

1 **A simple asthma prediction tool for pre-school children with wheeze or cough**

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35 Asthma, wheeze, cough, children, prediction, prognosis, persistence, longitudinal,
36 cohort study

37

38 **Clinical Implications**

39 The proposed asthma prediction tool is simple and uses information that is non-
40 invasive and easy to assess. This makes it an ideal instrument for use in clinical
41 practice and research.

42

43 **Capsule summary**

44 We have developed a simple tool to predict later asthma in preschool children
45 suffering from wheeze or cough. Its simplicity and internal validity facilitate use in
46 clinical practice and epidemiological research.

47

48 **Abbreviations**

49 ROC curve: receiver operating characteristic curve

50 AUC: area under the ROC curve

51 HL test: Hosmer-Lemeshow goodness-of-fit-test

52 OR: odds ratio

53

54 **Abstract**

55 **Background:** Many preschool children suffer from wheeze or cough, but only some
56 have asthma later. Existing prediction tools are difficult to apply in clinical practice or
57 exhibit methodological weaknesses.

58 **Objective:** To develop a simple and robust tool for predicting asthma at school-age
59 in pre-school children with wheeze or cough.

60 **Methods:** From a population-based cohort in Leicestershire, UK, we included 1-3
61 year-olds seeing a doctor for wheeze or cough, and assessed prevalence of asthma
62 five years later. We considered only non-invasive predictors that are easy to assess
63 in primary care: demographic and perinatal data, eczema, upper and lower
64 respiratory symptoms and family history of atopy. We developed a model using
65 logistic regression, avoided over-fitting with LASSO-penalty, and then simplified it to
66 a practical tool. We performed internal validation and assessed its predictive
67 performance using the scaled Brier score and the area under receiver operating
68 characteristic curve (AUC).

69 **Results:** Of 1226 symptomatic children with follow-up information, 345 (28%) had
70 asthma 5 years later. The tool consists of 10 predictors yielding a total score
71 between 0 and 15: sex, age, wheeze without colds, wheeze frequency, activity
72 disturbance, shortness of breath, exercise-related and aeroallergen-related
73 wheeze/cough, eczema, and parental history of asthma/bronchitis. The scaled Brier
74 scores for the internally validated model and tool were 0.20 and 0.16, and the AUCs
75 were 0.76 and 0.74, respectively.

76 **Conclusion:**

77 This tool represents a simple, low-cost and non-invasive method to predict the risk
78 for later asthma in symptomatic pre-school children, which is ready to be tested in
79 other populations.

80 **Introduction**

81 Many preschool children present to primary care with recurrent wheeze or cough.
82 These symptoms are a burden to families and lead to treatment with inhalers,
83 antibiotics or cough mixtures, hospitalizations and considerable health care costs.¹ In
84 this age-group, wheezing illness is heterogeneous and includes different phenotypes
85 with varying prognoses.²⁻⁵ Fortunately, only some children will have persistent
86 problems till school-age. The ability to predict persistence of wheeze up to school-
87 age would allow preventative and therapeutic efforts to be directed to those most in
88 need⁶ and would reassure parents of children with transient problems. It would also
89 help to select children for intervention studies aiming to alter the course of disease.⁷
90 Several groups have presented tools for prediction of later asthma in preschool
91 children⁸⁻¹⁶, but their use for primary care is limited.¹⁷ Some tools were developed in
92 study populations untypical for primary care. For instance, they included
93 asymptomatic children,^{8, 10, 14, 16} children with mild symptoms, who never visited their
94 doctor,^{13, 15} or only high-risk children hospitalized for bronchiolitis.¹² Several studies
95 excluded children with chronic cough,^{13, 15} who might actually suffer from a variant of
96 asthma.^{4, 18} Some tools included predictors, such as parental education, that are not
97 easily generalizable to other populations.⁹ Other tools involve invasive
98 measurements (blood tests or skin prick tests) that might not be accepted by all
99 families in primary care.^{8, 11, 13, 14} Finally, the methods commonly used to develop the
100 prediction tools are prone to over-fitting the data.^{9, 11, 13} Over-fitting leads to reduced
101 performance when tools are applied to other populations.^{19, 20}
102 In this study we aimed to develop a simple tool to predict asthma at school-age in
103 preschool children with wheeze or chronic cough. We designed the tool for
104 application in clinical practice, particularly primary care, by: a) studying a population

105 of symptomatic children, who had presented to the doctor for wheeze or cough; b)
106 defining a clinically relevant outcome; c) considering only predictive factors easily
107 assessed during a single consultation (a detailed symptom history, but no blood or
108 skin prick tests and no repeated observations); d) developing a robust model that
109 performs well in internal validation and relevant sensitivity analyses but does not
110 over-fit the data and is therefore likely to be transferable to other populations.

111

112 **Methods**

113 *Study population*

114 We analyzed data from a population-based childhood cohort from Leicestershire,
115 UK, described in detail elsewhere.^{21, 22, 23} In brief, we recruited a representative
116 population-based sample of 6808 children of white and south Asian ethnic origin,
117 born in 1993-97. Perinatal data were collected at birth; data on growth and
118 development were acquired prospectively during childhood. Upper and lower
119 respiratory morbidity, treatments and health care utilization, family history of atopic
120 disease and individual and family-related exposures were assessed by repeated
121 questionnaires (1998, 1999, 2001, 2003, 2006, 2010). The study was approved by
122 the Leicestershire Health Authority Research Ethics Committee.

123 *Presentation at baseline (inclusion criteria)*

124 Our analysis included all cohort children aged 1-3 years at baseline with parent-
125 reported wheeze or chronic cough (cough without colds or cough at night) with one
126 or more visits to the doctor for wheeze or cough during the past 12 months (Fig 1,
127 highlighted in grey). The original questions are provided in the online repository. We
128 included chronic cough, because some children with chronic cough might suffer from
129 a variant of asthma and be at risk for asthma later in life.^{4, 18} Information on

130 symptoms at baseline was taken from the 1998 or the 1999 questionnaire, favoring
131 the questionnaire when children were closest to age 2.0 years.

132 *Any asthma at school-age (definition of outcome)*

133 We defined a clinically relevant outcome as the combination of current wheeze *plus*
134 use of asthma medication during the past 12 months at the age of 6-8 years, i.e. 5
135 years later (see online repository for original questions). Asthma medication included
136 short- or long-acting beta-2-agonists, inhaled corticosteroids, leukotriene receptor
137 antagonists or oral corticosteroids.

138 We used Fisher's exact test to compare characteristics of children with and without
139 the outcome (Table E1, Table I) as well as to compare characteristics of children by
140 availability of follow-up information (Table E2). *Choice of potential predictive factors*

141 We used the following approach to compile the list of potential predictors. First, we
142 reviewed the literature to identify relevant risk factors for incidence or persistence of
143 childhood asthma.^{3, 24-31} From these, we only selected factors that are readily
144 available in primary care and do not require repeated observations or additional
145 investigations like blood or skin prick tests. The final list contained 24 potential
146 predictors (Table E1): demographic and perinatal data; eczema; upper and lower
147 respiratory symptoms, particularly those reflecting triggers and severity of wheeze;
148 and parental history of wheeze, asthma, bronchitis or hay fever (see online
149 repository for original questions). We did not include environmental or
150 socioeconomic information, because their prevalence and interpretation is likely to
151 vary between populations and, thus, their inclusion might reduce the generalizability
152 of the tool.

153 *Model development*

154 We used LASSO-penalized logistic regression to develop the prediction model.^{32, 33}

155 This approach allows to identify important predictors and to estimate their influence
156 on later asthma without over-fitting the data. Traditional methods used for selecting
157 predictors, such as stepwise backward or forward selection, tend to over-fit the data,
158 resulting in models that predict outcomes in the current dataset well, but become
159 unreliable in other datasets.²⁰ For our analysis, we recoded all potential predictors
160 with >2 response categories into multiple binary variables. Thus, 38 binary variables
161 derived from the 24 questions entered the variable selection process (see online
162 repository for details). LASSO regression selects predictors in the order of their
163 predictive importance. The final prediction model allows calculation of a prediction
164 score and the probability of later asthma for each child.

165 *Model performance*

166 We assessed our prediction model in terms of overall performance, discrimination
167 and calibration. To assess *overall performance* we calculated the scaled Brier
168 score,²⁰ a measure of the discrepancy between the predicted probability and the
169 actual outcome. A scaled Brier score with a value of zero means that the model does
170 not predict later asthma in an individual better than if it had been informed only by
171 the average prevalence of asthma at school-age; the maximal value of one indicates
172 perfect prediction. To determine the *discriminative ability* of the model (i.e. its ability
173 to distinguish between children with and without later asthma) we plotted the receiver
174 operating characteristics (ROC) curve and calculated the area under this curve
175 (AUC), also known as c-statistic.^{20, 34} The AUC can take on values from 0 to 1, with 1
176 being a perfectly discriminating model. Discrimination is considered not better than
177 chance if AUC=0.5, moderate if AUC is 0.6 to 0.8, and good if AUC>0.8.³⁴

178 *Calibration* of the model (how well the predicted probabilities agree with the
179 prevalence of the outcome in subgroups of children) was tested using the Hosmer-

180 Lemeshow goodness-of-fit-test (HL test)^{20, 35} and visualized using a calibration plot.²⁰
181 An HL test result of less than 0.05 indicates that the predicted probabilities and the
182 actual outcome agree poorly. In the calibration plot, a perfect calibration curve would
183 lie exactly on the diagonal line.

