SUPPLEMENTAL MATERIAL 1

Characteristics of Study Population at Recruitment

We evaluated the type and number of symptoms for which women underwent laparoscopy, and pelvic pain severity. Symptom types were: 1) pelvic pain without subfertility; 2) pelvic pain with subfertility; 3) subfertility without pelvic pain; and 4) no pelvic pain or subfertility. Because some symptoms (e.g., pelvic pain and dysmenorrhoea) are strongly correlated, principal-component analysis was used to identify underlying patterns. Using the principal axis method (1) with prior communality estimates of "1" and orthogonal rotation, we extracted factors (symptom patterns) and retained those with eigenvalues >1. A symptom was deemed to load onto a factor if its component loading was >0.40 for that pattern and ≤0.40 for the others. The mean number of individual symptoms within each factor was then compared across outcome groups. Pelvic pain severity was assigned by women as a numeric rating scale score (on a 1–10 scale).

The Care-Seeking Experience

Diagnostic delay (interval between symptom onset and laparoscopy) was compared across outcome groups. The age of a woman at symptom onset was derived as the average of her reported ages at onset of all the symptoms she reported. The influence of health care funding, type and number of symptoms, and pelvic pain severity was explored in multivariate analyses.

SUPPLEMENTAL MATERIAL 2

Mean dimension scores in case and sterilization/symptomatic control subjects were compared, with adjustment for relevant covariates.

SUPPLEMENTAL MATERIAL 3

Absenteeism and presenteeism were calculated as [hours missed due to symptoms/(hours missed due to symptoms + hours actually worked)] and reduced productivity while working, respectively, both expressed as percentages. Overall productivity loss was calculated as ([(hours missed due to symptoms + (percent reduced productivity while working × hours actually worked)]/[hours missed due to symptoms + hours actually worked]) × 100.

SUPPLEMENTAL MATERIAL 4

Principal-component analysis resulted in four categories of presenting complaints: "pelvic," "bowel," "urinary," and "pelvic mass" (Supplemental Table 1). Affected women reported more individual symptoms in all categories (P<.001) (Table 1).

SUPPLEMENTAL MATERIAL 5

Notably, even after adjusting for site, education, marital status, employment status, pelvic pain severity, type and number of presenting symptoms, and comorbidity, health-related quality of life in the domains of bodily pain (P=.026) and health perception (P<.001) and the PCS score (P=.009) fell as rAFS disease severity increased.

SUPPLEMENTAL MATERIAL 6

Most women were in paid or self-employment (77.2%, 95% CI 74.8–79.7%); those not working were mostly housewives or care givers. One in seven symptomatic unemployed women (14.5%, 95% CI 10.5–18.6%) were not working because of their original complaints.

REFERENCE

1. Jolliffe IT. Principal component analysis. New York: Springer-Verlag; 1986.

Participating centers and numbers of women recruited in the Global Study of Women's Health (n = 1,418).

San F/Palo Alto
11 women

Boston
76 women

Oxford
224 women

Leuven
104 women

Siena
25 women

Dublin
46 women

Rome
130 women

Washington
6 women

Barcelona
107 women

Shanghai
136 women

Guangzhou
294 women

Ibadan
81 women

Campinas
86 women

Buenos Aires
5 women

Sao Paolo
87 women

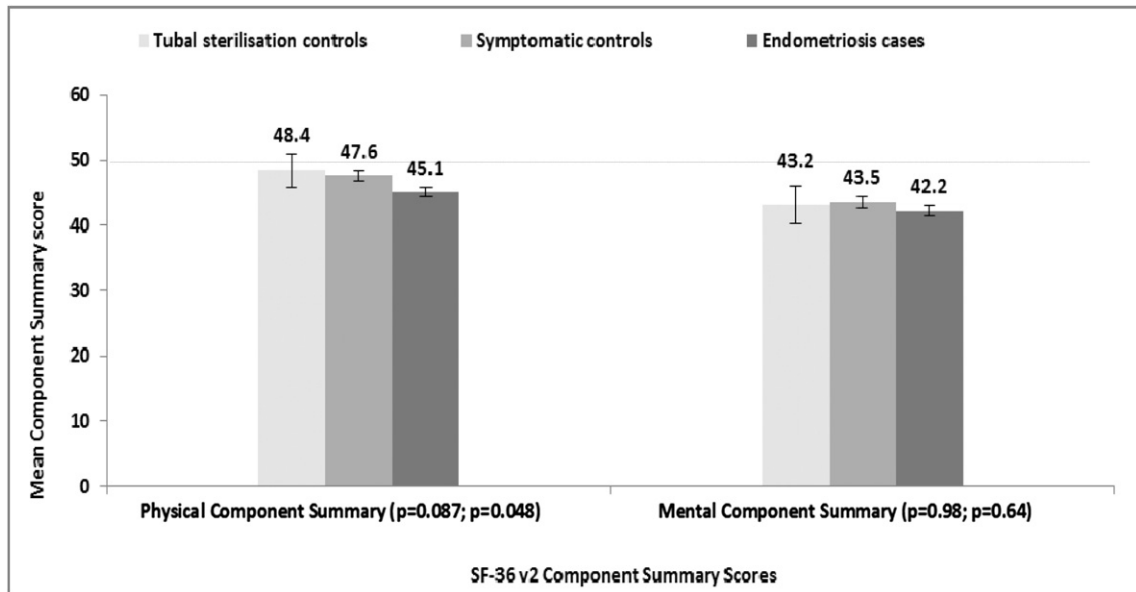*Nnoaham. Endometriosis, quality of life and work. Fertil Steril 2011.*

