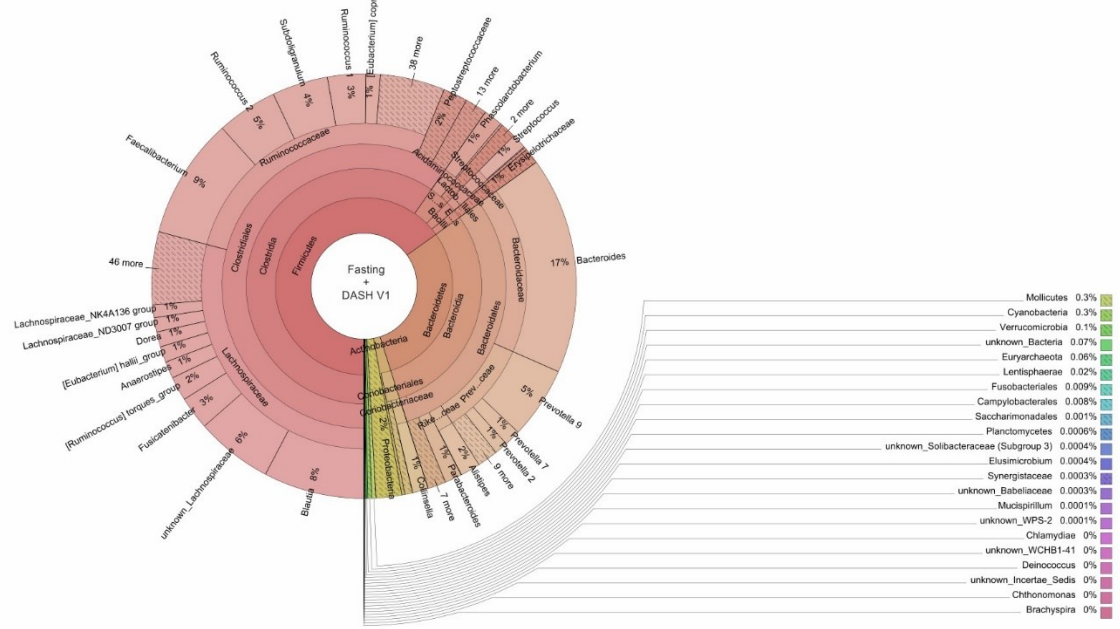


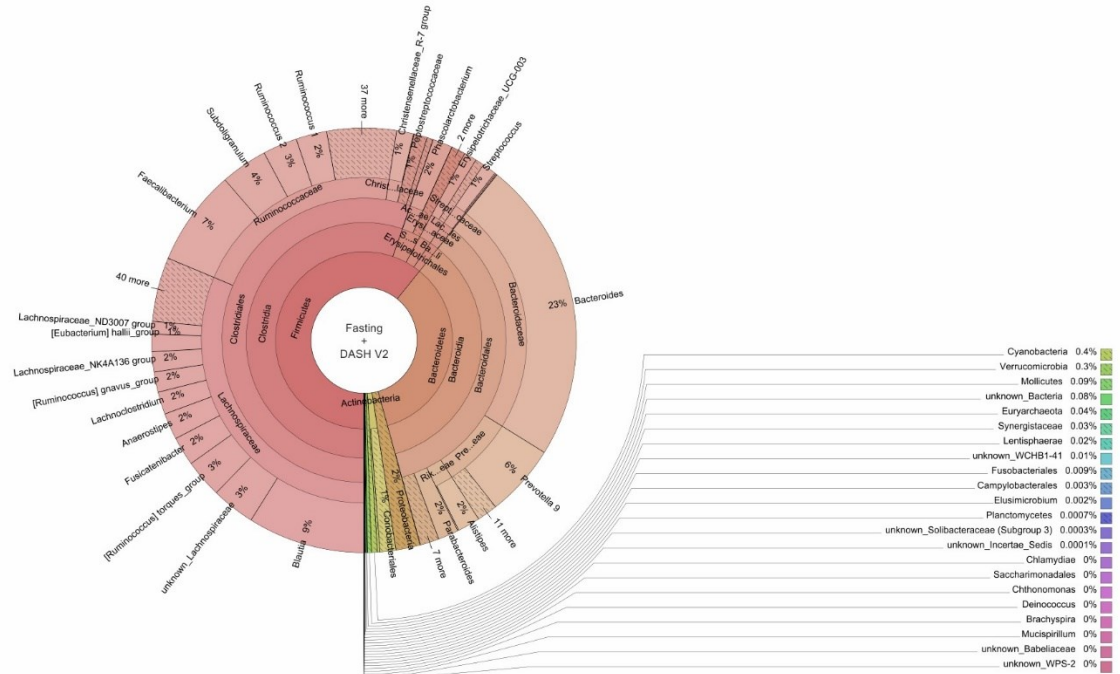
**Supplementary Fig. 1. Changes to the microbiome at the level of 16S OTUs in the fasting+DASH and DASH groups, and changes to the immunome in the DASH arm.** Unconstrained Principal Coordinates graph with first two dimensions shown. Axes show fasting and refeeding deltas in the case of fasting+DASH (A) and DASH, and V1-V2, V2-V3 deltas in the case of DASH after one-week intervention and three-month. Pseudonym participant ID numbers are shown on the point markers. Transparent circle markers show arithmetic mean position of one week intervention and three-month (A, B). Circles of (C) denote the same like in A and B, but with Euclidean distances.

