Venom-Induced Consumption Coagulopathy, Disseminated Intravascular Coagulation, and Compartment Syndrome Following Red-Tailed Green Pit Viper/ Lesser Sunda Pit Viper Envenomation in Timor-Leste: A Two-Case Report

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ABSTRACT

Snake envenomation, particularly in Southeast Asia, often results in venom-induced consumption coagulopathy (VICC), a life-threatening condition characterized by severe bleeding and coagulopathy. Despite its clinical significance, management protocols for VICC remain under-researched, especially in resource-limited settings such as Timor-Leste. Two male adults were bitten in Timor Leste by green snake with reddish tail. A 47 years old male was bitten by a green snake with reddish tail from municipality and presented with severe symptoms, including epistaxis, conjunctival bleeding, hematemesis, melena, hemoptysis, hematuria, compartment syndrome at bite site and immediate black out at the location before he was taken to referral hospital in Maliana municipality and referral immediately to our setting at hospital national Guido Valadares in Dili Timor-Leste. The second was a male 73 years old bitten by green snake with reddish tail at nearby Dili and presented with severe symptom of gums bleeding, nausea and hematemesis but kept at home for two days with the trial of traditional healer than presented to emergency department with uncontrolled bleeding and decrease level of consciousness. For both cases the diagnosis was made based on clinical and history of green snake bite because there was no confirmed with a 20-min whole blood clotting test as this practice is no routinely done in Timor-Leste setting.

Initial treatment involved transfusion of Packed red cells (PRC) transfusion, Intravenous Steroids, Intravenous tranexamic acid to stop bleeding, anticoagulant agent Vitamin K and broad-spectrum intravenous antibiotics to cover infection as per local guidelines. In local setting, do not have antivenom available for green snake bites. VICC management in local setting is challenging. The initial administration of anti-snake venom (ASV) is the key treatment to neutralize procoagulant toxins, but in the absence of ASV, the administration of blood transfusion such as packed red blood cells (PRCs) and Platelets (PC) can be utilized to manage coagulopathy and as supportive measures based on patient's clinical findings. The timing and combination of these treatments are crucial in optimizing the results. Proper diagnosis of VICC involves a thorough clinical assessment and diagnostic testing. Management of VICC requires prompt administration of ASV and management tailored to the patient's condition and available resources. These cases report aim to examine the management strategies of VICC, specifically the role of blood component transfusion, and highlight the challenges of treatment in resource-limited settings in the countries where ASV is always not available.

Keywords: ASV: Anti Snake venom, VICC: venom-induced consumption coagulopathy, DIC: disseminated intravascular coagulopathy, CS: compartment syndrome

INTRODUCTION

Venomous snakebite is a major global health issue, particularly in rural areas of South Asia, Southeast Asia, and sub-Saharan Africa. Significant morbidity and mortality are frequently the result of neglecting the disease. The

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most common systemic syndrome is coagulopathy, and venom-induced consumption coagulopathy (VICC) carries significant risks of severe and life-threatening bleeding.(1,2,17 20,21,22,23,24) The World Health Organization announced a global strategy in 2019 to cut the number of deaths and disabilities caused by snakebites in half by 2030, emphasizing prevention and efficient first response.(3,17,18,19,20) However, the management of snakebites remains underexplored, particularly in low middle income countries such as in South East Asian specifically Timor Leste and some of African countries such as sub-Sahara Africa. Anti-snake venom (ASV) and blood products are used not available in treatment protocols due to a lack of thorough research and evidence-based recommendations. Even though Anti venom is purchased but not for envenomated green snake in the local setting, Timor-Leste.

Case One

A male 47 years old farmer from Maliana was biting by a green snake while he was fixing a fence in the garden. He had bitten on the right lateral aspect of the distal forearm/wrist while he was fixing garden fence at around 13:00 and he immediately developing dizziness and blackout, the greens snake was killed by relatives taken a picture and buried at the same location at the incidence. Patient was then rushed to Maliana referral hospital then transported to HNGV for further management because Referral Maliana did not have facilities to treat the case and he arrived at 19:57 local time, with developing Hematuria, Bloody stool, Epistaxis from bilateral nostril, spitting blood from gums bleeding, vomiting blood, bilateral sub-conjunctival hemorrhage and swelling on the bite site on right forearm which became ecchymosis extended up to his shoulder, right chest abdomen, back site and right leg. He had no previous snake bites and no medical conditions such as blood disorders.

