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Issue Date: 08 June 2005

In the Matter of

MARY F. RIFFLE,
Claimant

v.

CARBON FUEL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Case No. 1989-BLA-01959

Appearances: Gregory W. Ewers, Esq.
For Complainant

William S. Mattingly, Esq.
For Employer

Before: William S. Colwell
Administrative Law Judge

DECISION AND ORDER ON REMAND – DENYING BENEFITS

This case is before me to address issues raised by a remand order from the Benefits Review Board (hereafter "BRB" or "Board"). This proceeding addresses a claim of benefits from Herbert E. Riffle ("Miner"), now deceased, and a claim by Mary Riffle ("Claimant" or "Survivor"), who is the survivor of the Miner. Their claims were filed pursuant to the Federal Coal Mine Health and Safety Act of 1969 (hereafter "Act"), as amended. The Act and implementing regulations, 20 C.F.R. Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of

the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 C.F.R. § 718.201.

The Miner filed his claim on November 7, 1979. The Miner died on October 20, 1988, and the Claimant filed a claim for survivor benefits on November 23, 1988. The claims were later joined for adjudication purposes. The Claimant, as the surviving dependent of the Miner, claims the Miner's death was due to pneumoconiosis.

The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969. These regulations at 20 C.F.R. Parts 718, 722, 725, and 726 became effective on January 19, 2001. The regulations at 20 C.F.R. §727.203 were not affected by the revised regulations. 20 C.F.R. §§725.2, 725.4(a), (d), (e).

BACKGROUND AND HISTORY OF THE CASE

After the Miner filed his claim on November 7, 1979 and the Claimant filed her claim on November 23, 1988, administrative law judges (ALJ) issued five separate final decisions – each decision was remanded by the Board back to the ALJ to address relevant issues. A summary of those decisions and related remands follow. My Decision and Order on Remand is designed to provide review of specific issues raised by the Board, and then decide the case.

Decision No. 1:

On November 14, 1991, ALJ Bober found the evidence sufficient to establish invocation of the interim presumption pursuant to 20 C.F.R. 727.203(a)(1) and insufficient to establish rebuttal of the presumption. He awarded benefits for the Miner's claim, but denied the Survivor's claim, because he found the evidence insufficient to establish the Miner's death was due to pneumoconiosis.

On July 28, 1994, the Board vacated the finding of entitlement on the Miner's claim and remanded the case for further consideration of rebuttal at 20 C.F.R. 727.203(b)(3). The Board also instructed that if on remand the ALJ awarded benefits on the Miner's claim, that the Survivor should be entitled to derivative benefits.

Decision No. 2:

On remand, by an order dated January 26, 1996, ALJ Holmes, relying primarily on Grigg v. Director, OWCP, 28 F.3d 416, 18 BLR 2-299 (4th Cir. 1994), found the evidence insufficient to establish rebuttal, and thus awarded benefits on both the Miner's and Survivor's claims.

On April 15, 1997, the Board vacated the award of benefits and found that the ALJ misapplied the holding of Grigg v. Director, OWCP, and failed to consider all relevant evidence.

On July 21, 1997, the Board denied the Claimant reconsideration regarding the Miner's claim. The Board instructed the ALJ to consider the Survivor's claim pursuant to Part 727, if benefits on the Miner's claim were denied.

Decision No. 3:

On remand, by an order dated April 8, 1998, ALJ Holmes opened the record on a limited basis and found that the Employer failed to establish the subsection (b)(3) rebuttal and affirmed the award of benefits to both claims.

On May 11, 1999, the Board upheld opening the record for a limited basis, but vacated the finding that rebuttal was not established. The Board directed the ALJ to consider the opinions of Drs. Fino and Kory since they were relevant to the issue of rebuttal. The Board also required an explanation why little weight was given to the opinions of Drs. Kleinerman and Naeye.

Decision No. 4:

ALJ Holmes found that the opinions of Drs. Fino, Kory, Naeye, and Kleinerman did not meet the subsection (b)(3) rebuttal standard from Bethlehem Mines Corp. v. Massey, 736 F.2d 120, 7 BLR 2-72 (4th Cir. 1984). The ALJ then awarded benefits on both claims.

On January 31, 2001, the Board vacated the award of benefits on both of the claims. The Board vacated the ALJ finding of the interim presumption of total disability due to pneumoconiosis pursuant to 20 C.F.R. 727.203(a)(1), and remanded the case to reconsider the invocation of the presumption and if necessary, to determine whether the presumption was established pursuant to 727.203(a)(2)-(4). The Board also held that if the ALJ found that the interim presumption was not established in the Miner's claim, he must consider entitlement in the Miner's claim under 20 C.F.R. Part 410, Subpart D, as well as entitlement in the Survivor's claim under 20 C.F.R. Part 718.

Decision No. 5:

On December 19, 2002, ALJ Holmes found that the invocation of the interim presumption was not established pursuant to subsection (a)(1), but was established pursuant to subsection (a)(2). The ALJ also found that rebuttal was established according to subsection (b)(4). Therefore, the ALJ found that entitlement to benefits in the Miner's claim was precluded under Part 410, Subpart D, and that entitlement to the Survivor's claim was precluded under Part 718. Thus, the ALJ denied both claims.

Claimant appealed citing many bases for appeal.

By a Decision and Order dated February 27, 2004, the Board remanded the case for additional review.

ORDER AND INSTRUCTIONS ON REMAND

By the February 27, 2004 Decision and Order, the Board affirmed, as unchallenged on appeal, the ALJ's finding that Claimant established invocation of the interim presumption pursuant to subsection (a)(2), relating to ventilatory studies.

The Board remanded the case for further consideration of the opinions of Drs. Klapproth, DeLara, Cinca and Muldong. Since these doctors found that the Miner had anthracosis and/or coal workers' pneumoconiosis based on their review of autopsy slides, the Board found the ALJ erred in rejecting their opinions. The ALJ was instructed to again consider these doctors' opinions and determine whether such opinions support a finding of invocation of the interim presumption pursuant to subsection (a)(1). In making this finding, the ALJ may consider any factors which affect the doctors' diagnoses of anthracosis and/or coal workers' pneumoconiosis.

The Board also instructed the ALJ to address and consider the autopsy reports of Drs. Kleinerman, Naeye, and Hansbarger, all of whom concluded that the Miner did not suffer pneumoconiosis or any disease related to coal mine employment or pneumoconiosis. The ALJ is to weigh these opinions in comparison with the reports of Drs. Klapproth, DeLara, Cinca and Muldong.

The Board also found that the record fails to demonstrate that either Dr. Fino or Dr. Kory reviewed the autopsy slides. (DX 47, 68) Thus, their opinions were medical reports and not autopsy reports, and while relevant to rebuttal at subsection (b)(4), cannot be considered to invoke the interim presumption at subsection (a)(1).

The Board found that since the ALJ's findings at subsection (a)(1) were not affirmable, the Board vacated the ALJ's determination that rebuttal of the interim presumption was established pursuant to subsection (b)(4). The Board further found that in view of the ALJ's findings regarding autopsy evidence, the finding that the employer rebutted the presumption at subsection (b)(4) by showing that the claimant does not suffer from pneumoconiosis could not stand. The ALJ is now instructed to "again consider on remand, all evidence relevant to the existence of pneumoconiosis at subsection (b)(4), if reached." The Board further directed that if the ALJ concludes that the Claimant is entitled to the presumption of total disability due to pneumoconiosis pursuant to subsection (a)(1), then a finding of rebuttal of that presumption at subsection (b)(4) is precluded.

The Board also directed the ALJ that if reached, the ALJ should reconsider his previous findings under subsection (b)(3) in light of all relevant evidence. Therefore, if reached on remand, the ALJ must again consider rebuttal of the interim presumption pursuant to subsection (b)(3) in a manner consistent with the Board's instructions in Riffle, 00-0324 BLA. Additionally, if the ALJ determines that entitlement has not been established under Part 727 in the Miner's claim, he must consider entitlement in the

Miner's claim under 20 C.F.R. Part 410, Subpart D, and if reached, entitlement in the survivor's claim under Part 20 C.F.R. Part 718.

