Finally, the detailed methods used for the self-controlled case series are not presented in the study or the online supplementary material. Correctly implementing this design requires a careful choice of observation and risk periods. Is it possible for the authors to provide further details on how the self-controlled case-series analysis was performed? This additional information would be helpful in the interpretation of the conclusions.

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In Reply Our main analysis focused on the immediate acute effects of fluoroquinolones. Therefore, as is usually done, we excluded patients exposed during the intermediate risk period. Because the intermediate risk period is not associated with an increased risk, this exclusion is unlikely to have affected the odds ratio. Individuals with a fluoroquinolone prescription during the 10 days preceding retinal detachment (RD) and exposed during the intermediate risk period (ie, during the 50 prior days) were not considered exposed during the risk period. Consistently, individuals with 2 fluoroquinolone prescriptions dispensed within 50 days in the control period were not considered exposed either.

In a complementary analysis, we included the 331 patients exposed during the intermediate risk period. As anticipated, the results were unchanged; exposure to fluoroquinolones remained significantly associated with the occurrence of RD during the 10-day risk period, with an adjusted odds ratio of 1.46 (95% CI, 1.17-1.81).

A potential confounding bias of the systemic disease for which fluoroquinolones may be prescribed is possible. Other studies previously managed this issue using another antibiotic as reference. The cohort study performed by Kuo et al reported, contrarily to the one performed by Daneman et al,
a significant association of fluoroquinolone use with RD after they compared the prescriptions of patients in the fluoroquinolone cohort with those of propensity score–matched adults treated with amoxicillin. Moreover, the study design that we used ensures the minimization of confusion by indication. Indeed, the self-matched design implies that time-invariant multiplicative confounders are necessarily adjusted for. Given the short observation period of our study (180 days), the clinical situations of the patients may be considered fixed during the control and risk periods. Therefore, the prescription of fluoroquinolones for an underlying respiratory, inflammatory, or infectious disease may occur in a nondifferential manner within control or risk periods. In addition, in our study, we excluded all patients who had been hospitalized within 6 months prior to the RD. This likely resulted in excluding patients with severe chronic diseases, including inflammatory diseases, and thus minimizing confounding by indication. Lastly, to control for potential residual bias, we conducted a sensitivity analysis excluding patients with long-term infectious or inflammatory conditions and respiratory failure. Exposure to fluoroquinolones remained significantly associated with the occurrence of RD over the 10-day period, with an adjusted odds ratio of 1.43 (95% CI, 1.11-1.84).

In the self-controlled case series design, we also looked at first event, and we used the same short observation period. The risk period was defined as the 10-day period after each fluoroquinolone prescription had been dispensed, whereas the risk-free period included all other periods when patients were considered to be at baseline risk. Individuals exposed to fluoroquinolones during the intermediate risk period (11-60 days) were excluded.

The incidence rate ratio and its 95% CIs were estimated by comparing the incidence of RD during the risk and risk-free periods using a conditional Poisson regression model with a logarithmic link function, taking the duration of the different study periods into account. Given the study observation period (180 days), age and comorbidities were considered to be “fixed” during the study period. Corticosteroid treatment was taken into account as a time-dependent variable.

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