

MINUTES OF THE HOUSE FEDERAL & STATE AFFAIRS COMMITTEE

The meeting was called to order by Chairperson Doug Mays at 1:40 p.m. on March 13, 2001 in Room 313-S of the Capitol.

All members were present except: Representative Joann Freeborn, Excused
Representative Ruby Gilbert, Excused
Representative Broderick Henderson, Excused
Representative Ethel Peterson, Excused

Committee staff present: Theresa M. Kiernan, Revisor of Statutes
Russell Mills, Legislative Research Department
Shelia Pearman, Committee Secretary

Conferees appearing before the committee:
Representative Mary Cook
John Kindley, Indiana Attorney
Lori Faerber, Registered Nurse
Kathy Ostrowski, Kansas for Life
Barbara Duke, American Association of University Women
Carla Mahany, Planned Parenthood of Kansas & Mid Missouri

Others attending: See attached list

The Chairman opened the hearing on HB 2517 - Abortion; woman's-right-to-know act; disclosure of increased cancer risks.

Representative Cook expressed her concern of providing education to women of an increased risk of cancer associated with abortion. She pointed out the numerous credible and statistically sound studies done that reveal a true woman's health is threatened by abortion. Because a woman's sexuality is so easily exploited, it is vital that protections are put in place to guard her health. (Attachment #1)

Mr. Kindley is an Indiana attorney currently prosecuting a consumer protection lawsuit in North Dakota based on informed consent and the abortion-breast cancer link. The proposed amendments (Attachment #2) to K.S.A. 2000 Supp. 65-6709(a)(8) expands the informed consent notification to all women seeking an abortion as to the increased risk of breast cancer in two independent way: first, by abrogating the protective effect of a full-term pregnancy, and second, by doing so at a time when estrogen overexposure during the first two trimesters has left the breast with an abnormally high number of cells which are vulnerable to cancerous mutation. (Attachment #3)

The current version of Kansas' woman's right-to-know law requires a woman be told the medical risks associated not only with having an abortions but also with "carrying a fetus to term." Both the letter and the spirit of the current statute therefore support a requirement that she be told that carrying her child to term is associated with decreased breast cancer risk.

Ms. Faerber has been a nurse for eight years in various pediatric, obstetrics, and gynecological health care settings. She stated there is a need to strengthen the public policy on cancer. She reviewed facts (per Attachment #4) including that breasts are permanently altered during a woman's first pregnancy. If during the first trimester, miscarriage or surgically-induced abortion interrupts this process, the immature cells are more susceptible to cancer-causing agents.

Ms. Ostrowski stated (Attachment #5) Breast Cancer risk is increased by abortion because the prolonged estrogen exposure of early pregnancy which is not followed by the protective hormonal activity of the late third trimester. She encouraged the committee to have **HB 2517** (Section 1 (a)(3)) include the additional statements of risks in the "If You Are Pregnant" booklet prepared by Kansas Department of Health and Environment:

1. Giving birth gives protection against breast cancer. Additional testimony (Attachment #5) submitted on March 15, clarified that naturally occurring or spontaneous abortions (or miscarriages) are not linked to elevated breast cancer because approximately 90 percent occur in the first trimester and are attributed to the lack of estrogen.

Mark Gillette, M.D. submitted testimony in support of **HB 2517** stating his concern that appropriate counseling regarding emotional and physical ramifications of abortion is not given to women prior to an abortion (Attachment #6)

Ms. Duke shared that as a breast cancer survivor, she knows the need for accurate, well-research information about the disease be provided to all women but warned that misinformation can also stigmatize women. (Attachment #7) She opposed **HB 2517** because of the inconclusive evidence of a link.

Ms. Mahany (Attachment #8) cited additional information from the National Breast Cancer Coalition Fund which does not support the implied link between abortions and breast cancer. The National Cancer Institute noted the most common risk factor for breast cancer is increasing age: 1 of 2,525 women in their thirties and 1 of 11 in their seventies. Other risk factors include family history of breast cancer and obesity.

Ms. Kenney cited several organizations (Attachment #9) including the National Cancer Institute which continue to question the link between abortion and breast cancer. She sited the study published in *Epidemiology* (January 2000) which found "no excess risk of breast cancer among women who reported having an induced abortion compared with those who did not, no did risk increase with increasing number of reported induced abortions."

Written testimony in opposition to **HB 2517** by Sharon Lockhart (Attachment #10) encouraged education of all cancer risks as well as the risk of heart disease especially for women.

The hearing on **HB 2517** was closed.

The committee meeting adjourned at 3:15 p.m. The next scheduled meeting is March 14, 2001.

HOUSE FEDERAL & STATE AFFAIRS COMMITTEE

COMMITTEE GUEST LIST

DATE: 3/13/01

NAME	REPRESENTING
NORBERT HERMES	PRO-LIFE
Marsha Strahn	CWA of KS
Connie O'Brien	Pro-Life-Leavenworth
Ed O'Brien	Pro-life - Leavenworth
Karen Roberts	Pro-life - R Cult. of Life League
Bruce Dimmitt	KFL
Keith Haxton	SEAK
Linda Kenney	KDHE
Carrie Kangas	Sen. Brownlee
Roger Franze	KGC
Chandra Buckholz	Washburn
Alexis D. Konrad	" "
Lindsay Moddelmog	" "
Gene J. Grant	Felicio Consulting
Paul M. Brown	REAP
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Breast Cancer Abortion Link March 13, 2001

Mr. Chairman, thank you for allowing me to testify today to support **HB 2517**. This bill strengthens the woman's right-to-know act, informing women about the increased risk of breast cancer associated with abortion.

There are pressures that drive women to undergo abortions, often in violation of their own moral and maternal beliefs. Compassion is needed for any woman who has ever had an abortion and is suffering from emotional pain and grief. What is essential is an attitude of understanding and charity. Faced with tough enough circumstances, perhaps any of us would cave in to the pressure to have an abortion, even if we knew it was the wrong thing to do.

Mr. Chairman and Committee, I am deeply disturbed by the fact that many politicians seem to be more interested in protecting the abortion industry rather than they are in protecting women. I hear the choice groups using phrases such as "Women's Health Alliance", and yet I hear no talk of protecting the woman's true health. Instead, what I hear is how essential it is to protect the rights of women to have abortions! And when there are credible and statistically sound studies done that reveal a true woman's health is threatened by abortion, they say "It's not true. It's just that crazy extreme group, trying to prevent women from getting an abortion."

There are many health issues surrounding abortion and women, and if the opponents of this bill were truly pro-choice, they would want women to know about abortion's true risks. Instead, they are offering women a bundle of half-truths and complete fabrications. They are so obsessed with making abortion a "right" that they no longer care for the woman. Organizations are threatened and doctors are afraid to speak out.

I remember back to the days of my college education when completing my Master's degree. In our business ethics class we were studying the "Dalkon Shield". For women who used it, it began with assurances that the little piece of plastic was safe, and the answer to their contraceptive concerns. When it ended, many of the women were sterile, or lost babies through miscarriage or ectopic pregnancy. There were several deaths, to both mothers and children.

We have before us today another travesty to women's health. Will we be "open" enough to listen to the true facts? Will we be compassionate enough to try to inform women of the true dangers of abortion? Because a woman's sexuality is so easily exploited, it is vital that protections are put in place to guard her health.

Thank you Mr. Chairman. I have chosen not to comment on the actual details of the abortion breast cancer link, and instead leave it to John Kindley, an attorney who has thoroughly researched this subject.

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Attachment No. 1

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HOUSE BILL No. 2517

By Committee on Federal and State Affairs

2-16

9 AN ACT concerning abortion; relating to requirements under the
10 woman's-right-to-know act; amending K.S.A. 2000 Supp. 65-6709 and
11 repealing the existing section.
12

13 *Be it enacted by the Legislature of the State of Kansas:*

14 Section 1. K.S.A. 2000 Supp. 65-6709 is hereby amended to read as
15 follows: 65-6709. No abortion shall be performed or induced without the
16 voluntary and informed consent of the woman upon whom the abortion
17 is to be performed or induced. Except in the case of a medical emergency,
18 consent to an abortion is voluntary and informed only if:

19 (a) At least 24 hours before the abortion the physician who is to per-
20 form the abortion or the referring physician has informed the woman in
21 writing of:

22 (1) The name of the physician who will perform the abortion;

23 (2) a description of the proposed abortion method;

24 (3) a description of risks related to the proposed abortion method,
25 including risks to the woman's reproductive health and alternatives to the
26 abortion that a reasonable patient would consider material to the decision
27 of whether or not to undergo the abortion;

28 (4) the probable gestational age of the fetus at the time the abortion
29 is to be performed and that Kansas law requires the following: "No person
30 shall perform or induce an abortion when the fetus is viable unless such
31 person is a physician and has a documented referral from another phy-
32 sician not financially associated with the physician performing or inducing
33 the abortion and both physicians determine that: (1) The abortion is nec-
34 essary to preserve the life of the pregnant woman; or (2) ~~the fetus is~~
35 ~~affected by a severe or life-threatening deformity or abnormality~~ a con-
36 *tinuation of the pregnancy will cause a substantial and irreversible im-*
37 *pairment of a major bodily function of the pregnant woman."* If the child
38 is born alive, the attending physician has the legal obligation to take all
39 reasonable steps necessary to maintain the life and health of the child;

40 (5) the probable anatomical and physiological characteristics of the
41 fetus at the time the abortion is to be performed;

42 (6) the medical risks associated with carrying a fetus to term; ~~and~~

43 (7) any need for anti-Rh immune globulin therapy, if she is Rh neg-

ative, the likely consequences of refusing such therapy and the cost of the therapy; ~~and~~

~~(8) the increased risk of breast cancer associated with the proposed abortion.~~

(b) At least 24 hours before the abortion, the physician who is to perform the abortion, the referring physician or a qualified person has informed the woman in writing that:

(1) Medical assistance benefits may be available for prenatal care, childbirth and neonatal care, and that more detailed information on the availability of such assistance is contained in the printed materials given to her and described in K.S.A. 2000 Supp. 65-6710, and amendments thereto;

(2) the printed materials in K.S.A. 2000 Supp. 65-6710, and amendments thereto, describe the fetus and list agencies which offer alternatives to abortion with a special section listing adoption services;

(3) the father of the fetus is liable to assist in the support of her child, even in instances where he has offered to pay for the abortion except that in the case of rape this information may be omitted; and

(4) the woman is free to withhold or withdraw her consent to the abortion at any time prior to invasion of the uterus without affecting her right to future care or treatment and without the loss of any state or federally-funded benefits to which she might otherwise be entitled.

