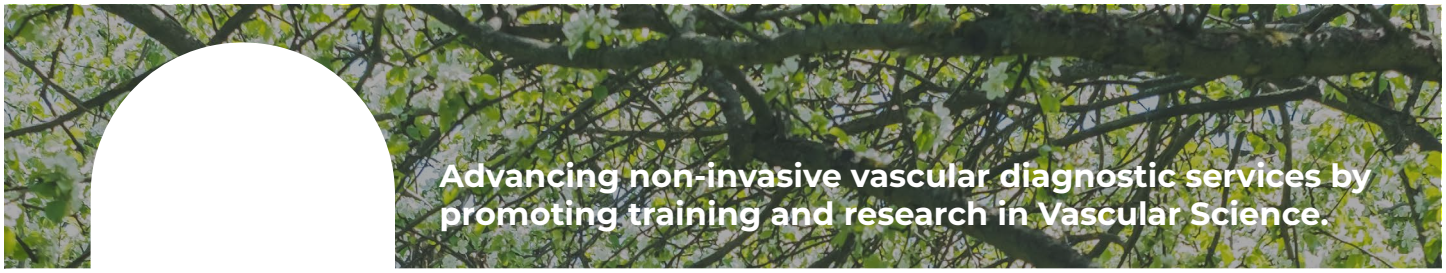

Advancing non-invasive vascular diagnostic services by promoting training and research in Vascular Science.

CSVS

THE COLLEGE AND SOCIETY
FOR CLINICAL VASCULAR SCIENCE
Great Britain and Ireland

SPRING
2026

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President's Message

This is a particularly busy time of year professionally, with many laboratories inevitably addressing waiting lists created by the drive to use annual leave before the end of the financial year. I am also aware that many units submitted data to the National Vascular Stocktake, which closed on 24 April.

Disappointingly, submissions from eligible trusts fell by 8% compared to last year (66% versus 74%). I recognise that changes to the data collection forms increased complexity this year, particularly in relation to cost information. It is important that we feed this back to the national team, so if you have any comments or reflections on the process, please do email me at President@csvs.org.uk so that I can pass these on to NHS England.

Separately, I am pleased to confirm that following recent changes at NHS England, the Clinical Reference Group (CRG) for Specialist Commissioning has been renewed. This remains an important mechanism through which our profession can influence national policy. Elective recovery priorities for venous intervention are now being more widely recognised by NHSE and have been taken forward by GIRFT. For some trusts this represents new activity that will require delivery, and I have been clear that additional investment in the vascular science workforce may be necessary to support this.

You may also be aware of the strategic plans for the NHS in England involving the development of new Modern Service Frameworks. CSVS contributed to a joint submission led by the UK Vascular Societies. While we await the outcome, it is apparent that there are strong synergies with other specialties, and that community-based Metabolic Clinics are likely to form part of the future model. Although the detailed scope of these services is not yet known, pilot programmes are underway and it is likely that basic vascular diagnostics, such as ABPI measurement, may be included. As the NHS continues its 'left shift' towards community-based care, this will increasingly form part of our professional remit, although the manner of implementation remains a key challenge.

In light of these increasing pressures, I have raised the workforce challenges facing vascular science with the Vascular Surgical Society Open Council, specifically in relation to how rising demands might realistically be met. While discussions are still at an early stage, one clear message is emerging: it will not be possible for the vascular science workforce to deliver all aspects alone, and a broader multidisciplinary team (MDT) approach will be required. This raises important questions about how we can safely and effectively support MDT colleagues, for example, surgeons undertaking varicose vein ultrasound or AHPs performing ABPI measurements, while maintaining quality and governance.

In other news, the SVTGBI was a founding member of the Consortium for the Accreditation of Sonographic Education (CASE), and I continue to represent CSVS interests on the CASE Board. However, the education and regulatory landscape is evolving, and CASE must adapt accordingly. Current discussions focus on reviewing its legal structure and exploring the value of CASE becoming an independent entity. While these conversations are complex and ongoing, CASE continues to deliver its core mission without interruption.

Some of you may have seen my recent LinkedIn post regarding STP equivalence. For several years, the CSVS Executive has worked with the AHCS to develop a Recognition of Prior Learning (RPL) process that accepts the AVS certificate as contributing evidence for STP equivalence. This process has now been finalised, and I have personally completed a pilot of the pathway. We are planning to launch this new process towards the end of May, alongside joint webinars explaining how it works. Importantly, the revised process is simpler and quicker and should support a greater number of vascular scientists in achieving HCPC registration.

Research Committee Update

The Research Committee continues to make good progress across several key initiatives. Further clarification will shortly be provided regarding the evidence required to demonstrate research competence for Accreditation purposes.

In addition, a prototype CSVS research eLearning resource has been developed. Further details regarding content expansion and launch timelines will be shared in due course. The committee has also updated grant application documentation to better support future applicants.

Education Committee Update

The Education Committee successfully delivered the Fundamentals Study Day in March and is now preparing for the forthcoming Revision Study Days scheduled for 20–21 May. Theory examination question-writing workshops are also planned for June.

Work on the practical examination revalidation project continues to progress well. Responses to the recent member survey are currently being analysed and will inform the next phase of review and development of the practical examination process.

The committee is also undertaking a comprehensive review of the theory examination syllabus, alongside updates to Accreditation, CPD, and practical examination documentation.

Professional Standards Committee Update

The Professional Standards Committee has continued to support the national vascular data collection initiative and has produced high-quality guidance to assist departments in this work.