Proportions of diagnostic endometriosis incidence and stage by center of recruitment. Others comprises Buenos Aires, Washington, DC, San Francisco, and Palo Alto.
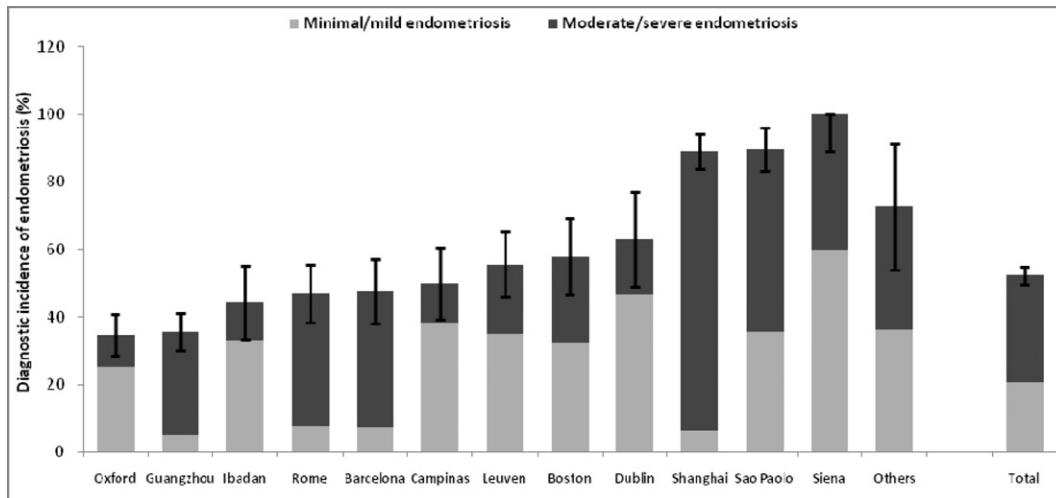
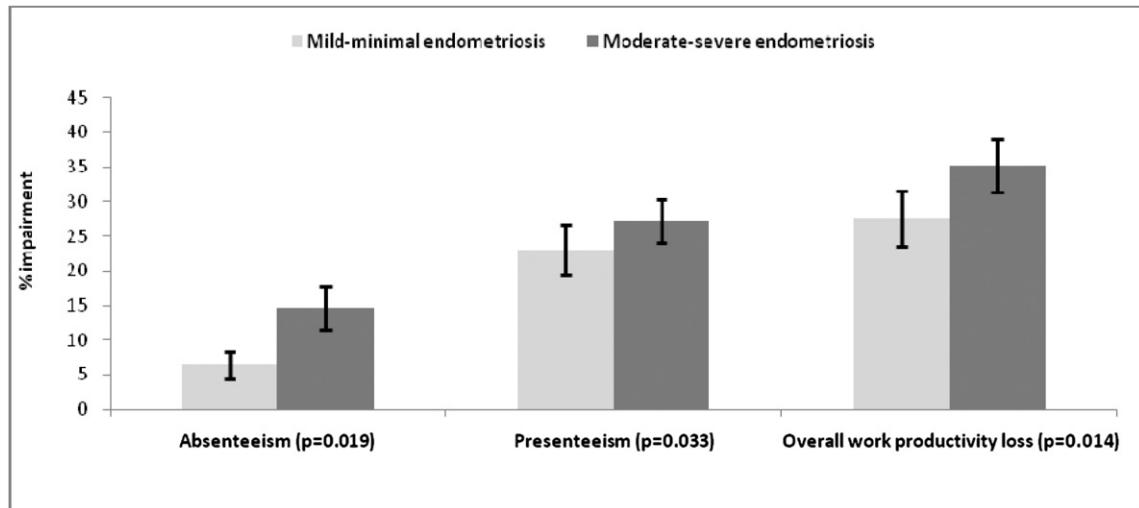*Nnoaham. Endometriosis, quality of life and work. Fertil Steril 2011.*

