

HERBAL THYMES



The newsletter for members of **The National Institute of Medical Herbalists**

Winter 2021





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Letter from the Editor

By Emma Barker



Hello everyone, where did the year go? I can't believe that it is almost the end of 2021. How's your year been? What plans do you have for 2022? It might be all too much to think about next year at the moment with the festive season almost upon us, or maybe you already have dates in your diary for the coming year? Whichever it is, I hope that you are all safe and well, and wish you all the best for the year ahead.

This season we have another fantastic edition to bring you. Our focus for this quarter is diabetes, and we have some brilliant articles for you from Afifah Hamilton, Gina Webley, and Anita Wąsik. Thank you all for your contributions to this edition, I am sure that members will find your articles both interesting and informative. In addition to our themed content we also have our regular news from the regional groups, and the Reading Corner feature from friends of the Institute, Aeon Books.

As many of you know, the Institute hosted its second online conference in October, and what an amazing event it was! I am still dipping into the content available on the conference platform Whova, watching bits I missed, and making sure that I've downloaded speakers notes. I have written a brief round up to try and illustrate and give a feel for what conference was like this year for those of you who didn't attend. This also includes details of this year's Institute awards - our well deserved recipients - congratulations to you all! What an inspiration you are. And talking about inspirational people, Emma Dalton has kindly written an article about the winner of the Christopher Headley Memorial Award, Mel Hornby and her Junior Herbalist Club. What a fantastic initiative, I'm sure many of you will agree.

As detailed in our last edition we no longer have a Student Editor. Students please consider applying for this position, information about this can be found in the student pages along with details of the Student Awards given as part of our conference weekend, and the announcement of our competition winner. Huge congratulations also go out to our student award winners - keep up the good work!



Finally, before I leave you to curl up and enjoy this season's Herbal Thymes I have one last announcement to make. During her studies Anita Wąsik was a valuable member of our HT Student Team, but has now graduated. Congratulations on your graduation Anita, well deserved! I am very pleased to be able to tell you that Anita is staying on as a member of our team and will be taking on the role of Assistant Editor. I look forward to working with her to bring you future editions of HT and am excited to embrace any new ideas and inspiration this new collaboration may bring. So pleased to still have you onboard! I feel that I also cannot go without mentioning Jan Alton too, our amazing proofreader. The unsung hero of the team, I would be lost without her and am hugely appreciative of both her support, amazing skills and eagle eyes for spotting the smallest of errors. You are a star! I am so lucky to have such a wonderful team.

So goodbye for now, I wish you all a very happy festive season and a happy New Year. Kick back, relax and enjoy, and I'll see you all again next year with our Spring edition at the beginning of March. Take care. ❁

Take care.

Em x





Characteristics of diabetic kidney disease and pathological mechanisms leading to its development

By Anita A. Wąsik

Introduction

Diabetes mellitus is a rapidly expanding worldwide problem with social, health, and economic consequences. It is a chronic disease that occurs when the pancreas is no longer able to produce insulin (Type 1 diabetes mellitus, T1DM; insulin-dependent diabetes mellitus), or when the cells fail to use insulin properly (Type 2 diabetes mellitus, T2DM; non insulin-dependent diabetes mellitus) (Table 1). Globally, in 2019 approximately 463 million people were living with diabetes and the number is estimated to increase up to 700 million by the year 2045 (International Diabetes Federation, 2019). All forms of diabetes increase the risk of long-term micro- and macrovascular complications. The microvascular complications refer to diabetic kidney disease (DKD), diabetic retinopathy and neuropathy, and the macrovascular complications include

Table 1. Characteristics of T1DM and T2DM

	T1DM	T2DM
Onset	• During childhood (but not exclusively).	• In adults (but increasing prevalence in younger people). • Strongly associated with obesity and sedentary lifestyle.
Mechanisms	• Destruction of insulin-producing pancreatic β-cells	• Insulin resistance coupled with inability of pancreatic β-cells to produce insulin
Pathological Characteristics	• Immune cell infiltration of pancreatic islets. • Autoantibodies. • Reduced β-cell mass.	• Insulin resistance in muscle, liver, and adipose cells. • Reduced β-cell mass and/or function.
Treatment	• Insulin injection or insulin pump. • Rarely, pancreatic islets or pancreas transplantation.	• Lifestyle changes. • Medication (Metformin, Sulphonylureas, Glitazones, Gliptins, GLP-1 mimetics, insulin).



cardiovascular disease, stroke, and peripheral vascular disease. Diabetes is now the leading cause of chronic kidney disease and kidney failure (Zimmet et al., 2001). The proportion of patients with renal failure caused by diabetes has progressively increased during the last few decades. Approximately one out of three patients with T1DM and half of patients with T2DM develop kidney complications (Thomas et al., 2015). The clinical risk factors for development of DKD include not only hyperglycemia, but also hypertension and dyslipidemia. DKD itself is also associated with increased risk of cardiovascular disease and mortality (Nathan et al., 2005; Groop et al., 2009) and with metabolic syndrome (Thorn et al., 2005).

Definition, clinical features, and risk factors of diabetic kidney disease

DKD (also termed diabetic nephropathy in patients with T1DM) is a progressive complication of diabetes resulting in decline of the kidney function and often, but not always, albuminuria. The first sign of DKD is microalbuminuria defined as albumin excretion rate (AER) 20-200 $\mu\text{g}/\text{min}$ or 30-300 $\text{mg}/24\text{ h}$. Macroalbuminuria (AER $>200\text{ }\mu\text{g}/\text{min}$ or $>300\text{ mg}/24\text{ h}$) or proteinuria (AER $>500\text{ mg}/24\text{ h}$) occur over a period of years and subsequently lead to a decrease in estimated glomerular filtration rate (eGFR $<60\text{ ml}/\text{min}/1.73\text{ m}^2$) (Reutens and Atkins, 2011). Microalbuminuria appears 5–15 years after the patient is diagnosed with diabetes mellitus. Once microalbuminuria/macroalbuminuria presents, kidney function progressively declines.

The incidence of DKD differs in T1DM and T2DM: one out of three patients with T1DM and 50% of patients with T2DM develop kidney complication (Thomas et al., 2015). The risk factors of developing DKD include lifestyle together with hyperglycemia, hypertension, and dyslipidemia, as well as duration of diabetes, genetic backgrounds and male gender (Thomas et al., 2015).

Kidney structure and function

The kidneys perform several major functions in the body. They maintain fluid and electrolyte balance, acid-base balance, and glucose balance via glucose reabsorption and/or gluconeogenesis. They also excrete metabolic waste products and foreign chemicals, and secrete hormones that regulate blood pressure and red blood cell formation. The basic structural and functional unit of the kidney is the nephron (Figure 1). Each human kidney has about one million nephrons. A nephron consists of a glomerulus and a tubulus. A glomerulus consists of a capillary tuft located inside the Bowman's capsule (Figure 1), and it is responsible for plasma filtration. The distal part of the nephron is the tubular system which is further divided into the proximal and distal tubule and the Loop of Henle (Figure 1). After passing through the renal tubule, the filtrate continues to the single collecting duct (Figure 1). Every day, about 180 L of primary urine is normally formed by the kidney glomeruli. However, the reabsorption of water and electrolytes in the tubular system results in urine concentrating, with a daily urine excretion around 1–1.5 L.

Filtration of plasma occurs in glomeruli (Figure 2). Primary urine is filtrated from the plasma through the glomerular filtration barrier (GFB) to the Bowman's space and then passes to the tubular system. Water and small molecules pass the barrier, whereas molecules the size of albumin and larger are retained in the blood.

Figure 1. Schematic illustration of nephron.

Modified from Marieb, 2001 and Wasik, 2014.

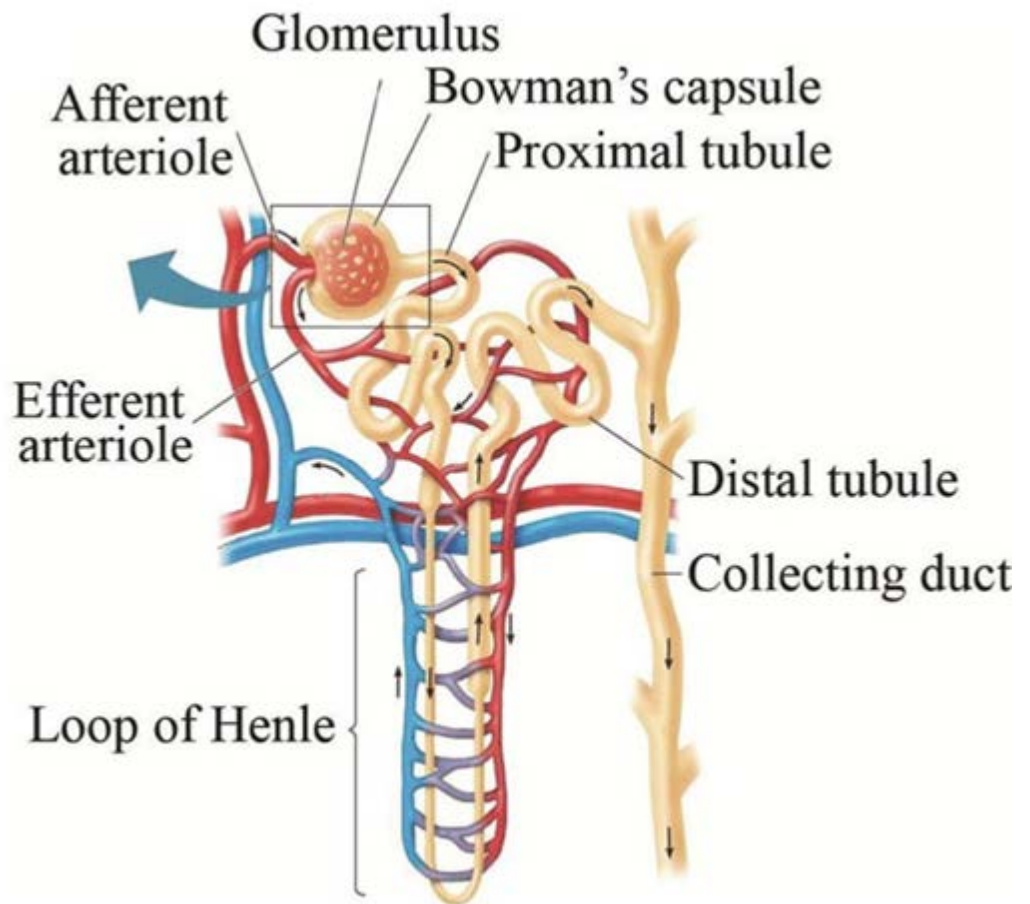
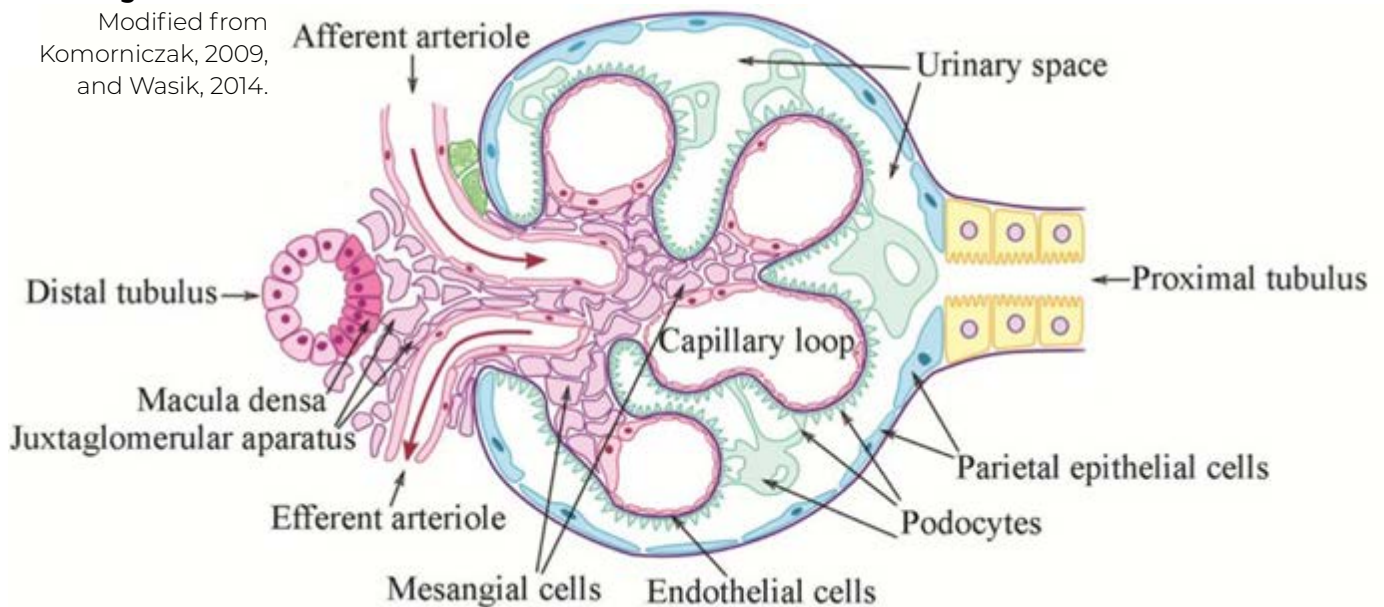


Figure 2. Schematic structure of the glomerulus.