In parallel, discussions with the NHS England national team are ongoing regarding the development of a unified, national approach to coding. This work is vital to ensure consistency across the UK and to improve the quality of national stocktake data used for workforce planning and capital investment decisions. Enhanced data quality will enable more accurate forecasting and strategic planning. Further guidance will be issued once this work is complete.

As always, thank you for the continued effort to provide optimal and timely diagnostics for vascular patients in environments and pressure never seen before in the NHS. Your effort is valued.

Finally, thank you to Jeny for their work in producing yet another excellent newsletter.

Best Wishes,

Dr Steven K. Rogers BSc(hons), PGCert, AVS, Ph.D, FCVS
President - The College and Society for Clinical Vascular Science

Bitesize Research:
UPPER LIMB ISCHEMIA

Author: Emily Morgan, Doppler Ultrasound, University Hospital Wales, Cardiff

PAPER 1: *Outcomes of Upper-Extremity Revascularization Following Acute Limb Ischemia*

: A Outcomes of Upper-Extremity Revascularization Following Acute Limb Ischemia. Jo, Diane et al. Journal of Hand Surgery, Volume 50, Issue 11, 1362 - 1369

Summary:

This retrospective study reviewed 366 patients treated for acute upper-extremity limb ischemia (≤14 days' duration) between 2003 and 2023 to evaluate outcomes following surgical revascularisation. The mean patient age was approximately 65 years and around 70% were women. Common causes included iatrogenic injury and embolism, often related to atrial fibrillation, with the brachial artery most frequently affected. Median ischaemia time was 12 hours, and overall complications occurred in about 22% of cases. Although longer ischaemia duration was associated with more severe presenting symptoms such as pain and paraesthesia, it did not clearly predict postoperative complications or length of hospital stay. Prophylactic fasciotomy did not demonstrate clear benefit and was associated with higher complication rates, suggesting its routine use in upper-extremity acute limb ischaemia should be carefully reconsidered.

Pros

This is a large cohort study for a rare condition (366 patients over 20 years). Additionally, the study was over a long period of 20 years which captures and allows insights into real world outcomes across evolving practise. This study addresses practical issues, for example, does ischaemia time predict outcomes? Is prophylactic fasciotomy beneficial? These are directly applicable to surgical and vascular practice. Retrospective, multi-year institutional data reflect routine clinical care rather than idealised trial settings, improving pragmatic relevance. Reporting complication rates (~22%) provides useful counselling information and benchmarking data.

Cons

Retrospective study design which is subject to selection bias, missing data and documentation variability. Cannot establish causation — only associations. Although the longer time frame is a positive It can also be seen as a negative factor. Long time frame can result in increased practise variation. Over 20 years, Imaging technology evolved, Endovascular techniques changed, Anticoagulation practices improved and surgical thresholds for fasciotomy likely shifted. This introduces heterogeneity that may confound outcomes.

Impact on Practise

Upper-limb ALI is uncommon but high-risk. Although less frequent than lower-limb ALI, complication rates are significant (~22%), so rapid recognition and escalation are critical. Even when ischaemia time isn't clearly predictive of outcome, delay still correlates with worse symptoms. This highlights the importance of timely diagnostic scans. Prompt duplex assessment of the brachial artery (most common site) and proximal inflow is essential. Be alert to embolic patterns, especially in patients with atrial fibrillation. Consider iatrogenic injury in recent arterial access/intervention cases.

PAPER 2: *Acute Upper Limb Ischemia: A Case of Successful Thrombosuction and Catheter-Directed Thrombolysis in a Resource-Limited Hospital*

Baskoro, A, Budiono, E, Sulastomo, H. et al. Acute Upper Limb Ischemia: A Case of Successful Thrombosuction and Catheter-Directed Thrombolysis in a Resource-Limited Hospital. J Am Coll Cardiol Case Rep. 2025 Nov, 30 (37)

Summary

This case report describes a patient presenting with acute upper-limb ischemia, a vascular emergency that accounts for only a small percentage of all acute limb ischemia cases. The authors detail how the diagnosis was made clinically and with vascular imaging, and then describe the successful use of thrombo-suction and catheter-directed thrombolysis as the primary intervention in a resource-limited hospital setting where more advanced surgical or hybrid approaches may not have been available. The report highlights the importance of early recognition, prompt intervention, and pragmatic use of endovascular techniques even in environments with limited infrastructure. It also underscores the feasibility of less invasive vascular procedures for limb salvage when conventional surgical options are constrained.

Pros

This paper provides real-world insights in a low-resource setting. It demonstrates how advanced vascular care can be delivered even when parts of the usual infrastructure are not available. This is important in a global health context. The paper also offered a practical step-by-step logic on how thrombo-suction and catheter-directed thrombolysis were performed and what challenges were encountered. This is educational for vascular teams. The case report highlights how real patients deviate from normal pathways and reinforces that unconventional routes can be limb saving with appropriate judgement.

Cons

By definition, a single case cannot establish effectiveness or compare outcomes across strategies. The successful outcome here doesn't prove that thrombo-suction + CDT is superior to surgery in all cases, especially in well-resourced settings. Unsuccessful cases of similar intervention in resource-limited environments are less likely to be published, so the report may reflect positive outcome bias. The focus is on acute success; longer follow-up data (e.g., limb function, re-occlusion, anticoagulation strategy) is typically limited or absent in case reports. There's no control or comparison group — we don't know, for example, whether a standard surgical embolectomy might have had a similar or better outcome in this specific situation.

Impact on practise

Acute upper limb ischemia can be successfully managed with endovascular techniques like thrombo-suction and catheter-directed thrombolysis even outside tertiary centres. Early diagnosis, followed by early intervention are key for upper limb success, regardless of setting. Practitioners should be aware of alternative workflow options when traditional surgical support is unavailable. In settings where hybrid approaches are limited, vascular scientists can play a key role but providing rapid access to diagnostics and escalating findings in an urgent manner. Follow up duplex can then be arranged to determine success of procedure.

