

Venous reports

1. 20/02/2024

Clinical history:

Slowly healing wound R lower leg; haemosideraosis both gaiter areas.

Report:

Right leg:

The great saphenous vein becomes incompetent via a superficial branch in the mid-thigh (the origin of this incompetent vein is unclear) and remains incompetent to the mid-calf, where the reflux drains into a superficial posteriomedial vein which drains into the small saphenous vein distally, and causes it to become incompetent.

There is a small incompetent branch which arises anterolaterally from the GSV in the distal thigh but this vein became difficult to follow.

No deep venous incompetence noted.

Please see attached venous diagram for further information and venous diameters.

Left leg:

The Great saphenous vein is incompetent for a very short length in the proximal calf - this reflux drains into a competent perforator medially. Outside of this segment the deep and superficial veins are competent in the left leg.

Conclusion:

Right leg - GSV insufficiency which drains into the SSV in the mid-distal calf. No DVI.

Left leg - very short section of GSV reflux in the proximal calf, otherwise no DVI or SVI.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

2. 20/02/2024

Clinical history:

vvs ache.

Report:

The Great saphenous vein has been obliterated shortly below the saphenofemoral junction.

There is a small competent superficial anterior thigh vein that drains into the saphenofemoral junction - this vein continues anteromedially down the thigh and aGSV the front of the knee into the anterior calf. An incompetent medial branch of this vein recanalises the Great saphenous vein at knee-level. The recurrent GSV is incompetent in the proximal calf, and this reflux drains into a small medial superficial varicosity which continues medially towards the ankle.

There is a tortuous incompetent vein that arises posteriorly approximately 10cm below the left buttock, which continues anterolaterally down the calf. The origin of this vein was difficult to determine but it appears to arrive from deep within the leg.

The Giacomini vein is competent.

Please see attached diagram for further information and venous diameters.

Conclusion:

Two small incompetent varicose veins - one anterolateral thigh/calf vein which arises posteriorly in the proximal thigh, and a recurrent medial Great saphenous vein branch which recanalises via a small anteromedial thigh vein at knee-level.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

3. 20/02/2024

Clinical history:

symptomatic VVs

Report:

The Great saphenous vein is incompetent from the saphenofemoral junction and is relatively straight in the thigh to the proximal calf. In the proximal calf, the reflux drains into an anteromedial varicosity which crosses the shin in the proximal calf and continues laterally down the calf towards the ankle. The Great saphenous vein is competent in the mid-distal calf.

The deep and small saphenous veins are competent.

Please see attached diagram for further information and venous diameters.

Conclusion:

GSV insufficiency stemming from an incompetent SFJ which feeds an anterolateral calf varicosity.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

4. 21/02/2024

Clinical history:

Unable to pass wire in L GSV; ? scarring/ occlusion.

Report:

The great saphenous vein is patent and competent throughout the leg, and takes a posterior course around the distal thigh to below the knee, then returns to a medial course. At this point the vein tapers to ~2mm. No appreciable scarring or stenosis.

Multiple varicosities noted arising anteriorly and posteriorly in the proximal and mid-calf. One of these posterior veins mid-calf connects with the thrombosed varicose vein that arises from the mid-small saphenous vein.

The small saphenous vein is thrombosed from the saphenopopliteal junction to the mid-calf, where the posteromedial varicose vein arises. This vein is occluded posteriorly and then refills via the previously mentioned GSV branch.

The femoropopliteal vein is competent.

Please see attached diagram for further information and venous calibres.

Conclusion:

No GSV scarring demonstrated today. Successfully treated proximal small saphenous vein and posteromedial varicosed branch.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

5. 21/02/2024

Clinical history:

bilateral venous incompetence ? source of VV

Report:

Right leg:

The great saphenous vein is incompetent from the saphenofemoral junction to the ankle. A large superficial tortuous varicosity arises in the mid-thigh which gives off multiple branches that drain back into the GSV and into the small saphenous vein in the mid and distal calf. An incompetent branch arises anteriorly from the GSV in the proximal calf that courses anterolaterally across the shin and continues laterally down the calf.

The small saphenous vein is incompetent from the saphenopopliteal junction to the mid-calf, where the reflux drains into a competent perforator.

