**SUPPLEMENTAL MATERIAL**

#### **Data S1. Sensitivity analyses to determine impact of alternate cohort definitions**

We sought to determine whether results would change significantly with implementation of stricter definitions of HFpEF, HFrEF, and no-HF controls. Accordingly, in this sensitivity analysis, we defined our cohorts as described below. Results are shown in Supplemental Tables S4 and S5.

HFpEF cases were defined by left ventricular ejection fraction (LVEF)  $> 45\%$ , diastolic dysfunction grade  $> 1$ , clinical history of HF determined by cardiologists at the time of catheterization, and one of the following objective indicators of HF in the 12 months before sample collection: elevated NT-proBNP (>400 pg/mL), loop diuretic use, or HF ICD-9 code associated with a clinical encounter. HFrEF controls were defined similarly to HFpEF cases, with the exception of having LVEF < 45%. No-HF controls were defined by LVEF > 45%, normal diastolic function, absence of heart failure symptoms, and no elevated NT-proBNP (>400 pg/mL), loop diuretic use, or HF ICD-9 code EVER before sample collection. Additionally, all patients were excluded who had a major adverse cardiac event (myocardial infarction, coronary artery bypass grafting, percutaneous coronary intervention) within 1 month of catheterization. Objective indicators of HF history were generated during routine clinical care and extracted by automated search of medical records.

We also sought to determine whether using alternate LVEF thresholds would impact results of our analyses. Accordingly, we regenerated our cohorts using all of the same inclusion criteria as the primary cohorts except that the HFpEF and No-HF groups had LVEF  $\geq$  50% and HFrEF LVEF  $< 35\%$ .

#### **Data S2. Approach to diastolic dysfunction classification**

Diastolic function assessments were made during routine clinical care. Given temporal variation in diastolic function classification practices, a 10% overread was performed by experienced echocardiographers (S.H.S. and M.G.K.) to ensure accuracy of these assessments. Diastolic classifications made during overreading were based on American Society of

Echocardiography guidelines (Supplemental Table S1, below).Concordance between present overreading and prior assessments was 84%, which was deemed to be an acceptable level of agreement to support using previous clinical assessments.  $\frac{1}{1}$ 

## **Data S3. Sensitivity analyses to determine the impact of insulin resistance**

As noted in the Discussion, elevations in plasma LCAC may be a cause or consequence of insulin resistance (IR). Although we reported and adjusted for overt diabetes in our analyses, it is possible that IR exerts an incremental mediation effect. To determine the impact of IR on the relationships observed between HFpEF, HFrEF, no-HF, and plasma LCAC, we performed several sensitivity analyses. In addition to repeating the primary analysis with adjustment for IR, we assessed correlations between IR and LCACs directly.

We used the Lipoprotein Insulin Resistance Index (LP-IR), a validated IR measurement derived from nuclear magnetic resonance (NMR)-based lipoprotein subclass particle size and concentration.<sup>2</sup> The LP-IR index has been shown to have strong correlations with glucose disposal rate (GDR) and HOMA-IR*.* <sup>2</sup>

# *Correlations between LCAC and IR*

To determine the relationship between LCAC and IR directly, we evaluated unadjusted correlations between Factor 4 (LCAC) and LP-IR for the full cohort using Spearman's rho. We found no correlation between LCAC and LP-IR ( $r = -0.04$ ;  $P = 0.3$ ).

### *Impact of IR Adjustment on Primary Analysis Results*

To determine whether IR mediates the relationship between HFpEF, HFrEF, no-HF, and plasma LCAC levels, we created two separate general linear models. The first model included all of the covariates used in the primary analysis (age, race, sex, body mass index, number of diseased coronary arteries, history of diabetes, hypertension, dyslipidemia, smoking, glomerular filtration rate, batch), and added LP-IR. The second model included all of the covariates used in the primary

analysis, but replaced 'history of diabetes' with LP-IR levels. We performed multivariate adjusted analysis of covariance (ANCOVA) with post-hoc pairwise comparisons using both models.

As shown in Supplemental Tables S6 and S7, this adjustment did not change the results. Specifically, LCAC factor levels remained significantly different among groups in the omnibus ANCOVA for both IR sensitivity analyses (both *P*<0.0001). Similarly, all pairwise comparisons of LCAC factor levels remained significantly different in the IR sensitivity analyses. Additionally, the trends in mean LCAC factor concentrations were preserved in the IR sensitivity analyses, with LCAC levels highest in HFrEF, intermediate in HFpEF, and lowest in no-HF patients. Analyses of individual LCAC metabolites in HFpEF, HFrEF, and no-HF patients (Supplemental Tables S8 and S9) confirmed findings from the IR sensitivity analyses and were concordant with those from the primary analysis. Altogether, these results suggest that LCAC factor findings were not driven by IR.

### **Data S4: Complete list of measured metabolites**

See Supplemental Table S2 below for the complete list of metabolites measured in this investigation.

#### **Data S5. Detailed results of principal components analysis**

Principal components analysis reduced the full set of 63 metabolites into a smaller number of uncorrelated factors. Fourteen factors exceeded the Eigenvalue threshold of 1.0, and are listed in Supplemental Table S3 below. This threshold is based on the Kaiser Criterion, which allows parsimonious selection of factors explaining a significant amount of inter-subject variation. Component metabolites are listed in order of magnitude of factor load, with only those having a factor load > |0.4| listed. Variance refers to the proportion of overall variance explained by a given factor.