# A FASTING + DASH

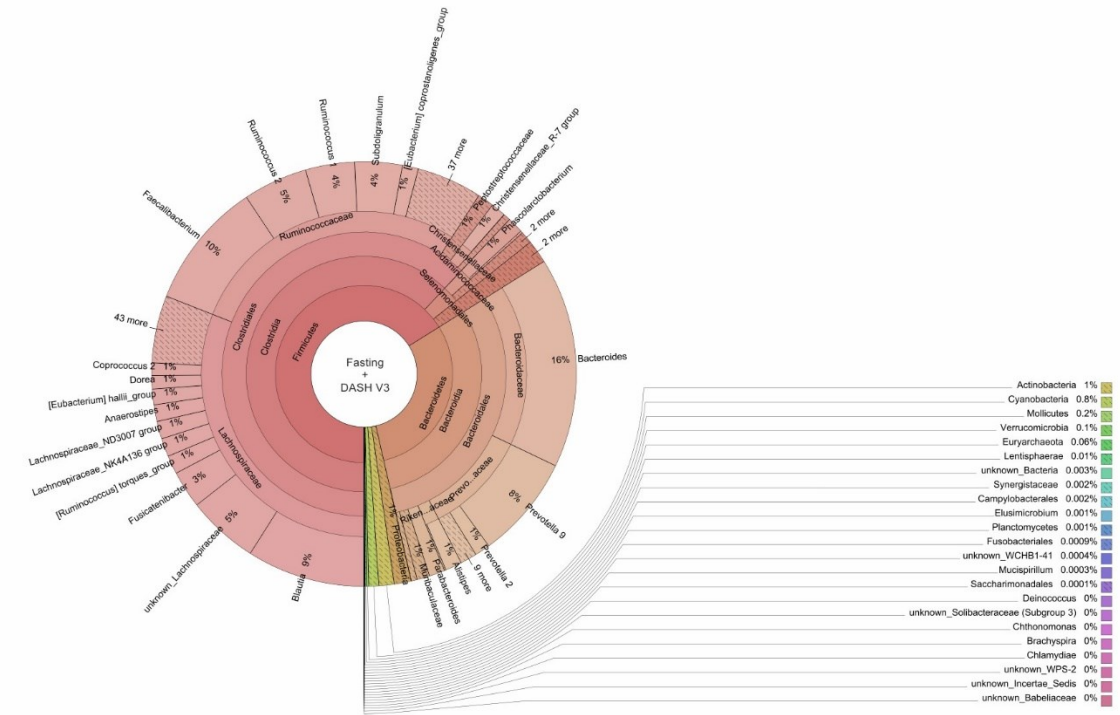
V1



V2

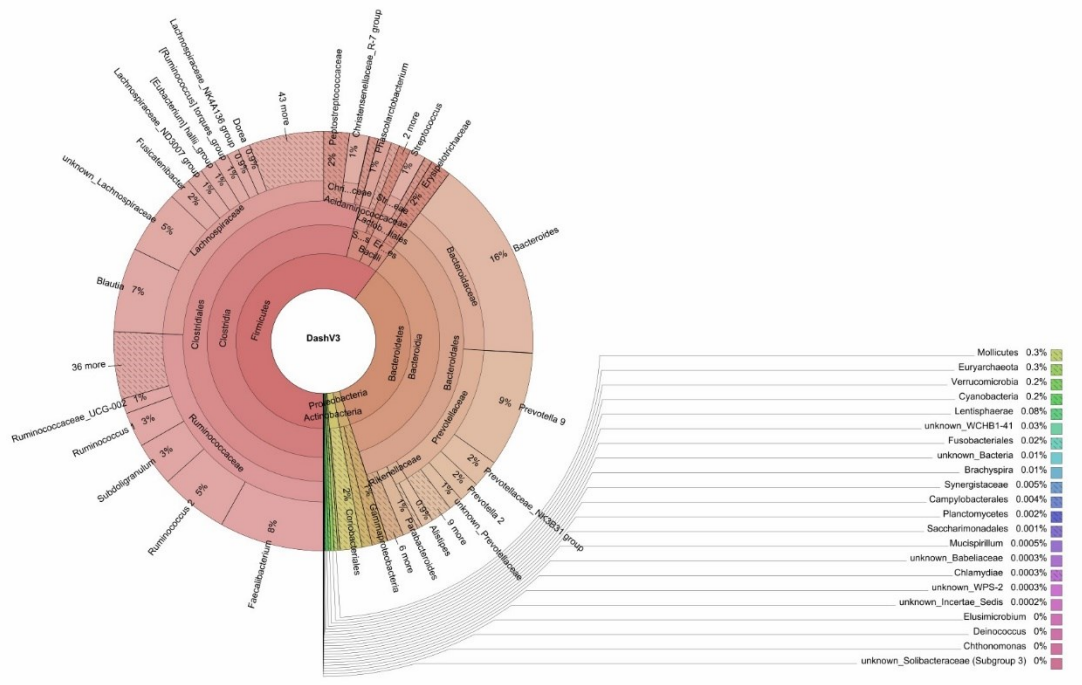


V3

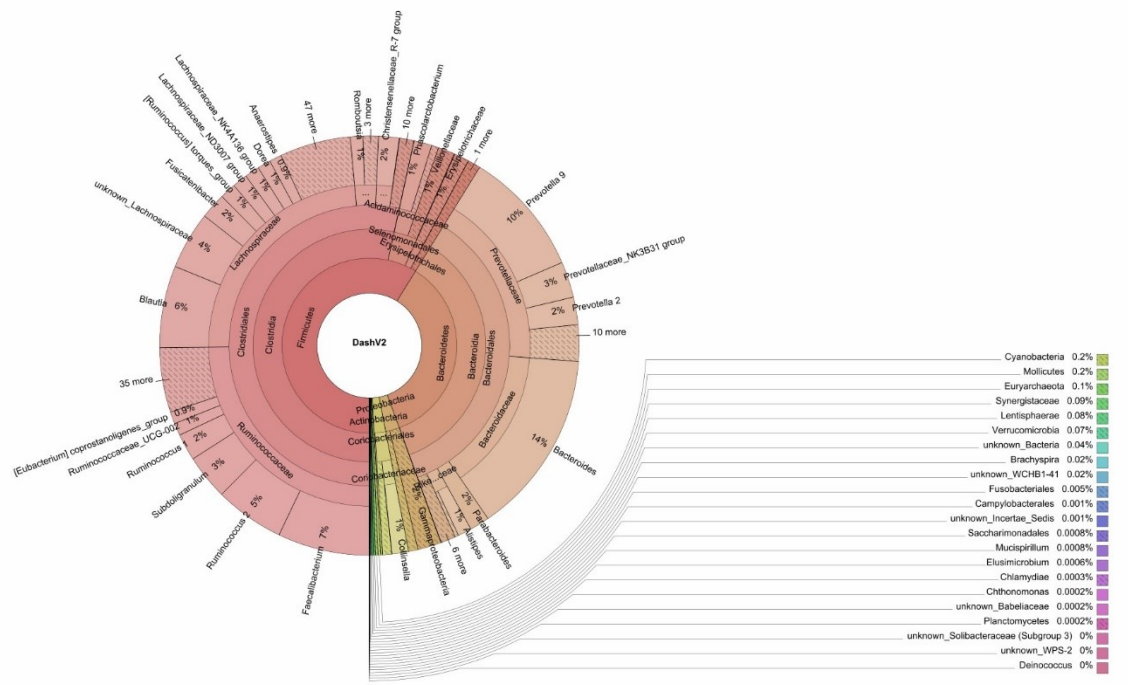


# B DASH

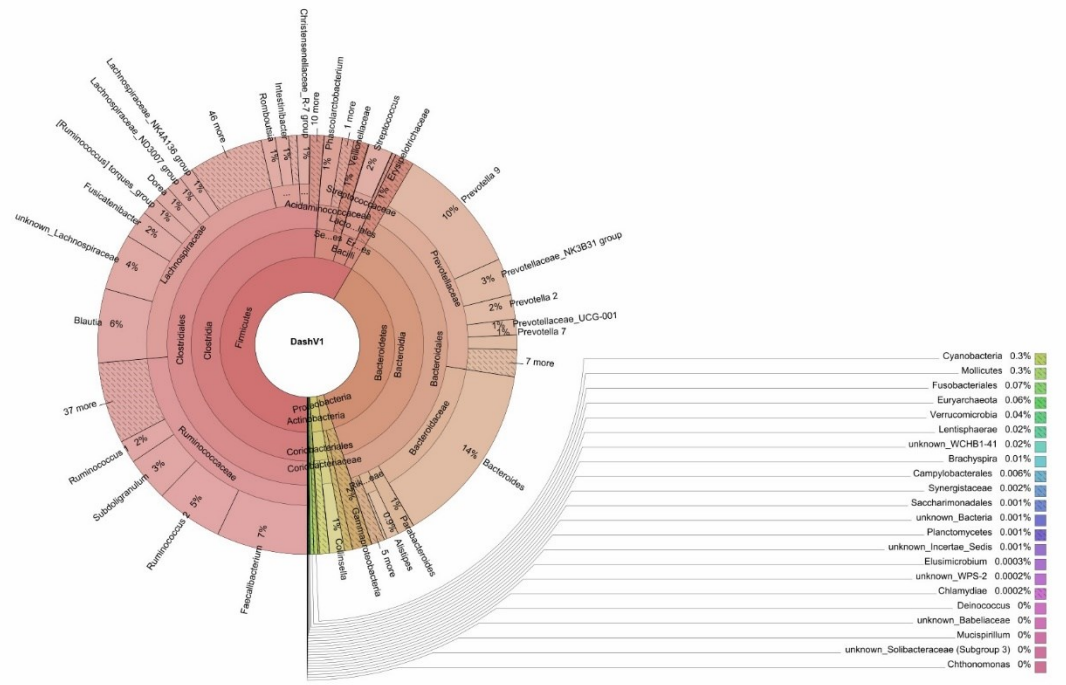
V1



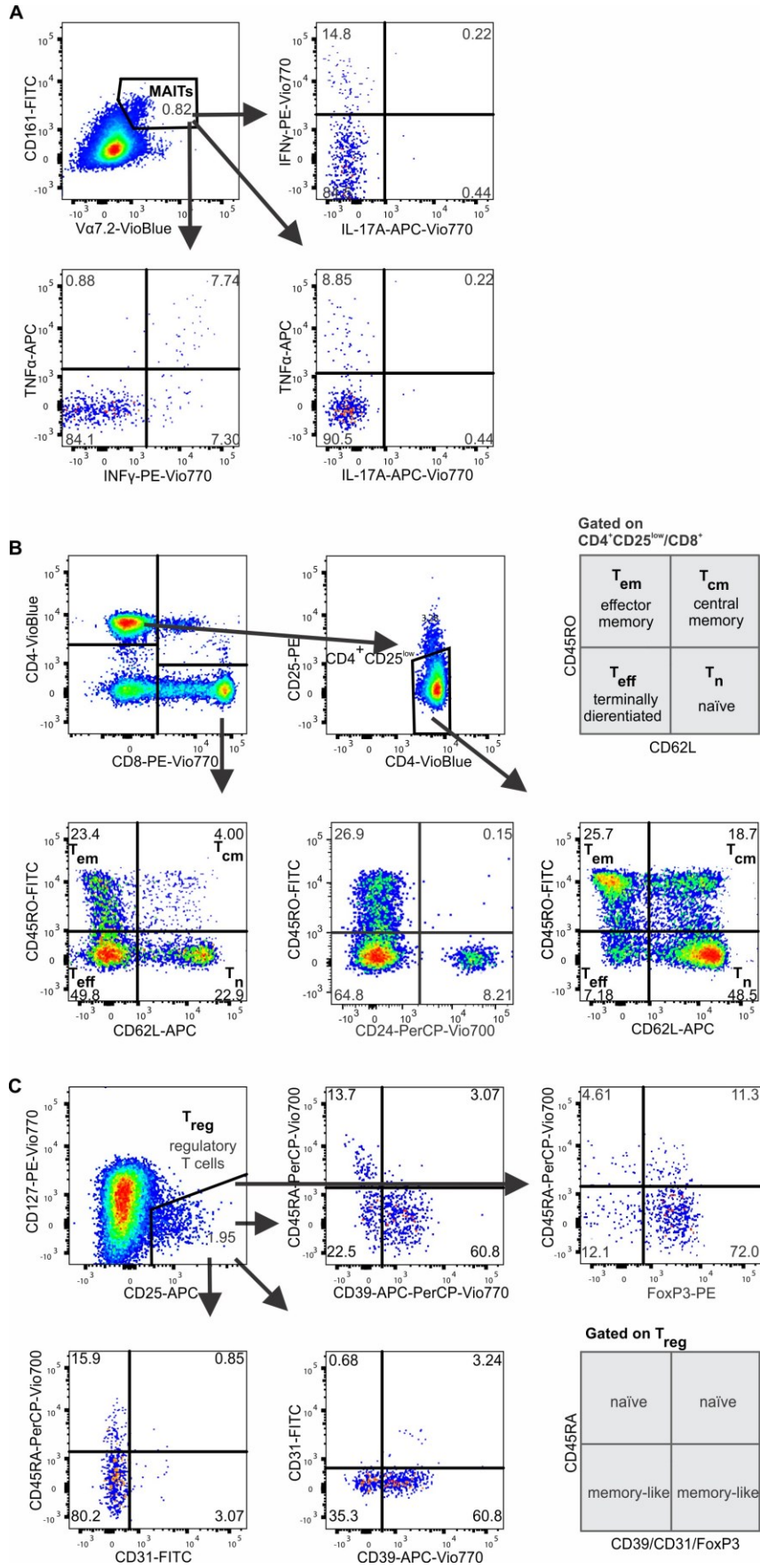
V2

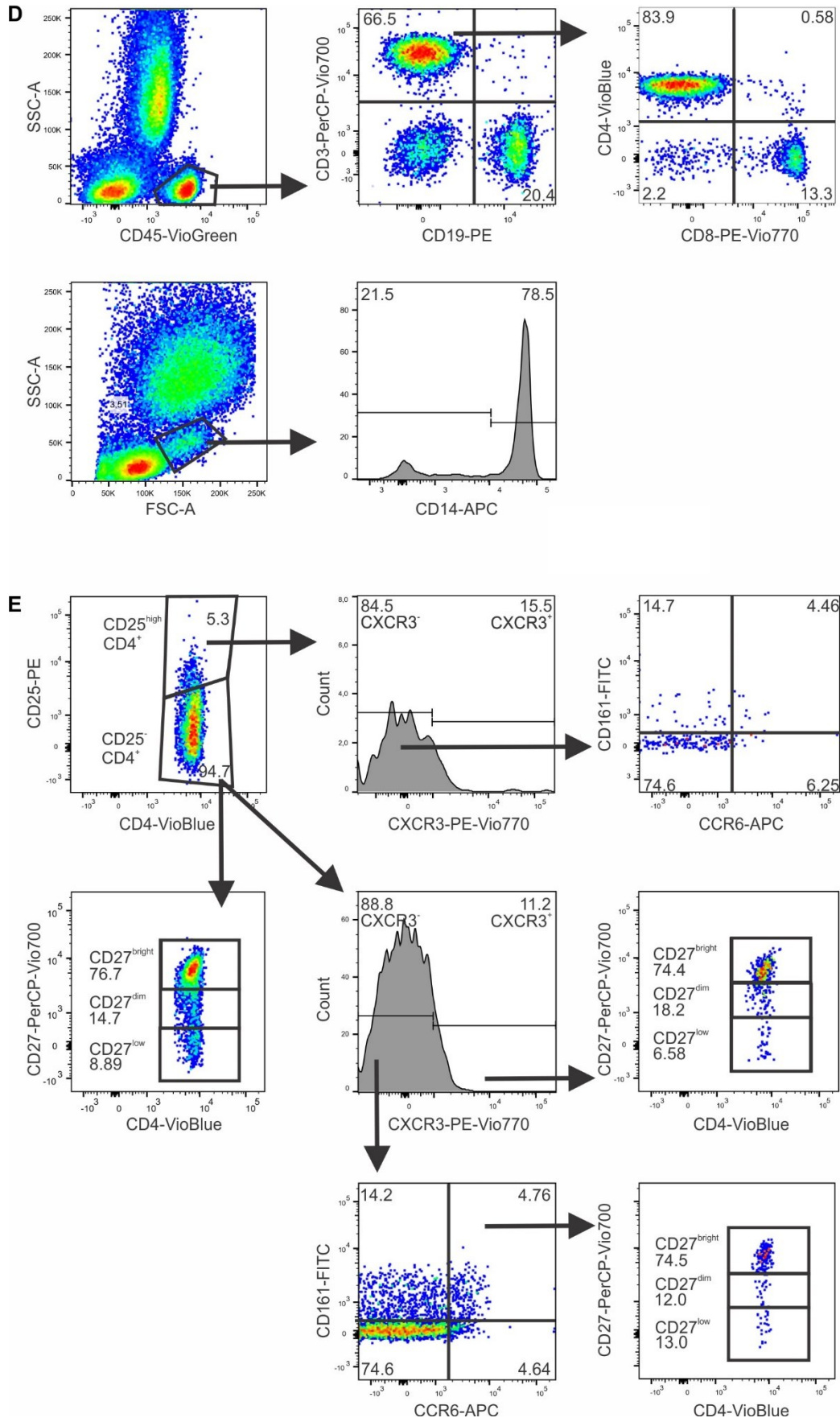


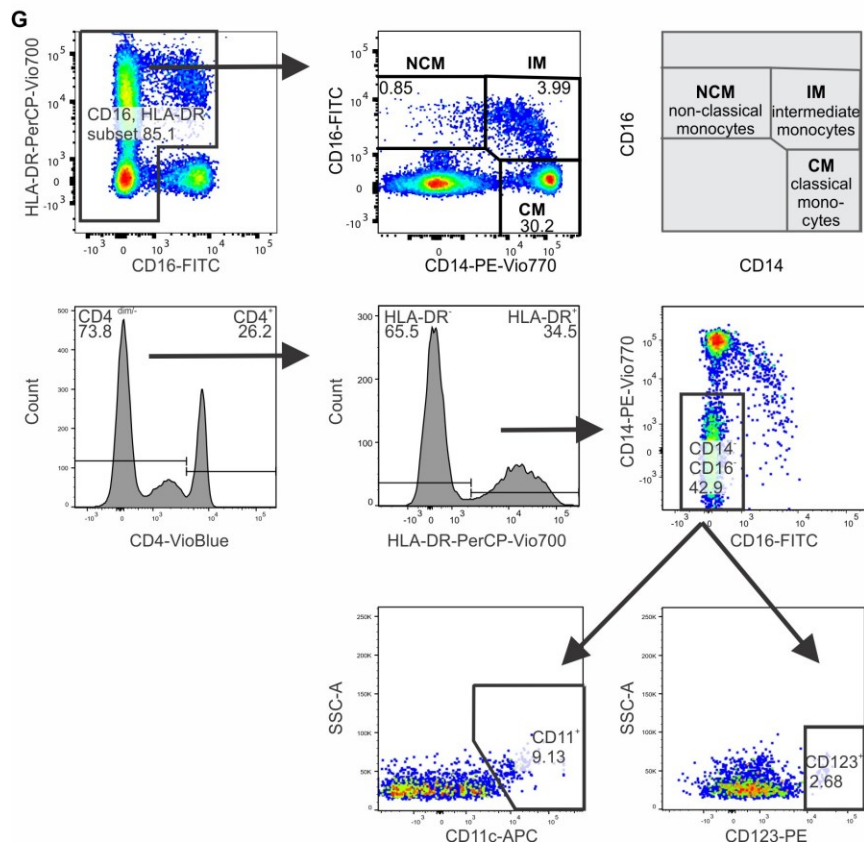
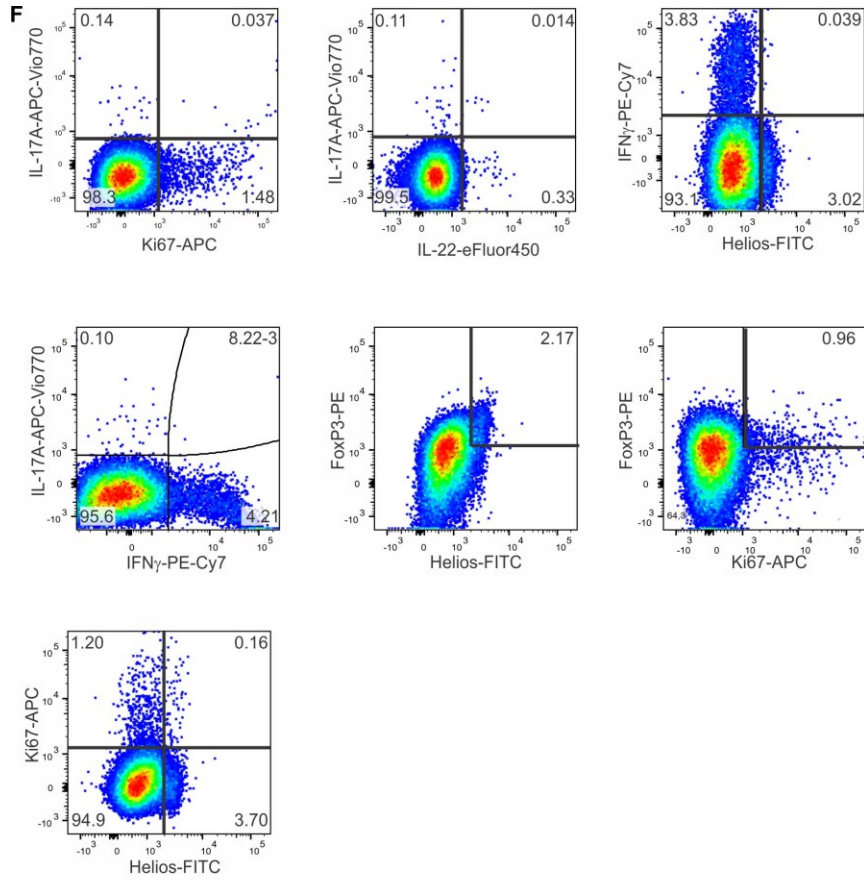
V3



**Supplementary Fig. 2. Krona plots of abundances of microbiome taxonomic units derived from 16S stool sequencing.** Graphical overview of relative taxonomic composition of gut microbiomes in the study. Stool samples were characterized using 16S sequencing from samples collected at baseline (V1), post fasting / one week of DASH (V2) and after three months (V3) intervention and. (A) Fasting + DASH. (B) DASH.



