
A Case Series Detailing the Successful Reversal of the Effects of Mifepristone Using Progesterone

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ABSTRACT:

Background: Some women who take mifepristone, a progesterone receptor antagonist, in order to terminate their pregnancies, change their minds and desire to stop the medical abortion process. There are only two articles in the medical literature documenting the reversal of the effects of mifepristone.

Objective: We present and analyze a series of women who attempted to reverse the effects of mifepristone by taking supplemental progesterone to determine if the reversal of the effects mifepristone with progesterone is possible and safe. Additionally, we compare different progesterone regimens to determine relative efficacies.

Methods: This is a retrospective analysis of clinical data of 754 patients who decided to attempt to reverse the medical abortion process after taking mifepristone but before taking the second drug in the protocol, misoprostol. We followed the patients, who were given progesterone in an effort to reverse

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the effects of mifepristone, and conducted statistical analyses to determine the efficacies of different protocols compared to a control mifepristone embryo survival rate, derived from the literature.

Results: Intramuscular progesterone and high dose oral progesterone were the most effective with reversal rates of 64% ($P < 0.001$) and 68% ($P < 0.001$), respectively. There was no apparent increased risk of birth defects.

Conclusions: The reversal of the effects of mifepristone using progesterone is safe and effective.

Introduction

Medical induced abortion utilizing mifepristone has been available in the United States since 2000. In 2014, 31% of non-hospital induced abortions were medical induced abortions.¹ Some women decide to attempt to reverse the medical abortion process after taking mifepristone but before taking misoprostol, and inquire about the possibility of reversing the effects of mifepristone.²

The new FDA protocol, approved for medical abortion in 2016, involves the administration of mifepristone 200 mg orally as a single dose, which leads to embryonic or fetal demise, followed 24-48 hours later by misoprostol 800 mcg buccally as a single dose, which stimulates myometrial contractions. The protocol is approved up to 70 days after the first day of the last menstrual period.³ Misoprostol is part of the protocol because mifepristone alone has an incomplete abortion rate of 20-40%, as determined by the end point of complete expulsion.⁴

Pharmacology

Mifepristone is a competitive antagonist of progesterone at the progesterone receptor (PR). It binds to the PR twice as avidly as progesterone.⁵ Mifepristone is an orally active compound with a nearly 70% absorption rate, but its bioavailability is reduced to approximately 40% because of the first-pass effect.⁶

Demethylation and hydroxylation are catalyzed by CYP3A4; three metabolites retain biologic activity. The half-life of mifepristone is approximately 18-25 hours. Mifepristone and its metabolites can be measured up to 72 hours after an ingested dose.⁵ The half-life of progesterone is longer, approximately 25-55 hours.^{6,7}

Effects of Mifepristone

By blocking progesterone receptors, mifepristone leads to the separation of the decidua basalis from the trophoblast. This separation diminishes the oxygen and nutrients that can be delivered to the embryo or fetus by the maternal circulation and is the primary embryocidal and fetocidal effect of mifepristone.^{4,8,9}

In addition to this primary effect, mifepristone causes softening and dilatation of the cervix.⁴ It also leads to myometrial contractions, increased myometrial sensitivity to prostaglandins^{4,10} and the disinhibition of prostaglandin synthesis by the myometrium.¹¹

Progesterone has been shown to have an autoregulatory effect on progesterone synthesis by the corpus luteum. Blocking progesterone receptors with mifepristone decreases progesterone secretion by the corpus luteum.¹²

Logic of Using Progesterone to Reverse Mifepristone Effects

Mifepristone is a competitive inhibitor of the progesterone receptor. It is well known that receptor agonism and antagonism are parts of a dynamic process that can be influenced by changing concentrations of the agonist or antagonist. Therefore, it makes biologic sense that increasing the progesterone levels in a pregnant woman by giving supplemental progesterone would favor the agonist progesterone effects and blunt the abortifacient effects of mifepristone.

