Summary

Using tincture of Licorice root as the principal therapeutic agent and tincture of Skullcap as a rehabilitative and sedative nervine, cluster headache can be gently and effectively treated and sufferers restored to normal functioning faster and more economically than possible using chemical pharmaceuticals, without damaging side effects.

Introduction

They are known as 'Suicide headaches' as they have driven many women and men to seek a permanent end to unbearable suffering. They are considered by many authorities to be among the most intensely painful things a human can experience; yet they leave no mark of passage, no damage to the body and few clues to their origin. And modern medicine is virtually unable to stop them.

Unless you suffer from them yourself, or know someone who does, you are in all likelihood unfamiliar with cluster headaches. This includes most physicians, and given the relatively low incidence of the syndrome this is not surprising. Cluster headache or CH is thought to affect approximately .07% of the population, about 7 per thousand people, with men affected 6 times more than women. Many practitioners can go years without seeing a cluster patient, and when and if they do both the body of knowledge and treatment options available to them are inadequate, ineffective and in some cases actually harmful. I will touch on this in more detail later on, but first we must consider what the cluster headache syndrome is and how it affects people.

I must begin with a brief biographical note: I have suffered from cluster headaches for roughly forty years, at times episodic and at others chronic (I will explain the distinction in the next section). I have been misdiagnosed, treated for the wrong condition, prescribed ridiculously dangerous and addictive drugs, told I was imagining things, and told to go away. This is sadly a fairly common experience among cluster sufferers, especially older ones. I wish to stress this point because unlike the stereotypical male obstetrician, I know precisely what it's like to have this baby. I began this research because I was desperate for a normal life, and I was no longer willing to accept inadequate care or quiet suffering as my only options. I had an enormous advantage from the start: A willing test subject who worked cheap, was always available and provided instant feedback. At that time I started this project I was experiencing an average of three to a maximum of six moderate to severe episodes a day, and an additional three (usually far worse) at night. There was no shortage of raw material to work with.

Definitions

So what is a cluster headache? Traditionally , in medical textbooks cluster headaches have been considered to be primarily unilateral vascular headaches although that began to be questioned about thirty years ago. Perhaps unsurprisingly, they are still mostly treated as if that definition was accurate, which it most emphatically is not. Observed vascular effects are just that, effects and not causes and this has caused a lot of problems.

Let us first look at what happens in a typical cluster attack (in this case one of mine) and then consider causality. I have intentionally avoided unnecessary use of technical jargon. A single cluster headache is an acute, intense episode involving one side of the head, face and frequently neck with extremely rapid onset (no symptoms to full involvement in as little as five to eight minutes). Unlike classic migraine, a cluster patient experiences no 'aura' and usually has no warning of impending attack. Classic migraine also has a considerably longer and more gradual onset than cluster, and the causative mechanisms are quite different to the extent that the only genuine similarities are quite superficial (yet CH was treated, especially when I was young, as a variant of classic migraine). To an observer a cluster episode would look like the world's worst allergy attack, and that is close to being

absolutely accurate. If hay fever were a thunderstorm, a cluster attack is a ninja typhoon. Sinuses on the affected side immediately swell and close with copious mucous discharge and there is usually heavy lacrimation (tearing) in the eye on the affected side. These episodes are frequently preceded and accompanied by rapid systemic overheating and arrhythmic heart disturbances and a percussive, rapid and irregular pulse. . Accompanying these gross physical symptoms is moderate to unbelievably severe pain which escalates rapidly as an attack progresses, usually along the pathways of the cranial, trigeminal and ocular nerves on the affected side. Pain radiates and seems to jump around in the affected areas; it is constant and not wave like, throbbing or pulsing. The affected eye closes as light itself can seem like jagged shards of glass, and the pain can render a person completely incapacitated in a matter of minutes. Whether treated or not, an attack will usually resolve and dissipate in about an hour, although they are capable of receding and then repeatedly rebounding to full or greater intensity for eight hours or more.

I should point out the obvious; cluster headaches are so named because they recur repeatedly and periodically without warning. It is not uncommon for people to experience several attacks a day and several more which wake them through out the night. Attacks are thought to occur more frequently at night. Because the night attacks wake the patient from a sound sleep and therefore no warning was obtained or prophylaxis attempted, they are far more vicious and frightening.

An important point to remember is that this is a very generalized description and because everyone is unique specific symptoms may vary considerably. The general features are always present. The onset of cluster headache is usually statistically speaking in early adulthood, although people are afflicted in their very early teens and into late maturity.

