Wellbeing International Foundation

The Athlete's Edge

CFT, Athletic Recovery, and WADA Compliance

Paper 09 in the CFT Advantage Series

WHITE PAPER

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Abstract

Professional and elite athletes are increasingly exploring regenerative medicine to support recovery, manage cumulative training load and protect career runway, while operating under the strict constraints of the World Anti-Doping Agency (WADA) Prohibited List. CFT appears to occupy a comparatively defensible position under the published 2026 WADA framework, provided the preparation is confirmed to be acellular, autologous, free of red blood cells, free of added prohibited substances, and administered within permitted route and volume parameters. The therapeutic content is the patient's own concentrated secretome: cytokines, growth factors and extracellular vesicles produced by the patient's own white blood cells under controlled environmental conditioning. This paper sets out the structure of the 2026 WADA Prohibited List as it applies to regenerative biologics (including the M1 blood-and-blood-component rules, the M2.2 intravenous-infusion volume rule, the M3 cell and cell-component rules, and the S1/S2 substance categories), explains where CFT sits within that structure on a plain reading of published WADA and USADA guidance, reviews the recovery biology that paracrine signalling supports, surveys the regenerative options elite athletes already use, and describes what athletes and their medical teams should verify with their own sport's governing body before treatment. The paper does not assert a formal WADA ruling on CFT specifically, because no published WADA review of cell-free secretome preparations exists; instead it sets out the defensible compliance case and the residual due-diligence work that any athlete and team physician should still complete. The CFT preparation is delivered as a 2 mL infusion, comfortably below the WADA M2.2 100 mL per 12-hour intravenous-infusion threshold, and would not appear to require a Therapeutic Use Exemption on M2.2 volume grounds alone.

Scope note: This paper does not claim that CFT enhances athletic performance, treats any sports injury or carries a formal WADA ruling. Anti-doping policy is interpreted by WADA, by national anti-doping organisations and by individual sport federations; any athlete considering CFT should obtain written confirmation of compliance from their own anti-doping authority before treatment. Multiple Wellbeing clients have done this successfully in the past.

Table of Contents

1. Introduction: Athletes as Early Adopters of Regenerative Medicine

Professional and elite athletes have long been early adopters of regenerative medicine. The reasons are structural rather than fashionable. Elite competitors carry a compressed career runway, train at an intensity that produces continuous low-grade tissue damage, and lose income on every week

missed. Any therapy that can support normal recovery biology within medically supervised programmes therefore has obvious appeal, provided two conditions are met: the therapy is biologically defensible, and it does not put the athlete at risk of an anti-doping violation.

The second condition is the binding one. The World Anti-Doping Agency (WADA) publishes its Prohibited List annually, and the 2026 edition came into force on 1 January 2026 with several updates that matter for regenerative biologics, including the explicit addition of cell components such as nuclei and organelles to the existing prohibition on cells. Athletes and their team physicians cannot afford to treat compliance as a back-office detail. A therapy that is biologically attractive but compliance-ambiguous is unusable in elite sport.

Across the regenerative landscape, three broad categories dominate the conversation in elite-athlete medicine: platelet-rich plasma, autologous conditioned serum (sold under names such as Orthokine and Regenokine), and various cell-based therapies including bone-marrow aspirate concentrate, adipose-derived stromal preparations and stem cell exosome products. Each occupies a different position in the WADA framework, and each carries a different mix of biological and regulatory risk. Cell-Free Therapy (CFT) sits in a fourth category. It is autologous, like PRP and conditioned serum. It is cell-free, like the soluble fraction of conditioned serum but unlike the cell-based approaches. And it is processed under controlled conditioning to concentrate the patient's own secretome, the biologically active mix of cytokines, growth factors and extracellular vesicles released by the patient's own white blood cells.

This paper sets out where CFT sits relative to the current WADA framework on a plain reading of published WADA and USADA guidance, what the underlying recovery biology is and is not, how the approach compares with the regenerative options athletes already use, and what compliance work an athlete and their medical team should still complete before treatment. It is written for sports medicine physicians, athletic trainers and the small number of agents and players' association representatives who screen new modalities on athletes' behalf.

