Multicenter study on recent portal venous system thrombosis associated with cytomegalovirus disease.

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PER, DV and CDB designed the study. CDB and PER wrote the manuscript. AP, IOH, SD, CDB, JPC, PS, OG, OC, KZ, and AP collected patients' data. NFH and YY provided virological insight. All authors read and critically revised the manuscript.

Abstract: 269 words.

Background and aims: Recent non-malignant non-cirrhotic portal venous system thrombosis (PVT) is a rare condition. Among risk factors for PVT, cytomegalovirus (CMV) disease is usually listed based on few reported cases. The aim of this study was to determine characteristics and outcome of patients with PVT associated with CMV disease.

Methods: We conducted a French multicenter retrospective study comparing patients with recent PVT and CMV disease ("CMV positive"; n = 23) with patients with recent PVT for whom CMV testing was negative ("CMV negative"; n = 53) or unavailable ("CMV unknown"; n = 297).

Results: As compared with patients from the "CMV negative" and "CMV unknown" groups, patients from the "CMV positive" group were younger, had more frequently fever, higher heart rate, higher lymphocyte count and higher serum ALT levels ($p \leq 0.01$ for all). Prevalence of immunosuppression did not differ between the 3 groups (4%, 4% and 6%, respectively). Extension of PVT was similar between the 3 groups. Thirteen out of 23 "CMV positive" patients had another risk factor for thrombosis. Besides CMV disease, number of risk factors for thrombosis was similar between the 3 groups. Heterozygous prothrombin gene mutation was more frequent in "CMV positive" patients (22%) than in the "CMV negative" (4%, $p = 0.01$) and "CMV unknown" (8%, $p = 0.03$) groups. Recanalization rate was not influenced by CMV status.

Conclusions: In patients with recent PVT, features of mononucleosis syndrome should raise suspicion of CMV disease. CMV disease does not influence thrombosis extension nor recanalization. More than half "CMV positive" patients have another risk factor for thrombosis, with a particular link with prothrombin gene mutation.

Lay summary: Patients with CMV-associated portal venous system thrombosis have similar thrombosis extension and evolution as patients without CMV disease. They more frequently have prothrombin gene mutation, suggesting a synergy between these two entities to promote thrombosis.

Introduction

Recent non-malignant non-cirrhotic extrahepatic portal venous system thrombosis (PVT) is characterized by new occurrence of a thrombus in the main portal vein and/or its right or left branches and/or splenic or mesenteric veins [1]. The incidence of PVT is estimated at 0.7 per 100.000 per year [2]. Recent PVT can lead to intestinal infarction in 2 to 20% of cases with an estimated mortality of 20% at 30 days [3]. The causes for PVT include inherited thrombophilia (protein C or S or antithrombin deficiency; factor V or factor II gene mutation), acquired thrombophilia (antiphospholipid antibodies, myeloproliferative neoplasms, paroxysmal nocturnal hemoglobinuria), hormonal factors, as well as local and systemic inflammation [4,5].

Human cytomegalovirus (CMV) infection is very frequent, usually without overt symptoms. Anti-CMV IgG, representing past infection, are found in 50-65% of adults in developed countries, and in more than 90% in developing countries [6]. After primary infection, CMV establishes a latent infection from which intermittent reactivation can occur, as with other *Herpesviridiae* [7,8]. Reinfection with new strains is also possible. CMV infection is defined by the evidence of CMV (plasma or organ-specific PCR) with or without symptoms, whereas CMV disease is defined by CMV infection with organ injury or clinical symptoms suggestive of the disease. Clinical manifestations depend on patient immunity. In immunocompromised patients and newborns, organ injury is more common [9]. In immunocompetent patients, viral replication is frequently asymptomatic, although CMV disease is possible [10]. CMV infection has been associated with indirect effects, such as increased all-causes mortality, increased risk of cardiovascular disease and increased risk of deep vein thrombosis and pulmonary embolism [11–16].

Recent PVT associated with CMV infection has only been described in few case reports so that the specificities of this association are unknown [17,18]. The aim of this retrospective multicenter study was to describe the characteristics, associated causes and outcome of patients with CMV-associated recent PVT.

Patients and methods

Inclusion criteria

This retrospective study included three groups of patients with recent PVT.

The group of patients with recent PVT and CMV disease, referred to as “CMV positive” group, included all patients with CMV-associated recent PVT diagnosed between January 2000 and December 2019 in one of the centers of the French network for Vascular Liver Diseases. Diagnosis of CMV disease was based on laboratory tests performed within 3 months before or after diagnosis of recent PVT. Details are presented in Supplementary Methods [19] [20] [21].

The group of patients with recent PVT without CMV disease, referred to as “CMV negative” group, included all patients with recent PVT, diagnosed between January 2014 and December 2019, at the French Reference Center for Vascular Liver Diseases (Hôpital Beaujon, Clichy) and tested negative for CMV. Absence of CMV disease was based on undetectable anti-CMV IgM and/or undetectable plasma CMV DNA, within 3 months before or after PVT diagnosis.

The group of patients with recent PVT untested for CMV disease, referred to as “CMV unknown” group, included patients with a diagnosis of recent PVT between January 2004 and December 2019 in one of the centers of the French network for Vascular Liver Diseases, without available CMV viral load or serology within 3 months before or after diagnosis of PVT.

The study was performed in accordance with the ethical guidelines of the 1975 Declaration of Helsinki and was approved by the institutional review board (CPP Ile de France IV, Paris; France). Informed consent was obtained from all patients included in the study.

Liver surface nodularity (LSN) quantification

LSN quantification was performed on portal venous phase computed tomography (CT) images using semiautomated CT software (LSN Software, version 0.88; Liver Nodularity llc) by an abdominal radiologist (RS) blinded to clinical data, using a method explained by De Vos and al. in [22] and detailed in the Supplementary Methods. The optimal cutoff value of 2.5 was chosen, based on previously published data, as reliably differentiating presence or absence of advanced fibrosis [23–26].

Definitions

Diagnostic criteria for recent PVT included imaging evidence of solid material in one or more segment of the portal venous system (portal trunk, left or right portal branch, splenic vein, superior or inferior mesenteric vein) on a CT-scan or a magnetic resonance imaging, associated with signs of a recent thrombosis: hyperdense thrombus on unenhanced CT phase and/or recent abdominal pain and/or systemic inflammatory response syndrome at diagnosis. Date of diagnosis of PVT was the date of the first imaging procedure fulfilling PVT diagnostic criteria. Patients having one of the following conditions at PVT diagnosis were not included in the study: cirrhosis, portal cavernoma, variceal bleeding, hepatic or biliary malignancies.

In patients from the “CMV positive” and “CMV negative” groups, absence of cirrhosis was ascertained using either the results of a liver biopsy, or the association of at least 2 out of the 3 following criteria: LSN < 2.5; no cause for cirrhosis; liver stiffness measurement using Fibroscan® < 10 kPa (Supplementary Figure 1). In patients from the “CMV unknown” group, the absence of cirrhosis was based on the opinion of the practitioner in charge of the patient.

