

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.<sup>4</sup>

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.<sup>1</sup> 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.<sup>2</sup>

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.<sup>3</sup>

#### References

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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.<sup>1</sup>

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.<sup>2</sup> Thus a wide range of jacket pressures must be used in each

infant to ensure that maximal flow is obtained.<sup>2</sup> The high mean coefficient of variation (CV) for maximum flow at functional residual capacity ( $\dot{V}_{\text{maxFRC}}$ ) of 19.7% (calculated from table 1) suggests that the methodology used by Hoskyns *et al* was not reliable.

Much of the data reported by the Nottingham group relates to 'squeezes applied at different points in the respiratory cycle.' The relevance of their observations relating to these 'mistimed' squeezes is obscure as the need for accurate timing of the squeeze at end-inspiration has been consistently stressed,<sup>2,4</sup> and acceptable CVs for  $\dot{V}_{\text{maxFRC}}$  (mean CV 9.5%<sup>3</sup> and 11%<sup>4</sup>) have been obtained using accurately timed end-inspiratory squeezes.

The authors claim that inspiratory muscle activity 'may interfere with measurement of airway function' but provide no data with correctly timed squeezes to substantiate this claim. Figure 5 does not support their assertions as inspiratory muscle activity has not affected  $\dot{V}_{\text{maxFRC}}$ : oesophageal pressure does not fall until *after* expiration has passed FRC. If inspiratory muscle activity does occur before FRC is reached, the problem can be simply solved by using a higher compression pressure.<sup>2</sup>

We would also like to point out that the 'supramaximal' flows for squeezes applied during expiration are likely to be caused by flow transients from compression of gas in large airways. If an adequate compression is used from end-inspiration and appropriate care is taken to ensure that expiration is flow-limited, additional compression force will not increase expiratory flow.<sup>2</sup>

Critical evaluations of new techniques are to be welcomed, but such evaluations must themselves be methodologically sound.

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## The colour of light for neonatal phototherapy

Sir,

In a recent paper by Ayyash *et al* comparing green and blue light for the phototherapy of neonatal jaundice the summary stated 'A total of 262 neonates were treated with

green (350-650 nm) or blue (300-600 nm) light . . . .'<sup>1</sup> We feel this statement is not only incorrect but potentially hazardous.

Firstly, the spectral ranges quoted by the authors are puzzling as green light is normally accepted to lie within the wavelengths interval 500-570 nm, and blue light within 440-500 nm.<sup>2</sup> More importantly, the statement that the

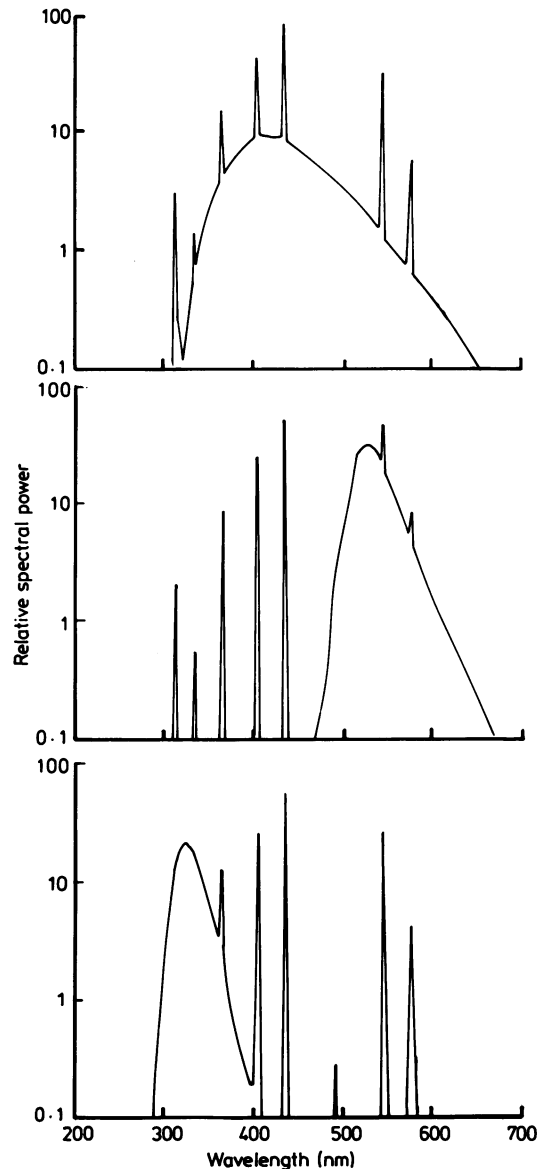


Figure The relative spectral power distribution from a Sylvania F20T12B (blue) lamp (top), T20T12G (green) lamp (middle), and Wolff Helarium (ultraviolet) lamp (bottom).