Concerning the second point—indeed we were sitting that day in the operating room discussing the different options of removing the foreign body and one of these options was to use the bladder biopsy and fluoroscopy.

As to the third point—I was the surgeon who bronchoscopied the child, identified the segmental bronchus, then introduced the forceps through the bronchoscope to come in contact with the foreign body. As my hands were busy with the bronchoscope, the direction of the forceps and the child’s head, at the other end of the forceps; at the grip of the forceps, Dr Rifai was trying to grasp the foreign body. Once it happened, I removed the bronchoscope including the forceps and the foreign body. So it was team work and a very obvious action for the sake of the patient as stated by Dr Rifai.

I never ignored the help and advice of Dr Rifai as my acknowledgement indicates. It was of less interest to the reader to know these details about the case. The aim was to present to the reader this new technique in order to help patients and save them major surgery.

[This correspondence is now closed. Editor]

Prevalence of Psychiatric Disorder in an Academic Primary Care Department in Riyadh

Sir

The article by Al-Fares et al. reported the prevalence of psychiatric disorders in an academic primary care centre. The prevalence of psychiatric disorders was calculated using two methods. In the first method, the GP’s assessment was compared with that of the psychiatrist while in the second, comparison was conducted between GHQ and psychiatrist. The authors found a close estimate of psychiatric disorders and concluded that the repeatability of the results of both methods was reassuring and may indicate their reliability.

One important issue that was not addressed in the article was the statistical significance of the reliability either between psychiatrist and GP or between psychiatrist and GHQ. The authors reported only percentage of agreement and failed to report the level of significance corresponding to such percentage of agreement.

Kappa statistic is a measure of reproducibility that tests whether the observed concordance rates is only due to chance. It can be estimated using the following formula:

\[ x = \frac{P_o - P_e}{1 - P_e} \]

where \( P_o \) and \( P_e \) are the observed and expected probability of concordance between the two assessment methods. Landis & Koch provided the following guidelines for the evaluation of kappa:

- \( x > 0.75 \) denotes excellent reproducibility.
- \( 0.4 \leq x \leq 0.75 \) denotes good reproducibility.
- \( 0 \leq x < 0.4 \) denotes marginal reproducibility.

Data in Tables 2 and 3 in Al-Fares et al. can be used to estimate whether reproducibility is not due to chance. The kappa statistic for agreement between assessment of primary care physician and psychiatrist is 0.29 (\( P_o = 0.6579 \) and \( P_e = 0.5166 \)) and is 0.26 (\( P_o = 0.6316 \) and \( P_e = 0.5014 \)) for agreement between CHO-28 score and psychiatrist, which indicates that the reproducibility, even with similar estimates of psychiatric

An Unusual Technique for the Removal of Peripheral Retained Foreign Body from a Paediatric Bronchial Tree

Sir

I was very pleased to read the case report of Professor A. A. Ashoor published in Saudi Med J 1991; 12(5): 424–426, where he presented an unusual technique for the removal of peripheral retained foreign body from a paediatric bronchial tree. I am very grateful to Professor Ashoor's acknowledgement regarding my 'advice and assistance'.

However, I have, for the sake of truth, to make the following comments:

1. The case was done at the Security Forces Hospital when Dr Ashoor was on special assignment and it was referred to Security Forces Hospital from the King Faisal University Hospital in Al-Khobar.

2. As Dr Ashoor will remember, it was I who introduced the idea of utilizing the bladder biopsy forceps after removing the lens from the paediatric bronchoscope and relying on fluoroscopy to grasp the foreign body. As a matter of fact, I had to do a small in vitro test to convince Dr Ashoor of the viability of the technique.

3. Although Dr Ashoor was the main consultant on the case, it was I, utilizing his bronchoscopy, who technically removed the foreign body and the bronchoscope in toto.

I hope this comment will clear the facts and shows how different specialities with same endoscopic experience can work together to achieve the patient's well being and avoid major surgical intervention.

