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

Thursday 23 March 2017

Present:

Professor G Cruickshank	Chairman
Dr Paul Reading	
Mr R Macfarlane	
Professor P J Hutchinson	
Dr D Shakespeare	
Dr A R Gholkar	
Dr C Tudur Smith	
Professor J Duncan	
Professor R Al-Shahi Salman	

Lay Members:

Mr C Jones

Ex-officio:

Dr S Mitchell	Civil Aviation Authority
Dr N Delanty	National Programme Office for Traffic Medicine, Dublin
Dr N Lewis	Panel Secretary, DVLA
Dr W Parry	Senior Medical Adviser, DVLA
Dr B G R Wiles	Panel Secretary, DVLA
Dr A Birliga	Medical Adviser, DVLA
Dr A Edgeworth	Medical Adviser, DVLA
Mr J Donavan	Medical Licensing Policy, DVLA
Mrs R Toft	Medical Licensing Policy, DVLA
Miss N Davies	Head of Drivers Medical Group, DVLA
Mrs S Charles-Phillips	Business Change and Support, DVLA
Mr P Davies	Continuous Improvement, DVLA
Mrs S Taylor	Assistant PA to the Head of Drivers Medical Group, DVLA

1. Apologies for absence

Apologies have been received from: Professor A G Marson, Mr R Nelson and Dr S Bell.

2. Chairman's remarks

The meeting began with a brief period of silence to reflect on the previous day's attack at Westminster.

It was noted that there had been no Chairmen's meeting in the last year, however it is hoped that the next such meeting will be held in June 2017.

There has recently been a meeting between the Senior Medical Adviser at DVLA, the Chairman of this Panel and the Chairman of the Panel for Disorders of the Cardiovascular System. During this meeting the standards quoted in the Assessing Fitness to Drive (AFTD) document, relating to transient losses of consciousness were reviewed and amended. An updated version of the AFTD, incorporating these changes, will soon be published (ref. Item 5.v. below).

3. Panel recruitment

It was acknowledged that among other positions, this Panel is short of a lay member and of a neuro-oncologist. There is concern that by failing to recruit new members in a staggered fashion and by therefore being forced to recruit and replace members in a single exercise in future, there will be loss of organizational memory. DVLA is still considering the recommendations on the review of the governance arrangements for the medical panels. It is hoped that the outcomes of the review will be shared at the Panel Chair's meeting.

4. Minutes of the meeting of 27 October 2016

In terms of accuracy of the October 2016 meeting's minutes, the only alteration is that the word 'objective' in relation to the Epworth assessment should be replaced by the word

'subjective' in paragraph 4.7: "The definition of the sleepiness was discussed. The Epworth is a *subjective* self assessment. There are other more objective assessments."

5. Matters arising

5.0 Proposed Research Study

Relating to Item 3.2 from the October 2016 minutes, there was exciting news that a proposal is soon to be submitted for a large-scale research project that should provide very useful current population data about seizure risk in relation to head injuries. The study will take the form of a randomized trial seeking to determine the optimal duration for treatment with anti epilepsy drugs, but it is anticipated that much useful data in terms of risk co-factors and seizure risk will also be collected in the non-intervention arm of the trial. Panel members were keen to support this research.

5.i Obstructive Sleep Apnoea (OSAS) Update by Dr Parry

Dr Parry advised the Panel that the existing guidance in Assessing Fitness to Drive complies with the Directive requirements.

However discussion ensued around the fact that in clinical practice, whilst measurement of AHI is commonly undertaken, the AHI does not equate with the degree of sleepiness. Effort is made to reduce AHI in order to reduce the health risks in many areas but not necessarily in order to reduce sleepiness, which itself may not be a problem for some patients with a high AHI.

Dr Parry advised that work was ongoing to redraft existing guidance in recognition of concerns raised by clinicians.

It was suggested that it may be helpful to consider the wording of the Irish guidelines as part of this work. It was anticipated that a further update would be given at the next panel meeting.

5.ii Policy Update

As per Items 3 and 5, members of the Policy Department at DVLA advised the Panel in relation to recruitment and in relation to OSAS.

