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Aviation Safety Through Aerospace Medicine

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For FAA Aviation Medical Examiners, Office of Aerospace Medicine Personnel, Flight Standards Inspectors, and Other Aviation Professionals.

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HEADS UP

New AMCS Version Being Prepared

You asked for it, and you got it! The new version of the Internet Aerospace Medical Certification Subsystem is about to arrive!

By Warren S. Silberman, DO, MPH

ONE MORNING in late September 2005 you will navigate to our AMCS Website, and you will not recognize what you see.

It is hard to believe, but all the comments on our system we received via E-mail, mail, face-to-face conversations, and aviation medical examiner (AME) seminars have been evaluated, combined, and we are preparing to roll out the new, improved version of the on-line software! Currently, we are beta-testing the program with several volunteer AMEs, regional medical offices, and our headquarters in Washington, DC. When we evaluate their suggestions, we will implement some and prioritize others for future enhancements.

Yes, folks, this new version includes many improvements that you recommended, some of which are described in this article. We will also post an on-line user's manual to help you navigate the new pages.

Continued on page 6

RESOURCES FOR AMEs

New Medications Brochure in Mail

By Mike Wayda

A new pilot safety brochure, *Medications and Flying*, is on its way to all aviation medical examiners' offices. Information in the brochure alerts pilots to the dangers of taking over-the-counter and prescription medications while flying. Common side effects of various medications are described.

The Medications and Flying brochure is a result of the National Transportation Safety Board's request after finding that fatal aircraft accidents occurred as a direct result of pilots' use of prescription and over-the-counter medications during flying duties. A recent study by the Civil Aerospace Medical Institute found that, from 1999 to 2003, about 52% of 1,587 pilots killed in fatal aircraft accidents had some type of medication in their system. This statistic does not imply that taking various medications necessarily caused the fatal accidents, only that the substances were found in the accident victims. However, it does identify an association between medications and fatal accidents.

A supply of the brochures is being sent to each AME, and more will be available to order if needed. A copy of the brochure's content is on page 8 and is also available online at the FAA Web site (www.faa.gov/pilots/safety/pilotsafetybrochures). You can easily print copies from this site if you run out of the brochures.

Paired with the brochure is a poster announcing the availability the brochure and encouraging pilots to ask you about it. Please consider printing the poster (also available for download from the Web site) and displaying it prominently in your office.

Medications and Flying: *Let's Get the Word Out*

The Federal Air Surgeon's Column

By Jon L. Jordan, MD,

DEALING WITH ISSUES related to use of medications by airmen has often proven to be a complex and, therefore, frustrating experience for both aviation medical examiners (AMEs) and those of us in the Federal Aviation Administration (FAA) who must make medical eligibility decisions. The extensive number of medications, including both over-the-counter and prescription medications is mind boggling, to say the least.

From time-to-time we have been urged to create a comprehensive "list" of either disqualifying medications or medications that might be used safely while performing aviation duties. While we have identified categories of medications that we consider either acceptable or unacceptable and have done the same for certain individual medications, we have for a number of reasons resisted the urging for a comprehensive list. These reasons include the formidable and labor-intensive task of developing and keeping current an easy-to-understand source document for medications and the resources such an effort would consume.

There are thousands of prescription and over-the-counter medications currently on the market, and hundreds of new medications approved by the Food and Drug Administration each year. Considering issues related to the underlying conditions for which medications are used, drug interactions, medication dosages, and the shear number of medications, it is unlikely that a source document could be developed and accurately maintained that would be used or clearly understood by airmen.

In spite of the obstacles and reasons for not establishing a source document for medications, I recognize that the absence of clear and comprehensive information on medications is problematic for both aviation medical examiners (AMEs) and airmen. To clarify the acceptability of certain medications, we provide information in the *Federal Air Surgeon's Bulletin* and various other publications, at seminars for AMEs and airmen, and in the *Guide for AMEs,* which, as you know, is available on the FAA Web site.

Recently, the National Transportation Board recommended that FAA develop, then periodically publish, an easy-to-understand source of information for pilots on the hazards of using specific medications when flying. This recommendation was an outgrowth on an observation that in many surface and aviation accidents investigated by the NTSB, the use of a licit medication by a vehicle operator has been causal or contributory to the accident.

The FAA's response to the NTSB recommendation indicated the belief that FAA's educational programs and regulations currently in place address the safety issue regarding medication use. We pointed out the various educational initiatives underway, including the planned development of a new brochure to expand information on over-the-counter and prescription medication and their impact on flying.

This response satisfied the NTSB, contingent on their review of the brochure and acceptability of a distribution plan that would ensure that pilots are provided a copy of the brochure. You will find elsewhere in this issue of the *Bulletin* a copy of the brochure [see page 8]. We will be printing and distributing the brochure very soon, but we need your help to make certain that applicants for medical certification are knowledgeable of the dangers of use of certain medications and have access to the brochure.

We are also making available, for the first time, a poster that you can choose to display in your office to pique airmen's interest in this brochure (see related article on page 1 of this issue).

I am completely in agreement with the NTSB regarding the safety issue presented by airmen who use over-the-counter or prescription medications that may negatively impact safety. It is important, therefore, that we caution airmen about the use of such medications. I trust that you, as aviation medical examiners, will do your part in raising the visibility of this issue to airmen and assist in this important safety initiative.

JLJ

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QUICK FIX

Order Forms and Supplies Early!

Problem: The Federal budget is very tight these days. One of the direct impacts on the Aviation Medical Examiner (AME) program has been a severe limitation in our funds for express mailing of forms and supplies. Since we are limited to regular mail service, it can take a long time for ordered items to reach their destinations— as much as three months for some overseas locations.

Result: Those AMEs who run out of forms and supplies may have to cancel applicant examinations (if examination forms are the problem) or use their own envelopes or postage (if these are the problem). Alternatively, if quick delivery is essential, we can send by priority mail or Fed Ex only if the AME provides the appropriate billing information; we cannot bail you out any other way.

Solution: For AMEs, the most likely fundamental problem is a failure in inventory management. You all know your historic or anticipated volume of work and how much of each form or other supplies you have on hand. You also know the average amount of time it takes to receive packages by routine mail coming from Oklahoma City or your regional office. It should be a simple matter to do the math and allow enough time to order and receive everything before you run out. If your mail services are unpredictably sporadic, you are welcome to "pad" the supplies on hand or to order earlier than might otherwise seem necessary. In this case, we recommend that:

- Domestic AMEs order when two-thirds of supplies have been used.
- International AMEs order when they have reached 50%.

We want to provide you the best level of service we can, but please give us the opportunity to do so by your planning ahead.

QUICK FIX

Training Delinquencies No Longer Tolerated

Problem: On July 22, 2005, ten percent of all non-military Aviation Medical Examiners (AMEs) were delinquent in meeting the training requirements mandated in FAA Order 8520.2E.

Apparently, many AMEs do not understand that it is their responsibility to obtain training at the required frequency and that Regional Flight Surgeons (RFSs) do not have an obligation to "hound" them to train. The RFSs recognize that we do not wish to lose competent AMEs, so they have been somewhat tolerant of delinquencies in training and grant extensions to AMEs who give acceptable reasons for delaying their refresher courses.

