2009 Affidavit: 100% of "Suction" Abortions Violate the 1947 Nuremberg Code and Increase Women's Risk of Subsequent Premature Births

I, Brent Rooney, MSc, affirm to the best of my knowledge, that all of the following statements by me are true:

1. My name is Brent Rooney; my mailing address is:
   3456 Dunbar St. (#146) Vancouver, Canada V6S 2C2
   The following are email accounts owned by Brent Rooney:
   fullterm40@gmail.com stopcancer@yahoo.com whatsup@vcn.bc.ca

2. Brent Rooney is the lead author of a May 2003 study published in the Journal of American Physicians and Surgeons that was critical to the U.S. state of Texas warning Texas women that prior IAs (Induced Abortions) raise their risk of later preterm newborns (gestation under 37 weeks) with serious handicaps such as Cerebral Palsy;
   URL: http://www.jpands.org/vol8no2/rooney.pdf ; Texas warnings:
   URL: http://www.dshs.state.tx.us/wrtk/pdf/booklet.pdf (page 17).

   My co-author was Dr. Byron Calhoun (Obstetrics & Gynecology professor at West Virginia University). The May 2003 Rooney/Calhoun study has never in 71 months been challenged via a 'letter to the editor' (email: editor@jpands.org); there is NO TIME LIMIT to a challenge. Brent Rooney (MSc) and Dr. Byron Calhoun provided overwhelming evidence via an extensive review of the APB (Abortion Preterm Birth) literature that prior induced abortions (IAs) raise preterm birth risk.

3. My publishing credits in the premature birth field are listed in point 32.

4. Premature newborns have raised risk of CP (Cerebral Palsy), mental retardation, autism, epilepsy, respiratory distress, blindness, deafness, serious infections, & gastrointestinal injury, compared to full-term newborns. [Behrman, 1] Example: the 2008 Dr. Eveline Himpens et al. meta-analysis reported that newborns between 28 and 31 weeks' gestation have 55 times the CP risk as full-term newborns.[Himpens, 2]

5. The U.S. has a very high preterm birth rate relative to other developed countries. In 2006 12.8% of U.S. newborns (over 500,000) were born prematurely.[Martin, 3]

6. About 2.04% of U.S. babies in 2006 were born very prematurely (under thirty-two weeks' gestation).[Martin, 3] Some may believe that 2.04% is a small per cent & should be ignored. A majority of 'preemie' deaths are

inflicted on very preterm newborns, even though very preterm newborns only comprise about 15% of the total yearly U.S. 'preemie' population.

7. Newborns with a birth weight under 1,500 grams (3 pounds 5 ounces) are termed Very Low Birth Weight (VLBW) and a majority of VLBW newborns are born very prematurely (under 32.0 weeks' gestation).

8. A statistically significant study is one in which the researchers are at least 95% confident of increased risk or are at least 95% confident of lowered risk. Generally, statistically significant studies fetch much more respect and concern by medical professionals than studies that are not statistically significant.

9. As of 27 April 2009 Brent Rooney is aware of eighteen (18) statistically significant studies of AVP (Abortion and Very Preterm birth) risk or AVLBW (Abortion and Very Low Birth Weight) risk. All 18 significant studies report that prior abortions elevate risk.[A1-A18] If it was true (it is NOT) that IAs have no effect on preterm (or VLBW) risk, then about half of the eighteen studies should have found lower, not higher, risk of very preterm birth or birth weight under 1,500 grams. Not one of the 18 significant studies reported lower risk. There is one chance in 262,144 that all eighteen (18) studies would find higher risk, if prior surgical induced abortions did not actually increase very preterm (or VLBW) risk; ((1 / 2) raised to the power of 18 = 1 / 262144).

10. Value of Competent Review Articles – There are over 130 published studies of IA & subsequent risk of preterm birth and/or low birth weight. No more than 20 or 25 professional researchers have a good knowledge of more than forty or fifty APB studies or ALBW (Abortion-Low-Birth-Weight) studies. Thus, competent REVIEW studies that survey existing literature in this field can enlighten the medical profession whether a purported risk is actually a risk or not. There is also a class of study termed a 'meta-analysis' (or 'study of studies'). A 'meta-analysis' uses data from prior studies (from as low as 2 to as many as well over 50) & computes risk numbers from this combined data. (Low Birth Weight (LBW) is a birth weight under 2,500 grams (5 pounds 8 ounces)).

