

CHAPTER 20

VERY EARLY ABORTIONS

These fall into two general categories: those that prevent implantation at one week of life and those which kill a developing baby days or weeks after implantation.

Before Implantation:

Which methods do this? In varying degree, the methods that prevent implantation, and therefore kill a baby at one week of life, include the intra-uterine device (IUD), Norplant, Depo Provera, Progesterone-only pills, low-dose contraceptive combination pills, and the morning-after pills. Let's take them one at a time.

How about Norplant?

This is an implant under the skin of her forearm that lasts five years. In the first half of that time, its effect is to almost always suppress ovulation. In the last half of that time, break-through ovulation is the rule. However, very few pregnancies survive. Clearly, this second half is commonly effective through micro-abortions and prevention of implantation.

What about Depo Provera?

As with Norplant, there is some variance from woman to woman, but in a far higher percent of cases Depo Provera suppresses ovulation. Break-through ovulation, however, does occur as attested to by full-term pregnancies recorded with women who were receiving this shot every three months.

What of the IUD?

The intrauterine device, commonly referred to as an IUD or coil (in Europe), is a small plastic or metal device that is inserted through the vagina and into the cavity of the uterus. The purpose of this is to “prevent” pregnancy.

Is an IUD a contraceptive or an abortive agent?

Until recently, almost all scientific papers had agreed that its effect was to prevent the implantation of the tiny new human being into the nutrient lining of the uterus; an abortive action.

The U.S. Food and Drug Administration stated in an official report that its effectiveness is “in direct proportion to the quantity and quality of the inflammatory reaction to various types of IUDs”...and states that there “is one common thread . . .” They all “interfere in some manner with the implantation of the embryo in the uterine cavity.”

Second Report on IUDs, Dec. 1978, U.S. Dept. of HEW, Food & Drug Administration Document 017-012-00276-5

“The inhibition of implanation of the embryo remains a major, if not the dominant, mechanism of action of IUDs”

J. Spinnato, “Mechanism of Action of IUDs . . .”
Am. J. OB & GYN, 3/97, Vol. 176, No. 3, pp. 503-6

A detailed report in a Planned Parenthood publication in 1989 claimed that a high percentage of its action

was the prevention of fertilization.

IUDs are Contraceptives, not Abortifacients:
A Comment on Research and Belief, I. Sivin, *Studies in Family Planning*,
Vol. 20, No. 6, Dec. '89

The above report, however, has not been duplicated and therefore has not presented enough evidence to change the conventional wisdom that the IUD is almost always an abortive agent.

What of Progesterone-only pills?

These fall into the same category as the Progesterone-only implant, Norplant, and the Progesterone-only injection, Depo Provera.

How does the morning-after pill work?

This medication has an antinidatory effect on the endometrium (that is, a hardening of the lining of the uterus), which prevents implantation of the tiny new human being (blastocyst stage).

If, for example, a rape victim had ovulated just before the assault and fertilization had occurred, then the use of such medication after the event would clearly be abortive.

There is a possibility that it can act in a sterilizing fashion. The large hormone dose could rapidly affect the ovary and prevent an ovulation that might have occurred one to three days after the intercourse. If sperm were still present and active in the woman's genital tract, she might be fertilized one to three days after the event. In this case, some have suggested that such treatment (as for an assault rape victim) might actually prevent a pregnancy, but this has not been proven.

Kahlenborn, Larimore, and Stanford
The Annals of Pharmacotherapy
"Effective Hormone Emergency Contraception"
March 2002, Volume 36, Number 3 Page 465-470

Kahlenborn, et al., amply document that the so-

called emergency contraceptive pill would more logically be termed, emergency abortion pill. We had always known that if she ovulated before she had intercourse, and the next day took this pill, that it was ridiculous to think that it could prevent a fertilization that had occurred 12 hours earlier. This study shows that even if it's taken prior to ovulation, it has a significant failure rate.

They also thoroughly document the abortive effect, that while ovulation and fertilization can occur, this pill prevents implantation at one week of life and therefore is legitimately called an abortifacient.

ibid.

What about the standard contraceptive pill?

There are over 30 “contraceptive” pills on the market, each differing a little from the others. They “prevent” pregnancy through three separate functions.

1. They thicken the mucous plug at the cervix. If this is the primary effect, then it truly is contraceptive because it prevents sperm from entering.

2. They prevent release of the ovum. If this is the primary effect, then the function is “temporary” sterilization.

3. They render the lining of the womb hostile to the implantation of the tiny new human at one week of life. This effect is abortifacient.

The earlier high-estrogen pills largely prevented ovulation. The newer low-estrogen pills allow “break-through” ovulation in up to 20% or more of the months used. Such a released ovum is fertilized 10% or more of the time. Most of these tiny new lives which result do not survive. The reason is that, at one week of life, this tiny new boy or girl cannot implant in the womb lining (see number 3 above) and dies. These are micro-abortions.

