SAMPLE LETTER — FICTIONAL VETERAN — FOR DEMONSTRATION PURPOSES ONLY

February 3, 2026

RE: Independent Medical Opinion
Veteran: Daniel A. Reeves
DOB: September 3, 1988
Branch: United States Marine Corps
Active Duty: August 2009 to November 2015
Discharge: Honorable
Condition: Obstructive Sleep Apnea (Secondary to Service-Connected PTSD)

I. PHYSICIAN QUALIFICATIONS

I, [Physician Name Redacted], [Degree], am board-certified in [Specialty Redacted] through [Board Redacted]. I hold an active medical license in [State Redacted] (License #[Redacted]) with NPI [Redacted]. I have no treatment relationship with this veteran. This letter is an independent medical opinion prepared for the purpose of his VA disability claim.

II. METHODOLOGY

An in-person or telehealth examination is not required for an independent medical opinion. The VA accepts medical opinions based on thorough record review, and this methodology is consistent with standard medical practice for rendering expert opinions. See Nieves-Rodriguez v. Peake, 22 Vet. App. 295 (2008), which held that the probative value of a medical opinion is determined by whether the opinion is factually accurate, fully articulated, and supported by sound reasoning.

III. RECORDS REVIEWED

I reviewed the veteran's DD-214, service treatment records including enlistment and separation physicals, the VA Rating Decision dated April 12, 2020 (PTSD rated at 70%), VA mental health treatment records from 2016 through 2025, VA pharmacy records from 2016 through 2025, VA primary care records including vitals and anthropometric data from 2016 through 2025, the in-laboratory polysomnography report by Dr. Thomas Okoro (August 2025), and the VA psychiatry note by Dr. Rachel Stein (July 2025).

IV. RELEVANT HISTORY

Mr. Reeves served on active duty in the United States Marine Corps from August 2009 to November 2015. His MOS was 0311, Rifleman. He completed two combat deployments to Helmand Province, Afghanistan (2010 to 2011 and 2013 to 2014) and was awarded the Combat Action Ribbon.

His PTSD was service-connected by VA Rating Decision dated April 12, 2020, currently rated at 70%. His VA mental health records document ongoing treatment since 2016 including individual therapy, group therapy, and pharmacotherapy. He has been on sertraline 150 mg daily since March 2017 and quetiapine 100 mg nightly since June 2019.

His weight history is significant. At enlistment in August 2009, Mr. Reeves weighed 178 lbs at 5'11" (BMI 24.8, normal). At separation in November 2015, he weighed 192 lbs (BMI 26.8, overweight). VA primary care records show steady progression: 208 lbs in March 2017 (within one month of starting sertraline), 224 lbs in January 2019, 241 lbs in September 2020, and 248 lbs in July 2025 (BMI 34.6, obese class I). That is a 70-pound gain from enlistment, with the steepest increase corresponding to initiation and escalation of psychiatric medications.

Dr. Stein's July 2025 psychiatry note documents chronic sleep disturbance including difficulty staying asleep, frequent nightmares, and witnessed apneic episodes reported by his spouse. She referred Mr. Reeves for a sleep study. His service treatment records contain no documentation of sleep complaints during active duty.

V. CURRENT DIAGNOSIS

Moderate obstructive sleep apnea, confirmed by in-laboratory polysomnography performed under the supervision of Dr. Thomas Okoro on August 22, 2025. The study documented an Apnea-Hypopnea Index of 22.4 events per hour (moderate OSA), with oxygen desaturation nadir of 84%. CPAP titration established therapeutic pressure at 10 cm H2O.

VI. MEDICAL REASONING AND RATIONALE

The connection between PTSD and obstructive sleep apnea is supported by two converging pathways in this veteran's case: medication-induced weight gain and autonomic dysregulation.

Sertraline and quetiapine are both associated with clinically significant weight gain. Quetiapine in particular carries a well-documented metabolic side effect profile. Mr. Reeves' weight trajectory makes this clear: normal BMI at enlistment, modest gain during service, then progressive obesity after starting psychiatric medications for service-connected PTSD. He gained 56 pounds from separation to his most recent recorded weight, with the steepest increases tracking the medication timeline. Obesity is the strongest modifiable risk factor for OSA; a 10% increase in body weight is associated with a roughly six-fold increase in OSA risk (Peppard PE et al., JAMA, 2000). Adipose tissue deposition in the pharyngeal spaces increases upper airway collapsibility during sleep, directly contributing to obstruction.

Independent of the weight pathway, PTSD itself contributes to OSA through autonomic dysregulation. PTSD is characterized by chronic sympathetic hyperactivation, which affects upper airway neuromuscular control during sleep. The pharyngeal dilator muscles that normally maintain airway patency are under autonomic and serotonergic control, and PTSD-related dysregulation reduces their compensatory activity. Colvonen et al. (Chest, 2020) demonstrated that veterans with PTSD have significantly higher rates of OSA than the general population even after controlling for BMI, supporting the role of PTSD-specific pathophysiology beyond weight gain alone.

Dr. Stein's notes also document reduced physical activity, social withdrawal, and avoidance of public spaces like gyms due to hypervigilance, all of which compound the weight gain from medications.

I considered other risk factors. Mr. Reeves is a 36-year-old male; while male sex is a demographic risk factor for OSA, it does not constitute an independent etiologic cause. His

records contain no family history of sleep apnea. He reports no alcohol use and no current tobacco use. There is no documented hypothyroidism, craniofacial abnormality, or other anatomic factor that would independently explain his OSA. The timing and trajectory of his weight gain, from normal BMI at enlistment through progressive obesity following initiation of PTSD medications, is the most clinically significant explanatory factor.

VII. OPINION

Based on my review of the records identified above, the relevant medical literature, and my clinical training and experience, it is my independent medical opinion that Mr. Reeves' obstructive sleep apnea is at least as likely as not (50% or greater probability) caused by or proximately due to his service-connected PTSD, through the combined mechanisms of medication-induced weight gain and PTSD-related autonomic dysregulation.

This opinion is supported by the clear temporal relationship between PTSD medication initiation and progressive weight gain, the well-established dose-response relationship between obesity and OSA, the independent contribution of PTSD-related autonomic dysfunction to upper airway collapse, and the absence of any competing predominant cause.

VIII. REFERENCES

1. Peppard PE, et al. Longitudinal study of moderate weight change and sleep-disordered breathing. JAMA. 2000;284(23):3015-3021.

2. Colvonen PJ, et al. Obstructive sleep apnea and posttraumatic stress disorder among OEF/OIF/OND veterans. Chest. 2020;158(1):331-340.

Respectfully submitted,

[Physician Signature Redacted]

[Physician Name Redacted], [Degree]
[Board Certification Redacted]
[State Medical License Redacted]
[NPI Redacted]