childhood whereas anal dilatation is very rarely seen in normal clinical practice. The only circumstances where anal dilatation has been documented is where anal abuse has occurred. Dr Wynne presented her data in a scholarly and thorough manner which clearly shows a strong association between the finding of anal dilatation and the disclosure of anal abuse. Our experience in Newcastle has been very similar.⁴

There is a pressing need for studies of anal findings in normal and encoporetic children to clarify this difficult area. In the meantime we must firmly resist the acceptance of dogmatic statements that are unsupported by objective data.

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Child abuse—consequences for health services

Sir,

During the course of a study on the work pattern of health visitors we have observed the effect the rise in the number of cases conferences (table) for child abuse has had on their work. The notification and follow up of possible child abuse takes precedence over all else. Some health visitors in this district are finding their attendance at case conferences is ranging from one a week to daily. Moreover each child placed on the register is made the subject of extra visiting, often requiring as many as three additional weekly visits. Each newly registered case of child abuse can add

Table Data from Tower Hamlets Youth and Community Section

Year	All case conferences	New case conferences
1980	100	78
1981	251	89
1982	299	91
1983	304	89
1984	335	90
1985	435	131
1986	566	190

Provided by Youth and Community Section Metropolitan Police Tower Hamlets.

anything from two to 12 hours to a health visitor's weekly workload, depending on its complexity. A senior health visitor estimated that four hours represented either 24 hearing tests, seeing 20 mothers and babies in a clinic, or six home visits. The very small amount of visiting to other important 'at risk' groups, such as the elderly, is further eroded. Only the effect on the work of health visitors has been directly observed but this is paralleled by similar effects on the work of general practitioners, child psychiatrists, paediatricians, and social workers, as many as 10 or more of whom may be involved in a case conference.¹ Staff shortages in social work departments and in the health visitors establishment are compounding the problem.

Insufficient cognisance is being taken of the cost for clients and professionals of the disruption to planned health programmes because of the crisis imperatives of child abuse and in particular the time devoted to attendance at case conferences. It has already been pointed out that little attempt has been made to evaluate their effectiveness.²

In consultation with other agencies every district should look anew at the number of professionals involved in case conferences and their particular contribution. This would allow 'agencies to place more emphasis on the earlier provision of services to children and families who need help' as recommended by the DHSS.³

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Validity of forced expiratory flow volume loops in neonates

Sir,

We are concerned that the methodology described in the paper of Hoskyns *et al* regarding the forced expiratory flow volume technique used in infants is flawed and that the conclusions reached by the authors may be misleading.¹

Our first concern is that these workers have not provided evidence that maximal expiratory flow was achieved in the infants they studied. They used a single narrow range of compression pressures and did not evaluate the transmission of pressure from the jacket to the pleural space in each subject. We have recently reported that a single jacket pressure will not reliably achieve maximal expiratory flow in all infants, as the transmission of pressure varies between different jackets and between different infants.² Thus a wide range of jacket pressures must be used in each