exercise tests where there is no contraindication. We use β blockers in addition to aspirin in patients with hypertension and angina and consider them in those whom we assess to be at high risk. In the remaining asymptomatic low risk group we do not think that the potential additional benefit from β blockers justifies their use. The potential side effects (reduction in exercise tolerance, a general feeling of depressed activity, and sleep disturbance) are precisely those that should be avoided in subjects encouraged to take an aggressive approach to exercise and return to work.

We therefore are satisfied, unlike Drs Eccles and Bradshaw, that their study reflects good practice, being disappointed only that use of a single prophylactic agent was achieved in 86% rather than 95% of patients. One must allow for a small percentage of patients who wish to forget all about their infarct and not take prophylactic medication at all. Until the necessary clinical trial is done we will continue to manage our patients in a way that we believe is based on a fair assessment of the available evidence and not on a clinical trial that has not even been done, let alone published.

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SIR,—In Drs Martin Eccles and Colin Bradshaw's important and somewhat depressing survey of the use of secondary prophylaxis against myocardial infarction in the north of England[1] one of the defined contraindications to β blockers was diabetes mellitus. I know that some doctors are reluctant to use β blockers in diabetic patients and I realise that Drs Eccles and Bradshaw probably wanted to restrict their analysis to patients who everyone would agree had no contraindications.

I think it should be pointed out, however, that many (or most) doctors do not regard diabetes as a contraindication to the use of β blockers after acute myocardial infarction. Indeed, two recent papers in the *European Heart Journal* suggest that β blockers after myocardial infarction may even be particularly beneficial in diabetic patients.[2,3]

Admittedly, both these papers were retrospective analyses, and, as the authors of the second paper point out, "a randomized trial involving diabetic patients in the peri-infection period would be required to prove efficacy." However, as our current trial efforts are concentrated mainly on thrombolysis and angiotensin converting enzyme inhibitors, we may have to wait a long time (perhaps for ever) for such a trial. While we are waiting I suggest that we do not regard diabetes as a contraindication to the use of β blockers after myocardial infarction.

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Major chemical disasters

SIR,—Dr Peter J Baxter calls for strengthening of local and national planning for chemical incidents. To respond to this need in the west midlands a regional advisory committee on chemical accidents has been established to coordinate the body of expertise already available within the region.

The committee and its associated task force include the regional director of public health, an academic occupational physician, two clinical toxicologists, and a senior member of the Employment Medical Advisory Service. Further experts are coopted when appropriate, and the contributions of the factory inspectorate and a chemical inspector from the field consultancy group of the Health and Safety Executive have been particularly valuable.

The committee ensures, firstly, that a coordinated response can be given in an emergency and, secondly, that accurate information and appropriate advice can be disseminated to the public. This helps to allay any unwarranted fears and anxieties after the release of a hazardous chemical, particularly after the publication of conflicting and often incorrect statements in the media.

The West Midlands Poisons Unit provides emergency advice to accident and emergency departments, individual clinicians, and directors of public health. When particular public concerns occur and remain a special task force is set up to review all available clinical, toxicological, chemical, and environmental data. A specialist in public health medicine is seconded to carry out an epidemiological assessment of the health impact of the major incident.

It has been fruitful not only to identify sources of locally available expertise but to develop much closer links among colleagues with similar interests within the west midlands. Regional medical planning for chemical incidents has been strengthened considerably, and we recommend that a similar pattern be adopted elsewhere.

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1 Baxter PJ. Major chemical disasters. *BMJ* 1991;**302**:62-3. (12 January.)

Fine needle aspiration of breast lesions

SIR,—We agree with much of Mr Michael J Dixon's article.[1] We have practised fine needle aspiration and immediate reporting in our clinic since 1983 and our results confirm a high sensitivity and specificity for this investigation.[2]

We believe that a cytology service in the clinic is important not only for aspiration of breast lesions but for examining nipple discharge and for aspirating associated lymphadenopathy in relation to breast lesions. Metastatic cancer in axillary lymph nodes can be diagnosed by this technique and thus enables an accurate preoperative staging. If adjuvant treatment is planned for women who are node positive this can also be discussed at the first clinic visit.

Although we are aware of the reports of haematomas producing artefacts on subsequent mammography, we routinely carry out needle aspiration before mammography and in eight years have never had problems in interpreting mammograms. It is important to use a fine needle such as a 21 gauge needle and it is our routine practice to do this.

We also carry out immediate fine needle aspiration and reporting on thyroid swellings and have found this to be valuable in both primary and secondary thyroid disease.[2,3]

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SIR,—Mr J Michael Dixon described the approach of Scandinavian pathologists, who take their own aspirates, as "best practice."[1] Good reasons exist for the rarity of the Scandinavian model in Britain. Too few pathologists are willing and able to take on this new role. Best use of scarce expertise and of a mammographic service is achieved only if patients referred to more than one surgeon attend a joint specialist breast clinic. This is the exception rather than the rule in Britain.

Further efficiency is achieved if cytopathologists take their own aspirates. The experience is concentrated and the number of false negative results minimised as clinical and cytological features can be correlated directly to determine the representativeness of the sample.

Inefficiency and frustration arise if the cytopathologist has to wait for the surgeon to return to a patient from whom an inadequate sample has been obtained or if the surgeon remains with the patient while the aspirate is being examined.

In Northampton cytopathologists have taken and reported on aspirates for four years. Audit of 1002 consecutive cases with over one year's follow up showed a sensitivity of 95·7% for cytology alone and 99·7% for cytology and mammography together. Only one carcinoma was missed at initial assessment and this was apparent at routine three month follow up. After this service was started the ratio of benign to malignant open biopsy specimens fell by 64% and requests for frozen section fell from 335 to 45 a year. Tru-Cut biopsies are rarely performed.

In our average sized district we estimate that the fine needle aspiration service at the breast clinic saves 350 bed days and 142 hours of theatre time a year. These resources cost over 20 times more than the required cytopathology manpower. If savings related to the non-operative diagnosis of cancers of the thyroid, lymph nodes, and other sites and the increased quality of care are included in the equation it is difficult to understand why surgeons and managers are not demanding the appointment of more cytopathologists.

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1 Dixon JM. Immediate reporting of fine needle aspiration of breast. *BMJ* 1991;**302**:428-9. (23 February.)

What will the medical director do?

SIR,—For some of us who are fairly long in the tooth, the article by Mr Ian H Johnston[1] ironically affords an impression of déjà vu.

Twenty years ago and more, when all the world was young, regional hospital boards throughout the United Kingdom employed medical administrators whose duties included the work now envisaged for the medical director. Mr Johnston would seem to be unacquainted with erstwhile