



The Introduction and Use of the Abortifacient Mifepristone (RU-486) in the United States

Randall K. O'Bannon, Ph.D.,

Director of Education & Research, National Right to Life Educational Trust Fund

Though the abortifacient mifepristone, popularly known as RU-486, is a relatively new drug, the desire for some easy, safe, effective, and non-invasive means of ending or reversing pregnancy goes back several centuries. In the modern era, however, those efforts took a back seat once surgical abortion became the norm, especially when states began allowing abortion under certain

circumstances in the 1960s and the U.S. Supreme Court made abortion on demand a constitutional right in the United States in *Roe v. Wade* in 1973.

Women's experiences with surgical abortion, though, were not universally positive. They described it as "intimidating" (*NY Times* 10/28/94), "traumatic" (*TIME*, 12/5/94), "impersonal," "invasive," "mechanical," "abrupt" (*Boston Globe*, 5/8/95). Women found the abortion experience humiliating. The April 1995 issue of *Contraceptive Technology Update* (CTU) described a woman's feelings this way:

... up on a table exposing her most intimate, private parts of herself and having someone else introduce instruments in a very scary way into this very private part of herself.

According to CTU, women considered surgery a risk they

wanted to avoid. They were concerned about anesthesia, the possibility of uterine perforation, and cervical injury. They didn't like the surgical instruments and were afraid of "scraping" leading to future infertility. The search for an easier, safer, less invasive means of abortion continued.

Hormone Research Opens the Door to New Chemical Abortion Method

The discovery of the pregnancy hormones progesterone (1929) and estrogen (1934) opened up whole new possibilities. Gregory Pincus, one of the co-inventors of the oral contraceptive pill, theorized that "anti-progestins should be implantation inhibitors," but did not follow up on this application.

A young French scientist who met Pincus in 1961 did. Etienne-Emile Baulieu visited Pincus in Puerto Rico, where trials were

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being conducted of the new birth control pill, and came away determined to devote his life to steroid research, believing chemical contraception central to women's health and to control of the world's population (Lader, *RU-486*, 29-30, Baulieu, 69).^{15,4} He returned to France and began working as a consultant to French pharmaceutical giant Roussel Uclaf as part of a group looking for an antiglucocorticoid (to chemically block the effects of cortisone in the body). Baulieu was looking for a competitive progesterone receptor binder, i.e., a compound that would bind to progesterone receptor sites, but would then, by taking progesterone's slots, keep it from producing its effects.

Normally in pregnancy, progesterone, produced by the corpus luteum, functions to build and maintain the endometrium which welcomes and then sustains the developing child in his or her earliest days. As pregnancy progresses, the placenta takes over progesterone production, but those critical first weeks are crucial to the establishment of the child's nurturing and protective environment.

Anti-progestins bind to the same receptor sites as progesterone, but then do not carry out the same tasks. With the progesterone signal

effectively blocked, the endometrial lining decays and sloughs off, depriving the developing child of essential nutrients, essentially starving her or him to death as the protective environment around her or him collapses.

George Teutsch, one of the members of the Roussel Uclaf team, synthesized a compound in 1980 that had these properties. It was compound number 38,486 developed at Roussel Uclaf, so it received the designation RU-38486, later shorted to RU-486.

After some animal testing, Baulieu had his friend Water Herrmann try it out the compound as an abortifacient on 11 women in Geneva in 1981. Nine of those women aborted. Baulieu went to the press to tout his discovery (NY Times 4/20/82) as results of the study were to be published in the June 1982 issue French journal *Contraception, fertilité, sexualité*.¹

Over the next couple of years, Baulieu and his colleagues tested RU-486 on hundreds of women and published their results (*CR Seances Acad Sci II, May 1982, NEJM 12/18/86, J Steroid Biochem, 1986, Eur J Obstet Gynecol Reprod Biol, 1988, Contracept Fertil Sex 1986*),^{13,6,2,3,7} obtaining "success" rates of around 80%. Roussel was also doing

research combining RU-486 with a prostaglandin to boost "effectiveness," by stimulating powerful uterine contractions to expel the tiny corpse. The two-pill combination raised success percentages enough that the French government approved distribution of the drug on September 23, 1988.

