U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue date: 24Sep2001

CASE NO.: 2000-BLA-662

In the Matter of:

ROY L. CHRISTIAN
Claimant

v.

SHANNON POCAHONTAS MINING COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party in Interest

Appearances:

W.F. Cox, Lay Representative
For the Claimant

William T. Brotherton, III, Esquire
For the Employer

Before: ROBERT J. LESNICK
Administrative Law Judge

DECISION AND ORDER - AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et. seq*. In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A hearing was conducted in Beckley, West Virginia on March 1, 2001 at which time all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and the Regulations issued thereunder, found in Title 20, Code of Federal Regulations. During the hearing Director's Exhibits Nos. 1 through 84, Administrative Law Judge Exhibits No. 1, Claimant's Exhibits Nos. 1 through 8, and Employer's Exhibits Nos. 1 and 9 were received in evidence.[1] Employer submitted three exhibits post-hearing that have been marked consecutively.[2] All of this evidence has been made part of the record.

The only issue to be decided in this claim is whether claimant has established a change in condition since the time of the prior denial or that there is a mistake in a determination of fact.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background

This claim has followed a long path in making its way to the undersigned, therefore, an extensive procedural history is necessary to understand the present posture of the above-captioned claim. Roy Christian ("claimant" or "miner") filed his present claim for benefits under the Act on May 21, 1992. (DX 1). Claimant received an award of compensation benefits from West Virginia Workers' Compensation Board ("WV Board") in 1981. (DX 1). Claimant filed with the WV Board for an increase in benefits in 1984 which was subsequently denied. Employer was notified of the pending claim on May 29, 1992 and promptly filed a notice of controversion of the claim on June 8, 1992. (DX 13 & 14). Claimant's claim for benefits was denied by the Office of Workers' Compensation Programs ("OWCP") on October 30, 1992 because claimant failed to establish any of the elements necessary for entitlement. (DX 15). Claimant requested a hearing before the Office of Administrative Law Judges ("OALJ") on December 17, 1992. (DX 16). The claim was forwarded to the OALJ on March 9, 1993. (DX 23).

A formal hearing was held in Beckley, West Virginia on October 19, 1993 before Administrative Law Judge Victor J. Chao. (DX 27). Judge Chao issued a Decision and Order Denying Benefits on December 16, 1993 finding that claimant did not meet any of the elements necessary for entitlement

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[1] The following abbreviations have been used in this opinion: DX = Director's exhibits; EX = Employer's exhibits; CX = Claimant's exhibits; ALJX = Court exhibits; TR = Hearing Transcript; NR = Not recorded; BCR = Board-certified radiologist; B = B reader.

[2] Employer's recently submitted exhibits consist of the deposition transcript of Dr. Darrick Leacock, chest x-ray interpretations of Drs. Jerome Wiot, Harold Spitz, and Ralph Shipley, and the deposition transcript of Dr. Rowena Gonzales-Chambers.

to benefits under the Act. (DX 29). Claimant appealed Judge Chao's decision to the Benefits Review Board ("Board") on January 4, 1994. (DX 30).

The Board affirmed in part and vacated in part Judge Chao's decision and remanded the claim to the OALJ. (DX 40). The Board remanded the claim for the judge to reweigh the evidence in accordance with the then recent decision in *Adkins v. Director, OWCP*, 958 F.2d 49, 16 BLR 2-61 (4th Cir. 1992). Additionally, the Board remanded the claim for the judge to examine and explain the weight afforded to the opinions of the West Virginia occupational pneumoconiosis board and to reevaluate the issue of total disability.

Administrative Law Judge Robert J. Mahony[3] issued a Decision on Remand on October 4, 1995. (DX 46). Judge Mahony found that claimant had established the existence of pneumoconiosis, however, had failed to establish total disability for such condition. (DX 46). Claimant promptly appealed Judge Mahony's decision to the Board. (DX 47). The Board vacated Judge Mahony's finding as to total disability and remanded the claim for further consideration. (DX 58). Judge Mahony issued a Decision on Remand on August 26, 1996 finding that claimant had failed to establish total disability due to pneumoconiosis. (DX 66).

Claimant again appealed to the Board. (DX 67). The Board issued a Decision on September 2, 1998 affirming Judge Mahony's Decision on Remand. (DX 72). Claimant subsequently filed a Request for Modification with OWCP on August 5, 1999. (DX 73). A Proposed Decision and Order Denying the Request for Modification was issued by OWCP on January 11, 2000. (DX 81). That Decision and Order found that the evidence did not show a change in condition nor did it show a mistake in determination of fact. (DX 82). Claimant then requested a hearing before the OALJ.[4] (DX 82). The claim was forwarded to the OALJ on April 12, 2000. (DX 84).

The above-captioned claim was set for hearing before Administrative Law Judge Edward Terhune Miller by notice dated June 23, 2000. On August 30, 2000, claimant requested that the hearing be continued. An Order granting the continuance was issued by Judge Miller on September 1, 2000. The undersigned issued a notice of hearing in this claim on October 23, 2000. On February 6, 2001, employer requested a continuance or in the alternative that the record remain open post-hearing for the submission of rebuttal evidence. The request for the record to remain open post-hearing was granted by the undersigned on February 7, 2001 without a formal order.

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[3] Between the time of the original decision and the remand order, Judge Chao became unavailable. The claim was then assigned to Judge Mahony.

[4] This request also included notification that S.F. Raymond Smith was replaced as counsel in this claim by W.F. Cox, lay representative on March 3, 2000. Mr. Cox was granted permission to represent claimant at the formal hearing held in this matter. (TR 5).

Claimant testified at the March 1, 2001 hearing that he began his coal mine employment with Allied Chemical in which position claimant was responsible for operating the clarification plant and the preparation plant. (TR 17). Claimant testified that he was then transferred to a different mine by the same company. (TR 19). Claimant worked at "Capels" for 11 years as a tipple mechanic and as a preparation plant mechanic. (TR 19). Claimant stated that this employment presented a very dusty work environment. (TR 19). Claimant stated that he did not work in the coal mining industry after this time and that his last coal mine employment was with Shannon Pochahontas Coal Company. (TR 20).

Claimant explained his job duties as including having to "exchange [burnt out motors] and manually replace them." Additionally, claimant stated that his job included replacing conveyers that "tear up, [p]lus a lot of shoveling and stuff like that. Pumps, water pumps tear up. We had to replace the water pumps." (TR 21). Claimant stated that the water pumps weighed approximately 60 to 70 pounds each and he had to climb 8 floors of stairs on a daily basis. (TR 21). Claimant also stated that he carried a 30-35 pound tool belt on his hip when he was climbing and descending the stairs. (TR 22). Claimant further explained that he does not believe that he could perform this work in his present condition because he becomes short of breath with minimal exertion. (TR 22). Claimant was being medicated for his condition with inhalers and a nebulizing machine at the time of the hearing. (TR 23).