Other definitions are presented in Supplementary Methods.

Investigations for risk factors for thrombosis

Investigations for risk factors for thrombosis are detailed in Supplementary Methods [27].

Statistical analysis

Quantitative variables were expressed as median (interquartile ranges) and were compared using the Mann-Whitney test. Qualitative variables were expressed as absolute and relative (percentage) frequencies and compared using the Chi-square or the Fisher's test, as appropriate. To reduce the risk of bias, we performed sensitivity analyses consisting in comparing “CMV positive” patients with “CMV negative” and “CMV unknown” patients, matched 1:1 and 1:4, respectively, using a propensity score. Covariables included in the propensity score model were selected based on their known associations with PVT development, namely age and body mass index (BMI) [28]. The model was then used to obtain matches using the nearest-neighbor matching method, with a maximal difference of propensity score of 0.05 [29].

We analyzed variables associated with complete recanalization of portal venous system thrombosis using Cox regression univariate analysis. Variables achieving a p-value below 5% by univariate analysis and with less than 5% of missing data were included in a Cox regression multivariate analysis.[28][27][29] Duration of follow-up used for these Cox regression models was the time period between PVT diagnosis and the first CT-scan or MRI showing a complete recanalization of the portal venous system, or -in the absence of recanalization- the last imaging procedure performed within 24 months after PVT diagnosis, or death if it occurred within 24 months after PVT diagnosis. Cumulative incidence of complete recanalization of the portal venous system was assessed using the Kaplan-Meier method and compared using the log-rank test.

All tests were bilateral and performed with a first-species risk of 0.05. Statistical analyses were performed using SPSS version 22.0 software (SPSS Inc., Chicago, IL). CTAT form is available in the online Supplement.

Results

Study population

"CMV positive" group

Twenty-three patients were included in the "CMV positive" group (Clichy, n=16; Caen, n=2; Lille, n=2; Besançon, n=1; Paris Cochin, n=1; Toulouse, n=1) (Supplementary Figure 2). Their virological characteristics are summarized in Supplementary Table 1.

Fifteen patients had a confirmed CMV disease: 13 had confirmed primary infection (11 had positive anti-CMV IgM antibodies with low avidity IgG; 2 had seroconversion); 1 immunocompromised patient (Patient 1) had colitis and plasma

CMV DNA at 4.61 LogUI/mL; and 1 (Patient 13) had colitis, colon biopsies with detectable CMV DNA and histological lesions compatible with CMV disease. Eight patients had probable CMV disease, based on positive anti-CMV IgM at diagnosis, but unavailable avidity. Plasma CMV DNA was available in 3 of them and was detectable in all cases. Out of the 8 patients with probable CMV disease, neutrophil to lymphocyte ratio was below 1 in 6 patients, and Downey cells were observed in 4 patients (including one with neutrophil to lymphocyte ratio above 1). These proportions were similar to that observed in patients with confirmed CMV disease: 5 out of 13 had neutrophil to lymphocyte ratio below 1 (unavailable in 2) and 4 out of 11 had Downey cells (unavailable in 4). A recent EBV infection was ruled out by positive anti-EBNA IgG in all 6 patients with a probable CMV disease tested. Supplementary results and Supplementary Table 2 detail characteristics of PVT including features attesting recentness of the thrombus.

"CMV negative" and "CMV unknown" groups

In 53 patients with recent PVT, CMV disease could be ruled out ("CMV negative" group): 48 had undetectable anti-CMV IgM antibodies and 23 had undetectable plasma CMV DNA. In 297 patients with recent PVT, neither CMV serology or nor viral load at the diagnosis of PVT was available, so that these patients were included in the "CMV unknown" group.

Characteristics at diagnosis of PVT

Characteristics of the patients are presented in Table 1 and Supplementary Table 3. None of the patients from the "CMV positive" and "CMV negative" and 3 patients of the "CMV unknown" group were receiving anticoagulation at the time of PVT

diagnosis. Patients with CMV disease were younger at the time of PVT diagnosis than patient from “CMV negative” and “CMV unknown” groups. “CMV positive” patients had more commonly signs of viral infection including tachycardia, fever and elevated transaminases and lymphocytes than patients from the control groups. Similar results were obtained when restricting the “CMV unknown group” to patients with available liver stiffness measurement (Supplementary Table 4). Similar results were also obtained when matching, using a propensity score, “CMV positive” patients with “CMV negative” and “CMV unknown” patients (Supplementary Table 5). There was no difference in site or extension of PVT nor in rate of immunosuppression between “CMV positive” patients and patients from the two control groups.

Risk factors for thrombosis

Heterozygous prothrombin G20210A gene mutation was 3 to 5-fold more frequent in patients from the “CMV positive” group than in patients from the two control groups (Table 2, Figure 1). Anti-cardiolipin antibodies were more commonly present at the time of PVT diagnosis in the “CMV positive” group, but these antibodies disappeared in all but one patient, 3 months after CMV disease. There was no difference in other risk factors for thrombosis. Besides CMV disease, the number of risk factors for thrombosis was similar between the 3 groups. Similar results were obtained when restricting the analysis to patients in the “CMV unknown group” with available liver stiffness measurement (Supplementary Table 4). Similar results were also obtained when matching, using a propensity score, “CMV positive” patients with “CMV negative” and “CMV unknown” patients, (Supplementary Table 5).

Evolution of patients according to CMV status

Complete recanalization of the portal venous system

Twenty patients from the “CMV positive” group and 42 patients from the “CMV negative” group had one or more cross-sectional imaging (CT scan or MRI) available during follow-up, allowing reliable analysis of PVT recanalization. Median duration between PVT diagnosis and last cross-sectional imaging was 16 months (3-44) and 13 months (8-24) in patients from the “CMV positive” and “CMV negative” groups, respectively (p=0.789). Number of abdominal cross-sectional imaging (CT scan or MRI) in the first 24 months was similar between “CMV positive” and “CMV negative” patients [1 (1-2), vs. 2 (0-2), respectively; p = 0.320]. Out of these 20 CMV positive and 42 CMV negative patients, anticoagulation was initiated at time of PVT diagnosis in all but one (Patient 1). In the latter patients, total duration of anticoagulation was 17 months (5-54) and 24 months (12-34), respectively (p=0.696). Twelve patients interrupted anticoagulation during follow-up, including 6 of the 20 “CMV positive” and 6 of the 42 “CMV negative” group. During the first 24 months after PVT diagnosis, 10 (50%) patients of the “CMV positive” group and 12 (27%) of the “CMV negative” group had a complete recanalization of the portal venous system (p=0.155). Cumulative incidence of complete recanalization of the portal venous system at 12 and 24 months of follow-up was 47 and 58% in the “CMV positive” group versus 24 and 50% in the “CMV negative” group (Supplementary Figure 3). We performed a univariate (Supplementary Table 6) and then a multivariate analysis to identify variables associated with complete recanalization of PVT at 24 months. As shown in Table 3, the only variable independently predicting complete recanalization of PVT at 24 months was a lower number of occluded segments at diagnosis. Similar results were obtained when matching, using a propensity score, “CMV positive” patients with “CMV negative” patients (Supplementary Table 7). Individual outcome of the patients

from the “CMV positive” group, including duration of anticoagulation, is detailed in Supplementary Figure 4.

