Arterial Scans

1	Lower limb graft	08/12/23
2	Lower limb arterial	07/12/23
3	Lower limb graft	05/12/23
4	Bilateral lower limb arterial and FFXO graft	04/12/23
5	Upper limb arterial	04/12/23
6	Lower limb arterial	04/12/23
7	Bilateral Thoracic outlet	04/12/23
8	Lower limb arterial	30/11/23
9	Lower limb arterial	30/11/23
10	Fistula	24/11/23
11	AAA	24/11/23
12	Lower limb arterial + ABPI	24/11/23
13	Bilateral Thoracic outlet	21/11/23
14	False aneurysm	02/11/23
15	False aneurysm	02/11/23
16	EVAR	27/10/23
17	AAA	25/10/23
18	Common iliac aneurysm	19/11/23
19	False aneurysm	24/10/23
20	Lower limb graft	13/10/23
21	Lower limb stent	04/10/23
22	Lower limb graft	03/10/23
23	AAA	03/10/23
24	Bilateral Lower limb arterial	03/10/23
25	Upper limb arterial	29/09/23

US Graft Surveillance VERIFIED Attended-08-Dec-2023 FULLSR/FULLSR-08-Dec-2023

AN ADDENDUM HAS BEEN ENTERED AT THE END OF THIS REPORT
GRAFT SURVEILLANCE:
6/12 post LEFT Fem-pop VEIN GRAFT (13/6/2023)
SYMPTOMS: Incision sites have now healed.

LEFT LEG:

TBI = 1.0 (absolute toe pressure 115mmHg, Brachial 117mmHg).
ABPI=1.6, raised due to arterial calcification (PTA 190mmHg, triphasic).

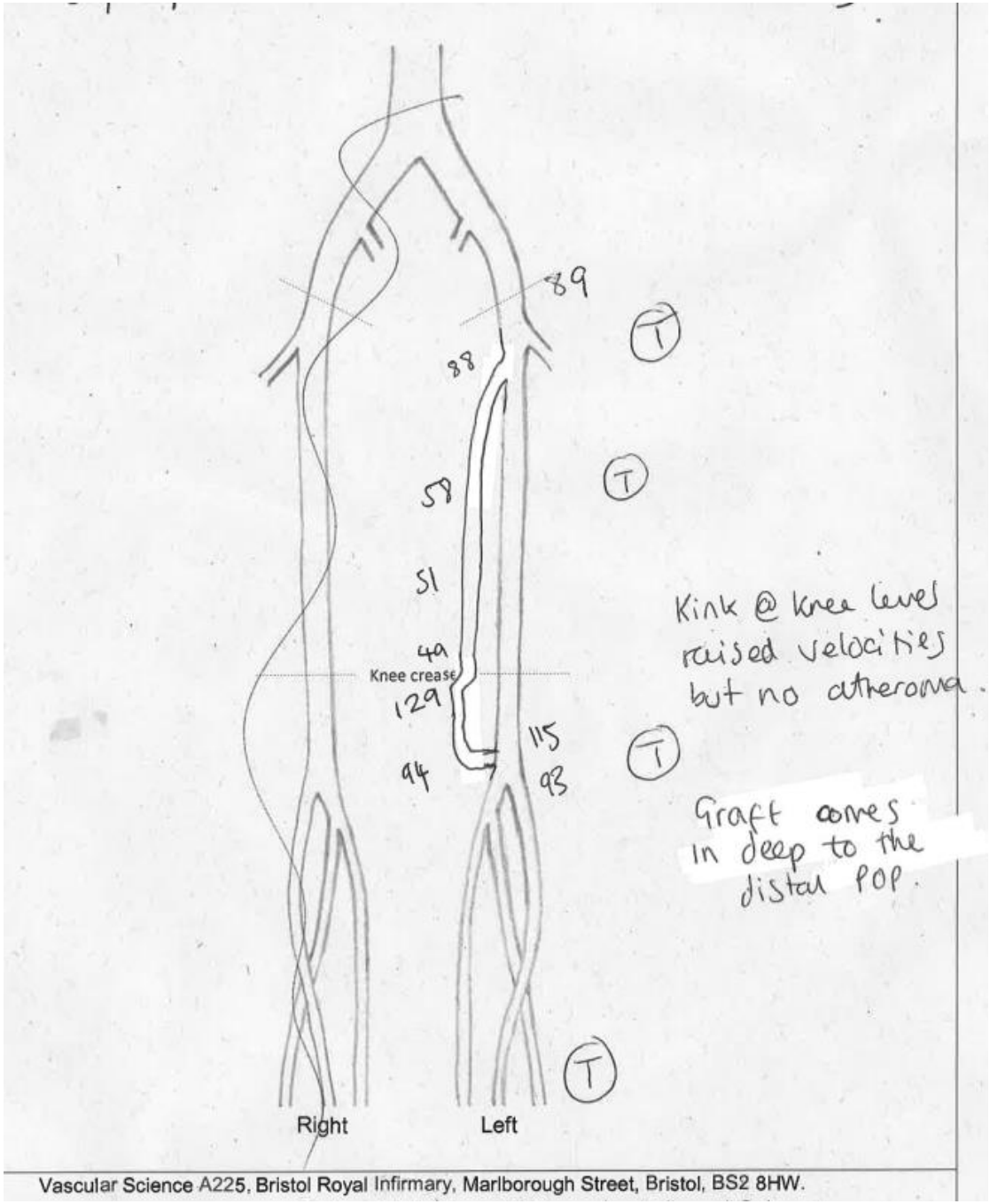
The common femoral artery is patent with triphasic waveforms.
The proximal anastomosis is widely patent.
The fem-pop vein graft is patent throughout with triphasic waveforms. There is a kink in the graft at knee level with raised velocities (49-129cm/s) indicating a 50-75% stenosis. However, no atheroma or irregularity seen at this point, to observe on next scan.
The distal anastomosis is widely patent.
The native distal popliteal artery is patent with triphasic waveforms.
ATA and PTA triphasic at ankle.

SUMMARY LEFT LEG: Graft patent throughout with good flow. Kink in the graft at knee level with raised velocities.

Patient will be automatically recalled for 6month surveillance on 13/03/2024

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Technical Quality: Good
Any queries please contact Vascular Science on 0117 34 27530.

See assocaited Schematic on the next page


89
88
58
51
49
Knee crease
129
94
115
93
T
T
T
T
Kink @ knee level raised velocities but no atheroma.
Graft comes in deep to the distal POP.
Right
Left

US Doppler iliac and femoral artery Both VERIFIED Attended-07-Dec-2023 FULLSR/FULLSR-07-Dec-2023