On cross-examination, claimant stated that he had sought coal mine employment after being laid off from his position with employer. (TR 24). Claimant testified to his medical history. In January, 1980, claimant underwent bypass surgery with 2 grafts being placed, both of which failed. (TR 24-25). In 1984, claimant worked for approximately 4 months installing heat pumps. (TR 25-26). Claimant began receiving social security disability benefits in 1990. (TR 26). Claimant stated that this award was predicated on his coronary condition. (TR 27). This award also permitted claimant to stop working, however, during the summer of 1990, claimant installed heat pumps on his own. (TR 27-28).

Claimant stated further that he underwent a heart catherization at Duke University in December of 1979 and again in 1991. (TR 29). Claimant heart condition is followed by Dr. Prescott presently. (TR 29). Claimant went on to explain his lung cancer condition. The cancer occurred first in claimant's left lung which claimant had removed in 1995. (TR 30). Prior to claimant's surgery, he testified that he was treated by Dr. Jabour, with his treatment being rendered by Dr. Chambers after the surgery. (TR 31). Claimant testified that he was later treated with chemotherapy for cancer in his right lung. (TR 32).

Claimant also testified to his cigarette smoking history on cross-examination. Claimant stated that he smoked cigarettes from 1947 to 1979. (TR 32). Claimant stated further that his smoking habit increased in severity as time progressed. (TR 33). Claimant illustrated this by stating that when he started to smoke, he smoked one pack per day, with that number increasing to approximately five packs per day from 1974 to 1979. (TR 33). Claimant also stated that when he asked Dr. Muscani for the "patches" to quit smoking, the patches were intended for his wife and not himself. (TR 33). Claimant's wife passed away on October 14, 1999. (TR 34).

Claimant stated that he continues to live in and maintain his home. (TR 35). Claimant also maintains a summer home in North Carolina. (TR 35). He stated further that he is currently taking two cardiac medications per day. (TR 35). Claimant explained that he has a neighbor who helps him maintain his home, but that he is able to perform routine daily activities for himself. (TR 36).

On redirect examination claimant stated that his cardiac condition began in 1979. (TR 37). He stated that he underwent two bypass surgeries in 1980 and was off of work for 6 weeks recuperating. (TR 38). He also stated that he was able to work in the preparation plant for approximately 3 1/2 years after his cardiac surgeries. (TR 38). Claimant also stated that he last went to Duke University for treatment in 1990 because the physician informed him that his arteries were regrowing. (TR 39).

Medical Evidence

Chest X-Rays[5]

Exhibit No.	***Date of X-ray***	***Date of Reading***	***Physician/ Qualifications***	***Interpretation***
DX 10	7-1-92	7-24-92	Francke, BCR/B	Negative
DX 11	7-1-92	7-9-92	Daniel, BCR/B	Negative
DX 24	5-19-93	9-1-93	Alexander, BCR/B	1/2
DX 24	5-19-93	9-2-93	Ahmed, BCR/B	2/1
DX 24	5-19-93	9-10-93	Capiello, BCR/B	1/2
DX 26	5-19-93	5-24-93	Smith, BCR/B	0/1
DX 26	5-19-93	6-17-93	Spitz, BCR/B	Negative
DX 26	5-19-93	6-25-93	Wiot, BCR/B	Negative
DX 73	10-27-98	11-24-98	Aycoth, B	1/2[6]

[5] There are nine chest x-ray interpretations that were rendered while claimant was a patient at Princeton Community Hospital and Bluefield Regional Medical Center. There interpretations are as follows: Dr. Miller (6-22-980; Dr. Rahman (2-25-98); Dr. Shahan (10-3-97, 11-1-95, & 9-6-00); Dr. Aycoth (3-10-97); Dr. Pathak (6-5-98, 5-15-95, & 11-30-00). I accord less weight to these interpretations because they were rendered while claimant was undergoing treatment for lung cancer.

[6] Dr. Aycoth found the existence of complicated pneumoconiosis on this x-ray film.

DX 73	10-27-98	10-28-98	Subramanian, BCR/A[7]	1/1
DX 78	10-27-98	9-20-99	Navani, BCR/B	Negative
DX 79	10-27-98	10-7-99	Gaziano, B	1/1
DX 80	10-27-98	10-21-98	Ranavaya, B	1/0
EX 8	10-27-98	8-2-00	Wiot, BCR/B	Negative
EX 8	10-27-98	8-9-00	Spitz, BCR/B	Negative
EX 8	10-27-98	8-1-00	Shipley, BCR/B	Negative
CX 1	12-19-00	12-20-00	Subramanian, BCR/A	1/1[8]
EX 11	12-19-00	3-2-01	Wiot, BCR/B	Negative
EX 11	12-19-00	3-10-01	Spitz, BCR/B	Negative
EX 11	12-19-00	3-16-01	Shipley, BCR/B	Negative

CT Scan Reports

June 7, 2000

Dr. Afzel Ahmed interpreted a CT scan taken of claimant on June 7, 2000. (CX 3). Dr. Ahmed is board certified in radiology and is a B-Reader. (CX 4). Dr. Ahmed interpreted the CT scan to show "status post left pneumonectomy with shift of mediastinum to the left." Simple pneumoconiosis changes were observed in the right lung. Dr. Ahmed "doubted" that the changes were due to complicated pneumoconiosis.

Drs. Wiot, Shipley and Spitz found that this CT scan showed nothing that was compatible with a diagnosis of coal workers' pneumoconiosis.

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[7] I take official notice of Dr. Subramanian's credentials from the American Board of Medical Specialties and the NIOSH certified reader list.

[8] Dr. Subramanian found the existence of complicated pneumoconiosis on this x-ray film.

January 27, 2000

Dr. Enrico Cappiello interpreted this CT scan to show "metastatic nodules in the right lung larger and more confluent than on prior exams." (EX 5). Dr. Cappiello is a board certified radiologist and a B-Reader. (CX 7).

Dr. Wiot found that the January 27, 2000 CT scan showed no evidence that would indicate coal workers' pneumoconiosis. Dr. Wiot is board certified in radiology and is also a B-Reader.

Dr. Spitz, who is board certified in radiology and is a B-Reader, found no evidence of coal workers' pneumoconiosis.

Dr. Shipley found no evidence of coal workers' pneumoconiosis.

July 13, 1999

Dr. Cappiello interpreted claimant's CT scan taken on July 13, 1999. (CX 6). Dr. Cappiello found "complicated pneumoconiosis with large opacites in right upper lobe."