(c) Prior to the abortion procedure, prior to physical preparation for the abortion and prior to the administration of medication for the abortion, the woman shall meet privately with the physician who is to perform the abortion and such person's staff to ensure that she has an adequate opportunity to ask questions of and obtain information from the physician concerning the abortion.

(d) At least 24 hours before the abortion, the woman is given a copy of the printed materials described in K.S.A. 2000 Supp. 65-6710, and amendments thereto. If the woman asks questions concerning any of the information or materials, answers shall be provided to her in her own language.

(e) The woman certifies in writing on a form provided by the department, prior to the abortion, that the information required to be provided under subsections (a), (b) and (d) has been provided and that she has met with the physician who is to perform the abortion on an individual basis as provided under subsection (c). All physicians who perform abortions shall report the total number of certifications received monthly to the department. The department shall make the number of certifications received available on an annual basis.

(f) Prior to the performance of the abortion, the physician who is to perform the abortion or the physician's agent receives a copy of the writ-

(8) the fact that the results of most studies indicate that there is an increased occurrence of breast cancer in women who terminate a pregnancy prior to full term; and

(9) the fact that the results of most studies indicate that there is a decreased occurrence of breast cancer in women who carry a pregnancy to full term.

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Abortion - Breast Cancer Link
March 13, 2001
Testimony of John Kindley, Esq.

Thank you, Mr. Chairman, for giving me the opportunity to testify today in support of House Bill 2517. My name is John Kindley. I am an attorney and author of an article in the Wisconsin Law Review on informed consent and the abortion-breast cancer link, and am currently prosecuting a consumer protection lawsuit in North Dakota based on this issue. I support House Bill 2517 because I am convinced that as a matter of law and public policy women considering abortion must be informed about the facts implicating abortion as a risk factor for breast cancer before consenting to the procedure.

First, I would like to anticipate an objection that is commonly made by affirming that it is entirely appropriate for the legislature to be examining this issue and setting public policy in this area. Science, to be sure, is the source through which the facts have been discovered and the data presented, but despite the disagreement among certain scientists as to the significance of these facts, the facts themselves are really not in dispute and are there for anyone to see. The question is not so much what the facts are but rather what to do about the facts. Therefore, whether women considering abortion have a right to be informed about these facts is in its essence a question not of science but of law and public policy.

Both of the propositions in the proposed amendment to section 6709 about the relationship between abortion, childbirth, and breast cancer express facts which are objectively beyond dispute. I will discuss each in turn, but first I will briefly summarize the underlying biological hypothesis that explains why induced abortion would be expected to increase breast cancer risk.

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It is universally acknowledged that most known risk factors for breast cancer – such as early onset of menstrual cycles or late age at menopause – are attributable to some form of overexposure to the main type of female sex hormone, estrogen. It is also known that the highest levels of natural active estrogen ever to occur in a woman’s body are during the first and second trimester of normal pregnancy. This surge of estrogen during pregnancy causes the cells of the breasts to divide, proliferate, and become more numerous. In approximately the last 8 weeks of a full-term pregnancy, other hormones cause these cells to differentiate into structured, milk-producing cells which are resistant to cancerous mutation. However, prior to this change, which permanently affects the structure of the breast, the cells are in an immature, undifferentiated, transitional state that is vulnerable to cancerous mutation. An induced abortion, therefore, would presumably increase breast cancer risk in two independent ways: first, by abrogating the protective effect of a full-term pregnancy, and second, by doing so at a time when estrogen overexposure during the first two trimesters has left the breasts with an abnormally high number of cells which are vulnerable to cancerous mutation. I will now discuss in turn each of these effects, which correspond with the propositions in proposed sections 6709(a)(8) and (a)(9).

As already noted, no one disputes that a first full-term pregnancy before age 30 is protective against breast cancer, or in other words, that “childbirth decreases risk of breast cancer.” The Planned Parenthood Federation of America’s web site, www.plannedparenthood.org, has a page titled “Choosing Abortion – Questions and Answers.” In response to the question “Does abortion cause breast cancer?”, Planned Parenthood answers “No. But abortion does not offer the same protection against breast cancer as a full term pregnancy.” In other words, it is known that a full term pregnancy early in a woman’s

reproductive years is protective against breast cancer, and that having an abortion instead of carrying the pregnancy to term abrogates this protective effect.

Although Planned Parenthood and other abortion providers admit this fact, it is quite unusual for them to admit its materiality to a woman's decision whether to choose abortion, and so the question and answer I just quoted from Planned Parenthood's web site is something of an anomaly. In response to the common-sense assertion that women considering abortion have a right to be informed that childbirth is protective against breast cancer, abortion providers typically argue that by this logic we'd have to warn teenagers that delaying pregnancy and childbirth through abstinence will increase their breast cancer risk. Not so. The decision a woman considering abortion faces is not comparable to a woman's decision to become pregnant in the first place. A woman who would not choose to become pregnant and have a baby in order to reduce her risk of breast cancer may be much more likely to take this benefit into consideration in weighing a decision whether or not to terminate a pregnancy that has already occurred, where it may be a deciding factor in combination with other personal considerations.

A woman considering abortion is already pregnant. Since the choice faced by her is in fact between childbirth and abortion, it would make no sense whatsoever to treat her choice as being between having an abortion and never having gotten pregnant at all. Whether the protective effect of a full-term pregnancy be termed a "benefit" of childbirth or its abrogation a "risk" of abortion, its materiality to the woman's decision is the same.

A constant refrain of abortion providers is that abortion is "safer than childbirth." If abortion providers are going to compare the safety of abortion with the safety of childbirth to help persuade prospective customers that an abortion is in their best interest, then it is certainly

reasonable that the law require them to inform these women about the significant protection against breast cancer associated with childbirth – protection which in fact shows childbirth to be much safer than abortion. Moreover, the current version of Kansas’ woman’s right-to-know law requires that the woman be told the medical risks associated not only with having an abortion but also with “carrying a fetus to term.” Both the letter and the spirit of the current statute therefore support a requirement that she be told that carrying her child to term is associated with decreased breast cancer risk.

Information about this protective effect certainly could be decisive for many women considering abortion, particularly those with a family history of breast cancer and those who are already ambivalent about having an abortion for other personal reasons.

Turning now to the statement in proposed section 6709(a)(8) – that “most studies show an increased risk of breast cancer associated with . . . abortion” – this likewise expresses an objective fact that cannot be seriously disputed.

In the worldwide literature, 27 of the 34 published independent studies which present specific data on induced abortion and the incidence of breast cancer report an increase in the risk of breast cancer overall among women who have one or more induced abortions, independently of the effect due to abortion’s delay of first full-term pregnancy. Seventeen of these 27 studies are “statistically significant,” a technical term which means there is at least a 95% certainty that the finding is not due to chance. In the 14 studies on American women, 13 show an overall risk increase, 8 with statistical significance. Clearly, whether one is speaking of the worldwide literature or only the studies on American women, it is true to say that “most studies show an increased risk of breast cancer associated with . . . abortion.”

Nevertheless, abortion providers have hypothesized that the statistical association found in these studies is not due to estrogen overexposure but to something called “recall bias.” This is the theory that in retrospective, interview-based studies – which describes most of the studies on the abortion-breast cancer link – women without breast cancer are more likely than women with breast cancer to not report abortions they have in fact had, thereby resulting in an artificial association between abortion and increased breast cancer risk.

The evidence which has been mustered in support of this theory is sparse, indirect and extremely weak. It is noteworthy that the only study on American women that was based on prospective medical records – a 1989 study by Dr. Holly Howe and colleagues – reported a statistically significant overall 90% percent risk increase, a finding that was immune from even the possibility of recall bias.

Nevertheless, the preclusion of any possibility of recall bias is the basis on which the 1997 study on Danish women by Mads Melbye and colleagues has been put forth by some as definitive proof that abortion does not increase breast cancer risk. Indeed, because of its prospective design, this study – like the 1989 study on American women – was not susceptible to the possibility of recall bias, but – unlike the 1989 American study – it reported no overall risk increase. Drs. Joel Brind and Vernon Chinchilli have argued in a letter to the New England Journal of Medicine that this study misclassified some 60,000 women who’d had abortions as not having had abortions, and therefore that its null finding resulted from a substantial underestimation of the actual overall relative risk. The other side of the debate argues that this misclassification did not significantly affect the overall finding. This debate over the methods of the Melbye study cannot be resolved here, but it does not need to be to show that even this study

clearly favors the "estrogen" hypothesis over the "recall bias" hypothesis as an explanation for the association between abortion and increased breast cancer risk. The Melbye study reported that "with each one week increase in the gestational age of the fetus . . . there was a 3 percent increase in the risk of breast cancer," so that among women who had second-trimester abortions there was a statistically significant 38 percent increased breast cancer risk and among women who had abortions after 18 weeks the risk was almost doubled. This trend of increasing risk with duration of pregnancy, which was itself statistically significant, is described in the Melbye study as in line with the hypothesis that breast cancer risk is increased by the prolonged estrogen exposure of early pregnancy not being followed by the protective hormonal milieu of late pregnancy. That is, the longer the breasts are exposed to the estrogen surge of pregnancy, the greater the expected risk increase. In any event, neither the trend of increasing risk with gestational age of the fetus at time of abortion nor the increased risk among women who had second-trimesters abortions can possibly be explained by recall bias.

Mr. Chairman and Committee, I thank you again for your willingness to weigh with an open mind the facts I have presented here today. I would be happy to stand for any questions that you may have.

The link between abortion and breast cancer:



What every woman in the world has a right to know!



In 1970 the World Health Organization published the results of its study¹ on reproductive experience in relation to the incidence of breast cancer. This study of more than 17,000 women in seven locations on four continents gained knowledge which is still undisputed almost 30 years later:

Women who begin bearing children at a young age are less likely to get breast cancer than those who have children later, or those who have no children at all.

How much protection against breast cancer do they get? Based on their findings, the W.H.O. scientists concluded:

"It is estimated that women having their first child when aged under 18 years have only about one-third the breast cancer risk of those whose first birth is delayed until the age of 35 years or more."¹

Does this mean that a young woman who gets pregnant lowers her risk of getting breast cancer, even if she has an abortion? In relation to abortion the W.H.O. scientists said their results

"suggested increased risk associated with abortion—contrary to the reduction in risk associated with full-term births."¹

Research published in respected medical journals has since confirmed these findings² and the hormonal basis for them:

Twenty-five out of 31 epidemiologic studies³⁻³³ worldwide—studies on women of African, Asian and European ancestry—have found that even one abortion increases the risk of getting breast cancer later in life.

