

# Lower limb arterials

Normal calibre aorta measuring 2.2cm AP, calcification noted.

**RIGHT:**

Calcified iliac arteries noted.

CIA and IIA patent with triphasic flow.

>75% stenosis in the proximal EIA, damped monophasic flow distally.

>50% stenosis in the proximal CFA.

There is a large body of dense calcified plaque in the distal CFA, difficult to quantify however velocities indicate +/-50% stenosis.

PFA origin, SFA, PopA and TPT are patent with monophasic flow; calcified SFA noted however no evidence of focal stenosis.

PTA, PerA and ATA are patent with monophasic flow.

**LEFT:**

Calcified iliac arteries noted.

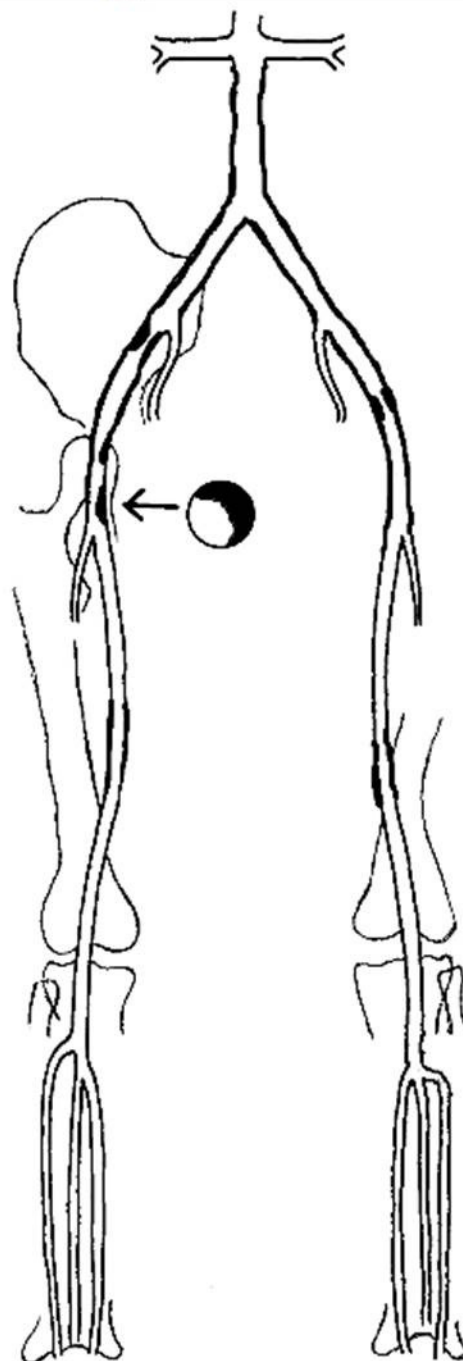
CIA and IIA are patent with triphasic flow.

>50% stenosis in the mid EIA, biphasic flow distally.

CFA, PFA origin, SFA, PopA and TPT are patent with biphasic flow; dense calcified plaque noted in the distal SFA however no evidence of focal stenosis.

PTA, PerA and ATA are patent with biphasic flow; TPT is absent, common ATA/PTA/PerA origin noted.

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LEFT:

Results similar to last scan (29/11/2018).

Aorto-iliac segment not assessed.

CFA and PFA origin are patent with triphasic pulsatile flow. Calcified plaque noted in the CFA, however no evidence of a haemodynamically significant stenosis.

SFA appears patent with triphasic pulsatile flow. As previously reported there are segments of dense calcification, however no evidence to suggest a focal stenosis.

There remains a >50% stenosis in the proximal PopA, monophasic pulsatile flow distally.

Severely calcified tibial arteries noted.

Proximal ATA is patent with triphasic pulsatile flow. Poor views of the mid ATA; ?occluded. Distal ATA is patent with monophasic flow.

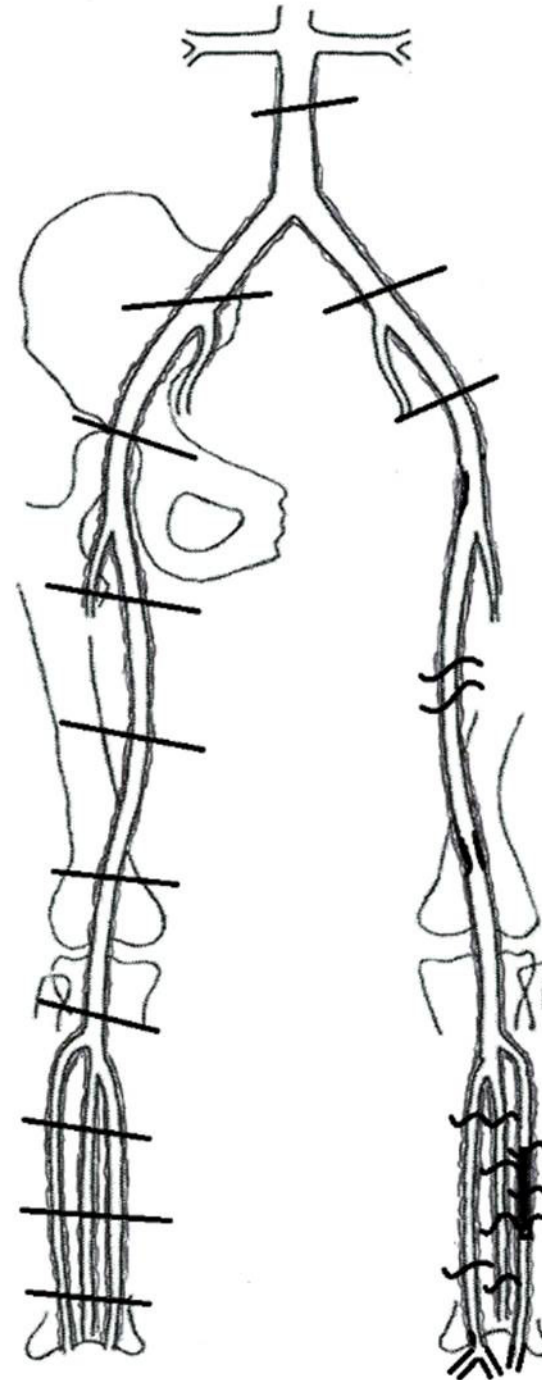
Poor views of the PerA; unable to confirm patency.

