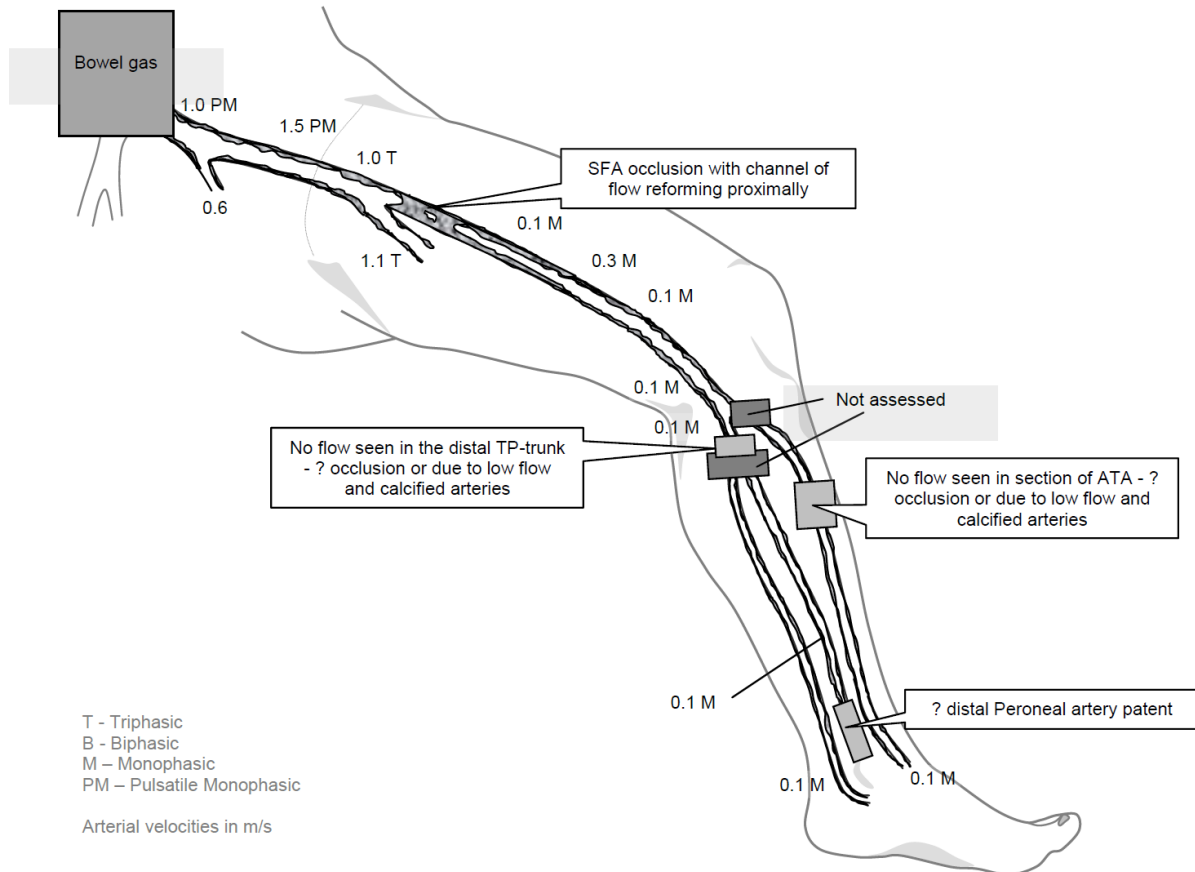


Patient:
 CHI:
 Date of Scan: 26.11.2019
 Referring Consultant: Mr O Falah
 Clinical Indication: Urgent inpatient, ward 206
 left ischaemic foot, ? embolic, known AF

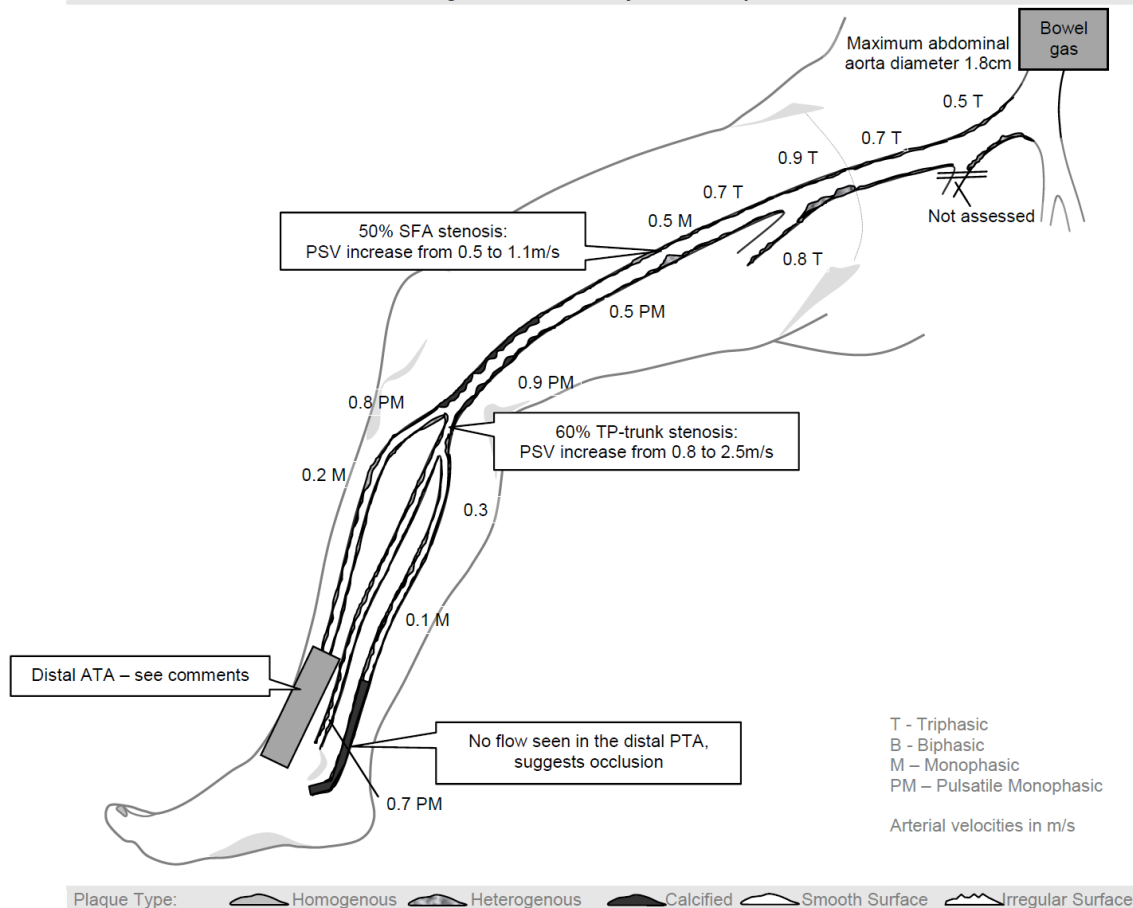
Left Lower Extremity Arterial Duplex



Plaque Type:	Homogenous	Heterogenous	Calcified	Smooth Surface	Irregular Surface
LEFT Aorto-iliacs:	Abdominal aorta and proximal CIA not assessed due to bowel gas. Distal CIA, IIA origin and EIA patent with <50% disease.				
LEFT CFA:	CFA patent with calcified atheroma, disease <50%.				
LEFT SFA:	SFA occludes 0.5cm below the SFA origin. Some retrograde recanalisation noted in the proximal SFA. Patent channel of antegrade flow (channel diameter approx 2mm, SFA diameter approx 5-6mm) noted in the SFA from proximal to mid thigh. Distal SFA patent with diffuse calcified atheroma and damped flow.				
LEFT PopA:	Popliteal artery patent with diffuse calcified atheroma throughout and low damped flow – difficult to grade disease.				
LEFT crurals:	Difficult assessment of the crural arteries due to heavy calcification and patient position - PTA origin, peroneal artery origin ATA origin not assessed. No flow seen in the distal TP-trunk and a section of the proximal ATA - ? occlusions or due to low flow and calcified arteries. Remaining crural arteries appear patent, heavily calcified, with very low damped flow, although views of the distal peroneal artery were very poor (? distal peroneal artery patent).				
Scanned by:	Beth Ness, Clinical Vascular Scientist.				

Patient:
 CHI:
 Date of Scan: 26.11.2019
 Referring Consultant: Mr R Jamieson
 Clinical Indication: Urgent inpatient, ward 105
 R leg swollen and hot, ? poor supply to foot ?

Right Lower Extremity Arterial Duplex



RIGHT Aorto-iliacs: Aorta not scanned at diaphragm due to bowel gas. Remaining abdominal aorta, CIA and EIA patent with no significant disease. IIA origin not assessed.

RIGHT CFA: CFA patent with a large calcified plaque but no elevated velocities – disease <50%.

RIGHT SFA: SFA patent, calcified, with a 50% stenosis in the proximal/mid thigh.

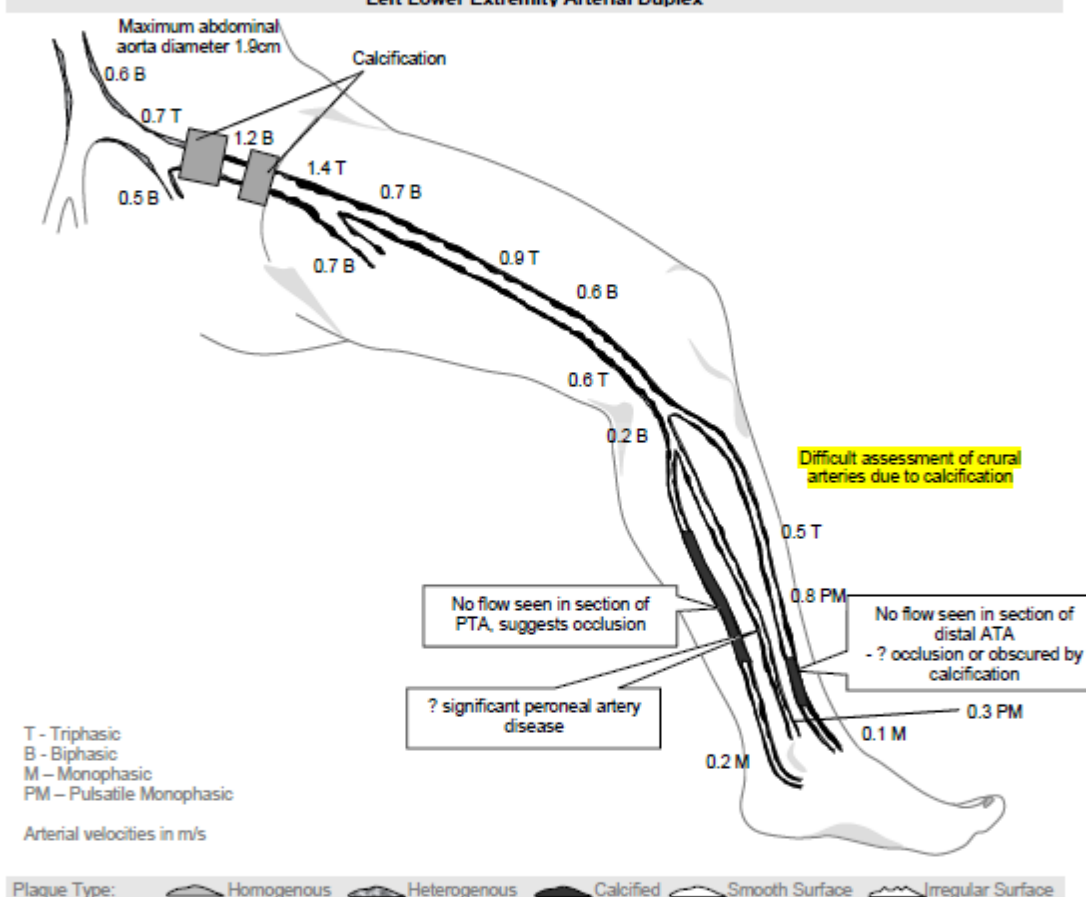
RIGHT PopA: Popliteal artery patent with diffuse heavily calcified atheroma throughout – disease <50%.

RIGHT crurals: Difficult assessment of the crural arteries – vessels heavily calcified. TP-trunk patent with elevated velocities proximally, suggesting 60% stenosis. Peroneal artery patent with no clear evidence of significant disease, but very poor views distally. No flow seen in the distal PTA, suggests occlusion. Very difficult assessment of the distal ATA due to calcification. Focal elevated velocities in the distal ATA suggest multiple stenoses: >95% (PSV increase from 0.2 to 2.2m/s), 80-85% (PSV increase from 0.2 to 1.3m/s) and 50% (PSV increase from 0.5 to 1.1m/s), however, the focal elevated velocities may represent collateral vessel communication. Cannot rule out short occlusion in the distal ATA.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 26.11.2019
 Referring Consultant: Mr A Tambyraja
 Clinical Indication: Urgent inpatient, ward 105
 Necrotic left 2 - 5th toes. Previous L infrapopliteal angio 8/11/19 and L popliteal angio 18/11/19.
 Intra-procedural thrombosis within popliteal artery. Ongoing necrosis of left toes. many thanks.

Left Lower Extremity Arterial Duplex



LEFT Aorto-Iliacs: Slightly poor views of the abdomen due to bowel gas. Only short section of EIA assessed as majority of EIA obscured by calcification. Biphasic flow noted in section of EIA assessed. Abdominal aorta, CIA and IIA origin patent with no clear evidence of significant disease.

LEFT CFA- PopA: CFA, SFA and popliteal artery patent, densely calcified, with <50% disease.

