Fecal microbiota transplantation induces remission of infantile allergic colitis through gut microbiota re-establishment

Liu, Sheng-Xuan; Li, Yin-Hu; Dai, Wen-Kui; Li, Xue-Song; Qiu, Chuang-Zhao; Ruan, Meng-Ling; Zou, Biao; Dong, Chen; Liu, Yan-Hong; He, Jia-Yi; Huang, Zhi-Hua; Shu, Sai-Nan

Published in:  
World Journal of Gastroenterology

Published: 28/12/2017

Document Version:  
Final Published version, also known as Publisher’s PDF, Publisher’s Final version or Version of Record

License:  
CC BY-NC

Published version (DOI):  

Published details:  

Citing this paper  
Please note that where the full-text provided on CityU Scholars is the Post-print version (also known as Accepted Author Manuscript, Peer-reviewed or Author Final version), it may differ from the Final Published version. When citing, ensure that you check and use the publisher's definitive version for pagination and other details.

General rights  
Copyright for the publications made accessible via the CityU Scholars portal is retained by the author(s) and/or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights. Users may not further distribute the material or use it for any profit-making activity or commercial gain.

Publisher permission  
Permission for previously published items are in accordance with publisher’s copyright policies sourced from the SHERPA RoMEO database. Links to full text versions (either Published or Post-print) are only available if corresponding publishers allow open access.

Take down policy  
Contact lbscholars@cityu.edu.hk if you believe that this document breaches copyright and provide us with details. We will remove access to the work immediately and investigate your claim.
EDITORIAL
8439 Serum levels of angiotensin converting enzyme as a biomarker of liver fibrosis
Miranda AS, Simões e Silva AC

MINIREVIEWS
8443 Mechanisms of autophagy activation in endothelial cell and their targeting during normothermic machine liver perfusion

ORIGINAL ARTICLE
Basic Study
8452 Human small intestine is capable of restoring barrier function after short ischemic periods
Schellekens DH, Hundscheid IH, Leenarts CA, Grootjans J, Lenaerts K, Buurman WA, Dejong CH, Derixs JP

8465 Stable gastric pentadecapeptide BPC 157 in treatment of colitis and ischemia and reperfusion in rats: New insights

8489 Exploring pathogenesis of primary biliary cholangitis by proteomics: A pilot study

8500 Influence of TBX21 T-1993C variant on autoimmune hepatitis development by Yin-Yang 1 binding
Sun W, Wu HY, Chen S

8512 Astragaloside IV inhibits pathological functions of gastric cancer-associated fibroblasts

Retrospective Cohort Study
8526 Prevalence and outcomes of pancreatic cystic neoplasms in liver transplant recipients

Retrospective Study
8533 Analysis of 12 variants in the development of gastric and colorectal cancers
Cavalcante GC, Amador MA, Ribeiro dos Santos AM, Carvalho DC, Andrade RB, Pereira EE, Fernandes MR, Costa DF, Santos NP, Assumpção PP, Ribeiro dos Santos Â, Santos S
8544 Childhood-onset inflammatory bowel diseases associated with mutation of Wiskott-Aldrich syndrome protein gene
Ohya T, Yanagimachi M, Iwasawa K, Umetsu S, Sogo T, Inui A, Fujisawa T, Ito S

8553 Comparison of totally laparoscopic total gastrectomy using an endoscopic linear stapler with laparoscopic-assisted total gastrectomy using a circular stapler in patients with gastric cancer: A single-center experience
Gong CS, Kim BS, Kim HS

8562 Prognostic significance of pretreatment serum carcinoembryonic antigen levels in gastric cancer with pathological lymph node-negative: A large sample single-center retrospective study

8570 Fecal microbiota transplantation induces remission of infantile allergic colitis through gut microbiota re-establishment
Liu SX, Li YH, Dai WK, Li XS, Qiu CZ, Ruan ML, Zou B, Dong C, Liu YH, He JY, Huang ZH, Shu SN

8582 Prognostic value of lymph node metastasis in patients with T1-stage colorectal cancer from multiple centers in China

Clinical Trial Study
8591 Association between acute pancreatitis and small intestinal bacterial overgrowth assessed by hydrogen breath test
Zhang M, Zhu HM, He F, Li BY, Li XC

Observational Study
8597 Endoscopic papillary large balloon dilatation with sphincterotomy is safe and effective for biliary stone removal independent of timing and size of sphincterotomy
Aujla UI, Ladep N, Dwyer L, Hood S, Stern N, Sturgess R

8605 Person-centered endoscopy safety checklist: Development, implementation, and evaluation
Dubois H, Schmidt PT, Creutzfeldt J, Bergenmar M