Physical examination: the patient appeared moderately ill with GCS E4M6V5, blood pressure 117/67 mmHg, pulse rate 68 beats /min, respiratory rate 20 breaths/min, body temperature 36.8 deg. Celsius and SpO2: 99 % room air. There was a swelling with hematoma and ecchymosis starting from right hand to lateral aspect of the distal forearm extending to right shoulder, chest wall and back site to the right leg, bleeding from gums and subconjunctival bilaterally. Notice small bite lesion on the right lateral aspect of the distal forearm which dried off. The patient was diagnosed with Venom-Induced Consumption Coagulopathy (VICC) and possible Disseminated Intravascular Coagulation (DIC) with compartment syndrome of the right hand.

Images

Figure 1: Day 0ne after bitten by green snake: with bilateral sub-conjunctival hemorrhage

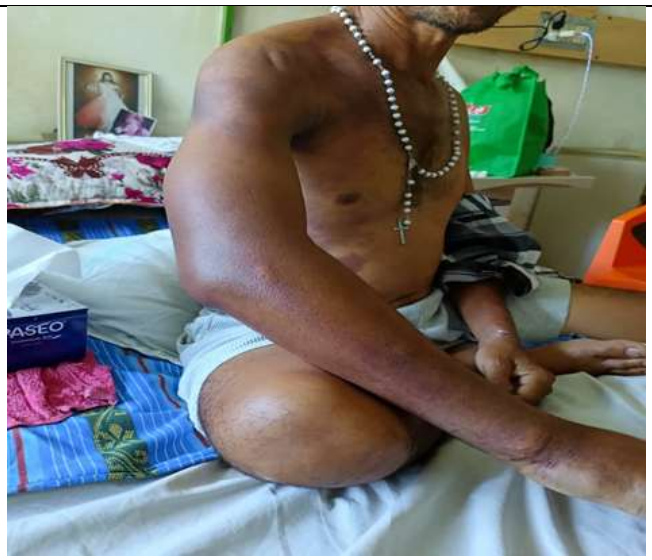

Figure2: Day two after bitten by green snake: Severe swelling with wide and extended ecchymosis and compartment syndrome

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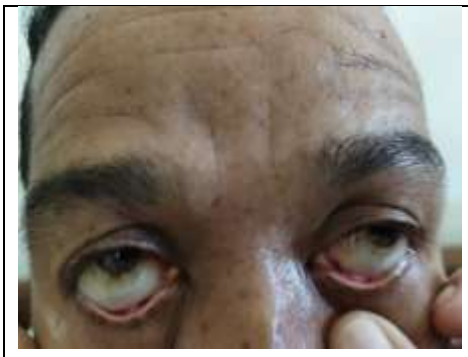

Figure 3: Day 7, still persistence bilateral sub-conjunctival hemorrhagic

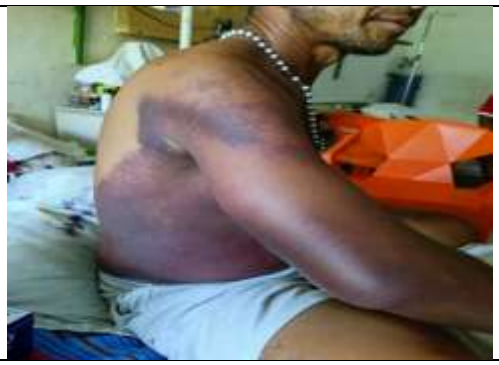

Figure 4: Day 7, still persistence extended ecchymosis

Figure 5: Day 14, Patient's signs and symptoms clinically.