The Abortion Pill Comes to America

Approval soon followed in Britain (1991) and Sweden (1992) and pressure began to be exerted on the United States to allow the drug. Newspapers touted the drug that made abortion "as private as taking a pill in your own home" (*Chicago Tribune*, 2/28/86), pronounced it "safe" (*Chicago Tribune* 12/29/86), and "effective" (*Newsweek*, 12/29/86), while the *New York Times* in an editorial all but dared a pharmaceutical company to apply to market the pill. "Clearly, then, there is an American market for RU-486," the Times said, "Now, where's the marketer?" (3/25/88).

Women's magazines joined the chorus, declaring the virtues of "the unpregnancy pill" (*Ms. Magazine*, April 1987), calling it a "miracle pill" (*Mademoiselle*, November 1988) and a "breakthrough – not only less painful but safer than a surgical

abortion,” (*Vogue*, August 1988). Sue Halpern of *Ms. Magazine* spoke of RU-486 as if it were some sort of magic pill that made babies disappear: “Imagine being pregnant, swallowing a pill, and – presto! – not being pregnant any longer.”

Groups like NOW and the Fund for the Feminist Majority sought to meet with medical leaders and pharmaceutical officials “to emphasize their moral obligation to expedite RU-486 and other fertility control research” (Release, 6/1/89), the American Medical Association endorsed testing possible use of RU-486 in a June 26, 1990 voice vote, and scientists and feminists from the American Public Health Association traveled to Paris to meet with officials from Roussel and Hoechst AG, Roussel’s major share holder. The Feminist Majority’s Eleanor Smeal presented 115,000 petitions from its supporters calling for the abortion drug to be made available in the U.S.

Roussel balked, saying that there were certain conditions that had to be met before they would market RU-486 in another country, saying that abortion must not only be legal, but that local, public, medical and political opinion must

favor abortion. It also said that a synthetic prostaglandin must be available locally, that patients should sign a consent form, and that distribution should be strictly controlled. While abortion was obviously legal, and consent and distribution requirements could be taken care of during approval, Roussel didn’t feel the public or the government was sympathetic to abortion at the time and there was no suitable prostaglandin available at the time (*NY Times*, July 29, 1990).

Testing in the U.S.

Things changed with the election of Bill Clinton in 1992. Three days into his presidency, on the anniversary of *Roe v. Wade*, Clinton issued an executive order directing the Department of Health and Human Services (HHS) and the U.S. Food and Drug Administration (FDA) to seek an application from Roussel to market RU-486 in the U.S. (Clinton Memo, 1/23/93).⁵

Ultimately, under what the *New York Times* termed “sustained political pressure from the Clinton administration,” a deal was struck granting U.S. licensing rights to the Population Council of New York in May of 1994. Roussel agreed to turn over all rights and responsibilities connected to the

drug to the Population Council for free, hoping to avoid becoming a boycott target.

U.S. trials of the drug were announced on October 27, 1994, in New York City. They were to involve 2,100 women in what was later found to be 17 clinics in 15 states across the United States, testing the safety, efficacy, acceptability and feasibility of using RU-486 to abort pregnant women at 49, 56, and 63 days after a woman’s last menstrual period (LMP). Women were to take three tablets of mifepristone (200 mg each) and then two days later, two tablets of the prostaglandin misoprostol (200 mcg each). Both medications were to be taken orally at the office under the supervision of a physician. A third visit, two weeks after the first, was to confirm the completion of the abortion.

The Population Council played up chemical abortion’s difference from surgical abortion, saying that use of mifepristone was “safe,” like a “natural miscarriage,” and assuring people that “medication abortion avoids a surgical procedure,” specifically pointing out that “There are no risks of anesthesia or uterine perforation or cervical canal injury, rare complications of surgical abortion” (Population Council release, 10/27/94).

Problems Surface

Despite the assurances and the hype, women's experiences with the drug in the trials proved to be more difficult and dangerous than advertised. *TIME* magazine, which followed some women through the process, called the part where the abortion occurred, "painful, messy, and protracted." (12/5/94). Other women spoke to reporters about the difficulty they encountered aborting at home and being forced to see their own dead children (*Health*, Jan/Feb 1995; *Newsweek*, 9/18/95).

A doctor who had treated a woman involved in the Iowa trials contacted reporters after seeing a notice in his local paper that the trial there had been completed with "no complications" among the 238 women who participated. "If near death due to the loss of half on one's blood volume, surgery, and a transfusion of four units of blood do not qualify as a complication," wrote Mark Louviere, "I don't know what does." (*Waterloo Courier*, 9/24/95).

