CHAPTER GROUP RESPONSE TO PUBLIC CONSULTATION FEEDBACK: PREVENTION GUIDELINE

REVIEWER OVERVIEW

#	TYPE	TYPE
1	Individual Reviewer (*2 partial completed surveys- included)	13
2	Reviewer on behalf of an organisation (*1 partial competed survey - included) *Northern Health, The Australian Orthotic Prosthetic Association, Royal Darwin Hospital, Australian Podiatry Association, Foot Forward, APP HRFG	6
	Answered	19*
	Skipped	0

BACKGROUND

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
You are involved with the care of patients for whom this draft Australian prevention guideline is relevant.	63%	12	21%	4	16%	3	0%	0	0%	0	**19**
There is a need for a new Australian prevention guideline in this population.	47%	9	47%	9	5%	1	0%	0	0%	0	**19**
The rationale for developing a new Australian prevention guideline on this topic is clear in this draft guideline.	63%	12	32%	6	5%	1	0%	0	0%	0	**19**
									Answered		**19**
									Skipped		**0**

METHODOLOGY

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
I agree with the overall methodology used to develop this draft Australian prevention guideline.	37%	7	53%	10	11%	2	0%	0	0%	0	**19**
The search strategy used to identify international guidelines on which this draft Australian prevention guideline was based is relevant and complete.	37%	7	53%	10	11%	2	0%	0	0%	0	**19**
The methods used to determine the suitability of identified international source guidelines upon which this draft Australian prevention guideline were based were robust.	42%	8	42%	8	16%	3	0%	0	0%	0	**19**
I agree with the methods used within this draft Australian prevention guideline to interpret the available evidence on this topic.	32%	6	58%	11	11%	2	0%	0	0%	0	**19**
The methods used to decide which recommendations to adopt, adapt or exclude for the Australian context were objective and transparent.	26%	5	63%	12	11%	2	0%	0	0%	0	**19**
									Answered		**19**
									Skipped		**0**

RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
The recommendations in this draft Australian prevention guideline are clear.	39%	7	56%	10	6%	1	0%	0	0%	0	**18**
I agree with the recommendations in this draft Australian prevention guideline as stated.	17%	3	72%	13	6%	1	6%	1	0%	0	**18**

The recommendations are suitable for people living with diabetes-related foot disease.	22%	4	72%	13	6%	1	0%	0	0%	0	**18**
The recommendations are too rigid to apply for people living with diabetes-related foot disease.	6%	1	6%	1	22%	4	61%	11	6%	1	**18**
The recommendations reflect a more effective approach to improving patient outcomes than is current practice.	11%	2	39%	7	44%	8	6%	1	0%	0	**18**
When applied, the recommendations should produce more benefits than harms for people living with diabetes-related foot disease.	44%	8	50%	9	6%	1	0%	0	0%	0	**18**
When applied, the recommendations should result in better use of resources than current practice allows.	33%	6	28%	5	33%	6	6%	1	0%	0	**18**
I would feel comfortable if people living with diabetes-related foot disease received the care recommended in this draft Australian prevention guideline.	39%	7	50%	9	11%	2	0%	0	0%	0	**18**
										Answered	**18**
										Skipped	**1**

IMPLEMENTATION OF RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
To apply the draft Australian prevention guideline may require reorganisation of services/care.	17%	3	33%	6	39%	7	11%	2	0%	0	**18**
To apply the draft Australian prevention guideline may be technically challenging.	0%	0	44%	8	39%	7	11%	2	6%	1	**18**
The draft Australian prevention guideline may be too expensive to apply.	11%	2	11%	2	39%	7	39%	7	0%	0	**18**
The draft Australian prevention guideline presents options that will likely be acceptable to people living with diabetes-related foot disease.	17%	3	67%	12	6%	1	11%	2	0%	0	**18**
										Answered	**18**
										Skipped	**1**

FINAL THOUGHTS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
This draft guideline should be approved as the new Australian prevention guideline.	33%	6	44%	8	22%	4	0%	0	0%	0	**18**
This draft Australian prevention guideline would be supported by the majority of my colleagues.	39%	7	44%	8	17%	3	0%	0	0%	0	**18**
If this draft guideline was to be approved as the new Australian prevention guideline, I would use or encourage their use in practice.	44%	8	44%	8	11%	2	0%	0	0%	0	**18**
										Answered	**18**
										Skipped	**1**

SPECIFIC COMMENTS ON RECOMMENDATIONS

#	RECOMMENDATION	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1	Recommendation 1	Organisation	Recommendation does not seem to address the PICO question - (PICO speaks to prevention, whereas the recommendation speaks to detecting risks). The evidence behind effective prevention is lacking, but evidence that PAD and LOPS increase risk for DFU is high - and thoughts are quality of evidence is not low. Perhaps reword to clarify?	We agree, however, due to the adaptation methodology employed by this guideline we are somewhat constrained by the source guidelines questions, and the recommendations addressing those questions. In saying that we also believe the issue the reviewer raises in terms of mismatch between the quality of evidence for the two parts of this recommendation, we addressed satisfactorily in the Summary of Justification to adapt section and have downgraded the overall quality of evidence rating for the recommendation accordingly.	N
2	Recommendation 1	Individual	Have you considered providing assessment templates?	We agree this would be a great resource however this was outside the scope of the guidelines development protocol and any funding to develop clinical assessment templates. However, we do refer the reviewer to the IWGDF risk stratification system (Table 5) and the clinical pathway (Figure 2) we have developed that helps the reader categorise ulcer risk and may partially address the reviewer's request.	N
3	Recommendation 1	Individual	Specific examples for patient education ie: use X to dry well between toes	Thank you for your suggestion. We have now added more specific example information into the 'Considerations for the Australian context: Recommendations 3,4 & 5',	Y, page 18
4	Recommendation 1	Individual	I agree screening is used widely in current practice	Thank you for your comment.	N
5	Recommendation 1	Individual	Clarification of who should be performing tenotomies: orthopaedics? Pod surgeons? Vascular?	In the recommendations related to surgical procedures, we have now clarified that procedures should be performed by "suitably qualified professionals who are able to demonstrate competence in the procedure and registered with the appropriate regulatory body".	Y, pages 27-28
6	Recommendation 2	Individual	regular screening assists with recognising deterioration in the feet earlier. Self-care can be difficult for some with diabetes due to physical limitations	We thank the reviewer for their comment. We have now added a statement advising patients seek	Y, page 15

				support from others to apply recommendations in this guideline, if unable to perform these themselves.	
7	Recommendation 3	Individual	Agree totally	Thank you for your comment.	N
8	Recommendation 4	Individual	Agree	Thank you for your comment.	N
9	Recommendation 4	Organisation	need options for people with retinopathy or poor mobility to also check feet	We agree and please refer to our response to a very similar suggestion in point 6.	Y, page 15
10	Recommendation 4	Individual	"use emollients to lubricate dry skin" the wording may be a little misleading and encourage patients with diabetes to apply moisturiser between the toes which is not recommended due to the risk of interdital maceration which can lead to tinea pedis and ulcerations. I would prefer a clarifying statement to say not to put emollient between the toes	We agree and clarification has been made to 'Considerations for the Australian context: Recommendations 3,4 & 5', stating to use emollients to lubricate dry skin but not between the toes.	Y, page 18
11	Recommendation 5	Individual	dependent on motivation of person with diabetes and physical limitations with use of temperature checking device	We agree with the comment and refer the reviewer to existing statements on motivation and adherence considerations for temperature monitoring in the Considerations for the Australian context (p31-32).	N
12	Recommendation 5	Organisation	need to consider the patients learning style	A sentence has now been added to acknowledge the importance of providing education tailored to individual learning styles.	Y, page 18
13	Recommendation 6	Individual	I would suggest further definition of 'medical grade footwear' - I believe that standard footwear that is of appropriate fit and style to accommodate foot shape/deformity, is suitable for many people. The 'medical grade footwear' terminology potentially leans to specially made footwear that is not readily available.	We refer the reviewer to the extensive medical grade footwear definitions in the glossary of terms stating that medical grade footwear can be pre-fabricated or custom made and definitions for those types of medical grade footwear as well (p69-71).	N
14	Recommendation 6		dependent on motivation of person with diabetes	We refer the reviewer to a very similar comment in point 11.	N
15	Recommendation 6	Organisation	unrealistic, no suitable measuring device, burdensome to patient	We thank the reviewer and suggest these points have already been extensively addressed and considered in the guideline within the summary of justification section for this recommendation (p29-32).	N
16	Recommendation 7	Organisation	Change the term 'custom-made insoles' to 'custom-made foot orthoses'. This reflects ISO terminology and terminology used by private health insurance funds, the NDIA, state equipment schemes and other funding bodies. Furthermore patients/clients need to be educated on visual inspection of orthoses, not just footwear. Orthoses with poor fit or degradation present risk to the diabetic foot.	The term 'custom-made foot orthoses' has been adopted as suggested. A general statement about accessing funding has been added. A statement recommending inspection of the integrity of orthoses has been added.	Y, pages 6, 22, 24-25, 40, 45, 51-52
17	Recommendation 7	Individual	Implementation of trauma prevention with use of aids will assist greatly	A statement to this effect has now been added into the discussion on recommendation 7.	Y, page 25

