Driver & Vehicle Licensing Agency

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

Meeting held on Thursday 13th October 11:00am

Present:

Panel Members:

Dr Robert Henderson (Chair)
Dr Leisa J Freeman
Mr Andrew Goodwin
Dr Sern Lim
Dr Shahid Aziz
Dr Douglas Fraser
Mr Amar Vara (Lay member)
Mrs Linda Samuels (Lay member)

OBSERVERS:

Dr Ed Bebb	Head of Health and Wellbeing, Rail Safety & Standards Board
Dr Ewan Hutchinson	Civil Aviation Authority

Expert Guests

Professor Colin Berry	Consultant Cardiologist

EX-OFFICIO:

Dr Nerys Lewis	Deputy Senior DVLA Doctor
Dr Aditi Kumar	DVLA Doctor
Dr Alun Hemington-Gorse	DVLA Doctor
Mrs Keya Nicholas	Driver Medical Licensing Policy Lead
Miss Gwen Owen	Driver Medical Licensing Policy
Mr Richard Phillips	Drivers Medical Operational Delivery & Support
Mrs Siân Taylor	DVLA Panel Coordinator/PA to the Senior DVLA Doctor
Miss Kirsty-Leigh Van Staden	DVLA Panel Coordinator Support

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SECTION A: INTRODUCTION

1. Apologies for Absence

Apologies were received from:

Dr Kim Rajappan	Consultant Cardiologist & Electrophysiologist
Dr Sue Stannard	Chief Medical Advisor, Maritime and Coastguard Agency
Dr Nick Jenkins	Senior DVLA Doctor
Ms Hayley Sergeant	Service Management
Dr Colin Graham	Occupational Health Service Northern Ireland
Dr Derek Crinion	National Programme Office for Traffic Medicine Ireland

2. CHAIR'S REMARKS

The Chair welcomed all attendees and advised regarding the etiquette of digital meetings. The Chair reminded members to ensure their declarations of interest were up to date.

The panel chair discussed the availability of exercise tests: DVLA has highlighted access to exercise testing as a concern following the COVID pandemic. Panel members noted that capacity for exercise treadmill tests has declined after NICE recommended Computed Tomography Coronary Angiography (CTCA) as the first line investigation for chest pain of suspected cardiac origin. Capacity may also be limited by staff shortages. Nevertheless, all hospitals managing patients with heart valve disease should still be able to carry out exercise tests.

The panel chair also discussed access to medical literature: panel members were surprised to learn that DVLA does not have full access to the published medical literature. Panel members agreed unanimously that DVLA should consider investing in access to medical literature (e.g., via Athens) for use by DVLA Doctors and advisory panels to ensure that standards and practice are based on the best available contemporary evidence.

3. ACTIONS/MATTERS ARISING FROM PREVIOUS MEETING

i. Clarification of the following standards which have been updated in the Assessing Fitness to Drive (AFTD) guidance in June 2022

Aneurysms including:

- Aortic aneurysm
- Chronic aortic dissection
- Marfan's Syndrome
- Loeys-Dietz and Ehlers Danlos aortopathies

Appendix C – regarding Hypertrophic Cardiomyopathy

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DVLA raised concern that vascular imaging after endovascular abdominal aortic aneurysm repair (EVAR) may report the size of the aortic aneurysm surrounding the graft, and current standards could suggest that the dilated aorta should disbar the driver even if the graft is satisfactory. In addition, current standards make no reference to endoleaks, especially type 1 and 3 endoleaks, which are associated with a risk of aortic dilatation and rupture after endovascular repair. The current wording was intended to apply to cases where there is an un-grafted segment of aortic dilatation, as well as to cases where there is an endoleak.

Panel agreed that an expert in endovascular intervention including EVAR and thoracic endovascular aortic repair (TEVAR) should be invited to the next Panel meeting. In the interim, and from an operational perspective, type 1 or type 3 endoleak should disbar from Group 2 licensing, but after successful EVAR (with no endoleak, or type 2 endoleak only, or a thrombosed false lumen) the diameter of the aorta aneurysm surrounding the graft should not influence licensing decisions.

