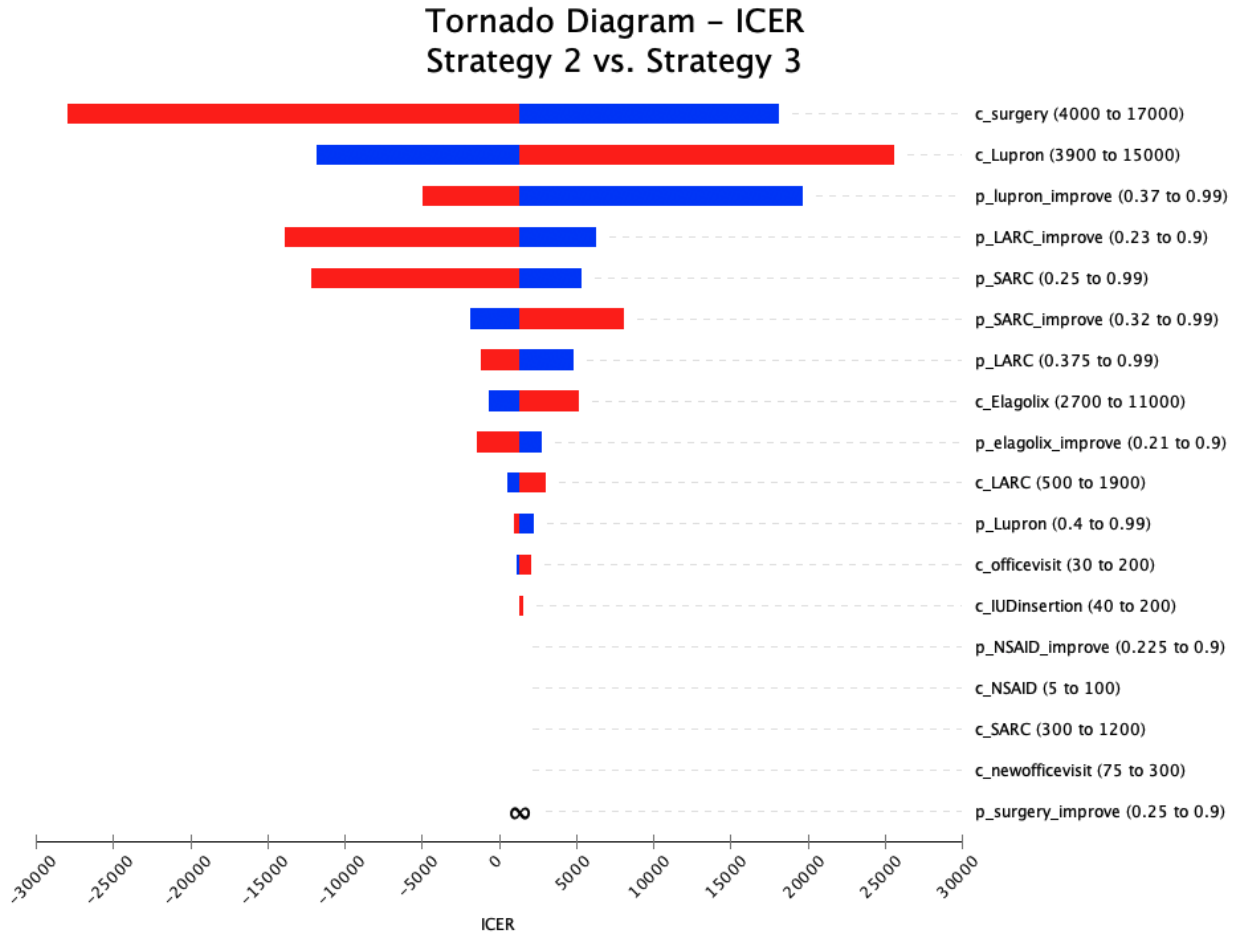**Appendix 1. Tornado diagrams were created between each strategy to identify the most influential variables. This figure displays the tornado diagram between strategy 2 and strategy 3. C represents cost and P represents the probability of improvement. The numbers in parentheses is the expanded value range from one half to twice the base estimate.**

Tornado Diagram – ICER
Strategy 2 vs. Strategy 3

Bohn J, Bullard KA, Rodriguez MI, Ecker AM. Stepwise approach to the management of endometriosis-related dysmenorrhea: a cost-effectiveness analysis. Obstet Gynecol 2021;138.
The authors provided this information as a supplement to their article.

