Would you Fly With This Pilot?

Dr. Mike Berry- Federal Air Surgeon
Dr. Stephen Altchuler- Psychiatry
Dr. Scott Phillips- Otolaryngology
Dr. Harriett Lester- Ophthalmology
Dr. Andrew Miller- Cardiology
Dr. Roger Hesselbrock- Neurology
Case 1: Addiction

- 50 y/o Commercial Airline pilot with 8900 flight hours
- 3 yrs ago multiple orthopedic surgeries: Left knee ‘89 & ‘08
- Prescribed Percocet post-op
- Pilot described significant pain relief with the Percocet
- Now taking wife’s Oxycodone (with her knowledge) and then purchased oxycodone off the street for 2 yrs.
- Used med for 2 days, then off for 7 days to avoid failing DOT testing
Addiction (cont’d)

• Airman snorted crushed oxycodone and passed out ->
• Son called 911, toxicology discovered that had snorted Fentanyl by mistake
What would you do now?

- Issue?
- Ask for records?
- Request more evaluations?
- Defer?
- Call RFS?
Addiction – Consultant Discussion
Addiction (cont’d)

• Pilot successful tx at Inpatient drug recovery center: 29 days
• Contacted and seen HIMS AME twice
• Highly motivated and admitted to substance abuse
• Currently attending 90/90 AA meetings
• No other history of mental health problems or relationship issues
• No other legal problems or DUls
• Supportive family
• Wife in tx. For opiate dependency as well.
Addiction (cont’d)

• Airman now 3 months post sentinel event

• What would you recommend?
Addiction Wrap-up

• Permanent abstinence from ETOH and ALL illicit substances
• Actively followed by HIMS AME
• Ongoing monitoring, regular testing, attendance in self-help program
• After 6 months an evaluation by HIMS Psychiatrist and Neuropsychologist
Case 2: Neurology

- 34 y/o First-class Commercial & Flight Instructor; 500+ hours as PIC
- Assaulted and found by Paramedics – GCS of 3;
- 1 cm Epidural hemorrhage; AND: Subarachnoid hemorrhage, Hemorrhagic parenchymal contusions of Frontal & Temporal lobes; AND: Parietal/Occipital Skull Fx.
- Urgent Ventriculostomy
- Follow-up demonstrated enlargement of Epidural to 2.1 cm
- Emergent craniotomy and evacuation with repair skull Fx
- BAC in ER -> 0.309
Neurology (cont’d)

• Referred for Rehabilitation
• Neuro evaluation reported as nml
• Cog Screen-AE, LRPV score 0.277 (nml),
• Neuropsychological testing: weak math performance, otherwise neg
• Completed treatment for ETOH dependence; no prior use of illicit medications; no hist. of DUI
• Feels ready to return to flying as Flight Instructor:
What would you do now?

– Issue?
– Ask for records?
– Request more evaluations?
– Defer?
– Call RFS?
Neurology – Consultant Discussion
Neurology (cont’d)

- Denied for Alcoholism and Severe TBI
- Claimed that the BAC of 0.309 as after only 2 drinks?
- Black out night of trauma likely secondary to ETOH and trauma
- Denied for 5-years due to risk of post traumatic seizures
- Began monitoring with HIMS AME
- Reconsideration after 5-yrs. If seizure-free, successful abstinence and monitoring, acceptable HIMS Psychiatric & Psychological evals.
Case 3: Cardiology

• 35 y/o Saudi airman for First-class with 6000 flight hours
• Flies for Saudia Airlines
• No medications
• Only positive history for Cholecystectomy 17 years ago
• Normal PE, BP 116/82, Resting Pulse 67
• EKG ->
Cardiology (cont’d)

- This airman is in your office and you obtain this graph, ....
Brugada?
What would you do now?

- Issue?
- Ask for records?
- Request more evaluations?
- Defer?
- Call RFS?
Cardiology – Consultant Discussion
Cardiology (cont’d)

• No FH sudden death
• Airman never any syncope
• Cardiac MRI negative with no cardiomyopathy or Arrhythmogenic Rt Ventricular Cardiomyopathy
• Echocardiogram: negative
• Nuclear Stress: 9.45 min; 102% of max hr., peak BP 167/77 -> negative electrically with few PVCs in Recovery; Nuclear portion negative for ischemia with nml wall motion; Rest EF 60% & Post Stress 65%
• Holter Monitor: avg rate 75, min 49, max 136-> 44 PVCs, 39 PACs
Cardiology (cont’d)

• No sustained arrhythmias

• EPS specialist seen and Conclusion was Type 1 pattern of BRUGADA but no syndrome
Cardiology – Consultant Discussion
Cardiology (Cont’d)

• Airman was Denied; case forwarded to FAS for further review about this particular situation, Denial was sustained by FAS.
Case 4: Ophthalmology