An Animal Model

A Japanese rat study provides basic-science evidence of the ability of progesterone to negate the effects of mifepristone. In this experiment, one group of pregnant rats was given mifepristone while a second was given mifepristone and progesterone. In the group that only received mifepristone, only 33% of the pups survived. In the group that received mifepristone and progesterone, 100% of the pups survived. Furthermore, the first group had characteristic changes in the myometrium and ovaries; the group that received the combination had no such changes.¹³

Early Mifepristone Studies Reporting Continuing Pregnancy

When mifepristone was first studied as an abortifacient, misoprostol was not part of the protocol. During the 1980's, researchers determined that even though mifepristone was effective as an abortifacient, they believed it was necessary to add a prostaglandin analog to achieve a satisfactory complete uterine evacuation rate.⁴ We must emphasize that the definition of incomplete abortion is incomplete emptying of the uterus.¹⁴ Embryo or fetus survival is not implied.

The earliest studies also revealed that some embryos survived mifepristone. Baulieu, the principal developer of the drug, stated that at 4-7 weeks the percentages of efficacy of the regimen were approximately 70% for complete abortions, 20% for incomplete abortions and 10% for ongoing pregnancies (i.e., presumed embryo survival). For gestations 8-10 weeks, the comparable rates were 50% for complete abortions, 35% for incomplete abortions and 15% for embryo survival.¹⁵

In 2015, Grossman et al. published a review of the first case series of progesterone reversal of mifepristone, as well as 13 studies from the 1980's, addressing continuing pregnancies after mifepristone. The authors concluded that there was insufficient evidence to show that progesterone therapy improved survival over expectant management, based on the reported high ongoing pregnancy rates in some of these older studies.¹⁶ However, closer scrutiny of the studies cited for high ongoing pregnancy rates reveals inadequate criteria for the diagnosis of continuing pregnancies. Many early researchers focused on an efficacy end point of complete uterine evacuation, and did not distinguish missed or incomplete abortions from continuing pregnancies (embryo or fetus

survival).¹⁷ Only eight studies cited by Grossman had criteria sufficient to determine embryo survival and showed continuing pregnancy rates of 8-25%.¹⁷

A recent review found that 18 of the 30 articles investigating mifepristone monotherapy had adequate criteria to determine embryo survival.¹⁷ After eliminating duplicate publications, 12 studies were identified which utilized follow-up ultrasound to distinguish between incomplete or missed abortion and embryo survival at the end of the study period. The mean percentage of embryos surviving mifepristone among all studies was 12.6%.¹⁷ A single dose of 600 mg in five studies of early gestations 42-49 days in 493 subjects showed survivals of 9.4-17.1%.^{17,18,19,20,21} Three studies of 58 women with gestations <49 days, using the current predominant 200-300 mg doses, noted embryo survival rates of 10-23.3%.^{19,22,23,24} Four studies of 83 women included gestations up to 70 days, daily doses of 100-200 mg, and total doses 400-800 mg.; in three of these four studies, embryo survival was <25%.^{25,26,27,28,29,30,31}

Methods

This is a retrospective analysis of clinical data of a group of pregnant women who took progesterone in an effort to reverse the effects of mifepristone. The study was reviewed and approved by an institutional review board. The lead author contributed clinical data from a variety of clinical settings across the United States and several other countries for comparison.

Subjects were pregnant women who had taken mifepristone, but had not yet taken misoprostol, and were interested in reversing its effects. Subjects called an informational hotline linked to an informational website and staffed by nurses and a physician assistant. After receiving information about the reversal process, those who decided to proceed with reversal were referred to physicians and mid-level practitioners in their respective geographic areas for treatment. The women gave written informed consent for treatment to their respective treating medical professionals that included permission to track their data. Data were collected from the women themselves and from their treating healthcare professionals.

Data were collected for different variables including gestational age at the time of mifepristone ingestion, mode of delivery of progesterone given, amounts of progesterone received, birth defects and preterm delivery. Progesterone was given in a variety of regimens by the 325 different medical professionals who treated these women. The modes of delivery of progesterone were intramuscular injection of progesterone in oil, oral administration of micronized progesterone, vaginal use of oral micronized progesterone capsules, compounded micronized progesterone vaginal suppositories, progesterone vaginal gel and progesterone vaginal suppositories.