Modified from Komorniczak, 2009, and Wasik, 2014.



The GFB consists of three distinct layers: the fenestrated endothelium, the glomerular basement membrane (GBM), and the podocytes with their slit diaphragms (SD) (Figure 3A). Podocytes are highly specialised cells that form a key part of the kidney filtration barrier.

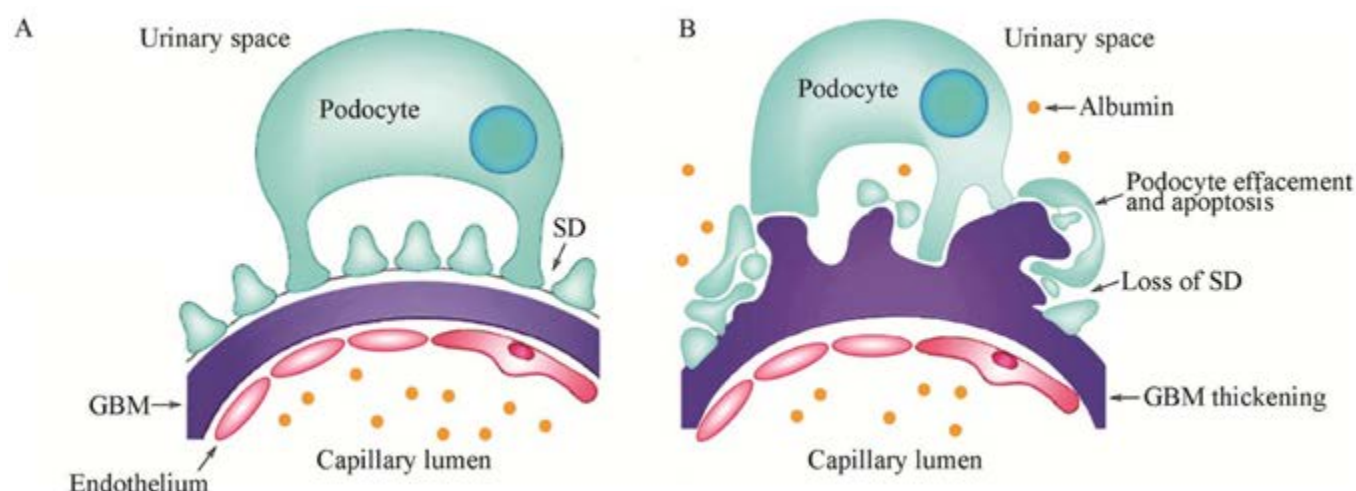


Figure 3. Glomerular filtration barrier changes during diabetic kidney disease.

(A) Normal glomerular filtration barrier.
(B) Diabetic kidney disease. GBM: glomerular basement membrane; SD: slit diaphragm. Modified from Suh and Miner, 2013, and Wasik, 2014.

Mechanisms leading to the development of dkd

The main detectable change in diabetic kidneys is the thickening of the GBM due to increased accumulation of the extracellular matrix, podocyte injury, and podocyte loss due to apoptosis (Susztak et al., 2006) (Figure 3B). These changes cause leakage of the albumin and bigger molecules into the urinary space and development of proteinuria. The pathophysiological mechanisms leading to the development of DKD remain incompletely understood. Genetic factors, inflammation, and metabolic disturbances are known to be involved (Harjutsalo and Groop, 2014). Insulin resistance may play a role in the development of kidney injury, as both clinical and experimental data suggest that insulin sensitizers have a renoprotective role in diabetes patients, as well as in animal models (Miyazaki et al., 2007; Zhang et al., 2008). Insulin resistance is a condition in which cells fail to respond to the normal actions of insulin. At the cellular level, the mechanisms leading to the development of insulin resistance may include mutations in the insulin receptor (IR) itself, impairments in the PI3K/AKT signalling pathway, or perturbations in the trafficking of glucose transporters (GLUTs). These changes may lead to reduced uptake of glucose into cells and contribute to the development of hyperglycaemia.

Insulin resistance is associated with an increased risk of chronic kidney disease and proteinuria (Thomas et al., 2011). Interestingly, podocytes are uniquely insulin-sensitive cells in the glomerulus of the kidney (Coward et al., 2005). Podocyte insulin resistance has been first demonstrated in early diabetes in T2DM mice (Tejada et al., 2008). Also, mice lacking insulin receptors in podocytes develop albuminuria and histological features of DKD even when their blood glucose level is normal (Welsh et al., 2010). Due to the invasiveness, it is challenging to define whether podocytes in human patients with diabetes develop insulin resistance and to determine whether podocyte insulin resistance per se contributes to the development of DKD. Research showing an increased incidence of DKD in insulin-resistant patients with a normal blood glucose level supports the role of insulin resistance in the pathogenesis of DKD (Filippone et al., 2014; Ahlqvist et al., 2018). However, insulin resistance alone may not be enough to lead to the development of DKD. Also, only some patients with mutations in insulin receptors and severe insulin resistance develop DKD, and some develop other kidney diseases (Musso et al., 2006). This suggests that insulin resistance, in combination with other factors, may contribute to kidney injury.

Conclusions

Excess glucose may activate several pathways that lead to kidney injury. The type of treatment depends on the stage of kidney disease. It is very important to keep glucose and cholesterol levels, as well as blood pressure, under control. Changes in the diet may also be applied. In case of late-stage kidney disease, treatment options include dialysis or a kidney transplant. Recently, research data highlighted the importance of insulin sensitivity of specialised kidney cells, podocytes, in the development of DKD. Therefore, herbal treatment approaches addressing insulin sensitivity could be used as prevention and treatment of DKD. ❁

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The Reading Room

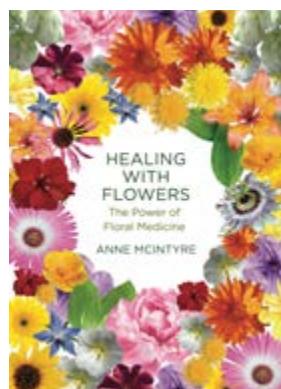
From Aeon Books



Festive herbal greetings from all of us at Aeon Books. As the year draws to a close, we are reflecting on all the wonderful books we have brought out this year and the journeys our authors have taken us on. We would like to thank you all for your ongoing support.

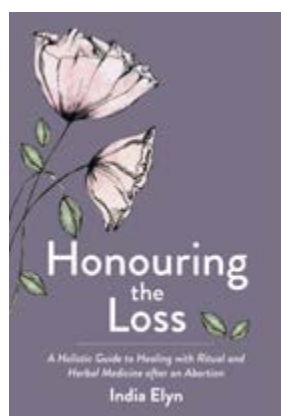
We kicked off the year with our Spring releases which included **The Tree Dispensary** by Christina Stapley which explored the uses, history and herbalism of native trees such as oak, elder, willow, and hawthorn. She followed this up with the autumn release of a companion volume looking at the medicine of exotic trees such as cacao, eucalyptus, almond, and frankincense.

Also released in Spring, Christine Herbert's **Sleep: The Elixir of Life** gave us natural and functional solutions to insomnia and sleep disturbance. Paul Michael's **Treating Digestive Disorders from an Endobiogenic Perspective** provides clinical solutions to conditions such as IBS, Crohn's, GERD, and dysbiosis; while Marie Reilly's comprehensive and cutting-edge work **Herbal Medicine and Reproductive Health** covers common issues in male and female fertility and reproductive health and outlines in-depth case studies alongside herbal and nutritional solutions.



We were saddened to hear of the passing of Andrew Stableford in April. We had worked with Andrew across the previous year to bring his insights to the page in **The Handbook of Constitutional and Energetic Medicine: The Lotus Within**. We are so pleased that his teachings and life's work have been recorded and will be his lasting legacy to all his many students and others yet to discover his unique perspective on our practice.

Summer launches included Kerry Bone's new ground-breaking text **Functional Herbal Therapy**, while Steve Taylor's **The Humoral Herbal** delves deeply into the humoral and planetary attributes of our *materia medica* and is a practical guide to the Western Energetic system. **Wild Apothecary: Reclaiming Plant Medicine For All** by Amaia Dadachanji with Claudia Manchanda is a herbal for all stages of life and all people – an inspirational and inclusive book designed to connect the reader to nature, landscape, and community. It is beautifully illustrated with the author's own paintings and includes recipes and rewilding exercises.



In the last few months, we have launched the comprehensive **CBD Handbook** by herbalist Karen Mallion which provides prescribing clarity for the use of cannabinoids. Rosarie Kingston has revealed **Ireland's Hidden Medicine**, while American herbalist Josh Williams gave us insights into **Spiritual Herbalism**. Anne McIntyre has produced the beautifully illustrated **Healing With Flowers: The Power of Floral Medicine**, and we are proud to have published possibly the first ever book written on abortion aftercare - **Honouring the Loss** by India Elyn – looking at herbs, rituals, and advice for self-care after a termination.

Looking forward to 2022, we have plenty of exciting titles in production: Kathie Bishop's **It's Your Power Portal: The Natural Vagina Care Manual for All Ages**; Elisabeth Brooke's **Goddess Astrology**; and **The Seed Sistas' Poison Prescriptions** which will delve into some of the Schedule 20 herbs, their history, magic, folklore, and medicinal applications. Carol Guyett's **The Herbalist's Guide to Pregnancy, Birth and Beyond** is much-anticipated; and we'll be releasing an updated edition of Michael Thomsen's **Phytotherapy Desk Reference** – much loved by herbalists. And keep an eye out for **Plant Medicine: A Collection of the Teachings of Herbalists Christopher Hedley and Non Shaw** – edited by Guy Waddell.

Aeon Books aims to give practitioners access to the best in contemporary herbal thought and information and to provide a platform for authors to share their knowledge. We are always looking for new book proposals so please do get in touch if you have an idea that you'd like to work with us on. **Sign up to our newsletter to receive discounts and updates. If you're a student, check with your school for special reading list reductions.** ❁





Understanding Diabetes (aka passing honey-like urine)

By Afifah Hamilton MNIMH

“The lower limit of dietary carbohydrate compatible with life apparently is zero, provided that adequate amounts of protein and fat are consumed.”

Institute of Medicine (2005). Dietary Reference Intakes for Energy, Carbohydrate, Fiber, Fat, Fatty Acids, Cholesterol, Protein, and Amino Acids. Washington, DC: The National Academies Press, p. 275. <https://doi.org/10.17226/10490>.

‘Diabetes mellitus’ is the name for the diseases that result when insulin fails to keep blood glucose levels within a tight physiological range. Some of the excess glucose is excreted in the urine, which therefore tastes sweet. This was the old way of detecting diabetes. Now we have urine dip sticks, thank goodness!

The amount of glucose in the blood is normally tightly controlled and held close to 4.6 mmol per litre of blood (mmol/L). Following a meal, blood glucose rises in proportion to the amount of carbohydrate in the meal. The pancreas responds to the rise in glucose levels by releasing a proportional amount of insulin into the blood. Insulin-dependent glucose receptors on the surface of cells enable them to take up the excess glucose, leading to a normalising of the amount left in the blood.

To put this in perspective, the normal level of glucose in the entire blood volume of an adult is approximately 1 teaspoon (5g). A typical UK meal may include 250g of carbohydrates (50 teaspoons of glucose), all of which will be released into the blood and must be safely removed and stored and the blood level returned to baseline.

There are two ways in which this mechanism can become disrupted, leading to dangerously high levels of glucose remaining in the blood. The first, known as type 1 diabetes, is where insulin production fails so cells receive no signal to take up glucose from the blood. This results in high levels of glucose remaining in the blood whilst the cells starve for want of glucose, leading to secondary issues. In the second form, type 2 diabetes, insulin production is normal, but the cells do not respond to the insulin signal, do not take it in, and thus the blood level remains high. This is known as insulin resistance.

Type 1 Diabetes (T1D)

T1D begins with autoimmune destruction of cells that produce insulin, the pancreatic islet cells. This is thought to be irreversible. Once these are gone, little or no insulin is produced, so blood levels of glucose climb higher and higher in anyone on a normal diet, i.e. a diet that includes carbohydrates. T1D is

sometimes called rapid onset diabetes as it can develop in a matter of weeks and it will suddenly descend into a crisis. Because the autoimmune destruction is permanent, patients require lifelong exogenous insulin injections, matching the dose to the carbohydrates in each meal. Understanding the condition is key to good management.