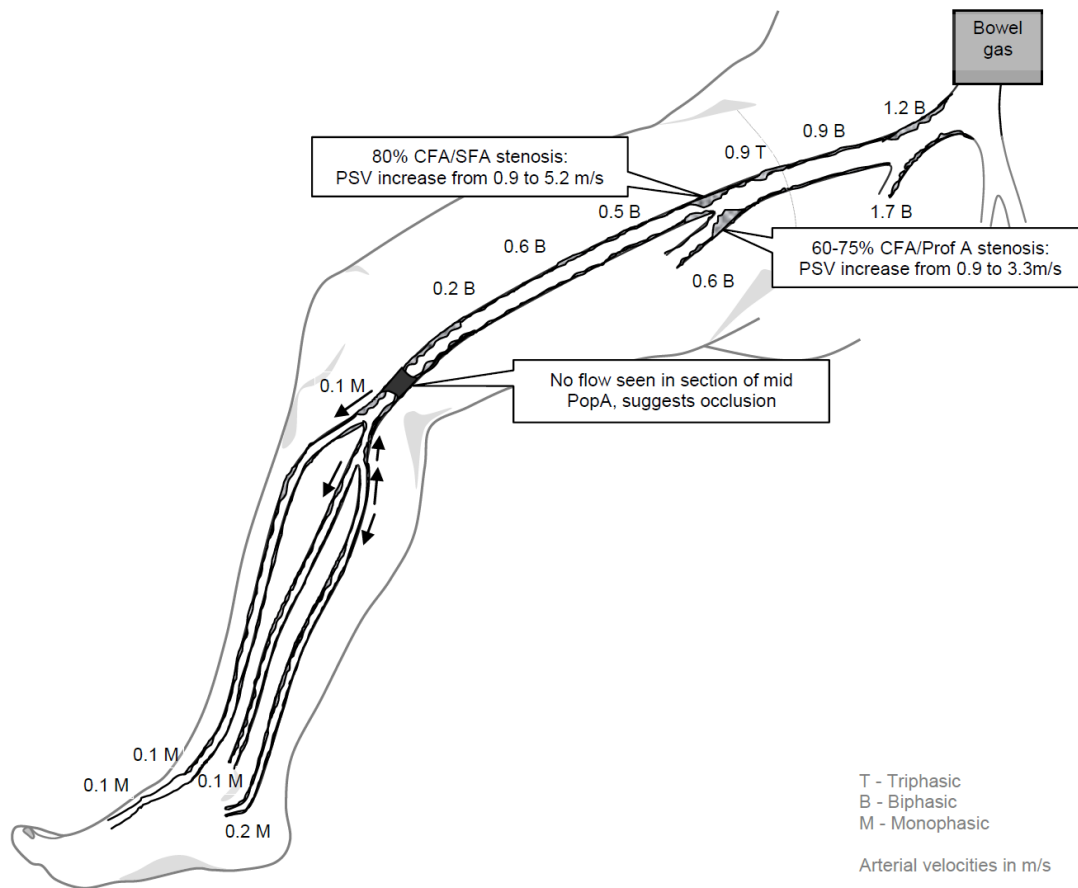
LEFT CRUALS: Crural arteries densely calcified - difficult assessment. No flow seen in the PTA from proximal to distal calf, suggests occlusion. No flow seen in section of distal ATA - ? occlusion or flow obscured by calcification. Peroneal artery appears patent with low velocities distally - ? significant peroneal artery disease. TP-trunk appears patent with <50% disease.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
CHI:
Date of Scan: 28.11.2019

Referring Consultant: Mr R Chalmers
Clinical Indication: Short dist right calf and thigh claudication with known CFA stenosis ?? change from previous scan (if not for surgery).

Right Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

RIGHT Aorto-iliacs: Distal aorta patent with no significant disease, remaining abdominal aorta not assessed due to bowel gas. Unable to assess abdominal aorta diameter. CIA, EIA and IIA origin patent with <50%.

RIGHT CFA/SFA/PFA: CFA patent with diffuse calcified atheroma. Mid to distal CFA disease <50%. 80% distal CFA/SFA origin stenosis. Remaining SFA patent with diffuse atheroma, disease <50%. 60-75% distal CFA/Profunda origin stenosis. Profunda artery origin divides into two branches approx 1.5cm below the Profunda artery origin.

RIGHT PopA: No flow seen in section of mid popliteal artery, suggests occlusion – difficult to assess due to heavy calcification at this level. Occlusion length approx 3cm. Remaining popliteal artery patent with diffuse calcified atheroma and low flow.

RIGHT crurals: Crural arteries calcified. TP-trunk appears patent (difficult assessment) with retrograde flow. PTA patent with retrograde flow noted at the PTA origin, antegrade flow reforms 2cm below the PTA origin. Remaining crural arteries patent with <50% disease.

Scanned by: Beth Ness, Clinical Vascular Scientist.

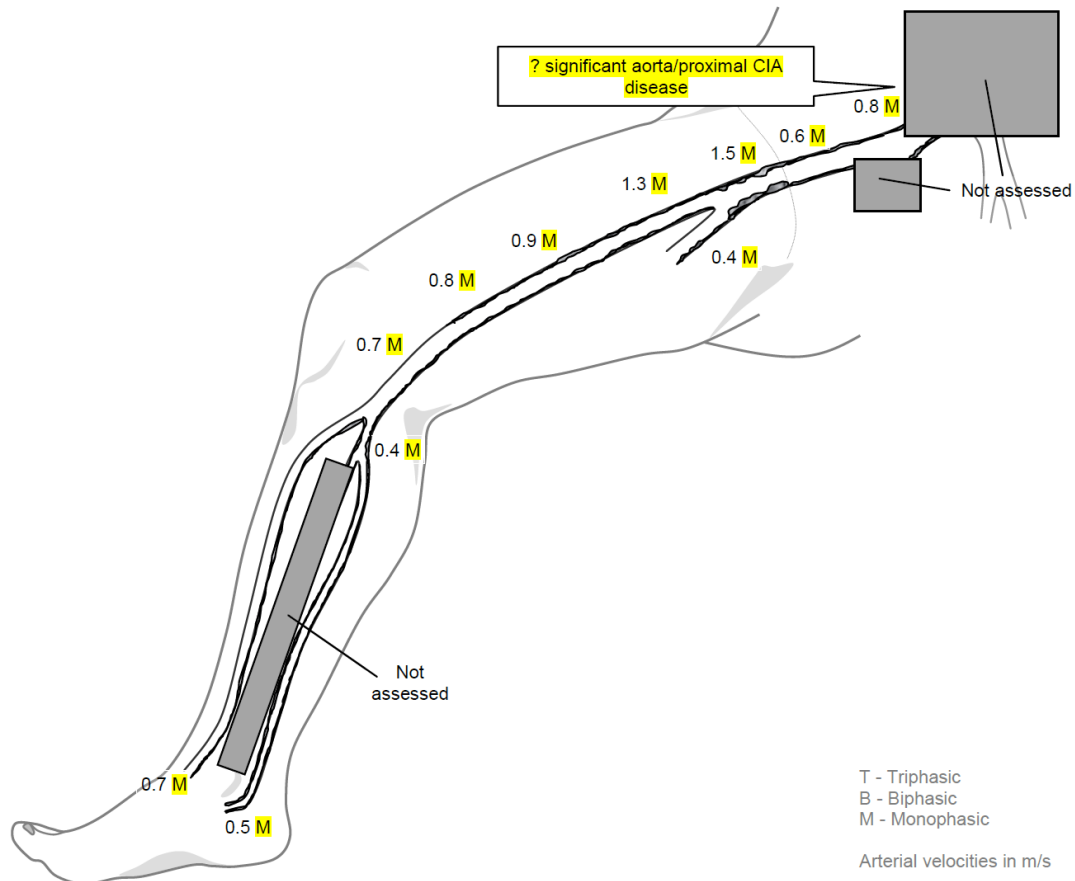
Patient:
CHI:
Date of Scan: 28.11.2019

Referring Consultant: Mr O Falah

Urgent outpatient

Clinical Indication: Dusky second toe, peripheral pulses (DP PT popliteal femoral) all palpable but smoking history and dusky toe, ? arterial disease

Right Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

RIGHT Aorto-iliacs: Abdominal aorta, proximal CIA and IIA origin not assessed due to patient build (high BMI). Distal CIA and EIA patent with damped monophasic flow - ? significant aorta/proximal CIA disease (? further imaging).

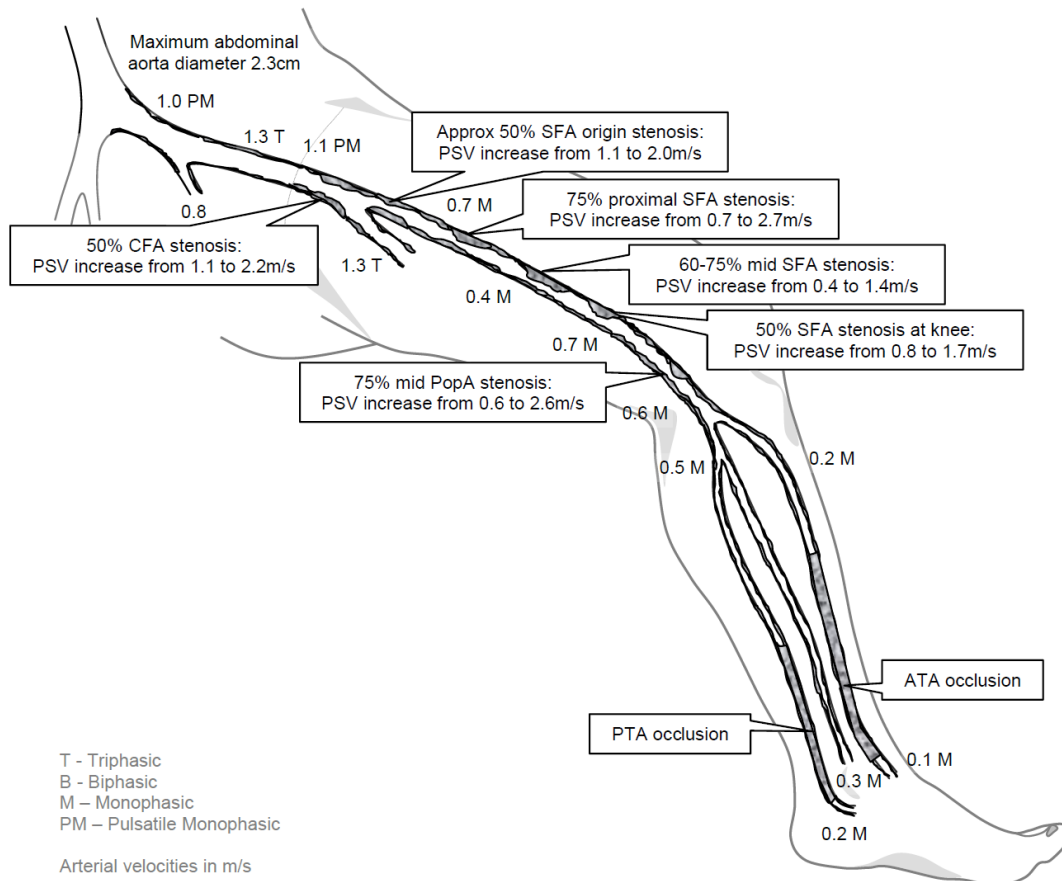
RIGHT femorals-PopA: CFA patent, heavily calcified, with damped monophasic flow. SFA and popliteal artery patent with diffuse calcified atheroma and damped monophasic flow.

RIGHT crurals: Peroneal artery not assessed due to patient build. Remaining crural arteries patent with damped monophasic flow.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 28.11.2019
 Referring Consultant: Mr RTA Chalmers
 Clinical Indication: Urgent outpatient
 Short dist IC with hack on heel ? SFA disease amenable to PTA

Left Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

LEFT Aorto-iliacs: Abdominal aorta, CIA, IIA origin, and EIA patent with no significant disease. Maximum diameter of the abdominal aorta at the diaphragm 2.3cm (poor views at this level).

LEFT CFA: CFA patent with calcified atheroma causing 50% stenosis.

LEFT SFA: SFA patent with diffuse calcified atheroma throughout causing stenoses at the SFA origin (approx 50%), proximally (75%), at mid thigh (60-75%), and at knee (50%).

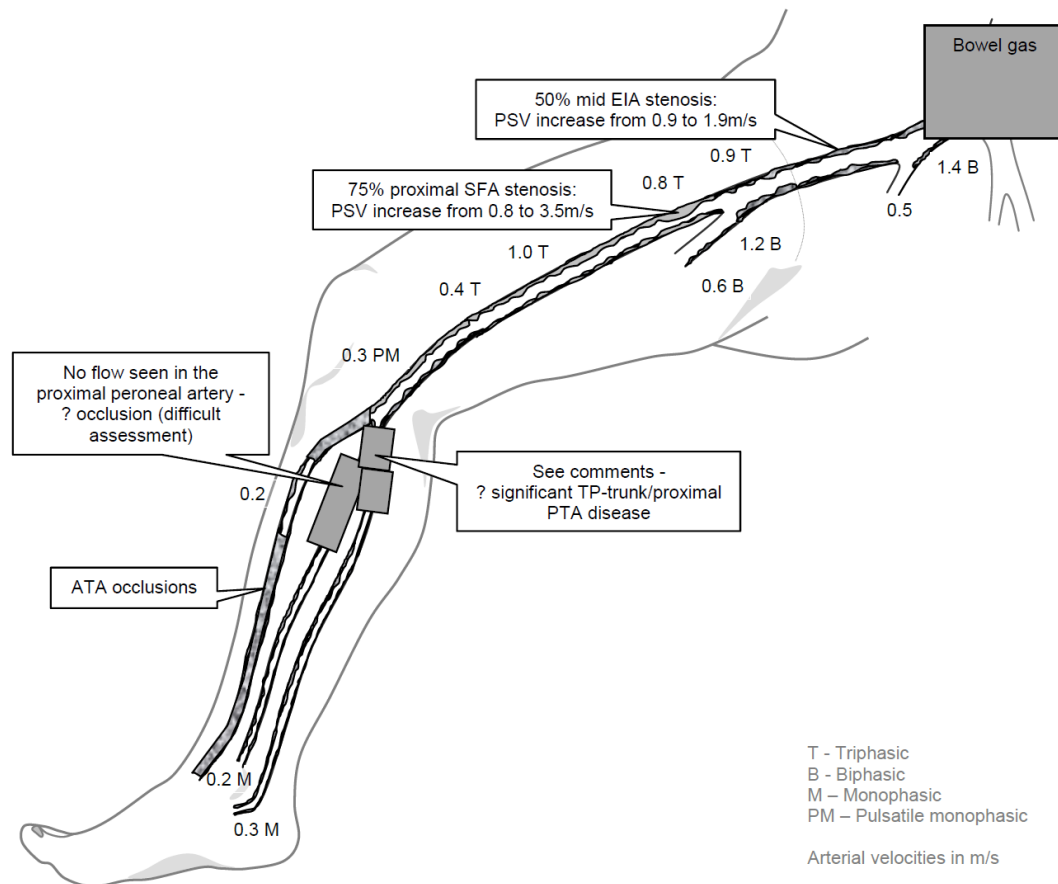
LEFT PopA: Popliteal artery patent with diffuse calcified atheroma and a mid popliteal artery stenosis (75%).

