NHS Number: 4\*\*\*\*\*\*\*\*4  
Referring Doctor: DEAN GODFREY ADG  
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**19B\*\*\*\*\*\*4 26/03/2019 US Doppler lower limb arteries Rt  
19B\*\*\*\*\*\*6 26/03/2019 US Doppler aortoiliac**   
  
Clinical History: Right leg shin trauma 6 months ago. Rest pain ?critical limb ischaemia.  
  
**SUMMARY: SEVERE DISEASE IN RIGHT CFA CAUSING WEAK MONOPHASIC FLOW DOWN TO FOOT  
  
\*\*also see diagram\*\***  
  
The aorta was patent and had a maximum AP diameter of 1.8cm. The left CIA and EIA were patent with triphasic signals. A minor stenosis was observed in the proximal CIA (X2 velocity increase, PSV 266cm/s).  
  
RIGHT SIDE: The CIA and EIA were patent with low-velocity monophasic flow.  
  
The CFA was heavily calcified and this was causing a very tight stenosis. Peak velocities were approaching 700cm/s which corresponds to an increase of X26.  
  
The PFA origin and SFA were patent with damped monophasic signals. A collateral vessel was also noted contributing flow to the SFA origin though there did not appear to be any occlusion.  
  
The popliteal artery was heavily calcified. It was patent proximally and distally with similarly weak, damped flow. No flow was readily detected across the knee indicating possible short occlusion.  
  
Calf vessels: No flow was shown in the tibioperoneal trunk or peroneal artery. The PTA was patent from upper calf to the distal end; it was calcified with very damped flow. Highly damped flow was demonstrated in the proximal ATA, which was small and calcified. No significant amount of flow was seen in the distal part of the ATA.  
  
Janine Fletcher - Vascular scientist

