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LETTER TO THE EDITOR

Rectal perforation following fist fornication

KEYWORDS
Fist fornication;
Sexual trauma;
Rectal perforation;
Hatmann

Introduction

Fisting is the act of inserting the closed hand and part or all of the fore arm or both fists into the rectum. The person who inserts is called a ''top''; the receiving individual, a ''bottom''. The top inserts first one finger, then another, until finally the thumb is tucked into the palm of the hand. The resulting ''collapsed'' hand is slowly moved forward past the anal sphincter. It may take up to several hours before the fist can be completely inserted. Once inserted, movement of the fist and arm in the rectum may continue for two or more hours. There are well-defined rules, e.g. the top must trim and file smooth the fingernails of the operant hand, and no jewelry is to be worn. The use of a non-irritant lubrication is mandatory. This fist fornication is a well-known act in the gay community. The practice of fisting may be included in the number of sexual activities, such as sadomasochism, in which pleasure and pain are intertwined. Physicians may be aware of this form of sexual practice and its complications. There is little written in the medical literature concerning manual-anal intercourse [1,2]. We report the case of a 52 year-old man who presented with rectal bleeding and abdominal pain secondary to this practice.

Case report

A 52-year-old patient, homosexual for 7 years, with history of HIV, admitted to emergency for abdominal pain and rectorrhages for 4 hours duration, following a fist fornication. He admitted these intra rectal courses for 3 years.

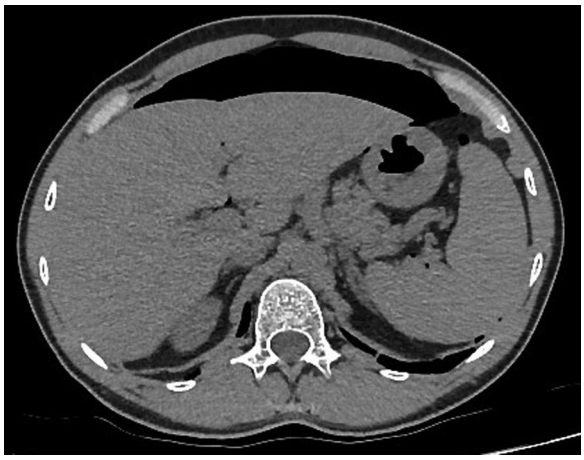

Figure 1 Pneumoperitoneum of above average and sub-meso-colic elevation.

The clinical examination finds a stable patient, afebrile, flexible and repressible abdomen with a slight defense in the left iliac fossa, but no guarding. Bowel sounds were present. No mass or palpable defect was noted on rectal examination, but the examination revealed bright red blood. The biological assessment found a hemoglobin level of 15.3 g/dL and the rest normal. The recto sigmoidoscopy was not performed. The AP scanner found a pneumoperitoneum of above average and sub-meso-colic elevation with visualization of air bubbles and a solution of parietal continuity of the upper rectum about 12 cm extending to the distal sigmoid with a small hematological collection in front of 39 × 25 mm. The walls of the middle and lower rectum are thickened hypo dense reaching 11 mm in places with discrete densification of the meso rectum. Absence of intraperitoneal effusion (Fig. 1).

The surgical exploration shows a long longitudinal perforation on the upper rectum and the sigmoid, about 15 cm (Fig. 2).

The surgical procedure consisted of a resection of the traumatic area and Hartmann left colostomy. The patient was discharged from the hospital after 7 days without complication. The recovery of digestive continuity is done

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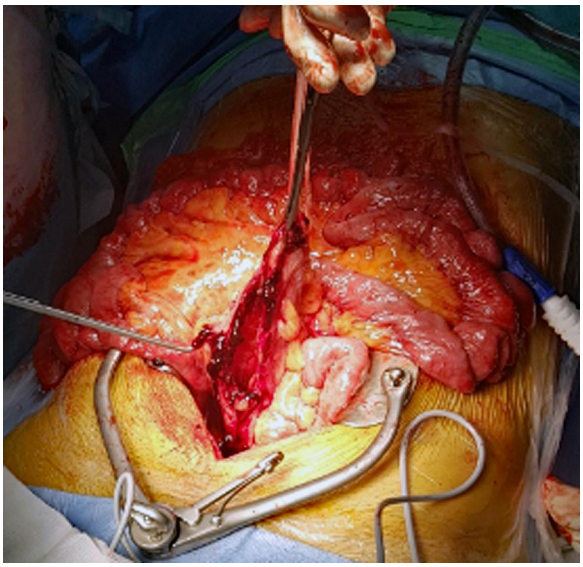

Figure 2 Longitudinal perforation on the upper rectum and the sigmoid, about 15 cm.

three months later by mechanical colorectal anastomosis. The patient is fine today.

