

Supplementary Appendix 1

This appendix has been provided by the authors to give readers additional information about their work.

Supplement to: McGeachie MJ, Yates KP, Zhou X, et al. Patterns of growth and decline in lung function in persistent childhood asthma. *N Engl J Med* 2016;374:1842-52. DOI: [10.1056/NEJMoa1513737](https://doi.org/10.1056/NEJMoa1513737)

Supplementary Appendix 1

Table of contents

Online Supplement.....	1
Contributing Authors.....	2
Additional Acknowledgements.....	6
Part 1. Additional Figures and Tables.....	10
Figure S1: CAMP trial and continuation studies design schematic.....	10
Figure S2: Derivation of the subset of CAMP participants included in pattern analyses.....	11
Figure S3: Kaplan-Meier estimates of lung growth features by sex.....	12
Table S1: Lung function growth pattern classification agreement between two investigators.....	13
Table S2: Lung function growth pattern classification agreement between two additional investigators of 100 CAMP participants' lung function curves.....	14
Table S3: Lung function growth pattern statistics by sex.....	15
Table S4: Lung function and lung function growth statistics by 4 patterns of lung function growth and decline	16
Table S5: Additional baseline characteristics and end of study smoking status of participants by pattern of lung function growth and decline	18
Table S6: Relative odds of completing spirometric testing at age 23 years of older in relation to baseline characteristics	19
Table S7: Multinomial regression of demographic and clinical risk factors of 4 patterns of lung function growth and decline: results for each predictor in the model	20
Part 2. Pattern Classification Procedures Guide and Coding Sheets	22
Part 2A: CAMP Pattern Classification Procedure Guide.....	22
Supplementary Appendix 2: Pattern coding sheets for the 1041 CAMP participants.....	42
Part 3. Public-use data file and documentation for the 1041 CAMP participants	43
Supplementary Appendix 3: CAMP patterns and spirometry public data dictionary.....	43
Supplementary Appendix 4: CAMP patterns and spirometry public use data file.....	43

Contributing Authors

Michael J McGeachie, PhD,^{1,2,+}

Katherine P Yates, ScM,^{3,+}

Xiaobo Zhou, PhD,^{1,2}

Feng Guo, PhD,^{1,2}

Alice L Sternberg, ScM,³

Mark L Van Natta, MHS,³

Robert A Wise, MD,⁴

Stanley J Szefler, MD,⁵

Sunita Sharma, MD,⁶

Alvin T Kho, PhD,^{1,2,7}

Michael H Cho, MD,^{1,2}

Damien C Croteau-Chonka, PhD,^{1,2}

Peter J Castaldi, MD,^{1,2}

Gaurav Jain, MS,⁸

Amartya Sanyal, PhD,^{8,9}

Ye Zhan,⁸

Bryan R Lajoie, PhD,⁸

Job Dekker, PhD,¹⁰

John Stamatoyannopoulos, MD,¹¹

Ronina A Covar, MD,^{5,12}

Robert S Zeiger, MD, PhD,¹³

N Franklin Adkinson, MD,⁴

Paul V Williams, MD,¹⁴

H William Kelly, PharmD,¹⁵

Hartmut Grasmann, MD,¹⁶

Judith M Vonk, PhD,¹⁷

Gerard H Koppelman, MD,¹⁸

Dirkje S Postma, MD,¹⁹

Benjamin A Raby, MD,^{1,2}

Isaac Houston, PhD,^{1,2}

Quan Lu, PhD,²⁰

Anne L Fuhlbrigge, MD,MS,^{1,2,21}

Kelan G Tantisira, MD,^{1,2}

Edwin K Silverman, MD,PhD^{1,2}

James Tonascia, PhD,³

Scott T Weiss, MD MS,^{1,2, ++,*}

Robert C Strunk, MD,^{22,++}

For the CAMP Research Group.**

This paper is subject to the NIH public access policy (<http://publicaccess.nih.gov/>).

^{+,++} Denotes equal contributions.

* To whom correspondence should be addressed.

** A full listing of CAMP contributors appears in an Appendix.

- ¹ Channing Division of Network Medicine, Brigham and Women's Hospital, Boston, MA, USA.
- ² Department of Medicine, Brigham and Women's Hospital and Harvard Medical School, Boston, MA, USA.
- ³ Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA.
- ⁴ Johns Hopkins University School of Medicine, Baltimore, MD, USA.
- ⁵ National Jewish Health, Children's Hospital Colorado, and University of Colorado Denver School of Medicine, Denver, CO, USA.
- ⁶ Division of Pulmonary Sciences and Critical Care Medicine, Department of Medicine, University of Colorado, Denver, CO, USA.
- ⁷ Boston Children's Hospital, Boston, MA, USA.
- ⁸ Program in Systems Biology, Department of Biochemistry and Molecular Pharmacology, University of Massachusetts Medical School, 368 Plantation Street, Worcester, MA, USA
- ⁹ School of Biological Sciences, Lee Kong Chian School of Medicine, Nanyang Technological University, Singapore
- ¹⁰ Howard Hughes Medical Institute, Program in Systems Biology, Department of Biochemistry and Molecular Pharmacology, University of Massachusetts Medical School, 368 Plantation Street, Worcester, MA, USA
- ¹¹ Genome Sciences, School of Medicine, University of Washington, Seattle, WA.
- ¹² University of Colorado, Denver, CO, USA.
- ¹³ University of California at San Diego, Pediatrics, La Jolla, CA and Kaiser Permanente Southern California Region, San Diego, CA, USA.
- ¹⁴ ASTHMA, Inc. Clinical Research Center and Northwest Asthma & Allergy Center, Seattle, WA, USA.
- ¹⁵ University of New Mexico Health Sciences Center, Albuquerque, NM, USA.

¹⁶ Division of Respiratory Medicine, Department of Pediatrics, The Hospital for Sick Children and University of Toronto, Toronto, Canada.

¹⁷ Groningen Research Institute for Asthma and COPD, University of Groningen, University Medical Center Groningen, Department of Epidemiology, Groningen, the Netherlands

¹⁸ University of Groningen, University Medical Center Groningen, Department of Pediatric Pulmonology and Pediatric Allergology, Beatrix Children's Hospital and Groningen Research Institute for Asthma and COPD, Groningen, the Netherlands

¹⁹ Groningen Research Institute for Asthma and COPD, University of Groningen, University Medical Center Groningen, Department of Pulmonology, Groningen, the Netherlands

²⁰ Program in Molecular and Integrative Physiological Sciences, Departments of Environmental Health and Genetics & Complex Diseases, Harvard T.H. Chan School of Public Health, Boston, MA, USA.

²¹ Division of Pulmonary and Critical Care Medicine, Brigham and Women's Hospital, Boston, MA, USA.

²² Division of Allergy, Immunology, and Pulmonary Medicine, Washington University School of Medicine, St. Louis, MO, USA.

Additional Acknowledgements

The Childhood Asthma Management Program trial and CAMP Continuation Study were supported by contracts NO1-HR-16044, 16045, 16046, 16047, 16048, 16049, 16050, 16051, and 16052 with the National Heart, Lung, and Blood Institute and General Clinical Research Center grants M01RR00051, M01RR0099718-24, M01RR02719-14, and RR00036 from the National Center for Research Resources. The CAMP Continuation Study/Phases 2 and 3 were supported by grants U01HL075232, U01HL075407, U01HL075408, U01HL075409, U01HL075415, U01HL075416, U01HL075417, U01HL075419, U01HL075420, and U01HL075408 from the National Heart, Lung, and Blood Institute. The National Jewish Health site was also supported in part by Colorado CTSA grant UL1RR025780 from NCRR/NIH and UL1TR000154 from NCATS/NIH.

Members of the CAMP Research Group:

Clinical centers

ASTHMA, Inc, Seattle, WA: Paul Williams, MD (Principal Investigator); Mary V. Lasley, MD (Co-Director); Tamara Chinn, MSN, ARNP (Coordinator). Michele Hinatsu, MSN, ARNP; Clifton T. Furukawa, MD; Leonard C. Altman, MD; Frank S. Virant, MD; Michael S. Kennedy, MD; Stephen Tilles, MD. Jonathan W. Becker, MD (1995-2010); C. Warren Bierman, MD (1992-1997); Dan Crawford, RN (1996-2002); Thomas DuHamel (1991-2004); Heather Eliassen, BA (1996-1999); Babi Hammond (1996-1999); Miranda MacLaren (2008-2011); Dominick A. Minotti, MD (1992-2003); Chris Reagan (1992-2003); Gail Shapiro (1991-2006, Principal Investigator); Marian Sharpe, RN (1992-1994); Ashley Tatum, MD (2004-2007); Grace White (1991-2007). Timothy G. Wighton, PhD (1994-1998).

Brigham & Women's Hospital and Harvard Vanguard Medical Associates, Boston, MA: Anne Fuhlbrigge, MD (Principal Investigator); Anne Plunkett, NP, MS (Coordinator). Nancy Madden, RN, BSN; Susan Anderson; Mark Boehnert, MD; Anita Feins, MD; Amanda Gentile; Natalia Kandror, MD; Kelly MacAulay, MD; Ernestina Sampong; Scott Weiss MD. Walter Torda, MD (Co-Investigator Director, 1993-2003); Martha Tata, RN (1993-2002); Sally Babigian, RN (1997-1999); Peter Barrant, MD (2004-2007); Linda Benson (1998-2004); Jose Caicedo (1998-1999); Tatum Calder (1998-2001); Christine Darcy (2001-2008); Anthony DeFilippo (1994-2000); Cindy Dorsainvil (1998-2001); Julie Erickson (1998-1999); Phoebe Fulton (1997); Mary Grace, RN (1994-1996); Jennifer Gilbert (1997-1998); Dirk Greineder, MD (1993-2000); Stephanie Haynes (1993-1998); Margaret Higham, MD (1996-1998); Deborah Jakubowski (1999); Susan Kelleher (1993-1997); Jay Koslof, PhD (1993-1995); Dana Mandel (1996-1998); Patricia Martin (2001-2003); Agnes Martinez (1994-1997); Jean McAuliffe (1994-1995); Erika Nakamoto (2002-2004); Paola Pacella (1993-1998); Paula Parks (1993-1995); Johanna Sagarin (1998-1999); Kay Seligsohn, PhD (1995-2004); Susan Swords (2003-2005); Meghan Syring (1998-2001); June

Traylor, MSN, RN (1996-1998); Melissa Van Horn, PhD (1996-1999); Carolyn Wells, RN (1993-1995); Ann Whitman, RN (1994-1996).

The Hospital for Sick Children, Toronto, Ontario, Canada: Hartmut Grasemann, MD (Principal Investigator); Melody Miki, RN, BSN (Coordinator); Melinda Solomon, MD; Padmaja Subbarao, MD. Ian MacLusky, MD, FRCP (Director 1999-2007); Joe Reisman, MD, FRCP(C), MBA (Director, 1996-1999); Henry Levison, MD, FRCP(C) (Director, 1992-1996); Anita Hall, RN (Coordinator, 1993-2007). Yola Benedet (1994-1999); Susan Carpenter, RN (1998-2001); Jennifer Chay (2004); Michelle Collinson, RN (1994-1998); Jane Finlayson-Kulchin, RN (1994-1998); Kenneth Gore, MA (1993-1999); Nina Hipolito, RN (2003-2004); Noreen Holmes, RRT (1998-1999); Erica Hoorntje, RN (2002-2003); Sharon Klassen, MA(1999-2000); Joseé Quenneville, MSc (1993-1995); Renée Sananes, PhD (1993-2004); Christine Wasson, PhD (1999); Margaret Wilson, RN (2001-2002).

Johns Hopkins Asthma & Allergy Center, Baltimore, MD: N. Franklin Adkinson, Jr, MD (Director); Deborah Bull, LPN (Coordinator); Stephanie Philips, RN. Peyton Eggleston, MD (Co-Director, 1991-2004); Karen Huss, DNSc (Co-Investigator, 1991-2004); Leslie Plotnick, MD (Co-Investigator, 1991-1999); Margaret Pulsifer, PhD (Co-Investigator, 1993-2004); Cynthia Rand, PhD (Co-Investigator, 1991-2004). Elizabeth Aylward, PhD (1991-2004), Nancy Bollers, RN (Coordinator, 1993-2004); Kathy Pessaro (2004-2007); Barbara Wheeler, RN, BSN (Coordinator, 1991-1999).

