

Wright State University

CORE Scholar

[Browse all Civil Aviation Medical Association Newsletters](#)

Civil Aviation Medical Association Records
(MS-526)

1-1986

Bulletin - January, 1986

Civil Aviation Medical Association

Follow this and additional works at: https://corescholar.libraries.wright.edu/special_ms526_newsletter



Part of the [Aviation Safety and Security Commons](#), and the [Medicine and Health Sciences Commons](#)

Repository Citation

Civil Aviation Medical Association (1986). *Bulletin - January, 1986*. .

This Newsletter is brought to you for free and open access by the Civil Aviation Medical Association Records (MS-526) at CORE Scholar. It has been accepted for inclusion in Browse all Civil Aviation Medical Association Newsletters by an authorized administrator of CORE Scholar. For more information, please contact library-corescholar@wright.edu.



BULLETIN OF THE

EAL

FEB 5 - 1986

MED DEPT.

Headquarters
775 Banker Lane — Room 211
Lake Forest, Illinois 60045
phone (312) 234-6330

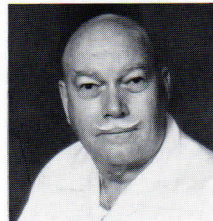
CAMA

CIVIL AVIATION MEDICAL ASSOCIATION

January, 1986

President's Message

By
Dr. John H. Boyd



Greetings! Now I am your elected leader! Where in Hell do you want to be led? Which way shall we go? What are your interests? What are your problems? Remember! No one can drive a group of professional people scattered over a major part of the world. You can only be led where you will go. I assure you that every effort, every available resource will be used to take CAMA where you want us to go. We need to set out specific goals and encourage our fellow AME's to participate in reaching for those goals. Some of us are good at "Let Charlie do it!" Some of us are fond of titles and fancy dress. Some of us are fair weather sailors who go ashore when seas rise. But there is still a nucleus, a cadre, of old soldiers available — people willing to do the work, write the letters, make the presentations, plan the meetings and generally do the daily chores. We know there are more of you out there who would enjoy participating in these activities if you will just join us. Come along and tell us where you want to go.

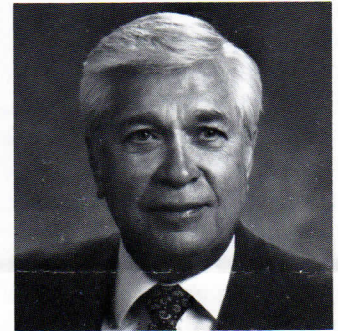
Those of you who elected not to come to San Antonio missed a fun gathering and a stimulating symposium. The weather was beautiful, the natives friendly, the hotel and food and drink great. We wish you could have joined us. The program was built to stimulate and I believe it did that.

Plans are already moving for the Boston meeting Sept. 24-28, 1986, and we are working with Dr. John Martin to co-sponsor a seminar on aviation medicine in Jamaica. Some of you above the frostbite line may want to watch for the announcement. John and Ruby promise a great reception from Jamaica.

To you Past Presidents, Vice Presidents, and ex-Board members who haven't been to a meeting in the last few years, I address an inquiry: What can we do to keep your interest after you have been elected to office? Can we do something to help you to emulate the Charlie Starr's and the Robert Poole's? Some have complained about past programs and reflected on those who have attended as looking for fun. Programs such as ours should stimulate! We have stacks of journals full of facts, bits of information. Symposiums are to stir the mind, not to refresh old memorized material.

EDITORIAL

By
Robert E. Field, M.D.



With the beginning of a new year we look forward to a new phase in the life of CAMA and to new hope and fulfillment. However, we doubt that Bob Wick's withdrawal from the editorship of the Bulletin offers us new hope. Bob's ability and knowledge will be surely missed. Al Carriere is our pivot man. The new editorial staff is noted on the masthead. We will do our best, and we do ask for your help.

John Boyd has started his presidency of CAMA in a whirlwind of activity and with a host of excellent ideas and projects in mind. We welcome his plans and encourage him in his efforts. The Bulletin intends that CAMA be a success.

New projects in the future will undoubtedly include evaluating the far reaching recommendation of the FAA authorized study of the Medical Standards for Civilian Airmen. This study was conducted with a federal grant involving 71 consultants in a 24 month study. Some of the consultants were specialists in aviation medicine, some were pilots, and some had a particular interest in aviation. We look forward to being helpful in evaluating this report.

The Bulletin wishes you all a successful 1986!

