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MINUTES OF THE MEETING OF THE SECRETARY OF STATE FOR TRANSPORT'S HONORARY MEDICAL ADVISORY PANEL ON DRIVING AND DISORDERS OF THE NERVOUS SYSTEM

14th March 2013

Present:	Professor Garth Cruickshank	(Chairman)
	Dr Paul Reading	
	Mr Robert Macfarlane	
	Mr Peter Hutchinson	
	Dr David Shakespeare	
	Dr Anil Gholkar	
	Mr Charlie Jones	
	Ms Rona Eade	
Ex-officio:	Dr Norman Delanty	National Programme Office for Traffic Medicine, Dublin
	Dr C Beattie	Occupational Health Service, Northern Ireland
	Dr Stuart Mitchell	Civil Aviation Authority
	Mr Kevin Rees	Head of Drivers Medical Group, DVLA
	Ms Jan Chandaman	Policy Branch, DVLA
	Ms Sue Charles	Medical Business Change, DVLA
	Dr Ben Wiles	Senior Medical Adviser, DVLA
	Dr Nerys Lewis	Medical Adviser, DVLA
	Dr Karen Davies	Medical Adviser, DVLA
	Dr Kathy Watts	Panel Secretary/Medical Adviser, DVLA

1. **Apologies for Absence**

Professor Anthony Marson
Professor Philip Smith
Professor Paula Williamson
Professor Peter Rothwell
Mr Richard Nelson
Dr Huw Morris

2. **Chairman's remarks.**

The Chairman informed the meeting that Sir Mark Walport is shortly to take over from Professor Sir John Beddington as Government Chief Scientific Adviser. The SAC Chair meetings will be continued as previously.

Rhona Eade and Dr Anil Gholkar had attended an induction day for Panel members held at DVLA in February. Both had found it useful to meet people working in Drivers Medical Group, the day had helped them understand the challenges faced by the unit due to the high workload. It would have been helpful to have advice about the role and requirements of Lay Members. It would also have been useful to have been able to meet with the Medical Advisers and look at the casework they do.

DVLA confirmed that work is currently underway to look at a contracted supplier for some of the services that Drivers Medical Group require, e.g. Opticians. There is no intention to contract out the work of MA's.

The Chairman reiterated that the success of Drivers Medical Group is due in considerable part to the legacy knowledge among the MA Group.

Item 7. – Taken early.

New Epilepsy Regulations.

DVLA confirmed that the epilepsy regulations came into force on the 8th March and are now being applied. There have been some objections to the eyesight part of the Statutory Instrument. Policy colleagues have met with the relevant parties to discuss further.

It was confirmed that the Group 2 epilepsy regulations remain unchanged. It is uncertain how many people will benefit from the changes for Group 1 licensing.

There has been a national press release about the new regulations. In addition the Epilepsy Society has provided updated information about the change in regulations on their website and also to their relevant contacts..

Jan Chandaman left the meeting following this item.

Item 3. Minutes of the Meeting held on 8th November 2012.

The minutes were accepted as accurate.

Item 4. Matters Arising.

The Panel was reminded that the "At a Glance Guide" advice about obstructive sleep apnoea syndrome and other causes of excessive sleepiness had been changed after the last Panel meeting. No further changes would be made until a report of the European Working Group on sleep disorders has been finalised. This is expected in June 2013.

Item 4a. Stroke/TIA – review of Group 2 standards.

The Panel was reminded of their previous discussion about stroke/TIA and seizure risk. It was agreed that the OXVASC data needs further analysis to determine seizure risk, this would require research funding. These data are also required by the CAA. The number of individuals who may benefit from Group 2 licence changes in this area is large and the issue is of economic importance.

DVLA indicated that there is research funding available and undertook to explore this with DfT. It is hoped there could be a joint research project with CAA Medical Unit.

Item 4b. Assessment of functional adaptation in people with long standing debarring visual field defects.

A case discussed at the previous meeting had raised the issue of visual adaptation by individuals with visual field defects (homonymous hemianopia). Two Neurology Panel members met with the Working Party of the Vision Panel earlier today. This had been very informative and helpful.

The following criteria had been established.

- The disease should be stable for 12 months.
- Perimetry should be stable (within defined limits) measured on 2 occasions 12 months apart.
- A neurological examination is required including assessment of neglect. If neglect is present this would be debarring. This examination could be done as part of a routine clinical assessment.

These criteria would allow clinicians to identify those individuals most likely to benefit from "exceptionality" and who are likely to be able to demonstrate safe driving competencies at assessment. These criteria will form the basis for assessment of neurological patients and if met such patients would then be required to meet the criteria which will be established by the Working Party of the Honorary Medical Advisory Panel on Driving and Visual Disorders. A Neurology Panel member has been co-opted onto the Working Group and will provide feedback to the Neurology Panel members at the next meeting. The agreed criteria will be added to the Neurology Section of the "At a Glance".

Item 4d. "At a Glance" advice about neurological impairment in relation to driving.