The pill, then, can have a contraceptive or temporary sterilization effect (by far the most common), or it can

be an abortifacient.

C. Kahlenbam "Breast Cancer,
Its Link to Abortion and the Birth Control Pill,"
One More Soul Publ, 2000, p. 315-324

You mean the effect is to abort?

Yes! "The morphological changes observed in the endometrium of oral contraceptive users have functional significance and provide evidence that reduced endometrial receptivity does indeed contribute to the contraceptive efficacy of OCs." In other words, because the endometrial lining is not receptive to the human being, who must implant in order to continue living, the human being will die.

Somkuti, et al., "The Effect of Oral Contraceptive Pills on Markers of Endometrial Receptivity," *Fertility and Sterility*, Vol. 65, #3, 3/96, p. 488

W. Larimore, et al. Post Fertilization Effects of Oral Contraceptives and Their Relationship to Informed Consent, *Arch. Fam. Med.*, Vol. 9, Feb. 2000, pg. 126-133.

Post-Implantation:

The best known example of this is the French abortion pill, RU 486 (Mifepristone).

How does RU 486 work?

RU 486 kills a developing baby after his or her heart has begun to beat.

It blocks a vital nutrient hormone, Progesterone. The embryonic baby, who had implanted into the nutrient lining of the mother's womb at least two weeks earlier, can be compared to a grape on a vine. If the stem is pinched, preventing the nourishing sap from reaching the grape, it will wither, die and drop off. Just so, if this drug is used, it causes the embryonic baby to wither and die. A second drug, prostaglandin, is used to expel the dead baby from her womb.

Counting from the first day of her last normal menstrual period, it is effective only from the fifth through the seventh week. Some claim success, but with decreasing effectiveness, into the 9th week.

RU 486 alone is effective from 60 to 80% of the time. If Prostaglandin is added, the abortion rate rises to 95%.

Couzinet et al., "Termination of Early Pregnancy by RU-486 (Mifepristone), *New Eng. J. of Med.*, vol. 315, no. 25, Dec. 18, 1986

O. Ylikorkala et al., *Outpatient Abortion With RU-486, OB-GYN*, vol 74, no. 4, Oct. 1989

M. Rodger et al., "Blood Loss . . . After RU-486 and Prostaglandin..." *Contraception*, vol. 40, no. 4, Oct. 1989.
Science Magazine, Sept. 1989

How is it used?

During the US clinical trials on RU 486, women who had one of the following conditions or diseases were prohibited from taking the drug:

Under 18 years of age, more than 35 years of age, smoked over 10 cigarettes a day and had another cardiovascular risk factor, liver disease, respiratory disease, kidney disease, adrenal disease, cardiovascular disease, blood clots, hypertension (high blood pressure), anemia, insulin-dependent diabetes, known allergy to prostaglandins (Cytotec), using an intrauterine device (IUD), breast-feeding, receiving anticoagulation therapy, receiving long-term cortisone therapy, masses or cysts in female organs, infection in female organs, ectopic (tubal) pregnancies, signs that she might abort spontaneously

These patient precautions were also followed during the clinical trials on RU 466 in France.

First Visit: She must have a thorough history, physical exam and blood count. She needs an ultrasound exam to confirm the age of her baby and to rule out a tubal pregnancy. She must sign permission and, in some states or nations, wait 1 or more days.

Second Visit: She takes the pills.

Third Visit: She is given the prostaglandin drug. This produces hard labor. Usually the baby parts are passed that day.

Fourth Visit: If she has not aborted, or if there is still bleeding, she will need an ultrasound to determine if the uterus is empty. If not, she needs a D&C. The French Ministry of Health requires that the abortion facility be equipped with an EKG, IV equipment, and a "crash cart" with a defibrillator in the event of a heart attack resulting from the drugs.

There are complications?

Yes. Bleeding is the most common. In the controlled testing reported, one woman in a hundred bled so profusely she either needed a D&C (surgical scraping out of her womb) and/or a blood transfusion. In an under-developed country, such a treatment would normally not be available and, very likely, some of these women would bleed to death.

e.g., In a controlled trial in the state of Iowa, one woman took the pills and went home. She bled so badly, she needed four emergency blood transfusions to save her life.

Interruption of Preg. with RU-486 & Prostaglandin,
Silvestre et al., *N. Eng. J. Med.*, Vol. 322, 3/8/90, No. 10
Efficacy of Mifepristone & Prostaglandin in 1st
Trimester Abortion, UK Multicentre Trial, *Br. J. OB/Gyn*,
June '90, Vol. 97, pp. 480-486

Other complications include substantial pain, tubal pregnancies, incomplete abortion, uterine rupture, e.g., an 18-week abortion with RU 486 and prostaglandin produced rupture of the uterus and a near fatality.

