Fisting—What is it and why should I have a high index of suspicion?

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Introduction

This article will define the sexual act of fisting; review the anatomy and physiology of the vaginal and anorectal areas; characterize sharp versus blunt force injuries; and highlight selected case studies. Fisting is also known as 'handballing' or 'fist fucking', 'brachiovaginal' or 'brachioproctic' insertion. Fisting can cause laceration or perforation of the vagina, perineum, rectum, and/or colon, with the potential for death.

The late 1960s/early1970s is when fisting first appeared on the homosexual club and party scene. Crisco was a common lubricant until other commercially prepared lubricants were available. Unprotected fisting may have been a causative factor in the transmission of HIV due to the micro-lacerations from penetration in the anal area. In the 21st century it has become more commonplace in heterosexual intercourse.

Accordingly it is useful to learn about this sexual practice.

Fisting definition

Fisting is a sexual act that involves using the whole hand to penetrate the body. People engage in both vaginal fisting, inserting the hand inside the vagina, and anal fisting, inserting the hand into the anorectal canal. The label fisting is deceptive, as the hand may not be made into a fist, if ever, until it has been fully inserted.

Two techniques recognized as the most commonly practised are the duck and the praying hands.

With the first technique, the fingers are extended and arranged to be overlapping; the thumb is positioned against the palm/base of the fingers. In this formation it resembles a bird's beak and is often called the 'silent duck' or 'duck billing'. The hand is then slowly inserted into the orifice of choice. Once insertion is complete, the fingers either naturally clench into a fist or remain straight.

The second technique is considered advanced and for the more experienced fistees. The hands are placed palm to palm, resembling a position of prayer. The hands are turned parallel to the floor with fingers again pointing to the orifice of choice for insertion.

Typically, fisting does not involve forcing the clenched fist into the vagina or rectum. In more vigorous forms of fisting, such as "punching," a fully clenched fist may be inserted and withdrawn slowly.

Anatomy and physiology

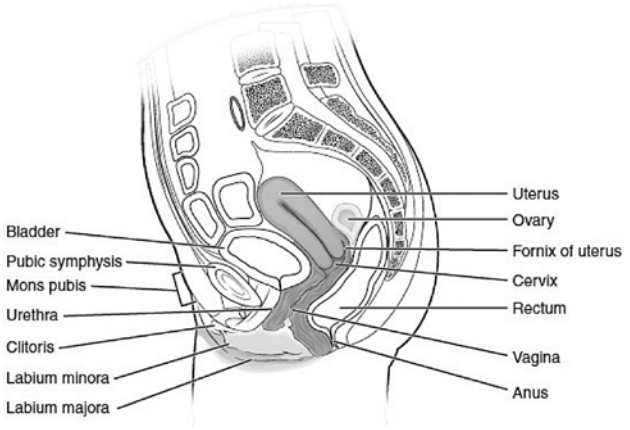

Figure 1. Vagina
https://commons.wikimedia.org/wiki/File:Female_Reproductive_Lateral.JPG
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The vagina is a thin-walled fibromuscular tubular structure that extends from the cervix to the vulva and measures 7–10 cm in length. The inner walls of the vagina are covered with rugae, which are ridges of tissue that allow for stretching and expansion. Normally, the vaginal walls are collapsed and in contact except at the upper end where the cervix keeps them separate. The elastic structure of the vagina allows it to stretch in both length and diameter to accommodate the penis and fetus. Glands near the opening of the vagina secrete mucus to keep the surface moist.

The vagina does change anatomically in response to stimuli. A person can be sexually aroused by a variety of factors, both physical and mental, which causes a number of physiological responses to occur in the body. These responses in the female can include vaginal lubrication, engorgement of the external genitalia and internal enlargement of the vagina.

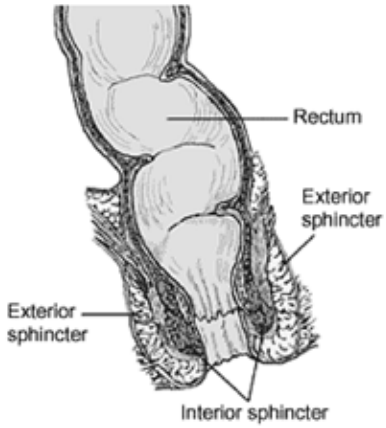

Figure 2. Anorectum
https://upload.wikimedia.org/wikipedia/commons/7/75/Anorectum.gif
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The anorectal area is the outlet of the gastrointestinal (GI) tract. The anal section is lined with skin that has no hair or sebaceous glands and merges with the rectal mucosa approximately 4 cm within the canal.

Innervation of the rectum is by autonomic nerves, but the anus and anal canal have numerous somatic sensory nerves. The sphincter muscles of the anus are quite sensitive and also are composed of numerous nerve endings. They facilitate pleasure or pain during anal intercourse. For the male, the pleasurable sensation is due to the contact with the prostate gland through the anal wall. For the female, the indirect stimulation of the clitoral nerve endings through the anal wall achieves the same outcome.

Injuries—Sharp versus blunt force

Sharp force trauma

Injuries produced by pointed objects or objects with sharp edges. These are characterized by a relatively well-defined traumatic separation of tissues, occurring when a sharp-edged or pointed object comes into contact with the skin and underlying tissues. These are commonly known as cuts or incisions.