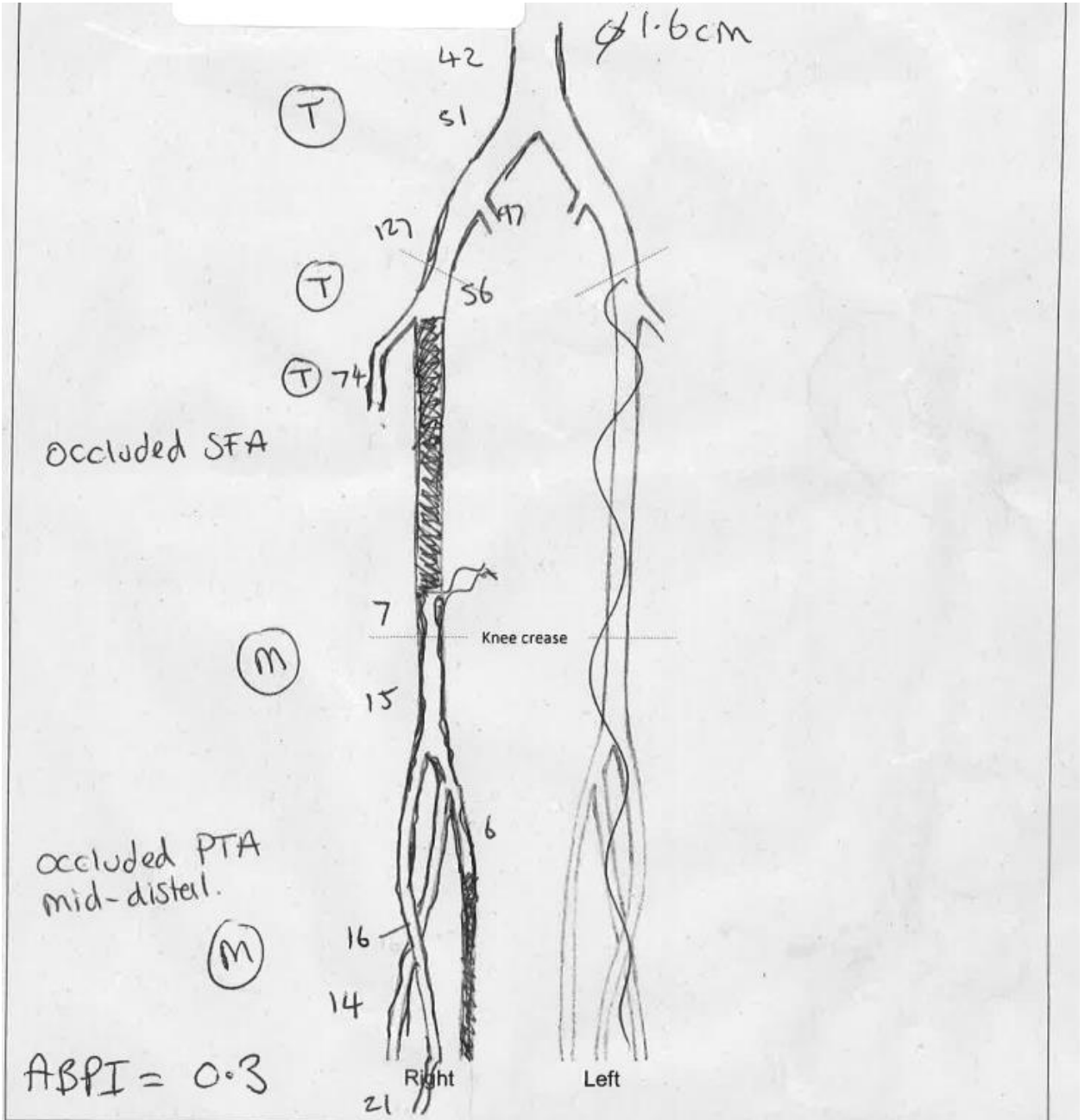
LOWER LIMB ARTERIAL DUPLEX:

AORTA: Maximum diameter 1.6cm. Mild atheroma, triphasic.

RIGHT SIDE:
The CIA, IIA and EIA are patent with mild atheroma, triphasic waveforms throughout.
The CFA and profunda artery origin are patent with mild atheroma, triphasic waveforms.
The SFA is OCCLUDED from origin.
The popliteal artery and TPT are patent with irregular atheroma, very damped low monophasic waveforms.
The ATA and peroneal artery are patent, calcified with damped monophasic flow seen to ankle.
The PTA is patent proximally but stringy and calcified. The mid to distal PTA is OCCLUDED.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Schematic available
Technical Quality: Good
Any queries please contact Vascular Science on 0117 34 27530.

See assocaited Schematic on the next page


Ø 1.6cm
42
51
127
47
56
74
Occluded SFA
7
Knee crease
15
6
occluded PTA
mid-distal.
16
14
21
ABPI = 0.3
Right
Left

US Graft Surveillance VERIFIED Attended-05-Dec-2023 FULLSR/FULLSR-05-Dec-2023

GRAFT SURVEILLANCE:

2/52 post RIGHT FEM-TPT vein graft (20/11/23)
SYMPTOMS: Pain has resolved in the right leg. Patient now has right leg tingling sensation.

RIGHT LEG:

ABPI: 1.1 (PTA 140mmHg, Brachial 128mmHg), multiphasic hyperemic Doppler signals.

Unable to visualise the CFA, proximal SFA and proximal graft including prox anastomosis due to dressings.
From mid-thigh to the distal anastomosis (at the TPT) the graft is widely patent with strong multiphasic hyperemic waveforms throughout (PSV 85-107cm/s).
Native TPT, PTA and peroneal arteries are patent with strong multiphasic hyperemic waveforms.

SUMMARY RIGHT LEG: Unable to visualise proximal graft. From mid-thigh to TPT the graft patent with good flow throughout.

Patients 6-week surveillance is booked for the 03/01/23.

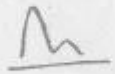
Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Schematic available
Technical Quality: Average
Any queries please contact Vascular Science on 0117 34 27530.

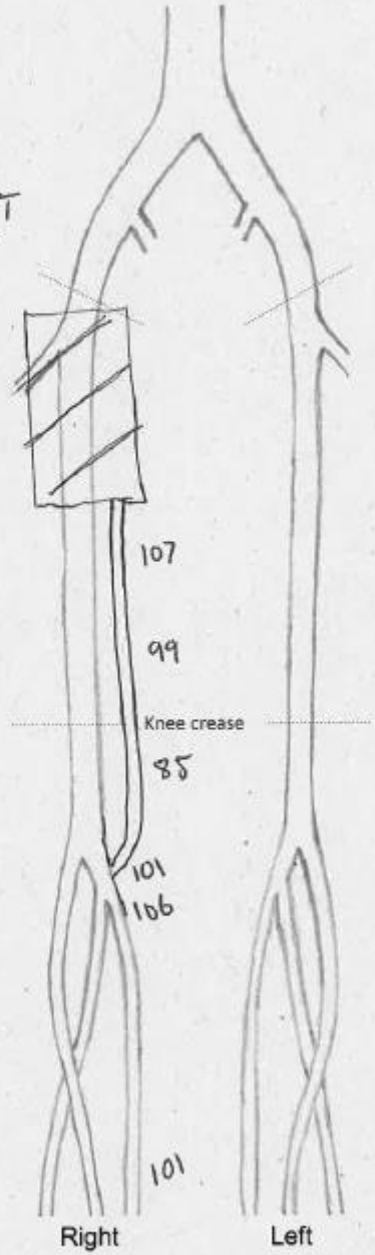
See assocaited Schematic on the next page

FEM-TPT VEIN GRAFT

Dressings

multiphasic
hyperemic
waveforms
throughout





US Doppler Arteries Femoro-Popliteal VERIFIED Attended-04-Dec-2023 FULLSR/FULLSR-04-Dec-2023

