patient. Was it because of the severity of disease in these patients, the technique of giving HBO₂T or due to certain other reasons.

- (iii) It is not clear whether the other medications were also stopped or only analgesics were stopped following improvement. Also certain studies have noted that hyperhomocysteinemia can be another cause of hypercoagulability in this disease and combination of folic acid, vitamin B-12, and vitamin B-6 (cofactors of homocysteine metabolism) are an effective treatment for hyperhomocysteinemia, hypercoagulability, and livedoid vasculopathy. Were they also used in these patients.¹
- (iv) Last but not the least, how does one decide the end point of the therapy or when to stop. Is it symptomatic relief, complete healing of ulcers, no improvement despite therapy or any other criteria.

In the end I would like to complement the editor for selecting such interesting case report related to use of HBO₂T. It will definitely give a wide publicity for use of HBO₂T in such

intractable disorders among all doctors and specially those serving in armed forces.

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Reply

Dear Sir,

I must at first thank the reader for taking the effort of reading my article and providing me the feedback. It is indeed endearing to receive any feedback and I will take my best effort to reply satisfactorily.

Thanks again to the reader for his compliments on the article. Answers to the queries are provided parawise below.

- (i) Yes it is true that checking the peri-wound partial pressure of oxygen (Po₂) using transcutaneous oximetry (TcPo₂) would have been beneficial in not only predicting the prognosis with use of HBOT but also for providing an objective proof of effectiveness as well as a measurable tool for judging end point if therapy. But TcPo₂ could not be done due to non-availability of the equipment with us at present. Maybe in the future if the equipment, TcPo₂ on every patient would be the way forward.
- (ii) The use of HBOT for this particular indication has been started much recently compared to other recognised indications and there are as such no randomised control trials. Therefore, adequate data on the average number of treatments required for complete healing is not available. It could be possible that with more patients being given HBOT for this particular indication, there would be more data available and an average of the optimum number of treatments could be arrived upon.
- (iii) As per documents of the patients available with the authors at the moment, it could not be ascertained whether or not the patients were taking any other medications apart from analgesics. At the time of treatment, patients had given history of use of analgesics along with conservative wound management only and the improvement in these parameters were recorded for ascertaining response to therapy. It is not clear whether

the other medications were also stopped or only analgesics were stopped following improvement. The readers input on homocysteine cofactors will definitely be used for managing similar patients in the future.

- (iv) In an ideal situation, the end point of therapy would be a combination of demonstration of elimination of peri-wound hypoxia using TcPo₂ along with clinical healing of ulcers. But in the absence of TcPo₂, clinical healing and symptomatic relief are the only criteria available. However, a randomised control trial into the indication would probably be able to provide more accurate data on the accurate end point of therapy.

In the end, it is relevant to mention that HBOT as a treatment modality is still in its nascent stages for many indications, livedoid vasculopathy being one of them. In times to come, as we treat more such patients across the world, we would have more data available and would be in a better position to treat these patients better.

Thanks again to the reader for very valuable inputs.

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