
— MASS TORT LITIGATION

Depo-Provera and Meningioma

Why the Individual Record Still Decides Each Claim

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Few mass torts have moved as fast as the Depo-Provera litigation. In March 2024, the *BMJ* published a large French case-control study finding that prolonged use (a year or more) of injectable medroxyprogesterone acetate was associated with more than five times the odds of meningioma requiring surgery. A 2025 study in *JAMA Neurology* using U.S. data also found an association, concentrated in women who'd used it for more than four years. Lawsuits came quickly. On February 7, 2025, the Judicial Panel on Multidistrict Litigation consolidated the federal cases as MDL 3140 in the Northern District of Florida before Judge M. Casey Rodgers. By September 2026, more than 6,400 cases were pending.

Two things changed the picture over the past year. On December 12, 2025, the FDA approved a meningioma warning for the Depo-Provera label, advising that patients be monitored for signs and symptoms. And on June 15, 2026, Pfizer reached what's been reported as a global settlement in principle. Its terms haven't been disclosed and it wasn't final as of the latest reports. The manufacturer has maintained that it didn't cause the injuries alleged.

Meningiomas grow from the membranes around the brain and spinal cord. Most aren't cancerous, but their location means they can cause headaches, seizures, vision loss, and weakness, and some need surgery or radiation.

SETTLEMENT DOESN'T MAKE VETTING OPTIONAL

It's tempting to think individual details stop mattering once a settlement is in sight. In mass torts generally, the opposite is true. Claims programs nearly always have eligibility criteria and point systems that turn on proof of use, a qualifying diagnosis, timing, and injury severity and treatment. A poorly documented claim may not qualify, or may be valued far below what it should be.

PROVE THE EXPOSURE

Because Depo-Provera is a clinic injection, the best evidence is usually the clinic's administration records: each date, the product, sometimes the lot number. Pharmacy and insurance claims records fill gaps.

Duration is critical. The research associations are strongest with prolonged use, a year or more in the French study and over four years in the U.S. study. Two injections and eight years of quarterly injections are very different exposures. Build a dated injection history.

Check whether she received brand-name Depo-Provera or a generic, and whether she used other progestins, some of which have their own reported associations with meningioma. Those facts may affect who the claim runs against and how it's evaluated.

Expect a records problem. Many women got injections over a decade at a college health center, a public health clinic, a family planning clinic, and a couple of private practices, and some of those have closed or merged. Retention periods vary, and older records may be gone. Start early, and use insurance data, pharmacy records, and the patient's own calendars, receipts, or appointment cards to fill holes.

PROVE THE DIAGNOSIS

Meningioma is usually diagnosed on MRI and confirmed by pathology if removed. Get the imaging reports, ideally the images, and the pathology. Location, size, number, and treatment all matter. An incidental tumor that's being watched is a very different claim from one that needed a craniotomy.

Read the years before diagnosis, too. Meningiomas often grow slowly. Were there earlier visits for headaches, vision changes, hearing problems, or seizures that nobody worked up? Those notes help date the tumor, show when symptoms started relative to the injections, and sometimes reveal a missed chance to diagnose it sooner.

GET THE TIMELINE RIGHT

When did injections start and stop? When did symptoms begin, and when was the tumor found? A tumor found during or after long use fits the pattern the research describes. One found before she started, or after a brief exposure, raises questions.

Some research suggests hormone-sensitive meningiomas can stabilize or shrink after the hormone is stopped. If she stopped and later imaging showed the tumor holding steady or shrinking, that's relevant scientifically and to damages. Did her neurosurgeon or neurologist discuss the hormone connection and recommend stopping? Those notes show what the treating clinicians themselves believed.

LOOK HONESTLY AT OTHER RISK FACTORS

Prior head radiation, including in childhood, is one of the strongest known risk factors. Certain genetic conditions, such as neurofibromatosis type 2, are associated with meningiomas. Meningiomas are more common in women and with age. Other progestin use may matter. None of these automatically defeats a claim, but a claim reviewed with them in mind is much stronger.

A FICTIONAL CASE

She received Depo-Provera every three months from 29 to 39. At 42 she developed headaches and blurred vision in one eye. MRI showed a large meningioma pressing on the optic nerve. She had surgery; pathology confirmed a benign meningioma. Her vision partly recovered.

To vet it: injection records for all ten years, pharmacy and insurance records, other hormone use, any head radiation or genetic history, the MRI and pathology, the operative note, and ophthalmology records documenting her vision before and after surgery.

THE LEGAL BACKDROP

The manufacturer argued that federal law barred it from adding a meningioma warning without FDA approval, which would defeat state-law failure-to-warn claims. That preemption argument got harder after the FDA approved the warning in December 2025, and the court's ruling has been closely watched. How it plays out is for counsel, but the timing of the warning, and what was known when, can matter.

DAMAGES

A small incidental tumor under observation, a craniotomy with seizures, and permanent vision loss are very different injuries. The neurosurgical records, post-op course, rehabilitation, and long-term imaging define the harm.

RECORDS WORTH REQUESTING

- Injection administration records from every clinic, with dates
- Pharmacy and insurance claims records
- Complete medication history, including other progestins
- Records of any head radiation and relevant genetic history
- MRI reports and images, and pathology
- Neurosurgery, neurology, and ophthalmology records
- Primary care records for the years before diagnosis
- Follow-up imaging after discontinuation

SOURCES

- Roland N, et al., “Use of progestogens and the risk of intracranial meningioma: national case-control study,” *BMJ* 2024;384:e078078
- *JAMA Neurology* (2025), U.S. study of medroxyprogesterone acetate and meningioma risk
- *In re: Depo-Provera (Depot Medroxyprogesterone Acetate) Products Liability Litigation*, MDL No. 3140 (N.D. Fla.)
- MDL Update, “Depo-Provera Lawsuit, MDL-3140” (Sept. 2026) (case counts, FDA label change, settlement in principle)

This newsletter is for education only and isn't medical or legal advice. It takes no position on the merits of any claim. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare and mass tort litigation. If you want Depo-Provera claims vetted for exposure, diagnosis, timing, and alternative risk factors, whether they're headed for trial or a claims program, we'd welcome the conversation.

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