LEFT crurals: Crural arteries calcified.
 PTA occludes at mid calf and reforms at the foot.
 ATA occludes at mid calf and reforms distally.
 Remaining crural arteries patent with damped monophasic flow.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 29.11.2019
 Referring Consultant: Mr R Jamieson
 Clinical Indication: Urgent inpatient, Day Surgery Unit
 Ulcers/necrosis over 1st big toe, 2nd and 3rd on right foot

Right Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

RIGHT Aorto-iliacs: Aorta and CIA origin not assessed due to bowel gas. EIA patent with elevated velocities in the mid EIA suggesting 50% stenosis. Remaining CIA and IIA origin patent with <50% disease.

RIGHT CFA: CFA patent with diffuse calcified atheroma – disease <50%.

RIGHT PFA: Profunda artery origin patent with mild irregular flow at it's origin – disease <50%.

RIGHT SFA: SFA patent with smooth atheroma throughout and a focal 75% stenosis 2cm below the SFA origin.

RIGHT PopA: Popliteal artery patent with smooth atheroma – disease <50%.

RIGHT crurals: ATA appears occluded with a section of flow in the proximal calf. Very difficult assessment of the TP-trunk, proximal peroneal artery and proximal PTA. No flow seen in the proximal peroneal artery - ? occlusion. Very difficult to assess patency and grade disease in the TP-trunk and proximal PTA - ? significant disease at this level - suggest further imaging. Remaining PTA and peroneal artery patent with monophasic flow.

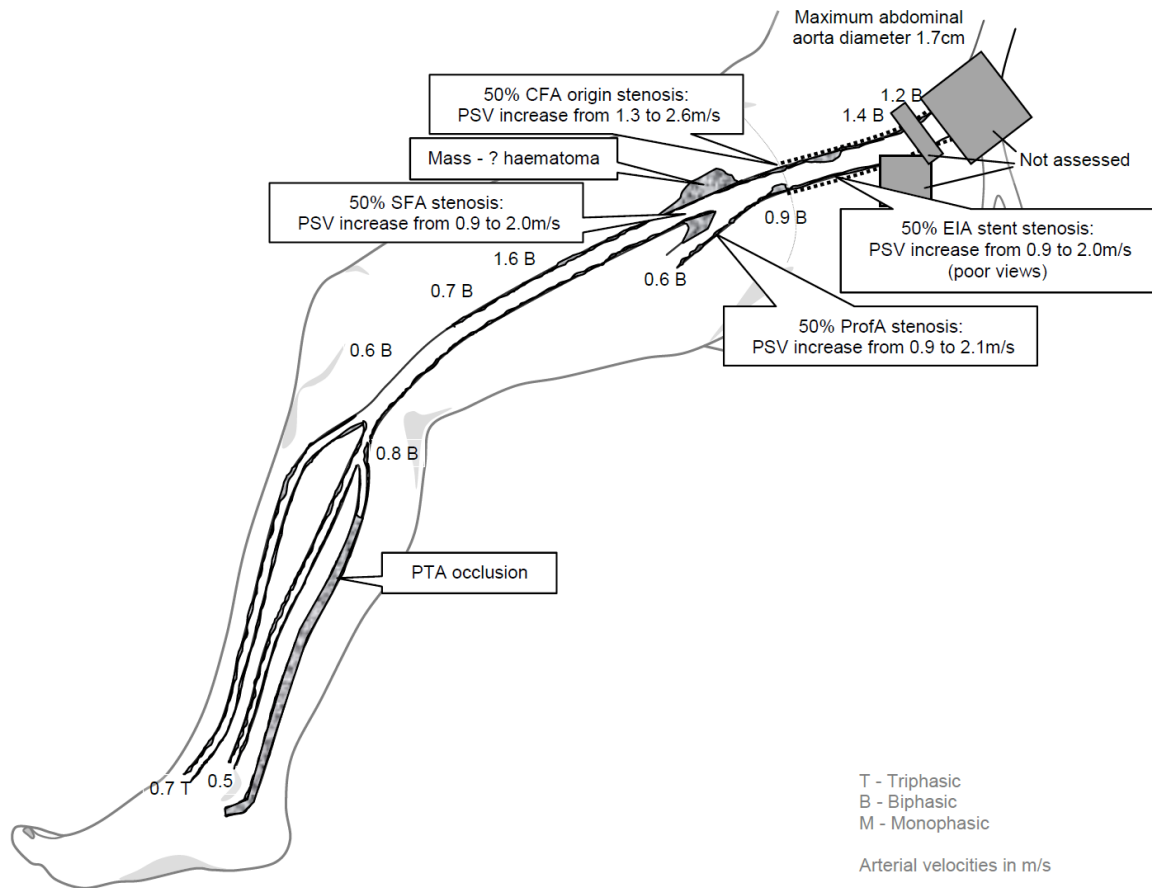
Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
CHI:

Date of Scan: 29.11.2019

Referring Consultant: Mr O Falah
Clinical Indication: ? urgent inpatient ward 105, ? outpatient
Ischaemic right leg

Right Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

RIGHT Aorto-iliacs: Distal aorta/CIA origin and mid CIA not assessed due to bowel gas. Remaining CIA stent patent with biphasic flow. EIA stent patent with elevated velocities in the mid EIA suggesting 50% stenosis, however, views were very poor at this level due to bowel gas. IIA origin not assessed – June 2019 MRA suggests occluded.

RIGHT CFA/SFA/PFA: Mixed echo mass noted adjacent to the CFA/SFA origin/Profunda artery origin (dimensions approx 1.2cm AP x 1.7cm laterally x 4.4cm length) - ? haematoma (no evidence of flow). CFA patent with elevated velocities at the CFA origin just distal to the EIA stent suggesting 50% stenosis. Mid to distal CFA patent with no significant disease. SFA patent with elevated velocities 1.6cm below the SFA origin suggesting 50% stenosis. <50% disease in the remaining SFA. Profunda artery origin patent with elevated velocities suggesting 50% stenosis.

RIGHT PopA: Popliteal artery patent with no significant disease.

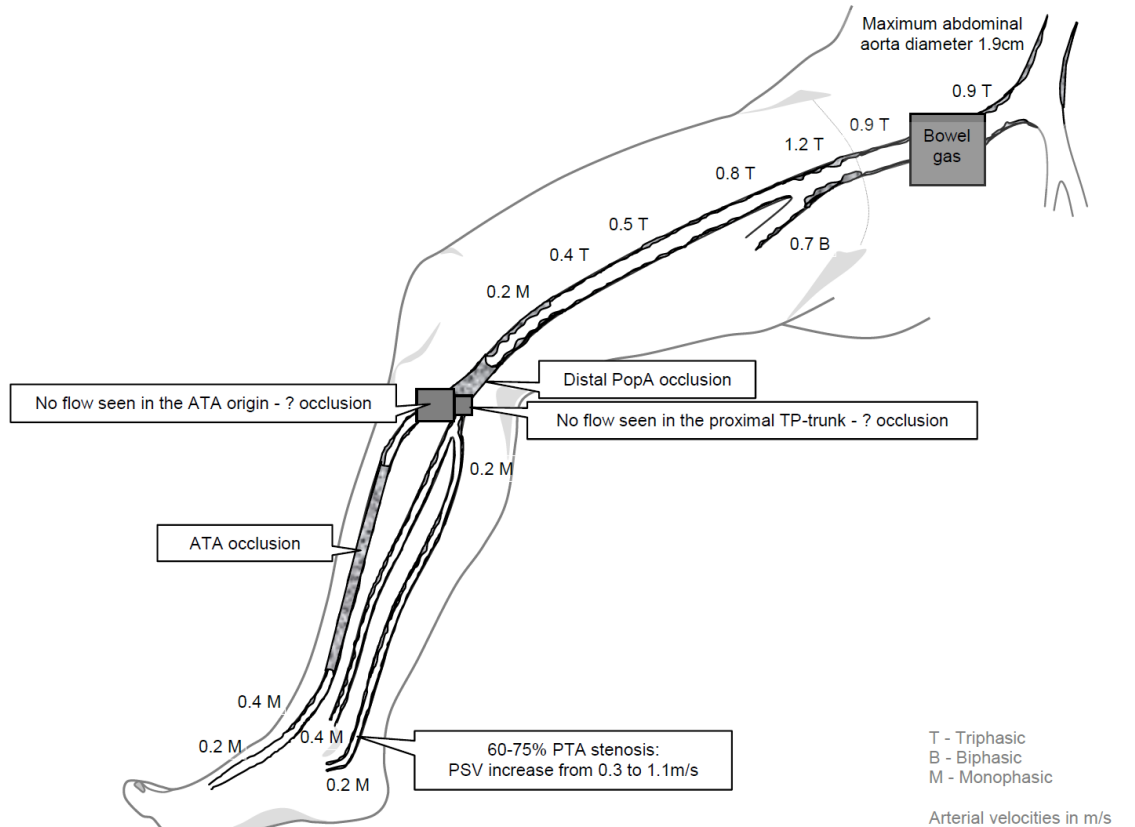
RIGHT crurals: PTA occludes proximally. Remaining crural arteries patent with <50% disease.

Note: Patient returned to ward 105 following the scan.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 05.12.2019
 Referring Consultant: Mrs P Burns
 Clinical Indication: **Urgent outpatient**
 Diabetic foot non healing ulcers. Right side. Arterial scan of right lower limb please. Apologies if I got the side wrong. Same side as the ulcers. If any concerns please call on the on call mobile

Right Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

RIGHT Aorto-iliacs: Distal CIA/IIA origin/proximal EIA not assessed due to bowel gas. Abdominal aorta and remaining CIA and EIA patent, calcified, with disease <50%. Triphasic flow noted throughout sections of CIA and EIA assessed.

RIGHT CFA: CFA patent with diffuse calcified atheroma – disease <50%.

RIGHT SFA: SFA patent with mild diffuse calcified atheroma – disease <50%.

RIGHT PopA: No flow seen in distal popliteal artery, suggests occlusion (length 2.7cm). Remaining popliteal artery patent with diffuse calcified atheroma, disease appears <50%.

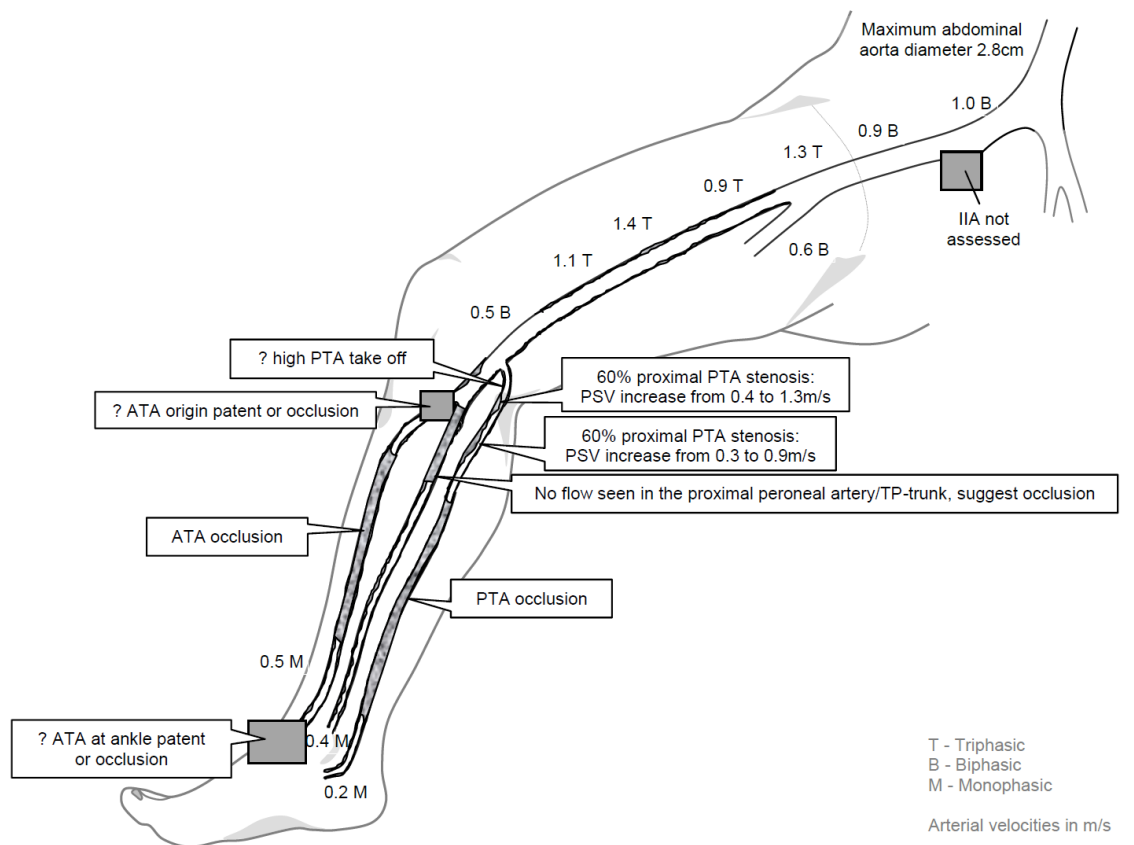
RIGHT crurals: No flow seen in the proximal TP-trunk and ATA origin - ? occlusions. No flow seen in the ATA from proximal calf, suggests occlusion, flow reforms distally. Elevated velocities in the distal PTA, suggests 60-75% stenosis. Remaining crural arteries patent, calcified, with monophasic flow.

