



The Efficacy of Crotalidae Polyvalent Immune Fab (Ovine) Antivenom Versus Placebo Plus Optional Rescue Therapy on Recovery From Copperhead Snake Envenomation: A Randomized, Double-Blind, Placebo-Controlled, Clinical Trial

Charles J. Gerardo, MD, MHS*; Eugenia Quackenbush, MD; Brandon Lewis, DO; S. Rutherford Rose, PharmD; Spencer Greene, MD, MS; Eric A. Toschlog, MD; Nathan P. Charlton, MD; Michael E. Mullins, MD; Richard Schwartz, MD; David Denning, MD; Kapil Sharma, MD; Kurt Kleinschmidt, MD; Sean P. Bush, MD; Samantha Ryan, BS; Maria Gasior, MD; Victoria E. Anderson, MPH; Eric J. Lavonas, MD

*Corresponding Author. E-mail: Charles.gerardo@duke.edu, Twitter: @dukeemergency.

Study objective: Copperhead snake (*Agkistrodon contortrix*) envenomation causes limb injury resulting in pain and disability. It is not known whether antivenom administration improves limb function. We determine whether administration of antivenom improves recovery from limb injury in patients envenomated by copperhead snakes.

Methods: From August 2013 through November 2015, we performed a multicenter, randomized, double-blind, placebo-controlled, clinical trial to evaluate the effect of ovine Crotalidae polyvalent immune Fab (ovine) (CroFab; FabAV) antivenom therapy on recovery of limb function in patients with copperhead snake envenomation at 14 days postenvenomation. The study setting was 18 emergency departments in regions of the United States where copperhead snakes are endemic. Consecutive patients aged 12 years or older with mild- to moderate-severity envenomation received either FabAV or placebo. The primary outcome was limb function 14 days after envenomation, measured by the Patient-Specific Functional Scale. Additional outcomes included the Patient-Specific Functional Scale at other points; the Disorders of the Arm, Shoulder, and Hand, Lower Extremity Functional Scale, and Patient's Global Impression of Change instruments; grip strength; walking speed; quality of life (Patient-Reported Outcomes Measurement Information System Physical Function-10); pain; and analgesic use.

Results: Seventy-four patients received study drug (45 FabAV, 29 placebo). Mean age was 43 years (range 12 to 86 years). Fifty-three percent were men, 62% had lower extremity envenomation, and 88% had mild initial severity. The primary outcome, the least square mean Patient-Specific Functional Scale score at 14 days postenvenomation, was 8.6 for FabAV-treated subjects and 7.4 for placebo recipients (difference 1.2; 95% confidence interval 0.1 to 2.3; $P=.04$). Additional outcome assessments generally favored FabAV. More FabAV-treated subjects experienced treatment-emergent adverse events (56% versus 28%), but few were serious (1 in each group).

Conclusion: Treatment with FabAV reduces limb disability measured by the Patient-Specific Functional Scale 14 days after copperhead envenomation. [Ann Emerg Med. 2017;70:233-244.]

Please see page 234 for the Editor's Capsule Summary of this article.

Readers: click on the link to go directly to a survey in which you can provide [feedback](#) to *Annals* on this particular article.

A [podcast](#) for this article is available at www.annemergmed.com.

0196-0644/\$-see front matter

Copyright © 2017 American College of Emergency Physicians. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

<http://dx.doi.org/10.1016/j.annemergmed.2017.04.034>

INTRODUCTION

Background

Approximately 5,000 to 9,000 people seek emergency care in the United States for crotaline snakebites annually, including rattlesnake, cottonmouth, and copperhead envenomation.¹ The copperhead (*Agkistrodon contortrix*) is responsible for nearly half of reported bites.² Copperhead

envenomation is generally less severe than rattlesnake envenomation.³⁻⁵ More than 95% of copperhead victims develop significant pain and swelling of the envenomated limb, but systemic venom effects are uncommon and death is rare.⁶⁻⁹ Current data support only a crude understanding of the time course of recovery from limb injury with or without antivenom therapy. Although most patients

Editor's Capsule Summary*What is already known on this topic*

Copperhead envenomation is rarely life threatening but may cause prolonged limb injury.

What question this study addressed

This multicenter randomized controlled trial evaluated the effect of antivenom administration on limb function in a cohort of patients with predominantly mild copperhead envenomations.

What this study adds to our knowledge

Seventy-four patients were enrolled in the study, of whom 45 were randomized to antivenom administration. Antivenom improved Patient-Specific Functional Scale score at day 14 (8.6 versus 7.4; $\Delta=1.2$; 95% confidence interval 0.1 to 2.3). All patients recovered by 4 months regardless of intervention. Opioid use was lower in the antivenom group.

How this is relevant to clinical practice

Outcomes in mild to moderate copperhead envenomation are generally good. Antivenom may improve limb function early in the course and minimize the need for prolonged opioid analgesia. Given associated costs, an individualized risk-benefit discussion should occur.

recover enough to return to work within 2 to 4 weeks, residual symptoms can last a year or more.^{6,10}

Importance

Crotalidae polyvalent immune Fab (ovine) (CroFab; FabAV) (BTG International Inc, West Conshohocken, PA) is the only antivenom currently Food and Drug Administration approved and marketed for the treatment of crotaline snake envenomation. Although FabAV is approved for the treatment of envenomation by all North American crotaline species, copperhead-envenomated patients were excluded from the registry trials because it was considered unethical to expose these patients to then-experimental antivenom (personal communication, R. C. Dart, Rocky Mountain Poison and Drug Center, 2012).^{11,12} The safety of FabAV was subsequently established, and observational studies demonstrated that FabAV administration is associated with cessation of progression of tissue injury in copperhead victims.^{8,13,14} Whether this leads to improved recovery of limb function is unstudied, and the role of FabAV in the management of

patients with nonlife-threatening envenomation is controversial. Although many experts recommend treating all crotaline envenomation patients according to clinical presentation, irrespective of species, others recommend withholding FabAV from copperhead victims.^{4,5,9,15-18}

These conflicting recommendations have resulted in wide practice variation, with 0% to 90% of patients at individual hospitals receiving antivenom.^{5,6,10,19-21} In 3 recent prospective studies, the proportion of copperhead patients receiving FabAV ranged from 14% to 75%, and in the largest study there was poor correlation between snakebite severity score and the decision to use antivenom ($r^2=0.06$).^{4,22,23} A 2004 editorial called for a clinical trial to study the efficacy of FabAV therapy for copperhead snake envenomation, but no such research has been performed.²⁴

Goals of This Investigation

The purpose of this study is to determine whether administration of antivenom improves recovery from limb injury in patients envenomated by copperhead snakes.

MATERIALS AND METHODS**Study Design**

We performed a multicenter, randomized, double-blind, placebo controlled, clinical trial to evaluate the effect of FabAV administration on limb recovery. The study was approved by the Western Institutional Review Board and the institutional review board at each study site. In addition to on-site monitoring by the sponsor's clinical research associates, study conduct was overseen by an independent data monitoring committee. Informed consent was obtained from all participants.

Selection of Participants

We enrolled consecutive patients from August 2013 through November 2015 at 18 emergency departments (EDs) in regions of the United States where copperhead snakes are endemic. Patients were nonpregnant adults (≥ 18 years) or adolescents (12 to 17 years) presenting with mild- to moderate-severity envenomation by a copperhead snake on only one extremity (distal to the elbow or knee) that occurred within 24 hours of enrollment. Mild envenomation was defined by swelling crossing 0 to 1 major joints (wrist, elbow, ankle, or knee), and moderate envenomation by swelling crossing 2 major joints. Copperhead species was confirmed by examination of the snake or photograph of the snake brought to the ED, patient identification of a copperhead from an array of snake photographs, envenomation in an area where only

copperheads are endemic, or envenomation by a captive copperhead snake.

Patients with severe venom effect at presentation (defined as swelling to an entire extremity [crossing the hip or shoulder joint], coagulopathy of possible medical importance [International Normalized Ratio >2.0, fibrinogen level <50 mg/dL, or platelet count <50,000 cells/ μ L], hypotension, compartment syndrome, or more than minimal bleeding) were excluded. The full protocol is provided in [Appendix E1](#), available online at <http://www.annemergmed.com>.

Subjects were assigned in a 2:1 ratio to receive FabAV or placebo, using centralized computer randomization, stratified by envenomation site (upper versus lower extremity), severity (mild versus moderate), and age (adolescent versus adult). All study personnel (except the unblinded study pharmacist) and patients were unaware of treatment assignments.