5.iii Seizure Risk and Seizure Type Following Epilepsy Surgery

Data from Professor Duncan's study (discussed at Panel's October 2016 meeting) have been analysed further and it is now confirmed that there is statistical evidence to support a change to the EU directive. Patients who have had surgery for epilepsy and who, post surgery, have seizures which cause no functional impairment and which do not affect consciousness, are excluded from meeting the relevant concession in the epilepsy regulations because of their previous history (prior to the surgery) of another type of seizure. The data obtained from this soon-to-be-published study, indicate that in this particular group of patients, the risk of having a different type of seizure (i.e. one which does affect consciousness or which does cause a functional impairment) is well below the 20% threshold normally applied to Group 1 drivers. It is estimated that in addition to the approximately 2000 people who would currently be affected by a change in legislation, an additional incidence of 100 drivers per year would be likely to benefit were legislation changed to permit driving (to enable the concession to be applied despite the pre-surgery history of another type of seizure).

5.iv Brain abscess/empyema

In the last meeting it was agreed that if there is clinical evidence to exclude absolutely supratentorial extension of infratentorial disease, licensing can be

considered earlier than currently. However, on reflection and further consideration, the Panel did not feel that the possibility of supratentorial extension can confidently be excluded. The current wording of the standards should not therefore be changed.

5.v AFTD Prodrome

In the Assessing Fitness to Drive (AFTD) guidelines, a greater emphasis has been placed on the significance of a reliable prodrome. The concept of prodrome, provocation and how, if at all, prodrome differs from pre-syncope was discussed. Panel advised that the presence of a reliable prodrome of sufficient duration to enable a driver to pull-over safely should it occur whilst driving, would permit licensing, regardless of the cause of the ensuing loss of consciousness. As documented in Item 2 (Chairman's remarks) discussion between two Panel Chairmen and the Senior Medical Adviser at DVLA have resulted in changes to the standards for transient losses of consciousness and will soon be published in the revised AFTD. In particular, for Group 2 (vocational) drivers, the new standards will require driving cessation and DVLA investigation for all episodes of transient loss of consciousness (standing or sitting), regardless of likely cause.

5.vi Cavernoma

It was agreed that the term, 'cavernoma' should consistently and exclusively be used in AFTD. For clarity, and to avoid ambiguity, changes to the current wording of the introduction to this section will also be made. DVLA is grateful to Professor Salman who proposed to work with the Panel secretary to achieve this.

It was acknowledged that the standards relating to cavernomas are generally consistent with the available current evidence, with a few exceptions. In particular, based on current published data, the current medical standards are considered to be inappropriately lenient for Group 2 drivers who have had stereotactic radiosurgery for a supratentorial cavernoma and for Group 2 drivers with a brainstem cavernoma (with haemorrhage and/or focal neurological deficit) who have no surgical treatment.

The statistical data available strongly support a change to these standards, upon which, again, Professor Salman has kindly agreed to advise.

In-line with published literature, the division of this section of AFTD into supra- and infra-tentorial cavernoma categories will be further subdivided under the heading of infratentorial cavernoma, into brainstem and cerebellar cavernoma.

For cases in which there are multiple cavernomas at different locations, as for any co-existing medical conditions that may affect driver licensing, the most restrictive licensing standards will apply. This should be made explicit in the guidelines since 20% of patients with cavernoma do have multiple cavernomas.

5.vii Review of medical standards

The Panel was reminded to raise any topic if/when Panel members become aware of new evidence relevant to the medical standards, so that the current guidelines can be reviewed and kept up to date.

6. Cough Syncope

The medical standards currently state:

"Must not drive and must notify the DVLA".

For Group 1:

Must not drive for 6 months following a single episode and for 12 months following multiple episodes over 5 years. Reapplication may be considered at any point if all of the following can be satisfied:

- Any underlying chronic respiratory condition is well controlled

- Smoking cessation
- Body mass index is below 30
- Gastro-Oesophageal reflux is treated

For Group 2:

Must not drive for 5 years from the date of the last episode. Reapplication may be considered after 1 year if all the following can be satisfied:

- Any underlying chronic respiratory condition is well controlled
- Smoking cessation
- Body mass index is below 30
- Gastro-Oesophageal reflux is treated
- Confirmation of these by a specialist doctor"

The following was put to the Panel:

For Group 1, if a person can already meet the four criteria when the cough syncope occurs, can they reapply immediately? Can Panel offer guidance as to the duration of smoking cessation that should be demonstrated prior to being considered to have met this requirement? Can cough induced pre-syncope (light-headed and dizzy) be dismissed as long as there is no altered awareness?"

It was agreed to invite an expert in this area to the next meeting so that this issue can be discussed further and the specific questions answered.

