Response

To the Editor:

We thank Ince and Senel1 for their interest in our research. The objective of our commentary article2 was to clarify an opacity incorporated into the bleeding risk score HAS-BLED (hypertension, abnormal renal/liver function [1 or 2 points], stroke, bleeding history or predisposition, labile international normalized ratio, elderly [≥ 65 years], drugs/alcohol concomitantly [1 or 2 points]). This question is encountered in everyday clinical practice: does a hemorrhagic stroke count as a bleeding event in addition to the stroke event? Using the well-validated nationwide Danish registries, we found that the recalibrated HAS-BLED score more accurately predicted major bleeding in patients sustaining an intracranial hemorrhage (ICH).

Ince et al3 have suggested adding additional discriminative features and points to the individual risk components. It should be noted that adding more risk components in (any) risk scoring system will increase the discriminative power per se relative to the "original" score. Specifically for ICH, they suggested differentiating between lobar vs nonlobar ICH because the two often carry different risk of recurrent ICH. Unfortunately, no guidance or direction for the implementation of their suggestions was given. Perhaps one might consider adding even more candidates for risk components (ie, imaging data and biomarkers) to incrementally increase the predictive value of the HAS-BLED score. Alas, this approach would be at the cost of practicality, with limited use in everyday clinical practice.

Although research has been focusing on predicting the exact risk using risk scoring systems such as the HAS-BLED score or the Congestive heart failure, Hypertension, Age ≥75 years (2 points), Diabetes mellitus, Stroke (2 points), Vascular disease, Age 65-74 years, Sex category (CHA2DS2-VASc) score, these estimates are often poorly correlated with events in clinical practice, as displayed by moderate predictive power (in terms of C-statistics hovering around 0.65). Hence, in clinical practice, these scoring systems may function merely as checklists, which can be used to remind physicians of important clinical manifestations that translate into increased risks. Specifically for the HAS-BLED score, the risk components can be used to identify modifiable risk factors that may attenuate the individual risk of bleeding, such as withholding concomitant use of aspirin or nonsteroidal antiinflammatory drugs.

Although a clinical assessment on the risk of bleeding is important, contemporary guidelines emphasize that a high bleeding risk (ie, HAS-BLED score ≥ 3) should not be used to exclude patients from antithrombotic treatment.4 Indeed, we previously explored the benefit of resuming oral anticoagulant treatment in patients sustaining ICH in which the majority (approximately 80%) of the study population had HAS-BLED scores ≥ 3.5 We observed associations of lower stroke rates and mortality among patients resuming oral anticoagulant treatment vs no antithrombotic treatment but also compared with antiplatelet therapy.

Peter Brønnum Nielsen, MSc, PhD
Torben Bjerregaard Larsen, MD, PhD
Aalborg, Denmark
Gregory Y. H. Lip, MD
Birmingham, England

References


