

THE WHATS HOWS AND WHYS OF MENSTRUAL EXTRACTION

If a woman got her period and didn't want it, she could get rid of it. If her period was missed because of pregnancy, she could have an extraction and end the pregnancy

By Rebecca Chalker

In Los Angeles in 1971, before *Roe v. Wade* legalized abortion, a small group of women began observing abortions in an underground clinic. Carol Downer, then a housewife with six young children, was one of those women. "We quickly saw that early pregnancies could be terminated safely and simply," Downer remembers. "We learned that the new suction technique being used in that clinic was less traumatic, and less risky, than the standard dilation and curettage (D&C)." In a D&C, the walls of the uterus are scraped with a sharp metal curette; in suction, a cannula, a flexible, plastic straw-like tube, is inserted into the uterus through the cervical canal, and a hand-held syringe (with the needle removed) is pumped. The uterine contents are suctioned through the cannula into the syringe.

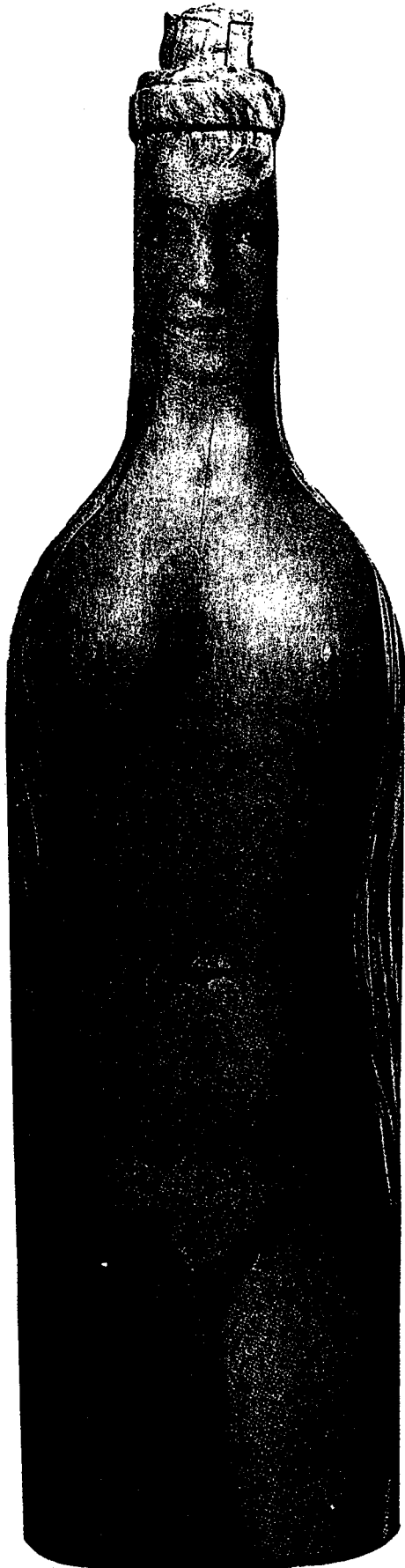
At about the same time, Downer went to the clinic with a young woman who was going to have an IUD inserted. Downer was permitted to watch. "I was just bowled over by how accessible the cervix (the entrance to the uterus) really is," Downer says. Suddenly, what she had observed in the clinic jelled. "I realized that if we just had some essential information about our bodies, we wouldn't have to put up with back-alley abortionists anymore."

The next time Downer went to the clinic, she "appropri-

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ated" a plastic speculum, a cannula and a large syringe and took them to her consciousness-raising group. That night the group discussed abortion laws, the lack of availability of abortion, and marveled at the new equipment. Then, not knowing how anyone would respond, Downer volunteered to demonstrate how to use the speculum. "When people saw my cervix, they instantly understood the potential of the new abortion technology," she says.

