

MINUTES OF THE MEETING OF THE SECRETARY OF STATE FOR
TRANSPORT'S HONORARY MEDICAL ADVISORY PANEL ON DRIVING
AND DISORDERS OF THE CARDIOVASCULAR SYSTEM HELD ON 31 MAY
AT GREAT MINSTER HOUSE, LONDON

Present: Dr M C Petch (Chairman)

Dr J E Burns

Professor M D Joy

Mr C J Hilton

Dr T Carter Chief Medical Adviser, DLTR

Dr R B Wallace Medical Adviser, OHS/Northern Ireland

Professor T Nicholson DERA

Dr J C Durston Senior Medical Adviser, DVLA

Dr K Davies Medical Adviser, DVLA

Dr J G G Hanley Medical Adviser, DVLA/Panel Secretary

1 CONGRATULATIONS

Dr T Carter, on behalf of all present, congratulated the Panel chairman on being awarded an OBE earlier this year.

2 APOLOGIES

Apologies were received from Dr D H Bennett and Drivers Policy Group, DVLA.

3 MINUTES OF CARDIAC PANEL MEETING - 29.11.2000

The draft Minutes were accepted as an accurate record.

4 MATTERS ARISING FROM MINUTES

(i) Panel membership - retirement and appointment programme to include lay membership

The House of Commons' Select Committee report (Science and Technology) recommended that members of the various Honorary Medical Advisory Panels should be replaced after a maximum period of 10 years service. Four of the six current Panel members will therefore need replacing. It is considered not only appropriate to increase the overall Panel membership with a wider geographical spread but also consider the appointment of a cardiovascular epidemiologist as well as another from a different transportation industry e.g. CAA.

The British Cardiac Society and the Cardiology committee, Royal College of Physicians, have been approached for names of those considered most appropriate to serve on the Panel. Three candidates per Panel member position will be submitted to the Minister for his consideration. To preserve the Panel's continuity, there will be a phased appointment and retirement timetable.

Drivers Policy Group reported that applications for lay membership had been slow, however, there were now 20 candidates, several of whom were prepared to sit on one or more panel. Interviews will occur during the summer months, with the intent that a lay member will be appointed in time for the next round of panel meetings. The Panel chairmen will form part of the interview panels to ensure that the appointee is appropriate to that panel's function. Due to a potential problem i.e. that the relevant panel chairman is unavailable for the lay member interview/s, the Cardiac Panel agreed that it would accept an appointee considered appropriate at interview by another panel chairman.

(ii) The Exercise Test - Group 2 licence

a) ST Segment changes during recovery period of the exercise test

The exercise test requirements prior to November 1997 specifically referred to 'pathological ST segment shift during or after the test...' Subsequent to this date, reference to changes during the recovery period had been removed, but remained implicit in the Standards' wording. This viewpoint had been questioned on several occasions. The Panel agreed that as ST changes may only become diagnostic during the recovery phase specific reference to ST segment changes during the recovery period should be restored to the Standards' wording.

b) De Novo Left Bundle Branch Block during the course of exercise testing

The Panel agreed that the development of this during exercise testing did not debar Group 2 licensing per se. The individual concerned must, however, complete Stage 3 of the standard Bruce protocol, without other debarring aspects arising during the test or recovery period.

c) Medication with anti-hypertensive and anti-anginal effects

The Panel reaffirmed that, when it was clear that such medication was being prescribed for its anti-hypertensive effect, then it should not be stopped prior to exercise testing.

Further evaluation of the effects of Beta and Calcium channel blockers on the predictive value of the exercise test will be undertaken by the Panel and the matter reviewed at the next meeting in November 2001.

d) Prognostic Hierarchy of Coronary Angiography, Exercise Testing and Myocardial perfusion scans - Group 2 licence

Exercise testing is frequently used to determine an individual's fitness for Group 2 licensing when there is a history of IHD, PVD, CVA/TIA or chest pain of uncertain origin. On occasion, the results of the Exercise test are supplemented by contemporaneous Coronary angiography and/or information from a stress Thallium scan.

When the results of such tests are concordant, there is no difficulty in deciding an individual's fitness for licensing. The Panel was asked for guidance in dealing with those whose investigation results were either discordant or when the combined effect somewhat equivocal from a licensing perspective.

During the discussion it was pointed out that Exercise testing and Myocardial Scintigraphy were assessing functional aspects and coronary angiography the anatomy. Coronary angiography may under-represent the severity of the actual disease due to an inadequate number of views of the lesion(s), as well as the assessment of the severity of the stenosis by 'eyeball' measurement, rather than by Quantitative Coronary Angiography (QCA).

The Panel noted from the cases referred by DVLA medical advisers for an ad personam opinion it was clear that excess weighting was being put on the ST segment change of 2mm or more aspect of the exercise test standard, rather than providing an interpretation of the significance of such changes in the individual and their known history.

Conclusions:

The prognostic hierarchy is:-

- 1) Coronary angiography with stenosis(es) being measured by QCA
- 2) Myocardial Scintigraphy in accredited centres
- 3) Exercise Testing

The Panel advised the continuing use of reference scrutineers when there were concerns about an exercise test report and/or where there were difficulties in decision making as a result of 2 or more investigation findings.

(iii) Loss of Consciousness - Group 1 and 2 licences

a) The algorithm (first published in March 2001 edition of 'At a Glance Guide to Medical Standards of Fitness to Drive) specifically refers to "loss of consciousness". The Neurology Panel has already agreed that the algorithm also encompasses "loss of awareness". Following discussion, the Cardiac Panel agreed that "loss of consciousness" and "loss of awareness" were synonymous when using the algorithm.