The femoropopliteal vein is incompetent above the SPJ. The deep veins are competent below.

No incompetent perforators noted.

Left leg:

The Great saphenous vein is incompetent from the saphenofemoral junction to the proximal calf, where the reflux drains into a posteromedial varicosity. A large medial superficial tortuous varicosity arises from the GSV in the mid-thigh which gives off multiple branches that drain back into the GSV and into the small saphenous vein in the mid and distal calf. An anterior branch arises from this vein in the distal thigh which crosses anterolaterally across the knee.

The small saphenous vein is a Giacomini variant which is competent throughout.

The deep veins are competent.

There is a small incompetent perforator which drains into the varicose vein in the medial distal calf.

Please see attached diagram for further information and venous calibres.

Conclusion:

Bilateral GSV insufficiency stemming from the SFJ in both legs.

Right small saphenous vein insufficiency from the SPJ with incompetent femoropopliteal vein.

Incompetent perforator in the distal left calf.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

6. 22/02/2024

Clinical history:

large symptomatic vv's right leg.

Report:

The great saphenous vein is incompetent from the saphenofemoral junction. The GSV is relatively straight in the thigh, and gives off a large network of interconnecting varicose veins throughout the calf that course medially, anterolaterally and posteriorly. The posterior branches drain into the small saphenous vein mid-calf.

The small saphenous vein continues above the knee and is competent throughout.

No deep venous incompetence or incompetent perforators noted.

Please see attached diagram for further information and venous calibres.

Conclusion:

Incompetent saphenofemoral junction and great saphenous vein, no deep venous insufficiency noted.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

7. 22/02/2024

Clinical history:

vvs svt.

Report:

The great saphenous vein is incompetent from just below the saphenofemoral junction. This reflux drains into a tortuous incompetent varicose vein in the distal thigh, and the Great saphenous vein is competent below this point.

The varicose vein gives off medial and anterolateral branches in the proximal calf.

The small saphenous and deep veins are competent.

No DVT/SVT seen.

Please see attached diagram for further information and venous calibres.

Conclusion:

GSV insufficiency arising just below the SFJ, which feeds varicose veins arising in the distal thigh.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

8. 12/03/2024

Clinical history:

symptomatic vv's both legs.

Report:

Right leg

The saphenofemoral junction is incompetent. The Great saphenous vein is incompetent, and the reflux drains into an incompetent superficial posteromedial varicosity ~10-15cm above the knee. This vein continues posterolaterally behind the distal thigh and the posteromedially across the prox-mid calf.

The GSV is competent beyond this point to the proximal calf, and then an incompetent branch (?perforator) drains into the GSV just below the knee and causes it to become incompetent again, until the GSV drains into a medial varicosity mid-calf. The GSV is competent distally.

The small saphenous vein and deep veins are competent.

Left leg

The saphenofemoral junction is incompetent. The Great saphenous vein is incompetent, and the reflux drains into an incompetent superficial tortuous varicose vein in the distal thigh. Multiple connections between the Great saphenous vein and varicose vein are noted throughout the calf. This varicose vein gives off a proximal posteromedial branch in the proximal calf, which drains into a competent posterior perforator in the prox-mid calf. The varicose vein then divides into two adjacent branches, both of which are fed by incompetent perforators mid-calf, and the more anterior of the branches also communicates with the GSV, which is competent distally.

The small saphenous vein and deep veins are competent.

Please see attached diagram for further information and venous calibres.

Conclusion:

Bilateral saphenofemoral junction incompetence, with VVs arising from the GSV bilaterally and being fed by incompetent perforators.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

9. 12/03/2024

Clinical history:

right leg VV + hx of vein thrombosis 1 year ago in Italy following covid ? dvt ?STB.

Report:

The saphenofemoral junction is incompetent and drains into the proximal Great saphenous vein, which then gives off a superficial tortuous varicose vein that courses anterolaterally down the thigh and gives off anterolateral and posterolateral branches in the proximal calf. The anterolateral branch drains into a competent perforator in the mid-distal calf, and the posterolateral branch continues posteriomediaally and drains into the small saphenous vein in the mid-distal calf.

The great saphenous vein is competent below the proximal thigh.

The small saphenous vein is competent.

