Author's response to reviews

Title: The foot-health of people with diabetes in a regional Australian population: a prospective clinical audit

Authors:

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Author's response to reviews: see over
Thank you for the opportunity to improve our paper. We have considered all the points raised by the editor and reviewers and would be grateful if the revised paper is considered for publication in the *Journal of Foot and Ankle Research*. Byron Perrin, Marcus Gardner and Susan Kennett.

**Editor's comment:**

1. Use italicised p to indicate p values.
   Completed
2. Review p values that are ‘0.0005’ and consider replacing with ‘<0.001’.
   Completed
3. Consider referring to Table 2 in page 6, paragraph 3, as this is where the UT classification system is first introduced.
   Completed
4. Be consistent with use of decimal points. For example, on page 7, where `13%` is used and should be `13.0%`. This also applies to Table 4 (frequency column) and Figure 2 (sub-acute bar).
   Completed
5. Review spacing between symbols and values (such as on page 8) and ensure consistent.
   Completed
6. Reformat Tables to remove vertical lines.
   Completed
   This has been completed, although we worry about how Table 1 looks. Horizontal lines may need to be removed also?
7. Tables 5 and 6: when reporting the 95% CI, consider replacing commas with ‘to’.
   Completed
8. In text referencing (pages 12 and 13): please ensure multiple references are merged appropriately (e.g., [20][21] should be [20,21]).
   Completed
9. References: Please abbreviate the journal for reference 16.
   Completed

**Reviewer 1**

**Major Compulsory Revisions**

1. Abstract: Results: Sentence 2. The suggestion is 49% of people had at least peripheral neuropathy. This is actually difficult for the reader to tell from the main paper and may be inaccurate as peripheral arterial disease or “ischaemic foot” has been pooled into the ‘at least neuropathic’ proportion. Please clarify whether this is accurate or requires changing as per Major point 4 etc.
   This is accurate. See below for discussion around the “ischaemic foot” classification

2. Background: Paragraph 2: Last Sentence. I’d probably change this strong statement to a more moderate statement as the authors seem to compare the findings of their study to other relevant Australian studies or papers throughout this paper (e.g. McGill (2005), Perrin (2006), Bergin (2011) etc). May I suggest you change the “There is a paucity ... “ to “there seems to be a limitation” or similar.
   Last sentence has been modified.
3. Background: Paragraph 3. The reviewer was somewhat confused throughout the paper on what patients were eligible to attend the services, and thus, the exact population of the study. May I suggest the authors add a sentence that exactly defines and clarifies the services overarching eligibility criteria to assist the reader to exactly understand what patients were eligible to attend, i.e. the study’s population, as this would seem to affect the entire article’s conclusions. This sentence may go here or probably better in the methods section. Maybe a sentence along the lines of “All patients with diabetes residing in the Loddon Mallee region were eligible, and local or national guidelines encouraged their referral, to attend the “Podiatry Diabetes Model” or publicly-funded podiatry services......... “. Just something that definitively tells the reader exactly what the study population is as the authors compare their findings to other studies with potentially different study populations throughout this paper. Please clarify as this would then address several other Major Revision points.

There is quite a detailed table (Table 1) that explains how the podiatric services within the model function with respect to the patients that are appropriate to be seen. The “aims for funding column” give an indication of who is eligible to be seen. To make this clearer, more information is given in this table that further describes this. This is formatted in the table as providing an “example case”

Note: the other reviewer felt the background of study population was detailed.

4. Methods: Paragraph 3. This is the first mention, however, throughout the article this reviewer has some difficulty reconciling having an “ischaemic foot” which may be an ABI recording of 0.8 according to the UT risk system (otherwise classified as mild peripheral arterial disease by American Diabetes Association (2003) ‘Consensus on PAD’) being included as an “active diabetes-related foot complication” in the same ‘category’ as “neuropathic wound”, “acute Charcot” or “infected foot”. This reviewer also has more concerns seeing “ischaemic foot” pooled into “at least peripheral neuropathy’ when it may very well not be neuropathic, however, it would appear that it could be collapsed into an “at least at risk” category. Please clarify.