- 25 y/o student from the United Kingdom with 0 flying hours
- Requesting 3rd class medical certification
- No medications
- Reported history of CONGENITAL NYSTAGMUS
- Was issued an EASA Class 1
- Distant Vision with correction - OD: 6/6 (=20/20) with slight head turn to the Rt.,
  - OS with correction 6/7.5 (=20/25)
Ophthalmology (cont’d)

• Takes longer to identify the letters than one would normally expect
• VFs are full when tested with Humphrey automated visual field
• Color vision was normal in each eye with Ishihara test book
• IOPs were normal at 18mmHg
• Eyelids, bulbar and tarsal conjunctival surfaces, cornea and irides were all nml
• Anterior chamber drainage angles both eyes nml
• No posterior vitreous detachment in either eye
Ophthalmology (cont’d)

- Ophthalmic exam presence of optic disc Drusen
- Both Maculae were nml
- Both foveae were nml with minimal changes on cross-sectional imaging
- Evaluated at Moorfields Eye Hospital by Consultant Ophthalmic Sgn.
- Nystagmus not changed since 2014
- Fine manifest horizontal nystagmus which reduces slightly when turns head slightly to Rt (null point)
- Convergence nml
Ophthalmology (cont’d)

- Ocular movements full and nystagmus increases on extreme Left gaze
- Stereopsis is below normal
- Wirt stereo test revealed 400 sec of arc (outside of nml limit)
- Prism cover testing was unchanged from 2014 and demonstrated good fusion
What would you do now?

– Issue?
– Ask for records?
– Request more evaluations?
– Defer?
– Call RFS?
Ophthalmology – Consultant Discussion
Ophthalmology (cont’d)

• Sent to Ophthalmology Consultant:
  – Noted airman achieves nml visual acuities with slight head turn
  – Noted the decreased stereopsis & worsening nystagmus with extreme left gaze
  – Recommended 3\textsuperscript{rd}-class medical certification, but MFT if requests higher class
Case 5: Psychiatry

- 19 y/o requesting First-class with only 50 hours
- Only med is EPIPEN for Peanut allergy history
- Diagnosed with ASPERGER’s Syndrome earlier in educational career
What would you do now?

– Issue?
– Ask for records?
– Request more evaluations?
– Defer?
– Call RFS?
• You want to assist the airman with consideration for special issuance.
• What evaluations and testing would you request?
Psychiatry (cont’d)

• Neuropsychological evaluation and testing performed at MAYO CLINIC, Rochester, MN

  – Very intelligent man
  – Wechsler Adult Intelligence Scale at 95\textsuperscript{th} percentile
  – Perceptual abilities just slightly lower
  – Working memory upper portion of avg. range
  – Basic processing speed avg.
Psychiatry (cont’d)

- Neuropsychological evaluation and testing performed at MAYO CLINIC, Rochester, MN
  - In Picture Completion performance low -> unable to recognize what significant aspect of a line drawing was missing or out of place -> seems consistent with Autism spectrum disorder
  - Visual sustained attention on the Conors’ showed significant number of commission errors as variable performance when intervals between stimuli changed
  - MMPI -2 no indication of a mood disorder
Psychiatry – Consultant Discussion
Psychiatry (cont’d)

• Psychiatry evaluation:
  – Saw Counselor at age 15 for difficulty with social cues, holding a conversation, and making friends
  – Would find himself talking in a conversation when no one else was listening
  – Today reports as more outgoing
  – Back when Dx made he had lack of interest in personal hygiene, but now more interested
  – No symptoms of depressed mood, feelings of depression, or anhedonia
  – Consultant opined that “he still had some mild intermittent difficulty with social communication dialogue.”
    • Felt that this would impact him more in being able to establish close relationships
What would you do now?

– Issue?
– Ask for records?
– Request more evaluations?
– Defer?
– Call RFS?
– Call AMCD?
Psychiatry (cont’d)

• He was issued with a time limitation with current status and statement from flight instructor on his performance
Case 6: Otolaryngology

- 46 y/o airman from United Kingdom with 7,600 flying hours; flies commercially
- Requires First-class medical certificate
- No medications
- C/o Dysphagia; Noted enlarged Rt tonsil
- Reports Robotic assisted resection trans oral Rt Partial Oropharyngectomy December 2 years ago
  - Rt Level II, III, IV neck dissection
- Pathology: Poorly differentiated Basaloid Squamous Cell cancer – Stage T2N0M0 and p16+
ENT (cont’d)

• FAA exam: 5” linear Rt anterior scar triangle of neck
• Rt tonsillar area “flattened”
• Passed Conversational Voice Test
• Meets vision standards
• EKG negative
What would you do now?

– Issue?
– Ask for records?
– Request more evaluations?
– Defer?
– Call RFS?
– Call AMCD?
ENT (cont’d)

• CT & MRI no evidence of spread
• Airman was not given chemotx or radiation
ENT – Consultant Discussion
ENT (cont’d)

• So one-year after surgery the airman was issued a time-limited med cert for 12 months with a current status report and CT or MRI of the neck and thorax and any other testing deemed necessary