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Uses for Mifepristone Beyond Abortion: Addressing Recent Controversies

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Executive Summary

- Some abortion advocates have raised concerns that reimposing limitations on mifepristone use, or removing its FDA approval, will harm women who may need access to mifepristone for indications unrelated to abortion, such as for Cushing's syndrome or miscarriage management.
- However, data remains limited that mifepristone can always safely and effectively replace other medications already in use for these non-abortion indications. Moreover, even when mifepristone may be safe and effective for some of these indications, simply reinstating the in-person dispensing and related requirements need not impact its proper use in these cases.
- Miscarriages that are managed with medication are done so with misoprostol alone the vast majority of the time, rather than mifepristone and misoprostol. However, there is evidence that pretreatment with mifepristone may increase successful expulsion rates relative to misoprostol alone. The most successful treatment, though, remains surgical aspiration.
- The current FDA REMS regulations, which allow prescribing of mifepristone remotely with distribution through the mail, have led to frequent unsupervised use without pre-abortion testing. This would not be an acceptable option for prescribing mifepristone for any of its other potential uses, and it should not be considered acceptable for women seeking abortion.

Introduction

Mifepristone, used along with misoprostol, was approved by the U.S. Food and Drug Administration (FDA) in 2000 under the brand name "Mifeprex" to induce abortion. The FDA has made a number of significant changes to its labelled instructions since that time,¹ and currently allows remote dispensing without pre-abortion testing or clinical follow-up, despite evidence that such omissions may result in harm to women.²

Mifepristone blocks progesterone receptors, cutting off critical hormonal support in pregnancy. If a living child is present in the uterus, this often disrupts placental blood flow and ends the child's life. If the child has already died in a miscarriage, mifepristone causes the cervix to soften, facilitating cervical dilation and extrusion of the pregnancy tissue. The expelling of this tissue is hastened by uterine

¹ "Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation." FDA.gov. <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation>.

² Elyse Gaitan, Tessa Cox, "Primer: Risks and Complications of Drug-Induced Abortion." April 6, 2026. <https://lozierinstitute.org/primer-risks-and-complications-of-drug-induced-abortion/>.

contractions initiated by the second drug in the regimen, misoprostol.³

Induced abortion remains a contentious issue in the United States, and as the percentage of abortions induced with mifepristone and misoprostol has risen steadily, much attention has been directed toward mifepristone. Some have called for its removal from the market,⁴ while others have called for reinstating previous safeguards removed by the FDA.⁵ Still others advocate that all remaining restrictions be removed and the drug be provided over the counter.⁶

In the midst of this animated conversation, an additional narrative has emerged concerning other potential uses for mifepristone. According to some advocates for drug-induced abortion, reimposing limitations on mifepristone use, or removing its FDA approval, will harm many Americans who may need access to mifepristone for its uses outside of induced abortion. As one abortion provider stated in the *Journal of the American Medical Association (JAMA)*, “[T]he drug even has utility that goes beyond pregnancy management, including reducing the size of fibroids, treating patients with Cushing syndrome, and providing emergency contraception prior to fertilization. ... No matter where you fall on the political spectrum, you or someone you know may very well need mifepristone one day.”⁷ Although abortion advocates remain hopeful that the additional clinical utility of mifepristone will prompt more widespread acceptance of the drug, the data remains limited that mifepristone can always safely and effectively replace other medications already in use for non-abortion indications. Moreover, even in cases in which mifepristone may be used safely and effectively for such indications, simply reinstating the in-person dispensing and related requirements for mifepristone need not impact its proper use for these other indications.

A frequent recommendation for mifepristone use unrelated to induced abortion is to facilitate medical treatment of miscarriages, when an unborn child has died naturally and the uterus needs to be evacuated. This paper will focus on this specific indication.

³ Spitz IM, Bardin W, Benton L, Robbins A. “Early Pregnancy Termination With Mifepristone and Misoprostol in the United States.” *New England Journal of Medicine* (1998). 338: 1241-1247; Spitz I. “Progesterone Antagonists and Progesterone Receptor Modulators: An Overview.” *Steroids* (2003). 68:981–993.