Extension of PVT

Two patients from the “CMV positive” group developed an extension of PVT. Patient 1 had obliterative portal venopathy and colitis at diagnosis of inferior mesenteric vein thrombosis. He was initially the only patient not treated with anticoagulation and developed 2 months later an extension of thrombosis to portal trunk. Patient 5 had at diagnosis of PVT (involving superior mesenteric vein, splenic vein and portal trunk thrombosis) no risk factor for thrombosis on top of CMV. Despite anticoagulation, he developed at month 33 a left portal branch thrombosis. A myeloproliferative neoplasm was then diagnosed based on detection of *CALR* mutation. In a third patient (Patient 7), without any risk factor for thrombosis on top of CMV nor any cause for cirrhosis, recanalization occurred, and anticoagulation was discontinued at month 22. Six months later, because of a decreasing portal flow velocity, anticoagulation was resumed, and portal flow velocity normalized. No extension of PVT was observed in the “CMV negative” group.

Portal hypertension related complications

Out of the 15 patients of the “CMV positive” group and the 36 patients of the “CMV negative” group who underwent gastroscopy during follow-up, 3 (20%) and 12 (33%) patients had esophageal varices, respectively ($p = 0.506$). Absence of endoscopy was related to complete recanalization of the portal venous system in 12 patients, to loss of follow-up in 6 patients, while there was no explanation in 7 patients (Supplementary Figure 5). No gastro-intestinal bleeding occurred during follow-up.

The only portal hypertension related complication was ascites in 2 patients from the "CMV negative" group at 5 and 47 months after PVT. There were three deaths during follow-up: one in the "CMV positive" group (Patient 1, 121 months after PVT diagnosis) and 2 in the "CMV negative" group (at 8 and 313 months after PVT diagnosis). Causes of death were extra-hepatic malignancies in 2 patients and unknown in the third one.

Discussion

Association of recent PVT and CMV disease has long been described. However, data reported so far (45 patients in 40 articles, summarized in Supplementary Table 8 [30–69]) were too fragmented to have a clear view of the impact of CMV disease on PVT presentation and outcome. Despite the rarity of this association, thanks to the French network on vascular liver diseases, we were able to fill this gap in knowledge. We collected data from 23 well characterized patients with recent PVT associated with CMV disease. Diagnosis of CMV disease was based on international guidelines as well as on data review by an expert virologist: 15 patients had confirmed CMV disease and 8 patients had highly likely CMV disease attested by detectable plasma anti-CMV IgM as well as in 7 out of these 8 patients either an elevated lymphocytes/neutrophil ratio or detectable Downey cells. Patients with CMV disease were compared with two control groups: patients with virological tests ruling out CMV disease ("CMV negative" group; n=53) and a large group of patients with unknown CMV status ("CMV unknown" group; n=297) having similar geographic origin and date of inclusion as patients of the "CMV positive" group. The large number of patients included in the "CMV unknown" group documents the unsystematic CMV testing across centers over the study period, which might have

induced a bias. Yet, characteristic of the patients of the two control groups were similar, suggesting that most patients with unknown CMV status did not have a CMV disease. Moreover, patients from the “CMV positive” and “CMV unknown” group were included in multiple French centers limiting the risk of bias due to a specific local recruitment.

The first major finding of this study was that CMV disease does not influence initial extension nor outcome of recent PVT. Indeed, we observed that the number of segments occluded in the portal venous system was not different between patients with CMV disease and patients of the two control groups. Moreover, cumulative incidence of complete recanalization was similar between patients of the “CMV positive” and “CMV negative” groups, with figures in line with those previously reported in a prospective European multicentric study [5]. The number of completely occluded segments at PVT diagnosis was the only variable independently associated with a lower incidence of recanalization. This information was lacking in the literature and one could have thought that an acute event, like a CMV disease, would have been associated with a better outcome of PVT. Our data do not allow us to draw conclusions with regard to anticoagulation initiation since only 1 out of 23 CMV positive patients did not receive anticoagulation at PVT diagnosis, nor on anticoagulation duration since anticoagulation was interrupted only in 6 of these patients. Yet, analysis of individual cases suggest that caution is needed when considering discontinuation of anticoagulation since one patient without any additional risk factor for thrombosis besides CMV infection had a decreasing portal flow velocity following anticoagulation interruption that normalized after anticoagulation was resumed. Our results did not allow us to test the effect of anti-

CMV antiviral treatment as only 3 patients received such treatment and they all had a severe presentation or extended thrombosis. Literature available regarding antiviral treatment for thrombosis in other vascular beds in patients with CMV disease is also limited and does thus not allow extrapolations [13–16,70].

The second major finding of this study is that more than half of the patients with CMV-associated PVT had another risk factor for thrombosis. Number of thrombosis risk factors for thrombosis, regardless of the presence of CMV disease, was not different between the three groups. This suggests that CMV disease is not a strong risk factor for PVT and may rather be a trigger for PVT in susceptible patients. This view is reinforced by the rarity of the association of CMV disease with PVT, contrasting with the high incidence of CMV infection in the general population (1% per year in young adults approximately) [20]. As a practical consequence, diagnosing CMV disease in a patient with recent PVT does not deter from performing a comprehensive screening for risk factor for thrombosis.

The third major finding of this study is the strong link between CMV-associated recent PVT and prothrombin G20210A gene mutation (Figure 1). Indeed, in our study, prothrombin gene mutation was detected in 22% of the patients with CMV-associated recent PVT *vs.* 4 and 8% in the two control groups. Detailed analysis of available literature supports our findings, since 5 out of the 25 patients (20%) reported with CMV-associated recent PVT and available data had prothrombin gene mutation, *vs.* 6% in all PVT patients in recent studies [28,71,72]. The prevalence of prothrombin G202010A gene mutation in general western European population is around 2% (Figure 1) [73]. This association could be explained by the synergy

between prothrombin gene mutation and CMV to promote thrombin generation: prothrombin G20210A gene mutation is associated with increased plasma prothrombin levels and dysthrombinemia with unstable prothrombin, hence more easily activated [74]; CMV surface contains procoagulant phospholipids allowing assembly of prothrombinase enzyme complex, and thus favors production of thrombin [75–77]. This effect was observed *in vitro* with infected cells and viral particles. Another hypothesis for CMV prothrombotic effect is the transient presence of antiphospholipid antibodies secondary to infection of endothelial cell by CMV, observed at diagnosis of PVT in our study and in the literature [78,79]. CMV disease was not associated with antiphospholid syndrome, as presence of antiphospholipid antibodies was similar in the 3 groups at 12 weeks, as described in the literature.

