2003, and 'Faranah', a strain isolated from a human in 1996. They were aligned with 22 other LASV sequences belonging to all lineages and dated by their day of collection. In BEAST (v1.10) tree reconstruction, the following settings were used: GTR+gamma distributed rate variation (four discrete categories) across each codon position and constant population size demographic model. Four clock models were tested: strict, uncorrelated relaxed, random local, and fixed local. The best model was determined by comparing the resulting likelihoods using AICM model testing. Markov chain Monte Carlo (MCMC) sampling was performed for a total of 20 million states (sampling every 10,000 states) to obtain an effective sample size above 200 for all parameters. Results of MCMC sampling were examined in Tracer 1.6. The results showed that the Upper Guinea clade emerged 153 years ago when the phylogeny was reconstructed for partial NP (nt = 754, better model fit with strict clock), 208 years ago with complete NP (nt = 1,707, better model fit with random local clock), and 350 years ago with complete polymerase (nt = 6,681, better model fit with strict clock). The difference of emergence 1, 2, or 3 centuries ago, can be explained by the inclusion of some parts of the genome evolving slower than the partial NP. Therefore, the longer the sequence, the greater the divergence time. In order to have an accurate time of divergence, we suggest to use complete genes to perform a time-calibrated phylogeny.

A41 Deep sequencing of respiratory syncytial virus links viral diversity to disease severity

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Respiratory syncytial virus (RSV) is a common virus that can cause bronchiolitis in infants and pneumonia in immunocompromised and elderly people. RSV belongs to the Pneumoviridae family and consists of a genome of 15 kb. Its genome contains ten genes that code for eleven proteins, with M2 coding for two different proteins in overlapping open reading frames. It is unclear why some infected children have severe disease and others have mild or asymptomatic disease. In this project, methods for complete genome sequencing of RSV via Sanger and Illumina MiSeq platforms were optimized. One hundred and twenty-four community samples (59 RSV A and 65 RSV B) from 2014 to 2018 were collected (in collaboration with the Royal College of General Practitioners) and sequenced. Samples were selected based on viral load (e.g. Ct values had to be < 30). The genotype of each sample was determined by constructing phylogenetic trees with reference sequences from all genotypes. Trees were reconstructed using the maximum likelihood method. Furthermore, Illumina sequencing was used to deep sequence seven community samples and four hospital samples that were spatiotemporally matched (obtained via Imperial College NHS Trust hospitals). Variants were studied to investigate if certain variants influence disease severity (e.g. cause mild (community samples) or severe infection (hospital samples)). Analysis so far showed that ON1 (with a seventy-two nucleotide duplication in attachment protein G) is the most common genotype in both community and hospitalized samples (90% and 75% of samples, respectively), with GA2 (without duplication) as the next most common genotype for RSV A subtypes (7% and 25%). Three per cent of community samples were of the GA5 genotype. Samples from the RSV B subgroup all belong to the BA genotypes with a 60-nucleotide duplication in G. Samples that were selected for Illumina sequencing had a Ct value between 19.0 and 29.1, while hospital samples had a Ct value of 18.3 to 29.1. Viral load, therefore, did not explain disease severity in these selected samples. The Shannon entropy from Illumina sequenced samples averaged at 22.78 in community samples (ranges from 15 to 28) and 38.78 in hospitalized samples (ranges from 31 to 57). This indicated that diversity of the virus pool might influence disease severity; however, more samples need to be analyzed. There are no specific variants that could explain disease severity. Diversity of the virus pool could explain the link between higher viral loads and disease severity, which is sometimes found but cannot always be confirmed. Higher viral loads can harbor more diverse viral particles compared to lower viral loads. Future work will focus on more in-depth variation and diversity analysis and on evolutionary analysis of both community and hospital samples. We will also investigate intra-host evolution of RSV in acute infections using consecutive samples and its possible implications on the host response.

A42 Next-generation sequencing to analyze multiple-strain infections, genotype distribution, and antiviral resistance in hematopoietic stem cell transplantation recipients with human cytomegalovirus infection

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Next-generation sequencing (NGS) produces comprehensive insights across the entire genome of the human cytomegalovirus (HCMV), which is an important opportunistic pathogen following hematopoietic stem cell transplantation (HSCT). To assess the clinical impact of HCMV diversity, genotype distribution, and resistance mutations, we performed NGS directly on plasma specimens from HSCT recipients with HCMV reactivation. Twenty-nine HCMV-positive plasma samples (median viral load 1.7×10^3 IU/ml) collected from a prospective allogenic HSCT recipient cohort ($n = 16$) between 21 and 80 days after transplantation were sequenced on an Illumina MiSeq after preparation of target-enriched sequencing libraries. Consensus HCMV genome sequences were assembled for 24 samples. The presence of multiple-strain infections and antiviral resistance mutations in genes UL54 and UL97 was determined by variant analysis. Genotype distribution was determined by specific marker analysis of several hypervariable genes (RL5A, RL6, RL12, RL13, UL1, UL9, UL11, UL73, UL74, UL120, UL146, and UL139). Associations between genomic and clinical features (e.g. graft-versus-host disease (GvHD), donor/recipient HCMV serostatus, dynamics of HCMV antigenemia, survival) were explored. Multiple infections involving up to 3 HCMV strains were detected in seven out of sixteen patients, with one patient analyzed at > 2 time points, showing a switch of the dominant HCMV population. No known antiviral resistance mutations were detected, which may be expected due to sample collection early after HSCT from patients without antiviral prophylaxis. Multiple-strain infection was associated with an earlier peak of HCMV-antigenemia ($P = 0.054$), but not with duration of viremia, antigenemia peak values, donor/recipient HCMV serostatus, T-cell depletion, acute or chronic GvHD, disease relapse, or reduced survival. Genotype distribution analysis revealed a potential link of one genotype of the immunomodulatory gene UL11 with GvHD incidence after HCMV reactivation. NGS of HCMV diversity directly from plasma samples, even with low viral loads, enables the acquisition of data of potential clinical interest. To identify reliable associations between clinical features and HCMV diversity, further patient cohorts with suitable sample sizes are required.

A43 Translational research: NGS metagenomics into clinical diagnostics

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As research next-generation sequencing (NGS) metagenomic pipelines transition to clinical diagnostics, the user-base changes from bioinformaticians to biologists, medical doctors, and lab-technicians. Besides the obvious need for benchmarking and assessment of diagnostic outcomes of the pipelines and tools, other focus points remain: reproducibility, data immutability, user-friendliness, portability/scalability, privacy, and a clear audit trail. We have a research metagenomics pipeline that takes raw fastq files and produces annotated contigs, but it is too complicated for non-bioinformaticians. Here, we present preliminary findings in adapting this pipeline for clinical diagnostics. We used information available on relevant fora (www.bioinfo-core.org) and experiences and publications from colleague bioinformaticians in other institutes (COMPARE, UBC, and LUMC). From this information, a robust and user-friendly storage and analysis workflow was designed for non-bioinformaticians in a clinical setting. Via Conda [https://conda.io] and Docker containers [http://www.docker.com], we made our