U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 28Aug2002

Case No. 2001-BLA-00230

In the Matter of

DANNY PAUL DUTY,

Claimant,

v.

SHIPYARD RIVER COAL TERMINAL,
d/b/a PIKE COUNTY COAL CORPORATION,
and ZEIGLER COAL HOLDING COMPANY,

Employer,

and

AEI RESOURCES, INCORPORATED,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES[1]

Clarissa M. Friend, Esq.
Pikeville, Kentucky
For the Claimant

Scott A. White, Esq.
St. Louis, Missouri
For the Employer/Carrier

Before: DANIEL J. ROKETENETZ

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[1] The Director, OWCP, was not present or represented by counsel at the hearing.

Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from a claim for black lung benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 (hereinafter referred to as "the Act"), 30 U.S.C. 901 et seq., and the implementing regulations which are located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order are contained in that Title.

On November 28, 2000, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a hearing. (Dir. Ex. 34)[2] A formal hearing in this matter was conducted on December 12, 2001, in Pikeville, Kentucky, by the undersigned. All parties were afforded full opportunity to present evidence as provided in the Act and the regulations issued thereunder. The opinion which follows is based on all relevant evidence of record.

ISSUES

The issues in this case are:

1. Whether the Claimant had pneumoconiosis as defined by the Act and the regulations;

2. Whether the Claimant's pneumoconiosis arose out of coal mine employment;

3. Whether the Claimant was totally disabled; and,

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[2] In this Decision and order, "Dir. Ex." refers to the Director's exhibits, "Er. Ex." refers to the Employer's exhibits, "Cl. Ex." refers to the Claimant's exhibits, and "Tr." refers to the transcript of the hearing.

4. Whether the Claimant's disability was due to pneumoconiosis.

(Tr. 11-12)

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background:

The Claimant, Danny Paul Duty, was born on January 16, 1946, and was 55 years old at the time of the hearing. (Dir. Ex. 1, 8; Tr. 15) He has a high school education and is married to Linda Ramey, whom he married December 9, 1981. (Dir. Exs. 1, 7) They have no other dependents for purposes of possible benefits augmentation.

The Claimant testified that he worked as a coal miner from 1975 to 2000. (Tr. 15) He worked as a solid blaster, shooting coal, and as a roof bolter, his last job of at least one year. (Tr. 16) He was constantly exposed to coal dust. (Tr. 17)

The Claimant stated that he has undergone two heart operations, afterwards returning to work for a year. Subsequently, a spot was discovered on his lungs. (Tr. 17) He found that during the last three years of his working life, he gradually got slower. (Tr. 17) By the time he would get home from work, he was too exhausted to do anything. (Tr. 18) He loses breath climbing stairs and treats with Dr. Puram for his breathing problems. (Tr. 19) The Claimant stated that his hypertension is under control. (Tr. 20) He receives Kentucky workers' compensation benefits and Social Security benefits. (Tr. 21)

State Workers' Compensation Claim:

The Claimant was awarded benefits through the Kentucky Department of Workers' Claims on December 21, 2000. (Dir. Ex. 35) He was found to be totally disabled by pneumoconiosis and was awarded $509.03 per week, beginning February 11, 2000, for the length of his disability.

Procedural History:

The Claimant filed his claim for benefits on February 29,

2000. (Dir. Ex. 1) According to a June 15, 2000, letter from a Department of Labor claims examiner, it was found that he may be entitled to benefits. (Dir. Ex. 13) On October 13, 2000, the Employer requested a hearing before an administrative law judge. (Dir. Ex. 32) The claim was referred to this office on November 28, 2000. (Dir. Ex. 34)

Coal Miner and Length of Coal Mine Employment:

The Claimant alleges 25 years of coal mine employment in his application for benefits. (Dir. Ex. 1) The Employer stipulated to 25 years of coal mine employment at the hearing. (Tr. 11) Accordingly, I accept the stipulation and find that the Claimant has established 25 years of coal mine employment. I further find that his last job of at least one year was as a roof bolter.

Dependents:

Mr. Duty claimed only one dependent for purposes of augmentation of any benefits awarded under the Act and regulations, namely, his wife, Linda.

Responsible Operator:

The Employer does not contest that it is properly designated the responsible operator herein. (Tr. 12) Accordingly, I find that Shipyard River Coal Terminal is properly designated as the responsible operator.

Applicable Regulations:

Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations.

Pneumoconiosis:

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis. Pursuant to Section 718.202, the claimant can demonstrate pneumoconiosis by means of 1) x-rays interpreted as positive for the disease, or 2) biopsy or autopsy evidence, or 3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable, or 4) a reasoned medical opinion which concludes the presence of the disease, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories.

Under Section 718.202(a)(1), a finding of the presence of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with Section 718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.

Dr. Kim, a B-reader[3] and board-certified radiologist, reviewed a film taken on February 18, 1983. (Dir. Ex. 24) In his narrative report, Dr. Kim stated there was no active cardiopulmonary disease.

An October 3, 1983, film was reviewed by board-certified radiologist and B-reader, Dr. Poulos. (Dir. Ex. 24) Dr. Poulos recorded observing no active cardiopulmonary disease.

Dr. Kim also reviewed a film taken on January 25, 1984. (Dir. Ex. 24) Once again, he found no evidence of active cardiopulmonary disease.

A December 22, 1998, x-ray was reviewed by B-reader and board-certified radiologist, Dr. Halbert. (Dir. Ex. 21) He noted the presence of diffuse bilateral infiltrates.

Dr. Ford, whose qualifications are not listed in the record, reviewed x-rays taken on January 4, 1999, January 5, 1999, January 6, 1999, and January 8, 1999. (Dir. Ex. 11) On the January 4th film he noted observing cardiomegaly, evidence of a previous left thoracotomy, extensive bilateral interstitial disease, and a probable right upper lob scar. The x-ray of January 5th showed no evidence of any new chest disease. The January 6th film observations included status post-extubation with stable perihiliar infiltrates improving aeration of the right lung base and a heart shadow increasing in size. Dr. Ford, on review of the January 8th

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[3] A “B-reader” is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the United states Department of Health and Human Services. 42 C.F.R. § 37.51. The qualifications of physicians are a matter of public record at the National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Because “B-readers” are deemed to have more training and greater expertise in the area of x-ray interpretation for pneumoconiosis, their findings may be given more weight than those of other physicians. Taylor v. Director, OWCP, 9 BLR 1-22 (1986).

film, noted interval resolution of pulmonary edema, increasing left lower lobe infiltrate, and stable focal right upper lobe infiltrate which was consistent with pneumonia.

Dr. Rice, whose qualifications are not listed in the record, reviewed x-rays dated January 9, January 10, and January 11, 1999. (Dir. Ex. 11) The January 9th film showed that aeration of the lungs was stable. The January 10th x-ray indicated cardiomegaly with patchy right upper and left lower lobe infiltrate. Dr. Rice noted that the January 11th film showed no changes in comparison to the January 10th x-ray.

A January 26, 1999, x-ray was reviewed by Dr. Halbert. (Dir. Ex. 25) He noted diffuse bilateral infiltrates and effusion.

There are a total of forty-nine readings of twenty-seven separate x-rays. There are also two CT scans. A review of the x-rays shows that the February 18, 1983, October 3, 1983, and January 25, 1984, x-rays were read as showing no active cardiopulmonary disease. The physicians who interpreted the x-rays are board-certified radiologists and B-readers. Accordingly, I place great weight on their opinions. Scheckler v. Clinchfield Coal Co., 7 BLR 1-128 (1984). The December 22, 1998, x-ray was read by Dr. Halbert, also a dually certified reader, as positive for diffuse bilateral infiltrates. The seven x-rays taken between January 4, 1999, and January 11, 1999, were conducted during the course of a hospitalization and were not read specifically for the presence or absence of pneumoconiosis. Dr. Halbert interpreted the January 26, 1999, x-ray as showing diffuse bilateral infiltrates and effusions. In summary, none of the first twelve x-rays was interpreted as positive for pneumoconiosis.

Dr. Kendall, whose qualifications are not listed in the record, reviewed a November 12, 1999, film. (Dir. Ex. 24) He observed chronic bilateral infiltrates which appeared to have increased within the right upper lobe since a December 22, 1998, x-ray.

Dr. Repsher, a B-reader, also reviewed the November 12, 1999, x-ray. He noted probable paresis of the right hemidiaphragm and a right upper lobe mass which he considered to be cancer, tuberculosis or some other process.