NOTE: Vascular on call Dr M Chandarana contacted following the scan, patient to go up to ward 105 for review.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 06.12.2019
 Referring Consultant: Mrs P Burns
 Clinical Indication: Small ulcer on right lateral malleolus. Good right femoral, nil distal. Has apt at 12md on 1.11.19 (Ortho). If apt could be that morning that would be great, thanks.

Right Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

RIGHT Aorto-iliacs: IIA origin not assessed.
 Abdominal aorta, CIA and EIA patent with no significant disease.
 Abdominal aorta appears ectatic at the diaphragm (maximum diameter 2.7-2.8cm), although views were poor at this level. Maximum diameter of the remaining abdominal aorta 2.0cm.

RIGHT CFA: CFA patent with no significant disease.

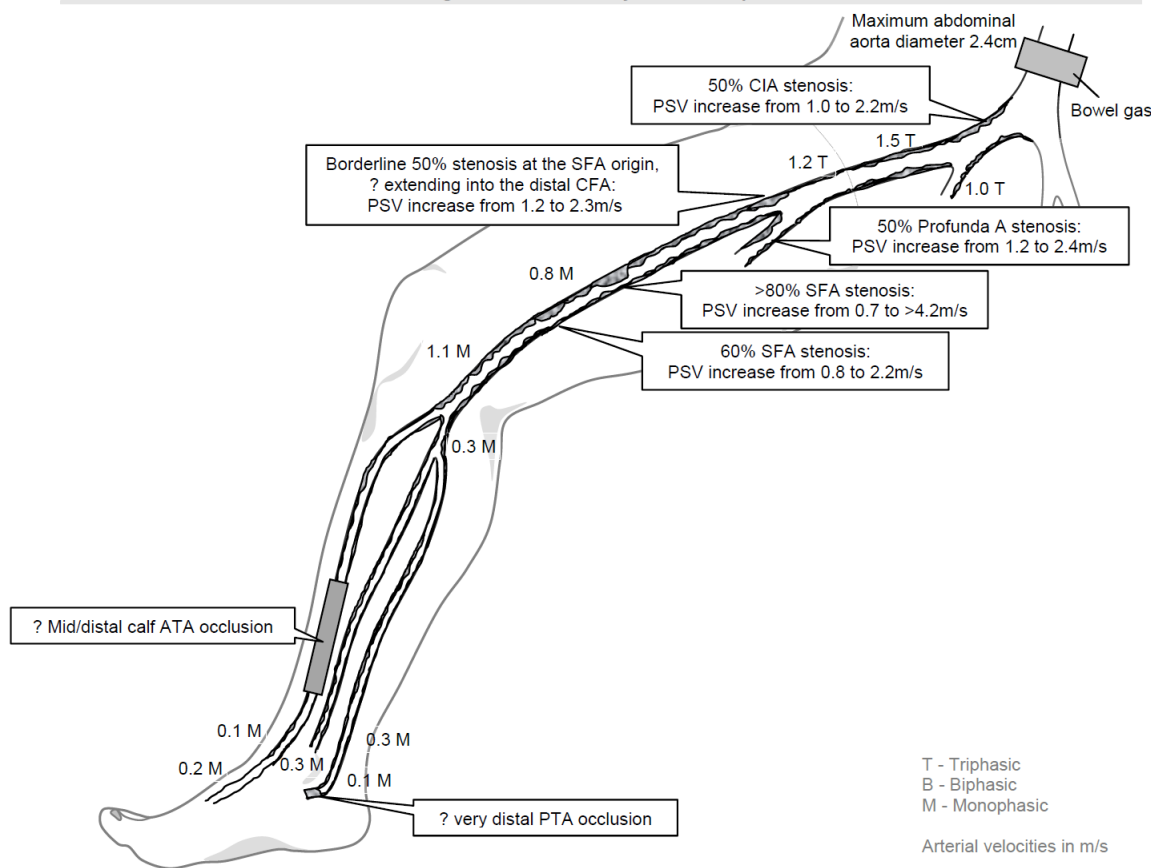
RIGHT SFA-PopA: SFA and popliteal artery patent with mild calcified atheroma – disease <50%.

RIGHT crurals: Crural arteries calcified.
 PTA occludes in the proximal calf and reforms distally.
 There appears to be high PTA take off, with the PTA arising off the mid popliteal artery and proximal PTA stenoses (60% and 60%).
 No flow seen in the TP-trunk/proximal peroneal artery, suggests occlusion, flow reforms in the peroneal artery in the proximal calf.
 Difficult assessment of the ATA origin - ? patent or occlusion. ATA occludes in the proximal calf and reforms distally. Unable to follow the ATA across the ankle into the dorsalis pedis artery - ? occlusion or patent.

Scanned by: Beth Ness, Clinical Vascular Scientist.

5Patient:	
CHI:	
Date of Scan:	09.12.2019
Referring Consultant:	Mr R Chalmers
Clinical Indication:	Urgent outpatient RIGHT leg short dist IC with hack on feel ? SFA disease amenable to PTA.

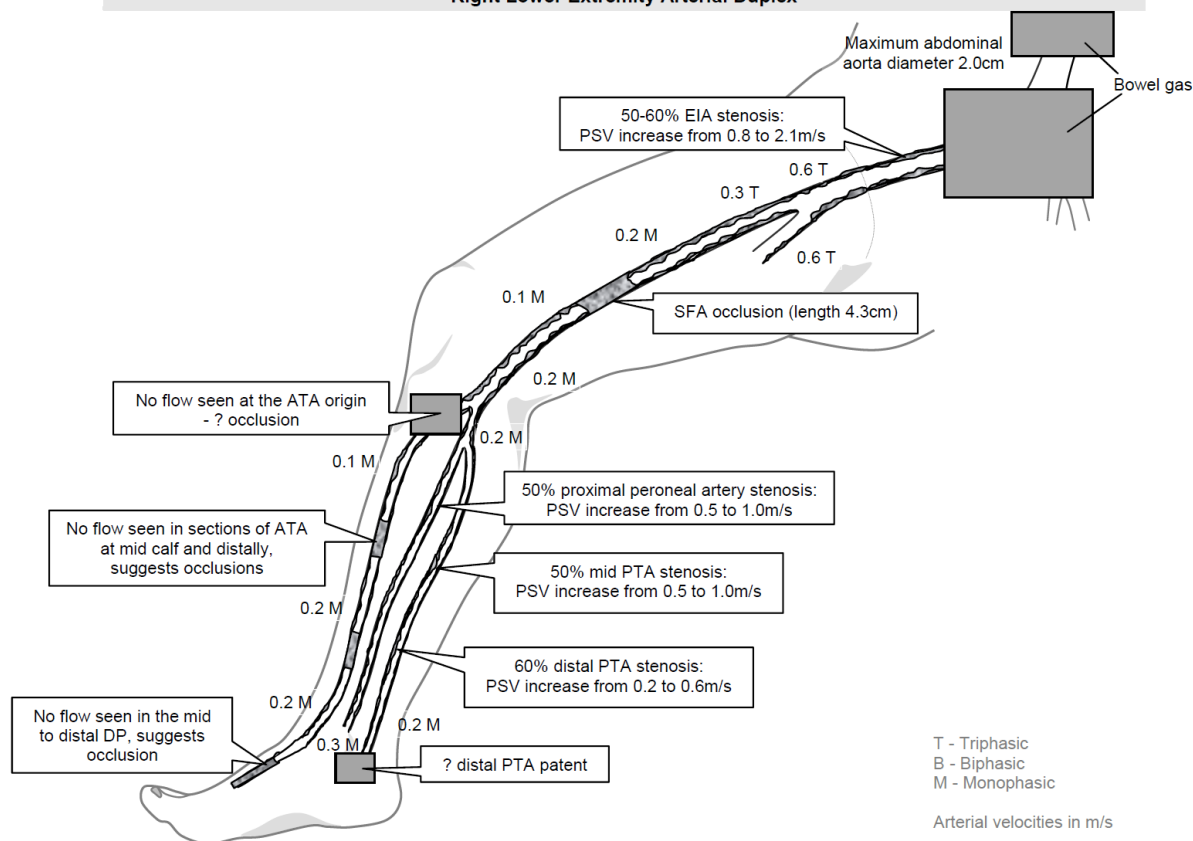
Right Lower Extremity Arterial Duplex



Plaque Type:	Homogenous Heterogenous Calcified Smooth Surface Irregular Surface
RIGHT Aorto-iliacs:	Section of mid abdominal aorta not assessed due to bowel gas (no significant abdominal aorta disease in 28/11/2019 ultrasound scan). Remaining aorto-iliac segment patent with 50% CIA stenosis and <50% EIA disease. Maximum diameter of the abdominal aorta at the diaphragm 2.4cm (although views were poor).
RIGHT CFA/PFA/SFA:	Femoral arteries patent with diffuse calcified atheroma throughout. Large plaque at the SFA origin (? extending into the distal CFA), suggesting borderline 50% stenosis. Further SFA stenoses at mid thigh (>80%) and knee (60%). Disease in the remaining CFA <50%. Profunda artery origin patent with 50% stenosis. Second prominent branch arises off the distal CFA, making it difficult to assess the level of the CFA bifurcation.
RIGHT PopA:	Popliteal artery patent with diffuse calcified atheroma throughout and monophasic flow – no elevated velocities, suggests disease <50%.
RIGHT crurals:	Unable to follow the PTA into the foot - ? very distal PTA occlusion. Prominent collateral vessels communicate with the ATA in the mid/distal calf, suggests ATA occlusion. Remaining crural arteries patent, calcified, with monophasic flow.
Scanned by:	Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 10.12.2019
 Mr O Falah
 Urgent inpatient, ward 104
 Referring Consultant:
 Clinical Indication: Wet necrosis of R 3rd toe with evidence of ?trashing with small dry necrotic patches on 5th toe, L hallux + R lat malleolus. Palpable femoral pulses and DP but may require amputation of R 3rd toe + debridement. ?AAA ?POP aneurysm ?occlusive disease

Right Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

RIGHT Aorto-iliacs: Abdominal aorta at diaphragm and distally, CIA, and IIA origin not scanned due to bowel gas. EIA patent with elevated velocities suggesting 50-60% stenosis. Mid abdominal aorta patent with no significant disease, maximum diameter 2.0cm.

RIGHT CFA: CFA patent with calcified atheroma – disease <50%.

RIGHT SFA: SFA occlusion just below mid thigh (length 4.3cm). Remaining SFA patent with diffuse calcified atheroma throughout.

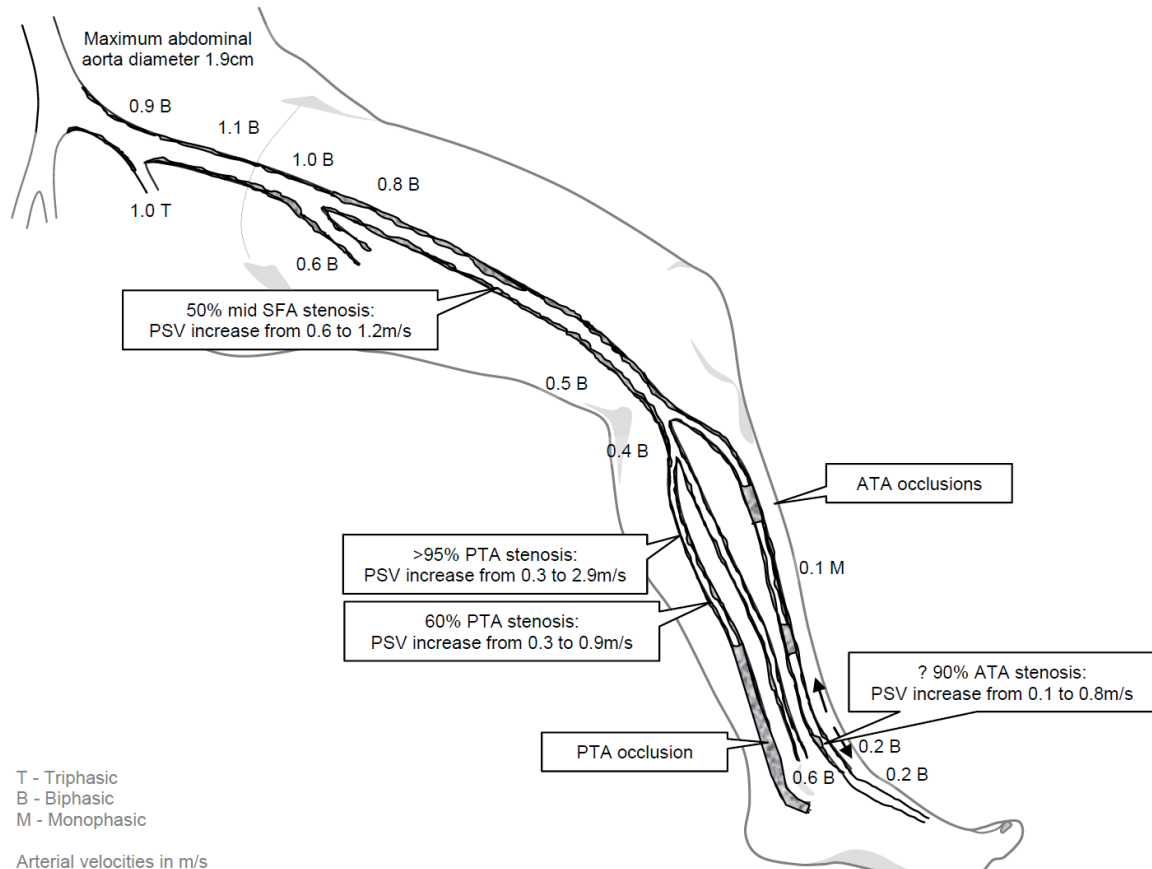
RIGHT PopA: Popliteal artery patent with diffuse calcified atheroma throughout and low monophasic flow. No clear evidence of a popliteal artery aneurysm.