It is our view that the priority when determining the significance of each of the risk categories should lie with what the originators of the UT Risk Classification system (Lavery, Armstrong et al.). Our interpretation of the original UT classification validation papers is that having an “ischaemic limb” is indeed an active diabetes-related foot complication that is a risk factor for a lower limb amputation. In the debate around how an ischaemic limb is diagnosed, we feel we must defer to the assessment methods described in the validation papers of the tool- which includes statistical analysis of original observations, rather than a consensus document as the ADA recommendations are. Furthermore, although there are limitations in assessing blood flow in people with diabetes as described in the discussion, our clinical practice adheres as much as possible to that described by the UT classification validation papers.

So, no changes are made in the text relating this point at this stage. Ischaemic limb is still regarded as an active foot problem.

The reviewer would suggest that either retain the original 8 categories as per the very good Perrin (2006) article and then be able to compare % of the eight categories to this article as they do later in this paper anyway. Or if the authors still wish to collapse 8 categories of the original UT risk system, then please collapse down
into that defined by existing literature. May the reviewer take the liberty to refer the authors either to the recent NHMRC or IWGDF guidelines (i.e. low, increased risk, high risk, acute risk) or an excellent recent Systematic Review of Diabetic Foot risk classification tools (Monteiro-Soares M et al. Risk stratification systems for diabetic foot ulcers: a systematic review. Diabetologia 2011.). This reviewer knows this may be a pain but believes it will add much value to the paper and decrease a substantial potential limitation or error of the paper.

The reason for the pooling is for a more appropriate, meaningful and powerful statistical analysis. If possible we sought to reduce the number of categories to be analysed. Whilst it is true that the eventual pooled categories are not those described by UT, NHMRC, IWGDF we would like to argue the following points: 1. There is still debate around the most appropriate risk classification to be used (e.g. UT, SAD(SAD), PEDIS) 2. Some of the systems suggested (e.g. NHMRC, IWGDF) are based on consensus statements 3. Most importantly: In reality the biomedical risk factors for serious diabetes-related foot problems are well known and despite the debate around the exact systems to be used, the assessment/diagnosis decision making is very similar across all systems. This reinforces our view that it is appropriate to pool the risk categories for the statistical analysis in the way we did as we believe it makes good clinical sense:

- No neuropathy- low risk of ulcer
- Neuropathy- Risk significantly increased (e.g. UT Texas cumulative risk of OR: 7x)
- History pathology- Significantly at risk of ulceration (e.g. UT Texas cumulative risk of OR 36x. Also, this category has been demonstrated to be very highly predictive of future ulceration in many studies
- Active foot problem- All the Categories 4-8 that increase the risk of lower limb amputation- the most severe diabetes-related foot consequence (apart from death.

In summary, we have made a further brief comment in the methods to further justify our thinking.

5. Methods: Paragraph 4: Sentence 2. It seems later in the results, although not definitively, that the authors have used post-hoc t-tests after using ANOVA to identify significant differences between 2 specific groups within the multiple groups tested with ANOVA. However, post-hoc t-tests haven't been mentioned although the authors seem to identify significant differences between 2 groups within the existing ANOVA test. Please clarify if the authors have used post-hoc t-tests or not. If authors have please add in methods.

Post hoc tests for the ANOVA analyses were used to determine where any differences between groups may lie, and the results are reported. To clarify, a modification to the sentence has been added in the methods.

6. Results: Paragraph 2: Sentences 3 & 6; Paragraph 3: Sentence 3. As per point 5 above it would appear that the authors have used a post-hoc t-test to make the statement that 2 specific groups within the ANOVA test were significantly different from one another. If not please clarify, and if so, please state the pValue of the post-hoc t-test in these sentences.
This change has been made.

