

Snakebite profile from a tertiary care setup in a largely rural setting in the hills of North-West India

Dear Editor,

I read Kumar *et al.*'s^[1] fascinating paper, a 1-year retrospective chart review of snakebite patients seen at a rural tertiary hospital in a hilly Indian location. It captured the demography, clinical profile, treatment, and outcome of the patients. I am excited at the authors' efforts in showcasing this Neglected Tropical Disease (NTD). However, I have a few observations:

1. Most findings of this study, such as victims' age, the timing of bites, time of hospital presentation, bite site, activity at the time of bite, use of tourniquets, and outcome at discharge in 2018, are similar to results from a prospective study of snakebite victims at a rural comprehensive health center in northcentral Nigeria in 2006.^[2] The center was one of the designated snakebite treatment centers in the country. However, despite the two studies being more than a decade apart and the geographical and cultural differences between the two study populations, the prehospital practices of the snakebite victims remain unchanged. This suggests that the reinstatement of snakebite envenoming (SBE) in the list of NTDs by the WHO in 2017 is timely.^[3] It is hoped that the current WHO road map that promises a multi-pronged approach (including motivating and helping at-risk communities take appropriate measures) towards controlling SBE will yield the desired results sooner than later if the 2030 target for halving the SBE mortality will be attained.^[4,5]
2. It is unclear why the comparison of variables in this study was limited to gender alone. Assessing the relationship between the outcome/s at discharge and the patient's demographic and clinical characteristics would have been more informative. For instance, in our study, we observed a mortality rate of 4.2% but also found that prehospital traditional treatment use was associated with a longer hospital stay; snake antivenom requirements were higher among those who applied a tourniquet and those who presented to the hospital after 4 hours of the bite.^[2] These information could be helpful in strategic planning for the care of snakebite victims in the hospital and health education.
3. I also share the authors' recommendation for integrating primary care physicians in the comprehensive emergency care of SBE, especially in the rural areas where snakebite is prevalent. The Nigerian center had family and community medicine physicians in the frontline who were trained and retrained in the management and control of SBE.

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Conflicts of interest

There are no conflicts of interest.

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