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Vaginal laceration after consensual practice of vaginal fisting: case report and brief overview of the literature

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ABSTRACT

Background. The term “fisting” refers to an uncommon sexual practice whereby the hand or the forearm is inserted into the vagina, anus, or both. The practice of consensual vaginal fisting may be under the umbrella term of “rough sex”.

Case presentation. We herein present a case of vaginal laceration in a 37-year-old woman during an uncommon sexual practice, the so-called “vaginal fisting”. The patient presented at the General Emergency Department complaining of abnormal vaginal bleeding after sexual activity. She was immediately referred to the Gynecological Department for consultation: objective examination showed a bilateral lesion of the posterior vaginal fornix (1 cm in the right side, 5 cm in the left side). Upon interview, the patient admitted she was practicing vaginal fisting for the first time with her partner. Due to her massive ongoing bleeding, the doctor in charge of emergency transferred the patient to the surgery room and a surgical repair was performed with no further complications. She was discharged on the first postoperative day. At the 30-day follow-up visit, her vaginal examination was completely negative, and she successfully resumed her sexual life.

Conclusions. Consensual vaginal fisting is an uncommon yet potentially dangerous sexual practice, and it seems of paramount importance to explore its frequency and to analyse its potential complications and their treatments.

INTRODUCTION

The term “fisting”, also known as “handballing”, “fist-fucking”, “brachiovaginal or brachioproctic insertion”, refers to an uncommon sexual practice

whereby the hand (fist) or the forearm is inserted into the vagina, anus, or both [1, 2].

The first description about this uncommon sexual practice appeared in 1968 [3], and in the subsequent years several authors published studies regarding

consensual anal fisting, whereas vaginal or anal nonconsensual fisting was often object of discussion in Forensics Medicine literature [2].

The practice of consensual vaginal fisting may be included in the number of sexual activities in which pleasure and pain are intertwined [2], and under the umbrella term of “rough sex”, used to identify sexual practices involving physical aggression, as biting, bondage, double penetration, hair pulling, scratching and spanking [4].

Even if not all cases result in injuries, the rate of medical and surgical complications of this practice have been increased [2]. However, at present, no conclusive data about the incidence of consensual vaginal fisting are available, and no gold standard treatment for its complications (*i.e.*, vaginal lacerations) is established.

CASE PRESENTATION

Our patient was a 37-year-old heterosexual woman. From a medical point of view, she had no general health issues, she did not take any medication, and she never underwent any surgical operation. Her height, weight and body mass index were 167 cm, 59 Kg and 21.6 Kg/m², respectively. She delivered a healthy baby ten years ago, with a spontaneous vaginal delivery (male, 3.150 Kg birth weight), the second stage of labour lasted 65 minutes, and she suffered from a first-degree obstetric perineal laceration, repaired without any complication. She did not report any genitourinary symptoms after the delivery and in the next years. Sexual history revealed that her husband died five years apart, and in the last six month she has been dating a new sexual younger male partner (30 years old), with whom she was consensually exploring new uncommon sexual practices.

The woman presented at the General Emergency Department (Azienda Ospedaliero-Universitaria SS. Antonio e Biagio e Cesare Arrigo, Alessandria, Italy) complaining of abnormal vaginal bleeding after intercourse. She was immediately referred to the Gynecological Department for consultation. Objective examination showed a bilateral lesion of the posterior vaginal fornix (1 cm in the right side, 5 cm in the left side). The rectal examination was negative. Upon interview, the patient admitted she was practicing vaginal fisting for the first time with her partner. At admission, the patient's temperature was 36.6 °C, heart rate was 100 bpm, respiratory

rate was 17 breaths per minute, blood pressure was 110/70 mmHg and oxygen saturation in air was 99%; the vital parameters remained always stable. She had no abdominal pain and only complained of vaginal bleeding and vaginal pain. Blood analysis displayed normal values of haemoglobin (14.3 g/dL), normal leukocytes and platelets count, and normal prothrombin, partial thromboplastin times, antithrombin, fibrinogen levels. The electrocardiogram result was also normal.

