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Erotic Deaths

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ABSTRACT

Background

Accidental deaths associated with sexual activities occur but are often unreported in the medical literature. ********

Aim

To review reported cases of such deaths to determine the characteristics.

Method

A Medline search from 1966 to June 2001 using such terms as 'coital deaths' was done to obtain publications and relevant references on accidental deaths from sexual intercourse. The data extracted included the gender and age of the victim, the sexual act involved, the marital relationships or status of the participants, the location and immediate cause of death.

Results

Deaths from sexual activities affect males and females. The victims were often adolescents. The age correlated with the type of erotic act. Some deaths occurred in consensual heterosexual and homosexual activities as well as autoerotic acts. Often, the consensual sexual act was 'illicit' and took place outside the home of either partner, while autoerotic deaths often occurred in the homes of the victims. The commonest causes of death were myocardial infarction and air embolism in consensual heterosexual intercourse and asphyxia in autoerotic acts. Predisposing factors include

older age in myocardial infarction, pregnancy in air embolism and paraphilia in autoerotic deaths. Autoerotic deaths predominantly occurred around the third decade. Psychiatric counseling can prevent autoerotic deaths. Psychological and psychiatric counseling are indicated for relations of victims.

Conclusion

It is essential to identify the circumstances of each case to exclude suicide or homicide. Deaths at sexual acts may be merely coincidental and are probably underreported. Legal and social implications demand careful forensic evaluation in each case.

Keywords: Erotic deaths; Aetiology; Prevention

Introduction

Sexual intercourse in this text refers to any physical activity intended to produce sexual satisfaction. Sporadic deaths have occurred in homes and hotels among couples engaged in marital, extramarital and autoerotic sexual intercourse. These are often reported as coroner cases but may not find their way into the medical literature. There is therefore scarce information on the epidemiology of death occurring in association with sexual intercourse [1,2]. Only a handful of cases have been reported in the regular and forensic medical journals [3,4,5]. Individuals occasionally indulge in sexual self-arousal by autoerotic actions which may be complicated by death [6,7]. AIDS is increasingly being contracted from sexual intercourse [8]. It is fatal but death from AIDS is protracted. While this paper is on the death of a participant in a sexual act, foetal deaths have occasionally occurred from membrane rupture at coitus [9]. Available reports on death of a participant as a direct complication of a sexual act are reviewed to emphasize the need for its awareness and to identify the causes and management of this disaster.

Methods

A search of the Medline data base from 1966 to June 2001, using such terms as 'death at coitus', 'complications of coitus', 'coital trauma' and 'coital mishap', as well as information obtained from libraries, were used to assemble reports of cases of death resulting from or during sexual intercourse. Relevant references from these publications were also obtained. All the retrieved publications were reviewed with emphasis on the gender and age of the victim, the sexual act involved, the marital relationships of the victim and the partner, the location and immediate cause of death.

Results

The publications were mainly single case reports[3,10]. Multiple case reports were fewer[7,11]. Two of the publications accessed reported over 20 coital fatalities [12,13]. Most of the victims of erotic deaths were men, especially in heterosexual intercourse [2,13] and autoerotic acts [14,15,16,17]. However, only females were victims of air embolism from orogenital heterosexual intercourse [4,11]. The victims extend from preadolescents through adolescents in the teens up to adults in the seventies [7,11,15,16]. The erotic acts involved included consensual heterosexual intercourse [4,10], homosexual anal intercourse [18] and autoerotic activities such as masturbation [5,7,19] and asphyxiophilia [16,20]. Heterosexual intercourse leading to death included precoital foreplay [21]. Aberrant sexual acts such

as cunnilingus [11], rear entry vaginal intercourse [22] and autoeroticism, including masturbation [7,19] have been implicated in erotic deaths. The immediate cause of death tended to relate to specific sexual bents. In heterosexual intercourse, the causes of death included myocardial infarction [2], air embolism [11], exsanguination [3] and sepsis [23]. Erotic deaths in homosexual men were usually due to asphyxia [18]. In autoeroticism, death was mainly due to asphyxia [7]. However a woman applying a carrot in her vagina to obtain sexual self-excitement, died from air embolism [5] while death has occurred in association with drug abuse in a case of anorectal autoeroticism [7]. Cunnilingus has been associated with air embolism in the female [11]. Masturbation fatally ended in asphyxial death in two reports [7,19].