PAPER 3: *True radial Artery Aneurysm: Diagnosis and Treatment*

Duncan A, Maslen C, Gibson True Radial Artery Aneurysm: Diagnosis and Treatment Ayers, Joseph D. et al. Journal of Vascular Surgery, Volume 62, Issue 3, 813 - 814.

Summary

Ayers and colleagues report a true radial artery aneurysm, a very rare vascular pathology because it involves dilation of all three layers of the arterial wall, unlike the much more common iatrogenic pseudoaneurysms. This case describes diagnosis using duplex ultrasonography (and likely cross-sectional imaging) which revealed a focal aneurysmal dilation of the radial artery. Definitive management involved surgical resection of the aneurysm and vascular reconstruction, tailored by assessing hand perfusion and collateral flow (e.g., Allen's test and imaging). The report emphasises that true radial artery aneurysms, although rare, can carry risks of distal embolisation, ischemia, nerve compression, or rupture, and thus require timely recognition and intervention to prevent complications.

Pros

Focus on a rare but clinically important entity: True radial artery aneurysms are extremely uncommon, and documented cases help broaden awareness and clinical suspicion. Clear diagnostic and management description: Illustrates how vascular imaging (duplex ultrasound as first-line) guides surgical planning and the role of collateral assessment in decision-making. Educational

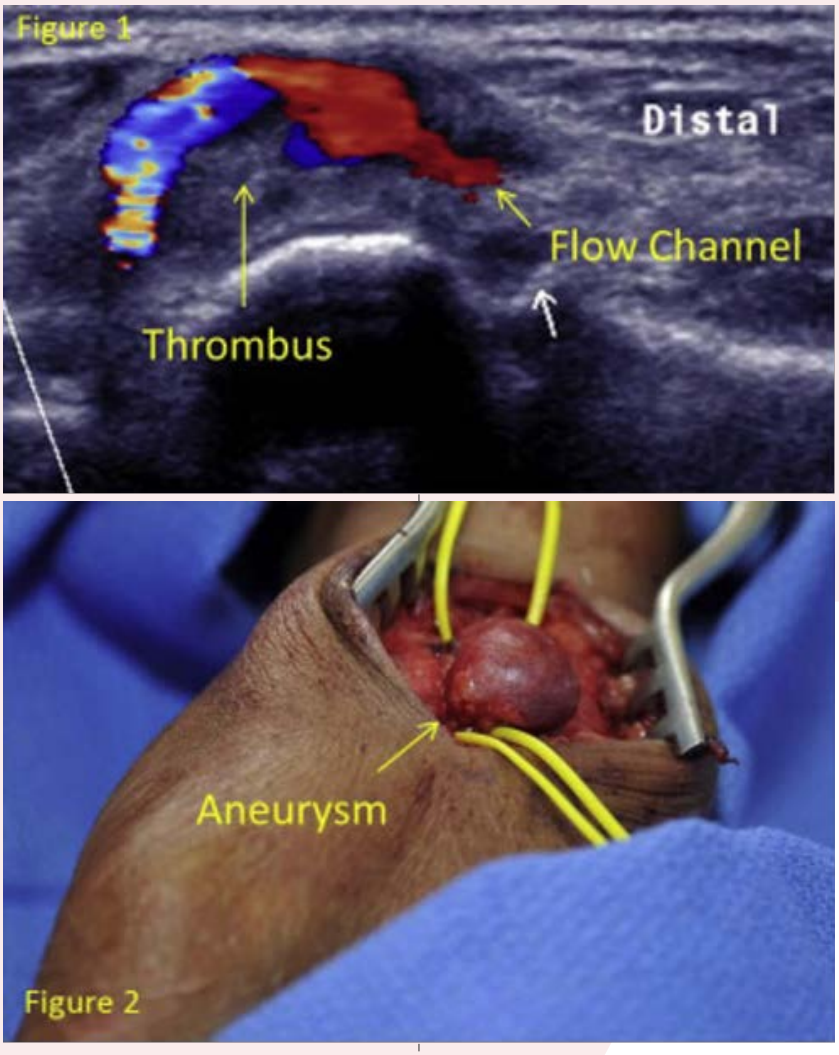

Figure 1 and Figure 2: Figure 1 showing ultrasound image of the radial artery aneurysm. Figure 2 shows the operative exposure of the radial artery aneurysm.

value: Provides a succinct but practical template for recognising and treating similar presentations, aiding clinicians who may never encounter this condition. Highlights another cause of upper limb ischemia.

Cons

Very low evidence level: As a short case report with only one subject, it cannot establish generalisable recommendations for management or outcomes. Lack of long-term outcome data: Most case reports (including this one) focus on acute technical success; follow-up on graft patency or late complications is limited or absent. Limited generalisability: Because these aneurysms are rare, individual case experience may not apply broadly, and clinical decision-making should still be guided by physiology and collateral assessment.

Impact on practise

No mention of follow up on graft patency. This highlights the importance of establishing follow up protocols with vascular surgery following intervention. With limited published guidance, this may be on a case by case basis. Generally lower limb grafting protocol can be followed for upper limb procedures. Consider performing all vascular diagnostic scans in one visit. For example, may be useful to perform vein mapping to avoid delay in treatment plans.

