

Core Modality 2: Peripheral Arterial

25 scans over a 3 month period: 26/05/21 – 26/08/21

Arterial report	Schematic	Assessment type	Assessment date
PAD 1, PAD 2	✓	ABPI, Bilateral leg duplex	26/07/21
PAD 3, PAD 4	✓	Bilateral leg duplex (WGH)	22/07/21
PAD 5, PAD 6	✓	Bilateral iliac duplex	20/07/21
PAD 7	✓	Right iliac duplex	17/06/21
PAD 8, PAD 9	✓	ABPI, Bilateral fem & run-off duplex	15/06/21
PAD 10	✓	Left femoral duplex	08/06/21
PAD 11, PAD 12	✓	ABPI, bilateral leg duplex	28/05/21
PAD 13	✓	TBI, right iliac & run-off	28/05/21
PAD 14	X	Aneurysm (aorta)	28/08/21
PAD 15	X	Aneurysm (iliac)	05/07/21
PAD 16	X	EVAR	17/08/21
PAD 17	X	EVAR	05/06/21
PAD 18	X	EVAR	07/06/21
PAD 19	✓	TBI, graft surveillance	19/08/21
PAD 20	✓	Graft	08/06/21
PAD 21	✓	Graft	08/06/21
PAD 22	✓	ABPI, stent surveillance	27/07/21
PAD 23	X	Upper limb arterial	22/07/21
PAD 24	X	False aneurysm	23/06/21
PAD 25	X	False aneurysm	23/06/21

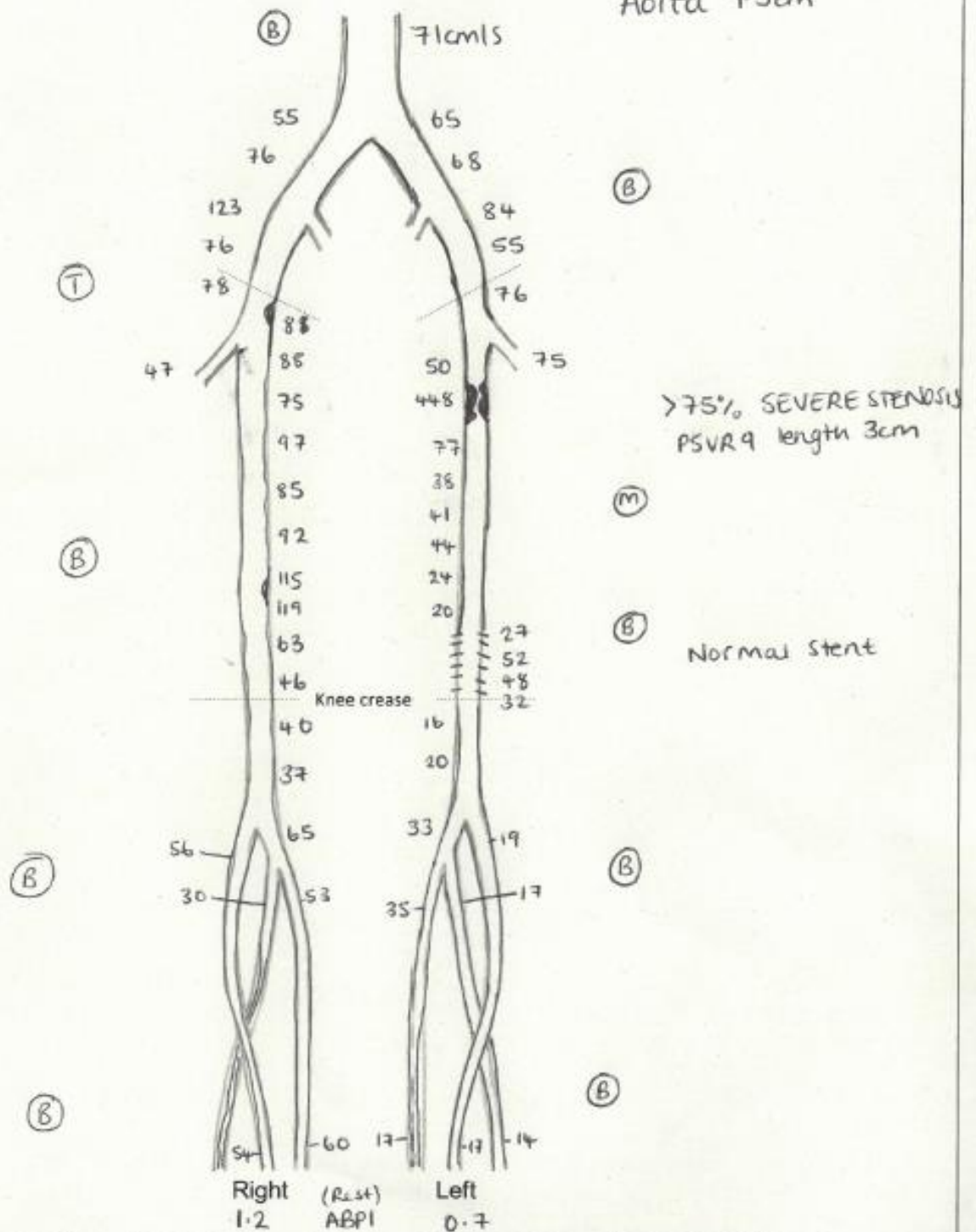
LOWER LIMB ARTERIAL DUPLEX (REPORTS 1-13)

PAD1 & PAD 2

US Ankle/Brachial Pressure Index	VERIFIED - Attended-26-Jul-2021 - RA7KATEHRAT7KATEH-26-Jul-2021
ABPI (ANKLE BRACHIAL PRESSURE INDEX) SYMPTOMS: Bilateral calf pain. Some days RIGHT is worse and others LEFT is worse. No ulcers or rest pain. INTERVENTION HISTORY: RIGHT fem-pop embolectomy in 2011 for arterial thrombus; LEFT pop angioplasty and stenting in 2008 for rest pain. RISK FACTORS: HTN, Past smoker (stopped 2012) RIGHT SIDE AT REST Brachial Tri ++ 130mmHg PTA Bi ++ 158mmHg ABPI=1.2 ATA Bi ++ 158mmHg ABPI= 1.2 DPA Bi ++ LEFT SIDE AT REST Brachial Tri ++ 122mmHg PTA Bi ++ 90mmHg ABPI= 0.7 ATA Bi ++ 96mmHg ABPI=0.7 DPA Bi ++ EXERCISE DETAILS Walked at 2.4km/hr at 10% incline for 1 minute. Test terminated due to fitness, patient out of breath. Reported mild pain to the left calf. Brachial Tri ++ 176mmHg RIGHT SIDE POST EXERCISE ATA Bi ++ 150mmHg ABPI= 1.2 LEFT SIDE POST EXERCISE ATA Mon ++90 mmHg ABPI= 0.6 NOTE: Limited exercise test due to SOB/ fitness level. SUMMARY RIGHT LEG: The post exercise ABPI of 1.2 with biphasic signals indicates good arterial supply. See duplex below. SUMMARY LEFT LEG: The post exercise ABPI of 0.6 with monophasic signals indicates peripheral arterial disease. See duplex below. ATA Anterior tibial artery, PTA Posterior tibial artery, DPA Dorsalis pedis artery ++ strong signal, + moderate signal, +-weak signal, - absent signal	

US Doppler Iliac & Femoral	VERIFIED - Attended-26-Jul-2021 - RA7KATEHRAT7KATEH-26-Jul-2021
LOWER LIMB ARTERIAL DUPLEX: Aorta 1.5cm, 71cm/s Bi RIGHT SIDE CIA mild 76cm/s Bi EIA mild 123cm/s Tri	
US Doppler Arteries Femoro-Popliteal	VERIFIED - Attended-26-Jul-2021 - RA7KATEHRAT7KATEH-26-Jul-2021
CFA Small calcified plaque <50% 88cm/s Tri PFA (origin) mild 47cm/s Bi SFA (proximal) Irregular 88cm/s Bi SFA (mid) mild 85cm/s Bi SFA (distal) mild 119cm/s Bi POP mild 46cm/s Bi TPT mild 65cm/s Bi PTA mild 60cm/s Bi ATA mild 56cm/s Bi PER mild proximally 30cm/s Bi	
US Doppler Iliac & Femoral	VERIFIED - Attended-26-Jul-2021 - RA7KATEHRAT7KATEH-26-Jul-2021
LEFT SIDE CIA mild 68cm/s Bi EIA mild 84cm/s Bi	
US Doppler Arteries Femoro-Popliteal	VERIFIED - Attended-26-Jul-2021 - RA7KATEHRAT7KATEH-26-Jul-2021
CFA mild 76cm/s Bi PFA (origin) 75cm/s Bi SFA (proximal) SEVERE STENOSIS (>75%; PSVR 9; 3cm in length) SFA (mid) mild 41cm/s Mono SFA (distal) mild 44cm/s Bi POP (above knee) normal stent ~6cm length 52cm/s Bi POP (below knee) mild 20cm/s Bi TPT mild 33cm/s Bi PTA mild 35cm/s Bi ATA mild 19cm/s Bi PER mild 17cm/s Bi SUMMARY RIGHT LEG: No significant arterial disease from aorta to ankle with tri/biphasic Doppler signals throughout. Resting ABPI of 1.2Bi. SUMMARY LEFT LEG: Severe stenosis seen in the proximal SFA. Normal POP stent. Biphasic signals throughout the calf. Resting ABPI of 0.7Bi. Technical Quality: Good Scanned by: Kate Houghton, Senior Clinical Vascular Scientist CIA Common iliac artery, EIA External iliac artery, IIA Internal iliac artery, CFA Common femoral artery, PFA profunda femoral artery, SFA Superficial femoral artery, POP Popliteal artery, TPT Tibio-peroneal trunk, ATA Anterior tibial artery, PTA Posterior tibial artery, PER Peroneal artery. Any queries please contact Vascular Science on 0117 34 27530.	