7. Discussion: Paragraph 1. The authors may also need to better clarify why this model is a “successful” use of scarce publicly-funded podiatry resources when nearly half of the people managed are in the low risk category. According to several papers and guidelines these low risk patients gain questionable benefit from specifically using podiatric resources.

The comment in this paragraph asserts that the Podiatry Diabetes Model has been successful relates to the empirical testing that has been previously been done (and is cited) into whether the PDM is achieving its aims- that it is ensuring that patients are being seen by the most appropriate podiatric service according to risk category. The paragraph has been modified (last sentence) to make this clearer.

8. Discussion: Paragraph 2: Sentence 2. As per Major Revision Point 4. Can the author’s definitively say that “under fifty percent of the sample had peripheral neuropathy” when that number potentially includes patients with only “ischaemia” or only “history of ischaemic wounds” etc. Please clarify.

This has been clarified.

9. Discussion: Paragraph 2: Sentence 2. As per Major Revision Point 3 the reviewer would suggest very clearly clarifying the population of this study and other comparative studies as the statement that “a high prevalence over double that of the clinical populations .... “ found in this study may be inaccurate if this study’s population is of a diabetic foot clinical population. The reference studies used to compare here could be better defined as population based studies or at the very least general diabetes clinic populations. Whereas this studies population may be argued as a diabetic foot clinical population, otherwise better clarified as per Major Revision point 3. If we compared this study to other diabetic foot clinical populations the 50% sample having at least peripheral neuropathy or “at increased risk” would be judged as low compared to 65% (Armstrong DG et al 1998), 63% (Peters EJG et al 2001), 58% (Perrin 2006) etc. This study’s population appears to potentially straddle the general diabetes and diabetic foot populations, and thus, the authors may need to specifically clarify or be careful how they compare to these or outline these differences somewhere (maybe in limitations).

This has been addressed in the limitations: Page 16, end of paragraph 2.

10. Discussion: Paragraph 2: Sentence 3 & 4. As per Major Revision point 4, including “ischaemic foot” in the category of “serious active diabetes-related foot complication” may need some clarification or portioning out of this overarching category.

See above.

11. Discussion: Paragraph 2: Sentence 4. As per Major Revision 9, clarifying the overarching eligibility criteria of this study’s model may need to be undertaken. Again compared to population-based or at the very least general diabetes clinical population this “incidence of new serious foot complications” is high, however compared to diabetic foot clinical populations it is low as seems evident when compared to the reference provided to Perrin 2011 in Paragraph 3.

Clarified in the last sentence of paragraph 3 (the Perrin 2011 reference)
12. Discussion: Paragraph 3: Last Sentence. As per Major Revision 3, 9 & 11. The authors probably need to clarify their population better, especially the overarching eligibility of their services. The figure of 30%+ for annual incidence of diabetes-related foot ulceration is not unusual when compared to other studies above investigating diabetic foot clinical populations.
No conclusions are reached about the results stated in the Perrin 2011 reference. This statement informs the reader of previous research undertaken in a sub-population of the current study.

13. Discussion: Paragraph 6: Sentence 1. Again as per Major Revision points 3, 9, 11, and 12, please clarify why it’s high against what defined population, explain or reference.
This sentence has been modified to reduce confusion. The paragraph is focusing on the risk factors for ulceration, so the last part of the original sentence is not required.

14. Discussion: Paragraph 6: Sentence 4. Again this reviewers statistical ability is limited, but quickly please clarify where its demonstrated that “the effect of age was reduced from a medium to a low effect”
The regression analysis suggested that younger age and diabetes duration confounded each others effect. The final model suggested that once these covariates were controlled for, only prior history of ulceration was the particularly strong predictor of incident ulceration.

