Safer than Tylenol? A Review of Medication Abortion

Christina A. Cirucci, M.D.

Medication abortion is accomplished with two drugs: mifepristone, which causes embryonic/fetal death, and misoprostol, which causes uterine contractions. First approved in the U.S. in 2000, it has now become the most prevalent abortion method here.[1]

Medication abortion is approved up to 70 days of gestation, with no required visit to a medical professional and no required ultrasound to determine gestational age and rule out ectopic pregnancy. The regimen is touted by Planned Parenthood as safer than Tylenol[2] and is easy to obtain online.

This article will review medication abortion, including pharmacology, complications, the Food and Drug Administration (FDA) approval and subsequent removal of safety measures, and limitations of studies.

Mifepristone and Misoprostol

The current protocol for medication abortion is 200 mg oral mifepristone, followed one to two days later by 800 mcg buccal misoprostol. The most common complications are hemorrhage and retained products of conception (RPOC), both of which often require surgical completion. The FDA Prescribing Information (PI) says to expect bleeding for an average of 9 to 16 days and that up to 8% of women have bleeding for 30 days or more.[3] It also includes a Black Box warning for hemorrhage and serious, sometimes fatal, infections. Mifepristone has been associated with *Clostridium sordellii* infection, which is nearly always fatal. The Black Box also warns of prolonged heavy bleeding that may be a sign of incomplete abortion or other complications. Side effects include nausea (51-75%), weakness (55-58%), fever/chills (48%), vomiting (37-48%), headache (41-44%), diarrhea (18-43%), and dizziness (39-41%).[3]

Mifepristone is FDA approved for induced abortion, in conjunction with misoprostol, as well as for treatment of hyperglycemia in patients with Cushing's syndrome.[4,5] Mifepristone is a synthetic steroid with both anti-progesterone and anti-glucocorticoid effects. It selectively antagonizes progesterone by competitively binding to progesterone receptor sites and exhibits a five-fold higher binding affinity to the progesterone receptor than progesterone.[5,6] When used for induced abortion, mifepristone causes fetal death by blocking progesterone, which is necessary to maintain the pregnancy, resulting in degeneration of the endometrium and embryonic/fetal death. At high doses, mifepristone blocks cortisol at the glucocorticoid receptor.[5] It has also been found to interfere with the innate immune system, which may contribute to its association with *Clostridium sordellii* sepsis.[7] It has no known teratogenic effects.[8]

Misoprostol, the second drug, is a prostaglandin E1 analog that is FDA approved to reduce the risk of non-steroidal anti-inflammatory drug (NSAID)-induced gastric ulcers. Misoprostol inhibits gastric acid secretion and protects mucosa. Misoprostol also causes cervical ripening and uterine contractions and is widely used off label for cervical ripening and labor induction in term pregnancy. It is contraindicated for these indications in those with a prior Cesarean section, due to the risk of uterine rupture. Misoprostol is also widely used for control of postpartum hemorrhage. Unlike mifepristone, misoprostol is a known teratogen, associated with Mobius sequence and terminal limb defects.[9,10]

When used together for pregnancy termination, mifepristone and misoprostol result in decidual necrosis, myometrial contractions, and cervical softening, resulting in both the death and expulsion of the embryo or fetus.[3]

Approval of Mifepristone for Abortion

Mifepristone (known as RU-486) was developed in the 1980s by Étienne-Émile Baulieu, a French endocrinologist/biochemist, as part of a research program with the French pharmaceutical company Roussel-UCLAF.[11,12] Although available in Europe, Roussel's parent company, Hoechst AG, prohibited Roussel from entering the U.S. market.[12-14] On President Bill Clinton's second full day in office on Jan 22, 1993, however, he directed Health and Human Services (HHS) to pursue legalization of abortion drugs in the U.S.[14] Roussel-UCLAF refused to distribute the drug in the U.S. because of the political controversy. Still, in 1994, at the Clinton Administration's urging, the company donated its U.S. patent rights to the Population Council, which was founded to address supposed world overpopulation.[15] After receiving the Population Council's new drug application on Mar 18, 1996, the FDA withheld marketing approval pending information on manufacturing and labeling.[14] Eventually, Danco Laboratories (Danco), located in the Cayman Islands, was created to market and distribute RU-486. Danco's only product is mifepristone.[16]