RIGHT crurals: Crural arteries heavily calcified. No flow seen in sections of ATA at mid calf and distally, and in the mid to distal Dorsalis Pedis artery, suggests occlusions. No flow seen at the ATA origin - ? further occlusion. PTA is difficult to follow distally - ? patent at this level. Remaining PTA patent with stenoses at mid calf (50%) and distally (60%). Peroneal artery patent with a stenosis in the proximal calf (50%). Remaining crural arteries patent with low monophasic flow.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 12.12.2019
 Referring Consultant: Mr R Chalmers
 Clinical Indication: Chronic venous skin changes left calf with champagne bottleleg also evidence of arterial insufficiency with impalpable foot pulses and monophasic Dopplers can she have arterial and venous scan please? Thanks

Left Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

LEFT Aorto-iliacs: Abdominal aorta, CIA, IIA origin and EIA patent, calcified, with no significant disease.

LEFT femorals-PopA: CFA, SFA and popliteal artery patent with diffuse calcified atheroma throughout. 50% mid SFA stenosis, disease in remaining femoral and popliteal arteries <50%.

LEFT crurals: Crural arteries calcified.
 No flow seen in sections of the ATA in the proximal and distal calf, suggests occlusions.
 Retrograde flow noted in a section of the distal ATA, with antegrade flow reforming just above the ankle, ? with a 90% stenosis just below this level.
 PTA patent proximally with elevated velocities suggesting stenoses in the proximal (>95%) and mid (60%) calf. PTA occludes in the distal calf.
 TP-trunk and peroneal artery patent with <50% disease.

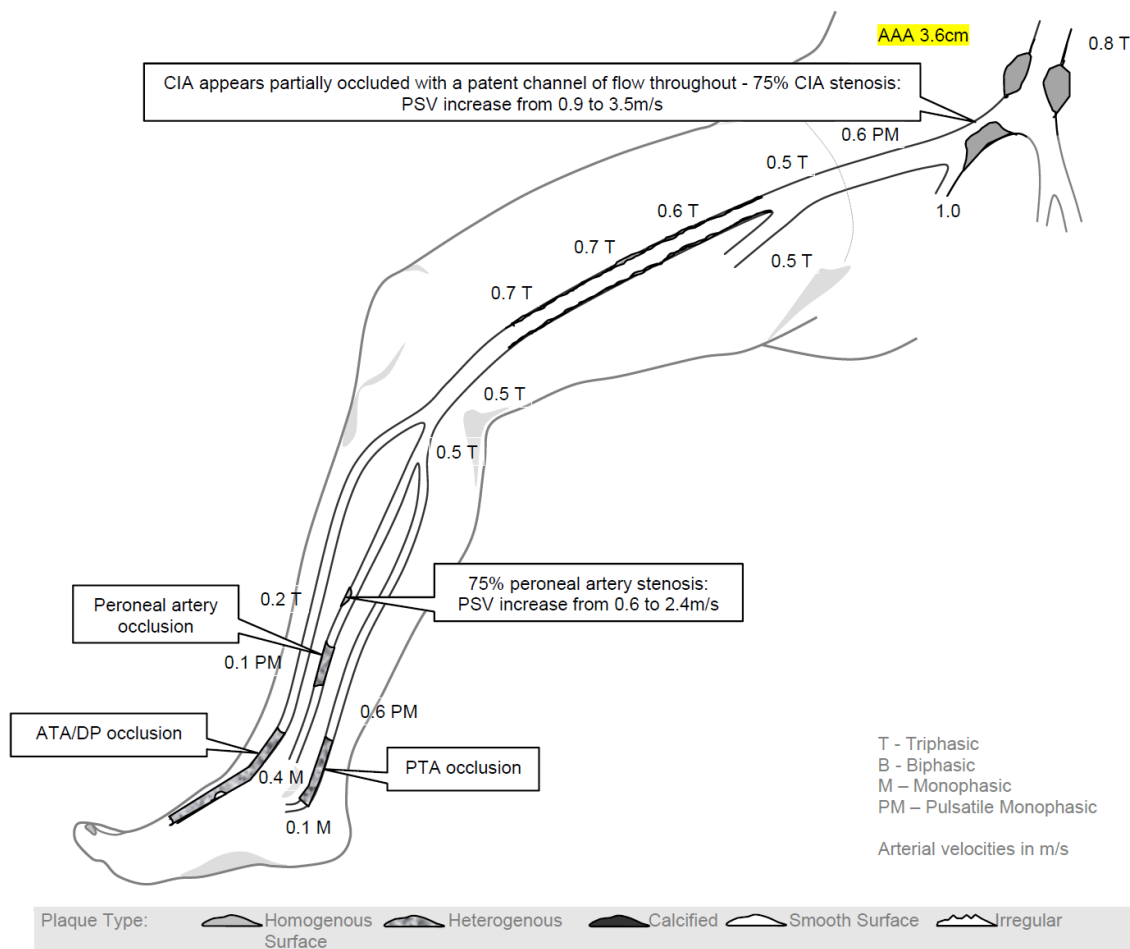
Note: Patient reported recent history of white/black discolouration of fingers.
 Patient told to tell a doctor if concerned e.g. GP.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
CHI:
Date of Scan: 13.12.2019

Referring Consultant: Mr O Falah
Urgent outpatient
Clinical Indication: PATIENT COMING AT 0900 FOR APPT on 13/12/19. Germ cell tumour on chemotx. Curative. CTA for staging showed non occ thrombus in distal aorta extending into R CIA. CT scan stopped at groin. ?run off ?emboli. Short dist claudication R leg

Right Lower Extremity Arterial Duplex



RIGHT Aorto-iliacs: Abdominal aorta patent with a distal abdominal aortic aneurysm (maximum diameter 3.6cm) with a large amount of non-flow limited mural thrombus at this level. CIA appears partially occluded with a patent channel of flow throughout - elevated velocities suggest 75% CIA stenosis. EIA and IIA origin patent with no significant disease.

RIGHT femorals-PopA: CFA, SFA and popliteal artery patent with no significant disease. SFA mildly calcified.

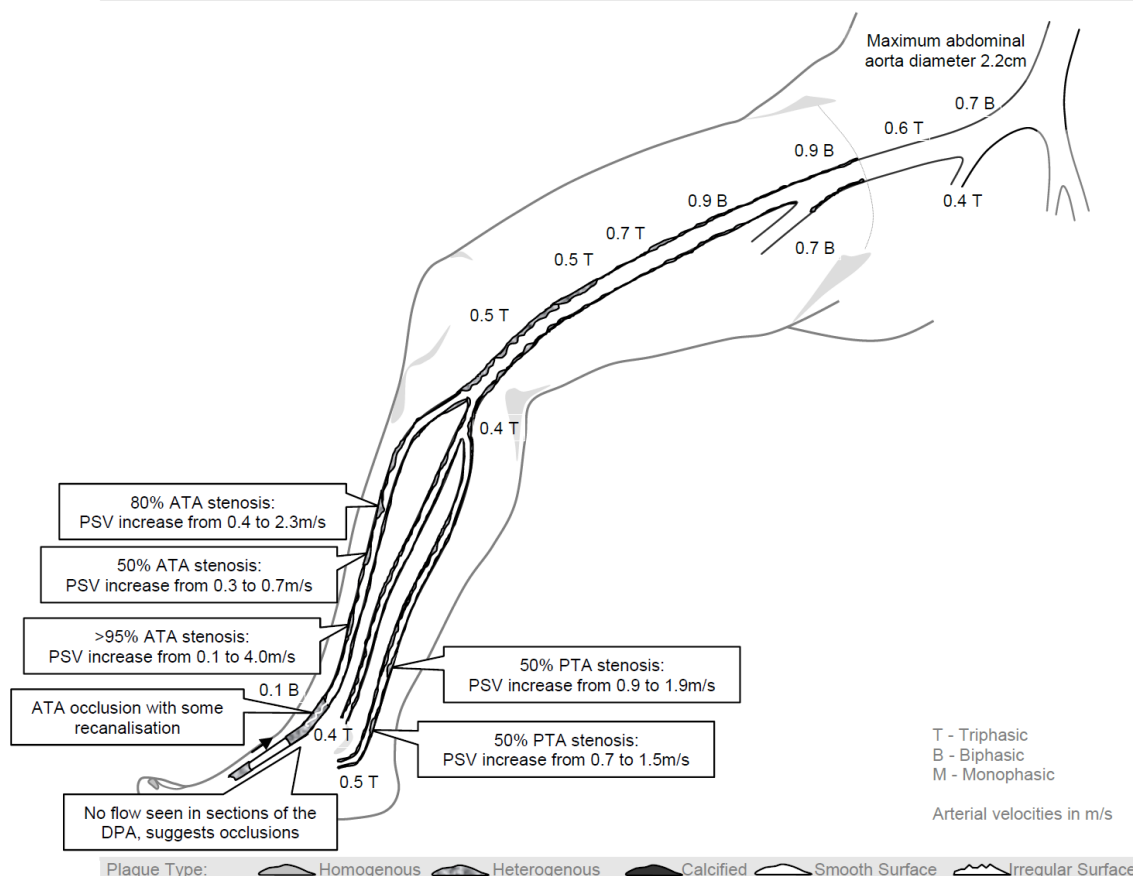
RIGHT crurals: Distal PTA occlusion. ATA occludes distally. Dorsalis Pedis artery occluded with some recanalisation in the mid Dorsalis Pedis artery. Peroneal occlusion in the distal calf (length approx 2.4cm), and 75% peroneal artery stenosis just below mid calf. Remaining crural arteries patent with no significant disease.

NOTE: Patient attended ward 105 following the scan for review. ? patient for AAA surveillance.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 17.12.2019
 Referring Consultant: Mr A Tambyraja
 Clinical Indication: **Urgent outpatient**
 Diabetic patient with dusky right 2nd toe. Pulses on right not felt. Needs urgent arterial scan for right lower limb please

Right Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

RIGHT Aorto-iliacs: Abdominal aorta, CIA, IIA origin and EIA patent with no significant disease.

RIGHT femorals-opA: CFA and proximal to mid SFA patent with mild calcified atheroma – no significant disease. Distal SFA and popliteal artery patent with diffuse calcified atheroma – disease <50%. Maximum diameter of the popliteal artery 1.3cm.

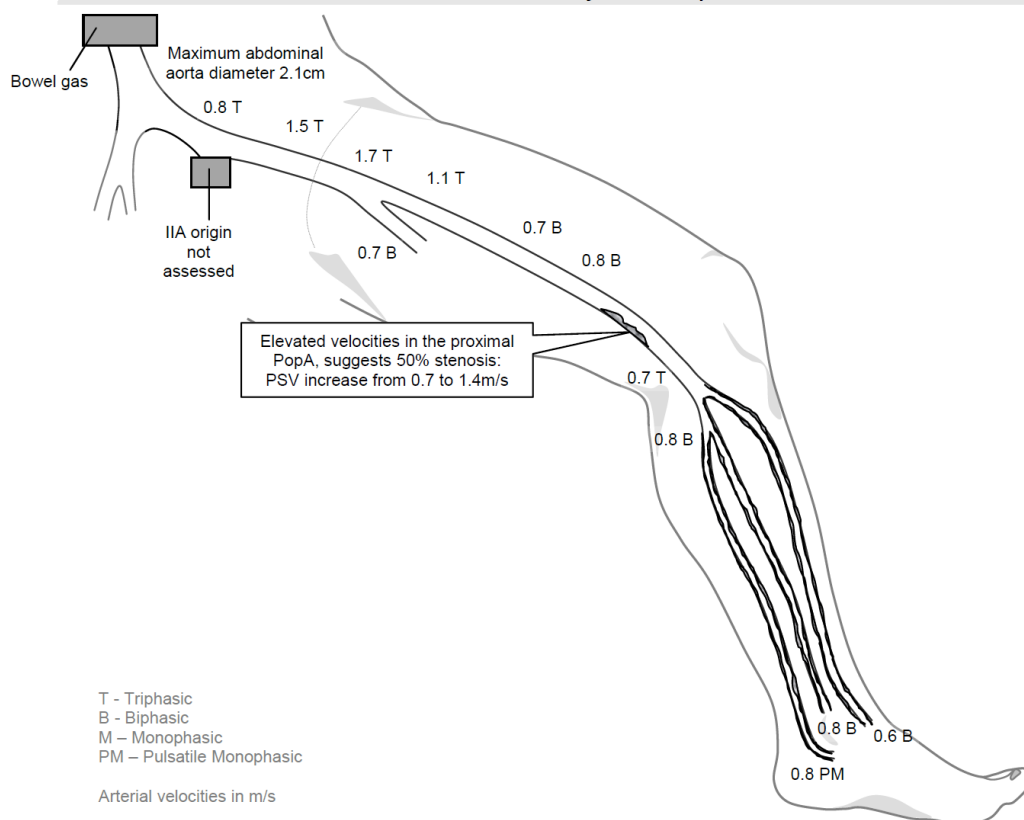
RIGHT crurals: Crural arteries calcified. ATA occludes distally, with some recanalisation noted. Remaining ATA patent with stenoses: just above mid calf (80%), at mid calf (50%), and distal calf (>95%). Difficult to follow the Dorsalis Pedis artery – no flow seen in the proximal and distal Dorsalis Pedis artery, suggests occlusions. Mid Dorsalis Pedis artery appears patent with retrograde flow. PTA patent with distal stenoses (50% and 50%). TP-trunk and peroneal artery patent with triphasic flow - disease <50%.