Interventions

Subjects in the FabAV group received 6 vials of FabAV in 250 mL normal saline solution as initial treatment, repeated once if needed to halt progression of venom effects. They then received 2 vials of FabAV 6, 12, and 18 hours later, in accordance with current Food and Drug Administration–approved dosing instructions. Placebo subjects received visually identical normal saline solution. Subjects were monitored for progression to severe venom effect and for adverse events during and after completion of treatment.

Patients who developed severe venom effect at any time moved into standard-of-care rescue treatment, which could include open-label FabAV at the discretion of the treating physician. Patients or physicians could also request withdrawal from the protocol treatment at any time. Subjects were evaluated according to the original treatment group assignment, with blinding maintained unless required for patient safety.

Data Collection and Processing

Study personnel collected data about the signs and symptoms of the envenomation and treatment delivered during the initial hospitalization. Protocol-specified in-person study assessments were performed at hospital discharge and on days 3, 7, 14, 21, and 28 after envenomation, with procedures for telephone follow-up in case of missed study visits. Subjects also completed follow-up assessments by telephone on days 10, 17, and 24. Patients who had not reached full recovery on the primary study outcome by the 28-day visit completed monthly telephone assessments until full recovery or 4 months, whichever occurred first.

Outcome Measures

The primary outcome, chosen a priori, was the Patient-Specific Functional Scale score at envenomation plus 14 days.²⁵ The scale is a patient-oriented outcome that has been extensively validated in numerous musculoskeletal disorders, including copperhead snake envenomation.²²⁻³⁵ Patients were asked to choose 3 activities they were unable to do or were having difficulty with because of their snake envenomation, and at each assessment reported their ability to perform these tasks on a scale of 0 (“unable to perform activity”) to 10 (“able to perform activity at the same level as before injury or problem”). The mean of these 3 values is the Patient-Specific Functional Scale score, with a score of 10 indicating full recovery. The Patient-Specific Functional Scale has excellent interrater reliability and test-retest validity.^{27,30,34} It assesses both upper or lower extremity conditions, thereby decreasing the sample size required to evaluate copperhead envenomation. The scale is closely correlated with limb-specific tools such as the Disorders of the Arm, Shoulder, and Hand, and the Lower Extremity Functional Scale instruments, but is more efficient to administer.^{22,26-29}

All additional study outcomes were chosen a priori and serve to further inform the results of the primary outcome; they were not intended as hypothesis testing. Additional outcomes were comparisons of the Patient-Specific Functional Scale at other points, time to full functional status recovery as measured by the Patient-Specific Functional Scale, scores on the Disorders of the Arm, Shoulder, and Hand and Lower Extremity Functional Scale instruments (administered to subjects with upper and lower extremity envenomation, respectively), physical function-related quality of life measured by the Patient-Reported Outcomes Measurement Information System Physical Function-10 (PROMIS PF-10),³⁶ numeric pain rating scale,³⁷ opioid analgesic use, and the Patient’s Global Impression of Change–1 instrument.³⁸ For upper extremity envenomation subjects, grip strength was measured with a Jamar hand dynamometer (Lafayette Instruments, Lafayette, IN)³⁹; lower extremity subjects completed a 7.62-m walking speed test.⁴⁰ The proportion of patients moved to rescue therapy was also a tertiary outcome. All outcome instruments are included in the protocol in [Appendix E1](#), available online at <http://www.annemergmed.com>.

Structured adverse event collection occurred from the first investigational product infusion through completion of all follow-up assessments. Blinded site investigators characterized each event as serious or nonserious, using standard criteria, and determined whether the adverse event was related to study drug administration.⁴¹ Each adverse event was characterized with Medical Dictionary for Regulatory Activities taxonomy (version 16.1).⁴²

Primary Data Analysis

All statistical tests were determined a priori and applied to the modified intent-to-treat population, composed of all patients who received at least one dose of study medication. The primary efficacy endpoint was analyzed by ANOVA. Least squared mean Patient-Specific Functional Scale score was calculated for each treatment group, using a linear mixed-effect model that included factors for the stratification variables: anatomic location of envenomation, severity of snakebite, and age. Treatment effect was computed as difference in mean Patient-Specific Functional Scale score at day 14. The last observation carried forward

method was used to impute data for missing assessments. A supportive analysis assessed the difference in least squared mean Patient-Specific Functional Scale scores between treatments, using a repeated-measures ANOVA. The full statistical analysis plan is provided in [Appendix E1](#), available online at <http://www.annemergmed.com>.

Time to full recovery on the Patient-Specific Functional Scale was analyzed with a Cox proportional hazards model, including stratification variables as above. Other efficacy endpoints were analyzed with ANOVA to compare the least squared mean of the other outcome assessments between the treatment groups at each measured point. The

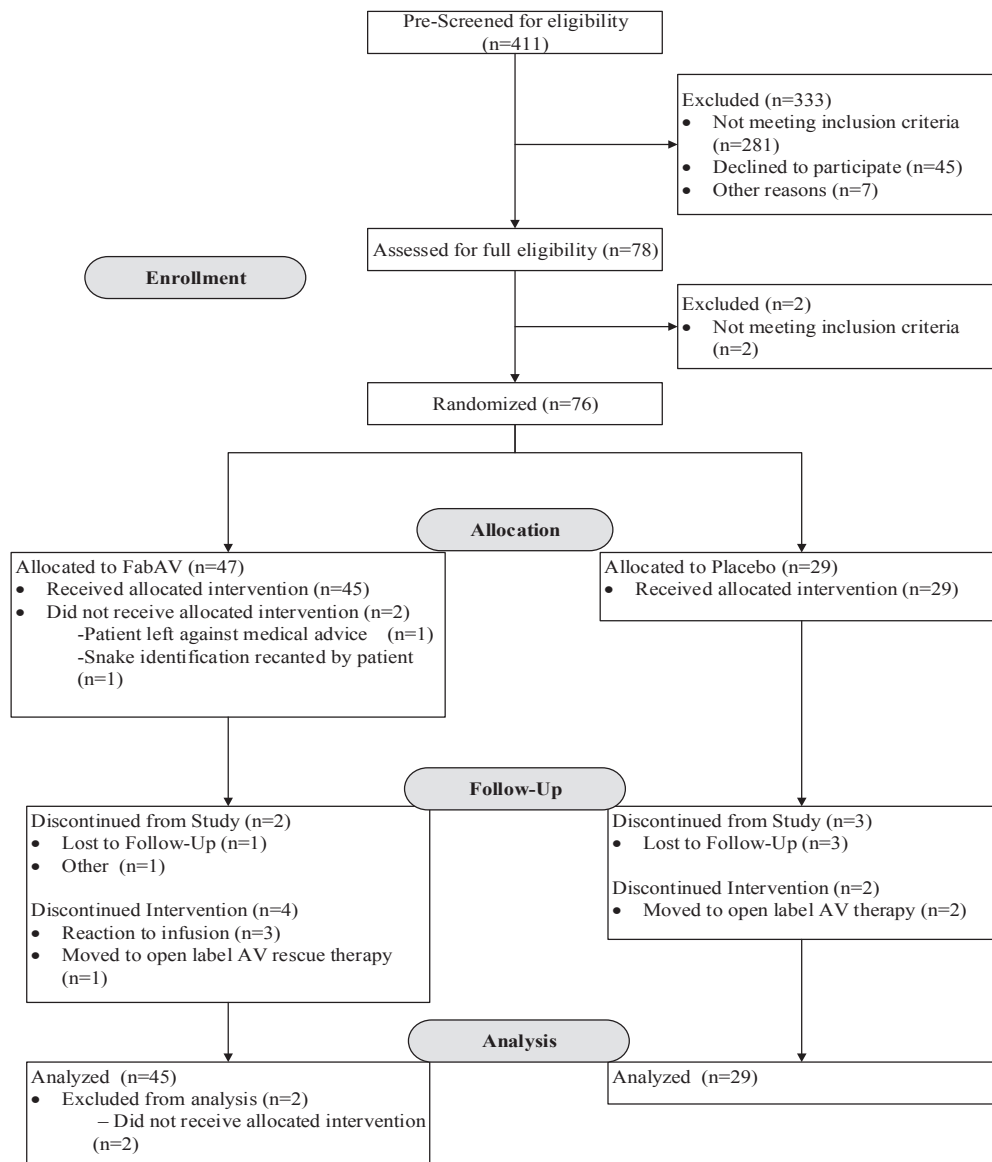


Figure 1. Patient flow. The unblinded investigational pharmacist at the investigative site accessed the Interactive Response Technology system to receive the treatment arm assignment for the subject. Only the unblinded pharmacy personnel had access to the treatment assignment to facilitate preparation of the study intervention. The subject, the investigator, and investigative site personnel remained blinded to the treatment assignment.

only departure from the statistical plan was that the original plan called for comparing analgesic use as any/none, but later it became clear that current opioid use was more clinically relevant. Thus, the opioid/no-opioid comparison is post hoc.

