placements and rotations is that trainees are able to demonstrate delivery of the educational objectives set out within the FPC.

The FPC is broad and generic. Following the Foundation Programme, trainees uncertain of their career direction can choose broad-based programmes[5] and unthemed core training programmes in medicine[6] and surgery.[7]

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Endocrine disease in pregnancy

Editor – I read with interest the excellent update on endocrine disease in pregnancy (*Clin Med* April 2013 pp179–81). I write to draw your attention to an often neglected pituitary emergency: pituitary apoplexy.

Pituitary apoplexy is a potentially life threatening medical emergency. Pregnancy is mentioned by Frise and Williamson as a possible cause of pituitary insufficiency. However, pregnancy and the immediate post-pregnancy period is a predisposing factor for pituitary apoplexy as a pre-existing pituitary adenoma may haemorrhage or infarct (eg, postpartum Sheehan's syndrome).

This could then lead to acute pituitary insufficiency requiring immediate recognition of this presentation and urgent replacement with hydrocortisone and other pituitary hormones. Patients often present with headaches, vomiting, hypotension and can suffer with visual loss or ophtalmoplegia. It is recommended that patients are urgently referred to a joint pituitary (endocrine & neurosurgery) team.

I would be grateful if you could draw your readers attention to the national guidelines on pituitary apoplexy.[1]

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Reference

1 Rajasekaran S, Vanderpump M, Baldeweg S *et al.* UK guidelines for the management of pituitary apoplexy. *Clin Endocrinol (Oxf)* 2011; 74:9–20.

Adverse effects of herbal medicine

Editor – We write with reference to the manuscript 'Adverse effects of herbal medicine: an overview of systematic reviews' by Posadzki *et al* (*Clin Med* February 2013 pp 7–12), which reviews the severity of the adverse effects of herbal drugs.

It was gratifying to note that very few of the drugs, such as *Cassia senna, Camellia sinensis, Commiphora mukul* and *Stevia rebaudiana*, which have serious or moderately severe side effects, are being used and prescribed by indigenous practitioners in India (Table 1). However, other herbal remedies, such as *Lavandula angustifolia miller, Ginkgo biloba, Trigonella foenum-graecum, Gymnema sylvestre, Panax ginseng, Silybum marianum* and *Cinnamomum* spp, which have mild side effects, are also commonly used by Indian practitioners. This is a point for caution.

Table 1. Herbal medicines causing serious adverse drug reactions.

Herbal medicine causing serious ADRs	Common names	Common uses
Larrea tridentate	Creosote	Cancer, acne, rheumatism, diabetes
Herbae pulvis standardisatus	Atropa belladonna, belladonna herbum, deadly nightshade	Menstrual symptoms, peptic ulcer disease, motion sickness
Piper methysticum	Kava kava	Anxiolytic
Cassia senna	Sena	Laxative

ADR = adverse drug reaction.

In addition, possible herb-drug interactions have also been reported which are associated with increased risk of adverse drug reactions (ADRs), probably due to the induction or inhibition of cytochrome P450 isoenzymes. For example, Ginkgo (*Ginkgo biloba*) can cause spontaneous bleeding when combined with warfarin, and coma when combined with trazodone. Ginseng (*Panax ginseng*) lowers concentrations of warfarin (and alcohol), and induces mania and insomnia if used concurrently with phenelzine.[1]

More studies are needed to clarify and determine the clinical importance of herb-drug interactions. It is imperative for health professionals, patients, regulatory authorities and suppliers of herbal medicines to be cognisant of the possible ADRs and drug interactions caused when herbal medicines

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