The articles published in this newsletter are presented for informational purposes and topics of discussion and do not necessarily represent the opinions or recommendations of the Civil Aviation Medical Association.

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Civil Aviation Medical Association (CAMA) Contact Information
Mailing Address:
CAMA
P. O. Box 2382
Peachtree City, GA 30269
Telephone: 770-487-0100
FAX: 770-487-0080
Email: civilavmed@aol.com
Web Site: www.civilavmed.org
Facebook: Civil Aviation Medical Association

2019 Annual Meeting Recap

If you didn’t attend the CAMA Annual Scientific Meeting in Cleveland, Ohio, this year, you missed an incredible meeting! Not only did the educational program receive rave reviews, but so did the Metropolitan at the 9 Hotel, the Crawford Auto/Air Museum with the old time carousel there and the food at both the field trip and the hotel. The staff at the Metropolitan at the 9 went out of their way to make sure that our meeting was amazing, even to the point of providing free coffee service for all three meeting days! We absolutely cannot praise the staff of the hotel enough!!

The field trip to the Crawford Auto/Air Museum on Thursday evening gave attendees a chance to relax after the first day of intensive medical training and to network with colleagues and new acquaintances. Many of us enjoyed riding the beautiful restored antique carousel, taking us back to the simple joys of a beloved childhood activity. It would have been impossible to frown while riding that beautiful machine! The gorgeous cars and airplanes in the museum were amazing and interesting. Everyone seemed relaxed and happy on the bus ride back to the hotel, and a number of happy individuals continued the party up on the rooftop bar/restaurant back at the Metropolitan.

We had a blast exploring the unusual and interesting architecture of the hotel. The beautiful Tiffany glass dome over the rotunda where we had breakfast and lunch was fascinating! The old 1908 bank vaults, complete with huge safe doors, now acting as cocktail lounges were such fun to explore.

(Continued on Page 2)
This year’s medical education program contained some unusual lectures, such as Medical Marijuana and CBD Oil by Dr. Eric Baron, a case study on sepsis and diabetes by Dr. Raymond Basri (many thanks to Paul Castellani, the subject of the case study, who assisted Dr. Basri by answering questions regarding his illness, recovery, and return to flight status), a research abstract presented by Dr. Pankaj Pant of the Directorate General Civil Aviation from New Delhi, India, and three presentations by medical professionals from the Cleveland Clinic. We were honored to host medical professionals from 12 different countries, including the USA. The program evaluations noted much appreciation to have the international perspective added to the discussions and Q & A sessions, particularly for the aviation medicine related subjects and the panel case reviews.

Dr. Gerald Dubowitz gave a fascinating keynote speech regarding his work and adventures with international rescue and safety organizations. Dr. Dubowitz was awarded the Forrest and Pamela Bird Recognition Award for his “exceptional contributions to all aspects of Aerospace Medicine as a researcher and instructor in high altitude medicine and physiology, wilderness medicine, and non-invasive research techniques in cardio-respiratory function monitoring. His career has demonstrated excellence as faculty and instructor for the US National Park Service, a medical officer on a British Mount Everest Expedition, a doctor and researcher on expeditions to the Himalayas and Andes, a ski area doctor in New Zealand, and in education and research for building a peri-operative health system in Uganda. He is devoted to International air and wilderness safety, research, and rescue.”

The awards ceremony included CAMA Fellowship being awarded to Steven I. Altculer, MD, PhD, Gary E. Crump of AOPA, James L. Edwards, MD, Robert Haddon, MD, Alan M. Kozarsky, MD, David G. Schall, MD, MPH, Courtney D. Scott, Jr., DO, MPH, and Basil P. Spyropoulos, MD. Congratulations to the 2019 class of CAMA Fellows!

The Audie and Bernice Davis Award, sponsored by Harvey Watt and Company in Atlanta, Georgia, was presented to Dr. Raymond Basri for his exceptional service to the airmen in his area to assure longevity and safety in aviation, and also to the community at large. Dr. Basri donates his services during unusual and dangerous situations, such as the “miracle on the Hudson” air crash January 15, 2009, and by serving on volunteer fire crews with the Excelsior Hook and Ladder Company in Middletown, NY, and as serving as deputy Orange County fire coordinator for 19 years.

The David P. Millett Award for Oratory Excellence was presented to Dr. Andrew Miller for his comprehensive presentations regarding cardiology in aviation medicine. Dr. Miller has been a very popular lecturer at CAMA functions for many years and always makes certain that his audience receives the most updated information in cardiac diagnostic techniques and treatment modalities, both related to aviation medicine and to the public at large.

The Jim and Sammie Harris Award was presented to Dr. Robin Dodge, CAMA Historian, for his many years of devoted service to CAMA and its ideals as an officer and a trustee and for his diligence as Historian in the collection and preservation of CAMA historical records and documents. His efforts have (Continued on Page 3)
resulted in the archival of an amazing repository of CAMA documents, programs, photos, and memorabilia at Wright State University that is readily accessible to researchers, as well as via the internet.

The President’s Commendation Award was presented to Richard Ronan Murphy, MBChB, CAMA Vice President of Education, in recognition of his enthusiasm and dedication to the field of Aerospace Medicine and support of CAMA, along with his concentrated efforts to make the 2019 Annual Scientific Meeting program truly outstanding. Dr. Murphy secured terrific FAA subject lecturers and elective subject lecturers to provide the most up to date medical information regarding not only aviation medicine, but also general medicine. As we are well aware, most AMEs also serve non-aviation patients, so a well rounded knowledge of the newest aspects of patient care is essential.

CAMA presented the President’s Service Award to Dr. Warren Silberman in recognition of his commitment to aerospace medicine and aviation safety and for his outstanding service to the organization as President in 2018 and 2019. Dr. Silberman both in his work at the FAA, a CAMA Officer, and a lecturer at all of the CAMA Annual Scientific Meetings has provided essential, enlightening information to AMEs, CAMA Members, and annual meeting attendees in a thorough, interesting, and often humorous manner.

