Standardized Examination Protocol for Pelvic organ prolapse and Urinary incontinence (SEPPU)

Master Thesis

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Abstract

Introduction: Pelvic organ prolapse (POP) and urinary incontinence (UI) are prevalent conditions that significantly impact women's quality of life. Effective diagnosis and treatment of these conditions can alleviate discomfort and improve overall well-being. However, the lack of a standardized examination protocol for the diagnostic process of POP and/or UI (SEPPU) poses a challenge in providing consistent and optimal care. This study addresses the need for a standardized examination protocol (SEPPU) for POP and UI in women. The objective is to identify predictors and diagnostic tools to be included in the SEPPU, along with underlying reasons for their inclusion.

Method: A questionnaire and focus group session involving pelvic physiotherapists (pPTs) were conducted to gather their opinions and beliefs. Univariate testing and logistic regression revealed significant differences in inclusion criteria and indicators of the diagnostic tools.

Results: Among the respondents (N=126), 54.8% expressed a perceived need for the SEPPU. Micturition diaries, Pelvic Organ Prolapse Quantification (POPQ), and pelvic physiotherapeutic examination (PPE) were recommended for inclusion, while consensus on diagnostic questionnaires is yet to be reached. Ultrasound and uroflowmetry were excluded due to additional costs.

Conclusion: According to the findings of this study, micturition diaries, the POPQ and PPE are recommended diagnostic tools to be included in the SEPPU. Further research is needed to finalize the protocol and explore the inclusion of diagnostic questionnaires.

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List of abbreviations

EMG: electromyography
MUI: Mixed Urinary Incontinence
POP: Pelvic organ prolapse
POP-Q: Pelvic organ prolapse quantification
PPE: Pelvic physiotherapeutic examination
PPT(s): Pelvic physiotherapist(s)
SEPPU: Standardized Examination Protocol for the diagnostic process of Pelvic organ prolapse and Urinary incontinence
SUI: Stress Urinary Incontinence
UI: Urinary Incontinence
UUI: Urge Urinary Incontinence

1. Introduction

Pelvic organ prolapse (POP) is a prevalent condition characterized by symptoms such as stress and/or urge urinary incontinence (UI), fecal incontinence, obstipation, dyspareunia, and abdominal pain [1,2]. Incidence rates of POP have been reported to be as high as 11%, while UI affects approximately 35.9% of the female population [2,3].

POP refers to the descent of one or more pelvic organs, including the anterior vaginal wall (bladder prolapse), posterior vaginal wall (rectal prolapse), uterus, and/or vaginal apex .

UI can be categorized into stress urinary incontinence (SUI), urgency urinary incontinence (UUI), and mixed urinary incontinence (MUI), which is a combination of SUI and UUI [4].

Women with POP and/or UI often experience emotional distress due to feelings of shame, disruption of daily routines, and a sense of incompleteness [1,4,5].

The development of POP is influenced by various risk factors, such as pregnancy, (instrumental) vaginal delivery, ethnicity, genetics, increased BMI, and heavy weight lifting [2,6]. Risk factors for UI include constipation, incontinence during pregnancy, (instrumental) vaginal delivery, and perineal trauma during labor [7].

Women with POP and/or UI may seek help from pelvic physiotherapists (pPTs). In the Netherlands, there are approximately 560 registered pPTs available for patients experiencing pelvic floor dysfunction symptoms [8]. pPTs provide therapy and exercises to individuals suffering from pelvic organ dysfunction. However, a proper diagnostic process must be conducted before initiating appropriate therapy.

Currently, there is no standardized examination protocol for the diagnostic process of POP and/or UI (SEPPU). Standardized examination protocols are designed to aid medical specialists in diagnosing patients, ensuring that serious complaints are distinguished from benign ones. These protocols help avoid overlooking relevant questions and ensure that complaints are taken seriously, thereby preventing potential harm associated with undiagnosed conditions [9].

Accurate diagnosis allows pelvic physiotherapists to apply appropriate treatments by gaining a comprehensive understanding of the patient's health issues [10]. Implementing a SEPPU enables pPTs to consider all complaints comprehensively, leading to accurate diagnoses and tailored treatments. Proper treatment can alleviate physical and emotional burdens, ultimately improving the patient's quality of life.

In order to determine the appropriate diagnostic tools for inclusion in the SEPPU, the following research questions are addressed in this study:

I. What diagnostic tools should be included in the SEPPU?
    i. Which indicators predict the inclusion of a certain diagnostic tool in this SEPPU?
    ii. Which indicators predict the overall inclusion of diagnostic tools in this SEPPU?
II. What is the perception of need among pPTs for this SEPPU?
    i. Which characteristics of the respondents predict this perceived need?

By investigating these research questions, valuable insights can be gained regarding the specific diagnostic tools that should be included in the SEPPU. Additionally, understanding the indicators that predict the inclusion of certain diagnostic tools will provide further guidance in designing an effective and comprehensive protocol. Furthermore, exploring the perception of need among pPTs and identifying the characteristics that influence this perceived need will help ensure the SEPPU's relevance and acceptance within the professional community.

2. Method

2.1 Research design

Previous research has explored diverse approaches to develope diagnostic protocols, employing different methods for their creation. Some of these methods include a Delphi procedure, statistical analysis using prediction models, workgroup collaboration, and observation and empirical data [11–14]. By leveraging these different methods, previous research has demonstrated various approaches to create diagnostic protocols. Each method has its own strengths and considerations, and the choice of approach depends on the specific context, available resources, and goals of the protocol development process.

Multi-Criteria Decision Analysis (MCDA) is an approach that extends decision theory to handle multiple objectives, as defined by Keeney and Raiffa [15]. The MCDA framework consists of seven steps [16]. The first three steps are reviewed in this study:

1. Defining the decision problem: The decision problem in this study focuses on determining which diagnostic tools should be included in the Symptom Evaluation Protocol for Pelvic Organ Prolapse (SEPPU).
2. Selecting and structuring criteria: Criteria for evaluation are selected based on their relevance to the decision problem. In this study, the criteria include "Availability," "Ease of use," and "Usefulness," which are derived from the Technology Acceptance Model (TAM) [17]. These criteria were operationalized into multiple indicators.
3. Measuring performance: The performance of the criteria is measured by statistically analyzing the responses obtained from a questionnaire. The questionnaire collects the attitudes, opinions, and beliefs of pPTs regarding the tools that can be used in the diagnostic process of POP and/or UI.

Remaining steps require scoring alternatives, weighting criteria, calculating aggregated scores, dealing with uncertainty and reporting and examination of findings. These steps will be expanded further in the discussion section.

By following these initial steps of the MCDA framework, this study aims to establish a foundation for evaluating and selecting the appropriate diagnostic tools to be included in the SEPPU.

In the context of the SEPPU, it is important to substantiate it with expert opinions in addition to relying solely on evidence-based information. This is because evidence-based research may not always fully align with real-world clinical practice [18]. Expert opinions provide valuable insights and practical considerations that can enhance the relevance and applicability of the diagnostic tools included in the protocol.

To gather these essential expert opinions, a focus group was conducted. The focus group served as a platform for pPTs to share their perspectives and insights regarding the inclusion or exclusion of specific diagnostic tools in the SEPPU. The discussions and feedback obtained from the focus group participants helped substantiate the rationale behind the selection of certain diagnostic tools, ensuring that their inclusion in the protocol is well-founded and supported by expert consensus.

By incorporating expert opinions alongside evidence-based research, the SEPPU can benefit from a more comprehensive and practical approach, addressing the specific needs and considerations of healthcare professionals and patients in the diagnostic process of POP and/or UI.

2.1.1 Survey design

Lancaster's theory of demand, as described by Lancaster [19], suggests that consumers perceive goods as a bundle of characteristics. In the context of this study, the questionnaire was designed based on this theory to measure the characteristics of diagnostic tools. The questionnaire consisted of three categories, comprising a total of 17 questions, to assess the specific characteristics of the diagnostic tools. Appendix A represents these questions.

The categories in the questionnaire aimed to gather information on the following aspects:

1. Availability: This category assessed whether the diagnostic method is readily accessible and affordable. It aimed to capture whether the diagnostic tool is easily obtainable for pPTs in terms of availability and cost.
2. Ease of use: This category examined the user-friendliness of the diagnostic method. It considered factors such as the ease of use for both the pPTs and the patients, as well as the time required to perform the diagnostic procedure. This category aimed to evaluate the practicality and convenience of using the diagnostic tool in clinical settings.
3. Usefulness: The usefulness category evaluated whether the diagnostic method provides added value in terms of diagnosing women with POP and/or UI

By measuring these specific characteristics, the questionnaire aimed to gather comprehensive data on the perceived availability, ease of use, and usefulness of the diagnostic tools, providing valuable insights for the development of the SEPPU.

In the questionnaire, attitudes, opinions, and beliefs regarding the diagnostic tools were assessed using a combination of yes/no answer options and a seven-point Likert scale. The Likert scale with seven points was chosen based on research suggesting that scales with more response options may yield higher reliability compared to scales with fewer points [20].

Each diagnostic tool included in the questionnaire had a final question asking whether it should be included in the SEPPU or not. This question aimed to gather a clear recommendation from the respondents regarding the inclusion of each specific tool in the SEPPU.

To ensure the validity and effectiveness of the questionnaire, a pilot testing process was conducted. The questionnaire was initially pilot tested by two pPTs. Based on their feedback and insights, necessary alterations were made to enhance the clarity and relevance of the questionnaire. Subsequently, the revised questionnaire was pilot tested again by another pPT to validate the modifications and ensure its suitability for the target population.

The pilot testing phase played a crucial role in refining the questionnaire and ensuring its comprehensibility and effectiveness in capturing the desired information from the respondents. By incorporating feedback from experienced pPTs, the questionnaire was strengthened to better measure the attitudes, opinions, and beliefs of healthcare professionals regarding the diagnostic tools, ultimately contributing to the development of a robust Symptom Evaluation Protocol for POP and/or UI.

2.1.2 Focus group design

The focus group served as a valuable method to gather additional information and insights regarding the inclusion or exclusion of diagnostic tools in the protocol. Specifically, if the questionnaire results indicated reasons why a certain diagnostic tool should not be included,

the focus group aimed to delve deeper into understanding the underlying reasons behind those responses. The focus group discussions aimed to explore the identified issues, potential solutions, and whether those issues could pose obstacles to the protocol's implementation.

The focus group discussions followed a semi-structured format, allowing flexibility for the interviewer to respond and probe further based on the participants' answers. This format facilitated an interactive and dynamic discussion among the participants, enabling the exploration of diverse perspectives and the generation of in-depth insights.

By combining the quantitative data from the questionnaire with the qualitative information obtained from the focus group, a comprehensive understanding of the reasons behind the participants' preferences and recommendations for the protocol was achieved. This integrated approach provided valuable insights into the considerations and perspectives of the experts involved, enhancing the development process of the SEPPU.

2.2 Research population

The research population for this study comprised of pelvic physiotherapists from the Netherlands who either held a master's degree in Pelvic Physiotherapy or were in the final phase of their master's degree program. This specific inclusion criterion ensured that the participants had a sufficient level of expertise and knowledge in the field of pelvic physiotherapy, making them qualified to provide insights and opinions regarding the development of the SEPPU.

The research population consisted of highly qualified and knowledgeable pelvic physiotherapists from the Netherlands, ensuring that the findings and recommendations of the study were grounded in the expertise and experiences of professionals working in the field of pelvic physiotherapy in that specific context.

2.2.1 Recruitment questionnaire

To maximize the reach and participation of pelvic physiotherapists, the NVFB (Dutch Association for Physiotherapy in Pelvic Issues) played a crucial role in disseminating the questionnaire. The NVFB utilized various channels to distribute the questionnaire link, including email, their union newsletter, and their Facebook page. These channels provided direct access to their members, ensuring that a significant number of qualified pelvic physiotherapists had the opportunity to participate in the study.

In addition to reaching out to individual practitioners through the NVFB channels, physiotherapy practices employing one or more pelvic physiotherapists were also contacted via email.

To further expand the respondent pool, the questionnaire link was shared with pelvic physiotherapy students who were in the final phase of their education. These students were encouraged to complete the questionnaire and share it with their supervisors, who likely possessed extensive experience and expertise in the field.

2.2.2 Recruitment focus group

The questionnaire included a question to assess the respondents' interest in participating in the focus group. A brief explanation of the focus group was provided to give respondents an understanding of its purpose and format.

Criterion sampling is a purposive sampling technique that involves selecting participants based on specific criteria to ensure a diverse and representative group. In this study, participants were chosen based on several criteria, including age, sex, educational institute, work experience in years, and the province of residence. These criteria aimed to capture a range of perspectives and experiences from pelvic physiotherapists across different demographics.

Additionally, to ensure the focus group discussions covered a comprehensive range of diagnostic tools, at least one participant with experience in ultrasound and at least one participant with experience in uroflowmetry were included in the selection process.

A total of eight participants were selected based on the defined criteria, and they were sent invitations to participate in the focus group. In case a selected respondent was unable to participate, another participant meeting the same criteria was selected as a replacement and invited to join the focus group.

By employing criterion sampling and selecting a diverse group of participants, the study aimed to gather insights from a varied range of pelvic physiotherapists, considering different backgrounds, experiences, and expertise. This approach allowed for a comprehensive exploration of the topic during the focus group discussions.

2.3 Analysis

2.3.1 Questionnaire

The data obtained from the questionnaire was analyzed using RStudio. To address missing data in the dataset, the multivariate imputation by chained equations (MICE) technique was employed. In Appendix B, an overview of the missing data in terms of the characteristics of the respondents and their answers regarding the diagnostic tools is provided. For missing values with two possible variables, logistic regression was used to impute the missing values. For missing values with more than two possible variables, polytomous regression was utilized.

By employing MICE and utilizing logistic regression and polytomous regression as appropriate, the missing data in the dataset was imputed, allowing for a more complete analysis of the questionnaire data and ensuring that missing values did not bias the results or interpretations.

2.3.1.1 Need for protocol

In the study, respondents were asked about their perceived need for a SEPPU. The aim was to gain insights into the perceived need for this protocol and examine whether it varied based on certain characteristics of the respondents, such as age, sex, educational institute, and work experience in years.