We selected a 25% embryo or fetus survival rate, if mifepristone alone is administered, as a control because it is at the upper range of mifepristone survival rates and close to the 23% survival rate of the one early study that used a single 200 mg dose, the dose currently favored for medical abortions.¹⁷ This study is designed to ascertain which progesterone treatments clinicians have offered to women seeking mifepristone

reversal that demonstrate efficacy beyond the 25% embryo survival rate, and compares the relative efficacies of different treatment protocols to the historic control.

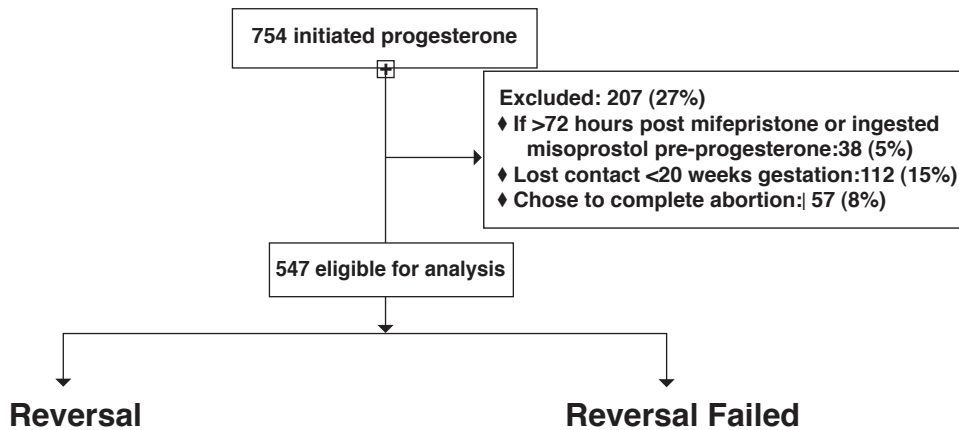
Results

From June 24, 2012 to June 21, 2016, 1,668 calls were received by the hotline from women who had taken mifepristone and were interested in reversal. Seven hundred fifty-four (45%) actually initiated progesterone therapy.

Subjects were included in the study if they were 72 hours or less post-mifepristone and had not taken misoprostol; 38 (5%) did not meet these criteria. Of the women who started progesterone therapy and met inclusion criteria, 116 (15.4%) were lost to follow-up at some point. Of those, 112 (14.9%) were lost to follow-up prior to 20 weeks gestation and were excluded from the analysis. Four (0.5%) women remained pregnant with viable fetuses but were lost to follow-up after twenty weeks gestation and were included in the analysis as reversals.

Fifty-seven (7.6%) of the women, after starting progesterone therapy, changed their minds again and either took misoprostol to complete the medical abortion or procured surgical induced abortion. Of those 57, 39 (5.2%) chose to complete abortion medically with misoprostol, seven (0.9%) procured surgical abortions and 11 (1.5%) completed

Figure 1



abortion by unspecified means. These were not included in the analysis as they chose to no longer attempt reversal. See Figure 1.

Women who delivered babies after progesterone therapy or who were lost to follow-up after 20-weeks gestation were considered to have reversed their medical abortions, since any pregnancy loss after 20 weeks would be unlikely to be attributable to the early mifepristone exposure. The data analysis was accomplished using the Statistical Hypothesis Test on a population proportion.

After exclusions, there were 547 patients with analyzable outcomes who underwent progesterone therapy. There were 257 births (47%). Another four were pregnant with viable fetuses but were lost to follow-up after 20 weeks gestation (0.7%). The overall rate of reversal of mifepristone was 48%.

Two subgroups had the highest reversal rates. Those who received progesterone intramuscularly (IM) initially or exclusively had a 64% reversal rate. One subject in this group had an undocumented number of injections. The high-dose oral subgroup received oral progesterone, 400 mg twice a day for three days, followed by 400 mg once a day until the end of the first trimester and had a reversal rate of 68%, similar to the IM group. These survival rates compare favorably with published embryo and fetal survival rate of 25%, if no treatment is attempted,¹⁷ the rate used as a control. See Table 1.

