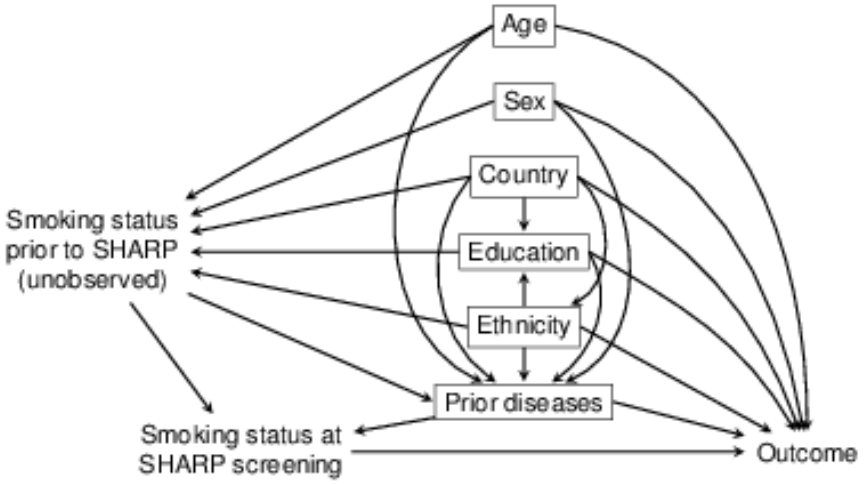
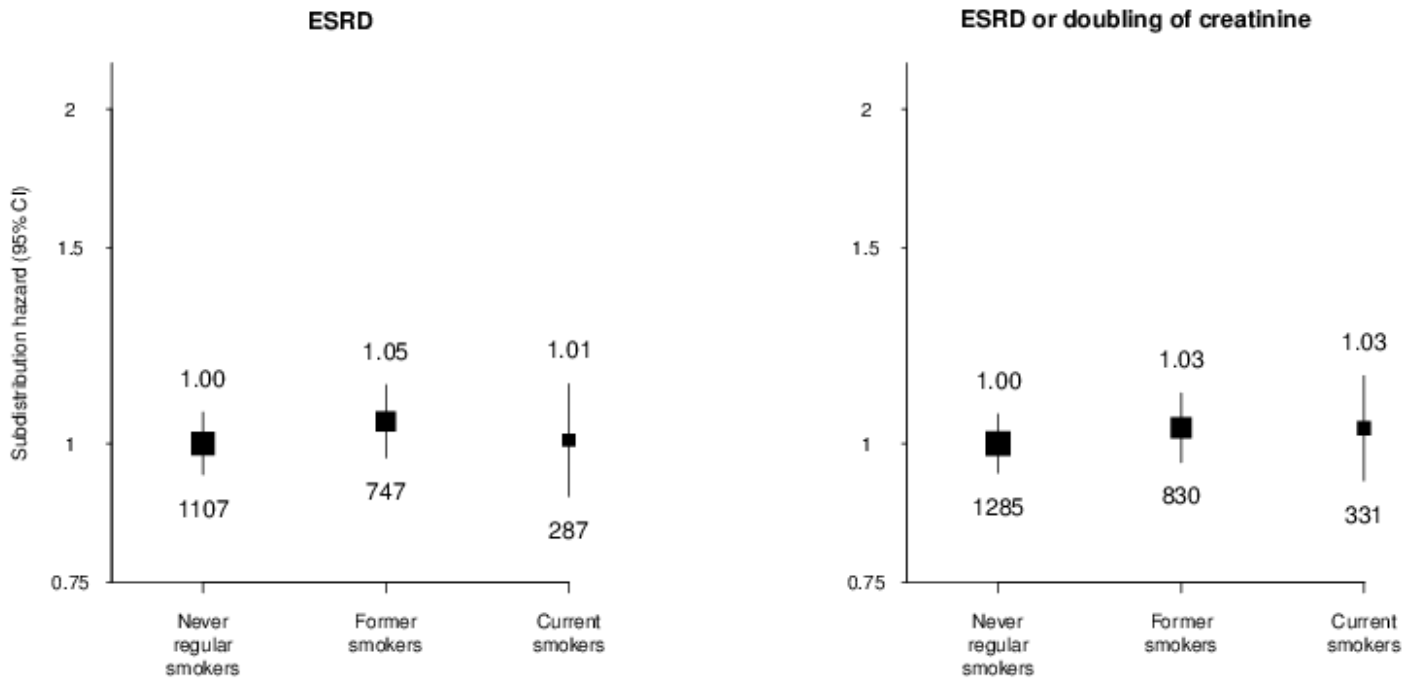
Figure S1: Causal diagram showing assumed associations between baseline smoking status, outcomes and baseline characteristics



