ANTIDOTE AND ADVERSE REACTION NEWS

Newsletter of CSM Wales and the National Poisons Information Service (Cardiff Centre)

Spring/Summer 2001

NATIONAL POISONS INFORMATION SERVICE (Cardiff Centre)

BITES AND STINGS - POISONOUS ANIMALS IN THE UK

The United Kingdom is fortunate in that it has relatively few poisonous animals. However, this article features the management of poisoning by three species that the NPIS (Cardiff Centre) is called about.

Adder (*Vipera berus*)
Weever Fish (*Trachinus vipera*)
Jellyfish - Portugese man-of-war (*Physalia*)

The Adder

The European viper or adder is the only venomous snake in the British Isles. It mainly lives in rough grass and heathland. Much of rural Wales provides ideal habitat for the adder. It is common in the Gower peninsula, the mountainous districts of Powys and Dyfed and in many coastal regions of Wales.

The adder is usually no more than 2 ft long and has a bold zigzag marking down the length of its back. This distinguishes it from the grass snake and smooth snake, neither of which are venomous.

The adder is not considered an aggressive snake and bites usually occur when it is disturbed. Since 1997 the NPIS (Cardiff Centre) has received 130 calls. Most of these calls are received during May-September, when the adder has emerged from hibernation.

Symptoms

A bite from an adder causes:

- Immediate pain at the bite site.
- Puncture marks may be visible.
- Swelling around the bite site usually occurs within 30 minutes to 2 hours.

Only about 50 % of patients bitten develop signs of envenomation. Therefore, absence of swelling within 2 hours of the bite means the patient has not been envenomed.

Systemic features:

- Abdominal pain, vomiting or diarrhoea
- Sweating and pallor
- Swelling can spread to whole limb and trunk.
- Shock – weakness, collapse, thirst, confusion, drowsiness,
- Low blood pressure
- ECG changes
- Bleeding abnormalities

Treatment

- All patients should be observed for 2 hours following a bite. If no swelling develops within these 2 hours the patient can be discharged.

- Clean the bite site.
- Immobilise or splint affected area.
- Give anti-tetanus prophylaxis if needed.

If there is swelling the patient should be observed for 12 hours.

- Monitor pulse, BP, respiration
- Perform ECG, full blood count, CPK and clotting studies.

The Zagreb antivenin should be considered if the patient has severe systemic symptoms or swelling beyond the next major joint from the bite site.

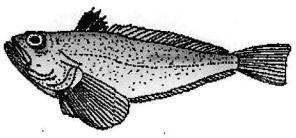
The NPIS (Cardiff Centre) has a stock of the antivenin. Please ring NPIS (Cardiff Centre) if you have any queries about the management of an adder bite or if you require the antivenin.

National Poisons Information Service (Cardiff Centre)
Llandough Hospital, Cardiff CF64 2XX

Tel: 029 2070 9901
poisons.information@uhw-tr.wales.nhs.uk
www.uwcm.ac.uk/uwcm/llandough/ttc
Cymru Web: nww.ttc.wales.nhs.uk

Weever Fish

The weever fish is a small venomous marine fish about 18 cm long. It is found in coastal areas of Britain during the summer months. The NPIS (Cardiff Centre) received 11 calls during July, August & September 2000.



Weever fish venom is found in glands at the base of dorsal and gill spines. Weever fish stings often occur when someone stands on the fish buried in the sand in the shallows.

Symptoms

Symptoms occur immediately.

- Burning stabbing pain that spreads up the effected limb.
- Pain may be intense and cause loss of consciousness.
- Area initially blanches then reddens
- Swelling may be extensive and persist for up to 48 hours.

There may be:

- Headache
- Pyrexia
- Chills
- Nausea
- Vomiting
- Dizziness
- Sweating
- Shortness of breath
- Bradycardia
- Palpitations

Treatment

Weever fish toxin is destroyed by heat. Therefore, immerse effected area in water as hot as can be tolerated for 15 minutes. Do not use cold applications.

Jellyfish - Portuguese man-of-war

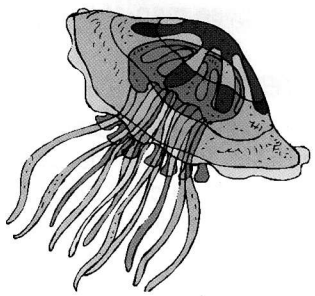
There is only one type of jellyfish in Britain that is capable of delivering a toxic sting, the Portuguese man-of-war. Since 1997 the NPIS (Cardiff Centre) has received 13 calls about jellyfish stings.

Symptoms

A sting from a Portuguese man-of-war causes:

- Local pain
- Muscular pain
- Griping abdominal pain
- Nausea
- Shortness of breath
- Cyanosis

Deaths have occurred in rare cases.



Treatment

The tentacles that contain the sting should be removed using adhesive tape.

Do not touch the tentacles with bare hands. As, they are able to deliver a sting several hours after being removed from the water.

Rinse the wound with saline (seawater) not fresh water.

Apply vinegar to the affected area for 30 minutes.

Local anaesthetics may help to control pain.

- Give anti-tetanus prophylaxis if needed.

For more information on the management of bites and stings from venomous animals call the NPIS (Cardiff Centre).

Important Notice

The NPIS may now be contacted using the national telephone number 0870 600 62 66. Calls made to this number will be diverted to the appropriate regional NPIS Centre. However to ensure that no users of the service are inconvenienced, the old telephone numbers will continue to operate for the forseeable future.

CSM WALES

SAFETY OF MENINGOCOCCAL GROUP C CONJUGATE VACCINES: THE WELSH EXPERIENCE

Background

In November 1999, a mass national immunisation campaign to vaccinate all children under 18 years with the new meningococcal C conjugate vaccines commenced. [1] So far three vaccines have been used, (Meningitec▼, Menjugate▼ and NeisVac-C▼). The first two were in use from the time of commencement of the programme and the third began to be used towards the end of 2000.

