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Hazards Associated with Anal Erotic Activity

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The recent liberalization of attitudes towards sexuality has brought with it the desire by some individuals to seek alternate methods of sexual stimulation and gratification, among them an exploration of anal eroticism. Various practices associated with anal sexuality carry with them the potential for medical complications. In this paper some of the hazards associated with anal eroticism are outlined and potential complications are discussed. Topics discussed include anal masturbation, enemas, sexually related anorectal disease, and the hazards of foreign objects introduced into the rectum. The intent of this paper is to provide concerned professionals dealing with various aspects of human sexuality with information relevant to anal eroticism.

KEY WORDS: anorectal pathology; enemas; klismaphilia; anal sexuality; sexually transmitted disease.

INTRODUCTION

With societal attitudes towards sexuality becoming increasingly liberal, many adults are engaging in sexual experimentation to discover new and alternate methods of sexual stimulation and gratification. Among these methods are various expressions of anal eroticism. Anatomical, physiological, and psychosexual aspects of anal eroticism have been described elsewhere (Agnew, 1985) and are not treated here. Rather, this paper focuses on some of the problems that may occur due to such activity.

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FOREIGN OBJECTS

Various objects may be inserted into the anus and rectum to provide sexual stimulation during heterosexual or homosexual activity or as a part of anal masturbatory activity. These devices may range in size from quite small objects, such as standard douche and enema nozzles (Hite, 1982), to very large objects, such as broom handles or soda bottles (Barone, Sohn, and Nealon, 1977).

The anus and rectum, unlike the vagina, contain no natural lubricating function. Thus insertion of unlubricated objects or inadequate dilation of the anus before insertion of a large object can result in tissue laceration. The internal and external anal sphincters are elastic rings of muscle which generally remain tightly constricted except during defecation. The anal sphincters are also intended for material to pass through them in a direction that leads out of the body. When an attempt is made to insert something in the reverse direction, the muscles of the sphincters constrict.

Unlike the vagina, which is lined with stratified squamous epithelium and is surrounded by a muscular tube intended for penile intromission, the rectum is lined with a delicate mucosal surface and a single layer of columnar epithelium intended primarily for the reabsorption of water and electrolytes. This structure is incapable of mechanical protection against abrasion and severe damage to the colonic mucosa can result if objects that are large, sharp, or pointed are inserted into the rectum, or if objects are inserted high into the rectum and enter the convolutions of the sigmoid colon.

The rectum above the pectinate line is generally insensitive to pain. Thus perforation of the colonic wall may occur without the individual being aware of it at the time. Any such perforation results in peritonitis due to the release of normal colonic organisms into the abdominal cavity.

It is easy for an individual to lose control of an object inserted into the anus, especially if the object is well-lubricated and if the individual is in a state of high sexual arousal. The object may slip up into the rectum, out of the individual's grasp. Reverse peristaltic waves have been observed in the intestine (Scott, 1976) and may cause the object to travel high into the rectum and require medical intervention for removal. It is also not unusual for the object to be of such a nature that it penetrates the colonic wall and requires extensive surgical intervention to repair the damage (Barone *et al.*, 1977).

Though emergency room physicians have in the past had to deal with transanal removal of objects such as enema nozzles and rectal thermometers lost in the rectum during self-treatment by individuals, they are now being called upon to also remove other more unusual objects. Some of these objects reported in the literature are quite large. Benjamin, Klamecki, and Haft

(1969) reported on the removal of a carborundum sharpening stone, a turnip, a toothbrush holder, a water glass, and a light bulb from the rectums of patients who had used these objects for anal masturbatory activity. Lucas and Ryan (1947) reported on the removal of soft-drink bottles, a steer's horn, cucumbers, apples, hard-boiled eggs, and a broom handle. Other miscellaneous objects have been a soldering iron handle (Daffner, 1976); a carbonated beverage bottle (Chenet and Cameron, 1972); a broom handle, vibrators, bananas, a soda battle, and a large rubber phallus (Barone *et al.*, 1977); and a salami, carrots, broomsticks, and whip handles (Marino and Mancini, 1978).

One of the newer variants in anal sexual activity is fist fornication, which is the practice of inserting the hand, usually up to the wrist, but possibly even up to the forearm, into the rectum of a sexual partner (Marino and Mancini, 1978; Sohn and Robilotti, 1977). Though primarily practiced by male homosexuals, this is also practiced by female homosexuals (Jay and Young, 1979). The insertion of such a large object as a hand or fist creates the potential for rupture of the rectum or severe damage to the anus or rectal walls (Sohn, Weinstein, and Gonchar, 1977).