Figure 6: Day 14, Ecchymoses and compartment symdrome has improved and patient is fit to discharge and follow at Out patient department

Figure 7: Taken at the Follow up OPD after two weeks discharged from the ward. Rt hand compartment syndrome had resolved with clear up all ecchymosis

Figure 8: Extended Ecchymosis had been resolved and he is now asymptomatic

Figure 9: Deceased green snake from patient's relative's camera captured

Figure 10: Trimeresurus albolabris: author own document

Figure 11: Trimeresurus insularis: author own document

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LABORATORIO RESULTS

Initial and follow up Full Blood Examination results (**Table 1**)

Test	Day 0 after bitten 18/11/2025	Day 2 after bitten 20/11/2025	Day 6 after bitten 24/11/2025	Day 8 after bitten 26/11/25	Follow in OPD 11/12/25	Normal ranges
White Blood cell	15.2	13.0	10.1	10.4	12.0	3.5-11.0x 10^9/L
Red blood cells	4.29	2.33	2.75	3.22	4.89	3.8-5.8 x10^{12}/L
Hemoglobin	112	60	73	88	134	120-150 g/L
Hematocrit	0.35	0.18	0.23	0.27	0.45	0.37-0.47 l/l
MCV	80.6	78.4	85	84	92.4	80-100 fl
MCH	26.1	25.9	26.4	27.5	27.3	27-32 pg
MCHC	324	328	312	326	296	300-500 g/L
Platelet count	19	47	222	332	232	150 -410 x10^9/L
IPF %	7	9	5	3	1	<5 %

Initial and follow up Biochemistry and electrolytes results (**Table 2)**

Test	Day 0 after bitten by snake 18/11/2025	Day 2 after bitten by snake 20/11/2025	Day 6 after bitten by snake 24/11/2025	Follow up Out Patient Clinic 11/12/25	Normal ranges
Sodium	141.8	138.8	144.7	140.8	135-145 mmol/L
Potassium	4.6	3.4	4.3	4.4	3.5-5.2 mmol/L
Urea	8.9	5.7	6.1	5.2	3.0-8.0 mmol/L
Creatinine	90.5	69	85.6	76.8	<100 umol/L
ALT	46	33	66	33	<35 U/L
AST	93	73	68	35	14-36 U/L
GGT	67	28	77	30	9-64 U/L
ALKP	39	26	38	40	30-110 U/L

In this patient, five (5) times laboratory examinations were carried out to monitor the progression of VICC. When the patient was in the emergency room, the results of the laboratory examination included hemoglobin levels of 112 g/L RBC: 4.29 x10^{12}/L, HCT: 0.53 L, WBC: 15.2 x10 ^{9}/L, platelets: 19 x10^9/L. IPF: 7%. Repeat Blood test in high dependency ward day 2 after bitten by green snake (18/11/2025) hemoglobin 60 g/L, RBC: 2.33 10^{12}/L, HCT: 0.18 l/l, Platelets: 47 x10^9/L IPF: 9%. This patient did not have specific laboratory test for VICC for green snake bite such as 20 WBCT (not commonly done in local setting), Prothrombin time (PT)/INR, activated partial thromboplastin time (aPTT), D-dimer/ fibrin degradation products (FDPs) and thromboelastographic (TEG/ROTEM) test, these modalities are NOT available in local setting.

The patient was managed with PRC Transfusion 2 units, intravenous injection hydrocortisone 200 mg three times daily, intravenous injection of cloxacillin 2 gr four times daily, intravenous tranexamic acid 500 mg three times daily, intramuscular Vitamin K 10 mg Daily, Intravenous clindamycin 600 mg three time daily, intravenous

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Piperacillin-tazobactam 4,5 g four times daily (Piperacillin 4 g+ tazobactam 0.5 g). Non-steroid anti-inflammatory drugs (NSAIDs) diclofenac intramuscular was immediately STOPPED in emergency department before patient transferred to the ward. Patient was closely monitoring in HDU and serial blood test to monitor his progress. Patient was continuously making clinical improving with the treatment choice given to the patient and at day 10th (28/11/2025) he was than discharged from hospital and booked for OPD follow up after 2 weeks. At two weeks follow up in OPD, he was clinically stable, with swelling, hematoma, ecchymosis resolved and his laboratory test result revealed normal values and he was returned to his daily routine as farmer at his home town in Maliana municipality.

Case Two

A male 73 years old, Timorese, subsistence agriculture from Dare, Dili, Timor-Leste was presenting to Emergency department after 2 day bitten by green snake with reddish tail while he was cleaning his garden in his surrounding home in Dare near to capital Dili, Timor Leste, after he was bitten by the green snake he developing gums bleeding, vomiting and loos bowel motion at home but relative kept him at home after 2 days than he was taken to ED HNGV. He presented with multiple ecchymosis and bleeding from intramuscular injection site with big hematoma on right buttock Intramuscular injection of Diclofenac site. He has no previous green snake bite, No history of bleeding disorder and other diseases.