To analyze the data, univariate testing was conducted to assess the differences between the perceived need for the SEPPU (dependent variable) and the characteristics of the

respondents (independent variables). This testing helps identify any significant associations or differences between the variables.

Linear regression models were used to determine the strength of association between the perceived need for the SEPPU (dependent variable) and the characteristics of the respondents (independent variables). Linear regression allows for assessing the relationship and quantifying the degree of association between a dependent variable (perceived need for the SEPPU) and one or more independent variables (characteristics of respondents).

The perceived need for the SEPPU was defined by the responses categorized as 'Agree' and 'Highly agree', indicating a positive perception of the need for the protocol. On the other hand, responses such as 'Highly disagree', 'Disagree', 'Slightly disagree', 'Nor disagree/nor agree', and 'Slightly agree' were considered to indicate no perceived need for the protocol according to the pPT.

By conducting univariate testing and utilizing linear regression models, the researchers aimed to understand the relationship between the perceived need for the SEPPU and the characteristics of the respondents, providing insights into the factors that may influence the perceived need for a SEPPU.

2.3.1.2 Diagnostic tools

In order to determine the inclusion of a diagnostic tool in the SEPPU, a threshold variable of 70% agreement among respondents was set. This threshold was used as a criterion for considering whether a diagnostic tool should be included in the protocol.

To facilitate the analysis and overcome potential issues arising from a low number of observations for certain answer options, the original seven-point Likert scale responses were recoded into a three-point Likert scale. This recoding process involved collapsing the original seven-point scale into three categories to simplify the analysis and interpretation of the data.

Table 1 presents the recoding scheme used to convert the original Likert scale responses into the new three-point scale.

Likert scale	Strongly disagree	Disagree	Slightly disagree	Nor disagree / nor agree	Slightly agree	Agree	Strongly Agree
Recoded as:	1	1	1	2	3	3	3

Table 1: Likert scale originating from the questionnaire, recoded

Univariate testing was employed to examine the differences between the inclusion of a diagnostic tool in the SEPPU as the dependent variable and the various indicators related to that specific diagnostic tool as independent variables.

The univariate testing aimed to assess whether there were statistically significant differences in the inclusion of a diagnostic tool in the SEPPU based on the different indicators. This testing helps identify which indicators are associated with the inclusion or exclusion of a particular diagnostic tool.

When significant differences were found through the univariate testing, linear regression models were used to further investigate the strength of association between the inclusion of a diagnostic tool in the SEPPU (dependent variable) and the indicators related to that specific tool (independent variables). Linear regression allows for the estimation of the

magnitude and direction of the association between the dependent variable and independent variables, providing insights into the relationship between the indicators and the decision to include a diagnostic tool in the SEPPU.

To establish predictors for the overall inclusion of a diagnostic tool in the SEPPU, the dataset was transposed so that the columns represented the characteristics of diagnostic tools. This allows for a systematic analysis of the associations between the inclusion of a diagnostic tool in the SEPPU (dependent variable) and the characteristics of diagnostic tools (independent variables).

Univariate testing was then conducted to examine the differences between including a diagnostic tool in the SEPPU (dependent variable) and the individual characteristics of the diagnostic tools (independent variables). This testing helps identify which specific characteristics of the diagnostic tools are associated with their inclusion or exclusion in the SEPPU.

If the univariate testing revealed statistically significant differences, linear regression models were utilized to determine the strength of association between including a diagnostic tool in the SEPPU (dependent variable) and the indicators related to the characteristics of the diagnostic tools (independent variables). Linear regression analysis allows for the estimation of the magnitude and direction of the association between the dependent variable and independent variables, enabling the identification of predictors that are strongly associated with the inclusion of diagnostic tools in the SEPPU.

2.3.2 Focus group

The focus group session was conducted through Microsoft Teams, and with the permission of the participants, it was recorded and transcribed. The transcription of the session was then shared with the participants for their verification and any necessary corrections.

To analyze the transcript, the software Atlas.ti was utilized. The coding process involved both inductive and deductive approaches.

For the deductive coding process, codes were created based on previously gathered literature. These codes were derived from relevant concepts and themes identified in the literature and were used to categorize and analyze specific fragments of the transcript. This deductive coding helped to ensure that the analysis was grounded in existing knowledge and theories.

The inductive coding process included open coding, axial coding, and selective coding. Open coding involved identifying and labeling concepts and ideas that emerged directly from the data without any preconceived notions. Axial coding involved making connections between different codes and identifying relationships and patterns within the data. Finally, selective coding focused on selecting and refining key codes that were most relevant and significant for answering the research questions.

The codes generated from both the deductive and inductive coding processes were then assigned to relevant fragments of the transcript. These coded fragments provided the basis for analyzing and interpreting the data, ultimately contributing to the answering of the research questions.

The codes and their corresponding assigned fragments can be found in Appendix C, providing a comprehensive overview of the coding process..

3. Results

3.1 Respondent sample

3.1.1 Questionnaire

126 pPTs filled out questions regarding their age, sex, educational institute, work experience in years and province. Table 2 represents the characteristics of the respondent sample.

Age	20-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70
N (%)	2 (1.6%)	5 (4.0%)	13 (10.3%)	15 (11.9%)	11 (8.7%)	13 (10.3%)	19 (15.1%)	20 (15.9%)	20 (15.9%)	8 (6.3%)
Sex	Female			Male				I'd rather not say		
N (%)	124 (98.4%)			1 (0.8%)				1 (0.8%)		
Educational institute	SOMT			Avans+			Erasmus MC		Other	
N (%)	96 (76.2%)			8 (6.3%)			12 (9.5%)		10 (8.0%)	
Work experience in years	0-5	6-10		11-15		16-20		21-25		>25
N (%)	23 (18.3%)	35 (27.8%)		35 (27.8%)		17 (13.5%)		7 (5.6%)		9 (7%)
Province	Friesland	Groningen		Drenthe		Overijssel		Gelderland		Utrecht
N (%)	4 (3.2%)	7 (5.6%)		4 (3.2%)		27 (21.3%)		23 18.3%)		8 (6.3%)
Province	Flevoland	Noord-Holland		Zuid-Holland		Zeeland		Noord-Brabant		Limburg
N (%)	5 (4.0%)	17 (13.5%)		14 (11.1%)		5 (4.0%)		8 (6.3%)		4 (3.2%)

Table 2.1: characteristics of respondent sample

Table 2.2 represents the number of observations for each diagnostic tool.

Diagnostic tool	**Number of observations N (%)**
PRAFAB	102 (81.0%)
PSK	77 (61.1%)
3IQ	42 (33.3%)
IPSS	36 (28.6%)
Wexner	28 (22.2%)
Rome IV criteria	22 (17.5%)
Micturition diaries	77 (61.1%)
POPQ	76 (60.3%)
PPE	74 (58.7%)
EMG	73 (57.9%)

Ultrasound	72 (57.1%)
Uroflowmetry	71 (56.3%)

Table 2.2: number of observations regarding diagnostic tools

3.1.2 Focus group

	Age	Sex	Educational institute	Work experience in years
Respondent 1	66-70	Female	SOMT	>25
Respondent 2	51-55	Female	SOMT	16-20
Respondent 3	66-70	Female	ErasmusMC	>25
Respondent 4	26-30	Female	SOMT	0-5
Respondent 5	56-60	Female	SOMT	16-20
Respondent 6	36-40	Female	Avans+	0-5

Table 3: characteristics of the participants of the focus group

Note: The province information has been excluded to protect the privacy of the participants. The province was varied among the participants.

3.2 Need for protocol

126 respondents gave an indication about their perceived need for a SEPPU. A total of 54.8% respondents (n=69) perceive a need for a SEPPU.

Based on the results of univariate testing, it was found that there were no significant differences between respondents who perceived a need for a SEPPU (dependent variable) and the characteristics of age, sex, educational institute, and work experience (independent variables). As a result, logistic regression models were not conducted, as there was no evidence of an association between these characteristics and the perceived need for the SEPPU.

3.3 Predictors for inclusion in protocol

Transposing the dataset resulted in 750 observations and 15 indicators (independent variables) and the perceived need for a SEPPU question (dependent variable). Univariate testing showed **differences in** the perceived need for a SEPPU and the independent variables *Use* (X=69.41; p=2.2e-16), *Fillable/Performable/Operable* (x=7.78 ; p=0.02), *Applicable* (x=16.05; p=3.27e-4), *Purpose* (x=37.32; p= 7.86e-09), *positive predictive value* (*PPV)* (x=99.05; p= 2.2e-16), *negative predictive value (NPV)* (x=79.66; p= 2.2e-16), *Effort* (x=84.93; p= 2.2e-16), *Speed*(x=182.68; p=2.2e-16), *Interpretation* (x=60.84; p=6.14e-14), and *Purchase* (x=18.24; p=1.09e-4).

Linear regression showed that wanting to include a diagnostic tool is significantly **influenced by** perceived *Use* (Use_{Yes} (PWU = 0.57 ; $P<2.71e^{-10}$), Use_{No} (PWU = -2.14 ; P<1.75e-13)), *Fillable/Performable/Operable* (PWU = 0.6473 ; $P<6.33e^{-3}$), *Applicable* ($Applicable_1$ (PWU = -0.53, ; P<0.02), $Applicable_3$ (PWU = 0.96; $P<1.03e^{-4}$)) *Purpose* ($Purpose_1$ (PWU = -1.31; P<0.0021), $Purpose_3$ (PWU = 1.78; $P<4.27e^{-05}$)) , *PPV* (PPV_1 (PWU = -1.12; $P<6.16e^{-08}$), (PPV_3 (PWU = 2.00; $P<2e^{-16}$)), *NPV* (NPV_1(PWU = -0.45; $P<1.07e^{-3}$), (NPV_3 (PWU = 1.55; $P<2.36e^{-15}$)), *Effort* ($Effort_1$ (PWU = -1.36; $P<6.13e^{-07}$), $Effort_3$ (PWU = 2.05; $P<1.34e^{-12}$)), *Speed* ($Speed_1$ (PWU = -1.78; $P<3.92e^{-14}$), $Speed_3$ (PWU = 2.96; $P<2e^{-16}$)), and *Interpretation* ($Interpretation_1$ (PWU = -2.35; $P<6.96e^{-06}$),

$Interpretation_3$ (PWU = 2.88; $P<5.92e^{-08}$)). Respondents who use a diagnostic tool were more likely to prefer inclusion and respondents who do not use a diagnostic tool are more likely to not prefer inclusion. Respondents who perceive a diagnostic tool as easy fillable/performable/operable were more likely to prefer inclusion. Respondents who perceive a diagnostic tool as not easy applicable were more likely to not prefer inclusion and respondents who perceived a diagnostic tool as easy applicable were more likely to prefer inclusion. Respondents who perceive the purpose of a diagnostic tool as not clear were more likely to not prefer inclusion and respondents who perceive the purpose as clear were more likely to prefer inclusion. Respondents who perceive the PPV of a diagnostic tool as low were more likely to not prefer inclusion and respondents who perceive the PPV as high were more likely to prefer inclusion. Respondents who perceive the NPV of a diagnostic tool as low were more likely to not prefer inclusion and respondents who perceive the NPV as high were more likely to prefer inclusion. Respondents who perceive to have to put high effort in a diagnostic tool were more likely to not prefer inclusion and respondents who perceive a low effort were more likely to prefer inclusion. Respondents who perceive the speed of a diagnostic tool as low were more likely to not prefer inclusion and respondents who perceive high speed were more likely to prefer inclusion. Respondents who perceive the results of a diagnostic tool as hard interpretable were more likely to not prefer inclusion and respondents who perceive the results as easy interpretable were more likely to prefer inclusion. Appendix D contains the regression models of those indicators associated with wanting to include a diagnostic tool.

3.4 Inclusion in protocol

Image 1 shows the agreement on inclusion of a diagnostic tool in the SEPPU.

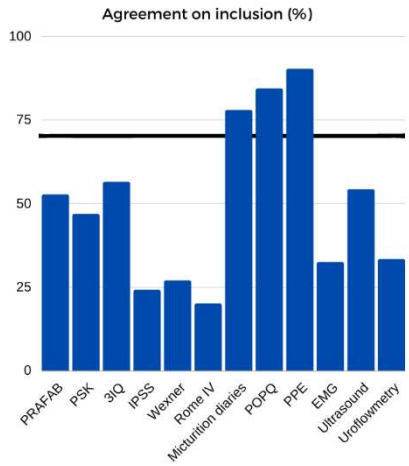

Image 1: schematic representation of the agreement on inclusion of a diagnostic tool in the SEPPU, where the black line is the threshold of inclusion (70%)

The decision to exclude the PFDI20, PISQ12, PFIQ7, UDI6, PGI-I, and ODS-S from further analysis in this research was based on the small number of respondents that answered questions regarding those tools. Due to the limited data available, it was deemed impractical to draw meaningful conclusions or obtain significant insights regarding their inclusion in the SEPPU. As a result, these measures were not considered for further examination or incorporation into the protocol.

Similarly, the 3IQ, IPSS, and Wexner tools were not further extensively discussed or explored in this research. No valuable findings emerged from the questionnaire or focus group.

3.5 Included diagnostic tools

Based on the results of the questionnaire, only micturition diaries, the POPQ, and PPE were identified as suitable for inclusion in the SEPPU. The agreement on inclusion of the protocol exceeds the threshold of 70%, shown in image 1.

Regarding micturition diaries, respondents who reported a higher likelihood of achieving an accurate PPV with micturition diaries and experiencing faster results with this tool were more inclined to include it in the SEPPU. The focus group participants also acknowledged the valuable insights provided by micturition diaries in understanding a patient's problems. Despite acknowledging the burden placed on patients, the participants expressed a consensus that micturition diaries should be included in the SEPPU. Additionally, participants highlighted the need for a standardized micturition diary that encompasses all relevant components, as there is currently no uniform version available.

Concerning the POPQ, the higher number of respondents who use the POPQ expressed a desire for this tool to be included in the protocol. On the other hand, the small number of respondents who did not use the POPQ all indicated that they do not want this tool in the protocol. Also, respondents who found it easy to perform, applicable, and interpret, and who perceived clear purpose and non-burdensome aspects for patients, along with accurate NPV were more likely to want to include it in the SEPPU. However, participants in the focus group acknowledged that the POPQ can be burdensome for patients due to the internal nature of the examination that requires pushing. Participants emphasized the importance of pPTs being skilled enough to perform the POPQ efficiently to minimize patient burden. Despite the challenges, the consensus among the focus group participants was that the POPQ should be included in the SEPPU.

