

A Rare Wild Boar Bite: Case Report

A. Saratha^{1,*}, S. Seetha Lakshmi²

¹Associate Professor, KMCH College of Nursing, Coimbatore, Tamil Nadu, India

²Assistant Professor, KMCH College of Nursing, Coimbatore, Tamil Nadu, India

ABSTRACT

Injuries caused by wild boar attacks are rare. A 58-year-old male came to the casualty with the history of wild boar bite. In casualty, he was treated with injection (inj.) Tetglob 500 mg. On the following day, under general anesthesia multiple wound debridement and radical muscle excision were done for necrotized skin and underlying muscles and wound washing done with saline. All the wounds were opened for dressing and the wounds were infected more and more with fungal growth and the surrounding areas were necrotized. His prognosis was very fatal. He was shifted to General Hospital (GH).

Keywords: bite, necrotized, debridement.

***Corresponding Author**

E-mail: hanuman.saratha@gmail.com

INTRODUCTION

Boar bite on humans is rare but can be serious and fatal. Boar bite causes multiple penetrating injuries, especially seen in the lower part of the body. Wild boar is often seen in agricultural areas or on paths leading to forest. Most of the wild boar bites are seen in rural areas and males are attacked most commonly.

CASE REPORT

A 58-year-old male came to the casualty with the history of wild boar bite 5 days back, and had taken treatment in local hospital. Initially, suturing was done there since the wound was infected, and the suturing was then removed. O/E he had bite in the left forearm, right forearm posterior aspect, abdomen and left thigh. Wound with surrounding skin discoloration and edema was noted in the right and left forearms and abdominal wall, and the left thigh wound was noted with big skin necrosis. All the wounds were infected and necrotized [1].

In casualty, he was treated with inj. TT 0.5 ml IM stat, TET GLOB 500 mg IM stat,

inj. Tiicarnic 3.1 g IV stat, inj. Tramadol 50 mg IV bd, inj. Emeset 8 mg IV bd, inj. Para 1 g IV tid, and IVF NS 100 cc/hr was started. We obtained cardiologist opinion for surgical fitness to undergo surgery. Basic lab investigations were done and he was found to be diabetic. Insulin scale was formed and blood sugar was monitored periodically, and accordingly, inj. Actrapid was given [5]. He was kept under midnight starvation. Preoperative drugs T. Anxit 0.25 mg, T. Pantocid 40 mg, T. Perinorm 10 mg, and inj. Tramadol 50 mg were given [2].

On the following day, under general anesthesia, multiple wound debridement and radical muscle excision were done for necrotized skin and underlying muscles, and wound washing was done with saline. Postoperatively, he was advised to elevate the left hand, right hand and left leg with two pillows. Drugs like inj [3]. Ticarnic 3.1 g tid, inj. Azom 1 g tid, inj. Amto care 50 mg pcm 1 g tid, inj. Neurobion 1 g Iv tid, T. Disperzyme tid, T. Osteocal bd, T. Rejunoron bd, inj. Rantac 50 mg IV, T.

Fill pack gold, T. Raciper 40 mg od, IVF RL/NS 100 ml/hr were given. Investigations like CBC, CPK, urea, creatinine and serum electrolytes were checked on the next day. On the following day, the CPK value was 6344 u/l, and the urea value of 63 mg/dl level was elevated. Wound dressing was done and fungus growth was noted, and C/S from the wound site was sent. C/S of abdomen taken was identified with a moderate growth of *Escherichia coli* and he was sensitive to ertapenem, imipenem, meropenem and amikacin and he was isolated. Since the left-hand wound was highly necrotized, decided for left-hand IMR amputation [4,5].

Left-hand IMR amputation was done under general anesthesia and he continued with the same drugs. Lab investigations revealed that the CPK level was elevated to 11,163, the Hb level was decreased to 5.4 g/dl, and the PCV level was 29.7% decreased [6]. The total WBC increased to 18,000 cells /cumm, polymorphs 91%, and lymphocytes 8% elevated. After receiving him from the post anesthetic care unit, his physiological parameters were monitored. His BP was found to be lowered to 80/40 mmHg, HR increased to 100 beats/min, RR to 20 breaths/min, temperature 98.8°F, and SaO₂ to 100%. He was conscious and he was transferred to ICU. Immediately, noradrenaline 4 mg in 50 ml of NS was added and 4.5 ml/hr was started. His urine output was clear and normal. BP was raised to 150/70 mmHg. So gradually the dosage of noradrenaline was reduced from 4.5 to 1 ml hourly, and then infusion was completely stopped. Patient was in room air. Two pints of was PRBC infused and the Hb was increased to 9.9 g/dl [7].

Bilateral lower limb arterial Doppler study was done, which showed no obvious stenosis, narrowing and thrombosis. Only mild subcutaneous edema was noted. Venous Doppler study of both lower limbs was also done and found to have no DVT.

Next day, all the wounds were opened for dressing and the wounds were found to be infected more and more with fungal growth and the surrounding areas were necrotized more. His prognosis was very poor [8]. So the condition was explained to the relatives and they decided to take him to General Hospital (GH) and he was sent to GH.

After a week, the authors made call to the relatives through telephone and came to know that the patient got expired.

CONCLUSION

Wild boar bite wound should start with proper local care. As like other animal bite's care, the wild boar bite wound should also be washed with plenty of water initially in order to remove the oral flora of the biting animal. Surgical closure of animal bite wound is controversial. According to the literature, the most common site of injury among reported cases of wild boar bite was the posterior thigh. In our case also the bite wound was seen in the left thigh. In conclusion, proper wound care, tetanus immunization, rabies prevention and appropriate antibiotics should be administered to the survivors of the wild boar attacks.

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