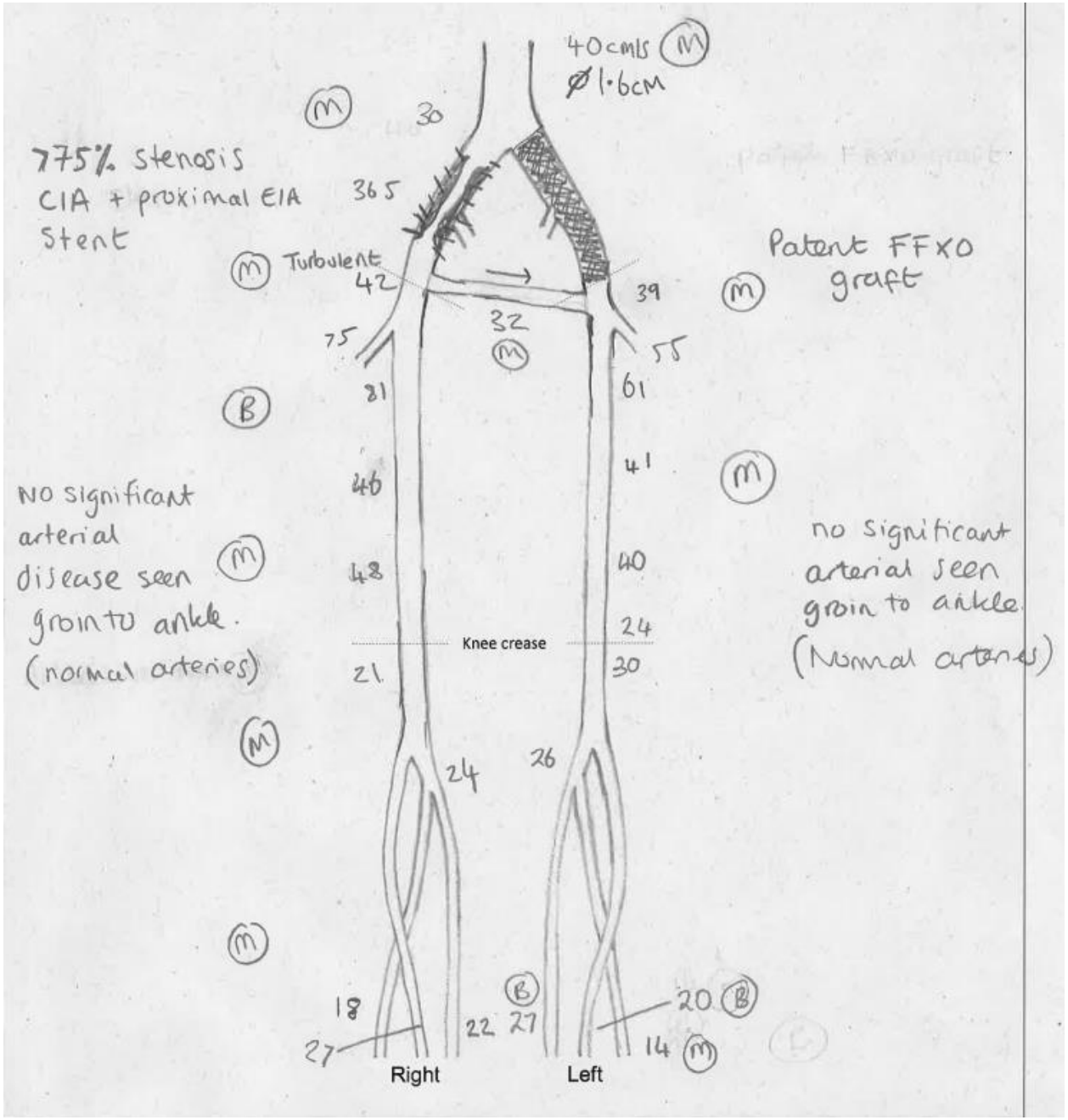
LOWER LIMB ARTERIAL DUPLEX:
SYMPTOMS: Right>left IC. Right to left FFXover.

AORTA: Maximum diameter 1.6cm. Mild atheroma, monophasic waveform.

RIGHT SIDE:
There is a long >75% STENOSIS of the CIA and proximal EIA stent (30-365cm/s, PSVR 12, monophasic).
The distal EIA is patent with mild atheroma, monophasic waveforms.
The right to left fem-fem cross over graft is widely patent throughout with monophasic waveform.
The CFA, profunda artery origin, SFA, popliteal artery, TPT and run-off vessels are all patent with no arterial disease seen. Biphasic/monophasic waveforms throughout.

LEFT SIDE:
Occluded CIA and EIA.
The CFA, profunda artery origin, SFA, popliteal artery, TPT and run-off vessels are all patent with no arterial disease seen. Biphasic/monophasic waveforms throughout.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Schematic available
Technical Quality: Good
Any queries please contact Vascular Science on 0117 34 27530.


40cms/s
Ø1·6cm
30
365
75% stenosis
CIA + proximal EIA
Stent
Turbulent
42
39
Patent FFxO
graft
32
75
55
81
61
41
46
NO significant
arterial
disease seen
groin to ankle.
(normal arteries)
48
40
24
Knee crease
21
30
24
26
18
22
27
27
20
14
Right
Left
no significant
arterial seen
groin to ankle.
(Normal arteries)

US Arterial VERIFIED Attended-04-Dec-2023 FULLSR/FULLSR-04-Dec-2023

UPPER LIMB ARTERIAL DUPLEX:

LEFT SIDE:
There is a >75% STENOSIS in the proximal subclavian artery (PSV 500cm/s, monophasic).
The distal subclavian artery is patent, normal with monophasic waveform.
The axillary, brachial, ulnar and radial arteries are patent, normal with monophasic waveform.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Schematic available
Any queries please contact Vascular Science on 0117 34 27530.

US Doppler Arteries Femoro-Popliteal VERIFIED Attended-04-Dec-2023 FULLSR/FULLSR-04-Dec-2023

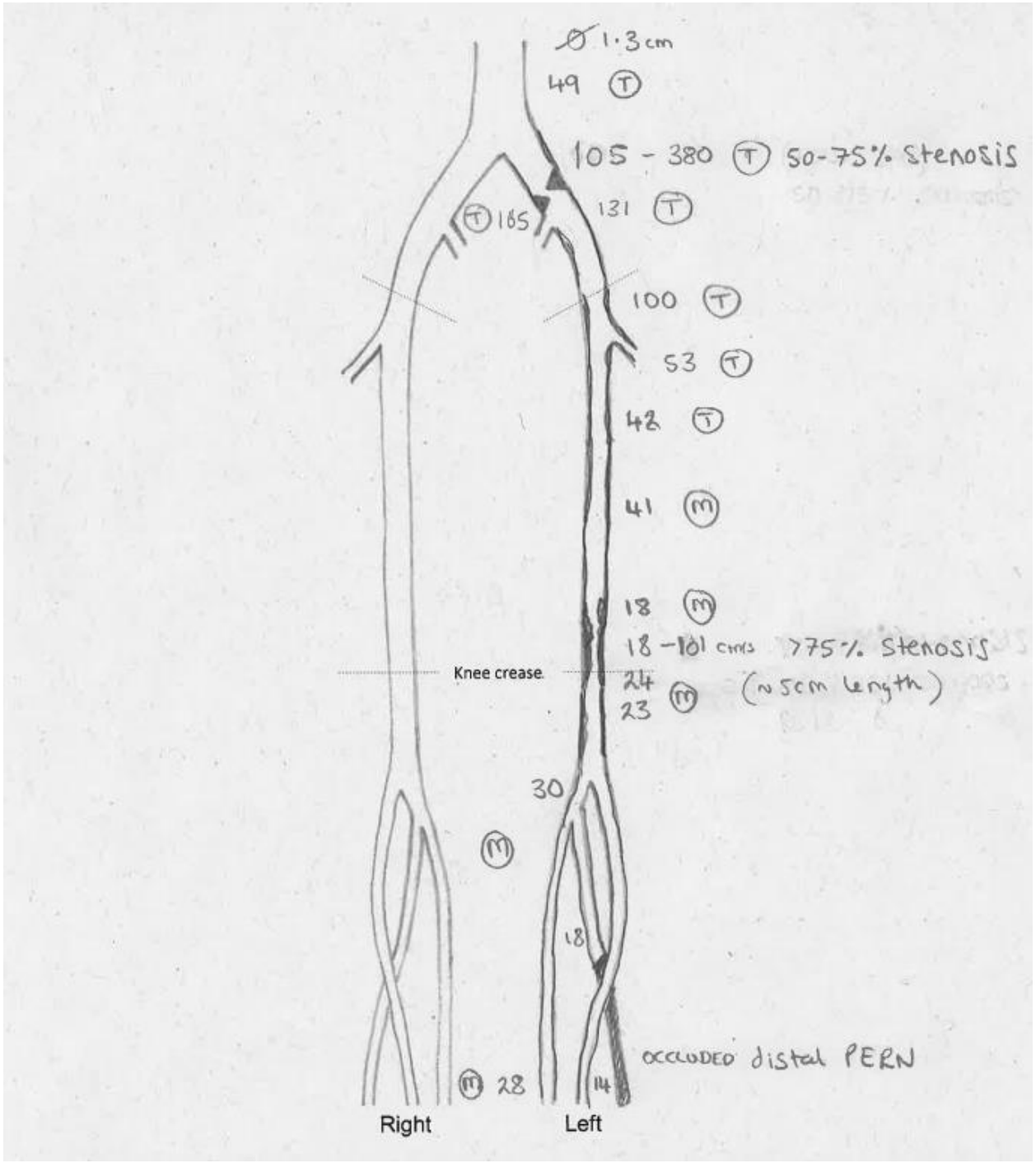
LOWER LIMB ARTERIAL DUPLEX:
SYMPTOMS: Left calf, thigh and buttock pain.

AORTA: Maximum diameter 1.3cm. Normal, triphasic waveform.

