

Clinical History :

Clinical details: diabetes, neuropathy, recent trauma to right toe becoming necrotic, query if trauma occluded digital vessels

Specific question to be answered: is there sufficient peripheral arterial perfusion for healing?

US Doppler lower limb arteries Rt :

US Doppler lower limb arteries Rt

VERIFIED-Attended-18-Dec-2018-MARAJ+HICKP/MARAJ-18-Dec-2018

Right:

CFA are PFA are patent with triphasic pulsatile waveforms, PSV 1.1m/sec and 1.3m/sec respectively.

SFA and PopA are patent with minor diffuse atherosclerotic disease, no evidence of haemodynamically significant stenosis, triphasic pulsatile waveforms, PSV 1.0m/sec and 0.89m/sec respectively.

Calf vessels:

ATA and Peroneal are patent throughout, triphasic pulsatile waveforms, no evidence of focal stenosis, distal PSV 1.3m/sec and 0.68m/sec respectively.

PTA has short segment (~3cm) occlusion in the distal level; retrograde flow detected below the ankle level, PSV 0.21m/sec.

Foot vessels:

Medial plantar is patent with triphasic pulsatile retrograde flow filling the distal PTA and lateral plantar artery, PSV 0.66m/sec.

Lateral plantar artery is patent with triphasic pulsatile waveforms, PSV 0.45m/sec.

DPA is patent throughout with no evidence of significant stenosis, triphasic pulsatile waveforms, PSV 0.93m/sec.

Inter digital artery between first/second and second/third toe are patent with triphasic hyperaemic waveforms, PSV 0.51m/sec and 0.73m/sec respectively.

2nd toe digital artery is seen proximally with monophasic pulsatile waveforms, PSV 0.37m/sec.

Unable to image the mid to distal part of the toe due to skin condition.

Clinical History :

Clinical details: R/3rd infected ulcer. Type 2 diabetes, neuropathy, PAD

Specific question to be answered: Deterioration of R/limb blood supply?

US Doppler lower limb arteries Rt :

US Doppler lower limb arteries Rt

VERIFIED - Attended-07-Dec-2018 - MARAJ+FREEBIMARAJ-07-Dec-2018

Right:

CFA is patent with triphasic pulsatile waveforms, PSV 1.3m/sec.

PFA is patent with biphasic pulsatile waveforms, PSV 0.93m/sec.

SFA and PopA are patent with diffuse calcifications, no evidence of significant stenosis detected, PSV 0.90m/sec and 0.71m/sec respectively.

Calf vessels are heavily calcified.

PTA have segmental occlusions at mid to distal level with evidence of collateral formations; >75% stenosis detected in the mid PTA, max PSV 2.2m/sec; distal PTA remains patent with monophasic pulsatile waveforms, PSV 0.43m/sec.

ATA have segmental occlusions at mid to distal level with evidence of collateral formations detected, 50-75% stenosis detected in the mid to distal ATA, distal ATA remains patent with monophasic pulsatile waveforms, PSV 0.76m/sec.

Peroneal artery is patent throughout and the main run off to the foot with diffuse stenosis at mid level.

Foot vessels:

DPA is patent throughout with diffuse calcifications, monophasic pulsatile waveforms detected, PSV 0.52m/sec.

Lateral plantar artery appears occluded.

Medial plantar artery is patent with monophasic pulsatile waveforms, PSV 0.20m/sec.

Clinical History :

Clinical details: right CLI. has SFA stent

Specific question to be answered: please right leg arterial scan, down to pedals

US Doppler lower limb arteries Rt :

US Doppler lower limb arteries Rt

VERIFIED - Attended-06-Dec-2018 - MARAJ+FREEB/MARAJ-06-Dec-2018

Right:

CFA and PFA are patent with triphasic pulsatile waveforms, triphasic pulsatile waveforms, PSV 1.3m/sec and 0.72m/sec respectively.

SFA stent seen at from the proximal SFA, patent throughout with 2x velocity increase at proximal level.

75-99% in-stent stenosis detected at proximal to mid SFA level causing 8x velocity increase, distal to this stenosis, monophasic severely damped waveforms are detected distal to stenosis;

SFA distal demonstrates monophasic damped waveforms detected likely due to collateral flow.

PopA is patent with monophasic damped waveforms, no evidence of significant stenosis, PSV 0.24m/sec.

Calf vessels:

PTA, ATA and Peroneal arteries are patent with monophasic damped waveforms, distal PSV's 0.14m/sec, 0.16m/sec and 0.14m/sec respectively.

Foot vessels:

DPA is patent with monophasic damped waveforms, PSV 0.14m/sec.

Medial and lateral plantar arteries are patent with 0.12m/sec and 0.05m/sec respectively.

Clinical History :

Clinical details: right CLI. ABPI showed damped flow in crurals

Specific question to be answered: please detailed arterial duplex scan

US Doppler lower limb arteries Rt :

US Doppler lower limb arteries Rt

VERIFIED - Attended-17-Dec-2018 - MARAJ+FREEBIMARAJ-17-Dec-2018

Right:

CFA and PFA origin are patent with triphasic pulsatile flow, PSV 0.76m/sec and 1.1m/sec.

Calcified plaque detected in the posterior wall of the CFA, however this is not causing significant stenosis.

SFA occlusion detected in the mid thigh ~10cm in length with reconstitution of flow at the distal level, collateral flows detected; diffuse calcified plaques detected throughout the SFA, monophasic pulsatile waveforms, PSV 0.64m/sec.

Popliteal artery is patent with no evidence of significant stenosis, monophasic pulsatile waveforms detected, PSV 0.52m/sec.

~2x velocity increase detected in the distal TPT suggestive of 50% stenosis, PSV 0.79m/sec.

Calf vessels are heavily calcified.

PTA is patent at proximal to mid level; occluded at mid to distal level with reconstitution of flow at ankle level, monophasic damped waveforms detected, PSV 0.26m/sec.

Peroneal artery origin has 50-75% stenosis, however appears patent throughout, monophasic pulsatile waveforms, 0.31m/sec.

ATA is patent with diffuse <50% stenoses, 50-75% stenosis detected at mid to distal level.

DPA is patent with monophasic pulsatile waveforms, PSV 0.30m/sec.