Randomized Clinicalled Trials
8615 Multicenter, randomized study to optimize bowel preparation for colon capsule endoscopy
Kastenberg D, Burch WC, Romeo DP, Kashyap PK, Pound DC, Papageorgiou N, Fernández-Urrien Sainz I, Sokach CE, Rex DK
<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>8626</td>
<td>Fusobacterium's link to colorectal neoplasia sequenced: A systematic review and future insights</td>
<td>Hussan H, Clinton SK, Roberts K, Bailey MT</td>
</tr>
<tr>
<td>8651</td>
<td>Psychiatric morbidity after surgery for inflammatory bowel disease: A systematic review</td>
<td>Zangenberg MS, El-Hussuna A</td>
</tr>
<tr>
<td>8666</td>
<td>Emphysematous pancreatitis associated with penetrating duodenal ulcer</td>
<td>Tana C, Silingardi M, Giamberardino MA, Cipollone F, Meschi T, Schiavone C</td>
</tr>
</tbody>
</table>
ABOUT COVER

Editorial board member of World Journal of Gastroenterology, Paola Iovino, MD, Associate Professor, Lecturer, Department of Medicine and Surgery, AOU San Giovanni di Dio e Ruggi di Aragona, Salerno 84131, Italy

AIMS AND SCOPE

World Journal of Gastroenterology (WJG), print ISSN 1007-9327, online ISSN 2219-2840, DOI: 10.3748, is a peer-reviewed open access journal. WJG was established on October 1, 1995. It is published weekly on the 7th, 14th, 21st, and 28th each month. The WJG Editorial Board consists of 1375 experts in gastroenterology and hepatology from 68 countries.

The primary task of WJG is to rapidly publish high-quality original articles, reviews, and commentaries in the fields of gastroenterology, hepatology, gastrointestinal endoscopy, gastrointestinal surgery, hepatobiliary surgery, gastrointestinal oncology, gastrointestinal radiation oncology, gastrointestinal imaging, gastrointestinal interventional therapy, gastrointestinal infectious diseases, gastrointestinal pharmacology, gastrointestinal pathophysiology, gastrointestinal pathology, evidence-based medicine in gastroenterology, pancreatogastroenterology, gastrointestinal laboratory medicine, gastrointestinal molecular biology, gastrointestinal immunology, gastrointestinal microbiology, gastrointestinal genetics, gastrointestinal translational medicine, gastrointestinal diagnostics, and gastrointestinal therapeutics. WJG is dedicated to become an influential and prestigious journal in gastroenterology and hepatology, to promote the development of above disciplines, and to improve the diagnostic and therapeutic skill and expertise of clinicians.

INDEXING/ABSTRACTING

WJG is now indexed in Current Contents®, Clinical Medicine, Science Citation Index Expanded (also known as SciSearch®), Journal Citation Reports®, Index Medicus, MEDLINE, PubMed, PubMed Central and Directory of Open Access Journals. The 2017 edition of Journal Citation Reports® cites the 2016 impact factor for WJG as 3.365 (5-year impact factor: 3.176), ranking WJG as 29th among 79 journals in gastroenterology and hepatology (quartile in category Q2).

FLYLEAF

I-IX

Editorial Board

EDITORS FOR THIS ISSUE

NAME OF JOURNAL

World Journal of Gastroenterology

ISSN

ISSN 1007-9327 (print)
ISSN 2219-2840 (online)

LAUNCH DATE

October 1, 1995

FREQUENCY

Weekly

EDITORS-IN-CHIEF

Damian García-Olmo, MD, PhD, Doctor, Professor, Surgeon, Department of Surgery, Universidad Autónoma de Madrid; Department of General Surgery, Fundación Jiménez Díaz University Hospital, Madrid 28040, Spain

Stephen C Strom, PhD, Professor, Department of Laboratory Medicine, Division of Pathology, Karolinska Institutet, Stockholm 141-86, Sweden

Andrzej S Tarasowski, MD, PhD, DSc (Med), Professor of Medicine, Chief Gastroenterology, VA Long Beach Health Care System, University of California, Irvine, CA, 9001 E. Seventh St., Long Beach, CA 90822, United States

EDITORIAL OFFICE

Jin-Lei Wang, Director
Ze-Mao Gong, Vice Director
World Journal of Gastroenterology
Baishideng Publishing Group Inc
7901 Stoneridge Drive, Suite 501, Pleasanton, CA 94588, USA
Telephone: +1-925-2238242
Fax: +1-925-2238243
E-mail: editorialoffice@wjgnet.com
Help Desk: http://www.f6publishing.com/helpdesk

PUBLISHER

Baishideng Publishing Group Inc
7901 Stoneridge Drive, Suite 501, Pleasanton, CA 94588, USA
Telephone: +1-925-2238242
Fax: +1-925-2238243
E-mail: bpgoffice@wjgnet.com
Help Desk: http://www.f6publishing.com/helpdesk

http://www.f6publishing.com

EDITORIAL BOARD MEMBERS

All editorial board members resources online at http://www.wjgnet.com/1007-9327/editorialboard.htm

