October 16, 2025 at 10:48 PM

Part II of II Mehta Complaint
from Geary J. Johnson
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June 12, 2025

Visit with Dr. Mehta

Question about Dr Barsanti rectal exam, not done by Dr. Mehta.

My questions about pros and cons. I heard MRI more accurate but there could be complications from a biopsy. Previous Dr adamant about the biopsy.

He standard of care across America that MRI is not the standard of care first because 20-20% of the time it can give false sense of security. Patients should get biopsy, but then get the MRI.

For biopsy, He said risk of infection in urine or blood; he said risk is 2% very low for infection. The biopsy may show cancer but MRI may not show the same cancer.

He neglects to say that most doctors recommend the MRI first to avoid the biopsy. He does not mention that long term risk of cancer almost same whether person gets biopsy of not; he does not mention …..

He mentions low grade vs high grade cancer. If MRI looks suspicious; he says MRI not used alone.

Google AI says “For context, a study noted a risk of infection from 5.9% to 7.2% between 2001 and 2007 for the transrectal approach, with complications like hospitalizations also increasing during that period.”

June 12, 2025 session with Dr. Mehta.
He does not mention the wait and see options and cancer growth rate for prostate cancer.
I ask his option of PSA value. He says mine has been elevated significant amount. He says numbers are concerning for the numbers but he said they would need the pathology tell the type of cancer.
I asked relation to how many catheters and blockage. He said not related to if there would be cancer.
I told him daily incontinence and adult diaper and terrible feeling when driving. What bearing on catheter affecting the driving? He does not think the driving issue has nothing to do with the prostate possible enlargement or the UTI.
I said is it something in my rear end or back related to sitting on car vs home. He does not know. It fears like fearful like I am dying and something terribly wrong. Why not happening all the time.
I told him I am off work another month and another Doctor prescribed Prozac.
MRI of brain scheduled.
He wants to do the biopsy first is standard of care. He says some patients want the MRI first. He said gold standard at Kaiser is to order biopsy first. He doesn't mention the 9.8 PSA result that was lower.
Is the biopsy painful? He said 1 out of 100 are anxious with the probe.
I told him lot to think about.
He recommends PSA every six months.

We are not trying to shrink it now? He said not until biopsy of MRI. He said not start shrink medicine until see Biopsy first. He said biopsy or MRI would tell them size, short of rectal exam.

My PSA was 9.8 in 9/11/2025, and 9.1 in 1/26/2024, and 10.4 12/2023 but Doctor Notes does not mention that. He has an agenda.

SEPTEMBER 11, 2025 session with Dr. Mehta

Mehta prescribes CIP-500. Does not mention any of side effects. Just generally says benefits outweigh the risks. I asked if take the medicine for ten days, does my urine get tested again and he said no. I asked how will you know if the medicine is effective and the ailment is gone unless you test the urine again. He said all we do is look at are you still having symptoms. That does not seem to be correct being that he already said you could be asymptomatic. The doctor tried to claim the end the portal he had suggested a urine test, but in actuality, I am the one who suggested another urine test because I was having trouble driving. Some matter does not want to do the urine flowmeter test, but he wants to do the urine test to see if bacteria. So I said, should I come back in 10 days to get another urine test and he again said no you don't need to do that because there may be good bacteria mixed up in there. In order to take the CIP-500, it seems he is only going on the urine test because there has been no new symptoms since the last infection, in other words I still have symotoms but they have not changed. How does he justify the CIP-500 other than the urine test? No answer. The doctor was irritated that I was even asking the question about the effect of the medicine. I'll try to take a nap. What were you gonna take treatment treatment treatment I just wanted to be assured that something is wrong. That's being treated that you're not just giving me some medicine for something that could happen in like 20 years down the road, and I mentioned about the peripheral nephrology that this medicine can make that worse and I said I think the other…he said very few side effects. I think he may have prescribed the CIP-500 without having the urine test done. I did take the CIP-500 and after completing it a few days later the bladder blockage occurred. The doctor had prescribed the CIP-500 around September 9 but did not meet with me until September 11, presumably did not discussed need for medicine until after he had ordered it.