Aorta 1.5cm



PAD 3& PAD 4

US Doppler Iliac and Femoral artery Both

LOWER LIMB ARTERIAL DUPLEX:

SYMPTOMS: Bilateral Claudication L>R. Slow healing wound (~6months) to the left shin. IDDM

RIGHT ABPI: 0.8m resting to 0.6m post exercise; TBI: 0.6

LEFT ABPI: 0.7m resting to 0.4m post exercise; TBI 0.5

Aorta 1.8cm, 72 cm/s Tri

RIGHT SIDE

CIA mild 139 cm/s Tri

EIA mild 194 cm/s Tri

US Doppler Arteries Femoro-Popliteal

CFA irregular 93 cm/s Tri

PFA (origin) ~50% MILD-MODERATE STENOSIS (167 cm/s, PSVR 2)

SFA (proximal) mild 108 cm/s Tri

SFA (mid) mild 62 cm/s Tri

SFA (distal) >75% SEVERE STENOSIS calcified (51-211 cm/s, PSVR 4, length ~3cm)

POP (proximal) mild 45 cm/s Tri

POP (distal) OCCLUDED, good collaterals

TPI (proximal) OCCLUDED, good collaterals

TPI (distal) mild 17 cm/s Mono

FIA mild 38 cm/s Mono

ATA OCCLUDED at origin, refilling proximally by collaterals 9 cm/s Mono

PER mild 11 cm/s Mono

US Doppler iliac and femoral arteries Both

LEFT SIDE

CIA mild 149 cm/s Tri

EIA mild 171cm/s Tri

US Doppler Arteries Femoro-Popliteal

CFA mild 101 cm/s Tri

PFA (origin) mild 93 cm/s Tri

SFA (proximal) mild 84 cm/s Tri

SFA (mid) mild 70 cm/s Tri

SFA (distal) Focal 50-75% MODERATE STENOSIS (56-163 cm/s, PSVR 3, length ~0.5cm)

POP (proximal) 62cm/s Tri

POP (distal) OCCLUDED, good collaterals

TPT (proximal) OCCLUDED, good collaterals

TPT (distal) mild Mono

PTA mild 42cm/s Mono

ATA mild 14cm/s Mono

PER mild 14cm/s Mono

SUMMARY RIGHT LEG: Mild iliac arteries. MILD-MODERATE (~50%) STENOSIS at the profunda origin. SEVERE (>75%) STENOSIS in the distal SFA. OCCLUDED popliteal artery and proximal TPT. ATA occluded at the origin, but refills proximally via collaterals. Mild PTA and PER

SUMMARY LEFT LEG: Mild iliac arteries. MODERATE (50-75%) STENOSIS in the distal SFA. OCCLUDED popliteal artery and proximal TPT. Three vessel run-off

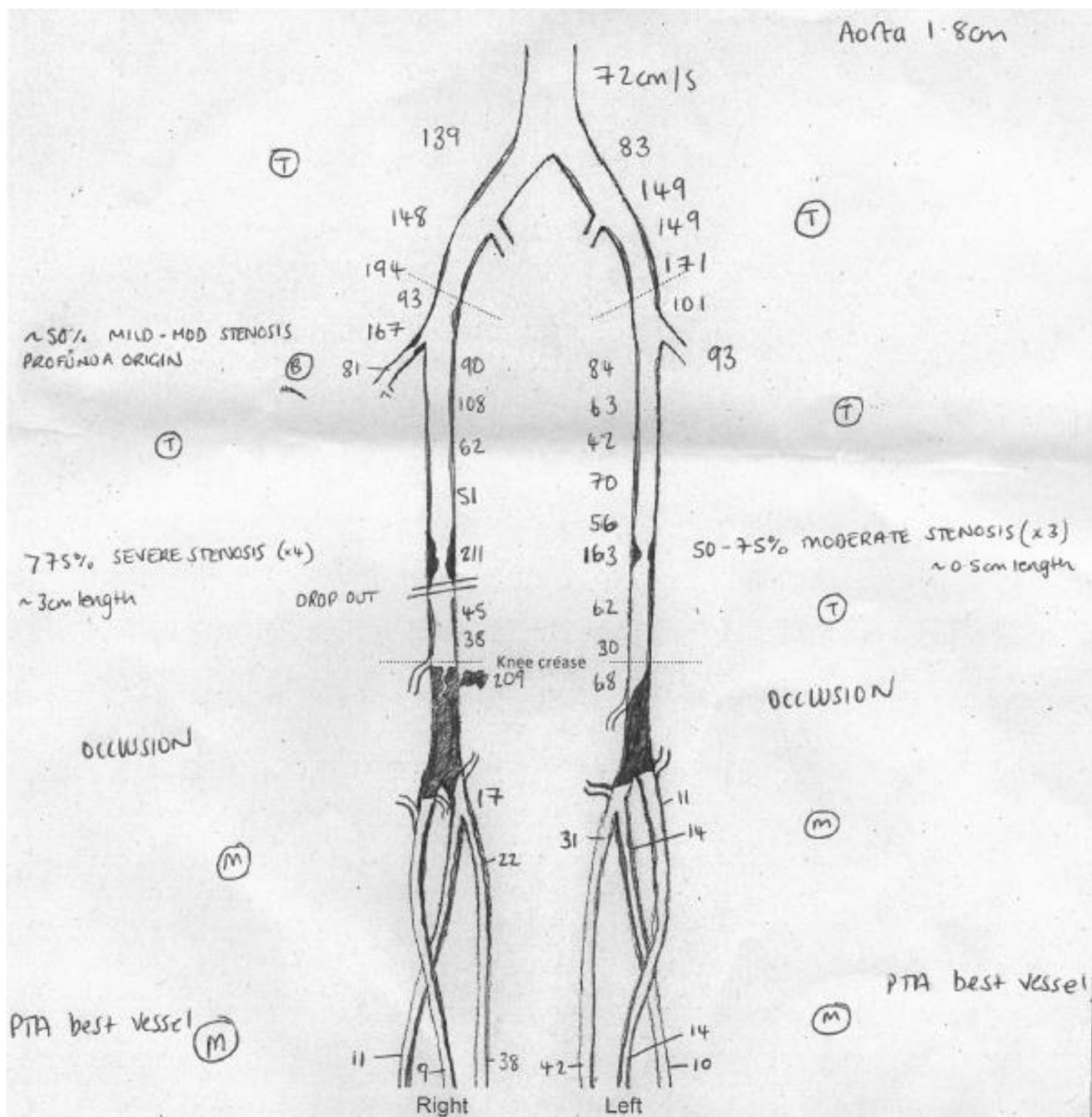
Technical Quality: Good

Scanned by: Shannon Halliwell, Junior Clinical Vascular Scientist

Supervised by: Kate Houghton, Senior Clinical Vascular Scientist

CIA Common iliac artery, EIA External iliac artery, IIA Internal iliac artery, CFA Common femoral artery, PFA profunda femoral artery, SFA Superficial femoral artery, POP Popliteal artery, TPT Tibio-peroneal trunk, ATA Anterior tibial artery, PTA Posterior tibial artery, PER Peroneal artery.

Any queries please contact Vascular Science on 0117 34 27530.

