**Compartmentalized dynamics of cytomegalovirus replication in treated congenital infection.**

Luck, S.E. 1,2, Emery, V.C. 1,3, Atkinson, C 1 Sharland, M 2 , Griffiths, P.D.1

1 Centre for Virology, University College London Medical School, London, UK

2 Paediatric Infectious Diseases Research Group, St George’s University of London, London, UK

3 Department of Microbial and Cellular Sciences, University of Surrey, Guildford, UK

**Corresponding author:**

Dr Suzanne Luck

Centre for Virology, University College London Medical School, Royal Free Campus, Rowland Hill Street, London NW3 2PF

Telephone: 0207 830 2997

Fax: 0207 830 2854

Suzanne.luck@ucl.ac.uk

Author contributions: SL planned, set up and ran the study, processed samples, analysed and interpreted the data and produced the first draft of the manuscript. VE provided supervision, contributed to analysis and data interpretation and revised drafted manuscript. CA contributed to management and conduct of study, carried out CMV PCR analysis and revised drafted manuscript. MS and PG were involved with study conception, supervised the study and revised manuscript drafts.

All authors have approved the final article.

**KEY WORDS**

Congenital cytomegalovirus; Virus half-life; virus dynamics; antiviral treatment

**Abbreviations:**

Basic reproductive number (Ro)

Central nervous system (CNS)

Congenital Cytomegalovirus (CCMV)

Cytomegalovirus (CMV)

Ganciclovir (GCV)

High performance liquid chromatography (HPLC)

Randomised controlled trial (RCT)

Sensorineural hearing loss (SNHL)

Valganciclovir (VGCV)

Viral load and immunology in congenital CMV study (VICC)

Virus half-life (T1/2)

Virus transport medium (VTM)

**ABSTRACT**

**Background:** Cytomegalovirus (CMV) is the most prevalent congenital infection in developed countries. A significant number of infected infants develop long-term neurodevelopmental and hearing impairment irrespective of whether disease is detectable at birth. Studies of viral load and replication dynamics have informed the treatment of CMV in adult populations but no similar data exist in neonates.

**Objectives:** To study CMV virus kinetics in different body fluids of babies treated for congenital infection.

**Study design:** CMV virus load was sequentially analyzed in blood, urine and saliva in 17 babies treated for symptomatic congenital CMV infection.

**Results:** Virus was detectable in the urine and saliva of all babies at baseline but in only 15/17 in blood. At the end of 6 weeks of antiviral treatment CMV remained detectable in 9/14 blood samples, 9/12 urine samples and 4/7 salivary swabs. Median half-life (T1/2) of virus decline in blood was 2.4 days (IQR 1.9-3.3) and basic reproductive number (Ro) was 2.3. Although T1/2 values were similar in urine and saliva to those observed in blood, virus dynamics differed both during and after treatment.

**Conclusions:** T1/2 and Ro in blood in this group of neonates were similar to values derived from studies of immunocompromised adults. The persistent viremia observed in treated neonates cannot therefore be adequately explained by the virus dynamics early in treatment. The different dynamics exhibited in blood and urine suggests that studying changes in distinct body compartments may assist in further understanding long-term manifestations of disease.

**Word count 243 (limit 250)**

**BACKGROUND**

Cytomegalovirus (CMV) is a common congenital infection and an important cause of sensorineural hearing loss (SNHL) [1, 2]. A minority of those infected will have clinically detectable disease at birth, but 13% of those without disease will subsequently develop significant impairments, particularly SNHL [3].

Antiviral treatment improves hearing and neurodevelopmental outcomes when started in the first month of life in symptomatic newborns [4, 5]. There are no randomized studies to support treatment of babies without detectable disease at birth and the search for prognostic markers for adverse long term outcome in these newborns is ongoing .

Natural history studies in adult transplant recipients show that high viral load and viral kinetics in whole blood correlate with the development of CMV end-organ disease [6] with viruria independently associated with disease in renal transplant patients.

High viral load has also been associated with poor long-term outcomes in congenitally infected babies in some studies [7-11] but not others [12]. A major limitation is the lack of adequate numbers of babies without disease at birth that subsequently develop CMV-related morbidity. As SNHL is progressive, the duration of follow-up required to produce meaningful results further impacts on the conduct of such studies [13].

