

external portion of guidewire, which could not be retrieved through transfemoral route using a vascular snare.

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Percutaneous retrieval of malpositioned, kinked and unraveled guide wire under fluoroscopic guidance during central venous cannulation

Sir,

We thank the reader for their keen interest in our case report and value their useful suggestions/comments:

1. We agree and have mentioned in the manuscript that passage of tissue dilator over malpositioned guidewire was the triggering event for its kinking. One should never advance the dilator beyond the skin and subcutaneous tissue as it may not only cause similar complications but may also cause injury to the vessels.
2. We understand that all centers, which practice central venous cannulations cannot have interventional radiology suite. In those places when traction fails, surgical exploration remains the only option. Vigorous blind attempts at removal may cause breakage and subsequent embolization and should be avoided.
3. We agree that manipulations like pushing the guide wire inside for a few centimeters, gently twisting or removal of guidewire and catheter assembly together are other additional maneuvers which can be of help in some cases.
4. Deep passage of dilator at subclavian area is not good choice; however, it was used in fluoroscopic suit as a last resort and a part of retrieval of almost fully unraveled