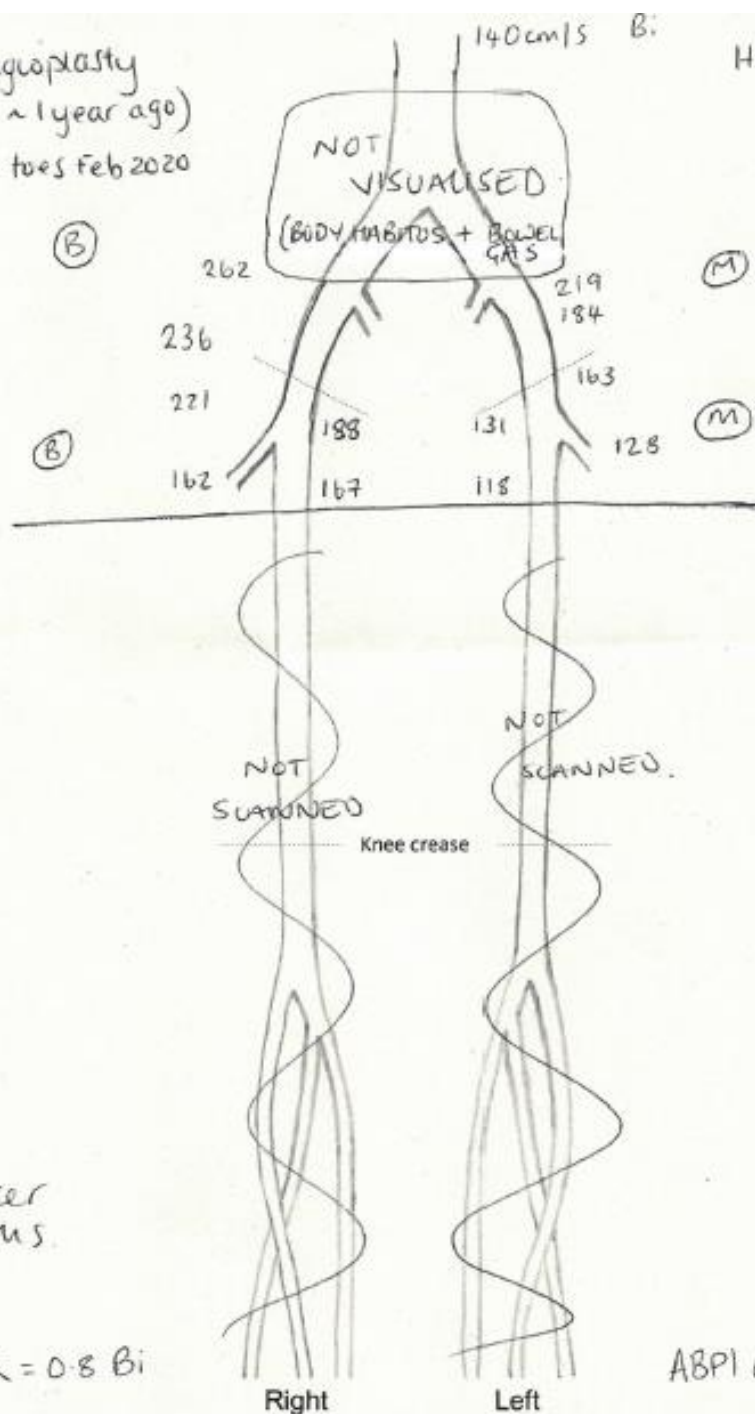


PAD 5 & PAD 6

US Ankle /Brachial Pressure Index		VERIFIED - Attended-20-Jul-2021 - RA7KATEHRA7KATEH-20-Jul-2021
ABPI (ANKLE BRACHIAL PRESSURE INDEX) SYMPTOMS: ulcer to RIGHT heel for 18months, improving post angioplasty. History of RIGHT leg angioplasty x2 (~1month and ~1 year ago). Amputation of RIGHT toes 18months ago. History of LEFT leg angioplasty (~2 years ago). Poor mobility. Absent femoral pulses and Doppler filling of the iliacs on ultrasound during cardiac procedure this morning. ? iliac occlusion. RISK FACTORS: IHD, HTN, IDDM.		
RIGHT SIDE AT REST Brachial Bi ++ 172mmHg PTA - not detected ATA - not detected DPA dressing PER Bi ++ 140mmHg ABPI= 0.8		
LEFT SIDE AT REST PTA - Not detected ATA Mon ++ 80mmHg ABPI= 0.5 DPA - Not detected		
++ strong signal, + moderate signal, +-weak signal, - absent signal		
US Doppler Iliac & Femoral		VERIFIED - Attended-20-Jul-2021 - RA7KATEHRA7KATEH-20-Jul-2021
LOWER LIMB ARTERIAL DUPLEX: Aorta: poor views, not visualised distally, Bi		
RIGHT SIDE CIA not visualised EIA mild 262cm/s Bi CFA mild 188 Bi PFA (origin) mild 162cm/s Bi SFA (origin) mild 167cm/s Bi		
US Doppler Iliac & Femoral		VERIFIED - Attended-20-Jul-2021 - RA7KATEHRA7KATEH-20-Jul-2021
LEFT SIDE CIA not visualised EIA mild 219cm/s perky mono CFA mild 163cm/s perky mono PFA (origin) mild 128cm/s perky mono SFA (origin) mild 188cm/s damped mono		
COMMENTS: Unable to visualise the distal aorta and bilateral common iliacs arteries due to large body habitus and bowel gas.		
SUMMARY RIGHT LEG: Known peripheral arterial disease. Raised velocities throughout the EIA and CFA but no evidence of focal stenosis. Good biphasic signals indicate reasonable supply proximally in the non-visualised CIA. The ABPI of 0.8 indicates PAD however the Biphasic signals at the ankle indicates reasonable arterial supply to the foot.		
SUMMARY LEFT LEG: Known peripheral arterial disease. Raised velocities throughout the EIA and CFA but no evidence of focal stenosis. Perky monophasic signals (with good systolic rise time) in the EIA suggests the non-visualised CIA is not occluded. The ABPI of 0.5 with damped monophasic signals indicates reduced arterial supply to the foot. The Doppler signals at SFA origin and ankle suggest likely disease in the non-scanned fem-pop region.		
Technical Quality: Average/Poor Scanned by: Kate Houghton, Senior Clinical Vascular Scientist		
CIA Common iliac artery, EIA External iliac artery, IIA Internal iliac artery, CFA Common femoral artery, PFA profunda femoral artery, SFA Superficial femoral artery, POP Popliteal artery, TPT Tibio-peroneal trunk, ATA Anterior tibial artery, PTA Posterior tibial artery, PER Peroneal artery.		
Any queries please contact Vascular Science on 0117 34 27530.		

Hx of x2 Angioplasty
(~ 1 month + ~ 1 year ago)
Amputation of toes Feb 2020

Hx of x1 Angioplasty
(~ 2 ~~month~~ year ago)



Diabetic ulcer
for 18 months
(improving)

ABPI @ PER = 0.8 Bi

ABPI @ ATA = 0.5 Mono

LOWER LIMB ARTERIAL DUPLEX:

HISTORY: Right pelvic reconstruction 24 years ago.

RIGHT]

CIA: Normal Triphasic 99 cm/s

EIA: Groin arterial reconstruction.

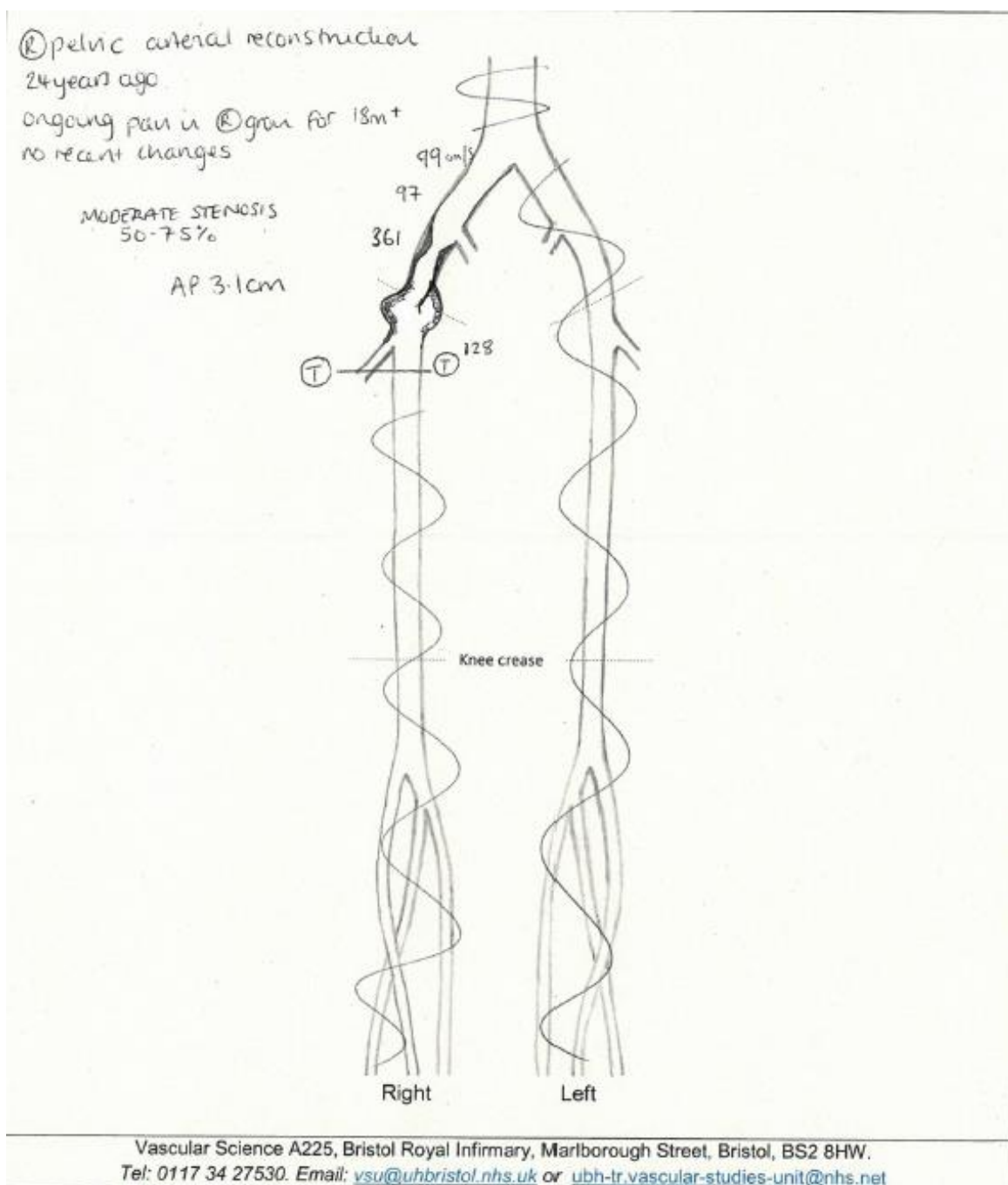
Proximal section of reconstruction: Moderate stenosis (50-75%) 97-361 cm/s (no change in 6 months)

Distal section of reconstruction: dilated measuring AP 3.1cm (no change in 6 months)

SFA Proximal: 128 cm/s, Triphasic

Note: complex scan of arterial reconstruction

SUMMARY RIGHT LEG: No change from previous scan in Dec 2020. Moderate stenosis (50-75%) at the proximal section of reconstruction. Dilatation at distal section of reconstruction to 3.1cm.

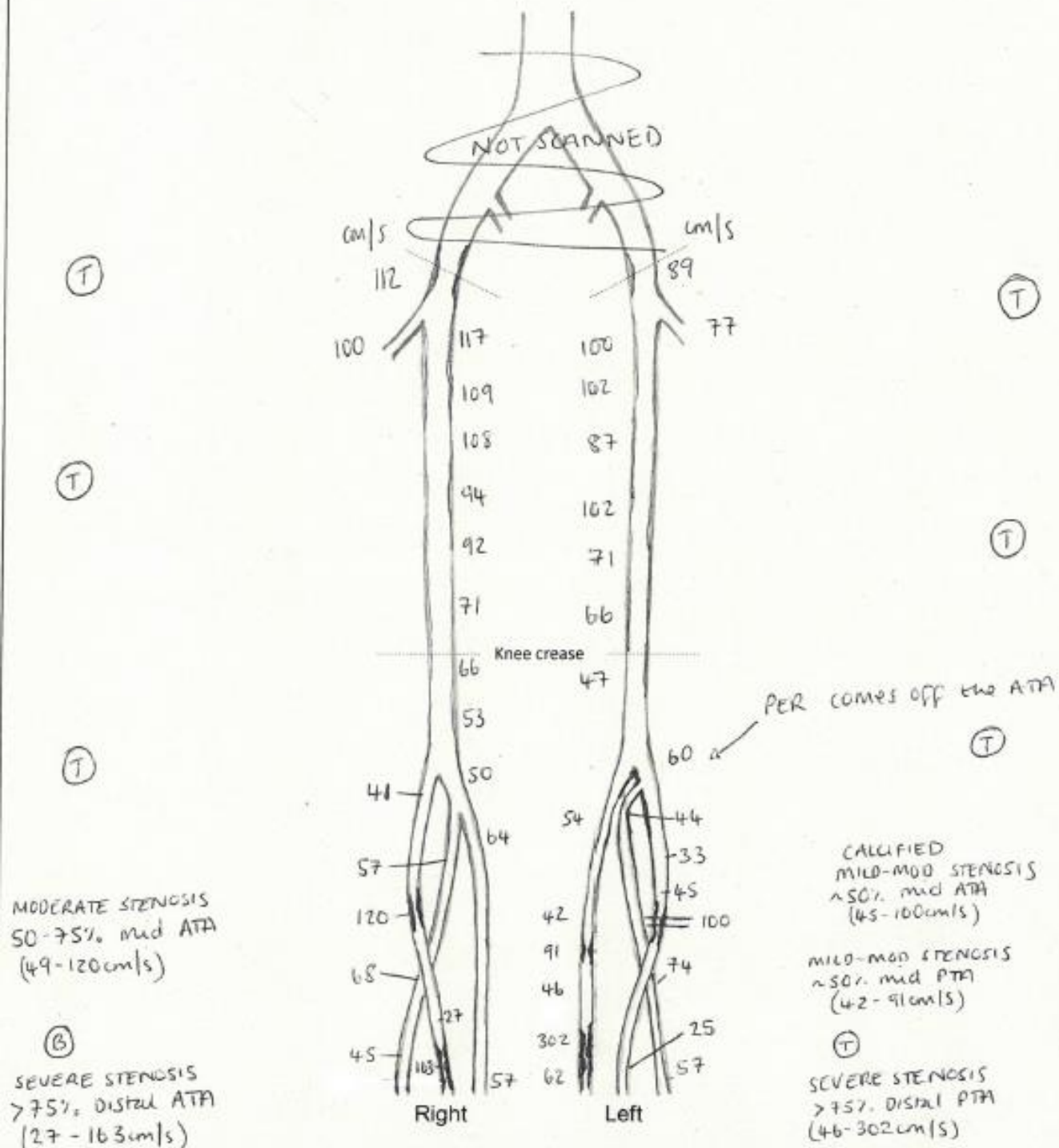
Scanned by: Kate Houghton (Senior Vascular Clinical Scientist)CIA Common iliac artery, EIA External iliac artery, IIA Internal iliac artery, CFA Common femoral artery, PFA profunda femoral artery, SFA Superficial femoral artery
Any queries please contact Vascular Science on 0117 34 27530.