On physical examination in the ward at day 5th of Snake bite, the patient was severely sick with decrease level of consciousness, agitated, confusion GCS E4V3M4. Blood pressure 106/66 mmHg, Pulse rate 76 beats/min Respiratory rate 24 breaths/min with SpO2 93% with oxygen 5 L/min via nasal prongs. Body temperature: 35.6 deg. Celsius. There was a swelling with hematoma and ecchymosis starting from left hand to lateral aspect of the distal forearm extending to right shoulder, chest wall and back site. There was a big hematoma on the right gluteal region at the intramuscular injection site of diclofenac which extended to right thigh blood oozing non-stoppable and right thigh forming compartment syndrome. Notice small bite lesion on the left lateral aspect of the distal forearm with blood oozing from the wound. The patient was diagnosed with Venom-Induced Consumption Coagulopathy (VICC) and Disseminated Intravascular Coagulation (DIC) with compartment syndrome of the right thigh.

Figure 12: Day 5 after bitten by green snake, patient condition deteriorating, decrease level of consciousness, agitated, Pallar conjunctive and shortness of breath

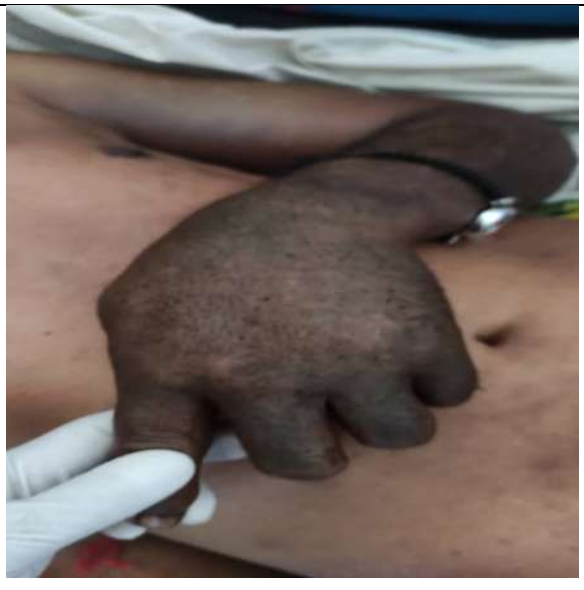

Figure 13: Right hand, bitten side becomes ecchymosis and darkness, skin with active bleeding.

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Figure 14: Right gluteal region, Intramuscular injection site becomes ecchymosis with formation of compartment syndrome on the right thigh

Figure 15: Blood oozing from intramuscular injection site non stoppable.

LABORATORIU RESULTS

Full Blood Examination results (**Table 3**)

Test	Day 2 after bitten	Day 5 after bitten	Normal ranges
White Blood cell	12.0	21.2	3.5-11.0x10^9/L
Red blood cells	5.48	1.0	3.8-5.8^{12}/L
Hemoglobin	164	35	120-150 g/L
Hematocrit	0.48	0.10	0.37-0.47 l/l
MCV	87.8	98.4	80-100 fl
MCH	29.9	34.8	27-32 pg
MCHC	341	354	300-500 g/L
Platelet count	24	83	150 -410 x10^9/L
IPF %	5	5	<5 %

Biochemistry and electrolytes results (**Table 4)**

Test	Day 2	Day 5	Normal ranges
Sodium	135.9	132.2	135-145 mmol/L
Potassium	4.9	3.8	3.5-5.2 mmol/L
Urea	13.4	10.4	3.0-8.0 mmol/L
Creatinine	137	163.8	<100 umol/L
ALT	20	120	<35 U/L
AST	29	70	14-36 U/L
GGT	19	12	9-64 U/L
ALKP	49	24	30-110 U/L

In this patient, two laboratory examinations were carried out on December 9, 2025, and December 12, 2025. When the patient was in the emergency room (9/12/2025), the results of the laboratory examination included