Importantly, the increased risk from abortion is in addition to the increased risk from delaying a woman's first childbirth, so **abortion increases breast cancer risk in two ways!**

Do you wonder why, in less than half a century, while abortion became legal and common, the incidence of breast cancer in the industrialized world, **has more than doubled?**^{34,35}

Do you have questions about the real impact on the women of your country of importing "reproductive rights" from the industrialized world? **Is your country's health care system prepared for an epidemic of breast cancer?**

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Attachment No. 4

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The Estrogen Connection:

Why induced abortions raise breast cancer risk—and most miscarriages don't

Estrogen is the hormone—the chemical messenger—that turns a girl's body into a woman's body at puberty. Actually, there is a whole class of similar steroids, estrogens, which can stimulate the growth of the breasts and other female tissues. The most abundant and important estrogen secreted by a woman's ovaries is called estradiol. Estradiol is so potent that its concentration in a woman's blood is measured in parts per trillion! There is even some estradiol—about a tenth as much—made in a man's body, and both men and women need some estradiol for normal growth and maintenance of the bones.

After puberty, the levels of estrogen rise and fall twice with each menstrual cycle. Under the influence of the pituitary gland's follicle stimulating hormone (FSH), new, egg-containing follicles develop in the ovaries during the first half (called the follicular phase) of the menstrual cycle. The follicular, estradiol-secreting cells surrounding the eggs proliferate, and so the ovaries secrete ever larger quantities of estradiol, reaching a peak about one day before ovulation. This preovulatory peak is the highest blood level of estradiol a woman ever normally experiences in the non-pregnant state. It stimulates her pituitary gland to secrete another hormone, luteinizing hormone (LH), which actually triggers ovulation.

After ovulation, the follicle which has expelled the egg becomes filled with another kind of cell called a luteal cell. These luteal cells proliferate under the influence of pituitary LH, thus secreting ever larger quantities of both estradiol and the pregnancy hormone progesterone, from which estradiol is made.

Since pituitary secretion of LH falls off quite sharply after ovulation, the corpus luteum (as the former follicle is now called) begins to regress about a week after ovulation, unless fertilization of the egg (conception) has taken place. If conception has occurred, the

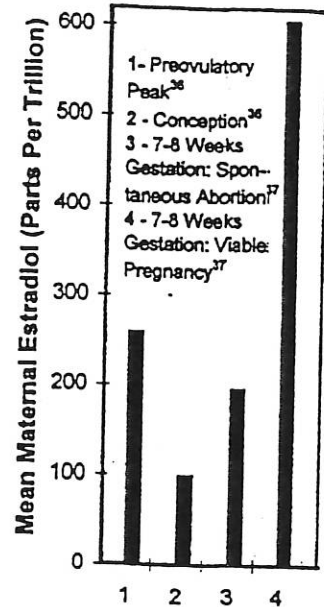
embryo begins—almost immediately—to secrete another chemical messenger, human chorionic gonadotropin (HCG)*, which acts like LH to "rescue" the corpus luteum. If conception has not taken place, the corpus luteum essentially dies. Since luteal estrogen and progesterone are needed for (respectively) the growth and maturation of the endometrium (the uterine lining in which the embryo implants), the endometrium is shed as the menstrual flow or menses.

If, however, conception has occurred and the corpus luteum has been rescued, it proceeds to generate enormous concentrations of progesterone (necessary to permit implantation of the embryo and maintenance of the pregnancy) and estradiol. Significantly elevated levels (compared to non-pregnant levels at the same time of the menstrual cycle) of estradiol can be detected as early as 5 days after conception³⁶. As shown in *Figure 1*, by 7 to 8 weeks gestation (after the last menstrual period, or LMP), a pregnant woman's blood already contains six times more (i.e., 500% more) estradiol than it did at the time of conception, more than twice the highest level attained in the non-pregnant state (preovulatory peak).³⁷

In marked contrast, pregnancies destined to abort spontaneously (i.e., end in miscarriage) during the first trimester usually do not generate estradiol in quantities exceeding non-pregnant levels^{37,38} (*Figure 1*). One team of Swiss obstetricians, as far back as 1976, was actually able to predict spontaneous abortions with 92% accuracy with just a single measurement of estradiol!³⁸ Theoretically, this makes perfect sense: The very reason for the abortion is an inadequate supply of progesterone from which estradiol is made.

*Although HCG is commonly referred to as a hormone, in fact, it is not. Since it is a chemical message between two individuals of a species (in this case, mother and child), it is more properly described as a pheromone. Since it is not normally secreted by a woman's body at all, specific detection of the presence of HCG is the basis of every pregnancy test.

Figure 1 - Blood Estradiol Levels in Pregnant and Non-Pregnant Women



How estradiol, or estrogens in general, relate to breast cancer risk, has to do with their role in the growth of breast tissue. It is estradiol which makes the breasts grow to mature size at puberty, and which makes them grow again during pregnancy (at least the first two trimesters). The cells in the breast which are responsive to estradiol are those which are primitive, or undifferentiated. Once terminally differentiated into milk-producing cells, something which happens under the influence of other (still largely unknown) factors, breast cells can no longer be stimulated to reproduce.

It is the undifferentiated cells, which are also vulnerable to the effects of carcinogens (radiation, certain chemicals, etc.), which can give rise to cancerous tumors later in life. If a woman therefore has gone through some weeks of a normal pregnancy, and then aborts

that pregnancy, she is left with more of these cancer-vulnerable cells than she had in her breasts before she was pregnant. In addition, any abnormal, potentially cancer-forming cells already in her breasts (and such cells are present to some extent in all people) have also been stimulated to multiply. All this translates into a statistically greater probability that a cancerous tumor may eventually arise.

In contrast, a full term pregnancy results in full differentiation of the breast tissue for the purpose of milk production, which leaves fewer cancer-vulnerable cells in the breasts than were there before the pregnancy began. This translates into the well known breast cancer risk lowering effect of a full term pregnancy.

It is also widely known that women who start having children at a younger age lower their risk of getting breast cancer later in life¹. The sooner the breasts become fully mature for the purpose of milk production, the less likely is the presence of abnormal, potentially cancer-forming cells, from accumulated carcinogenic insults (and what these are is still largely unknown). In support of this theory, an experimental study of the effect of pregnancy and induced abortion on breast cancer incidence in young rats treated with chemical carcinogens was published in 1980³⁹. The same research team has also published an excellent study of the differentiation in human breast tissue as a function of pregnancy and age.⁴⁰

In addition, since there are always

some undifferentiated cells (and even some abnormal cells) in a woman's breasts, overexposure to the growth-promoting effects of estradiol or other estrogens, whenever the exposure takes place, contributes to breast cancer risk.

Not surprisingly, then, most known risk factors for breast cancer involve some form of estrogen overexposure. For example, women who attain puberty at an early age, or who enter the menopause at a late age, or who have fewer or no children, are exposed to more surges of estradiol that come with more menstrual cycles. Women who breast feed their children also experience fewer menstrual cycles, thereby helping to lower their risk.

Even risk factors which are unrelated to reproduction seem to operate via an estrogen-mediated mechanism. For example, post-menopausal obesity increases risk, presumably because adipose (fat) cells actually synthesize estrogens, thus raising an obese woman's blood estrogen levels. Even chronic alcohol consumption seems to raise breast cancer risk by increasing estrogen levels in a woman's blood. Likewise for a diet high in animal fat, compared to a vegetarian diet. Conversely, certain vegetables known to help protect against cancer, such as members of the broccoli and cabbage family, help a woman's body to eliminate estrogens

more rapidly.

Since the effect of estrogens on breast cancer risk has been well recognized for many years, doctors have been wary of prescribing such medications as post-menopausal estrogen replacement therapy for older women, especially those with any family history of breast cancer. As it turns out, such medications do seem to raise the risk of breast cancer risk slightly, when they are used for several years.

One would think, therefore, that doctors would long ago have been concerned about possible increases in breast cancer risk attributable to induced abortion, given the extremely high estradiol levels experienced by women even in the first several weeks of a normal pregnancy.

Finally, there is one additional and crucial aspect of spontaneous abortion vis-a-vis breast cancer risk that must be noted, namely the effect of post-first trimester miscarriages. Most miscarriages occur in the first trimester, and over 90% of these are characterized by abnormally low maternal estradiol levels³⁸. However, there is reason to believe that pregnancies which survive the first trimester (and they couldn't survive without adequately high progesterone levels, which are paralleled by estradiol) are likely to raise breast cancer risk, if they go on to miscarry. □

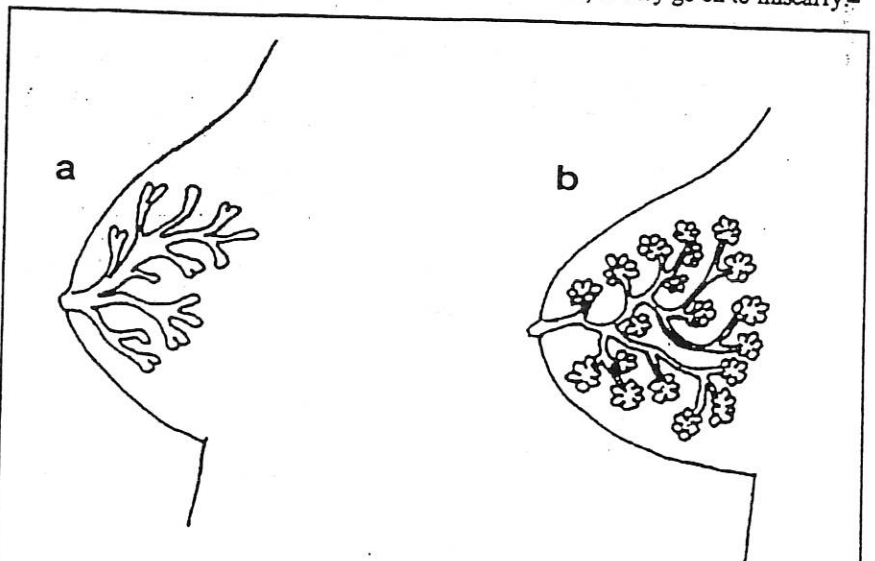


Figure 2. Schematic representation of a breast a) in a never-pregnant woman, and b) at the end of a full-term pregnancy. Never-pregnant breast tissue consists of primitive, terminal end buds and ducts, which are vulnerable to carcinogens, while lactating breast consists mostly of mature lobules—clusters of milk-secreting alveoli—which are resistant to carcinogens.

(Adapted from references #39 and 40)

The World Conference on Breast Cancer acknowledges the link between abortion and breast cancer

The first World Conference on Breast Cancer took place in July of 1997 in Kingston, Ontario, Canada. The conference was co-founded by the Women's Environment and Development Organization, which was chaired at the time by the late Bella Abzug.

