Anogenital Photography Documentation Guideline 2025

Consent obtained from all subjects used in photos

Introduction:

Clinicians in the field of forensic healthcare frequently examine individuals who are affected by violence, trauma, and abuse. The use of this guideline will help promote the continuing education and development of the highly specialized skills necessary for effective evaluation, evidence collection, and forensic photodocumentation of a person who has experienced a sexual assault.

This photodocumentation guideline will be beneficial in assisting physicians, physician assistants, first responders, nurses, forensic nurses, advance practice nurses and emergency department healthcare providers, in assessment and documentation as part of a thorough medical forensic examination.

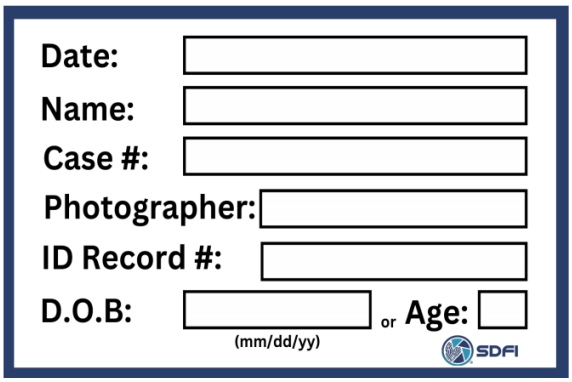
Consent should be provided by patients, both verbally and in writing, prior to taking photographs. Some exceptions may be made based upon organizational or jurisdictional policies or court orders, so always follow local protocols. Photographs may be used as evidence and are necessary in identifying and documenting the presence or absence of injuries. Photographs should be taken before cleaning or evidence collection. Photographs of injury or areas of interest should also be retaken after cleaning or evidence collection. Photodocumentation supplements the medical history and the written documentation of physical findings. Always minimize a patient's discomfort during photography. Respect a patient's need for modesty and privacy and drape patients appropriately while taking photographs. All people are vulnerable to crime and violence, regardless of race, age, gender, sex, ability, or socioeconomic status. When abuse and violence occur, patients deserve competent and compassionate care that encompasses a thorough assessment with photodocumentation, comprehensive evaluation and treatment, and proper evidence collection.

Follow-up photography may be helpful. In addition to documenting emerging or evolving injuries, follow-up photographs provide documentation of healing or resolving injuries and clarify findings of stable, normal variants in anatomy. Nonspecific findings like erythema or swelling can be confused with acute injuries.

Patients may be unable to give a history of forced oral copulation due to poor memory recall. Follow standard oral procedure with all patients unless the patient declines.

Series of 4, as defined within this guideline, is used to compose a series of four or more photographs for each finding. This systematic approach generally refers to distance, mid-distance, close-up, and close-up with photomacrographic scale. In some cases, extreme close-up may also be necessary.

1. The very first photo the forensic examiner should capture is that of a bookend card or a patient's ID wristband. Bookend cards mark the start of the photodocumentation portion of the examination and the end of the photodocumentation portion of the examination ***(APD 1***).