Annual Scientific Meetings has provided essential, enlightening information to AMEs, CAMA Members, and annual meeting attendees in a thorough, interesting, and often humorous manner.

Particular thanks go out to Dr. John Perry for serving as the CAMA photographer at the past three year’s annual scientific meetings. His beautiful photos of the venues, activities, and the individuals in attendance at the events are featured in this newsletter, along with other candid shots sent in by several attendees.

Pennant from the 1939 Air Races on display at the Crawford Air and Auto Museum

Field Trip Dinner at the Crawford Museum

Dr. Mark and Sarah Eidson having fun on the carousel

Dr. Leigh Speicher, Sonja Lewis, and Will Speicher enjoying the ride! Anyone notice a marked resemblance among these three? Those amazing eyes!

(Continued on Page 4)
Attendees were greeted in the hotel lobby with the CAMA logo!

Yalonda Silberman & Deb Altchuler opened registration early.

Federal Air Surgeon Dr. Michael Berry, an integral part of the meeting.

Dr. Don Walker and Dr. Daniel Danczyk—lots of networking and case discussions took place during meals.

Dr. Alex Wolbrink reliving childhood delights on the carousel.

Attendees getting to know each other during lunch

Long time CAMA AME colleagues, Dr. Heinz and Gerta Wykypiel of Austria and Dr. Joseph Laguna of Clearwater, Florida

First time AMA meeting attendee Dr. James Rycyna

Dr. Noha Emara of Cairo, Egypt, Dr. Stephen Veronneau of the OKC FAA, and Dr. Daniel Danczyk of Mayo Clinic

Dr. David Schall answers questions between lectures

Old 1908 bank vault in the bar area

Dr. Madeline Kwiatkowski appears delighted to attend her first CAMA meeting.
Gorgeous old Cleveland Air Races plane at the museum

Cleveland by night as seen from the rooftop bar

Dr. Warren Silberman and Yalonda at the carousel

View of the rotunda where we took our meals and the amazing deli downstairs

Amazing cars at the museum

Back to the Future in this DeLorean?

Dinner at the Museum

Relaxing and networking during the field trip dinner

Lovely ladies making plans to see Cleveland—Yalonda Silberman, Elaine Perry, Sarah Eidson

Sightseeing in Cleveland—Edlyne Boyer, Sarah Long, Sarah Eidson, Carol Carpenter, & Deb Altchuler

Cleveland Arcade area near the hotel

Rock & Roll Hall of Fame within walking distance of hotel

(Continued on Page 6)
Enjoying Cleveland—Deb Altchuler, Yaloda Silberman, Elaine Perry, Edyne Boyer, Leah Hale, Lisa Veronneau, and Sarah Eidson

Cocktail lounges in the old vault

Relaxing at the end of the meeting—David Hale, Dr. Andrew Miller, Donna Miller, Leah Hale, Stephen Veronneau, and Lisa Veronneau

Dr. Michael Boyer and Dr. Sydney Schneidman exchanging information

Crawford Heritage Museum site of the Thursday Field Trip

Richard McLaughlin, Dr. Kay McLaughlin and Dr. Paul Kruse exchanging ideas and information during a break in the meeting

Dr. Eric Baron and Dr. James DeVoll discussing Medical Marijuana and CBD Oil
Hello CAMA members! And, a special welcome to all International and FAA aviation medical examiners (AMEs) who, if not already submitting their applications to CAMA, we hope will be joining our roster soon. We are grateful for the support of our International CAMA colleagues through the years with members from 12 different countries represented in attendance at our recent scientific meeting. This Association stood on the shoulders of many laureates in aviation medicine in the past, who served as CAMA’s Presidents, with such notables as John Stapp, MD, and Forrest Bird, MD. These past two years we have continued to be “led from the front” by Warren Silberman, DO. Thank you, Warren, for the insightful information that you have personally provided to all AMEs for their practice, but more so, for your past two years of leadership in moving our Association forward in keeping AMEs informed on how to best keep aviators safe and flying.

A special Thank You! To our Executive Vice President, Ms. Sherry Sandoval, for her fantastic organization and venue management of the terrific CAMA scientific meeting we just completed in Cleveland OH. To our Vice President Education, R. Ronan Murphy, MBChB, for his exceptional work obtaining and scheduling a superb roster of experts for our annual Scientific Meeting addressing, “New and Emerging Treatments Relevant to Aviation Medicine.” And to Michael Berry, MD, FAA Federal Air Surgeon, and his FAA staff (Drs. James DeVoll, David Schall, Warren Silberman, Stephen Veronneau and Mr. Gary Sprouse) for providing their always welcomed podium and panel participation, and needed core material, for attending AMEs to receive FAA refresher training credit after completion of the offered FAA examination.

To understand CAMA and why we are here, some history is in order. CAMA is a non-profit International organization concerned with the safety of civil aviators. We started life post World War II as the Airline Medical Examiners Association (AMEA), from 1948 to 1955. Then in March 1955, changed our name to the Civil Aviation Medical Association and widened the scope of membership to include other aeromedical professionals beyond airline medical examiners.

CAMA became a constituent organization with the Aeromedical Association in 1955, that went on to become the Aerospace Medical Association (AsMA), from 1948 to 1955. Then in March 1955, changed our name to the Civil Aviation Medical Association and widened the scope of membership to include other aeromedical professionals beyond airline medical examiners.
As CAMA embarks on a new year, our membership will be working on initiatives developed to support fulfilling our mandate. CAMA Six Objectives:

(A) To promote the best methodology for the assessment of mental and physical requirements of civil aviators.

(B) To actively enlarge our scientific knowledge.

(C) To advocate, through continuing education, both basic and advanced civil aeromedical knowledge.

(D) To promote professional fellowship among our colleagues from allied scientific disciplines.

(E) To bind together all civil aviation medical examiners into an effective, active medical body to promote aviation safety for the good of the public.

