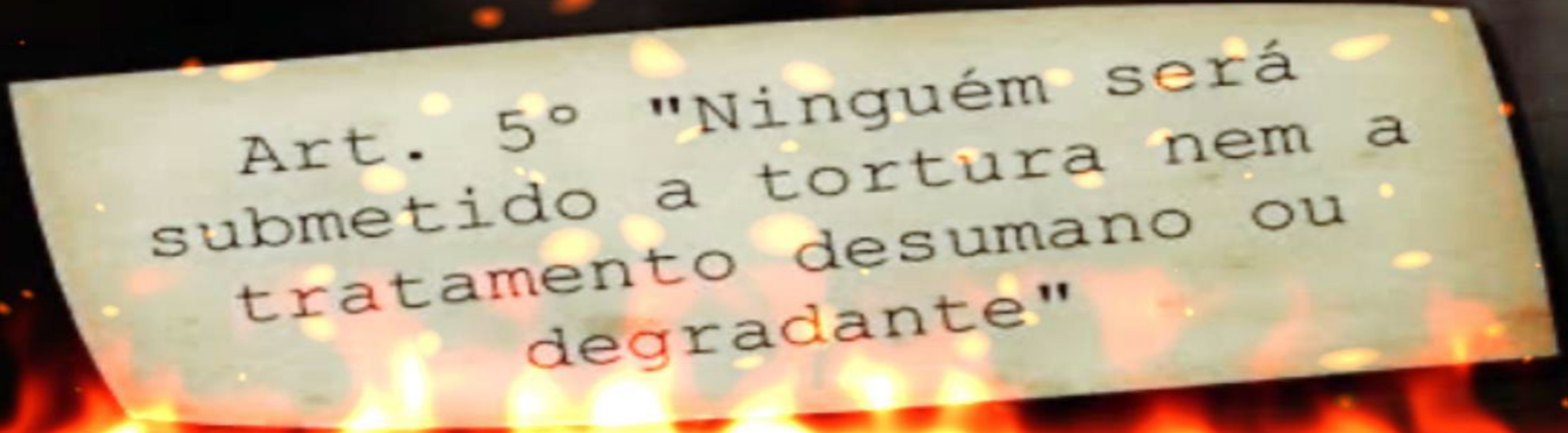

17 DE JUNHO
Horário: 9h
Local: Plenário do Senado Federal
Sessão de Debates Temáticos para discutir a
TORTURA FETAL


AUTORIZADO
QUEIMAR CRIANÇA

26 de Junho

Dia Internacional de Apoio às Vítimas de Tortura



MPF
Ministério Público Federal

RECOMENDAÇÃO Nº 6/2022/MPF/PRMG/PRDC, de 5 de maio de 2022

Ref.: NF-e nº 1.22.000.001276/2022-14

O **MINISTÉRIO PÚBLICO FEDERAL**, por meio do Procurador Regional dos Direitos do Cidadão em Minas Gerais infra-assinado, no uso de suas atribuições legais e constitucionais, com base no art. 129, II e III, da Constituição Federal de 1988, no art. 6º, XX, da Lei Complementar n.º 75/93 e nos termos da Resolução CSMPF nº 87/2006;

CONSIDERANDO que o Ministério Público Federal é instituição permanente, essencial à função jurisdicional do Estado, incumbido da defesa da ordem jurídica, do regime democrático e dos interesses sociais e individuais indisponíveis, conforme dispõe o art. 127 da Constituição Federal e o art. 1° da LC nº 75/1993;

CONSIDERANDO que compete ao Ministério Público Federal expedir recomendações, visando à **melhoria dos serviços públicos e de relevância pública**, bem como ao respeito, aos interesses, direitos e bens cuja defesa lhe cabe promover, fixando prazo razoável para a adoção das providências cabíveis, conforme previsto no art. 6º, inciso XX, da Lei Complementar nº 75/1993;

SOCIETY of FAMILY PLANNING
research, education, and leadership

Contraception xx (2010) xxx–xxx

Clinical Guidelines

Induction of fetal demise before abortion

Release date January 2010
SFP Guideline 20101

Abstract

For decades, the induction of fetal demise has been used before both surgical and medical second-trimester abortion. Intracardiac potassium chloride and intrafetal or intra-amniotic digoxin injections are the pharmacologic agents used most often to induce fetal demise. In the last several years, induction of fetal demise has become more common before second-trimester abortion. The only randomized, placebo-controlled trial of induced fetal demise before surgical abortion used a 1 mg injection of intra-amniotic digoxin before surgical abortion at 20–23 weeks' gestation and found no difference in procedure duration, difficulty, estimated blood loss, pain scores or complications between groups. Inducing demise before induction terminations at near viable gestational ages to avoid signs of life at delivery is practiced widely. The role of inducing demise before dilation and evacuation (D&E) remains unclear, except for legal considerations in the United States when an intact delivery is intended. There is a discrepancy between the one published randomized trial that used 1 mg intra-amniotic digoxin that showed no improvement in D&E outcomes and observational studies using different routes, doses and pre-abortion intervals that have made claims for its use. Additional randomized trials might provide clearer evidence upon which to make further recommendations about any role of inducing demise before surgical abortion. At the current time, the Society of Family Planning recommends that pharmacokinetic studies followed by randomized controlled trials be conducted to assess the safety and efficacy of feticidal agents to improve abortion safety.