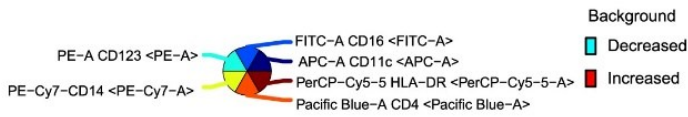
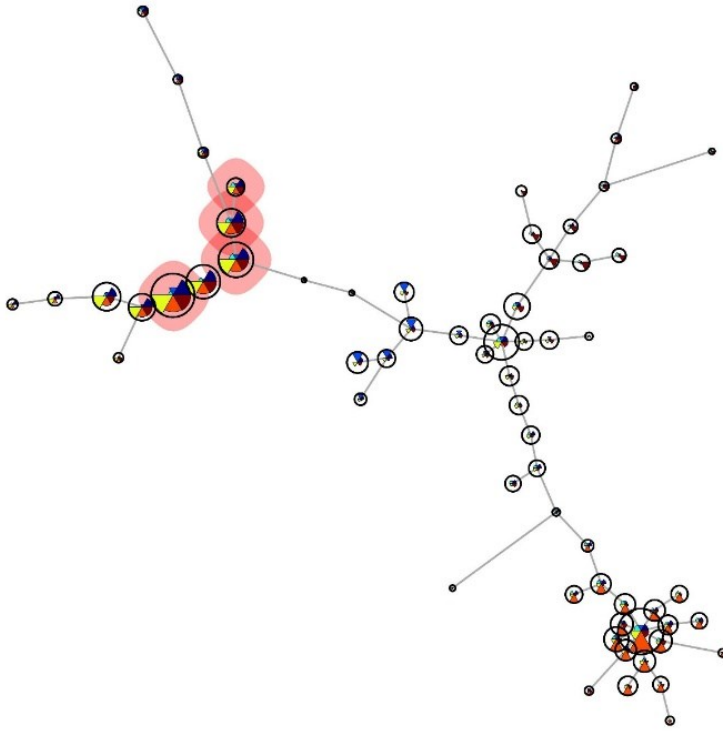




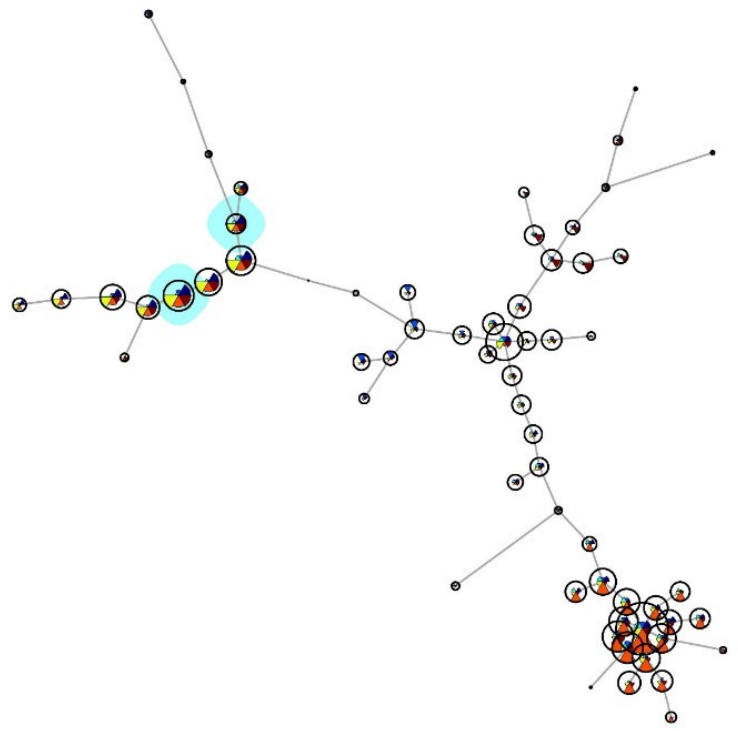
**Supplementary Fig. 3. Gating strategies.** Events are shown after gating onto FSC-Area vs. SSC-Area, followed by gating on doublet and dead cell exclusion. (A) Mucosa associated invariant T (MAIT) cells were detected in PBMCs depleted of CD4<sup>+</sup> cells using magnetic microbead sorting. MAITs were defined as CD161<sup>+</sup>TCRV $\alpha$ 7.2<sup>+</sup>CD4<sup>-</sup>CD3<sup>+</sup>. After restimulation with phorbol 12-myristate 13-acetate (PMA) and ionomycin for 4hrs, MAITs were stained for IL-17A, TNF $\alpha$ , and IFN $\gamma$ . (B) Plots show cells gated on live events using LIVE/DEAD Fixable Aqua Dead Cell Stain kit, for 405nm. T cell subsets were gated as CD8<sup>+</sup>CD4<sup>-</sup>, CD25<sup>-</sup>CD4<sup>+</sup>CD8<sup>-</sup>, and CD25<sup>high</sup>CD4<sup>+</sup>CD8<sup>-</sup>. Activation of the T cells was assessed by expression patterns of CD45RO and CD62L. Cells were defined as i) effector memory (Tem): CD45RO<sup>+</sup>CD62L<sup>-</sup>, ii) central memory (Tcm): CD45RO<sup>+</sup>CD62L<sup>+</sup>, iii) naïve (Tn): CD45RO<sup>-</sup>CD62L<sup>+</sup>, iv) terminally differentiated (Teff): CD45RO<sup>-</sup>CD62L<sup>-</sup>, as shown in the scheme to the right. (C) Regulatory T cells (Treg) were defined as CD4<sup>+</sup>CD25<sup>high</sup>CD127<sup>low</sup> population in isolated PBMCs. Activation status of the cells was detected by the means of surface markers (CD45RA, CD39, and CD31). Representative plots shown. (D) Identification of major cell population from whole blood staining. Whole blood was stained with the respective antibodies followed by the subsequent lysis of the erythrocytes. Samples were measured in a volumetric manner. (E) Identification of Th17 cells and Th17-like CD25<sup>high</sup>CD4<sup>+</sup> cells by surface staining. (F) Intracellular marker expression of CD4<sup>+</sup> T cells. CD4<sup>+</sup> cells were enriched from PBMCs using magnetic microbead sorting. After restimulation with phorbol 12-myristate 13-acetate (PMA) and ionomycin for 4hrs, cells were stained with the respective antibodies. For the analysis cells were further gated on the CD3<sup>+</sup> population. (G) Monocytes were detected from whole peripheral blood mononuclear cell (PBMC) fraction. Monocytes were gated in an HLA-DR<sup>+</sup> or HLA-DR<sup>-</sup>CD16<sup>-</sup> subset. Classical, non-classical, and intermediate monocytes were defined as CD14<sup>high</sup>CD16<sup>-</sup>, CD14<sup>low</sup>CD16<sup>++</sup>, and CD14<sup>+</sup>CD16<sup>+</sup>, respectively. Plasmacytoid dendritic cells were defined as HLA-DR<sup>+</sup>, CD14<sup>-</sup>, CD16<sup>-</sup>, CD123<sup>+</sup>. Myeloid dendritic cells were defined as HLA-DR<sup>+</sup>, CD14<sup>-</sup>, CD16<sup>-</sup>, CD11c<sup>+</sup>. (A-G) correspond to Fig. 1,3,4, (A, E-G) correspond to Fig. 5, (A,F,G) correspond to Fig. 6, (A,B,C,E) correspond to Fig. 7.



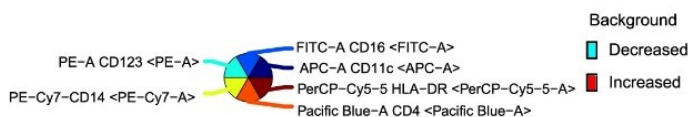
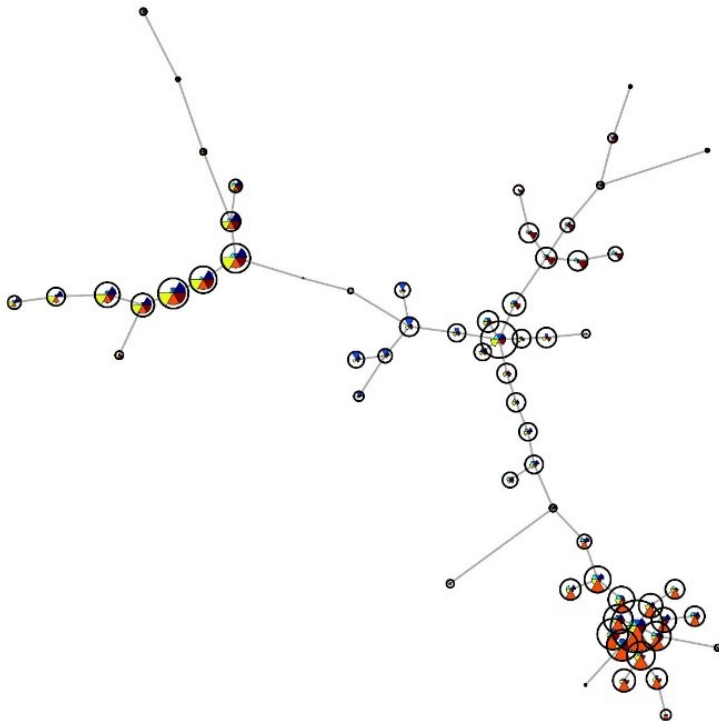
### A Baseline (V1) vs. Fasting (V2)