Jill June, president of the Planned Parenthood affiliate conducting the Des Moines trial, said that "no complications refers to the trial – that the trial was conducted successfully – and not to the condition of the

participants." (*Des Moines Register*, 9/21/95).

While official results were not published until 1998, the U.S. trial ended in September of 1995 and the FDA held a hearing on the drug application July 19, 1996. Despite testimony from Dr. Louviere and others raising serious questions about the safety of the drug, and at least one panelist raising the politically inconvenient question about the drug's therapeutic "benefit" for the unborn baby, the Reproductive Health Drugs Advisory Committee voted 7 to 0 with one abstention to recommend approval (though two voted against declaring the drug "safe" and "effective"). The FDA then issued an "approvable" letter on September 18, 1996, saying that the drug was acceptable, but saying that certain unidentified "labeling and manufacturing" issues remained to be resolved.

Results of the trial were published in the *New England Journal of Medicine* on April 30, 1998.¹⁸ Not surprisingly, the authors, employees of the Population Council, concluded that the drug was both "safe and effective for women seeking medical abortions of pregnancies of 49 days duration or less." There were, however, buried in the

text and the charts, information that attenuated that somewhat rosy assessment.

The "success" rate obtained by the researchers for 49 days LMP was 92%, a lower figure than the 95-96% reported in European trials. The authors speculated that the U.S. abortionists intervened and performed surgical abortions more quickly than in Europe, because of the excessive bleeding suffered by their patients. One of the authors told the *Los Angeles Times* that the abortionists were "not yet comfortable with the amount of bleeding caused by the medication" (*LA Times*, 4/30/98)

Efficacy declined sharply the longer the length of gestation. Success rates for women 50-56 days LMP were 83%, for those 57-63 days LMP, 77%. Of those who abort, 49% did so within four hours of taking the prostaglandin, misoprostol, but the rest who aborted did so only after leaving the clinic. 75% aborted within 24 hours.

Side effects were common, and sometimes serious. Abdominal pain, reported by more than 96%, was so severe that 68% of women received at least one medication for pain, with 29% receiving opiates. Pain was so intense that one woman had to be hospitalized

for it, and this was the reason given for at least two “surgical interventions.” Nausea, vomiting, and diarrhea were also common, 61%, 26%, and 20% respectively for the group 49 days LMP and under, with increases for women at higher gestations. Vomiting was the reason for at least one woman’s hospitalization.

Though described as “a natural consequence of the abortion process,” bleeding from these abortions was significant. Excessive bleeding was responsible for 25 of the hospitalizations mentioned in the study, 56 “surgical interventions” and 22 women requiring intravenous fluids. Bleeding was so bad that even in the 49 days or less group, 5% were given some drug to manage the bleeding. It was not always over quickly, either. Overall, 9% of women bled for over 30 days.

Onto the U.S. Market

Mifepristone was granted final marketing approval by the FDA on September 28, 2000. Sold under the name Mifeprex, it was to be used in combination with the prostaglandin, misoprostol, and was approved for abortion in women up to 49 days of pregnancy. It came with a number of conditions, but nowhere near what

might have been expected given the length and arduousness of the process and the severity and danger of some of the side effects. Several limits that had been considered were tabled after the sponsor and activists in the abortion industry mounted a public campaign decrying any restrictions.

Under the approved protocol, instead of mandated training and an ultrasound requirement, the abortionists needed only certify that they had read and understood the prescribing information and claim an ability to date pregnancy and diagnose ectopic pregnancy. They did not have to be able to surgically treat complications, but had to have some sort of arrangements for surgical backup if they themselves couldn’t provide it. They had to assure that women had access to emergency services, but gone was any requirement about being within a certain range of a qualified ER where the doctor had admitting privileges (FDA, Prescriber Agreement, 9/28/00).¹⁰

There would still be, according to the approved protocol, three visits and two sets of pills. Women would come in, be screened, receive information about the drug, and if selected, take three mifepristone tablets there in the clinic under the physician’s supervision. They would return

in two days to take two tablets of misoprostol by mouth. A third visit, two weeks out from the first, would determine whether or not the abortion was complete or further intervention was required (FDA, Mifepristone Label, 9/28/00).¹⁰

