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Supplemental Statistical Methods

We used means and standard deviations or medians and interquartile ranges for descriptive statistics for normally and non-normally distributed variables respectively. We assessed the correlation between intake of food groups and dietary potassium using Pearson's correlation coefficient and scatter plots after adjusting for total dietary intake using the residual (energy-adjusted nutrients) method[1].

We defined the period of observation from the time of inclusion in the study to the time of death or censoring. Participants were censored if they departed from the dialysis network, underwent kidney transplantation, transferred to another renal replacement modality, cessed dialysis treatments, recovered kidney function, went on vacation, were lost to follow-up or survived until the end of the follow-up period

Part 1: Association between dietary potassium and mortality in the complete cohort

We first modelled the survival time using an accelerated failure time (AFT) model with an exponential, Weibull, Gompertz, log-logistic and log-normal distribution for the error term. The Weibull distribution minimized the Akaike's Information Criterion (AIC) and was retained for the analyses. We defined "C", a set of 19 covariables selected by subject matter knowledge for their potential to confound the effect of dietary potassium or serum potassium on mortality while minimising the introduction of biases.[2] Were included in C: age, sex, smoking status, body mass index, physical activity, presence of a life partner, Charlson comorbidity index, history of any cardiac disease (angina, myocardial infarction, coronary artery bypass, coronary angioplasty, congestive heart failure, pulmonary oedema, cardiac arrest, atrial fibrillation, other arrythmias, permanent pacemaker, pericarditis, valvular heart disease, valve replacement, other cardiac disease), history of diabetes, history of cancer, status on the transplant waiting list, type of vascular access, intraHD body weight decrease, HD vintage, total HD time per week, Kt/V, serum albumin, whether they received angiotensin converting enzyme inhibitors (ACEI) or angiotensin II receptor blockers (ARB) and total calorie intake. The model was sequentially adjusted first for the set of covariables C and then for the intake of each food groups in portions per week (grains, fruits, vegetables, legumes and nuts, red meat, fish and white meat, dairy, eggs and sweets and sweet drinks). We modelled all non-linear covariables using cubic splines. We used a frailty term in the model to account for cluster by country. We tested for interactions of the effect of dietary potassium with the presence of cardiac disease, diabetes, having a missing value for serum potassium, having a serum potassium greater or equal to 5.5 mEq/L and greater or equal to 6.0 mEq/L. We tested the assumption that the exposure variables have multiplicative effects on survival time that are consistent over time using plots of the log−log of the survival function against the log of time.

Dietary potassium intake was modelled first as a continuous variable and then as quartiles. We assessed for a non-linear relationship between dietary potassium intake and all-cause and cause-specific mortality visually using cubic splines (Figure S8). We also compared the AIC of the model with and without the cubic spline and adding a cubic spline did not significantly improve the AIC criterion for all-cause and cause-specific mortality. We did so in the unadjusted and the adjusted model. To facilitate the interpretation of our results, we converted the acceleration factors (AF) obtained from the AFT models to hazard ratios (HR).[3] We also graphically assessed the effect of correcting for the competing risk of transplantation on the outcome of all-cause mortality and for the competing risk of non-cardiovascular death on the outcome of cardiovascular death and vice versa.

Part 2: Mediation analysis within a subgroup of the cohort

A direct acyclic graph showing the potential causal relationship between dietary potassium intake and mortality is presented in Figure 1. In the subgroup for which a measurement of serum potassium was available, we assessed (a), the association between dietary potassium intake and serum potassium levels, using linear regression and (b), the association between serum potassium levels and mortality using an AFT model. We then assessed (c) the controlled direct effect of dietary potassium intake on mortality at fixed serum potassium levels using an AFT model.

Association of dietary potassium and serum potassium levels (a)

We used Pearson's correlation coefficient, and a scatter plot as preliminary assessment of the relationship between log-transformed dietary potassium and serum potassium. We then built a linear regression model of dietary potassium predicting serum potassium that was first adjusted for the same set of covariates C, and then for the intake of each food groups. We used cubic splines for non-linear variables and assessed the model assumptions by examining the residuals. We also built two logistic regression models to assess the association between dietary potassium and the prevalence of hyperkalemia at baseline. We first defined hyperkalemia as a value equal or greater than 5.5 mEq/L and then as a value greater or equal to 6.0mEq/L. We adjusted the logistic regression models for the same set of covariables C, followed by adjustment for the intake of each food groups. We used cubic splines for non-linear variables and assessed the fit of the model using the Hosmer-Lemeshow test.

Association between serum potassium and mortality (B)

After selecting the subgroup of participants for which serum potassium was available, we followed the same methods for the AFT models as previously mentioned, but this time with serum potassium as the exposure of interest. We modelled serum potassium as a continuous variable first adjusted for the set of covariables C, then for the set of

covariable C and food groups intake. We assessed for a non-linear relationship between serum potassium intake and all-cause and cause-specific mortality visually using cubic splines (Figure S8). We also compared the AIC of the model with and without the cubic spline and adding a cubic spline did not significantly improve the AIC criterion for all-cause and cause-specific mortality. We therefore did not observe a U-shaped relationship between serum potassium and mortality. We did so in the unadjusted and the adjusted model. We tested for interactions of the effect of serum potassium with the presence of cardiac disease and with the presence of diabetes. We used a log-log plot to assess the plausibility of the assumption of multiplicative effect.

Association of dietary potassium intake and mortality adjusting for serum potassium level or controlled direct effect (C)
Following the same methods described in part 1, we assessed the association between dietary potassium intake and mortality this time adjusting for serum potassium levels. This represent the effect of dietary potassium on mortality independent of serum potassium levels.

Direct, Indirect and Total effect of dietary potassium on mortality
Using the models previously described, we determined three effects: the direct effect of dietary potassium on mortality independent of serum potassium, the indirect effect of dietary potassium on mortality through serum potassium and the total of the two. All three effects are conditional on the set of covariable C and the intake of each food group. We tested for an interaction between the mediator, serum potassium, and dietary potassium. The statistical software did not allow for a frailty parameter; thus, the country of origin was included as a fixed effect covariate rather than as the clustering unit. Non-linear covariables were modelled using cubic splines.

Sensitivity analyses
To infer causality onto the estimates of the direct and indirect effects, mediation analyses relies on four assumptions:

(1) There are no unmeasured confounders of the association between the exposure and the outcome given the covariables
(2) There are no unmeasured confounders of the association between the mediator and the outcome given the covariables
(3) There are no unmeasured confounders of the association between the exposure and the mediator given the covariables
(4) The confounders of the association between the mediator and the outcome are not affected by the exposure

As these assumptions are quite strong, we will use sensitivity analyses to assess the robustness of our findings to their violation.

Since dietary potassium was derived from the intake of each food, our analysis is likely taking into account most of the confounders for potassium intake. Indeed, it is unlikely that an unmeasured confounder would modify potassium intake through a pathway other than through the composition of diet and adjusting for the intake from each food group is likely to capture most, although not all, of the effect of diet composition on potassium intake. Assumption (1) and (3), that there is no unmeasured confounder of the exposure-outcome and the exposure-meditator relationship, are therefore likely to be respected. Nevertheless, we conducted sensitivity analysis for assumption (1), (2) and (3).

Extended adjustments
To assess the plausibility of the first three assumptions we first ran all the analyses adjusting for nine supplementary variables selected from 31 baseline characteristics by stepwise forward selection, forcing the 19 covariables from C and the food groups into the model. The nine variables were education level, history of gastrointestinal (peptic ulcer, liver disease or other gastrointestinal disease), peripheral artery and psychiatric disease, aetiology of kidney failure, number of different drug classes, pre-dialysis systolic blood pressure, serum calcium and phosphate levels, alcohol intake, normalized protein catabolic rate and net endogenous acid production estimated using the Remer and Manz's equation[4].

Sensitivity analysis for the total effect
We assessed how strong an unmeasured confounder U would need to be to significantly bias our estimates of the total effect. We calculated corrected AF for a hypothetical unmeasured confounder using the method described by Ding and VanderWeele. The approach relies on two sensitivity parameters: the maximal relative risk(RR) of the exposure on U adjusting for C, and the maximum RR of U on the outcome adjusting for C. As our results were AF rather than relative risk, we used the equation demonstrated in Appendix 8 of Ding and Vanderweele for ratios of expectations of non-negative outcomes[5]. We constructed tables of hypothetical values of both parameters to illustrate how different combinations of the two would affect the AF for the total, direct and indirect effect.

Sensitivity analysis for the direct and indirect effect
We assessed how strong an unmeasured confounder U would need to be to significantly bias our estimates of the direct and indirect effect. We used the same equation for a bias factor described by Ding and Vanderweele[5] which has been extended to direct and indirect effects from mediation analyses by Smith and VanderWeele[6]. The approach relies on two sensitivity parameters: the maximum relative risk of U on the outcome among the exposed not through the mediator adjusting for C and the maximum RR for U on the mediator within a level of the exposure (as a proxy for the maximum

RR of the exposure on some value of U within a level of the mediator) adjusting for C. Using AF rather than RR for the relationship between U and the outcome, we constructed tables of hypothetical values of both parameters to illustrate how different combinations of the two would affect the AF for the direct and indirect effect of dietary potassium.

Since assumption (2) was more prone to bias from unmeasured confounder in our study design, we conducted a supplementary sensitivity analysis for the direct and indirect effect, using the method described by Imai et al[7]. If an unmeasured confounder affects both the mediator and the outcome, then the error terms for the outcome model and the mediator model will be correlated. Let p denote the correlation between the error terms for the outcome and the mediator models. If the assumptions are respected, p should have a value of zero and any departure from zero would suggest the presence of unmeasured confounders. By expressing the average direct and indirect effect as function of p, we ask how far departed from zero would p need to be to significantly bias our estimates of the effects.
However, since this method had not yet been implemented for time-to-event data, we built a probit model of the association between potassium intake and the risk of the binary outcome of death versus surviving or being censored. The model was adjusted for the same variables as was the mediation analysis (set of covariables C, food groups and country of origin). Since the software package could not accommodate cubic splines, we instead categorised the non-linear variables. We used nonparametric bootstrapping with the percentile method for the confidence intervals and did not include an interaction between the exposure and the mediator as an interaction did not affect the estimates of the effect.

Sensitivity analyses for assumption 4
Assumption #4 stipulate that there is no confounder on the serum potassium-mortality relationship that is affected by dietary potassium intake. While methods have been developed to assess the robustness of the fourth assumption[8-11], to our knowledge none has been extended to mediation analyses based on accelerated time failure models. This assumption will therefore, at this point in time, remain unverifiable.

Measurement error
The impact of measurement error, particularly measurement error of the mediator, on the estimates of the direct and indirect effects is well established.[12] Furthermore, our exposure was assessed through a food frequency questionnaires which are susceptible to measurement error. To assess the robustness of our findings to non-differential measurement error, we conducted a sensitivity analysis using the simulation-extrapolation (SIMEX) method. We estimated the corrected total effect in the model adjusted for the set of covariables C and food groups but ignoring the mediator, assuming a conservative correlation coefficient of 0.5 for the measurement error of dietary potassium intake. We then estimated the corrected direct effect in the model adjusted for C, food groups and the mediator, serum potassium, assuming a correlation coefficient of 0.5 for the measurement error of both dietary potassium and serum potassium. We then calculated the indirect effect corrected for measurement error by dividing the corrected total effect by the corrected direct effect, assuming no interaction between the exposure and the mediator. We conducted the analysis in each imputed dataset and then combined the corrected estimated using Rubin's Rules.[13]

Supplemental Discussion for the results of the sensitivity analyses

To confound the association between an exposure and an outcome, the confounder needs to affect both the exposure and the outcome. Therefore, to confound the effect of dietary potassium on mortality, an unmeasured confounder would need to both be associated with potassium intake and modify the risk of death. Since our analysis is adjusted for intake from each food groups, to bias our estimates, an unmeasured confounder would need to affect potassium intake through another pathway than through modification of the dietary intake of each food group. Therefore, assumption (1), that there is no unmeasured confounder between the exposure and the outcome, and assumption (3), that there is no unmeasured confounder between the exposure and the mediator, are most likely respected. Nevertheless, we ran sensitivity analysis to test the robustness of our findings to violation of these assumptions. Assumption (2), that there is no unmeasured confounding between the mediator and the outcome, appears more vulnerable to unmeasured confounding by design and will be the subject of supplementary sensitivity analyses.

Sensitivity analyses for unmeasured confounding

Extended adjustments
We ran a sensitivity analysis adjusting for the set of covariables C, food groups and an extended set of covariables selected by stepwise forward selection, including education level, history of gastrointestinal, peripheral artery and psychiatric disease, aetiology of kidney failure, number of different drug classes, pre-dialysis systolic blood pressure, serum calcium and phosphorus levels, alcohol intake, normalized protein catabolic rate and estimated net endogenous acid production. Extended adjusting did not modify the estimates of the total, direct and indirect effect remained unchanged (Table S5 in the Supplement).

Sensitivity analysis for the total effect
We estimated how strongly associated with dietary potassium and mortality an unmeasured confounder would need to be to bias our estimates as to mask a harmful effect of dietary potassium. We set a clinically significant harm at an AF of 0.95 or lower and assume no interaction between the exposure and the mediator. On Table S7a in the Supplement, the vertical axis displays a spectrum of potential relative risk for an unmeasured binary confounder U per gram/day of potassium intake and the horizontal axis displays a spectrum of potential AF for U on the time-to-death (all causes). The values inside the table represent the corrected AF for all-cause mortality per gram of potassium intake for the corresponding value for U on the rows and on the columns. It can be seen that to have biased the AF for the total effect from 0.95 to the observed value of 1.01, a binary unmeasured confounder with a prevalence increasing by 20% for each gram/day of potassium intake would need to have an AF for all-cause mortality of 1.32 or higher, which, in our model, would correspond to an HR of 0.72 or lower. It appears unlikely for a factor so strongly associated with either potassium intake or death to have been missed from our analysis.

Sensitivity analyses for the direct and indirect effects
Table S7b in the Supplement displays the corrected estimates of the direct effect for multiple combinations of the relative risk of an unmeasured binary confounder U per gram/day of potassium intake (on the vertical axis) with the AF of U for all-cause mortality (on the horizontal axis). Since the estimate for the direct effect was very close to the estimate for the total effect, the results of the sensitivity analysis are very similar, and the direct effect also appears to be relatively robust to unmeasured confounding. Table S7c in the Supplement displays the corrected estimates of the Indirect Effect for multiples combinations of relative risks of an unmeasured binary confounder U per gram/day of potassium intake (on the vertical axis) with the AF of U on all-cause mortality (on the horizontal axis). It can be seen that to have biased the AF for the Indirect Effect from 0.95 to the observed value of 1.00, a binary unmeasured confounder with a prevalence increasing by 20% for each gram/day increase in potassium intake would need to have an AF for all-cause mortality of 0.76 or lower which, in our analysis, corresponds to a HR of 1.38 or higher. It appears unlikely for a factor so strongly associated with either potassium intake or death to have been missed from our analysis.

If a confounder for the association between the mediator and the outcome is not adjusted for, then the error term in the outcome model and the error term in the mediator model will be correlated. By expressing the estimates of the Indirect effect as a function of the sensitivity parameter p, defined as the correlation coefficient between the error terms from both models, we can assessed how strong does the correlation between the error terms need to be (or how departed from 0 does p need to be) before our estimates of the indirect effect are biased.

- Figure S10a in the Supplement shows the estimate and 95%CI of the direct effect in relationship to p. It can be seen that through the whole spectrum of values for p, the 95%CI for the estimate of the Indirect Effect always includes zero (or 1 on the log-scale), which signifies no statistically significant association. While this analysis relies on a probit model of death as a binary outcome rather than on a time-to-event analysis, it remains an argument in favour of the robustness of our findings to an unmeasured confounder of the relationship between the mediator and the outcome.

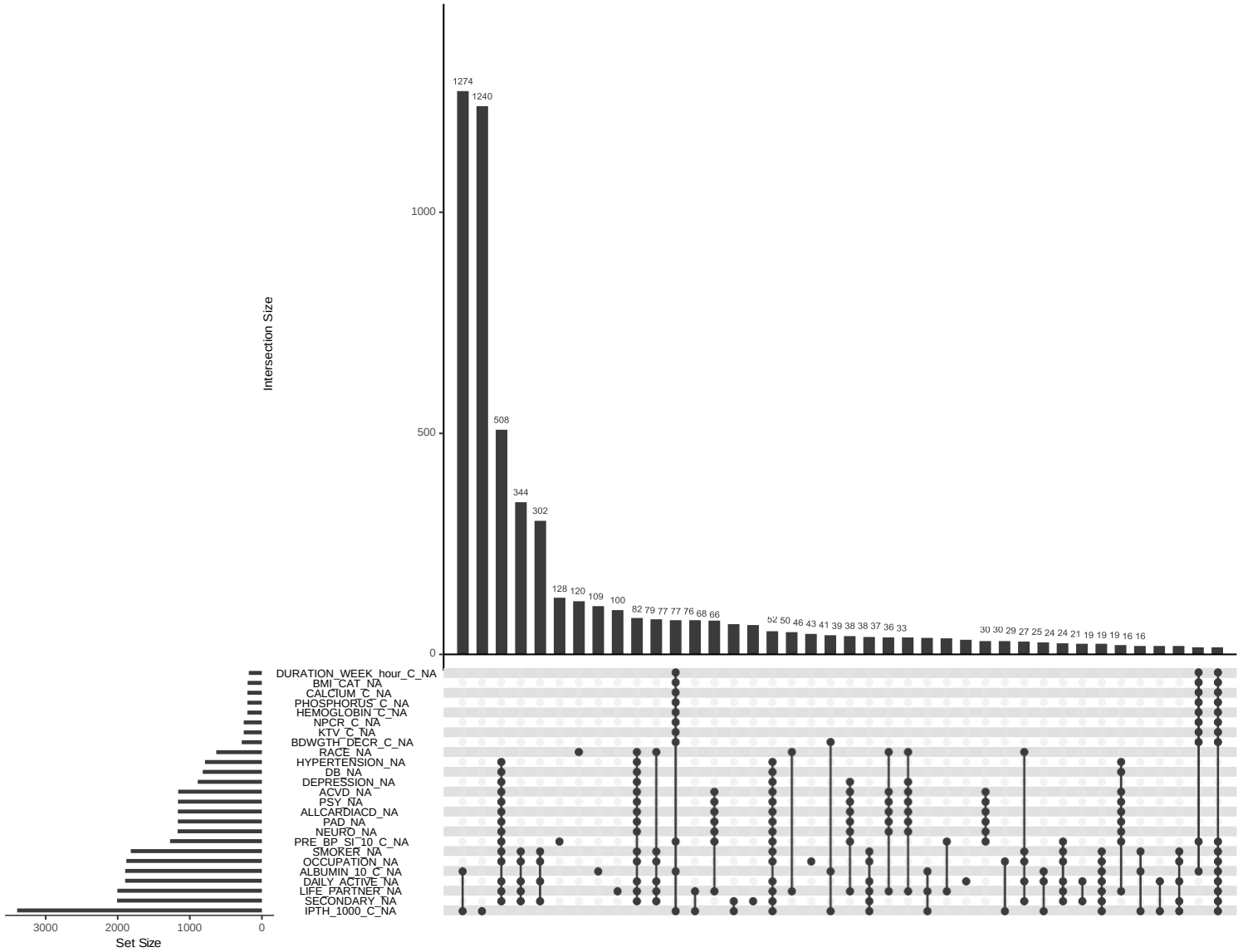
- Figure S10b in the Supplement shows the estimate and 95%CI of the Indirect Effect in relationship to p. It can be seen that through the whole spectrum of values for p, the 95%CI for the estimate of the Indirect Effect always includes zero, which represents an AF of 1 or no statistically significant association. While this analysis relies on a probit model of death as a binary outcome rather than on a time-to-event analysis, it remains an argument in favour of the robustness of our findings to an unmeasured confounder for the relationship between the mediator and the outcome.