In conclusion, CMV disease can be associated with recent PVT, but without influence on thrombosis extension, localization nor recanalization. Accordingly, diagnosis of CMV disease should not influence clinical decisions on PVT management. Other risk factors for thrombosis are often present so that identification of CMV disease does not obviate the need for a complete work-up for risks factors for thrombosis. In particular, a special link exists between prothrombin gene mutation and CMV disease.

Abbreviation list:

APLS, antiphospholipid syndrome; CMV: cytomegalovirus; HCV, hepatitis C virus; HIV, Human immunodeficiency virus; Ig, Immunoglobulin; OPV, obliterative portal

venopathy; PNH, paroxysmal nocturnal hemoglobinuria; PVT, Portal venous system thrombosis

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REFERENCES:

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[1] EASL Clinical Practice Guidelines: Vascular diseases of the liver. J Hepatol 2016;64:179–202.

[2] Rajani R, Björnsson E, Bergquist A, Danielsson Å, Gustavsson A, Grip O, et al. The epidemiology and clinical features of portal vein thrombosis: a multicentre study: The epidemiology and clinical features of portal vein thrombosis. Aliment Pharmacol Ther 2010;32:1154–1162.

[3] Clair DG, Beach JM. Mesenteric Ischemia. N Engl J Med 2016;374:959–968.

[4] Hernández-Gea V, De Gottardi A, Leebeek FWG, Rautou P-E, Salem R, Garcia-Pagan JC. Current knowledge in pathophysiology and management of Budd-Chiari syndrome and non-cirrhotic non-tumoral splanchnic vein thrombosis. J Hepatol 2019;71:175–199

[5] Plessier A, Darwish-Murad S, Hernandez-Guerra M, Consigny Y, Fabris F, Trebicka J, et al. Acute portal vein thrombosis unrelated to cirrhosis: A prospective multicenter follow-up study. Hepatology 2010;51:210–218

[6] Cannon MJ, Schmid DS, Hyde TB. Review of cytomegalovirus seroprevalence and demographic characteristics associated with infection. Rev Med Virol 2010;20:202–213

[7] Gandhi MK, Khanna R. Human cytomegalovirus: clinical aspects, immune regulation, and emerging treatments. Lancet Infect Dis 2004;4:725–738

[8] Griffiths P, Baraniak I, Reeves M. The pathogenesis of human cytomegalovirus: Pathogenesis of human cytomegalovirus. J Pathol 2015;235:288–297

[9] Linares L, Sanclemente G, Cervera C, Hoyo I, Cofán F, Ricart MJ, et al. Influence of Cytomegalovirus Disease in Outcome of Solid Organ Transplant Patients. Transplant Proc 2011;43:2145–2148

[10] Rafailidis PI, Mourtzoukou EG, Varbobitis IC, Falagas ME. Severe cytomegalovirus infection in apparently immunocompetent patients: a systematic review. Virol J 2008;5:47

[11] Simanek AM, Dowd JB, Pawelec G, Melzer D, Dutta A, Aiello AE. Seropositivity to Cytomegalovirus, Inflammation, All-Cause and Cardiovascular Disease-Related Mortality in the United States. PLoS ONE 2011;6:e16103.

[12] Gkrania-Klotsas E, Langenberg C, Sharp SJ, Luben R, Khaw K-T, Wareham NJ. Seropositivity and Higher Immunoglobulin G Antibody Levels Against Cytomegalovirus Are Associated With Mortality in the Population-Based European Prospective Investigation of Cancer–Norfolk Cohort. Clin Infect Dis 2013;56:1421–1427

[13] Paran Y, Shalev V, Steinvil A, Justo D, Zimmerman O, Finn T, et al. Thrombosis following acute cytomegalovirus infection: a community prospective study. Ann Hematol 2013;92:969–974

[14] Schimanski S, Linnemann B, Luxembourg B, Seifried E, Jilg W, Lindhoff-Last E, et al. Cytomegalovirus infection is associated with venous thromboembolism of immunocompetent adults—a case–control study. Ann Hematol 2012;91:597–604

[15] Atzmony L, Halutz O, Avidor B, Finn T, Zimmerman O, Steinvil A, et al. Incidence of Cytomegalovirus-associated thrombosis and its risk factors: A case-control study. Thromb Res 2010;126:e439–443

[16] Kelkar AH, Loc BL, Tarantino MD, Rajasekhar A, Wang H, Kelkar M, et al. Cytomegalovirus-Associated Venous and Arterial Thrombotic Disease. Cureus 2020;18;12(12):e12161

[17] Justo D, Finn T, Atzmony L, Guy N, Steinvil A. Thrombosis associated with acute cytomegalovirus infection: A meta-analysis. Eur J Intern Med 2011;22:195–199

[18] Bertoni M, Squizzato A, Foretic M, Zanieri S, Di Natale ME. Cytomegalovirus-associated splanchnic vein thrombosis in immunocompetent patients: A systematic review. Thromb Res 2018;168:104–113

[19] Kotton CN, Kumar D, Caliendo AM, Huprikar S, Chou S, Danziger-Isakov L, et al. The Third International Consensus Guidelines on the Management of Cytomegalovirus in Solid-organ Transplantation: Transplantation 2018;102:900–931

[20] Coll O, Benoist G, Ville Y, Weisman LE, Botet F, Maurizio M. Anceschi the WPIW, et al. Guidelines on CMV congenital infection. J Perinat Med 2009;37(5):433-445

[21] **Miendje Deyi Y, Goubau P, Bodéus M.** False-Positive IgM Antibody Tests for Cytomegalovirus in Patients with Acute Epstein-Barr Virus Infection. Eur J Clin Microbiol Infect Dis 2000;19:557–560

[22] De Vos N, Sartoris R, Cauchy F, Rautou P-E, Vilgrain V, Ronot M. Performance of liver surface nodularity quantification for the diagnosis of portal hypertension in patients with cirrhosis: comparison between MRI with hepatobiliary phase sequences and CT. Abdom Radiol 2020;45:365–372.

[23] EASL Clinical Practice Guidelines on non-invasive tests for evaluation of liver disease severity and prognosis – 2021 update. J Hepatol 2021;75(3):659-689

[24] Pickhardt PJ, Malecki K, Kloke J, Lubner MG. Accuracy of Liver Surface Nodularity Quantification on MDCT as a Noninvasive Biomarker for Staging Hepatic Fibrosis. Am J Roentgenol 2016;207:1194–1199.

[25] Lubner MG, Jones D, Said A, Kloke J, Lee S, Pickhardt PJ. Accuracy of liver surface nodularity quantification on MDCT for staging hepatic fibrosis in patients with hepatitis C virus. Abdom Radiol 2018;43:2980–2986.

