Reviewer's report

Title: Phase II Trial of Sequential Gefitinib After Response to Chemotherapy in Chinese Advanced Non-Small-Cell Lung

Version: 1 Date: 24 October 2006

Reviewer: David Spigel

Reviewer's report:

General
An interesting theory worthy of study.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)
1. It is odd that you would define survival from the start of chemotherapy when the chemotherapy used varied as did the line of treatment.
3. Dates for enrollment are different in the abstract and on page 7.
4. Were the chemotherapy responses confirmed? Doesn't seem likely if only 2 mos of treatment for some.
5. You should define the chemotherapy received.
6. In the discussion you mention that the TTP and OS compare to historical data. Historical data for which line of treatment? First? Second?
7. Need to make your point in the introduction why 2-3 cycles of chemo is "enough"
8. I'm confused re: your sentence on pg 12 re: subsequent synergy with chemo. Synergy refers to the effects of chemo and gefitinib together. But these drugs are not given together. It is only an assumption on your part that subsequent gefitinib in a pt who did not respond to chemo will not be effective (which is what I think you meant to say.) This is not fact. Pts indeed can respond to gefitinib or erlotinib after not responding to chemo.
9. Some would fault your choice to take someone off a therapy that was benefitting them (as evidenced by PR or SD) only to put them on another tx. I think in a study, however, this is worthy of investigation. Still, how would those pts have done had you kept them on their original tx? One way to look at this trial is that most of the PRs previously achieved with chemo were "lost" with gefitinib.
10. It is contradictory to say that the TTP and OS were "markedly" longer than with combination chemo, when earlier you say these results are comparable
11. Seems to be a bold statement that gefitinib should be used after a response is achieved after 2-3 cycles. This is a small phase II study - with a varied treatment population. I think you should soften.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
1. Would change to "Chinese Patients" in the title and in the conclusion of the abstract
2. Gefitinib should not be capitalized
3. First sentence of abstract: should be "has"
4. Abstract: Patients recived gefitinib at an oral dose of 250mg.
5. Use erlotinib instead of Tarceva
6. Would add "potentially" considerable toxicity in the introduction. Pemetrexed often is not toxic.
7. Define EGFR when using the acronym for the first time
8. Sequential regimen's - pg 4
9. Should put confidence intervals in the abstract
10. Fourteen...(should delete "of them"...) - pg 8
11. "observed at all sites of disease..." - pg 9
12. reported in "the" literature - pg 11
13. In this regard... - pg 12
14. should be n"a"velbine
15. who "have" thus...-pg13
16. study demonstrate...pg13
14. Table 1 - range not listed
15. Table 1 - why the asterisk next to smoking?
16. Prior shouldn't be capitalized
17. Should include median values on the graphs

Discretionary Revisions (which the author can choose to ignore)

1. Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article of importance in its field

Quality of written English: Needs some language corrections before being published

Statistical review: No

Declaration of competing interests:

I did one talk for Astra-Zeneca 3 years ago - and received small honorarium.