For PPE, respondents who found it easy to perform, applicable, and interpret, along with accurate PPV, NPV, and fast results, were more likely to include it in the SEPPU. The focus group participants mentioned that PPE is burdensome for patients due to its internal nature, and there may be instances where deviations from the standard procedure are necessary due to patient trauma, for example. Nonetheless, participants agreed that PPE should be included in the protocol.

3.6 Not included diagnostic tools

The PRAFAB, PSK, Rome IV, EMG, ultrasound, and uroflowmetry were not included in the SEPPU based on the results of the analysis.

For the PRAFAB, respondents who reported an inaccurate PPV, longer time to obtain results, and difficulty in interpretation were more likely to state their preference against including this diagnostic tool in the SEPPU. However, the participants in the focus group disagreed with excluding the PRAFAB and reached a consensus that it should be included.

Regarding the PSK, respondents who did not use it in the diagnostic process, experienced inaccurate PPV and NPV, had to invest effort to obtain results, and found it time-consuming

were more likely to state their preference against including this tool in the SEPPU. Additionally, the focus group participants mentioned instances where patients returned a PSK with inaccurate disability descriptions, and that it is not a diagnostic but an evaluative questionnaire.

Univariate testing did not reveal any significant differences in indicators concerning the Rome IV criteria and the desire to include this tool in the SEPPU. However, the focus group participants disagreed with excluding the Rome IV criteria, emphasizing its usefulness in referring patients with dysfunctions requiring specialized expertise.

For EMG, respondents who did not use it in the diagnostic process, perceived high NPV, and faced delays in obtaining results were more likely to state their preference against including this diagnostic tool in the SEPPU. In contrast, the focus group participants reported using EMG for additional information when previous tests did not provide certainty about the patient's dysfunction. They also mentioned using EMG as a means of treatment for pelvic floor dysfunction rather than solely as a diagnostic tool.

No significant associations were found between ultrasound and the indicators examined. Respondents who did not have access to ultrasound did not have enough experience with this diagnostic tool to answer further questions. The financial aspect of ultrasound was considered a disadvantage by the focus group participants, as the costs for the device, maintenance, and additional training courses were not reimbursed. While ultrasound was deemed valuable for its noninvasive and visualizing nature, the costs were perceived to outweigh the advantages.

For uroflowmetry, no significant associations were found between this tool and the indicators examined. Among respondents who did not have access to uroflowmetry, only one had sufficient experience with this diagnostic tool to provide further insights. The focus group participants highlighted the costs associated with uroflowmetry as a significant disadvantage. They also noted that uroflowmetry alone is not as exploratory as when combined with EMG or a bladder scan, emphasizing the importance of having these additional tools available.

Appendix E presents a detailed overview of the results, including univariate testing and logistic regression models for all diagnostic tools.

3.7 Additional focus group results

3.7.1 Questionnaires

During the focus group discussions, participants reached a consensus that questionnaires should be included in the standardized examination protocol for the diagnostic process of POP and/or UI. Specifically, the participants highlighted the importance of incorporating the PRAFAB and the Rome IV criteria for obstipation and abdominal pain syndromes in the protocol.

The participants suggested that these questionnaires should be completed by the patients independently, prior to their initial consultation. By having patients fill out the questionnaires in advance, valuable time during the consultation can be saved.

3.7.2 pPT and finances

During the focus group discussions, participants emphasized that certain diagnostic tools, such as ultrasound, uroflowmetry, and residual determination, are not within the competence

profile of pPTs. Participants highlighted that the educational program for pPTs do not typically include these specific diagnostic techniques.

The participants further noted that the financial aspect plays a significant role in the decision to include these tools in the regular educational program for pPTs. The costs associated with acquiring and maintaining the necessary equipment, as well as the expenses for additional training and certification, can pose challenges and limit the accessibility of these tools for pPTs. This financial barrier becomes a significant influence on the inclusion of the SEPPU

Additionally, the participants highlighted the potential role of pPTs in relieving first-line healthcare providers, particularly general practitioners. By incorporating comprehensive diagnostic tools and protocols in their practice, pPTs can contribute to the overall healthcare system by offering specialized expertise in pelvic floor disorders.

4. Discussion

4.1 Results and practical implications

This study examined the perceived need for a SEPPU among pPTs and to identify which diagnostic tools should be included in this protocol. Around 60% respondents expressed a perceived need for a SEPPU. No significant differences were observed between respondents with a positive or negative perspective on the need for a SEPPU. Age, sex, educational institute and years of work experience did not appear to influence the preference for or against the protocol.

Results showed the following indicators as predictors for the inclusion of a diagnostic tool in the SEPPU: *Use*, easy *Fillable/Performable/Operable*, *Applicable*, clear *Purpose*, high *PPV*, low *NPV,* low *Effort,* high *Speed*, and easy *Interpretation.* These criteria are valuable for the Analytical Hierarchy Process (AHP) of the MCDA which will be discussed further in section 4.3. The results suggest to include micturition diaries, the POPQ, and PPE. Micturition diaries should be included because it has a perceived high *PPV* and high *Speed*. The POPQ should be included based on *Use*, and because it is easy *Performable*, easy *Applicable,* has a clear *Purpose,* is not *Burdensome,* has a high *NPV*, and easy *Interpretation*. PPE should be included because it is easy *Performable,* easy *Applicable,* has a high *PPV* and *NPV,* high *Speed,* and easy *Interpretation*.

Results of the focus group addressed additional results outside the questionnaire. Participants stated the absence of a uniform micturition diary that contains all the relevant components. This implication is also mentioned in literature. There are several micturition diaries available with different lay-outs and containing different relevant components. There is no uniform micturition diary containing all the relevant components that is commonly used [21].

Participants of the focus group addressed the influence of costs on the accessibility which diagnostic tools are accessible for pPTs. Having access to ultrasound and uroflowmetry are because of purchase costs, maintenance costs and costs of additional education outside the standard Master's program not feasible for all pPTs. Computing those costs to the consultation fee makes the health care provided by pPTs less affordable for patients, and is currently not reimbursed by healthcare insurance. Research has shown that an increase in the fee for healthcare services paid by patients leads to a decreased utility of these services [22]. Costs make it, in the prevailing circumstances, impossible to add ultrasound and uroflowmetry to the SEPPU.

4.2 Strengths and limitations

This study contributes expert opinions to the existing literature, supporting the inclusion of specific diagnostic tools in the SEPPU. By incorporating pPTs, this study offers novel insights into how these individuals perceive the available diagnostic tools for the diagnostic process of POP and/or UI. The focus group provided additional relevant information for the development of the SEPPU. Importantly, the information gathered for the creation of the protocol is reinforced by expert opinions, which strengthens its alignment with practical application [18].

Statistical analysis encountered limitations for certain indicators. The indicator *Financial* could not be analyzed comprehensively for the diagnostic tools EMG ultrasound, and

uroflowmetry due to the limited number of respondents providing specific answers. Regarding EMG, only one respondent mentioned the unavailability of EMG in their practice, limiting further analysis. Similarly, respondents who reported the complete absence of ultrasound in their practice lacked the necessary experience to answer subsequent questions. Regarding uroflowmetry, only one respondent who reported its unavailability possessed sufficient experience to provide further insights. Information concerning these topics was obtained through the focus group session, adding valuable context to the study findings.

During the application of the chi-square function, RStudio alerted that the chi-squared approximation might be unreliable due to the small number of respondents in some categories. This caution was raised as the validity of the chi-square test relies on having sufficient sample sizes within each category for accurate inference.

Due to the limited number of responses in specific categories, the predictive values derived from logistic regression analysis were rendered inaccurate in certain calculations. In some cases, logistic regression could not be performed due to the uniformity of responses, where all respondents had selected the same answer option within a category.

4.3 Scientific relevance and practical recommendations

In this study, the initial steps of developing a SEPPU were conducted by performing the first three steps of an MCDA. The study identified the diagnostic tools that should be included in the protocol. The complete development of a new protocol was not feasible. To address this limitation, the study proposes a framework for conducting the remaining steps of the MCDA. This approach allows for the evaluation of future diagnostic tools using the MCDA methodology. By implementing this proposed framework, the SEPPU can be further refined and expanded to incorporate emerging diagnostic tools.

In future research, the completion of the remaining steps of the MCDA framework (scoring alternatives, weighting criteria, calculating aggregated scores, dealing with uncertainty, and reporting and examining findings) will enable the comprehensive development of the SEPPU [23]. The Analytical Hierarchy Process (AHP) is recommended for scoring alternatives and weighting criteria [24]. Previous healthcare studies have successfully employed the AHP methodology [25–27]. Within the AHP framework, a group of stakeholders will compare different diagnostic tools pairwise based on predefined criteria, including *Use*, easy *Fillable/Performable/Operable*, *Applicable*, clear *Purpose*, high *PPV,* low *NPV,* low *Effort*, high *Speed*, and easy *Interpretation* as identified in this study. The criteria will be assessed on a 1-9 ratio scale to reflect their relative importance. Aggregated scores are not required when utilizing AHP within the MCDA framework. Sensitivity analysis will address uncertainties, and the comprehensive MCDA findings will be reported and examined to inform the final SEPPU.

It is recommended to utilize a decision-tree format for the SEPPU. This format enables healthcare professionals to determine a diagnosis by following a series of symptom-based criteria [28]. Decision trees have been successfully employed in various healthcare domains, including the diagnosis of heart diseases [29], early detection of breast cancer [30], and diagnosis of type II diabetes [31]. Previous research has also demonstrated reasonable accuracy of decision tree models in diagnosing urinary incontinence [32]. By utilizing a decision-tree format, pPTs can navigate through the diagnostic process based on the

specific patient's symptoms and the outcomes of previous diagnostic tests, thereby enhancing the efficiency and effectiveness of the diagnostic procedure.

To develop the decision tree and its pathways for the SEPPU, a collaborative workgroup comprising pPTs should be established. This workgroup will collectively determine the subsequent steps and decisions for each path and node within the decision tree. The decision-making process should be informed by relevant literature, which will guide the selection of appropriate diagnostic tools based on specific complaints or outcomes of previous diagnostic procedures. The active involvement of pPTs in this process is crucial, as their expertise and insights contribute to the development of robust and effective medical protocols [18].

The performance matrix derived from the AHP and MCDA can be utilized by experts to select diagnostic questionnaires that can provide added value to the SEPPU. The disagreement of focus group participants regarding not including questionnaires in the SEPPU suggests the need for further evaluation. Through a comparison of available diagnostic questionnaires based on the ranked criteria, the most suitable questionnaires can be identified for inclusion in the SEPPU.

Moreover, it is important to conduct a comparative analysis of ultrasound and uroflowmetry in relation to micturition diaries, the POPQ, PPE, and other existing tools. This comparison will assess whether ultrasound and uroflowmetry outperform the currently employed tools. Although focus group participants indicated that ultrasound and uroflowmetry are currently excluded from the SEPPU due to cost and lack of reimbursement, demonstrating the superiority of these diagnostic tools through comparison may provide a basis for persuading insurance companies to consider reimbursing their purchase and maintenance expenses.

Additionally, it is advisable to conduct pilot testing of the protocol following any modifications made based on feedback from pPTs. This iterative process allows for refinement and validation of the protocol, ensuring its effectiveness and suitability for implementation.

During the focus group discussion, participants addressed the absence of a uniform micturition diary encompassing all essential components to gather information on the patient. This was also revealed in a previous study [21]. Conducting a study that focuses on developing a uniform diary containing all components to gather necessary patient information to take further steps in the diagnostic process for POP and/or UI. This uniform diary would not only provide benefits to pPT and the patient, but would also contribute to the advancement of the SEPPU. Furthermore, making the diary available in both digital and paper formats would enhance accessibility for all patients.

5. Conclusion

Overall, respondents express the need for a SEPPU. Micturition diaries, POPQ, and PPE should be included in this SEPPU. Future research should determine the inclusion of diagnostic questionnaires. Exclusion of ultrasound and uroflowmetry is due to costs related to purchase, maintenance and additional education. A decision tree format is recommended for the protocol, enabling pPTs to address patients' specific issues efficiently.