Lorraine Rothman, a school teacher in Orange County, just south of Los Angeles, and herself the mother of four children, was at the meeting. "We knew that the suction equipment had enormous potential, but I thought it needed improvement," Rothman remembers. Rothman had a scientific background and had worked in a chemistry lab. She took the device home and came to the next meeting with an improved model.

In the new model, the uterine contents passed through the cannula into a tube, and then into a collection jar, instead of going directly into the syringe/pump. Rothman, who dubbed her device the "Del-Ern," points out that it's more uncomfortable for the woman having the extraction when the pump is connected directly to the cannula.

The group now had the technology not just to terminate pregnancies, but for genuine reproductive control. "If a woman got her period and didn't want it, she could get rid of it. If she didn't get her period, perhaps because she was pregnant, she could have an extraction and end the pregnancy," Downer observes.

Over the last two decades, perhaps 1,000 to 2,000 women have learned how to do M.E., and an estimated 20,000 procedures have been performed in which pregnancies have been terminated — a tiny number compared to the 1.5 million abortions performed each year.

Suddenly and unexpectedly, on January 22, 1973, the Supreme Court announced its decision in the case of *Roe v. Wade*, making first-trimester abortion a decision between a woman and her doctor, and second trimester subjected to minimal regulation by the states. Two months later, Downer and Rothman borrowed \$1,500, hired a doctor and opened an abortion clinic in Los Angeles. Shortly thereafter, they opened a number of other clinics across the country forming the Federation of Feminist Women's Health Centers, an association of independent, women-owned clinics that provide abortions, birth control and well-woman gynecological care. At the centers, the suction technique rather than curettage for first-trimester abortions remains the method of choice. Downer and Rothman continued to share information with women who were interested in learning about menstrual extraction (M.E.), but with clinics to run and other critical issues in women's health to consider, M.E. went on the back burner.

When the Reagan/Bush Supreme Court allowed significant restrictions on abortion in its *Webster* (1989) and *Casey* (1992) decisions, women in the prochoice movement, including Downer and Rothman and many of their colleagues, began to wonder what they were going to do if *Roe* were overturned. At this point, the concept of M.E. and its practical potential began to take on new resonance.

WHY MENSTRUAL EXTRACTION IS A GOOD IDEA

By **Rebecca Chalker**

Menstrual extraction (M.E.), a technique that can remove the contents of the uterus safely with a hand-held suction device, was developed in the days before abortion was legal by women who grew tired of waiting for the Supreme Court to legalize abortion. In those heady years of the emergence of the modern women's movement, thousands of women learned about M.E. and many formed self-help groups and were instructed in this simple but revolutionary technique. But when abortion rights presumably became secure, and with mountains to be moved in the name of full social equality for all women, M.E., for the most part, ceased to be a pressing issue. However, with the continuing assault on abortion rights, and ever-decreasing access to safe, legal abortion, renewed interest has been sparked in M.E. and other safe methods of fertility control.

The Safety of Menstrual Extraction

Some physicians and family planning advocates have expressed concerns about lay practitioners performing M.E. These concerns are usually expressed as fears of medical complications, although the same complications can occur when abortions are performed by physicians. Some critics have also expressed fears that desperate women who are unfamiliar with their own anatomy and with the M.E. equipment will harm themselves.

These concerns are well-intentioned, but they are based, for the most part, on a lack of understanding about how M.E. is practiced by women in the United States.

These criticisms include:

The lack of a formal diagnosis of pregnancy. Most women know when they are pregnant, and diagnose themselves, either by recognizing the signs and symptoms of pregnancy, or by using a home pregnancy test. Ultrasound, an image of the body's interior made with high-frequency sound waves, is not necessary to confirm pregnancy in most cases, even though it is now widely employed by abortion clinics. How far the pregnancy has advanced is usually determined by a

uterine-size check, which experienced self-helpers have become quite efficient at doing.