Coital deaths may result from local complications such as vaginal tear leading to peritonitis [23], vaginal evisceration [24] and exsanguination from lacerations of sexual [3,12,25] and extrasexual [26] organs. The victims were mainly of single marital status 10,15 but a few married men died from autoerotic acts [7,20], while married women died from air embolism from orogenital intercourse especially in pregnancy [11]. Erotic deaths occurred in a variety of locations including the victim's homes [7,16,20], friend's home [21] and secluded parks [7,18,27]. The major causes of death were presumed or proven myocardial infarction [2,28,29], air embolism [11,30] and asphyxia [20,31]. Uncommon causes of death were postcoital sepsis [23] and exsanguination from coital trauma [3]. Criminal sexual intercourse resulting in the death of a victim was uncommon but was reported [32].
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Discussion

Sexual intercourse is a rampant social activity and is usually intended for procreation or pleasure. Several complications in both males and females have been documented. Vaginal lacerations predominate in complications among females, especially those without previous coital experience [33,34], while penile trauma is the predominant injury among males [35,36]. Death from coitus is an unfortunate and embarrassing complication.

The preponderance of males over females and of adolescents over the elderly could be accounted for by the agility differences and higher propensity to take risks generally. It is generally believed that males are more promiscuous than females [22]. While males suffer coital death more often than females, they are also implicated in the death of a female from air embolism [11,21]. Because of paucity of data, it is not possible to identify any significant difference between married and single individuals. However, it has been observed that most elderly men who die at sexual intercourse have engaged younger females in illicit relationships outside the home [2,13] although it has been shown that the frequency of coital death in normal matrimonial intercourse is higher than it is outside the matrimonial home [1]. The deaths from local complications, while of erotic origin, result from inadequate management of the coital complications. The potential for fatal exsanguination from coital haemorrhage is underscored by a case in which haemorrhage was so severe as to necessitate bilateral internal iliac artery ligation for control [37]. Intraperitoneal haemorrhage without an obvious source has been reported [38], although this was non-fatal.

Victims of fatal coital events such as myocardial infarction [1], asphyxia [16,20] or air embolism [4,10] do not present for medical help in time because of logistic reasons [11]. Myocardial infarction is a risk in patients with atherosclerosis who are usually elderly. Men with atherosclerosis are also at increased risk of erectile dysfunction (ED) [39]. Death at coitus from myocardial infarction has been termed 'coital coronary' [1]. With the efficient treatment of ED with sildenafil, it was feared that

coital coronaries would increase. Fortunately, it has been shown that cardiac patients who are not on nitrates do not have an increased risk of myocardial infarction with the use of sildenafil [40]. In patients who have survived myocardial infarction and who are therefore at risk of reinfarction that may be fatal, a suggestion has been made to counsel the affected couple to 'explore extracoital options for lovemaking prior to the resumption of intercourse' [41]. This is expected to enable early resumption of coital activity without extra risk in the cardiac patient. Many survivors of myocardial infarction resume coitus early safely [42]. Contrary to earlier beliefs [39], sexual intercourse is a comparatively weak precipitant of acute coronary events [28,43]. While fatal myocardial infarction during or after sexual intercourse is commoner in men than in women [13], it is possible that older males engage in more sexual activities than their female counterparts.