11. In the 21st century there have been four (4) extensive APB reviews and one APB meta-analysis. An extensive APB review will review at least twenty-four prior APB (Abortion Preterm Birth) or ALBW (Abortion Low Birth Weight) studies. ALL four (4) 21st century APB extensive reviews affirm higher preterm birth risk for women with prior induced abortions compared to women who had zero prior induced abortions. [Thorp, 4; Rooney/Calhoun, 5; Swingle, 6; van Oppenraaij, 18]

12. The February 2009 Dr. Hanes Swingle et al APB meta-analysis was published in the Journal of Reproductive Medicine.[Swingle, 6] 'Swingle' reported the statistically significant result that women with prior IAs have 64% higher relative odds of a very preterm delivery (under 32 weeks' gestation) than women with zero prior IAs. (A copy of the abstract portion of the Swingle meta-analysis is in Attachment A to this April 2009 affidavit.). Swingle also performed an extensive APB review.

13. Lancet is one of the most respected medical journals. Lancet has often published articles and news items that defended the purported 'safety' of induced abortions in past years.

14. On 12 January 2008 Lancet published the 2nd in a serious of three (3) articles about preterm birth with authors of Dr. Jay Iams, Dr. Robert Romero, Dr. Robert L. Goldenberg, and Jennifer F. Culhane (PhD). Dr. Iams, Dr. Romero, and Dr. Goldenberg are very highly regarded preterm birth expert.[Iams, 7]

15. On page 165 (column 1, paragraph 3) of the 12 January 2008 'Iams' Lancet article appears the sentence: "For example, greater public and and professional awareness of evidence of repeated uterine instrumentation—eg. uterine curettage or endometrial biopsy—is associated with an increased risk of subsequent preterm birth might, over time, influence decision-making about these procedures. [2, 9-12]" Some or many people reading the 'Iams' Lancet sentence will not realize that 'Iams' et al. have identified surgical abortions as boosting the risk of subsequent premature births.[Iams, 7]. Continued in point 16 below:

16. Two of the 'Iams' citation numbers for the quoted sentence in 'point' 15 directly above are references "9" and "10". The 'Iams' reference "9" is the 2004 'Ancel' study in Human Reproduction (2004, volume 19, pages 734-740) & his reference "10" is the 2005 'Moreau' study in the British Journal of Obstetrics and Gynaecology (BJOG, 2005, volume 112, pages 430-437). The 2004 'Ancel' study reported that women with one prior IA had 34% higher relative odds of a very preterm delivery (defined as under 33.0 weeks' gestation) compared to women with zero prior IAs; the relative odds became 82% higher for women with more than one prior induced abortion.[Ancel, 9] The 2005 'Moreau' study of French women reported 50% higher relative odds of a very premature delivery (< 33 weeks) for women with prior IAs compared to women with zero prior induced abortions.[Moreau, 10] Statistical significance was achieved by both the 2004 'Ancel' study & the 2005 'Moreau' study. Thus, there is zero doubt that Ohio State Professor Dr. Jam Iams (and co-authors Dr. Robert Romero, Dr. Robert

L. Goldenberg, and Jennifer L. Culhane (PhD)) in the page 165 quote (see 'point' 15) have identified surgical abortions as raising preterm birth risk in subsequent pregnancies.

17. The [U.S.] National Academy of Sciences (NAS) is a very prestigious scientific organization and the Institute of Medicine is a unit of the NAS.

18. In the1st & 2nd editions (2006 & 2007) of a massive textbook about pre-term birth risk factors the Institute of Medicine listed 14 "Immutable Medical Risk Factors Associated with Preterm Birth"; the 3rd of 14 risks is: "Prior first trimester induced abortion".[Behrman, 1] Those 'preemie' risks appear on page 625 of the 2007 edition of the IoM book: "Preterm Birth: Causes, Consequences, and Prevention": http://www.nap.edu/openbook.php?record_id=11622&page=625 . The author of the list of 14 'preemie' risks is Greg Roy Alexander (ScD) who was an eminent reproductive health scientist. Greg Alexander (ScD) died in February 2007. The 14 preterm risks factors are listed in Attachment B.

19. Major Scientific Concept: It is an iron clad convention of all Scientific efforts that the BURDEN of PROOF lies upon those making a claim, NOT upon those disputing a claim.