Keywords: Abortion; Feticide; Feticidal agents; Dilation or dilatation and evacuation; Potassium chloride; Digoxin; Transection umbilical cord; Partial Birth Abortion Ban Act; Selective termination; Multifetal pregnancy reduction

Background

Induced abortion is the second most common surgery for reproductive-aged women in the United States, after cesarean delivery [1,2]. The safety of this common procedure is well-established [3]. Surgical and medical methods of abortion can be performed safely in the second trimester, and even in the third trimester when pregnancy termination usually is completed by medical induction for lethal fetal anomalies or other significant medical conditions affecting the pregnant woman [4].

During the past three decades, many modalities for causing fetal demise (often described as "feticide" in the medical literature) have been used. In the last several years, induction of fetal demise has become more common before second-trimester abortion, as well as for selective fetal reduction. Improved methods of inducing ovulation, and treatments such as in vitro fertilization (IVF) and gamete intrafallopian transfer (GIFT), have increased the rate of multiple pregnancies; almost 70% of twins and 99% of all higher-order multiple pregnancies are now iatrogenic [5]. In addition, since the Supreme Court of the United States upheld the case of *Gonzalez v. Carhart* — affirming the constitutionality of the Partial-Birth Abortion Ban Act of 2003 (the Act) — many abortion providers have begun to induce and document fetal demise before an abortion begins, to avoid any potential accusations of intending to violate the law.

Since the early 1980s, various modalities of inducing fetal demise have been documented. Aberg et al. [6] published the first successful selective termination in 1978 by intracardiac puncture, and soon thereafter many techniques for multifetal pregnancy reduction, selective termination and inducing demise in singletons were investigated. However, most of these cases and studies did not precede abortion.

Mechanical methods

The first documented selective termination was performed on a single fetus of a twin pregnancy discordant for Hurler's disease [6]. This occurrence led to research for better techniques to terminate selectively pregnancies found to be discordant for anomalies, as well as to reduce higher-order multiple gestations to triplets, twins or singletons in

0010-7824/$ – see front matter © 2010 Elsevier Inc. All rights reserved.
doi:10.1016/j.contraception.2010.01.018

A pharmacokinetic study was performed to describe patient serum absorption after 1 mg intra-amniotic digoxin injection. Eight patients received baseline coagulation labs and had a Holter cardiac monitor placed before their digoxin injection. They were observed in the hospital overnight, and serial serum digoxin levels were drawn during the 24 h preceding their abortion. No digoxin-associated arrhythmias or clinically significant cardiac events occurred, and patient serum digoxin levels were not within a toxic range [65].

There has been one randomized trial of intra-amniotic digoxin vs. placebo, in which 126 women were randomized to receive a dose of 1 mg digoxin or normal saline via amniocentesis. The injection occurred before laminaria were placed, 24 h before the abortion. There was a failure rate of 8% to achieve cessation of cardiac activity, documented by ultrasonography before the D&E [68]. The retrospective cohort analysis by Molaei et al. [69] assessed varying doses of intra-amniotic digoxin (from 0.125 to 0.5 mg) and found an overall failure rate of 31% by this route.

The same study assessed varying doses of intrafetal digoxin and reported no failure to induce demise at a 1 mg dose among any of 107 patients. Overall, the failure rate of various doses of intrafetal digoxin was 5%. They reported no adverse events suggesting digoxin toxicity, and there was no increase in anti-emetic medicines prescribed, but information was not collected from patients about these side effects [69].

Transection of umbilical cord

Dilation of the cervix and transection of the umbilical cord were first described in the English medical literature in 1972 [70]. Recently, some providers have had success with umbilical transection techniques performed during multifetal pregnancy reduction and selective termination endoscopic procedures [82–91] or under sonographic guidance alone [92–94]. Although these techniques described in the selective reduction literature are far more invasive and bear more risk than other methods of feticide before an abortion is performed, they relate an important concept. After the umbilical cord has been divided, fetal cardiac activity ceases. This suggests an additional method of inducing demise before abortion that has yet to be investigated rigorously: the feasibility of direct cord transection before surgical termination of pregnancy.

6. What is the effectiveness of feticidal agents in achieving fetal demise?

Data are summarized in Table 1. In recent literature, KCl has shown excellent efficacy at achieving fetal

