

## Supplement Figures

### Data from Delphi survey from the 299 respondents on the definition of exacerbation as an outcome for clinical trials

#### Statement (i): Definition of exacerbation as an outcome for clinical trials

##### Statement (i)-a

In children/adolescents with bronchiectasis, we suggest that a non-severe respiratory exacerbation is considered present when there is:

A required change in respiratory management (prescribed antibiotics for respiratory symptoms or intensification of airway clearance) AND at least ONE of the following:

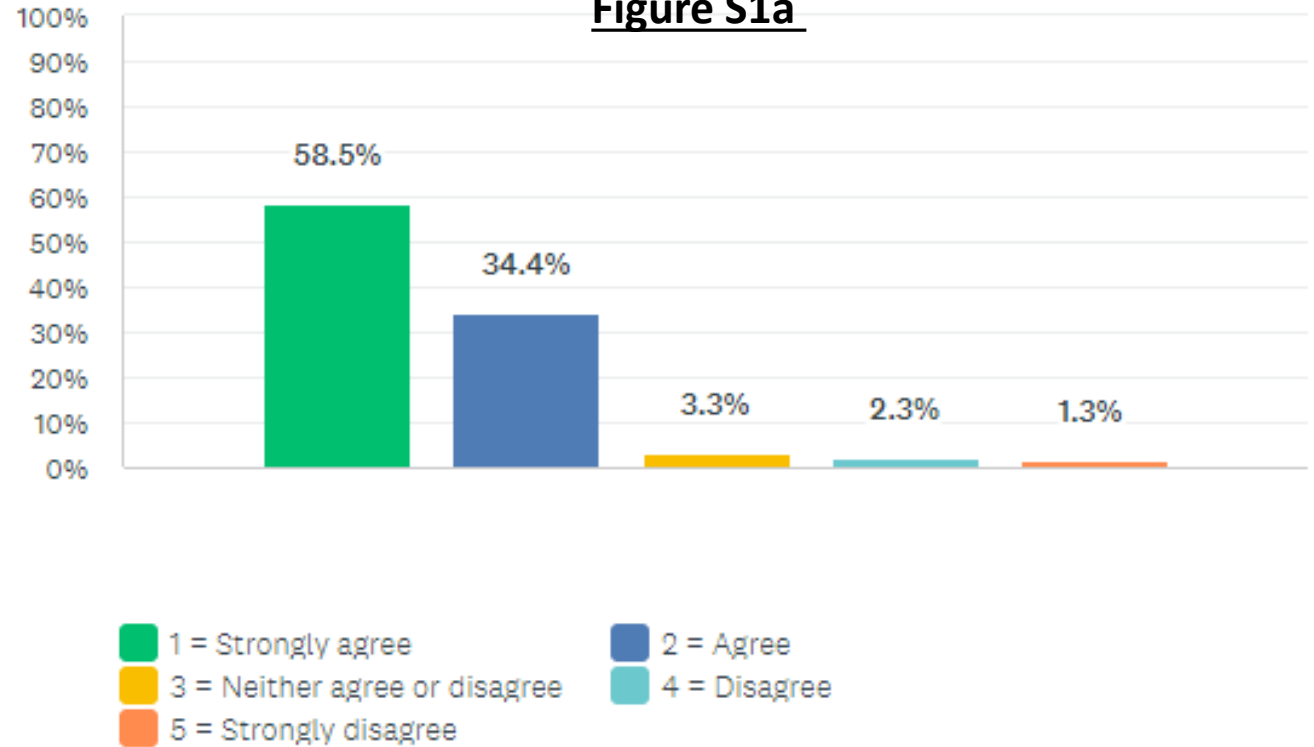
- An increase in sputum volume/purulence OR Change in cough character (dry to wet) OR increased wet/productive cough frequency for >3 days.
- Onset of chest pain or discomfort.
- Onset of new or worsening chest auscultation or palpable (vibration) secretion findings.
- Onset of new or worsening radiographic changes (e.g chest x-ray).
- Drop in FEV<sub>1</sub> (>10%).

