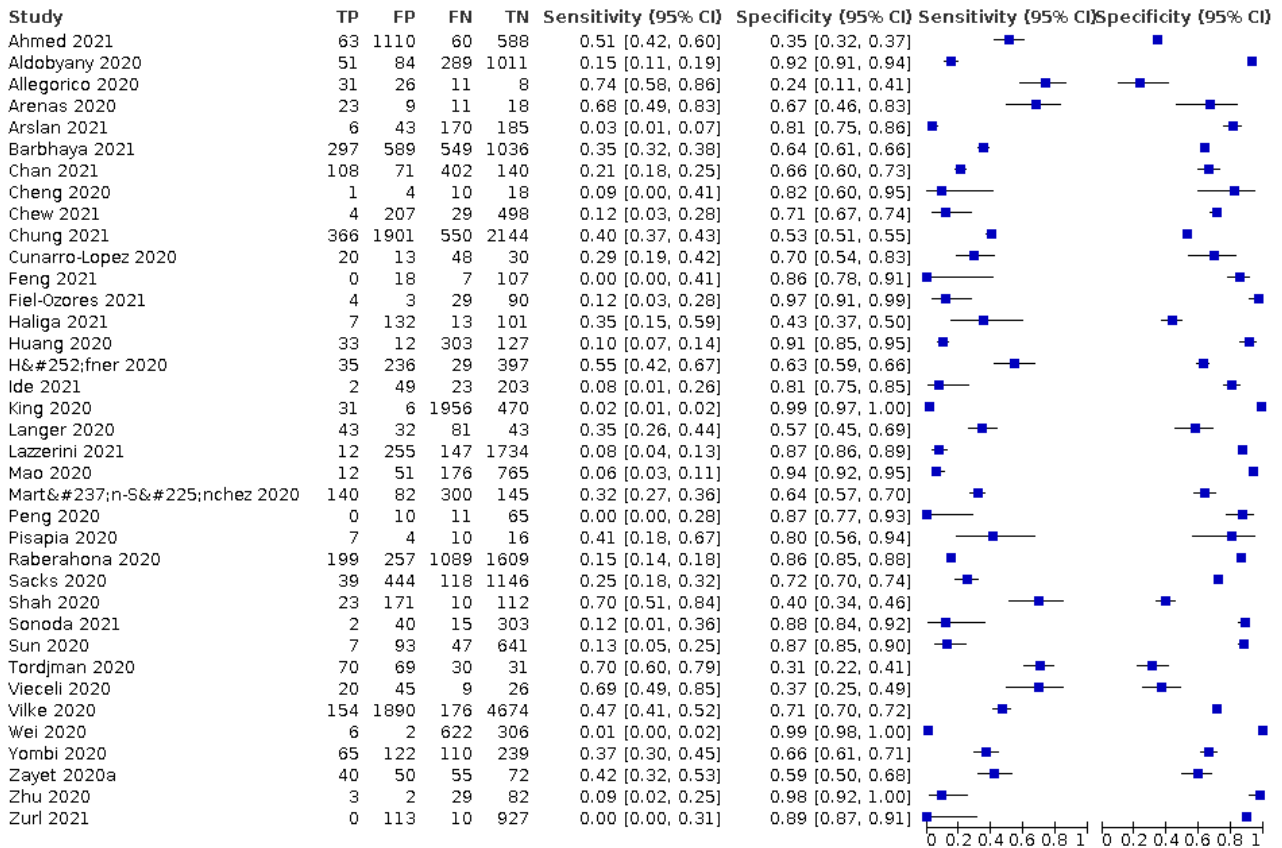
**Test 98. Fever (retrospective data collection)**

Fever (retrospective data collection)



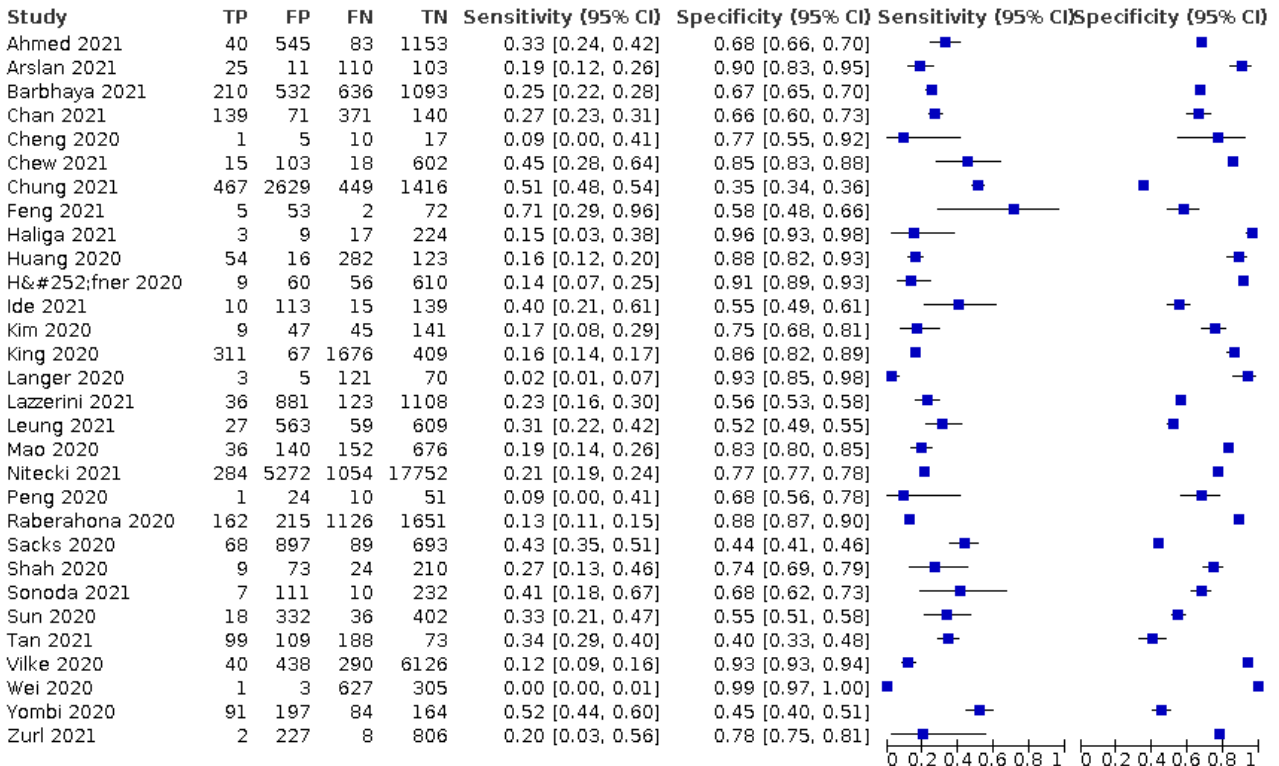
**Test 99. Dyspnoea (retrospective data collection)**

Dyspnoea (retrospective data collection)



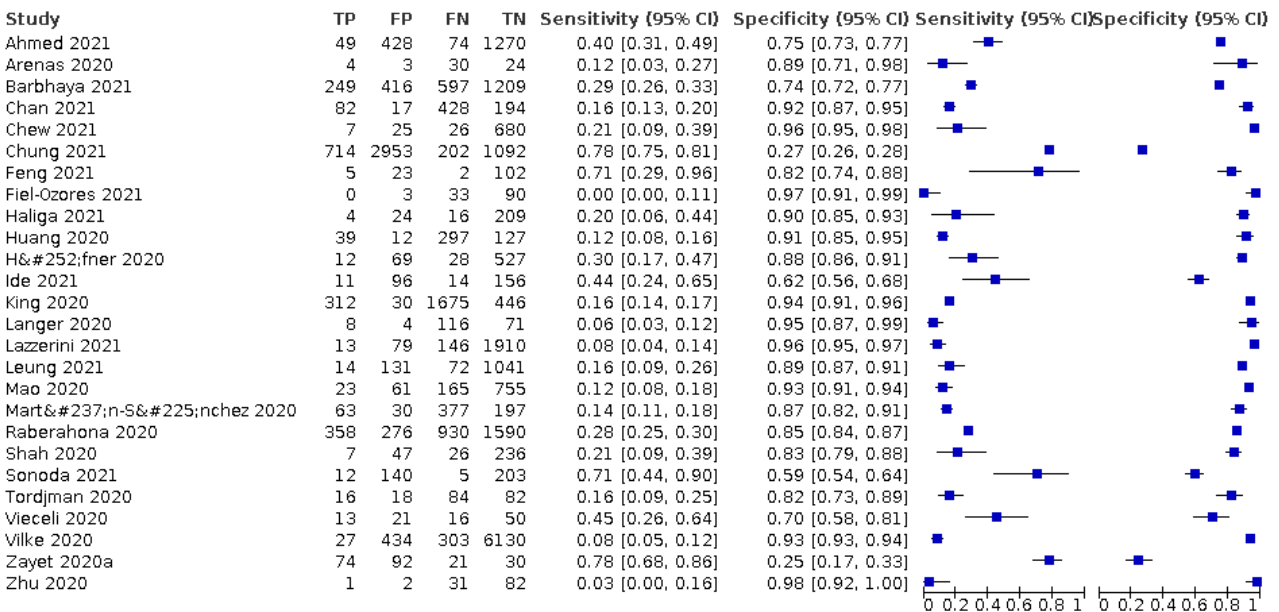
**Test TST-100. Sore throat (retrospective data collection)**

Sore throat (retrospective data collection)



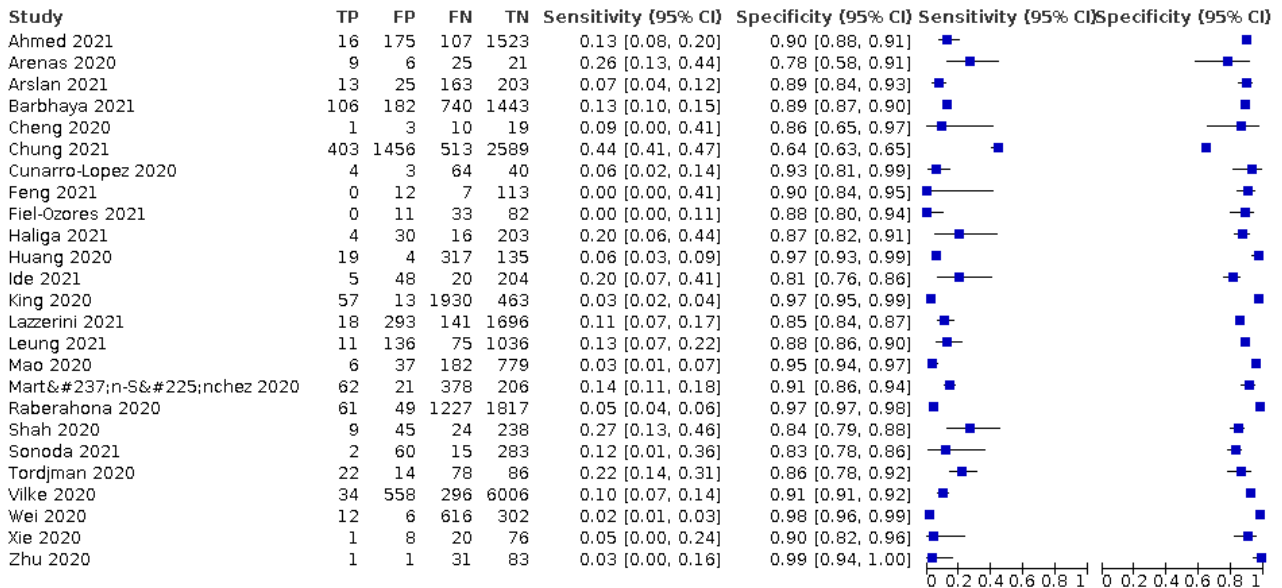
**Test TST-101. Headache (retrospective data collection)**

Headache (retrospective data collection)



