Sexual assault of men: a series

R J Hillman, D Tomlinson, A McMillan, P D French, J R W Harris

Abstract
The case records of five male victims of sexual assault presenting to two genito-urinary clinics are presented. The cases were chosen to illustrate the variety of presentations and possible sequelae of sexual assault of adult males.

Introduction
Over the past two decades there has been a significant increase in the public awareness of sexual assault of women and children, associated with the development of specific agencies providing care and support for such victims. Sexual assault of males, however, is still barely recognised as a problem and is rarely reported.

The incidence of sexual assault of men in the community is unknown. Data from the United States suggest that, when specific services are developed within a given area, the proportion of all rape victims coming forward who are men may be as high as 22.7%. In the United Kingdom, the situation is complicated by the fact that, under British law, the term "rape" specifies forcible vaginal penetration and cases concerning the sexual assault of men are included with other acts of consensual and non-consensual buggery in the 1976 Sexual Offences (Amendment) Act. Fear of being labelled a homosexual and society's concept that a "real man" cannot be raped, may lead to a significant under-presentation of cases. Furthermore, there is a perception that treatment by police and the courts is unlikely to be sympathetic.

We describe the cases of five men who presented to two genito-urinary clinics admitting to having been sexually assaulted by other men, and discuss some of the implications.

Case reports
Case 1
A 16 year old homosexual man initially presented with a request for HIV antibody testing. On taking a full history it was revealed that his only sexual contact was two years previously, when he had been sexually assaulted by a man with the Acquired Immune Deficiency Syndrome. The victim had sustained violent penetrative anal intercourse, necessitating surgical repair of a perforated rectum and the fashioning of a temporary colostomy. During the operation he received 4 units of blood, this being his only lifetime transfusion. Both the assault and the transfusion occurred in North America in 1984. He denied ever abusing drugs intravenously.

Physical examination revealed abdominal and perianal scars consistent with his previous surgery, as well as generalized lymphadenopathy. Tests for sexually transmitted diseases (including syphilis and Hepatitis B) were negative. After counselling, he underwent an HIV antibody test, which was found to be positive using both Wellcome and Abbott ELISA methods.

He has remained physically well apart from occasional faecal incontinence, but HIV antigen has recently been detected in his serum. There have been no sexual contacts since the assault, but the victim considers himself to have a homosexual orientation. He has declined offers of psychological support and remains socially rather isolated, but manages to continue in full-time employment.

Case 2
A 16 year old man presented 8 hours after he had been forced to be the recipient partner during homosexual oral and anal intercourse. Since the episode he complained of pain in his anal region, painful defaecation with blood-streaking of the toilet paper and a sore throat. He had had previous sexual contacts with a regular male partner, but receptive anal intercourse had occurred only on one previous occasion some four weeks prior to the assault. The assailant was known to the victim and at least twice in the preceding three weeks the assailant had attempted to have intercourse with him. On the night of the incident the victim had met the assailant in a local bar and had been taken to the assailant’s home where the assault occurred. The victim had consumed an unknown quantity of alcohol, but had not used other drugs. There was no history of treatment for sexually transmitted disease and no relevant past medical history.

He appeared shaken and was markedly withdrawn.
There was a recent “love bite” on the left shoulder, but no other bruising was noted. The pharynx was inflamed, but there was no oropharyngeal ulceration. External genitalia were normal, as was abdominal examination. Reddening of the perianal region was noted, together with multiple linear shallow fissures within the anal canal and moderate oedema of the distal 5 cm of the rectum. Three condylomata acuminata were also found in the anal canal.

Cultures of rectal material for Neisseria gonorrhoeae, Chlamydia trachomatis and herpes simplex virus and of pharyngeal and urethral secretions yielded negative results on each of two occasions. Serological tests for syphilis (VDRL and TPHA) were negative at his presentation and 3 months later. Neither hepatitis B surface antigen nor antibodies against hepatitis B virus were detected in the serum. After counselling and obtaining informed consent, blood was taken for testing for anti-HIV with negative results on presentation, 6, 12 and 18 months after the assault.

He was offered psychological support and was given hepatitis B vaccine 24 hours after the assault, 28 days and six months later. The condylomata were removed surgically and the histology was typical.