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Appendix A: Questionnaire

Tool	Question
All tools	Ik maak gebruik van o.a. deze tool bij het diagnostische proces van POP en/of UI
PRAFAB, PSK, PFDI20, PISQ12, PFIQ7, 3IQ, UDI6, IPSS, PGI-I, ODS-S, Wexner, RomeIV, Micturition diaries	Deze tool is in de praktijk waar ik werkzaam ben beschikbaar in het elektronisch patiënten dossier
PRAFAB, PSK, PFDI20, PISQ12, PFIQ7, 3IQ, UDI6, IPSS, PGI-I, ODS-S, Wexner, RomeIV, Micturition diaries	Ik zou deze diagnostische tool graag in het elektronisch patiënten dossier willen
POPQ, PPE, EMG, ultrasound, uroflowmetry	Ik zou deze diagnostische tool graag willen gebruiken
EMG, ultrasound, uroflowmetry	Mijn praktijk heeft de financiële middelen tot zijn beschikking om deze diagnostische tool aan te schaffen
POPQ	Voor de POP-Q is in het elektronisch patiënten dossier een invulformulier beschikbaar
POPQ	Ik zou graag een invulformulier voor de POP-Q in het elektronisch patiënten dossier willen
All tools	Ik heb ervaring met het werken met deze tool en kan daarom hierover vragen beantwoorden
PRAFAB, PSK, PFDI20, PISQ12, PFIQ7, 3IQ, UDI6, IPSS, PGI-I, ODS-S, Wexner, RomeIV, Micturition diaries	Deze diagnostische tool is makkelijk in te vullen
POPQ, PPE	Deze diagnostische tool is makkelijk uit te voeren
EMG, ultrasound, uroflowmetry	Deze diagnostische tool is makkelijk te bedienen
All tools	Deze diagnostische tool is makkelijk toepasbaar in een consult
ultrasound	Het is makkelijk om te leren hoe er met deze diagnostische tool gewerkt moet worden
All tools	Het doel van deze diagnostische tool is duidelijk voor de patiënt
All tools	Deze diagnostische tool is niet belastend voor de patiënt
All tools	Indien deze diagnostische tool boven de afkapwaarde scoort, is er vaak sprake van POP en/of UI
All tools	Indien deze diagnostische tool onder de afkapwaarde scoort, is er vaak geen sprake van POP en/of UI
All tools	De inspanning die ik moet leveren bij deze diagnostische tool voor een testresultaat staat in verhouding tot het resultaat dat het me oplevert
All tools	Deze diagnostische tool levert snel een resultaat dat gebruikt kan worden in het diagnostisch proces bij POP en/of UI
All tools	De resultaten die deze diagnostische tool levert zijn makkelijk te interpreteren

EMG, ultrasound, uroflowmetry	Ik zou deze diagnostische tool aanschaffen omdat ik hem nuttig vind
All tools	Deze diagnostische tool moet in het protocol voor het diagnostisch proces van POP en/of UI

Table 4: Questions asked in questionnaire

Appendix B: Missing values

Tool	PRAFAB	PSK	3IQ	IPSS	Wexner	Rome IV	MD	POPQ	PPE	EMG	Ultrasound	Uroflowmetry
Availability	0	0	0	0	0	0	0	0	-	0	0	0
Use	28	0	0	1	0	0	0	21	0	1	1	0
Experience	4	1	0	1	0	7	3	3	1	3	3	1
Fillable/ Performable/ Operable	3	1	4	0	0	7	1	1	2	2	0	0
Applicable	6	1	4	0	0	7	1	1	2	2	0	0
Purpose	4	1	3	0	0	7	1	1	3	2	0	0
Burden	4	1	3	0	0	7	1	1	2	2	0	0
PPV	16	6	4	2	1	7	1	1	2	2	0	0
NPV	16	6	4	2	1	7	1	1	2	2	0	0
Effort	15	6	5	2	1	7	2	2	2	2	0	0
Speed	15	6	4	2	1	8	3	2	2	3	0	0
Interpretation	15	6	4	3	2	7	2	1	3	2	0	0
Purchase	-	-	-	-	-	-	-	-	-	2	0	0
Protocol	15	7	4	2	1	7	2	1	2	2	0	0

Table 5: Missing values completed by MICE during the data analysis

Appendix C: Inductive and deductive coding schemes

Inductive cooding theme	Subtheme	Total number of quotes	Example quote	Respondent number
3IQ	3IQ not diagnostically usable	2	Het is echt heel vaag, hoor, als diagnostisch doen we daar echt helemaal niets mee.	1
	3IQ unclear questionnaire	3	Nou, in de eerste plaats is dit een hele vage lijst en ik denk dat je als je naar de zinnen kijkt, dat je inderdaad daar sowieso al moet gaan afvragen voor wie dit geschreven is. Ik denk heel eerlijk gezegd dat je met je defecatiedagboek veel meer informatie krijgt dan deze hele lijst.	1
IPSS	IPSS hindrance	1	Ja dat, dat ben ik het mee eens, maar ik denk dat ik persoonlijk als vrouwelijke patiënt het heel erg ga vinden als ik een prostaat vragenlijst moet gaan invullen	1
	IPSS not suitable	1	Ze hebben hem een keer getest om zeg maar de betrouwbaarheid ervan te toetsen en op een heel ander onderwerp. En toen kwamen er toch wel verrassende dingen uit die eigenlijk niet zo geschikt zou zijn.	3
Micturition diaries	Importance of explanation	10	Ja, je legt het uit en je merkt soms wel weerstand van een patiënt, meer omdat ze inderdaad zeggen, “ja, maar als ik naar mijn werk ga, zit ik met een bekertje en blablabla”, maar als je het al goed uitlegt, dan staan ze er vaak wel voor open om het in ieder geval op een vrije dag in te vullen.	4
	Burdensome for patient	12	Maar dat is het grote nadeel. Het is echt heel bewerkelijk voor patiënten, en zeker omdat ze het eigenlijk een aantal dagen moeten doen. En de defecatielijst moet dan ook nog wat langer volgehouden worden, dus op je werk is dat lastig en als je inderdaad schoolgaande kinderen hebt, weet je dat soort dingen. Dat is echt heel, heel erg lastig.	1
	Diagnostically usable	1	Ja, het is diagnostisch.	1
	Burden no hindrance for protocol	5	Het is een belemmering, maar ik zou dat niet een belemmering voor het protocol zien.	1
	Little information better than nothing	7	Maar persoonlijk zou ik zeggen. Alles is beter dan niks, dus ik heb ook wel oude mensen gehad waarvan ik dacht, nou weet u? Meet dan even ‘s morgens als je wakker wordt met het plassen en dan weet ik in ieder geval een beetje wat je grootste capaciteit is als dat je grootste plas is, nou verzin maar, zo kun je alleen maar aantallen laten turven. Dan heb je alleen niet meer een officiële mictie lijst en daarbij wijken wij denk ik allemaal als therapeut er wel eens vanaf. Omdat het nou	3

			eenmaal niet haalbaar is zoals je het graag zou willen.	
	Insight for patient	3	Maar ik ontdek ook dat mensen, als ze het wel doen dat ze heel veel informatie er zelf uit halen. En dan heb je eigenlijk al een leereffect.	5
	Difficult to fill out	2	Nou, maar dat is het omdat hij zo lastig invulbaar is.	1
	Must be in protocol	3	We willen hem absoluut erbij hebben.	2
	Motivating patient	5	Nou, mictie defecatie ben ik met je eens hoor, dan moet je behalve uitleg ook een motivational talk geven om het überhaupt te gaan doen, zodat jij het belang kan duidelijk maken om dat in te vullen.	3
	No uniform diary	3	Er zijn 100.000 verschillende mictie defecatie lijsten.	1
	Wrong feedback	5	Maar dan krijg je niet altijd de lijst waar je soms wat mee kan, dus, als je ze vooraf het mictie dagboek meegeeft.	5
	Valuable information	6	Maar sowieso de mictie defecatie lijst geeft heel veel informatie.	6
EMG	Supplementary diagnostics	9	Niet als eerste instantie? Voor mij is het meer een ondersteuner als je er niet uitkomt. En dan kan je terugvallen, bijvoorbeeld op myofeedback, dus niets diagnostisch…	1
	Treatment	1	Het is een behandelmethode. Ik gebruik myofeedback niet diagnostisch voor urine incontinentie.	2
	Costs for patient	3	Want één van de grote belemmeringen is dat het de patiënt geld kost.	1
	Visualizing for patient	1	UI is natuurlijk weer een ander verhaal dan POP, maar ik zou hem sowieso niet diagnostisch inzetten, maar meer evaluatief. Of als iemand, als ik merk dat iemand misschien, of die het moeilijk vindt om het aan te spannen om het dan te kunnen laten zien op een scherm, maar diagnostisch niet.	4
POPQ	Alternative	5	Nou, wij doen het met echo en daar heb ik helemaal geen pop-q voor nodig, dus.	2
	Determine next step	2	Het gaat er uiteindelijk niet zozeer om dat jij nu wetenschappelijk onderzoek doet met die pop-q, maar het is wel dat jij de pop-q wil doen om voor jezelf qua therapie te weten: wat komt er nou eigenlijk naar beneden?	3
	Must be in protocol	3	En als we dan terugkoppelen, moet het wel of niet in het protocol. Dan zou ik heel duidelijk zeggen, het moet wel in het protocol. De collega's moeten er gewoon voor zorgen dat zij goed vaardig zijn.	1

	Skill pPT	11	Dus als het voor jou gefreut blijft dan, dan ligt het aan jouw vaardigheid. Maar daar moet je dus dan wel op gaan trainen, zodat het voor die patiënt zo min mogelijk belastend is.	3
PRAFAB	Alternative ICIQ	2	Ja, en de ICIQ-UI kun je ook nog gebruiken.	5
	Diagnostically usable	3	De PRAFAB is ook niet ontwikkeld als een evaluatief meetinstrument, maar als een diagnostisch meetinstrument.	1
	Must be in protocol	1	De lijsten vooraf, dat zijn de PRAFAB, als het echt puur diagnostisch is dan de PRAFAB, en in mijn optiek de ROME IV criteria.	2
	No zero score	3	Ik vind de PRAFAB, die kun je niet tot nul scoren en dat vind ik één groot nadeel van de PRAFAB.	5
	Repetition anamnesis	1	Ja en wat ik wat ik zelf ook wel merk, is dat mensen dan ook wel het idee hebben van “Ja, dat heb ik toch al verteld in de anamnese?” dus dat er natuurlijk een stukje herhaling optreedt.	6
PSK	Evaluation complaint	5	Ik gebruik hem eerder voor evaluatief, dat je echt aan iemand kan laten zien of die beperkingen ergens in heeft, dat je echt kan laten zien van: “hé, maar kijk eens, u gaf toen aan dat u veel meer beperkt was dan nu”. Maar voor diagnostiek vind ik dat dan weer moeilijk in te zetten.	4
	Feedback often bad	2	We krijgen hem ook vaak heel slecht ingevuld terug, dus het is moeilijk voor patiënten om daar goed geformuleerd hun problematiek in te omschrijven, hun beperkingen in te beschrijven	2
	Not diagnostically usable	2	Ja, maar je mag hem ook niet diagnostisch inzetten, want dit is geen diagnostisch instrument.	1
	Poor fillability	2	Ja, maar het gaat heel erg op beperking niveau en als iemand incontinent is, ja, dan hoeft dat niet dat die minder of meer beperkt is. Ik vind hem wel heel lastig voor patiënten om in te vullen.	5
Rome IV	Diagnostically usable	4	Ik ben het er helemaal mee eens, het zijn diagnostische vragenlijsten en je kunt er inderdaad wel naar kijken of je nog meer moet helpen en kan ik het zelf aan. Dus ik vind ook dat dat er in zou moeten, eerlijk gezegd.	1
	Easy applicable	1	Dat is kort, echt voor de patiënt. Nou, als we er lang over doen, 10 minuten werken, dan hebben we het gehad. En als we snel zijn, 3 minuten.	1
	Helps to refer	3	Wij hebben dan wel een richtlijn van hé, dit moeten wij doorschuiven naar onze andere paramedici.	5

	Informative	1	Ja, dan geeft hij heel veel informatie.	1
	Must be in protocol	6	Ik ben het er helemaal mee eens, het zijn diagnostische vragenlijsten en je kunt er inderdaad wel naar kijken of je nog meer moet helpen en kan ik het zelf aan. Dus ik vind ook dat dat er in zou moeten, eerlijk gezegd.	1
Uroflow	Combining diagnostics	3	In je eentje heb je met de Uroflow volgens mij weer minder waarde dan met echografie. Wat wij bedoelen, je kan ook iemand in de maatbeker laten plassen en daarna natuurlijk een maat en residumeting nemen met de echo.	5
	Costs	4	Het is het gewoon financieel niet, en het staat gewoon niet in het beroepscompetentieprofiel.	1
	Diagnostically usable	2	En, maar dat vind ik wel. Voor de diagnostiek vind ik de Uroflow echt wel minder waarde dan de echo hoor.	2
	Informative pelvic floor activity	2	Nou, ik heb gewoon heel veel met de Uroflow gewerkt, dus voor mij gaf het wel heel veel informatie, ook over urineverlies. Maar ook over de flow en de bekkenbodem activiteit. Ik deed Uroflow met bekkenbodem activiteit.	1
	Less burdensome	1	En is het belastend voor de patiënt? Nee, het is weer minder belastend voor de patiënt.	2
	Not in protocol	1	Uroflowmetrie kan niet in het protocol.	1
	Requires space	3	Dat, dus je hebt ruimte nodig voor zo'n ding. Voor de echo heb je niet echt een ruimte nodig, voor de Uroflow heb je een aparte ruimte nodig.	1
Wexner	Alternatives	3	Ja, maar hij geeft in principe niet heel veel meer informatie als wanneer je een mictiedagboek en defecatiedagboek moet bijhouden.	1
	Pleasant questionnaire	1	Nee, ik vind het altijd over het algemeen wel een prettige lijst.	2
	Qol question	1	Nou, hij geeft nog wel als laatste vraag natuurlijk aan wat de impact is op je leven. Dat vind ik wel een verschil.	2
pPT	Competence profile	5	Maar officieel valt een residubepaling niet onder de competenties van de bekkenfysiotherapeut.	3
	Less insurance	1	Waarom gaan we naar het ziekenhuis? Want “ja, dat wordt tenminste allemaal betaald. Ik ben met 6 weken van mijn klachten af”. Ik verzin het allemaal maar.	3
	Relieve health care	3	Omdat we denken dat bekkenfysiotherapie veel meer kan bijdragen, juist ook in de	3

			eerste lijn waar ze het op het ogenblik zo fanatiek over hebben.	
	Shortage	1	Er zijn te weinig goed opgeleide bekkenfysiotherapeuten in Nederland en dat blijft nog even zo. Dat maakt het ook weer even extra ingewikkeld.	1
	Skill	10	Als je gaat kijken naar het effecten van “ja god, *naam* was zo'n aardig mens en ze heeft zo haar best gedaan, dus ik ga natuurlijk niet zeggen dat het eigenlijk helemaal niet zoveel geholpen heeft.”	3
	Working creatively	10	Maar persoonlijk zou ik zeggen: alles is beter dan niks, dus ik heb ook wel oude mensen gehad waarvan ik dacht, nou weet u? Meet dan even 's morgens als je wakker wordt met het plassen en dan weet ik in ieder geval een beetje wat je grootste capaciteit is als dat je grootste plas is, nou verzin, maar zo kun je of alleen maar aantallen laten turven. Dan heb je alleen niet meer een officiële mictie lijst en daarbij wijken wij denk ik allemaal als therapeut er wel eens vanaf. Omdat het nou eenmaal niet haalbaar is zoals je het graag zou willen.	3
Finances	Hindrance for purchasing tools	5	Nee, Ik denk dat de algemene tendens is dat we als bekkenfysiotherapeuten veel meer zouden kunnen als we de financiële middelen zouden krijgen om dat ook daadwerkelijk te doen.	3
	Determine protocol	6	Maar ik denk dat er wel in het protocol daar op de een of andere manier duidelijk moet worden aangegeven. Over ‘dit zouden we idealiter kunnen, maar vanwege de financiën en vanwege dit en dat, kunnen we dat niet hè?’ Dat geldt natuurlijk ook voor basisverzekeringen, aanvullende verzekeringen: welke keuzes maken mensen voor naar welke therapie ze willen gaan?	3
Internal exam	Burdensome for patient	12	Dit blijft bij mij bovenaan staan. Elk inwendig onderzoek is belastend voor een patiënt.	1
	Motivated deviation	9	Nee, of jij of de patiënt het als onwenselijk acht of retraumatiserend of, vul het maar in. Ja, dan doe je dat onderzoek niet doen en dan moet je op een andere manier aan je informatie zien te komen.	3
	Patient decides	2	Inwendig handelen, dus jij moet zorgen dat alle randvoorwaarden kloppen en dat je trauma's hebt uitgesloten en al het andere waarvan we weten dat je het dan niet moet gaan doen. En dan nog: als de patiënt nee zegt, is het ook klaar.	3
Questionnaires	Influenced by desirable behavior	2	Ik vind het sowieso bij vragenlijsten, is dat vaak lastig, omdat ik me altijd afvraag in hoeverre de patiënt wenselijk gedrag vertoont bij het invullen.	3