Additional written briefs submitted by parties

By an Order dated June 30, 2004, the parties were granted until July 30, 2004 to file written briefs. At the request of the parties, this deadline was extended. Both briefs were received at this office by September 2, 2004.

APPLICABLE STANDARDS

Because the Miner's claim was filed after January 1, 1974 and before March 31, 1980, and the Miner had more than 10 years of coal mine employment, the regulations at 20 C.F.R. Part 727 apply. See 20 C.F.R. § 727.1; 20 CFR § 718.2; Pauley v. Bethenergy Mines, Inc., 501 U.S. 680 (1991). Disability benefits are payable to miners totally disabled by pneumoconiosis arising out of coal mine employment. 30 U.S.C. §§ 902(b) and 921(a). Pursuant to Part 727 of the regulations, the Miner is entitled to the rebuttable presumption that he is totally disabled from pneumoconiosis arising out of his coal mine employment if any of the following relevant requirements are satisfied:

The relevant portions of 20 C.F.R. 727.203, Interim Presumptions, read as follows:

> (a) *Establishing interim presumption*. A miner who engaged in coal mine employment for at least 10 years will be presumed to be totally disabled due to pneumoconiosis, or to have been totally disabled due to pneumoconiosis at the time of death, or death will be presumed to be due to pneumoconiosis arising out of that employment, if one of the following medical requirements is met:
>
> (1) A chest roentgenogram (X-ray), biopsy, or autopsy establishes the existence of pneumoconiosis . . . ;
>
> (2) Ventilatory studies establish the presence of a chronic respiratory or pulmonary disease . . . as demonstrated by values which are equal to or less than the values specified in the following table [table is listed]. . . .
>
> . . .
>
> (4) Other medical evidence, including the documented opinion of a physician exercising reasoned medical judgment, establishes the presence of a totally disabling respiratory or pulmonary impairment; . . .

The Claimant bears the burden of satisfying at least one of these elements by a preponderance of the evidence. Mullins v. Director, OWCP, 484 U.S. 135 (1987).

Once the presumption is invoked, the Employer may rebut the presumption by one of the following methods provided in 20 C.F.R. § 727.203:

> (b) Rebuttal of interim presumption. In adjudicating a claim under this subpart, all relevant medical evidence shall be considered. The presumption in paragraph (a) of this section shall be rebutted if : . . .
>
> . . .
>
> (3) The evidence establishes that the total disability or death of the miner did not arise in whole or in part out of coal mine employment; or
>
> (4) The evidence establishes that the miner does not, or did not, have pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The evidence does not support invocation of the interim presumption at 20 C.F.R. § 727.203(a)(1)

As directed by the Board, I considered the autopsy reports of Drs. Klapproth, DeLara, Cinca and Muldong, all submitted by the Claimant. I specifically considered any factors which affect their diagnoses of anthracosis and/or coal workers' pneumoconiosis. I also considered the autopsy reports of Drs. Kleinerman, Naeye, and Hansbarger submitted by the Employer. After considering the evidence from the above seven listed doctors, I find that the Claimant has not shown by a preponderance of evidence that the autopsy evidence establishes the existence of pneumoconiosis. I did not consider any evidence from Drs. Fino or Kory regarding this issue. Below, I have provided my analysis and findings concerning this matter.

A prosector may observe black pigment or anthracotic pigment in the lungs on autopsy. This pigment may be the result of coal deposits embedded in the miner's lungs. In order for a diagnosis to qualify as pneumoconiosis, as discussed below, there must be evidence that the lung tissue has reacted to the embedded coal deposits. Black pigment in the lungs, standing alone, does not constitute a finding of pneumoconiosis. However, observations of black pigment with associated fibrosis would qualify as a diagnosis of the disease. A finding of anthacotic pigment with associated fibrosis is the same as finding anthracosis and satisfies the definition of pneumoconiosis.

I have evaluated the evidence from the following seven physicians.

Dr. Karl L. Klapproth

After the Miner's death on October 20, 1988, Dr. Karl L. Klapproth completed a four-page autopsy report dated October 21, 1988. (DX 58, CX 12). The autopsy was limited to an examination of the chest organs only. For the final diagnosis, he noted the status of post chemotherapy and radiation therapy for small cell carcinoma of the lung, originally diagnosed in 1975.

His findings included "massive adhesions of right upper lobe to apical chest wall," "consolidation and scarring around main bronchus and pulmonary artery of right upper lobe with small focus of residual tumor," "bilateral pneumonia and pulmonary edema; focal microabscess formation," and of special note for this review of the evidence, "anthracosis with confluent consolidation in apex of right lung."

He commented that the Miner had a "longstanding history of small cell carcinoma of the lung, treated with chemotherapy and radiation therapy" and "died with evidence of bilateral pneumonia."

In providing additional information about the lungs, Dr. Klapproth's findings included the following:

> . . . around the hilus of the right lung, particularly towards the upper lobe, there is a slight induration and fibrosis around both the bronchus and the pulmonary artery without any grossly recognized tumor. The entire upper lobe appears to be shrunken and replaced by a charcoal black mass of tissue. The remainder of the right lung and the entire left lung are extremely heavy and appear firm rubbery in consistency.
>
> Dr Klapproth further reported, concerning the Miner's lungs, the following:
>
>> There is extensive hilar scarring in sections of the right hilus. There is focal area of destruction of cartilage of the main bronchus with dense fibrosis and scarring containing small nests of anaplastic hyperchromatic small hyperchromatic small neoplastic cells intermingled with many plasma cells. Many of the sections show alveolar spaces filled with fibrin and leukocytes intermingled with macrophages and occasional focal microabscess formation. In sections of the subpleural scarring of the right upper lobe, coal dust is trapped in the dense collegen scar tissue. There is likewise coal dust pigmentation of hilar lymph nodes.
>
> In an April 3, 1990 letter (CX-17), Dr Klapproth offered additional comments.
>
> Based on the review of my description of gross findings as well as a re-examination of the microscopic slides, this gentleman had evidence of Coal Workers' Pneumoconiosis with progressive massive fibrosis involving

> the right upper lobe. In layman's terms, this would -- I believe – be considered "black lung."

Dr Klapproth further stated (CX-17) that whether the condition by itself disabled the Claimant from working in the coal mines, should be addressed by a pulmonary specialist.

Attached to the April 3, 1990 letter is a one-page Cirriculum Vitae (CV). Dr. Klapproth has passed the anatomical pathology examination. On that date, he was an attending pathologist at the Charleston Area Medical Center, a consulting pathologist at Montgomery General Hospital, and worked at two listed hospitals; his duties are not listed for these two other hospitals.

Dr. Carlos F. DeLara

Dr. Carlos F. DeLara, a pathologist, reviewed 19 autopsy slides of the Miner. In a December 19, 1989 report (CX 15), Dr. DeLara stated the following:

> Sections of the right lung show extensive fibrosis with scarring at the hilus with some infiltrates of atypical small neoplastic cells intermingled with plasma cells and lymphocytes. Diffuse deposits of coal dust are also present in the areas. Other areas of the lung show deposits of coal in alveolar septae, alveoli, around blood vessels and bronchioles with reactive fibrosis . Macule and nodule formation is present especially in the upper lobes of the right lung. Some of the coal dust is within histiocytes. . . . He had bilateral pneumoconiosis with nodule formation which was present prior to the diagnosis of malignant neoplasm. The immediate cause of death was due to organizing bronchopneumonia of both lungs. The pneumoconiosis was the cause of his disability prior to the diagnosis of the tumor and also was a contributing factor to the death.

Dr. DeLara recorded that the Miner had chemotherapy and radiation for small cell carcinoma of the lung diagnosed in 1975.

A two-page CV (CX 15) shows that Dr. DeLara is a Medical Examiner for Logan County, WV; is Director of Laboratory of a general hospital; and a consulting pathologist for two other hospitals. His CV does not show that he is board certified in pathology.

