their self-reported views, in 17% of cases the user said they changed their working diagnosis after using Isabel.²

The authors state that randomised CDSS study designs are rare. Readers may, therefore, be interested in two recent such studies carried out by two US medical schools.3,4

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Optimising stroke prevention in patients with atrial fibrillation

We would like to thank Dr McKinnell for his comments on our recent article highlighting the substantial underutilisation (40%) of oral anticoagulation (OAC) in patients with atrial fibrillation (AF) at risk of stroke managed in general practice.1

We agree that presentation of HAS-BLED scores in conjunction with CHA2DS2-VASc scores would have been informative but unfortunately the data for some variables (such as, previous bleeding, International Normalised Ratio (INR) values, alcohol intake, and liver function) comprising the HAS-BLED score were not consistently available from electronic records and the GRASP-AF tool does not currently assess bleeding risk; therefore HAS-BLED could not be calculated.

'Contraindication' to anticoagulation has been used very subjectively in primary care and does not necessarily equate only to a high HAS-BLED score (≥3). To clarify, a HAS-BLED score of ≥3 is NOT a contraindication to OAC and should not be used as a reason to withhold OAC. Instead, modifiable bleeding risks should be addressed (strict blood pressure and INR control, removal of non-essential concomitant antiplatelet therapy/NSAIDs, reduced alcohol consumption if excessive) and patients reviewed more frequently. As it was not possible to calculate the HAS-BLED score we cannot determine whether or not those with a lower risk of bleeding (HAS-BLED score = 2) fell into the 'contraindicated' or 'refused' groups.

Finally, OAC is recommended for all patients with AF with a CHA2DS2-VASc score ≥2 and should be considered for males with a CHA2DS2-VASc score = $1;^{2,3}$ there is a net clinical benefit of OAC with CHA2DS2-VASc score ≥1, regardless of bleeding risk.4,5

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