Insulin is also involved in passing protein into cells (by a glucose independent mechanism) and this means that T1 diabetics will always need some exogenous insulin. Without insulin, cells are starved of energy and protein. Body weight and muscle loss are key signs of T1D onset. This state of increasingly severe starvation prompts the liver to convert body fats to energy, as most cells (except the brain) can use fatty acids as fuel just as well as glucose. To provide an alternative fuel source for the brain, the liver converts some fat to ketone bodies. The brain can only use glucose or ketones for its considerable energy demands. In a normal healthy individual, the absence of dietary carbohydrates is a perfectly healthy option, with many systems in the body appearing to function better on free fatty acids and ketones than on the usual glucose, including the heart. These mechanisms are behind the benefits of fasting.

The problem in T1D that distinguishes it from the normal fasting state is the presence of high blood glucose. Together with high ketone bodies and high free fatty acids, the pH balance of the blood and tissues tips towards acidity (low pH) causing diabetic ketoacidosis. This leads to profound tissue damage. Normal blood pH is 7.4 and is tightly controlled through complex mechanisms. If the pH drops to 7.0 or lower this is categorised as severe ketoacidosis. Coma and death can follow. Even a shift in pH to 7.3 or 7.25 causes morphologic and functional brain changes.

Management of T1D is primarily based on injecting insulin with every meal, to ensure blood sugar is controlled. The dose of insulin (measured in units) is matched to the amount of carbohydrate in the meal. This can never match the precision of a fully functioning pancreas, and experience has led endocrinologists to always slightly underdose the insulin, meaning that type 1 patients will have long-term slightly elevated blood glucose. The reason for this is that the risk of overdosing with insulin (leading to hypoglycaemia) is far more serious and sudden than underdosing (leading to chronically raised glucose). Consequently, standard treatment encourages patients to eat carbs with every meal, then inject insulin to lower the glucose levels those carbs release. Whereas an ideal blood glucose level is 4.6 -5 mmol/L, T1 diabetics are told to aim for 6 - 7 mmol/L, but many never get this low and run at 8 - 10mmol/L. Their HbA1c climbs over the years. The result is chronic disease. See the graphic showing vascular and other damage at the end of this article illustrating this point.

Apart from the very clear and potentially deadly ketoacidosis, which is most likely to occur in the early stages of T1D, and of sudden hypoglycaemic episodes ('hypos') that T1 diabetics are highly susceptible to all their lives (both of which are medical emergencies), the main problem with both T1D and T2D is the continuous, long term excessive amounts of glucose sloshing about in the blood. It is the glucose that causes the damage that all diabetes patients suffer in the long term. On average, diabetics have a twenty year shorter life expectancy than non-diabetics. The approach I take to treating both T1D and T2D reduces the damage done by chronically raised blood glucose, and ketoacidotic episodes, but also of hypos.



Hypoglycaemia

In brief, a hypo-glycaemic episode occurs when blood glucose drops to 4mmol/L or less. The lower it goes and the more rapidly it drops, the more terrifying and indeed life threatening it is. The normal, healthy, ongoing level of blood glucose is, as stated above around 4.6mmol/L. The most common cause of hypoglycaemia is too large a dose of insulin especially if paired with unusually timed, or vigorous exercise, which drives some glucose into muscles (muscle glycogen) and out of the blood. Exercise must be taken into account when dosing insulin. If blood glucose goes below 2.2 mmol/L the patient will become unconscious, descend into a coma and, if glucose is not administered, will die. Some estimates suggest that as many as 1 in 20 Type 1 diabetics die this way. Please follow the link to a paper published on this subject which I have provided at the end of this article. Jelly baby sweets are used for fine dosing of glucose to raise blood glucose again in the event of a hypo, but I find a hot cup of standard tea, with milk, to be the most rapid method of lifting blood glucose from the danger zone. Eating jelly babies, or glucose tablets usually ends up raising glucose too high, setting the roller coaster off once again.

Type 2 diabetes (T2D)

In T2D, the cells that should receive glucose reduce the number of insulin receptors (GLUT4) which are primarily on adipose and muscle cell membranes. These would trigger the admission of glucose into such cells but the reduction in insulin receptors expressed means the cells do not remove much of the glucose from the blood when insulin is released, leaving a hyperglycaemic state. The pancreas detects the continued presence of glucose in the blood and secretes more insulin. The blood now has excess glucose and excess insulin. The problem gets worse over the years and decades as more cells 'tune out' the messenger, insulin, turning a deaf ear, i.e. becoming insulin resistant. Meanwhile glucose wreaks havoc, everywhere (more on the mechanisms below). Insulin resistance usually coincides with developing obesity, i.e. the cells have plenty of energy stored, and resist having to take on more. Patients are often blamed for their excessive weight, whereas our food environment and terrible dietary advice, either through medical professionals or popular culture, are more to blame.

Glucose – the preferred energy source?

You may have read that glucose is the preferred energy substrate for cells, especially the brain, which implies that the chief function of insulin is to provide glucose to fuel cellular activity. However, another perspective suggests that one major role of insulin is 'rescuer'. It tries to protect the vasculature and delicate tissues from the ravages of excess blood glucose. Here are two facts that support this perspective:

- 1) All the damage seen in diabetic patients (for example the retinopathy and amputations) is directly due to the blood glucose and the glycation it causes.
- 2) Cells will actually take up blood alcohol as a fuel 'in preference' to glucose, showing that the word 'preferred' should not be interpreted as 'optimal', but rather, 'most important to remove'. Indeed, no cell in the human body requires blood glucose levels above basal concentration at any time, as stated above (4.6 - 5 mmols/L in UK units, 83 - 90 mg/dL in US units). In non-diabetics, even if carbohydrate intake is zero, these basal levels will be

maintained by gluconeogenesis. This ability to maintain adequate blood glucose without any dietary supply is amply demonstrated by the ability of humans to fast for many days.

Carbohydrates and glycation

Glucose is a monosaccharide. All common starches and sugars (polysaccharides and disaccharides) are turned *into* glucose in a short time after digestion (including over 90% of fructose, galactose and lactose). The word 'carbohydrate' means starches and sugars, including glucose.

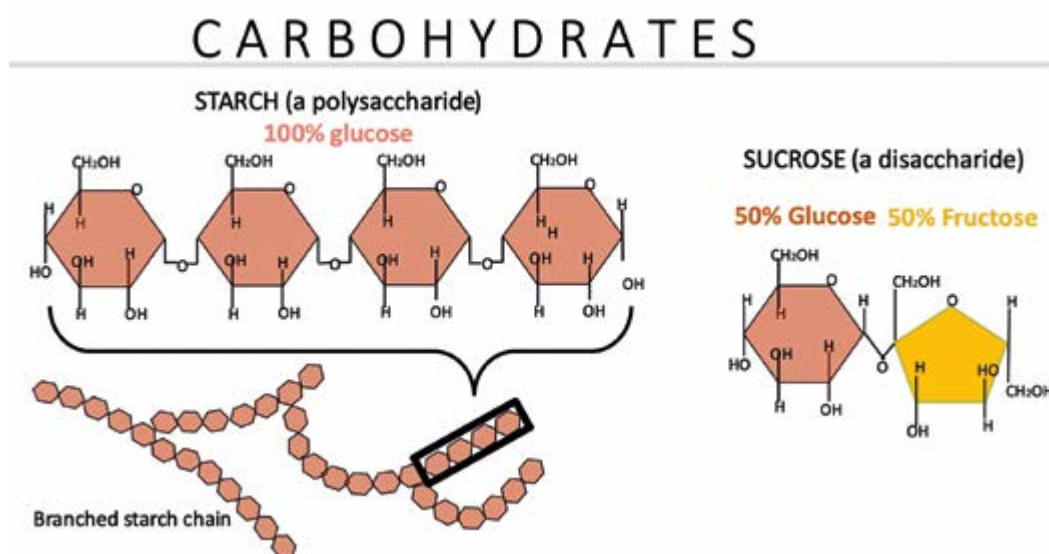


Figure 1 Showing how common dietary starches and sugars contribute to glucose absorption

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Glucose is the main tissue disruptor in diabetes. When it is raised it damages all the proteins and lipids it makes contact with, via a process called glycation. As shown in the diagram above, glucose takes the form of a ring most of the time, but it has two different ring forms which it flips between. While changing shape it momentarily passes through a linear form. It is in this acyclic, linear form that glycation can take place. The more glucose in the blood, the more is passing through the acyclic form and the more glycation will occur. See figure 2 below.

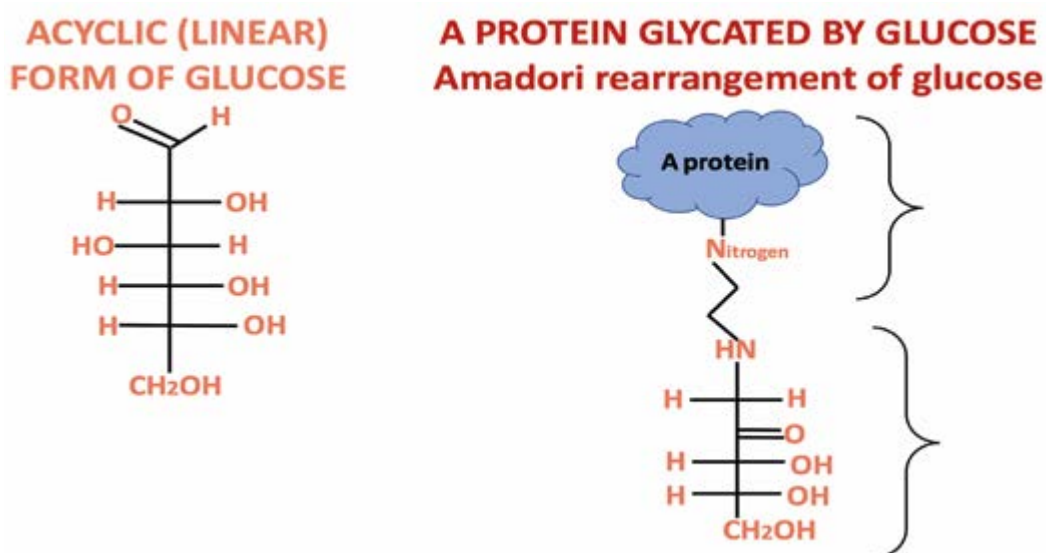


Figure 2 Showing glucose in the non-ring form, during which it can glycate (chemically bind with) proteins

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Glycation

Glycation is a non-enzymatic, covalent chemical reaction. It is non-reversible. The process can double the mass of the protein it is attached to, preventing normal function. Glycated proteins become stiffened, produce reactive oxygen species, and inflammation ensues. The HbA1c test is a measure only of the degree of glycation of haemoglobin. Diabetics typically have their HbA1c measured every three months as an indication of how well controlled their blood glucose levels have been. Because red blood cells only have a limited lifetime, HbA1c measurements provide an indication of average glucose levels over the preceding three months. The old measurement was by percentage of glycation and is easier to understand than the new IFCC metric. (See comparison of the various measures in the chart below).

There are 60,000 – 100,000 miles of blood vessels in the human body. Every part of the vascular endothelium is vulnerable to glycation, and every form of blood cell is also vulnerable to glycation: RBCs, WBCs and platelets. Thus anyone with even slightly raised blood glucose of any duration develops some degrees of damage leading to inflammation, clot formation, and fibrinolysis, with increasing risk of atherosclerotic plaque formation. The risk of rupture increases the longer the blood glucose remains high. The finest capillaries are damaged soonest, and diabetic retinopathy is one such common pathology, leading to blindness; kidney capillaries are damaged leading to kidney failure and the need for dialysis; compromise to distal blood vessels affecting the lower limbs and toes can lead to amputation.

The largest organ in the human body is the glycocalyx. This lines all those thousands of miles of blood vessels and directly relates to the vascular endothelium. It is here that nitric oxide (NO) is made. NO is a vital molecule which, amongst other functions, maintains the healthy, relaxed, open condition of blood vessels. Reduction in NO adds to many of the pathologies we see in diabetes, such as erectile dysfunction, high blood pressure, and an increase in infections (NO is involved in killing bacteria). Diabetics are prone to urinary tract infections, skin infections, upper respiratory infections, sinus infections, toe-nail infections, etc.

There are 8 types of diabetes mellitus:

Type 1 – insufficient insulin due to autoimmune attack of insulin-producing cells

Type 1.5 or LADA – Latent Autoimmune Diabetes of Adulthood

Type 2 – insulin resistant diabetes (usually late onset but can be children too)

Type 3 – brain insulin resistance, as seen in Alzheimer's and other dementias

GDM – gestational diabetes (in pregnant women)

PCOS – polycystic ovary syndrome type 1 (i.e. insulin resistant PCOS)

CFRD – cystic fibrosis-related diabetes

DID – drug-induced diabetes

The Solution

The solution, thankfully, is far simpler than one might expect, and a famous writer recently tweeted the most concise version of the solution that I have yet seen.

“Diabetes is bankrupting people. Meanwhile, cutting out carbs is zero cost and frees people from the need for insulin usually within days-weeks. Diabetes associations don’t tell ppl this bc they’re funded by Big Pharma. That’s it, the whole sad story.”

Nina Teicholz, author of Big Fat Surprise, in a tweet on 25/9/21.