2. The 2026 WADA Prohibited List: What It Covers

The Prohibited List is structured into substances and methods. Substance categories include anabolic agents, peptide hormones and growth factors, beta-2 agonists, hormone and metabolic modulators, diuretics and masking agents, and a smaller group of substances prohibited only in particular sports or only in competition. Method categories cover the manipulation of blood and blood components (M1), chemical and physical manipulation (M2) and gene and cell doping (M3). For regenerative medicine, three areas of the list are most relevant: M3 cell doping (and the 2026 expansion to cell components), M1 blood and blood-component manipulation, and the various substance categories that cover hormones and growth factors that might be added to a regenerative preparation.

2a. Stem Cells and Cell Components

WADA's framework treats living cells as the central concern in M3 (Gene and Cell Doping). The current wording prohibits the use of normal or genetically modified cells where their use has the potential to be performance-enhancing. USADA's 2026 athlete advisory explains the practical reading: non-transformed stem cells used alone, with no added growth factors or hormones, for the healing of injuries are not prohibited as long as they return the affected area to normal function and do not enhance performance. That carve-out is narrow. As soon as the preparation contains added growth factors or hormones, or as soon as the preparation has the potential to be performance-enhancing rather than purely restorative, the carve-out closes and the therapy becomes prohibited.

The 2026 list extended this regime to cell components. Nuclei and organelles such as mitochondria and ribosomes have been added to the existing prohibition of cells, with the same conditional structure: cell components are prohibited where their use is, or has the potential to be, performance-enhancing. The practical effect for 2026 is that mitochondrial transplantation is captured by the list, and any future therapy that introduces nucleic-acid-bearing organelles into an athlete is captured as well. The regime applies to the components themselves; it does not, on a plain reading of the 2026 wording, extend to soluble paracrine factors or to extracellular vesicles released by the patient's own cells.

USADA has issued a separate advisory on exosomes that runs parallel to the cell wording. In most cases, exosome preparations are not prohibited. They become prohibited where the preparation contains red blood cells and is delivered intravenously, where growth factors or hormones have been added, or where the procedure has the potential to be performance-enhancing in the WADA sense.

2b. Blood and Blood-Component Manipulation (M1)

M1 covers blood doping in its various forms. The administration or reintroduction of any quantity of autologous, allogeneic or heterologous blood, or red blood cell products of any origin, into the circulatory system is prohibited. The withdrawal of blood or blood components, with or without reinfusion, is also prohibited, with carve-outs for analytical purposes (medical tests and doping control) and for collection in an accredited donation centre. A new sub-section, M1.4, was added in 2026 to cover non-diagnostic use of carbon monoxide because of its erythropoietic potential.

The M1 wording is the source of the most common confusion around regenerative biologics. Read in isolation, the 'withdrawal of blood' clause appears to capture any procedure that begins with a venous draw. In practice the clause is interpreted alongside the activity it is intended to prevent, which is the manipulation of an athlete's circulating blood volume or oxygen-carrying capacity. Platelet-rich plasma was removed from the Prohibited List on this basis: the procedure begins with a small autologous draw, but the product reinjected into the patient is not blood and does not change the athlete's circulating blood. PRP, including intravenous PRP, is currently not prohibited.

2c. Hormones, Growth Factors and Adjuvant Substances

Several substance categories interact with regenerative preparations. The S2 category covers peptide hormones, growth factors and related substances, including erythropoietin (EPO), human growth hormone (hGH), insulin-like growth factor 1 (IGF-1), vascular endothelial growth factor (VEGF) when added exogenously, and various other named factors. S1 covers anabolic androgenic steroids, including exogenous testosterone. Where a regenerative preparation contains any of these added substances, the preparation crosses into prohibited territory regardless of whether the underlying cell or secretome biology would otherwise be carved out.

The endogenous-versus-exogenous distinction is important. WADA does not prohibit the presence of endogenous growth factors or cytokines at the levels the athlete's own physiology produces. The concern arises with addition of exogenous substances that would create concentrations or species the athlete's body would not produce on its own.

2d. IV Infusion Volume (M2.2)

Method M2.2 covers intravenous infusions and injections. WADA prohibits intravenous infusions or injections of more than 100 mL per 12-hour period, with exceptions for defined medical contexts such as hospital treatment, surgical procedures and clinical diagnostic investigations. The rule is agnostic about the contents of the infusion: a fully permitted substance can still trigger a method violation if the volume exceeds the threshold and no permitted-context exception applies. Any intravenously administered regenerative biologic must therefore be assessed against M2.2 as well as against the M1, M3 and substance categories.

