Systematic review of reviews of symptoms and signs of COVID-19 in children and adolescents

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ABSTRACT
Objective To undertake a systematic review of reviews of the prevalence of symptoms and signs of COVID-19 in those aged under 20 years.

Design Narrative systematic review of reviews. PubMed, medRxiv, Europe PMC and COVID-19 Living Evidence Database were searched on 9 October 2020.

Setting All settings, including hospitalised and community settings.

Patients Children and young people (CYP) under age 20 years with laboratory-proven COVID-19.

Study review, data extraction and quality Potentially eligible articles were reviewed on title and abstract by one reviewer. Quality was assessed using the modified AMSTAR criteria and data were extracted from included studies by two reviewers.

Main outcome measures Prevalence of symptoms and signs of COVID-19.

Results 1325 studies were identified and 18 reviews were included. Eight were high quality, 7 medium and 3 low quality. All reviews were dominated by studies of hospitalised children. The proportion of asymptomatic CYP ranged from 14.6% to 42%. Fever and cough were the two most common symptoms; proportions with fever ranged from 46% to 64.2% and with cough from 32% to 55.9%. All other symptoms or signs including rhinorrhoea, sore throat, headache, fatigue/myalgia and gastrointestinal symptoms including diarrhoea and vomiting were infrequent, occurring in less than 10%–20%.

Conclusions Fever and cough are the most common symptoms in CYP with COVID-19, with other symptoms infrequent. Further research on symptoms in community samples are needed to inform pragmatic identification and testing programmes for CYP.

BACKGROUND
Most countries rely on symptom-based testing systems for SARS-CoV-2, the virus that causes COVID-19. This is based on the assumption that testing symptomatic individuals and tracing, testing and isolating their positive contacts is the most efficient way of using limited testing resources. In the UK, the criteria for testing individuals for SARS-CoV-2 are the presence of fever, a new persistent cough or loss or change in smell (https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms/coronavirus-in-children/) with similar symptom-based case definitions operating in other countries.

Such case definitions imply that individuals with fever and/or cough have COVID-19 until proven otherwise, requiring those who are symptomatic to quarantine until a negative SARS-CoV-2 test is obtained. Despite evidence that individual symptoms and signs have relatively poor diagnostic properties for COVID-19 in adults, other causes of fever and cough are uncommon in healthy adults. However, children and young people (CYP), particularly young children, may have 8–10 upper respiratory infections (URIs) per year, particularly over winter. Thus, fever and URI symptoms are likely to be less reliable indicators of SARS-CoV-2 positivity in children, even when virus prevalence is high.

The resumption of schooling in the UK in September 2020 led to a 10-fold increase in the numbers of CYP 0–18 years old reporting potential COVID-19 symptoms in England. This almost certainly represented large numbers of children attending school with mild fevers and URI symptoms, caused by a variety of common circulating winter viruses. Yet these URI symptoms led to many CYP being asked to quarantine or be tested for SARS-CoV-2 before returning to school. Moreover,
there has been some uncertainty about which symptoms indicate likely COVID-19 in CYP, as some recent studies have suggested that other symptoms such as gastrointestinal symptoms or fatigue may be common in CYP with COVID-19.

Policy on case definitions and testing policy for COVID-19 in CYP requires evidence on which symptoms are most commonly associated with test positivity, but also those that are not. In view of a rapidly growing literature in this area including a number of systematic reviews, we undertook a systematic review of reviews (or umbrella review) of symptoms or signs of proven COVID-19 in CYP aged under 20 years.

METHODS
We undertook a rapid systematic review of systematic reviews, reporting Methods and Findings using the PRISMA checklist.

Review question
Our review question was: What is the prevalence of symptoms and signs of COVID-19 in those aged under 20 years?

Search strategy
We searched four databases (PubMed; medRxiv; COVID-19 Living Evidence database; European PMC) on 9 October 2020. Search terms in PubMed were (“COVID-19”[Text Word] OR “2019-nCoV”[Text Word] OR “SARS-CoV-2”[Text Word]) AND (“child”[All Fields] OR “infant”[All Fields]) AND (“symptom”[All Fields] OR “clinical presentation”[All Fields] OR “Signs”[All Fields]), applying the filters for Meta-Analysis or Systematic review. Search terms in the medRxiv preprint server were “COVID-19 AND child AND systematic review AND (symptom OR sign OR clinical)”—note that these searches were undertaken separately due to the inability to perform Boolean searches in this database. The COVID-19 Living Evidence database (https://zika.ispm.unibe.ch/assets/data/pub/search_beta/) and European PMC (https://europepmc.org) were searched subsequently using similar terms. We did not limit studies by date or language. Identified relevant reviews were hand-searched for additional likely studies. Studies were also identified through the professional networks of the authors.

