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EUGENE F. DIAMOND, M.D.

Oliver Wendell Holmes has wisely stated, "A medicine should always be presumed to be hurtful. It is always directly hurtful; it may sometimes be indirectly beneficial." It is an axiom, laid down originally by Aristotle, that a drug given to a healthy person cannot augment health but only diminish it. What kind of drugs are the oral progestins? Their package inserts suggest that their many contraindications indicate definite risks in their use. They are given to healthy persons and given without contraindication. As physicians, how are we to evaluate their use against time-honored therapeutic principles?

In a recent editorial on bias in *The New England Journal of Medicine*, it is alleged that no participant in a therapeutic trial is ever totally disinterested in the outcome of this experiment but rather brings to it either a positive or negative enthusiasm. One great source of bias is the so-called "Zeitgeist." This accepted view of the majority, or an elite minority, about a drug may influence an investigator and make him skeptical about an observed result. The Zeitgeist surrounding "the pill" is not only medical but sociological, demographical, theological, political and economic as well. Almost all of these agencies bring to bear upon oral progestins a positive enthusiasm. It is against a background of positive bias, then, that the pill must be evaluated.

Dr. Diamond is associate professor of clinical pediatrics, Stritch School of Medicine, Loyola University, Chicago.

SIDE EFFECTS AND CONTRAINDICATIONS

In pregnancy, there is a hypercoagulable state related to augmented levels of intrinsic thromboplastin, Stuart factor, plasma thromboplastin component, and fibrinogen. When this hypercoagulable state is further complicated in pregnancy by stasis or slowing of blood flow, an ominous setting for thrombosis occurs. Indeed, thrombophlebitis and thromboembolism are well recognized complications of pregnancy.

It has been shown that the hypercoagulable state of pregnancy is reproducible, at least in part, by the administration of oral progestins. As a matter of fact, hematologists at two centers have reported the use of oral progestins in the therapy of hemorrhagic disorders — notably those due to Factor VII and Factor X deficiency. In addition, it has been shown that the oral progestins produce pelvic vasodilitation which in turn could produce slowing and stasis of venous circulation. Such an ominous combination of circumstances would make the association between oral progestins and thrombotic complications highly plausible, if not proven. As a matter of fact, recent publications fairly uniformly admit the association between oral progestins and thrombophlebitis

while denying an association with thromboembolism.

The oral progestins profoundly affect the individuals endocrine homeostasis, probably by way of their effect on the pituitary-hypothalamic complex. The protein-bound iodine and serum corticoids are elevated during progestin therapy, while aldesterone secretion is increased, urinary corticoids are diminished and the glucose tolerance curve is altered. Considering the rudimentary state of medical knowledge in the area of endocrinology (particularly the delicate interaction and reciprocal inhibition among glands), the use of such a disturbing drug is potentially explosive. It has been suggested that the fact that the pill might provoke diabetes in certain susceptible individuals should be considered a "blessing in disguise since it enables early treatment." Most of us would be surprised to know that it is a blessing to get diabetes at 30, rather than at 60.

With regard to the hepatic effects of the drug, the report of the Puerto Rican field trials discloses fairly frequent abnormalities of bromsulfalien excretion and transaminase levels among those on oral progestins. This caused some anxiety as to the effect of long-term use of the pill on hepatic function and, as a matter of fact, reports of jaundice during therapy are now being published with regularity.

Most of the oral progestins now on the market are 19-nor-steroid derivatives. Since they have the 17-OH group in the beta position, they have an a[n]drogenic effect similar to that of [m]ethyltestosterone. When given i[n] the usual dosage to women during [t]he first eight to twelve weeks [o]f pregnancy, they can and do p[r]oduce masculinization of the fetus. [T]he experience indicates that [a]bout 1.5 percent of women will b[e] pregnant during the time they [are] on progestins, this places a sig[ni]ficant number of female fetuses [at] risk in a nation where millio[ns] of women are taking the pill.

DOCTOR-CLE[R]GY COLLABORATION

Because thi[s] is a potent drug, it would seem im[pe]rative that it always be given und[er] the careful supervision of a phys[i]cian. The impetus for the dispensing [o]f such a drug should never come fr[om] the patient or from a clergyman. [N]o priest, in or out of the confessional, should ever recommend the pill. To say that the priest does not recommend the pill but only "refers the patient to her physician" truly begs the question. Against the background of what may seem a poignant and urgent family situation, medical arguments for refusing the pill may seem specious and pedantic. It is certainly to be expected that a priest might see an indication for family planning or child spacing, through his counseling, but he should leave the means for achieving this end up to the family physician who, alone, knows which method would be safe and successful for what patient.