Analysis by the UK Department of Health suggests that there was an overall reduction of 75% in the number of confirmed meningococcal group C disease cases last winter (1999/2000) compared with the previous winter. By 31 May 2001, the CSM/MCA had received 13,073 reports of patients experiencing suspected adverse reactions in association with the meningococcal group C conjugated vaccines. [2]

The adverse reactions reported most commonly for those vaccines include dizziness, pyrexia, headache, nausea, vomiting and faints. Most of them were non-serious reactions and patients recovered rapidly. [2]

Adverse drug reactions reported to CSM Wales

Over a 15-month period to the end of January 2001 CSM Wales received 1,084 reports of patients experiencing 1,924 suspected reactions in association with the meningococcal group C conjugated vaccine. The majority of the reports (around 80%) were from the older age group (>5 years). Of the 1,924 suspected adverse reactions, 223 (11.6%) were classed as serious. Syncope was the most frequently reported serious suspected reaction (113 reports). There were also 18 reports of seizures in association with the vaccine.

The adverse reactions reported most frequently were injection site reaction, headache, dizziness, nausea, vomiting, rash, urticaria and syncope. Apart from syncope, all of these were non-serious reactions and the outcome was uneventful.

Suspected adverse reaction	No. of reports	% of total reactions
Injection site reaction	386	20
Headache	256	13
Nausea	121	6
Rash	119	6
Syncope	113	6
Dizziness	102	5
Vomiting	82	4
Urticaria	35	2

Approximately 50% of the reports were completed by nurses, with general practitioners (GPs) and hospital doctors reporting the rest.

Reporter	No. of reports	reactions
Nurse	521	917
GP	294	485
Hospital Doctor	262	508
Community Pharmacist	3	7
Hospital Pharmacist	3	7
Other	1	1
Total	1084	1925

The profile of these reports is similar to that stated in the Summary of Product Characteristics for the vaccines used. There were no new serious suspected adverse reactions. Meningococcal meningitis is a serious life threatening illness and the vaccination programme has achieved its aim to reduce the incidence of the condition. The vaccine will not prevent meningitis caused by the other serotypes of meningococci or other organisms. Thus meningitis should still be considered in those with suggestive clinical features, even if they have previously received meningococcal C conjugate vaccine.

The data support the view that the benefits of meningococcal C conjugate vaccine outweigh any risks involved. However, the only way to identify unforeseen risks to any medicine is through the continuing vigilance of health professionals. **So please continue to report suspected adverse reactions using the Yellow Card System.**

References:

1. *Start of the new meningococcal C conjugate vaccine immunisation programme* 18 October 1999: Circular from Department of Health.

2. Personal communication CSM/MCA

VIGABATRIN AND VISUAL FIELD DEFECTS

Vigabatrin (Sabril) is a gamma-aminobutyric acid (GABA) analogue. It should be used only for treatment (in combination with other anti-epileptic drugs) of patients with resistant partial epilepsy with or without secondary generalisation; that is, where all other appropriate drug combinations have proved inadequate or have not been tolerated. It is also used as monotherapy in the treatment of infantile spasms (West's syndrome). Treatment may only be initiated by a specialist in epileptology, neurology or paediatric neurology. Follow-up should be arranged under supervision of a specialist in epileptology, neurology or paediatric neurology

Visual field defects in patients receiving vigabatrin were first reported by Eke and co-workers in 1977 in three individuals [1]. Descriptions of asymptomatic defects were then reported by Mackenzie and Kilsthorner [2].

There were 815 reports detailing 1464 suspected adverse reactions in association with vigabatrin on the CSM ADROIT database as of 25th January 2001. One hundred and twelve of these were reports of visual field defects (not specified), 2 were of hemianopia and 4 reports concerned tunnel vision; in total comprising 8% of all suspected reported adverse drug reactions associated with vigabatrin.

It is now known that around a third of epileptic patients receiving vigabatrin may experience visual field defects, which may occur after 1 month or after several years. These defects range from asymptomatic to severe and potentially disabling, the visual field loss may be permanent despite cessation of therapy. For these reasons this agent is not recommended for patients with pre-existing visual field defects. The maximum recommended daily dose of vigabatrin has been reduced to 3g. Ophthalmological consultation and visual field assessment is necessary prior to commencement of therapy and visual field assessment should be repeated six-monthly thereafter in those individuals on treatment. Patients should be advised to report any new visual symptoms that develop and should then be referred for an urgent ophthalmological opinion. If a GP has a patient receiving vigabatrin in the community he/she may wish to consider contacting the patient to explain that they require follow-up and to obtain their permission for referral. The following specialist centres would be pleased to receive any such referrals.

South Wales

Dr P Smith
Welsh Epilepsy Unit
University Hospital of Wales
Heath Park
Cardiff
CF14 4XN

North Wales

Dr David Smith
The Walton Centre for Neurology & Neurosurgery
Lower Lane
Fazakerley
Liverpool
L9 7LJ

References

1. Eke T, Talbot JF, Lawden MC. Severe persistant visual field constriction associated with vigabatrin. BMJ 1997;314180-1.

2. Mackenzie R, Klistorner A. severe persistant visual field constriction associated with vigabatrin. BMJ 1998;316:232-3 (letter)

STOP PRESS

Adverse Drug Reactions in Children

The reporting of all suspected adverse drug reactions in children is **strongly encouraged** through the Yellow Card Scheme even if the intensive monitoring symbol (▼) has been removed, because experience in children may still be limited. BNF 2001; 41:11

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