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 Conscious 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.

In a third paper from the same study (published elsewhere) entitled Validation of the GHQ we calculated the kappa agreement of the GHQ vs psychiatrist assessment (similar to Dr Osman’s result). In addition to kappa agreement the sensitivity, specificity and predictive values were calculated and discussed too but in the right context.

We had not been actually affirmative in our conclusions; we had rather suggested more investigations in this area. Both of the GHQ and GP’s assessments were adjusted by the psychiatrist’s assessment (neither of them was taken as definite).

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A Rare Cause of Severe Surgical Anaemia: 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 poly 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. 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 (Saudi Med J 1991; 12(4): 333–335), on a case of