Clinical History :

Clinical details: Right SFA aneurysm noted on ct - for doppler and vascular review

Specific question to be answered: ?needs intervention

US Doppler lower limb arteries Rt :

US Doppler lower limb arteries Rt

VERIFIED-Attended-21-Nov-2018-MARAJ-FREEM/MARAJ-21-Nov-2018

Aorta is patent with normal tapering contour, measures 1.7cm.

Right:

CIA and EIA are patent with no evidence of significant stenosis detected.

CFA is patent with triphasic pulsatile waveforms, appears dilated appearances may be consistent with previous endarterectomy.

PFA is patent with triphasic hyperaemic waveforms, PSV 0.96m/sec.

SFA is chronically occluded.

There is a patent synthetic common femoral to above knee popliteal bypass graft.

Proximal anastomosis is patent with no evidence of significant stenosis.

Graft is patent throughout with no evidence of significant stenosis, there is notable tortuosity noted in the mid thigh level, however this is not causing significant stenosis.

Evidence of halo sign throughout the graft body ?peri graft infection.

Pseudoaneurysm with ~60% mural thrombus detected at the distal anastomosis, neck measuring 1.2cm.

Distal anastomosis is patent with no evidence of significant stenosis.

PopA is patent with triphasic pulsatile waveforms, no evidence of significant stenosis detected.

PTA, PeroA, ATA and DPA are patent with tri/biphasic pulsatile waveforms, no evidence of significant stenosis, distal PSV's 1.1m/sec, 0.50m/sec, 0.92m/sec and 0.85m/sec respectively.

Conclusion:

1. Patent synthetic graft with corrugated appearance at mid thigh level and perigraft halo all features suggestive of graft infection.
2. There is a large mostly thrombosed false aneurysm/detachment of the distal anastomosis.

Ward team informed of result.

Urgent referral to vascular surgeon advised.

Clinical details: IN OCTOBER HAD ANGIOPLASTY which ended with trashing of PeA. ATA patent to foot, PTA occluded. also had dissection flap and angioseal stenosis at CFA level. now coming with deterioration of foot pain + coldness

Specific question to be answered: please rescan left leg. from CFA down to DPA and new changes

US Doppler lower limb arteries Lt :

Left:

CFA - wall irregularity (?dissection/angioseal remnant) present causing 50-75% stenosis and turbulent flow to profunda and SFA origins. SFA, POP and TPT patent throughout triphasic flow.

ATA - patent throughout with triphasic flow, PSV 0.42 m/s distally.

DPA- patent with triphasic flow, PSV 0.39 m/s.

PTA - The origin is patent, however it is then occluded to ankle.

There is reconstitution of the medial plantar artery with monophasic pulsatile flow, PSV 0.14 m/s (not from lateral plantar but from collateral further down).

The lateral plantar artery is occluded.

Peroneal - patent from origin to mid calf with a short occlusion at distal calf. Patent above ankle with monophasic flow, PSV 0.16 m/s.

Clinical History :

Clinical details: Left 5th toes diabetic and ischaemic ulcer, seems to have deteriorated clinically plus discussed with Mr Rashid

Specific question to be answered: To have detail arterial Doppler of left foot to check for severity and feasibility for a vascular intervention

US Doppler lower limb arteries Lt :

US Doppler lower limb arteries Lt

VERIFIED-Attended-26-Oct-2018-MARAJ+DIXON/MARAJ-26-Oct-2018

Please see PACS for diagram.

Left:

Diffuse atherosclerotic plaques throughout the arterial walls.

CFA is patent with triphasic pulsatile waveforms, PSV 1.4m/sec.

PFA is patent with <50% stenosis, with triphasic pulsatile waveforms, PSV 1.8m/sec.

SFA is patent with multi level stenosis, focal 75-99% stenosis detected at the proximal-mid level, PSV 3.7m/sec; at mid and mid to distal level, there are two focal 50-75% stenosis.

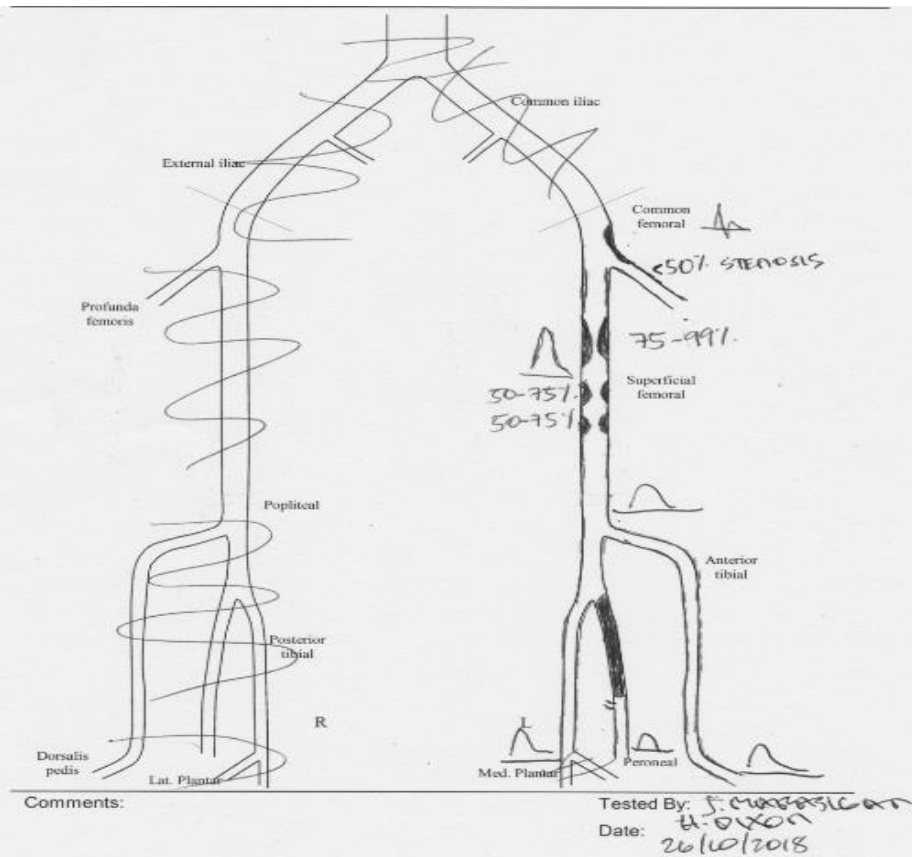
Popliteal artery is patent with no evidence of significant stenosis, monophasic damped waveforms, PSV 0.70m/sec.