The Panel had previously agreed it would be helpful to have a statement about which areas of cognition are of particular importance for driving, this could be used as a general heading

to the Neurology section of "At a Glance". The current wording was discussed at length. The Panel agreed that insight is particularly important. The questions about cognition on the NEURO2/2C questionnaires are considered "red flags" and if answered positively will lead to licence refusal/revocation. The Panel agreed it would be helpful to canvas the views of GP's about this and about what other "red flag" questions may be useful. DVLA agreed to undertake some market testing with GP's about this. The current wording in "At a Glance" will remain at present.

Item 4e New Parkinson's disease questionnaires.

Feedback about new Parkinson's disease questionnaires will be provided at the next Panel meeting.

Item 5. Stereotactic radiotherapy for meningiomas.

The Panel was advised that there have been 3 large series published within the last 3 years of patients having single dose stereotactic radiosurgery for meningiomas. For supratentorial tumours these suggest that the current standards are appropriate for Group 1 where no seizures are involved, the data also imply that where seizure is a presenting feature the epilepsy regulations should apply. For Group 2, based on the risk of recurrence and the seizure risk, the current 3 year period is appropriate. In infratentorial tumours there is no evidence to suggest that the current standard to drive on recovery needs to be changed.

The Panel agreed that this area needs to be regularly reviewed as treatment options and technology are rapidly evolving. One of the important benefits of having a Panel of experts is that they will be aware of relevant changes in their area of specialist knowledge.

Panel confirmed that increasing amounts of relevant and useful data are available to help inform appropriate standard setting.

Item 6. Grade III gliomas, review of new data and current standard.

The Panel was asked to consider if there is a sub-group of patients with Grade III gliomas with a better prognosis than the group as a whole. The Panel advised that for anaplastic oligodendrogliomas there is a sub-set with a better prognosis, this is well evidenced. The evidence about seizure risk is weaker.

Three large data sets of cases, The National Hospital for Nervous Diseases, Leeds General Infirmary and QE in Birmingham will be used to gather the required information. There is a biological marker available, 1p/19q codelition, which if present confers a 50% improved survival rate in patients with anaplastic oligodendroglioma tumours. It was agreed that a question about this be added to the current tumour questionnaire. At present this will be for information only. DVLA will collect all these cases over the next 6 months and bring them to the next Panel meeting. A medical code will be added to the cases to help data gathering.

Item 8. Craniectomy and subsequent cranioplasty.

The Panel discussed the issue of the head injury population who have had a craniectomy, have not had immediate replacement of the skull section and have subsequent skull reconstruction. Reconstruction may occur at 6 months, 12 months or beyond this time. The procedure also applies to craniectomy after stroke, tumour etc. A Panel member has had a number of enquiries about returning to driving following skull reconstruction. The Panel was advised that there are about 800,000 cranioplasties performed in the U.K. each year. There is currently no advice in "At a Glance" about this. The Panel noted that skull reconstruction is not without significant morbidity but members considered the seizure risk to be less than 20% per annum.

The following wording to be added to "At a Glance":

> *"Following cranioplasty driving may resume when clinically recovered providing there are no complications, if these occur appropriate licensing standard would apply. It will also be necessary to consider the underlying condition which required surgery".*

Item 9. Untreated, presumed low grade gliomas.

DVLA had received an email enquiry about "At a Glance" guidance to patients with presumed low-grade supratentorial tumours who have not had a biopsy or any treatment but remain under radiological surveillance. If they do not have seizures and have not had primary treatment should they be advised not to drive for a year? The Panel's advice was that if a truly incidental finding with no seizures, no neurological symptoms and if following MDT meeting treatment is not considered to be indicated, then driving may be allowed, DVLA would need to be notified.

The Panel felt that the numbers of truly incidental findings would be small as most would present with neurological symptoms. Current practice is increasingly to biopsy these tumours as there is evidence that a portion of them are not low grade gliomas but may be of higher grade histologically.

Item 10. Cases for discussion.

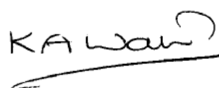
There were 4 cases discussed including a mid brain glioma tumour which had undergone transformation, gelastic seizures which in this individual were considered not to have an effect on consciousness or the ability to act, a traumatic brain injury and a Group 2 driver who had suffered an intracerebral haemorrhage some 9 years ago as a result of a deep seated AVM which had been treated by stereotactic radiosurgery. Following discussion of this case and on the basis of available data it was agreed that the "At a Glance" standard for Group 2 driving following intracerebral haemorrhage due to an AVM treated with stereotactic radiotherapy could be amended.

Item 11. Any other business.

A Panel member asked about the Gov.UK. website, which it was felt is not user friendly and offered only minimal information about epilepsy. The Panel wondered if there is another way individuals can find information about their medical condition written in a straightforward way. The Gov.UK website does not offer this. The Panel asked if there could be a link with other organisations offering appropriate advice about medical conditions and driving. DVLA undertook to offer advice and help with this.

Item 12. Place and time of next meeting.

To be arranged.



DR K A WATTS MB BCh MRCGP
Secretary to the Secretary of State for Transport's Honorary Medical Advisory Panel on Driving and Disorders of the Nervous System.