

Clinical History :

Clinical details: VNUS on 18th June

Specific question to be answered: Post VNUS status

US Doppler lower limb veins Rt :

US Doppler lower limb veins Rt

VERIFIED - Attended-28-Feb-2019 - MARAJ+FREEB/MARAJ-28-Feb-2019

Venous incomp (RT)

SITE	RIGHT	
Common femoral:	NR	No reflux
Femoral:	NR	No reflux
Popliteal:	R	Reflux
Saphenofemoral junction:	NR	No reflux
Long saphenous:	MR	Minor reflux
Saphenopopliteal:	A	Absent / not detected
Mid Calf Short Saphenous:	MR	Minor reflux

Comments:

Right:

Perforators:

Previously mentioned incompetent perforator is now competent.

Comments:

No evidence of proximal DVT.

Minor reflux in the distal FV, no evidence of thrombus/scarring.

Incompetent PopV with no evidence of thrombus/scarring.

SFJ is competent, thigh LSV successfully treated by VNUS.

Remnant calf LSV is incompetent.

SSV is incompetent and draining above popliteal vein; SSV measures 3.0mm in diameter in supine position.

Clinical History :

Is transport required?: No

Infection risk: No

Clinical details: post VNUS 2015, superficial reticular veins worsening

Specific question to be answered: ? PERFORATOR INCOMPETENCE

US Doppler lower limb veins Rt :

US Doppler lower limb veins Rt

VERIFIED—Attended-28-Feb-2019—MARAJ+HICKP/MARAJ-28-Feb-2019—

Venous incompet (RT)

SITE	RIGHT	
Common femoral:	NR	No reflux
Femoral:	NR	No reflux
Popliteal:	MR	Minor reflux
Saphenofemoral junction:	R	Reflux
Long saphenous:	S	See comments
Saphenopopliteal:	A	Absent / not detected
Mid Calf Short Saphenous:	NR	No reflux

Comments:

Right:

Perforators:

Incompetent perforator ~21cm above the floor, measures 2.3mm in diameter contributing to calf varicosities.

Comments:

No evidence of proximal DVT.

Minor reflux in the distal PopV with no evidence of thrombus/scarring.

Recurrent SFJ incompetence is the main source of varicosities in the right lower limb, with **no segment suitable for VNUS**.

No remnant thigh LSV, remnant calf LSV is incompetent and contributing to calf varicosities.

Clinical History :

Varicosities in the posterior calf.

US Doppler lower limb veins Rt :

US Doppler lower limb veins Rt

Venous incomp (RT)

SITE	RIGHT	
Common femoral:	MR	Minor reflux
Femoral:	NR	No reflux
Popliteal:	NR	No reflux
Saphenofemoral junction:	R	Reflux
Long saphenous:	R	Reflux
Saphenopopliteal:	A	Absent / not detected
Mid Calf Short Saphenous:	NR	No reflux

Comments:

Right:

Perforators:

Nil.

Comments:

No evidence of proximal DVT/scarring.

Minor reflux in CFV likely due to SFJ incompetence.

Incompetent SFJ and LSV is the main source of lower limb varicosities, it is fairly straight and suitable for VNUS, measures 3.0mm at proximal calf level in supine position.

An incompetent tributary arising from distal thigh LSV is the main source of posterior and lateral calf varicosities.

Clinical History :

Varicosities bilaterally.

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

VERIFIED- Attended-08-Feb-2019-MARAJ/MARAJ-08-Feb-2019

Venous incomp (LT)

SITE	LEFT	
Common femoral:	<input type="text" value="NR"/>	No reflux
Femoral:	<input type="text" value="NR"/>	No reflux
Popliteal:	<input type="text" value="NR"/>	No reflux
Saphenofemoral junction:	<input type="text" value="R"/>	Reflux
Long saphenous:	<input type="text" value="R"/>	Reflux
Saphenopopliteal:	<input type="text" value="A"/>	Absent / not detected
Mid Calf Short Saphenous:	<input type="text" value="NR"/>	No reflux

Comments:

Left:

Perforators:

Nil.

Comments:

No evidence of proximal DVT.

SFJ, LSV and ATV are the main source of varicosities, ATV and LSV joins together at proximal thigh level.