If you have further interest in our past, our CAMA Historian, Robin Dodge, MD, notes that our rich CAMA archives are now available for discovery online through the Wright State University (WSU) Library, Dayton, OH. The CAMA material at the WSU Library has been cataloged and is available for research (e.g., CAMA news bulletins, newsletters, Flight Physician, CAMA comments in the AsMA journal and isolated CAMA relevant news items).

Link to WSU Library, CORE Scholar: http://corescholar.libraries.wright.edu/
Click on “Collections” at left sidebar
Scroll to bottom of the section to the heading: “Universal Libraries,” then to the sub heading “Special Collections,” then click on the sub sub heading “Civil Aviation Medical Association Records (MS-526)”

Your mandate? Other than participate with your other CAMA members (www.civilavmed.org), is to get out and go Fly!! One of the most important endeavors that an AME can personally become involved is to become an active participant in flying, become a pilot. As many AMEs know, there is a personalized letter available from the FAA Federal Air Surgeon that could provide a tax deduction to AME pilots for costs associated with 40 to 50 hours flying time annually to maintain flying skills, as well as owned aircraft depreciation expenses, when properly documented and described. AMEs who are learning to fly or are already pilots may contact Mr. Gary Sprouse (gary.sprouse@faa.gov) to receive a personalized letter from the FAA Federal Air Surgeon substantiating this past favorable tax decision for AMEs, to take to your personal tax professional for tax deduction consideration. As you spread your wings, seek out other associations that can additionally benefit your medical involvement in the civil aviation community such as the Aerospace Medical Association (www.asma.org) and the Flying Physicians Association (www.fpadrs.org). Consider becoming a member of the aeromedical advisory board for the Aircraft Owners and Pilots Association (www.aopa.org) or the Experimental Aircraft Association (www.eaa.org).

During the next year our objectives will continue to be worked with beneficial AME materials placed on the CAMA website. We will continue with our warm working relationship with the FAA to offer AME education, as well as to offer advice as indicated to help the aeromedical certification process continually be improved. Email me your ideas through Ms. Sandoval at our CAMA office, as we prepare for our next scientific meeting 24-26 Sep 2020, at the Hotel Albuquerque Old Town, Albuquerque, NM. I encourage our medical, human factors and equipment specialists to come forward with articles for the Flight Physician and presentations for our annual scientific meeting. Topics regarding commercial off-the-shelf (COTS) aviation hearing protection comparisons, COTS sunglasses and corrective lens comparisons at high and low light levels with age, AME office FAA color vision screening methodology discussions, and use of COTS aviation supplemental oxygen equipment comparisons would be welcomed.
PRESS RELEASE

Governor General is one of three recipients of the University of the West Indies Alumni Association Pelican Awards.

His Excellency Sir Rodney Williams, Governor General of Antigua and Barbuda, was among three recipients of the prestigious University of the West Indies Alumni Association Pelican Awards. The event, to mark the occasion, was held at Government House on Saturday, the 12th October 2019.

The Pelican Award is the highest honor an Alumni Association can bestow on an individual and is indicative of the pride that the Alumni has in the individual who has achieved success nationally, regionally or internationally. Such an awardee is considered to be a global role model for the UWI.

Sir Rodney, who graduated from the University as a medical doctor was a member of the Medical Faculty Board for the Class of 1976. He served as a member of University Council succeeding his father, the Late Ernest Emanuel Williams. They were the first father and son to serve on the UWI Council. His Excellency’s service to his alma mater continues even now in his portfolio as Governor General, having taken on the role of Patron of the UWI Global Giving Fund some years ago.

Other recipients of the Pelican Awards included Professor Gerald Grell, noted Cardiologist and the Rev Dr. William Wilberforce Watty both from the Commonwealth of Dominica. Past recipients of the Pelican Award from Antigua and Barbuda include Doctors Alford Walwyn and Jillia Bird.

In his response, Sir Rodney said that the Theme for this year’s Pelican Awards Ceremony and Chancellor’s Forum - UWI Embracing and Engaging Alumni” is very apt, since the Alumni brings persons together. He stated that its members are products of a common foundation with a common understanding and appreciation of the needs and psyche of the region.

Sir Rodney further stated that there is a need to strengthen the links between our different islands, people and the UWI. He added that since a chain is only as strong as its weakest link so too, when we strengthen the Alumni Associations in our individual countries, we fortify the entire chain of islands in the Caribbean region.

In attendance at the ceremony were His Excellency Sir W.A Tapley Seaton Governor General of St Kitts, President Charles Savarin and his wife of the Commonwealth Dominica, UWI Chancellor, Mr. Robert Bermudez and his wife, Vice Chancellor Professor Sir Hilary Beckles, many Heads of Faculty and Administration, Principal of the new UWI Five Islands Campus Professor Griffith and members of the UWI Alumni Association - Antigua-Barbuda Chapter.
2020 CAMA Annual Dues Increase

The CAMA Board of Directors and Trustees has voted to increase the CAMA annual dues for 2020 to $150.00 for an Individual Member, $300.00 for a Sustaining Member, $1500.00 for a Life Member, and $350 for a Corporate Member. Although CAMA expenses are kept to a bare minimum, the cost of office and meeting supplies, web site programming and maintenance, meeting facilities, audio-visual equipment rental, and CME certification for CAMA programs have risen in the past several years since the last dues increase. Now would be a good time to become a Life Member before the dues go up!
Today, the Federal Aviation Administration (FAA) published in the Federal Register a notice on a Diabetes Protocol for Applicants Seeking to Exercise Air Transport, Commercial, or Private Pilot Privileges. The innovative new protocol makes it possible for airline transport or commercial pilots with insulin-treated diabetes mellitus (ITDM) to potentially receive a special-issuance medical certification.

Medical science has come a long way in the treatment and monitoring of diabetes. This new medical protocol takes into account medical advancements in technology and treatment and opens the door for individuals with ITDM to become airline pilots.

Since 1996, private pilots with ITDM have been issued medical certificates on a case-by-case basis after assessing their risks. This new protocol is based on established advancements in medical science that make management and control of the disease easier to monitor thereby mitigating safety risks.