The November 12, 1999, film was also reviewed by Drs. Renn and Wheeler. (Dir. Exs. 20, 21) Both are B-readers with Dr. Wheeler being a board-certified radiologist. Dr. Renn found the film unreadable. Dr. Wheeler noted the presence of subtle interstitial fibrosis or infiltrate, possibly miliary, but mainly

linear in both mid lungs from the heart borders to the lateral pleura. He also recommended the Claimant be checked for granulomatous disease such as tuberculosis or histoplasmosis. Accordingly, I find that the November 12, 1999, film was not read as positive for pneumoconiosis by any of the reviewing physicians.

A November 19, 1999, x-ray was reviewed by Drs. Poulos, Repsher, Renn, and Wheeler. (Dir. Ex. 24, Er. Exs. 17, 20, 21) Dr. Poulos noted a slight increase in the density and consolidation of the area of infiltrate in the right upper lobe since the film of November 12, 1999. Dr. Repsher marked the film as exhibiting a 2/3 profusion, but opined the Claimant did not have coal workers' pneumoconiosis. Rather, he again suspected cancer or tuberculosis. He also noted probable paresis of the right hemidiaphragm and a right upper lobe mass which he considered to be cancer, tuberculosis, or some other disease process. Dr. Renn found the x-ray positive with a 1/2 profusion and category A large opacities. He observed a right upper lobe lesion and made a differential diagnosis of neoplasm or progressive massive fibrosis. Dr. Wheeler stated observing subtle interstitial fibrosis, possible miliary, but mainly linear, in both mid lungs from the heart border to the lateral pleura. He recommended the Claimant be checked for granulomatous disease such as tuberculosis or histoplasmosis. Because neither of the two better-qualified readers felt the film showed pneumoconiosis, I consider this x-ray negative for coal workers' pneumoconiosis.

Dr. Whaley, whose qualifications are not listed in the record, reviewed a February 15, 2000, x-ray. (Er. Ex. 11) He noted a persistent nodular infiltrate or soft tissue mass in the right upper lobe with some surrounding infiltrate.

A February 18, 2000, x-ray was reviewed by Dr. Patsey. (Dir. Ex. 11) No qualifications are listed in the record for Dr. Patsey. He observed diffuse bilateral interstitial disease and a right upper lobe mass. As neither Drs. Whaley or Patsey mention specifically the presence or absence of pneumoconiosis, I find their opinions of little assistance herein.

Dr. Younes, a B-reader, reviewed a March 22, 2000, x-ray. He found it positive for pneumoconiosis with a 2/3 profusion and category A large opacities. He also noted a mass in the right upper lobe most likely a large opacity, however, he stated in the report he could not rule out the possibility it was caused by a pathology. Dr. Younes recommended comparison with prior chest x-rays.

The March 22, 2000, x-ray was also reviewed by Drs. Sargent, Renn, Barrett, Wheeler, and Repsher. (Dir. Exs. 9, 10, Er. Exs. 1, 3, 9) Drs. Barrett and Sargent are B-readers and board-certified radiologists. Dr. Sargent found the film to be negative for pneumoconiosis and questioned whether a right upper lobe mass was a neoplasm or granulomatous disease. Dr. Renn found the film positive for pneumoconiosis with a 1/2 profusion and size A large opacities. Dr. Renn also felt that the right upper lung mass lesion must be further examined to determine whether it was a neoplasm of complicated pneumoconiosis. Dr. Barrett found the x-ray positive with a 2/3 profusion and size A large opacities. He also stated that the right upper lung needed further review. Dr. Wheeler noted a 4 cm by 3 cm oval mass in the lower right upper lobe or possibly in the superior segment of the right lower lobe compatible with inflammatory disease or cancer. He recommended a CT scan to determine if the mass was calcified, which would in turn favor inflammatory disease as a diagnosis. He also noted probable linear interstitial fibrosis in the periphery mid and lower lungs. Dr. Repsher found the film positive for pneumoconiosis with a 2/3 profusion. He stated that the mass in the right upper zone did not have the appearance of progressive massive fibrosis but was very suspicious for cancer or granulomatous disease.

Although two of the dually qualified readers found the March 22, 2000, x-ray negative for pneumoconiosis, and only one equally qualified reader found it positive, the three B-readers determined that some degree of pneumoconiosis existed, notwithstanding the written comments by Drs. Renn and Repsher. The Benefits Review

Board has held that such comments do not affect the diagnosis of pneumoconiosis, only the source of the disease. Cranor v. Peabody Coal Co., 22 BLR 1-1 (1991). Consequently, I consider this x-ray positive for pneumoconiosis.

A June 10, 2000, film was reviewed by Drs. Repsher and Kendall. (Dir. Ex. 24, Er. Ex. 17) Dr. Repsher found the film to be unreadable. Dr. Kendall noted chronic interstitial lung disease with small infiltrate in the right lung base. There was a 4 cm ill-defined opacity within the right upper lobe which had increased in size since the films of December 22, 1998, and November 19, 1999. Dr. Kendall felt this mass could represent an infiltrate or lung mass.

The June 10, 2000, x-ray was also reviewed by Drs. Renn and Wheeler. (Er. Exs. 20, 21) Dr. Renn found the film unreadable. Dr. Wheeler noted the presence of a 4 cm mass in the right mid-lung compatible with inflammatory disease or cancer. There was also possible subtle interstitial infiltrate, edema, or fibrosis in the mid-lungs and medial portion of the right upper lobe, mainly linear in nature. Dr. Wheeler suggested the Claimant undergo a high resolution CT scan for a better evaluation. In summary, I find that the June 10, 2000, x-ray was not found positive for pneumoconiosis by any reader.

Dr. Simpson, whose qualifications are not listed in the record, reviewed a June 20, 2000, x-ray. (Er. Ex. 11) He observed a large infiltrate in the right mid-lung zones and cardiomegaly with diffuse interstitial infiltrate. He could not exclude an infiltrating neoplasm. As he did not specifically diagnose the presence or absence of pneumoconiosis, I find Dr. Simpson’s opinion of little assistance herein.

Dr. Barrett interpreted a June 7, 2000, film as positive for pneumoconiosis with a 2/1 profusion. (Dir. Ex. 35) He questioned whether a mass in the right upper lung was cancer. However, as he did make a definitive finding of pneumoconiosis, I find this film positive for the disease.

A June 14, 2000, x-ray was reviewed by Dr. Halbert. (Dir Ex. 24) He noted chronic interstitial changes in both lungs and a confluent infiltrate or mass in the right apex, but did not specifically find an occupationally related lung disease. As such, I find this film negative for pneumoconiosis.

Drs. Lieber and Wheeler reviewed a June 17, 2000, film. (Dir. Ex. 29, Er. Ex. 21) Dr. Lieber, who is a B-reader and board-certified radiologist, found the film positive for pneumoconiosis with a 2/3 profusion and category A large opacities. Dr. Wheeler

noted subtle ill-defined mixed linear and possibly miliary infiltrates of fibrosis in both mid-lung zones and in a portion of the right upper lobe. These findings were compatible with granulomatous disease, tuberculosis, or histoplasmosis. He recommended a CT scan be performed because of the underexposed portions of the mid and lower lungs. If the nodules were real, Dr. Wheeler opined, then some could be pneumoconiosis, but the pattern on x-ray was asymmetrical. He stated the large opacity was not complicated pneumoconiosis because its pattern was minimal and extended to the lateral periphery and pleura while ordinarily, complicated pneumoconiosis appears as symmetrical small nodules in the central portion of both mid and upper lung zones. Based on Dr. Lieber's reading, which is not directly controverted by Dr. Wheeler's findings, I find this film positive for simple pneumoconiosis.

Dr. Dahhan, a B-reader, found an August 2, 2000, film positive for pneumoconiosis with a 1/2 profusion. (Dir. Ex. 27) Dr. Wheeler also reviewed this film and noted a 4 cm mass in the right upper lung compatible with conglomerate tuberculosis, other inflammatory disease, or tumor. He identified probable subtle interstitial infiltrate or fibrosis mainly in the mid lungs accentuated by the underexposure of the x-ray. He did not find pneumoconiosis.

Dr. Renn found the August 2, 2000, film positive for pneumoconiosis with a 1/2 profusion. (Er. Ex. 2) He noted observing cancer of the right upper lobe. Dr. Repsher also marked this film as evidencing a 2/3 profusion. (Er. Ex. 4) However, he explained that it was not coal workers' pneumoconiosis as the overall observations strongly suggested bronchogenic cancer and less likely, the presence of granulomatous disease. He recorded that the right upper zone mass had doubled in size since the film of March 22, 2000. There was a right hiliar adenopathy and probable paresis of the right hemidiaphragm. Because Dr. Wheeler's credentials are superior to those of Drs. Dahhan, Renn, and Repsher when it comes to x-ray interpretation, I rely on his finding and consider this film negative.