October 15 2025

I asked Doc about taking catheter out in five days. He said catheter should stay in due to time to treat the infection. I am not sure of his stated relationship with the catheter and the UTI being that the catheter itself can cause a UTI if left in too long.
One of my questions to the portal was how much time should catheter stay in so he does not answer that nor does he admit that the catheter could make the infection worse if left in too long.
He mentioned the CIP-500 was given before they had the culture back the shows the UIT and need for Macrobid.
What does he say in his Notes my chief complaint? Does he answer the notes I have written the portal.
Does the audio show we discussed high cholesterol?
From Mehta summary and his notes I do not see any discussion of the effect of the UTI on driving or balance, or of that effect from the medicine. The driving and balance issues are a part of my medical history. There is also no discussion of what is causing the bacterial infection that causes the UTI and blockage.
My notes from Google on can high lipids cause bacterial infection: “While bacteria can use lipids, high lipid levels do not cause infections; rather, they are often a consequence of the body's response to fighting an existing infection. Research suggests a complex interplay where both high and low lipid levels can have different implications for infectious disease, with some studies even indicating that very low LDL cholesterol might be associated with a higher risk of infection, according to the NIH.”

Mehta claims we had numerous discussions that Flomax could help with bacteria by cleaning out the bladder. Mehta, however, does not indicate what is causing the bladder infection and does not indicate any proof that the bladder is not emptying adequately. His portal notes do not indicate such past discussions about Flomax. My believe is that the Flomax might have been mentioned in the past but only in relation to the PSA numbers and possible enlarged prostate. Although Mehta claims the enlarged prostate would not cause the bladder blockage. I have indicated my objection to side effects of Flomax. I asked him what is causing the UTI? He said probably because the bladder is not emptying but I said the bladder volume that was previously tested no one told me of that problem; I believe the bladder volume was tested at least three times. At first he could not find the tests. He offered no alternatives or other treatment other than the Flomax. He offered no other ailments that can cause the bladder problems, nor did he offer any such tests. He did not say he would offer me any tests to that degree.

The second time CIP-500, says Mehta, occurred because they had not gotten the culture back so they started me on the CIP-500. Once they got the culture back, they changed the medication. So in my eyes, there may have been little justification to put me back on the CIP-500 and could have waited until the culture came back. The doctor was irritated I was asking so many questions.

So I have had at least two different bacterial infections in the bladder and it doesn't seem that the Kaiser doctor is doing anything to find out the cause in origin of the bacteria infection.

10-10-25 white blood cells in urine. LEUKOCYTE ESTERASE,

- “Macrobid can cause **Headache and dizziness**: These are also common side effects.” On October 17 I asked Dr. Mehta to take me off work letter thru the time of the Macrobid since I had two episodes of dizziness in a car today and was not able to go to work. At the time the Macrobid was prescribed I was not told by any Kaiser doctor about the possible side effects like dizziness or trouble driving.

Mehta (Oct 15) said that he wants me to take the Flomax to improve the flow of urine and to improve the ability to empty effectively the bladder and possibly reduce the rate of infection .(He said the previous bacteria was in my stomach (October), not in my uriine. Metha never answers what is the infection that is occurring and other than Flomax what tests to determine where the bad bacteria comes from. He feels he is going in circles and repeating himself so he says again that the Flomax helps to open up the doorway to improve your ability to urinate and empty your bladder which reduces the rate of infection occurring. I note here that he never establishes and test that shows the bladder is not emptying properly. I said that you are not saying what causes the infection. He is irritated and repeats himself and says when you don't empty your bladder very well and retain urine can cause an infection. So I ask what tests are you doing to assure that I am retaining the urine so I mentioned past tests where Kaiser said the amount of urine in bladder was very low. At first he said tests were not done and then he found one test. I told him no one ever told me the urine amount was too high. He said I could have the PVR test done again. I told him it was obvious he had not read the record in terms of the amount of urine in the bladder. He is upset he says because he feels he is telling me things over and over. Why did he not order prior to this the PVR test? Mehta complained that my medical record shows I have "tons and tons of messages every month" but as I go thru them, there is not a single one message that talks about the PVR (why would I talk about because I am not the one responsible to tell me the test is off. I believe Kaiser has done the test at least three times and also does it after the catheter is taken out, so that would be Urgent Care). He says he cannot pull it up because it would be in the Doctor notes. I disagreed. He said the PVR would not be a separate lab result. Then he found one from a year ago from Dr Barazani and he says PVR was 725. He does not explain the circumstances of the test. He claims the 725 is abnormal. Mehta says October 2024.

I found test results from 9/25/24 by Dr Barasani. Also says office visit Oct 14, 2024. He notes the PVR is 75ml. “Results of a post-void residual test report the amount of pee left in your bladder, or PVR volume. A normal post-void residual volume is between 50 mL (milliliters) and 100 mL.” https://my.clevelandclinic.org/health/diagnostics/16423-postvoid-residual . Even if Mehta misspoke, the 75 ml is not considered abnormal. If that is his justification for taking the Flomax, the evidence does not bear him out.