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hemoglobin levels of 164 g/L RBC: 5.48 x10^{12}/L, HCT: 0.48 L, WBC: 12.0 x10 ^{9}/L, platelets: 24x 10^{9}/L. IPF: 5%. Repeat Blood test in high dependency ward day 2 after bitten by green snake (12/12/2025) just before patient passed away, hemoglobin 35 g/L, RBC: 1.0 x10^{12}/L, HCT: 0.10 l/l, WBC: 21.2 x10 ^{9}/L Platelets: 83 10^{9}/L IPF: 5%. This patient also did not have specific laboratory test for VICC for green snake bite such as 20 WBCT (not commonly done in local setting), Prothrombin time (PT)/INR, activated partial thromboplastin time (aPTT), D-dimer/ fibrin degradation products (FDPs) and thromboelastographic (TEG/ROTEM) test, these modalities are NOT available in local setting.

The patient was managed by attending physician on call team from internal medicine at emergency department (ED) with intravenous injection hydrocortisone 200 mg three times daily, intravenous cloxacillin 1 gr four time daily, intravenous tranexamic acid 500 mg three times daily, intramuscular Vitamin K 10 mg Daily, Intramuscular Diclofenac 75 mg three times daily, Intravenous Omeprazole 40 mg two time daily, cold compress on affected areas and hydration with normal saline 0.9 % 500 ml every 8 hourly. The patient was kept in emergency department for three (3) days (09/12/2025-12/12/2025) before patient was transferred to the internal medicine ward. Delayed in ED because bed space in the ward. When arrived in internal medicine ward the condition deteriorated with decrease level of consciousness, agitated, bleeding uncontrolled from intramuscular injection Diclofenac side, large hematoma on Right gluteal area, Patient was seen and review the treatment and STOPPED diclofenac intramuscular injection, immediately requested for PRC, repeated laboratory test and transferred to High dependency unit (HDU) for close monitoring however patient passed away few hours later before PRC transfusion was given.

DISCUSSION

Snake bites are common among people who work in outdoor and agricultural environments in Southeast Asia, particularly in Timor-Leste (2,5,17,18,19) However, a significant challenge arises because many victims are unable to identify the snake species that bit them, complicating the administration of specific antivenom. There are over 3000 snake species known to exist worldwide, and about 600 of them are venomous (6). The World Health Organization states that bites from the genus Trimeresurus–which includes Trimeresurus albolabris and Trimeresurus insularis–are among the reasons for snake bites in South east Asian region and neighborhood country Indonesia such as in west Timor which land border to Timor Leste (21,24). In Timor- Leste most common green snake bite with VICC is Trimeresurus Insularis /lesser Sunda green pit viper (21,24). These snakes are typically identified by their bright green color and the reddish-brown surface of their tails. The distinctions are streamlined according to geography. While T. insularis is as well found in the eastern region of Java, Bali, and the Lesser Sunda Islands, In Timor Island there been documented T. Insularis and T. albolabris. The scientific study so far has identified the snake species however identification is based on the report from victim after had bitten by the snakes. Assessing the clinical symptoms and identifying the responsible snake is essential to make an accurate diagnosis of a venomous snake bite. This may be accomplished by identification of the deceased snake or a photograph of the snake, if available. An alternative method of identification involves evaluating clinical symptoms and signs, analyzing the patient's description, and observing the bite wounds [2,8] In our first case, the patient has bite marks on his right lateral aspect of the distal forearm/wrist. The bite mark was identified as a snake bite, which than developed to extended ecchymosis to chest wall and back site with compartment syndrome on the affected hand and relatives had killed the snake and taken a photograph of the dead snake which showed green with reddish tail (figure 4) provide further details about the snake, it was then assumed to be from Trimeresurus insularis based on the description of its color and geographical distribution of the snake where is located in the South east Asian region and in the Indonesian Archipelagoes. Snakebite symptoms and clinical signs are typically categorized into local and systemic effects. Local manifestations include bite marks, pain, swelling, and bleeding at the site of the bite (8,17) Systemic symptoms may present as nausea, subconjunctival hemorrhage, hematemesis, hematuria, epistaxis, gums bleeding and anuria. Snake venom toxins can generally be classified into five primary categories: neurotoxic, cytotoxic, hemotoxic, nephrotoxic, and myotoxic. Different snake species may produce various combinations of these toxic effects (9,10) In this case, the patient exhibited bleeding secondary to consumptive coagulopathy, massive bleeding from several site indicative of hemotoxicity. Both local and systemic bleeding manifestations mark the hemotoxicity effects of snake venom and VICC. These may include bleeding from the gums, sites of previous wounds, the area of the snakebite, as well as gastrointestinal and genitourinary bleeding, hematemesis, and