⁴ Sarah Fentem, “Josh Hawley Calls on Congress to Ban Abortion Pill Mifepristone.” *St. Louis Public Radio*. March 12, 2026. <https://www.stlpr.org/health-science-environment/2026-03-12/hawley-congress-ban-abortion-pill-mifepristone>.

⁵ *State of Louisiana et al. v. Food and Drug Administration et al.* <https://litigationtracker.law.georgetown.edu/litigation/state-of-louisiana-et-al-v-food-and-drug-administration-et-al/>.

⁶ Selena Simmons-Duffin, “Over-the-counter Medication Abortion? These Researchers Say it Would Be Safe.” *NPR*. April 6, 2026. <https://www.npr.org/2026/04/06/nx-s1-5773372/medication-abortion-jama-safety-mifepristone-misoprostol>.

⁷ Chen J, “The Clinical Indications for Mifepristone Go Beyond Abortion.” *JAMA* (2025). 334;(12):1059-1060. <https://jamanetwork.com/journals/jama/article-abstract/2838183>.

Common methods of miscarriage management

When an unborn child has died naturally, a health care provider will often offer three management options. If the woman is stable and there is no indication for immediate uterine evacuation, she may choose expectant management, or “watchful waiting.” For thousands of years, before the advent of modern surgical techniques, this was the method by which most miscarriages occurred. Alternatively, if a patient is bleeding heavily, has signs of infection or unstable vital signs, or desires the completion of the miscarriage to occur in a controlled setting, the uterus may be evacuated surgically. This is performed by cervical dilation and suction aspiration, often called D&C (dilation and curettage), although most doctors will try to avoid sharp curettage of the uterus, which may damage the uterine wall leading to future pregnancy complications. A later pregnancy loss (after 13-14 weeks of gestation) may be managed by surgical dilation & evacuation (D&E) or labor induction, but this paper will focus upon the treatment of pregnancy loss in the first trimester.

The middle of the road option for an early pregnancy loss is medical management. This was traditionally provided with misoprostol to induce uterine contractions to expel the pregnancy tissue, although recently some have recommended cervical preparation with mifepristone before the misoprostol is given.⁸ Notably, a recent systematic review concluded that surgical aspiration is the gold standard for treatment of a missed miscarriage (embryonic or fetal demise without immediate expulsion of pregnancy tissue). It has a much higher success rate (98-99%), shorter bleeding duration (three fewer days), and fewer complications compared to medical management.⁹

Research on mifepristone use for miscarriage

Despite mifepristone’s availability since 2000, interest in its use for miscarriage is more recent. In a 2017 Cochrane Database Systematic Review of 24 studies on medical miscarriage management, only misoprostol use was assessed in the studies without the addition of mifepristone.¹⁰ A Randomized Controlled Trial (RCT) published the following year in the New England Journal of Medicine described mifepristone pretreatment followed by misoprostol in 148 women diagnosed with miscarriage compared to 149 women who received misoprostol alone, finding that complete expulsion occurred in 83.8% vs 67.1% of cases, respectively. Uterine aspiration was required in 8.8% vs. 23.5%.¹¹ An Indian RCT published that same year also demonstrated improvement with mifepristone pretreatment before misoprostol, significantly increasing the complete expulsion rate, with 86.7% vs. 57.8% of cases achieving complete expulsion, respectively. Correspondingly, this reduced the need for surgical evacuation, with only 13.3% in the mifepristone pre-treatment group needing surgery compared to

⁸ ACOG Practice Bulletin No. 200: Early Pregnancy Loss. Obstet Gynecol 2018 Nov;132(5):e197-e207.

⁹ Wei K, Huang S, Deng L, et al. “Comparative Efficacy and Safety of Medical and Surgical Management for Missed Miscarriage: A Systematic Review and Meta-analysis.” *Frontiers in Medicine*. 2026;113:1801007.

¹⁰ Kim C, Bernard S, Neilson JP, et al. “Medical Treatments for Incomplete Miscarriage.” *Cochrane Database Syst Rev*. 2017 Jan 31;1(1):CD007223.

¹¹ Schreiber C, Creinin M, Atrio J, et al. “Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss.” *N Engl J Med* 2018;378:2161-2170.