18	Recommendation 7	Organisation	Access to MGF is expensive with limited qualified pedorthotists and few footwear style options.	We agree. We refer the reviewer to existing and new statements in the discussion for recommendation 7 that aims to provide consideration for options and funding.	Y, page 25
19	Recommendation 7	Individual	Access to Medical grade and custom footwear is limited and expensive. Lots of work around access to these devices at a coal face, and therefore a preventative, level and not just through Tertiary Hospital settings, post an ulcerative event, is required	We agree and refer the reviewer to the above very similar comment in point 18.	Y, page 25
20	Recommendation 8	Organisation	Consistently refer to (semi) rigid orthoses. This terminology could also be used in recommendation 7.	The terminology used in this specific recommendation is as per the IWGDF guidelines and the specific literature.	N
21	Recommendation 8	Individual	Access to orthoses of any description at Primary Health care level is again expensive. Patients need to be self funded currently unless they are seen in a GP superclinic setting, numbers of which are limited. Funding access via Medicare to enable eligible people to obtain a device as prescribed by a Podiatrist would be beneficial to this outcome.	Agreed and we refer the reviewer to a similar comment in point 18. We would though highlight that these guidelines used the GRADE system (as did IWDGF) to consider and balance the available evidence along with general Australian applicability and feasibility issues (including costs) to develop this and all evidence-based recommendations. This then is further considered as the balance of effects for the recommendation and in turn the strength of the recommendation to use. In this case the strength of the recommendation is rated as weak because of these considerations. Otherwise how each Primary Health Care region accesses or implements the recommendation is outside the scope of guidelines.	N
22	Recommendation 9	Organisation	As with recommendation 1; the recommendation does not address PICO question (which addresses prevention, whereas the recommendation speaks to reducing risk factors e.g peak pressures). suggest revising judgement to include recommendation but with a caveat it doesn't actually address the PICO question	We thank the reviewer for their comment. We have reviewed this and still believe that the PICO question has been appropriately addressed in context of the literature. The question asks what specific orthotic (including footwear) intervention is effective for preventing a foot ulcer and the recommendation suggests to prescribe medical grade footwear (with demonstrated plantar pressure relieving effects) to prevent a recurrent foot ulcer.	N
23	Recommendation 9	Organisation	Expand this recommendation to include the provision of orthoses. In the justification of this recommendation, it was noted that the panel identified the role orthoses have in	The use of orthoses has been addressed in recommendations 7 & 8 and we refer the reviewer to those recommendations instead.	N

			reducing the risk of foot ulcers. This should be reflected in the wording of the recommendation		
24	Recommendation 9	Organisation	access and cost is a restrictive issue, guidelines should contain funding options	A general statement about accessing funding has been added to the relevant 'Considerations for the Australian context' section. Otherwise we refer the reviewer to similar comments in points 18, 19 and 21.	Y, pages 24-25
25	Recommendation 10	Organisation	no mention of consideration of PAD before commencing treatment	We thank the reviewer for their suggestion. A statement has been added to reflect that the level of risk should be considered when selecting treatment, in particular PAD and referred the reader to the PAD guideline.	Y, page 26
26	Recommendation 10	Individual	"Treat... any fungal infection on the foot"; This does not specify between skin and nail. Nail fungal infections are very difficult to clear in people with diabetes. It is often not feasible due to mobility of patients to reach the toes, duration of treatment (Daily for 6-12mnths) and low success rates of every clearing it. Fungal nails rarely cause pathology in people with diabetes provided that the nails are kept thin (if they arent then subungual wounds can occur) therefore management rather than treatment is often advised. I would like to say that i fully support treating fungal skin infections as there is significant anecdotal and recorded evidence of fungal skin infections leading to ulcerations therefore fungal skin infections should be treated.	We thank the reviewer for their observation, however, we believe this is suitable in context of considering ulcer risk in this population and the available evidence.	N
27	Recommendation 11	Organisation	should we include this recommendation for which there is very limited access	We have in the discussion that access to services may be a barrier, and may not be suitable for all individuals, however, as there is evidence to support the use of this intervention, we have included it. Otherwise we refer the reviewer to a similar comment in point 21 in which we addressed access issues.	N
28	Recommendation 11	Individual	Develop a pathway for this to occur outside of the Tertiary Hospital setting but that is still funded through Medicare. Utilise Podiatric Surgeons to perform the procedure - this speciality are best placed to access the biomechamics of the foot post surgical and limit the potential of other mechanically induced pathologies	Thank you for this suggestion, however, as per similar comments in point 21, unfortunately this is not in the scope of this project. We do highlight though that we have developed a one-page clinical pathway incorporating all recommendations which may be of some use (Figure 2).	N
29	Recommendation 12	Individual	Potential foot surgeries are mentioned, if applicable. Yet, the subject of heel height in shoes is not mentioned, despite Achilles Tendon lengthening being considered. Even zero drop anatomically lasted, protective sports	We thank the reviewer for their observation and have adopted the evidence available based on the guideline methodology. We are	N

			shoes are a good starting point for unloading an overloaded forefoot, when in the wrong shoes.	unaware of peer-reviewed trials or other studies investigating such suggested footwear to prevent ulcers, whereas there are studies for Achilles tendon lengthening.	
30	Recommendation 12	Organisation	Could be rewritten as consider orthopeadic review	In the recommendations related to surgical procedures, we have clarified that procedures should be performed by “suitably qualified professionals who are able to demonstrate competence in the procedure and registered with the appropriate regulatory body”.	Y, pages 27-28
31	Recommendation 12	Individual	Imbed Podiatric Surgery in this process. The Biomechanics of these surgeries and the post surgical outcomes are at the forefront of the surgical approaches taken by this specialty	We refer the reader to a very similar comment in point 5 and 30 above.	Y, pages 27-28
32	Recommendation 14	Organisation	Expand recommendation to include "orthoses" i.e. "any increase in weight-bearing activity should be gradual, ensuring appropriate footwear and/or orthoses are worn"	We thank the reviewer for this good suggestion. We have now altered recommendation 14 to include footwear “and / or prescribed offloading device(s)”	Y, pages 7, 31-32, 46
33	Recommendation 14	Organisation	footwear appropriate for what?	We thank the reviewer for their comment. We have reviewed this and believe this is clear in context of the recommendation.	N
				Answered	11
				Skipped	8

OVERALL COMMENTS/FEEDBACK

#	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1	Organisation	I suggest the prevention guidelines table 5 explicitly state that: “ Involves at a minimum (but is not limited to): Screening for LOPS with a 10-g Semmes Weinstein monofilament (20) or if unavailable, use of the Ipswich Touch Test (21) and screening of vibratory sensation with a tuning fork or biothesiometer/neurothesiometer, if the monofilament testing is negative does not show LOPS.	We thank the reviewer for their suggestion. Table 5 is a reproduction of the IWGDF original document. Therefore its contents are reflective of this source.	N
2	Individual	As technological advances have changed, including in footwear & orthotic industries, it is now possible to help prevent foot ulcers and pressure lesions, as well as offloading the at risk/diabetic foot. Many of these changes have been seen in the field of orthotic and shoe sole “therapy”. When the first rocker footwear, Massai Barefoot Technology (MBT) of Switzerland arrived in Australia in 2004, commercially produced rockers were a new concept. This original “unstable” rocker because TGA approved as medical grade footwear here in Australia. In the intervening 17 years, many commercial copies and adaptions have been brought to market worldwide. It is also an integral feature of offloading CAM walker boots. Medical Grade footwear traditionally contains heel height (referred to as drop in the sports footwear industry) as well as in the shoes insole/footbed. E.g. Dr Comfort of USA specifically markets depth/wide footwear to the diabetic market with the in-shoe footbed being approximately 6mm in heel height. As we know with ulcers of the forefoot, heel height in shoes/orthotics is not ideal. Under Prevention Recommendation 12, potential foot surgeries are mentioned, if applicable. Yet, the subject of heel height in shoes is not mentioned, despite Achilles Tendon lengthening being considered. Even zero drop anatomically lasted, protective sports shoes are a good starting point for unloading an over-loaded forefoot, when in the wrong shoes. As well, proprioceptive facilitating orthotics are now available which work specifically to switch on foot intrinsics, while also offloading heel and forefoot. A model for diabetes also contains a material called Celliant in the top cover, which is clinically proven to increase oxygenation of tissues.	We thank the reviewer for their observation. As previously mentioned in point 29, we adopted the evidence available based on the guideline methodology. We are unaware of peer-reviewed trials or other studies investigating such suggested footwear to prevent ulcers, whereas there are these studies for Achilles tendon lengthening.	N
3	Individual	I welcome the use of this tool in guiding everyday practice.	We thank the reviewer for their kind comment	N
4	Organisation	The authors have done a great job addressing limitations for geographical rural/remote and Aboriginal Torres Strait Islander people but a lot is lost in text and repeated. ? Separate dot point summary of issues/challenges facing this subgroup to facilitate easier uptake?	We thank the reviewer for their suggestion and agree to some extent that there is some repetition, however, we believe that addressing the considerations to the Australian context for each recommendation is important, as there may be some clinicians only referring to a specific	N