NOTE: Please request surveillance of the right popliteal artery if required.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 19.12.2019
 Referring Consultant: Mr O Falah
 Clinical Indication: Urgent outpatient
 59 IDDM, Prev MI, CVA and high BMI, presents with non-healing necrotic heel ulcer left leg despite OPAT abx- absent pedal pulses ? PVD contributing ? for intervention.

Left Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

LEFT Aorto-iliacs: Abdominal aorta not scanned at diaphragm due to bowel gas. IIA origin not assessed. Remaining abdominal aorta, CIA and EIA patent with no significant disease.

LEFT femorals: CFA and SFA patent with no significant disease.

LEFT PopA: Popliteal artery patent with elevated velocities in the proximal popliteal artery suggesting 50% stenosis. No significant disease in the remaining popliteal artery.

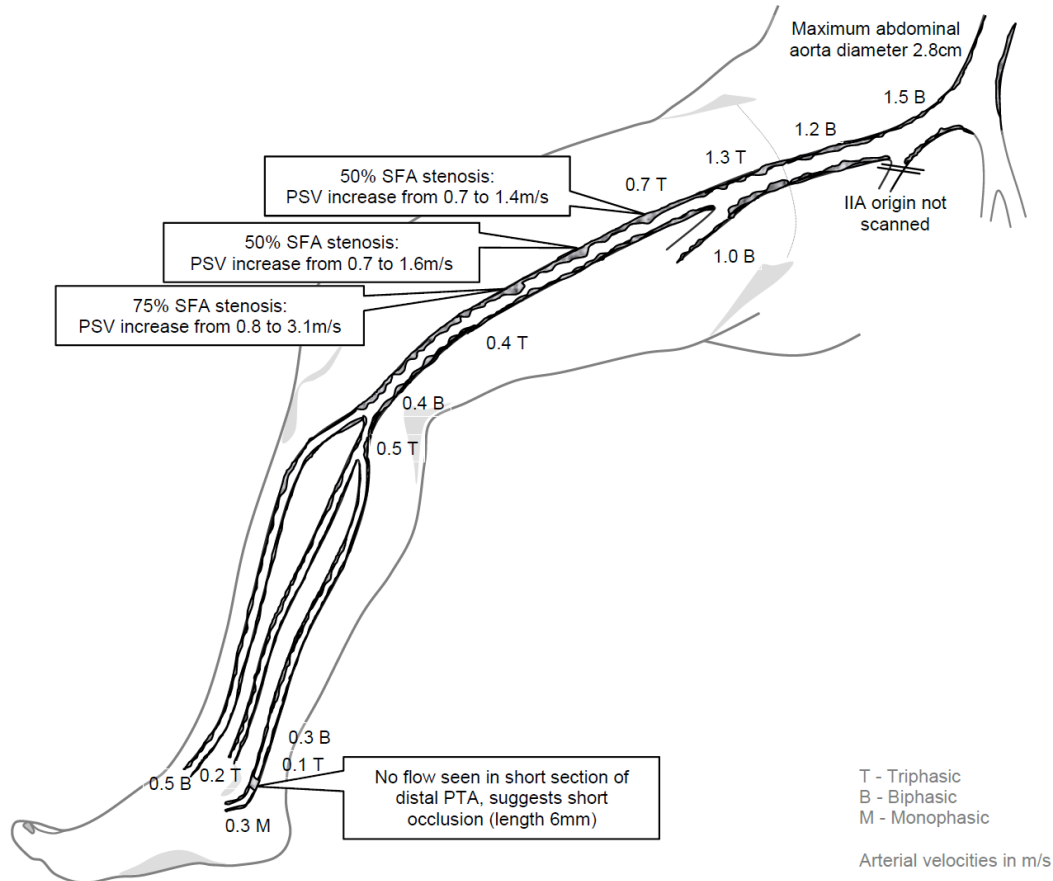
LEFT crurals: Crural arteries patent, mildly calcified, with no significant disease.

NOTE: Following the scan, result reviewed with vascular doctor on call Dr Mihir Chandarana, patient ok to go home and results to be followed up.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 20.12.2019
 Referring Consultant: Mr Z Raza
 Clinical Indication: Previous Left SFA angioplasty. Had a dissection flap. Request has been submitted for left SFA dissection flap. Needs Right SFA angioplasty - please check if any sig stenosis on right

Right Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

RIGHT Aorto-iliacs: Abdominal aorta patent with <50% disease. Abdominal aorta ectatic, maximum AP diameter 2.7cm, lateral diameter 2.8cm. EIA patent with minor irregular flow in the mid EIA, but no clear evidence of significant disease - disease appears <50%. CIA patent with <50% disease. IIA origin not assessed.

RIGHT CFA: CFA patent with calcified atheroma, disease <50%.

RIGHT SFA: SFA patent with diffuse calcified atheroma throughout and stenoses: proximally (50%), mid thigh (50%), and mid/distal thigh (75%).

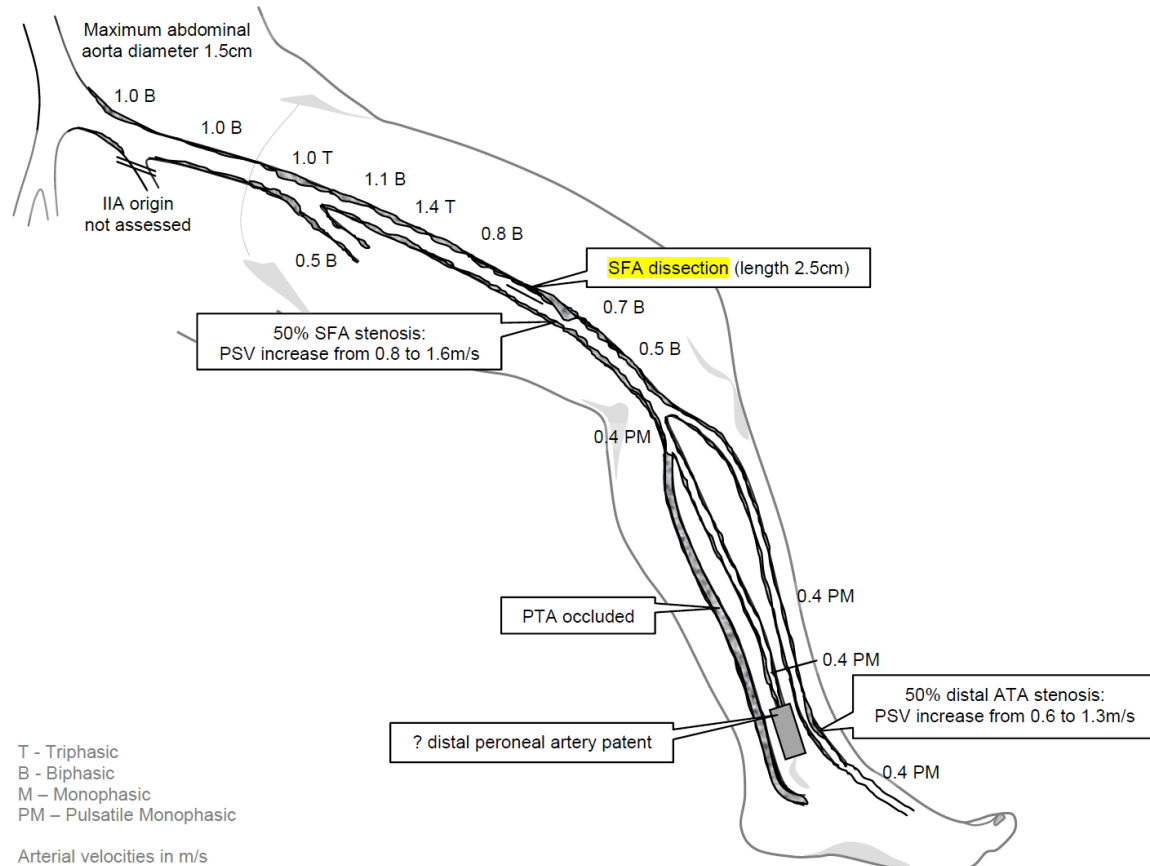
RIGHT PopA: Popliteal artery patent with diffuse calcified atheroma, disease <50%.

RIGHT crurals: Crural arteries calcified. No flow seen in very short section of distal PTA, suggests short occlusion (length 6mm). Peroneal artery patent with low flow (poor views at ankle). Remaining crural arteries patent with <50% disease.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 27.12.2019
 Referring Consultant: Mr A Tambyraja
 Clinical Indication: Urgent outpatient
 Left leg angioplasty in Nov 2011. Has rest pain although ulcers are improving. Out-patient arterial scan please as per discussion in MDT.

Left Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

LEFT Aorto-iliacs: Abdominal aorta, CIA and EIA patent with <50% disease. IIA origin not assessed.

LEFT CFA: CFA patent with calcified atheroma - disease <50%.

LEFT SFA: SFA patent with diffuse calcified atheroma throughout. Dissection noted in the SFA in the mid/distal thigh (length 2.5cm), with a 50% stenosis just below this. Mild irregular flow in short section of the proximal SFA. <50% disease in the remaining SFA.

LEFT PopA: Popliteal artery patent with diffuse calcified atheroma - disease <50%.

LEFT crurals: Crural arteries heavily calcified. PTA occluded. ATA patent with distal 50% stenosis. Prominent branch arises off the distal peroneal artery - ? distal peroneal artery patent. Remaining crural arteries patent with <50% disease.

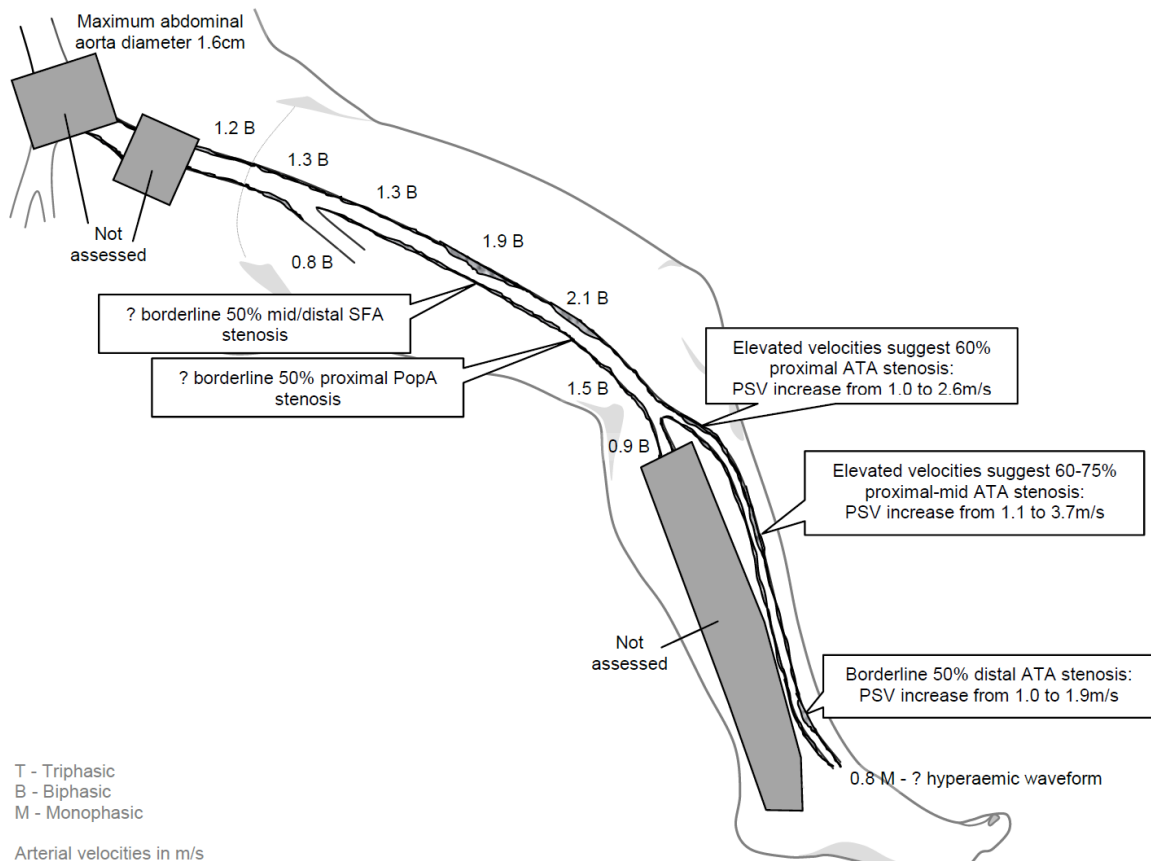
NOTE: Patient is concerned as he experienced left big toe discoloration 1 week ago (darker, blackish appearance) and he also experiences right big toe throbbing. Left ulcer improving. Right heel ulcer. Patient would like to speak to a Vascular Consultant. Vascular doctor on call Mr Raza contacted (in theatre) following the scan due to patient's concerns. Patient ok to go home and results to be reviewed.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
CHI:
Date of Scan: 06.01.2020

Referring Consultant: Mr Z Raza
Clinical Indication: Urgent inpatient, WGH, ward 43
83 yo current inpatient in RIDU WGH, chronic osteomyelitis and diabetic foot ulcers. Currently on IV treatment for likely osteomyelitis with IV vanc. Other PMHs includes, CKD, diabetes, BL foot ulcers, CLL. Was due angio with Vascular last week for right leg however at present left leg more symptomatic with worse ulcer and infection. Duplex left side to investigate vascular supply and any indication for intervention

Left Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

LEFT Aorto-iliacs: Large sections of the aorto-iliac segment not assessed due to patient build (see diagram). Section of the abdominal aorta, mid CIA and mid to distal EIA patent with no significant disease.