184 *Internal validity*

185 A prediction model can be validated internally to provide a more accurate estimate of
186 model performance in other populations. As an internal validation of our model, we
187 used the leave-one-out cross-validation method^{20, 34} assessing overall performance
188 (Brier), discrimination (AUC), and calibration (see online repository for further
189 explanations).

190 *Sensitivity analyses*

191 To test the robustness of the model developed in our original study population (P0),
192 we performed sensitivity analyses using modified inclusion criteria at baseline or
193 modified definitions of the outcome, resulting in slight changes of the study
194 populations (P1 to P4, described in more detail in Tables E3 and E4 of the online
195 repository).

196 We first applied our existing prediction model to these modified populations and
197 calculated the scaled Brier score and AUC (Sensitivity analysis I). Second, we
198 developed new models within the slightly modified study populations P1 to P4, and
199 assessed their performance (Sensitivity analysis II).

200 *Clinical prediction tool*

201 To simplify our model to a practical tool, we considered three different approaches:
202 a) multiplying regression coefficients by factors 10, 5 and 3 and rounding them to the
203 nearest integer;²⁰ b) setting the penalty of the LASSO-penalized logistic regression
204 so that only a few important predictors (5 or 3) were retained, and c) considering a

205 model with frequency of wheeze as the only predictor.¹⁹ All these approaches aimed
206 to reduce the number of variables while maintaining a comparable predictive
207 performance.

208

209 **Results**

210 *Study population*

211 At the baseline survey, 5878 of 6808 children were aged 1-3 years. Figure 1 shows
212 how many of the 1-3 year old children reported episodes of wheeze, cough without
213 colds or cough at night in the past 12 months and in addition reported visits to a
214 doctor (N=2444), making them eligible for the study. For 1226 we had information on
215 any asthma five years later. Their characteristics are shown in Table I for the
216 variables selected by the main model and in Table E1 (online repository) for all
217 potential predictors considered. At baseline, 336 children (27.4%) were aged one
218 year, 702 (57.3%) two years and 188 (15.3%) three years. The mean prediction
219 interval from baseline to outcome was 4.5 (\pm SD 0.5) years. At school-age, 345
220 (28.1%) had any asthma.

221 Table E2 in the online repository compares eligible children with and without follow-
222 up information. The groups were comparable in many aspects (chronic cough, upper
223 respiratory infections, eczema and parental history), but those with follow-up
224 information were more likely to be of white ethnicity and less likely to have wheeze at
225 baseline.

226 *Main prediction model*

227 Of the 38 binary predictors that entered variable selection, the LASSO-penalized
228 logistic regression retained 22 (Table II). The 5 most important predictors were, in
229 order of importance, shortness of breath, frequent wheeze, wheeze without colds,

230 activity disturbance by wheeze and wheeze/cough triggered by exercise. In addition,
231 the model included aeroallergen-related wheeze/cough, male sex, age, birth weight,
232 gestational age, eczema, upper respiratory symptoms, and parental history of
233 wheeze, asthma, bronchitis or hay fever.

234 In the original study population, the overall performance of the main model measured
235 by the scaled Brier score was 0.23 and its discriminative ability (AUC) was 0.78. In
236 internal validation, these measures were comparable, 0.20 and 0.76 respectively.
237 The calibration plot (Fig 2) shows good agreement between the predicted
238 probabilities of later asthma and the observed frequencies in internal validation. The
239 same was indicated by the Hosmer-Lemeshow test ($p=0.6$).

240 *Sensitivity analyses*

241 Sensitivity analyses I: The main model was robust to changes in baseline criteria
242 (P1, P2 in Table E3). When the outcome definition was changed to wheeze plus a
243 doctor's diagnosis of asthma (P3) or to moderately severe asthma (≥ 4 attacks plus
244 inhaled corticosteroids; P4), the AUC improved to 0.80 and 0.87 respectively (P3
245 and P4 in Table E3). Sensitivity analyses II: The performance of new models
246 developed in these alternative study populations was comparable to the main model
247 for P1-P3 and slightly improved for P4 (Table E4). The selected predictors and
248 estimated coefficients in the newly developed models (Table E5) were comparable to
249 those of the main model. Severity-related predictors (wheeze without colds, frequent
250 attacks, shortness of breath, activity disturbance) gained comparatively more weight
251 when predicting moderately severe asthma (P4).

252 *Clinical prediction tool*

253 We then simplified the model using the three planned approaches. Our preferred
254 simplification includes 10 variables (13 binary predictors), each of which contributes

255 with one of 3 values (1, 2 or 3) to the prediction score (Fig 3; an online version of the
256 prediction tool is available on www.leicestercohorts.org).

257 This tool was derived from the original model by multiplying all regression
258 coefficients with 3 and rounding them to the nearest integer, dropping variables with
259 coefficients rounded to zero.²⁰ It had almost the same discriminative ability
260 (AUC=0.775) as the main model (AUC=0.782) (Fig.4). Other approaches to
261 simplification retained more predictors (making the tool complicated with little benefit)
262 or had reduced discriminative ability (Table E6), particularly the model with
263 frequency of wheeze only.

264 In internal validation, the prediction tool showed only a minor decrease in
265 performance compared to the main model: the scaled Brier score was 0.16 and the
266 AUC 0.74.

267 The maximum score a child can attain using the prediction tool is 15, corresponding
268 to a 95% probability of having any asthma 5 years later (Fig 3). Sensitivity and
269 specificity of the tool are 0.72 and 0.71 for a score of 5, and 0.22 and 0.98 for a
270 score of 10 (additional performance measures are reported in Table E7). In our study
271 sample, 840 (69%) children were at low risk (score ≤ 5), 288 (23%) at medium risk
272 (score ≥ 6 and ≤ 9) and 98 (8%) at high risk (score ≥ 10) of any asthma 5 years later.
273 The percentage of children with any asthma at school age was 16%, 48% and 79%
274 in the low, medium and high risk groups respectively.

275

276 **Discussion**

277 *Summary of findings*

278 We have developed a new tool for predicting asthma at school-age in preschool
279 children who see a doctor for wheeze or cough. Our tool includes 10 predictors

280 representing wheeze severity and triggers, male sex, age, eczema and parental
281 respiratory history. It showed good internal validity and is distinguished by ease of
282 use in primary care and epidemiological studies.

283 *Comparison with previous prediction models*

284 Several prediction models have been proposed for estimating the risk of persistent
285 asthma in preschool children.⁸⁻¹⁶ Table III summarizes inclusion criteria, outcome,
286 methods used to derive the tool, predictors and performance for three tools that used
287 a similar prediction interval as ours and had a sample size of >300. In short, Castro-
288 Rodriguez (Tucson Children's Respiratory Study) used data from 2-3 year-olds with
289 and without respiratory symptoms to develop two prediction tools for asthma at
290 school-age (loose and stringent asthma predictive index, API; Table III).⁸

291 Kurukulaaratchy (Isle of Wight birth cohort) proposed a score for persistence of early
292 wheeze up to age 10.¹³ Caudri (PIAMA birth cohort), developed a clinical risk score
293 for 0-4 year-olds with wheeze or cough to predict asthma at age 7-8.⁹

294 The performance of these tools was comparable or slightly less than ours (Table III),
295 with a Youden index³⁶ (sensitivity + specificity -1) varying from 0.32⁸ to 0.38¹³
296 (calculated based on the maximal sum of sensitivity and specificity reported in the
297 respective studies) compared to 0.43 in our study. The Youden index ranges
298 between 0 and 1. Values close to 1 indicate large predictive effectiveness and values
299 close to 0 limited effectiveness.

300 The method used to derive the APIs is difficult to replicate,⁸ while methods used for
301 the other tools^{9, 13} (logistic regression with stepwise variable selection) tend to over-
302 fit the data, i.e. the models might be overly influenced by the random variation in the
303 data used to develop them. This limits the application of the models to other
304 populations.

305 Only Caudri et al. performed an internal validation of their prediction model and
306 reported a similar AUC (0.72) to the one we obtained (0.74). They included 8
307 predictors with exact regression coefficients, while our model includes 10 predictors
308 with simplified regression coefficients that facilitate calculation of individual risks in a
309 clinical setting. The PIAMA risk score and the API have been tested in a small
310 external population.^{19, 37}

311 In comparison to our tool, previous asthma prediction rules included at most two
312 descriptors of wheeze (out of frequency, duration or wheeze without colds).^{8-10, 14} In
313 addition, they relied on blood or skin prick tests,^{8, 11-13, 15} which are more time
314 consuming, costly and cumbersome than a detailed symptom history.

