AIR-NET

Trial Assessments

	Visit 1 Screening	Visit 2 Baseline	Visit 3	Visit 4	Visit 5	Visit 6	Safety visit
	Days -35 to 0	Day 0	Day 7	Day 14	Day 28	Day 56	If required
Informed consent	X						
Eligibility check	X	X					
Demographics	X						
Medical history	X						
Concomitant medications	X	X	X	X	X	X	X
Physical examination	X						
Height & weight	X						
Record AEs		X	X	X	X	X	X
Record exacerbations		X	X	X	X	X	X
BP, pulse, temp, O_2 stats	X	X	X	X	X	X	X
ECG	X						
6 minute walk test		X			X		
Post bronchodilation spirometry	X	X	X	X	X	X	X
QoL-B	X	X	X	X	X	X	
BIM baseline		X					
BIM follow-up			X	X	X	X	
BEST diary		X	X	X	X		
Full blood count, urea and electrolytes, liver function tests	X			X	X	X	X
Research blood sample for endpoint analyses		X	X	X	X	X	
Sputum sample for screening eligibility (NEATstik)[a]	X						
Research sputum sample for endpoint analyses		X	X	X	X	X	
Nasal sample		X			X		
Pregnancy test, if required	X	X	X	X	X		
Randomisation		X					
Dispensing of trial drugs		X					
Drug accountability					X		
Sub-study only							
Pulse wave velocity		X			X	X	
Laser doppler perfusion imaging		X			X	X	

Demographic details

- Ensure participants are 18 years or over and no more than 85 years old on the date of randomisation

Smoking Status

- A participant's pack year history should be calculated using the following website:
- www.smokingpackyears.com
- Document the figures used for the pack years calculation in the medical notes for source data verification (SDV).
- Participants who have a **primary** diagnosis of COPD and have a pack year history of more than 10 years are not eligible.

History of Bronchiectasis

- Participants should have a clinical diagnosis and CT evidence of bronchiectasis in at least one lobe, if not they are not eligible for the trial.

Medical History

- Medical History should be completed as fully as possible and should be as diagnosed by a doctor.
- "Other relevant medical conditions" should include:
  - Medical conditions for which the participant is receiving concomitant medications
  - Medical conditions which impact on the participant's Activities of Daily Living or ability to complete the trial assessments.
- Abbreviations should not be used.
- Date of diagnosis is not required.
- The participant should be assessed by a delegated doctor as to whether they have any unstable co-morbidities which in their opinion would make the participant unsuitable to be enrolled in the trial.

Height WPG

Equipment

- Height measure

Procedure

- Ask the patient to remove their shoes and any bulky clothing (e.g., jacket, coat, cardigan).
- Raise the head plate of the height measure and ask the patient to stand with their feet flat on the centre of the base plate, with their feet together and heels against the rod.
- Their back should be as straight as possible, against the rod but not leaning on it and their arms should be hanging loosely by their side.
- The patient's head should be in a horizontal position.
- Ask the patient to look straight ahead, breathe in deeply and stretch to their fullest height.
- Lower the headplate until it is resting on the patient's head, and then ask them to step forward.
- Record the height to the nearest mm, where the arrow points to the measuring scale.

Weight WPG

Equipment

Weighing scales

Procedure

- Ask patients to remove all outer layers of clothing (e.g., jackets, heavy or baggy jumpers, cardigans, or waistcoats) and shoes, and to empty their pockets and remove any heavy jewellery.
- Turn on the scales and wait for the display to read zero.
- Ask the patient to stand on the scales with their feet together in the centre, their weight evenly distributed and their heels against the back edge.
- Their arms should be hanging loosely at their sides and their head facing forwards.
- Once the scales have stabilised, record the reading in kg to the nearest 100 g. Repeat the measurement, and if the reading is different, repeat a third time and take the average of the three readings.

Vital Signs WPG

Equipment

- Blood Pressure Monitor
- Oxygen saturation monitor
- Tympanic thermometer

Procedure: Blood Pressure & Pulse

- Select appropriately sized cuff
- Place the cuff directly against the skin, as clothing may cause a faint heartbeat and result in error
- Ensure that the patient is sitting comfortably for at least 5-10 minutes before measurement is taken
- Ask the patient not to talk or move during blood pressure measurement.
- The blood pressure should be taken twice and the second reading entered in the eCRF.
- Record the readings in the medical records for SDV.