Calf vessels:

PTA is patent throughout with no evidence of significant stenosis, monophasic damped waveforms, distal PSV 0.48m/sec.

Peroneal A is occluded at proximal to mid level with reconstitution of flow at mid to distal level, distal PSV 0.10m/sec.

ATA and DPA are patent throughout, no evidence of significant stenosis, monophasic damped waveforms, PSV 0.61m/sec.



Clinical History :

Clinical details: Diabetic, bilateral claudicant at short distance <50m, no rest pain, no tissue loss, no pulses palpable bilaterally ABPI's and duplex please to assess arterial flows please
Specific question to be answered: as above

US Doppler lower limb arteries Lt :

Please see PACS for diagram.

LEFT:

50-75% stenosis detected in the CIA, PSV 3.4m/sec.

EIA is patent with no evidence of significant stenosis, biphasic pulsatile waveforms, PSV 0.79m/sec.

CFA is patent with no evidence of significant stenosis, diffuse calcified plaques, PSV 0.83m/sec.

PFA is patent with 50-75% stenosis detected in the origin, PSV 2m/sec.

SFA is patent with diffuse calcified plaques, two focal 50-75% stenosis detected in the mid/distal and distal SFA, causing 2-3x velocity increase, monophasic pulsatile waveforms, PSV 3m/sec.

Popliteal artery is patent with 50-75% stenosis in the distal level, monophasic pulsatile waveforms, PSV 1.0m/sec.

Calf vessels:

PTA is patent to ~3cm from the origin then becomes occluded from the proximal to mid level with reconstitution of flow at the distal PTA, monophasic damped waveforms, PSV 0.19m/sec.

Peroneal artery is patent throughout with diffuse calcified plaques, PSV 0.28m/sec.

ATA is patent throughout with diffuse calcified plaques, monophasic pulsatile waveforms, PSV 0.46m/sec.

DPA is patent with monophasic pulsatile waveforms, PSV 0.29m/sec.

Clinical History :

Clinical details: Diabetic, bilateral claudicant at short distance <50m, no rest pain, no tissue loss, no pulses palpable bilaterally ABPI's and duplex please to assess arterial flows please
Specific question to be answered: as above

US Doppler lower limb arteries Rt :

Please see PACS for diagram.

RIGHT:

~50% stenosis detected in the CIA, PSV 3.4m/sec.

EIA is patent with no evidence of significant stenosis, triphasic pulsatile waveforms, PSV 1.7m/sec.

CFA and PFA are patent with no evidence of significant stenosis, diffuse calcified plaques, PSV 1.5 - 1.9m/sec.

SFA is patent with diffuse calcified plaques, 75-99% stenosis detected in the distal SFA, causing 4-5x velocity increase, monophasic pulsatile waveforms, PSV 4.5m/sec.

Popliteal artery is patent with no evidence of significant stenosis, monophasic pulsatile waveforms, PSV 0.60m/sec.

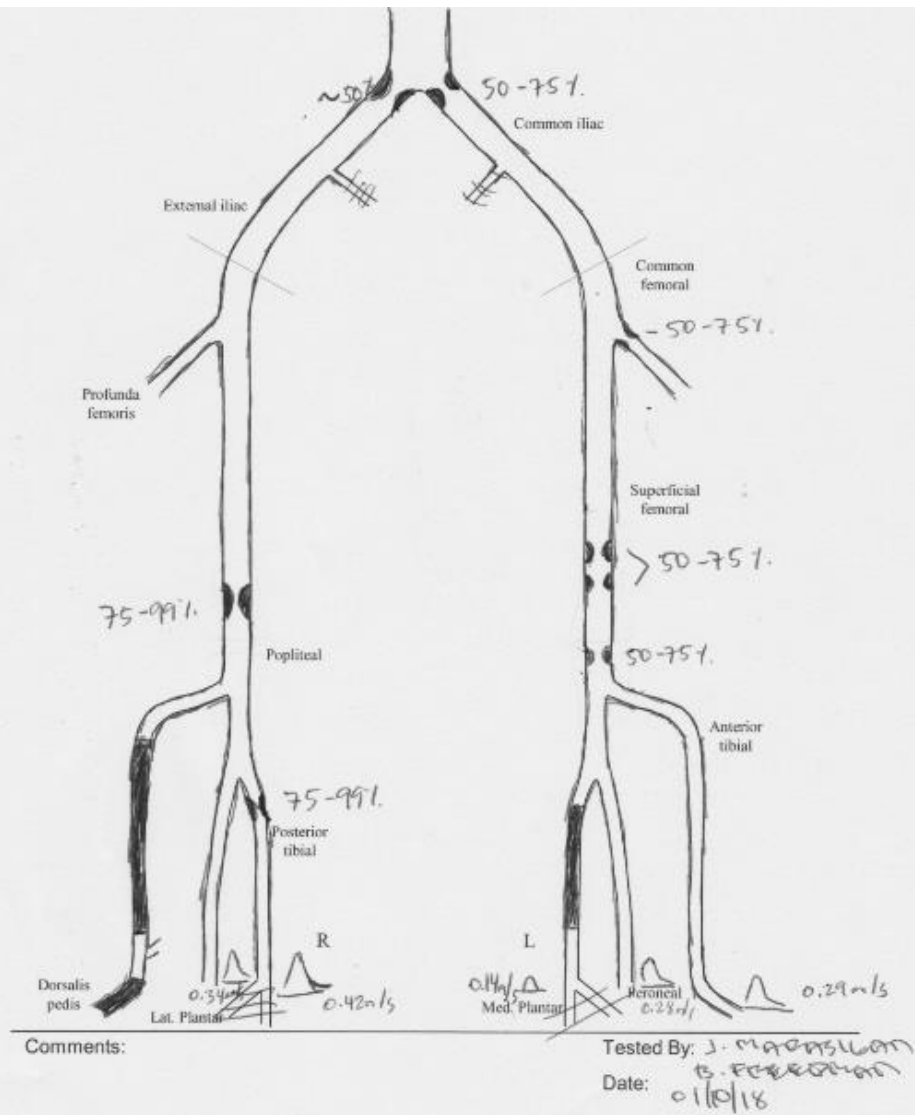
Calf vessels:

50-75% stenosis detected in the proximal PTA causing 4-5x velocity increase, monophasic damped waveforms noted distally, PSV 2.6m/sec.