Publications Committee

President *John H. Boyd, D.O.*
President-Elect *Robert S. Poole, M.D.*
Past-President *Robert E. Field, M.D.*
Secretary-Treasurer *Floyd F. McSpadden, M.D.*

Staff

Editor *Robert E. Field, M.D.*
Associate Editor *Stephen V. A. Blizzard, M.D.*
Managing Editor *Albert Carriere*

SPECIAL REPORT

November 19, 1985

TO: Executive Council Aerospace Medical Association
FROM: John H. Boyd, D.O., President
SUBJECT: Interim Report

This has been a troubled year for the Civil Aviation Medical Association. In spite of our troubles, under the leadership of Robert E. Field we have gained in national and international recognition and stature. No attempt will be made to lead you through the tangled maze that took us from Guadalajara, to Jamaica, and finally, to San Antonio for our meeting site. Our results in terms of attendance were what you would expect in the face of such uncertainty. Most of the cadre of the faithful did appear, and the usual malcontents, who never come anyway, had the expected words of bitter reaction to our every move. We have emerged on the field of this year's endeavors stronger and more united with new interest and new blood.

Plans for our annual meeting are already moving forward. We shall meet Sept. 24-28, 1986 in Boston and negotiations to complete our program have begun. In 1987 we shall meet in Chicago, and, if events allow, in London in 1988.

We appreciate our affiliation with Aerospace Medical Association and the assistance Dr. Hessberg has offered us. For the present, we wish to continue with this relationship.

“Fudging A Medical”

“Love of flight is such by all of us that we airmen would do almost anything to keep flying, keep our pilot's license. But fudging a medical certificate is not only a critical mistake for a medical examiner, for obvious reasons, it is also a critical mistake for an airman. One of the principal reasons, putting aside the element of safety, fraudulently procuring a medical certificate can very well result in no insurance coverage. Not only can you kill yourself, but you can prevent others whom you injure or kill from being compensated by insurance that you thought was in effect.”

—Aviation Attorney, Arthur A. Wolk,
speaking at CAMA's San Antonio meeting,
October 24, 1985.

You Are Invited . . .

The Board of Directors will meet during the annual convention of the Aerospace Medical Association in Nashville, in the Donaldson Room of the Opryland Hotel, on Monday, April 21, 1986 at 8:00 a.m. President John Boyd wants to emphasize that this is an open meeting to which all members are welcome.

Note from the FAA

On November 25, 1985, the Federal Air Surgeon approved a letter to all Aviation Medical Examiners (AME) announcing a change in FAA practice regarding the certification of airmen with hypertension. Beginning now, all airmen taking medication for hypertension will be required to undergo a specified cardiovascular evaluation initially and at each renewal examination for Class 2 or 3 certification or annually for Class 1. These evaluations may be accomplished by the applicant's own physician or by the AME **at the applicant's option**. If the AME is satisfied that the applicant does not have coronary heart disease or otherwise represents a risk to flight safety, a Class 2 or Class 3 certificate may be issued by the AME. All such actions will be subject to further review by the FAA. Complete details are provided in a letter to all AME's now being mailed.

Would You Fly With This Pilot?

By Robert S. Poole, M.D.

This topic has been one of the most popular parts of the FAA AME seminars. If you have any certification problems or good cases for your fellow AME's edification, please send them in to me at Headquarters.

History: The patient was a 39 year old male pilot who denied any cardiovascular symptoms except an occasional “heart flip” once or twice in his life. On routine physical examination an ECG revealed Wolf-Parkinson-White syndrome. Would you fly with this pilot?

Discussion: Wolf-Parkinson-White syndrome can be recognized on routine ECG by the shortened PR interval (typically less than 0.12 sec.) and the prolonged QRS (greater than 0.10 sec.). The initial 30-50 msec. is caused by Delta wave. W-P-W can be divided into three types on the basis of direction of the Delta wave. This deflection is caused by conduction through accessory connections or tracts resulting in accelerated conduction. This pre-excitation can result in paroxysmal supraventricular tachycardia or atrial fibrillation. The true incidence of tachyarrhythmias is not known but is estimated to be around 50%. This incidence of W-P-W is about 1% and patients usually have normal hearts. However, the syndrome may be associated with Ebstein's anomaly of the tricuspid valve, mitral valve prolapse or cardiomyopathy. It is occasionally associated with an inherited form of familial cardiomyopathy. The echocardiogram is an excellent way to rule out these abnormalities, thus if negative with a negative history of arrhythmia, the patient has an excellent prognosis.