At the conference, Dr. Joel Brind, Ph.D., Professor of Endocrinology at Baruch College of the City University of NY and Editor of the *Abortion-Breast Cancer Quarterly Update*, led a seminar on the connection between abortion and breast cancer. Dr. Brind's talk included an update of the "Comprehensive review and meta-analysis"² on the subject, originally published in the British Medical Association's *Journal of Epidemiology and Community Health*. Ms. Abzug attended Dr. Brind's seminar, participating in a lively and cordial discussion on the abortion-breast cancer link.

A year later, in the fall of 1998, the World Conference published its *Global Action Plan Report*⁴, in which the organization outlined its agenda for the ultimate eradication of breast cancer. Under the subject of risk factors related to hormones, the *Report* reads in pertinent part:

"Today, women in general are exposed to higher levels of estrogen during their lifetime than was the case in previous generations. It is believed that women now face excess levels of both natural and synthetic estrogens, increasing their risk of breast cancer. Prolonged use of the birth control pills, late or lack of pregnancies and breast-feeding, INDUCED TERMINATION OF PREGNANCIES, a diet high in fat, meat or dairy products, and hormone replacement therapy following menopause, all are cited as risk factors for increased estrogens and breast cancer." (Emphasis added.)

Remember: Reproductive rights are meaningless without the right of women to know all the consequences of the choices they may make.

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Good afternoon Mr. Chairman and Committee members.

My name is Kathy Ostrowski and I am here to testify on behalf of **Kansans For Life** in **support of HB 2517**. First off, I'd like to rebut an outrageous sentiment expressed to this body last Tuesday. I refer to a Mr. Swomley who said "Abortion ... is as American as apple pie". To which Kansans For Life responds: apple pie... does not cause cancer. Women do not feel suicidal... after apple pie. There can be no flag-waving... about women suffering psychological problems, anniversary date depression, and mental health hospitalizations. Abortion is not a health "service" and over 20 years of scientific studies document its physical ravages on women. Please refer to my first attachment for further reference.

The No. 1 killer of middle age American women is Breast Cancer and the evidence overwhelmingly points to a connection with abortion. An American woman's lifetime overall Breast Cancer risk keeps increasing--it now stands at 12% (1 in 8). **Pregnancy, especially an early full birth, reduces her risk. Abortion increases her risk, because it delays pregnancy and also in and of itself.** The 1996 overview of Abortion-Breast Cancer studies indicates a minimum of 30% overall increase with respect to the general population. But certain other factors, including age, can lift that risk dramatically. A 1994 National Cancer Institute study showed an alarmingly higher 80% risk for teens under age 18 who aborted after 8 weeks of pregnancy and an almost incalculable increase for aborted teens with a family history of the disease.

From as early as 1957, researchers understood that the naturally occurring hormonal surge of estrogen in pregnancy, when cut short by abortion, results in raising breast cells' vulnerability to cancer. (Please refer to my second attachment for further explanation.) To date, 27 of 34 worldwide studies and **13 out of 14 US studies** bear this out. Last year the British Royal College of Obstetricians & Gynecologists warned abortionists that the **Abortion-Breast Cancer link must not be disregarded.** An upcoming British study has been headlined as it shows a dramatic correlation of aborted first pregnancies and subsequent Breast Cancer rates.

The link is clear. 1) Abortion of first pregnancy prevents the known protection against breast cancer afforded by an early full term birth. This has been known since 1970, when the World Health Organization published the results of its very large study. Fertility is a sign of health, not a disease. **Giving birth gives protection against breast cancer.** How many women, especially young ones, are aware of this? It is certainly not mentioned in the "If You Are Pregnant" booklet, but **should be included** under the intent of Section 1, (a) (3) in HB 2517. A woman reading this booklet gets a very distorted, negative view of childbirth without hearing of all the long-term health benefits. (Please refer again to 1st attachment.)

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Kansas affiliate to the National Right to Life Committee

2) Abortion increases Breast Cancer risk because the prolonged estrogen exposure of early pregnancy is not followed by the **protective hormonal activity of the late third trimester period**. After abortion, the child's life is ended, but the mother's body remains compromised by the invasion into the process that was gearing up to nurse her child. In the words of an old commercial, "It's not nice to fool Mother Nature." In this case it can be deadly.

3) Abortion also can cause subsequent pregnancies to end in pre-term birth, again preventing protective end-of-pregnancy hormones from accomplishing their task of shutting down breast cell vulnerability to cancer.

The Breast Cancer explosion mirrors the abortion explosion. In 1962, there were 63,000 total US cases of Breast Cancer. Currently there are 44,000 new cases each year! Leading researcher Dr. Joel Brind estimates that 5,000-8,000 cases each year are attributable to abortion. He projects as many as 50,000 new cases per year by the year 2020. And this epidemic is hitting harder (25% incurable rate) and earlier.

HR 2517 simply requires the essential element of informed consent: a person who is at risk must be told that they are at risk. Period. Breast cancer researcher for the National Cancer Institute, Janet Daling, (self-described as strongly pro-choice) stated, "I have 3 sisters with breast cancer and I resent people messing with the scientific data to further their own agenda, be they pro-choice or pro-life. I would have loved to have found no association between breast cancer and abortion, but our research is rock solid and our data is accurate." Daling complained, "**No one is getting any of the correct information out to the public.**"

Women are now suing for lack of informed consent and against false advertising that abortion is safe. Kansas has had abortionists (including George Tiller) sued for lack of informed consent. The Kansas State Board of Healing Arts has accused Lawrence and Wichita abortionist Ann Kristin Neuhaus of negligence and of being a danger to the public. Among the myriad of current charges are 1) failure to provide appropriate informed consent, 2) failure to obtain informed consent for various procedures and 3) aborting after consent was withdrawn!

Abortion is a grisly business, focused on the immediate profit. The abortion industry (like the tobacco industry) does not welcome mandates to inform about long-term harm. Information about the Abortion-Breast Cancer link has been withheld for far too long. Public service announcements that educate women about this deadly link are desperately needed. What a dirty trick to offer free mammograms without disclosing that **the biggest avoidable risk for Breast Cancer is an elective abortion!**

Kansans For Life maintains that the true best interests of the Mother and Child are always entwined: what is good for one, benefits the other and what harms the one, hurts the other. Let us help the mother make good choices...to choose Life for her child and a safer life for herself.

Please pass HB 2517. Thank you, I stand for questions.

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You are already PREGNANT- **How will your HEALTH be affected when you**

Choose Birth:

Give birth to your daughter or son, possibly your only child

Protect your future fertility

Protect your future children's health

Lower your risk of Breast Cancer

Lower your risk for Ovarian Cancer

Lower your risk for Cancer of Uterus; there's a consistent protective effect for each term birth.

Lower your likelihood of drug & alcohol use & abuse

Prevent, reduce or end smoking because responsibility for another is more successful motivation than concern for your own future

Lower the possibility of life-threatening hypertension/ pre-eclampsia in future pregnancies

Choose Abortion:

40-50% of abortions are of 1st pregnancy; an estimated 19-36% of those women never have another child

Become infertile from the procedure itself, from pelvic inflammatory disease and from infections during abortions.

Increase your risk during any other pregnancies for neonatal life-threatening infections, cerebral palsy; placenta complications, pre-term and low birth weight with their attendant problems and various birth defects.

Raise your risk of Breast cancer: most studies show the abortion itself, independent of delaying birth, prevents end-of-term beneficial hormonal activity and aggravates proliferation of vulnerable pre-cancerous cells

Do not get protection against the 26,000 new cases of ovarian cancer each year, with 15,000 annual deaths

Do not get protection against the 35,000 new cases of uterine cancer each year with 6,000 annual deaths

Seriously increase your chances of drug & alcohol use (from 200-600% depending on age & other factors)

Increase your stress and anxiety, the reasons studies consistently say women give for smoking; aborted women smoke more than moms of "unwanted" pregnancies

Raise your risk of pregnancy complications, life-threatening to both you and your child, especially if combined with smoking

CHOOSE LIFE...CHOOSE HEALTH!

Kansans
forLife



The Estrogen Connection

How estradiol, or estrogens in general, relate to breast cancer risk, has to do with their role in the growth of breast tissue. It is estradiol which makes the breasts grow to mature size at puberty, and which makes them grow again during pregnancy (at least the first two trimesters). The cells in the breast which are responsive to estradiol are those which are primitive, or **undifferentiated**. Once **terminally differentiated** into milk-producing cells, something which happens under the influence of other (still largely unknown) factors, breast cells can no longer be stimulated to reproduce.

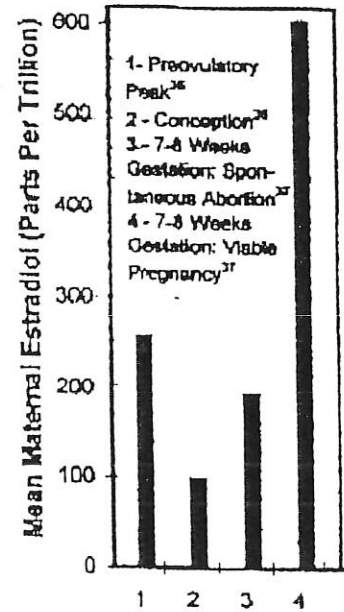
It is the undifferentiated cells, which are also vulnerable to the effects of carcinogens (radiation, certain chemicals, etc.), which can give rise to cancerous tumors later in life. If a woman therefore has gone through some weeks of a normal pregnancy, and then aborts that pregnancy, she is left with more of these cancer-vulnerable cells than she had in her breasts before she was pregnant. In addition, any abnormal, potentially cancer-forming cells already in her breasts (and such cells are present to some extent in all people) have also been stimulated to multiply. All this translates into a statistically greater probability that a cancerous tumor may eventually arise.

In contrast, a full term pregnancy results in full differentiation of the breast tissue for the purpose of milk production, which leaves fewer cancer-vulnerable cells in the breasts than were there before the pregnancy began. This translates into the well known breast cancer risk lowering effect of a full term pregnancy.

It is also widely accepted (although not universally observed) that women who start having children at a younger age lower their risk of getting breast cancer later in life³⁹. Presumably, this is because the sooner the breasts become fully mature for the purpose milk production, the less likely is the presence of abnormal, potentially cancer-forming cells, from accumulated carcinogenic insults (and what these are is still largely unknown). In support of this theory, an experimental study of the effect of nulliparity (i.e., not having any babies) and induced abortion in increasing breast cancer incidence in young rats treated with chemical carcinogens was published as far back as 1980⁴⁰. (Interestingly, the data and conclusions of this research are still positively acknowledged even by those who disparage the ABC link².) More recently, the same research team has also published an excellent study of the differentiation in human breast tissue as a function of pregnancy and age.⁴¹

In addition, since there are always some undifferentiated cells (and even some abnormal cells) in a woman's breasts, overexposure to the growth promoting effects of estradiol or other estrogens, whenever the exposure takes place, contributes to breast cancer risk.