PAPER 4: *Outcomes of Surgical Revascularisation for Acute Upper Limb Ischemia- A Single Centre Retrospective Analysis.*

Ayman El-Sayed; Navanith Murali; Angela Lee; Ishtiaq Aziz; Adel Abdallah; Philip Stather. Outcomes of Surgical Revascularisation for Acute Upper Limb Ischemia- A Single Centre Retrospective Analysis. Annals of Vascular Surgery, January 01, 2025, Volume 110, Pages 506-512.

Summary

This single-centre retrospective study analysed 96 patients who underwent brachial artery embolectomy for acute upper-limb ischemia (AULI) between 2010 and 2021. The brachial artery was the most common site of occlusion, with computed tomography angiography used routinely as the diagnostic modality. The procedure achieved a technical success rate of 76.4%, but overall perioperative complication rates were high: major adverse events occurred in over 11% of patients, including stroke and in-hospital death, while local complications (e.g., haematoma, thrombosis) affected about 24%, and amputation occurred in 2.1%. No clear predictors of local surgical complications were identified. The authors conclude that although Fogarty embolectomy can be effective in selected patients, AULI carries significant morbidity and mortality, and evidence to guide optimal management remains limited. Larger prospective studies are needed to better identify predictors of poor outcomes and refine treatment strategies.

Pros

The paper addresses a clinically meaningful gap: Acute upper-limb ischemia is rare and understudied; this paper provides useful real-world data on surgical outcomes where evidence is sparse. Detailed outcome reporting: Includes both technical success and important perioperative outcomes like stroke, thrombosis, and amputation, giving a balanced view of risks/benefits. Use of modern imaging: CTA as first-line diagnosis reflects current practice and adds consistency to patient evaluation. The paper provides real-world context: Data covers over a decade, reflecting practice evolution and providing practical relevance for clinicians.

Cons

Retrospective single-centre design: Inherently subject to selection bias, missing data, and practice variability over time; findings may not generalise to other settings. Modest sample size: Ninety-six patients isn't small for this condition, but the numbers may still limit statistical power, especially for multivariable analysis or subgroup predictors. Lack of control group: Without non-operative or endovascular comparators, it's hard to judge whether surgery was optimal in all cases.

Impact on practise

Upper-limb ALI treated surgically has significant morbidity, even with technically successful embolectomy, underscoring the importance of rapid diagnosis and patient selection. CTA is valuable as first-line imaging for planning intervention however duplex should not be forgotten, and it might be worth discussing with vascular surgery how ultrasound imaging can aid early diagnosis, especially in cases where CT may not be readily available. Furthermore, ultrasound imaging can be used in patients needing bypass procedure.

CSVS Research Committee announcement

Members of the College and Society for Clinical Vascular Science (CSVS) are encouraged to take advantage of the Society's research funding opportunities. The CSVS offers a Research Grant of up to £4,000 to support vascular science research projects, as well as a £500 Writing Grant designed to provide members with the time to write grant applications. These grants provide an excellent opportunity to develop research skills, contribute to the vascular science evidence base, and support professional development. Members interested in applying can find further details and application information on the CSVS website.

CSVS members are invited to share their work on the Current Research section of the CSVS website. If you are involved in a research project, service evaluation, audit, or have recently presented or published work related to vascular science, we would be delighted to highlight it. Sharing your research helps showcase the valuable work being undertaken by our members and supports the growth of the vascular science evidence base. If you would like your research featured, please get in touch with the CSVS research team on team on research@csvs.org.uk

Congratulations to Marina, the winner of this edition's prize. She will be awarded a free place at a CSVS study day for her article on the 'Cystic Adventitial Disease: A Case Study'.

Cystic Adventitial Disease: A Case Study

Introduction

A 74-year-old male patient was referred by a Vascular Surgeon to the Vascular Assessment Unit with history of pain in his right calf after walking 150 yards, with no issue at rest or when cycling. He had no cardiovascular risk factors, he was a non-smoker who was generally fit and active. Consultant examination revealed a full complement of pulses throughout the leg. He attended for an arterial duplex of his right leg to determine if there was any peripheral arterial disease to account for his symptoms, with the suggestion of possible cystic adventitial disease.

Images and Results

An arterial duplex scan of the patient's right leg was carried out to our departmental protocol, which includes the Aorta to vessels at the ankle. The scan from Aorta to distal Superficial Femoral artery showed no disease with good triphasic flow, therefore only relevant images of the Popliteal artery are shown below.