To be considered under this protocol, applicants will provide comprehensive medical and overall health history, including reports from their treating physicians, such as their endocrinologist. They will also provide evidence of controlling their diabetes using the latest technology and methods of treatment being used to monitor the disease.

The FAA developed the new protocol based on the reliability of the advancements in technology and treatment being made in the medical standard of care for diabetes and on input from the expert medical community.

Public comment on the new protocols closes 60 days from the date of publication. The new protocols are effective November 7, 2019. However, the FAA may revise the new protocol based on comments.

Contact: Marcia Alexander-Adams
Email: marcia.adams@faa.gov

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Echography is an important method for evaluating an eye with opaque media. It can yield information not obtainable by any other method. The contact method is used to evaluate the posterior segment. In those cases in which the anterior segment needs to be evaluated, immersion technique or UBM can be performed. However, these later methods require additional training or additional instruments and software.

Inverted globe scan is a transverse anterior scan taken further anterior to bring a quick view of the anterior segment. It requires no additional tools, fluids, or software. It could be used in as an additional view to the normal ultrasound to give an idea about the state of the anterior segment.

Materials and Methods:

A case series study including patients who had ocular ultrasound (Sonomed) examinations in Al Mashreq Hospital between November 20, 2018, and August 4, 2019, and had either a history of rupture globe, multiple surgeries, or came with opaque cornea and gave a vague history. A total of seven with one normal case with clear media was taken as control. The diagnoses were further confirmed by surgeries for these cases.

The scan technique:

Introduction:

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The scan technique:

Patient is positioned properly for echographic examination. The examined eye is near the screen, so that the echogram and probe position can be simultaneously monitored. Patient is then asked to look as far nasal as he possibly can, then the probe is put on the lateral orbital rim, resting on the zygomatic bone with 12 o’clock orientation. (Figs. 1 & 2) Generous amount of gel is used to fill any space between the globe and the probe. Starting the scan and with fine to and fro manipulation of the probe, watching the screen until the view of the anterior segment shows up. The patient may be asked to look slightly upward and medial through the scan to get a clearer view, depending on the size of the globe and its orientation with the zygomatic bone.

Results:

Case 1: (Fig. 3) (see next page)

Control case, left globe of a normal male, 40 y old with clear media. Scan shows normal anterior chamber (AC), iris (I), ciliary body (CB) and lens (L).
Case 2: (Fig. 4)

Right globe of an 18y old male, with history of multiple trauma (bomb), and vague details of primary repair. Scan shows formed AC iris and fibrosed lens capsule (LC).

Case 3: (Fig. 5)

Left globe of a 58y old male with history of prolonged glaucoma and opaque edematous cornea. Scan shows cataractous (intumescent) lens (L) with formed AC.

Case 4: (Fig. 6 and 7)

Right globe of a 60y old female, she is diabetic asthmatic and suffers from atrial fibrillation. Cornea was hazy and edematous. Scan shows shallow AC, swollen cataractous (intumescent) lens.

Case 5: (Fig. 8)

Right globe of a 38y old male, with history of recurrent uveitis with hazy media. Scan shows formed AC, posterior lens capsule thickening, and vitritis.
Case 6: (Fig. 9 and 10)

Right globe of a 51y old female, who is glaucomatous, and on antidepressants, with hazy edematous cornea. She came with a complaint of increased ocular pain. Globe was congested with high intra ocular pressure. Scan shows swollen lens pushing the iris forward with shallow AC.

Advantages of the technique:
It is easy to perform with a short learning curve. It does not cost further than the normal B-scan. We can get much more information with a few simple manipulations of the probe.

Drawbacks of the technique:
If the globe is small or sunken into the orbit it will not be possible to obtain. Also it needs co-operation between the examiner and the patient, but so are most of the examinations. However, on doing multiple exams using this technique it will get better.

Conclusion:
It is hoped that the inverted globe scan will help practitioners extend the limits of their normal ultrasound scan. This scan could get better evaluation for the state of the eye, especially in trauma cases with vague history, in a more quick and affordable way. It is not an alternative to UBM though.

References
1. Byrne SF, Green RL. Ultrasound of the eye and orbit. 2nd ed. St. Louis: Mosby Year Book; 2002
ORIGINAL RESEARCH - ABSTRACT

Original Research Performed by:
Gp Capt. Keshavamurthy G
Gp Capt. P. Pant
Grp Capt. MPS Marwaha

This Abstract was presented at the CAMA Annual Scientific Meeting by Dr. Pankaj Pant, MBBS, MD, MED DTE, Directorate General Civil Aviation, Aurobindo Marg, New Delhi, India. (See CAMA web site at www.civillavmed.org, “Archives” tab, to view Dr. Pant’s lecture slides and abstract graphics.

PREVALENCE OF HYPERTENSION AND OBESITY IN CIVIL AVIATION PILOTS IN INDIA AND THEIR CORRELATION: IS IT TIME TO CHANGE FITNESS CERTIFICATION GUIDELINES?

INTRODUCTION:
Hypertension (HT) is a common cardiovascular disease with prevalence 20-24%. Obesity has reached epidemic proportions. Their prevalence and correlation in Indian Pilots not studied.

METHODS:
In a cross sectional observational study, 1185 consecutive civil pilots who underwent routine medical examination were included after due consent, necessary permission and ethics committee approval. Height, Weight and Blood Pressure (BP) were measured. BMI calculated. Ambulatory blood pressure monitoring was recorded before final diagnosis of HT or White Coat Hypertension (WCH). They were also analysed as per new ACC/AHA criteria of 2017. The data were also analysed for overweight and obesity as per Asia - Pacific guidelines for the region.

RESULTS:
A total of 1185 pilots were studied. The mean age of the pilots was 34.8±13.7 years, with 91.4% males. The highest number of hypertensives was noted in 26 to 35 years age group! Eighty-nine point one percent had normal casual office BP; 10.9% had average casual BP ≥ 140/90 mmHg. After 24 h ABPM, 4.1 % had HT; 6.8% had WCH. As per ACC/AHA criteria, 18.7 % had HT (additional 14.6 %). Additional 6.2% qualified for drug therapy. 39% were overweight and 7.3 % were obese. When Asia Pacific criteria applied, 46.3 % were obese and 23.3 % overweight . When BMI ≥ 23, likelihood of hypertension increased [OR 2.432; 95% CI 1.050 - 5.632, p < 0.05].

