MLCPC 207:

Abortion Education:

Procedures, Risks, and the Research

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Abstract

This session will educate participants on abortion procedures, risks, and research. Coaches will learn how to educate and empower their clients in an effective way. Participants will become aware of how they may be affected by compassion fatigue, and will learn how to cope while working with abortion-minded clients. This is difficult material to process for anyone and may be particularly stressful to those who have abortion in their past. Any concerns should be discussed with the pregnancy center director before continuing with this section. For those who complete this section, a lengthier debriefing is recommended to aid in processing thoughts and feelings in more detail.

Learning Objectives

1. Participants will study abortion procedures.

2. Participants will be able to articulate the risks of abortion based on current research.

3. Participants will be able to identify the characteristics and symptoms of compassion fatigue.

Caution – The material in this section contains drawings depicting abortion procedures that are graphic in nature. Discretion is advised.

I. Medical Accuracy

A. Medical Accuracy is the provision of information that is derived from material found in reliable medical resources.

B. Reliable Medical Resources

1. Scientific studies

- Reliable, quality studies are well designed, controlled, and contain adequate numbers of subjects. The findings are duplicated by additional studies, and the results are statistically significant. Such studies are typically found in peer-reviewed journals, such as the New England Journal of Medicine.

2. Publications from nationally recognized authorities

- These include the NIH (National Institutes of Health), the CDC (Centers for Disease Control), and top university hospitals and medical schools.

3. Websites:

- Be careful when referring to websites. There are no real mechanisms in place to assure the validity of any given website and its material.
- Look for sites that publish footnotes and references indicating where the information was derived.
- Examples: www.medinstitute.org or www.wecareexperts.org

4. Medical Textbooks

5. Recent and Representative:
    - Cite current articles: recently (time frame can vary, depending upon the topic) published information on a topic.
    - Okay to include older seminal or landmark studies.
    - Review articles are often good choices because they combine multiple studies on a given topic.
    - A single study may not be solid evidence unless there are large numbers of study participants (thousands).
    - Selected data reflects the prevailing evidence: Does the study's conclusions represent the basic consensus on this topic? Or, do most of the studies in the database point to a different conclusion?

6. Care Net's Before You Decide brochure: this publication is regularly updated and reviewed by Care Net's Medical Advisory Board

C. Quality Assurance

1. Develop policies and procedures that assure:
    - Abortion education materials reviewed and approved by medical director or other qualified professional; this is critical
    - Abortion risk information supported by reliable and recognized sources
    - Rigorous training and supervision of client advocates/phone staff

II. Awareness

A. According to the Guttmacher Institute, at least half of American women will experience an unintended pregnancy by age 45, and, at current rates, one in 10 women will have an abortion by age 20, one in four by age 30, and three in 10 by age 45.[1]

B. Many who come to volunteer and work in this ministry come precisely because they have been affected by abortion, either personally or through a family member or close friend.

C. This material is difficult to receive, but is even more potentially distressing to those affected by an abortion experience.

D. Care Net advocates the use of positive images to most effectively demonstrate fetal life and educate on pregnancy options. Clients are always given the option of accepting or declining to receive or view any educational materials.

E. No gruesome images are included, however, there will be a few illustrations depicting abortions at various gestational ages.

F. The goal is to equip participants with the information to help other women understand exactly what they are considering for themselves and their babies.

G. Educational materials for client use should be reviewed by a qualified professional for content accuracy.

H. **No** client will ever be asked, pressured, or coerced to view abortion education materials which she or he has indicated a desire not to see.

III. Medical (also called "Medication") Abortion[2]

There are three medications used for the purposes of inducing an abortion: Mifeprex (mifepristone + misoprostol); Methotrexate and Misoprostol .

A. Mifeprex (mifepristone + misoprostol)[3, 4, 5, 6, 7]

1. This drug has been approved by the FDA for inducing abortion up to 49 days into pregnancy (as measured from the woman's last menstrual period).

2. Extensive patient agreement signed before initiating the procedure[8]

3. Three visits:

- Day 1: Three tablets of 200 mg of Mifeprex orally at once
- Day 3:Two tablets of 200 mcg of misoprostol orally at once
- Day 14: The patient must return to confirm that a complete abortion has occurred. If not, surgical abortion is recommended to manage medical abortion treatment failures.

4. This drug is used **off label** throughout the first trimester and into the second trimester.

5. This is a regimen that involves two different medications. The first pills block the embryo's attachment to the uterus causing the blood supply to the baby to be disrupted, resulting in his death. The second pills cause contractions that expel the embryo and uterine contents.

6. Mifeprex (the brand name) also called "The Abortion Pill". Synonyms include RU-486, and Mifepristone (the generic name). It is an anti-progesterone meaning that it blocks the effects of progesterone on the body. Progesterone is a female hormone critical to the maintenance of pregnancy.

7. As of 2008, Mifeprex accounted for approximately ¼ of all induced abortions before nine weeks.[9]

8. Side effects[10, 11, 12, 13]

- Bleeding: one in 100 women need a D&C (a scraping of the uterus), to stop the bleeding. Bleeding typically lasts for an average of 9 to 16 days
- Death[14]: Up to April 2011, the FDA reports 14 fatalities among users.
- Infection:[15, 16] The FDA warns of rare cases of fatal septic shock.

FDA Box Warning:[17]

"Serious and sometimes fatal infections and bleeding occur very rarely following spontaneous, surgical, and medical abortions. Ensure that patient knows whom to call and what to do, including going to emergency room if provided contacts are not reachable, if experiencing sustained fever, severe abdominal pain, prolonged heavy bleeding, or syncope, or if experiencing abdominal pain/discomfort or general malaise >24 hours after taking misoprostol. Serious bacterial infections and sepsis can present without fever, bacteremia or significant findings on pelvic examination following an abortion; high index of suspicion is needed to rule out serious infection and sepsis. Prolonged heavy bleeding may be a sign of incomplete abortion or other complications; prompt medical/surgical intervention may be needed. Advise patients to take the Medication Guide with them when visiting an emergency room or another health care provider who did not prescribe the drug, so that provider will be aware that patient is undergoing medical abortion"

Clostridia Sordellii identified, a bacteria found in low concentration in female reproductive tract.

C. Sordellii infection is not accompanied by fever

Symptoms from infection overlap with the expected Mifeprex side effects.