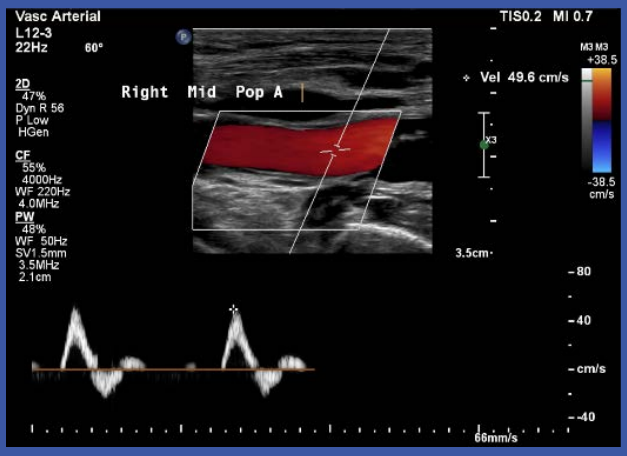

Figure 1: Normal triphasic flow in the mid Popliteal artery

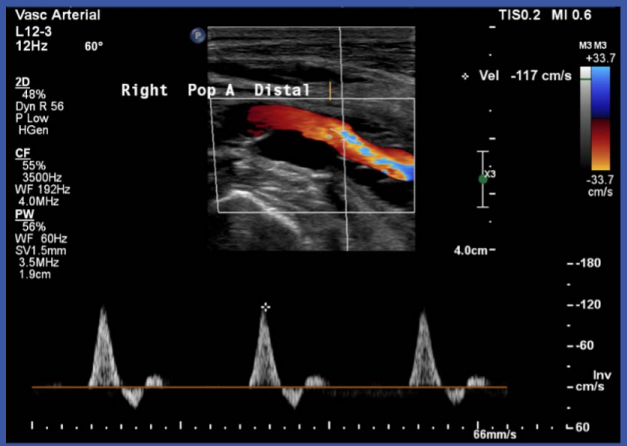

Figure 2: Flow within the distal Popliteal artery is triphasic however a degree of aliasing can be seen on the colour image suggesting turbulent flow with raised velocities. Calliper placement measures a x2 velocity shift from 50cm/s in the mid Popliteal artery to 117 cm/s distally.

With the velocity increase in mind, closer inspection was made of the mid to distal Popliteal artery to identify a possible stenosis or cause for the velocity increase.

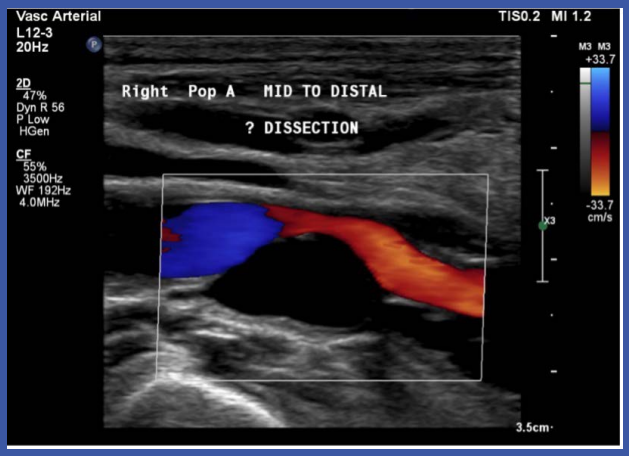

Figure 4: Colour Doppler image of the mid to distal Popliteal artery in longitudinal plane reveals marked narrowing of flow around an echolucent structure, initially with the appearance of a dissection.

Figure 5: Transverse B-mode image of the Popliteal artery shows an echogenic line through the lumen, similar to that seen in a dissection.

On B-mode there appeared to be a linear structure across the lumen, much like an intimal flap which can be seen in a dissection. Figure 4 using colour Doppler shows flow around the structure which was not filling.

Figure 6 shows a different appearance further distally in the Popliteal artery which is less in favour of dissection as it is present along each side of the artery wall. Some echoes are present within the 'pockets', which do not have the appearance of thrombus but of a fluid, however this is not blood flow as it is not demonstrated on colour Doppler. A diagrammatical report was produced, describing an 'approximate 50% narrowing of the mid to distal Popliteal artery by ? fluid filled areas of the vessel wall, ? cystic adventitial disease'.

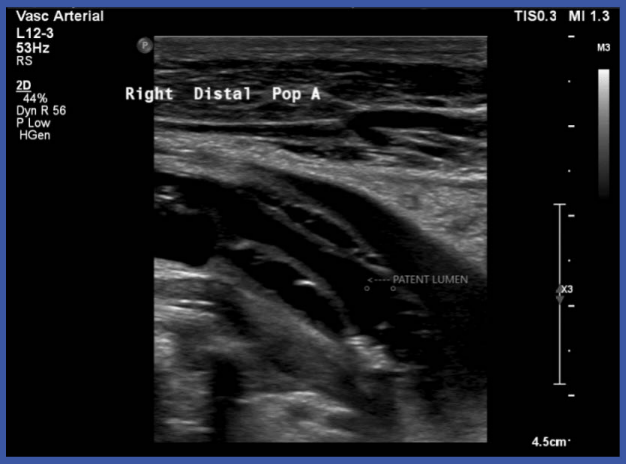

Figure 6: Longitudinal B-mode image of the distal Popliteal artery demonstrates 'pockets' of echolucent material along the walls of the artery with a patent lumen annotated. Visually it looks approximately 50% diameter reduction.

The patient was followed up with MRA of the lower limbs, which confirmed cystic adventitial disease of the Popliteal artery, causing 25-49% stenosis. As the degree of narrowing was considered minor, the patient returned to our Vascular Assessment unit for exercise ABPIs. However, this demonstrated no drop in pressure, with a pressure of 1.2 post exercise. At the patient's final follow-up with the Vascular Consultant, he was encouraged to exercise normally. No surgical intervention was offered, and the patient was discharged.

Discussion

Cystic adventitial disease (CAD) is a rare vascular pathology most commonly affecting the Popliteal artery, usually in males with no risk factors for atherosclerotic disease. It results from the build-up of cystic fluid within the artery wall which can cause a narrowing and most often presents as intermittent claudication [1]. Its cause is not fully understood, but theories have been proposed in literature, which include repeated trauma to the artery wall, systemic connective tissue disorder and abnormalities in embryologic development [2, 3].

Imaging is used to confirm the clinical suspicion of CAD, with duplex ultrasound as the first-line method of investigation but MRI and CT are other valuable imaging techniques [4]. Its appearance can appear as 'multi-lobulated hypoechoic structures without vascular flow, causing focal stenosis' when imaged on ultrasound [5].

The management of CAD is generally guided by the severity of symptoms. Exercise ABPIs can be a useful diagnostic tool to help quantify this. Conservative management is often considered first, as it is possible for CAD cysts to spontaneously resolve and/or symptoms improve over time [6]. Treatment in more severe cases can include percutaneous aspiration of cystic fluid or surgery, however it is possible for cysts to recur following aspiration [7,8].