The case of residual kidney function
Two unmeasured potential confounders, residual kidney function (RKF) and dialysate potassium concentration are worth considering individually. Previous literature has estimated the presence of significant RKF to be associated with a HR for all-cause mortality between 0.44[14] and 0.70[15]. This is therefore a strong confounder that had not been measured in our cohort. Since our analysis is adjusted for diet and potassium intake is derived from the dietary assessment, it is unlikely that RKF would violate assumption (1) or (3). However, RKF could violate assumption (2) and bias the estimates of the direct and indirect effect. We would expect individuals with significant RKF to have more liberal diets and therefore higher potassium intake. According to eTables 6b and 6c, failing to adjust for a confounder that is protective for mortality (i.e., that has an AF greater than 1) that is also positively correlated with potassium intake would result in estimates that overestimate the true AF of the direct effect and underestimate the true AF of the indirect effect. Controlling for RKF is therefore likely to result in an AF for the indirect effect that is greater than the observed value of 1.00, which would mean that potassium intake would reduce mortality through higher levels of serum potassium. Such a scenario appears implausible. Furthermore, our second sensitivity analysis of the direct and indirect effect through assessment of the correlation between the error terms has shown them to be robust to unmeasured confounding.

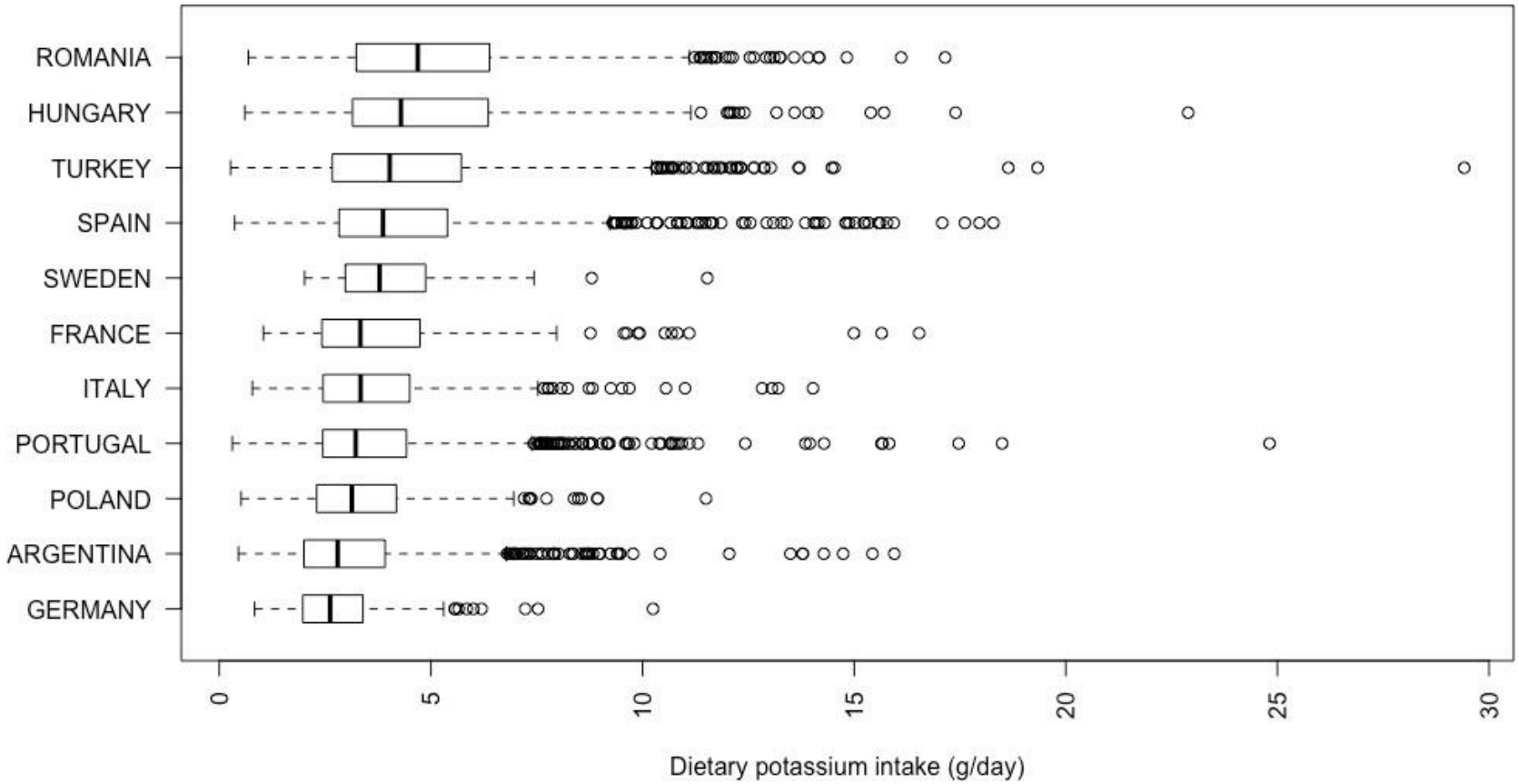
The case of dialysate potassium concentration
Dialysate potassium concentration has been associated with mortality and will affect serum potassium levels during and immediately following the dialysis session.[16] However, the dialysate serum potassium concentration is typically prescribed by the treating physician according to serum potassium levels. Therefore, dialysate potassium concentration lies in the pathway between serum potassium levels and death and should not be conditioned on. It is not a confounder but rather a mediator of the effect of serum potassium levels on death.

Measurement error
Food frequency questionnaires are susceptible to random and systematic measurement error that can bias the estimates of effect.[17] Furthermore, measurement error of the mediator can significantly bias the results of a mediation analysis. Therefore, to assess the robustness of our findings to measurement error, we conducted sensitivity analyses to simulate the effect of non-differential measurement error in the potassium intake and in the serum potassium levels. We used the SIMEX approach assuming no interaction between the exposure and the mediator and assuming non-differential measurement errors. Table S8 and Figure S11 shows the results using both a linear and a quadratic estimator. The estimates for the measurement error-free direct, indirect and total effect of dietary potassium on all-cause and cause-specific mortality all remained close to 1.00. While some extrapolated estimates of the indirect effect are statistically significant due to very narrow confidence intervals, for all direct, indirect and direct effects, the corrected acceleration factors differ by no more than 0.05 from the observed acceleration factors. These results suggest that our findings are likely to be robust to non-differential measurement errors.

Supplemental Figure 1. Patterns of missingness for the imputed variables

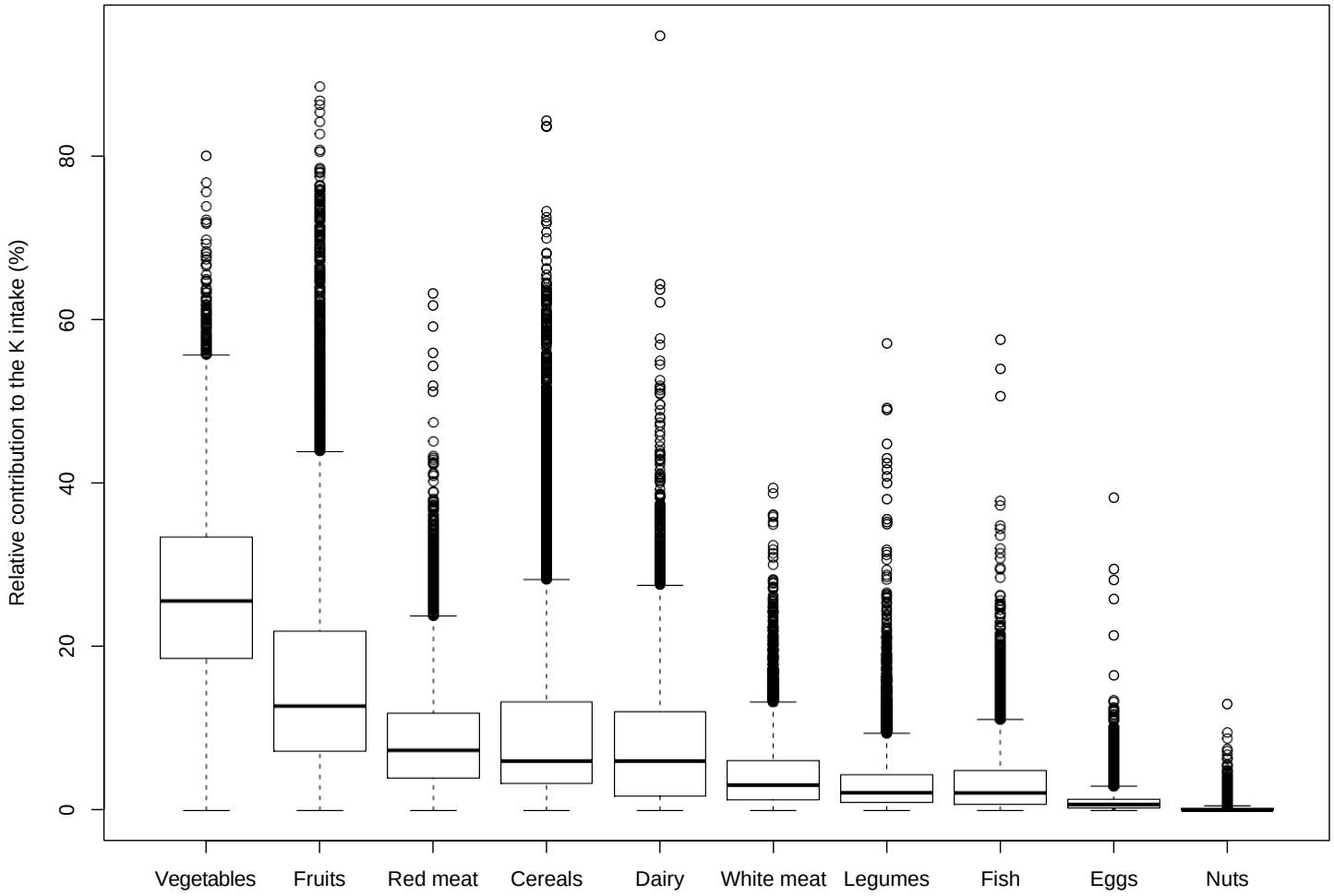


Supplemental Figure 2. Boxplots of the dietary potassium intake in gram per day by country

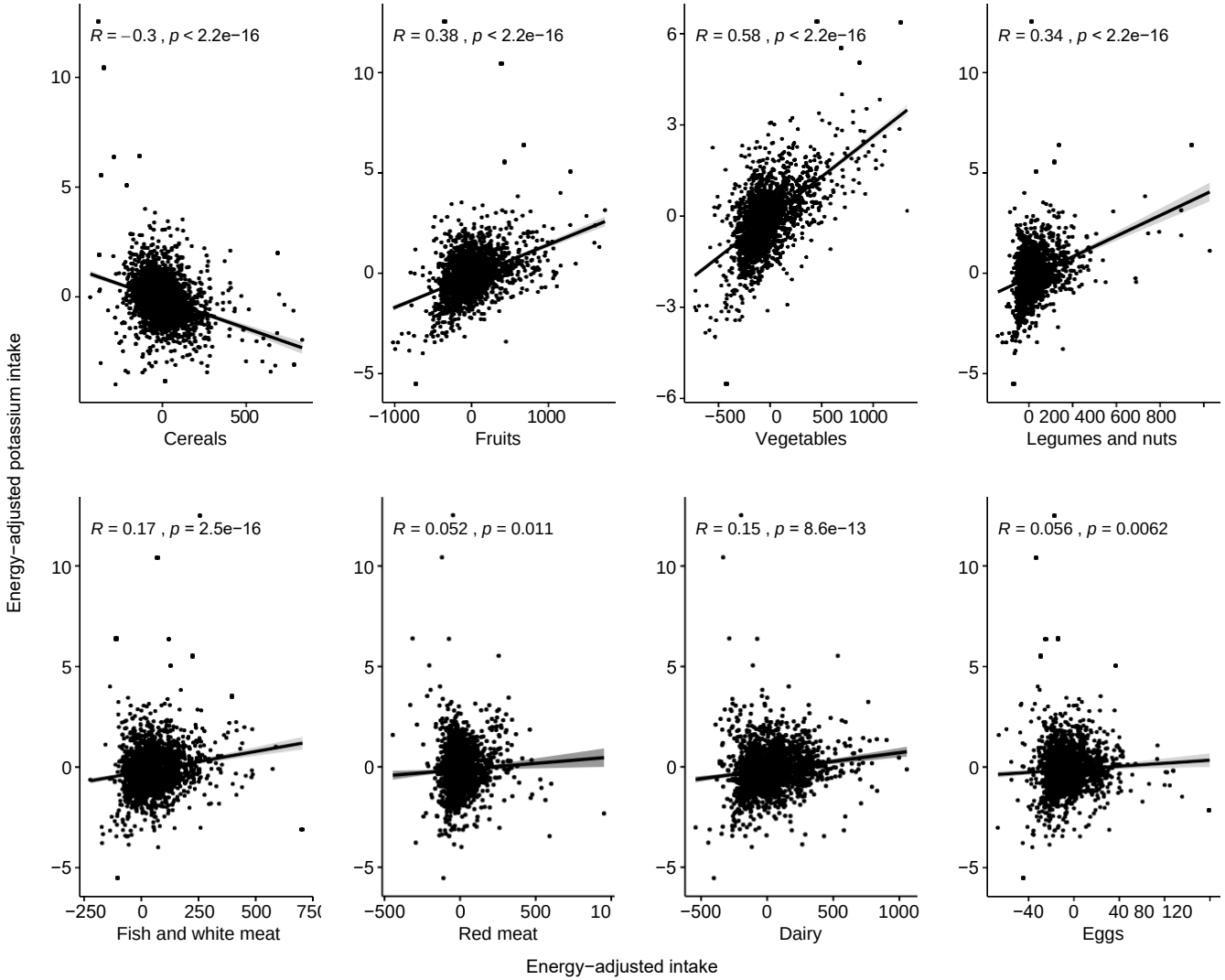


Dietary potassium intake in gram per day by country. Number of participants per country: Argentina 1190, France 220, Germany 177, Hungary 521, Italy 543, Poland 426, Portugal 1775, Romania 992, Spain 1041, Sweden 51 and Turkey 1107.

Supplemental Figure 3. Boxplots of the relative contribution of each food groups to the total potassium intake

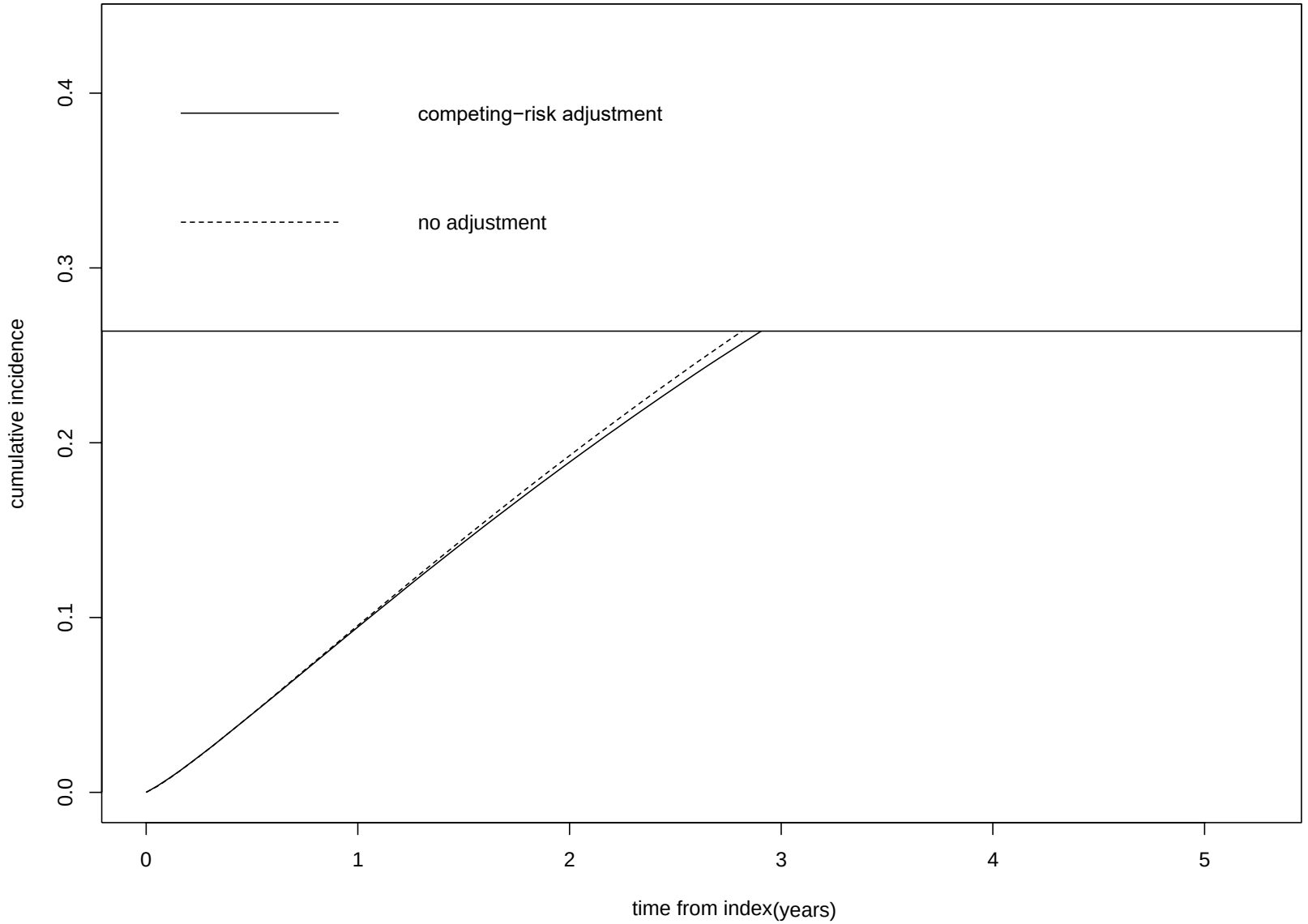


Supplemental Figure 4. Correlation between the energy-adjusted intake from each food group and the energy-adjusted potassium intake