DISCUSSION:
The prevalence of Hypertension in our civil pilots was 4.1 %; much less compared to general population but consistent with a Chinese study where it was 4.96%. However, it increased to 18.7% if new criteria were applied. Additional 6.2 % qualified for medication. Are we allowing pilots with increased ASCVD risk to fly thereby compromising flight safety? There is no similar study published on the prevalence of HT as per new criteria.

The prevalence of obesity was 7.3% and overweight 39%; consistent with those in urban population where it is 30-65%. However, they increased to 46.3% for obesity and 23.3% for overweight when Asia Pacific standards were applied. There is no study which has examined such prevalence rates.

CONCLUSIONS:
The risk of developing Hypertension increased with BMI > 23 kg/m2 (OR 2.43). Hence therapeutic life style measures should be instituted at BMI of 23 and not to be delayed till it reaches 25 which is the current practice. Change in practice and use of new criteria for HT and Asia Pacific Criteria for obesity needed to reduce morbidity amongst pilots in the interest of flight safety.

LEARNING OBJECTIVES:
Assessment for medical fitness certification of pilots is currently on JNC VIII criteria. The new ACC/AHA criteria of 2017 will be required to be adapted gradually in the interest of flight safety. Similarly region specific overweight /obesity criteria need to be adapted in South Asian countries to address this menace which is the substrate for other illnesses like Hypertension, Diabetes and Cardio vascular diseases.

The Article was published recently in the ‘Aerospace Medicine and Human Performance’ Journal Vol.90, No.8 August 2019 (Pg. 703-708).
ABPM Increases Flexibility for Diplomates by Combining Lifelong Learning and Self-Assessment Requirement into a Single Continuing Medical Education Requirement

Expanded Eligibility Recognition Serves as Step Toward Single Accreditation System
Chicago, IL, August 30, 2019 (from the ABPM web site www.theabpm.org)

The American Board of Preventive Medicine (ABPM) announced today that, as a first-step toward a comprehensive overhaul of its Maintenance of Certification (MOC) program, the ABPM Board of Directors has approved a revision to its current MOC Part II requirement by combining MOC Part IIA, Lifelong Learning and Self-Assessment (LLSA) and MOC Part IIB, Continuing Medical Education (CME) into a single, comprehensive MOC Part II requirement.

Specifically, diplomates will no longer be required to complete a minimum number of ABPM-approved LLSA credits in order to complete MOC Part II. Instead, beginning on February 1, 2020 and during each ten-year Certification Cycle, a Diplomate’s total of 250 MOC Part II credits can include any combination of LLSA and AMA PRA Category 1 CME credits (or their equivalent).

In announcing this new policy, the ABPM’s Board Chair Hernando “Joe” Ortega, Jr., MD, MPH, said “The ABPM is pleased to offer our Diplomates a simplified and less burdensome MOC Part II requirement.” Dr. Ortega went on to say that “Since there will be no required minimums for either type of credit, Diplomates will have the flexibility to choose between and amongst the various LLSA and AMA PRA Category 1 CME credits that best fits their practice. Our doctors can select the CME offerings that will be most effective and impactful in achieving their individual learning goals. This is a small, but important step on the ABPM’s journey toward a Continuing Certification program that incorporates the recommendations of the ABMS Vision Commission and, more importantly, is responsive to feedback from our Diplomates.”

The process by which Diplomates will be able to obtain MOC Part II credit from the ABPM will remain unchanged. Diplomates must forward certificates/transcripts for completed LLSA and/or CME credits to the ABPM office at moc@theabpm.org.

Any questions about this updated policy can be directed to the ABPM Staff at abpm@theabpm.org.

The ABPM is a Member Board of the American Board of Medical Specialties (ABMS). Founded in 1948, ABPM works with the ABMS in the development of standards for the ongoing assessment and certification of over 12,000 physicians certified by the ABPM in the Specialties of Aerospace Medicine, Occupational Medicine, and Public Health and General Preventive Medicine, and in the Subspecialties of Addiction Medicine, Clinical Informatics, Medical Toxicology and Undersea and Hyperbaric Medicine.

Editor Note: Discussion with the ABPM has clarified that the CME assessed each year by the AAFP for the CAMA Annual Scientific Meeting program will be sufficient to satisfy ABPM MOC requirements, since it is accepted as the equivalent of AMA PRA Category 1 CME credits, as outlined above. This will simplify the process of approval of our Annual Scientific Meeting programs to fulfill both CME and MOC requirements with our verification of attendance/participation at the meeting and the CME certificates provided by CAMA for attendees. The “three self-assessment questions per hour” requirement has been revised, so it will no longer be necessary for CAMA to augment the FAA AME recertification test for subjects not specifically included in the FAA core curriculum. If you have questions, please contact Kevin Patrick, MOC Manager, American Board of Preventive Medicine, 111 West Jackson Blvd, Suite 1340, Chicago, IL 60604
Imagine the distress of an airline passenger when the seatbelt sign is illuminated and an overwhelming urge to urinate presents. This is even more disconcerting for a pilot when such urges may present at critical phases of flight. Urinary urgency, defined as the sudden and compelling desire to urinate which is difficult to defer, is a classic component of the clinical syndrome of overactive bladder (OAB). OAB symptoms often also include urgency urinary incontinence (UUI), urinary frequency, and nocturia.

OAB is an exceedingly common condition with an overall prevalence in the United States estimated to include 16.0% of men and 16.9% of women. However, global population-based studies have indicated rates may actually be as high as 27% in men and 43% in women. In general, OAB is secondary to a failure of the bladder to store urine passively. A variety of anatomic and physiologic deficits may contribute to OAB symptoms, including age, neurologic disease, a history of pelvic surgery, prior pelvic radiation, diabetes, bowel issues, as well as an array of medications. As the defects noted in any individual patient are accumulated insults, it is often complex to discern the true etiology of the bladder storage systems, thus most OAB is termed “idiopathic.”