The deep veins are patent and competent with no evidence of DVT. No incompetent perforators seen.

Please see attached diagram for further information and venous calibres.

Conclusion:

Incompetent anterior thigh vein arising from the SFJ and giving off varices in the proximal calf.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

10. 12/03/2024

Clinical history:

bilateral leg swelling, looks like lymphoedema. exclude venous reflux before onward referral

Report:

The deep and superficial veins are patent and competent bilaterally with no evidence of venous insufficiency or incompetent perforators.

There is an avascular cystic collection within the right popliteal fossa measuring 36 x 27 x 14mm.

Conclusion:

No evidence of venous insufficiency in either leg.

Right popliteal fossa cystic collection. Dedicated MSK USS advised if clinically appropriate.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

11. 05/04/2024

Clinical history:

aching legs, ?vvs L leg.

Report:

Right leg:

The saphenofemoral junction is competent. The great saphenous vein is straight and competent to the mid-distal calf (~10cm above the medial malleolus), where a small incompetent vein drains in and causes the distal GSV to become incompetent. The source of this small incompetent vein was difficult to determine due to the vein's small calibre.

The small saphenous and deep veins are competent.

Left leg:

The saphenofemoral junction is competent. An incompetent proximal posteromedial ?pelvic vein (visible over the skin) drains into the great saphenous vein in the proximal thigh, which becomes incompetent and straight to the proximal calf. The GSV superficialises in the proximal calf, and the reflux drains into a competent perforator mid-calf. The distal GSV is competent.

The small saphenous and deep veins are competent.

Please see attached diagram for further information and venous calibres.

Conclusion:

Bilateral GSV incompetence - Rt. leg distal calf (?source), Lt. leg prox thigh (?pelvic vein).

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

12. 17/04/2024

Clinical history:

Bilateral symptomatic VVs.

Report:

Right leg

The deep and superficial veins are patent and competent throughout the leg. No varicose veins visualised and [patient] was unable to show me any symptomatic veins on this leg - he reports that this leg is much less symptomatic than the left leg.

Left leg

The SFJ and GSV are competent.

The SPJ and proximal SSV are incompetent. The reflux drains out of the SSV in the mid-calf via an incompetent tortuous superficial posterolateral vein which drains into a medial GSV tributary mid-calf, which is also fed by an incompetent medial perforator distally.

No DVI seen.

There is an enlarged lymph node in the left inguinal region, measuring 13mm short axis diameter, that appears reactive in nature with a fatty echogenic centre, internal vascularity and no necrosis- please correlate with the patient's general clinical picture and investigate further if indicated.

Conclusion:

No right leg venous insufficiency.

Left SPJ + SSV reflux feeding posterolateral VV mid-calf.

Enlarged lymph node in the left inguinal region, measuring 13mm short axis diameter, that appears reactive in nature- please correlate with the patient's general clinical picture and investigate further if indicated.

FURTHER ACTION REQUIRED

It remains the responsibility of the referring clinician to ensure that the appropriate action is taken as a result of this report.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

13. 17/04/2024

Clinical history:

recurrent bilateral VV - had stripping..

Report:

Right leg

The SFJ is incompetent and drains into an incompetent superficial anterolateral thigh vein.

The proximal GSV is competent to mid-thigh, where the vein appears to have been obliterated below this point. An incompetent superficial vein drains out of the GSV at this point and continues medially down the calf, where it feeds medial and anterior varices. The GSV refills in the proximal calf and is competent distally.

The SPJ and SSV are competent.

No DVI seen.

A 36mm avascular cystic collection is noted behind the right knee ?Baker's cyst. Dedicated MSK USS advised.

Left leg

The SFJ is incompetent and drains into an incompetent superficial anterolateral thigh vein, which feeds the GSV mid-thigh causing it to become incompetent to the proximal calf, where the reflux drains into an incompetent superficial medial varicosity.

The SPJ and SSV are competent.

No DVI seen.

Conclusion:

Bilateral incompetent SFJs feeding anterior thigh varices. Partially treated right GSV fills an incompetent medial VV mid-thigh.

Please see attached diagram for further information and venous calibres.

A 36mm avascular cystic collection is noted behind the right knee ?Baker's cyst. Dedicated MSK USS advised.