### **Data S6: Plasma LCAC means for additional HFpEF, HFrEF, and control cohorts**

To provide insight into how the plasma LCAC values of our cohorts compare with those reported in similar populations, we have provided baseline plasma LCAC means for three additional cohorts: 1) N=161 patients enrolled in the RELAX trial of sildenafil in HFpEF;  $3/2$ ) N=453 patients enrolled in the HF-ACTION trial of exercise in HFrEF;  $^4$  and 3) N=3653 patients without HF enrolled in CATHGEN who were not included in the primary analysis.<sup>5</sup>

As shown in Table S10 below, we found similar levels of individual LCAC metabolites for HFpEF and no-HF controls between the respective cohorts. For HFrEF, there were some metabolites that were higher in CATHGEN as compared with HF-ACTION, likely related to the fact that HF-ACTION participants were outpatients and CATHGEN participants included inpatients with more acute heart failure presentations. Results of these analyses support generalizability of the present findings to broader populations.







chain length; OH, hydroxyl; DC, dicarboxyl.



### **TABLE S4: Metabolite Factor Means and Comparisons Between HFpEF, HFrEF, and No-HF Controls Using Strict Cohort Definitions**



\*Statistical significance in omnibus ANCOVA analyses was *P<*0.0036, reflecting Bonferroni correction for 14 factor comparisons. † *P* values for basic model, adjusted for age, race and sex. ‡ *P* values for full model, adjusted for age, race, sex, body mass index, number of diseased coronary arteries, history of diabetes, hypertension, dyslipidemia, smoking, glomerular filtration rate, and batch. § Pairwise comparisons for factors significant at Bonferroni corrected threshold test for significant between-group differences. *P* values for factors significant at nominal threshold of *P<*0.05 are reported for exploratory purposes. *P* values reflect between-group pairwise contrasts generated from the fully adjusted ANCOVA procedure. *¶* Values are least square means, adjusted for all 11 covariates. Standard error of the mean is provided beneath each value. Abbreviations: HFpEF indicates heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HF, heart failure; ANCOVA, analysis of covariance; BCAA, branched-chain amino acids; C, carbon chain length.

### **TABLE S5: Metabolite Factor Means and Comparisons Between HFpEF, HFrEF, and No-HF Controls Using Alternate LVEF Thresholds**



\*Statistical significance in omnibus ANCOVA analyses was *P<*0.0036, reflecting Bonferroni correction for 14 factor comparisons. † *P* values for basic model, adjusted for age, race and sex. ‡ *P* values for full model, adjusted for age, race, sex, body mass index, number of diseased coronary arteries, history of diabetes, hypertension, dyslipidemia, smoking, glomerular filtration rate, and batch. § Pairwise comparisons for factors significant at Bonferroni corrected threshold test for significant between-group differences. *P* values for factors significant at nominal threshold of *P<*0.05 are reported for exploratory purposes. *P* values reflect between-group pairwise contrasts generated from the fully adjusted ANCOVA procedure. *¶* Values are least square means, adjusted for all 11 covariates. Standard error of the mean is provided beneath each value. Abbreviations: HFpEF indicates heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HF, heart failure; ANCOVA, analysis of covariance; BCAA, branched-chain amino acids; C, carbon chain length.

# **TABLE S6: Adjusted Metabolite Factor Means and Comparisons Between HFpEF, HFrEF, and No-HF Controls, Controlling for History of Diabetes and Insulin Resistance\***



\* Statistical significance in omnibus ANCOVA analyses was *P<*0.0036, reflecting Bonferroni correction for 14 factor comparisons. † *P* values adjusted for age, race, sex, body mass index, number of diseased coronary arteries, history of diabetes, hypertension, dyslipidemia, smoking, glomerular filtration rate, insulin resistance, and batch. ‡ Pairwise comparisons for factors significant at Bonferroni corrected threshold test for significant between-group differences. *P*  values for factors significant at nominal threshold of *P<*0.05 are reported for exploratory purposes. *P* values reflect between-group pairwise contrasts generated from the fully adjusted ANCOVA procedure. § Values are least square means, adjusted for all 12 covariates. Standard error of the mean is provided beneath each value. Abbreviations: HFpEF indicates heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HF, heart failure; ANCOVA, analysis of covariance; BCAA, branched-chain amino acids; C, carbon chain length.

#### **TABLE S7: Adjusted Metabolite Factor Means and Comparisons Between HFpEF, HFrEF, and No-HF Controls, Controlling for Insulin Resistance but NOT Diabetes\***



\* Statistical significance in omnibus ANCOVA analyses was *P<*0.0036, reflecting Bonferroni correction for 14 factor comparisons. † *P* values adjusted for age, race, sex, body mass index, number of diseased coronary arteries, hypertension, dyslipidemia, smoking, glomerular filtration rate, insulin resistance, and batch. ‡ Pairwise comparisons for factors significant at Bonferroni corrected threshold test for significant between-group differences. *P* values for factors significant at nominal threshold of *P<*0.05 are reported for exploratory purposes. *P* values reflect between-group pairwise contrasts generated from the fully adjusted ANCOVA procedure. § Values are least square means, adjusted for all 11 covariates. Standard error of the mean is provided beneath each value. Abbreviations: HFpEF indicates heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HF, heart failure; ANCOVA, analysis of covariance; BCAA, branched-chain amino acids; C, carbon chain length.



unadjusted mean concentrations. Standard deviation is provided beneath each value. Abbreviations: HFpEF indicates heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HF, heart failure; ANCOVA, analysis of covariance; C, carbon chain length.



carbon chain length.



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