In order to accommodate normal urine volumes and maintain continence via the viscoelastic properties of the detrusor muscle and connective tissues, filling must occur at low intravesical pressures. Such low pressure filling additionally protects the upper urinary tracts. Appropriate sensations of filling must also be present, which are distinctly sensitive to neurovascular insults. Any defect in the neurophysiology of bladder relaxation or contraction can result in disorderly storage and micturition reflexes. As a brief primer, urine storage is facilitated by the sympathetic nervous system stimulating β-3 adrenergic receptors (β-3 AR) in the detrusor via norepinephrine. Voiding is precipitated by stimulation of the parasympathetic muscarinic receptors via acetylcholine. All our contemporary pharmaceutical targets for OAB treatment are based on these primary pathways. The somatic system is additionally involved to either contract or relax the internal sphincter, dependent upon which autonomic system is activated.

OAB symptoms present a very substantial impact to patient’s quality of life both in terms of impairment in undertaking daily activities, but moreover the profound psychosocial implications and associated costs. Patients with OAB may experience social isolation, depression, increased caregiver burden, skin breakdown, sleep disturbance, increased risk of urinary tract infection, sexual dysfunction, and an increased risk of mortality.

Diagnosis and treatment of OAB is performed in a stepwise fashion from least to most invasive and predicated on guidelines created by the American Urological Association. (6-8) (See Figure 1 on Page 18)

Basic evaluation includes a dedicated history, physical exam, and urinalysis designed to be performed by primary providers without the requirement for subspecialty expertise to begin treatments. For patients presenting with complaints of OAB, critical aspects of the history include the frequency of voids during the day and night, degree of urgency, presence of incontinence, and degree of bother. A range of conditions with symptoms overlapping OAB remain in the differential diagnosis, including urinary tract infection, stress urinary incontinence, bladder outlet obstruction, overflow incontinence, or even malignancy. Comorbid processes impacting the urinary tract, particularly bowel issues such as constipation, prostatic enlargement, or use of medications such as diuretics should be elucidated.
Another component that will assist with both evaluation and management is developing an understanding of the patient’s fluid intake. Do they consume large amounts of bladder irritants such as caffeinated beverages, acidic fruit juices, or alcohol? Many patients with OAB unfortunately restrict fluids in an effort to decrease their urinary frequency/urgency which should not be endorsed.

A physical exam should be performed with focus on the abdominal and pelvic components. In men, a genitourinary exam includes assessment for penile pathology and digital rectal exam to evaluate for prostatic enlargement or nodularity. In women, assessment of vaginal epithelial atrophy and pelvic organ prolapse are essential. A focused neurologic exam to assess sensation and muscle function of the pelvic floor as well as cognitive impairment can often provide insight into the patient’s urinary complaints.

Urinalysis is performed in patients presenting with OAB symptoms to rule out urinary tract infection, which mimics the irritative storage symptoms of OAB, and hematuria requiring further evaluation. Additional tests which are not required to begin treatment, but which may provide further clarity, include measurement of post-void residual volume, urine cultures, intake and voiding diaries, and patient-reported questionnaires. Rarely are invasive measures to evaluate functional and anatomic abnormalities such as imaging, cystoscopy or urodynamics, indicated for the index OAB patient.

Once evaluation rules out other processes, idiopathic OAB should be considered a symptom complex as specific etiology is often elusive. Thus, treatments are directed at suppression of symptoms and improving the patient’s quality of life. Stepwise approach to management of symptoms with increasing risk/benefit ration and concomitant degree of invasiveness.

First-line therapy includes behavioral counseling to assist patients in understanding normal bladder function and relationship of fluid intake to warning
time prior to voiding. Many aspects of OAB symptoms may improve with such behavioral interventions such as timed voiding, modification of fluid intake, reduction of bladder irritants, weight loss, ameliorating difficulty in toileting, and urgency suppression techniques.(9) Often such patient-centered interventions are combined with second-line pharmaceutical treatments.

Medications are a mainstay of second-line therapy for treatment of OAB symptoms and multiple options are currently available. Anti-muscarinic and the β-3 adrenergic receptor agonist mirabegron are the general classes with demonstrated efficacy in OAB.(10,11) Some situations advocate combination therapy with both medication classes when patients have failed single-drug therapy.

Anticholinergic medications utilized for OAB potentiate therapeutic effect by binding to the muscarinic receptor in the detrusor muscle and decreasing contractility. Unfortunately, although innovations have developed compounds with higher bladder specificity, no substantial difference in effectiveness is noted between agents and as a class the side effect profile can be profound.(10) Common side effects of antimuscarinic agents include dry mouth, dry eyes, constipation, and blurred vision. Additionally, due to the mechanism of action in relaxation of the detrusor during contraction, there is a distinct risk of urinary retention with use of anticholinergics.

Additional contemporary concerns related to all anticholinergic medications is the potential relationship to the development of dementia.(12, 13) Emerging evidence in several case-control studies indicate anticholinergics utilized for urologic indications are associated with the future incidence of dementia. The exposure period only slightly increases the odds ratio for development of dementia, indicating duration of treatment as low as 3 years imparts risk. If these associations between anticholinergics and dementia are eventually determined to be causal, this medication class may account for up to 10% of diagnoses. Patients should be counseled regarding these risks of cognitive impairment and dementia. Likewise, prudent use of the lowest effective dose for a minimal duration while decreasing dosages of other anticholinergics is recommended.