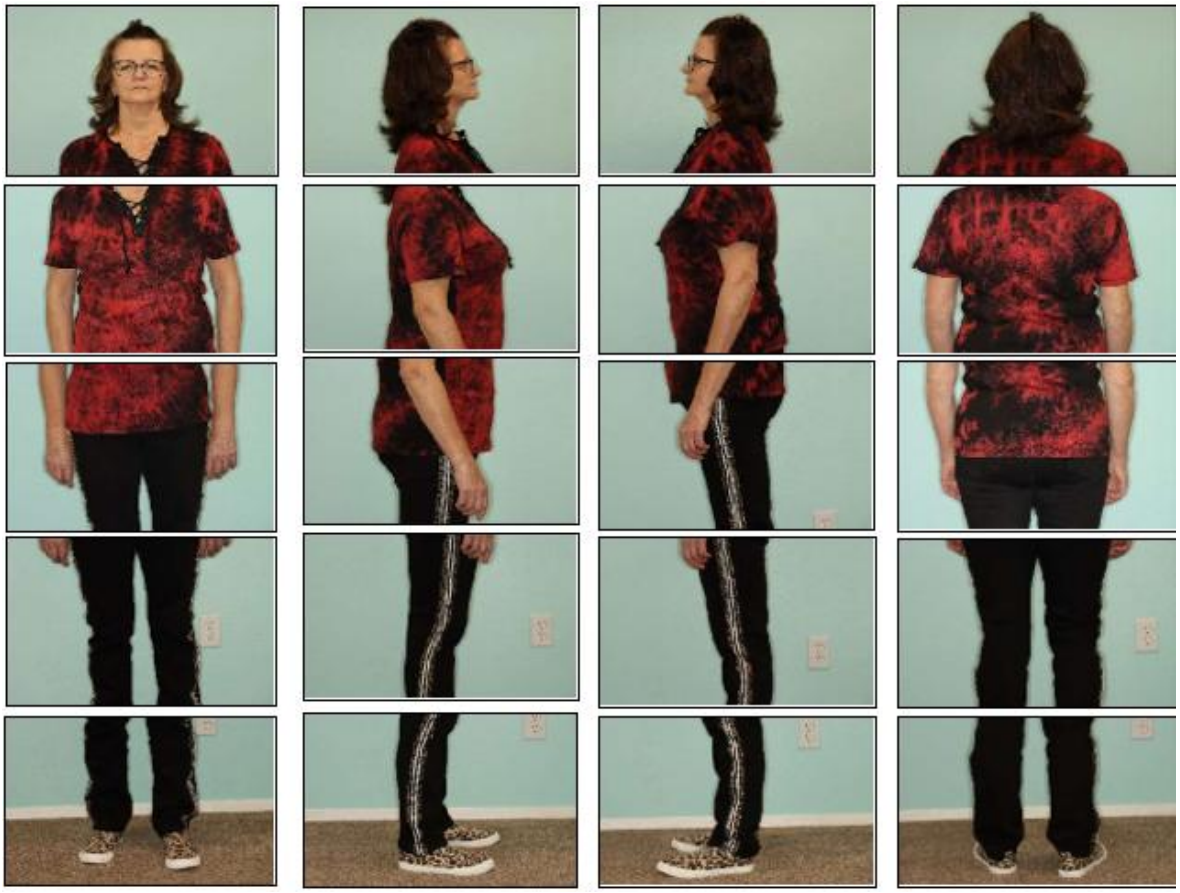


APD 1. SDFI Bookend Card

Note: A copy of the SDFI bookend card can be downloaded at https://www.sdfi.com/Downloads/bookends.pdf

2. Capture an orientation/full body, overlapping photographic storyboard. This series of photos will identify the patient and will be useful in determining the general condition of the patient at the time of the examination (APD 2).

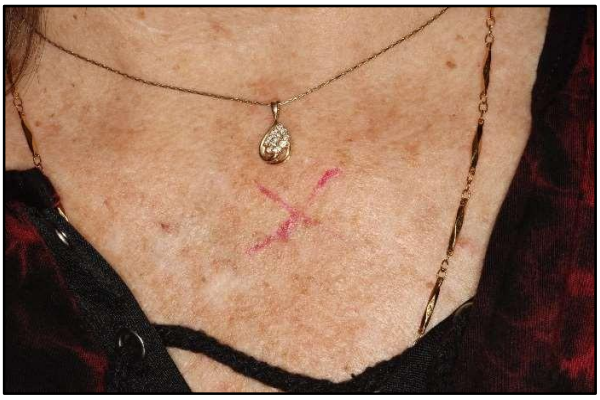
Note: Refer to the SDFI Digital Forensic Photography Documentation Guideline for more information about this step.



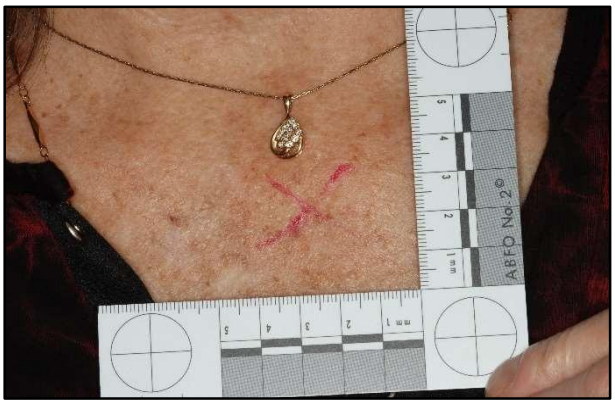
APD 2. An orientation/full body, overlapping photographic storyboard

3. Capture a **Series of 4** and if necessary, extreme close-up, of all non-genital areas of injury and areas of interest from the head-to-toe assessment. Stand directly in front of the area and take the pictures at a 90-degree angle to the area of interest.
    - The mid-distance example picture ***(APD 3-a)*** shows the area of interest at the center of the image (shown as a red X) at the same time showing the front of the neck and both shoulders to demonstrate anatomical location.
    - Next, take a close-up picture of the area of interest or injury on the person's body without a photomacrographic scale ***(APD 3-b).*** Then, take a picture with the photomacrographic scale ***(APD 3-c)***.
    - After completing the close-up photos of a particular non-genital area of interest with and without a photomacrographic scale, capture an extreme close-up of that particular area to demonstrate details of the finding ***(APD 3-d)***. For areas too large for a single extreme close-up shot, capture an overlapping photo storyboard of that particular area of interest.
    - When taking extreme close-up pictures, make sure that the area of interest fills the viewfinder without cutting any part of it off the frame.
    - Repeat taking this series of pictures of all non-genital areas of interest.