3. Where CFT Sits Relative to the 2026 List

CFT can be assessed against each of the relevant categories in turn. The structural features of the preparation, set out in detail in Paper 02 of this series, are that it is autologous, that it begins with a single 150 mL peripheral venous blood draw, that white blood cells are isolated and exposed to controlled environmental conditioning to elicit secretome release, and that the resulting acellular preparation is then characterised, released and infused. The product contains the patient's own soluble factors and extracellular vesicles. It does not contain living cells, donor material, or added growth factors, hormones or other substances.

3a. Cell-Free, Not Cell or Cell Component

The M3 prohibition on cells is the first category to consider. CFT contains no living cells. The release-test panel includes confirmation of intact-cell absence; this is a property of the preparation, not an aspiration. The 2026 extension to cell components such as nuclei and organelles is also relevant: extracellular vesicles in the 30 to 1,000 nm size range are not nuclei and are not whole organelles in the sense WADA's 2026 wording captures (the policy target is mitochondrial transplantation and

similar interventions). On a plain reading of the 2026 list, neither the cell prohibition nor the cell-component prohibition applies to a properly characterised cell-free secretome preparation.

USADA's exosome advisory provides a parallel reading. In most cases exosome preparations are not prohibited; the boundary cases are exosome preparations contaminated with red blood cells and given intravenously, exosome preparations to which growth factors or hormones have been added, or exosome preparations marketed for performance enhancement. CFT is not configured in any of these ways.

3b. Autologous and Free of Added Prohibited Substances

CFT does not contain added EPO, hGH, IGF-1, exogenous VEGF, exogenous testosterone or any other S1 or S2 substance. The growth factors, cytokines and signalling molecules present in the preparation are those the patient's own white blood cells released during the conditioning step. The autologous origin matters in two ways. It means the growth factor and cytokine profile is the patient's own endogenous output, not an exogenous addition. And it means there is no foreign donor material to trigger the allogeneic-cell concerns that sit alongside the doping framework in cell-therapy regulation more broadly.

3c. Why CFT Requires Separate M1 Analysis from Blood Re-Infusion

M1 is the part of the list that most frequently surfaces as a question in athlete consultations. The M1 prohibition targets the withdrawal of blood and blood components, and the reintroduction of blood or red blood cell products into the circulatory system. WADA does carve out specific permitted uses, including withdrawal of whole blood for the purpose of separating and locally reinjecting platelet-rich plasma. CFT is not PRP and the released preparation is not whole blood or a red-blood-cell product; it is an acellular concentrate of soluble factors and extracellular vesicles derived from the patient's own conditioned white blood cells. However, the blood-withdrawal step, processing, route, volume and reinfusion pathway should still be confirmed with the relevant anti-doping authority. The 2026 removal of platelet-derived preparations from the Prohibited List, on the basis that they do not produce performance enhancement beyond a potential therapeutic effect, is a useful interpretive precedent for autologous, acellular preparations more broadly, but it is not a substitute for a preparation-specific ruling on CFT.

The conservative position remains that any athlete considering CFT should obtain written confirmation of compliance from their own sport federation or national anti-doping organisation, including an explicit view on M1 as it applies to a cell-free, autologous, secretome preparation. The related question of intravenous-infusion volume and the M2.2 rule is addressed in the next subsection.

3d. IV Infusion Volume and M2.2

CFT administration must also be assessed under WADA M2.2, which restricts intravenous infusions or injections exceeding 100 mL per 12-hour period except in defined medical contexts (hospital treatment, surgical procedures and clinical diagnostic investigations). The CFT preparation is delivered as a single 2 mL vial per infusion. The standard protocol is three 2 mL infusions, three months apart, followed by further 2 mL infusions as required, supplied from a single banking draw at the start of treatment. Each individual infusion volume, and the total volume delivered within any 12-hour window, sits well below the M2.2 threshold of 100 mL. On a plain reading of the published 2026 WADA framework, CFT administration would not appear to require a Therapeutic Use Exemption on M2.2 volume grounds alone. The per-infusion volume should still be recorded in the athlete's compliance file alongside the other checklist items in Section 7. The WADA Statement of January 2018 (which superseded the prior 50 mL per 6-hour limit) is the operative reference.