315 Socioeconomic position is a proxy measure for a variety of exposures and health
316 care access and might have a variable impact in different populations.⁹

317 *Strengths and limitations*

318 The main strengths of our tool are the objective approach used for its development
319 and its clinical applicability. We used a population-based sample of an adequate size
320 to develop the model. We included only children with health care visits for wheeze or
321 cough, assuring that the sample represents a clinically relevant population. We
322 defined a clinically relevant outcome measure (wheeze needing treatment). When
323 defining a more severe outcome (moderately severe asthma, defined as ≥ 4 attacks
324 per year and inhaled corticosteroid treatment) the tool performed even better. All
325 predictors are obtained routinely when taking a respiratory history for a child
326 presenting with chronic cough or wheeze and predictors are easy to assess even
327 during a short primary care consultation or in a questionnaire survey. We used a
328 method that minimizes over-fitting and is less affected by sampling variability
329 compared to stepwise variable selection procedures,³⁸ and we did an internal

330 validation. Finally, our model predicts a range of probabilities rather than predicting
331 only a low or high risk as the API.⁸

332 Like other studies,^{8, 9, 11, 13} ours relies on parent-reported questionnaire data.
333 However, it uses standardized questions, mostly from the ISAAC-study³⁹ and reflects
334 to some extent the clinical situation, where parents report respiratory symptoms. The
335 applied questionnaire showed good repeatability.⁴⁰ We did not use objective
336 measurements to define our outcome. However, for a subsample of our study
337 population (N=451), we assessed bronchodilator response in a later survey
338 conducted in 2006 (Table E8). Using the same outcome definitions (any asthma and
339 moderately severe asthma), mean percent change in forced expiratory volume in the
340 1st second (FEV₁) was significantly higher in children with any asthma compared to
341 those without (5.5% (95% CI 3.6-7.3) vs 2.6% (2.0-3.2), p<0.001). For maximal
342 expiratory flow at 50% of vital capacity (MEF₅₀), mean percent change was 16.7%
343 (12.8-20.5) and 10.7% (8.8-12.5) respectively (p=0.003). This is less than the cut-
344 offs recommended for clinical situations.⁴¹ However, our measurements came not
345 from hospital-based children referred when they were unwell, but from community-
346 based children with very mild asthma who were usually asymptomatic when
347 measured. Our results are in line with data from Galant et al, where bronchodilator
348 responses for FEV₁ were 7.3% (4.2-10.4) in mild persistent asthmatics and 7.6%
349 (5.8-9.5) in mild intermittent asthmatics compared to 2.2% (0.2-4.3) in non-
350 asthmatics.⁴² Children with and without follow-up information were comparable
351 (Table E2), although we cannot exclude that selection bias has affected the
352 composition of the final model. Finally, we interpreted missing values in potential
353 predictor variables as an absence of the respective risk factor, which may also have

354 affected the results. However, the number of missing values did not exceed 5.8% in
355 any of the potential predictor variables.

356 *Meaning of the study*

357 Our model was robust and results changed little with modifications of the inclusion
358 criteria and outcomes. In fact, the performance improved (AUC 0.89 vs. 0.78) when
359 we predicted moderately severe asthma, rather than any asthma. After internal
360 validation, the AUC of main model and tool were similar to the ones before
361 validation, suggesting that there was little over-fitting.

362 Our tool used only information on symptoms that can be gathered in a simple
363 patient's history. Despite that, it had a similar or better predictive performance than
364 previous tools including more complex measurements.^{8, 11, 13-15} This suggests that a
365 detailed description of presented symptoms might predict later asthma equally well
366 as more invasive methods, including blood eosinophilia or skin prick tests.^{8, 11, 13-15}

367 Seven of 10 predictors (including the 5 strongest) describe the symptoms: frequency
368 of attacks, activity disturbance, shortness of breath, triggers (wheeze apart from
369 colds, exercise, aeroallergens) and eczema. This is consistent with the old
370 knowledge that frequent wheeze strongly predicts asthma persistence,^{10, 43} and with
371 our previous report, showing that frequency of wheeze predicted asthma nearly as
372 well as the complicated API rule.¹⁹ In our tool, adding more symptoms (in addition to
373 wheeze frequency) improved the performance (AUC after internal validation 0.74 for
374 the tool vs. 0.57 for wheeze frequency only; Table E6). This shows that more
375 detailed assessment of symptoms in pre-school children improves prediction of later
376 asthma.

377 *Future research*

378 To further evaluate the predictive performance of the proposed tool and assess its
379 generalizability to other populations, external validation in independent samples is
380 necessary.³⁴ We therefore encourage the application and validation of this tool in
381 ongoing epidemiological studies and clinical care (particularly primary care). Some
382 earlier prediction models^{8, 9, 13} performed similarly in external populations, but their
383 performance remained modest.^{15, 19, 37}

384 Compared to other prediction rules, our tool includes detailed description of symptom
385 severity and pattern. This raises the possibility that further refinement in the
386 description of preschool wheeze phenotype might improve precision of prediction of
387 later asthma. Additional gains might be made by detailed assessment of age-related
388 changes, physiological measurements (lung function, bronchial
389 hyperresponsiveness, exhaled nitric oxide, atopy), environmental, socioeconomic
390 and genetic risk factors.¹⁷ All this could, however, compromise the tool's simplicity.

391 *Conclusions*

392 This tool represents a simple, low-cost and non-invasive method to predict the risk
393 for later asthma in symptomatic preschool children, which is ready to be tested in
394 other populations.

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Table I. Characteristics of the study population (N=1226) at baseline, by development of asthma 5 years later*

		5 yrs later:		5 yrs later:		
		Asthma (n=345)		No Asthma (n=881)		
		n (%)	n (%)	n (%)	n (%)	p-value†
Demographic and perinatal data						
Male		224 (64.9)	454 (51.5)			<0.001
Age (years):	1	85 (24.6)	251 (28.5)			0.388
	2	204 (59.1)	498 (56.5)			
	3	56 (16.2)	132 (15.0)			
	3	56 (16.2)	132 (15.0)			
Gestational age <37 weeks		35 (10.1)	49 (5.6)			0.006
Birth weight <2500 g		41 (11.9)	68 (7.7)			0.025
Wheeze-related symptoms‡						
Current wheeze		272 (78.8)	425 (48.2)			<0.001
Wheeze without colds		127 (36.8)	95 (10.8)			<0.001
Frequency of attacks:	0	81 (23.5)	476 (54.0)			<0.001
	1-3	111 (32.2)	281 (31.9)			
	4-12	117 (33.9)	106 (12.0)			
	>12	36 (10.4)	18 (2.0)			
Activity disturbance:	no	141 (40.9)	649 (73.7)			<0.001
	little	129 (37.4)	185 (21.0)			
	moderate	57 (16.5)	39 (4.4)			
	a lot	18 (5.2)	8 (0.9)			
Shortness of breath:	never	129 (37.4)	668 (75.8)			<0.001
	sometimes	166 (48.1)	190 (21.6)			
	always	50 (14.5)	23 (2.6)			
Exercise-related wheeze/cough§		196 (56.8)	286 (32.5)			<0.001
Aeroallergen-related wheeze/cough		52 (15.1)	37 (4.2)			<0.001
Other symptoms‡						
Cough without colds		233 (67.5)	536 (60.8)			0.030
Duration of colds (weeks):	<1	75 (21.7)	203 (23.0)			0.194
	1-2	198 (57.4)	533 (60.5)			
	>2	72 (20.9)	145 (16.5)			
Nasal symptoms		186 (53.9)	350 (39.7)			<0.001
Eczema (ever)		190 (55.1)	343 (38.9)			<0.001
Parental history						
Wheeze, asthma or bronchitis:	none	142 (41.2)	499 (56.6)			<0.001
	father	68 (19.7)	136 (15.4)			
	mother	85 (24.6)	182 (20.7)			
	both	50 (14.5)	64 (7.3)			
Hay fever:	none	152 (44.1)	474 (53.8)			0.001
	father	56 (16.2)	144 (16.3)			
	mother	93 (27.0)	203 (23.0)			
	both	44 (12.8)	60 (6.8)			

* This table includes all predictors that were selected for the main model

† Fisher's exact test

‡ During the last 12 months

§ Wheeze or cough with running, playing, laughing or crying

Table II. Important factors for prediction of asthma at school age in symptomatic preschool children (selected by penalized logistic regression)

	OR [§]	Regression coefficient (RC)	Simplified RC*	Order of inclusion
		Main model	Tool	
Demographic and perinatal data				
Male	1.48	0.394	1	9
Age: >1 year	1.19	0.171	1	16
Gestational age <37 weeks	1.11	0.108		18
Birthweight <2500g	1.17	0.154		17
Wheeze-related symptoms†				
Current wheeze	1.18	0.163		13
Wheeze without colds	1.40	0.337	1	3
Frequency of attacks: >3	1.65	0.500	2	2
Activity disturbance:				
any	1.28	0.243	1	4
moderate or a lot	1.16	0.144		7
a lot	1.63	0.491	1	13
sometimes or				
Shortness of breath: always	1.98	0.684	2	1
always	1.56	0.442	1	6
Exercise-related wheeze/cough‡	1.26	0.233	1	5
Aeroallergen-related wheeze/cough	1.22	0.198	1	10
Other symptoms†				
Cough without colds	1.09	0.086		18
Duration of colds: at least 1 week	0.97	-0.031		22
Nasal symptoms	1.17	0.157		12
Eczema (ever)	1.52	0.420	1	7
Parental history				
Wheeze, asthma or bronchitis:				
mother or father	1.23	0.203	1	10
both parents	1.26	0.235	1	13
Hay fever:				
mother or father	1.03	0.025		21
both parents	1.12	0.110		18
Number of binary predictors	22	22	13	22
Number of variables	17	17	10	17

* RC of the main model multiplied by 3 and rounded to the nearest integer (simplification approach where the number of variables was substantially reduced without relevant decrease in predictive performance)

† During the last 12 months

‡ Wheeze or cough with running, playing, laughing or crying

§ Confidence intervals for the ORs are not provided because OR estimates result from penalized logistic regression which is primarily a method for variable selection rather than for statistical inference. Estimates are deliberately biased toward null with the benefit of reducing their variance and improving overall prediction. Confidence intervals are misleading in this context.