Once infection is present, no identifiable window of opportunity for treatment : 100% mortality rate[18]

- Failed abortion:[19, 20] Means pregnancy continues (fetus may/may not be alive). In most cases, woman undergoes surgical abortion.
  Up to 49 days from the LMP: 8% failure rate
  50-56 days from the LMP: 17% failure rate
  57-63 days from the LMP: 22% failure rate

- Fetal malformations:[21, 22] misoprostol has been associated with certain types of birth defects among medication abortion 'failures' in the first trimester. Central nervous system and limb defects have been observed.

- Unknown psychological impact of 'self-aborting':
  Self-administers pills
  Observes tissue that passes out of her body
  1 woman in the U.S. trial was hospitalized for depression after attempting suicide

B. Methotrexate[23, 24]

1. Originally approved by the FDA to treat certain cancers and rheumatoid arthritis.

2. Used **off-label** to treat ectopic pregnancies and for induced early abortions

3. Stops growth of the rapidly dividing cells.

4. It is given orally or injected. Misoprostol is given seven days later.

5. Side effects:

- Mouth ulcers
- Low white blood cell count
- Nausea and abdominal distress
- Decreased resistance to infection
- Reports of fatal toxicity

C. Misoprostol Alone

1. Inserted vaginally

2. Higher failure rate than the Mifeprex regimen

3. Side effects are nausea, vomiting, and diarrhea

4. Risks include central nervous system and limb defects for pregnancies that continue.

IV. Surgical Abortion

A. The following general information is for the coach and **is not intended to be used with clients**.

B. Surgical Abortion Overview[25, 26, 27, 28]

1. Surgical abortions are usually **physician performed**. There is a movement to train nurse practitioners and other midlevel providers in abortion.[29]

3. The **Gestational Age** (GA) determines the method of abortion. As the baby grows the uterus enlarges. The degree of anesthesia is dependent upon the patient's need for comfort, the size of the uterus (due to the gestational age of the baby) and how far the cervix needs to be opened.

4. The cervix is opened.

5. The baby, placenta, and membranes are removed by:

- Suctioning, scraping, and/or pulling out
- The baby must be dead prior to removal from uterus
- The uterus should be fully emptied

The following pages contain drawings depicting abortion procedures. You may skip ahead to page 157 to begin the next section of notes and avoid seeing these images.

C. First Trimester Surgical Abortion:[30, 31] This surgical abortion is done throughout the first trimester and is generally referred to as an "aspiration abortion".

1. Anesthesia: typically, local anesthetic is injected in the cervix.

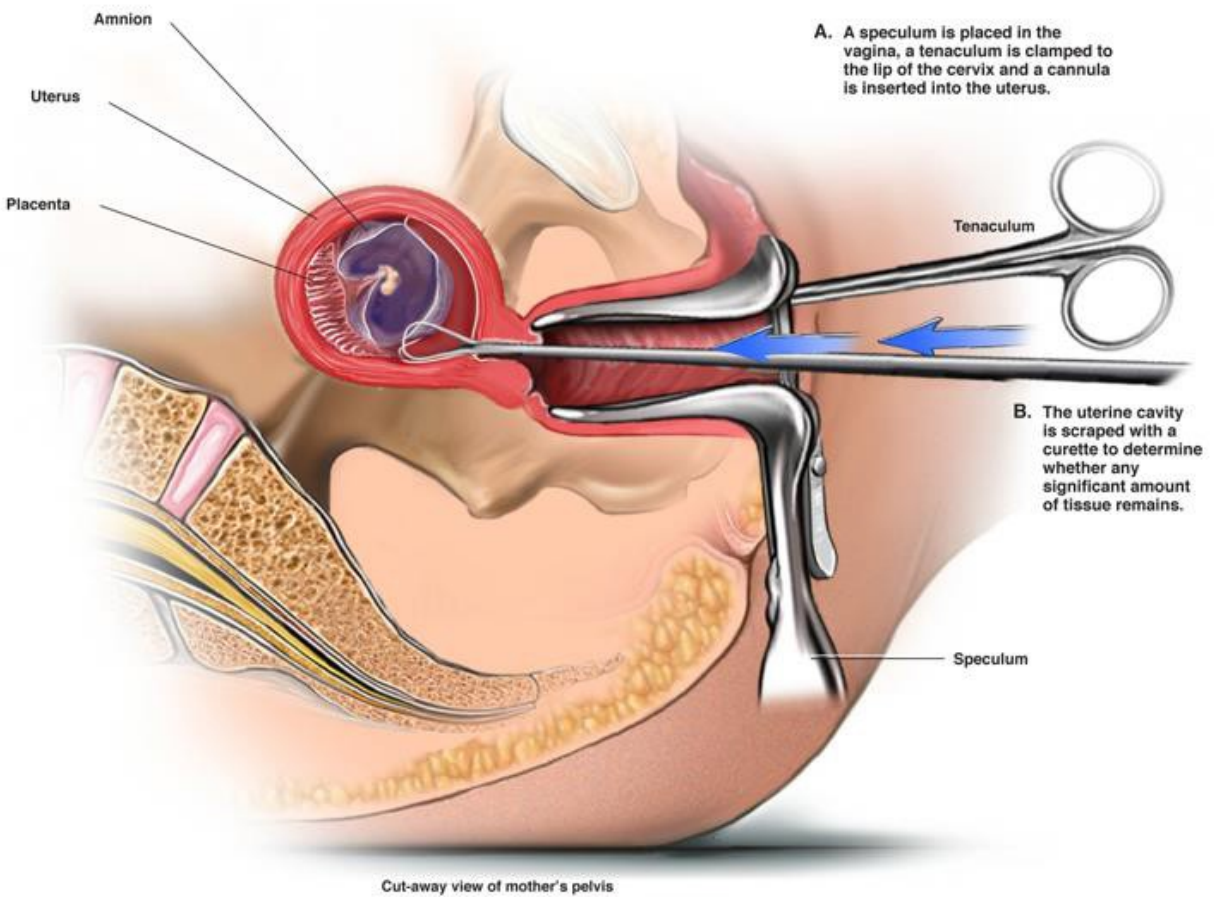
2. For very early pregnancies (4-7 weeks LMP), a long, thin tube is inserted into the uterus which is attached to a manual suction device and the embryo is suctioned out.