15. Discussion: Paragraph 7. This paragraph makes some very bold and potentially inaccurate statements. It needs either reworking or much clarification as it doesn’t seem accurate when compared to recent NHMRC guidelines (Ref 28 in this paper) on this subject, in particular the statement “only two preventative strategies are supported by high level evidence to reduce the incidence of ulceration in a very high-risk population .... “. It would seem there are at least 4 recommendations with supporting level B, II or RCT evidence on this subject in the NHMRC guidelines and 8 recommendations with supporting level C, III evidence. The “two preventative strategies” mentioned here include one that is not mentioned in the NHMRC guidelines (i.e. dermal thermograph) although it does have level B evidence supporting; the other multi-d teams to manage diabetic foot ulcers has level C evidence supporting. I also question the reference to dermal thermometry and lengthy explanation when it wasn’t used in this study. Please strengthen, clarify or correct this paragraph.
In light of the other reviewers concern on this point- this paragraph has been deleted.

16. Discussion: Paragraph 8: Sentence 1. As per multiple points above. Please clarify population referring too here so as to quantify the strong statement made. It could be argued that there is in fact a low proportion of high risk patients seen compared some other studies as mentioned above.
The first sentence has been modified. In light of previous changes in line with this issue we think it makes logical sense.

17. Discussion: Paragraph 9. Existing literature would seem to argue against the statement “for these (low risk) patients it is important to provide podiatric treatment, management and implement prevention plans”. Again in the recent NHMRC guidelines (Reference 28 in this paper) there are no recommendations or evidence backing this statement that podiatrists should be providing management of low risk
foot patients. These guidelines are consistent with NICE (UK) and IWGDF which suggest that these low risk patients should have an annual screen by a trained health professional, but that’s about it. An Australian article by McGill et al (2006) even goes as far as to say that Numbers Needed to Treat (NNT) to prevent one foot ulcer in low risk patients by podiatrist is in excess of 266 patients. The NNT for people with neuropathy is 25 and those with previous pathology 8. These figures and recommendations would contradict much of the gist of this paragraph. Please review this paragraph or clarify.

We have deleted the sentence in this paragraph that we feel leads to possible confusion. (Sentence 2). The remaining points in the paragraph as still valid and evidence is supplied.

18. Discussion: Paragraphs 10 & 11. Whilst the limitations identified in the paper by the authors are appropriate, more would appear to be a little glossed over. Please clarify why the following weren’t viewed as potential limitations:

I. The difficulties in defining the population of this study and thus, difficulties in making definitive statements comparing to other studies
   See above- more detail in given in limitations

II. Potential problems with different eligibility criteria for patient intake across the different sectors within the model
   The eligibility criterion has been given more detail. We feel though that it is a strength of the model that several different podiatric services are involved and that they see patients across the entire risk spectrum.

III. Pooling diabetic foot risk classification into a ‘unique’ system
   More detail is added to the final paragraph of the discussion

IV. Problem with including “ischaemic foot” as a “serious active complication”
   See above

V. An actual control group or matching sites would have been nice, but potentially not feasible. However, this may be worth mentioning in limitations as it would have been interesting to see the foot health characteristics and utilisation of services without such a model or even at the same sites pre-model. This was referred to in Discussion: Paragraph 8.
   This is addressed in a new sentence at the end of paragraph 1, Discussion.

VI. There didn’t seem to be a real multi-disciplinary aspect to the study although multi-disciplinary approach is stated as a key factor in preventative care mentioned in Discussion: Paragraph 7. This maybe worthy of a mention in limitations as it would have decreased the new incidence of ulceration.
   We would suggest that no changes are required here. As recognised it is stated that the service that needs to be multi-disciplinary according to evidence (the service that is dealing with active problems in the main) is, in fact, multi-disciplinary.