Peroneal artery is patent throughout with diffuse calcified plaques, PSV 0.34m/sec.

ATA is patent for short segment from the origin then becomes occluded at proximal to mid/distal level with reconstitution of flow at the distal ATA for short segment then becomes occluded again as it courses to DPA.

DPA is occluded.



Clinical History :

Clinical details: Type 1 diabetes. PAD, neuropathy

Specific question to be answered: L/F chronic infected ulcer not healing,

US Doppler lower limb arteries Lt :

US Doppler lower limb arteries Lt

VERIFIED-Attended-13-Dec-2018-MARAJ+FERNF/MARAJ-13-Dec-2018

Left:

CFA and PFA are patent with diffuse calcifications, biphasic pulsatile waveforms, PSV 1.3m/sec and 0.70m/sec respectively.

SFA is patent throughout with diffuse <50% stenosis and calcifications throughout; 50-75% stenosis detected in the mid SFA level causing 2-3x velocity increase, max PSV 2.3m/sec.

PopA and TPT are patent with no evidence of significant stenosis, biphasic pulsatile waveforms detected, PSV 0.67m/sec.

Calf vessels:

PTA is heavily calcified, appears occluded throughout with reconstitution of flow at the ultra distal level just above plantar artery bifurcation.

ATA is heavily calcified and appears occluded with reconstitution of flow at distal level via collaterals.

Peroneal artery is patent and is the main run off to the foot; there is 50-75% stenosis detected in the mid calf level causing 2-3x velocity increase, PSV 2.4m/sec.

Foot vessels:

Medial plantar artery is patent with monophasic damped waveforms, PSV 0.17m/sec.

Lateral plantar artery appears occluded.

DPA is heavily calcified which appears to have segmental occlusion, with evidence of multiple collateral vessels seen supplying blood to the foot.

Clinical History :

Clinical details: .MORNING APPOINTMENT PLEASE - TO BE SEEN IN DIABETIC FOOT JOINT VASCULAR CLINIC - chronic bilateral foot ulcers and pain in left leg and foot

Specific question to be answered: diabetes, bilateral ulceration

US Doppler lower limb arteries Lt :

US Doppler lower limb arteries Lt

VERIFIED-Attended:30-Oct-2018-MARAJ+FERNF/MARAJ-30-Oct-2018

Left:

CFA and PFA are patent with triphasic pulsatile waveforms, no evidence of significant stenosis detected, PSV 1.2m/sec and 1.4m/sec respectively.

SFA is patent with two focal stenoses detected; at ~50% stenosis at proximal to mid level causing 1.94x velocity increase, PSV 2.06m/sec and **>75% stenosis at mid to distal level causing 4.8x velocity increase, PSV 4.12m/sec, (length of plaque in this level is ~2.8cm).**

Popliteal artery is patent with no evidence of significant stenosis, PSV 0.90m/sec.

Calf vessels:

PTA, PeroA and ATA are patent throughout with no evidence of significant stenosis, monophasic pulsatile waveforms, distal PSV 0.74m/sec, 0.47m/sec, 0.52m/sec respectively.

DPA is patent with monophasic pulsatile waveforms, PSV 1.1m/sec.

Clinical History :

patient with rest pain coming to KCH for second opinion. Had failed attempt at angioplasty and failed attempt at bypass elsewhere (leg opened but no bypass actually made as peroneal and vein both seemed poor on table).

Needs up to date arterial aorta to ankle right leg and vein map both legs (not sure if R LSV was harvested or not).

Going to urgent walk in to hisham clinic on wednesday. Referral came via email from hisham.
on 08-Aug-2018 at 16:59)

US Doppler lower limb arteries Rt :

US Doppler lower limb arteries Rt

VERIFIED - Attended-15-Aug-2018 - MARAJ+HICKP/MARAJ-15-Aug-2018

PLEASE SEE PACS FOR DIAGRAM

Aorta is patent measures 2.2cm in diameter, shows triphasic pulsatile waveforms, no evidence of significant stenosis, PSV 0.96m/sec.

Right:

CIA and EIA are patent with triphasic hyperaemic waveforms, no evidence of significant stenosis, PSV 0.86m/sec.

CFA and PFA are patent with monophasic pulsatile waveforms, PSV 1.3m/sec and 0.80m/sec respectively.

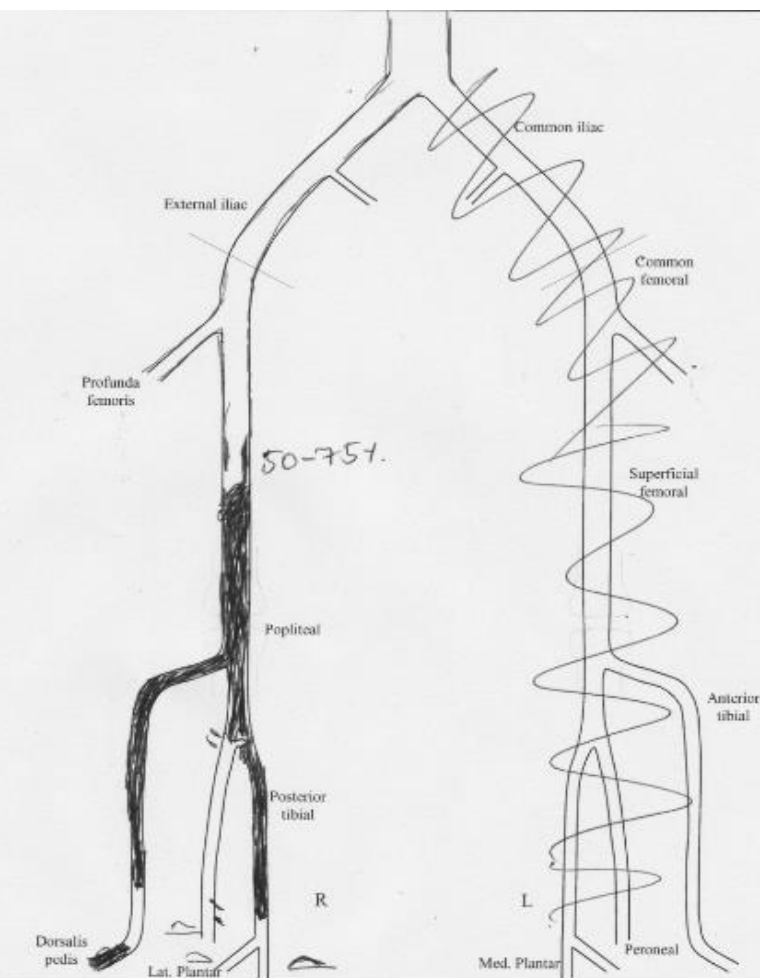
SFA is patent and proximal to mid level with 50-75% stenosis at mid level before it becomes occluded.