LEFT SIDE:
The proximal CIA is patent with mild atheroma, triphasic waveforms. There is a 50-75% STENOSIS in the distal CIA (105-380cm/s, PSVR 3.6, triphasic).
The EIA and IIA are patent with mild atheroma, triphasic waveforms.
The CFA, profunda artery origin and proximal-mid SFA are patent with mild atheroma, triphasic waveforms throughout.
The distal SFA is patent with irregular atheroma, monophasic waveforms. A large collateral vessel is noted.
There is a >75% STENOSIS in the very distal SFA/proximal popliteal artery (18-101cm/s, PSVR 6) - approximately 5cm in length at the level of the adductor hiatus.
The distal popliteal artery is patent with irregular mild atheroma, monophasic waveforms.
The TPT is patent with mild atheroma, monophasic waveforms.
The PTA and ATA are patent, normal with monophasic waveforms.
The proximal to mid peroneal artery is patent, normal with monophasic waveforms. The distal peroneal artery is OCCLUDED.

Scanned by: R Fulls, Senior Clinical Vascular Scientist
Schematic available
Technical Quality: Good
Any queries please contact Vascular Science on 0117 34 27530.

See assocaited Schematic on the next page


Ø 1·3cm
49 T
105 - 380 T 50-75% stenosis
T 165
131 T
100 T
53 T
42 T
41 M
18 M
18 - 101 cms >75% stenosis
Knee crease
24
23 M
(~5cm length)
30
M
18
M 28
14
occluded distal PERN
Right
Left

US Arterial VERIFIED Attended-04-Dec-2023 FULLSR/FULLSR-04-Dec-2023

UPPER LIMB ARTERIAL DUPLEX

RIGHT SIDE AT REST:
The subclavian, axillary and brachial arteries are normal with triphasic Doppler waveforms.
The subclavian vein is patent but with raised, turbulent venous flow.
The axillary vein is patent with venous triphasic flow.

RIGHT SIDE WITH ARM ABDUCTED AND EXTERNAL ROTATED:
Patent subclavian and axillary artery with triphasic Doppler waveforms and no evidence of calibre change or extrinsic compression.
Subclavian vein: On abduction the subclavian vein remains patent however there is an increase in velocity of venous flow (129-214cm/s) indicating some extrinsic compression.

LEFT SIDE AT REST:
The subclavian, axillary and brachial arteries are normal with triphasic Doppler waveforms.
The subclavian and axillary veins are patent with venous triphasic flow.

LEFT SIDE WITH ARM ABDUCTED AND EXTERNAL ROTATED:
Subclavian artery: On abduction there was an increase in the PSV from 119 cm/s to 310cm/s and turbulent monophasic waveforms, indicating extrinsic compression.
Subclavian vein: On abduction there was no flow detected in the subclavian vein at clavicular level indicating extrinsic compression.

SUMMARY RIGHT SIDE: Evidence of compression of the subclavian vein at the thoracic outlet
SUMMARY LEFT SIDE: Evidence of significant compression of the subclavian vein and artery at the thoracic outlet

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Any queries please contact Vascular Science on 0117 34 27530

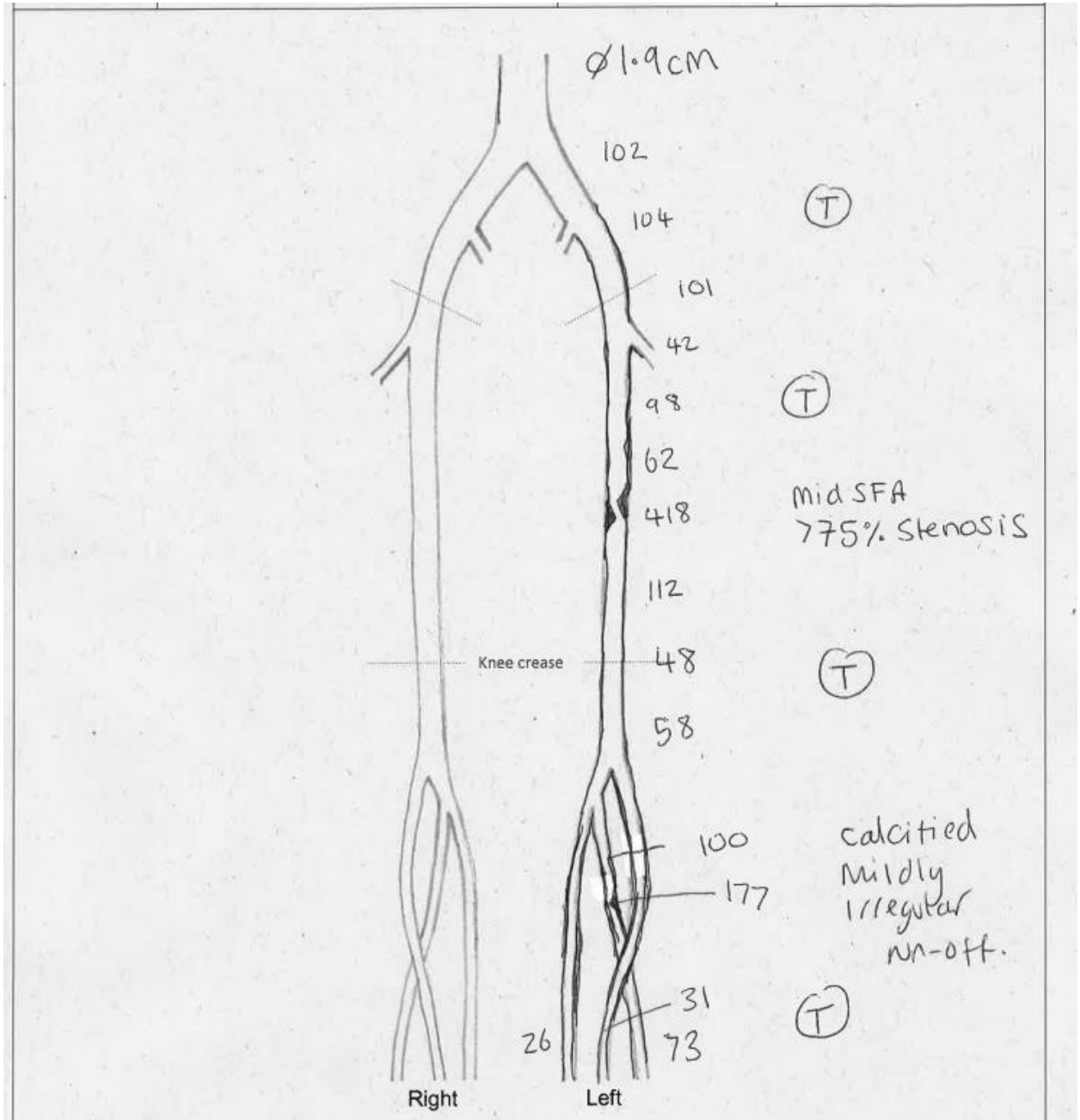
US Doppler Iliac & Femoral — VERIFIED — Attended-30-Nov-2023 — RENGELANN/RENGELANN-30-Nov-2023

AORTA: Maximum diameter 1.9cm. Patent, normal, triphasic waveforms.

LEFT SIDE:
The CIA, IIA and EIA are patent with triphasic waveforms.
The CFA is patent with mild atheroma, triphasic waveforms.
The proximal SFA is patent with mild atheroma, triphasic waveforms. There is a >75% STENOSIS in the mid-SFA (PSVR 7, 62-418cm/s, triphasic). The distal SFA is patent with mild atheroma, triphasic waveforms.
The popliteal, TPT and peroneal artery are patent with mild atheroma, triphasic waveform (peroneal is the dominant run-off vessel).
The PTA and ATA are small calibre and calcified but patent to ankle with biphasic waveforms.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Schematic available
Technical Quality: Good
Any queries please contact Vascular Science on 0117 34 27530.