VII. The ‘Acute’ setting saw all risks of diabetes-related foot complications when it would naturally appear that this setting should see the most acute foot complications only. It is worth mentioning why the service chooses to use Acute in this fashion.
   This is clarified in Table 1. The risk categories seen on acute are mixed because the podiatric service on the acute site was funded by a funding stream that deals with active foot problems (HARP) but also a stream that aims to service older people with chronic disease (GEM). As the number of patients seen on the acute service is low, we do not feel that this mix influences the overall conclusions.

Minor Essential Revisions
1. Abstract: Background: Sentence 2 & Background: Last Paragraph. Please make the aims stated in the Abstract and in the main paper more consistent with each other. For example one is “investigating” the other “understanding”, one refers to “regional” the other just “the “model”, one includes “characteristics” while the other doesn’t.
In light of the other reviewers comment- the word has been changed to “document”. No other changes have been made. The aim as stated in the introduction is more specific, and builds upon the information about the Podiatry Diabetes Model, which is within an Australian regional population. The abstract is accurate, but broader.

2. Background: Sentence 1. Please reference first statement. Whilst this is obvious to content experts and you provide further evidence in this paragraph, this may not be as obvious to non-content experts. Even just reference to AIHW (ref 4) as it discusses and quantifies diabetic foot burden
This has been done.

3. Background: Paragraph 2: Sentence 2. Reference 10 seems to be placed in a very odd spot and may not actually be required as it’s a methodological report for the findings in reference 11 from memory. Please either shift reference to the appropriate spot or remove if it’s not adding anything.
Reference shifted to end of sentence- it directs the reader to the age of the study.

4. Results: Paragraph 6. Statistical analysis is not this reviewer’s strong suit, however, although this is a logistic regression rather than linear should we technically have an “Adjusted R2” results or similar to clearly outline the explanatory power or the variance accounted for by the variables? I can’t work out from the results given and Table 6, how the authors have concluded that “accounted for 23.4% of the variance for the logistic regression model, of which history of pathology accounted for over 18% of the variance”. Please clarify as it might just be this reviewer’s basic knowledge of analysis.
The % of variance is based upon the Nagelkerke R Square test, which acts as a pseudo R square indication as can be found in linear regression. This is clarified in the text.

Discretionary revisions
1. Abstract: Conclusion: Sentence 1. You may need to compare the “disproportionally large number” with something here, e.g. compared to population-based studies etc.
This sentence has been changed to be more specific and less generalised- in light of other reviewers comment also.

2. Background: Sentence 2 & 3. May I suggest you combine these sentences as it’s essentially the same list of potential diabetic foot complications.
Not changed to aid in readability. The complications are different and joining the sentences will ensure a much longer sentence.

3. Background: Paragraph 3: Sentence 1. It would be very useful if the authors could state a population figure for the “Greater Bendigo area” or “Loddon Mallee region” or the total general population that the services service. This would assist other services with estimating services needed in their regions and add perceived value to the paper
A figure has been added. It is not referenced, as it is a figure that we are approximating. The ABS cites that the Loddon Mallee region of Victoria has around 300,000 people, but the podiatric services within the Podiatry Diabetes Model do not extend their services throughout the entire Loddon mallee region. Therefore, an approximation by the authors has been made.

4. Background: Paragraph 3: Sentence 3; It would be very useful if the authors could state the full-time equivalent podiatry or diabetic foot staff that service each service category (i.e. community, sub-acute and acute). This again would assist other services with estimating services needed in their region’s service sectors and add perceived value to the paper. This information has been added to Table 1.

5. Background: Paragraph 3: Sentence 7. To better clarify this sentence, may I suggest adding in the underlined to better clarify, “the fundamental goal of the model is to help direct a patient with diabetes to the most appropriate podiatric service equipped to manage that patient’s future risk …. “as the authors have done themselves later on in the paper. Change made as suggested

6. Background: Paragraph 3: Last Sentence. I’d suggest also toning down this statement to read something like “The model has been evaluated and seems to be effective in achieving this goal”. It could be argued on face value that its success in achieving the goal was questionable considering many patients attending the “acute service” are not acute and in fact low risk. To the reader this may not be a “proven” and “successful” use of resources. Otherwise please clarify. The term “proven” relates to the statistical analysis undertaken previously that does indicate that the PDM is functioning as intended- that is, that it is directing the patient to the most appropriate service. However the sentence has been modified slightly.