SFA is occluded at mid to Popliteal distal level with reconstitution of flow at proximal peroneal artery.

PTA is occluded at proximal to distal level, however the ultra distal PTA is patent, medial and lateral plantar arteries are patent with monophasic damped waveforms, PSV 0.08m/sec and 0.11m/sec respectively.

ATA is occluded at proximal to distal level with short segment that is patent at distal level just before the DPA.

Peroneal artery is patent throughout from proximal to distal level with damped monophasic waveforms, PSV 0.35m/sec.



Comments:

Tested By: JOHAN MARGALAN
Date: F. FERNANDES
15/08/2018

REPORT E-72558033

VERIFIED-Attended-30-Jan-2019-MARAJ/MARAJ-30-Jan-2019

Clinical History :

R FEM PERO incl jump graft to distal pero A

1M

US Graft Surveillance Right :

US Graft Surveillance Right

VERIFIED-Attended-30-Jan-2019-MARAJ/MARAJ-30-Jan-2019

Bypass graft follow-up

FAU interval:	6WEEKS	Location:	R SFA-PE+JUMP PE	Type:	VEIN
Best Resting Ankle Pressure	0	mmHg			
Brachial systolic Pressure:	0	mmHg			
ABPI:	0	mmHg			
ABPI Not Measured	-				

Comments:

Inflow:

CFA, PFA and SFA are patent with triphasic pulsatile waveforms, no evidence of significant stenosis.

SFA to Pero graft:

Proximal Anastomosis - patent with no evidence of significant stenosis.

Graft within the thigh is patent with no significant stenosis, PSV typically 0.30m/sec - 0.21m/sec.

Jump graft to Pero distal:

proximal anastomosis - patent with no evidence of significant stenosis.

3x velocity increase detected in the graft at mid calf level suggestive of 50-75% stenosis, PSV 1.5m/sec.

distal anastomosis - patent with no evidence of significant stenosis.

Run-Off:

Distal peroneal artery is patent with monophasic pulsatile waveforms, PSV 0.54m/sec.

Date of next scan

12/03/2019.

Comments:

3x velocity increase detected in the graft at mid calf level suggestive of 50-75% stenosis, PSV 1.5m/sec.

Clinical History :

Clinical details: HTN\,br\Right arm BP>L arm

Specific question to be answered: Subclavian stenosis

US Doppler artery map upper limb Rt :

US Doppler artery map upper limb Rt

VERIFIED - Attended-21-Dec-2018 - MARAJ+FREEB/MARAJ-21-Dec-2018

Upper limb arteries (RT)

RIGHT		
132	-	mmHg
<hr/>		
Upper Limb Artery Waveforms		
Subclavian artery:	TP	Triphasic pulsatile
Axillary artery:	TP	Triphasic pulsatile
Brachial artery:	TP	Triphasic pulsatile
Ulnar artery:	TP	Triphasic pulsatile
Radial artery:	TP	Triphasic pulsatile
<hr/>		
Thoracic Outlet Manoeuvres		
Adson's manoeuvre:	NO	Normal
Costoclavicular:	NO	Normal
Hyper-abduction:	S	See comments

Comments:

Comments:

Right:

No evidence of haemodynamically significant stenosis with patient in baseline (supine) position.

Adson's manoeuvre and costoclavicular position shows no haemodynamic changes.

Hyper-abduction:

Brachial artery demonstrates monophasic damped waveforms in hyper abduction of arm 180degrees pointing to the ceiling with head facing to the left.

Cessation of flow in the axillary vein is noted in the same position.

Normal antegrade flow detected in the vertebral artery.

Above findings may suggest thoracic outlet compression.

Clinical History :

Clinical details: known high brachial artery bifurcation with aneurysmal degeneration of radial artery origin. Nearly thrombosed in past duplex.

High risk patient with 2 previous aortic valve replacements

Specific question to be answered: Have the dimensions of the aneurysm changed? Has it fully thrombosed? If not will have to

US Doppler artery map upper limb Rt :

US Doppler artery map upper limb Rt

Upper limb arteries (RT)

	RIGHT	
	<input type="text"/>	<input type="text"/> mmHg
<hr/>		
Upper Limb Artery Waveforms		
Subclavian artery:	<input type="text"/>	-----
Axillary artery:	<input type="text"/>	-----
Brachial artery:	TP <input type="text"/>	Triphasic pulsatile
Ulnar artery:	TP <input type="text"/>	Triphasic pulsatile
Radial artery:	TP <input type="text"/>	Triphasic pulsatile
<hr/>		
Thoracic Outlet Manoeuvres		
Adson's manoeuvre:	<input type="text"/>	-----
Costoclavicular:	<input type="text"/>	-----
Hyper-abduction:	<input type="text"/>	-----

Comments:

Comments:

Right:

High brachial artery bifurcation at mid humerus level.

Aneurysmal radial artery origin, measures 2cm x 2.3cm in longitudinal view.

The proximal radial artery is thrombosed at humerus level and is filled via collateral from the ulnar artery.