PAD 8 & PAD 9

US Ankle /Brachial Pressure Index	VERIFIEDAttended-15-Jun-2021RA7KATEHRA7KATEH-15-Jun-2021
ABPI (ANKLE BRACHIAL PRESSURE INDEX) SYMPTOMS:None (no intermittent claudication, rest pain or tissues loss). Being worked up for major oncological resection (mandibulectomy) and reconstruction with vascularised fibula free flap. RISK FACTORS: HTN. No IHD, DM or smoking history.	
RIGHT SIDE AT REST Brachial Tri ++ 138mmHg PTA Bi ++ 172mmHg ABPI=1.2 ATA Bi ++ 160mmHg ABPI= 1.1 DPA Bi ++165mmHg ABPI= 1.2	
LEFT SIDE AT REST Brachial Tri ++ 142mmHg PTA Tri ++ 165mmHg ABPI= 1.2 ATA Tri ++ 160mmHg ABPI=1.1 DPA Bi ++148mmHg ABPI= 1.0	
SUMMARY RIGHT LEG:Resting ABPI of 1.2 with biphasic signals - duplex findings below. SUMMARY LEFT LEG:Resting ABPI of 1.2 with triphasic signals - duplex findings below.	
ATA Anterior tibial artery, PTA Posterior tibial artery, DPA Dorsalis pedis artery ++ strong signal, + moderate signal, +-weak signal, - absent signal	

US Doppler Iliac & Femoral	VERIFIEDAttended-15-Jun-2021RA7KATEHRA7KATEH-15-Jun-2021
LOWER LIMB ARTERIAL DUPLEX: RIGHT SIDE	
US Doppler Arteries Femoro-Popliteal	VERIFIEDAttended-15-Jun-2021RA7KATEHRA7KATEH-15-Jun-2021
CFA mild 112cm/s Tri PFA (origin) mild 100cm/s Tri SFA (proximal) mild 117cm/s Tri SFA (mid) mild 94cm/s Tri SFA (distal) mild 71cm/s Tri POP mild 66cm/s Tri TPT mild 53cm/s Tri PTA mild 64cm/s Tri, changing to Bi at ankle ATA MODERATE STENOSIS (50-75%) in the mid ATA (49-120cm/s); SEVERE STENOSIS (>75%) in the distal ATA (27-163cm/s) Tri, changing to Bi at ankle PER mild 68cm/s Tri, changing to Bi at ankle	

US Doppler Iliac & Femoral	VERIFIEDAttended-15-Jun-2021RA7KATEHRA7KATEH-15-Jun-2021
LEFT SIDE	
US Doppler Arteries Femoro-Popliteal	VERIFIEDAttended-15-Jun-2021RA7KATEHRA7KATEH-15-Jun-2021
CFA mild PFA (origin) mild SFA (proximal) mild SFA (mid) mild SFA (distal) mild POP mild PTA MILD-MODERATE STENOSIS (~50%) in the mid PTA (42-91cm/s); SEVERE STENOSIS (>75%) in the distal PTA (46-302cm/s) tri signals throughout ATA calcified MILD-MODERATE STENOSIS (~50%) in the mid ATA (45-100cm/s) tri signals throughout PER mild with Tri signals throughout - note the PER arises from the ATA	
SUMMARY RIGHT LEG: Very mild atheroma of the CFA, SFA, POP, TPT, PTA and PER. 50-75% stenosis in the mid ATA and >75% stenosis in the distal ATA. Triphasic signals changing to Biphasic at the ankle. Consistent with CTA 4/6/21. SUMMARY LEFT LEG:Very mild atheroma of the CFA, SFA, POP and PER. ~50% stenosis in the mid PTA and >75% stenosis in the distal PTA. ~50% calcified stenosis in the mid ATA. Triphasic signals throughout. Consistent with CTA 4/6/21. Technical Quality: Good	
Scanned by: Kate Houghton, Senior Clinical Vascular Scientist	
CIA Common iliac artery, EIA External iliac artery, IIA Internal iliac artery, CFA Common femoral artery, PFA profunda femoral artery, SFA Superficial femoral artery, POP Popliteal artery, TPT Tibio-peroneal trunk, ATA Anterior tibial artery, PTA Posterior tibial artery, PER Peroneal artery.	
Any queries please contact Vascular Science on 0117 34 27 530.	



PAD 10

US Doppler Arteries Femoro-Popliteal

VERIFIED - Attended-08-Jun-2021 - HOUGHTON/HOUGHTON-08-Jun-2021

LOWER LIMB ARTERIAL DUPLEX:

SYMPTOMS: woke up 5 days ago with swollen painful left leg. Recent CTA suggested possible extrinsic compression of the popliteal artery and ?small false aneurysm.

SFA (proximal) normal 128 cm/s Tri

SFA (mid) normal 142 cm/s Tri

SFA (distal) normal 122 cm/s Tri

POP normal 108 cm/s Tri

TFT normal 97 cm/s Tri

PTA (ankle only) normal 81 cm/s Tri

ATA (ankle only) normal 91 cm/s Tri

PER not assessed

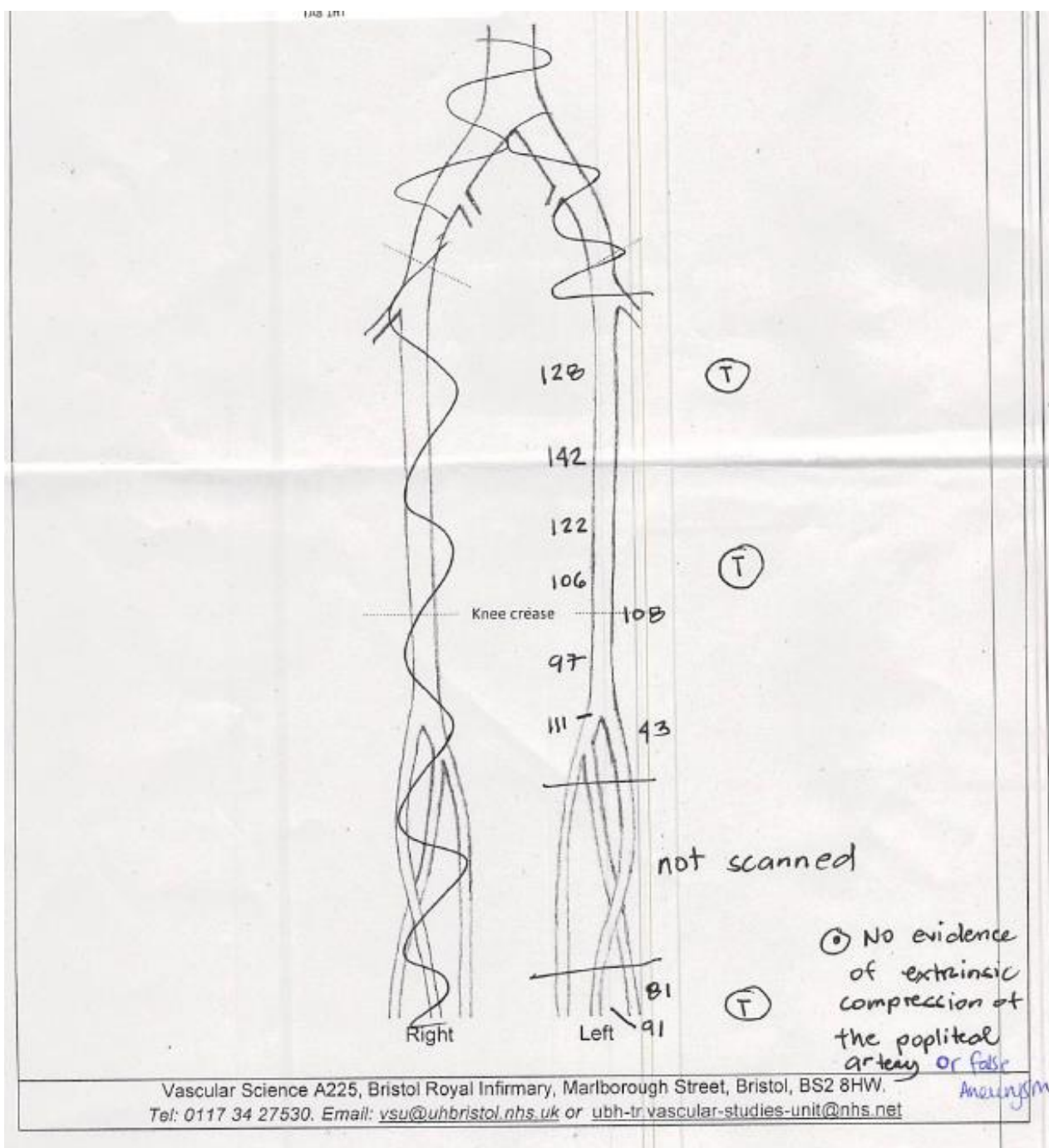
SUMMARY LEFT LEG: Normal arterial duplex scan. No evidence of extrinsic compression of the popliteal artery or evidence of false aneurysm.

Technical Quality: Good

Scanned by: K. Houghton, Senior Vascular Scientist

CIA Common iliac artery, EIA External iliac artery, IIA Internal iliac artery, CFA Common femoral artery, PFA profunda femoral artery, SFA Superficial femoral artery, POP Popliteal artery, TFT Tibio-peroneal trunk, ATA Anterior tibial artery, PTA Posterior tibial artery, PER Peroneal artery.

Any queries please contact Vascular Science on 0117 34 27530.

