

Medical abortion reversal: science and politics meet



TO THE EDITORS: I read with great interest today your recent publication of the article by Bhatti et al.¹ The 2 senior authors are well experienced in medical and surgical abortion and are highly qualified to comment on the medical aspects of abortion. The authors use evidence-based medicine to demonstrate the safety and effectiveness of medical abortion.

The remainder of their article is basically their personal opinion of abortion and abortion law masked as science. Their claim that “medical abortion reversal bills are not based in science” is untenable. Medical abortion reversal is completely based on science and medicine and on a valid, common-sense, and not-disproven medical theory and has no proof of deleterious effect. Its efficacy is currently in the state of systematic evaluation because medical abortion efficacy was investigated years ago.

The authors are quite inconsistent in their use of evidence-based data. Their claim that “counseling about medical abortion reversal ... poses a direct threat to women’s health” is completely unsupported by any such evidence. The inclusion of references to multimillion dollar lawsuit information is tangential to the nature of the paper (relevant to neither medicine nor politics) and is a carefully manufactured and included distraction or scare tactic designed to inflame emotion favorable to the authors’ personal beliefs.

Medical abortion reversal is a physician-initiated and supervised practice of growing popularity that has not been proven harmful. Evidence of its efficacy continues to accumulate. It is based on the principles of human safety and dignity and the sanctity of the life of all humans, not just that of an inconvenienced mother. There are no reported cases of death or permanent disability related to medical abortion reversal. The authors’ failure to use evidence-based medicine to prove the practice unsafe is inconsistent and does not hold up to academic scrutiny.

A more appropriate conclusion by the authors would have been a modification of their final sentence to the following: “given the current paucity of evidence for medical abortion reversal toxicity, and given its potential efficacy, it is the responsibility of physicians and obstetrician-gynecologists to advocate for our patients who are undecided about their medical abortion to offer this as a safe alternative. To do otherwise violates our moral obligation to provide informed consent.”

Until and unless medical abortion reversal is demonstrated to be harmful, there should be no law prohibiting it. Conversely, with the current growing state of knowledge of the potential efficacy of it, a law that requires it to be discussed is reasonable. Any law that requires truly informed consent from abortion practitioners is beneficial to the public good. ■

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The author reports no conflict of interest.

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1. Bhatti KZ, Nguyen AT, Stuart GS. Medical abortion reversal: science and politics meet. *Am J Obstet Gynecol* 2018;218:315.e1–6.

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REPLY



We thank Dr Doherty for his letter to the editor.

The purpose of a medical abortion is to achieve the termination of an early pregnancy using abortion-inducing medication(s). Therefore, among those women with an embryo/fetus, the intent is embryonic/fetal demise.

A medication must have proven safety and effectiveness in its proposed use(s). The US Food and Drug Administration requires a supplemental new drug application to add new indications for an already-approved drug that examines the safety profile in the new population as well as provide comparisons with previously approved indications.¹ However, evidence of the effectiveness of progesterone for medical abortion reversal is theoretical, observational, and sparse. Mifepristone alone is not an effective abortion-inducing medication because up to 25% of women will have a continued pregnancy after a single dose of 200 mg of oral mifepristone without misoprostol.²

Since the publication of our article, Delgado et al³ published a case series about abortion reversal in *Issues in Law & Medicine*, a journal cosponsored by the Watson Bowes Research Institute, which focuses on “balanced research into the life sciences” and is affiliated with the American Association for Pro-Life Obstetricians and Gynecologists.

Of 547 participants from multiple countries who were recruited via an informational hotline linked to a website, 48% continued their pregnancies after receiving nonstandardized progesterone therapy from 325 different medical providers.³

It is difficult to draw conclusions from this study because it did not follow the usual standards of reporting and study design for observational trials.⁴ As noted by Dr Hal Lawrence, executive vice president of the American College of Obstetricians and Gynecologists, the case series was “poorly designed and falls far short of providing sufficient evidence to recommend this course of treatment.”⁵

We believe that women have a choice in whether to undergo a medical abortion and a choice in whether they then seek to reverse it. However, women should be informed that the evidence to support this choice is weak. Most importantly, legislation should not be imposed on physicians and patients when they are based on hopeful medicine rather than evidence-based medicine. ■

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The unforeseen psychological, behavioral and physiological complications associated with intra uterine device use contraceptions



TO THE EDITORS: I read with great interest the recent article by Kebodeaux et al¹ published in the Journal. This retrospective study evaluates the effectiveness of intrauterine device (IUD) insertion in sexually active (SA; n = 128) and never sexually active (NSA; n = 82) adolescent females. The office-alone subanalysis results shows that compared with SA adolescent females (n = 121), NSA adolescent females (n = 43) are likely to have unsuccessful IUD insertion outcomes (16.3% vs 4.3%) and higher procedural intolerance outcomes (81.4% vs 94.2%). It is surprising to identify that abnormal uterine bleeding, pelvic pain, and dysmenorrhea are the noted reasons for IUD insertion to SA and NSA adolescent females.¹

An earlier retrospective cohort study from Bangladesh (n = 330) reports 47.3% of women discontinued the IUD by 1 year after insertion; discontinuation was associated with menstrual bleeding, doubling of menstrual days, blood loss, abdominal pain, and sociopsychological boundaries. During menstrual periods, women in south Asia often face social and cultural isolations that may turn into an abusive, violent, and disrespectful environment if male members of the family find IUD insertion as the cause of abnormal bleeding.²

Beyond psychological, behavioral, and physiological adversities, IUD insertion does not provide protection against sexually transmitted disease such as transmission of human immunodeficiency virus (HIV).³ Also, that hormonal IUDs are suspected to accelerate HIV infection may increase psychological pressure in women opting for long-term contraception devices.³ However, any decision that cuts down use of hormonal contraception for women at higher risk of acquiring HIV can be more harmful than expected goodness.³ Use of the copper-based IUD may counter this argument because these devices does not involve the use of hormones.

I would argue against the health care recommendation by Kebodeaux et al¹ that IUD uptake should increase in adolescent NSA females. Why should adolescent NSA females go through the painful events related to IUD insertion before being psychologically prepared for sexual life? Arguably, IUD recommendations to SA or NSA adolescent females belonging to Asian reserved-culture societies that still do not accept the use of condom and contraceptive pills as birth control option may be futile.² Sexual education and large-scale intention-to-treat clinical trials may pave the foundation toward acceptance of next-generation contraceptive approaches. ■

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