NHS Number: 6\*\*\*\*\*\*\*\*6  
Referring Doctor: DEAN GODFREY ADG  
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**19B\*\*\*\*\*\*6 07/02/2019 US Doppler lower limb arteries Rt**

**19B\*\*\*\*\*\*8 07/02/2019 US Doppler aortoiliac  
19B\*\*\*\*\*\*1 07/02/2019 Doppler Ankle Pressure Measurement (ABPI)**   
  
Clinical History: Right necrotic foot.   
  
\*\*Note patient seen through hot clinic\*\*  
  
**SUMMARY: RIGHT MID-DISTAL SFA OCCLUSION AND POP BK OCCLUSION, AT LEAST 2 VESSEL RUNOFF, ABPI 0.29  
  
\*\*also see diagram\*\***  
  
The aorta was patent and had a maximum AP diameter of 2.0cm. The CIA and EIA on both sides were patent with triphasic signals.  
  
RIGHT LEG: The CFA and PFA origin were patent with triphasic signals.  
  
The proximal SFA was patent with weak triphasic signals. The flow lumen began to reduce on colour Doppler at upper thigh before fully occluding around mid thigh (approximately 14cm from the SFA origin). Refill was observed distally with damped monophasic flow. Length of SFA occlusion was approximately 5cm and it was mid-echodensity disease present.   
  
The popliteal artery was patent and mildly calcified above knee with weak monophasic flow. The popliteal artery occluded at knee with no flow demonstrated below knee. The lumen contained low-echodensity disease and the walls were calcified.  
  
Calf vessels: The ATA and PTA were patent and calcified throughout demonstrating extremely damped and weak flow. The peroneal was difficult to visualise though weak flow was detected at mid calf.  
  
ABPI measurements  
  
Brachial systolic BP (mmHg): Right 140, Left 130  
  
RIGHT:-  
At rest: DP (40) 0.29, damped monophasic; PT (130) \*\*0.93, damped monophasic  
  
\*\*this PT value is not representative of the state of disease as is falsely elevated due to calcification.  
  
LEFT:-  
At rest: DP (more than 220) \*\*more than 1.57, biphasic; PT (220) \*\*1.57, triphasic  
\*\*values indicate incompressible vessels  
  
Janine Fletcher - Vascular scientist

