*Major Concerns:*  
The Long Abstract identifies MED as the minimal erythemal dose to an average Caucasian skin, but the technique described is designed to find the unique MED for an individual. Average values can be estimated by using the Fitzpatrick or Boston skin type method of choosing a start dose.  
  
Response: Individual testing is now specified in the abstract and first paragraph of the discussion.

The Protocol preparation point 1 should include a warning to the patient that some areas of the skin will be burned and may be sore, but that this is expected and normal, in order to 'bracket' the MED area with definitely erythemal and non-erythemal areas.

Response: Warning text was added to point 1.

The fore-arm is not the ideal site, since most people expose the arm to sun. A better choice (though less convenient) is the skin of the upper buttock, which is unlikely to be sun-exposed in most people.

Response: We prefer the inner fore-arm because it is more convenient and gets less UV exposure than some other body parts. However, we now mention the upper buttocks as another good option in the discussion.

The site needs to be chosen carefully to avoid skin blemishes.

Response: We added avoidance of skin blemishes to point 5 of the protocol.

In Point 8, the patient should be warned that the sensation of warmth is not burning during the test, to avoid rendering the test null and void through non-participation.  
  
Response: Point 8 was revised accordingly.

Note that in Protocol 2/5, the exposures are incorrect. After 20 minutes, hole 2 has 16 not 18 minutes, hole 3 gets 12 not 16 mins, hole 4 gets 8 not 12 minutes, hole 5 has 4 not 8 minutes and hole 6 gets 2 not 6 minutes.

Response: These times were corrected.

It's better to use a geometric ratio series with a constant ratio between adjacent apertures, such as 1.0, 1.4, 2.0, 2.8, 3.0, 5.6, 8.0 etc. with a ratio of the square root of 2 between adjacent sites. Better resolution can be achieved with more apertures and a ratio between of the cube-root of 2, so that there are two apertures between each doubling of dose.

Response: These suggestions were added to the discussion.

In the discussion of alternatives at the end, it is not acceptable to use a solar simulator for MED testing, since the spectrum of the metal-halide lamp is completely different from that of a TL-01 or UV6 fluorescent tube, and will give incorrect results.

Response: This was removed.

The Durham tester is a passive device that delivers 8 or 10 graded irradiances in a single exposure, without opening or closing of motorised apertures, by employing graded opaque printed dots or etched small holes in a metal foil, so that in one exposure, all the desired irradiances are delivered simultaneously. Saalmann GmbH (now MedLite) also offer a similar device.  
  
Response: Additional information about the DURHAM tester was added to the last paragraph of the discussion.

Any method of testing which employs a separate UV source from that of the treatment device must have its spectrum and irradiance verified and correlated with the treatment cabin's parameters, as noted in the last paragraph. This is probably the biggest source of error and confusion in using any MED/MPD methodology.

Response: This was emphasized in the last paragraph of the discussion.   
  
*Minor Concerns:*  
Note that Waldmann GmbH is short for Waldmann Gesellschaft mit beschraenkte Haftung (company with limited liability) so that adding '& Co. KG.' is redundant.  
  
Response: This was corrected.

The picture of the post-test result is poor - a better-illuminated photo would make this easier to read and assess.  
  
Response: If the editors would like a new image, we can create one when the video is created.

Further discussion of MED/MPD testing, and the importance of calibration and dosimetry can be found in the British Photodermatology Group Guidelines for dosimetry and calibration in UV radiation therapy (Br J Dermatol 2002, 146: 755-763.

Response: Information about this citation was added.