National Jewish Health, Denver, CO: Stanley Szeffler, MD (Director); Ronina Covar, MD (Medical Director); Harold S. Nelson, MD (Co-Director 1991-2000, Co-Investigator 2000-present); Bruce Bender, PhD (Co-Investigator); Andrew Liu, MD (Co-Investigator); D Sundström (Coordinator); Melanie Phillips; Michael P. White; Melanie Gleason, PA-C. Kristin Brelsford (1997-1999); Jessyca Bridges (1995-1997); Jody Ciacco (1993-1996); Michael Eltz (1994-1995); Jeryl Feeley, MA (Coordinator, 1992-1995); Michael Flynn (1995-1996); Tara Junk-Blanchard (1997-2000); Joseph Hassell (1992-1998); Marcia Hefner (1992-1994); Caroline Hendrickson, RN (1995-1998; Coordinator, 1995-1997); Daniel Hettleman, MA (1995-1996); Charles G. Irvin, PhD (1992-1998); Alan Kamada, PharmD (1994-1997); Marzena Krawiec, MD (2008-2010); Gary Larsen, MD (Co-Investigator, 2000-2010); Sai Nimmagadda, MD (1993-1996); Kendra Sandoval (1995-1997); Jessica Sheridan (1994-1995); Joseph Spahn, MD (Co-Investigator 1993-2010); Gayle Spears, PA-C (2003-2007); Trella Washington (1993-1997); Eric Willcutt, MA (1996-1997). We also thank the pediatric allergy/immunology and pulmonary fellows for their participation (Ivan Cardona, MD; Kirstin Carel, MD; Jayna Doshi, MD; Rich Hendershot, MD; Jeffrey Jacobs, MD; Neal Jain, MD; June-ku Brian Kang, MD; Tracy Kruzick, MD; Harvey Leo, MD; Beth Macomber, MD; Jonathan Malka, MD; Chris Mjaanes, MD; John Prpich, MD; Lora Stewart, MD; Ben Song, MD; Grace Tamesis, MD).

University of California, San Diego and Kaiser Permanente Southern California Region, San Diego, CA: Robert S. Zeiger, MD, PhD (Director); Noah Friedman, MD (Co-Investigator); Michael H. Mellon, MD (Co-Investigator); Michael Schatz, MD (Co-Investigator); Terrie Long, RN (Coordinator). Travis Macaraeg. Sandra Christensen, MD (2004-2007); James G. Easton, MD (Co-Director, 1993-1994); M. Feinberg (1997-1998); Linda L. Galbreath (1991-2002); Jennifer Gulczynski (1998-1999); Kathleen Harden, RN (Coordinator, 1993-2010); Ellen Hansen (1995-1997); Al Jalowayski, PhD (Co-Investigator, 1991-2005); Elaine Jenson (2004-2007); Alan Lincoln, PhD (Co-Investigator, 1991-2003); Jennie Kaufman (1994); Shirley King, MSW (1992-1999); Brian Lopez (1997-1998); Michaela Magiari-Ene, MA (1994-1998); Kathleen Mostafa, RN (1994-1995); Avraham Moscona (1994-1996); Catherine A. Nelle, RN (1991-2005); Jennifer Powers (2001-2003); Elsa Rodriguez (2003-2007); Eva Rodriguez, RRT (1994-2008); Karen Sandoval (1995-1996); Nevin W. Wilson, MD (Co-Director, 1991-1993).

University of New Mexico, Albuquerque, NM: Hengameh H Raissy, PharmD (Director); Aaron Jacobs (Co-Investigator); H William Kelly, PharmD (Director, 1998-2011); Mary Spicher, RN (Coordinator). Christina Batson; Michelle Harkings, MD; Katie McCallum. Robert Annett, PhD (Co-Investigator, 1993-2004); Teresa Archibeque (1994-1999); Naim Bashir, MD (Co-Investigator, 1998-2005); H. Selda Bereket (1995-1998); Marisa Braun (1996-1999); Carrie Bush (1995-1999); Shannon C. Bush (2002-2007); Michael Clayton, MD (Co-Investigator, 1999-2001); Angel Colon-Semidey, MD (Co-Investigator, 1997-2000); Sara Devault (1993-1997); Anna Esparham (2004-2007); Roni Grad, MD (Co-Investigator, 1993-1995); David Hunt, RRT (1995-2004); Jeanne Larsson, RN (1995-1996); Sandra McClelland, RN (Coordinator, 1993-1995); Bennie McWilliams, MD (Co-Investigator, Director, 1992-1998); Elisha Montoya (1997-2000); Margaret Moreshead (1996-1999); Shirley Murphy, MD (Co-Investigator, 1992-1994); Barbara Ortega, RRT (1993-1999); David Weers (1997-1998); Jose Zayas (1995-1996).

Washington University, St. Louis, MO: Robert C. Strunk, MD (Director); Leonard Bacharier, MD (Co-Investigator); Denise Rodgers, RPFT (Coordinator). Ellen Albers, RN, CNS-P, MSN (1997-1999); Gregg Belle, MA (1996-2001); Gordon R. Bloomberg, MD (Co-Investigator, 1994-2007); W Patrick Buchanan (1998-2001); Mary Caesar MHS (1993-1996); James M. Corry, MD (Co-Investigator, 1994-2004); Karen DeMuth (2006-2007); Marisa Dolinsky, MA (1996-2001); Edwin B Fisher, PhD (1993-2001); Stephen J Gaioni, PhD (1993-2001); Emily Glynn, RN, MSN, CSPNP (1993-2001); Bernadette D Heckman, MA (1996-2001); Debra Kemp, RN, BSN (1994-2001); Lila Kertz, MSN, RN, CPNP (2005-2007); Claire Lawhon (1994-2003); Valerie Morgan, RRT (2000-2004); Cynthia Moseid (1997); Tina Oliver-Welker, CRTT (1994-2007); Diana Richardson (1994-1997); Elizabeth Ryan, PhD (1994-1997); Sharon Sagal, MD (1996-2001); Thomas F Smith, MD (1993-1998); Susan Sylvia, PhD (1994-1997); Carl Turner (1995-1997); Deborah K. White, RPFT, RRT (1994-2007).

Resource centers

Data Coordinating Center, The Johns Hopkins University, Baltimore, MD: James Tonascia, PhD (Director). Patricia Belt; Karen Collins; Betty Collison; John Dodge; Michele Donithan, MHS; Cathleen Ewing; Rosetta Jackson; Patrick May, MS; Jill Meinert; Girlie Reyes; Michael Smith; Alice L. Sternberg, ScM; Mark L. Van Natta, MHS; Annette Wagoner; Laura Wilson, ScM; Robert Wise, MD; Katherine Yates, ScM.

Project Office, National Heart, Lung, and Blood Institute, Bethesda, MD: Virginia Taggart, MPH (Project Officer); Lois Eggers; James Kiley, PhD; Howard Moore; Gang Zheng, PhD. Paul Albert, PhD (1991-1999); Suzanne Hurd, PhD (1991-1999); Sydney Parker, PhD (1991-1994); Pamela Randall (1992-2003); Margaret Wu, PhD (1991-2001).

Committees

Data and Safety Monitoring Board: Michelle Cloutier, MD (Chair); John Connett, PhD; Leona Cuttler, MD; Frank Gilliland, MD, PhD. Clarence E. Davis, PhD (1993-2003); Howard Eigen, MD (1993-2009, Chair); David Evans, PhD (1993-2007); Meyer Kattan, MD (1993-2007); Rogelio Menendez, MD (1993-2007); F. Estelle R. Simons, MD (1993-2007); Sanford Leikin, MD (1993-1999).

Steering Committee: Robert Strunk, MD (Study Chair); N. Franklin Adkinson, MD; Robert Annett, PhD (1992-1995, 1997-1999); Bruce Bender, PhD; Mary Caesar, MHS (1994-1996); Reuben Cherniack, MD (Study Chair 1993-2007); Ronina Covar, MD; Thomas R. DuHamel, PhD (1992-1994, 1996-1999); Anne Fuhlbrigge, MD; Hartmut Grasemann, MD; H. William Kelly, PharmD; Henry Levison, MD (1992-1996); Alan Lincoln, PhD (1994-1995); Ian MacLusky, MD (1999-2006); Bennie McWilliams, MD (1992-1998); Curtis L. Meinert, PhD; Sydney Parker, PhD (1991-1994); Hengameh H Raissy, Pharm D; Joe Reisman, MD, FRCP(C), MBA (1991-1999); Denise Rodgers; Kay Seligsohn, PhD (1996-1997); Gail G. Shapiro, MD (1991-2006); Marian Sharpe (1993-1994); D Sundström (1998-1999); Stanley Szeffler, MD; Virginia Taggart, MPH; Martha

Tata, RN (1996-1998); James Tonascia, PhD; Scott Weiss, MD, MS; Barbara Wheeler, RN, BSN (1993-1994); Paul Williams, MD; Robert Wise, MD; Robert Zeiger, MD, PhD.

Part 1. Additional Figures and Tables

Figure S1: CAMP trial and continuation studies design schematic

Dec 93 – Sept 95

1,041 children 5-12 years of age

Mild to moderate persistent asthma

PC20 \leq 12.5 mg/ml (mean 1.1 mg/ml)