I have been lenient with International AMEs who cannot afford the expense of traveling to the U.S. for our seminars, permitting them to substitute locally attended courses relating to aviation medicine. We have always exempted military AMEs from the refresher training because the Surgeons General requested an exemption from training on the basis of the quality of their training and the experience level of their flight surgeons, and a lack of budgeted funds for our training.

I am writing this Quick Fix to advise you that the days of leniency in excusing training delinquencies may be gone. We will find it necessary to terminate the designations of AMEs who significantly lapse in their training.

Result: All FAA Designee programs were recently audited by the Government Accountability Office (GAO). The Federal Air Surgeon, Dr. **Jon Jordan**, discussed the audit results in his editorial in the last *Federal Air Surgeon's Medical Bulletin*. The AME program was identified as an example for the other 17 designee programs to use as a model for performance monitoring. A lack of good oversight of some FAA designee programs was identified. The following are consequences of this report.

- Formal internal audits of all designee programs, with reporting to at least the FAA Associate Administrator's level,
- Certain reevaluation by the GAO to determine how well we have responded to their recommendations for improvement,
- Program reviews to evaluate how well we are meeting the requirements outlined in existing guidance, and
- Training requirements will be better defined for each designee program and we will be held more accountable for ensuring that no one lapses.

I'm afraid the remedy for unacceptable delinquency will be termination of designation.

Solution: It has always been the AME's responsibility to avoid delinquencies in training. We in the Office of Aerospace Medicine do our best to help AMEs avoid becoming delinquent:

- The AME seminar schedule is published in every quarterly *Federal Air Surgeon's Medical Bulletin*.
- We send invitation letters to all AMEs within reasonable distance of each seminar warning them of an impending need to refresh.
- We record your training dates on each annual AME performance report.
- We permit distance education at the mid-point of the 6-year maximum interval between seminars.
- We schedule frequent theme seminars and rotate them around the country for your convenience.

We can't do much more. I ask all of you to plan ahead, and use all of these tools to avoid training delinquencies or risk the loss of your designations. International AMEs, please follow the instructions I have outlined in a letter to each of you, as interim guidance, while we determine what impact the GAO audit may have on you.

—Richard F. Jones, MD
Manager, Aerospace Medical
Education Division

Certification Update

Information About Current Issues

By Warren S. Silberman, DO, MPH

The following are four interesting cases that provide medical certification teaching points. These cases are examples of syncope or unexplained loss of consciousness and their various therapies — and how the FAA approaches them. Thank you for your continued interest in these case presentations. If there are any medical conditions you would like to have addressed in future articles, please let me know.

A 33-YEAR-OLD, 1st-class airman with 10,000 hours of flight time took several nurses on a flight from Wiley Post airport in Oklahoma City to Dallas Love Field. The night prior to the flight he had "not felt good" and had diarrhea. The twin propeller-driven aircraft took off and during cruise flight the pilot, who was the only pilot on board, said he did not feel well. He complained of feeling warm and was noted to be sweating. He took off his jacket. One of the nurses noted that the pilot looked at her and then his "eyes rolled back" in his head and he had a syncopal event, falling over towards her. She asked if he was okay, but there was no response. The aircraft began to roll to the left and dive. One of the other nurses had coffee that spilled on her lap. They began to scream that they were going to die. The nurse who was sitting in the co-pilot's seat grabbed the yoke, managing to level the plane from its dive and level the wings. The pilot was acting "lethargic" and not "focused." Finally, he awoke and landed at the nearest airfield. The passengers were taken to a local motel and given coffee and donuts. They were subsequently taken home in a ground vehicle.

The pilot related that he had a history of syncope, especially when he had gastrointestinal illnesses. He was just told by his treating physician that he had vasovagal syncope. He had never disclosed this to the Federal Aviation Administration, as his aviation medical examiner had told him "it wasn't important." As an AME, what do you think of this?

Note: An Authorization for Special Issuance can only be granted with verbal or written approval from the Federal Air Surgeon, one of the physicians from AMCD or the regional medical office.

Answer 1: This time, a medical incident report was completed by the regional medical office in Dallas, and an extensive medical workup ensued. The FAA denied his medical certificate for "unconsciousness without adequate explanation of cause." The workup, which included 24-hour Holter monitoring, 2 D echocardiogram, and complete neurologic evaluation, elicited no pathology. The final diagnosis was vasovagal syncope secondary to gastrointestinal upset. The airman ultimately did get his medical certificate re-issued. The medical certificate was reissued by the FAA because by the time the workup was completed and more medical history was obtained we were convinced of the diagnosis. As for the judgment of the airman to pilot an aircraft the day of the incident that is another story perhaps left up to his company.

A 55-YEAR-OLD, 2nd-class airman was driving in his automobile and the next thing he recalled was awakening at the side of the road. Since he was a commercial pilot, he underwent a complete workup. This included bilateral carotid duplex ultrasound, 2 D echocardiogram, 24-hour Holter monitoring, and a maximal Bruce stress test. All of these tests were negative. He subsequently had a head-up Tilt Table Test (TTT). At 13 minutes into the test, the airman began to have similar premonitory symptoms, nonpalpable blood pressure, and a drop in heart rate and subsequent asystole. This required some chemical resuscitation. The interpretation of the syncope was malignant cardiogenic syncope. Should this airman continue his medical certification? What would the FAA have done if the airman initially had a positive TTT then subsequently presented with a negative one?

Answer 2: Malignant neurocardiogenic syncope implies that the syncope is associated with a cardiac arrhythmia. The FAA requires that an airman not gain medical certification for 2 years after one of these events. In order to gain medical certification at the 2 year time point, the airman will be required to provide a report of current cardiovascular and neurologic status.

The main teaching point in this case is that, should an airman ask you whether demonstrating a negative TTT is grounds for granting medical certification, assuming that the initial one was positive, your response should be in the negative. The literature tells us that the body can "learn" to respond to a TTT, thus in many cases giving a negative reaction (no syncope) even after a positive one with no treatment. So, should applicants ask your advice about having a TTT in the process of a workup for syncope, tell them *no!*

Dr. Silberman manages the Civil Aerospace Medical Institute's Aerospace Medical Certification Division.

Continued ➤

3 **Airman Sky King** was a 45 year-old commercial pilot working for a small commuter company. This company was permitted single-pilot operation. On the day of the accident, the airman was flying six people from Dallas, Texas, to Westheimer Field in Norman, Okla., for an University of Oklahoma football game. While in cruise flight, one of the passengers noted that they appeared not to be heading towards Norman. She had made the trip in the past and did not observe some of the recognizable landmarks. She noted that the aircraft had turned east when she new well that Norman, OK was straight north of Dallas. The pilot disagreed and suddenly passed out. It was quite fortunate that day that one of the passengers happened to be taking flying lessons and was able to land the aircraft at a local airfield. However, the landing was wheels-up. There was minimal damage to the aircraft, and the passengers were uninjured. When the emergency technicians went through the pilot's flight bag, they found sublingual nitroglycerin! The FAA knew of a diagnosis of hypertension and hyperlipidemia but did not know of any history of angina pectoris or coronary disease. If this airman showed up in your office, what would you do?