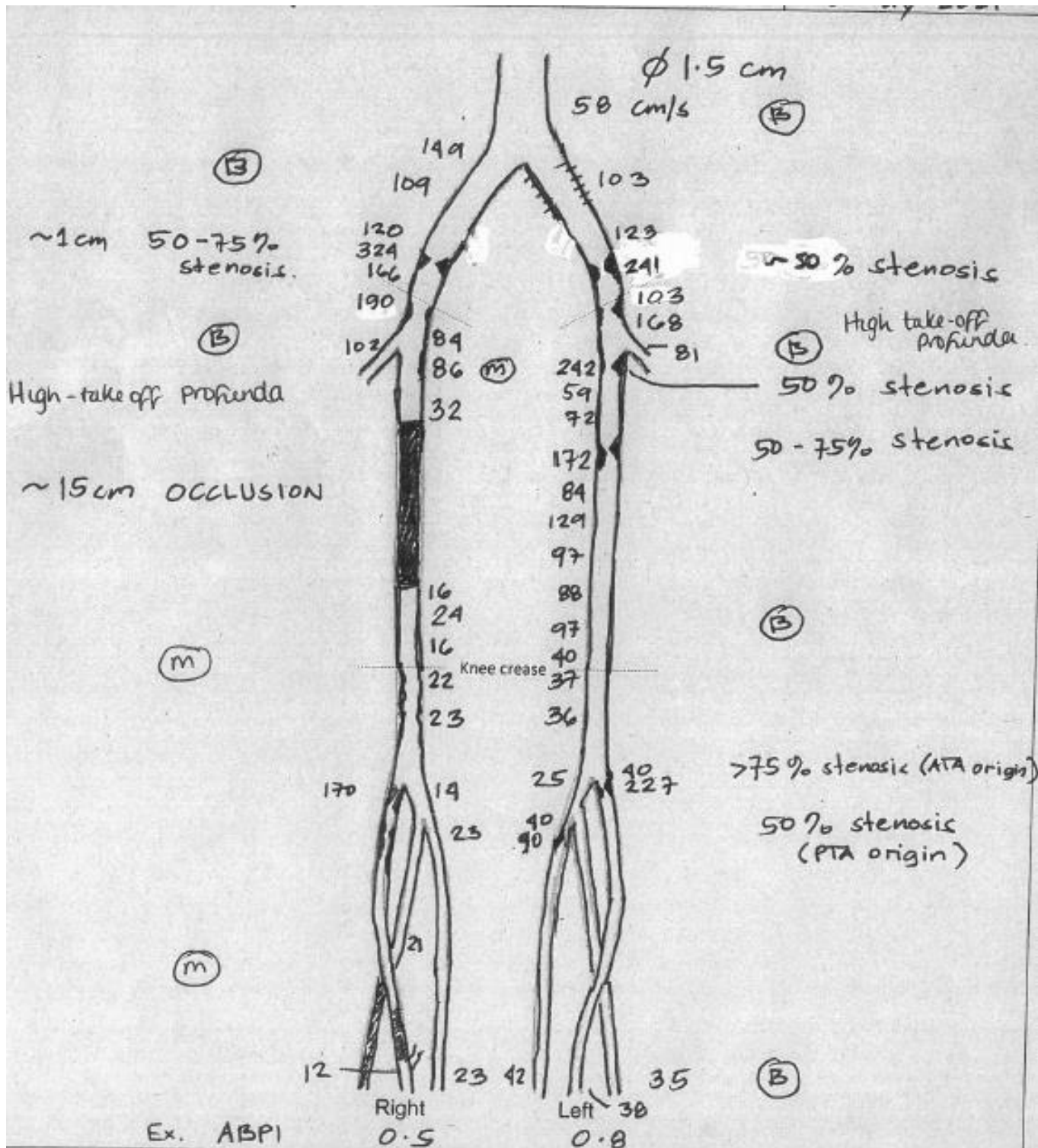


PAD 11 & PAD 12

<div>US Ankle /Brachial Pressure Index</div> <div>ABPI (ANKLE BRACHIAL PRESSURE INDEX) SYMPTOMS: Bilateral claudication at 20 yards. LEFT sided intervention previously (angioplasty and CIA stenting). RISK FACTORS: HTN, Ex-smoker 20 years ago, MI in 1998 RIGHT SIDE AT REST Brachial Tri ++ 140 mmHg PTA Mono ++ 108 mmHg ABPI= 0.8 ATA not detected DPA Mono + 92 mmHg ABPI= 0.7 LEFT SIDE AT REST Brachial Tri ++ 140 mmHg PTA Bi ++ 118 mmHg ABPI= 0.8 ATA Bi ++ 118 mmHg ABPI= 0.8 DPA Bi ++ EXERCISE DETAILS Corridor walk for 3 minutes with bilateral buttock pain at Right Brachial Tri ++ 158 mmHg RIGHT SIDE POST EXERCISE PTA Mono ++ 74 mmHg ABPI= 0.5 LEFT SIDE POST EXERCISE PTA Mono ++ 130 mmHg ABPI= 0.8 SUMMARY RIGHT LEG: The reduced post exercise ABPI of 0.5 with monophasic signals and the presence of buttock pain during the exercise test is consistent with the presenting symptoms. This supports a diagnosis of intermittent claudication caused by peripheral arterial disease. SUMMARY LEFT LEG: The post exercise ABPI of 0.8 with monophasic signals supports a diagnosis of peripheral arterial disease however the absence of a significant decrease in ABPI pressure post exercise suggests the presenting symptom of buttock pain is not exclusively caused by peripheral arterial disease. Assessed by:K. Houghton, Senior Clinical Vascular Scientist ATA Anterior tibial artery, PTA Posterior tibial artery, DPA Dorsalis pedis artery ++ strong signal, + moderate signal, +-weak signal, - absent signal</div>	<div>VERIFIED</div> <div>Attended-28-May-2021</div> <div>RA7GUARINNRA7OUARINN-28-May-2021</div>
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<div>US Doppler Iliac & Femoral</div> <div>LOWER LIMB ARTERIAL DUPLEX: Aorta 1.5 cm RIGHT SIDE CIA irregular 149 cm/s Bi IIA (origin) not visualised, known occlusion EIA (mid) ~1 cm MODERATE (50-75%) STENOSIS; PSV 120-324 cm/s Bi; PSVR 2.7 US Doppler Arteries Femoro-Popliteal</div> <div>CFA calcified plaque <50%; 190 cm/s Bi PFA (origin) (high bifurcation) mild 102 cm/s Bi SFA (origin-prox) (high bifurcation) irregular SFA (prox-mid) ~15 cm OCCLUSION SFA (adductor level) irregular 16 cm/s Mono POP irregular 23 cm/s Mono TPT calcified and irregular 14 cm/s Mono PTA mild 23 cm/s Mono ATA only seen at the origin 170 cm/s Mono, OCCLUDED distally PER only seen to mid 21 cm/s Mono</div> <div>US Doppler Iliac & Femoral</div> <div>LEFT SIDE CIA (stent) patent 103 cm/s Bi IIA (origin) not visualised, known occlusion EIA (mid) BORDERLINE (50%) STENOSIS; PSV 123-241 cm/s Bi; PSVR 2</div>	<div>VERIFIED</div> <div>Attended-28-May-2021</div> <div>RA7GUARINNRA7OUARINN-28-May-2021</div>
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<div>US Doppler Arteries Femoro-Popliteal</div> <div>AN ADDENDUM HAS BEEN ENTERED AT THE END OF THIS REPORT CFA calcified plaque <50% 168 cm/s Bi PFA (origin) mild 81 cm/s Bi SFA (origin) BORDERLINE (50%) STENOSIS; PSV 242 cm/s Bi SFA (proximal) irregular 59 cm/s Bi SFA (mid) MODERATE (50-75%) STENOSIS; PSV 72-172 cm/s Bi;PSVR 2.4 SFA (distal) irregular 97 cm/s POP irregular 40 cm/s Bi TPT irregular 25 cm/s Bi PTA (origin) BORDERLINE (50%) STENOSIS 42 cm/s Bi ATA (origin) SEVERE (75%) STENOSIS; PSV 40-227 cm/s Bi; PSVR 5.7 PER mild seen to ankle 35 cm/s Bi SUMMARY RIGHT LEG:Focal 50-75% stenosis in the Mid EIA. Calcified plaque <50% in the CFA. Note high bifurcation. The SFA occludes ~10cm from the origin, and is occluded for ~15cm. Irregular calcified POP and TPT. Single vessel run-off via the PTA. SUMMARY LEFT LEG: Normal CIA stent. Diffuse ~50% stenosis in the mid-distal EIA. Calcified plaque <50% in the CFA. Note high bifurcation. Calcified plaque at the SFA origin causing a ~50% stenosis. Stenosis (50-75%) in the mid SFA. Irregular calcified POP and TPT. Small irregular PER but seen in continuity. Stenosis at the ATA (origin) and PTA (proximal) but both seen to ankle. Technical Quality: Good Scanned by: K. Houghton, Senior Clinical Vascular Scientist CIA Common iliac artery, EIA External iliac artery, IIA Internal iliac artery, CFA Common femoral artery, PFA profunda femoral artery, SFA Superficial femoral artery, POP Popliteal artery, TPT Tibio-peroneal trunk, ATA Anterior tibial artery, PTA Posterior tibial artery, PER Peroneal artery. Any queries please contact Vascular Science on 0117 34 27530. ADDENDUM START by Kate Houghton, Vascular Scientist 28-May-2021 13:46 EXERCISE DETAILS Corridor walk for 3 minutes (distance 208m) with bilateral buttock pain immediately and ongoing throughout test.</div>	<div>VERIFIED</div> <div>Attended-28-May-2021</div> <div>RA7GUARINNRA7OUARINN-28-May-2021</div>
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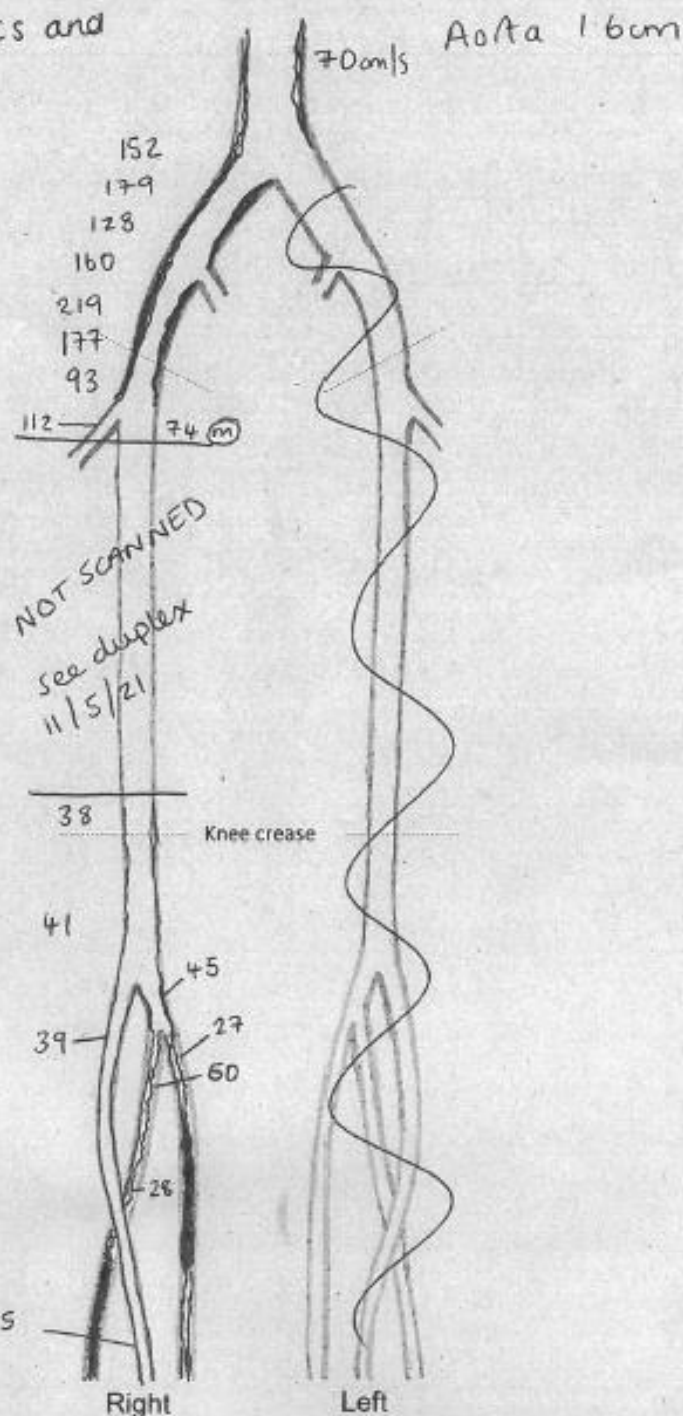
US Ankle /Brachial Pressure Index	VERIFIED - Attended-28-May-2021 - RA7KATEHRA7KATEH-28-May-2021
History: Patient seen for RIGHT stent surveillance 11/05/21 with ABPI of 0.2. Further assessment of iliac and run-off arteries.	
TBI (TOE BRACHIAL INDEX) Right index finger 179mmHg Right great toe 55mmHg SUMMARY RIGHT LEG: TBI of 0.3	
US Doppler Iliac & Femoral	VERIFIED - Attended-28-May-2021 - RA7KATEHRA7KATEH-28-May-2021
LOWER LIMB ARTERIAL DUPLEX: SYMPTOMS: Patient seen for RIGHT stent surveillance 11/05/21 with ABPI of 0.2. Further assessment of iliac and run-off arteries.	
Aorta 1.6cm, 70cm/s	
RIGHT SIDE CIA (prox) mild-moderate atheroma 152cm/s Tri CIA (distal) mild-moderate atheroma 179cm/s Tri EIA mild (prox) mid-moderate atheroma 160cm/s Tri EIA mild (distal) mid-moderate atheroma 219cm/s Tri	
US Doppler Arteries Femoro-Popliteal	VERIFIED - Attended-28-May-2021 - RA7KATEHRA7KATEH-28-May-2021
CFA mild 93cm/s Tri PFA (origin) mild 112cm/s Tri SFA (origin only) mild 74cm/s Mon SFA (stent): not scanned - see duplex 11/05/21 POP mild 41cm/s Mon TPT mild 45cm/s Mon PTA OCCLUDED in the mid section. ATA mild seen to ankle PER OCCLUDED in the distal section.	
SUMMARY RIGHT LEG: mild-moderate atheroma (<50%) with triphasic signals throughout the iliac arteries and CFA. SFA stent not scanned today. Mild atheroma of the POP and TPT. Single vessel run-off via the ATA. The PTA (mid) and PER (distal) are occluded.	
Technical Quality: Good.	
Scanned by: Kate Houghton, Senior Clinical Vascular Scientist	
CIA Common iliac artery, EIA External iliac artery, IIA Internal iliac artery, CFA Common femoral artery, PFA profunda femoral artery, SFA Superficial femoral artery, POP Popliteal artery, TPT Tibio-peroneal trunk, ATA Anterior tibial artery, PTA Posterior tibial artery, PER Peroneal artery.	
Any queries please contact Vascular Science on 0117 34 27530.	

