



**VASCULAR LAB REPORT**

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

**Name:** [REDACTED]

**Hospital No:** [REDACTED]  
**Patients DOB:** [REDACTED]

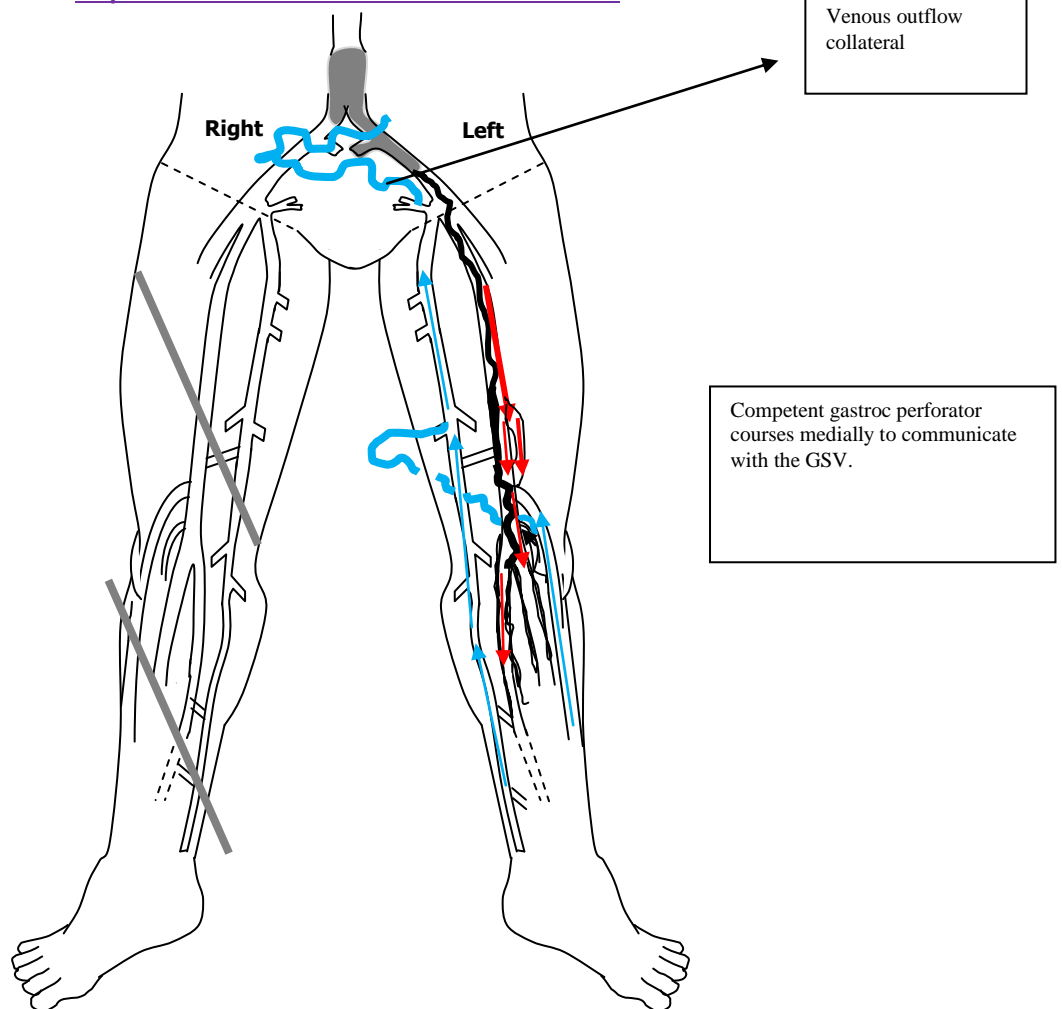
**Consultant:** [REDACTED]

**Date of Exam:** 04/01/2019

**Outpatient/Inpatient:** OP

**Clinical Indications:** LT LEG DVT 25 years ago still swelling of leg.

**Duplex Examination of the Lower Limb Veins**



**ABDOMEN:**

There is well-developed venous collateral measuring 5.8mm arising from the level of the SFJ; this vein tracks onto the lower abdomen and courses over to the right of the mid-line and back over onto the left lower abdo – unable to trace any further due to poor views / tiny calibre. Proximal abdominal IVC is patent with spontaneous phasic flow detected. No evidence of

thrombus. The remaining IVC and iliac veins could not be assessed due to overlying bowel.

The distal External iliac vein contains chronic linear strands of scarring consistent with previous DVT episode.

#### LEFT LEG:

##### **DEEP VEINS:**

There is normal phasic, spontaneous flow in the distal External iliac / common femoral vein, indicative of no occlusive proximal venous disease.

Patent and compressible Common Femoral, Superficial Femoral, Popliteal and Gastrocnemius veins however these veins contain linear strands of echogenic scarring throughout with significant low velocity reflux all in-keeping with chronic sequel DVT.

Posterior Tibial and Peroneal veins are patent however the PTVs show filling defects along the walls with evidence of reflux. No evidence of acute DVT. Difficult to assess the PEROVs for chronic DVT due to depth of vessels however there is evidence of filling defects along the walls in-keeping with chronic DVT.

##### **SUPERFICIAL VEINS:**

The GSV (d=4mm) and SSV are patent and compressible throughout, no evidence of acute or chronic thrombus. No venous incompetence to note.

#### CONCLUSION:

No evidence of acute DVT within the left lower limb.

Chronic sequel DVT noted within the distal EIV, CFV, FV, POPV, GASTROC and proximal PTV/PEROVs with evidence of significant reflux throughout.

Venous outflow collateral noted at the level of the SFJ.

(Widely patent competent gastroc perforator).

No superficial incompetence.