[26] Catania R, Furlan A, Smith AD, Behari J, Tublin ME, Borhani AA. Diagnostic value of MRI-derived liver surface nodularity score for the non-invasive quantification of hepatic fibrosis in non-alcoholic fatty liver disease. Eur Radiol 2021;31:256–263

[27] Poisson J, Plessier A, Kiladjian J-J, Turon F, Cassinat B, Andreoli A, et al. Selective testing for calreticulin gene mutations in patients with splanchnic vein thrombosis: A prospective cohort study. J Hepatol 2017;67:501–507

[28] **Bureau C, Laurent J**, Robic MA, Christol C, Guillaume M, Ruidavets JB, et al. Central obesity is associated with non-cirrhotic portal vein thrombosis. J Hepatol 2016;64:427–432

[29] Haukoos JS, Lewis RJ. The Propensity Score. JAMA 2015;314:1637.

[30] Hyakutake MT, Steinberg E, Disla E, Heller M. Concomitant Infection With Epstein-Barr Virus and Cytomegalovirus Infection Leading to Portal Vein Thrombosis. J Emerg Med 2019;57:e49–51.

[31] de Rooij E, Verheul R, de Vreede M, de Jong Y. Cytomegalovirus infection with pulmonary embolism, splenic vein thrombosis and monoclonal gammopathy of undetermined significance: a case and systematic review. BMJ Case Rep 2019;12:e226448

[32] Salembier A, Verhamme M, Verhamme P, Moerkercke WV. Acute non-cirrhotic portal vein thrombosis : review 2018:81(2):318-322

[33] Neppelenbroek SIM, Rootjes PA, Boxhoorn L, Wagenaar JFP, Simsek S, Stam F. Cytomegalovirus-associated thrombosis. Neth J Med 2018;76(5):251-254

[34] Kelkar AH, Jacob KS, Yousif EB, Farrell JJ. Venous thromboembolism related to cytomegalovirus infection: A case report and literature review. Medicine (Baltimore) 2017;96:e9336

[35] Tufano A, Contaldi P, Coppola A, Nardo A, Franco N, Cerbone A, et al. Cytomegalovirus-Associated Splanchnic Vein Thrombosis in Immunocompetent Patients: Two Case Reports and Literature Review. Semin Thromb Hemost 2018;44:298–303

[36] Mendoza Lizardo SS, Losa García JE, Moreno Nuñez L. Trombosis portal asintomática asociada a infección aguda por citomegalovirus en paciente inmunocompetente. Med Clínica 2018;150:82–83.

[37] Ceccarelli M, Venanzi Rullo E, Nunnari G. Risk factors of venous thrombo-embolism during cytomegalovirus infection in immunocompetent individuals. A systematic review. Eur J Clin Microbiol Infect Dis 2018;37:381–390.

[38] Puccia F, Lombardo V, Giannitrapani L, Licata A, Mazzola G, Soresi M. Case report: acute portal vein thrombosis associated with acute cytomegalovirus infection in an immunocompetent adult. J Ultrasound 2017;20:161–165.

[39] Vael A, Degryse H, Bracke P. Acute Cytomegalovirus Infection as a Rare Cause of Portal Vein Thrombosis with Small Bowel Infarction in an Immunocompetent Patient. J Belg Soc Radiol 2017;101:16

[40] Rojo Alvaro. Mesenteric vein thrombosis associated with a cytomegalovirus infection. Rev Esp Entfermedades Dig 2015:251–252.

[41] Wang T, Kuttikat A, Pulsalkar P, Nanguzgambo A, Bhalara S. Cytomegalovirus-associated portal vein thrombosis in an immunocompetent patient: an underestimated complication. Oxf Med Case Rep 2015;2015:294–296.

[42] Lissandrin R, Mojoli F, Baldanti F, Brunetti E, Pascarella M, Giordani MT, et al. Acute Cytomegalovirus infection as a cause of venous thromboembolism. Mediterr J Hematol Infect Dis 2014;6:e2014041.

[43] Pichenot M, Morell-Dubois S, Flateau C, Deconinck L, Hatron P-Y, Lambert M. Acute cytomegalovirus infection as a transient risk factor for thrombosis: Report of three cases and focus on specific coagulation pathways. Thromb Res 2013;132:145–147

[44] Galloula A, Rossi A, Gautier V, Minozzi C, Messas E, Mirault T. Thrombose portale associée à une infection aiguë à cytomégalovirus. J Mal Vasc 2014;39:224–230

[45] Krähenmann, Dürig, Sendi, Oestmann. Persistierendes Fieber im Alter. Praxis 2011;100:985–988

[46] Kalaitzis J, Basioukas P, Karzi E, Markakis C, Liarmakopoulos E, Hadjimarkou A, et al. Small-bowel necrosis complicating a cytomegalovirus-induced superior mesenteric vein thrombosis in an immunocompetent patient: a case report. J Med Case Reports 2012;6:118

[47] Schreiner M, Barck T, Foroutan B, Baumgarten U. A rare cause of portal vein thrombosis in a previously healthy young man with acute hepatitis. J Clin Virol 2011;51:152–154

[48] Massoure M-P, Ezanno A-C, Millot I, Fixot K, Rey P, Sockeel P. Thrombose aiguë de la veine porte associée à une primo-infection à cytomégalovirus chez

un adulte immunocompétent et compliquée d'un syndrome du compartiment abdominal. Gastroentérologie Clin Biol 2010;34:e3–5

[49] Ladd AM, Goyal R, Rosainz L, Baiocco P, DiFabrizio L. Pulmonary embolism and portal vein thrombosis in an immunocompetent adolescent with acute cytomegalovirus hepatitis. J Thromb Thrombolysis 2009;28:496–499.

[50] Moerkercke WV, Pauwelyn K, Brugman E, Verhamme M. Cytomegalovirus-associated superior mesenteric vein thrombosis treated with systemic and in-situ thrombolysis: Eur J Gastroenterol Hepatol 2009;21:587–592.

[51] Zarza J, Centurión MÉ, Armoa A, Acosta T. Anemia hemolítica autoinmunitaria relacionada con infección por parvovirus B19 humano. Med Clínica 2010;135:336–337

[52] Tanizawa K, Nakatsuka D, Tanaka E, Inoue T, Sakuramoto M, Minakuchi M, et al. Pulmonary Thrombosis with Transient Antiphospholipid Syndrome after Mononucleosis-like Illness. Intern Med 2009;48:1231–1234

[53] Zamani F, Amiri A, Mohit M, Zolfaghari M, Jalaeefar A, Ranjbar M, et al. CMV infection in a pregnant woman complicated by toxic megacolon and mesenteric vein thrombosis. Turk J Gastroenterol 2009;20:234–235

[54] Ergas D, Herskovitz P, Skurnik Y, Mavor E, Sthoeger ZM. Superior Mesenteric Vein Thrombosis with Pulmonary Embolism: A Rare Presentation of Acute Cytomegalovirus Infection. Isr Med Assoc J. 2008;10(3):235-236

[55] Squizzato A, Ageno W, Cattaneo A, Brumana N. A Case Report and Literature Review of Portal Vein Thrombosis Associated with Cytomegalovirus Infection in Immunocompetent Patients. Clin Infect Dis 2007;44:e13–6.