Dr. Ellis, whose qualifications are not listed in the record, reviewed a film taken on August 16, 2000. (Dir. Ex. 35) He noted the presence of diffuse interstitial disease consistent with CWP. He recommended evaluation of the right upper lobe coin lesion with older films or by CT scan. Dr. Jarboe, a B-reader, also reviewed this x-ray. (Cl. Ex. 1) He found it positive for pneumoconiosis with a 2/2 profusion and category A large opacities. Dr. Barrett found the film positive for pneumoconiosis with a 2/1 profusion and category A large opacities. (Dir. Ex. 35)

Dr. Wheeler also reviewed the August 16, 2000, x-ray. (Er. Ex. 21) He noted subtle ill-defined mixed linear and possibly miliary infiltrates or fibrosis in both mid-lungs and in the lower portion of the right upper lobe compatible with granulomatous disease, tuberculosis, or histoplasmosis. He recommended comparison with a CT scan. Once again, Dr. Wheeler stated that the pattern of nodules were asymmetrical. The right upper lobe mass was not complicated pneumoconiosis because the pattern was minimal and extended to the lateral periphery and pleura. Because Drs. Ellis, Jarboe, and Barrett all found pneumoconiosis, and Dr. Wheeler did not rule it out, I consider this x-ray positive for the disease.

There is a September 16, 2000, letter from Dr. John E. Myers, Jr., who is board-certified in internal medicine. (Cl. Ex. 2) He reviewed the reports of Drs. Lieber and Barrett, who both found category 2 pneumoconiosis with size A large opacities. He then looked at both KRS 342.732(a)(d) and § 718.304 and concluded that category A large opacities and progressive massive fibrosis are the same.

An October 5, 2000, x-ray was reviewed by Dr. Rice. (Er. Ex. 11) He noted bilateral interstitial pulmonary disease as well as a right upper lobe pulmonary mass. He noted there were no significant changes since the June 21, 2000, film. As Dr. Rice did not comment on the presence or absence of pneumoconiosis, I find his opinion of little assistance herein.

A February 8, 2001, x-ray was reviewed by Drs. Repsher, Renn, and Wheeler. (Er. Exs. 17, 20, 21) Dr. Repsher marked the film as evidencing a 2/1 profusion, but stated he did not feel the film was compatible with coal workers' pneumoconiosis. He also noted that the right upper lobe mass had increased two to three times in size and he observed paresis of the right hemidiaphragm. Dr. Renn found the x-ray positive with a 1/2 profusion and category A large opacities. He noted linear atelectasis in the middle zone and right lower zone. A differential diagnosis of the right upper lobe lesion included neoplasm and progressive massive fibrosis. Dr. Wheeler, who did not diagnosis pneumoconiosis, noted a 5 cm mass in the lower posterior portion of the right upper lobe with adjacent infiltrate probably extending into the superior segment of the right lower lobe and right hilium. This finding was compatible with inflammatory disease or cancer. There were minimal interstitial infiltrates or fibrosis in the left mid and probably left lower lung and in the right mid-lung from the heart border to the lateral pleura. Such was mainly linear with a possible miliary pattern compatible with granulomatous disease. Dr. Wheeler recommended the Claimant be checked for tuberculosis or

histoplasmosis. The right upper lung mass was unlikely a large opacity because the background of interstitial disease is sparse, asymmetrical, and largely linear. As to this x-ray, I assign greatest weight to the interpretation of Dr. Wheeler, given his superior qualifications, and find the February 8, 2001, film, negative for pneumoconiosis.

Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. Dixon v. North Camp Coal Co., 8 BLR 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the reader's qualifications. Goss v. Eastern Associated Coal Co., 7 BLR 1-400 (1984). Accordingly, greater weight may be assigned to an x-ray interpretation of a B-reader. Aimone v. Morrison Knudson Co., 8 BLR 1-32 (1985). Even greater weight may be given to an x-ray interpretation of a B-reader who is also a board-certified radiologist. Scheckler v. Clinchfield Coal Co., 7 BLR 1-128 (1984).

In summary, the x-ray evidence is clearly conflicting. It is made all the more confusing by the fact that Dr. Repsher diagnosed category 2 pneumoconiosis but indicated in writing that he did not feel the disease was present. However, in Cranor v. Peabody Coal Co., 22 BLR 1-1 (1999), the Board held that an interpreting physician's comment that pneumoconiosis found on x-ray was not coal workers' pneumoconiosis did not affect his diagnosis of the disease under § 718.202(a)(1), "but merely addresses the source of the diagnosed pneumoconiosis." Therefore, there is precedent for my considering Dr. Repsher's readings positive for pneumoconiosis. In that case, of the most highly qualified interpreters who read the x-rays specifically for the presence or absence of pneumoconiosis, eleven B-readers found the films positive and only one found them negative, while four dually certified readers found the x-rays positive and nine found them negative. I find that the x-ray evidence tends to support a finding of pneumoconiosis. Further supportive of this finding are the CT scan results.

Mr. Duty underwent a CT scan of the chest on February 16, 2000. (Er. Ex. 11) Dr. James S. Simpson interpreted the scan as revealing an infiltrative nodular triangular density in the right upper lung zone posteriorly, which he felt had increased in size and density since January 1999. He felt it represented an inflammatory process and possibly progressive massive fibrosis in the presence of pneumoconiosis, but he added that an infiltrating, low-grade, slowly progressing tumor could not be excluded.

Dr. Wheeler interpreted the August 2, 2000, chest CT as

revealing a 5-7 cm, partly irregular mass in the posterior right upper lung between the hilum and pleura, compatible with inflammatory disease more likely than cancer. He found no definite nodular infiltrates in the central portion of the mid and upper lungs to suggest coal workers' pneumoconiosis. Dr. Renn reviewed the CT scan and felt it showed changes consistent with simple coal workers' pneumoconiosis. (Er. Exs. 2, 20) He ruled out complicated pneumoconiosis, believing instead that the right upper lobe mass indicated a tumor mass that is probably malignant. Dr. Repsher reviewed the CT scan and felt it strongly suggested bronchiolitis obliterans organizing pneumonia because the combination of wide-spread micronodules, progressively enlarging mass lesion, and evidence of alveolitis in the mid and lower lung zones is consistent with that disease, but he could not rule out an atypical presentation of cancer or a granulomatous infection. He felt that the large opacity in the right upper zone had none of the characteristics of a massive lesion from coal workers' pneumoconiosis. He opined that its shape was entirely inconsistent with a massive lesion, and there was no evidence of hilar traction.

Dr. Wheeler was deposed on March 6, 2001. (Er. Ex. 22) He explained that in pneumoconiosis, the upper lung zones are usually affected first. He reviewed and reiterated his x-ray and CT scan reports. Dr. Wheeler also expressed his shock that the Claimant's mass had not yet been definitively diagnosed. He suggested that the most definitive diagnosis would be with an open chest biopsy.

In summary, the February 16, 2000, CT scan was interpreted by Dr. Simpson, whose credentials are not part of the record, as possibly showing progressive massive fibrosis in the presence of pneumoconiosis, although he could not exclude a tumor. No other physician interpreted this CT scan. The August 2, 2000, CT scan was read by Drs. Wheeler, Renn, and Repsher. Once again, Dr. Renn felt the scan showed evidence of simple coal workers' pneumoconiosis, but Dr. Wheeler ruled out pneumoconiosis, and Dr. Repsher commented that complicated pneumoconiosis was not present. Although Dr. Wheeler has the best credentials of the physicians who interpreted the CT scans, I am persuaded by the readings of Dr. Simpson and Dr. Renn. Consequently, I find that while the evidence is certainly mixed, the x-ray evidence under § 718.202(a)(1) tends to support a finding of pneumoconiosis.

Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, on a biopsy.

Dr. Sibu P. Saha evaluated the Claimant for a right lung mass, and, on February 18, 2000, Dr. Patsey Tamara performed a needle aspiration of the right lung. (Dir. Ex. 24). The biopsy report includes both a gross and microscopic description.

Microscopically, the pathologist, Dr. Louis D. Dubilier, saw:

> bits of parenchyma consisting of histiocytes containing carbon pigment and by polarization, many fragments of polarizable material which are spiculated and compatible with silicates. No neoplastic cells are identified. The smears are similar with anthracotic pigment containing macrophages. Some bronchial epithelium is also present showing some reactive changes.