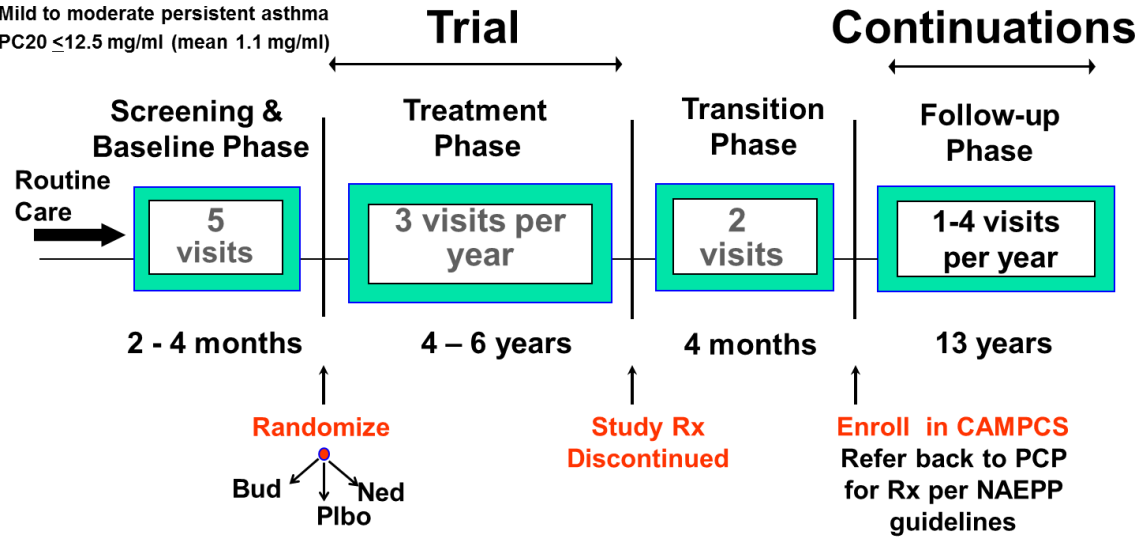
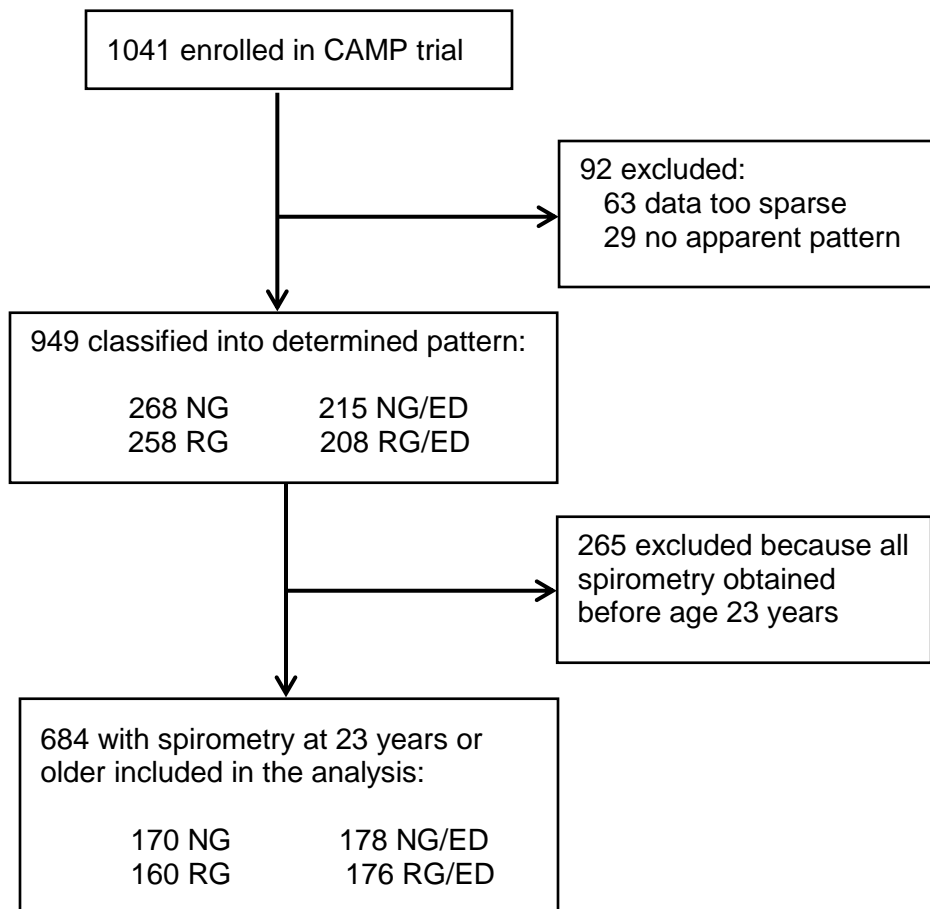
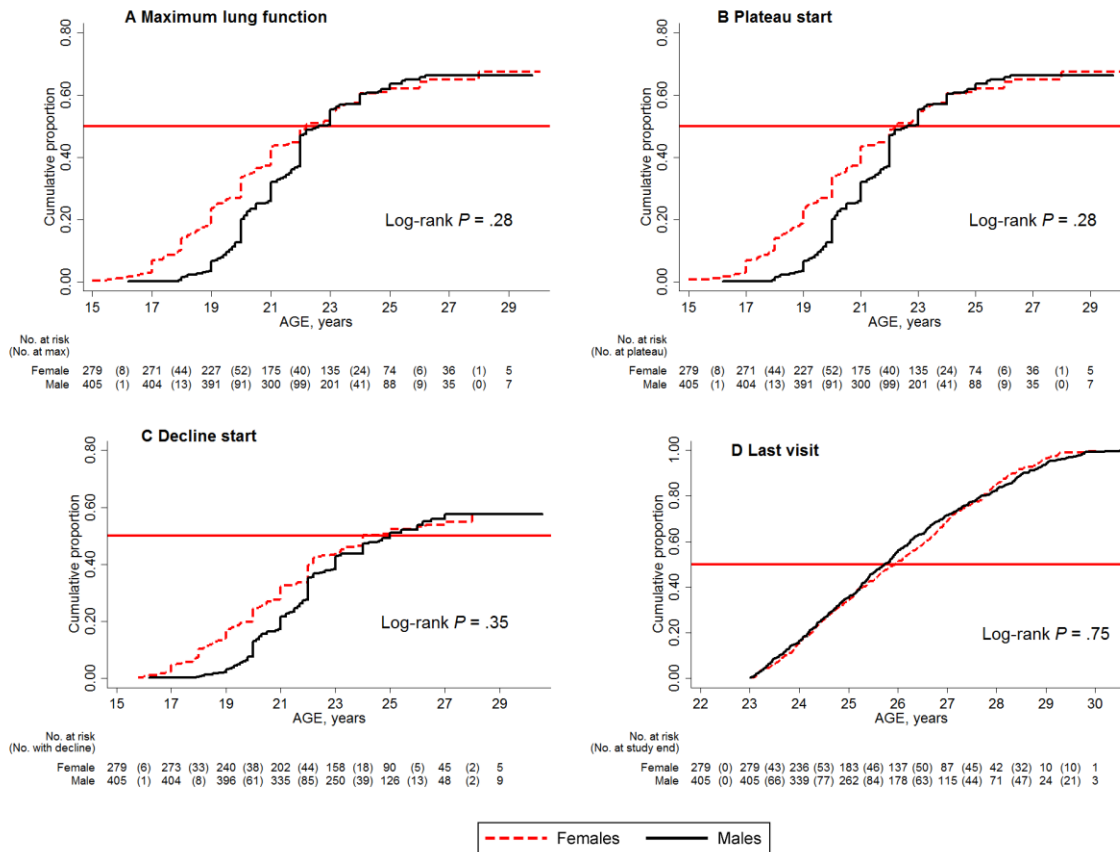


Figure S2: Derivation of the subset of CAMP participants included in pattern analyses



Abbreviations: NG denotes Normal growth, NG/ED denotes Normal growth with early decline; RG denotes Reduced growth; RG/ED denotes Reduced growth with early decline

Figure S3: Kaplan-Meier estimates of lung growth features by sex



Kaplan-Meier estimates of lung growth features by sex for the 684 CAMP participants with at least one FEV₁ measure at age 23 years or older and a determined pattern assignment. Each panel displays the cumulative proportion of participants reaching an event by age: Panel A), attainment of maximum lung function growth; Panel B), beginning the plateau phase (or maximum lung function if no plateau due to an immediate decline); Panel C), beginning the decline phase, which may or may not be earlier than expected from NHANES III; Panel D), completing their last visit in the study. The red line indicates the median age to each event. The difference between the survivorship functions is calculated by a log-rank test.

Table S1: Lung function growth pattern classification agreement between two investigators for initial pattern review

Investigator 1 Pattern Classifications	Investigator 2 Pattern Classifications*					
	No.	NG	NG/ED	RG	RG/ED	Total
	NG	28	0	0	0	28
	NG/ED	2	20	0	2	24
	RG	0	0	21	0	21
	RG/ED	0	1	1	26	28
Total	30	21	22	28	101†	
Kappa	0.92					
95% C.I.	0.86-0.98					
P‡	<0.001					
<p>* NG denotes Normal growth, NG/ED denotes Normal growth with early decline, RG denotes Reduced growth, RG/ED denotes Reduced growth with early decline</p> <p>† 110 patterns classified independently by 2 investigators; of these, 3 patterns were classified as sparse data by at least 1 investigator, and 6 were classified as unknown pattern by at least 1 investigator, which resulted in 101 patterns classified with a determined pattern by both investigators.</p> <p>For the 110 patterns: Kappa=0.83, 95% C.I.: 0.76-0.91, P<0.001.</p> <p>‡ P determined from the asymptotic test of the hypothesis that kappa equals zero.</p>						

Table S2: Lung function growth pattern classification agreement between two additional investigators of 100 CAMP participants' lung function curves

Investigator 4 Pattern Classifications	Investigator 3 Pattern Classifications*					
	No.	NG	NG/ED	RG	RG/ED	Total
	NG	36	1	0	0	37
	NG/ED	2	11	0	0	13
	RG	1	0	25	1	27
	RG/ED	0	0	3	20	23
	Total	39	12	28	21	100†
	Kappa	0.89				
	95% C.I.	0.81-0.96				
	P‡	<0.001				
<p>* NG denotes Normal growth, NG/ED denotes Normal growth with early decline, RG denotes Reduced growth, RG/ED denotes Reduced growth with early decline</p> <p>† 100 patterns were selected randomly from the total number of 684 participants with high-confidence patterns (i.e., participant had a determined pattern code and at least 1 spirometry at age 23 years or older) used for the analyses of pattern characteristics and predictors. Each of the 100 patterns was classified independently by 2 investigators, after an initial training period.</p> <p>‡ P determined from the asymptotic test of the hypothesis that kappa equals zero.</p>						

Table S3: Lung function growth statistics by sex

	Male (N=405)	Female (N=279)	P*
Maximum lung function:			
Attained, N (%)	254 (63%)	175 (63%)	0.99
Age at highest attained lung function, years	21.3 (1.8) [16.2, 27.8]	20.3 (2.5) [15.0-28.0]	<0.001
Kaplan-Meier estimated median (95% C.I.) age, years	22.7 (22.0,23.0)	22.2 (21.5,23.2)	0.28†
Plateau phase:			0.73
Not attained, N (%)	151 (37%)	104 (37%)	
No plateau, immediate decline	125 (31%)	93 (33%)	
Plateau attained, N (%)	129 (32%)	82 (29%)	
Age when attained plateau, if have a plateau, years	21.4 (1.7) [18.0,26.0]	20.6 (2.4) [15.0,26.0]	0.002
Kaplan-Meier estimated median (95% C.I.) age start at plateau, years	22.6 (22.0,23.0)	22.2 (21.5,23.2)	0.28†
Plateau length, if plateau phase complete:			
N (%) with a plateau	84 (21%)	53 (19%)	0.58
Length of plateau, years	1.7 (0.9) [0.8,4.5]	1.6 (0.8) [1.0, 5.2]	0.34
Decline phase: N (%)	209 (52%)	146 (52%)	0.85
Had an early decline, N (%)	209 (52%)	145 (52%)	0.89
Age at start of early decline, years	21.7 (1.9) [16.2,27.0]	20.5 (2.4) [15.8,28.0]	<0.001
Kaplan-Meier estimated median (95% C.I.) age at start of any decline, years	25.0 (24.0,26.5)	24.0 (23.0,.)	0.35†
Age at last visit, N (%)	25.9 (1.8) [23.0,30.6]	26.0 (1.7) [23.0,30.1]	0.66
Kaplan-Meier estimated median (95% C.I.) age, years	25.7 (25.4,26.0)	26.0 (25.6,26.3)	0.75†
* Means (SD) [minimum, maximum] estimates are presented unless otherwise denoted. P (2-sided) determined from either a Pearson's chi-square test for categorical variables or a t-test for continuous variables.			
† Median and 95% confidence interval determined from the Kaplan-Meier product-limit estimates of the survival function. P determined from the log-rank test for equality of survivor functions between genders.			

Table S4: Lung function and lung function growth statistics by 4 patterns of lung function growth and decline