The gestational age at the time of ingestion was directly related to reversal success. See Table 2. This is not surprising since mifepristone embryocidal and fetocidal rates fall with advancing gestational age.³³

There was no correlation between maternal age and rate of reversal. In the subset of records noting time intervals, the time between mifepristone ingestion and the first progesterone dose was not statistically significant in relation to the success rate for reversals attempted within 72 hours of mifepristone injection.

Birth Defects

There were seven reported birth defects in the women who had reversals and follow-up after their deliveries for a rate of 7/257 (2.7%). See Table 3. This is equal to the birth defect rate in the general population of approximately 3%³⁴ and suggests that there is no increased risk of birth defects in babies born after mifepristone reversal.

Preterm Delivery

There were seven deliveries at <37weeks for a preterm delivery rate of 2.7%. The United States average is 10%.³⁵

Multiple Gestations

There were nine sets of twins (4.3% of the pregnancies). There were no higher order multiples.

Discussion

Progesterone Safety

Progesterone is a naturally occurring hormone produced by the corpus luteum and by the placenta, and is essential for maintenance of the maternal fetal interface of pregnancy. It has been used safely in pregnancy for over 50 years.³⁶ The American Society of Reproductive Medicine states that no long-term risks have been identified when progesterone is used in pregnancy.³⁷ The FDA has given progesterone a category B rating in pregnancy, in contrast to synthetic progestins.³⁸

Table 1: Reversals Compared to Reported Control of 25% Survival if No Treatment Undertaken

| Progesterone Group | Number | Reversals | Reversal Failures | Percent Reversals | P Value | 95% Confidence Intervals |
|--------------------------------|--------|-----------|-------------------|-------------------|---------|--------------------------|
| All Groups | 547 | 261 | 286 | 48% | <0.001 | 0.44-0.52 |
| High Dose Oral | 31 | 21 | 10 | 68% | <0.001 | 0.51-0.84 |
| Intramuscular, All groups | 125 | 80 | 45 | 64% | <0.001 | 0.56-0.72 |
| IM, 1 Injection | 50 | 24 | 26 | 48% | <0.001 | 0.34-0.62 |
| IM, 2-5 Injec. | 36 | 21 | 15 | 58% | <0.001 | 0.42-0.74 |
| IM, 6-8 Injec. | 9 | 9 | 0 | 100% | <0.001 | 0.67-1 |
| IM, 9-10 Injec. | 10 | 9 | 1 | 90% | <0.001 | 0.77-1.0 |
| IM, 11 or More Injec. | 19 | 17 | 2 | 89% | <0.001 | 0.76-1.0 |
| Oral, All Groups | 119 | 64 | 55 | 54% | <0.001 | 0.45-0.63 |
| Oral Caps Vaginally, All Doses | 156 | 61 | 95 | 39% | <0.001 | 0.31-0.47 |
| Vaginal Suppository | 34 | 11 | 23 | 32% | 0.161 | 0.17-0.48 |

A recent retrospective study of a Danish infertility cohort suggested a possible increased risk of acute lymphocytic leukemia and sympathetic neural tumors in children born to mothers who had taken progesterone during pregnancy and before pregnancy. The increased risk was greatest in women who had taken progesterone for three or more cycles.³⁹ However, the infertility population examined in the Danish study, exposed to

Table 2: Gestational Age Compared to Reversal Rate

| Gesta-tional Age | Total | Reversal | Reversal Failure | Reversal % | P value | 95% Confidence Intervals |
|------------------|-------|----------|------------------|------------|---------|--------------------------|
| 5 weeks | 76 | 19 | 57 | 25% | 0.5 | 0.15-0.35 |
| 6 weeks | 113 | 52 | 61 | 46% | <0.001 | 0.37-0.55 |
| 7 weeks | 102 | 50 | 52 | 49% | <0.001 | 0.39-0.59 |
| 8 weeks | 88 | 54 | 34 | 61% | <0.001 | 0.51-0.72 |
| 9 weeks | 30 | 23 | 7 | 77% | <0.001 | 0.62-0.92 |

Table 3: Birth Defects

| Birth Defect | Instances |
|--------------------------------|-----------|
| Port Wine Stain | 1 |
| Bilateral Absent Toe | 1 |
| Unilateral Two Absent Fingers | 1 |
| Choroid Plexus Cyst | 1 |
| Cystic Kidney | 1 |
| Unilateral Failed Hearing Test | 1 |
| Heart Murmur | 1 |

many cycles of progesterone and other medications, differs significantly from our population of fertile women who had a single exposure to progesterone.

