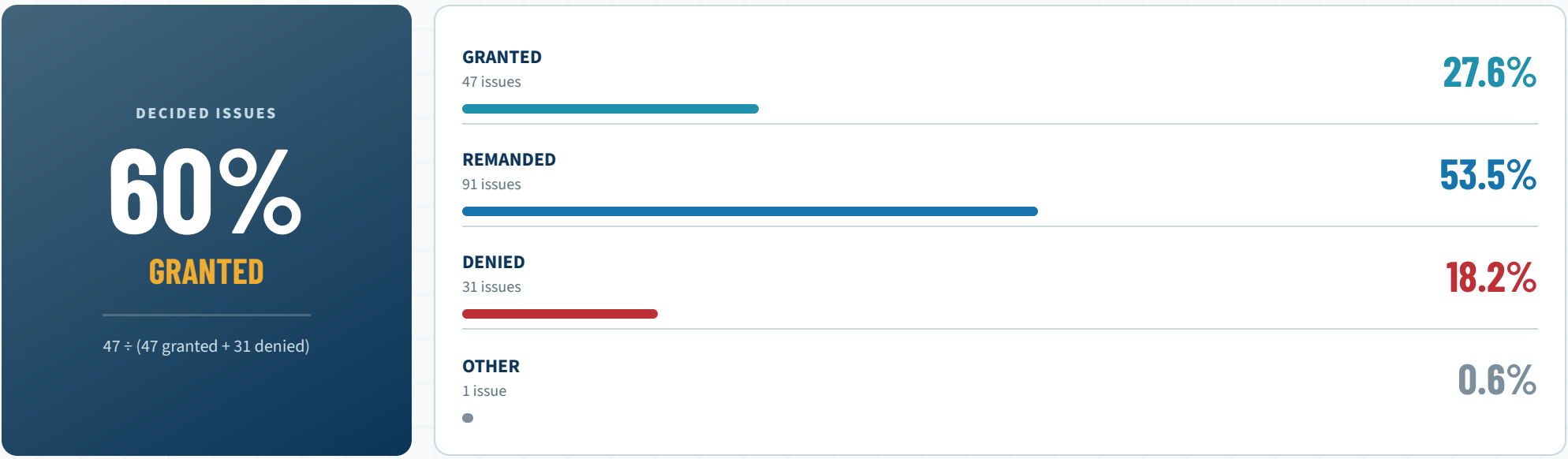




BOARD RESEARCH SNAPSHOT

DC 8045 → DC 6847 • shard generated August 10, 2026

170 PUBLISHED ISSUES ON THIS EXACT PAIRING



TWO DIFFERENT DENOMINATORS: 27.6% is granted among all 170 issues. 60% is granted among the 78 issues decided granted or denied. Remands are shown separately and are not losses.

ALL 47 GRANTS WERE CLASSIFIED



100% CLASSIFICATION COVERAGE 47 of 47 grants were identified as caused or aggravated. The nexus opinion should still answer both legal paths separately.

THE DIAGNOSTIC FORK

The sleep study controls this question

START WITH THE TYPE OF SLEEP APNEA

CSA
CENTRAL SLEEP APNEA

BREATHING SIGNAL

The brain temporarily does not send the expected breathing signal. A neurological theory must identify injury findings and explain why they affect respiratory control.

Focus: neurological control and apnea classification

OSA
OBSTRUCTIVE SLEEP APNEA

UPPER AIRWAY

The airway narrows or collapses during sleep. The opinion must explain how TBI residuals, treatment, activity, weight, or another documented pathway affects airway obstruction.

Focus: airway mechanism and intermediate steps

MIX
MIXED OR COMPLEX PATTERN

BOTH COMPONENTS

If both central and obstructive events appear, the specialist should identify which component is medically linked to TBI and which alternative factors remain relevant.

Focus: distinguish each component

DO NOT BUILD THE THEORY FROM THE LABEL ALONE. The sleep study, its interpretation, and the diagnosing clinician's records should establish the apnea type.

POTENTIAL MEDICAL PATHWAYS

Clinical association is not automatic secondary service connection

THE OPINION MUST TRACE A SUPPORTED CHAIN

01
NEUROLOGICAL CONTROL
For central events, identify the affected neurological system and connect the documented injury to disordered breathing control.

02
ACTIVITY AND WEIGHT
If TBI residuals reduced activity or contributed to weight change, document every step and address other causes.

03
MEDICATION EFFECTS
Identify the medication, indication, dose, timing, and medically supported effect rather than referring to treatment in general.

04
AGGRAVATION
If apnea predated the TBI or residuals, identify measurable worsening beyond ordinary progression and explain the mechanism.

CLINICAL CONTEXT
A 2025 scoping review found OSA prevalence ranging from 20% to 77% across TBI cohorts, but the limited comparison studies did not show significant differences from non-TBI groups. A large VA cohort found TBI associated with increased later sleep-apnea diagnoses. These findings support screening and evaluation, not automatic causation.

MAKE SIX ANCHORS EASY TO FOLLOW

1
INJURY
Date, mechanism, severity, loss or alteration of consciousness, imaging, and acute treatment.

2
TBI RESIDUALS
Service-connection decision, neurological findings, cognition, function, headaches, and rehabilitation.

3
MEDICATIONS
Names, dates, doses, sedating effects, weight effects, and treatment changes.

4
SLEEP SYMPTOMS
Onset of snoring, gasping, breathing pauses, hypersomnia, fatigue, and witnessed observations.

5
SLEEP STUDY
Apnea type, AHI or REI, central-event index, oxygen findings, interpretation, and PAP plan.

6
NEXUS OPINION
Correct facts, individualized mechanism, literature applied to the file, alternative risks, and both legal paths.

NEXUS QUALITY CHECK

CAN THE OPINION ANSWER THESE QUESTIONS?

1
What exact TBI residual is claimed to affect breathing during sleep?

2
Does the sleep study show obstructive, central, mixed, or treatment-emergent events?

3
Did the opinion distinguish sleep disturbance from sleep apnea?

4
How were BMI, anatomy, age, medications, PTSD, and other risk factors considered?

5
Was general research applied to this injury, timeline, and testing?

6
Were causation and aggravation answered separately with full rationales?

WHAT SEPARATES A THEORY FROM A SUPPORTED CLAIM

STRONGER RECORD

- TBI residuals are already service connected
- Sleep study identifies the apnea type
- Injury, residuals, symptoms, and diagnosis form a dated sequence
- Opinion explains the physiology in this veteran
- Alternative risks and aggravation are addressed

WEAKER RECORD

- TBI and sleep apnea merely coexist
- Sleep problems are treated as proof of apnea
- Central and obstructive apnea are confused
- Generic literature replaces individualized reasoning
- Weight, anatomy, medications, or other risks are ignored

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READ THE RECORD, NOT THE ODDS

These are descriptive patterns in published Board decisions. Board decisions are not binding precedent, remands are not final merits decisions, and the data does not predict any individual claim.