V EDICIÓN JORNADA CIENTÍFICA

Gesitra-IC

ACTUALIZACIÓN EN LA PATOLOGÍA INFECCIOSA DE PACIENTES INMUNOCOMPROMETIDOS

5 Y 6 MARZO 2026

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Ilustre Colegio Oficial de Médicos de Madrid

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Gesitra-IC

Grupo de Estudio de Infección en el Trasplante y el Huésped Inmunocomprometido

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Lo mejor del año en...

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INFECCIONES EN EL PACIENTE PEDIÁTRICO INMUNODEPRIMIDO

Carlos Grasa

Pediatría, enfermedades infecciosas y tropicales.
Hospital Universitario la Paz

SaludMadrid Hospital Universitario La Paz
Hospital de Cantoblanco
Hospital Carlos III
Comunidad de Madrid

IdiPAZ Instituto de Investigación Hospital Universitario La Paz

SEIP Sociedad Española de Infectología Pediátrica

ciber | INFEC

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Conflictos de interés

Compañía	Honorarios / Gastos	Consultoría / Advisory Board	Financiación investigación	Royalties / Patentes	Acciones	Empleador	Otros (especificar)
Pfizer	X						
Gilead	X		X				
Shionogi	X						
AstraZeneca	X						
GSK-ViiV (Penta)		X					
MSD							Ensayo clínico (IP)

Índice

Clinical Microbiology and Infection 31 (2025) 37–42

Contents lists available at ScienceDirect

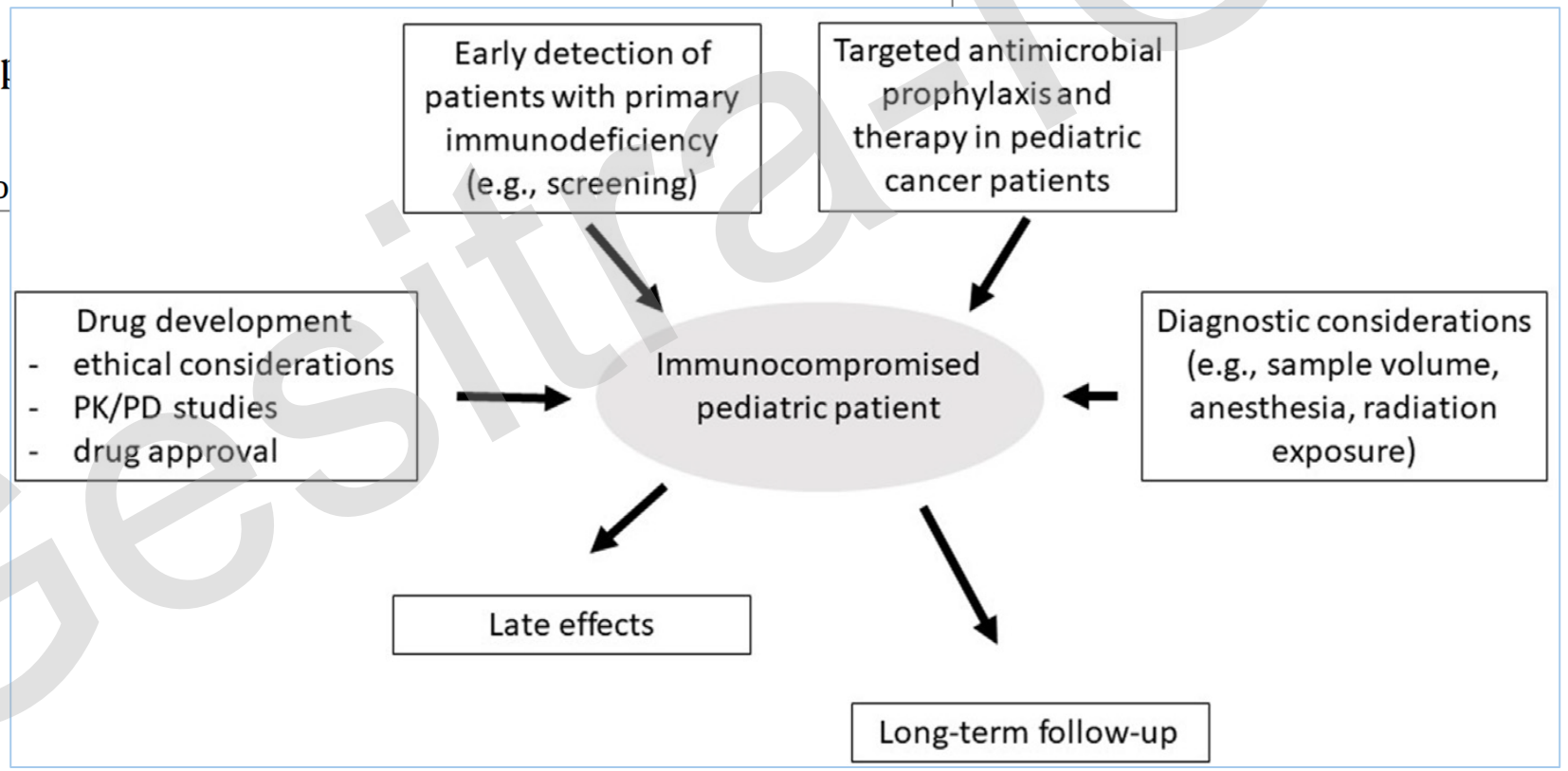
Clinical Microbiology and Infection

journal homepage: www.clinicalmicrobiologyandinfection.com

Review

Infectious complications in the p
a narrative review

Thomas Lehrnbecher [1, *], Andreas H. Gro



Lehrnbecher T, Groll AH. *Clin Microbiol Infect*. 2025 DOI: *10.1016/j.cmi.2024.06.002*

Clinical Microbiology and Infection 31 (2025) 37–42

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Clinical Microbiology and Infection

journal homepage: www.clinicalmicrobiologyandinfection.com

Review

Infectious complications in the paediatric immunocompromised host: a narrative review

Thomas Lehrnbecher [1,*], Andreas H. Groll [2]

Table 1
Considerations on diagnostic tools in the paediatric population

Diagnostic procedure	Comment	Reference
Blood culture	Recovery of a pathogen largely depends on the blood volume, which may be limited in children, in particular in the younger age group	[30]
Next-generation sequencing (NGS) such as cell-free DNA NGS or metagenomic NGS	Culture-independent identification of pathogens, which may increase the yield of positive results, but not yet validated for routine clinical practice	[31]
Respiratory viral panel	Required in symptomatic patients to isolate the patient and to consider therapy (e.g. oseltamivir in influenza)	
Non-culture-based diagnostic tools for fungi		
galactomannan	Prospective monitoring is recommended as screening of paediatric patients at high risk for invasive fungal disease not receiving mould-active prophylaxis and as a diagnostic tool for children with prolonged febrile neutropenia unresponsive to broad-spectrum antibiotics or for children	[32]
ß-D-glucan	Not recommended in the paediatric population because of poor positive predictive values	[32]
PCR-based methods	Recommended as a diagnostic tool (blood, tissue)	[32]
Invasive diagnostic procedures such as lung biopsy	Significantly higher rate of complications in children compared with adults, which is a limitation in the paediatric population	[34]
Imaging studies		
computerized tomography	Findings often non-specific (even in proven invasive fungal disease); radiation exposure as major limitation in paediatrics	[35,36]
magnetic resonance imaging	Limited by the potential need of anaesthesia, in particular in the younger age group	

