Author's response to reviews

Title: Life threatening intracerebral haemorrhage following Saw scaled viper (Echis carinatus) envenoming-Authenticated case report from Sri Lanka

Authors:

Vijayabala Jeevagan (jeevaganv@yahoo.com)
C Lakmal Fonseka (fonseka_lakmal@gmail.com)
C Ariaranee Gnanathasan (ariaraneegnanathasan@gmail.com)

Version: 4 Date: 20 February 2013

Author's response to reviews: see over
Dear Dr Tom,

We would like to thank you in advance for accepting our paper to publish in your journal. We also thank the reviewers for their comments. A point-by-point response in bold type to the reviewer’s remarks is given below.

Reviewer: Georges Mion

The authors must tell us how much is the usual dose of AVS for Echis envenoming in Asia.

Manufacturers’ recommendations are to use 50ml (5vials) polyvalent anti venom in Indian Echis carinatus envenoming. We don’t have any studies in Sri Lanka to assess antivenom dosing in Echis carinatus envenoming. Sri Lankan guidelines recommend using 10 vials of polyvalent anti-snake venom, raised against Indian D.russelii, Echis carinatus, Naja naja and Bungarus caeruleus venoms in envenoming of any of these snake bites. If the blood remains incoagulable (as measured by 20WBCT) six hours after the initial dose of antivenom, the same dose should be repeated. In patients who continue to bleed briskly, the dose of antivenom should be repeated within 1-2 hours.

References


2. Guidelines for Management of Snakebite in Hospital. (Sri Lanka Medical Association 2005)

Comparison with Australian snakebites must be very careful, because the snakes and the venoms are in Australia very different from viper envenoming, and it is known that AVS are not as efficient as anti Echis venoms are. The authors cannot drive any therapeutic conclusion from Australian experience.

We undoubtedly agree with you. Each and every snake is different. Echis carinatus in other part of the Asia is different from what is found in Sri Lanka. Unless studies are done in Sri Lanka, we cannot drive any conclusions. We have clearly stated in our manuscript “These findings should be confirmed in well designed randomized controlled trials in Sri Lankan Echis carinatus, before making any conclusions”.
I remain convinced that AVS was efficient here, as proven by normalization of hemostatic parameters.

Even though hemostatic parameters normalized, his clinical condition deteriorated. Routine coagulation parameters (20minWBCT, PT/APTT) do not have 100% sensitivity to assess the in vivo coagulability. Our patient neurological deficit was progressive even after antivenom serum administration, which clearly indicated either inadequate antivenom was used or antivenom was less effective in prevention of progression of neurological deficit.

It is undoubtedly certain that physicians must insist for the use of AVS when hemostatic disorders are observed.

We do not say not to use antivenom in Sri Lankan Echis carinatus envenoming. We only mentioned that there is a wide variation in the treatment methods used in SSV envenoming. There have been no fatalities reported with Sri Lankan Echis carinatus envenoming and administration of antivenom serum has several complications. Therefore it is understandable some clinicians do not use the antivenom in Sri Lankan Echis carinatus envenoming.

In anticipation of your response, on behalf of the co-authors,

With kind regards,

V.Jeevagan