Equipment

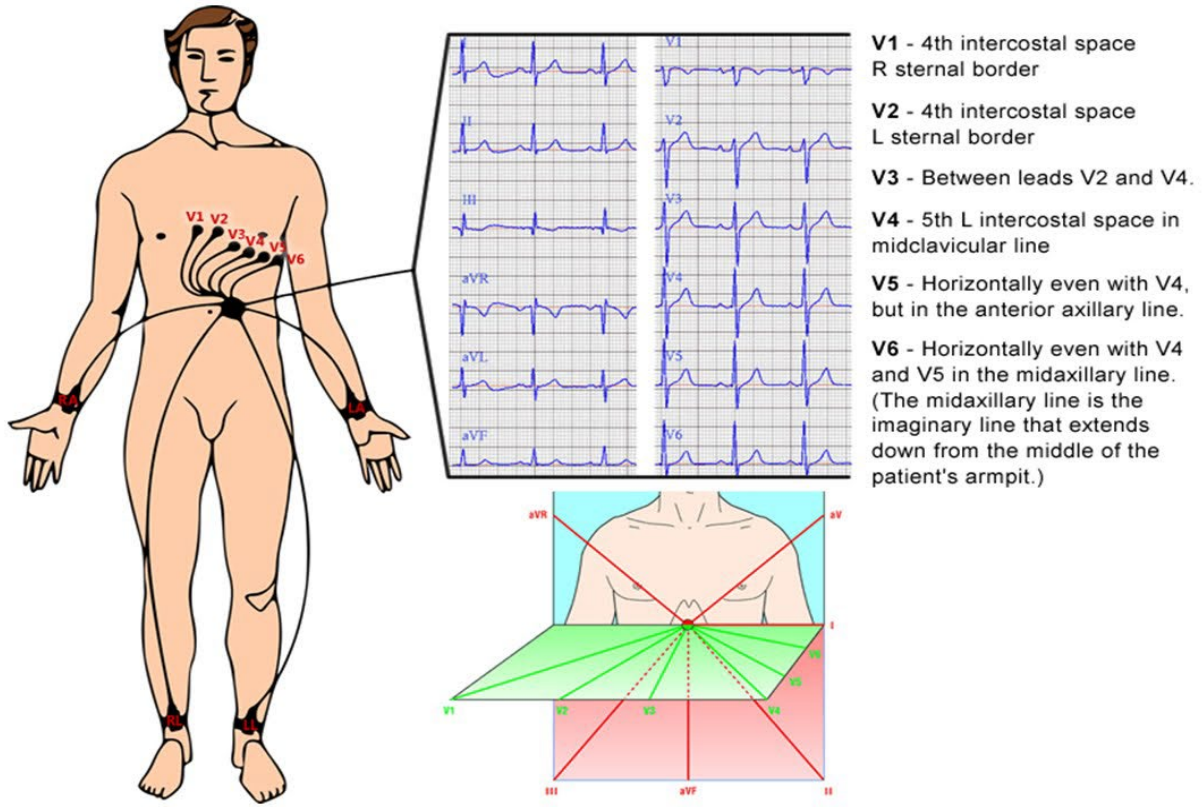
- ECG Machine

Procedure

- Ensure the recorder is in working order and that the annual safety and calibration checks are up to date
- Ensure all sundries are available i.e. razors, skin cleaners, exfoliating tape, adequate supply of ECG paper and electrodes.
- Arrange a room of ambient temperature with privacy/curtains
- Patients should be asked to remove clothing from above the waist and to wear the gown provided.
- Allow the patient to rest supine for 10 minutes.
- Assess the chest area for the need to remove hair and do so if necessary, using a razor.
- If necessary, cleanse the skin, dry, and exfoliate to ensure good adhesion of the electrodes.
- Apply electrode pads (see below)

ECG WPG (cont.)