Since the massive ongoing bleeding, the patient was transferred to the surgery room for immediate operative treatment; intravenous liquids, antibiotic prophylaxis with a cephalosporin and tranexamic acid were administered. The vaginal lacerations were repaired under general anaesthesia in a single layer using absorbable multifilament material (polyglactin 910, Vicryl™ 0) with an interrupted technique. The surgical operation lasted 22 minutes. Intraoperative estimated blood loss was 1000 mL. Postoperative course was uneventful, and she was discharged from the hospital on the first postoperative day (**Figure 1** and **Figure 2** show the outcome the day after the surgical repair); due to the impressive bleeding, her haemoglobin levels decreased to 8.7 g/dL. Then, oral iron therapy was prescribed until the 30-day follow-up visit. At examination, her vaginal tissues showed complete healing; haemoglobin levels increased to 11.8 g/dL. She successfully resumed her sexual life, and function and distress measured by Female Sexual Function Index (FSFI) and Female Sexual Function Distress-revised (FSDS-R) questionnaires, respectively, was completely normal (> 26.55 and > 11 scores, respectively) after two months.

Written informed consent with guarantees of confidentiality was obtained from the subject, and the principles of the Helsinki Declaration were followed.

DISCUSSION

The first description about fisting as an uncommon sexual practice appeared in 1968 by Metsälä *et al.*, who described the incidence and types of traumatic lesions of the vagina by searching records from 1931 to 1965 of the I and II Clinics of Obstetrics and Gynaecology, Helsinki University Central Hospital [3]. In the subsequent years, several authors published studies regarding anal fisting (especially regarding sexual activities between MSM individuals), whe-

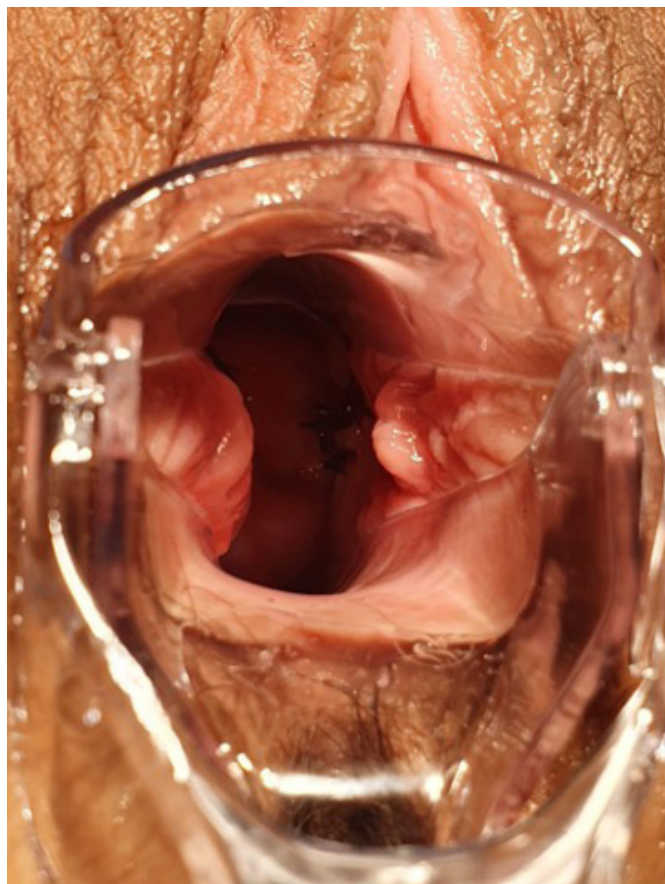


Figure 1. Vaginal laceration of the right side of the posterior fornix after surgical repair.



Figure 2. Vaginal laceration of the left side of the posterior fornix after surgical repair.

reas vaginal or anal nonconsensual fisting was often object of discussion in Forensics Medicine literature [2].

By analysing only those papers in which the practice of vaginal fisting was consensual (or at least was not specified that it has not been consensual), we found only two other manuscripts [5, 6]. In 1989, Fain *et al.* [5] published the first case report of death after vaginal fisting: a young girl died as the result of extensive haemorrhage due to vaginal laceration caused by the insertion of a clenched hand and forearm inside her vagina. In 1997, Cerqui *et al.* [6] published a case series of three heterosexual women who presented at the emergency department for bleeding caused by vaginal lacerations after vaginal fisting, alerting to the potential dangers of this form of sexual practice in the heterosexual community.

Vogels *et al.* [4] included vaginal fisting under the umbrella term of “rough sex”, used to identify sexual practices involving physical aggression; other examples are biting, bondage, double penetration, hair pulling, scratching, spanking. However, among all those different rough sex practices,

fisting appears to be one of the less desired and practiced.