In accordance with a clinical difference of 1 SD in the prospective observational pilot data,²² we calculated that a sample size of 182 evaluable subjects would produce 80% power to detect a statistically significant difference in the primary study outcome, with overall 2-sided α of 5.0% and one interim analysis. The original study plan was to enroll these patients during 2 complete snakebite seasons and perform an interim analysis after the first season. However, after the first full season it became clear that we would not reach target enrollment and the decision not to perform an interim analysis was made and communicated to all study sites. This decision was made in a blinded fashion before review or analysis of any data. According to pilot study

data, the original sample size was understood to be underpowered for the additional outcome measures; therefore, they did not affect the interim analysis decision.

RESULTS

Characteristics of Study Subjects

Seventy-six patients were randomized and 74 received study drug (modified intent-to-treat population) (Figure 1). Two patients were randomized, but withdrew from the study before administration of the study drug. One patient requested withdrawal because of a family emergency and left the hospital against medical advice. The other patient was unable to identify the snake as a copperhead. Forty-five patients received FabAV and 29 received placebo. Sixty-nine subjects (93.2%) completed the study through final follow-up, with 2 withdrawals from the FabAV group and 3 from the placebo group. Baseline characteristics were well balanced between groups (Table).

Table. Patient demographic and baseline characteristics (modified intent-to-treat population).

Demographics	FabAV Treated Patients (N=45)	Placebo Treated Patients (N=29)	Total Treated Patients (N=74)
Age, y			
Mean (SD)	43.9 (17.9)	41.7 (17.2)	43.0 (17.6)
Range	12–86	13–69	12–86
Age strata, No. (%)			
Adult	42 (93.3)	24 (82.8)	66 (89.2)
Adolescent	3 (6.7)	5 (17.2)	8 (10.8)
Sex, No. (%)			
Male	23 (51.1)	16 (55.2)	39 (52.7)
Race, No. (%)			
White	40 (88.9)	25 (86.2)	65 (87.8)
Black	2 (4.4)	2 (6.9)	4 (5.4)
Asian	1 (2.2)	0	1 (1.4)
Other	2 (2.2)	2 (6.9)	4 (5.4)
Ethnicity, No. (%)			
Hispanic or Latino	3 (6.7)	4 (13.8)	7 (9.5)
Not Hispanic or Latino	42 (93.3)	25 (86.2)	67 (90.5)
Anatomic location, No. (%)			
Upper extremity	16 (35.6)	12 (41.4)	28 (37.8)
Lower extremity	29 (64.4)	17 (58.6)	46 (62.2)
Severity at enrollment, No. (%)			
Mild	40 (88.9)	25 (86.2)	65 (87.8)
Moderate	5 (11.1)	4 (13.8)	9 (12.2)
Study site, No. (%)			
Duke University, Durham, NC	16 (35.6)	12 (41.4)	28 (37.8)
University of North Carolina, Chapel Hill, NC	12 (26.7)	4 (13.8)	16 (21.6)
St. Joseph Regional Health Center, Bryan, TX	8 (17.8)	4 (13.8)	12 (16.2)
Virginia Commonwealth University Medical Center, Richmond, VA	2 (4.4)	2 (6.9)	4 (5.4)
Vidant Medical Center, Greenville, NC	2 (4.4)	1 (3.4)	3 (4.1)
Barnes-Jewish Hospital, St Louis, MO	2 (4.4)	1 (3.4)	3 (4.1)
Other sites	3 (6.7)	5 (17.3)	8 (10.8)
Method of snake species identification			
Snake or photograph brought to hospital	11 (23.4)	10 (47.6)	21 (27.6)
Patient or parent chose copperhead from photograph array	22 (46.8)	16 (55.2)	38 (50.0)
Envenomation occurred in an area endemic only to copperheads	14 (29.8)	3 (10.3)	17 (22.4)

Other sites enrolling subjects were Ben Taub General Hospital and Texas Children's Hospital, Houston, TX; Marshall Health Medical Center, Huntington, WV; University of Virginia Medical Center, Charlottesville, CA; and Augusta University Medical Center, Augusta, GA.

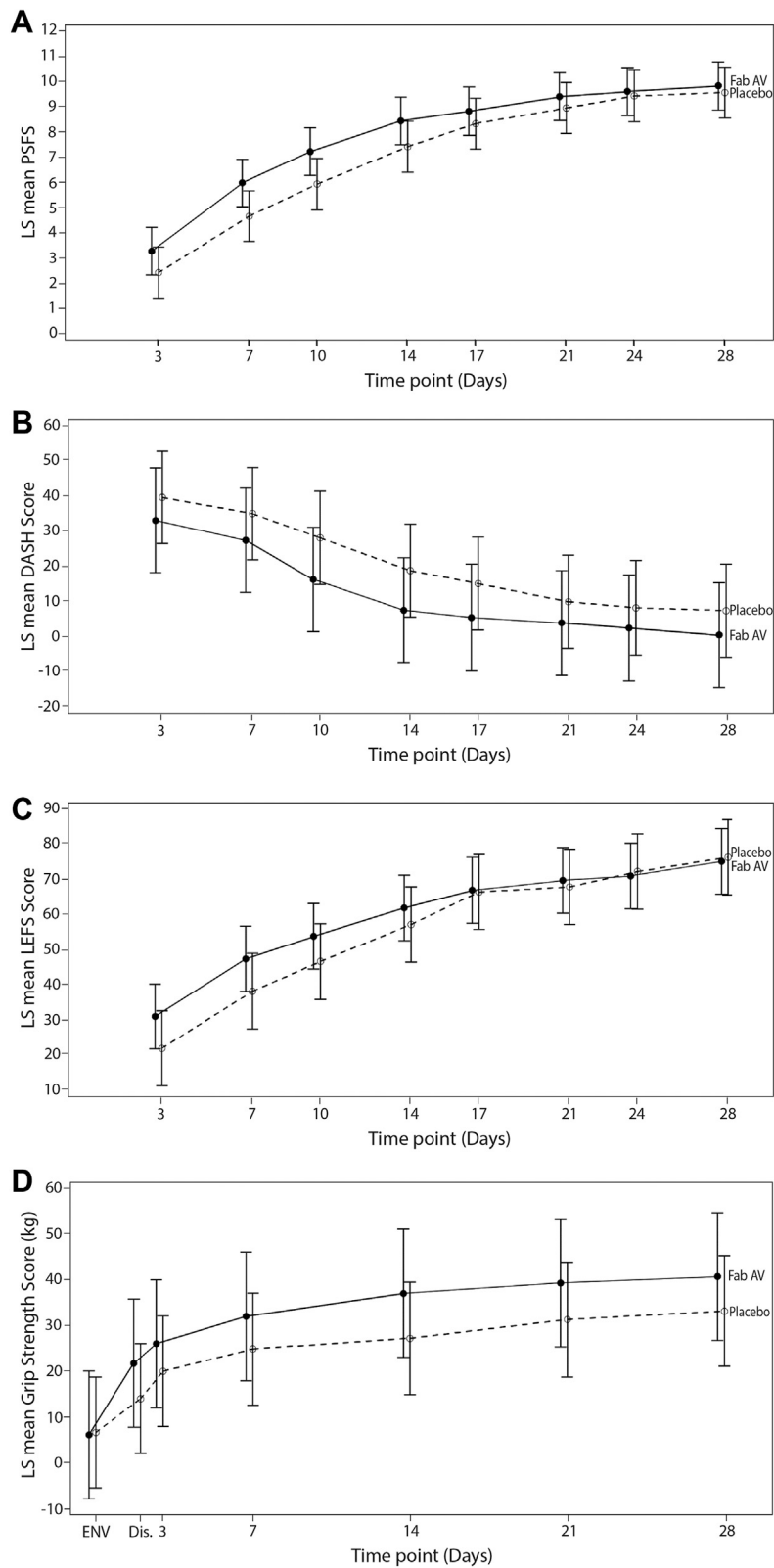


Figure 2. Supportive outcomes: recovery in copperhead envenomation patients treated initially with FabAV or placebo. *A*, PSFS scores. *B*, DASH scores. *C*, LEFS scores. *D*, Grip strength. *E*, NPRS scores. *F*, PROMIS PF-10 scores. *G*, Time to return to normal function in copperhead envenomation patients treated with FabAV or placebo. Error bars=95% confidence interval for each treatment group. The 95% confidence interval for the difference between treatment groups is analyzed with pooled standard error and is narrower. DASH: A lower score indicated better function; best possible score is 0. LEFS: A higher score indicated better