Dr. Richard L. Naeye, who is board-certified in Anatomic and Clinical Pathology, reviewed the biopsy slides on June 11, 2000. (Dir. Ex. 23) In addition, he considered hospital records, records from the Marrowbone Clinic, records from Dr. Saha, Dr. Dubilier's pathology report, and the March 22, 2000, pulmonary function study, as well as the reviews thereof by Drs. Tuteur and Repsher. Dr. Naeye further reviewed the March 2000 blood gas study and considered 11 years of coal mine employment as a roof bolter, and a history as a non-smoker. Dr. Naeye opined that the Miner does not have pneumoconiosis:

> The only possible evidence of coal worker[s'] pneumoconiosis (CWP) is the 4 cm mass seen on X-ray in the upper lobe of his right lung. The fact that bloody fluid was aspirated from it accompanied by some black pigment and medium and large birefringent crystals is not diagnostic evidence of the presence of CWP. I agree with the diagnosis of the hospital pathologist that the birefringent crystals are silicates. Because silicates are non-toxic they are not associated with any tissue damage and hence are not a constituent feature of CWP.

He also found no evidence of disability that would prevent the Claimant from returning to his work as a roof bolter.

Dr. P. Raphael Caffrey reviewed the two slides and diagnosed aortic stenosis and anthracotic pigment with silicates but no carcinoma. Dr. Caffrey was unable to make a definite diagnosis of simple or complicated pneumoconiosis. He believed that the Claimant would have to undergo an open lung biopsy which could prove to be either carcinoma, complicated pneumoconiosis, or a large granulomatous lesion.

On October 6, 2000, the Claimant underwent another fine needle, CT guided lung biopsy. (Er. Ex. 11) The procedure was performed by Dr. Nelson Thomas Rice, and Dr. James C. McManis provided the pathology report. His report includes both a gross and microscopic description. Grossly, the two slides showed few

atypical cell groups and cells which were suspicious for adenocarcinoma. The microscopic report showed numerous cell groups mixed with blood and pigmented macrophages. The second aspirate showed fragments of dense fibrous tissue in which there was abundant anthracotic pigment and numerous pigmented macrophages. No neoplastic cells were seen.

On February 28, 2001, Dr. Naeye reviewed a glass slide from the biopsy. (Er. Ex. 18) He made the following interpretation:

> The finding of large numbers of large crystals in these newly available pieces of lung tissue raises questions about their nature and origin but not about their toxicity and clinical significance. It is puzzling how so many large crystals could have seemingly accumulated at a single site and thereby produced an X-ray shadow without the remainder of the lungs being also affected. Based on occupational history these crystals are most likely non-toxic silicates. There is not the slightest possibility that the tissues available for examination came from a site where progressive massive fibrosis (PMF) or complicated coal worker's [sic] pneumoconiosis is present. This latter type of CWP is characterized by the presence of massive fibrosis and anthracotic pigment, both of which are absent in the newly received tissues. In my 6/11/00 review of this case I cited the absence of pulmonary functional abnormalities that would prevent this man['s] returning to work mining coal. None of the findings in the 3 tiny pieces of lung tissue now made available for review change this assessment.

Dr. Caffrey reviewed the pathology slide, as well as the pathology report and Dr. Naeye's report, on June 2, 2001. (Er. Ex. 19). He again was unable to make the diagnosis of pneumoconiosis, whether simple or complicated. While there was anthracotic pigment present on the slide, Dr. Caffrey opined that not all of it was consistent with pigment from coal dust. He felt the etiology of the right lung mass could not be determined. Dr. Caffrey was unaware of the Claimant's length of coal mine employment and offered that if he had worked for fewer than ten years, it would be very unlikely that the slides evinced pneumoconiosis.

Both pathologists found anthracotic pigment. However, a finding of anthracotic pigment is not sufficient to support a finding of pneumoconiosis. Griffith v. Director, OWCP, 49 F.3d 184 (6th Cir. 1995). Dr. Naeye and Dr. Caffrey examined slides from both biopsies, and neither physician was able to diagnose coal workers' pneumoconiosis. Both found anthracotic pigment with

silicates but not pneumoconiosis or silicosis. Because of the superior credentials of Drs. Naeye and Caffrey, and because there is no evidence supporting a diagnosis of pneumoconiosis by biopsy, I conclude that the Claimant has failed to establish same pursuant to § 718.202(a)(2). Scott v. Mason Coal Co., 14 BLR 1-38 (1990).

Section 718.202(a)(3) provides that it shall be presumed that the miner was suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305, or 718.306 are applicable. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of Miners who died on or before March 1, 1978. Under § 718.304, there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if he is suffering from a chronic dust disease of the lung, which, when diagnosed by x-ray, yields one or more large opacities and would be classified in Category A, B, or C. In this case, there is conflicting evidence as to the presence of complicated pneumoconiosis.

Complicated pneumoconiosis was diagnosed by x-ray by Drs. Renn, Younes, Barrett, Lieber, and Jarboe. Drs. Repsher, Poulos, Wheeler, Sargent, Kendall, and Simpson addressed the large mass in the right upper lobe found by x-ray. They did not diagnose complicated pneumoconiosis. Based on the biopsy evidence, Dr. Caffrey was unable to made a definite diagnosis regarding complicated pneumoconiosis. Dr. Naeye felt that complicated pneumoconiosis was not present on the biopsy slides. Of those physicians providing medical reports, Drs. Burki and Jarboe diagnosed complicated pneumoconiosis, while Drs. Dahhan, Caffrey, and Repsher did not.

The first x-ray to mention and attempt to diagnose the right upper lobe mass was the November 12, 1999, film in which Dr. Repsher suggested cancer or tuberculosis. Dr. Renn found the x-ray unreadable, and Dr. Wheeler felt it showed granulomatous disease such as tuberculosis or histoplasmosis. Thus, the x-ray was not read as positive for complicated pneumoconiosis.

The November 19, 1999, x-ray was interpreted by Dr. Renn as revealing size A large opacities. He felt it could be either neoplasm or progressive massive fibrosis. Dr. Poulos noted infiltration but made no more specific finding. Dr. Repsher again felt that cancer and tuberculosis should be considered, and Dr. Wheeler felt that tuberculosis or histoplasmosis was likely. I defer to the superior credentials of Dr. Wheeler, in conjunction with the fact that Dr. Renn felt that progressive massive fibrosis was possible, as was neoplasm, to consider this x-ray negative for

complicated pneumoconiosis.

The March 22, 2000, x-ray was found to reveal size A large opacities by Dr. Younes. He added that the mass was most likely a large opacity but he could not rule out other pathology. Dr. Renn also found size A large opacities, but felt that the mass could be either neoplasm or complicated pneumoconiosis. Dr. Barrett detected size A large opacities. Drs. Repsher, Sargent, and Wheeler disagreed, however. Dr. Repsher opined that the mass does not have the appearance of progressive massive fibrosis. He suspected either cancer or granulomatous disease. Dr. Sargent hypothesized that the mass was either neoplasm or granulomatous disease, and Dr. Wheeler once again averred that the mass was compatible with inflammatory disease or cancer. I rely on the readings of the best qualified interpreters, who, in this case, are Drs. Sargent, Barrett, and Wheeler. Of these three physicians, only Dr. Barrett felt that the diagnosis of complicated pneumoconiosis was warranted. I find Dr. Sargent and Dr. Wheeler's readings more probative because of their concurrence. Thus, I consider this x-ray negative for complicated pneumoconiosis.

The June 16, 2000, x-ray was found by Dr. Kendall to evince either infiltrate or a 4 cm-lung mass. Dr. Wheeler once again felt the film showed inflammatory disease or cancer. Because this x-ray was not read as revealing complicated pneumoconiosis, I find it negative for that condition.

Dr. Simpson noted a large infiltrate on the June 20, 2000, x-ray, and he could not exclude a neoplasm. This x-ray was not reread. I consider it negative for complicated pneumoconiosis.

The July 17, 2000, x-ray was found to be positive for complicated pneumoconiosis by Dr. Lieber, who is a dually certified reader. Dr. Wheeler reread the film and diagnosed a mass compatible with granulomatous disease, tuberculosis, or histoplasmosis. He ruled out a large opacity of pneumoconiosis because the pattern was asymmetrical, minimal, and extended to the lateral periphery and pleura. While two equally qualified experts made opposing diagnoses, I find Dr. Wheeler's interpretation more persuasive because he provided a fuller explanation. Consequently, I consider this x-ray negative for complicated pneumoconiosis.