The affected population are often considered low risk for vascular disease which may cause a delay in diagnosis, and low prevalence may mean lack of experience among Vascular scientists and other healthcare professionals when interpreting imaging. One paper presents CAD in the external iliac artery of a 29-year-old, which was reported as a dissection with a thrombosed false lumen on both CTA and MRA. Although there was clinical suspicion, it was only confirmed to be CAD in surgery for an iliofemoral bypass graft [9]. A second case study describes a 54-year old male with a 2-month history of unilateral claudication and reduced pedal pulses [10]. Initial Duplex imaging reported a Popliteal aneurysm with evidence of dissection, however subsequent CTA demonstrated a cystic structure causing near-occlusion of the Popliteal artery with no evidence of dissection. The presumptive diagnosis of CAD on CTA was confirmed in surgery where a cystectomy was performed [10].

The case presented, and the two cases outlined above show that CAD can easily be mistaken for other vascular pathologies, and there are many more examples in literature. Often, multiple imaging modalities are needed to confirm diagnosis, and treatment depends on the severity of symptoms as they are not always successful long-term.

Conclusion

It is important to recognise this rare pathology and its possible differential diagnoses. Within the MDT, careful history taking, particularly among young otherwise healthy individuals with low cardiovascular risk factors, and awareness of CAD among vascular labs and radiology professionals, can help with an accurate and timely diagnosis.

Written by Marina Sealey
Portsmouth Hospitals University NHS Trust

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My STP Elective – Sun, Sand and Duplex Scans

As part of my STP elective, I wanted to fundamentally consider how our role as vascular scientists varies abroad (preferably somewhere warm and sunny), which led me to Portugal. A country where I have never lived but have citizenship and can speak the language. Also a country in which clinical scientists are well integrated in the healthcare system.

To make the connection I reached out through a fellow STP colleague at Imperial College Healthcare NHS Trust. With the help of Carlos Pinho, I was able to get in contact with fellow clinical scientists in Portugal and organise a placement at the Santa Maria Hospital in Lisbon. This is the biggest hospital in Portugal, located in the central Lisbon neighbourhood of Campo Grande, known for being a university district and home to football's Sporting CP.

The System

As I learnt, Portugal has a role for physiological scientists in which they are trained through a course not dissimilar to the STP but with fundamental differences. Aspiring scientists will be rotated through different physiological disciplines for months at a time, becoming familiar and proficient in a number of different diagnostic examinations. Once finished, they will enrol in the speciality in which they are most interested and most likely show a flair for. This enables trainees to gain knowledge in a broad range of complementary disciplines.

"Vascular" is split into two sub-specialities, peripheral vascular ultrasound, which is considered to be from the neck down and cerebral haemodynamics, considered to be from the neck up. My placement was in the cerebral haemodynamics lab, with a small team comprising of three vascular scientists, called technologists in Portugal, plus a HCA and a secretary. The team reported directly to neurologists who requested the majority of scans. They also had

a fellow trainee technologist on their rotation there, as well as a junior doctor learning how to carry out the different scans.

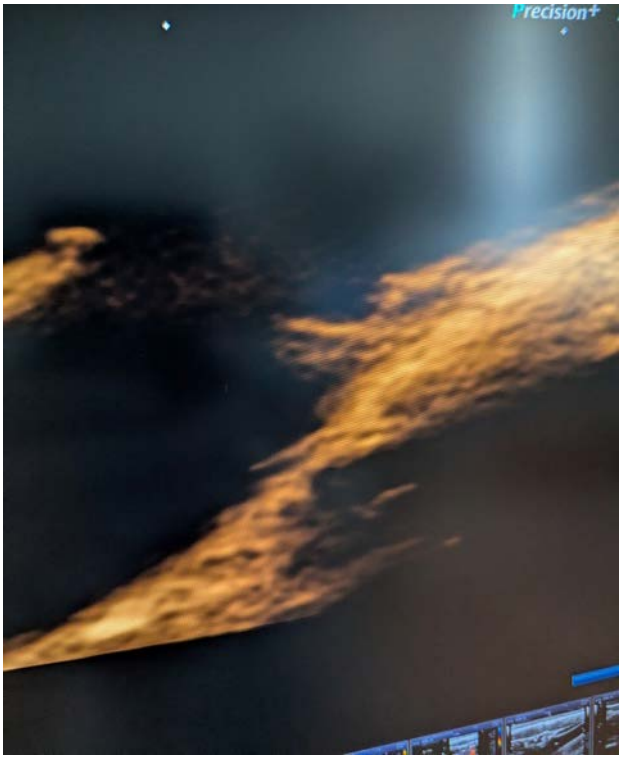
The team was also situated on Level 6 of the hospital with stunning views of the surrounding Lisbon skyline, in the midst of a hot summer.

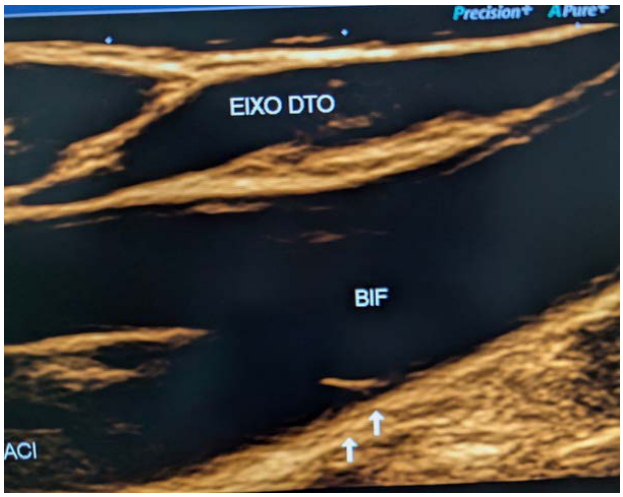
Scans and machines

The team was responsible for carrying out several diagnostic exams which include, carotid duplex scans, transcranial Doppler scans, PFO tests (Patent Foramen Ovale - hole in the atria), temporal artery and ophthalmic artery scans. While a number of these scans were not familiar to me, I was allowed to start the scans off before a technologist would come and take the images.

