BMJ 2015;351:h6043 doi: 10.1136/bmj.h6043 (Published 19 November 2015)

LETTERS

FAECAL TRANSPLANTS

Obstacles to establishing an NHS faecal transplant programme

Benjamin H Mullish *clinical research fellow*, Horace R T Williams *consultant gastroenterologist and honorary senior lecturer*

Division of Digestive Diseases, Faculty of Medicine, Imperial College London, St Mary's Hospital, London W2 1NY, UK

Having recently established a faecal microbiota transplantation (FMT) programme, we raise two points about Spector and Knight's editorial on FMT.[1]

Firstly, despite the UK's relatively permissive regulatory framework on FMT, we encountered considerable obstacles to establishing an NHS programme. Donor screening is expensive (>£500 (€703; $755)/screen/donor, repeated regularly). It is unclear whether FMT governance falls under the remit of microbiology, gastroenterology, or pharmacy. There is reluctance to transfer patients with recurrent *Clostridium difficile* infection into an FMT centre because of infection control implications; conversely, clinicians from FMT centres may encounter difficulties taking transplant material to other hospitals owing to lengthy administrative processes—for example, issuing honorary contracts.

Similar difficulties are described elsewhere,[2] and they may result in FMT not being available to patients who might benefit greatly. Regional FMT networks could be one solution, with a "hub" centre to coordinate donors and transplant preparation and "spoke" centres that have agreed protocols with the hub centre on FMT delivery.

Secondly, despite the interest in the therapeutic implications of FMT in a range of conditions, the exact mechanisms by which it works remain unclear.[3] Because FMT treats *C difficile* infection so effectively in most cases, analysis of the few donors whose stool does not induce remission of infection may be particularly useful. To make scientific advances, researchers need access to donors for sample analysis and robust clinical records of outcomes from FMT for each donor; this should be borne in mind as "stool banks" become established.

Competing interests: None declared.

Full response at: www.bmj.com/content/351/bmj.h5149/rr.

1 Spector T, Knight R. Faecal transplants. *BMJ* 2015;351:h5149. (20 October.)
2 Porter RJ, Fogg C. Faecal microbiota transplantation for Clostridium difficile infection in the United Kingdom. *Clin Microbiol Infect* 2015;21:578-82.
3 Holmes E, Li JV, Marchesi JR, et al. Gut microbiota composition and activity in relation to host metabolic phenotype and disease risk. *Cell Metab* 2012;16:559-64.

Cite this as: *BMJ* 2015;351:h6043

b.mullish@imperial.ac.uk