LEFT CFA: CFA patent with no significant disease.

LEFT SFA-PopA: SFA and popliteal artery patent, calcified with elevated velocities in the mid/distal SFA and proximal popliteal artery - ? borderline 50% stenoses.

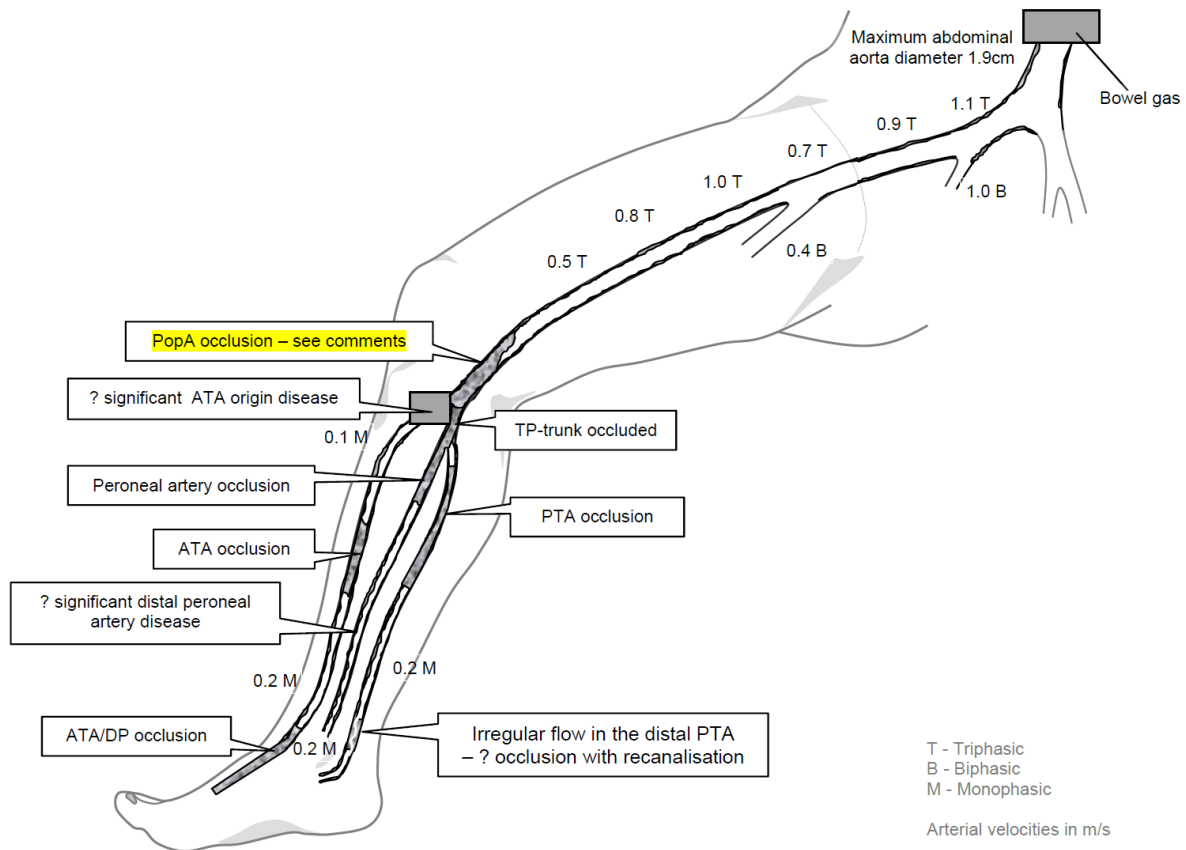
LEFT crurals: Peroneal artery and PTA not assessed due to large calf (2016 MRA report suggests essentially single vessel run off via the ATA). Difficult assessment of the ATA. ATA patent with elevated velocities suggesting stenoses: proximally (60%), in the proximal/mid calf (60-75%) and distally (borderline 50%). TP-trunk appears patent with <50% disease.

NOTE: ? prominent lymph nodes noted in the left groin.
Oedema noted below the knee.
Result reviewed with Vascular Doctor on Call Dr Cathleen Grossart, patient attended ward 105 following the scan for review.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
 CHI:
 Date of Scan: 07.01.2020
 Referring Consultant: Mr Z Raza
 Clinical Indication: Urgent ? outpatient ? inpatient
 70M T1DM with painful R foot, rest pain. Femoral pulse, but nil else, Buerger's positive.

Right Lower Extremity Arterial Duplex



Plaque Type:	Homogenous	Heterogenous	Calcified	Smooth Surface	Irregular Surface
RIGHT Aorto-iliacs:	Aorta not assessed at the diaphragm due to bowel gas. Remaining abdominal aorta patent, calcified, with <50% disease. CIA, IIA origin and EIA patent, with no significant disease.				
RIGHT femorals:	Femoral arteries patent with no significant disease. Mild calcification in the CFA. Diffuse calcification throughout the SFA.				
RIGHT PopA:	Calcified popliteal artery is partially occluded in the mid popliteal artery and occluded below the mid popliteal artery. On B-mode imaging (PACS images 31 and 36), the popliteal artery occlusion has some low level echogenicity, suggesting thrombus with some organisation. It is, however, difficult to age the occlusion using ultrasound - recommend correlating with patient's symptom onset. Slightly poor views of the popliteal artery due to patient position, however, no clear evidence of popliteal artery aneurysm.				
RIGHT crurals:	Crural arteries calcified. No flow seen in the TP-trunk, suggests occluded. PTA origin patent. PTA occludes proximally, flow reforms at mid calf. Irregular flow in the distal PTA - ? occlusion with recanalisation. Poor views of the ATA origin, with irregular flow at this level - ? significant disease. Mid ATA occlusion. ATA occludes at ankle, Dorsalis pedis artery appears occluded. Proximal peroneal artery occlusion. Poor views of the distal peroneal artery - ? significant disease.				
NOTE:	Result reviewed with Vascular Reg on call Dr C Grossart, patient to attend ward 105.				
Scanned by:	Beth Ness, Clinical Vascular Scientist.				

Referring Consultant: Mrs P Burns
Clinical Indication: Right infrapopliteal angioplasty 11/10/19. Had 1 week post-procedure duplex 18/10. For 3 month follow-up duplex 11/01/20.

Maximum abdominal aorta diameter 1.8cm

0.8 B

0.7 B

0.8 B

0.6

0.8 B

0.9 B

0.6 B

0.8 B

0.2 M

No flow seen at the profunda artery origin, ?? occlusion – poor views

0.7 B

Not assessed

High PTA take-off

75% TPT/proximal peroneal artery stenosis:
PSV increase from 0.6 to 2.3m/s

0.2 B

0.2 B

ATA occlusion

0.1 M

? PTA occlusion – see comments






0.03 M

0.4 B

0.2 PM

T - Triphasic
B - Biphasic
M - Monophasic
PM - Pulsatile Monophasic

Arterial velocities in m/s

Plaque Type:	 Homogenous Surface	 Heterogenous	 Calcified	 Smooth Surface	 Irregular
RIGHT AORTO-ILIACS:	Abdominal aorta, CIA, IIA origin and EIA patent, calcified, with disease <50%.				
RIGHT CFA:	CFA patent with calcified atheroma, disease <50%.				
RIGHT PFA:	No flow seen for approx 1cm length at the profunda artery origin, ?? occlusion – poor views.				
RIGHT SFA:	SFA stents and remaining SFA patent with <50% narrowing. Diffuse calcified atheroma throughout the SFA.				
RIGHT PopA:	Popliteal artery stent and native distal popliteal artery patent with <50% narrowing. Popliteal artery calcified.				
RIGHT CRURALS:	Crural arteries calcified. ATA origin not assessed. ATA occludes at mid calf with some very low flow noted distally. High PTA origin take-off (PTA arises off popliteal artery at the knee skin crease). Low flow in the PTA in the mid to distal calf with prominent collateral vessels noted- ? PTA occlusion. TP-trunk/proximal peroneal artery 75% stenosis.				
NOTE:	Post up and over access from left during Dec 2019 angioplasty, patient is concerned about his left groin due to occasional shooting pains. No further Vascular Lab follow up/surveillance requested on Trak.				
Scanned by:	Beth Ness, Clinical Vascular Scientist.				

Patient:
CHI:

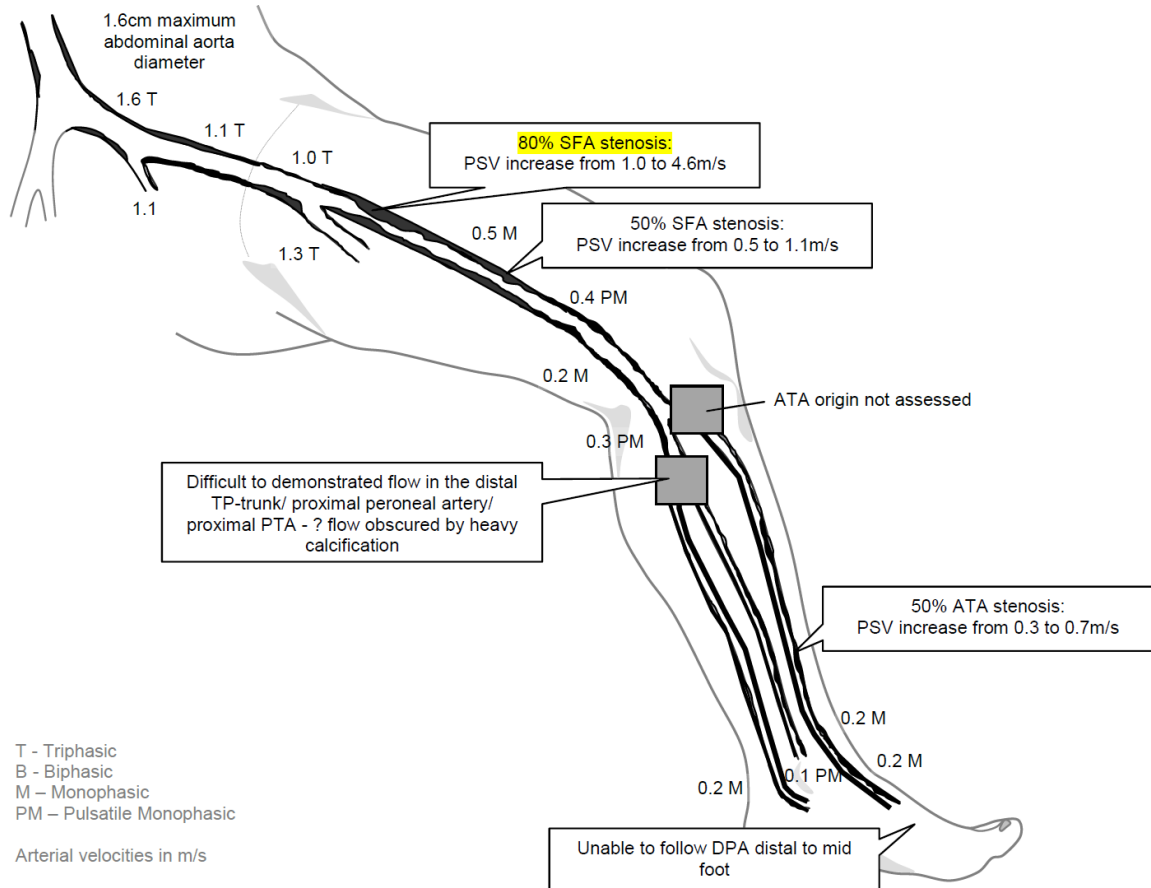
Date of Scan: 10.01.2020

Referring Consultant: Mr R Jamieson

Clinical Indication: Urgent outpatient

THIS WEEK IDEALLY Previous left hallux amputation and SFA angioplasty in March - now exposed bone 2nd toe. Please ask registrar to review ?possible to just amputate toe or needs urgent redon angioplasty.

Left Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

LEFT Aorto-Iliacs: Abdominal aorta, CIA, IIA origin and EIA patent, calcified, with no significant disease.

LEFT CFA/PFA: CFA patent with diffuse calcified atheroma, with disease <50%. Profunda artery origin patent, calcified, with disease <50%.

LEFT SFA: SFA patent with heavy diffuse calcification throughout. SFA stenoses: proximally (80%) and in the mid/proximal thigh (50%). SFA appears generally of small calibre (6mm diameter proximally).

LEFT PopA: Popliteal artery patent with diffuse calcified atheroma throughout and low flow, disease appears <50%.

LEFT CRUALS: Crural arteries heavily calcified - poor views. ATA origin not assessed. Remaining ATA patent with a 50% stenosis in the distal calf. Dorsalis pedis artery followed to mid foot, unable to follow beyond this. Difficult to demonstrate flow in the distal TP-trunk/proximal PTA/proximal peroneal artery - ? obscured by heavy calcification. Remaining crural arteries patent, disease appears <50%.