Data in infants largely reports single measurements of viral load rather than sequential monitoring coupled with viral kinetic modelling. A recent study in neonates treated for congenital CMV (CCMV) observed a correlation between higher burden of CMV DNA in the blood in the first 6 weeks of treatment and subsequent SNHL [5]. Given the known prolonged urinary excretion of CMV in those infected in early life it is possible that virus kinetics differ between body fluids in this group, but no data exist currently.

Further defining the natural history of CMV virus kinetics in different body fluids in those with CCMV could aid our understanding of the pathogenesis of this virus and assist in developing biomarkers.

**OBJECTIVES**

This study aimed to define the kinetics of CMV replication in blood, urine and saliva in a group of babies receiving treatment.

**STUDY DESIGN**

The Viral load and Immunology in Congenital CMV (VICC) study recruited babies into an ethically approved protocol in the UK. 19 babies with CCMV were recruited from 7 study sites between 2008 and 2011. After CCMV diagnosis, participants in the study provided blood, urine and salivary samples at set time-points during and after treatment and up to two years of age. CMV quantitative analysis was performed in the Department of Virology at the Royal Free Hospital. Only the 11 babies that received treatment, with sufficient viral load results for meaningful analysis, are presented here (see supplemental data).

An ethically approved treatment registry for CCMV was also active in the UK during the same time period. Babies in this registry with multiple entries for CMV viral load were included for analysis (N=2)(see supplemental data). The parent(s) or legal guardian(s) of participants in both the above studies provided written informed consent.

Multiple samples were also received at our laboratory from 3 treated babies as part of routine clinical care.

**Definitions*:***

 CCMV was confirmed if a sample tested positive for CMV within 21 days of life. Symptomatic infection was defined according to criteria used in a previously published randomised controlled trial (RCT) of treatment [4].

**Salivary swab acquisition:**

Salivary samples were taken using neonatal flocked swabs (Sterilin™ Cambridge, UK) at least one hour after the baby’s last feed. Swabs were resuspended in 1ml virus transport medium (VTM) prior to extraction.

**Detection and quantitation of CMV DNA:**

 Total nucleic acid was extracted using the commercial Nuclisense Easymag system (Biomerieux, Basingstoke UK) according to manufacturer’s instructions. CMV viral load was then determined using an in-house real-time quantitative PCR as described previously (lower limit of detection being 200 copies/ml, (168 IU/ml)). [14].

An estimate of the volume of saliva held on swabs was obtained by weighing swabs pre- and post- saturation in saliva. The mean of 3 samples gave an estimated volume of 27ul of saliva which allowed for calculations of CMV viral load/ml of saliva.

**Measurement of ganciclovir levels:**

Ganciclovir (GCV) levels were determined by the Bristol Antimicrobial reference laboratory as described in detail elsewhere [15].

**Statistical analysis:**

‘Baseline’ samples were included if they had been obtained before, or within 7 days of, treatment commencing. If multiple samples had been obtained prior to treatment the sample taken closest to treatment onset was used. End of treatment samples were accepted if taken +/- 3 days from the last day of treatment. For analyses involving comparison of virus load between different body fluids samples were only considered if taken within one day of each other.

Viral load measurements of <200 copies/ml were entered as half the limit of detection to enable log conversion and construction of virus decline curves. Mann-Whitney U test was used to compare median values, with Wilcoxon signed rank test used for comparison of paired samples.

Virus decline was calculated using methodology described previously [16]. The slope of decline of loge (ln) viral load was computed using segmental regression in GraphPad Prism (GraphPad Software, La Jolla, CA) with X0 constraint for decline set at the point where the phase of most rapid viral decline appeared to end. Virus half-life was then defined using the formula (-ln2)/slope.

For the calculation of the basic reproductive number (Ro) after cessation of therapy the following formula was used:

Ro = 1+ r/δ ert where r is the growth rate of virus after stopping therapy, δ Is the death rate of a CMV infected cell (taken from Emery et al, 1999) and t is a time delay between infection and production of new virions (set at 2 days)[16].

**RESULTS**

**Participants:**

The study included viral load data from 17 babies treated for congenital CMV. All babies had clinical signs or symptoms of congenital infection with central nervous system (CNS) involvement. SNHL was the only evidence of suspected CNS disease in one neonate.

Treatment was with intravenous ganciclovir (iv GCV) at a dose of 5-6mg/kg twice daily (bid) (n=10), oral valganciclovir (VGCV) at a dose of 10-17mg/kg bid alone (n=2) or a combination of iv GCV followed by VGCV (n=5). All babies receiving mixed treatment commenced with iv GCV for a minimum of 6 days.