[56] Fridlender ZG, Khamaisi M, Leitersdorf E. Association Between Cytomegalovirus Infection and Venous Thromboembolism. Am J Med Sci 2007;334:111–114.

[57] Gueddi S, Righini M, Mezger N, Morard I, Kaiser L, Angelillo-Scherrer A, et al. Portal vein thrombosis following a primary cytomegalovirus infection in an immunocompetent adult. Thromb Haemost 2006:199–201.

[58] Lijfering WM, Sprenger HG, van Son WJ, van der Meer J. Mesenteric vein thrombosis associated with primary cytomegalovirus infection: a case report: Blood Coagul Fibrinolysis 2007;18:509–511.

[59] Spahr L, Cerny A, Morard I, Rubbia-Brandt L, Schrenzel J. Acute partial Budd-Chiari syndrome and portal vein thrombosis in cytomegalovirus primary infection: a case report. BMC Gastroenterol 2006;6:10

[60] Chelbi F, Boutin-Le Thi Huong D, Frigui M, Asli B, Hausfater P, Piette J-C. Thrombose portale compliquant une infection à cytomégalovirus aiguë chez un sujet immunocompétent. Rev Médecine Interne 2006;27:54–58.

[61] Girszyn N, Leport J, Baux N, Kahn JE, Blétry O. Thrombose portale au cours d'une hépatite aiguë de primo-infection à cytomégalovirus de l'immunocompétent. Rev Médecine Interne. 2006;27(5):426-428.

[62] Benoist S, Laisné M, Joly F, Boudiaf M, Panis Y, Valleur P. Cytomegalovirus infection as a cause of acute superior mesenteric vein thrombosis with jejunal infarction. Surgery 2003;133:222–223.

[63] Dueñas C, Grande C, Martín A, Ceballos I, Sevil M, Fernández A. Trombosis mesentérica asociada a infección por citomegalovirus en paciente inmunocompetente. Enfermedades Infecc Microbiol Clínica 2002;20:96.

[64] Ofotokun I, Carlson C, Gitlin SD, Elta G, Singleton TP, Markovitz DM. Acute Cytomegalovirus Infection Complicated by Vascular Thrombosis: A Case Report. Clin Infect Dis 2001;32:983–986.

[65] Inacio C, Hillaire S, Valla D, Denninger M-H, Casadevall N, Erlinger S. CASE REPORT: Cytomegalovirus infection as a cause of acute portal vein thrombosis. J Gastroenterol Hepatol 1997;12:287–288.

[66] Labarca JA, Rabaggliati RM, Radrigan FJ, Rojas PP, Perez CM, Ferres MV, et al. Antiphospholipid Syndrome Associated with Cytomegalovirus Infection: Case Report and Review. Clin Infect Dis 1997;24:197–200.

[67] de Celis G, Mir J, Casal J, Gómez D. 31-year-old woman with an enlarged tender liver. The Lancet 1995;346:1270.

[68] **Arav-Boger R, Reif S, Bujanover Y**. Portal vein thrombosis caused by protein C and protein S deficiency associated with cytomegalovirus infection. J Pediatr 1995;126:586–588.

[69] Amitrano L, Guardascione MA, Scaglione M, Menchise A, Romano L, Balzano A. Acute portal and mesenteric thrombosis: unusual presentation of cytomegalovirus infection: Eur J Gastroenterol Hepatol 2006;18:443–445.

[70] Deconinck L, Flateau C, Pichenot M, Morell-Dubois S, Maillard H, Hatron P-Y, et al. Antiviral therapy of primary cytomegalovirus infection with vascular thrombosis in immunocompetent adults. Médecine Mal Infect 2016;46:87–92.

[71] Turon F, Cervantes F, Colomer D, Baiges A, Hernández-Gea V, Garcia-Pagán JC. Role of calreticulin mutations in the aetiological diagnosis of splanchnic vein thrombosis. J Hepatol 2015;62:72–74.

[72] Qi X, Ren W, De Stefano V, Fan D. Associations of Coagulation Factor V Leiden and Prothrombin G20210A Mutations With Budd–Chiari Syndrome and Portal Vein Thrombosis: A Systematic Review and Meta-analysis. Clin Gastroenterol Hepatol 2014;12:1801-1812.e7.

[73] Rosendaal FR, Doggen CJM, Zivelin A, Arruda VR, Aiach M, Siscovick DS, et al. Geographic Distribution of the 20210 G to A Prothrombin Variant. Thromb Haemost 1998;79:706–708.

[74] Soria JM, Almasy L, Souto JC, Tirado I, Borell M, Mateo J, et al. Linkage analysis demonstrates that the prothrombin G20210A mutation jointly influences plasma prothrombin levels and risk of thrombosis. Blood 2000;95:2780–2785.

[75] **Pryzdial E, Wright J**. Prothrombinase assembly on an enveloped virus: evidence that the cytomegalovirus surface contains procoagulant phospholipid. Blood 1994;84:3749–3757.

[76] Etingin OR, Silverstein RL, Friedman HM, Hajjar DP. Viral activation of the coagulation cascade: Molecular interactions at the surface of infected endothelial cells. Cell 1990;61:657–662.

[77] Popović M, Smiljanić K, Dobutović B, Syrovets T, Simmet T, Isenović ER. Human cytomegalovirus infection and atherothrombosis. J Thromb Thrombolysis 2012;33:160–172.

[78] Squizzato A, Gerdes V, Büller H. Effects of human cytomegalovirus infection on the coagulation system. Thromb Haemost 2005;93:403–410.

[79] Orts J, Colomina J, Zuniga A, Guerrero A. Cytomegalovirus infection and antiphospholipid syndrome in humans. Arthritis Rheum 2003;48:3296–3297.