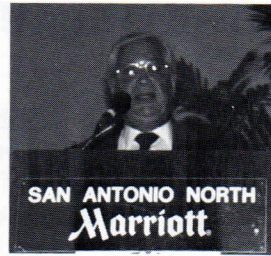
Disposition: This patient was returned to third class flying status.



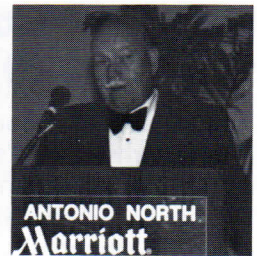
CAMA Annual Banquet, San Antonio, Texas, Oct. 26, 1985. CAMA Gift given P. Pres. Robert Field by CAMA President John Boyd.



CAMA Reception and Banquet. CAMA President John Boyd gives pin to Robert Field (P. President).



CAMA Reception and Banquet. Robert Field, presiding.

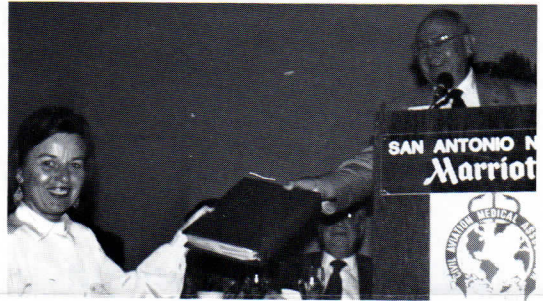


CAMA Annual Banquet, CAMA, President John Boyd.



CAMA Reception and Banquet, CAMA President Robert Field gives pin to John Boyd (New President).

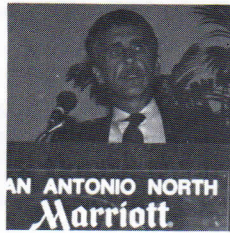
COME TO THE AEROSPACE MEETING! APRIL 21-24, 1986.



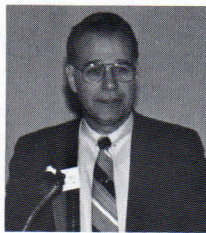
CAMA Reception and Banquet, Nancy Kidder receiving book of photos from Young Stokes.



Party at "the Gambit", Floyd McSpadden of Houston, TX, CAMA's new Secretary/Treasurer.



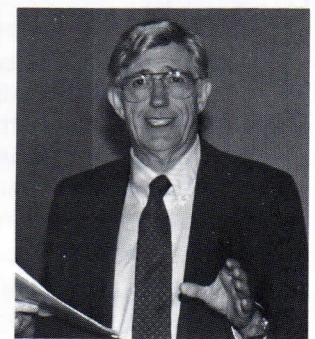
CAMA Annual Banquet, Carter Alexander, Speaker.



Final CAMA Lecture Session Robert Poole, M.D. of Washington DC, CAMA Past & Future President.



Speaker, Hans Grimm



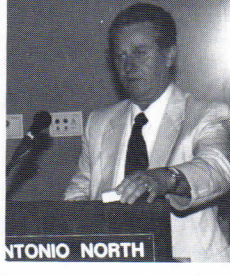
Saturday, Robert Winstanley, M.D., speaking.



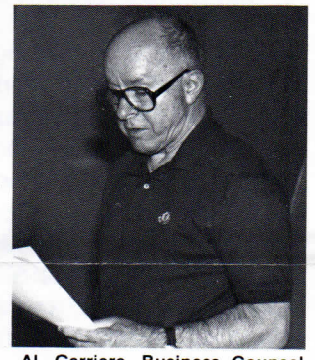
Saturday Speaker Captain James R. Whiteley of United Airlines.



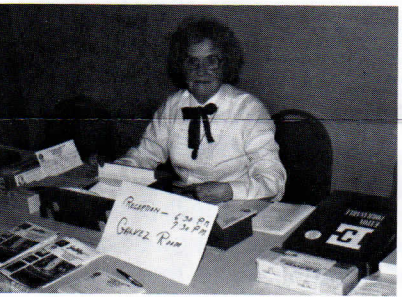
Scientific Program, Sat. Speaker/Attorney Arthur Wolk of Philadelphia, PA.



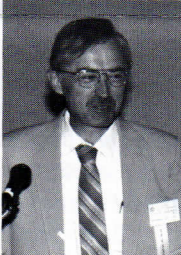
Scientific Program, Saturday Speaker, Don R. Copley.