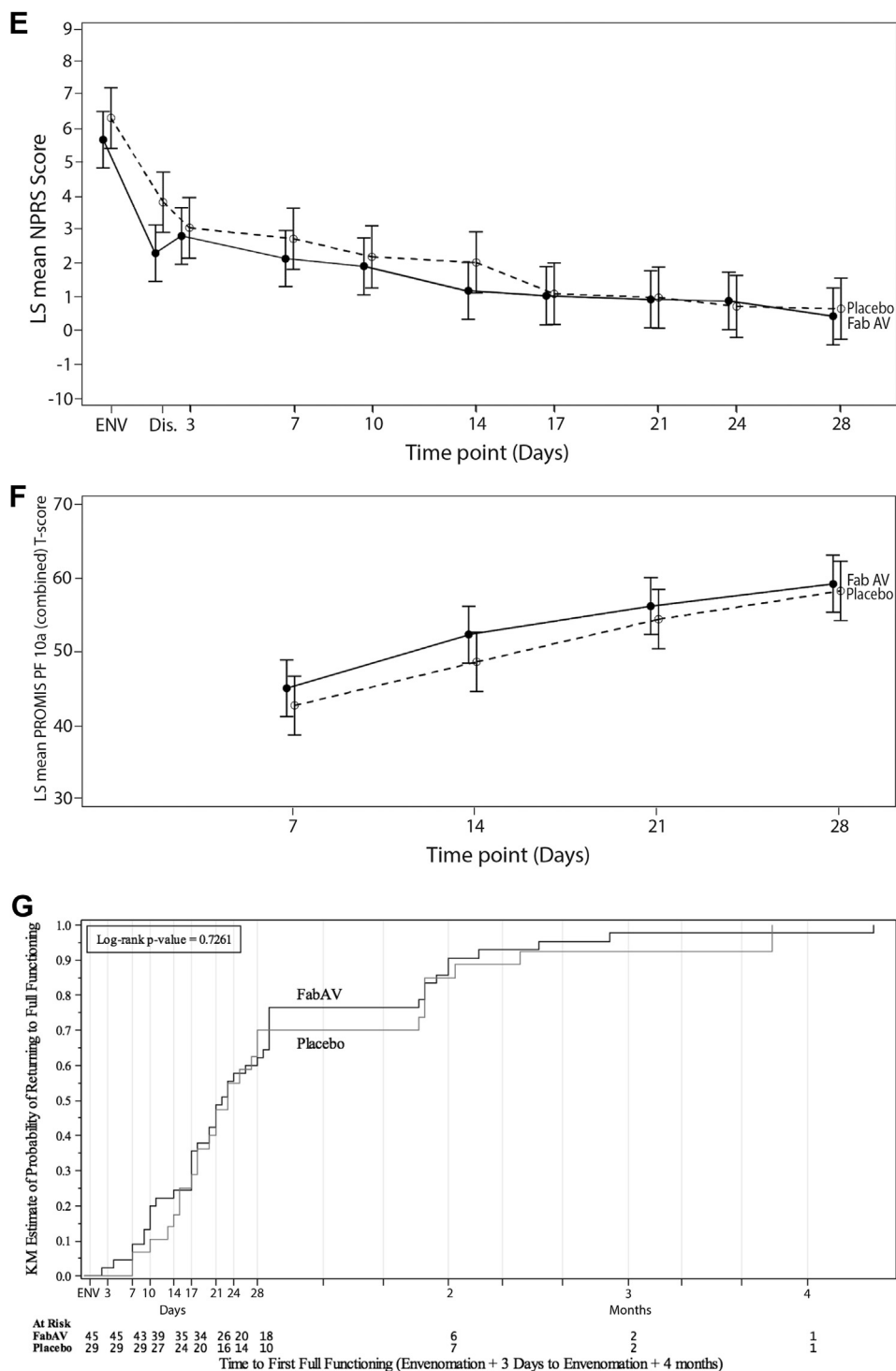


Figure 2. Continued.

function; best possible score is 80. Grip strength: A value of 0 kg was imputed for subjects unable to perform the test. NPRS: A lower score indicated less pain; range of possible scores is 0 to 10. PROMIS PF-10: A higher score indicated better quality of life; US population mean score is 50. Sample sizes: DASH (B) and grip strength (D): N=17 for the FabAV group and N=12 for placebo; LEFS (C): N=28 for the FabAV group and N=17 for placebo. All other assessments (A, E to G): N=45 for the FabAV group and N=29 for the placebo group. PSFS, Patient-Specific Functional Scale; DASH, Disorders of the Arm, Shoulder, and Hand; LEFS, Lower Extremity Functional Scale; NPRS, numeric pain rating scale.

The primary outcome, the least squared mean Patient-Specific Functional Scale score on day 14, was 8.6 for FabAV-treated subjects and 7.4 for placebo recipients (difference 1.2; 95% confidence interval 0.1 to 2.3; $P=.04$).

The point estimates for the additional outcomes routinely favored recovery in the FabAV group compared with placebo. The difference in the point estimates of the least squared mean Patient-Specific Functional Scale score favored FabAV at all other measured points. Patient-Specific Functional Scale total scores at each point are listed in Table E1, available online at <http://www.annemergmed.com>. Results from the limb-specific outcome measures; Disorders of the Arm, Shoulder, and Hand; Lower Extremity Functional Scale; and grip strength, pain assessments, and the global measure of recovery, PROMIS PF-10, in general favored the FabAV group as well (Figure 2A to F). No apparent difference was observed between treatments in time to full recovery (score of 10) on the Patient-Specific Functional Scale (Figure 2G) or walking speed. Opioid analgesic use was less in the FabAV-treated patients at all points (Figure 3). Two patients in each group moved to rescue treatment (Table E2, available online at <http://www.annemergmed.com>). No patients required emergency unblinding of study group assignment. All patients recovered by 4 months.

In the per-protocol population, the least squared mean Patient-Specific Functional Scale score on day 14 was 8.4

for FabAV-treated subjects and 7.1 for placebo recipients (difference 1.5; 95% confidence interval 0.4 to 2.7). No important differences were observed between the modified intent-to-treat and per-protocol analyses in supportive outcome analyses.

More patients had adverse events determined to be related to treatment per the blinded site investigator in the FabAV group (16/45; 36%) than did the placebo group (3/29; 10%). One patient in each group had a serious adverse event as determined by the blinded site investigator (Table E3, available online at <http://www.annemergmed.com>). The most common adverse events were headache, pruritus, nausea, dizziness, urticaria, and pyrexia. All adverse events are presented in Appendix E1, available online at <http://www.annemergmed.com>.

LIMITATIONS

This study had several limitations. It was designed and funded to enroll for 2 full snakebite seasons, and enrollment was concluded at this point without reaching the target sample size. Even at target enrollment, the study was known to be underpowered for its supportive analytic endpoints. The trial was not stopped early for benefit and consequently is not subject to the reported limitations of this approach.^{43,44} However, the smaller-than-optimal sample size leads to imprecision in the estimate of treatment effect.