Case 3
A 31 year old unemployed homosexual man was referred to the genito-urinary medicine department by the psychiatric department, following an overdose of benzodiazepines and alcohol. He had taken his overdose in response to having been sexually assailed by three men under the threat of violence three weeks previously. His only previous sexual activities had been restricted to episodes of mutual masturbation and orogenital contact. There was no past history of sexually transmitted disease, no other risk factors for HIV infection and no relevant past medical history. The victim did, however claim to have been sexually abused by his father as a child. There was a psychiatric history of previous admissions following overdoses, and he was regarded as having a passive-dependent personality disorder.

The attack took place at night in a night shelter and his assailants were not known to him. He was forced to have receptive anal and oral sexual intercourse with all three men, one of whom claimed to be HIV seropositive. This man then told the victim that he “would get AIDS now”. Since the attack he had had constant rectal pain, exacerbated by defaecation and associated with intermittent post-defaecation rectal bleeding but with no rectal discharge.

Examination revealed generalised non-tender lymphadenopathy in three extragenital regions only. External genitalia were normal, but proctoscopy revealed a posterior midline anal tear without clinical evidence of proctitis. Microscopy of urethral and rectal slides was negative, as were cultures for N. gonorrhoeae from urethra, rectum and pharynx. Serological tests for syphilis and hepatitis B surface antigen were negative, although surface antibody was detectable at a concentration of less than 10 miu/ml. Herpes simplex was not isolated from a rectal swab. Following counselling he declined to have an HIV antibody test.

The patient was given 5% lignocaine ointment to apply prior to defaecation and given stool softeners to promote healing of the perianal tear. Unfortunately he failed to attend subsequently and was lost to follow-up.

Case 4
A 23 year old unemployed bisexual male prostitute was referred from an outreach agency specifically set up to provide help for men involved in selling sex. He had been sexually assaulted at knife-point ten weeks previously. The victim had been involved in male prostitution for three months, but only had orogenital contact or mutual masturbation with his clients. He had had several casual girl friends, but had always used condoms for vaginal intercourse and there were no other identifiable risk factors for HIV infection. His past history was otherwise unremarkable.

The attack occurred in the early hours of the morning in a train depot, where the assailant and victim were sleeping rough. The assailant was not known to the victim and they had not met for sexual purposes. The victim was forced to have receptive anal intercourse and the assailant ejaculated inside the victim’s rectum. After the attack the victim attempted distal colonic lavage with soap and water and experienced some rectal bleeding which stopped spontaneously.

Physical examination at presentation was unremarkable. Routine microscopy of rectal and urethral smears was negative and cultures from urethra, rectum and throat failed to isolate N. gonorrhoeae. Serological tests for syphilis and hepatitis B were negative. Following counselling, blood was taken for HIV-1 and 2 antibodies at presentation and one month later. These results were negative.

Case 5
A 40 year old man attended a genito-urinary clinic complaining of severe anal discomfort, pain on defaecation and a mucoid anal discharge. He reported that, 2 weeks previously, he had been sexually assaulted by 3 men sustaining forceful receptive oral and anal intercourse from each of his assailants. The victim had been diagnosed HIV antibody positive 3 years previously and was known to carry hepatitis B surface antibody. There was no history of any other sexually transmissible disease and he had had no other sexual contacts between the time of assault and his presentation to the clinic.

Examination was unremarkable other than for
proctoscopy which revealed severe proctitis with large quantities of pus visible. Microscopy of a rectal swab showed numerous pus cells and intracellular Gram negative diplococci. *N gonorrhoeae* sensitive to penicillin and spectinomycin was cultured from swabs taken from the rectum and throat, but not from the urethra. Herpes simplex virus was not isolated from a rectal swab and serological tests for syphilis remained negative 16 months after the assault.

The gonorrhoea was treated successfully with intramuscular spectinomycin, but unfortunately the victim has gone on to develop the acquired immune deficiency syndrome.