Table 1
Efficacy

Author	Year	Regimen	Dose	*n*	Gestation	First injection failure rate
Molaei et al. [69]	2008	Intra-amniotic digoxin	0.125 mg	22	17–24	46%
		Intra-amniotic digoxin	0.25 mg	20	17–24	70%
		Intra-amniotic digoxin	0.375 mg	53	17–24	26%
		Intra-amniotic digoxin	0.5 mg	36	17–24	8%
Jackson et al. [68]	2001	Intra-amniotic digoxin	1.0 mg	62	20–23	8%
Drey et al. [65]	2000	Intra-amniotic digoxin	1.0 mg	8	19–23	0%
Molaei et al. [69]	2008	Intrafetal digoxin	0.125 mg	98	17–24	14%
		Intrafetal digoxin	0.25 mg	466	17–24	6%
		Intrafetal digoxin	0.5 mg	993	17–24	4%
		Intrafetal digoxin	1.0 mg	107	17–24	0%
Hern [66]	2001	Intrafetal digoxin[a]	1.5–2 mg[a]	1677	18–34	0%
Hern et al. [67]	1993	Intrafetal digoxin[a]	1.5–2 mg[a]	118[b]	15–34	0%
Pasquini et al. [57]	2008	Intracardiac KCl	6–10 mEq	124	20–36	0%
Hern [53]	2004	Intracardiac KCl	6–40 mEq	4	32+	0%[c]
Bhide et al. [47]	2002	Intracardiac KCl	8–40 mEq	73	18–35	0%
Eddleman et al. [48]	2002	Intracardiac KCl	6–18 mEq	200	12–24	0%[d]
Bhide et al. [47]	2002	Intrafunic KCl	6–16 mEq	21	17–33	9%[f]
Senat et al. [58]	2002	Intrafunic KCl	20 mEq	10	22–38	0%
Gill et al. [52]	1994	Intrafunic KCl	5–10 mEq	60	18–32	13%
Evans et al. [51]	1999	Intracardiac or intrafunic KCl	Not reported	369	9–25+	Not reported
Berkowitz et al. [46]	1997	Intracardiac or Intrafunic KCl	3–10 mEq	100	12–23	Not reported
Evans et al. [50]	1996	Intrathoracic KCl[e]	Not reported	1789	Not reported	Not reported
Evans et al. [10]	1994	Intrathoracic KCl[e]	Not reported	1084	6–11	Not reported
Evans et al. [95]	1993	Intrathoracic KCl	Not reported	463	6–14	0%[d]

[a] Study administered 40 g intrafetal hyperosmolar urea after digoxin in patients over 24 weeks of gestation.
[b] Exact number of total patients to receive interventions was not stated.
[c] Demise was induced in all cases; however, 75% required a second injection.
[d] Induction of demise was 100% successful, but required one or more injections when the first failed to cause asystole, and the number of re-injections required was not reported.
[e] Includes transabdominal, transcervical and transvaginal routes of intrathoracic KCl.
[f] In one case, demise was not achieved. In a second case, demise was achieved with a second injection.

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The Supreme Court's decision explicitly permits providers to complete a "standard D&E," a definition that can include multiple passes with the use of extracting forceps. On the other hand, serial dilation or osmotic dilators with adjuvant misoprostol may be viewed as intent to perform the banned procedure.

Those providers electing not to use the injection of a feticidal agent before performing a standard D&E should know that they still may be protected against performing the banned procedure by documenting their intended procedure as long as they have not performed any dilatory procedures that show intent to perform the banned procedure. The "standard dilation and evacuation" is defined by the Supreme Court decision in part by multiple passes required to complete a destructive procedure. The standard D&E is not an attempt to "deliver" a "living fetus"; this is especially true considering the landmarks demarcated by the Act. By its Supreme Court definition, a "standard D&E" excludes the deliberate and intentional delivery of an intact fetus. If delivery of a more intact fetus were to occur during an intended "standard D&E," it was neither a deliberate nor an intentional act.

Because the terms "Partial Birth Abortion" and "Standard D&E" are not defined or recognized medically, nor do they have clear surgical definitions, the Society of Family Planning is not able to make any evidence-based

The most common technique of KCl administration is via transabdominal intracardiac injection performed with ultrasound guidance. Concentrated KCl (2 mEq/mL) is injected in aliquots of 2–3 mL until asystole is observed for 2–5 min [71]. Typically, a total of 6–10 mEq is needed. An ultrasound may be repeated 30 min to 1 h later to confirm the absence of cardiac activity. In addition to verifying asystole, ultrasound is crucial in determining intracardiac placement of the injection needle. This technique was advocated by the Royal College of Obstetricians and Gynaecologists (RCOG) before medical termination at 22 weeks of gestation or greater and before all induction terminations [79,80]; however, the more recently published and more general RCOG guidelines for abortion care include no recommendation about the use of potassium injection before abortion, because "the nature of the procedure ensures that there is no risk of a live birth" [81].

There are no RCTs comparing routes of administering concentrated KCl. A large retrospective review compared 846 transabdominal procedures to 238 transcervical procedures. All cases were ultimately successful, although 1% required a second injection to achieve cardiac asystole. Their study focused on delivery rates after selective termination or multifetal pregnancy reduction. However, little data were reported about the feticidal injection itself [10].

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Digoxin

GAZETA DO POVO
Sexta-feira, 14 de Junho de 2024.

Artigo

O que um feto, filho de um cantor da MPB, pode ensinar a Alexandre de Moraes?

Por **Danilo de Almeida Martins** 21/05/2024 08:02

48 COMENTÁRIOS


SALVE
SALVEMOS
AS 2 VIDAS
Projeto SALVE
DEFENSORES DA VIDA.