The way to remediate all forms of diabetes is to markedly reduce the intake of all carbohydrates. It is the carbohydrate (glucose) that causes all the disruptions, albeit brought about through different originating ‘faults’. Careful management of the various types is essential, and of course every patient is different, but the principles will guide the dedicated practitioner and patient as they take this entirely logical approach.

Treating autoimmune diabetes

In T1D and LADA (T1.5D), injectable insulin is required to manage the blood glucose. As the dietary glucose intake (i.e. all carbohydrate foods) goes down, so the number of units of insulin must be reduced. **These patients will always need some insulin**, but the dose can be vastly reduced over time. This way the risk of hypos is markedly reduced. Hypos are the critical issue in T1D patients.

Daily attention via finger prick testing, before each meal, and after each meal, and 90 mins after each meal for the first two to three weeks will give invaluable information about individual requirements. Good records must be kept. The process of gradually reducing dietary carbohydrates should be done by weighing all starchy or sweet foods, using a high spec set of kitchen scales, such as the Heston Blumenthal ones: (<https://salterhousewares.co.uk/heston-blumenthal-precision-dual-platform-digital-kitchen-scales/>) as they are precise down to a tenth of a gram, and from there work out the carb content via a site like this: <https://nutritiondata.self.com>. Each day the carbs eaten should be reduced **by 10% only**. The insulin (both short acting and long acting) must be calculated to match the carb content of each meal. **DO NOT RUSH THE LOWERING OF THE CARBS. IT MUST BE SLOW AND METHODICAL.**

Also in T1D and T1.5 all gluten-containing grains (including oats in my experience) should be removed from the diet. It is well known that antibodies to gluten can trigger antibodies to ‘self’, including the beta cells of the Islets of Langerhans, so all gluten, without exception, should be strictly excluded from the diet. Since gluten occurs in carbohydrate-based foods this will be easy. In some cases, cow’s milk casein triggers T1D. Read up on A1 and A2 milk to grasp this story in *Devil In the Milk* by Keith Woodford (Chelsea Green Publishing, 2009). Human, goat, sheep, Guernsey and buffalo milk are all A2, and therefore safer re triggering autoimmunity.



Young children with T1D

Many children have been put on a ketogenic diet for drug resistant epilepsy, with great success. Concerns about growth retardation have largely been answered. Glucose and insulin are growth promoters, so it is reasonable to consider child growth on a low carb diet. Results of studies are mixed, with some showing slowed growth in some cases, but this study is generally encouraging and dates from 2019: <https://pubmed.ncbi.nlm.nih.gov/31247999/> Obviously protein, which is required for growth, must not be so low as to limit growth. In childhood epilepsy treatment, the carbs AND protein are very restricted. This is not necessary in T1D, meaning the diet can be more normal and cheaper.

Treating the other forms of diabetes

In almost all other forms of diabetes, the process of restricting carbohydrate intake should also include a consideration of any medications the patient is taking. The greatest success is always obtained by gradual and methodical carbohydrate reduction, but in T2D, T3D, PCOS, CFRD, and GDM, the rate of reduction can be more rapid than those on injectable insulin (assuming your T2D cases are not yet on injectable insulin. If they are, treat as above for T1D). In these cases, dropping the daily carb intake by 20 – 30% should be achievable. Drug doses can be dropped by the same proportion (using a sharp knife and a chopping board usually works if lower dose versions cannot be prescribed). Finger-tip blood testing is, again, a vitally important tool for getting the meds matched to the lower carb intake. All T2D drugs can be withdrawn entirely, once the blood glucose has returned to normal though (unlike in T1D).

In most T2D cases, they will need to drop their carbs as low as 20g -50g total daily carbs (depending on the height/build of the individual). Their diet can be built around those foods that fit within these bounds. Adding fat provides the requisite energy substrate that all cells can function on. Ketones will be produced when glucose is low enough, and it is ketones that support really good brain function. Adding coconut oil, or MCT oil, is the quickest way to induce ketone body production. Many Alzheimer's patients have benefited from coconut oil, as explained in these recent papers:

<https://pubmed.ncbi.nlm.nih.gov/28126466/>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6720297/>

Chart 1 Drugs known to be capable of inducing diabetes, and how to cease their use

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STATINS and other cholesterol-lowering drugs	STEROIDS	BETA-BLOCKERS	ANTI-HYPERTENSIVES e.g. thiazides and others
These drugs can simply be stopped, from one day to the next according to cardiologist Aseem Malhotra (see link below to video). Statins can also be tapered, over a week or two.	Must be tapered over a period of time, depending on the dose and duration of steroid use. Short term highish dose steroid use, e.g. one week, can be stopped abruptly.	Taper these drugs over a few weeks or months while attending to both heart rhythm and anxiety levels of the patient, and treat with appropriate herbs.	Lowering dietary carbs can lead to lower blood pressure in itself, so such anti-hypertensive drugs may become superfluous, and can be lowered accordingly/ replaced with herbal medicine.

Drug induced diabetes treatment

The last category of diabetes, DID, is in a class of its own in that the solution is obvious – the patients need to get off the drugs that are causing a worse problem than the one they started with, i.e. diabetes. They may well also need to be on a low carbohydrate diet, as it is a more positive diet for everyone, clearly. Below is a chart for dealing with the four main categories of drugs that are commonly the culprit for causing DID:

Regarding statins, at the Public Health Collaboration Dr Aseem Malhotra gave an excellent presentation. At the 15 mins to 18 mins section he discusses a case study regarding statins that is pertinent to the point about being able to stop them with no tapering:

<https://www.youtube.com/watch?v=mAoTwfx1Sic&t=2240s>

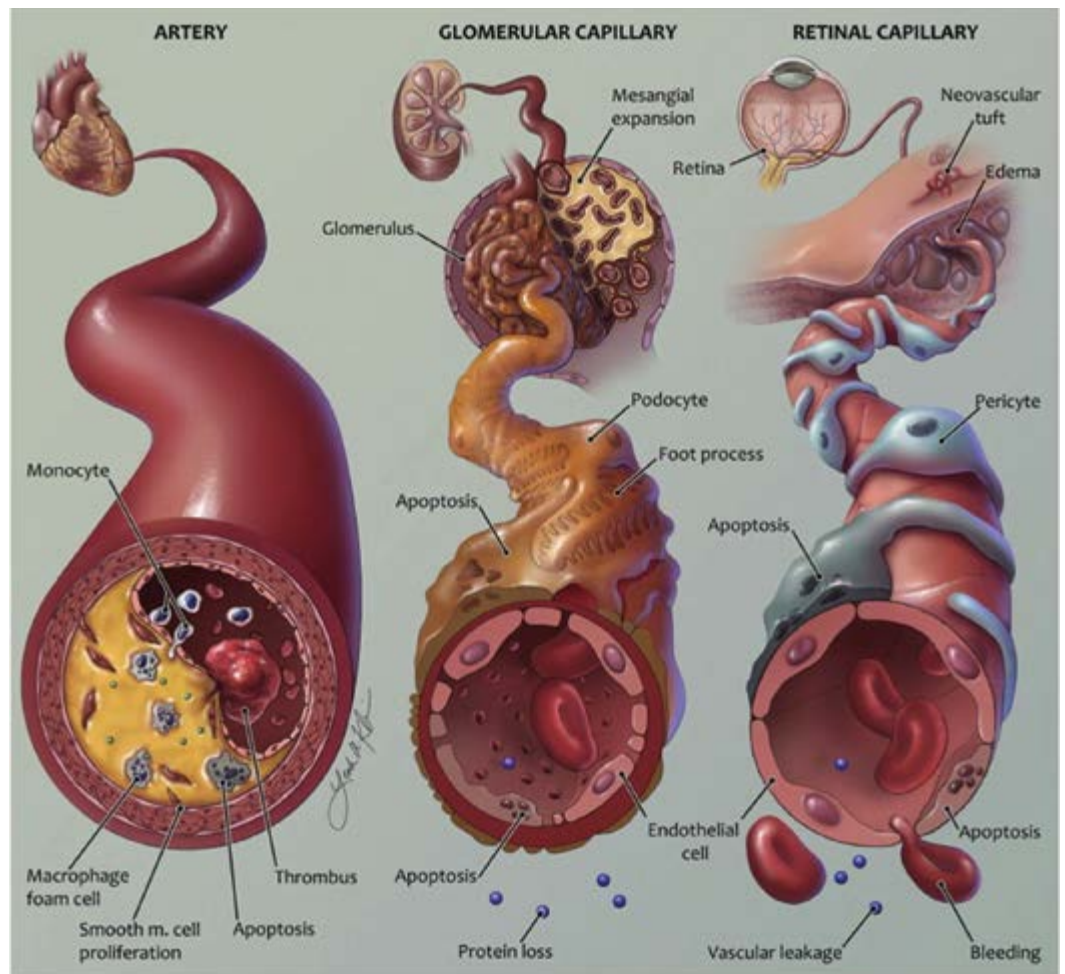
Below is a chart of daily dietary ideas that can easily be employed and adjusted to individual taste.

Daily meal ideas

Chart 2 Low carb meal ideas.

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Low carb breakfast ideas	Low carb lunch ideas Also snack & dessert ideas	Low carb dinner ideas.
'Bullet-proof' coffee (i.e. black coffee + butter + double/clotted cream). Sweeten with glycine (an amino acid) or stevia. Omelettes – fill with cheese, ham, mushroom, tomatoes. Scrambled egg with double cream, cooked in plenty of butter or coconut oil, with fresh herbs/garlic or smoked trout/salmon/grated cheese. 'Full English' (sausages, eggs, bacon, halloumi, mushrooms +/- tomatoes (depending on blood glucose reaction), but without baked beans as too carby. A seedy breakfast (e.g. 'Linwoods' seed mixes from supermarkets, + desiccated coconut (unsweetened), broken pecans/walnuts/flaked almonds/roasted hazelnuts, a few berries, a dollop of yogurt/cottage cheese/clotted cream and blue top milk.	Salads with protein, e.g. leaves + chicken drumstick/ham/hardboiled egg/cheese/pate with a dressing of olive oil/vinegar Avocado eggs (see recipes on my blog, below) Mixed grill (halloumi for vegetarians) Dinner leftovers Snacks Brazil or macadamia nuts Olives Chunks of cheese Slice of ham with soft cheese spread on it, rolled up like a cigar. Desserts Clotted cream + chopped nuts, glycine, a few berries Ice cream (egg yolk, double cream, glycine or stevia + vanilla essence) Keto bounty bars	Any beef, lamb, pork, poultry, fish, shellfish, game, offal, cooked in any style or manner of your choosing, using herbs, spices, veg combinations, but no flour. Serve with lots of above ground vegetables (root veg contain starch i.e. glucose) with butter on, or serve with salad. Beetroot has some value, due to the betaine, but watch the blood glucose. In place of pasta use shredded cabbage, spiralised courgette or squid! (in place of lasagne). Vegetarians – cheese and eggs are the foundation of a low carb diet. Vegans – fermented soya like tempeh is the basis. Many vegan products are considered 'ultra-processed' and as such waste micronutrients.



This schematic illustration shows pathological changes in a coronary artery (left) and in glomerular and retinal capillaries (middle and right, respectively) in diabetes. Some of the main features are accumulation of lipid-laden macrophages in the atherosclerotic plaque and subsequent macrophage apoptosis (left); podocyte apoptosis, thickening of the glomerular basement membrane, and breakdown of the filtration barrier in the renal glomeruli (middle); and pericyte and endothelial cell apoptosis, vascular leakage, and haemorrhage in the retina (right). Proportions, in particular size of the artery relative to the capillaries, are not to scale.

Artwork by Leah A. Klein, in Rask-Madsen, C., & King, G. L. (Jan 8, 2013). Vascular Complications of Diabetes: Mechanisms of Injury and Protective Factors. *Cell Metabolism*, 17(1), 23. DOI:<https://doi.org/10.1016/j.cmet.2012.11.012>

Thoughts on supplements in brief

Chromium is frequently insufficient in diabetics, and they regain better glucose levels when supplementing with chromium, especially as picolinate at 100 – 600 mcg daily. One 28 year old T1D woman achieved a drop of her HbA1c from 11.3% to 7.9% over three months using 200 mcg three times daily. (Clearly 7.9% is still pathologically high as it would be best at 4.6%, like non-diabetics, but the drop is significant). Some herbs contain chromium in low amounts. These are: *Dioscorea villosa*, *Urtica dioica*, *Nepeta cataria*, *Equisetum arvensis*, *Achillea millefolium*, *Trifolium pratense*, *Glycyrrhiza glabra*, *Smilax officinalis*, *Basilicum spp.* Foods containing worthwhile amounts of chromium are: broccoli, poultry, beef, shellfish, and Brazil nuts.

Important comparison chart.

Please familiarise yourselves with the different units and norms of measuring blood glucose.