3. Late in the first trimester, the cervix needs to be opened wider because the fetus is larger. It may be softened the day before using medication placed in the vagina and/or slowly stretched open using thin rods made of seaweed inserted into the cervix. The day of the procedure, the cervix may need further stretching by metal dilating rods.

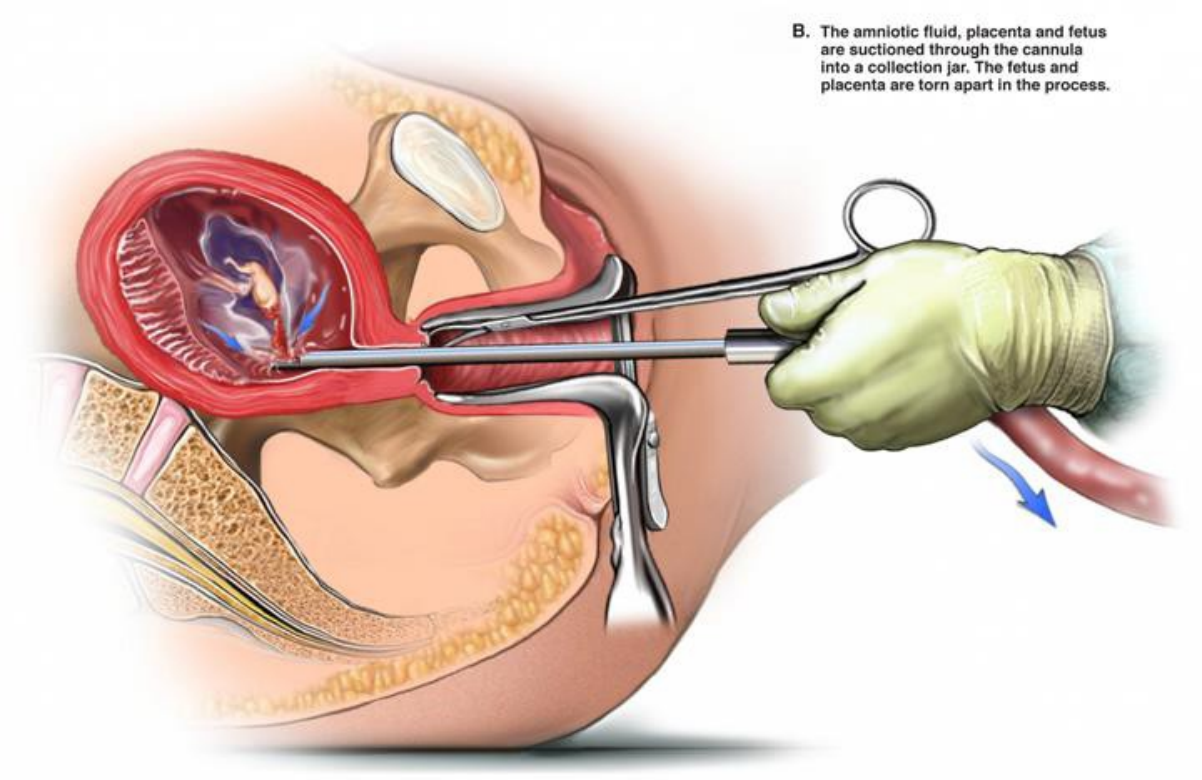
4. Plastic tube inserted into the uterus and suction is applied by an electric or manual vacuum device. The suction pulls the fetus' body apart and out of the uterus. The doctor may also use a loop-shaped tool, called a curette, to scrape any remaining tissue out of the uterus.

5. A suction tube is inserted into the uterus.

6. A curette scrapes the wall of the uterus to loosen and remove remaining membranes and tissues.



Cut-away view of mother's pelvis



D. Second Trimester Surgical Abortion: Dilation and Evacuation (D & E):[32, 33] The majority of second trimester abortions are performed using this method.

1. Up to 16 weeks is similar to the first trimester method.

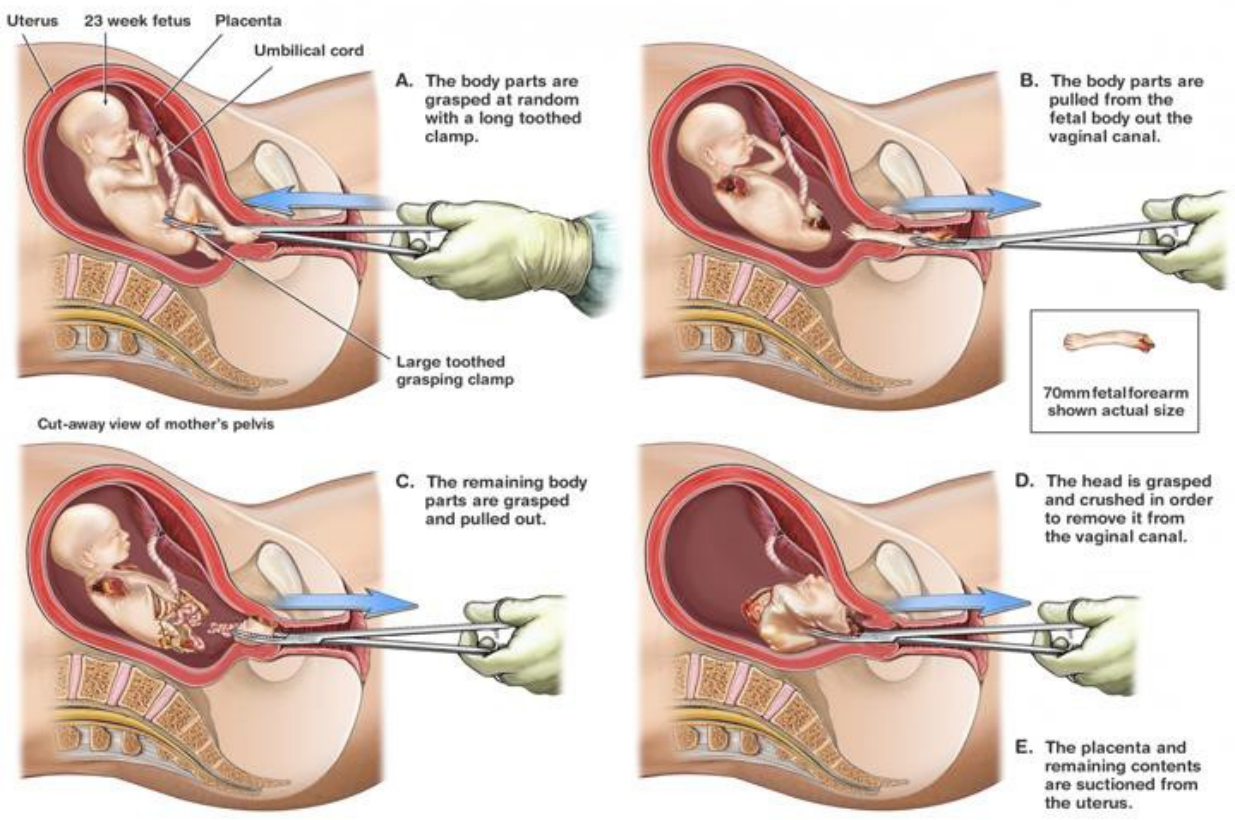
2. Greater degrees of anesthesia more common in second trimester surgical abortions.