EDITORIAL OFFICE

Jin-Lei Wang, Director
Ze-Mao Gong, Vice Director
World Journal of Gastroenterology
Baishideng Publishing Group Inc
7901 Stoneridge Drive, Suite 501, Pleasanton, CA 94588, USA
Telephone: +1-925-2238242
Fax: +1-925-2238243
E-mail: editorialoffice@wjgnet.com
Help Desk: http://www.f6publishing.com/helpdesk

PUBLISHER

Baishideng Publishing Group Inc
7901 Stoneridge Drive, Suite 501, Pleasanton, CA 94588, USA
Telephone: +1-925-2238242
Fax: +1-925-2238243
E-mail: bpgoffice@wjgnet.com
Help Desk: http://www.f6publishing.com/helpdesk

http://www.f6publishing.com

http://www.wjgnet.com

COPYRIGHT

© 2017 Baishideng Publishing Group Inc. Articles published by this Open-Access journal are distributed under the terms of the Creative Commons Attribution Non-commercial License, which permits use, distribution, and reproduction in any medium, provided the original work is properly cited, the use is non-commercial and is otherwise in compliance with the license.

SPECIAL STATEMENT

All articles published in journals owned by the Baishideng Publishing Group (BPG) represent the views and opinions of their authors, and not the views, opinions or policies of the BPG, except where otherwise explicitly indicated.

INSTRUCTIONS TO AUTHORS

Full instructions are available online at http://www.wjgnet.com/bpg/generifos/204

ONLINE SUBMISSION

http://www.f6publishing.com

WJG | www.wjgnet.com

IV

December 28, 2017 | Volume 23 | Issue 48
Fecal microbiota transplantation induces remission of infantile allergic colitis through gut microbiota re-establishment

Sheng-Xuan Liu, Yin-Hu Li, Wen-Kui Dai, Xue-Song Li, Chuang-Zhao Qiu, Meng-Ling Ruan, Biao Zou, Chen Dong, Yan-Hong Liu, Jia-Yi He, Zhi-Hua Huang, Sai-Nan Shu

AIM
To investigate the impact of fecal microbiota trans-
plantation (FMT) treatment on allergic colitis (AC) and gut microbiota (GM).

METHODS
We selected a total of 19 AC infants, who suffered from severe diarrhea/hematochezia, did not relieve completely after routine therapy or cannot adhere to the therapy, and were free from organ congenital malformations and other contraindications for FMT. Qualified donor-derived stools were collected and injected to the AC infants via a rectal tube. Clinical outcomes and follow-up observations were noted. Stools were collected from ten AC infants before and after FMT, and GM composition was assessed for infants and donors using 16S rDNA sequencing analysis.

RESULTS
After FMT treatment, AC symptoms in 17 infants were relieved within 2 d, and no relapse was observed in the next 15 mo. Clinical improvement was also detected in the other two AC infants who were lost to follow-up. During follow-up, one AC infant suffered from mild eczema and recovered shortly after hormone therapy. Based on the 16S rDNA analysis in ten AC infants, most of them (n = 6) had greater GM diversity after FMT. As a result, Proteobacteria decreased (n = 6) and Firmicutes increased (n = 10) in post-FMT AC infants. Moreover, Firmicutes accounted for the greatest proportion of GM in the patients. At the genus level, Bacteroides (n = 6), Escherichia (n = 8), and Lactobacillus (n = 4) were enriched in some AC infants after FMT treatment, but the relative abundances of Clostridium (n = 5), Veillonella (n = 7), Streptococcus (n = 6), and Klebsiella (n = 8) decreased dramatically.

CONCLUSION
FMT is a safe and effective method for treating pediatric patients with AC and restoring GM balance.

Key words: Pediatric; Infantile allergic colitis; Fecal microbiota transplantation; Gut microbiota; Immune reaction

© The Author(s) 2017. Published by Baishideng Publishing Group Inc. All rights reserved.

Core tip: This retrospective study explored the therapeutic effects and safety of fecal microbiota transplantation (FMT) treatment in 19 allergic colitis (AC) infants who were younger than 1 year old. After FMT treatment, AC symptoms were relieved in the patients rapidly, and no patient relapsed within 15 mo. With gut microbiota (GM) analysis, six of ten patients exhibited higher microbial diversity after FMT treatment. Moreover, decreased Proteobacteria and increased Firmicutes supplied the hints of GM re-establishment in the patients after FMT treatment. Therefore, this work showed the curative effects of FMT in AC infants and its possible mechanism.
Patient selection
AC was diagnosed based on the following clinical symptoms: (1) rectal bleeding with/without mucus and diarrhea; (2) exclusion of infectious colitis, anal fissure, lymphoid nodular hyperplasia, and uncommon conditions such as necrotizing enterocolitis, Hirschsprung’s enterocolitis, IBD\(^{[15]}\), and IBS\(^{[16]}\); (3) clinical remission after milk exclusion and recurrence after milk re-challenge\(^{[3,17]}\); and (4) histological examination indicated that the intestinal mucosa exhibited chronic inflammation with eosinophils infiltration and colonic lesions (Supplementary File 1). Pediatric AC patients meeting the following criteria were selected as FMT candidates: (1) the patients had no complete remission after routine therapy, the patients cannot adhere to the therapy thoroughly, or their parents had strong intention to receive the treatment of FMT; (2) free from contraindications for FMT, such as intestinal obstructions, perforations, and bleeding, or severe immunodeficiency diseases; and (3) colonoscopic inspection indicated no mucosal congestion, edema, multiple spot-like erosion, or lymphoid granular nodes (four cases included in Figure 1). As a result, 19 AC patients were enrolled in the study between September 2015 and December 2015 (Table 1).