20. The producers of a new pharmaceutical drug have the BoP (BURDEN of PROOF) squarely on their shoulders to demonstrate that a new drug when taken in the recommended dose is safe; BoP must NOT be placed on skeptics to demonstrate that the drug is unsafe when taken in the dose recommended by the pharmaceutical firm. The BURDEN of PROOF does shift to 'safety skeptics' after & only after all THREE (3) hurdles have been cleared (animal safety validation, small human trial safety validation, general use safety validation (which can take decades):

    a. A new pharmaceutical drug must first be safety validated via animal testing (nonhuman PRIMATE testing has the most relevance to humans). If a new drug fails to be safety validated on animals, testing MUST NOT proceed to HUMAN testing, since this would violate the 3rd principle of the 1947 Nuremberg Code.[Rooney, 11; Nuremberg, 12]

    b. Small human trials of the pharmaceutical drug to validate safety. If the new drug is not safety validated in small human trials, the drug MUST NOT be approved for use by the general population.

    c. In general commercial use the new pharmaceutical drug must be demonstrated to be safe; it may take decades to show all serious side effects (e.g. increased risk of cancer). If the pharmaceutical drug is shown to yield more serious harms than important benefits, it should be removed

from the market place.

21. Just as pharmaceutical drug makers have the BoP upon them, inventors of NEW surgical procedures have the BURDEN of PROOF upon them to demonstrate safety. The exact same THREE (3) safety 'hurdles' must be cleared (animal safety validation, small human trial safety validation, and general use safety validation) for a new surgery to be considered safe:

    a. New surgeries must 1st be safety validated on animals. If a new surgery fails to be safety validated on animals, testing must NOT proceed to human testing (this would violate principle 3 of the Nuremberg Code) .[Rooney, 11] "Suction" abortion has never been safety validated via animal studies published in peer-reviewed medical journals.[Rooney, 11] Doctors who perform "suction" abortions (the most common induced abortion procedure) have the BURDEN of PROOF to cite published animal vacuum aspiration (aka "suction") abortion studies. Since "suction" abortion has never been safety validated via published animal studies, testing should NOT have proceeded to the next of three 'safety hurdles', small human trials; as shown in 'point' 23, there was an initial human trial of "suction" abortion in Communist China prior to 1959 but there was no indication at all in the 1958 Wu/Wu study that prior animal "suction" abortions studies had been published in peer-reviewed medical journals.[Wu, 14]

    b. Small human trials of the new surgery to validate safety. If the new surgery is not safety validated in small human trials, the surgery must NOT be performed on people in the general population. A small human trial before 1959 was performed in China.[Wu, 14] The 1958 published paper (Chinese Journal of Obstetrics and Gynaecology) considered only very short term (a few weeks) side-effects of "suction" abortion. The 1958 CJOG study failed to examine long term possible adverse medical outcomes, such as:

        Premature birth risk in the next pregnancy, Suicide risk, Breast Cancer risk, Substance Abuse risk, Infertility risk, Cerebral Palsy risk.

    Thus, in addition to failing the animal safety testing (no such testing done), the second 'safety hurdle' was not cleared. All three (3) 'safety hurdles' must be cleared for a new surgery to be considered safe.

    Despite two 'must have' hurdles not having been 'cleared', "suction" abortion was applied to women in the general U.S. Population (in cases where abortion was allowed) circa 1968; by 1972 a majority of U.S. surgical abortions were "suction" abortions.

c. In general commercial use the new surgery must be demonstrated to be safe; it may take decades to reveal all serious side effects. "Suction"

abortion should have never reached this stage, since 'safety hurdle one' (animal safety validation) was not even attempted; 'safety hurdle two' (small human trial safety validation) was NOT cleared, since very serious potential side-effects were excluded from the testing.[Wu, 14] In the 21st century 4 extensive reviews [4,5,6,18] and the ONLY meta-analysis of the APB (Abortion Preterm Birth) risk [Swingle, 6] strongly supports higher very preterm birth risk for women with prior induced abortions. In sum, three 'safety hurdles' were ALL absolute musts to be cleared and ZERO of the 3 standard safety hurdles have been cleared by "suction" abortion as of 27 April 2009.