Dr. Arthur Levy also interpreted the July 13, 1999 CT scab of claimant's thorax. (EX 5). Dr. Levy found "metastatic nodules in the right lung with some slight increase in size in the interval between films."

December 10, 1998

Dr. Edward Aycoth interpreted a CT scan of claimant's thorax on December 10, 1998. (EX 5). Dr. Aycoth found a "slight increase in the number and size of faint nodular densities of right lung since" prior studies.

June 22, 1998

Dr. Michael Shahan interpreted a CT of claimant's chest on June 22, 1998. (EX 5). Dr. Shahan found "greater indistinetness of multiple predominantly upper lung pulmonary densities with at least one appearing larger." Dr. Shahan also noted pulmonary metastasis with active granulomatous diseases.

December 12, 1997

Dr. Ahmed interpreted the December 12, 1997 CT scan to show a 25% increase in "neoplastic process right chest when compared" to previous interpretations. Dr. Ahmed also noted that claimant had undergone a left pneumonectomy. (EX 5).

October 3, 1997

Dr. Aycoth interpreted the October 3, 1997 CT scan to show nodules in the right lung that were likely metastatic disease. (EX 5).

October 3, 1996

Dr. Kishor Pathak interpreted claimant's October 31, 1996 CT scan. (EX 5). Dr. Pathak found that the scan showed a prior left pneumonectomy. Additionally, Dr. Pathak found changes consistent with chronic obstructive pulmonary disease in the miner's right lung with "ill-defined fibrotic densities." Dr. Pathak also found no change in the miner's condition since September, 1996.

September 4, 1996

Dr. Aycoth interpreted the miner's September 4, 1996 CT scan to show "faint 1 cm density foci of the right mid lung, right posterior mid chest wall and right anterior upper chest wall which are possibly superimposition of shadows and fibrosis." Dr. Aycoth noted that metastatic disease could not be ruled out.

Pulmonary Function Studies

Ex. No.	***Date***	***Age***	***Height***	***FEV1***	***MVV***	***FVC***	***Tracings***	***Qualify***
DX 7	7-1-92	59	66.5	2.91	92	4.13	Yes	No
DX 63	5-9-95	61	70	2.57	65	3.43	No	No
DX 63 EX 1	2-15-95	61	70	2.57 2.69*[9]	64.97 66.68*	3.43 3.99*	Yes	No No
DX 73	7-29-99[10]	66	68	1.73	NR	2.47	Yes	Yes
CX 1	12-19-00	67	68	1.45	47	2.49	Yes	Yes

[9] The * denotes that the test results are post-bronchodilation treatment.

[10] This pulmonary function study was found not to be of acceptable quality by Dr. M.I. Ranavaya because claimant exhibited less than optimal effort and the study was improperly performed. (DX 76). Dr. Ranavaya is board certified in occupational medicine and is NIOSH certified in spirometry.

EX 9	8-7-00[11]	67	67	1.65 1.84*	NR	2.92 3.13*	Yes	No No

For a miner of claimant's height of 68.5[12] inches, § 718.204 (c)(1) requires an FEV1 equal to or less than 1.95 for a male 59 years of age, 1.92 for a male 61 years of age, 1.84 for a male 66 years of age, and 1.82 for a male of 67 years of age. If such an FEV1 value is shown, there must be in addition, an FVC equal to or less than 2.48, 2.45, 2.36, and 2.34, respectively or an MVV equal to or less than 78, 77, 74, and 73; or a ratio equal to or less than 55% when the results of the FEV1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table above. The FEV1/ FVC ratio requirement remains constant.

Arterial Blood Gas Tests

Exhibit No.	***Date***	***pO2***	***pCO2***	***Qualify***
DX 9	7-1-92	66	32.8	Yes
DX 73	10-27-98	73	38	No
CX 1	12-19-00	89	35	No
EX 9	8-7-00	82.4	36.3	No

Physician Reports

Dr. John Daniel

Dr. John Daniel[13] examined claimant on July 1, 1992. (DX 8). Dr. Daniel notes that claimant was employed in the coal mining industry for 25 years, with his last coal mine employment from 1980 to 1984 as a tipple mechanic. Dr. Daniel noted that claimant has suffered from heart disease since 1979.

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[11] The physician note attached to this study indicates that a poor initial effort was noted. However, cooperation and comprehension were both noted as good on the documented report.

[12] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in this claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 3 (4th Cir. 1995). In this case, Mr. Christian's listed height ranges from 66.5 to 70 inches. Taking the average of the heights listed, I find that claimant is 68.5 inches tall.

[13] I take official notice of Dr. Daniel's credentials from the American Board of Specialties. Dr. Daniel is board certified in family practice.

Dr. Daniel noted claimant's cigarette smoking history as including smoking one pack per day for 32 years, ending in 1979. Claimant stated that his symptoms included sputum production, wheezing, dyspnea, a cough, chest pain, and ankle edema. Dr. Daniel conducted a chest x-ray, pulmonary function study, arterial blood gas study, and an EKG.

Dr. Daniel diagnosed claimant as suffering from chronic obstructive pulmonary disease ("COPD"), based on claimant's smoking history, abnormal arterial blood gas test results, and pulmonary function test results. Dr. Daniel opined that claimant's condition was caused by his cigarette smoking history. Dr. Daniel concluded that claimant's studies indicated a moderate pulmonary impairment, caused by COPD, "which would prevent performing moderate or heavy manual labor." Dr. Daniel opined that if properly medicated, claimant's condition could improve.

Dr. Robert J. Crisalli

Dr. Robert Crisalli, who is board certified in internal medicine and pulmonary disease, examined claimant on May 19, 1993. (DX 26). Dr. Crisalli diagnosed claimant as suffering from chronic bronchitis, atherosclerotic heart disease. Dr. Crisalli reached the conclusion that claimant suffers from chronic bronchitis based on claimant's history of a sputum producing cough for 20 years.

Dr. Crisalli noted that claimant had 24 years of coal mine employment, ending in 1985. A cigarette smoking history of one pack per day for 30 years, ending in 1980. Dr. Crisalli notes that this is a heavy smoking history. Dr. Crisalli noted the following symptoms: 10 years of dyspnea with one flight of stairs; daily cough productive of sputum for 20 years; orthopnea for the 3 to 5 years prior to the examination date; paroxysmal nocturnal dyspnea for the 3 to 5 years prior to the examination; occasional ankle edema for the 3 to 4 years prior to the examination; and "anginal-type" chest pain. Dr. Crisalli also noted that claimant suffered from a kidney stone in 1972, has continuing angina, and had a coronary artery bypass graft in 1980.

