How to start the Discussion

This pdf shows four opening paragraphs of different discussion sections. They display different ways to open your discussion: by a short recap of the study's aim or hypothesis, the contribution of the paper – or a combination of those, but they all end up with presenting the major finding(s). You can also skip all the run-up and start out with stating the major findings.

1. Contribution, aim, focus, findings

This is the largest study evaluating the presence, including the composition, of ductal carcinoma in situ-associated immune cells in relation to ductal carcinoma in situ subtype based on immunohistochemistry. In our series, we found an association between ductal carcinoma in situ subtype and the presence of TILs, whereby ER-PR-HER2+ and triple- negative cases had the highest numbers of TILs, which is in line with previous studies [25, 33, 34].

2. Focus, hypothesis, findings

This single-center prospective study assessed the real-world clinical utility of plasma-based genotyping in patients with metastatic NSCLC. We hypothesized that adding plasma NGS would increase detection of therapeutically targetable mutations and allow personalized therapy for more patients. Therapeutically targetable mutations were detected in 113 of 323 patients (35.0%) overall. Importantly, mutations for 35 of 113 patients (31.0%) were detected in plasma only when tissue DNA was insufficient or unavail- able, or no mutation was detected in tissue. Targetable mutations were detected for 31 patients in plasma and tis- sue. In 16 patients, targetable mutations were found in tissue only.

3. Aim and contribution, findings

Our results seek to provide clarity and refine the estimate of the cost to develop a single oncologic drug. Specifically, we found that the cost to develop one cancer drug is approximately $648.0 million ($757.4 million when opportunity costs are included), a figure that falls between prior estimates but is significantly smaller than a widely publicized figure of $2.7 billion.

4. Contribution, aim, findings

To our knowledge, this study is the first to reliably examine the risk of BC after HL according to radiation volume. Mantle field irradiation was associated with a 2.7-fold increased risk of BC compared with mediastinal irradiation alone. Our results support the hypothesis that reducing the proportion of breast tissue exposed to radiation will indeed decrease the future risk for BC, the most important late treat- ment effect among female survivors of HL.