Focused scan of iliacs and
Run-off.

Atheromatous
but no focal
stenoses

(T)

(T)



Single vessel R/O
via ATA.

(m)

Finger = 179 mmHg
Great Toe = 55 mmHg
TBI = 0.3

ANEURYSM (REPORTS 14-15)

PAD 14

US Abdominal Aorta

VERIFIED - Attended-26-Aug-2021 - RA7KATEHRA7KATEH-26-Aug-2021

ANEURYSM SURVEILLANCE: BMode examination of the abdominal aortic aneurysm to assess for expansion. All diameter measurements are maximum inner-wall to inner-wall AP (anterior to posterior).

Infra-renal Abdominal Aorta TS 3.2cm LS 3.1cm

SUMMARY: AAA 3.2cm (compared to previous measurement of 3.0cm in Nov 2019). Vascular Science will automatically recall the patient for surveillance in 1 year (Aug 22) in accordance with the BBW vascular network protocol. Patient also having temporal artery duplex today, therefore aneurysm surveillance performed at the same time.

Scanned by: Kate Houghton, Senior Clinical Vascular Scientist

BRISTOL, BATH & WESTON VASCULAR NETWORK AAA PROTOCOL
Patient is under the care of Mr Neary. The surgical intervention threshold is currently set at 5.5cm and the patient will be referred back to the Vascular Nurse Specialist at 5.0cm. Any queries please contact Vascular Science on 0117 34 27530

PAD 15

US Abdominal Aorta

VERIFIED - Attended-05-Jul-2021 - RA7KATEHRA7KATEH-05-Jul-2021

ANEURYSM SURVEILLANCE: BMode examination of the abdominal aortic aneurysm to assess for expansion. All diameter measurements are maximum inner-wall to inner-wall AP (anterior to posterior).

Referral from the AAA screening programme, enlarged Right common iliac artery.

Infra-renal Abdominal Aorta TS 2.4cm LS 2.4cm
Right common iliac artery TS 2.4cm LS 2.4cm
Left common iliac artery 1.5cm
Right popliteal artery 1.1cm
Left popliteal artery 1.1cm

SUMMARY: RCIA 2.4cm. Vascular Science will automatically recall the patient for surveillance in 1 year (July 2022) in accordance with the BBW vascular network protocol.

Scanned by: Kate Houghton, Senior Clinical Vascular Scientist

BRISTOL, BATH & WESTON VASCULAR NETWORK AAA PROTOCOL
Patient referred from the AAA screening programme and has been automatically placed under the care of Mr Beckett. The vascular network will be contacted to request a vascular nurse specialist review in clinic. Any queries please contact Vascular Science on 0117 34 27530

EVAR (REPORTS 16-18)

PAD 16

<div>US Doppler Aorta</div> <div>DUPLEX EVAR SURVEILLANCE: BMode and Doppler ultrasound examination of the EVAR stent to assess for sac expansion, kinking, stenosis and endoleak.</div> <div>3 years post EVAR stent for AAA (29/6/18)</div> <div>Residual sac measures 4.4 cm AP and 4.7 cm LM in transverse section and 4.4 cm AP in longitudinal section and comparison with previous measurements of 4.3 cm x 4.6 cm (August 2020) indicates stable sac size. No evidence of colour Doppler filling within sac lumen. Triphasic/biphasic Doppler signals noted throughout EVAR stent and iliac arteries with no evidence of significant stenosis or kinking.</div> <div>NOTE: Has been reported as challenging assessment on past visits due to bowel gas, hernia and tense abdomen. PACS images were reviewed prior to scan as suggested in last report. Technical quality good today.</div> <div>SUMMARY: Patent EVAR stent with no evidence of endoleak. Vascular Science will automatically recall the patient for surveillance in 1 year (August 2022) in accordance with the BBW vascular network protocol.</div> <div>Scanned by: S. Halliwell, Junior Clinical Vascular Scientist Supervised by: K. Houghton, Senior Clinical Vascular Scientist</div> <div>Any queries please contact Vascular Science on 0117 34 27530</div>	<div>VERIFIEDAttended-19-Aug-2021HALLIWESHALLIWESH-19-Aug-2021</div>
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PAD 17

<div>US Doppler Aorta</div> <div>8 years post EVAR stent for AAA (Dec 2013 in Gloucester). Right iliac limb extension and onyx Dec 2016. Mr Brooks is considering further re-intervention for proximal and left limb seal.</div> <div>Residual sac measures 7.2 cm AP and 7.0 cm LM in transverse section and 7.1 cm AP in longitudinal section. Comparison with previous measurements of 7.1 cm in July 2020 indicate sac size is stable.</div> <div>No evidence of endoleak today. There is dilatation of the LEFT common iliac artery at the attachment site of the LEFT stent limb. The diameter changes from 1.8cm (LEFT limb stent) to 2.6cm (LEFT CIA) but there is no evidence of a type 1b endoleak back filling into the sac.</div> <div>Triphasic/biphasic Doppler signals noted throughout EVAR stent and iliac arteries.</div> <div>SUMMARY: Patent EVAR stent with no evidence of endoleak. Dilatation of the LEFT CIA at the site of LEFT stent limb attachment.</div> <div>Scanned By: Kate Houghton, Senior Clinical Vascular Scientist</div> <div>Vascular Science will automatically recall the patient in 6 months as requested by Mr Brooks (January 2022) in accordance with the BBW vascular network protocol</div>	<div>VERIFIEDAttended-05-Jul-2021RA7KATEHRA7KATEH-05-Jul-2021</div>
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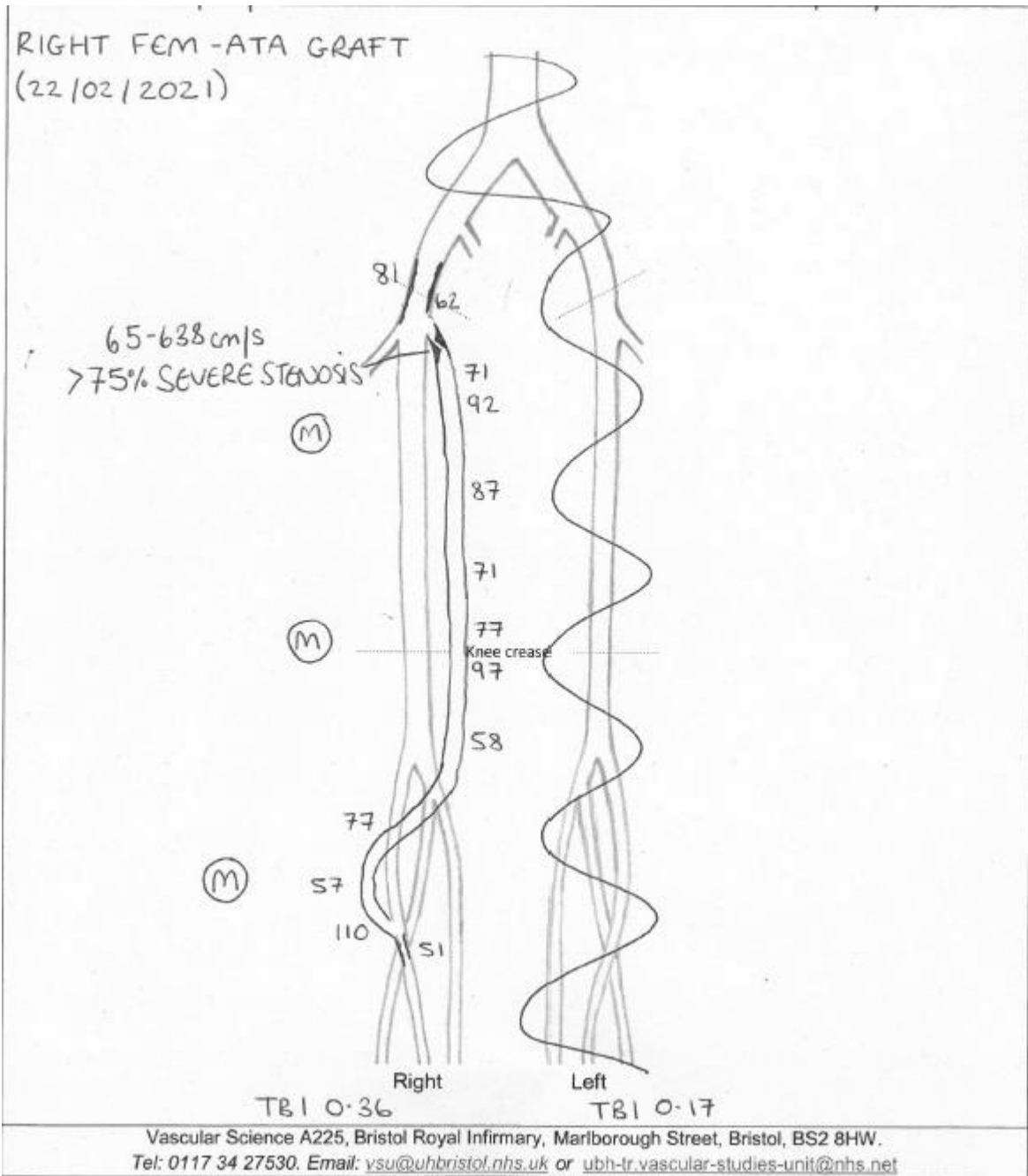
PAD 18

