integrating them, and beginning to answer the very questions that are raised in this article—that is, what is the need for protection, what is the need for work, who should carry this out, and how should it be supervised?

If we follow the DHSS guidelines I will gladly be handing over the chairing of such conferences to my social work colleagues. I hope I will continue to be present and that myself and my colleagues will still continue to do assessment work with families that I hope will assist conferences to make the sort of decisions that sadly do not seem to have occurred in Drs Chapman and Woodmansey's experiences.

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Sir,

The Society of Clinical Psychiatrists state that 'case conferences are inherently ineffectual'.¹ I disagree. Child abuse case conferences are often ineffectual, but not inherently so.

The case conference is like a ship, and its aim should be to reach a stated destination. It is 14 years since the Tunbridge Wells study group made the child abuse case conference its cardinal recommendation.² Is it any wonder that in that time the ship has acquired some barnacles? In addition, too many passengers have come on board.

A case conference can exchange information, decide on registration and the nomination of a primary worker, and offer to the primary worker various forms of support.

Bearing in mind this aim, I believe:

- (i) Too many people attend, including those who have neither information nor an involvement with later management.
- (ii) Information is poorly given. It should be the aim to circulate written information before the day of the case conference.
- (iii) Far too much discussion takes place on the details of management. This can only be a matter for the primary worker and even if a valid decision is made at a case conference it is, as stated in the clinical psychiatrists' document, only valid for that moment. 'The decision cannot be made once and for all'.¹
- (iv) Most minutes are ineptly written, chairmen not being skilled as committee clerks. The anxieties of professional workers can be discussed without being minuted. Minutes should record the location and constitution of the meeting with the decisions taken.

The case conference is a working method. Without it professionals would again begin to act in isolation. Without it the choice of primary worker would be seen as arbitrary and as setting one group of professionals above the others.

So I agree with much of the thinking of the Society of Clinical Psychiatrists but not with their conclusion. Without the case conference cooperation in child abuse would cease and the anxiety of professional workers would not be allayed.

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The sweat test

Sir,

Dr Littlewood's annotation on the sweat test is to be welcomed as misdiagnosis of cystic fibrosis is a continuing and serious problem.¹ We agree that most misdiagnoses can be avoided if experienced laboratory staff perform the sweat test with meticulous attention to detail and the results are interpreted in the light of the clinical findings.

Two points arise from the annotation, however, that we feel need further comment. Contrary to Dr Littlewood's opening paragraph, the sweat test in most hospitals does not usually imply measurement of both sodium and chloride. In our experience many centres measure only one ion, and there is a need to reinforce to both biochemists and paediatricians the importance of measuring sodium and chloride. Secondly, we do not support Dr Littlewood's conclusion about the use of pancreatic function tests. Diagnostic difficulty is more likely to occur in the 10% of patients with cystic fibrosis who have adequate exocrine pancreatic function, and it is in these patients that further investigation of pancreatic function may not be helpful.

In our own prospective study of 344 patients over two years 441 sweat tests were performed at our hospital and only nine fell into an equivocal group. One of these nine was subsequently confirmed to have cystic fibrosis. The other eight patients all had sodium values considerably higher than the chloride values; they all had normal pancreatic function as judged by normal results of faecal chymotrypsin and *para*-aminobenzoic acid tests and, in two patients, normal secretin-pancreozymin stimulation tests. It was the interpretation of the results of their sweat test together with their natural history that excluded the diagnosis of cystic fibrosis rather than reliance on normal pancreatic function tests. We think that it is misleading to suggest that demonstration of abnormal pancreatic function is the gold standard for the confirmation of the diagnosis of cystic fibrosis in equivocal cases. Until deoxyribonucleic acid technology can identify the gene the