Fatal air embolism from sexual intercourse occurs more commonly in pregnant women [4,30,44,45]. In the pregnant female, air is forced into the cervical canal by insufflation or the piston effect of the penis or finger in the vagina. The air then dissects the placental membranes to rupture and enter the engorged non-collapsible veins at the placental edge [21,46]. The first report, published in 1936, occurred through vaginal insufflation at orogenital sexual intercourse[47]. Fatal air embolism has been reported in non-pregnant females also, following repeated insertion of the fist into the vagina [48] and following penile vaginal intercourse [10,49]. A case has been reported in a woman using a carrot in the vagina during an autoerotic practice [5]. The mechanism of air embolism in the non-pregnant female is thought to be through vaginal laceration and rupture of vaginal wall veins into which a large volume of air is introduced by the piston effect of either the finger [21], fist [48] or penis [10,49] in the vagina. The veins of the genital tract in the non-pregnant female engorge as a result of sexual arousal. This engorgement predisposes to rupture of the vaginal wall veins, and subsequently, to air embolism [10]. Cases of nonfatal air embolism have been reported [44,46]. One was treated for thromboembolism with heparin before the correct diagnosis, from the revised true history, was made [46]. Although the effect of coital posture in air embolism has not been studied, a case was reported during coitus in a rear entry position [49] and blowing air under pressure into the vagina with the woman sitting [11]. A seasonal variation in coital injuries and perinatal mortality [50] with peak incidence around the end of spring and the beginning of summer has been reported. Perinatal mortality was found to relate to increased maternal coital activity in this period [9]. It has been suggested that orogenital intercourse resulting in air embolism in pregnant women is the effect of prohibition of vaginal intercourse in pregnancy [11]. However, several reports claim that sexual intercourse in pregnancy is safe [51-53].

Asphyxia from consensual intercourse was reported in homosexual activity when the 'male' with his penis in the anus of his consort accidentally strangled his partner during 'choke holding' at orgasm [18]. Asphyxiophilia is the urge to increase sexual excitement or achieve orgasm through transient hypoxia during sexual self-excitation [54]. It is an autoerotic act. Death resulting when a victim induces asphyxia on self for sexual gratification is termed autoerotic death. There are typical and atypical autoerotic deaths. Typical autoerotic death occurs from asphyxia from mechanical compression of the neck, chest or abdomen, while atypical autoerotic deaths occur from sexual self-stimulation with other means such as chemical agents [7]. Atypical autoerotic death has also been reported in a dental surgeon 55. The autoerotic act is practised by both men [14] and women [16,56] although males predominate [15]. It is hypothesized that among female ejaculators, asphyxia increases the chances of ejaculatory orgasm with ejaculation. Ejaculatory orgasm brings more delight than orgasm without ejaculation and is said to be easier to achieve through asphyxia [54]. Autoerotic asphyxia is an ancient practice found in Europe, the Orient and Innuit and Yaghan

Indians [57]. The methods applied include neck constriction [16,20,27], use of drugs [7,55], abdominal ligature [31], chest compression [20], electrocution [58] and other methods of self-suffocation [54] during sexual self-stimulation. The incidence is rising in the USA [15,59]. The orgasm ensuing from autoerotic act and causing death has been aptly termed 'orgasm of death' [60]. It is essential to exclude suicide [6, 61] and homicide [62] in these circumstances for legal, insurance, social and family psychological purposes [61,63]. The exclusion is aided by the presence or otherwise of 'props' such as pornographic materials, female underwear and erotic materials at the scene of an incident [6].

Coital deaths may remain unproven and misdiagnosis is a problem [6]. Such causes of sudden death as cardiopulmonary arrest and cardiac arrhythmia would be impossible to prove if they occurred during an autoerotic act. Aberrant sexual orientations, including autoeroticism are repetitive [7,20]. It is possible that asphyxiophilia is practised by individuals who have fear of pregnancy or of interpersonal relationships. Identification of such individuals and others at risk, followed by psychiatric counseling, can reduce the incidence of such deaths [64]. Pregnant women should be advised to avoid orogenital sexual intercourse, as has been suggested [45].

The management of deaths at sexual intercourse requires careful history from the consort as well as examination of the consort and the victim to determine the existence or absence of a criminal intent [34,65]. The surviving spouse or consort in such deaths may require special psychological and psychiatric counseling. It has been suggested that knowledge of the special circumstances of each case is essential in counseling the surviving partner [66].

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