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Commentary Article

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When the Bladder and the Body Stop Agreeing Autonomic Dysfunction, Urinary Hesitancy, Urgency, and Erectile Dysfunction in Older men: a Medical Humanities Manuscript

Bruce H. Knox*

Independent Scholar, Auckland, New Zealand

***Corresponding Author**
Bruce H. Knox, Independent Scholar, Auckland, New Zealand.

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Abstract

This paper explores how autonomic dysfunction can disturb bladder function and sexual function together in older men, with particular attention to urinary hesitancy, urgency, incomplete emptying, nocturia, and erectile dysfunction around the age of 73. The central clinical argument is that these symptoms often coexist because bladder storage, bladder emptying, outlet relaxation, vascular supply, and erection share overlapping autonomic, pelvic, and vascular control pathways. In later life, these pathways may be altered not by one mechanism alone but by mixed contributions from ageing, benign prostatic enlargement, detrusor underactivity, detrusor overactivity, impaired afferent signalling, medication burden, endothelial dysfunction, and broader dysautonomia. The paper is written in a medical-humanities register and cites a six-song cycle as a creative parallel text. The songs do not replace science; they illuminate lived experience—especially the paradox of 'must go' urgency with poor flow, the embarrassment of hesitancy, the burden of nocturia, and the emotional consequences of erectile dysfunction. Taken together, the scientific and creative sources suggest that the ageing male bladder is often best understood as a problem of mistimed coordination rather than a single isolated fault. A humane clinical approach therefore requires attention not only to symptom scores and prostate size, but also to residual urine, pelvic timing, sleep disruption, self-management, dignity, and the gradual adaptation required in later life.

Keywords: Autonomic Dysfunction, Dysautonomia, Lower Urinary Tract Symptoms, Urinary Hesitancy, Urgency, Erectile Dysfunction, Ageing Men, Medical Humanities

Key messages

Autonomic dysfunction can produce a mixed pattern of urgency, hesitancy, incomplete emptying, nocturia, and erectile dysfunction because the same pelvic systems must switch cleanly between storage, voiding, and sexual function.

In older men, urgency does not exclude poor emptying. "Must go" can coexist with weak detrusor contraction, residual urine, and outlet discoordination.

Erectile dysfunction often belongs in the same clinical conversation as lower urinary tract symptoms because of shared autonomic, vascular, and endothelial mechanisms.

Medical humanities methods help clinicians hear what symptom checklists miss: unpredictability, embarrassment, sleep disruption, altered masculinity, and the disciplined labour of adaptation.

Opening note

In older men, bladder symptoms and sexual symptoms often arrive together, and they are not always separate stories. The same autonomic wiring that helps the body store urine, release urine, and support penile erection can lose precision with age, disease, vascular change, medication burden, or broader dysautonomia [1-6]. The result may be a mixed picture: urgency and frequency on

one side, hesitancy and incomplete emptying on the other, with erectile dysfunction travelling in the same company [2,4,7-10] .

That is the central image of this paper. The problem is not simply weakness, and not simply obstruction. Very often it is timing. The bladder, outlet, pelvic floor, blood vessels, and sexual organs still work after a fashion, but they do not always switch in harmony. The songs tell that story with humour, frustration, grief, stubborn dignity, and eventually a guarded kind of hope [15-20].

1. The Shared Wiring: Why Bladder Symptoms and Erectile Dysfunction Often Belong in the Same Conversation

Normal bladder function depends on a coordinated relay between the brain, spinal cord, autonomic nerves, and somatic pelvic floor control. During storage, sympathetic activity helps the bladder relax and the outlet stay closed. During voiding, parasympathetic outflow drives detrusor contraction while outlet resistance falls. The pudendal system adds voluntary sphincter control [1,3,11,12].

Penile erection shares part of this same pelvic autonomic territory. Parasympathetic pathways are central to erection, while sympathetic pathways are involved in storage, emission, and detumescence [3,7]. That is why autonomic dysfunction can present as a cluster rather than a single symptom: dizziness, bowel irregularity, sweating change, palpitations, urinary symptoms, and erectile dysfunction may all be different accents of the same disturbed system [4].

In practical terms, a 73-year-old man may notice that the bladder has become unpredictable and the erection less reliable for overlapping reasons: autonomic dysregulation, age-related endothelial and vascular change, pelvic ischaemia, altered nitric oxide signalling, coexisting prostate enlargement, and the cumulative effects of medication and comorbidity [2,5,7-10].

2. Why Hesitancy Happens: the Body Cannot Quite Find the Green Light

Hesitancy is the lived sensation of wanting to void but not being able to begin smoothly. In older men, this can happen for at least three overlapping reasons. First, outlet resistance may be increased by benign prostatic enlargement or bladder outlet obstruction. Second, the bladder muscle may contract too weakly or too briefly, a pattern called detrusor underactivity. Third, the sphincter or pelvic floor may fail to relax in proper sequence, so the bladder and outlet pull against one another instead of collaborating [2,3,11-14].