Forearm:

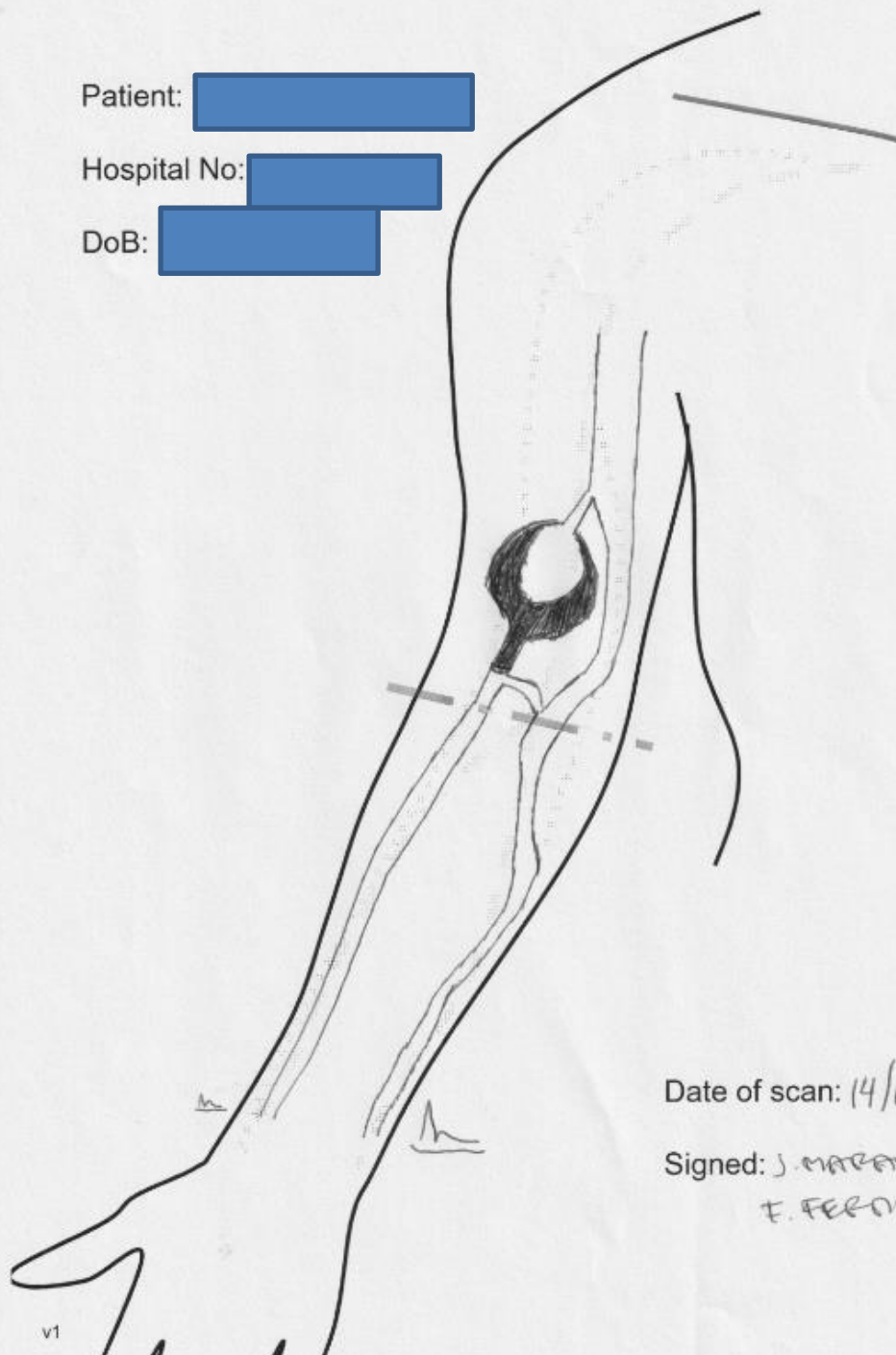
Ulnar artery is patent throughout with no evidence of stenosis, distal PSV 0.55m/sec.

Radial artery is patent throughout with no evidence of stenosis, distal PSV 0.15m/sec.

Patient: [REDACTED]

Hospital No: [REDACTED]

DoB: [REDACTED]



Date of scan: 14/12/2018

Signed: J. MARASIKAN
E. FERNANDES

Clinical History :

TCI for right carotid-axillary bypass graft cutdown & graft angioplasty for right brachial occlusion on 04-Sep-2018 at 14:55)

US Doppler artery map upper limb Rt

Upper limb arteries (RT)

		RIGHT	
	0	0	mmHg
<hr/>			
Upper Limb Artery Waveforms			
Subclavian artery:	-		-----
Axillary artery:	MP		monophasic pulsatile
Brachial artery:	-		-----
Ulnar artery:	M		monophasic
Radial artery:	M		monophasic
<hr/>			
Thoracic Outlet Manoeuvres			
Adson's manoeuvre:	-		-----
Costoclavicular:	-		-----
Hyper-abduction:	-		-----

Comments:

Comments:

The CCA and proximal ICA are patent with normal waveforms and velocities.

The proximal anastomosis is patent, PSV 0.46m/s.

The graft is patent with monophasic pulsatile flow throughout, PSV 0.36m/s - 0.48m/s.

The stented area of the graft is patent, PSV 0.42m/s.

There is ~8x velocity increase detected in the distal anastomosis of the graft (0.38m/sec - 3.0m/sec) indicative of >75% stenosis.

The axillary vein is patent with no evidence of stenosis, PSV 1.2m/s.

Known distal brachial artery occlusion with reconstitution of flow at proximal radial and ulnar level.

Radial and ulnar arteries are patent at wrist level with monophasic flow, PSV 0.50m/sec and 0.23m/sec respectively.

Please advise vascular lab for next scan appointment.

Clinical History :

Clinical details: post TAVI patient. Alternating RBBB/LBBB, significant difference/changes in BP readings was recorded on both arms this morning

Specific question to be answered: Vascular duplex scan of subclavian artery, to rule out vascular changes - narrowing of vessels

US Doppler artery map upper limb Rt :

Upper limb arteries (RT)

RIGHT		
140	0	mmHg
<hr/>		
Upper Limb Artery Waveforms		
Subclavian artery:	TP	Triphasic pulsatile
Axillary artery:	TP	Triphasic pulsatile
Brachial artery:	TP	Triphasic pulsatile
Ulnar artery:	TP	Triphasic pulsatile
Radial artery:	TP	Triphasic pulsatile
<hr/>		
Thoracic Outlet Manoeuvres		
Adson's manoeuvre:	-	-----
Costoclavicular:	-	-----
Hyper-abduction:	-	-----

Comments:

Comments:

Right:

Subclavian and axillary arteries are patent with triphasic pulsatile waveforms, no evidence of significant stenosis, minor plaque formation noted in the posterior wall of axillary artery however this is not causing significant stenosis.

