MINUTES OF THE MEETING OF THE SECRETARY OF STATE'S HONORARY MEDICAL ADVISORY PANEL ON DRIVNG AND DISORDERS OF THE NERVOUS SYSTEM HELD ON 7TH NOVEMBER 2001

Present:	Dr J M Bamford	Chairman
	Dr A Johnson	
	Professor A D Mendelow	
	Mr R S C Kerr	
	Professor R A Kenny	
	Dr A Zeman	
	Professor I R Whittle	
	Professor G Cruickshank	
	Dr L Nashef	
	Mrs M Cooper	
	Mrs J Wightman	
	Professor A Nicholson	
	Dr G L Wetherall	MA/DVLA Panel Secretary
	Dr C Jenkins	MA/DVLA
	Ms S Martin	DPG/DVLA

1 APOLOGIES

1.1 Apologies for absence were received from Professor D W Chadwick, Professor DT Wade, Dr M Brada, Dr T Carter, Dr J C Durston and colleagues from the Northern Ireland Occupational Health Service.

1.2 Dr Bamford had agreed to act as Chairman in the absence of Professor Chadwick and welcomed members to the meeting.

2 MINUTES OF THE LAST MEETING HELD ON THE 2ND MAY 2001

2.1 The Minutes of the meeting held on the 2nd May 2001 were accepted as a true account.

3 MATTERS ARISING

3.1 **Combined Alcohol/Neurology Meeting on 21st May 2001**
It was noted there was a dichotomy of view concerning seizures related to drug and alcohol use. The range of views and discussions at the meeting were outlined by Dr Bamford. The conclusions of the combined meeting were agreed by the Panel.

3.2 **Eclamptic seizures**
Dr Bamford had not had a reply to his letter to a Professor of Gynaecology despite reminders. The Secretary was asked to write.

[*Action by Panel Secretary*]

3.3 It was mentioned that the Chairman of the Steering Group of the Millennium Cohort Study was keen on introducing questions concerning accidents into the Study.

3.4 Dr Zeman asked whether a paper concerning the changes in the loss of consciousness guidelines had been prepared for publication in a Journal. It was understood that there had been mention of Professor Chadwick and

Dr Petch writing a combined paper. As Professor Chadwick was not at the meeting the Secretary will make enquiries.

[*Action by Panel Secretary*]

4 UPDATE FROM THE PANEL CHAIRMEN'S MEETING

4.1 Professor Nicholson started off the discussion by outlining the research reviews which had been undertaken. The risk analysis paper highlighted the limitations of relying on risk analysis alone. In particular, society needs to determine what level of risk is acceptable. A sensitivity analysis will be needed.

4.2 The other review looked at literature concerning clinical examination and fitness to drive, including mild dementia and cognitive impairment. This will be one of the next research topics looking at all methods of assessment for fitness to drive. It is the intention in the near future to invite expressions of interest, form a Steering Group and then issue contracts for studies. The Psychiatry and Neurology Panels will receive progress reports and the Panel Chairmen (or other members) will be ex-officio in the Steering Group. Another area identified is excessive daytime sleepiness. It was thought that this area would be best served by having a workshop in a similar fashion to that used to redefine the standards for unexplained loss of consciousness.

4.3 Professor Nicholson outlined the research currently ongoing in both diabetes and vision.

4.4 It was mentioned that the Panel Chairmen's Panel Meeting highlighted the usefulness of joint Panel meetings to ensure a consistent approach.

4.5 The Panel went on to discuss the Phillips Report on the Spongiform Encephalopathy Advisory Committee (SEAC). The Panel endorsed the finding that the Panel is only responsible for advice and not how the advice is taken and implemented. The Chairman of the meeting pointed out that one point raised in the SEAC report was that meeting agendas should not be overloaded and there should be adequate time to digest information. He felt this should be applied to the Panel meetings so that cases are not tabled on the day of the meeting.

4.6 In the general discussion which followed, Professor Nicholson confirmed that the Dementia/Cognitive Impairment Study was intended to demonstrate how the clinical examination of an individual related to their safety to drive and went on to outline the cost and scope of the Diabetes Study. The Panel welcomed the focus on research. The view was expressed that an increase in traffic density could be associated with a reduction in accident rate as speed would be reduced with a greater number of vehicles. It was pointed out that when risk is being estimated, uncertainty needs to be modelled and estimates of uncertainty need to be included throughout the whole process. The Panel agreed that the sensitivity analysis should go ahead.

7 HEAD INJURY ISSUES (This was taken out of order)

7.1 **Opportunities For Up-to-date Knowledge, Based On Incidence Of Seizures After CT Positive Scanned Patients Not Requiring Surgery.**

7.1.1 A discussion paper was presented concerning seizure risk following closed head injury not requiring surgical intervention. The paper outlined the situations in which CT scans would be undertaken and highlighted the fact that many patients with CT proven contusions may never be referred to a neurosurgical unit. The difficulty arises when the epilepsy risk requires assessment. It was pointed out that "At A Glance" lacks guidance in this area.

7.1.2 The "Crash Trial" (early use of steroids in head injury) was referred to and the early data from this shows an overall seizure risk of 19% within the first year with the highest risk in the moderate injury group. The fact that greater numbers are having CT scans following head injury will mean that the uncertainty concerning cerebral contusions and epilepsy risk will also increase. The situation is complicated by the insertion of intracranial pressure (ICP) monitors and no data exists as to whether these devices add to the seizure risk. It was noted that the situation is becoming more common. However, it was suggested that the American Trauma Databank, Japanese and UK databases have relied on the Marshall CT classification for head injuries so this information

may be available. The Marshall classification will differentiate between haemorrhagic and non-haemorrhagic contusions. A Panel member agreed to research the data concerning ICP monitors. The view was expressed that databanks may have quite incomplete data with follow-up and end point being sketchy.

