



Patient

NHS No

D.O.B.

Patient Ref

Reason

Ulceration, Varicose vein

Outcome

?infection, Lymph nodes, Superficial thrombophlebitis, Incompetence, Poor images

	Right		Left	
Deep Veins	Patency	Competency	Patency	Competency
Common Iliac Vein				
External Iliac Vein				
Internal Iliac Vein				
Common Femoral Vein	Widely Patent	Competent	Widely Patent	Competent
Profunda Vein	Widely Patent	Competent	Widely Patent	Competent
Superficial Femoral Vein	Widely Patent	Competent	Widely Patent	Competent
Popliteal Vein	Widely Patent	Competent	Widely Patent	Competent
Posterior Tibial Vein	Patent	Isolated Incompetence	Patent	Isolated Incompetence
Anterior Tibial Vein	Patent	Competent	Patent	Competent
Peroneal Vein	Patent	Competent	Patent	Competent
Soleal Vein				
Gastrocnemius	Patent	Incompetent (medial)	Patent	Incompetent (medial)
Superficial Veins				
Saphenofemoral Junction	Widely Patent	Competent	Widely Patent	Competent
L Saphenous Vein Above	Widely Patent	Competent	Widely Patent	Competent
L Saphenous Vein Below	Widely Patent	Competent	Widely Patent	Slight Incompetence
Vein of Giacomini	Widely Patent	Competent	Widely Patent	Competent
Saphenopopliteal Junction	Not Identified		Not Identified	
S Saphenous Vein	Areas of Thrombus	Old Thrombus (comp)	Widely Patent	Isolated Incompetence
Evidence of D.V.T.				
Above the knee	No		No	
Popliteal	No		No	
Below the knee	No		No	

Notes**BILATERAL LOWER LIMB VENOUS DUPLEX ASSESSMENT**

Iliac veins not viewed, bilaterally. Flow in the right and left common femoral veins is phasic with respiration and a normal response on Valsalva manoeuvre, suggesting proximal vein patency, bilaterally. All visualised deep veins, appear widely patent / patent and competent with no evidence of previous DVT, except for the right and left medial gastrocnemius veins (incompetent), as well as, the right and left posterior tibial veins (isolated incompetence). No evidence of previous DVT noted in the left posterior tibial veins, at this time.

All measurements are proximal to the medial malleolus unless otherwise stated. Diagrams omitted due to complexity.

RIGHT

Assessed by

Lukasz Koprowski

Checked by



Patient

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An avascular, mixed echogenic mass noted at the groin, measuring ~ 1.0 cm TS x ~1.4cm ML ?enlarged lymph node ?infection.

Sapheno-femoral junction (SFJ) is competent. Long saphenous vein (LSV) is competent throughout its length.

Sapheno-popliteal junction (SPJ) was not identified. Short saphenous vein (SSV) contains minimal areas of non-occlusive chronic thrombus, but appears to be competent and is continuous with a competent vein of Giacomini.

At mid calf (~20cm) two prominent, incompetent perforators leave the incompetent posterior tibial, as well as, the medial set of gastrocnemius veins, respectively. Together, the two perforators supply the incompetent superficial tributaries / minimal varicosities of the postero-medial calf.

LEFT

An avascular, mixed echogenic mass noted at the groin, measuring ~ 1.8 cm TS x ~1.2cm ML ?enlarged lymph node ?infection.

Sapheno-femoral junction (SFJ) is competent. Long saphenous vein (LSV) is competent down to mid calf (~20cm), at which point, it becomes slightly incompetent, distal to a confluence with an incompetent tributary.

Sapheno-popliteal junction (SPJ) was not identified. Short saphenous vein (SSV) competent and is continuous with a competent vein of Giacomini, except for a very short section at mid calf (~20cm), between two incompetent branches.

At mid calf (~20cm) two prominent, incompetent perforators leave the incompetent posterior tibial, as well as, the medial set of gastrocnemius veins, respectively. Together, the two perforators supply the incompetent superficial tributaries / minimal varicosities of the postero-medial calf.