42.2% in the misoprostol-only group.¹² Demonstrating the newness of this treatment option, a 2019 systematic review concluded there was “mixed evidence of low confidence suggest[ing] increased effectiveness for MIFE+MISO compared to MISO alone.”¹³

A 2020 RCT from the United Kingdom documented failures requiring aspiration in 17% of the mife/miso cohort (n=355) compared to 25% in the miso cohort (n=353), a more modest benefit.¹⁴ An additional 2021 Cochrane Database Systematic Review found that only three of seven studies showed statistically significant improvements in complete uterine evacuation following the addition of mifepristone, and only one of six showed statistically significant improvement in the need for a surgical procedure after mifepristone was added.¹⁵ A 2022 RCT from the Netherlands evaluating economic factors reported 79.1% complete expulsion after mife/miso and 58.7% after miso alone, causing the investigators to conclude it was overall more cost-effective to prioritize the use of mife/miso over miso alone.¹⁶ In a small 2023 European RCT, 94.3% of mife/miso cases resulted in complete expulsion (n=105) and 82.5% of miso alone cases had complete expulsion (n=103).¹⁷ A 2025 Systematic Review of 12 studies reported that overall success was statistically improved with the mifepristone and misoprostol combination compared to misoprostol alone.¹⁸

Professional recommendations

In 2018, the American College of Obstetrics & Gynecologists (ACOG), based on the limited data available at that time, recommended that adding mifepristone to misoprostol for medical management of miscarriage “may significantly improve treatment efficacy.”¹⁹ In 2022, ACOG filed a citizen’s petition asking the FDA to add miscarriage management as an indication on mifepristone’s label.²⁰

¹² Sinha P, Suneja A, Guleria K, et al. “Comparison of Mifepristone Followed by Misoprostol with Misoprostol Alone for Treatment of Early Pregnancy Failure: A Randomized Double-Blind Placebo-Controlled Trial.” *J Obstet Gynecol India* 2018;68(1):39-44.

¹³ Al Wattar B, Murugesu N, Tobias A, et al. “Management of First-trimester Miscarriage: A Systematic Review and Network Meta-analysis.” *Hum Reprod Update* 2019;25(3):362-374.

¹⁴ Chu J, Devall A, Beeson L, et al. “Mifepristone and Misoprostol Versus Misoprostol Alone for the Management of Missed Miscarriage (MifeMiso): A Randomised, Double-blind, Placebo-controlled Trial.” *The Lancet*. 2020; 396(10253): 770–778.

¹⁵ Ghosh J, Papadopoulou A, Devall A, et al. “Methods for Managing Miscarriage: A Network Meta-analysis.” *Cochrane Database of Systematic Reviews* 2021(6):CD012602, p. 212-216.

¹⁶ Hamel C, Snijders M, Coppus S, et al. “Economic Evaluation of a Randomized Controlled Trial Comparing Mifepristone and Misoprostol with Misoprostol Alone in the Treatment of Early Pregnancy Loss.” *PLoS One*. 2022 Feb 9;17(2):e0262894.

¹⁷ Bettencourt-Silva B, Rego MT, Miranda C, et al. “The Role of Mifepristone on First Trimester Miscarriage Treatment – A Double-blind Randomized Controlled Trial – MiFirsT.” *European Journal of Obstetrics & Gynecology and Reproductive Biology* 2023;289:145-151.

¹⁸ Pirrami R, Reinert J. “Efficacy and Safety of Mifepristone and Misoprostol Compared to Misoprostol Alone for the Resolution of Miscarriage and Intrauterine Fetal Death: A Systematic Review and Meta-Analysis.” *Annals Pharmacother* 2025 Jul;59(7):636-647.

¹⁹ ACOG Practice Bulletin No. 200: Early Pregnancy Loss. *Obstet Gynecol* 2018 Nov;132(5):e197-e207.

²⁰ ACOG Citizen’s Petition to FDA. October 4, 2022. <https://fdapetitions.com/wp-content/uploads/2019/04/2022P-2425.01.pdf>.