Dr. Wheeler addressed the large mass on the August 2, 2000, x-ray, diagnosing either tuberculosis, another inflammatory disease, or a tumor. Dr. Repsher suggested the film showed bronchogenic cancer, with granulomatous disease being a less likely diagnosis. He noted that the mass had doubled in size in less than five months. Dr. Renn once again found category A large opacities but

suggested the differential diagnoses of neoplasm and progressive massive fibrosis. Based on Dr. Wheeler's superior credentials and Dr. Renn's inclusion of differential diagnoses, I consider this x-ray negative for complicated pneumoconiosis.

Drs. Jarboe and Barrett found category A large opacities on the August 16, 2000, x-ray. Dr. Wheeler reread the film and commented that the mass was not a large opacity of pneumoconiosis because the pattern was minimal and extended to the lateral periphery and pleura, whereas pneumoconiosis should give symmetrical small nodules in the central portion of both the mid and upper lung zones. He once again suggested the diagnoses of granulomatous disease, tuberculosis, and histoplasmosis. Because Dr. Barrett's credentials are equivalent to Dr. Wheeler's, and Dr. Dahhan, who is a B-reader, agreed with Dr. Barrett's assessment, I consider this x-ray, when viewed in isolation, positive for complicated pneumoconiosis.

The final x-ray was read by Dr. Renn, who detected size A large opacities but again added the differential diagnoses of neoplasm and progressive massive fibrosis. Dr. Wheeler interpreted the film as showing a mass compatible with inflammatory disease or cancer and interstitial infiltration compatible with granulomatous disease, tuberculosis, or histoplasmosis. He opined that the mass was not likely a large opacity of pneumoconiosis because the background interstitial disease was sparse, asymmetrical, and largely linear. I defer to Dr. Wheeler's interpretation because of his superior credentials and his well reasoned comment. I find it partially supported by Dr. Renn's offer of differential diagnoses. Thus, I consider this x-ray negative for complicated pneumoconiosis.

Dr. Simpson found the possibility of progressive massive fibrosis on the February 16, 2000, CT scan. However, he could not eliminate a slowly progressing tumor as the cause of the mass either. Dr. Renn ruled out complicated pneumoconiosis based on the August 2, 2000, CT scan and felt the mass indicated a malignant tumor. Dr. Repsher opined that the mass had none of the characteristics of a large opacity from coal workers' pneumoconiosis because of its shape and lack of hilar traction. Dr. Wheeler again suggested inflammatory disease and possibly cancer. Because there is no opinion stated in terms of reasonable medical probability that the CT scans revealed complicated pneumoconiosis, I find that the CT scan evidence does not tend to support such a finding.

Regarding the biopsy evidence, neither prosector mentioned the condition. Dr. Caffrey, a reviewing pathologist, was unable to

make a definite diagnosis of complicated pneumoconiosis. He felt an open biopsy was necessary to diagnose the lesion as either carcinoma, complicated pneumoconiosis, or a large granulomatous lesion. Dr. Naeye, the other reviewing pathologist in this case, stated more assertively that there was not the slightest possibility that the tissue came from a site where complicated pneumoconiosis was present because that disease is characterized by the presence of massive fibrosis and anthracotic pigment, both of which he found absent. Accordingly, a finding of complicated pneumoconiosis cannot be made based on the biopsy evidence.

As to the medical opinion evidence, Dr. Burki's diagnosis of complicated pneumoconiosis seems to be based solely on the x-ray interpretation of Dr. Lieber. Dr. Lieber is a board- certified radiologist and a B-reader. Thus, Dr. Burki's reliance on his x-ray reading is certainly reasonable. Furthermore, the pulmonary function study he administered yielded qualifying values which would be consistent with complicated pneumoconiosis. Therefore, I place weight on Dr. Burki's opinion. Likewise, Dr. Jarboe's opinion is supported by not only his x-ray reading, but also Dr. Barrett's, a dually certified reader. However, he made no clinical findings consistent with complicated pneumoconiosis. Accordingly, I place some, but not significant, weight on Dr. Jarboe's opinion.

Dr. Dahhan's opinion is well-documented and reasoned. Perry v. Director, OWCP, 9 BLR 1-1 (1986). It is based not only on his own physical examination of the Claiamnt, but also a review of the other medical evidence of record, thereby providing him with a more complete picture of the Claiamnt's health. His conclusion is consistent with his clinical findings of good air entry to both lungs with no crepitation, rhonchi, or wheeze. It is also supported by the non-qualifying pulmonary function study and blood gas study he administered. Finally, Dr. Dahhan provided cogent, persuasive reasons why he was able to rule out the complicated form of pneumoconiosis: normal clinical findings of the lungs, adequate blood gas exchange, normal pulmonary function studies, and a lack of radiological evidence since the mass was irregular, solitary, and had a cavity in it. For these reasons, I place greater weight on Dr. Dahhan's opinion.

I find that Dr. Repsher's opinion is also well-documented and merits greater weight. He reviewed all the medical evidence of record, including six x-rays and the August 2, 2000, CT scan. Dr. Repsher illustrated at his deposition that he had put considerable thought into the Claimant's case, consulting with radiologists, and ultimately diagnosing a rare condition known as bronchiolitis obliterans organizing pneumonia. He gave persuasive reasons as to why he was able to eliminate complicated pneumoconiosis as a

diagnosis: the mass's shape; its lack of peripheral or traction emphysema; the lack of reduction of profusion of the small opacities in the area of the large opacity, since small opacities combine to ultimately form a large opacity; and the mass having doubled in size in less than five months.

Finally, I note that Dr. Renn, who also reviewed the medical evidence of record, did not diagnose complicated pneumoconiosis despite his x-ray readings. I consider his failure to diagnose the condition as supportive of the conclusions of Drs. Dahhan and Repsher.

Having reviewed all the evidence of record bearing on the presence or absence of complicated pneumoconiosis, and for the reasons stated above, I find that the x-ray evidence in conjunction with the CT scan evidence, the biopsy evidence, and the medical opinion evidence, fails to establish the existence of complicated pneumoconiosis. Thus, the Claimant is not entitled to the rebuttable presumption of total disability due to pneumoconiosis under § 718.304.

The fourth and final way to establish the existence of pneumoconiosis is set forth in Section 718.202(a)(4). This subsection provides for such a finding where a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based upon objective medical evidence and shall be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. Upon review of the medical opinion evidence, I find that the better-reasoned and better-documented reports of record establish that pneumoconiosis is present.

<u>Hospital Records:</u>

Progress notes from the Marrowbone Clinic, dating back to June 3, 1980, show diagnoses of arteriosclerotic heart disease, arthritis, bronchitis, and hypertension. (Dir. Ex. 21, p. 61) The attending physician was Dr. Valera.

The record contains 639 pages of hospital records from Pikeville Methodist Hospital. (Dir. Ex. 24) A thorough review of these records reveals that the Claimant was treated for conditions unrelated to the presence or absence of pneumoconiosis. Dr.

Brahmaji S. Puram evaluated the Claimant on December 22, 1998, and followed him up on several occasions thereafter, through May 18, 2000. (Dir. Ex. 24, p. 518; Dir. Ex. 25) He considered a medical history, symptoms, a history as a coal mine, no smoking history, a family medical history, and the results of a physical examination. Dr. Puram diagnosed hypertension with heart disease, an old myocardial infarction, status post aortic repair, and congenital bicuspid aortic valve with aortic stenosis. On December 30, 1998, the Claimant underwent a left heart catheterization and a coronary arteriogram. (Dir. Ex. 24, p. 545) The handwritten progress notes show a variety of diagnoses that include coronary artery disease and black lung/lung mass. (Dir. Ex. 25)

Dr. Saha examined the Claimant on January 4, 1999, for a recommendation regarding his bicuspid aortic valve with aortic stenosis and insufficiency. He recommended aortic valve replacement. (Dir. Ex. 11) That procedure was successfully completed on January 5, 1999.