3e. Non-Approved Substances (S0) and the Substance-versus-Method Question

One category on the List sits outside the method sections and warrants direct treatment. S0 (Non-Approved Substances) prohibits, at all times, any pharmacological substance that is not addressed by another section of the List and that carries no current approval by any governmental regulatory health authority for human therapeutic use. It is aimed principally at experimental, designer, discontinued and veterinary-only compounds. The relevant question for CFT is one of characterisation: whether an autologous, cell-free preparation of the patient's own signalling factors is assessed as a pharmacological substance under S0, or as an autologous procedure under the method sections that govern PRP, autologous stem cells and related preparations. Established practice treats autologous regenerative preparations as method questions, judged on whether anything prohibited has been added and on whether the intent is restorative rather than performance-enhancing, and does not apply S0 to them. CFT, which adds no exogenous substances and returns only the patient's own conditioned secretome, fits that established treatment. This characterisation is not settled by a single global pronouncement, because WADA does not rule on individual preparations. It is confirmed, as with any regenerative therapy, case by case by the athlete's national anti-doping organisation, which is the appropriate route for an explicit view on S0 as it applies to a cell-free autologous preparation.

4. Recovery Biology: What Paracrine Signalling Supports

Compliance is the gating question, but it is not the biological case. The biological case for CFT in athletic recovery rests on what concentrated paracrine factors do once they reach damaged or stressed tissue. The aim is to support the body's own recovery machinery, not to push athletic

biology beyond its baseline. It is worth being explicit about how the evidence base sits across this section. The mechanistic rationale (paracrine signalling effects on inflammation resolution, macrophage polarisation, angiogenesis) is supported by a substantial body of preclinical and translational work on autologous blood-derived therapies and cell-free secretome preparations. Athlete-specific clinical evidence for CFT is limited. Return-to-play acceleration in elite populations is not established. Performance improvement in the WADA sense is not claimed and should not be inferred. Four mechanistic threads matter.

4a. Microtrauma and the Resolution of Inflammation

Elite training produces continuous low-grade microtrauma to muscle, tendon and connective tissue. The acute response to this damage is inflammatory: damage-associated molecular patterns are released, neutrophils and monocytes are recruited, and pro-inflammatory cytokines such as IL-1, IL-6 and TNF-alpha rise transiently. This phase is necessary; it clears damaged material and signals subsequent repair. The problem in elite training is not the acute response but its chronicity. When training intensity outruns the resolution of inflammation, IL-6, CRP and other circulating markers stay elevated, the tendinous and myofascial environment shifts toward chronic inflammation, and recovery between sessions degrades.

Paracrine secretomes contain anti-inflammatory and pro-resolving factors, including IL-10, TGF-beta in its resolution-supporting context, and lipid mediators carried in extracellular vesicles. In preclinical and clinical work on autologous blood-derived therapies and cell-free secretome products, preparations of this kind have been associated with reduced markers of chronic inflammation and improved pain and function in tendinopathy and overuse conditions. The mechanism that is best supported is acceleration of resolution, not suppression of the necessary acute response.

4b. Macrophage Polarisation and Tissue Repair

Macrophages occupy the central node in tissue repair. During the early inflammatory phase they sit in the M1 phenotype, clearing debris and producing pro-inflammatory signals. For repair to proceed, they need to polarise toward the M2 phenotype, which produces anti-inflammatory signals and supports tissue remodelling. Failure of M1-to-M2 transition is one of the recognised mechanisms behind chronic non-healing soft-tissue injury.

Several factors carried in paracrine secretomes (IL-10, TGF-beta, vesicle-associated miRNAs and lipid mediators) are involved in the M1-to-M2 transition. The published literature on extracellular vesicles and conditioned-cell secretomes describes effects on macrophage polarisation in vitro and in preclinical injury models. The clinical translation in athletes is plausible biology rather than demonstrated outcome data, and is presented here as a mechanistic rationale rather than a claimed treatment effect.

4c. Angiogenesis and Microvascular Recovery

Repair of soft-tissue injury and overuse damage depends on perfusion. New blood vessel formation (angiogenesis) and the maturation of the existing microvasculature both support the delivery of oxygen, nutrients and resolution-phase immune cells to the injury site. VEGF and FGF-2 are well-established drivers of these processes and are present as part of the autologous secretome profile, rather than added as purified exogenous growth factors.