Missed tubal (ectopic) pregnancy. In pregnancies under eight weeks, when most abortions and M.E.s are done, the first indication of a tubal pregnancy is the lack of pregnancy tissue when the uterus is evacuated. Chorionic villi, the feathery tissue that is characteristic of pregnancy, is not difficult to identify, and can be readily recognized by women in M.E. groups as well as by doctors. In any event, in clinical practice, tissue examination is usually done by nurses or lab technicians, rather than by the doctor.

The failure to recognize existing infections or unusual conditions such as fibroids or ovarian cysts. If women in M.E. groups want to make sure that they do not have an asymptomatic infection such as chlamydia or gonorrhea, which could be introduced into the uterus during a menstrual extraction, they can go to a clinic or to their own doctors to have the appropriate screening tests done. If a woman is receiving regular gynecological care, she will probably be aware of having fibroids, cervical scarring called "stenosis" that may be caused by surgery on the cervix, or rare conditions such as a double uterus. Fibroids are not a contraindication to abortion or M.E., but may make the pregnancy seem more advanced than it really is, or may cause more bleeding than normal.

If a woman has significant scarring of the cervical canal, chances are the cannula would be difficult to insert, and her group will probably be aware of this condition, which may or may not make an M.E. more difficult or painful. If this is the case, she and her group can evaluate whether or not it might be better for her to have a clinical abortion.

Prophylactic (preventative) antibiotics are given routinely in most clinics for early abortions, but they are not essential unless a woman has a history of pelvic inflammatory disease, or is predisposed to infection because of diabetes or other conditions. Menstrual extraction groups do not routinely use any drugs, but if antibiotics or other drugs become necessary, a woman could see her own doctor or go to an emergency room.

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Use of sterile technique. Sterile technique simply means

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THE CASE AGAINST MENSTRUAL EXTRACTION

By Louise Tyrer

With abortion debates escalating, "self-help" menstrual extraction (M.E.) has been promoted as a way for women to exercise full control over their reproductive options. While all women should be actively involved in all matters related to their healthcare, the health dangers and political risks associated with this unsupervised medical procedure far outweigh any possible conveniences or advantages in a society in which legal abortion is still an option.

Every woman should be free to choose whether or not to undergo "self-help" M.E., be it to minimize monthly cramps or to terminate a suspected pregnancy. However, women deserve the opportunity to make a fully informed decision which must include the case against menstrual extraction.

Health Risks

Menstrual extraction refers to removing, by suction, the contents of a woman's uterus, which may be the lining that builds up prior to menstruation as well as the products of conception. This entails the insertion of a small, flexible, blunt-tipped cannula into the uterus and attaching it to a vacuum source, generally a hand-held syringe. Most lay women who perform this procedure for other women will only do so within 50 days of the onset of the last menstrual period, in an attempt to avoid initiating an abortion in a woman whose pregnancy is so far advanced it cannot be completed with the equipment utilized. Some lay providers will perform it for women with late periods without establishing that the woman is in fact pregnant. In all cases, M.E. can pose serious health risks.

Infection. Every time a woman's uterus is invaded, as it is when a cannula is inserted into the uterus during monthly menstrual extractions, the chance of pelvic infection becomes greater. Any degree of pelvic infection can increase a woman's chance of subsequent ectopic (tubal) pregnancy, or lead to infertility.

Hidden symptoms. Heavy menstrual flow, which sometimes leads to a desire for repeated menstrual extractions, may be an indication of cancer of the lining of the uterus, as may intermenstrual bleeding. Women with such symptoms need to be examined by specially trained physicians to evaluate, diagnose, and manage their condition.

Pregnancy. For a woman who is pregnant, the risks associated with M.E. as a "self-help" abortion technique are particularly great. First of all, pregnancy tests alone are not always accurate. If a woman thinks she may be pregnant, a pelvic examination and sometimes ultrasonography are necessary to establish the certainty of a suspected pregnancy, and to identify whether the pregnancy is a normal uterine implantation, or is an ectopic pregnancy. Furthermore, some women continue to have periodic bleeding with pregnancy and a woman may be unknowingly 12 or more weeks pregnant before she suspects that she is so. Since "self-help" M.E. is performed by a non-medical person unqualified to determine the site and duration of the pregnancy or perform a complete medical examination, the risk of complications — such as the inability to complete the abortion, uterine perforation, hemorrhage and/or infection — would be significantly increased.