LSV is fairly straight and is suitable for VNUS, measures 2.7mm in the proximal calf level (supine position).

Clinical History :

Recurrent varicosities.

US Doppler lower limb veins Rt :

US Doppler lower limb veins Rt

Venous incomp (RT)

SITE	RIGHT	
Common femoral:	NR	No reflux
Femoral:	NR	No reflux
Popliteal:	NR	No reflux
Saphenofemoral junction:	R	Reflux
Long saphenous:	A	Absent / not detected
Saphenopopliteal:	NR	No reflux
Mid Calf Short Saphenous:	NR	No reflux

Comments:

Right:

Perforators:

Incompetent perforator in the medial aspect of the distal calf ~19cm above the floor measures 4.0mm in diameter.

Comments:

No evidence of proximal DVT.

The main source of right lower limb varicosities is the recurrent SFJ incompetence with no treatable segment for VNUS.

Patient reports numbness of the foot with diabetes, please see separate ABPI report.

Clinical History :

Clinical details: had left GSV RF ablation with MSAs in July 2018. Now C/O soft tissue swelling on left lower limb ?thrombophlebitis

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

Venous incomp (LT)

SITE	LEFT	
Common femoral:	NR	No reflux
Femoral:	NR	No reflux
Popliteal:	NR	No reflux
Saphenofemoral junction:	NR	No reflux
Long saphenous:	S	See comments
Saphenopopliteal:	A	Absent / not detected
Mid Calf Short Saphenous:	NR	No reflux

Comments:

Left:

Perforators:

Incompetent perforator with minor reflux in the medial aspect of the calf ~14cm above the floor, measures 2.4mm in diameter.

Comments:

No evidence of proximal DVT.
No recurrent varicosities noted.

Thigh LSV is successfully thrombosed likely due to previous procedure done.
Low velocity reflux in the calf LSV.

The lump in medial aspect of patient's calf is likely due to thrombosed varicosities.

Clinical History :

Pain in the distal thigh, lump in the anterior calf, previous vein surgery in the past.

US Doppler lower limb veins Rt :

US Doppler lower limb veins Rt

VERIFIED - Attended-22-Jan-2019 - MARAJ+FREEB/MARAJ-22-Jan-2019

Venous incomp (RT)

SITE	RIGHT	
Common femoral:	NR	No reflux
Femoral:	NR	No reflux
Popliteal:	NR	No reflux
Saphenofemoral junction:	R	Reflux
Long saphenous:	S	See comments
Saphenopopliteal:	R	Reflux
Mid Calf Short Saphenous:	NR	No reflux

Comments:

Right:Perforators:

No incompetent perforator seen.

Comments:

Deep veins are patent and competent with no evidence of thrombus/scarring.

SFJ appears to be ? previously tied but patent feeding the LSV which is fairly straight and remains within the fascia ~12cm from the groin; at mid to distal thigh level the LSV is out of fascia and seen to be giving rise to varicosities in the distal thigh.

The calf LSV is not seen likely due to previous procedure done.

LSV measurements:

standing: proximal thigh= 6.2mm, mid thigh= 3.9mm.

supine: proximal thigh= 3.7mm, mid thigh= 3.7mm, distal thigh= 3.6mm.

SPJ and proximal SSV are incompetent, seen feeding the competent giacomini which is the main source of reflux in the thigh LSV; Mid calf SSV is competent.

There is a non vascularised structure noted in the anterior calf which appears to perforate the fascia, please recommend other imaging modality to confirm this findings.

Please see PACS for diagram.

Clinical History :

Clinical details: bilateral symptomatic varicose veins with skin change on left.

Specific question to be answered: level of incompetency please

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

VERIFIED—Attended-21-Jan-2019—MARAJ/MARAJ-21-Jan-2019

Venous incorp (LT)

SITE	LEFT	
Common femoral:	R	Reflux
Femoral:	R	Reflux
Popliteal:	S	See comments
Saphenofemoral junction:	R	Reflux
Long saphenous:	R	Reflux
Saphenopopliteal:	R	Reflux
Mid Calf Short Saphenous:	R	Reflux

Comments:

Left:Perforators:

No incompetent perforator seen.

Comments:

CFV and FV has low grade persistent reflux with no evidence of thrombus/scarring.