It is worth being explicit about the regulatory implication. The presence of VEGF and FGF-2 in an autologous preparation as part of the patient's own secretome is biologically and regulatorily distinct from exogenous administration of these factors. WADA's S2 prohibition on growth factors targets exogenous addition; presence as part of the autologous secretome profile, with no added exogenous factors, is not the regulatory concern.

4d. Return-to-Activity Timelines and Their Biological Anchors

Sports medicine practice currently anchors return-to-play decisions on a mix of imaging, functional testing and clinician judgement. The biological anchors that underlie those decisions (resolution of inflammation, completion of the macrophage phenotype switch, deposition and remodelling of new matrix, restoration of microvascular supply) are the same processes paracrine signalling supports. The realistic claim is that CFT may support normal recovery biology and may help athletes maintain recovery quality within medically supervised load-management programmes. It should not be presented as reducing return-to-play time or enhancing performance unless supported by athlete-specific clinical data and confirmed as permissible by the relevant anti-doping authority.

Where head-to-head trial data exist for autologous blood-derived therapies, effect sizes on return-to-play are modest and variable across injury types. The realistic clinical claim for CFT, pending its own controlled studies in athlete populations, is consistent with that pattern: a biologically plausible contribution to recovery quality, layered into the athlete's existing physiotherapy, load management and performance medicine programme.

5. The Competitive Landscape: What Elite Athletes Currently Use

CFT does not sit in a market vacuum. Elite athletes already have access to a stack of regenerative options, each with its own biological rationale, regulatory position and operational profile. A brief comparison helps situate CFT within that stack.

5a. Platelet-Rich Plasma

PRP is the most widely used regenerative preparation in elite sport. It is autologous, point-of-care, low operational complexity, and not prohibited by WADA. The biological premise is to concentrate the platelet-derived growth factors released on activation. Effect sizes in randomised trials vary by indication. Patellar tendinopathy and lateral epicondylitis show more consistent benefit; outcomes in knee osteoarthritis and Achilles tendinopathy are more mixed. PRP is freshly prepared at every treatment and has no banking equivalent: every session is a new collection.

5b. Autologous Conditioned Serum (Orthokine and Regenokine)

Autologous conditioned serum is the closest commercial neighbour to CFT in operational terms. The preparation begins with a venous draw, the blood is incubated under conditions that elicit elevated production of anti-inflammatory cytokines (notably IL-1 receptor antagonist), the serum fraction is separated, and it is reinjected. The therapy is best known under the Orthokine and Regenokine brands developed in Düsseldorf, and gained mainstream attention through use by athletes including Kobe Bryant. Like PRP it is autologous and not on the WADA Prohibited List. It differs from CFT in two ways: it captures the soluble fraction of conditioned whole blood rather than the secretome of isolated white blood cells under defined conditioning, and it does not employ a single-draw multi-dose banking model.

5c. Autologous Stem Cell and Bone-Marrow Concentrate Approaches

Several practices in elite sports medicine offer bone-marrow aspirate concentrate (BMAC) or adipose-derived stromal cell preparations. These are cell-based interventions, with the biology and the regulatory profile that follows from being cell-based. Under the WADA framework, autologous non-transformed stem cell preparations used to restore normal function may be carved out from the M3 prohibition, but the carve-out closes if the preparation is used for performance enhancement, contains added growth factors or hormones, or is delivered in a way that has the potential to enhance performance. Operationally, the collection step is more invasive than a venous draw and the preparation is freshly produced at each treatment.

5d. Where CFT Sits in the Stack

CFT differs from each of the above on a small number of structural axes. Compared with PRP and conditioned serum, it captures a more comprehensively conditioned secretome from isolated white blood cells rather than from whole blood, and it employs a single-draw multi-dose banking workflow rather than a fresh-collection-per-session workflow. Compared with cell-based approaches, it is cell-free at release, removing the categories of cell-based safety risk reviewed in Paper 11 of this series. Compared with all of them, it occupies a defensible position on the 2026

WADA list on a plain reading of the published guidance, while still requiring per-athlete confirmation from the relevant federation or national anti-doping organisation before use.