Answer 3: Airmen with angina pectoris can be granted medical certification if they do not have any significant coronary disease, have demonstrated at least a 6-month pain-free interval, or are 6 months post-adequate inertventional treatment, provided all proper documentation and testing ultimately being approved by the Federal Air Surgeon's cardiology consultant. Several months prior to this scary event, the airman was diagnosed with angina pectoris and placed on medical therapy by his aviation medical examiner, who also happened to be his treating physician. The AME did the proper thing and deferred medical certification. However, the airman also had a residence in Arkansas, and several weeks later he went to different AME there and falsified his FAA examination. Fortunately, the AMCD discovered this and denied the current examination. Note, many airmen have examinations performed while they are on job-related travel. Of course, an AME can do nothing about airmen whose intent is to falsify their medical examination.

4 A 58-year-old airman who worked for a major air carrier operation suffered an inferior wall myocardial infarction. During the infarction, he developed complete atrioventricular block and syncope. A permanent pacemaker was eventually inserted. The airman also had a percutaneous transluminal angioplasty with stent of a dominant right coronary artery. He waited the required 6 months and provided the FAA with a negative 6-month post-event catheterization, non-ischemic nuclear stress testing, and normal post-pacemaker evaluations with no evidence of pacemaker dependency. Do you think this airman will gain medical certification? How long must he wait prior to reconsideration for his syncopal event?

Answer 4: Since this syncopal event can be directly related to his myocardial infarction and ischemia to the AV node, he was able to gain his 1st-class medical certification after review by the Federal Air Surgeon's Cardiology Panel. Even though he had had a syncopal event, it was obviously observed and even monitored. As long as there is no evidence of pacemaker dependency, which the FAA has not yet allowed in 1st- or 2nd- class airmen, the applicant should be able to regain his medical certificate. Reminder: A stent requires angioplasty; thus, a six-month observation period applies.

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URLs and You

AME Web Site Links Revised

By David Nelms

The Federal Aviation Administration has revised its Web site to comply with new design guidelines for all of the agency's organizations, including the Office of Aerospace Medicine. Thus, the Office of Aerospace Medicine was required to modify and move the Web site you are familiar with.

Although you may still be able to access the www.cami.jccbi.gov site, the information on it is not being updated, and that Web site eventually will be discontinued.

The following is a listing of URLs (uniform resource locators, or links) commonly used by aviation medical examiners:

AMCS Login
https://diws1.cami.jccbi.gov/
(available in late September 2005)

General AME Links
www.faa.gov/other_visit/aviation_industry/designees_delegations/designee_types/ame/

AMCS Support Page
www.faa.gov/other_visit/aviation_industry/designees_delegations/designee_types/ame/amcs/

Directory of AMEs
www.faa.gov/pilots/amelocator/

AME Guide
www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame_guide/

Regional Flight Surgeon Contact Information
www.faa.gov/licenses_certificates/medical_certification/rfs/

Office of Aerospace Medicine home page
www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/

Or, you can navigate to the FAA's main page, **www.faa.gov**, click on the **Licenses & Certificates** tab, and you will find the various medical certification links. Alternatively, use the **Quick Find** drop-down list at **www.faa.gov** and select **Aerospace Medicine**.

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David Nelms is a computer specialist at the Civil Aerospace Medical Institute.

AMCS from page 1

If you have recently attended an AME Basic or Theme seminar, you have heard **Jana Weems** or **Starla Jones** describe this new system. Most, if not all of the changes that were made are intuitive. You can read more about this new system by selecting the links now located on the current AMCS support page.

We will introduce even further improvements with a new Web site that will be available to all 8500-8 applicants around the end of this calendar year or early 2006! This Web site will allow the applicant to create and submit an electronic copy of their 8500-8 form. Once submitted, you will be able to access their form, with the front page already completed by the applicant. This should reduce the amount of time you have to spend keying their information in yourself. We will keep you informed of that progress in the next *Bulletin*.

Highlights of the New AMCS Version

Fewer Data Entry Pages

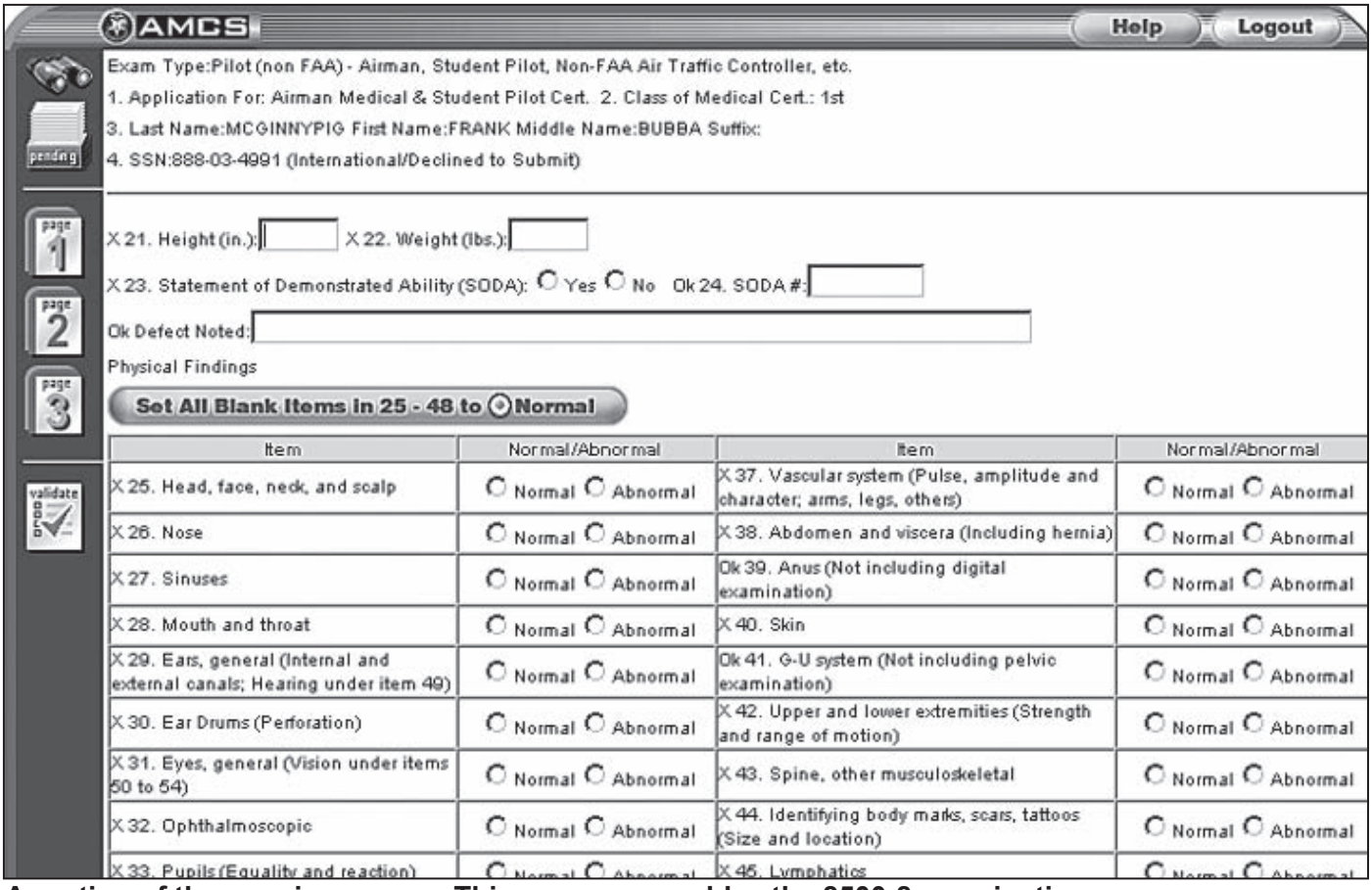
The new version has only three data entry pages instead of seven. Pages one and two represent the front and back of the 8500-8 form, while the third page represents the certificate. Where the current version forces you to move sequentially through the data entry pages, the new version will allow you to move easily between the three pages. Although the system will save any changes you make when you switch between pages or entry screens, we still recommend that you save frequently to prevent loosing information if you loose your connection. If you do have to re-enter the site, you will be able to pick up where you left off.