- Print ECG
- Ensure date, patient name, CHI/hospital number and study ID number are printed or written on the ECG.
- A doctor delegated this task on the Delegation Log should review the ECG before randomisation of participant
- Doctor reviewing ECG should write any abnormal findings and actions taken in patient's medical notes.
- With the patient's consent their GP should be informed of any abnormal findings.
- File ECG in patient's medical notes as source data



V1 - 4th intercostal space R sternal border

V2 - 4th intercostal space L sternal border

V3 - Between leads V2 and V4.

V4 - 5th L intercostal space in midclavicular line

V5 - Horizontally even with V4, but in the anterior axillary line.

V6 - Horizontally even with V4 and V5 in the midaxillary line. (The midaxillary line is the imaginary line that extends down from the middle of the patient's armpit.)

Spirometry WPG

Standard spirometry: post bronchodilator spirometry at visits will be carried out as per American Thoracic Society/European Respiratory Society's guidelines.
FEV1 forced vital capacity (FVC) and Forced Expiratory Flow at 25-75% (FEF25-75) will be measured.

Equipment

- As per standard spirometry procedure
- Participant's own salbutamol inhaler or 2.5mg salbutamol for nebulisation

Procedure

- If required by local policy, doctor to prescribe 2.5mg salbutamol for nebulisation if needed.
- Ask the patient to take their salbutamol inhaler or provide salbutamol inhaler and use a single-use spacer. Dose of inhaled salbutamol should be as local policy

  or
- Administer 2.5mg of salbutamol via nebuliser.
- Wait 15 minutes for bronchodilator to take effect.
- Complete spirometry as per standard procedure

Physical Examination

Physical examination is mandatory and if not performed the participant should be withdrawn from the trial.

Should be completed by a delegated doctor and documented in the participant's medical notes as well as on the eCRF.

Examination to include:

- Respiratory
- Cardiovascular
- Abdominal
- Neurological
- Dermatological

Pregnancy test

For women of childbearing potential.

Blood samples

Collected, processed, and stored as per laboratory manual.

Sputum samples

Collected, processed divided and stored as per laboratory manual.
Participants will be asked to bring a spontaneous early morning sputum sample with them to visits, from day 1 visit.

Where a participant is unable to produce a sputum sample at a visit a hierarchical approach to obtaining sputum samples will be used:

1. spontaneous sputum sample produced at the visit
2. spontaneous early morning sputum brought from home on the day
3. spontaneous early morning sputum brought in within the following 48 hours after the scheduled visit.
4. Induced sputum in sites able to perform induced sputum according to local protocols.

Exacerbation recording

- If the participant has had any signs or symptoms of pulmonary exacerbation since the last visit a **Pulmonary Exacerbation Record Form** should be completed in the eCRF.
- A separate Pulmonary Exacerbation Record Form should be completed for each distinct exacerbation.
- If symptoms have resolved for at least 48 hours before more symptoms develop then this should be classified as a new exacerbation.
- Details of any pulmonary exacerbations should be recorded in the medical notes

Exacerbations will be defined according to the EMBARC/BRR definition as follows:
A deterioration in three or more of the following key symptoms for at least 48 hours
a. Cough
b. Sputum volume and/or consistency
c. Sputum purulence
d. Breathlessness and/or exercise tolerance
e. Fatigue and/or malaise
f. Haemoptysis ‘

AND a clinician determines that a change in bronchiectasis treatment is required.

Questionnaires WPG

- The latest approved version of the questionnaires should be used at all times.
- Ensure the patient identification number, the correct visit number and date of visit are entered on each page.
- The questionnaires are intended for self-completion on the day of visit.
- If the respondent is unable to complete the questionnaire by themselves, it may help for the researcher to read aloud the questionnaire. It is acceptable for a third party to record the respondent's replies but care should be taken to avoid prompting.
- If the respondent finds statements too limiting - the researcher should repeat the questionnaire instruction 'to indicate which statements best describe your own health state today' and that there are no right or wrong answers. *NB it is the respondent's own evaluation that is required, and no prompts should be given*.
- If a participant has completed the questionnaire themselves or with the help of a relative/friend the researcher should check the questionnaire for completeness and go through any missing questions or ambiguous answers e.g. 2 answers ticked instead of one, go through the questionnaire with the participant. with the participant.
- If a respondent has ticked 2 statements on a dimension, unless it is possible to clarify, these answers should be treated as missing data.