See assocaited Schematic on the next page



Vascular Science A225, Bristol Royal Infirmary, Marlborough Street, Bristol, BS2 8HW.
Tel: 0117 34 27530. Email: vsu@uhbristol.nhs.uk or ubh-tr.vascular-studies-unit@nhs.net

US Doppler Arteries Femoro-Popliteal VERIFIED Attended-30-Nov-2023 FULLSR/FULLSR-30-Nov-2023

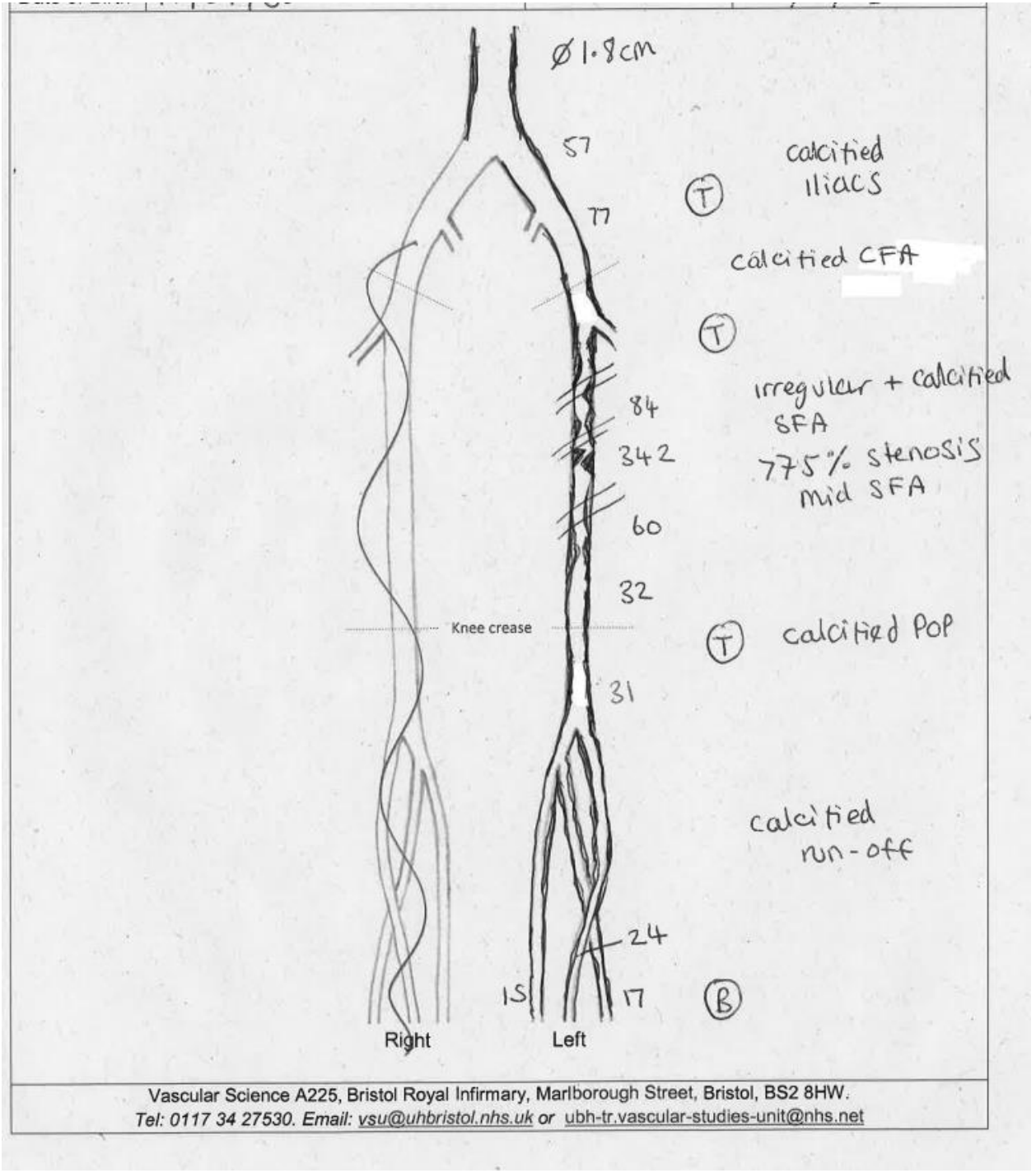
LOWER LIMB ARTERIAL DUPLEX:
SYMPTOMS: Pain in left calf when walking.

AORTA: Maximum diameter 1.8cm. Calcified mild atheroma, triphasic waveforms.

LEFT SIDE:
The CIA and EIA are patent with calcified mild atheroma, triphasic waveforms.
The CFA is patent with calcified mild atheroma, triphasic waveforms.
The SFA is patent with irregular and calcified atheroma throughout causing a >75% STENOSIS in the mid-SFA (PSVR 4.1, 84-342cm/s). Triphasic waveforms.
The popliteal artery is patent with calcified mild atheroma, triphasic waveforms.
The TPT and run-off are patent to ankle, calcified mild atheroma, biphasic waveforms.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Schematic available
Technical Quality: Good
Any queries please contact Vascular Science on 0117 34 27530.

See assocaited schematic on the next page



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Tel: 0117 34 27530. Email: vsu@uhbristol.nhs.uk or ubh-tr.vascular-studies-unit@nhs.net

US Arterial VERIFIED Attended-24-Nov-2023 FULLSR/FULLSR-24-Nov-2023

ARTERIOVENOUS FISTULA DUPLEX:
SYMPTOMS: Patient reports occasional pain in her fistula.

RIGHT RADIO-CEPHALIC AVF

Radial Arterial Inflow: normal PSV 162cm/s
Radial Arterial Inflow Volume flow: 724ml/min (previously 962ml/min)
Native Radial distal to arterial anastomosis: presence of steal (retrograde flow)

Arterial Anastomosis: PSV 697cm/s, PSVR 4.3, moderate-severe 50-75% stenosis (~2cm in length), dilatation measuring 1.8cm (previously measuring 1.6cm).

Cephalic venous outflow: normal PSV 80cm/s
Volume flow in Cephalic venous outflow: 860ml/min (previously 1036ml/min)
Basilic venous outflow junction with deep Axillary vein: normal 68cm/s

SUMMARY RIGHT AVF: Arterial anastomosis moderate-severe 50-75% stenosis followed by 1.8cm dilatation. Otherwise patent AVF. Drop in inflow and outflow volume flows compared to previous scan September 2023.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Any queries please contact Vascular Science on 0117 34 27530.

US Abdominal Aorta VERIFIED Attended-24-Nov-2023 FULLSR/FULLSR-24-Nov-2023

ANEURYSM SCREENING: All diameter measurements are maximum inner-wall to inner-wall AP (anterior to posterior).

Infra-renal Abdominal Aorta TS 7.0cm LS 7.0cm
Right common iliac artery 2.6cm
Left common iliac artery 2.6cm
Right popliteal artery 1.1cm
Left popliteal artery 0.9cm

SUMMARY: AAA 7.0cm. Right CIA aneurysm 2.6cm. Left CIA aneurysm 2.6cm.

PLEASE DO AN URGENT REFERRAL TO VASCULAR SURGERY AT NORTH BRISTOL TRUST FOR URGENT REVIEW.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Any queries please contact Vascular Science on 0117 34 27530

US Ankle /Brachial Pressure Index — VERIFIED — Attended-24-Nov-2023 — FULLSR/FULLSR-24-Nov-2023

ABPI (ANKLE BRACHIAL PRESSURE INDEX)

LEFT SIDE AT REST
Brachial Tri ++ 92 mmHg
Left great toe 96mmHg, TBI= 1.0
PTA Tri ++
ATA Tri ++
DPA Tri ++

SUMMARY LEFT LEG: A TBI of 1.0 with triphasic Doppler signals indicates no significant peripheral arterial disease.

US Doppler Arteries Femoro-Popliteal — VERIFIED — Attended-24-Nov-2023 — FULLSR/FULLSR-24-Nov-2023

LOWER LIMB ARTERIAL DUPLEX:

LEFT SIDE:
The common femoral artery, profunda artery origin, superficial femoral artery and popliteal artery are patent, normal with triphasic waveforms throughout.
The tibioperoneal trunk, peroneal artery, posterior tibial artery, anterior tibial artery are patent, normal with triphasic waveforms throughout.
No significant arterial disease seen from groin to ankle.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Technical Quality: Good
Any queries please contact Vascular Science on 0117 34 27530.

US Arterial VERIFIED Attended-21-Nov-2023 FULLSR/FULLSR-21-Nov-2023

UPPER LIMB ARTERIAL AND VENOUS DUPLEX:

SYMPTOMS: Bilateral hand and feet pins and needles at anytime. Wakes patient up at night. Note: Patient has large muscular shoulders/upper chest.

