Unmasking the Truth About Chemical Abortions

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ABSTRACT: The goals of those in government and healthcare include expanding access to abortion. The American College of Obstetricians and Gynecologists as well as the U.S. Food and Drug Administration have circumvented many state laws restricting abortion by allowing telemedicine chemical abortions without a clinic in-person visit by the teen or woman. These recommendations are based on studies on telemedicine abortions in the U.S., which show minimum side effects from medication abortions. The data upon which this is based is in sharp contrast to European studies, which show significant morbidity for the patient, even with a physical exam, ultrasound, screening, and treatment for STDs and in-person follow-up. States need to ban telemedicine abortions without an in-person visit, including a pelvic exam and pelvic ultrasound. Key words: Abortion, medication abortion, chemical abortion, telemedicine abortion, complications of chemical and medical abortions.

IT IS A PRIVILEGE to write about a crucial life issue which is flying under the radar for most people, even in the pro-life community. It is the expansion of abortion in this country and around the world with chemical abortions. The Planned Parenthood Federation of America (PPFA) and the American College of Obstetricians and Gynecologists (ACOG) refer to these as "medication abortions" or "self-managed abortions."

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Their goals were outlined in an ACOG Committee Opinion, published in December of 2020, entitled *Increasing Access to Abortion*. They include the following: 1) Eliminate the federal Hyde Amendment, attached to every appropriations bill in Congress since the 1970's, which prevents taxpayer funding of abortion. 2) Eliminate other federal and state restrictions on Medicaid, Medicare and private insurance coverage of abortion. 3) Repeal of all laws that ban abortions at certain gestational ages and that require that a physician, particularly an ob-gyn, perform the abortion. 3) Repeal all laws putting restrictions on chemical abortions and requirements for mandatory counseling and a 24-hour waiting period before having the abortion. 4) Repeal all laws requiring an ultrasound before the abortion. 5) Repeal all laws requiring parental notification or permission to have the abortion. 6) Repeal all laws requiring certain facility and staff requirements. 7) Expand the number of abortion providers by requiring all Obstetric-Gynecology residency training programs to provide abortion training and get funding for opt-out residents. 8) Require all hospitals and healthcare systems to view abortion as "essential healthcare."[1]

Chemical abortions are being done primarily with a drug called mifepristone. It was developed in 1980 by a French company, Roussel-Uclaf, and the chemical name was RU-486. The parent company was Hoescht-AG, the German company that was part of I.G. Farben, which was responsible for developing the gases used in the gas chambers in the concentration camps in World War II.

In 1988, the parent company's board actually voted to stop production of this drug, due to pro-life protests, but was overruled by the French government two days later, "in the interests of public health." As its use expanded as an abortifacient in Europe, boycotts by pro-life groups prompted its transfer to a company that was a single product company, Danco Laboratories, LLC. Danco has a New York City mailing address and a confidential board of directors. The site of the manufacturing plant for the drug is unknown. It is funded

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[1] ACOG Committee Opinion, Number 815. Increasing Access to Abortion. *Obstet Gynecol*. 2020; 136(6): e107-e115.

by the Packard Foundation, George Soros, Warren Buffett, and the Kaiser Family Foundation.

Mifepristone is a selective progesterone receptor modulator that binds to the progesterone receptor with an affinity greater than progesterone itself without activating the receptor, thus preventing the normal progesterone support of the pregnancy. It acts as an anti-progestin, causing decidual necrosis, resulting in the separation of the decidua from the trophoblast and death of the fetus. It also causes softening of the cervix and increased uterine contractility. Given alone up to 49 days, this drug results in a complete abortion in only 60 to 80% of cases. So to complete the abortion, misoprostol, a prostaglandin E1 analogue, is given 24 to 48 hours later to facilitate uterine contractions and empty the uterus. It has been formally approved by the FDA for this purpose in abortions, though it was originally used for gastric ulcers under the name Cytotec®, made by Pfizer.

In 2000, the Food and Drug Administration (FDA), under President Clinton, gave an expedited approval of mifepristone for abortions up to 49 days from the first day of the last menstrual period. It was approved with restricted access called a "risk evaluation mitigation strategy" or REMS, which meant the drug had to be prescribed and dispensed in-person in a clinic, medical office, or hospital by a physician; there had to be a written disclosure of side effects; and a pelvic ultrasound and gynecological exam needed to be performed to rule out an ectopic pregnancy, along with a hemoglobin and blood screen for the Rh factor (RhD). The first drug would then be dispensed to the patient and taken while in the clinic or medical setting. The patient would return 48 hours later to receive the second drug, misoprostol. A return visit two weeks later was done to confirm a complete abortion by ultrasound or exam.