Dr. Crisalli conducted a physical examination that exhibited no evidence of any pulmonary disease nor any pulmonary related cardiac disease. Dr. Crisalli also found no evidence of an upper airway obstruction. Dr. Crisalli reviewed the chest x-ray interpretations of Drs. Smith, Spitz, and Wiot, none of which found any occupational pneumoconiosis. Dr. Crisalli also interpreted a pulmonary function study to show results within the normal range but Dr. Crisalli notes that the FEV/FVC ratio indicates a mild airflow obstruction. Dr. Crisalli notes that he found no restrictive defect nor any air trapping, as well as finding normal arterial blood gas results.

In rendering his ultimate opinion, Dr. Crisalli reviewed Dr. Daniel's report, a job description of claimant's last coal mine job, office notes from Princeton Internists, a letter from March, 1991 from Duke University, and a rehabilitation consultant's report. Dr. Crisalli opines that claimant does not suffer from coal workers' pneumoconiosis. Dr. Crisalli concludes that claimant suffers from a "mild pulmonary impairment secondary to chronic bronchitis which is secondary to a heavy smoking history."

Dr. Crisalli opines that claimant's exertional limitations are "secondary to a very significant cardiac disease." However, Dr. Crisalli finds that this condition is not related to nor is it contributed to by coal dust exposure.

Dr. Gopal Pardasani

Dr. Gopal Pardasani conducted a biopsy of claimant's lung on March 2, 1995. (DX 41 & EX 2). Dr. Pardasani found no obvious nodules of pneumoconiosis. However, Dr. Pardasani did find evidence of coal workers' pneumoconiosis of a variety that Dr. Pardasani opined needed to be "correlated with [claimant's] occupational history." Dr. Pardasani conducted both a microscopic and macroscopic examination. Dr. Pardasani diagnosed claimant as suffering from "well differentiated multicentric bronchioalveolar adenocarcinoma involving apical portion of the upper lobe with diffuse involvement of the lower lobe." Dr. Pardasani found evidence of coal worker's pneumoconiosis of the "simple macular variety."

Dr. Richard Naeye

Dr. Richard Naeye issued a report in this claim on February 27, 1997. (DX 61). Dr. Naeye is board certified in pathology. Dr. Naeye reviewed the biopsy slides of claimant's lung. Dr. Naeye noted that the amount of black pigment present in the sections varies in size. Dr. Naeye finds that the black deposits are large enough to be classified as "anthracotic micro-nodules." Dr. Naeye also found focal emphysema in the rims surrounding the "anthracotic micronodules and some smaller black deposits" that constitute "2 -3% of the total emphysema."

In his microscopic examination, Dr. Naeye found evidence of chronic bronchitis. Dr. Naeye also found that other than the existence of coal workers' pneumoconiosis, the "most striking abnormality in the lungs is the large masses of bronchoalveolar adenocarcinoma in several lung sections and in several regional lymph nodes." Dr. Naeye interpreted this information to show mild to moderately "severe simple coal workers' pneumoconiosis." Dr. Naeye found that this condition was characterized by multiple anthracotic micronodules and a large number of small black deposits. Dr. Naeye opines that claimant's coal workers' pneumoconiosis is not severe enough to prevent claimant from engaging in "hard physical work in the coal mining industry."

Dr. Naeye found that this diagnosis was supported by the results of the pulmonary function studies. Dr. Naeye opines that little or none of the centrilobular emphysema present resulted from claimant's exposure to coal dust. Dr. Naeye states that this conclusion is supported by studies

conducted by "ALFORD scientists."[14] Dr. Naeye states that these studies show that coal dust exposure "does not cause clinically significant emphysema in U.S. miners."

Dr. Joseph J. Renn

Dr. Joseph J. Renn, who is board certified in internal medicine and pulmonary disease, issued a report in this claim on May 29, 1997.[15] (DX 62). Dr. Renn noted an occupational history including 25 years of coal mine employment. Additionally, Dr. Renn noted a cigarette smoking history listed one time as 32 years, ending in 1979, and on another report, 30 years, ending in 1980. Dr. Renn also noted claimant's cardiopulmonary history including coronary artery bypass surgery in 1980, with an additional bypass being necessary in 1993. Dr. Renn reviewed the laboratory data and interpreted the results in the following manner.

Dr. Renn opines that the pulmonary function evidence shows a "very mild obstructive ventilatory defect." Dr. Renn states that the July, 1992 and May, 1993 MVV results are invalid because they do not correlate with the observed FEV1 values. Dr. Renn states further that claimant's May, 1993 lung volumes are normal. This finding eliminates the possibility that claimant suffers from a restrictive defect or a significant obstructive defect. Claimant's May, 1993 diffusing capacity was interpreted by Dr. Renn to be invalid because claimant failed to reach 90% of the observed inspiratory vital capacity. Additionally, Dr. Renn interpreted claimant's July, 1992 resting arterial blood gas results as illustrating "mild alveolar hyperventilation." Dr. Renn found the May, 1993 resting arterial blood gas results to be normal. Lastly, Dr. Renn, a certified B reader, found the chest x-ray evidence to lack changes consistent with coal workers' pneumoconiosis.

Dr. Renn reached the conclusion that claimant suffers from chronic bronchitis with mild obstruction and "arteriosclerotic coronary vascular disease manifested by angina pectoris." Dr. Renn recommended that claimant undergo another coronary artery bypass graft. Summarizing, Dr. Renn concludes that claimant does not suffer from pneumoconiosis. Claimant suffers, according to Dr. Renn, from a very mild obstructive defect that is "insufficient to prevent [claimant] from being able to perform his last coal mine employment or work of similar effort." Dr. Renn opines that when considering only claimant's respiratory capacity, claimant "retains the physiologic ability to perform his usual coal mine employment of preparation plant mechanic or similar work effort."

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[14] Dr. Naeye states that these studies find that a drop in FEV levels in American miners is "too small to produce any disability when age and cigarette smoking are taken into account."

[15] In rendering his opinion, Dr. Renn relied on the following documentation: physical demand classification of claimant's last coal mining job; medical history and examination of Dr. Daniel; the report of Dr. Crisalli; arterial blood gas testing; pulmonary function testing; and chest x-ray evidence.

Dr. E. Rhett Jabour

The records of Dr. E. Rhett Jabour pertaining to claimant are a part of the record in this claim.[16] (DX 63). The progress notes include the dates of February 15, 1995 through May 15, 1995. Dr. Jabour consistently notes through his notes that claimant suffers from multifocal bronchoalveolar carcinoma, coronary artery disease with congestive heart failure, and pneumoconiosis. Dr. Jabour also has notes pertaining to claimant's pneumonectomy in March of 1995. The note states that a large mass was found in the left lower lobe of claimant's left lung with another mass adjacent to that one. It is also noted that all of the specimens taking from claimant's resected lung show well differentiated multi-centric bronchoalveolar carcinoma.