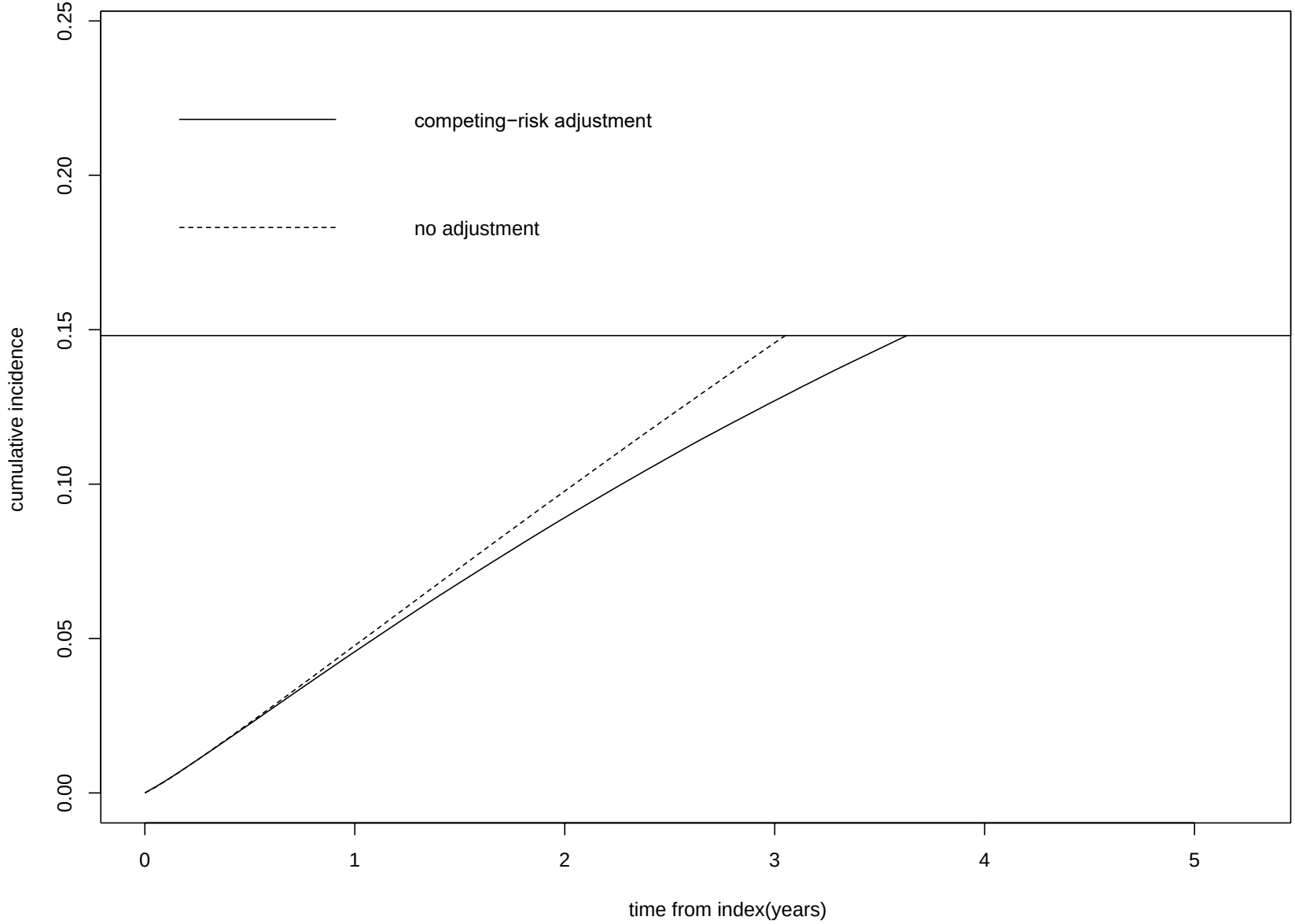


Energy adjustment was performed using the residuals method which consist in taking the residuals from the regression of dietary intake over total energy intake. Therefore, the values on the x axis represent the residuals of the intake from each food groups (in g/day) regressed over the total energy intake (in 1000 kCal/day). The values on the y axis represent the residuals of dietary potassium intake (in g/day) regressed over the total calorie intake (in 1000 kCal/day).
R= Pearson's correlation coefficient

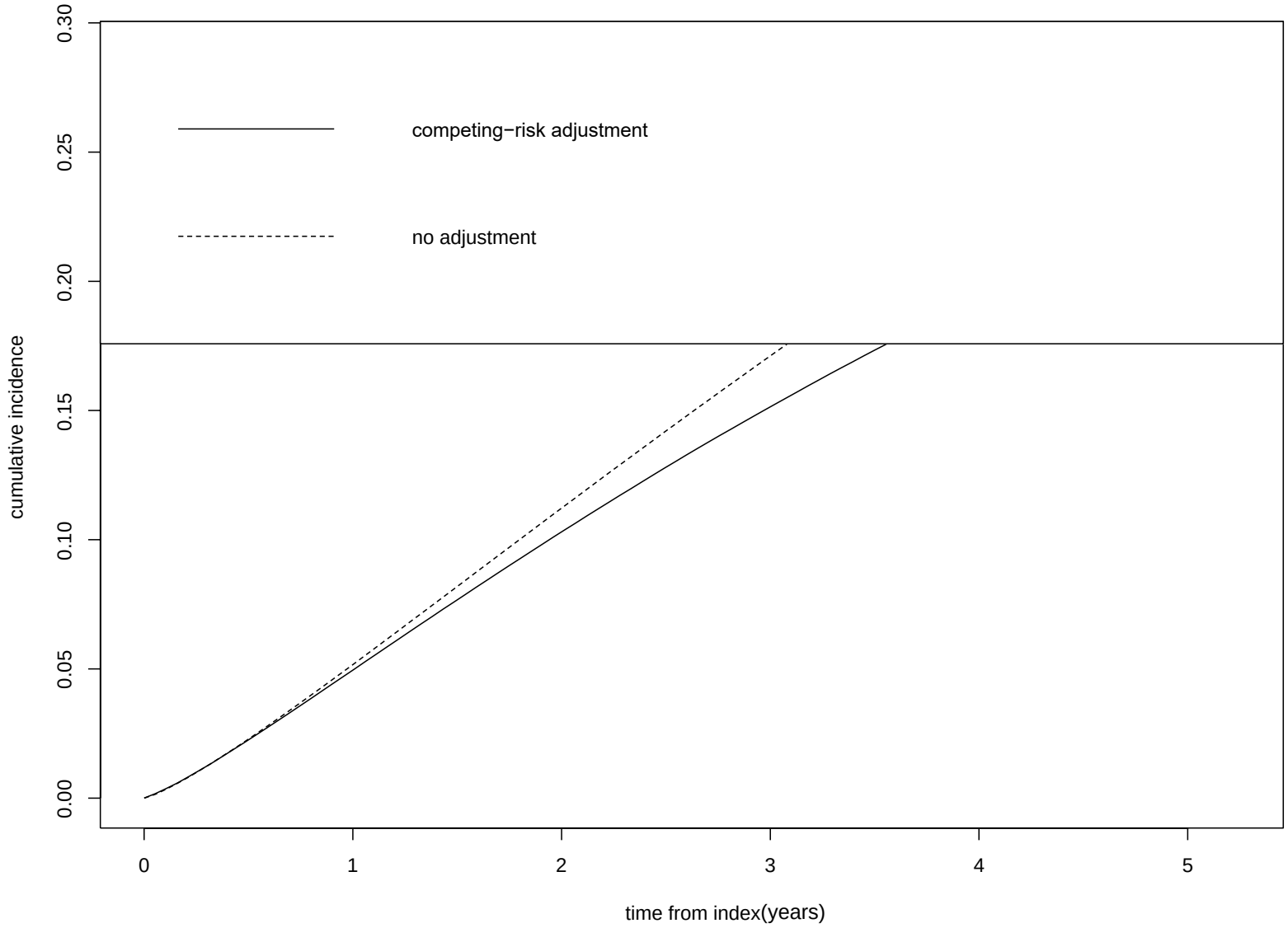
Supplemental Figure 5. Comparison of cumulative incidence function of all-cause mortality with and without adjustment for the competing-risk of transplantation



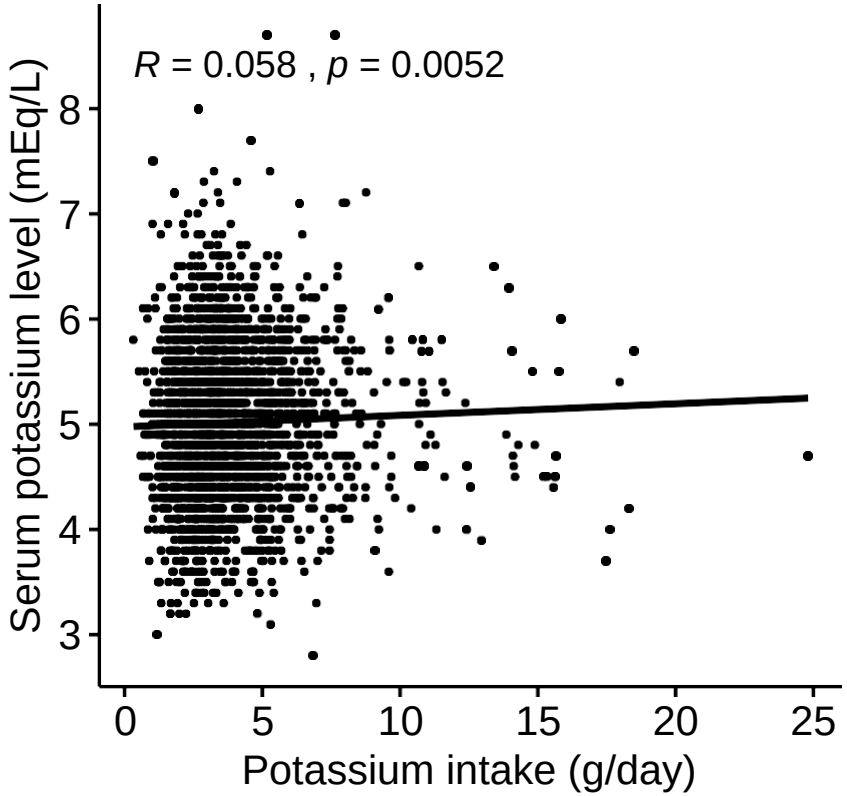
Supplemental Figure 6a. Comparison of cumulative incidence function of cardiovascular mortality with and without adjustment for the competing-risk of non-cardiovascular mortality



Supplemental Figure 6b. Comparison of cumulative incidence function of non-cardiovascular mortality with and without adjustment for the competing- risk of cardiovascular mortality

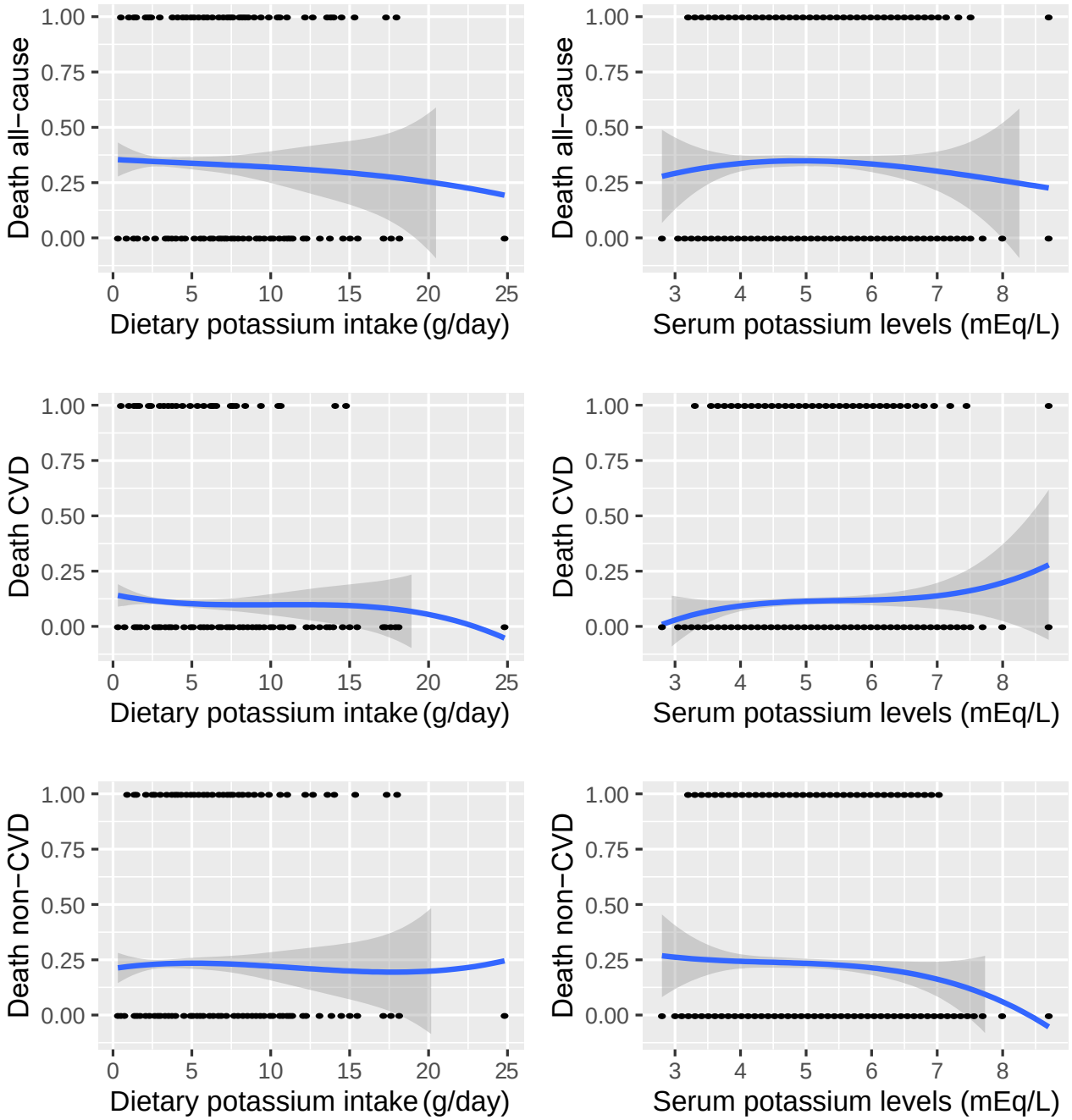


Supplemental Figure 7. Correlation between dietary potassium intake (g/day) and serum potassium levels (mEq/L)



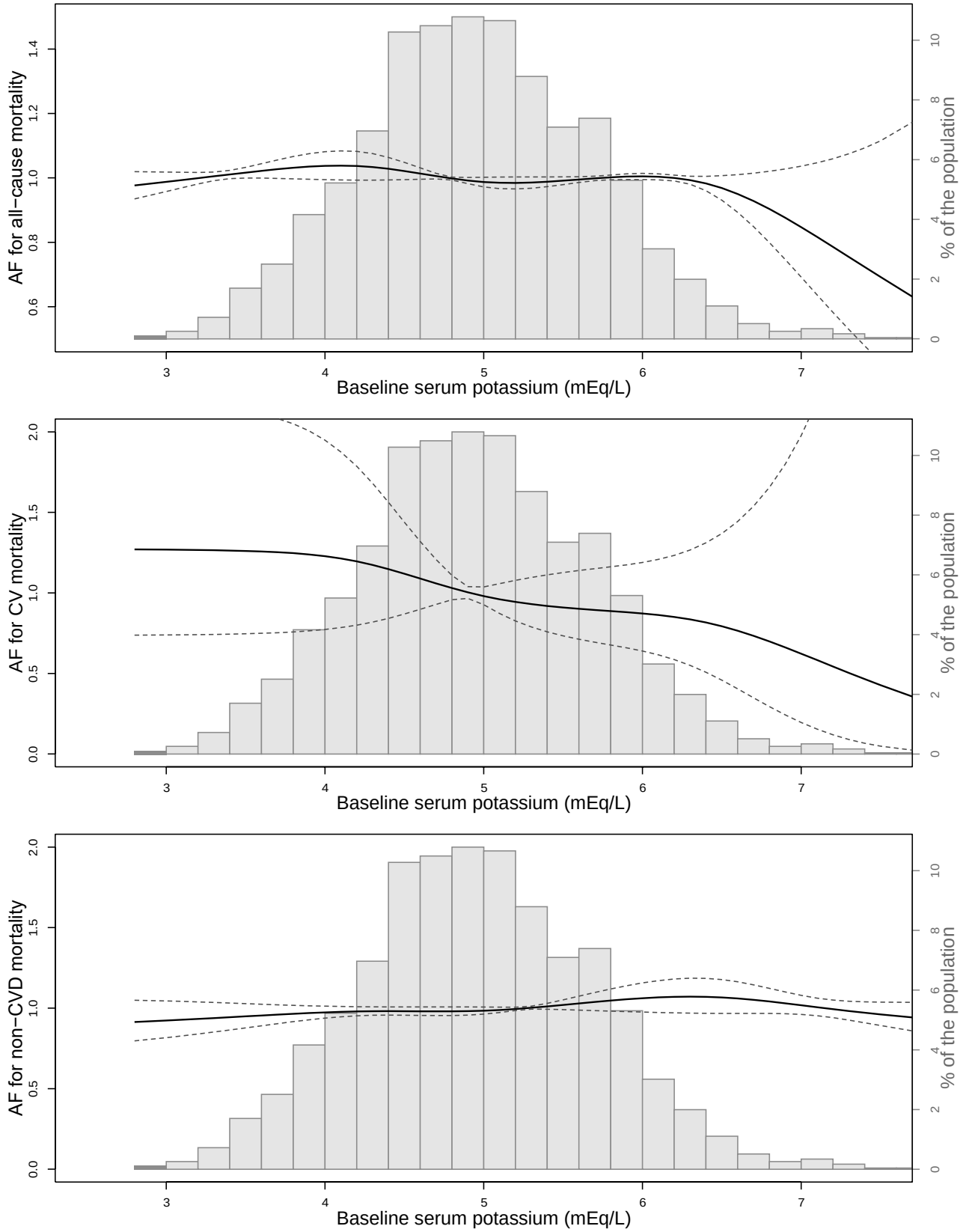
Correlation between potassium intake and serum potassium level at baseline.
R=Spearman's correlation coefficient

Supplemental Figure 8. Cubic splines of dietary (exposure) and serum (mediator) potassium with mortality outcomes without adjustment for covariates



Cubic splines of the exposure and the mediator with the outcomes. In all cases shown above, including a spline in the model did not significantly improve the Akaike Information Criteria.