Blunt force trauma

Injuries resulting from an impact with a dull, firm surface or object. Individual injuries may be patterned (e.g., characteristics of the wound suggest a particular type of blunt object) or non-specific. Blunt force trauma may cause contusions or bruises and lacerations.

Lacerations are often confused with cuts. The differentiation is based on the appearance of the separated tissues. With a laceration there is tissue bridging such as seen when there is tearing or pulling apart the tissue. The edges of the injury are not as well defined as in a cut.

Principles of why blunt force injuries occur

The amount of kinetic energy transferred and the tissue to which the energy is transferred will determine the severity of the injury.

The characteristics of the blunt object and the surface that is in impact will also determine severity. Impacts involving a large surface area—either with regard to the impacting object or with regard to the tissues being impacted—will result in a greater dispersion of energy over a larger area and, therefore, less injury to the impacted tissues.

The composition, or plasticity, of the tissues impacted also affects the resultant injuries.

Another factor is the amount of time that the body and the impacting object are in contact. A longer period of contact allows kinetic energy to be dissipated over a prolonged period, resulting in less damage to the tissues than an equally forceful impact with dispersion of energy over a brief period.

It has been simply said "an injury occurs when the force applied to a body surface exceeds the ability of that surface to stretch." (Lecture notes, Sheila Early, BCIT Forensic Program, circa 2005).

Selected case studies

Case 1

In 1989, Fain et al. wrote that the death of a 16-year-old female occurred in relation to a fisting incident. The male involved in the event did admit to having his entire fist and most of his forearm in the female's vagina. The autopsy findings include an 8 cm vaginal laceration that was surrounded by a contusion. It was located posterior to the cervix and extended through the posterior vaginal wall. Also present was a bladder and rectum contusion that extended into the rectal musculature without laceration. There were also numerous smaller lacerations on the lateral surface of the vaginal walls. Within the wall of the female's abdominal cavity there was 75–100 cc of blood. There were also two pubic hairs collected that were matched to the male in question. The cause of death was attributed to shock from blood loss due to 8 cm vaginal laceration.

Case 2

Cohen et al. (2004) described the following case of a 39-year-old male who presented to the ER 14 hours post consensual anal fisting. The male gave a history of ketamine use, which included him snorting and inserting it rectally. He reported that during fisting, he heard a 'pop', and his partner stopped the activity. Rectal bleeding did start following, but it was the increasing abdominal pain and bloating that brought him to the hospital. He presented with a distended abdomen and guarding of the left lower abdomen. A chest x-ray revealed free air under his diaphragm. A laparotomy revealed 550 ml of blood in his peritoneal cavity and a 1 cm full thickness laceration of the lower sigmoid colon.

Case 3

Anorectal penetration by forearm that resulted in a rectal perforation is the last case. Delacroix et al., in 2011, described the following case. A 16-year-old female patient presented to the ER with complaints of vaginal bleeding, rectal incontinence and chest pain. She also indicated that she had lethargy, epigastric pain, nausea and vomiting and rectal pain. She gave history of ingesting a large amount of alcohol and engaging in vaginal and anal intercourse with a male. Although she could not recall all the events of the day, she did insist that there was only penile penetration. Also of note is that the patient was intoxicated when presenting to the ER. She also had been diagnosed with a major depressive disorder with psychotic features and was on appropriate medications. On examination in the ER, an anal inspection revealed a superficial laceration at the anterior aspect, no active bleeding and intact sphincter tone. A vaginal speculum exam revealed no vaginal lesions, and a small amount of menstrual-type blood in the vault. A forensic examination was done; the speculum examination was deferred, as it had already been done. The findings were bleeding from the vagina and rectum; redness and a laceration to the left thigh; bilateral edema to the labia minora; and a laceration to the posterior fourchette (area just outside of the vaginal opening). The patient was kept in the ER overnight for observation. In the morning her condition had deteriorated and a CAT scan of her abdomen revealed free air and fluid in the abdominal cavity. An exploratory laparotomy was done. The anus was noted to have erosion and a laceration; the abdomen had large quantities of fecal matter and fluids with resulting diffuse peritonitis and the rectum had a linear tear. The tear was sutured and the patient received a colostomy, which was reversed nine months later to ensure healing of the tear occurred.

Clinical considerations

A high index of suspicion with fisting must be encouraged due to the potential serious consequences if these injuries are not identified.

We should bear in mind that regardless of whether the sexual activity was consensual or non-consensual, our patient may have difficulty verbalizing what has happened, and they may not remember the details, even in the absence of inebriation. With the disclosure of fisting activity, take into account that there is an increased risk of perforation. Combine that knowledge with the patient complaining of anal and/or vaginal bleeding, abdominal pain and/or genital injuries, and act accordingly.

About the author

Susan Short has been a registered nurse for 25 plus years with the majority of her career in the emergency department. She has specialized in forensic nursing and is currently the Coordinator of the Fraser Health program at the Abbotsford Regional Hospital, BC. Susan was the first student to complete the BCIT Advanced Specialty Certificate in Forensic Science Technology – Forensic Health Sciences Option, with Distinction. Building on that certificate, she has completed the courses for a BCIT Bachelor of Technology in Forensic Science. Susan has also been teaching for BCIT since 2006. She is the past president of the Canadian Forensic Nurse's Association and a lifetime member of the International Association of Forensic Nurses.

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