RIGHT SIDE AT REST
The subclavian, axillary and brachial arteries are normal with triphasic Doppler waveforms.
The subclavian vein is patent with high velocity but phasic venous flow at rest (146cm/s).
The axillary vein are patent with normal venous flow.

RIGHT SIDE WITH ARM ABDUCTED AND EXTERNAL ROTATED
Subclavian artery: Patent with triphasic Doppler waveforms and no evidence of calibre change or raised velocities.
Subclavian vein: On abduction there was no flow detected indicating extrinsic compression

LEFT SIDE AT REST
The subclavian, axillary and brachial arteries are normal with triphasic Doppler waveforms.
The subclavian vein is patent with high velocity but phasic venous flow at rest (150cm/s).
The axillary vein are patent with normal venous flow.

LEFT SIDE WITH ARM ABDUCTED AND EXTERNAL ROTATED
Subclavian artery: Patent with triphasic Doppler waveforms and no evidence of calibre change or raised velocities.
Subclavian vein: On abduction visible reduction in diameter and increased velocity of flow indicating extrinsic compression (271cm/s)

SUMMARY RIGHT SIDE: Evidence of significant compression of the subclavian vein at the thoracic outlet
SUMMARY LEFT SIDE: Evidence of significant compression of the subclavian vein at the thoracic outlet

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Any queries please contact Vascular Science on 0117 34 27530

US Arterial VERIFIED Attended-02-Nov-2023 FULLSR/FULLSR-02-Nov-2023

VASCULAR PSEUDOANEURSYM DUPLEX:

LEFT SIDE
2 days post CATH

Brachial artery: Patent with normal Doppler signals
Brachial veins: Patent with normal Doppler signals
No evidence of pseudoaneurysm or fistula in the LEFT ACF.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Any queries please contact Vascular Science on 0117 34 27530

US Arterial VERIFIED Attended-02-Nov-2023 FULLSR/FULLSR-02-Nov-2023

VASCULAR PSEUDOANEURSYM DUPLEX:

RIGHT SIDE
1 day post CATH
CFA: Patent with normal Doppler signals
CFV: Patent with normal Doppler signals
There is a small pseudoaneurysm in the RIGHT groin originating from the common femoral artery.
Very poor b-mode views so difficult to accurately measure the sac size, appears to approximately measure 1.5cm AP x 1.5cm LM. Unable to determine if partially thrombosed or not.
Poor visuaisation of the jet, approximate diameter is 3mm and length is 1.5cm.

Comments: Please consider referral for focused field of view CT angiogram (mid abdomen to upper femur only) and discussion with Dr Nathan Manghat (Consultant cardiovascular and interventional radiologist).

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Any queries please contact Vascular Science on 0117 34 27530

US Doppler Aorta VERIFIED Attended-27-Oct-2023 FULLSR/FULLSR-27-Oct-2023

DUPLEX EVAR SURVEILLANCE: B-Mode and Doppler ultrasound examination of the EVAR stent to assess for sac expansion, kinking, stenosis and endoleak.

EVAR stent for AAA (13/04/2012)
Onyx embolisation for type II endo leak (9/10/2015)

Residual sac measures 7.9 cm AP and 7.9 cm LM in transverse section and 8.0 cm AP in longitudinal section and comparison with previous measurements indicate this is stable.
No evidence of colour Doppler filling within sac lumen.
Biphasic Doppler signals noted throughout EVAR stent and iliac arteries with no evidence of significant stenosis or kinking.

SUMMARY: Patent EVAR stent with no evidence of endoleak. Vascular Science will automatically recall the patient for surveillance in 6/12 (21/04/2024) due to anxiety surrounding EVAR stent.

Scanned by: R Fulls, Senior Clinical Vascular Scientist

Any queries please contact Vascular Science on 0117 34 27530.

US Abdominal Aorta VERIFIED Attended-25-Oct-2023 MOHAMEDNAD+FULLSR/MOHAMEDNAD-25-Oct-2023

ANEURYSM SURVEILLANCE: All diameter measurements are maximum inner-wall to inner-wall AP (anterior to posterior).

Infra-renal Abdominal Aorta TS 4.5cm LS 4.5cm

SUMMARY: AAA 4.5cm.

This patient will be automatically recalled for surveillance in 6 months (25/04/2024). Patient is under the care of Mr Neary. The surgical intervention threshold is set at 5.5cm.

Scanned by: Nada Mohamed, Junior Clinical Vascular Scientist
Rebecca Fulls, Senior Clinical Vascular Scientist

Any queries please contact Vascular Science on 0117 34 27530

US Abdominal Aorta VERIFIED Attended-19-Oct-2023 MOHAMEDNAD+FULLSR/MOHAMEDNAD-19-Oct-2023

ANEURYSM SURVEILLANCE: All diameter measurements are maximum inner-wall to inner-wall AP (anterior to posterior).

Right common iliac artery 1.9 cm
Left common iliac artery 2.4 cm

Summary: Left CIA aneurysm 2.4cm

This patient will be automatically recalled for surveillance in 12 months (19/10/2024). Patient is under the care of Mr Neary. The surgical intervention threshold is presumed at 3.5cm.

Scanned by: Nada Mohamed, Junior Clinical Vascular Scientist
Rebecca Fulls, Senior Clinical Vascular Scientist

Any queries please contact Vascular Science on 0117 34 27530

US Arterial VERIFIED Attended-24-Oct-2023 FULLSR/FULLSR-24-Oct-2023

VASCULAR PSEUDOANEURSYM DUPLEX:

RIGHT SIDE
4/7 post CATH
CFA: Patent with normal Doppler signals
CFV: Patent with normal Doppler signals. No thrombus.
No evidence of pseudoaneurysm or fistula in the RIGHT groin

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Any queries please contact Vascular Science on 0117 34 27530

US Graft Surveillance — VERIFIED Attended-13-Oct-2023 FULLSR/FULLSR-13-Oct-2023

GRAFT SURVEILLANCE:
6/12 post left BK pop to pedal artery vein graft (14/4/2023)

SYMPTOMS: Ulceration has greatly improved, almost completely healed.
TBI: 0.9 (Toe 150mmHg, Brachial 164mmHg)