3. The cervix needs to be opened wider because the fetus is larger. This is done by inserting numerous thin rods made of seaweed (laminaria) a day or two before the abortion and/or giving other oral or vaginal medications to further soften the cervix.

4. A larger suction device is used so that the fetal parts will pass through the tubing and into the collection jar.

5. After suctioning, remaining fetal parts are removed with a grasping tool (forceps). A curette (a loop-shaped tool) may also be used to scrape out any remaining tissue.

6. Later Term Surgical Abortions: After about 16 weeks, much of the procedure is done with tools to grasp and pull fetal parts out through the cervical opening, as suction alone will not work due to the fetus' size. Operator must keep track of what fetal parts have been removed so that none remain to become a source of infection. Lastly, a curette, and/or the suction machine are used to remove any remaining tissue or blood clots, which if left behind could cause infection and bleeding. Risk of complications higher.



- This procedure typically takes 2-3 days and is associated with increased risk to the life and health of the mother.

- Because a live birth is possible, injections are given to cause fetal death. This is done to comply with the federal Partial-Birth Abortion Ban Act of 2003 which requires that the fetus be dead before complete removal from the mother's body. The medications (digoxin and potassium chloride) are either injected into the amniotic fluid, the umbilical cord, or directly into the fetus' heart.[34]

- The remainder of the procedure is the same as the second trimester D&E.

- Fetal parts are reassembled after removal from the uterus to make sure nothing is left behind to cause infection.

E. Intact D&E: An alternate technique, called "Intact D&E" is also used. The goal is to remove the fetus in one piece, thus reducing the risk of leaving parts behind or causing damage to the woman's body (such as from pulling jagged bone fragments through the cervix). This procedure requires the cervix be opened wider; however, it is still often necessary to crush the fetus' skull for removal as it is difficult to dilate the cervix wide enough to bring the head out intact.

F. Medication Methods for Second Trimester Induced Abortion[35, 36]

- This technique induces abortion by using medicines to cause labor and eventual delivery of the fetus and placenta. Like labor at term, this procedure typically involves 10-24 hours in a hospital's labor and delivery unit. Digoxin or potassium chloride is injected into the amniotic fluid, umbilical cord or fetal heart prior to

labor to avoid the delivery of a live fetus. The cervix is softened with the use of seaweed sticks and/or medications. Next, oral mifepristone and oral or vaginal misoprostol are used to induce labor. In most cases, these drugs result in the delivery of the dead fetus and placenta. The patient may receive oral or intravenous pain medications. Occasionally, scraping of the uterus is needed to remove the placenta.

- Potential complications include hemorrhage and the need for a blood transfusion, retained placenta and possible uterine rupture (splits open).

V. Abortion Risks[37, 38]

A. In the U.S., data on abortions are not comprehensive due, in part, to incomplete reporting as well as the relative lack of record keeping connecting abortion to complications. The Centers for Disease Control (CDC) requests data from individual states, but not all states are mandated to report, and within other states, there is often spotty reporting, not including all counties. There is no enforcement mechanism for states that fail to report[39, 40]

B. We do not have nationalized medicine, where all abortions are listed in databases and any complications are a matter of record.

C. Scientific bias further contributes to this problem by selective data collection among certain researchers and skewed interpretation of results from studies.

D. Induced abortion carries the potential for immediate complications to occur such as bleeding, infection and/or damage to internal organs. Such complications happen infrequently during first trimester abortions, but the risk rises with increasing gestational age. It is standard medical practice for the physician to list all the potential complications of a given procedure, even if the risk is extremely low.

E. According to the Guttmacher Institute, the risk of dying from a surgical abortion performed under 8 weeks is approximately 1 in a million. While that is a very low number, if you are that one, it matters, and you have a right to know what risks you are facing.[41]

F. Beyond the immediate risks, there is evidence in the medical literature that induced abortion can be associated with significant loss of both emotional and physical health long term.[42]

G. The **immediate** risks of surgical abortions:

1. **Bleeding**[43, 44]
    - As with any pregnancy outcome, some level of bleeding is to be expected during and after an abortion
    - Various factors may contribute to a greater risk of bleeding. Damage to structures, the presence of infection, failure of the uterus to contract down after the procedure can all lead to heavier bleeding.
    - If the cervix is torn or the uterus is punctured by the instruments, heavier bleeding is more likely. If a significant hemorrhage occurs, a blood transfusion may be necessary.

2. Infection[45, 46, 47, 48]

- Any surgical procedure carries the risk of infection.
- Although the vagina is prepped with cleansing solution and sterile instruments are used, simply placing instruments in the uterus carries the risk of contamination.
- Pelvic infections can cause scarring of the pelvic organs.
- Tissue left behind acts as an ideal growth source for any bacteria present and may lead to sepsis, a form of total body infection, which can be life-threatening.
- The use of antibiotics reduces the risk of this complication.
- Ask if the client has had any sexually transmitted infections (STIs), or has been tested recently. If she has had multiple partners, or is in an unstable relationship, it is advisable that she be tested before any abortion. Many STIs are without symptoms and could be present without her knowledge.

3. Damage to organs[49, 50]

- Surgical instruments can damage the cervix, uterus, and vagina. If the suction catheter inadvertently punctures the uterus during the procedure, it can damage surrounding pelvic structures such as the bowel and blood vessels. If this occurs, further surgery may be necessary.
- The likelihood of these complications goes up with increasing gestational age of the baby.