Incomplete views of the PTA; appears patent with monophasic flow and diffuse disease noted. >50% stenosis detected at the ankle level.

Medial and lateral plantar arteries are calcified but appear patent with monophasic flow.

DPA is calcified but appears patent with damped monophasic flow detected to the mid foot.

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Normal calibre aorta.

**RIGHT:**

CIA, IIA and EIA are normal calibre and patent with triphasic pulsatile flow.

CFA is patent with triphasic pulsatile flow.

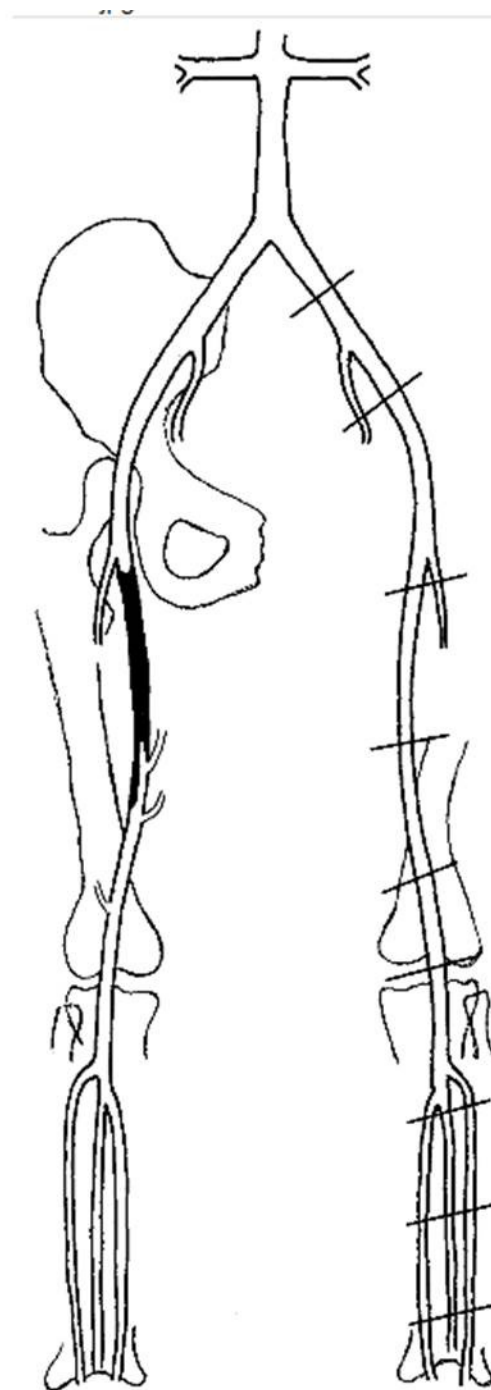
SFA origin is patent for ~1cm, occluded distally. Flow reconstitutes in the distal SFA with damped monophasic flow. Increased velocities noted in the PFA origin, most likely due to SFA occlusion.

PopA and TPT are patent with monophasic pulsatile flow.

ATA, PTA and PerA are patent with monophasic flow.

*Scan observed by Matt Slater.*

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## King's Lynn referral

### LEFT:

Aorto-iliac segment not scanned.

CFA and PFA origin are patent with triphasic pulsatile flow.  
There is a body of dense calcified plaque in the distal CFA,  
however no evidence of a haemodynamically significant stenosis.

SFA, PopA and TPT are patent with triphasic pulsatile flow,  
diffuse disease noted in the PopA.

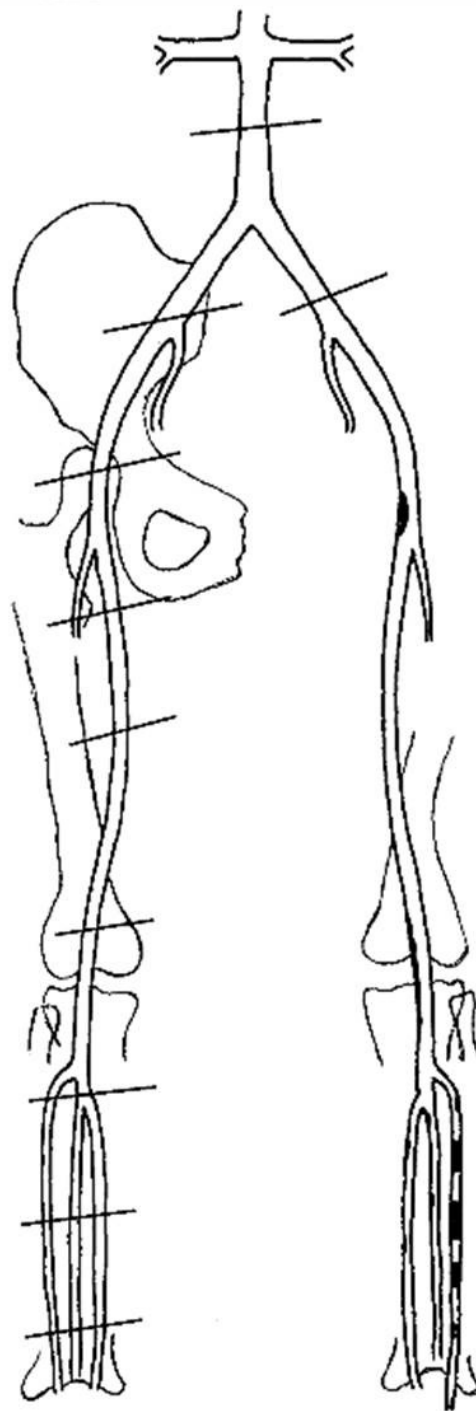
>50% stenosis in the proximal ATA.  
Multiple short mid ATA occlusions.  
>50% stenosis in the distal ATA.  
Damped monophasic flow detected at ankle level.