Eligibility
We included systematic reviews or meta-analyses of clinical presentations (symptoms or signs) of laboratory-proven COVID-19 disease in CYP. We only included reviews which
► Systematically searched and reviewed the literature using prespecified protocols,
► Examined CYP from 0 to 19 years. Studies with a wider age range which provided data on CYP separately were eligible,
► Included only studies with laboratory-proven SARS-CoV-2 cases,
► Assessed and reported the frequency or prevalence of symptoms or signs of COVID-19.

We excluded studies of investigation results, cross-age studies that did not separate data on CYP; studies of conditions linked with COVID-19 (eg, paediatric inflammatory multisystem syndrome), and preprints that had been deposited for >5 months without update or publication.

Study selection
The search and inclusion flowchart is shown in figure 1. Titles and abstracts were reviewed and potentially eligible articles identified by one reviewer (RMV). Full-text review and agreement on final inclusion was undertaken by two reviewers (RMV, JLW). The abstracts of 1325 studies were reviewed and 21 potentially eligible articles were identified for full-text review, with one additional study identified through handsearching of citation lists and three studies through professional networks. After further review, 18 reviews are included in this review.

Data extraction
Descriptive findings were extracted to a spreadsheet and checked for accuracy by two reviewers (JLW, RMV).

Quality evaluation
Quality including risk of bias was assessed using an adapted version of Assessing the Methodological Quality of Systematic Reviews (AMSTARS). We characterised reviews as high, medium or low quality. High-quality reviews were required to have provided a priori designs; searched at least two bibliographic databases; searched for reports regardless of publication type; listed and described included studies; used at least two people for data extraction; documented the size and quality of included studies and used this to inform their syntheses; synthesised study findings narratively or statistically; assessed the likelihood of publication bias; and included a conflict of interest statement. Those unable to meet six of these eight requirements were characterised as low quality, with those meeting six or seven criteria characterised as medium quality. We made no attempt to assess the quality of studies included in each review. Quality assessments for each review are shown in online supplemental appendix table 1.
### Table 1 Characteristics of included studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Source Type Context</th>
<th>Search end</th>
<th>Age</th>
<th>Case definition</th>
<th>Included studies</th>
<th>Total children</th>
<th>Countries of studies</th>
<th>Quality summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mantovani et al</td>
<td>Professional SR/MA All</td>
<td>11 April</td>
<td>NS</td>
<td>NS</td>
<td>19</td>
<td>2855</td>
<td>China, USA, Spain</td>
<td>High</td>
</tr>
<tr>
<td>Hoang et al</td>
<td>PubMed SR All</td>
<td>14 May</td>
<td>≤21 years</td>
<td>RT-PCR+</td>
<td>131</td>
<td>7780</td>
<td>China, Vietnam</td>
<td>Low</td>
</tr>
<tr>
<td>Yasuhara et al</td>
<td>PubMed SR All</td>
<td>20 June</td>
<td>≤18 years</td>
<td>RT-PCR+</td>
<td>46</td>
<td>114</td>
<td>China, USA, Spain, Italy, Korea, Vietnam</td>
<td>Low</td>
</tr>
<tr>
<td>Cui et al</td>
<td>PubMed SR/MA All</td>
<td>30 April</td>
<td>&lt;18 years</td>
<td>RT-PCR+</td>
<td>48</td>
<td>5829</td>
<td>China, Singapore, Korea, Spain, USA, Italy</td>
<td>High</td>
</tr>
<tr>
<td>De Sousa et al</td>
<td>PubMed SR All</td>
<td>6 April</td>
<td>&lt;18 years</td>
<td>RT-PCR+</td>
<td>38</td>
<td>1124</td>
<td>China, Italy, Iran, Singapore, South Korea, Vietnam</td>
<td>Low</td>
</tr>
<tr>