**Discussion**

Sexual assault of males is a poorly understood phenomenon and little scientific information is available. The majority of reports have been from the United States, with victims selected from accident and emergency departments,^3^ law enforcement agencies,^7^ federal prisons^8^ and psychiatric departments.^9,10^ Guidelines on the management of male victims of sexual assault have been published,^11,12^ but reliable data on the incidence, nature and sequelae of such attacks are lacking.

In the United Kingdom there are no centrally collected data on the incidence of sexual assault in men, and no formal support systems. Several volunteer-run agencies exist to provide counselling and support for victims. It is likely that many victims fail to seek help following assault,^3^ or if they do then they may not disclose the occurrence of the attack to the medical staff. These five cases of sexual assault were chosen to illustrate the spectrum of victims of sexual assault which are likely to present to departments of genito-urinary medicine.

The sexual orientation of the victims was homosexual in four cases and bisexual in one. This may not be representative of the true incidence of sexual abuse of men, as larger studies suggest that heterosexuals comprise a significant minority.^2^ It may be that homosexuals are less reluctant to come forward to a service they perceive as likely to be supportive. In none of the cases was the sexual orientation of the assailant known. Evidence suggests, however, that sexual assault is more an expression of power than a means of satisfying sexual desires,^13^ and that assailants frequently have a heterosexual orientation.^7^

Compared with their female counterparts, male victims of sexual assault are more likely to sustain violent genital and non-genital trauma during the attack.^1^ This is illustrated by Case 1, where the attack was so severe that he required the fashioning of a temporary colostomy and transfusion with four units of blood. It is possible that the victim was transfused with blood infected with HIV, as estimates suggest that approximately 0·04% donations carried this agent at this time in North America. ^14^ However, since HIV transmission can clearly occur as a consequence of sexual assault of women,^15^ we feel that this is probably the most likely mode of transmission in this case. Not only is HIV a possible sequel of such attacks, but also the threat of HIV transmission is frequently used by assailants as a form of aggression,^16^ as illustrated by Case 3. Cases 3 and 5 illustrate the observation^7^ that multiple assailants are more common when the victim is a man rather than a woman.

The likelihood of transmission of infection as a consequence of sexual assault of men is unknown,^17^ but Case 5 shows that rectal and oral gonorrhoea may be contracted through sexual assault as, presumably, can all sexually transmissible infections.

The interrelationship between prostitution and sexual assault is a complex one. Those who have been sexually assaulted seem at greater risk of entering into prostitution, and the lifestyle of prostitutes renders them particularly vulnerable to assault. This phenomenon is known to occur in women prostitutes, and there is some evidence to support this in male prostitutes,^18^ as in Case 4.

Published guidelines on the management of male victims of sexual assault^11,12^ emphasise the need for thorough history taking, including questioning the victim about cleansing procedures performed after the event, as in Case 4. Meticulous examination of the whole body should be performed, looking particularly for signs of extragenital injury which are common in these cases.^4^ Particular attention should be taken of the oropharynx, genital and anal areas. Documentation by drawing, or, preferably photography is essential. Investigations should include full screening for sexually transmissible infections, including syphilis and hepatitis B, both at presentation and three months later. Testing for HIV should be offered following appropriate counselling. Prophylactic treatment of victims of sexual assault for gonorrhoea is widely practised, although of uncertain benefit. Our impression is that nonspecific genital infection is a more likely event, as is found in the general population attending genito-urinary medicine departments. ^19^ More contentious is the need for hepatitis B immunoglobulin immediately following the assault. Until more information about the characteristics of assailants and the likelihood of transmission of hepatitis B is established, it would seem prudent, however, to offer this to all victims, in addition to a subsequent active vaccination program.

Genito-urinary medicine departments are well-placed to provide the necessary medical and counselling resources required by these victims. It is essential, however, that a supportive environment is created to allow these individuals to overcome their initial anxieties and come forward for help. Male
victims may have the equivalent of the “rape trauma syndrome”, and skilled psychological support must be available. We believe that increased awareness of this distressing condition is essential for the further understanding and development of appropriate services.

Address for correspondence: Dr Richard Hillman, Jefferiss Wing, St Mary’s Hospital, London W2 1NY, UK.

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R J Hillman, D Tomlinson, A McMillan, P D French and J R Harris

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