Proximal PopV is incompetent with no evidence of thrombus/scarring, reflux is likely due to SPJ and SSV incompetence; distal PopV remains competent.

SFJ and LSV are incompetent, LSV is fairly straight and remains within the fascia throughout, LSV lies superficially at distal thigh to calf level, ~3mm below skin surface.

LSV measurements (standing):

proximal thigh= 6.3mm, mid thigh= 5.5mm, distal thigh= 5.6mm, knee= 5.3mm, proximal calf= 5.5mm.

LSV measurements (supine):

distal thigh= 5.0mm, knee= 4.1mm, proximal calf= 3.7mm.

SSV and SPJ are incompetent and the main source of posterior calf varicosities, SSV is fairly straight and joins the PopV at the normal level.

SSV measurements:

standing: proximal calf= 7.7mm, mid calf= 7.0mm.

prone: proximal calf= 2.7mm, mid calf= 4.0mm.

Clinical History :

Clinical details: has mixed vessel left lower leg ulcers + venous hypertention skin damage. had successful ata, pta plasty with excellent pedal pulses, howevre now need to investigate and possiblky treat any underlying venous incompetence

Specific question to be answered: please left leg venous incompetence scan

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

Venous incomp (LT)

SITE	LEFT	
Common femoral:	NR	No reflux
Femoral:	R	Reflux
Popliteal:	R	Reflux
Saphenofemoral junction:	R	Reflux
Long saphenous:	R	Reflux
Saphenopopliteal:	R	Reflux
Mid Calf Short Saphenous:	S	See comments

Comments:

Left:Perforators:

Nil.

Comments:

No evidence of proximal DVT/scarring.

No reflux in proximal FV, minor reflux in mid FV.

Incompetent distal FV and PopV.

SFJ and LSV are incompetent, fairly straight measures 2.8mm in supine position at knee level.

Segmental reflux in the SSV, proximal SSV is competent; SPJ and mid calf SSV is incompetent, an incompetent tributary is seen arising from the proximal SSV connected to mid SSV.

Clinical History :

History of bleeding in the varicosities of the left lower limb.

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

Venous incomp (LT)

SITE	LEFT	
Common femoral:	NR	No reflux
Femoral:	NR	No reflux
Popliteal:	NR	No reflux
Saphenofemoral junction:	R	Reflux
Long saphenous:	R	Reflux
Saphenopopliteal:	A	Absent / not detected
Mid Calf Short Saphenous:	NR	No reflux

Comments:

Left:

Perforators:

Nil.

Comments:

No evidence of proximal DVT.

SFJ and LSV is the main source of left lower limb varicosities, LSV is fairly straight, uniform in calibre and is suitable for VNUS, measures 5.8mm in proximal calf level (supine position).

Clinical History :

Previous vein surgery 4 years ago.

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

VERIFIED-Attended-01-Feb-2019-MARAJ/MARAJ-01-Feb-2019

Venous incompet (LT)

SITE	LEFT	
Common femoral:	<input type="text" value="NR"/>	No reflux
Femoral:	<input type="text" value="NR"/>	No reflux
Popliteal:	<input type="text" value="NR"/>	No reflux
Saphenofemoral junction:	<input type="text" value="R"/>	Reflux
Long saphenous:	<input type="text" value="S"/>	See comments
Saphenopopliteal:	<input type="text" value="A"/>	Absent / not detected
Mid Calf Short Saphenous:	<input type="text" value="NR"/>	No reflux

Comments:

Left:Perforators:

Two incompetent perforators in the left lower limb;

- 1.) medial aspect of the distal thigh ~9cm above knee crease, measures 1.8mm in diameter.
- 2.) medial aspect of the distal calf ~16cm above the floor, measures 4.1mm in diameter.

Comments:

No evidence of proximal DVT.

SFJ, remnant proximal LSV and above mentioned perforators are the main sources of varicosities in the thigh and calf.

An incompetent tributary is seen arising from the remnant proximal LSV and is feeding the varicosities in the mid to distal thigh, it is fairly straight and but small in calibre, measures 2.7mm in distal thigh in standing position.