	Normal Growth (N=170)	Normal Growth/ Early Decline (N=178)	Reduced Growth (N=160)	Reduced Growth/ Early Decline (N=176)	Total* (N=684)	P†
No. of lung function measures per participant, mean (SD) [min, max]:						
Total number	23.0 (2.8) [12, 27]	23.1 (2.8) [10,27]	22.9 (2.9) [4, 27]	23.4 (2.6) [14, 27]	23.1 (2.8) [4, 27]	0.24
Number at age 23+ years	3.1 (1.6) [1, 7]	3.3 (1.9) [1, 8]	3.1 (1.9) [1, 8]	3.6 (1.9) [1, 8]	3.3 (1.8) [1, 8]	0.001
Characteristics of follow-up:						
Number of years of follow-up	16.4 (0.6)	16.4 (0.7)	16.4 (0.6)	16.4 (0.7)	16.4 (0.6)	0.70
Age at randomization (years)	9.3 (1.7)	9.7 (1.7)	9.3 (1.8)	9.9 (1.7)	9.6 (1.7)	0.006
Age at last visit (years)	25.7 (1.7)	26.0 (1.8)	25.8 (1.9)	26.3 (1.7)	26.0 (1.8)	0.008
Maximum lung function attained: N (%)						
Age at highest attained lung function, years	22.3 (2.2)	20.6 (2.2)	21.9 (1.7)	20.6 (1.8)	20.9 (2.1)	<0.001
Velocity from maximum to study end:						
Velocity (mL pre-BD FEV ₁ /yr), median [Q1, Q3]§	-0 [-22, 12]	-30 [-67, -12]	-10 [-45, 24]	-32 [-68, -15]	-28 [-62, -8]	0.002
Velocity (% predicted pre-BD FEV ₁ /yr), median [Q1, Q3]§	0.2 [-0.2, 0.9]	-0.6 [-1.4, -0.2]	0.1 [-0.7, 0.5]	-0.9 [-1.4, -0.2]	-0.5 [-1.2,-0.1]	<0.001
Plateau phase:						
Plateau not attained: maximum lung function not attained	125 (74%)	0 (0%)	130 (81%)	0 (0%)	255 (37%)	<0.001
No plateau, immediate decline	0 (0%)	112 (63%)	0 (0%)	106 (60%)	218 (32%)	
Attained plateau	45 (26%)	66 (37%)	30 (19%)	70 (40%)	211 (31%)	
Age when attained plateau, years	22.3 (2.2)	20.6 (2.1)	21.9 (1.7)	20.5 (1.6)	21.1 (2.1)	<0.001
Plateau phase is complete, N (%)‡¶	1 (1%)	66 (37%)	0 (0%)	70 (40%)	137 (20%)	0.60
Length of plateau if complete, years‡¶	2.0	1.5 (0.6)	--	1.8 (0.9)	1.6 (0.8)	0.03
For subjects attaining a plateau:						
Length of follow-up, years	16.4 (0.6)	16.3 (0.8)	16.4 (0.3)	16.4 (0.7)	16.4 (0.7)	0.44
No. spirometry measures after plateau start, mean (SD) [minimum, maximum]	4.4 (2.0) [2, 10]	5.8 (2.1) [2, 13]	4.6 (2.4) [2, 10]	6.1 (2.2) [4, 13]	5.3 (2.3) [3, 7]	<0.001
Time from randomization to plateau start, years	12.7 (2.3)	10.8 (2.0)	12.5 (2.3)	10.7 (2.2)	11.4 (2.3)	<0.001
Time from plateau start to last visit, years	3.7 (2.1)	5.4 (2.1)	3.0 (2.4)	5.7 (2.2)	4.9 (3.3)	<0.001
Decline phase: N (%)						
Age at start of decline, years	24	21.1 (2.3)	-	21.3 (2.0)	21.2 (2.2)	0.46
Had an early decline‡¶: N (%)	-	178 (100%)	-	176 (100%)	354 (52%)	
Time from decline to last visit, years	-	5.0 (2.3)	--	5.0 (2.3)	5.0 (2.5)	0.76
No. spirometry measures after decline start, mean (SD) [minimum, maximum]	--	5.5 (2.5) [2, 12]	--	5.5 (2.3) [2, 12]	5.5 (2.4) [2.0, 12]	0.94
Rate of decline (mL pre-BD FEV ₁ /yr), mean (SD) [minimum, maximum]	--	-50 (54) [-295, 0]	--	-53 (59) [-506, 0]	-51 (57) [-506, 0]	0.99
Rate of decline (% predicted pre-BD FEV ₁ /yr), mean (SD) [minimum, maximum]	--	-1.1 (1.2) [-6.3, 0]	--	-1.1 (1.4) [-11.6, 0]	-1.1 (1.3) [-11.6, 0]	0.79
Lung function at randomization:						
% predicted pre-BD FEV ₁	100.5 (13.4)	99.7 (12.9)	87.5 (12.6)	83.8 (12.9)	93.0 (14.9)	<0.001
% predicted pre-BD FVC	107.7 (12.0)	107.1 (11.2)	99.6 (12.4)	96.3 (12.6)	102.7 (13.0)	<0.001
Pre-BD FEV ₁ /FVC (%)	81.9 (6.9)	81.6 (7.5)	76.5 (7.9)	76.5 (8.4)	79.2 (8.1)	<0.001
Bronchodilator response**(%)	8.9 (7.8)	8.2 (7.8)	12.7 (9.9)	12.4 (11.3)	10.5 (9.5)	<0.001
Airway responsiveness**(log mg/ml)	0.3 (1.2)	0.4 (1.1)	-0.2 (1.1)	-0.2 (1.1)	0.1 (1.2)	<0.001

Lung function at last follow-up visit:						
% predicted pre-BD FEV ₁	104.3 (7.6)	97.7 (9.5)	87.1 (7.9)	79.7 (10.0)	92.2 (13.0)	<0.001
% predicted pre-BD FVC	109.9 (8.9)	105.7 (10.3)	100.6 (10.8)	94.7 (10.9)	102.7 (11.7)	<0.001
Pre-BD FEV ₁ /FVC (%)	80.4 (6.4)	78.1 (7.2)	73.0 (8.0)	71.2 (9.6)	75.7 (8.7)	<0.001
Post-BD FEV ₁ /FVC (%)	83.3 (6.1)	81.8 (6.2)	77.0 (7.6)	75.6 (8.6)	79.4 (7.9)	<0.001
Bronchodilator response**(%)	3.7 (2.9)	5.2 (5.4)	6.1 (4.7)	8.2 (9.1)	5.8 (6.2)	<0.001
Airway responsiveness**(log mg/ml)	2.4 (1.4)	2.3 (1.5)	1.7 (1.7)	1.5 (1.8)	2.0 (1.6)	<0.001
Have chronic airflow obstruction (pre-BD)††	11 (6%)	21 (12%)	56 (35%)	75 (41%)	163 (24%)	<0.001
Have chronic airflow obstruction (post-BD)‡‡	2 (1%)	9 (5%)	25 (16%)	37 (21%)	73 (11%)	<0.001

Number (percent of pattern) or mean (SD), unless otherwise noted.

Abbreviations: BD = bronchodilator

* Participants with a determined pattern and at least 1 spirometry measure at age 23 years or higher were included.

† P value (2-sided) for difference across pattern groups determined from either a chi-square test for non-ordered categories (categorical variables) or ANOVA (continuous variables).

‡ P value (2-sided) for difference across the 2 pattern groups with either participants attaining a plateau or having an early decline determined from either a chi-square test for non-ordered categories (categorical variables) or ANOVA (continuous variables); the data of the 1 participant with NG was excluded.

§ Rate of decline from the maximum attained lung function to study end estimated from each participant's visit spirometry measures between age at maximum lung function and end of follow-up divided by the number of years from the attainment of maximum to end of study; the smoothed curve's lung function estimates were not utilized in this estimation.

¶ 1 participant with a NG pattern was determined to have a decline; however, the decline was not earlier than expected.

|| Rate of decline estimated from each participant's visit spirometry measures between age at start of decline and end of follow-up divided by the number of years from the start of decline to end of study; the smoothed curve's lung function estimates were not utilized in this estimation; therefore, 27 (8%) participants did not exhibit a negative rate using this method and were excluded from the averages reported. The average including all participants was: -43 (65) mL FEV₁/yr decline, 9.9 (1.5) % predicted FEV₁/yr decline, no difference between NG/ED and RG/ED.

** Bronchodilator response defined as [(post-BD FEV₁ - pre-BD FEV₁)/pre-BD FEV₁] * 100; airway responsiveness defined as the concentration of methacholine interpolated between a concentration in the nebulizer that when aerosolized caused a 20 percent decrease in FEV₁ and one that did not.

†† Chronic airflow obstruction defined as pre-BD FEV₁/FVC<0.70; using the modified definition pre-BD FEV₁/FVC<LLN (NHANES III 5th percentile value): 28 (16%) of NG, 52 (29%) of NG/ED, 85 (53%) of RG, 105 (60%) of RG/ED, 270 (39%) of 684 subjects (P<0.001)

‡‡ Chronic airflow obstruction defined as post-BD FEV₁/FVC<0.70 as specified by the GOLD spirometric classification criterion; using the modified GOLD criteria defined as post-BD FEV₁/FVC<LLN (NHANES III 5th percentile value): 10 (6%) of NG, 19 (11%) of NG/ED, 57 (36%) of RG, 63 (36%) of RG/ED, 149 (22%) of 684 subjects (P<0.001)

Table S5: Additional baseline characteristics and end of study smoking status of participants by pattern of lung function growth and decline

	Normal Growth (N=170)	Normal Growth/ Early Decline (N=178)	Reduced Growth (N=160)	Reduced Growth/ Early Decline (N=176)	P*
Pattern, %	25%	26%	23%	26%	
Trial treatment group:					0.94
Budesonide	53 (31%)	51 (29%)	45 (28%)	51 (29%)	
Nedocromil	46 (27%)	59 (33%)	50 (31%)	53 (30%)	
Placebo	71 (42%)	68 (38%)	65 (41%)	72 (41%)	
Demographic/Physical exam:					
Race/ethnicity:					<0.001
White non-Hispanic	125 (74%)	114 (64%)	110 (69%)	107 (61%)	
Black non-Hispanic	31 (18%)	31 (17%)	14 (9%)	17 (10%)	
Other non-Hispanic	3 (2%)	10 (6%)	17 (11%)	15 (9%)	
Hispanic	11 (6%)	23 (13%)	19 (12%)	37 (21%)	
Parent education†: College degree or higher	97 (57%)	97 (54%)	78 (49%)	87 (49%)	0.35
Income < \$30,000	46 (27%)	36 (20%)	28 (18%)	34 (19%)	0.13
Age at puberty†, years	11.1 (1.4)	11.1 (1.4)	11.3 (1.5)	11.4 (1.3)	0.08
Vitamin D insufficiency (≤ 30 ng/ml) at randomization	50 (30%)	70 (40%)	59 (38%)	68 (39%)	0.15
Asthma history/Atopy/Inflammation:					
Moderate severity	79 (47%)	104 (58%)	82 (51%)	95 (54%)	0.16
Maternal history of asthma	42 (25%)	53 (30%)	52 (33%)	49 (28%)	0.36
Ever had a physician diagnosis of eczema	46 (27%)	52 (29%)	33 (21%)	31 (19%)	0.04
≥ 3 positive skin tests	120 (71%)	134 (75%)	116 (73%)	143 (81%)	0.11
Eosinophils ≥275 cells/μL	109 (65%)	112 (64%)	102 (65%)	122 (70%)	0.65
Serum IgE ≥ 1150 ng/ml	52 (31%)	43 (25%)	47 (30%)	55 (32%)	0.48
Sensitive and exposed to perennial allergen†	122 (72%)	132 (74%)	116 (73%)	137 (78%)	0.58
Smoking‡ exposure:					
Smoke‡ (ever)	63 (37%)	58 (33%)	57 (36%)	59 (34%)	0.82
Lifetime smoked‡ (pack-years)	0.5 (1.5)	0.4 (1.4)	0.4 (1.1)	0.5 (1.5)	0.97
Number (percent of pattern) or mean (SD). Abbreviations: IgE=immunoglobulin E * P value (2-sided) for difference across pattern groups determined from either a chi-square test for non-ordered categories (categorical variables) or ANOVA (continuous variables). † Parent education denotes the highest level reached by either parent; age at puberty defined as the year of age when at least 1 Tanner component (pubic hair and either breast for girls or genital stage for boys) greater than Stage 1; perennial allergens include dog, cat, cockroach, mite, mold. ‡ Cigarette smoking only; smoking and amount determined through the end of follow-up					

Table S6: Relative odds of completing spirometric testing at age 23 years or older in relation to baseline characteristics

Baseline characteristics	Completers vs. Non-completers*		
	O.R.†	95% C.I.†	P†
Sex: male vs. female	0.98	0.73-1.32	0.90
Age at randomization (years)	1.69	1.53-1.87	<0.001
Race/ethnicity:			0.57
White Non-Hispanic	1.00		
Non-Hispanic Black	1.17	0.73-1.87	0.51
Any Hispanic	1.26	0.77-2.06	0.36
Asthma severity: moderate vs. mild	0.93	0.69-1.27	0.66
Duration since asthma diagnosis:			0.89
Medium (< 3 years)	1.00		
Short (3-6 years)	0.93	0.65-1.31	0.67
Long (≥7 years)	1.02	0.67-1.56	0.93
Tanner stage 1 (vs. stage 2-5)‡	1.77	1.16-2.70	0.008
≥ 3 positive skin tests (yes vs. no)	1.16	0.75-1.78	0.51
Assigned treatment group:			0.51
Budesonide vs. Placebo	0.87	0.62-1.23	0.44
Nedocromil vs. Placebo	1.09	0.76-1.54	0.65
<p>* Completer defined as a participant having at least one spirometric measure at age 23 years or older and a defined lung function growth pattern. A non-completer is defined as a participant with insufficient longitudinal spirometric data or having a lung function growth pattern that is not defined by one of the 4 growth pattern groups.</p> <p>† OR (odds ratios), 95% C. I. (confidence interval), and P values derived from multiple logistic regression analyses comparing baseline characteristics in relation to completers versus non-completers. All covariates listed in the table were included in the model; additionally the model also included indicator variables for clinic.</p> <p>‡ Tanner stage 1 defined as pre-pubertal, i.e., no Tanner components (pubic hair and either breast for girls or genital stage for boys) greater than Stage 1.</p> <p>Note: Of the 1041 participants randomized into the CAMP trial, data for a total of 1036 (99.5%) participants were included in the logistic regression distributed as follows: 681 in completer group and 355 in the non-completer group. Missing data in 1 or more of the predictors excluded 5 participants from inclusion in the regression.</p>			