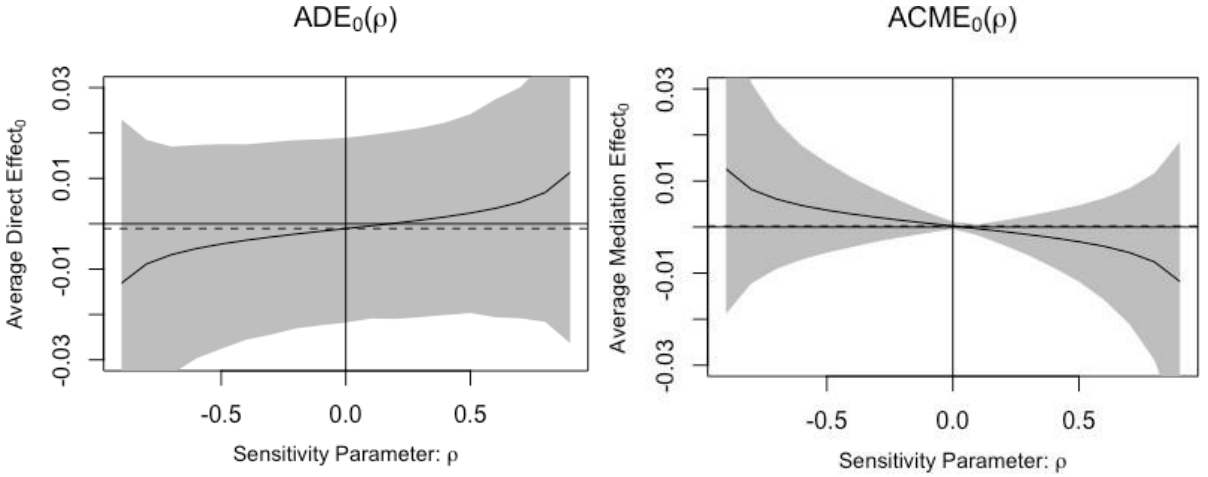
Supplemental Figure 9. Association of baseline serum potassium levels (mEq/L) with a) all-cause mortality, b) cardiovascular mortality and c) non cardiovascular mortality.



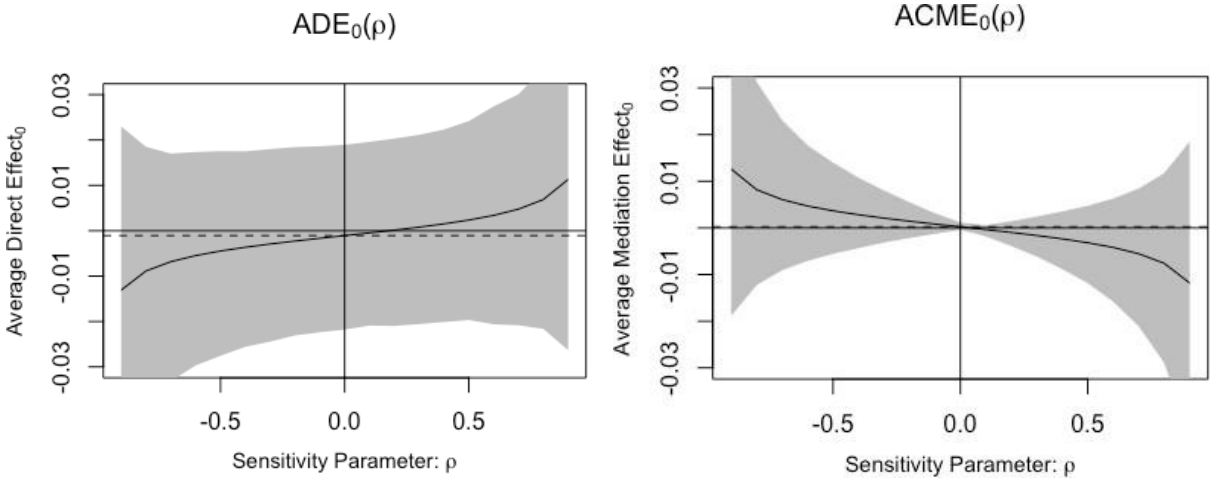
Models adjusted for the age, sex, smoking status, body mass index, physical activity, presence of a life partner, Charlson comorbidity index, history of cardiac disease, history of diabetes, history of cancer, listed for transplant, type of vascular access, bodyweight decrease during HD session, number of minutes of HD per week, HD vintage, Kt/V, receiving angiotensin converting enzyme inhibitors or angiotensin II receptor blockers, serum albumin, total energy intake and daily intake of each food group. AF, acceleration factor; CV, cardiovascular

Supplemental Figure 10. Sensitivity analysis for the direct (ADE) and the indirect (ACME) effect using the correlation between error terms

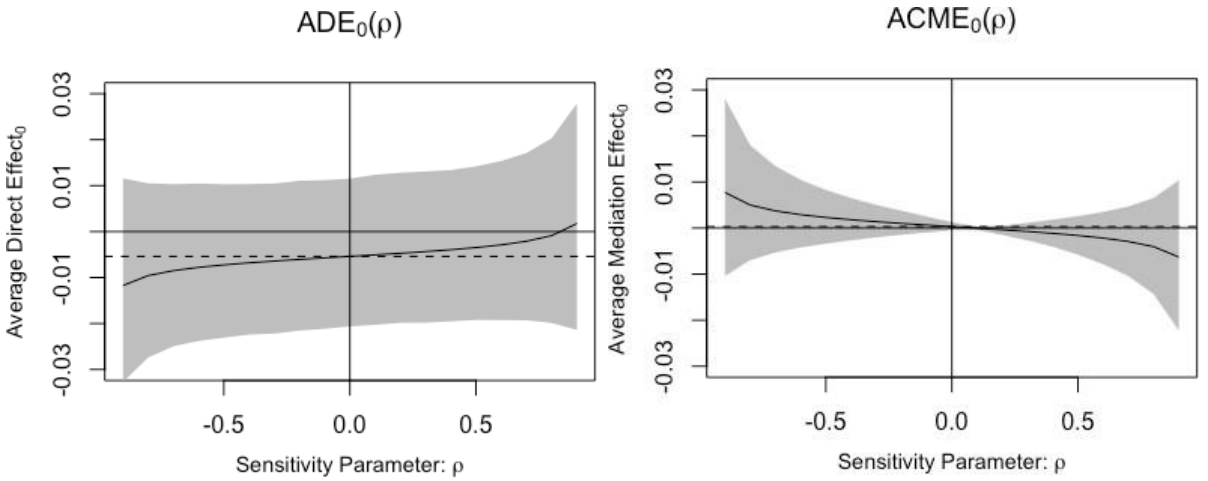
a) All-cause mortality



b) Cardiovascular mortality



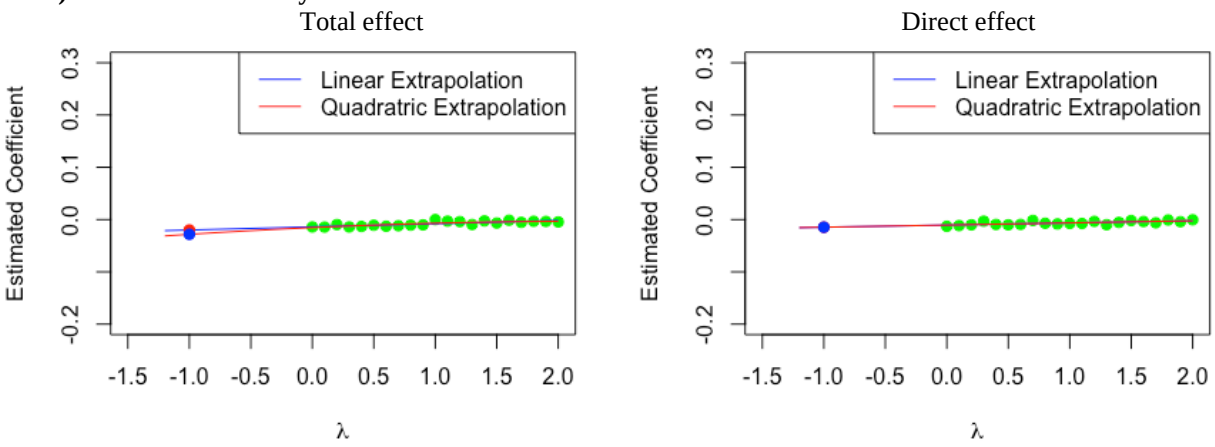
c) Non-cardiovascular mortality



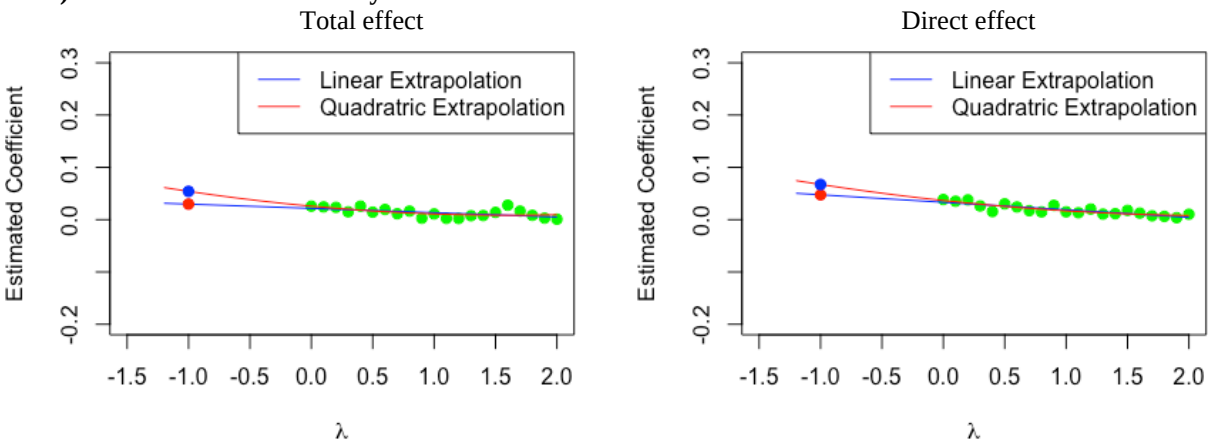
On the x-axis, the sensitivity parameter p represents the correlation between the error terms for the exposure and the mediator models and varies from -1 to 1. If the assumption of no unmeasured confounding between the mediator and the outcome holds, p should take a value a zero. On the y-axis is the value of the estimate (before exponentiation) for the indirect effect of dietary potassium on mortality as a binary outcome using probit regression. The dash line represents the estimate of the indirect effect we have observed in our study. The full line represents the corrected indirect effect for the corresponding level of p, surrounded by its 95% confidence interval represented in grey. Note that for every value of p, the confidence interval for the estimate of the indirect effect includes zero, i.e. no effect. It is therefore unlikely that an unmeasured confounder of the mediator-exposure relationship biased our results. Of note, while we conducted the sensitivity analysis in every imputed dataset, only one randomly selected dataset is represented here.

Supplemental Figure 11. Plot of the SIMEX extrapolation curve for the assessment of measurement error

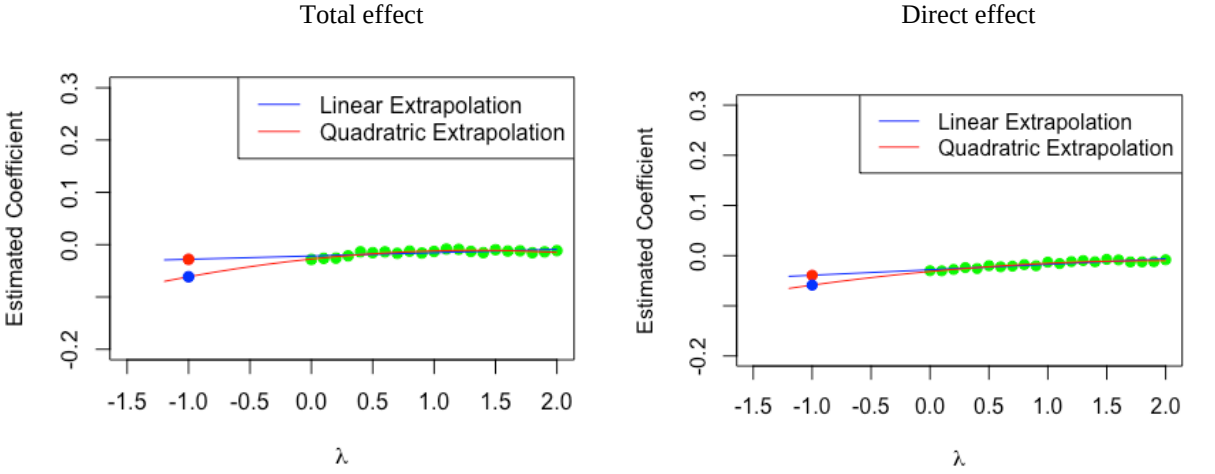
a) All-cause mortality



b) Cardiovascular mortality



c) Non cardiovascular mortality



The SIMEX analysis was conducted in every imputed dataset and the pooled corrected estimates are presented in eTable7. This figure represents the SIMEX plots for one randomly selected dataset.

Supplemental Table 1. Baseline characteristics of the DIET-HD participants with and without a measurement of serum potassium

	Serum potassium available	Serum potassium missing
	N (%)	N (%)
N	2355	5688
Demographics:		
Age (years)		
< 60	685 (29)	2339 (41)
60 - 80	1228 (52)	2760 (49)
> 80	442 (19)	589 (10)
Sex, N of men	1429 (61)	3229 (57)
Ethnicity		
White/Hispanic	1911 (91)	5181 (98)
Black	157 (8)	17 (0)
Others	34 (2)	110 (2)
Body Mass Index (kg/m2)		
<18.5	107 (5)	257 (5)
18.5-25	1071 (46)	2226 (40)
25-30	768 (33)	1882 (34)
>30	396 (17)	1139 (21)
Occupation status		
Working	268 (14)	424 (10)
Retired	1500 (76)	3109 (75)
Unemployed	217 (11)	646 (16)
Having a life partner	1346 (67)	2743 (68)
Secondary level education	696 (37)	1966 (48)
Country		
Argentina	0 (0.0)	1190 (21)
France	1 (0.0)	219 (4.0)
Germany	0 (0.0)	177 (3)
Hungary	59 (3)	462 (8)
Italy	0 (0.0)	543 (10)
Poland	0 (0.0)	426 (8)
Portugal	1708 (73)	67 (1)
Romania	0 (0.0)	992 (18)
Spain	540 (23)	501 (9)
Sweden	47 (2.0)	4 (0)
Turkey	0 (0.0)	1107 (20)
Lifestyle factors:		
Former or current smoker	705 (35)	1351 (32)
Performs physical activity daily	198 (10)	719 (17)
Dialysis:		
Etiology of kidney disease		
Diabetes	535 (23)	1424 (25)
Hypertension	387 (16)	1166 (21)
Glomerular disease	725 (31)	1873 (33)
Others	708 (30)	1225 (22)
> 5 years on HD	925 (39)	2065 (36)
> 12 hrs of HD/ week	335 (14)	864 (16)
Kt/V ≥ 1.4	2212 (95)	4708 (86)
Dialysed through AVF	1870 (80)	4597 (81)
Listed for transplant	465 (20)	1012 (18)
Intradialytic weight loss, kg[a]	3.2 (1)	3.0 (1)
Comorbidities:		
Charlson Index > 5	1598 (68)	2965 (52)
Cardiac disease	1172 (50)	2086 (46)
Hypertension	2077 (88)	4082 (83)
Diabetes	792 (34)	1530 (31)
Cancer	491 (21)	549 (10)
GI disease	662 (28)	1094 (19)

Pulmonary disease	367 (16)	569 (10)
Predialysis systolic BP, mmHg[a]	131 (23)	131 (21)
Under ACEI or ARB	751 (32)	1689 (30)
> 4 different drug class	657 (28)	1586 (28)
Pre-dialysis blood results:		
Calcium, mg/dL[a]	9.1 (1)	8.9 (1)
Phosphate, mg/dL[a]	4.2 (1)	4.9 (1)
Intact PTH, pg/ml[a]	430 (337)	425 (421)
Albumin, g/dL[a]	4.0 (0.4)	4.0 (0.4)
Haemoglobin, g/dL[a]	11.1 (1)	11.0 (1)
Dietary assessment:		
Total energy intake, $\bullet 10^3$ kCal/day[b]	1.9 [1.4, 2.5]	1.9 [1.4, 2.6]
NPCR[a]	1.1 (0.3)	1.1 (0.3)
Fibre intake, g/day[a]	14.1 (8.6)	14.0 (9.0)
Estimated NEAP[a, c]	52.9 (25.3)	45.5 (30.1)
Food groups, servings/day		
Cereal[b]	2.4 [1.4, 3.2]	2.2 [1.1, 3.4]
Fruit[b]	2.4 [1.4, 4.2]	2.6 [1.4, 4.6]
Vegetable[b]	3.3 [1.9, 5.5]	3.9 [2.4, 5.9]
Legumes and nuts[b]	0.4 [0.1, 0.7]	0.3 [0.1, 0.6]
Dairy[b]	1.4 [0.6, 2.3]	1.4 [0.6, 2.4]
Fish and white meat[b]	1.1 [0.6, 1.6]	0.4 [0.2, 0.9]
Red meat and meat[b]	1.2 [0.7, 2.0]	1.0 [0.5, 1.8]
Eggs[b]	0.1 [0.1, 0.4]	0.4 [0.1, 0.7]
Sweets and sweet drinks[b]	2.1 [1.0, 3.4]	2.6 [1.4, 4.3]