Clinical History :

Clinical details: HAD LEFT LSVABLATION FOLLOWED BY MA, HOWEVER STILL HAS VERY PROMINANT POPLITEAL FOSSA AND POSTERIOR CALF VV

Specific question to be answered: ? SOURCE

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

VERIFIED-Attended-18-Jan-2019-MARAJ/MARAJ-21-Jan-2019

Venous incomp (LT)

SITE	LEFT	
Common femoral:	NR	No reflux
Femoral:	NR	No reflux
Popliteal:	NR	No reflux
Saphenofemoral junction:	R	Reflux
Long saphenous:	S	See comments
Saphenopopliteal:	NR	No reflux
Mid Calf Short Saphenous:	NR	No reflux

Comments:

Left:

Perforators:

There is a 5.2mm incompetent perforator 11cm above the level of the medial malleolus which supplies residual varicosities on the distal medial and posterior calf.

Comments:

SFJ is incompetent feeding the LSV.

There is LSV recanalisation at proximal to mid thigh level; partial recanalisation at mid to distal thigh level with some segments that remains occluded; the SFJ and LSV are still the main source of varicosities.

Deep veins are patent and competent with no evidence of thrombus/scarring.

SSV and SPJ are patent and competent with no evidence of thrombus/scarring.

Clinical History :

Clinical details: intermittent left leg swelling worse in summer. No previous DVT but has noticed a few prominent veins in anterior calf. ?

Venous reflux

Specific question to be answered: standard VV scan on left on 19/01/19 please

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

VERIFIED-Attended-18-Jan-2019-MARAJ/MARAJ-18-Jan-2019

Venous incomp (LT)

SITE	LEFT	
Common femoral:	NR	No reflux
Femoral:	NR	No reflux
Popliteal:	NR	No reflux
Saphenofemoral junction:	NR	No reflux
Long saphenous:	NR	No reflux
Saphenopopliteal:	NR	No reflux
Mid Calf Short Saphenous:	NR	No reflux

Comments:

Left:

Perforators:

No incompetent perforator seen.

Comments:

Deep veins are patent and competent with no evidence of thrombus/scarring.

SFJ, LSV, Anterior thigh vein, SPJ and SSV are patent and competent with no evidence of thrombus/scarring.

Minor reflux noted in the superficial vein in the anterior calf with no deep source identified.

Clinical History :

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

VERIFIED - Attended-16-Jan-2019 - MARAJ+HICKP/MARAJ-16-Jan-2019

Venous incomp (LT)

SITE	LEFT	
Common femoral:	NR	No reflux
Femoral:	NR	No reflux
Popliteal:	NR	No reflux
Saphenofemoral junction:	A	Absent / not detected
Long saphenous:	A	Absent / not detected
Saphenopopliteal:	NR	No reflux
Mid Calf Short Saphenous:	S	See comments

Comments:

Left:

Perforators:

No incompetent perforator seen.

Comments:

Deep veins are patent and competent with no evidence of thrombus/scarring.

SFJ and LSV are not detected likely due to previous procedure done.

SPJ and proximal SSV are patent and competent, segmental reflux in the mid SSV with no deep source identified.

Clinical History :

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

VERIFIED Attended-11-Jan-2019 MARAJ/MARAJ-11-Jan-2019

Venous incomp (LT)

SITE	LEFT	
Common femoral:	MR	Minor reflux
Femoral:	NR	No reflux
Popliteal:	NR	No reflux
Saphenofemoral junction:	R	Reflux
Long saphenous:	S	See comments
Saphenopopliteal:	NR	No reflux
Mid Calf Short Saphenous:	NR	No reflux

Comments:

Left:Perforators:

Competent perforator in the medial aspect of the calf draining varicosities into the deep veins.
No incompetent perforator seen.

Comments:

CFV have minor reflux likely due to SFJ incompetence.
FV and PopV are patent and competent with no evidence of thrombus/scarring.

SFJ and ATV are the main source of varicosities in the left lower limb; the ATV is fairly straight and remains within the fascia for >15cm, suitable for VNUS.

Mid thigh ATV measurements:**standing= 5.7mm.****supine= 4.9mm.**

LSV is competent at thigh level and becomes incompetent as it joins the varicosities in the calf which are coming from the incompetent ATV.

SPJ and SSV are patent and competent.