7. Methods: Paragraph 4: Sentence 3 & 4; Results: Paragraph 5. It may be the reviewer’s poor grasp of gramma, but “incident ulceration” always sounds confusing through-out the article. Would it be less confusing to refer to it as “new incidents of ulceration” or just “new ulceration”? No change has been made- will defer to editors direction if required.

8. Results: Paragraph 3. As per Discretionary point 4, it would additionally useful to state the % staffing overall allocated to each sector (i.e. community, sub-acute and acute) to determine if the higher number of patients seen by a particular sector may have corresponded to a higher staffing mix. This is beyond the scope of the current paper, which is reporting on the foot-health characteristics. The focus on the staffing mix of the PDM is given to a previous article. (Reference 14)

9. Results: Paragraph 3. Again it would be useful to evaluate the number of visits per diabetic foot risk category in the 3 months. This would assist other services when estimating the staff mix required to service different diabetic foot risk categories. See previous article. (reference 14)

10. Results: Paragraph 3 & 4. Can these paragraphs be potentially shortened as they seem to be taking the exact results from a previous study, instead of introducing and outlining results from this specific study, in the results section?
We felt it important to briefly outline some of the background information but without elaboration, which can be found in article 14. The paragraphs have been joined, but no other changes made.

11. Results: Paragraph 6. This is a very long sentence. Can it be broken up a little for ease of reading and understanding for the audience? Paragraph now in two sentences.

12. Discussion: Paragraph 1. Sentence 1. Consider breaking this long sentence up and clarifying better. I’d also suggest adding in the word “diabetes” in “across populations of people with diabetes attending .... “. The word diabetes has been added.

13. Discussion: Paragraph 1: Sentence Last. As per Discretionary Revision point 6, I’d suggest toning down this conclusion of “successfully” functioning model. Sentence has been modified.

14. Discussion: Paragraph 2: Last Sentence. Whilst this is true, isn’t this what the service should want to see? Maybe clarify this as the case. No changes made here.

15. Discussion: Paragraph 5. Probably suggest not abbreviating IRSD as it’s only been used a handful of times and it’s therefore easier for the reader to follow if spelt out. Change made.

16. Discussion: Paragraph 8: Sentence 3. Overall there are some very good recommendations made in this paragraph. It may be useful to use the gist of this sentence as a recommendations to counter the potential limitation of this paper that it ‘straddles a population-based, general diabetes clinical and diabetic foot clinical population’. No changes made here.

17. Discussion: Paragraph 9: Sentence 1. Again as per Discretionary point 14 above, this point would go well as a recommendation to counter this limitation of the study. No changes made here.

Reviewer 2

Major Compulsory Revisions

Abstract. The participants with neuropathy were older than those with no neuropathy, those with neuropathy + previous history and those with active foot pathology + neuropathy. The statement in the results that “Higher risk at baseline was associated with younger age” is an oversimplification. Please rephrase this to include which groups are being compared and report the ages as reported in the main text. We agree that the statement regarding younger age may be confusing in the abstract without further explanation. We have removed this reference to comply with brevity for the abstract. The issue is still important, but is explained in detail in the results section.

The study cited in page 11 paragraph 1 provides important data on hospital separations and the impact of socio-economic disadvantage but does not draw
conclusions about the incidence of diabetic foot complications per se. Other factors such as access and how the condition is managed will affect admission rates. The results of the current study add to the body of data for this region but are not evidence of a higher incidence of disease in the regional population. The 30% rate of foot ulceration for the Diabetic Foot Clinic cited elsewhere as “in press” may also be explained by re-ulceration. It would be interesting to know if this ulceration rate is in a population of people with previous admission for diabetes-related foot complications. This section needs revision in order to be relevant to the results or deleted.