ENEMAS

Enemas may be used as a part of heterosexual or homosexual stimulation or for anal masturbation. Enemas are often used to cleanse the bowel prior to anal intercourse. However, in addition, some individuals are sexually aroused by giving enemas and some are aroused by receiving them (klismaphilia). Various aspects of sexually oriented enemas, known to their devotees as "water sports," have been discussed elsewhere (Agnew, 1982; Denko, 1973, 1976; Kaplan, 1976).

The obvious hazard related to an enema is potential laceration of the anus or rectal mucosa due to improper insertion of the enema nozzle (Szunyogh, 1958; Large and Mukheiber, 1956) or possible perforation of the anterior rectal wall by the nozzle (Roland and Rogers,1959). Enema devotees have been known to attempt full insertion of a rubber colon tube into their rectum (Denko, 1973). While this procedure can be performed successfully by trained medical personnel, it is inadvisable for recreational use due to the potential for perforating the colonic wall. In particular, it is difficult to successfully round the sharp curves of the sigmoid colon and the tube, which is 24 inches long, may either coil up in the rectum or the distal end may perforate the colonic wall if insertion is forced with the distal end of the catheter trapped in a blind pouch of intestine. Frech and Lanier (1957) list the three most likely causes of rectal perforation during an enema procedure as (i) using a hard nozzle, instead

of a soft-rubber rectal tube; (ii) injection pressure being too high; and (iii) the enema nozzle being inserted with the patient in a sitting position.

Improper techniques for enemas may also be used. It is not unknown for the end of the tubing to be attached to a faucet instead of to an enema bag or for the bag to be hung at excessive heights, such as from the top of a door (Smith and Gips, 1963). Both would lead to excessive injection pressure and a direct faucet connection would result in uncontrolled water temperature. Very high pressures and large volumes of enema solution are sometimes injected as part of sadomasochistic practices. Three or 4 quarts, to as much as 5 quarts, of enema solution may be injected, as opposed to the 1 to 2 quarts usually recommended for a cleansing enema. This practice carries with it the potential for colonic rupture and the possibility of reflux of colonic contents and microorganisms into the small intestine through a leaky or overstressed ileocecal value. Sadomasochistic practices may also involve the injection of enemas of substances such as dishwashing detergents that are highly irritating to the colonic mucosa and may cause caustic colitis (Arena, 1964; Kirchner *et al.*, 1977). Hyperemia and increased mucus production have been noted on proctoscopy following chemically irritant enema solutions (Tillery and Bates, 1966). Egdell and Johnson (1973) reported on the case of a 23-year-old woman who developed hypotension and erythema following an enema of castile soap in water. Acute colitis following soapsuds enemas has been reported by Barker (1945) and Patterson (1951).

Large volume or repeated tap-water enemas may cause water intoxication due to colonic absorption and the alteration of circulating blood volume. Symptoms may include weakness, pallor, vomiting, dizziness, and sweating (Fuerst, Wolff, and Weitzel, 1974; Hiatt, 1951). More severe reactions include shock, coma, and convulsions (Ziskind and Gellis, 1958). Colonic irrigations, which generally use several gallons of water flowing in and out of the bowel, have been reported to cause abdominal distention and cramps, nausea, epigastric distress, weakness, and fainting (Patterson, 1951). Repeated tap-water enemas can result in significant hypokalemia (Dunning and Plum, 1956). Simodynes (1981) described a man who went into preoperative shock for no apparent reason. Upon investigation it was found that he had been giving himself enemas that produced results similar to a series of colonic irrigations. He had, in effect, been rectally dialyzing himself, which resulted in severe hypocalcemia and hypokalemia.

Various intoxicants, such as beer or wine, or hallucinogens, such as peyote, may be injected into the body in the form of an enema. Due to the absorptive function of the colonic mucosa, alcohol is absorbed very rapidly into the bloodstream by this route. This can lead to a fast onset of intoxication and possible overdose if administered too rapidly or in a concentrated form, such as distilled spirits. Rectally injected intoxicants or hallucinogens

closely resemble intravenous injections in rapidity of effects (Furst and Coe, 1977).

ANORECTAL DISEASES

Sexually transmitted diseases (STDs) are not restricted to the genitals. Most common STDs, as well as some specialized ones due to intestinal pathogenic organisms, may be transmitted via anal erotic activity.

