Clinical pathway for management of patients with envenomation post snake bite

The on-call Toxicology Service should be contacted early for advice.

If the patient is **critically unwell** manage as per usual ACLS protocols.

Commence antivenom:

- The antivenom is ALWAYS given intravenously and the patients should remain in a resuscitation area while having antivenom.
- The rate of allergic reaction to the antivenom varies between 5 and 45% depending on the type of antivenom given. This rate is higher in individuals with atopy, or if previously treated with antivenom. In these scenarios premedication may be indicated - discuss with the on-call Toxicologist.

Remove PBI halfway through the antivenom.

Admit the patient for observation (development of bleeding complications or neurotoxicity).

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Repeat bloods (FBC, UEs, INR, aPTT, fibrinogen, D-dimer, CK) at 6, 12 and 24 hours post antivenom.

The patient can be discharged home once the coagulopathy and myotoxicity are resolving, and there is no evidence of renal impairment, haemolysis or neurotoxicity.

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Check tetanus vaccination status prior to discharge.

Advise the patients about the possibility of serum sickness 7-10 days after treatment with antivenom. This may require treatment with prednisolone.