A participant's smoking status prior to SHARP is also assumed to be prior to any documented vascular disease and could therefore affect the risk of developing such disease. As prior vascular disease at the time of entry into SHARP would have been diagnosed prior to screening, then a participant's smoking status at screening could not influence the risk of prior disease but might have been modified by it (i.e. the participant quits smoking as a result of being diagnosed with vascular disease). Analyses were adjusted for the confounders enclosed by boxes in the causal diagram.

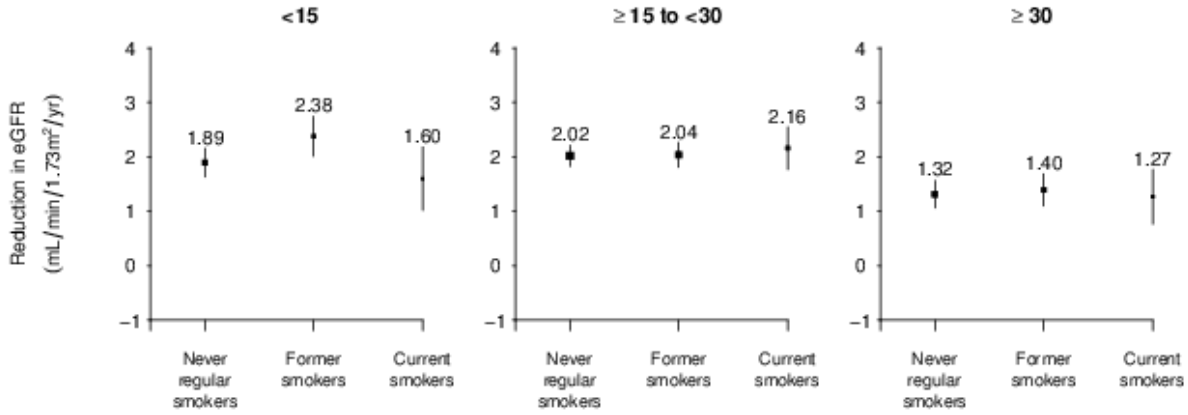
Figure S2: Relevance of baseline smoking status to renal progression among 6245 patients not on dialysis at randomization using Fine and Gray regression



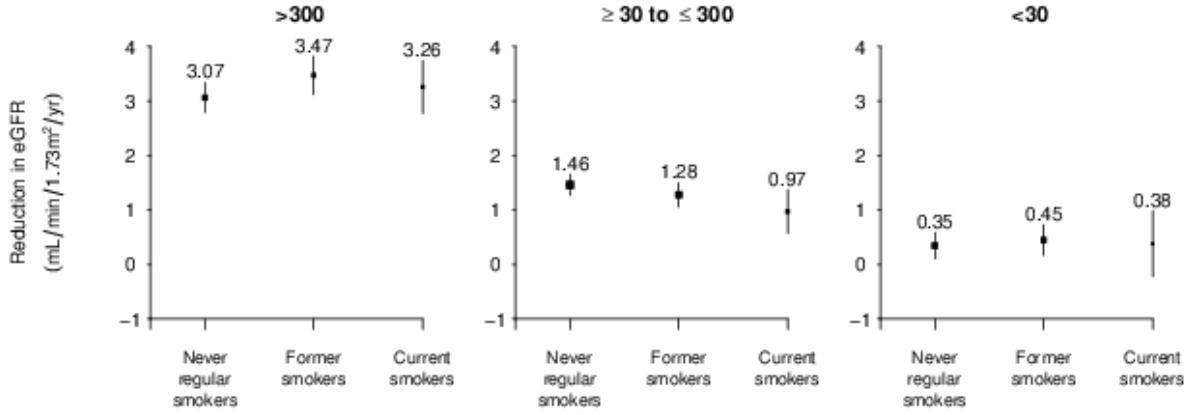
Subdivision hazards adjusted for age, sex, ethnicity, country, education, and prior disease. Fine and Gray regression was used to take account of the competing risk of death before ESRD. The estimated subdistribution hazards here reflect the actual rate at which current smokers would be expected to present with ESRD, whereas the Cox estimates previously presented (in Figure 3 of the article) reflect the rates in the hypothetical absence of deaths before ESRD.

