

**Electronic supplementary material****ESM Table 1** Detail of methodology and definitions of cardiovascular disease, cardiovascular risk factors and metabolic complications

<b>Variable</b>	<b>Definition</b>
Hypertension	Systolic and diastolic brachial blood pressures were measured in the right arm to the nearest 2 mmHg using a stethoscope and an aneroid sphygmomanometer (Acceson, AC Cossor & Son (Surgical), Harlow, UK) Blood pressure >130/85 mmHg and/or the use of antihypertensive therapy
Obesity measures	BMI was calculated using measurements of standing height and weight Waist and hip circumferences were measured to the nearest 0.1cm Body fat percentage was taken as the average of three consecutive readings (to the nearest 0.1%), using an OMRON BF306 Body Fat Monitor (OMRON Healthcare [UK], Henfield, UK)
Dyslipidaemia	HDL-cholesterol lower than 1.0 mmol/l and/or the use of lipid-lowering therapy
Myocardial infarction	Two out of the first three of the following criteria were met, or if both the first and last criteria were met: (1) self-report of heart attack (2) myocardial infarction indicated by WHO Chest Pain Questionnaire [1] (3) ECG evidence of ischaemia (4) prior hospital discharge code for myocardial infarction (ICD-10 codes <sup>a</sup> I21–I23, I252)
Angina	Two out of the first three of the following criteria were met, or if both the first and last criteria were met: (1) self-report of doctor-diagnosed angina or taking regular anti-anginal medication (2) angina indicated on WHO Chest Pain Questionnaire (3) ischaemic ECG code (4) prior hospital discharge code for ischaemic heart disease (ICD-10 codes <sup>a</sup> I20–25)
Ischaemic heart disease	History of either myocardial infarction or angina
Stroke	Two out of three of the following criteria were met: (1) participant recall of a doctor's diagnosis of stroke (2) prior hospital discharge code consistent with stroke (ICD-10 codes <sup>a</sup> I61, I63–I66, I679, I694) (3) confirmation by clinical notes review that event not due to transient ischaemic attack (TIA)
TIA	Two out of three of the following criteria were met: (1) participant recall of a doctor's diagnosis of stroke (2) prior hospital discharge code consistent with TIA (ICD-10 codes <sup>a</sup> G45 and G659) (3) confirmation by clinical notes review that event due to TIA TIA was also recorded if participants self-reported a history of 'TIA', 'mini-stroke' or 'slight stroke'
Cerebrovascular disease	History of either stroke or TIA
Neuropathy	Neuropathy was evaluated with hand-held neurothesiometer readings taken from the apex of the great toe (Horwell Neurothesiometer, Scientific Laboratory Supplies, Nottingham, UK) Neurothesiometer threshold higher than 15 V This vibration perception threshold has been previously used in the literature to define moderate to high neuropathy [2]
Retinopathy	Standard 7 field digital retinal colour photographs of both eyes were taken at 30° by a single specially trained medical photographer, following pupillary dilatation and using a high resolution digital retinal camera (TOPCON TRC-50FX). Graded as present (mild, moderate or severe) or absent based on a modification of the system described by the Early Treatment Diabetic Retinopathy Study Research Group [3]
ACR	Calculated by dividing the urinary albumin concentration (mg) by the urinary creatinine concentration (mmol)
ABPI	Right and left brachial, posterior tibial and dorsalis pedis systolic pressures were recorded using an aneroid sphygmomanometer and a Doppler probe (Dopplex Advanced Pocket Doppler, Huntleigh Healthcare, Cardiff, UK) and the ABPI calculated by dividing the lowest of the ankle pressures by the higher of the two arm pressures

<sup>a</sup>[www.who.int/classifications/icd/en/](http://www.who.int/classifications/icd/en/)

## References

1. Rose G, McCartney P, Reid DD (1977) Self-administration of a questionnaire on chest pain and intermittent claudication. *Br J Prev Soc Med* 31:42–48
2. Young MJ, Breddy JL, Veves A, Boulton AJ (1994) The prediction of diabetic neuropathic foot ulceration using vibration perception thresholds. A prospective study. *Diabetes Care* 17:557–560
3. Anonymous (1991) Grading diabetic retinopathy from stereoscopic color fundus photographs—an extension of the modified Airlie House classification. ETDRS report number 10. Early Treatment Diabetic Retinopathy Study Research Group. *Ophthalmology* 98:786–806