Please note that several relatively rare and potentially life threatening conditions mimic some CH symptoms, so it is definitely advisable to obtain a differential diagnosis. Cluster is recognized by what is not present; there is no detectable pathology.

There are fundamentally two forms this malady takes, referred to as episodic and chronic. 'Episodic' refers to people who experience distinct cluster periods, frequently seasonally associated, with attack periods averaging between one and two months with extended periods of remission lasting several months or even years with no symptoms. This is thankfully the far more common form. 'Chronic' sufferers do not experience remission periods of more than a week or two at most, ever. I am of the opinion that chronic sufferers are precisely like episodic people with only one significant difference: a much greater 'allergic' susceptibility to what I call 'outside in' causality caused by irritants referred to as triggers. Between the two categories there is no real difference in the relative severity of individual attacks, just the frequency and periodicity.

Cluster headaches, for all of their fury, leave no trace of passage and do absolutely no physical damage to the tissues of an affected individual. The emotional and psychological toll,however, is staggering. The lack of physical evidence has made the work of biochemically oriented researchers highly frustrating. There is no distinction or difference, either gross or biochemical (as far as I have been able to discern from the literature) between the hypothalamus or other involved tissues of a cluster sufferer and anyone else.

At this point one further personal note seems appropriate. For the first 35 or so years of my cluster experience I was what is referred to as a long period episodic with approximately 3 month remissions; my right side was affected. I then obtained a remission of about a year, after which the syndrome returned, switched sides and became chronic with no headache free periods longer than a few days. This change of pattern, although infrequent, is not considered unusual.

Etiology

It is probably as good a time as any to point out that no one really knows what causes cluster headaches. Likewise no one has any plausible explanation of why they affect one side and only one side of the head at a time. Biochemical changes have been noted, and rising and falling levels of neurotransmitters and other metabolites have been observed, but nobody really knows if these

things are causes or effects. One thing that research has seemingly confirmed is that the typical episodic attack is preceded by a flurry of activity in the hypothalamus, often referred to as a "serotonin storm", but again the question is cause or effect? Obviously this becomes pertinent when considering how to treat a condition. In cluster headache, supposition rules.

I have derived a model of the chain of causality and effect in CH primarily from careful observation of my own episodes studied in real time as they happened as impersonally as possible under the circumstances. I have come to believe that two distinct routes of causation exist; I will refer to them as inside out, and of course outside in. The primary and most frequent causation in episodic attacks is inside out, and here is what I believe to be the sequence of events:

**(The prime mover underlying the syndrome is energetic, emotional, stress related, or all three. I have been deeply influenced by the work of Dr. Gabor Mate in this area and highly recommend reading his book, When the Body Says No. Cluster will only be cured when these factors are understood. For now we must stick to the observable.)

Some as yet unknown factor causes the 'wake cycle' in the hypothalamus, controlled by a grouping of cells located directly behind where the optic nerve passes through, to fire in error. This particular interaction employs histamine as a neurotransmitter and this is of the utmost significance to subsequent events. The metabolism starts to fire up, the core starts to mistakenly heat up. You feel unaccountably and uncomfortably overheated. All kinds of neurotransmitter errors occur and levels of all, particularly serotonin, which is the principle neurotransmitter in all of these secondary clock functions, are affected. The heart rhythm speeds up and becomes noticeably disturbed.

What happens next is particularly interesting. Immediately following the flush of the wake cycle the nerves which pass through the hypothalamus , principally the trigeminal in my case, begin to immediately signal pain which radiates and progresses outwards from its approximate origin, perceived in the area of the sphenopalatine bone (the hard palate), on outward towards the several termini of the nerve.. Cluster attacks are first and foremost classic inflammation reactions, but the normal progression of such reactions is that pain should follow and be subsequent to swelling, but the opposite is what actually happens. In this model, it is the nerves themselves and not the local presence of foreign proteins which precipitate the cascade of histamine release and subsequent inflammation in the tissues they pass through. It is as if the nerves are somehow detecting the loose, unused and un-disassembled histamine or its energetic signature in the hypothalamus and reacting as if an attack by foreign proteins was underway, signaling pain and initiating the inflammation defense all along their pathways. The pain signals in these nerves are disproportionately severe well in advance of any swelling. The pain level continues to elevate in response to the presence of the histamine, and the downstream inflammation reactions begin: Mast cells release histamine, a cytologic irritant which triggers capillaries to swell and get 'leaky', engorging tissues, discharging protective mucous, and so on. Once the inflammation reaction gets underway, the nerve becomes a loop, which like a frayed wire causes further disruption in the areas of the hypothalamus it passes through. A cluster headache is born. The total time elapsed from initiation to full involvement is approximately ten minutes.