Figure S3: Relevance of baseline smoking status to annual rate of decline in eGFR, by baseline eGFR and baseline albumin:creatinine ratio, among 6245 patients not on dialysis at randomization

(a) By baseline eGFR (mL/min/1.73m^2)

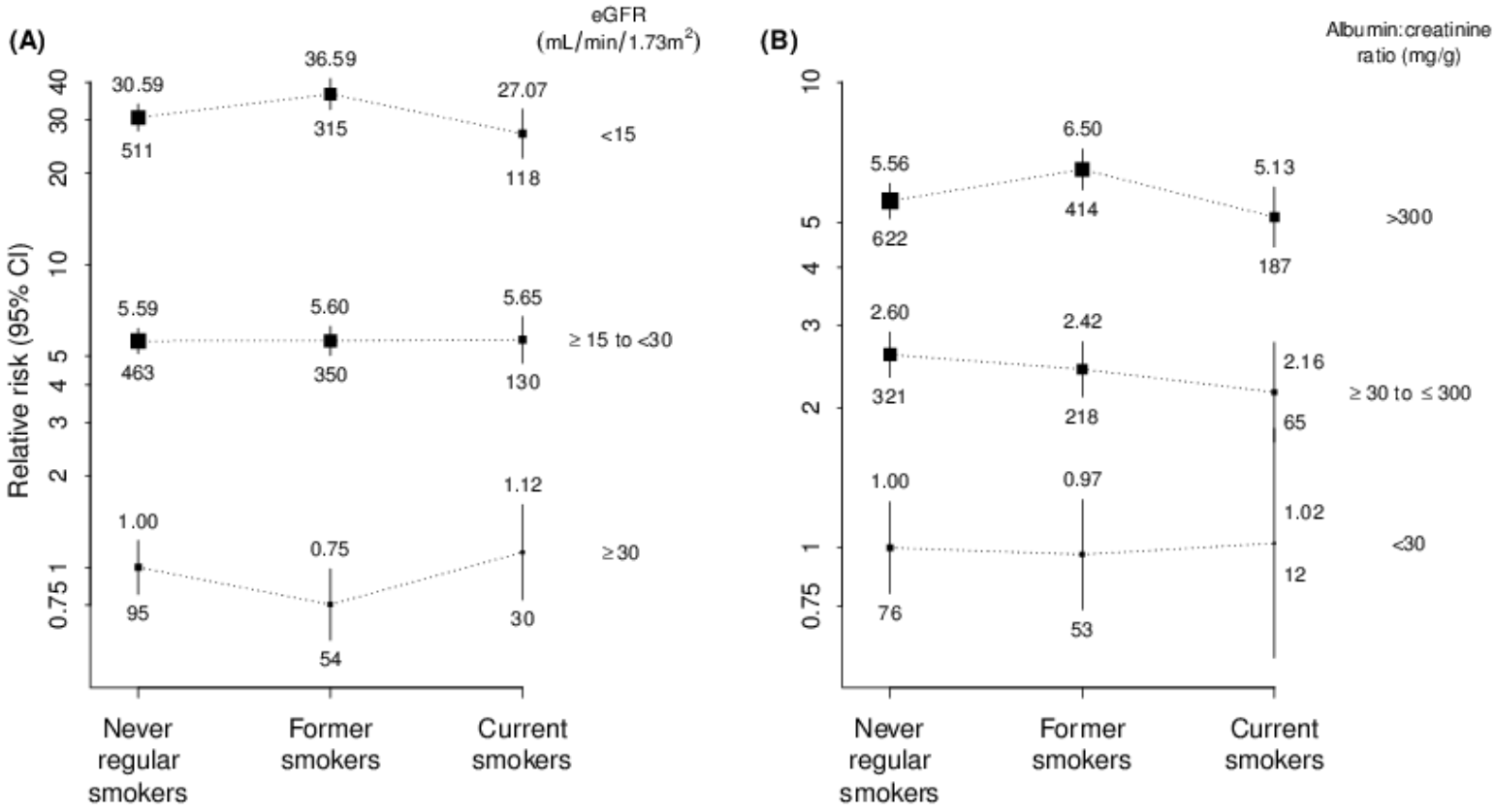


(b) By baseline albumin:creatinine ratio (mg/g)