Table S7: Multinomial regression of demographic and clinical risk factors of 4 patterns of lung function growth and decline: results for all predictors in the model

	NG/ED vs. NG				RG vs. NG				RG/ED vs. NG			
	Normal Growth/Early Decline vs. Normal Growth				Reduced Growth vs. Normal Growth				Reduced Growth/Early Decline vs. Normal Growth			
	OR	95% C.I.	P*		OR	95% C.I.	P*		OR	95% C.I.	P*	
BASELINE:												
Lung function												
Pre-BD FEV ₁ % predicted	1.00	0.97	1.03	0.90	0.86	0.83	0.90	<0.001	0.85	0.82	0.88	<0.001
Bronchodilator response† (%)	1.01	0.97	1.06	0.60	0.91	0.87	0.96	<0.001	0.91	0.87	0.95	<0.001
Airway responsiveness† (log _e (mg/ml))	1.03	0.79	1.34	0.83	0.61	0.44	0.84	<0.001	0.66	0.49	0.89	0.008
Demographic:												
Sex: Male vs. female	1.40	0.82	2.39	0.22	8.18	4.14	16.16	<0.001	3.07	1.65	5.68	<0.001
Age (yrs)	1.06	0.86	1.31	0.58	0.55	0.43	0.70	<0.001	0.62	0.49	0.80	<0.001
Race: White Non-Hispanic	1.00			0.86	1.00			0.25	1.00			0.42
Non-Hispanic Black	1.07	0.49	2.36	0.86	0.44	0.16	1.22	0.12	0.57	0.21	1.54	0.27
Any Hispanic	1.19	0.44	3.25	0.73	1.14	0.37	3.50	0.82	1.27	0.45	3.55	0.65
Income: < \$30,000 vs. ≥\$30,000	0.55	0.28	1.09	0.09	0.54	0.24	1.22	0.14	0.74	0.34	1.58	0.43
Highest parent education†: college degree or higher vs. some college or less	0.70	0.39	1.27	0.24	0.33	0.17	0.66	0.002	0.43	0.22	0.83	0.01
Asthma:												
Severity: moderate vs. mild	1.72	0.99	3.01	0.06	0.79	0.41	1.55	0.50	0.79	0.41	1.49	0.46
Duration since diagnosis:				0.89				0.65				0.31
Medium (< 3 yrs)	1.00				1.00				1.00			
Short (3 - 6 yrs)	0.99	0.53	1.84	0.97	0.83	0.40	1.74	0.63	0.84	0.41	1.75	0.65
Long (≥ 7 yrs)	1.17	0.60	2.27	0.65	1.27	0.59	2.76	0.54	1.61	0.77	3.37	0.21
Maternal history of asthma (yes vs. no)	1.21	0.67	2.19	0.54	1.90	0.96	3.77	0.07	1.08	0.56	2.11	0.82
Physical:												
BMI Z-score	1.39	1.07	1.82	0.02	0.81	0.60	1.09	0.17	1.02	0.76	1.36	0.89
Age at puberty† (yrs)	1.08	0.88	1.32	0.45	1.19	0.93	1.52	0.16	1.21	0.95	1.54	0.13
Vitamin D (≤30 vs. >30 ng/ml)	1.35	0.76	2.41	0.31	2.15	1.10	4.23	0.03	1.64	0.85	3.14	0.14
Atopy/Inflammation:												
3+ positive skin test vs. <3	1.21	0.62	2.34	0.58	1.18	0.54	2.60	0.67	2.42	1.09	5.33	0.03
Eczema (ever physician diagnosis; yes vs. no)	1.01	0.56	1.84	0.96	0.90	0.43	1.89	0.79	0.69	0.34	1.43	0.32
Serum IgE: ≥ 1150 vs. <1150 ng/ml	0.61	0.33	1.11	0.11	0.64	0.32	1.28	0.21	0.75	0.39	1.45	0.39
Eosinophils: ≥275 vs. <275 cells/μL	1.06	0.59	1.92	0.84	0.54	0.27	1.09	0.09	0.64	0.32	1.26	0.20
Exposures:												
Maternal smoking during	2.33	1.03	5.26	0.04	1.09	0.41	2.89	0.87	2.22	0.89	5.51	0.09

gestation‡ (yes vs. no)													
Sensitive and exposed to perennial allergen† (yes vs. no)	0.98	0.52	1.83	0.94	0.99	0.47	2.10	0.98	0.86	0.41	1.78	0.68	
Assigned trial treatment group:				0.40				0.44				0.90	
Budesonide vs. Placebo	0.78	0.42	1.44	0.42	0.63	0.30	1.31	0.22	0.85	0.42	1.73	0.66	
Nedocromil vs. Placebo	1.22	0.66	2.26	0.52	0.74	0.36	1.52	0.42	0.96	0.48	1.92	0.91	
Treatment 6 months before randomization:													
Inhaled corticosteroid(days/wk)	1.00	0.89	1.11	0.95	1.11	0.99	1.25	0.07	1.10	0.98	1.23	0.11	
No. days on prednisone	1.04	0.99	1.10	0.15	0.99	0.93	1.06	0.86	1.00	0.94	1.07	0.99	
Morbidity year before randomization:													
Urgent care visits due to asthma (No.)	1.00	1.00	1.00	0.09	1.00	1.00	1.00	0.27	1.00	1.00	1.00	0.24	
Hospitalizations due to asthma (any vs none)	1.23	0.37	4.09	0.74	1.71	0.49	6.01	0.40	0.61	0.16	2.41	0.49	
Use of albuterol for symptoms (puffs/wk)	0.99	0.96	1.03	0.79	1.00	0.97	1.04	0.98	1.00	0.97	1.04	0.98	
FOLLOW-UP:													
Treatment through end of trial or age 18:													
Mean ICS dose/yr through end of trial	1.01	0.99	1.03	0.41	1.01	0.99	1.03	0.41	1.01	0.99	1.03	0.22	
No. prednisone courses/year through trial	0.60	0.18	2.00	0.41	0.65	0.18	2.31	0.50	0.62	0.18	2.09	0.44	
No. prednisone courses/year from trial end to age 18	1.15	0.37	3.55	0.81	4.12	1.14	14.91	0.03	2.73	0.82	9.06	0.10	
Morbidity (through trial):													
Urgent care visits (no./PY)	1.00	0.99	1.01	0.52	1.00	0.99	1.01	0.78	1.00	0.99	1.01	0.65	
Hospitalizations (any)	0.49	0.17	1.43	0.19	0.36	0.11	1.16	0.09	0.26	0.08	0.81	0.02	
Episode free days† (%)	1.01	1.00	1.03	0.03	1.01	0.99	1.02	0.27	1.00	0.99	1.02	0.71	
Exposure (through end of follow-up)													
Smoked 100 or more cigarettes by age 18‡ (yes vs. no)	0.71	0.33	1.56	0.40	1.17	0.48	2.85	0.73	0.53	0.21	1.31	0.17	
Abbreviations: BD=bronchodilator; rz=randomization; BMI=body mass index; IgE=immunoglobulin E; ICS=inhaled corticosteroids													
* Multinomial model conditional odds ratios (OR), 95% confidence limits (C.I.), and P values derived from multinomial regression analysis comparing NG/ED, RG, RG/ED to NG. All covariates listed in the table were included in the model; 7 indicator variables to account for the fixed effects of clinical site were also included in the model. Of the 684 participants with spirometry at age 23 or older, 614 (90%) had complete data on all variables and are included in the table. The 614 subjects were distributed among the groups as: 162 (26%) in NG/ED, 138 (22%) in RG, 158 (26%) in RG/ED, and 156 (25%) in NG.													
† Bronchodilator response defined as $[(\text{post-BD FEV}_1 - \text{pre-BD FEV}_1)/\text{pre-BD FEV}_1] * 100$; airway responsiveness defined as the concentration of methacholine that caused a 20 percent decrease in FEV ₁ ; highest parent education denotes the highest level reached by either parent; age at puberty defined as the year of age when at least 1 Tanner component (pubic hair and either breast for girls or genital stage for boys) was greater than Stage 1; perennial allergens include dog, cat, cockroach, mite, mold; episode free day defined as a day with no night awakenings, morning and evening peak flow ≥ 80 percent of personal best peak flow, no use of albuterol for symptoms, no use of prednisone, no absence from school or contact with a physician because of asthma symptoms, and no episode of wheezing, coughing, chest tightness, or shortness of breath.													
‡ Cigarette smoking only													

Part 2. Pattern Classification Procedures Protocol and coding sheets

Part 2A. CAMP Pattern Classification Procedures Protocol

CAMP Procedure for Lung Growth and Decline Pattern Classification

Materials: Each expert pulmonologist was provided with a hard copy book of printouts, one page for each CAMP participant; each page contained the smoothed pre-bronchodilator FEV₁ spirometry plot by age, raw data points, and the NHANES III 50th, 25th, 10th, and 5th percentile curves for someone of that sex, age, race/ethnicity and height for one participant (see Figure 1). Participants were identified with a new random ID number developed for grading (i.e., not their standard CAMP patient ID number). All data through March 1, 2012 were used to calculate these curves. There are no duplicate subjects in this set of 1,041. The order of the subjects is by random ID; the ID number assigned is neither the CAMP subject ID nor the ID used for the subject if they were in the 443 (November 2009) or 563 (October 2010) pattern sets.

Instructions: Each curve should first be classified into one of the four distinct patterns, if possible, using the smoothed curve (NOT the data points) in relation to the NHANES III reference curves. Then, determination of whether maximum growth has been attained, and whether there is a plateau or an earlier than expected decline. As a reminder, the overall pattern classification should be based on a gestalt assessment using the NHANES III reference curves as rough guidelines as below:

1. Classification of each participant as NG or RG:
 - Normal growth (NG) defined as almost always above the 25th percentile (see Example 2A, ID=1004).
 - Reduced growth (RG) defined as almost always below the 25th percentile (see Example 2B, ID=1006).

2. Classification of each participant as ED or No ED:
 - Early decline (ED) is defined as the curve rises, may plateau, and then decreases at an earlier age than expected when compared to NHANES III percentile curves.
 - No early decline is defined as any decrease in the curve following the “expected” pattern of lung function from the NHANES III 50th percentile reference curve (See Examples 2C and 2D, ID=1014 (NG/ED) and ID=1005 (RG/ED), respectively).
 - CAUTION: A data point at the very end of the curve may cause the pattern to appear to have a decline or uptick; but this may be spurious due to the influence of the last point (see Examples 2E, 2F, and 2G, IDs=1172, 1632, 1228, respectively).
 - The height of the NHANES III percentile reference curve is not used to determine whether “decline” has occurred. The *height* of the smoothed curve helps to determine whether the pattern is normal or reduced. Use the “expected” *pattern* from the lung function growth 50th percentile reference curve to determine whether the decline has occurred *earlier* than expected. Example 2H, ID=1956, displays a NG pattern with a decline, in which the decline occurs at the age expected; therefore, the pattern is coded as NG without early decline (Pattern code 1).