Even these watered down requirements were largely ignored by the abortion industry from the very beginning. A packet prepared and distributed by the National Abortion Federation (NAF) upon the drug’s approval contained the official FDA labeling, journal articles, supply lists, and sample consent forms, as well as a revised protocol which suggested extending the cut off limit from 49 to 63 days LMP, reducing the number of RU-486 pills from three to one, doubling the dose of misoprostol, and allowing the woman to take the misoprostol home and administer it to herself, vaginally, rather than orally.¹⁶ It was significant that the revised protocol allowed abortionists to cut costs (with RU-486 selling at \$90 a pill), increase profits, free up office space, and expand the pool of potential customers.¹⁴

Slow to Catch On

Though earlier surveys had led the abortion establishment to believe that a large number of ob-gyns and family practitioners would offer RU-486 upon approval

(44% of Ob-Gyns, 31% of family practitioners said they were “somewhat likely” to offer RU-486 in a 6/8/00 Kaiser Family Foundation survey, echoing an earlier Kaiser survey from September of 1995), few offered it once approval came, with only 6% of gynecologists, and just 1% of family practitioners in the summer of 2001 after months of heavy promotion. Perhaps even more surprising, only 12% of regular abortionists had added mifepristone to their services (Kaiser, Summer, 2001).

Reasons given by doctors for their reluctance included costs, the difficulty involved in managing such cases, issues with other doctors in the practice, and moral objections.

Growth did occur, albeit slowly. The percentage of “other procedures,” which is where the use of chemical abortifacients would have been recorded by the Centers for Disease Control (CDC) in their annual count increased from 1.7% in 2000 to 12.1% in 2005 (CDC, Abortion Surveillance summaries, 2000-2005). The Guttmacher Institute (GI) recorded 187,000 abortions with RU-486 in 2008, about 15.4% of all abortions it recorded that year (*Perspectives in Sexual and Reproductive Health*, March 2011).

The increase in use was mostly among those already in the abortion business and overall the number of abortionists continued to decline. However, there were doctors, who had not previously been involved in abortion, who began to offer the new abortion drug. While the number of abortion “providers” declined by 2% from 2000 to 2005, Guttmacher says it would have declined by 8% if not for the new doctors adding chemical abortions. In its later survey, Guttmacher indicated that the number of doctors offering chemical abortifacients rose by forty from 2005 to 2008.

Patient Deaths from the Use of RU-486

In 1991, a death was reported in France, where the drug was first approved. Hers turned out to be only the first of many. September of 2001, less than a year after U.S. marketing approval, saw two more deaths — Brenda Vise, from Chattanooga, Tennessee, who died of a ruptured undetected ectopic pregnancy (chattanooga.com, 8/14/02), and an unnamed Canadian woman who died of a rare *Clostridium sordellii* infection (National Post, 9/17/01, *Times Colonist*, 7/31/05)

Over the next four years, four more young women died of these same rare infections — Holly Patterson, from Livermore, California, dying September 17, 2003, just days after her 18th birthday, Vivian Tran, 22 years old from Costa Mesa, California, dying December 29, 2003, less than a week after taking the abortion pill, Chanelle Bryant, 22, of Pasadena, California, who died on the operating table on January 14, 2004, and Orianne Shevin, a 34 year old attorney, and mother of two, who died in Sherman Oaks, California on June 14, 2005 (*San Francisco Chronicle*, 9/19/03; eastbayexpress.com, 12/17/03; *Contra Costa Times*, 2/25/04; *New York Times*, 11/23/05).

The FDA and the CDC held a joint conference in May of 2006 attempting to investigate the sudden swell of clostridial infections in the U.S. Various presenters offered evidence of the risk of mifepristone and explained how it might suppress the immune system, making aborting women susceptible to such bacteria. However, representatives of the FDA and the CDC argued that there was no consensus and tried to make pregnancy, rather than chemical abortion, the risk factor. Despite calls to reduce or eliminate use of mifepristone, the

FDA merely issued alerts, telling prescribing doctors to keep an eye out for signs of infection (FDA/CDC, Transcript, “Emerging Clostridial Disease Workshop, 5/11/06).^{8,9}

As news of the deaths in the U.S. were being published, stories of other deaths of mifepristone patients surfaced. Two teens from Europe bled to death, 16 year old Rebecca Tell Berg, who died in her boyfriend’s shower in Udevalla, Sweden on June 3, 2003, and Manon Jones, 18, who bled to death on June 27, 2005 awaiting a transfusion in an emergency room in Bristol, England (expressen.de, 3/17/04, Swedish National Board of Health Report, 10/29/03; *Daily Mail*, 6/13/08, BBC News, 6/20/08).