Mifepristone was approved for use with misoprostol for medication abortion in the U.S. in September 2000 under 21 CFR 314 Subpart H.[17] Subpart H is an FDA framework that allows accelerated approval of certain drugs that treat a serious or life-threatening illness for which there is no adequate therapy and that provide a significant advantage over existing therapies.[18-20] But pregnancy is not a serious

or life-threatening illness, and even if it were, there was an existing method (surgical abortion) that was safer and more effective, a fact known at that time.[21] The FDA conducted no additional trials comparing the two methods. Although the FDA requires two randomized, blinded, placebo-controlled trials for drug approval, the FDA approved mifepristone based on one U.S. study and two unpublished French trials, none of which was a randomized controlled trial (RCT).[16,22-24] The FDA also did not perform the mandated studies in the pediatric population.[17]

Another irregularity in the approval of mifepristone abortion was the unlawfully mandated unapproved use of misoprostol as part of the medication abortion regimen. Misoprostol's only FDA-approved use is the prevention of NSAID-induced gastric ulcers. It is not and has never been FDA approved for termination of pregnancy, yet this drug was tacked onto the mifepristone 2000 approval despite the manufacturer opposing this use.[10] The Prescribing Information requires its use with misoprostol.[3]

At the time of approval, use was permitted for termination of pregnancy up to 49 days gestation, and it had to be prescribed by a physician who could assess the duration of pregnancy accurately, diagnose ectopic pregnancies, provide surgical intervention in cases of incomplete abortion or severe bleeding (or have made plans through other qualified physicians), and assure access to medical facilities equipped to provide blood transfusions and resuscitation if needed. The physician had to report any hospitalization, transfusion, serious event, or ongoing pregnancy to the sponsor. The medications had to be dispensed in a medical facility.[17] Additionally, three office visits were required: day 1, day 3, and a follow-up to confirm completion.[25]

Regulation Changes

Since its approval in 2000, the FDA has progressively relaxed mifepristone requirements. These changes are summarized in Table 1 and discussed below.

Table 1. Relaxed Restrictions on Medical Abortion

	2000	2016	2021/2023
Dosage Regimen	Day 1: Mifepristone oral 600 mg	Day 1: Mifepristone oral 200 mg	Day 1: Mifepristone oral 200 mg
	Day 3: Misoprostol oral 400 mcg	Day 2 or 3: Misoprostol buccal 800 mcg	Day 2 or 3: Misoprostol buccal 800 mcg
Gestational Age	Up to 49 days	Up to 70 days	Up to 70 days
Prescriber	Physician	"Health care provider"	"Health care provider"
In-person Visits	3 Visits (day 1, day 3, and follow-up)	1 Visit (day 1)	None
Place of Dispensing	"Health Care facility"	"Health care facility"	"Health care facility," pharmacy, mail
Repeat Misoprostol 800 mcg	No	Misoprostol buccal 800 mcg	Misoprostol buccal 800 mcg
Required Reporting	Hospital admissions, transfusions, serious adverse events, ongoing pregnancy, death	Death	Death

2011 Risk Evaluation and Mitigation Strategy (REMS)

In 2011, the FDA instituted the Risk Evaluation and Mitigation Strategy (REMS) for mifepristone, incorporating the previous requirements.[26] Congress had authorized the FDA in 2007 to implement a REMS if it was determined to be "necessary to ensure that the benefits of a drug outweigh the risks of the drug."[14] If a previously approved drug had elements to assure safe use, these elements or restrictions would be converted to REMS. The term "REMS" is often used to refer to current regulations on medication abortion.