**Baseline viral loads:**

In blood and urine samples 13/17 and 14/15 were taken prior to, or on the day of, treatment initiation. In saliva 6/8 baseline specimens were acquired after day 0 of treatment (median 3 days).

DNAemia was detected in 15/17 (88%) neonates at baseline. All urine and saliva samples were CMV DNA positive. Both the neonates with undetectable DNAemia had samples taken prior to treatment commencing. Median and interquartile ranges (IQR) of CMV loads at baseline in blood, urine and saliva were 3.8 (3.3-4.2), 7.7 (7.0-8.4) and 7.2 (6.8-8.3) log10 genomes/ml with corresponding means of 3.8 (SD ± 0.8), 7.7 (± 0.9) and 7.3 (± 1.5) (*Figures 1 and 2*).

More than one blood sample and more than one urine sample were taken in five neonates before treatment. In 2/5 of these babies viral load in blood and urine decreased by more than 1.0 log10 genomes/ml (blood: range 0.2-1.5 log10 genomes/ml over 6-21 days; urine: range 0.1-1.6 log10 genomes/ml over a period of 1-23 days).

**End of treatment viral load:**

At the end of a 42 day treatment course CMV remained detectable in 9/14 blood samples (65%), 9/12 urine samples (75%) and 4/7 salivary swabs (57%). Median CMV load in blood, urine and saliva in babies with virus still detectable was 2.8 log10 genomes/ml (IQR 2.5-3.5), 2.9 log10 genomes/ml (IQR 2.7-3.9) and 4.0 log10 genomes/ml (IQR 3.2-5.5) respectively. CMV loads were significantly lower at the end of treatment in blood and urine, but not saliva, compared to baseline values (P = <0.01, 0.02 and 0.13 respectively).

**CMV kinetics during therapy:**

Baseline CMV loads were approximately 4.0 log10 genomes/ml higher at the start of treatment in urine and saliva as compared with blood but this difference narrowed during the 42 days of treatment (*Figure 1*). In keeping with this observation, viral decline between the start and end of 42 days treatment was higher in urine and saliva compared to blood with an absolute decline of -1.2 log10 genomes/ml (IQR -1.8 to -0.9) observed in 14 paired blood samples compared to -4.4 log10 genomes/ml (IQR -5.5 to -3.8) in urine (N=10) and -4.8 log10 genomes/ml (IQR -5.2 to -3.9) in saliva (N=7)(*Table 1*). In 2/14 paired blood samples no decline was observed during treatment whereas CMV DNA decreased in all urine and salivary samples.

CMV DNA decline in blood and urine was more rapid during the first 7 days of treatment when compared to the full 42 days of treatment (*Table 1*). Salivary samples from early sampling points were too few to allow for analysis.

Using these data, the half-life of decline (T1/2) was calculated using segmental regression of the most rapid phase of virus decline (examples shown in *Figure 3*). The median T1/2 in blood of 14 neonates was 2.4 days (IQR 1.9-3.3 days),in urine it was 2.0 days (IQR 1.3-2.6) (N=14) and in saliva 1.5 days (IQR 1.4-2.4) (N=4).

**Post therapy kinetics:**

Once treatment had stopped, a rebound of CMV DNA levels was observed within 1 week in 4/8 blood, 6/9 urine and 1/5 saliva samples. The median increase in CMV load over the first 7 days post-treatment was 0.52 (blood), 1.04 (urine) and 2.05 (saliva) log10 genomes/ml (*Figure 2*). Where no rebound was observed virus had been undetectable at the end of treatment in 2/4 (blood), 1/3 (urine) and 2/4 (saliva) babies; in the remaining babies virus was still detectable but continued to decrease after treatment discontinuation.

Maximum virus levels following treatment were at age 3 months in blood and age 6 months in urine and saliva samples (*Figure 2*). Median maximum virus load was not significantly different from baseline in blood (3.78 vs 2.96 log10 genomes/ml respectively; P=0.3) or saliva (7.39 vs 7.16 log10 genomes/ml respectively; P = 0.72). Urine CMV load was, however, significantly lower at 6 months of age compared to baseline (median 5.94 vs 7.74 log10 genomes/ml respectively; P= <0.01).