FURTHER ACTION REQUIRED

It remains the responsibility of the referring clinician to ensure that the appropriate action is taken as a result of this report.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

14. 17/04/2024

Clinical history:

recurrent bilateral VV - had stripping..

Report:

Right:

The SFJ and above-knee GSV are incompetent. The reflux drains out of the GSV into a medial VV in the proximal calf that feeds medial and posterior branches throughout the calf. The posterior calf drains into the SSV in the proximal calf.

The SPJ and SSV are competent. No DVI seen.

Left:

The SFJ and GSV are incompetent. The GSV feeds anterior and posterior VVs in the proximal calf, and medial VVs below the ankle.

The SPJ and SSV are competent. No DVI seen.

Multiple superficial hyperechoic avascular masses seen throughout both thighs - appearance suggestive of lipomas.

Conclusion:

Bilateral SFJ and GSV incompetence feeding VVs throughout both calves.

Multiple lipomas in both thighs - no follow-up required.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

15. 17/04/2024

Clinical history:

bilateral lower legs swelling + significant venous hypertension skin changes.

Report:

Challenging examination due to high BMI and superficial oedema.

Right leg:

The SFJ and proximal GSV are competent. The GSV becomes incompetent in the proximal thigh via an incompetent posteromedial perforator. The reflux drains out of the GSV at knee-level into a network of varices throughout the calf.

The SPJ and SSV are competent.

No DVI seen.

Left leg:

The SFJ and above-knee GSV are competent. The GSV becomes incompetent in the proximal calf, although the source of reflux could not be identified. The reflux drains out of the GSV into a small superficial varicose vein mid-calf.

The SPJ and SSV are competent.

No DVI seen.

Conclusion:

Right leg - incompetent prox thigh perforator feeding above-knee GSV and calf varices

Left leg - incompetent below-knee GSV (source unclear) and small calf VV

Please see attached diagram for further information and venous calibres.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

16. 17/04/2024

Clinical history:

ulcer L ankle.

Report:

[*Patient*] arrived with compression bandaging to the proximal calf - there was not time to completely remove and reapply the dressings so the leg was imaged to the proximal calf.

The GSV is incompetent from the groin to the proximal calf. The source of this reflux is either the SFJ or a small incompetent pelvic vein that drains into the GSV immediately below the SFJ - it was difficult to determine which is the source of the reflux. Borderline reflux noted in the thigh (0.8s) however the compression bandaging may have reduced the reflux time.

The FV is incompetent and drains into the SSV via the incompetent SPJ. The SSV feeds an incompetent superficial lateral varicose vein in the proximal calf and appears incompetent below this point.

The POPV is competent.

Conclusion:

Incompetent FV, GSV and SSV seen to proximal calf.

Please see attached diagram for further information and venous calibres.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

17. 17/04/2024

Clinical history:

recurrent bilateral legs VV with skin changes.

Report:

Right:

Previous GSV stripping noted at the groin. The SFJ is incompetent and feeds a tortuous posteromedial varicose vein which refills the GSV in the mid-thigh. The GSV is incompetent for a short length in the mid to distal thigh, then the reflux drains into a network of small superficial varicose veins throughout the calf. A medial varicosity in the mid-calf appears to be fed by an incompetent posterior tibial vein perforator.

The SPJ and SSV are competent. An incompetent lateral soleal vein perforator feeds a posterior varicose vein in the mid-calf, which drains into the SSV.

Incompetent posterolateral soleal vein and single incompetent proximal posterior tibial vein noted (PTV competent distally - reflux drains out via perforator). Otherwise all deep veins are competent.

Left:

Previous GSV stripping noted at the groin. The SFJ is incompetent and feeds a tortuous posteromedial varicose vein in the proximal thigh, that refills the GSV in the distal thigh. The GSV is incompetent to the proximal calf, then the reflux drains into a network of small superficial varicose veins throughout the calf. A medial varicosity in the mid-calf appears to be fed by an incompetent perforator.

The SPJ and SSV are competent.

No DVI seen.

Conclusion:

Bilateral recurrent VVs fed by the SFJ bilaterally. Segmentally obliterated / incompetent GSV in both legs.