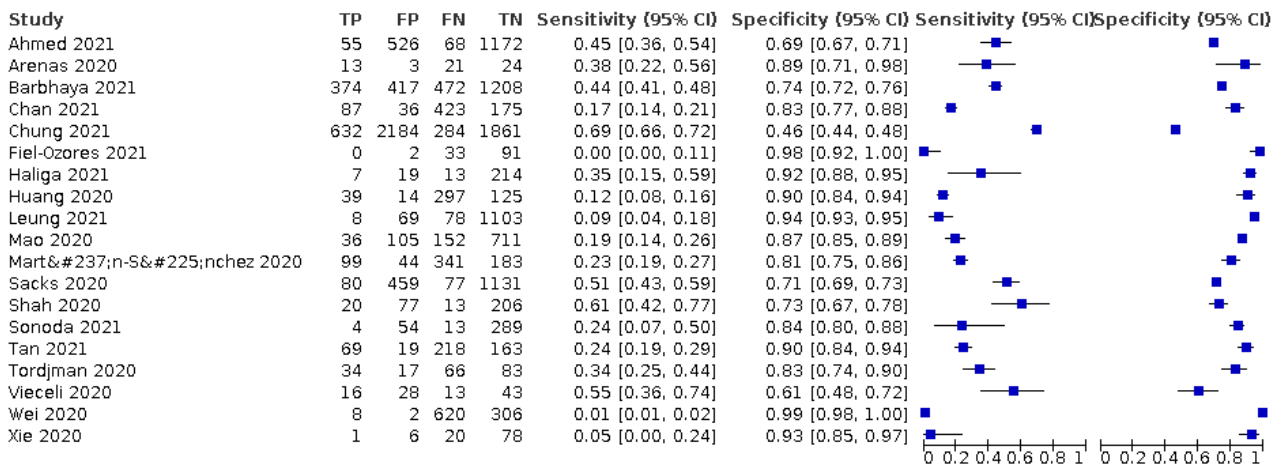
**Test TST-102. Diarrhoea (retrospective data collection)**

Diarrhoea (retrospective data collection)



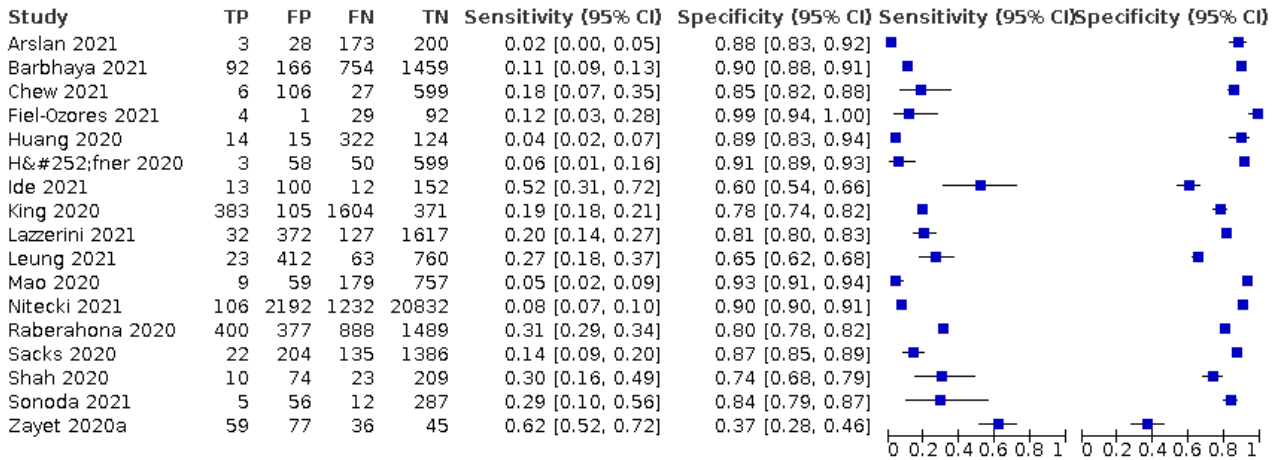
**Test TST-103. Myalgia (retrospective data collection)**

Myalgia (retrospective data collection)



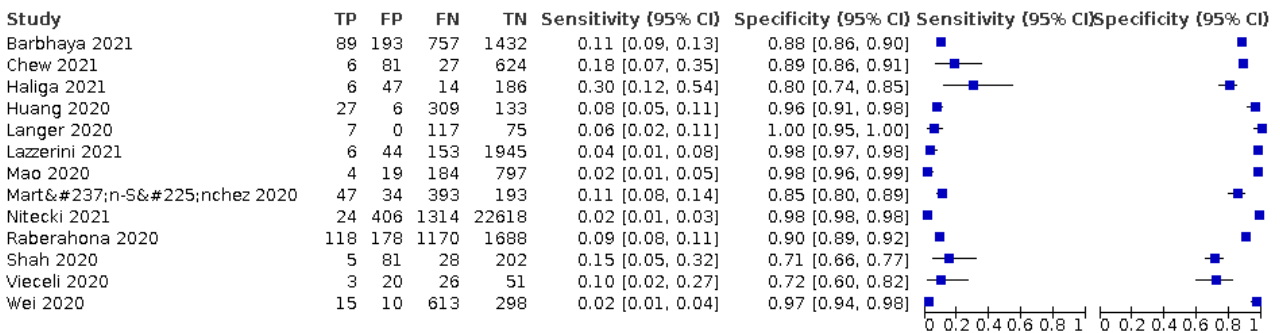
**Test TST-104. Rhinorrhoea (retrospective data collection)**

Rhinorrhoea (retrospective data collection)



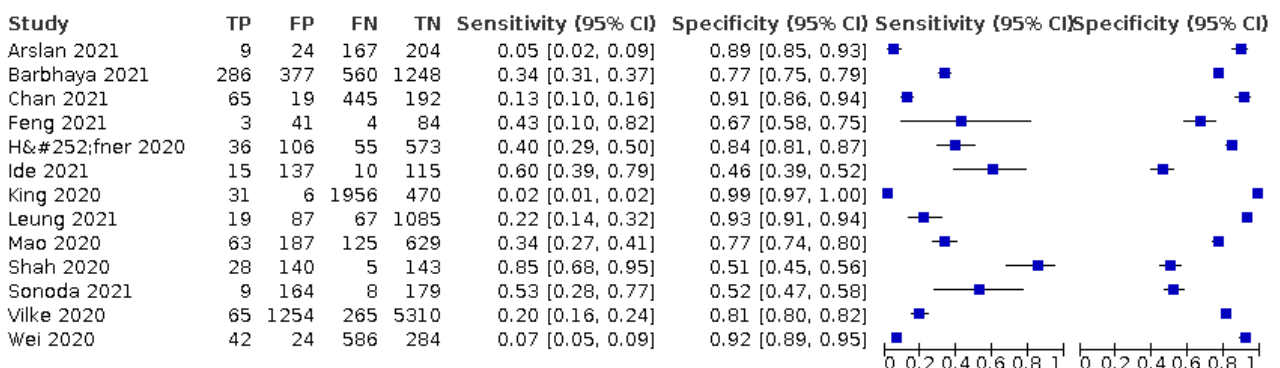
**Test TST-105. Chest tightness/pain (retrospective data collection)**

Chest tightness/pain (retrospective data collection)



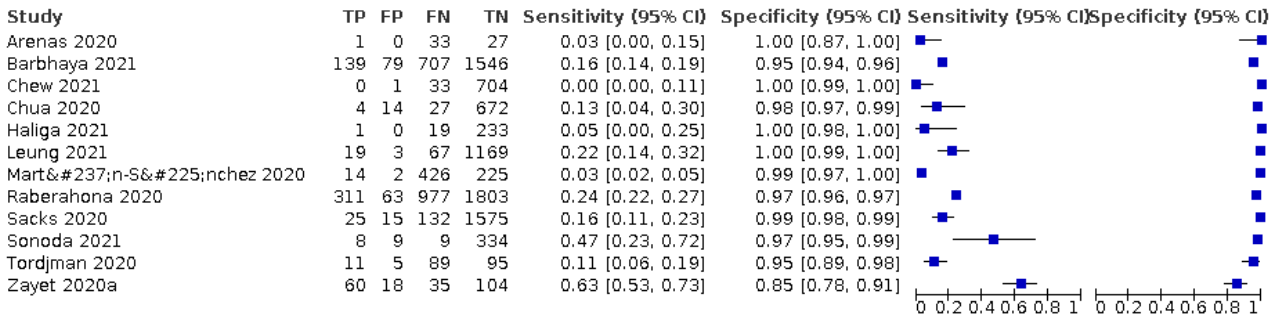
**Test TST-106. Fatigue (retrospective data collection)**

Fatigue (retrospective data collection)



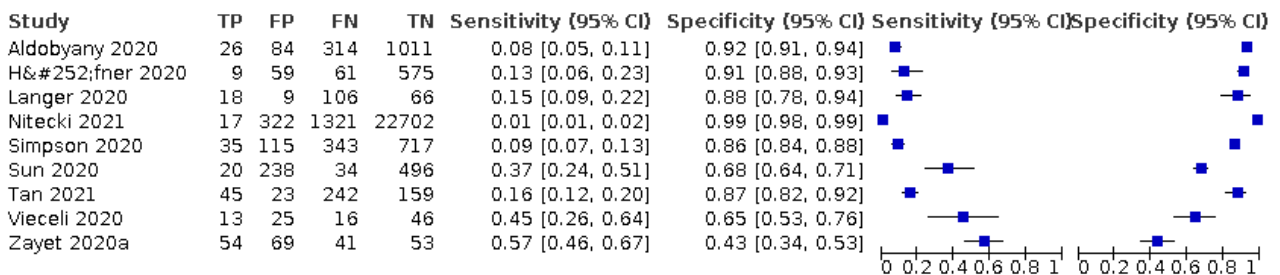
**Test TST-107. Anosmia (retrospective data collection)**

Anosmia (retrospective data collection)



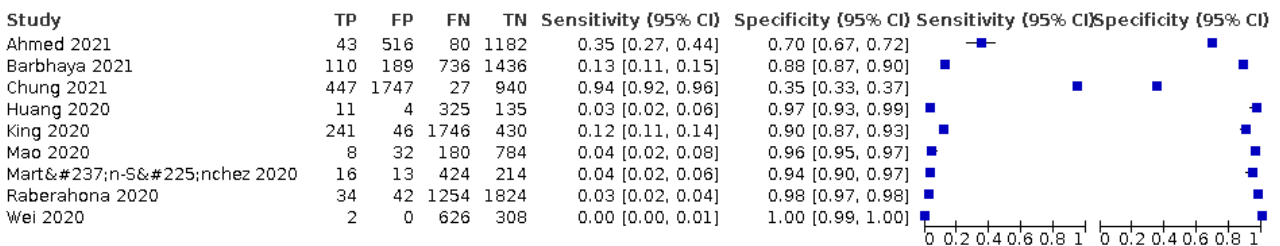
**Test TST-108. Gastrointestinal symptoms not specified (retrospective data collection)**

Gastrointestinal symptoms not specified (retrospective data collection)



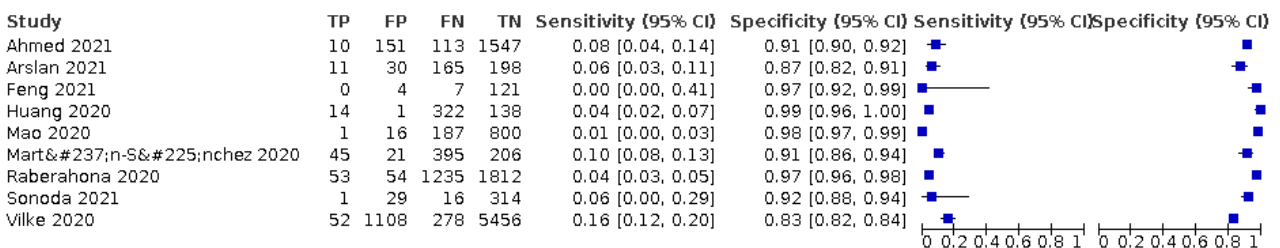
**Test TST-109. Nasal congestion (retrospective data collection)**

Nasal congestion (retrospective data collection)