Discharge Report from Princeton Community Hospital

Claimant was admitted to Princeton Community Hospital on March 1, 1995 and discharged on March 10, 1995. (DX 63). Also included as a part as a part of this exhibit are the operative report, consultation report, and the pre-admission history and physical. (DX 63). At the time of claimant's discharge, it was noted by Dr. Generoso Duremdes that claimant had undergone a "left exploratory thoracotomy and left pneumonectomy for bronchoalveolar carcinoma of left lower lobe with extension to the left upper lobe." The principle diagnosis at this time was "bronchiole alveolar adenocarcinoma, well differentiated, multicentric." The secondary diagnoses by Dr. Duremdes include: 2 large tumor masses in the left lower lobe, 3 tumor masses in the left upper lobe, no evidence of tumor metastasis to the hilar lymph nodes, coal workers' pneumoconiosis, coronary artery disease, atrial fibrillation, and controlled congestive heart failure.

Also included as a part as a part of the exhibit are the operative report, consultation report, and the pre-admission history and physical. (DX 63).

Dr. Darrick Leacock

Dr. Darrick Leacock, a board eligible family practitioner, issued his first report in this claim on August 5, 1999. (DX 73). Dr. Leacock began treating claimant at the Tug River Health Association, Inc. in October, 1998. Dr. Leacock notes claimant's symptoms as including shortness of breath since 1975, occasional cough and wheezing, lung cancer, and congestive heart failure. Dr. Leacock also noted claimant's prior procedures including a left pneumonectomy and triple bypass surgery.

Dr. Leacock noted that claimant's cigarette smoking history including smoking 2 packs of cigarettes per day for 35 years, ending in 1980. Occupationally, Dr. Leacock noted 25+ years of coal

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[16] I take official notice of Dr. Jabour's credentials from the American Board of Medical Specialties. Dr. Jabour is board certified in internal medicine and pulmonary disease.

mine employment. On July 29, 1999, Dr. Leacock conducted a physical examination, a pulmonary function study, an arterial blood gas test, and a chest x-ray. Dr. Leacock acknowledges that the results of these tests are higher than the disability requirements of the Department of Labor, however, Dr. Leacock concludes that claimant is unable to return to his last job mining job. Dr. Leacock bases this on the fact that claimant has a variety of pulmonary problems, including the pneumonectomy, obstructive lung disease, and possible restrictive lung disease. Dr. Leacock states that all 3 of these conditions contribute to claimant's pulmonary impairment and that the source of these conditions include lung cancer, cigarette smoking, and coal dust exposure. Dr. Leacock concludes that claimant's coal workers' pneumoconiosis is significant in nature.

Dr. Leacock issued an additional report in this claim on January 26, 2001. (CX 1). Dr. Leacock again noted symptoms and history that he noted above. Dr. Leacock states that he has treated claimant frequently and that claimant suffers from shortness of breath being treating with inhalers and other breathing medications. Again, Dr. Leacock conducted diagnostic testing in rendering his opinion.[17] Dr. Leacock also notes that claimant's pulmonary function study results of October, 1998 show that claimant's pulmonary function is significantly reduced, with that result being supported and showing further deterioration with the results of the December, 2000 study.

Dr. Leacock summarized the evidence as showing the existence of coal workers' pneumoconiosis. Dr. Leacock notes that Dr. Chambers diagnosed claimant with lung cancer and coal workers' pneumoconiosis. Additionally, Dr. Leacock notes that Dr. Iosif stated that claimant suffers from significant cardiac disease and a disabling respiratory impairment caused by lung cancer and claimant's previous surgical treatment for lung cancer. In Dr. Leacock's opinion, claimant suffers from a disabling lung disease. Dr. Leacock opines that claimant's duties as a coal miner involved strenuous labor. Dr. Leacock opines further that claimant's cardiac disease is significant in nature. Dr. Leacock opines that based on his professional knowledge and the medical information available, claimant suffers from coal workers' pneumoconiosis and is totally disabled from a respiratory standpoint. Dr. Leacock finds that claimant's total disability is due to lung cancer and coal workers' pneumoconiosis. Dr. Leacock stated that claimant's coal workers' pneumoconiosis was caused by his coal mine employment and that claimant's coal workers' pneumoconiosis was a contributing cause to his total disability.

Dr. Leacock was also deposed in connection with this claim on February 20, 2001. (EX 10). Dr. Leacock stated that he has seen claimant 2 times since beginning his treatment, at Tug River Clinic. However, claimant has been seen at the clinic since 1998, approximately 5 times. Dr. Leacock stated that all of claimant's coronary problems, including congestive heart failure, contribute to claimant's respiratory problems. Dr. Leacock states that these conditions as well as claimant's lung cancer, cigarette smoking, and pneumoconiosis contribute to claimant's total disability. Dr. Leacock explained

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[17] In addition to the diagnostic testing, Dr. Leacock reviewed the chest x-ray readings of Drs. Shipley, Wiot, Cappiello, and Ahmed and the reports of Drs. Pardasani, Chambers, and Iosif.

that he understood Dr. Chambers' notation that claimant suffers from progressive coal workers' pneumoconiosis to mean that claimant's lungs are deteriorating with regard to lung function because of the coal workers' pneumoconiosis.

Dr. Leacock went on to testify that the removal of claimant's left lung would lead to a substantial reduction in claimant's respiratory capacity. Dr. Leacock opines that claimant's lung cancer was caused by his history of cigarette smoking. Dr. Leacock went on to state that cancer has spread to claimant's right lung and that the spread of that disease would also cause a reduction in respiratory function. Dr. Leacock find that the removal of the left lung and the cancer spreading to the right lung alone would render claimant totally disabled. However, Dr. Leacock does not believe that claimant's coronary disease alone would render claimant totally disabled.

Dr. Leacock states that he is unable to attribute causation to each of the disease processes outlined above. Dr. Leacock took issue with Dr. Iosif's determination that comparing pre-pneumonectomy pulmonary function results to post-pneumonectomy results would adequately represent the effect of the pneumonectomy on claimant's pulmonary function. Dr. Leacock takes issue with this because he states that such a comparison only looks at one factor and completely discounts the effects of the coal workers' pneumoconiosis. Dr. Leacock stated that coal workers' pneumoconiosis was not a significant contributing factor in claimant's respiratory impairment and that there is no way to establish that claimant's coal workers' pneumoconiosis alone would be totally disabling. However, on cross-examination, Dr. Leacock clarified that claimant's coal workers' pneumoconiosis was a contributing cause to claimant's pulmonary disability. Dr. Leacock further clarified that the coal workers' pneumoconiosis is aggravating an already disabling condition in claimant's lung cancer.