22. Nuremberg Code – The 1947 Nuremberg Code is considered the standard for principles governing ethical human medical experimentation. The 1947 Nuremberg Code consists of ten principles, the third principle being:

> "3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment."[Nuremberg Code, 12]

23. In 2008 the British Medical Journal reminded its readers of the Chinese origins of "suction" abortion.[Coombes, 13] "Suction" (vacuum aspiration) abortion was first described in the Chinese Journal of Obstetrics and Gynaecology in 1958; in 2008 the BMJ announced that the 1958 article had been translated into English.[Wu, 14] Brent Rooney has read that English translation of the 1958 CJOG article. "Suction" abortion was a revolutionary new induced abortion technique in 1958 and the first test subjects, to avoid violating the medical ethics standard of the 1947 Nuremberg Code, should have been animals, not human beings. All 300 subjects described in the translated 1958 CJOG study were women (presumably, all Chinese women). The translated CJOG study referred to no animal studies. In fact, the article strangely has no reference section or any references, something that Brent Rooney has never seen before in a published medical study.[Wu, 14] The closest that the 2 authors (Wu & Wu) came to having a reference was their opening sentence:

> "More than 100 years after Recaimer first invented curettage in 1844, it remains used by all gynaecologists for a variety of reasons."[Wu, 14]

Translated title of the 1958 CJOG study by Yuantai Wu & Xianzhen Wu:

"A report of 300 cases using vacuum aspiration for the termination of pregnancy"

That these 300 cases involved human beings, not animals, is confirmed by a quote from the Wu/Wu CJOG 1958 article:

> "Authors' note
> Most of the 300 procedures were performed at the central hospital of Ti Lan Qian district (about 200 cases). The remainder were performed at other public hospitals, and a few were performed at Nan Yang Hospital."[Wu, 14]

24. In Britain the Royal College of Obstetricians and Gynaecologists (RCOG) has never taken a strong stand that prior surgical abortions (e.g.s. "suction", D & E) raise a woman's risk of a premature delivery in a later pregnancy. The RCOG publishes the medical journal BCOG (British Journal of Obstetrics and Gynaecology).

25. In Britain (and in other countries) medical professionals may use the acronym TOPs (Termination Of Pregnancies) to refer to induced abortions.

26. In 2006 Dr. Philip Steer (RCOG member) was the Editor-in-Chief of BJOG (British Journal of Obstetrics and Gynaecology). Dr. Philip Steer sent an email to whatsup@vcn.bc.ca (one of my accounts) and that email was date and time stamped as: January 16, 2006 (10:15 am). Dr. Philip Steer's email address is: <p.steer@imperial.ac.uk> ; Professor Dr. Philip Steer teaches at the Imperial College London. Dr. Steer's email was a result of a complaint email I sent to the BJOG about a peer-review of an article (by Dr. Byron Calhoun, Dr. Elizabeth Shadigian, and Brent Rooney (MSc)) submitted for publication but rejected by the BJOG in early 2006.

27. Dr. Steer's email mentioned in point 26 above contained this sentence :

> "I still feel it was fatally unbalanced because, contrary to what the author below says, they were not trying to establish the link between TOP and preterm labour (which none of us dispute, the evidence is already overwhelming) but to quantity the costs of the resulting preterm labour (and we didn't even agree with how they did that) without quantifying the the costs of not doing the TOPs or preventing their necessity."

In the quoted Dr. Philip Steer sentence directly above is the phrase, "the evidence is already overwhelming", which in context means that the Editor-in-Chief of the British Journal of Obstetrics and Gynaecology has conceded that the evidence that prior induced abortions boost subsequent risk of preterm labour [British spelling of labor] is overwhelming.

28 Some who read this April 2009 Brent Rooney affidavit may believe that the 16

January 2006 (10:15 am) quote attributed to Dr. Philip Steer, BJOG Editor-in-Chief, is bogus. Those doubting the quote validity in point 27 are free to request that Dr. Philip Steer swear an affidavit that he did not send an email to email
account whatsup@vcn.bc.ca on 16 January 2009 containing the point 27 quote. Dr. Philip Steer's email address is: <p.steer@imperial.ac.uk>

29. There are two published studies that have reported that women who deliver a a newborn under 32.0 weeks' gestation double their own risk of breast cancer. [Melbye, 15; Innes, 16] The Burden of Proof that surgical abortions do not elevate women's breast cancer risk rests upon those doing surgical abortions. Doctors performing surgical abortions can not even cite published animal studies showing that female nonhuman primates with prior surgical abortions (e.g. "suction" abortion) do not have higher mammary tumor risk than non-human primates with zero prior surgical abortions.

