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Anaphylaxis After Rattlesnake Bite

To the Editor:

We recently treated a patient with Northern Pacific Rattlesnake (*Crotalus oreganus*) envenomation that was complicated by anaphylactoid reaction. The patient, a 30-year-old man, was bitten on the right thumb by a captive

snake. A pressure band was placed on the right arm near the elbow immediately after the bite. The patient presented to the emergency department within 30 minutes and was hemodynamically stable, with moderate swelling and severe pain at the right hand. Before the administration of antivenom, the pressure band was removed, at which point the patient had rapid onset of face and neck swelling and became acutely dyspneic. An endotracheal tube was placed, and treatment was begun with epinephrine, diphenhydramine, and systemic glucocorticoids. Treatment with Crotalidae polyvalent immune Fab (ovine) (CroFab; FabAV) antivenom was started approximately 30 minutes after intubation, once hemodynamic stability was achieved.

The patient remained intubated for 3 days and received a total of 18 vials of FabAV. His clinical condition improved steadily and, other than transient thrombocytopenia, he had no further complications.

This case is noteworthy because the anaphylaxis occurred immediately after removal of the pressure band and before antivenom administration. Although the responsible mechanism in this case is not entirely clear, it may have been related to venom accumulation in the lymphatics of the arm. Under normal circumstances (in the absence of intravascular envenomation), injected venom probably migrates into the lymphatics gradually. Removal of the pressure band may have allowed a more concentrated bolus of venom-contained antigens to reach the systemic circulation.

Guidelines for first aid management of crotaline snakebites universally discourage the use of arterial tourniquets; however, some advocate the use of lymphatic pressure bands until definitive care can be administered.¹ This case affirms recommendations that, once pressure bands are applied, they should not be removed in the field.² The appropriate setting for their removal is the emergency department, where invasive airway management can be conducted more easily and where the limb can be evaluated for venom-induced and tourniquet-induced damage. It also suggests that antivenom should be given before pressure band removal.

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1. Juckett G, Hancox JG. Venomous snakebites in the United States: management review and update. *Am Fam Physician*. 2002;65:1367-1374.
 2. McKinney PE. Out-of-hospital and interhospital management of crotaline snakebite. *Ann Emerg Med*. 2001;37:168-174.
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