Figure 1 - Blood Estradiol Levels in Pregnant and Non-Pregnant Women



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Not surprisingly, then, most known risk factors for breast cancer are characterized by some form of estrogen overexposure. For example, women who attain puberty at an early age, or who enter the menopause at a late age, or who have fewer or no children, are exposed to more surges of estradiol that come with more menstrual cycles. Women who breast feed their children also experience fewer menstrual cycles, thereby helping to lower their risk.

Even risk factors which are unrelated to reproduction seem to operate via an estrogen-mediated mechanism. For example, post-menopausal obesity increases risk, presumably because adipose (fat) cells actually synthesize estrogens, thus raising an obese woman's blood estrogen levels. Even in the dietary realm, it is known that chronic alcohol consumption raises blood estrogen levels, and it also appears to raise breast cancer risk. Likewise for a diet high in animal fat, compared to a vegetarian diet. Conversely, certain vegetables known to help protect against cancer, such as members of the broccoli and cabbage family, help a woman's body to eliminate estrogens more rapidly.

Since the effect of estrogens on breast cancer risk has been well recognized for many years, doctors have been wary of prescribing such medications as post-menopausal estrogen replacement therapy for older women, especially those with any family history of breast cancer. As it turns out, epidemiological studies do not even find a consistent trend of increasing risk among such women, probably because the dosage is much lower than the estrogen levels naturally produced by premenopausal ovaries.

One would think, therefore, that doctors would have been concerned about possible increases in breast cancer risk attributable to induced abortion, even in the absence of epidemiological data, given the extremely high estradiol levels experienced by women even in the first several weeks of normal pregnancy.

Then again, epidemiological data has hardly been lacking. As early as 1957, a large study of Japanese women⁴² evidenced a significantly increased breast cancer risk among women who had had any induced--but not spontaneous--abortions. To date, 30 separate studies of induced abortion have been published worldwide, with 24 showing increased risk. In contrast, over 30 studies involving only or mostly spontaneous abortions fail to show any significant trend¹.

Finally, there is one additional and crucial aspect of spontaneous abortion vis-a-vis breast cancer risk that must be noted, namely the effect of post-first trimester miscarriages. Most miscarriages occur in the first trimester, and over 90% of these are characterized by abnormally low maternal estradiol levels³⁸. However, there is reason to believe that pregnancies which survive the first trimester (and they couldn't survive without adequately high progesterone levels, which are paralleled by estradiol) *are* likely to raise breast cancer risk, as induced abortions do.

Theoretically, a miscarriage due to physical trauma or anatomic defect (e.g. "lazy cervix") is essentially an unintended induced abortion, with the same hormonal changes associated with an elective induced abortion.

Although epidemiological evidence of this is very scanty, prudence would suggest a heightened vigilance for breast cancer among such women and their doctors.-JB-

there also being a forty per cent increase, it was eighty per cent so it seemed to be a synergistic—a greater risk increase than adding the two together alone; the whole greater than the sum of its parts. But it was particularly strong for a first abortion that occurred prior to age 18 years. Twelve case patients and zero control patients; relative risk: infinity. In other words, in their whole population of 900 patients with breast cancer by the age of 45, and 900 patients who didn't get breast cancer of the same age group, they found twelve study subjects who had had an abortion before age 18 and also had family history, and none of them turned up in the non-cancer group. They all got breast cancer by age 45. Now no other study is going to find that sort of absolute association. However other studies also report an apparent synergy, a much greater increased risk in women who have a positive family history of breast cancer. So for example a study in France published in the same year in 1994 showed that women in France who reported two or more induced abortions had about a 600 per cent breast cancer risk increase.

But as I said, that didn't make the papers, and the reason is pretty obvious. When an epidemiological study comes out in a medical journal, it may come out with an editorial. There are usually one or two editorials about what the editor thinks are the most important papers in that issue of the journal. And usually—or almost all the time—the editorial will tell you why the paper is important, and why you should take it seriously. But in this particular case, mirroring the kind of reaction that Pike's study got in 1981, the editorial was there to tell you "However the overall result as well as the particulars are far from conclusive and it is difficult to see how they will be informative to the public." Right! An elective procedure that is exceedingly common seems to show an increased risk of getting a life-threatening disease that is also exceedingly common and the editorial writer can't figure out how that might be informative to the public! That statement strikes me as disingenuous to say the least. Well, what was the main criticism of the methodology and of the results of the study by the editorialist, Lynn Rosenberg? "A major concern", she said, "especially because the observed effect was small"—and that is true: a fifty per cent increased risk overall is epidemiologically relatively small, kind of near to the borderline of what can be accurately measured—"is the possibility of reporting bias."

Reporting Bias

Reporting bias as I told you before was a difference in the accuracy of responses. In this particular case, by the way, you would guess from an editorial like that, the paper at hand—the Daling study—did not deal with the question of bias or certainly didn't deal with it adequately. The bias in particular that she is talking about is based on a hypothesis that was put forth by a team of Swedish researchers headed by Olaf Meirik of the World Health Organisation in Geneva. They had done a couple of studies on

reproductive risk factors in breast cancer. One of them was of the same kind of retrospective interview-based case-control type, and another one was based upon prospective records; a computerized registry of abortions from Sweden where the records were generated at the time of the abortion. And, since everybody in Sweden has a number, and has these records, they were actually able to obtain the computerized records from everybody in the case control study, and therefore, compare how accurate were the responses of these women. Well they claim to have found a statistically significant difference—that is what this P007 means—between "underreporting of previously induced abortions among controls..." (That is what they have hypothesized; that healthy women would be more likely to lie about their abortions, but that breast cancer patients, considering their life-threatening condition, would be more likely to be honest about reporting their abortions.) They found a difference between "underreporting of previous induced abortions among controls relative to over reporting among cases." In other words, that women with breast cancer would make up abortions that didn't happen. That is really the sole basis of their statistically significant finding: that seven breast cancer, seven Swedish breast cancer patients in their study and one healthy Swedish woman reported having had an abortion of which the computer had no record. Sorry lady: the computer says you didn't have one; you didn't have one. In other words, their statistically significant conclusion that response bias applied was absolutely dependent upon the assumption that the computer record was right, that women did not have an abortion unless the computer said they did; even if the woman said she had one but the computer said she didn't, she didn't. Well over reporting, I think, is a pretty preposterous assumption, and I've used that word in describing it in publications. Janet Daling, in her study, was much more diplomatic. However she wrote "We believe it is reasonable to assume that virtually no women who truly did not have an abortion would claim to have had one". I think that is reasonable too. In fact, that that these Swedish women who claimed to have had an abortion that the computer had no record of represents over reporting, has since been retracted in March of 1998, and that group—that Olaf Meirik, group in their subsequent research, do not mention reporting bias as an explanation for the connection of abortion and breast cancer any more.

Well another thing that is interesting about the bias connection is that subsequent to the Daling Study—about five months later [overhead]—a study came out by Lipworth and colleagues, which showed actually the overall identical result of a fifty one per cent increase in breast cancer risk in Greek women. But they treated response bias by looking, by doing a literature review in Greece, noting "even before legalization, induced abortions were practiced in Greece with widespread social acceptance.

This can be interpreted as indicating that healthy women then in Greece report reliably their history of induced abortion." So they claim their finding

was not attributable to response bias. Interesting that this study was submitted for publication on October 20th 1994, exactly one week before October 27th 1994, when Harvard epidemiologist Karen Michaels told Dr. Lawrence Altman, epidemiologist reporter of the New York Times, that "that is a flaw in the design because women who have breast cancer are more likely to disclose an abortion than women who did not develop breast cancer". You see it's a fact.

1996 Brind Meta-analysis

Everybody knows it. Who should that Karen Michaels be but [overlay overheads] the same one who is on the by-line of the study in Greece: Karen B Michaels! What a difference a week makes in one's interpretation of whether it's response bias or not.

We finally came out with our study: [overhead] "Induced Abortion as an Independent Factor for Breast Cancer – A Comprehensive Review and Meta-analysis" in the Journal of Epidemiology and Community Health in October of 1996. That is a British Medical Association publication. It was no accident that I submitted the paper to an English journal—and this journal in particular—because I felt strongly that we would get fair treatment. I didn't want, for example, to publish the paper in the Journal of the National Cancer Institute and be sabotaged by an editorial like Daling's study was. PS: two months later the Journal of the National Cancer Institute published an editorial directly attacking our research anyway, but at least we had a little bit of lead time. Well this study was rather wordy: we analyzed every study that had been done and published and also stacked them all up in a meta-analysis. That is, we lined up all the studies and ended up—through a statistical compilation method called the weighted average—using a couple of different models, and the most conservative estimate gave us a thirty per cent increased risk on average overall.

This [overhead] is an updated meta-analysis. We had at the time 23 studies. Now there are 31, and 25 out of the 31 show data with a point estimate to the right side of this line of unity, i.e., increased risk, with 18 out of the 25 statistically significant on their own. That is where this whole confidence interval is to the right side of the line—doesn't cross the line—and studies on the left side would be negative, or studies showing a negative association, or that abortion would be a protective effect. This is what you find with just about any, even well-acknowledged risk factors. You always find a couple of studies that go the other way but the overwhelming predominance of these studies is to the right side of the line. Now the study designs are very different. In a lot of cases the point estimates are very different. These studies may be described as being rather heterogeneous which makes it a little bit unreliable to say 30 per cent. Maybe it's fifty per cent, eighty per cent? It's best to say that there is a range of increased risk

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March 13, 2001

Thank you Mister Chairman for the opportunity to testify in favor of House Bill 2517.

I am a family physician who delivers babies and cares for women who have breast cancer. I also counsel women after they have had an abortion. I am concerned that many women do not receive appropriate counseling regarding emotional and physical ramifications of abortion prior to undergoing the procedure.

Multiple studies have shown an increased risk of developing breast cancer in women who have had one or more abortions. When the data from multiple studies are considered in sum the risk for future breast cancer appears to be increased from 1/3 to 1/2. Even studies designed and carried out by "pro-choice" researchers, at the Fred Hutchinson Cancer Research Center in Seattle, have revealed this link between abortion and future breast cancer risk. These studies also show that the younger the woman's age at the time of an induced abortion, the greater the increased risk of breast cancer.

Because the abortion industry is so influential and because abortion has become such a politicized issue, the health risk related to having an abortion have been somewhat disregarded and ignored by many, especially those who stand to gain financially from the abortion industry. I would have thought that abortion providers would be the people most interested in informing their patients of this risk, particularly since they are now vulnerable to lawsuits alleging lack of informed consent. I am already aware of one lawsuit brought by a young woman because she was not informed of the increased risk of breast cancer related to her abortion. If someone claims to be "pro-choice" they should at least support an informed choice.