Dr. Angel M. Cinco

Dr. Angel M. Cinco provides a one-page analysis (CX 13) after reviewing "the autopsy slides." His findings include the following:

> There was found, in several sections, a conglomerate of hyalinized silicotic nodules with antharacotic dusts. In other sections, I found a moderate amount of black pigments in a background of fibrosis, with

> evidence of focal emphysema. The lesion is compatible with a macular lesion of pneumoconiosis. . . . On the basis of the histological findings of the available slides, the criteria for diagnosis of simple Coal Workers' Pneumoconiosis is met.

Dr. Cinco's CV shows at the time of the report he was a board certified pathologist. He was chief pathologist of the Pathology Department for Thomas Memorial Hospital.

Dr. Ben D. Muldong

Dr. Ben D. Muldong provides a March 7, 1990, two-page analysis (CX 16) after reviewing the autopsy slides. His findings include the following:

> Microscopic examination of the autopsy slides of [the Miner] revealed PROGRESSIVE MASSIVE FIBROSIS WITH ANTHRACOSIS INVOLVING PERIBRONCHIAL LUNG PARENCHYMA AND LYMPH NODES. In addition, there is an unusual chronic peribronchial chondritis with strangulation or stenis of the bronchial lumen. Other slides of the lungs exhibit an extensive chronic constrictive pleuritis with anthracosis extending to the adjacent parietal pleura intercostal muscles with osseous metaplasia. Another section of the lung exhibits anthracosis with micronodular fibrosis accompanied by destructive emphysematous changes. The most significant finding is pneumonia.
>
> . . .
>
> The question whether the claimant suffered from Occupational Pneumoconiosis or not, the answer is yes. The cause of death is attributed to pulmonary failure due to pneumonia and Coal Workers' Pneumoconiosis is a contributing factor.

Dr. Muldong's CV shows at the time of the report he was a board-certified pathologist. He was pathologist and Director of Laboratories of Montgomery General Hospital.

Dr. Jerome Kleinerman

Dr. Jerome Kleinerman, a pathologist, provided an extensive, 12-page autopsy report (DX 63) dated May 19, 1989. He also provided detailed explanation of his reasoning during a deposition (EX 2) taken on May 12, 1990.

In the autopsy report, Dr. Kleinerman discussed the Miner's occupational history, job duties, cigarette smoking history, and medical records. He also reviewed x-ray readings from 10 B-readers, four medical consultation reports, autopsy reports and the pathological reviews of Drs. Naeye and Hansbarger. He reviewed all ventilatory studies

and analyzed them. He also reviewed the medical records concerning the Miner's treatment in 1975 for a small cell malignant tumor and the related radiation and chemotherapy. The Miner was also treated in 1976 for chronic active hepatitis. Dr. Kleinerman evaluated the Miner's extensive smoking history, and noted that the Miner was still smoking in 1979.

Dr. Kleinerman stated that chest x-rays performed in 1981 revealed severe radiation induced changes which had remained static when compared to previous films. He found that the pulmonary function results suggested a complex lung disease characterized by restrictive and obstructive lung changes which Dr. Kleinerman thought were the result of radiation and chemotherapy.

Dr. Kleinerman stated that the immediate cause of death was reported to be cardiopulmonary arrest as a result of a left middle cerebral artery infarct, and small cell carcinoma of the lung.

He reviewed the autopsy report of Dr. Klapproth.

At page 10 and 11 of his report, Dr. Kleinerman provides an extensive analysis of his reading of the autopsy slides. He described the areas of interstitial fibrosis which contain black granular and brown pigment. He further stated the following:

> The dense fibrocollagenous scar, which has replaced lung tissue, contains black granular pigment; however, the form of the collagenous fibrosis and its acellularity is not characteristic of complicated pneumoconiosis. This dense fibrosis appears to be the result of radiation and chemotherapy.
>
> . . .
>
> The lungs show no evidence of simple or complicated coalworkers pneumoconiosis, simple nodular silicosis, or conglomerate silicosis. The dense fibrosis present at the apex is the result of radiation and chemotherapy.

During his May 9, 1990 deposition, Dr. Kleinerman provided very detailed explanations to matters related to his autopsy report. He also stated his qualifications, which are extensive. He is board certified in anatomical pathology and clinical pathology. He served as the chairperson of the committee for the National Institute of Occupational Safety and Health to develop pathological standards for the diagnosis of coal workers' pneumoconiosis. The purpose of the study was to develop a series of criteria to serve as a guide to the pathology diagnosis of coal workers' pneumoconiosis.

In the deposition, Dr. Kleinerman stated why he believed that although a description of the gross findings of an autopsy is important, the critical and most important step is the review of the histologic slides. He testified that only then can coal workers' pneumoconiosis be distinguished from other types of pathology which may

simulate them. He also testified that based on his review of Dr. Klapproth's autopsy report, "apparently Dr. Klapproth did not have access to much of the clinical history, the x-ray reports or an understanding of the physiological changes that Mr. Riffle experienced during life at the time Dr. Klapproth did the autopsy."

Dr. Kleinerman further testified why microscopic examination is essential in an analysis for pneumoconiosis.

> The reason the microscopic examination is so important in simple coal workers' pneumoconiosis is that when you look at the lung with the naked eye as the dissecting pathologist or prosecting pathologist does, you can't with certainty, exclude that this simply may be a collection of dust rather than a true macule with a small amount of scar tissue in it. . . . a small collection of dust without the macular scar looks in the gross very much – virtually identical to that you see with the macule. So microscopic examination is the only way of identifying it.

Dr. Kleinerman further testified that he found no evidence of simple coal workers' pneumoconiosis with any macules in any of the sections he studied. Also, the fibrosis found in the Miner's lung was not the kind found in the complicated form or the complicated scar of complicated coal workers' pneumoconiosis. The fibrosis was caused by the radiation and chemotherapy. He believes that the radiation for the tumor, over time, affected the Miner's pulmonary function.

Dr. Kleinerman has a voluminous CV (DX 63) of 22 pages. He currently serves as the Director, Department of Pathology, Cleveland Metropolitan General Hospital, and as Professor and Vice Chairman, Department of Pathology, Case Western Reserve University School of Medicine. He is listed as a leader or member of numerous medical/advisory committees. A listing of his medical publications requires 13 pages of his CV.

The Fourth Circuit recognized the "impeccable qualifications" of Dr. Kleinerman in Sterling Smokeless Coal Company v. Akers, 131 F.3d 438 (4th Cir. 1997). In that opinion, the Court found the following:

> [T]he ALJ ignored entirely the qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnosis. And this, in spite of the impeccable credentials of one of the physicians who testified that Akers' pneumoconiosis could not have contributed toward his death, (FN2) . . . .

At footnote 2, at page 442, the Court further discussed Dr. Kleinerman's qualifications.

> . . . Dr. Kleinerman is a distinguished and board certified pathologist with a specialty in pulmonary pathology, and at the time he rendered his opinion he was a professor of pathology at Case Western Reserve Medical School, a member of the Mine Health Research Advisory Committee on the National Institute of Occupational Safety and Health, a member of the American College of Radiology Task Force on Pneumoconiosis, and had written hundreds of articles on lung pathology.

Dr. Richard L. Naeye

Dr. Richard L. Naeye, a pathologist, supplied a one-page autopsy report dated April 14, 1989 (DX 59). He had been provided medical records, work and smoking histories, and reports of chest x-rays, pulmonary function studies and arterial blood gas analyses. He also received for review an autopsy, related consultation reports, and 19 slides with tissue removed at autopsy. He reviewed the reports of Drs. Cinco, DeLara, Muldong, and the supplemental report of Dr. Klapproth.

Dr. Naeye found the following:

> There is a small amount of black pigment in the areas of the lung not associated with massive fibrosis. It is free in the tissues, mainly around the small arteries and airways. All of the black deposits are less than 1 mm in diameter so they are too small to be classified as anthracotic micronodules. There is usually no fibrous tissue or very tiny birefringent crystals associated with the black pigment.

Dr Naeye further reported:

> The most striking abnormalities in these lungs are massive fibrosis, solitary and small nests of malignant cells in dense fibrous tissue, a severe acute lobular pneumonia and plugging of airways by acute inflammatory debris and mucous. There is varying amounts of black pigment admixed with the dense fibrous tissue but no associated small birefringent crystals. Most of the fibrous tissue has no associated pigment.