TABLES:

Table 1: Clinical and laboratory characteristics of patients with recent portal venous system thrombosis, according to CMV status

	N	"CMV positive" group n=23	N	"CMV negative" group n=53	*p value* pos. *vs.* neg.	N	"CMV unknown" group n=297	*p value* pos. *vs* unk.	*p value* neg. *vs.* unk.
Comorbidity									
Gender (female)	23	8 (35)	53	21 (40)	0.799	297	117 (39)	0.825	1.000
Age (years)	23	36 (31–47)	53	51 (38–62)	**0.001**	297	47 (36-59)	**0.002**	0.339
BMI (kg/m^2)	23	28 (26–32)	47	28 (23–32)	0.824	239	26 (23-30)	**0.034**	**0.033**
Obesity (BMI > 30 kg/m^2)	23	8 (35)	48	19 (40)	0.797	238	58 (25)	0.314	**0.033**
Alcohol consumption (%) *	23	1 (4)	53	1 (2)	0.516	249	13 (5)	1.000	0.477
Immunosuppression	23	1 (4)	53	2 (4)	1.000	297	19 (6)	1.000	0.752
Positive anti-HCV antibodies	21	0	52	0	-	218	5 (2)	1.000	0.587
Positive HBs antigen	21	0	52	1 (2)	-	218	3 (1)	1.000	0.247
Diabetes	23	4 (17)	53	6 (11)	0.479	231	12 (5)	**0.045**	0.117
Arterial hypertension	23	2 (9)	52	14 (27)	0.125	231	28 (12)	1.000	**0.016**
Liver stiffness measurement using Fibroscan®	8	6 (4-7)	31	5 (5-7)	0.875	143	5 (4-7)	0.824	0.718
Clinical characteristics at diagnosis									
No symptoms at diagnosis	23	0	53	8 (15)	0.097	297	39 (17)	**0.031**	0.840
Duration of symptoms	23		45		0.413	198		0.431	0.356
< 1 week		10 (44)		24 (45)			98 (50)		
1 week- 1 month		11 (48)		18 (34)			66 (33)		
1 – 6 months		2 (9)		1 (2)			19 (10)		
> 6 months		0		2 (4)			15 (8)		
Body temperature > 38.5°C	23	11 (48)	52	10 (19)	**0.014**	286	57 (20)	**0.006**	1.000
Abdominal pain	23	20 (87)	53	45 (85)	1.000	280	221 (79)	0.434	0.357
Heart rate (bpm)	19	105 (88–107)	49	80 (70–97)	**<0.001**	160	76 (70-88)	**<0.001**	0.196
Laboratory characteristics at diagnosis									
Leukocytes count (G/L)	23	7.6 (6.6–10.9)	52	8.1 (5.2–10.8)	0.374	281	7 (5.5-10.4)	0.117	0.644
Neutrophils (G/L)	22	3.4 (2.5–5.9)	52	4.6 (3.3–7.8)	0.100	274	4.1 (2.8-7.1)	0.261	0.217
Eosinophils (G/L)	21	0.1 (0.0-0.3)	52	0.1 (0.0-0.2)	0.392	274	0.1 (0.1-0.2)	0.694	0.059
Lymphocytes (G/L)	21	3.1 (2.4–4.9)	52	1.6 (1.2–2.2)	**<0.001**	271	1.7 (1.2-2.3)	**<0.001**	0.549
Platelets count (G/L)	23	221 (157–288)	51	276 (202–348)	**0.019**	281	257 (188-330)	**0.044**	0.409
Prothrombin time (%)	20	82 (75–97)	51	85 (75–96)	0.720	278	87 (73-100)	0.702	0.646
Serum ALT (UI/L)	22	99 (55-204)	52	30 (19-46)	**<0.001**	279	43 (26-66)	**<0.001**	0.005

Serum albumin (g/L)	23	34 (31–36)	50	33 (30–38)	0.820	273	37 (33-42)	**0.010**	**<0.001**
Serum bilirubin (µmol/L)	22	9 (7–11)	52	12 (8–16)	0.067	276	10 (7-16)	0.151	0.496
Serum ferritin (µg/L)	19	573 (261–1154)	44	237 (83–508)	**0.007**	189	168 (51-382)	**<0.001**	0.085
Serum CRP (mg/L)	22	76 (22–152)	49	51 (8–162)	0.723	212	30 (5-100)	**0.024**	**0.044**
Triglyceride (mmol/L)	16	1.81 (1.21-2.18)	44	1.1 (0.8-1.5)	**0.005**	200	1.08 (0.74-1.54)	**0.001**	0.504

Data are expressed as median (range) or absolute value (percentage) and were compared using the Mann-Whitney test for quantitative variables, the Chi-square or Fisher's test for qualitative variables. *p-values* were calculated between "CMV positive" (pos.), "CMV negative" (neg.) and "CMV unknown" (unk.) groups.

Abbreviations: ALT, alanine transaminase; BMI, body mass index; CRP, C-reactive protein; HCV, hepatitis C virus.

* Alcohol consumption ≥ 140 g per week.

Table 2: Risk factors for thrombosis identified at diagnosis of recent portal venous system thrombosis, according to CMV status

	N	"CMV positive" group n=23	N	"CMV negative" group n=53	*p value* pos. *vs.* neg.	N	"CMV unknown" group n=297	*p value* pos. *vs.* unk.	*p value* neg. *vs.* unk.
Factor V Leiden	23	0	51	2 (4)	1.000	285	18 (6)	0.628	0.750
Prothrombin gene mutation	23	5 (22)	51	2 (4)	**0.010**	286	22 (8)	**0.033**	0.222
Protein C deficiency	23	3 (13)	53	7 (13)	1.000	189	15 (8)	0,423	0.278
Protein S deficiency	23	2 (8)	53	3 (6)	1.000	187	12 (6)	0,332	0.728
Antithrombin deficiency	21	1 (5)	53	6 (11)	0.665	192	10 (5)	1,000	0.122
Myeloproliferative neoplasm	23	1 (4)	52	9 (17)	0.264	287	31 (11)	0.713	0.239
JAK2^{v617f} mutation	21	0	50	7 (14)	0.180	282	27 (10)	0.235	0.319
Antiphospholipid syndrome	22	1 (4)	51	1 (2)	0.515	277	17 (6)	1.000	0.327
Lupus anticoagulant	21	5 (24)	48	4 (8)	0.119	273	31 (11)	0.155	0.801
Anticardiolipin antibodies	20	6 (30)	49	4 (8)	**0.029**	251	12 (5)	**0.001**	0.308
Anti-β2-Gp1 antibodies	20	3 (15)	49	1 (2)	0.070	249	4 (2)	**0.010**	1.000
PNH	20	0	52	1 (2)	1.000	261	1 (0)	1.000	0.305
Behçet's disease	23	0	53	1 (2)	1.000	271	0	-	0.164
Oral contraceptives	8	5 (72)	17	4 (24)	0.061	131	60 (46)	0.254	0.118
Other systemic factors*	23	1 (4)	53	0 (0)	0.307	284	9 (3)	0.655	0.906
Local factors	23	2 (9)	53	12 (23)	0.205	297	67 (23)	0.285	1.000
Personal history of thrombosis	23	2 (9)	53	10 (17)	0.327	297	38 (13)	1.000	0.417
1st degree-relative history of thrombosis	23	5 (22)	53	14 (26)	1.000	297	52 (17)	0.805	0.861
Number of risk factors for thrombosis (0 / 1 / 2 / 3 and more)**	23	10/12/1/0	53	18/27/4/4	0.828	297	95/128/55/19	0.634	0.329

Data are expressed as median (range) or absolute value (percentage) and were compared using the Mann-Whitney test for quantitative variables, the Chi-square or Fisher's test for qualitative variables. *p-values* were calculated between "CMV positive" (pos.), "CMV negative" (neg.) and "CMV unknown" (unk.) groups.