The most common mechanism of female genital tract tears, besides obstetric injury, is sexual intercourse [7]. Consensual intercourse is usually associated with minor sexual trauma, although rare cases of extensive vaginal rupture are reported in literature [8]. The risk of vaginal laceration is higher during first sexual experiences and in patients with atrophic vaginal tissue, such as women in the late postmenopausal age [9, 10]. Injuries seem more frequent with penetration with finger/s and possible pre-existing genital infection [11, 12]. Vaginal injury presents a diagnostic challenge considering that many patients are very embarrassed and can report an incomplete or misleading history. For this reason, the physicians should be carrying out the examination without the presence of family or partners. A careful medical history is also necessary to understand whether the patient has been a victim of sexual violence. Furthermore, a complete vaginal examination with the use of the speculum and a rectal examination helps us in diagnosis and in the most correct management.

Some studies have observed deep vaginal tears to occur with a right-side predominance [13, 14], and it has been suggested that the retroversion of the uterus may guide penetration to the posterior fornix which, given the relative weakness in its endopelvic fascia support, may be more vulnerable to tears [14, 15]. Furthermore, other reasons for the prevalence of lacerations on the right side could be the anatomical position of the rectus-sigma posteriorly on the left side and by the general anteversion and dextro-rotation of the uterus [16]. However, a recently published case series with literature review suggested that there is no site predominance between vaginal fornix or mid-vagina and between right and left side [10].

A gold standard treatment for these injuries that often need surgical repair to control the bleeding is not established. In literature the packing may be used as treatment for superficial lacerations with minimal bleeding. For deeper lacerations and major bleeding, suturing is required. Different suturing techniques have been reported: delayed-absorbable polyglactin single-layer suturing [17], continuous locking or nonlocking suture or interrupted sutures using absorbable multifilament material such as polyglactin 910 or rapidly absorbable polyglactin 910 [10].

The broad accessibility of online Sexually Explicit Material (SEM) exposes viewers to a wide range of uncommon sexual practice and behaviours, and viewing rough sexual practices positively correlates with desire and participation in those behaviours [4]. Even if fisting appears to be one of the less desired practices [4], at present we are totally missing data concerning the frequency of consensual vaginal fisting practice in the general population, and the variability of genital injuries that can occur. It seems therefore interesting to analyse frequency of such practice in the general population in order to investigate the variability of the genital lesions associated with consensual vaginal fisting practice. Indeed, the lack of data prevent from standardizing treatment and implementing education and empowering women's strategies.

CONCLUSIONS

In women with a history of recent sexual intercourse presenting with vaginal bleeding it is important to record a detailed anamnesis without

the presence of relatives or partners, to reduce the patient embarrassment and, most important, to understand if the patient has been a sexual victim. Also, the visit should be performed without relatives or partner and should include the use of a speculum and a rectal examination. The physician must check the patient's vital signs and proceed to a rapid intervention. We also suggest a period of sexual abstinence of approximately 30 days to promote complete healing of the wound, also in order to reduce the fear and trauma that can occur in patients who have suffered a major vaginal laceration. Could be useful for patients provide instructions about the necessity to avoid potentially risky sexual behaviours, giving psychological support to women who need it. Only an adequate differential diagnosis will be able to avoid severe further complications in patients who experience this type of trauma.

COMPLIANCE WITH ETHICAL STANDARDS

Authors' contributions

D.D., D.B., R.E.N.: Conceptualization. D.B., C.P., M.G.: Data curation. E.M., M.C., D.D.: Formal analysis. D.B., C.P., M.C.: Investigation. E.M., M.G.: Methodology. D.D.: Project administration. D.B.: Resources. C.P.: Software. R.E.N., G.S.: Supervision. D.D., R.E.N.: Validation. G.S.: Visualization. D.D., D.B.: Writing – original draft. G.S.: Writing – review & editing.

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Disclosures of interests

D.D. serves as Member of the Board of the Italian Society of Minimally Invasive Surgery in Gynecology (SICMIG).

R.E.N. has financial relationships (Lecturer, Member of Advisory Board and/or Consultant) with Abbott, Astellas, Bayer HealthCare AG, Exeltis, Fidia, Gedeon Richter, HRA Pharma, Merck Sharpe & Dohme, Novo Nordisk, Organon & Co, Theramex, Viatrix. She serves as President Elect of the International Menopause Society (IMS) and as President of the Italian Association of Academic Gynecologi-

sts (AGUI – Associazione Ginecologi Universitari Italiani).

All other authors declare that they have no conflict of interests.

Ethical approval

The study was conducted according to the guidelines of the Declaration of Helsinki.

Informed consent

Written informed consent with guarantees of confidentiality was obtained from the subject involved in the study, and the principles of the Helsinki Declaration were followed.

Data sharing

Data are available along with the article.

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