[a] Mean (standard deviation)
[b] Median (interquartile range)
[c] Calculated from the Remer and Manz's equation
ACEI, angiotensin converting enzyme inhibitor; ARB, angiotensin II receptor blocker; AVF, arteriovenous fistula; BP, blood pressure; HD, haemodialysis; IQR, interquartile range; potassium, potassium; N, number; NEAP, net endogenous acid production; NPCR, normalised protein catabolic rate; PTH, parathyroid hormone

Supplemental Table 2. Mortality acceleration factors and hazard ratios associated with all the variables (C[a] and food groups)

	All-cause mortality			Vascular deaths			Non-vascular deaths		
	AF (95%CI)	HR (95%CI)	p	AF (95%CI)	HR (95%CI)	p	AF (95%CI)	HR (95%CI)	p
Dietary potassium intake (g/day)	1.00 (0.96 to 1.04)	1.00 (0.95 to 1.05)	0.94	0.95 (0.90 to 1.02)	1.05 (0.98 to 1.13)	0.16	1.04 (0.98 to 1.10)	0.96 (0.89 to 1.02)	0.19
Age (per 10y)	0.81 (0.78 to 0.84)	1.28 (1.23 to 1.34)	<0.001	0.81 (0.76 to 0.86)	1.27 (1.19 to 1.35)	<0.001	0.81 (0.77 to 0.85)	1.30 (1.23 to 1.38)	<0.001
Sex (ref = male)	0.86 (0.79 to 0.93)	1.20 (1.10 to 1.32)	<0.001	0.86 (0.76 to 0.98)	1.18 (1.03 to 1.35)	0.02	0.85 (0.77 to 0.95)	1.22 (1.07 to 1.38)	0.002
Current or previous smoker	0.89 (0.82 to 0.96)	1.15 (1.05 to 1.26)	<0.001	0.86 (0.76 to 0.97)	1.18 (1.03 to 1.36)	0.02	0.90 (0.82 to 1.00)	1.13 (1.00 to 1.28)	0.05
BMI									
<18.5 kg/m^2	-	-		-	-		-	-	
18.5-25 kg/m^2	1.38 (1.19 to 1.60)	0.69 (0.58 to 0.81)	<0.001	1.33 (1.04 to 1.69)	0.73 (0.56 to 0.95)	<0.001	1.40 (1.17 to 1.68)	0.66 (0.53 to 0.82)	<0.001
25-30 kg/m^2	1.61 (1.38 to 1.87)	0.57 (0.48 to 0.69)		1.54 (1.20 to 1.98)	0.62 (0.47 to 0.81)		1.63 (1.35 to 1.97)	0.55 (0.43 to 0.69)	
>30 kg/m^2	1.69 (1.43 to 1.98)	0.54 (0.45 to 0.66)		1.67 (1.28 to 2.18)	0.57 (0.42 to 0.76)		1.68 (1.37 to 2.06)	0.53 (0.41 to 0.68)	
Daily physical activity	1.11 (1.00 to 1.24)	0.88 (0.78 to 1.00)	0.06	1.11 (0.94 to 1.31)	0.89 (0.74 to 1.06)	0.20	1.11 (0.96 to 1.28)	0.88 (0.74 to 1.05)	0.16
Life partner	1.05 (0.97 to 1.14)	0.95 (0.86 to 1.04)	0.26	1.04 (0.91 to 1.19)	0.96 (0.82 to 1.11)	0.56	1.06 (0.96 to 1.17)	0.93 (0.82 to 1.06)	0.27
Charlson comorbidity score	0.89 (0.87 to 0.91)	1.15 (1.12 to 1.18)	<0.001	0.89 (0.86 to 0.93)	1.13 (1.09 to 1.18)	<0.001	0.89 (0.86 to 0.91)	1.16 (1.12 to 1.20)	<0.001
Cardiac disease	0.87 (0.80 to 0.94)	1.18 (1.08 to 1.29)	<0.001	0.72 (0.64 to 0.82)	1.43 (1.25 to 1.64)	<0.001	0.99 (0.90 to 1.09)	1.01 (0.90 to 1.14)	0.81
Diabetes	0.90 (0.83 to 0.98)	1.12 (1.02 to 1.24)	0.02	0.84 (0.74 to 0.96)	1.21 (1.04 to 1.41)	0.01	0.95 (0.86 to 1.05)	1.07 (0.94 to 1.21)	0.33
Cancer	1.06 (0.97 to 1.17)	0.93 (0.83 to 1.04)	0.21	1.26 (1.07 to 1.49)	0.77 (0.64 to 0.93)	0.01	0.97 (0.86 to 1.09)	1.04 (0.90 to 1.20)	0.62
Waitlisted for transplant	1.30 (1.14 to 1.48)	0.74 (0.63 to 0.86)	<0.001	1.14 (0.94 to 1.38)	0.87 (0.70 to 1.07)	0.19	1.47 (1.22 to 1.78)	0.62 (0.49 to 0.78)	<0.001
Access is AVF	1.28 (1.19 to 1.38)	0.75 (0.69 to 0.82)	<0.001	1.13 (1.00 to 1.28)	0.88 (0.76 to 1.00)	0.06	1.38 (1.26 to 1.52)	0.67 (0.60 to 0.75)	<0.001
Interdialytic body weight decrease	0.96 (0.93 to 0.99)	1.05 (1.02 to 1.08)	<0.001	0.94 (0.91 to 0.98)	1.07 (1.02 to 1.11)	0.01	0.97 (0.94 to 1.01)	1.03 (0.99 to 1.08)	0.13
Serum albumin (per 10g)	1.84 (1.66 to 2.05)	0.49 (0.43 to 0.55)	<0.001	1.59 (1.35 to 1.88)	0.60 (0.50 to 0.72)	<0.001	2.05 (1.81 to 2.32)	0.41 (0.36 to 0.48)	<0.001
Duration of HD (in hours/week)	0.99 (0.96 to 1.02)	1.02 (0.98 to 1.05)	0.39	0.98 (0.94 to 1.03)	1.02 (0.96 to 1.08)	0.51	0.99 (0.95 to 1.03)	1.02 (0.97 to 1.07)	0.52
Under ACEI or ARB	1.03 (0.96 to 1.11)	0.97 (0.89 to 1.05)	0.40	1.01 (0.90 to 1.13)	0.99 (0.88 to 1.12)	0.87	1.05 (0.96 to 1.15)	0.94 (0.84 to 1.05)	0.27
Total energy intake (spontaneous)	0.97 (0.88 to 1.06)	1.04 (0.94 to 1.16)	0.46	0.99 (0.86 to 1.13)	1.02 (0.87 to 1.19)	0.83	0.94 (0.83 to 1.06)	1.08 (0.93 to 1.25)	0.31
β_2 of HD (per 10^3 kcal)	-	-	0.08	-	-	0.29	-	-	0.12
Kt/V (per unit)	1.06 (0.95 to 1.18)	0.94 (0.83 to 1.06)	0.31	1.07 (0.90 to 1.27)	0.93 (0.76 to 1.12)	0.44	1.05 (0.91 to 1.21)	0.94 (0.79 to 1.12)	0.49
Vintage									
Food groups intake in servings per day									
Cereals	1.01 (0.98 to 1.03)	0.99 (0.97 to 1.02)	0.59	1.01 (0.98 to 1.05)	0.99 (0.95 to 1.02)	0.45	1.00 (0.97 to 1.03)	0.99 (0.96 to 1.03)	0.78
Fruits	1.01 (1.00 to 1.03)	0.98 (0.97 to 1.00)	0.03	1.03 (1.00 to 1.05)	0.97 (0.95 to 1.00)	0.02	1.01 (0.99 to 1.02)	0.99 (0.97 to 1.01)	0.42

Vegetables [b]	1.01 (1.00 to 1.03)	0.98 (0.97 to 1.00)	0.04	1.02 (1.00 to 1.04)	0.98 (0.96 to 1.01)	0.13	1.01 (0.99 to 1.03)	0.98 (0.96 to 1.01)	0.16
Legumes and nuts	1.01 (0.96 to 1.07)	0.98 (0.92 to 1.05)	0.61	1.05 (0.96 to 1.16)	0.94 (0.85 to 1.05)	0.28	0.99 (0.92 to 1.06)	1.02 (0.94 to 1.11)	0.68
Dairy	0.98 (0.96 to 1.00)	1.02 (1.00 to 1.05)	0.10	0.97 (0.93 to 1.00)	1.04 (1.00 to 1.08)	0.04	0.99 (0.97 to 1.02)	1.01 (0.97 to 1.04)	0.62
Fish and white meat	0.98 (0.93 to 1.03)	1.02 (0.96 to 1.09)	0.46	1.07 (0.98 to 1.17)	0.93 (0.84 to 1.03)	0.15	0.93 (0.87 to 0.99)	1.10 (1.01 to 1.19)	0.02
Splines of red meat and meat products	-	-	>0.99	-	-	0.79	-	-	0.78
Eggs	1.07 (1.00 to 1.15)	0.92 (0.85 to 1.00)	0.05	1.04 (0.94 to 1.15)	0.96 (0.85 to 1.07)	0.44	1.10 (1.00 to 1.21)	0.89 (0.79 to 1.00)	0.04
Sweets and sweet drinks	1.00 (0.98 to 1.02)	1.00 (0.98 to 1.02)	0.82	1.02 (0.99 to 1.05)	0.98 (0.95 to 1.01)	0.19	0.98 (0.96 to 1.01)	1.02 (0.99 to 1.05)	0.13

[a] set of covariables C includes: age, sex, smoking status, body mass index, physical activity, presence of a life partner, Charlson comorbidity score, history of cardiac disease, history of diabetes, history of cancer, listed for transplant, type of vascular access, bodyweight decrease during HD session, number of minutes of HD per week, HD vintage, Kt/V, receiving angiotensin converting enzyme inhibitors or angiotensin II receptor blockers, serum albumin and total calorie intake

ACEI, angiotensin converting enzyme inhibitor; AF, acceleration factor; ARB, angiotensin II receptor blocker; AVF, arteriovenous fistula; HD, haemodialysis;

These results are exploratory and should not be interpreted as causal effects.

Supplemental Table 3. Mortality acceleration factors and hazard ratios associated with quartiles of dietary potassium intake

	All-cause mortality			Vascular deaths			Non-vascular deaths		
	Acceleration Factor (95%CI)	Hazard Ratio (95%CI)	p for trend	Acceleration Factor(95%CI)	Hazard Ratio (95%CI)	p for trend	Acceleration Factor (95%CI)	Hazard Ratio (95%CI)	p for trend
Unadjusted									
Q1	-	-		-	-		-	-	
Q2	1.05 (0.96 to 1.15)	0.95 (0.86 to 1.05)	0.001	1.06 (0.92 to 1.24)	0.94 (0.80 to 1.09)	0.92	1.04 (0.92 to 1.17)	0.96 (0.84 to 1.09)	< 0.001
Q3	1.01 (0.92 to 1.11)	0.99 (0.90 to 1.10)		0.96 (0.83 to 1.11)	1.04 (0.90 to 1.21)		1.04 (0.93 to 1.18)	0.95 (0.83 to 1.09)	
Q4	1.18 (1.07 to 1.30)	0.84 (0.75 to 0.93)		1.03 (0.89 to 1.20)	0.97 (0.83 to 1.13)		1.31 (1.15 to 1.49)	0.74 (0.64 to 0.85)	
Adjusted for C[a]									
Q1	-	-		-	-		-	-	
Q2	1.06 (0.97 to 1.16)	0.93 (0.84 to 1.04)	0.04	1.06 (0.91 to 1.23)	0.94 (0.80 to 1.10)	0.27	1.06 (0.95 to 1.19)	0.93 (0.81 to 1.07)	0 07
Q3	1.04 (0.95 to 1.15)	0.95 (0.85 to 1.07)		1.04 (0.89 to 1.21)	0.96 (0.81 to 1.14)		1.05 (0.93 to 1.20)	0.94 (0.80 to 1.10)	
Q4	1.17 (1.02 to 1.34)	0.84 (0.71 to 0.98)		1.14 (0.92 to 1.41)	0.87 (0.68 to 1.10)		1.19 (1.00 to 1.43)	0.81 (0.65 to 1.01)	
Adjusted for C[a] and food groups									
Q1	-	-		-	-		-	-	
Q2	1.05 (0.96 to 1.16)	0.94 (0.84 to 1.05)	0.33	1.06 (0.91 to 1.24)	0.93 (0.79 to 1.11)	0.57	1.04 (0.93 to 1.18)	0.95 (0.82 to 1.10)	0 41
Q3	1.02 (0.92 to 1.14)	0.97 (0.86 to 1.10)		1.03 (0.87 to 1.22)	0.97 (0.80 to 1.17)		1.02 (0.89 to 1.17)	0.98 (0.83 to 1.16)	
Q4	1.09 (0.94 to 1.27)	0.90 (0.75 to 1.08)		1.09 (0.86 to 1.38)	0.91 (0.70 to 1.18)		1.10 (0.90 to 1.34)	0.89 (0.70 to 1.13)	

[a] set of covariables C includes: age, sex, smoking status, body mass index, physical activity, presence of a life partner, Charlson comorbidity score, history of cardiac disease, history of diabetes, history of cancer, listed for transplant, type of vascular access, bodyweight decrease during HD session, number of minutes of HD per week, HD vintage, Kt/V, receiving angiotensin converting enzyme inhibitors or angiotensin II receptor blockers, serum albumin and total calorie intake

Supplemental Table 4. Mortality acceleration factors and hazard ratios associated with energy-adjusted potassium intake[a] and potassium density[b]

	All-cause mortality			Cardiovascular mortality			Non-cardiovascular mortality		
	AF (95%CI)	HR (95%CI)	p	AF (95%CI)	HR (95%CI)	p	AF (95%CI)	HR (95%CI)	p
Energy-adjusted potassium intake[a]									
Unadjusted	1.03 (1.00 to 1.07)	0.96 (0.93 to 1.00)	0.03	0.95 (0.91 to 0.99)	1.06 (1.01 to 1.11)	0.01	1.11 (1.07 to 1.16)	0.89 (0.85 to 0.93)	<0.001
Adjusted for C[c]	1.03 (1.00 to 1.07)	0.96 (0.93 to 1.00)	0.03	1.01 (0.96 to 1.05)	0.99 (0.94 to 1.05)	0.83	1.06 (1.02 to 1.11)	0.93 (0.88 to 0.98)	0.01
Adjusted for C[c] and food groups[d]	1.00 (0.96 to 1.04)	1.00 (0.96 to 1.05)	0.86	0.95 (0.89 to 1.02)	1.05 (0.98 to 1.13)	0.14	1.04 (0.98 to 1.09)	0.96 (0.89 to 1.03)	0.22
Potassium density[b]									
Unadjusted	1.07 (1.00 to 1.14)	0.93 (0.87 to 1.00)	0.04	0.87 (0.79 to 0.96)	1.15 (1.04 to 1.27)	0.01	1.27 (1.16 to 1.38)	0.77 (0.70 to 0.85)	<0.001
Adjusted for C[c]	1.07 (1.00 to 1.15)	0.92 (0.85 to 1.00)	0.04	1.03 (0.93 to 1.14)	0.97 (0.87 to 1.08)	0.58	1.11 (1.02 to 1.22)	0.88 (0.78 to 0.98)	0.02
Adjusted for C[c] and food groups[e]	1.03 (0.95 to 1.12)	0.96 (0.87 to 1.06)	0.48	0.98 (0.86 to 1.11)	1.02 (0.89 to 1.18)	0.74	1.08 (0.96 to 1.21)	0.91 (0.79 to 1.05)	0.19

[a] Energy-adjusted potassium intake is the residuals of the absolute dietary potassium intake in g/day regressed over the total energy intake in kcal/day.
[b] Potassium density is the absolute potassium intake in g/day divided by the total energy intake in 1000 kcal/day
[c] Set of covariables C includes: age, sex, smoking status, body mass index, physical activity, presence of a life partner, Charlson comorbidity score, history of cardiac disease, history of diabetes, history of cancer, listed for transplant, type of vascular access, bodyweight decrease during HD session, number of minutes of HD per week, HD vintage, Kt/V, receiving angiotensin converting enzyme inhibitors or angiotensin II receptor blockers and serum albumin (unlike the other analyses, total energy intake is not included as a covariable since the potassium intake is regressed over or divided by the total energy intake).
[d] Energy-adjusted food groups (i.e. regressed over total energy intake)
[e] Food groups density (i.e. divided by total energy intake)

Supplemental Table 5. Mediation analysis adjusted for the extended set of covariables (sensitivity analysis)

		All-cause mortality		Cardiovascular mortality		Non-cardiovascular mortality	
Mediation analysis:	N	AF (95%CI)	HR (95%CI)	AF (95%CI)	HR (95%CI)	AF (95%CI)	HR (95%CI)
Direct Effect	2355	0.98 (0.89 to 1.07)	1.01 (0.96 to 1.07)	1.05 (0.86 to 1.24)	0.98 (0.90 to 1.08)	0.95 (0.85 to 1.06)	1.02 (0.98 to 1.08)
Indirect Effect	2355	1.00 (1.00 to 1.00)	1.00 (1.00 to 1.00)	0.99 (0.98 to 1.01)	1.00 (1.00 to 1.01)	1.00 (1.00 to 1.00)	1.00 (1.00 to 1.00)
Total Effect	2355	0.98 (0.89 to 1.07)	1.01 (0.96 to 1.07)	1.04 (0.85 to 1.23)	0.98 (0.91 to 1.08)	0.95 (0.85 to 1.06)	1.02 (0.98 to 1.08)

Adjusted for education level, history of gastrointestinal disease, history of peripheral artery disease, history of psychiatric disease, underlying etiology of kidney failure, number of different class of drug taken, pre dialysis systolic blood pressure, serum calcium levels, serum phosphate levels, alcohol intake, normalized protein catabolic rate and estimated net endogenous acid production as well as the set of covariables C forced into the model (age, sex, smoking status, body mass index, physical activity, presence of a life partner, Charlson comorbidity score, history of cardiac disease, history of diabetes, history of cancer, listed for transplant, type of vascular access, bodyweight decrease during hemodialysis session, number of minutes of hemodialysis per week, hemodialysis vintage, Kt/V, receiving angiotensin converting enzyme inhibitors or angiotensin II receptor blockers, serum albumin and total calorie intake).