2016 Regulation Changes

In 2016, the FDA made significant changes to the prescribing requirements for medication abortion. The FDA changed the dosing regimen, increased gestational age from 49 to 70 days, eliminated the requirement for a physician to prescribe, and eliminated all but one office visit. The FDA also allowed for a second dose of misoprostol if complete expulsion did not occur after the first dose. Rather than maintaining the requirement to report all serious adverse events, the FDA lifted reporting requirements except for death, thereby eliminating the ability to track the sequelae of these changes.[27] In evaluating these changes, the FDA did not include a single adequate, well-controlled trial that evaluated safety and effectiveness under the revised conditions. The FDA relied on studies that evaluated only one or some of the changes; no study evaluated mifepristone and misoprostol with all the changes. Only one of the seven U.S. studies and three of the 14 international studies included pregnancies up to 70 days.[28] All studies had a significant loss to follow-up (LTFU).[14] The FDA again waived the pediatric study requirements.[29]

2021 and 2023 Regulation Changes

In April 2021, the FDA said it would not enforce the in-person visit requirement during the COVID-19 pandemic.[30] FDA Acting Commissioner Janet Woodcock said FDA had reviewed and identified four publications and that, although the study designs had limitations, the findings did not appear to show increased safety concerns with removing the in-person dispensing requirement. FDA also said it had reviewed post-marketing adverse events that reportedly occurred during the pandemic and found that the small number of reported events did not appear related to noncompliance with REMS. Since the FDA no longer required adverse event reporting, a review of reported events is not compelling. Even when adverse event reporting was required before 2016, the system proved inadequate to accurately reflect adverse events.[31,32]

The four studies Woodcock cites are not compelling either.[33-36] None of the four studies were randomized trials. Three were small studies, in which most patients were 63 days of gestation or less, making it impossible to assess

safety up to 70 days.[33,34,36] In two of these studies, more than two-thirds of women had a pre-abortion ultrasound, and there was a high LTFU rate (16.8% and 12.2%).[33,34] The fourth study was a large retrospective study in the UK. As the authors noted, the main limitation of their study was the inability to actively follow up patients after their abortions.[35] The LTFU rate was unknown.

On Dec 16, 2021, the FDA announced it would permanently eliminate the in-person requirement and permit certified pharmacies to dispense the drugs.[37] It also permitted dispensing of mifepristone by mail. Removal of the in-person dispensing requirement was not just about where to pick up the drugs. By reducing three visits to none, it removed the requirement for a woman to see a clinician before taking these drugs for abortion.

On Jan 3, 2023, the FDA officially approved the 2021 changes, eliminating the requirement for any in-person visit.[38,39] The FDA said it reviewed three studies evaluating mail-order dispensing and five studies evaluating clinic dispensing by mail. The three mail-order studies were small, and none were RCTs.[40-43] Less than 4% of patients across the three studies were beyond 63 days. The LTFU rate was 22% in the largest study (Hyland),[41] 14% in the Upadhyay study,[42] and 6.7% in the Grossman study.[43] In two studies, all patients had a pre-abortion ultrasound.[41,43] Three of the five studies evaluating clinic dispensing by mail were the same as those cited by FDA in 2021 during the pandemic,[33-35] with the limitations discussed above. The fourth study was a small (N=248) descriptive study; all women had a pre-abortion ultrasound, and 88% of patients were 63 days gestation or less.[44] The LTFU rate was 23%. The fifth study was a small prospective non-randomized study in which abortion outcome was determined by phone or survey.[45] The LTFU rate was about 12 %. Incomplete abortion was almost three times higher in those who did not have a pre-abortion ultrasound.

Current State of Abortion Drugs in the US

It is now legal in the U.S. for a woman to get a medication abortion with no visit to a medical professional, no ultrasound, and no follow-up. Without an ultrasound, gestational age is uncertain, as is the location of the pregnancy. It is impossible to rule out ectopic pregnancy without an ultrasound, and neither mifepristone nor misoprostol treats ectopic pregnancy. Delay can be fatal. Two of the deaths in the U.S. from mifepristone occurred due to undiagnosed ruptured ectopic pregnancy.[46] In no other area of medicine would such laxity be permitted. Women are expected to figure out how far along they are, receive drugs by mail, take the pills, and have an abortion with the associated heavy bleeding in their own bathroom or dorm room, and then decide themselves whether the abortion is complete and whether they need follow-up care.