The Society of Obstetricians & Gynaecologists of Canada published more nuanced advice in 2025. They recommended that “clinicians should use mifepristone and misoprostol or multidose misoprostol alone for medical management of early pregnancy loss (gestational sac present)” and that “[c]linicians should use a misoprostol-only regimen when patients request medical management of incomplete Early Pregnancy Loss (thickened endometrium with no gestational sac present).” Both suggestions were counted as “strong” recommendations, based on high-quality data.²¹ The Canadian Society seemed to be acknowledging that mife/miso and miso alone may be similar in efficacy (since they did not provide a strong recommendation preferring mife/miso). Omitting mifepristone from the recommendation for treatment of an incomplete miscarriage (when some but not all tissue has passed through the cervix) indicates an acknowledgement that mifepristone’s primary contribution is cervical preparation before dilation, and thus mifepristone may not be indicated in miscarriages if the cervix is already dilated.

What are doctors doing in practice?

Despite the recommendations from professional societies, it appears that very few miscarriages are medically managed with both mifepristone and misoprostol. A 2024 retrospective cohort study of 31,977 miscarriages managed medically discovered that only 3% were treated with mife/miso and 97% were treated with miso alone. Rates of uterine aspiration were 10.5% and 14%, respectively.²² Although the number of mifepristone prescribers registered through the FDA REMS program is unknown, it is likely that many health care practitioners do not have the ability to prescribe mifepristone and thus are not able to use it in medical miscarriage management. A 2023 Kaiser Family Foundation survey of practicing ob/gyns found that only 14% prescribe mifepristone for in-person abortions.²³

A recent JAMA study utilizing an insurance claims database implied that miscarriage management is worse in pro-life states after the *Dobbs* decision, but inadvertently documented that mifepristone is still used in only a minority of miscarriages. Expectant management of miscarriage occurred in 73.2% of cases pre-*Dobbs* and 76.7% of cases post-*Dobbs* in states with abortion limitations, and in 69.7% of cases pre-*Dobbs* and 70.4% of cases post-*Dobbs* in states without abortion limitations (that is, nearly three-fourths of miscarriages in all states were managed expectantly). Surgical management occurred in 17.9% of cases pre-*Dobbs* and 15.5% of cases post-*Dobbs* in pro-life states and 19.6% of cases pre-*Dobbs* and 17.5% of cases post-*Dobbs* in pro-choice states (that is, approximately one in six miscarriages were treated with surgery in all states). Medication management occurred rarely: in 8.9% of cases pre-*Dobbs* and 7.9% of cases post-*Dobbs* in pro-life states and in 10.7% of cases pre-*Dobbs* and 12.1% of

²¹ Pymar H, Waddington A, Prager S, et al. “SOGC Clinical Practice Guideline 460: Diagnosis and management of intrauterine early pregnancy loss.” *J Obstet Gynecol Canada* 2025;47(s1):102914.

²² Benson L, Gunaje N, Holt S, “Outcomes After Early Pregnancy Loss Management With Mifepristone Plus Misoprostol vs Misoprostol Alone.” *JAMA Network Open*. 2024;7(10):e2435906.

²³ Brittni Frederiksen, Usha Ranji, Ivette Gomez, Alina Salganicoff, “A National Survey of OBGYNs’ Experiences After *Dobbs*.” KFF. July 21, 2023. <https://www.kff.org/womens-health-policy/a-national-survey-of-obgyns-experiences-after-dobbs/>.

cases post-*Dobbs* in pro-choice states (approximately one in ten). Of miscarriages treated medically, mife/miso was used in 1.9% of cases pre-*Dobbs* and 3.1% of cases post-*Dobbs* in pro-life states and in 15.9% of cases pre-*Dobbs* and 31.5% of cases post-*Dobbs* in pro-choice states. Across the U.S., the vast majority of medical management of miscarriage is still performed with misoprostol alone.²⁴

In a 2023 study by Benson et al., there seemed to be a difference in treatment options recommended in emergency departments vs. outpatient clinics. Patients with private insurance evaluated in the ER were less likely to receive surgical management than if they sought care in an outpatient clinic (14.0% , 24.3%, respectively) or to receive medical management (5.4% vs, 11.2%, respectively). However, the study did not distinguish between mife/miso and miso only provision. These findings reflect the likelihood that if a miscarriage diagnosis is made in the ER in the absence of a true emergency, patients may be told to follow-up with their primary ob/gyn rather than being offered active miscarriage management.²⁵ It is also possible that diagnostic uncertainty in the ER may cause the provider to hesitate to recommend definitive treatment.

