

## Quality Control Worksheet – Report HAS NOT gone out

Today's date: 03/25/2026

Practice/Physician: TPC – Brea Seaburg

Patient name: BAKER, DERICK

Scan date: 09/08/2025

### Scan/reading information:

Scan Date	03/16/26	09/09/25	11/11/24	11/11/24 (REREAD NOT SENT)
Sono	Sheri	Sheri	Javier	Javier
Reader	Nielson	Nielson	Nielson	Morgan

### Concerns:

Scan Date	03/16/26	09/09/25	11/11/24	11/11/24 (REREAD NOT SENT)
LCB	1.8 S	1.0	.6	2.1 H

Quality control flagged. Patient was noted in the previous completed QC from Todd to have difficulty on the left side with measurements. The plaque in the LCB called in this exam was noted by Morgan in her reread of the November exam. However, that report was NOT sent, and the plaque was NOT reported because when Todd reviewed the images, he said,

“I believe that D.M. was attempting to measure an artifact on the near wall of the image labeled LCB. It is not a lesion or at least can not reliably be called as such given its weak appearance in the long view and no appearance in the TRV view.”

Looking at the images from the November exam to the 2026 exam, it appears to be the same lesion, or potentially an artifact again. However, in this exam, it appears you can also see it in the TRV view, which would explain why D.N. called it this year and not previously. Given the patient's history, the noted difficulty on the left side, and the previous annotation that it may have been an artifact on the near wall, it was decided that Todd needed to review these images to confirm the new lesion (if it is new).

### Todd's Comments:

I have carefully reviewed all available imaging for this patient across the 2024, 2025, and 2026 examinations. At present, I do not believe the findings in the 2026 study provide sufficiently definitive evidence to confidently classify this as plaque.

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While the observed structure could represent an echolucent–heterogeneous plaque measuring approximately 1.8 mm, the image quality and interface definition are not adequate to support a definitive diagnosis. Given that such a designation may materially influence clinical decision-making, a higher level of certainty is required.

This patient has consistently presented technical challenges in image acquisition, likely related to anatomical factors—specifically a high carotid bifurcation—which limits optimal transducer positioning (particularly beyond the level of the earlobe). Although posterior transducer positioning can sometimes improve visualization in these cases, it remains limited in its effectiveness here. These constraints appear to be reproducible across multiple sonographers and time points.

On retrospective review of the November 2024 images, there is a subtle near-wall shadow in the LCB image that may suggest a possible lesion; however, it is not sufficiently defined to allow measurement, nor is it visualized in two planes, and therefore cannot be classified as plaque. No corroborating findings are identified in the remaining left-sided images from that study.

In the 2025 examination, the most prominent area of interest within the LCB is located in the far wall and measures approximately 1.1 mm. This finding does not appear to correspond anatomically with the current area of concern. Additionally, in the second of the two images labeled LICA (which clearly includes the entirety of the LCB), there is a shadow present in both the near and far walls that could represent plaque; however, once again, the interfaces are not sufficiently well-defined to support a diagnostic conclusion.

Turning to the 2026 study, the near wall of the LCB image demonstrates what appears to be a clearly defined lumen–intima (LI) interface. Immediately adjacent to this, and positioned posteriorly (toward the center of the lumen relative to the near wall), is a second echogenic line which, in my assessment, is most consistent with a classic ultrasonic artifact. The transverse LCB image shows a curved, interface-like structure along the near wall, which I believe may represent curvature of the distal vessel reflecting back into the imaging plane, rather than discrete pathology. That said, the possibility of true pathology cannot be entirely excluded, and further review is warranted.

Importantly, the absence of significant inflammation within the common carotid segments makes the presence of a discrete plaque at this location somewhat discordant with the broader clinical picture, further supporting a cautious interpretation.

Given these complexities, I recommend that this case be reviewed collaboratively. Specifically, I would like to schedule a discussion with Diane N. to review the images in detail, incorporating both the patient’s longitudinal imaging history and the considerations outlined above. To support a thorough and efficient review, I recommend that she be provided in advance with all prior image sets, along with the previously completed QC reports—including my detailed notes from the two prior QC reviews—as I believe this historical context will be highly valuable in preparing for our discussion.

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I have great respect for her expertise and would value her additional perspective before making a final determination.

If helpful, I would also be available to review the images directly with the provider. While a repeat scan could be offered at no additional charge, it is uncertain whether this would yield improved image quality given the patient's anatomical limitations.

Ultimately, our shared objective is to ensure the most accurate and clinically appropriate interpretation. These are challenging images in a technically difficult patient, and a thoughtful, collaborative approach is warranted.