**Notes from the SVT Conference, 24 – 26th November 2020**

**DVT Services during Covid-19**

Many Doctors were re-deployed and many routine patients were ignored. Health priorities changed and patients worried about getting Covid in hospital.

More above-knee DVTs, numbers increased as patients waited longer to present. There was an increase in severity but a reduction of A & E attendances.

There was a loss of chronic cases and a need public awareness was realised.

Less people were on holidays using long-haul flights and people were encouraged to exercise, less commuting and sitting at desks.

**Re-deployment for Vascular Scientists during Covid-19**

Found he wasn’t useful on Nightingale in his role. Ended up doing nights, fetching things including body-bags, watching patients, organising equipment and supplies.

Work was very challenging, but enjoyable and felt satisfying although very strenuous.

Helped doing DVT scans and line placements.

Staff worried about passing infection on to older family members.

Consider whether Vascular Scientists do some ward work as part of their routine training.

**EVAR**

Performed to prevent AAA rupturing. Need surveillance for endo-leaks, either CT contrast or colour / contrast ultrasound.

Risks with CT – contrast and radiation.

**Surveillance of AVF in Vascular Access**

SONAR

Assess to see how likely to mature or fail, thus improve fistula patency rate.

Scan at 2, 4, 6 and 10 weeks.

By week 10 – good result.

Optimal if wrist level 4 mm AP diameter with 400 ml/L flow, elbow level 5 mm AP diameter and 500 ml/L flow.

Wrist can have up-flow atherosclerosis, so elbow has better vascular flow.

Earlier scanning between 2 – 4 weeks predicted failure well.

**Profunda Vein Assessment**

Important for venous stenting and exclude DVT.

**TIA Pathway using 2 Imaging Modalities**

Carotid ultrasound of great value but cannot see intra-cranial proximal disease. Use CTA for this +/- MRA.

**DVT – Should we scan Iliac & Calf Veins routinely?**

Iliac vein scan less sensitive with ultrasound.

Scanning calf reduces re-scan rate saving resources.

Imperial guidelines state scan iliac to calf.

NICE protocol state femoral and popliteal only.

SVT guidelines state CFV to calf, iliac only when indicated.

Reliance on phasic flow in CFV needs studying as possibly non-occlusive thrombus in the iliac may still give phasic flow, giving a false negative.