ID 1[arias]:

- Mejoría en la supervivencia por profilaxis
- Mejor tratamiento (TPH) – Dco. precoz (TRECs…)
  - IDCG

ID 2[arias]:

- 3% mortalidad (niños con cáncer)
- Bacterias
  - > CGP vs BGN
  - > leucemias vs sólidos
- Hongos (LMA, LLA recaída…)
- Infección viral grave: TPH y más tardío

Dificultad acceso a antimicrobianos para pediatría:

- Aprobación
  - Formulación (jarabes…)
  - PK/PD diferente
- Uso *off-label*
- Ejemplo: Isavuconazol ~ 10 años (Adultos → pediatría)

Incertidumbre en el impacto a largo plazo de infecciones en pediatría

"Los niños no son adultos pequeños" → **¡Necesidad de guías específicas!**

Lehrnbecher T, Groll AH. *Clin Microbiol Infect*. 2025

DOI: *10.1016/j.cmi.2024.06.002*

THE LANCET

Early stoppage of empirical antibiotic therapy in paediatric acute leukaemia with high-risk febrile neutropenia: a randomized, open-label, phase 3, non-inferiority trial

Santosh Kumar Chellapuram,[a,e] Santosh Kumar Sreenivas Vishnubhatla,[c] Shuvadeep Ganguly,[a,d]

EJC Paediatric Oncology 6 (2025) 100321

Contents lists available at ScienceDirect

EJC Paediatric Oncology

journal homepage: www.journals.elsevier.com/ejc-paediatric-oncology

Original research

Early discontinuation of empiric antibiotic therapy in children treated for cancer who develop febrile neutropenia: A prospective cohort study

Smaragda Papachristidou [a,b,1,*], Dimitrios Doganis [a], Georgia Kourlaba [c], George Pantalos [d], Sophia Pasparaki [b], Margarita Baka [a], Apostolos Pourtsidis [a], Lydia Kossiva [b], Vasiliki Papaevangelou [e], Nikolaos Spyridis [f], Maria Tsolia [b]

Chellapuram SK et al. *Lancet*. 2025

DOI: 10.1016/j.eclinm.2025.103610

THE LANCET

Early stoppage of empirical antibiotic ther
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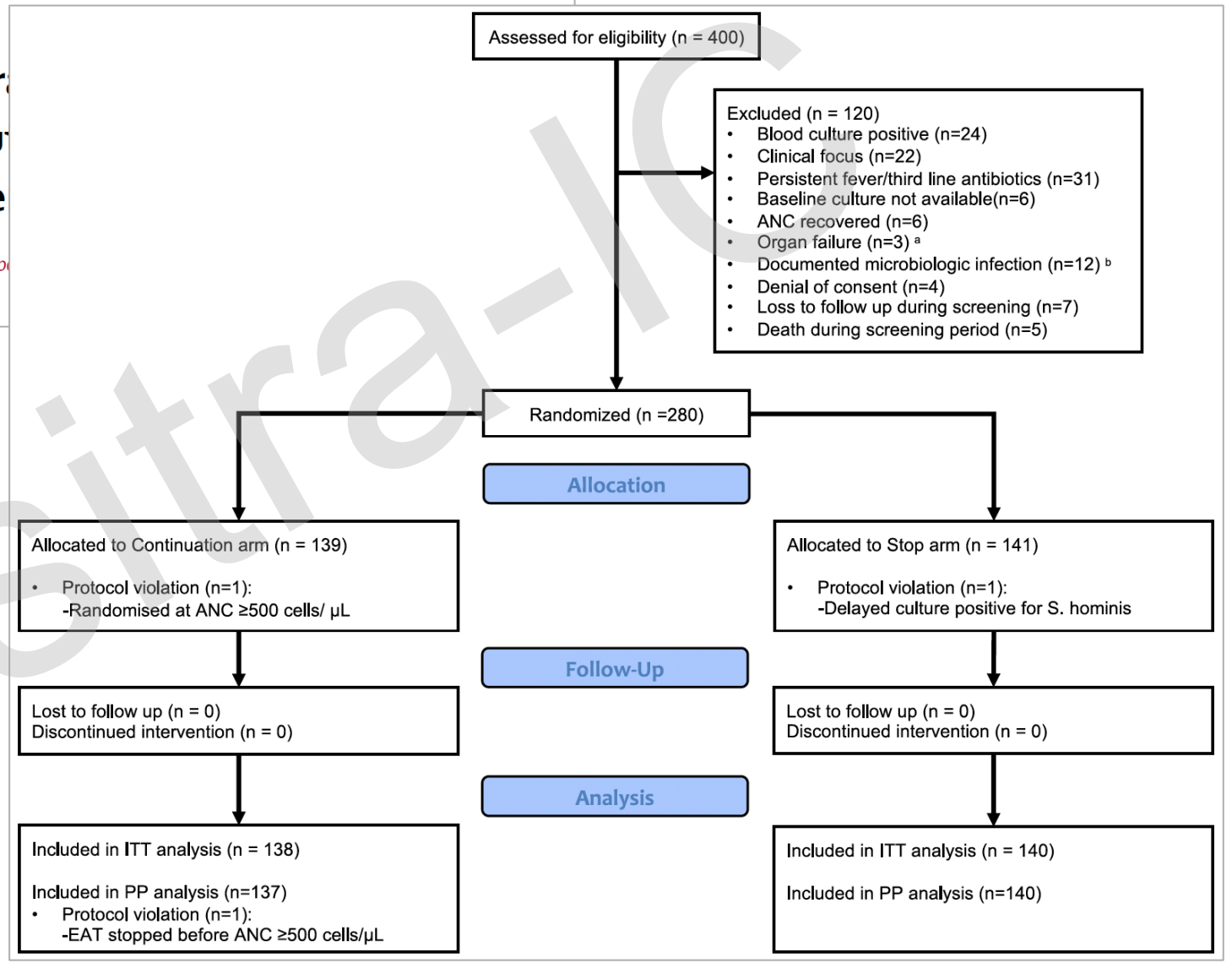
randomized, open-label, phase 3, non-infe

Santosh Kumar Chellapuram,[a,e] Santosh Kumar Kn,[a,e] Manraj Singh Sra,[b,e] Rupak Kumar Giri,[a] Deep
Sreenivas Vishnubhatla,[c] Shuvadeep Ganguly,[a,d,**] and Sameer Bakhshi[a,*]

