

# Infectious Diseases Society of America Guidelines on the Diagnosis of Coronavirus Disease 2019: Serologic Testing

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**Background.** The role of serologic testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has evolved during the pandemic as seroprevalence in global populations has increased. The Infectious Diseases Society of America convened an expert panel to perform a systematic review of the coronavirus disease 2019 (COVID-19) serology literature and construct updated best practice guidance related to SARS-CoV-2 serologic testing. This guideline is an update to the fourth in a series of rapid, frequently updated COVID-19 guidelines developed by the Infectious Diseases Society of America.

**Objective.** To develop evidence-based recommendations and identify unmet research needs pertaining to the use of anti-SARS-CoV-2 antibody tests for diagnosis, decisions related to vaccination and administration of monoclonal antibodies or convalescent plasma in immunocompromised patients, and identification of a serologic correlate of immunity.

**Methods.** A multidisciplinary panel of infectious diseases clinicians, clinical microbiologists, and experts in systematic literature reviewed, identified, and prioritized clinical questions related to the use of SARS-CoV-2 serologic tests. Grading of Recommendations Assessment, Development and Evaluation methodology was used to assess the certainty of evidence and make testing recommendations.

**Results.** The panel recommends against serologic testing to diagnose SARS-CoV-2 infection in the first 2 weeks after symptom onset (strong recommendations, low certainty of evidence). Serologic testing should not be used to provide evidence of COVID-19 in symptomatic patients with a high clinical suspicion and repeatedly negative nucleic acid amplification test results (strong recommendation, very low certainty of evidence). Serologic testing may assist with the diagnosis of multisystem inflammatory syndrome in children (strong recommendation, very low certainty of evidence). To seek evidence for prior SARS-CoV-2 infection, the panel suggests testing for immunoglobulin G (IgG), IgG/IgM, or total antibodies to nucleocapsid protein 3 to 5 weeks after symptom onset (conditional recommendation, low certainty of evidence). In individuals with previous SARS-CoV-2 infection or vaccination, the panel suggests against routine serologic testing given no demonstrated benefit to improving patient outcomes (conditional recommendation, very low certainty of evidence). The panel acknowledges further that a negative spike antibody test may be a useful metric to identify immunocompromised patients who are candidates for immune therapy.

**Conclusions.** The high seroprevalence of antibodies against SARS-CoV-2 worldwide limits the utility of detecting anti-SARS CoV-2 antibody. The certainty of available evidence supporting the use of serology for diagnosis was graded as very low to low. Future studies should use serologic assays calibrated to a common reference standard.

**Keywords.** COVID-19; diagnosis; serology; SARS-CoV-2.

Received 13 February 2024; editorial decision 19 February 2024; published online 15 March 2024

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<https://doi.org/10.1093/cid/ciae121>

## EXECUTIVE SUMMARY

As of December 2022, more than 96% of the US population was estimated to have antibodies against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) [1]. Although global seroprevalence data are more sparse, similar estimates have been reported from numerous other countries and regions [2]. The utility of anti-SARS-CoV-2 antibody testing for diagnostic or epidemiologic purposes has declined as global seroprevalence due to vaccination and natural infection has increased. The current The Infectious Diseases Society of America (IDSA) Guideline for Serologic Testing in the Diagnosis of SARS-CoV-2 Infection reflects this evolution. The panel now makes a strong (vs weak) recommendation against serologic testing to diagnose acute coronavirus disease 2019 (COVID-19) in the first 2 weeks after symptom onset. Similarly, the updated guideline recommends strongly against (vs previously recommending weakly for) using immunoglobulin G (IgG) antibodies to provide evidence of COVID-19 in symptomatic patients with a high clinical suspicion and repeatedly negative nucleic acid amplification tests (NAATs). Unlike NAATs, which detect viral RNA, antibody-based assays measure the host's humoral immune response to current or past infection. Anti-SARS-CoV-2 antibodies typically become detectable more than 2 weeks after onset of symptoms (Figure 1). As a result, SARS-CoV-2 serology lacks sufficient sensitivity to confidently exclude a diagnosis of COVID-19 when antibodies are not detected in the acute phase of illness. Furthermore, given the very high baseline seroprevalence of anti-SARS-CoV-2 antibodies in most populations, a positive serologic result may likely be due to vaccination or a distant history of COVID-19 as opposed to an acute or recent SARS-CoV-2 infection.

For the current update, the panel identified very few clinical scenarios in which serologic testing may be useful. The first is to assist in the diagnosis of Multisystem Inflammatory Syndrome in children (MIS-C). In addition, the panel agreed that a negative spike antibody test may be a useful metric to identify immunocompromised patients who are candidates for immune therapy, such as convalescent plasma or monoclonal antibodies, if such therapy were available, or to prioritize administration of monoclonal therapies when supplies are limited. When antibody testing is done, the panel makes a weak recommendation for using SARS-CoV-2 IgG, IgG/IgM, or total antibodies and against using IgM, because of lower sensitivity of IgM alone. IgA tests were not considered in the current, updated guideline because of their past poor performance and because they are rarely tested in clinical laboratories.

The current IDSA guideline includes 2 new recommendations. The first is a weak recommendation to use serologic assays that target nucleocapsid protein rather than spike protein when evidence of prior COVID-19 is desired. This recommendation is made to improve the specificity of testing in highly vaccinated

populations because most available vaccines result in formation of anti-spike antibodies, although some inactivated whole virus vaccines (eg, CoronaVac and BBIBP-CorV, manufactured by Sinovac and Sinopharm, respectively) can also result in formation of anti-nucleocapsid antibodies.

The second new recommendation suggests against routine serologic testing in patients with previous SARS-CoV-2 infection or vaccination, given that no demonstrated benefits for improving patient outcomes were identified. Data were found to support higher levels of binding antibodies or the presence of neutralizing antibodies as being associated with protection against SARS-CoV-2 infection, but a single titer that predicts protection was not identified.

Summarized here are specific recommendations and comments related to the use of SARS-CoV-2 serologic testing in clinical practice. A detailed description of background, methods, evidence summary, and rationales that support each recommendation can be found online and in the full text.

**Recommendation 1.** The IDSA panel recommends against using serologic testing to diagnose SARS-CoV-2 infection during the first 2 weeks following symptom onset (strong recommendation, low certainty of evidence).

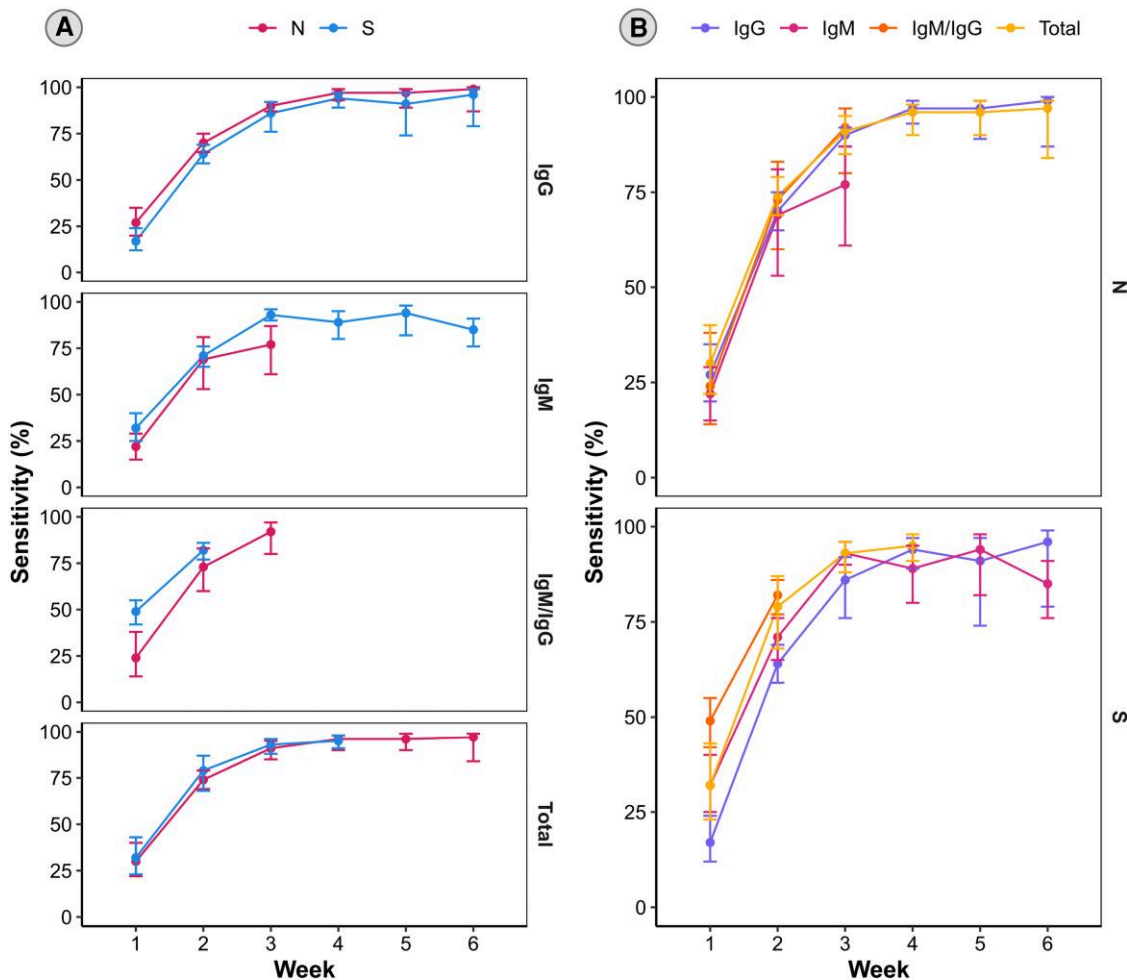
### Remarks:

- Most studies included in this recommendation's literature review assessed unvaccinated individuals and so the panel's findings might not apply to individuals who have been vaccinated, especially with respect to specificity, rendering test accuracy worse than presented here.
- Similarly, in today's population, there is a higher likelihood of prior SARS-CoV-2 infection than assessed in the included studies, which could also negatively affect specificity, rendering test accuracy worse than presented.
- Analogous to other respiratory viruses where nonserologic tests are preferred for diagnosis of acute infection, serologic testing should not be routinely performed for diagnosis of acute COVID-19.

**Recommendation 2.** The IDSA panel recommends against using IgG antibodies to provide evidence of COVID-19 in symptomatic patients with a high clinical suspicion and repeatedly negative NAATs (strong recommendation, very low certainty of evidence).

### Remarks:

- Contemporary populations are more likely to have had prior SARS-CoV-2 infection or vaccination than the populations assessed in the included studies, which could negatively affect pooled specificity calculations, rendering test accuracy worse than presented here.



**Figure 1.** Detection of SARS-CoV-2 antibodies after symptom onset in patients with COVID-19. *A*, Sensitivity of detection of anti-nucleocapsid (N) and anti-spike (S) antibodies over time, stratified by antibody class. *B*, Sensitivity of assays that detect SARS-CoV-2 IgG, IgM, IgM/IgG, and total antibody over time, stratified by antibody target. Abbreviations: COVID-19, coronavirus disease 2019; IgG, immunoglobulin G; IgM, immunoglobulin M; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

**Recommendation 3.** To assist with the diagnosis of multisystem inflammatory syndrome in children (MIS-C), the IDSA panel recommends using both IgG antibody testing and NAATs to provide evidence of current or recent past COVID-19 (strong recommendation, very low certainty of evidence).

**Remarks:**

- Combining IgG antibody testing and NAAT may improve both the ability to diagnose MIS-C and to rule it out, compared with using NAATs alone. Knowing the patient's vaccination and COVID-19 history may be helpful in interpreting serology results.
- Differentiating MIS-C from conditions with overlapping symptomatology, such as Kawasaki disease, is important because Kawasaki disease requires treatment with specific therapies such as intravenous immunoglobulin or rituximab if diagnosed. The 2 diseases also differ in terms of potential

complications and need for long-term medication and follow-up.

- The January 2023 definition of MIS-C agreed upon by US Centers for Disease Control and Prevention (CDC) and other public health officials requires evidence of current or recent SARS-CoV-2 infection by polymerase chain reaction (PCR), antigen, or serologic testing [3].