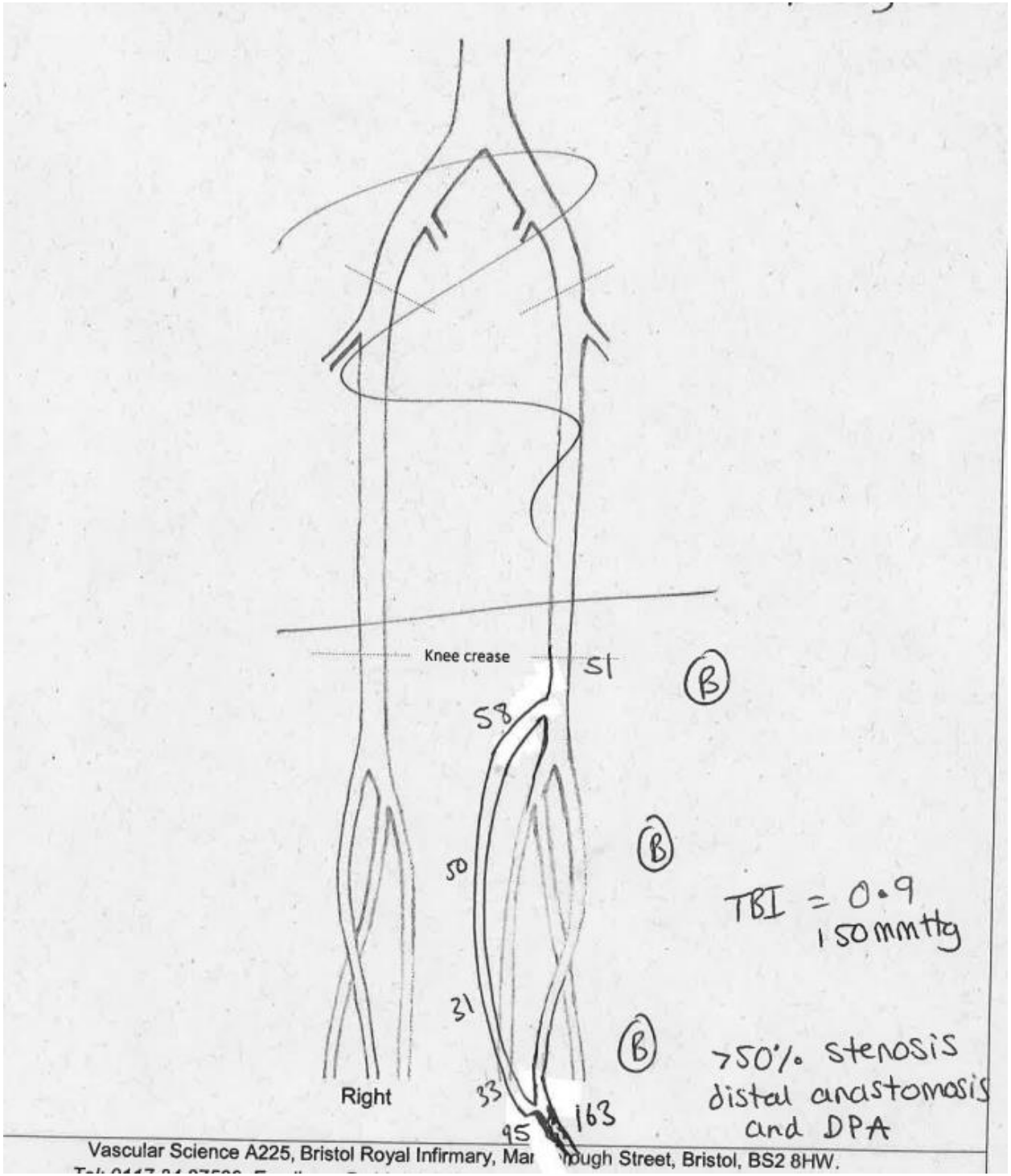
LEFT LEG:
The native popliteal artery is patent with biphasic flow.
The graft is patent throughout. However, low velocity flow in the distal graft 31cm/s, biphasic.
Compared to previous scan on 30/26/23, the velocity of flow has reduced throughout the graft and is now biphasic compared to triphasic on previous scan.
The distal anastomosis and first 2cm of native DPA distal to anastomosis are irregular and calcified with raised velocities 163cm/s.
Difficult to grade due to calibre mismatch of graft and DPA, however appears to be >50% stenosis. Still biphasic flow.

SUMMARY LEFT LEG: Graft patent but with low velocity flow (<35cm/s). Distal anastomosis and DPA >50% stenosis.

Patient referred to NBT via refer a patient due to <35cm/s flow in the graft.
Extra surveillance booked for 6 weeks (24/11/23), unless patient goes for angio.

Schematic available
Technical Quality: good
Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)

See assocaited Schematic on the next page



TBI = 0.9
150mmHg

>50% stenosis
distal anastomosis
and DPA

Vascular Science A225, Bristol Royal Infirmary, Ma ough Street, Bristol, BS2 8HW.

US Doppler Iliac & Femoral VERIFIED Attended-04-Oct-2023 FULLSR/FULLSR-04-Oct-2023

STENT SURVEILLANCE:
12/12 post left SFA stent (3/10/22)
Angio of distal SFA & popliteal on 20/04/23

SYMPTOMS: Left leg ulcer has now completely healed.
ABPI: 0.6 (ATA 106mmHg, Brachial 170 mmHg)

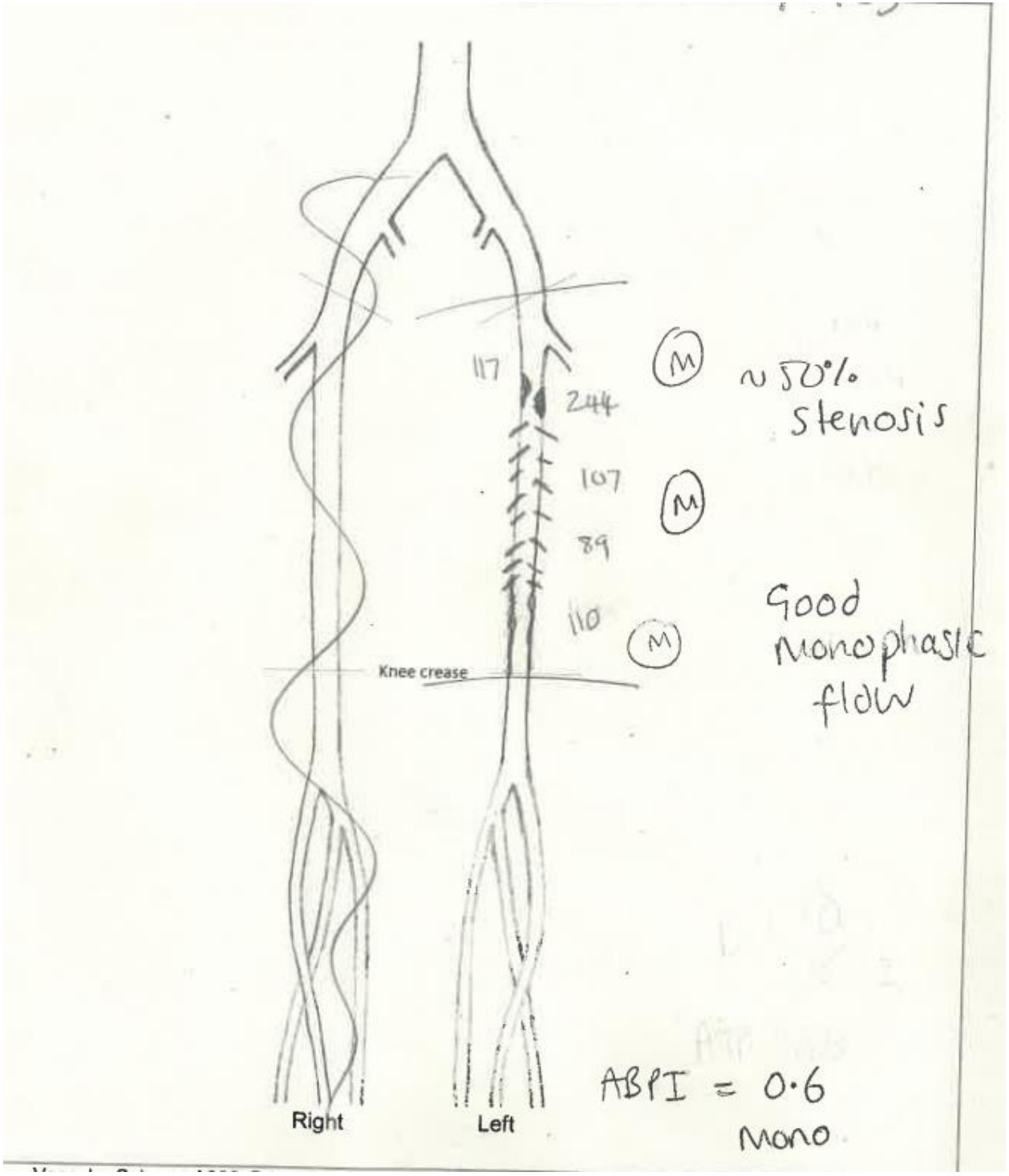
The proximal SFA is irregular and calcified with a 50-75% STENOSIS (117-244cm/s, PSVR 2, mono)
The mid-SFA stent is widely patent. Monophasic.
The distal SFA is patent, mildly irregular. Monophasic.
Although flow is still monophasic, waveforms have greatly improved and are 'perky' monophasic compared to damped monophasic 6 months ago.

SUMMARY LEFT LEG: Stent patent with good monophasic throughout. 50-75% stenosis proximal SFA.

Mr T Beckitt emailed to confirm if patient can be discharged from surveillance. Any queries please contact Vascular Science on 0117 34 27530.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)

See assocaited Schematic on the next page



~50% stenosis

Good monophasic flow

ABPI = 0.6
Mono

US Graft Surveillance VERIFIED Attended-03-Oct-2023 FULLSR/FULLSR-03-Oct-2023

GRAFT SURVEILLANCE:
9/12 post LEFT SFA- BK POP GRAFT (04/01/23)
SYMPTOMS: Patient reports ongoing left leg pain since the procedure. Spoke to consultant, this is nerve pain.