With regards to issuance of airman medical certificates, due to the side effect profile, anticholinergic medications are not allowed and disqualify the applicant (Do Not Issue). (14)

This is the case for the entire class of antimuscarinics, including those with limited passage across the blood-brain barrier (tros pem). A novel class of medications indicated for OAB has emerged over the past several years, the β-3 adrenergic receptor agonists.(15) β-3 agonists exert effect by relaxation of the detrusor muscle during filling. Common side effects include hypertension and headaches, although the initial clinical trials reported only a very modest increase in systolic pressure. The most common bothersome side effects of the antimuscarinics, namely dry mouth and constipation, occur less frequently with β-3 agonists, making them generally more tolerable. Likewise, the mechanism of action does not impact parasympathetic activation of bladder emptying, so β-3 agonists are often a preferred choice for men with any element of comorbid outlet obstruction or incomplete emptying from prostatic enlargement.

For airman medical certification, β-3 adrenergic receptor agonists are allowed but require a 2 week observation period and physician status report.

Third line therapies are indicated for patients who have failed or are intolerant of the side effect profiles of medical therapy. In general, these are all mechanisms of neuromodulation, impacting both motor efferent and sensory afferent input to the bladder that is disrupted in patients with OAB.

Percutaneous tibial nerve stimulation (PTNS) is an office-based procedure where stimulation of the peripheral nerve provides input to the bladder and pelvic floor innervation.(16) Patients present for relatively non-invasive treatment for 12 weeks for 30-minute sessions. Although the procedure is very low risk, the efficacy may be modest and wane over time.

Sacral nerve stimulation is the surgical implant of an electrode into the S3 sacral foramen through a percutaneous approach.(17) A generator implanted in a staged procedure after assessing efficacy provides a programmable electrical current and impact both efferent and afferent bladder innervation. The current devices are approved for OAB symptoms of urgency, frequency and urgency incontinence as well as fecal incontinence and non-obstructive urinary retention. Sacral neuromodulation is a remarkably effective and durable option for patients with medication refractory OAB, but currently does have some limitations with regards to spinal MRI and need for revision/generator replacement.

(Continued on Page 20)
Currently there is no direct FAA guidance with regards to tibial nerve or sacral neuromodulation implants, and petition for a special issuance would be necessary.

Intradetrusor injection of onabotulinum toxin-A (Botox) prevents release of acetylcholine from the parasympathetic nerve terminals, thus decreasing contractility and many of the sensations associated with OAB. (18) Botox in generally administered endoscopically in the clinic environment with local anesthesia. Botox can diminish both volitional and involuntary contractility, carrying a risk of urinary retention requiring self-catheterization for a period following injection in a small percentage of patients. Overall, Botox may provide symptom relief for many months. Botox has demonstrated excellent ability to suppress OAB symptoms, however patients must be able and willing to perform intermittent catheterization, be vigilant for potential urinary tract infection, and be willing to undergo repeat injections.

Botox for bladder indications is an allowed medication, however the airman is counseled no flying for 72 hours after each injection.

Patients with end-stage symptoms, particularly when impacting renal function, may be candidates for urinary diversion procedures which either augment the bladder capacity with a detubularized bowel segment, or completely eliminate urinary storage with cystectomy.

With the exceptional prevalence of OAB which is increasing with our aging population, these patients are going to be present in virtually every physician’s practice and are hopefully not sitting in the window seat next to you. Overall attention to the often-hidden symptoms of OAB can facilitate care for this condition with tremendous quality of life improvement and the tools to begin evaluation and treatment are in every clinician’s armamentarium.

References


14. Federal Aviation Administration: https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/pharm/[


NOTE: The articles published in this newsletter are presented for informational purposes and topics of discussion and do not necessarily represent the opinions or recommendations of the Civil Aviation Medical Association.

CAMA Refund Policy

As of 01/01/2018, the cancellation/refund policy with regard to Annual Scientific Meeting registration fees and guest fees is as follows:

1) If a refund is requested due to cancellation of attendance prior to the catering guarantee date (normally 2-3 weeks prior to the first day of the meeting – it varies by hotel, caterer, and location), 10% of the total registration fee amount, or $50.00, whichever is greater, will be withheld to cover bank and service processing fees.

2) If a refund is requested due to a cancellation of attendance after the catering guarantee date, the cost of the meals will be withheld from the refund, plus 10% of the total registration fee to cover bank and service processing fees.

3) Dire or unusual circumstances which require cancellation/refund (attendee and/or guest fees) after the guarantee date will be determined on a case by case basis (death in the immediate family, accidents, emergency surgery, etc.), but the 10% fee will be applicable in all cases.

4) The cutoff date for the guarantees will be shown on the registration form for each year, so that there will be no misunderstandings.
Recap—2019 Annual Scientific Meeting in Cleveland, Ohio

Our 2019 annual scientific meeting at the Metropolitan at the 9 Hotel was a resounding success! The Metropolitan was an unusual and excellent venue for our annual meeting! Cleveland proved to be an amazing city—several annual meeting attendees decided to stay over after the meeting in order to tour and enjoy the beautiful city.

While each annual scientific meeting is unique, this year’s meeting was a bit unusual in that we had more international participation than in some of the previous years. Everyone seemed to have a terrific time, and all promised to attend next year’s meeting in Albuquerque. Check out the lecture slides from the educational portion of this year’s meeting, now posted on “Archive” page of the CAMA web site (www.civilavmed.org).

Membership Renewal Fee Changes for 2020

The CAMA Board of Directors and Trustees has voted to increase the CAMA annual dues for 2020 to $150.00 for an Individual Member, $300.00 for a Sustaining Member, $1500.00 for a Life Member, and $350 for a Corporate Member. Although CAMA expenses are kept to a bare minimum, the cost of office and meeting supplies, web site programming and maintenance, meeting facilities, audio-visual equipment rental, and CME certification for CAMA programs have risen in the past several years since the last dues increase. Now would be a good time to become a Life Member before the dues go up!

2019 In Review

CAMA is ending a very productive and successful year with the Annual Scientific Meeting recently held recently in Cleveland, OH. Our organization has become more involved in resolving issues facing not only AMEs, but also pilot organizations and Federal agencies such as the FAA. CAMA is widely respected for its representation of aeromedical professionals, as well as its extensive educational programs at CAMA Sunday, the CAMA Luncheon during AsMA, and the CAMA Annual Scientific Meeting. Our publication, “The Flight Physician,” is not only entertaining, but educational, as well.

