NHS Number: 4\*\*\*\*\*\*\*\*6  
Referring Doctor: JAMES METCALFE  
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**19B\*\*\*\*\*\*6 11/04/2019 US Doppler lower limb arteries Both  
19B\*\*\*\*\*\*7 11/04/2019 US Doppler aortoiliac**   
  
Clinical History: Bilateral CLI with ulceration and rest pain.  
  
**SUMMARY: RIGHT DISTAL CFA AND SFA OCCLUSION, LEFT CFA TIGHT STENOSIS, CALF VESSEL DISEASE BILATERALLY  
  
\*\*also see diagram\*\***  
  
The aorta was patent and mildly calcified with a maximum AP diameter of 2.2cm. The CIA and EIA on both sides were patent with strong monophasic flow. Only minor disease was seen with no obvious stenoses.  
  
RIGHT LEG: The proximal part of the CFA was patent however the distal end was heavily diseased and no flow was detected. A collateral branch was shown filling the PFA origin while the SFA was occluded from origin. Refill was observed at the distal end of the SFA going into the proximal popliteal artery. The vessel was of good calibre at this point, as was the remainder of the popliteal artery, which was patent with damped monophasic signals and minor disease.   
  
Calf vessels: The tibioperoneal trunk, PTA and peroneal artery were occluded. The ATA was patent with low-velocity damped flow down to just above ankle then it occluded distally with flow going into a large collateral.   
  
LEFT LEG: The CFA was patent and heeavily calcified, which was causing a tight stenosis of X8 velocity increase (PSV 420cm/s) at the distal end. The PFA origin and SFA were patent with monophasic signals. Mild disease was seen throughout the SFA and there was a minor stenosis proximally (X2 velocity increase, 155cm/s).  
  
The popliteal artery was patent with significant calcified plaque at knee level but no significant stenoses. Doppler signals were monophasic.  
  
Calf vessels: Both the PTA and ATA demonstrated monophasic flow down to around mid calf then were occluded distally with prominent collateral vessels observed. The peroneal artery was not clearly identified.  
  
Janine Fletcher - Vascular scientist

