

**Vascular lab report**

**Assessed by:** Emily Blake (CVS)

Name: [REDACTED]	Hospital: [REDACTED]	Date of Exams: 22/03/2019
DOB: 1 [REDACTED]	NHS No: [REDACTED]	Ip/Op: OP
Referrer: [REDACTED]	Hospital Site: UHL	

Clinical Indications: SURVEILLANCE

**Left Lower Limb – Stent Surveillance scan – 6 months since previous scan sept'18**

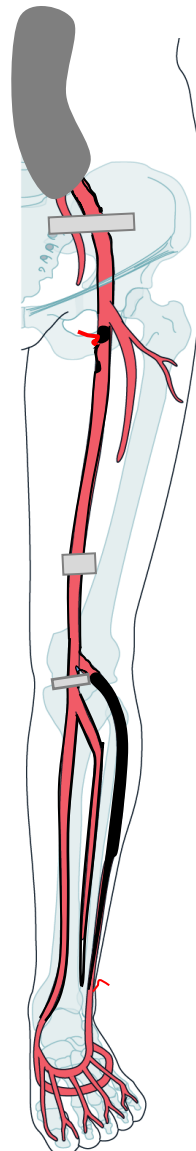
**Inflow vessel = Triphasic**

CFA patent with triphasic flow

Short 1cm length SFA origin occlusion +  
50% proximal SFA stenosis

POP/TPT/PTA/PERO – patent with  
monophasic flow

ATA predominantly occluded with  
reconstitution at ankle.



**LABPI = 0.87**

Black colour fill indicates  
occlusion or stenosis

Dashed green line  
indicates stent in situ

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**Report:**

Aorto-iliacs:

Aorta and Left CIA could not be visualised due to obscuring bowel gas.

The left EIA is patent where seen with triphasic flow. There is a 3cm length of heavy calcific atheroma causing strong acoustic shadowing artefact (signal drop out) but no change in waveform or PSVs distal to this area to suggest significant disease.

CFA and PFA are patent with triphasic flow and no significant stenosis.

Short 1cm length occlusion noted at the origin of the SFA with reformation via collateral flow.

5-7cm BGC there is a 50% stenosis (PSV increase from 0.37m/sec to 0.61m/sec).

The remaining SFA is patent (some obscured adductor segments due to heavy calcification / artefact).

POPA, TPT, PT and PEROA are all patent although diffusely diseased but no significant stenosis detected. Monophasic flow throughout.

ATA origin patent thereafter the ATA occludes with reconstitution at 5cm ALM via collateral flow noted distally at ankle level (PSV = 0.36m/sec).

PEROA = 0.32m/sec.

PTA = 0.24m/sec

ATA = 0.36m/sec

DPA = 0.8m/sec

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**Conclusion:**

Heavy calcification within distal EIA but no significant change in waveform / PSVs distally to suggest significant disease.

Short FA occlusion.

50% proximal FA stenosis.

ATA occlusion with reconstitution via collateral flow.

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