**Recommendation 4.** When evidence of previous SARS-CoV-2 infection is desired, the IDSA panel suggests testing for SARS-CoV-2 IgG, IgG/IgM, or total antibodies 3 to 5 weeks after symptom onset and against testing for SARS-CoV-2 IgM (conditional recommendation, low certainty of evidence).

**Remarks:**

- SARS-CoV-2 NAAT and antigen tests have superior performance characteristics for diagnosis of COVID-19 compared with serologic testing.

- There are very limited situations in which SARS-CoV-2 antibody testing might be useful (eg, in helping to diagnose MIS-C).

#### **Recommendation 5.**

- When evidence of prior SARS-CoV-2 infection is desired, the IDSA panel suggests using serologic assays that target nucleocapsid protein rather than spike protein (conditional recommendation, low certainty of evidence).

#### **Remarks:**

- Most available vaccines result in formation of only anti-spike antibodies but some (eg, CoronaVac and BBIBP-CorV, manufactured by Sinovac and Sinopharm, respectively) that contain inactivated whole virus can also result in formation of anti-nucleocapsid antibodies [4].
- Given the high prevalence of vaccination in most populations and the persistence of anti-spike antibodies over time, detection of anti-spike antibodies has low positive predictive value for diagnosis of recent COVID-19 in most individuals.

#### **Recommendation 6.**

- In individuals with previous SARS-CoV-2 infection or vaccination, the IDSA panel suggests against routine serologic testing given no demonstrated benefit to improving patient outcomes (conditional recommendation, very low certainty of evidence).

#### **Remarks:**

- Serologic testing may be useful for diagnosing MIS-C in pediatric patients, especially when NAAT or antigen testing is negative, to provide evidence of recent COVID-19 (see Recommendation 3).
- A negative spike antibody test may be a useful metric to identify immunocompromised patients who are candidates for immune therapy such as convalescent plasma or monoclonal antibodies, if such therapies were available, or to prioritize administration of monoclonal therapies when supplies are limited.

## **BACKGROUND**

Since its emergence in December 2019, SARS-CoV-2 has caused more than 760 million confirmed infections and nearly 7 million deaths worldwide [5]. Definitive diagnosis of COVID-19 and asymptomatic SARS-CoV-2 infection rely on the direct detection of virus-specific RNA or virus-specific glycoprotein antigens in respiratory specimens. Serologic tests that use blood samples to detect the host antibody response to SARS-CoV-2 cannot diagnose SARS-CoV-2 infection or COVID-19, nor can they identify persons who are protected from future infection, but they may help confirm past infection. The current high seroprevalence of anti-SARS-CoV-2 antibodies in most populations

limits the utility of antibody testing for clinical or epidemiologic purposes.

Coronavirus genomes encode four major structural proteins including spike (S), envelope (E), membrane (M), and nucleocapsid (N). Both the S and N proteins of SARS-CoV-2 are immunogenic in humans; current serologic tests target antibodies directed against these antigens [6]. The S protein is the most exposed viral protein and is responsible for viral attachment and entry into host cells via binding to the angiotensin-converting enzyme 2 receptor [7]. The S protein comprises an N-terminal S1 subunit, involved in virus-receptor binding, and a C-terminal S2 subunit involved in fusion to the host cell membrane. The S1 subunit is further divided into an N terminal domain and a receptor binding domain (RBD). There has been particular focus on the SARS-CoV-2 RBD for vaccine development and targeted antibody therapies because neutralizing antibodies against this region effectively block viral entry [8, 9]. The N protein is an RNA-binding protein that is abundantly expressed during infection and plays a role in RNA transcription and replication [10].

There are 2 general types of antibodies, neutralizing antibodies (nAbs) and nonneutralizing (also known as binding antibodies) [11]. Neutralization is defined as the loss of infectivity that occurs when a nAb binds to a viral particle. Virus-specific or vaccine-induced nAbs can play a role in controlling viral infection, but definitive data are lacking regarding the level of anti-SARS-CoV-2 nAbs that provides protection against reinfection. In comparison, binding antibodies are characterized by their inability to prevent viral infection of permissive cells. Regardless of their function, both types of virus-specific antibodies are potentially useful as diagnostic indicators of past infection or vaccination.

Commercially available anti-SARS-CoV-2 antibody tests use different technologies to qualitatively measure single immunoglobulin classes (IgM, IgG, or IgA) or total antibody, and to differentiate nAbs from binding antibodies. IgM antibodies directed against microorganisms are typically produced first after infection and are used as a measure of recent infection. IgG antibodies generally develop later than IgM antibodies and remain elevated for months to years after infection. Although IgM antibodies can be detected within the first 2 weeks of symptoms in some patients, SARS-CoV-2 infection appears unusual in that IgM and IgG more commonly rise together, more than 2 weeks after the onset of symptoms [12]. Secretory IgA is important for mucosal immunity. IgA can also be detected systemically in certain types of infection including SARS-CoV-2, but comparatively little is known about the kinetics of IgA in blood. The components of “total antibody” presumably include IgM and IgG and theoretically other antigen-specific immunoglobulins as well.

The most common clinical diagnostic platforms utilized for SARS-CoV-2 include lateral flow devices, enzyme-linked

immunosorbent assays (ELISA), and chemiluminescent immunoassays (CIA). Lateral flow assays typically require a drop of blood (or serum or plasma) applied to a test strip, with results read in approximately 15–30 minutes. These devices are suitable for point-of-care testing and have potential to be deployed in the field as a part of large serological surveys. ELISA comes in a variety of different formats. Typically, a bound antigen–antibody complex is detected using a type-specific secondary antibody linked to a substrate that generates a colorimetric or fluorescent signal. CIA methods are similar to ELISA but use chemical probes that emit light instead of enzymatic substrates. Both ELISA and CIA are clinical laboratory-based methods amenable to high-throughput testing using serum, plasma, or potentially dried blood spots. At this time, neutralization assays are mainly used in research settings or offered as laboratory developed tests by reference laboratories.

As of this writing, most commercially available SARS-CoV-2 antibody tests marketed in the United States have Emergency Use Authorization (EUA) through the US Food and Drug Administration (FDA). Early in the pandemic, however, official EUA review was voluntary. Test developers were expected only to internally validate their tests and notify the FDA of their intent to market. As a result, the market was flooded with poorly performing assays. In response, the FDA issued a “removed” test list that includes tests with significant performance problems, assays for which official EUA review was not appropriately submitted or assays voluntarily withdrawn by the developer. Subsequently, on 23 September 2021, the FDA revised the EUAs of certain molecular, antigen, and serology tests to establish additional Conditions of Authorization in response to the ongoing emergence of new SARS-CoV-2 variants. The lifting of the Federal COVID-19 Public Health Emergency on 11 May 2023 was accompanied by release of a transition plan by the FDA with recommendations for marketing submission and other actions needed to enable ongoing use of COVID-19 laboratory tests that were issued EUA [13].

Many serologic tests for SARS-CoV-2 are commercially available. Although most of these assays are currently available under FDA EUA, it is expected that many will soon achieve FDA clearance. The speed of development has continued to outpace rigorous assessments of test performance. In response, IDSA convened an expert panel to systematically review the available serologic literature, compare pooled estimates of test accuracy, and make evidence-based recommendations for informed use in clinical practice.

## METHODS

This guideline was developed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach for evidence assessment. This guideline serves

as the first update to the original IDSA guidelines on the serologic testing of COVID-19 [14]. The list of questions addressed in the initial guideline and the current update can be found in [Supplementary Table 1](#).

### Panel Composition

The panel was composed of clinicians and clinical microbiologists who are members of the IDSA, the American Society for Microbiology (ASM), the Society for Healthcare Epidemiology of America (SHEA), and the Pediatric Infectious Diseases Society (PIDS). They represented the disciplines of infectious diseases, pediatrics, clinical microbiology, and healthcare epidemiology. The Evidence Foundation provided technical support and guideline methodologists for the development of this guideline.

### Disclosure and Management of Potential Conflicts of Interest

The conflict of interest (COI) review group included 2 representatives from IDSA who were responsible for reviewing, evaluating, and approving all disclosures. All members of the expert panel complied with the COI process for reviewing and managing conflicts of interest, which required disclosure of any financial, intellectual, or other interest that might be construed as constituting an actual, potential, or apparent conflict, regardless of relevancy to the guideline topic. The assessment of disclosed relationships for possible COI was based on the relative weight of the financial relationship (ie, monetary amount) and the relevance of the relationship (ie, the degree to which an association might reasonably be interpreted by an independent observer as related to the topic or recommendation of consideration). The COI review group ensured that the majority of the panel and chair were without potential relevant (related to the topic) conflicts. The chair and all members of the technical team were determined to have no COIs relevant to the guidelines.

### Question Generation

Clinical questions were developed into a Population, Intervention, Comparison, Outcomes format (PICO) [15] before the first panel meeting. Using online surveys, the panel members decided to reassess the evidence and the recommendation for 4 PICO questions that were addressed in the initial guideline in 2020 [14]. Additionally, panel members prioritized 3 new questions that have emerged as clinically important ([Supplementary Table 1](#)). Because very limited data were identified to answer 2 of these questions, they were combined in a single recommendation (Recommendation 6).

### Search Strategy

The National Institute of Health and Care Excellence’s and the CDC’s highly sensitive search was reviewed by the

methodologists in consultation with an experienced information specialist and was determined to have high sensitivity. Terms identified in the PICO questions and the term “COVID” were added to the search strategy used for the databases PubMed, Embase, and Cochrane for antigen, molecular, and serology diagnostic test terms (Supplementary Table 2). Monthly searches were performed from 2019 through 1 January 2023. During September 2022, with the help of an information specialist, improvements to the search strategy were made to reflect the COVID19/Sars-CoV-2 epidemic and remove general terms like “coronavirus” that may pick up articles about a different virus (Supplementary Table 2). Any reference lists and literature suggested by the panelists were also reviewed throughout the guideline development process.

### Screening and Study Selection

A member of the review team screened the titles and abstracts of the references identified by the search strategy and assessed if the study addressed antigen, molecular, or serologic testing. A member of the review team then assessed the studies addressing serologic testing in more detail using the full texts of the studies under consideration for potential inclusion in the review. When the inclusion of an article was debated, it was first resolved through discussion within the review team. In the case of disagreement, articles were discussed with the panel members to make the final decision.

Studies were included if they reported data on the diagnostic test accuracy of anti-SARS-CoV-2 IgM, IgG, and/or total antibody tests compared with NAATs as the reference standard. Studies were excluded if the tests evaluated were not EUA or European Commission approved, studies with fewer than 30 patients/samples, studies with incomplete test accuracy information (ie, reported sensitivity without specificity), studies reporting atypical serology sample site collection (eg, dried blood spots, mucosal fluids), machine learning studies, protocols, preprints, and abstracts.

### Data Collection and Analysis

A member of the review team completed data extraction using a standardized data extraction form in duplicate. Study characteristics (authors, publication year, country, study design, inclusion criteria, age, gender), index test information (timing from onset of symptoms, sample type, target antigen, platform, immunoglobulin class, FDA EUA status, and European Economic Area European Commission marking status), reference test (name of test, sample type), and diagnostic test accuracy results (true and false positives and negatives) were extracted.

For each study, the sensitivity and specificity of the diagnostic index test were calculated and the Clopper–Pearson method used to estimate 95% confidence intervals (CI). We then fit the random-effects bivariate binomial model of Chu and Cole [16] to pool accuracy estimates using the `glmer` function of the

`lme4` package in R (version 4.1.2). To pool accuracy estimates for analyses including fewer than 5 studies, we fit a fixed-effects model as implemented in the `meta` package in R (version 4.1.2). Forest plots were used to plot individual and summary estimates and conducted subgroup analyses to explore heterogeneity. To evaluate the effects of study design on results, sensitivity analyses were performed by including or excluding case control studies and assessing the effect on pooled results of test accuracy.

