metabolism (Rivera-Calimlim *et al*, 1973). These two pieces of evidence suggest that reduction of the dosage of neuroleptic might be a more appropriate way by which to combat drug-induced Parkinsonism.

In his final sentence, Dr Bennie suggests that anti-parkinson drugs be administered to neuroleptic treated schizophrenic patients who appear to be depressed. Certainly it is easy to confuse the mask-like facies of Parkinsonism with retardation attributable to depression and in such cases the administration of anti-parkinson drugs, might be useful. Some anti-parkinson drugs have been claimed to possess anti-depressant properties but the evidence for this is weak (Onuaguluchi, 1964; Mindham *et al*, 1972).

For the reasons given here and elsewhere, I do not believe that patients receiving long-term medication with neuroleptics should also be given anti-parkinson drugs on a routine measure. Firm recommendations, such as that made by Dr Bennie, require better evidence than is at present available.

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DAYTIME ENURESIS

DEAR SIR,

Dr Barton and Dr Felker have responded to my *Comments* article Child Psychiatry and Enuresis (*Journal*, September 1981, **139**, 247–8) with a letter (*Journal*, March 1982, **140**, 325) in which they suggest that imipramine is effective in treating diurnal enuresis. However, they admit that they have no evidence from a controlled trial to support their view. I have, to support mine.

I recently participated in a randomized, double blind controlled trial of imipramine in diurnal enuresis, carried out by Professor Roy Meadow, Paediatrician in Leeds. This has not yet been published. Twenty-seven children were included in the study. Although there was some improvement in day wetting during treatment there was no difference in response between the placebo and the active drug groups of cases. In my view, considering the dangers for children of overdose with this hazardous drug, until there is some real evidence for its efficacy in treating diurnal enuresis it should not be used for this condition.

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PROPRANOLOL IN SCHIZOPHRENIA

DEAR SIR,

In a recent article in this *Journal* (August, 1981, **139**, 105–11), Peet *et al* concluded that propranolol did not improve schizophrenic symptomatology relative to placebo, while the effects of chlorpromazine were small and inconsistent. It is not the purpose of this letter to question the effects of these drugs, but rather to examine the quality of the evidence marshalled to draw these conclusions.

Finding that treatments do not differ from each other may arise from two different circumstances: they do not in fact differ, and the authors have arrived at the correct conclusion; or they do differ, but the investigators have failed to detect this difference. The reason for the latter result (known in statistical jargon as a Type II error) is that the power of the