

We chose this strategy because it seemed to us more natural and appropriate to keep matched sets to compare cases to their controls rather than to artificially assign a ‘tumour side’ to the controls as in Interphone³ and Hardell *et al*’s studies,^{4 5} which leads to the exclusion of a large number of participants.

However, as requested by Dr Hardell, [table 1](#) presents results of the laterality analysis using Interphone’s method,³ for the main indicator (cumulative duration of use). As with our method, the results give higher OR for ipsilateral use (OR=4.21, 95% CI 0.70 to 25.52 for gliomas) compared with contralateral use (OR=1.61, 95% CI 0.36 to 7.14), without significant association. Moreover, as with our method, the two estimates of the ‘stratified’ OR are not grouped around the ‘total’ estimated OR for meningiomas. Such a result was also observed in a recent publication by Hardell *et al*⁵ (in [table 4](#)). All these results suggest higher ORs for heavy ipsilateral use than for heavy contralateral use, however, they are not all statistically significant. Furthermore, when using cases only as in Inskip *et al*’s⁶ study, we found a significant association between the side of phone use and the side of the tumour for glioma (OR=2.40, 95% CI 1.002 to 5.73) but not for meningiomas (OR=0.77, 95% CI 0.26 to 2.22).

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Author’s response: Re ‘Mobile phone use and brain tumours in the CERENAT case–control study’

We thank Dr Hardell for his comment¹ on our article concerning analyses regarding head position of mobile phone use.²

In our analysis on ipsilateral use, we included cases who used their mobile phone on the same side as the tumour or on both sides of the head, cases who were not regular users (the reference category) and all their matched controls. In our analysis on contralateral use, we used cases who used their mobile phone on the opposite side as the tumour, cases who were not regular users (the reference category), and all their matched controls. The reference category was thus made by the same participants in the two separate analyses. These two separate analyses are thus not really ‘stratified’ analyses since the two subsamples are not disjoint.

Table 1 Adjusted conditional logistic regression by side of use of mobile phone using two methods

	Gliomas						Meningiomas					
	Ipsilateral			Contralateral			Ipsilateral			Contralateral		
	Ca	Co	OR* (95% CI)	Ca	Co	OR* (95% CI)	Ca	Co	OR† (95% CI)	Ca	Co	OR† (95% CI)
<i>Initial analysis</i>												
Cumulative duration of calls (hours)												
Not regular user	107	173	Reference	107	148	Reference	114	163	Reference	114	169	Reference
<43	11	45	0.43 (0.21 to 0.88)	9	42	0.24 (0.10 to 0.57)	10	32	0.39 (0.16 to 0.96)	10	27	0.53 (0.23 to 1.19)
(43–112)	11	44	0.39 (0.18 to 0.84)	6	27	0.23 (0.08 to 0.63)	6	30	0.34 (0.13 to 0.85)	6	31	0.26 (0.10 to 0.68)
(113–338)	18	36	0.87 (0.43 to 1.75)	4	28	0.13 (0.04 to 0.44)	1	34	0.03 (0.01 to 0.25)	8	31	0.39 (0.17 to 0.92)
(339–895)	11	20	0.86 (0.38 to 1.93)	9	21	0.51 (0.21 to 1.28)	3	13	0.30 (0.08 to 1.15)	0	16	
≥896	9	7	2.11 (0.73 to 6.08)	9	12	0.66 (0.23 to 1.89)	6	4	2.29 (0.58 to 8.97)	6	6	1.18 (0.34 to 4.12)
<i>Interphone's method</i>												
Cumulative duration of calls (hours)												
Not regular user	83	137	Reference	83	126	Reference	76	126	Reference	80	140	Reference
<43	5	32	0.29 (0.11 to 0.80)	3	20	0.25 (0.07 to 0.95)	4	9	0.64 (0.15 to 2.73)	6	10	0.99 (0.34 to 2.90)
(43–112)	6	23	0.44 (0.16 to 1.23)	4	16	0.33 (0.10 to 1.08)	3	16	0.37 (0.10 to 1.39)	1	12	0.13 (0.02 to 1.07)
(113–338)	7	19	0.78 (0.27 to 2.24)	4	17	0.25 (0.06 to 1.02)	0	11		6	16	0.65 (0.23 to 1.80)
(339–895)	7	8	1.69 (0.52 to 5.49)	2	13	0.23 (0.05 to 1.11)	1	7	0.14 (0.02 to 1.24)	0	6	
≥896	4	2	4.21 (0.70 to 25.52)	5	4	1.61 (0.36 to 7.14)	3	3	2.27 (0.42 to 12.39)	3	3	1.24 (0.21 to 7.48)

CERENAT, 2004–2006, France.

*OR adjusted for level of education and ionizing radiation exposure.

†Odds ratio adjusted for level of education.

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