LETTER

Assessment of faecal microbial transfer in irritable bowel syndrome with severe bloating

We read with interest the work by Halmos et al in which they describe the effects of dietary FODMAP (Fermentable Oligo-, Di- and Mono- saccharides And Polyols) restriction in patients with IBS on the intestinal microbiota. They showed that low FODMAP intake was associated with reduced total bacterial and lower relative abundance of butyrate-producing Clostridium cluster XIVa, changes that are generally considered unfavourable. Therefore, they discourage long-term dietary FODMAP restriction, a suggestion also supported by the recent work of McIntosh and colleagues who noticed unfavourable changes in both microbiota and metabolome of patients with IBS who were on a low FODMAP diet. Although low FODMAP intake reduces GI symptoms in almost 75% of patients with IBS, the effects of this diet on the intestinal microbiota might be disadvantageous in the long run.

Combining these observations with the important role for the intestinal microbiota in IBS pathogenesis, we report here faecal microbiota transplantation (FMT) as an alternative to FODMAP restriction in patients with IBS. We applied FMT in 12 refractory IBS patients (Rome III...
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In this study nine patients (75%) met the primary endpoint being: ‘adequate relief of global IBS symptoms and abdominal bloating’, 12 weeks after FMT. A significant reduction in general abdominal discomfort (−21%), abdominal pain (−26%), bloating (−35%) and flatulence (−37%) was reported. The overall quality of life also improved significantly (±12.9%) (see online supplementary table S2, figure 4). Responders were followed up and

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and severe bloating, and mapped the associated microbiota changes after therapy 5 6 (see online supplementary file).

In our cohort, the median disease duration was 14.5 years (5–40) and patients (8/12 female) had undergone at least three conventional treatment attempts prior to inclusion (see online supplementary table S1). Consecutive faecal samples were collected from the last seven patients for microbiome analyses.

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Microbiota analysis showed no community differences between patients and donors and no difference in microbial dissimilarity between patient–donor responders and non-responder pairs at baseline. However, we observed a trend of higher

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counts in donors compared with patients (uncorrected p=0.011) and successful donors tended to have higher baseline counts of Streptococcus compared with non-successful donors (figure 2). Interestingly, we also observed a trend of higher enrichment potential in responders compared with non-responders (figure 2). In line with earlier observations in IBD, the median number of successfully transferred phylotypes was also higher in responders (n=6) versus non-responders (n=2.5) (not significant).

With this open-label FMT study in patients with IBS, we found a similar response rate as for the low-FODMAP diet. Interestingly, positive effects on IBS-related symptoms seem to be linked to changes in the intestinal microbiota due to FMT. This study suggests FMT as a possible treatment option for IBS and supports correlations between abnormalities in the intestinal microbiota and IBS.

The main limitation of our study is its design as an open-label trial. Of note, however, placebo response rates in similar IBS patient cohorts are reported to be approximately 37.5%, which is considerably lower than the response rate of 75% that we report here. Nonetheless, double-blind, placebo-controlled trials, addressing also microbial changes, are necessary to provide clear answers about the applicability of FMT in IBS and are currently on-going both in our centre (NCT02299973) and elsewhere (NCT02092402; NCT02154867).

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