There are absolute contraindications to the drug, including an ectopic pregnancy, the presence of an intrauterine device, long-term corticosteroid use, and adrenal failure (because the drug also binds to

glucocorticoid receptors). It is also absolutely contraindicated if the woman has a coagulopathy or is on anticoagulants, has inherited porphyria, anemia, or a known allergy to either of the two drugs. The risk of blood transfusion is 10 times greater with a chemical abortion than for a surgical abortion. Side effects include bleeding, severe cramping, infection, nausea (43-66%), vomiting (23-40%), diarrhea (23-35%), headache (13-40%), chills and fever (32-69%) and incomplete abortion. As of 2020, 4,000 adverse effects have been reported to the FDA with 24 maternal deaths, but since 2016, only maternal deaths are reportable. Emergency rooms are not required to report complications from abortions.[2]

In March of 2016, the FDA approved its use up to 70 days from the first day of the last menstrual period (LMP). The protocol, until April of 2021, was an in-person visit in a clinic or office with a pelvic ultrasound to determine the gestational age and to rule out an ectopic pregnancy. The woman is then given 200 mg of mifepristone, on the order of a physician, to take in the clinic or office by mouth in front of the "healthcare professional." The patient is given 800 mcg of misoprostol to take buccally 24 to 48 hours later with a phone follow-up in a week. The cost of a chemical and surgical abortion is the same: $300-$500.

How many abortions are actually done each year in the U.S.? The answer is we do not know. Since 1969, reporting of abortions to the Centers for Disease Control (CDC) has been voluntary in the 50 states, New York City, and Washington, D.C. However, for many years, there has been no data reported from California, our most populous state, or Maryland, New Hampshire, or Washington, D.C. In many of the states that do report, they do not separate chemical abortions from surgical abortions, and because many of these are being done in private medical offices, the actual number is unknown.

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[2] ACOG Practice Bulletin, Number 225. Medication abortion up to 70 days of gestation. *Obstet Gynecol*. 2020; 136(4): e31-e47.

As of 2017, chemical abortions comprised 39% of all abortions performed in the U.S. Between 2001 and 2008, a million doses of mifepristone were dispensed in the U.S., according to the drug company, Danco.

If we do not have reliable statistics in the U.S., how can we determine the risk from chemical abortions? The answer is we cannot, so we have to look to other countries that have more reliable tracking of abortion patients. One such country is Finland where a group of investigators reported on outcomes for 42,619 women having either a chemical or surgical abortion up to 63 days from the first day of the LMP. The women were followed up to 6 weeks after the abortion, using national health registries with each woman having a unique personal identification number. Adverse events were counted from treatment in the public health system but not if they were seen with complications outside the hospital. They found the overall incidence of complications was **four times higher** with chemical abortions than with surgical abortions (20.0% vs 5.6%). The leading complication was hemorrhage (15.6% vs 2.1%) followed by incomplete abortion (6.7% vs 1.6%). There was no difference between the two types of abortion in the incidence of infection, thromboembolic disease, psychiatric morbidity, or death.[3]

In another Finnish study from 2011, a comparison was made between teenage and adult women having a chemical abortion in one county with a homogeneous population, between 2000 and 2006. The study included 3,024 adolescents and 24,006 adult women. The rate of chlamydial infection was higher in the adolescent population versus the adult women (5.7% vs 3.7%). Complications of the chemical abortions included hemorrhage (12.8% teen versus 15.4% adult), incomplete abortion (7.0% teen versus 10.2% adult), with 11% of teens and 13.0% adults requiring a dilation and curettage to complete the abortion. Over 80% of the abortions

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[3] Niinimaki M, Pouta A, Bloigu A et al. Immediate complications after medical compared with surgical termination of pregnancy. *Obstet Gynecol*. 2009; 114(4):795-804.

in each group were at 9 weeks or less but they were doing chemical abortions up to 20 weeks of pregnancy.[4]

Another study was carried out in Sweden, where induced abortion is the most common gynecological procedure performed with a rate of 20/1,000 women of reproductive age per year. Complications were studied in one hospital system, Skaraborg Hospital, between 2008 and 2015. This hospital system captures **all** the women having an abortion in that region. A total of 4,945 abortions were performed with 74.7% of them chemical abortions at less than 12 weeks. Women were first seen by a gynecologist in the gyn clinic. An ultrasound exam was performed to determine the correct gestational age, and a pelvic exam was performed with screening for bacteria and sexually transmitted infections (STDs). If the tests were positive, the woman was treated for the infection prior to the abortion. It should be noted that the World Health Organization (WHO) recommends antibiotic prophylaxis in **all** women having an abortion to prevent infectious complications. Women who were young and in their first pregnancy had the medical abortion in the hospital, while the rest took the medications and aborted at home. They were seen a month later by a midwife and had a repeat level of β-hCG drawn to confirm the abortion was complete. The complication rate for the chemical abortions averaged 7.3%, and they found that the rate of complications increased from 4.2% in 2008 to 8.2% in 2015, which they attributed to more abortions being done at home.[5] When women were tested and treated for infections prior to the abortion, there was no difference in post-abortion infections than with the women who tested negative.