>50% stenosis at the PerA origin and >50% stenosis in the mid  
PerA, monophasic pulsatile flow detected distally.

>50% stenosis in the proximal PTA and +/-50% stenosis in the  
mid PTA, monophasic pulsatile flow detected distally.

>50% stenosis detected in the mid DPA.

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Normal calibre aorta, measuring 2.0cm AP maximum diameter.

**RIGHT:**

Suboptimal views of the CIA due to depth. CIA, EIA and IIA are patent with triphasic pulsatile flow.

CFA, PFA origin, SFA and TPT are patent with triphasic pulsatile flow.

>50% stenosis in the proximal ATA and >50% stenosis in the distal ATA.

Small calibre PTA noted; suboptimal views proximally, triphasic flow distally.

PerA is patent with triphasic pulsatile flow.

DPA is patent with triphasic pulsatile flow.

**LEFT:**

Suboptimal views of the CIA and IIA due to depth. CIA and EIA are patent with triphasic pulsatile flow.

CFA, PFA origin, SFA and TPT are patent with triphasic pulsatile flow.

>50% stenosis in the mid ATA.

PTA and PerA is patent with triphasic pulsatile flow.

DPA is patent with triphasic pulsatile flow.

*Incidental finding: irregular heart rate noted, technically challenging to quantify stenoses.*

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Incomplete views of the aorta due to depth/overlying bowel gas, normal calibre where seen.

#### RIGHT:

Suboptimal views of the CIA due to depth/overlying bowel gas, however velocities indicate >50% stenosis in the distal CIA.

EIA and IIA are patent with biphasic flow.

CFA, PFA origin, SFA, PopA and TPT are patent with biphasic pulsatile flow. Mild/moderate calcification noted in the SFA and mild plaque noted in the proximal PopA, however no evidence of a haemodynamically significant stenosis.

PTA, PerA and ATA are patent with biphasic pulsatile flow, mild/moderate calcification noted.

#### LEFT:

Suboptimal views of the CIA due to depth/overlying bowel gas, however there is >75% stenosis in the distal CIA.

EIA and IIA appear patent with monophasic flow.

CFA, PFA origin, SFA, PopA and TPT are patent with monophasic pulsatile flow. Mild/moderate calcification noted in the SFA, however no evidence of a haemodynamically significant stenosis.

PTA, PerA and ATA are patent with monophasic flow, mild/moderate calcification noted.

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## BILATERALLY:

Poor views of the aorta and CIA due to body habitus.  
EIA is patent with triphasic pulsatile flow.

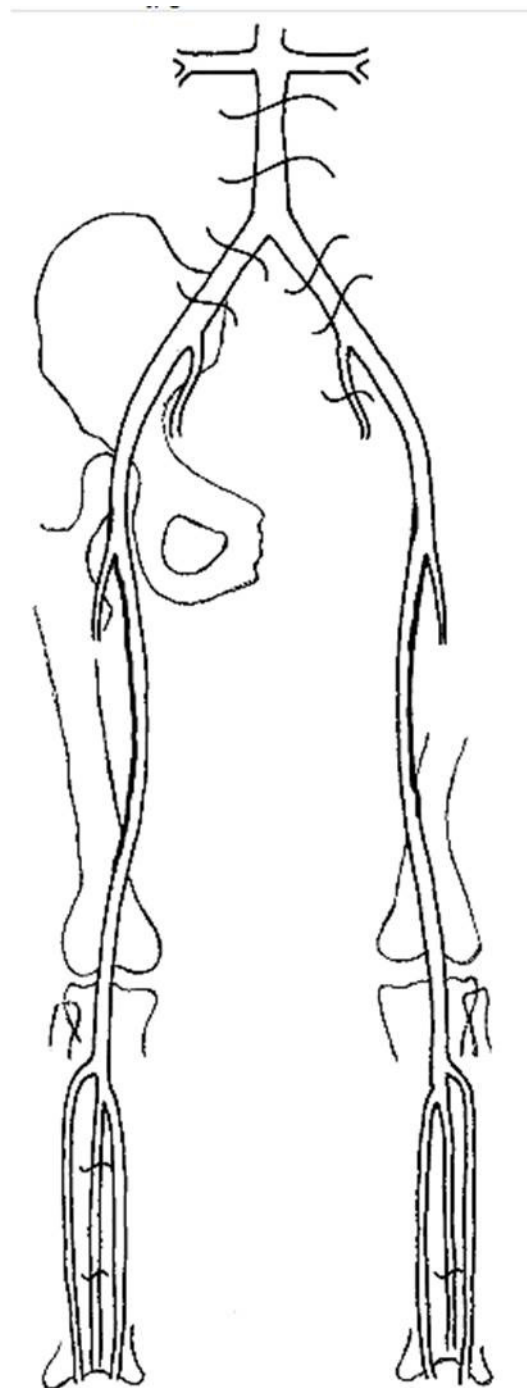
CFA and PFA origin are patent with triphasic pulsatile flow,  
calcified plaque noted in the distal CFA however no evidence of a  
haemodynamically significant stenosis.

Irregular densely calcified SFA, however appears patent with  
triphasic flow and no evidence of a focal stenosis.

PopA is patent with triphasic pulsatile flow.

Moderately calcified tibial arteries noted.  
ATA and PTA are patent with triphasic pulsatile flow.  
Small calibre PerA noted with triphasic flow.

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**Scan performed on the ward.**

**LEFT:**

CFA, SFA and PopA are patent with triphasic pulsatile flow.

ATA is patent with triphasic pulsatile flow.

Poor views of the PTA in the calf due to small calibre/limited patient positioning, however good triphasic pulsatile flow at the ankle level.