There is another form of causation which I call 'outside in'. This is a cluster attack instigated by environmental, chemical toxin or protein/allergen means. CH people refer to these things as triggers. There are probably as many potential triggers as there are cluster patients, but there are a number of very common ones. Alcohol is by far the most common, affecting a very large percentage of people. Ingestion of alcohol, as little as a single drink, can precipitate a fully involved attack in as little as fifteen minutes. Marijuana is another very common trigger and has similar effects. Nicotine is a particularly insidious trigger as its effects are persistent but deferred. Triggers initiate acute histamine mediated inflammation reactions in areas previously sensitized by 'inside out' attacks. The involved nerves become the frayed wires which again disrupt the hypothalamus. Onset of this type of attack is extremely rapid. Residual soreness, sensitivity and dull persistent pain from these attacks are referred to as 'shadows' and indicate to the cluster sufferer that they are close to further attack. The resulting anxiety can trigger an attack all by itself.

In episodic sufferers, the number of mast cells, which increases in affected areas during periods, reduces and returns to normal levels after a cluster period is over. I believe the principle difference in chronic patients is that this does not occur and hypersensitivity to outside triggers does not diminish as it does in the episodic. Seasonal periods do affect the chronic patient, but for most of the year 'outside in' causation is the bigger problem. For this reason treatment of the chronic sufferer must heavily emphasize identification and avoidance of triggers and rehabilitation of stressed nerves.

Conventional Treatment

Conventional treatment of CH is usually based on the use of vasoconstrictors, tryptans such as Imitrex originally used for prophylaxis in migraine patients, common and exotic analgesics, antidepressants and antihypertensives; all prescribed based on a faulty understanding of the progression of the syndrome.

It is not my purpose or intent to enter into a detailed discussion of the failings of the pharmaceutical industry and mainstream allopathic medicine in regard to cluster headache, or the inadequacy and general ineffectiveness of standard therapies. But a few observations are definitely in order.

Cluster is and has been the last step-child in line to the industry, receiving second hand drugs intended for the use of others and other ailments, and failed drugs that had outlived their primary functions. A typical example of this is the antihypertensive drug Verapamil which is frequently prescribed for cluster patients based on what is ultimately a wrong impression of the etiology of the condition. Not only is it ineffective and actually damaging (it causes, exacerbates and prolongs rebound as the body desperately attempts to restore equilibrium to the circulation) but the dosage needs to be continually adjusted upwards to the point where patients cannot stand up without fainting and normal sexual functioning becomes impossible, to name just two of a long list of horrific side effects. Most patients do not stay on it for long, but doctors continue to prescribe it purely by rote. Drugs sold to cluster patients are ridiculously expensive and statistically perform only marginally better than placebos. The plain truth here is that there is quite simply no effective drug for the treatment of cluster headache in the standard contemporary medical pharmacoepia, certainly none that solve more problems than they cause. Lets face it, if this were not the case there would be little reason for me to be writing this, and even less reason for anyone to read it.

I would not be the first person to observe that doctors are uncomfortable dealing with conditions that primarily manifest as pain. The tools available in the form of sanctioned chemical analgesics have not fundamentally improved or changed in hundreds of years. Alternative or non-traditional methods of pain control have until very recently been largely dismissed and in many cases ridiculed by the medical establishment. I should also point out in passing that no analgesic known has any effect on cluster headaches, including natural and synthetic opiates. You can drug a cluster patient to the point of unconsciousness and not affect the pain one bit. I speak from experience here.

The 'management' as they call it of chronic or acute pain is usually of secondary concern to physicians who are primarily interested in 'curing' pathological conditions. I don't mean this as an attack, simply my impression of their professional focus. Dealing with a condition whose principle feature is spectacular amounts of the worst pain imaginable that comes and goes like a ghost is understandably frustrating for any compassionate health care professional.

Alternative Treatments

The failure of establishment medicine to help them has led some cluster headache sufferers to willingly adopt a do-it-yourself attitude, accept responsibility for their own health and plunge into the wider world of the as yet unknown in an attempt to help themselves. I of course include myself

in this category.

Many modalities and treatments have been offered and tried. Some, quite frankly, are ridiculous and even fraudulent. Most have been merely ineffective. There is, however, one ray of light in this darkness and it is this developing story that has led me directly to the protocol I offer herein.