AME Guide Links and Improved Validation

Each question in the HISTORY AND PHYSICAL EXAMINATION now has a hotlink to the online *Guide for Aviation Medicine Examiners*.

There is validation for the numeric values that we request. This validation correlates with the class of medical that the airman requests. Therefore, if the airman requests a first-class medical examination and his corrected distant visual acuity is 20/100, the system warns you that this is out of standards. Each field displays a blue **"?",** red **"X",** or a green **"OK"** beside it.

- The **"?"** indicates that the information has not yet been validated. The **"OK"** indicates that the information has been validated and that information entered is acceptable.
- The **"X"** indicates that a required field was left blank or that an error was found with the information entered into a field during validation. Holding your mouse over the **"X"** will display text describing what is required or what the validation on that field consists of.

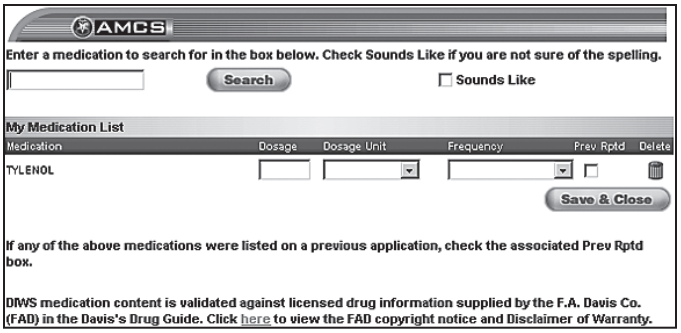


A portion of the opening screen. This screen resembles the 8500-8 examination page.

• Clicking on the **"OK"** or the **"X"** will take you to text in the on-line *Guide for Aviation Medical Examiners* that explains the type of information that belongs in a particular field.

Medication Search Tool

You will also see a new way of recording the medications (Block 17a) so that we can categorize the medications. Currently, *all* medications are rejected for review. This comes to some 99,000-plus cases per year. Because we continually try to speed up the medical certification process, this will allow us to place a check mark, so to speak, in the background for any medication that we would like to review, such as *Zoloft*, or even all the Serotonin Reuptake Inhibitors. For those of you that recall the emphasis that we have placed about recording the comments and other items on the front side of the form 8500-8 (exactly as the airman wrote/spelled them), the system will indicate the incorrect spelling along with the correct one.



Medications pop-up window for listing applicant's medications data.

How It Works

When you select the "Add Medications" button, the Add Medications window will pop up, so you can enter the name of the medication you wish to search for. Check the SOUNDS LIKE box if you are not sure of the spelling.

Click on the SEARCH button. A list of possible matches will display. Double-click on the medication name to add it to the Medication List.

Type in the dosage amount and select the DOSAGE UNIT and FREQUENCY from the drop-down lists provided. The medication and its description will populate in the COMMENTS box for Block 60 so that you can comment on the medication(s).

If the medication has been previously reported, check the box below the PREVIOUSLY REPORTED column.

Repeat this procedure for each medication listed.

Click the SAVE & CLOSE button to the save the changes and the medication(s) will display in the appropriate place on Page 1 of the 8500-8 Data Entry screens.

Click on the TRASH CAN icon to delete the associated medication from the exam.

Clicking on the ADD TO MASTER button will add the medication you searched for to the list of medications if it does not currently exist in the database.

IMPORTANT: You will be required to try both the STANDARD and SOUNDS LIKE searches before the option to add the medication becomes available. You should be certain you wish to add the medication, as it will become part of the master list.

Quick Access to Pending Exams

When you first log onto the new version, you will see a list of any pending exams you may have in the system. This will allow quick access to any exam transmissions that you have not yet completed. This will eliminate the need to search for untransmitted exams.

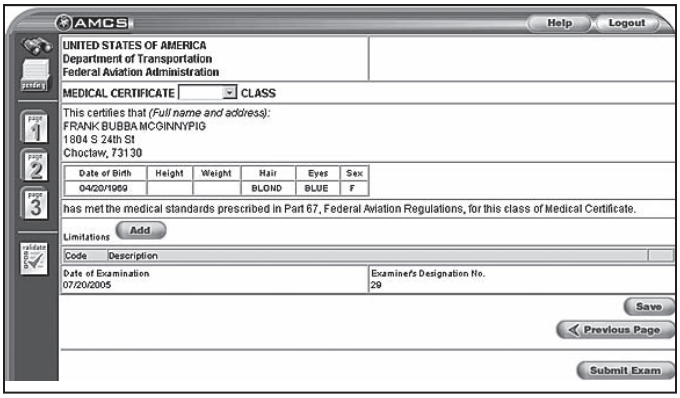
Comments Assigned to Specific Item

The new version now provides for an area to enter comments for item 18, items 25 through 48 and for block 60. Pressing one of the "Comments" buttons will launch a screen that looks similar to that shown in the ADD COMMENT graphic. This will also give you a way to easily identify conditions that are disqualifying.

System Requirements

As with any system upgrade, there is now a new set of system requirements. The new version is optimized for Microsoft Windows Internet Explorer® (version 5.0 or higher) and Netscape (version 6.0 or higher). These browsers are available for download from the Internet. You will also find that, although your existing computer system may be able to access the Web site, its performance will be significantly improved with these operating specifications:

- 233MHz or higher processor speed
- 56K modem
- 128 MB or higher RAM
- popup blockers must be turned off for this site.



Final AMCS screen for exam submission.

This new system represents a major improvement by transmitting more accurate data and processing exams faster.

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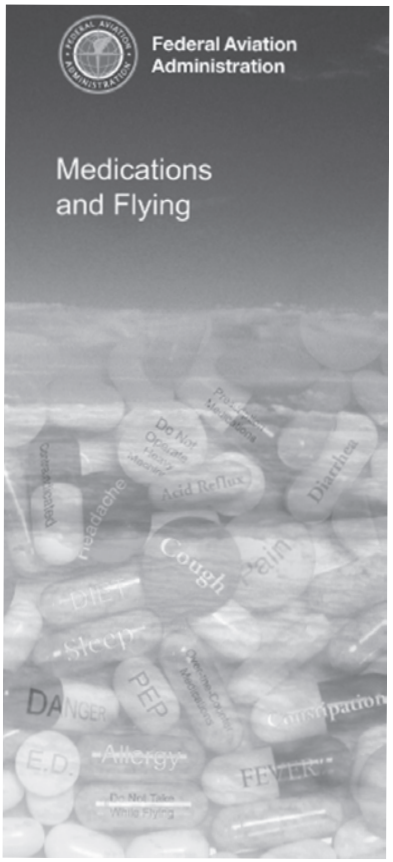
Dr. Silberman manages the Aerospace Medical Certification Division.