*Informal chaperone present (parents).*

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## **BILATERALLY:**

CFA, PFA origin, SFA and PopA are patent with triphasic pulsatile flow, no evidence of stenosis.

High PFA origin noted on the left.

PTA and ATA are patent with triphasic pulsatile flow, no evidence of stenosis.

Suboptimal views of the PerA due to calf oedema, however appears patent with triphasic pulsatile flow.

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**LIMITED SCAN PERFORMED AS REQUESTED.**

**LEFT:**

CFA, PFA origin and SFA not scanned (see report on 11/01/2019).

Proximal PopA is patent with triphasic flow.  
+/-50% stenosis in the distal PopA.  
TPT is patent with triphasic hyperaemic flow.

PerA not scanned.

PTA is patent with triphasic flow to ankle level where it occludes,  
collateral noted.

Medial plantar artery appears patent with monophasic flow  
detected into the forefoot.

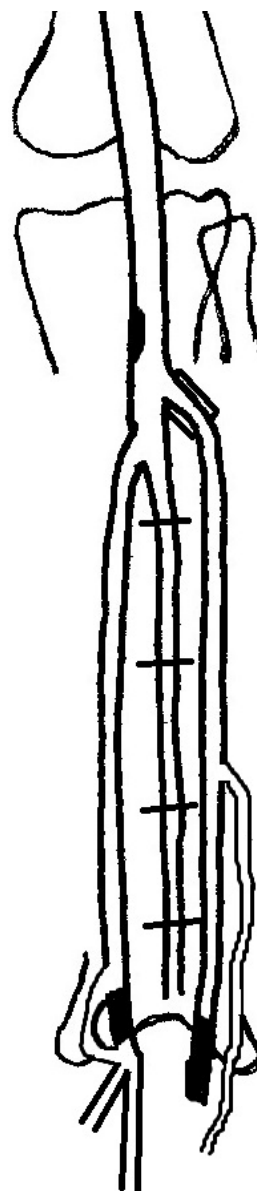
Lateral plantar artery is patent with monophasic flow.

Proximal ATA is patent post-stenting (04/03/2019), triphasic  
hyperaemic flow distally.

DPA is occluded.

There is a lateral collateral from the mid calf which is patent with  
monophasic pulsatile flow detected into the mid foot.

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**LEFT:**

CFA, PFA origin, SFA, PopA and TPT are patent with triphasic pulsatile flow, mild calcification noted.

Crural arteries are moderately/severely calcified.  
Diffuse disease in the mid/distal PTA, triphasic hyperaemic flow distally (most likely due to infection).

PerA and ATA are patent with triphasic hyperaemic flow.

DPA is calcified, monophasic flow detected.

The lateral plantar artery is patent with triphasic hyperaemic flow.  
Small calibre, calcified medial plantar artery, monophasic flow detected.

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Technically challenging scan due to patient movement due to foot pain.

**RIGHT:**

CFA and PFA are patent with triphasic pulsatile flow.

Proximal segment of the SFA is patent with triphasic pulsatile flow.

>75% stenosis in the mid segment.

Distal SFA/PopA stent is patent with damped monophasic flow.

Extensive oedema noted in the calf, calcified crural arteries.

Proximal ATA is patent with damped monophasic flow, occluded distally.

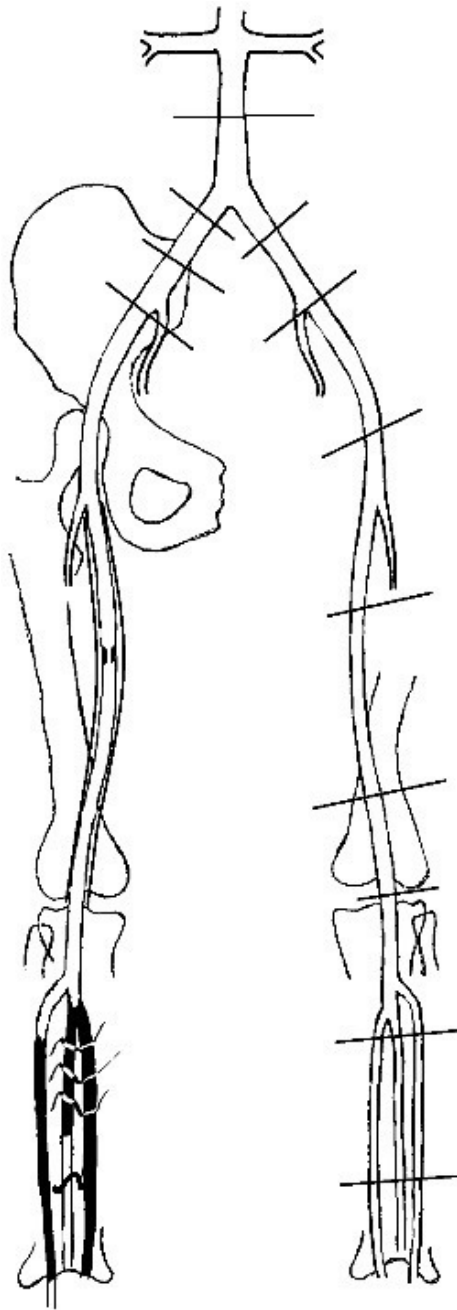
PTA is occluded.

Poor views of the PerA, unable to detect flow.

Damped monophasic flow detected in the DPA, calcified.

*Ms Hildebrand informed of the results by email.*

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**LEFT:**

CFA, PFA origin, SFA, PopA and TPT are patent with triphasic pulsatile flow.