The first event of 2020 will be the Winter CAMA Board Meeting on February 22nd at the Hyatt Place Hotel at DFW Airport. CAMA members are always welcome to attend and observe board meetings, and if you are interested in serving on the various committees that plan activities (both immediate and long range), work on educational programs, nominate officers and trustees, make recommendations for awards, encourage communications and membership, determine changes to the CAMA Bylaws, etc., please let the CAMA Home Office know. We are always in need of articles, case studies, photos, and other information of interest to AMEs and other aeromedical professionals for publication in “The Flight Physician.” Your experience and expertise is invaluable to others in the organization.

Membership renewal is now open for 2020. The individual and corporate membership forms are found on the last two pages of this publication and can also be found on the CAMA web site at www.civilavmed.org. Please take a few moments and fill out your membership form for 2020 and send it to CAMA via email, fax, or regular mail. The most secure method of sending information, forms, and materials to CAMA is via email or fax. Both are protected, secure connections. If you are hesitant to send credit card information in either of these modes, send the form(s) and call the CAMA Home Office to give your credit card information over the telephone.

Our focus for the remainder of this year will be on finalizing the details of the next Annual Scientific Meeting in Albuquerque, New Mexico, September 24-26, 2020, and on determining a location for our 2022 meeting. Suggestions for hotels and cities for future meetings are much appreciated, especially if you have had a positive experience in a particular facility. Bear in mind that accessibility to an International airport is a critical factor in choosing a meeting location.

The Aerospace Medical Association (AsMA) Annual Scientific Meeting 2020

The AsMA Annual Scientific Meeting will be held at the Hyatt Regency Atlanta Hotel, 265 Peachtree Street NE, Atlanta, GA 30303, Sunday May 17th through Thursday, May 21st, 2020. CAMA will sponsor the CAMA Sunday program and the CAMA Luncheon (Monday the 18th) and will host an exhibition table for the duration of the meeting.
Membership forms, annual meeting programs and registration forms, and other information will be available. Please stop by the CAMA table if you are at the AsMA meeting.

**2020 Annual Scientific Meeting in Albuquerque, New Mexico**

The Hotel Albuquerque Old Town will be the site of the 2020 Annual Scientific Meeting. The hotel is situated right in the middle of the Albuquerque, New Mexico, Old Town shopping and restaurant area, with various museums and points of interest within a short walking distance of the hotel.

The Albuquerque CAMA annual scientific meeting will be held from Thursday 09/24/20 through Saturday 09/26/20. This is shortly before the 2020 International Balloon Fiesta in Albuquerque, so those who attend the meeting may wish to block off some days after the meeting to participate in the balloon festivities, sightseeing, shopping, hiking, or indulging in the amazing New Mexico cuisine! Santa Fe and Taos are a short ride north of Albuquerque, and there are a number of Indian pueblos nearby for sightseeing and shopping.

Our Thursday field trip will be to the Anderson Abruzzo Albuquerque International Balloon Museum, where we will tour the various colorful and interesting exhibits covering the history of balloon flight and the various hot air vehicles used over the years. Our dinner will take place on the second story of the museum (there is an elevator), overlooking the incomparable views of Sandia Mountain and Balloon Fiesta Park.

**2021 Annual Scientific Meeting in San Antonio, Texas**

The 2021 Annual Meeting will take place September 23-25, in San Antonio, Texas, at the new Embassy Suites at the old Brooks Air Force Base. Brooks Air Force Base was a US Air Force facility, located in San Antonio, Texas. President John F. Kennedy dedicated the School of Aerospace Medicine on November 21, 1963, the day before he was assassinated in Dallas, Texas. This was Kennedy's last official act as president.

The School of Osteopathic Medicine is on 16 acres in the northwest part of Brooks City Base (at 100 Kennedy Circle), in buildings which were once the Air Force School of Aerospace Medicine. Classes began in August 2017.

The USAF at Brooks City-Base in San Antonio, TX, operates a human centrifuge. The centrifuge at Brooks is operated by the aerospace physiology department for the purpose of training and evaluating fighter pilots and Weapon Systems Officers for high-G flight in Air Force fighter aircraft. Today the Brooks complex houses the AFRL Department of Hyperbaric Medicine and the Davis Hyperbaric Laboratory. As part of our field trip during the Annual Meeting, we hope to be able to tour the centrifuge and pressure chamber areas.

We wish each of you a joyous and prosperous holiday season and new year, and we look forward to working with you in the coming year to pursue the CAMA goals of education and support of aeromedical and aviation professionals.

**RAYMAN’S CLINICAL AVIATION MEDICINE**

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The price for the book is $25.00, plus $8.00 postage in the U. S., $26.00 to Canada, and shipping rate to other locations outside of the U. S. is variable. (NOTE: The postage rates may change effective January 2020). Payable by check, VISA, MasterCard, or American Express.

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The financial resources of individual member dues alone cannot sustain the Association’s pursuit of its broad goals and objectives. Its fifty-plus-year history is documented by innumerable contributions toward aviation health and safety that have become a daily expectation by airline passengers worldwide. Support from private and commercial sources is essential for CAMA to provide one of its most important functions: that of education. The following support CAMA through corporate and sustaining memberships, and we recognize the support of our lifetime members:

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CAMA is very pleased to announce a number of new members to our organization since our last publication. We welcome the following physicians and organizations into CAMA, and we look forward to working with each of them over the coming years.

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<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Specialty/Medical Practice</th>
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<tbody>
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<td>Robert L. Gear, III, DO</td>
<td>6817 N. 57th Place</td>
<td>Senior AME, Pilot, Specialty: Family Practice/OSTEOPO. Manipulative treatment</td>
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<tr>
<td>Gregory L. Kirk, MD</td>
<td>2036 East 17th Avenue</td>
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<td>Madeline Kwiatkowski, DO</td>
<td>2 South 484 White Birth Lane</td>
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<td>Nicole Owolabi, MBBS, FRCEM</td>
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