Dr. Naeye, in his summary and interpretation, concluded after review of “this very complicated case” that coal workers’ pneumoconiosis was absent. He stated the following:

> Specifically there are no anthracotic micronodules present and the very small black deposits that are present have no associated fibrous tissue or very small birefringent crystals. The important finding is that the areas of the lungs that do not have small cell carcinoma or reactions to old radiation therapy have none of the findings of coal workers’ pneumoconiosis. Since coal workers’ pneumoconiosis is absent it could

> not have caused any impairment in lung function or contributed in any way to this man's death. . . . Death was due to a long list of problems, none of them related to occupational exposure to coal or coal mine dust. The problems started with his many years of cigarette smoking which led to a small cell carcinoma of the lung. The combined effects of the carcinoma, its treatment and recurrence followed by an apparent cerebral vascular accident led to pneumonia and airway plugging which were the most direct causes of death.

Attached to this report is Dr. Naeye's CV consisting of 15 pages. Dr. Naeye is board certified in anatomic and clinical pathology. Dr Naeye, at the time of the report, was a professor of pathology and Chairman, Department of Pathology, for the Pennsylvania State University College of Medicine. His CV also records positions on numerous high profile advisory and editorial boards. His CV includes a 14-page list of medical publications; a majority of the listed articles are related to medical subjects other than coal workers' pneumoconiosis.

Dr. Naeye also provided testimony through a deposition (EX 3). He was a member of a national committee appointed by the College of Pathologists -- which at the request of the National Institute of Occupational Safety and Health -- established criteria for diagnosing coal workers' pneumoconiosis by examination of lung tissue. This committee was chaired by Dr. Kleinerman, and the report was published in 1979 in the Archives of Pathology and Laboratory Medicine.

Dr. Naeye testified that over 95% of his coal workers' pneumoconiosis cases are done at the request of the Department of Labor.

Dr. Naeye testified to the minimum criteria to making a finding of coal workers' pneumoconiosis. "Number one, one possibility is to have deposits of anthracotic or black pigment in the lung that are 1 millimeter in diameter or larger in size. If there is black pigment in the lung but all of the deposits are smaller, it is not coal workers' pneumoconiosis unless there is associated fibrosis and small birefringent crystals."

Dr. Naeye found that the Miner did not have coal workers' pneumoconiosis. His reasons included the following:

> In the first place, that was only a very small amount of black pigment in his lungs, and this was present in areas where there was no associated fibrosis, so clearly, the two were not causally related; and the small amount of black pigment that were present did not reach . . . one centimeter in diameter, so they were too small to be classified anthracotic micronodules; and because there was no fibrous tissue or very tiny birefringent crystals associated with this black pigment, coal workers' pneumoconiosis was absent.

Dr. Naeye also explained why he determined that the Miner did not have complicated coal workers' pneumoconiosis.

> There was a lot of fibrosis in his lungs. None of the masses actually reached 2 centimeters in diameter, but the more important factor . . . is the fact that the fibrous tissue that was present was not associated with black pigment or with very tiny birefringent crystals; so clearly, it did not have an occupational origin.

Dr. Naeye testified that he was "at least 95% certain that [the fibrosis] was due to the original radiation therapy." Dr. Naeye recounted that the Miner had received a high level of radiation in 1975 for his lung cancer. It was unusual for a person to survive another 13 years after such cancer was diagnosed. Dr. Naeye further testified that there was a lot of fibrous tissue in the lungs, but this was not due to occupational exposure. In his opinion, the radiotherapy left behind a substantial amount of fibrosis which caused impairment and reduced the reserve of his lung capacity. He testified that he could rule out coal workers' pneumoconiosis or exposure to coal dust as causing the fibrosis. He has taught medical students and residents "many years" about drugs that injure the lungs, and has reviewed "many cases in which there is lung damage as a result of chemotherapy." He had "seen scores and scores of progressive massive fibrosis related to occupational exposure to coal and coal mine dust, and the fibrosis in this case in no regard resembles those cases. There is just no black pigment or tiny birefringent crystals associated with the bulk of this fibrous tissue."

Dr. Naeye further testified that he could rule out coal workers' pneumoconiosis or coal dust contributing to the Miner's death, because the postmortem material that he received was of high quality and "there was no way that I could have had nine slides of lung tissue and pneumoconiosis . . . could have been present if it wasn't on one of those slides."

Dr. Echols A. Hansbarger

Dr. Echols A. Hansbarger, board certified as an anatomic and a clinical pathologist, provided an evaluation dated April 11, 1989 (DX 59). He reviewed medical records, the autopsy protocol, and numerous medical and consultation reports which began in 1975. He also reviewed the 19 autopsy slides. He is the Director of Laboratories at two hospitals in Charleston, WV. His two-page CV is attached to his report.

Dr. Hansbarger found that the Miner died as a result of "Cerebrovascular Disease With Terminally Acute Aspiration Bronchopneumonia." The Miner "suffered in addition from a Very Mild Degree of Anthracotic Pigmentation of the Lung, not of a degree sufficient to warrant diagnosis of Coal Workers' Pneumoconiosis, or any other Occupational Pneumoconiosis of the Lung . . . ."

He further found massive scarring of the lung, primarily right upper lobe with marked pleural fibrosis. He stated the Miner suffered from "a Severe Fibrotic Process which was secondary to the scarring, resulting from the apparent cure of some thirteen years duration of a Small Cell Carcinoma of the Lung."

Under his Microscopic Description, his findings included the following:

> The lung shows several different disease processes. . . . Scattered throughout the lung parenchyma are noted focal deposits of anthracotic pigment without reactive fibrosis. Coal maculae are not identified. The outstanding histologic change is a marked fibrotic response of several sections with dense bands of scar . . . .

In summary, Dr. Hansbarger stated that, "I do not believe that the Anthracotic Pigmentation of the Lung contributed to Mr. Riffle's death. He certainly did not suffer from Coal Workers' Pneumoconiosis and so this disease did not contribute to his demise either."

Analysis of conclusion that evidence does not support invocation of the interim presumption at 20 C.F.R. § 727.203(a)(1)

I give more weight to the reports and evaluations of Drs. Kleinerman, Naeye, and Hansbarger, because they are more thorough and complete in their analyses, and their findings are more in line with the medical facts and circumstances of this case. Dr Kleinerman's report was 12 pages. In addition, Drs. Kleinerman, Naeye, and Hansbarger are clearly more qualified for evaluating the slides for evidence of coal workers' pneumoconiosis; all are board certified as both anatomical and clinical pathologists. Drs. Kleinerman's and Naeye's extensive, powerful CVs show they are two of the masters in their field. Dr. Kleinerman was selected as the Chairman, and Dr. Naeye was selected as a member of the special committee requested by the National Institute of Occupational Safety and Health to develop pathological standards for the diagnosis of coal workers' pneumoconiosis by examining lung tissue. This study was published in 1979. In addition, Drs. Kleinerman and Naeye have further demonstrated leadership in their field by the extensive production of medical publications.

In contrast, the reports by Drs. Klapproth, DeLara, Cinca and Muldong, are short and terse in their analysis. It does not appear that they thoroughly studied the Miner's medical history. Dr. Klapproth's reports lack a helpful explanation to support his conclusion that coal workers' pneumoconiosis is present. It is unclear how Dr. DeLara justifies his findings of coal workers' pneumoconiosis. He does not supply any analysis, but provides brief conclusions. He does not attempt to explain how coal workers' pneumoconiosis was the cause of the disability. His report does not show he evaluated any other records. Dr. Muldong provided a cursory report which was of superficial quality. It is not apparent from the CVs of Drs. Klapproth and DeLara that they are

board certified in pathology. Dr. DeLara's CV does not state he is board certified. Dr. Klapproth states he has "passed the anatomical pathological examination."

Drs. Naeye and Hansbarger reviewed the reports of these four doctors for the Claimant and provided well-reasoned responses to rebut their findings. They are persuasive in asserting that the experts for the Claimant either didn't take the time to take the extra step to analyze in closer detail what was the relationship between the black pigment and fibrosis – or they did not have the expertise to make the distinction. None of the four doctors for Claimant addressed or responded to the extremely thorough explanations submitted by Drs. Kleinerman, Naeye, and Hansbarger.