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Table III. Comparison of four asthma prediction tools for preschool children

	Leicester (present study) (Leicestershire Respiratory Cohort Studies)	Tucson (API)^{8*} Tucson Children's Respiratory Study	IoWBC¹³ Isle of Wight Birth Cohort	PIAMA⁹ Prevention and Incidence of Asthma and Mite Allergy
N (included in analysis)	1226	776	336	2054
Inclusion criteria				
Age (y)	1-3	2-3	4	1-4
Symptoms	Health care visit due to respiratory problems plus at least one of the following symptoms in the past 12 months: Wheeze, cough without colds, cough at night	Entire cohort (including a majority of children without symptoms)	Wheeze at ages 1,2 and 4 yrs	Wheeze or cough at night without colds (or both) in the past 12 months
Outcome definition				
Age (y)	6-8	8	10	7-8
Prediction interval (y)	4-5	5	6	3-7
Criteria	Wheeze plus asthma medication (past 12 mo)	Doctor's diagnosis of asthma plus current wheeze, or more than 3 wheeze episodes (past 12 mo)	Current wheeze	At ages 7 and 8y: Current wheeze or prescription of inhaled corticosteroids or doctor's diagnosis of asthma (past 12 mo)
Outcome prevalence	28.1 %	13.7%	37.2%	11.7%
Predictor variables included in tool	Male sex, Age: >1y, wheeze without colds, frequent wheeze, activity disturbance, shortness of breath, exercise-related wheeze/cough†, aeroallergen-related wheeze/cough, eczema, parental asthma or wheeze bronchitis	Wheeze, frequent wheeze‡ , wheeze without colds, eczema, parental asthma, blood eosinophilia, allergic rhinitis	Family history of asthma, recurrent chest infections (at 2yrs), skin prick test positivity (at 4yrs), nasal symptoms (at 1yr)	Male sex, post term delivery, wheeze/dyspnea without colds, frequent wheeze, eczema, respiratory infections, inhalation medication (parents), parental education
Method used to derive tool	Penalized logistic regression	The combination of predictors was chosen that yielded the highest PPV and specificity	Stepwise backward logistic regression	Stepwise backward logistic regression
Performance measures§	Score-cutoff: ≥5	Loose API	Score-cutoff: ≥3	Score-cutoff: ≥20
Youden index ³⁶	0.43	0.32	0.38	0.36
Sensitivity (%)	72	51	53	60
Specificity (%)	71	81	85	76
PPV (%)	49	29	68	23
NPV (%)	86	91	74	94

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API, Asthma Predictive Index; PPV, positive predictive value; NPV, negative predictive value.

* To have a prediction interval comparable to the one in our tool, we focused here on the API for prediction at 8 yrs

† Wheeze or cough with running, playing, laughing or crying

‡ This variable is only part of the stringent API, but not of the loose API

§ Reported for cut-off where sum of sensitivity and specificity pair was maximal. It is possible that a higher sum of sensitivity and specificity exists at a cut-off point that was not reported in the respective studies.

530 **Figure legends**

531

532 **Fig 1. Wheeze, cough and health care visits in 1 to 3 year-old children.**

533 Proportional Venn diagram for children aged 1 to 3 years, showing frequency of
534 health care visits due to wheeze or cough, current wheeze and chronic cough (cough
535 without colds or cough at night). The shaded grey represents our study population.

536

537 **Fig 2. Calibration plot of main model (assessed in leave-one out cross-**

538 **validation).** Children are grouped into deciles of their predicted probability. The
539 average predicted probability for later asthma among children within each decile is
540 plotted against the actual observed frequency (prevalence) of asthma in that group.
541 As a visual aid a smoothing technique (locally-weighted polynomial regression) was
542 applied to these data.

543 The straight line represents perfect calibration.

544

545 **Fig 3. Asthma prediction tool.** For any 1-3-year-old child seeking health care due
546 to wheeze or cough the applicable predictors are summed to a total score in the
547 upper part of the figure. The estimated probability of having asthma 5 years later is
548 given below for different total scores.

549

550 **Fig 4. Receiver operating characteristic (ROC) curves for the main asthma**
551 **prediction model and for the prediction tool.**

552 The dots represent sensitivity and specificity for different cutoff-values of the
553 prediction tool.

554

1 **A simple asthma prediction tool for pre-school children with wheeze or cough**

2

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13 * Shared last authorship

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24 **Online Repository**

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26 **Details of statistical methods**

27 *Development of the main prediction model*

28 We used the R package glmnet to fit the penalized logistic regression. The
29 parameter alpha was set to 1 so that only a LASSO type penalty was included. This
30 tends to retain only the most influential predictors. The parameter lambda, which
31 determines the magnitude of the penalty was set to a value that maximized the area
32 under the receiver operating characteristic curve of resulting predictions in 10-fold
33 cross-validation¹. All potential predictors with more than 2 response categories were
34 coded as binary variables. If the original categories were ordered, these
35 dichotomous variables represented all possible cut-off points separating lower from
36 higher categories. For instance, frequency of wheezing episodes in the past 12
37 months (0, 1-3, 4-12, >12) was coded into 3 binary variables indicating >0, >3, and
38 >12 episodes respectively. This procedure resulted in 38 binary variables entering
39 variable selection.

40 Confidence intervals for the ORs are not provided because OR estimates result from
41 penalized logistic regression which is primarily a method for variable selection rather
42 than for statistical inference. Estimates are deliberately biased toward null with the
43 benefit of reducing their variance and improving overall prediction. Confidence
44 intervals are misleading in this context.

45 Data were prepared using Stata 11.0 and analysed using R version 2.12.2. We used
46 the R package ROCR to assess discrimination and the functions hosmerlem and
47 val.prob.ci to assess calibration².

48

49 *Clinical prediction tool*

50 To simplify our model to a practical tool, we considered three different approaches:

51 a) multiplying regression coefficients by factors 10, 5 and 3 and rounding them to the

52 nearest integer;²⁰ b) setting the penalty of the LASSO-penalized logistic regression
53 so that only a few important predictors (5 or 3) were retained, and c) considering a
54 model with frequency of wheeze as the only predictor.¹⁹ All these approaches aimed
55 to reduce the number of variables while maintaining a comparable predictive
56 performance.

57 In Table E7 the performance of these tools are compared with the main model in
58 sample (sample used for model development) and by internal validation (see below).
59 In a final step, we recalibrated the probabilities for later asthma of the preferred tool
60 by re-running a logistic regression of the outcome on simplified scores.

61

62 *Internal validation*

63 To assess the reliability of our result of model performance within our study sample
64 (i.e. to test its repeatability within our development sample) we tested our model in
65 leave-one-out cross-validation. The first step in this technique is to omit the first of
66 total n observations and to use the remaining n-1 observations from the entire study
67 sample to develop a new model. Using this new model, the probability for later
68 asthma is estimated for the one observation left out before. In total, this procedure is
69 repeated n times, each time omitting an observation that has not previously been left
70 out. In the end, internal validity of the model is tested based on these estimated
71 probabilities.

72 Because the purpose was to test the main model's predictive performance and not
73 how the method performs (including variable selection), we chose leave-one-out
74 cross-validation as an internal validation technique that aims to fit models which are
75 very similar to the main model. Other approaches, such as bootstrapping, would
76 result in fitting models that are less similar to the main model, and thus would have

77 tested the repeatability of the method (variable selection approach and estimation of
78 regression coefficients) rather than have validated the main model itself.

