Would you Fly With This Pilot?

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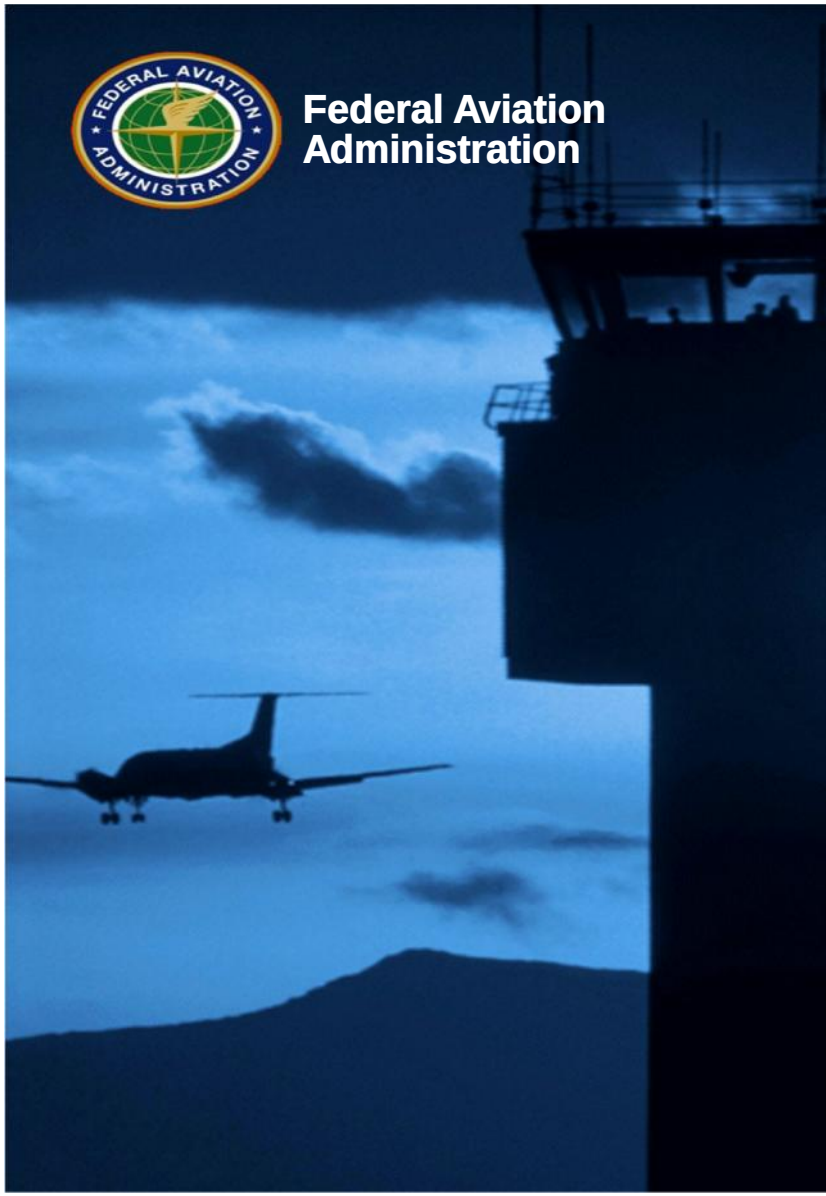
Dr. Veronneau- Mgr. FAA Education Div
Dr. Murphy- Neurologist
Dr. Miller- Cardiologist
Dr. Danczyk- Psychiatrist/Addiction
Dr. Schall- FAA Otolaryngologist
Dr. Silberman- FAA Certification



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 DUIs**
- **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)

