intracranial mass if the patient’s mental status deteriorates after CSE.

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**Entrapped central venous catheter**

Editor—The case presented by Dhanani and colleagues* formed an interesting and informative read. I commend the authors on the careful way in which they handled the situation. However, a couple of points struck me:

(i) The main reason for putting in a new catheter was the suspicion that the old one could have been infected. So if the new catheter had passed through the old (‘supposedly infected’) catheter, was it wise to leave the new one *in situ*? Surely this defeats the very purpose for which the whole exercise was started?

(ii) In the management algorithm, the method of continuous gentle traction seems like one that could go either way, in that this could also gradually increase the tear and end up with what you wanted to avoid in the first place—a complete fracture?

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Editor—We thank Dr Paul for the concerns raised and the Editor for the opportunity to respond. In reply, there is concern regarding the new catheter becoming contaminated by the old. Though there are different ways for line-related infection to develop (contaminated hub, insertion site infection, blood stream infection, etc.), we cannot find any evidence for catheter entrapment increasing the risk of infection. We do not believe our approach posed any greater risk than the common practice of inserting a new line prior to removal of the older one even when they may brush against each other *in vivo*. Furthermore, after one major procedural complication, we felt it prudent to leave the new line *in situ* and consider a line change only if there were ongoing concerns of catheter-related sepsis. Fortunately, the patient improved clinically and was discharged without further complications.

With regard to the management algorithm, the approach was formulated after considering the extent of the fracture, the degree of entrapment, and the available institutional resources. There were also concerns regarding the volume of contrast media needed as more would be required if catheter manoeuvring was attempted. We believe gentle traction would be appropriate as a first line intervention in cases with minimal entrapment (<25% of circumference) and fracture.

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**Bedside prediction of central venous catheter insertion depth**

Editor—I read this article* with keen interest, as it may change the practice of routine chest X-ray (CXR) after central line insertion in ICU patients. This practice can lead to a decrease in cost of patient care and radiation exposure. However, this technique of checking line tip position is not suitable for those patients who have no CXR before central line insertion. If a patient requires a CXR to establish the position of the carina and to measure length from the clavicle notch to the carina, then why not do this after central line insertion, when we can see the tip of the line and serious complications such as pneumothorax. Another point is that the length between the