hemoptysis (1,2). Such bleeding is frequently exacerbated by blood clotting disorders resulting from VICC. VICC is a condition that is characterized by the activation of the coagulation cascade by snake venom components, such as prothrombin, factor X, and V activators. In contrast to disseminated intravascular coagulation (DIC), this coagulation cascade is initiated by procoagulant toxins. VICC is distinguished by the rapid onset and resolution of coagulopathy, which normally occurs within 24–48 hours, and the absence of nonrenal end-organ damage. (1,9,10) The diagnosis and monitoring of VICC require coagulation studies and assessment of clotting times. The laboratory findings in patients with VICC are characterized by thrombocytopenia, extended coagulation times (including clotting time, prothrombin time, and activated partial thromboplastin time), decreased fibrinogen levels, increased levels of fibrinogen degradation products (including serum crosslinked fibrin and D-dimer), decreased coagulation factor levels, and decreased antithrombin III levels (1,11,17). In resource-limited health facilities, diagnosing VICC primarily relies on thorough clinical history, focused physical examination, and basic diagnostic tests. In our cases, the above tested names were not done because not available in our setting. Anamnesis and a targeted physical exam are crucial for identifying symptoms and signs indicative of VICC. Simple yet effective diagnostic tools, such as the 20 WBCT are valuable in assessing coagulopathy (1,8,2, 17,18,19). This test also not done for the two cases as it is not commonly practice in the local setting. Antivenom serves as the primary treatment for snake envenomation, showing high efficacy in binding toxins and neutralizing their effects (11,18) Antivenom should be administered promptly for optimal effectiveness (13). The literature points out the importance of administering antivenom promptly following the identification of the snake species. This semi-mechanistic model indicates that antivenom administration should occur within 15–30 min post-bite to prevent or reduce the onset of VICC (14,16,17,18,19). The role of ASV is solely to stop the consumption process of coagulopathy, yet it may not eliminate the irreversible toxic effects. Whereas the body's re-synthesis of blood clotting factors requires in 24–48 hours, the patient is still at risk of bleeding during this time. One of the case managed in Hospital National Guido Valadares (without ASV) yields satisfactory results, there are still concerns that prompt management with PC and PRC with steroids, Vitamin K may prevent worsen coagulopathy by providing additional substrate for the activation of procoagulant toxins in the venom.(10,12)Nonetheless, recent studies suggest that administering PC and PRC within 4 hours of antivenom can lead to a more rapid restoration of clotting function in many patients.(1,17,18,19).The benefit of PC and PRC in cases of VICC without-active bleeding remains uncertain, and more research is needed to determine its efficacy in this particular patient subgroup. In Timor-Leste setting, the two severe cases were administered PC and PRC instead of FFP because of limited stock for FFP to prevent continues bleeding and severe anemia (17,18,19). In life-threatening bleeding scenarios associated with VICC, current evidence supports not delaying PC and PRC administration (10,17,18,19). In Timor-Leste, there are currently no established guidelines for the administration of antivenom, including specific dosage and timing protocols, and there are not available ASV for green snake bite in the country yet. In this case, due to the limited availability of ASV, FFP, and other blood products were administered before antivenom, with specific ASV not being administered for the post-bite. In addition to PC, PRC, as the management of VICC, in these two cases involves the administration of steroid, tranexamic acid, Vitamin K and broad-spectrum intravenous antibiotic to cover any infection that may occurs as per local setting, this management may not exist in global snake bite guidelines. The use of PC, PRC transfusion is usually intended for cases where the platelet count remains insufficient despite the administration of antivenom (4,17,18,19). This relies on the principle that antivenom counteracts procoagulant toxins that cause platelet dysfunction. Therefore, the main focus must be on the administration of antivenom to fix the underlying toxicological issue. If the platelet count does not improve after antivenom treatment, a platelet transfusion may be considered to reduce the risk of bleeding (1,17,18,19) Conversely, PRC transfusion is administered to avoid decreases in hemoglobin that may occur despite optimal antivenom and FFP therapy. This is crucial for the stabilization and recovery of patients, as it ensures that tissues get adequate oxygen (4,19) The decision to administer PRC depends on the patient's hemoglobin levels and clinical condition, rather than being directly linked to coagulopathy. The Outcomes of the first case was overwhelming after he was been admitted in High dependency unity (HDU) for tent (10) days than discharged home after clinically improving (figure 5). His blood results were normalizing after day 10^{th} in the ward. He was than seen again at OPD with normal condition and he was return to his daily routine as farmer at his home town in Maliana. The second case was passed away just few hours in the ward after three (3) days kept in Emergency department and delay two days to Emergency department as he was kept at home for two days with severe symptoms of gums bleeding nausea vomiting and hematemesis. He also had Intramuscular injection of NSAID (diclofenac for three consecutive days) at Emergency department. The patient did not receive PRC transfusion until passed away.