Donor screening
Patients’ mothers were considered to be donors of the highest priority, followed by fathers and healthy peers. Adult donors were screened as follows\(^{[18-20]}\): (1) no infectious diseases history (e.g., tuberculosis and hepatopathy); (2) no metabolic diseases history (e.g., obesity and diabetes); (3) no gastrointestinal diseases (e.g., diarrhea, constipation, IBD, IBS, colorectal polyps, and gastrointestinal tumors); (4) no allergic diseases (e.g., food allergy, eczema, and allergic gastrointestinal tumors); (5) no antibiotic exposure in the last 3 months; (6) no mental disorders or autoimmune diseases; and (7) no drug abuse history, amenorrhea (for mother donors), or psychological imbalance.

Candidate donors of the same age were selected with the following criteria\(^{[18-20]}\): (1) preferred relatives with breast milk fed and same gender; (2) no antibiotic treatment in the last 3 months; (3) no allergic disease (e.g., food allergy, eczema, and allergic gastrointestinal tumors); (4) no gastrointestinal disease (e.g., diarrhea, constipation, IBD, IBS, colorectal polyps, and gastrointestinal tumors); (5) no metabolic disease history (e.g., obesity and diabetes); and (6) no infectious disease history (e.g., tuberculosis, hepatopathy, and measles), and normal health and development. Tests for serum biochemistry and stool were performed for donors to ensure subject safety (Table 2).

FMT procedure
The application of parenteral nutrition and probiotics was stopped as soon as FMT began in the patients. No bowel preparation (cleanout or antibiotic pretreatment) was used prior to FMT, but pre-FMT clinical tests were performed as described in Table 3. Donor stool, collected 2 h before FMT, was diluted and mixed with sterile saline (1 mg of stool was diluted with 3 mL of saline). Samples were filtered through sterile gauze and 30-50 mL fecal suspension was prepared for FMT. FMT was administered over 5-10 min via a rectal tube into the left colon. The rectal tube was removed 15 min after administration and the fecal suspension was retained in the recipients’ gut for 4-6 h. Multi-FMT was given for patients with severe symptoms (Table 1).

Follow-up
Clinical symptoms, stool frequency, symptom remission time, and adverse events (e.g., abdominal pain, gastrointestinal infection, constipation, fever, and allergic disease) were recorded at the end of FMT (Table 1). Follow-up was conducted at ≥ 15 mo after FMT, except for two cases with 0.3 and 0.5 mo follow-up (AC17 and AC19), to evaluate FMT efficacy and safety (Table 1). The remission of AC was defined as the cease of rectal bleeding and decreased stool frequency (no more than two times/d) in the patients. The primary endpoint was the improved AC symptoms and sustained clinical remission at 12 mo. Secondary endpoint was the safety of FMT which was implied by the occurrence of adverse events.

Microbiota analysis and statistics
Fecal microbiota was analyzed for ten patients before FMT and during follow-ups. Donor feces were also assayed for GM. Microbial DNA was extracted using a PowerSoil DNA Isolation Kit (Mo Bio Laboratories, Carlsbad, CA) according to the manufacturer’s protocol and the hyper-variable V3-V4 region was amplified using 338F (5’-ACTCCTACGGGAGGCAGCA-3’) and 806R (5’-GGACTACHVGGGTWTCTAAT-3’) primers. Library construction and sequencing were conducted on an Illumina MiSeq platform (Illumina, San Diego, United States). Data filtration and sequencing were performed as a prior report with the RDP database as an annotation reference\(^{[21]}\). A Wilcoxon signed-rank test was used to compare samples of one patient, which were collected at different time points, and a Wilcoxon rank-sum test was used to compare donor and patient samples. Graphs were produced with R.
patients, and decreased defecation frequency with improved stool consistency was also observed (Table 1). Within more than 15 mo of follow-up, the symptoms of AC had not relapsed except two patients who were lost to follow-up (AC17 and AC19). Only one patient suffered from eczema, which appeared 2 mo after FMT and was resolved with hormone therapy. Beyond this, no other adverse event was recorded during FMT or the follow-up.