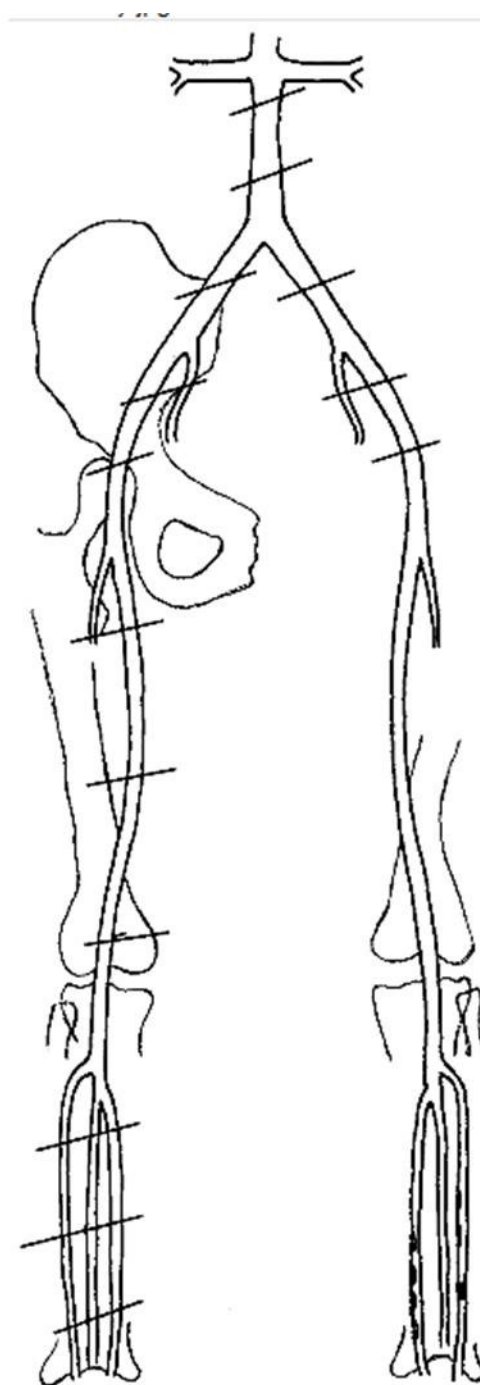
PerA is patent with triphasic pulsatile flow, no evidence of stenosis.

There are two >50% stenoses in the mid ATA and a short occlusion distally.

Distal ATA is patent with biphasic pulsatile flow.

Multiple >50% stenoses in the mid/distal PTA, biphasic pulsatile flow distally.

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**RIGHT:**

Limited scan performed as requested.

Moderate calcification noted throughout.

Incomplete views of the iliac arteries due to limited patient positioning; EIA is patent with triphasic flow and no evidence to suggest focal stenosis.

CFA and PFA are patent with triphasic flow.

Calcified plaque with >50% stenosis at the SFA origin.

**LEFT:**

Moderate calcification noted throughout.

Incomplete views of the iliac arteries due to limited patient positioning; known EIA occlusion, flow reconstitutes in the distal EIA with monophasic flow.

CFA is patent with monophasic flow.

Suboptimal views of the PFA origin, monophasic flow detected.

Calcified plaque with >50% stenosis at the SFA origin.  
Diffuse plaque in the mid/distal SFA, no focal stenosis detected.

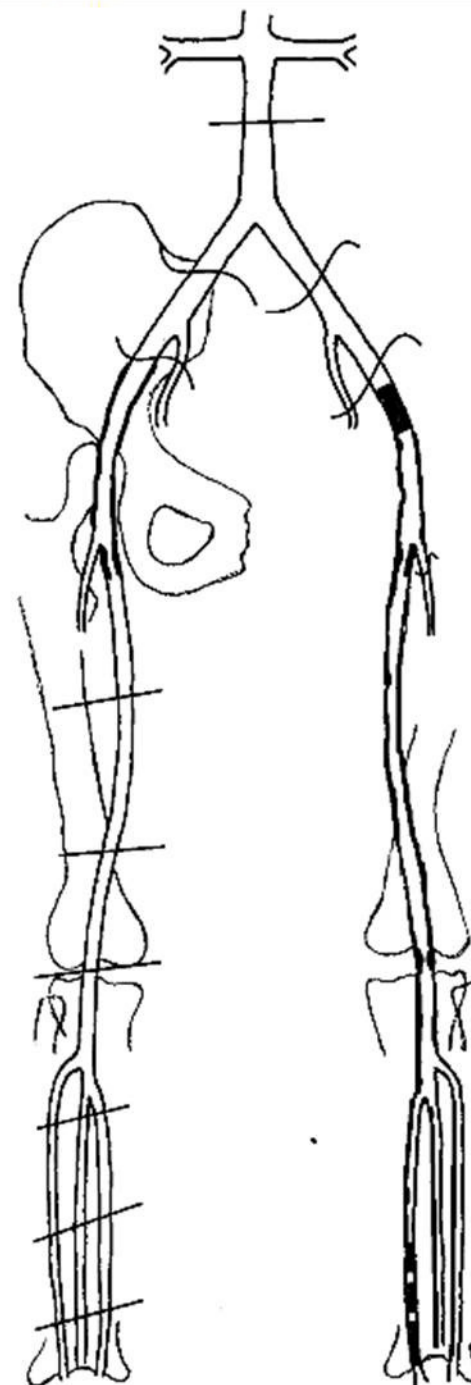
PopA with >50% stenosis in the mid PopA, monophasic flow distally.

ATA is patent with monophasic flow throughout.

>50% stenosis in the proximal PerA, monophasic flow distally.

>50% stenosis in the mid PTA.  
Mid/distal PTA is mostly occluded, monophasic flow detected below ankle level.

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Technically challenging scan as the patient was distressed due to pain, limited patient positioning.

**RIGHT:**

Aorto-iliac segment not scanned.

CFA and PFA origin are patent with triphasic pulsatile flow.

Moderately/severely calcified SFA with >50% stenosis in the mid SFA and >50% distally.

Incomplete views of the proximal PopA due to patient positioning, monophasic flow distally.

