Supplementary Table 2. Additional Summary Results for Studies Where There was Insufficient Room in Table 2

Predictors of Healing and Amputation in Diabetic Foot Ulcers (DFUs)	
Vascular and Perfusion Parameters	
Ankle-Brachial Index (ABI)	For patients with diabetic foot ulcers, an ABI of 0.9 or higher does not provide definitive information regarding increased probability of healing, healing after minor amputation, or risk of major amputation. Conversely, an ABI less than 0.5 may be associated with a 30%–45% increase in the probability of non-healing or non-healing following minor amputation. When ABI falls below 0.4, the probability of major amputation increases by more than 45%.
Ankle Pressure (AP)	An ankle pressure (AP) of 50 mm Hg or greater is not consistently linked with enhanced probability of healing or healing after minor amputation. However, AP thresholds between less than 50 and less than 80 mm Hg may correspond to a 15% increase in the probability of major amputation.
Toe-Brachial Index (TBI) and Toe Pressure (TP)	The data reviewed do not indicate that TBI predicts healing of DFUs or minor amputation, nor does it predict outcomes of minor or major amputation. Toe pressure (TP) of 30 mm Hg or higher may be associated with at least a 30% increase in the probability of DFU and post-minor amputation healing. In contrast, TP below 30 mm Hg could correspond with a 15% increase in the probability of major amputation.
Transcutaneous Oxygen Pressure ($TcPO_2$)	$TcPO_2$ levels of 25 mm Hg or higher may improve the probability of DFU healing by at least 45%. When $TcPO_2$ is less than 20 mm Hg, there may be a small increase in the probability of minor amputation, but there is no evidence for an increased risk of major amputation.
Skin Perfusion Pressure (SPP) and Pedal Pulses	Skin perfusion pressure (SPP) of 40 mm Hg or higher can elevate the probability of healing or healing after minor amputation by up to 45%. The presence of pedal pulses may only slightly increase the probability of DFU healing (by 15%), but more substantially increase healing following minor amputation (by 45%). There is no evidence that abnormal or absent pedal Doppler waveforms affect the probability of DFU healing or the risk of minor or major amputation.
Predictive Accuracy of Percentage Area Reduction (PAR) in DFUs and VLUs	
Many studies examining PAR were post-hoc analyses and varied in the timing of measurements (ranging from 2 to 8 weeks). Different statistical methods were used. PAR demonstrates good discriminatory performance for predicting complete wound healing in DFUs, with C-statistic values between 0.72 and 0.91 (considered acceptable to outstanding). For VLUs, C-statistics ranged from 0.68 to 0.83, indicating a broader range from poor to excellent performance. Differences in wound age between DFU and VLU studies may partially explain variations in predictive accuracy.	

