CSVS

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

Service Guidelines

CSVS Scan Time Guidance

Version 1.1

September 2025

Doc Ref PS-SM002

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Version Number	Change	Author	Date
1.0			
1.1	**Revised with minor edits**	**Author: PSC committee** **Review:** September 2028 **Approval: CSVS Exec committee**	**Sep 2025**

Purpose

This document was prepared by the Professional Standards Committee (PSC) of the College and Society for Clinical Vascular Science (CSVS) to support the practise and delivery of high quality standardised Clinical Vascular Science. This document may be used in its entirety (or referenced in part with suitable additions made by local policy implementers) by all parties involved with clinical vascular science. Suggestions for improving this document are welcome and should be sent to the Chair of the PSC (see csvs.org.uk for current PSC Chair details).

Introduction

The purpose of this document is to give managers a starting point for preparing workload and time/capacity planning – please see appendix 1. The following is a list of points that need to be considered when reading the table in Appendix 1:

1. Scan time versus reporting time

2. Image storage requirements

3. Reporting platform – PACS, CRIS, internal system, paper….

4. Is there a separate reporting room?

5. Is there a maximum number/limit on number of scans locally?

6. Healthcare assistant/vascular assistant availability/support in the unit

7. RSI issues need to be considered

8. Time taken for each assessment is dependent on patient-specific factors such as severity/extent of disease, frailty, mobility, habitus.

9. Time taken for each assessment is dependent on experience of the Clinical Vascular Scientist

10. Training times should be longer than that of an AVS

11. How in-depth is the scan (Aorta to ankle, BK deep veins for DVT, basic screening for carotids etc..

12. What is a sustainable/paced number of scans achievable on a routine basis?

13. Some units have an abundance of one type of scan - need to mix and match scan

14. May be used as a starting point for planning clinics and scanning sessions

15. May be amended to suit local practice

16. May be used to support clinical activity planning alongside capacity and demand analysis and scoping

General Comments

1. All quoted values refer to a range up to the maximum time per scan

2. If bilateral Duplex is indicated, the time slots change from 45 minutes to 60 minutes

3. All quoted times are for guidance only

TEST	TEST TIME	FUNCTION	INDICATION
Ankle and brachial index measurement (ABPI)/ **Toe-Brachial Index (TBI).**	30mins	Inflatable cuffs to determine any arterial insufficiency mainly in the lower limbs and toes. ABPI may be used to determine of compression bandaging is suitable for patients with leg swelling or ulceration. TBI: assess distal circulation particularly in diabetic patients where ABPIs appear falsely elevated due to calcified vessels.	• intermittent claudication • ischemic rest pain • gangrene and ulceration. NICE recommends compression bandaging should be avoided where ABPI <0.8.
Pre and post exercise ABPI (treadmill testing).	45mins	ABPI measurements pre and post controlled exercise may be used to exclude or quantify the effects of disease in relation to claudication symptoms.	See above
Arterial Duplex (lower/upper limb)	45mins	To assess for occlusive and aneurysmal disease in the major lower limb and upper limb arteries.	• Claudication • Rest pain • Critical limb ischaemia • Evaluation of suspected subclavian steal syndrome, thoracic outlet syndrome and popliteal artery entrapment syndrome. • Ulceration and tissue loss
Thoracic outlet syndrome	45mins	Duplex of the subclavian/ axillary arteries at rest and on upper limb provocation. The presence of	• Tingling/ pain sensation in fingers.

		increased flow velocities, turbulence or cessation of flow in the vessel indication positive TOS.	
DVT– upper/lower limb	30mins	Assess the deep and superficial venous system of upper and lower limb to detect any presence or absence of thrombosis.	• Unilateral swelling • Pain • Tenderness • ?source of PE
Venous Duplex (Lower limb)	45mins	To assess venous reflux stimulated by the muscle pump in the calf which is usually squeezed. To establish the source of any reflux identified in the superficial lower limb veins.	• Skin changes- eczema, hyperpigmentation, and ulcers. • Swelling • Pain • Venous claudication • Varicose veins
Vein Map	30mins	Assess the patency and size of the GSV down the leg. Some departments mark the vein prior to surgery. In some cases the SSV is assessed if GSV not available.	• Bypass surgery
Aortic Aneurysm Surveillance	30mins	Assess for occlusive and aneurysmal disease in the major arteries of the abdomen	• Men >65 • Strong family history • Incidental finding
EVAR surveillance	30mins	Routine surveillance post procedure to detect and evaluate complications that can arise which may result in potential aneurysm rupture. Looking out for endoleaks, sac growth, further	• Routine EVAR surveillance • Post-surgical intervention follow up • False aneurysm/ fluid collection at access site.

		aneurysm formation, in-stent stenosis and Stent kinking.	
Renal artery	30mins	Assess the presence/ absence of stenosis and/or aneurysmal disease in the renal arteries.	• Uncontrolled high blood pressure • Renal artery stenosis/ parenchymal disease • Evaluation of renal transplant dysfunction
Visceral assessment-	30mins	Assess the splenic, superior mesenteric and inferior mesenteric arteries for stenosis or occlusion in chronic mesenteric ischaemia.	• Rapid weight loss • Chronic post prandial pain • Acute, intermittent abdominal pain • Post mesenteric angioplasty, stent, bypass graft
Arterial Fistula Surveillance	30mins	Assess the anatomy, patency and function of AVF or haemodialysis. Flow characteristics prior to fistula, within in and downstream from it are examined.	• Post-operative surveillance • Failing AVF • Difficult accessing for dialysis • Suspected steal syndrome • ?aneurysm/pseudoaneurysm
Assessment of graft patency (graft surveillance)	45mins	Assess the anatomy, patency and haemodynamic of the graft. Flow characteristics prior to graft, within graft and downstream (tibial arteries) are examined.	• Post operative surveillance • Stenosed graft • Claudication • Tissue loss • Rest pain
Carotid Duplex	30mins	Extracranial cerebrovascular u/s to assess presence of pathology and the haemodynamic status of the CCA, ICA, ECA and vertebral artery.	• TIA • Carotid bruit • Amaurosis fugax • Follow up of carotid stenosis • Post intervention- carotid

			endarterectomy or stent • Suspected subclavian steal syndrome • Trauma – dissection
Transcranial Doppler	30mins	To assess for presence/ absence of stenosis in the intracranial arterial flow.	• Unilateral weakness / paralysis • Memory problems • Aphasia
Temporal Artery	30mins	To assess the temporal and axillary arteries for the presence of inflammation suggesting Giant cell arteritis. Detecting all oedema throughout length of the vessel.	• Visual disturbance • throbbing headaches • sudden permanent loss of vision in one eye, • Tenderness of the scalp or over the temporal arteries • jaw claudication.

References

1. The College and Society for Clinical Vascular Science (CSVS) Service Specification Document. Service Management | The College and Society for Clinical Vascular Science
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3. https://www.rcr.ac.uk/sites/default/files/quality-standard-for-imaging-qsi.pdf