Clinical History :

Varicose veins.

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

VERIFIED-Attended-09-Jan-2019-MARAJ+FERNF/MARAJ-09-Jan-2019

Venous incomp (LT)

SITE	LEFT	
Common femoral:	NR	No reflux
Femoral:	NR	No reflux
Popliteal:	NR	No reflux
Saphenofemoral junction:	R	Reflux
Long saphenous:	R	Reflux
Saphenopopliteal:	A	Absent / not detected
Mid Calf Short Saphenous:	R	Reflux

Comments:

Left:

Perforators:

Incompetent perforator seen in the medial aspect of the mid to distal thigh ~7-8cm above knee which is the main source of varicosities in the mid to distal thigh, measures 3.5mm in diameter.

Comments:

CFV and PopV are patent and competent with no evidence of thrombus/scarring.

Mid FV is incompetent likely due to aforementioned incompetent perforator; proximal and distal FV are patent and competent with no evidence of thrombus/scarring.

SFJ and duplicate small calibre LSV are incompetent with low velocity reflux; incompetence is likely due to varicosities that is coming from the aforementioned incompetent perforator vein.

Thrombophlebitis seen in the varicosities at mid to distal thigh level.

SSV is incompetent but remains small in calibre; seen to be draining from the mid FV where minor reflux is noted.

Mid calf SSV measurements:

standing: 2.7mm.

prone: 1.6mm.

Clinical History :

Clinical details: VVs both legs. Bleeding +

Specific question to be answered: ?pattern of incompetence

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

VERIFIED - Attended-27-Jun-2018 - MARAJ+DIXOH/MARAJ-27-Jun-2018

Venous incompet (LT)

SITE	LEFT	
Common femoral:	<input type="text" value="NR"/>	No reflux
Femoral:	<input type="text" value="NR"/>	No reflux
Popliteal:	<input type="text" value="NR"/>	No reflux
Saphenofemoral junction:	<input type="text" value="R"/>	Reflux
Long saphenous:	<input type="text" value="R"/>	Reflux
Saphenopopliteal:	<input type="text" value="A"/>	Absent / not detected
Mid Calf Short Saphenous:	<input type="text" value="NR"/>	No reflux

Comments:

LEFT:

Perforators:

No incompetent perforator seen.

Comments:

Deep veins are patent and competent with no evidence of thrombus/scarring.

SFJ and LSV are incompetent which are being filled by a pelvic source.

Varicose veins in the distal lateral thigh above the knee are seen filled by pelvic source.

The LSV is fairly straight, remains within the fascia, incompetent with low velocity reflux and small in calibre, which measures in standing; proximal thigh= 5.0mm, mid thigh= 3.4mm, distal thigh= 2.3mm, knee= 2.5mm, proximal calf= 2.0mm

SSV is competent, no proper SPJ detected.

Clinical History :

Venous ulcer on the left medial ankle.

US Doppler lower limb veins Lt :

US Doppler lower limb veins Lt

Venous incomp (LT)

SITE	LEFT	
Common femoral:	<input type="text" value="R"/>	Reflux
Femoral:	<input type="text" value="S"/>	See comments
Popliteal:	<input type="text" value="S"/>	See comments
Saphenofemoral junction:	<input type="text" value="R"/>	Reflux
Long saphenous:	<input type="text" value="R"/>	Reflux
Saphenopopliteal:	<input type="text" value="R"/>	Reflux
Mid Calf Short Saphenous:	<input type="text" value="R"/>	Reflux

Comments:

Left:

Perforators:

Incompetent perforator vein seen in the medial aspect of the calf ~23cm above the ground measures 4.2mm in diameter.

Comments:

CFV is patent and incompetent with no evidence of thrombus/scarring.

FV at proximal to lower mid level is patent and competent with no evidence of thrombus/scarring.

FV distal have low velocity reflux likely due to SPJ/SSV incompetence.

Popliteal vein proximal is incompetent likely due to SPJ/SSV incompetence.

Popliteal vein distal has a minor reflux.

SFJ and LSV are incompetent and is the main source of varicosities in the thigh, the LSV remains within the fascia throughout, fairly straight ~25cm from the groin and is mildly tortuous at mid thigh to proximal calf level.