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[4] Niinimaki M, Suhonon S, Mentula M et al. Comparison of adverse events in adolescent and adult women undergoing medical abortion: population register based study. *BMJ* 2011; 342:d2111. doi:10.1136/bmj.d2111.

[5] Carlsson I, Breding K and Larsson P-G. Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health*. 2018; 18:158. https//doi.org/10.1186/s12905-018-0645-6

In contrast to these large studies with reliable follow-up, a leading abortionist in this country, Dr. Daniel Grossman, who is also a consultant for the PPFA, published a retrospective cohort study in 2017 of women receiving a chemical abortion either in-person or via telemedicine in Iowa through Planned Parenthood of the Heartland. The purpose was to get around Iowa's law, and those of many other states, which require that an abortion must be performed by a physician. Telemedicine would allow a physician to cover a whole state, even in remote, rural areas. Data was collected from July 1, 2008, to June 30, 2015, from PPFA clinics in Iowa. A total of 8,765 telemedicine and 10,405 in-person chemical abortions were performed. It was never stated how many patients had complete follow-up. All patients were initially seen at a Planned Parenthood clinic where a medical history was obtained, a hemoglobin, pelvic exam, and ultrasound were performed. In five clinics there was a doctor on-site and in 13 clinics a physician reviewed the results and prescribed the drugs via telemedicine. The data was analyzed for hospital admission, surgery (but not a D&C for an incomplete abortion), blood transfusion, and death. They surveyed 119 emergency rooms from June to October 2014 by Survey Monkey asking for any women who had had an abortion in the past 12 months presenting to the emergency room (ER) with complications. Of the 35% of ERs who responded, no visits were recorded. Data was also sought from Danco Laboratories. They claimed that only .18% of telemedicine patients and .32% of in-person patients had an adverse event. These percentages are in sharp contrast to the Finnish and Swedish studies, which showed much higher complication rates. Studies such as these surveys are being used to relax abortion practices in this country.[6]

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[6] Grossman D, Grindlay K. Safety of medical abortion provided through telemedicine compared with in person. *Obstet and Gynecol*. 2017; 130(4): 778-782.

We have gone over the original evaluation and follow-up for women seeking a chemical abortion in the U.S and have discussed the complications found in large series in countries with reliable statistics. What does the American College of Obstetricians and Gynecologists (ACOG), which is supposed to be the chief advocates for women's' health in the U.S., recommend?

In the ACOG Practice Bulletin no. 225 from October of 2020, the work-up prior to dispensing a chemical abortion should be simply a history of the first day of the last menstrual period within the last 56 days and if no signs, symptoms, or risk factors for an ectopic pregnancy are present, then **no exam or ultrasound is needed**. ACOG states that the ectopic pregnancy rate is low in this country but there are no statistics since 1992! No cultures for STDs are done, and no antibiotics are prescribed. As an aside, many crisis pregnancy centers provide a pregnancy test, ultrasound, and testing for STDs at no cost to the woman, and that information could be taken to the abortion clinic. ACOG officially recommends Rh testing but in this document they state that "experts" no longer think that testing and Rhogam treatment in Rh negative women who are less than ten weeks pregnant are necessary after an abortion. The woman is counseled that a chemical abortion is "safe and effective" and that mifepristone is not teratogenic but misoprostol is. ACOG proposes that any clinician (physician, PA, CNM, NP) "with skills to screen patients for eligibility for medication abortion and to provide appropriate follow-up can provide medication abortion. Clinicians who wish to provide medication abortion services should be trained to perform evacuation procedures or *should be able to refer to a clinician who has the training* (emphasis added)." In most cases that is an emergency room.[7]

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[7] ACOG Practice Bulletin, Number 225. Medication abortion up to 70 days of gestation. *Obstet Gynecol*. 2020; 136(4): e31-e47.