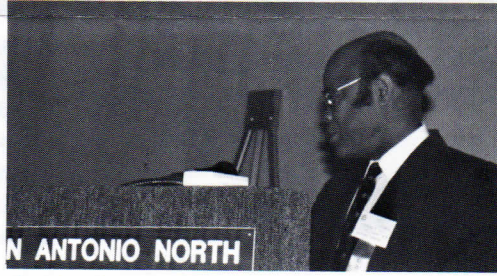
Al Carriere, Business Counsel (acting as Secretary for CAMA).



San Antonio, TX, Board of Trustees Meeting, Harriet Carriere at Registration.



Scientific Program, Saturday, Jerry Hordinsky from FAA, OKC, actually spoke on Friday.



Speaker, Steve Blizzard.

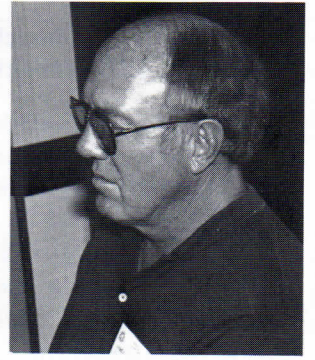


Party at "the Gambit" Helen & Charles Starr from CA (Past President of CAMA & FPA).

CAMA Reception and Banquet, Debebe Biratu from Ethiopia as member who traveled farthest.



Board of Trustees Meeting, David Gregg of CA.



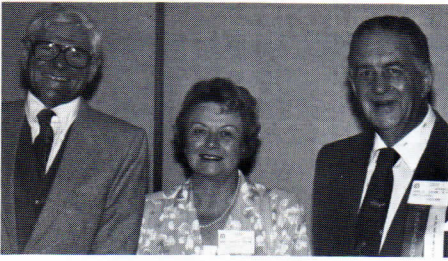
Board of Trustees Meeting, James Cooper, M.D. of TX.



CAMA Annual Meeting

San Antonio, Texas - October 24-27, 1986

Pictures taken by Dr. M. Young Stokes, III



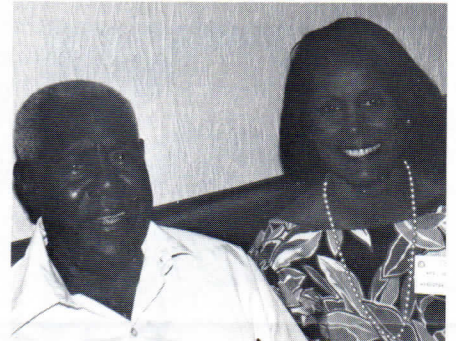
Al Shackelford (medical writer) with Mieki and Hans Grimm.



Dr. and Mrs. Heinz F. Wykypiel from Innsbruck.



Party at "the Gambit" Debebe Biratu, Steve Blizzard, and Don Copley.



Doctor John and Mrs. Ruby Martin from Kingston, Jamaica.



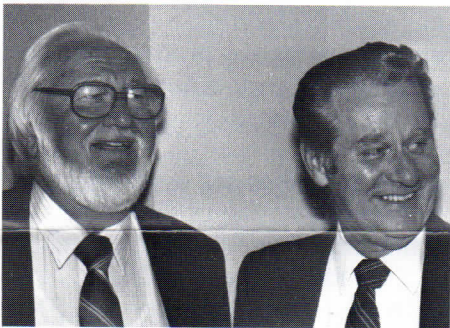
CAMA President Robert Field and First Lady Mrs. Flo Field.



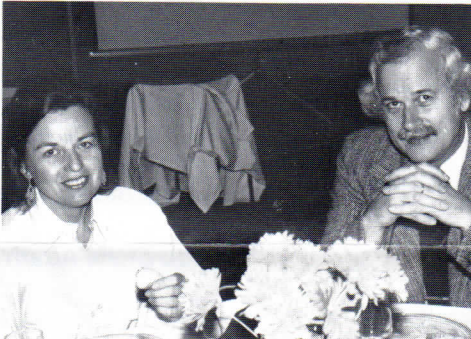
Kathy and Robert Poole from Washington, DC.



Dr. and Mrs. Isaac Terr from Las Vegas, NM.



CAMA Reception and Banquet, David Gregg and Don Copley.



Nancy and Criss Kidder, CAMA's Immediate Past President.



Dr. & Mrs. DeWayne Caviness from Chico, CA.



Party at "the Gambit" Harriet and Al Carriere.



Robert and Betty Winstanley from Johnstown, PA.