4. Rh Sensitization[51]

- Every pregnant woman should receive blood type testing to learn if her blood type is “Rh positive” or “Rh negative”. Pregnant women who are Rh negative should receive Rhogam, an injection given to prevent the formation of antibodies that may harm the baby. If an Rh negative woman does not receive

Rhogam with each pregnancy, she may develop antibodies which can cause serious complications with her next pregnancy. Rhogam is needed for Rh negative women who undergo abortion.

5. Anesthesia[52]

- Complications from general anesthesia used during abortion surgery may result in convulsions, heart complications, and in extreme cases, death.

6. Death[53, 54]

- In extreme cases, complications from abortion (excessive bleeding, infection, organ damage from a perforated uterus, and adverse reactions to anesthesia) may lead to death.
- The risk of death immediately following an induced abortion performed at or below 8 weeks is extremely low (approximately 1 in a million) but increases with length of pregnancy.
- From 8 weeks to 16-20 weeks, the risk of death increases 30 times
- From 8 weeks to 21 weeks and over, it increases 100 times (1 in 11,000).
- "Abortion is safer than childbirth" disputed: several studies have noted an increased risk of death with induced abortion as compared to childbirth in the year following the event (birth or abortion)[55, 56, 57, 58]

H. Long term risks of surgical abortions:

1. Preterm Birth[59, 60 ,61, 62, 63, 64, 65]

- The scientific literature carries dozens of studies that have repeatedly demonstrated that women who have one or more induced abortions carry a significantly increase risk of delivering prematurely in the future.
- Preterm delivery is a major risk factor for cerebral palsy and other complications of prematurity such as respiratory, bowel, and eye problems.
- Even abortions done very early in gestation where no cervical dilatation is required are associated with an increased risk.

2. **Breast Cancer:**[66, 67, 68, 69, 70, 71]

   Medical experts continue to debate the association between abortion and breast. Research has shown the following:

   - Protective effect of carrying the pregnancy to term: Carrying a pregnancy to full term gives a measure of protection against breast cancer, especially a woman's first pregnancy. Terminating a pregnancy results in loss of that protection. During pregnancy, breast tissue grows dramatically and glands mature in preparation for lactation after delivery. Not until 32 weeks of pregnancy have been completed is the breast tissue mature enough to be rendered relatively more cancer resistant. This is why women who deliver prematurely before the 32nd week have a higher risk of developing breast cancer.
   - Many reliable studies conclude that induced abortion is a risk factor for developing breast cancer.

3. The **psychological impact** of abortion: Following abortion, many women experience initial relief. The perceived crisis is over and life returns to normal. For many women, however, the crisis isn't over. Months and even years later, significant problems

develop. There is evidence that abortion is associated with a decrease in long-term emotional and physical health[72, 73, 74, 75] Scientific evidence indicates that abortion is more likely to be associated with negative psychological outcomes when compared to miscarriage, or carrying an unintended pregnancy to term[76, 77]

- A number of studies from national representative samples indicate that abortion significantly increases the following mental health problems:

  Depression[78, 79, 80, 81]
  Anxiety[82, 83, 84]
  Substance abuse[85, 86, 87, 88, 89]
  Post-traumatic stress disorder[90, 91]
  Suicidal ideation and behavior[92, 93, 94, 95]

- Relationship Impact: Many couples choose abortion believing it will preserve their relationship.
  Research on this topic reveals just the opposite.[96, 97] Couples who choose induced abortion are at increased risk for relationship problems. Women experiencing lack of support and pressure to abort from their partners were more likely to choose abortion.

- World Expert Consortium for Abortion Research and Education (WECARE): A group of international research scientists studying the physical, psychological and/or relational effects of abortion on women and those closest to them.

- www.wecareexperts.org

VI. Weariness in Well-doing

*"My soul is weary with sorrow; strengthen me according to your word."—**Psalm 119:28***

A. Compassion Fatigue: A negative emotional state that develops in an empathetic individual as a result of exposure to another's trauma. Symptoms of compassion include:

1. Dwelling on a client

2. Avoidance

3. Sleep disturbances

4. Depression, anxiety

5. Headaches, upset stomach

6. Blaming self

B. Compassion fatigue is similar to **Post Traumatic Stress Disorder** (PTSD).

C. When a client chooses an abortion:

1. We must rest in the Holy Spirit and trust in Him to work in her life.

2. Part of our work is to grieve and stand in the gap, remember these short lives, and pray for these women.

D. Factors that increase your vulnerability to compassion fatigue:

1. The gift of mercy

2. Depth of empathy

3. Length of exposure
4. History of trauma
5. Unclear boundaries
6. History of emotional issues
7. Lack of adequate support
8. Lack of training and awareness

E. Prescription for Weariness: Remembering the calling to this work is powerful protection against discouragement and compassion fatigue. Prayer is the fence of protection against the attacks of the enemy. Just as God is the one who saves, His Holy Spirit is the one who does the work of changing the hearts and minds of our clients. Use God's Word to plant seeds of hope, life, and faith in your clients and to refresh your soul.

"Like cold water to a weary soul is good news from a distant land." ***—Proverbs 25:25***

"Do you not know? Have you not heard? The Lord is the everlasting God, the Creator of the ends of the earth. He will not grow tired or weary, and His understanding no one can fathom." ***—Isaiah 40:28***

"He gives strength to the weary and increases the power of the weak." ***—Isaiah 40:29***

"Come to me, all you who are weary and burdened, and I will give you rest." ***—Matthew 11:28***

"Let us not become weary in doing good, for at the proper time we will reap a harvest if we do not give up." ***—Galatians 6:9***

F. Debriefing: The R.A.P. Session

1. **R**eview the visit

2. **A**nalyze what worked and what didn't

3. **P**rocessing
   - Express your doubts and fears
   - Modify your future approach
   - Let go and let God: we cannot control how our clients respond to the information we provide, be it verbal, written, or ultrasound images.

G. Know Thyself: It is essential for those in the helping profession to be aware of their strengths and points of vulnerability.