- 2-18 años
- LMA o LLA, nuevo Dco o recaída
- Fiebre y neutropenia durante QT inducción

- Hemocultivo: negativo
- Afebril 72 horas

- No evidencia de infección
- No ATB 3ª línea o AF
- No TPH, VIH, FG <30



Chellapuram SK et al. *Lancet*. 2025

DOI: 10.1016/j.eclinm.2025.103610

Early stoppage of empirical antibiotic therapy in paediatric acute leukaemia with high-risk febrile neutropenia: a rando

Santosh Kum
Sreenivas Vish

Characteristic	Overall cohort (n = 278)	Stop arm (N = 140)	Continuation Arm (N = 138)
Age [median (IQR)]	8 (5–14)	8 (5–13)	8.5 (5–15)
Sex			
Male	183 (65.8%)		
Female	95 (34.2%)		
Diagnosis			
AML	74 (26.6%)		
B-ALL	117 (42.1%)		
T-ALL	14 (5.0%)		
Relapsed AML	32 (11.5%)		
Relapsed B-ALL	38 (13.7%)		
Relapsed T-ALL	3 (1.1%)		
Serum albumin in g/dL [median (IQR)]	3.8 (3.4–4.1)		
Haemoglobin in g/dl [median (IQR)]	7.20 (6.2–8.5)		
Absolute neutrophil count in cells/μL [median (IQR)]	200 (100–300)		
Platelets in cells/μL [median (IQR)]	28,500 (18,000–50		

AML, acute myeloid leukaemia; B-ALL, B-cell acute lymphoblastic leukaemia; T-ALL, T

Table 1: **Demographic and disease characteristics of participants (n = 278).**

Outcome	Stop arm (N = 140)	Continuation arm (N = 138)	p-value
Days of antibiotic administration [median (IQR)]	4.2 (0.0–10.0)	11.0 (7.2–15.0)	<0.0001
Hospital admission	41 (29.3%)	30 (21.7%)	0.15
Use of third-line antibiotic	29 (20.7%)	34 (24.6%)	0.44
Use of therapeutic antifungals	23 (16.4%)	30 (21.7%)	0.26
Mortality	7 (5%)	11 (7.9%)	0.31
Use of inotropes	13 (9.3%)	13 (9.4%)	0.97
Use of mechanical ventilation	8 (5.7%)	11 (7.9%)	0.46
Received PRBC infusion	118 (84.3%)	122 (88.4%)	0.32
Received SDP infusion	102 (72.9%)	112 (81.2%)	0.10
Received PRP infusion	85 (60.7%)	87 (63.0%)	0.69
Received granulocyte infusion	7 (5.0%)	8 (5.8%)	0.77
Required emergency visits	49 (35.0%)	42 (30.4%)	0.42
Required dialysis	1 (0.7%)	1 (0.7%)	0.99

PRBC, packed red blood cells; PRP, platelet rich plasma; SDP, single donor platelets.

Table 2: **Secondary outcomes in each treatment arm.**

Chellapuram SK et al. *Lancet*. 2025

DOI: 10.1016/j.eclinm.2025.103610

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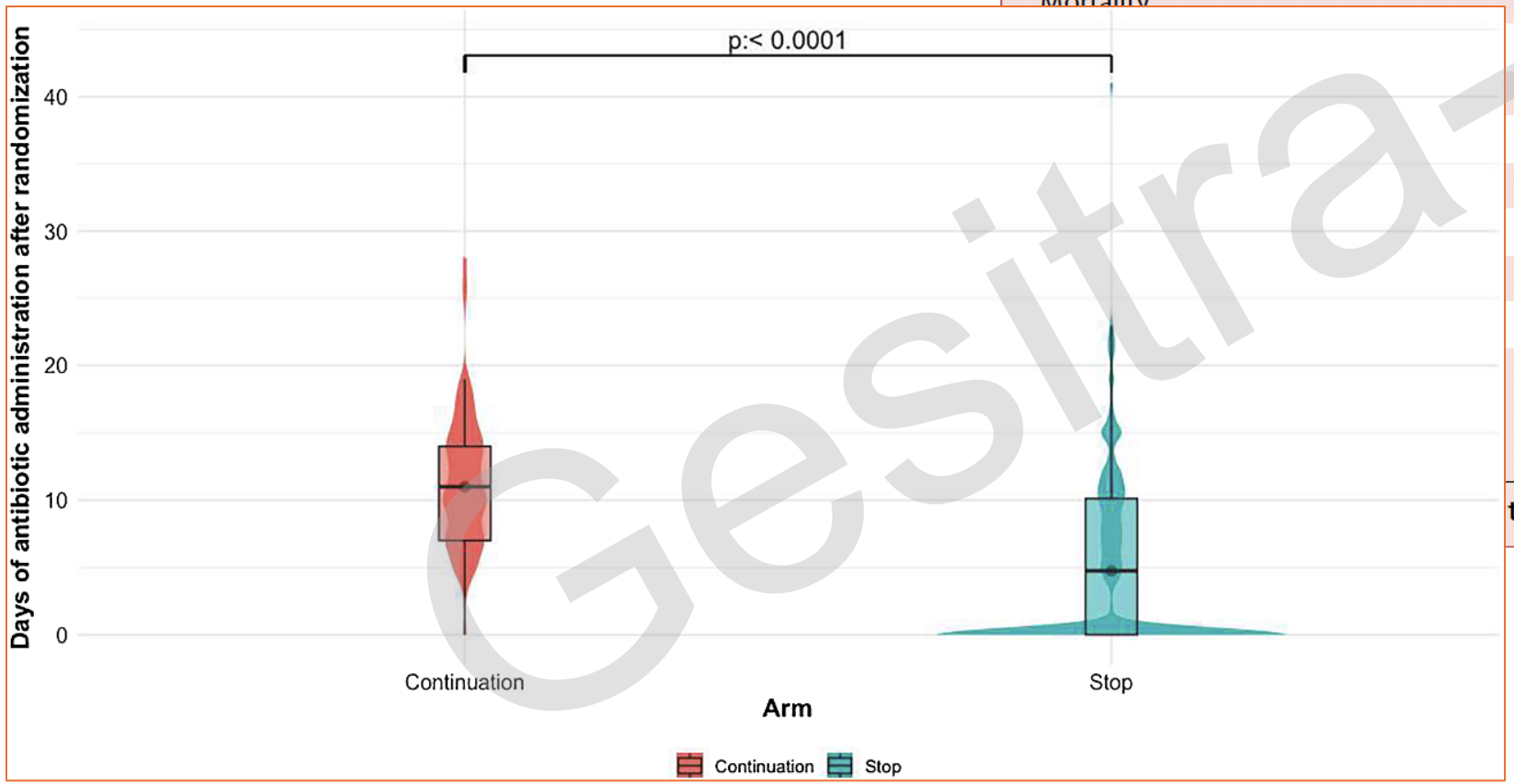
rich plasma; SDP, single donor platelets.

treatment arm.