ACOG is also promoting abortion via telemedicine to increase access where there is not an abortion provider in the area. They claim an adverse event of only 0.3% with telemedicine abortions, which is not consistent with the well-controlled Scandinavian studies we mentioned above. Telemedicine for chemical abortion was vastly expanded in April of 2021. The Supreme Court ruled in January of 2021, that a woman had to be seen in-person to receive the drugs for an abortion, despite attempts to overrule the FDA and dispense the drugs online and by mail. However, under the new administration, claiming increased risk of in-person visits to a woman of childbearing age in a pandemic, that FDA rule was lifted, allowing for women seeking an abortion to do so without ever seeing a physician in-person. This greatly expanded the reach of abortionists to cover women and girls in multiple states, thus fulfilling the promise of the new administration to expand abortion.

Some women change their minds after beginning a chemical abortion and they seek out a physician to help them by taking bioidentical progesterone to counter the effects of the mifepristone. First, let us consider how often would a fetus survive if the woman took mifepristone alone? Davenport et al did a systematic review of the world's literature from 1980 through March of 2016 to identify studies that documented survival of the fetus by ultrasound after being exposed to varying doses of mifepristone. Of 1855 studies identified only 18 met the criteria describing embryo survival, not just a failure to abort. In patients who were 49 days pregnant or less and received 200 to 300 mg of the drug, 10-23% of babies survived.[8] Grossman et al also performed a systematic review of articles published through March of 2015 on continuing pregnancies, but not necessarily embryonic survival, after varying doses of mifepristone.

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[8] Davenport ML, Delgado G, Harrison MP, Khauv V. Embryo survival after mifepristone: a systematic review of the literature. *Issues in Law and Medicine.* 2017; 32(1): 3-18.

They looked at continuing pregnancies 7-14 days after the drug was taken and found a range of 8% to 46%, but survival of the embryo was not documented.[9] However, those who support abortion use that upper number of 46% to say that abortion pill reversal with progesterone is no better than stopping the abortion process before giving misoprostol.

Is there an animal model for reversing RU-486? A Japanese study in 1989 compared pregnant rats exposed to mifepristone compared with pregnant rats given the drug plus progesterone. There was a 33% survival in the mifepristone group and 100% survival when give progesterone with the drug.[10] After Delgado et al published six cases of successful reversal with progesterone[11] they undertook an observational case series of 754 patients who asked to stop the abortion process before they took the misoprostol. Data was collected by multiple doctors around the U.S. to whom the patients were referred geographically, and patients were followed to delivery. The overall rate of reversal with a live baby was 48% in the 547 who completed the study.[12]

An attempt was made to discredit this series of cases with a randomized control study by an obstetrician-gynecologist with 30 years of published research on various drugs to cause abortion. The 12 participants were 44-63 days pregnant and were given

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[9] Grossman D, White K, Harris, L et al. Continuing pregnancy after mifepristone and "reversal" of first trimester medical abortion: a systematic review. *Contraception*. 2015; 92: 206-211.

[10] Yamabe S, Katayana K, Mochuzuki M. The effects of RU-486 and progesterone on luteal function during pregnancy. *M. Folio endocrine*. 1989; 65: 497-511.

[11] Delgado G and Davenport M. Progesterone use to reverse the effects if mifepristone. *Ann Pharmacother*. 2012;46. Published online, 27 Nov 2012, *theannals.com*, DOI: 10.1345/aph.1R252.

[12] Delgado G, Condly SJ, Davenport M et al. A case series detailing the successful reversal of the effects of mifepristone using progesterone. *Issues in Law and Medicine*. 2018; 33(1): 3-14.

mifepristone 200 mg, followed 24 hours later by 400 mg oral progesterone or placebo twice daily for 72 hours and then once daily until they had a surgical abortion 14-16 days later. Two women dropped out due to side effects and of the remaining 5 in each group, 4 in the progesterone group and two in the placebo group had cardiac activity two weeks later. Two of the placebo patients and one of the progesterone patients experienced a significant hemorrhage, and the study was discontinued as inconclusive.[13]

In summary, we can expect a shift from surgical abortions to chemical abortions and increasing numbers above the estimated 3,000 abortions performed per day at this time because it has been made so easy. A chemical abortion can be obtained on impulse, with no one else knowing, including the father of the baby. The woman will bear the side effects of these drugs after being told a chemical abortion is safe and effective. She herself will be causing the abortion in her own home, not in some separate facility by an unknown doctor. It also puts women at risk for abuse and sex trafficking by allowing someone to obtain these drugs by telemedicine without an in-person visit and testing of the pregnant woman herself. In the end, abortion is not healthcare, as it ends the life of an unborn child. It is clear that these new allowances for unrestricted telemedicine chemical abortions will also have an adverse effect on women's health.

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[13] Creinin M, Hou M, Dalton L et al. Mifepristone antagonization with progesterone to prevent medical abortion: a randomized controlled trial. *Obstet Gynecol*. 2020; 135(1): 158-165.