We agree that the Bergin article cited does not make inferences about true incidence of pathology. However, the article’s data is clearly suggests that local government areas areas with higher disadvantage are more likely to have more diabetes-related hospital separations than areas with lower disadvantage. The text has been simplified to avoid confusion.

It is true that the previously found incidence of ulceration in the region (from the Diabetic Foot Clinic) may include new re-ulceration. This still indicates true “incidence”, which is important as all ulcers need to be managed by health care professionals. The issue of “first ulcer” in a patient without prior ulceration is very important for other research questions, for example relating to interventions to prevent first ulceration.

Page 12, paragraph 1. Delete this paragraph on IRSD as it does not relate to results.

With great respect, we disagree with this suggestion. This paragraph provides further evidence that the local government areas of the Podiatry Diabetes Model have higher levels of disadvantage, building on the results found by Bergin et al. Our results found that there was a high proportion of people with diabetes seen by the PDM who had poor foot health and it is important to explore why this may be the case. The results from Bergin et al. suggest that it is not improbable that levels of disadvantage may be a factor, even if this was not specifically analysed in the present study. We have added a sentence at the end of the paragraph to reflect that this should be investigated further in future research.

4. Page 13. Delete the paragraph on dermal thermography as it does not relate to results.

This paragraph has been deleted

5. In the conclusion, the proportion of patient at significant risk might be better described as half. Consider as a discretionary revision - relating this to recommendations of the National Guidelines already cited and using the terminology used in this document.

Changed as suggested

6. Figure 1 needs more explanation

An explanatory legend has been added, including reference to the detailed description of the PDM.

7. While the definitions are published elsewhere, defining the characteristics (which are not adequately represented in Table 2) for each risk category would improve understanding of the results. Consider combining tables 2 and 4. As an example: Pooled risk category Definition / characteristics Frequency
1= No Neuropathy (Sensate to 10 g monofilament), No ischaemia (ABI >0.8, Toe systolic pressure 45mmHg)
2= Neuropathy with or without foot deformity, No ischaemia
3= History of neuropathic foot ulcer and/or Charcot’s joint, No ischaemia
4= etc

We have added detail about what each category means in Table 2. The description of how these were pooled is already in the methods section- page 7 paragraph 1

Minor Essential Revisions

1. In the aim: The term “to document” rather than “to understand” may be more appropriate
   Changed as suggested

2. Page 4 Line 16 “Over ten years ago”… move reference to later in the sentence
   Changed as suggested

3. The use of the term “baseline” in the abstract implies further results are available. As this is not the case I suggest this be rephrased.
   As the study is a longitudinal prospective study in that in some cases people were seen more than once and therefore followed up over the three month period. The term baseline refers to the results reported for their first contact during the study period. This is in contrast to the results from the longitudinal nature of the study, which refers to the three-month incidence of ulceration. No changes have been made at this stage to the text.

Discretionary Revisions

1. Page 5, line 2. Suggest the authors refer to ANDIAB data for foot complications taken from a survey of >3000 adults attending Diabetes Centres across Australia. 25.5% had Peripheral neuropathy. View the report for their statement of “Who will access a Diabetes Centre”. http://www.health.gov.au/internet/main/publishing.nsf/content/A1005EC898900956CA2571310006746B/$
   Thank you for this reference. The data has been added.

2. Page 11, paragraph 2. The age of those with active foot pathology is comparative to other published data on patients with foot ulceration. The majority of participants in the current study (85.6%) are older people with diabetes, half of which are have “no neuropathy” and are attending a service aimed at primary prevention and care of the frail elderly. The authors' phrasing may lead readers to conclude that those who ulcerated in this study were unusually young which is not the case.
   No changes made