In the years since, there have been additional deaths due to ruptured ectopic pregnancy, infection, and other causes associated with the use of mifepristone, fourteen total counted in the U.S. by the FDA as of April 30, 2011, with an additional five from other countries mentioned in the same report (FDA, “Mifepristone U.S. Postmarketing Adverse Events Summary through 04/30/2011”).¹¹

The FDA reported 2,207 total cases of adverse events in the

U.S., with 612 hospitalizations (excluding the deaths). Included in those adverse events were 58 ectopic pregnancies, 339 cases of blood loss sufficient to require transfusion, and 256 infections, 48 of which were termed “severe.”

The idea that this was merely some limited regional outbreak of a rare infection was called into question not simply by the large number of infections, but also by accounts of at least four additional clostridial deaths, including one by a different bacteria, *Clostridium perfringens* and the report of deaths outside the United States. The death of a 16 year old girl in Portugal with *C. sordellii* announced in 2011 showed *C. sordellii* infections could show up anywhere (T. Reis, Abstract R2542, European Society of Clinical Microbiology and Infectious Diseases, May 7-10, 2011)¹⁷ and the death of an Australian women in 2010 who contracted a group A strep infection made it plain that there was an issue with infection generally (*The Australian*, 3/19/12, Australian Broadcasting Corporation, 3/19/12).

Why Chemical Abortions are Problematic

A common medical issue in many of these deaths is how difficult it is, for both patients and

doctors, to distinguish between the ordinary side effects of chemical abortion, which are often severe, and the signs of a serious problem like hemorrhage, ruptured ectopic pregnancy, or infection.

Women are told to expect heavy bleeding, akin to a heavy period, and understand that the abortion will be painful. When these occur, they assume that they are related to the abortion process. If the pain and bleeding become so substantial that they call the clinic or go to the emergency room, even the medical professional may consider the events to be abortion related. Brenda Vise called the clinic repeatedly and was told that her considerable pelvic pain was normal. The doctor at the ER did a physical exam of Holly Patterson and sent her home with more pain medication. Both were dead before the week was out.

In addition, standard medical indicators may be insufficient. Personnel at the clinic where Brenda Vise received her abortion pills did an ultrasound but failed to find her ectopic pregnancy. *Clostridium sordellii* infections often have the odd feature of coming without fevers.

Many abortion clinics are ignoring the FDA protocol, changing doses of the drugs,

extending the cut off date from 49 days to 63, eliminating the second visit and letting women take the misoprostol at home (San Francisco Chronicle, 12/5/11), or even going so far as to prescribe the drugs via webcams, eliminating all direct physical contact between doctor and patient entirely (KCCI, 5/19/10; Sioux City Journal, 10/8/10). Failures and complications are not only common, but more problematic, as women are farther removed from the careful medical monitoring that is essential to this process.

Prescriber Response to Dangers

Planned Parenthood, the nation's largest abortion chain, responded to the growing controversy by announcing protocol changes and eventually

decided to add antibiotics to its chemical abortion regimen.

There were five known deaths of mifepristone patients in North America when another two were announced in March of 2006, both happening to be Planned Parenthood customers (one was later determined not to be related to abortion or infection). At that point, Planned Parenthood came forward and announced that they would no longer be asking patients to administer the prostaglandin vaginally (*New York Times*, 5/11/06; *Weekly Standard*, 10/22/07).

A study by Planned Parenthood appearing in the July 9, 2009 issue of the *New England Journal of Medicine* indicated that infections among its patients dropped substantially after the switch, from 69 out of 77,182, to 25 of 166,510. Planned Parenthood instituted another protocol change, adding a prophylactic antibiotic, first at several clinics, finally as organization-wide policy in July of 2007. With the antibiotics, there were just five serious infections among 116,082 chemical abortion patients.

Not everyone was happy with the changes. Vicki Saporta, president of the National Abortion Federation, and Beverly Winikoff,

a longtime promoter of chemical abortifacients, told a reporter from the Associated Press (7/8/09) that while antibiotics could prevent a few infections, they could also “trigger rare allergic reactions, add to the problem of antibiotic resistance, and raise the cost of the procedure, making it unaffordable in developing countries.”

Many of those working with Saporta and Winikoff also continue to direct patients to do the vaginal self-administration of misoprostol, whose safety and efficacy the FDA warns has not been established (FDA, “Mifeprex (mifepristone) Information, 7/19/11). In its 4/30/11 postmarketing report on adverse events, the FDA noted that vaginal misoprostol was used in seven out of the eight sepsis deaths.