On Nov 18, 2022, the Alliance for Hippocratic Medicine (AHM) and a group of physicians sued the FDA to remove mifepristone's approval.[14] They cited harms to women and the inadequate studies and process the FDA used to approve it and remove safeguards. After moving through the courts, the case reached the Supreme Court of the United States (SCOTUS). On June 13, 2024, SCOTUS ruled against the plaintiffs because they lacked standing.[47]

On Oct 6, 2025, the state of Louisiana and plaintiff Rosalie Markezich sued the FDA to reinstate the in-person visit.[48] Rosalie Markezich, who lives in Louisiana, became pregnant and wanted to keep her baby. According to the lawsuit, her boyfriend ordered abortion pills, and she took them under coercion and fear for her life. The lawsuit contends that if Rosalie had received the drugs in person, she could have told the doctor she didn't want an abortion and could have sought help. Abortion coercion is not uncommon.[49-53] The lawsuit is currently moving through the courts.

Although women can currently obtain a mifepristone abortion without a visit with a physician, in the current FDA model, the patient does have a prescriber who is a "health care provider" (HCP). But abortion pills can easily be obtained online in any state without a prescription or any relationship with an HCP. The Plan C Pills website advertises "abortion pills by mail in every state."[54] A brief visit to this website reveals how easy abortion drugs are to obtain without any medical supervision or guardrails. As of this writing, a search for pills in Texas, where abortion is illegal, provides options for eight U.S. online clinics, two other online clinics, one community network, and eight websites that sell pills. Most of these options have no age limit to supply pills, and some supply pills up to 14 weeks gestation. In June 2026, the American Association for Prolife Obstetricians and Gynecologists (AAPLOG) undertook an undercover review of online abortions. Posing as a 13-year-old girl on anticoagulants, with an intrauterine device (IUD) in place, and a history of three prior Cesarean sections and an ectopic pregnancy, AAPLOG CEO Dr. Christina Francis was able to order pills easily and received them by mail four days later in her home state of Indiana, where abortion is illegal.[55]

Complications

Medication abortion is widely touted as being safe and effective. Planned Parenthood states that "Medication abortion is very safe. In fact, it's safer than many other medicines like penicillin, Tylenol, and Viagra."[2] The American College of Obstetricians and Gynecologists (ACOG) states that medication abortion is "a safe and effective method of providing abortion."[56] The American Medical Association (AMA) states that "Abortion is a safe and common medical procedure…"[57] In 2023, *The New York Times* published an article stating, "More than 100 scientific studies, spanning continents and decades, have examined the effectiveness and safety of mifepristone and misoprostol.... All conclude that the pills are a safe method for terminating a pregnancy."[58] U.S. studies generally do show a low complication rate. Yet not everyone agrees that mifepristone is safe, citing methodological flaws and study limitations such as a large LTFU rate in U.S. studies and much higher complication rates

in studies from countries with record linkage, which would capture all outcomes.[59-61]

Most U.S. studies reporting low complication rates have significant limitations. In many studies, women have safeguards that are not required in real life, such as a physical exam and ultrasound. Another significant limitation is the high LTFU rate. Dettori recommends that the LTFU rate should be less than 5%,[62] yet U.S. studies on medication abortion often have rates greater than 20%. Below is a summary of some of the most commonly cited U.S. studies to support the safety and efficacy of medication abortion.