6. Documented Athlete Use of Regenerative Therapies

Several elite athletes have publicly used regenerative therapies without anti-doping consequences. These cases do not constitute a formal ruling on CFT; they illustrate the regulatory tolerance for autologous, non-cellular regenerative preparations in elite sport.

Kobe Bryant travelled to Germany in 2011 and again in 2013 for treatment under the Orthokine and Regenokine programmes developed by Peter Wehling and colleagues, principally for chronic knee and ankle complaints. Bryant discussed the treatment publicly. He continued to compete in the NBA and was selected for the United States team that won the 2012 Olympic gold medal. Orthokine has not been the subject of WADA action against any elite athlete who has disclosed its use.

Rafael Nadal has spoken publicly about platelet-rich plasma treatment for chronic knee tendinopathy and other injuries during a long professional career, including the period leading into and following his 2013 return to the tour. PRP is not prohibited under the WADA framework. Nadal has continued to compete at the highest level without doping concerns arising from PRP use.

Tiger Woods has used PRP across more than a decade of injury management on the PGA Tour. Troy Polamalu has publicly used PRP during his NFL career. PRP is widely used across professional team sports as a routine sports-medicine option. None of these athletes has been subject to anti-doping action in connection with the use of PRP.

These examples support a general point: WADA's framework, as administered by national anti-doping organisations and individual sport federations, has consistently permitted autologous, non-cellular, additive-free regenerative preparations to be used by elite athletes for recovery and injury management. CFT shares the autologous, non-cellular and additive-free properties that these accepted therapies share. Consistent with this pattern, CFT itself has been taken through case-by-case review by national anti-doping organisations, without anti-doping consequences for the athletes involved.

7. Practical Compliance: What Athletes and Medical Teams Should Verify

The plain reading of the 2026 list is necessary but not sufficient. Athletes and their medical teams should treat the following items as per-athlete due diligence before treatment.

First, confirm with the relevant national anti-doping organisation. USADA in the United States, UK Anti-Doping in the United Kingdom, and equivalents in other jurisdictions can be consulted directly and have processes for written confirmation on specific therapies. The wording of WADA guidance is interpreted in practice by these national bodies.

Second, confirm with the sport federation. Some international federations apply additional restrictions or specific reporting requirements that go beyond the WADA Prohibited List. Federations that govern out-of-competition testing pools should be notified of any planned regenerative therapy and the associated calendar.

Third, confirm the preparation. Athletes should obtain a written description of the preparation they are about to receive, including confirmation that it contains no added growth factors, hormones, anabolic steroids or other prohibited substances and no donor material. CFT preparations carry a characterisation profile that supports this confirmation; other preparations marketed under similar language may not.

Fourth, document. All treatment records (collection date, processing parameters, release results, infusion date) should be maintained for the duration relevant to the athlete's testing window. If a subsequent test result raises a question, the documented preparation profile is the protective record.

Athlete Compliance Checklist

- Product is autologous.
- No donor material.
- No intact cells.
- No red blood cells.
- No nuclei, mitochondria or ribosomes.
- No added EPO, hGH, IGF-1, VEGF, testosterone, peptides, steroids or other prohibited substances.
- Route of administration recorded.
- Total IV volume per 12 hours recorded against the M2.2 100 mL threshold (CFT is delivered as a 2 mL infusion; well below the threshold).
- Written national anti-doping organisation and federation confirmation obtained.
- Treatment records retained for the relevant testing window.

8. Implications for Sports Medicine Physicians

For sports medicine physicians evaluating CFT for an elite athlete, several practical implications follow from the discussion above.

Match the preparation to the indication. CFT is positioned as paracrine support across cumulative training load and operational recovery, not as a single-shot treatment for an acute injury that

already has a robust standard-of-care pathway. Where a dedicated PRP injection has stronger evidence for a specific indication (some tendinopathies are the clearest example), the dedicated indication should guide therapy choice. CFT may be most relevant where the question is broader: how to support a season's worth of recovery rather than how to treat a single named lesion.

Frame the WADA conversation explicitly. The compliance question is not whether CFT would produce a conventional positive analytical finding, but whether the preparation and method fall within a prohibited substance or method category. On the current published framework, the key questions are product contents, route, volume, intended use, and written confirmation from the relevant anti-doping authority. The paper sets these out in §3a (M3 cells and cell components), §3b (added substances), §3c (M1 blood and blood components), and §3d (M2.2 intravenous-infusion volume).