These were carried out using two cart-based Cannon Applio machines as well as smaller non-imaging TCD machines, which were often taken onto the wards, usually neurocritical care. An interesting difference in practice I found in the department was the use of a lot of different ultrasound technology, utilising a vast range of different ultrasound functions and getting the most out of their machines.

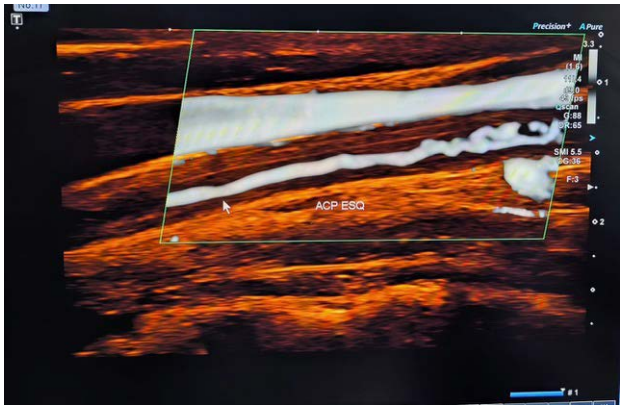
An example of this can be seen in the use of a different spectral Doppler tint colours as well as B-mode tint maps to support plaque visualisation. This could then be used to further support the technologist's written report.





An example where these maps were used can be seen in the figure above, where a web was queried as opposed to a small plaque.

Another example is the use of the microflow imaging setting used demonstrated plaque neovascularization which could indicate plaque instability in smaller plaques. Whilst the stenosis may not be sufficient to indicate surgery an unstable mixed plaque could call for pharmacotherapy. Microflow can also be used to demonstrate vessel patency where there is low flow. The figure below demonstrates microflow confirming patency in Takayasu arteritis.



The team also used "blind" Doppler for carrying TCD work, which was used mostly for stroke patients but also in sickle cell surveillance. This is used in conjunction with MRI and CT to support diagnoses of intracranial disease, forming a key part of the imaging stroke patients receive. The TCD work was the biggest novelty to me as it is a technique not commonly used in Vascular labs in the UK, especially with stroke patients. The technique would be used to identify intracranial stenoses and blockages through the transtemporal and suboccipital windows, visualising the MCA, PCA and ACA as well as the vertebral and basilar arteries. When the find-

ings were combined with the carotid duplex, the scans could also help determine whether carotid disease was clearly significant or not. If cross-flow was seen in the ACA, this would suggest compensatory contralateral flow, thus helping to confirm significant disease in more complicated cases. In my experience trying TCD was initially very challenging where stroke patients were older as the acoustic window was often limited. However, over the few weeks I spent at the lab I became more accustomed to the technique and was able to visualise the different intracranial vessels.

Whilst most TCD scans are carried out with imaging TCD, the "blind Doppler" is used primarily on neurocritical care wards, as well as when testing for a PFO. If a spike was seen in the spectral Doppler trace confirming the presence of a PFO, this would be followed up with a DVT check from the common femoral veins to the popliteal veins, ruling out a potentially embolic origin of a stroke. Other scans carried out include temporal artery scans for GCA and ophthalmology scans, which would be additionally requested for all patients typically having a carotid scan and TCD as standard. The ophthalmic scans were also a novelty to me. They were primarily used to study the ophthalmic arteries. This was carried out in patients who had TIAs with visual symptoms or visual disturbances with suspected vascular origin.

Culture and Language

The experience in the Santa Maria hospital was a phenomenal opportunity to learn from other colleagues in a particularly specialised centre. Many similarities could be seen in regard to the common protocols and practices, the structure of the team and the role of different team members. The differences could be seen in the extent of specialisation within the speciality, the tools available and the fundamental cultural differences. With a team of three scientists working in the largest hospital in the country, there is a large workload to be negotiated among the staff. The small team has a tight dynamic where breaks are cherished times for all scientists, admin staff, the team's HCA and any students or other visiting staff to sit and eat together.

I was fortunate enough to be part of this and was treated to a leaving meal at the end of my placement. Portuguese culture in my experience, is often a tight-knit family centric surrounded by long conversation, good fresh food and short "bica" coffees enjoyed by all.

This experience I will remember fondly, knowing that whilst learning a lot in a new department, I was able to experience another part of my culture within a work environment. I have met colleagues who have shared a lot of knowledge with me and remain in contact with me today. We discuss complicated cases and share experiences and I hope to maintain these connections throughout my working career. I also got to experience another lovely Portuguese summer full of heat, the seaside in the afternoons and exploring more of Lisbon's food, art and culture during the cooler parts of the evening and night.

It's worth noting that whilst I am fluent in conversational Portuguese, my understanding of technical terms took longer to understand. Fortunately, the team-lead Fatima was very proficient in English and helped me through this, thus demonstrating a brilliant opportunity for any other aspiring student who would like to consider such a placement. Overall, a very enjoyable and worthwhile experience.