FMT treatment associated microbiota changes

Figures 2 and 3 depict microbiota changes of ten patients before and after FMT compared to donors. Microbiota diversity increased dramatically in five patients while it decreased in three patients after FMT (Figure 2). When sampled 1 or 2 mon after FMT, microbiota of six patients was more similar to donors’ microflora by comparison with pre-FMT samples (Figure 3).

After FMT treatment, Firmicutes accounted for the greatest proportion of GM in the AC infants, followed

Figure 1 Colonoscopic inspection of four allergic colitis patients prior to fecal microbiota transplantation. Colonoscopic images of patients (AC1, AC3, AC9, and AC10) were obtained prior to FMT. AC: Allergic colitis; FMT: Fecal microbiota transplantation.
### Table 1  Clinical information for 19 allergic colitis infants

<table>
<thead>
<tr>
<th>ID</th>
<th>Gender</th>
<th>Age (mo)</th>
<th>Symptom(s)</th>
<th>Duration of disease (mo)</th>
<th>Treatment(s) before FMT</th>
<th>Donor source</th>
<th>FMT times</th>
<th>Symptom remission after first FMT (d)</th>
<th>Stool frequency before and after FMT (times/d)</th>
<th>Follow-up (mo)</th>
<th>Availability of gut microbiota data</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC1</td>
<td>Female</td>
<td>7</td>
<td>Diarrhea, hematochezia sometimes; anemia; hypohepatia</td>
<td>&gt; 3</td>
<td>Applying amino acid formula and probiotics <em>(C. butyricum)</em></td>
<td>Mother</td>
<td>2</td>
<td>1</td>
<td>3, 4, 1</td>
<td>19</td>
<td>Yes</td>
</tr>
<tr>
<td>AC2</td>
<td>Male</td>
<td>10</td>
<td>Hematochezia</td>
<td>&gt; 0.5</td>
<td>Applying amino acid formula and probiotics <em>(Bifidobacteria)</em></td>
<td>Healthy infants aged 10 mo old</td>
<td>2</td>
<td>1</td>
<td>2, 3, 1</td>
<td>18</td>
<td>Yes</td>
</tr>
<tr>
<td>AC3</td>
<td>Female</td>
<td>11</td>
<td>Hematochezia</td>
<td>&gt; 3</td>
<td>Applying amino acid formula and probiotics <em>(S. boulardii)</em></td>
<td>Healthy infants aged 8 mo old</td>
<td>3</td>
<td>1</td>
<td>5, 6, 2</td>
<td>19</td>
<td>Yes</td>
</tr>
<tr>
<td>AC4</td>
<td>Male</td>
<td>9</td>
<td>Hematochezia</td>
<td>&gt; 3</td>
<td>Applying amino acid formula and probiotics <em>(S. boulardii)</em></td>
<td>Mother's cousin sister</td>
<td>3</td>
<td>1</td>
<td>6-7, 1-2</td>
<td>18</td>
<td>Yes</td>
</tr>
<tr>
<td>AC5</td>
<td>Male</td>
<td>5</td>
<td>Diarrhea and hematochezia sometimes</td>
<td>&gt; 3</td>
<td>Applying amino acid formula</td>
<td>Healthy infants aged 8 mo old</td>
<td>3</td>
<td>1</td>
<td>3, 4, 2</td>
<td>19</td>
<td>Yes</td>
</tr>
<tr>
<td>AC6</td>
<td>Male</td>
<td>5</td>
<td>Hematochezia</td>
<td>&gt; 3</td>
<td>Applying amino acid formula</td>
<td>Mother</td>
<td>1</td>
<td>2</td>
<td>5-6, 1</td>
<td>18</td>
<td>Yes</td>
</tr>
<tr>
<td>AC7</td>
<td>Male</td>
<td>4</td>
<td>Hematochezia and cough sometimes</td>
<td>&gt; 2</td>
<td>Applying amino acid formula and nebulization</td>
<td>Mother</td>
<td>2</td>
<td>2</td>
<td>4-7, 1</td>
<td>15</td>
<td>Yes</td>
</tr>
<tr>
<td>AC8</td>