Supplemental Table 6a. Estimates of the total, direct and indirect effect for all-cause mortality corrected for an unmeasured confounder

TOTAL EFFECT = 1.01 95%CI (0.96 to 1.06)

RR of U per gram/day of potassium intake \ AF of U on the time-to-death	0.50	0.55	0.61	0.67	0.74	0.82	0.90	1.00	1.11	1.22	1.35	1.49	1.65	1.82	2.01
0.50	NA	0.16	0.34	0.50	0.64	0.77	0.88	0.99	1.09	1.17	1.25	1.32	1.38	1.44	1.50
0.55	0.16	0.32	0.46	0.59	0.71	0.81	0.90	0.99	1.07	1.14	1.20	1.26	1.31	1.36	1.40
0.61	0.34	0.46	0.57	0.67	0.77	0.85	0.92	0.99	1.05	1.11	1.16	1.20	1.24	1.28	1.31
0.67	0.50	0.59	0.67	0.75	0.82	0.88	0.94	0.99	1.04	1.08	1.12	1.15	1.18	1.21	1.24
0.74	0.64	0.71	0.77	0.82	0.87	0.91	0.95	0.99	1.02	1.05	1.08	1.10	1.13	1.15	1.16
0.82	0.77	0.81	0.85	0.88	0.91	0.94	0.97	0.99	1.01	1.03	1.05	1.06	1.08	1.09	1.10
0.90	0.88	0.90	0.92	0.94	0.95	0.97	0.98	0.99	1.00	1.01	1.02	1.02	1.03	1.04	1.04
1.00	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99
1.11	1.09	1.07	1.05	1.04	1.02	1.01	1.00	0.99	0.98	0.97	0.97	0.96	0.95	0.95	0.94
1.22	1.17	1.14	1.11	1.08	1.05	1.03	1.01	0.99	0.97	0.96	0.94	0.93	0.92	0.91	0.90
1.35	1.25	1.20	1.16	1.12	1.08	1.05	1.02	0.99	0.97	0.94	0.92	0.91	0.89	0.87	0.86
1.49	1.32	1.26	1.20	1.15	1.10	1.06	1.02	0.99	0.96	0.93	0.91	0.88	0.86	0.84	0.83
1.65	1.38	1.31	1.24	1.18	1.13	1.08	1.03	0.99	0.95	0.92	0.89	0.86	0.84	0.81	0.79
1.82	1.44	1.36	1.28	1.21	1.15	1.09	1.04	0.99	0.95	0.91	0.87	0.84	0.81	0.79	0.77
2.01	1.50	1.40	1.31	1.24	1.16	1.10	1.04	0.99	0.94	0.90	0.86	0.83	0.79	0.77	0.74

DIRECT EFFECT = 1.01 95%CI (0.96 to 1.06)

RR of U per gram/day of potassium intake \ AF of U on the time-to-death	0.50	0.55	0.61	0.67	0.74	0.82	0.90	1.00	1.11	1.22	1.35	1.49	1.65	1.82	2.01
0.50	NA	0.17	0.34	0.50	0.64	0.77	0.89	0.99	1.09	1.17	1.25	1.32	1.39	1.44	1.50
0.55	0.17	0.32	0.46	0.59	0.71	0.81	0.91	0.99	1.07	1.14	1.20	1.26	1.31	1.36	1.40
0.61	0.34	0.46	0.57	0.67	0.77	0.85	0.92	0.99	1.05	1.11	1.16	1.20	1.24	1.28	1.31
0.67	0.50	0.59	0.67	0.75	0.82	0.88	0.94	0.99	1.04	1.08	1.12	1.15	1.18	1.21	1.24
0.74	0.64	0.71	0.77	0.82	0.87	0.91	0.95	0.99	1.02	1.05	1.08	1.11	1.13	1.15	1.17
0.82	0.77	0.81	0.85	0.88	0.91	0.94	0.97	0.99	1.01	1.03	1.05	1.06	1.08	1.09	1.10
0.90	0.89	0.91	0.92	0.94	0.95	0.97	0.98	0.99	1.00	1.01	1.02	1.03	1.03	1.04	1.04
1.00	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99
1.11	1.09	1.07	1.05	1.04	1.02	1.01	1.00	0.99	0.98	0.97	0.97	0.96	0.95	0.95	0.94
1.22	1.17	1.14	1.11	1.08	1.05	1.03	1.01	0.99	0.97	0.96	0.94	0.93	0.92	0.91	0.90
1.35	1.25	1.20	1.16	1.12	1.08	1.05	1.02	0.99	0.97	0.94	0.92	0.91	0.89	0.87	0.86
1.49	1.32	1.26	1.20	1.15	1.11	1.06	1.03	0.99	0.96	0.93	0.91	0.88	0.86	0.84	0.83
1.65	1.39	1.31	1.24	1.18	1.13	1.08	1.03	0.99	0.95	0.92	0.89	0.86	0.84	0.81	0.79
1.82	1.44	1.36	1.28	1.21	1.15	1.09	1.04	0.99	0.95	0.91	0.87	0.84	0.81	0.79	0.77
2.01	1.50	1.40	1.31	1.24	1.17	1.10	1.04	0.99	0.94	0.90	0.86	0.83	0.79	0.77	0.74

INDIRECT EFFECT = 1.00 95%CI (1.00 to 1.00)

RR of U per gram/day of potassium intake \ AF of U on the time-to-death	0.50	0.55	0.61	0.67	0.74	0.82	0.90	1.00	1.11	1.22	1.35	1.49	1.65	1.82	2.01
0.50	NA	6.00	2.92	1.99	1.55	1.29	1.12	1.00	0.91	0.84	0.79	0.75	0.71	0.69	0.66
0.55	6.00	3.08	2.14	1.68	1.40	1.22	1.09	1.00	0.93	0.87	0.82	0.79	0.75	0.73	0.71
0.61	2.92	2.14	1.73	1.47	1.29	1.17	1.07	1.00	0.94	0.89	0.86	0.82	0.80	0.77	0.75
0.67	1.99	1.68	1.47	1.32	1.21	1.12	1.05	1.00	0.95	0.92	0.89	0.86	0.84	0.82	0.80
0.74	1.55	1.40	1.29	1.21	1.14	1.08	1.04	1.00	0.97	0.94	0.92	0.90	0.88	0.86	0.85
0.82	1.29	1.22	1.17	1.12	1.08	1.05	1.02	1.00	0.98	0.96	0.94	0.93	0.92	0.91	0.90
0.90	1.12	1.09	1.07	1.05	1.04	1.02	1.01	1.00	0.99	0.98	0.97	0.97	0.96	0.95	0.95
1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
1.11	0.91	0.93	0.94	0.95	0.97	0.98	0.99	1.00	1.01	1.02	1.02	1.03	1.04	1.04	1.05
1.22	0.84	0.87	0.89	0.92	0.94	0.96	0.98	1.00	1.02	1.03	1.05	1.06	1.08	1.09	1.10
1.35	0.79	0.82	0.86	0.89	0.92	0.94	0.97	1.00	1.02	1.05	1.07	1.09	1.11	1.13	1.15
1.49	0.75	0.79	0.82	0.86	0.90	0.93	0.97	1.00	1.03	1.06	1.09	1.12	1.15	1.17	1.20
1.65	0.71	0.75	0.80	0.84	0.88	0.92	0.96	1.00	1.04	1.08	1.11	1.15	1.18	1.21	1.25
1.82	0.69	0.73	0.77	0.82	0.86	0.91	0.95	1.00	1.04	1.09	1.13	1.17	1.21	1.25	1.29
2.01	0.66	0.71	0.75	0.80	0.85	0.90	0.95	1.00	1.05	1.10	1.15	1.20	1.25	1.29	1.34

CI, confidence interval; potassium, potassium; AF, acceleration factor; RR, relative risk; U, unmeasured confounder

The columns represent the acceleration factor of an unmeasured confounder U for all-cause mortality. The rows represent the relative risk of U per gram per day of potassium intake. The numbers in the tables represent the corrected acceleration factors for the effect of dietary potassium on all-cause mortality where we have adjusted for U and U takes the sensitivity values in the corresponding column and row. The zone in grey represent a clinically significant harm (which we have defined at an acceleration factor of 0.95 or less) that would have been missed by not adjusting for U.

Supplemental Table 6b. Estimates of the total, direct and indirect effect for cardiovascular mortality corrected for an unmeasured confounder

TOTAL EFFECT = 0.98 95%CI (0.91 to 1.07)

RR of U per gram/day of potassium intake \ AF of U on the time-to-death	0.50	0.55	0.61	0.67	0.74	0.82	0.90	1.00	1.11	1.22	1.35	1.49	1.65	1.82	2.01
0.50	NA	0.17	0.35	0.52	0.67	0.80	0.92	1.04	1.14	1.23	1.31	1.38	1.45	1.51	1.56
0.55	0.17	0.34	0.48	0.62	0.74	0.85	0.95	1.04	1.12	1.19	1.26	1.32	1.37	1.42	1.46
0.61	0.35	0.48	0.60	0.70	0.80	0.89	0.96	1.04	1.10	1.16	1.21	1.26	1.30	1.34	1.37
0.67	0.52	0.62	0.70	0.78	0.86	0.92	0.98	1.04	1.08	1.13	1.17	1.20	1.24	1.26	1.29
0.74	0.67	0.74	0.80	0.86	0.91	0.95	1.00	1.04	1.07	1.10	1.13	1.15	1.18	1.20	1.22
0.82	0.80	0.85	0.89	0.92	0.95	0.98	1.01	1.04	1.06	1.08	1.09	1.11	1.13	1.14	1.15
0.90	0.92	0.95	0.96	0.98	1.00	1.01	1.02	1.04	1.05	1.05	1.06	1.07	1.08	1.08	1.09
1.00	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04
1.11	1.14	1.12	1.10	1.08	1.07	1.06	1.05	1.04	1.03	1.02	1.01	1.00	1.00	0.99	0.99
1.22	1.23	1.19	1.16	1.13	1.10	1.08	1.05	1.04	1.02	1.00	0.99	0.97	0.96	0.95	0.94
1.35	1.31	1.26	1.21	1.17	1.13	1.09	1.06	1.04	1.01	0.99	0.97	0.95	0.93	0.91	0.90
1.49	1.38	1.32	1.26	1.20	1.15	1.11	1.07	1.04	1.00	0.97	0.95	0.92	0.90	0.88	0.86
1.65	1.45	1.37	1.30	1.24	1.18	1.13	1.08	1.04	1.00	0.96	0.93	0.90	0.87	0.85	0.83
1.82	1.51	1.42	1.34	1.26	1.20	1.14	1.08	1.04	0.99	0.95	0.91	0.88	0.85	0.82	0.80
2.01	1.56	1.46	1.37	1.29	1.22	1.15	1.09	1.04	0.99	0.94	0.90	0.86	0.83	0.80	0.77

DIRECT EFFECT = 0.98 95%CI (0.91 to 1.07)

RR of U per gram/day of potassium intake \ AF of U on the time-to-death	0.50	0.55	0.61	0.67	0.74	0.82	0.90	1.00	1.11	1.22	1.35	1.49	1.65	1.82	2.01
0.50	NA	0.17	0.36	0.52	0.67	0.81	0.93	1.04	1.14	1.23	1.32	1.39	1.46	1.52	1.57
0.55	0.17	0.34	0.49	0.62	0.74	0.85	0.95	1.04	1.12	1.20	1.26	1.32	1.38	1.43	1.47
0.61	0.36	0.49	0.60	0.71	0.81	0.89	0.97	1.04	1.11	1.16	1.22	1.26	1.31	1.35	1.38
0.67	0.52	0.62	0.71	0.79	0.86	0.93	0.99	1.04	1.09	1.13	1.17	1.21	1.24	1.27	1.30
0.74	0.67	0.74	0.81	0.86	0.91	0.96	1.00	1.04	1.08	1.11	1.14	1.16	1.19	1.21	1.23
0.82	0.81	0.85	0.89	0.93	0.96	0.99	1.02	1.04	1.06	1.08	1.10	1.12	1.13	1.15	1.16
0.90	0.93	0.95	0.97	0.99	1.00	1.02	1.03	1.04	1.05	1.06	1.07	1.08	1.08	1.09	1.10
1.00	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04
1.11	1.14	1.12	1.11	1.09	1.08	1.06	1.05	1.04	1.03	1.02	1.02	1.01	1.00	1.00	0.99
1.22	1.23	1.20	1.16	1.13	1.11	1.08	1.06	1.04	1.02	1.01	0.99	0.98	0.97	0.96	0.95
1.35	1.32	1.26	1.22	1.17	1.14	1.10	1.07	1.04	1.02	0.99	0.97	0.95	0.94	0.92	0.91
1.49	1.39	1.32	1.26	1.21	1.16	1.12	1.08	1.04	1.01	0.98	0.95	0.93	0.91	0.89	0.87
1.65	1.46	1.38	1.31	1.24	1.19	1.13	1.08	1.04	1.00	0.97	0.94	0.91	0.88	0.86	0.84
1.82	1.52	1.43	1.35	1.27	1.21	1.15	1.09	1.04	1.00	0.96	0.92	0.89	0.86	0.83	0.81
2.01	1.57	1.47	1.38	1.30	1.23	1.16	1.10	1.04	0.99	0.95	0.91	0.87	0.84	0.81	0.78

INDIRECT EFFECT = 1.00 95%CI (1.00 to 1.01)

RR of U per gram/day of potassium intake \ AF of U on the time-to-death	0.50	0.55	0.61	0.67	0.74	0.82	0.90	1.00	1.11	1.22	1.35	1.49	1.65	1.82	2.01
0.50	NA	5.97	2.90	1.98	1.54	1.28	1.11	0.99	0.91	0.84	0.79	0.74	0.71	0.68	0.66
0.55	5.97	3.07	2.13	1.67	1.39	1.21	1.09	0.99	0.92	0.86	0.82	0.78	0.75	0.72	0.70
0.61	2.90	2.13	1.72	1.46	1.29	1.16	1.07	0.99	0.94	0.89	0.85	0.82	0.79	0.77	0.75
0.67	1.98	1.67	1.46	1.31	1.20	1.12	1.05	0.99	0.95	0.91	0.88	0.86	0.83	0.81	0.80
0.74	1.54	1.39	1.29	1.20	1.13	1.08	1.03	0.99	0.96	0.93	0.91	0.89	0.87	0.86	0.84
0.82	1.28	1.21	1.16	1.12	1.08	1.04	1.02	0.99	0.97	0.96	0.94	0.93	0.91	0.90	0.89
0.90	1.11	1.09	1.07	1.05	1.03	1.02	1.00	0.99	0.98	0.98	0.97	0.96	0.95	0.95	0.94
1.00	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99
1.11	0.91	0.92	0.94	0.95	0.96	0.97	0.98	0.99	1.00	1.01	1.02	1.03	1.03	1.04	1.04
1.22	0.84	0.86	0.89	0.91	0.93	0.96	0.98	0.99	1.01	1.03	1.04	1.06	1.07	1.08	1.09
1.35	0.79	0.82	0.85	0.88	0.91	0.94	0.97	0.99	1.02	1.04	1.07	1.09	1.11	1.13	1.14
1.49	0.74	0.78	0.82	0.86	0.89	0.93	0.96	0.99	1.03	1.06	1.09	1.11	1.14	1.17	1.19
1.65	0.71	0.75	0.79	0.83	0.87	0.91	0.95	0.99	1.03	1.07	1.11	1.14	1.18	1.21	1.24
1.82	0.68	0.72	0.77	0.81	0.86	0.90	0.95	0.99	1.04	1.08	1.13	1.17	1.21	1.25	1.29
2.01	0.66	0.70	0.75	0.80	0.84	0.89	0.94	0.99	1.04	1.09	1.14	1.19	1.24	1.29	1.33

CI, confidence interval; potassium, potassium; AF, acceleration factor; RR, relative risk; U, unmeasured confounder
The columns represent the acceleration factor of an unmeasured confounder U for all-cause mortality. The rows represent the relative risk of U per gram per day of potassium intake. The numbers in the tables represent the corrected acceleration factors for the effect of dietary potassium on all-cause mortality where we have adjusted for U and U takes the sensitivity values in the corresponding column and row. The zone in grey represent a clinically significant harm (which we have defined at an acceleration factor of 0.95 or less) that would have been missed by not adjusting for U.