1. Personality type
2. Spiritual gifts
3. Take personality and spiritual gift assessment
4. Deal with 'baggage'

H. Personal Support Network

1. Friends
2. Co-workers: One of the joys of pregnancy center work: full of people who understand and are good listeners!
3. Family
4. Church family

I. **Gain a New Perspective:** Spend time in the Word to see through God's lens more and more. It is an awesome responsibility and privilege to enter into another person's life during a time of crisis. One outcome becomes clear:

1. Those who work with the suffering suffer because of the work.
2. "For just as the sufferings of Christ flow over into our lives, so also through Christ our comfort overflows."—II Corinthians 1:5
3. We get to comfort those with the comfort we have received. "

J. **Emotional Response**

1. Allow yourself to feel.
2. Take time to enter the moment.
3. Grieve the losses.

K. **Memorials and Standing Stones**

1. Photo albums of ultrasound images
2. Book of Remembrances
3. Annual memorial service
4. Light a candle
5. Expect grief, allow it and work through it. God in His great mercy has given the world this ministry precisely because He does not wish to see any more perish, but also because He knows that His followers are the only ones who can offer true healing and redemption.

VII. Options Counseling

A. Our clients come with strong emotions, convinced that abortion is the only option. They are seeking honest answers.

B. Guiding Principles:

1. RESPECT

- T**R**uth in Love
- **E**ducate
- **S**upport
- Em**P**ower
- **E**ncourage
- Un**C**onditional love and acceptance
- **T**rust in the Holy Spirit

2. Be willing to say difficult things so that they know. *"You shall know the **truth** and the truth shall set you free."**—John 8:32***

3. The goal is to **educate**:

- Use clear and simple language without exaggeration
- Share information reflecting present day practices (accurate, up-to-date information)
- Stick to the facts using reliable references
- Clients benefit from factual information that empowers informed decision-making
- Focus on the client's needs and adopt an agenda-free, neutral tone

4. **Empower**
    - Adopt a positive approach
    - Use tools that display the beauty of fetal development
    - Avoid gruesome images or provocative descriptions of procedures ("baby is murdered").

5. **Encourage** literally means to "put courage into." Our clients are at all-time low points in their lives. They feel trapped and perhaps beaten down by their circumstances. As God's people, we are uniquely equipped with the power of God's Word to truly build our clients up.

6. **Love and acceptance:** The last thing clients need is to be judged. It is not our place to pass judgment. We ALL have fallen short of the glory of God and our righteousness is as filthy rags. We are no different than our clients except that we are covered by the blood of the Lamb and are listening to the Shepherd's voice. We can point the way to healing and wholeness and share our own story of brokenness.

7. **Trust the Holy Spirit**: We can no more cause our clients to choose life for their babies than we can cause them to be saved. This is totally the work of the Holy Spirit. We are the hands and feet of Jesus; He is the heart surgeon.

VIII. Role Play with Lindsay Closson, B.A.

A. Notes: _____

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B. Reactions: _____

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"The Spirit of the Sovereign Lord is on me,
because the Lord has anointed me
to proclaim good news to the poor.
He has sent me to bind up the brokenhearted,
to proclaim freedom for the captives
and release from darkness for the prisoners
to proclaim the year of the Lord's favor
and the day of vengeance of our God,
to comfort all who mourn and provide for those who grieve in Zion—
to bestow on them a crow of beauty
instead of ashes the oil of joy instead of mourning,
and a garment of praise instead of a spirit of despair.
They will be called oaks of righteousness,
a planting of the Lord for the display of his splendor."**—Isaiah 61:1-3**

Endnotes

[1]Guttmacher Institute, "Facts on induced abortion in the United States ." Last modified 2011. Accessed September 17, 2012. http://www.guttmacher.com/pubs/fb_induced_abortion.pdf.

[2]American Congress of Obstetricians & Gynecologists “Medical Management of Abortion ACOG Practice Bulletin #67 Updated 2011. Accessed September 13, 2012 at: http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_--_Gynecology/Medical_Management_of_Abortion

[3]Physician's Desk Reference, "Mifeprex concise monograph." Last modified 2012. Accessed September 10, 2012. http://www.pdr.net/drugpages/concisemonograph.aspx?concise=1759.

[4]Food and Drug Administration, "Mifeprex (mifepristone) Information." Last modified 2011. Accessed September 11, 2012.

[5]Food and Drug Administration, "MEDICATION GUIDE Mifeprex® (mifepristone)." Last modified 2009. Accessed September 11, 2012. http://www.fda.gov/downloads/Drugs/DrugSafety/UCM088643.pdf

[6]Food and Drug Administration, "MIFEPREX® (mifepristone) Tablets, 200 mg Packaging information." Last modified 2005. Accessed September 11, 2012. http://www.accessdata.fda.gov/drugsatfda_docs/label/2005/020687s013lbl.pdf.

[7]Lichtenberg, PM. Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care. West Sussex: Wiley-Blackwell, 2009.

[8]Danco Laboratories, LLC, "Risk evaluation and mitigation strategy (REMS)." Last modified 2009. Accessed September 11, 2012. http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM258412.pdf

[9]Guttmacher Institute. Facts on induced abortion in the United States. August 2011. Available at: http://www.guttmacher.com/pubs/fb_induced_abortion.pdf. Accessed July 10, 2012

[10]Food and Drug Administration, "Mifeprex Questions and Answers." Last modified 2010. Accessed September 11, 2012. http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111328.htm.

[11]Physician's Desk Reference, "Mifeprex concise monograph."

[12]Food and Drug Administration, "Mifeprex (mifepristone) Information."

[13]Food and Drug Administration, "MEDICATION GUIDE Mifeprex®

[14]Food and Drug Administration, "Mifepristone U.S. Postmarketing Adverse Events Summary through 04/30/2011." Last modified 2011. Accessed September 25, 2012. http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf.

[15]Gary, MM. "Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient." The Annals of Pharmacotherapy. 40. (2006). www.theannals.com (accessed September 11, 2012).

[16]Food and Drug Administration, "Mifeprex Questions and Answers." Last modified 2010. Accessed September 11, 2012. http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111328.htm.

[17]Physician's Desk Reference, "Mifeprex concise monograph."

[18]Department of health and human services, Centers for disease control, Food and drug administration, National institutes of health, "Emerging Clostridial Disease Workshop: Summary of Proceedings." Last modified 2006. Accessed September 11, 2012. http://www.fda.gov/downloads/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/UCM183030.pdf.

[19]Lichtenberg, PM. Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care. West Sussex: Wiley-Blackwell, 2009.

[20]Spitz, IM. "Early pregnancy termination with mifepristone and misoprostol in the United States." New England Journal of Medicine. 338. no. 18 (1998): 1241-7.