Mifepristone Teratogenicity

While previous human studies are not large in number, the available evidence suggests that mifepristone is not teratogenic.^{4,40,41} The American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin March 2014 states that there is no evidence that mifepristone is associated with teratogenicity.⁴² Our data set, the largest of babies exposed to mifepristone in utero, also indicates that the birth defect risk in women who have reversed mifepristone abortions is no higher than the risk in the general population.

Study Limitations

This study is limited in that it is not a randomized placebo-controlled trial. However, a placebo-controlled trial in the population of women who regret their abortion and

want to save the pregnancy would be unethical. Furthermore, although the number of women lost to follow-up was small, it could have affected the results. In addition, some data collection was incomplete.

One potential confounding variable is the use of ultrasound to select for living embryos prior to the first progesterone dose. It is possible that those embryos who were alive at the time of sonogram may have survived without progesterone therapy. However, our study also included some women who started progesterone therapy prior to sonographic documentation that the embryo was alive. Undoubtedly, this group included women who already had an embryonic demise prior to initiation of progesterone therapy. Inclusion of these women would falsely lower the success rate of progesterone therapy. The numbers of women who received or did not receive ultrasound exams prior to initiating therapy were not available to our researchers. If ultrasound is readily available, sound practice would dictate that embryonic or fetal viability should be confirmed, or at least suggested, before treatment is started in order to avoid giving women progesterone unnecessarily and to exclude ectopic pregnancy before starting progesterone therapy.

Conclusions

The use of progesterone to reverse the effects of the competitive progesterone receptor blocker, mifepristone, appears to be both safe and effective. Progesterone therapy makes biologic sense, has been previously published as effective in an animal model and is supported by this case series which demonstrates a statistically significant difference in survival between treatment groups and the historic control. Mifepristone is embryocidal and fetocidal but not teratogenic; progesterone is not associated with birth defects.

Based on these new data, two reasonable protocols can be suggested for women who seek to reverse the effects of mifepristone:

1. Progesterone micronized 200 mg capsule two by mouth as soon as possible and continued at a dose of 200 mg capsule two by mouth twice a day for three days, followed by 200 mg capsule two by mouth at bedtime until the end of the first trimester; and
2. Progesterone 200 mg intramuscular as soon as possible and continued at a dose of 200 mg intramuscular once a day on days two and three, then every other day for a total of seven injections. Some clinicians may choose to continue intramuscular treatment longer since this recommendation is based on relatively small numbers.

Recommendations for Future Research

We propose that further research employing randomized controlled trials comparing progesterone doses and routes of administration are needed to confirm which mode of delivery, dose and duration of progesterone therapy is most efficacious and carries the least burden for the patient.