Are there other concerns regarding mifepristone use to resolve miscarriages?

Some have raised concerns that rare complications following mifepristone use may not be detected in the limited studies on miscarriage use. For example, a 2007 article proposed a pathologic mechanism by which mifepristone could predispose to excessive hemorrhage.²⁶ Indirect evidence for this was provided in a very small RCT evaluating progesterone use after mifepristone in women who regretted beginning a mifepristone abortion (before misoprostol was taken). The study was stopped early due to 3 of 10 enrolled women experiencing hemorrhage after taking mifepristone (2 of the 3 required surgery and one required a transfusion).²⁷

Additional concerns have been expressed about a possible increased risk of atypical sepsis, for which the FDA maintains the following boxed warning on mifepristone: "Serious and sometimes fatal infections or bleeding occur very rarely ... following Mifeprex use."²⁸ A cluster of four deaths in California women following mifepristone abortions led to the formation of a working group in 2006,²⁹

²⁴ Rodriguez MI, Fuerst M, Schrote K. "Management of Spontaneous Abortion Among Commercially Insured Individuals in the United States After *Dobbs v. Jackson*." JAMA 2026; 336(1): 48-55. doi:10.1001/jama.2026.6344.

²⁵ Benson L, Holt S, Gore J. "Early Pregnancy Loss Management in the Emergency Department vs Outpatient Setting." JAMA Netw Open 2023;6(3):e232639.

²⁶ Miech R, "Pathopharmacology of Excessive Hemorrhage in Mifepristone Abortions." Annals of Pharmacotherapy 2007;41(12):2002-2007.

²⁷ Creinin M, Hou M, Dalton L, et al. "Mifepristone Antagonization with Progesterone to Prevent Medical Abortion: A Randomized Controlled Trial." Obstet Gynecol 2020;135(1):158-165.

²⁸ Mifeprex (mifepristone) tablets Label. FDA.gov.

https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf.

²⁹ "Experts Split on Abortion Pill's Role in 4 Deaths." NBC News. May 17, 2006.

<https://www.nbcnews.com/id/wbna12842383>.

and additional research postulated the likely etiology of these tragic events.³⁰

Not all of the RCTs cited above specifically addressed the question of comparative hemorrhage and infection, so the data is sparse. In the previously mentioned 2018 New England Journal of Medicine study, “[b]leeding that resulted in blood transfusion occurred in 2.0% of the women in the mifepristone-pretreatment group and in 0.7% of the women in the misoprostol-alone group,” although rates of pelvic infection were the same, “diagnosed in 1.3% of the women in each group.”³¹ The 2021 Cochrane Database Systematic Review did not show a statistically significant difference in rates of pelvic inflammatory disease, sepsis, or endometritis between the two groups in the five studies that measured these factors. Only two studies measured bleeding, and the differences were not statistically significant.³² Differences in blood transfusion and infection were not found to be statistically significant in the 2025 Systematic Review.³³ However, due to the limited evidence thus far, additional research is warranted to examine more closely whether mifepristone is likely to increase the risk of these rare but potentially clinically significant harms.

Other uses for mifepristone

Because of its hormonal blocking effects on progesterone and glucocorticoid receptors, mifepristone can theoretically be used for any condition that is caused or worsened by these hormones. Thus, a litany of other uses have been proposed.

In addition to its approval for induced abortion, mifepristone is currently FDA-approved in a different dose to improve control of high blood sugars caused by high cortisol levels in adults with Cushing's syndrome (under the brand name “Korlym,” with the dosage 300 mg daily instead of 200 mg once along with misoprostol 800 mcg for induced abortion). This patient population includes those who have failed or are unable to undergo surgical treatment.³⁴ Endocrinology consensus recommendations reported by Brown et al. in a 2020 study, however, affirm that surgical treatment is the first-line treatment for patients with Cushing's syndrome. They also report that other treatment options include pituitary radiation, pituitary-directed medical agents, and steroid synthesis inhibitors, in addition to glucocorticoid receptor (GR) antagonists like Korlym. The authors of the study note that mifepristone-

³⁰ Cohen A, Bhatnagar J, Reagan S, et al. “Toxic Shock Associated With *Clostridium sordelli* and *Clostridium perfringens* After Medical and Spontaneous Abortion.” *Obstet Gynecol* 2007;110(5):1027-1033; Miech, R. “Pathophysiology of Mifepristone-Induced Septic Shock Due to *Clostridium sordellii*.” *Annals of Pharmacotherapy*. 2005;39(9): 1483-1488; Fischer M, Bhatnagar J, Guarner J, et al. “Fatal Toxic Shock Syndrome Associated with *Clostridium sordellii* after Medical Abortion.” *N Engl J Med* 2005;353:2352-2360.

