Supplementary Online Content


**eFigure 1.** Change in Comitance Based on Prior Strabismus Surgery

**eFigure 2.** Change in Comitance With 6 Months or More of Follow-up In Asymmetric vs Symmetric Surgery and by Procedure Type

**eFigure 3.** Change in Comitance in Pediatric and Adult Patients

**eFigure 4.** Change in Comitance vs Surgical Dosage For Asymmetric Surgery

**eFigure 5.** Change in Comitance for First vs the Final Postoperative Visit

**eFigure 6.** Change in Comitance in Patients Undergoing Simultaneous Vertical Strabismus Surgery

This supplementary material has been provided by the authors to give readers additional information about their work.
In both groups, induced incomitance was smallest in the symmetric group ($p < 0.0001$). There was a significantly larger change in comitance in the 3-muscle re-operation group ($p = 0.01$) compared with the other groups. Error bars indicate standard deviation.
Asymmetric surgery had the largest CIC (p < 0.0001), and none of the asymmetric procedure types (1-muscle, 2-muscle asymmetric and 3-muscle surgery) had more CIC than the others (P=0.67). Error bars indicate standard deviation.
No age-based differences in subgroups were observed (P>0.05 in all instances.) Error bars indicate standard deviation.
eFigure 4. Change in Comitance vs Surgical Dosage For Asymmetric Surgery

No correlation between the change in comitance and the surgical dosage was gleaned.
A) Comitant patients who developed postoperative incomitance (P<0.001). B) Incomitant patients who had comitance restored (P=0.9). Error bars indicate standard deviation.
Overall there was no significant difference between groups (p = 0.21) Among subgroups, there was a larger CIC in patients undergoing simultaneous vertical rectus and oblique surgery (p = 0.006.) Error bars indicate standard deviation.