Uterine Rupt.-Ab.-Second Trimester:
J. Norman, *Br. J. Ob/Gyn*, vol. 102,
Apr. '95, p. 332

And psychological upset, ranging from mild to seri-

ous, post-abortion syndrome and, in a few cases, death of the woman.

In April, 2002, the FDA required the drug company to report that four women developed “serious illnesses” and that two more died after taking RU 486. These problems included ruptured tubal pregnancies, infections, and a heart attack.

Danco Labs. April 17, 2002

Are there problems with the baby?

RU 486 and a prostaglandin will produce an abortion 95% of the time. The rest will be advised to have a surgical abortion. But there will be some who will refuse surgery and carry to term. These babies will have a significant possibility of fetal deformity. Why?

Two poisonous drugs were given when the heart, limbs, etc., were being formed. This didn’t quite kill, but the effect can be to cause severe structural deformities as a direct toxic effect, similar to those from Thalidomide.

In the tightly controlled French experience, there has been one such tragedy. Under the far looser private care in North America, the number of deformed babies should be greater.

Two French researchers report on two women who continued their pregnancies after their RU 486 failed to cause abortion. One delivered a normal baby. “The second pregnancy was terminated because of malformations (sirenomelia)” [fusion of lower extremities].

J.C. Pons et al., letter to *Lancet*, Scrip, Sept. 26, 1991

Aren’t there therapeutic uses?

To date, there are *no* proven uses of RU 486 to treat any human illness. Research is underway testing whether it will have any beneficial effect on one type of breast cancer, on meningioma (brain tumor), Cushing’s Syndrome or endometriosis. No serious research

is projected for any other conditions.

Note that pro-life groups have never opposed research with RU 486 to find therapeutic uses. To date all studies of this drug were paid for by, or associated with, the manufacturer.

Where can I find more details?

A pamphlet, "RU 486, A Human Pesticide," is available from Hayes Publishing Company in Cincinnati – Phone (513) 681-7559.

A detailed scientific description of function, effects, efficacy, complications, etc. is available.

J. Willke, "Mifepristone – A Boom or a Bust,"
Ann. Pharmacotherapy, Vol. 35, No. 3, Mar. 2002, pp 376-381

What about Methotrexate?

This also works to kill a baby after his or her heart has begun to beat. It works roughly within the same timeframe, but in a different fashion. The RU 486 essentially starves the baby which then dies and is lost. Methotrexate is a direct poison and kills the developing baby.

Methothrexate & Misoprostol, M. Creinin et al., *JAMA*, Oct. 19, 1994

Methotrexate & Misoprostol to Terminate Early Pregnancy,
R. Hausknecht, *N. Eng. J.M.*, Vol. 333, No. 9, 8/31/95, pg. 537

Is Methotrexate safe?

Definitely not. It is a cellular toxin and has been used for years to kill cancer cells. The object of cancer treatment is to kill cancer cells before the drug kills the patient. This is a commonly used chemotherapeutic agent. Most readers have known loved ones who have had chemotherapy. There are some serious side-effects at times -loss of hair, inability to digest food, diarrhea, anemia and even death. All of these have been caused by methotrexate. The trick is to use a dose just large enough to kill the sensitive embryonic baby but not

large enough to do any serious damage to the mother.

It works alone?

No. It also needs a follow up dose of prostaglandin to empty the uterus.

What of Prostaglandin alone?

A pill form, Cytotec or Misoprostol, has been used alone in concomitant oral and vaginal doses. Its “effectiveness” is in question. Used without medical supervision in Brazil, it has frequently failed to produce abortions and has caused fetal deformity.

“The most striking manifestations . . . were growth retardation, underdeveloped bones, short equinovarus feet, joint rigidity and webs, hypoplasia or atrophy of limb muscles . . .”

Other researchers report cranial nerve deficiency, hydrocephalus, delayed motor and mental development and mobius anomaly.

Coelho, et al. “Misoprostol Embryotoxicity Evaluation of 15 Patients with Arthrogryposis,” *Am. J. Med., Genetics*, 95, 2000, pp 297-301

The maker approves?

Absolutely not. The maker of Cytotec, the Searle Co., sent a drug warning to physicians stating, “Cytotec administration, by any route, is contraindicated in women who are pregnant . . . Serious adverse effects reported following its use in pregnant women include maternal or fetal death, uterine hyperstimulation, rupture or perforation requiring surgical repair, hysterectomy, amniotic fluid embolism, severe vaginal bleeding, retained placenta, shock . . .”

Searle Co., M. Cullen, 23 Aug. 2000

This drug is being used for induction of labor at term. But the USFDA reports over 50 cases of uterine rupture and other serious complications, some with neonatal and maternal deaths.

Misoprostol and the Politics of Convenience, *The Lancet*, p 2142, 6-30-01

Label Change:

The Searle Co. (above) refused to change the label. Then, in July, 2002, the FDA itself changed it, changing Searle's warning to merely stating that women taking it should not get pregnant.

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