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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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