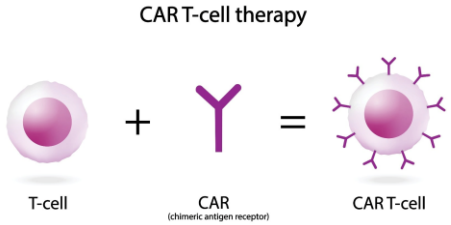
→ No inferioridad en la interrupción precoz ATB en pacientes pediátricos con leucemia aguda con FyN alto riesgo

Chellapuram SK et al. *Lancet*. 2025

DOI: 10. 1016/j.eclinm.2025. 103610

blood ICT
immunology & cellular therapy

Infections Following CAR-T therapies in Children, Adolescents, and Young Adults: A Systematic Review and Meta-Analysis



Infection (2021) 49:215–231
https://doi.org/10.1007/s15010-020-01521-5

REVIEW

Recommendations for screening, monitoring, prevention, and prophylaxis of infections in adult and pediatric patients receiving CAR T-cell therapy: a position paper

Ibai Los-Arcos[1,2] · Gloria Iacoboni[3,4] · Manuela Aguilar-Guisado[5] · Laia Alsina-Manrique[6] · Cristina Díaz de Heredia[7] · Claudia Fortuny-Guasch[8] · Irene García-Cadenas[9] · Carolina García-Vidal[10] · Marta González-Vicent[11] · Rafael Hernani[12] · Mi Kwon[13] · Marina Machado[14] · Xavier Martínez-Gómez[15] · Valentín Ortiz Maldonado[16,17] · Carolina Pinto Pla[18] · José Luis Piñana[19] · Virginia Pomar[20] · Juan Luis Reguera-Ortega[21] · Miguel Salavert[22] · Pere Soler-Palacín[23] · Lourdes Vázquez-López[24] · Pere Barba[3,4] · Isabel Ruiz-Camps[1,2]

Michael M, et al. *Blood*. 2026

DOI: 10.1016/j.bict.2026.100040

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Infections Following CAR-T therapies in Children, Adolescents, and A Systematic Review and Meta-Analysis

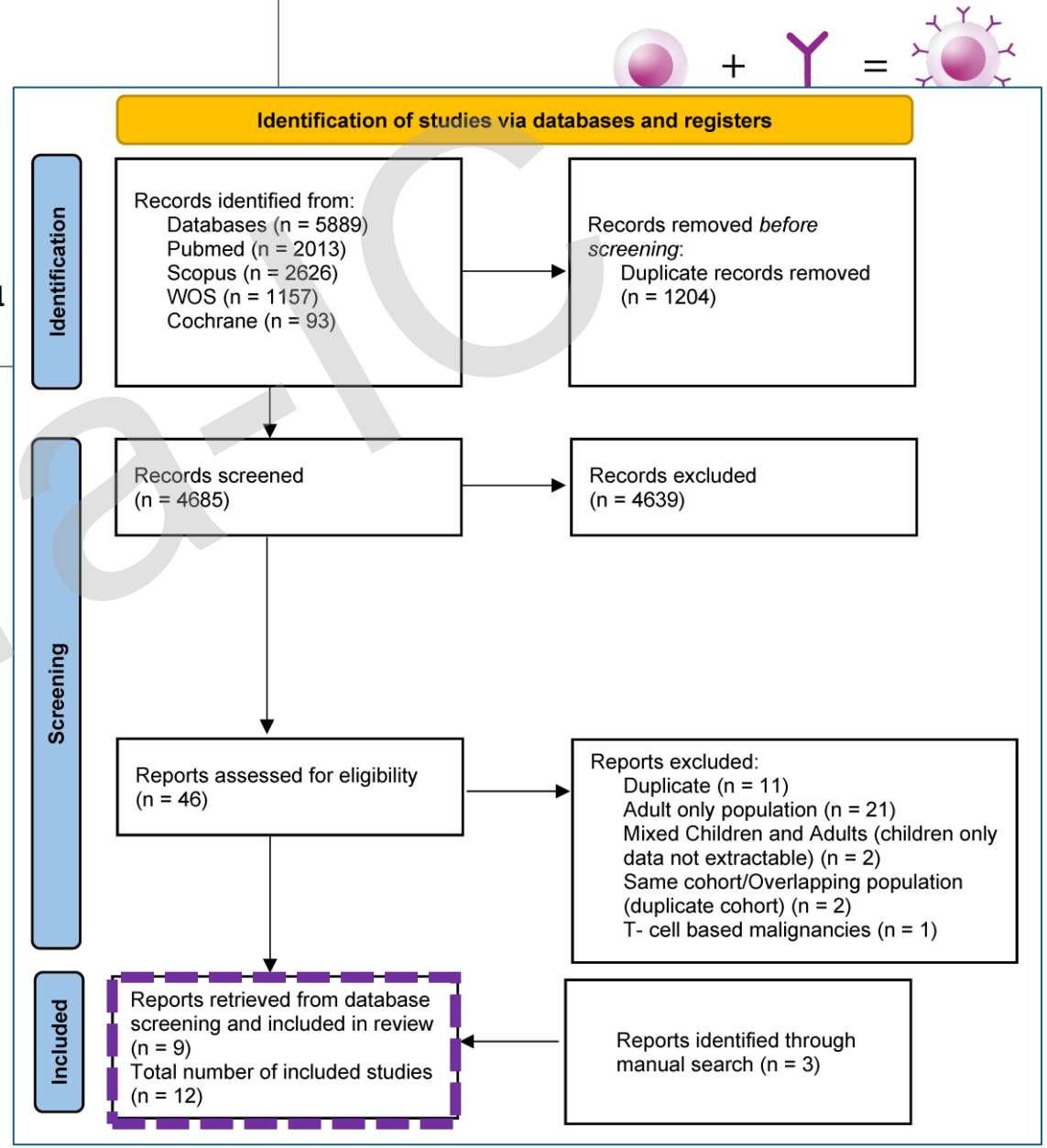
Revisión sistemática y meta-análisis (<u>hasta 17 junio 2025</u>):

- CAR-T cell → recaída / refractaria - tumores hematológicos
- <26 años (no mezclados con datos de adultos)

<u>Primario</u>: cuantificar prevalencia de infecciones

<u>Secundarios</u>:

- Prevalencia infecciones graves
- Mortalidad atribuida a infecciones
- % infecciones virales, bacterianas y fúngicas:
  - Tempranas (≤28-30 días) vs tardías (>28-30 días)



