Commentary: Patient's experience

A Bond with the support of Colin Rees

It was terrifying waking up in intensive care.¹ I didn't know where I was or what had been done. In particular, having the balloon in my mouth was terrifying. This frightened me into discharging myself. I was so frightened at the thought I might die, and I wanted to be in familiar surroundings and hoped I would be OK.

I know alcohol is harming me, but I like to drink and enjoy the feeling it gives me. It's also escapism, particularly as I am a worrier. I feel well after a spell in hospital and think I'm OK to go back to drinking again. I don't think professionals could do more to help me stop drinking. It's down to me. They can't make me do what I don't want to do.

I feel that I can stop if I want to. I did stop for a year after my first time in hospital five years ago. I know I should stop drinking as I know all the risks and problems. My girlfriend is the reason why I should stop really. This and my family issues upset me, and although they should make me stop, they are one of the reasons I keep drinking.

I have been treated well by my general practitioner and by medical, nursing, and other staff. I don't ever feel I've been discriminated against because of my drinking. That is one of the reasons I am happy to contribute to this discussion—I would like to help in return.

I know there is debate about how much treatment patients like me should get. I think that if I continue to bleed then I should get treatment to stop the bleed because ultimately what happens to me if there is a limit placed on my treatment—do you let me bleed to death? I don't think that I should receive a liver transplant if I continue to drink—liver transplants should go to the really needy. Patients who stop drinking shouldn't get liver transplants either.

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1 McPherson S, Rees CJ. An alcoholic patient who continues to drink: case outcome. *BMJ* 2006;332:276.

Department of
Gastroenterology,
South Tyneside
Healthcare NHS
Foundation Trust,
South Shields
NE34 0PL

Colin John Rees
consultant
gastroenterologist

Correspondence to:
C J Rees
Colin.rees@
sthct.nhs.uk

Commentary: Challenge for doctors and policy makers

Paul Haber

Mr Bond's management raises several issues.¹ In the rapid responses on *bmj.com*, Mark Willenbring succinctly summarises the most practical approach to the management of Mr Bond's alcohol dependence.² Regular follow-up with feedback on progress and continuing encouragement to reduce alcohol use can be surprisingly effective. It is also a straightforward management plan that can be offered by the patient's current medical team. Cirrhotic patients can safely be offered treatment to control their alcohol use with acamprosate, naltrexone, or disulfiram, singly or in combination.³ These drugs are simpler to prescribe and monitor than many used in routine clinical practice and do not have to be given by addiction specialists. Colin Brewer correctly notes that the oldest of these, disulfiram, may be the most effective if administration is supervised by a community nurse or family member.² However, unsupervised disulfiram is ineffective.

Is there any specific medical therapy for progressive alcoholic liver disease? S-adenosyl methionine has been shown to be effective in one clinical trial.⁴ A replication study is underway, but this promising drug has not yet entered routine practice. Transplantation is effective for patients with end-stage liver disease who have achieved stable long term abstinence but is not relevant in Mr Bond's case.

Effect of mental illness

Mental health comorbidity is common in people with alcohol dependence and adversely influences the outcome of treatment.⁵ Clinicians should screen for

anxiety, depression, and other disorders and introduce appropriate management or referral. Mr Bond's history of depression strongly suggests he may be currently depressed, which may have contributed to his self-discharge. This decision may also be associated with cognitive dysfunction related to multifactorial delirium, Wernicke-Korsakoff syndrome, administration of benzodiazepines, or other brain disorders. It may be related to unrelieved alcohol withdrawal or continuing dependence on alcohol. It may reflect other mental illness. In some cases, the patient may not understand the clinical situation and the effectiveness of proposed treatment. All these issues should ideally be considered before the patient leaves hospital.

Use of resources

Mr Bond's case also raises questions about allocation of health resources. Unlike some of the commentators, I feel it is reasonable to question the use of expensive treatment in this setting, as continuing alcohol consumption reduces the effectiveness of any treatment. However, much adult illness is due to failure to modify a range of high risk behaviours, including tobacco use, diet, and physical inactivity. Clinicians must try to reach balanced treatment decisions: to avoid futile therapy but also to ensure the recidivist drinker is not subjected to greater stigmatisation than the recidivist smoker, eater, or non-exerciser.

Royal Prince Alfred
Hospital, NSW 2050,
Australia

Paul Haber
head of department
of drug and alcohol
services

phaber@
mail.usyd.edu.au