Use the banking model to plan the season. CFT's single-draw multi-dose workflow (described in detail in Paper 08) supports planning across a season rather than scheduling a series of independent procedures. The collection event is a banking decision, made early enough that infusions can be scheduled around the competitive calendar.

Maintain documentation as a clinical record. The same records that protect the athlete in a doping investigation are the records that support the medical team in subsequent clinical decisions. CFT release-test profiles, infusion dates and any associated biomarker work are clinical assets, not compliance overhead.

9. Limitations and Open Questions

Several limitations merit explicit acknowledgement. There is no published WADA review of cell-free secretome preparations specifically; the compliance position set out above is a defensible reading of the published 2026 guidance, not a formal WADA ruling. Athletes and federations are entitled to request and rely on their own confirmation.

Controlled clinical trial data on CFT specifically in elite athletes are limited. The biological rationale draws on a substantial body of work on paracrine signalling, extracellular vesicles and autologous blood-derived therapies, but generalisation to athlete-specific outcomes (return-to-play intervals, season availability, injury-recurrence rates) requires its own studies. The realistic clinical claim is consistent with the modest effect sizes seen in adjacent autologous biologic literature.

Sport-specific federations sometimes adopt rules that are stricter than the WADA framework. A treatment that is permissible under the WADA Code may still require disclosure or carry restrictions in particular sports. Per-athlete federation confirmation is the only reliable check on this.

Regulatory landscapes evolve. The 2026 cell-component addition is itself an example of how the Prohibited List can extend year on year. CFT's compliance position should be revisited annually against each new edition of the list, and athletes should be notified of any change relevant to their eligibility.

10. Conclusion

Athletes have practical reasons to seek therapies that support recovery without compromising competitive eligibility. The regenerative-medicine market offers several options, each with its own biological case and its own position on the WADA Prohibited List. Cell-Free Therapy appears to occupy a comparatively defensible position under the published 2026 framework, provided the preparation is confirmed to be acellular, autologous, free of red blood cells, free of added prohibited substances, and administered within permitted route and volume parameters (including the M2.2 100 mL per 12-hour intravenous-infusion threshold). It is not within the M3 cell or 2026 cell-component prohibitions on a plain reading of the published guidance. The released preparation is not whole blood or a red-blood-cell product in the M1 sense; the blood-withdrawal, processing, route and reinfusion pathway should still be confirmed with the relevant anti-doping authority. The biological case rests on supporting the resolution of training-induced inflammation, the macrophage phenotype switch, microvascular recovery and the readiness of tissue for the next training stimulus, drawing on the same paracrine factors the athlete's own body produces. The mechanistic rationale is supported by a substantial body of preclinical and translational work; athlete-specific clinical evidence for CFT is limited; return-to-play acceleration in elite populations is not established; performance improvement in the WADA sense is not claimed.

The defensible position is therefore this. CFT is consistent with the published 2026 WADA framework as that framework currently reads, on the same interpretive logic that keeps platelet-rich plasma and autologous conditioned serum off the Prohibited List. Per-athlete confirmation from the relevant national anti-doping organisation and federation should still be obtained before treatment, and the athlete's medical team should retain the documentation that supports the compliance position. With those steps in place, CFT offers elite athletes a defensible regenerative option in a category of therapy where the operational and regulatory frictions have historically been the binding constraints.

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Disclaimer: Individual results vary. Cell-Free Therapy is not intended to diagnose, treat, cure, or prevent any disease. The information in this paper is provided for educational purposes and does not constitute medical advice. CFT supports the body's normal biological function through autologous, cell-free biological preparations. Anti-doping policy is interpreted by WADA, by national anti-doping organisations and by individual sport federations; this paper does not constitute a formal WADA ruling on CFT, and athletes should obtain written confirmation of compliance from their own anti-doping authority before treatment. CFT administration must also be assessed under WADA rules on intravenous infusion volume and method of administration, including the 100 mL per 12-hour M2.2 threshold where applicable. The CFT preparation is delivered as a 2 mL infusion, well below the M2.2 threshold, and would not appear to require a Therapeutic Use Exemption on M2.2 volume grounds alone.

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