Would you Fly With This Pilot?

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Dr. Veronneau- Mgr. FAA Education Div
Dr. Murphy- Neurologist
Dr. Miller- Cardiologist
Dr. Danczyk- Psychiatrist/Addiction
Dr. Schall- FAA Otolaryngologist
Dr. Silberman- FAA Certification
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 normal 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?
Psychiatry (cont’d)

• 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 95th 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

- 56 y/o Airline Pilot with 17,000 hrs
- New Hx of R Tonsil/BOT SCC, staged T2N2bM0
- Tx’d w Trans-oral resection and R Selective Neck dissection
  - Levels IIA/B, III and IV
- Poorly Differentiated on Path; Neg Margins; No Perineural, No Lymphovascular; 2/34 Nodes (+)
- XRT 6000cGy in 30 Fx’s completed Dec 2016
- Pathology: Poorly differentiated Basaloid Squamous Cell cancer p16 (+)
ENT (cont’d)

- FAA exam: 5” linear Rt anterior scar triangle of neck
- R tonsillar area “flattened”
- Passed Conversational Voice Test
- Some Dysphagia but no aeromedical concerns
- Hx of provoked DVT of R lower extremity, Tx’d w Eliquis now stopped;
- Remote Hx of GSW to L lower extremity
- Remote Hx of Valley Fever
What would you do now?

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

- Treating Physician current status report was favorable
- Imaging reports (PET/CT) showed NED
ENT - Consultant Discussion
The FAA was recently notified by his AME that the most recent PET/CT showed a single FDG (+) 15mm nodule in the L lower lobe of the lung.

- Bx showed SCC
- Developed mild iatrogenic pneumothorax
- Received 5000cGy XRT in 5 Fx’s to chest
- Noted to have poorly controlled Hypothyroidism
- Special Issuance withdrawn