The basic reproductive number (Ro) was calculated using the growth rate derived from the post therapy virus rebound and previous estimates of the death rate of a CMV infected cell in vivo (~0.98 day). This calculation revealed a median Ro value of CMV in blood of 2.3 (n=2) in urine of 2.8 (n=2) and in saliva of 4.6 (n=1).

**Long-term viral control:**

CMV DNA remained detectable in no blood samples (n=6) at month 12 but in most urine (7/7) and saliva (6/8) samples. By 24 months CMV DNA remained undetectable in all blood samples (n=3) but was detectable in 2/3 urine and 1/3 saliva samples. In urine the median CMV load at 12 months was 4.7 log10 genomes/ml (IQR 4.5-5.8)(N=7) which was significantly lower than the baseline load (7.7 log10 genomes/ml (p<0.01)). Similarly, salivary viral load was significantly lower at month 12 than at baseline [4.5 log10 (IQR 2.5- 5.1) vs 7.56 log10 (IQR 6.76-8.44) genomes/ml respectively (p <0.01)].

**Ganciclovir levels:**

Ganciclovir levels were mostly below quoted reference values of 0.5 mg/L (trough) and 7.0mg/L (peak) (*Figure 4).* Plotting log10 virus decline during the first 7 days of treatment against peak and trough GCV levels at day 7 did not reveal any significant association between these two parameters in the 5 babies studied (supplemental data).

**DISCUSSION**

The results of this study provide insight into the kinetics of CMV in different biological compartments in neonates during and after antiviral therapy. Despite the differences in baseline CMV load, half-livesduring the initial phase of treatment were comparable across compartments (P = 0.1-0.4 for inter-group comparisons) and similar to the 2 days observed in infrequently sampled adult immunocompromised hosts [16].

In contrast to data from studies in adult transplant patients with similar starting virus loads over half of the neonates still had DNAemia detectable at the end of the 6 week treatment course [14]. This observation and that of an initially rapid virus decline followed by a nadir is in keeping with similar observations in treated neonates [17].

The reasons for this incomplete suppression in neonates are unclear. In the setting of CMV replication in HIV infection the efficacy of iv GCV (5mg/kg/bid) has been estimated at 91.5% [18] but where plasma levels are lower the efficacy will be reduced. Therapeutic drug monitoring of GCV levels in the neonates enrolled in this study indicate that plasma GCV levels were low but consistent with other data in children [15]. Higher levels of GCV may be needed in this population to fully inhibit replication. Analysis of the CMV UL97 locus showed no evidence of mutations known to confer GCV resistance.

Alternatively, persistent viremia may represent continued virus excretion from ‘sanctuary sites’ inaccessible to antiviral agents. Given the increased audiological and neurological morbidity observed in CCMV when compared to immunocompromised adults, the inner ear or CNS would be possible sources of such virus reservoirs and drug penetration at these sites correspondingly suboptimal [19]. Testing such a hypothesis is challenging since no data evaluating virus persistence in CSF exist, nor is this likely to be ethically acceptable.

Although rebound of virus was common in all body fluids in the first week post-treatment, maximal rebound occurred earlier in blood when compared to urine and saliva; the rebound in DNA-emia is consistent with other recent reports during neonatal treatment [5]. Only virus in urine rebounded to a level significantly lower than baseline in our study. This is an important observation if the ‘threshold’ concept of CMV disease proposed in adults applies to CCMV [20].

If virus is not in a steady state at the initiation of therapy then the dynamic models adopted may not be fully applicable. However, congenital infection often occurs months before birth and the values obtained here are consistent with those derived in adults. The growth of CMV during the rebound phase allowed us to estimate Ro for CMV during this resurgence in replication. The Ro values are relatively modest at 2.3 and 2.8 for blood and urine respectively, consistent with those observed in D+R- solid organ transplant recipients [21].

Overall the data presented here imply that initial viral response to treatment is similar to that observed in adult immunocompromised hosts. However, following this initial response, CMV replication patterns differ in neonates when compared to immunocompromised adults. In keeping with this altered virus kinetics is the ongoing audiological damage and neurological damage unique to this age group. The reasons for this remain to be elucidated but are likely a complex combination of host and virus factors, including immunological immaturity and a possible increased susceptibility of the rapidly dividing cells in early life to viral damage.

It is possible that even longer periods of treatment or antiviral drugs with better CNS penetration will be needed if the continued detection of high amounts of virus in urine is of relevance for subsequent neurological outcomes. The challenge must now be to evaluate whether current antiviral agents reach the body compartments relevant for disease at sufficient levels to prevent viral replication and/or damage and whether monitoring virus load in multiple body compartments can assist in further defining viral parameters of importance for future prognosis.