Michael M, et al. *Blood*. 2026

DOI: 10.1016/j.bict.2026.100040

Study	Country/Region	Design	CAYA patients, n	All-Grade Infections, n (%)	Malignancy, n	Median Age, years (range)	Male, n (%)	Target Antigen	Lymphodepletion	Follow-up, months (range)*
Wu et al, 2024	China	Observational (Retrospective single-institution)	79	53/79 (67%)	R/R B-ALL (n=79)	8 (5-11 IQR)	58/79 (73%)	CD19 and CD22	Flu/Cy	3
Maron et al., 2022	USA	Observational (Retrospective single-institution)	38	19/38 (50%)	B-ALL (n=37), B-lymphoblastic lymphoma (n=1)	9 (1.8–23.6)	20/38 (53%)	CD19	Flu/Cy	3
Maude et al., 2018	Multiple	Phase 2	75	32/75 (43%)	R/R B-ALL (n=75)	11 (3–23)	43/75 (57%)	CD19	Flu/Cy(n=71), Cytarabine/ Etoposide (n=1)	Median 13.1 (2.1-23.5)
Lust et al., 2025	USA	Observational (Retrospective database review)	70	17/70 (24%)	R/R B-ALL (n=70)	Brexu-cel group: 22.5 (18–26) Tisa-cel group: 21(18–26)	Brexu-cel group: 70% (14/20) Tisa-cel group: 58% (29/50)	CD19	Flu/Cy(n=64), Other (n=6)	Brexu-cel group: 9.9 (2.2–15.1) Tisa-cel group: 12.7 (1.1–27.2)
Curran et al., 2019	USA	Phase 1	25	9/25 (36%)	R/R B-ALL (n=25)	13.5 (1–22.5)	NR	CD19	Cy only (n=19), Flu/Cy (n=6)	Median 7.7 (0.5–43.7)
Diamond et al., 2023	Australia	Observational (Retrospective single-institution)	27	6/27 (22%)	R/R B-ALL (n=27)	11 (1-17)	13/27 (48%)	CD19	NR	3.3
Vora et al., 2020	USA	Observational (Retrospective single-institution)	83	44/83 (53%)	R/R B-ALL (n=81), B-cell lymphoma (n=1), mixed leukemia (n=1)	12 (1–25)	50/83 (60%)	CD19	Flu/Cy (n=54), Cy only (n=23 patients), Other regimens (n=6)	Median 1.5 (0.3-3)
Cordoba et al., 2021	UK	Phase 1	15	8/15 (53%)	R/R B-ALL (n=15)	8 (4-16)	11/15 (73%)	CD19 and CD22	Flu/Cy	Median 14 (2–28)
Ghorashian et al., 2019	UK	Phase 1	14	6/14 (43%)	R/R B-ALL (n=14)	9 (6–10)	13/14 (93%)	CD19	Flu/Cy	Median 14.4
Pan et al., 2023	China	Phase 2	81	10/81 (12%)	R/R B-ALL (n=81)	8	50/81 (62%)	CD19 and CD22	Flu/Cy	Median 17.7 (IQR 11.4-20.9)
Dayagi et al., 2021	Israel	Observational (Retrospective based on single center phase 1b/2)	36	13/36 (36%)	B-ALL (n=30), NHL (n=6)	13 (1.9–24.3)	27/36 (75%)	CD19 with a CD28 co-stimulatory domain	Flu/Cy	2

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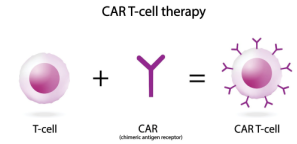
Infections Following CAR-T therapies in Children, Adolescents, and Young Adults: A Systematic Review and Meta-Analysis



12 artículos (2018-2025):

→ 567 pacientes

- Mediana 11 años (rango 1-26)
- 63% varones

39% infección (217/543): mediana <u>90 días</u> [rango 30-438]

- Gravedad (grado ≥3): 50/270 → mediana 234 días
- Fallecimiento por infección: 16/567 → 2.8%

TIPO INFECCIÓN	%, precoz (≤28-30 d)	%, tardía (>28-30d)
Global	32	20
Bacteriana	14	8
Viral	13	4
Fúngica	2	0.8

[mediana 90 d]

<u>Lugar de infección</u>:
- Bacteriemia (34.5%, 59/171)
- Tracto respiratorio (24%)

84 aislamientos bacterianos:
- 17 – *Staphylococci (6 - S.aureus)*
- 12 – *E.coli*
- 10 – *E.faecalis*
- 8 – *P.aeruginosa*
- *(…)*

54 detecciones virales:
- 14 - RhV / EV
- 6 – VRS
- 6 – Parainfluenza
- 3 – CMV // 3 – VEB
- (…)

Fallecimiento relac.:
- 3 *E.faecalis*
- 1 *Escherichia*
- 1 *Stenotrophomonas*
- 1 *Aeromonas hydrophila*
- 1 *Staphyloccous wallichii*
- 1 *Acinetobacter baumannii*
- 2 Mucormicosis

Michael M, et al. *Blood*. 2026

DOI: 10.1016/j.bict.2026.100040

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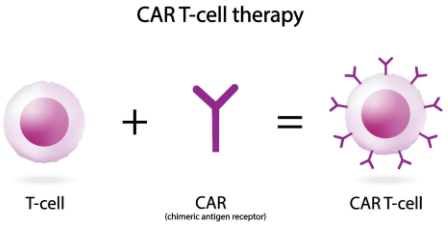


Descenso de las infecciones fase tardía vs precoz, aunque se **mantiene 20%** (con predominio de bacteriano)

- vs Adultos: > infección bacteriana en 1er mes → >virus en >1er mes
- No recomendada profilaxis en 1er mes (generalizada), considerar individualmente >1er mes (SLC, recuperación Nt, etc.)

No muchas infecciones virales graves (predominio respiratorios vs CMV/VEB) → No profilaxis generalizada

Poca infección fúngica pero grave:

→ Profilaxis de IFI según factores de riesgo (Neutropenia persistente, SLC grave, corticoides…)

Relativamente alto % infecciones graves (20%) → Necesidad de intervención precoz (no solo en 1er mes)

Michael M, et al. *Blood*. 2026

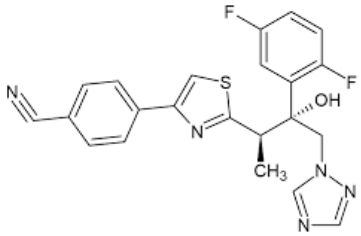
DOI: 10.1016/j.bict.2026.100040

J Antimicrob Chemother 2026; **81**: dkaf394
https://doi.org/10.1093/jac/dkaf394 Adv

Journal of Antimicrobial

Real-life use of isavu

Natalia Mendoza-Palomar [1,2]*†, S
Clara Izquierdo Anto[6], Marta Taid
Cristina Jiménez Núñez [12], Elen
Begoña Carazo Gallego [16], I
Ángela Manzanares [18]



EMEA/H/C/002734

Cresemba (*isavuconazol*)

Información general sobre Cresemba y sobre los motivos por los que se autoriza su uso en la UE

¿Qué es Cresemba y para qué se utiliza?