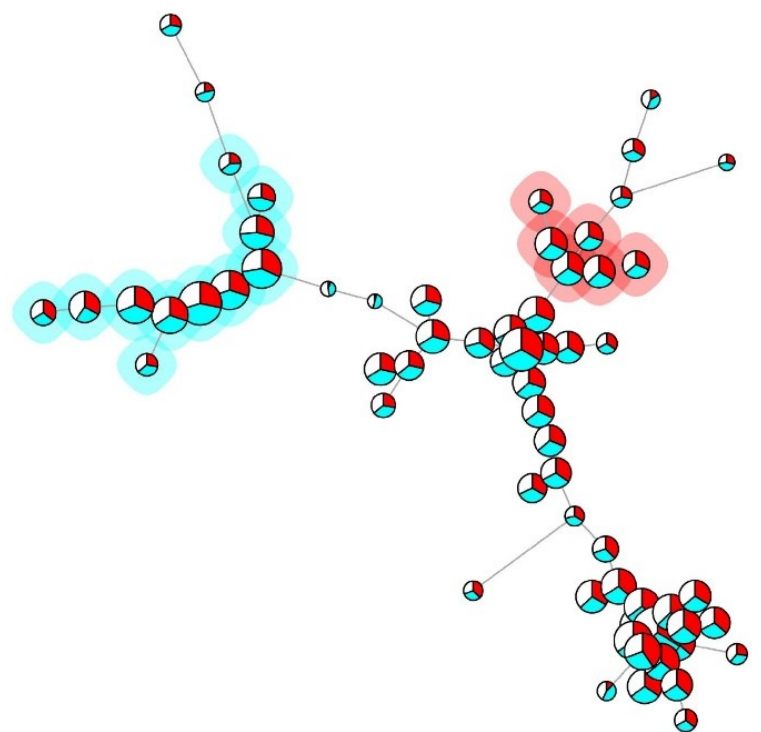
### B Fasting (V2) vs. Follow-up (V3)



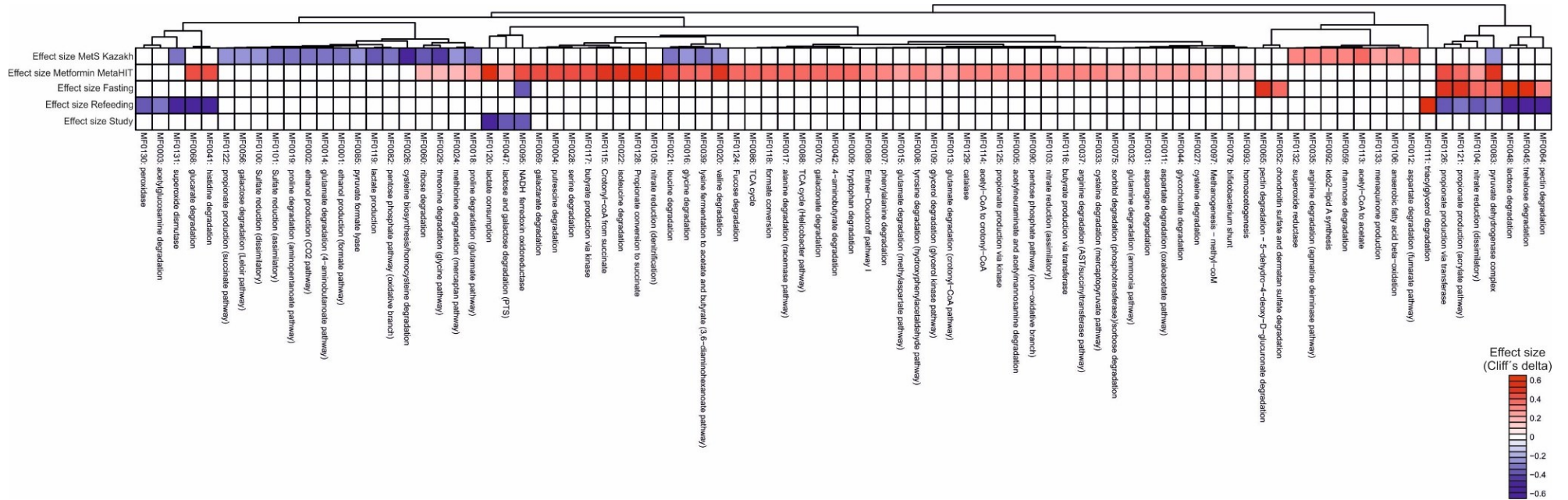
### C Baseline (V1) vs. Follow-up (V3)



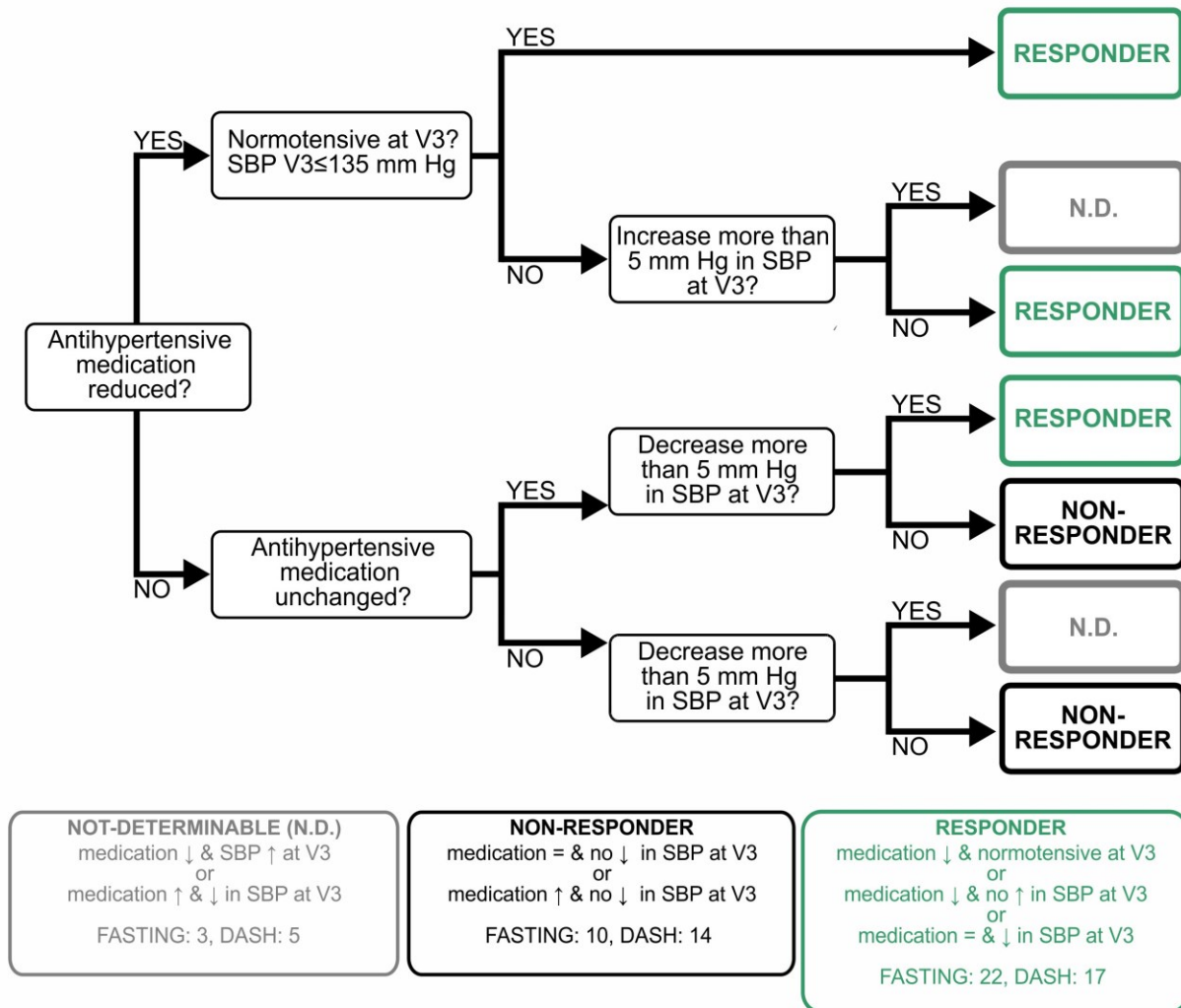
### D Relative abundance at V1, V2 and V3