The study by Chen and Creinin in 2015 (the primary study the FDA used for the 2016 REMS relaxation) was a systematic review (SR) that included 20 studies and 33,846 women.[63] Despite the large number of women, there were only 332 women with gestational age between 64 and 70 days of gestation, with 304 of these from a single trial. The study documented decreasing efficacy with increasing gestational age; at 63 to 70 days, the failure rate was 6.9%, and the ongoing pregnancy rate was 2.9%. Transfusions were low (0.03%–0.6%), as were hospitalizations (0.04%–0.9%). Some may find this data reassuring, yet 76% of the data came from just two retrospective studies: one that did not evaluate ER visits and had an LTFU rate of 15.5%,[64] and one that did not evaluate ER visits or hospitalizations and had an LTFU of 16%.[65]

An SR by Raymond et al. in 2013 (also used by the FDA for the 2016 modifications) included 87 trials and 120 trial groups (N = 45,528), but none included gestational age after 63 days.[66] Results indicated efficacy of 95.2%, ongoing pregnancy of 1.1%, transfusion of 0.1%, and hospitalization of 0.3%; however, in the largest study, hospitalization was 1.1%. The studies used different doses and routes of medication. Most studies were small, with only seven studies involving more than 1,000 patients and two involving more than 2,500 patients.

Another major study the FDA relied on for the 2016 changes was a retrospective cohort study by Ireland et al. comparing medical abortion to surgical abortion.[67] Like many of the other studies, this study only evaluated abortions up to 63 days. Women had a pre-abortion ultrasound, a safeguard that has never been required. Serious complications were reported in just 0.1% in both groups. Women undergoing medication abortion had four times the risk of failure and twice the risk of ongoing pregnancy compared to surgical abortion. The LTFU rate in the medication abortion group was 15.9%, and those LTFU were not excluded from the denominator in calculating percentages.

A large retrospective study by Cleland et al. in 2013 analyzed all Planned Parenthood medical abortions in 2009 and 2010 and included more than 200,000 abortions up to 63 days gestation.[68] The authors stated that the overall complication rate was 0.65%. Yet they excluded RPOC, hemorrhage without transfusion, or surgical evacuation other than for ongoing pregnancy. The authors did not report LTFU rates but note that the data are only those reported to or received by Planned Parenthood. It is unclear whether the authors even knew the LTFU rate. The methodology is not clearly described.

In a 2024 article on telemedicine abortion, Upadhyay et al. concluded that telehealth medication abortion is effective, safe, and comparable to published rates of in-person medication abortion.[69] The authors claimed that 97.7% of telehealth abortions were completed without intervention, 1.3% had an ER visit, 0.16% were treated for an ectopic pregnancy, and 0.25% had a serious abortion-related event. Outcomes were determined by text message, phone call, and, in 26.5% of cases, a survey. In this study, 72.3% of patients received asynchronous care (i.e., care by text message). Not surprisingly, those with asynchronous care had twice the percentage of unknown outcomes (30.4%) as those with synchronous care (15.3%).

International studies often show higher complication rates. In a Finnish study comparing medication abortion to surgical abortion up to 63 days, the authors found that 20% of women undergoing medication abortion had an adverse event (5.6% for those undergoing surgical abortion), 15.6% hemorrhaged (2.1% for surgical abortion), and 5.9% required surgical re-evacuation (1.8% for surgical abortion).[70] In a study by Carlsson et al. in Sweden, the authors evaluated all induced abortions at their hospital.[71] All patients had a pre-abortion pelvic exam, ultrasound, and screening for infection. Even with these safeguards, the authors found that for medication abortions up to 12 weeks, the overall complication rate was 7.3%. Interestingly, this rate increased from 4.2% in 2008 to 8.2% in 2015.

The FDA has approved mifepristone up to 70 days gestation, without requiring an ultrasound to determine gestational age. Yet failure rate and complications increase with increasing gestational age. The PI for mifepristone notes that surgical intervention was required in 0.3% of patients at 49 days, gradually increasing to 3.1% at 64 to 70 days.[3] Thus, the risk of needing surgical intervention, based on this data, increases ten-fold from 7 weeks of pregnancy to 10 weeks. In Ireland's study, the risk of ongoing pregnancy increased by 50% for each week of gestational age in the medication abortion group.[67] In Mentula's study in Finland, surgical evacuation was needed in 7.9% of those who had medication abortion in the first trimester compared to 38.5% in the second trimester.[72] Infection was twice as high in the second trimester (4%), compared to the first trimester (1.9%). In another study in Finland, Niinimaki observed that "advanced duration of gestation was strongly related to the risk of incomplete abortion and surgical evacuation."[73]

