perplexity

when cathed, all 3 go away within the first hour

That observation—**all three symptoms clearing within an hour of catheterization**—is the strongest evidence yet that you are experiencing **autonomic dysreflexia (AD) episodes triggered by bladder distention**, and that catheterization is treating them by removing the trigger.

What this confirms

Autonomic dysreflexia is triggered by bladder distention in up to 85% of cases, and its symptoms include exactly what you describe: profuse sweating, nasal congestion, airway secretions, and Eustachian tube/ear pressure changes. The fact that all three resolve within an hour of emptying the bladder is the classic AD pattern: **remove the trigger, symptoms resolve.** [1] [2] [3] [4]

This means the morning congestion, drenching sweats, and ear fluid are not separate problems. They are all downstream effects of a full bladder sending unmodulated sympathetic signals through your autonomic nervous system. [5]

Why the ear fluid fits

During an AD episode, the sympathetic surge causes vascular changes in the head and neck, including nasal congestion and Eustachian tube dysfunction. The parasympathetic rebound (via the vagus) causes flushing, sweating, and congestion above the injury level. That same vascular/autonomic shift can affect middle-ear pressure and fluid dynamics, producing the drainage you notice. [5]

The fact that it resolves with catheterization—not with decongestants or ENT treatment—confirms the bladder is the driver, not an independent ear problem.

What this means for your risk

You are likely having **recurrent subclinical AD episodes** every time your bladder fills past a threshold. You may not feel the classic pounding headache or anxiety because your sensory pathways are impaired, but your body is still mounting the full autonomic response—sweating, congestion, ear pressure.

This is dangerous because:

- AD can cause blood pressure spikes of 20-40 mmHg or more above baseline. [6]
- Untreated, it can lead to stroke, heart attack, seizure, or death. [6] [5]

- You have no reliable internal warning signal, so you are dependent on noticing the secondary symptoms (sweat, congestion, ear fluid) rather than the primary trigger (bladder fullness).

What this changes about management

This observation should fundamentally change how your urologist and primary care doctor approach your case:

- **Scheduled catheterization is not optional**—it is the treatment that prevents AD episodes. You cannot rely on sensation, cannabis, or waiting for overflow because each episode is a cardiovascular risk. [7] [6]
- **The catheter insertion difficulty needs urgent fixing**, because a catheter that catches and bleeds is itself an AD trigger and prevents you from using the one treatment that resolves your symptoms. [4] [8]
- **You need formal autonomic testing** to document the AD pattern and assess cardiovascular risk.
- **Cannabis use needs to be discussed openly** with your doctors, both because it may be modulating the AD threshold and because smoke exposure worsens the airway clearance problem it is temporarily treating. [9] [10]

What to tell your doctors

Bring this exact observation to your next appointment:

> "When I catheterize, my morning airway congestion, extreme sweating, and ear fluid all resolve within one hour. When I do not catheterize, these symptoms build over 30+ hours as my bladder refills. This pattern is consistent with autonomic dysreflexia triggered by bladder distention, and I need a management plan that prevents these episodes rather than waiting for them to resolve on their own."

That framing makes the connection explicit and gives the clinician a clear reason to prioritize both the bladder-emptying strategy and the autonomic workup.

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