Abbreviations: CMV, cytomegalovirus; PNH, paroxysmal nocturnal hemoglobinuria.

* inflammatory bowel disease (n=2), systemic lupus erythematosus (n=3), sarcoidosis (n=1), celiac disease (n=1), rheumatoid arthritis (n=1), juvenile idiopathic arthritis (n=1), psoriasis (n=1).

** The following risk factors for thrombosis were taken into account: factor V Leiden, prothrombin gene mutation, myeloproliferative neoplasm, confirmed antiphospholipid syndrome, PNH, Behcet's disease, oral contraceptive use, systemic disease, local inflammation or surgery, personal or 1st degree-relative history of thrombosis**.**

Table 3: Multivariate analysis using Cox regression model of variables associated with complete recanalization of portal venous system thrombosis at 24 months in 62 patients with recent PVT and follow-up imaging available (20 patients from the "CMV positive" group and 42 from the "CMV negative" group)

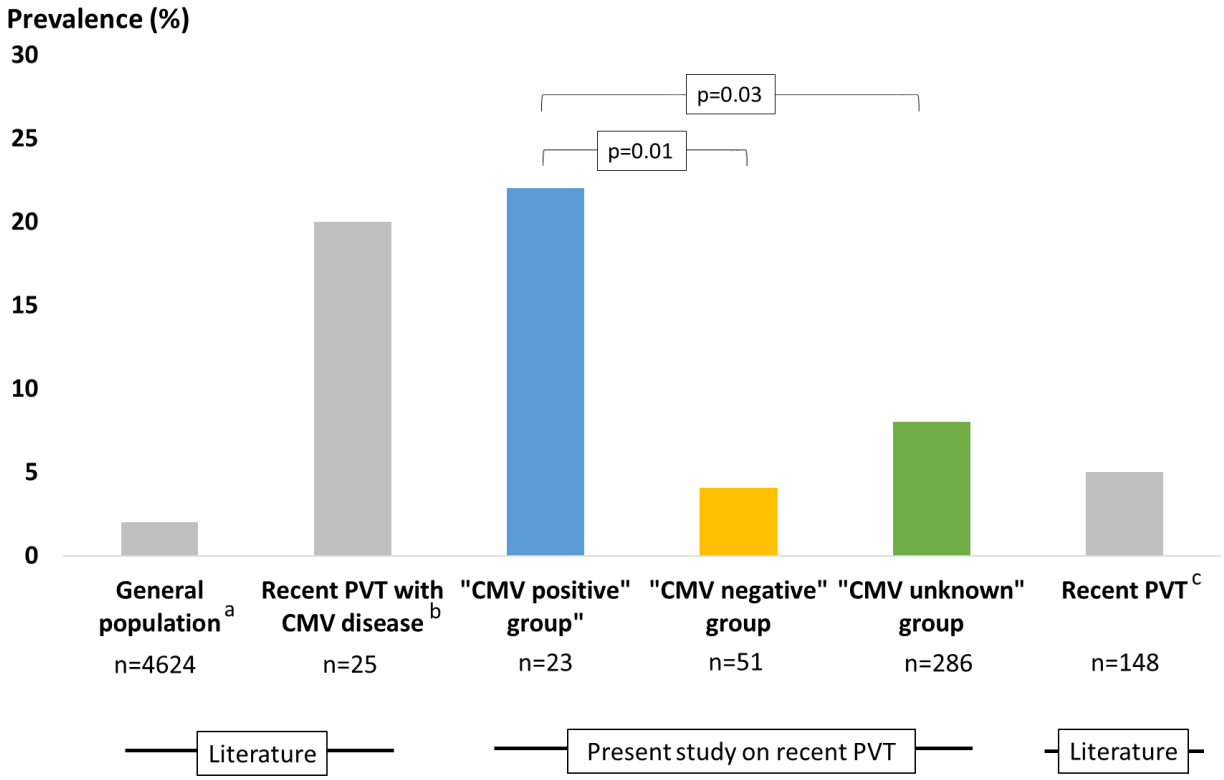
Variable	Hazard ratio	95% CI	*p value*
Abdominal pain	0.581	0.188-1.802	0.348
Number of occluded segments of the portal venous system*	0.591	0.403-0.866	**0.007**
Serum ALT (UI/L)	1.002	0.999-1.004	0.219

This analysis included variables associated persistence of portal venous system thrombosis at 24 months by univariate analysis, with p value < 0.05 and with available data for more than 95% of the patients. Regarding imaging features, only number of completely occluded segments was included in the analysis and not each specific location.
Abbreviation list: ALT, alanine aminotransferase; CI, confidence interval.
*The following segments were considered: right portal branch, left portal branch, portal trunk, splenic vein, superior mesenteric vein.
Variables with Hazard ratio > 1 are associated with complete recanalization at 24 months.

FIGURE LEGEND

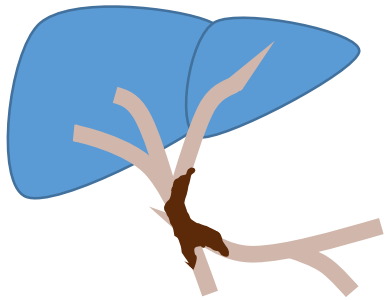
Figure 1: Prevalence of prothrombin gene mutation in patients with recent portal venous system thrombosis in our study as well as in the literature, according to CMV status

Data were compared using the Fisher's test.
[a] Prevalence of prothrombin gene mutation in the general population is based on a study by Rosendaal and colleagues[73]. [b] Prevalence of prothrombin gene mutation in cases of recent PVT and CMV disease reported so far in the literature is based on studies summarized in Supplementary Table 8. [c] Prevalence of prothrombin gene mutation in patients with recent PVT from the literature based on 2 recent studies on PVT [28,71]


Prevalence (%)
30
25
20
15
10
5
0
p=0.03
p=0.01
General population a
Recent PVT with CMV disease b
"CMV positive" group"
"CMV negative" group
"CMV unknown" group
Recent PVT c
n=4624
n=25
n=23
n=51
n=286
n=148
Literature
Present study on recent PVT
Literature

Recent portal venous system thrombosis (PVT) associated with cytomegalovirus disease

A multicentric controlled cohort study of the French Network for the vascular liver diseases



Recent PVT

	cytomegalovirus disease	No cytomegalovirus disease	Unavailable cytomegalovirus status
	n = 23	**n = 53**	**n = 297**
	• Younger • More signs of viral infection		
	• > 50% patients had another risk factor for thrombosis		
Prothrombin G20210A gene mutation	**22%**	**4%**	**8%**

No difference regarding localization, extension or recanalization of PVT