79

80

81 **References**

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Table E1. Characteristics of the study population (N=1226) at baseline by development of asthma 5 years later (all potential predictors considered in the analysis)

Question number*		Total study population (N=1226)	5 yrs later: Asthma (N=345)		5 yrs later: No Asthma (N=881)		p-value†
			n (%)	n (%)	n (%)	n (%)	
Demographic and perinatal data							
	Male	678 (55.3)	224 (64.9)	454 (51.5)			<0.001
	Age (years)						0.388
		1	336 (27.4)	85 (24.6)	251 (28.5)		
		2	702 (57.3)	204 (59.1)	498 (56.5)		
		3	188 (15.3)	56 (16.2)	132 (15.0)		
	Gestational age <37 weeks	84 (6.9)	35 (10.1)	49 (5.6)			0.006
	Birth weight <2500 g	109 (8.9)	41 (11.9)	68 (7.7)			0.025
	South Asian ethnicity (versus white)	316 (25.8)	78 (22.6)	238 (27.0)			0.127
Wheeze-related symptoms‡							
8	Current wheeze	697 (56.9)	272 (78.8)	425 (48.2)			<0.001
9	Wheeze without colds	222 (18.1)	127 (36.8)	95 (10.8)			<0.001
10	Frequency of attacks:						<0.001
		0	557 (45.4)	81 (23.5)	476 (54.0)		
		1-3	392 (32.0)	111 (32.2)	281 (31.9)		
		4-12	223 (18.2)	117 (33.9)	106 (12.0)		
		>12	54 (4.4)	36 (10.4)	18 (2.0)		
11	Activity disturbance:						<0.001
		no	790 (64.4)	141 (40.9)	649 (73.7)		
		little	314 (25.6)	129 (37.4)	185 (21.0)		
		moderate	96 (7.8)	57 (16.5)	39 (4.4)		
		a lot	26 (2.1)	18 (5.2)	8 (0.9)		
12	Shortness of breath:						<0.001
		never	797 (65.0)	129 (37.4)	668 (75.8)		
		sometimes	356 (29.0)	166 (48.1)	190 (21.6)		
		always	73 (6.0)	50 (14.5)	23 (2.6)		
13	Sleep disturbance:						<0.001
		never	790 (64.4)	148 (42.9)	642 (72.9)		
		<1	269 (21.9)	122 (35.4)	147 (16.7)		
		>=1	167 (13.6)	75 (21.7)	92 (10.4)		
14	Exercise-related wheeze/cough§	482 (39.3)	196 (56.8)	286 (32.5)			<0.001
14	Aeroallergen-related wheeze/cough	89 (7.3)	52 (15.1)	37 (4.2)			<0.001
14	Food-related wheeze/cough	186 (15.2)	54 (15.7)	132 (15.0)			0.791
Other symptoms‡							
15	Cough without colds	769 (62.7)	233 (67.5)	536 (60.8)			0.030
16	Cough at night	631 (51.5)	190 (55.1)	441 (50.1)			0.127
17	Frequency of colds:						0.001
		<4	447 (36.5)	101 (29.3)	346 (39.3)		
		4-6	461 (37.6)	134 (38.8)	327 (37.1)		
		>6	318 (25.9)	110 (31.9)	208 (23.6)		
18	Duration of colds (weeks):						0.194
		<1	278 (22.7)	75 (21.7)	203 (23.0)		
		1-2	731 (59.6)	198 (57.4)	533 (60.5)		
		>2	217 (17.7)	72 (20.9)	145 (16.5)		
19	Ear infection(s):						0.020
		0	599 (48.9)	151 (43.8)	448 (50.9)		
		1	351 (28.6)	99 (28.7)	252 (28.6)		
		>1	276 (22.5)	95 (27.5)	181 (20.5)		
20	Nasal symptoms	536 (43.7)	186 (53.9)	350 (39.7)			<0.001
21	Snoring	880 (71.8)	267 (77.4)	613 (69.6)			0.006
22	Eczema (ever)	533 (43.5)	190 (55.1)	343 (38.9)			<0.001

Parental history									
23/24	Wheeze, asthma or bronchitis:	none	641	(52.3)	142	(41.2)	499	(56.6)	<0.001
		father	204	(16.6)	68	(19.7)	136	(15.4)	
		mother	267	(21.8)	85	(24.6)	182	(20.7)	
		both	114	(9.3)	50	(14.5)	64	(7.3)	
23/24	Hay fever:	none	626	(51.1)	152	(44.1)	474	(53.8)	0.001
		father	200	(16.3)	56	(16.2)	144	(16.3)	
		mother	296	(24.1)	93	(27.0)	203	(23.0)	
		both	104	(8.5)	44	(12.8)	60	(6.8)	

* See Online Repository: Original questions used in questionnaires

† Fisher's exact test

‡ During the last 12 months

§ Wheeze or cough with running, playing, laughing or crying

Table E2. Characteristics of children at baseline, by availability of follow-up information (N=2444)

		Follow-up information available (N=1226)		Follow-up information not available (N=1218)		p-value*
		n	(%)	n	(%)	
Demographic and perinatal data						
Male		678	(55.3)	633	(52.0)	0.105
Gestational age <37 weeks		84	(6.9)	86	(7.1)	0.874
Birth weight <2500 g		109	(8.9)	86	(7.1)	0.101
South Asian ethnicity (versus white)		316	(25.8)	386	(31.7)	0.001
Wheeze-related symptoms†						
Current wheeze		697	(56.9)	762	(62.6)	0.004
Wheeze without colds		222	(18.1)	272	(22.3)	0.010
Frequency of attacks:	0	557	(45.4)	482	(39.6)	0.012
	1-3	392	(32.0)	419	(34.4)	
	4-12	223	(18.2)	269	(22.1)	
	>12	54	(4.4)	48	(3.9)	
Activity disturbance:	no	790	(64.4)	725	(59.5)	0.044
	little	314	(25.6)	371	(30.5)	
	moderate	96	(7.8)	91	(7.5)	
	a lot	26	(2.1)	31	(2.5)	
Shortness of breath:	never	797	(65.0)	749	(61.5)	0.193
	sometimes	356	(29.0)	387	(31.8)	
	always	73	(6.0)	82	(6.7)	
Sleep disturbance:	never	790	(64.4)	728	(59.8)	0.059
	<1	269	(21.9)	304	(25.0)	
	>=1	167	(13.6)	186	(15.3)	
Exercise-related wheeze/cough‡		482	(39.3)	531	(43.6)	0.033
Aeroallergen-related wheeze/cough		89	(7.3)	104	(8.5)	0.261
Food-related wheeze/cough		186	(15.2)	196	(16.1)	0.540
Other symptoms†						
Cough without colds		769	(62.7)	798	(65.5)	0.152
Cough at night		631	(51.5)	612	(50.2)	0.571
Frequency of colds:	<4	447	(36.5)	420	(34.5)	0.498
	4-6	461	(37.6)	484	(39.7)	
	>6	318	(25.9)	314	(25.8)	
Duration of colds (weeks):	<1	278	(22.7)	268	(22.0)	0.897
	1-2	731	(59.6)	737	(60.5)	
	>2	217	(17.7)	213	(17.5)	
Ear infection(s):	0	599	(48.9)	613	(50.3)	0.481
	1	351	(28.6)	322	(26.4)	

	>1	276	(22.5)	283	(23.2)	
Nasal symptoms		536	(43.7)	569	(46.7)	0.143
Snoring		880	(71.8)	877	(72.0)	0.928
Eczema (ever)		533	(43.5)	548	(45.0)	0.464
Parental history						
Wheeze, asthma or bronchitis:	none	641	(52.3)	647	(53.1)	0.581
	father	204	(16.6)	178	(14.6)	
	mother	267	(21.8)	276	(22.7)	
	both	114	(9.3)	117	(9.6)	
Hay fever:	none	626	(51.1)	646	(53.0)	0.702
	father	200	(16.3)	199	(16.3)	
	mother	296	(24.1)	271	(22.2)	
	both	104	(8.5)	102	(8.4)	

* Fisher's exact test

† During the last 12 months

‡ Wheeze or cough with running, playing, laughing or crying

Table E3. Sensitivity analysis I: Testing performance of *main asthma prediction model* in alternative study populations

Study population	Baseline criteria			Outcome definition			N Total	n Outcome	(%)	Brier (scaled)	AUC*
	1-3 year-olds			5 yrs later							
	Health care visit and any wheeze or chronic cough	Health care visit and any wheeze	Any wheeze	Any wheeze and asthma medication	Any wheeze and ever doctor-diagnosed asthma	>4 episodes of wheeze and inhaled corticosteroids					
P0 (used for main model)	✓			✓			1226	345	(28.1)	0.23	0.78
P1			✓	✓			769	285	(37.1)	0.21	0.77
P2		✓		✓			697	272	(39.0)	0.22	0.77
P3	✓				✓		1239	331	(26.7)	0.25	0.80
P4	✓					✓	1053	71	(6.7)	-0.51†	0.87

Baseline and outcome criteria refer to the past 12 months, if not otherwise stated

*Area under receiver operating characteristic curve

† The negative scaled Brier score is due to the large difference in the prevalence of the outcome in P0 and P4. A simple recalibration without changing the score would lead to a scaled Brier score of 0.24

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96**Table E4. Sensitivity analysis II:** Testing performance of *newly developed asthma prediction models* based on alternative study populations

