

Supplementary table 2. Results of round 1 of the Delphi process

Domain and statements	Agree	Somewhat agree	Somewhat disagree	Disagree
1. Epidemiology of MAFLD and CKD				
1.1 The prevalence of CKD in individuals with MAFLD is higher compared to that in the non-MAFLD population.	82%	18%		
1.2 MAFLD is an independent risk factor for CKD in patients with T2DM, even after adjustment for common risk factors for CKD.	72%	28%		
1.3 MAFLD is an independent risk factor for CKD in patients without T2D, even after adjustment for common risk factors for CKD.	60%	38%	2%	
1.4 MAFLD is associated with a greater risk of CKD than patients with liver fat but without evidence of systemic metabolic	50%	34%	16%	

dysregulation.				
1.5 MAFLD is associated with an increased incidence of CKD.	82%	18%		
1.6 MAFLD is associated with an increased risk of kidney disease in childhood.	30%	46%	18%	6%
1.7 CKD increases the risk of overall mortality among patients with MAFLD.	74%	24%	2%	
2. Severity of MAFLD and CKD				
2.1 The presence of metabolic steatohepatitis (MESH) on liver histology is independently associated with a higher prevalence of CKD than simple steatosis.	48%	44%	6%	2%
2.2 The presence of MESH on liver histology is independently associated with a higher incidence of CKD than simple steatosis.	46%	44%	8%	2%
2.3 MAFLD with advanced fibrosis (stage F3/4) has a higher	64%	34%	2%	

prevalence of CKD than MAFLD without advanced fibrosis (stage F0-F2).				
2.4 MAFLD with advanced fibrosis (stage F3/4) has a higher incidence of CKD than MAFLD without advanced fibrosis (stage F0-F2).	52%	46%	2%	
2.5 Advanced liver fibrosis in patients with MAFLD is independently associated with an increased risk of incident CKD in patients with T2D.	56%	40%	4%	
2.6 Liver stiffness measured by transient elastography is independently associated with an increased presence of albuminuria.	40%	46%	12%	2%
3. Mechanisms linking MAFLD with CKD				
3.1 MAFLD and CKD share multiple risk factors such as abdominal obesity, insulin resistance, dyslipidemia, hypertension and	90%	10%		

dysglycemia.				
3.2 The MAFLD-associated genetic polymorphisms <i>PNPLA3</i> rs738409 variant, <i>HSD17B13</i> variant and <i>TM6SF2</i> variant are associated with CKD.	30%	54%	14%	2%
3.3 Gut microbiota is linked to both MAFLD and CKD.	48%	40%	10%	2%
3.4 Metabolic dysfunction is an important mechanistic link between MAFLD and CKD.	86%	14%		
4. Managing and treating MAFLD and CKD				
4.1 Lifestyle intervention including a hypocaloric diet and regular physical exercise is associated with improvements in both MAFLD and CKD.	74%	22%	4%	
4.2 Cardiometabolic risk factors should be treated in patients with MAFLD and CKD.	96%	4%		

4.3 The use of antihypertensive treatment (if required) is important in MAFLD for decreasing risk of CKD.	82%	18%		
4.4 Screening for MAFLD should be undertaken in patients with CKD.	54%	40%	4%	2%
4.5 Patients with MAFLD and CKD should ideally be treated in a multidisciplinary team setting.	90%	8%	2%	