Medication Abortion Compared to Surgical Abortion

Multiple studies have shown that medication abortion is less successful and has more complications than surgical abortion. Niinimaki et al. compared medication abortions to surgical abortions in Finland up to 63 days and found that medication abortion had eight times the risk of hemorrhage, more than five times the risk of incomplete abortion, and more than four times the risk of an adverse event.[70] Liu's study in

Canada also showed higher complications with medication abortion compared to surgical abortion.[74] In Ireland's study comparing the efficacy of medication abortion to surgical abortion up to 64 days gestation, medication abortion had four times the risk of failure compared to surgical abortion; 6.6 times the risk of any adverse event; 5.8 times the risk of persistent pain, bleeding, or both; four times the risk of ongoing pregnancy; and 1.6 times the risk of unanticipated aspiration.[67] In Studnicki's study evaluating acuity of ER visits, an ER visit after a medication abortion was significantly more likely to have a severe or critical acuity than an ER visit after a surgical abortion or live birth, or in women who were never pregnant.[75]

Mental Health

The Turnaway Study has been widely touted as demonstrating that women need abortion for mental health.[76] This was a prospective longitudinal study that compared the psychological trajectories of women who received an abortion to those who sought an abortion but were "turned away" due to being past the gestational limit. The study was survey-based, with phone interviews at 8 days and then every 6 months for 5 years. The authors concluded that "during a 5-year period, women receiving wanted abortions had similar or better mental health outcomes than those who were denied a wanted abortion."[76] Yet only 37.5% of invited women agreed to participate, and of those who did, more than 50% were LTFU by the final interview. With the risk of selection bias due to the low participation rate, the high LTFU rate, and the survey-based methodology, the study can hardly be conclusive about mental health and abortion. Yet the study is widely cited as the final answer on abortion and mental health,[77] despite criticism in the literature.[78,79]

In contrast to the claims of the Turnaway Study, the overwhelming conclusion in the medical literature is that abortion is detrimental, not beneficial, to mental health. In 2018, Reardon evaluated all major studies since 1995 and found a consistent trend: women who abort are at higher risk of many mental health problems.[80] A recent retrospective study in Canada by Auger et al. evaluated whether having an induced abortion was associated with an increase in the long-term risk of mental health hospitalization.[81] They found that abortion was associated with higher mental-health hospitalization, substance-use disorders, and suicide attempts than other pregnancies. Studnicki et al. produced two recent mental-health studies: one study compared mental-health utilization after a first pregnancy abortion to after a first pregnancy live birth, and the second compared first pregnancy abortion to miscarriage.[82,83] They found that abortion was associated with a higher risk of mental-health utilization than either live birth or miscarriage. In both studies, the abortion cohort had lower pre-pregnancy utilization of mental-health services, challenging the claim that higher mental-health utilization is due to preexisting mental-health problems.

Maternal Mortality

The assertion is often made that abortion decreases maternal mortality, with the implication that if women cannot access abortions, more women will die. Often quoted is the famous Raymond and Grimes study, which concluded that abortion is 14 times safer than childbirth.[84] In this study, the authors compared mortality rates from live births and legal induced abortions in the U.S. from 1998 to 2005. The issue with this study is that the number of deaths from either abortion or childbirth is only an estimate, as is the number of abortions. The authors admit that a weakness of their study is likely under-reporting of deaths.