Please see attached diagram for further information and venous calibres.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

18. 17/04/2024

Clinical history:

sever right leg VV + skin damage. right venous insufficiency + quick arterial scan check to rule out any significant PVD for stockings

Report:

The SFJ and above-knee GSV are incompetent. The GSV feeds a network of anteromedial and posterior varices arising in the proximal calf. The GSV is competent distally.

An anteromedial varicose vein is fed by an incompetent perforator ~10cm above the medial malleolus. A posterior varicose vein continues posterolaterally superficial to the SSV in the proximal calf.

No DVI seen.

Conclusion:

Incompetent SFJ + GSV feeding varices throughout the calf.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

19. 17/04/2024

Clinical history:

right leg varicose veins?cause.

Report:

Mild reflux (~0.8s) in the common femoral vein. This reflux drains into the incompetent saphenofemoral junction and proximal great saphenous vein. A superficial incompetent varicose vein arises from the GSV in the proximal thigh - the GSV is competent below this point. The varicose vein continues superficially and mildly tortuously down the thigh and feeds a few smaller branches in the proximal calf. One anteromedial branch is fed by an incompetent perforator mid-calf. One medial branch continues down towards the ankle. One posterior branch drains posteromedially into the small saphenous vein mid-calf, causing it to become incompetent distally.

The femoropopliteal and tibial veins are competent.

Conclusion:

Incompetent SFJ + GSV feeding a medial VV in the prox thigh. SSV reflux distally. Please see attached diagram for further information and venous calibres.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

20. 17/04/2024

Clinical history:

right leg extensive Vv + early skin changes in the Gaiter area.

Report:

The SFJ is incompetent. The reflux drains into the proximal GSV and a small tortuous anteromedial varicose vein in the groin.

The GSV is incompetent to the mid-thigh and feeds an incompetent tortuous superficial varicose vein just below the SFJ, which continues medially down the thigh and is also fed by the anteromedial varicose vein in the prox-mid thigh, and a small incompetent perforator mid-thigh. This incompetent vein continues anteromedially in the calf and anteriorly along the dorsum of the foot. The GSV is competent below mid-thigh, where the reflux drains into the aforementioned medial thigh varicosity.

The SSV is incompetent from the distal thigh, where the reflux drains in via a small medial superficial vein (source - unclear). The SSV feeds small superficial varices in the mid and distal calf, and is incompetent to the ankle.

No DVI demonstrated.

Conclusion:

SFJ reflux feeding incompetent thigh veins which continue anteromedially into the foot

SSV reflux arising from small medial vein distal thigh (source unclear) which feeds small varices in the calf

Please see attached diagram for further information and venous calibres.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

21. 18/04/2024

Clinical history:

Symptomatic VVs L leg.

Report:

The SFJ and GSV are incompetent in the thigh. Post-thrombotic scarring noted throughout the proximal GSV.

The GSV feeds an incompetent posteromedial varicose vein mid-thigh, which continues posteriorly and medially down the thigh. The GSV is incompetent to mid-calf, where the reflux drains into the aforementioned varicose vein. The distal GSV is small and was not clearly visible.

The posterior branch of the aforementioned varicose vein contains post-thrombotic scarring and drains into the proximal SSV causing it to become incompetent to the ankle.

The medial branch is fed by the GSV in the mid-calf and an incompetent medial perforator distally, and feeds small varices towards the ankle.

No DVI seen.

Conclusion:

SFJ reflux feeding incompetent GSV and varices throughout the thigh and calf.

Please see attached diagram for further information and venous calibres.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

22. 18/04/2024

Clinical history:

bilateral legs VV + venous hypertension skin changes right >> left.

Report:

Right leg

It is unclear if the right SFJ is incompetent - both the proximal GSV and the proximal anterior thigh vein are incompetent from the groin however it was difficult to clearly demonstrate SFJ reflux. The GSV is incompetent and fairly straight to the calf with post-thrombotic scarring throughout. The GSV feeds medial and posterior varices in the proximal calf, and is competent distally. One of these varices is fed by an incompetent posterior tibial vein perforator in the distal calf.