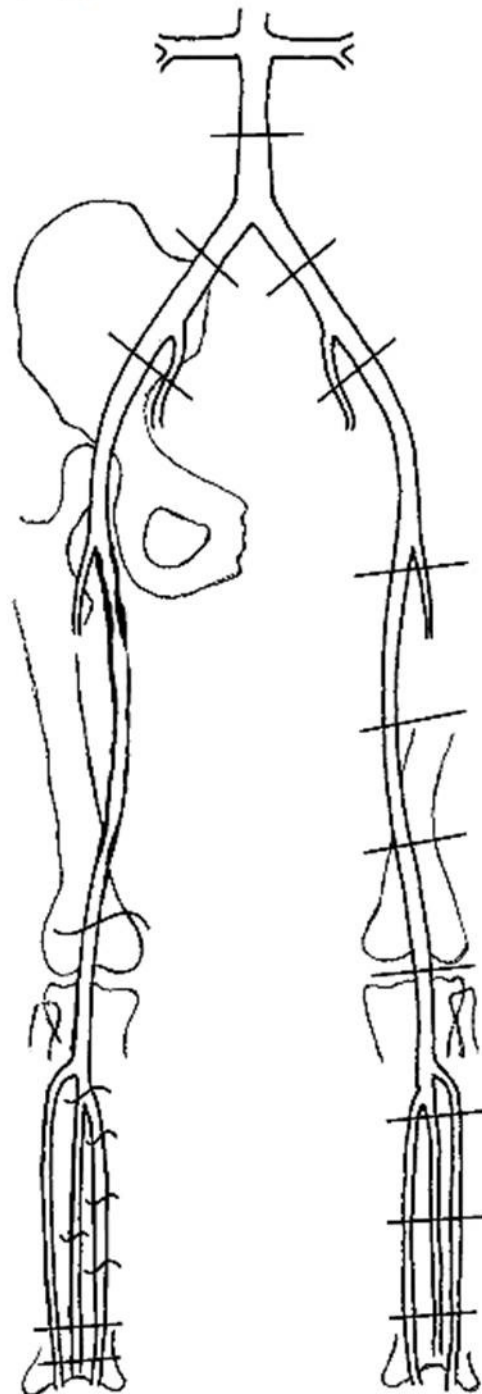
Incomplete views of the TPT, monophasic flow detected.

Proximal/mid ATA is patent with monophasic flow, moderate calcification noted. Distal ATA not scanned as unable to fully remove bandaging.

PTA is densely calcified, unable to detect flow ?occluded.

Suboptimal views of the PerA, however patent with monophasic flow detected where seen.

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Normal calibre aorta, measuring 1.8cm AP maximum diameter.  
Calcification noted.

**RIGHT:**

Arterial spotcheck performed as patient reported symptoms on the left only.

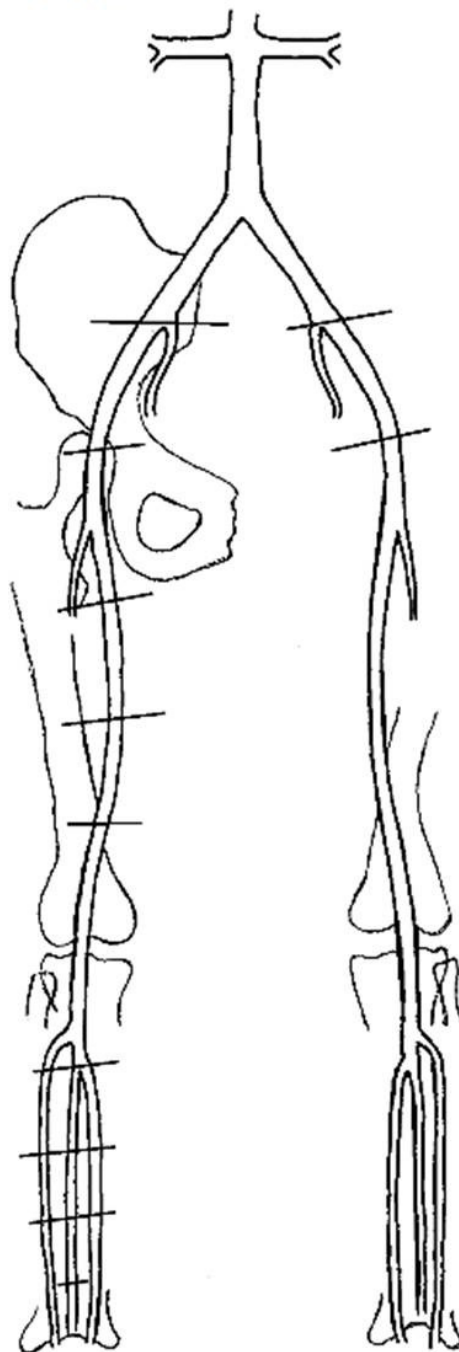
CFA, PopA, distal ATA and distal PTA are patent with triphasic pulsatile flow. Mild/moderate calcification noted.

**LEFT:**

CFA, PFA origin, SFA, PopA and TPT are triphasic pulsatile flow, mild calcification noted.

PTA, PerA and ATA are patent with tri/biphasic pulsatile flow. Moderate calcification noted, no evidence of stenosis.

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**LEFT:**

Aorto-iliac segment not scanned.

CFA and PFA origin are patent with triphasic pulsatile flow.

Proximal/mid SFA is diffusely calcified.

There remains a >50% stenosis in the distal SFA and >75% stenosis at the adductor canal.

Proximal PopA is patent with damped monophasic flow.

+/-50% stenosis in the distal PopA.

New finding of >50% stenosis in the TPT.

New finding of >50% stenosis in the proximal PTA, patent with monophasic distally.

Suboptimal views of the PerA due to calcification, small calibre but patent with damped monophasic flow where seen.