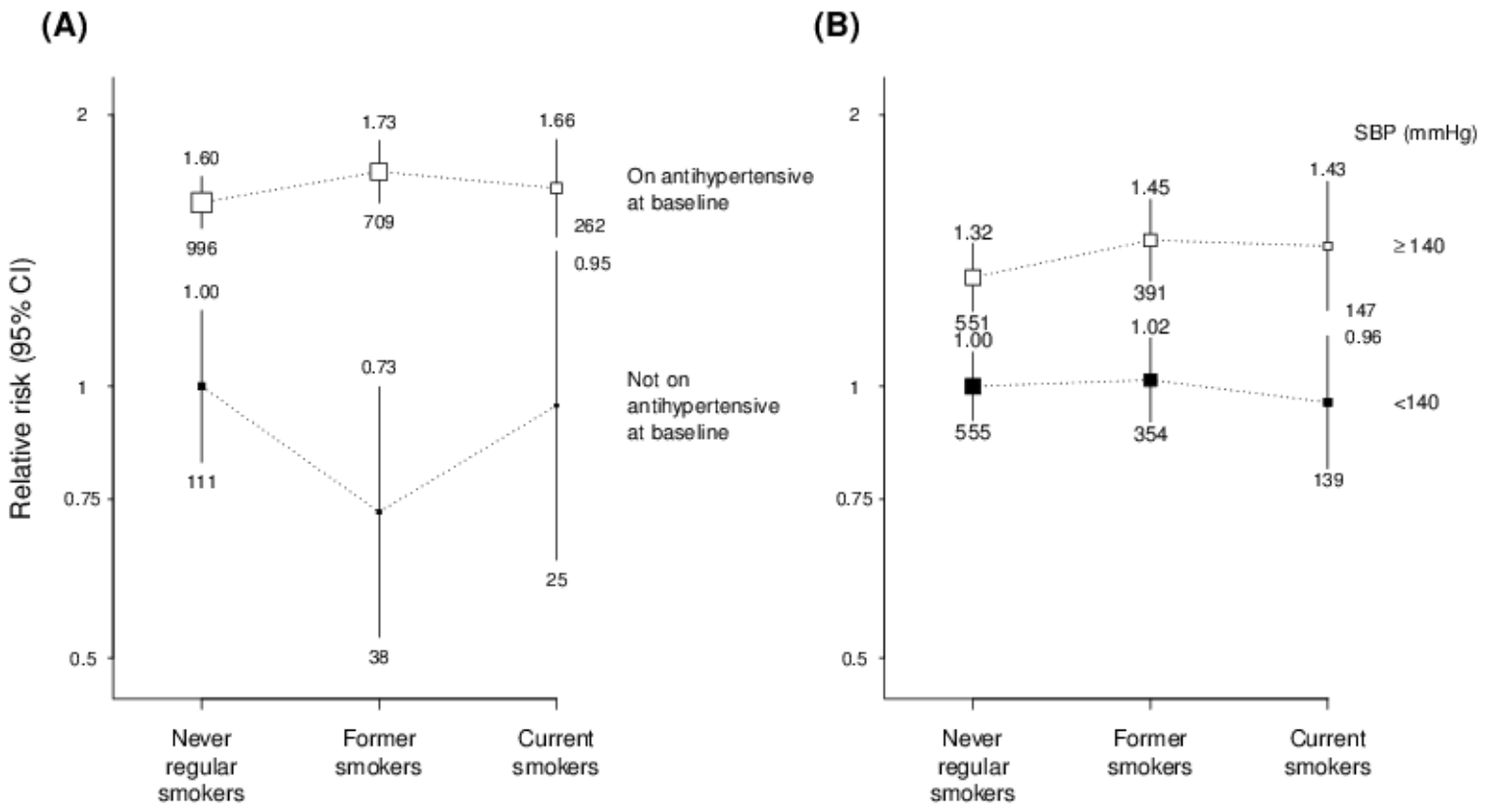
Rates adjusted for age, sex, ethnicity, country, education and prior disease (prior cardiovascular or diabetes).