It has been amply and repeatedly proven that some drugs and plant materials of the class narrow-mindedly referred to as 'hallucinogens' have an uncanny ability to stop and remit cluster headaches. Specifically, LSD and psylocibin containing mushrooms produce the most consistently positive results. LSA containing plants such as morning glory and hawaiian woodrose are also said to work but not nearly as well.

The theory as I understand it is that the psylocin indoles present in both the lsd and mushrooms bind to serotonin receptors in the hypothalamus, as they are structurally almost identical to serotonin, blocking serotonin reuptake and acting in some unknown way to reset the hypothalamus itself, preventing further attacks. This effect is present even at low level doses, lower than required to produce psychotropic effects. Having experimentally tried both of these methods, I can attest to their effectiveness. They work so well, at least temporarily, that purposely attempting to induce cluster attacks with infallible triggers produces no results.

Recently, headlines have been made by research into a non-psychoactive analog of LSD known as BOL148 which produces the same therapeutic results with no psychotropic effects at all. This research and the formation of a startup pharmaceutical firm to pursue potential commercial production of this material has been viewed by many cluster patients as the realization of a dream. Hopefully without sounding too negative, I would like to make a few points regarding these developments.

1. As effective as it may be, BOL148 is not a single use 'vaccine' imparting immunity from subsequent attack. It is acknowledged to be a treatment, not a cure. This means that any drug company in possession of this proprietary material would have a ready supply of life-long clients dependant on their product. Given the altruistic nature and history of the pharmaceutical industry, what could possibly go wrong with this picture?

(I have been told personally that the researchers and backers of the startup in question are really good people, including cluster activists and advocates. I have no reason to doubt their judgment or sincerity. This will be fine, until they get bought out and the firm [whose name translates to, no kidding, the "God Drug Corporation"] is purchased and absorbed by one of the giants. If this sounds overly cynical, bear in mind that in the entire history of drug companies and drug researchers in the western world this exact scenario has failed to occur once and only once. The exceptions' name was Jonas Salk.)

2. The inherent difficulty in attempting to establish legitimate medical uses for so called "controlled dangerous substances" (thanks, President Nixon!) is pretty much common knowledge these days. Despite literally thousands of years of therapeutic use by cultures all over the world and incontrovertible medical evidence, idiots in this country (and there really is no other fitting adjective for them) continue to insist that cannabis has no legitimate medical value. Now transpose this attitude onto substances with less social cachet than marijuana that evoke fear and hostility in the minds of the ignorant, factor in a conservative legislature and a Neanderthal bureaucracy and you tell me exactly how soon this product will come to market.

3. Hallucinogens are inarguably marvelously effective, but they do not have any effect on the secondary neuralgias associated with cluster which constitute the principle avenue of 'outside in' triggering.

Whatever else I thought about them, reading the research into hallucinogens and how they interrupted and reset a malfunctioning hypothalamus was catalytic to my own thinking. I remembered something William Goldman wrote in Marathon Man; that to defeat the best basketball player in the world, you didn't have to completely block his shots- you merely had to nudge an elbow. You had simply to break the pattern.

If the pattern and moebius looping of CH could be interrupted by hallucinogens with good results,

was there an herb that would act in similar fashion? I suddenly remembered some obscure references I had come across years earlier while researching herbal treatments for hepatitis C. I was on to licorice root, Glycyrrhiza glabra, and what follows reflects my most current place on that path.

The Herbal Protocol

Before we Begin

This protocol cannot be employed simultaneously with conventional allopathic medical treatment. For the safety and health of the client and the efficacy of the treatment this rule must be inviolate. We will be using arguably the single most biologically active herb on the planet. While absolutely safe when used properly, licorice root interacts with, exacerbates and magnifies the effects of many drugs in different bodily systems. Particularly in regard to drugs routinely prescribed for CH, interaction with licorice root can instigate rebound reactions and precipitate headaches that HP Lovecraft, Clive Barker and Satan working in committee could not invent. I hope I have made myself sufficiently clear.

There are people for whom the use of licorice root is unequivocally not recommended. Individuals with a history of significant hypertension, previous heart attack or renal disease should not use this herb. Use in pregnancy should be very cautious and carefully monitored due to the potential for elevated blood pressure and fluid retention.

Although knowledgeable herbalists will be aware that the use of deglycyrrhizinated licorice (DGL) in which all the glycyrrhizin has been removed avoids almost all issues of toxicity, such products are useless in this application as it is the metabolites of glycyrrhizin itself that are the active agents in the therapy under consideration.