ANNOUNCING
A New Brochure for Pilots

This is the text of a new pilot safety brochure that is being distributed to all aviation medical examiners



Does this story sound familiar?

It's Sunday morning, the last day of a three-day trip. You have four hours of flying ahead of you to get back home, but something about the air conditioner last night has left you with stuffy nose and sinuses this morning. You know from your training and experience that flying with congested upper airways is not a good thing. As it turns out, one of the others on the trip has some new over-the-counter sinus pills that are "guaranteed" to unstop your breathing passages and let you fly without any worries about the congestion. Should you take the medication?

Another scenario

You and your spouse are on the second leg of a five-leg, cross-country flight. While visiting relatives, you stayed up late at the party they threw in your honor, ate too much, and the next morning your stomach feels sort of queasy. Your spouse, a non-pilot, offers you a common motion-sickness pill prescribed by the family doctor. Should you take the medication?

Get the facts

Just like any other decision (equipment, weather, etc.) that you must make when you fly, you should know all the facts before you can answer this question. There are several things that you need to know and take into account before you make the go/no-go decision. Add these to your check list:

First, consider the underlying condition that you are treating. What will be the consequences if the medication doesn't work or if it wears off before the flight is over? A good general rule to follow is not to fly if you must depend on the medication to keep the flight safe. In other words, if the untreated condition is one that would prevent safe flying, then you shouldn't fly until the condition improves — whether you take the medication or not.

Second, you must consider your reaction to the medication. There are two broad categories of medication reactions. One is a unique reaction based on an individual's biological make-up. Most people don't have such reactions but anyone can, given the right medication. Because of this, you should NEVER fly after taking any medication that you have not taken before. It is not until after you have taken the medication that you will find out whether you have this uncommon and unexpected reaction to the medication.

Third, consider the potential for adverse reactions, or *side effects* — unwanted reactions to medications. This type of reaction is quite common, and the manufacturer of the medication lists these on the label. You MUST carefully read all labeling. If you don't have access to the label, then don't fly while using the medication.

Look for such key words such as *lightheadedness*, *dizziness*, *drowsiness*, or *visual disturbance*. If these side effects are listed or if the label contains a warning about operating motor vehicles or machinery, then you should not fly while using the medication.

Side effects can occur at any time, so even if you've taken the same medication in the past without experiencing side effects, they could still occur the next time. For this reason, you must never fly after taking a medication with any of the above-noted side effects (see table).

Common side effects of frequently used medications

If you must take over-the-counter medications,

- Read and follow the label directions.
- If the label warns of significant side effects, do not fly after taking the medication until at least two dosing intervals have passed. For example, if the directions say to take the medication every 6 hours, wait until at least 12 hours after the last dose to fly.
- Remember that you should not fly if the underlying condition that you are treating would make you unsafe if the medication fails to work.
- Never fly after taking a new medication for the first time.
- As with alcohol, medications may impair your ability to fly—even though you feel fine.
- If you have questions about a medication, ask your aviation medical examiner.
- When in doubt, don't fly.

Prescription Medications

When your treating physician prescribes a medication for you, be sure to ask about possible side effects and the safety of using the medication while flying. Since most of their patients are not pilots, many physicians don't think about the special needs of pilots when they prescribe medication. You must also discuss the medical condition that is being treated. You may want to ask your physician to contact your aviation medical examiner to discuss the implications of flying with the medical condition and the medication.

When your pharmacy fills the prescription, let the pharmacist know that you are a pilot. Pharmacists are experts in medication side effects and can often provide advice that supplements the information that your physician gives you. The pharmacist will provide you with written information about your medication. You should treat this just like the label of an over-the-counter medication mentioned above. Read, understand, and follow the information and instructions that are given with the medication. Never hesitate to discuss possible problems with your physician, pharmacist, or aviation medical examiner.

The Bottom Line

What you must remember about medications

Sometimes…

…you will develop a medical condition that is not safe to fly with. Whether you take a medication for the condition or not, you should wait to fly until the condition is either gone or significantly improved.

…you will have an ongoing (chronic) medical condition that your physician has prescribed a medication to treat. You should discuss the medical condition and treatment with your physician, pharmacist, and aviation medical examiner and make your flying decision based on their advice.

…you will have a medical condition that makes you uncomfortable but does not impair your ability to safely fly. If flying is very important, you may take either over-the-counter medications or prescription medications — within the guidelines suggested above.

Flying is important for many reasons. Not one of these reasons, however, is worth risking your life or the lives of those around you. Treat all medications with caution, and you'll be around to become one of the "old" pilots.

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Common side effects of frequently used medications.

Problem	Type Medication	Example	Potential Side Effects
Colds, congestion, and allergies	- Decongestant - Antihistamine	Pseudoephedrine (Sudaphed®) Diphenhydramine (Benadryl®)	Palpitations, jitteriness, anxiety, drowsiness
Cough	- Cough suppressant	Dextromethorphan (Robitussin DM®)	Dizziness, drowsiness
Fever	- Antipyretic	Aspirin	Ringing in ears, upset stomach
Pain	- Analgesic	Ibuprofen (Motrin®)	Dizziness, upset stomach
Nausea / Vomiting	- Antinauseant	Dimenhydranate (Dramamine®)	Drowsiness
Diarrhea	- Antidiarrheal	Loperamide (Imodium®)	Drowsiness
Acid reflux	- Antacid	Ranitidine (Zantac®)	Headache, nausea
Constipation	- Laxative	Various	Abdominal cramping, diarrhea
Overweight	- Diet pill	Ephedrine (Ephedra)	Palpitations, jitteriness, anxiety, heart attack, stroke
Insomnia	- Sleeping pills	Diphenhydramine (Tylenol PM®)	Prolonged drowsiness and impairment of reaction times

Thymic Carcinoma

Case Report, by Sacha St. Hill, MD

Thymic carcinoma is a rare and highly aggressive type of tumor found in the anterior mediastinum. Following is a case report of a 66-year-old male pilot who was found on routine chest X-ray to have a mediastinal mass. After diagnosis, he underwent chemotherapy, surgery, and radiation therapy. One year after completion of therapies he was re-issued a third-class medical certificate to fly.

History. On September 11, 2001, a 66-year-old male pilot was found on routine chest X-ray to have an abnormal mediastinal mass. He denied any symptoms of cough, shortness of breath, wheezing, or hemoptysis. He also denied any history of chest pain with or without exertion, as well as any symptoms of trouble swallowing or sensation of globus, hoarseness, abdominal pain, nausea, vomiting, or diarrhea.

Subsequent CT scan of the chest showed a 6 cm mass in the anterior mediastinum. No other lesions were noted, and there did not appear to be any invasion of surrounding structures. Fine needle biopsy provided a preliminary diagnosis of non-small cell carcinoma.