Appendix 2. Tornado diagrams were created between each strategy to identify the most influential variables. This figure displays the tornado diagram between strategy 3 and strategy 4. C represents cost and P represents the probability of improvement. The numbers in parentheses is the expanded value range from one half to twice the base estimate.
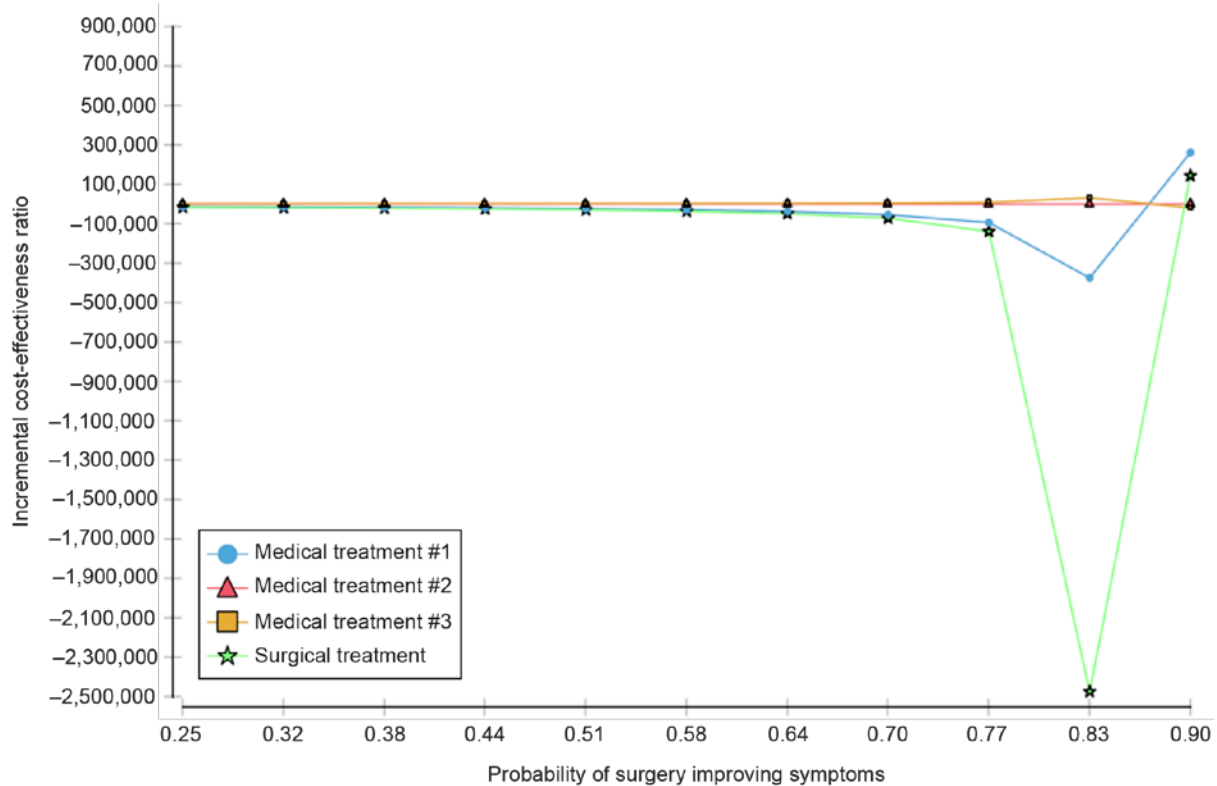