As an advocate for my patients and for women's health in general, I feel strongly that women should be well informed of significant potential health risks related to abortion.

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I am in a group of about 40 health care providers in Kansas. We are concerned that the health risk of future breast cancer is not appreciated by many of our patients considering an abortion. As our group cares for about 80,000 patients, I feel confident many of the women we care for would choose adoption rather than abortion if they were informed of their future breast cancer risk related to abortion.

Sadly, there may be people who want to hide this well-documented health risk from women considering an abortion. Please stand up for the right of these women to be well-informed regarding how their current choice between abortion and adoption may affect their future health, and even their life, by supporting H.B.2517. I believe this bill will save the lives of many women in our practice, and even more women across the state of Kansas. I realize there may be strong opposition to this bill from those who believe the bill may cause some women to be more inclined to give their unwanted child to adoptive parents than have an abortion. Please let me assure you that adoption is potentially a very good choice, with fewer regrets physically and emotionally for many women. Adoption is certainly a very positive experience for adoptive parents and their adoptive children. I have yet to encounter any patient who regrets adopting an infant or being adopted themselves. I unfortunately have many patients who struggle with grief and regret over an abortion many years ago. It is sad that some of these women now have to deal with breast cancer. It will be even sadder if we do not inform women currently considering an abortion of their increased future breast cancer risk.

Thank you Mister Chairman for allowing me to testify in favor of helping the women of Kansas have the right to make informed choices through H.B. 2517.

Mark L. Gillett M.D.

The Kansas Choice Alliance

House Federal and State Affairs Committee
Testimony in Opposition to HB2517
March 13, 2001

Aid for Women
American Association of University
Women - Baldwin Branch
American Association of University
Women - Kansas
American Association of University
Women - Shawnee Mission Branch
American Civil Liberties Union of
Kansas and Western Missouri
Choice Coalition of Greater Kansas
City
Greater Kansas City Chapter of
Hadassah
Jewish Community Relations
Bureau/American Jewish
Committee
Jewish Women International
Kansas Religious Leaders for
Choice
KU Pro-Choice Coalition
League of Women Voters of
Johnson County
League of Women Voters of Kansas
League of Women Voters of
Wichita-Metro
MAINstream Coalition
National Council of Jewish Women,
Greater Kansas City Section
National Organization for Women,
Johnson/Wyandotte County
Chapter
National Organization for Women,
Kansas Chapter
National Organization for Women,
Kansas City Urban Chapter
National Organization for Women,
Lawrence Chapter
National Organization for Women,
Manhattan Chapter
National Organization for Women,
Wichita Chapter
Planned Parenthood of
Kansas & Mid-Missouri
Pro-Family Catholics for Choice
Wichita Family Planning
Women's Health Care Services
YWCA of Wichita

Submitted by Barbara M. Duke on behalf of the Kansas
Association of University Women and the other members of
the Kansas Choice Alliance (785-749-0786)

Chairman Mays and Members of this Committee:

We are opposed to requiring that women be told that having an
abortion increases the risk of breast cancer simply because we find no credible
source for this information and think it is incorrect.

Neither the American Cancer Society nor the National Cancer Institute
recognizes an association between breast cancer and abortion. A highly
regarded study of 1.5 million women published in the New England Journal of
Medicine in 1997 found no overall connection between the two. A Swedish
study of 49,000 women showed no overall risk of breast cancer after an
abortion but suggested that there could well be a slightly reduced risk.

About 25 studies over the past 20 years have examined the possibility
of a relationship. Cancer researchers say the most reliable studies show no
increased risk, and they consider the entire body of research inconclusive.

As a breast cancer survivor I know how important it is for people to
get accurate, well-researched information about this disease. Suggesting there
is any kind of a connection with abortion meets none of these criteria. I also
know that women with breast cancer can be stigmatized when misinformation
is spread about their condition and the reasons for it.

The legislature puts its own credibility at risk if it uses questionable
medical information to make a political statement. We request that HB 2517
be defeated.

Thank you for your attention.

Barbara M. Duke



The Kansas Choice Alliance
902 Pamela Lane, Lawrence, KS 66049-3020

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Testimony of Carla Mahany
representing Planned Parenthood of Kansas & Mid-Missouri
before the House Federal and State Affairs Committee
of the Kansas Legislature
in Opposition to House Bill 2517
on March 13, 2001

Good Afternoon! My name is Carla Mahany. I am the Public Affairs Director for Planned Parenthood of Kansas and Mid-Missouri.

We oppose Section 1 (a) (new subsection 8), which would require misinforming women seeking an abortion of “the increased risk of breast cancer associated with the proposed abortion.”

HB 2517 is grounded in an unsubstantiated association between abortion and the subsequent risk of breast cancer. Earlier, smaller studies showed a wide fluctuation in results with estimates of risk ranging from moderately elevated to significantly lowered. The massive study of 1.5 million Danish women (Melbye et al., *New England Journal of Medicine*, 1997), which was able to avoid some of the flaws in earlier research, found that induced abortion was not associated with an increased risk of breast cancer.

Although this bill does not help achieve it, the goal of protecting women from this potentially deadly disease is a laudable one. There is much that can be done in this area. This year, Kansas legislators can support SB 19, which would give women freer access to physicians who specialize in women’s health—obstetricians and gynecologists—because research shows that this increases the level of preventive screenings for cancer and other deadly diseases that they will receive.

But real commitment to reducing the incidence of and deaths from this leading cancer in women also requires substantial investment in research to find real preventable causes and more effective treatments—and additional funds for treatment following diagnosis for those who do not have insurance coverage. No matter your position on HB 2517, we urge your consideration of measures such as these, which would do much to help prevent, diagnose and treat breast cancer.

Attachments:

Page 17 from If You are Pregnant, published by KDHE in compliance with the current provisions of the “Woman’s-Right-to-Know Act”

National Breast Cancer Coalition Fund, “Position Statement on Abortion and Breast Cancer Risk” (October 1999)

National Cancer Institute, “Abortion and Breast Cancer,” CancerNet article (January 31, 2001)

Letter from Gerard M. Doherty, M.D. regarding Missouri Senate Bill 34 (February 5, 2001)

Washington Times article, “Study finds no link between abortion and breast cancer: Danish research relies on hard data” (1997)

Newsweek, “Making Scare Tactics Legal” (this week’s issue, March 12, 2001)

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Perforation of the uterus wall: A medical instrument may go through the wall of the uterus. The reported rate is 1 out of every 500 abortions. Depending on the severity, perforation can lead to infection, heavy bleeding or both. Surgery may be required to repair the uterine tissue, and in the most severe cases hysterectomy may be required.

Anesthesia-related complications: As with other surgical procedures, anesthesia increases the risk of complications associated with abortion. The reported risks of anesthesia-related complications is around 1 per 5,000 abortions.

Rh Immune Globulin Therapy: Protein material found on the surface of red blood cells is known as the Rh Factor. If a woman and her fetus have different Rh factors, she must receive medication to prevent the development of antibodies that would endanger future pregnancies. (See page 18 for additional information on Rh Immune Globulin Therapy.)

LONG-TERM MEDICAL RISKS

Future childbearing: Early abortions that are not complicated by infection do not cause infertility or make it more difficult to carry a later pregnancy to term. Complications associated with an abortion may make it difficult to become pregnant in the future or carry a pregnancy to term.

- * **Cancer of the breast:** Several studies have found no overall increase in risk of developing breast cancer after an induced abortion, while several studies do show an increased risk. There seems to be consensus that this issue needs further study. Women who have a strong family history of breast cancer or who have clinical findings of breast disease should seek medical advice from their physician irrespective of their decision to become pregnant or have an abortion.

EMOTIONAL REACTIONS

Because every person is different, one woman's emotional reaction to an abortion may be different from another's. After an abortion, a woman may have both positive and negative feelings, even at the same time. One woman may feel relief, both that the procedure is over and that she is no longer pregnant.

Another woman may feel sad that she was in a position where all of her choices were hard ones. She may feel sad about ending the pregnancy. For a while after the abortion she also may feel a sense of emptiness or guilt, wondering whether or not her decision was right.

Some women who describe these feelings find they go away with time. Others find them more difficult to overcome.

NBCCF

NATIONAL BREAST CANCER COALITION FUND

• grassroots advocacy in action •

Position Statement on Abortion and Breast Cancer Risk October 1999

Position

It has been hypothesized that surgical and spontaneous abortions increase breast cancer risk. However, the results of two recent case-control studies, two large cohort studies, and two meta-analyses suggest that there is no association between abortion and risk of breast cancer.¹ Based on this evidence, the National Breast Cancer Coalition does not support the opinion that the data at present show that abortion is associated with an overall increase in breast cancer risk. Based on the science described above, NBCC does not support any public policy efforts that imply such a link exists.

Background

Several past case-control studies have suggested that both spontaneous and induced abortions may be associated with small increases in the risk of breast cancer.² However, these case-control studies have been criticized due to their potential for reporting bias; women who have breast cancer may be more likely to give accurate reports of their abortion histories than women who do not have breast cancer.³ One of the more recent cohort studies⁴ avoided the problem of reporting bias by relying on data collected from registries rather than individual reports. This study found no association between abortion and breast cancer risk.

In general, the causes of breast cancer are poorly understood.⁵ Two studies have found a transient increase in the risk of breast cancer following full-term pregnancy.⁶ The effects of

¹ McCredie M, Paul C, Skegg DC, Williams S. Reproductive factors and breast cancer in New Zealand. *Int J Cancer* 1998;76(2):182-8.

Palmer JR, Rosenberg L, Rao RS, et al. Induced and spontaneous abortion in relation to risk of breast cancer (United States). *Cancer Causes Control* 1997;8(6):841-9.

Melbye M, Wohlfahrt J, Olsen JH, et al. Induced abortion and the risk of breast cancer. *N Engl J Med* 1997;336(2):81-5.

Calle EE, Mervis CA, Wingo PA, et al. Spontaneous abortion and risk of fatal breast cancer in a prospective cohort of United States women. *Cancer Causes Control* 1995;6(5):460-8.

Bartholomew LL, Grimes DA. The alleged association between induced abortion and risk of breast cancer: biology or bias? *Obstet Gynecol Surv* 1998;53(11):708-14.

Wingo PA, Newsome K, Marks JS, et al. The risk of breast cancer following spontaneous or induced abortion. *Cancer Causes Control* 1997;8(1):93-108.

² Newcomb PA, Storer BE, Longnecker MP, et al. Pregnancy termination in relation to risk of breast cancer. *JAMA* 1996;275(4):283-7.