			recommendation and not reading the guideline in its entirety. Thus, we have included considerations for those living in rural/remote regions of Australia and for those who identify as an Aboriginal and Torres Strait Islander person for each recommendation for this reason.	
5	Organisation	AOPA is pleased to see DFU guidelines take a holistic and well-evidenced approach. Our suggestions for the recommendations promote consistent use of terminology and ensure the recommendations accurately reflect the justifications provided. Orthoses were cited numerous times throughout the guidelines as an important feature in diabetic foot care. If the guidelines are to be used to help inform best-practice, programs and services, the recommendations need to clearly reflect the justifications.	We thank the reviewer for your comment. We have reviewed your comments and are satisfied that they are addressed in the revised paper. For example, to improve consistency and be applicable to the Australian context / terminology, we have changed the term 'custom-made insoles' to 'custom-made foot orthoses'.	Y, pages 6, 22, 25, 40, 45, 51-52
6	Organisation	It is really good to see the recognition of Aboriginal and Torres Strait Islander people in these guidelines. We should all be aiming at best practice interventions and these guidelines cover this. However it is important that it documented that many of the suggested prevention strategies (ie temperature testing, the use of medical grade footwear) are not realistic for many regional and remote patients, and I think this is clearly documented.	We thank the reviewer for their kind comment.	N
7	Individual	Thank you for completing this valuable and extensive body of work	We thank the reviewer for their kind comment.	N
8	Individual	Thank you for the great work and effort you have put in this document. It is much appreciated.	We thank the reviewer for their kind comment.	N
9	Individual	I think the off-loading/footwear section is where Australian care lacks-particularly when it comes to the time delays/patient-associated/Medicare funding costs of accessing medical grade footwear/specialist custom-made footwear. As a clinician, this is where I stumble-I don't know who I can access/put patients in touch with to get them	We agree and we refer the reader to our response in point 21.	N
10	Individual	Overall I support this draft and am very happy with it. I am being pedantic and would be happy with the draft in its current form to be our guidelines. I feel that in recommendation 4 the wording could be misleading and lead to potential harm. I also felt that recommendation 10 was not based off clear evidence/is actually feasible based on my clinical experience and readings of current evidence in regards to onychomycosis.	We thank the reviewer for their kind comments. In recommendation 4, we do not believe that these instructions on foot self-care will lead to any potential harm, therefore, no changes have been made. We refer the reviewer to the IWGDF prevention guideline and systematic reviews (see below) for a summary of the evidence surrounding recommendation 10. Bus SA, Lavery LA, Monteiro-Soares M, Rasmussen A, Raspovic A, Sacco ICN, et al. Guidelines on the prevention of foot ulcers in persons with diabetes (IWGDF 2019 update). Diabetes Metab Res Rev. 2020;36 Suppl 1:e3269. van Netten JJ, Raspovic A, Lavery LA, Monteiro-Soares M, Rasmussen A, Sacco ICN, et al. Prevention of foot ulcers in the at-risk patient with	N

			diabetes: a systematic review. Diabetes Metab Res Rev. 2020;36 Suppl 1:e3270. van Netten JJ, Sacco ICN, Lavery LA, Monteiro-Soares M, Rasmussen A, Raspovic A, et al. Treatment of modifiable risk factors for foot ulceration in persons with diabetes: a systematic review. Diabetes Metab Res Rev. 2020;36 Suppl 1:e3271.	
11	Individual	Great interpretation of the IWGDF guidelines and not adopting some that would be impractical and difficult to implement in Australia (such as patient centered temperature testing)	We thank the reviewer for their kind comment.	N
			Answered	11
			Skipped	8

REVIEWER OVERVIEW

#	TYPE	TYPE
1	Individual Reviewer	0
2	Reviewer on behalf of an organisation *Northern Health, St Vincent's Hospital Melbourne, AOPA, Pedorthic Association of Australia	4
	Answered	4
	Skipped	0

BACKGROUND

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
You are involved with the care of patients for whom this draft Australian wound classification guideline is relevant.	75%	3	0%	0	25%	1	0%	0	0%	0	**4**
There is a need for a new Australian wound classification guideline in this population.	50%	2	25%	1	25%	1	0%	0	0%	0	**4**
The rationale for developing a new Australian wound classification guideline on this topic is clear in this draft guideline.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

METHODOLOGY

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
I agree with the overall methodology used to develop this draft Australian wound classification guideline.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
The search strategy used to identify international guidelines on which this draft Australian wound classification guideline was based is relevant and complete.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
The methods used to determine the suitability of identified international source guidelines upon which this draft Australian wound classification guideline were based were robust.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
I agree with the methods used within this draft Australian wound classification guideline to interpret the available evidence on this topic.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
The methods used to decide which recommendations to adopt, adapt or exclude for the Australian context were objective and transparent.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
The recommendations in this draft Australian wound classification guideline are clear.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
I agree with the recommendations in this draft Australian wound classification guideline as stated.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**

The recommendations are suitable for people living with diabetes-related foot disease.	50%	2	25%	1	25%	1	0%	0	0%	0	**4**
The recommendations are too rigid to apply for people living with diabetes-related foot disease.	0%	0	0%	0	0%	0	50%	2	50%	2	**4**
The recommendations reflect a more effective approach to improving patient outcomes than is current practice.	25%	1	25%	1	25%	1	25%	1	0%	0	**4**
When applied, the recommendations should produce more benefits than harms for people living with diabetes-related foot disease.	50%	2	25%	1	25%	1	0%	0	0%	0	**4**
When applied, the recommendations should result in better use of resources than current practice allows.	50%	2	50%	2	0%	0	0%	0	0%	0	**4**
I would feel comfortable if people living with diabetes-related foot disease received the care recommended in this draft Australian wound classification guideline.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

IMPLEMENTATION OF RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
To apply the draft Australian wound classification guideline may require reorganisation of services/care.	0%	0	50%	2	0%	0	25%	1	25%	1	**4**
To apply the draft Australian wound classification guideline may be technically challenging.	0%	0	50%	2	0%	0	25%	1	25%	1	**4**
The draft Australian wound classification guideline may be too expensive to apply.	0%	0	0%	0	25%	1	0%	0	75%	3	**4**
The draft Australian wound classification guideline presents options that will likely be acceptable to people living with diabetes-related foot disease.	50%	2	50%	2	0%	0	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

FINAL THOUGHTS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
This draft guideline should be approved as the new Australian wound classification guideline.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
This draft Australian wound classification guideline would be supported by the majority of my colleagues.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
If this draft guideline was to be approved as the new Australian wound classification guideline, I would use or encourage their use in practice.	75%	3	25%	1	0%	0	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

SPECIFIC COMMENTS ON RECOMMENDATIONS

#	RECOMMENDATION	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1	Recommendation 1	Organisation	Under future research considerations, Please add orthotist/prosthetists to the list of "target groups".	We thank the reviewer for the considered comment. We agree that orthotist/prosthetist should be added to the list of Target groups, which has now been realized in the revised text.	Y, page 12
2	Recommendation 2	Organisation	How should we help develop a prognosis?	We thank the reviewer for the considered comment. This item is detailed in 'Future research considerations' under Recommendation 2 in the text. We have now more overtly recognised in the future directions that Australian data could help to develop more granular information to aid in an individual prognosis for a particular patient and wound. In the interim adapted recommendation 2 is we assert, appropriate, with due caution being required 'in the application of any of the currently available classification/scoring systems to offer an individual prognosis for a person with diabetes and a foot ulcer.'	Y, page 16
3	Recommendation 4	Organisation	Used by Pods, not really used by Vasc Surgeons. Toe pressured and diagnostic tools used instead.	We thank the reviewer for the considered comment. We appreciate that certain wound classification systems are used by some specialists and clinicians and not others in the HRFS team. A wound classification system common to all is SINBAD as per the chapter text. Subsequently, the wound classification system used should be familiar to all clinicians involved in the care of the relevant patient – this has now been addressed as shown in the Clinical Pathways figure, with recommendation to use validated Wound Classification systems that are used by the multidisciplinary treating team.	Y, page 34 (Figure 1)
				Answered	2
				Skipped	2