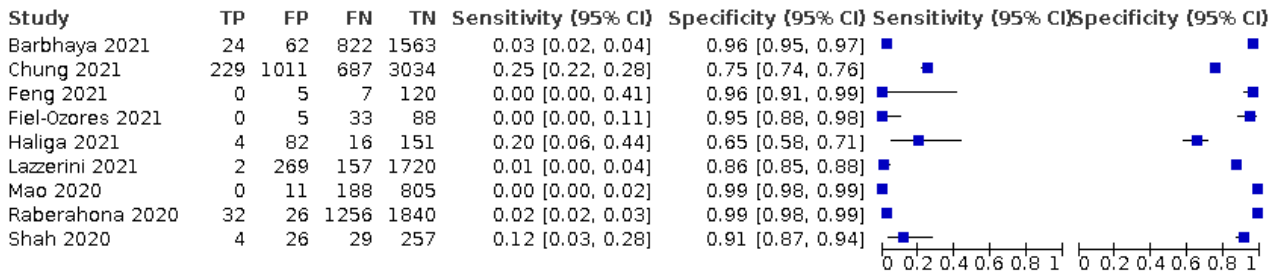
**Test TST-110. Nausea or vomiting (retrospective data collection)**

Nausea or vomiting (retrospective data collection)



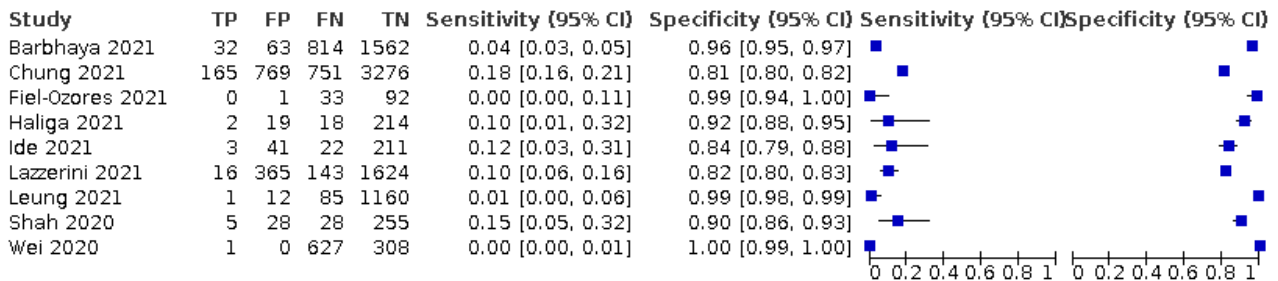
### Test TST-111. Abdominal pain (retrospective data collection)

#### Abdominal pain (retrospective data collection)



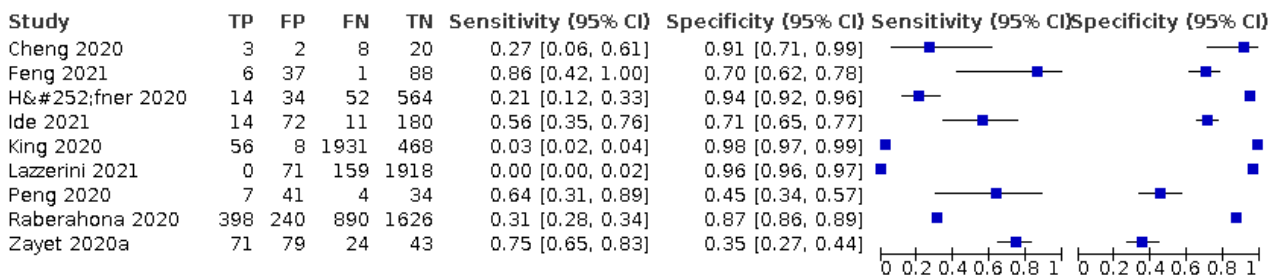
### Test TST-112. Vomiting (retrospective data collection)

#### Vomiting (retrospective data collection)



### Test TST-113. Myalgia or arthralgia (retrospective data collection)

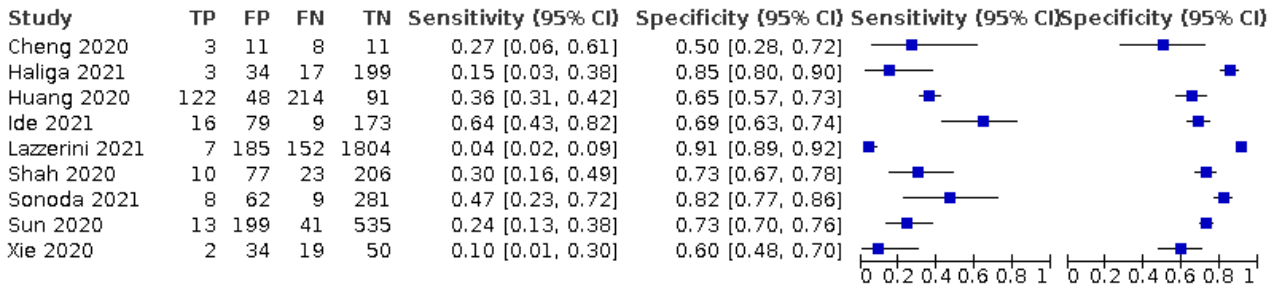
#### Myalgia or arthralgia (retrospective data collection)





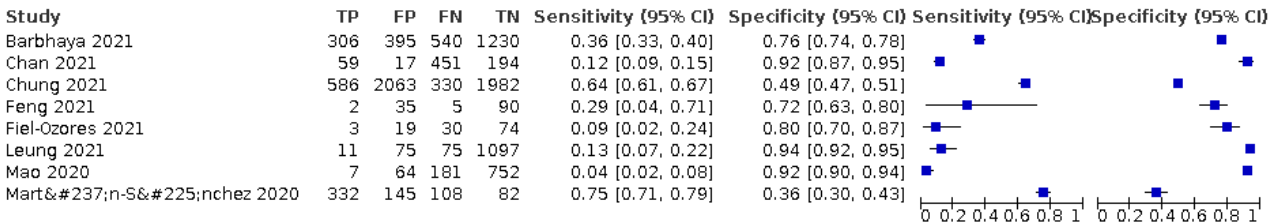
**Test TST-114. Sputum production/productive cough (retrospective data collection)**

Sputum production/productive cough (retrospective data collection)



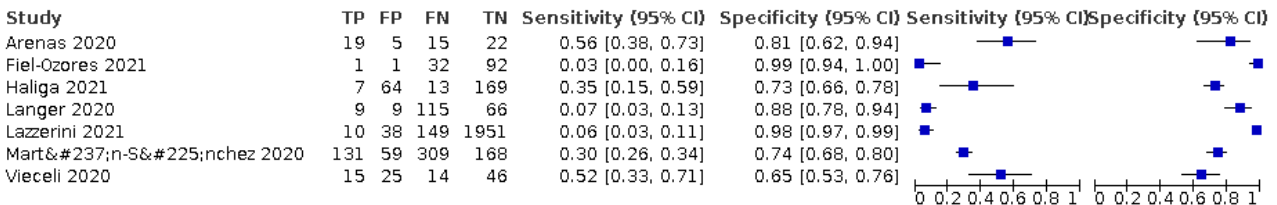
**Test TST-115. Chills/shivers (retrospective data collection)**

Chills/shivers (retrospective data collection)



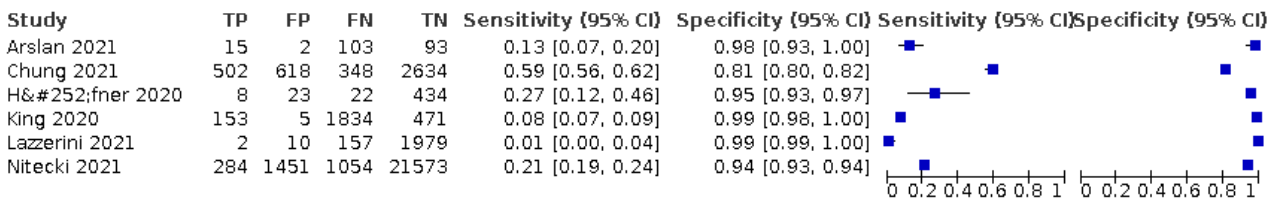
**Test TST-116. Asthenia (retrospective data collection)**

Asthenia (retrospective data collection)



**Test TST-117. Anosmia or ageusia (retrospective data collection)**

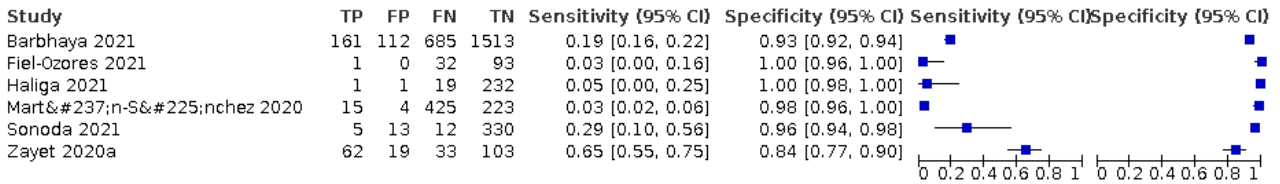
Anosmia or ageusia (retrospective data collection)





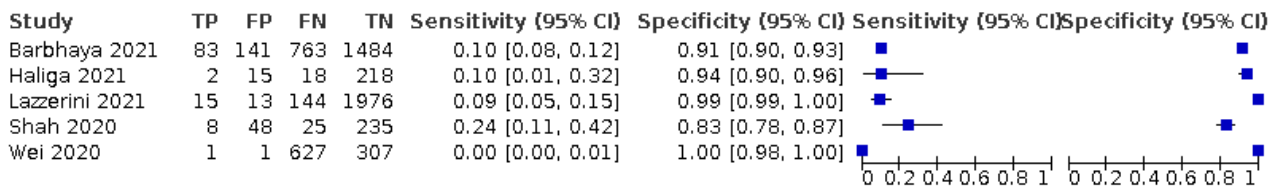
### Test TST-118. Dysgeusia (retrospective data collection)

#### Dysgeusia (retrospective data collection)



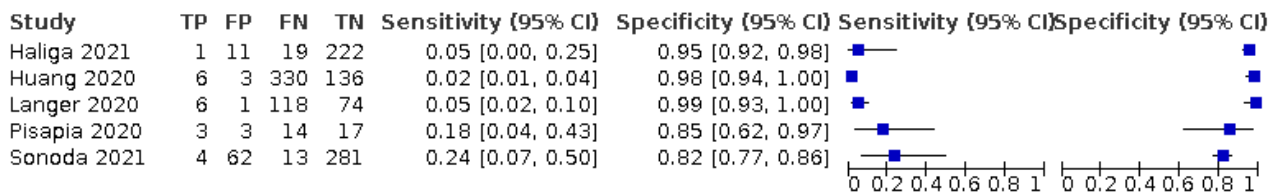
### Test TST-119. Nausea (retrospective data collection)

#### Nausea (retrospective data collection)



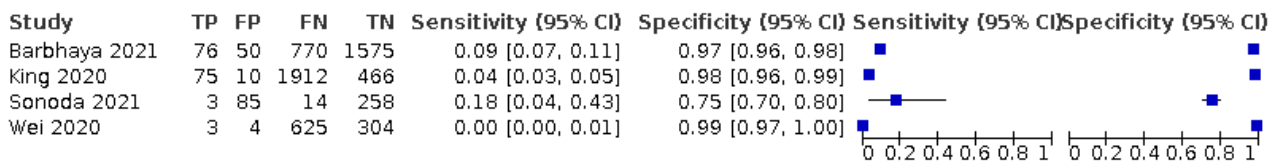
### Test TST-120. Arthralgia (retrospective data collection)

#### Arthralgia (retrospective data collection)



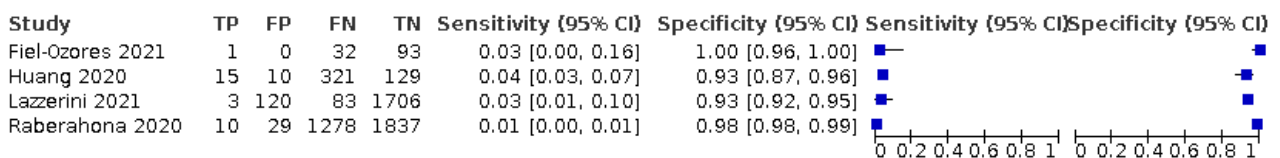
### Test TST-121. Anorexia (retrospective data collection)

#### Anorexia (retrospective data collection)



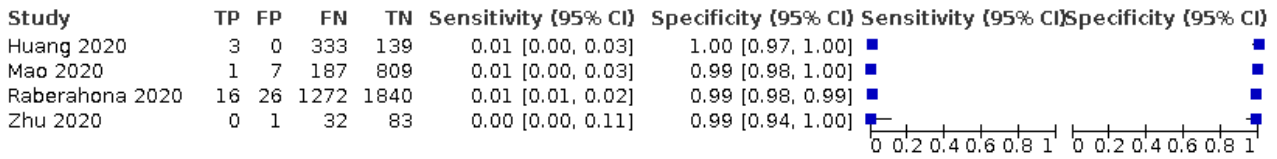
### Test TST-122. Wheeze (retrospective data collection)