Ewertz M, Duffy SW. Risk of breast cancer in relation to reproductive factors in Denmark. *Br J Cancer* 1988;58(1):99-104.

³ Bartholomew LL, Grimes DA. The alleged association between induced abortion and risk of breast cancer: biology or bias? *Obstet Gynecol Surv* 1998;53(11):708-14.

Hartge P. Abortion, breast cancer, and epidemiology. *N Engl J Med* 1997;336(2):127-8.

⁴ Melbye M, Wohlfahrt J, Olsen JH, et al. Induced abortion and the risk of breast cancer. *N Engl J Med* 1997;336(2):81-5.

⁵ Kelsey JL, Gammon MD, John EM. Reproductive factors and breast cancer. *Epidemiol Rev* 1993;15(1):36-47.

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Abortion on breast cancer risk may be similar to those of full-term pregnancy - i.e. they may be transient and weaken with age. In addition, some evidence suggests that later abortions (after the first 12 weeks of gestation) may be associated with an increased risk of breast cancer.⁷ Clearly, there is much more we need to learn about the hormonal effects of pregnancy and abortion on breast cancer risk. More epidemiologic studies, particularly prospective studies and studies that consider effect modification by gestational age at abortion, are needed before further conclusions can be drawn.⁸

Women should be informed of the controversial nature of this issue and of the results of the studies to date. Lawmakers and policy makers should support continued research into these important aspects of women's health so that proper informed decisions can be made in the future. The NBCC supports more research to answer questions regarding any possible link between breast cancer and abortion. In particular, the Coalition calls for an international collaboration to evaluate all of the existing data.

About NBCCF

The National Breast Cancer Coalition Fund is a grassroots organization dedicated to ending breast cancer through the power of action and advocacy. The Coalition's main goals are to increase federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; improve access to high quality health care and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates in all aspects of the breast cancer decision making process.

[Faint, illegible text, likely bleed-through from the reverse side of the page]

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⁶ Lambe M, Hsieh C, Trichopoulos D, et al. Transient increase in the risk of breast cancer after giving birth. N Engl J Med 1994;331(1):5-9.

Thompson WD. The risk of breast cancer after giving birth. N Engl J Med 1995;332(1):63-64.

⁷ Melbye M, Wohlfahrt J, Olsen JH, et al. Induced abortion and the risk of breast cancer. N Engl J Med 1997;336(2):81-5.

⁸ Wingo PA, Newsome K, Marks JS, et al. The risk of breast cancer following spontaneous or induced abortion. Cancer Causes Control 1997;8(1):93-108.

Gammon MD, Bertin JE, Terry MB. Abortion and the risk of breast cancer. Is there a believable association. JAMA 1996;275(4):321-2.



Abortion and Breast Cancer

CancerNet from the National Cancer Institute

CANCER FACTS National Cancer Institute National Institutes of Health The relationship between abortion and breast cancer has been the subject of extensive research. However, evidence of a direct relationship between breast cancer and either induced or spontaneous abortion is inconsistent. Some studies have indicated small elevations in risk, while others have not shown any risk associated with either induced or spontaneous abortions.

A large-scale epidemiologic study of this question, reported in *The New England Journal of Medicine* in 1997, determined that the risk of developing breast cancer for women with a history of induced abortion was not different from the risk for women without such a history. The authors, Melbye and others, used data from Danish health registries. Registry data on abortions was collected before the diagnosis of breast cancer was made. Using information on abortions that was collected before breast cancer developed avoids recall or reporting bias, which may occur in retrospective studies when information about abortions is collected after the diagnosis of breast cancer. The authors concluded that "induced abortions have no overall effect on the risk of breast cancer."

Earlier studies that attempted to evaluate the association between abortion and breast cancer were limited in many cases by small numbers of women in the studies, questions of comparability between the study groups, inability to separate induced from spontaneous abortions, and incomplete knowledge of other potentially pertinent lifestyle factors.

Also, most early studies were retrospective; that is, they relied on women's reports of their reproductive history. A significant potential problem in the interpretation of retrospective studies is related to the possibility of recall bias (inaccurate reporting of abortions in retrospect by study participants). Women with breast cancer may be more likely to accurately report sensitive reproduction issues, such as having had an abortion, than women without breast cancer. This type of reporting bias could make abortion appear to be more common among women with breast cancer, possibly leading to the false conclusion that abortion increases the risk of breast cancer.

One earlier study, published in the *Journal of the National Cancer Institute* in 1996, found a 90 percent increase in risk for breast cancer after an induced abortion (the risk of breast cancer among women who reported having had an abortion was 1.9 times the risk among those who did not report a history of abortion). However, the authors, Rookus and van Leeuwen of The Netherlands Cancer Institute, suggested that this figure may have been influenced by inaccurate recall associated with the underreporting of abortion by healthy control subjects in the religiously conservative southeastern region of The Netherlands. In the more liberal western regions of the country, the association between abortion and breast cancer was statistically insignificant. Rookus and van Leeuwen concluded that their study "does not support an appreciably increased risk for breast cancer after an induced abortion."

Another article, published in the *Journal of the National Cancer Institute* in 1994, illustrates the difficulty of drawing conclusions. In this study, Daling and others evaluated the risk of breast cancer among young women with a history of abortion. The results, based on self-reports of abortions, indicated that induced abortion was associated with a 50 percent increase in the average risk of developing breast cancer (the

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women who reported abortions had 1.5 times the risk of those who did not). Risk did not vary consistently with number of abortions, the woman's age at abortion or length of pregnancy, nor did the study show an increase in risk associated with spontaneous abortions. An accompanying commentary by Rosenberg, in the same journal, concluded that "While the findings of Daling et al. add to the limited evidence that induced abortion increases the risk of breast cancer, neither a coherent body of knowledge nor a convincing biologic mechanism has been established." Because the evidence is weak and inconsistent, researchers cannot be sure that there is a direct or causal relationship between abortion and breast cancer. At the time of publication, the National Cancer Institute released a press statement, concluding that "Taken together, the inconsistencies and scarcity of existing research do not permit scientific conclusions."

The most common risk factor for breast cancer is increasing age: In this country, this disease affects 1 out of 2,525 women in their thirties and 1 out of 11 in their seventies. Other well-established risk factors include a family history of breast cancer, early age at menarche, late age at menopause, late age at the time of the first full-term birth of a child, and certain breast conditions. Obesity is a risk factor for breast cancer in postmenopausal women. The increased risk of developing breast cancer associated with each factor varies, from 1.5 to 4 times the average risk.

References

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2. Daling JR, Malone KE, Voigt LF, et al. Risk of breast cancer among young women: Relationship to induced abortion. *J Natl Cancer Inst* 1994;86:1584-1592.
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Washington University in St. Louis

SCHOOL OF MEDICINE

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February 5, 2001

The Honorable Betty Sims
Missouri State Capitol Building
Senate Post Office
Jefferson City, MO 65101

By facsimile: 573-526-2612

RE: Senate Bill 34
91st General Assembly

Dear Senator Sims,

I am a surgeon on the full-time faculty at Washington University in St. Louis, MO, with considerable experience and expertise in breast cancer treatment, and in the interpretation of clinical data. I am writing to you to express my dismay at what I consider to be an error in the interpretation of the data about the risk of breast cancer after induced abortion. I have included a copy of my curriculum vitae to document my background in this area.

As you know, Senate Bill 34 would require physicians to inform women "of the increased risk of breast cancer associated with the proposed abortion," as a part of the informed consent process. However, there is no credible evidence linking pregnancies that do not reach term (ended either spontaneously or induced) and a subsequent increased risk of breast cancer. While there are older, flawed studies that suggest such a link, more recent studies with better methodology demonstrate that there is no increased risk.

The original studies that suggested an increased risk of breast cancer in women with a history of abortion had a substantial flaw, in that they all sought the information regarding the history of

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abortion after the diagnosis of breast cancer had been made (a case-control design). Women with breast cancer (cases) were then compared to a group of women without breast cancer (controls), who were asked similar questions. While this may seem reasonable, it turns out to be a fatal flaw for the accuracy of the study, because the women with breast cancer are more likely to fully report their past history, including sensitive, personal occurrences such as abortion. When their reports are subsequently compared to those of the women without breast cancer, it appears that there were more abortions among the cases than the controls. Thus we have the data upon which some have seized to suggest that abortion increases the risk of breast cancer.

Better study designs have now demonstrated that these concerns are unwarranted. A cohort study is one in which a population has been identified and the information of interest collected prior to the occurrence of the event (in this instance breast cancer) thus avoiding the issue of differential reporting of these sensitive life histories. Four recent studies each demonstrate that when this more appropriate methodology is used, there is no evidence of an increase in the risk of breast cancer after induced abortion:

- An evaluation of women in a health plan in Seattle, where all of the reproductive history was obtained by each woman's physician prior to the diagnosis of breast cancer. There was no increased risk of breast cancer in the women who reported induced abortions (RR=0.9) [Newcomb PA. Mandelson MT. A record-based evaluation of induced abortion and breast cancer risk. *Cancer Causes & Control*, 11(9):777-781, 2000 October].
- 37,247 women from Iowa who participated in a women's health study, and who reported no history of breast cancer at the time of the original study in 1986, were subsequently followed for the development of breast cancer. Comparison of their reproductive histories showed no difference in abortion frequency between the women who developed breast cancer and those who did not (RR=1.1) [Lazovich D. Thompson JA. Mink PJ. Sellers TA. Anderson KE. Induced abortion and breast cancer risk. *Epidemiology*. 11(1):76-80, 2000 Jan.].
- An evaluation of women in 13 counties in Western Washington who recorded reproductive history in birth certificate records between 1984 and 1994. Records from women who subsequently developed breast cancer were compared to women who did not. There was no increased risk noted (RR=0.9). [Tang MT. Weiss NS. Malone KE. Induced abortion in relation to breast cancer among parous women: a birth certificate registry study. *Epidemiology*. 11(2):177-80, 2000 Mar].
- In the largest study, the reproductive histories of 1.5 million women in Denmark were compared with their subsequent risk of the development of breast cancer. There was clearly

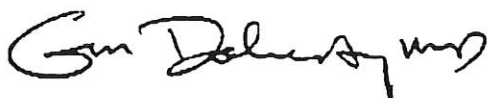
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no impact of having had an abortion (RR=1.0). [Melbye M. Wohlfahrt J. Olsen JH. Frisch M. Westergaard T. Helweg-Larsen K. Andersen PK. Induced abortion and the risk of breast cancer. New England Journal of Medicine. 336(2):81-5, 1997 Jan 9].

In my professional opinion, there is no evidence of an increased risk of breast cancer following an induced abortion, and so the language of SB 34 is fundamentally flawed. I hope that this information is useful as you discuss the merits of this legislative proposal.