Cresemba es un medicamento antifúngico que se utiliza para tratar a adultos y niños mayores de 1 años con aspergilosis invasiva o mucormicosis (infecciones causadas por hongos). Para la mucormicosis, Cresemba se utiliza cuando otro medicamento, la anfotericina B, no es adecuado.

La aspergilosis invasiva y la mucormicosis son raras, y Cresemba ha sido designado «medicamento huérfano» (es decir, un medicamento utilizado en enfermedades raras). Puede encontrar más información sobre la designación de medicamento huérfano en la página web de la EMA. 4 de junio de 2014; aspergilosis invasiva: 4 de julio de 2014).

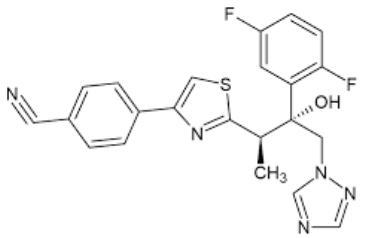
Cresemba contiene el principio activo isavuconazol.

f isavuconazole as a
ediatric patients: a

[6] Michael Neely,[7] Victoria Bordon,[8] Benjamin
l,[14] Shamim Sinnar,[6] Rodney Croos-Dabrera,[6]

J Antimicrob Chemother 2026; **81**: dkaf394
https://doi.org/10.1093/jac/dkaf394 Advance Access publication 22 October 2025

Journal of Antimicrobial Chemotherapy 50 years



Real-life use of isavuconazole in Spanish children and adolescents

Natalia Mendoza-Palomar [1,2]*†, Silvia Simó Nebot [3,4]†, Laura Roig-Soria [1,2], Laura Alonso García [2,5], Clara Izquierdo Anto[6], Marta Taida García Ascaso [7], David Díaz Pérez [8], Carlos Grasa Lozano [9,10,11], Cristina Jiménez Núñez [12], Elena María Rincón López [11,13,14], Maria Luisa Navarro Gómez [11,13,14,15], Begoña Carazo Gallego [16], Beatriz Álvarez Vallejo [1,2,17], Jose Tomás Ramos Amador [11,15,18], Ángela Manzanares [18], Beatriz Jiménez Montero [19], Antoni Noguera Julian [3,4,20]† and Pere Soler-Palacin [1,2]†

Descriptivo

Retrospectivo (2018-2023)

Multicéntrico (9 hospitales)

≤18 años

Profilaxis o tratamiento

107 pacientes

Mediana 11 años / 56% ♂

Tratamiento: 95

- 2ª línea, 64 (67%)
  · Por toxicidad, 27 (42%)

Profilaxis: 12

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https://doi.org/10.1093/jac/dkaf394 Advance Access publication 22 October 2025

Journal of Antimicrobial Chemotherapy 50 years

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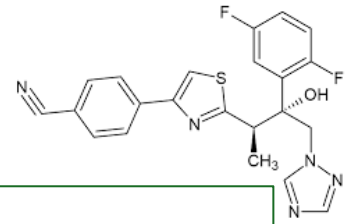

Table 1. Patient and invasive fungal disease characteristics

Patient characteristics ($n=107$)	*n*, %
Underlying disease	
Haematological malignancies	
• Acute lymphoblastic leukaemia	32 (23 SCT)
• Acute myeloblastic leukaemia	23 (17 SCT)
• Acute bilineal leukaemia	5 (5 SCT)
• Chronic myeloid leukaemia	1 (1 SCT)
• Lymphoma	4
Solid organ transplant	
• Lung transplant	3
• Heart transplant	2
• Liver transplant	1
• Multivisceral transplant	1
Inborn errors of immunity	10 (6 SCT)
Non-malignant haematological diseases	
• Severe acquired aplasia	11 (9 SCT)
• Haemoglobinopathies	3 (3 SCT)
• Amegakaryocytic thrombocytopenia	1 (1 SCT)
ECMO support	4
Other[a]	5 (3 SCT)
Treatment modality ($n=95$)	
• Proven	17 (18)
• Probable	36 (38)
• Possible	41 (44)
Disease ($n=95$)	
• Disseminated	15 (16.5)
• Lung	66 (69.5)
• CNS	4 (4)
• Abdominal	5 (5)
• Rhinosinusitis	3 (3)
• Oral cavity	1 (1)
• Fever without source	1 (1)
Isolated microorganism ($n=31$)	
• *Aspergillus* spp.	16 (51)
• *Rhizopus* spp.	4 (13)
• *Fusarium* spp.	2 (6)
• *Candida* spp.	2 (6)
• *Trichosporon* spp.	2 (6)
• *Lichtheimia corymbifera*	1 (3)
• *Mucor indicus*	1 (3)
• *Rasamsonia* spp.	1 (3)
• *Scopulariopsis* spp.	1 (3)
• *Stemphylium vesicarium/Acremonium murorum*	1 (3)