#### Wheeze (retrospective data collection)



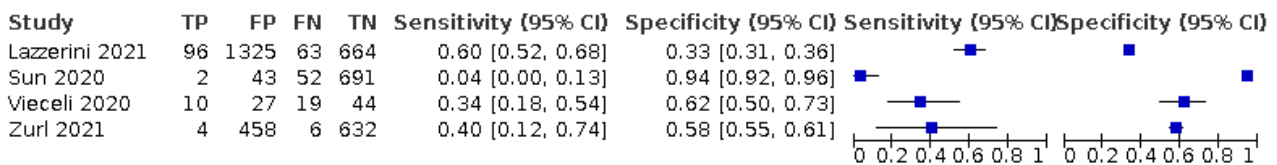
**Test TST-123. Haemoptysis (retrospective data collection)**

Haemoptysis (retrospective data collection)



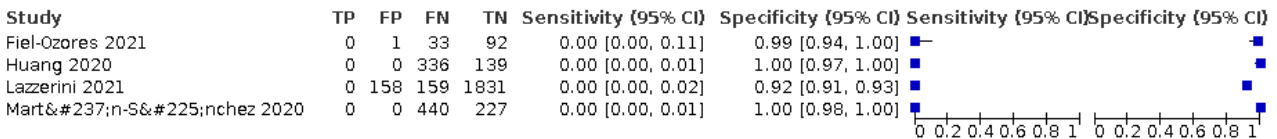
**Test TST-124. Respiratory symptoms (not specified; retrospective data collection)**

Respiratory symptoms (not specified; retrospective data collection)



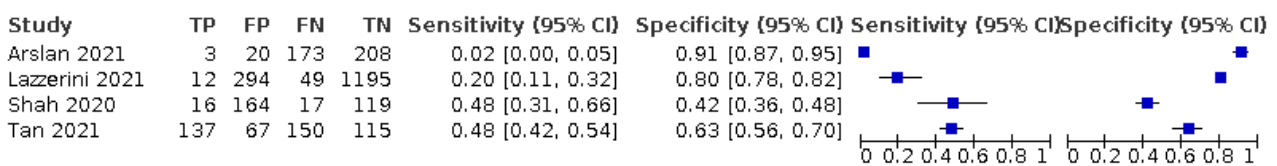
**Test TST-125. Skin lesions (retrospective data collection)**

Skin lesions (retrospective data collection)



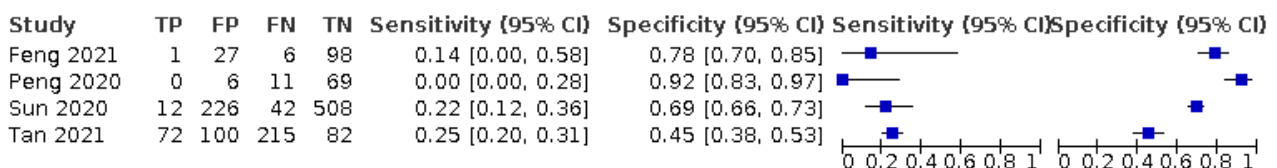
**Test TST-126. Tachycardia (retrospective data collection)**

Tachycardia (retrospective data collection)



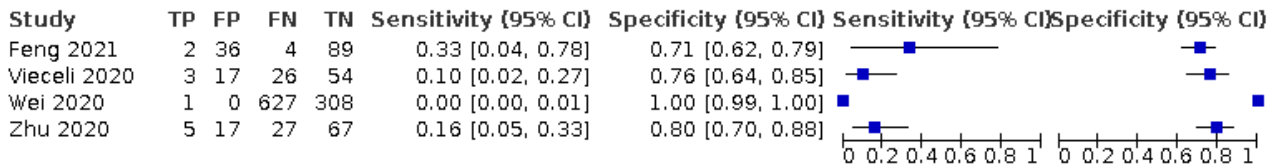
**Test TST-127. Nasal symptoms (retrospective data collection)**

Nasal symptoms (retrospective data collection)



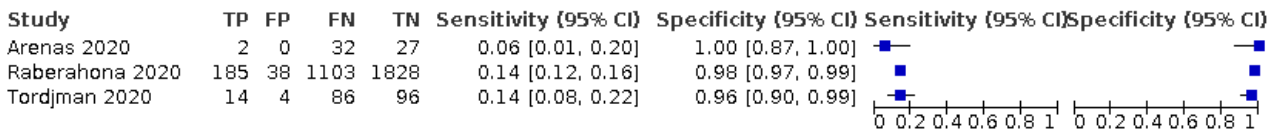
**Test TST-128. Expectoration (retrospective data collection)**

Expectoration (retrospective data collection)



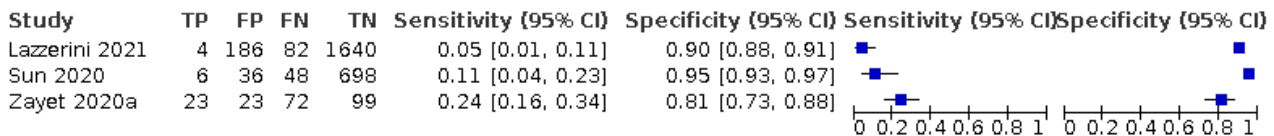
**Test TST-129. Ageusia (retrospective data collection)**

Ageusia (retrospective data collection)



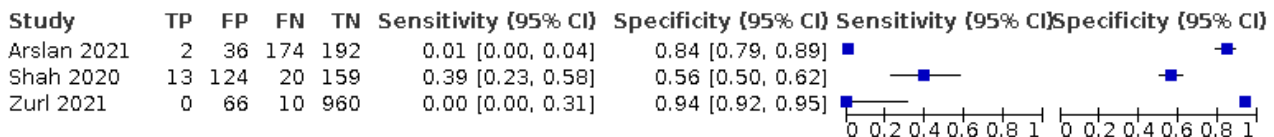
**Test TST-130. Positive auscultation findings (retrospective data collection)**

Positive auscultation findings (retrospective data collection)



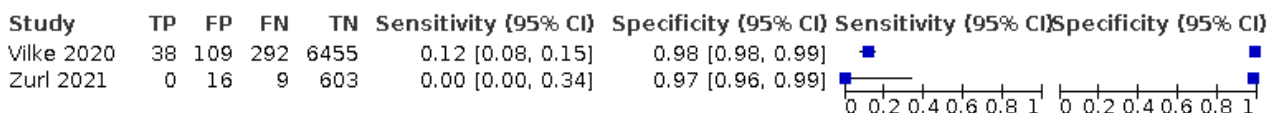
**Test TST-131. Tachypnea (retrospective data collection)**

Tachypnea (retrospective data collection)



**Test TST-132. Anosmia/dysosmia or ageusia/dysgeusia (retrospective data collection))**

Anosmia/dysosmia or ageusia/dysgeusia (retrospective data collection))



**Test TST-133. Earache (retrospective data collection)**

Earache (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Huang 2020	1	0	335	139	0.00 [0.00, 0.02]	1.00 [0.97, 1.00]		
Raberahona 2020	7	15	1281	1851	0.01 [0.00, 0.01]	0.99 [0.99, 1.00]		

**Test TST-134. Sneezing (retrospective data collection)**

Sneezing (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
King 2020	132	18	1855	458	0.07 [0.06, 0.08]	0.96 [0.94, 0.98]		
Mao 2020	2	2	186	814	0.01 [0.00, 0.04]	1.00 [0.99, 1.00]		

**Test TST-135. Dizziness (retrospective data collection)**

Dizziness (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Barbhaya 2021	36	50	810	1575	0.04 [0.03, 0.06]	0.97 [0.96, 0.98]		
Wei 2020	1	0	627	308	0.00 [0.00, 0.01]	1.00 [0.99, 1.00]		

**Test TST-136. Malaise (retrospective data collection)**

Malaise (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Chan 2021	74	28	436	183	0.15 [0.12, 0.18]	0.87 [0.81, 0.91]		
King 2020	165	25	1822	451	0.08 [0.07, 0.10]	0.95 [0.92, 0.97]		

**Test TST-137. Fever (subjective) (retrospective data collection)**

Fever (subjective) (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Barbhaya 2021	520	498	326	1127	0.61 [0.58, 0.65]	0.69 [0.67, 0.72]		
Shah 2020	27	125	6	158	0.82 [0.65, 0.93]	0.56 [0.50, 0.62]		

**Test TST-138. Enlargement of lymph nodes (retrospective data collection)**

Enlargement of lymph nodes (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Huang 2020	0	2	336	137	0.00 [0.00, 0.01]	0.99 [0.95, 1.00]		
Lizzerini 2021	11	158	148	1831	0.07 [0.04, 0.12]	0.92 [0.91, 0.93]		

### Test TST-139. Conjunctivitis (retrospective data collection)

#### Conjunctivitis (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Lazerini 2021	8	60	151	1929	0.05 [0.02, 0.10]	0.97 [0.96, 0.98]		
Pisapia 2020	1	2	16	18	0.06 [0.00, 0.29]	0.90 [0.68, 0.99]		

### Test TST-140. Hypoxia (retrospective data collection)

#### Hypoxia (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Arslan 2021	3	18	173	210	0.02 [0.00, 0.05]	0.92 [0.88, 0.95]		
Lazerini 2021	1	21	65	1554	0.02 [0.00, 0.08]	0.99 [0.98, 0.99]		

### Test TST-141. Pulmonary auscultation: rhonchi (retrospective data collection)

#### Pulmonary auscultation: rhonchi (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Arslan 2021	5	63	171	165	0.03 [0.01, 0.07]	0.72 [0.66, 0.78]		
Zurl 2021	1	88	9	942	0.10 [0.00, 0.45]	0.91 [0.90, 0.93]		

### Test TST-142. Loss of appetite (retrospective data collection)

#### Loss of appetite (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Haliga 2021	3	10	17	223	0.15 [0.03, 0.38]	0.96 [0.92, 0.98]		
Mao 2020	24	55	164	761	0.13 [0.08, 0.18]	0.93 [0.91, 0.95]		

### Test TST-143. Altered mentation/confusion (retrospective data collection)

#### Altered mentation/confusion (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Mart&#237;n-S&#225;nchez 2020	9	9	431	218	0.02 [0.01, 0.04]	0.96 [0.93, 0.98]		
Shah 2020	2	39	31	244	0.06 [0.01, 0.20]	0.86 [0.82, 0.90]		

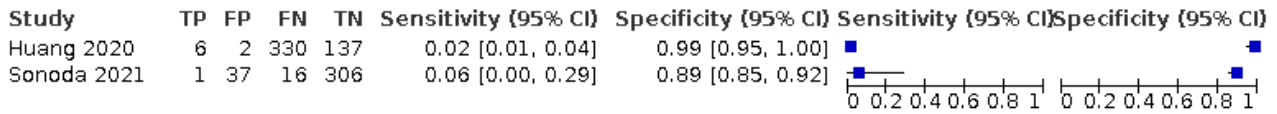
### Test TST-144. Presyncope or syncope (retrospective data collection)

#### Presyncope or syncope (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Langer 2020	2	3	122	72	0.02 [0.00, 0.06]	0.96 [0.89, 0.99]		
Mart&#237;n-S&#225;nchez 2020	21	9	419	218	0.05 [0.03, 0.07]	0.96 [0.93, 0.98]		

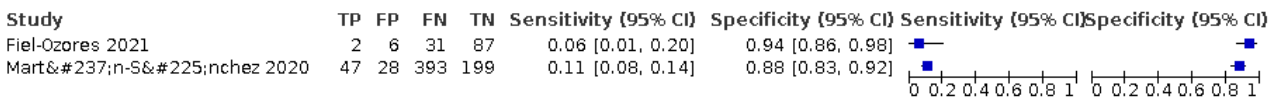
**Test TST-145. Stomach ache (retrospective data collection)**

Stomach ache (retrospective data collection)