Dr. Rowena Gonzales-Chambers

Dr. Gonzales-Chambers issued a letter in this claim on December 4, 2000. (CX 5). Dr. Gonzales-Chambers explained that claimant had undergone "exploratory thoracotomy and left pneumonectomy for multifocal bronchioalveolar carcinoma of the left lower lobe with extension to the left upper lobe" in March, 1995. Dr. Gonzales-Chambers also stated that claimant had undergone chemotherapy treatment. Dr. Gonzales-Chambers elaborates that claimant suffers from "baseline" pneumoconiosis and black lung. This condition is evidence by the macular deposits of black pigment found in claimant's resected lung. Dr. Gonzales-Chambers states that claimant's chest x-rays show the deterioration associated with pneumoconiosis and that claimant suffers from progressive worker's pneumoconiosis.

Dr. Gonzales-Chambers' office records with regard to claimant are also included in the record in this claim. (EX 7). In these records Dr. Gonzales-Chambers details her treatment of claimant's lung cancer with chemotherapy. Also included in these records is a consultation report from Dr. Gonzales-Chambers from March 1, 1995. This report lists claimant's admitting diagnosis as follows: "multi-focal bronchiolo-alveolar carcinoma of the left lower lobe with extension to the left upper lobe, status post

exploratory thoracotomy and left pneumonectomy; coronary artery disease with congestive heart failure; pneumoconiosis; and hypoproteinemia." Dr. Gonzales-Chambers reiterated this diagnosis on claimant's visits to her office, dated May 15, 1995, November 1, 1995, and March 4, 1996. Dr. Gonzales-Chambers added to this diagnosis on June 5, 1996 when she added "senile keratosis with actinic keratosis of both upper extremities."

With this additional diagnosis, Dr. Gonzales-Chambers listed the same assessment for claimant's office visits for September 4, 1996 through November 6, 1997. On December 17, 1997, Dr. Gonzales-Chambers noted a 25% increase in the size of the tumor in claimant's right lung. On January 2, 1998, Dr. Gonzales-Chambers added to the original diagnoses the following, "now with newly documented multiple nodules in the remaining lung, probably from recurrent disease, but cannot technically do a biopsy." Claimant was then started on chemotherapy for the condition in his right lung.

Dr. Gonzales-Chambers notes claimant's functional status first on February 2, 1998. At that time, claimant's status was listed as at least 80%. Between February 25, 1998 and March 23, 1998, claimant's functional capacity was listed as being at 100%. Additionally, Dr. Gonzales-Chambers lists claimant's assessment on that date as

> history of multifocal bronchioalveolar carcinoma of the left lobe with extension to the upper lobe, S/P exploratory laparotomy, left pneumonectomy now with newly documented multiple nodules, in the remaining lung, probably recurrent disease, but cannot technically do a biopsy, S/P four course of carboplatinum and Taxol with stabilization of disease.

Between April 20, 1998 and October 29, 1998, claimant's functional status is listed between 80% and 100% with the assessment being the same as the March 23, 1998 notation. On December 10, 1998, Dr. Gonzales-Chambers again added hyperlipidemia, chronic obstructive pulmonary disease and pneumoconiosis, and senile actinic keratosis to her assessment of claimant's condition. That assessment by Dr. Gonzales-Chambers stayed the same until January 26, 2000.

At that time, Dr. Gonzales-Chambers noted that claimant's radiographic evidence was worsening. She noted that the worsening condition was most likely due to pneumoconiosis and black lung, rather than cancer. Dr. Gonzales-Chambers maintained that position throughout the remainder of her office notes.

Dr. Gonzales-Chambers was deposed in connection with this claim on March 20, 2001. (EX 12). Dr. Gonzales-Chambers is a board certified in internal medicine and oncology. Began treating claimant when asked to perform a consultation after claimant's left pneumonectomy. Dr. Gonzalez-Chambers stated that the tumor in claimant's right lung was first discovered in October, 1997. The situation remained stable for several months. Dr. Gonzales-Chambers explained that a needle biopsy was impossible with claimant because he only has one lung and with the biopsy the chance of the lung

collapsing is a significant risk. After monitoring the right lung for 2 months, the tumor increased in size by 25% and Dr. Gonzales-Chambers felt that some action was necessary. Claimant underwent four courses of chemotherapy, ending on March 24, 1998.

On a follow-up CT scan and chest x-ray it was noted that claimant's tumor was continuing to grow. Dr. Gonzales-Chambers has not seen any further indication of a metastatic lung cancer since that time. She states that claimant is "basically stable." Dr. Gonzales-Chambers states further that each progressive radiographic examination shows progression of the granulomatous disease process. Dr. Gonzales-Chambers indicates that pneumoconiosis is a granulomatous disease.

Dr. Gonzales-Chambers states that claimant's lung function remains stable in spite of the fact that claimant's chest x-ray and CT evidence shows disease progression. Dr. Gonzales-Chambers states that this is indicative of coal workers' pneumoconiosis. Dr. Gonzales-Chambers explains that she bases her finding of progressive pneumoconiosis on the radiographic films that she was examining. In addition to basing her opinion on the radiographic evidence, she also bases the finding of progressive pneumoconiosis on the pathology report of the left lung that stated that the areas that were not involved with the cancer process were involved with pneumoconiosis. Dr. Gonzales-Chambers reaches the conclusion that if pneumoconiosis was present in the left lung, it must also be present in the right lung.

Dr. Gonzales-Chambers states that claimant's radiographic evidence shows nodules of 3 cm, and therefore, this would rise to the level necessary to term this progressive massive fibrosis. Dr. Gonzales-Chambers states that she would be unwilling to defer to the opinion of a certified B reader concerning the reading of claimant's CT scans and chest x-ray films. She takes this position because she feels that she is in the best position to assess claimant's condition because she has followed his disease progression for such an extended period of time. Even if claimant's pulmonary function study showed no significant change since the pneumonectomy, Dr. Gonzales-Chambers would still diagnosis claimant with progressive massive fibrosis. She makes this statement based on the fact that all persons have a pulmonary reserve that deteriorates at different rates in different people. Therefore, Dr. Gonzales-Chambers believes that a diagnosis of progressive massive fibrosis would still be warranted regardless of the pulmonary function study results.