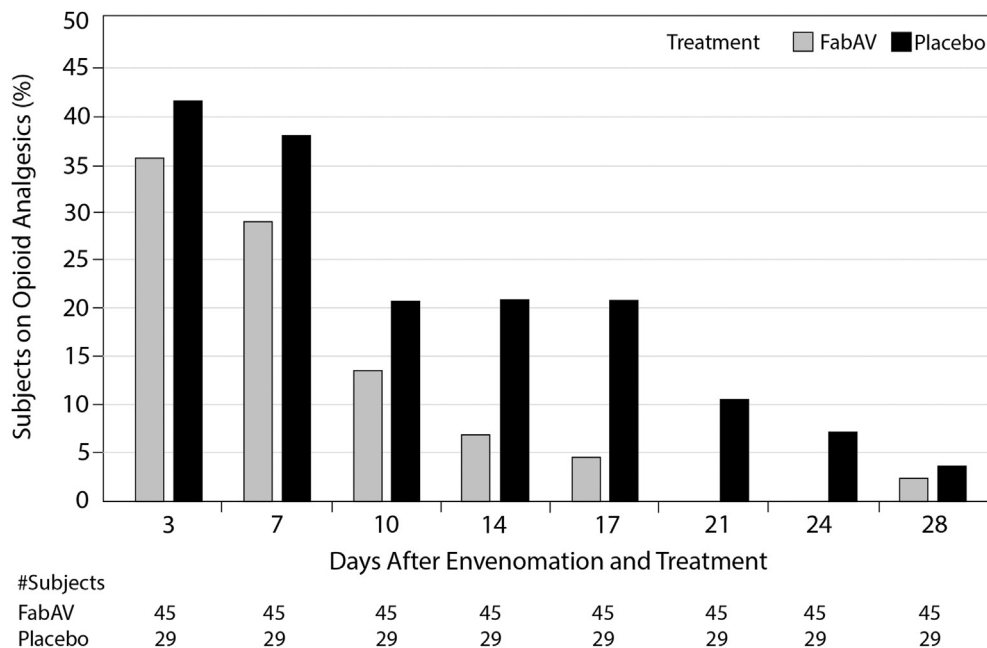


Figure 3. Opioid analgesic use in the previous 24 hours in copperhead envenomation patients treated initially with FabAV or placebo. Proportion of subjects who reported using an opioid analgesic (including tramadol) to treat snakebite-related pain in the 24 hours before each assessment. Sample size: FabAV, N=45; placebo, N=29.

The precise minimal clinically important difference in snakebite is unknown. For other disease states previously studied, the minimal clinically important difference is generally in the range of the average treatment effect observed in this trial.^{27,33-35} However, it remains unknown how the difference varies by disease state, by upper versus lower extremity, or how it varies along the ordinal Patient-Specific Functional Scale. Additionally, the effect size found in this study may be artificially lower because of enrollment of a low-severity cohort. The majority (88%) of subjects in this study had minor-severity swelling at study entry. This is distinctly different from the subjects enrolled in the copperhead pilot study conducted by our group in many of the same study centers, 80% of whom had moderate envenomation.²² We speculate this is because patients with minor envenomation are more willing to enroll in a placebo-controlled study than those with more severe disease. Acknowledging these limitations, we believe the benefit from FabAV administration observed in this study is likely clinically important to patients because the Patient-Specific Functional Scale reliably measures functional outcomes that the patient chooses and values.

Although this trial included 18 centers, most patients came from 3 sites in North Carolina and Texas. Because there is some geographic variation in within-species venom composition, the generalizability to all copperhead envenomation populations is questionable.⁴⁵ Thirteen centers from West Virginia to Texas contributed subjects, and exploratory analyses showed no apparent between-site differences. We believe the results are generalizable to copperhead victims as a whole, unless high-quality geographically specific data contradict our findings. A recent observational study in North Texas followed copperhead envenomation patients by telephone.²³ Although direct comparison is not possible, recovery appeared to be faster than in either the copperhead recovery pilot study or the present work.²¹

Children younger than 12 years, rattlesnake and water moccasin victims, and patients with severe envenomation were excluded from this study. There remains no direct evidence of the effect of FabAV on recovery of limb function in these populations. Because relatively few adolescent and elderly patients enrolled in this study, extrapolation from the overall results to these subgroups should be done with caution.

Finally, cost is an important consideration with modern antivenom use, and this study was not designed to support a pharmacoeconomic analysis. Currently, the cost to the hospital ranges from \$2,000 to \$2,900 per vial of FabAV. The charge to the payer is typically a multiple of this and includes the charge for care aside from the antivenom. The

cost to the individual patient varies widely, depending on his or her insurance coverage. We suggest that the relationship between cost, potential harm, and potential benefits be discussed with patients during care.

DISCUSSION

In this randomized, double-blind, placebo-controlled trial of adolescent and adult patients with mild- to moderate-severity copperhead snake envenomation, treatment with FabAV improved limb function recovery as measured by Patient-Specific Functional Scale score at envenomation plus 14 days. The greatest benefit of antivenom therapy was experienced from 1 to 2 weeks after treatment, and all patients experienced full recovery within 4 months. Robust additional assessments, determined a priori, supported the primary study outcome, and no new or major safety issues were identified compared with those discussed in the existing literature.^{14,46}

Before the development of highly purified, ovine-derived FabAV, patients with nonlife-threatening copperhead envenomation were generally managed without antivenom because of the risks associated with equine antivenom therapy.⁶ In addition to excluding copperhead patients, the registry trials leading to Food and Drug Administration approval of FabAV were comparatively small (42 total subjects) open-label studies designed to assess safety and short-term efficacy; limb recovery was not evaluated.^{11,12}

Before the current study, to our knowledge the only investigations to prospectively assess limb recovery in crotaline snakebite were an open-label observational study²² and a small clinical trial published only in abstract form.⁴⁷ In addition, 2 studies reported the time to return to full activities at work or school,^{7,10} 1 study collected self-reported data about resolution of pain, swelling, and disability by telephone,²³ and 1 study reported limb outcomes in unstructured terms.⁵ As expected from the heterogeneity of study design and outcomes assessed, estimates of duration of disability produced by these studies vary widely, and any important benefit from equine antivenom or FabAV was impossible to assess.

To our knowledge, this trial provides the only blinded prospective data on limb function recovery from crotaline snake envenomation and provides important data that can be used to inform risk-benefit discussions with patients about the effect of antivenom on their recovery from venom-induced limb injury. Although novel, these results are concordant with existing clinical trial evidence of FabAV efficacy in noncopperhead populations, using both short-term outcomes and venom effects aside from limb recovery.^{11,12,48} The consistency of these findings and the

congruence of our additional outcome measures support the findings of our primary outcome.

Existing guidelines on the care and treatment of crotaline envenomation recommend treatment of mild envenomation if venom effects are progressing.^{15,16} Progressive venom effects were not required for enrollment in this trial. Previous research has shown that this approach does not result in decreased antivenom administration.¹⁹ Therefore, the strategy of delaying antivenom administration while watching for progression should be further evaluated.^{17,19,48} This study also demonstrates that crude outcome measures, such as the need for surgical intervention, do not fully capture outcomes that are important to patients.⁴⁹

In this study, patients treated with FabAV had lower pain scores and substantially less opioid use throughout recovery. Because prescribing opioid analgesia carries some risk of iatrogenic opioid abuse disorder and ED opioid prescriptions may contribute to the development of addiction, the role of FabAV in decreasing opioid requirements during recovery is intriguing.⁵⁰⁻⁵⁴ Because these findings are exploratory, future research is necessary to determine the potential effect of FabAV treatment on long-term opioid use after envenomation.

In conclusion, administration of FabAV to patients with mild- and moderate-severity copperhead envenomation improves recovery of limb function at 14 days postenvenomation compared with placebo.

The authors acknowledge the contributions of Thomas King, MD, MPH (editorial and writing assistance); Claire Daugherty, MS (biostatistics support); Elizabeth Orfe, MS, Shirley Steiner, MS, and Maria Gaisor, MD (clinical study management); Stephanie Gilman, BS (administrative assistance); and the clinical study site subinvestigators and coordinators (study logistical and site support).

Supervising editor: Matthew D. Sztajnkrzyer, MD, PhD

Author affiliations: From the Division of Emergency Medicine, Duke University School of Medicine, Durham, NC (Gerardo); the Department of Emergency Medicine, University of North Carolina School of Medicine, Chapel Hill, NC (Quackenbush); the Department of Emergency Services, St Joseph Regional Health Center, Bryan, TX, and Texas A&M University Health Science Center, College Station, TX (Lewis); the Department of Emergency Medicine, Virginia Commonwealth University School of Medicine, Richmond, VA (Rose); the Section of Emergency Medicine, Baylor College of Medicine, Houston, TX (Greene); the Department of Surgery, East Carolina University, Greenville, NC (Toschlog); the Department of Emergency Medicine, University of Virginia, Charlottesville, VA (Charlton); the Division of Emergency Medicine, Washington University School of Medicine, St. Louis, MO (Mullins);

the Department of Emergency Medicine, Augusta University, Augusta, GA (Schwartz); the Department of Surgery, Marshall Health, Huntington, WV (Denning); the Department of Emergency Medicine, University of Texas Southwestern Medical Center, Dallas, TX (Sharma, Kleinschmidt); the Department of Emergency Medicine, East Carolina University Brody School of Medicine, Greenville, NC (Bush); BTG International Inc, London, UK (Ryan); BTG International Inc, West Conshohocken, PA (Gasior); the Department of Emergency Medicine (Lavonas), Rocky Mountain Poison and Drug Center, Denver Health and Hospital Authority, Denver, CO (Anderson, Lavonas); and the Department of Emergency Medicine, University of Colorado School of Medicine, Aurora, CO (Lavonas).

