SIR,—With reference to the article "Postnatal depression: does no one care?" (8 December, p 1487), I would like to point out that the subject of postpartum psychiatric disorders has been scrutinised and been the subject of a lot of time and energy of many researchers for over a century.¹ Needless to say, numerous papers and research projects have been published during this time. These concern many aspects of the whole spectrum of these disorders—from acute psychotic disorders² to the "three-day blues syndrome,"³ including postpartum depression.⁴

With this history in mind I would like to reassure the author that the lack of "appropriate hormones" to treat people like his wife is not the result of people "not having a care" to answer the queries he poses but is much more likely to be a direct reflection of the complexity of the biochemical and endocrinological state of the psychiatrically ill puerperal women.

As far as the "lack of warning" that patients will be affected is concerned, epidemiological studies and research into the aetiology of these disorders are plentiful⁵⁻⁷ and concern in this respect is in an ever-evolving state.

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¹ Savage G. *Guy's Hosp Rep* 1875;20:83-117.

² Karnosh LJ, Hope JM. *Am J Psychiat* 1937;94:537.

³ Pitt B. *Br J Psychiat* 1973;122:431-3.

⁴ Pitt B. *Br J Psychiat* 1968;114:1325-35.

⁵ Nilsson A, Kaij L, Jacobson L. *J Psychosom Res* 1967;10:341-7.

⁶ Kaij L, Nilsson A, Jacobson L. *J Psychosom Res* 1967;10:317-25.

⁷ Jacobson L, Kaij L, Nilsson A. *Br Med J* 1965;1:1640-3.

SIR,—I read with interest "Postnatal depression: does no one care?" (8 December, p 1487).

As a practising health visitor, I found it strange that the couple concerned did not seek or were not offered support from a health visitor during this stressful event in their lives. The author describes the care of the mother in the puerperium as one of the few remaining deficiencies in an otherwise magnificent and comprehensive health service. The care of the mother in the puerperium, both physically and emotionally, has always been and will continue to be a health visiting priority.

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SIR,—Your contributor's wife has come through a severe postnatal depression and lived to tell the tale, but only just. Instead of "Does no one care?" could I ask what went wrong?

I thought that the article was a little short of background. There was no mention of postnatal visits from the midwife, no mention at all of the health visitor—surely one of the first people to turn to. Could a health visitor or general practitioner restrict visits to one a week when the mother and baby are in danger? Surely an attempted suicide merits either daily visits or referral to a psychiatrist for inpatient or outpatient treatment.

Your contributor feels that postnatal depression has a hormonal cause but surely other factors are just as important: responsibility, the feeling of being alone with an unpredictable baby, lack of sleep, loss of previous role,

and possibly lack of preparation. It is the job of all concerned to treat postnatal depression actively, but we have a bigger part to play in preventing problems in the neonatal period developing into a full-blown depression.

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SIR,—As a psychotherapist, I read with great interest the article "Postnatal depression: does no one care?" (8 December, p 1487). First of all, let me express my admiration for the charming and sensitive way in which it was written. Of course, lots of people do care and many are concerned—fortunately one being this gentleman's doctor.

Regarding the responsibility of hormones, I have it from the horse's mouth that profound changes in the production and levels of various hormones—particularly oestrogens and progesterone—occur during and at the end of every woman's pregnancy. It is therefore clear that these changes alone cannot be held responsible for the postnatal depression which affects only a small proportion of women who have undergone pregnancy. Other factors must be involved and it is reasonable to suppose that these include the woman's emotional reactions to her past and present experiences.

It is curious that no mention is made of the central figure—namely, the baby. Who was caring for baby, mother, and home, for instance? Where were the grandmothers (important people, these)? We are not told the duration of the illness, or the effect of the relationship on the mother and her child, to say nothing of that between the husband and his wife. Although it is made out that all is now well, I find it hard to believe that your correspondent can feel free from the anxiety of a recurrence of emotional problems should there be another moment of critical life experience.

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Kidney transplants and long-term immunosuppression

SIR,—The observations on our paper (18 August, p 421) made by Dr B Jones (22 September, p 735) and by Dr H Graf and others (13 October, p 936) deserve some additional comment.

Since the mechanisms involved in graft acceptance or rejection are many and specific for every tissue,¹ in-vitro tests have been often disappointing as predictors of graft rejection.² We wonder therefore if reliable data on the well-being of an allograft may be obtained by performing some in-vitro tests on peripheral blood cells such as the mixed lymphocyte culture or lymphocyte-mediated cytotoxicity test.

Moreover, it was not our aim to correlate the alterations of the immune parameters studied with the acceptance of the graft. We have detected and reported only the concomitant existence of these events. We personally think that non-specific immunosuppression induced by corticosteroids plus azathioprine and antilymphocyte globulin is one but perhaps not the most important factor in graft acceptance or rejection.

With regard to the second letter, we must state that, in the absence of side effects, we have never withdrawn immunosuppressive treatment in transplant recipients because we are aware of the possibility of rejection. These data are reported in the literature,³ and we also had the opportunity to see in a kidney transplant recipient an irreversible rejection crisis after the spontaneous suspension of immunosuppressive treatment. None the less, we consider our case report is interesting because it raises many questions. We hope that answers will rapidly follow.

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¹ Russell PS, Cosimi AB. *N Engl J Med* 1979;301:470-479.

² Dosssetor JB, Myburgh JA. *Transpl Proc* 1978;10:661-670.

³ Dandavino R, Trunet P, Descamps B, Kreis H. *Transpl Proc* 1978;10:655-657.

Donor kidneys and restrictions on their supply

SIR,—Guidelines now published by the DHSS on organ donation and transplantation (15 December, p 1596) promise to lend a questionable authority to the oversimplified thesis that the supply of kidneys could easily be increased if, as well as more understanding from the public, there was better co-operation from doctors. Much is written of the difficulties met by the transplant surgeon in harvesting kidneys, even by those with an essentially lay interest,¹ but less is heard of the practical problems encountered in setting up kidney donation from ventilated cadavers. May we try to redress the balance?

The neurosurgical intensive care ward in Swansea has over several years contributed not only to satisfying our Cardiff transplant colleagues' own requirements but to making Cardiff a major "net exporter" of kidneys, so that we can fairly be counted as positively motivated providers. The three cardinal clinical donor groups are patients with severe head injury, primary intracranial haemorrhage, and terminal primary intracranial tumour. All patients in these three categories who fulfil the royal colleges' criteria for brain death² while being ventilated are regarded as potential donors and it is the clinician who has care of the donor patient who approaches the family for consent. During 1978 and 1979 there have been 86 such cases. In most instances we have supplemented these criteria with the evidence of an electroencephalogram: an isoelectric record is a great "reassurance" to nurses and doctors as well as to relatives.

The potential donors are, however, whittled down by various exclusions, which we have classified as age and cardiorespiratory factors, infection and other medical reasons, refusal of consent, and miscellaneous circumstances. Exclusion by age implies a limit of 60 years, though the age factor has more recently become a biological rather than a chronological concept. Cardiorespiratory factors include obvious arteriopathic disease, known hypertension in the donor, prolonged refractory renal underperfusion, and sudden cardiac