##### NOTES:

- 1. Blood markers reflective of pulmonary exacerbation (eg .elevated C-reactive protein, neutrophils, serum amyloid-A, interleukin-6) may also be present.
- 2. Systemic symptoms (fever, fatigue, malaise, change in child's behaviour or appetite) may also herald onset of an exacerbation, but are non-specific.

**Summary: 93% Strongly Agree/Agree**

Figure S1a



## Statement (i): Definition of exacerbation as an outcome for clinical trials

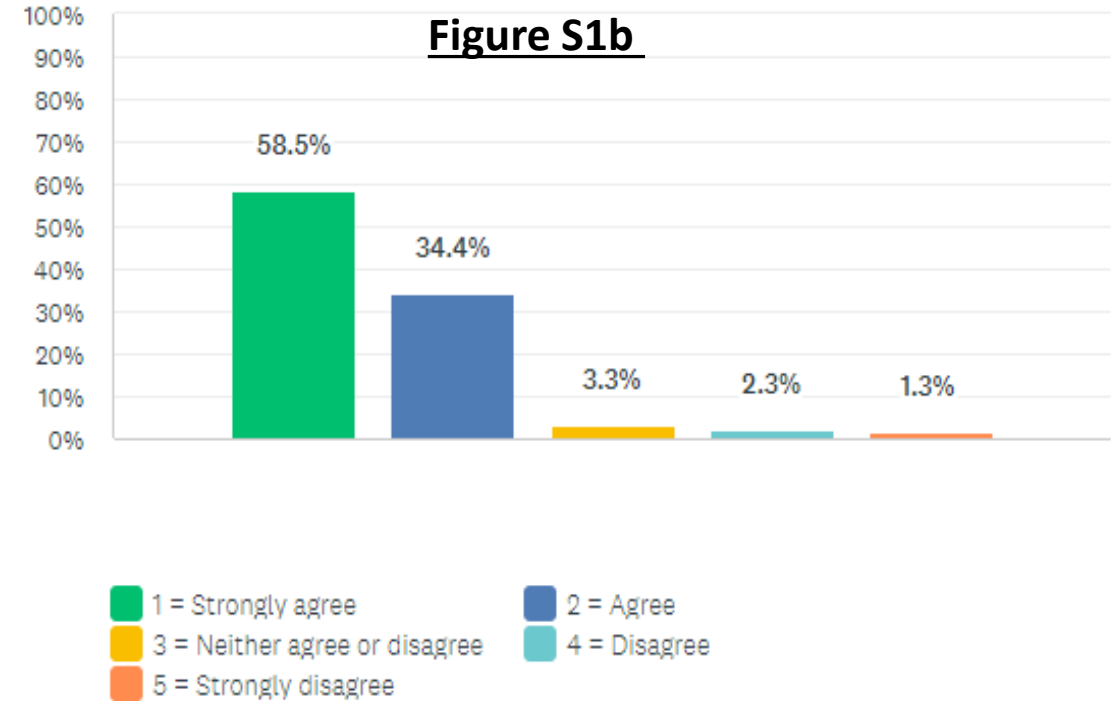
### Statement (i)-b

**In children/adolescents with bronchiectasis, we suggest that a severe respiratory exacerbation is considered present when the criteria for a non-severe exacerbation (see question above) are met AND:**

A clinician deems hospitalisation for intravenous antibiotics and/or supportive management is indicated: BECAUSE of at least ONE of the following:

- Onset of new or worsening tachypnoea (age-adjusted respiratory rate (RR) >50 if aged <12-months; RR >40 if aged 1-2 years; RR >30 if 3-9 years; RR >25 if 10-18 years).  
Onset of new or worsening dyspnoea (increased work of breathing).
- Onset of new or worsening hypoxia (SpO2 persistently <92% in room air or 4% below stable state).
- Any haemoptysis.
- Worsening chest pain.
- Failed oral antibiotic treatment.