WORD COUNT 2536

**Funding**

This work received no formal grant funding.

The work was supported by funding from the Royal Free Charitable Trustees

**ACKNOWLEDGEMENTS**

Competing interests: None declared

Ethical approval:

Congenital CMV Treatment Registry Thames Valley Multi-centre REC Ref: 07-MRE12-5

VICC study Royal Free Hospital and Medical School REC Ref: 07/Q0501/30

We would like to acknowledge all local participating centres who recruited babies into these studies and whose data are included in these analyses particularly Dr Ryan Watkins and Dr Heike Rabe (Brighton & Sussex University Hospitals), Dr Bernadette O’Hare (Cardiff & Vale UHB, Wales), Dr Hermione Lyall (Imperial College Healthcare NHS Trust), Dr Julia Clarke and Dr Eleri Williams (The Newcastle Upon Tyne Hospitals NHS Foundation Trust), Dr Vivienne van Someren (Royal Free London, NHS Foundation Trust), Prof Andrew Pollard and Dr Clara Sisnett (Oxford University Hospital’s NHS Trust). We would like to thank the parents who gave consent for their children to be involved with studies and the CMV parent group who reviewed study concepts and critically appraised the parent information sheets for the two ethically approved studies (cmvaction.org).

We would also like to acknowledge and thank Prof Andrew Lovering and staff at the UK Antimicrobial reference laboratory (BCARE) for conducting analysis of ganciclovir levels.

Reference List

 (1) Kenneson A, Cannon M. Review and meta-analysis of the epidemiology of congenital cytomegalovirus (CMV) infection. Reviews in Medical Virology **2007**; 17(4):253-76.

 (2) Nance W, Lim G, Dodson K. Importance of congenital cytomegalovirus infections as a cause for pre-lingual hearing loss. J Clin Virol **2006**; 35:221-5.

 (3) Dollard S, Grosse S, Ross D. New estimates of the prevalence of neurological and sensory sequelae and mortality associated with congenital cytomegalovirus infection. Reviews in Medical Virology **2007**; 17(5):355-63.

 (4) Kimberlin D, Lin C, Sanchez P, et al. Effect Of Ganciclovir Therapy On Hearing In Symptomatic Congenital Cytomegalovirus Disease Involving The Central Nervous System: A Randomized, Controlled Trial. Journal of Pediatrics **2003**; 143:16-25.

 (5) Kimberlin DW, Jester PM, Sanchez PJ, et al. Valganciclovir for symptomatic congenital cytomegalovirus disease. N Engl J Med **2015 Mar 5**; 372(10):933-43.

 (6) Emery V, Sabin C, Cope A, Gor D, Hassan-Walker A, Griffiths P. Application of viral-load kinetics to identify patients who develop cytomegalovirus disease after transplantation. The Lancet **2000**; 355:2032-6.

 (7) Boppana S, Fowler K, Pass R, et al. Congenital Cytomegalovirus Infection: Association Between Virus Burden in Infancy and Hearing Loss. Journal of Pediatrics **2005**; 146:817-23.

 (8) Lanari M, Lazzarotto T, Venturi V, et al. Neonatal Cytomegalovirus Blood Load and Risk of Sequelae in Symptomatic and Asymptomatic Congenitally Infected Newborns. Pediatrics **2006**; 117:76-83.

 (9) Rivera LB, Boppana SB, Fowler KB, Britt WJ, Stagno S, Pass RF. Predictors of hearing loss in children with symptomatic congenital cytomegalovirus infection. Pediatrics **2002 Oct**; 110(4):762-7.

 (10) Walter S, Atkinson C, Sharland M, et al. Congenital cytomegalovirus: association between dried blood spot viral load and hearing loss. Archive of Diseases in Childhood Fetal Neonatal Edition **2008 Jul**; 93(4):F280-F285.

 (11) Whitley RJ, Cloud G, Gruber W, et al. Ganciclovir treatment of symptomatic congenital cytomegalovirus infection: results of a phase II study. National Institute of Allergy and Infectious Diseases Collaborative Antiviral Study Group. J Infect Dis **1997 May**; 175(5):1080-6.

 (12) Ross SA, Novak Z, Fowler KB, Arora N, Britt WJ, Boppana SB. Cytomegalovirus blood viral load and hearing loss in young children with congenital infection. Pediatr Infect Dis J **2009 Jul**; 28(7):588-92.