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References

- ¹ Jones RK and Jerman J. Abortion incidence and service availability in the United States, 2014. *Perspectives on Sexual and Reproductive Health*, 2017, 49(1), DOI: 10.1363/psrh.12015.
- ² Delgado G, Davenport M. Progesterone Use to Reverse the Effects of Mifepristone. *Ann Pharmacother* 2012;46. Published Online, 27 Nov 2012, *theannals.com*, DOI: 10.1345/aph.1R252.
- ³ Medication Guide, Mifeprix. www.fda.gov/downloads/drugs/drugsafety/ucm088643.pdf (accessed November 19, 2016).
- ⁴ Creinin, M, Gemzell Danielsson, K. Chapter 9, Medical abortion in early pregnancy, in *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. Published Online: 22 May 2009 DOI: 10.1002/9781444313031.ch9.
- ⁵ Heikinheimo O, Kekkonen R, Lahtenmaki P. The pharmacokinetics of mifepristone in humans reveal insights into differential mechanisms of antiprogestins action. *Contraception* 2003;68:421-6.
- ⁶ Sarkar NN. Mifepristone: bioavailability, pharmacokinetics and use-effectiveness. *Eur J Obstet Gynaecol Reprod Bio*; 2002;101:113-20.
- ⁷ Drug Bank Progesterone. <http://www.drugbank.ca/drugs/DB00396> (accessed 2011 Oct 8).
- ⁸ Johannisson E, Oberholzer M, Swahn ML, Bygdeman M. Vascular changes in the human endometrium following the administration of the progesterone antagonist RU 486. *Contraception* 1989; 39: 103–107.
- ⁹ Schindler AM, Zanon P, Obradovic D, Wyss R, Graff P, Hermann WL. Early ultrastructural changes in RU-486-exposed decidua. *Gynecol Obstet Invest* 1985; 20: 62–67.
- ¹⁰ Swahn ML, Bygdeman M. The effect of the antiprogesterin RU 486 on uterine contractility and sensitivity to prostaglandin and oxytocin. *Br J Obstet Gynaecol* 1988; 95: 126–134.
- ¹¹ Herrmann WL, Schindler AM, Wyss R, Bishof P. Effects of the antiprogesterone RU 486 in early pregnancy and during the menstrual cycle. In: Beaulieu EE, Siegel S, eds. *The Antiprogesterin Steroid RU 486 and Human Fertility Control*. Plenum, New York, 1985: 259–262.
- ¹² Ottander U, et al. A Putative Stimulatory Role of Progesterone Acting via Progesterone Receptors in the Steroidogenic Cells of the Human Corpus Luteum. *Biology of Reproduction* March 1, 2000 vol. 62 no. 3 655-663.
- ¹³ Yamabe, S; Katayana, K; Mochuzuki, M *Folio endocrine*. 65, 497-511, 1989. The Effects of RU486 and Progesterone on Luteal Function During Pregnancy.
- ¹⁴ <http://medical-dictionary.thefreedictionary.com/incomplete+abortion> (accessed November 20, 2016).
- ¹⁵ Beaulieu EE. RU-486: An antiprogesterin steroid with contragestive effect in women. In Baulieu EE, Siegel S (eds): *The Antiprogesterin Steroid RU 486 and Human Fertility Control*. New York, Plenum, 1985. pp. 2-6.
- ¹⁶ Grossman D et al. Continuing pregnancy after mifepristone and “reversal” of first-trimester medical abortion: A systematic review, *Contraception* (2015) September 2015 Volume 92, Issue 3, pp. 206–211, DOI: 10.1016/j.contraception.2015.06.001).
- ¹⁷ Davenport M, Delgado G, Khau V. Embryo survival after mifepristone: review of the literature. *Issues in Law and Medicine* 2017, 32 (1): 3-18.
- ¹⁸ Ylikorkala O, Alfthan H, Kääriäinen M, Rapeli T, Lähtenmäki P. Outpatient therapeutic abortion with mifepristone. *Obstet Gynecol* 1989;74:653-7.
- ¹⁹ Maria B, Chaneac M, Stampf F, Ulmann A. [Early pregnancy interruption using an antiprogesterone steroid: Mifepristone (RU 486)]. *J Gynecol Obstet Biol Reprod (Paris)* 1988;17:1089-94.
- ²⁰ Carol W, Klinger G. [Experiences with the antigestagen mifepristone (RU 486) in the interruption of early pregnancy]. *Zentralbl Gynakol* 1989;111:1325-8.
- ²¹ Somell C, Olund A. Induction of abortion in early pregnancy with mifepristone. *Gynecol Obstet Invest* 1990;29:13-5.
- ²² Kovacs L, Sas M, Resch BA, Ugocsai G, Swahn ML, Bygdeman M, Rowe PJ. Termination of very early pregnancy by RU 486—an antiprogesterational compound. *Contraception* 1984;29:399-410.