Study population	Baseline criteria 1-3 year-olds			Outcome definition 5 yrs later			No. of binary predictors in the model	N Total	n Outcome	(%)	Brier (scaled)	AUC*
	Health care visit and any wheeze or chronic cough	Health care visit and any wheeze	Any wheeze	Any wheeze and asthma medication	Any wheeze and ever doctor-diagnosed asthma	>4 episodes of wheeze and inhaled corticosteroids						
P0 (used for main model)	✓			✓			22	1226	345	(28.1)	0.23	0.78
P1			✓	✓			25	769	285	(37.1)	0.22	0.77
P2		✓		✓			23	697	272	(39.0)	0.23	0.78
P3	✓				✓		26	1239	331	(26.7)	0.26	0.81
P4	✓					✓	20	1053	71	(6.7)	0.28	0.89

Baseline and outcome criteria refer to the past 12 months, if not otherwise stated

*Area under receiver operating characteristic curve

TABLE E5. Selected predictors in sensitivity analysis II and corresponding ORs

		Main model*	New models (alternative populations)			
			P1†	P2‡	P3§	P4
		Odds Ratio (OR)	OR	OR	OR	OR
Demographic and perinatal data						
Male		1.48	1.43	1.49	1.68	1.00
Age (years)	≥2	1.19	1.53	1.51	1.28	1.00
	3	1.00	1.00	1.01	1.06	0.95
Gestational age <37 weeks		1.11	1.13	1.00	1.16	1.00
Birth weight <2500 g		1.17	1.18	1.28	1.34	1.00
South Asian ethnicity (versus white)		1.00	1.00	1.00	1.00	0.53
Wheeze-related symptoms¶						
Current wheeze		1.18	1.00	1.00	1.59	1.46
Wheeze without colds		1.40	1.55	1.45	1.42	2.11
Frequency of attacks	≥1	1.00	1.00	1.00	1.05	1.00
	>3	1.65	1.53	1.60	1.37	1.16
	>12	1.00	1.00	1.00	1.00	2.10
Activity disturbance	any	1.28	1.30	1.25	1.28	1.49
	moderate or a lot	1.16	1.31	1.17	1.14	1.00
	a lot	1.63	1.94	1.87	1.81	2.18
Shortness of breath	sometimes or always	1.98	1.90	1.91	1.84	2.06
	always	1.56	1.40	1.41	2.10	2.70
Sleep disturbance	≥1/week	1.00	1.00	1.00	1.10	1.00
	>1/week	1.00	1.00	1.00	1.00	1.20
Exercise-related wheeze/cough**		1.26	1.09	1.15	1.40	1.27
Aeroallergen-related wheeze/cough		1.22	1.05	1.04	1.33	1.00
Food-related wheeze/cough		1.00	1.03	1.02	0.97	1.00
Other symptoms¶						
Cough without colds		1.09	1.10	1.07	1.16	1.37
Cough at night		1.00	1.12	1.13	1.06	1.00
Frequency of colds	>3	1.00	1.00	1.00	1.00	1.06
	>6	1.00	0.97	1.00	1.00	1.00
Duration of colds (weeks)	≥1	0.97	0.89	0.90	0.80	1.00
	>2	1.00	1.00	1.00	1.00	1.00
Ear infection(s)	≥1	1.00	1.13	1.00	1.00	1.00
	>1	1.00	1.00	1.00	1.00	1.00
Nasal symptoms		1.17	1.14	1.13	1.18	1.14
Snoring		1.00	1.00	1.00	1.00	1.00
Eczema (ever)		1.52	1.42	1.50	1.39	1.62
Parental history						
Wheeze or bronchitis	mother or father	1.23	1.14	1.06	1.45	1.07
	mother or both	1.00	1.00	1.00	1.00	1.00
	both parents	1.26	1.57	1.36	1.39	2.02
Hay fever	mother or father	1.03	1.00	1.00	1.00	1.09
	mother or both	1.00	1.05	1.01	1.00	1.00

	both parents	1.12	1.28	1.37	1.41	1.34
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Baseline and outcome criteria refer to the past 12 months, if not otherwise stated

* Inclusion criteria: 1-3 year-olds with health care visit plus either wheeze or cough without colds or cough at night;

Outcome: Wheeze plus asthma medication at age 6-8 yrs

† Inclusion criterion: 1-3 year-olds with wheeze; Outcome: same as in main model

‡ Inclusion criteria: 1-3 year-olds with health care visit plus wheeze; Outcome: same as in main model

§ Inclusion criteria: same as in main model; Outcome: Current wheeze plus doctor's diagnosis of asthma (ever) at age 6-8 yrs

|| Inclusion criteria: same as in main model; Outcome: >4 episodes of wheeze and using inhaled corticosteroids

¶ During the last 12 months

**Wheeze or cough with running, playing, laughing or crying

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Table E6. Predictive performance of simplified versions of the main asthma prediction model

Simplification approach		No. of binary predictors in the model	Brier score (scaled)		AUC*	
			before vall	after val¶	before vall	after val¶
Main model	no simplification	22	0.23	0.20	0.78	0.76
Rounded model†	factor 10	20	0.23	0.19	0.78	0.75
	factor 5	19	0.23	0.21	0.78	0.77
	factor 3††	13	0.22	0.16	0.78	0.74
Reduced model	first five predictors only‡	5	0.14	0.13	0.75	0.64
	first three predictors only§	3	0.12	0.11	0.73	0.60
Frequent wheeze only**		3	0.13	0.12	0.70	0.57

* Area under receiver operating characteristics curve

†: Using simplified regression coefficients of the model (regression coefficients of main model multiplied by 10, by 5 or by 3, respectively, and rounded to the next integer)

‡ Shortness of breath due to wheeze, frequent wheeze episodes (>3), wheeze without colds, activity disturbance due to wheeze; exercise-related wheeze/cough

§ Shortness of breath due to wheeze, frequent wheeze episodes (>3), wheeze without colds

¶ Before internal validation: assessment using same sample as used to develop the model

¶¶ After internal validation: assessment using leave-one-out crossvalidation

** A 4-level variable coded as 3 binary dummy variables; analysis using logistic regression without penalization

†† Preferred model

Table E7. Performance measures of the prediction tool for different cutoff-values (calculated in sample used to develop the tool without crossvalidation)

Score-cutoff	Sensitivity	Specificity	PPV	NPV	LR+	LR-
0	>0.99	<0.01	0.28	NA	1.00	*
1	>0.99	0.02	0.29	0.95	1.02	0.12
2	0.96	0.14	0.30	0.89	1.11	0.30
3	0.91	0.37	0.36	0.92	1.45	0.23
4	0.79	0.57	0.42	0.87	1.84	0.37
5	0.72	0.71	0.49	0.86	2.47	0.40
6	0.62	0.80	0.55	0.84	3.18	0.47
7	0.52	0.88	0.62	0.82	4.19	0.55
8	0.42	0.92	0.68	0.80	5.53	0.63
9	0.33	0.96	0.77	0.79	8.32	0.70
10	0.22	0.98	0.79	0.76	9.36	0.80
11	0.13	0.99	0.80	0.74	10.45	0.88
12	0.06	>0.99	0.83	0.73	12.77	0.95
13	0.02	>0.99	0.89	0.72	20.43	0.98
14	0.01	>0.99	>0.99	0.72	*	0.99
15	<0.01	>0.99	NA	0.72	*	>0.99

PPV, positive predictive value; NPV, negative predictive value; LR+, likelihood ratio positive; LR-, likelihood ratio negative

Sensitivity, Specificity, PPV, NPV: restricted to values between 0 and 1

* Great uncertainty of estimate due to sensitivity and specificity close to 0 or 1

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Table E8. Comparison of percentage change in FEV₁ and MEF₅₀ after bronchodilator administration by questionnaire-based outcome definitions assessed at the same time

Outcome criteria	Any asthma (current wheeze and asthma medication)		Moderately severe asthma (>4 episodes of wheeze in the past 12 months and inhaled corticosteroids)	
	Yes	No	Yes	No
Fulfilling outcome criteria				
N _{FEV1}	111	340	30	389
Mean % change in FEV ₁ after bronchodilator administration	5.46 95%CI=[3.58,7.34]	2.59 95%CI=[1.96,3.21]	9.10 95%CI=[3.74,14.45]	2.76 95%CI=[2.15,3.38]
N _{MEF50}	109	334	29	382
Mean % change in MEF ₅₀ after bronchodilator administration	16.66 95%CI=[12.80,20.53]	10.65 95%CI=[8.75,12.54]	18.60 95%CI=[9.75,27.46]	11.21 95%CI=[9.39,13.03]

103 *FEV₁*, Forced expiratory volume in the 1st second; *MEF₅₀*, maximal expiratory flow at 50% of vital capacity
 104 t-tests: any asthma: $p_{FEV1} < 0.001$; $p_{MEF50} = 0.003$; moderately severe asthma: $p_{FEV1} < 0.001$; $p_{MEF50} = 0.039$;

