An epidemiological study of snake bite envenomation in Papua New Guinea

To the Editor: Dr Curne and colleagues, in their recent study of snake bite in Papua New Guinea, referred to the current rarity of Papuan black snake (Pseudechis papuanus) in Central Province and the absence of a positive identification since 1977.1 We have recently identified two dead adult male specimens measuring 137 cm and 163 cm in length killed near Vaila, a two hours' drive northwest of Port Moresby. Over 80% of the patients admitted to Port Moresby General Hospital with systemic envenomation following snake bite have taipan (Oxyuranus scutellatus cani) venom antigen detectable in their serum by enzyme immunoassay.2 These patients generally present with incoagulable blood and severe neurotoxicity. In our current series, 27% of patients admitted to Port Moresby General Hospital with signs of envenomation following snake bite required ventilation despite treatment with antivenom.3 In contrast, the pattern of envenomation in patients admitted to Vaila's Health Centre appears to be different. Over a 20-month period, 58 patients admitted with signs of systemic envenomation: 47 of these had neurotoxicity and 20 incoagulable blood. Only one patient (1.8%) required ventilation during this period.

At present there is no conclusive evidence of a patient being envenomed by a Papuan black snake in the last four years. There seems little doubt that there has been a change in the snake population of Central Province over the last 20 years, and that there has been a decline in the numbers of Papuan black snakes over this period, largely attributable to the cane toad. However, the confirmation of the presence of the Papuan black snake in the Vaila's area and a clinical pattern of envenomation which differs in the severity of the neurotoxicity from that observed in Port Moresby, suggest that the Papuan black snake may still be of significance in this part of the province.

We are currently conducting a prospective study of all victims of snake bite in the Bougainville Central Province of Papua New Guinea. This should help to further clarify the distribution of venomous species and the clinical syndrome that each species produces.

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References

The war against drugs

To the Editor: How can Alex Wodak and others claim that the "war against drugs" is not working? Surely he knows the statistics. With well over 90% of drug deaths in Australia attributed to the legal drugs, alcohol and tobacco, and only a tiny percentage to the illegal, surely it appears that the illegality of the latter has been and continues to be the major effective way to keep its potential for harmful effects on society. When sufficient and ill health induced by the illegal drugs reaches the levels produced by the legal ones, only then will it be clear that our "authoritarian" efforts to contain them have been unsuccessful.

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Lead: subtle forms and new modes of poisoning

To the Editor: The article by Alperstein et al. serves well to remind the clinical physician and intern that either premedicated or accidental chemical poisoning still needs to be borne in mind in diagnostic decisions.1 From the viewpoint of a medical practitioner dealing with occupational and environmental lead exposures, lead levels are in the general range between 100 and 200 µg/dL in the blood, which is considered the upper limit of normal for the layman (60 µg/dL for the physician) and the majority of specimens are of this magnitude.

The case reported by Dr Naughton and Dr Grant reinforces the need to assess mineral homeostasis in all seriously ill patients, but even if severe hypophosphataemia is found the search for other causes of an altered conscious state should continue.

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References