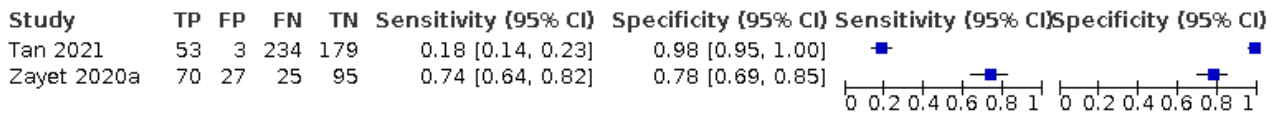
**Test TST-146. Odynophagia (retrospective data collection)**

Odynophagia (retrospective data collection)



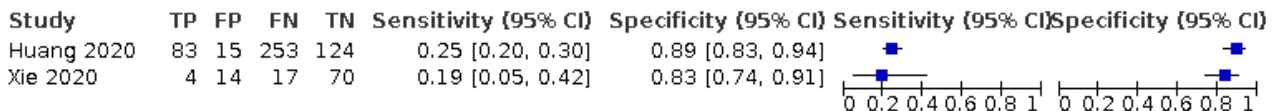
**Test TST-147. Anosmia or dysgeusia (retrospective data collection)**

Anosmia or dysgeusia (retrospective data collection)



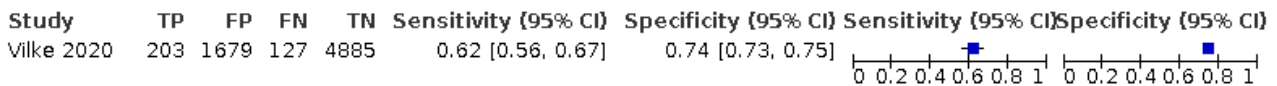
**Test TST-148. Weakness or fatigue (retrospective data collection)**

Weakness or fatigue (retrospective data collection)



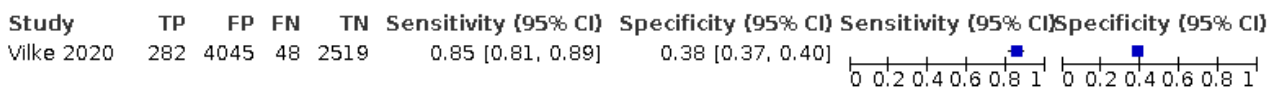
**Test TST-149. Objective fever (≥ 38 °C) or recent fever/chills (retrospective)**

Objective fever (≥ 38 °C) or recent fever/chills (retrospective)



**Test TST-150. Body aches or fatigue or dyspnoea or cough or objective fever (≥ 38 °C) or recent fever/chills (retrospective)**

Body aches or fatigue or dyspnoea or cough or objective fever (≥ 38 °C) or recent fever/chills (retrospective)



**Test TST-151. Fatigue or dyspnoea or cough or objective fever ( $\geq 38^\circ\text{C}$ ) or recent fever/chills (retrospective)**

Fatigue or dyspnoea or cough or objective fever ( $\geq 38^\circ\text{C}$ ) or recent fever/chills (retrospective)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Vilke 2020	280	4001	50	2563	0.85 [0.81, 0.89]	0.39 [0.38, 0.40]		

**Test TST-152. Dyspnoea or cough or objective fever ( $\geq 38^\circ\text{C}$ ) or recent fever/chills (retrospective)**

Dyspnoea or cough or objective fever ( $\geq 38^\circ\text{C}$ ) or recent fever/chills (retrospective)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Vilke 2020	274	3430	56	3134	0.83 [0.79, 0.87]	0.48 [0.47, 0.49]		

**Test TST-153. Cough or objective fever ( $\geq 38^\circ\text{C}$ ) or recent fever/chills (retrospective)**

Cough or objective fever ( $\geq 38^\circ\text{C}$ ) or recent fever/chills (retrospective)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Vilke 2020	266	2680	64	3884	0.81 [0.76, 0.85]	0.59 [0.58, 0.60]		

**Test TST-154. Recent fever or chills (retrospective data collection)**

Recent fever or chills (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Vilke 2020	193	1608	137	4956	0.58 [0.53, 0.64]	0.76 [0.74, 0.77]		

**Test TST-155. Sinusitis (retrospective data collection)**

Sinusitis (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Vilke 2020	31	266	299	6298	0.09 [0.06, 0.13]	0.96 [0.95, 0.96]		

**Test TST-156. Systemic soreness (malaise/myalgia/arthralgia) (retrospective)**

Systemic soreness (malaise/myalgia/arthralgia) (retrospective)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Vilke 2020	59	420	271	6144	0.18 [0.14, 0.22]	0.94 [0.93, 0.94]		

**Test TST-157. Malaise or fatigue (retrospective data collection)**

Malaise or fatigue (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Raberahona 2020	403	303	885	1563	0.31 [0.29, 0.34]	0.84 [0.82, 0.85]		

**Test TST-158. Lethargy (retrospective data collection)**

Lethargy (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Ahmed 2021	40	461	83	1237	0.33 [0.24, 0.42]	0.73 [0.71, 0.75]		

**Test TST-159. Nausea or vomiting or diarrhoea (retrospective data collection)**

Nausea or vomiting or diarrhoea (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Sacks 2020	38	258	119	1332	0.24 [0.18, 0.32]	0.84 [0.82, 0.86]		

**Test TST-160. Respiratory triage score > 4 (retrospective data collection)**

Respiratory triage score > 4 (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Aldobyany 2020	224	557	116	538	0.66 [0.61, 0.71]	0.49 [0.46, 0.52]		

**Test TST-161. Respiratory triage score > 5 (retrospective data collection)**

Respiratory triage score > 5 (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Aldobyany 2020	218	485	122	610	0.64 [0.59, 0.69]	0.56 [0.53, 0.59]		

**Test TST-162. Lower respiratory tract symptoms (retrospective data collection)**

Lower respiratory tract symptoms (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Simpson 2020	13	54	365	778	0.03 [0.02, 0.06]	0.94 [0.92, 0.95]		



**Test TST-163. Neurologic symptoms (not specified; retrospective data collection)**

Neurologic symptoms (not specified; retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Simpson 2020	71	124	307	708	0.19 [0.15, 0.23]	0.85 [0.82, 0.87]		

**Test TST-164. Upper respiratory tract symptoms (retrospective data collection)**

Upper respiratory tract symptoms (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Simpson 2020	119	266	259	566	0.31 [0.27, 0.36]	0.68 [0.65, 0.71]		

**Test TST-165. Laryngitis/hoarseness/stridor (retrospective data collection)**

Laryngitis/hoarseness/stridor (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Zurl 2021	1	119	8	923	0.11 [0.00, 0.48]	0.89 [0.86, 0.90]		

**Test TST-166. High fever (≥ 38.5 °C) (retrospective data collection)**

High fever (≥ 38.5 °C) (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Mao 2020	33	234	155	582	0.18 [0.12, 0.24]	0.71 [0.68, 0.74]		

**Test TST-167. Abdominal distention (retrospective data collection)**

Abdominal distention (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Wei 2020	0	1	628	307	0.00 [0.00, 0.01]	1.00 [0.98, 1.00]		

**Test TST-168. Aversion to cold (retrospective data collection)**

Aversion to cold (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Wei 2020	1	1	627	307	0.00 [0.00, 0.01]	1.00 [0.98, 1.00]		

**Test TST-169. Xerostomia (retrospective data collection)**

Xerostomia (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Wei 2020	1	0	627	308	0.00 [0.00, 0.01]	1.00 [0.99, 1.00]		

**Test TST-170. Hypersomnia (retrospective data collection)**

Hypersomnia (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Wei 2020	1	0	627	308	0.00 [0.00, 0.01]	1.00 [0.99, 1.00]		

**Test TST-171. Hyposmia (retrospective data collection)**

Hyposmia (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Chua 2020	3	8	28	678	0.10 [0.02, 0.26]	0.99 [0.98, 0.99]		

**Test TST-172. Fever and cough and dyspnoea (retrospective)**

Fever and cough and dyspnoea (retrospective)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Yombi 2020	33	31	142	330	0.19 [0.13, 0.25]	0.91 [0.88, 0.94]		

**Test TST-173. Fever and cough and sore throat (retrospective)**

Fever and cough and sore throat (retrospective)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Yombi 2020	48	44	127	317	0.27 [0.21, 0.35]	0.88 [0.84, 0.91]		

**Test TST-174. Fever and cough (retrospective data collection)**

Fever and cough (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Yombi 2020	85	65	90	296	0.49 [0.41, 0.56]	0.82 [0.78, 0.86]		

**Test TST-175. Unconsciousness (retrospective data collection)**

Unconsciousness (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Huang 2020	1	0	335	139	0.00 [0.00, 0.02]	1.00 [0.97, 1.00]		

**Test TST-176. Rash (retrospective data collection)**

Rash (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Huang 2020	2	0	334	139	0.01 [0.00, 0.02]	1.00 [0.97, 1.00]		

**Test TST-177. Fever or cough or dyspnoea (retrospective data collection)**

Fever or cough or dyspnoea (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Arslan 2021	104	210	72	18	0.59 [0.51, 0.66]	0.08 [0.05, 0.12]		

**Test TST-178. Pulmonary auscultation: crackling (retrospective data collection)**

Pulmonary auscultation: crackling (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Arslan 2021	18	68	158	160	0.10 [0.06, 0.16]	0.70 [0.64, 0.76]		

**Test TST-179. Dysphonia (retrospective data collection)**

Dysphonia (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Haliga 2021	0	7	20	226	0.00 [0.00, 0.17]	0.97 [0.94, 0.99]		

**Test TST-180. Dry cough (retrospective data collection)**

Dry cough (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Shah 2020	12	62	21	221	0.36 [0.20, 0.55]	0.78 [0.73, 0.83]		

**Test TST-181. History of fever at home (retrospective data collection)**

History of fever at home (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Haliga 2021	12	74	8	159	0.60 [0.36, 0.81]	0.68 [0.62, 0.74]		

**Test TST-182. Cough or dyspnoea (retrospective data collection)**

Cough or dyspnoea (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Kim 2020	13	55	41	133	0.24 [0.13, 0.38]	0.71 [0.64, 0.77]		

**Test TST-183. Anosmia and dysgeusia (retrospective data collection)**

Anosmia and dysgeusia (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Zayet 2020a	52	11	43	111	0.55 [0.44, 0.65]	0.91 [0.84, 0.95]		

**Test TST-184. Palpitations (retrospective data collection)**

Palpitations (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Feng 2021	0	3	7	122	0.00 [0.00, 0.41]	0.98 [0.93, 1.00]		

**Test TST-185. Anosmia or hyposmia (retrospective data collection)**

Anosmia or hyposmia (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Fiel-Ozores 2021	0	1	33	92	0.00 [0.00, 0.11]	0.99 [0.94, 1.00]		

**Test TST-186. Myalgia or fatigue (retrospective data collection)**

Myalgia or fatigue (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Zhu 2020	5	6	27	78	0.16 [0.05, 0.33]	0.93 [0.85, 0.97]		

**Test TST-187. Respiratory distress (retrospective data collection)**

Respiratory distress (retrospective data collection)

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Vieceli 2020	2	16	27	55	0.07 [0.01, 0.23]	0.77 [0.66, 0.87]		

**ADDITIONAL TABLES**

**Table 1. QUADAS-2 checklist**

Index test(s)	Signs and symptoms
<b>Patients (setting, intended use of index test, presentation, prior testing)</b>	<p>Primary care, hospital outpatient settings including emergency departments</p> <p>Inpatients presenting with suspected COVID-19</p> <p>No prior testing</p> <p>Signs and symptoms often used for triage or referral</p>
<b>Reference standard and target condition</b>	The focus will be on the diagnosis of COVID-19 disease and COVID-19 pneumonia. For this review, the focus will not be on prognosis.
<b>Participant selection</b>	
<b>Was a consecutive or random sample of patients enrolled?</b>	<p>This will be similar for all index tests, target conditions, and populations.</p> <p>YES: if a study explicitly stated that all participants within a certain time frame were included; that this was done consecutively; or that a random selection was done.</p> <p>NO: if it was clear that a different selection procedure was employed; for example, selection based on clinician's preference, or based on institutions.</p> <p>UNCLEAR: if the selection procedure was not clear or not reported.</p>
<b>Was a case-control design avoided?</b>	<p>This will be similar for all index tests, target conditions, and populations.</p> <p>YES: if a study explicitly stated that all participants came from the same group of (suspected) patients.</p> <p>NO: if it was clear that a different selection procedure was employed for the participants depending on their COVID-19 (pneumonia) status or SARS-CoV-2 infection status.</p> <p>UNCLEAR: if the selection procedure was not clear or not reported.</p>
<b>Did the study avoid inappropriate exclusions?</b>	<p>Studies may have excluded participants, or selected participants in such a way that they avoided including those who were difficult to diagnose or likely to be borderline. Although the inclusion and exclusion criteria will be different for the different index tests, inappropriate exclusions and inclusions will be similar for all index tests: for example, only elderly patients excluded, or children (as sampling may be more difficult). This needs to be addressed on a case-by-case basis.</p> <p>YES: if a high proportion of eligible patients was included without clear selection.</p> <p>NO: if a high proportion of eligible patients was excluded without providing a reason; if, in a retrospective study, participants without index test or reference standard results were excluded; if exclusion was based on severity assessment post-factum or comorbidities (cardiovascular disease, diabetes, immunosuppression).</p>