OVERALL COMMENTS/FEEDBACK

#	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1	Organisation	Will the recommended wound classification systems be detailed in this document or another published by DFA? If recommending SINBAD, IDSA/IWGDF infection classification and WIfI systems these may be well placed in the guideline document for ease of access	We thank the reviewer for the considered comment. We have provided the essentials of the SINBAD system in the Clinical Pathways figure document as it is the minimum Wound Classification system recommended.	Y, page 34 (Figure 1)
			Answered	1
			Skipped	3

REVIEWER OVERVIEW

#	TYPE	TYPE
1	Individual Reviewer	1
2	Reviewer on behalf of an organisation Pedorthic Association of Australia (ANZSVS also submitted an email separately)	1
	Answered	2
	Skipped	0

BACKGROUND

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
You are involved with the care of patients for whom this draft Australian PAD guideline is relevant.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
There is a need for a new Australian PAD guideline in this population.	50%	1	0%	0	0%	0	50%	1	0%	0	**2**
The rationale for developing a new Australian PAD guideline on this topic is clear in this draft guideline.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
									Answered		**2**
									Skipped		**0**

METHODOLOGY

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
I agree with the overall methodology used to develop this draft Australian PAD guideline.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
The search strategy used to identify international guidelines on which this draft Australian PAD guideline was based is relevant and complete.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
The methods used to determine the suitability of identified international source guidelines upon which this draft Australian PAD guideline were based were robust.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
I agree with the methods used within this draft Australian PAD guideline to interpret the available evidence on this topic.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
The methods used to decide which recommendations to adopt, adapt or exclude for the Australian context were objective and transparent.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
									Answered		**2**
									Skipped		**0**

RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
The recommendations in this draft Australian PAD guideline are clear.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
I agree with the recommendations in this draft Australian PAD guideline as stated.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**

The recommendations are suitable for people living with diabetes-related foot disease.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
The recommendations are too rigid to apply for people living with diabetes-related foot disease.	0%	0	0%	0	0%	0	50%	1	50%	1	**2**
The recommendations reflect a more effective approach to improving patient outcomes than is current practice.	50%	1	50%	1	0%	0	0%	0	0%	0	**2**
When applied, the recommendations should produce more benefits than harms for people living with diabetes-related foot disease.	50%	1	50%	1	0%	0	0%	0	0%	0	**2**
When applied, the recommendations should result in better use of resources than current practice allows.	50%	1	50%	1	0%	0	0%	0	0%	0	**2**
I would feel comfortable if people living with diabetes-related foot disease received the care recommended in this draft Australian infection guideline.	50%	1	50%	1	0%	0	0%	0	0%	0	**2**
										Answered	**2**
										Skipped	**0**

IMPLEMENTATION OF RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
To apply the draft Australian PAD guideline may require reorganisation of services/care.	0%	0	100%	2	0%	0	0%	0	0%	0	**2**
To apply the draft Australian PAD guideline may be technically challenging.	0%	0	50%	1	50%	1	0%	0	0%	0	**2**
The draft Australian PAD guideline may be too expensive to apply.	0%	0	0%	0	50%	1	50%	1	0%	0	**2**
The draft Australian PAD guideline presents options that will likely be acceptable to people living with diabetes-related foot disease.	50%	1	50%	1	0%	0	0%	0	0%	0	**2**
										Answered	**2**
										Skipped	**0**

FINAL THOUGHTS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
This draft guideline should be approved as the new Australian PAD guideline.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
This draft Australian PAD guideline would be supported by the majority of my colleagues.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
If this draft guideline was to be approved as the new Australian PAD guideline, I would use or encourage their use in practice.	100%	2	0%	0	0%	0	0%	0	0%	0	**2**
										Answered	**2**
										Skipped	**0**

SPECIFIC COMMENTS ON RECOMMENDATIONS

#	RECOMMENDATION	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1			NIL	Not applicable (N/A)	N
				Answered	0
				Skipped	2

OVERALL COMMENTS/FEEDBACK

#	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1	Individual Reviewer	NIL	N/A	N
2	Pedorthic Association of Australia	NIL	N/A	N
			Answered	0
			Skipped	2

CHAPTER GROUP RESPONSE TO PUBLIC CONSULTATION FEEDBACK: INFECTION GUIDELINE

REVIEWER OVERVIEW

#	TYPE	TYPE
1	Individual Reviewer	3
2	Reviewer on behalf of an organisation *Northern Health	1
	Answered	4
	Skipped	0

BACKGROUND

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
You are involved with the care of patients for whom this draft Australian infection guideline is relevant.	50%	2	50%	2	0%	0	0%	0	0%	0	**4**
There is a need for a new Australian infection guideline in this population.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
The rationale for developing a new Australian infection guideline on this topic is clear in this draft guideline.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

METHODOLOGY

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
I agree with the overall methodology used to develop this draft Australian infection guideline.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
The search strategy used to identify international guidelines on which this draft Australian infection guideline was based is relevant and complete.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
The methods used to determine the suitability of identified international source guidelines upon which this draft Australian infection guideline were based were robust.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
I agree with the methods used within this draft Australian infection guideline to interpret the available evidence on this topic.	25%	1	75%	3	0%	0	0%		0%	0	**4**
The methods used to decide which recommendations to adopt, adapt or exclude for the Australian context were objective and transparent.	25%	1	75%	3	0%	0	0%		0%	0	**4**
									Answered		**4**
									Skipped		**0**

RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
The recommendations in this draft Australian infection guideline are clear.	0%	0	75%	3	0%	0	25%	1	0%	0	**4**
I agree with the recommendations in this draft Australian infection guideline as stated.	0%	0	75%	3	0%	0	25%	1	0%	0	**4**

The recommendations are suitable for people living with diabetes-related foot disease.	0%	0	100%	4	0%	0	0%	0	0%	0	**4**
The recommendations are too rigid to apply for people living with diabetes-related foot disease.	0%	0	0%	0	0%	0	100%	4	0%	0	**4**
The recommendations reflect a more effective approach to improving patient outcomes than is current practice.	25%	1	0%	0	50%	2	25%	1	0%	0	**4**
When applied, the recommendations should produce more benefits than harms for people living with diabetes-related foot disease.	25%	1	25%	1	25%	1	25%	1	0%	0	**4**
When applied, the recommendations should result in better use of resources than current practice allows.	25%	1	0%	0	50%	2	25%	1	0%	0	**4**
I would feel comfortable if people living with diabetes-related foot disease received the care recommended in this draft Australian infection guideline.	25%	1	50%	2	25%	1	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

IMPLEMENTATION OF RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
To apply the draft Australian infection guideline may require reorganisation of services/care.	25%	1	0%	0	50%	2	25%	1	0%	0	**4**
To apply the draft Australian infection guideline may be technically challenging.	25%	1	25%	1	50%	2	0%	0	0%	0	**4**
The draft Australian infection guideline may be too expensive to apply.	25%	1	0%	0	50%	2	25%	1	0%	0	**4**
The draft Australian infection guideline presents options that will likely be acceptable to people living with diabetes-related foot disease.	0%	0	100%	4	0%	0	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

FINAL THOUGHTS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
This draft guideline should be approved as the new Australian infection guideline.	25%	1	50%	2	0%	0	25%	1	0%	0	**4**
This draft Australian infection guideline would be supported by the majority of my colleagues.	0%	0	75%	3	25%	1	0%	0	0%	0	**4**
If this draft guideline was to be approved as the new Australian infection guideline, I would use or encourage their use in practice.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

SPECIFIC COMMENTS ON RECOMMENDATIONS

#	RECOMMENDATION	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1	Recommendation 4	Individual	I find this confusing as in the Prevention Guidelines Recommendation 6 recommends self-monitoring of foot-skin temperature daily (contingent on available resources)	We agree this is confusing, however, the Infection Recommendation relates to use of temperature screening to diagnose infection compared with the Prevention Recommendation that relates to early identification of hot spots, allowing offloading and prevention of foot ulcers. These differences are highlighted in the PICO framework questions associated with each recommendation.	N
2	Recommendation 10	Organisation	A link to eTG to direct treatment options of antibiotics to prescribe needs to be included to make the guideline useful in clinical practice as more podiatrists become ESM	We agree and have included a reference to eTG in this section.	Y page 34
3	Recommendation 11	Individual	Perhaps additional consideration could be given to discussing the merits of prior multidrug resistant organism (eg MRSA) colonisation status on empiric antibiotic prescribing? This is briefly mentioned in one of the subsequent discussion sections with regard to ATSI and MRSA , but perhaps it should be more clearly included in the recommendation section (as was done for Pseudomonas)?	We agree this is an important consideration and have added additional detail to this section to the Summary Justification and Implementation sub-sections.	Y pages 36-37
				Answered	3
				Skipped	1