<td>Female</td>
<td>3</td>
<td>Diarrhea and mucoid feces sometimes</td>
<td>&gt; 2</td>
<td>Applying amino acid formula</td>
<td>Mother</td>
<td>2</td>
<td>1</td>
<td>3-4, 1-2</td>
<td>19</td>
<td>Yes</td>
</tr>
<tr>
<td>AC9</td>
<td>Male</td>
<td>11</td>
<td>Interval hematochezia</td>
<td>&gt; 6</td>
<td>Applying amino acid formula and probiotics <em>(S. boulardii)</em></td>
<td>Mother</td>
<td>2</td>
<td>1</td>
<td>3-4, 2</td>
<td>23</td>
<td>Yes</td>
</tr>
<tr>
<td>AC10</td>
<td>Female</td>
<td>3</td>
<td>Hematochezia</td>
<td>&gt; 1.5</td>
<td>Applying amino acid formula</td>
<td>Healthy infants aged 10 mo old</td>
<td>4</td>
<td>2</td>
<td>5-6, 1</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>AC11</td>
<td>Male</td>
<td>7</td>
<td>Diarrhea</td>
<td>&gt; 2</td>
<td>Applying amino acid formula, probiotics *(Bifidobacteria), Smects and Oral Rehydration Salts (ORS)</td>
<td>Healthy infants aged 10 mo old</td>
<td>5</td>
<td>1</td>
<td>5-6, 1</td>
<td>23</td>
<td>No</td>
</tr>
<tr>
<td>AC12</td>
<td>Female</td>
<td>10</td>
<td>Diarrhea and hematochezia sometimes</td>
<td>&gt; 1</td>
<td>Applying amino acid formula and probiotics <em>(Bifidobacteria)</em></td>
<td>Mother</td>
<td>3</td>
<td>1</td>
<td>5-6, 1-2</td>
<td>22</td>
<td>No</td>
</tr>
<tr>
<td>AC13</td>
<td>Male</td>
<td>5</td>
<td>Hematochezia and diarhrea sometimes</td>
<td>&gt; 3</td>
<td>Applying amino acid formula</td>
<td>Mother</td>
<td>1</td>
<td>1</td>
<td>3-4, 1</td>
<td>15</td>
<td>No</td>
</tr>
<tr>
<td>AC14</td>
<td>Female</td>
<td>5</td>
<td>Hematochezia and then peptone shaped feces</td>
<td>&gt; 1</td>
<td>Applying amino acid formula and probiotics <em>(Bifidobacteria)</em></td>
<td>Mother</td>
<td>1</td>
<td>1</td>
<td>7-8, 2</td>
<td>15</td>
<td>No</td>
</tr>
<tr>
<td>AC15</td>
<td>Male</td>
<td>7</td>
<td>Diarrhea</td>
<td>&gt; 2</td>
<td>Applying amino acid formula, ORS, and probiotics <em>(C. butyricum)</em></td>
<td>Mother</td>
<td>5</td>
<td>1</td>
<td>5-6, 1</td>
<td>21</td>
<td>No</td>
</tr>
<tr>
<td>AC16</td>
<td>Female</td>
<td>5</td>
<td>Interval hematochezia</td>
<td>&gt; 2</td>
<td>Applying amino acid formula</td>
<td>Healthy infants aged 8 mo old</td>
<td>2</td>
<td>1</td>
<td>4-5, 1</td>
<td>21</td>
<td>No</td>
</tr>
<tr>
<td>AC17</td>
<td>Male</td>
<td>7</td>
<td>Diarrhea and hematochezia sometimes</td>
<td>&gt; 3</td>
<td>Applying amino acid formula, probiotics <em>(Bifidobacteria and C. butyricum)</em></td>
<td>Healthy infants aged 11 mo old</td>
<td>1</td>
<td>2</td>
<td>3-4, 1-2</td>
<td>0.5</td>
<td>No</td>
</tr>
<tr>
<td>AC18</td>
<td>Female</td>
<td>8</td>
<td>Diarrhea and cough sometimes</td>
<td>&gt; 3</td>
<td>Applying amino acid formula and nebulization</td>
<td>Healthy infants aged 8 mo old</td>
<td>2</td>
<td>1</td>
<td>3-4, 2</td>
<td>17</td>
<td>No</td>
</tr>
<tr>
<td>AC19</td>
<td>Male</td>
<td>5</td>
<td>Interval diarrhea</td>
<td>&gt; 4</td>
<td>Applying amino acid formula</td>
<td>Mother</td>
<td>4</td>
<td>1</td>
<td>3-4, 1</td>
<td>0.3</td>
<td>No</td>
</tr>
</tbody>
</table>