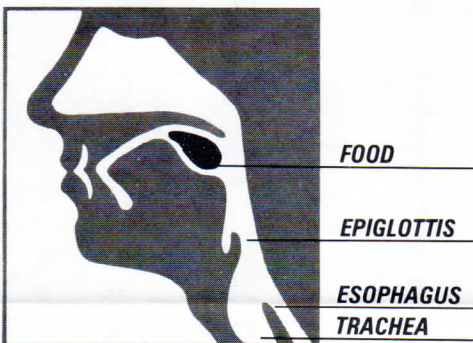


Reception and Banquet, Dr. & Mrs. Ed Luchansky from Strafford, CT.

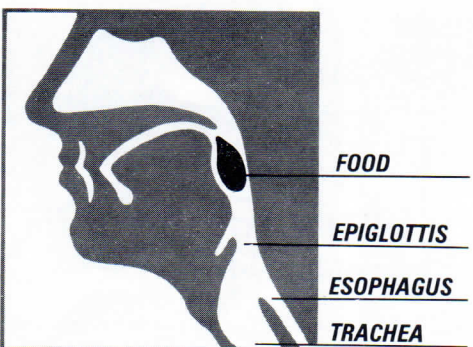
Heimlich Maneuver

CHOKING: The Slip 'Twix The Lip and The Epiglottis

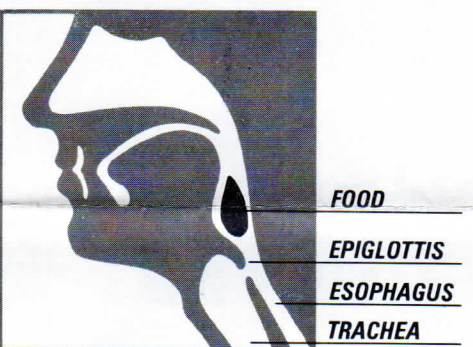
A slightly tongue-in-cheek explanation of the difference between swallowing and choking, and how to avoid the latter.



Food moves to back of throat



As food nears the trachea,
the epiglottis closes



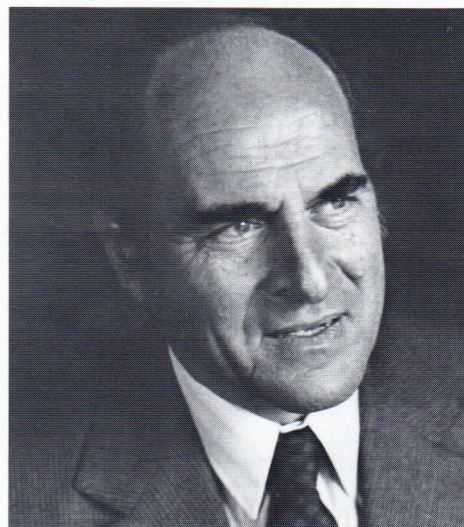
Food passes safely into
the esophagus

Choking and swallowing are *almost* the same. It's only a matter of where the food goes—a slight difference, but one that can be fatal.

To understand the difference between choking and swallowing, you need to review the names of three body parts. You probably first learned the names in junior high science.

First, the *esophagus*. The way to a man's—or anybody's—stomach is the esophagus. It's the tube through which food travels through the throat to the stomach.

Second, the *trachea*, or windpipe. That's the tube



Dr. Henry J. Heimlich

through which air travels, after having passed through the nose, mouth, and throat, into the lungs. When you swallow, don't confuse the trachea with the esophagus: you'll choke.

Now it seems such confusion would be easy to avoid. But through some fluke of design, the opening to the esophagus—where food goes—is *behind* the opening to the windpipe. That means food must pass over the opening to the windpipe on its way to the esophagus. How in the world do we avoid choking every time we swallow?

Ah. Another interesting element of anatomical design provides a kind of flap or trap door that covers the opening to the windpipe when we swallow food or liquid. The flap is called the *Epiglottis*.

But here's the rub: The presence of food near the openings to the esophagus and windpipe doesn't automatically cause the epiglottis to close off the windpipe.

To get an idea of how and when the epiglottis *does* go to work, put your fingertips on your throat, just on top of the Adam's apple. What you feel is the larynx (or voice box) which sits above the windpipe. Now swallow, and you'll feel an *upward* movement. That movement causes the closing of the epiglottis over the opening to the windpipe. If you allow food to get into that opening before you begin the swallowing action, it could become stuck.