### Risk of Bias and Certainty of Evidence

The Quality Assessment of Diagnostic Studies-2 revised tool was used to assess the risk of bias in the test accuracy studies [17] (Supplementary Table 3). When assessing evidence other than test accuracy in the studies of intervention, the Risk of Bias in Nonrandomized Studies of Interventions was used [18] (Supplementary Table 4). The GRADE framework was used to assess the overall certainty by evaluating the body of evidence for each outcome on the following domains: risk of bias, imprecision, inconsistency, indirectness, and publication bias [19, 20]. GRADE summary of findings tables were developed using the GRADEpro Guideline Development Tool [21].

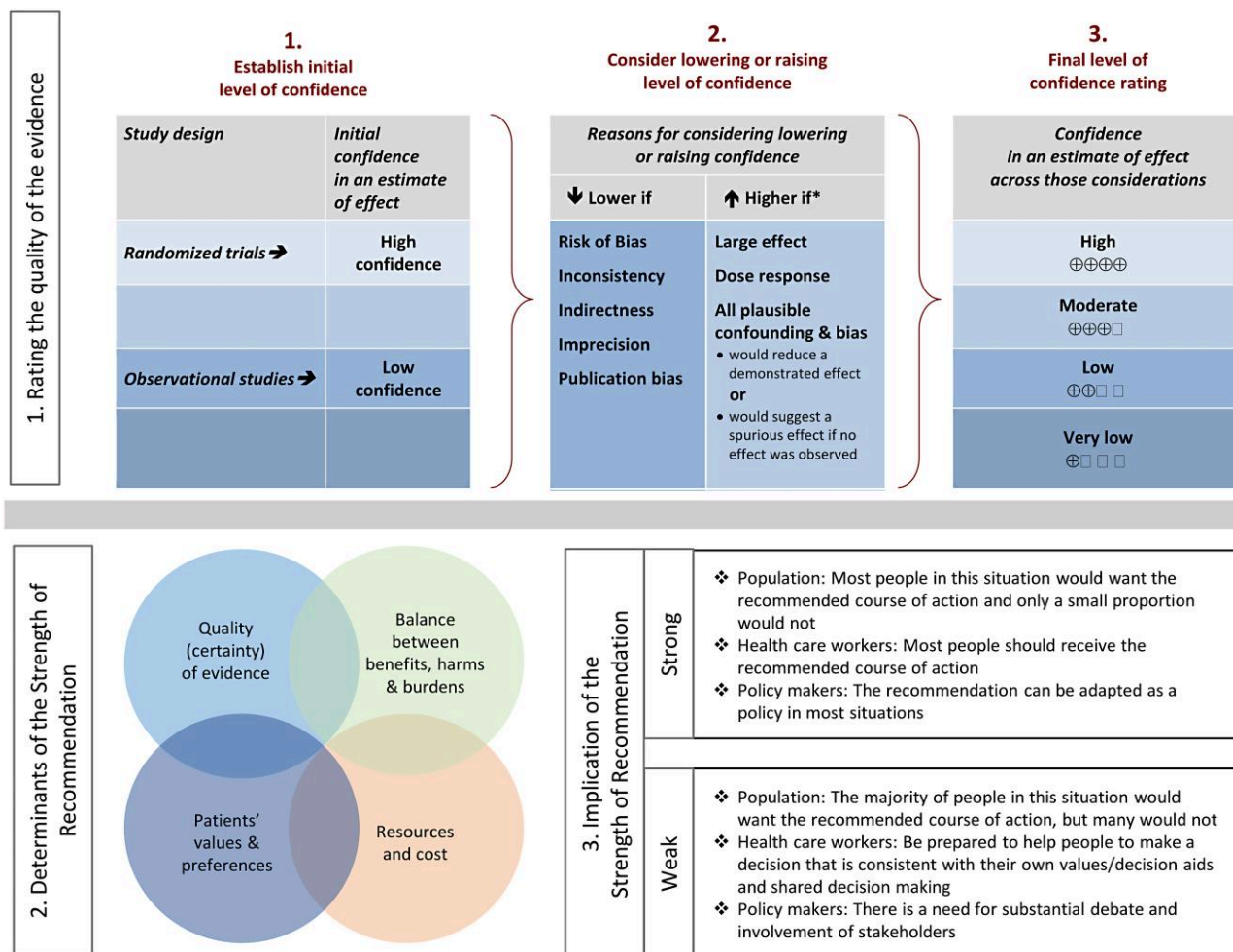
### Evidence to Recommendations

The panel considered the core elements of GRADE evidence in the decision process, including certainty of evidence and balance between desirable and undesirable effects. Additional domains were acknowledged where applicable (eg, feasibility, resource use, acceptability). For all recommendations, the expert panelists reached consensus. Voting rules were agreed on before the panel meeting for situations when consensus could not be reached.

As per GRADE methodology, recommendations were labeled as “strong” or “conditional.” The words “we recommend” indicate strong recommendations and “we suggest” indicate conditional recommendations. Figure 2 provides the suggested interpretation of strong and weak recommendations for patients, clinicians, and healthcare policymakers. For recommendations where the comparators are not formally stated, the comparison of interest was implicitly referred to as “not using the test.” Some recommendations acknowledge a current “knowledge gap” and aim at avoiding premature favorable recommendations for test use and to avoid encouraging the rapid diffusion of potentially nonuseful tests.

### Revision Process

The draft guideline underwent review for approval by the Standards and Practice Guidelines Subcommittee of the IDSA and by the IDSA Board of Directors external to the guideline development panel. The guideline was reviewed and endorsed by ASM, PIDS, and SHEA.



**Figure 2.** Approach and implications to rating the quality of evidence and strength of recommendations using the GRADE methodology (unrestricted use of the figure granted by the US GRADE Network). Abbreviation: GRADE, Grading of Recommendations Assessment, Development and Evaluation.

### Updating Process

Regular, frequent screening of the literature will take place to determine the need for revisions based on the likelihood that any new data will have an impact on the recommendations. If necessary, the entire expert panel will be reconvened to discuss potential changes.

### Search Results

Systematic review of the literature identified 30 645 references, of which 163 informed the evidence base for this guideline recommendation (Supplementary Figure 1). Characteristics of the included studies can be found in Supplementary Tables 5–9.

## RECOMMENDATIONS

### Serology Testing in the First Two Weeks After Symptom Onset

**Recommendation 1.** The IDSA panel recommends against using serologic testing to diagnose SARS-CoV-2 infection during

the first 2 weeks following symptom onset (strong recommendation, low certainty of evidence).

### Remarks:

- Most studies included in this recommendation's literature review assessed unvaccinated individuals and so the panel's findings might not apply to individuals who have been vaccinated, especially with respect to specificity, rendering test accuracy worse than presented here.
- Similarly, in today's population there is a higher likelihood of prior SARS-CoV-2 infection than assessed in the included studies, which could also negatively affect specificity, rendering test accuracy worse than presented.
- Analogous to other respiratory viruses where nonserologic tests are preferred for diagnosis of acute infection, serologic testing should not be performed routinely for diagnosis of acute COVID-19.

### Summary of Evidence

We found no direct evidence of patient- or population-centered outcomes of testing versus no testing in symptomatic patients. Therefore, the panel relied on diagnostic test accuracy data to inform this recommendation.

Using the applied search strategy, we identified 111 studies [22–132] that assessed diagnostic test accuracy of serologic tests (IgM, IgG, IgM, or IgG) compared with a SARS-CoV-2 reverse transcription PCR (RT-PCR) test in the first 2 weeks after symptom onset (Tables 1A–1C). Studies used varied sources for negative controls, including samples collected from healthy individuals, patients who had other respiratory or nonrespiratory infections, patients with autoimmune diseases whose blood had been collected before the COVID-19 pandemic, symptomatic patients with negative NAATs for SARS-CoV-2, and/or patients hospitalized for reasons other than COVID-19. Although most studies used case-control designs, some used longitudinal or cross-sectional cohort designs. For assays that detected and differentiated IgM from IgG using the same platform, an interpretation of “IgM or IgG” was considered a positive test (ie, detection of 1 of the 2 immunoglobulins qualified as a positive test).

The total number of patient samples across all included studies ranged from 1137 to 5161 and 4388 to 22,321, for sensitivity and specificity analyses, respectively (Supplementary Figures 2A–7B). The pooled sensitivity at 1 week after symptom onset ranged from 24% to 35% and at 2 weeks ranged from 64% to 74%, whereas the pooled specificity ranged from 98% to 99% (Tables 1A–1C).

The quality of evidence that informed sensitivity determinations was low, whereas the quality of evidence that informed specificity was moderate. Quality was rated downward for both sensitivity and specificity because of serious indirectness and unexplained inconsistency in sensitivity. Concerns with indirectness stemmed from the participants being evaluated in the prevaccination era and before widespread infection. Given the current very high global estimates of current SARS-CoV-2 seroprevalence, the test accuracy estimated from these studies would likely not reflect performance today.

### Benefits and Harms

If performed within 14 days of onset of symptomatic infection, the low sensitivity of serologic tests can lead to a high number of falsely negative results. Individuals who test falsely negative would be classified as uninfected, when, in fact, they would be infected but they would not have developed a detectable antibody response. Although the specificity of serologic testing was calculated to be 98%–99%, this likely does not represent performance in vaccinated and/or previously infected individuals, who were not assessed in the included studies. Tests with low specificity can lead to a false-positive result for recent infection at any time point of testing. A positive result can lead to the

incorrect conclusion that an individual has been recently infected, thus eliminating the search for the true etiology of their symptoms or resulting in unnecessary treatment or isolation.

### Other Considerations

IgM antibody responses often occur earlier after infection compared with IgG antibody responses. In contrast, with SARS-CoV-2 infection, there does not appear to be a substantial difference in the time after infection when IgM and IgG antibodies can be detected. At 1 week after onset of symptoms, the pooled sensitivity for IgM tests was 27% compared with 24% for IgG tests, and at 2 weeks after onset of symptoms, the pooled sensitivity of IgM tests was 64% compared with 66% for IgG tests.

### Conclusions and Research Needs for This Recommendation

Serologic testing should not be performed routinely for diagnosis of acute COVID-19, analogous to the situation with other respiratory viruses. Achieving a better understanding of the role of serology as a correlate of protection with current circulating variants is a research need, especially in populations at highest risk of severe disease such as the elderly and immunocompromised. Correlation of viral RNA shedding and culture positivity (or other surrogate for infectivity) should be studied relative to immunoglobulin titers over time to help inform isolation guidelines for patients with COVID-19.

### Serology Testing in Individuals With High Clinical Suspicion for SARS-CoV-2 Infection and Negative NAAT

**Recommendation 2.** The IDSA panel recommends against using IgG antibodies to provide evidence of COVID-19 in symptomatic patients with a high clinical suspicion and repeatedly negative NAATs (strong recommendation, very low certainty of evidence).

### Remarks.

- Contemporary populations are more likely to have had prior SARS-CoV-2 infection or vaccination than the populations assessed in the included studies, which could negatively affect pooled specificity calculations, rendering test accuracy worse than presented here.

### Summary of the Evidence

We identified 19 studies [30, 109, 128, 130, 133–147] that compared the diagnostic test accuracy of serologic tests among patients with high clinical suspicion for COVID-19 and negative NAATs throughout the course of their illness. The percentage of PCR-negative/IgG-positive test results ranged from 0% to 93%, with most studies reporting this test result combination for fewer than 50% of samples. The percentage of samples with PCR-negative/IgM-positive test results ranged from 2% to 83%, and the percentage of samples with PCR-negative/



**Table 14. Performance of IgM Serologic Testing 1 and 2 Weeks After Onset of COVID-19 Symptoms**

Outcome	Week 1		Week 2	
	Pretest Probability of 5% <sup>a</sup>	Pretest Probability of 20% <sup>a</sup>	Pretest Probability of 5% <sup>a</sup>	Pretest Probability of 20% <sup>a</sup>
Sensitivity	27% (95% CI, 22–34)	64% (95% CI, 58–70)	27% (95% CI, 22–34)	64% (95% CI, 58–70)
Specificity	99% (95% CI, 98–99)	99% (95% CI, 98–100)	99% (95% CI, 98–99)	99% (95% CI, 98–100)
Outcome	Effect per 1000 patients tested			
True positives (patients with COVID-19)	14 (11–17)	54 (44–68)	135 (110–170)	128 (116–140)
False negatives (patients incorrectly classified as not having COVID-19)	36 (33–39)	146 (132–156)	365 (330–390)	72 (60–84)
Quality of the evidence	50 studies, 2464 patients ⊕⊕○○ Low <sup>b,c</sup>		52 studies, 3481 patients ⊕⊕○○ Low <sup>b,c</sup>	
True negatives (patients without COVID-19)	941 (931–941)	792 (784–792)	941 (931–950)	792 (784–800)
False positives (patients incorrectly classified as having COVID-19)	9 (9–19)	8 (8–16)	5 (5–10)	8 (0–19)
Quality of evidence	50 studies, 10,077 patients ⊕⊕⊕○ Moderate <sup>c</sup>		52 studies, 9956 patients ⊕⊕⊕○ Moderate <sup>c</sup>	

Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; IgM, immunoglobulin M.