**Summary: 93% Strongly agree/Agree**



## Statement (ii): Definition of a non-severe exacerbation that warrants treatment for clinical trials

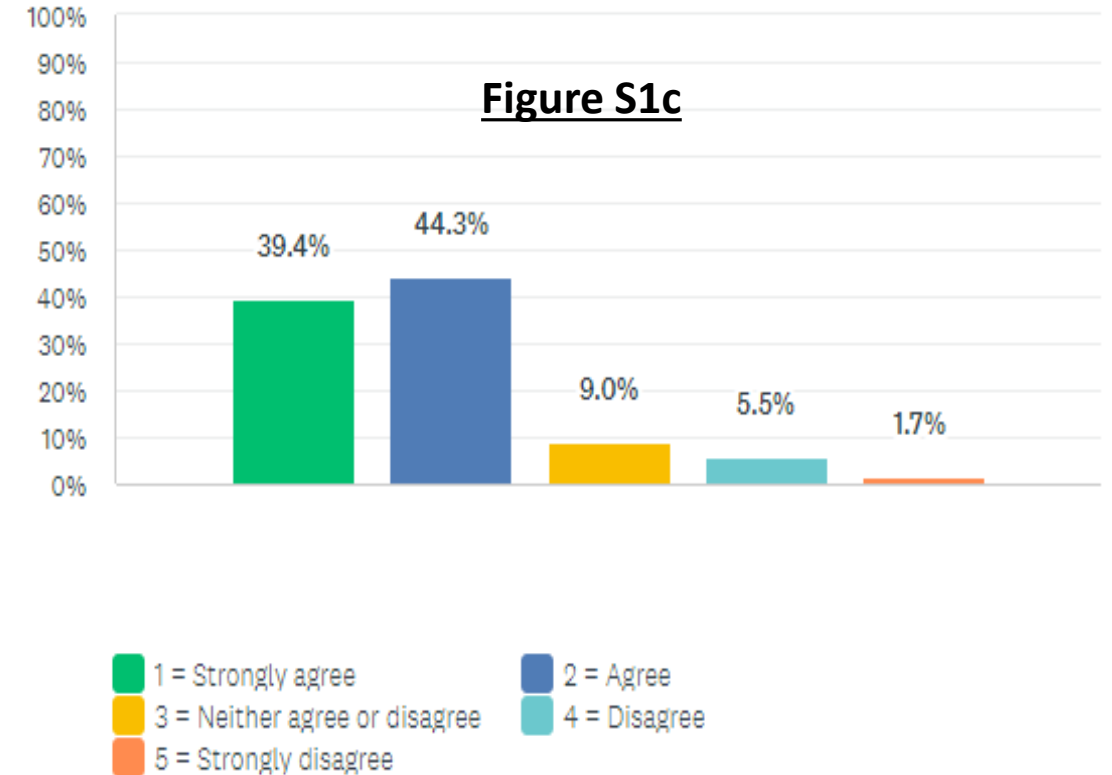
In children/adolescents with bronchiectasis, we suggest that a non-severe respiratory exacerbation is considered present when at least ONE of the following:

- An increase in sputum volume/purulence OR Change in cough character (dry to wet) OR increased wet/productive cough frequency for >3 days.
- Onset of chest pain or discomfort.
- Onset of new or worsening chest auscultation or palpable (vibration) secretion findings.
- Onset of new or worsening radiographic changes (e.g chest x-ray).
- Drop in FEV<sub>1</sub> (>10%).

### NOTES:

- 1. Blood markers reflective of pulmonary exacerbation (eg .elevated C-reactive protein, neutrophils, serum amyloid-A, interleukin-6) may also be present.
- 2. Systemic symptoms (fever, fatigue, malaise, change in child's behaviour or appetite) may also herald onset of an exacerbation, but are non-specific.

**84% Strongly agree/Agree**



### Statement (iii): Definition of resolution of a non-severe exacerbation

In children/adolescents with bronchiectasis, we suggest that a non-severe respiratory exacerbation is considered resolved when the child/adolescent's clinical state has returned to baseline state (respiratory symptoms and signs) for at least 2 consecutive days.

**82% Strongly agree/Agree**