	Importance filling out solitarily	4	Maar om te beginnen, vragenlijsten die je door de patiënt separaat thuis of waar dan ook laat invullen zonder inmenging van de therapeut, dan wel de secretaresse, dan wel de verpleegkundige.	3
	Language and digital skill barrier	4	En ook het stukje, hoe noem je dat, taalvaardigheid hè? Of dat mensen het ook begrijpen wat ze in moeten vullen? Soms dan vatten ze dingen helemaal verkeerd op.	6
	Fill out prior	5	En, het is mijn voorkeur inderdaad ook dat je vragenlijsten van tevoren hebt, want dan kan je zelf ook als therapeut een beetje kijken wat er speelt.	1
	No questionnaire worrying	1	Nou, dat zegt meer over de bekkenfysiotherapie, ietwat zorgwekkend moet ik je eerlijk zeggen. Ik lach wel, maar eigenlijk vind ik dat heel zorgwekkend.	3
Patient	Laguage barrier	5	De taal. Ik heb een Oekraïense gehad en als ze het niet begrijpen, maar dat is de enige belemmering die ik kan bedenken.	5

Table 6: Inductive codes, subthemes and example quotes

Deductive coding theme	Subtheme	Total number of quotes	Example quote	Respondent number
3IQ	Noninvasive	0	-	-
	Short	0	-	-
Anamnesis	Anamnesis	3	Ik vraag me altijd af met dit soort lijsten die zeg maar een soort extra zijn op je anamnese, hele gesprekken wat je al gehad hebt, dat er dan die lijsten nog eens een keertje bij komen, of je hebt ze naar huis gestuurd en dat mensen echt denken van nou ja, ik vul maar wat in, dat is net zo goed als bij het eind van het verhaal.	3
Competence profile	Competence profile	7	De opleidingen die houden zich aan beroepscompetentieprofiel.	1
EMG	Predictive validity	0	-	-
	Reliability	0	-	-
	Treatment	1	Het is een behandelmethode, maar het is niet een diagnostiek.	2
IPSS	For men	2	Ja , daar ben ik het mee eens, maar ik denk dat ik persoonlijk als vrouwelijke patiënt het heel erg ga vinden als ik een prostaat vragenlijst moet gaan invullen.	1

	Internal consistency	1	Ze hebben hem een keer getest om zeg maar de betrouwbaarheid ervan te toetsen en op een heel ander onderwerp. En toen kwamen er toch wel verrassende dingen uit die eigenlijk niet zo geschikt zou zijn.	3
Micturition diaries	No uniform diary	3	Er zijn 100.000 verschillende mictie defecatie lijsten.	1
POPQ	Internal examination	3	Het is een inwendige handeling.	1
	Reliability	1	Ik bedoel, het kan natuurlijk wel zo zijn dat er wel een beetje dan verschil in zit tussen de mensen die het hebben ingevuld.	4
	Validity	0	-	-
PPE	Internal examination	-	-	-
	Standing vs. lying position	-	-	-
PRAFAB	Construct validity	0	-	-
	Internal consistency	0	-	-
	Treatment evaluation	1	De PRAFAB is ook niet ontwikkeld als een evaluatief meetinstrument, maar als een diagnostisch meetinstrument.	1
PSK	Diagnostic	3	Ja, maar je mag hem ook niet diagnostisch inzetten, want dit is geen diagnostisch instrument.	1
	Evaluative	3	Omdat dit namelijk een hele makkelijke en duidelijke vragenlijst is die wel evaluatief is, waar je wel iets kan gaan zeggen over de ontwikkeling van de klacht.	1
Rome IV	Diagnostically usable	2	Er zijn denk ik 20 verschillende lijstjes met Rome 4 criteria en voor ons van belang, is met name de defecatieproblematiek, dus de obstipatie, fecale incontinentie. Ja, ik vind dat hij er wel in zou moeten, want dat zijn echt diagnostische criteria.	1
	Validity	0	-	-
Ultrasound	Diagnostically usable	1	Het is voor de therapeut en voor de patiënten een ideaal instrument om daar mee diagnostiek te krijgen, waardoor je ook je patiënt gelijk inzicht geeft. Kijk, bij een inwendig onderzoek, kun jij vertellen wat je hebt gevonden. Maar die patiënt kijkt niet mee. Met echo diagnostiek zie je het direct, de patiënt ziet direct wat er aan de hand is.	2
	Not commonly used	1	Zolang het nog niet In de reguliere opleiding zit al helemaal niet en dat gaat pas in de reguliere opleiding als het allemaal wat beter	3

			betaalbaar wordt voor Iedereen. Dus tot die tijd zijn het lonesome cowboys in the dessert.	
Uroflowmetry	Diagnostically usable	2	Ik heb heel veel met Uroflow gewerkt, dus ik vind de Uroflow echt heel, heel goed in de diagnostiek.	1
	Measure urogynecological disorders	1	Nou, ik heb gewoon heel veel met de Uroflow gewerkt, dus voor mij gaf het wel heel veel informatie, ook over urineverlies. Maar ook over de flow en de bekkenbodem activiteit. Ik deed Uroflow met bekkenbodem activiteit.	1
	Residu determination	2	Maar in combinatie dan ook met echo, voor residu bepaling?	6
	Specificity	1	Ik vind dat heel erg knap dat zij dat er Sensitiviteit en responsiviteit over de Uroflow worden geroepen. Omdat het dat dus heel erg afhankelijk is wat je wil gaan meten.	1
	Validity	0	-	-
Wexner	Constipation	0	-	-
	Validity	0	-	-

Table 7: Deductive codes, subthemes and example quotes

Appendix D: Predictors general inclusion

Chi Square	Use	Fillable/ Performable/Operable	Applicable	Purpose	PPV	NPV	Effort	Speed	Interpretation	Purchase
X^2	69.41	7.78	16.05	37.32	99.05	79.66	84.93	182.68	60.84	18.24
df	1	2	2	2	2	2	2	2	2	2
p-value	$2.2e^{-16}$	0.0204	$3.27e^{-4}$	$7.86e^{-09}$	$< 2.2e^{-16}$	$< 2.2e^{-16}$	$< 2.2e^{-16}$	$< 2.2e^{-16}$	$6.14e^{-14}$	$1.10e^{-04}$

Table 8: Chi Square outcomes regarding significant indicators on diagnostic tools for inclusion in SEPPU

Linear models	Coefficients	Estimate	Std. Error	Z value	Pr(>|z|)
Use	Intercept	0.58	0.09	6.32	$2.71e^{-10}$***
	Use_{No}	-2.14	0.29	-7.37	$1.75e^{-13}$***
	Intercept	-0.26	0.21	-1.19	0.23

Fillable/ Performable/ Operable	Fillable2/Performable2/Operable2	0.39	0.43	0.92	0.36
	Fillable3/Performable3/Operable3	0.65	0.24	2.73	$6.33e^{-03}$ **
Applicable	Intercept	-0.53	0.23	-2.31	0.02 *
	Applicable2	0.67	0.38	1.75	0.08 .
	Applicable3	0.96	0.25	3.88	$1.03e^{-04}$
Purpose	Intercept	-1.31	0.43	-3.10	0.002 **
	Purpose2	0.25	0.56	0.44	0.66
	Purpose3	1.78	0.43	4.10	$4.27e^{-05}$ ***
PPV	Intercept	-1.12	0.21	-5.41	$6.16e^{-08}$ ***
	PPV2	0.51	0.32	1.58	0.12
	PPV3	2.00	0.23	8.56	$< 2e^{-16}$ ***
NPV	Intercept	-0.45	0.14	-3.13	$1.74e^{-03}$ **
	NPV2	0.5	0.25	0.19	0.85
	NPV3	1.55	0.20	7.92	$2.36e^{-15}$ ***
Effort	Intercept	-1.36	0.27	-4.99	$6.13e^{-07}$ ***
	Effort2	0.17	0.44	0.39	0.70
	Effort3	2.05	0.29	7.09	$1.34e^{-12}$ ***
Speed	Intercept	-1.78	0.24	-7.56	$3.92e^{-14}$ ***
	Speed2	1.20	0.34	3.48	$4.94e^{-04}$ ***
	Speed3	2.96	0.26	11.23	$< 2e^{-16}$ ***
	Intercept	-2.35	0.52	-4.50	$6.96e^{-06}$ ***

Interpretation	Interpretation2	1.52	0.65	2.35	0.019 *
	Interpretation3	2.88	0.53	5.42	$5.92e^{-08}$ ***
Purchase	Intercept	$-1.86e^{+01}$	$2.06e^{+03}$	-0.009	0.99
	Purchase2	$3.50e^{-11}$	$2.70e^{+03}$	0.00	1.00
	Purchase3	$1.85e^{+01}$	$2.06e^{+03}$	0.009	0.99

Table 9: linear models of significant indicators regarding inclusion in SEPPU, with significant codes 0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1

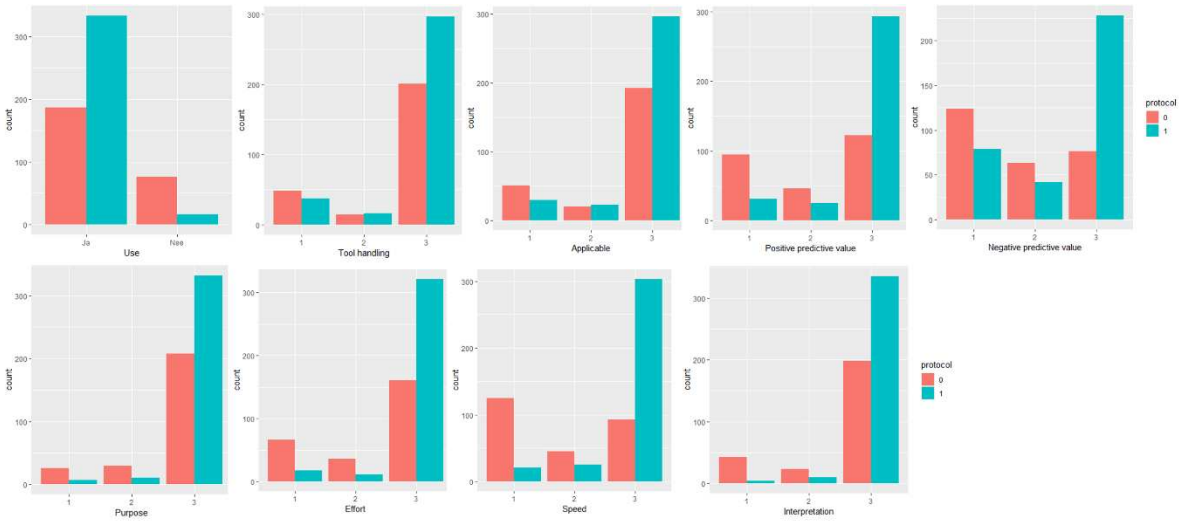

Image 2: Schematic representation of how indicators predict inclusion of diagnostic tools in SEPPU, where on the x-axis 1 indicates to not agree, 2 indicates neutral, and three indicate to agree, and where 0 indicates no inclusion in SEPPU and 1 indicates inclusion in SEPPU

Appendix E: Predictors tool specific

PRAFAB

PRAFAB	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Fillable N (%)	2 (2%)	1 (1%)	4 (4.1%)	3 (3%)	12 (12.4%)	40 (41.3%)	35 (36.2%)
Applicable N (%)	2 (2%)	2 (2%)	3 (3%)	3 (3%)	11 (11.4%)	49 (50.7%)	27 (27.9%)
Purpose N (%)	2 (2%)	3 (3%)	4 (4.1%)	8 (8.2%)	12 (12.4%)	50 (51.7%)	18 (18.6%)

Burden N (%)	0 (0%)	0 (0%)	6 (6.2%)	7 (7.2%)	6 (6.2%)	54 (55.7%)	24 (24.7%)
PPV N (%)	3 (3%)	5 (5.2%)	12 (12.4%)	6 (6.2%)	12 (12.4%)	41 (42.2%)	18 (18.6%)
NPV N (%)	9 (9.3%)	28 (28.8%)	18 (18.6%)	12 (12.4%)	16 (16.4%)	9 (9.3%)	5 (5.2%)
Effort N (%)	2 (2%)	7 (7.2%)	9 (9.3%)	14 (14.4%)	21 (21.6%)	34 (35.2)	10 (10.3%)
Speed N (%)	6 (6.2%)	15 (15.5%)	4 (4.1%)	10 (10.3%)	20 (20.6%)	37 (38.1%)	5 (5.2%)
Interpretation N (%)	0 (0%)	3 (3%)	7 (7.2%)	6 (6.2%)	12 (12.4%)	47 (48.5%)	22 (22.7%)
Want in protocol N(%)	1 (1%)	7 (7.2%)	8 (8.2%)	16 (16.5%)	14 (14.5%)	37 (38.2%)	14 (14.4%)

Table 10.1: Results of the questionnaires regarding the indicators on PRAFAB

Chi Square	Applicable	Burden	PPV	NPV	Speed	Interpretation
X^2	9.09	6.54	13.74	6.58	25.76	10.51
df	2	2	2	2	2	2
p-value	0.011	0.038	0.0010	0.037	$2.55e^{-06}$	0.0052

