RATEMYVSO RESEARCH SHEET

SECONDARY SERVICE CONNECTION • 38 C.F.R. § 3.310

SLEEP APNEA SECONDARY TO TINNITUS

This pairing requires careful attention to direction, mechanism, and individualized evidence.

PRIMARY • DC 6260	CAUSES OR AGGRAVATES	SECONDARY • DC 6847
SERVICE-CONNECTED TINNITUS	→	SLEEP APNEA

BOARD RESEARCH SNAPSHOT

DC 6260 → DC 6847 • shard generated September 23, 2026

619 PUBLISHED ISSUES ON THIS EXACT PAIRING

DECIDED ISSUES

57%

GRANTED

166 ÷ (166 granted + 125 denied)

GRANTED	166 issues	26.8%
REMANDED	310 issues	50.1%
DENIED	125 issues	20.2%
OTHER	18 issues	2.9%

TWO DIFFERENT DENOMINATORS: 26.8% is granted among all 619 issues. 57% is granted among the 291 issues decided granted or denied. Remands are shown separately and are not losses.

HOW THE CLASSIFIED GRANTS WON

166 of 166 grants classified • 100% coverage

CAUSATION AND AGGRAVATION MUST STAY SEPARATE

138 GRANTS	CAUSED BY TINNITUS	83.1%

28 GRANTS	AGGRAVATED BY TINNITUS	16.9%

0 GRANTS UNCLASSIFIED — 166 of 166 grants were identified as caused or aggravated from available decision text. Each legal path still needs its own medical rationale.

THE DIRECTION PROBLEM

Read every study for direction and limits

ASSOCIATION DOES NOT TELL YOU WHICH CONDITION CAUSED WHICH

1 BETTER-SUPPORTED DIRECTION

OSA ASSOCIATED WITH TINNITUS

A 2024 meta-analysis found sleep apnea associated with tinnitus, particularly severe sleep apnea. That evidence does not automatically support the reverse claim.

Do not reverse a study's direction

2 CLAIMED DIRECTION

TINNITUS → SLEEP APNEA

The thinner evidence base includes studies showing more sleep-disordered breathing in tinnitus populations. These are associations, not proof that tinnitus caused airway collapse.

The nexus must supply the missing reasoning

3 AGGRAVATION THEORY

MEASURABLE WORSENING

If OSA already existed, a provider must explain whether tinnitus-related sleep disruption or another documented pathway worsened apnea beyond ordinary progression.

Track AHI, PAP data, and clinical course

POOR SLEEP IS NOT THE SAME AS SLEEP APNEA. Tinnitus may disturb sleep quality, but a sleep study must establish apnea and a qualified opinion must explain the claimed connection.

BUILD THE INDIVIDUAL THEORY

General literature is only one part of the record

MOVE FROM COEXISTENCE TO CASE-SPECIFIC REASONING

01 TINNITUS TIMELINE
Onset, severity, nighttime effects, treatment, mental-health overlap, and longitudinal documentation.

02 OSA TIMELINE
Snoring, gasping, witnessed pauses, sleep study, apnea type, severity, and PAP treatment.

03 OBJECTIVE WORSENING
AHI or REI trends, oxygen findings, PAP pressures, adherence, symptoms, and specialist interpretation.

04 COMPETING RISKS
BMI, anatomy, age, family history, medications, and other conditions must be addressed individually.

CLINICAL CONTEXT

The 2024 meta-analysis found sleep apnea associated with higher tinnitus prevalence, with the significant subgroup result concentrated in severe sleep apnea. A smaller study found higher sleep-disordered-breathing prevalence and severity in men with chronic tinnitus. Neither establishes tinnitus as a cause of OSA.

BUILD THE EVIDENCE FILE

SIX RECORD GROUPS SHOULD ANSWER ONE THEORY

1 TINNITUS RECORDS
Service connection, onset, severity, nighttime symptoms, and treatment.

2 SLEEP STUDY
Apnea type, AHI or REI, oxygen findings, interpretation, and diagnosis.

3 PAP DATA
Prescription, pressure, adherence, residual AHI, tolerance, and longitudinal changes.

4 LAY OBSERVATIONS
Dated first-hand reports of snoring, gasping, pauses, sleep disruption, and progression.

5 RISK-FACTOR RECORD
Weight, anatomy, age, medications, family history, and other relevant conditions.

6 NEXUS OPINION
Correct direction, individualized mechanism, literature limits, and both legal paths.

NEXUS QUALITY CHECK

CAN THE OPINION ANSWER THESE QUESTIONS?

1. Does every cited study actually support tinnitus causing or worsening OSA?
2. Did the opinion distinguish sleep disruption from diagnosed sleep apnea?
3. What mechanism connects tinnitus to airway collapse or apnea severity?
4. Were BMI, anatomy, age, family history, and other risks addressed?
5. If aggravation is claimed, what objective evidence shows worsening?
6. Were causation and aggravation answered separately?

COMMON BREAK POINTS

WHAT MAKES THIS DIFFICULT PAIRING MORE CREDIBLE

STRONGER RECORD

- Study direction and limits are stated accurately
- Sleep study confirms current apnea and type
- Opinion applies a mechanism to the veteran
- AHI and PAP data support claimed worsening
- Alternative risks and both legal paths are addressed

WEAKER RECORD

- OSA-to-tinnitus research is cited backward
- Poor sleep is treated as proof of apnea
- Conditions merely coexist
- Generic literature replaces individualized reasoning
- Obesity, anatomy, age, or aggravation are ignored

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.

Clinical context: Gao et al., Ear Nose Throat J. 2024, PMID 38321723; Lai et al., Clin Otolaryngol. 2018, PMID 29106763.

AUDITORY PAIRING