Gonorrhea: Rectal gonorrhea may be contracted via anal intercourse, both by women engaging in heterosexual anal intercourse and more commonly by men engaging in homosexual relations (Hyde, 1982; Marino and Mancini, 1978). Symptoms may include itching and discharge from the rectum, but the disease may also be asymptomatic.

Syphilis: If anal intercourse has occurred with an infected person, the spirochete can penetrate the mucus membrane of the rectum and a syphilitic chancre may appear around the anus (Owen, 1983).

Anogenital Herpes: Anal intercourse with an infected person may cause the development of small painful bumps or blisters around the anus. This is usually caused by the Type II Herpes simplex virus (Hyde, 1982; Owen, 1983).

AIDS: Autoimmune disturbances may be induced via anal activity. AIDS is probably caused by multiple factors, but the presence of semen in the colon and subsequent penetration into the vascular bed of the rectal mucosa following anal intercourse has recently been implicated in male homosexuals as a possible source of the human T-cell lymphotropic (HTLV III) virus, the probable cause of AIDS (Sonnabend, Witkin, and Purtilo, 1983).

Pathogenic Organisms: Anal activity can lead to transmission of enteric pathogens by several different methods. *Giardia lamblia, entamoeba histolytica, shigella,* or *salmonella* infections may result from oral-anal or penile-anal activity. The obvious cause is the transmission of intestinal organisms from the rectum to the vagina, with the development of subsequent vaginitis, due to engaging in vaginal intercourse immediately following anal intercourse without adequately cleansing the penis. The same transfer of organisms may also occur after manual stimulation of the anus or insertion of a finger into the rectum, followed by clitoral stimulation or insertion of the finger into the vagina without washing the hands.

Less obvious modes of transmission of infection are from person to person via inadequately cleaned dildos used by different individuals for anal penetration, or from anal and then vaginal penetration by the same person; via inadequately cleaned enema equipment used by different individuals; and

via combination syringes used for both enemas and vaginal douching either by different individuals or by the same individual. These last two causes are not uncommon and may be unrelated to sexual activity. Reverse pressure caused by peristalsis in the intestine during an enema may result in intestinal organisms being forced out of the rectum back into the syringe and result in contamination of the enema bag and tubing (Merrill, 1967; Meyers, 1960; Steinbach *et al.*, 1960). These organisms can be transmitted rectally to another person using the same enema equipment or can be transmitted from rectum to vagina in the same person if the syringe is used both for enemas and vaginal douching. Istre *et al.* (1982) reported on a series of illnesses and deaths in a chiropractic clinic caused by the transmission of amebiasis between individuals on an inadequately cleaned colonic irrigation apparatus.

Colonic Irritation: Frequent rectal sexual activity, either from repeated anal intercourse, frequent enemas, or continued insertion of foreign objects into the anus and rectum, can lead to a variety of anorectal symptoms including diarrhea, excessive mucus production, anorectal pain, tenesmus, intestinal cramps, flatus, bloody discharge, purulent discharge, blood in the stools, anorectal laceration, anal or rectal ulcers, anal fissures, pruritus ani, and varying degrees of rectal prolapse. Collectively many of these symptoms have been termed the "gay bowel syndrome" (Sohn and Robilotti, 1977).

Miscellaneous: Various other problems may be transmitted by anal sexual activity, including streptococcal and meningococcal infections, anal warts, cytomegalovirus, helminths, and hepatitis A and B virus (Owen, 1983).

Allergic proctitis can be caused by substances, such as soaps, shampoos, suntan lotions, or medicinal creams that may be used as lubricants during anal intercourse (Owen, 1983). Even K-Y Lubricating Jelly, a substance intended and commonly used for douche and enema tube lubrication, has been known to cause contact allergy (Fisher and Brancaccio, 1979).

There may be continued rectal leakage of fecal material, mucus, and moisture due to inadequate closure of the anal sphincters caused by repeated anal insertion of large objects stretching the sphincter muscles. This leakage may be a causitive factor in pruritus ani (Sullivan and Garnjobst, 1978).

Anal sexual activity, such as frequent anal intercourse or enemas, may be a causative factor in hemorrhoids or may aggravate existing hemorrhoids (Rowan and Gillette, 1978).

CONCLUSION

Even though anal sexual activity may be a relatively harmless extension of human sexual practices, it carries with it the potential for serious consequences. Thus it is important for individuals engaging in such activity

and for professionals dealing with these individuals to have an understanding of all the aspects and consequences of this variant in human sexual behavior.

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