 (13) Dahle A, Fowler K, Wright J, Boppana S, Britt W, Pass R. Longitudinal investigation of hearing disorders in children with congenital cytomegalovirus. Journal of the American Academy of Audiology **2000**; 11(5):283-90.

 (14) Mattes FM, Hainsworth EG, Hassan-Walker AF, et al. Kinetics of cytomegalovirus load decrease in solid-organ transplant recipients after preemptive therapy with valganciclovir. Journal of Infectious Diseases **2005 Jan 1**; 191(1):89-92.

 (15) Luck S, Lovering A, Griffiths P, Sharland M. Ganciclovir treatment in children: evidence of subtherapeutic levels. International Journal of Antimicrobial Agents **2011 May**; 37(5):445-8.

 (16) Emery VC, Cope AV, Bowen EF, Gor D, Griffiths PD. The Dynamics of Human Cytomegalovirus Replication In Vivo. J Exp Med **1999 Jul 19**; 190(2):177-82.

 (17) Kimberlin DW, Acosta EP, Sanchez PJ, et al. Pharmacokinetic and pharmacodynamic assessment of oral valganciclovir in the treatment of symptomatic congenital cytomegalovirus disease. Journal of Infectious Diseases **2008 Mar 15**; 197(6):836-45.

 (18) Emery VC, Griffiths PD. Prediction of cytomegalovirus load and resistance patterns after antiviral chemotherapy. PNAS **2000 Jul 5**; 97(14):8039-44.

 (19) Strazielle N, Ghersi-Egea JF. Factors affecting delivery of antiviral drugs to the brain. Reviews in Medical Virology **2005 Mar**; 15(2):105-33.

 (20) Griffiths PD. Burden of disease associated with human cytomegalovirus and prospects for elimination by universal immunisation. Lancet Infect Dis **2012 Oct**; 12(10):790-8.

 (21) Atabani SF, Smith C, Atkinson C, et al. Cytomegalovirus replication kinetics in solid organ transplant recipients managed by preemptive therapy. American Journal of Transplantation **2012 Sep**; 12(9):2457-64.

**Table 1: Median viral decline in different body fluids over time in 17 babies treated for congenital CMV.**

**Figure 1**

**Mean viral load over time in different body fluids in 17 babies treated for congenital cytomegalovirus.**
 CMV viral load was measured in blood, urine and saliva using quantitative real-time PCR.
Treatment was with either ganciclovir or valganciclovir in all babies and for a duration of 42 days +/- 1 day in 16/17 babies.

**Figure 2**

**CMV virus load over time in different body compartments in 17 babies treated for congenital CMV**

Quantitative CMV viral load measured in (A) blood, (B) urine and (C) saliva at different time points during and after treatment.

Baseline = start of treatment; End treatment = end of treatment course; D3 and D7 Post = 3 and 7 days after treatment discontinued respectively; M3, 6, 12 = age 3, 6 and 12 months of life respectively.

Error bars represent median and interquartile range.

**Figure 3: Example of segmental regression of loge blood viral load in 6 babies treated over 42 days for congenital cytomegalovirus.**

Plots were constructed using GraphPad Prism software to define 2 phases of virus decline. Examples are shown for 6 babies. Plots in the remaining 8 babies and in other body fluids were constructed in a similar way.

**Figure 4: Pre- (A) and Post- (B) dose ganciclovir levels in babies treated for congenital CMV**

Ganciclovir (GCV) levels measured in babies aged <6 months of age (<6mo) and <28 days of age (<28 days) being treated for congenital CMV. Levels are compared between those derived from anonymized data received from the British Antimicrobial reference laboratory and described in detail elsewhere (Luck et al IJAA 2011 [15]) and those obtained during the viral load and immunology in congenital CMV (VICC) study.

**Supplemental data: Relationship between virus decline in blood (A. and B.) and urine (C. and D.) and ganciclovir levels over the first 7 days of antiviral treatment for congenital cytomegalovirus infection.**
Data are shown for day 7 pre- (trough: B. and D.) and post- (peak: A. and C.) ganciclovir levels taken on day 7 of treatment in 5 babies. Treatment was with ganciclovir in 4 and valganciclovir in 1 baby.

**Supplemental data: Viral load at each time point in different body fluids in 17 babies treated for congenital cytomegalovirus (CMV)**