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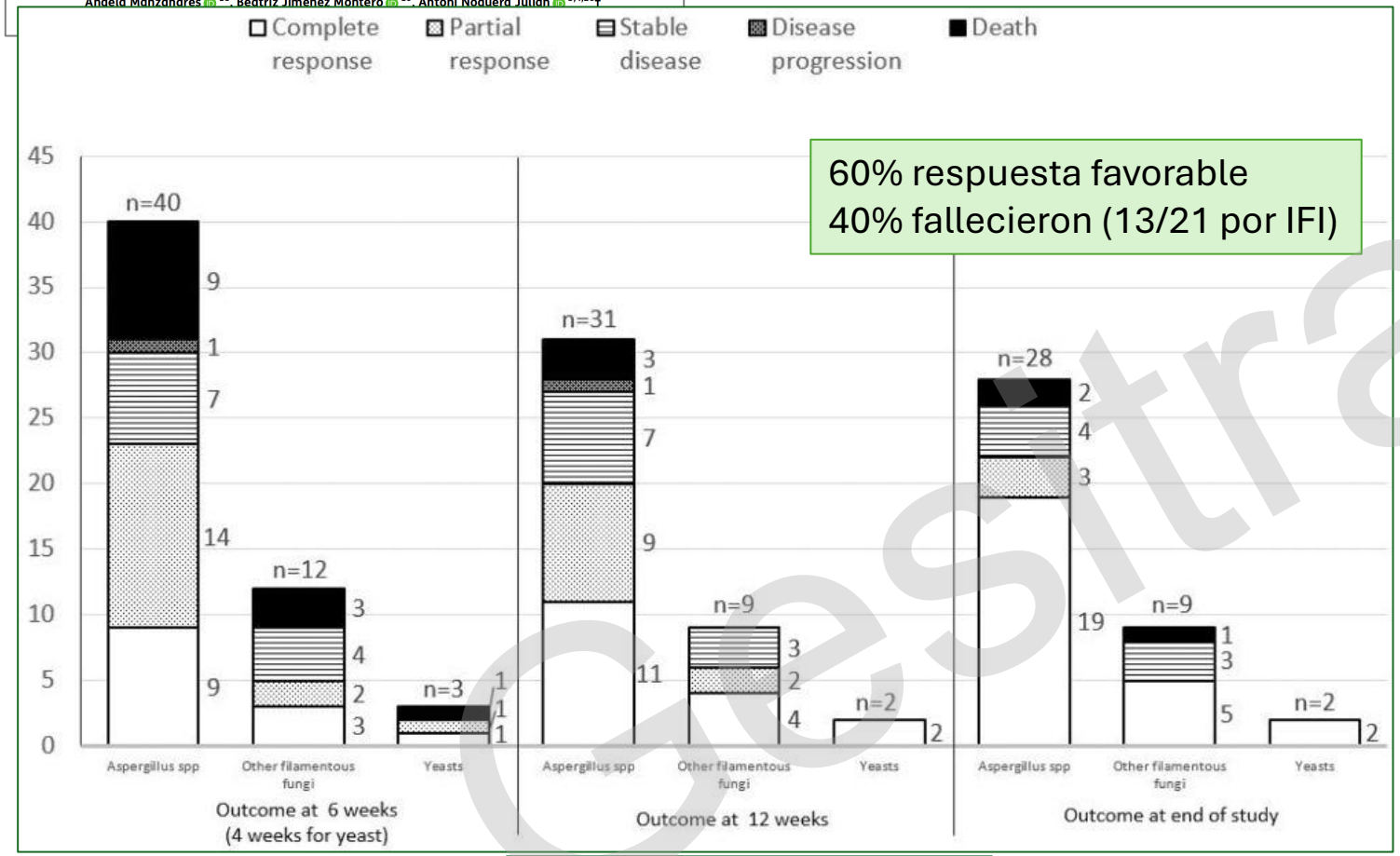
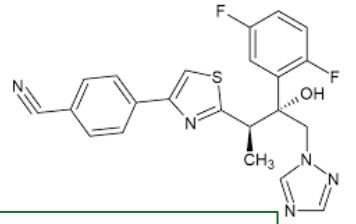


60% respuesta favorable
40% fallecieron (13/21 por IFI)

No IFI de brecha (n=12)



Seguridad:
- 27/107 (25%) EA posiblemente relacionado con ISA
- Principal: toxicidad hepática (14, 13%)
- Interrupción en 10/107:
  - 5 toxicidad hepática
    - 3 intolerancia GI
    - 1 neutropenia
    - 1 dermatitis
- No SAE

TDM:
- 2.5-5 mg/L (1-10)
- 76 pacientes → 330 determinaciones
- Mediana [ ]: 3.1 mg/L (RIC 2.1-4.9)
  - **195/330 (59%) fuera del rango**
    - 118 sub- vs 77 supraterapéuticos

→ **ISA en niños: seguro, eficaz, precisa TDM**

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Ideas clave

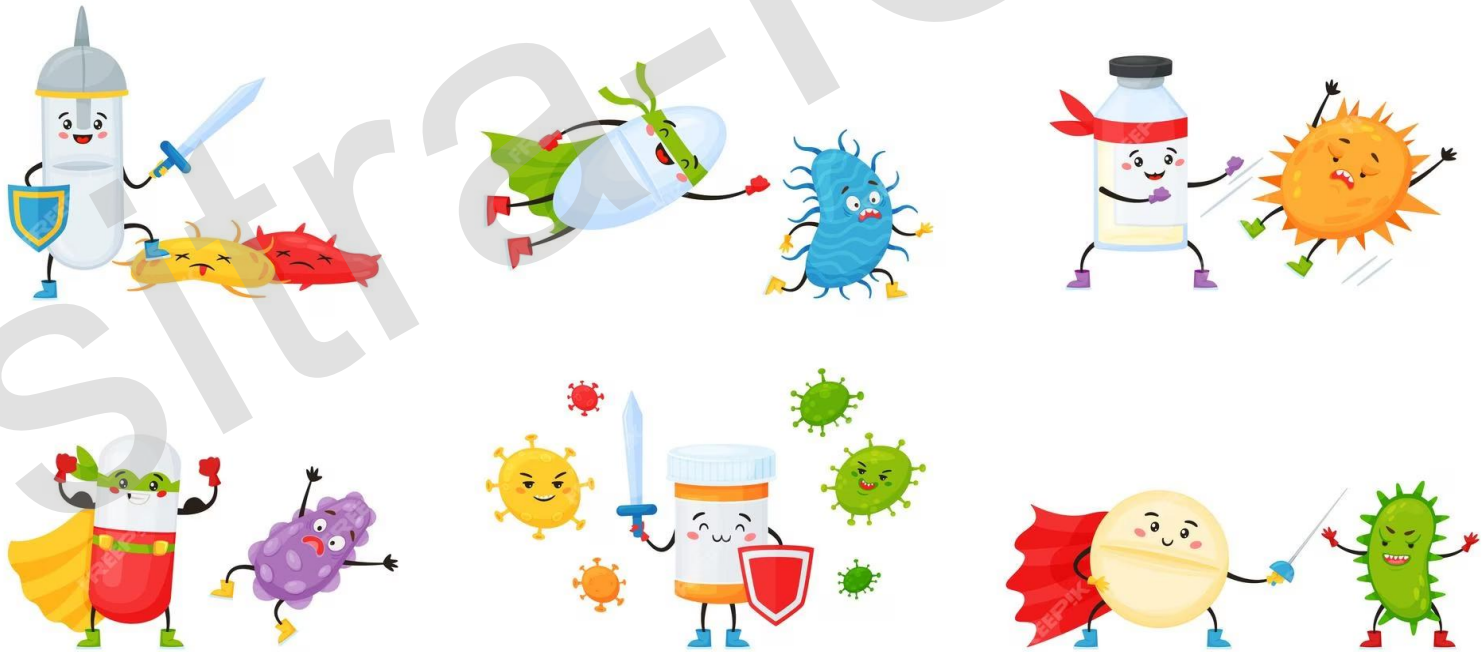
- Mejoría en el diagnóstico y manejo de niños inmunocomprometidos y sus infecciones, pero continua habiendo limitaciones en el diagnóstico. infecciones y opciones terapéuticas. Importante considerar el manejo e implicaciones a largo plazo

- Parece posible acortar tratamiento antibiótico en niños con leucemia y neutropenia febril de alto riesgo antes de recuperación medular

- Post CAR-T cell (<26 años): infecciones frecuentes (Bacterias > virus >>> hongos - ¡más riesgo!), no solo en 1er mes

- Isavuconazol en pediatría: seguro, eficaz, aunque necesidad de TDM

Muchas gracias



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Special Feature

OPEN

The Fourth International Consensus Guidelin on the Management of Cytomegalovirus in So Organ Transplantation

Camille N. Kotton, MD,[1] Deepali Kumar, MD,[2] Oriol Manuel, MD,[3] Sunwen Chou, MD,[4] Randall T. Hayde Lara Danziger-Isakov, MD, MPH,[6] Anders Asberg, PhD,[7] Helio Tedesco-Silva, MD,[8] and Atul Humar, MD behalf of The Transplantation Society International CMV Consensus Group*

TABLE 11.

