# please describe the risks of valsalva pressures in this setting

it was not 30+ horus retentions
it was after 30 hours of cath removal (that it started returning to the state before cath placement). and it was maybe 4-8 hours between each overflow runout that i would take the breath and push with....

and dont forget about the tiny full pressure bursts gradually holding more in bladder each time leading up to this rough 30 hours mark before bladder goes back to original state.....

Thank you for clarifying the timeline. That changes the risk picture: you are doing **repeated Valsalva/Credé efforts every 4–8 hours over a 30-hour window**, on a bladder with no sensation, while it is gradually re-accumulating volume. That is a different risk profile from a single Credé after a one-time retention.

### What is actually happening over those 30 hours

Your description of "tiny full-pressure bursts gradually holding more each time" suggests the bladder is relearning to store in stages. Each overflow runout partially empties it, but the residual creeps back up between episodes. By the 30-hour mark, you are back to the pre-catheter state: no sensation, no reliable trigger, and only mechanical pressure or cannabis to start anything.

That means each Valsalva is happening on a bladder that is **already partially full and climbing**, not on an empty one. The pressure you generate stacks on top of whatever storage pressure is already there.

### Valsalva risks in this setting

### High intravesical pressure stacking

Valsalva raises intra-abdominal pressure, which transmits directly to the bladder. If the bladder already holds several hundred mL with some baseline pressure, a Valsalva push can spike intravesical pressure well above what either the bladder or the abdomen would produce alone. In a sensory-impaired bladder, you have no warning signal that the pressure has become dangerous. [1] [2]

### Vesicoureteral reflux

Repeated high-pressure spikes can force urine backward through the ureterovesical junction into the ureters and kidneys. This is the mechanism behind reflux-related kidney damage, and it is worse when it happens repeatedly rather than once. The fact that you have no hydronephrosis on one scan does not rule out episodic reflux during these pushes—it only means the damage has not accumulated enough to show up yet.[3] [4] [5]

### Autonomic dysreflexia risk

This is the most serious concern given your sensory impairment. Autonomic dysreflexia is triggered by a noxious stimulus below the level of injury—**bladder distention is the number one cause, accounting for 75–85% of episodes**. In someone with impaired sensation, a full bladder can trigger AD without any pain or discomfort you can feel.[6] [7]

AD causes a dangerous blood pressure spike, and guidelines specifically warn that **neither Valsalva nor Credé should be used to empty the bladder** in patients at risk of AD, because the straining can worsen the syndrome.[2] [7]

Signs to watch for during or after a push: pounding headache, sweating above the injury level, slow pulse, flushing, nasal congestion, blurred vision, or cold clammy skin below the injury. Some people have no symptoms at all despite dangerous blood pressure.[6]

### Cardiovascular effects of Valsalva itself

Even in people without neurogenic bladder, Valsalva causes a predictable blood-pressure swing: a brief rise during the strain, then a sharp drop on release, then a rebound overshoot. In someone with impaired autonomic regulation—which your sensory loss hints at—that swing can be exaggerated and less well controlled.[7]

### Why repeated efforts over 30 hours compound the risk

A single Credé after a one-time retention is a different situation from what you are describing. You are doing:

- Multiple Valsalva efforts over 30 hours
- On a bladder with no sensory feedback
- While volume is climbing between episodes
- With cannabis as an unpredictable modifier of autonomic tone

Each push is a fresh pressure spike on a bladder that never fully empties. The cumulative effect is more reflux exposure, more autonomic stress, and more risk of a pressure-related event than any single episode would suggest.

## What the guidelines say

Current guidance is clear: Valsalva or Credé voiding may be considered only when bladder outlet resistance is low and detrusor contraction is simultaneously decreased by a specific sacral injury pattern. They are **not recommended** in patients with detrusor-sphincter dyssynergia, vesicoureteral reflux, or bladder outlet obstruction—all of which are concerns in your case given the catheter catching and the pressure pattern you describe. [2]

Clean intermittent catheterization remains the safest emptying method precisely because it avoids these pressure spikes. Given your sensory impairment and the catheter difficulties you are having, the priority is getting the urethral problem assessed so catheterization can be made safe again, rather than relying on Valsalva as a workaround. [2]

## What to watch for and when to act

Seek emergency care immediately if during or after a push you develop:

- Pounding headache or sudden severe headache
- Marked sweating above the waist with cold clammy skin below
- Blurred vision, flushing, or nasal congestion
- Slow pulse with high blood pressure
- Any of the above without a clear cause

These are AD warning signs, and they need immediate treatment, not waiting to see if it passes. [7] [6]

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