In conclusion, the study by Bonilla-Aldana et al.1 accurately shows the prevalence and microbiological patterns of snakebite-related infections. On the basis of the international literature, there is no evidence for the effectiveness of routinely administered prophylactic treatment. Nevertheless, empiric antibiotics can be used in targeted cases with high contamination of the fecal flora of prey, which may defecate while being ingested, or from the environment (e.g., A. hydrophila, especially in wet areas).12 In most cases, the pathogenic bacteria are naturally resistant to AMC.9,12 In addition, in a well-designed study by Sachet et al.5 in the Amazon region, AMC showed poor efficacy in preventing secondary infection from snakebites. Accordingly, first-line AMC is not an appropriate option to treat snake-bitten patients, except when guided by microbiological results. Unfortunately, prophylactic AMC is still largely prescribed in this context.9,13

From a microbiological point of view, most M. morganii strains are naturally susceptible to piperacillin, ticarcillin, third- and fourth-generation cephalosporins, carbapenems, aztreonam, fluoroquinolones, aminoglycosides, and chloramphenicol.14 These antibiotics are also effective against most Enterobacteriaceae, including Escherichia coli, Klebsiella pneumoniae, and Proteus mirabilis. Aeromonas hydrophila are naturally susceptible to third-generation cephalosporins, piperacillin–tazobactam, ciprofloxacin, and amikacin.10,16 Enterococcus faecalis is typically susceptible to non- 

cephalosporin β-lactams and vancomycin, which represent therapeutic mainstays.17 Staphylococcus aureus is naturally susceptible to many antibiotics, including oxacillin, first-generation cephalosporins, linezolid, trimethoprim-sulfamethoxazole, gentamicin, clindamycin, ofloxacin, tetracycline, and erythromycin.18 Anaerobes are rarely isolated in secondary infection after snakebite. Although piperacillin–tazobactam, ciprofloxacin, clindamycin, or third-generation cephalosporin are active against a wide range of anaerobes, metronidazole is the drug of choice in case of identification of such bacteria or clinical signs suggestive of their involvement.19,20 Anaerobic soft-tissue infections usually develop hours or days after the bite, mainly in devitalized tissues. They can present as collections and crepitus at the bite site.

Considering the frequently isolated bacteria in snakebite-related infection, piperacillin–tazobactam, ciprofloxacin, or a third-generation cephalosporin are the most appropriate antibiotics for empiric therapy. After identification of the causal bacteria, antibiotics must be changed to narrower spectrum drugs based on the microbiological results. Little information is available to guide the optimal duration of antibiotic therapy or the value of combination drug therapy. Available data report antibiotic use for 7 to 10 days with several proposed therapeutic regimens without documented advantages of one strategy over another.9,21

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suspicions of infection, mainly those with necrosis or local signs suggestive of cellulitis. The most appropriate empiric antibiotics are piperacillin/tazobactam, ciprofloxacin, or a third-generation cephalosporin. First-line AMC should no longer be considered because it is ineffective against most bacteria involved in snakebite-related infection. Once the microbiological results are available, deescalation is necessary to provide the narrowest spectrum drug active against the responsible microorganism. Finally, efficiently managing snakebite envenoming requires not only safe and effective antivenom but also appropriate antibiotics, both of which are, unfortunately, often unavailable in poor and disadvantaged regions.

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