He was evaluated at M.D. Anderson Cancer Center, and a course of preoperative chemotherapy was recommended. He completed three courses of carboplatin and Taxol in December 2001. The chemotherapy was tolerated without complications. PET scan showed partial metabolic response of the mediastinal lesion. Brain MRI, chest X-ray, and CT scans showed no other new lesions.

On January 16, 2002, the patient underwent a fiberoptic bronchoscopy, median sternotomy, mediastinal mass resection en bloc with pericardectomy, thymectomy, and resection of the left innominate vein, as well as a mediastinal lymph node dissection. Pathology proved the resected tumor to be a thymic carcinoma. The patient then completed a course of radiation therapy in April 2002. During the course of diagnosis and treatment, the patient had remained completely asymptomatic. Follow-up chest X-ray and CT scans four months, eight months, and 11 months after completion of treatment showed no evidence of new or recurrent disease.

Aeromedical Certification Outcome. In this case, the airman was very lucky that his tumor was found early and it was amenable to treatment. About one year after the completion of all therapies, he applied for 3rd-class medical re-certification. He had remained off flight status during the diagnosis and treatment of his disease. His AME deferred re-certification to the Aerospace Medical Certification Division. After careful review of the application and supporting documents, it was determined that a time-limited Special Issuance certificate would be granted. To continue the Special Issuance certification, annual current status reports and CT scans of the chest will have to be submitted for at least five years. Any sign or symptom of recurrence or adverse sequela would be grounds to revoke the Special Issuance.

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Dr. St. Hill is an Occupational Medicine Resident at the University of Texas Tyler Health Center. She was on a clinical residency program at the Civil Aerospace Medical Institute when she wrote this case report.

Thymic Carcinoma

Similar to thymomas [see Thymoma, case report by Chris Tabqatzky, MD, *FASMB* Vol. 42, No. 3, p. 10] but much more aggressive, thymic carcinomas are epithelial neoplasms of the thymus. They exhibit a strong propensity for early local invasion and widespread metastasis. As a group, thymic carcinomas comprise a heterogeneous number of cell types. Included are squamous cell, spindle cell, lymphoepithelioma-like, mucoepidermoid, basaloid, clear cell, and adenoid cystic. Because of the histological resemblances to lung malignancies, it is important to exclude an occult primary in the lung.[1] Squamous cell and lymphoepithelioma-like carcinomas are the most common cell type of this extremely uncommon tumor. Squamous cell has a lower malignant potential than the much more aggressive malignancy of the lymphoepithelioma-like tumors.[2]

The mean age at diagnosis is 46 years for the squamous cell and lymphoepithelioma-like tumors.[1] Five-year survival rates are 33%. For high-grade tumors (those with lobular growth patterns, severe cytologic atypia, extensive necrosis, and high mitotic activity), five-year survival is 15-20%, as opposed to 90% for low-grade tumors.[1] Prognosis is intimately linked to tumor histology and stage at diagnosis. Patients are commonly asymptomatic until a very late stage. The most common symptoms are related to compression, obstruction, and/or invasion of nearby structures. Ill-defined chest pain, cough, and shortness of breath are most common symptoms. Myasthenia gravis is associated with 10-50% of patients with thymoma.[2]

Treatment consists of surgical excision if possible. Unfortunately, due to the propensity for locoregional invasion before diagnosis,[3] these tumors are often inoperable.

'Mister Chairman…'

The Federal Air Surgeon Testifies on Age 60 Rule Before Senate Subcommittee

On July 19, 2005, Federal Air Surgeon Dr. ***Jon L. Jordan*** *gave testimony before the Senate Committee on Commerce, Science, and Transportation, Subcommittee on Aviation on the Federal Aviation Administration's "Age 60" Commercial Pilot Rule. Following are excerpts of Dr. Jordan's remarks.*

It's Inevitable

AT SOME AGE, every individual reaches a level of increased infirmity leading to decreased reliability. That age will vary from person to person but cannot yet be predicted in a specific individual. While science does not absolutely dictate the age of 60 for commercial passenger pilot retirement, that age is within the age range during which sharp increases in disease mortality and morbidity occur.

Clearly, there is a progressive anatomic, physiological, and cognitive decline associated with aging, albeit variable in severity and onset among individuals. There is no absolute, scientific formula that may be readily applied. It is indisputable that, as people age, they experience more illnesses and disorders, and suffer more cognitive decline.

Cardiovascular disease rises with age, steeply, beginning between ages 55 and 65, and, though mortality has dropped since 1960, cardiovascular disease remains the most frequent cause of death in pilots and the general population. With this increased incidence of cardiovascular disease in the older population, the risk for unexpected events that could be a threat to safety of flight is increased. Cardiac events (e.g., heart attacks, heart failure) during flight have continued to occur in low but fairly consistent numbers over the years and have caused general aviation accidents.

Other health conditions are known to increase in incidence or to become more complicated with aging. Many present greater difficulties of detection and risk assessment than do cardiovascular disease. Among these are cerebrovascular disease; malignancies; endocrine dysfunction; neurological disorders; psychiatric disorders, including depression; and decline in sensory and motor capabilities.

Continuing Reviews. The Age 60 rule has served well as a regulatory limit in the United States. It remains the best determination that can be made of the time when a general decline in health-related functions and overall cognitive capabilities has reached a level where decrements in a pilot's performance may jeopardize safety. The Age 60 rule has been repeatedly reviewed to determine whether new and sufficient evidence exists to warrant a reconsideration of the regulation. Studies conducted to date do not present sufficient information that would address concerns about negatively impacting the current level of safety by changing the rule.

The FAA has invited the public to provide comments on the viability of the Age 60 rule. The most recent comment period was opened in September 2002 in relation to a petition for exemption to the rule filed by a coalition of U.S. pilots approaching age 60. Nearly 7,000 comments were submitted during the month-long open comment period. Overwhelmingly, the comments favored retaining the current Age 60 rule. They cited safety and medical issues most often as reasons for retention of the current rule. Several U.S. Courts of Appeals have reviewed the Age 60 rule and studies related to the rule. Uniformly, these courts have denied petitioners' requests for relief from the rule.

Congressional Interest. In recent years, several bills to revise the age limit for airliner pilots have been introduced [but not passed]. Most recently, legislation was proposed earlier this year that would tie an age limit for air carrier pilots to Social Security retirement age eligibility.

For Public Safety. Modifying the long-standing baseline of age 60 in the U.S. requires that the public be shown how such modification would maintain an equivalent level of safety. The Age 60 rule is a long-standing operational rule that pre-dates subsequent studies completed over the years. No protocols exist to reliably predict when or whether an over-age-60 pilot might experience a medical event that could jeopardize aviation safety. With inconclusive data and no practical experience with pilots above age 60, the FAA does not agree, at this time, to modify the current age limit for airliner pilots.

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WHAT IS *AGE 60*?

The Age-60 rule provides that a pilot may not engage in what are known as Title 14 of the Code of Federal Regulations part-121 operations if the pilot has reached his 60th birthday. 14 CFR Part 121, or simply, *part 121*, covers operations of large commercial passenger aircraft, smaller propeller aircraft with 10 or more passenger seats, and common carriage operations of all-cargo aircraft with a payload capacity of 7500 pounds.

