**Table 5: Monitoring and follow up according to treatment status**

|  |  |
| --- | --- |
| No treatment given | Treatment given |
|  - | **Investigations whilst on treatment**1 |
| - | FBC1, LFT2 and U&E suggested weekly for first 4 weeks and then at least monthly until completion of treatment course (ganciclovir/valganciclovir)3 (**Quality B, Strength 2**)Weight measurement and drug dose review at time of blood sampling. |
| - | Viral load at baseline (**Quality C, Strength 2**).Consider Viral load 2-4 weekly whilst on antiviral therapy (**not consensus;** **Quality D, Strength 2**)4  |
| - | Consider therapeutic drug monitoring if:-viral load increase >1.0log10 during treatment5-toxicity is suspected -there is an increased risk of toxicity: e.g. prematurity <36 weeks, abnormal renal function (**Quality D, Strength 2**) |
| Follow up | **Follow up** |
| Audiology assessment every 3-6 months in the first year, then every 6 months until 3 years of age and then every 12 months until 6 years old6 (Quality C, Strength 1) |
| Paediatric infectious disease clinic review (or general paediatric clinic following consultation with a specialist) until at least one year, and ideally two years, of life.(Quality D, Strength 1) | Paediatric infectious disease clinic as soon as possible in the first month, then annual review until at least age two years (specialist or general clinic with paediatric infectious diseases input depending on local agreements).**(Quality D,**  **Strength 1)** |
| Monitor development (Quality D, Strength 1) | Monitor development with neurodevelopmental assessment at one year in a child development service**(Quality D,**  **Strength 1)** |
| Ophthalmic assessment as directed by ophthalmologist, but baseline and annual review up to age 5 years old in those with clinically detectable symptoms/signs at birth recommended7(Quality D, Strength 2) | Ophthalmic assessment directed by ophthalmologist, but baseline and annual review up to age 5 years old recommended7(**Quality D,**  **Strength 2**) |

FBC: Full blood count; LFT: Liver function tests; U&E: Urea, creatinine and electrolytes.

1 Interrupt treatment and/or consider granulocyte colony stimulating factor (GCSF) if absolute neutrophil count <0.5 x109/L. Decreasing dose may be considered for less severe neutropenia.

2 LFT monitoring monthly is sufficient if sampling difficulties

3Increase frequency and/or seek advice if there is deterioration

4 Measuring viral load is not evidence based but offers some evaluation of virus response and enables detection of possible viral resistance.

5Consider CMV resistance testing (sequencing) in unexplained elevations/breakthrough of viremia

6 According to current UK newborn hearing screening guidelines

7 There is limited evidence on late ocular manifestations of cCMV. They are rare and include visual impairment and strabismus (6;53)