On cross-examination, Dr. Gonzales-Chambers clarified that there is no tuberculosis present on claimant's x-ray and CT evidence. Dr. Gonzales-Chambers goes on to state that coal workers' pneumoconiosis is a contributor to claimant's present pulmonary status and that such status would keep claimant from performing strenuous labor and that coal workers' pneumoconiosis at least contributed to claimant being unable to work in such a capacity. Dr. Gonzales-Chambers states further that claimant's left pneumonectomy alone would have rendered him totally disabled and unable to return to coal mine employment from a pulmonary standpoint.

Dr. Generoso Duremdes

The records of Dr. Generoso Duremdes regarding claimant are included in the record in this claim.[18] (EX 3). The records cover the dates of March 1, 1995 and January 6, 1998.

Dr. Samuel A. Muscari, Jr.

The records of Dr. Samuel A. Muscari, Jr. are included as part of the record in this claim. (EX 4). The records included cover the time period of June 7, 1994 through December 14, 1998. Most notably, on June 7, 1994, Dr. Muscari noted that claimant is a "tobacco addict," and that claimant requested "patches to stop smoking."

Dr. Gordon F. Prescott

The office records of Dr. Gordon F. Prescott are included in the record in this claim.[19] (EX 6). The records of Dr. Prescott span a time period including August 5, 1992 through June 26, 2000. Over that time period, Dr. Prescott noted that claimant showed symptoms of shortness of breath with a non-productive cough. Dr. Prescott notes over this time period, however, that claimant's breathing is good. In February, 1997, Dr. Prescott begins to note that claimant is suffering from a cough productive of yellow sputum. Claimant then begins to suffer from a chronic cough in September, 1998. Dr. Prescott notes that in June, 2000, claimant is using inhalers that appear to aid his breathing.

Dr. German Iosif

Dr. German Iosif examined claimant on August 7, 2000 and issued a report detailing that examination on August 14, 2000.[20] (EX 9). Dr. Iosif is board certified in internal medicine and pulmonary disease. Dr. Iosif notes 25 years of coal mine employment with claimant being employed as a preparation plant manager for the majority of that time. Dr. Iosif notes that claimant's respiratory history includes exertional dyspnea worsening over the 10 to 12 years prior to the examination. Such dyspnea occurred after walking only a few yards on level ground. Dr. Iosif also notes a daily productive cough, producing no more than 1/2 teaspoon of clear sputum. Claimant also indicated that he

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[18] I take official notice of Dr. Duremdes' credentials from the American Board of Medical Specialties. Dr. Duremdes is board certified in surgery.

[19] I take official notice of Dr. Prescott's credentials from the American Board of Medical Specialties. Dr. Prescott is board certified in internal medicine.

[20] In addition to physically examining claimant, Dr. Iosif also reviewed numerous records included as a part of this claim.

would wheeze when lying in bed and on exertion. Dr. Iosif noted a surgical history consistent with all of the other reports. Dr. Iosif determined that claimant's cigarette smoking habit amounted to 37 pack years.

On physical examination, Dr. Iosif found claimant to become dyspneic walking from the office to the examination room after administration of the pulmonary function testing. That pulmonary function test was interpreted by Dr. Iosif to show a moderate obstructive ventilatory defect that showed no improvement with bronchodilation. A normal arterial blood gas study was also performed, however, exercise was not administered because of claimant's cardiac condition.

Dr. Iosif classified claimant's last job as requiring moderate physical demands and noted that claimant was able to perform the duties of his job until October, 1984. Dr. Iosif notes that claimant's oxygenation has been preserved in spite of claimant's lung having been removed and the existence of cancer in claimant's right lung. Dr. Iosif relies on this and the record in concluding that claimant's right lung has been able to compensate for the resected left lung. Dr. Iosif states that this is a "rather striking considering that the residual right lung has been found to be extensively involved by bronchoalveolar adenocarcinoma." Dr. Iosif also notes that claimant's respiratory function was well preserved prior to the pneumonectomy. Dr. Iosif concludes that claimant's obstructive defect is negligible and that such is consistent with claimant's cigarette smoking history.

Dr. Iosif points out that simple coal workers' pneumoconiosis was diagnosed by biopsy. Dr. Iosif concludes that this diagnosis "does not bear any clinical or functional effects before or after the pneumonectomy in 1995." Dr. Iosif states that this conclusion is supported by the respiratory function studies and clinic follow up examinations.

Dr. Iosif determined that progressive tumor involvement of the remaining lung is "the unquestionable explanation for the radiographic abnormalities that have gradually affected the right lung." Dr. Iosif goes on to state that claimant is totally disabled due to his ischemic cardiomyopathy and coronary artery disease. Dr. Iosif explains that claimant's current respiratory impairment, which contributes to his disability, is explained by the resection of claimant's left lung. Dr. Iosif concludes by stating that there is "[n]o medical or other evidence that would support any significant contribution to this individual's respiratory functional impairment from his prior coal dust exposure and incidental pathologic findings of simple coal workers' pneumoconiosis."

Office Notes Princeton Internists, Inc.

Office notes from Princeton Internists, Inc. are included in the record for this claim. (DX 26). The time span of these notes appear to cover several months in 1991. The exhibit includes notations to shortness of breath and frequent chest pain with exertion. On April 10, 1991, claimant informed his physician that he felt that he was unable to return to work at that point.

Duke University Medical Center

A record from Mary 25, 1991 from Duke University Medical Center is included in the record in this claim. (DX 26). The record indicates that claimant underwent an "outpatient diagnostic cardiac catherization" on March 25, 1991. This record recommended that claimant continue to work and that such continuation should be possible if claimant's symptoms are properly controlled.

Conclusions of Law

Modification may be sought at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. § 725.310(a). In evaluating a request for modification under § 725.310, it is not enough that the judge conduct a substantial evidence review of the District Director's finding. Rather, claimant is entitled to de novo consideration of the issue. *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *aff'd on recon.* 16 B.L.R. 1-71 (1992); *Dingess v. Director, OWCP*, 12 B.L.R. 1-141 (1989); *Cooper v. Director, OWCP*, 11 B.L.R. 1-95 (1988).

In order to be entitled to modification of the prior adjudication, the party requesting modification must establish a change in condition or a mistake in determination of fact. The Board has held that, for purposes of establishing modification, the phrase "change in conditions" refers to a change in claimant's physical condition. *See Lukman v. Director, OWCP*, 11 B.L.R. 1-71 (1988) (*Lukman II*).

In determining whether a "change in condition" is established, the fact-finder must conduct an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial) and consider it in conjunction with the previously submitted evidence to determine if the weight of the evidence is sufficient to demonstrate an element or elements of entitlement which were previously adjudicated against claimant. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993); *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *aff'd on recon.*, 16 B.L.R. 1-71 (1992).