Table 10.2: Chi Square outcomes regarding significant indicators on PRAFAB

Models	Coefficients	Estimate	Std. Error	Z value	Pr(>|z|)
Applicable	Intercept	-1.946	1.069	-1.820	0.0687
	Applicable2	-14.620	1385.378	-0.011	0.9916
	Applicable3	2.227	1.091	2.041	0.0412*
PPV	Intercept	-1.5041	0.5528	-2721	0.006509**
	PVV2	1.2164	0.9428	1.290	0.196987
	PVV3	2.0464	0.6073	3.370	0.000753***
NPV	Intercept	-0.1054	0.2653	-0.397	0.6912
	NPV2	-0.5878	0.6086	-0.966	0.3341
	NPV3	1.0498	0.5184	2.025	0.0429*
Speed	Intercept	-1.6582	0.5455	-3.040	0.00237**
	Speed2	0.5596	0.8614	0.650	0.51593
	Speed3	2.5862	0.6162	4.197	2.7e-05***
Interpretation	Intercept	-2.1972	1.0540	-2.085	0.0371*

	Interpretation2	0.8109	1.5365	0.528	0.5977
	Interpretation3	2.5421	1.0776	2.359	0.0183*

Table 10.3: Linear models of significant indicators regarding inclusion in SEPPU ,with significant codes 0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1

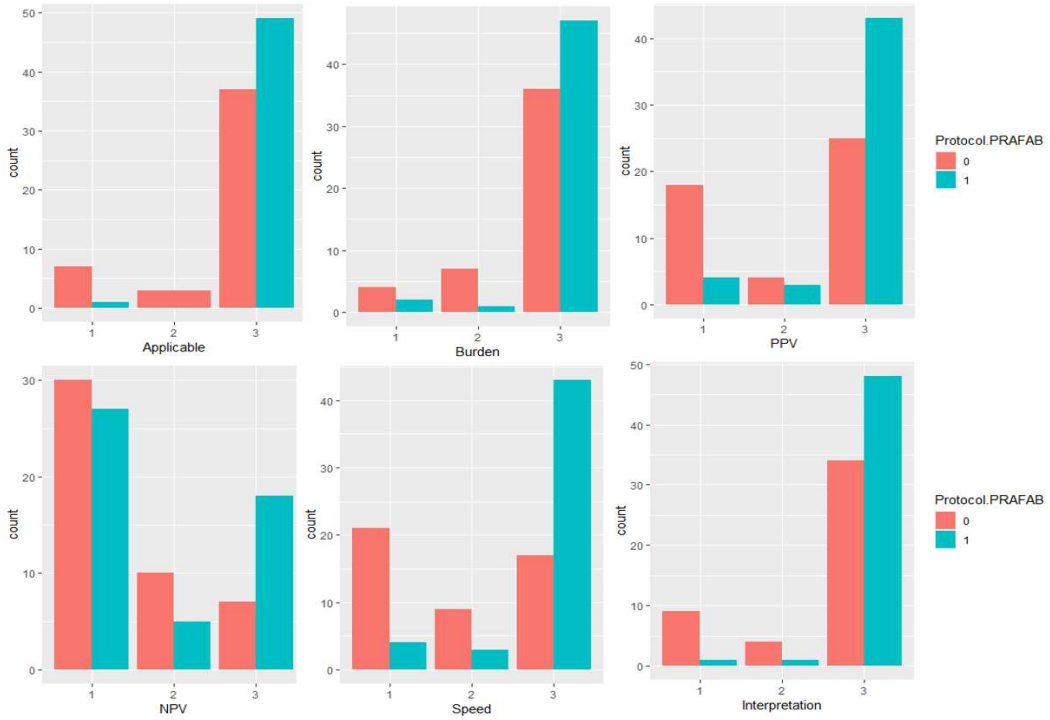

Image 3: schematic representation of how indicators predict inclusion of PRAFAB in SEPPU, where on the x-axis 1 indicates to not agree, 2 indicates neutral, and three indicate to agree, and where 0 indicates no inclusion in SEPPU and 1 indicates inclusion in SEPPU

PSK

PSK	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Fillable N (%)	0 (0%)	1 (1.3%)	3 (3.9%)	2 (2.6%)	11 (14.3%)	41 (53.2%)	19 (24.7%)
Applicable N (%)	2 (2.6%)	1 (1.3%)	4 (5.2%)	2 (2.6%)	6 (7.8%)	44 (57.1%)	18 (23.4%)
Purpose N (%)	1 (1.3%)	0 (0%)	4 (5.2%)	3 (3.9%)	13 (16.9%)	41 (53.2%)	15 (19.5%)
Burden N (%)	0 (0%)	0 (0%)	2 (2.6%)	3 (3.9%)	8 (10.4%)	50 (65.0%)	14 (18.2%)
PPV N (%)	11 (14.3%)	12 (15.6%)	1 (1.3%)	17 (22.1%)	8 (10.4%)	20 (26.0%)	8 (10.4%)
NPV N (%)	11 (14.3%)	14 (18.2%)	4 (5.2%)	19 (24.7%)	10 (13.0%)	14 (18.2%)	5 (6.5%)

Effort N (%)	5 (6.5%)	6 (7.8%)	4 (5.2%)	4 (5.2%)	14 (18.2%)	29 (37.7%)	15 (19.5%)
Speed N (%)	9 (11.7%)	14 (18.2%)	4 (5.2%)	13 (16.9%)	10 (13.0%)	21 (27.3%)	6 (7.8%)
Interpretation N (%)	3 (3.9%)	3 (3.9%)	0 (0%)	5 (6.5%)	13 (16.9%)	39 (50.6%)	14 (18.2%)
Want in protocol N(%)	7 (9.1%)	5 (6.5%)	1 (1.3%)	19 (24.7%)	9 (11.7%)	27 (35.1%)	9 (11.7%)

Table 11.1: Results of the questionnaires regarding the indicators on PSK

Chi Square	Use	PPV	NPV	Effort	Speed	Interpretation
X^2	5.1689	26.181	25.297	13.523	34.219	11.268
df	1	2	2	2	2	2
p-value	0.02299	$2.065e^{-06}$	$3.212e^{-06}$	0.001157	$3.71e^{-08}$	0.003574

Table 11.2: Chi Square outcomes regarding significant indicators on PSK

Models	Coefficients	Estimate	Std. Error	Z value	Pr(>|z|)
Use	Intercept	0.09237	0.24833	0.372	0.7099
	UseNo	-1.70181	0.81342	-2.092	0.0364*
PPV	Intercept	-1.3350	0.5026	-2.656	0.00791**
	PPV2	-0.2054	0.8108	-0.253	0.79997
	PPV3	2.5878	0.6429	4.025	$5.7e^{-05}$**
NPV	Intercept	-0.7985	0.4014	-1.989	0.046660*
	NPV2	-0.8755	0.7463	-1.173	0.240756
	NPV3	2.3671	0.6346	3.730	0.000192***
Effort	Intercept	-1.8718	0.7596	-2.464	0.01373*
	Effort2	-14.6943	119.7726	-0.012	0.99023
	Effort3	2.2201	0.8050	2.758	0.00582**
Speed	Intercept	-2.0794	0.6124	-3.396	0.000684***
	Speed2	0.8755	0.8991	0.974	0.330177
	Speed3	3.5347	0.7424	4.761	$1.92e^{-06}$***

Table 11.3: Linear models of significant indicators regarding inclusion in SEPPU ,with significant codes 0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1

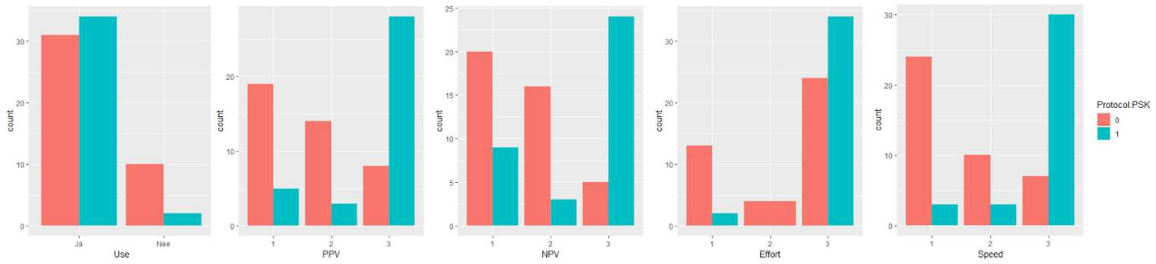

Image 4: schematic representation of how indicators predict inclusion of PSK in SEPPU, where on the x-axis 1 indicates to not agree, 2 indicates neutral, and three indicate to agree, and where 0 indicates no inclusion in SEPPU and 1 indicates inclusion in SEPPU

3IQ

3IQ	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Fillable N (%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	25 (64.1%)	14 (35.9%)
Applicable N (%)	0 (0%)	1 (2.6%)	0 (0%)	1 (2.6%)	0 (0%)	22 (56.4%)	15 (38.5%)
Purpose N (%)	0 (0%)	0 (0%)	0 (0%)	6 (15.4%)	1 (2.6%)	20 (51.3%)	12 (30.8%)
Burden N (%)	0 (0%)	0 (0%)	0 (0%)	3 (7.7%)	1 (2.6%)	22 (56.4%)	13 (33.3%)
PPV N (%)	0 (0%)	1 (2.6%)	2 (5.1%)	9 (23.1%)	2 (5.1%)	17 (43.6%)	8 (20.5%)
NPV N (%)	0 (0%)	2 (5.1%)	1 (2.6%)	13 (33.3%)	5 (12.8%)	14 (35.9%)	4 (10.3%)
Effort N (%)	0 (0%)	2 (5.1%)	3 (7.7%)	1 (2.6%)	7 (18.0%)	16 (41.0%)	10 (25.6%)
Speed N (%)	0 (0%)	2 (5.1%)	2 (5.1%)	0 (0%)	7 (18.0%)	18 (46.2%)	10 (25.6%)
Interpretation N (%)	0 (0%)	0 (0%)	1 (2.6%)	0 (0%)	4 (10.3%)	23 (59.0%)	11 (28.2%)
Want in protocol N(%)	0 (0%)	1 (2.6%)	2 (5.1%)	10 (25.6%)	4 (10.3%)	14 (35.9%)	8 (20.5%)

Table 12.1: Results of the questionnaires regarding the indicators on 3IQ

Chi Square	Purpose	Burden
X^2	9.1765	4.2059
df	1	1
p-value	0.002451	0.04028

Table 12.2: Chi Square outcomes regarding significant indicators on 3IQ

IPSS

IPSS	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Fillable N (%)	0 (0%)	0 (0%)	4 (13.8%)	1 (3.4%)	8 (27.6%)	12 (41.4%)	4 (13.8%)
Applicable N (%)	0 (0%)	0 (0%)	5 (17.2%)	3 (10.3%)	5 (17.2%)	13 (44.8%)	3 (10.3%)
Purpose N (%)	0 (0%)	0 (0%)	4 (13.8%)	2 (6.9%)	9 (31.0%)	12 (41.4%)	2 (6.9%)
Burden N (%)	0 (0%)	1 (3.4%)	3 (10.3%)	4 (13.8%)	5 (17.2%)	12 (41.4%)	4 (13.8%)
PPV	3 (10.3%)	8 (27.6%)	2 (6.9%)	6 (20.7%)	4 (13.8%)	4 (13.8%)	2 (6.9%)

N (%)							
NPV N (%)	5 (17.2%)	8 (27.6%)	2 (6.9%)	6 (20.7%)	3 (10.3%)	4 (13.8%)	1 (3.4%)
Effort N (%)	1 (3.4%)	2 (6.9%)	2 (6.9%)	4 (13.8%)	5 (17.2%)	12 (41.4%)	3 (10.3%)
Speed N (%)	3 (10.3%)	4 (13.8%)	4 (13.8%)	4 (13.8%)	6 (20.7%)	6 (20.7%)	2 (6.9%)
Interpretation N (%)	0 (0%)	1 (3.4%)	2 (6.9%)	0 (0%)	7 (24.1%)	14 (48.3%)	5 (17.2%)
Want in protocol N(%)	3 (10.3%)	4 (13.8%)	2 (6.9%)	6 (20.7%)	7 (24.1%)	4 (13.8%)	3 (10.3%)

Table 13.1: Results of the questionnaires regarding the indicators on IPSS

Chi Square	Speed
X^2	9.8864
df	2
p-value	0.007132

Table 13.2: Chi Square outcomes regarding significant indicator on IPSS

Wexner

Wexner	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Fillable N (%)	0 (0%)	2 (7.7%)	2 (7.7%)	0 (0%)	2 (7.7%)	14 (53.8%)	6 (23.1%)
Applicable N (%)	0 (0%)	1 (3.8%)	1 (3.8%)	0 (0%)	5 (19.2%)	13 (50%)	6 (23.1%)
Purpose N (%)	0 (0%)	0 (0%)	0 (0%)	1 (3.8%)	4 (15.4%)	15 (57.7%)	6 (23.1%)
Burden N (%)	0 (0%)	1 (3.8%)	2 (7.7%)	1 (3.8%)	6 (23.1%)	12 (46.2%)	4 (15.4%)
PPV N (%)	3 (11.5%)	7 (26.9%)	5 (19.2%)	6 (23.1%)	1 (3.8%)	3 (11.5%)	1 (3.8%)
NPV N (%)	0 (0%)	7 (26.9%)	5 (19.2%)	8 (30.8%)	1 (3.8%)	2 (7.7%)	3 (11.5%)
Effort N (%)	3 (11.5%)	1 (3.8%)	2 (7.7%)	4 (15.4%)	3 (11.5%)	11 (42.3%)	2 (7.7%)
Speed N (%)	4 (15.4%)	6 (23.1%)	4 (15.4%)	4 (15.4%)	2 (7.7%)	4 (15.4%)	2 (7.7%)
Interpretation N (%)	2 (7.7%)	0 (0%)	1 (3.8%)	1 (3.8%)	7 (26.9%)	8 (30.8%)	7 (26.9%)
Want in protocol N(%)	3 (11.5%)	5 (19.2%)	4 (15.4%)	6 (23.1%)	1 (3.8%)	3 (11.5%)	4 (15.4%)

