We read with interest the study by Ozer et al. [1]. However, several issues deserve further discussion or documentation, as follows.

1. Was it appropriate medical care for these patients to receive pegfilgrastim?
   The expected rate of febrile neutropenia (FN) was 8.2% based on registry data. The available guidelines at the time suggested a cutoff risk of about 40%, but these patients had good performance status and few comorbidities. No other data were presented to justify pegfilgrastim use.

2. Were patients informed of the benefits, risks, and alternatives when receiving pegfilgrastim, when the expected risk of FN was only 8.2%?
   G-CSFs are not harmless drugs. Bone pain is seen in up to one third of patients who receive G-CSF [2] and the odds ratio for bone pain is 2.9 from a meta-analysis [3]. There is also concern that these drugs may increase the risk for subsequent hematologic malignancies [4].

3. Who paid for the pegfilgrastim, because it was used outside the national guidelines?
   The cost of this drug is substantial. If 2,202 patients received pegfilgrastim, for a median of 4.6 cycles, at a cost of $3,139 per injection (http://www.drugstore.com), the total cost of drug alone would be $31,795,559. Was the cost borne by the sponsor or by the patients and their insurers?
   Practicing oncologists should not conclude that the use of pegfilgrastim is indicated when the risk for FN is only 8% in patients with a good performance status and few comorbidities. This question can only be answered by a randomized clinical trial.

REFERENCES

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