OVERALL COMMENTS/FEEDBACK

#	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1		No comments entered		Y/N
2				Y/N
3				Y/N
			Answered	0
			Skipped	4

REVIEWER OVERVIEW

#	TYPE	TYPE
1	Individual Reviewer (*1 partial completion - included)	9
2	Reviewer on behalf of an organisation *Northern Health, The Australian Orthotic Prosthetic Association, Royal Darwin Hospital, Pedorthic Association of Australia, YNLHN	5
	Answered	14*
	Skipped	0

BACKGROUND

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
You are involved with the care of patients for whom this draft Australian offloading guideline is relevant.	78.57%	11	0%	0	21.43%	3	0%	0	0%	0	**14**
There is a need for a new Australian offloading guideline in this population.	64.29%	9	35.71%	5	0%	0	0%	0	0%	0	**14**
The rationale for developing a new Australian offloading guideline on this topic is clear in this draft guideline.	64.29%	9	35.71%	5	0%	0	0%	0	0%	0	**14**
									Answered		**14**
									Skipped		**0**

METHODOLOGY

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
I agree with the overall methodology used to develop this draft Australian offloading guideline.	42.86%	6	42.86%	6	14.29%	2	0%	0	0%	0	**14**
The search strategy used to identify international guidelines on which this draft Australian offloading guideline was based is relevant and complete.	35.71%	5	50%	7	14.29%	2	0%	0	0%	0	**14**
The methods used to determine the suitability of identified international source guidelines upon which this draft Australian offloading guideline were based were robust.	35.71%	5	50%	7	14.29%	2	0%	0	0%	0	**14**
I agree with the methods used within this draft Australian offloading guideline to interpret the available evidence on this topic.	35.71%	5	50%	7	14.29%	2	0%	0	0%	0	**14**
The methods used to decide which recommendations to adopt, adapt or exclude for the Australian context were objective and transparent.	35.71%	5	57.14%	8	7.14%	1	0%	0	0%	0	**14**
									Answered		**14**
									Skipped		**0**

RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
The recommendations in this draft Australian offloading guideline are clear.	57.14%	8	28.57%	4	14.29%	2	0%	0	0%	0	**14**
I agree with the recommendations in this draft Australian offloading guideline as stated.	35.71%	5	42.86%	6	21.43%	3	0%	0	0%	0	**14**

The recommendations are suitable for people living with diabetes-related foot disease.	35.71%	5	42.86%	6	7.14%	1	14.29%	2	0%	0	**14**
The recommendations are too rigid to apply for people living with diabetes-related foot disease.	14.29%	2	7.14%	1	21.43%	3	42.86%	6	14.29%	2	**14**
The recommendations reflect a more effective approach to improving patient outcomes than is current practice.	35.71%	5	21.43%	3	28.57%	4	14.29%	2	0%	0	**14**
When applied, the recommendations should produce more benefits than harms for people living with diabetes-related foot disease.	50%	7	42.86%	6	7.14%	1	0%	0	0%	0	**14**
When applied, the recommendations should result in better use of resources than current practice allows.	42.86%	6	28.57%	4	21.43%	3	7.14%	1	0%	0	**14**
I would feel comfortable if people living with diabetes-related foot disease received the care recommended in this draft Australian offloading guideline.	57.14%	8	28.57%	4	14.29%	2	0%	0	0%	0	**14**
									Answered		**14**
									Skipped		**0**

IMPLEMENTATION OF RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
To apply the draft Australian offloading guideline may require reorganisation of services/care.	38.46%	5	38.46%	5	15.38%	2	7.69%	1	0%	0	**13**
To apply the draft Australian offloading guideline may be technically challenging.	30.77%	4	46.15%	6	15.38%	2	7.69%	1	0%	0	**13**
The draft Australian offloading guideline may be too expensive to apply.	30.77%	4	15.38%	2	23.08%	3	23.08%	3	7.69%	1	**13**
The draft Australian offloading guideline presents options that will likely be acceptable to people living with diabetes-related foot disease.	23.08%	3	53.85%	7	7.69%	1	15.38%	2	0%	0	**13**
									Answered		**13**
									Skipped		**1**

FINAL THOUGHTS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
This draft guideline should be approved as the new Australian offloading guideline.	46.15%	6	38.46%	5	7.69%	1	7.69%	1	0%	0	**13**
This draft Australian offloading guideline would be supported by the majority of my colleagues.	38.46%	5	53.85%	7	7.69%	1	0%	0	0%	0	**13**
If this draft guideline was to be approved as the new Australian offloading guideline, I would use or encourage their use in practice.	61.54%	8	30.77%	4	7.69%	1	0%	0	0%	0	**13**
									Answered		**13**
									Skipped		**1**

SPECIFIC COMMENTS ON RECOMMENDATIONS

#	RECOMMENDATION	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1	Recommendation 1a	organisation	In regards to the section 'Aboriginal and Torres Strait Islander people' on page 11 - in the sentence about facilitating culturally appropriate follow-up care, I think it might be good to add 'where or if possible'.	We thank the reviewer for their suggestion, agree and have revised as suggested.	Y p16 Aboriginal and Torres Strait Islander people section
2	Recommendation 1b	organisation	This recommendation may have the unintended consequence of DFU services opting not to invest in the resources and workforce necessary to provide TCC. While AOPA commend the panel on writing recommendations that reflect realistic and practical scenarios, we encourage the panel to promote treatment based first on clinical need and client preference, then by resources and available skillset. To promote sustainable best practice for all Australians, this recommendation could be reworded to reflect that sustainable DFU offloading options should not be limited by available resources and skillset, and to encourage investment in DFU offloading resources and workforce to meet consumer needs.	We thank the reviewer for these comments and we both disagree and agree. We disagree that we have not drafted a recommendation based on best evidence, clinical need and preference as we agreed with the IWGDF panel that the balance of effects of the available evidence does not favour either the TCC or non-removable walker as the preferred non-removable knee-high offloading device type for any of the critical or important outcomes, except that non-removable knee-high walkers have been found to be more cost-effective. Thus, broadly according to best available evidence either device can be recommended as the non-removable knee-high offloading device as long as not contraindicated. However, we agree that services should be able to provide or at least have direct pathways to TCCs (and non-removable walkers) when patients cannot appropriately fit into a non-removable walker or if the patient after being fully informed of the benefits and risks of both devices prefers a TCC. Thus, we have added a sentence in the procedures section of Recommendation 1B that organisations “should offer, or be able to directly refer for, both types of non-removable knee-high offloading devices.”	Y p18 Procedure section
3	Recommendation 2	organisation	would also include additional of total contact insole within the knee high walker	We thank the reviewer for this comment and we partially agree as we considered that total contact insoles are an insole type included under the catchall term “pressure offloading insoles” in Recommendation 1A in which Recommendation 2 refers too. However, the panel has made some revisions to the Supplementary material where insole materials are covered in more detail to specifically include total contact insoles more specifically if required. We also point out that we found no evidence for the use of total contact insoles over other insoles to heal DFU within the literature but agree in theory and in practice such insoles may be suggested to provide some minor	Y p15 in the Procedure section & eTable B1 in the Supplementary material

				additional plantar pressure reduction benefit when included within knee-high walkers.	
4	Recommendation 2	organisation	consideration of patient capacity to adhere to knee high removable offloading, consideration of felt to foot with ankle high.	We also thank the reviewer for these comments and we again partially agree as we felt (excuse the pun) we had provided consideration for the addition of felted foam to the device or foot in the Procedures section of Recommendation 2 which is referred to also in Recommendation 1B. However, we have now made this consideration more explicit in this section. Furthermore, we have clarified that felt only (more commonly used in Australia) was considered as a type of felted foam by IWGDF, and thus, using simply felt can be considered for this recommendation in both the rationale and description sections of Recommendation 5. Lastly, we added the additional suggestion to consider the patient's capacity to adhere as suggested.	Y p20 in Procedures section & P26 in the Rationale and Description sections & eTable A6 in the Supplementary material.
5	Recommendation 3	organisation	consider add felt to foot for removable offloading	Similar to our response to the above comment, we have now made this referral to Recommendation 5 (i.e. felted foam in the device) more explicit. We also point out we have now also reinforced this point by developing a new Australian evidence-based clinical pathway on offloading treatment (Figure 1).	Y p22 in Procedures section & p46 in Figure 1
6	Recommendation 3	organisation	what about low top moonboots?	We thank the reviewer for this query. We consider low top moonboots to be potentially another term for ankle-high walker of which we had already included in the broad definition for ankle high offloading devices. However, as low top moonboots is a term the panel has rarely come across before and not in the literature to our knowledge, we have decided to not make any specific revisions so as not to potentially confuse the wider guideline readership and hope the reviewer understands. We reiterate though that ankle-high walkers are included under the definition of ankle-high offloading devices.	N
7	Recommendation 4	Individual	Medical grade footwear recommendations: need to verify the offloading capacity which may include footwear adaptation/modifications and accommodative foot orthotics. Medical Grade Footwear itself may not be sufficient in those cases without checking the offloading capacity and further modifications and adding a customised foot orthotics. Evidence exists for four cases where patients were in knee high removable offloading devices but the progress were very	We thank the reviewer for these comments and their personal case series observations. We strongly agree with the reviewer that in the rare cases that all offloading devices are contraindicated or not tolerated by patients that the offloading capacity of the medical grade footwear (including insoles, footwear modifications etc) should be verified using validated plantar pressure measuring equipment to provide more plantar pressure reduction than removable offloading devices in each case. We refer the reader to our	Y p46 Figure 1