Written by Samuel Alves-Short
Oxford University Hospitals NHS Trust

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A VERN Multi-CentreSurvey | In collaboration with the Leicester Vascular Institute

We are pleased to share an exciting research opportunity from the Vascular and Endovascular Research Network (VERN). The **SAVVY** survey is a short, multi-centre, international study exploring how vein conduit suitability is assessed prior to bypass surgery for patients with critical limb-threatening ischaemia (CLTI).

Background

Recent trials have highlighted the importance of venous conduit suitability in determining lower limb revascularisation strategy for patients with CLTI. However, assessment of vein conduit suitability remains largely subjective.

External factors — including patient position, hydration status, and ambient room temperature — can significantly influence duplex ultrasound measurements, leading to inconsistency across centres and professional groups.

SAVVY aims to capture current national practice and help inform the development of more consistent, standardised assessment protocols.

Who Should Participate?

All vascular practitioners involved in vein conduit assessment prior to bypass surgery, including:

- Vascular scientists
- Sonographers
- Vascular surgeons
- Interventional radiologists

Key details:

- Takes less than 5 minutes to complete
- Open to practitioners across all centres nationally and internationally

A message to Vascular Scientists

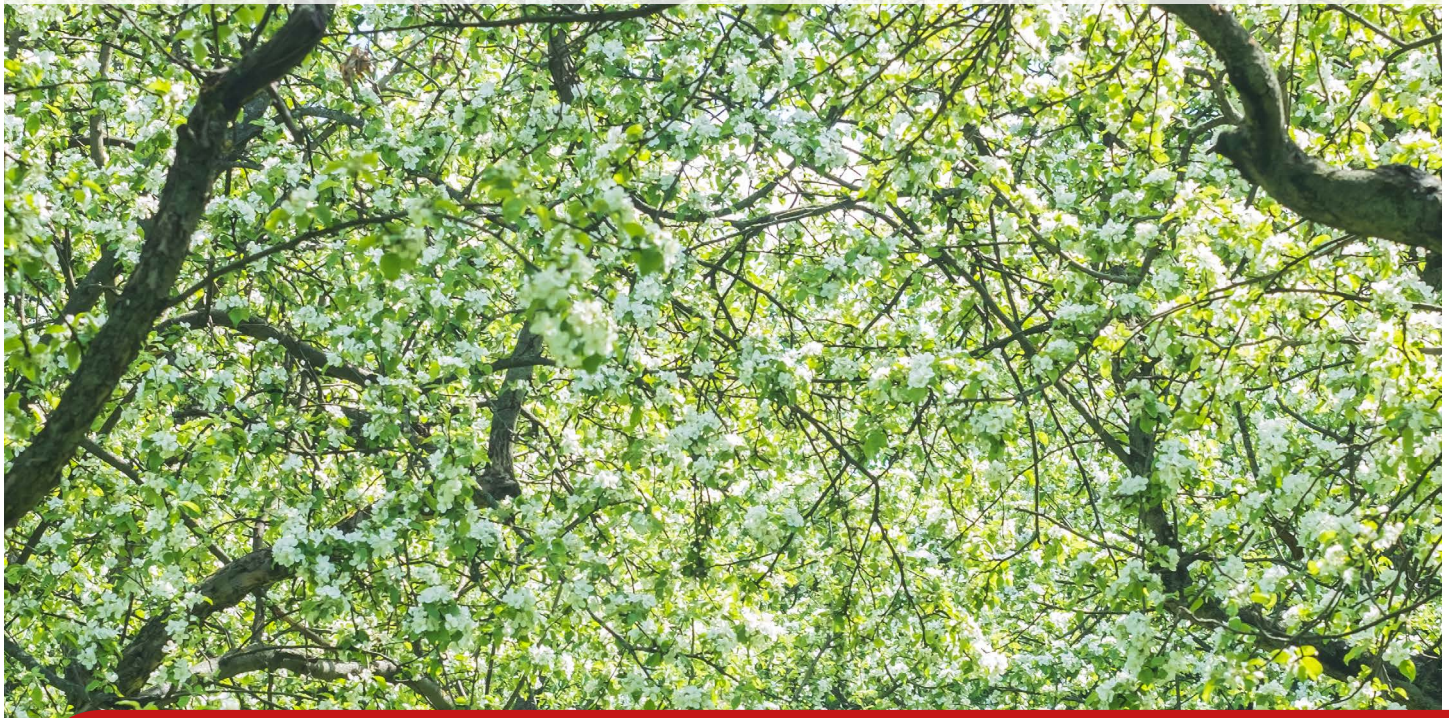
As the practitioners who perform the vast majority of vein conduit assessments, vascular scientists are at the heart of this issue. The quality and consistency of pre-operative duplex assessment directly influences whether a patient proceeds to bypass — and with which conduit. Yet the factors that affect these measurements (patient position, hydration status, room temperature) are rarely formally standardised.

Your voice is essential. SAVVY cannot meaningfully inform national protocols without broad representation from vascular scientists across all centres. This survey takes less than 5 minutes — please do take part and encourage your colleagues to do the same.

Take Part — It Takes Less Than 5 Minutes

Or follow the survey link directly:

https://docs.google.com/forms/d/e/1FAIpQLSfb0LuKvyV-2vdfdGNXw-FSVwZcHpmWyBrGvGaJyCi1Zlrex7w/viewform



AVS Accreditation

Huge congratulations to these members for successfully passing their AVS Exams

- Chloe Bishop
- Beverely Daping
- Emily Torkington

CSVS
THE COLLEGE AND SOCIETY FOR CLINICAL VASCULAR SCIENCE
Great Britain and Ireland