[21]Gonzalez, CH. "Congenital abnormalities in Brazilian children associated with misoprostol misuse in first trimester of pregnancy." Lancet. 351. (1998): 1624-27.

[22]Food and Drug Administration, "MIFEPREX® (mifepristone) Tablets, 200 mg Packaging information."

[23]Physician's Desk Reference, "Methotrexate . Concise monograph.." Last modified 2012. Accessed September 11, 2012. http://www.pdr.net/drugpages/concisemonograph.aspx?concise=589.

[24]MD Lloyd, "The effects of methotrexate on pregnancy, fertility and lactation. ," Rheumatology, 44, no. 5 (2005): 697, http://qjmed.oxfordjournals.org/content/92/10/551.full (accessed September 11, 2012).

[25]American Congress of Obstetricians and Gynecologists, ""Induced Abortion" Patient Education Pamphlet." Last modified 2011. Accessed September 13, 2012. http://www.acog.org/Resources_And_Publications/Patient_Education_Pamphlets/Files/Induced_Abortion.

[26]Lentz: Comprehensive Gynecology: Induced abortion, Chapter 13 (Philadelphia: Mosby-Elsevier, 2012)http://www.mdconsult.com/books/page.do?eid=4-u1.0-B978-0-323-06986-1..00013-5--s0525&isbn=978-0-323-06986-1&sid=1353910002&uniqId=361642857-3

[27]MA Stenchever, Comprehensive Gynecology, 4th Edition, (St. Louis: Mosby, 2001).

[28]Rock, J.A. TeLinde's Operative Gynecology. Philadelphia: Lippincott-Raven, 1997.

[29]Regents of the University of California, " Providing Abortion Care." Last modified 2009. Accessed September 21, 2012. http://apctoolkit.org/executive.html.

[30]Lichtenberg, PM. Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care. West Sussex: Wiley-Blackwell, 2009.

[31]American Congress of Obstetricians and Gynecologists, ""Induced Abortion" Patient Education Pamphlet."

[32]Ibid.

[33]Lichtenberg, PM. Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care.

[34]L Pasquini, "Intracardiac injection of potassium chloride as method for feticide: experience from a single UK tertiary centre," Br J Obstet Gynaecol, 115, no. 4 (2008): 528-31

[35]Ibid.

[36]Lichtenberg, PM. Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care.

[37]American Congress of Obstetricians and Gynecologists, ""Induced Abortion" Patient Education Pamphlet." Last modified 2011. Accessed September 13, 2012. http://www.acog.org/Resources_And_Publications/Patient_Education_Pamphlets/Files/Induced_Abortion.

[38]Lentz: Comprehensive Gynecology: Induced abortion, Chapter 13

[39]Pazol, K.L. Centers for disease control and prevention, "Morbidity and Mortality Weekly Report: Abortion Surveillance --- United States, 2008." Last modified 2011. Accessed September 13, 2012. http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6015a1.htm?s_cid=ss6015a1_w.

[40]Centers for disease control and prevention, "CDC's Abortion Surveillance System FAQs." Last modified 2012. Accessed September 13, 2012. http://www.cdc.gov/reproductivehealth/Data_Stats/Abortion.htm.

[41]Guttmacher Institute, "Facts on induced abortion in the United States ." Last modified 2011. Accessed September 13, 2012. http://www.guttmacher.com/pubs/fb_induced_abortion.pdf.

[42]Thorp, JM. "Long term physical and psychological health consequences of induced abortion: review of the evidence.." Obstet Gynecol Surv. 58. no. 1 (2003): 67-79

[43]American Congress of Obstetricians and Gynecologists, "Induced Abortion. ACOG Patient Education Pamphlet

[44]Lentz: Comprehensive Gynecology: Induced abortion, Chapter 13

[45]Ibid

[46]American Congress of Obstetricians and Gynecologists, "Antibiotic prophylaxis for gynecologic procedures. Practice Bulletin No. 104." Last modified 2011.http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_--_Gynecology/Antibiotic_Prophylaxis_for_Gynecologic_Procedures (accessed September 13, 2012)

[47]American Congress of Obstetricians and Gynecologists, "Dilatation & Curettage. Patient Education Pamphlet." Last modified 2012. Accessed September 13, 2012. http://www.acog.org/Resources_And_Publications/Patient_Education_Pamphlets/Files/Dilation_and_Curettage.

[48]American Congress of Obstetricians and Gynecologists, "Pelvic Inflammatory Disease, Patient Education Pamphlet." Last modified 2010. Accessed September 13, 2012. http://www.acog.org/Resources_And_Publications/Patient_Education_Pamphlets/Files/Pelvic_Inflammatory_Disease.

[49]American Congress of Obstetricians and Gynecologists, "Induced Abortion. ACOG Patient Education Pamphlet

[50]American Congress of Obstetricians and Gynecologists, "Dilatation & Curettage. Patient Education Pamphlet." Last modified 2012. Accessed September 13, 2012. http://www.acog.org/Resources_And_Publications/Patient_Education_Pamphlets/Files/Dilation_and_Curettage

[51]American Congress of Obstetricians and Gynecologists, "Management of Alloimmunization During Pregnancy: ACOG Practice Bulletin. Last modified 2010. Accessed September 13, 2012. http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_--_Obstetrics/Management_of_Alloimmunization_During_Pregnancy

[52]Miller's Anesthesia, 7th ed. Section IV Chapter 33 Risk of Anesthesia. Churchill Livingstone, an imprint of Elsevier, 2009. http://www.mdconsult.com/books/page.do?eid=4-u1.0-B978-0-443-06959-8..00033-9&isbn=978-0-443-06959-8&sid=1354403842&uniqId=361897526-8

[53]Guttmacher Institute, "Facts on induced abortion in the United States."

[54]Miller's Anesthesia, 7th ed. Section IV Chapter 33 Risk of Anesthesia

[55]DC Reardon, "Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980–2004," Med Sci Monit, 18, no. 9 (2012): 71-76, http://www.medscimonit.com/fulltxt_free.php?ICID=883338 (accessed September 17, 2012).

[56]Thorp, JM. "Long term physical and psychological health consequences of induced abortion: review of the evidence.." Obstet Gynecol Surv. 58. no. 1 (2003): 67-79

[57]M Gissler, "Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland, l987-2000," American Journal of Obstetrics and Gynecology, 190 (2004): 422-7,

[58]M Gissler, "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000.," European Journal of Public Health, 15 (2005): 459-463,

[59]Moreau C, . "Previous induced abortions and the risk of very preterm delivery: results of the EPIPAGE study.." Br J Obstet Gynaecol. 112. no. 4 (2005): 430-7.

