March 17, 2023
Supporting Testimony of KS HB 2439
To Mr Long, Committee Assistant
House Health and Human Services Committee

Dear House HHS Committee Members,

My name is Dr Lisa Gilbert, a family physician and in practice since 2009 with women's health and obstetrics. I am also an Abortion Pill Reversal Provider. I have been called through the hotline several times by women in Kansas seeking reversal of mifepristone ingestion.

Throughout my practice, I have discussed options with women with unplanned pregnancies and recognize the extreme distress that this causes. I firmly believe that informed consent includes disclosure of all options, that includes discussion of abortion, and also support of parenting for those who desire to parent, and options of adoption for those who are unable to parent. Informed consent should also include disclosure of risks, benefits and alternatives; in the case of abortion, on reversal methods of mifepristone. Women can and do change their minds regarding abortion. Sometimes the finality of this decision, once made, is immediately regretted once the sense of distress and panic subside and she has had more time to reflect. She may come up with other solutions for continuing a pregnancy.

Careful protocols regarding use of natural progesterone to reverse mifepristone (a progesterone receptor blocker) have been established, which I attach here. There is a success rate at continuing a viable pregnancy of around 68% with progesterone from a baseline of 23% without progesterone, especially if progesterone is taken soon after mifepristone. Progesterone must be taken prior to misoprostol, the second drug in the abortion regimen, for which there is no antidote.

There are no known adverse outcomes to these women or to their preborn child. Progesterone is a natural hormone of pregnancy that increases dramatically during pregnancy to maintain the placenta. It is provided to some women with a history of miscarriage who present with another threatened miscarriage. Additionally, a recent study from Crenin et al was trying to disprove APR's safety and efficacy but it actually showed the opposite - in the 12 patients who were enrolled and received either placebo or progesterone after mifepristone, there were three adverse outcomes. Two of the three women had taken placebo and they required transfusion and a D&C. The other one who took progesterone had bleeding and passage of tissue, but this resolved without any further interventions. While it did not reach statistical significance, this suggests that progesterone after mifepristone is safer than not taking progesterone.

For further information, please see the education video on AAPLOG's website:
https://aaplog.org/abortion-pill-reversal/

I am happy to provide more information if desired. I also know at least 6 other OBGYNs and Family Physicians in Kansas who provide APR and are also receiving calls through the hotline. I believe all Kansas women have a right to know about this option if they are considering mifepristone. It does not guarantee successful reversal of mifepristone but it does significantly increase her chances of maintaining the pregnancy if she changes her mind.

Sincerely,
Lisa
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Official APRN aProgesterone Protocols for The Attempted Reversal of Mifepristone
https://aaplog.org/wp-content/uploads/2021/07/B-Progesterone-Protocols-05.2021-Final.pdf

Oral Protocol
1. Prometrium brand or progesterone generic micronized oral capsules 200 mg, two capsules (400 mg) by mouth ASAP and bedtime on day 1 (must be at least 5 hours apart). 200mg, two capsules (400 mg) AM and PM on day 2 and 3.
2. Continue progesterone 200mg, two capsules (400mg) at bedtime for a minimum of two weeks or according to your clinical judgment.

Vaginal Protocol (Capsules per vagina)
1. If the patient is unable to take oral capsules or intramuscular injections, consider vaginal administration of oral capsules Prometrium brand or progesterone generic micronized oral capsules 200 mg, two capsules (400 mg) inserted vaginally ASAP AND at bedtime day 1 (must be at least 5 hours apart). 200mg, two capsules (400 mg) AM and PM on day 2 and 3.
2. Continue progesterone 200mg, two capsules (400 mg) inserted vaginally daily at bedtime for a minimum of two weeks or according to your clinical judgment.

Intramuscular Protocol
1. Compounded progesterone in oil 200mg (100mg/ml or 50mg/ml) intramuscularly (IM) upper outer quadrant of gluteal muscle, slowly over 2-3 minutes as soon as possible after the ingestion of mifepristone.
2. Continue progesterone in oil, 200 mg IM once a day for two more days.
3. Continue progesterone in oil, 200mg IM every other day until day 14 after mifepristone ingestion.

4. Continue progesterone in oil, 200 mg IM twice a week for a minimum of two weeks or according to your clinical judgment.

24/7 HOTLINE (877) 558-0333 ••info@apr.life

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Additional Instructions for the Reversal Provider:
• Do not prescribe Prometrium based in peanut oil if the patient is allergic to peanuts.
• If prescribing oral, prescribe enough for 1 week at a time with refills. One month's supply may be unaffordable if the patient's insurance doesn't cover.
• Provide ultrasound per Clinic Protocol as soon as possible to confirm embryonic viability and intrauterine location. If less than 6 weeks after LMP, consider monitoring serial HCG levels and simply do ultrasound at 6 weeks.
• If bleeding or cramping occurs and an intrauterine location of pregnancy has not been confirmed, treat as an ectopic pregnancy and appropriately refer until an intrauterine location is confirmed.
• For an ectopic pregnancy or an incomplete abortion, seek consultation as necessary.
• Provide an ultrasound every 1-2 weeks during the first trimester to confirm continued viability.
• The physician, midwife, PA or NP who prescribes should see patient within 72 hours or ensure a plan for ongoing care.
• Providers should use their own professional judgement based on experience prescribing progesterone.
Some providers have successfully prescribed 600 mg twice a day for two days, followed by 400 mg twice a day for two days and then 400 mg at bedtime. Other doctors, particularly in Europe have used even higher doses.

Reversal in Second and Third Trimester:
• If the patient has had laminaria inserted and been given mifepristone, but still has a living fetus, progesterone should be prescribed, the laminaria removed, and she should be evaluated for rupture of the membranes. The patient should also be assessed for the need for antibiotics, as laminaria will increase the chance for chorioamnionitis in a pregnancy that continues after their use.
• A minimum of two weeks of progesterone treatment is recommended in second and third trimesters of pregnancy for reversal of mifepristone. The individual prescribing provider should use his or her clinical judgement for dose and duration of progesterone treatment.

Approved by:
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