

To the Senate Community Affairs Committee RU 486 Inquiry
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RU486 – R U 4 it?

Last November I was invited to Canberra to speak to politicians on the scientific background of the abortion pill, RU486. As a consultant gynaecologist & senior university lecturer I prepared for this by reviewing recent newspaper articles, AMA press releases, & a series of scientific publications & commentaries on the subject. General media releases quoting medical experts claimed RU486 is gentler, more natural, as safe as, & no more expensive than surgical abortion. Chemical abortion purports to offer completed abortion without surgery or anaesthesia, mimicking “natural miscarriage”, & providing a more private patient experience. (1) Australia has apparently fallen behind many other countries by not offering the option of chemical abortion, with women’s “reproductive rights” allegedly compromised by a successful handful of antiabortion politicians. Media reports left me with the impression that opposition to RU486 was grounded in prolife attitudes & not scientific evidence, until I encountered the writings of two prominent prochoice feminists voicing staunch opposition to RU486: Germaine Greer & Dr Renate Klein. Dr Klein has been so “appalled by the misinformation that is given to the public by supporters of RU486” she has coauthored an indepth study into RU486 in 1991, publically supported Senator Harradine’s RU486 amendment in 1996, & recently wrote a 4 page letter to all Members of the Australian Parliament which is the clearest & most honest account of the potential dangers of RU486 I have read to date.(2)

Currently there is little evidence that chemical abortion is in any way preferable to surgical abortion. (3) A Cochrane Review of medical versus surgical methods for first trimester termination of pregnancy found that the trials available for review were relatively small, & there was inadequate evidence to compare the acceptability & side effects between the two methods. (4)

The RU486 question is therefore best answered by comparing & contrasting it to surgical abortion, applying common sense & good judgement.

First, I’d like to look at the cost implications of introducing chemical abortion by initially examining medical workforce ramifications on the one hand, & family care & workforce implications for the patient on the other. Later I will touch on drug expenses & the cost of dealing with complications & sequelae unique to chemical abortion.

When comparing the medical workforce demands of surgical abortion versus chemical abortion, the former requires 30 minutes for the operator &, when a GA is used, 30 minutes for the anaesthetist. Thus 2 doctors are “tied up” for half an hour in a day procedure unit, whilst chemical abortion requires an average of 3-4 doctors visits over 2 weeks, some of which will be urgent, to deal with the 23% of women who experience severe side-effects from the treatment. Emergency medical care must be readily available to patients for 2 weeks after starting a chemical abortion. In addition 2-10% of women will require a surgical abortion to complete the abortion or control excessive bleeding. (1,5,6)

Hence chemical abortion still relies on surgical abortion for backup, whilst surgical abortion is self-reliant & women with an incomplete surgical abortion may have the procedure repeated.

A woman having a surgical abortion is usually in hospital for a few hours, she experiences variable cramping & vaginal loss for a few days, & usually returns to work & normal activities after 2 days. In contrast chemical abortion takes an average of 9-16 days, with 9% of women bleeding over 30 days. Thus with chemical abortion women are sicker for longer & will need more help at home, & more time off work. The process is less predictable & gives women less control, anonymity & privacy, as the abortion can occur anywhere & at any time.

In spite of media claims that chemical abortion is a less expensive treatment than its surgical counterpart, abortion providers in the USA charge up to double the price of a surgical abortion because of the medication costs, extra visits, counselling & monitoring involved in a chemical abortion. (7,8)

Chemical abortion has additional potential medicolegal implications & costs over surgical termination:

1. Should a woman choose to stop her 2-stage chemical abortion after taking only RU486 there is an increased risk of birth defects in surviving babies, for example sirenomyelia with fusion of the lower limbs .(9)
2. Chemical abortion is psychologically & physically more stressful than surgical abortion. (10,11). Chemical abortion may result in the delivery of a live foetus, the allegation in a recent prosecution of a doctor in Sydney. (12)
3. Although the risk of maternal death from chemical abortion is very low, recent US data shows it is three times that of early surgical abortion (1.5/100,000 vs 0.5). (13)
4. There is a potential for long term effects on the gonads & genital tract as RU486 has been found to cross the blood-follicle barrier & has been found in the egg follicles of women taking ru486. The implications of this for future fertility, pregnancies & the health of future children have not been established. (14)

In summary, chemical abortion places greater demands on the health system, it still relies on the existing abortion method for backup, & demands more home assistance & work relief for the woman. It is likely to have a greater medicolegal impact than surgical abortion & has future unknown implications for the woman & her future children. It is highly likely to be to be more expensive for the government & community to fund than surgical termination alone.

Next, I'd like to examine claims made by Prof Caroline de Costa that chemical abortion is a "gentler" option , & by AMA President Dr Haikerwal that RU486 has less side effects & problems than surgical abortion. Two recent UK studies have compared women having surgical abortions with women having chemical abortions. The researchers found that women having chemical abortions rated the procedure as more stressful & painful, & they experienced more post-termination physical problems & disruption to their lives. Women may not expect, or are not told, that they may see the foetus, & this was associated with more intrusive events – nightmares, flashbacks & unwanted thoughts related to the procedure. 53% of the chemical abortion group said they would choose the same procedure again, compared with 77% of the surgical group.

The other study by the same authors found the same results – chemical abortion was more stressful. This was related to the physical & emotional aspects of the process, seeing or feeling the foetus, waiting times during the procedure, & the process itself. The researchers noted that seeing the foetus is a particularly distressing experience for women. (10),(11)

These studies provide good evidence that chemical abortion is associated with more side effects & problems, not less, than surgical abortion, & it is actually a harsher rather than a gentler option for women.

The final comments I wish to make relate to the role of the TGA in putting RU486 on the Australian formulary. AMA President Dr Haikerwal has gone on record stating that RU486 needs to go through the TGA, whose processes he describes as “robust”. I am opposed to using the TGA in this instance on 2 important grounds. First, the robustness of the TGA has recently been called into question over its approval of a COX 2 inhibitor which has allegedly been responsible for the death of at least 300 Australians. Second, TGA approval of chemical abortion involves the approval of not just RU486 but also a second drug misoprostol, a prostaglandin, which is given 48 hours after RU486 to increase the abortion rate from 60% to over 90%. The use of misoprostol in gynaecology is “off label” . In other word it is not licensed by its manufacturer to be used gynaecologically, not even for dealing with miscarriages. Thus whilst the use of misoprostol in chemical abortion is legal, it is unethical, & the TGA would be asked to approve a drug for an indication for which it is unlicensed.

RU486 – the evidence is against it. R U still 4 it?

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