			slow and devices were inconvenient for those patients for their everyday activities. When trialed MGF with further adjustments to soles/rocker soles and custom foot orthotics and offloading verified by F-Scan systems, the outcome was positive with faster healing and long term in remission (over two years). The patients were from RPA and St Vincent's hospital Sydney. Evidences can be available if needed and has permission from the patients to share the case history.	original text under Procedures in Recommendation 4 in which consider we had covered these sentiments. In addition, as per our response to earlier comments, we highlight we have now reinforced considerations for including pressure offloading insoles by developing the new Figure 1 Australian evidence-based clinical pathway on offloading treatment.	
8	Recommendation 4	organisation	Under procedures change ‘insoles’ to ‘orthoses’. Include ‘orthotist’ in the sentence ‘trained footwear professional (such as pedorthist orthotist/prosthetist). Orthotics/prosthetics is a dual qualification, graduates are qualified orthotist/prosthetists. Change the sentence “…only recommended when contraindicated or where …” to “…only recommended when other offloading devices are contraindicated or where …” Under geographically remote people remove “likely a much more effective and”. Effectiveness should not be based on the geographic location of the client. The panel must exercise caution when discussing limitations to services based on available resources and workforce. We encourage the panel to consider the impact these recommendations will have on establishing and retaining DFU services. It is vital that all recommendations and justifications reflect the need to invest in resources and workforce to ensure equitable access to DFU services.	We thank the reviewer for these comments and partially agree. We have now included the term “orthoses”, alongside “foot device interface” within the catchall term of “pressure offloading insole” to try and improve clarity for the multi-disciplinary reader in Recommendation 1A & 4. Furthermore, we have added “orthotist/prosthetist” to the trained footwear professional examples and “offloading devices” to the contraindication sentence and apologise for our original oversights. With regard to the geographical remote comment, we do understand the reviewers sentiments. However, in this case regardless of geographical remoteness, offloading devices have been found in the best evidence available to be more effective than medical grade footwear for the offloading treatment of foot ulcers. We had originally adapted from the original IWGDF recommendation, which recommended not to use footwear for the purpose of treating ulcer, for this Australian guideline so as to provide the ability for clinicians to prescribe medical grade footwear in the very rare circumstances that offloading devices are contraindicated or not tolerated by patients. However, we have now also added a sentence to highlight in this section, that although there is much evidence for not using medical grade footwear to treat DFU, there is much evidence for using medical grade footwear to prevent ulcer recurrence once healed and we have gone on to refer the reader to the Prevention Guideline. Otherwise we believe we are making a valid point on potential solutions to the challenges of health care for geographically remote people. In saying that we have revised to remove “more effective” for geographically remote people as we agree this does not need to be highlighted once more here.	Y p15 in Procedures, p23-24 in Procedures & P25 Geographically remote people

9	Recommendation 4	organisation	consideration of NWB, eg; Crutches, wheel chair, knee scooteretc	We thank the reviewer for this comment, and we agree that these devices may be considered when offloading devices and footwear are contraindicated or not tolerated. However, like Recommendation 8, while these devices are sometimes used in clinical practice there is no evidence to support their use in the management of people with DFU specifically. Thus, we have added a very similar sentenced to the end of the Procedures section in Recommendation 4 that we original had in Recommendation 8 to also consider these devices, ie "Finally, while there is no literature to support their use as treatment to heal people with DFU, wheelchairs, knee scooters or electric scooters may also potentially be considered in these circumstances."	Y p 24 in Procedures
10	Recommendation 5	organisation	If the aim of the recommendation is to provide a client with an interface between the foot and the offloading device/footwear, then the panel should consider expanding this recommendation to include 'felted foam or other suitable orthotic material'. There are a range of orthotic materials that are well suited to serve as an interface. Keeping this recommendation as it is may unintentionally place limitations on services and client choice. Under description replace 'insole' with 'orthosis'. This reflects ISO terminology and terminology used by private health insurance funds, the NDIA, state equipment schemes and other funding bodies. It is a term that is professionally recognised and consumers are more likely to come across.	We thank the reviewer for this comment and we feel consideration of pressure offloading insoles, a catchall term for orthoses and foot device interface, is included in the Procedures of all Recommendations to this point, plus, in more detail around materials in eTable B1 in the Supplementary Material. Additionally, as per our response to earlier comments we have now highlighted that pressure offloading insoles should be considered alongside felted foam to further reduce plantar pressure in the new Figure 1 Australian evidence-based clinical pathway on offloading treatment.	Y p46 Figure 1
11	Recommendation 5	organisation	Consider upgrading felt to foot as clinically used regularly	We thank the reviewer for this comment and as we had a recommendation devoted to felted foam (unlike the IWGDF guideline) we were a little confused by the reviewers comment we are sorry. However, if the reviewer means to upgrade the quality of evidence from very low, we disagree based on the detailed justifications we have outlined in eTable A6 in the Supplementary material. Additionally, we considered this recommendation to be weak based on the small positive balance of effects probably favoring felted foam over not using it in devices or footwear, the very low quality of supporting evidence, probable acceptability to patients and probable feasibility to patients and services providing. Thus, we do not consider we can increase the strength of	N

				recommendation from weak to strong based simply on that it is clinical used regularly we are sorry.	
12	Recommendation 6(a)	organisation	issues with easy access	We thank the reviewer for the comment and agree there are challenges with accessing surgical offloading procedures at present. We refer the reviewer to our original Feasibility section in eTable A7 and General implementation section in eTable B7 in the Supplementary Material where we concurred with the reviewer and suggest "that if these surgeons aren't available in a treating organisation, then at the very least the organisation should have a formal referral pathway to a specialist foot and ankle surgeon to advise when surgical offloading is required". Further we discuss these access challenges in some detail in a paragraph of the Implementation Considerations of the Discussion and recommend a nationally equitable scheme for patients to access best practice offloading treatments including knee-high offloading devices and surgical offloading procedures in particular. We hope local services can now use these new national evidence-based guidelines, the new pathway provided in Figure 1 (see above comments) and suggestions for the introduction of national equitable schemes etc to help improve access to surgical procedures in their local regions to enact these recommendations.	N
13	Recommendation 6(a)	organisation	would be great to see higher evidence on these to support	We also agree very much with the reviewer on this comment that higher quality evidence for surgical procedures would be wonderful and we refer the reviewer to where we have discussed this in several areas of the guideline, including our original Future research considerations summary in the Discussion where "we recommend future high-quality trials are still very much needed to test the effectiveness of all other offloading treatments (including removable offloading devices, footwear, other non-surgical interventions and surgical offloading procedures) against non-removable knee-high offloading device controls" and more specific future surgical procedure research recommendations in the Future research priorities section in eTable B7.	N
14	Recommendation 6(b)	organisation	issues with easy access	Similar to our response to the comment 12, we essentially agree with the reviewer and refer to similar sections as above for Recommendation 6B and associated eTables as well.	N

15	Recommendation 8	organisation	any evidence on moving struts to affect heel loading?	We thank the reviewer for this query and have quickly searched all papers included in the IWGDF systematic review (Lazzarini et al 2020 DMMR) and could only find one included paper mentioning “struts”. However, this study was referring to strut height rather than moving struts and did not investigate rearfoot ulcer healing or rearfoot plantar pressure offloading unfortunately (Crews et al 2012 Clin Biomech). Otherwise the above IWGDF systematic review and IWGDF guideline (Bus et al 2020 DMMR) summarized the findings of the collective studies reporting healing or plantar pressures in those with rearfoot ulcers, however, none of the four identified controlled trials and several non-controlled studies identified reported struts either. The IWGDF systematic review does though report two related evidence statements that may help the reviewers query a little, including: “TCCs and removable knee-high offloading devices are equally effective in reducing peak pressure at the DFU location and forefoot and rearfoot areas” (based on a moderate quality of supporting evidence) and “Removable knee-high offloading devices are more effective in reducing peak pressure at the DFU and forefoot area than removable ankle-high offloading devices” (again based on moderate quality of evidence). Thus, we suggest there is virtually no evidence regarding moving struts to affect heel (off)loading. However, we do highlight that we recommend more studies are required in multiple Future research priority sections in eTables B of the Supplementary material investigating different methods or makes of offloading devices throughout the guideline which should address the reviewers overarching point.	N
				Answered	5
				Skipped	9