The specific and detailed information provided by Drs. Kleinerman, Naeye, and Hansbarger about the effect of the radiation treatment on the massive fibrosis appears very reasonable and in line with the Miner's history of cigarette smoking and the related radiation and chemotherapy treatment. The deposition testimony by Drs. Kleinerman and Naeye helps show why they have both served as professors for such lengthy periods. They focused directly on addressing the findings of Claimant's four pathologists that the Miner's tissue samples showed evidence of anthracosis and/or coal workers' pneumoconiosis. Drs. Kleinerman's and Naeye's testimony is a straightforward tutorial explained why the black pigmentation was not related to coal workers' pneumoconiosis and how the 1975 cancer treatment caused the massive fibrosis.

Dr. Kleinerman was also persuasive in explaining his belief that his microscopic examination was more exacting and his review of the slides was more informative than Dr. Klapproth's evaluation. Dr. Naeye carefully explained how he determined that the black pigment was not associated with the massive fibrosis. He was at least 95% certain that the radiation caused the impairment in the Miner's lung capacity. Dr. Hansbarger's explanation that he found anthracotic pigment without reactive fibrosis fell in agreement with the findings of Drs. Kleinerman and Naeye.

In summary, after evaluating the pathological evidence provided by the above seven listed physicians, I find that the Claimant did not show by a preponderance of evidence that the presumption at 20 C.F.R. § 727.203(a)(1) should apply.

Interim presumption at 20 C.F.R. § 727.203(a)(2) previously established

In its February 27, 2004 Decision and Order, the Board affirmed, as unchallenged on appeal, the ALJ's finding that claimant established invocation of the interim presumption pursuant to 20 C.F.R. 727.203(a)(2).

Thus, there is an interim presumption for the Miner, that since he engaged in coal mine employment for at least 10 years, he will be presumed to be totally disabled due to pneumoconiosis, or to have been totally disabled due to pneumoconiosis at the time of death, or death will be presumed to be due to pneumoconiosis arising out of that

employment, since the following element has been previously shown by a preponderance of the evidence:

> (2) Ventilator studies establish the presence of a chronic respiratory or pulmonary disease . . . as demonstrated by values which are equal to or less than the values specified in the following table [table is listed]. . . .

Once the presumption is invoked, the Employer may rebut the presumption by one of the following methods provided in 20 C.F.R. § 727.203:

> (b) Rebuttal of interim presumption. In adjudicating a claim under this subpart, all relevant medical evidence shall be considered. The presumption in paragraph (a) of this section shall be rebutted if: . . .
>
> . . .
>
> (3) The evidence establishes that the total disability or death of the miner did not arise in whole or in part out of coal mine employment; or
>
> (4) The evidence establishes that the miner does not, or did not, have pneumoconiosis.

<u>The interim presumption at 20 C.F.R. § 727.203 (a)(2) is rebutted at § 727.203 (b)(4), because the evidence establishes that the Miner did not have pneumoconiosis</u>.

The interim presumptions shall be rebutted if the evidence establishes that the miner does not have pneumoconiosis.

To rebut the presumption by 727.203(b)(4), the party opposing entitlement must affirmatively show the absence of legal or clinical pneumoconiosis. See <u>Curry v. Beatrice Pocahontas Coal Co.</u>, 67 F.3d 517 (4th Cir. 1995).

Pneumoconiosis is defined at 20 C.F.R. § 727.202 as follows:

> For the purposes of the act, pneumoconiosis means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosisanthro-silicosis, massive pulmonary fibrosis, progressive massive fibrosis silicosis, or silicotuberculosis arising out of coal mine employment. For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or aggravated by, dust exposure in coal mine employment.

For this issue, I have considered all evidence in the record to determine whether the Employer has shown by a preponderance of the evidence that the Miner did not have pneumoconiosis.

Physicians supporting finding of pneumoconiosis

Dr. D. L. Rasmussen

Dr. D. L. Rasmussen provided a report dated November 4, 1988 (CX 7) regarding his physical examination of the Miner. Although the Miner was unable to provide a history due to his memory and brain damage, a family member gave a history. Dr. Rasmussen referred to an x-ray interpretation by Dr. Lois Speiden, who was a board-certified radiologist and B-reader. Dr. Rasmussen reported that Dr. Speiden found "small pulmonary parenchymal densities consistent with simple pneumoconiosis t/p with a profusion of 1/0 throughout all three lung zones on the left side, and the lower two lung zones on the right." He also reported that considering the Miner's significant history of coal mine exposure, that it "is medically reasonable to conclude that he does have coal workers' pneumoconiosis which arose from his coal mine employment." He further reported the following:

> The patient also has x-ray evidence which would tend to confirm a volume loss of the lungs which may have occurred secondary to radiation therapy in the right upper lobe presuming that is the location of his malignancy. The later could be, in part, responsible for the reduction in diffusing capacity and the restrictive ventilatory impairment. There would be no way in which a clear separation can be made between this affect, his coal mine exposure, and his cigarette smoking.

Dr. Lois Speiden

Dr. Lois Speiden, a board-certified radiologist and B-reader, in her report (CX 14) November 6, 1989, stated in addition to what was reported by Dr. Rasmussen, the following:

> The right upper lobe shows significant volume loss and localized pleural thickening. This is associated with retraction of the right hilum upward and retraction of the mediastinum toward the right side. The findings here are highly suggestive of a carcinoma in the right upper lobe perhaps with some treatment causing some scarring and retraction of the adjacent structures. . . . Clinical correlation is needed to identify the findings here. The changes seen in the right apex are not felt to be due to pneumoconiosis.

Dr. W. Alva Deardorff

Dr. W. Alva Deardorff, a board-certified radiologist and a B-reader, in a report dated "1-12-88" (CX 20), evaluated x-ray films of the Miner. He found the films to be Grade One quality, and reported that "the upper lobe deformities result from complicated pneumoconiosis, because I see no definite evidence of old surgery on the right upper lobe . . . ." This report is attached to a copy of a reading dated "1-15-88."

Dr. Deardorff also provided a report dated November 4, 1988 (CX 8). He found the films to be Grade One quality, and reported that that "there are many small opacities throughout all parts of the left lung and in the middle zone on the right. Findings are compatible with pneumoconiosis."

Dr. Dominic Gaziano

The Claimant submitted a letter by Dr. Dominic Gaziano dated March 29, 1990 (CX 26). After he reviewed the pathological reports of Dr. DeLara and Dr. "Muldone," he stated that although those two doctors had found that the Miner had coal workers' pneumoconiosis, Dr. Graziano did "not think pneumoconiosis contributed to the [M]iner's death. It was felt that his death was due to his lung cancer and subsequent treatments." On a handwritten note dated 4/4/90, Dr. Graziano added that he had seen Dr. Klapproth's 4/3/90 report diagnosing complicated pneumoconiosis, and this would qualify the Miner for black lung benefits.

Dr. Gaziano provided a letter dated April 4, 1990 (CX 28). He had treated the Miner for lung cancer. Based on his review of Dr. Klapproth's report, Dr. Gaziano stated that the Miner had "simple coal workers' pneumoconiosis." He referred to the "progressive massive fibrosis involving the right upper lobe due to coal workers' pneumoconiosis. He further stated his belief that the "development of progressive massive fibrosis may have been accelerated by radiation and chemotherapy but in of itself is not stimulus enough to produce the findings consistent with complicated pneumoconiosis." Dr. Gaziano's CV lists him as being board certified in internal medicine, chest diseases, and critical care.

Dr. Gaziano was deposed on May 17, 1990 (CX 32). His testimony included the following information. He diagnosed the Miner with lung cancer and black lung disease at the same time in 1975. He based his diagnosis of pneumoconiosis primarily on x-ray readings. He is not a radiologist. He is now a B-reader, but was not in 1975 at the time of diagnosing pneumoconiosis. He based his finding of complicated pneumoconiosis on the autopsy report of Dr. Klapproth. At the deposition, he stated he learned for the first time there were different standards for diagnosing complicated pneumoconiosis using radiographic and pathologic readings.