Assignment of donor/recipient serostatus in infants younger than 12 mo

Donor	Recipient	Suggested risk categorization
+	+ or −	D+/R−[a]
−	+	D−/R+
−	−	D−/R−

[a]If recipient confirmed positive by CMV NAT, assign D+/R+.
CMV, cytomegalovirus; D/R, donor/recipient (serostatus); NAT, nucleic acid testing.

TABLE 12.

Recommended regimens for CMV prevention in children

			Recommended prevention strategies		
Organ	Serostatus[a]	Risk level	Prophylaxis	Surveillance after short-term prophylaxis	Preemptive therapy
All except small bowel	D−/R−	Low	Not routinely recommended	Not routinely recommended	Some experts recommend monitoring due to the risk for CMV acquisition[b]
Kidney	R+	Intermediate	3–6 mo of (V)GCV	2–4 wk of (V)GCV with surveillance after prophylaxis	Yes
	D+/R−	High	3–6 mo of (V)GCV		Yes
Liver	R+	Intermediate	3–4 mo of (V)GCV	2–4 wk of (V)GCV with surveillance after prophylaxis	Yes
	D+/R−	High	3–4 mo of (V)GCV	2–4 wk of (V)GCV with surveillance after prophylaxis	Yes
Heart	R+	Intermediate	3–6 mo of (V)GCV	2–4 wk of (V)GCV with surveillance after prophylaxis	
	D+/R−	High	3–6 mo of (V)GCV	4 wk (V)GCV with surveillance after prophylaxis	
Lung	R+	High	6–12 mo of (V)GCV		
	D+/R−	High	12 mo of (V)GCV		
Small bowel[c]	D−/R−	Low	Not routinely recommended	2 wk GCV with surveillance after prophylaxis	Yes
	R+	High	3–12 mo of (V)GCV	2 wk GCV with surveillance after prophylaxis	
	D+/R−	High	3–12 mo of (V)GCV		

TABLE 13.

Valganciclovir dosing in pediatric SOT

Valganciclovir dosing in pediatric SOT recipients	BSA-based dosing	BW-based dosing
Formula for determination of dose[a]	7 × BSA[b] × CrCL[c]	15–18 mg/kg
Dosage	Higher, especially in children younger than 6 y	Lower
GCV AUC exposure	Higher	Lower
Attainment of designated AUC-based targets[d]	More frequent	Less frequent
Rate of hematologic toxicities	Higher (26%–69%)	Lower (8%–53.6%)
Incidence of breakthrough CMV DNAemia	4.8%–16%	10%–16%
CMV DNAemia in the first year posttransplant	15.9%–33%	14%–34%

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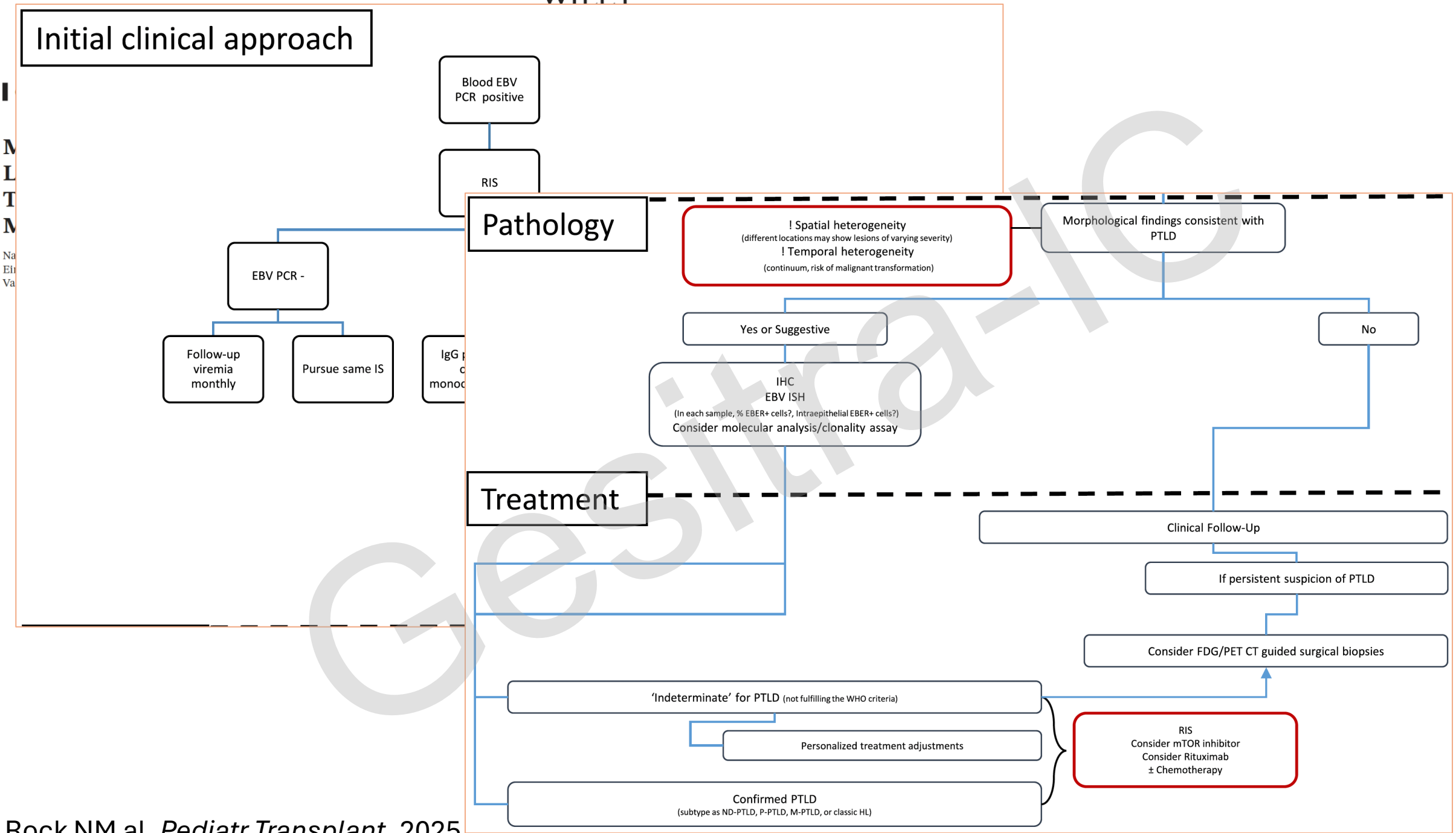

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