³¹ Schreiber C, Creinin M, Atrio J, et al. “Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss.” *N Engl J Med* 2018;378:2161-2170.

³² Ghosh J, Papadopolou A, Devall AJ, et al. “Methods for managing miscarriage: a network meta-analysis.” *Cochrane Database of Systematic Reviews* 2021, Issue 6. Art. No.: CD012602, p. 212-216.

³³ Pirrami RG, Reinert JP. “Efficacy and Safety of Mifepristone and Misoprostol Compared to Misoprostol Alone for the Resolution of Miscarriage and Intrauterine Fetal Death: A Systematic Review and Meta-Analysis.” *Annals of Pharmacotherapy*. 2025;59(7):636-647.

³⁴ Korlym label. FDA.gov. https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/2021075008lbl.pdf.

associated adverse effects may include “symptoms of cortisol withdrawal, hypokalemia, and change in thyroid function; effects related to its antiprogesterone activity; and rash.” They concluded that “[s]afe and effective use of mifepristone requires clinical judgment and close patient monitoring to ensure optimal clinical outcomes.”³⁵

A 2023 systematic review of clinical indications for mifepristone, in addition to noting mifepristone’s use for Cushing’s syndrome, reported that mifepristone produces “therapeutic effects in the treatment of some psychiatric disorders, such as major depressive disorder and psychotic depression,” and is a “successful treatment option for adenomyosis and leiomyomas.” These researchers proposed mifepristone has “immense potential to provide symptomatic relief in patients suffering from a wide array of complicated diseases” and offered reassurance that mifepristone has been “proven to have an incredible safety profile.”³⁶

It should be noted again, however, that mifepristone is one of a plethora of options for treating these disorders. In 2019, the FDA listed seven classes of drugs (not including progesterone/glucocorticoid receptor antagonists like mifepristone) effective for treating depression.³⁷ Similarly, in 2025, the FDA listed five classes of drugs (including selective progesterone receptor modulators, of which mifepristone is one of several listed options) that can be used to treat leiomyomas (fibroids), in addition to surgery and other procedures.³⁸ A 2021 review of treatment options for adenomyosis listed eleven classes of drugs that could be used for treatment in addition to surgery. Mifepristone was not included.³⁹

Additional proposed uses include reducing the risk of developing breast cancer in high-risk women⁴⁰ and extending a person’s lifespan by enhancing mitophagy, the process that clears mitochondria.⁴¹ However, these are only theoretical benefits, as no clinical trials have been performed to evaluate these uses. It should also be acknowledged that since mifepristone has effects on two separate endocrine systems (reproductive and adrenal systems), a beneficial effect in one system may be negated by a non-beneficial effect in the other system. Mifepristone has been associated with many adverse effects and drug-drug interactions.⁴²

³⁵ Brown, D.R., East, H.E., Eilerman, B.S. et al. “Clinical management of patients with Cushing syndrome treated with mifepristone: consensus recommendations.” *Clin Diabetes Endocrinol* 6, 18 (2020).

³⁶ Mathew S, Ticsa MS, Qadir S, et al. “Multiple Clinical Indications of Mifepristone: A Systematic Review.” *Cureus*. 2023 Nov 6;15(11):e48372.

³⁷ “Depression Medicines.” FDA.gov. <https://www.fda.gov/consumers/womens-health-topics/depression-medicines>.

³⁸ “Uterine Fibroids.” FDA.gov. <https://www.fda.gov/consumers/womens-health-topics/uterine-fibroids#How%20are%20fibroids%20treated>.

³⁹ Sharara FI, Kheil MH, Feki A, et al. “Current and Prospective Treatment of Adenomyosis.” *J Clin Med*. 2021 Jul 30;10(15):3410. doi: 10.3390/jcm10153410.