The general practice when he treated the Miner for cancer was to give the level of radiation therapy necessary to kill the cancer. He has seen patients where the radiation treatment has caused significant fibrosis.

Dr. Gaziano testified that he believed that an autopsy is a better method to diagnose coal workers' pneumoconiosis than use of a radiograph. He almost always defers to the pathologist. He stated that a large amount of radiation to the chest can cause changes on the x-ray that could confuse the reader of the x-ray. Chemotherapy, to a lesser extent, can also cause this. The medicine Cytoxan, proscribed for the Miner for his cancer treatment, can result in producing pulmonary fibrosis. He agreed with the statement that concerning radiation injuries of the lung, that "within the therapeutic range of doses usually administered, the pulmonary parenchyma reacts to ionizing radiation in up to 100% of patients." Dr. Graziano stated that he really didn't know if the Miner had pneumoconiosis. He stated, ". . . my impression of complicated is a pathological decision. We have this discrepancy in pathology, and I'm not the one you need to see to resolve this issue."

Dr. Gaziano provided a July 3, 1980 reading of an x-ray taken the same day. He found the reading positive for pneumoconiosis. He was not then a board-certified radiologist or a B-reader.

Dr. Charles D. Smith

Dr. Smith provided an August 17, 1980 reading of a July 3, 1980 x-ray (DX 21). A board-certified radiologist and a B-reader, Dr. Smith determined that the film quality was 2, and found simple pneumoconiosis.

Dr. Stephen W. Fisher

Dr. Fisher, a board-certified radiologist and a B-reader, on July 1, 1984 gave a reading of an x-ray taken on May 4, 1984 (DX 23). He found the reading positive for pneumoconiosis.

Dr. B.H. Goerlich

Dr. Goerlich provided a medical statement dated April 23, 1981 (DX 25) which states that that his impression is "pneumoconiosis, category 1/1q." He states in part that, "[t]here is some scattered q and r nodulation over the mid lung zones, consistent with pneumoconiosis, category 1/1q. There is increased density over the right apex, medially, with retraction of the trachea towards the right. We think that this is caused by the patient's previous radiation therapy for reported carcinoma of the lung." There is no reference to what x-ray study he used as a reference.

By a September 1, 1989 letter (DX 27), Dr. Goerlich provides a review of a film taken August 5, 1983. Dr. Goerlich statements include the following: "There is some scattered q-type nodulation in all lung zones, consistent with pneumoconiosis category 1/1q . . . ." He further stated that the film was of adequate technical quality, and he believed that the Miner had pneumoconiosis. He noted "considerable fibrotic streaking

over the right upper lung field with considerable pleural apical capping and retraction of the trachea towards the right." This suggested an "old tuberculous process."

Dr. Goerlich's qualifications are not shown.

Dr. R. O. Cale

Dr. Cale provides an August 5, 1983 consultation (DX 26) in which he finds that the "Chest examination is satisfactory for black lung determination." He also states the "classification for pneumoconiosis would be borderline, category 1/0, Q, P, tbu." No other information is provided about this report.

Dr. Maurice Bassali

Dr. Bassali, a B-reader, submits a report date April 5, 1984 (DX 28). He stated the technical quality of the films is considered "Good – No. 1." He found that there "is a diffuse chronic interstitial lung disease consistent with pneumoconiosis, type p/s with profusion of 2/2 affecting all six lung zones. A large opacity size B is seen in the right lung apex." His impression was that "there is evidence of complicated pneumoconiosis, category B, superimposed upon pneumoconiosis, type p/s with profusion of 2/2 affecting all six lung zones." He also found a "right apical pleural thickening which of width B and extent 1, which could be caused by pneumoconiosis."

Physicians supporting finding of no pneumoconiosis

Drs. Kleinerman, Naeye, and Hansbarger

For the reasons explained above, I give strong weight to the autopsy reports of Drs. Kleinerman, Naeye, and Hansbarger that pneumoconiosis was not present in the Miner.

The Board has held that autopsy evidence is the most reliable method of ascertaining the existence of pneumoconiosis. Kimick v. National Mines Corp., 2 B.L.R. 1-221 (1979).

Dr. Paul Francke, Jr.

The medical records (DX 37) include two x-ray readings by Dr. Francke. On February 24, 1982, he made readings of x-rays taken on July 3, 1980 and April 21, 1981. Dr. Francke is a board-certified radiologist and a B-reader. He saw "no definite x-ray evidence of pneumoconiosis." He identified fibrosis in the upper right lobe.

Dr. W. K. C. Morgan

The medical records (DX 37) include two x-ray readings by Dr. Morgan. On March 29, 1982, he made readings of x-rays taken on July 3, 1980 and April 21, 1981. Dr. Morgan is a B-reader. He found no evidence of pneumoconiosis.

Dr. George L. Zaldivar

Dr. Zaldiver gave a medical exam to the Miner on May 18, 1983. He provided a three-page report (DX 38) concluding that the Miner did not have pneumoconiosis. He reviewed the Miner's medical records and obtained a work history from the Miner. Dr. Zaldivar completed an x-ray evaluation on May 18, 1983 in which he found no evidence of pneumoconiosis. Dr. Zaldivar is a B-reader and board-certified in pulmonary diseases and internal medicine. Dr. Zaldivar stated as his findings that the Miner did not have pneumoconiosis. He found that "the only abnormality seen in the chest x-ray pertains to the cancer in the right upper lobe which was radiated. There is a great deal of fibrosis in that area." Dr. Zaldivar also stated that the Miner's treatment using cytoxan could be a factor, since that medicine can cause fibrosis in the lungs. Dr. Zaldivar stated that the moderate obstructive impairment was the result of chronic cigarette smoking. The Miner continued to smoke after his treatment for lung cancer. Another possible cause is cirrosis of the liver. A 1976 biopsy showed that the Miner had severe hepatitis with necrosis of areas of the liver. He was diagnosed "as a chronic, active hepatitis and, therefore, still has it to this date." Dr. Zaldivar also found that the Miner had emphysema which was the result of chronic inhalation of tobacco smoke and was not related to his work.

Dr. Zalidar's CV shows he has served as an associate professor of medicine at West Virginia University and as Medical Director of the Respiratory Therapy Program of the University of Charleston.

Dr. Zaldivar provide two additional x-ray readings that he found negative for pneumoconiosis. On November 21, 1983, he provided a reading of an August 5, 1983 x-ray (DX 39). On March 26, 1984, he provided a reading of a July 3, 1980 x-ray (DX 41).

Dr. Paul S. Wheeler

Dr. Wheeler, a board-certified radiologist, is an associate professor of radiology at the John Hopkins School of Medicine and the John Hopkins Hospital. He submitted a chest x-ray reading with a report dated November 26, 1985 (DX 42). Attached to the report is his reading of an x-ray dated April 5, 1984. He found no evidence of pneumoconiosis.

His report also states that the examination shows the following:

> . . . extensive healed tuberculosis of the right upper lobe and apex with dense fibrosis extending from the apex to the upper right hilum . . . . I believe the entire right upper lobe is scarred and contracted by healed tuberculosis judging from the dense apical pleural thickening and calcified granulomata in the right hilum and paratracheal area.

Dr. Wheeler also submitted an x-ray reading (DX 40) dated February 9, 1984 of an x-ray taken August 5, 1983. He found that the x-ray did not contain evidence of pneumoconiosis.

His CV shows he graduated from undergraduate and medical school at Harvard University. His CV of six pages shows numerous publications, most relating to adapting computers to assist in medicine. Two articles directly related to diagnosing pneumoconiosis.

Dr. William G. Hayes

Dr. Hayes provided an April 5, 1984 x-ray reading of an April 21, 1981 x-ray (DX 41). He is board certified in radiology (diagnostic radiology), nuclear medicine, and pediatrics, and he is qualified as a B-reader. He found that the x-ray did not contain any findings suggestive of occupational pneumoconiosis.

Dr. Hayes' CV shows he is a Clinical Associate Professor, Department of Radiology, West Virginia University School of Medicine. He also works with Associated Radiologists, Inc. at the Charleston Area Medical Center, in Charleston, WV.

