**Supplementary Table 4｜**Comparison of the disease phenotype of PD-1 inhibitor-associated type 1 diabetes to traditional type 1 diabetes mellitus(T1DM)

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|  | **PD-1 inhibitor-associated type 1 diabetes** | **Type 1 diabetes mellitus** |
| **Presentation** | PD-1 inhibitor-associated type 1 diabetes is most diagnosed in older. DKA in 76% at presentation. 41.33% have a comorbid irAE, most common being thyroid (34.67%). The accompanying hyperglycemia can be more severe than in conventional T1DM and the onset is abrupt[1]. | T1DM is most commonly diagnosed in children and young adults. DKA in 19.8% childhood and adolescence at presentation [2]. |
| **Clinical course** | No spontaneous remission phase or "honeymoon phase". Overt insulin deficiency and low C-peptide at presentation[3]. | Patients with T1DM present a "honeymoon phase" with partial recovery of islet β-cell function[4]. |
| **Autoantibodies** | Only 32.86% of PD-1 inhibitor-associated type 1 diabetes individuals are positive for any islet autoantibody; anti‐GAD65 is by far the most common at 86.96%. | Over 90% of T1DM patients have developed at least one positive autoantibody by the time of diagnosis[5]. |
| **Genetic predisposition** | 61% with T1DM susceptibility haplotype, 16% with T1DM protective haplotype[6]. | T1DM susceptible haplotypes in 90%[7]. |
| **Exocrine pancreas involvement** | Pancreatic enzymes elevated, pancreatic atrophy on imaging[1]. | Lower lipase vs normal controls except in fulminant phenotype, reduced pancreatic volumes.[8]. |
| **Proposed pathophysiology** | Exposure to PD-1 inhibitor unmasks autoimmunity and triggers β-cell destruction. | Genetic predisposed individual exposed to an environmental trigger, leading to autoimmune β-cell destruction. |

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