**Table 1. QUADAS-2 checklist** *(Continued)*

	UNCLEAR: if the exclusion criteria were not reported.
<b>Did the study avoid inappropriate inclusions?</b>	<p>YES: if samples included were likely to be representative of the spectrum of disease.</p> <p>NO: if the study oversampled patients with particular characteristics likely to affect estimates of accuracy.</p> <p>UNCLEAR: if the exclusion criteria were not reported.</p>
<b>Could the selection of patients have introduced bias?</b>	<p>HIGH: if one or more signalling questions were answered with NO, as any deviation from the selection process may lead to bias.</p> <p>LOW: if all signalling questions were answered with YES.</p> <p>UNCLEAR: all other instances.</p>
<b>Is there concern that the included patients do not match the review question?</b>	<p>HIGH: if accuracy of signs and symptoms were assessed in a case-control design, or in an already highly selected group of participants, or the study was able to only estimate sensitivity or specificity.</p> <p>LOW: any situation where signs and symptoms were the first assessment/test to be done on the included participants.</p> <p>UNCLEAR: if a description about the participants was lacking.</p>
<b>Index tests</b>	
<b>Were the index test results interpreted without knowledge of the results of the reference standard?</b>	<p>This will be similar for all index tests, target conditions, and populations.</p> <p>YES: if blinding was explicitly stated or index test was recorded before the results from the reference standard were available.</p> <p>NO: if it was explicitly stated that the index test results were interpreted with knowledge of the results of the reference standard.</p> <p>UNCLEAR: if blinding was unclearly reported.</p>
<b>If a threshold was used, was it prespecified?</b>	<p>This will be similar for all index tests, target conditions, and populations.</p> <p>YES: if the test was dichotomous by nature, or if the threshold was stated in the methods section, or if authors stated that the threshold as recommended by the manufacturer was used.</p> <p>NO: if a receiver operating characteristic curve was drawn or multiple threshold reported in the results section; and the final result was based on one of these thresholds; if fever was not defined beforehand.</p> <p>UNCLEAR: if threshold selection was not clearly reported.</p>
<b>Could the conduct or interpretation of the index test have introduced bias?</b>	<p>HIGH: if one or more signalling questions were answered with NO, as even in a laboratory situation knowledge of the reference standard may lead to bias.</p> <p>LOW: if all signalling questions were answered with YES.</p> <p>UNCLEAR: all other instances.</p>
<b>Is there concern that the index test, its conduct, or interpretation differ from the review question?</b>	<p>This will probably be answered 'LOW' in all cases except when assessments were made in a different setting, or using personnel not available in practice.</p>
<b>Reference standard</b>	

**Table 1. QUADAS-2 checklist** (Continued)

<b>Is the reference standard likely to correctly classify the target condition?</b>	<p>We will define acceptable reference standards using a consensus process once the list of reference standards that have been used has been obtained from the eligible studies.</p> <p>For severe pneumonia, we will consider how well processes adhered to the WHO case definition in <a href="#">Appendix 1</a>.</p>
<b>Were the reference standard results interpreted without knowledge of the results of the index test?</b>	<p>YES: if it was explicitly stated that the reference standard results were interpreted without knowledge of the results of the index test, or if the result of the index test was obtained after the reference standard.</p> <p>NO: if it was explicitly stated that the reference standard results were interpreted with knowledge of the results of the index test or if the index test was used to make the final diagnosis.</p> <p>UNCLEAR: if blinding was unclearly reported.</p>
<b>Did the definition of the reference standard incorporate results from the index test(s)?</b>	<p>YES: if results from the index test were a component of the reference standard definition.</p> <p>NO: if the reference standard did not incorporate the index standard test.</p> <p>UNCLEAR: if it was unclear whether the results of the index test formed part of the reference standard.</p>
<b>Could the conduct or interpretation of the reference standard have introduced bias?</b>	<p>HIGH: if one or more signalling questions were answered with NO.</p> <p>LOW: if all signalling questions were answered with YES.</p> <p>UNCLEAR: all other instances.</p>
<b>Is there concern that the target condition as defined by the reference standard does not match the review question?</b>	<p>HIGH: if the target condition was COVID-19 pneumonia, but only RT-PCR was used; if alternative diagnosis was highly likely and not excluded (will happen in paediatric cases, where exclusion of other respiratory pathogens is also necessary); if tests used to follow up viral load in known test-positives.</p> <p>LOW: if above situations were not present.</p> <p>UNCLEAR: if intention for testing was not reported in the study.</p>
<b>Flow and timing</b>	
<b>Was there an appropriate interval between index test(s) and reference standard?</b>	<p>YES: this will be similar for all index tests, populations for the current infection target conditions: as the situation of a patient, including clinical presentation and disease progress, evolves rapidly and new/ongoing exposure can result in case status change, an appropriate time interval will be within 24 h.</p> <p>NO: if there was more than 24 h between the index test and the reference standard or if participants were otherwise reported to be assessed with the index versus reference standard test at moments of different severity.</p> <p>UNCLEAR: if the time interval was not reported.</p>
<b>Did all patients receive a reference standard?</b>	<p>YES: if all participants received a reference standard (clearly no partial verification).</p> <p>NO: if only (part of) the index test-positives or index test-negatives received the complete reference standard.</p> <p>UNCLEAR: if it was not reported.</p>
<b>Did all patients receive the same reference standard?</b>	<p>YES: if all participants received the same reference standard (clearly no differential verification).</p> <p>NO: if (part of) the index test-positives or index test-negatives received a different reference standard.</p>

**Table 1. QUADAS-2 checklist** *(Continued)*

	UNCLEAR: if it was not reported.
<b>Were all patients included in the analysis?</b>	<p>YES: if all included participants were included in the analyses.</p> <p>NO: if after the inclusion/exclusion process, participants were removed from the analyses for different reasons: no reference standard done, no index test done, intermediate results of both index test or reference standard, indeterminate results of both index test or reference standard, samples unusable.</p> <p>UNCLEAR: if this was not clear from the reported numbers.</p>
<b>Could the patient flow have introduced bias?</b>	<p>HIGH: if one or more signalling questions were answered with NO.</p> <p>LOW: if all signalling questions were answered with YES.</p> <p>UNCLEAR: all other instances.</p>
<p><b>ICU:</b> intensive care unit; <b>RT-PCR:</b> reverse transcription polymerase chain reaction; <b>SARS-CoV-2:</b> severe acute respiratory syndrome coronavirus 2; <b>WHO:</b> World Health Organization</p>	



**Table 2. Study characteristics (cross-sectional prospective studies only)**

Study ID	Target condition	Sample size	Prevalence	Country	Setting	Population	Reference standard
<a href="#">Alizadehsani 2021</a>	COVID-19 pneumonia	319	39%	Iran	ED	All patients referred to the imaging department on suspicion of COVID-19 (with flu-like symptoms)	Thin-slice high-resolution multi-slice spiral CT scan in a supine position, and high-resolution CT images
<a href="#">Bhattacharya 2021</a>	COVID-19	378	33%	India	ED	Patients who were suspected of COVID-19. From 1066 suspected patients who were tested during this period, 384 patients were enrolled in the study based on the availability of informed consent and successful telephonic communication. Suspicion based on the testing advisory developed by the Indian Council of Medical Research (ICMR), Version 5, dated May 18, 2020. "ILI symptoms", defined as acute respiratory infection with fever $\geq 38^\circ\text{C}$ AND cough	RT-PCR for SARS-CoV-2 (nasal + throat swab)
<a href="#">Bouزيد 2020</a>	COVID-19	596	45%	France	ED	All consecutive patients presenting with an influenza-like illness (ILI: fever with a temperature $> 38.5^\circ\text{C}$ , malaise, headache, and myalgia; and 1 respiratory symptom (cough, sore throat, and dyspnoea)) and admitted to the hospital through the ED	Either with QIAS-tat-Dx Respiratory SARS-CoV-2 Panel or with a combination of the RT-PCR RealStar SARS-CoV-2 Kit RUO and rapid multiplex PCR FilmArray RP2; specimen not specified
<a href="#">Brendish 2020</a>	COVID-19	1054	33%	UK	ED	All consecutive adults presenting with an acute respiratory illness or otherwise clinically suspected of having COVID-19	Either laboratory RT-PCR or MPOCT (QIAGEN) for SARS-CoV-2 (nasopharyngeal swab)
<a href="#">Buonafine 2020</a>	COVID-19	295	42%	Brazil	Outpatient setting	HCW with self-reported fever or any of the following: acute respiratory symptoms (cough, nasal congestion, sore throat, shortness of breath), loss or changed sense of	RT-PCR for SARS-CoV-2 (nasopharyngeal and oropharyngeal swab)

**Table 2. Study characteristics (cross-sectional prospective studies only)** (Continued)

						smell or taste, ocular symptoms, headache, arthralgia, myalgia, fatigue, diarrhoea, nausea, and vomiting	
<a href="#">Clemency 2020</a>	COVID-19	961	23%	USA	Outpatient setting	HCWs triaged by phone, tested at drive-through site	RT-PCR on nasopharyngeal or oropharyngeal swabs
<a href="#">Drager 2020</a>	COVID-19	2257	7%	Germany	Outpatient setting	All patients presenting themselves at the outpatient clinic: patients with symptoms (not further specified) + high-risk contacts or returning from a high-risk area were tested for SARS-CoV-2	Not specified (throat swab)
<a href="#">Fink 2021</a>	COVID-19/ COVID-19 pneumonia	219	33%	Germany	ED	Patients who presented at ED with signs of a respiratory infection suspicious for COVID-19 and received radiological imaging as well as RT-PCR for SARS-CoV-2	RT-PCR for SARS-CoV-2 (nasopharyngeal and oropharyngeal swab)
<a href="#">Gilbert 2020</a>	COVID-19	598	29%	Belgium	Outpatient setting	Suspected patients sent to testing centres close to ED	RT-PCR on nasopharyngeal swabs
<a href="#">Haehner 2020</a>	COVID-19	500	7%	Germany	Outpatient setting	Patients presenting with symptoms of a common cold to a corona testing centre	RT-PCR on throat swabs
<a href="#">Ishii 2021</a>	COVID-19	3540	5%	Japan	Outpatient setting	All consecutive participants who underwent drive-through nasopharyngeal swab testing at an outpatient clinic. Reason for testing: upon request of the participant or participants who had been confirmed to have contacted COVID-19 patients based on contact tracing. No clinical suspicion needed per se, but 54% of individuals were symptomatic, suggestive of COVID-19	RT-PCR, nasopharyngeal swab
<a href="#">Jeyashree 2021</a>	COVID-19	277	21%	India	Outpatient setting	All consecutive adults who visited COVID-19 testing centres in Chennai city in Southern India	RT-PCR, nasopharyngeal swab
<a href="#">Just 2020</a>	COVID-19	374	11%	Germany	Primary care	Convenience sample of patients who were tested in GPs' practices	RT-PCR, samples not specified