Dr. William S. Cole

Dr. Cole provided a January 6, 1986 reading of an April 5, 1984 x-ray (DX 43). Dr. Cole is a board-certified radiologist and a B-reader. He did not find evidence of pneumoconiosis, but found fibroid tuberculosis in the right upper lobe.

His CV shows he has lectured extensively from 1970 to 1982 about issues related to pneumoconiosis. He is a delegate or consultant major medical centers and federal government agencies on pneumoconiosis.

Dr. Richard P. O'Neill

Dr. O'Neill provides a January 16, 1986 reading of an x-ray taken April 5, 1984 (DX 44). Dr. O'Neil is a B-reader. He found that the reading did not show evidence of pneumoconiosis. He stated in his report dated January 17, 1986, that "there is loss of volume of the right lung with broadening of the right upper mediastinum with dense fibrotic contracture of part of the right upper lobes." He stated as the impression,

"Fibrotic contracture right upper lobe – probably due to previous granulomatous disease."

Dr. O'Neill's CV shows that he made a report before the U.S Senate on pneumoconiosis (paper published in the National Archives), plus he lists 24 publications, many of which directly relate to pneumoconiosis.

Dr. Ross C. Kory

Dr. Kory provides a May 4, 1988 review (DX 47) of the Miner's medical records with an evaluation of the case. His review is extensive after reviewing the Miner's medical records from 1975 to 1984. He provides seven comprehensive pages of essential findings. He describes the severe treatment that the Miner endured due to his lung cancer and that the treatment helped the Miner survive an "extraordinary" nine years when the life expectancy is 12 – 18 months. Dr. Kory then explained the expected changes to the lung with the radiation treatment and chemotherapy. He states that Drs. Fisher, Bassali, Goerlich, and Gale -- who determined that the x-rays they studied showed pneumoconiosis -- apparently did not know about the effects of the radiation and chemotherapy, and thus those readings are flawed.

Regarding the radiation treatment and chemotherapy, Dr. Kory stated the following:

> There is a failure on the examining physicians to recognize the damaging effects of radiation and chemotherapy on the lung parenchyma. This pattern of therapy regularly results in localized fibrosis secondary to the radiation, and often more generalized interstitial pneumonitis and fibrosis from the combination of radiation therapy and chemotherapy. Progressive impairment in pulmonary function is the rule rather than the exception after these combined chemotherapy-radiation therapy programs particularly if the patient continues to smoke.

Dr. Kory, in summary, stated "with more than a reasonable medical certainty that there is insufficient objective evidence to justify diagnosis of coal workers' pneumoconiosis." He also found (in Dr. Kory's 1988 report) that the last medical records received by the doctor (to 1984) did show "moderate obstructive ventilatory impairment. This undoubtedly was caused by the lung cancer, the post-radiation therapy and post-chemotherapy changes, and by Mr. Riffle's continued cigarette smoking."

Dr. Kory's CV is very impressive, showing that has served as a professor of medicine for the Pulmonary Disease and Critical Care Division, University of South Florida College of Medicine and has published 43 medical articles and three books. He is board certified in internal medicine with a subspecialty in pulmonary disease.

Dr. Kory provided a March 19, 1990 addendum (EX 1) to his 1988 report for which he reviewed additional medical records and reports from April 1988 to December 1989. His report is a very comprehensive seven pages. Dr. Kory further stated that no chest x-rays before June 1975 (when small cell bronchogenic carcinoma was diagnosed) suggested the presence of pulmonary opacities consistent with coal workers' pneumoconiosis. Dr. Kory further explained how the radiation therapy and chemotherapy would cause severe scarring. The Miner's case was also complicated by the Miner continuing to smoke, thus helping maintain inflammation.

Dr. Kory stated, "It is impossible to interpret chest x-rays in this milieu without knowledge of what basic process was present (lung cancer), what therapy was given (radiation and chemotherapy), and what complications ensued (continued inflammation from infection and from continued cigarette smoking)." He also stated in his evaluation the following:

> Radiation and chemotherapy can produce diffuse radiation pneumonitis and chemotherapy fibrosis. This could easily be confused radiologically. Thus in patients who have been treated with heavy thoracic radiation and chemotherapy, simple coal workers' pneumoconiosis cannot be diagnosed radiologically unless it can be proven that it was present prior to the radiation and chemotherapy.

Dr. Kory specifically discounts the reliability of reports from Drs. Deardorff and Speiden, who found pneumoconiosis, because they did not account for the affects of the cancer treatment.

In summary, Dr. Kory found that the Miner did have "significant respiratory impairment" and stated it "was secondary to his small cell carcinoma of the lung and most especially to the radiation and chemotherapy. . . . None of this impairment can be attributed to pneumoconiosis."

Dr. Gregory J. Fino

Dr. Fino provided a medical evaluation dated May 26, 1988 (DX 47). He reviewed medical records from 1975 to May 1984 and gave a very comprehensive 12-page review. Dr. Fino found that the Miner had a "remarkable" survival of 13 years from a cancer for which survival length is normally a short period. He found that the Miner did not have pneumoconiosis. He stated the following:

> First of all, the great majority of chest x-ray readings are negative for pneumoconiosis. Indeed, he has an abnormal chest x-ray, but the fibrotic changes, the volume loss of the upper lobe, the retraction of the hilar areas, and any other abnormalities that have been seen on the chest x-ray are clearly due to his carcinoma of the lung and radiation therapy. Radiation fibrosis is a well known cause of pulmonary fibrosis. It is well

documented in the literature. The chest x-ray is most consistent with his previous carcinoma of the lung and radiation therapy.

In conclusion, he found that there was insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis.

Dr. Fino provided a supplement report dated May 32, 1989 (DX 68) for which he analyzed later medical exams and reports. A B-reader, Dr. Fino read the May 3, 1988 x-ray that Dr. Deardorff had read positive for pneumoconiosis and the chest x-ray dated September 28, 1988 that Dr. Speiden had read positive for pneumoconiosis. Dr. Fino classified each film as 0/0, and stated they did not contain evidence of coal workers' pneumoconiosis.

He noted that the autopsy physician did not make a diagnosis of coal workers' pneumoconiosis, but noted anthracosis or the deposit of coal pigment in lung tissue.

He found that "the reduced diffusing capacity along with the mild obstructive lung disease can be explained by his heavy cigarette smoking, his lung cancer, and the effects of his treatment for lung cancer based on the autopsy findings."

Dr. Fino's CV shows he is board-certified in internal medicine with a subspecialty in pulmonary diseases. He also serves as an assistant clinical professor of medicine, Division of Pulmonary Disease, University of Pittsburg.

Dr. Robert J. Crisalli

Dr. Crisalli examined the Miner on August 12, 1988 and provided a report dated December 14, 1988 (DX 49). He also reviewed the medical records of the Miner. Dr. Crisalli pointed to the effects of the treatment for lung cancer. He stated that "multiple x-rays performed at NIH since that time indicated the presence of changes secondary to his radiation therapy. Radiation therapy can cause fibrotic changes in the lung and ultimately volume loss." Dr. Crisalli, in his summary, stated that after review of x-rays back to 1980, "nearly everyone of the x-ray reports indicates the presence of findings consistent with right upper lobe volume loss. . . . In sixteen of the twenty-two radiographic reports available, no occupational pneumoconiosis is present."

Dr. Crisalli concluded that "the only medically reasonable interpretation of all of these x-rays is that the patient has no radiographic evidence of occupational pneumoconiosis but does have chronic right upper lobe changes related to his small cell carcinoma of the lung and the subsequent therapy."

Dr. Crisalli attached to his report an August 12, 1988 x-ray reading by Dr. J.L. Leef which finds "no evidence of occupational pneumoconiosis."

Dr. Crisalli's CV shows he is board certified in internal medicine.