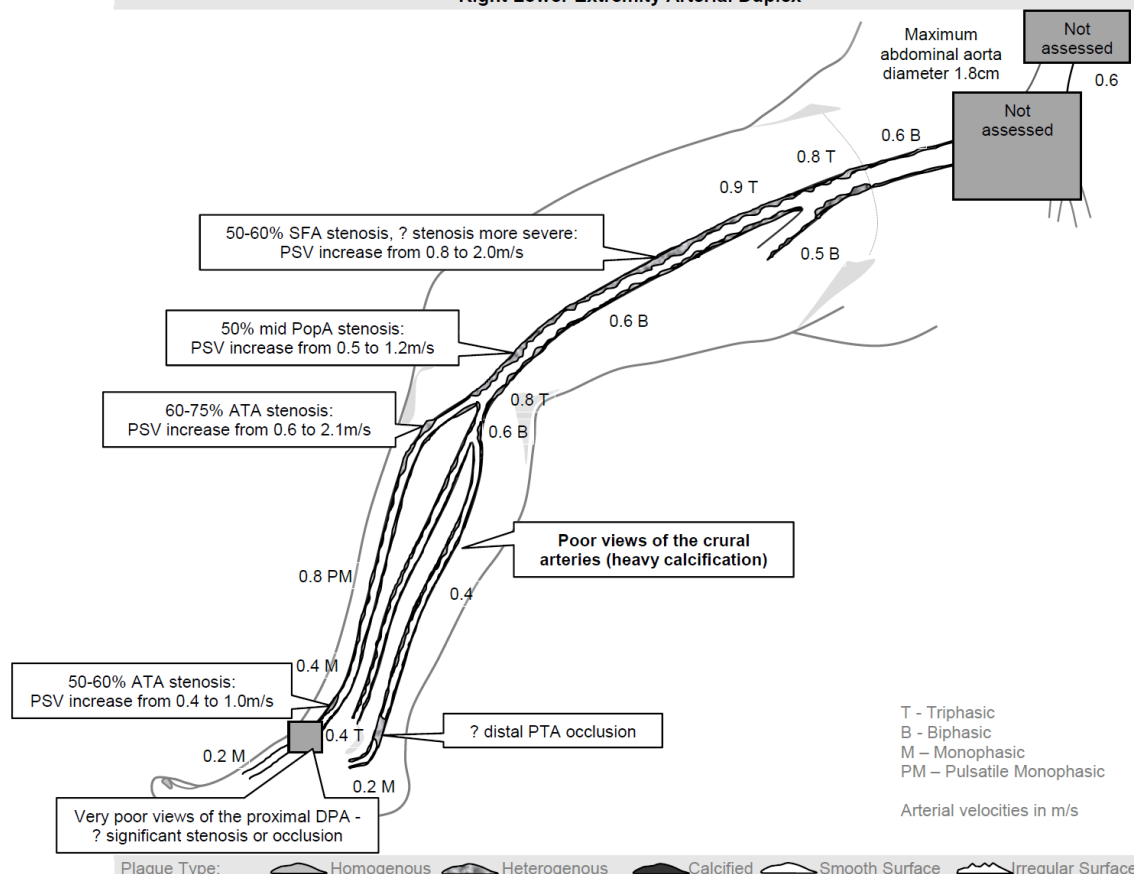
NOTE: Result reviewed with Vascular Doctor on call. Patient to attend ward 105 for review.

Scanned by: Beth Ness, Clinical Vascular Scientist.

Patient:
CHI:
Date of Scan: 14.01.2020

Referring Consultant: Mr A Tambyraja
Clinical Indication: Urgent inpatient, ward 206
Necrotic tips to R toes, palpable femoral pulse but nil else. T2DM, ESRF on HD

Right Lower Extremity Arterial Duplex



RIGHT Aorto-iliacs: Poor views of the abdomen due to bowel gas and patient build – unable to assess the aorta at diaphragm/distally, CIA, IIA origin and EIA origin. Remaining EIA and mid abdominal aorta patent with no significant disease. Triphasic flow in the CFA, suggests no significant proximal disease.

RIGHT CFA: CFA patent with calcified atheroma – disease <50%.

RIGHT SFA: SFA patent with diffuse calcified atheroma throughout. 50-60% mid SFA stenosis - ? visually stenosis appears more severe.

RIGHT PopA: Popliteal artery patent with diffuse calcified atheroma throughout. 50% stenosis in the mid popliteal artery.

RIGHT crurals: **Difficult assessment of the crural arteries as vessels heavily calcified.** ATA patent with stenoses proximally (60-75%) and distally (50-60%). Very poor views of the proximal Dorsalis Pedis artery - ? significant disease or short occlusion. Mid to distal Dorsalis Pedis artery patent with monophasic flow. Very poor views of the PTA. Prominent collateral vessels communicate with the distal PTA, with monophasic flow noted at the foot, suggests distal PTA occlusion. Remaining crural arteries appear patent with <50% although views were poor.

Scanned by: Beth Ness, Clinical Vascular Scientist.

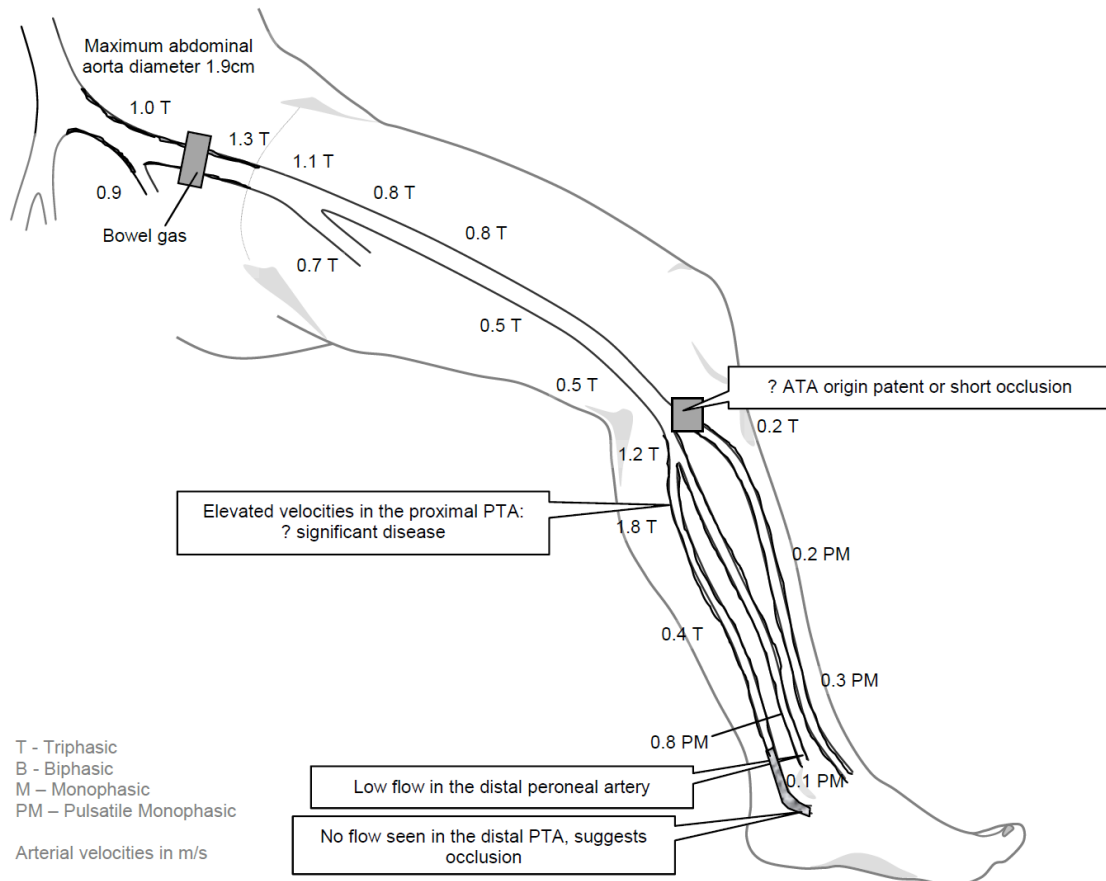
Patient:
CHI:

Date of Scan: 17.01.2020

Referring Consultant: Mr R Jamieson

Clinical Indication: Leg leg symptoms likely due to deep venous near occlusion. Need to ensure arterial perfusion intact before considering deep venous intervention. History of arterial emboli to left arm.

Left Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

LEFT Aorto-iliacs: Short section of proximal EIA not assessed due to bowel gas. Abdominal aorta, CIA, IIA origin and remaining EIA patent with no significant disease. Triphasic flow in the distal EIA, suggests not significant proximal EIA disease.

LEFT CFA-PopA: CFA, SFA and Popliteal artery patent with no significant disease.

LEFT crurals: Crural arteries appear mildly calcified. No flow seen in the distal PTA, suggests occlusion. Proximal PTA patent with elevated velocities - ? significant disease. No flow noted at the ATA origin - difficult assessment, ? patent or short occlusion. Remaining ATA appears patent with low flow noted in the proximal to distal ATA. Branch communicates with the ATA distally (? Peroneal artery branch). Peroneal artery patent - disease appears <50%, however, very low flow is noted in the distal peroneal artery after a branch arises. TP-trunk patent with no significant disease.

Scanned by: Beth Ness, Clinical Vascular Scientist.

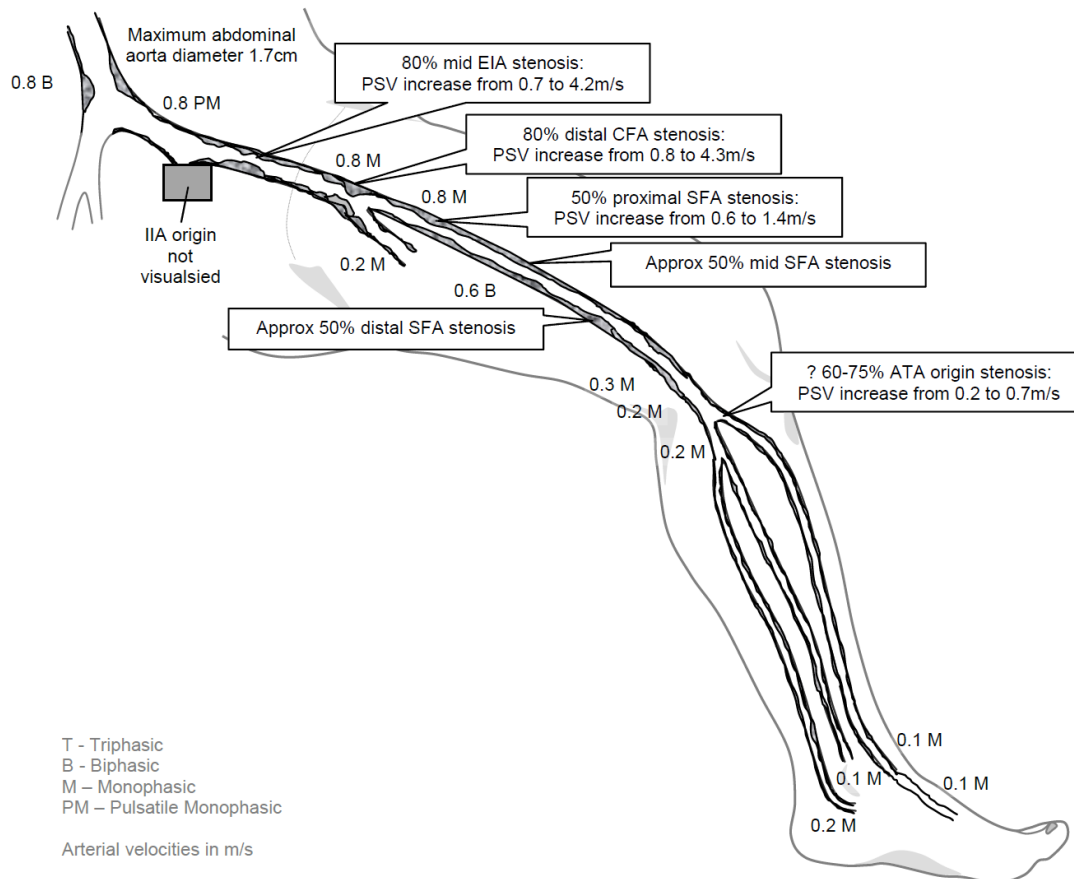
Patient:
CHI:

Date of Scan: 17.01.2020

Referring Consultant: Vascular Nurse Specialist Steven Sim

Clinical Indication: left calf claudication at 50m. Stopped smoking 4 months ago. Type II diabetic well controlled , ABPIL 0.68

Left Lower Extremity Arterial Duplex



Plaque Type: Homogenous Heterogenous Calcified Smooth Surface Irregular Surface

LEFT Aorto-iliacs: Abdominal aorta patent, calcified, with atheroma noted distally – disease <50%. EIA patent with 80% stenosis in the mid EIA (IIA origin not visualised so unable to determine exact level of disease). CIA patent with <50% disease.

LEFT CFA: Calcified CFA patent with a mixed echo plaque distally causing 80% stenosis.

LEFT PFA: Profunda artery origin patent – disease appears <50%.

LEFT SFA: SFA patent with diffuse smooth calcified atheroma throughout. SFA stenoses: proximally 50%, at mid visually approx 50% and distally visually approx 50%. SFA diameter approx 5.5 to 6mm.

LEFT PopA: Popliteal artery patent with diffuse calcified atheroma in the proximal to mid popliteal artery – disease appears <50%. Low flow noted in the popliteal artery.

LEFT crurals: Crural arteries calcified. ATA patent with focal elevated velocities at the origin - ? 60-75% stenosis. Remaining crural arteries patent with low monophasic flow.

Scanned by: Beth Ness, Clinical Vascular Scientist.