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**AdironDoc**

Backcountry Health and Hygiene

Serpents in the Garden

The field management of snake bites is one of those topics which is included in most every wilderness medication publication, whether aimed at the professional or the casual user of the backcountry. Although there are reports of rattlesnakes in some areas of the Adirondacks (e.g., Lake George) and the Catskills, I am unaware of any reported serious injuries or fatalities. On the other hand, I am well aware that the readership of *AdironDoc* is wide ranging, and treks for many of us are far from the confines of the Empire State. Additionally, there has been a considerable amount of new information on this topic over the past several years. Many of us may find that our favorite references on wilderness first aid are a bit dated when it comes to the management of this rare but potentially devastating problem.

First of all, some definitions are in order. Venomous snakes fall into two broad groups. Rattlesnakes and their relatives (the cottonmouths and copperheads) are properly classified as crotalids, the *pit vipers*. This is the only group of poisonous snakes found in New York (excluding, of course, zoos and similar facilities). The other group of snakes is the elapids. These include species such as the coral snakes, and are predominantly tropical in their distribution.

Pit viper envenomations may cause quite a bit of local tissue damage, but are rarely fatal. In fact, about a quarter of bites do not even result in significant injection of venom. On the other hand, there is no correlation between the size and appearance of the wound and the quantity of venom present. Despite the time-honored advice to look for paired "fang" marks, a significant envenomation may appear to be nothing more than a bad scratch. Thus, all suspected rattlesnake bites should be handled the same way at once.

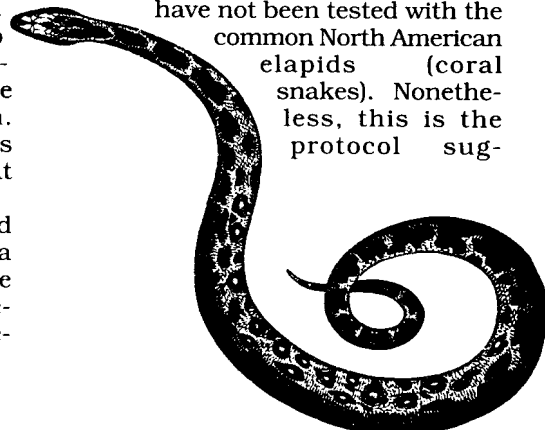
As with any wound, the bite should be cleansed with soap and water and a dressing applied. The limb should be splinted, as one would do for a fracture. There may be some utility to plac-

ing a loose constricting band above the bite. I stress "loose;" the concept is to restrict lymphatic flow, not blood flow as one would do with a tourniquet. It should be possible to slip a finger easily under the band. If swelling or redness begins to develop, it is useful to mark the borders of this with a pen every so often, to define the rapidity of progression for medical personnel.

Evacuation for medical care is mandatory and must be immediate. Waiting for symptoms to develop (which may be delayed for hours) is ill advised. This is especially important if the victim will need to be walking.

In this day of "universal precautions" the old concept of making deep cuts over the bite and then applying mouth suction (Yeech!) has been abandoned. If anyone ever did this anyway, it probably did more harm than good. The only other first aid which has been studied is the use of the Sawyer Extractor®. This suction device, applied directly over the bite, may remove some venom if placed within a few minutes of the injury. How much difference this makes is debatable, but the procedure is probably harmless. On the other hand, few hikers carry these devices in the northeast.

ELAPID ENVENOMATIONS are a completely different story. These are extremely dangerous, life-threatening injuries. Shock, paralysis, and respiratory failure can develop rapidly. In these situations, field first aid has a real place. The most current recommendations for elapid bites have actually been developed for Australian snakes; they have not been tested with the common North American elapids (coral snakes). Nonetheless, this is the protocol sug-



gested by the Wilderness Medical Society. An elastic wrap (such as an Ace® bandage) is applied from just above the bite upward to the top of the extremity (i.e., the armpit or groin) and back to the bite. The wrap should incorporate a splint in it, as one would do for a cro-talid injury. This should be done immediately, and should be as tight as one would apply the wrap on a sprained ankle. The idea of this is to keep the venom in local tissues, where the body's enzymes can break it down before it is absorbed systemically. Evacuation is also recommended for these injuries, but it must be carried out much more carefully; the victim should undertake a minimum of physical activity and movement, in order to minimize absorption of venom.

The injection of "antivenom" does not

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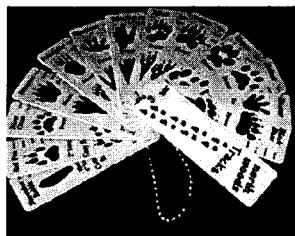
have much of a place in the first aid of these injuries. It is often difficult to be sure of the specific species of snake involved, and identification is mandatory to insure use of the appropriate product. These preparations are actually rather crude extracts of horse plasma, and have substantial toxicity of their own. Health professionals treating such injuries should always obtain a phone consultation with a physician knowledgeable in this esoteric field. One resource for this is the antivenin index at the Arizona Poison Control Center (520-626-6016).

- Thomas R. Welch, M.D.

*I appreciate the helpful review and advice provided by Edward Otten, M.D., past president of the Wilderness Medical Society and an internationally recognized authority on the management of snakebites.*

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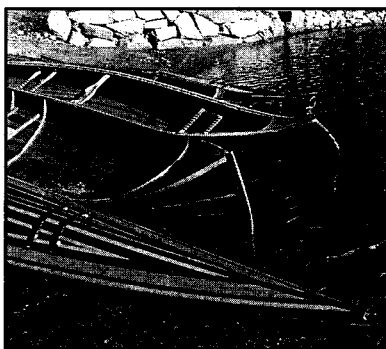
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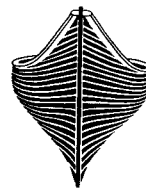
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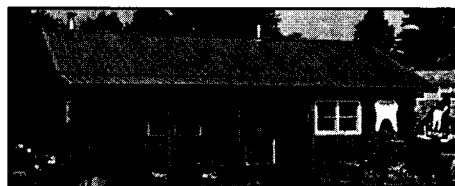
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