APD 3-a. Mid-distance photo



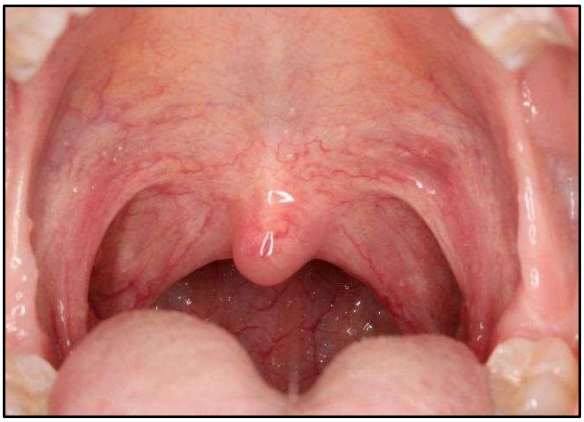
APD 3-b. Close-up without measurement



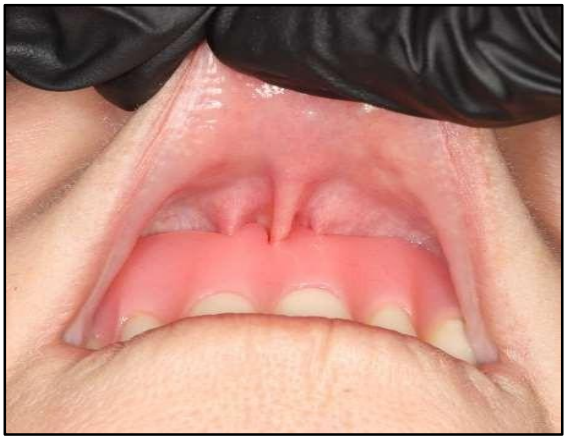
APD 3-c. Close-up without measurement

APD 3-d. Extreme close-up

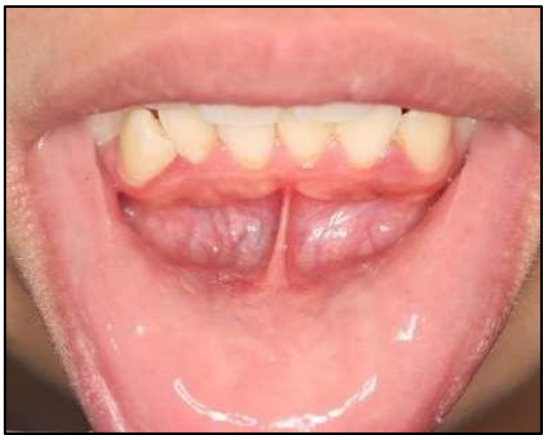
4. Perform a comprehensive assessment of the oral cavity, hard and soft palate, uvula, posterior oropharynx, dorsal and ventral surfaces of the tongue, inner aspects of the upper and lower lips, superior and inferior labial frenum, sublingual frenum, and bilateral buccal mucosa. Photograph all structures and document all injuries and areas of interest, including but not limited to, contusions, abrasions, petechiae, and petechial hemorrhages**.** There may be injury on the back soft palate related to forced oral copulation.



