

Policies and Unacceptable Medications

Since the most common error that an aviation medical examiner makes is placing an airman on a medication that is unacceptable, I thought I would spend the next several columns going over “policies” and specific medications that are unacceptable to the FAA.

Those of you who have heard me speak at seminars know that when you want to decide whether a medication is acceptable or not, you should first consider the medical condition that caused the need for it. For example, if an airman has osteoarthritic knees and the treating physician places the airman on Ultram (tramadol), this would not be acceptable. However, if the physician prescribed the non-steroidal anti-inflammatory Naprosyn (naproxen), that would be fine. My concern as an AME would be: Does the airman have the range of motion and strength to manipulate the rudder controls?

Another guideline you should consider is that, unless the medication is in a category of medications that we already accept, a medication in a new category or even a medication that has a slightly different mechanism of action that has some different side effects will not be considered by the FAA until one year after Food and Drug Administration approval. So, for example, consider beta-blockers. If a new one were approved by the FDA, more than likely it would be acceptable and allowed upon release. We want to see what the effects of a medication are on the general population before considering it for approval.

The FAA will not approve a medication just at the request of a pharmaceutical company. We will consider a new medication if we start seeing its use in our aviators or if one of the pilot advocacy organizations requests our review because some of their clients

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have asked about the medication or treatment.

If we discover side effects that are incompatible with aviation duties after we accept a medication, we will re-review our policy, check the computer database to see how many airmen of each class reported taking the medication, and perhaps even change the drug's acceptance. A recent example is the medication Chantix (varenicline), the non-nicotine drug used for smoking cessation. When the news broke that some Chantix users had demonstrated undesirable behavioral changes—hostility, agitation, depressed mood, suicidal thoughts or actions—while using the medication to help them quit smoking and that some people had these symptoms when they began taking Chantix, and others developed them after several weeks of treatment or after stopping Chantix, we convened our Pharmacy and Therapeutics Committee. The group agreed that these effects were not compatible with the safety of flight and notified all the airmen that were taking Chantix to cease its use or not fly while they were undergoing withdrawal.

Dosing Interval

One last policy point. Up until the past year, if an airman had taken an unacceptable medication, we recommended waiting for two dosage intervals before flying. We are now reviewing our policy. Our exceptional

Bioaeronautical Sciences Research Laboratory at the Civil Aerospace Medical Institute, under the leadership of Dr. **Dennis Canfield**, is performing research to see if they can determine the most appropriate dosing interval. In the meantime, we have changed this to five dosage intervals. In other words, if the directions on the label say to take the medication every six hours, the pilot should wait at least 30 hours after taking the last dose to fly.

Specific Medications

Antihistamines. Let's begin our discussion of medications with the antihistamines. The FAA does not accept the use of sedating antihistamines. We do not accept the use of Benadryl (diphenhydramine) and Zyrtec (cetirizine), which are two of the more commonly prescribed drugs. We also do not accept Astelin (azelastine), which is a nasal spray and interestingly, a sedating antihistamine. We do accept the use of Claritin (loratadine) and Clarinex (desloratadine), which are non-sedating. Even though we realize that informing the airman not to take his/her sedating antihistamine for five dosing intervals (to be legally able to fly) may be the improper treatment for a particular condition, we would accept this statement in block #60 of the FAA medical exam. That is, if we see that the airman is taking an unacceptable medication but the AME noted in Block 60 of our exam form that the airman was informed not to take the medication for let's say 48 hours prior to flight, we would not deny the airman for taking an unacceptable medication. *This disclaimer only applies to antihistamines.*

Selective serotonin reuptake inhibitors. I hope everyone has become familiar with our new policy on antidepressant medications (www.faa.gov/licenses_certificates/medical_certification/specialissuance/antidepressants/). We currently only will allow the long-term use of four SSRI medications. They are Prozac (fluoxetine), Zoloft (sertraline), Celexa

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(citalopram), and Lexapro (escitalopram). The airman will have to request special issuance and provide the FAA with a workup, as described at our Web site (above). An airman may still be able to fly 90 days after discontinuing the use of any antidepressant, once we have a chance to review the medical history and a detailed, current status report provided by the treating physician. Recall that it is the medical condition first, not the treatment, when making a determination about a therapy!

