SUPPLEMENTARY MATERIAL

Table 1. Results achieved by the experts after the two rounds of Delphi consensus

	Median (IQR)	% agreement
Topic 1. Diagnosis		
1. The definition of SAD should be established on the basis of physiopathological criteria.	7 (1)	75.6
2. The importance of SAD has not been adequately assessed due to the difficulty in its study.	8 (2)	81.4
3. All patients with uncontrolled asthma, once modifiable factors have been ruled out, should undergo specific tests to study SAD (plethysmography, CT scan, oscillometry, etc.).	7 (2)	68.6
4. All patients with asthma suspected of having SAD should undergo specific tests (plethysmography, CT scan, oscillometry, etc.)	7 (2)	59.3
5. The ranges of normality for small airways assessment should be precisely defined.	8 (2)	84.9
6. SAD is more important in patients who smoke.	7 (2)	69.8
7. The first affected area for patients with asthma is the small airways.	6 (2)	34.9
8. Poor exercise tolerance is a symptom of SAD.	7 (1)	73.3
9. Asthma symptoms at night suggest SAD.	6 (2)	45.4
10. Spirometry underestimates obstruction of small airways.	7 (2)	67.4
11. SAD precedes the diagnosis of asthma.	5 (1)	23.3
12. SAD is present in asthmatics of all levels of severity.	8 (1)	77.9
13. The time of evolution of asthma influences small airways.	7 (1)	80.2
14. The presence of symptoms requiring control medication accompanied by normal lung function implies involvement of small airways.	7 (0)	75.6
15. In patients with obesity-associated asthma, assessment of SAD is relevant.	7 (0)	75.6
16. In patients with neutrophilic asthma, assessment of SAD is relevant.	7 (1)	64.0
17. The development of specific tools is necessary to confirm SAD.	9 (1)	87.2
18. During patient follow-up, complementary explorations should be	7 (2)	68.6

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performed for appropriate evaluation of SAD.		
19. Impulse oscillometry should be incorporated into pulmonary function units or laboratories.	7 (2)	69.8
20. Impulse oscillometry is a cost-effective measure.	7 (1)	62.8
21. In patients with mild asthma, cough, shortness of breath on exertion, and normal lung function, a high FeNO value may be a sign of SAD.	7 (1)	61.6
22. In patients with severe uncontrolled asthma, an inspiration-expiratory chest CT scan should be performed.	7 (2)	74.4
23. For measurement of air entrapment in cases of poor exercise tolerance, a plethysmography should be performed after a stress test.	7 (1)	68.6
24. MRI may play a more relevant role in assessing SAD if its costs are reduced and its use is widespread.	5 (1)	16.3
Topic 2. Treatment		
25. In patients with asthma, SAD should be treated when there are suggestive symptoms.	8 (2)	79.1
26. In patients with asthma, SAD should be treated if FEF25-75 is very low and FeNO level is high.	8 (2)	74.4
27. In patients with asthma, SAD should be treated according to the time of year, and in the months when infections and/or allergenic exposures are most frequent.	5 (1)	20.9
28. Patients with asthma should be treated from the beginning with glucocorticoids or combinations (ICS+LABA) of extrafine particles.	6 (3)	38.4
29. Despite maintenance treatment of patients with uncontrolled asthma, it is preferable to move to the next therapeutic step than to switch to extrafine particle therapy.	5 (1)	11.6
30. Despite maintenance treatment of patients with uncontrolled asthma, it is preferable to prescribe extrafine particle therapy than to move to the next therapeutic step.	6 (2)	38.4
31. Maintenance treatment with non-extrafine particles also improves SAD.	7 (1)	60.5
32. Treatment with LTRA improves SAD.	5 (1)	19.8
33. If SAD is suspected, a therapeutic trial with drugs capable of better reaching the distal airway should be performed.	8 (2)	84.9
34. Treatment with extrafine particles means less need for ICS.	7 (3)	61.6
35. The favorable clinical response to treatment with LTRA indicates that there is underlying involvement of small airways.	5 (0)	3.5

36. Within the same therapeutic range, patients experience improvement when they switch to extrafine particle therapy.	6 (2)	39.5
37. Extrafine particle ICS are more effective in treating SAD than non-extrafine particle ICS.	7 (2)	66.3
38. In the therapeutic prescription, criteria on device type and inhalation technique should prevail over those on particle size.	7 (2)	69.8
39. In the therapeutic prescription, patient's preference should be considered for the device over particle size.	7 (1)	70.9
40. In the therapeutic prescription, the required inspiratory flow from each device should prevail over particle size.	7 (1)	70.9
41. Prescription of biological drugs should take into account their involvement of the small airway.	5 (2)	26.7
42. Extrafine particle size ensures more homogeneous pulmonary deposition than that obtained with non-extrafine particle size.	7 (1)	76.8
43. In patients with elevated FeNO, its measurement is a sensitive method for evaluating response to treatment of SAD.	7 (1)	55.2
44. Slow spirometry is a sensitive method for evaluating response to treatment of SAD.	5 (1)	17.2
45. Plethysmography is a sensitive method for evaluating response to treatment of SAD.	7 (1)	62.1
46. Chest CT is a sensitive method for evaluating response to treatment of SAD.	6 (2)	33.3
47. Dynamic hyperinflation after the 6-minute walk test (6MWT) analysis is a sensitive method for evaluating response to treatment of SAD.	5 (2)	3.5
48. Since only indirect methods are available, several of them should be used to evaluate response to treatment of SAD.	8 (1)	80.2
49. A decrease in the number of eosinophils in the peripheral blood is a marker of good response to treatment for SAD.	5 (0)	5.8
50. Improvement of cough is a marker of good response to treatment of SAD.	7 (1)	64.4

CT: computed tomography; FEF25-75: forced expiratory flow 25-75%; FeNO: fractional exhaled nitric oxide; ICS: inhaled corticosteroids; IRQ: interquartile range; LABA: long-acting beta2-agonist; LTRA: leukotriene receptor antagonist; MRI: magnetic resonance imaging; SAD: small airway dysfunction.
Green: consensus in agreement; Orange: no consensus.

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