High brachial artery bifurcation at proximal to mid humerus level, ulnar artery demonstrates triphasic pulsatile waveforms proximally then triphasic hyperaemic distally, PSV 0.49m/sec.

Radial artery not assessed in the forearm due to presence of lines, however radial artery at wrist level is patent with triphasic hyperaemic waveforms, PSV 0.58m/sec.

Upper limb arteries (LT)

LEFT		
110	0	mmHg
<hr/>		
Upper Limb Artery Waveforms		
Subclavian artery:	MP	monophasic pulsatile
Axillary artery:	MP	monophasic pulsatile
Brachial artery:	MP	monophasic pulsatile
Ulnar artery:	MP	monophasic pulsatile
Radial artery:	MP	monophasic pulsatile
<hr/>		
Thoracic Outlet Manoeuvres		
Adson's manoeuvre:	-	-----
Costoclavicular:	-	-----
Hyper-abduction:	-	-----

Comments:

Comments:

Left:

Subclavian, axillary and brachial arteries are patent has monophasic pulsatile waveforms with delayed systolic acceleration time suggestive of more proximal stenosis; however, subclavian artery imaged to origin, no velocity increase where seen; significant stenosis likely anatomically obscured with a collateral flow noted in the proximal CCA.

Retrograde flow detected in the vertebral artery consistent with subclavian steal.

Ulnar artery is the main outflow for the forearm, PSV 0.54m/sec.

Radial artery is small in calibre with monophasic damped waveforms, PSV 0.10m/sec.

REPORT E-72465303

VERIFIED-Attended-27-Nov-2018-MARAJ/MARAJ-27-Nov-2018

Clinical History :

1month post, Right CFA to TPT (vein)
on 01-Nov-2018 at 10:53)

US Graft Surveillance Right :

US Graft Surveillance Right

VERIFIED-Attended-27-Nov-2018-MARAJ/MARAJ-27-Nov-2018

Bypass graft follow-up

FAU interval:	2M	Location:	R CFA-TPT	Type:	VEIN
Best Resting Ankle Pressure	0				mmHg
Brachial systolic Pressure:	0				mmHg
ABPI:	0				mmHg
ABPI Not Measured	-				

Comments:

Inflow:

Increased velocities in CFA however likely <50% stenosis, PSV 2.8m/sec.

Proximal Anastomosis:

Patent with no evidence of significant stenosis.

Graft:

Patent throughout with no evidence of significant stenosis, PSV typically 1.2m/sec to 1.4m/sec.
Increased velocities in proximal graft likely due to calibre mismatch, max PSV 2.2m/sec.

Distal Anastomosis:

Patent with no evidence of significant stenosis.

Run-Off:

Short segment occlusion in the distal PTA; PTA at the ankle level remains patent with monophasic pulsatile waveforms, PSV 0.45m/sec.
DPA is patent with monophasic pulsatile waveforms, PSV 0.48m/sec.
PeroA is patent with monophasic pulsatile waveforms, PSV 0.22m/sec.

Date of next scan

3months time.

Comments:

No significant interval changes.

Clinical History :

Clinical details: Patient had CFA to PTA bypass right leg on 12/12. 4th toe gangrene and other toes dusky - repeat duplex to assess status of graft and perfusion of distal limb

Specific question to be answered: graft patency

US Graft Surveillance Right :

US Graft Surveillance Right

Bypass graft follow-up

	F/U interval:	7DAYS POST	Location:	R CFA-PTA	Type:	VEIN
Best Resting Ankle Pressure		0		mmHg		
Brachial systolic Pressure:		0		mmHg		
ABPI:		0		mmHg		
ABPI Not Measured		-				

Comments:

Inflow:

Unable to visualise the CIA today due to bowel gas.

The EIA and CFA are patent with monophasic pulsatile hyperaemic waveforms and PSV of 1.7m/sec. According to this waveforms, there is possible residual narrowing in the CIA.

Proximal Anastomosis:

Patent with no evidence of stenosis.

Graft:

Patent throughout, with 2-3x velocity increase detected in mid to distal thigh likely due to a valve cusp, PSV 2.7m/sec.

Distal Anastomosis:

Patent with no evidence of stenosis.

Run-Off:

The PTA is patent with monophasic pulsatile hyperaemic and PSV 1.1m/sec distally.

Date of next scan

14/01/2019

Comments:

50-75% stenosis detected within the graft in the mid to distal thigh level likely due to valve cusp.
Good monophasic pulsatile flow in the distal PTA detected.

Clinical History :

Clinical details: 2013 Tx worsening renal function, poor compliance to immunosuppressive therapy

Specific question to be answered: ?stenosis

US Doppler kidney transplant :

US Doppler kidney transplant

Transplant renal artery

Range of Pulsatility Index:

1.7-1.9

Peak Systolic Velocity in Renal Artery:

1.2

m/s

Comments:

Comments:

Transplant kidney is well perfused and seen in the right iliac fossa.

Tortuous transplant renal artery, however no evidence of RAS.

Transplant renal vein is patent.

Right EIA is patent with triphasic pulsatile waveforms.

Right EIV is patent with normal phasic waveforms.

Clinical History :

6months Aorto bifem (iliac)

US Graft Surveillance :

US Graft Surveillance

VERIFIED - Attended-06-Mar-2019 - MARAJ/MARAJ-06-Mar-2019

Bypass graft follow-up

F/U interval:	6M	Location:	AO-BIFEM (ILIAC)	Type:	
Best Resting Ankle Pressure	0			mmHg	
Brachial systolic Pressure:	0			mmHg	
ABPI:	0			mmHg	
ABPI Not Measured	-				

Comments:

Inflow:

No evidence of inflow stenosis.

Proximal Anastomosis:

Patent with no evidence of significant stenosis, biphasic pulsatile waveforms.

Graft:**Graft bifurcation to right and left limb origin is kinked causing 2-3x velocity increase, however distal to this kinked segment is good biphasic pulsatile flow.**

Right limb - PSV typically 0.98m/sec - 1.4m/sec.