Author contributions: CJG, KS, KK, SPB, SR, and EJL conceived the study and worked on the design. CJG, EQ, BL, SRR, SG, EAT, NPC, MEM, RS, DD, KS, and KK were principal investigators. CJG and EJL drafted the article. SR, VEA, and EJL provided biostatistical analysis and programming. MG provided study sponsor management and clinical supplies. All authors reviewed, commented on, and approved the final draft of the article. CJG takes responsibility for the paper as a whole.

All authors attest to meeting the four [ICMJE.org](http://www.icmje.org) authorship criteria: (1) Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND (2) Drafting the work or revising it critically for important intellectual content; AND (3) Final approval of the version to be published; AND (4) Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). Drs. Gerardo and Lavonas report receiving grants from BTG International Inc during the conduct of the study and grants from BTG International Inc outside the submitted work. Dr. Rose reports speakers bureau fees from BTG International Inc outside the submitted work. Dr. Greene reports receiving consulting fees and honoraria from BTG International Inc outside the submitted work. Drs. Charlton, Mullins, and Kleinschmidt and Ms. Anderson report receiving study-related grants from BTG International Inc during the conduct of the study. Dr. Gasior and Ms. Ryan are employees of BTG International Inc. This trial was funded by BTG International Inc.

Publication dates: Received for publication January 20, 2017. Revisions received March 23, 2017, and April 13, 2017. Accepted for publication April 20, 2017. Available online June 13, 2017.

Trial registration number: NCT01864200

Presented at the 2016 Venom Week meeting, March 2016, Greenville, NC.

REFERENCES

1. O'Neil ME, Mack KA, Gilchrist J, et al. Snakebite injuries treated in United States emergency departments, 2001-2004. *Wilderness Environ Med.* 2007;18:281-287.

2. Mowry JB, Spyker DA, Brooks DE, et al. 2014 Annual report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 32nd annual report. *Clin Toxicol*. 2016;53:962-1147.
3. Ali AJ, Horwitz DA, Mullins ME. Lack of coagulopathy after copperhead snakebites. *Ann Emerg Med*. 2015;65:404-409.
4. Gale SC, Peters JA, Allen L, et al. FabAV antivenin use after copperhead snakebite: clinically indicated or knee-jerk reaction? *J Venom Anim Toxins Incl Trop Dis*. 2016;22:1-6.
5. Walker JP, Morrison RL. Current management of copperhead snakebite. *J Am Coll Surg*. 2011;212:470-474.
6. Thorson A, Lavonas EJ, Rouse AM, et al. Copperhead envenomations in the Carolinas. *Clin Toxicol*. 2003;41:29-35.
7. Lavonas EJ, Gerardo CJ, O'Malley G, et al. Initial experience with Crotalidae polyvalent immune Fab (ovine) antivenom in the treatment of copperhead snakebite. *Ann Emerg Med*. 2004;43:200-206.
8. Yin S, Kokko J, Lavonas E, et al. Factors associated with difficulty achieving initial control with Crotalidae polyvalent immune fab antivenom in snakebite patients. *Acad Emerg Med*. 2011;18:46-52.
9. Gerardo CJ, Vissoci JR, Brown MW, et al. Coagulation parameters in copperhead compared to other Crotalinae envenomation: secondary analysis of the F(ab')₂ versus Fab antivenom trial. *Clin Toxicol*. 2017;55:109-114.
10. Spiller HA, Bosse GM. Prospective study of morbidity associated with snakebite envenomation. *Clin Toxicol*. 2003;41:125-130.
11. Dart RC, Seifert SA, Carroll L, et al. Affinity-purified, mixed monospecific crotalid antivenom ovine Fab for the treatment of crotalid venom poisoning. *Ann Emerg Med*. 1997;30:33-39.
12. Dart RC, Seifert SA, Boyer LV, et al. A randomized multicenter trial of Crotalinae polyvalent immune Fab (ovine) antivenom for the treatment of crotaline snakebite in the United States. *JAMA Intern Med*. 2001;161:2030-2036.
13. Gerardo CJ, Lavonas EJ, McKinney RE. Ethical considerations in design of a study to evaluate a US Food and Drug Administration-approved indication: antivenom versus placebo for copperhead envenomation. *J Clin Trials*. 2014;11:560-564.
14. Schaeffer TH, Khatri V, Reifler LM, et al. Incidence of immediate hypersensitivity reaction and serum sickness following administration of Crotalidae polyvalent immune Fab antivenom: a meta-analysis. *Acad Emerg Med*. 2012;19:121-131.
15. Gold BS, Dart RC, Barish RA. Bites of venomous snakes. *N Engl J Med*. 2002;347:347-356.
16. Lavonas EJ, Ruha A-M, Banner W, et al. Unified treatment algorithm for the management of crotaline snakebite in the United States: results of an evidence-informed consensus workshop. *BMC Emerg Med*. 2011;11:1-5.
17. Kanaan NC, Ray J, Stewart M, et al. Wilderness Medical Society practice guidelines for the treatment of pitviper envenomations in the United States and Canada. *Wilderness Environ Med*. 2015;26:472-487.
18. Corneille MG, Larson S, Stewart RM, et al. A large single-center experience with treatment of patients with crotalid envenomations: outcomes with and evolution of antivenin therapy. *Am J Surg*. 2006;192:848-852.
19. Gerardo CJ, Scott Evans C, Kuchibhatla M, et al. Time to antivenom administration is not associated with total antivenom dose administered in a copperhead-predominant snakebite population. *Acad Emerg Med*. 2015;22:308-314.
20. Ward K, Wortley A, Quackenbush E, et al. Variability in antivenom treatment in snake envenomations between two major tertiary care emergency departments. *Ann Emerg Med*. 2014;64:S141.
21. Scharman EJ, Noffsinger VD. Copperhead snakebites: clinical severity of local effects. *Ann Emerg Med*. 2001;38:55-61.
22. Lavonas EJ, Gerardo CJ. Prospective study of recovery from copperhead snake envenomation: an observational study. *BMC Emerg Med*. 2015;15:1-21.
23. Roth B, Sharma K, Onisko N, et al. Prospective evaluation of pain, swelling, and disability from copperhead envenomation. *Clin Toxicol*. 2016;54:271-276.
24. Caravati EM. Copperhead bites and Crotalidae polyvalent immune Fab (ovine): routine use requires evidence of improved outcomes. *Ann Emerg Med*. 2004;43:207-208.
25. Stratford P, Gill C, Westaway M, et al. Assessing disability and change on individual patients: a report of a patient specific measure. *Physiother Can*. 1995;47:258-263.
26. Anderson V, Burnham R, Gillman S, et al. Validation of Patient Specific Functional Scale in copperhead snakebite patients. *Clin Toxicol*. 2015;53:649.
27. Hefford C, Abbott JH, Arnold R, et al. The Patient-Specific Functional Scale: validity, reliability, and responsiveness in patients with upper extremity musculoskeletal problems. *J Orthop Sports Phys Ther*. 2012;42:56-65.
28. Beaton DE, Katz JN, Fossel AH, et al. Measuring the whole or the parts? validity, reliability, and responsiveness of the disabilities of the arm, shoulder and hand outcome measure in different regions of the upper extremity. *J Hand Ther*. 2001;14:128-142.
29. Binkley JM, Stratford PW, Lott SA, et al. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. *Phys Ther*. 1999;79:371-383.
30. Chatman AB, Hyams SP, Neel JM, et al. The Patient-Specific Functional Scale: measurement properties in patients with knee dysfunction. *Phys Ther*. 1997;77:820-829.
31. Westaway MD, Stratford PW, Binkley PW. The Patient-Specific Functional Scale: validation of its use in persons with neck dysfunction. *J Orthop Sports Phys Ther*. 1998;27:331-338.
32. Abbot JH, Schmitt JS. The Patient-Specific Functional Scale was valid for the group level change comparisons and between group discrimination. *J Clin Epidemiol*. 2014;67:681-688.
33. Nicholas P, Hefford C, Tumilty S. The use of the Patient-Specific Functional Scale to measure rehabilitative progress in a physiotherapy setting. *J Manual Manipulative Ther*. 2012;20:147-152.
34. Namamaru K, Vernon H, Aizawa J. Reliability, validity, and responsiveness of the Japanese version of the Patient-Specific Functional Scale in patients with neck pain. *Eur Spine J*. 2015;24:2816-2820.
35. Koehorst ML, van Trijffel E, Lindeboom R. Evaluative measurements properties of the Patient-Specific Functional Scale for the primary shoulder complaints in physical therapy practice. *J Orthop Sports Phys Ther*. 2014;44:595-603.
36. Fries JF, Krishnan E, Rose M, et al. Improved responsiveness and reduced sample size requirements of PROMIS physical function scales with item response theory. *Arthritis Res Ther*. 2011;13:1-8.
37. Vickers AJ. Comparison of an ordinal and a continuous outcome measure of muscle soreness. *Int J Technol Assess Health Care*. 1999;15:709-716.
38. Hurst H, Bolton J. Assessing the clinical significance of change scores recorded on subjective outcome measures. *J Manipulative Physiol Ther*. 2004;27:26-35.
39. Peters MJ, van Nes SI, Vanhoutte EK, et al. Revised normative values for grip strength with the Jamar dynamometer. *J Peripher Nerv Syst*. 2011;16:47-50.
40. Bohannon RW. Comfortable and maximum walking speed of adults aged 20-79 years: reference values and determinants. *Age Ageing*. 1997;26:15-19.
41. US Department of Health and Human Services. FDA Guidance for Industry and Investigators Safety Reporting Requirements for INDs and BA/BE Studies. 2010. Available at: <https://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM332846.pdf>. Accessed May 22, 2017.
42. Baber N. International conference on harmonisation of technical requirements for registration of pharmaceuticals for human use (ICH). *Br J Clin Pharmacol*. 1994;37:401-404.