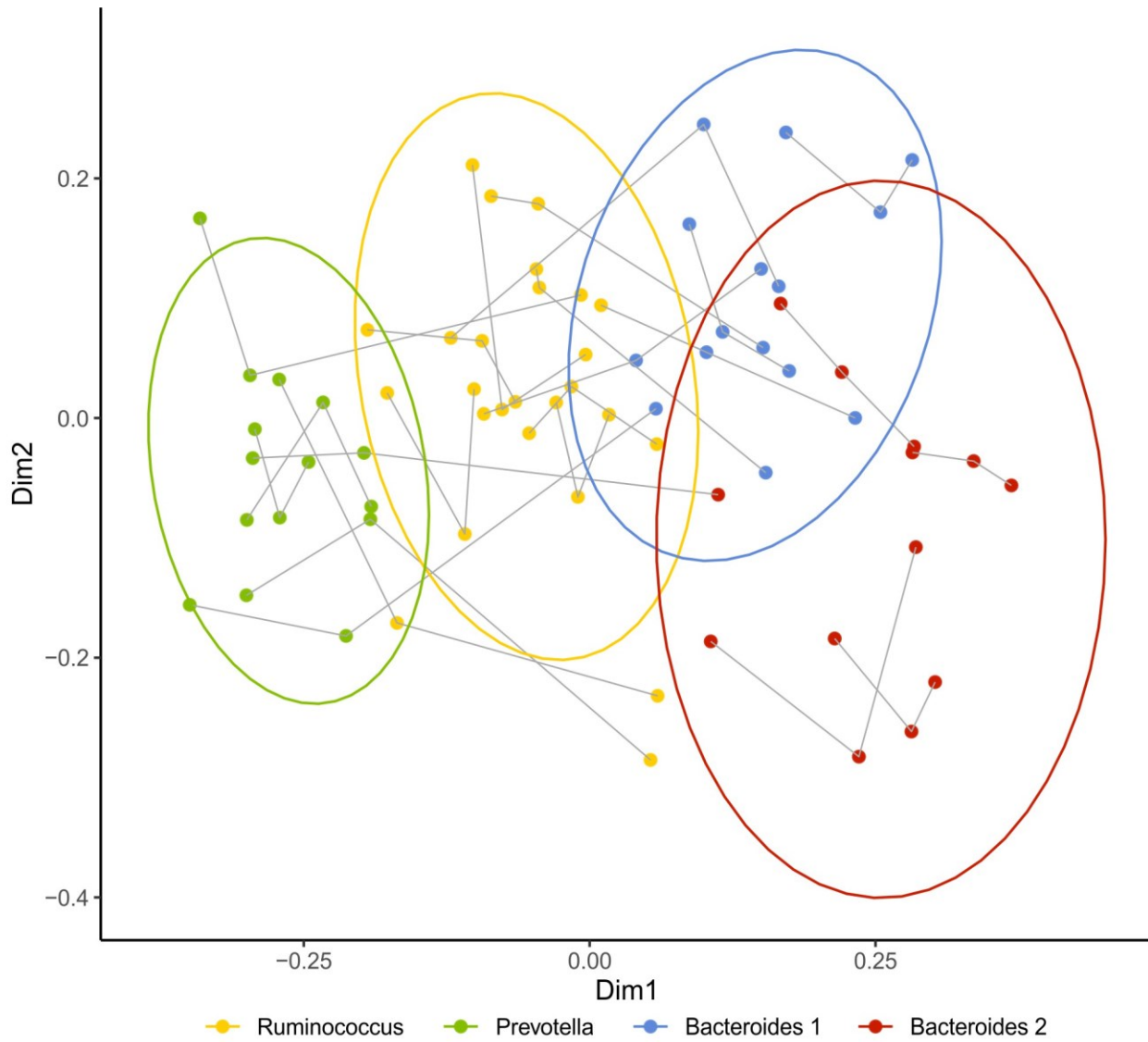
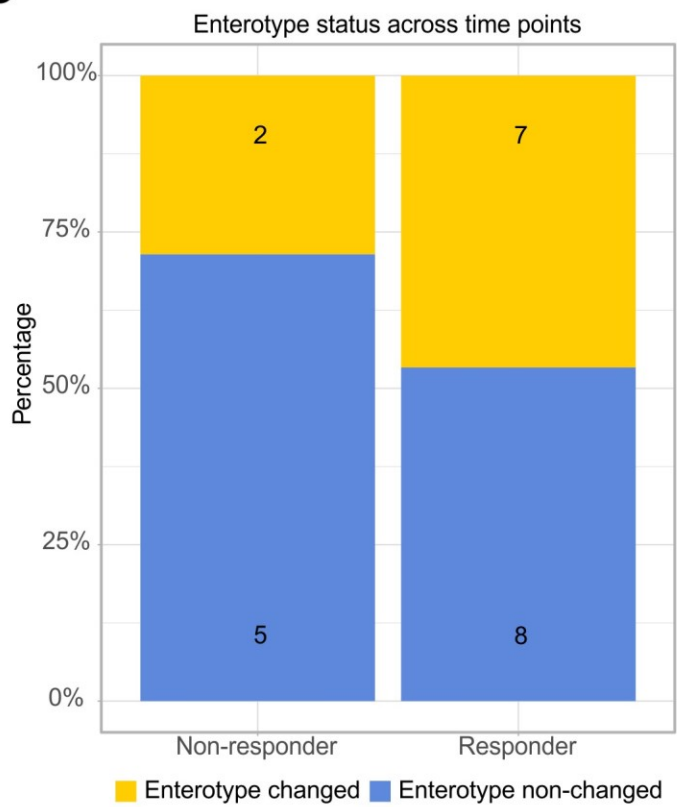
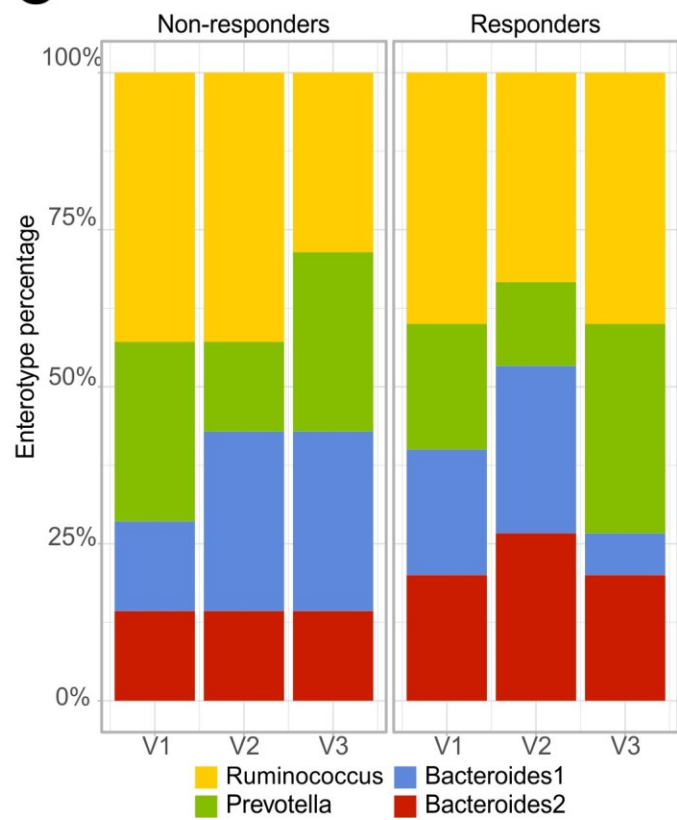
**Supplementary Fig. 4. FlowSOM analysis of monocytes and antigen-presenting cells (APCs) in the fasting arm.** Peripheral blood mononuclear cells were labelled with fluorophore conjugated monoclonal antibodies and measured with multicolor flow cytometry. Data was extracted from the viable gate after doublet-exclusion and down sampled to 6000 events. Samples lacking 6000 events from the viable gate were excluded from the analysis. Monocyte like and APC-like nodules were identified and annotated using the CD markers of the respective node. A-C, Increase (red) or decrease (blue) for Fasting effect (A), Refeeding effect (B), and Study effect (C) is shown within the nodes. D, Quantification of the relative changes between all three time points is shown by the pie chart within the nodes. White, blue and red pie slices refer to V1, V2 and V3, respectively. Blue and green background depicts monocytes and antigen-presenting cells, respectively. (n = 17 for V1, V2 and V3).



**Supplementary Fig. 5. Microbiome functional potential changes during fasting are similar to those induced by metformin and unlike those characteristic for MetS.** To compare the microbiome signatures of fasting and refeeding to those seen in metabolic syndrome and in the treatment of insulin resistance with metformin, we reanalyzed gut microbiome data from two previous studies powered to test these two factors, respectively. To test associations between gut microbiome functional module (GMM) abundances and metabolic syndrome status, we reanalyzed samples from Kushgulova et al.<sup>1</sup>, controlling for metformin treatment. To test associations between gut microbiome functional module (GMM) abundances and metformin treatment, we reanalyzed samples from Forslund et al.<sup>2</sup>, controlling for metabolic syndrome status. Size and direction (Cliff's delta) of significant effects are shown in the heatmap alongside corresponding signals from the present study. Fasting, recovery, and overall study effect from our novel data are shown. Blue and red indicate significant (MWU FDR < 0.1 for metformin/MetS status, respectively, post-hoc nested model test for confounder (the other variable) P < 0.05) depletion/enrichment in each data set. White indicates non-significant effect or absence of the module in a dataset. Modules significantly different in abundance in the metformin substudy show some overlap with and similar directional changes as in our fasting study, whereas recovery exhibits the opposing pattern. MetS and metformin functional signals are starkly different from one another, however there is little overlap between features altered in MetS and by fasting in our novel data.

