life and show the public that we say what we mean.

Lastly, I was sorry you did not publish Dr Wilkinson's[2] guidelines on the management of snakebite. I imagine they are just as important as the paper itself.

Ian Kennedy

Bamalete Lutheran Hospital
Ramotswa
Botswana

1. Davies T. *Discrimine salus* (Viewpoints). *S Afr Med J* 1994; **84:** 819-820.
2. Wilkinson D. Retrospective analysis of snakebite at a rural hospital in Zululand. *S Afr Med J* 1994; **84:** 844-847.

Retrospective analysis of snakebite at a rural hospital in Zululand

To the Editor: I enjoyed reading Dr Wilkinson's analysis of snakebite.[1] However, I cannot let the following go unchallenged: 'Patients not admitted were discharged from the outpatient department if there were no signs of significant or progressive envenomation after several hours (usually overnight). This policy is questionable as shown by progression of local swelling in 24% of admissions and the development of systemic features of envenoming in 12%. At times this occurred after several hours or even a few days and was unpredictable. It is recommended that all snakebite victims be admitted for observation for 24 hours, especially as bites by some elapidae may produce no local signs but do produce significant systemic neurological envenoming which in itself may be delayed in onset, and indeed re-occur. Conversely it has been stated that if no symptoms or signs of envenomation have become apparent within 1 hour, clinically significant envenomation will not occur;[2] the data presented here show this not to be true.'

I suggested that 'if symptoms and signs of poisoning have not become apparent within 1 hour, clinically significant envenomation has not occurred and will not occur'.[2] This requires confident communication with the patient (difficult with children, if there is a language barrier or if the information is obtained telephonically) and a doctor experienced in initial assessment of snakebite cases.

Dr Wilkinson discharged patients from the outpatient department if there were no signs of *significant* or *progressive* envenomation after several hours. There is no mention of the time of *onset* of clinical envenomation, which is completely different. It is like comparing apples and pears.

Progression of local swelling occurred in 24% of patients admitted and systemic features of envenoming developed in 12%. I fully agree with this. If the patient does not receive antivenom, swelling progresses for up to 3 - 4 days after bites by the Mozambique spitting cobra (*Naja mossambica*), a common snake in Dr Wilkinson's Zululand area. Progression of swelling after bites by the stiletto snake (*Atractaspis bibronii*), perhaps the commonest cause of swelling in this area, continues for 2 days. Any patient with moderate, severe and especially gross swelling (classified as minor, mild, moderate, severe and gross) is at risk of systemic features of envenoming.

Dr Wilkinson goes on to say that '. . . bites by some elapidae may produce no local signs but do produce significant systemic neurological envenoming which in itself may be delayed in onset, and indeed re-occur'. I know of no published well-documented southern African elapid bite where the *onset* of clinical envenomation did not occur within the first hour. Once again *significant* has a different meaning to *onset*.

It is of interest to note that 12% of 336 snakebite patients presenting to Eshowe Hospital in Zululand between 1990 and 1993 had no clinical envenomation but 47% were pyrexial, which was maximal on the day of the bite in 93% of cases. Perhaps these pyrexial patients were envenomed after all!

I agree that southern African snakebite victims should be admitted for observation for 24 hours (but preferably overnight only, as this is more practical) *unless* there is a doctor present well experienced in the management of snakebite who sees the patient at least 1 hour after the bite, finds no symptoms or signs of envenomation, and has confident communication with the patient. This is not common, but has occurred several times in my 40 years or so of interest in snakes and snakebite.

R. S. M. Blaylock

Leslie Williams Memorial Hospital
Carletonville, Gauteng

1. Wilkinson D. Retrospective analysis of snakebite at a rural Hospital in Zululand. *S Afr Med J* 1994; **84:** 844-847.
2. Blaylock RSM. Time of onset of clinical envenomation following snakebite. *S Afr Med J* 1983; **64:** 357-360.

Dr Wilkinson replies: I am grateful for Dr Blaylock's interest in my paper, not least because I know of his experience and interest in snakebite. I do not think our opinions differ much.

My study was actually prompted by 2 patients that I managed personally. Both presented soon after the bite (around an hour) and had no signs at all of envenomation; I observed them as outpatients overnight and both were much worse in the morning. I therefore cannot agree that *all* patients with significant envenomation will have symptoms or signs within an hour, although it is undoubtedly true of *most*. As Dr Blaylock rightly points out, early discharge of patients bitten by snakes demands confident communication and significant clinical experience; I agree that this is often missing, hence the paper and the development of protocols of care for use by less experienced staff.

I was struck by the amount of nonspecific toxicity seen in our patients, and agree with Dr Blaylock that his patients in Eshowe with pyrexia and no other signs probably were envenomed!

I think the bottom line is that snakebite is potentially very dangerous, is unpredictable, and should be managed very circumspectly, at whatever time the patient presents. Furthermore, there is much more that we need to know about the epidemiology and clinical management of these patients.

To the Editor: I find it interesting that Dr Wilkinson[1] makes no mention of fasciotomy for compartmental syndrome.

A patient was flown to me at Livingstone Hospital in 1993 with a history of puff adder bite on the hand 8 hours previously. The arm was pulseless and swollen to the axilla, and he also had systemic signs of envenomation. Polyvalent serum was administered as part of the resuscitation and he was then taken to theatre.

Fasciotomy was performed along both volar and dorsal aspects of the forearm and upper arm. The tissue was black and non-viable. No debridement was undertaken. The wound was dressed with tulle gras and the patient was returned to the intensive care unit. He developed