43. Montori VM, Devereaux P, Adhikari NK, et al. Randomized trials stopped early for benefit: a systematic review. *JAMA*. 2005;294:2203-2205.
44. Bassler D, Briel M, Montori VM, et al. Stopping randomized trials early for benefit and estimation of treatment effects: systematic review and meta-regression analysis. *JAMA*. 2010;303:1180-1187.
45. Keyler D, Vandervoort J. Copperhead envenomations: clinical profiles of three different subspecies. *Vet Hum Toxicol*. 1999;41:149-152.
46. BTG International Inc. CroFab approved package labeling. 2016. Available at: <https://www.crofab.com/CroFab/media/CroFab/PDF%20Files/CroFab-Full-Prescribing-Information-2016.pdf>. Accessed July 29, 2016.
47. Lavonas E, Kerns W, Gerardo C, et al. Long-term limb function outcomes following copperhead snakebite. *Ann Emerg Med*. 2008;52:S141-S142.
48. Weant KA, Bowers RC, Reed J, et al. Safety and cost-effectiveness of a clinical protocol implemented to standardize the use of Crotalidae polyvalent immune Fab antivenom at an academic medical center. *Pharmacotherapy*. 2012;32:433-440.
49. Larson KW, Schaefer KR, Austin C, et al. Management of tissue loss after *Agkistrodon* snakebite: appropriate use of Crotalidae-Fab antivenin. *J Trauma Nurs*. 2016;23:169-172.
50. Beauchamp GA, Winstanley EL, Ryan SA, et al. Moving beyond misuse and diversion: the urgent need to consider the role of iatrogenic addiction in the current opioid epidemic. *Am J Public Health*. 2014;104:2023-2029.
51. Clarke H, Soneji N, Ko DT, et al. Rates and risk factors for prolonged opioid use after major surgery: population based cohort study. *BMJ*. 2014;348:g1251.
52. Strayer RJ, Motoiv SM, Nelson LS. Something for pain: responsible opioid use in emergency medicine. *Am J Emerg Med*. 2017;35:337-341.
53. Butler MM, Ancona RM, Beauchamp GA, et al. Emergency department prescription opioids as an initial exposure preceding addiction. *Ann Emerg Med*. 2016;68:202-208.
54. Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use—United States, 2006-2015. *MMWR Morb Mortal Wkly Rep*. 2017;66:265-269.

Images in Emergency Medicine

The *Annals* Web site (www.annemergmed.com) contains a collection of hundreds of emergency medicine-related images, complete with brief discussion and diagnosis, in 18 categories. Go to the Images pull-down menu and test your diagnostic skill today. Below is a selection from the Trauma Images.



“Child With Dinner Fork Deformity” by Kardouni, February 2016, Volume 67, #2, pp. 165, 188.

Table E1. Patient-Specific Function Scale total score, at each point.

Subject ID [†]	Time from Env. to Treatment	Severity of Env.	PSFS Total Score*											
			Env. + 3 Days	Env. + 7 Days	Env. + 10 Days	Env. + 14 Days	Env. + 17 Days	Env. + 21 Days	Env. + 24 Days	Env. + 28 Days	Env. + 2 Months	Env. + 3 Months	Env. + 4 Months	
Treatment: FabAV														
001-002	6 h 48 min	Mild	4.33	8.33	8.67	10.00	10.00	10.00	10.00	10.00				
001-003	11 h 12 min	Mild	1.67	8.00	8.33	9.00	9.33	9.33	9.33	9.67	10.00			
001-004	24 h 36 min	Moderate	2.00	8.00	8.00	9.67	10.00	10.00	10.00	10.00				
001-005	7 h 53 min	Mild	2.00	6.67	4.00	7.00	8.67	8.67	10.00	10.00				
001-006	25 h 53 min	Moderate	0.67	3.67	3.67	3.67	3.00	3.67	6.67	8.00	10.00			
001-007	3 h 54 min	Mild	8.00	9.33	10.00	10.00	10.00	10.00	10.00	10.00				
001-009	4 h 4 min	Mild	1.33	2.00	6.00	5.67	7.33	7.67	8.33	9.00	10.00			
001-011	3 h 57 min	Mild	0.00	1.00	5.00	7.67	7.67	10.00	10.00	10.00				
002-001	5 h 20 min	Mild	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00				
002-002	5 h 35 min	Mild	4.33	5.33	8.00	9.33	9.33	10.00	10.00	10.00				
002-003	5 h 17 min	Mild	0.00	1.00	4.67	8.00	9.33	9.67	10.00	10.00				
002-005	5 h 26 min	Mild	4.67	6.00	5.33	6.33	8.00	9.00	8.67	10.00				
002-006	6 h 55 min	Mild	1.00	3.33	5.33	8.67	9.00	9.33	9.33	10.00				
002-007	6 h 6 min	Mild	5.33	8.33	9.33	9.33	9.33	9.33	9.33	10.00				
002-008	7 h 41 min	Mild	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00				
002-009	5 h 39 min	Mild	1.67	6.00	8.67	9.67	9.67	10.00	10.00	10.00				
002-012	20 h 22 min	Mild	4.00	5.00	5.33	5.33	8.00	8.00	9.33	9.33	10.00			
002-013	5 h 11 min	Mild	0.00	3.00	6.67	8.67	9.67	10.00	10.00	10.00				
002-014	4 h 35 min	Mild	3.00	6.33	6.00	6.67	7.33	9.67	9.67	9.67	10.00			
002-015	4 h 42 min	Mild	9.33	10.00	10.00	10.00	10.00	10.00	10.00	10.00				
003-001	3 h 34 min	Mild	0.67	2.33	10.00	10.00		10.00		10.00				
003-003	7 h 29 min	Mild	2.00	4.00	6.33	7.33	6.33	7.00	8.67	10.00				
003-007	8 h 26 min	Moderate	2.00	3.33	4.67	7.67	8.67	8.67	9.00	9.67	9.67	9.67	10.00	
003-011	5 h 10 min	Mild	4.67	9.67	10.00	10.00	10.00	10.00	10.00	10.00				
003-013	4 h 16 min	Mild	1.67	4.00	7.00	9.00	10.00	10.00	10.00	10.00				
003-015	4 h 5 min	Mild	0.00	6.67	8.00	9.33	10.00	9.33	9.33	9.67	10.00			
003-016	7 h 5 min	Mild	5.00	6.00	8.33	8.33	8.33	9.00	9.33	10.00				
003-017	3 h 35 min	Mild	6.67	8.33	9.00	9.67	10.00	10.00	10.00	10.00				
003-018	3 h 34 min	Mild	2.00	3.00	4.67	8.67	8.33	9.67	9.67	10.00				
003-019	3 h 59 min	Mild	0.00	0.00	0.00	7.00		9.33	9.33	10.00				
003-021	5 h 38 min	Mild	0.33	1.67	2.67	5.67		9.33	8.67	9.00				
003-022	3 h 14 min	Mild	3.33	8.00	8.33	8.67	9.33	10.00	10.00	10.00				
003-024	3 h 52 min	Mild	9.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00				
003-027	6 h 17 min	Mild	0.00	2.33	6.33	7.33	8.33	9.00	10.00	10.00				
003-028	5 h 28 min	Mild	0.00	0.00	0.67	2.33	4.67	5.33	4.67	6.00	10.00			
003-029	4 h 4 min	Mild	0.33	4.00	4.00	5.33	6.00	9.00	9.33	9.33	10.00			
005-001	24 h 23 min	Moderate	0.00	4.67	9.33	10.00	10.00	10.00	10.00	10.00				
005-002	6 h 35 min	Mild	2.67	6.33	8.33	8.67	9.00	9.00	9.33	9.33	10.00			
006-001	3 h 26 min	Mild	2.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00				
006-002	3 h 5 min	Mild	7.33	10.00	10.00	10.00		10.00	10.00	10.00				
007-001	17 h 7 min	Mild	3.00	6.67	7.67	7.67	9.33	9.33		10.00				
007-004	15 h 20 min	Mild	2.33	5.67	8.33	9.00	9.67	10.00	10.00	10.00				
009-003	5 h 55 min	Moderate	2.33	6.67	4.33	7.33	4.33	7.33	7.67	6.00	9.00	10.00		
014-001	11 h 3 min	Mild	6.00	10.00		10.00								
014-002	5 h 20 min	Mild	5.33	9.00	9.00	10.00		10.00	10.00	10.00				