Loeys-Dietz Syndrome (LDS): is a rare condition with high risk of vascular events (rupture and dissection) involving the aorta, and coronary and cerebral arteries. Limited evidence suggests that individuals with transforming growth factor beta-2 (TGRFB2) mutations (type 1 and 2 LDS) are at particularly high risk.

Panel advised amending the group 2 standard to allow individual specialist assessment. A group 2 licence should be issued for 1 year and only renewed if further specialist review and vascular imaging is satisfactory. As this is a rare condition and experience is limited, panel suggested that any future cases of LDS should be reviewed by panel.

Hypertrophic cardiomyopathy: The text on exercise testing for hypertrophic cardiomyopathy is satisfactory. If ischaemic heart disease is suspected in a patient with HCM, stress perfusion MR scan, combined with Gadolinium scan, can be considered for Group 2 licensing.

ii. Transient Loss of Consciousness (TLOC)
In June 2022 a subgroup meeting was held to finalise and agree the revised medical standards. See Item 6 for discussion.

iii. Aortic stenosis (AS)
In March 2022 panel confirmed that the current Group 1 medical standard for symptomatic aortic stenosis was appropriate.
The recent change to the Group 1 standard for symptomatic AS has generated informal comment from clinical colleagues and British Cardiovascular Intervention Society (BCIS). Panel discussed that there is a group of patients with severe aortic stenosis who are awaiting aortic valve replacement, or who are not candidates for aortic valve replacement and are managed conservatively. Panel accepted that whilst these patients may be at increased cardiovascular risk, in some the risk of a sudden disabling event is unlikely to exceed 20% per annum and the standard is therefore unnecessarily restrictive.

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Patients with mild or moderate aortic stenosis may also complain of symptoms, although in these cases there may be concern that the symptoms may be unrelated to the aortic valve disease or that the severity of the stenosis has been underestimated. The current standard will need to be revised, pending receipt of correspondence from BCIS.

If exercise testing is not possible in an individual with aortic stenosis, a stress perfusion MR scan may be appropriate (combined with a Gadolinium scan). Further discussion and review with an imaging specialist will be required on this topic.

iv. Exercise tolerance testing and associated wording of Appendix C
Proposed revision of wording – Panel agreed multiple proposed changes need to be incorporated into a draft final version for review by panel

v. Heart transplant: Proposed changes to AFTD standard
Agreement that coronary arteriography (routine in many transplant centres) should not supersede functional testing in these cases, as it is difficult to interpret an anatomical test, for example and angiogram, as there is often diffuse disease. Transplant patients have cardiac denervation and may not experience typical ischaemic symptoms. Denervation may also cause chronotropic incompetence and reduced exercise capacity. Individual case review may be appropriate for such cases (i.e., cases where the driver is unable to complete 9 minutes of the exercise test). Panel agreed that the proposed change to the Group 2 standard should be added to AFTD.

SECTION B: TOPICS FOR DISCUSSION

4. DVLA Update Mr Richard Phillips

The Drivers Medical overall operational position and customer service continues to improve. There has been a huge amount of work done across the Agency to support operational recovery from the impact of COVID-19.

DVLA has recruited and trained over 400 Drivers Medical colleagues across three operational sites. DVLA has delivered two new customer service centres in Swansea and Birmingham. Customer service centre colleagues are being trained in both telephony and Drivers Medical casework.

DVLA has also developed new and innovative ways of working, such as introducing a simplified renewal process for those drivers who hold a short period driving licence and changing the law to allow non-medical registered healthcare professionals to be authorised to complete DVLA medical questionnaires. Drivers Medical has made significant operational progress and are reducing the volume of customer cases in progress week on week.

Mr Phillips thanked the Secretary of State Medical Advisory panels for their support and guidance as DVLA continues to review their processes to facilitate timely and safe driver licensing decisions.

Panel thanked Mr Phillips for the update, Chair congratulated DVLA on progress.