30. In 1980 Drs. Jose and Irma Russo published their results about the mammary cancer risk to rats who had induced abortions performed on them.[Russo, 17] Female rats who had induced abortions (via surgical removal of their wombs with the gestating rat pups inside their wombs) were later fed DMBA, a cancer inducing chemical, laced food after their induced abortions. Likewise, female rats who had delivered newborns were fed DMBA laced food. The mammary cancer rate in the female rats with induced abortions was fourteen times the mammary cancer rate in female rats who delivered newborn rats.[Russo, 17]

31. The Institute of Medicine preterm birth textbook (2006 edition & 2007 edition) clearly states that nonhuman primates [which includes monkeys, marmosets, chimpanzees, apes, etc.] are the animal class for medical experiments most relevant to human reproductive health [Behrman, 1 (p. 192)]:

"Recent research with nonhuman primates suggests that they have a reproductive biology that is the most similar to that of humans and represent the most appropriate model with which to study [human] preterm birth;"[Behrman, 1 (p. 192)]

32. Brent Rooney (MSc) is author or co-author of the following articles & letters:

a) Brent Rooney, Byron Calhoun, Lisa Roche. Does induced abortion account for racial disparity in preterm births and violate the Nuremberg Code? J American Physicians Surgeons 2008;13(4):102-104 [http://www.jpands.org.vol13no4/rooney.pdf]

b) Byron Calhoun, Elizabeth Shadigian, Brent Rooney. Cost Consequences of of Induced Abortion as an Attributable Risk for Preterm Birth and Implications for Informed Consent. Journal Reproductive Medicine 2007;52:929-937 [Abstract: http://www.ncbi.nlm.nih.gov/pubmed/17977168?dopt=Abstract]

c) Brent Rooney, Byron Calhoun. Induced abortion and risk of later premature

births. Journal American Physicians Surgeons 2003;8(2):46-49 [URL: http://www.jpands.org/vol8no2/rooney.pdf]

d) Brent Rooney. Is elective induced abortion healthy for women and their future newborn? Ars Medica [Spanish language] 2002;4(6):95-111 [URL: http://escuela.med.puc.cl/publ/ArsMedica/ArsMedica6/Art09.html]

e) Brent Rooney. Elective Surgery boosts Cerebral Palsy risk. European Journal Obstetrics Gynecology Reproductive Biology 2001;96(2):239-240 [Letter; 1st ever English language medical journal item to credibly link an induced abortion of a previous pregnancy with higher risk of a newborn with Cerebral Palsy in a later pregnancy]

f) Brent Rooney. Having an induced abortion increases risk in future pregnancies. British Medical Journal 2001;322:430 [Letter]

g) Brent Rooney. Delayed birth equals more cancers and preterm births. Western Journal Medicine. 2001;174:385-386 [Letter]

h) Brent Rooney. Is Cerebral Palsy Ever a 'Choice'? The Post-Abortion Review 2000 (Oct.-Dec.);8(4):4-5

i) Brent Rooney. Racism, Poverty, Abortion, and Other Reproductive Outcomes. Epidemiology 2000;11:740-741 [Letter]

j) Brent Rooney. Low Birth Weight: Reducing the Risk. Birthing magazine Fall 1998

33. Of 4 very extensive 21st century APB reviews ['Thorp','Rooney/Calhoun', 'Swingle', 'Oppenraaij'] the 2009 'Oppenraaij' APB review is the most recent.[Oppenraaij, 18] Their conclusion about the APB risk is the following (p. 6, column 1, 3rd paragraph):

> "Despite these methodological drawbacks, it can be concluded that a history of TOP is associated with an increased risk of PPROM, PTD and VPTD. These risks depend on the number of TOP" [Oppenraaij, 18], where:
>
> TOP - Termination Of Pregnancy (ie. induced abortion)
> PPROM - Preterm Premature Rupture Of Membranes
> PTD - Preterm Delivery (under 37.0 weeks' gestation)
> VPTD - Very Preterm Delivery (under 32.0 weeks' gestation)

The phrase "These risks depend on the number of TOP" means that the more prior induced abortions a woman has, the higher her risk of a preterm delivery or a very preterm delivery. The medical terminology for this is "dose/response" (the higher the dose, the higher the risk). In this affidavit the term "preterm delivery" & "preterm birth" are used synonymously (as is the case in peer-reviewed medical journals). The Oppenraaij quote above is in Attachment C.

