

Supplementary 2

Table. Summary of Consensus statements on indications of FMT in clinical practice.

<i>Indication</i>	<i>Statement</i>	<i>QoE</i>	<i>SoR</i>
CDI: · Recurrent · Refractory · First episode	FMT is recommended both in mild and severe disease . FMT can be considered as effective option. Insufficient evidence to suggest FMT; only research.	High Low Low	Strong Strong Weak
IBD: · UC · CD · Pouchitis	Insufficient evidence to suggest FMT; only research Insufficient evidence to suggest FMT; only research Insufficient evidence to suggest FMT; only research	Moderate Low Low	Weak Weak Weak
IBS	Insufficient evidence to suggest FMT; only research	Low	Weak
Metabolic disorders	Insufficient evidence to suggest FMT; only research	Low	Weak
Pediatrics: · Recurrent CDI · IBD	FMT may have a role in clinical practice. Insufficient evidence to suggest FMT; only research.	Low Low	Weak Weak

Table. Summary of Consensus statements on donor selection.

<i>Donor selection</i>	<i>Statement synthesis</i>	<i>QoE</i>	<i>SoR</i>
Collection of medical history: · General · Specific situations	Preliminary clinical interview to exclude risk factors (see Table 4) After laboratory testing and on day of donation, further clinical interview to check for potential harmful issues (see Table 5) Additional exclusion criteria for other non-CDI indications	Low Low Low	Strong Strong Weak
Testing of donor: · General · Specific situations	Suitable donors for FMT should undergo both blood and stool testing preferably by 6 weeks before donation (see Table 6) Potential donors could undergo additional testing when FMT is performed in research for other indications other than CDI	Low Low	Strong Weak
Choice of donors	Related or unrelated donors can be chosen when FMT is performed to treat CDI	Moderate	Strong

Table. Summary of Consensus statements on preparation of faecal material.

<i>Preparation of faecal material</i>	<i>Statement synthesis</i>	<i>QoE</i>	<i>SoR</i>
Stool handling and preparation of fresh faeces	A minimum set of general steps have to be followed (see Table 7)	Moderate	Strong
Frozen faeces preparation and defrosting	Freeze-stored faeces can be used in FMT. Use at least 30 grams of faeces, 150 ml of saline solution and 20 ml of 85% glycerol. The final suspension should be clearly and traceably labelled and stored at -80°C. After thawing, saline solution can be added. Repetitive thawing and freezing should be avoided	Moderate	Strong
Microbiota assessment	The assessment of total microbiota by high throughput 16S rDNA sequencing or metagenomics is recommended for research purposes, but not for routine clinical treatment of CDI	Low	Weak

Table. Summary of Consensus statements on clinical management and faecal delivery.

<i>Faecal delivery and follow-up</i>	<i>Statement</i>	<i>QoE</i>	<i>SoR</i>
Recipient preparation: · Antibiotics · Bowel lavage	A 3-day antibiotic pre-treatment course is suggested for recurrent CDI before FMT. Stop antibiotics 12 to 48 hours before stool infusion Bowel cleaning before FMT should be performed	Moderate Low	Strong Strong
Route of faecal delivery: · Colonoscopy · Enema(s) · Upper GI tract	Apply stool in right colon in CDI patients; if not possible or in severe colitis, apply stools in left colon. Apply one or more enemas in usual manner. Via endoscope, NGT, NJT, or gastrostomy. Keep patients in upright position after infusion.	High Low High	Strong Strong Strong
Safety considerations	FMT is safe. In critically ill patients consider infusion by enema	Low	Strong
Repeated faecal infusion	Faecal infusion can be repeated after treatment failure	High	Strong
Monitoring of patients: · Short-term AE · Long-term AE · Efficacy outcomes	Observe patients for complication after the procedure Long-term period is not determined; monitor clinical data CDI patients should be followed up for at least 8 week after FMT	Low Low Low	Weak Weak Strong

Table. Summary of Consensus statements on FMT centre.

<i>FMT centre</i>	<i>Statement</i>	<i>QoE</i>	<i>SoR</i>
Clinical requirements and facilities	Implementation of referral centres in proficient hospitals is encouraged FMT staff should be trained FMT staff should be multidisciplinary Availability of general facilities Clinical governance is mandatory	Moderate Low Low Low Low	Strong Strong Strong Strong Strong
Microbiological requirements and facilities	Safe processing of human samples is mandatory Documentation stored for at least ten years	Low Low	Strong Strong
Regulatory requirements	Implementation of registers to collect data is recommended. If any, specific national rules should be followed	Low Low	Strong Strong

AE: adverse events. CDI: *Clostridium difficile* infection. FMT faecal microbiota transplantation. GI: gastrointestinal. IBD: inflammatory bowel disease. NGT: nasogastric tube. NJT: nasojejunal tube. QoE: quality of evidence. SoR: Strength of recommendation.