

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

**18 SEPTEMBER 2008**

<b>Present:</b>	Professor Charles P Warlow	Chairman
	Dr A Johnson	
	Professor A D Mendelow	
	Professor G Cruickshank	
	Dr L Nashef	
	Professor P E M Smith	
	Dr A G Marson	
	Dr P Reading	
<b>Lay members:</b>	Mrs M Cooper	
	Mrs J Wightman	
<b>Ex-officio:</b>	Dr P Collins Howgill	Civil Aviation Authority
	Dr M K Pawley	Medical Adviser, DVLA
	Dr J E Morgan	Panel Secretary/MA, DVLA
	Mrs J White	Med EO, DVLA

**1. Apologies for Absence**

Apologies were received from Professor D Wade, Professor I R Whittle, Professor M Brada, Dr C J Mathias, Mr K S C Kerr, Dr R Al-Shahi Salman, Dr H G Major, Dr J McVicker, Dr P Prasad, Mr B Jones, Miss J Chandaman.

**2. Chairman's Remarks**

The Chairman confirmed that Dr Tim Carter has retired as the Chief Medical Officer; Dr Tim Crayford has been appointed to the post. Dr Read, the Research Manager for the DfT, has also left the department.

### **3. Minutes of the Meeting of 13 March 2008**

Amendments were made to the following sections:

Item 4.2. The reference to infratentorial arteriovenous malformations should be deleted from the second line. The sentence should now read, ‘the Panel considered further the standards agreed at the last meeting concerning cavernomas’.

Item 5. Fifth line from bottom: the word ‘relevant’ should be inserted such that the phrase reads, ‘no relevant structural abnormality of the brain on imaging’.

Item 6. Reflex anoxic seizures. The first line of the second paragraph should be amended to read, ‘ if the appropriate specialist involved in any particular case is satisfied ...’

The minutes were then accepted as accurate.

It was confirmed that febrile convulsions in childhood could be discounted when considering the seizure-free period before Group 2 licensing after a solitary seizure in adulthood.

The Panel advised that a bulletin should be sent to the Association of British Neurologists regarding the advice for confirmed reflex anoxic seizures.

### **4. Matters Arising**

#### **4.1 Supplementary Paper on Cavernous Malformations.**

The Panel thanked Dr Rustam Al-Shahi Salman for providing a supplementary report on the data from the Scottish Intracranial Vascular Malformation Study.

The Chairman noted that cavernous malformations have only been recognised over the last fifteen years and that there are no long-term data concerning the outcomes of treatment. It is an emerging issue with more being diagnosed with an increasing frequency of MRI scanning. A detailed discussion took place concerning the data and it was agreed that the standards for cavernous malformations agreed at the March meeting would be implemented for the time being. It is possible that revision will take place to these standards in the light of further data on treatment outcomes.

#### 4.2 Update on Progress of EC Working Group on Seizure Risk.

The Panel was informed that the next meeting of the EC Working Group on Epilepsy has been delayed until 2009. The Panel made several observations and suggested amendments to the most recent draft proposals.

#### 4.3 Changes to the At A Glance Guide

It was agreed that the phrase ‘the diagnosis of intracranial venous thrombosis should replace ‘venous sinus thrombosis’ in the cerebrovascular disease section.

Amendments were made to the standards for benign supratentorial tumour to replace ‘benign meningioma’ with ‘WHO grade I meningioma’.

A new entry is to be constructed concerning arachnoid cysts (see Annexe 4.3).

Minor amendments were made to the wording in some sections and these will be reflected in the next edition of the At A Glance Guide.

#### 4.4 Consideration of Changes to Standards following Craniotomy.

Further revision was made to the standards following treatment for acute subdural and intracerebral haematomas and pituitary tumours (see Annexe 4.4).

#### 4.5 Letter regarding Data Collection

The Panel Chairman is liaising with the Chairs of the other Honorary Medical Advisory Panels in drafting a letter to the department with regard to health-related data and accidents.

#### **5. Attendance of Neurology Panel Members at the Psychiatry Panel Meeting regarding Presentation on Cognitive Impairment and Driving**

One of the representatives from the Neurology Panel who was present at this meeting summarised the discussion.