LSV measurements (standing):

proximal thigh= 10mm, mid thigh= 7.5mm, distal thigh= 4.6mm, knee= 3.5mm, proximal calf= 3.0mm.

LSV measurements (supine):

proximal thigh= 7.8mm, mid thigh= 4.9mm, distal thigh= 3.4mm, knee= 3.5mm, proximal calf= 2.5mm.

SPJ and SSV are incompetent, the SSV is fairly straight from the mid calf to the junction and connects to the lateral aspect of the popliteal vein ~2-3cm above the knee crease.

SSV measurements:

Standing: mid calf= 7.0mm

Prone: mid calf= 5.3mm, proximal calf= 3.2mm.

Supine with knee slightly bent: proximal calf= 6.1mm.

Please see PACS for diagram.

Clinical History :

Clinical details: Dialysis patient - had failed left bbvt -

Specific question to be answered: Please assess suitable veins/arteries for avf formation - thanks

US Pre-Fistula Mapping Right :

US Pre-Fistula Mapping Right

VERIFIED - Attended-11-Feb-2019 - MARAJ/MARAJ-11-Feb-2019

Right:

Veins: (all veins measured with tourniquet applied)

Cephalic vein is patent and small in calibre, measures;

proximal humerus= 1.9mm.

distal humerus= 1.4mm.

proximal forearm= 1.3mm.

distal forearm= 1.4mm.

Basilic vein is patent, ~ 12cm in length, joins the deep vein at proximal humerus level, measures;

proximal= 2.9mm.

distal= 3.2mm.

Central veins are patent.

Artery:

Brachial artery is patent with no significant stenosis, triphasic pulsatile waveforms, measures 3.5mm in diameter.

Clinical History :

Clinical details: New ESRF on dialysis, for prep for fistula

Specific question to be answered: Fistula mapping

US Pre-Fistula Mapping Left :

Left: (non dominant hand)

Veins:

Cephalic vein is patent throughout with no evidence of thrombus/scarring, measures:

upper arm proximal= 5.2mm.

upper arm distal= 5.2mm.

forearm proximal= 3.6mm.

forearm distal= 3.0mm.

Basilic vein is patent throughout and joins the brachial vein at proximal humerus level, measures:

proximal humerus= 5.6mm.

distal humerus= 6.1mm.

Central veins are patent with no evidence of thrombus/scarring.

Artery:

Brachial and radial arteries are patent with triphasic pulsatile waveforms, no evidence of significant stenosis detected, measures, 5.9mm and 3.3mm respectively.

Brachial artery has normal bifurcation level.

Clinical History :

Clinical details: Right AVF- thrombus- failed thrombectomy- advised for repeat vein mapping

Specific question to be answered: ? ongoing thrombosis/ stenosis

US Bilateral Pre-Fistula Mapping :**US Bilateral Pre-Fistula Mapping**

VERIFIED- Attended-30-Nov-2018 - MARAJ/MARAJ-30-Nov-2018

All veins measured with tourniquet applied.

Left:(non dominant hand)

The brachial artery is patent and measures 3.4mm in mid upper arm with the bifurcation noted at the level of the ACF.

Failed previous brachio-cephalic fistula seen, remaining upper arm cephalic vein is patent at proximal to distal humerus level measure;
proximal upper arm= 2.6mm.

mid upper arm= 3.5mm.

distal upper arm= 3.1mm.

The basilic vein is patent, joins the deep vein at proximal humerus level and measures:

4.0mm in the proximal upper arm

4.0mm in the mid upper arm

4.3mm in the distal upper arm

The brachial, axillary and subclavian veins are patent.

Right:

The brachial artery is patent and measures 3.5mm in mid upper arm with the bifurcation noted at the level of the ACF.

Failed previous brachio-cephalic fistula seen, remaining upper arm cephalic vein is patent at proximal to mid humerus level measure;
proximal upper arm= 3.0mm.

mid upper arm= 2.9mm.

The basilic vein is patent, joins the deep vein at proximal humerus level and measures:

3.8mm in the proximal upper arm

3.9mm in the mid upper arm

3.3mm in the distal upper arm

The brachial, axillary and subclavian veins are patent.