Inconsistencies in PAR measurement timing and outcome measurement timing across studies reduce the reproducibility and generalizability of PAR as a predictor of complete wound healing. Several measurement combinations have been evaluated, such as PAR measured at 2, 4, or 6 weeks to predict healing at 12 or 24 weeks. These variations may reflect differences in wound severity and evolving understanding of optimal measurement intervals.	
In summary, PAR shows promising discriminatory power for predicting complete wound healing and may be valuable in clinical trials. However, due to insufficient external validation and rigorous analysis, it cannot be recommended for routine clinical use by itself.	
Key Studies in DFUs and VLUs (N ≥200)	
DFUs: Notable Findings from Large Cohorts	
Beckert (2006)[1]:	Developed the Diabetic Ulcer Severity Score (DUSS) based on palpable pedal pulses, probing to bone, ulcer location, and presence of multiple ulcerations. Higher DUSS scores were associated with lower healing rates and increased likelihood of surgery or hospitalization. Each point increase in DUSS reduced the odds of healing by 35%.
Ince (2007)[2]:	Found that healing time was significantly associated with ulcer area, presence of peripheral arterial disease, and duration of diabetes. No association with age, gender, type of diabetes, or infection was observed in multivariate analysis.
Margolis (2003)[3]:	Identified that wound age greater than 2 months, area greater than 2 cm^2, and grade ≥3 increased the probability of non-healing. The probability of non-healing increased steadily with the number of these risk factors present.
Snyder (2010)[4]:	Reported that DFUs with less than 50% PAR at 4 weeks were less likely to heal by 12 weeks compared to those with 50% or greater PAR. Week 4 PAR showed the highest predictive accuracy.
Takahashi (2009)[5]:	Found that an increased number of ulcers and lower hemoglobin levels were significant predictors of non-healing status.
Chen (2017)[6], Ezeani (2020)[7], Ha Van (2020)[8], He (2017)[9], Hicks (2018)[10], Mathioudakis (2017)[11], Mohammad Zadeh (2019)[12], Tong (2020)[13]:	These studies highlighted the significance of factors such as MRSA infection, osteomyelitis, peripheral arterial disease, ulcer duration, renal function (eGFR), WIfI stage, wound area, and other comorbidities in predicting healing and adverse outcomes in DFUs.
VLUs: Key Predictors and Scoring Systems	
Cardinal (2009)[14]:	Convex-shaped VLUs with strong linear correlation between wound margin and area healed more rapidly and were more likely to close by 12 weeks. VLUs with $r^2 \geq 0.80$ had significantly higher closure rates than those with $r^2 < 0.80$.
Gohel (2005)[15]:	Older patient age and longer ulcer duration independently delayed healing.

Margolis (1999[16], 2000[17], 2004[18]):	Larger wound area, higher wound age, prior venous surgery, and certain clinical features increased the risk of non-healing. Logistic regression models based on wound size and duration predicted healing with good accuracy.
Parker (2016)[19]:	Living alone, less than 25% ulcer area reduction in two weeks, higher ulcer severity scores, and lack of high-level compression therapy were independent predictors of failure to heal by 24 weeks.
Marston (2017)[20]:	Female gender, leg wound location, smaller area, and shorter duration were associated with better healing.
Edwards (2014[21], 2018[22]):	Higher depression scores, more concurrent symptoms, and other patient and wound characteristics influenced time to healing. Area reduction and calf circumference reduction at two weeks were also predictive.
Finlayson (2017)[23]:	High-level compression and lower PUSH scores were strongly associated with healing.
Kerstein (2002)[24], Kulkarni (2007)[25], Skene (1992)[26], Taylor et al (2002)[27]:	Factors such as ulcer age, depth, area, location, VRT, BMI, patient age, and exudate amount were all found to influence healing rates in VLUs, with several studies proposing scoring systems for risk stratification.
Fife (2020)[28]:	A large dataset confirmed that factors like wound size, age, infection, ambulatory status, and hospitalization are significant predictors of healing, though the model performance (Cstat) was moderate.
Yang (2016)[29]:	Smaller ulcer size, lower wound age, and dyslipidemia were associated with improved wound healing.

Note: This is not an exhaustive list but limited to studies as relevant and/or N ≥200 as part of our selection criteria. These are presented as summary results to avoid plagiarism and readers are referred to original studies for more details.

Abbreviations: ABI, ankle-brachial index; AP, ankle pressure; BMI, body mass index; Cstat, C statistic; CVD, cerebrovascular disease; DFU, diabetic foot ulcer; DUSS, Diabetic Ulcer Severity Score; DVD, deep venous disease; eGFR, estimated glomerular filtration rate; IHD, ischemic heart disease; MRSA, methicillin-resistant *Staphylococcus aureus*; NLR, negative likelihood ratio; NPV, negative predictive value; PAD, peripheral arterial disease; PAR, percentage area reduction; PDFS, pain, depression, fatigue, and sleep disturbance; PLR, positive likelihood ratio; PP, pretest probability; PPV, positive predictive value; PUSH, Pressure Ulcer Scale for Healing; SPP, skin perfusion pressure; TBP, toe blood pressure; $TcPO_2$, transcutaneous oxygen pressure; TP, toe pressure; VLU, venous leg ulcer; VRT, venous refilling time; WIfI, wound, ischemia, and foot infection.

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