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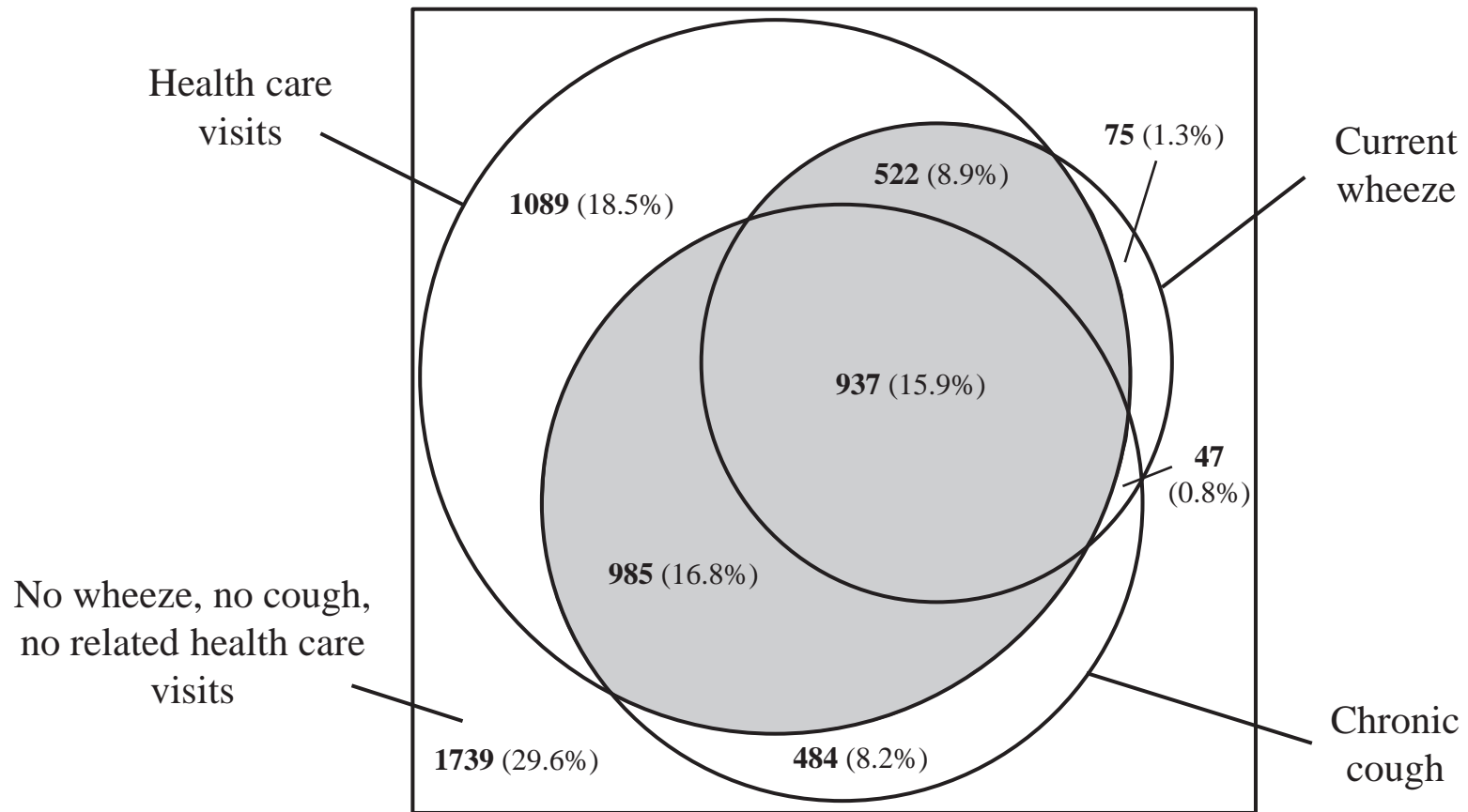
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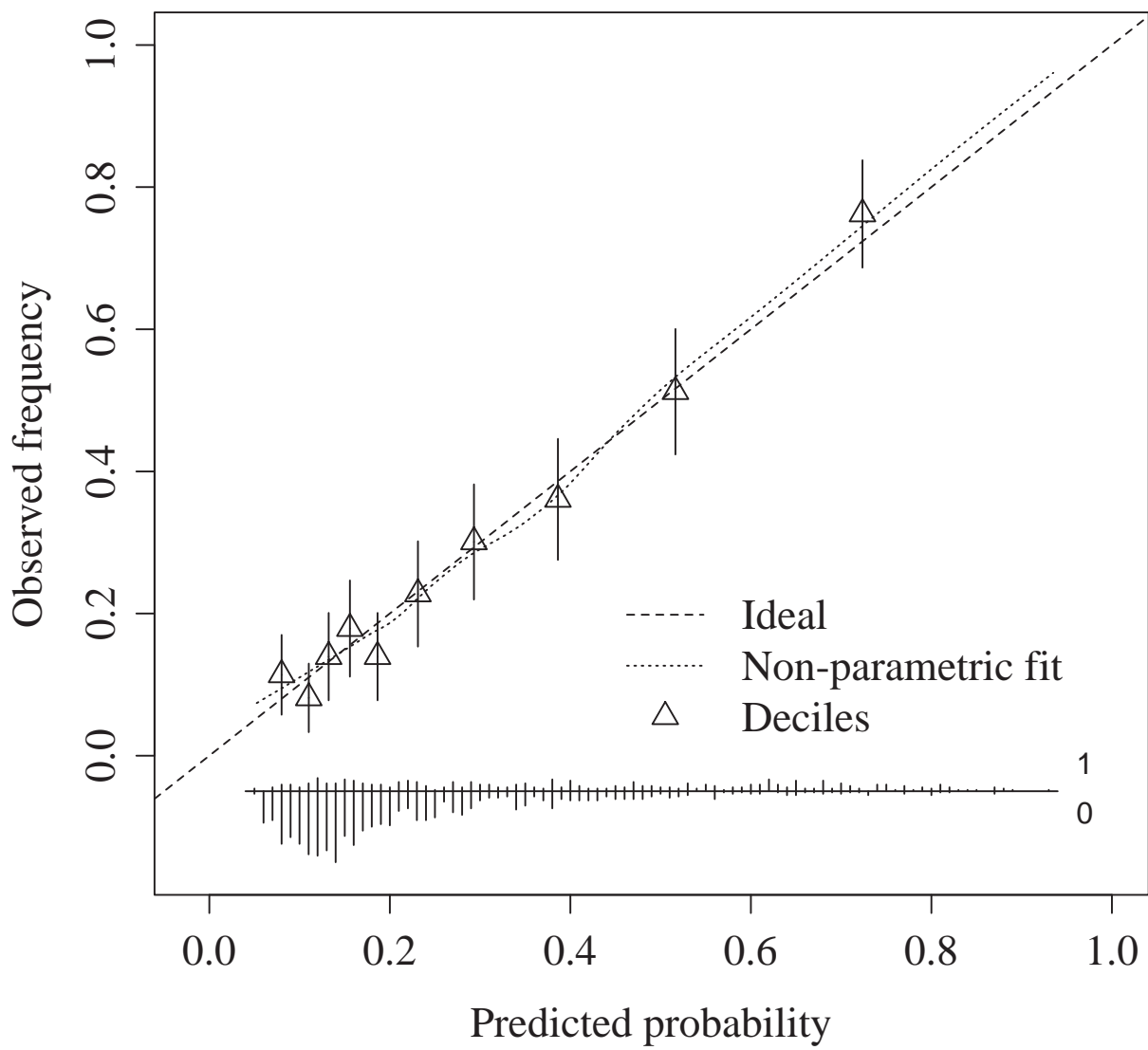
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120 **Fig E1. Original questions used to define inclusion criteria at baseline**121 **Fig E2. Original questions used to assess outcome at follow-up**122 **Fig E3. Original questions used as potential predictive factors**