<div>US Doppler Aorta</div> <div>DUPLEX EVAR SURVEILLANCE: BMode and Doppler ultrasound examination of the EVAR stent to assess for sac expansion, kinking, stenosis and endoleak.</div> <div>3 Years Post EVAR stent for AAA (25/05/2018)</div> <div>Residual sac measures 4.6 cm AP and 4.7 cm LM in transverse section and 4.7 cm AP in longitudinal section and comparison with previous measurements (April 2019) indicate there was a decrease in sac size. No evidence of colour Doppler filling within sac lumen. Triphasic/biphasic Doppler signals noted throughout EVAR stent and iliac arteries with no evidence of significant stenosis or kinking.</div> <div>SUMMARY: Patent EVAR stent with no evidence of endoleak. Vascular Science will automatically recall the patient for surveillance in 1 year (June 2022) in accordance with the BBW vascular network protocol.</div> <div>Scanned by: K. Houghton, Senior Clinical Vascular Scientist</div> <div>Any queries please contact Vascular Science on 0117 34 27530</div>	<div>VERIFIEDAttended-07-Jun-2021RATOUARINRATOUARIN-07-Jun-2021</div>
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GRAFT (REPORTS 19-21)

PAD 19

US Ankle/Brachial Pressure Index	VERIFIED - Attended: 19-Aug-2021 - HALLIWESHA HALLIWESHA-19-Aug-2021
TBI (TOE BRACHIAL INDEX) SYMPTOMS: For RIGHT graft surveillance today: slowly healing ulcer RIGHT foot. Patient reports severe pain to the LEFT great toe (with ulceration), pain significantly worse with elevation and describes rest pain at night. CT (26/01/21) reports multiple stenoses throughout the LEFT leg.	
Right index finger 154 mmHg Right great toe 57 mmHg TBI= 0.4 Left great toe 27 mmHg TBI= 0.2	
US Graft Surveillance	VERIFIED - Attended: 19-Aug-2021 - HALLIWESHA HALLIWESHA-19-Aug-2021
RIGHT GRAFT SURVEILLANCE: 6/12 post RIGHT FEM-Mid ATA GRAFT (22/02/2021)	
Proximal to the graft: 62 cm/s Tri Proximal graft: New >75% SEVERE STENOSIS ~1 cm from the proximal anastomosis (65-638 cm/s, PSVR 10) Mono Mid graft: 77 cm/s Mono Distal graft: 57 cm/s Mono Distal to graft: irregular and calcified 51 cm/s Mono	
SUMMARY RIGHT LEG: >75% SEVERE STENOSIS in the proximal graft. TBI of 0.4. Slow healing ulcer. SUMMARY LEFT LEG: Absolute toe pressure of 27 mmHg and TBI of 0.2. Rest pain. Known arterial disease on CT Jan 21.	
Scanned by: S. Halliwell, Junior Clinical Vascular Scientist K. Houghton, Senior Clinical Vascular Scientist	
Mr Raj has been informed of the result in accordance with the BRW vascular network protocol. Any queries please contact Vascular Science on 0117 34 27530.	



GRAFT SURVEILLANCE:

15/12 post RIGHT CFA-ATA VEIN GRAFT (26/03/2020)
 12/12 post CIA stenting and CFA angioplasty (24/06/2020)

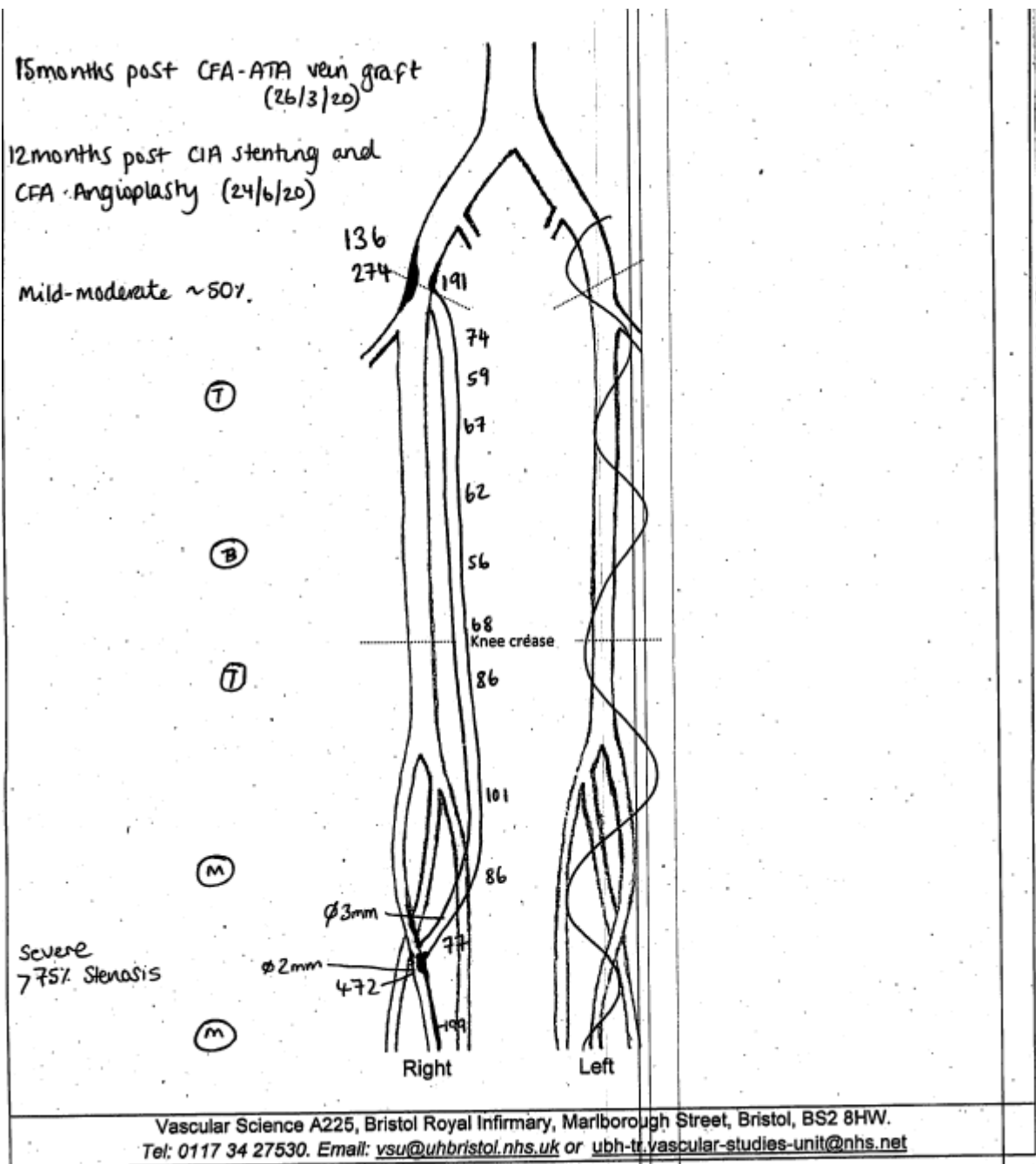
SYMPTOMS: One-stop clinic, check if there is a calibre mismatch causing the >75% stenosis at the distal anastomosis.
 ABPI: Not performed due to distal graft.

CFA (plasty site): MILD-MODERATE ~50% STENOSIS (PSVR 2, 136-274cm/s) no change Tri
 Proximal anastomosis: patent Bi 191cm/s
 Proximal graft (upper thigh): 74cm/s Bi
 Mid graft (knee): 68cm/s Tri
 Distal graft (upper calf): 101cm/s Tri
 Distal graft (mid calf): 77cm/s Mono (0.3cm diameter)
 Distal anastomosis: SEVERE >75% STENOSIS (PSVR 6, 77-472cm/s) (0.2cm diameter)
 Distal to graft (ATA @ankle): 199cm/s Mono

SUMMARY RIGHT LEG: ~50% stenosis remains in the CFA. Graft patent. Severe >75% stenosis at the distal anastomosis as seen previously, no evidence of significant calibre mismatch. Distal ATA patent to ankle with monophasic signals. For 6month additional follow up scan to observe as requested by Miss Martin.

Scanned by: N. Guarin (Senior Vascular Scientist) and K. Houghton (Senior Vascular Scientist)

Vascular Science will automatically recall the patient for surveillance in 6 months (December 21). Any queries please contact Vascular Science on 0117 34 27530.



GRAFT SURVEILLANCE:

1 year 11 months post LEFT CFA to BK-POP VEIN GRAFT (18/7/2019)
 10/12 post jump graft for proximal graft stenosis (3/8/2020)

SYMPTOMS: Asymptomatic

ABPI: 1.0 (Right Brachial Tri ++ 162 mmHg; Left AIA Mono ++ 165 mmHg)