I have not evaluated the possible effectiveness of forms of licorice other than tincture. I was initially drawn to the tinctured form of the herb for the concentration, rapid onset of effect and ease of use, and I am still of the opinion that for most people it is the most practical approach.

First Steps

The practice of good classical herbalism requires that no problem be treated as an isolated set of localized circumstances separable from the complete individual. In other words, a completely holistic approach is absolutely required if any course of treatment is to be effective. I cannot overstress this point.

The responsibility to disarm and neutralize the cascade of rogue histamine reactions which characterize this syndrome falls largely on the liver and the adrenal glands . A healthy and efficient liver is vital to a cluster patient, and this is problematic because the constant low grade stress experienced by CH people is fatiguing and damaging to this organ. I would venture the opinion that most people in the modern world are very hard on their livers, mostly inadvertently. The liver manufactures the enzyme histaminase which disassembles histamine circulating in the blood stream. Histamine, though produced by the body, is a toxic irritant and that is necessary to its' function. As we have seen, this process gone wrong is centrally important in cluster headache. A liver which is compromised, loaded with fats and clogged up is simply incapable of producing histaminase. Treating cluster headache begins with detoxifying, restoring and fortifying the liver.

Probably not coincidentally at all, licorice root is extremely beneficial to the liver. It has been used, well, forever in traditional Chinese medicine for treatment of jaundice and research confirms it lowers serum bilirubin levels more efficiently than the drugs commonly used for this purpose. Licorice lowers triglyceride and other hepatotoxin levels in the liver and is of great value in the treatment of cirrhosis and hepatitis.

Cluster sufferers would be well advised to work on toning and strengthening their livers in the 'off season', as this greatly improves the effectiveness of treatment when cluster periods start. A considerable number of good herbal alterative tonic formulas are available to assist this process. My personal favorite is a compound tincture of equal parts of burdock root, yellow dock root, dandelion root, milk thistle, licorice root and mugwort. I would suggest this be taken 1/2 teaspoon once a day.

Alkalizing the diet is also an important first step. Sugar and dairy are minimized or eliminated; high quality proteins, dark leafy greens are added. Detailed advice regarding diet is hard to reduce to generalities and simple pronouncements, but good advice for an individual's somatotype is available in many places. Lowering your body's pH is a tune up for every system in it, improving efficiency and all self-correcting mechanisms.

Related closely to the subject of diet is the advisability of supplements intended to enhance anti-inflammatory functioning, and this has everything to do with the aforementioned adrenal glands. These small but powerful entities are responsible, among many other things, for the manufacture and circulation of cortisol, a steroid hormone which suppresses the immune function of white blood cells and activates anti-inflammatory pathways and processes. Chronic low grade or subconscious stress which is probably present as an aggravating factor and/or precursor in all CH sufferers negatively impacts the ability of the adrenals to do their job. Stress of this type can cause a deficiency of pantothenic acid, vitamin B5, and results in impaired adrenal function and lowered cortisol production. (A tendency towards hypoglycemia can be indicative of B5 deficiency, although once again ascribing cause and effect is tricky). Although present in many foods, directly adding pantothenic acid as a supplement is definitely advisable. Pantothenic acid should not be used alone without other B complex vitamins since it can eventually cause deficiencies in other B vitamins. A good range of dosage would be 300-600 mg of sustained release pantothenic acid taken in conjunction with a good comprehensive general B complex supplement.

I have also alluded to 'triggers' several times in discussing the etiology of CH and this bears brief discussion. This concept is vital in controlling and minimizing the incidence of attacks. Identifying, removing and/or avoiding triggering substances can of itself completely stop 'outside-in' attacks. As this sometimes involves varying degrees of behavior modification it can be difficult for people to comply with, yet the benefits are almost immediately apparent. A word about nicotine: Cluster sufferers who smoke should be advised to stop in no uncertain terms as recent research has definitively established that nicotine exacerbates perceived pain levels in CH by an order of magnitude. This can frequently be recognized in smokers as an exaggerated area of pain (in attacks) manifesting unilaterally in the sphenopalatine region. Removing nicotine completely can relieve this portion of the syndrome in as little as 48 hours.

The mainstay of this treatment program is the use of two tinctures, Licorice Root and Skullcap. First we will consider the licorice and its physiological effects; this herb is doing most of the heavy lifting and I will try to show how its many virtues are admirably suited to the task.