Left limb - PSV typically 1.0m/sec - 1.6m/sec.

Distal Anastomosis:

Patent with no evidence of stenosis.

Run-Off:Right:

CFA is patent with biphasic pulsatile waveforms, PSV 1.1m/sec.

PopA is patent with biphasic pulsatile waveforms, PSV 0.36m/sec.

PTA and DPA are patent with biphasic pulsatile waveforms, PSV 0.31m/sec and 0.24m/sec respectively.

Left:

CFA is patent with biphasic pulsatile waveforms, PSV 0.78m/sec.

PopA is patent with monophasic pulsatile waveforms, PSV 0.28m/sec.

PTA and DPA are patent with monophasic pulsatile waveforms, PSV 0.29m/sec and 0.19m/sec respectively.

Date of next scan

04/06/2019.

Comments:**No significant interval change.**

Clinical History :

Right to Left fem-fem crossover using 6mm PTFE graft, 3month post-op
on 12-Oct-2018 at 16:00)

US Graft Surveillance :

US Graft Surveillance

VERIFIED-Attended-12-Nov-2018-MARAJIMARAJ-12-Nov-2018

Bypass graft follow-up

F/U interval:	3M	Location:	R-L FEM XO	Type:	PTFE
Best Resting Ankle Pressure	0				mmHg
Brachial systolic Pressure:	0				mmHg
ABPI:	0				mmHg
ABPI Not Measured	-				

Comments:

Inflow:

As noted in previous scans, increased velocities detected in the EIA with a maximum PSV of 5.06m/s, velocities and visual B-mode appearance suggestive of ~50% stenosis.

Proximal Anastomosis:

Patent with no evidence of stenosis.

Graft:

Patent throughout with PSV ranging from 1.4-1.9m/s.

No evidence of significant stenosis.

Distal Anastomosis:

Patent with no evidence of stenosis.

Run-Off:Left:

CFA, PFA, SFA and PopA are patent with biphasic pulsatile waveforms throughout, no evidence of significant stenosis detected, PSV typically 1.6m/sec - 1.2m/sec.

DPA and PTA are patent with triphasic pulsatile waveforms, PSV 0.43m/sec and 0.87m/sec respectively.

Date of next scan

3months time.

Comments:

No significant interval changes from the previous scan.

Clinical History :

Clinical details: 78 YO lady. Uncronrolled HTN (160 systolic) and CKD. ? Cause

Specific question to be answered: ? RAS

US Doppler renal Both :

US Doppler renal Both

VERIFIED-Attended-31-Oct-2018-MARAJ+FERNF/MARAJ-31-Oct-2018

Native Renal Artery

	RIGHT	LEFT
Kidney Size:	12.8 cm	13.2 cm
Intra Renal RI:	0.86	0.86
Peak Systolic Velocity		
Main RA:	0.55 m/s	1.8 m/s
Aorta (PSV):	1.2 m/s	
Abdominal Aorta Diameter:	1.7 cm	

Comments:

Right:

Kidney is perfused with moderately raised renovascular resistance.

No evidence of RAS.

Renal vein is patent.

Left:

Kidney is perfused with moderately raised renovascular resistance.

~60% stenosis detected in the proximal renal artery.

Renal vein is patent.

Clinical History :

Clinical details: EVAR March 2018. AAA 7.6cm Oct 2018

Specific question to be answered: ?Endoleak,

US EVAR Surveillance :

US EVAR Surveillance

VERIFIED - Attended-14-Mar-2019 - MARAJ+FERNF/MARAJ-14-Mar-2019

EVAR stent patent with good biphasic flow to both right and left EIA.

Right and left limbs of the EVAR overlap to each other but no obvious stenosis or kinking seen.

There was no obvious endoleak found.

The max diameter measured was 7.6cm (but I note pre-op CT was >8cm)

No significant interval change.

Mr. Gambhir e-mailed of the results and patient's appointment.

Clinical History :

Clinical details: Had left Brachio-axillary PTFE graft thrombectomy and balloon angioplasty yesterday. Vascular scan today to review patency.
Specific question to be answered: ? Patency of left Brachio-axillary PTFE graft.

US Doppler for dialysis access :

US Doppler for dialysis access

VERIFIED - Attended-20-Dec-2018 - MARAJ/MARAJ-20-Dec-2018

Dialysis fistula duplex

AV fistula location:	LA	Left arm
Type of AV fistula:	G	Graft
Estimated flow into AV fistula:	850-950	ml/min
Diameter of Vein	0	mm
Outcome:	G	Green

Comments:

Arterial inflow:

No evidence of inflow stenosis.

Graft:

Arterial anastomosis is patent with high velocities, PSV 6.3m/sec, however b-mode imaging suggests no evidence of significant stenosis.
Very short segment of the graft is not imaged due to presence of dressings, however no evidence of haemodynamic changes identified above the unseen segment.

Graft appears patent throughout with no evidence of significant stenosis/residual thrombus.

Venous anastomosis is patent with no evidence of stenosis.

Venous outflow:

Axillary, subclavian and brachiocephalic veins are patent with no evidence of thrombus/scarring.

Comments:

Improved flow post thrombectomy and balloon angioplasty.

Clinical History :

Clinical details: L AV graft

Specific question to be answered: Please review blood flows of AV Graft. Any complications seen?

US Doppler for dialysis access :

US Doppler for dialysis access

VERIFIED-Attended-09-Oct-2018-MARAJ+HICKP/MARAJ-09-Oct-2018

Dialysis fistula duplex

AV fistula location:	LA	Left arm
Type of AV fistula:	G	Graft
Estimated flow into AV fistula:	700-800	ml/min
Diameter of Vein	0	mm
Outcome:	R	Red

Comments:

Arterial inflow:

No evidence of arterial inflow stenosis.

Graft:

Arterial anastomosis is widely patent with no evidence of significant stenosis.

Patent throughout with no evidence of significant stenosis.

Venous anastomosis has significant stenosis as previously seen in the previous report; in today's scan it causes 5.5x velocity increase suggestive of >75% stenosis.

Venous outflow:

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

Comments:

Red flagged due to >25% decrease in volume flow from the previous scan.

Access nurse informed about above findings.