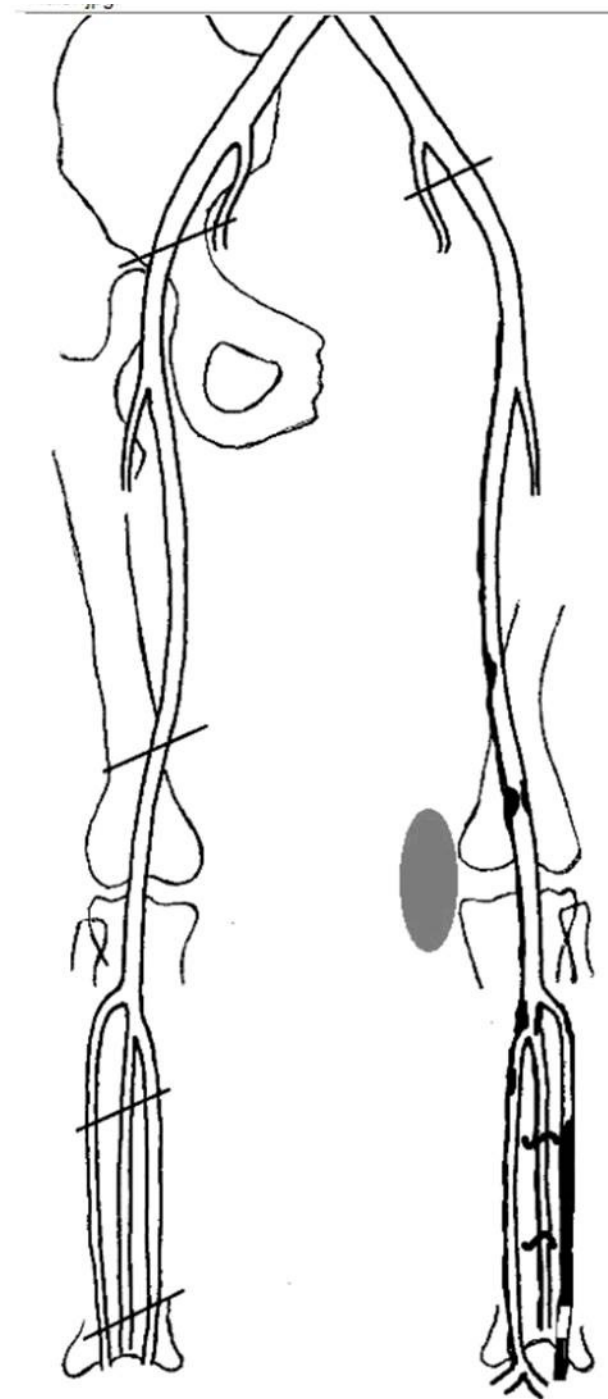
ATA is mostly occluded.

Calcified DPA.

Medial and lateral plantars are patent with monophasic flow.

*Incidental finding: there is a collection of mixed echogenicity measuring ~3.5cm x 1.5cm at the medial popliteal fossa, ?Baker's cyst.*

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**RIGHT:**

**At rest:**

CFA, PFA origin, SFA, PopA and TPT are patent with triphasic pulsatile flow.

Calf arteries not scanned.

Distal ATA and PTA are patent with triphasic pulsatile flow.

**Provoked:**

PopA waveform remained triphasic pulsatile and PSV did not show a haemodynamically significant increase; no evidence of compression of the artery.

**LEFT:**

**At rest:**

CFA, PFA origin, SFA, PopA and TPT are patent with triphasic pulsatile flow.

Calf arteries not scanned.

Distal ATA and PTA are patent with triphasic pulsatile flow.

**Provoked:**

PopA waveform remained triphasic pulsatile and PSV did not show a haemodynamically significant increase; no evidence of compression of the artery.

*Please note: bilateral scan performed as the patient reported symptoms on the right also.*

*Incidental finding: the patient reported a 'lump' at the left groin, enlarged lymph node noted ?cause.*

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Poor views of the aorta due to depth.

#### RIGHT:

Suboptimal views of the iliac arteries due to depth; CIA, EIA and IIA are patent with triphasic pulsatile flow.

CFA, PFA origin, SFA and PopA and TPT are patent with triphasic pulsatile flow; moderate calcification noted, however no evidence of focal stenosis.

As previously reported, high ATA origin noted.

ATA and PTA are moderately calcified but patent with triphasic pulsatile flow, no evidence of stenosis.

PerA is relatively small calibre but appears patent with triphasic pulsatile flow.

#### LEFT:

Poor views of the CIA due to depth.

Suboptimal views of the EIA and IIA, however patent with triphasic pulsatile flow.

Dense calcified plaque in the distal CFA; +/-50% stenosis detected.

PFA origin and SFA are patent with triphasic pulsatile flow. Densely calcified distal SFA, however no evidence of a haemodynamically significant stenosis.

>50% stenosis in the distal PopA.

Poor views of the ATA origin. ATA is moderately calcified with triphasic flow.

PTA and proximal PerA are patent with triphasic flow.

Medial and lateral plantar arteries are patent with triphasic flow.

Proximal DPA is patent, however high resistant reduced velocity flow detected. Densely calcified distally, ?occluded.

*Please note: dressings removed from the left foot for the scan, loosely bandaged to enable patient to return to ward.*



**RIGHT:**

CFA, PFA origin, SFA, PopA, TPT, PTA and ATA are patent with triphasic pulsatile flow, no evidence of stenosis.

Incomplete views of the PerA due to oedema, however triphasic pulsatile distally is not suggestive of stenosis.

DPA is patent with triphasic pulsatile flow.

Unable to scan plantar arteries due to ulceration.

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Aorto-iliac segment not scanned.

**RIGHT:**

CFA, PFA origin, SFA and PopA are patent with triphasic pulsatile flow, diffuse plaque noted however no evidence of focal stenosis.

Poor views of the tibial arteries due to calcification and extensive calf oedema.

There are at least two >50% stenoses in the mid ATA, monophasic flow detected distally.  
Calcified DPA.

Proximal PTA appears patent with triphasic flow.  
Dense calcified plaque in the distal PTA, likely tight stenosis/occlusion as severely damped monophasic flow detected below ankle.  
Poor views of the plantar arteries.

Poor views of the PerA.

**LEFT:**

CFA, PFA origin, SFA and PopA are patent with triphasic pulsatile flow, diffuse plaque noted however no evidence of focal stenosis.