1. Licorice has been demonstrated to be a very efficient serotonin reuptake inhibitor (SRI). So efficient, in fact, that it has been shown in studies to be superior to most pharmaceuticals designed to do the same thing. Why is this important? In the hypothalamus, serotonin is the neurotransmitter principally active in 'biological clock' mode which as we have seen is the basic trigger of CH. Every drug ever found to be effective in cluster has a positive effect on serotonergic transmission rates, which is fundamentally the definition of an SRI. (Please note that there are important differences between serotonin reuptake inhibitors and the class of artificial substances known as selective serotonin reuptake inhibitors that are not pertinent here. A growing body of critical literature is available to those interested; for our purposes here, it may be concisely distilled to SRI's good, SSRI's bad.) This ability alone would make licorice useful in treating cluster, be we are far from done.

2. Licorice is a powerful anti-inflammatory agent. It performs this function in several different ways.

In the liver, licorice blocks the metabolization of cortisol (produced by the adrenal glands, the body's own principle anti-inflammatory) prolonging its action in the body, and mimics and enhances steroidal-type activity in affected cells. It lowers vascular permeability (reducing swelling) and inhibits mast cell activity. Inflammation, as we have seen, is the secondary result of the causative process in cluster and a main cause of symptoms and pain.
3. Licorice has antipyretic (temperature reducing) ability equal to aspirin and contributes to stabilizing body temperature after the 'wake cycle' flush.
4. A secondary yet clinically significant effect of the serotonin reuptake inhibition of the herb is a powerful mood elevating anti-depressant action which is highly beneficial in treating this syndrome.
5. As interesting and, I hope, impressive as this clinical scientific information is, I would be remiss if I did not include my personal impressions of this plant, as important to me as anything previously mentioned. The great Chinese herbalists have characterized licorice root as an herb which balances the actions of other components in a wide range of preparations; it is included in roughly 70% of all herbal formulas in TCM. It is my intuitive belief that licorice in the body acts to balance and bring into dynamic equilibrium the systems in which it exerts influence by reinforcing and supporting the body's self-regulatory corrective mechanisms. It is extremely powerful and efficient, but not overbearing.

There has been a good deal of misinformation and exaggerated reports of the potential toxicity of licorice which has been parroted around and accepted as fact by writers and other people who really should know better. As recently as this past Halloween, the FDA, no less, was circulating warnings of the potential health risks of eating too much licorice candy. Without dignifying this baseless witch hunt with a detailed rebuttal, suffice it to say that every documented case of pseudoalderstonism attributed to licorice has resulted from predisposed individuals consuming large (700 grams in one case, two pounds in another) quantities of candy containing licorice extract. I could located no documented cases of significant toxicity resulting from use of whole plant products, which is what I would expect since whole herbs have built in governing mechanisms that prevent the excesses of single components. I would remind everyone that water is toxic in sufficient quantities. Even in susceptible persons, any potential adverse effects of licorice root would be completely avoided by adding potassium to the diet and limiting sodium intake. The dosages recommended in this protocol are not high enough to cause deleterious effects in the vast majority of people; however this statement is not meant to supercede the contraindication warnings previously given.

A brief but important digression here is required, more for the interested lay person or CH sufferer than the herbal practitioner, but perhaps valuable for all to remember. Herbal medicine has sometimes been disparaged and dismissed in the popular press by medical 'experts', by alleged authorities of all kinds with their own agendas, and of course by people who just believe what they hear. I am not here to prove anything or argue with anyone. Believe what you will, and bless you. If you have read this far, I probably wouldn't have to argue with you anyway.

If herbal medicine gets a bad rap, it is not and has never been the fault of the plants. It is the fault of the people. It would be out of place here to go into a lengthy diatribe, but even when well meaning somewhat enlightened physicians like Andrew Weil prescribe herbs they do it wrong, recommending capsules and 'extracts' of powdered herbs to be taken like drugs. Any herbalist worth the dirt on his/her knees knows powdered herbs lose their potency quickly and are frequently made from inferior raw material, and the principle behind 'extracts' is just plain wrong. Would you powder a cheeseburger and wait six months to eat it? Herbs are essentially foods that the body uses to heal itself, not drugs which force processes. That is just one example. People come to believe herbs don't work because products do exist which honestly are little more than fads and fraudulent rip offs, they get bad advice from crappy magazine articles written by presumably well meaning but ignorant authors, or a variety of other possibilities which turn them off to herbal medicine despite the record of thousands of years of accumulated knowledge and use and literally billions of successful case histories. Fortunately, alternatives exist.