Chart 3 Comparisons of the various units and measuring methods of blood glucose

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HbA1c (% glycation)	HbA1c (mmols/mol)	Average blood glucose (mmol/L)	Average blood glucose (mg/dL)
13	119	18	327
12	108	16.5	298
11	97	15	267
10	86	13	240
9	75	12	212
8	64	10	183
7	53	8.5	154
6	42	7	126
5	31	5	97
4	20	4	68
3	9	2	40
2	0	0	12

Vanadium is slightly insulin mimicking, so it will be useful in T1D and T1.5D (LADA). Very little human research has been done and there are different forms, which may have opposite effects. Vanadyl sulphate appears to be beneficial at about 100 mg daily for a few weeks only. Foods and herbs that contain vanadium are black pepper, *Antheum graveolens fructus* (dill seed), *Petroselinum crispum*, shellfish, especially oysters, fish in general, mushrooms, spinach, dairy products, and olive oil.

Vitamin B3 – nicotinamide. This vitamin, necessary in energy production, protects pancreatic β cells from autoimmune destruction by maintaining NAD levels. The dose is disputed, so do some digging. It naturally occurs in poultry and fish and nuts, but an additional supplement may be very helpful.

Inositol has been helpful in reversing diabetic neuropathy, as has Vitamin B12 of course (especially the injectable methylcobalamin) and note that metformin appears to reduce B12 status somewhat. Inositol is found in meat, eggs, nuts, and seeds. B12 is in all animal products, but absorption is frequently impaired.

Vitamin B1 – thiamine supplementation reduces urinary albumin excretion and improves glucose responsiveness in T2D. Here is one paper on this: <https://pubmed.ncbi.nlm.nih.gov/19057893/>. Some people believe the fat soluble version of B1 (benfotiamine) is more effective. B1 is found in fish, especially trout, beef, shellfish, especially mussels, pork, black beans, sunflower seeds, and dairy products.

Magnesium is found to be low in most diabetics, so supplementation with a good bisglycinate or threonate version is more than sensible, along with eating more green leafy vegetables.



Taurine is often found to be low in diabetics, leading to greater blood viscosity, so a supplement may be of use. It is found in fish and shellfish, poultry, beef, and seaweed.

Vitamin B6 improves glucose tolerance, especially noted in gestational diabetes. It is in beef liver, fish, poultry, dairy, and nuts.

Other obvious candidates for supplementation - preferably naturally but via supplements if necessary - are Vitamin D, Vitamin C, Vitamin E (as tocotrienols, not as tocopherols!) manganese, and of course zinc.

And finally please read about the dangers of going hypo for insulin users: 'Hypoglycaemia: The Neglected Complication' Kalra S et al 2013: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3784865/>

Link to my blog for articles and recipes:
<https://rosemarycottageclinic.co.uk/blog/>

STOP PRESS!!

As the final copy of this edition of Herbal Thymes was about to be finalised and sent to our designer, Afifah contacted the team to alert us to a great presentation, just released, by a 17 year old who was diagnosed with Type 1 diabetes when he was 11. He gives a great little discussion of his story and some of the ins and outs, perfectly illustrating Afifah's comments on T1D in the article. This is fresh off the press, as it only came out three days ago! (16th October 2021).

Note, this young man works in American units, so Afifah's conversion chart is important.

One of the most important features is noted at 8:30 into the video - regarding failure of proper brain growth in children with high blood glucose, and is what Afifah would like to highlight to you.

Here is the link: <https://www.youtube.com/watch?v=QHnSNneh7ck>

If you are interested in this topic we would highly recommend that you watch this, maybe even watch it twice!

The site this comes from is a general low carb site from Australia, run by the great Paul Mason, who speaks at the end in a brief discussion with Prof Brukner.

And finally...

Whilst waiting for her document to go through our editing procedures Afifah also asked for, and received permission to use this image for publication in Herbal Thymes. It is from a Twitter user called Steve Bennett@_HealthResults and it has been refined by him following comments made by his twitter followers as he created it and put it out there for consideration. Afifah has requested it's inclusion as it touches on some of the things she wasn't able to include in her article. ❁

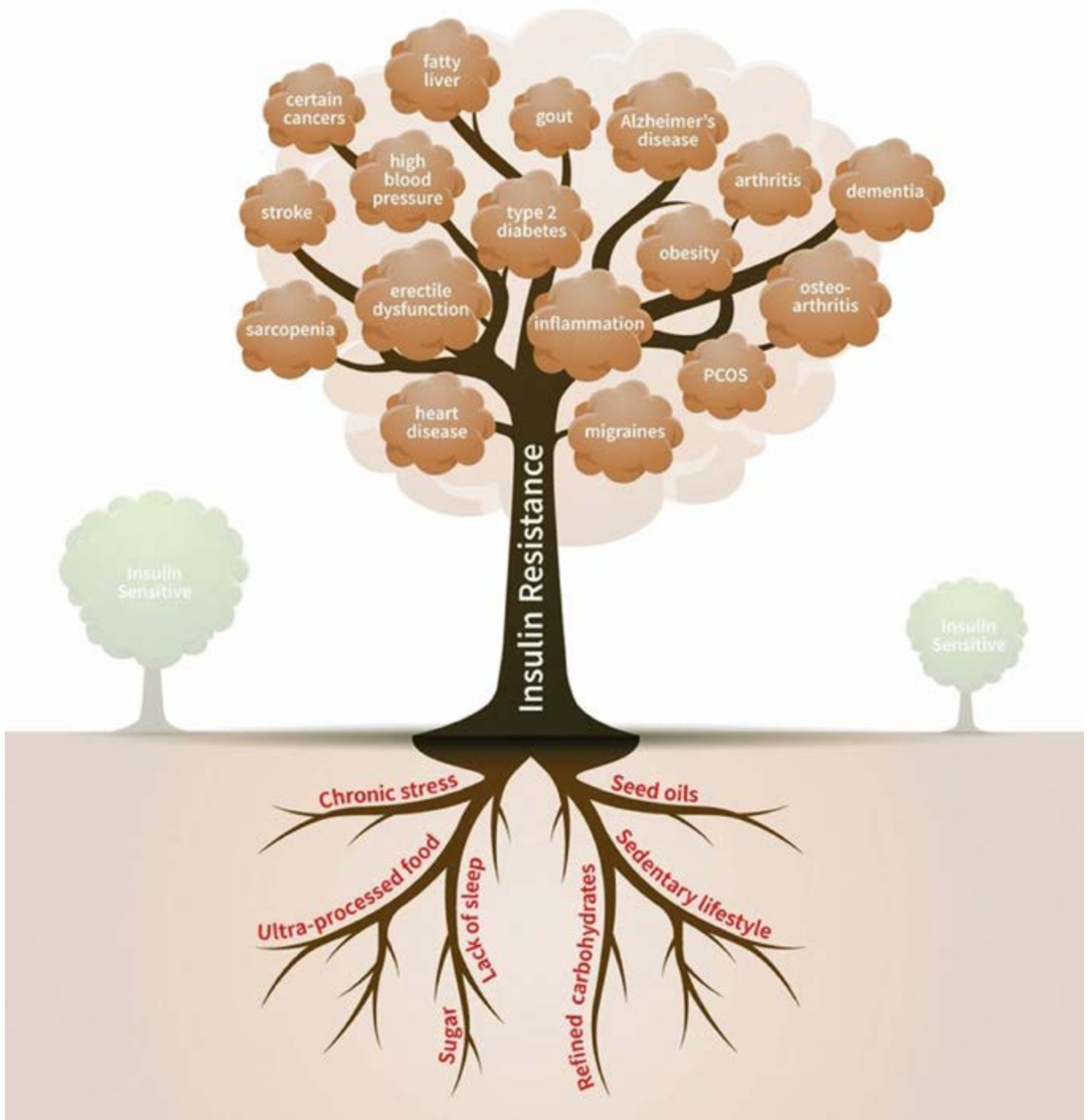


Image credit - Steve Bennett@_HealthResults®



What's growing near you?

The Herbal Thymes Team asked all our regional group coordinators for any updates they may have since our last edition. Here are the responses from some of our regional group coordinators.

CAMBRIDGESHIRE

Group coordinator for this region, Schia Mitchell Sinclair checked in with the Herbal Thymes Team to report that their September meeting was unfortunately cancelled and their next isn't due before our current deadline, so we can expect to hear what they have been up to in our next edition. We look forward to the next installment!

E.DORSET/S.WILTS/W.HAMPSHIRE

Gemma Wild, coordinator for this region, has asked us to remind members in this geographical region to get in touch. She would welcome a get-together of herbalists in this area either face to face or via Zoom if that is easier for people. Her contact details can be found in the information pages at the back of this edition.

INTERNATIONAL

Our international coordinator Kerry got back to us to report that unfortunately there is no further news from our Canadian or American members at this time but sends her regards.

Reports from our group coordinators have unfortunately decreased in recent months. With the lifting of restrictions, the team was hoping that we would have more stories coming in and not less. Many of us have felt the inertia I think in trying to get back into the flow of how things were before the pandemic, and it has been harder for some than for others to re-emerge in this post pandemic world we find ourselves in. The Institute is here to help where they can. If you are an existing member of a group that has struggled to start meeting up again, or if there isn't a group near you and would like to start one up please contact the Institute's office team at info@nimh.org.uk and they will help support you with this.

Meeting up with other herbalists I have found is very useful and it is quite comforting to be in a room where people truly appreciate what you have to say and speak the same language. Don't struggle on your own, help may be closer than you think! 🌿

Do you have any local news? Send your news, stories and updates to the Team at herbalthymes.org.uk. We would love to hear from you.



A role for herbal medicine in preventing the progression of prediabetes into Type 2 diabetes

By **Gina Webley** MNIMH

Prediabetes is characterised by an increase in blood glucose levels which are higher than the normal range but not sufficiently high to be diagnosed as Type 2 diabetes. A fasting plasma glucose concentration of between 5.5 mmol/L to 6.9 mmol/L and glycated haemoglobin HbA1c of 42 to 47 mmol/mol (6.0 to 6.4%) are indicative of poor blood glucose control and signs of a prediabetic state.

The condition develops gradually, and many people are completely unaware that they do not have the necessary tight control of blood glucose that occurs in healthy individuals. Alarming, 7 million people in the UK are estimated to have prediabetes.

Fortunately, if prediabetes is diagnosed early, it can be reversed, preventing progression into full-blown type 2 diabetes. Each year in the UK, 5% to 10% of people diagnosed with prediabetes go on to develop type 2 diabetes. Many GP practices are proactive in trying to identify those individuals with prediabetes in order to initiate changes that can significantly improve glucose control and prevent the long-term health problems associated with diabetes.

Drug treatment with the associated side effects is not an option in controlling blood glucose at this early stage. Instead, a change in diet and increase in exercise are key to reversing prediabetes. If combined with taking herbal medicines, the chances of early glucose control are increased. Herbal treatment provides support to the challenges of changing diet and maintaining lifestyle modifications and increases the chances of successfully and permanently bringing about normal blood glucose control.

The understanding of how diabetes develops and how it can be reversed has been greatly enhanced by the work of Professor Roy Taylor at Newcastle University.¹ His studies have shown that diabetes is the result of too much fat in the liver and pancreas. Insulin secreted by the beta cells in the islets of Langerhans in the pancreas act on the liver to control the uptake of glucose and therefore how much glucose is circulating in the blood. If excess fat has built up in the liver, it becomes less responsive to insulin and releases more glucose. This increase in blood glucose results in the conversion of excess glucose into fat and a build-up of fat in adipose tissue and crucially also in the pancreas. Excess fat in the pancreas prevents the insulin-producing beta cells from functioning correctly. The beta cells become unable to respond to rising glucose levels or secrete sufficient insulin to control the glucose levels. Comprehensive studies have shown that weight loss that leads to loss of fat in the liver and pancreas results in a return to normal function for insulin release, liver insulin response, and glucose control.



There are recent clinical trials that demonstrate the benefits of taking herbal medicines to improve glycaemic control in prediabetes. Of particular interest in light of the role of a fatty liver as a predeterminant for poor glucose control is a study which looked at the action of silymarin on liver damage and glucose control in prediabetic patients.² The incidence of non-alcoholic fatty liver disease (NAFLD) was much higher in prediabetic individuals. Of 212 prediabetic patients, 104 followed a Mediterranean diet for 6 months and 108 followed the same Mediterranean diet together with a supplement of silymarin extracted from *Silybum marianum* and *Morus alba*. Those on the Mediterranean diet showed a significant decrease in measures of liver damage and HbA1c ($p < 0.001$) and those taking the silymarin supplement showed a further significant decrease ($P < 0.001$) compared to the diet alone. The study demonstrates the link between a fatty liver, liver disease and prediabetes, and the benefits of both diet and silymarin on reversing liver damage and improving glycaemic control.