Tornado Diagram – ICER
Strategy 3 vs. Strategy 4
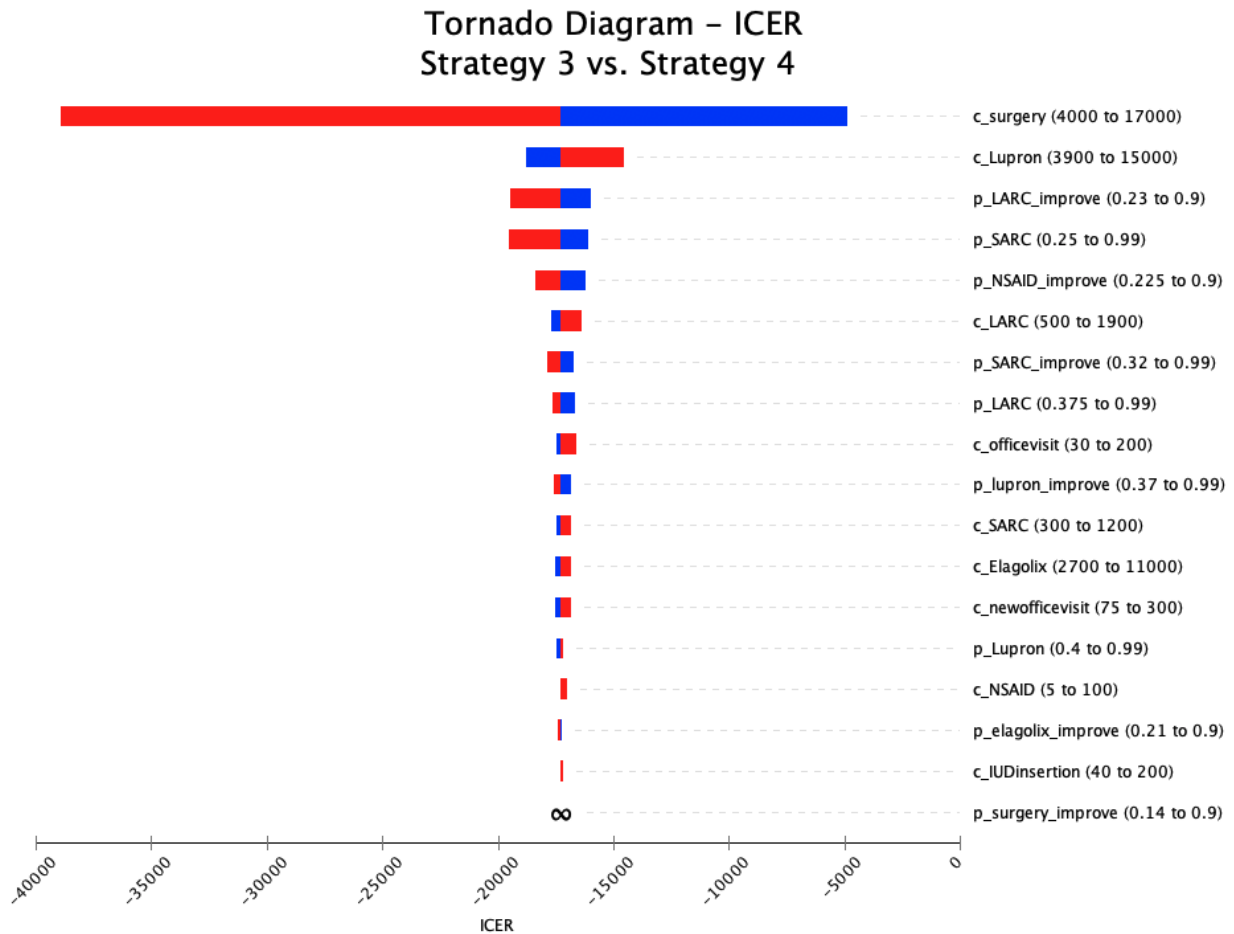
Bohn J, Bullard KA, Rodriguez MI, Ecker AM. Stepwise approach to the management of endometriosis-related dysmenorrhea: a cost-effectiveness analysis. Obstet Gynecol 2021;138.
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Appendix 3. Sensitivity analysis of the incremental cost-effectiveness ratio of each strategy on the probability of surgery improving dysmenorrhea. Univariate sensitivity analysis. All strategies intersect at 0.83, meaning that for surgical management to be the preferred first-line approach, the probability of improvement following surgery would need to exceed 83%. Medical treatment #1: nonsteroidal anti-inflammatory drugs (NSAIDs). Medical treatment #2: NSAIDs then short-acting reversible contraceptives (SARCs) or long-acting reversible contraceptives (LARCs). Medical treatment #3: NSAIDs, then a SARC or LARC, then a LARC or GnRH modulator

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