management to prevent relapse and optimise functioning. Lithium carbonate has long been the main long-term drug and there is reasonable evidence that it is effective, particularly in preventing manic episodes.⁵ Lithium also appears to have an antisuicidal effect in mood disorders.^{6,8} More recently, fashion and convenience have led to an increase in the prescribing of valproate, and the evidence for this drug is now accumulating.⁴ The BALANCE trial comparing lithium, valproate, and combination therapy with lithium plus valproate is currently under way (<http://cebmb.warne.ox.ac.uk/balance/balance1/index.html>). In general the long term drug treatment of bipolar disorder is under-researched, and many drugs, particularly antiepileptics and unproved combinations, are used off-licence and with little evidence of efficacy. Psychosocial interventions such as family psychoeducation, cognitive behaviour therapy, and symptom recognition training are promising, although the evidence is still fairly limited.³

The optimal long term management of bipolar disorder remains a specialist activity entailing expert psychopharmacological management, psychosocial interventions, and self management. Evidence is emerging that specific collaborative disease management programmes may improve outcomes.^{6,9}

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Interactive case report

An alcoholic patient who continues to drink: case presentation

Stuart McPherson, Colin John Rees

Mr Bond is a 42 year old man with alcoholic cirrhosis who was admitted to our unit with haematemesis. He had had three previous admissions with alcohol related problems and had twice bled from oesophageal varices. The varices had been treated by sclerotherapy and banding, and he was taking propranolol 40 mg twice daily as secondary prophylaxis. His most recent endoscopy had shown three, barely noticeable oesophageal varices.

Mr Bond has a history of excessive alcohol intake over five years, with no periods of abstinence. He was drinking 3-4 litres of strong cider a day up until the day of admission. A consultant psychiatrist had previously diagnosed depression and alcohol dependence syndrome. Although Mr Bond had been treated with paroxetine, he discontinued it as he thought it was unhelpful. He had also seen the drug and alcohol team several times. His attendance at appointments with the psychiatrist and drug and alcohol team was sporadic as he felt that these were of little benefit to him. He complied with medical drug treatment.

Results of investigations at presentation

Investigation	Result (normal range)
Haemoglobin (g/l)	114 (130 to 180)
Platelets ($\times 10^9/l$)	53 (150 to 450)
Mean corpuscular volume (fl)	90 (76 to 96)
Prothrombin time (seconds)	19 (10 to 15)
Serum urea (mmol/l)	2.9 (2.5 to 7)
Total bilirubin ($\mu\text{mol/l}$)	82 (0 to 17)
Alanine aminotransferase (U/l)	63 (5 to 40)
Alkaline phosphatase (U/l)	123 (30 to 125)
Albumin (g/l)	30 (35 to 50)

Questions

1 What are the likely causes of Mr Bond's bleeding?

2 How would you rate the severity of this bleed?

3 What initial steps should be taken in his management?

4 Given Mr Bond's continued alcohol consumption, how far should we go with treatment?

Please respond through bmj.com, remembering that Mr Bond is a real patient and that he and his carers will read your response

Mr Bond lives with a partner and has three children from a previous marriage, whom he rarely sees. He worked for the local council for 22 years but stopped working several years ago because of his alcohol dependence and depression. His marriage break-up a few years earlier had precipitated particularly heavy drinking. Mr Bond describes himself as a worrier and turns to alcohol when things go wrong. His mother died at the age of 60 from alcoholic liver disease.

On presentation with gastrointestinal bleeding he was jaundiced and showed signs of chronic liver disease (table). He was not encephalopathic. His pulse was 140/min and blood pressure 118/67 mm Hg with no appreciable postural drop. He had mild ascites but no hepatosplenomegaly. Per rectal examination showed melaena.

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This is the first of a three part case report where we invite readers to take part in considering the diagnosis and ethical issues surrounding the management of a case using the rapid response feature on bmj.com. Next week we will report the case progression, and in four weeks' time we will report the outcome and summarise the responses