The corresponding author for the 7 March 2009 'Oppenraaij' review study is Dr. Niek Exalto (email: exalto@gyn.nl)

34. Summary of the main points of this Brent Rooney April 2009 sworn affidavit:

1. In violation of the 1947 Nuremberg Code the most common abortion procedure in the U.S., Canada and Europe, vacuum aspiration (aka "suction") abortion, has zero published animal studies to validate its safety.

2. It is a principle of SCIENCE that the Burden of Proof rests upon those making a claim, not upon those disputing a claim.

3. The claim that "suction" abortions do not elevate the risk of premature births in later pregnancies has not been strongly demonstrated in animal studies (zero such studies exist), in small human trials, or in general use in the United States, Canada or Europe. The Burden of Proof is especially heavy, since ALL four extensive APB review studies in the 21st century report that prior induced abortions significantly elevate a woman's risk of a future preterm delivery (aka preterm birth).

4. The Institute of Medicine (part of the National Academy of Sciences) in a massive textbook (both the 2006 and 2007 editions) identified "Prior first trimester induced abortion" as one of fourteen (14) "Immutable Medical Risk Factors Associated with Preterm Birth"; URL: [URL: http://www.nap.edu/openbook.php?record_id=11622&page=625] [Behrman, 1]

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Appendix A: Eighteen Statistically Significant Studies of Abortion-Preterm Birth or Abortion-Low-Birth-Weight Risk

A1 Reime B, Schuecking BA, Wenzlaff P. Reproductive Outcomes in Adolescents Who Had a Previous Birth or an Induced Abortion Compared to Adolescents' First Pregnancies. BMC Pregnancy and Childbirth 2008;8:4

A2+ Voigt M, Olbertz D, Fusch C, Krafczyk D. Briese V, Schneider KT. The influence of previous pregnancy terminations, miscarriages, and still-birth on the incidence of babies with low birth weight and premature births as well as somatic classification of newborns. Z Geburtshilfe Neonatol 2008;212:5-12

A3 Smith GCS, Shah I, White IR, Pell JP, Crossley JA, Dobbie R. Maternal and biochemical predictors of spontaneous preterm birth among nulliparous women: a systematic analysis in relation to degree of prematurity. International J Epidemiology 2006;35(5):1169-1177

A4 Stang P, Hammond AO, Bauman P. Induced Abortion Increases the Risk of Very Preterm

Delivery; Results from a Large Perinatal Database. Fertility Sterility. Sept 2005;S159

A5+ Moreau C, Kaminski M, Ancel PY, Bouyer J, et al. Previous induced abortions and the risk of very preterm delivery: results of the EPIPAGE study. British J Obstetrics Gynaecology 2005;112(4):430-437

A6 Ancel PY, Lelong N, Papiernik E, Saurel-Cubizolles MJ, Kaminski M. History of induced abortion as a risk factor for preterm birth in European countries: results of EUROPOP survey. Human Reproduction 2004;19(3):734-740.

A7+* Ancel PY, Saurel-Cubizolles M-J, Renzo GCD, Papiernik E, Breart G. Very and moderate preterm births: are the risk factors different? British J Obstetrics Gynaecology 1999;106:1162-1170.

A8+ Zhou W, Sorenson HT, Olsen J. Induced Abortion and Subsequent Pregnancy Duration. Obstetrics Gynecology 1999;94:948-953.

A9+ Martius JA, Steck T, Oehler MK, Wulf K-H. Risk factors associated with preterm (<37+0 weeks) and early preterm (<32+0 weeks): univariate and multi-variate analysis of 106 345 singleton births from 1994 statewide perinatal survey of Bavaria. European J Obstetrics Gynecology Reproductive Biology 1998;80:183-189.

A10+ Lumley J. The association between prior spontaneous abortion, prior induced abortion and preterm birth in first singleton births. Prenatal Neonatal Medicine 1998;3:21-24.