3. Coding of the “undetermined”:

- If there is enough data to determine a pattern but the pattern does not fit in any of the 4 categories, then this pattern should be coded as “(9) Undetermined Pattern” (see Example 3A, ID=1056).
 - If there is NOT enough data to determine a pattern, then code this as “(8) Sparse data” – the last choice of the pattern choices (see Examples 3B and 3C, IDs=1038, 1481, respectively).
4. Determination of maximal lung function, start of plateau, and start of decline.
- These 3 events are to be determined independent of accompanying NHANES III percentile curves; the age at which each phase begins and if the phase has occurred should be based on the participant’s individual smoothed pattern.
 - Determine whether maximum lung function growth has been attained. There is a checkbox for this on the form (see Examples 4A and 4B, ID=1140 for NG not reaching maximum lung function, ID=1018 for NG reaching maximum lung function). When maximum lung function growth occurs at the last collection of data so that it cannot be determined whether the curve will continue to rise, then check choice “No.”
 - There are also checkboxes for whether the plateau phase has begun (i.e., the smoothed lung function curve levels off after reaching maximum lung function”) or there is no plateau (i.e., the smoothed lung function curve does not reach maximum lung growth, but continues to rise) (see Example 4C, ID=1441 for RG with a plateau).
 - If the decline phase begins immediately after the maximum lung function is attained, then check “No plateau”, “yes” decline started, and code age at plateau as “99” (see Example 4D, ID=1907 for NG/ED with no plateau and immediate decline).
 - If a phase has not begun, then code the corresponding age question for that phase as “99” (see Example 4E, ID=1759 for RG without reaching maximum lung function, a plateau start or a decline).
 - The age of attained maximum lung function and the age at the start of the plateau (if there is a plateau) must be the same. Write the age in years on the appropriate age line.
 - The age in years at which decline begins should be noted. If a decline has not started, then code age at decline as “99”.

Procedure:

1. The 2 pulmonologists should BOTH classify the FIRST 50 patterns.
2. The 2 pulmonologists should SCAN and e-mail (or mail) the first 50 pages to DCC. The scanned coded sheets should be sent prior to the date of the teleconference to assess agreement between the independent coding of the first set of patterns.
3. The 2 pulmonologists should teleconference to compare classifications; DCC’s representation is optional, but suggested, on this call.
4. Depending on their gestalt on the degree of agreement on the classifications, the 2 pulmonologists can each classify an additional 30 - 50 patterns, then SCAN and e-mail forms to DCC, and teleconference to compare results.
5. Once the 2 pulmonologists are satisfied that high agreement has occurred, then ONLY the first pulmonologist will classify the remaining patterns.
6. When the first pulmonologist is finished classifying the remaining patterns, he should SCAN the pages (in sets) and email to the DCC for data entry and analysis.

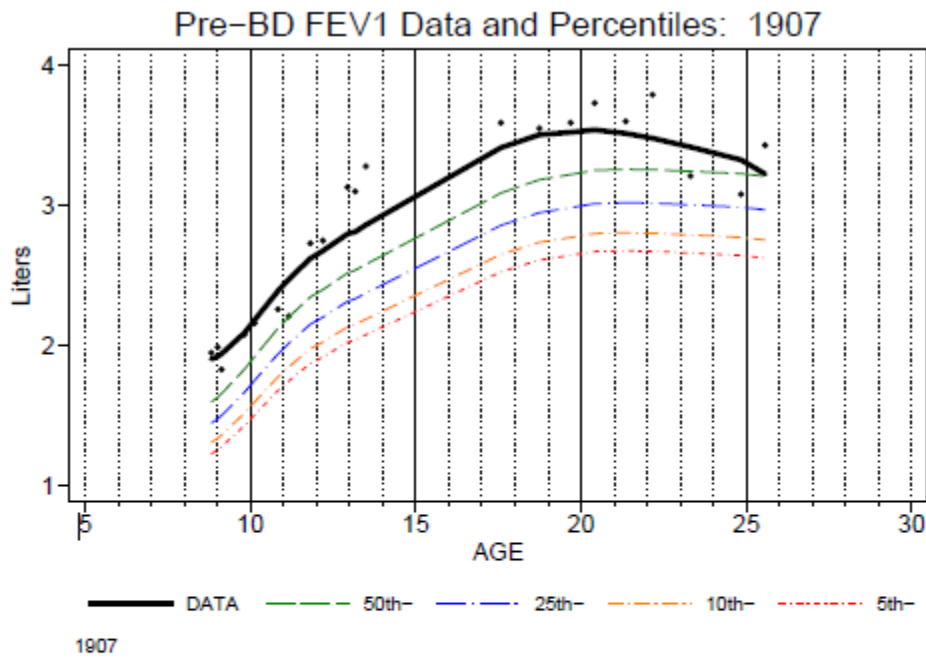
Adjudication of patterns the first pulmonologist could not grade conclusively:

1. The first pulmonologist sends the pattern ID number to DCC and to the second pulmonologist for a determination.
2. Results are shared after determination and patterns for which a conclusive grading was not met are discussed by the 2 pulmonologists and the DCC statistician; the first pulmonologist will make the final determination for that pattern.
3. The goal is to keep this set of patterns small; the first pulmonologist should attempt to make the grading based on his best judgment as much as possible.

Example 1A: Pattern Classification Form

09/08/2015

Page 456 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: (1) Yes (0) No
 Plateau started: (2) No plateau (1) Yes (0) No
 Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ____ . ____

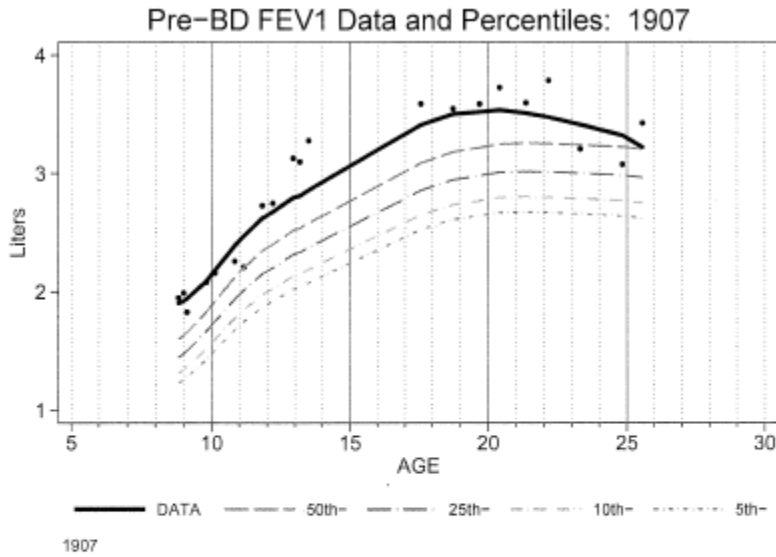
Start of Plateau: ____ . ____

Start of Decline: ____ . ____

Example 1B: Coded Pattern Classification Form

09/08/2015

Page 456 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: () Yes (0) No
 Plateau started: () No plateau (1) Yes (0) No
 Decline started: () Yes (0) No

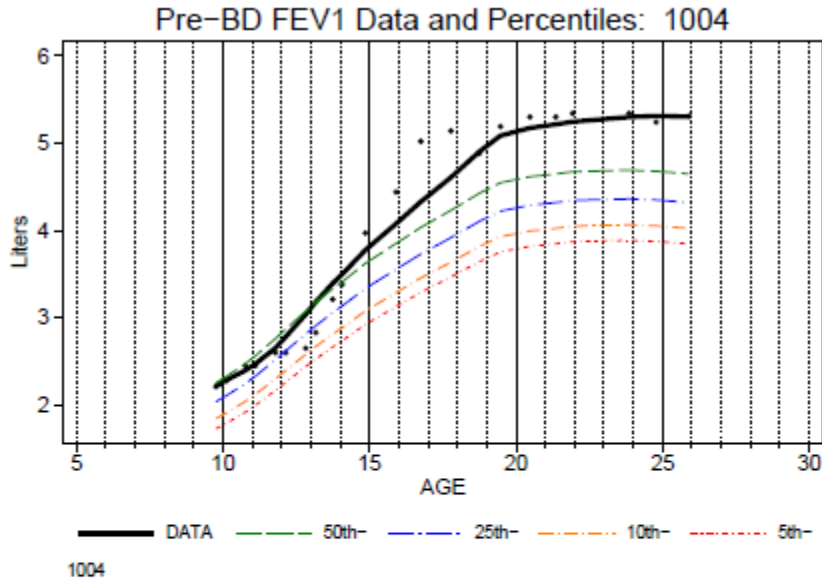
AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: 20.3
 Start of Plateau: 99.
 Start of Decline: 20.3

Example 2A: Normal Growth

09/08/2015

Page 1 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: (1) Yes (0) No

Plateau started: (2) No plateau (1) Yes (0) No

Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ____ - ____

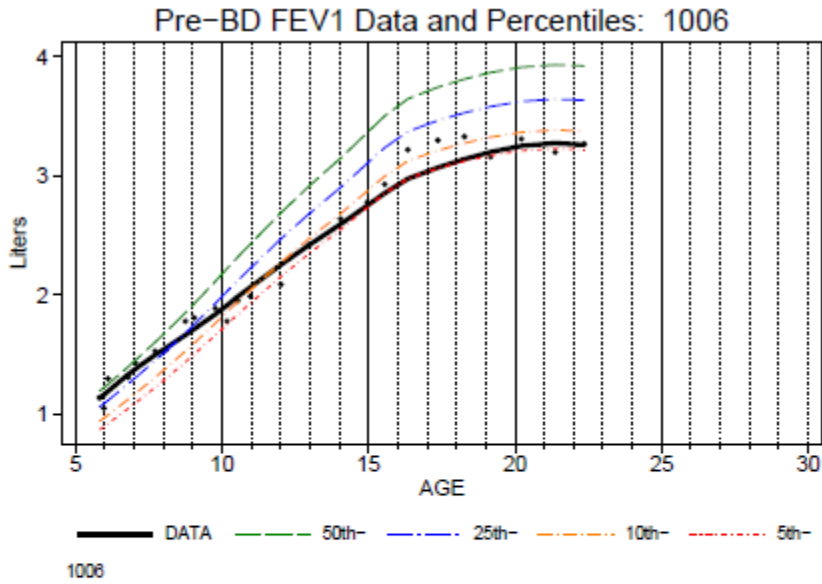
Start of Plateau: ____ - ____

Start of Decline: ____ - ____

Example 2B: Reduced Growth

09/08/2015

Page 485 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

- Maximum lung growth attained: (1) Yes (0) No
- Plateau started: (2) No plateau (1) Yes (0) No
- Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ____ - ____ - ____

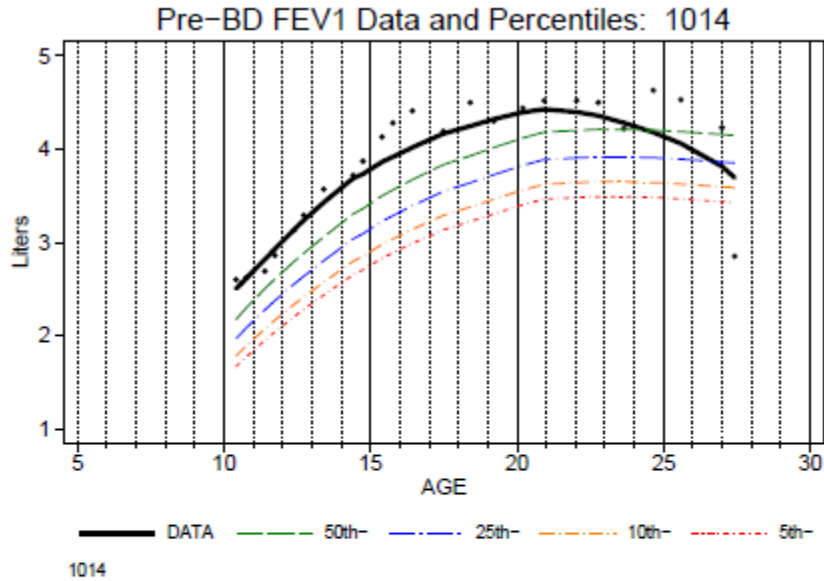
Start of Plateau: ____ - ____ - ____

Start of Decline: ____ - ____ - ____

Example 2C: Normal Growth with Early Decline

09/08/2015

Page 272 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

- Maximum lung growth attained: (1) Yes (0) No
- Plateau started: (2) No plateau (1) Yes (0) No
- Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ___ - ___