ABPI: 1.0 triphasic (PTA 138mmHg, brachial 140mmHg)

LEFT LEG: The native SFA, SFA-POP graft and distal native popliteal are all widely patent with triphasic flow through.

SUMMARY LEFT LEG: Graft patent with good flow throughout.

Patient will be automatically recalled for 12 month surveillance on 04/01/24.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Any queries please contact Vascular Science on 0117 34 27530.

US Doppler iliac and femoral artery Both VERIFIED Attended-03-Oct-2023 FULLSR/FULLSR-03-Oct-2023

LOWER LIMB ARTERIAL DUPLEX:

AORTA: Maximum diameter 2.0cm. Heavily calcified with severe atheroma in the distal aorta and ilaic bifurcation.

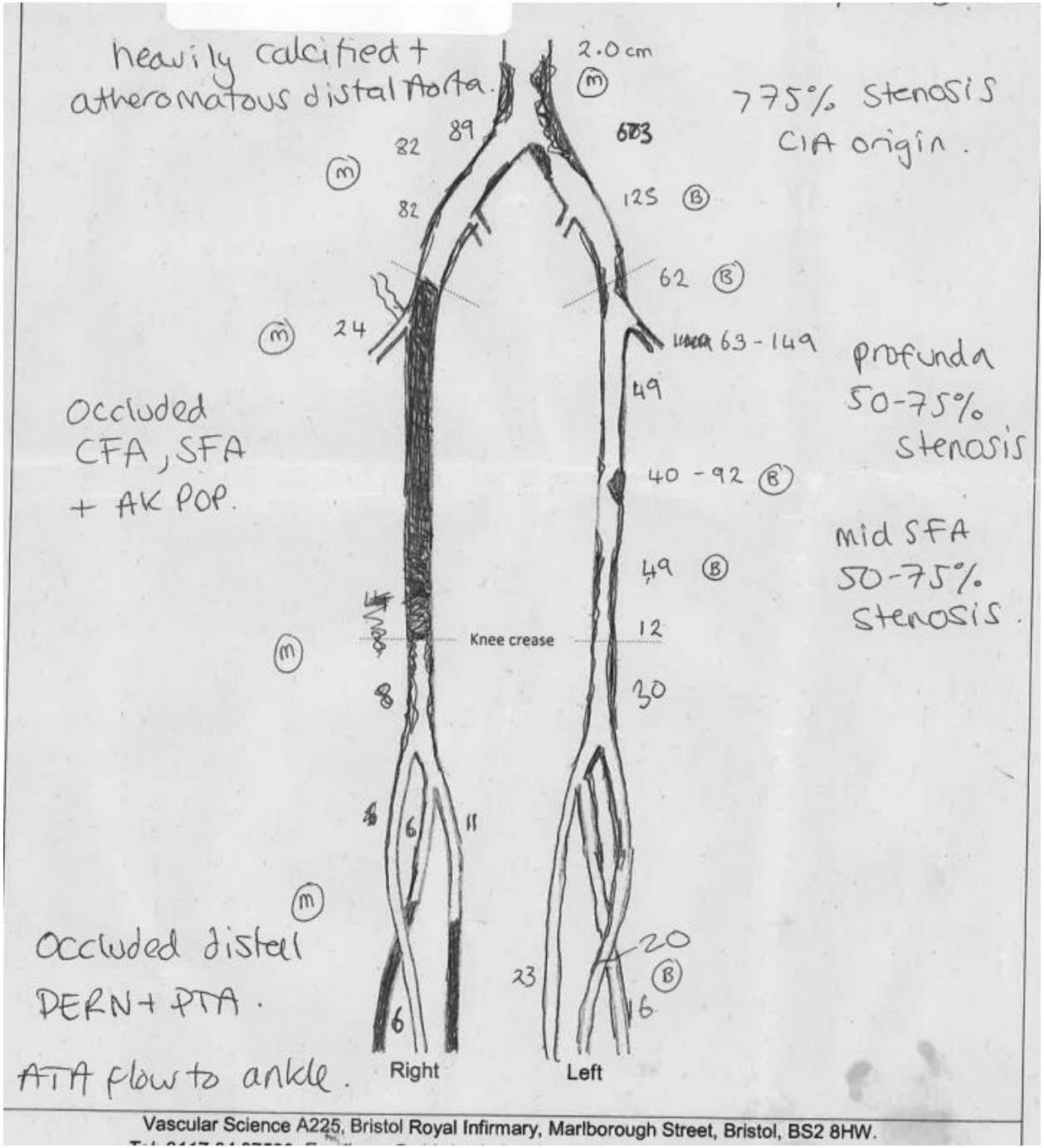
RIGHT SIDE:
The CIA and EIA are patent with mild atheroma. Monophasic flow.
The CFA, SFA and proximal popliteal are OCCLUDED.
The profunda is patent (collateral vessel seen refilling the profunda origin). Monophasic.
The distal popliteal and TPT are patent but irregular and calcified with damped, monophasic flow (8cm/s).
The ATA is calcified but patent with flow seen in continuity to the ankle. Monophasic flow.
The peroneal is calcified but patent proximally with monophasic flow. Occluded distally.
The PTA is calcified but patent proximally with monophasic flow. Occluded distally.

US Doppler iliac and femoral artery Both VERIFIED Attended-03-Oct-2023 FULLSR/FULLSR-03-Oct-2023

LEFT SIDE:
There is a tight >75% STENOSIS at the CIA origin (PSV 673cm/s).
The EIA is patent with mild atheroma. Biphasic flow.
The CFA is patent with irregualr calcified atheroma <50%. Biphasic flow.
There is a 50-75% STENOSIS of the profunda artery origin (63-149cm/s).
The SFA is patent with a 50-75% STENOSIS mid-SFA (40-92cm/s). Irregular calcified atheroma in the distal SFA. Biphasic flow throughout the SFA.
The popliteal and TPT are patent with irregular and calcified atheroma. Biphasic flow.
The ATA, PTA and Peroneal arteries are calcified but patent with flow seen in continuity to the ankle. Three vessel run-off. Biphasic flow.

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Schematic available
Technical Quality: Average
Any queries please contact Vascular Science on 0117 34 27530.

Associated schematic on the next page


heavily calcified + atheromatous distal Aorta.
2.0 cm
M
775% stenosis CIA origin.
82
89
603
82
125 B
62 B'
M
24
63 - 149
profunda 50-75% stenosis
49
Occluded CFA, SFA + AK POP.
40 - 92 B'
49 B
mid SFA 50-75% stenosis.
Knee crease
12
M
8
30
6
11
M
Occluded distal DERN + PTA.
20
23
B
6
6
ATA flow to ankle.
Right
Left

US Abdominal Aorta — VERIFIED — Attended-03-Oct-2023 — FULLSR/FULLSR-03-Oct-2023

ANEURYSM SCREENING: All diameter measurements are maximum inner-wall to inner-wall AP (anterior to posterior).

Infra-renal Abdominal Aorta TS 5.0cm LS 5.0cm
Right common iliac artery TS 2.3cm LS 2.4cm (saccular aneurysm - torturous vessel)

SUMMARY: AAA 5.0cm and RCIA 2.4cm.

Patient is under the care of Miss Martin. Patient has an appointment with Miss Martin on the 31/10/23. Miss Martin has been emailed to discussed suitability for continued surveillance (patient is wheelchair bound & non driver). The surgical intervention threshold is set at 5.5cm.

Scanned by: R Fulls, Senior Clinical Vascular Scientist
Any queries please contact Vascular Science on 0117 34 27530

US Arterial VERIFIED Attended-29-Sep-2023 FULLSR/FULLSR-29-Sep-2023

UPPER LIMB ARTERIAL DUPLEX:

LEFT SIDE:
The supra- and infra-clavicular subclavian, axillary, brachial, ulnar and radial arteries are all patent but with very low, monophasic flow throughout (16cm/s). This indicates a stenosis/occlusion proximally (subclavian artery origin) that is outside the field of view of ultrasound.

(Normal triphasic flow in the right subclavian artery)

Scanned by: Rebecca Fulls (Senior Vascular Clinical Scientist)
Schematic available
Any queries please contact Vascular Science on 0117 34 27530.