A11+ Lumley J. The epidemiology of preterm birth. Bailliere's Clinical Obstetrics Gynecology. 1993;7(3):477-498

A12+ Algert C, Roberts C, Adelson P, Frammer M. Low birth weight in New South Wales, 1987: a Population-Based Study. Aust New Zealand J Obstet Gynaecol 1993;33:243-248

A13+* Zhang J, Savitz DA. Preterm Birth Subtypes among Blacks and Whites. Epidemiology 1992;3:428-433.

A14+ Mueller-Heubach E, Guzick DS. Evaluation of risk scoring in a preterm birth prevention study of indigent patients. Amer J Obstetrics Gynecol 1989;160:829-837.

A15+ Lumley J. Very low birth-weight (less than 1500g) and previous induced abortion: Victoria 1982-1983. Australia New Zealand J Obstetrics Gynecology 1986;26:268-272.

A16 Schuler D, Klinger A. Causes of low birth weight in Hungary. Acta Paediatrica Hungarica 1984;24:173-185

A17+ Levin A, Schoenbaum S, Monson R, Stubblefield P, Ryan K. Association of Abortion With Subsequent Pregnancy Loss. J American Medical Assoc 1980;243(24):2495-2499

A18 Van Der Slikke JW, Treffers PE. Influence of induced abortion on gestational duration in subsequent pregnancies. British Medical Journal 1978;1:270-272 [>95% confident of preterm risk for gestation less than 32.0 weeks].

* study combines spontaneous & induced abortions (ie. not treated separately)
\+ studies that found dose/response (the more surgical abortions, the higher the risk)

References

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2 Himpens E, Van den Broeck C, Oostra A, Calders P, Vanhaesebrouck P. Prevalence, type, and distribution and severity of cerebral palsy in relation to gestational age: a meta-analytic review. Developmental Medicine Child Neurology 2008;50:334-340

3 Martin JA, Kung H-C, Matthews TJ, Hoyert DL, Strobino DM, et al. Annual Summary of Vital Statistics: 2006. Pediatrics 2008;121(4):788-201

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5 Rooney B, Calhoun BC. Induced abortion and risk of later premature births. J Amer Physicians Surgeons 2003;8(2):46-49 [URL: http://www.jpands.org/vol8no2/rooney.pdf]

6 Swingle HM, Colaizy TT, Zimmerman MB, Moriss FH. Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review and Meta-Analysis. J Reproductive Med 2009;54:95-108

7 Dr. Jay D. Iams, Dr. Robert Romero, Jennifer F. Culhane (PhD), Dr. Robert L. Goldenberg. Primary, secondary, and tertiary interventions to reduce the morbidity and mortality of preterm birth. Lancet 2008;371:164-175 [http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T1B-4RJS1PD-14&_user=10&_rdoc=1&_fmt=&_orig=search&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=727caa3fee5e184f09b6fecb114b2e3d]

8 Szychowski JM, Owen J, Hankins G, Iams J, Sheffield J, et al. Timing of mid-trimester cervical length shortening in high-risk women. Ultrasound in Obstetrics Gynecology 2009;33(1):70-75

9 Ancel P-Y, Lelong N, Papiernik E, Saurel-Cubizoilles M-J, Kaminski M. History of induced abortion as a risk factor for preterm birth in European countries: results of the EUROPOP survey. Human Reproduction 2004;112:734-740 [abstract URL: http://humrep.oxfordjournals.org/cgi/content/abstract/19/3/734?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=%22History+of+Induced+Abortion+as+a+risk+factor+for+preterm+birth+in+European+countries%22&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT]

10 Moreau C, Kaminski M, Ancel PY et al. Previous Induced abortions and the risk of very preterm

delivery; Results of the EPIPAGE study. British J Obstetrics Gynaecology 2005;112:430-437

11 Rooney B, Calhoun BC, Roche L. Does induced abortion account for racial disparity in preterm births, and violate the Nuremberg Code? J American Physicians Surgeons 2008; 13(4):102-104 [URL: http://www.jpands.org/vol13no4/rooney.pdf]

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Date: _____ April 2008 at Vancouver, British Columbia, Canada

Signed by: Brent Rooney, MSc.

Witnessed by: _____

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Attachments: A. Dr. Hanes Swingle's 2009 APB Meta-Analysis ABSTRACT
B. Institute of Medicine's list of 14 Preterm Birth Risk Factors
C. Dr. Oppenraaij's 2009 Conclusion about the Abortion-Preterm Risk