**Table 2. Study characteristics (cross-sectional prospective studies only)** (Continued)

<a href="#">Kalayjian 2020</a>	COVID-19	345	34%	USA	Outpatient setting	Clients entering the health centre (walk-in clinic) were screened for symptoms and triaged to the COVID-19 clinic. Testing was performed for patients with a documented or subjective fever within the past 72 h.	Labcorp's nucleic-acid amplification, threshold not specified, nasopharyngeal swabs
<a href="#">Kempker 2020</a>	COVID-19	283	18%	USA	Outpatient setting	HCWs with a viral-like illness, triaged to the employee health services staff for a virtual clinical assessment and then scheduled for SARS-CoV-2 testing	RT-PCR, nasopharyngeal swab
<a href="#">Krastinova 2020</a>	COVID-19	314	110	France	Outpatient setting	Symptomatic HCWs, defined as the presence of fever and/or respiratory symptoms	RT-PCR, nasopharyngeal swabs
<a href="#">Leal 2020</a>	COVID-19	1583	28%	Brazil	Outpatient setting	Patients meeting the suspected COVID-19 case definition (tested after initial screening questionnaire)	RT-PCR, samples not specified
<a href="#">Maechler 2020</a>	COVID-19	4333	8%	Germany	Outpatient setting	Until 24 March 2020: symptomatic patients with high-risk contacts or return from high-risk area. From 24 March: also symptomatic people with risk factors and if the test capacity allowed also only symptomatic patients. Plus 2 subgroups of high-risk patients in a nightclub and Charité employees	SARS-CoV-2 RT-PCR test (combined oro- and nasopharyngeal swab)
<a href="#">Mansella 2020</a>	COVID-19	4815	12%	Switzerland	Outpatient setting	All patients presenting at the test centre with respiratory symptoms (such as shortness of breath), other flu-like symptoms (fever, sore throat, cough) and self-reported exposure to COVID-19	RT-PCR, 2 swabs from naso- and oropharyngeal sites combined into 1
<a href="#">Martin-Sanz 2020</a>	COVID-19	355	61%	Spain	Outpatient setting	HCWs with suspicion of COVID-19 infection. Suspicion of COVID-19 was determined by the presence of either cough, fever (> 37.5 °C), headache, or breathlessness, regardless of contact with a COVID-19 patient	SARS-CoV-2 next-generation sequencing or real-time (RT)-PCR methods (nasal and pharyngeal swabs)
<a href="#">Nazerian 2021</a>	COVID-19	838	23%	Italy	ED	Patients with suspected COVID-19 were prospectively enrolled in 2 EDs	RT-PCR, positive result within 5 days after ED presentation, or sugges-

**Table 2. Study characteristics (cross-sectional prospective studies only)** (Continued)

							tive symptoms plus chest imaging (showing acute interstitial lung disease in the absence of an alternative diagnosis), or panel adjudication (for 3 cases without a positive PCR)
<a href="#">Olivar Lopez 2020</a>	COVID-19	510	15%	Mexico	ED	All patients < 18 years who presented with a clinical picture compatible with COVID-19 (= fever, respiratory symptoms or general malaise) at the ED of a COVID paediatric reference hospital	RT-PCR, nasopharyngeal swabs
<a href="#">O'Reilly 2020a</a>	COVID-19	240	5%	Australia	ED	Patients who meet the testing criteria for COVID-19 and who present at the ED	RT-PCR, sample not specified
<a href="#">O'Reilly 2020b</a>	COVID-19	1334	4%	Australia	ED	All adult patients who met criteria for "suspected COVID-19" and underwent testing for SARS-CoV-2 were eligible for inclusion. Testing criteria guided by various health jurisdictions and evolved throughout the project	SARS-CoV-2 RT-PCR test (nasopharyngeal swab)
<a href="#">Peyrony 2020</a>	COVID-19	391	58%	France	ED	Patients tested at ED, decision to test based on clinician's discretion	RT-PCR on nasal swabs
<a href="#">Pivetta 2020</a>	COVID-19	228	47%	Italy	ED	All adults ( $\geq 18$ years) who screened positive for acute symptoms associated with SARS-CoV-2 infection at triage (= fever, dyspnoea, new or worsening cough, sore throat, diarrhoea, ageusia, anosmia and asthenia)	RT-PCR (nasopharyngeal swabs), and in some cases other information including clinical, lab, imaging
<a href="#">Pokorska-Śpiewak 2021</a>	COVID-19	319	5%	Poland	Mixed in/out-patient paediatric setting	All consecutive paediatric patients referred to a tertiary healthcare department (referral based on clinical symptoms (WHO definition) of the disease or positive epidemiological history (international travel or contact with infected person)	RT-PCR (nasopharyngeal swabs)

**Table 2. Study characteristics (cross-sectional prospective studies only)** (Continued)

<a href="#">Porto 2021</a>	COVID-19	1297	32%	Brazil	Outpatient setting	All patients presenting at the Piquet Carneiro Polyclinic, test indication not specified, but high proportion of symptomatic individuals in recruited population	RT-PCR (nasopharyngeal swabs)
<a href="#">Romero-Gameros 2020</a>	COVID-19	139	52%	Mexico	ED	Patients who sought a respiratory triage assessment at ED of tertiary care hospital due to COVID-19 suspicion	RT-PCR (nasopharyngeal swabs)
<a href="#">Romero-Gameros 2021</a>	COVID-19	2137	54%	Mexico	ED	Adults > 17 years, with high clinical probability of SARS-CoV-2 and confirmatory RT-PCR available	RT-PCR (nasopharyngeal swabs)
<a href="#">Rutten 2020a</a>	COVID-19	1969	44%	The Netherlands	Nursing home	Patients with at least 2 of the following symptoms: fever/feverish feeling, cough and shortness of breath - later on (from 10 April 2020) patients with atypical symptoms were added	RT-PCR test (specimen not specified)
<a href="#">Rutten 2020b</a>	COVID-19	4007	38%	The Netherlands	Nursing home	All nursing home residents with a clinical suspicion of COVID-19 based on the physician's assessment and for whom they had the result of the RT-PCR	RT-PCR test (specimen not specified)
<a href="#">Saegerman 2021</a>	COVID-19	2152	27%	Belgium	ED	All suspected patients directed to the triage centres of 2 university hospital EDs (no definition of 'suspected')	RT-PCR test (specimen not specified)
<a href="#">Salmon Ceron 2020</a>	COVID-19	1824	47%	France	Outpatient setting	Patients suspected of SARS-CoV-2 infection, tested at screening centre	RT-PCR test (nasopharyngeal swabs)
<a href="#">Trubiano 2020</a>	COVID-19	2935	4%	Australia	Outpatient setting	Patients presenting at a COVID-19 rapid assessment screening clinic, meeting DHHS screening criteria <sup>a</sup>	RT-PCR test (nasopharyngeal swabs)
<a href="#">Tudrej 2020</a>	COVID-19	816	24%	France	Primary care/outpatient setting	Patients referred by GPs for PCR testing at lab	RT-PCR test (nasopharyngeal swabs)
<a href="#">Van Loon 2021</a>	COVID-19	373	50%	Belgium	Outpatient setting	All hospital HCWs self-reporting mild symptoms of an acute upper or lower respiratory	RT-PCR test (nasopharyngeal swab)



**Table 2. Study characteristics (cross-sectional prospective studies only)** (Continued)

						ry tract infection were tested in a large non-academic hospital	
<a href="#">Van Walraven 2021</a>	COVID-19	9172	6%	Canada	Outpatient setting	Presence of symptoms including rhinorrhoea; fever symptoms including rigor, chills, perceived fever, or documented fever at home or at the screening clinic; cough; and shortness of breath. Any infection risk factor including close contact with a person with known or presumed COVID-19 disease or recent travel outside of Canada. In the absence of these indications, HCWs were included if they had symptoms of sore throat, sputum production, or rhinorrhoea.	RT-PCR test (nasopharyngeal and throat swabs)
<a href="#">Villerabel 2021</a>	COVID-19	809	7%	France	Outpatient setting	All HCWs and adult patients presenting themselves at the COVID-19 screening facility of the university hospital of Montpellier	RT-PCR test (nasopharyngeal swabs)
<a href="#">Wee 2020</a>	COVID-19	870	18%	Singapore	ED	Patients presenting with respiratory symptoms or travel history	RT-PCR test (nasopharyngeal swabs)
<a href="#">Wernhart 2020</a>	COVID-19	80	6%	Germany	Primary care	All patients with respiratory symptoms reporting to 3 rural GP offices in North Rhine-Westphalia, Germany	RT-PCR test (nasopharyngeal swabs)
<a href="#">Yonker 2020</a>	COVID-19	174	28%	USA	Mixed in/out-patient paediatric setting	Paediatric patients $\leq$ 22 years of age; symptoms concerning for COVID-19 or admitted for acute symptoms related to COVID-19 or multisystem inflammatory syndrome in children	RT-PCR test (nasopharyngeal or oropharyngeal swabs)
<p><b>CT:</b> computed tomography; <b>ED:</b> emergency department; <b>GP:</b> general practitioner; <b>HCW:</b> healthcare worker; <b>MPOCT:</b> molecular point-of-care test; <b>RT-PCR:</b> reverse transcription polymerase chain reaction; <b>WHO:</b> World Health Organization</p>							

<sup>a</sup>DHHS (Victorian Department of Health and Human Services) criteria for SARS-CoV-2 testing: fever OR chills in the absence of an alternative diagnosis that explains the clinical presentation OR acute respiratory infection symptoms (e.g. cough, sore throat, shortness of breath, runny nose, loss of smell or loss of taste)

**Table 3. Summary estimates of test accuracy for selected index tests, including 95% confidence intervals (bivariate meta-analysis of prospective studies with low risk of bias for participant selection)**

Index test	Number of studies	Number of COVID-19 positives/ Total number of participants (%)	Summary sensitivity % (95% CI)	Summary specificity % (95% CI)	Summary LR+ (95% CI)	Summary LR- (95% CI)
<b>Fever</b>	12	3221/28,495 (11.3)	37.6 (23.4 to 54.3)	75.2 (56.3 to 87.8)	1.520 (1.099 to 2.101)	0.829 (0.740 to 0.928)
<b>Dyspnoea</b>	12	2753/19,545 (14.1)	23.3 (16.4 to 31.9)	75.7 (65.2 to 83.9)	0.959 (0.830 to 1.107)	1.013 (0.966 to 1.063)
<b>Cough</b>	11	2586/18,702 (13.8)	62.4 (50.6 to 72.9)	45.4 (33.5 to 57.9)	1.143 (1.043 to 1.253)	0.828 (0.738 to 0.928)
<b>Diarrhoea</b>	11	1633/13,669 (11.9)	18.5 (15.7 to 21.6)	84.1 (79.4 to 87.9)	1.167 (0.967 to 1.408)	0.969 (0.935 to 1.003)
<b>Sore throat</b>	10	2116/14,548 (14.5)	31.0 (20.2 to 44.5)	61.9 (46.7 to 75.0)	0.814 (0.714 to 0.929)	1.114 (1.021 to 1.216)
<b>Fatigue</b>	8	1286/7967 (16.1)	40.2 (19.4 to 65.1)	73.6 (48.4 to 89.3)	1.522 (1.213 to 1.909)	0.813 (0.709 to 0.932)
<b>Rhinorrhoea</b>	7	1620/17,972 (9.0)	30.3 (18.7 to 45.1)	70.0 (56.8 to 80.6)	1.011 (0.848 to 1.205)	0.985 (0.922 to 1.074)
<b>Headache</b>	7	929/10,899 (8.5)	35.8 (17.2 to 60.0)	73.0 (53.4 to 86.4)	1.325 (1.161 to 1.513)	0.879 (0.767 to 1.008)
<b>Anosmia</b>	7	938/9456 (9.9)	26.4 (13.8 to 44.6)	94.2 (90.6 to 96.5)	4.546 (3.461 to 5.972)	0.781 (0.648 to 0.942)
<b>Anosmia or ageusia</b>	6	794/6142 (12.9)	39.2 (26.5 to 53.6)	92.1 (84.5 to 96.2)	4.992 (3.215 to 7.751)	0.659 (0.551 to 0.790)
<b>Myalgia</b>	6	563/2684 (21.0)	37.5 (20.6 to 58.1)	75.4 (58.4 to 87.0)	1.525 (1.207 to 1.926)	0.829 (0.708 to 0.970)
<b>Chills/shivers</b>	5	1080/14,472 (7.5)	25.3 (15.1 to 39.3)	85.0 (72.1 to 92.6)	1.691 (1.231 to 2.323)	0.878 (0.812 to 0.950)
<b>Ageusia</b>	5	748/8644 (8.7)	23.2 (10.6 to 43.3)	92.6 (83.1 to 97.0)	3.137 (1.786 to 5.510)	0.830 (0.701 to 0.982)

**Table 3. Summary estimates of test accuracy for selected index tests, including 95% confidence intervals (bivariate meta-analysis of prospective studies with low risk of bias for participant selection) (Continued)**

CI: confidence interval; LR+: positive likelihood ratio; LR-: negative likelihood ratio

## APPENDICES

### Appendix 1. World Health Organization case definitions

#### Severe pneumonia

Adolescent or adult: fever or suspected respiratory infection, plus one of the following: respiratory rate higher than 30 breaths per minute; severe respiratory distress; or oxygen saturation (SpO<sub>2</sub>) 93% or less on room air. Child with cough or difficulty in breathing, plus at least one of the following: central cyanosis or SpO<sub>2</sub> less than 90%; severe respiratory distress (for example, grunting, very severe chest indrawing); signs of pneumonia with a general danger sign: inability to breastfeed or drink, lethargy or unconsciousness, or convulsions.