The SPJ and proximal SSV are incompetent. The reflux drains out of the SSV into a superficial medial varicosity, however the SSV becomes incompetent again distally via a medial varicose vein fed by the aforementioned incompetent perforator. Mild post-thrombotic scarring within the SSV distally.

The femoral and popliteal veins are incompetent. The deep veins within the popliteal fossa are incompetent and drain into the SSV. One of the posterior tibial veins is incompetent.

Left leg

The SFJ and GSV are incompetent above the knee. The SFJ also feeds an incompetent anterior thigh vein which fills back into the GSV in the prox-mid thigh. The GSV contains post-thrombotic scarring within the prox-mid thigh.

The GSV reflux drains into an incompetent medial varicose vein in the proximal calf, which feeds into the SSV via a posteromedial branch that causes the SSV to become incompetent distally.

The femoral vein is incompetent. The popliteal vein is competent distally - the reflux appears to leave the popliteal vein mid-vessel and cause one of the posterior tibial veins to become incompetent.

Conclusion:

Bilateral incompetent GSVs with post-thrombotic scarring, feeding varices within the calf. Please see attached diagram for further information and venous calibres.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

23. 18/04/2024

Clinical history:

Symptomatic VVs R leg with inflammatory symptoms.

Report:

The SFJ and GSV are incompetent. The GSV is relatively straight and lies within the fascia throughout the leg.

The GSV fills small varices throughout the calf.

The SPJ and SSV are competent.

No DVI seen.

Conclusion:

Incompetent SFJ and GSV filling varices throughout the calf.

Please see attached diagram for further information and venous calibres.

Scanned and reported by Ben Warner-Michel CS21218

Clinical Specialist Ultrasonographer

24. 18/04/2024

Clinical history:

vvs ulcer gsv reflux.

Report:

Right leg

The SFJ is incompetent. The reflux drains into a proximal anterior thigh varicose vein, which drains back into the GSV mid-thigh, causing it to become incompetent. The GSV superficialises in the distal thigh, and feeds medial and posterior varicosities throughout the calf, and is competent distally.

The SPJ and proximal SSV are competent. The distal SSV is incompetent via an incompetent medial GSV branch, and is also fed by a borderline incompetent perforator (~0.7s) in the distal lateral calf.

No DVI seen.

Left leg

The SFJ and GSV are incompetent. The GSV is relatively straight throughout the thigh and feeds medial and posterior varicosities throughout the calf, and is borderline incompetent distally (~0.7s).

The SPV and SSV are competent.

No DVI seen.

Conclusion:

Bilateral SFJ incompetence with GSV reflux feeding varices throughout both calves.
Please see attached diagram for further information and venous calibres.

Scanned and reported by Ben Warner-Michel CS21218
Clinical Specialist Ultrasonographer

25. 30/04/2024

Clinical history:

heavy aching legs, venous skin change right ankle, previous pelvic vein embolisation, reduced ABPI.

Report:

Right leg

GSV stripping noted. The incompetent SFJ drains into tortuous recurrent superficial anterolateral and posteromedial varices. The anterolateral VV is fed by three incompetent perforators throughout the lateral calf.

The posteromedial VV drains into the SSV mid-calf, causing it to become incompetent.

The FV is competent. The proximal POPV appears briefly incompetent, with the reflux draining into an incompetent medial gastrocnemius vein. The GSV is refilled via an incompetent medial perforator draining out of the medial gastroc vein, with the reflux draining into a small medial varicose vein mid-calf.

Left leg

GSV and SSV stripping noted. The incompetent SFJ drains into a tortuous superficial posteromedial varicose vein, which also appears to be fed by a small incompetent pelvic vein. This vein feeds posteromedial and anterolateral varices throughout the calf, and refills the previously stripped SSV mid-calf. The SSV is incompetent mid-distally.

An incompetent perforator is seen contributing to these varices in the posterior thigh just above the knee. The anterolateral VV is fed by three incompetent perforators throughout the lateral calf.

The FV and POPV are competent. An incompetent lateral gastrocnemius vein is noted.

Conclusion:

Bilateral GSV stripping and left SSV stripping, with tortuous superficial varices being fed by the SFJ bilaterally (and a small left-sided pelvic vein). Numerous incompetent perforators noted with incompetent gastrocnemius veins bilaterally (medially on the right and laterally on the left).

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