Faecal microbiota transplantation in clinical practice

We thank Dr Terveer and colleagues for their correspondence on our faecal microbiota transplantation (FMT) consensus report.[1 2] Their comments enrich the discussion on this topic, which was not fully developed in the paper because of word count limitations.

Our report aimed at providing evidence-based statements on the application of FMT in clinical practice. Thus, consensus experts were chosen according to their scientific profiles in the field of FMT (including the various procedural steps) and its possible clinical application (IBD, IBS, metabolic syndrome, etc). The experts were also representative of the different European countries.

At the time of planning the working group, we were aware that donor faeces banks already exist in some countries. Nevertheless, as the consensus had evidence-based practical purposes, and since the aforementioned banks had not published any scientific report on their activities, we did not want to be biased a priori in formulating our statements and therefore we chose not to involve these banks.

The consensus report, beyond encouraging the development of referral FMT centres, includes a series of statements to recommend their implementation in hospitals with appropriate expertise (including a trained multidisciplinary team) and facilities, to safely perform the procedure and manage the potential-related adverse events. This is a critical point, and we understand that it might conflict with the interests of biobanks, which would instead implement the faecal delivery regardless of the safety requirements provided in reference centres. The critical steps regarding (i) patient selection, (ii) donor selection and screening and (iii) biobanking of faeces have been thoroughly analysed and discussed in the manuscript, together with other critical steps (patient preparation, faecal delivery, monitoring of side effects and many others), on which we have issued appropriate statements.

Honestly, it is not clear to us why Dr Terveer and colleagues discourage the implementation of such centres and reference team to prevent unnecessary secondary spread of *Clostridium difficile*, and even how the cited reference fits with this topic.

Moreover, a number of advantages of the use of frozen donor faeces were reported in the consensus paper. In particular, it was remarked that frozen stool banks allow faecal donors to be thoroughly screened, and that FMT procedure and donor screening documentation should be recorded and stored for at least 10 years to archive material in case of future adverse events. We thank Dr Teever and colleagues for having pointed out the advantage of re-testing frozen donor faeces. However, this possibility was implicit both in our statements and in the related comments.

Finally, we commend the activities of the non-profit Netherlands donor faeces bank, and believe that this model does not conflict with FMT centres in any way. Although the ultimate goal of the European FMT working group was precisely to encourage and drive the spreading and the governance of FMT referral centres fully structured within the healthcare system, we think that many of the issues raised in the report can be useful to regulate the development of donor faeces banks. After all, the common objective is to create a harmonised context to increasingly improve the offer of FMT procedure in clinical practice across different European countries.

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