7. Recurrent Meningioma and Glioma

The following was put to Panel:

'*In October 2015 'It was agreed that for grade I and II gliomas, having established one year seizure free following completion of primary treatment it would be appropriate to permit relicensing despite imaging evidence of recurrence or progression as long as there is no clinical disease progression (and whether or not chemotherapy is given – as proposed in 2011). The At a Glance may therefore be changed accordingly'.*

Can the same principle be applied to low grade meningiomas?

The revised standard mentions chemotherapy, but if treatment of the recurrence is surgery, radiosurgery or radiotherapy, would a period of time off driving be required despite there being no clinical disease progression?'

Panel advised that, as for drivers with recurrent low-grade glioma, drivers with recurrent low-grade meningioma do not need to cease driving as long as there is no clinical disease progression. However, with the exception of chemotherapy (which will not affect licensing), if further treatment such as radiotherapy or surgery is required then the relevant duration of driving ban following treatment should be applied (both for recurrent low-grade meningioma and for recurrent low-grade glioma).

8. AFTD: seizures due to prescribed medication

The Panel was asked to clarify standards in relation to seizures secondary to prescribed medication.

It was agreed that the wording of the appendix should be changed to make it clear that seizures due to prescribed medication are not considered as provoked and will require as a minimum, six months of driving cessation. However, should a further provoked or unprovoked seizure occur in due course, except where legislation dictates otherwise, the

previous seizure, due to prescribed medication, could be discounted and the subsequent seizure considered to be the first provoked/unprovoked seizure.

9. Recurrent LOC likely cardiovascular origin but excluding vasovagal syncope

Panel was advised that following the meeting between two Panel Chairmen and the Senior Medical Adviser (referred to in Items 2 and 5v), and the subsequent redraft of the standards relating to transient loss of consciousness, this issue has been resolved.

10. Cases for discussion

One case was brought for discussion. Panel was asked to consider the argument that because the surgery for a grade 1 meningioma had not violated the brain parenchyma, an exception should be made to the standard six month driving ban. Panel felt that there was insufficient statistical evidence to support a change to the standard.

11. Any other business

11.1 Subarachnoid Haemorrhage (SAH): it was noted that there is discrepancy between the medical standards in AFTD and the guidance for customers published in the DVLA's A to Z list. By way of explanation, it was pointed out that AFTD is intended for medical professionals and can therefore include medical detail to enable sub-categorization of conditions to explain the different standards for different sub groups of the same broad medical condition. However as the A to Z is designed for the lay-person, it generally relates to broad categories, distinguishing only between medical conditions and cannot include detail in complex scenarios about medical- or treatment- subdivisions, nor can it therefore provide the same degree of accuracy. It was promised however that the content of the A to Z would be reviewed and where possible, changes made to reduce inconsistencies.

11.2 On a related note, it was drawn to the Panel's attention that the AFTD does not include reference to convexity subarachnoid haemorrhage associated with

cerebral amyloid angiopathy for which the risk of intracerebral haemorrhage is high. Drivers with convexity SAH may not report their condition to DVLA as stroke or TIA but rather as SAH. Clinical practice does not always necessitate an angiogram for these patients who may be assumed to have small vessel disease and given that the medical standards for subarachnoid haemorrhage are generally dependent upon angiographic outcome, so consideration should be given to the driving standards for this group of people. It was agreed that this be discussed further at the next meeting.

11.3 Use of the term 'dizziness' in the AFTD was questioned; it was agreed that this represented an improvement from the previously used term 'giddiness' and no further change to the current terminology was suggested.

11.4 Panel was asked to consider whether drivers of 'blue-light' emergency vehicles should be advised not to drive such vehicles if they had epilepsy. The Panel felt that Group 2 standards should be applied in these circumstances.

11.5 DVLA has received a number of requests from clinicians asking that their patients with a solitary brain metastasis who have responded very well to immunotherapy, be considered as exceptional cases and be permitted to drive prior to completion of the standards 1 year driving ban. Panel appreciated the concern but felt that there is currently insufficient evidence to change the medical standards. The Panel will however endeavour to obtain further data

12. Date and time of next meeting

Thursday 12th October.

Original Draft Minutes prepared by: **Dr N Lewis**
Panel Secretary

28 March 2017

Final Minutes signed off by: **Professor Garth Cruickshank**
Chairman

Date: 12th October 2017