Supplemental Table 6c. Estimates of the total, direct and indirect effect for non-cardiovascular mortality corrected for an unmeasured confounder

TOTAL EFFECT = 1.01 (0.98 to 1.08)

RR of U per gram/day of potassium intake \ AF of U on the time-to-death	0.50	0.55	0.61	0.67	0.74	0.82	0.90	1.00	1.11	1.22	1.35	1.49	1.65	1.82	2.01
0.50	NA	0.16	0.33	0.49	0.63	0.76	0.87	0.98	1.07	1.16	1.23	1.30	1.36	1.42	1.47
0.55	0.16	0.32	0.46	0.58	0.70	0.80	0.89	0.98	1.05	1.12	1.18	1.24	1.29	1.34	1.38
0.61	0.33	0.46	0.57	0.66	0.75	0.84	0.91	0.98	1.04	1.09	1.14	1.18	1.22	1.26	1.29
0.67	0.49	0.58	0.66	0.74	0.81	0.87	0.93	0.98	1.02	1.06	1.10	1.13	1.16	1.19	1.22
0.74	0.63	0.70	0.75	0.81	0.86	0.90	0.94	0.98	1.01	1.04	1.06	1.09	1.11	1.13	1.15
0.82	0.76	0.80	0.84	0.87	0.90	0.93	0.95	0.98	1.00	1.01	1.03	1.05	1.06	1.07	1.08
0.90	0.87	0.89	0.91	0.93	0.94	0.95	0.96	0.98	0.99	0.99	1.00	1.01	1.02	1.02	1.03
1.00	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98
1.11	1.07	1.05	1.04	1.02	1.01	1.00	0.99	0.98	0.97	0.96	0.95	0.95	0.94	0.93	0.93
1.22	1.16	1.12	1.09	1.06	1.04	1.01	0.99	0.98	0.96	0.94	0.93	0.92	0.91	0.90	0.89
1.35	1.23	1.18	1.14	1.10	1.06	1.03	1.00	0.98	0.95	0.93	0.91	0.89	0.88	0.86	0.85
1.49	1.30	1.24	1.18	1.13	1.09	1.05	1.01	0.98	0.95	0.92	0.89	0.87	0.85	0.83	0.81
1.65	1.36	1.29	1.22	1.16	1.11	1.06	1.02	0.98	0.94	0.91	0.88	0.85	0.82	0.80	0.78
1.82	1.42	1.34	1.26	1.19	1.13	1.07	1.02	0.98	0.93	0.90	0.86	0.83	0.80	0.78	0.75
2.01	1.47	1.38	1.29	1.22	1.15	1.08	1.03	0.98	0.93	0.89	0.85	0.81	0.78	0.75	0.73

DIRECT EFFECT = 1.02 (0.97 to 1.08)

RR of U per gram/day of potassium intake \ AF of U on the time-to-death	0.50	0.55	0.61	0.67	0.74	0.82	0.90	1.00	1.11	1.22	1.35	1.49	1.65	1.82	2.01
0.50	NA	0.16	0.33	0.49	0.63	0.76	0.87	0.97	1.07	1.15	1.23	1.30	1.36	1.42	1.47
0.55	0.16	0.32	0.45	0.58	0.69	0.80	0.89	0.97	1.05	1.12	1.18	1.24	1.29	1.34	1.38
0.61	0.33	0.45	0.56	0.66	0.75	0.83	0.91	0.97	1.03	1.09	1.14	1.18	1.22	1.26	1.29
0.67	0.49	0.58	0.66	0.74	0.81	0.87	0.92	0.97	1.02	1.06	1.10	1.13	1.16	1.19	1.22
0.74	0.63	0.69	0.75	0.81	0.86	0.90	0.94	0.97	1.01	1.04	1.06	1.09	1.11	1.13	1.15
0.82	0.76	0.80	0.83	0.87	0.90	0.93	0.95	0.97	0.99	1.01	1.03	1.05	1.06	1.07	1.08
0.90	0.87	0.89	0.91	0.92	0.94	0.95	0.96	0.97	0.98	0.99	1.00	1.01	1.01	1.02	1.03
1.00	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97
1.11	1.07	1.05	1.03	1.02	1.01	0.99	0.98	0.97	0.97	0.96	0.95	0.94	0.94	0.93	0.93
1.22	1.15	1.12	1.09	1.06	1.04	1.01	0.99	0.97	0.96	0.94	0.93	0.92	0.90	0.89	0.89
1.35	1.23	1.18	1.14	1.10	1.06	1.03	1.00	0.97	0.95	0.93	0.91	0.89	0.88	0.86	0.85
1.49	1.30	1.24	1.18	1.13	1.09	1.05	1.01	0.97	0.94	0.92	0.89	0.87	0.85	0.83	0.81
1.65	1.36	1.29	1.22	1.16	1.11	1.06	1.01	0.97	0.94	0.90	0.88	0.85	0.82	0.80	0.78
1.82	1.42	1.34	1.26	1.19	1.13	1.07	1.02	0.97	0.93	0.89	0.86	0.83	0.80	0.78	0.75
2.01	1.47	1.38	1.29	1.22	1.15	1.08	1.03	0.97	0.93	0.89	0.85	0.81	0.78	0.75	0.73

INDIRECT EFFECT: 1.00 (1.00 to 1.00)

RR of U per gram/day of potassium intake \ AF of U on the time-to-death	0.50	0.55	0.61	0.67	0.74	0.82	0.90	1.00	1.11	1.22	1.35	1.49	1.65	1.82	2.01
0.50	NA	6.01	2.92	2.00	1.55	1.29	1.12	1.00	0.91	0.85	0.79	0.75	0.72	0.69	0.66
0.55	6.01	3.09	2.15	1.68	1.41	1.22	1.10	1.00	0.93	0.87	0.83	0.79	0.76	0.73	0.71
0.61	2.92	2.15	1.73	1.47	1.30	1.17	1.07	1.00	0.94	0.90	0.86	0.82	0.80	0.77	0.75
0.67	2.00	1.68	1.47	1.32	1.21	1.12	1.06	1.00	0.96	0.92	0.89	0.86	0.84	0.82	0.80
0.74	1.55	1.41	1.30	1.21	1.14	1.09	1.04	1.00	0.97	0.94	0.92	0.90	0.88	0.86	0.85
0.82	1.29	1.22	1.17	1.12	1.09	1.05	1.03	1.00	0.98	0.96	0.95	0.93	0.92	0.91	0.90
0.90	1.12	1.10	1.07	1.06	1.04	1.03	1.01	1.00	0.99	0.98	0.97	0.97	0.96	0.96	0.95
1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
1.11	0.91	0.93	0.94	0.96	0.97	0.98	0.99	1.00	1.01	1.02	1.03	1.03	1.04	1.05	1.05
1.22	0.85	0.87	0.90	0.92	0.94	0.96	0.98	1.00	1.02	1.04	1.05	1.06	1.08	1.09	1.10
1.35	0.79	0.83	0.86	0.89	0.92	0.95	0.97	1.00	1.03	1.05	1.07	1.09	1.12	1.13	1.15
1.49	0.75	0.79	0.82	0.86	0.90	0.93	0.97	1.00	1.03	1.06	1.09	1.12	1.15	1.18	1.20
1.65	0.72	0.76	0.80	0.84	0.88	0.92	0.96	1.00	1.04	1.08	1.12	1.15	1.18	1.22	1.25
1.82	0.69	0.73	0.77	0.82	0.86	0.91	0.96	1.00	1.05	1.09	1.13	1.18	1.22	1.26	1.30
2.01	0.66	0.71	0.75	0.80	0.85	0.90	0.95	1.00	1.05	1.10	1.15	1.20	1.25	1.30	1.34

CI, confidence interval; potassium, potassium; AF, acceleration factor; RR, relative risk; U, unmeasured confounder
The columns represent the acceleration factor of an unmeasured confounder U for all-cause mortality. The rows represent the relative risk of U per gram per day of potassium intake. The numbers in the tables represent the corrected acceleration factors for the effect of dietary potassium on all-cause mortality where we have adjusted for U and U takes the sensitivity values in the corresponding column and row. The zone in grey represent a clinically significant harm (which we have defined at an acceleration factor of 0.95 or less) that would have been missed by not adjusting for U

Supplemental Table 7. Estimates of the total, direct and indirect effects corrected for non-differential measurement error using Simulation-Extrapolation (SIMEX)

Effect	Observed AF (95%CI)	Corrected AF	
		Linear estimator (95%CI)	Quadratic estimator (95%CI)
All-cause mortality:			
Direct Effect	0.99 (0.91 to 1.08)	0.99 (0.91 to 1.08)	0.98 (0.86 to 1.11)
Indirect Effect	1.00 (1.00 to 1.00)	0.98 (0.98 to 0.98)	1.00 (1.00 to 1.00)
Total Effect	0.99 (0.90 to 1.08)	0.97 (0.89 to 1.06)	0.98 (0.87 to 1.11)
Cardiovascular mortality:			
Direct Effect	1.04 (0.87 to 1.22)	1.05 (0.88 to 1.25)	1.09 (0.84 to 1.41)
Indirect Effect	0.99 (0.98 to 1.00)	0.99 (0.99 to 0.99)	0.97 (0.97 to 0.97)
Total Effect	1.04 (0.86 to 1.21)	1.03 (0.86 to 1.23)	1.05 (0.81 to 1.36)
Non-cardiovascular mortality:			
Direct Effect	0.97 (0.88 to 1.07)	0.97 (0.88 to 1.07)	0.95 (0.83 to 1.10)
Indirect Effect	1.00 (1.00 to 1.00)	1.00 (1.00 to 1.00)	1.00 (1.00 to 1.00)
Total Effect	0.98 (0.88 to 1.07)	0.97 (0.88 to 1.07)	0.95 (0.83 to 1.10)

AF, acceleration factor

Supplemental Table 8. Exploratory analyses adjusted for the set of covariables C[a] and fibre and alkali intake[b]

a) Association of dietary potassium intake (g/day) with mortality

	N	AF (95% CI)	HR (95% CI)
All-cause mortality	8043	1.03 (0.99 to 1.07)	0.97 (0.93 to 1.01)
Vascular death	8043	1.00 (0.95 to 1.05)	1.00 (0.95 to 1.06)
Non-vascular death	8043	1.06 (1.01 to 1.11)	0.93 (0.88 to 0.99)

b) Association of dietary potassium (g/day) with serum potassium (mEq/L), continuous outcome[d] (cross-sectional)

	N	Difference in 1g/day of potassium intake (95% CI)
Serum potassium (mEq/L)	2355	0.02 (-0.02 to 0.05)

c) Association of dietary potassium (g/day) with the prevalence of hyperkalemia at baseline, binary outcome (cross-sectional)

	N	OR (95% CI)
Hyperkalemia defined as ≥ 5.5 mEq/L[e]	2355	1.01 (0.91 to 1.13)
Hyperkalemia defined as ≥ 6.0 mEq/L[f]	2355	1.06 (0.90 to 1.24)

AF, acceleration factor; CI, confidence interval; HR, hazard ratio; N, number of participants

[a] Set of covariables C includes: age, sex, smoking status, body mass index, physical activity, presence of a life partner, Charlson comorbidity score, history of cardiac disease, history of diabetes, history of cancer, listed for transplant, type of vascular access, bodyweight decrease during HD session, number of minutes of HD per week, HD vintage, Kt/V, receiving angiotensin converting enzyme inhibitors or angiotensin II receptor blockers and serum albumin (unlike the other analyses, total energy intake is not included as a covariable since the potassium intake is regressed over or divided by the total energy intake).

[b] Estimated using the Remer and Manz's equation[4].

[c] There was no significant interaction with fibre (p=0.86) nor alkali intake (p=0.39)

[d] There was no significant interaction with fibre (p=0.38) nor alkali intake (p=0.38)

[e] There was no significant interaction with fibre (p=0.85) nor alkali intake (p=0.39)

[f] There was no significant interaction with fibre (p=0.18) nor alkali intake (p=0.98)

Supplemental Table 9. Exploratory analysis of the association of dietary potassium intake(g/day) from unprocessed plant sources[a] versus other sources of dietary potassium with mortality

	All-cause mortality		Vascular deaths		Non-vascular deaths	
	AF (95%CI)	HR (95%CI)	AF (95%CI)	HR (95%CI)	AF (95%CI)	HR (95%CI)
Univariate						
Unprocessed plant K	1.06 (1.03 to 1.08)	0.94 (0.92 to 0.97)	1.04 (1.01 to 1.08)	0.96 (0.92 to 0.99)	1.07 (1.04 to 1.10)	0.93 (0.89 to 0.96)
Other sources of K	1.01 (0.99 to 1.03)	0.99 (0.97 to 1.01)	0.99 (0.96 to 1.01)	1.02 (0.99 to 1.04)	1.03 (1.01 to 1.06)	0.97 (0.94 to 0.99)
Adjusted for C						
Unprocessed plant K	1.02 (1.00 to 1.05)	0.97 (0.95 to 1.00)	1.03 (0.99 to 1.07)	0.97 (0.93 to 1.01)	1.02 (0.99 to 1.05)	0.97 (0.94 to 1.01)
Other sources of K	1.01 (0.99 to 1.03)	0.99 (0.97 to 1.01)	1.00 (0.98 to 1.03)	1.00 (0.96 to 1.03)	1.01 (0.99 to 1.04)	0.99 (0.96 to 1.02)
Adjusted for C and food groups						
Unprocessed plant K	0.99 (0.95 to 1.03)	1.01 (0.96 to 1.06)	0.95 (0.90 to 1.02)	1.05 (0.98 to 1.13)	1.02 (0.96 to 1.08)	0.98 (0.91 to 1.05)
Other sources of K	0.99 (0.95 to 1.03)	1.01 (0.97 to 1.06)	0.95 (0.90 to 1.00)	1.06 (0.99 to 1.13)	1.02 (0.97 to 1.08)	0.97 (0.91 to 1.03)

[a] unprocessed plant sources included: whole fruits, whole vegetables, wholegrain cereal products, nuts and legumes

Supplemental Material: The GA^{2}LEN Food frequency questionnaire

Dietary intake in adults with end-stage kidney disease treated with hemodialysis (DIET) study

Food Frequency Questionnaire

This questionnaire asks for background information related to what you eat. We would like you to describe the frequency of consumption in the last 12 months of the foods listed.

Your answers will be treated as strictly confidential and will be used only for the purposes of this research.

Please fill in the following boxes:

Date today	Date of birth	Indicate whether a
DD/MM/YYYY	DD/MM/YYYY	Female (F) or Male (M)

Dear Participant:

We would like to ask you to complete and return this food frequency questionnaire (FFQ). Please tick (√) in the box to indicate how often, on average, you have eaten the specified amount of each food during the last 12 months. Do not tick more than one box per food.

- Because this FFQ is being used in several countries, YOU WILL BE UNFAMILIAR WITH some of the foods listed in this questionnaire. If you do not eat some of these, please tick the option "Rarely/never".
- If you make a mistake and put a tick in the wrong box just cross through the tick as shown below, and put a tick in the correct box.

EXAMPLE

Vegetables excluding potatoes (medium serving)	Rarely/ Never	1-3 times a month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 day	4+ day
Lettuce			√	~~√~~				

- PLEASE TICK **ONE BOX ONLY** PER LINE AND DO NOT LEAVE FOODS WITHOUT ANSWER.

- For seasonal fruits such as strawberries or grapes, if you eat them about once a week when in season, you should put a tick in the column "once a week".

We thank you very much for your collaboration.

DIET Study Research Team

Tick one box for every food to show how often you ate it. Please answer every question, if you are uncertain about how to answer a question then do best you can, but please do not leave a question blank.

1. Bread and rolls

	Rarely/ Never	1-3 times a month	Once a week	2-4 week	5-6 week	Once a day	2-3 day	4+ day
q1p1 Any type of bread	1	2	3	4	5	6	7	8
q1p2 Wholemeal or brown bread (with or without seeds)	1	2	3	4	5	6	7	8
q1p3 White bread (e.g. baguette, rolls, sliced)	1	2	3	4	5	6	7	8
q1p4 Rye bread (any)	1	2	3	4	5	6	7	8
q1p5 Nan bread	1	2	3	4	5	6	7	8
q1p6 Chapatti	1	2	3	4	5	6	7	8
q1p7 Yeast based bread	1	2	3	4	5	6	7	8

2. Breakfast cereals

q2p1 Any breakfast cereals (e.g. oatmeal, wheat germ, cornflakes, Quaker, kasha)	1	2	3	4	5	6	7	8
q2p2 Wheat germ	1	2	3	4	5	6	7	8
q2p3 Quaker (or other oat cereal)	1	2	3	4	5	6	7	8
q2p4 Corn-flakes	1	2	3	4	5	6	7	8
q2p5 All-bran cereals	1	2	3	4	5	6	7	8

3. Semolina

q3p1 Couscous	1	2	3	4	5	6	7	8

4. Pasta (and wheat derived foods)

q4p1 Any pasta (on average)	1	2	3	4	5	6	7	8
q4p2 Plain (refined) pasta (e.g. spaghetti)	1	2	3	4	5	6	7	8
q4p3 Plain wholemeal (unrefined) pasta	1	2	3	4	5	6	7	8
q4p4 Filled pasta (with meat/cheese/vegetables)	1	2	3	4	5	6	7	8
q4p5 Noodles (excluding rice noodles)	1	2	3	4	5	6	7	8

5. Bakery products/desserts

q5p1 Any cakes or pastries (on average)	1	2	3	4	5	6	7	8
q5p2 Cakes (e.g. sponge, chocolate)	1	2	3	4	5	6	7	8
q5p3 Pastries (e.g. croissants)	1	2	3	4	5	6	7	8
q5p4 Rolls (with/without stuffing)	1	2	3	4	5	6	7	8
q5p5 Muffins	1	2	3	4	5	6	7	8
q5p6 Doughnuts, buns (plain or filled)	1	2	3	4	5	6	7	8
q5p7 Rice pudding	1	2	3	4	5	6	7	8
q5p8 Cheese cake	1	2	3	4	5	6	7	8
q5p9 Pancakes	1	2	3	4	5	6	7	8
q5p10 Plain biscuits (with no fillings or cream)	1	2	3	4	5	6	7	8

6. Rice

q6p1 Rice (any)	1	2	3	4	5	6	7	8
q6p2 White rice	1	2	3	4	5	6	7	8
q6p3 Brown/wholemeal (unrefined) rice	1	2	3	4	5	6	7	8
q6p4 Rice noodles	1	2	3	4	5	6	7	8

7. Sugar & jam

	Rarely/ Never	1-3 times a month	Once a week	2-4 week	5-6 week	Once a day	2-3 day	4+ day
q7p1 Table sugar (white)	1	2	3	4	5	6	7	8
q7p2 Jam	1	2	3	4	5	6	7	8
q7p3 Marmalade	1	2	3	4	5	6	7	8
q7p4 Honey	1	2	3	4	5	6	7	8

8. Sugar products excluding chocolate

q8p1 Any sweets or bonbons	1	2	3	4	5	6	7	8
q8p2 Boiled sweets, toffees, caramels	1	2	3	4	5	6	7	8
q8p3 Mixed candies	1	2	3	4	5	6	7	8
q8p4 Cereal bars, flapjacks/fruit bar	1	2	3	4	5	6	7	8
q8p5 Water ice (lolly ice)	1	2	3	4	5	6	7	8

9. Chocolate

q9p1 Chocolates (any)	1	2	3	4	5	6	7	8
q9p2 Chocolate snack bars (e.g. Mars bar)	1	2	3	4	5	6	7	8
q9p3 Dark chocolate	1	2	3	4	5	6	7	8
q9p4 Milk chocolate	1	2	3	4	5	6	7	8

10. Vegetable oils

q10p1 Vegetable oil (blended, any)	1	2	3	4	5	6	7	8
q10p2 Sunflower oil	1	2	3	4	5	6	7	8
q10p3 Olive oil	1	2	3	4	5	6	7	8
q10p4 Extra virgin olive oil	1	2	3	4	5	6	7	8
q10p5 Palm oil	1	2	3	4	5	6	7	8

11. Margarine and lipids of mixed origin

q11p1Any margarine or spread (excluding soya spread)	1	2	3	4	5	6	7	8
q11p2 Low-fat margarine	1	2	3	4	5	6	7	8
q11p3 Normal margarine	1	2	3	4	5	6	7	8
q11p4 Blended spreads	1	2	3	4	5	6	7	8
q11p5 Soya-based margarine or spreads	1	2	3	4	5	6	7	8
q11p6 Any margarines or vegetable spreads fortified with omega-3	1	2	3	4	5	6	7	8