⁴⁰ Utjes D, Alkasalias T, Cameron ST, et al. “The Potential Role of Mifepristone in Breast Cancer Prevention: Beyond Medical Abortion.” *Lancet Obstet Gynecol Women’s Health* 2025; 1, e146-e148.

⁴¹ “Extending Lifespan: Scientists Discover Potential New Use for Widely Known Drug.” *SciTechDaily*. March 5, 2025. <https://scitechdaily.com/extending-lifespan-scientists-discover-potential-new-use-for-widely-known-drug/>.

⁴² Autry BM, Wadhwa R. “Mifepristone.” *StatPearls*. <https://www.ncbi.nlm.nih.gov/books/NBK557612/>.

Even weight loss has been postulated as another potential benefit of mifepristone, but a RCT studying the use of mifepristone with inadequately controlled type II diabetes with hypercortisolism demonstrated only a slight, non-statistically significant difference in body weight and waist circumference. Notably, nearly half (46%) of the mifepristone group discontinued treatment due to side effects.⁴³

There have been several failed applications of mifepristone. A trial adding mifepristone to methotrexate for treatment of ectopic pregnancy showed no significant difference over methotrexate treatment alone.⁴⁴ A Dutch study of mifepristone used as a contraceptive was stopped early when an “unexpectedly high number of participants became pregnant.” This decision was also “driven by concerns over ectopic pregnancies observed during the trial.”⁴⁵

Other untoward effects have been documented. A case report expressed concern that a woman being treated long-term with mifepristone for Cushing’s syndrome developed massive simple endometrial hypertrophy (a potentially pre-malignant condition) and a markedly enlarged uterus, but both problems resolved after mifepristone was discontinued.⁴⁶

Conclusion

Although many non-abortion uses of mifepristone have been proposed, it is critical to recognize that there is no medical condition unrelated to abortion for which mifepristone is the only, or always the preferred, treatment option. Even when mifepristone could be a treatment option for a non-abortion-related medical condition, such as miscarriage management, it is standard care for a physician to evaluate a patient to confirm the diagnosis and determine eligibility for mifepristone treatment, as well as provide supportive care during and after the miscarriage process.⁴⁷

The current FDA REMS regulations, which allow prescribing of mifepristone remotely with distribution through the mail, have led to frequent unsupervised use without pre-abortion testing.⁴⁸ This would not be an acceptable option for prescribing the drug for any of the other potential uses listed above, and it should not be considered acceptable for women seeking abortion. Thus, to emphasize again, even in

⁴³ DeFronzo RA, Fonseca V, Aroda VR, et al. “Inadequately Controlled Type 2 Diabetes With Hypercortisolism: Improved Glycemia With Mifepristone Treatment.” *Diabetes Care* 2025;48(12):2036-2044.

⁴⁴ Feng C. “Predictors for the Efficacy of Methotrexate and Mifepristone Treatment in Ectopic Pregnancy.” *J of Gynecology, Obstetrics and Human Reproduction* 2025; 54(10).

⁴⁵ “Dutch Study of New Contraceptive Halted After Many Pregnancies, Several Ectopic Cases” *NL Times*. June 3, 2026. <https://nltimes.nl/2026/06/03/dutch-study-new-contraceptive-halted-many-pregnancies-several-ectopic-cases>.

⁴⁶ Newfield RS, Spitz IM, Isacson C, New MI. “Long-term Mifepristone (RU486) Therapy Resulting in Massive Benign Endometrial Hyperplasia.” *Clin Endocrinol* 2001;54(3):399-404.

⁴⁷ “ACOG Practice Bulletin No. 200: Early Pregnancy Loss.” *Obstet Gynecol* 2018 Nov;132(5):e197-e207.

⁴⁸ Mia Steupert, “An Overview of Online Abortion Drug Access in Post-Dobbs America.” *Charlotte Lozier Institute*. May 26, 2026. <https://lozierinstitute.org/an-overview-of-online-abortion-drug-access-in-post-dobbs-america/>.

cases in which mifepristone may be helpfully used for alternative indications, simply reinstating the in-person dispensing requirement should not impact mifepristone's proper use for these other indications.

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