positive perception of anticholinergic drugs by the patients may be that they relieve the discomforting experience of bradykinesia or *akathisia* associated with antipsychotic medications".

That "the relative liability for Parkinsonism of the various antipsychotic drugs available cannot be confidently predicted" is clearly Dr Barnes' personal opinion. A large literature (see Tamminga & Gerlach, 1987) presently supports the view that drugs such as clozapine, sulpiride or thioridazine are much less prone than high-potency neuroleptics to produce extrapyramidal side-effects. Finally, the relationship between anticholinergic treatment and the development of tardive dyskinesia is certainly debatable, but, as the discussant himself recognises, the experimental and clinical evidence supporting a predisposing role of anticholinergics is compelling, and it would have been irresponsible for us to ignore it.

In conclusion, we welcome Dr Barnes' comments although they do not lead us to propose changes in the document's recommendations.

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SIR: The WHO Consensus Statement (*Journal*, March 1990, **156**, 412) provides welcome guidance in view of the widespread use of concurrent anticholinergic antiparkinsonian and neuroleptic medication. Studies in Oxford, Birmingham and Newcastle have shown that 50–55% of patients are maintained on both drugs concurrently and, in some cases, for over 12 months (McClelland *et al*, 1974).

There are additional reasons for not routinely co-prescribing the two agents. A longitudinal survey (Johnson, 1978) demonstrated that Parkinsonian side-effects show marked spontaneous fluctuation, making the interpretation of the effects of treatment difficult to interpret. Moreover, in one study, a deterioration in schizophrenic symptoms was observed when an antichlorinergic antiparkinsonian drug was introduced (Johnston *et al*, 1983).

However, there remains a useful role for these antiparkinsonian anticholinergic drugs in certain areas of clinical practice. For example, many clinicians would consider prescribing both drugs concurrently in patients with a previous history of acute dystonic reactions. The statement failed to highlight the uncommon, but potentially fatal, complication of asphyxia secondary to neuroleptic-induced laryngeal pharyngeal dystonia (McDonal, 1981) or to oesophageal dysmotility (Moss & Green, 1982) which might be preventable in this way. Similarly it has been observed (Van Putten, 1974) that many patients dropped out of treatment as a result of drug-induced extrapyramidal disorders. Hence patients who have previously defaulted due to such side-effects may benefit from co-prescription.

The decision as to whether to use anticholinergic antiparkinsonian drugs may only be decided by a clinical assessment of the balance of risks. It is important to emphasise that once prescribed it is essential that the patient and the indications for such therapy are reviewed regularly.

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SIR: Putting aside for a moment the *content* of the recently published WHO concensus statement on prophylactic anticholinergic medication (*Journal*, March 1990, **156**, 412), I would like to deliberate on the fact that a more conventionally laid out review appeared in the same edition (*Journal*, March 1990, **156**, 413). I wonder if this might in part be reflecting