AFTD Review Feedback

Thank you for this opportunity to feedback. I have made some suggestions below to be consistent with current terminology (apologies for overlooking this on first review but I thought neurologists would pick this up) and just a couple of typos. Otherwise, it's definitely improved.

Question 1: Are the proposed changes to Assessing Fitness to Drive appropriate? Please comment on matters relevant to the topic and provide evidence (i.e., data, research or documentation) to support your views. Where possible, also provide a proposed solution (i.e., corrective wording) to the issues identified.

Note:

1. **Seizure terminology has changed** (2017) and the below suggested changes are in line with the current terminology proposed by International League Against Epilepsy in consultation with leading neurologists around the world. (The International League Against Epilepsy (ILAE) is the world's preeminent association of health professionals and scientists working toward a world where no person's life is limited by epilepsy). Reference https://www.ilae.org/files/dmfile/Operational-Classification---Instruction-manual-Fisher_et_al-2017-Epilepsia-1.pdf
2. Also, **antiepileptic drugs are now called antiseizure medication** (this is not critical for change in this document though, but I see there are both terms used)

Suggested Changes:

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2.3.4 Information and assistance for drivers

- Condition-specific support and advocacy agencies may also offer advice, support and services, for example, Diabetes Australia, Dementia Australia, MS Australia, Epilepsy Action Australia and Epilepsy Foundation.

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6.2 Seizures and epilepsy

Refer also to section 1. Blackouts and section 2. Cardiovascular conditions.

6.2.1 Relevance to the driving task

Effects of seizures on driving[1–3] (Reference used: Drazkowski, J. (2007), An overview of epilepsy and driving. Epilepsia, 48: 10-12. https://doi.org/10.1111/j.1528-1167.2007.01392.x)

Seizures vary considerably, some being purely subjective experiences – for example, some focal aware seizures where the person retains awareness – but most seizures involve some impairment of consciousness (e.g.including major motor (tonic-clonic) seizures, absence and complex partialfocal impaired awareness seizures.)A less clear situation is when a seizure does not alter awareness but affects voluntary motor control to the degree of potentially impairing driving. or loss of voluntary control of the limbs (e.g. tonic-clonic, focal motor and complex partialfocal impaired awareness seizures). Convulsive (tonic- clonic) seizures may be generalised from onset or secondarily generalised withevolve from a focal onset. Seizures associated with loss of awareness, even if brief or subtle, or loss of motor control, have the potential to impair the ability to control a motor vehicle.

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Commented [JB1]: I think this sentence doesn't hold much relevance here

6.2.2 General assessment and management guideline[7,8]

Epilepsy refers to the tendency to experience recurrent seizures. Not all people who experience a seizure have epilepsy.

Epilepsy is a common disorder with a cumulative incidence of 2 per cent of the population, with 0.5 per cent affected and taking medication at any one time. Most cases respond well to treatment, with a long term terminal remission for two in three people with epilepsy. ~~rate of 80 per cent or more.~~ The majority suffer few seizures in a lifetime, and about half will have no further seizures in the first one or two years after starting treatment. Some people with epilepsy may eventually cease medication. For others, surgery may be beneficial.

In general, responsible people with well-managed epilepsy (as demonstrated by an appropriate seizure-free period and compliance with treatment and other recommendations) may be considered by the driver licensing authority to be fit to drive a private vehicle.

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6.2.3 Medical standards for licensing

Given the considerable variation in seizures and their potential impact on safe driving, a hierarchy of standards has been developed that provides a logical and fair basis for decision making regarding licensing (see also Figure 13). This hierarchy comprises:

• a default standard, applicable to all cases of seizure, unless reductions are allowed (refer below and to the table on page **Error! Bookmark not defined.**)

Question 2: Please describe your experience using the current Assessing Fitness to Drive medical criteria or supporting information. What sections or content are most valuable? How could the document and support materials be improved?

I use a ch 6.2 primarily, and the table commencing on page 136 is probably the section I refer to the most (depending on the nature of the enquiry).

I sometimes refer to Part A and find your charts and algo rhythms and easy reference in both sections.

Question 3: What support or training could be provided to health care professionals to increase usage and knowledge of the guidelines?

Possibly some online training opportunities?