Table E1. Continued.

Subject ID [†]	Time from Env. to Treatment	Severity of Env.	PSFS Total Score*											
			Env. + 3 Days	Env. + 7 Days	Env. + 10 Days	Env. + 14 Days	Env. + 17 Days	Env. + 21 Days	Env. + 24 Days	Env. + 28 Days	Env. + 2 Months	Env. + 3 Months	Env. + 4 Months	
Treatment: Placebo														
001-001	6 h 25 min	Moderate	8.00	10.00	8.33	9.00	10.00	10.00	10.00	10.00	10.00			
001-008	11 h 44 min	Mild	6.33	8.67	8.33	8.33	9.00	9.33	10.00	10.00				
001-010	6 h 8 min	Mild	3.67	8.67	9.67	10.00	10.00	10.00	10.00	10.00				
001-012	16 h 40 min	Mild	0.00	9.33	9.67	9.67	10.00	10.00	10.00	10.00				
002-004	3 h 48 min	Mild	2.33	4.33	8.00	8.00	6.33	6.33	8.00	9.67				
002-010	6 h 18 min	Mild	0.00	0.00	3.00	3.00	4.00	8.33	9.33	9.67	10.00			
002-011	5 h 40 min	Mild	8.67	5.33	9.33	9.33	10.00	10.00	10.00	10.00				
002-016	3 h 49 min	Mild	1.33	7.00		10.00	10.00	10.00	10.00	10.00				
003-002	4 h 20 min	Mild	2.33	3.67	4.33	6.67	8.33	9.00	9.33	10.00				
003-005	4 h 13 min	Mild	0.00	0.00	2.67	4.67	6.00	7.00	7.67	9.00	10.00			
003-006	2 h 41 min	Mild	0.67	3.33	5.67	8.33	10.00	10.00	10.00	10.00				
003-008	3 h 36 min	Mild	1.00	2.00		2.00								
003-009	4 h 12 min	Mild	0.00	0.00	2.00	5.00	8.00	7.67	9.67	10.00				
003-012	3 h 22 min	Mild	3.67	10.00	10.00	10.00	10.00	10.00	10.00	10.00				
003-014	2 h 55 min	Mild	0.00	1.33	5.00	5.33	9.00	10.00	10.00	10.00				
003-020	6 h 46 min	Mild	0.00	3.00	5.67	8.33	9.00	9.33	9.33	9.67	10.00			
003-025	6 h 50 min	Mild	1.00	1.67	2.00	10.00	10.00	10.00	10.00	10.00				
003-026	4 h 21 min	Mild	0.00	0.00	0.00	1.00	4.00	4.33	5.33	6.00	10.00			
003-030	11 h 59 min	Mild	0.33	3.33	4.00	5.67	8.00	8.33	10.00	10.00				
005-003	6 h 21 min	Moderate	0.00	1.67	1.00	7.00	9.00	10.00	10.00	10.00				
007-002	19 h 2 min	Moderate	4.00	4.33	3.67	1.33	2.33	7.00	8.33	6.67	8.33	9.33	10.00	
007-003	5 h 20 min	Mild	4.67	5.67	6.33	7.33	7.67	8.00	8.33	8.67	10.00			
008-001	5 h 45 min	Mild	0.00	1.00	5.67	9.67	10.00	10.00	10.00	10.00				
009-002	5 h 10 min	Mild	5.00	8.67	9.00	9.00	9.00	10.00	10.00	10.00				
020-001	3 h 40 min	Mild	3.33	10.00	10.00	10.00	10.00	10.00	10.00	10.00				
024-001	5 h 6 min	Mild	1.00	2.67	3.00	5.67	6.00	7.67	8.00	9.33	10.00			
024-002	3 h 17 min	Mild	4.00	5.67	9.67	10.00	10.00	10.00	10.00	10.00				
025-001	5 h 31 min	Mild	5.67	8.33	7.67	8.33	9.67	9.67	10.00	10.00				

mITT, Modified intention-to-treat population.

Time from env. to treatment=(date and time of first exposure to treatment–date and time of envenomation). PSFS total score=sum of activity scores divided by the number of activities reported. Each activity is rated on a scale of 0 to 10, where 0=unable to perform activity and 10=able to perform activity at the same level as before the injury or problem.

*A higher score indicates better recovery; best possible score is 10.

[†]The *mITT* population for the placebo group is composed of n=29 patients. However, one patient in the *mITT* patient population did not have any posttreatment observations and therefore does not appear in this table.

Table E2. Patients moved to open-label rescue therapy.

Age, Years/Sex	Treatment Group Assignment	Description
20/M	FabAV	Progressed to severe venom effect and moved to standard-of-care treatment per protocol. Received 6 vials of open-label FabAV, with good response.
20/F	FabAV	Developed recurrent local tissue venom effects after initial control. Received 2 vials of open-label FabAV at the discretion of the treating physician, with good response.
56/F	Placebo	Progressed to severe venom effect and moved to standard-of-care treatment per protocol. Received 4 vials of open-label FabAV with good response.
14/F	Placebo	Patient with a moderate envenomation and apparent good initial response to blinded study medication (placebo), but developed worsening local tissue venom effects (tenderness, ecchymosis, and edema) after the second maintenance dose of normal saline solution. She did not have coagulopathy, thrombocytopenia, hypotension, or other systemic venom effects. The investigator discontinued study medication and administered 6 vials of open-label FabAV as rescue therapy, with good response.

M, Male; F, female.

Table E3. Serious adverse events.

Age, Years/Sex	Treatment Group Assignment	Reason Event Was Serious	Description
71/M	FabAV	Life threatening	Patient with a mild envenomation developed a severe pulmonary embolism after receiving a full course of 18 vials of FabAV. The adverse event was considered not related to study treatment by the investigator because the patient was recovering from recent spinal surgery.
14/F	Placebo	Significant medical event, prolonged hospitalization	Patient with a moderate envenomation and apparent good initial response to blinded study medication (placebo), but developed worsening local tissue venom effects (tenderness, ecchymosis, and edema) after the second maintenance dose of normal saline solution. She did not have coagulopathy, thrombocytopenia, hypotension, or other systemic venom effects. The investigator discontinued study medication and administered 6 vials of open-label FabAV as rescue therapy, with good response.