Pre-existing pelvic conditions. Sometimes women unknowingly have a pelvic pathology such as uterine fibroid tumors, a double uterus, ovarian cysts, or cervical scarring. When a woman is pregnant, each of these conditions can increase the likelihood of an incomplete abortion, or complicate the performance of the procedure. A pelvic evaluation by a specially trained health professional is essential to determining the appropriate procedures and techniques to terminate pregnancy safely in these situations.

Puncturing the uterus. Improper use of surgical equipment can occur in "self-help" M.E. and may result in uterine perforation. This risk is lessened when the procedure is performed by an experienced clinician.

Incomplete abortion. The more complex the abortion procedure, the less chance of hemorrhage, infection, or both. Health professionals experienced in performing abortions are more capable of determining whether the products of conception have been fully removed. They can send the specimen to a pathology laboratory when indicated in order to establish whether a woman's pregnancy is ectopic, which

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getting the cannula — the straw-like instrument that is inserted into the uterus in M.E.s or abortions — “sterile,” and keeping it that way during the procedure. There is no doubt that self-helpers can learn this simple technique as well as doctors can. In abortion and in many surgical procedures, “sterile” actually means “high-level disinfection,” since true sterility is nearly impossible to establish and maintain. In M.E., the cannula can be adequately disinfected by soaking in certain chemical germicides such as Zephiran or household bleach. Some self-help groups have been able to make arrangements through a friendly practitioner to have cannulas sanitized in a commercial gas sterilizer at a hospital or clinic.

Although there is very little blood involved in M.E. and what there is goes directly into a collection jar, taking universal precautions, such as using disposable gloves, is necessary, and wearing goggles, masks and plastic gowns is recommended. Each group needs to assess how rigorously the precautions must be followed.

Use of local anesthesia. Local anesthesia, an injection of a novacaine-like drug into the cervix, is not necessary in either early abortion or M.E. In clinical abortion, the injection is given to relax and soften the cervix, but it does nothing to mask or diminish cramping. Some women actually find the injection more uncomfortable than the two or three minutes of suction in clinical abortion.

Risk of uterine perforation. The small (4 or 5mm) cannulas used in M.E. are *highly* unlikely to perforate the uterus. In clinical abortion, perforations typically happen when metal instruments, such as a curette, are used, or when doctors are tired, pressured or distracted. Perforations also occur more often when women have general anesthesia, since doctors are sometimes not as careful when a woman is asleep and unaware of pain.

The importance of follow-up. Women in M.E. groups keep in close touch with the woman who had a procedure and with each other after an M.E. Just as in clinical abortion, a woman who has had an M.E. monitors her own cramping, bleeding and temperature, and reports anything unusual to her self-help group. If the procedure appears to be incomplete, the group will evaluate the situation and decide if a second aspiration is necessary.

The signs of complications of M.E. and early abortion are very specific: Heavy bleeding, defined as bleeding through

one pad an hour, pelvic pain, a temperature over 100 degrees, and signs of pregnancy that do not go away. These signs are very specific and can be recognized by anyone who knows what to look for.

Menstrual extraction done by committed, trained women can be done as safely as clinical abortion. Pointing to rare conditions, or denigrating the skills and abilities of experienced self-helpers is an unfair and incorrect indictment of M.E. The lack of safe, legal abortion is far more dangerous to women's health, and is the real risk factor for women who experience unintended pregnancies.