Prediabetes is often accompanied by lipid abnormalities as well as insulin resistance, impaired fasting glucose, and impaired glucose tolerance. *Aloe vera* improved both glucose and lipid profiles in prediabetic subjects in a randomised controlled trial³ demonstrating the link between glucose and lipid control. Fasting blood glucose (FBG) levels significantly decreased after taking 300 and 500 mg *Aloe vera* for four (respectively: $p = 0.006$ and $p = 0.001$) and eight weeks (respectively $p = 0.002$, $p < 0.001$) compared with those of the control group. Also, HbA1c levels in both case groups had a significant decrease in the eighth week of the study (respectively, $p = 0.042$ and $p = 0.011$). Measurement of the lipid profile showed that taking 500 mg of *Aloe vera* for eight weeks significantly decreased cholesterol ($p < 0.001$), LDL ($p = 0.01$) and triglyceride ($p = 0.005$) while HDL levels in the group increased ($p = 0.004$). Use of *Aloe vera* extract in prediabetic patients can therefore significantly regulate levels of fast blood glucose within four weeks and revert lipid profile levels within eight weeks.

Cinnamon, the bark of *Cinnamomum* spp, has been shown to reduce blood glucose and improve insulin signalling in a number of clinical and animal studies. In a metaanalysis of diabetic and prediabetic patients,⁴ cinnamon significantly reduced FBG and a homeostatic model assessment for insulin resistance (HOMA-IR) levels compared to placebo. A recent clinical study looked specifically at the action of cinnamon in improving glycaemic control in individuals with prediabetes.⁵ The study showed that 12 weeks of taking 500 mg of cinnamon three times a day improved FBG and glucose tolerance. From a similar baseline, FBG rose after 12 weeks with placebo but remained stable with cinnamon, leading to a mean between-group difference of 5 mg/dL ($P < .05$). There was also a moderate decrease in HbA1c, indicating a long-term impact on glucose control.

A role for fenugreek (*Trigonella foenum-graecum*) in preventing the development of type 2 diabetes has been studied in people with prediabetes.⁶ To determine the long-term benefits of taking fenugreek, the study was carried out over three years. A group with prediabetes (66 subjects) took 5 g of fenugreek powder twice a day and the effects were compared with matched controls (74 subjects). Measurements were taken every three months. In the fenugreek group there was a significant decrease in FBG ($P < 0.05$) and postprandial plasma glucose ($P < 0.01$) at the end of the three years. The lipid profile showed a significant decrease in LDL ($p < 0.05$) in the fenugreek group



and serum insulin levels had significantly increased in the group ($p < 0.01$) by the end of study period. In the study the controls had a 4.2 times higher chance of developing diabetes compared to subjects taking fenugreek.

Gymnema sylvestre has long been known for its hypoglycaemic effects. An investigation⁷ was carried out to determine the effect of gymnema administration on glycaemic control, insulin secretion, and insulin sensitivity in patients with impaired glucose tolerance. Fifteen patients randomly received gymnema in doses of 300 mg twice a day and another 15 received placebo. There was a significant reduction in 2-h oral glucose tolerance test ($p = 0.003$), HbA1c ($p = 0.025$), and LDL cholesterol levels, and increased insulin sensitivity in the gymnema group. At the end of the study, 46.7% of the patients taking gymnema had normal HbA1c values.

The benefit of combining herbs with known antidiabetic action in a polyherbal formula is being investigated in a clinical trial⁸ in prediabetic subjects. The herbs in the formula are cinnamon bark, banaba leaf (*Lagerstroemia speciosa*), kudzu root (*Pueraria lobata*), fenugreek seed, gymnema leaf, American ginseng root (*Panax quinquefolius*), and berberine derived from the bark of *Berberis aristata*. The study is designed to monitor 12-week changes in short-term, medium-term, and longer-term markers of glycaemic function, by measuring fasting blood glucose and fasting insulin (short-term), fructosamine (medium-term), and HbA1c (longer-term). Measurement will also be made of insulin resistance, β -cell function, insulin sensitivity, lipid profile, inflammation (high-sensitivity C-reactive protein) and progression to type 2 diabetes.

A study⁹ using a polyformula of Ayurvedic herbs for prediabetics has already



been completed. The formula consisted of *Tinospora cordifolia*, *Pterocarpus marsupium*, *Gymnema sylvestre*, *Zingiber officinale* and *Momordica charantia*. These herbs have been shown individually to be effective as hypoglycaemic agents, and to decrease insulin resistance. Treatment of participants with this formula resulted in a 47% risk reduction in developing types 2 diabetes and significant decreases ($P < 0.001$) in their blood glucose level (fasting and postprandial), HbA1c, fasting serum insulin and HOMA-IR values.

These clinical trials provide clear evidence of the action of individual herbs and polyherbal formulas in improving glucose control in prediabetic patients. The need for this herbal action is very evident. The incidence of prediabetes is increasing due to consumption of high-calorie food and decreasing levels of physical activity. It poses a threat not only from the increased risk of developing type 2 diabetes but also the risks of the prediabetic state itself including microvascular and macrovascular disease. Combining crucial lifestyle changes with herbal medicine treatment provides a real opportunity to reverse poor control of blood glucose and to prevent the development of type 2 diabetes and the associated long term health problems. ❁

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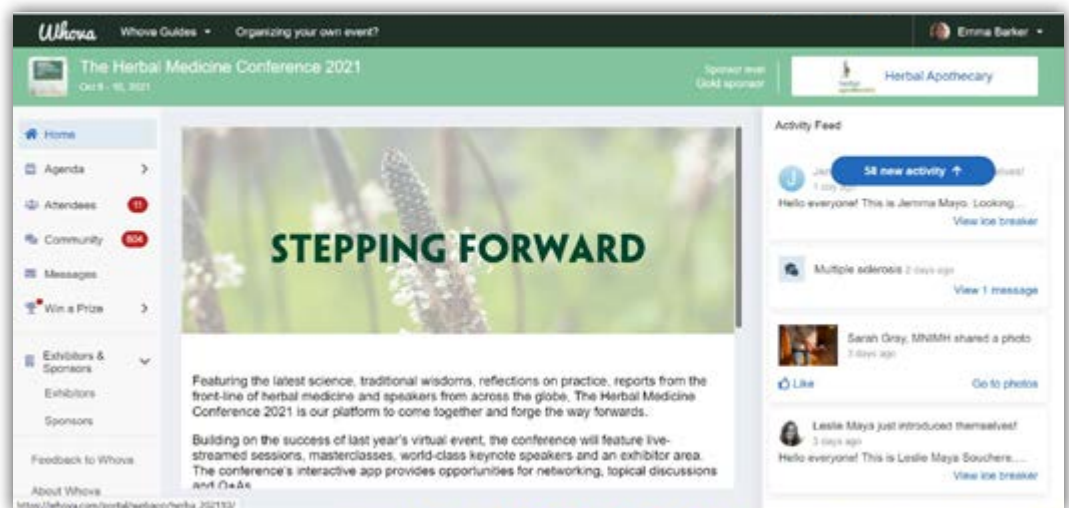
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HMC 2021 – Stepping Forward

By **Emma Barke** MNIMH

The Institute's Herbal Medicine Conference for 2021 was another huge success following on from last year's superb event. Hosted again online using the Whova platform, the Institute welcomed 35 speakers and over 500 attendees from all corners of the globe, with ticket sales still ongoing. Due to everything either being pre recorded or recorded live on the day, everything can be accessed subsequently, meaning that delegates can still benefit from the weekend's content in the coming weeks and months. Those of you that already have tickets now have access to the Whova platform for the next six months which gives you plenty of time to watch, rewatch, download notes, and have a chance to fully absorb everything. With some sessions running side by side this also allows attendees to enjoy the sessions they would otherwise have missed at an in-person event. This also means that if you couldn't attend the actual conference weekend this year, it's still not too late to do so!

Screenshot of the conference home page on Whova.



Conference Community

Conference for many who attend is an ideal opportunity to meet up with old friends, make new ones and have conversations with others who you may not have otherwise met. Whilst it may not always be as fun as actually meeting people in person, the Institute's virtual conference still allowed for plenty of networking, meet-ups and general discussion and collaboration between attendees, speakers and exhibitors. It was a real hive of activity that continues to bubble away. Whilst activity on the Whova site has decreased since the main event, as people dip in and out conversations are continuing.



SOME OF THE SPEAKERS WE HAD AT THIS YEAR'S EVENT.



Nat Mady



Adrian McDermott



Jekka McVicar



Claudia Manchanda



Anne McIntyre



Simon Mills

As part of the ongoing discussions I created a space on Whova for attendees to forward their comments to to share with the readers of Herbal Thymes. I asked 'What have you liked about this year's conference? What have been your highlights? Is there anything that you've not enjoyed? Have you any suggestions on future content, or how it could be done better?' Here's the response thread these questions created -

Kathleen Jones

Hi Emma, I really enjoyed Rasheeqa Ahmad's talk regarding her work and community herbalism. Thanks very much, Kathleen

Emma Barker

Thanks Kathleen. That talk resonated with me too. I would love to do more of this, but have found it difficult to get the right balance of paid 'work' and voluntary contributions to such projects. It would be nice to be able to do these things whilst earning decent money which is often not the way these things turn out. Rasheeqa's work is an inspiration, along with the work of so many herbalists working in this way.

Hannah Rose

A fantastic opportunity to network and connect with other like-minded people. Anne McIntyre's garden was beautiful and has given me a lot of food for thought with regards to a local community project.

Emma Barker

Yes @Hannah Rose! I started designing and planting my own herb garden this year. It's nowhere near the scale of Anne's garden, but seeing hers has given me loads of ideas!

Aude Echaliér

@emma Barker I was wondering if we could have a series of interviews or exchanges with conventional medics and other complementary therapists. It would be nice to learn how they see medicine and we all could work in an integrated healthcare system (might not be popular with everyone, but I would certainly find it fascinating)

Elena Renier

Enjoyed every part of this long weekend. I prefer the live talks and hope next year there we will be given the option to meet up in person.

Emma Barker

@Aude Echaliér this has already begun! 😊 Please check out the recorded session released on Saturday at 3:30pm with the Herbal Doc's. There was also a live Q&A session which I believe was also recorded, I can't seem to find it but guessing it will be uploaded in due course xx

Aude Echaliér

@Emma Barker absolutely! It was great to see that the Docs were invited to speak! It would be great to see more of these interactions and perhaps medical herbalists invited to speak in medical conferences next!

Emma Barker

@Elena Renier conference will remain online as it enables the Institute to connect better at an international level. As @Robyn Soma explained in her closing speech, the Institute is very keen to host a face to face event next year as I think we all like to socialise in person when we can. Keep your eyes peeled for the announcement of this new event due to take place next July 😊 xx Yes! @Aude Echaliér I agree 👍

Kerry Harvey

As a student visiting the conference for the first time, it was truly inspirational. Such a variety of passionate people and projects focusing on healing. Thank you to everyone involved, it's been an amazing event. Plus we get to enjoy it for another 6 months!

Emma Barker

I know right!? @Kerry Harvey Having access to everything after the event is really useful 😊 So pleased that enjoyed your first conference, lovely to have so many students here 💜 🌿 xx

It was so nice to meet new people and hear what they had to say. Thank you to those who contributed to this thread, your participation is much appreciated.

Behind the Scenes

I hope those of you who attended the conference will agree that from the front of house seats, the weekend was delivered seamlessly with live streams and recorded content being broadcast according to the agenda, with our conference team on standby should delegates require any help and support accessing these. Regular updates and announcements from our organisers highlighted any changes or potential issues, keeping attendees informed at all times.

The conference team did an amazing job, so on behalf of the Institute Council - Thank you! Not just for the time spent supervising and contributing during the conference weekend itself, but also for all the hard work and effort put into planning and organising this event on our behalf. You are all truly amazing and words cannot fully express our thanks. I would also like to take this opportunity to thank our Gold sponsors Herbal Apothecary for supporting the event and for the generosity of Avicenna who also donated various prizes to our competition winners. Thank you!

I would like to share with you some of the feedback from the conference team and illustrate some of the challenges that our team faced. I think that the biggest challenge was that the internet connection to our head office in Exeter went down on Thursday afternoon, less than 24hrs before the conference was due to begin! With everything planned and set up at the office ready for commencement of the weekend's activities, this was really bad timing! It certainly threw a rather large spanner in the works, with our team having to react quickly to ensure that conference went ahead as planned.

I spoke to Jenna Chynoweth, our newest member of staff, to ask her about her experiences of her first herbal medicine conference. She replied, "I really enjoyed being a part of it. It's true that we experienced some fairly major Internet problems the day before the event went live. James (our Chief Executive) and I ended up decamping to our respective homes in order to pull the final stages together and ensure a smooth delivery. James also (rather amazingly) managed to find a workspace for us to use on all three days which was located on The Quay in Exeter. We couldn't rely on the Internet in the office and so the only other option would have been to run the conference from our homes. However, the shared space worked really well and James' wife, Jemma was amazing and a huge help. I was very keen to soak up Jemma's experience from last year's conference! With fantastic leadership and teamwork, we pulled out all the stops to try and make the conference a success and it's so nice to receive feedback from the attendees."

