

# THE LANCET

## Respiratory Medicine

### Supplementary appendix

This appendix formed part of the original submission and has been peer reviewed. We post it as supplied by the authors.

Supplement to: Hay AD, Redmond NM, Turnbull A, et al. Development and internal validation of a clinical rule to improve antibiotic use in children presenting to primary care with acute respiratory tract infection and cough: a prognostic cohort study. *Lancet Respir Med* 2016; published online Sept 1. [http://dx.doi.org/10.1016/S2213-2600\(16\)30223-5](http://dx.doi.org/10.1016/S2213-2600(16)30223-5).

WEB APPENDIX

Web Figure 1: Baseline Case Report Form

Page 1

CASE REPORT FORM

ID 999999  
 Today's date

Informed consent for study obtained

**Background information**  
 Mother's age   # children in home (inc. unwell child)    
 Does the mother smoke?  No  Yes  Don't know  
 Mother still breast feeding child at 3 months?  No  Yes  Don't know

DOB     
 Gender  Female  Male  
 Ethnicity    
*PTO for codes, if other ethnicity, please describe below*

**Carer reported symptoms**  
 How unwell does the parent consider the child to be?             
 Well  Very unwell

Duration of illness  days  
 Has illness got a lot worse recently?  No  Yes  
 If Yes, how many days ago did it start to get worse?  days

Symptoms present	During illness?			Last 24 hours?			Severity in last 24 hours (tick one)		
	No <sub>0</sub>	Yes <sub>1</sub>	If yes	No <sub>0</sub>	Yes <sub>1</sub>	If yes	Mild <sub>1</sub>	Moderate <sub>2</sub>	Severe <sub>3</sub>
Dry cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Productive/ wet cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barking/ croupy cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blocked or runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in cry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing faster than normal (shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheeze or whistling in the chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills/ shivering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting (including after cough)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking fewer fluids/ milk feeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low energy/ fatigue/ lethargy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disturbed sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Passing urine less often/ dryer nappies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Please tick NA if the child is too young/ uncommunicative for the parent to know about the following &gt; NA <input type="checkbox"/></i>									
Chest/ shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle aches all over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion/ disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Clinician examination and management**  
 Temperature    °C Pulse  bpm  
 Respiratory rate  bpm O<sub>2</sub> sat  %  Unable to take O<sub>2</sub> sat/no equipment  
 Consciousness level  normal  irritable  drowsy  
 Capillary refill time  2 seconds or less  3 seconds or more

**How unwell do you consider the child to be?**  
            
 Well  Very unwell

**Throat swab taken?**  No  Yes  
 If No, reason:  
 Child refusal  
 Parent refusal  
 Other (specify)

Main working respiratory tract diagnosis   
 My gut feeling is 'something is wrong'  No  Yes  
 Antibiotics prescribed?  No  Yes, immediate  Yes, delayed by  days  
 Referral for acute admission today?  No  Yes

### **Ethnicity showcard**

*To which of these ethnic groups do you consider your child belongs? / What is your ethnic group?*

**White**

- 1 British
- 2 Irish
- 3 Any Other White background (please describe to the doctor or nurse)

**Mixed**

- 4 White and Black Caribbean
- 5 White and Black African
- 6 White and Asian
- 7 Any Other Mixed background (please describe to the doctor or nurse)

**Asian or Asian British**

- 8 Indian
- 9 Pakistani
- 10 Bangladeshi
- 11 Any Other Asian background (please describe to the doctor or nurse)

**Black or Black British**

- 12 Caribbean
- 13 African
- 14 Any Other Black background (please describe to the doctor or nurse)

**Chinese**

- 15 Chinese

**Other ethnic group**

- 16 Any Other (please describe to the doctor or nurse)

*To the clinician: please record the number corresponding to the patients response in the case report form ethnicity box along with any additional description about their ethnicity the patient may wish to provide*

**Web Table 1: Final<sup>a</sup> model applied *post hoc* to the 750 children with diagnosis of asthma<sup>b</sup>**

**Table 2: Multivariable<sup>a</sup> predictors of hospitalisation<sup>c</sup>**

Characteristic		Data source	OR <sup>b</sup>	95% CI
Inter/subcostal recession	Present vs absent	Clinician	6.04	2.07-17.62
Age of child (years)	<2 vs ≥2	Parent	4.82	1.57-14.79
Illness duration (days)	<4 vs ≥4	Parent	3.45	1.22-9.71
Vomiting in the last 24 hrs	Mod/severe vs mild/absent	Parent	0.37	0.04-3.17
Wheeze	Present vs absent	Clinician	3.73	1.11-12.59
High temperature or fever in last 24 hours	≥37.8°C or severe fever vs <37.8°C or mild/moderate fever	Clinician or parent	2.07	0.66-6.45

<sup>a</sup> Asthma variable removed from model since it is an inclusion criterion for analysis

<sup>b</sup> Defined as present if asthma in medical notes problem list and asthma medication issued in the previous 12 months

<sup>c</sup> Model includes 743/8394 (8.9%) of the cohort, of whom 19 were hospitalised.