7.1.3 The Chairman read out some written comments submitted by Professor Wade who had expressed the view that only the clinical features of the head injury should be considered. The Panel agreed with this for ordinary licensing but thought vocational licensing was more problematic. The Panel agreed there was a lot of uncertainty concerning the epilepsy risk associated with cerebral contusions and a study should be undertaken. The Chairman asked Professor Cruickshank to keep the "Crash Trial" under review and discuss the issue at the next Panel meeting.

7.1.4 The Panel went on to discuss a paper from the 1970's outlining a mathematical approach to the prediction of epilepsy risk. The Panel were of the opinion that because the paper had been written pre CT scanning, it didn't contribute to the previous debate. However, it would be helpful to consider the complex mathematical paper which had been tabled at the last minute, outside the meeting.

7.1.5 There was unanimous agreement there needed to be further consideration for research. The Paper will be developed further for discussion at the next Panel meeting.

7.2 **Anticonvulsant Medication Following Early Epilepsy**
The Panel discussed whether drivers who sustained a head injury with early seizure would need to satisfy Group 2 Epilepsy Regulations (10/10 rule) if antiepileptic medication is prescribed when standards may allow a return to Group 2 driving at an earlier date subject to certain criteria. The Panel agreed that an early seizure did not constitute epilepsy per se and the routine application of the requirement to remain seizure free off medication for 10 years was not appropriate. The Panel were of the view that the driver needed to remain symptom free off antiepileptic drugs for a minimum period in addition to satisfying other standards. The minimum period should be based on the findings of the MRC Antiepileptic Drug Withdrawal Study. A Panel member agreed to consult the figures and correspond with the Panel Secretary.

5 PANEL MEMBERSHIP AND RETIREMENT

5.1 The discussion was prefaced by brief introductions and outlining of interests. It was pointed out that previous discussions had resulted in advice to nominate expert advisers for a five year tenure of office renewable for a further five year period. In addition, the Phillips' report highlighted the limitations of expert advice and that if the work of the adviser materially altered during the tenure of the office, the adviser should step down from the Committee. With regard to the Advisory Panels for driving, this has been interpreted as no longer being involved in active clinical management. Essentially, the Terms of Reference had developed from this advice. The Panel accepted the draft Terms of Reference.

6 GROUP 2 DRIVING AND MELANOMA

6.1 The Panel were asked to consider the nomograms used by the Civil Aviation Authority (CAA) to assess the risk of cerebral secondaries. The Panel thought the information was interesting but thought it more appropriate to discuss the matter with Dr Brada present. This item will be on the Agenda for the next meeting.

8 OBSTRUCTIVE SLEEP APNOEA AND GROUP 2 DRIVING

8.1 The Panel were asked their opinions as to whether it would be reasonable to issue longer period licences to Group 2 drivers with obstructive sleep apnoea (currently licensed yearly) if the drivers sign an undertaking to comply with treatment and to inform the Department of any change in condition. This approach had been used by the Cardiologists for Group 2 drivers with a history of an implanted pacemaker. The Panel thought the accompanying paper concerning sleep apnoea and accidents very interesting. The Panel agreed it would be helpful to have an expert on sleep apnoea on the Panel. In the meantime, a Panel member agreed to discuss the

issue with an expert in the field of sleep apnoea and report back.

9 GDC COILING AND GROUP 1 LICENSING

9.1 The Panel were asked for an up-date on the results of the GDC coiling trial. It was pointed out that by issuing three year licences to Group 1 drivers, this results in the loss of C1 (vehicles of between 3.5 and 7.5 tonnes) and D1 (minibuses of up to 16 passenger seats not used for hire or reward) entitlements.

9.2 Although the results of the trial are not known, there are a lot of patient years of follow-up and the suggestion is that the risk of re-haemorrhage is very low as are the risks of further complications. However, the data is not due for publication until approximately 2003. It was suggested that there may be alternative papers which could provide evidence. It was also suggested that possibly the advice on aneurysms which had bled and were left untreated needed to be reviewed.

9.3 A Panel member agreed to review the papers concerning GDC coiling.

10 SUDDEN AND DISABLING VERTIGO AND GROUP 2 DRIVING

10.1 The Panel were asked to review the standard concerning Group 2 driving and sudden and disabling vertigo. Vertigo is a common symptom, which is often indicated on the D4 medical form. As often there is no firm diagnosis and it is usually impossible to determine whether a severe bout of vertigo is going to reoccur, drivers are often required to remain symptom free for a period of 12 months before resuming Group 2 driving.

10.2 A Panel member offered to discuss the subject with an ENT Specialist and report back to the Panel.

11 UPDATE ON STATS 19

11.1 Mrs Martin indicated that the STATS 19 form is being reviewed by the Transport Statistics Department. DVLA have asked specifically that the driver licence number or failing that full name and date of birth, be included for any drivers involved. This will enable linking to the driver licence file. The aim is to report the review and consultation process in approximately one year's time and then any changes would be implemented shortly after this.

12 CASES

12.1 Seven individual cases were discussed at the Panel meeting.

13 ANY OTHER BUSINESS

13.1 There was no other business.

14 DATE & TIME OF NEXT MEETING

As Professor Chadwick was not at the meeting, he will be contacted for availability and Panel members circulated with prospective dates.

IMPORTANT: THESE ADVISORY NOTES REPRESENT THE BALANCED JUDGEMENT OF THE SECRETARY OF STATE'S HONORARY MEDICAL ADVISORY PANEL AS A WHOLE. IF THEY ARE QUOTED THEY SHOULD BE REPRODUCED AS SUCH NOT AS THE VIEWS OF INDIVIDUAL PANEL MEMBERS.