Over the last 20 years, M.E. has been practiced by women who are highly aware of self and body. These women work in tight-knit, friendship groups, often referred to as “self-help” groups. These normally consist of up to a dozen women who meet monthly or more often to discuss their feelings about M.E., study the reproductive anatomy, and polish their skills. If a woman enters an already-existing group, she may observe extractions for several months before she has one herself, or actually tries her hand at moving the cannula in the uterus. If the group is new, its members may practice the basic skills of vaginal and cervical self-examination, and do uterine-size checks to learn to estimate the size of the uterus. Knowing how to do accurate uterine-size checks is essential in order to avoid doing a procedure on a woman who is too far pregnant.

Women in a new group may seek out an experienced member of another group, or even a sympathetic doctor to serve as mentor and supervise extractions until the group feels confident to do them on its own. As a member of one group told me, “Our first three years were one long learning process.”

Women in self-help groups know the abilities of the others in the group and can therefore depend on a high level of skill and commitment.

In the week or so after an M.E., the group keeps in close touch with the woman who had the extraction to monitor any signs of a complication. The woman herself monitors her temperature, bleeding and cramping, just as women who have abortions do, and she reports anything unusual to the group.

Every group ideally has a back-up plan — a trusted physician or nurse practitioner to call in the event of any complication. This is far preferable to going to an emergency room where many of the physicians are unfamiliar with

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is a life-threatening condition.

Post-abortion infection. Health professionals are trained and better equipped to minimize the risk of infection, as well as diagnose and treat possible infections that may occur after abortion. Carefully sterilized instruments, "no-touch" techniques, and minimal insertions of instruments into the uterus are necessary to reduce risk. A "self-help" procedure, however, may require multiple insertions of the suction cannula to finish the abortion procedure. Furthermore, trained health professionals are better able to identify abnormal cervical and vaginal discharge, which may require antibiotic treatments, as well as administer antibiotics at the time of abortion to minimize the risk of post-abortion infection. "Self-help" M.E. groups are not able to do so.

AIDS. The emergence of AIDS and Hepatitis B pose an ever greater need to minimize possibilities of infection during the abortion procedure. This requires the wearing of clothes, gloves, and plastic eye and face masks to protect the operator and patient from any potential contamination with blood and other bodily fluids, such as vaginal secretions. Abortion tissue requires the utmost care in analysis. Furthermore, all instruments must be decontaminated and sterilized, and all disposables must be properly bagged and handled by designated collection centers. Even the slightest break in skin, e.g., a torn hangnail, can be an entry point for the fatal HIV virus. It is reasonable to assume that women seeking abortion care and providers alike will want to be in a medical-care environment that can assure the minimum risk.

Consistency and continuity of care. The woman who obtains an abortion from a licensed and specially trained health professional is assured of more consistent quality of care, as well as 24-hour access to experienced physicians who have surgical capabilities for the rare — but sometimes serious — complications that may occur with any abortion.

Political Risks

It is unfortunate that current laws and harassment by antichoice bigots have created a climate in which physicians are discouraged from providing abortion services. However, "self-help" menstrual extraction is *not* the answer.

As a resident physician in ob/gyn prior to the legalization of abortion, I saw too many women die from every manner of complication or become reproductive cripples for the rest of

their lives as a result of illegal abortion. We cannot, we must not, go back to those dark days, nor should women ever need to rely on less than the most informed, technically advanced and individually sensitive reproductive healthcare services — including elective abortion.

For the benefit of the health of women in the U.S., we need to expand our energies to ensure that abortion remains a legal, available and accessible option for all women. In this light, "self-help" menstrual extraction must be seen not only as a potential health risk, but also as a counterproductive political tactic. Women must not be lulled into thinking that menstrual extraction will provide a safety net should abortion again be made illegal. I say we can *Never* go back.

I envision that a more useful way to ensure women control over their reproductive health is to take two courses of action. First, we need to change the dynamics of the political in this country so that medical providers and women seeking abortion can feel comfortable in providing and receiving high quality abortion care. Bill Clinton's promise to overturn the "gag rule" is an important step in this direction.