The Guttmacher Institute estimated that in 2008, more than a quarter of all abortions done at 9 weeks gestation or earlier were chemical abortions and both the overall percentage of chemical abortions and the number of clinics offering these abortions have been steadily increasing. If things continue trending as they are, it means that we can expect more women will die, along with tens of thousands more of their unborn children.



Randall K. O'Bannon, Ph.D., received his doctorate in philosophy from Georgetown University in 1998. He first joined National Right to Life in 1989 and has served as its director of education and research since 1994. For nearly two decades, he has tracked the latest scientific research and statistics on abortion and other life issues for the National Right to Life Educational Trust Fund. He has done research and written on the abortion industry's efforts to develop and deploy RU-486 in the U.S., and he has tracked the deaths associated with this abortifacient. He has produced numerous publications on the topic to educate the public about the dangers of RU-486.

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The Use of the Abortifacient Mifepristone (RU-486) in the Developing World

Donna Harrison, M.D.,

Director of Research and Public Policy, American Association of
Pro-Life Obstetricians and Gynecologists

The use of non-surgical (medical) abortion in the developing world has had great appeal for abortion advocates. Surgical procedures in third world countries with

poor medical infrastructure, lack of dependable transportation to emergency centers, and even inadequate water supplies pose health risks for patients electing to have a surgical abortion. On the other hand, simply taking a pill to undue the pregnancy appears to be a good solution for third world women. The reality is that surgical abortions are still necessary in a number of cases because the pill fails; medical abortions are being attempted in settings with inadequate backup to care for complications; and hemorrhaging, a common side-effect of RU-486 abortions, is harder to control in third world environments. Unfortunately, there is a tendency to disregard such problems by enthusiastic abortion advocates, eager to expand abortion use in these countries.

In a moment of unguarded honesty, an ironic article entitled “*Medical abortion: is it a blessing or curse for the developing nations?*” was published in the medical literature in 2011¹. Despite the requisite opening praise of medical abortion, which is a

requirement for publication in most medical journals, this article gives a rare glimpse into the reality of willy-nilly access to drugs which can end a pregnancy, in the setting of rural Sri Lanka. The abstract opens with this statement

“Medical abortion is definitely a safer and a better option but in developing countries, its widespread misuse has led to partial or septic abortion thereby increasing maternal mortality and morbidity.”

The article goes on to state that less than half of the women had complete abortions [49.62%], while the remaining had “incomplete (41.54%), septic (6.54%) or failed abortion (1.15%) or ectopic pregnancy (1.15%).” And further on the authors state:

“When the medical methods of abortion were launched in developing countries like India it was thought that frequency of illegal unsafe abortions by local dais and unregistered practitioners will decrease to a large extent and it will help in managing such unwanted pregnancies through

Donna Harrison, M.D. graduated from the University of Michigan Medical School in 1986 and completed her residency in Obstetrics and Gynecology in Ypsilanti, MI in 1990. She worked in Haiti as a consultant physician from 1989 to 1994. She has been actively involved in pro-life public policy activities since medical school. She has testified before state and national hearings on the abortion issue, including the House subcommittee on Criminal Justice, Drug Policy and Human Resources of the U.S. House of Representatives regarding adverse events related to the use of mifepristone (RU-486) and before the Reproductive Health Advisory Committee of the Food and Drug Administration, regarding the approval of RU-486 for use as a chemical abortifacient. In 2000, Dr. Harrison retired from clinical practice to pursue a more active role in pro-life public policy work. She is currently serving as chairman-elect of the board of directors of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG). She is chairperson of the AAPLOG subcommittee on RU-486 and co-authored the Citizen Petition filed with FDA to remove RU-486 from the market. She has published several medical journal articles on the adverse effects of RU-486 on women. She is board certified by the American Board of Obstetrics and Gynecology.

safe and legalized abortions in peripheral health centres (PHCs), community health centres (CHCs), and civil hospitals. No doubt, though unsafe surgical abortions have decreased largely due to strict legislations but these have been replaced by increasing number of unsafe medical abortions.”

Another article⁴ from Vietnam, published in *Contraception*, reveals the complications from misoprostol abortions vs. combined mifepristone+misoprostol abortions:

“... the misoprostol alone regimen tested had a success rate of 76.2%.” [This means that for every four women treated, one would have to have surgery to complete the abortion]

“The rate of ongoing pregnancy was... 16.6% with misoprostol-alone. This means that for every seven women treated with misoprostol-alone ... one ongoing pregnancy would occur.”