Medical records -- additional information

Medical records of the Miner (DX 37) on numerous evaluations report severe radiation-induced changes caused to the lung related to the lung cancer treatment. A March 18, 1980 report records "severe post-radiation fibrotic changes especially affecting the right upper lung zone with attendant volume loss." A June 8, 1978 report stated that there "is considerable paramediastinal scarring particularly in the right apex with pleural reaction as before. A few nodular densities in the right mid-lung are again noted and unchanged presumably representing scarring." A November 16, 1977 report states "examination of the chest again demonstrates the apical fibrosis on the right with loss of volume." Other reports are similar. An undated report by Dr. S. Weinberger states the impression, "CXR picture most compatible with radiation-induced fibrosis . . . . No obvious tumor, but obviously difficult to ascertain in scarred area."

Analysis of conclusion that evidence supports finding that the Miner did not have pneumoconiosis (simple or complicated)

The Miner's medical history (especially records related to his cancer treatment) supports the more persuasive findings of doctors' reports and evaluations submitted by the Employer that the Miner's severe radiation and chemotherapy treatment caused the scarring and fibrosis to the Miner's lungs – and his disability, and that the Miner did not have pneumoconiosis (simple or complicated). As pointed out by Employer's doctors, there was no x-ray evidence of pneumoconiosis before the Miner began his severe cancer treatment in 1975. All doctors -- who commented on the length of the Miner's survival – marveled at the extraordinary length of time (about 13 years) the Miner survived after beginning treatment, when 12-18 months was considered the maximum survival time. The more convincing evidence shows that the extensive radiation treatment and medicine taken for chemotherapy to provide such an extension of the Miner's life resulted in debilitative scarring and fibrosis in his lungs. The fibrosis and scarring then resulted in continued lung impairment.

The superior qualifications of the Employer's doctors are an important factor in supporting their uniform theory of this case. I have previously discussed the eminent qualifications of Drs. Kleinerman and Naeye. They, plus Dr. Hansbarger, are all board certified as both anatomical and clinical pathologists. Dr. Gaziano, a doctor submitted by the Claimant, concedes that for this case, he defers to the pathologists to determine the findings. He also supports the Employer's doctors' position when they state that extensive fibrosis would cause changes on x-rays that could confuse reading of x-rays.

The qualifications and experience of Drs. Cole, O'Neill, and Kory are also significantly more powerful in comparison to any doctors submitted by the Claimant, and I find their opinions persuasive.

The depth and comprehensive nature of the reports (including testimony) of Drs. Kleinerman, Naeye, Kory, and Fino merit greater probative weight than any reports of the Claimant, which are generally short and terse. Also telling, numerous doctors of

the Employer reviewed all medical records and the reports of the critical doctors submitted by the Claimant and provided cogent, direct answers to those reports. Claimant did not provide responses to the focused, on-target, and consistent reports submitted by the Employer. There was no answer back.

Numerous doctors submitted by the Claimant recognized that there was severe scarring caused by the cancer treatment, which supports the Employer's position that this severe scarring hindered x-ray interpretations by Claimant's doctors. Dr. Kory chastised Drs. Fisher, Bassali, Goerlich, Cale, Deardorff, and Speiden for providing x-ray readings of pneumoconiosis without showing they understood the effect of the radiation and chemotherapy treatment.

I did consider that Drs. Speider, Deardorff, Smith, and Fisher are board-certified radiologists and B-readers that found by their x-ray readings that the Miner had pneumoconiosis. Dr. Bassali, a B-reader, in addition to several other doctors without such qualifications, also interpreted x-rays to show pneumoconiosis. In addition, Drs. Klapproth, Gaziano, Muldong, and Bassali stated they saw evidence of complicated pneumoconiosis. As discussed within my evaluation, the more persuasive evidence submitted by the Employer's doctors is convincing that the Miner did not have clinical pneumoconiosis, either simple or complicated.

I find that the medical experts submitted by the Employer -- listed above, who find no pneumoconiosis on the x-ray readings -- present a theory of this case more logical and consistent with the severe cancer treatment that caused extensive fibrosis and scarring. The continued smoking by the Miner would cause continued inflammation to the affected lung tissue.

With the recognized effects of the cancer treatment of fibrosis and scarring, any positive x-ray reading for pneumoconiosis is suspect. This is especially so since no x-rays showed the evidence of pneumoconiosis before the cancer treatment. Therefore, the pathological reports take on an even more increased importance. The reports and testimony of Drs. Kleinerman and Naeye are convincing that under the circumstances of the Miner's cancer treatment, the essential step to determine if pneumoconiosis is present is the pathological analysis of the lung tissue to verify the relationship of the fibrosis and the coal deposits or black pigment.

The medical experts for the Employer also showed, by a preponderance of evidence, that there was no "legal" pneumoconiosis. The Miner did not have any chronic pulmonary disease, arising out of coal mine employment, resulting in respiratory or pulmonary impairment significantly related to, or aggravated by, dust exposure in coal mine employment. Medical opinions are relevant to the issues of whether a miner has legal pneumoconiosis. A determination of the existence of pneumoconiosis may be made by a physician exercising sound medical judgment if they are supported by objective medical evidence.

Drs. Kleinerman, Zalivar, Kory, Fino, and Crisalli, all provided well-reasoned medical opinions after extensive review of the Miner's medical records. Drs. Zaldivar and Crisalli examined the Miner. The reports submitted by the Employer strongly support a finding that the Miner died of the effects of small cell carcinoma of the lung and other related conditions to the Miner's chronic inhalation of tobacco smoke. Also, the Miner did not have any disease related to coal mine employment. The medical reports submitted by the Claimant, including those of Drs. Rasmussen and Gaziano, did not provide evidence of any other chronic pulmonary disease, arising out of coal mine employment, resulting in respiratory or pulmonary impairment significantly related to, or aggravated by, dust exposure in coal mine employment. They focused on pneumoconiosis, primarily justified by x-ray readings, which I discussed above.

In summary, I find the reports and medical opinions submitted by the Employer merit greater probative weight and show by a preponderance of evidence that the Miner did not have pneumoconiosis. These credible and well-reasoned medical opinions are convincing for purposes of establishing that the Miner did not have pneumoconiosis, simple or complicated, or any other respiratory or pulmonary impairment arising out of coal mine work. This evidence outweighs the contrary conclusions provided by the numerous doctors submitted by the Claimant. I conclude, therefore, that the Miner was disabled by the severe treatment for his lung cancer caused by smoking, and his continued smoking, and other related conditions caused by his smoking. The Miner's disability and death were not caused by coal mine employment.

Based on the above factual findings, there is no reconsideration of previous findings under subsection (b)(3)

The remand instructions state that if reached on remand, the ALJ must again consider rebuttal of the interim presumption pursuant to subsection (b)(3) in a manner consistent with the Board's instructions in Riffle, 00-0324 BLA. As I find the evidence shows that the Miner did not have pneumoconiosis, I do not reach the analysis under this subsection.

Entitlement has not been established in the Miner's claim under 20 C.F.R. Part 410, Subpart D

The remand instructions state if entitlement has not been established under Part 727 in the Miner's claim, the ALJ must consider entitlement in the Miner's claim under 20 C.F.R. Part 410, Subpart D. Since I have found that rebuttal has been established under 20 C.F.R. § 727.203(b)(4), entitlement is then precluded under Part 410. See Lefler v. Freeman United Coal Co., 6 B.L.R. 1-579 (1983).

Entitlement not established in the Survivor's claim under Part 20 C.F.R. Part 718

The remand instructions state that if entitlement in the Miner's claim under 20 C.F.R. Part 410, Subpart D, is found, then consider entitlement in the Survivor's claim under Part 20 C.F.R. Part 718. Here, the evidence shows that the Miner did not have

pneumoconiosis, and the Miner's claim under 20 C.F.R. Part 410, Subpart D was not established. The Survivor's claim was not established under Part 20 C.F.R. Part 718, since the Miner's death was not due to pneumoconiosis.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing and the arguments of the parties.

Because the Claimant has failed to meet her burden to establish that the Miner had pneumoconiosis, the Miner and the Claimant are not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to her in pursuit of this claim.

ORDER

The claims for benefits by the Miner and the Claimant are hereby DENIED.

A

WILLIAM S. COLWELL
Administrative Law Judge

WSC:dj

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2004), any party dissatisfied with this order of dismissal may appeal it to the Benefits Review Board within 30 days from the date of this order of dismissal`, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.