Second, we need to expand the pool of adequately trained abortion providers to include licensed, non-physician reproductive healthcare specialists as well as certified nurse midwives, nurse practitioners, and physician's assistants. The health professionals, many of whom are women, already grounded in the anatomy and physiology of women's reproductive systems. Unlike "self-help" menstrual extraction providers, this cadre of specially trained health professionals can recognize in advance when a patient has a pelvic pathology and make sure that she receives specialized physician care. Furthermore, they are experienced in working as members of teams, including physicians, who are experienced in handling the sometimes threatening emergencies that can occur with abortion.

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Not only has this innovative approach to women's reproductive healthcare been endorsed by organizations such as the American College of Obstetricians and Gynecologists, the National Abortion Federation, the Association of Reproductive Health Professionals and the Planned Parenthood Federation of America, it has proven successful: A report by NAF found that women undergoing early abortion by trained physician health professionals experienced no increase in complications than had the procedure been performed by a medical d

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the pathology.

Menstrual extraction is not something that can be initiated overnight. It takes a considerable amount of resourcefulness and commitment just to assemble the equipment. Parts of the Del-Em are easily accessible — the glass jar and aquarium tubing — but it can take several weeks to find a source for cannulas and order the chemistry lab stopper and two-way bypass valve. By the time all parts have arrived, pregnancy would probably be too far advanced for M.E. to be effective.

The Legality of Menstrual Extraction

So far, M.E. has not been held up to legal scrutiny, and is unlikely to be, unless a serious complication occurs and a complaint is filed with local prosecutors. Nevertheless, there are interesting questions about M.E. that bear exploration.

With the exception of Vermont, which allows physicians' assistants to do abortions, all other state laws require that abortions be done by physicians. Today, so few doctors know how to do abortions, or are willing to do them, one wonders how long they can justify retaining exclusive control over the practice.

According to a recent nationwide survey done by Dr. Trent MacKay, assistant professor of obstetrics/gynecology at the University of California, Davis, just 12 percent of approximately 270 training hospitals with programs in ob/gyn now require training for first-trimester abortions and 7 percent require residents to learn to do second-trimester abortions. A little over 56 percent were found to offer optional training.

Any legal challenge to M.E. would probably be made under state Medical Practice Acts, most of which specify that abortions can only be done by licensed physicians.

Any legal challenge to M.E. would probably also raise a number of questions about the constitutionally guaranteed right to privacy. Just how far can the

government go in dictating what people can or can't do in the privacy of their own homes with adequate knowledge of the risks and consequences of their activities?

The Whats, Hows and Whys of M.E.

Women who have learned M.E. tend to agree that the training is too arduous and the commitment too profound for the technique to be widely practiced. Only women who have a specific interest in taking more control over their reproduction, and in meeting regularly for several years, will spend the time required to acquire the necessary skills. Nonetheless, these same women feel that the concept of M.E. is a powerful tool for the prochoice movement.

Any woman can start a self-help group, and, in a reasonable amount of time, could learn the technique and practice it quietly and confidently, away from the prying eyes of the authorities and the taunts of anti-abortion zealots.

At the very least, that could be a lifesaver.

Rebecca Chalker is an internationally known abortion counselor and an active speaker on women's health issues.

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"Self-help" menstrual extraction — no matter how many anecdotal reports of individual experience are put forward — cannot be considered either safe or empowering. Women deserve, and must demand, the best healthcare available, including abortion training for non-physician health professionals. Furthermore, women must unite to ensure that safe and legal abortion is always an option. We can never forget how many women lost their lives before the right to choose became the law of the land.

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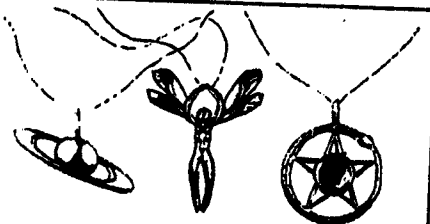
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