Respectfully,



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LEADERS

11:30 a.m. briefing — noon — The Worldwatch Institute is planning to release its State of the World 1997 report. Speaker: Peter Brown, Worldwatch Institute president, and co-author Hilary French, co-authors of State of the World. Location: 1100 Massachusetts Ave. NW. Contact: 202/452-1992.

7:15 p.m. — John Michael Snyder, public affairs director of the Senate Committee for the Right to Keep and Bear Arms, will speak for public relations of the American Federation of Small Arms, a legislative liaison of the Abraham Lincoln Foundation for Small Arms. Location: Northern Virginia Citizens Action Center, 6507 Leesdale. Contact: 202/543-3363.

WS

11:30 a.m., "The State of the World 1997" — Washington Post reporter and author Tom Clavin with Tom Clavin.

11:30 a.m., "The State of the World 1997" — Charles Johnson with Tom Clavin.

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Study finds no link between abortion and breast cancer

Danish research relies on hard data

BOSTON (UPI) — In what is said to be the biggest study so far of a possible connection between abortion and breast cancer, scientists found no link.

National Cancer Institute researcher Patricia Hartge said a study of 1.5 million women in Denmark indicates no connection between abortion and breast cancer in the "overwhelming majority of women."

But New York City researcher Dr. Joel Brind of Baruch University, whose own study a year ago found an increased risk of breast cancer due to abortions, blasted the Danish study, saying it was scientifically "terrible."

In a report appearing in today's New England Journal of Medicine, Danish researchers compare data on abortion and breast cancer for all women born in the country from 1935 to 1978. Of the 1.5 million women, there were 370,715 induced abortions performed and 10,246 women with breast cancer.

The Copenhagen-based Danish Epidemiology Science Center researchers could find no link between abortions and breast cancer.

"The use of data on abortion obtained from population registries rather than from interviews and the large size of the study strengthens the credibility of the findings," Miss Hartge said. "The study thus provides important new evidence to resolve a controversy that previous investigations have been unable to settle."

The Danish research did raise some puzzling points about links between breast cancer and abortion, Miss Hartge said. Women who had very rare late-term abortions — less than one-half of one percent of the study population — had a slightly elevated risk of breast cancer. But women who had very early abortions had a slightly decreased risk of breast cancer.

Miss Hartge suggested that these differences in risk might

have more to do with the mechanisms of breast cancer than with abortion. "It shows we have a lot more to learn about breast cancer," she said.

Previous studies that have suggested there could be a link between abortion and breast cancer were based on personal interviews of the women, Miss Hartge said. Researchers have suggested that women who contract breast cancer will delve deeply into their backgrounds to try to find possible links to the disease, and will recall instances such as abortions.

However, healthy women, especially those who grew up in social or religious circles in which abortion was considered sinful, were not likely to "remember" abortions during the interviews.

This bias, Miss Hartge said, is scientifically unreliable, yet it pervades virtually all linkage studies with the exception of the new Danish work.

She said the Danish study might silence some of the debate about the link, but she wouldn't call the work "definitive" until another group using the same high scientific standards replicates the results.

The new study sets a new scientific standard for abortion research, relying on hard data rather than on potentially biased personal interviews, said Miss Hartge.

Last year, Polly Newcomb, an associate professor in the department of medicine at the University of Wisconsin Comprehensive Cancer Center in Madison, studied more than 16,000 women in Wisconsin, Massachusetts, Maine and New Hampshire. She found that in women who had a miscarriage or abortion there was a 12 percent higher risk of breast cancer compared with women who had never had a pregnancy termination.

Other studies have also shown linkage.

Participants include Barbara Roper, CFA director of investor protection; Mark Spangler, NAPFA chairman and a financial adviser in the Seattle area; and Tom Grzymala, an Alexandria financial adviser and chairman of media relations for the National Association of Personal Finance Advisors. Location: Zenger Room, National Press Club, 14th and F streets NW. Contact: 703/276-1116 or 703/736-7307.

Farm bill news conference — 10 a.m. — Rep. Nick Smith, Michigan Republican, holds a news conference to announce his introduction of a bill to allow farmers and ranchers to average their farm-related income over a two-year period to mitigate their greater risk of year-to-year income fluctuations under the new farm bill. Also participating are to be the bill's co-sponsors, Reps. John Hostettler, Indiana Republican; and Earl Pomeroy, North Dakota Democrat. Location: 1300 Longworth House Office Building. Contact: 202/225-6276.

Junk guns bill news conference — 10:30 a.m. — Sen. Barbara Boxer, California Democrat, holds a news conference to announce legislation for junk guns, or "Saturday night specials," to meet safety and quality standards presently applied to imported handguns. Location: Capitol, Room EF-100. Contact: 202/224-8120.

Reich speech — noon — Labor Secretary Robert B. Reich holds his last speech as a member of President Clinton's Cabinet, discussing the "Unfinished Agenda." Location: Sheraton Carlton Hotel, 923 16th St. NW. Contact: 202/219-8211.

Auschwitz discussion — 12:30 p.m. — The U.S. Holocaust Memorial Museum holds a program titled "Auschwitz, 1270 to the Present." The speakers are Deborah Dwork, Clark University professor, and Jan van Pelt, co-author of "Auschwitz, 1270 to the Present." Location: 100 Raoul Wallenberg Place SW. Contact: 202/488-6162.

Women's Inaugural ball announcement — 1 p.m. — The



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threatens show business's most important labor negotiation in a decade—and the future of our favorite TV shows. A possible strike, which could begin any day after the Writers Guild of America contract expires May

for the picket lines, networks may be forced to fill their schedules with more news, reality and game shows, which are not covered by WGA contracts. A strike by both the screenwriters and the Screen

A B O R T I O N

Making Scare Tactics Legal

THOUGH THE FIRST ANTI-abortion administration in eight years is just over a month old, emboldened abortion foes have already launched a novel legal push. Abortion-rights advocates say 15 states are considering bills requiring abortion doctors to tell patients that abortion increases breast-cancer risk. The American Medical Association and American Cancer Society oppose the bills, which force doctors to “tell our patients

something that is not true,” says AMA board member Dr. John C. Nelson. Early '90s surveys suggested a link, which was disputed by more recent studies.

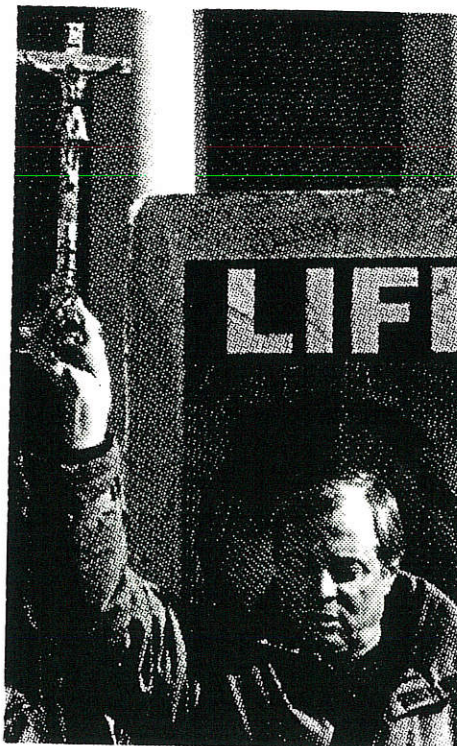
The new strategy has medical ethicists worried. “It is despicable,” says Art Caplan of the University of Pennsylvania’s Center

for Bioethics.

“There is nothing else going on here other than abortion politics.”

Illinois state Rep. Dan Reitz, who introduced one of the bills, agrees.

“I’m not really sure about the science,” he says. “My intent was strictly about limiting abortion.”



At the Ohio Legislature



KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT
BILL GRAVES, GOVERNOR
Clyde D. Graeber, Secretary

KDHE Testimony Example

Testimony on House Bill 2517
to
Committee on Federal and State Affairs
Presented by Linda Kenney

March 13, 2001

Chairperson Mays and members of the Committee, I am honored to appear before you today to discuss House Bill 2517.

This bill requires that materials published and disseminated by the Kansas Department of Health and Environment contain the information that there is an "increased risk of breast cancer associated with the proposed abortion." Under the bill, this information would be provided despite a growing body of epidemiological evidence which show no statistically significant link between induced abortion and breast cancer risk. Since 1981, there have been over a dozen published studies which have examined any possible link between breast cancer and abortion. The largest and most comprehensive investigation on 1.5 million women born in Denmark between 1935 and 1978 was published in the *New England Journal of Medicine*. It concluded, "induced abortions have no overall effect on the risk of breast cancer." Another study in the January, 2000 issue of *Epidemiology* found "no excess risk of breast cancer among women who reported having an induced abortion compared with those who did not, nor did risk increase with increasing number of reported induced abortions."

A number of organizations have released statements relating to this issue. The National Cancer Institute has stated that "taken together, the inconsistencies and scarcity of existing research do not permit scientific conclusions." Other independent experts including the National Breast Cancer Coalition, the American Cancer Society, and the World Health Organization have indicated that a link between abortion and breast cancer has not been established.

Thank you for the opportunity to appear before the Committee on Federal and State Affairs and will stand for questions the committee may have on this topic.

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National Organization for Women
KANSAS Chapters
Lawrence Manhattan/KSU Wichita JO/Wy Counties
PO Box 15531 Lenexa, KS 66285 913 384 7900

March 13, 2001

HB 2517 Opposing "Women's Right to Know Act"

Dear Chairman Mays and Members of the Federal and State Affairs Committee:

Women have the right to know the truth. In the 21st Century, misinformation, old wives tales and outright lies should not be used in the campaign to keep women "barefoot and pregnant". Attempts to control women's lives with unwanted pregnancies is an outmoded tactic best left in the 19th Century when ignorance and quackery were the norm.

There is no compelling evidence linking breast cancer and abortion. Those of you truly concerned about women's lives could lobby to educate women about the real dangers they face. Only one in eight women will develop breast cancer while women are more than twice as likely to develop heart disease. Yet there is no outcry to educate women to the risk they face with heart disease. In fact, they are uninformed.

At least 7 research studies worldwide have collected data about breast cancer and reproductive factors such as childbirth, menstrual cycles, birth control pills, and abortion. Approximately 2 studies have examined the risk of developing breast cancer for women who have had abortions. Cancer researchers at the National Cancer Institute, the American Cancer Society, and major universities say that the most reliable studies show no increased risk, and they consider the entire body of research inconclusive (ACS, 1999; NCI, 1999; Rosenfield, 1994?)

Today's women refuse to be kept in the dark or the Dark Ages.

The Kansas National Organization for Women requests the House Federal and State Affairs Committee to oppose this bill.

Respectfully submitted by

Sharon Lockhart
KS NOW State Coordinator

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