AC: Allergic colitis; FMT: Fecal microbiota transplantation.
Liu SX et al. FMT for infantile AC treatment

The rarefaction of samples

AC1

AC2

AC3

AC4

AC5

AC6

AC7

AC8
by Bacteroidetes and Proteobacteria. Proteobacteria decreased dramatically to < 10% for most patients except four patients (Supplementary File 2). Whilst, Firmicutes increased in all patients (Supplementary File 2).

The relative abundance of *Escherichia* significantly increased in eight AC infants (Supplementary File 3). *Bacteroides* increased in five AC infants including three who had no *Bacteroides* pre-FMT (Supplementary File 3). For four patients, *Lactobacillus* was enriched after FMT, but for three subjects, it was absent even after FMT. Possible pathogens including *Clostridium* and *Klebsiella* generally decreased after FMT.

*Clostridium* and *Klebsiella* decreased in five and eight AC infants respectively (Supplementary File 3). The relative abundance of *Streptococcus* was lowered in six patients. Whilst, *Veillonella* was found decreased in seven patients and its relative abundance was no more than 

---

**Table 2  Laboratory testing on donors**

<table>
<thead>
<tr>
<th>Blood testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>TORCH examinations: Detections on toxoplasmosis IgG, toxoplasmosis IgM, rubella virus IgG, rubella virus IgM, cytomegalovirus IgG, cytomegalovirus IgM, herpes simplex virus 1/2 IgG, and herpes simplex virus 1/2 IgM.</td>
</tr>
<tr>
<td>Detection on parvovirus B19.</td>
</tr>
<tr>
<td>Epstein-Barr virus examinations: Detections on Epstein-Barr virus capsid antigen IgA, Epstein-Barr virus capsid antigen IgG, Epstein-Barr virus capsid antigen IgM, Epstein-Barr virus early antigen IgG, and Epstein-Barr virus nuclear antigen IgG.</td>
</tr>
<tr>
<td>Blood type examination.</td>
</tr>
<tr>
<td>Lymphocyte subpopulation examination.</td>
</tr>
<tr>
<td>Blood allergy examination (sIgE).</td>
</tr>
<tr>
<td>Hepatic and renal function examinations: Glutamic-pyruvic transaminase, glutamic oxalacetic transaminase, total protein, albumin, globulin, prealbumin, total bilirubin, direct bilirubin, indirect bilirubin, alkaline phosphatase, gamma glutamyltranspeptidase, total cholesterol, triglycerides, high-density lipoprotein, low density lipoprotein, apolipoprotein A1, apolipoprotein B, lactic dehydrogenase, calcium, corrected calcium, phosphorus, magnesium, urea, creatinine, triosxyprurine, bicarbonate radical, total bile acid, 5-nucleotidase, α-L-fucosidase, cholinesterase, cystatin C, and lipase and amylopsin.</td>
</tr>
<tr>
<td>Mycobacterium tuberculosis antibody examination (or the enzyme-linked immuno-spot assay test for tuberculosis).</td>
</tr>
<tr>
<td>Detection on hepatitis A-IgM.</td>
</tr>
<tr>
<td>Qualifications of C-reaction protein and erythrocyte sedimentation rate.</td>
</tr>
</tbody>
</table>

**Stool testing**

| Fecal routine examinations: Detections on fecal color, character, red blood cells, white blood cells, occult blood, parasite eggs, protozoon, fat ball, rotavirus antigen, and fungus. |
| Bacterial culture tests: Detections on Vibrio cholera, Salmonella, Shigella, Aeromonas, Plesiomonas, and pathogenic Escherichia coli. |

**Other testing**

| Chest X-ray. |
| Abdominal ultrasound scan. |
| Electrocardiographic examination. |

---

Figure 2  Shannon rarefaction curves of gut microbiota from ten allergic colitis infants and their donors. Each image represents one AC infant, and each curve represents one fecal sample from a patient or the corresponding donor. Sample ID has three parts: ‘R’ or ‘D’ indicates AC infants or donors, ‘pre’ or ‘post’ represents the stools collected before or after FMT, and fecal collection date. Microbiota diversity in six patients (AC1, AC4, AC5, AC7, AC8, and AC9) increased after FMT treatment. AC: Allergic colitis; FMT: Fecal microbiota transplantation.
Liu SX et al. FMT for infantile AC treatment

AC1

AC2

AC3

AC4

AC5

AC6

AC7

AC8

Liu SX et al. FMT for infantile AC treatment
8% after FMT. *Bifidobacterium* kept decreased in seven AC infants after FMT, and increased in two cases.

**DISCUSSION**

We chiefly considered the curative effects of FMT therapy in 19 AC infants and microbiota changes during treatment. Stools from both infant and adult donors suggested the same efficacy, and it was noted that all subjects had relieved symptoms of hematochezia and/or diarrhea in 2 d after the first FMT treatment. Due to the longer illness time or severe clinical symptoms, 15 patients experienced multi-FMT for the sustained clinical remission. And the multiple FMT in these patients gave us the idea that artificially modified microbiota for the specified patient might elevate the efficiency of FMT and attenuate transplantation times in the future. After being discharged from hospital, the patients were advised to take hypoallergenic milk powder instead of formula, and most patients had no relapse of colitis within more than 15 mo of follow-up. The recurrence of eczema
in one infant might be caused by the inflammatory reactions which were triggered by discontinuous intake of hypoallergenic milk powder.

Fecal microbiota was analyzed in ten patients and their donors. We noted that the microbiota diversity increased in six patients after FMT. For three other subjects, GM diversity decreased after an initial increase while all the patients demonstrated clinical improvement. Individual-specific GM changes suggested the effect of donor’s GM complexity and patient’s gut micro-ecology imbalance. Khoruts et al(10) also suggested that bacteria can be eliminated due to nutrient competition, antimicrobial peptide suppression, and immune-mediated colonization resistance during GM re-establishment.

