Congenital CMV: are we treating too many?

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I read with interest the article by Amir et al. in the last issue of the journal [1]. I agree that urgent reassessment for congenital cytomegalovirus (CMV) treatment is needed. However, as the treatment should be started in the first 6 months of age, we need clear CNS findings on ultrasound (US) to establish specific findings for congenital CMV infection.

The authors acknowledge the small sample size as a limitation of their retrospective study. It could be even smaller as four out of 22 neonates (18%) are diagnosed with lenticulostriate vasculopathy (LSV). It is well known that lenticulostriate vasculopathy is a normal finding in brain US within the neonatal period, which has been assessed in prospective trials. The proportion of LSV is 0.4% of liveborn newborns and as much as 5.8% in sick neonates [4]. Thus, LSV may only represent an unspecific finding in a sick neonate for a reason different from congenital CMV infection.

Furthermore, long-term studies to ensure absence of future side effects due to valgancyclovir treatment are lacking.

On the other hand, there are no data evaluating the possibility of congenital CMV infection in neonates with LSV on US. It could be interesting as after the third week of

life, dried blood spot PCR testing is able to reach the diagnosis of congenital CMV infection. Finally, a larger number of patients could have been retrospectively diagnosed using US as LSV is more frequent in the late neonatal period [2, 3].

Conflict of interest I declare that I have no conflict of interest.

References

1. Amir J, Wolf DG, Levy I (2010) Treatment of symptomatic congenital cytomegalovirus infection with intravenous ganciclovir followed by long-term oral valganciclovir. *Eur J Pediatr* 169:1061–1067
2. Barbi M, Binda S, Primache V, Luraschi C, Corbetta C (1996) Diagnosis of congenital cytomegalovirus infection by detection of viral DNA in dried blood spots. *Clin Diagn Virol* 6:27–32
3. Leijser LM, Steggerda SJ, de Bruïne FT, van Zuijlen A, van Steenis A, Walther FJ et al (2010) Lenticulostriate vasculopathy in very preterm infants. *Arch Dis Child Fetal Neonatal Ed* 95:F42–F46
4. Makhoul IR, Eisenstein I, Sujov P, Soudack M, Smolkin T, Tamir A et al (2003) Neonatal lenticulostriate vasculopathy: further characterisation. *Arch Dis Child Fetal Neonatal Ed* 88:F410–F414

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