## Summary

This document provides healthcare providers with background information regarding fisting and hemorrhoids. Individuals that engage in fisting are likely to ignore Grade I hemorrhoids. They will also typically abstain only a few days from fisting before attempting a new session, even if still experiencing some level of pain. Understanding your patient's mindset, practices, and knowledge can help you develop treatment plans that will likely have the most success in reducing the severity and manifestation of the disease.

### Levels of Evidence

The data and conclusions in this data sheet are considered *weak* according to academic processes. This is due to the lack of medical research on this topic.

The background and focal assessment tools are beneficial because they increase your awareness of the psychosocial aspects of fisting, fisting practices that may have led to sepsis, and acute physiological effects triggered by routine fisting.

## Background

Anal fisting provides intense physical and psychological stimulation for its participants, who refer to themselves as "Fisters." Most fisters report that the psychological stimulation is the most rewarding component of the practice. Regular practitioners develop strong identities around the activity, including strong social groups and lifestyle alterations. When asked to limit or abandon the practice, they report extreme duress and anxiety. Most are unable to abstain, even when knowing the risk factors of continued practice.

In large metropolitan areas, fisters may have two, three, or even four sessions per week (sessions is the name used by fisters for a sexual encounter focused on fisting). In rural areas, this frequency is limited due to the unavailability of geographically close fisting partners.

## Acute Medical Conditions Associated with Fisting

Common medical conditions after a fisting session include:

- Moderate to severe inflammation and swelling, particularly of the rectum, anal canal, and anal orifice lasting less than 24 hours.
- Paralytic ileus lasting less than 36 hours due to extreme stimulation, extensive douching into the transverse colon,  or use of anti-diarrheal medication.
- Bloating due to the inadvertent introduction of air into the sigmoid during fisting lasting about 12 hours.
- Imbalances of the gut flora that may be overwhelmed by candida which may not present for several days and may last weeks or months.
- Anal itching due to STIs, microbial imbalances, microtears in the anal canal, or adverse reactions to lubrication or lubrication additives (including numbing agents and anti-inflammatory agents).
- Tenesmus lasting less than 12 hours.

- Mild methemoglobinemia due to extensive use of inhaled nitrites.
- Flatulence once intestinal movement resumes, lasting up to 6 hours.

## Sexually Transmitted and Other Infections

Fisters have an increased risk for gonorrhea and chlamydia. As a fringe practice, many are willing to experiment and take risks. A majority of fisters that began fisting prior to PrEP are HIV+.

Always encourage your patient to use protection, test regularly, avoid sharing lube, and ensure partners are practicing good hand hygiene before penetration, especially when fisting in a group setting.

Many fisters are likely to equate pain or bleeding in the anorectal area as hemorrhoidal pain instead of acknowledging the probability of actual STIs.

## Focal Assessment

Having a specific understanding of the patient's fisting practices can help you advise the patient on his behavior related to the hemorrhoidal disease. During your assessment, inquire about the following:

- ***Type of Fisting*** | With the exception of "basic," these are common terms used by fisters:
  - Basic – confined primarily to the rectum, often referred to as shallow play.
  - Punching – rapid piston like movements that may involve partial or full extraction of an open or closed fist.
  - Pistoning – rapid piston like movements that are confined to lower GI tract (limited extraction); often used synonymously with punching.
  - Width play / stretching – introduction of two hands into the rectum or attempts to introduce an additional hand into the rectum.
  - Depth play – insertion of a portion of the arm. Many fisters may refer to penetration of the sigmoid colon (second hole, second or third ring, second or third sphincter); however, the most accurate measurement tool is the arm itself.
  - Toy play – insertion of various sized sexual toys from small (finger size) to extremely large (75 centimeters length and 35 centimeters circumference). Many fisters enjoy heavily textured toys that can cause shearing in the hemorrhoidal plexuses.

  Knowing the *type of fisting* will provide you with an understanding regarding potential development of hemorrhoids: punching, pistoning, width play/stretching, and toy play all increase the likely development of external hemorrhoids.

- ***Clean-out Practices*** **|** Details including douching routines, douching tools, and supplemental medications (including fiber pills, laxatives, and anti-diarrheal medications). Some fisters have 'long clean-outs' that last 4 or more hours, and others have 15-minute cleanouts. Tools include low intensity enemas, mild intensity douche bulbs, and high intensity 'shower shots' which are connected directly to handheld showers and can introduce large amounts of water in short periods of time.

  Fisters with long cleanouts are more likely to have diminished mucosal membranes and are more prone to internal hemorrhoids.

- ***Lubrication Practices*** **|** Novice fisters may be prone to hemorrhoidal development due to insufficient lube practices as compared to experienced fisters. Fisters typically use one of three types of lubes:
    - PEO-based lubes (often referred to as powdered lube or water-based lubes). Polyethylene Oxide (PEO) is very slippery and is used in obstetrics (both human and large farm animal). Most fisters exceed the FDAs daily recommended allowance. Names of these lubes include X, K, FFausten, or J. Fisters using these lubes have little drag with penetration; however, they may have longer sessions because there is less discomfort with slippery lubes.
    - Lipid-based lubes such as Crisco. Lipid-based lubes may be solid or semi-solid at body temperature. Solid/semi-solid lubes may need time to melt inside the body before their lubricity approaches that of PEO lubes. Fisters that use Crisco may experience more drag and shearing in the hemorrhoidal plexuses.
    - Petroleum-based lubes such as Vaseline or mineral/baby oil, often in commercial fisting lubes. Solid/semi-solid lubes always have some level of drag and plexus shearing.

  Lubrication is typically applied externally but can be injected or poured into the rectum.

  Many fisters will add clove oil, Voltaren cream, or lidocaine to their lubes to extend the amount of time they can play. This may prevent them from recognizing the development of a hemorrhoid.

  Knowing the lubrication practices will help you educate and advise your patient on shearing in the plexus. Fister's should be encouraged to use lubricious lubes with moderate viscosity. Semi-solid lubes should be allowed to melt before engaging in extreme fisting practices (punch, width/stretch play, textured toy play).

  Crisco/vegetable shortening does not melt at body temperature and must have mechanical energy added to provide ideal levels of lubrication. *Crisco fisters* should be advised to have longer warmup periods before engaging in extreme fisting practices.

- ***Frequency of Fisting*** **|** Many may feel shame about this number and will underreport.

  Knowing the *frequency of fisting* will provide help you understand if sufficient recovery time is allowed for full mucosal replenishment. Three to four days of recovery is ideal for extreme fisting before re-engaging in another play session.

## Patient Education

Having completed a focal assessment, you will be able to advise your patient regarding practices that must absolutely be avoided. Remember that fisters are unlikely to abandon fisting altogether, so harm reduction should be your focus.

Discussions may need to include the topic of over lubrication and moderation in play. Advising fisters regarding healing time for exacerbated hemorrhoids is extremely motivating because most fisters do not want to forego fisting for any extended length of time.

If performing an outpatient or inpatient procedure, patients need to know the likelihood of stenosis and fibrosis. Hemorrhoidectomies typically result in loss of fisting ability and patients will experience extreme distress and emotional discomfort. Always start with the least invasive procedure that creates the least amount of scarring.

Use follow-up questions to help determine fisting motivations behind the questions your patient asks.