Reviewer’s report

Title: Dual oxidase 1 and NADPH oxidase 2 exert favorable effects in cervical cancer patients by activating immune response

Version: 0 Date: 01 Jul 2019

Reviewer: Paul B. Kaplowitz

Reviewer's report:

Having recently reviewed the literature on this topic for a review article, I applaud the authors for their attempt to tackle a difficult and confusing topic and to come up with good explanations for their findings. Also the cutoff of < or >20 for normal TSH makes more sense than a cutoff of 5 or 1 or 15. Their literature review is all focussed and reasonably complete.

Specific comments:

1. It is important to include under methods the method for free T4 used during the study period and the normal ranges for different post-natal periods for term babies and premies if available. RIA methods are more like to give low results for sick premies than equilibrium dialysis methods and could explain why so many of their infants with delayed TSH rise had initially low FT4.

2. In terms of measuring outcomes for treated and non-treated children, the fact that these 2 groups were not matched for severity of TSH elevation is important to emphasize and that makes it difficult to conclude that treatment with l-thyroxine was not beneficial though I suspect that is the case.

4. The authors state that 95% of infants with delayed TSH rise were exposed to 1 or more stressors in the 2 weeks prior to the TSH elevation being detected. Can they state for comparison the % of controls without TSH rise who were subject to stressors during a similar time frame?

5. Under "Natural history and outcome of TSH elevation", it is stated that TSH elevation is always transient. That can clearly be stated for the ones who were never treated, but can it truly be said for the ones who were treated, TSH normalized as expected, and they remained on therapy for a mean of 625 days? Were the authors able to find the records of all these infants and see if they were eventually taken off treatment and what the results were? If so this would be very worthwhile information, as many clinicians are reluctant to discontinue treatment in children who at any time had a TSH of >100, feeling they likely represent "true" congenital hypothyroidism.

6. Can the authors make some final recommendations as to the proper timing of TSH testing in ELBW infants and the proven transient nature of delayed TSH elevation for those whose highest TSH was <40?
Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Yes

Are the conclusions drawn adequately supported by the data shown?
If not, please explain in your comments to the authors.

Yes

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