<sup>a</sup>5%, 20%, and 50% pretest probabilities were used to account for low and moderate community transmission rates, for cases of known close contact (eg, household contacts), and for outbreaks or surges of highly transmissible variants (eg, first Omicron surge).

<sup>b</sup>Unexplained inconsistency in the sensitivity results.

<sup>c</sup>The population from the studies was mainly unvaccinated individuals and those without a known history of COVID-19, which may overestimate test accuracy within vaccinated or previously infected populations.

**Table 1B. Performance of IgG Serologic Testing 1 and 2 Weeks After Onset of COVID-19 Symptoms**

IgG	Week 1		Week 2	
	Pretest Probability of 5% <sup>a</sup>	Pretest Probability of 20% <sup>a</sup>	Pretest Probability of 5% <sup>a</sup>	Pretest Probability of 20% <sup>a</sup>
Sensitivity	24% (95% CI, 19–30)	66% (95% CI, 62–69)	33 (31–34)	132 (124–138)
Specificity	99% (95% CI, 99–99)	99% (95% CI, 99–99)	17 (16–19)	68 (62–76)
Outcome	Effect per 1000 patients tested			
True positives (patients with COVID-19)	12 (10–15)	48 (38–60)	120 (95–150)	330 (310–345)
False negatives (patients incorrectly classified as not having COVID-19)	38 (35–40)	152 (140–162)	380 (350–405)	170 (155–190)
Quality of the evidence	88 studies, 4250 patients ⊕⊕○○○ Low <sup>b,c</sup>		90 studies, 5161 patients ⊕⊕○○○ Low <sup>b,c</sup>	
True negatives (patients without COVID-19)	941 (941–941)	792 (792–792)	941 (941–941)	792 (792–792)
False positives (patients incorrectly classified as having COVID-19)	9 (9–9)	8 (8–8)	5 (5–5)	8 (8–8)
Quality of evidence	88 studies, 22 321 patients ⊕⊕⊕○○ Moderate <sup>c</sup>		90 studies, 19 982 patients ⊕⊕⊕○○ Moderate <sup>c</sup>	

Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; IgG, immunoglobulin G.

<sup>a</sup>5%, 20%, and 50% pretest probabilities were used to account for low and moderate community transmission rates, for cases of known close contact (eg, household contacts), and for outbreaks or surges of highly transmissible variants (eg, first Omicron surge).

<sup>b</sup>Unexplained inconsistency in the sensitivity results.

<sup>c</sup>The population from the studies was mainly unvaccinated individuals and those without a known history of COVID-19, which may overestimate test accuracy within vaccinated or previously infected populations.

**Table 1C. Performance of IgM or IgG Serologic Testing 1 and 2 Weeks After Onset of COVID-19 Symptoms**

IgM or IgG	Week 1		Week 2							
	Sensitivity	Specificity	Pretest Probability of 5% <sup>a</sup>	Pretest Probability of 20% <sup>a</sup>	Pretest Probability of 50% <sup>a</sup>	Pretest Probability of 20% <sup>a</sup>	Pretest Probability of 50% <sup>a</sup>	Pretest Probability of 20% <sup>a</sup>	Pretest Probability of 50% <sup>a</sup>	
	35% (95% CI 27–44)	98% (95% CI 96–99)	17 (14–22)	70 (64–88)	175 (135–220)	37 (34–40)	148 (138–158)	370 (345–395)	74% (95% CI 69–79)	98% (95% CI 96–99)
	98% (95% CI 96–99)		33 (28–36)	130 (112–146)	325 (280–365)	13 (10–16)	52 (42–62)	130 (105–155)		
Outcome	Effect per 1000 patients tested									
True positives (patients with COVID-19)	28 studies, 1137 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>									
False negatives (patients incorrectly classified as not having COVID-19)	28 studies, 1685 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>									
True negatives (patients without COVID-19)	931 (912–941)	784 (768–792)	490 (480–495)	931 (912–941)	784 (768–792)	490 (480–495)	931 (912–941)	784 (768–792)	490 (480–495)	
False positives (patients incorrectly classified as having COVID-19)	19 (9–38)	16 (8–32)	10 (5–20)	19 (9–38)	10 (5–20)	19 (9–38)	16 (8–32)	10 (5–20)	16 (8–32)	10 (5–20)
Quality of evidence	28 studies, 4466 patients ⊕⊕⊕⊕ Moderate <sup>c</sup>									

Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; IgG, immunoglobulin G; IgM, immunoglobulin M.

<sup>a</sup>5%, 20%, and 50% pretest probabilities were used to account for low and moderate community transmission rates, for cases of known close contact (eg, household contacts), and for outbreaks or surges of highly transmissible variants (eg, first Omicron surge).

<sup>b</sup>Unexplained inconsistency in the sensitivity results.

<sup>c</sup>The population from the studies was mainly unvaccinated individuals and those without a known history of COVID-19, which may overestimate test accuracy within vaccinated or previously infected populations.

IgM- or IgG-positive test results ranged from 11% to 62%. Finally, the percentage of samples that yielded PCR-negative/total antibody-positive results ranged between 0% and 60%. These studies varied in terms of assay (chemistry, method, platform) and the timing of testing (eg, <20 days vs >15 days) ([Supplementary Table 6](#)).

The overall certainty of the evidence was very low because of concerns for risk of bias (case-control study design) and imprecision (as a result of small sample size). The use of clinical symptoms as a reference standard in some studies might have resulted in misclassification (ie, labeling noninfected patients as true-positive cases based on symptoms and serology alone).

#### **Benefits and Harms**

The panel's consensus opinion was that the clinical benefit of performing SARS-CoV-2 serologic testing in patients with high clinical suspicion for COVID-19 and repeatedly negative SARS-CoV-2 NAAT is low. This is because contemporary human populations have high SARS-CoV-2 seroprevalence resulting from natural, vaccine-induced, or hybrid immune responses. A positive serologic result in a symptomatic patient who tests repeatedly negative by NAATs may be attributed to vaccination and/or past infection as readily as to recent SARS-CoV-2 infection. Concluding that a positive serologic test is responsible for a patient's current symptoms can lead to misdiagnosis, particularly in periods when SARS-CoV-2 circulation is low and other respiratory virus circulation is high. In individuals who have not been vaccinated or previously infected (the population included in this recommendation's literature review), the negative predictive value of a SARS-CoV-2 serologic test is high when performed more than 2 weeks after symptom onset. In this instance, negative serologic results should prompt further evaluation of the patients' symptoms for alternative etiologies, if symptoms persist.

#### **Other Considerations**

No currently available SARS-CoV-2 serologic test can differentiate between recent or remote infection. Serologic tests cannot differentiate a serologic response to a vaccine antigen from a response elicited by recent or remote infection.

#### **Conclusions and Research Needs for This Recommendation**

Assessing anti-SARS-CoV-2 antibodies provides no added benefit over repeat NAATs for the diagnosis of acute COVID-19 and may lead to diagnostic uncertainty. Further research on the role of serologic and immunologic testing for diagnosis or management of long-COVID may be warranted.

#### **Serologic Testing in Pediatric Patients With Suspicion of MIS-C**

**Recommendation 3.** To assist with the diagnosis of MIS-C, the IDSA panel recommends using both IgG antibody testing and NAATs to provide evidence of current or recent past

COVID-19 (strong recommendation, very low certainty of evidence).

#### **Remarks.**

- Combining IgG antibody testing with NAAT may improve both the ability to diagnose MIS-C and to rule it out, compared with using NAAT alone. Knowing the patient's vaccination and COVID-19 history may be helpful in interpreting serology results.
- Differentiating MIS-C from conditions with overlapping symptomatology, such as Kawasaki disease, is important because Kawasaki disease requires treatment with specific therapies such as intravenous immunoglobulin or rituximab if diagnosed. The 2 diseases also differ in terms of potential complications and need for long-term medication and follow-up.
- The January 2023 definition of MIS-C agreed upon by US CDC and other public health officials requires evidence of current or recent SARS-CoV-2 infection by PCR, antigen, or serologic testing [3].

#### **Summary of the Evidence**

We identified 10 case series [148–157] that evaluated the use of SARS-CoV-2 serologic tests in pediatric patients presenting with signs of MIS-C ([Supplementary Table 7](#)). The case definitions of this inflammatory syndrome, typically manifesting with fever and shock similar to Kawasaki disease, varied across studies. Most reports were from early in the pandemic and did not require laboratory evidence of SARS-CoV-2 infection to define the syndrome. However, these studies reported a higher rate of MIS-C diagnosis when IgG antibodies were added to NAATs compared with using NAATs alone. NAATs were positive in ~30%–50% of cases in these studies, whereas IgG antibodies were positive in >80% cases in most studies. The major limitation of the evidence is that not all case series specified the timing of testing (either NAATs or serology) with respect to symptom onset. In addition, the type of serologic test utilized and epidemiologic links to COVID-19 cases were also not uniformly specified. The overall quality of evidence was very low because of the limitations of the case series study design and serious risk of bias. Even with very low certainty evidence, the panel issued a strong recommendation given the potentially catastrophic consequences of missing a diagnosis of MIS-C.

#### **Benefits and Harms**

The diagnosis of MIS-C is important to provide appropriate treatment and follow-up care for children, but no specific test is available to confirm this diagnosis. Another acute inflammatory syndrome in children, Kawasaki disease, which generally affects those younger than age 5 years, can present with symptoms very similar to those of MIS-C. Although the initial treatment of both MIS-C and Kawasaki disease typically includes supportive care and hospitalization, the differentiation of these

2 syndromes is important because Kawasaki disease requires treatment with specific therapies such as intravenous immunoglobulin or rituximab if diagnosed. The 2 diseases also differ in terms of potential complications and need for long-term medication and follow up. The management of children with MIS-C usually requires supportive care, including hospitalization and treatment of shock and respiratory distress, evaluation of cardiac function, and administration of medications that decrease inflammation. Diagnostic tools including serology to help exclude the diagnosis of MIS-C can therefore be helpful and important, but serologic testing may not be helpful in the actual diagnosis of MIS-C because many children have serologic evidence of past COVID-19 disease and/or vaccination. Further, given the high seroprevalence of antibodies to SARS-CoV-2 in the pediatric population, a negative serologic test result provides stronger evidence against a diagnosis of MIS-C than a positive result provides evidence for MIS-C. Although the certainty of evidence to inform this recommendation was very low, the panel concluded that the potential harm associated with a misdiagnosis of MIS-C warranted a strong recommendation for serologic testing together with NAAT in suspected cases.

#### **Other Considerations**

The clinical description and definition of MIS-C, as well as other SARS-CoV-2–associated inflammatory syndromes in children and adults, have varied over the pandemic and across countries and regions. Different clinical criteria with or without laboratory evidence of infection make comparisons of early studies problematic. It should be noted that the 2023 CDC definition of a *confirmed* case of MIS-C [3] requires meeting clinical and laboratory criteria; the latter include detection of SARS-CoV-2 RNA or antigen in a specimen up to 60 days before or during hospitalization or postmortem, or detection of SARS-CoV-2–specific antibodies in serum, plasma, or whole blood associated with the current illness resulting in or during hospitalization [158]. Assessment of the reliability, sensitivity, and specificity of laboratory diagnostic criteria to document MIS-C will be difficult in the future because laboratory criteria are now included in the case definition, and because case rates of MIS-C are falling. Given that U.S. pediatric seroprevalence for SARS-CoV-2 was 96.3% in December 2022, it is not surprising that 99% of recent US cases of MIS-C are seropositive for SARS-CoV-2 [159].