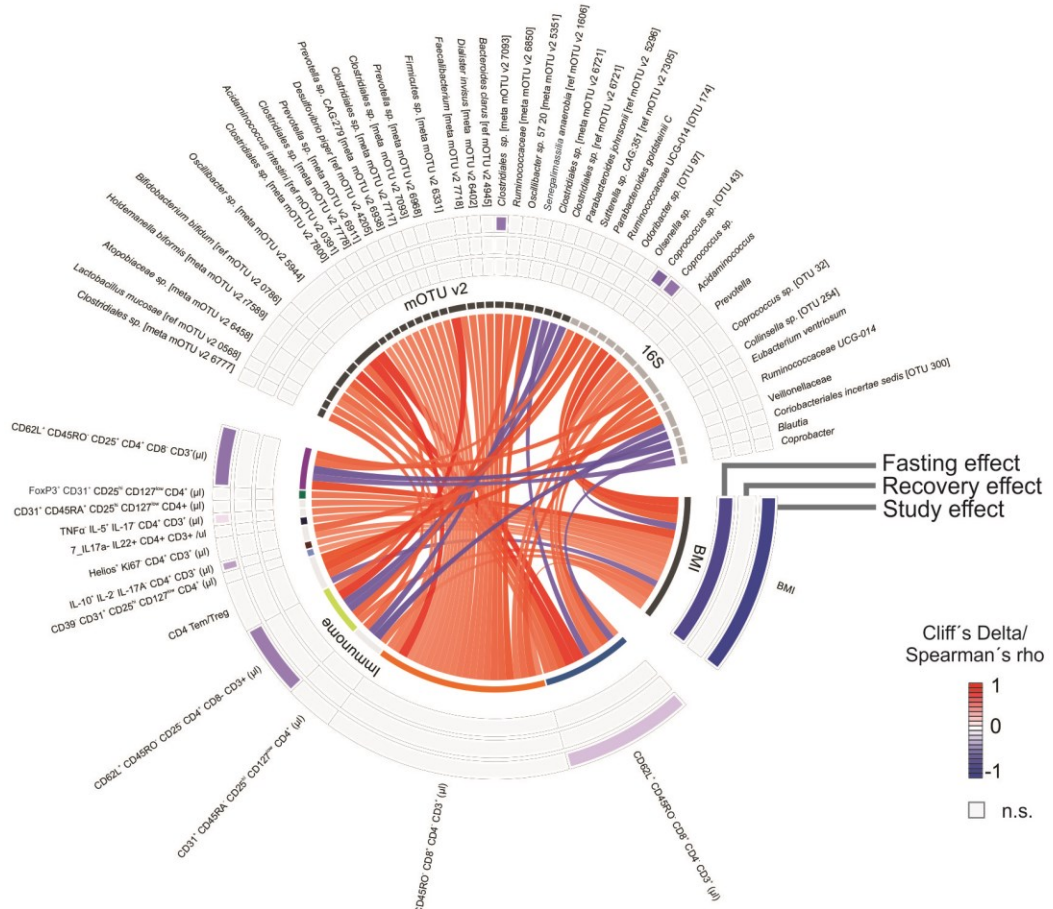


**Supplementary Fig. 6. Decision tree for the determination of blood-pressure responders and non-responders.** Individual 24h systolic ambulatory blood pressure (SBP) and individual anti-hypertensive medication at 3 months (V3) was evaluated in relation to baseline (V1) and patients were categorized as responder, non-responder or not determinable. Normotensive SBP was defined as being  $\leq 135$  mm Hg. Significant change in the SBP was defined as an increase or decrease being  $\geq 5$  mmHg. Patients were categorized as responders if at V3: i) their anti-hypertensive medication was reduced and SBP was  $\leq 135$  mm Hg, ii) anti-hypertensive medication was reduced and SBP did not increase significantly, iii) if their anti-hypertensive medication did not change and their SBP significantly decreased (Fasting  $n=22$ , DASH  $n=17$ ). Patients were categorized as non-responders if at V3: i) their anti-hypertensive medication was not changed and SBP did not decrease significantly, ii) if their anti-hypertensive medication was increased but SBP did not decrease (Fasting  $n=10$ , DASH  $n=14$ ). Patients were categorized as not-determinable if at V3: i) their anti-hypertensive medication was decreased and SBP significantly increased, ii) their anti-hypertensive medication was increased and SBP significantly decreased (Fasting  $n=3$ , DASH = 5).

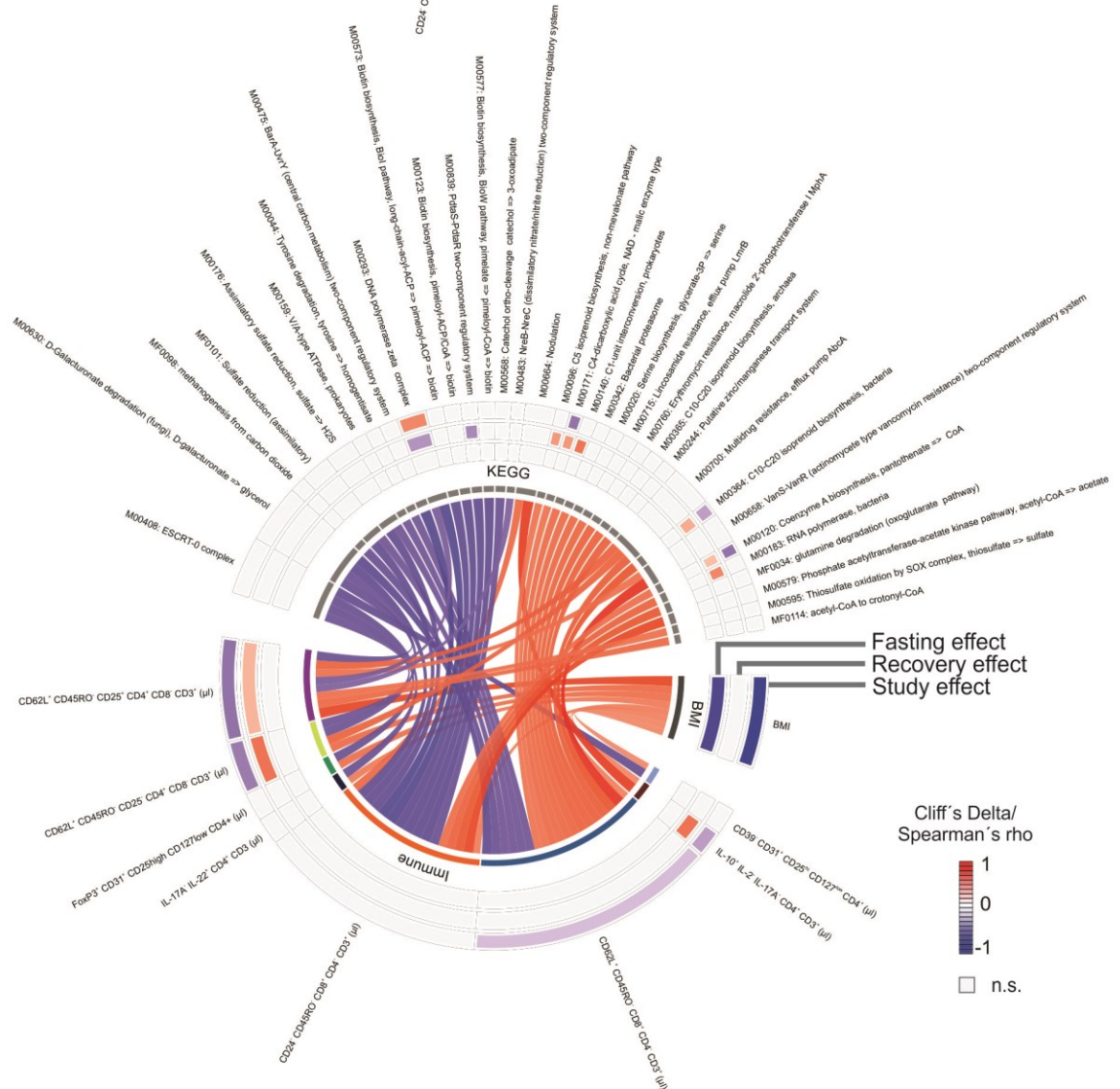
**A****B****C**

**Supplementary Fig. 7. Enterotype of fasting arm samples.** Four enterotypes were identified, which we classify as *Ruminococcus*-dominated, *Prevotella*-dominated, and two *Bacteroides*-dominated enterotypes. (A) Fecal microbiome (n = 69) community variation on genus level, shown in a principal coordinates analysis based on Bray-Curtis dissimilarities. Four enterotypes are resolved, and shown using different colors. Paired samples are linked by grey lines. Ellipses indicate 95% confidence interval. (B) Percentage of individuals with changed or unchanged enterotype throughout the three time points (pre-intervention, post-fasting, followup). Raw counts of samples falling within each outcome group are shown in the bars. (C) Proportion of enterotypes in each case represented by stacked bar plot across time points. Most individuals retained the same enterotype throughout the intervention, with a trend of change in enterotype (chi-squared test,  $P = 0.65$ ).