The Age-60 rule represents the FAA's best determination of the time when a general decline in health-related functions and overall cognitive and performance capabilities may begin and reach a level where a pilot's judgment and physical ability may begin to decline and jeopardize safety. Pilots at age 60 must leave part-121 operations, but they may continue working in aviation: screening, recruiting, and training pilot applicants; or serve as flight engineers, fly in non-part 121 operations, become flight instructors, or even work as safety inspectors for the FAA.

Office of Aerospace Medicine's Annual Awards for Excellence Held to Honor Employee Achievements

By Mike Wayda

The twelfth annual awards program for the Office of Aerospace Medicine's (AAM's) outstanding employees was held to honor their contributions to aerospace medicine. Federal Air Surgeon **Jon L. Jordan**, MD (left), presented each award recipient with a special recognition mementoes. Deputy Federal Air Surgeon **Fred E. Tilton**, MD, assisted Dr. Jordan during the Washington, DC, ceremony.

AAM employees across the country nominated their associates for specific award categories. Nominations were also sought for a separate award, the "Friend of AAM," for which only individuals outside of the Office of Aerospace Medicine organization are eligible. A national awards panel selected the winners in each category.

The following are the 2004 award recipients.

David J. Schroeder, PhD
Outstanding Manager
Civil Aerospace Medical Institute
"...all 6 research goals met... positive, productive working environment...represented AAM nation-

Tracie L. Allison, R.N.
Outstanding Leadership
Civil Aerospace Medical Institute
"took initiative to enhance effectiveness of Health Awareness Program...taught 30 class-

Nelda J. Milburn, PhD
William E. Collins Publication
Civil Aerospace Medical Institute
"...diligent research contributed to the development of color vision tests for ATCS employees..."

Tie

Richard L. DeWeese
William E. Collins Publication
Civil Aerospace Medical Institute
"...first-class study also provided important scientific and engineering insight into design features ..."

David M. Moorcroft
Outstanding Innovator
Civil Aerospace Medical Institute
"...FAA lead engineer developing mathematical modeling for aircraft seat certification testing..."

Steven A. Schwendeman, MD
Outstanding Customer Service
Civil Aerospace Medical Institute
"...unwavering professionalism and optimism...communicated effectively under pressure...unfailingly

Sue M. Glowacki
Administrative Excellence
Headquarters
"...energetically seeks input, knowledge, advice from managers and peers...tenacity, professionalism..."

Tie

Cynthia P. Ingrao
Administrative Excellence
Headquarters
"...commitment to safety...integated responsibilities of AAM, AFS, AGC, regional counsel offices..."

Karen L. Leamon
AAM Mission Support
Headquarters
"...exceptionally talented...managed Compliance & Enforcement Review Team...led the initiative...

Dominick S. Zito, MD
Flight Surgeon of the Year
Eastern Region
"...contributions have enhanced safety, aerospace medicine...called upon for his medical expertise..."

Sara L. Prideaux
Regional Employee of the Year
Central Region
"...willingly accepts addiditional, diverse assignments, volunteers... provides invaluable support..."

Tie

Peggy M. Luck
Regional Employee of the Year
Southern Region
"...professionally monitored program activities...exceptional specialized service..."

Robert J. Neal
Inspector of the Year
Fort Worth, Texas
"...highly motivated and dedicated employee who always rises to a challenge...saved time and mon-

Nancy L. Claussen
Friend of AAM
Phoenix, Arizona
"...consistently provided excellent cabin safety, security, and health consultation and support..."

Aerospace Human Factors Research Division
AAM Office of the Year

Individual Awards Winners

Medical Records and Correspondence Team
Outstanding Team

LETTERS

Dear Editor:

Greetings from Anbar Province in Western Iraq. Read with earnest the *Federal Air Surgeon's Medical Bulletin* cover to cover as it is a most excellent source of FAA medical news; my wife sends it along from home.

I am an AME from Peekskill, N.Y. Noted in your last issue (Vol 43 No. 2) under Office of Aerospace Medicine News of two physicians recalled to active duty. Well, here I am as well, and I have enclosed a picture for your use.

In Peekskill, in addition being Associate Director of Emergency Services at the Hudson Valley Hospital Center in Cortlandt Manor, N.Y., I am also the Assistant Division Physician for the New York State Police (sworn member), and in the Navy Reserve as Flight Surgeon with Marine Air Group 49 out of Naval Air Station Willow Grove, Pa. I have 24 years in the Navy between active duty and the reserve, and was recalled to active duty in February 2005, assigned to HMM-764, a USMC Marine Reserve CH-46 squadron in Al Asad, Iraq. I have also been assigned to provide emergency medicine support in Al Qa'im, also in the Anbar province along the Syrian border.

Captain John McGurty, Jr., MD

Keep up the great work with the *Bulletin*.

John A. McGurty, Jr., MD
CAPT MC (FS) USNR
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Dear Editor,

Q. What is the difference between these limitations? —

1. Must wear corrective lenses for near and distant vision.

2. Must wear corrective lenses, possess glasses for near/intermediate vision.

Answer 1. When corrective lenses are required to meet the standards, an appropriate limitation will be placed on the medical certificate (e.g., lenses are needed for distant vision only):

HOLDER SHALL WEAR CORRECTIVE LENSES

For multiple vision defects involving distant and/or intermediate and/or near vision when one set of monofocal lenses (e.g., high astigmatism) corrects for all distances, the above limitation will be placed on the medical certificate.

For combined defective distant and near visual acuity where multifocal lenses (e.g., bifocal or two single-vision lenses) are required, the appropriate limitation is:

HOLDER SHALL WEAR LENSES THAT CORRECT FOR DISTANT VISION AND POSSESS GLASSES THAT CORRECT FOR NEAR VISION

Answer 2. For multiple vision defects involving distant, near, and intermediate visual acuity when more than one set of lenses (e.g., trifocal or progressive addition lenses, or distant lenses with 2nd pair, which corrects for near and intermediate) is required to correct for all vision defects, the appropriate limitation is:

HOLDER SHALL WEAR LENSES THAT CORRECT FOR DISTANT VISION AND POSSESS GLASSES THAT CORRECT FOR NEAR VISION

Q. What is the difference between *possessing* and *having* or between *having* and *being required to wear lenses* for near [vision] (as in 1.)?

A. This is really the same thing. The airman has to have glasses immediately available in the aircraft. If the restriction says that airmen *must possess,* that means that they are required to have the lenses available in the aircraft. If the restriction says that they *shall wear* corrective lenses, they must wear glasses while flying; however, airmen are not required to wear glasses for near.

Q. Who needs an extra pair of glasses?

A. All airmen should fly with an "emergency" pair of glasses, particularly when multiple vision defects are a concern. This is prudent advice that should be given to all airmen. It is not a requirement but a smart thing to do.

Q. When should the AME add the extra pair limitation?

A. There is no limitation of an extra pair of lenses; it is just a recommendation.

Thanks,
William A. Blank, MD
La Crosse, Wis.

[All answers were supplied by the Aerospace Medical Certification Division and the Vision Research Team at the Civil Aerospace Medical Institute.]