Given NSAIDs in VICC patient is worsening due to platelets dysfunction, it is clearly shown by many evidences and the two cases (20,22.23). First case, the Diclofenac was immediately STOPPED and not receiving any dose yet. Otherwise, the first case was much more severe than the second case in terms of clinically presentation and laboratory tested results. PRC transfusion was given and patient progressively improving until discharged home by day 10^{th} and follow up at the 24^{th} days and patient was returning to normal life. While second case was receiving NSAIDs (intramuscular injection of diclofenac for 3 days) and not receiving PRC transfusion and distance from first laboratory test to the next was wide which leads to delayed in decision for given PRC transfusion. It is strong recommended that NSAIDs is should be AVOID in cases of snake bite suspected of VICC.

Challenges in managing green snake bite with VICC/ DIC in low middle income countries; diagnostic challenges in VICC Vs DIC because of scoring system due to laboratory limitation, limited access to fibrinogen, D-dimers, factors assays, PT/INR, aPTT. Mostly relays on 20WBCT leading to misdiagnosis of DIC and inappropriate transfusion. ASV is not available for specific snake bite. Geographic and health system factor with traditional believes affecting on management due to late referral to hospital, traditional healer used before presentation, and limited referral pathway, Blood bank limitation with FFP, PC and PRC when urgent needed in severe cases of VICC and or DIC. Human resource and training gaps with variable experience among clinician with lack of local guideline for specific setting leading to administration of NSAIDs in VICC as this can worsening the outcome as happen to the second case of the report (19,20,21,22,23). The description of the two cases study has strengthened the management of VICC following snake envenomation in a resource limiting setting. The case reports provide valuable insight into the difficulties faced in Timor Leste, particular the absence of available selected right antivenom therapy and reliance supportive management. The detailed clinical presentation of bleeding manifestations, diagnostic challenges, and treatment approaches improves understanding of severe snake bite complications. The study also emphasizes the importance of early recognition, blood component support, and adapting treatment strategies according to available resources. However, the author recognized the report is only two cases, which limits the ability to draw broader conclusions regarding VICC management strategies. The snake species was not confirmed through laboratory identification, and diagnosis relied mainly on clinical history and patient's descriptions which may introduced uncertainty. The absence of routine coagulation investigations, including 20WBCT (20-minute whole blood clotting test), limits objective assessment of disease severity and treatment response. The management approaches described include several interventions, but the effectiveness of individual treatment cannot be determined from these cases only.

Therefore, the author suggestive for further study by including laboratory confirmation of coagulation abnormalities such as clotting time, fibrinogen levels, platelet counts, and coagulation profile, whenever resources in the countries permit. Future reports should also include long term follow up periods to evaluate recovery, complications, and long-term outcomes after supportive treatment, establishing reliable snake species identification methods would improve understanding antivenom characteristics and guide treatment decisions.

CONCLUSION

Effective management of VICC in resource-limited settings requires a tailored strategy, especially in the absence or delay of antivenom. The prompt administration of antivenom is essential for neutralizing venom and preventing coagulopathy; however, in its absence, alternative treatment strategies are necessary. Blood transfusions, including PRCs, PC and FFP serve as effective alternatives in addressing coagulopathy. NSAIDs must be avoid in cases of Snake bite with VICC. This emphasizes the importance of clinical judgment in tailoring treatments to improve patient outcomes in resource-limited settings.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/ her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published, and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest

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