Figure S4: Relevance of smoking to ESRD by (A) baseline eGFR and (B) albumin:creatinine ratio



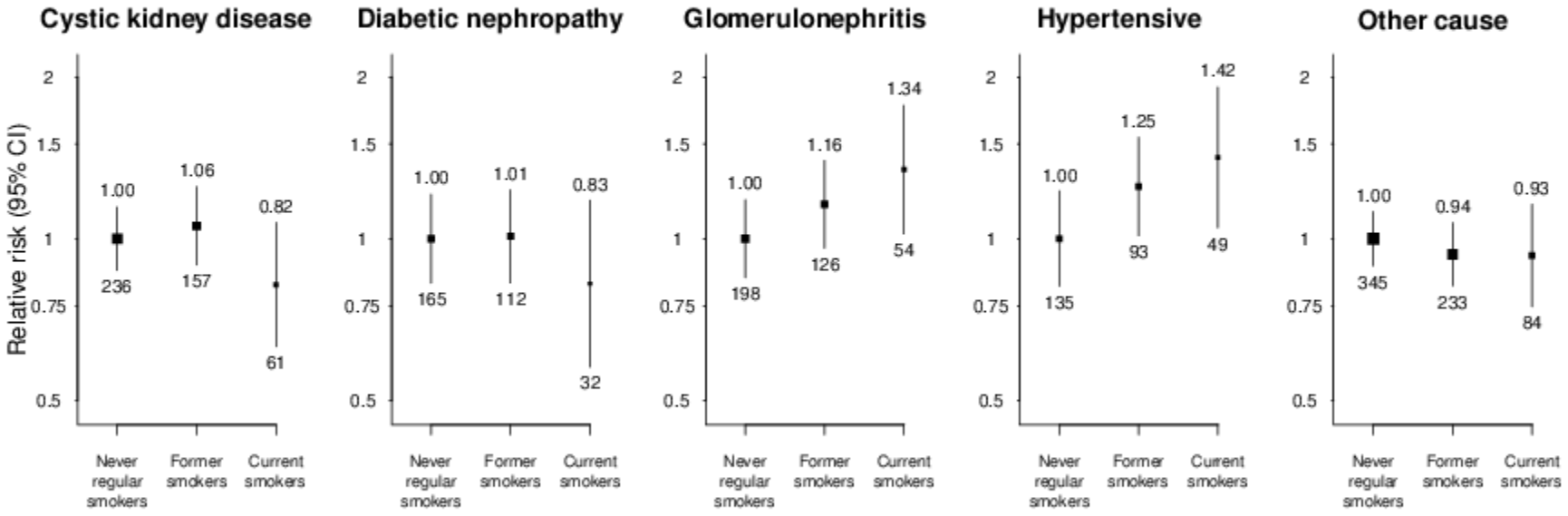
Relative risks adjusted for age, sex, ethnicity, country, education and prior disease (prior cardiovascular and diabetes). In panel (A), never regular smokers with eGFR greater than or equal to 30 used as reference category. In panel (B), never regular smokers with albumin:creatinine ratio <30 mg/g used as reference category.

Figure S5: Relevance of smoking to ESRD by (A) baseline antihypertensive use and (B) baseline systolic blood pressure



Relative risks adjusted for age, sex, ethnicity, country, education and prior disease (prior cardiovascular and diabetes). In panel (A), never regular smokers not on antihypertensive at baseline used as reference category. In panel (B), never regular smokers with systolic blood pressure <140 mmHg used as reference category

Figure S6: Relevance of baseline smoking status to ESRD, by cause of kidney disease



Relative risks adjusted for age, sex, ethnicity, country, education and prior disease. Test for interaction between smoking status and cause of kidney disease: χ^2_8=11.2; p=0.19.