Table 14.1: Results of the questionnaires regarding the indicators on Wexner

Chi Square	PPV	NPV	Speed
X^2	17.19	9.5659	21.553
df	2	2	2
p-value	0.000185	0.008371	2.0.89e-05

Table 14.2: Chi Square outcomes regarding significant indicators on Wexner

Models	Coefficients	Estimate	Std. Error	Z value	Pr(>|z|)

PPV	Intercept	-1.8718	0.7596	-2.464	0.0137*
	PPV2	-18.6943	7238.3932	-0.003	0.9979
	PPV3	22.4379	7929.2625	0.003	0.9977
NPV	Intercept	-1.8718	0.7596	-2.464	0.0137*
	NPV2	0.7732	1.1152	0.693	0.4881
	NPV3	20.4379	3765.8472	0.005	0.9957

Table 14.3: Linear models of significant indicators regarding inclusion in SEPPU ,with significant codes 0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1

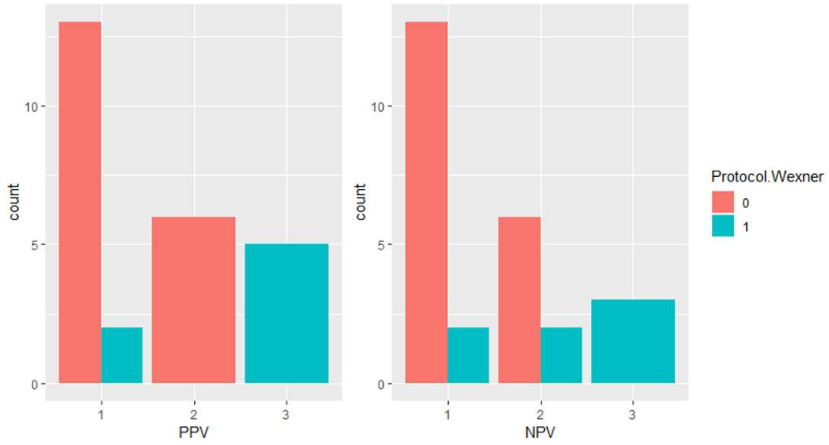

Image 5: schematic representation of how indicators predict inclusion of Wexner in SEPPU, where on the x-axis 1 indicates to not agree, 2 indicates neutral, and three indicate to agree, and where 0 indicates no inclusion in SEPPU and 1 indicates inclusion in SEPPU

Rome IV

Rome IV	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Fillable N (%)	0 (0%)	0 (0%)	0 (0%)	3 (20%)	1 (6.7%)	7 (46.7%)	4 (26.7%)
Applicable N (%)	0 (0%)	0 (0%)	0 (0%)	1 (6.7%)	2 (13.3%)	8 (53.3%)	4 (26.7%)
Purpose N (%)	0 (0%)	0 (0%)	0 (0%)	4 (26.7%)	2 (13.3%)	5 (33.3%)	4 (26.7%)
Burden N (%)	0 (0%)	0 (0%)	0 (0%)	3 (20%)	1 (6.7%)	7 (46.7%)	4 (26.7%)
PPV N (%)	4 (26.7%)	6 (40%)	1 (6.7%)	4 (26.7%)	0 (0%)	0 (0%)	0 (0%)
NPV N (%)	3 (20%)	6 (40%)	2 (13.3%)	4 (26.7%)	0 (0%)	0 (0%)	0 (0%)
Effort N (%)	0 (0%)	0 (0%)	0 (0%)	1 (6.7%)	4 (26.7%)	6 (40%)	4 (26.7%)
Speed N (%)	2 (13.3%)	7 (46.7%)	0 (0%)	1 (6.7%)	2 (13.3%)	1 (6.7%)	2 (13.3%)
Interpretation N (%)	0 (0%)	0 (0%)	0 (0%)	1 (6.7%)	0 (0%)	10 (66.7%)	4 (26.7%)
Want in protocol N(%)	2 (13.3%)	6 (40%)	1 (6.7%)	2 (13.3%)	1 (6.7%)	1 (6.7%)	2 (13.3%)

Table 15.1: Results of the questionnaires regarding the indicators on Rome IV

Micturition diaries

Micturition diares	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Fillable N (%)	3 (3.9%)	11 (14.3%)	18 (23.4%)	8 10.4(%)	26 (33.8%)	11 (14.3%)	0 (0%)
Applicable N (%)	8 (%)	14 (18.2%)	7 (9.1%)	12 (15.6%)	12 (15.6%)	16 (20.8%)	8 (10.4%)
Purpose N (%)	0 (0%)	3 (3.9%)	1 (1.3%)	3 (3.9%)	8 (10.4%)	50 (64.9%)	12 (15.6%)
Burden N (%)	10 (13.0%)	26 (33.8%)	24 (31.2%)	12 (15.6%)	4 (5.2%)	1 (1.3%)	0 (0%)
PPV N (%)	5 (6.5%)	5 (6.5%)	2 (3.6%)	4 (5.2%)	12 (15.6%)	37 (48.1%)	12 (15.6%)
NPV N (%)	5 (6.5%)	8 (10.4%)	5 (6.5%)	11 (14.3%)	16 (20.8%)	27 (35.1%)	5 (6.5%)
Effort N (%)	0 (0%)	1 (1.3%)	4 (5.2%)	5 (6.5%)	10 (13.0%)	42 (54.5%)	15 (19.5%)
Speed N (%)	1 (1.3%)	8 (10.4%)	7 (9.1%)	13 (16.9%)	11 (14.3%)	25 (32.5%)	12 (15.6%)
Interpretation N (%)	1 (1.3%)	1 (1.3%)	2 (2.6%)	4 (5.2%)	14 (18.2%)	46 (59.5%)	9 (11.7%)
Want in protocol N(%)	1 (1.3%)	1 (1.3%)	2 (2.6%)	6 7.8(%)	7 (9.1%)	37 (48.1%)	23 (29.9%)

Table 16.1: Results of the questionnaires regarding the indicators on micturition diaries

Chi Square	PPV	Effort	Speed
X^2	11.09	11.45	14.66
df	2	2	2
p-value	$3.91e^{-03}$	$3.27e^{-03}$	$6.55e^{-04}$

Table 16.2: Chi Square outcomes regarding significant indicators on micturition diaries

Models	Coefficients	Estimate	Std. Error	Z value	Pr(>|z|)
PPV	Intercept	-0.34	0.59	-0.58	0.57
	PPV2	1.44	1.30	1.11	0.27
	PPV3	2.09	0.69	3.04	$2.37e^{-03}$ **
Speed	Intercept	-0.25	0.50	-0.50	0.62
	Speed2	1.46	0.83	1.76	0.08

	Speed3	2.40	0.69	3.48	5.04e-04 ***

Table 16.3: Linear models of significant indicators regarding inclusion in SEPPU ,with significant codes 0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1

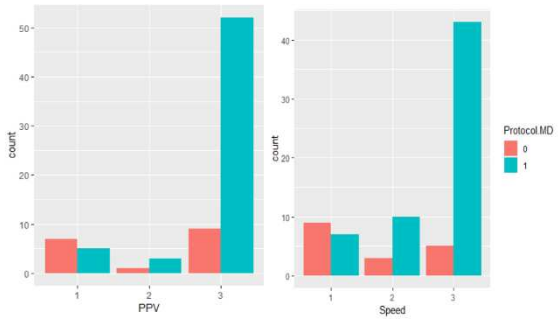

Image 6: schematic representation of how indicators predict inclusion of micturition diaries in SEPPU, where on the x-axis 1 indicates to not agree, 2 indicates neutral, and three indicate to agree, and where 0 indicates no inclusion in SEPPU and 1 indicates inclusion in SEPPU

POPQ

POPQ	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Performable N (%)	0 (%)	6 (8.6%)	7 (10%)	6 (8.6%)	19 (27.1%)	26 (37.1%)	6 (8.6%)
Applicable N (%)	0 (%)	2 (2.9%)	4 (5.7%)	9 (12.9%)	12 (17.1%)	33 (47.1%)	10 (14.3%)
Purpose N (%)	0 (%)	3 (4.3%)	3 (4.3%)	4 (5.7%)	8 (11.4%)	41 (58.6%)	11 (15.7%)
Burden N (%)	0 (%)	10 (14.3%)	20 (28.6%)	15 (21.4%)	17 (24.3%)	6 (8.6%)	2 (2.9%)
PPV N (%)	0 (%)	0 (%)	1 (1.4%)	0 (%)	7 (10%)	33 (47.1%)	29 (41.4%)
NPV N (%)	0 (%)	3 (4.3%)	6 (8.6%)	0 (%)	15 (21.4%)	31 (44.3%)	15 (21.4%)
Effort N (%)	0 (%)	2 (2.9%)	2 (2.9%)	3 (4.3%)	8 (11.4%)	38 (54.3%)	17 (24.3%)
Speed N (%)	0 (%)	3 (4.3%)	0 (%)	3 (4.3%)	9 (12.9%)	38 (54.3%)	17 (24.3%)
Interpretation N (%)	0 (%)	3 (4.3%)	1 (1.4%)	3 (4.3%)	13 (18.6%)	38 (54.3%)	12 (17.1%)
Want in protocol N(%)	0 (%)	2 (2.9%)	1 (1.4%)	3 (4.3%)	5 (7.1%)	30 (42.9%)	29 41.4%)

Table 17.1: Results of the questionnaires regarding indicators on POPQ

Chi Square	Use	Performability	Applicability	Purpose	Burden
X^2	22.755	6.4279	13.87	17.779	8.1397
df	1	2	2	2	2
p-value	1.84e-06	0.0402	0.0009731	0.0001379	0.01708
Chi square	PVV	NPV	Effort	Speed	Interpretation
X^2	5.4414	6.4363	23.98	17.897	12.326
df	1	1	2	2	2
p-value	0.01967	0.01118	6.204e-06	0.00013	0.002106

Table 17.2: Chi Square outcomes regarding significant indicators on POPQ

Models	Coefficients	Estimate	Std. Error	Z value	Pr(>|z|)
Use	Intercept	2.1316	0.3998	5.332	9.7e-08***
	UseNo	-19.6977	1978.0902	-0.010	0.992
Performability	Intercept	0.4700	0.5701	0.824	0.410
	Performability2	1.1394	1.2349	0.923	0.356
	Performability3	1.7492	0.7394	2.366	0.018*
Applicability	Intercept	-0.6931	0.8660	-0.800	0.42349
	Applicability2	1.9459	1.1802	1.649	0.09919
	Applicability3	2.9957	0.9849	3.042	0.00235**
Purpose	Intercept	-0.6931	0.8660	-0.800	0.42349
	Purpose2	0.6931	1.3229	0.524	0.60030
	Purpose3	3.0910	0.9840	3.141	0.00168**
Burden	Intercept	0.8473	0.3984	2.127	0.0334*
	Burden2	1.7918	1.1091	1.615	0.1062
	Burden3	2.3308	1.0954	2.128	0.0334*
NPV	Intercept	0.2231	0.6708	0.333	0.7394
	NPV3	1.8199	0.7819	2.328	0.0199*
Interpretation	Intercept	-1.099	1.155	-0.951	0.34139
	Interpretation2	1.792	1.683	1.064	0.28712
	Interpretation3	3.178	1.222	2.600	0.00932**

Table 15.7: Linear models of significant indicators regarding inclusion in SEPPU ,with significant codes 0 ‘***’ 0.001 ‘**’ 0.01 ‘*’ 0.05 ‘.’ 0.1 ‘ ’ 1

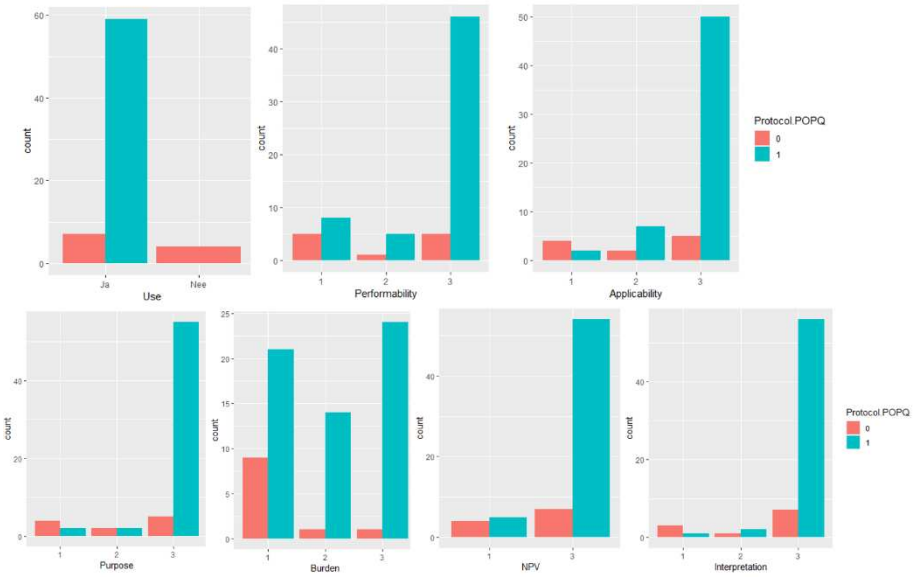

Image 7: schematic representation of how indicators predict inclusion of POPQ in SEPPU, where on the x-axis 1 indicates to not agree, 2 indicates neutral, and three indicate to agree, and where 0 indicates no inclusion in SEPPU and 1 indicates inclusion in SEPPU