Autonomic dysfunction fits particularly well into the second and third of these mechanisms. If afferent sensation is blunted, the bladder fills without sending a crisp message. If efferent signalling is impaired, the detrusor contraction comes late, comes weakly, or fades too soon. If the switching system misfires, the outlet may continue to guard when the bladder is trying to empty [2,3,11,12].

This is why some men describe a strange contradiction: they feel urgent, but when they stand at the toilet nothing much happens. The songs capture that paradox better than medical language often does. The problem is not merely that the bladder is slow; it is that the moment of release is badly choreographed [15,16].

3. Why Urgency Happens: the Bladder Becomes Over-Alert While Emptying Remains Incomplete

Urgency, the compelling need to pass urine that is hard to defer, often sounds as if it must come from an overactive bladder alone. But in older men, urgency may coexist with poor emptying. This matters because the bladder can become irritable both when it contracts too soon and when it never empties fully. Residual urine changes the mechanics of the next cycle; the bladder starts the next round already disadvantaged [2,11-14].

Ageing itself shifts the pattern. Studies in older populations show rising rates of detrusor underactivity, detrusor overactivity, and mixed syndromes rather than one neat single diagnosis [2,11-14]. That helps explain the familiar bedside contradiction: the man who says ‘must go, must go’ may also be the man who hesitates, strains, and leaves significant residual urine behind.

So urgency in autonomic dysfunction is not always a simple excess signal. Sometimes it is the cry of a bladder that is irritable, incompletely emptied, poorly modulated, or all three at once [2,6,11,12].

4. Why Erectile Dysfunction Belongs in the Same Chapter

Erectile dysfunction in later life is common, but it should not be dismissed as merely inevitable. It often reflects the same broad biology that is disturbing the bladder: autonomic imbalance, endothelial dysfunction, impaired nitric oxide signalling, reduced pelvic blood flow, chronic disease burden, and the layered effects of ageing on nerves and vessels [5,7-10].

Large observational studies have shown a strong association between lower urinary tract symptoms and erectile dysfunction, even after adjustment for age and other factors [8-10]. That association does not mean every bladder symptom causes erectile dysfunction directly. It means these two problems often share mechanisms and should be assessed together rather than in separate silos.

For the older man, that clinical truth also has an emotional dimension. Sexual function is not a trivial extra. When bladder confidence, continence, and erectile reliability all become uncertain, identity itself can feel under siege. Medical humanities writing matters here because it allows the body to be described not only as a malfunctioning system, but also as a lived companion that has become difficult to trust [17,20].

5. What Tends to Happen With Age: From Bother to Burden to Adaptation

At 73, the pattern is often less dramatic than cumulative. Early symptoms may have been nocturia, urgency, or a weaker stream. Later, there may be hesitancy, stop-start voiding, dribbling, a sense of incomplete emptying, and more pronounced erectile difficulty. What changes with age is not only symptom count, but the stakes.

Residual urine raises the risk of recurrent urinary tract infection, bladder decompensation, overflow leakage, and, in vulnerable cases, upper tract damage [2,11,13,21,22].

The natural history is usually mixed rather than linear. Some days feel nearly normal; other days the system seems to forget itself. Hydration, constipation, posture, fatigue, medications, intercurrent illness, and emotional stress can all shift the pattern. That variability is one reason dysautonomia can be misunderstood by clinicians and exhausting for patients [4,17,19].

Many older men are told they have 'prostate symptoms', and sometimes that is true. But prostate enlargement is not the whole story. In some men, the outlet is only part of the problem, and in others the greater issue is poor contractility, impaired sensory signaling, or discoordination. That is why symptom severity alone cannot reliably distinguish obstruction from underactivity; the two frequently overlap [12-14].

6. The Night-Time Story: Nocturia, Routine, and the Labour of Self-Management

One of the quiet cruelties of bladder dysfunction in later life is that it reorganises time. Sleep fractures. Confidence shrinks after dark. Toileting becomes planning rather than reflex. The repeated night-time journey can feel small to outsiders and enormous to the person living it [17,19].

This is where the songs are especially strong. They do not romanticise the problem, but they recover dignity through routine. Night and morning, empty well. Night and morning, protect the kidneys. Night and morning, pay attention to what remains. That is not defeat; it is stewardship [17,19].

In men with significant residual urine or neurogenic lower urinary tract dysfunction, intermittent self-catheterisation may become part of that stewardship. It is often the preferred method of bladder drainage when needed because it can improve emptying while avoiding some of the burdens of a long-term indwelling catheter [21,22]. But it also brings technique, discipline, inconvenience, and infection risk into ordinary life. Song 4 rightly refuses to pretend that careful management erases vulnerability [18,21].

