

Vascular lab report
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Referrer: Mr Donati /Nurse Brewer		Hospital Site: UHL

Clinical Indications: bilateral leg pains, worse on incline ? pad . smoker, af

Lower Limb – Arterial Duplex [Both] – Diseased

Abdominal Aorta diameter = 2.2cm max AP
1.9cm distal LT CIA aneurysm.

RIGHT LEG:

CIA (1.2cm diameter), IIA orig, EIA = Patent with tri/biphasic

CFA, PFA, SFA = Patent, Triphasic

Pop = mid >75% stenosis

TPT = Patent - Monophasic

Run off:

ATA = Short distal occlusion and 50-75% stenosis.

PTA = chronically occluded.

Peroneal = widely Patent – monophasic

LEFT LEG:

CIA, IIA orig, EIA = Patent with tri/biphasic

CFA, PFA, SFA, Pop = Patent, triphasic

TPT = 50% origin stenosis

Run off:

ATA = >75% proximal stenosis 10cm BK

PTA = chronically occluded with reconstitution distally via collateral flow (triphasic flow feeding into the foot).

Peroneal = Widely Patent with Triphasic

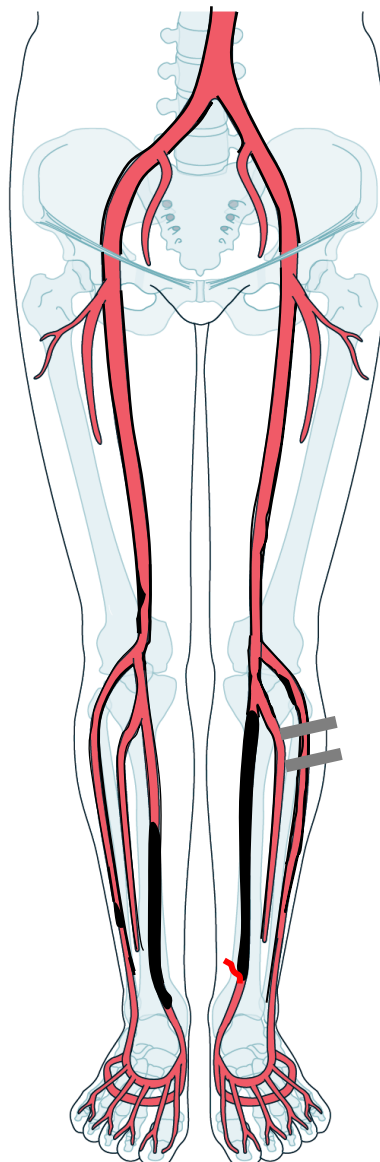
Interpretation of resting toe brachial pressure indices (TBPI)


Resting TBPI	Severity of disease
>0.7	Normal arterial supply
0.64 – 0.7	Borderline
<0.64	Significant PAD present


Left brachial systolic pressure:
140mmHg


Great toe pressure: 104mmHg


Great toe pressure: 42mmHg


RTBPI = 0.3
LTBPI = 0.7


 Black colour fill indicates stenosis or occlusion

 Grey and white texture indicates calcified plaque

 Grey dotted line indicates medial wall calcification

 Grey box indicates acoustic shadowing from calcification

 Dashed green line indicates stent in situ

Report:

Abdominal aorta is patent and normal in calibre. Left small 1.9cm distal CIA aneurysm. The right and left iliac arteries are all patent where seen, no haemodynamically significant stenosis.

Right leg:

CFA, PFA origin and SFA patent with triphasic flow. Diffuse atheroma noted but no haemodynamically significant stenosis.

>75% tight mid POPA stenosis with soft atheroma (PSV increase from 0.13m/sec to 5.46m/sec). Flow distally is damped and monophasic.

TPT and PEROA are patent with monophasic flow. PEROA distal PSV = 0.27m/sec.

Proximal to mid PTA patent. Mid to distal PTA chronically occluded.

Short ATA occlusion at 15cm ALM (0.5cm length) with 50-75% upper end stenosis distally (PSV increase from 0.21m/sec to 0.80m/sec). Distal ATA PSV = 0.72m/sec.

DPA is patent (PSV = 0.33m/sec).

Left leg:

CFA, PFA origin, SFA and POPA are patent with triphasic flow. Diffuse atheroma noted but no haemodynamically significant stenosis.

50% TPT origin stenosis (PSV increase from 0.48m/sec to 1.0m/sec).

>75% ATA stenosis ~ 10cm BK (PSV increase from 0.46m/sec to 3.73m/sec). Distal ATA PSV = 0.43m/sec. DPA is patent (PSV = 0.38m/sec).

Widely patent PEROA with triphasic flow distally (PSV = 0.83m/sec). No significant stenosis.

PTA is chronically occluded 1cm distal to its origin with reconstitution via collateral flow at 5cm AMM – triphasic flow feeding into the foot (PSV = 0.57m/sec).

Conclusion:

No significant aorto-iliac disease. Triphasic inflow to legs.

Right leg:

>75% tight mid POPA stenosis with damped monophasic flow thereafter.

Short distal ATA occlusion and 50-75% stenosis.

Mid to distal chronically occluded PTA.

Left leg:

No sig FEM-POP disease.

50%TPT origin stenosis.

3 x vessel run-off with 1 x vessel reformed via good triphasic collateral flow.

>75% ATA stenosis.

Chronically occluded PTA with reconstitution distally.



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