#### **6. Draft Report on Vascular Risk Workshop**

Detailed discussion took place on this draft report. It was confirmed that the Neurology Panel is currently the only one with a statistician as a full member.

Attention was drawn to the fact that, for licensing purposes, each medical condition is considered individually against the published standards, generally without reference to other or combined risk factors. The workshop highlighted the challenges of undertaking more individualised risk assessment of each driver based on the presence, absence or effective management of risk factors and on whether primary or secondary screening was being considered. The importance of using current data in standard-setting and decision-making is critical to the development of any appropriate risk-modelling tools.

There was general acceptance that the 2% risk per annum of a sudden and disabling event is appropriate for Group 2 licensing. A debate took place concerning the difference in assessment of excess and absolute risk and of the relevant relationship of age-related risk.

It was appreciated that polymorphic risk assessment to take account of all the risk factors, including age, would be a major change to the way in which drivers were assessed.

The Panel recommended removal of automatic exercise tolerance testing after a cerebrovascular event for Group 2 licensing. The consensus opinion was that it would be advantageous to further discussion if an additional expert in cerebrovascular risk assessment could join the Panel.

Further options for consideration of change await wider discussion of the Workshop report and policy guidance.

## **7. Cases for Discussion**

Four cases were discussed. They included a Group 2 driver with a solitary seizure, a Group 1 driver with immediate seizures after a head injury, a Group 2 driver with bilateral craniotomies for ruptured and unruptured middle cerebral artery aneurysms and a Group 2 driver with a tectal plate haemorrhage secondary to a cavernoma.

## **8. Research Update**

It was noted that the research on the 'Attitudes of Health Professionals to Giving Fitness to Drive Advice' has yet to be published.

## **9. Reference Papers**

No new reference papers were presented.

## **10. Retirement of Panel Members and Appointment of New Members**

The Chairman thanked the retiring members (Dr Johnson, Professor Mendelow, Mr Kerr, Professor Brada and Professor Wade) for their service to the Panel over the last 10 years.

It was confirmed that new nominees are currently being considered at DVLA.

It was agreed that consideration should be given to the appointment of an expert in cerebrovascular risk assessment.

## **11. Any Other Business**

### **Assessment of seizure risk following head injury**

Discussion took place concerning the ongoing difficulties in the interpretation of seizure risk post head injury. The Panel was reminded of the presentation made by Dr Johnson, Statistician to the Panel, in October 2005. It was confirmed that when determining the eligibility for licensing, the per annum risk should be used rather than the residual risk.

### **Continuing Education to the Medical Profession**

There was general agreement that it is important for the DVLA to be proactive in disseminating knowledge of driving standards to the medical profession.

## **12. Date and Time of Next Meeting**

It was confirmed that the next meeting will take place on Thursday, 12 March 2009 at 1.00 pm. The Autumn meeting will be on 1 October 2009.

**DR J MORGAN MB BCh DRCOG DDAM**  
Secretary to the Honorary Medical Advisory Panel  
on Driving and Disorders of the Nervous System

22 September 2008

### ANNEXE 4.3

ARACHNOID CYSTS	GROUP 1	GROUP 2
Asymptomatic and untreated	<b>No restriction</b>	No restriction
Craniotomy and/or endoscopic treatment	6 months off.	Can drive 2 years after treatment, provided that there is no debarring residual impairment likely to affect safe driving.

### ANNEXE 4.4

PITUITARY TUMOURS	GROUP 1	GROUP 2
Transphenoidal surgery/ other treatment	Can drive when there is no debarring residual impairment likely to affect safe driving.	Can drive when there is no debarring residual impairment likely to affect safe driving.
Craniotomy	6 months off.	2 years off.

ACUTE SUBDURAL	GROUP 1	GROUP 2
Surgical treatment	12 months off.	Refusal or revocation. May return to driving when the risk of seizure has fallen to 2% or less per annum with no debarring residual impairment likely to affect safe driving.

ACUTE INTRACEREBRAL	GROUP 1	GROUP 2
Burr holes	6 months off.	Refusal or revocation. May return to driving when the risk of seizure has fallen to 2% or less per annum with no debarring residual impairment likely to affect safe driving.
Craniotomy	12 months off	