A



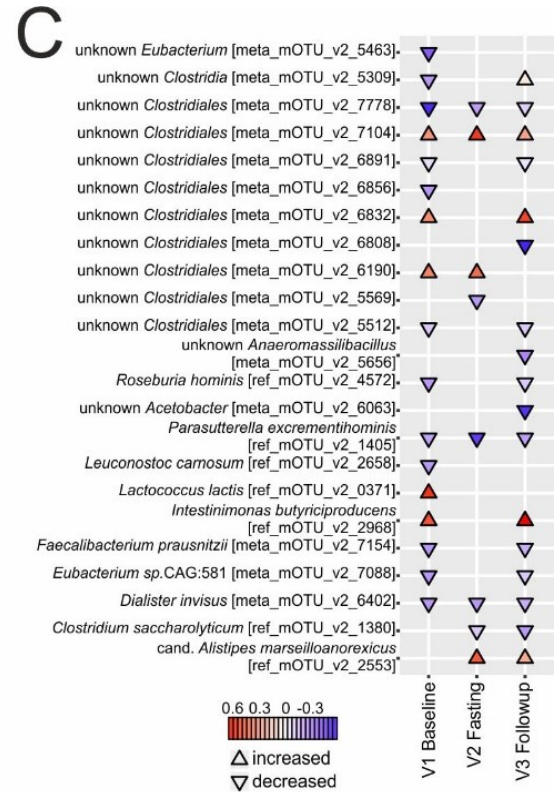
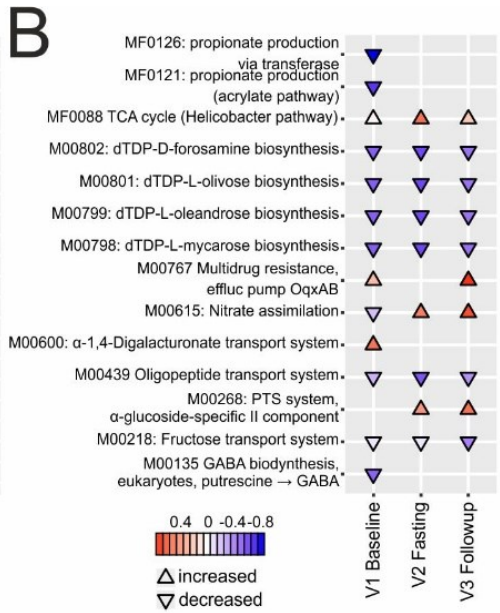
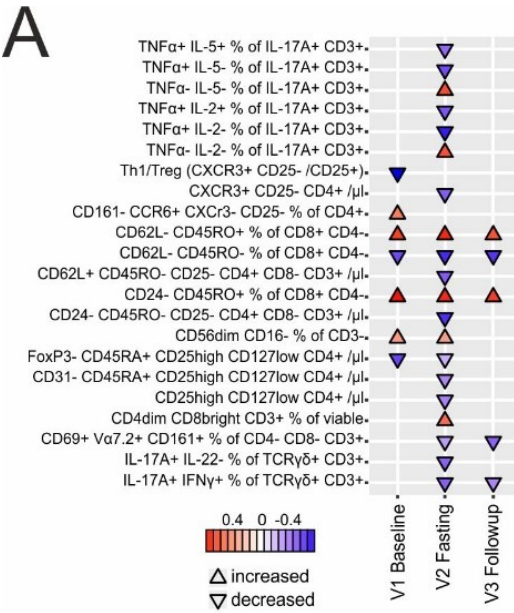
B



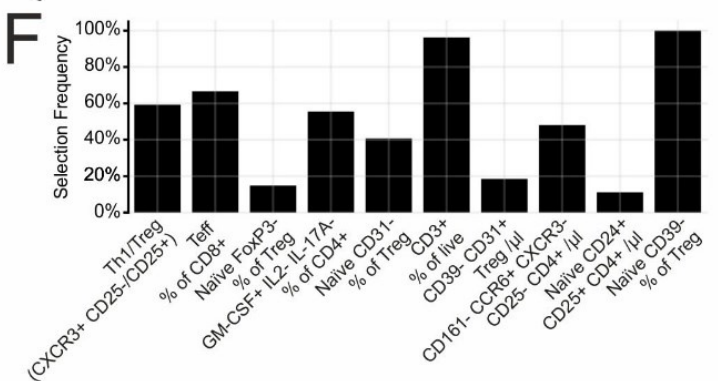
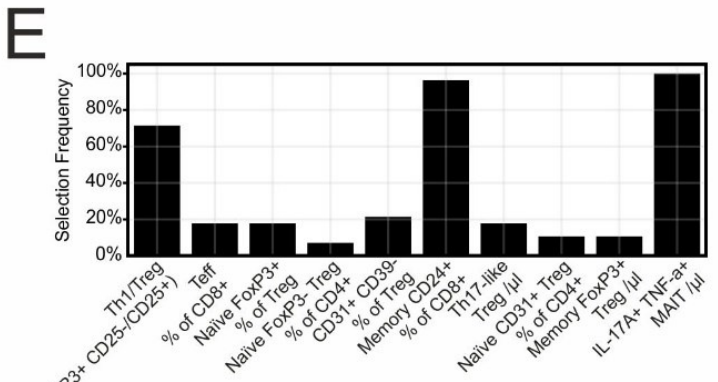
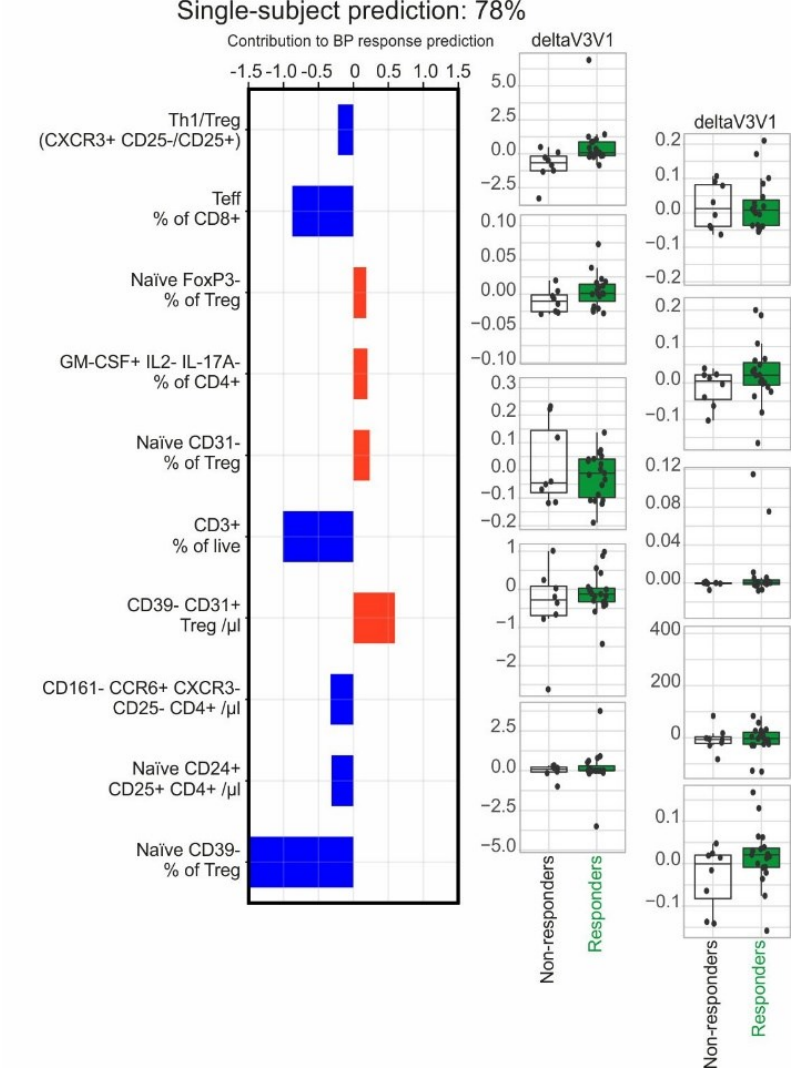
**Supplementary Fig. 8. Association between the immunome, microbiome features and BMI.**

Chord diagrams visualize the interrelation between body mass index (BMI), fasting impacted microbiome functional or taxonomic features, and immune cell subsets. Features are shown that form triplets of immune, microbial and phenotype variables where at least two of three correlations are significant (Spearman FDR < 0.05, post-hoc nested model test accounting for same-donor samples < 0.05) in the fasting arm of our cohort, and where in addition one or more feature significantly (drug-adjusted post-hoc FDR < 0.05) are affected by the intervention. Color of the connectors indicates positive or negative correlation (Spearman's rho), color of the cells within the tracks indicates changes upon fasting, refeeding or the overall study effect (Cliff's delta). (A) BMI/immune/taxonomic microbiome interrelations, (B) BMI/immune/microbiome KEGG annotation interrelations. Identical non-gray colors of the inner track of immune features denote the same immune features on (A) and (B).





### D Classifier study effect



**Supplementary Fig. 9. Long-lasting blood pressure responders and non-responders differ in microbiome and immunome composition.** (A-C) Cuneiform plot shows effect sizes (Cliff's delta; hue and marker size shows effect size, marker direction shows sign of effect) of immunome features (A), gut functional profiles using KEGG and GMM (B), and gut taxon abundances assessed using the mOTUv2 framework (C) significantly (posthoc FDR < 0.05) differing between responders and non-responders at the different time points. (D), Prediction model for blood pressure response using the changes of immune features between baseline (V1) and follow-up (V3). Single subject prediction was quantified using a leave-one-out cross-validation approach. Ten immune cell features were used to build up a multivariate logistic-regression algorithm. The bar plots represent the regression in a model with binary output (responder yes=1 vs no=0) for every feature. (E), Selection frequency of the different parameters for the prediction model shown in Fig. 4c over the different classifiers built by using a leave-one-out cross-validation. (F), Selection frequency of the different parameters for the prediction model shown in (D) over the different classifiers built by using a leave-one-out cross-validation. Treg: CD25<sup>high</sup>CD127<sup>low</sup>CD4<sup>+</sup>.

## Supplementary References

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