And *that*, dear reader, is called choking.

If the object swallowed is very small or liquid, you *might* be able to force the food out of the airway by coughing. If it blocks the airway, you won't be able to cough it out.

Then, if you're lucky, there'll be somebody nearby who can use the Heimlich Maneuver, someone who knows to press the diaphragm upward to force air explosively out of the lungs, blasting the stuck food out. Or, perhaps, you'll have seen *The Heimlich Maneuver*, second edition, and will know how to save yourself.

(Continued on page 6.)

Reagan, Koch on Heimlich's "List of 2000"

Ronald Reagan and New York mayor Ed Koch are on Dr. Henry Heimlich's list of 2000 people whose lives were in jeopardy and were saved with the Heimlich Maneuver. When Mr. Reagan began choking on a peanut, Deputy White House Chief of Staff Michael Deaver used the Heimlich Maneuver to pop the nut out of the President's throat. David Margolis, president of Colt Industries, used the Heimlich Maneuver on Mayor Koch.

The effect of the Heimlich Maneuver is to force air out of the lungs explosively, as a cough would, literally blowing the obstruction out of the victim's airway.

Old-Fashioned "Common Sense" Can Kill Choking Victims

The urge to pound a choking victim on the back is almost as natural as walking—or breathing. And the temptation to shove a finger into a choking victim's throat to retrieve the offending morsel is nearly as strong.

But scores of renowned medical authorities insist that these seemingly "perfectly natural" reactions can be—and often are—fatal to the victim. Dr. Heimlich advises against using a finger to try to reach food stuck in a victim's throat, "because too often," he says, "the rescuer's fingers only drive the object deeper into the airway."

As to the back-slapping would-be rescuer, Heimlich says, "Backslappers often drive the object more tightly into the airway. Backslaps can drive the object from the throat into a lung, necessitating surgical removal."

Citing a study reported at Yale University School of Medicine, Heimlich says, "Slapping the back of a choking victim produces a *downward* force on the object lodged in the airway, moving it towards the lungs, not upward. And the downward force is greater than 3 gs—three times the force of gravity."

Heimlich offers Tips on Prevention of Choking

1. *Cut food into small pieces.*
2. *Chew food slowly and thoroughly.*
3. *Avoid talking, laughing, or drinking while you're chewing.*
4. *Choking is often associated with intoxication: drinkers become careless swallowers. If you're drinking alcoholic beverages and eating, be careful when you swallow.*
5. *If you begin to choke and you're not alone, stay where you are: There may be someone present who can help.*

6. *Children's play areas should be "childproofed" — cleared of small toys or other objects that could end up in a child's mouth.*
7. *Children should be taught not to run with food or any other object in the mouth.*

Four Minutes to Live

The human body takes oxygen pretty seriously. We can live without food for weeks, if we have enough water. We can live without water for days. But without oxygen, we can die in as little as four minutes.

With the body at rest, we breathe in about a cup of oxygen a minute. That oxygen is taken into the lungs, in which there are about 300 million tiny air sacs, called alveoli. The surface area of the walls of all those alveoli amounts to about 600 square feet. Oxygen passes through the alveoli walls into the blood. In twenty seconds, the blood has made one circuit through the body and is back in the lungs, dumping carbon dioxide and picking up a new load of oxygen.

Brain cells, like all our cells, need oxygen to live. When their oxygen supply is cut off, they die. Brain cells can live for only about four minutes, on the average, without oxygen. After those critical four minutes, chances are very good that they'll die, causing irreversible brain damage even if the victim's breathing has been restored.

The "four-minute factor" makes prompt, almost instinctive, reaction extremely important in cases of choking accidents.

How Can You Tell If A Person Is Choking? Heimlich Explains

Even the responsible individual who wants to respond to an emergency may feel a bit uncertain about just what's happening. Is the person in fact a choking victim? How can you tell? In *The Heimlich Maneuver: How to Save a Choking Victim*, second edition, Dr. Henry Heimlich tells how to recognize a choking victim.

"Usually he or she has been eating." Dr. Heimlich says. "The victims are unable to breathe or to speak. They may clutch the throat to make the universally recognized signal (the Heimlich sign) that means 'I am choking.' The skin may turn blue or flush, and then to deep blue. If treatment isn't immediate, the victim will lose consciousness and collapse."

The Heimlich Maneuver should be used as soon as choking is recognized to dislodge the object from the victim's airway and restore breathing as quickly as possible.

Reprinted by permission of Aims Media, Glendale, California.