[60]Ancel, PY. "History of induced abortion as a risk factor for preterm birth in European countries: results of EUROPOP survey." Human Reproduction. 19. no. 3 (2004): 734-40.

[61]Stang, P. "Induced abortion increases the risk of very preterm delivery, results from a large perinatal database.." Fertility Sterility. (2005).

[62]Brown, TS. "Previous abortion and the risk of low birth weight and preterm births." Journal of Epidemiology & Community Health.. 62. (2008): 16-22.

[63]Freak-Poli, R. "Previous abortion and risk of preterm birth: a population study." J Matern Fetal Med. 22. no. 1 (2009): 1-7.

[64]Rooney, B. "Induced abortion and risk of later premature births." Journal of American Physicians & Surgeons. 8. no. 2 (2003): 46-9.

[65]Behrman, R. "Preterm birth: causes, consequences, and prevention." Institute of Medicine of the National Academy of Sciences. (2006).

[66]National Cancer Institute at the National Institutes of Health, "Reproductive History and Breast Cancer Risk." Last modified 2011. Accessed September 13, 2012. http://cancer.gov/cancertopics/factsheet/Risk/reproductive-history.

[67]Hsieh, C. "Delivery of premature newborns and maternal breast cancer risk." Lancet. (1999).

[68]Russo, J.A. "Developmental, molecular and cellular basis of human breast cancer." J Natl Cancer Inst Monogr.. 27. (2000): 17-37.

[69]Brind, J. "Induced abortion as an independent risk factor for breast cancer: a critical review of recent studies based on prospective data.." Journal of American Physicians & Surgeons. 10. no. 4 (2005).

[70]Carroll, P. "The breast cancer epidemic: modeling and forecasts based on abortion and other risk factors." Journal of American Physicians & Surgeons. 12. no. 3 (2007).

[71]JM Dolle, "Risk Factors for Triple-Negative Breast Cancer in Women Under the Age of 45 Years," Cancer Epidemiol Biomarkers Prev, 18, no. 4 (2009): 1157-1166,

[72]Thorp, JM. "Long term physical and psychological health consequences of induced abortion: review of the evidence.." Obstet Gynecol Surv. 58. no. 1 (2003): 67-79.

[73]P Coleman, "Reproductive history patterns and long-term mortality rates: a Danish, population-based record linkage study," The European Journal of Public Health (2012): 1-6,

[74]DC Reardon, "Deaths associated with delivery and abortion among California Medicaid patients: a record linkage study," Southern Medical Journal, 95 (2002): 834-41,

[75]M Gissler, "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000.," European Journal of Public Health, 15 (2005): 459-463,

[76]Broen, AN. "Psychological impact on women of miscarriage versus induced abortion: a 2-year follow-up study.." Psychosom Med. 66. no. 2 (2004): 265-71.

[77]Broen, AN. "The course of mental health after miscarriage and induced abortion: a longitudinal, five-year follow-up study." BMC Med. 5. no. 3 (2005): 18.

[78]Cougle, JR. "Depression associated with abortion and childbirth: a long-term analysis of the NLSY cohort." Medical Science Monitor. 9. no. 4 (2003): 105-12.

[79]Fergusson, DM. "Abortion in young women and subsequent mental health." J Child Psychol Psychiatry. 47. no. 4 (2006): 16-24.

[80]Pedersen, W. "Abortion and depression: a population-based longitudinal study of young women." Scand J Public Health. 36. no. 4 (2008): 424-8.

[81]Rees, DI. "The relationship between abortion and depression: new evidence from the Fragile Families and Child Wellbeing Study." Med Sci Monit. 13. no. 10 (2007): 430-6.

[82]Pedersen, W. "Abortion and depression: a population-based longitudinal study of young women."

[83]Fergusson, DM. "Abortion in young women and subsequent mental health."

[84]J Cougle, "Generalized anxiety associated with unintended pregnancy: a cohort study of the 1995 National Survey of Family Growth.," J Anxiety Disord, 19, no. 10 (2005): 137-42,

[85]Coleman, P. "Prior history of induced abortion in relation to substance use during subsequent pregnancies carried to term.." Am J Obstet Gynecol. 178. (2002): 1673-8.

[86]Coleman, P. "Substance use among pregnant women in the contest of previous reproductive loss and desire for current pregnancy.." Br J Health Psychol. 10. (2005): 255-68.

[87]Pedersen W, "Childbirth, abortion and subsequent substance use in young women: a population-based longitudinal study.," Addiction, 100, no. 12 (2007): 1971-8,

[88]Reardon, DC. "Substance use associated with prior history of abortion and unintended birth: a national cross sectional cohort study.." Am J Drug Alcohol Abuse. 26. (2004): 369-83.

[89]P Coleman, "Resolution of unwanted pregnancy during adolescence through abortion versus childbirth: individual and family predictors and psychological consequences," J Youth Adolesc., 35 (2006): 903-11,

[90]Thorp, JM. "Long term physical and psychological health consequences of induced abortion: review of the evidence."

[91]V Rue, "Induced abortion and traumatic stress: a preliminary comparison of American and Russian women," Med Sci Monit, 10 (2004): 5-16,

[92]Fergusson, DM. "Abortion in young women and subsequent mental health."

[93]Reardon,D "Deaths associated with abortion compared to childbirth: a review of old and new data and the medical and legal implications," J Contemp Health Law Policy, 20, no. 2 (2004): 279-327,

[94]Gissler M, "Injury deaths, suicides and homicides associated with pregnancy," Eur J Public Health, 15, no. 5 (2005): 459-63,

[95]E Shadigian, "Pregnancy-associated death: a qualitative systematic review of homicide and suicide," Obstet Gynecol Surv, 60, no. 3 (2005): 183,

[96]Coleman, P. "Induced abortion and intimate relationship quality in the Chicago Health and Social Life Survey.." Public Health. 123. no. 4 (2009): 331-8.

[97]P Coleman, "Predictors and correlates of abortion in the Fragile Families and Well-Being Study: paternal behavior, substance use, and partner violence," Int J Ment Health Addict, 7, no. 3 (2009): 405-22