Valganciclovir

6.4. Antiviral medicines
6.4.3. Other antivirals

Valganciclovir

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**Indication**
Cytomegaloviral retinitis

**ICD11 code:** 9B72.00

**INN**
Valganciclovir

**Medicine type**
Chemical agent

**List type**
Core (EML)
Complementary (EMLc)

**Formulations**
Oral > Liquid: 50 mg per mL powder for oral solution (EMLc)
Oral > Solid > tablet: 450 mg

**EML status history**
First added in 2015 (TRS 994)

**Sex**
All

**Age**
Also recommended for children

**Therapeutic alternatives**
The recommendation is for this specific medicine

**Patent information**
Patents have expired in most jurisdictions
Read more about patents.

**Wikipedia**
Valganciclovir

**DrugBank**
Valganciclovir

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**Summary of evidence and Expert Committee recommendations**

An application was submitted by Dr Nathan Ford, WHO Department of HIV/AIDS, for the addition of valganciclovir to the Model List for the treatment of cytomegalovirus retinitis (CMVr), a preventable late-stage opportunistic infection in people living with HIV/AIDS. Comments in support of the application were received from Myriam Henkens, International Medical Coordinator, Medecins Sans Frontieres. CMVr is part of a systemic infection, although in HIV/AIDS patients in low- and middle-income countries, the eye is the only end-organ where the presence of clinical infection is easy to establish. Evidence from both before and after the introduction of highly active anti-retroviral therapy (HAART) in resource-rich and resource-poor settings has shown that CMV viraemia predicts mortality and, in most reports, is the most powerful predictor of mortality (1-4). Left untreated, CMVr can lead to permanent loss of vision as a result of damage to the optic nerve or macula, of retinal detachment (which can present years after CMVr has been treated) or of the development of immune recovery uveitis. Early diagnosis and treatment are crucial to preventing both vision loss and transmission of CMVr to the contralateral eye, which occurs within six months of infection in 50–61% of untreated CMVr cases (5). Estimates of the incidence and prevalence of CMVr in resource-limited settings vary. CMVr incidence ranges from 0 to 19.6% in sub-Saharan Africa (6), while estimated prevalence ranges from less than 5% in southern Africa to more than 30% in south-east Asia (7). Although the introduction and scaleup of HAART in developed countries has dramatically reduced the prevalence of CMVr in these settings, high ART accessibility does not correlate completely with reduced CMVr. Clinical guidelines first recommend that HIV/AIDS patients at risk for or recently diagnosed with CMVr have access to HAART, which slows progression of the condition (6). Treatment options for CMVr include intravenous ganciclovir, foscarnet, or cidofovir; ganciclovir implant; intravitreal injections of ganciclovir, foscarnet, cidofovir or famciclovir; and oral valganciclovir or ganciclovir (8). Intravenous ganciclovir has been the gold standard for treatment of CMVr; however, this requires daily infusions and indwelling catheters, with attendant risks of secondary sepsis (6), and this treatment is not always feasible in resource-limited settings. Valganciclovir is an oral medication that has been shown to be therapeutically equivalent to intravenous ganciclovir in adults (9) and is recommended because of its lower cost, lower risk of adverse reactions, high efficacy and easy administration, and the fact...