Health-related quality of life in women with endometriosis (n = 745), symptomatic control women (n = 587), and laparoscopic sterilization control women (n = 86): SF36v2 component summary scores with adjusted *P* values and 95% confidence intervals. A lower score means lower health-related quality of life. *P* values are presented as (*P*=x; *P*=y), x being the *P* value for comparison of endometriosis and laparoscopic sterilization control subjects and y being the *P* value for comparison of endometriosis and symptomatic control subjects. Dashed line represents mean component summary score (50) for normative population. All *P* values are adjusted for site, education, marital status, employment status, pelvic pain severity, type and number of presenting symptoms, and comorbidity.

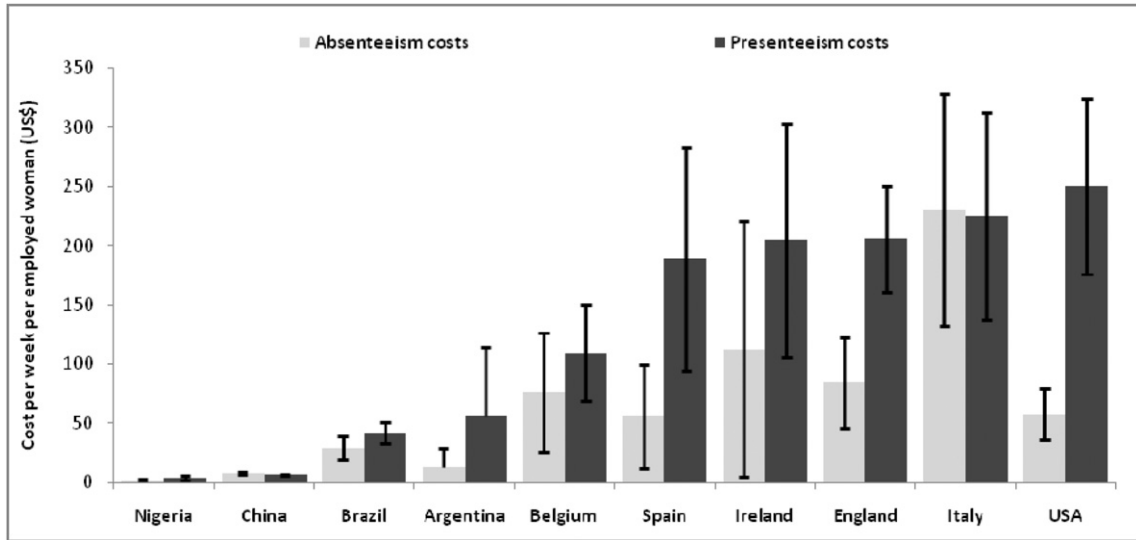*Nnoaham. Endometriosis, quality of life and work. Fertil Steril 2011.*

Absenteeism, presenteeism, and overall work productivity loss by endometriosis severity (Revised American Fertility Society classification [rAFS]). Adjusted P values for the association between each work productivity dimension and rAFS disease stage (trend test) are given. Variables adjusted for included educational attainment, marital status, type and number of symptoms, severity of pelvic pain, and comorbidity.

Nnoaham. Endometriosis, quality of life and work. Fertil Steril 2011.

Monetary loss from endometriosis-associated work absenteeism and presenteeism.

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Factors (symptom patterns) and loading symptom variables.

"Pelvic" symptoms	"Bowel" symptoms	"Urinary" symptoms	"Pelvic mass" symptoms
Chronic pelvic pain	Painful bowel opening	Pain on passing urine	Pelvic mass
Painful periods	Bloody bowel opening	Blood in urine	Ovarian cyst
Painful intercourse	Bowel upset	Other urinary problems	Not subfertile
Heavy periods			

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Care-seeking for symptoms, mean (SD).

Variables	Endometriosis (n = 745)	Symptomatic control (n = 587)	Unadjusted *P* value
Age at symptom onset (y)	25.9 (7.6)	27.2 (7.3)	.0063
Age at first contact with general physician for symptoms (y)	26.2 (7.9)	27.6 (7.4)	.0016
No. of visits to general physician before referral to specialist	6.5 (10.2)	6.8 (10.6)	.59
Age at diagnosis (y)	32.6 (6.2)	33.1 (6.4)	.10
Diagnostic delay (y)	6.7 (6.3)	5.9 (6.0)	.017

Nnoaham. Endometriosis, quality of life and work. Fertil Steril 2011.