ACTION

The "loss of consciousness" section in 'At a Glance Guide to Medical Standards of Fitness to Drive' will be reworded to specifically include "loss of awareness".

b) The Panel chairman reported on the progress of an overview 'paper' he is preparing (co-author: Professor D Chadwick - Chairman of the Neurology Panel), which will explain the development of the current "loss of consciousness" algorithm.

(iv) Implantable Cardioverter Defibrillators (ICD) - Group 1 licence

a) ICD (other than prophylactic and Atrial defibrillators) – feedback following implementation of May '95 guidelines and subsequent revisions of May '96, November '97, November '98, March '99, July '99, April 2000 and November 2000.

Between 1.6.95 and 25.4.01, the DVLA has assessed or been made aware of (by way of licence surrender) 1619 persons with an I.C.D. There are, as of 25.4.01, 1180 licence holders with such devices implanted. 498 are on their first licence, 343 on their second, 187 on their third, 88 on their fourth, 50 on their fifth and 14 on their sixth sequential annual licence.

During this assessment period, 141 persons, having initially satisfied the relevant I.C.D. licensing criteria, were subsequently debarred due to an I.C.D. related event. Many of these cases have regained their licence after meeting the criteria once again.

The Panel agreed that as there were now data that covered in excess of 5 years licensing experience with such devices, there was no need to continue with this exercise. The data should remain accessible to explain the evolution of the licensing criteria.

b) Licensing Criteria (other than prophylactic devices) - Revisit

The Panel was asked to consider whether annual (re)licensing of such persons was reasonable in the light of the ever increasing information about the devices and the attendant technological improvements in them.

Following discussion, the Panel agreed that the annual review licence no longer served any purpose. An unrestricted duration licence (appropriate to age) could now be issued provided:

1)

The I.C.D. licensing criteria can be met

2) A declaration is completed by the licence holder confirming that he/she will regularly attend for device follow-up, as required by their Cardiologist

3) The licence holder is provided with an information letter that explains the I.C.D. licensing criteria and what action he/she must take if following licence issue, they are again unable to satisfy these criteria

4) The same information is sent to the relevant Cardiologist and General Practitioner.

c) Prophylactic I.C.D.

A prophylactic device is defined as an I.C.D. that has been implanted in an asymptomatic individual considered to be at high risk of a significant arrhythmia but prior to implantation, a significant arrhythmia has not occurred.

The Panel discussed a licence holder with Hypertrophic Cardiomyopathy (HCM) who had suffered a documented V.F. arrest some 17 years prior to a recent I.C.D. implantation. In the interim time, no further significant arrhythmia had occurred. The family history and investigation suggested that the licence holder was at high risk of further significant arrhythmia(s).

The question was whether or not the prophylactic I.C.D. licensing criteria should apply when the putative arrhythmia was this remote from I.C.D. implantation.

Conclusion:

Provided the symptomatic arrhythmia has occurred 5 years or more prior to implantation, then the I.C.D. should be considered to be a prophylactic device with the attendant licensing criteria.

5. REVIEW LICENCES - GROUP 2 LICENCE

Pacemaker and Valve replacement

Group 2 licence holders with a pacemaker and/or valve replacement have required medical review every 3 years. The Panel was asked to consider if this was now reasonable in view of the fact that the licence holders have a legal obligation to notify the DVLA of any adverse medical development that might affect their fitness to drive.

Conclusions:

Pacemaker

The Panel agreed that an unrestricted duration licence (appropriate to age) could be issued provided:-

- 1) The licence holder completed a declaration confirming that he/she will attend regularly for device follow-up as required by their Cardiologist. The declaration should also provide guidance to the licence holder about the action(s) that needed to be undertaken should there be adverse medical developments
- 2) There was no other reason to review the licence earlier
- 3) The Consultant and General Practitioner were sent an information letter advising that an unrestricted duration licence had been issued and what advice/action was required of them should there be adverse medical developments to include the failure to attend for regular pacemaker follow-up.

Valve Replacement

The Panel agreed that due to the reliability of valve replacement and low risk of complications, an unrestricted duration licence (appropriate to age) could now be issued.

6 ASYMPTOMATIC CONGENITAL COMPLETE HEART BLOCK - GROUP 1 AND 2 LICENCE

The Panel previously advised in 1987 that those with unpaced Congenital Complete Heart Block should not be granted a Group 2 licence. A review of this previous recommendation occurred using the paper 'Isolated Congenital Complete Atrioventricular Block in Adult life – a prospective study (Authors: M Michaelson et al) as a basis for the discussion.

Conclusions:-

Group 2 licence

Due to the unpredictable onset of Stokes-Adams attacks, pacemaker implantation is required before (re)licensing may occur.

Group 1 licence

Pacemaker implantation is not specifically required for (re)licensing.

7. ANY OTHER BUSINESS/LATE ENTRIES

1. Research Programme

The Panel was advised of the Neurological risk research programme being undertaken. The areas of interest included:-

- (i) Arteriovenous malformations, Cavernous angiomas and their associated risks
- (ii) Predictive value of CT/MRI scanning of cerebral contusion(s) and subsequent epilepsy risk
- (iii) Cognitive impairment
- (iv) Excessive daytime sleepiness
- (v) Alcohol related seizures and future epilepsy risk

The Panel was advised that any Cardiac research programme has to be established within the next 2 months. Arrhythmias seem a suitable subject for further evaluation and Professor Nicholson will approach Panel members for further input.

2. Cor pulmonale with treated Right Ventricular failure - Group 2 licence

The Panel agreed that (re)licensing could only occur if:

- a) The individual was asymptomatic
- b) The exercise test criteria could be met

8. DATE AND TIME OF NEXT MEETING

Thursday, 29 November 2001 at 11.00 am