#### **Conclusions and Research Needs for This Recommendation**

Acute febrile inflammatory syndromes in children are challenging to diagnose, but updated definitions of MIS-C are making this diagnosis more uniform. Differentiation of Kawasaki disease from MIS-C will continue to be a challenge, particularly in young children. In addition, changes in MIS-C epidemiology have been seen, with fewer cases of MIS-C now reported in association with new SARS-CoV-2 variants [160]. In addition, COVID-19

vaccination is associated with reduced incidence of MIS-C, especially if 2 doses are given [161]. Continued investigation of the epidemiology and treatment of MIS-C is warranted.

#### **Serologic Testing to Assess Previous SARS-CoV-2 Infection—Antibody Class**

**Recommendation 4.** When evidence of previous SARS-CoV-2 infection is desired, the IDSA panel suggests testing for SARS-CoV-2 IgG, IgG/IgM, or total antibodies 3 to 5 weeks after symptom onset and suggests against testing for SARS-CoV-2 IgM (conditional recommendation, low certainty of evidence).

#### **Remarks.**

- SARS-CoV-2 NAAT and antigen tests have superior performance characteristics for diagnosis of COVID-19, compared with serologic testing.
- There are very limited situations in which SARS-CoV-2 antibody testing might be useful (eg, in helping to diagnose MIS-C).

#### **Summary of the Evidence**

Using our search strategy, 53 studies [22–24, 29, 30, 34, 35, 38–42, 47, 51, 53, 54, 57, 58, 60–63, 66, 67, 71, 73, 76, 82, 83, 90, 91, 93, 94, 98, 102, 105, 106, 109, 110, 112, 114, 117, 118, 121, 129, 134, 162–168] were identified that assessed the diagnostic accuracy of serologic tests (IgM, IgG, IgM or IgG, and total antibodies) between weeks 3 and 8 after symptom onset compared with SARS-CoV-2 NAATs (Tables 2A–2D). Many of these same studies also informed Recommendation 1 in this guideline.

The number of samples in these studies that were included in analyses of sensitivity ranged from 44 to 2591 and the number included in the specificity analyses ranged from 386 to 10 537 (Supplementary Figures 8A–28B). The pooled sensitivity at week 3 after symptom onset ranged from 83% to 93%, at week 4 from 86% to 95%, at week 5 from 89% to 95%, at week 6 from 85% to 97%, at week 7 between 73% and 92%, and at week 8 between 73% and 94%, whereas the pooled specificity ranged from 98% to 100% (Tables 2A–2D). When analyzed by antibody class, IgM consistently demonstrated the lowest analytical sensitivity compared with IgG alone, IgM/IgG, or total antibodies.

The certainty of evidence that informed sensitivity determinations was low, whereas the certainty of evidence to inform specificity determinations was moderate. Quality was rated downward for both sensitivity and specificity because of serious indirectness and because of unexplained inconsistency in sensitivity. Concerns with indirectness stemmed from the fact that study populations dated mainly from the prevaccination era, and preceded infection with currently circulating viral variants. Thus, the analyses presented here may overestimate test accuracy in contemporary populations with high SARS-CoV-2 seroprevalence.

### **Benefits and Harms**

There are limited data on antibody level stability after natural infection, and even less on interpretation of antibody levels in the setting of a patient who has been both vaccinated and infected. Clinicians must be aware of the limitations of antibody testing, as well as the impact of patient vaccination history. Most published studies were performed early in the pandemic, before widespread vaccination or large numbers of infected individuals. In the studies included in the literature review for this recommendation, all antibody classes had similar specificities up to 8 weeks, but the lack of sensitivity of IgM-only assays means that more patients would be incorrectly classified as not having been infected if they were tested for IgM alone.

### **Other Considerations**

Antibody testing to demonstrate prior infection may be helpful in limited scenarios. These could include evaluating patients with possible MIS-C or assessing immune response in immunocompromised patients with ongoing PCR positivity who might be candidates for monoclonal antibody or convalescent antibody therapy, if effective therapy were available, especially in setting of limited supplies.

### **Conclusions and Research Needs for This Recommendation**

Antibody testing for respiratory viruses is not part of routine clinical care and should not be used to guide decisions regarding vaccination or nonpharmacologic infection prevention precautions. Further study is needed to determine duration of antibody response to either vaccination or infection, and to clarify the clinical scenarios in which measuring these analytes can benefit individual patients or populations.

### **Serologic Testing to Assess Previous SARS-CoV-2 Infection—Antibody Target**

#### **Recommendation 5.**

- When evidence of prior SARS-CoV-2 infection is desired, the IDSA panel suggests using serologic assays that target nucleocapsid protein rather than spike protein (conditional recommendation, low certainty of evidence).

#### **Remarks.**

- Most available vaccines result in formation of only anti-spike antibodies but some (eg, CoronaVac and BBIBP-CorV, manufactured by Sinovac and Sinopharm, respectively) which contain inactivated whole virus, can also result in formation of anti-nucleocapsid antibodies [4].
- Given the high prevalence of vaccination in most populations and the persistence of anti-spike antibodies over time, detection of anti-spike antibodies has low positive predictive value for diagnosis of recent COVID-19 in most individuals.

### **Summary of the Evidence**

We identified 6 studies [55, 69, 109, 169–171] that assessed in the same study population the diagnostic test accuracy of serologic tests that target spike and nucleocapsid proteins and compared the results of a recent (past 1–8 weeks) positive SARS-CoV-2 NAAT (Tables 3A and 3B). All 6 studies included results for IgG, and 1 study also assessed IgM [170]. The sensitivity of assays targeting spike were 69% (95% CI, 65–73) and 69% (95% CI, 49–84) for IgM and IgG, respectively. The sensitivity of assays targeting nucleocapsid were 63% (95% CI, 58–69) and 75% (95% CI, 58–87) for IgM and IgG, respectively. The specificity ranged between 99% and 100% for both targets with IgM and IgG (Supplementary Figures 29A–30B).

The certainty of evidence that informed sensitivity and specificity for IgM was low, and the certainty of evidence that informed sensitivity and specificity for IgG was low and moderate, respectively. The certainty was downgraded for concerns related to indirectness and imprecision (single study for IgM) and unexplained inconsistency (sensitivity of IgG). Indirectness is a concern because these studies were conducted primarily in an unvaccinated population and with SARS-CoV-2 variants that no longer predominate in the population. Together, these factors may overestimate test accuracy for the current population, which has high seroprevalence for SARS-CoV-2 because of vaccination and/or natural infection. We did not lower the certainty for indirectness of comparison as the studies tested the same population with the same anti-spike and anti-nucleocapsid antibody assays.

### **Benefits and Harms**

Regardless of target, serologic assays are likely to provide poor estimates of recent infection by SARS-CoV-2. Although specificity was high in the studies evaluated, studies were conducted before widespread SARS-CoV-2 vaccination and infection. Specificity of anti-spike IgG as a marker of prior infection is expected to be low when testing the current, highly vaccinated population, as the spike antigen is the target for most available vaccines. In contrast, a positive result for IgM or IgG nucleocapsid antibodies is indicative of prior infection in most individuals, with the exception of those who received a vaccine that resulted in formation of anti-nucleocapsid antibodies, such as the inactivated whole-virus vaccines available outside the United States.

### **Other Considerations**

Although not specifically evaluated, waning of antibody levels over time after natural infection and vaccination has been noted. In particular, nucleocapsid-specific antibodies may be more short-lived in both immunocompetent [172] and immunocompromised individuals [173], although comparing results between studies is often difficult because of the different antibody assays used. As such, timing of antibody testing is

**Table 2A. Performance of IgM Serologic Testing in Weeks 3 to 8 After Onset of COVID-19 Symptoms**

IgM	Week 3		Week 4		Week 5		Week 6		Week 7		Week 8							
	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>						
Sensitivity	83% (95% CI, 74–90)																	
Specificity	99% (95% CI, 98–100)																	
	86% (95% CI, 75–93)																	
	89% (95% CI, 75–96)																	
	99% (95% CI, 97–100)																	
	85% (95% CI, 75–91)																	
	99% (95% CI, 94–100)																	
	73% (95% CI, 60–83)																	
	100% (95% CI, 31–100)																	
	99% (95% CI, 57–100)																	
Outcome	Effect per 1000 patients tested																	
True positives (patients with COVID-19)	42 (37–45)	166 (148–180)	415 (370–450)	43 (38–47)	172 (150–186)	430 (375–465)	45 (38–48)	178 (150–192)	445 (375–480)	43 (38–46)	170 (150–182)	425 (375–455)	37 (30–42)	146 (120–166)	365 (300–415)	37 (31–41)	146 (124–164)	365 (310–410)
False negatives (patients incorrectly classified as not having COVID-19)	8 (5–13)	34 (20–52)	85 (50–130)	7 (3–12)	28 (14–50)	70 (35–125)	5 (4–12)	22 (18–50)	55 (20–125)	7 (4–12)	30 (18–50)	75 (45–125)	13 (8–20)	54 (34–80)	135 (85–200)	13 (9–19)	54 (36–76)	135 (90–190)
Quality of the evidence	33 studies, 2054 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>			17 studies, 1211 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>			10 studies, 890 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>			10 studies, 693 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>			4 studies, 337 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>			4 studies, 328 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>		
True negatives (patients without COVID-19)	941 (931–950)	792 (784–800)	495 (490–500)	941 (922–950)	792 (776–800)	495 (485–500)	941 (922–950)	792 (776–800)	495 (485–500)	941 (893–950)	792 (752–800)	495 (470–500)	950 (925–975)	800 (748–852)	500 (455–545)	941 (893–989)	792 (744–840)	495 (446–544)
False positives (patients incorrectly classified as having COVID-19)	9 (9–19)	8 (0–16)	5 (0–10)	9 (0–28)	8 (0–24)	5 (0–15)	9 (0–28)	8 (0–24)	5 (0–15)	9 (0–57)	8 (0–48)	5 (0–30)	0 (0–655)	0 (0–552)	0 (0–345)	0 (0–408)	8 (0–344)	5 (0–215)
Quality of Evidence	33 studies, 7640 patients ⊕⊕⊕⊕ Moderate <sup>c</sup>			17 studies, 5095 patients ⊕⊕⊕⊕ Moderate <sup>c</sup>			10 studies, 2457 patients ⊕⊕⊕⊕ Moderate <sup>c</sup>			10 studies, 3687 patients ⊕⊕⊕⊕ Moderate <sup>c</sup>			4 studies, 552 patients ⊕⊕⊕⊕ Moderate <sup>c</sup>			4 studies, 1919 patients ⊕⊕⊕⊕ Moderate <sup>c</sup>		

Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; IgM, immunoglobulin M; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.  
<sup>a</sup>5%, 20%, and 50% pretest probabilities were used to account for low and moderate community transmission rates, for cases of known close contact (eg, household contacts), and for outbreaks or surges of highly transmissible variants (eg, first Omicron surge).  
<sup>b</sup>Unexplained inconsistency in the sensitivity results.  
<sup>c</sup>These studies were conducted mainly with populations who had not been vaccinated and before emergence of currently circulating viral variants. Therefore, the estimates presented here may overestimate test accuracy in contemporary populations with high seroprevalence to SARS-CoV-2.