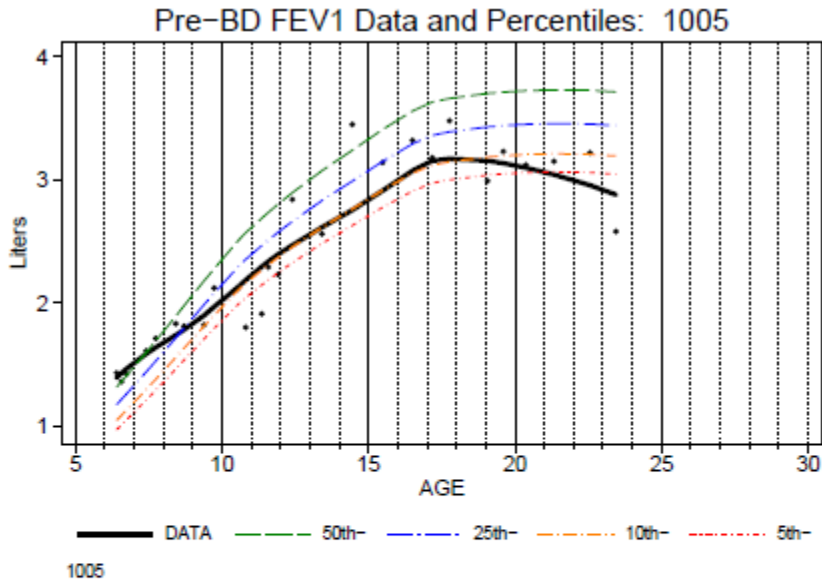
Start of Plateau: ___ - ___

Start of Decline: ___ - ___

Example 2D: Reduced Growth with Early Decline

09/08/2015

Page 743 of 1041



- PATTERN OF GROWTH/DECLINE (Check One)
- (1) Normal Growth
 - (2) Normal Growth, Early Decline
 - (3) Reduced Growth
 - (4) Reduced Growth, Early Decline
 - (9) Undetermined Pattern
 - (8) Undetermined - not enough data

- Maximum lung growth attained: (1) Yes (0) No
- Plateau started: (2) No plateau (1) Yes (0) No
- Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ____ - ____

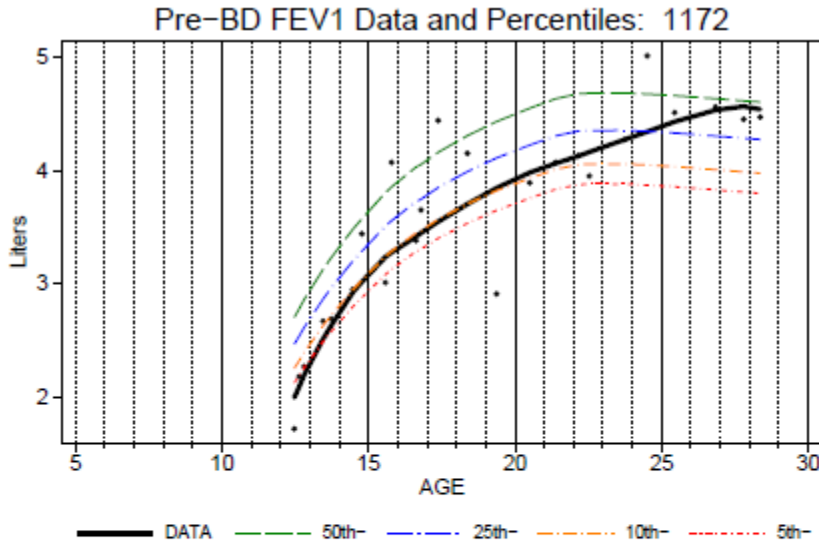
Start of Plateau: ____ - ____

Start of Decline: ____ - ____

Example 2E: RG - not enough data points to determine plateau or decline

09/08/2015

Page 524 of 1041



1172

PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: (1) Yes (0) No
 Plateau started: (2) No plateau (1) Yes (0) No
 Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ___ - ___

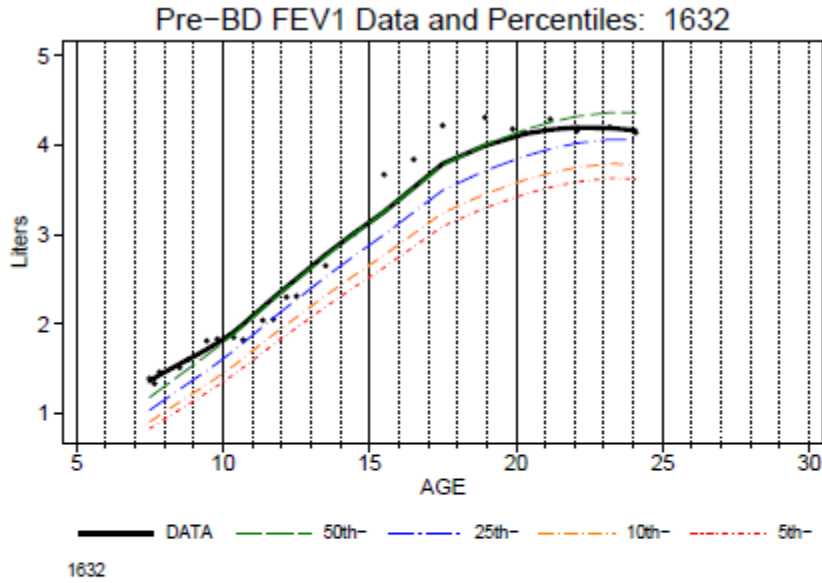
Start of Plateau: ___ - ___

Start of Decline: ___ - ___

Example 2F: NG/ED - adequate number of data points to determine decline

09/08/2015

Page 403 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: (1) Yes (0) No

Plateau started: (2) No plateau (1) Yes (0) No

Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ____ - ____

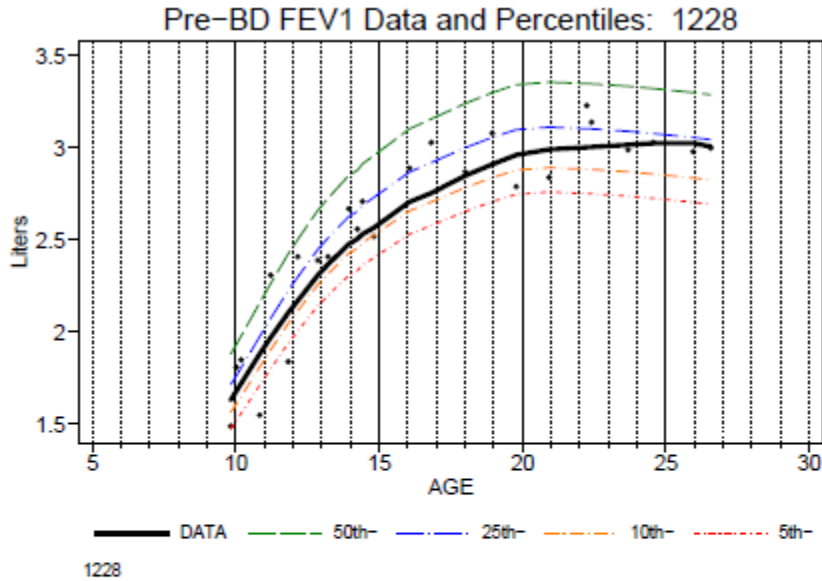
Start of Plateau: ____ - ____

Start of Decline: ____ - ____

Example 2G: RG - not enough data points to determine plateau or decline

09/08/2015

Page 535 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: (1) Yes (0) No

Plateau started: (2) No plateau (1) Yes (0) No

Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ____ - ____

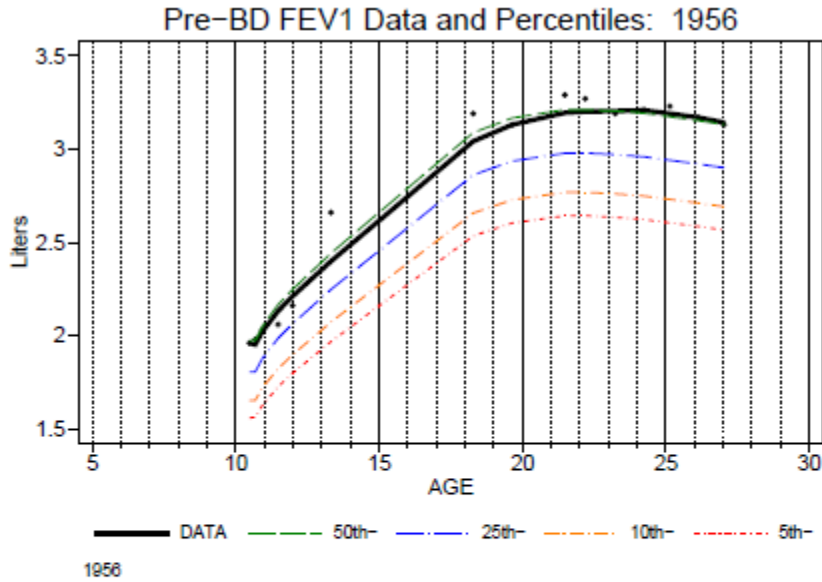
Start of Plateau: ____ - ____

Start of Decline: ____ - ____

Example 2H: NG with decline occurring at expected age

09/08/2015

Page 244 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: (1) Yes (0) No

Plateau started: (2) No plateau (1) Yes (0) No

Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ____ - ____

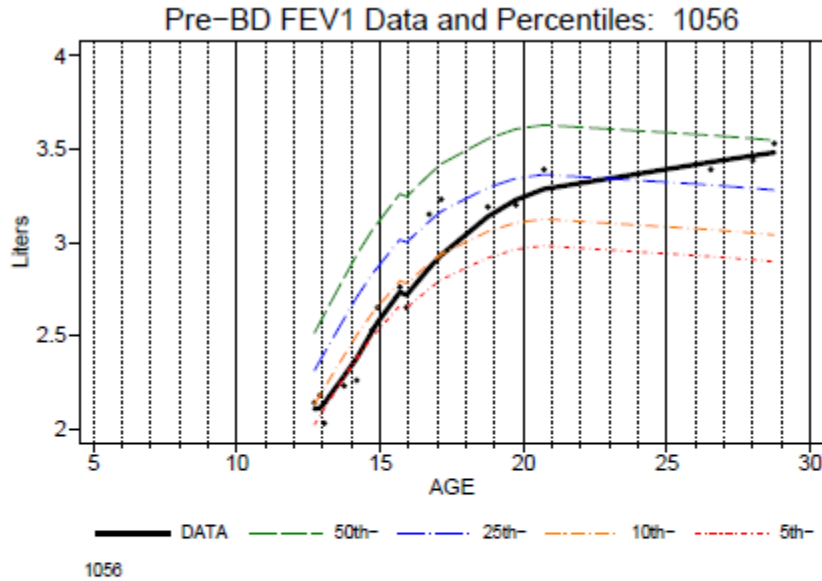
Start of Plateau: ____ - ____

Start of Decline: ____ - ____

Example 3A: Undetermined

09/08/2015

Page 1014 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: (1) Yes (0) No

Plateau started: (2) No plateau (1) Yes (0) No

Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ____ - ____

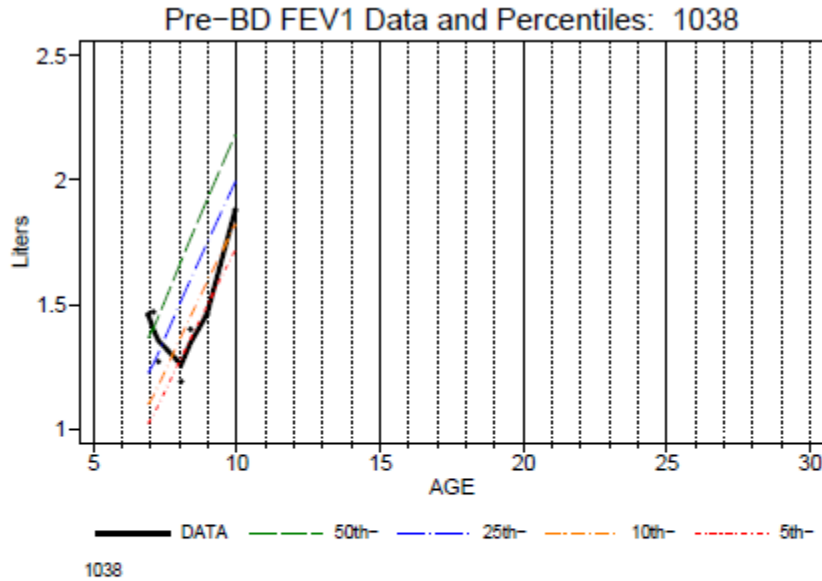
Start of Plateau: ____ - ____

Start of Decline: ____ - ____

Example 3B: Sparse Data

09/08/2015

Page 950 of 1041



- PATTERN OF GROWTH/DECLINE (Check One)**
- (1) Normal Growth
 - (2) Normal Growth, Early Decline
 - (3) Reduced Growth
 - (4) Reduced Growth, Early Decline
 - (9) Undetermined Pattern
 - (8) Undetermined - not enough data