<td>Zhang et al</td>
<td>PubMed SR/MA All</td>
<td>4 May</td>
<td>0–18 years</td>
<td>Laboratory confirmed COVID-19</td>
<td>46</td>
<td>551</td>
<td>China, Singapore, Malaysia, Spain, USA, Vietnam</td>
<td>High</td>
</tr>
<tr>
<td>Ma et al</td>
<td>PubMed SR/MA Hospitalised</td>
<td>21 April</td>
<td>NS</td>
<td>RT-PCR+</td>
<td>15</td>
<td>486</td>
<td>China</td>
<td>Medium</td>
</tr>
<tr>
<td>Ding et al</td>
<td>Professional SR/MA All</td>
<td>1 April</td>
<td>0–17 years</td>
<td>RT-PCR+</td>
<td>14</td>
<td>371</td>
<td>China</td>
<td>High</td>
</tr>
<tr>
<td>Christophers et al</td>
<td>PubMed SR All</td>
<td>15 May</td>
<td>1 month to 18 years</td>
<td>RT-PCR+</td>
<td>21</td>
<td>123</td>
<td>China, USA, Italy, Iran, Malaysia</td>
<td>Medium</td>
</tr>
<tr>
<td>Liguoro et al</td>
<td>PubMed SR All</td>
<td>1 May</td>
<td>0–18 years</td>
<td>‘Confirmed cases’</td>
<td>62</td>
<td>7480</td>
<td>China, South Korea, Italy, Spain, USD, Malaysia</td>
<td>Medium</td>
</tr>
<tr>
<td>Assaker et al</td>
<td>PubMed SR All</td>
<td>3 May</td>
<td>NS</td>
<td>RT-PCR+</td>
<td>28</td>
<td>1614</td>
<td>China, Malaysia, Spain, Italy</td>
<td>Medium</td>
</tr>
<tr>
<td>Chang et al</td>
<td>Handsearch SR/MA All</td>
<td>15 March</td>
<td>&lt;18 years</td>
<td>WHO definition</td>
<td>9*</td>
<td>93</td>
<td>China</td>
<td>Medium</td>
</tr>
<tr>
<td>Wang et al</td>
<td>medRxiv SR/MA All</td>
<td>31 March</td>
<td>&lt;18 years</td>
<td>WHO definition</td>
<td>49†</td>
<td>1667</td>
<td>China, Singapore, Korea, Vietnam, Iran</td>
<td>High</td>
</tr>
<tr>
<td>Jahangir et al</td>
<td>PubMed SR All</td>
<td>9 April</td>
<td>0–19 years</td>
<td>NS</td>
<td>27</td>
<td>NS</td>
<td>China, South Korea, Spain, USA: numbers not stated</td>
<td>Low</td>
</tr>
<tr>
<td>Pei et al</td>
<td>PubMed SR All</td>
<td>3 March</td>
<td>0–18 years</td>
<td>RT-PCR+</td>
<td>5</td>
<td>70</td>
<td>China</td>
<td>Medium</td>
</tr>
<tr>
<td>Kharoud et al</td>
<td>Europe PMC SR/MA All</td>
<td>15 July</td>
<td>0–18 years</td>
<td>Laboratory confirmed COVID-19</td>
<td>37</td>
<td>668</td>
<td>China, Italy, USA, Spain</td>
<td>High</td>
</tr>
<tr>
<td>Wang et al</td>
<td>Europe PMC SR/MA</td>
<td>10 August</td>
<td>NS</td>
<td>NS</td>
<td>38</td>
<td>3028</td>
<td>China, other countries (not listed)</td>
<td>High</td>
</tr>
</tbody>
</table>

*Search end: all dates are in 2020. Countries: where countries have no number next to them, each country had one included study.*

†In Wang et al, only studies with at least 9 cases were included in the meta-analysis.

*In Chang et al, 2 studies examined neonates only which were not included in the meta-analysis.

All, all contexts; MA, meta-analysis; NS, not stated; SR, systematic review.
The USA. Eight were high quality,11 14 15 17 19 24 27 28  seven were in Spain, South Korea, Malaysia, Singapore, Vietnam, Iran and all reviews were from China, with studies also from Italy, reviews were in English. The great majority of studies included in all reviews were of hospitalised CYP. No reviews specifically focused on symptoms or signs among community samples of infected children, and none compared symptoms in hospitalised compared with non-hospitalised children. One review included only studies of infants,16 one included a comparison of symptoms in children with those in adults from China26 and one examined only gastrointestinal symptoms.28

One study provided descriptive data from included studies only and did not report pooled estimates of symptom prevalence.23

**Figure 2** Proportions of children and young people with symptoms and signs of COVID-19 across reviews.

**Data synthesis and summary measures**

We confined our analysis to descriptive measures of the prevalence of each symptom or sign in each included review. We made no attempt to quantitatively summarise findings across reviews.