Dr. Saha attended the Claimant during hospitalizations from 1999 and 2000. (Dir. Ex. 20) He performed a fiberoptic bronchoscopy with washings on November 30, 1999. (Dir. Ex. 21, p. 28) He noted bronchitis but saw no mass lesions. Dr. Saha considered a history as a non-smoker, a medical history significant for repair of coorctation of the aorta, a chest x-ray, and the results of a physical examination. Follow-up progress notes through October 8, 2000, show that Dr. Saha diagnosed anthracosis and silicosis based on the needle biopsy from February 2000. (Dir. Ex. 30)

The record contains 522 pages of hospital records from Central Baptist Hospital, from January 19, 1999, through October 2000. (Er. Ex. 11) Dr. Avichai Eres provided a cardiac consultation on June 20, 2000. Based on a medical history, presenting symptoms, a history as a nonsmoker, status as a disabled coal miner, the Claimant’s cardiac history, a June 16, 2000, x-ray, an EKG, and a physical examination, he diagnosed atypical angina, hypertension, hypercholesterolemia, infiltrate on chest x-ray with a 4 cm opacity in the right upper lobe with a history of previous right lung biopsy demonstrating silicosis and coal workers’ pneumoconiosis.

The Claimant was hospitalized from February 24, 2000, to February 26, 2000. (Dir. Ex. 24, p. 63) Dr. Puram attended him. The Claimant presented with dizziness, weakness, and diaphoresis. Dr. Puram considered the presenting symptoms, the Claimant’s recent biopsy, a medical history, employment as a coal miner, his status as a nonsmoker, and a family history. A review of the Claimant’s systems showed no wheezing or rhonchi. An EKG and a CT of the head

were performed. Discharge diagnoses included: 1) dizziness, near syncope; 2) severe headache and palpitations; 3) chills and diaphoresis, rule out sepsis; 4) right lung mass with biopsy positive for silicosis and anthracosis; 5) hypertensive heart disease; and 6) congenital bicuspid aortic valve with coaptation of aorta, status post aortic valve replacement.

The Claimant went to the emergency room on June 16, 2000 because of chest pain. (Dir. Ex. 24, p. 209) Dr. Patrick Von Dippe examined him, and based on physical examination, symptomatology, a history as a nonsmoker, an EKG, and an x-ray, he diagnosed bronchospasm and probable viral pneumonia with a 4 cm density in the right upper lobe.

The Claimant was hospitalized from June 17, 2000, to June 20, 2000. (Dir. Ex. 24, p. 125) Dr. A.M.A. Malik attended him. He considered complaints of chest pain, a medical history, and the Claimant's status as a nonsmoker. Dr. Malik also reviewed the results of an EKG and blood work. Physical examination revealed vesicular breath sounds with no rales or rhonchi. Dr. Malik diagnosed: 1) chest pain; 2) status post aortic valve replacement; 3) history of hypertension; 4) history of hypercholesterolemia; 5) history of surgery for coaptation of the aorta; and 6) pulmonary opacity.

Medical Opinions:

Dr. Ramanarao V. Mettu examined the Claimant on November 19, 1999. (Dir. Ex. 24, p. 6) He considered an x-ray reading by another physician, a medical history, and symptomatology. There was no mention of either a smoking or coal mine employment history. Physical examination showed distant breath sounds but no wheezing, rales, or rhonchi. Dr. Mettu diagnosed an abnormal chest x-ray with infiltrate in the right upper lobe, a history of hypertension, hyperlipidemia, and status post valvular heart replacement.

Dr. Mettu again saw the Claimant on November 22, 1999. (Dir. Ex. 24, p. 7) Based on the chest x-ray reports, Dr. Mettu suggested that the Claimant be evaluated by Dr. Saha.

Dr. Mettu also consulted on the Claimant's hospital stay on February 25, 2000, for his pulmonary and sleep problems. (Dir. Ex. 24, p. 26) Dr. Mettu considered the Claimant's status as a coal miner for many years and a nonsmoker. He noted a history of coal workers' pneumoconiosis. He diagnosed symptoms of sleep apnea, a mass on the right lung, and a history of coal workers' pneumoconiosis.

Dr. Sujata Gutti examined the Claimant on March 15, 2000, for complaints of dizzy spells. (Dir. Ex. 23) Physical examination and the results of blood tests led Dr. Gutti to diagnose the onset of vertigo.

Dr. Maan Younes examined the Miner on March 22, 2000. (Dir. Ex. 8) He considered 25 years of coal mine employment as a roof bolter, a family history including high blood pressure, diabetes, cancer, and stroke, and a medical history significant for pneumonia, arthritis, heart disease, high blood pressure, and rheumatic fever. Dr. Younes was informed that the Claimant had never smoked. The Claimant presented with complaints of dyspnea, a cough, chest pain, and ankle edema. Physical examination showed normal breath sounds. He further considered the results of an x-ray, a pulmonary function study, a blood gas study, and an EKG. Dr. Younes diagnosed coal workers' pneumoconiosis primarily due to occupational dust exposure, and hypertension due to coorctation of the aorta. He found no pulmonary impairment and opined that the Claimant retains the respiratory capacity to perform the work of a coal miner.

On July 17, 2000, Dr. N.K. Burki examined the Claimant. (Dir. Ex. 29) He considered complaints of exhaustion for one year and bilateral, vague chest pain. He recorded that the Claimant was a life-long non-smoker and a coal miner for 25 years, lastly as a roof bolter. Physical examination revealed clear lungs with no shortness of breath. Dr. Burki took into account the results of the x-ray read by Dr. Lieber and a pulmonary function study. He diagnosed complicated pneumoconiosis and decreased lung function. He felt that the Claimant did not retain the physical capacity to return to coal mine employment. However, Dr. Burki opined that any pulmonary impairment was not caused in part by coal dust exposure.

On August 2, 2000, Dr. Abdulkadar Dahhan examined the Claimant. (Dir. Ex. 27) He considered 25 years of coal mine employment as a roof bolter, the Claimant's status as a non-smoker, symptomotology, and medical history. Physical examination showed good air entry to both lungs with no crepitation, rhonchi, or wheeze. Dr. Dahhan ordered an EKG, a blood gas study, a pulmonary function study, an x-ray, and a CT scan of the chest. Based on the x-ray, Dr. Dahhan found evidence of simple coal workers' pneumoconiosis. He was able to rule out complicated pneumoconiosis based on the normal clinical examination of the lungs, adequate blood gas exchange mechanisms, normal pulmonary function studies, and lack of radiological evidence of the disease. Dr. Dahhan found no evidence of total or permanent pulmonary disability and thus reasoned that the Claimant retains the respiratory capacity to

continue his last coal mining job. Dr. Dahhan is board- certified in Internal Medicine and Pulmonary Disease.

Dr. Dahhan reviewed medical evidence and provided a report dated January 24, 2001. (Er. Ex. 7) He considered the reports of Drs. Younes, Burki, Naeye, and Caffrey, several x-ray reports, pulmonary function studies, and blood gas studies, office notes and records from Drs. Saha, Valera, Mettu, Puram, and Gutti, as well as records from Central Baptist Hospital and Pikeville Methodist Hospital, the spirometry reviews by Drs. Renn, Tuteur, and Repsher, and the February 2000 biopsy report. Dr. Dahhan found the evidence sufficient to diagnose simple pneumoconiosis but not complicated pneumoconiosis because of the lack of abnormal findings of the chest on physical examination, the absence of reduction in lung volume or diffusion capacity on pulmonary function studies, the x-rays, the CT scans as read by Dr. Wheeler, the rise in the partial pressure of oxygen with exercise on blood gas studies, and the biopsy evidence. He further opined that the Claimant retains the physiological capacity to return to his last coal mining job.

Dr. Dahhan reviewed the Central Baptist Hospital records on February 6, 2001. (Er. Ex. 12) Based on that information, especially the lung biopsy, he felt that it supported his previous conclusions, particularly his suspicions regarding the possibility of cancer.

Dr. Dahhan was deposed on December 11, 2001. (Er. Ex. 24) He reiterated the conclusions he provided in his medical reports and reviewed his examination findings. He felt the large mass in the Claimant’s right upper lobe was not complicated pneumoconiosis because it was irregular, it was a lone mass, and it had a cavity in it. His physical examination, which did not show crackles, edema, cyanosis, or clubbing, also ruled out progressive massive fibrosis, as did the absence of a significant restrictive ventilatory defect with a reduction in diffusion capacity, and the absence of hypoxemia at rest that worsens with exercise.