Poor views of the tibial arteries due to calcification and extensive calf oedema.

ATA appears patent proximally with triphasic flow.  
Dense calcified plaque in the distal ATA, likely tight stenosis/occlusion as damped monophasic flow detected in the DPA.

Proximal PTA appears patent with triphasic flow.  
Dense calcified plaque in the distal PTA, likely stenosis/occlusion as damped monophasic flow detected distally.  
Medial plantar artery is patent with damped monophasic flow.  
Poor views of the lateral plantar artery.

Poor views of the PerA, triphasic flow detected in the mid PerA.

Results discussed with Ms Hildebrand.

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**RIGHT:**

Aorto-iliac segment not scanned.

CFA, PFA origin and SFA are patent with triphasic pulsatile flow.

>50% stenosis in the proximal PopA, triphasic pulsatile flow distally.

ATA is patent with triphasic pulsatile flow, diffuse disease noted.

There are two +/-50% stenoses in the mid PTA, triphasic flow distally.

Suboptimal views of the PerA due to depth, however patent with triphasic pulsatile flow where seen.

DPA is widely patent with triphasic pulsatile flow into the forefoot.

Medial plantar artery is patent with triphasic pulsatile flow.

Poor views of the lateral plantar artery.

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**LEFT:**

**Limited scan performed as requested.**

Triphasic pulsatile flow detected in the CFA.

PFA/SFA not scanned.

PopA is patent with triphasic flow.

Incomplete views of the calcified TPT, however increased velocities detected in the distal segment are indicative of >50% stenosis.

Known PTA and PerA occlusions.

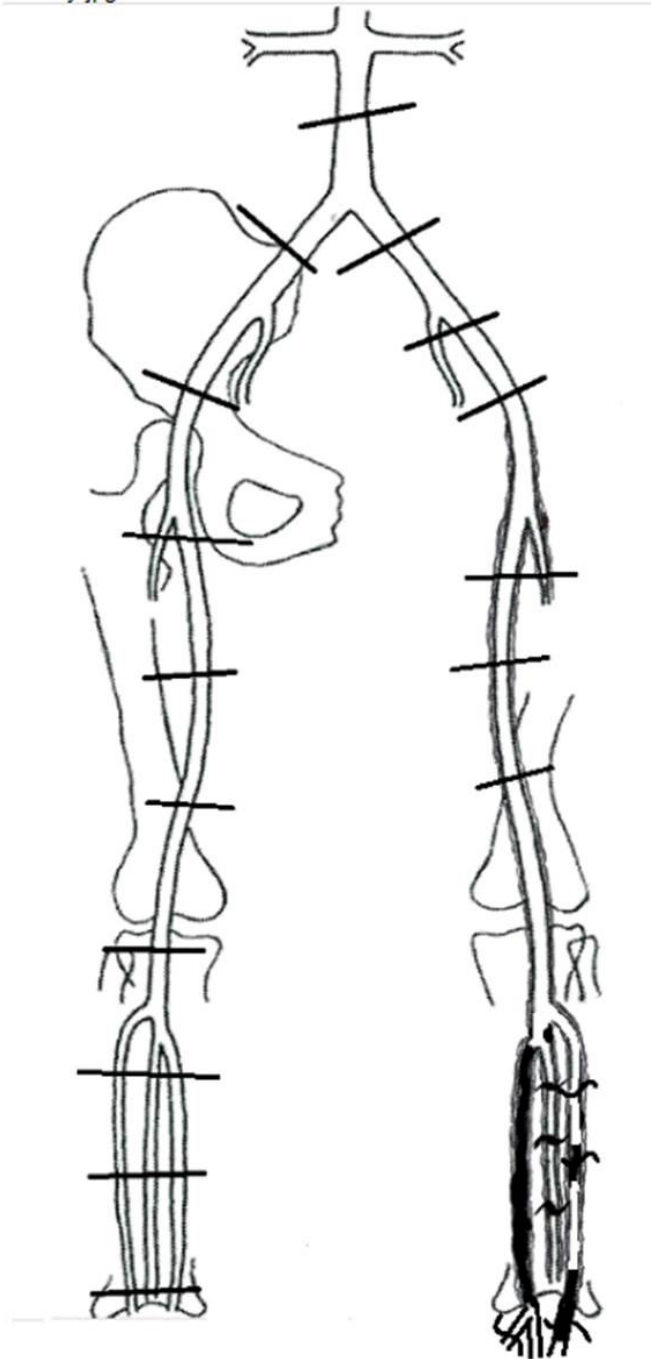
Proximal ATA is patent with triphasic flow.  
Incomplete views of the mid and distal ATA due to dense calcification, likely at least one short occlusion. Monophasic flow detected distally.

Poor views of the DPA due to dense calcification. Monophasic flow detected at the forefoot.

Poor views of the later plantar artery due to dense calcification.

Medial artery is calcified but appears patent with severely damped monophasic flow detected to the mid arch.

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Aorto-iliac segment not scanned.

**RIGHT:**

CFA, PFA origin, SFA, and PopA are patent with triphasic pulsatile flow, mild calcification noted.

Moderately calcified TPT.

>75% stenosis in the mid ATA, damped monophasic flow distally.

>50% stenosis in the proximal PerA, diffuse disease with biphasic pulsatile flow detected distally.

Proximal PTA is patent with triphasic pulsatile flow, densely calcified mid/distal segment ?occluded. Monophasic flow detected at the ankle level.

**LEFT:**

CFA, PFA origin and proximal SFA are patent with triphasic pulsatile flow, mild calcification noted.

>50% stenosis in the mid SFA.

PopA and TPT are patent with biphasic pulsatile flow.

ATA is moderately/severely calcified with at least two >50% stenosis, monophasic flow distally.

PerA is patent with triphasic pulsatile flow.

>50% stenosis in the proximal PTA, densely calcified mid/distal segment ?occluded. Damped monophasic flow detected at the ankle level.

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