**IDSA Guidelines on the Diagnosis of COVID-19**

**Supplement H**

**Recommendation 8:** In asymptomatic individuals who may have been exposed to COVID-19, should nucleic acid amplification testing vs. no testing be done to diagnose COVID-19 (to guide decisions about quarantine and contact tracing)?

Forest Plots for the sensitivity of URT sampling among symptomatic patients. (This was used to indirectly determine the sensitivity of URT sampling among asymptomatic patients)

**Figure s11.** Sensitivity pooled by proportion from the 6 studies reporting comparative data

**Figure s12.** Specificity Pooled by Proportion from 2 studies that reported specificity

**Figure s13.** Sensitivity pooled by proportion from the two studies that used NP as a reference standard
Table s28. GRADE Evidence Profile of Test Accuracy Results for Prevalence/Pre-Test Probability of 10% 25% and 50% for SARS COV2 PCR testing

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Sensitivity of SARS-COV2 PCR testing</th>
<th>Specificity of SARS-COV2 PCR testing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.75 (95% CI: 0.55 to 0.95)</td>
<td>0.99 (95% CI: 0.99 to 1.00)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factors that may decrease certainty of evidence</th>
<th>Effect per 1,000 patients tested&lt;sup&gt;d&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of bias</td>
<td>Pre-test probability of 10%</td>
</tr>
<tr>
<td>Indirectness</td>
<td>75 (55 to 95)</td>
</tr>
<tr>
<td>Inconsistency</td>
<td>25 (5 to 45)</td>
</tr>
<tr>
<td>Imprecision</td>
<td>900 (891 to 900)</td>
</tr>
<tr>
<td>Publication bias</td>
<td>0 (0 to 9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test accuracy CoE</th>
<th>Very Low</th>
</tr>
</thead>
</table>

**True positives (patients with COVID-19)**

- **Number of studies (Number of patients):** 6 studies (385 patients)
- **Study design:** cohort & case-control type studies
- **Risk of bias:** serious<sup>a</sup>, serious<sup>b</sup>, not serious
- **Indirectness:** serious<sup>b</sup>, not serious
- **Inconsistency:** serious<sup>c</sup>
- **Imprecision:** None
- **Effect per 1,000 patients tested:** 75 (55 to 95), 188 (138 to 238), 375 (275 to 475)
- **Test accuracy CoE:** Very Low

**False negatives (patients incorrectly classified as not having COVID-19)**

- **Number of studies (Number of patients):** 2 studies (457 patients)
- **Study design:** cohort & case-control type studies
- **Risk of bias:** serious<sup>a</sup>, serious<sup>b</sup>, not serious
- **Indirectness:** serious<sup>b</sup>, not serious
- **Inconsistency:** serious<sup>c</sup>
- **Imprecision:** None
- **Effect per 1,000 patients tested:** 0 (0 to 9), 0 (0 to 8), 0 (0 to 5)
- **Test accuracy CoE:** Very Low

**False positives (patients incorrectly classified as having COVID-19)**

**Explanations**

This table is based on applying the sensitivity and specificity estimates to calculate True and false positives and negatives in a hypothetical population of 1000 individuals.

- a. Reference standard considered to be nasopharyngeal specimen RT-PCR.
- b. Studies report test accuracy results but do not report on patient-important outcomes based on these results.
- c. A small number of patients included.
- d. We assessed studies that reported the prevalence of COVID-19 among asymptomatic individuals who were exposed to COVID-19 and determined that the prevalence may range from 10% to 50% based on household clusters, nursing home outbreak, active surveillance of passengers quarantined on a cruise ship or passengers of repatriation flights, hospital employees with close contact with COVID-19 positive patients and customers and employees of a restaurant that had a COVID-19 outbreak.