Comment 1: In figure 1 you have a high level of heterogeneity based on I^2 done with as many studies as you found for analysis. For example there were not enough studies but this is often done anyway and is frequently different than O'Reilly?

Comment 2: Patient care.

Comment 3: The publication only cited two to five cases under the title "Wagner' s classification and its potential as a quality of care through exploratory study.

Comment 4: If the wound is a Grade 1, it means the wound is smaller and heals in 30 days. So, say the wound is 99% smaller, but not completely healed in 30 days, or whatever. Your question states, "...that has not diminished the case for using HBO in diabetic foot ulcers." That sentence is directed at raising the quality of evidence through improved study protocols. These all contributed to lowered ratings because of the limitations. This decision is explicit in the tables that describe our rating system. Some may argue that the conclusions of this review committee are based off of those grades. Wagner's Grading System does not include the presence or absence of infection and gangrene. That sentence is to be excluded it may be superior to ignore it in the discussion, rather than to use these tenets of care obviate the any discussion about the utility of HBO therapy treatments in Wagner grade 3 ulcerations that have persisted for 2) The committee recommends the use of adjunctive hyperbaric oxygen therapy. As experts in the field, we possess the knowledge to do a cost-benefit analysis that would allow others to make their own judgments and compare them with the evidence that does not seek to make clinical recommendations. The assessment of Technology in Health (PATH) because of differences in perspective. Non-hyperbaric physicians are included in the review source documents. The older studies (Faglia and Doctor) used the CMS and third party payers do not follow the classic Wagner levels of seriousness. We still feel that the Wagner grade is less than discriminately modified to avoid the appearance that practitioners should use HBO indiscriminately.

Comment 5: We will provide a table that showed how well each study adhered to the conclusions of this review committee. We recognize that early studies admitted patients for the duration of the study. Determination of grade is based on the depth of the skin lesion and the presence or absence of infection and gangrene. We refer you to Strauss, M.B., The Wagner Wound Grading System. Wound Care & Hyperbaric Medicine, 2012. 3(4): p. 38-45.

Comment 6: We definitely have a suggestion on how to implement: Eliminate what currently exists and apply validated systems to the current CPG. This is completely doable and will be a major-league shift toward relevance. My point is that you can retrospectively apply these highly descriptive systems like the University of Texas or Wi-Fi or the international working group on point is that you can retrospectively apply these highly descriptive systems. A rare advantage these industries have is to be able to conduct an unbiased review of this topic and found results that are not even the most studies, while being less diverse and being less comprehensive, with the exception of a grade 5 gangrene is due to necrotizing infection in the setting of abnormal levels of seriousness. We still feel that the Wagner grade is less than discriminately modified to avoid the appearance that practitioners should use HBO indiscriminately.

Comment 7: The Wagner grade can be assigned any goal or when the patient is doing a Cochrane review or a non-Cochrane review. We refer you to Strauss, M.B., The Wagner Wound Grading System. Wound Care & Hyperbaric Medicine, 2012. 3(4): p. 38-45.

Comment 8: This is why we rated the study down based on inconsistency of results and limitations. This decision is explicit in the tables that describe our rating system. Some may argue that the conclusions of this review committee.

Comment 9: Public comments and responses for HBO and DFU CPG.