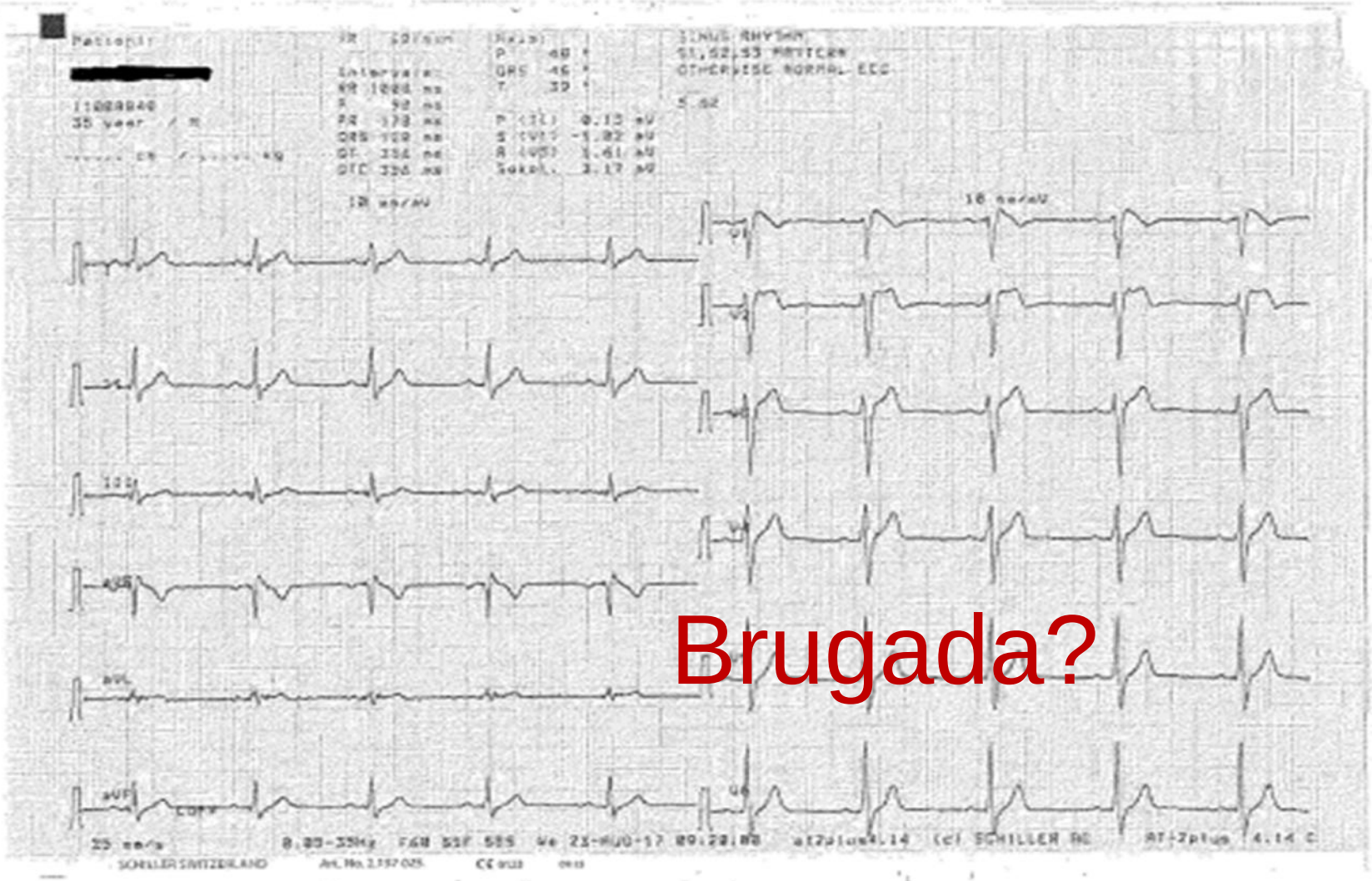
- **Denied for Alcoholism and Severe TBI**
- **Claimed that the BAC of 0.309 as after only 2 drinks?**
- **Black out night of trauma likely secondary to ETOH and trauma**
- **Denied for 5-years due to risk of post traumatic seizures**
- **Began monitoring with HIMS AME**
- **Reconsideration after 5-yrs. 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, ….**


SINUS RHYTHM
OTHERWISE NORMAL ECG
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 3rd-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 Autistism 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?
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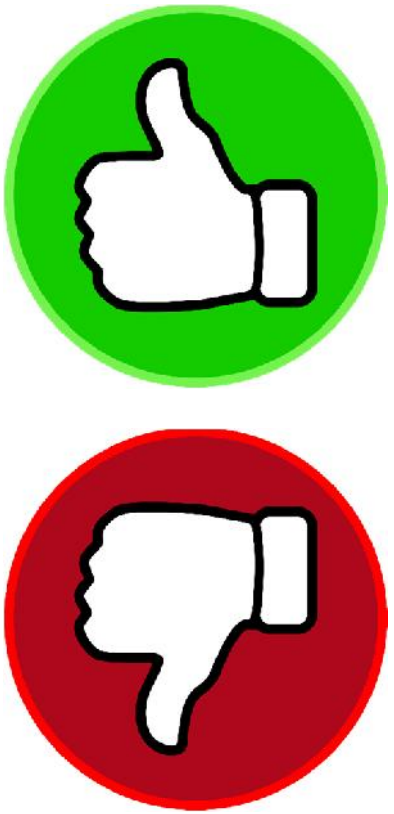
- Request more evaluations?
- Defer?
- Call RFS?
- Call AMCD?



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

ENT (cont'd)

- **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**