We agree with Philip P Mortimer and Elizabeth Miller's comments in their commentary on the article.[2] Most cases of hepatitis B in Britain occur in adults, and therefore reliance on the vaccination of infants will not lead to a reduction in cases for over 20 years. Alternative vaccination strategies need to be considered before universal vaccination is adopted, including the strengthening of those strategies currently in place, with attention to some of the improvements suggested above.

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1 Boxall EH. Antenatal screening for carriers of hepatitis B virus. *BMJ* 1995;311:1178-9.
2 Van Damme P, Kane M, Meheus A on behalf of the Viral Hepatitis Prevention Board. Integration of hepatitis B vaccination into national immunisation programmes. *BMJ* 1997;314:1033-7. [With commentary by P P Mortimer and E Miller.] (5 April.)
3 Department of Health. *Immunisation against infectious disease.* London: HMSO, 1996.

Treatment of postnatal depression

Two weeks of depression may not be long enough to exclude spontaneous recovery

EDITOR—In their study of the treatment of postnatal depression in primary care Louis Appleby and colleagues observed substantial improvement in patients' mood within one week.[1] They raised the important question of how to distinguish transient distress from more severe types of depressive disorder and they suggested that the presence of depressive symptoms for at least two weeks identified what they called true depression.

Findings from the Edinburgh primary care depression study suggest that this criterion may not be sufficient.[2] Freeman and I studied patients with major depression—that is, dysphoric mood accompanied by at least four biological features of depression for at least two weeks.[3] Randomised patients were interviewed by an independent rater immediately before they started treatment and within 72 hours of a diagnostic interview. Four patients satisfied the a priori definition of recovery even before they started treatment. The four patients who recovered had experienced depressive symptoms for at least two but not as long as four weeks.

The identification of factors that can be used to select depressed patients in primary care who require specific treatment to aid recovery is important but controversial. A major naturalistic study identified two associations with the likelihood of recovery from depression—namely, milder symptoms and a short duration of illness.[4] Our study found that the diagnosis of melancholia, a more severe form of major depression characterised by a pervasive loss of interest, identified patients with a poor prognosis after 16 weeks.[2] Most depressed patients in primary care do not have this more severe form of depression, and there is still the problem of how to prioritise treatment among other, non-melancholic, patients. The use of the duration of the index episode of depression merits further study. Our preliminary data suggested that symptoms lasting two weeks are not sufficient to exclude the possibility of rapid recovery without any specific treatment.

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1 Appleby L, Warner R, Whitton A, Faragher B. A controlled study of fluoxetine and cognitive-behavioural counselling in the treatment of postnatal depression. *BMJ* 1997;314:932-6. (29 March.)
2 Scott AIF, Freeman CPL. Edinburgh primary care depression study: treatment outcome, patient satisfaction, and cost after 16 weeks. *BMJ* 1992;304:883-7.
3 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders.* 3rd ed. Washington: APA, 1980.
4 Keller MB, Lavori PW, Mueller TI, Endicott J, Coryell W, Hirschfeld RMA, et al. Time to recovery, chronicity, and levels of psychopathology in major depression. *Arch Gen Psychiatry* 1992;49:809-16.

Additional information would enhance value of study

EDITOR—The trial by Louis Appleby and colleagues of treatment in postnatal depression deserves further comment.[1]

Firstly, the wide recruitment criteria mean that many mild cases of depression were included; many women had apparently not sought medical help. Forty one of the 87 women in the study had a personal or family history of depression not related to pregnancy and 46 had a personal or family history of postnatal depression. We believe that postnatal depression and depressive illness at other times (for example, bipolar or unipolar depression) are different conditions and that the analysis should have tried to separate them—though of course some women may have both.

Secondly, mothers who were breast feeding were excluded because fluoxetine is contraindicated for them, so the trial results cannot be applied to them. It would be useful to know how many such mothers were among the 218 women excluded because they did not satisfy the entry requirements. Breast feeding may have stopped by six weeks or never started because of social pressure, low maternal instinct, or the mother tried and failed.

Thirdly, to give an estimate of the prognosis in the population studied it is useful to know how many women had recovered—that is, achieved a score on the clinical interview of <12, or a score on the Edinburgh postnatal depression scale of <10, or Hamilton scores of <8—in each of the four groups by the end of the study. In a separate letter, Appleby has kindly given us this information. Also deserving of follow up is what the women who took fluoxetine were told about continuing or stopping the drug at the end of the trial, and what they did.

Fourthly, we have learnt from Appleby that all counselling was done by one clinically untrained graduate psychologist under his supervision. His reason for using such an inexperienced person was to show that a non-specialist in mental health could deliver the counselling intervention. This seems to us an important achievement.

Lastly, the paper omitted to note that the trial was funded by Eli Lilly, which makes fluoxetine. Appleby has told us that the company's staff suggested only minor and helpful modifications to the protocol.

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1 Appleby L, Warner R, Whitton A, Faragher B. A controlled study of fluoxetine and cognitive-behavioural counselling in the treatment of postnatal depression. *BMJ* 1997;314:932-6. (29 March.)

Sri Lankan refugees

Ethnic cleansing is in progress

EDITOR—Life is not easy for Tamils in Sri Lanka, as claimed by the 14 Sri Lankan doctors in their letter.[1] Some of the authors' outrageous remarks need rebuttal. World media have no access to the Tamil areas; the international community is unaware of the extent to which Tamils are denied basic human rights in Sri Lanka.

Since the British left Ceylon in 1948 the multiethnic island has degenerated into a kind of hell. The revival of ancient racial hatred and denial of equality of opportunity have destroyed national unity. Tamils in the plantation districts were disenfranchised and thousands of them were repatriated without consent to India. No other country in the modern world has done anything similar. The Sinhala-only Act deprived minorities of linguistic rights. Tamil members of parliament were expelled from the legislature, and Tamils have not had fair elections or democratic rights since then.

Any passive Tamil dissent resulted in violence with the loss of thousands of Tamil lives and destruction of Tamil property. It was after 30 years of harassment and humiliation that Tamil militancy emerged. The current ethnic civil war is a reality. No one can condone the methods used by Tamil militants, especially the use of suicide squads. A more objectionable feature is the exercise of state terrorism against Tamils and indiscriminate aerial bombing and naval shelling of Tamil areas by government forces.

The civil war can be ended only by reconciliation and working towards national unity. Sadly, the Colombo government is intent on crushing the Tamils militarily and eliminating any Tamil dissent. The burning by government forces of Jaffna's library and the military blockade of Tamil areas since 1983 indicate Colombo's intent. Ethnic cleansing is in progress; the situation in the north and east of Sri Lanka is similar to that in the former Yugoslavia. Political detainees were massacred in a Colombo prison some years ago. Since the military conquest of the Jaffna peninsula by government forces over 700 young Tamils have disappeared without trace. Thousands run away for their lives and to seek a living elsewhere.