**Table 2B. Performance of IgG1 Serologic Tests Weeks 3 to 8 After Onset of COVID-19 Symptoms**

IgG	Week 3		Week 4		Week 5		Week 6		Week 7		Week 8	
Sensitivity	89% (95% CI, 85–92)		95% (95% CI, 90–98)		95% (95% CI, 90–98)		97% (95% CI, 91–99)		92% (95% CI, 88–95)		94% (95% CI, 85–98)	
Specificity	99% (95% CI, 99–99)		99% (95% CI, 98–99)		99% (95% CI, 98–99)		99% (95% CI, 98–100)		99% (95% CI, 98–100)		99% (95% CI, 97–100)	
Outcome	Effect per 1000 patients tested											
	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>
True positives (patients with COVID-19)	45 (43–46)	178 (170–184)	445 (425–460)	48 (45–49)	190 (180–196)	475 (450–490)	48 (45–49)	190 (182–198)	475 (455–495)	46 (44–48)	184 (176–190)	460 (440–475)
False negatives (patients incorrectly classified as not having COVID-19)	5 (4–7)	22 (16–30)	55 (40–75)	2 (1–5)	10 (4–20)	25 (10–50)	2 (1–5)	10 (4–20)	25 (10–45)	1 (0–4)	6 (2–24)	40 (25–60)
Quality of the evidence	47 studies, 2591 patients		27 studies, 1545 patients		16 studies, 918 patients		14 studies, 832 patients		5 studies, 246 patients		3 studies, 251 patients	
	⊕⊕⊕⊕ Low <sup>b,c</sup>		⊕⊕⊕⊕ Low <sup>b,c</sup>		⊕⊕⊕⊕ Low <sup>b,c</sup>		⊕⊕⊕⊕ Low <sup>b,c</sup>		⊕⊕⊕⊕ Low <sup>b,c</sup>		⊕⊕⊕⊕ Low <sup>b,c</sup>	
True negatives (patients without COVID-19)	941 (941–941)	792 (792–792)	495 (495–495)	941 (931–941)	792 (784–792)	495 (490–495)	941 (931–941)	792 (784–792)	495 (490–495)	941 (931–941)	792 (784–792)	495 (490–495)
False positives (patients incorrectly classified as having COVID-19)	9 (9–9)	8 (8–8)	5 (5–5)	9 (9–19)	8 (8–16)	5 (5–10)	9 (9–19)	8 (8–16)	5 (5–10)	9 (9–19)	8 (8–16)	5 (5–10)
Quality of evidence	47 studies, 10 537 patients		27 studies, 6323 patients		16 studies, 3240 patients		14 studies, 3944 patients		5 studies, 696 patients		3 studies, 1082 patients	
	⊕⊕⊕⊕ Moderate <sup>c</sup>		⊕⊕⊕⊕ Moderate <sup>c</sup>		⊕⊕⊕⊕ Moderate <sup>c</sup>		⊕⊕⊕⊕ Moderate <sup>c</sup>		⊕⊕⊕⊕ Moderate <sup>c</sup>		⊕⊕⊕⊕ Moderate <sup>c</sup>	

Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; IgG1, immunoglobulin G1; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.  
<sup>a</sup>5%, 20%, and 50% pretest probabilities were used to account for low and moderate community transmission rates, for cases of known close contact (eg, household contacts), and for outbreaks or surges of highly transmissible variants (eg, first Omicron surge).

<sup>b</sup>Unexplained inconsistency in the sensitivity results.

<sup>c</sup>These studies were conducted mainly with populations who had not been vaccinated and before emergence of currently circulating viral variants. Therefore, the estimates presented here may overestimate test accuracy in contemporary populations with high seroprevalence to SARS-CoV-2.



**Table 2C. Performance of IgM or IgG Serologic Tests 3 to 8 Weeks After Onset of COVID-19 Symptoms**

IgM or IgG	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
Sensitivity	93% (95% CI, 88–96)	93% (95% CI, 83–98)	94% (95% CI, 88–97)	96% (95% CI, 80–99)	NR	NR
Specificity	98% (95% CI, 96–99)	99% (95% CI, 94–100)	99% (95% CI, 95–100)	99% (95% CI, 89–100)	NR	NR
Outcome	Effect per 1000 patients tested					
	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>
True positives (patients with COVID-19)	47 (44–48)	186 (176–192)	465 (440–480)	47 (42–49)	188 (176–194)	470 (440–485)
False negatives (patients incorrectly classified as not having COVID-19)	3 (2–6)	14 (8–24)	35 (20–60)	3 (1–6)	12 (6–24)	30 (15–60)
Quality of the evidence	17 studies, 646 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>	6 studies, 363 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>	6 studies, 442 patients ⊕⊕⊕⊕ Low <sup>b,c</sup>	3 studies, 91 patients ⊕⊕⊕ Low <sup>b,c</sup>	NR	NR
True negatives (patients without COVID-19)	931 (912–941)	784 (768–792)	490 (480–495)	941 (893–950)	792 (760–800)	495 (475–500)
False positives (patients incorrectly classified as having COVID-19)	19 (9–38)	16 (8–32)	10 (5–20)	9 (0–57)	8 (0–48)	5 (0–25)
Quality of evidence	17 studies, 3075 patients ⊕⊕⊕⊕ Moderate <sup>c</sup>	6 studies, 1344 patients ⊕⊕⊕⊕ Moderate <sup>c</sup>	6 studies, 950 patients ⊕⊕⊕⊕ Moderate <sup>c</sup>	3 studies, 450 patients ⊕⊕⊕ Moderate <sup>c</sup>	NR	NR

Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; IgG, immunoglobulin G; IgM, immunoglobulin M; NR, not reported; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.  
<sup>a</sup>5%, 20%, and 50% pretest probabilities were used to account for low and moderate community transmission rates, for cases of known close contact (eg, household contacts), and for outbreaks or surges of highly transmissible variants (eg, first Omicron surge).

<sup>b</sup>Unexplained inconsistency in the sensitivity results.

<sup>c</sup>These studies were conducted mainly with populations who had not been vaccinated and before emergence of currently circulating viral variants. Therefore, the estimates presented here may overestimate test accuracy in contemporary populations with high seroprevalence to SARS-CoV-2.

**Table 2D. Performance of Total Antibodies Serologic Tests Weeks 3 to 8 After Onset of COVID-19 Symptoms**

Total Antibodies	Week 3		Week 4		Week 5		Week 6		Week 7		Week 8					
Sensitivity	92% (95% CI, 88–94)		95% (95% CI, 92–97)		95% (95% CI, 91–97)		96% (95% CI, 90–99)		88% (95% CI, 71–95)		NR					
Specificity	100% (95% CI, 99–100)		99% (95% CI, 99–100)		99% (95% CI, 98–100)		99% (95% CI, 98–100)		100% (95% CI, 87–100)		NR					
Outcome	Effect per 1000 patients tested															
	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	5% <sup>a</sup>	20% <sup>a</sup>	50% <sup>a</sup>	
True positives (patients with COVID-19)	46 (44–47)	184 (176–188)	460 (440–470)	48 (46–49)	190 (184–194)	475 (460–485)	48 (46–49)	190 (182–194)	475 (455–485)	48 (45–50)	192 (180–198)	480 (450–495)	44 (36–48)	176 (142–190)	440 (355–475)	
False negatives (patients incorrectly classified as not having COVID-19)	4 (3–6)	16 (12–24)	40 (30–60)	2 (1–4)	10 (6–16)	25 (15–40)	2 (1–4)	10 (6–18)	25 (15–45)	2 (0–5)	8 (2–20)	20 (5–50)	6 (2–14)	24 (10–58)	60 (25–145)	
Quality of the evidence	23 studies, 1177 patients ⊕⊕⊕○ Low <sup>b,c</sup>		14 studies, 706 patients ⊕⊕⊕○ Moderate <sup>c</sup>		11 studies, 479 patients ⊕⊕⊕○ Moderate <sup>c</sup>		8 studies, 239 patients ⊕⊕⊕○ Moderate <sup>c</sup>		3 studies, 44 patients ⊕⊕⊕○ Moderate <sup>c</sup>		NR		NR		NR	
True negatives (patients without COVID-19)	950 (941–950)	800 (792–800)	500 (495–500)	941 (941–950)	792 (792–800)	495 (495–500)	941 (931–950)	792 (784–800)	495 (490–500)	941 (931–950)	792 (784–800)	495 (490–500)	950 (827–950)	800 (696–800)	500 (435–500)	NR
False positives (patients incorrectly classified as having COVID-19)	0 (0–0)	0 (0–8)	0 (0–5)	9 (0–9)	8 (0–8)	5 (0–5)	9 (0–19)	8 (0–16)	5 (0–10)	9 (0–19)	8 (0–16)	5 (0–10)	0 (0–123)	0 (0–104)	0 (0–65)	NR
Quality of evidence	23 studies, 4991 patients ⊕⊕⊕○ Moderate <sup>c</sup>		14 studies, 2949 patients ⊕⊕⊕○ Moderate <sup>c</sup>		11 studies, 2109 patients ⊕⊕⊕○ Moderate <sup>c</sup>		8 studies, 1558 patients ⊕⊕⊕○ Moderate <sup>c</sup>		3 studies, 386 patients ⊕⊕⊕○ Moderate <sup>c</sup>		NR		NR		NR	

Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; NR, not reported; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.  
<sup>a</sup>5%, 20%, and 50% pretest probabilities were used to account for low and moderate community transmission rates, for cases of known close contact (eg, household contacts), and for outbreaks or surges of highly transmissible variants (eg, first Omicron surge).  
<sup>b</sup>Unexplained inconsistency in the sensitivity results.  
<sup>c</sup>These studies were conducted mainly with populations who had not been vaccinated and before emergence of currently circulating viral variants. Therefore, the estimates presented here may overestimate test accuracy in contemporary populations with high seroprevalence to SARS-CoV-2.

These studies were conducted mainly with populations who had not been vaccinated and before emergence of currently circulating viral variants. Therefore, the estimates presented here may overestimate test accuracy in contemporary populations with high seroprevalence to SARS-CoV-2.

**Table 3A. Performance of IgM Serologic Tests that Target the Spike Versus Nucleocapsid Antigens**

		IgM Spike		IgM Nucleocapsid			
		69% (95% CI, 65–73)		63% (95% CI, 58–69)			
		100% (95% CI, 100–100)		100% (95% CI, 100–100)			
		Effect per 1000 Patients Tested					
		Pretest Probability of 5% <sup>a</sup>		Pretest Probability of 20% <sup>a</sup>		Pretest Probability of 50% <sup>a</sup>	
		IgM Spike		IgM Nucleocapsid		IgM Nucleocapsid	
		34 (33–37)		138 (130–146)		345 (325–365)	
		2 more TP in IgM Spike		12 more TP in IgM Spike		30 more TP in IgM Spike	
		16 (13–17)		62 (64–70)		155 (135–175)	
		2 fewer FN in IgM Spike		12 fewer FN in IgM Spike		30 fewer FN in IgM Spike	
		950 (950–950)		800 (800–800)		500 (500–500)	
		0 fewer TN in IgM Spike		0 fewer TN in IgM Spike		0 fewer TN in IgM Spike	
		0 (0–0)		0 (0–0)		0 (0–0)	
		0 fewer FP in IgM Spike		0 fewer FP in IgM Spike		0 fewer FP in IgM Spike	
		0 (0–0)		0 (0–0)		0 (0–0)	
Sensitivity		69% (95% CI, 65–73)		63% (95% CI, 58–69)			
Specificity		100% (95% CI, 100–100)		100% (95% CI, 100–100)			
		Factors That May Decrease Certainty of Evidence					
Outcome	Number of Studies (Number of Patients)	Risk of Bias		Publication Bias		Test Accuracy	
		Study Design	Indirectness	Inconsistency	Imprecision	IgM Spike	IgM Nucleocapsid
True positives (patients with COVID-19)	1 studies 909 patients <sup>b</sup>	case-control type studies	Not serious	Not serious	serious <sup>d</sup>	None	IgM Spike: 34 (33–37) IgM Nucleocapsid: 138 (130–146) Pretest Probability of 5%: 2 more TP in IgM Spike Pretest Probability of 20%: 12 more TP in IgM Spike Pretest Probability of 50%: 30 more TP in IgM Spike
False negatives (patients incorrectly classified as not having COVID-19)	1 studies 14,778 patients <sup>e</sup>	case-control type studies	Not serious	not serious	serious <sup>d</sup>	none	IgM Spike: 950 (950–950) IgM Nucleocapsid: 800 (800–800) Pretest Probability of 5%: 2 fewer FN in IgM Spike Pretest Probability of 20%: 12 fewer FN in IgM Spike Pretest Probability of 50%: 30 fewer FN in IgM Spike
True negatives (patients without COVID-19)	1 studies 14,778 patients <sup>e</sup>	case-control type studies	Not serious	not serious	serious <sup>d</sup>	none	IgM Spike: 0 fewer TN in IgM Spike IgM Nucleocapsid: 0 fewer TN in IgM Spike Pretest Probability of 5%: 0 fewer TN in IgM Spike Pretest Probability of 20%: 0 fewer TN in IgM Spike Pretest Probability of 50%: 0 fewer TN in IgM Spike
False positives (patients incorrectly classified as having COVID-19)	1 studies 14,778 patients <sup>e</sup>	case-control type studies	Not serious	not serious	serious <sup>d</sup>	none	IgM Spike: 0 fewer FP in IgM Spike IgM Nucleocapsid: 0 fewer FP in IgM Spike Pretest Probability of 5%: 0 fewer FP in IgM Spike Pretest Probability of 20%: 0 fewer FP in IgM Spike Pretest Probability of 50%: 0 fewer FP in IgM Spike

Abbreviations: CI, confidence interval; CoE, certainty of evidence; COVID-19, coronavirus disease 2019; FN, false negative; FP, false positive; IgM, immunoglobulin M; TN, true negative. <sup>a</sup>5%, 20% and 50% pretest probabilities were used to account for low and moderate community transmission levels, for cases of known close contact (eg, household contacts), and for outbreaks or surges of highly transmissible variants (eg, first Omicron surge).