Multiple other studies have shown that more women die after abortion than after childbirth. Gissler's study in Finland, where there is linkage of records and therefore more complete data, showed that death within one year after abortion is three times that of death after childbirth.[85] A study by Reardon and Coleman looked at data from medical records in Denmark (linked to death certificates) and found that women who had an abortion had significantly higher mortality rates for all time periods examined through 10 years than women who delivered.[86] For example, at 180 days, the risk of death in women who had a first-trimester abortion was nearly twice that of women who delivered. Multiple other studies have shown higher risk after abortion than childbirth.[87-91]

Abortion Pill Reversal (APR)

Some women change their minds after taking mifepristone but before taking misoprostol. Ongoing pregnancy after taking mifepristone alone is estimated to be about 23%.[92] Studies indicate that taking high-dose progesterone within 72 hours of mifepristone may increase survival of the pregnancy. The reasoning is that high-dose progesterone outcompetes mifepristone at the progesterone receptor. In a 2018 retrospective analysis of 754 patients, ongoing live pregnancies occurred in 64% of those who were given high-dose intramuscular progesterone and in 68% of those given high-dose oral progesterone.[93] In a subsequent retrospective cohort of 765 patients, 55% had confirmed continuation of pregnancy 2 weeks post-initiation of progesterone.[94] ACOG has criticized APR, contending that it is "unproven and unethical."[95] Interestingly, however, ACOG warns against giving depot medroxyprogesterone acetate, a progestin-only birth control, on the same day as mifepristone, as it may increase the risk of ongoing pregnancy.[56]

An RCT randomizing women to progesterone or placebo in women who want to keep their baby would be unethical. However, Creinin et al. attempted an RCT in women who wanted a surgical abortion.[96] Patients received mifepristone and were then randomized to progesterone or placebo. They were to be followed for 15 days, after which they would undergo a surgical abortion if indicated. The plan was to enroll 40 patients, but the study stopped after enrolling 12 because three patients hemorrhaged: one in

the progesterone group and two in the placebo group. The patient in the progesterone group went to the ER, but her bleeding was self-limited. Both patients in the placebo group, however, went to the ER and underwent surgical aspiration, and one required a transfusion. Four out of five patients in the progesterone group (80%) and two out of five (40%) in the placebo group had ongoing pregnancies at two weeks. However, these differences are not statistically significant.

Further studies are needed on APR, but it is an option to offer women who regret their abortion after taking just mifepristone. Progesterone has been used for decades in pregnant women for both threatened miscarriage and during in vitro fertilization. Progesterone has no known association with birth defects.[97]

Misoprostol-only Abortion

In places where mifepristone is unavailable, abortions are sometimes done with misoprostol alone. In most countries, misoprostol is considered an essential medicine and can be obtained over the counter.[98] In preparation for potential additional restrictions on mifepristone, pro-abortion medical organizations have developed a protocol for misoprostol-only abortion in the US.[99] The Society of Family Planning recommends 800 mcg of misoprostol administered buccally, sublingually, or vaginally every 3 hours for three or more doses to induce abortion at 12 weeks or less.[100]

Misoprostol alone is less effective than mifepristone followed by misoprostol. In an SR by Raymond et al, 22% of misoprostol-only abortions required surgical completion and 6.8% had ongoing pregnancies; however, this was pooled data of all doses and routes.[101] Moseson assessed more recent relevant studies using three or more doses of 800 mcg of misoprostol every 3 hours and found efficacy ranged from 82% to 100%, and ongoing pregnancy ranged from 0% to 9%.[99] Moseson recognized that misoprostol-only is less effective than combination drugs but stated that it was imperative to expand access to abortion and that "in the rapidly changing abortion landscape in the United States, misoprostol-only medication abortions may play a key role."[99]

Conclusion

Although mifepristone/misoprostol abortions are promoted as safe and effective, studies are plagued by flaws and limitations, particularly the LTFU rate. Studies also often use safeguards such as pre-abortion ultrasound and physical exam, which are neither required by the FDA nor always used in real-world abortion. From its approval in 2000 to the present, the FDA has eliminated nearly all safeguards for medication abortion. Although approved up to 70 days gestation, no ultrasound is required to determine gestational age or pregnancy location, and no visit to a clinician is required. Women are left to manage their abortions on their own. Those promoting abortion access consider this a win for women's health, while others see this as, at the very minimum, a disservice to women who deserve the same kind of medical care they would expect for other life-changing interventions.

Christina A. Cirucci, M.D., is a board-certified obstetrician/gynecologist and is an associate scholar with the Charlotte Lozier Institute. Contact: chris@aaplog.org.

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