Take advantage of this forum on airman medical certification by contacting:
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P.O. Box 25082, AAM-400
Oklahoma City, OK 73125
E-mail: Mike.Wayda@faa.gov

OAM Active Participant at Nation's Major

Southern Region Assists 300 Airmen at Sun 'n Fun

15th Air Show Logged

By David P. Millett, MD
Southern Regional Flight Surgeon

From April 12–18, 2005, the Southern Region Medical Division participated for the 15th straight year in the 31st edition of the "Sun 'n Fun" Fly-In. As usual, the big event was held in Lakeland, Fla. Rather than adding the daily attendance figures, it was determined that 170,000 individuals attended during a week of spectacular air shows and hundreds of educational forums and exhibits.

Dr. Millett (r.) and Dr. Miller taking care of business at Sun 'n Fun

Leading the medical presence was Southern Regional Flight Surgeon Dr. **David P. Millett,** who was attending his 15th consecutive fly-in. During the first half of the week, Flight Surgeon Dr. **Michael B. Miller** joined Dr. Millett. Dr. **Walter D. Davis**, Deputy Southern Regional Flight Surgeon, and Dr. **Brian D. Johnson,** Aerospace Medical Certification Division medical officer, manned the booth during second half of the week. On April 15th, Federal Air Surgeon Dr. **Jon L. Jordan** visited the fly-in and presented a very successful medical certification forum.

For the first time ever, we were able to use the on-line Document Imaging and Workflow System to access medical records on-the-spot and assist airmen with their aeromedical certification questions. We were able to assist at least 50 airmen on their medical applications. About 300 airmen visited the exhibit, and we answered their medical questions. It was a very successful way to provide quality customer service.

OAM NEWS
Office of Aerospace Medicine

AirVenture Oshkosh

Busiest Ever, Estimated Attendance of 700,000

By Nestor Kowalsky, MD
Great Lakes Regional Flight Surgeon

This year, the FAA Office of Aerospace Medicine's booth, for the first time, featured the presence of laptop computers configured for on-line access to the FAA's Aerospace Medical Certification Subsystem. This feature was popular and well received, permitting airmen visiting our booth to obtain personalized, real-time information as to the status of their pending medical certification cases. We had many visitors that also had the opportunity to interact face-to-face with senior OAM representatives and ask questions about certification issues.

The OAM Booth was sponsored by the FAA Great Lakes Regional Medical Office and was staffed by Federal Air Surgeon Dr. **Jon Jordan**, Dr. **Will Simmons**, (Alaskan Region Regional Flight Surgeon), Dr. **Steve Schwendeman** (of CAMI's Occupational Health Division), Dr. **Warren Silberman**, **Joan Morgan**, (Airman Aerospace Medical Certification Analyst, Great Lakes Region Medical Office), and Dr. **Nestor Kowalsky.**


White Knight/SpaceShip One Flyby at Oshkosh

A sister booth featuring the hands-on Gyro spatial disorientation demonstrator was very popular with visitors and was staffed by **Rogers Shaw II**, **Eric Simson**, and **Donald Dumuth,** of CAMI's Airman Education Program.

Dr. **Jon Jordan** gave a presentation entitled "Flying Left Seat" and also participated in the FAA Administrator's "Meet the Administrator" panel.

Dr. **Warren Silberman**, Manager of the Aerospace Medical Certification Division in Oklahoma City, gave a presentation on pilot medical certification, and he also participated in an Experimental Aircraft Association medical advisory panel presentation on aeromedical issues.

New Certification 'Tiger Team' Convenes

Responding to a large backlog of complex medical certification cases, Dr. **Warren Silberman,** manager, Aerospace Medical Certification Division (AMCD), led a team of eight medical certification specialists at the Civil Aerospace Medical Institute. In an intensive effort during the week of August 22-26, 2005, the team completed about 750 medical review decisions.

Team members are recruited from the FAA regions, headquarters, and the AMCD. They meet at irregular intervals to consider cases that are time-sensitive for airmen that have pending medical authorizations to fly.


TIGERS (L-R). Drs. Silberman; Willis Simmons, Alaskan Regional Flight Surgeon; Bill Salazar (seated), SW Regional Flight Surgeon; Jim Fraser, Manager, Hq. Medical Specialties; Kim Christensen, Albuquerque Center; Chris Taylor, NW Regional Flight Surgeon; Richard Carter, AMCS. Not pictured: Dr. Steve Schwendeman, CAMI Occupational Medicine.

California Investigation Targets 'Disabled' Pilots

Operation Safe Pilot Nets 46

By Stephen Griswold, MD

OPERATION SAFE PILOT was initiated by the Inspector Generals for the Department of Transportation and the Social Security Administration. This investigation focused on individuals in the central and northern California area who held current airman medical certificates while also collecting Social Security medical disability benefits for total disability. The investigation resulted in federal criminal charges filed against 46 individuals. The investigation is ongoing and additional charges may be filed.

FAA Associate Administrator for Aviation Safety, **Nicholas Sabatini** said, "The fraud and falsification allegedly committed by these individuals is extremely serious and adversely affects the public interest in air safety." He added, "The FAA has cooperated closely with the Department of Transportation's Office of Inspector General at every phase of its investigation and has begun revoking the airman and medical certificates of those individuals found to have falsified their certificate applications."

Mr. Sabatini's remarks were underscored by U.S. Department of Transportation's Office of Inspector General **Kenneth Mead**, who stated, "Pilots who provide false information about their health to the FAA on their medical certification not only violate the law, but could pose potential threats to safety as well."

Aviation medical examiners are reminded to thoroughly review the 8500-8 form and remind airmen to complete the form truthfully and in its entirely.

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Dr. Griswold is the Western Pacific Deputy Regional Flight Surgeon.

Aviation Medical Examiner Seminar Schedule

2005		
September 12 - 16	Oklahoma City, Okla.	Basic (1)
November 18 - 20	Savannah, Ga.	AP/HF (2)
December 5 - 9	Oklahoma City, Okla.	Basic (1)
2006		
January 20 - 22	San Diego, Calif.	OOE (2)
March 6 - 10	Oklahoma City, Okla.	Basic (1)
May 15 - 18	Orlando, Fla. (AsMA)	Cardio (3)
June 12 - 16	Oklahoma City, Okla.	Basic (1)
July 14 - 16	Albuquerque, N.M.	N/NP/P (2)
August 4 - 6	Washington, D.C.	AP/HF (2)
September 11 - 15	Oklahoma City, Okla.	Basic (1)
September 22 - 24	Atlanta, Ga.	OOE (2)
December 11 - 15	Oklahoma City, Okla.	Basic (1)

CODES

AP/HF Aviation Physiology/Human Factors Theme

CAR Cardiology Theme

OOE Ophthalmology - Otolaryngology - Endocrinology Theme

N/NP/P Neurology/Neuro-Psychology/Psychiatry Theme

(1) A 4½-day basic AME seminar focused on preparing physicians to be designated as aviation medical examiners. Call your regional flight surgeon.

(2) A 2½-day theme AME seminar consisting of 12 hours of aviation medical examiner-specific subjects plus 8 hours of subjects related to a designated theme. Registration must be made through the Oklahoma City AME Programs staff, (405) 954-4830, or -4258.

(3) A 3½-day theme AME seminar held in conjunction with the Aerospace Medical Association (AsMA). Registration must be made through AsMA at (703) 739-2240. A registration fee will be charged by AsMA to cover their overhead costs. Registrants have full access to the AsMA meeting. CME credit for the FAA seminar is free.

The Civil Aerospace Medical Institute is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.