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Mifepristone (RU-486)

In 33 countries including the United States, New Zealand, France, Israel, Sweden and Britain the drug mifepristone, also known as RU-486, can be lawfully administered to women by their doctors under an approved treatment regime. This is a 'medical' abortion rather than a 'surgical' one. Mifepristone, sometimes called the 'abortion pill', is used to terminate pregnancies 40 - 63 days gestation (up to a limit of 7 weeks pregnancy). The woman initially takes a specified quantity of the drug then, in a further appointment two days later, a prostaglandin (such as misoprostol) is administered and an abortion will follow. There is generally a follow up appointment after two weeks to ensure that the pregnancy has been successfully terminated.

Legislative barriers

RU 486 has not been approved for use in the termination of pregnancy by the Therapeutic Goods Association (TGA) in Australia, following legislative changes made in 1996. It has been shown to be of use in treating endometriosis, Cushing's syndrome, glaucoma, inoperable meningiomas, bowel, kidney, liver and uterine cancers¹. Patients wishing to use the drug can apply to the Federal Health Minister for an exemption, and the TGA has received four applications for supply of the drug specifically for cancer treatment.

Benefits and past Australian trials

Women who sought medical abortion in the Australian arm of an international trial sponsored by the World Health Organization in 1997 were satisfied with the method and most found the associated level of pain acceptable. This trial commenced prior to the legislative change in 1996. Women who had previously had surgical abortions reported that the medical method was more acceptable. Reasons given by Australian women for choosing medical abortion included avoidance of an anaesthesia and increased autonomy, that medical abortion is more "natural" and emotionally acceptable, and that it is less stressful². Australian women who participated in the trial also reported feeling more involved in the process and therefore able to achieve a greater sense of autonomy. For many women in the trial, the non-clinical approach used during the medical abortion was also seen psychologically preferable³.

Other countries experiences

Studies performed in other countries have indicated that "the safety, efficacy, and acceptability of the regimen combining 200 mg mifepristone and the option of home administration of Misoprostol used suggests that it should be considered further in more developed and less-developed countries"⁴. Another further notes "Although a small number of women (<5%) still need evacuation of the uterus, the requirement for skilled personnel and sterile surgical facilities is much less for medical abortion than for

routine vacuum aspiration [evacuation of the contents of the uterus using suction]”.⁵ This study comments that “we have never suggested that oral abortifacents may compensate for the lack of access to family planning and health care; rather they make it easier to provide this facility on a wider scale, in circumstances where money and skilled medical personnel are in short supply”.⁶

Australian calls for

A recent article in the *Medical Journal of Australia* highlights the benefits of mifepristone as “most women undergoing early medical abortion do not require further surgical assistance or intervention”.⁷ The report further notes that medical abortion using mifepristone is a highly successful procedure, which can be administered under limited supervision, requires surgical intervention in a small number of cases and that mifepristone is on the World Health Organisations list of essential medicines for developing countries. This article and another both comment on the low mortality rate from using this form of pregnancy termination; in over five years in the United States, only five deaths have occurred from infection.⁸ Both articles note that while the effectiveness of mifepristone in medical abortions is high, where generalized complications occur, women should seek advice at their nearest hospital or emergency room where Doctors have experience in treating spontaneous abortion or miscarriage.

Conclusion

What these studies highlight is that mifepristone should not be used as a substitute for family planning services and health care, it is an easily accessible, easily administered, inexpensive, less surgically invasive regime, useful in situations where access to a broad range of gynecological or skilled medical personnel presents a difficulty. While this has utility in developing nations where the standard of health care services may be low, women in rural areas of developed nations some distances from medical services can likewise benefit. Where permitted by law, mifepristone used in combination with a prostaglandin has been shown to provide a reliable medical alternative to other surgical pregnancy termination procedures.

Footnotes

¹ Cordner, S. and Ettershank, K. “Mifepristone faces major setback in Australia” *The Lancet* v347 June 8, p 1611

² Henshaw 1997 *Mifepristone (RU486) and abortion* MJA V167 pp 292-293

³ Mamers, et.al 1997 *Women’s satisfaction with medical abortion with RU486* MJA V 167 pp 316-317

⁴ Elul, B et.al 2001 “Can women in less-developed countries use a simplified medical abortion regimen?” *The Lancet* v357 May 5, p1402-5

⁵ Baird, D.T. et.al 1992 Misopristol, mifepristone and abortion *The Lancet* v339 February 1, p313

⁶ *ibid.*

⁷ De Costa, C. 2005 *Medical Abortion for Australian Women: it’s time* MJA v183 no.7 pp 378-380

⁸ Miner, J 2005 *Safety of Mifeprex (RU-486) Considered After Five Deaths From infection* Med Page Today <http://www.medpagetoday.com/OBGYN/Pregnancy/tb/1383> accessed October 2005