7. Recovery, Fluctuation, and the Importance of not using the word 'Failure' too Quickly

A striking idea in the song cycle is that imperfect function is still function. Clinically, this matters. Older men with autonomic bladder symptoms do not always progress in a straight line towards complete retention or complete incontinence. Many live in the mixed middle: partly compensated, partly vulnerable, improving in one domain while still struggling in another [15,16,20].

That mixed state can be profoundly frustrating. Blood pressure may stabilise before bladder confidence returns. A man may walk better than he voids. He may feel stronger yet still dribble. He may no longer be collapsing on standing and yet still be frightened of travel because toilets are unpredictable. This apparent contradiction is medically plausible because autonomic recovery, compensation, and ageing do not unfold at identical speeds across organ systems [4,15,16,20].

8. A Humane Clinical Reading

A humane clinical approach to the 73-year-old man with dysautonomia, erectile dysfunction, hesitancy, and urgency begins by refusing reductionism. The questions are not only 'Is it the prostate?' or 'Is it just age?' The better questions are these: How well is the bladder sensing filling? How well is it emptying? How much residual urine remains? Is the outlet obstructed, over-guarded, or both? What medications are helping one system while worsening another? And how much of the suffering comes from unpredictability, sleep disruption, embarrassment, and diminished sexual confidence rather than from the symptom score alone? [4,12-14,21,22].

In that sense, the songs do something that the clinic often struggles to do. They restore sequence, feeling, and voice. They recognise that urgency is not only detrusor activity, hesitancy is not only flow rate, and erectile dysfunction is not only a vascular event. All three can be experienced as a crisis of timing, trust, and masculinity. Good care has to attend to all three.

Conclusion

Autonomic dysfunction in older men can disturb the bladder and sexual function through a common anatomy of switching, signalling, vascular support, and pelvic coordination. At age 73, the typical pattern is not a single pure disorder but an overlap of urgency, nocturia, hesitancy, incomplete emptying, dribbling, and erectile dysfunction, often intensified by ageing, prostate change, comorbidity, and medication burden [1-10,12-14].

https://brucehknox.aflip.in/b2b3bff4db.html

Musical Narratives of Autonomic Dysfunction

A Musical Patient Perspective on Autonomic Vulnerability, Bladder Dysfunction, and Recovery

Bruce H. Knox, D.Litt., ATEMF
Independent Scholar, Auckland, New Zealand
ORCID 0009-0004-1637-2017
bhknox52@gmail.com

Abstract

This manuscript presents a patient-centred exploration of autonomic dysfunction through an integrated narrative and musical framework. Focusing on bladder dysfunction in later life, it combines clinical insight with lived experience expressed through six lyrical compositions. These works are presented as reflective data, capturing uncertainty, adaptation, symptom burden, recovery, and partnership in self-management. Positioned within a Journal of Patient Experience–style submission format, the paper brings together narrative medicine and creative practice to illuminate aspects of dysautonomia that are difficult to convey through clinical description alone. The song cycle complements the prose narrative by translating physiological complexity into memorable, emotionally resonant form while retaining clinical seriousness. Together, the manuscript and appendix argue that creative expression can extend patient testimony, deepen understanding of illness experience, and support communication across patients, clinicians, and readers.

Keywords: dysautonomia; bladder dysfunction; patient experience; narrative medicine; ageing; reflective data

Key Messages

- Autonomic dysfunction is often experienced as a disorder of coordination rather than an isolated organ problem.
- Bladder symptoms can reveal gaps between subjective sensation and physiological reality.
- Creative works can function as reflective data when they are grounded in sustained lived experience.
- A song cycle can communicate symptom burden, ambiguity, adaptation, and recovery in forms accessible to both clinical and non-clinical readers.

Patient Contribution Statement

The author is the patient and sole contributor. The narrative analysis and the six songs derive from lived experience, reflective interpretation, and patient-authored creative practice.

Introduction

The following artistic works are presented as reflective data. These compositions represent longitudinal reflective observations, translating lived physiological experience into musical language while remaining anchored in the embodied realities of autonomic dysfunction, bladder disturbance, uncertainty, and recovery.

Appendix A. Song Cycle (Reflective Data)

For readability and presentation, the songs are centred on the page. Chorus and refrain markers are italicised, and brief call-and-response cues are indented. Each new song begins on an even-numbered page.

What the songs add is not decoration but explanation. They show that this condition feels like mixed messages in the body: the urge without the stream, the effort without completion, the waking without rest, the care without guaranteed control, and sometimes the hope of partial recovery without a return to innocence [15-20].

In medical humanities terms, this is exactly the point. The science explains how the bladder and erection lose synchrony. The songs explain what it is like to live inside that loss, and how older men may continue to improvise dignity, humour, discipline, and tenderness even when the body no longer changes gear cleanly.

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