Priests as well as doctors encounter many unhappy women. Some are single, some are married with small families, some are married with large families. The pill may seem a facile solution to some situations productive of unhappiness, particularly among mothers of large families. When such a temptation exists, it is important to remember the recent report from the American Psychiatric Association convention which indicated that, using the Minnesota Multiphasic Survey, 50 percent of women taking the pill had symptoms of depression.

WISDOM IN FAMILY PLANNING

When women say they do not want another child, what they usually mean is that they do not wish to be pregnant for awhile, or that they do not want another noisy preschooler around the house. They do not mean that they wish to be sterile, and they certainly do not mean that they want time to save for the next child's college education. In this day of "buy now, pay later," and even "fly now, pay later," it is ridiculous to assume that a significant percentage of our population plans their next child on the basis of economic considerations to materialize eighteen years hence. Priests and physicians must help young couples realize that it is possible to grow apart as well as together in marriage. The last twenty years of their lives will be just as long as the middle twenty years.

The average American woman now completes her childbearing by age 26, which means that by 45 or so, she will be mistress of an empty house and a relatively empty life. When I am told of the great chaos and anguish being caused by supernumerary and unwanted children, I must say that I cannot verify such a situation in the last fifteen years of treating parent-child relationships. In a family constellation in which the father's job is dehumanized by automation and the mother's work stripped of creativity by modern gadgets and mixes, the children are frequently the only access parents have to a vitality and a vicarious meaning in their lives.

OVER-POPULATION CHALLENGE

I was raised in the era of apologetics and I will admit to some difficulties in adjustment in this age of the search for a consensus. I am particularly anguished by those who say that the only difference between the Catholic position and the modernist position is a matter of means to a common end. I doubt this very much. I doubt that the average Catholic is ready to adopt the contraceptive mentality. We are separated from the modernist view by formidable obstacles.

First of all, we are separated by a reverence for life which prevents our accepting their views on abortion — therapeutic or otherwise.

Secondly, we are separated by a reverence for the human body which prevents our accepting their views on sterilization — voluntary or otherwise.

Thirdly, we are separated by a reverence for sex which makes their tasteless and mechanistic methods of sex education unacceptable and repugnant.

Finally, we are separated by a reverence for God which makes us entirely unable to accept their "new morality," woven out of the fabric of the old immorality and made

relevant in what they like to call "the post-Christian era."

The problem of the pill is largely an American problem. Planned Parenthood International now places its emphasis largely on intrauterine devices. We are not an under-industrialized economy. We are not an over-populated country. We have added fifty million people to our population since 1945, a 25 percent increase. During the same period, we have added $400 billion to our gross national product, our per-capita income has doubled and our unemployment has dropped to below 5 percent. [illegible] have two billion acres of land [illegible] he United States, and only 6 pe[illegible] of it is used for residential pu[illegible]es.

We have s[illegible] a breakdown in our value sys[illegible]s. We have seen a devaluation [illegible] the child, and an over-valuatio[illegible]his education. We have lost the [illegible]se of the child as a reward fo[illegible]. in favor of the view of the [illegible] as a penalty for sex. We are [illegible]ous about the population explo[illegible] but unconcerned about the co[illegible]ation explosion at all levels of [illegible]naturity. In short, we have a cru[illegible] moral dilemma.

ADVICE TO AUTHORS

Articles on topics of potential interest to the Catholic physician *as a Catholic and as a physician* are earnestly solicited. A goodly portion of THE LINACRE QUARTERLY readers are not members of the medical profession but are engaged in allied health fields, teach moral theology, or serve in hospitals, and material for their benefit would also be welcome. The subject matter may be predominantly philosophical, religious, or medico-moral in nature. Material should be typewritten, double-spaced, with good margins and on one side of the paper only. Manuscripts (*original* and *one copy*) should be submitted to the Editorial Office of THE LINACRE QUARTERLY, 1438 South Grand Blvd., St. Louis, Missouri, 63104. One additional copy should be retained by the author. Full editorial privileges are reserved. References if used should appear at the end of the article and should conform to the usage of the *Index Medicus*. (This format is that employed in the Abstract Section of THE LINACRE QUARTERLY.) A brief but pertinent *curriculum vitae* of the author(s) should accompany the manuscript. The Thomas Linacre Award is made annually to the author(s) of the original article adjudged to be the best to appear in THE LINACRE QUARTERLY during each calendar year.