to phenylbutazone and related compounds, sulfadiazine, and sulfisoxazole. Patients with an active peptic ulcer should not be given sulphinpyrazone. Finally it should be publicised that blood dyscrasias have been reported to be due to this drug, although rarely.

I hope these comments will heighten the clinical awareness of the side effects of sulphinpyrazone.

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Tuberculin testing

SIR,—I refer to the note on tuberculin testing (13 January, p 108), in which reference is again made to the unreliability of the tine tuberculin test. The only alternative mentioned is the Mantoux test. This calls for accurate intracutaneous injection of the tuberculin. I find that young doctors have not been trained in this technique and do not trust themselves (nor are trusted by their seniors) to perform the test satisfactorily.

This causes me to ask what has become of the Heaf test. I used it with complete confidence for many years and advised its use throughout Northern Ireland in connection with the BCG vaccination programme of the Northern Ireland Tuberculosis Authority. The Heaf gun demands no special skill in its operation. Has it already been discarded as an obsolete instrument?

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Nice people with no manners

SIR,—"Nice people with no manners" by Dr Stephen Lock (23 December, p 1774) aptly portrays problems which can slightly mar an enjoyable evening for the speaker. These are, as he shows, not confined to our profession. Indeed Stephen Leacock, humorist and academician, wrote an essay on "How it feels to be a lecturer." He wittily described experiences he had when touring England and elsewhere: chairman had forgotten his name or got it wrong and one had to read out the subject of his talk from the programme. He wrote that "the first of the troubles . . . is the fact that the audience will not come to hear him." Research could be done on what inspires doctors to attend meetings: how important is the subject, the speaker—or perhaps the meal? Some years ago as secretary to a medical society I got a speaker who had filled a vast hall in New York. Here the usual audience of about 19 attended. Shortly afterwards I invited an expert on income tax for doctors: the place was packed.

Most speakers could vie with each other in telling depressing tales—for example, an audience hardly more numerous than the speakers who had travelled many miles through snow and ice on a Sunday. Another time, after being surrounded by about 200 people when being given sustenance just before the lecture, as the time approached the crowd faded away leaving a handful of people, as the lecture had coincided with the hospital ball. Nevertheless, it was a pleasant evening, as the audience was one of quality rather than quantity.

Fortunately, the nice people with no manners are, in my experience as well, rare. Usually the clearest details are given about the time, place, duration of talk, and type of audience—and hospitality is generous. The commonest difficulties are technical, particularly when showing slides. Some problems are avoidable, such as having a spare bulb, spare projector, and someone who understands the machine. Others are unpredictable, such as poor attendance or a power cut.

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Haemodynamic effects of buprenorphine after heart surgery

SIR,—It is impossible to find justification in the article by Dr F L Rosenfeldt and others (9 December, p 1602) for their conclusion that "Buprenorphine appears to be safer than morphine for use in patients with reduced cardiac reserve. . . ."

No evidence is presented by the authors to suggest that their patients, studied after open heart surgery, were in an unstable cardiovascular state or had a reduced cardiac reserve and the effects of morphine were not studied. The finding of a 24 mmHg fall in the mean arterial pressure in 18% of the patients studied suggests that the hypotensive effect of intravenous buprenorphine may be clinically relevant. The subsequent statement by the authors that "there was no overall change in mean arterial pressure" cannot be evaluated as no relevant data are provided.

One must conclude that buprenorphine may cause a fall in arterial blood pressure in some patients and that there is no justification on the evidence presented in the study for considering it to be safer than morphine as an intravenous analgesic.

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**We sent a copy of this letter to the authors, whose reply is printed below.—ED, *BMJ*.

SIR,—Thank you for allowing us to reply to the important issues raised by Dr Bethune.

The purpose of this paper was to report the haemodynamic effects of buprenorphine after cardiac surgery. In keeping with the style of the *BMJ* we trimmed our paper in many directions and are therefore delighted for the opportunity of supplying further information to Dr Bethune. He may judge from our previous publications on a similar group of patients[1 2] that these patients do indeed have an unstable cardiovascular system. This is well recognised by most workers in the immediate period following open heart surgery, when such patients have to be treated in an intensive care unit to monitor closely the circulatory state.

Regarding Dr Bethune's query about the fall in arterial pressure, table printed below shows the change in mean arterial pressure, cardiac output, and heart rate, justifying our statement that "there was no overall change in mean arterial pressure."

We carefully referred to our review of the haemodynamic effects of other analgesic agents[3] and we have directly compared buprenorphine with Omnopon in the same patients, using the protocol we outlined in our paper. Considering the known haemodynamic effects of morphine in such patients we firmly believe that our conclusions are justified.

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[1] Lewis, G J R, *et al*, *European Journal of Cardiology*, 1978, **7**, 283.
[2] Lewis, G J R, *et al*, *American Heart Journal*, 1978, **95**, 301.
[3] Malcolm, A D, and Coltart, D J, in *Pain—New Perspectives in Measurement and Management*, ed A W Harcus, R B Smith, and B A Whittle, p 41. Edinburgh, Churchill Livingstone, 1977.

Normality and abnormality in psychiatry

SIR,—The letter of Dr J G Edwards (4 November, p 1296) is a timely reminder of the problems of delineating normality in psychiatric practice. Indeed, it has been cynically noted in a university students' publication that those who are normal are "other people a psychiatrist has never met."[1] That there may be an element of truth in this is attested to by the fact that "homoclite" was coined to indicate a mentally healthy young man.[2] Furthermore, it has been suggested that those persons who claim to be free of any psychological symptoms may only be unusually capable of concealing their symptoms.[3]

"Normality and the psychiatrist" was the subject of a recent Australian paper.[4] In addition to the statistical, clinical, and prognostic aspects referred to by Professor Geoffrey Rose and Dr D J P Barker (23 September, p 873) and the sociocultural component noted by Dr Edwards, this alluded to the fact that a Utopian ideal of health is sometimes regarded as normal and to the differing standards of normality taken in a developmental sense.

There is no doubt that normality must be considered according to many parameters, and one can only endorse Dr Edwards's comments that it is most important for doctors to recall that the designation of abnormality has far-reaching implications. For the individual it may involve expensive and uncomfortable investigations, isolation from the community, and uncertainty for the future. For society, it offers a means of categorising an individual.

Haemodynamic response in eight patients followed for 60 minutes after administration of buprenorphine Values are mean ±1 SEM

	Minutes after administration					
	0	5	10	15	30	60
Mean arterial pressure (mm Hg)	85 ± 6	85 ± 6	85 ± 5	83 ± 5	87 ± 5	82 ± 5
Cardiac output (l/min)	3·6 ± 0·3	3·6 ± 0·3	3·6 ± 0·3	3·5 ± 0·3	3·7 ± 0·3	3·5 ± 0·3
Heart rate (b/min)	103 ± 4	103 ± 5	100 ± 5	100 ± 5	100 ± 5	99 ± 4