I think that delegates will agree that we had no idea that all this happened the afternoon before the conference launch! Cool, calm, collected and always professional, qualities that we can always expect from our Exeter Team. Bravo to you all! ❀



Exhibitors



Aven Books

www.aeonbooks.co.uk

Avicenna
Herbal Products ^{LTD}

Avicenna

www.avicennaherbs.co.uk



Earthsong Seeds

earthsongseeds.co.uk



Hannah Grace

hgraceoc.com



Herbal Apothecary

www.herbalapothecaryuk.com



Herbal Reality

www.herbalreality.com



Into the Wyld

www.intothewylde.com



Jekka's

www.jekkas.com



**THE NATIONAL INSTITUTE OF
MEDICAL HERBALISTS**

www.nimh.org.uk



Planta Medica

www.plantamedica.co.uk



Prisso Ltd

www.prisso.com



The Herb Society

www.herbsociety.org.uk

The Herbal Medicine Awards 2021

Huge congratulations go to all our award winners this year, we have some truly amazing and inspiring herbalists amongst us! It is lovely to see so much innovation, passion and creativity within the herbal community. Long may it last!



The Christopher Hedley Memorial Award Winner - Mel Hornby

Mel qualified as a Medical Herbalist after completing a 5-year degree in Herbal Medicine in 2007. As a little girl, she would gather flowers and plants from the garden and attempt to make them into medicines using a homemade pestle and mortar (a bowl and dolly-peg!) then try to administer them to her unwilling family.

Because she would have loved to have been taught which plants were safe to use, their healing properties and also how to make 'real' plant medicines, Mel established and has taught the Junior Herbalist Club (JHC) program since 2013, which is now proudly supported by the National Institute of Medical Herbalists. As well as running a busy clinic in Lancashire, Mel still regularly teaches the JHC program, the JHC leader training course and herbal workshops for adults.
<https://nimh.org.uk/jhc-course-leaders/>



Innovation in Practice Award Winner - Kathie Bishop

Kathie is a medical herbalist, clinically specialising in vaginal health, and the founder of the award winning intimate pleasure brand Into the Wylde. Into the Wylde's debut product is a herb and water based intimate lubricant, Wylde One is registered with the Vegan Society as vegan, and with The Soil Association as organic. Wylde One won in the Feminine Care category of the Janey Loves Platinum Awards September 2020.

She works one a day a week clinically, online and dispenses for her clients from her dispensary at home. The rest of the working week is dedicated to Into the Wylde, where she enjoys interacting with the online community, liaising and building connections with retailers, nurtures the practitioner group and runs the post room, among many other things! Kathie has also just finished writing her first book which will be published by Aeon Books mid 2022.

Kathie graduated from The University of Westminster, London in 2009 with a first class BSc (Hons) degree in Western Herbal Medicine. She has additional qualifications in Bach Flower Remedies, Mizan Abdominal Massage, Ceremonial Cacao, and Gong. Kathie is also a member of the British Herbal Medicine Association (BHMA) and a member of the Institute.

<http://www.intothewylde.com>

<http://www.thewyldeherbalist.com>

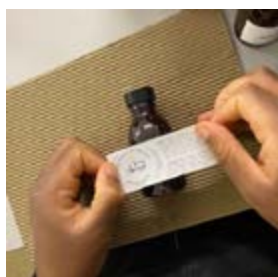




Herbalism in the Community Awards – UK Winner Wester Hailes Community Herbal Clinic

Wester Hailes Community Herbal Clinic are an Edinburgh and Glasgow based workers' co-operative. Their central philosophy is that herbal medicine is the medicine of the people and should be accessible to everyone. They offer a series of practical courses and workshops and support students with their clinical hours

They also grow herbs in the Blackford Glen Medicine Garden and produce resources to enable people to practice herbalism at home. Earlier this year, they formed a collaboration with Nikki Darrell and Alex Duffy of the Plant Medicine School in Ireland in order to create the Plant Medicine School Scotland. They are awarded a prize of £350 as well as some herbal goodies from Avicenna.



Herbalism in the Community Awards – UK Runner-Up The Mobile Apothecary

The Mobile Apothecary is a collaboration between Phytology, Rasheeqa Ahmad of Hedge Herbs and a growing network of talented volunteers spanning the areas of arts, herbalism, and horticulture. Since April 2019, they have been bringing people together to collectively learn about medicinal plants and create herbal medicine for distribution to fellow community members facing barriers to health, food and shelter. They believe that human health and planetary health are intertwined, and that people have the right to basic knowledge and skills in herbal medicine and medicine-making

The Mobile Apothecary supports underserved communities in the locality with good quality, homegrown and communally-made herbal remedies and they have won a runner-up prize of £150 and some herbal goodies from Avicenna.



Herbalism in the Community Awards – International Winner Dublin Herb Bike

The Dublin Herb Bike is a mobile clinic providing free, herbal care and comfort to communities in need around Dublin

The project is the combined effort of herbalists, health workers and communities who are rolling up their sleeves in order to provide holistic support to those who need it most. The Dublin Herb Bike built their project from the street up, creating their own medicines, building their kits and fitting out their bike. They have been awarded £350 as well as some herbal goodies from Avicenna.



Herbalism in the Community Awards – International Runner-Up Herbalista Herbal Clinic

Herbalista recognises healthcare as a fundamental human right. They sponsor health services and herbal education through a variety of programs, empowering people to care for themselves and their neighbours. They believe that true healthcare is based on a foundation of mutual respect and mutual aid–solidarity, not charity

Herbalista Lorna created her first mobile clinic in Atlanta and has since shared this model of care with herbal communities across the US, Ireland and the UK. They have won a runner-up prize of £150 together with some herbal goodies from Avicenna. 🌿

**Congratulations
everyone, well
deserved!**

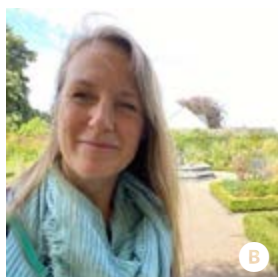


Congratulations to all of our student award winners! We certainly have some amazing talent within our herbal schools at the moment. Best wishes to those of you who have recently graduated and are starting out on the next chapter of your herbal careers, and for those of you who are yet to complete your herbal training - good luck with your studies and keep up the great work!

Phyto Products Award for Pharmacology

Jo Webster, Betonica A

Jo achieved the highest grade (91%) for her Pharmacology Assignment in year 4



Henry Potter Award for Best First Year Student

Laura Evans, Betonica B

Laura scored the highest marks in the year 1 written exams. She also set up and led a weekly herb tea tasting event over Zoom during lockdown



The Rutland Biodynamics Award for Innovation (in memory of Nigel Wynn)

Tryphena Huntingford, Betonica C

Tryphena has established an organic herbal tea business called Harpford Farm Herbs - <https://harpfordherbs.co.uk/>

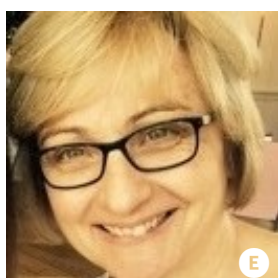
As well as producing a range of excellent tea blends she hosts open days and group visits with tours of the growing areas. She has produced excellent signage for all of the herbs which contains information for the visitors on the different herbs and the benefits of herbal medicine



The Arthur Barker Best Graduate Award

Alice Johnston, Heartwood D

Alice clearly demonstrated impressive practitioner-level skills and clinical reasoning in her Final Clinical Exam and throughout her studies



Outstanding Final Year Student Award

Clare Dimitrou, Heartwood E

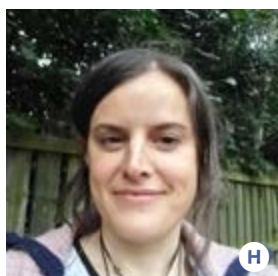
Clare consistently demonstrated high levels of attainment across the breadth of her final year of studies, as well as integrating her knowledge clinically

**Herbs in a Bottle Award for Pharmacy****Claudia Germana, Lincoln College** F

This prize has been won by Claudia Germana for her innovative product that she made in the first year of her studies. An excellent report on the process was also written. Well, done Claudia

**Arthur Barker Award for Best Graduate****Abi Jackson, Lincoln College** G

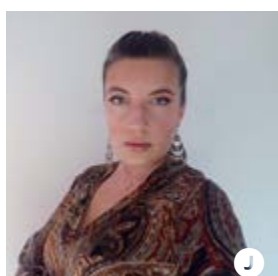
An outstanding student in all aspects of her degree. Abi has a cheerful disposition and was positive and encouraging throughout her training, producing excellent work throughout. She will no doubt become an outstanding herbalist - well done Abi!

**Dorothy Carroll Award****Claire Parkinson** H **and Wendy Sullivan** I (joint winners),
Lincoln College

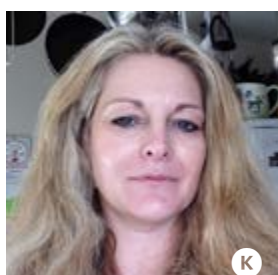
This award goes jointly to two students, both of whom have excelled in their final exams, and we were very impressed with their skills and herbal knowledge. Well, done Claire Parkinson and Wendy Sullivan

**Henry Potter Award for Best First Year Student****Georgina Chloe Paterson, The School of Herbal Medicine** J

Georgie Paterson has received the Henry Potter Award for the Best First Year Student as she has accumulated the highest marks across the board in her first year

**Panacea Health Award for Materia Medica****Deborah Davies, The School of Herbal Medicine** K

Debbie Davies has received the Panacea Health award for Materia Medica as her work in this subject has been outstanding 🌿





Junior Herbalist Club

By Emma Dalton

MEL HORNBY'S JUNIOR HERBALIST CLUB

The Institute was honored to have Mel speak at conference about this amazing initiative she has developed and is now sharing with qualified herbalists who are wanting to teach children about herbal medicine. Emma Dalton was a member of the first cohort of Junior Herbalist Club Leaders trained by Mel and who graduated this July. She has kindly written us this piece detailing more about this training and what it involves. Enjoy!

Have you ever wanted to teach children about the amazing healing properties of herbs but been overwhelmed as to where to start? If you have a passion for plant medicine and want to teach children, then this is the course for you.

The Junior Herbalists Club is a creation belonging to Mel Hornby who has been running the course in Lancashire for the last 8 years. She developed the course in response to local demand and although originally was a one-year course; demand from the first-year graduates for a second year led to the course design that it is now.

Mel has a fabulous local park that has been winning awards for some years. In 2018 it won Best Park in the UK and special mention was made of the Junior Herbalists Club (JHC). Originally Mel started teaching classes outdoors as she did not have anywhere under cover. Then as funding was applied for, an ecopod was purchased which is home to not only the Junior Herbalist Club but also Forest School, Beach School and yoga amongst many other community courses.





The facilities in the park for children and adults is phenomenal and has a kitchen garden growing many of the herbs for the course tended to by a team of volunteers.

The training of the first cohort of Junior Herbalist Club leaders was delayed by a year due to the pandemic but finally in July 2021, Emma Dalton, Kate Parker, Sandra O'Neill, Chantal Perkins, Elizabeth Alderson met in person with Davina Hopkinson joining us on Zoom.

We spent a week channelling our "inner 8 year olds" by being taught each lesson to learn how to gauge the language to the appropriate age being taught. The course is primarily aimed at 7- to 12-year-olds however children can be younger provided they are accompanied by an adult to support them. Mel has found many parents enjoy staying to help and that this is a useful resource when teaching.

Each session lasts 90 minutes and there are 10 sessions in each year. The curriculum is progressive and spiral which helps to consolidate information over the course of the programme.

The first lesson starts with a gentle introduction to herbs and the children are given the history and description of lavender and shown how to make lavender bags, lavender sugar, and lavender lemonade whilst learning about botany and plants.

Over the 2-year course of 20 sessions, lemon balm, chamomile, cinnamon, liquorice, calendula, chickweed, cleavers, nettles, elderflower and elderberry, plantain, marshmallow, aniseed, comfrey, rose, sage, dandelion, daisy, rosemary and peppermint are all introduced to the children.



The children make lots of different products with varying levels of difficulty culminating in making a hydrosol (something I never got taught at University!).

The beauty of the training is that Mel has done everything for you. As part of the training package you receive a comprehensive leaders handbook containing all the class plans and worksheet answers and a USB stick with all the printable materials you need including risk assessment forms, flyers, parent information sheets, booking letters and forms, enrolment documents, attendance register templates as well as feedback forms.

The Junior Herbalist Club is supported by the Institute and The Herbal Trust (The NIMH Education Fund) and talks are ongoing with both Avicenna and Planta Medica for further support for the leaders in supplies. The Herbal Trust has given a financial grant to each junior herbalist leader to help purchase equipment which has been hugely appreciated.

Mel has recently been the recipient of the 2021 Christopher Hedley Award in recognition for her innovation in developing and delivering this project.