If you are fortunate enough to live in an area with access to a practicing local herbalist avail

yourself of their services. There is really no substitute for good handmade herbal medicines made with loving care from the best quality plant material. I confess to a prejudice against most commercially made tinctures. I am used to controlling the entire process from harvesting or selecting raw materials to finished product. The difference between crafted small batch tinctures and commercial products is like the distinction between a fine French vintage wine and anything with a screw cap. That having been said, there are extremely ethical small firms operated by (mostly) families of knowledgeable, highly skilled herbalists who make outstanding preparations. All of them, I assume, do business on the Internet. If they are worthy of the name, they should be able and willing to answer any questions as to how their products are prepared and what goes into them. Curiously enough, unlike wines you can tell nothing about the quality of a tincture based on price. Retail establishments will sell poor quality mass produced stuff at about $20 for a two ounce bottle, and that price is about the same as that charged by the better makers. I suppose I could have made this point more succinctly by simply advising readers to buy the best product they can find, but it is important to understand what I mean by that statement.

One further note; as a rule, always use products produced from whole plant source material, not extracts. Whole herbs have evolved over millions of years in complex chemical interactions which balance the excesses of individual components, and thinking that we are smarter than nature is usually delusional.

The licorice tincture used in developing this protocol is a 1:5 percolated extraction of whole organic licorice root, 40% alcohol and 60% distilled water by volume.

The second important therapeutic component of this protocol is Skullcap, Scutellaria latiflora. This humble little flowering gem of the damp woodlands is one of the best of the herbal nervine/analgesics, and it has qualities which make it particularly suited for use here.

Skullcap is soothing, calming, and restorative to frayed and damaged nerves. It has excellent analgesic qualities and is an exceptionally efficient sedative for the overwrought 'halloween cat' nerves affected by cluster, which are similar in affect to the jittery hypersensitivity experienced in addiction withdrawal. This herb is widely and justifiably renowned for treating this particular type of symptom.

One of the more persistent and difficult to resolve facets of the cluster syndrome is the hypersensitivity of the involved nerve groups, which as we have seen become chronic loops. These nerves, especially in chronic CH people, become routes of causation in themselves as they overreact to detected foreign proteins or other triggering metabolites. Skullcap gently sedates and nourishes these nerves, providing a respite of sorts in which they can restore themselves.

A tincture of Skullcap prepared from fresh plant material is regarded as highly superior, but as I initiated this experiment in the 'off season' so to speak, this was not possible, so I prepared a 1:5 tincture of freshly dried organic skullcap, 60% alcohol and 40% distilled water by volume. I achieved good results and can only speculate that a fresh plant product would work even better.

And so, at last, we come to the heart of this treatment protocol. At the first signs of onset of a cluster period, immediately discontinue any and all known triggering substances or behaviors. Take 1/2 teaspoon of each tincture three times daily spaced approximately six hours apart. The simplest method is to just mix them in about 2 ounces of room temperature water and drink it; it is very pleasant tasting.. Within 48 hours the frequency of attacks should reduce by about 80%, and those that do occur should be of shorter duration and be much easier to abort. This is also true of night attacks. Over a period of two to three weeks the frequency of incidents should continue to diminish. (In my most recent experience, a period which started in late October which ordinarily would last minimally three to four months completely terminated in three weeks.) After five or so pain free days are experienced, discontinue the morning dose (both herbs). If still pain free after another week, discontinue the afternoon dose, and repeat this with the evening dose if the situation is still stable after a final week. After discontinuing the treatment, if an attack should occur for any reason, a full dose of each herb may be taken immediately. As the time of effective onset is very short (20 to

30 minutes) this is an effective strategy for aborting the occasional triggered incident.

An important point to stress, though it is a highly subjective one, is that the guidelines for titrating down the dosages should be considered generalizations of the most nebulous kind. CH patients need to pay mindful and conscious attention to their own internal state. They will know when they are feeling better. All that is possible to say here in actual language is that as soon as the licorice can be removed it should be removed. It is a powerful agent, and when it has done its' job it can cause unnecessary problems. As Alan Watts was fond of saying, when you get the message hang up the phone.

One last thing; removing the licorice may in some people result in varying degrees of temporary insomnia. Although it will resolve all by itself, if troublesome, a quarter teaspoon of the Skullcap tincture (alone) taken 1/2 hour before bedtime should knock it right out.

While the treatment is still kicking in, it is occasionally necessary to abort acute attacks. Virtually every cluster sufferer has 'personal best' methods they employ for this purpose and it is not pertinent here to catalog or rate these techniques. My philosophy here is that if it works for the individual without being inherently dangerous or harmful, well and good. I would, however, like to offer a few thoughts; particularly for herbalists who may wish to suggest possibilities to clients.

