In Opposition to SB23-190 – Concerning Policies to Make Punishable Deceptive Actions Regarding Pregnancy-Related Services

I am concentrating on APR and will leave the issue of pregnancy resource centers to others:

1) Women sometimes immediately regret their abortion decision after taking mifepristone but before taking the second drug, misoprostol, in the two-drug medication abortion regimen.
2) In 2022, 32 Colorado women initiated the abortion pill reversal protocol through the Abortion Pill Reversal Network.
3) APR is backed by a plausible scientific mechanism – mifepristone reversibly competes for progesterone receptors in the uterus and corpus luteum. Therefore, high dose progesterone can mitigate the effects of mifepristone to terminate the pregnancy.
4) Animal research has confirmed that progesterone can block the effects of mifepristone.
5) A large randomized, placebo controlled clinical trial showed that another progestin (medroxyprogesterone) can reduce the impact of mifepristone/misoprostol and increase the odds (X4) of a continued pregnancy. This provides randomized, placebo-controlled proof of principle in humans.
6) A large case series of 754 patients showed that high dose progesterone more than doubled the chances of a continued pregnancy after mifepristone compared to historic controls.
7) The last systematic review published by an abortion rights activist researcher was in 2015 before this large IRB supervised case series was published. Its arguments against APR are horribly outdated based on the sum of the evidence. Similarly, ACOG draws on this old data to recommend against APR.
8) The only randomized, placebo-controlled trial of APR was stopped prematurely because of safety concerns. Two people who did not take high dose progesterone after ingesting mifepristone required surgical intervention and transfusion. None of the high dose progesterone patients required surgical intervention or transfusion. The patients randomized to high dose progesterone had double the odds of an ongoing pregnancy. None of these observations were statistically significant because of the small size of the trial.
9) When medical professionals create clinical pathways and guidelines, they commonly use lower-level evidence (C) to make their recommendations – about 40% for the American College of Cardiology Guidelines– which use the most rigorous evidence-based methodology – certainly more than ACOG. Only about 10-15% of the highest quality guideline recommendations are based on the highest level of evidence (A).
10) When the intervention is low risk, like natural progesterone, and the potential benefit large, like a life saved, the strength of the recommendation increases. Any evidence-based clinician, not blinded by ideology, would choose to recommend APR.

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