Antiepileptics. We do not accept the use of antiepileptic (antiseizure) medications as treatment for any medical condition. These medications have side-effects that are incompatible with flying. An example here might be the use of Neurontin (gabapentin) in the treatment of a neuropathy. We do not accept these medications because a seizure or epilepsy is obviously a condition that is not acceptable for flight. These medications also have side effects that are incompatible with flying.

Antispasmodics. The use of antispasmodics for diarrhea, abdominal cramping, etc. are not acceptable. Some examples of such medications are Bentyl (dicyclomine), Levsin (hyoscyamine), Librax (chlordiazepoxide and clidinium), and

Lomotil (diphenoxylate and atropine). The medication Imodium (loperamide) is acceptable, but please inform us why the medication is being used, especially if the airman is taking more than two tablets a day. This would be another example of the condition making the determination.

Antihypertensives. Antihypertensive medications are seen regularly by us, as they are the most common medical condition we accept. There are more than 37,000 hypertensive airmen flying that are being treated with medications. Currently, there are six medications we do not accept: reserpine, alpha methyl dopa, guanadrel, guanethidine, guanabenz, and clonidine.

Alpha-blockers. In the past year, we have been reconsidering the use of alpha-blocking medications and are currently not accepting the use of Catapres (clonidine). We are still discussing the other alpha-blockers and have not made a final determination. Those that are being used to promote urine flow in men with prostatism are still acceptable. Examples are Cardura (doxazosin), Hytrin (terazosin), and Flomax (tamsulosin).

That is all for now. Be sure to read the next issue for a continuation of this series on medications. →

Three AAM Staff Receive Industry Awards

The Aerospace Medical Association (AsMA), representing physicians and medical professionals with knowledge of the flight environment, presented its annual awards on May 13 in Phoenix, Ariz.

“This year our FAA folks cleaned up,” said Dr. **James Fraser**, Deputy Federal Air Surgeon.

Winners are: Dr. **Melchor Antuñano**, who received the Louis H. Bauer Founders Award for his internationally recognized expertise in aerospace medicine. Dr. Antuñano, director of the FAA’s Civil Aerospace Medical Institute, has led teams of aeromedical specialists in the generation, administration, and promulgation of both national and international aeromedical planning and policy, and he holds senior leadership positions with numerous international aeromedical organizations.



Dr. **G.J. Salazar** received the John A. Tamisiea Award for his “outstanding contributions to aviation medicine in its application to the general aviation field.” Dr. Salazar is the Southwest Regional Flight Surgeon and is also responsible for the development of the night vision goggle orientation facility at the Civil Aerospace Medical Institute.

CAMI Video Wins Telly Award

The Civil Aerospace Medical Institute earned the television industry’s equivalent of an Academy Award for its “Stress in Aviation” video. CAMI’s Airman Education Team’s video won a bronze award in the Employee Communication category from the 31st Annual Telly Awards. A collaboration with the FAA’s Media Solutions team, the video describes the causes of stress in the human body, the aviation environment, and how to better cope with these stresses.

The high-definition video is the third in a planned ten-part series on human factors. The fourth video, “Risk Management in Aviation,” was just released.

“Our mission is ‘safety through education,’ and the videos reinforce what we teach in our Crew Resource Management Program,” said team member **J.R. Brown**. “We’ve already made 32 videos with Media Solutions, and we give away over 5,000 free DVDs each year, or anyone can download them from our Web site.” To view the videos, go to www.faa.gov/library/online%5Flibraries/aerospace%5Fmedicine/aircrew/hf%5Fvideos/.



Dr. **Warren Silberman** received the Theodore C. Lyster Award for his “outstanding achievement in the general field of aerospace medicine.” He was cited for having “significantly improved civil aeromedical certification policies and practices for pilots of all classes through his medical training and administrative skills.”

—Excerpts from AVS Flyer