The authors go on to discuss the promotion of medical methods of abortion:

“Use of misoprostol-alone has been advocated in the absence of mifepristone availability in many regions, particularly sub-Saharan Africa and Latin America. Yet, the results from the present trial clearly document the inferiority of misoprostol-only compared to a combined regimen”

The Sukwinder and the Ngoc article demonstrate what could have been easily predicted from an understanding of the adverse events associated with medical abortions even under the very best conditions in the West. A recent large registry based study from Finland demonstrated that under the best conditions, medical abortion had four times higher total number of adverse events than surgical abortion (20% vs. 5.6%, $p<0,001$). Medical abortion patients hemorrhaged over seven times more often than surgical abortion patients (15.6% v. 2.1%, $p<0.001$). Medical abortion patients had incomplete abortions at a rate of 6.7% compared with 1.6% of failed surgical abortions, ($p<0.001$). 5.9% of medical abortion patients had to have surgery to complete their abortion or manage complications, vs. 1.8% of surgical abortion patients ($p<0.001$). And medical abortion patients had 20 times greater risk of operative injuries from the emergency surgeries required as did surgical abortion patients (medical 0.6% vs. surgical 0.03% $p<0.001$) These findings led the authors of the Finnish study to conclude:

“Because medical abortion is being used increasingly in several countries, it is likely to result in an elevated incidence of overall morbidity related to termination of pregnancy.”

So, we know from multiple studies that first trimester medical abortions with mifepristone and misoprostol result in:

- 20 out of every 100 women with a significant adverse event (hemorrhage, infection, retained tissue, continued pregnancy exposed to drugs which can cause fetal malformation)
- 15 out of every 100 women hemorrhage
- 7 out of every 100 women have tissue left inside, which can become infected, and
- 6 out of every 100 women need surgery, sometimes as emergency surgery.

What about second trimester terminations?

Another study from the Finnish registry reveals that women who have a second trimester medical abortion are 7.8 times more likely to need subsequent surgery than women who have a first trimester medical abortion, and twice as likely to get infected.

So, who is promoting the false idea that medical abortion is somehow safer than surgical abortion? Let’s contrast the reality of the Sukwinder and Ngoc articles to the wildly glowing claims of one of the organizations responsible

for the irresponsible promotion of abortion drugs: Ipas, a global nongovernmental organization “advancing women’s reproductive rights.” In their publication entitled, “Providing Medical Abortion without Technology in Nepal,” Ipas claims that without ultrasound or pre-operative testing, and without physicians or clinics staffed to handle emergencies:

- “The overall success rate of medical abortion during the pilot phase was 96 percent and in the six subsequent months it was 98 percent, thus demonstrating that the service can be provided with virtually no technology.
- Well-trained and experienced providers already provide care by relying on their clinical skills, history and evaluation to assess an array of health conditions. They’ve proven that the same skills are ample to assess a woman’s condition

and gestational age prior to medical abortion, assess and provide treatment should a rare complication arise, and evaluate success of medical abortion.”

Can it be that women who go to rural clinics in Nepal somehow magically do better than Scandinavian women with nationalized health care, or women in Sri Lanka or Vietnam? Or could it be that Ipas is counting on no one checking their claims?

Ipas makes even more frankly fraudulent claims:

“Before the legalization of abortion in Nepal in 2002, it was estimated that up to half of the maternal mortality was due to unsafe abortion. The maternal mortality rate prior to legalization of abortion was 539 per 100,000 live births”

But, how does IPAS’s claim relate to peer-reviewed medical literature

on maternal mortality? Hogan⁶ reports the maternal mortality rate for Nepal by year as:

Rate	Year
865	1980
471	1990
343	2000
240	2008

Abortion was legalized in Nepal in 2002, at which point the maternal mortality rate was 343 per 100,000 live births, not 539 per 100,000 live births as Ipas claimed. Clearly, the maternal mortality rate was dramatically falling in Nepal BEFORE the legalization of abortion. Yet, these false claims by Ipas and others about the rate of maternal mortality due to “unsafe” abortion are used to persuade governments to not only legalize abortion, but also to allow for the unsupervised use of abortion drugs, which will actually increase maternal mortality in the developing world.



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