**RESULTS**

We included 18 reviews in our analysis.11–28 Characteristics of the included reviews are shown in [table 1](#); all are freely available online (see online supplemental appendix table 2). All reviews were in English. The great majority of studies included in all reviews were from China, with studies also from Italy, Spain, South Korea, Malaysia, Singapore, Vietnam, Iran and the USA. Eight were high quality,11 14 15 17 19 24 27 28 seven were medium16 18 20–23 26  and three were low quality.12 13 25 The very great majority of studies within the reviews were of hospitalised CYP. No reviews specifically focused on symptoms or signs among community samples of infected children, and none compared symptoms in hospitalised compared with non-hospitalised children. One review included only studies of infants,16 one included a comparison of symptoms in children with those in adults from China26 and one examined only gastrointestinal symptoms.28

One study provided descriptive data from included studies only and did not report pooled estimates of symptom prevalence.23

**Figure 2** shows the proportions of CYP in each review with reported symptoms or signs of COVID-19 data shown by study in online supplemental appendix table 3. The proportion who were asymptomatic ranged from 14.6% to 42%. Fever and cough were the most common symptoms; proportions with fever ranged from 46% to 64.2% and with cough from 32% to 55.9%. All other symptoms or signs were present at less than 10%–20%. Vomiting, diarrhoea and abdominal pain were reported separately in the majority of studies; however, some reported gastrointestinal symptoms together. These estimates ranged from 7.4%15 to 17.7%.28 All studies which reported fatigue and myalgia did so as ‘fatigue or myalgia’, with the exception of Assaker et al22 who reported myalgia in 14% and fatigue in 8%.

Only two studies reported on combinations of symptoms or signs. Wang et al24 in a high-quality review reported that 30% had both fever and cough, while a medium-quality review by Christophers et al20 reported that 58.4% had only a single symptom; in 23.2% this was fever, 5.6% cough and in 1.6% diarrhoea.

Few studies addressed differences in symptom profiles by age among CYP. A large high-quality review by Cui et al15 reported that proportions with fever and cough were similar in infants to those in older children, conclusions supported by a small low-quality review by Yasuhara et al.13

In contrast, in a small medium-quality review, Christophers et al20 reported that fever appeared more common in older children (65%) than in infants (48%). Christophers et al20 also reported that vomiting and diarrhoea occurred largely in those under 9 years, whereas Yasuhara et al13 reported gastrointestinal symptoms to be more common in adolescents, although numbers were small and symptoms uncommon in all ages.

Only one review compared CYP with adults. Pei et al26 undertook a medium-quality review comparing symptoms in 170 children and 275 adults, restricting the analysis to studies from China. They reported that CYP were more likely to be asymptomatic than adults (20% compared with 5.5%).

**DISCUSSION**

We identified 18 systematic reviews and meta-analyses that were informative about the prevalence of symptoms and signs of COVID-19 in CYP. Findings show clearly that fever and cough are the most common symptoms occurring in around 40%–60% of infected CYP, with all other symptoms occurring at much lower prevalences, under 10%–20%. Common URI symptoms such as rhinorrhea or sore throat are uncommon in COVID-19, as are somatic symptoms such as headache and fatigue/myalgia and gastrointestinal symptoms including diarrhoea and vomiting. We found no data on the frequency of loss or change in smell in these reviews.

Few data were available on the frequency of combinations of symptoms although one study reported that the combination of fever and cough occurred in around one-third of CYP, less common than fever or cough alone. The common symptoms of fever and cough appeared equally prevalent across younger and older children. There were insufficient data to conclude that there were age differences in the frequency of other symptoms between younger and older children.
Conclusions
Available data suggest that fever and cough are the predominant symptoms of COVID-19 in CYP, supporting their use in case definitions of potential COVID-19 in this age group. Other symptoms are less much frequent, suggesting their inclusion in case definitions for COVID-19 for CYP may reduce specificity. Rhinorrhea and sore throat are infrequent in COVID-19 in CYP, which, given the frequency of URI and associated symptoms in young children, suggests that their presence is much more likely to indicate infection with viruses other than SARS-CoV-2. Further data on symptoms in community samples including in schools are urgently needed to inform pragmatic identification and testing programmes for CYP and reduce misclassification of CYP as potential COVID-19 cases requiring isolation of peers and families.

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Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

Data availability statement No data are available. All data are from open-access published papers.

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References
Original research