Discussion

Human sexual behaviour includes a huge range of practices that vary historically and across cultures. What is normal to one person may be weird, unheard-of or morally unacceptable to another [3]. There have been several reports citing rising trends in high risk sexual behaviour among men having sex with men (MSM), with concomitant use of recreational drugs. Activities include fisting and unprotected anal intercourse with a partner who is HIV serodiscordant or of unknown status [4]. Sexual-related trauma is not a rare situation in the emergency departments. Most are minor injuries which do not require medical attention and can be resolved with minimal treatment. More extensive and deeper vaginal lacerations or even perforations, associated mainly with forced or excessively vigorous intercourse, often require immediate surgical treatment. Injuries of such severity could involve the rectum and even lead to rectovaginal fistula [5]. Enough articles are interested in the insertion of objects and their diversity (anal fingering, use of insertive sex toys, fisting, sounding, enema use, erotic asphyxiation, use of sex sling, felching, rimming...). All insist on the dangerousness of such practices that can go as far as life-threatening. Cases of full thickness perforation with or without peritonitis do occur occasionally with a fatal outcome, but the majority of rectal foreign body insertions cause mucosal injury only. Anal fisting injuries represent a specific subgroup of rectal insertion injury and are more likely to cause full thickness injury [6,7].

The history in these cases may be obscure. Because of the fact that these injuries, even when accidental, are embarrassing and unacceptable from a social perspective, admissions to hospital are usually delayed. Patients may withhold information and attempt to conceal the facts, trying to protect the guilty party or due to hesitancy. Reluctance to seek medical care may lead to delayed presentation. Delayed presentation is a major contributing factor for morbidity. This remains one of the most common challenges in the management of trans-anal rectal injuries [6]. The greatest medical danger associated to anal fisting involves the injury of the fragile inner walls of the lower colon. When colon perforation takes place, severe hemorrhage, fecal contamination of the abdominal cavity and possible subsequent peritonitis occur. Intra-abdominal hemorrhage and stercoral peritonitis have a high mortality rate if not promptly treated [2]. Physicians therefore need to be aware of the complications that can result from fisting and use of foreign bodies in the rectum, ranging from rectal bleeding and pain to overt peritonitis. In order to diagnose the cause accurately, a sensitive approach in gaining the history is mandatory, which will otherwise omit valuable clues [4]. The assessment of rectal injury is by a combination of clinical, endo luminal and radiographic means. Abdominal radiographs are neither sensitive nor specific for colorectal injury but can reveal useful diagnostic information such as free sub-diaphragmatic air and are a rapid method for confirming a retained rectal foreign body. As for the role of ultra sonography, free intra peritoneal air detection using ultrasound is operator dependent and can be difficult even for an experienced ultrasound operator. Ultrasound is useful in disaster and austere situations when formal X-rays cannot be performed. If needed, and if the patient is hemo dynamically stable, then an abdominal CT scan may give more [6].

The treatment of low rectal injuries is still on debate, whether simple suturing, diverting stoma or Hartman procedure is the optimal choice [5]. Laparotomy was always considered to be the first choice to manage colon perforation due to its advantages such as adequate localization of the perforation, closure or repair of the defect and the possibility for peritoneal lavage. A more recent study showed that outcomes in laparoscopic repair of colonic perforation are the same as in open surgery [8].

Conclusion

The fist fornication is a well-known act in the gay community. But less known by the doctors. Doctors need to be aware of the complications that can result from fisting, ranging from rectal bleeding and pain to rectal perforation and peritonitis. There is little written in the medical literature concerning this hanballing. Patients may delay their presentation because of embarrassment, fear of stigmatisation, or ignorance regarding the seriousness of their symptoms. CT scanning is sensitive and specific for rectal injury and should be performed if the patient's condition allows. The ''key'' factor in successful management is the early detection of any visceral injury following this practice.

Disclosure of interest

The authors declare that they have no competing interest.

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