LEFT LEG

Proximal to the graft: mild 195 cm/s Tri

Proximal graft: normal 157 cm/s Tri

Mid graft: normal 141 cm/s Bi

Distal graft: normal 153 cm/s Mono

Distal anastomosis: normal 147 cm/s Mono

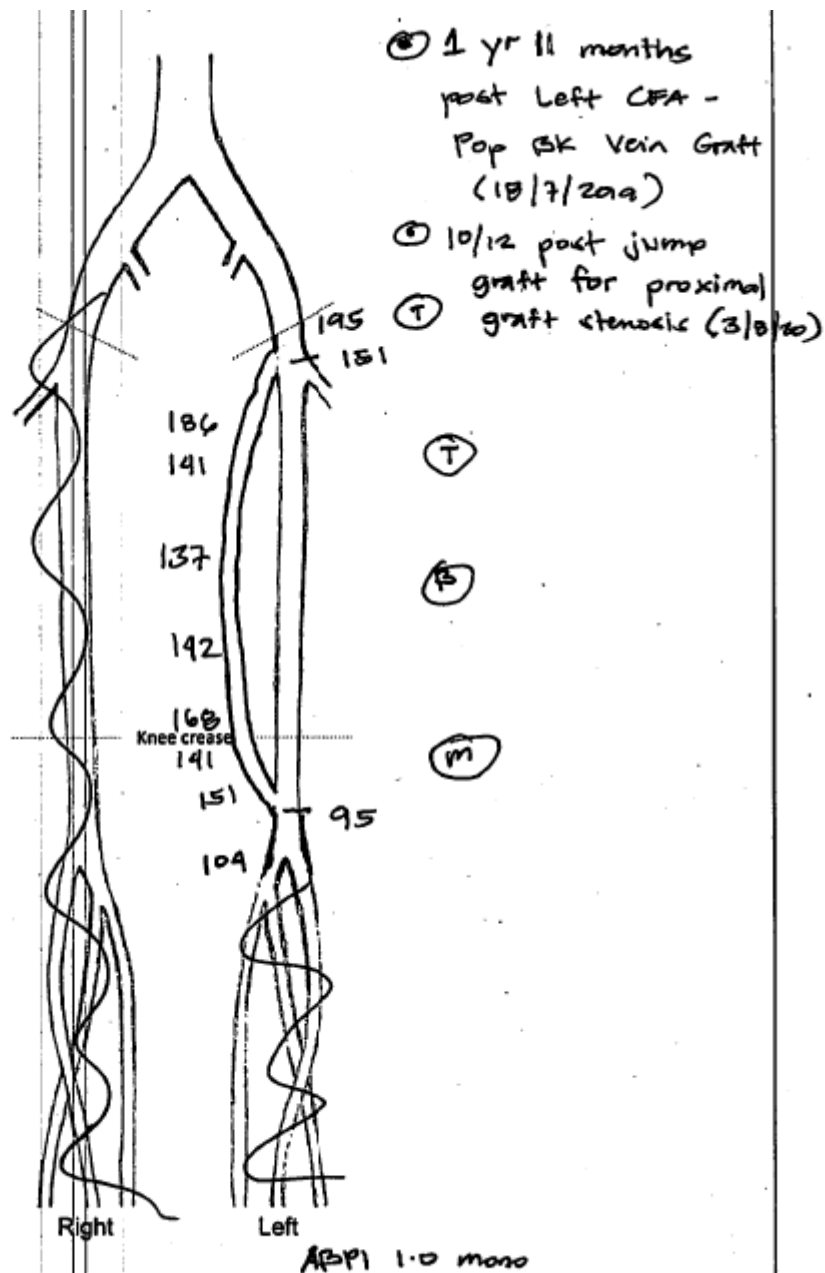
Distal to graft (TII): irregular 104 cm/s Mono

SUMMARY LEFT LEG: Graft patent with good flow throughout.

Scanned by: N. Guarin, Senior Vascular Scientist

K. Houghton, Senior Vascular Scientist

Vascular Science will automatically recall the patient for surveillance in August 2021 in accordance with the BBW vascular network protocol. Any queries please contact Vascular Science on 0117 34 27530.



STENT (REPORT 22)

PAD 22

US Graft Surveillance

VERIFIED - Attended 27-Jul-2021 - RA7/KATEHRA7/KATEH-27-Jul-2021

STENT SURVEILLANCE:

5.5 years post LEFT SFA Stents (12cm and 15cm length stents) (01/01/2016)

3.5 years post SFA stent PTA (18/12/2017)

SYMPTOMS: None reported.

RIGHT Brachial Tri ++ 156 mmHg

LEFT SIDE AT REST

PTA Tri ++ 174 mmHg ABPI = 1.1

ATA Tri ++ 142 mmHg ABPI = 0.9

DPA Tri ++

Proximal to the stent: 103 cm/s Tri

Proximal stent: 89 cm/s Tri

Mid stent: ~50% stenosis at the joining of the two stents (66-158 cm/s, PSVR 2.4) Tri

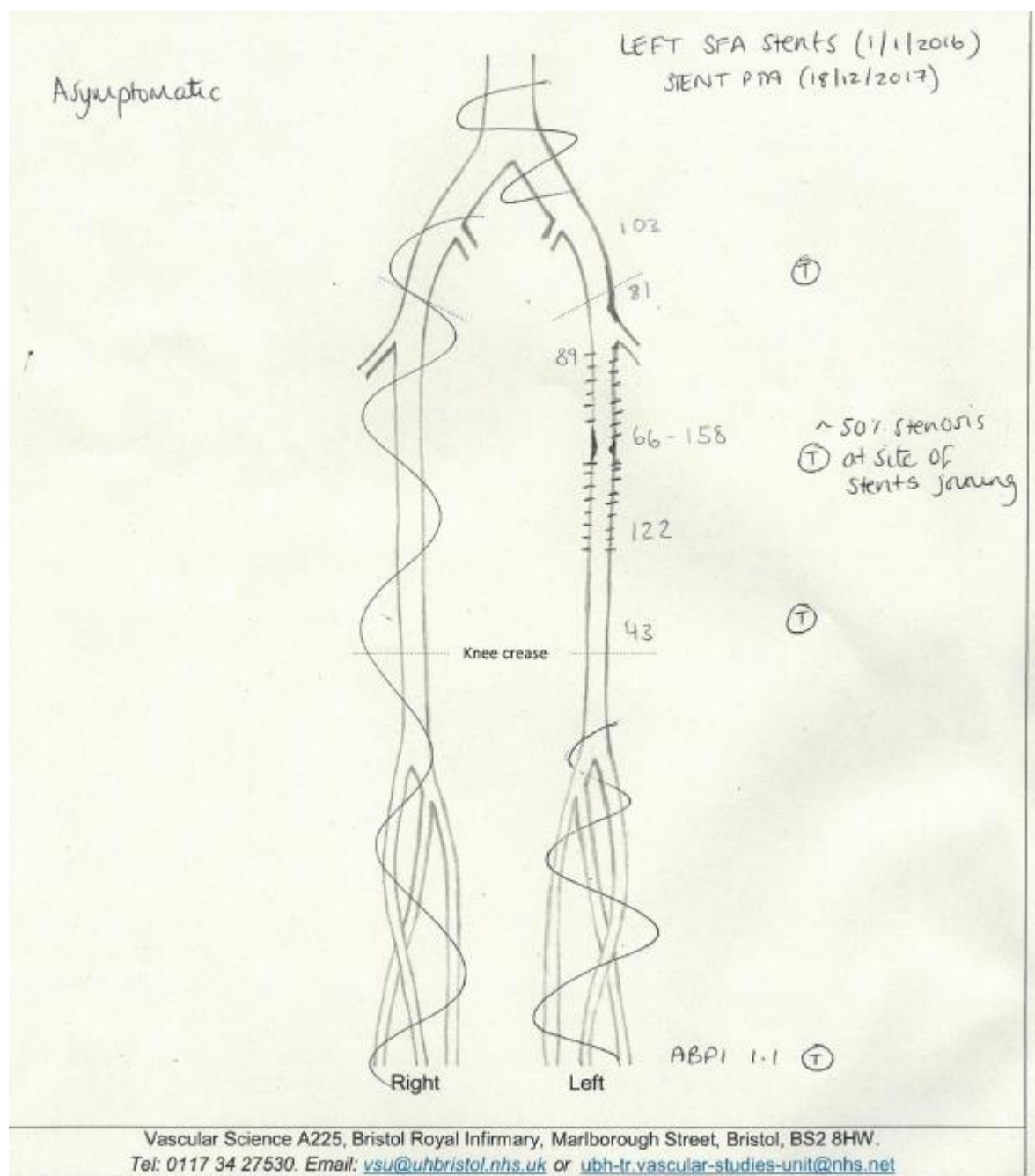
Distal stent: 122 cm/s Tri

Distal to stent: 43 cm/s Tri

SUMMARY LEFT LEG: Stent patent with good flow throughout. Mild stenosis (~50%) in the mid thigh as seen previously (Jan 2021). Has been on extended surveillance to monitor stenosis, no worsening in stenosis over the last three visits (Since Jan 2020) and no symptoms.

Scanned by: S. Halliwell (Junior Clinical Vascular Scientist) and K. Houghton (Senior Clinical Vascular Scientist)

Mr. Bevis has been contacted regarding further surveillance. Any queries please contact Vascular Science on 0117 34 27530.



UPPER LIMB (REPORT 23)

PAD 23

==REPORT E-21247636	VERIFIED-Attended-22-Jul-2021-HOUGHTONKHOUGHTONK-22-Jul-2021==
Clinical History : middle finger and distum of left hand goes dusky/blue when hangs arm down for prolonged time. radial pulse nad. not lifted in surgery. intermittent several months painfree . check blood supply. Requested By: Dr K Wight G4193632 Bleep: [NOT KNOWN]	
==US Arterial	VERIFIED-Attended-22-Jul-2021-HOUGHTONKHOUGHTONK-22-Jul-2021==
UPPER LIMB ARTERIAL DUPLEX: SYMPTOMS: Left hand gets very cold and blue during winter months. Left middle finger is worst affected.	
RIGHT SIDE Brachial artery pressure: Tri ++ PS 140 mmHg	
LEFT SIDE Brachial artery pressure: Tri ++ PS 132 mmHg	
Subclavian artery: normal TRI PS 175 cm/s Axillary artery: normal TRI PS 94 cm/s Brachial artery: normal TRI PS 84 cm/s Ulnar artery: normal TRI PS 63 cm/s Radial artery: normal TRI PS 59 cm/s	
SUMMARY LEFT ARM: No significant arterial disease	
Scanned by: S. Halliwell (Junior Clinical Vascular Scientist) and K. Houghton (Senior Clinical Vascular Scientist)	
Any queries please contact Vascular Science on 0117 34 27530	

FALSE ANEURSYM (REPORT 24-25)

PAD 24

==US Arterial	VERIFIED-Attended-23-Jun-2021-RA7KATEHRA7KATEH-23-Jun-2021==
VASCULAR GROIN DUPLEX: Bmode and Doppler examination of the common femoral artery (CFA) and vein (CFV) to assess for the presence of pseudoaneurysm or fistula.	
RIGHT SIDE 1 day post AF ablation. CFA: Patent with normal Doppler signals CFV: Patent with normal Doppler signals No evidence of pseudoaneurysm or fistula in the RIGHT groin	
Scanned by: Kate Houghton, Senior Clinical Vascular Scientist	
Any queries please contact Vascular Science on 0117 34 27530	

PAD 25

==US Arterial	VERIFIED-Attended-23-Jun-2021-BOWENSOPBOWENSOP-23-Jun-2021==
VASCULAR GROIN DUPLEX: Bmode and Doppler examination of the common femoral artery (CFA) and vein (CFV) to assess for the presence of pseudoaneurysm or fistula.	
RIGHT SIDE No TRAUMA/CATH CFA: Patent with normal Doppler signals CFV: Patent with normal Doppler signals SFA (upper thigh): Patent with normal Doppler signals FV (upper thigh): Patent with normal Doppler signals No evidence of pseudoaneurysm or fistula in the RIGHT groin	
Scanned by: S Bowen, Junior Clinical Vascular Scientist and K Houghton, Senior Clinical Vascular Scientist	
Any queries please contact Vascular Science on 0117 34 27530	