Proteobacteria, which contain opportunistic pathogens22, decreased in six AC infants, and their relative abundance was less than 10% after FMT. In contrast, Firmicutes increased in all AC infants. Previous work implied that Firmicutes decreased in patients with Cohn’s disease23, and the proportion of Firmicutes was negatively associated with gastrointestinal inflammation24.

After FMT, the relative abundances of Bacteroides and Lactobacillus increased. Prior reports showed that species in Bacteroides could secrete polysaccharide A, which promoted the number of T regulatory (Treg) cells25,26. Interleukin (IL)-10 produced by Treg cells also eliminated inflammatory reactions and protected against infectious pathogens25,26. Lactobacillus can secrete lactic acid, increase the proportion of Treg cells, and relieve symptoms of AC27. Generally, the relative abundance of opportunistic pathogens decreased, including Veillonella, Streptococcus, Clostridium, and Klebsiella. Prior reports suggested that the combination of Veillonella and Streptococcus had been found in various GM systems and can augment IL-8, IL-6, and tumor necrosis factor-α (TNF-α) responses, which were associated with inflammatory reactions28. Clostridium can cause diarrhea via enterotoxin secretion, and Klebsiella was positively associated with macrophage migration-inhibitory factor (MIF) and affected host immunity29. However, GM imbalance and post-FMT improvement need more analysis to understand the mechanisms underlying AC improvements.

This study pioneered the application of FMT in AC treatment and provided important reference to understand microbiota changes before and after FMT. Although the results favor the application of FMT for AC treatment, it is still important to clarify whether AC symptoms can be improved in our future studies with larger sample size. Also, we will explore the microbiota changes at the gene or functional level before and after FMT, to further the understanding of GM imbalance and re-configuration during FMT treatment of infantile AC.

ARTICLE HIGHLIGHTS

Research background
Allergic colitis (AC), which is characterized as hematochezia and severe diarrhea, is caused by an intense allergic reaction of the digestive system. Currently, first-line therapies for AC patients are reducing exposure to suspicious allergens and applying hypoallergenic milk powder. However, some pediatric patients could not relieve from AC symptoms completely with routine treatment, and long-term illness causes adverse impact on nutrition absorption and physical development in the children.

Research motivation
Previous studies indicated that gut microbiota (GM) was closely related with the digestive system, neural system, and immune system in human. Meanwhile, the positive effects of fecal microbiota transplantation (FMT) have been confirmed in various gastrointestinal diseases, including Clostridium difficile infection (CDI), inflammatory bowel disease (IBD), and irritable bowel syndrome (IBS). However, FMT had not been applied to treat AC infants before. This research could provide important references for the treatment and research of infantile AC with FMT therapy.

Research objectives
The research aimed to detect the safety and efficiency of FMT treatment in AC, and compare GM composition before and after FMT treatment in the patients.

Research methods
The procedures of FMT, including selection of AC patients and donors, were conducted according to the guidelines established by the Institutional Review Board of Tongji Hospital, Tongji Medical College, Huazhong University of Science and Technology. Wilcoxon tests were adopted in the research.

Research results
In this study, the safety and efficacy of FMT treatment were investigated in 19 AC infants with GM analysis. The results indicated that the AC symptoms, which included rectal bleeding, diarrhea and hematochezia, were relieved rapidly by FMT treatment. During the 15 mo follow-up, no relapse was recorded except that eczema happened in one patient. After FMT treatment, the elevation of microbial diversity was detected in six of ten patients. Meanwhile, the relative abundances of Proteobacteria and Firmicutes were decreased (6/10) and increased (10/10), respectively, in the AC infants.

Research conclusions
This study documents the positive effect of FMT treatment on infantile AC remission, suggesting the potential of FMT in gastrointestinal allergic diseases. Individual-specific GM re-configuration also extended our understanding of FMT efficacy and associated mechanisms.

Research perspectives
Despite the aspiring results of FMT in pediatric AC, verified improvements with larger cohorts and longer follow-up are necessary. In parallel, GM analysis should be performed before and after FMT, to unravel keystone microbial components in the specific disease.

ACKNOWLEDGEMENTS

We thank the nurses who helped with sample collection at Tongji Hospital and the staff at WeHealthGene Institute who contributed to the project analysis.

REFERENCES

1 Ohtsuka Y. Food intolerance and mucosal inflammation. Pediatr
Liu SX et al. FMT for infantile AC treatment


van den Bogert B, Meijerinck M, Zoetendal EG, Wells JM, Kleerebezem M. Immunomodulatory properties of Streptococcus and Veillonella isolates from the human small intestine microbiota.

**P- Reviewer:** Daniel F, Iizuka M, Owczarek D
**E- Editor:** Ma YJ

**L- Editor:** Wang TQ