OVERALL COMMENTS/FEEDBACK

#	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1	Individual	As technological advances have changed, including in footwear & orthotic industries, it is now possible to help prevent foot ulcers and pressure lesions, as well as offloading the at risk/diabetic foot. Many of these changes have been seen in the field of orthotic and shoe sole "therapy". When the first rocker footwear, Massai Barefoot Technology (MBT) of Switzerland arrived in Australia in 2004, commercially produced rockers were a new concept. This original "unstable" rocker because TGA approved as medical grade footwear here in Australia. In the intervening 17 years, many commercial copies and adaptions have been brought to market worldwide. It is also an integral feature of offloading CAM walker boots. Medical Grade footwear traditionally contains heel height (referred to as drop in the sports footwear industry) as well as in the shoes insole/footbed. E.g. Dr Comfort of USA specifically markets depth/wide footwear to the diabetic market with the in-shoe footbed being approximately 6mm in heel height. As we know with ulcers of the forefoot, heel height in shoes/orthotics is not ideal. Under Prevention Recommendation 12, potential foot surgeries are mentioned, if applicable. Yet, the subject of heel height in shoes is not mentioned, despite Achilles Tendon lengthening being considered. Even zero drop anatomically lasted, protective sports shoes are a good starting point for unloading an over-loaded forefoot, when in the wrong shoes. As well, proprioceptive facilitating orthotics are now available which work specifically to switch on foot intrinsics, while also offloading heel and forefoot. A model for diabetes also contains a material called Celliant in the top cover, which is clinically proven to increase oxygenation of tissues.	We appreciate the reviewer's comments and personal observations. However, as the reviewer is referring to preventing ulcers and the prevention guidelines specifically there does not seem to be any specific content we can consider to address in terms of offloading treatment for those with ulcers we are afraid. We also note the reviewer submitted similar comments to the prevention guideline group/panel to consider as well and we will allow the prevention panel to consider those comments to address in the prevention guideline.	N
2	Individual	Although outside of the scope of the guidelines, it would also be useful to have practical guides or an outline of minimum expectations for offloading modalities. While the guidelines provide recommendations and what should / could be done, they are limited in then instructing a professional on how that should be done. It's frequently acknowledge that management of DFU is a complex area and requires specialist skills, a greater framework around offloading expectations and process would be useful to build clinical skillsets and set benchmarks.	We thank the reviewer for these comments, and we think we agree but we were a little confused as well. We say this as we had thought that the guidelines did provide minimum best evidenced expectations of what offloading modalities should be considered in which foot ulcer situations when systematically weighing up all eight GRADE parameters that essential facilitate marrying the evidence and practicalities for treatments. Further, we had hoped that the Implementation considerations sections for each recommendation also cover some of the how a professional should practically apply the recommendation (including when specifically in geographically	Y p2 Tables of Contents & p46 Figure 1

			remote/resource limited locations) and how this can be monitored in terms of benchmark data collection with future details on these in the eTables B in the Supplementary Material. However, we apologise to the reviewer if this hadn't come across in the guideline and to try to make this more explicit we have now added a Table of Contents at the start of the guideline for readers to be able to more readily identify what they are looking for, plus a new Australian evidence-based clinical pathway on offloading treatment (Figure 1) that tries to bring all these points together in a simple one page pathway.	
3	Individual	This is a great initiative and congratulations to the team involved in this rigorous work. It is a very well researched, written and presented guideline which will have a huge positive impact in everyday clinical care and improved patient outcome. It was much needed and on time.	We very much thank and appreciate the reviewer's kind comments and hope as well that these guidelines will have a positive impact on clinical care and improved outcomes for our patients.	N
4	organisation	Under implementation considerations: - change insole to orthoses. This reflects ISO terminology and terminology used by private health insurance funds, the NDIA, state equipment schemes and other funding bodies. It is a term that recognised by professionals and consumers. - AOPA commend the panel's comment for an "equitable national access to recommended offloading devices via a national publicly-funded scheme, such as Medicare Benefits Schedule". AOPA continue advocating for the adoption of the Allied Health Reference Group's recommendation 3 to include an orthotic item in the MBS. This would reduce the cost to patients who need to access an assessment by an orthotist/prosthetist.	We thank the reviewer for their comments and refer them to our earlier responses to similar comments regarding including the term "orthoses" now more explicitly under the catchall term of "pressure offloading insole". Otherwise we appreciate the reviewer's efforts and support for our strong suggestion that equitable national access to offloading devices needs to be considered by governments if we are to reduce the national DFD burden.	N
5	Organisation	We appreciate and value the new sections for subgroup considerations for geographically remote and Aboriginal and Torres Strait Islander people. It is great that the guidelines acknowledge the significant health disparities for these populations.	We very much thank and appreciate the reviewer's kind comments on our new sections on geographical remote and Aboriginal and Torres Strait Islander considerations. We obviously completely agree that they are/were needed and now hope that all health professionals in their daily DFU practice work with Aboriginal and Torres Strait Islander patients, families, health workers and communities to produce the best outcomes for Aboriginal and Torres Strait Islander people with DFU and close the DFU gap in Australia.	N
6	Organisation	Thank you for the hard work you put into this document! Appreciate it.	We appreciate the reviewer's kind comments.	N
7	Organisation	Need more evidence for the neuroischemic DFD. Consideration of clinical practice	We thank the reviewer for their concluding comments and completely agree. We hope the	N

		Consideration of current funding for TCC etc.	reviewer agrees that we had already addressed these suggestions throughout the guideline. For example we suggested more research is required to improve the offloading evidence based for all DFU types (including nueroischeamic), consideration of clinical practice is included in the procedures of all recommendations, and consideration for current funding for non-removable knee-high offloading devices (including TCCs) is also covered in multiple areas throughout the Guideline recommendations and discussion section already along with more detail in the eTables in the Supplementary material.	
8	Individual	The logistics of funding for off-loading devices/logistics of having a fully-trained, easily accessible TCC service is one of the big challenges in offloading access for clinicians in Australia	We again thank the reviewer for their comments on the funding, training and accessibility of non-removable knee-high offloading devices (including TCCs) and agree. We again refer the reviewer to a similar comment immediately above and our response to that comment which we hope addresses this comment as well.	N
9	Individual	Further guidelines on how to successfully step down an individual from a knee high device is also required once they are healed.	We very much thank the reviewer for this very valid point and again completely agree that recommendations for offloading treatment for those patients that have recently healed is a major gap in the evidence and guidelines on offloading to prevent ulcers (in the prevention guideline) and heal ulcers (in the offloading guideline) in both the Australian and IWGDF guideline. To address this very good point we have added a sentence to the end of the Limitations section in the Discussion to identify this important global limitation and strongly suggest future guideline iterations on offloading treatments should include recommendations for those with recently healed ulcers.	Y p41 in the Discussion
			Answered	9
			Skipped	5

REVIEWER OVERVIEW

#	TYPE	TYPE
1	Individual Reviewer	1
2	Reviewer on behalf of an organisation *Northern Health, Dietitians Australia, Pedorthic Association of Australia	3
	Answered	4
	Skipped	0

BACKGROUND

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
You are involved with the care of patients for whom this draft Australian wound healing guideline is relevant.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
There is a need for a new Australian wound healing guideline in this population.	25%	1	50%	2	25%	1	0%	0	0%	0	**4**
The rationale for developing a new Australian wound healing guideline on this topic is clear in this draft guideline.	50%	2	50%	2	0%	0	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

METHODOLOGY

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
I agree with the overall methodology used to develop this draft Australian wound healing guideline.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
The search strategy used to identify international guidelines on which this draft Australian wound healing guideline was based is relevant and complete.	25%	1	50%	2	0%	0	25%	1	0%	0	**4**
The methods used to determine the suitability of identified international source guidelines upon which this draft Australian wound healing guideline were based were robust.	25%	1	50%	2	25%	1	0%	0	0%	0	**4**
I agree with the methods used within this draft Australian wound healing guideline to interpret the available evidence on this topic.	25%	1	50%	2	25%	1	0%	0	0%	0	**4**
The methods used to decide which recommendations to adopt, adapt or exclude for the Australian context were objective and transparent.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
									Answered		**4**
									Skipped		**0**

RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
The recommendations in this draft Australian wound healing guideline are clear.	50%	2	25%	1	25%	1	0%	0	0%	0	**4**
I agree with the recommendations in this draft Australian wound healing guideline as stated.	25%	1	25%	1	25%	1	25%	1	0%	0	**4**

The recommendations are suitable for people living with diabetes-related foot disease.	25%	1	50%	2	0%	0	25%	1	0%	0	**4**
The recommendations are too rigid to apply for people living with diabetes-related foot disease.	0%	0	0%	0	25%	1	75%	3	0%	0	**4**
The recommendations reflect a more effective approach to improving patient outcomes than is current practice.	0%	0	25%	1	50%	2	25%	1	0%	0	**4**
When applied, the recommendations should produce more benefits than harms for people living with diabetes-related foot disease.	0%	0	100%	4	0%	0	0%	0	0%	0	**4**
When applied, the recommendations should result in better use of resources than current practice allows.	0%	0	25%	1	50%	2	25%	1	0%	0	**4**
I would feel comfortable if people living with diabetes-related foot disease received the care recommended in this draft Australian Wound healing guideline.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
										Answered	**4**
										Skipped	**0**

IMPLEMENTATION OF RECOMMENDATIONS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
To apply the draft Australian wound healing guideline may require reorganisation of services/care.	0%	0	75%	3	25%	1	0%	0	0%	0	**4**
To apply the draft Australian wound healing guideline may be technically challenging.	25%	1	25%	1	50%	2	0%	0	0%	0	**4**
The draft Australian wound healing guideline may be too expensive to apply.	25%	1	25%	1	25%	1	25%	1	0%	0	**4**
The draft Australian wound healing guideline presents options that will likely be acceptable to people living with diabetes-related foot disease.	25%	1	75%	3	0%	0	0%	0	0%	0	**4**
										Answered	**4**
										Skipped	**0**

FINAL THOUGHTS

QUESTION	STRONGLY AGREE		AGREE		NEITHER AGREE OR DISAGREE		DISAGREE		STRONGLY DISAGREE		TOTAL
This draft guideline should be approved as the new Australian wound healing guideline.	25%	1	50%	2	25%	1	0%	0	0%	0	**4**
This draft Australian wound healing guideline would be supported by the majority of my colleagues.	0%	0	75%	3	25%	1	0%	0	0%	0	**4**
If this draft guideline was to be approved as the new Australian wound healing guideline, I would use or encourage their use in practice.	25%	1	50%	2	0%	0	25%	1	0%	0	**4**
										Answered	**4**
										Skipped	**0**

SPECIFIC COMMENTS ON RECOMMENDATIONS

#	RECOMMENDATION	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1	Recommendation 1	Organisation	what about maggot debridement, ultrasound debridement. No mention of amputation.	We thank the reviewer for their suggestion. We have updated the manuscript to reflect that we agree with the IWGDF that there lacks high quality evidence in preferencing alternative methods of debridement over sharp debridement, and as such sharp debridement is the preferred method of choice across multiple settings. We have also updated the manuscript to reflect that surgical debridement may be indicated in the presence of gas forming infection, abscess or necrotizing fasciitis, as stated in the IWGDF Guideline (2019).	Y, p11-12
2	Recommendation 2	Organisation	What is prioritised? shouldn't it be cost benefit? Other wound characteristics need to be considered eg TIME principle.	We thank the reviewer for their suggestion. TIME is a widely used principle/wound assessment tool and we agree that it is useful as a guiding principle. However, we respectfully disagree that this should be included in the recommendation; the overwhelming evidence is that apart from sucrose-octasulfate impregnated dressing (Recommendation 4), there is no evidence to support the use of one dressing product over another in accelerating wound healing in DFU. In view of this, the IWGDF (and the panel) have addressed the PICO question with generic principles of wound care, being a holistic assessment, exudate control, comfort and cost. However, we have suggested that TIME principles be additionally considered when choosing an appropriate dressing. We have separately addressed, in the discussion section, that apart from the single study addressing cost-effectiveness of sucrose-octasulfate as an adjunctive therapy in noninfected, neuroischemic wounds, there is, overall, a dearth of cost-effectiveness data across all 13 wound healing recommendations, and until backed by high	Y, p17

				quality data, the evaluation of cost effectiveness of one product over another remains subjective.	
3	Recommendation 8	Organisation	this is really vague.	We thank the reviewer for their feedback, and have edited the summary justification to clarify the rationale behind the decision. We refer the reader to the IWGDF guidelines and systematic review for evidence behind this decision, which we have summarized in the manuscript. The wording “we suggest not using” is reflective of the weak strength of recommendation against the intervention (NPWT in non-surgical DFU) according to GRADE terminology and suggestions for wording of recommendations.	Y, p24
4	Recommendation 9	Organisation	if not TGA approved why is it recommended? Is this contrary to recommendation 2 re: cost?	We thank the reviewer for their suggestion. The panel agreed to adapt this recommendation (as opposed to exclude) on the merits of the strength of evidence and balance of effects in favour of placental-derived products, despite lack of cost-effectiveness data, which is acknowledged in the manuscript and identified as an area for future research. The panel is aware of dehydrated placental membrane products receiving TGA approval in December 2020. We encourage users/health practitioners to take into account potential (but yet unknown) costs when choosing to implement this treatment option.	N
5	Recommendation 11	Organisation	If not TGA approved why recommend?	We thank the reviewer for their suggestion. The panel thoroughly debated the decision to adapt (as opposed to exclude) this recommendation based on its current unavailability. The collective and unanimous decision of the panel was to include the recommendation with the caveat “only if this adjunctive treatment becomes approved for use in Australia”, reflecting the current evidence of benefit of this product as an adjunctive treatment and so as not to preclude its use in future if this treatment did become approved by the TGA in future.	N
6	Recommendation 13	Individual	Include only the affirmative suggestion.	We thank the reviewer for their suggestion. The recommendation was made to answer the PICO question “In individuals with active	N

				DFU that are difficult to heal, do interventions aimed at correcting the nutritional status (including supplementation of vitamins and trace elements, pharmacotherapy with agents promoting angiogenesis) in comparison to standard care help promote healing? In reflection of the importance of general nutrition in wound healing, the panel added the statement “but note nutritional status should be reviewed, and adequate daily nutritional requirements should be met as part of best standard of care”. Unfortunately, removing the negative suggestion would not reflect the original PICO question in the IWGDF Guideline and hence we have retained the recommendation as stated.	
7	Recommendation 13	Organisation	This recommendation would be easier to follow if it was split into two statements, with the positive statement first, ie "Optimal nutritional status is essential for good diabetes management and wound healing. Nutritional status should be reviewed and adequate daily nutritional requirements should be met as part of best standard of care, using a standard assessment tool such as MST,MNA, PS-SA or SGA and preferably provided by a dietitian experienced in diabetes management. We suggest that there is insufficient evidence to recommend using supplements of protein, vitamins and trace elements or pharmacotherapy with agents promoting angiogenesis in patients with a diabetic foot ulcer."	We thank the reviewer for their suggestion and refer to the comment above (comment 6) on wording of the recommendation to answer the PICO question asked. We acknowledge there are recommended assessment tools for nutrition, however as this was outside the scope of the guideline the panel did not evaluate the evidence behind these tools as part of the guideline methodology, and as such are unable to include these. We have updated the implementation considerations in the guideline to recommend referral to a dietician experienced in diabetes management for additional nutritional support, and thank the reviewer for this suggestion.	Y, p39
				Answered	3
				Skipped	1

OVERALL COMMENTS/FEEDBACK

#	REVIEWER TYPE	REVIEWER COMMENT RECEIVED	CHAPTER GROUP RESPONSE	MANUSCRIPT CHANGE (& PAGE NUMBER IF CHANGED)
1	Individual	I find the inclusion of negative suggestions i.e. 'we suggest not using ....' to be confusing. For Recommendation 13 for example why not just use the affirmative 'We suggest that nutritional status should be reviewed, and adequate daily nutritional requirements should be met as part of best standard of care'.	We thank the reviewer for their feedback. As mentioned above, the wording of recommendations in the negative was based on responses to the PICO question(s) and recommended terminology by GRADE when the balance of effects favors good standard of care over the intervention. In addition, the Clinical Pathway has made the negative suggestions a separate box in red text, to provide clarity in this point, and ease of reading the organisation of the wound healing pathway.	N
2	Organisation	Many of the recommendations start with a negative. They would be easier to follow if the positive came first. eg "We recommend best standard of care in preference to ....."	We thank the reviewer for their feedback; and refer the reviewer to the above response.	N
			Answered	2
			Skipped	2