- ²³ Kovacs L, Termination of Very Early Pregnancy with Different Doses of RU-486: A Phase I Controlled Clinical Trial. In Beaulieu EE, Siegel S (eds): *The Antiprogestin Steroid RU 486 and Human Fertility Control*. pp. 179-198. New York, Plenum, 1985.
- ²⁴ Swahn ML, S. Cekan, G. Wang, V. Lundstom, and M. Bygdeman. In Beaulieu EE, Siegel S (eds): *The Antiprogestin Steroid RU 486 and Human Fertility Control*. pp. 249-258. New York, Plenum, 1985.
- ²⁵ Herrmann WL, Schindler AM, Wyss R, et al: Effects of the antiprogestone RU 486 in early pregnancy and during the menstrual cycle. In Beaulieu EE, Siegel S (eds): *The Antiprogestin Steroid RU 486 and Human Fertility Control*. pp. 179-198. New York, Plenum, 1985.
- ²⁶ Herrmann W, Wyss R, Riondel A, Philibert D, Teutsch G, Sakiz E, Baulieu EE. [The effects of an antiprogestone steroid in women: interruption of the menstrual cycle and of early pregnancy]. *Comptes Rendus Seances Acad Sci III*. 1982 May 17;294(18):933-8. French.
- ²⁷ Vervest HAM, Haspels AA, Preliminary results with antiprogestone RU-486. (mifepristone) for interruption of early pregnancy. *FertilSteril*. 1985;44: 627-32.
- ²⁸ Haspels AA Interruption of early pregnancy by the antiprogestational compound RU 486 In Beaulieu EE, Siegel S (eds): *The Antiprogestin Steroid RU 486 and Human Fertility Control*. pp. 199-210, New York, Plenum, 1985.
- ²⁹ Haspels AA. Interruption of early pregnancy by an anti-progestational compound, RU 486. *Eur J Obstet Gynecol Reprod Biol*. 1985 Sep;20(3):169.
- ³⁰ Cameron IT, Michie AF, Baird DT. Therapeutic abortion in early pregnancy with antiprogestogen RU486 alone or in combination with prostaglandin analogue (gemeprost). *Contraception* 1986;34:459-68.
- ³¹ Cameron IT, Baird DT. Early pregnancy termination: a comparison between vacuum aspiration and medical abortion using prostaglandin (16,16 dimethyl-trans-delta 2-PGE1 methyl ester) or the antiprogestogen RU 486. *Br J Obstet Gynaecol*. 1988 Mar; 95(3):271-6.
- ³² Elia D. Clinical study of RU 486 in early pregnancy. In Beaulieu EE, Siegel S (eds): *The Antiprogestin Steroid RU 486 and Human Fertility Control*. pp. 211-220. New York, Plenum, 1985.
- ³³ Spitz IM, Bardin W, Benton L, Robbins A, et al. Early pregnancy termination with mifepristone and misoprostol. *N Engl J Med* 1998;338:1241-7. DOI: 0.1056/NEJM199804303381801.
- ³⁴ CDC MMWR January 11, 2008 / 57(01);1-5.
- ³⁵ Preterm Birth. <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm> (accessed December 7, 2016).
- ³⁶ Dante G, Vaccaro V, Facchinetti. Use of progestogens in early pregnancy. Facts, Views and Vision. *ObGyn*. 2013 5(1): 66-71.
- ³⁷ Progesterone. <https://www.asrm.org/detail.aspx?id=1881>(accessed December 3, 2016).
- ³⁸ Progesterone package insert. <https://www.drugs.com/pro/progesterone-capsule.html>. (accessed December, 3, 2016).
- ³⁹ Hargreave M, et al. Maternal use of fertility drugs and risk of cancer in children—a nationwide population-based cohort study in Denmark. *Int. J. Cancer*: 136, 1931–1939 (2015).
- ⁴⁰ Bernard N, Elefant E, Carlier P, Tebacher M, Barjhoux CE, Bos-Thompson MA, Amar E, Descotes J, Vial T. Continuation of pregnancy after first-trimester exposure to mifepristone: an observational prospective study. *BJOG*. 2013 Apr;120(5):568-74. DOI: 10.1111/1471-0528.12147. Epub 2013 Jan.
- ⁴¹ Regine Sitruk-Ware a, Angela Davey , Edouard Sakiz. Fetal malformation and failed medical termination of pregnancy. *The Lancet*, Volume 352, Issue 9124, Page 323, 25 July 1998.
- ⁴² Medical Management of First Trimester Abortion. *ACOG Practice Bulletin* 143 March 2014, reaffirmed 2016.