Clinical History :

Clinical details: PICC line insitu, leaking when administration of IV Abx. For vascular assessment as per Access team

Specific question to be answered: ?Cause of leaking PICC line

US Doppler vein map upper limb Lt :

US Doppler vein map upper limb Lt

Arm vein (LT)

SITE	LEFT	
Internal jugular vein:	<input type="text" value="NT"/>	No thrombus
Brachiocephalic vein:	<input type="text" value="NT"/>	No thrombus
Subclavian vein:	<input type="text" value="NT"/>	No thrombus
Axillary vein:	<input type="text" value="NT"/>	No thrombus
Brachial vein:	<input type="text" value="NT"/>	No thrombus
Ulnar veins:	<input type="text" value="NT"/>	No thrombus
Radial veins:	<input type="text" value="NT"/>	No thrombus
Cephalic vein:	<input type="text" value="NT"/>	No thrombus
Basilic vein:	<input type="text" value="NT"/>	No thrombus

Comments:

Comments:

Left:

No evidence of DVT.

PICC line seen in-situ.

Clinical History :

Clinical details: Buring feeling to arm

Specific question to be answered: ?dvt

US Doppler vein map upper limb Rt :

US Doppler vein map upper limb Rt

VERIFIED-Attended-10-Aug-2018-MARAJ+HICKP/MARAJ-10-Aug-2018

Arm vein (RT)

SITE	RIGHT	
Internal jugular vein:	NT	No thrombus
Brachiocephalic vein:	NT	No thrombus
Subclavian vein:	NT	No thrombus
Axillary vein:	NT	No thrombus
Brachial vein:	NT	No thrombus
Ulnar veins:	NT	No thrombus
Radial veins:	NT	No thrombus
Cephalic vein:	S	See comments
Basilic vein:	NT	No thrombus

Comments:

Comments:

Right:

No evidence of DVT.

Minor scarring noted in the cephalic vein at the ACF level, however there is no evidence of acute thrombophlebitis.

Basilic vein is small in calibre however no evidence of thrombus where seen.

Clinical History :

Clinical details: Left temporal low grade lesion favouring oligodendroglioma WHO grade 2, debulking in January 2017. Persistence of auras with no seizures. for surgery

Specific question to be answered: ?DVT pre-op

US Compression venography lower limb B :

US Compression venography lower limb B

DVT (B)

SITE	RIGHT		LEFT	
External iliac:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Common femoral:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Profunda femoris:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Femoral:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Popliteal:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Gastrocnemius:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Soleal vein:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Posterior tibial:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Anterior tibial:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Peroneal vein:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Long saphenous:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Short saphenous:	<input type="text" value="NT"/>	No thrombus	<input type="text" value="NT"/>	No thrombus
Summary:	<input type="text" value="N"/>	No DVT	<input type="text" value="N"/>	No DVT

Comments:

Comments:

Bilateral:

No evidence of DVT.

Clinical History :

Clinical details: B-ALL, left leg swelling

Specific question to be answered: ?DVT

US Compression venography lower limb Lt :

US Compression venography lower limb Lt

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DVT (LT)

SITE	LEFT	
External Iliac:	<input type="text" value="S"/>	See comments
Common femoral:	<input type="text" value="T"/>	THROMBUS
Profunda femoris:	<input type="text" value="T"/>	THROMBUS
Femoral:	<input type="text" value="PT"/>	PARTIAL THROMBUS
Popliteal:	<input type="text" value="NT"/>	No thrombus
Gastrocnemius:	<input type="text" value="N"/>	Not done
Soleal vein:	<input type="text" value="N"/>	Not done
Posterior tibial:	<input type="text" value="N"/>	Not done
Anterior tibial:	<input type="text" value="N"/>	Not done
Peroneal vein:	<input type="text" value="N"/>	Not done
Long saphenous:	<input type="text" value="N"/>	Not done
Short saphenous:	<input type="text" value="N"/>	Not done
Summary:	<input type="text" value="P"/>	Proximal DVT

Comments:

Comments:

Left:

Proximal DVT in the left lower limb likely acute to sub-acute.

Unable to rule out presence of partial thrombus in the EIV, unable to visualise CIV due to bowel gas.

Right:

EIV and CFV are patent with good phasic waveforms which suggests IVC patency.