PPE

PPE	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Performable N (%)	1 (1.4%)	2 (2.8%)	1 (1.4%)	2 (2.8%)	10 (13.5%)	41 (55.4%)	15 (20.3%)
Applicable N (%)	0 (0%)	4 (5.4%)	0 (0%)	4 (5.4%)	12 (16.2%)	34 (45.9%)	18 (24.3%)
Purpose N (%)	0 (0%)	0 (0%)	0 (0%)	4 (5.4%)	4 (5.4%)	46 (62.2%)	18 (24.3%)
Burden N (%)	1 (1.4%)	11 (14.9%)	17 (23.0%)	17 (23.0%)	19 (25.7%)	6 (8.1%)	1 (1.4%)
PPV N (%)	1 (1.4%)	3 (4.1%)	2 (2.8%)	7 (9.5%)	8 (10.8%)	32 (43.2%)	19 (25.7%)
NPV N (%)	1 (1.4%)	4 (5.4%)	7 (9.5%)	13 (17.6%)	11 (14.9%)	24 (32.4%)	12 (16.2%)
Effort N (%)	0 (0%)	2 (2.8%)	0 (0%)	3 (4.1%)	4 (5.4%)	42 (56.8%)	21 (28.4%)
Speed N (%)	0 (0%)	2 (2.8%)	2 (2.8%)	5 (6.8%)	7 (9.5%)	36 (48.6%)	20 (27.0%)
Interpretation N (%)	0 (0%)	1 (1.4%)	3 (4.1%)	4 (5.4%)	11 (14.9%)	37 (50.0%)	16 (21.6%)
Want in protocol N(%)	0 (0%)	0 (0%)	3 (4.1%)	2 (2.8%)	2 (2.8%)	27 (36.5%)	38 (51.4%)

Table 18.1: Results of the questionnaires regarding indicators on PPE

Chi Square	Performability	Applicability	PPV	NPV	Effort	Speed	Interpretation
X^2	7.9552	20.73	12.426	9.2834	21.552	21.788	22.332
df	2	2	2	2	2	2	2
p-value	0.01873	3.152e-05	0.002003	0.009641	2.09e-05	1.875e-05	1.415e-05

Table 18.2: Chi Square outcomes regarding significant indicators on PPE

Models	Coefficients	Estimate	Std. Error	Z value	Pr(>|z|)
Performability	Intercept	2.156e-15	1000e+00	0.000	1.0000
	Performanility2	1.757e+01	2.797e+03	0.006	0.9950
	Performability3	2.501e+00	1.103e+00	2.268	0.0233*
Applicability	Intercept	-1.099	1.155	-0.951	0.34139
	Applicability2	18.665	1978.091	0.009	0.99247
	Applicability3	3.807	1.265	3.009	0.00262**
PVV	Intercept	-7538e-15	8165e-01	0.000	1.0000
	PPV2	1.857e+01	2.465e+03	0.008	0.99399
	PPV3	2.621e+00	9.669e-01	2.711	0.00671**
NPV	Intercept	0.6931	0.6124	1.132	0.2577
	NPV2	1.7918	1.2076	1.484	0.1379
	NPV3	2.4204	0.9471	2.555	0.0106*
Speed	Intercept	-1.099	1.155	-0.951	0.3414

	Speed2	2.485	1.607	1.546	0.1221
	Speed3	4.094	1.297	3.156	0.0016**
Interpretation	Intercept	-1.099	1.155	-0.951	0.34139
	Interpretation2	2.197	1.633	1.346	0.17846
	Interpretation3	4.111	1.297	3.169	0.00153**

Table 18.3: Linear models of significant indicators regarding inclusion in SEPPU ,with significant codes 0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1

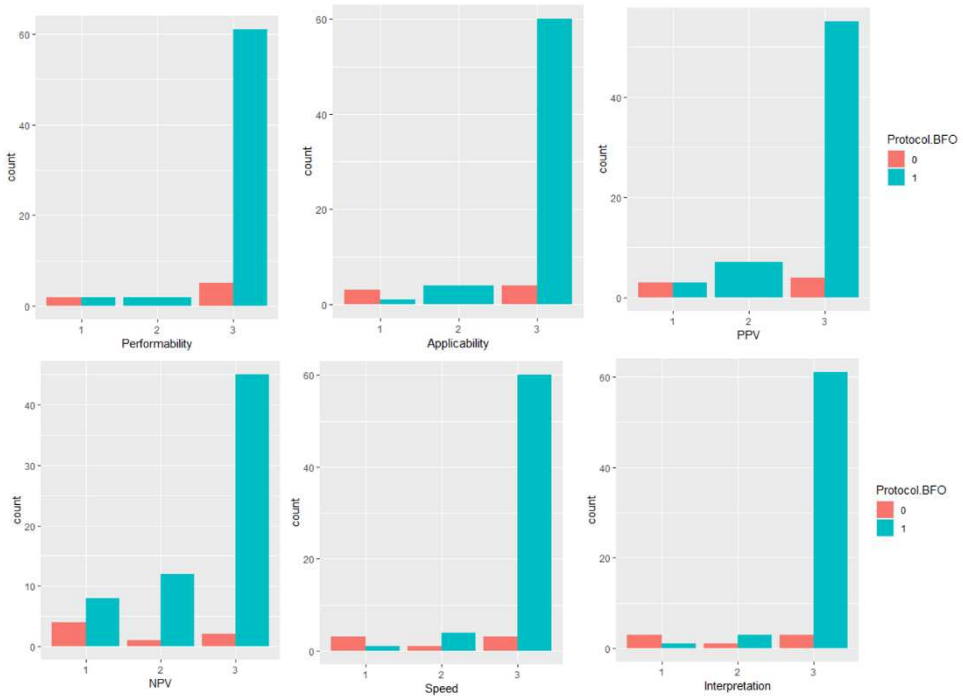

Image 8: schematic representation of how indicators predict inclusion of PPE in SEPPU, where on the x-axis 1 indicates to not agree, 2 indicates neutral, and three indicate to agree, and where 0 indicates no inclusion in SEPPU and 1 indicates inclusion in SEPPU

EMG

EMG	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Operable N (%)	1 (1.5%)	5 (7.4%)	6 (8.8%)	3 (4.4%)	16 (23.5%)	28 (41.2%)	9 (13.2%)
Applicable N (%)	3 (4.4%)	5 (7.4%)	8 (11.8%)	4 (5.9%)	17 (25%)	27 (39.7%)	4 (5.9%)
Purpose N (%)	1 (1.5%)	2 (2.9%)	1 (1.5%)	2 (2.9%)	12 (17.6)	40 (58.8%)	10 (14.7%)
Burden N (%)	5 (7.4%)	13 (19.1%)	16 (23.5%)	15 (22.1%)	13 (19.1%)	4 (5.9%)	2 (2.9%)
PPV N (%)	3 (4.4%)	4 (5.9%)	5 (7.4%)	4 (5.9%)	14 (20.6%)	29 (42.6%)	9 (13.2%)
NPV N (%)	3 (4.4%)	6 (8.8%)	13 (19.1%)	10 (14.7%)	10 (14.7%)	23 (33.8%)	3 (4.4%)
Effort N (%)	2 (2.9%)	5 (7.4%)	10 (14.7%)	5 (7.4%)	10 (14.7%)	28 (41.2%)	8 (11.8%)
Speed N (%)	5 (7.4%)	10 (14.7%)	7 (10.3%)	10 (14.7%)	13 (19.1%)	18 (26.5%)	5 (7.4%)
Interpretation N (%)	2 (2.9%)	2 (2.9%)	6 (8.8%)	6 (8.8%)	16 (23.5%)	30 (44.1%)	6 (8.8%)
Purchase	2 (2.9%)	3 (4.4%)	3 (4.4%)	9 (13.2%)	8 (11.8%)	29 (42.6%)	14 (20.6%)

N (%)							
Want in protocol N(%)	4 (5.9%)	6 (8.8%)	7 (10.3%)	20 (29.4%)	9 (13.2%)	15 (22.1%)	7 (10.3%)

Table 19.1: Results of the questionnaires regarding indicators on EMG

Chi Square	Use	NPV	Effort	Speed	Interpretation	Purchase
X^2	10.568	7.8554	15.554	11.259	6.9899	10.841
df	1	2	2	2	2	2
p-value	0.00115	0.01969	0.0004193	0.00359	0.03035	0.004426

Table 19.2: Chi Square outcomes regarding significant indicators on EMG

Models	Coefficients	Estimate	Std. Error	Z value	Pr(>|z|)
NPV	Intercept	-1.8458	0.6213	-2.971	0.00297**
	NPV2	0.4595	1.0055	0.457	0.64765
	NPV3	1.7346	0.7053	2.459	0.01391*
Speed	Intercept	-2.3026	0.7415	-3.105	0.00190**
	Speed2	0.9163	1.8039	0.845	0.39789
	Speed3	2.3026	0.8129	2.832	0.00462**

Table 19.3: Linear models of significant indicators regarding inclusion in SEPPU ,with significant codes 0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1

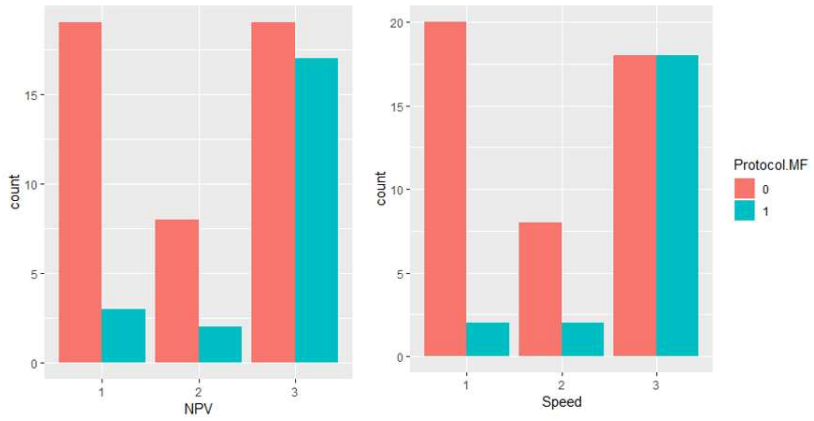

Image 9: schematic representation of how indicators predict inclusion of EMG in SEPPU, where on the x-axis 1 indicates to not agree, 2 indicates neutral, and three indicate to agree, and where 0 indicates no inclusion in SEPPU and 1 indicates inclusion in SEPPU

Ultrasound

Ultrasound	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Operable N (%)	0 (0%)	1 (4.2%)	2 (8.3%)	3 (12.5%)	7 (29.2%)	7 (29.2%)	4 (16.7%)
Applicable N (%)	0 (0%)	0 (0%)	2 (8.3%)	2 (8.3%)	3 (12.5%)	12 (50%)	5 (20.8%)

Learning N (%)	0 (0%)	2 (8.3%)	5 (20.8%)	5 (20.8%)	4 (16.7%)	7 (29.2%)	1 (4.2%)
Purpose N (%)	0 (0%)	0 (0%)	0 (0%)	1 (4.2%)	3 (12.5%)	13 (54.2%)	7 (29.2%)
Burden N (%)	0 (0%)	1 (4.2%)	1 (4.2%)	1 (4.2%)	4 (16.7%)	12 (50%)	5 (20.8%)
PPV N (%)	2 (8.3%)	1 (4.2%)	1 (4.2%)	2 (8.3%)	6 (25%)	10 (41.7%)	2 (8.3%)
NPV N (%)	2 (8.3%)	0 (0%)	4 (16.7%)	3 (12.5%)	6 (25%)	6 (25%)	3 (12.5%)
Effort N (%)	0 (0%)	1 (4.2%)	3 (12.5%)	1 (4.2%)	4 (16.7%)	10 (41.7%)	5 (20.8%)
Speed N (%)	0 (0%)	0 (0%)	2 (8.3%)	5 (20.8%)	3 (12.5%)	9 (37.5%)	5 (20.8%)
Interpretation N (%)	0 (0%)	1 (4.2%)	0 (0%)	4 (16.7%)	7 (29.2%)	9 (37.5%)	3 (12.5%)
Purchase N (%)	1 (4.2%)	0 (0%)	0 (0%)	4 (16.7%)	1 (4.2%)	11 (45.8%)	7 (29.2%)
Want in protocol N(%)	1 (4.2%)	2 (8.3%)	2 (8.3%)	2 (8.3%)	4 (16.7%)	8 (33.3%)	5 (20.8%)

Table 20.1: Results of the questionnaires regarding indicators on ultrasound

Chi Square	Use	Interpretation	Purchase
X^2	9.4545	7.4641	7.4641
df	1	2	2
p-value	0.002106	0.02394	0.02394

Table 20.2: Chi square outcomes regarding significant indicators on ultrasound

Uroflowmetry

Uroflowmetry	Strongly disagree	Disagree	Slightly disagree	Nor disagree nor agree	Slightly agree	Agree	Strongly agree
Operatable N (%)	0 (0%)	1 (5.6%)	0 (0%)	0 (0%)	7 (38.9%)	9 (50%)	3 (16.7%)
Applicable N (%)	0 (0%)	0 (0%)	0 (0%)	3 (16.7%)	5 (27.8%)	9 (50%)	1 (5.6%)
Purpose N (%)	0 (0%)	0 (0%)	1 (5.6%)	1 (5.6%)	2 (11%)	12 (66.7%)	2 (11%)
Burden N (%)	0 (0%)	0 (0%)	3 (16.7%)	4 (22.2%)	6 (33.3%)	5 (27.8%)	0 (0%)
PPV N (%)	0 (0%)	2 (11%)	1 (5.6%)	5 (27.8%)	1 (5.6%)	5 (27.8%)	4 (22.2%)
NPV N (%)	1 (5.6%)	3 (16.7%)	2 (11%)	3 (16.7%)	1 (5.6%)	7 (38.9%)	1 (5.6%)
Effort N (%)	1 (5.6%)	0 (0%)	1 (5.6%)	1 (5.6%)	4 (22.2%)	8 (44.4%)	3 (16.7%)
Speed N (%)	2 (11%)	4 (22.2%)	3 (16.7%)	0 (0%)	1 (5.6%)	7 (38.9%)	1 (5.6%)
Interpretation N (%)	0 (0%)	0 (0%)	1 (5.6%)	0 (0%)	6 (33.3%)	10 (55.6%)	1 (5.6%)
Purchase N (%)	0 (0%)	0 (0%)	1 (5.6%)	1 (5.6%)	3 (16.7%)	11 (61.1%)	2 (11%)
Want in protocol N(%)	1 (5.6%)	2 (11%)	3 (16.7%)	4 (22.2%)	2 (11%)	5 (27.8%)	1 (5.6%)

Table 21.1: Results of the questionnaires regarding indicators on uroflowmetry

Chi Square	Use
X^2	4
df	1

p-value	0.0455

Table 21.2: Chi Square outcomes regarding significant indicators on uroflowmetry