12. Butter and animal fats

q12p1 Any butter	1	2	3	4	5	6	7	8
q12p2 Low/reduced fat butter	1	2	3	4	5	6	7	8
q12p3 Normal butter	1	2	3	4	5	6	7	8
q12p4 Lard	1	2	3	4	5	6	7	8

13. Nuts

	Rarely/ Never	1-3 times a month	Once a week	2-4 week	5-6 week	Once a day	2-3 day	4+ day
q13p1 Any nuts	1	2	3	4	5	6	7	8
q13p2 Peanuts	1	2	3	4	5	6	7	8
q13p3 Cashew nuts	1	2	3	4	5	6	7	8
q13p4 Almonds	1	2	3	4	5	6	7	8
q13p5 Walnuts	1	2	3	4	5	6	7	8

14. Legumes

q14p1Any legumes	1	2	3	4	5	6	7	8
q14p2 Kidney (red), black beans	1	2	3	4	5	6	7	8
q14p3 Lentils	1	2	3	4	5	6	7	8
q14p4 Chickpeas (also hummus)	1	2	3	4	5	6	7	8
q14p5 Cluster beans (guar)	1	2	3	4	5	6	7	8
q14p6 French beans (string beans)	1	2	3	4	5	6	7	8
q14p7 Fava beans	1	2	3	4	5	6	7	8
q14p8 Soya beans	1	2	3	4	5	6	7	8

15. Vegetables excluding potatoes

q15p1 Any vegetables (excluding potatoes)	1	2	3	4	5	6	7	8
q15p2 Lettuce	1	2	3	4	5	6	7	8
q15p3 Spinach (including lamb's quarters)	1	2	3	4	5	6	7	8
q15p4 Chard	1	2	3	4	5	6	7	8
q15p5 Fenugreek	1	2	3	4	5	6	7	8
q15p6 Wild greens (e.g. purslane, watercress)	1	2	3	4	5	6	7	8
q15p7 Okra	1	2	3	4	5	6	7	8
q15p8 Tomato	1	2	3	4	5	6	7	8
q15p9 Aubergine	1	2	3	4	5	6	7	8
q15p10 Courgette	1	2	3	4	5	6	7	8
q15p11 Sweet peppers (e.g. red, green, yellow)	1	2	3	4	5	6	7	8
q15p12 Cucumber	1	2	3	4	5	6	7	8
q15p13 Bitter melon (Karela)	1	2	3	4	5	6	7	8
q15p14 Carrots	1	2	3	4	5	6	7	8
q15p15 Parsnip	1	2	3	4	5	6	7	8
q15p16 Turnip or Swede	1	2	3	4	5	6	7	8
q15p17 Artichokes	1	2	3	4	5	6	7	8
q15p18 Radish	1	2	3	4	5	6	7	8
q15p19 Beetroot	1	2	3	4	5	6	7	8
q15p20 Celery	1	2	3	4	5	6	7	8
q15p21 Coleslaw	1	2	3	4	5	6	7	8
q15p22 Sweet Corn	1	2	3	4	5	6	7	8
q15p23 Asparagus	1	2	3	4	5	6	7	8

	Rarely/ Never	1-3 times a month	Once a week	2-4 week	5-6 week	Once a day	2-3 day	4+ day
q15p24 Herbs (e.g. mint, fennel, chive, basil, dill, coriander, parsley)	1	2	3	4	5	6	7	8
q15p25 Leek	1	2	3	4	5	6	7	8
q15p26 White/other mushrooms	1	2	3	4	5	6	7	8
q15p27 Onion	1	2	3	4	5	6	7	8
q15p28 Garlic	1	2	3	4	5	6	7	8
q15p29 Cauliflower	1	2	3	4	5	6	7	8
q15p30 Pumpkin	1	2	3	4	5	6	7	8
q15p31 Brussels sprouts	1	2	3	4	5	6	7	8
q15p32 Peas (green)	1	2	3	4	5	6	7	8
q15p33 Broccoli	1	2	3	4	5	6	7	8
q15p34 Cabbage (e.g. white, green red, Savoy)	1	2	3	4	5	6	7	8
q15p35 Stuffed vegetables (e.g. vine/green leaves with rice or meat)	1	2	3	4	5	6	7	8
q15p36 Pickled vegetables (e.g. cucumber, radish, cabbage)	1	2	3	4	5	6	7	8
q15p37 Ginger (e.g. in savoury and sweet dishes, in infusion)	1	2	3	4	5	6	7	8

16. Starchy roots or potatoes

q16p1 Potatoes (on average, in all forms)	1	2	3	4	5	6	7	8
q16p2 Mashed potatoes	1	2	3	4	5	6	7	8
q16p3 Baked/roasted/casserole	1	2	3	4	5	6	7	8
q16p4 Chips/French fries	1	2	3	4	5	6	7	8
q16p5 In salads	1	2	3	4	5	6	7	8
q16p6 Potato dumpling, bread dumpling, gnocchi	1	2	3	4	5	6	7	8
q16p7 Potato tortilla (omelette)	1	2	3	4	5	6	7	8
q16p8 Sweet potato	1	2	3	4	5	6	7	8

17. Fruits

q17p1 Fresh fruits (any)	1	2	3	4	5	6	7	8
q17p2 Apple	1	2	3	4	5	6	7	8
q17p3 Pear	1	2	3	4	5	6	7	8
q17p4 Avocado	1	2	3	4	5	6	7	8
q17p5 Mango	1	2	3	4	5	6	7	8
q17p6 Apricot	1	2	3	4	5	6	7	8
q17p7 Nectarine	1	2	3	4	5	6	7	8
q17p8 Peach	1	2	3	4	5	6	7	8
q17p9 Plum	1	2	3	4	5	6	7	8
q17p10 Cherries	1	2	3	4	5	6	7	8
q17p11 Rhubarb	1	2	3	4	5	6	7	8
q17p12 Berries (e.g. blueberry, strawberry, blackcurrants, blackberry raspberry)	1	2	3	4	5	6	7	8

Fruit (continued)

	Rarely/ Never	1-3 times a month	Once a week	2-4 week	5-6 week	Once a day	2-3 day	4+ day
q17p13Banana	1	2	3	4	5	6	7	8
q17p14 Melon/ Watermelon	1	2	3	4	5	6	7	8
q17p15 Grape	1	2	3	4	5	6	7	8
q17p16 Squeezed fresh fruit	1	2	3	4	5	6	7	8
q17p17 Pineapple	1	2	3	4	5	6	7	8
q17p18 Kiwi	1	2	3	4	5	6	7	8
q17p19 Lemon	1	2	3	4	5	6	7	8
q17p20 Orange	1	2	3	4	5	6	7	8
q17p21 Mandarin/Tangerine	1	2	3	4	5	6	7	8
q17p22 Grapefruit	1	2	3	4	5	6	7	8
q17p23 Tinned fruits	1	2	3	4	5	6	7	8
q17p24 Raisin, sultana	1	2	3	4	5	6	7	8
q17p25 Fig	1	2	3	4	5	6	7	8
q17p26 Prune	1	2	3	4	5	6	7	8
q17p27 Olives (e.g. black, green)	1	2	3	4	5	6	7	8
q17p28 Dates	1	2	3	4	5	6	7	8

18. Fruit juices (1 glass 200 ml)

q18p1 Concentrated juice, with sugar	1	2	3	4	5	6	7	8
q18p2 Concentrated juice, without sugar (with sweetener)	1	2	3	4	5	6	7	8

19. Non-alcoholic beverages (1 glass 200ml)

q19p1 Carbonated/soft drinks with sugar	1	2	3	4	5	6	7	8
q19p2 Carbonated/soft drinks with artificial sweetener	1	2	3	4	5	6	7	8
q19p3 Tap water	1	2	3	4	5	6	7	8
q19p4 Mineral water (e.g. still or sparkling)	1	2	3	4	5	6	7	8

20. Tea/coffee

q20p1 Black tea (any)	1	2	3	4	5	6	7	8
q20p2 Coffee (instant or ground)	1	2	3	4	5	6	7	8
q20p3 Greek (Turkish) Coffee	1	2	3	4	5	6	7	8
q20p4 Green tea	1	2	3	4	5	6	7	8
q20p5 Peppermint tea	1	2	3	4	5	6	7	8
q20p6 Other herbal infusions	1	2	3	4	5	6	7	8

21. Beer (1/2 pint or 1 glass 200 ml)

q21p1 Beer (any)	1	2	3	4	5	6	7	8

22. Wine (1 glass125 ml)

q22p1 Any wine	1	2	3	4	5	6	7	8
q22p2 Red wine	1	2	3	4	5	6	7	8
q22p3 White wine	1	2	3	4	5	6	7	8
q22p4 Rose wine	1	2	3	4	5	6	7	8

23. Other alcoholic beverages (1 glass 50 ml)

	Rarely/ Never	1-3 times a month	Once a week	2-4 week	5-6 week	Once a day	2-3 day	4+ day
q23p1 Fortified wines (Liqueurs) (e.g. Sherry, port, Madeira)	1	2	3	4	5	6	7	8
q23p2 Spirits (e.g. whisky, vodka, rum, gin)	1	2	3	4	5	6	7	8

24. Red meat and meat products

q24p1 Any red meat (e.g. beef, veal, lamb, pork, game)	1	2	3	4	5	6	7	8
q24p2 Hot/cold roast beef, boiled beef, beef steak, fillet, loin	1	2	3	4	5	6	7	8
q24p3 Beef burger (hamburger)	1	2	3	4	5	6	7	8
q24p4 Minced beef meat (e.g chilli con carne, Bolognese sauce, meatballs)	1	2	3	4	5	6	7	8
q24p5 Beef meat in stew, casserole, in curry	1	2	3	4	5	6	7	8
q24p6 Pork cutlet, chop, steak, fillet, loin, pork ribs, minced	1	2	3	4	5	6	7	8
q24p7 Meat pies	1	2	3	4	5	6	7	8
q24p8 Sausages	1	2	3	4	5	6	7	8
q24p9 Veal	1	2	3	4	5	6	7	8
q24p10 Small game (e.g. rabbit, goat, pheasant, duck)	1	2	3	4	5	6	7	8
q24p11 Other game (e.g. deer, moose)	1	2	3	4	5	6	7	8
q24p12 Lamb (e.g. in stews, kebabs)	1	2	3	4	5	6	7	8
Smoked/cured meat (3 slices)								
q24p13 Cured pork (cold or hot-cooked)	1	2	3	4	5	6	7	8
q24p14 Gammon, ham (e.g. Serrano, prosciutto)	1	2	3	4	5	6	7	8
q24p15 Dried cured sausages (chorizo, salchichon, salami)	1	2	3	4	5	6	7	8
q24p16 Frankfurter	1	2	3	4	5	6	7	8
q24p17 Bacon, bacon cubes	1	2	3	4	5	6	7	8
q24p18 Smoked lamb	1	2	3	4	5	6	7	8
q24p19Smoked game (any)	1	2	3	4	5	6	7	8

25. Poultry

q25p1 Any poultry with skin	1	2	3	4	5	6	7	8
q25p2 Any poultry without skin	1	2	3	4	5	6	7	8
Fresh (un-smoked)								
q25p3 Chicken (e.g. boiled, roasted, chicken burgers)	1	2	3	4	5	6	7	8
Q25p4 Chicken (e.g. stews or casserole)								
q25p5 Turkey (e.g. roasted, boiled, strips)	1	2	3	4	5	6	7	8
Smoked or cured poultry								
q25p6 Any smoked/cured poultry	1	2	3	4	5	6	7	8

26. Offal

	Rarely/ Never	1-3 times a month	Once a week	2-4 week	5-6 week	Once a day	2-3 day	4+ day
q26p1 Liver (eg panita), pates, potted meat	1	2	3	4	5	6	7	8
q26p2 Other offal (e.g. tongue, brain, heart, kidney, tripe)	1	2	3	4	5	6	7	8

27. Fish and seafood

q27p1 Any fish or seafood (fresh, tinned, smoked, etc)	1	2	3	4	5	6	7	8
q27p2 Fresh fatty fish (e.g. salmon, tuna, trout, anchovy, herring, mackerel, sardine, gravalex, eel)	1	2	3	4	5	6	7	8
q27p3 Fresh white fish (e.g. hake/burbot, cod, haddock, plaice, whiting)	1	2	3	4	5	6	7	8
q27p4 Other fresh fish/seafood products (e.g. taramasalata)	1	2	3	4	5	6	7	8
q27p5 Fresh Crustaceans and molluscs (e.g. mussel, crab, calamari, octopus, cuttlefish, shrimp, clam)	1	2	3	4	5	6	7	8
q27p6 Cured or smoked fatty fish (e.g. sardines, tuna, salmon, kipper)	1	2	3	4	5	6	7	8
q27p7 Cured or smoked white fish (e.g. cod, bacalhau)	1	2	3	4	5	6	7	8
q27p8 Tinned fish (sardine, tuna or salmon)	1	2	3	4	5	6	7	8
q27p9 Tinned crustaceans and molluscs (e.g. mussel, crab, calamari, octopus, cuttlefish, shrimp, clam)	1	2	3	4	5	6	7	8

28. Eggs (from hen)

q28p1 Eggs (any, on average)	1	2	3	4	5	6	7	8
q28p2 Eggs (fried/poached/boiled/hard boiled/in sandwiches)	1	2	3	4	5	6	7	8
q28p3 Egg-based savoury dishes	1	2	3	4	5	6	7	8
q28p4 Egg-based desserts (e.g. Egg cakes, tarts, egg and nuts sweets)	1	2	3	4	5	6	7	8

29. Milk, dairy and soya

q29p1 Milk (any, excluding soya)	1	2	3	4	5	6	7	8
Cow milk								
q29p2 Full-fat milk	1	2	3	4	5	6	7	8
q29p3 Semi-skimmed milk	1	2	3	4	5	6	7	8
q29p4 Skimmed milk	1	2	3	4	5	6	7	8
q29p5 Milk fortified with omega 3 fatty acids	1	2	3	4	5	6	7	8
q29p6 Yogurt (any type including fromage)	1	2	3	4	5	6	7	8
Soy								
q29p7 Soy milk	1	2	3	4	5	6	7	8
q29p8 Yogurt from soy	1	2	3	4	5	6	7	8
q29p9 Tofu	1	2	3	4	5	6	7	8

30. Cheese

	Rarely Never	1-3 times a month	Once a week	2-4 week	5-6 week	Once a day	2-3 day	4+ day
q30p1 Any cheese	1	2	3	4	5	6	7	8
q30p2 Hard cheeses (e.g. Cheddar, parmesan)	1	2	3	4	5	6	7	8
q30p3 Soft cheeses (e.g. Brie, camembert, Philadelphia, tomini, boursault, brinza, chaource, coulommiers, Humboldt fog, kochkase)	1	2	3	4	5	6	7	8
q30p4 Semi-hard cheeses (e.g. Gouda, Emmental/Edam)	1	2	3	4	5	6	7	8
q30p5 Cottage cheese (cheese curd) (natural/with scents)	1	2	3	4	5	6	7	8
q30p6 Hard and semi-hard Greek cheeses (e.g. Kaseri, kefalotiri, Grafiera, Kefalograviera, Ladotiri)	1	2	3	4	5	6	7	8
q30p7 Fresh cheeses (e.g. Feta, mozzarella)	1	2	3	4	5	6	7	8

31. Other milk-derived products

q31p1 Ice cream	1	2	3	4	5	6	7	8
q31p2 Single cream crème	1	2	3	4	5	6	7	8
q31p3 Crème fraîche	1	2	3	4	5	6	7	8
a31p4 Sour cream	1	2	3	4	5	6	7	8
q31p5 Double or clotted cream	1	2	3	4	5	6	7	8

32. Miscellaneous food

q32p1 Dressing sauces (e.g. French, Cesar, thousand islands)	1	2	3	4	5	6	7	8
q32p2 Mayonnaise)	1	2	3	4	5	6	7	8
q32p3 White sauce	1	2	3	4	5	6	7	8
q32p4 Ketchup	1	2	3	4	5	6	7	8
q32p5 Instant soup	1	2	3	4	5	6	7	8
q32p6 Pizza (any)	1	2	3	4	5	6	7	8
q32p7 Brown sauce	1	2	3	4	5	6	7	8

Additional questions:

33. Products for special nutritional use

Do you REGULARLY take any nutritional supplement? e.g. vitamin C, selenium etc?

Yes ☐ No ☐

If you answered yes to question 33, please indicate:

Nutrient supplement (or brand name)	Dose taken	Times per week dose is taken
q33p1	q33p1dose	q33p1daily
q33p2	q33p2dose	q33p2daily
q33p3	q33p3dose	q33p3daily
q33p4	q33p4dose	q33p4daily
q33p5	q33p5dose	q33p5daily

34. Are there any other foods you normally eat once or more a week?

Yes ☐ No ☐

If yes, please list below:

Food (if it is a local dish, and you know the main components or ingredients, please name them)	Usual serving size	Number of times eaten per week
q34p1	q34p1size	q34p1times
q34p2	q34p2size	q34p2times
q34p3	q34p3size	q34p3times
q34p4	q34p4size	q34p4times

35. What kind of fat did you most often use for frying, roasting, grilling, etc?

Select one only please:

Butter	1
Lard/dripping	2
Sunflower oil	3
Solid vegetable fat	4
Margarine	5
Olive oil	6
None	0

36. How often do you add salt to food while cooking?

Always	1
Sometimes	2
Rarely	3
Never	0

37. In the last year, on average, how many times a week did you eat a medium serving (unit/glass or cup) of the following food groups?

Food type	Times/week
q37p1 Vegetables (excluding potatoes)	q37p1times
q37p2 Potatoes	q37p2times
q37p3 Fruits and fruit products (excluding fruit juice)	q37p3times
q37p4 Fish	q37p4times
q37p5 Fish products	q37p5times
q37p6 Meat, meat products or meat dishes (including bacon, ham and chicken)	q37p6times
q37p7 Milk (skimmed, full fat, any)	q37p7times

38. Are there any foods you do not eat because they cause you allergy or intolerance?

Yes ☐ No ☐

If yes, please name these foods below:

Food not consumed	Reason
q38p1	q38p1reason
q38p2	q38p2reason
q38p3	q38p3reason
q38p4	q38p4reason

THANK YOU FOR YOUR COOPERATION!

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