I think the reason why I had trouble driving in July 2025 was a direct result of the catheter being in too long. So I don't know why the doctor Meta did not consider that in the discussions about the catheter and the UTI. Why did urinary obstruction occur up to a week after the CIPRO stopped? This is never explained by Dr. Mehta.

The October 6 Urgent Care/Emergency shows that catheter inserted after PVR measurement of 400ml, which is to be expected because of urinary retention. The Apr 28 2025 Urgent Care shows catheter inserted after urinary retention 500 cc bladder scan. Many questions about best time frame for catheter to be removed. No answers from Kaiser employees. I voluntarily asked for it to be removed on May 12, 2025. PVR 71. Again, Mehta is incorrect. Therefore no justification to use the Flomax. I again told Mehta I have trouble getting out of bed and walking in the morning, getting to the wheelchair. Mehta said that has nothing to do with prostate.

I disagree. “Therefore, it is important to consider gait and balance concerns when making treatment recommendations for older adults with BPH and LUTS. Physicians and health-care providers need to be aware of, and remain vigilant for, increasing falls risk and mobility impairment that may emerge from treatments including medications, bed rest, and occasional catheterization (Hsieh, Fleegle, & Arenson, 2014).” https://pmc.ncbi.nlm.nih.gov/articles/PMC6537265/

"The primary risk of using a Foley catheter is a urinary tract infection. The longer you use a Foley catheter, the higher your risk of developing a UTI. You shouldn't use a Foley catheter longer than three months." https://my.clevelandclinic.org/health/treatments/foley-catheter . **"Longer Term:** The risk of a full-blown infection increases with every additional day the catheter is in place, making it crucial to remove it as soon as it is no longer needed." Google AI. "Bacteriuria is the presence of bacteria in urine. Because indwelling urinary catheters become colonized so easily, the incidence of bacteriuria is 3-7% per day. Nearly 100% of patients with urinary catheters will have bacteriuria after one month." "After 1-2 weeks of catheter treatment it is estimated that almost everyone has bacteria in the urine which subsequently may lead to infections."https://www.bactiguard.com/common-complications/

"Prevention

If you have an indwelling catheter, you must do these things to help prevent infection:

- Clean around the catheter opening every day.
- Clean the catheter with soap and water every day.
- Clean your rectal area thoroughly after every bowel movement.
- Keep your drainage bag lower than your bladder. This prevents the urine in the bag from going back into your bladder.
- Empty the drainage bag at least once every 8 hours, or whenever it is full.
- Have your indwelling catheter changed at least once a month.
- Wash your hands before and after you touch your urine." https://medlineplus.gov/ency/article/000483.htm About

About 40% of infections in healthcare are urinary tract infection in which 80% of it is triggered by catheter placement. https://pmc.ncbi.nlm.nih.gov/articles/PMC6953942/. “The number of infections 3%-5% and 3%-10% every day for indwelling catheter placement in short-term and long-term.” The catheter placement was a major common urinary tract infection in healthcare. Our finding shows that approximately 43.90% of patients had catheter-associated tract infection [13]. We used the *Center Disease Control* criteria to set as catheter-associated tract infection [14]. Bacteria type found was Escherichia coli 36.11%. Similarly, the study [8], [9], [15] that Escherichia coli was the most commons catheter-associated urinary tract infection. Type 1 Fimbriae was Escherichia coli gen causing infection. “Duration of catheterisation was the most influential independent factor with catheter-associated urinary tract infection. It has been shown in another study [21], [28], [29]. The odds of the duration of catheterisation 32.85 higher for a patient who inserted a catheter for five days or more. The length the catheter insertion, the more susceptible to infection [30]. Patients who insert the indwelling catheter have a risk to growth bacteriuria [31]. The catheter urine will form a biofilm. Bacteria can enter after catheter insertion or after three days.” No doctor at Kaiser explains to me the risk of infection from catheter placement and no doctor tells me the catheter should not be in longer than five days. Current my catheter placement duration 10-13 days.

Editor Note: The worst thing I can say about Kaiser Permanente is you may have a hard time getting a straight answer out of them. Why would Kaiser want the catheter to stay in longer than five days? Maybe because the more people that get a catheter infection, the more hospital care that is needed, the more prescriptions that can be filled, the more money the hospital makes.