123

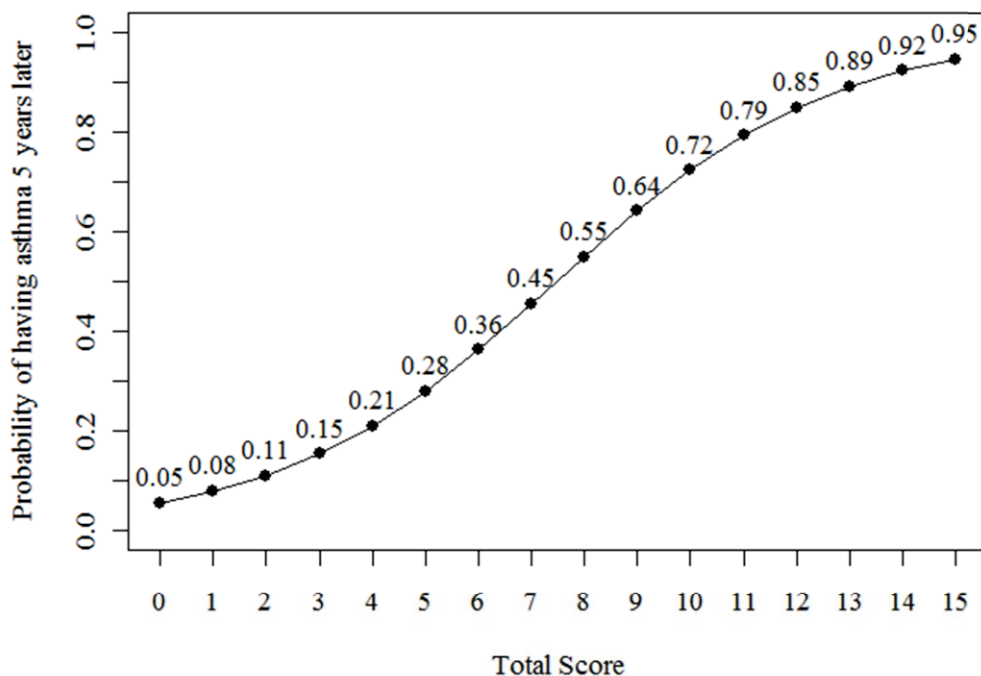


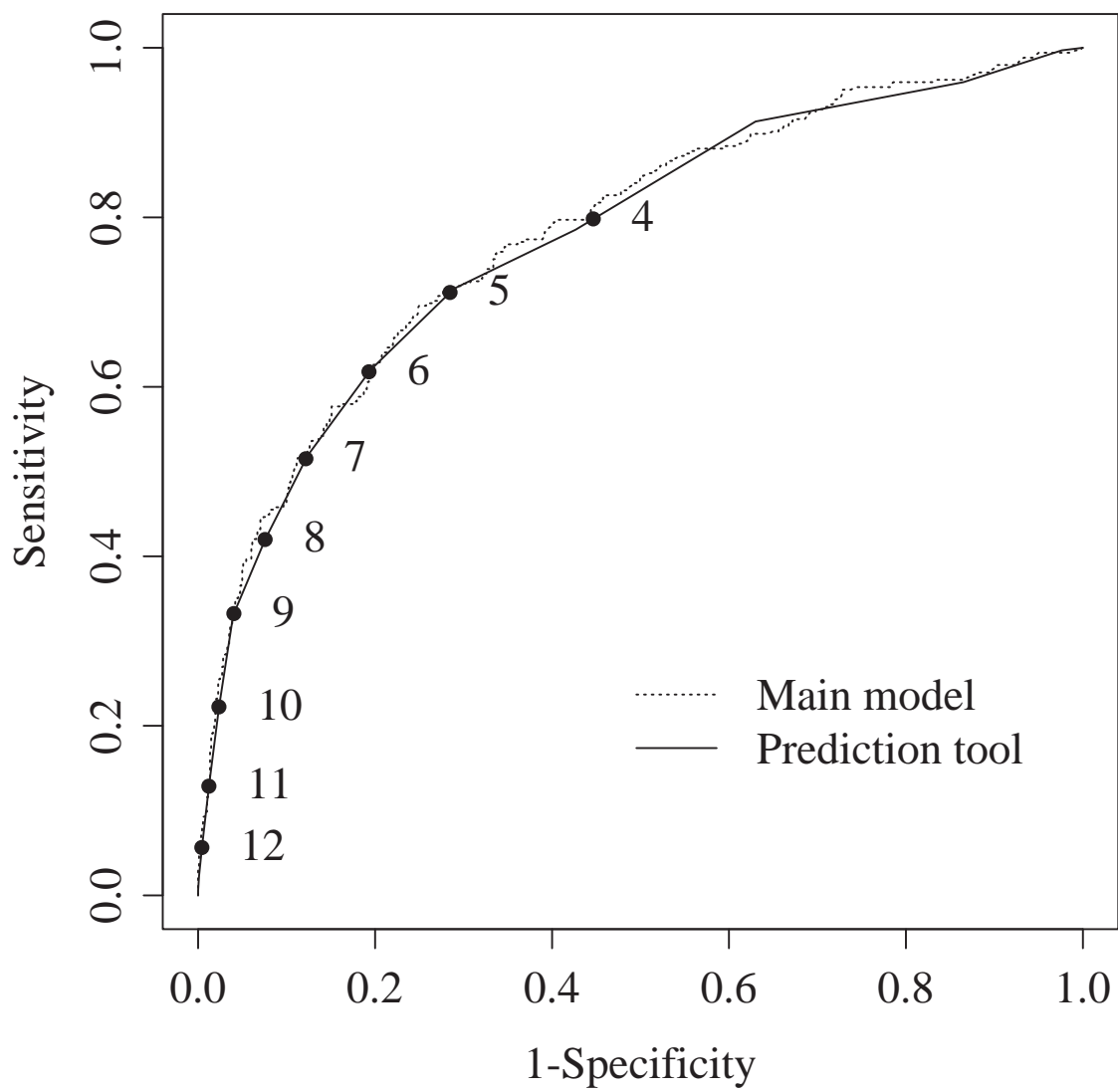


Asthma Prediction Tool

1. What is the child's sex? Female 0
Male 1
2. How old is the child? (in years) 1 0
2 1
3 1
3. In the last 12 months, has the child had wheezing or whistling in the chest even without having a cold or flu? No 0
Yes 1
4. How many attacks of wheeze has the child had during the last 12 months? 0-3 0
>3 2
5. In the last 12 months, how much did wheezing interfere with the child's daily activities? No 0
A little 1
A lot 2
6. Do these wheezing attacks cause him/her to be short of breath? Never 0
Sometimes 2
Always 3
7. In the last 12 months, did exercise (playing, running) or emotions (laughing, crying or excitement) cause wheezing or coughing in the child? No 0
Yes 1
8. In the last 12 months, did contact with dust, grass, pets or other animals cause wheezing or coughing in the child? No 0
Yes 1
9. Has the child ever had eczema? No 0
Yes 1
10. Have the child's parents ever suffered from wheezing, asthma or bronchitis? None 0
Mother 1
Father 1

Total Score = SUM= _____





1. Has your child had **wheezing or whistling in the chest** in the last 12 months? yes no

2. Does your child usually have a **cough apart from colds**? yes no

3. In the last 12 months, has your child had a **dry cough at night**, apart from a cough associated with a cold or a chest infection? yes no

4. How often did your child see the **GP for coughing or wheezing** during the last 12 months?
never once 2 - 3 times 4 - 6 times 7 or more times

5. In the last 12 months, has wheezing or asthma resulted in your child:

- being referred to a consultant in hospital yes no
- being admitted to hospital yes no
- attending the casualty (A and E) department yes no
- attending (or calling) the GP in an emergency yes no

6. Has your child had **wheezing or whistling in the chest** in the last 12 months? yes no

7. Did your child take any of the following during the last 12 months?

a blue inhaler (Salbutamol, Ventolin, Bricanyl or other) yes no don't know

a brown or orange inhaler (Pulmicort, Flixotide, Becotide, Beclovent or other) yes no don't know

Serevent or Oxis (a green or green-white inhaler) yes no don't know

Seretide or Symbicort (a violet or red-white inhaler) yes no don't know

8. Has your child had **wheezing or whistling in the chest** in the last 12 months? yes no

9. In the last 12 months, has your child had wheezing or whistling in the chest even **without** having a cold or flu? yes no

10. **How many attacks of wheezing** has your child had during the last 12 months?
None 1 to 3 4 to 12 more than 12

11. In the last 12 months, how much did **wheezing interfere with your child's daily activities**? not a
all a little a moderate amount a lot

12. Do these attacks cause him/her to be **short of breath**?
yes, always yes, occasionally no, never

13. In the last 12 months, how often, on average, has your child's **sleep been disturbed due to wheezing**?
Never woken with wheezing less than one night per week one or more nights per week

14. In the last 12 months did the following things cause wheezing in your child?

- exercise (playing or running) yes no don't know
- laughing, crying or excitement yes no don't know
- contact with pets or other animals yes no don't know
- food or drinks yes no don't know

15. Does your child usually have a **cough apart from colds**? yes no

16. In the last 12 months, has your child had a **dry cough at night**, apart from a cough associated with a cold or a chest infection? yes no

17. In the last 12 months, how many times has your child had a **cold or flu**?
never 1 - 3 times 4 - 6 times 7 -10 times more than 10 times

18. How long does a cold usually last in your child?
less than 1 week 1 to 2 weeks 2 to 4 weeks more than 4 weeks

19. In the past 12 months, has your child had **ear infections**?
no, never yes, once yes, more than once

20. In the past 12 months, has your child had a problem with **sneezing, or a runny, or blocked nose** when he/she did **NOT** have a cold or the flu? yes no

21. Over the past 12 months, has your child **snored** at night? yes no

22. In the past 12 months, has your child had **eczema**? yes no

23. Has the **child's father** ever suffered from any of the following conditions?

- **wheezing?** yes no don't know
- **asthma?** yes no don't know
- **bronchitis?** yes no don't know
- **hayfever?** yes no don't know

24. Has the **child's mother** ever suffered from any of the following conditions?

- **wheezing?** yes no don't know
- **asthma?** yes no don't know
- **bronchitis?** yes no don't know
- **hayfever?** yes no don't know