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Saudi Medical Journal 1993; 14(1): 84

Sir

The first point made by Dr Rifai is true; the procedure was done at the Security Hospital when I was on special assignment.
disorder from both methods, suggests that more investigations are needed before widely using CIS or GHQ-28 in primary care settings.

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References

Sir

I wish to comment on Dr Osman’s letter as follows.

The point raised on the failure to emphasize the statistical significance of the inter-rater reliability between the psychiatrist and the General Practitioner (GP) or between the psychiatrist and the General Health Questionnaire (GHQ) using the kappa statistic is well appreciated. However, Dr Osman must have missed the theme of this paper and as a statistician concerned himself only with the level of significance. There is a big difference between the reliability of estimating the prevalence of psychiatric disorders (i.e. getting similar results by using different methods) and the validity of the GHQ or GP’s assessment by comparing them with the psychiatrist assessment. The paper was about the first whereas Dr Osman was talking about the second. In other words we are not in a context of validating the GHQ or the GP’s assessment by the use of the kappa. The kappa statistic is not unfamiliar to us and in fact because of the ordinal scale of the measurement of the assessment procedure (GP vs psychiatrist), as it is shown below*, the statisticians in our department even suggested the use of Spearman’s correlation co-efficient in another paper (Hidden and Conspicious Psychiatric Morbidity) in preference to kappa agreement as suggested by Dr Osman.

*GP and psychiatrist severity rating scale
0: No psychiatric disturbance
1: Mild subclinical disturbance
2: Clinically significant (mild) psychiatric disturbance
3: Clinically significant (moderate) psychiatric disturbance
4: Clinically significant (severe)

Categories (2, 3 and 4) were considered as possible cases.

A Rare Cause of Severe Surgical Anæmia: Metastatic Renal Cell Carcinoma to the Stomach

SIR

A 62-year-old man was admitted with a 2-month history of shortness of breath on exertion. Blood tests revealed a haemoglobin of 5.4 g/dl. Gastroscopy showed a large lesser curve ulcer which was confirmed on biopsy to be malignant. Chest X-ray and ultrasound scan of the liver were normal. Twelve years previously, the patient had undergone a radical right nephrectomy for a clear cell adenocarcinoma. After preoperative blood transfusion, he underwent a polya gastrectomy. The final histology showed 'clear cell adenocarcinoma i.e. from the kidney'. The pathologist, who had no prior knowledge of the previous nephrectomy, advised that the possibility of a primary renal cancer should be excluded. A subsequent intravenous urogram showed a normal solitary left kidney.

Following an initial satisfactory progress from the partial gastrectomy, the blood tests showed a raised serum calcium (corrected) and renal failure which were satisfactorily treated. The bone scan showed a sacral bony deposit but this has remained static. The patient is in remarkably good health 2 years after his latest operation, and 14 years after the nephrectomy. It is very unusual for a metastatic carcinoma in the stomach to be amenable to curative surgery at presentation. But this case shows that the situation can be different where the metastasis is from a renal cell carcinoma and confirms the observations of Sullivan et al. about the slow growing nature of both the primary and metastatic deposits of renal cell carcinoma. To our knowledge only nine previous metastatic renal cell carcinomas to the stomach have been reported.1-4

This case reiterates that in the setting of a previously excised renal cell carcinoma, the possibility of a metastatic deposit should be borne in mind because in these cases curative surgical resection should be the objective. If necessary peroperative frozen sections can be performed to validate the diagnosis.

I wish to thank Mr A. E. Stuart most sincerely for all his support and for his permission to report this case. I must also thank Dr L. H. Carrasco for his valuable assistance and Dr A. Taghizadeh, Consultant Histopathologist, for his permission to publish the histological details.

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References

Cordylobia anthropophaga Causing Cutaneous Myiasis in Saudi Arabia

SIR

I read with interest the article by M. Gupta and M. S. A. Chowdhury (Saudia Med J 1991; 12(4): 333-335), on a case of