5. **Myocardial Infarction with Non-Obstructive Coronary Arteries (MINOCA) and Ischemia and No Obstructive Coronary Artery disease (INOCA)**

DVLA asked the panel to consider whether MINOCA and INOCA require the development of a separate medical standard.

Prof Colin Berry, from the University of Glasgow provided an informative presentation to the panel. A diagnosis of INOCA includes patients with microvascular and vasospastic angina. INOCA is associated with cardiovascular risk factors and has a greater prevalence in women. Angina due to INOCA is at least as prevalent as angina due to obstructive coronary artery disease. The prognosis for patients with INOCA is generally good, although recurrent episodes of angina are very common. Patients with microvascular angina have a better prognosis than patients with vasospastic angina. Exercise testing has prognostic value in patients with INOCA and current standards for angina can reasonably be applied to individuals with INOCA.

MINOCA is characterised by myocardial injury (troponin rise) and is a working diagnosis. More detailed investigation (invasive coronary imaging and magnetic resonance scan) may confirm a diagnosis of myocardial infarction (due to coronary obstruction) or myocardial injury due to other causes (e.g., myocarditis). In practice, many patients in the UK are not investigated and the cause of the myocardial injury is not established.

Panel discussed the licensing implications of diagnoses of INOCA and MINOCA with Prof Berry. Panel agreed that current standards for angina and myocardial infarction should apply to patients with INOCA and MINOCA, respectively. Panel advised that the terms INOCA and MINOCA should be added to the relevant sections in AFTD.

6. **Transient Loss of Consciousness (TLOC)**

Panel were given an update on the syncope and TLOC standards from the subgroup meeting held after the Spring Panel meeting.

Panel agreed that proposed standards for reflex syncope and unexplained transient loss of consciousness are ready for discussion with the Neurology panel. Minor changes have been incorporated into the draft standards. A definition of presyncope has been included in the preamble: 'The term presyncope describes the symptoms and signs due to cerebral hypoperfusion that occur before complete loss of consciousness. For licensing decisions, an episode of presyncope without progression to TLOC is relevant if accredited medical opinion

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considers that the episode has or might interfere with an individual's ability to safely control a vehicle.'

7. Communication of Cardiac Test Results

Panel discussed the issue raised by a case: a group 2 driver underwent myocardial perfusion imaging to assess fitness to drive. The scan demonstrated myocardial ischaemia, but the result was not shared with the patient or his medical attendants. He was subsequently admitted to hospital with a heart attack. There was unanimous agreement by the panel that investigation results should ideally be communicated to the customer and/or his/her general practitioner.

DVLA commented that results are sometimes communicated to GP 'in customer's best interests' but currently DVLA does not have consent to communicate results routinely. Discussions regarding this are ongoing.

SECTION C: ONGOING AGENDA ITEMS

8. Tests, horizon scanning, research and literature

DVLA reminded all panel members that as part of the Terms and Conditions they have an obligation to update panel about any information/tests/research that could impact on standards or existing processes. There were no items for discussion.

A question was raised about post-covid syndrome. Panel commented that the cardiovascular complications of COVID-19, such as arrhythmia, cardiomyopathy etc, would be covered under the existing medical standards.

9. AOB

Panel Recruitment

DVLA reported that an advert has invited applications for membership of the cardiovascular panel. Members were encouraged to inform colleagues of this opportunity.

The chair and panel members thanked Leisa Freeman for her contribution to panel work over the last ten years.

10. Date and time of next meeting

Thursday 16th March 2023

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Original draft minutes prepared by:	Sian Taylor Note Taker Date: 18th October 2022
Final minutes signed off by:	Dr R Henderson Chairperson Date: 7th November 2022

THE DVLA WILL CONSIDER THE ADVICE PROVIDED BY THE PANEL AND NO CHANGES TO STANDARDS WILL TAKE EFFECT UNTIL THE IMPACT ON INDIVIDUALS AND ROAD SAFETY IS FULLY ASSESSED.

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