Dr. Caffrey reviewed the medical evidence on May 18, 2000. (Dir. Ex. 26) He considered the records of Drs. Valera, Saha, Mettu, Gutti, and Puram, the hospital records, an accurate smoking and coal mine employment history, a medical history, the reports of Drs. Younes and Naeye, three x-ray reports, the March 22, 2000, pulmonary function study, two pathology reports dated January 5, 1999, and February 17, 2000, and the two biopsy slides. His review of the two slides resulted in the diagnoses of aortic stenosis and anthracotic pigment with silicates but no carcinoma. Dr. Caffrey was unable to make a definite diagnosis of simple or complicated pneumoconiosis. He believed that the Claimant would have to

undergo an open lung biopsy which could prove to be either carcinoma, complicated pneumoconiosis, or a large granulomatous lesion. He opined that the Claimant has only a very mild or mild restrictive ventilatory defect, which, alone, would not have disabled him from performing his regular job in the coal mines. Dr. Caffrey is board-certified in Clinical and Anatomic Pathology.

Dr. Thomas M. Jarboe examined the Claimant on August 16, 2000. (Cl. Ex. 1) Based on 25 years of coal mine employment, primarily as a roof bolter, symptoms of some dyspnea on exertion and a daily productive cough, a history of never having smoked, a medical history, an x-ray, a pulmonary function study, a blood gas study, and a physical examination which revealed no rales or wheezes, Dr. Jarboe diagnosed complicated coal workers' pneumoconiosis due to coal dust inhalation. He recommended no further exposure to coal dust. Dr. Jarboe is board-certified in Internal Medicine and Pulmonary Diseases.

Dr. Lawrence Repsher provided a medical report based on a review of medical evidence, dated February 8, 2001. (Er. Ex. 15) He considered six x-ray readings of four separate x-rays, the August 2, 2000, high-resolution CT scan, three pulmonary function studies, two blood gas studies, aa non-smoking history, a history of working as a coal miner for 25 years, a medical and family history, and the reports of Drs. Younes, Naeye, Burki, Caffrey, and Dahhan. Dr. Repsher found no evidence of coal workers' pneumoconiosis. Rather, he diagnosed probable bronchiolitis obliterans organizing pneumonia (BOOP) and felt that an underlying infection and cancer should be considered, although he doubted their existence. Dr. Repsher based his opinion on the x-ray evidence, the pulmonary function studies, the fact that the Claimant's arterial oxygen pressure rises with exercise, and a normal MVV. He opined that the symptoms of dyspnea on exertion are explained by the Claimant's incompletely [sic] treated hypertension, superimposed on a bifid aortic valve which had resulted in clinically significant aortic stenosis, requiring are placement with an artificial valve. Dr. Repsher advised a thoracoscopic lung biopsy of both the right lower lobe alveolitis and the upper lobe growing mass lesion to definitively diagnose his respiratory disease.

Dr. Repsher was deposed on February 28, 2001. (Er. Ex. 23) He testified that he is board-certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine. Dr. Repsher reiterated the results of his review of the medical evidence. He testified that the Claimant's case is unusual and challenging. He feels the least likely condition the Claimant has is coal workers' pneumoconiosis. He agreed with Dr. Wheeler's statement that it was appalling that the Claimant has yet to be definitively diagnosed and went so far as to assert that the Claimant has been a victim of gross medical malpractice. Dr. Repsher pointed out that the Claimant's biopsies revealed silicatosis, which is due to silicates, and which have mild, if any, toxicity to the lung. He explained that while some of the medical evidence suggests cancer or infection, both of those conditions are unlikely because the biopsies did not show malignant tumor cells, and no infections organism was grown from the biopsy tissue. He reviewed the CT scan with two radiologists and felt the most likely diagnosis was bronchiolitis obliterans organizing pneumonia (BOOP), a condition not due to coal mine dust exposure. Dr. Repsher explained that both infections and cancer can be missed by the fine needle biopsies because the mass is so large and the needles extract such a tiny amount of tissue. Likewise, the needle biopsies cannot remove a coal macule needed to make the diagnosis of coal workers' pneumoconiosis because of the small size of the needle. He opined that it is extraordinarily unlikely that the large opacity is

pneumoconiosis or progressive massive fibrosis because of its shape, the fact that it doesn't have peripheral or traction emphysema, and the fact that the profusion of the small opacities is not reduced in the area of the large opacity. Dr. Repsher also pointed out that the mass more than doubled in size in four and one-half months, which has never been reported in coal workers' pneumoconiosis, thus strongly suggesting some other process like a malignancy, an infection like tuberculosis, a fungus, or BOOP. Dr. Repsher also reviewed additional medical evidence, including x-rays and Dr. Jarboe's report. Finally, he opined that the Claimant is not totally disabled due to coal mine dust inhalation.

Dr. Joseph J. Renn, III, provided a report based on a review of medical evidence, dated February 12, 2001. (Er. Ex. 13) Based on all the medical evidence of record, accurate smoking, employment, and medical histories, Dr. Renn diagnosed: 1) right upper lobe mass lesion which cannot be further defined from the present medical database; 2) simple coal workers' pneumoconiosis; 3) mild restrictive ventilatory defect due to mediastinotomy; 4) status post-op coarctation of the aorta; 5) status post-op artificial aortic valve placement for bicuspid aortic valve with aortic stenosis and aortic insufficiency; 6) systemic hypertension; 7) hypercholesterolemia; and 8) anxiety/depression. When Dr. Renn considered only the Claimant's respiratory system, he opined that he was not totally and permanently impaired to the extent that he would be unable to perform either his last coal mining job as a roof bolter or any similar work. Dr. Renn is board-certified in Internal Medicine and Pulmonary Disease. (Er. Ex. 14).

Of the physicians who attended the Claimant during his hospital stays, Drs. Puram, Saha, and Eres diagnosed silicosis/anthracosis/coal workers' pneumoconiosis based on the biopsy evidence. Among the examining and reviewing physicians, Dr. Mettu diagnosed a history of pneumoconiosis, and Drs. Younes, Burki, Dahhan, Jarboe, and Renn diagnosed pneumoconiosis. Dr. Caffrey was unable to make a definite diagnosis of pneumoconiosis. Dr. Repsher opined that the Claimant does not have coal workers' pneumoconiosis. Several factors affect the weight I place on these opinions.

I place very little weight on the diagnoses made by Drs. Puram, Saha, and Eres because their findings are based only on the biopsy reports of the prosectors, yet the biopsy evidence does not support a finding of pneumoconiosis. The prosectors found anthracotic pigment, which, standing alone, is not equivalent to pneumoconiosis, and the reviewing physicians unanimously agreed that pneumoconiosis was not present on biopsy. Furthermore, there

is no evidence that Drs. Puram, Shah, and Eres relied on any other data in reaching their conclusions.

I do not consider Dr. Mettu's note of "a history of coal workers' pneumoconiosis" equivalent to a diagnosis of the disease. Furthermore, he did not consider an accurate coal mine employment history, thus rendering his opinion inadequately documented. Perry, 9 BLR 1-1 Accordingly, I place no weight on his finding. Because Dr. Caffrey stated that he was unable to make a definite diagnosis of either simple or complicated pneumoconiosis, I interpret this to mean that he believed it was still possible that the disease exists. Because I do not consider Dr. Caffrey's opinion a definitive finding, I place no weight upon it. Justice v. Island Creek Coal Co., 11 BLR 1-91 (1988)

The opinions of Drs. Younes, Burki, Dahhan, Jarboe, and Renn are well-reasoned and well-documented. Drs. Dahhan and Renn reviewed the medical evidence of record, thereby providing them with a broader base of data from which to draw their conclusions. Drs. Burki, Dahhan, Jarboe, and Renn maintain superior qualifications in the field of pulmonary diseases. Scott v. Mason Coal Co., 14 BLR 1-38 (1990) Additionally, their conclusions are supported by the overall x-ray evidence. Consequently, I place greater weight on the opinions of these five physicians.

Dr. Repsher's opinion is also well-documented and reasoned. It is based on a thorough review of the medical evidence of record, and Dr. Repsher's credentials are equivalent to those of Drs. Burki, Dahhan, Jarboe, and Renn. However, when I view the medical opinion evidence in its entirety, I am more persuaded by the uniformity of opinions shared by Drs. Younes, Burki, Dahhan, Jarboe, and Renn, some of whom are not the Claimant's experts, than I am by Dr. Repsher's lone, contrary opinion. These opinions are bolstered by the myriad abnormal x-ray readings and the Claimant's lengthy coal mine employment history. Consequently, I find that the medical opinion evidence tends to establish the existence of pneumoconiosis pursuant to § 718.202(a)(4).

In considering all the evidence under § 718.202(a), I am most persuaded by the medical opinion evidence as supported by the x-ray evidence, which, in turn, is bolstered somewhat by the biopsy finding of anthracotic pigment. Therefore, although the issue of the existence of pneumoconiosis is an extremely difficult issue to decide in this case, I find that the Claimant has established it by a preponderance of the evidence.