The dates for the next Junior Herbalist leader training course have now been released on a first come, first served basis: Monday 16th May to Friday 20th May 2022 inclusive. 🌿

**For more information contact Mel Hornby MNIMH on 07813 840394 or melhornby@live.co.uk
<https://namasteherbalhealing.co.uk/junior-herbalist-club-2/>
<https://nimh.org.uk/event/junior-herbalist-club-leader-training/>
 Get booking; you won't regret it!**

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email updates

Herbal medicine and
the coronavirus

LOCAL COVID-19
RESTRICTIONS
23/10/2020

NEW GOVERNMENT
RESTRICTIONS IN ENGLAND

have added summary guidance
to the Hub to support

**DON'T FORGET TO SIGN UP TO GET NEWS STRAIGHT
TO YOUR INBOX**

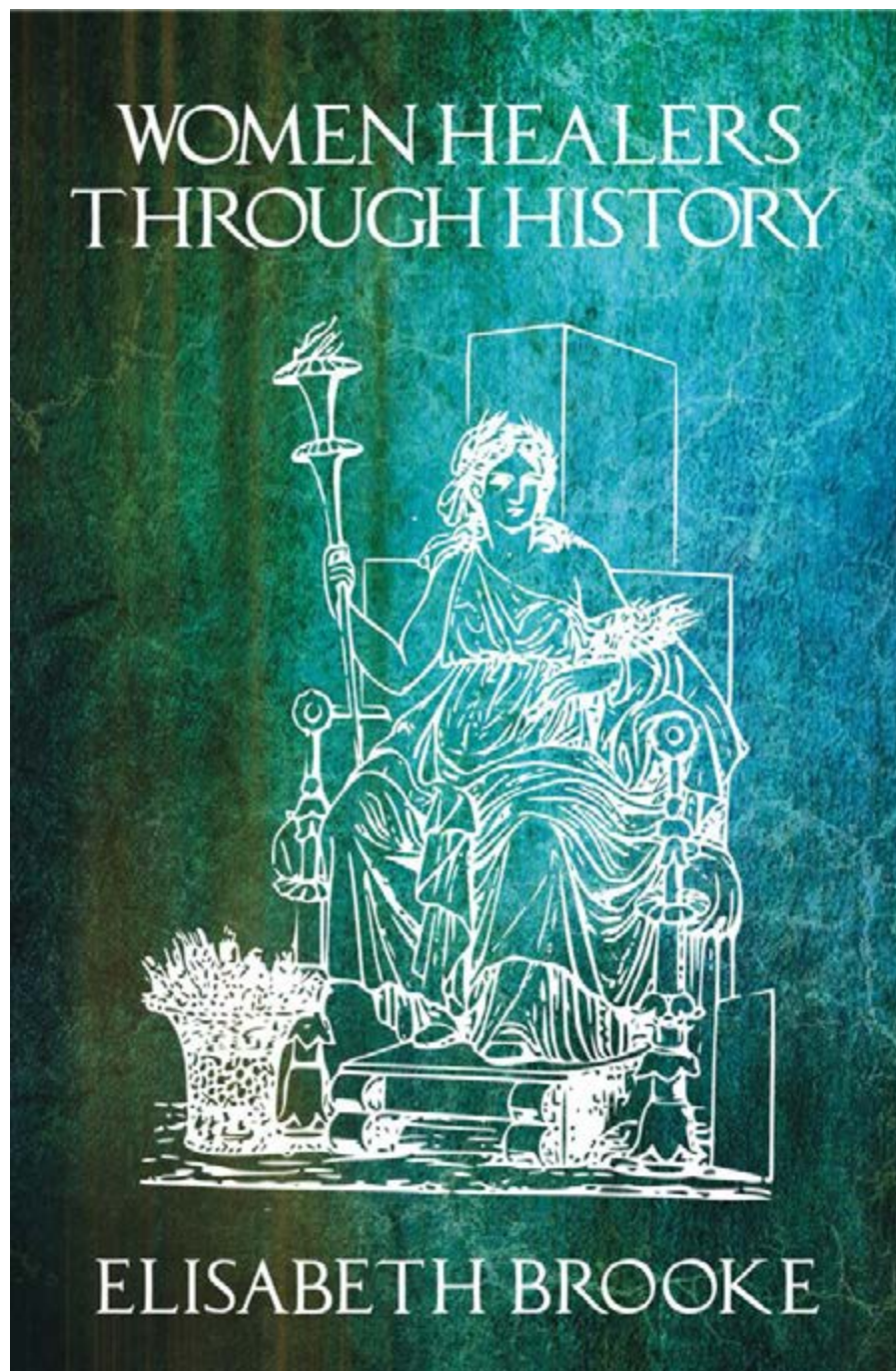
You can now register for regular email news updates
on the 'Member News' page of our website:



Competition Winner!

Congratulations go to Anna Animelli who won a copy of Elisabeth Brooke's book *Women Healers Through History*. Your prize is currently winging its way to you in Italy, enjoy!

Thanks also go to Frances Watkins MNIMH, our very kind and generous member who donated the prize for this competition. Much appreciated.



Vacancy for a new Student Editor

We still haven't filled this position yet so please do get in touch if you think that this might be something you are interested in doing.

Have you experience or a background in journalism or publishing? Or maybe just an interest in reporting, writing, or curating informative news, reviews, and features? If so, then maybe this is something you would be interested in.

Working as part of a team you would be responsible for preparing material representative of our student membership for each quarterly edition of the Institute's Herbal Thymes publication. Content for the student pages of each edition can be completed with any items thought appropriate, and of potential interest to your fellow herbal students and members of the Institute. This can be achieved by producing work yourself and/or organising and collecting content from within the herbal student community.

You will need to have good communication and IT skills, be able to work on your own initiative as your work is primarily self-driven, and be able to meet strict deadlines. The HT Team works virtually on Google Workspace and uses Google Drive to collaborate, edit, and form final copies of editions before they go to our designer. Prior experience therefore of this software, or something similar, is desirable but not essential as training will be given where necessary.

That all sounds good, but I've never done anything like this before and I'm not sure if I can do it?

Not to worry! You will be supported and guided by the existing Team who will do all they can to help you settle into your new post. It can be daunting to take on new challenges, but we will do our best to make this an enjoyable experience that will help grow your confidence and experience. Our current Student Editor has already offered to produce a piece for the next edition of HT to help relieve unnecessary pressure on the incoming person to this position, and to ease the transition period.

I already like what I read in the student pages of HT, but I also have other ideas. Will I have the opportunity to grow these ideas into a reality?

The HT Team welcomes new thoughts and ideas and strives to embrace an individual's passion and enthusiasm in whatever form that may take. All realistic changes and proposals are always open to discussion and we encourage all members of the Team to participate in these. Any proposed major changes would need to be approved by the Institute's Member Support Committee, under which the HT Team sits within the Institute's governance structure, but minor changes and the general content of our publications are managed and curated by the HT Team, so new items and ideas may be trialled at any time.

I would like to do this, but I don't think that I have the time to commit to such a project.

It is often difficult to estimate the amount of time such a role requires as it depends on the person conducting the duties of such a position. We don't foresee that this post would need more than five hours per edition, so twenty hours a year, or just over an hour and a half each month when you break it down. It may also be possible to complete this work in a shorter time frame depending upon how quickly you work. As with anything, if you manage your time well, then we believe that this can be scheduled in line with your student workload. If you are writing some material yourself, then treat it as another essay or clinic report and add it to your timetable. If you are collecting articles and input from your fellow students then allow time to reach out to your contacts, explain what you require, and then add further time to remind and chase work when deadlines loom. Additional time may only be required if you have a new project you would like to launch, and that would only be until the campaign had completed its initial trial and lessons learnt of how to manage it better in the future if there are any teething problems that need to be overcome. So, time considerations really come down to you, and depend upon what you want to get out of being in this position.

What will I gain from taking on this responsibility?

The Institute relies on the help and support of its members, and whilst it provides a stable vehicle to get members from A to B it needs the power and energy of its membership to fuel the journey. By joining the Institute Team as a student, you get the opportunity to gain knowledge and experience of what being a member of the Institute truly is. You will get to grow working relationships and make friends with other members who volunteer their time and effort to benefit the wider herbal community. You'll get to experience the family feeling you will benefit from should you choose to join the Institute upon graduation, as you become a valuable part of a hard-working team that respects, values, and supports one another. And finally, you'll gain confidence in a supportive and nurturing environment. Taking on new challenges can often show us what we are capable of, and inspires us to do things that we had never even dreamed of doing before. This opportunity could be a platform from which to achieve newly found goals and aspirations.

If you would like to apply for the role of Student Editor then please send a letter of interest to the main Institute office at info@nimh.org.uk. Many thanks.



INFORMATION PAGES

REGIONAL GROUPS

What's growing near you?

The Institute has many regional groups and we are keen to get more of these in place as it is important that members have a place to share ideas and knowledge, discuss concerns, and help each other with challenging patients. Being a herbalist can often be a lonely profession and whilst many of us have virtual means of doing everything mentioned, it is nice to be able to interact with fellow practitioners face to face when we are able to.

Some of our groups meet on a regular basis and some only ad hoc. Find out if there is a group near you and contact the group leader to find out more -

CAMBRIDGESHIRE

Schia Mitchell herbalist@cambridgeherbalist.org.uk

DEVON

Sara Hills sarajanehills@gmail.com

E. DORSET/S. WILTS/W. HAMPSHIRE

Gemma Wild gcwild@doctors.org.uk

HAMPSHIRE/E. SURREY

Kate Parker kate@horsechestnutherbals.co.uk

NORFOLK

Val Thomas herbs.val@gmail.com

SURREY

Caroline Galloway herbalist1@btinternet.com

SUSSEX WEST

Emma Baynes emmaherbalist@hotmail.co.uk

WEST MIDLANDS

Anne Chiotis annechiotis@outlook.com

SHEFFIELD

Calder Bendle muddycrow@gmail.com

SOUTH WALES

Mark Jack mark@markjack.co.uk

INTERNATIONAL

Kerry Hackett info@kerryhackett.ca

Not a group near you? Or are you interested in starting up your own group? In either case get in touch with the Institute office who can help you find members near you or get your group listed here in our next edition to attract new members.

WE WANT TO HEAR FROM YOU

Have you read any interesting books lately, picked up some research that you started as a student, or maybe visited somewhere that you think would be of interest to your herbal family? If so please send in your news, articles, photos or anything else herby to [**herbalthymes@nimh.org.uk**](mailto:herbalthymes@nimh.org.uk)

Get your mail to us before **JANUARY 10th 2022** to be included in the Spring edition of HT.

ADVERTISING RATES

Herbal Thymes – rates per issue	Member	Non-Member
Classified advert	Free up to 25 words (+20p per extra word)	£10 up to 25 words (+30p per extra word)
Display advert Non-NIMH business with no financial gain eg job vacancy		
Full page	£75	£150
½ page	£40	£80
¼ page	£25	£50
⅛ page	£15	£30
Display advert for Non-NIMH business with potential financial gain/commercial businesses		
Full page	£90	£180
½ page	£50	£100
¼ page	£30	£60
⅛ page	£20	£40

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Jo Webster MNIMH



What was your journey into herbalism?

My journey was circuitous. Despite a lifelong love of nature, my first career was as a London property lawyer. Parenthood led me to study nutrition which, via setting a Guinness World Record for a very large batch of sauerkraut, led me to Betonica School of Herbal Medicine.

Tell us about your practice.

My practice is expanding steadily. I work from home and grow and process increasing amounts of my own herbs. My practice revolves around my knowledge of nutrition, herbs and microbes. I see a broad range of people from the young to the elderly, experiencing a wide range of health issues.

How would you describe your approach as a herbalist?

I aim to understand each client deeply, so that I can work with them to craft the best support possible to achieve their health goals. I am anything but formulaic and I use herbal medicine alongside nutrition, always with the far-reaching influence of gut health in mind. I am rigorous, but also down to earth (with a keen sense of humour).

What's your 'Hero Herb'?

Lobelia inflata. It is one of the first medicinal herbs I grew from seed and my first experience of chewing a leaf serves as a lasting reminder of the sheer potency of the medicinal herbs with which I have the privilege to work.

Do you have a top tip for diet or lifestyle?

Don't believe 95% of the stuff you read on social media. If you have a health issue that is affecting your quality of life, find someone qualified to work with you to find achievable, effective and safe solutions.

If you could change one thing about being a herbalist what would it be?

I would immediately create multidisciplinary health centres countrywide, where people could see nutritionists, doctors, osteopaths, herbalists and other practitioners in one place in a system that recognised the value of each discipline's contribution to health without one model dominating.

Who are the people who have influenced you the most?

My husband, who has supported me and my commitment to this vocation despite the significant extra workload this placed on us as a family, the incredible peer group I have through Betonica and all those original herbalists that have gone before, learning so much from direct relationship with the herbs with no extra help from the internet.

What would your perfect day look like?

Up early, a run in the woods with the dog, family breakfast, uninterrupted time to myself to research any of my current topics of enquiry. This would be punctuated with herbal teas and/or mushroom coffee and dark nutty chocolate. The afternoon would pass harvesting and processing herbs/mushrooms. Dinner would be cooked for me. I would then watch a fabulous film with the family and still have time to read one of the books in the book mountain by my bed before sleep.

Why should people see a herbalist, in one sentence?

We are able to spend time really getting to know our clients in all their complexity to fully understand their health needs and we can then use herbalism, both a science and an art, to treat them.