<sup>b</sup>Of the 909 patients, 606 samples were tested for IgM Spike and 303 were tested for IgM nucleocapsid.

<sup>c</sup>There is no indirectness of comparison because these studies compared the 2 targets within the same population and assay. However, the population from the studies is mainly individuals with prevaccination, and before currently circulating variants infection, which may overestimate the test accuracy in contemporary populations.

<sup>d</sup>Serious imprecision due to low number of studies and events.

<sup>e</sup>Of the 14,778 patients, 6852 samples were tested for IgM anti-spike antibodies and 4926 were tested for IgM anti-nucleocapsid antibodies.

**Table 3B. Performance of IgG Serologic Tests that Target the Spike Versus the Nucleocapsid Antigen**

Outcome	IgG Spike		Factors that may Decrease Certainty of Evidence				Pretest probability of 5% <sup>a</sup>			Pretest probability of 20% <sup>a</sup>			Test Accuracy CoE			
	Sensitivity	Specificity	Number of studies (Numbers of Patients)	Study Design	Risk of Bias	Indirectness	Inconsistency	Imprecision	Publication Bias	IgG Spike	IgG Nucleocapsid	IgG Spike		IgG Nucleocapsid	Pretest probability of 50% <sup>a</sup>	
																IgG Nucleocapsid
True positives (patients with COVID-19)	69% (95% CI, 49–84)	99% (95% CI, 99–100)	6 studies 2379 patients <sup>b</sup>	Case-control type accuracy study	Not serious	serious <sup>c</sup>	Not serious	Not serious	None	34 (25–42)	38 (29–44)	138 (98–168)	150 (116–174)	345 (245–420)	375 (290–435)	⊕⊕○○ Low
False negatives (patients incorrectly classified as not having COVID-19)										<b>4 fewer TP in IgG Spike</b> 16 (8–25)	<b>12 fewer TP in IgG Spike</b> 12 (6–21)	<b>12 fewer TP in IgG Spike</b> 62 (32–102)	<b>50 (26–84)</b>	<b>30 fewer TP in IgG Spike</b> 155 (80–255)	<b>125 (65–210)</b>	
True negatives (patients without COVID-19)			6 studies 21 495 patients <sup>d</sup>	cohort & case-control type studies	not serious	serious <sup>c</sup>	not serious	not serious	none	941 (941–950)	941 (931–941)	792 (792–800)	792 (784–792)	495 (495–500)	495 (490–495)	⊕⊕⊕○ Moderate
False positives (patients incorrectly classified as having COVID-19)										<b>0 fewer TN in IgG Spike</b> 9 (0–9)	<b>0 fewer TN in IgG Spike</b> 9 (9–19)	<b>0 fewer TN in IgG Spike</b> 8 (0–8)	<b>8 (8–16)</b>	<b>0 fewer TN in IgG Spike</b> 5 (0–5)	<b>5 (5–10)</b>	
										<b>0 fewer FP in IgG Spike</b>	<b>0 fewer FP in IgG Spike</b>	<b>0 fewer FP in IgG Spike</b>	<b>0 fewer FP in IgG Spike</b>	<b>0 fewer FP in IgG Spike</b>	<b>0 fewer FP in IgG Spike</b>	

Abbreviations: CI, confidence interval; CoE, certainty of evidence; COVID-19, coronavirus disease 2019; FN, false negative; FP, false positive; IgG, immunoglobulin G; TN, true negative. <sup>a</sup>5%, 20%, and 50% pretest probabilities were used to account for low and moderate community transmission levels, for cases of known close contact (eg, household contacts), and for outbreaks or surges of highly transmissible variants (eg, first Omicron surge).

<sup>b</sup>Of the 2379 patient samples, 1339 samples were tested for IgM anti-spike antibodies and 1040 were tested for IgM anti-nucleocapsid antibodies.

<sup>c</sup>There is no indirectness of comparison since these studies compared the 2 targets within the same population and assay. However, the population from the studies is mainly individuals pre-vaccination, and pre-infection with currently circulating variants, which may overestimate the test accuracy in contemporary populations.

<sup>d</sup>Unexplained inconsistency in the sensitivity results.

<sup>e</sup>Of the 21 495 patient samples, 13 194 samples were tested for IgM anti-spike antibodies and 8301 were tested for IgM anti-nucleocapsid antibodies.

critical to the negative predictive value of the test and should ideally be performed within 3 and 5 weeks of symptom onset (See Recommendation 4).

#### **Conclusions and Research Needs for This Recommendation**

Sensitivity and specificity of nucleocapsid and spike antibody tests are similar, although interpretation of results as indicative of past infection (anti-nucleocapsid) versus past infection or vaccination (anti-spike) requires that clinicians know and understand the antibody target of the test that is used. Although NAATs remain the recommended approach for diagnosis of COVID-19, detection of anti-nucleocapsid IgG, combination IgG/IgM, or total antibodies may be useful for determining recent past infection in selected clinical situations (eg, MIS-C; see Recommendation 3).

### **SEROLOGIC TESTING TO IMPROVE OUTCOMES IN INDIVIDUALS WITH HISTORY OF VACCINATION OR PREVIOUS INFECTION**

#### **Recommendation 6.**

- In individuals with previous SARS-CoV-2 infection or vaccination, the IDSA panel suggests against routine serologic testing given no demonstrated benefit to improving patient outcomes (conditional recommendation, very low certainty of evidence).

#### **Remarks.**

- Serologic testing may be useful for diagnosing MIS-C in pediatric patients, especially when NAAT or antigen testing is negative, to provide evidence of recent COVID-19 (see Recommendation 3).
- A negative spike antibody test may be a useful metric to identify immunocompromised patients who are candidates for immune therapy such as convalescent plasma or monoclonal antibodies, if such therapies were available, or to prioritize administration of monoclonal therapies when supplies are limited.

#### **Summary of the Evidence**

**Studies Addressing Natural Infection.** We found no direct evidence to correlate serologic testing with improved outcomes at the population or individual level for persons with prior COVID-19. We identified 6 studies [174–179], 5 cohort and 1 case control study [176] that evaluated the relationship between antibody level (eg, seropositivity) and decreased SARS-CoV-2 reinfection rates. This included 5 studies that assessed binding antibodies and 1 that assessed neutralizing antibodies [174]. Across the cohort studies, subjects with a seropositive result after infection appeared to have a lower likelihood of developing reinfection. In the case control study [176], doubling of the antibody level was associated with reduced odds of reinfection. These studies, however, varied in the definition of reinfection, the timing of testing in relation

to history of COVID-19, the antibody test used, and the comparison groups (Supplementary Table 8).

**Studies Addressing Vaccination.** We identified 10 postvaccination studies [180–189] including 6 cohort studies, 1 clinical trial [183], 1 systematic review [182], and 2 case control studies [181, 188] that evaluated the relationship between binding antibody (bAb) level and SARS-CoV-2 breakthrough infection rates [188, 189]. Results were inconsistent: 5 studies reported a correlation between seropositivity and decreased SARS-CoV-2 infection rates, whereas 2 [186, 187] reported no difference in infection rates between those who had seroconverted after vaccination and those who had not. Of note, the number of breakthrough infections in some studies was small, and several studies focused on patient populations with immunocompromising conditions.

The presence of nAbs appears to correlate with protection against breakthrough infection based on a clinical trial and a systematic review (Supplementary Table 9). However, a single tier or threshold antibody level that is predictive of protection has not been identified, and unless calibrated to a common reference standard, quantitative results are not commutable across assays (See Other Considerations). We also did not identify any studies measuring the predictive value of hybrid immunity (ie, serologic testing in individuals with confirmed previous SARS-CoV-2 infection and COVID-19 vaccination).

**Summary Statement.** The overall quality of evidence was very low because of risk of bias (Supplementary Table 4), indirectness, and imprecision. There is indirectness in comparison, as the included studies only describe differences between subjects who underwent serologic testing. It is unclear if patient outcomes are any different because of testing (ie, if test results would lead to any meaningful changes in care or outcomes). It is unclear therefore if serologic testing provides any benefit for patient care decisions or to patients.

#### **Benefits and Harms**

Anti-SARS-CoV-2 antibody tests help identify people who may have been infected with SARS-CoV-2 or were vaccinated. However, a universal antibody level that is predictive of protection from reinfection after infection or vaccination has not been identified. The panel did not identify any benefits to antibody testing in most individuals to inform management decisions.

There may be selected scenarios for immunocompromised hosts, however, where serologic testing could be considered. One example is for patients with symptomatic COVID-19 and significant humoral immune impairment who are being evaluated for treatment with convalescent plasma. The European Conference of Infections in Leukemia as well as the National Comprehensive Cancer Network recommend consideration of

convalescent plasma for hematologic/bone marrow transplant patients who are SARS-CoV-2 seronegative [190, 191–193]. An additional use of serology is for prioritization of new monoclonal antibody therapies, if they become available in the future, especially if supplies are limited. Prioritizing treatment for those individuals most in need of protection could help optimize utilization of resources. Of note, a thorough review of convalescent plasma or monoclonal antibody therapies for COVID-19 is outside of the scope of this guideline.

Positive anti-SARS-CoV-2 antibody testing is part of the CDC case definition for MIS-C [194]. However, false-positive results may detract from identifying the true cause of illness. For example, for children, it is important to differentiate MIS-C from other inflammatory processes such as bacterial infections, Kawasaki disease, or rheumatic fever because the management and long-term follow up of these entities is different. There are also potential harms to serologic testing after vaccination. False-positive results may promote a false sense of security and lead individuals to take fewer steps to protect themselves against SARS-CoV-2 or to not seek treatment when it would otherwise have been indicated.

False-negative results are also possible, which could cause emotional distress for previously vaccinated individuals by leading them to assume that the vaccine was ineffective. Postvaccination antibody test results may be negative in individuals without a history of previous natural infection if the test used does not detect the type of antibodies induced by the vaccine.

#### **Other Considerations**

Although current EUA indications do not preclude the use of SARS-CoV-2 antibody tests in vaccinated individuals, none of the currently authorized tests has been authorized to assess humoral immunity after vaccination or to define a threshold of protection after infection. Therefore, the FDA recommends against SARS-CoV-2 antibody testing to assess immunity.

Detection of anti-RBD-bAbs has generally correlated with the emergence of nAbs, and the detection of nAbs has been associated with protection against COVID-19. Vaccine clinical trial data also showed that higher antibody levels (either bAbs or nAbs) were associated with fewer breakthrough infections. Despite these observations, a definitive correlate of protection has not been identified. One complicating factor is that antibody levels measured across different studies used different antibody tests that had not been calibrated to a common reference standard such as the WHO international standard for anti-SARS-CoV-2 immunoglobulin [195]. Currently, only 1 commercial test has been authorized to detect nAbs from individuals with recent or prior SARS-CoV-2 infection [196]. Although this assay has been calibrated against the WHO standard, it was not validated for testing after vaccination or for predicting protection from reinfection. In addition, a given antibody titer may provide lower protection against variants

compared with the strains included in the vaccine or that caused prior infection. Furthermore, serologic testing does not assess the full spectrum of immune responses to infection or vaccination. Induction of T-cell immunity plays a critical role in protection against SARS-CoV-2, and although the potential importance of viral mutations and T-cell immune evasion is debated, it is unlikely that variants will be able to evade SARS-CoV-2-specific cell-mediated immunity. Currently, assays designed to quantify T-cell immune function are not widely available for clinical use.