- Maximum lung growth attained: (1) Yes (0) No
- Plateau started: (2) No plateau (1) Yes (0) No
- Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ____ - ____

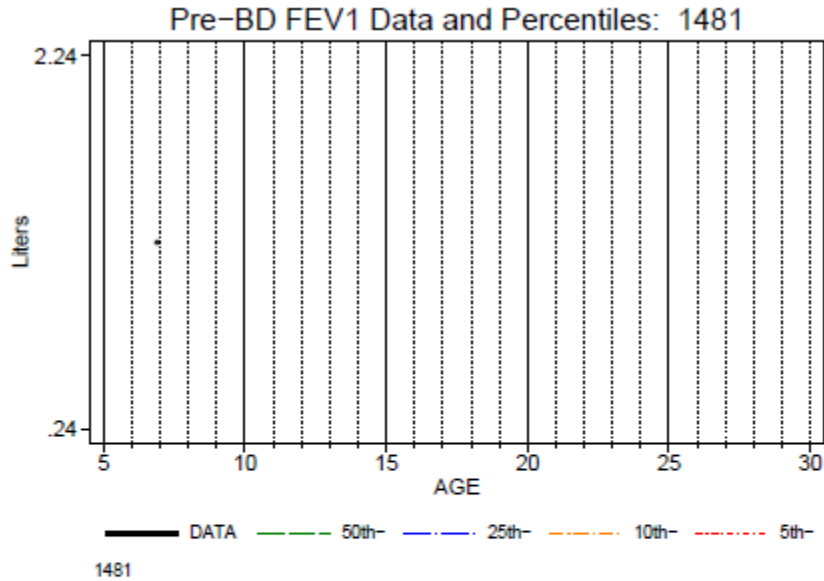
Start of Plateau: ____ - ____

Start of Decline: ____ - ____

Example 3C: Sparse Data

09/08/2015

Page 974 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: (1) Yes (0) No

Plateau started: (2) No plateau (1) Yes (0) No

Decline started: (1) Yes (0) No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: ____ - ____

Start of Plateau: ____ - ____

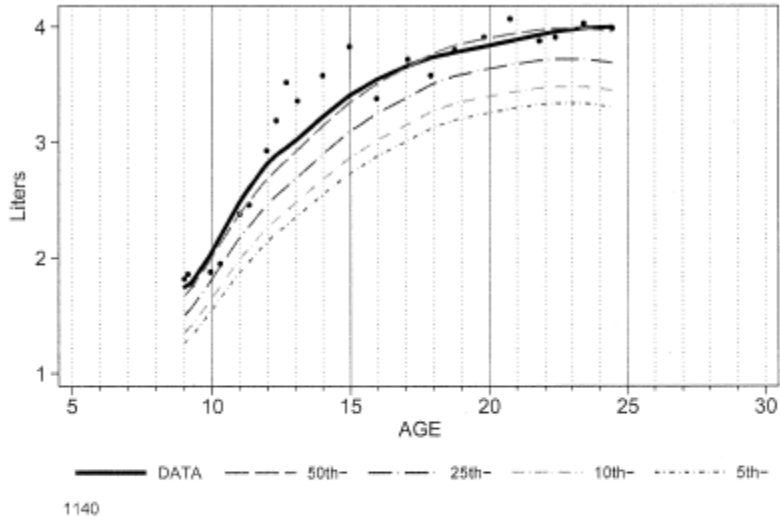
Start of Decline: ____ - ____

Example 4A: NG, no maximum lung function

09/08/2015

Page 40 of 1041

Pre-BD FEV1 Data and Percentiles: 1140



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

- Maximum lung growth attained: (1) Yes () No
- Plateau started: (2) No plateau (1) Yes () No
- Decline started: (1) Yes () No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: 9 9 .

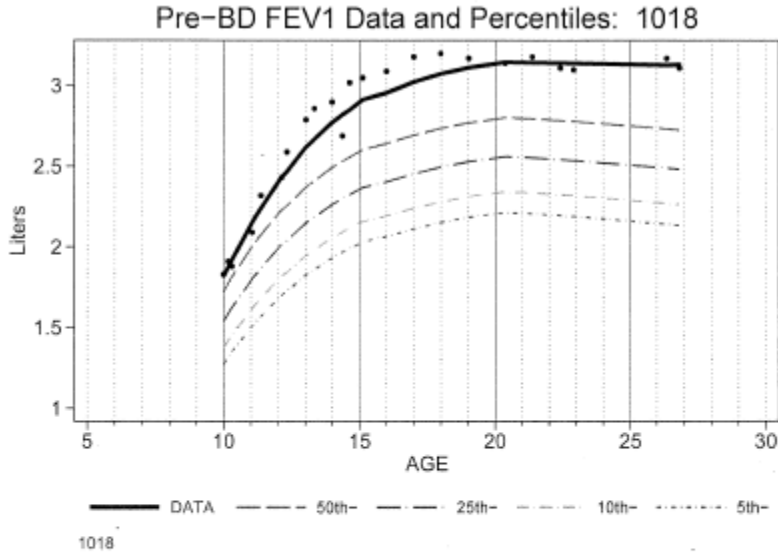
Start of Plateau: 9 9 .

Start of Decline: 9 9 .

Example 4B: NG, maximum lung function growth attained

09/08/2015

Page 6 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: Yes No
 Plateau started: No plateau Yes No
 Decline started: Yes No

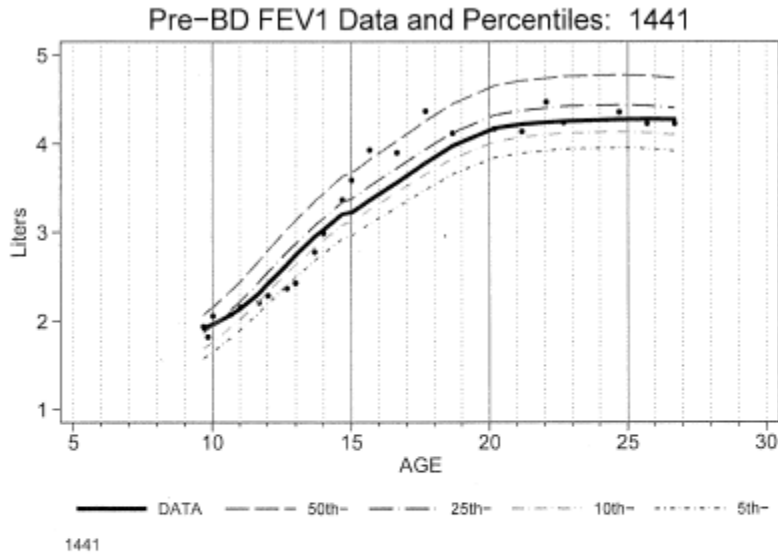
AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: 20 . 0
 Start of Plateau: 20 . 0
 Start of Decline: 99 .

Example 4C: RG, plateau begun

09/08/2015

Page 593 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: (1) Yes (0) No
 Plateau started: (2) No plateau (1) Yes (0) No
 Decline started: (1) Yes (0) No

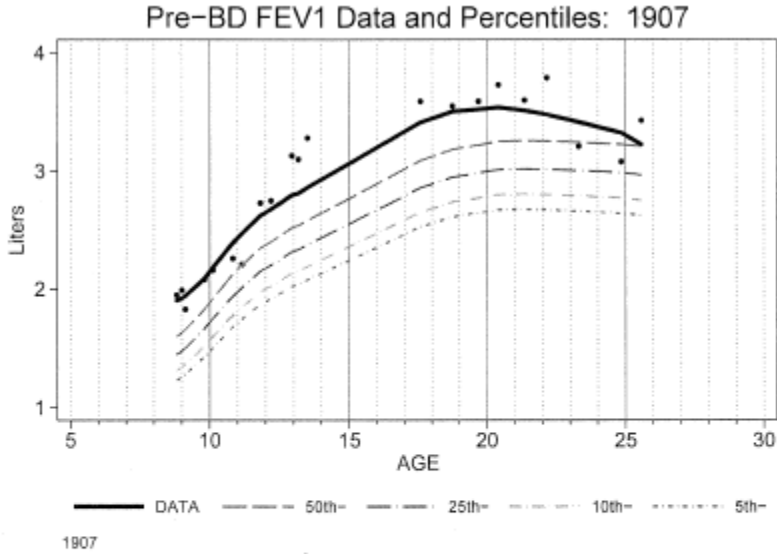
AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: 23.0
 Start of Plateau: 23.0
 Start of Decline: 99.0

Example 4D: NG/ED, with an immediate decline

09/08/2015

Page 456 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: () Yes (0) No
 Plateau started: () No plateau (1) Yes (0) No
 Decline started: () Yes (0) No

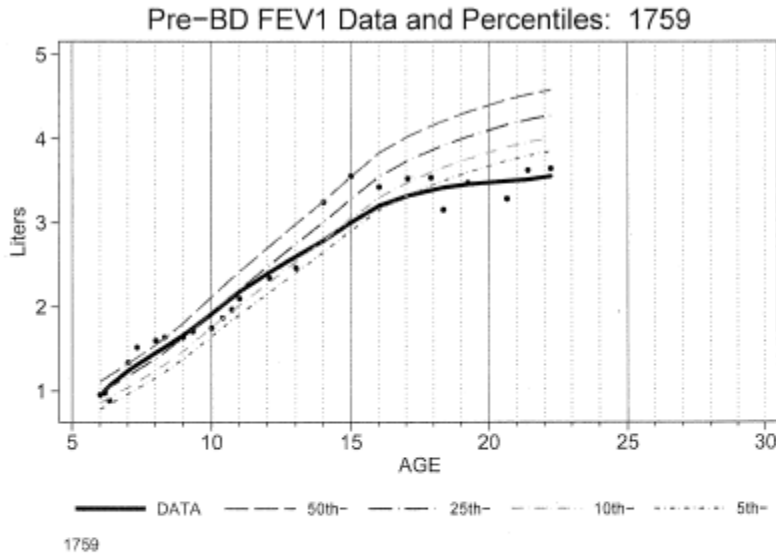
AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: 20.3
 Start of Plateau: 99.
 Start of Decline: 20.3

Example 4E: RG, maximum lung function not attained, no plateau or decline started

09/06/2015

Page 677 of 1041



PATTERN OF GROWTH/DECLINE (Check One)

- (1) Normal Growth
- (2) Normal Growth, Early Decline
- (3) Reduced Growth
- (4) Reduced Growth, Early Decline
- (9) Undetermined Pattern
- (8) Undetermined - not enough data

Maximum lung growth attained: (1) Yes No
 Plateau started: (2) No plateau (1) Yes No
 Decline started: (1) Yes No

AGE AT each of the following periods (use '99' if N/A):

Maximum Lung Growth: 99 . __
 Start of Plateau: 99 . __
 Start of Decline: 99 . __

Supplementary Appendix 2. Pattern coding sheets for the 1041 CAMP participants. See Supplementary Data File *Appendix2B.CAMPcodingSheets.pdf*

Part 3. Public use data file of 1041 CAMP participants' pattern and spirometry data

Supplementary Appendix 3. CAMP patterns and spirometry public use data dictionary.

Supplementary Appendix 4. CAMP patterns and spirometry public use data file.

SAS Output file *CAMPPDFLinkage.xpt* contains the pattern code, age, spirometry measures and the NHANES III expected spirometry values at each spirometry visit of follow-up for the 1041 CAMP participants. Each participant is identified by a unique random ID which is the same ID used for the pattern coding sheets located in Supplementary Appendix 2, and the CAMP study public use data files located at the NHLBI BioLINCC Repository. The file *CAMPPDFLinkage.contents.pdf* contains the data dictionary and explanations of data contained in *CAMPPDFLinkage.xpt*.