Pharmaceuticals make poor abortive agents for two fundamental reasons: 1. Unless inhaled or injected they are all too slow to be effective 2.Virtually all carry a high risk of rebound and/or 'side effects'. In no case should any prescription drugs be used as abortives at any time while using this protocol. Remember the interaction warnings.

High flow oxygen is a very popular and effective abortive among cluster people; it produces vasoconstriction and raises serotonin levels, stopping attacks with low incidence of rebound.(Surprisingly, or perhaps not so, this therapy was identified and introduced by mainstream medical investigators close to 60 years ago but many doctors today are still completely unaware of it). A low tech alternative is, strange but true, strenuous aerobic physical activity at the onset of an attack which produces the same results.

Cold packs to reduce swelling, acupressure, cold showers or immersion, meditative breathing techniques; well the list goes on but I will close by offering two 'crazy herbalist' options that I have found to be highly effective. First, for rapidly obstructing painful sinuses: Take a small (perhaps 1/8 teaspoon or less) amount of cayenne pepper and dissolve in 1/4 or so teaspoon of water. Snort it up the affected side. This works really well, and you can sometimes totally forget the pain for a minute or so. For pain in the sphenopalatine (upper palate) which can be particularly fierce, shake about a fifty cent piece size bit of cayenne onto the back of your hand. Stick it to your tongue and press your tongue to the affected side of your palate. Hold it there as long as is comfortable. It will help clear your sinuses and anaesthetize the painful area very efficiently.

Conclusion

[I beg the reader's indulgence to insert one more note of a personal nature: I used this protocol for the first time approximately one year ago. I was able to achieve complete remission of the chronic nature of my condition and experienced no recurrence of episodic symptoms until this Fall. I also shared this information, as it was developing, with fellow CH people through the "Clusterbusters" page of the Clusterheadache.com website. The thread was read many thousands of times, and I know that many people tried the herbs, some with completely successful outcomes, but I have no real substantial feedback to report, having made no effort to get any. The treatment plan herein is considerably more thorough and comprehensive than what I was suggesting at that time. I waited to finalize this report until I could repeat my own earlier experience;... was it a fluke, or coincidence the first time? Happily, I can now say no to these questions with confidence. When my customary Fall period commenced, I had immediate recourse to the Licorice and Skullcap

combination. Daytime attacks almost immediately reduced to nearly none; those that did occur I could clearly attribute to outside triggers some of which were tests and others, to be honest, were my own stupidity. Attacks that did occur were by and large much less severe than typical for me and far easier to abort. Nighttime events were immediately reduced to predominately minor disturbances and those disappeared completely after two weeks. I considered the cluster period completely terminated after three weeks of treatment. When you awaken after sleeping undisturbed through the night, life becomes a dance again.]

This treatment plan is neither perfect nor universal. Because cluster headache is such a highly individuated condition and systems may be severely compromised by long and unfortunate exposure to damaging chemicals I fully expect that there will be a small percentage of people for whom this protocol will not work. Even when it does, it does not prevent every cluster attack. Nothing does, and nothing will until we reach a deep understanding of the real and ultimate causes of this syndrome. I have found, however, that applying these herbs and the other steps previously discussed almost immediately reduces the incidence of attacks by at least 80%, virtually eliminates nighttime attacks and renders those attacks that do manage to occur far less severe, of markedly shorter duration and therefore easier to abort. It also substantially shortens episodic cluster periods. This is a substantially better outcome than is currently possible with any other existing modality.

These humble and miraculous plants are able to accomplish this without causing any deleterious "side effects" at a tiny fraction of the cost of treatment with conventional pharmaceuticals. Other than specifically contraindicated persons, these herbs are safe for use by virtually anyone.

I believe based on my experience and observations that cluster headaches are at heart and in presentation essentially hyper acute "allergy attacks" as I have described. This idea is probably something of a departure from the way this syndrome is usually thought of. I believe that these herbs, licorice root in particular, to have much wider potential application and possibilities for use in other histamine mediated inflammatory reactions, perhaps even systemic ones and autoimmune conditions affecting millions of people. Licorice has already been cited as a potential antidepressant replacement for toxic dependancy inducing SSRIs. Humans have traveled with this plant since before recorded history, but we may have barely scratched the surface of it's potential.

This simple application of common plants and common sense known to healers for thousands of years has given me my life back. It is my fervent hope and prayer that through this work others will find the same peace and relief.

To the cluster sufferers of the world, to the people who love them and the people who care for them, and to those who continue to love, live and breathe the wisdom of the plants, I respectfully dedicate this work.