#### **Conclusions and Research Needs for This Recommendation**

Higher antibody levels generally correlate with protection against SARS-CoV-2 infection, but a single titer that predicts protection has not yet been identified. Therefore, antibody testing (either with bAb or nAbs) to assess for immunity to SARS-CoV-2 is not recommended routinely. Antibody testing should not be used to guide vaccination, revaccination, or booster decisions.

More research is needed to determine the role of SARS-CoV-2 antibody testing in evaluating immunity against SARS-CoV-2 and to better understand if antibody tests will be helpful for identifying “nonresponders” who should receive repeated COVID-19 vaccination or a different schedule for boosters. Efforts to better predict antibody longevity, correlation of bAb levels to nAbs levels, and serological surrogates of immune protection (including how this may differ in individuals who also have a history of both natural COVID-19 and vaccination) are needed. Future studies should use standardized assays that are calibrated to an international standard.

#### **DISCUSSION**

Early in the COVID-19 pandemic, there was intense interest in measuring antibody responses to SARS-CoV-2 infection, with the hope that a correlate of protective immunity would be identified. Similar interest accompanied release of results of clinical trials of the first SARS-CoV-2 vaccines. In response, in-depth and wide-ranging research into the immunology of SARS-CoV-2 was conducted. This work yielded important insights, including that prior infection and vaccination reduce the risk of severe and fatal COVID-19, and that the presence of neutralizing antibodies (vs their absence) and higher binding antibody concentrations (vs lower concentrations) provide greater risk reduction. Yet despite these discoveries, and after almost 800 million infections and administration of 13.5 billion vaccine doses [5], the hope that a serologic marker of protection will be found remains unrealized. Consequently, current clinical indications for testing SARS-CoV-2 antibodies are few. In addition, as seroprevalence approaches 100% in most human populations, measuring

antibodies has declined in importance as a public health strategy to surveil for SARS-CoV-2 infection.

In the current guideline, the IDSA panel identified only 1 clinical situation in which antibody testing is recommended: to assist with the diagnosis of MIS-C in children. Of note, ongoing assessment of the value of serologic testing in this clinical setting will be difficult because a positive test result is included in the case definition [3]. The panel also acknowledges that a negative spike antibody test may be a useful metric to identify immunocompromised patients who are candidates for immune therapy such as convalescent plasma, monoclonal antibodies, or to prioritize administration of monoclonal therapies when supplies are limited.

To optimize diagnostic test accuracy when considering serologic testing, IgG, IgG/IgM, or total antibody assays are suggested over an IgM assay because of reduced sensitivity of IgM alone. Testing should not be done during the first 2 weeks of symptoms because antibody production is often not detectable until week 3 or later; of note, few data are available after 8 weeks of symptoms, and the panel did not assess studies that reported results after this time. If serologic testing is being done to assess for evidence of previous SARS-CoV-2 infection in someone who has been vaccinated with an mRNA (eg, Moderna COVID-19 vaccine), protein subunit (eg, Novavax COVID-19 vaccine), or viral vector vaccine (eg, J&J/Janssen COVID-19 vaccine, which is no longer available for use in the United States), serologic assays that target the nucleocapsid protein are preferred over those that target the spike protein because these vaccines elicit anti-spike antibodies.

It is important to emphasize that serologic test performance remains variable and sometimes the same manufacturer's assay performed quite differently across studies. Factors that may have contributed to heterogeneity of results include differences in the patient population tested, the exact timing of testing relative to symptom onset, and the use of different NAAT assays as the reference standard for comparison. Patients with mild symptoms, or those who are asymptomatic [197], may display weaker immune responses to SARS-CoV-2 compared with those with severe illness. Standardized reporting of disease severity was not included in most studies. The exact timing of testing was also not specified in all studies. Uncertainty around the timing of testing could have affected the time-stratified analyses. In addition, most studies did not include a reference standard. Future assays should be calibrated against an international reference standard such as that developed by the WHO [198]. Although in the previous version of this guideline, the clinical performance of lateral flow assays was more variable than ELISA or CIA tests, this difference was not observed in the current updated literature review. Finally, in a new subgroup analysis, we found no substantive differences in test characteristics (ie, sensitivity and specificity) based on viral antigen (ie, spike vs nucleocapsid protein).

## CONCLUSIONS

Clinicians and public health officials need to understand the indications for serologic testing and the performance of serology assays used in their settings to accurately interpret anti-SARS-CoV-2 antibody test results. Whenever possible, serologic assays with established high sensitivity and specificity (ie,  $\geq 99.5\%$ ) should be employed. IgG, IgG/IgM, and total antibody tests appear to have better sensitivity and specificity than other immunoglobulin classes and perform best when used between 3 to 5 weeks after symptom onset. The clinical indications for antibody testing to support a diagnosis of COVID-19 are limited. Antibodies to SARS-CoV-2 support the diagnosis of MIS-C in children. A negative spike antibody test may be a useful metric to identify immunocompromised patients who are candidates for immune therapy such as convalescent plasma, monoclonal antibodies, or to prioritize administration of monoclonal therapies when supplies are limited. The current high seroprevalence of anti-SARS-CoV-2 antibodies in most populations reduces the value of antibody testing for epidemiologic purposes. Although higher antibody titers and presence of neutralizing antibodies correlate with reduced risk of SARS-CoV-2 infection, a correlate of immune protection from infection has not been defined.

## Supplementary Data

**Supplementary materials** are available at *Clinical Infectious Diseases* online. Consisting of data provided by the authors to benefit the reader, the posted materials are not copyedited and are the sole responsibility of the authors, so questions or comments should be addressed to the corresponding author.

## Notes

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**Financial support.** This project was funded in part by a cooperative agreement with the Centers for Disease Control and Prevention (CDC; grant number 6 NU50CK000477-04-01). The CDC is an agency within the Department of Health and Human Services (HHS). The contents of this guideline do not necessarily represent the policy of CDC or HHS and should not be considered an endorsement by the federal government.

**Potential conflicts of interest.** The following list displays what has been reported to the IDSA. To provide thorough transparency, the IDSA requires full disclosure of all relationships, regardless of relevancy to the guideline topic. Evaluation of such relationships as potential conflicts of interest is determined by a review process which includes assessment by the Board of Directors liaison to the Standards and Practice Guideline Committee and, if necessary, the Conflicts of Interest and Ethics Committee. The assessment of disclosed relationships for possible conflicts of interest is based on the relative weight of the financial relationship (ie, monetary amount) and the relevance of the relationship (ie, the degree to which an association might reasonably be interpreted by an independent observer as related to the topic or recommendation of consideration). The reader of these guidelines should be mindful of this when the list of disclosures is reviewed. M. H. serves on a clinical adjudication panel for Sanofi; receives research funding from the Centers for Disease Control and Prevention (CDC) and CDC Foundation; serves on the *Society for Healthcare Epidemiology of America (SHEA)* Board of Directors and Chair of the SHEA Education & Research Foundation; received other remunerations from Sage, Medline, and Molnylycke; and served as Chair of the IDSA Diagnostics Committee. K. H. served an advisor to Quidel, BioFire, Pfizer, and Takeda; received other remunerations from Quidel, Pfizer, and Takeda; served as Editor to American Society of Microbiology (ASM) and member of Clinical and Laboratory Standards Institute Antifungal Committee; received research funding from the National Institutes of Health (NIH); and served on the exam committee for the American Board of Internal Medicine, and associate editor for Open Forum Infectious Diseases. J. E. serves as a consultant for Sanofi Pasteur, Pfizer, and AstraZeneca; an advisor/consultant for Meissa Vaccines; receives research funding from the CDC, Pfizer, Brotman Baty Research Institute, Merck, Novavax, GlaxoSmithKline, and AstraZeneca; served as an advisor to Teva Pharmaceuticals; and served as member of Pediatric Infectious Diseases Society (PIDS) Publication Committee and Transplant ID Committee. R. H. serves on the advisory board for Specific Diagnostics; serves as an advisor for ThermoFisher, Qiagen, Torus, and Roche; serves as an editor for the *Journal of Clinical Microbiology*; serves as a member of the microbiology committee for the College of American Pathology and a member of the AST subcommittee for the Clinical and Laboratory Standards Institute; serves as Vice-chair for the Diagnostics Committee at the Infectious Diseases Society of America (IDSA); serves on the Professional Practices Group at the American Society for Microbiology (ASM); receives research funding from Qiagen, bioMerieux, Momentum Diagnostics, Specific Diagnostics, IHMA, and Pattern; served as a consultant for bioMerieux. M. L. serves as an advisor for Sanofi, Seqirus, Medicago, GSK, Janssen, Novavax, Pfizer, MD Brief; receives research funding from the Canadian Institutes of Health Research, World Health Organization (WHO), Medical Research Council (United Kingdom), has received in-kind supply of vaccine from Sanofi, has been paid for expert testimony on institutional and workplace vaccine policy, and has served on the DSMB for CanSino Biologics and an advisor to Merck. D. M. serves as a member of the direct taskforce for diagnostic stewardship for the Society for Healthcare Epidemiology of America (SHEA); receives research funding from the Centers for Disease Control and Prevention (CDC), National Institute of Health (NIH), Veterans Affairs, Health Services Research and Development (HRSD), and the Agency for Healthcare Research and Quality (AHRQ). R. P. has a patent on *Bordetella pertussis*/parapertussis PCR issued, a patent on a device/method for sonication with royalties paid by Samsung to Mayo Clinic, and a patent on an anti-biofilm substance issued; serves as consultant to PhAST, Torus Biosystems, Day Zero Diagnostics, Mammoth Biosciences, Netflix, Abbott Laboratories, Oxford Nanopore Technologies, CARB-X, Qvella, and HealthTrackRx; receives other remuneration from NBME, UpToDate, and the Infectious Disease Board Review

Course; received grants from CD Diagnostics, Merck, Hutchison Biofilm Medical Solutions, Accelerate, ContraFect, TenNor Therapeutics Limited, Shionogi, NIH, BIOFIRE, Adaptive Phage Therapeutics, National Science Foundation, and the Department of Defense; and has served as a consultant to Curetis, Specific Technologies, NextGen Diagnostics, Pathoquest, Selux Diagnostics, and 1928 Diagnostics. S. S. serves as a Board member for the Evidence Foundation, receives honoraria for evidence reviews, methodological support and teaching from the Evidence Foundation; serves on guideline panels for the American Gastroenterological Association (AGA); and receives research funding from the Department of Veterans Affairs Evidence Synthesis Program. Y. F. Y. serves as a Board member for the Evidence Foundation; receives honoraria for evidence reviews, methodological support and teaching from the Evidence Foundation, the AGA for evidence reviews, and the Institute for Clinical and Economic Review (ICER) for committee meetings; serves as a Director for the Evidence Foundation and for the U.S. GRADE Network; and served on an Independent Appraisal Committee for ICER. R. M. serves as a Board member for the Evidence Foundation; and receives honoraria for evidence reviews, methodological support and teaching from the Evidence Foundation. M. H. M. serves as a Board member for the Evidence Foundation; receives honoraria for evidence reviews, methodological support and teaching from the Evidence Foundation; receives research funding from the Agency for Healthcare Research and Quality, the Endocrine Society, and the Society for Vascular Surgery; has received research funding the American Society of Hematology and the WHO; and has served as a guideline methodologist for the WHO. A. B. received honorarium from the ICER. R. A. M. serves as a Board member for the Evidence Foundation; receives honoraria for evidence reviews, methodological support and teaching from the Evidence Foundation, and ICER for committee meetings; receives research funding from the NIH, the WHO, the American College of Rheumatology, the American Society of Hematology, and Bohringer Ingelheim; serves as Chair of the Midwest Comparative Effectiveness Public Advisory Council of the ICER; serves on the Methods Committee for Kidney Disease Improving Global Outcomes Work Group; serves on the Clinical Guidelines Committee for the Canadian Society of Nephrology; and previously served on the Clinical Guidelines Committee for the American College of Physicians (ACP). All other authors report no potential conflicts.

All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

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