<u>Arising Out of Coal Mine Employment:</u>

Next, the Claimant must establish that his pneumoconiosis arose, at least in part, out of coal mine employment. See § 718.205(a)(2) It is presumed that pneumoconiosis of a miner who establishes ten or more years of coal mine employment arose out of coal mine employment. See § 718.203(a) As I have found 25 years of coal mine employment, I find that the Claimant's pneumoconiosis arose out of coal mine employment.

Total Disability:

The Claimant must also establish that he is totally disabled. Total disability is defined as the miner's inability, due to pneumoconiosis, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the Miner's residence. § 718.204(b)(1) Total disability can be established pursuant to one of the four standards in Section 718.204(b)(2) or the irrebuttable presumption of Section 718.304, which is incorporated into Section 718.204(b). The presumption is not invoked here for the reasons stated above – there is insufficient evidence of large opacities classified as category A, B, or C, and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in Section 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under Section 718.204(b)(2), (formerly § 718.204(c)) all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. Shedlock v. Bethlehem Mines Corp., 9 BLR 1-195, 1-198 (1986); Rafferty v. Jones & Laughlin Steel Corp., 9 BLR 1-231, 1-232 (1987) Furthermore, the Claimant must establish this element by a preponderance of the evidence. Gee v. W.G. Moore & Sons, 9 BLR 1-4, 1-6 (1986)

Subsection (b)(2)(i) of § 718.204 provides for a finding of total disability where pulmonary function tests demonstrate FEV1[4] values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC[5] or MVV[6] values equal to or less than the applicable table values. Alternatively, a qualifying FEV1 reading together with an FEV1/FVC ratio of 55 percent or less

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[4] Forced expiratory volume in one second

[5] Forced vital capacity

[6] Maximum voluntary ventilation

may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. § 718.204(b)(2)(i) and Appendix B. Assessments of these results is dependent on the Claimant's height which was recorded as 69, 71, 69, 68, and 68 inches, respectively, in the five tests of record. Considering this discrepancy, I find the Claimant's height to be 69 inches for the purposes of evaluating the pulmonary function studies. Protopappas v. Director, OWCP, 6 BLR 1-221 (1983)

A study was performed on March 22, 2000. (Dir. Ex. 8) Dr. Peter G. Tuteur, who is board-certified in Internal Medicine and Pulmonary Disease, found this study valid. (Dir. Ex. 21, p. 89) He found the study revealed a very mild restrictive ventilatory defect. Dr. Lawrence H. Repsher, who is also board-certified in Internal Medicine and Pulmonary Disease, found a very mild restrictive disease which he felt was most likely due to a lack of full inspiration. (Dir. Ex. 21, p. 90) Overall, he opined that the Claimant probably has a normal spirometry. Dr. Joseph J. Renn, III, who is board-certified in Internal Medicine and Pulmonary Disease, found the study valid for accurate interpretation despite some technical deficiencies. (Dir. Ex. 22) He felt it showed normal ventilatory function.

The Claimant underwent a second pulmonary function study on April 24, 2000. (Dir. Ex. 24) Dr. Mettu, who ordered the study concluded it was indicative of mild restrictive airway disease.

A third spirometry was performed on July 17, 2000. (Dir. Ex. 29) Dr. Burki, who reviewed the study, found it demonstrated a restrictive defect with no obstruction. He also opined that the diffusing capacity invalid due to inadequate inspiration.

A fourth pulmonary function study was performed on August 2, 2000. (Dir. Ex. 27) Dr. Dahhan stated the results were indicative of a possible mild restrictive ventilatory defect.

A fifth spirometry was performed on August 16, 2000. (Cl. Ex. 1) Dr. Jarboe found the test demonstrated a mild restrictive ventilatory defect.

The only study to produce qualifying values under the regulations was the one of July 17, 2000, conducted by Dr. Burki. I note, however, that he did not document the Claimant's comprehension and cooperation. More importantly, the two pulmonary function studies conducted more recently, both within one month of Dr. Burki's test, produced non-qualifying results. A review of all the studies shows that the July 17, 2000, test yielded

inconsistently low values. Therefore, I consider it anomalous. Furthermore, the only study that was reviewed by pulmonary specialists, the March 22, 2000, study, was found to be valid by Drs. Tuteur, Repsher, and Renn. It resulted in non-qualifying values. Consequently, I find that total disability has not been established pursuant to § 718.204(b)(2)(i).

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO2 to pO2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from the Claimant's lung alveoli to his blood. § 718.204(b)(2)(ii) and Appendix C The test results must meet or fall below the table values set forth in Appendix C following Section 718 of the regulations. The record contains the results of six arterial blood gas analysis performed on January 5, 1999, January 6, 1999, February 15, 2000, March 22, 2000, August 2, 2000, and August 16, 2000. (Dir Exs. 8, 27, Er. Ex. 11, Cl. Ex. 1) None of these blood gas studies of record, including those taken during the Claimant's hospitalizations, produced qualifying values under the regulatory standards for disability. Therefore, I find that the blood gas study evidence of record fails to establish total disability under subsection 718.204(b)(2)(ii).

Total disability under Section 718.204(b)(2)(iii) is inapplicable because the Claimant failed to present evidence of cor pulmonale with right-sided congestive heart failure.

Finally, the Claimant fails to establish total disability under Section 718.204(b)(2)(iv). Where total disability cannot be established under subparagraphs (b)(2)(i), (b)(2)(ii), or (b)(2)(iii), Section 718.204(b)(2)(iv) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner form engaging in his usual coal mine work or comparable gainful work.

Of the physicians who addressed the issue of total disability, only Dr. Burki asserted that the Claimant does not retain the physical capacity to return to coal mine employment. However, he added that any impairment was not due to coal mine dust exposure. Dr. Naeye opined that the Claimant had no disability which would keep him from doing his last mining job. Dr. Younes found no impairment. Drs. Dahhan, Caffrey, and Renn felt that the Claimant is not totally disabled. Dr. Repsher specified that the Claimant is not totally disabled due to coal mine dust inhalation.

Dr. Burki's opinion is supported by the results of the pulmonary function study he administered. However, as I found above, his was the only ventilatory study to produce qualifying values. All other tests, including the two most recent of record, produced very consistent, non-qualifying values. Therefore, because the study on which Dr. Burki relied was anomalous, and because the results of his physical examination do not support a finding of total disability, I assign his opinion less weight.

The opinions of the remaining physicians are supported by the pulmonary function study evidence, the blood gas study evidence, and all the clinical findings. Consequently, I place greater weight on the opinions of Drs. Naeye, Younes, Dahhan, Caffrey, Renn, and Repsher. Therefore, I conclude that the evidence fails to establish that the Claimant is totally disabled pursuant to § 718.204(b)(2)(iv).

Total Disability Due to Pneumoconiosis:

As the Claimant has failed to establish total disability, he has also failed to establish total disability due to pneumoconiosis pursuant to §718.204(c)(1). Total disability due to pneumoconiosis requires that pneumoconiosis as defined in §718.201, be a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Substantially contributing cause is defined as having a "material adverse effect on the miner's respiratory or pulmonary condition" or as "materially worsen[ing] a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment." §718.204(c)(1)(i) and (ii) Absent a showing of cor pulmonale or that one of the presumptions of §718.305 are satisfied, it is not enough that a miner suffer from a disabling pulmonary or respiratory condition to establish that this condition was due to pneumoconiosis. See §718.204(c)(2) Total disability due to pneumoconiosis must be demonstrated by documented and reasoned medical reports. Id. In interpreting this requirement, the Sixth Circuit has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. Peabody Coal Co. v. Smith, 12 F.3d 504, 506-507 (6th Cir. 1997)

The evidence fails to establish that the Claimant is totally disabled due to pneumoconiosis pursuant to §718.204(c)(1). No evidence of cor pulmonale or evidence satisfying the presumptions of §718.305 has been offered. Of those physicians who addressed the total disability causation issue, none found that the Claimant's disability was due to pneumoconiosis. Accordingly, the Claimant has failed to establish that he is totally disabled due to pneumoconiosis.

Entitlement:

As the Claimant has failed to establish total disability or that his total disability is due to penumoconiosis, I find that he is not entitled to benefits under the Act.

Attorney's 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 the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for legal services rendered in pursuit of benefits.

ORDER

It is therefore ORDERED that the claim Danny Paul Duty for benefits under the Act is hereby DENIED.

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DANIEL J. ROKETENETZ
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.