

Vascular lab report
Assessed by: Emily Blake (CVS)

Name	[REDACTED]	Hospital	[REDACTED]	Date of Exams:	29/03/2019
DOB	[REDACTED]	NHS No	[REDACTED]	Ip/Op:	IP
Ref	[REDACTED]	Hospital Site:	UHL		

Clinical Indications: reviewed by acute foot service for ?infected area of L heel. Found no pulses bilaterally in lower limb below popliteal. ?arterial disease. not diabetic

Lower Limb – Arterial Duplex [Both]
**RIGHT LEG:
TRIPHASIC INFLOW**

CFA = Patent, triphasic flow
PFA = Patent, triphasic flow
SFA = >75% mid stenosis with occluded mid to distal SFA
Pop = occluded
TPT = occluded

1 x vessel run-off:

ATA / DP = Patent with damped monophasic flow

PTA = no flow
Peroneal = no flow

**LEFT LEG:
TRIPHASIC INFLOW**

CFA = Patent, triphasic flow
PFA = Patent, triphasic flow

SFA = occluded from mid-thigh
Pop = occluded
TPT = occluded

1 x vessel run-off:

ATA = Patent with damped monophasic flow

PTA = no flow
Peroneal = no flow

**Occlusive vessels contain
lightly echogenic material
suggestive of thrombus ?
embolic event**

RTBPI = no reading
LTBPI = no reading


Black colour fill indicates
occlusion or stenosis



Dashed green line
indicates stent in situ

Report:**RIGHT LEG:**

CFA is patent with triphasic flow (PSV = 0.66m/sec). Diffuse wall calcification / atheroma detected but no significant stenosis.

PFA is patent with triphasic flow, no significant stenosis.

Proximal SFA is diffusely diseased with calcified arterial walls / atheroma but patent with triphasic flow. At ~10cm BGC the SFA remains patent but with damped biphasic flow just proximal to a >75% stenosis. Thereafter the SFA is tightly stenosed for a 1-2cm segment then occludes at mid-thigh level. The SFA at the level of the occlusions contains lightly echogenic material within its lumen ? thrombus ? embolic event. Difficult to ascertain from patient when symptoms started – confused. I note this lady has AF.

POPA, TPT are occluded.

PTA shows no flow ? embolic occlusion (lightly echogenic material noted within the lumen on a background of heavy calcification).

PEROA is heavily calcified ? chronically occluded.

ATA is reconstituted via collateral flow and patent all the way down to the ankle (PSV = distal 0.15m/sec). DPA is patent with damped monophasic flow feeding into the foot (PSV = 0.14m/sec).

LEFT LEG:

CFA is patent with low velocity triphasic flow (PSV = 0.12m/sec). Diffuse wall calcification / atheroma detected but no significant stenosis.

PFA is patent with triphasic flow, no significant stenosis.

Proximal to mid SFA is diffusely diseased with calcified arterial walls / atheroma but patent with triphasic flow (PSV = 0.27m/sec).

SFA is occluded at mid-thigh level. Similar appearances to the right with lightly echogenic material noted within the lumen ? thrombus ? embolic event.

POPA and TPT are occluded.

PTA shows no flow ? embolic occlusion (lightly echogenic material noted within the lumen on a background of heavy calcification).

PEROA is heavily calcified ? chronically occluded.

ATA is reconstituted via collateral flow ? level (unable to assess due to poor views) patency is noted all the way down to the ankle.

DPA is patent with damped monophasic flow feeding into the foot (PSV = 0.08m/sec).

Conclusion:

Right:

>75% mid SFA stenosis with occluded mid to distal SFA, POPA, TPT, PTA and PEROA.

1 x reconstituted run-off vessel (patent ATA / DP).

Left:

Occluded mid to distal SFA, POPA, TPT, PTA and PEROA.

1 x reconstituted run-off vessel (patent ATA / DP).

Appearances are highly suggestive of an embolic event on a background of chronic wall calcification / atheroma.