In its decision on reconsideration in *Kovac*, the Board stated that modification proceedings, based upon a mistake of fact need not be predicted on newly submitted evidence but, if a modification proceeding is based upon an alleged change in conditions, then new evidence must be submitted in support of such allegation.

Employer has conceded that claimant has established a change in condition by establishing that he is now totally disabled. *See* Employer's post-hearing brief, p.8. However, employer contends that such disability is not due to pneumoconiosis.

The only issue remaining to be decided in this petition for modification is the etiology of claimant's total disability. In a part 718 claim, such as this, claimant has the burden of proving not only total disability, but also that the total disability is due to pneumoconiosis. Even if the arterial blood gas tests and pulmonary function studies are qualifying to prove total disability, the Board has consistently held that blood gas tests and pulmonary function studies are not diagnostic of the etiology of respiratory impairment, but are diagnostic only of the severity of the impairment. *Tucker v. Director, OWCP*, 10 B.L.R. 1-35, 1-41 (1987). Thus a claimant who established total disability through arterial blood gas tests or pulmonary function studies has not also established that the disability is due to pneumoconiosis. *Id.* Pneumoconiosis is a "substantially contributing cause" of claimant's total disability if it "(i) [h]as a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) [m]aterially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment." 20 C.F.R. § 718.204(c)(1)(i)&(ii).

The cause of a miner's total disability may be shown through the reasoned medical opinion of a qualified physician. To begin, I accord less weight to the office and hospital records contained in the record because they fail to address the issue presented with any specificity. Additionally, I accord less weight to the opinions of Drs. Daniel and Crissalli because the opinions are from 1992 and 1993, respectively. I also accord less weight to the biopsy report of Dr. Pardasni because it does not address total disability.

Dr. Naeye found that the miner suffers from bronchoalveolar adenocarcinoma with mild to moderately severe coal workers' pneumoconiosis. However, Dr. Naeye found that claimant's condition was not severe enough to prevent him from performing heavy manual labor. Dr. Naeye's examination was limited to only the resected lung. Therefore, it is less persuasive as to the disease process present in the miner's remaining lung. Dr. Renn found that claimant suffers from chronic bronchitis and arteriosclerotic coronary artery disease. Dr. Renn found that from a respiratory standpoint, claimant would be able to perform his last coal mine employment. Dr. Iosif found that claimant suffers from coal workers' pneumoconiosis, but that claimant is totally disabled by cardiomyopathy and coronary artery disease. Dr. Iosif found that claimant's respiratory impairment is caused by the resection of claimant's left lung. Dr. Iosif found that claimant's exposure to coal dust does not contribute to his total disability.

Dr. Leacock found that claimant suffers from lung cancer and coal workers' pneumoconiosis. Dr. Leacock found that the miner's totally disability is due to lung cancer, cigarette smoking, and coal dust exposure. Dr. Leacock found that claimant's coal workers' pneumoconiosis is a significantly contributing causes of claimant's pulmonary disease because the pneumoconiosis is aggravating claimant's already disabling lung cancer. Dr. Gonzales-Chambers found that claimant suffers from

complicated pneumoconiosis as well as lung cancer.[21] From a pulmonary standpoint, Dr. Gonzales-Chambers found that claimant is unable to perform his last coal mine employment and that coal workers' pneumoconiosis at least contributed to the miner's inability to return to work.

I find the opinions of Drs. Leacock and Gonzales-Chambers to be more persuasive. Dr. Gonzales-Chambers is claimant's treating oncologist. The interaction between claimant's coal workers' pneumoconiosis and lung cancer can be best assessed by her expertise. As such, I find that claimant's coal workers' pneumoconiosis has materially worsened his already existing, totally disabling lung cancer. Accordingly, claimant has established that coal workers' pneumoconiosis is a substantially contributing cause of claimant's total disability. Therefore, claimant has established that he is totally disabled due to pneumoconiosis.

Date of Onset of Disability

Section 725.503(b) provides that payment of benefits is to commence with the month of the onset of total disability, but if the evidence does not establish the month of onset, payment of benefits shall begin with the month in which the claim was filed. When benefits are awarded on modification, the petitions for modification merges with the originally filed claim, the date of the original filing serves as the earliest date from which benefits may be paid. *Garcia v. Director, OWCP*, 12 B.L.R. 1-24 (1988).

In determining the onset date, the administrative law judge must consider all of the evidence in the record, as well as the credibility of that evidence. *See Lykins*, 12 B.L.R. at 1-183. The first medical record in evidence indicating the existence of total disability does not establish the onset date. This evidence indicates only that at some point before the date of the report that reveals the disability, the miner became totally disabled. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984). X-Ray readings alone also do not establish the onset of disability. Such evidence reveals only the existence of pneumoconiosis, not the extent of the disability. *See Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127, 1-129 (1987). All of the medical evidence, including the x-ray reports, and lay testimony in combination with other evidence of record may be used to establish the onset date of claimant's total disability due to pneumoconiosis. *Gottke v. Director, OWCP*, 6 B.L.R. 1-1300, 1-1302 (1984); *Cantrell v. United States Steel Corp.*, 6 B.L.R. 1-1003, 1-1007 (1984).

After considering all of the evidence included in the record, I find that claimant was not totally disabled before December, 2000. Not until December, 2000 does the record produce any credible evidence that claimant is totally disabled due to coal workers' pneumoconiosis. As such, I find that claimant is totally disabled commencing in December, 2000.

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[21] I make no specific finding as the Dr. Gonzales-Chamber's diagnosis of complicated pneumoconiosis. No such finding is necessary in rendering a decision in this claim.

Entitlement

Upon consideration of all of the evidence of record, I find that claimant has met his burden of proof on all elements of entitlement under the Act and is therefore eligible for benefits.

Attorney's Fees

An application by claimant's attorney for approval of a fee has not been received and, therefore, no award of attorney's fees for services is made. Thirty days is hereby allowed to claimant's counsel for the submission of such an application and attention is directed to Sections 725.365 and 725.366 of the regulations. A service sheet showing that service has been made upon all parties, including claimant, must accompany the application. Parties have ten days following the receipt of any such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

It is hereby ordered that the claim of Roy L. Christian for benefits the Black Lung Benefits Act is hereby GRANTED.

It is further ordered that the employer, Shannon Pocahontas Mining Company, shall pay to claimant all benefits to which he is entitled under the Act commencing December 1, 2000.

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ROBERT J. LESNICK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this (Order of Dismissal/Decision and Order) may appeal it to the Benefits Review Board within 30 days from the date of this (Order of Dismissal/Decision and Order), 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 Avenue, NW, Washington, D.C. 20210.