Aphasia in a farmer after viper bite

Sir—J M Polo and colleagues (June 22, p 2164) report aphasia in a farmer after he was bitten on the left thumb by a viper. He developed swelling and ecchymosis of the corresponding limb. He reported to hospital within 2 h of being bitten, and his status was an absolute indication for immediate administration of polyvalent antivenom, according to WHO recommendations, to avoid the systemic effects of venom. However, delayed administration of antivenom or waiting until he had had systemic manifestations—ie, a 6 h wait—resulted in systemic envenoming.

We work in a rural area and have reported various poisonous snake bites. Between June, 2001, and May, 2002, six people were admitted to hospital for viper bite (four Echis carinatus, one Pit viper, one Russell’s viper). The time lapse between bite and admission was 2-5, 1-0, 1-25, 4-5, 1-5, and 1-5 h, respectively. All patients brought the killed snakes to the hospital for identification.

Every patient developed progressive local oedema extending beyond the bitten segment of the limb, with ecchymosis. All were given polyvalent antivenom without test dose, preceded by subcutaneous adrenaline as prophylaxis against anaphylaxis to the antivenom. Each patient recovered within 48 h without development of systemic manifestations.

A male farmer aged 32 years was bitten on the dorsum of his right hand by a Russell’s viper while harvesting grass. He felt giddy and experienced severe pain at the site of the bite. Swelling developed rapidly with bleeding from the fang marks. He reported to hospital within 1-5 h. On arrival, his blood pressure was 80/60 mm Hg. He developed rapid progressive swelling with ecchymosis over the bitten limb, and enlarged tender lymph nodes in right axilla. His head was placed in a low position, intravenous crystalloid solution was administered, and 4 mL blood was drawn into a clean glass test tube for coagulation testing. His blood did not clot for 20 min and remained incoagulable. We gave the patient ten vials of polyvalent antivenom in 200 mL dextrose over 60 min. Oedema lessened gradually over 48 h. His blood clotted within 10 min after 6 h of administration of antivenom. We gave him penicillin for wound infection and tetanus immunisation; he did not have diabetes.

Early administration of antivenom if the indication is clear can prevent development of venom-induced thrombus and subsequent development of disseminated intravascular coagulation. The delayed administration of antivenom to Polo and colleagues’ patient resulted in systemic envenoming; the patient kept his head turned to the left, which suggests that he was pointing the lesion at left cerebral cortex. Timely administration of appropriate and adequate quantity of polyvalent antivenom is more beneficial than waiting.

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Drug resistance and influenza pandemics

Sir—Nikolaos Stilianakis and colleagues (May 25, p 1862) discuss the issue of drug resistance and influenza pandemics.

They state that amantadine is associated with substantial toxic effects when used in the elderly and renally impaired. This belief is based on use of doses higher than those recommended when used in the elderly and renally impaired. This belief is based on use of doses higher than those recommended for people with various levels of renal function.

Amantadine has lowered the incidence of secondary complications of influenza. Amantadine has also lowered the rate of progression to pneumonia in immunocompromised patients in hospital. Any restrictions on the use of amantadine would therefore lessen its therapeutic value.

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Lap burn due to laptop computer

Sir—The following story should be taken as a serious warning against use of a laptop computer in a literal sense. The patient, a previously healthy 50-year-old scientist and the father of two children, had been writing a report one evening in his home. Sitting comfortable in an armchair, he had placed his laptop computer on his lap while writing for about 1 h. The next day he noticed irritation and oedema of his penile prepuce. Furthermore, the ventral part of his scrotal skin had turned red, and there was a blister with a diameter of about 2 cm. These findings were verified when I saw the patient 1 day later. There were no signs of phimosis or balanitis. The patient recalled that, while sitting 2 days earlier with his computer on his lap, he occasionally had felt heat and a burning feeling on his lap and proximal thigh, a sensation that was relieved at least temporarily when the computer was moved slightly.

After the first 2 days, the penile and scrotal blisters broke and developed into infected wounds that caused extensive suppuration. More than a week later, the wounds were covered by dry crusts and thereafter were healing quite rapidly. No antibiotic treatment was needed.

When retrospectively checking the manual of the computer, the following safety instructions were found: “Do not allow your portable computer to operate with the base temporarily when the computer was

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