Other signs of pneumonia may be present: chest indrawing, fast breathing (in breaths per minute): aged under 2 months: 60 or higher; aged 2 to 11 months: 50 or higher; aged 1 to 5 years: 40 or higher. While the diagnosis is made on clinical grounds; chest imaging may identify or exclude some pulmonary complications.

#### Acute respiratory distress syndrome (ARDS)

Onset within one week of a known clinical insult or new or worsening respiratory symptoms.

Chest imaging (that is, X-ray, computed tomography (CT) scan, or lung ultrasound): bilateral opacities, not fully explained by volume overload, lobar or lung collapse, or nodules.

Origin of pulmonary infiltrates: respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (for example, echocardiography) to exclude hydrostatic cause of infiltrates/oedema if no risk factor present.

Oxygenation impairment in adults:

- mild ARDS: 200 mmHg less than ratio of arterial oxygen partial pressure/fractional inspired oxygen (PaO<sub>2</sub>/FiO<sub>2</sub>) 300 mmHg or less (with positive end-expiratory pressure (PEEP) or continuous positive airway pressure (CPAP) 5 cmH<sub>2</sub>O, or more, or non-ventilated);
- moderate ARDS: 100 mmHg < PaO<sub>2</sub>/FiO<sub>2</sub> ≤ 200 mmHg (with PEEP ≥ 5 cmH<sub>2</sub>O, or non-ventilated);
- severe ARDS: PaO<sub>2</sub>/FiO<sub>2</sub> ≤ 100 mmHg (with PEEP ≥ 5 cm H<sub>2</sub>O, or non-ventilated);
- when PaO<sub>2</sub> is not available, SpO<sub>2</sub>/FiO<sub>2</sub> ≤ 315 mmHg suggests ARDS (including in non-ventilated patients).

Oxygenation impairment in children: note OI = Oxygenation Index and OSI = Oxygenation Index using SpO<sub>2</sub>. Use PaO<sub>2</sub>-based metric when available. If PaO<sub>2</sub> not available, wean FiO<sub>2</sub> to maintain SpO<sub>2</sub> ≤ 97% to calculate OSI or SpO<sub>2</sub>/FiO<sub>2</sub> ratio:

- bilevel (non-invasive ventilation or CPAP) ≥ 5 cm H<sub>2</sub>O via full-face mask: PaO<sub>2</sub>/FiO<sub>2</sub> ≤ 300 mmHg or SpO<sub>2</sub>/FiO<sub>2</sub> ≤ 264;
- mild ARDS (invasively ventilated): 4 ≤ OI < 8 or 5 ≤ OSI < 7.5;
- moderate ARDS (invasively ventilated): 8 ≤ OI < 16 or 7.5 ≤ OSI < 12.3;
- severe ARDS (invasively ventilated): OI ≥ 16 or OSI ≥ 12.3.

### Appendix 2. University of Bern living search database

From 30 October 2020

#### Embase:

(exp SARS-related coronavirus/ or severe acute respiratory syndrome/ or coronavirus disease 2019/ or (coronavir\* or corona virus\* or HCoV\* or nCoV\* or 2019 cov or covid or covid19 or sars-cov\* or sarscov\* or sars-coronavirus\* or Severe Acute Respiratory Syndrome Coronavirus\* or nCoV).mp.) and 20191101:20301231.(dc).

#### MEDLINE:

("severe acute respiratory syndrome coronavirus 2"[Supplementary Concept] OR "COVID-19" [Supplementary Concept] OR "coronavirus" OR "corona virus" OR "HCoV" OR "nCoV" OR "2019 CoV" OR "covid" OR "covid19" OR "Severe Acute Respiratory Syndrome Coronavirus 2" OR "SARS-CoV2" OR "SARS-CoV 2" OR "SARS Coronavirus 2") AND (2019/11/01:3000/12/31[PDAT])

**Signs and symptoms to determine if a patient presenting in primary care or hospital outpatient settings has COVID-19 (Review)**

339



### Appendix 3. Search classification model

We needed a more efficient approach to keep up with the rapidly increasing volume of COVID-19 literature. A classification model for this specific review was built with the model-building function within Eppi Reviewer, which uses the standard SGCCClassifier in Scikit-learn on word trigrams. As outputs, new documents receive a percentage (from the predict\_proba function) where scores close to 100 indicate a high probability of belonging to the class 'relevant document' and scores close to 0 indicate a low probability of belonging to the class 'relevant document'. We used three iterations of manual screening (title and abstract screening, followed by full-text review) to build and test classifiers. The final included studies were used as relevant documents, while the remainder of the COVID-19 studies were used as irrelevant documents. The classifier was trained on the first round of selected articles, and tested and retrained on the second round of selected articles. Testing on the second round of selected articles revealed poor positive predictive value but 100% sensitivity at a cut-off of 10. The poor positive predictive value is mainly due to the broad scope of our topic (any signs or symptoms associated with COVID-19), poor reporting in abstracts, and a small set of included documents.

#### WHAT'S NEW

Date	Event	Description
15 February 2022	New citation required and conclusions have changed	Findings from 42 prospective studies involving 52,608 participants included in this second update version indicate that there is currently no evidence to support further testing in all individuals presenting only with upper respiratory symptoms such as sore throat, coryza or rhinorrhoea. Based on currently available data, neither absence nor presence of a single sign or symptom are accurate enough to rule in or rule out COVID-19 disease.
16 November 2021	New search has been performed	Review updated with search until 10 June 2021.

#### HISTORY

Review first published: Issue 7, 2020

Date	Event	Description
4 March 2021	Amended	Corrected peer reviewer's name in Acknowledgements section
11 February 2021	New citation required and conclusions have changed	Review updated: We retrieved 28 more studies on signs and symptoms in suspected COVID-19 patients, allowing pooling of the data for some features and estimation of summary measures of diagnostic accuracy. Moreover, this update contains new studies on the diagnostic value of olfactory symptoms, and includes a limited number of studies on combinations of symptoms.
8 December 2020	New search has been performed	Review updated
7 July 2020	Amended	Resolution of two figures improved

#### CONTRIBUTIONS OF AUTHORS

JD, JDi, YT, CD, ML, RS, LH, AVdB, and DE, contributed clinical, methodological and/or technical expertise to drafting the protocol. JD coordinated contributions from all co-authors and drafted the protocol. ML drafted the QUADAS-2 criteria. AVdB oversaw the overall progress of this review, participated in the selection process, data extraction, quality appraisal and drafting of the manuscript. TS co-ordinated the review process, analysed the data, drafted the manuscript and participated in the selection, data extraction and quality appraisal. JDo, DW, AT, VL, SJ and SH participated in the data extraction, quality appraisal, interpretation of the findings and commented on the manuscript.

## DECLARATIONS OF INTEREST

Thomas Struyf: none known

Jonathan J Deeks: no relevant interests; published eight podcasts, including Talk Evidence (BMJ), More-or-Less (Radio 4), Inside Science (Radio 4), The Newscast (Radio 4). Five opinion pieces in Guardian, unHerd and the BMJ. Numerous television, radio and mainstream media interviews giving substantial coverage of scientific issues related to test evaluation for COVID-19. Presented evidence to the House of Lords Select Committee, and the All Parliamentary Party Investigation on COVID-19. Two invited editorials on COVID-19 for the BMJ; Editor, Cochrane Diagnostic Test Accuracy Review editorial team

Jacqueline Dinnes: no relevant interests; Editor, Cochrane Diagnostic Test Accuracy Review editorial team

Yemisi Takwoingi: no relevant interests; Editor, Cochrane Infectious Diseases; Statistical Editor, Cochrane Bone, Joint and Muscle Trauma; Editor, Cochrane Diagnostic Test Accuracy Review editorial team

Clare Davenport: no relevant interests; Contact Editor for Cochrane Diagnostic Test Accuracy Review editorial team and was not involved in the editorial process for this review

Mariska MG Leeflang: no relevant interests; team member, Cochrane Diagnostic Test Accuracy Review editorial team

René Spijker: none known

Lotty Hooft: no relevant interests; editorial roles with the Cochrane Diagnostic Test Accuracy Review editorial team and Prognosis Methods Group implementation team

Devy Emperador: no relevant interests; employed by FIND with funding from DFID and KFW. FIND is a global non-for profit product development partnership and World Health Organization Diagnostic Collaboration Centre. It is FIND's role to accelerate access to high-quality diagnostic tools for low-resource settings and this is achieved by supporting both research and development, and access activities for a wide range of diseases, including COVID-19. FIND has several clinical research projects to evaluate multiple new diagnostic tests against published Target Product Profiles that have been defined through consensus processes. These studies are for diagnostic products developed by private sector companies who provide access to know-how, equipment/reagents, and contribute through unrestricted donations as per FIND policy and external SAC review

Julie Domen: no relevant interests; works as a general practitioner

Anouk Tans: none known

Stéphanie Janssens: no relevant interests; works as a general practitioner in training in 'De Wijkpraktijk' in Antwerp

Dakshitha Wickramasinghe: none known

Viktor Lannoy: none known

Sebastiaan Horn: no relevant interests; works as a resident general practitioner: Praktijkhuis Baarle, University of Antwerp, Antwerp, Belgium

Ann Van den Bruel: none known

## SOURCES OF SUPPORT

### Internal sources

- Liverpool School of Tropical Medicine, UK
- University of Birmingham, UK

### External sources

- Foreign, Commonwealth and Development Office, UK

Project number 300342-104

- National Institute for Health Research (NIHR), UK
- NIHR Birmingham Biomedical Research Centre at the University Hospitals Birmingham NHS Foundation Trust and the University of Birmingham, UK

## DIFFERENCES BETWEEN PROTOCOL AND REVIEW

As the evidence base evolves over the course of the pandemic, we have made some adjustments to our original approach with the following changes between earlier versions of the review and this second update:

- Clarification regarding inclusion criteria: suspicion of infection was interpreted as: **clinical suspicion of SARS-CoV-2 infection based on a symptomatic presentation. At least 50% of the study population had to present with COVID-19 compatible symptoms.**
- Both studies using a retrospective and a prospective data collection were included, but **the main findings of this review were based on the prospective studies only**, as retrospective studies tend to overestimate the diagnostic accuracy of the index tests.
- Preprints that were included in previous versions of the review were now excluded (unless they were published in the meantime), and they were no longer included from this update onwards. Consequently, this second review update does not contain any preprints. Records from preprint archives were no longer evaluated for eligible studies because of an increase in COVID-19 study references from recommended diagnostic test accuracy sources (MEDLINE and Embase). For the baseline review, preprint archives were essential to identify emerging evidence; but for the second update, it was no longer necessary to search these sources.
- Search sources included in the protocol and the previous version of this review, the Cochrane COVID-19 Study Register and the CDC Database of COVID-19 Research Articles, were not included in this version as the single source from the University of Bern living search database proved more efficient to process as it did not involve manual effort to deduplicate.
- We did not set out to identify any ongoing studies for this 2022 review version since the review will no longer be updated in its current form (see [Objectives](#)).

## INDEX TERMS

### Medical Subject Headings (MeSH)

\*Ageusia [complications]; Anosmia [diagnosis] [etiology]; Artificial Intelligence; Cough [etiology]; \*COVID-19 [diagnosis] [epidemiology]; COVID-19 Testing; Dyspnea; Fatigue [etiology]; Fever [diagnosis] [etiology]; Hospitals; Outpatients; \*Pharyngitis; Primary Health Care; Prospective Studies; SARS-CoV-2; Sensitivity and Specificity

### MeSH check words

Aged; Child; Humans