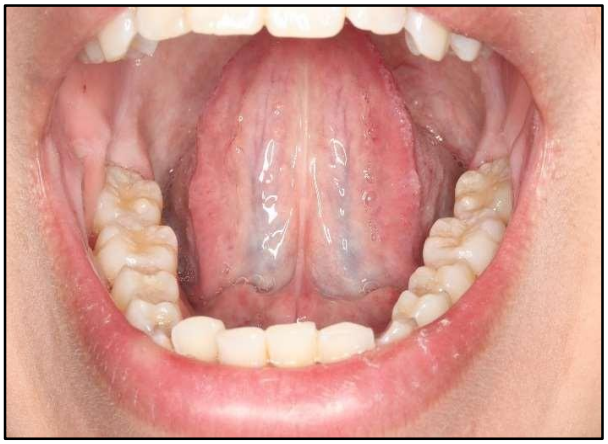
APD 4-a. Posterior oropharynx and uvula



APD 4-b. Superior labial frenum



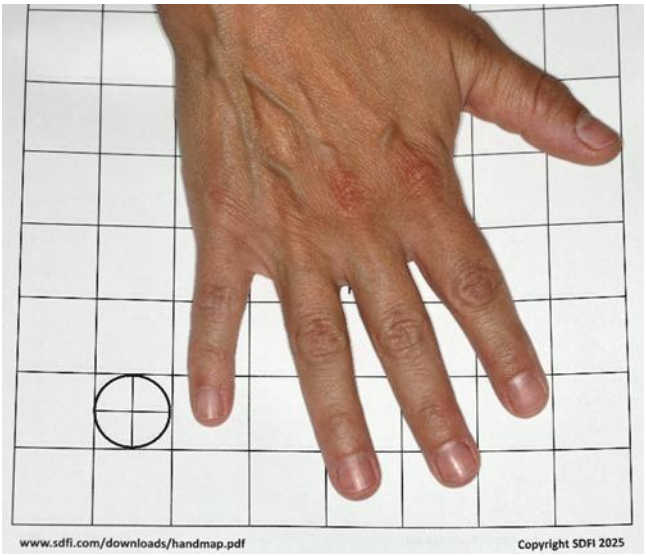
APD 4-c. Inferior labial frenum



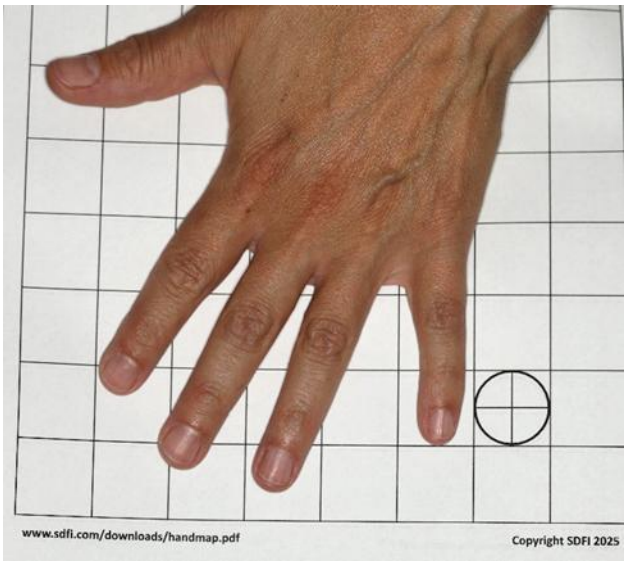
APD 4-d. Sublingual frenum

5. Take a close-up photo of each hand separately ***(APD 5-a and b)***. Use of the SDFI hand maps may facilitate this process. If you see any injury or other areas of interest, capture additional close-up photos with and without a photomacrographic scale.

Note: A copy of the SDFI hand map can be downloaded at *https://www.sdfi.com/Downloads/handmap.pdf*

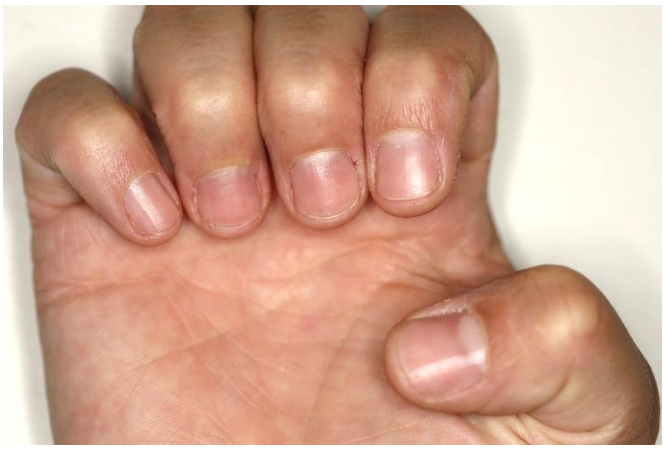


APD 5-a. Close-up of right hand

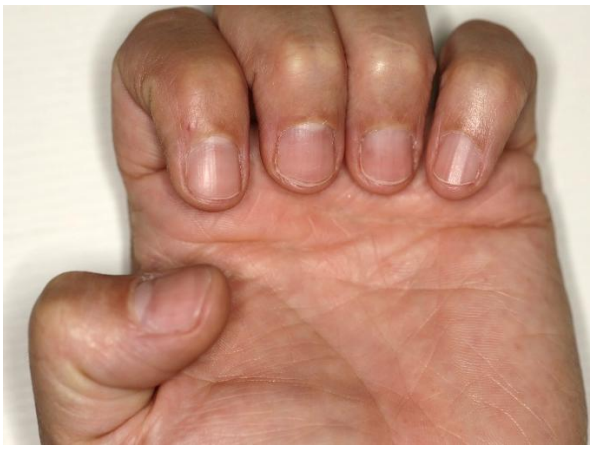


APD 5-b. Close-up of left hand

6. Take close-up photos of the fingertips and fingernails of each hand. If you see any injury or other areas of interest, capture additional close-up photos with and without a photomacrographic scale ***(APD 6-a and b.)***



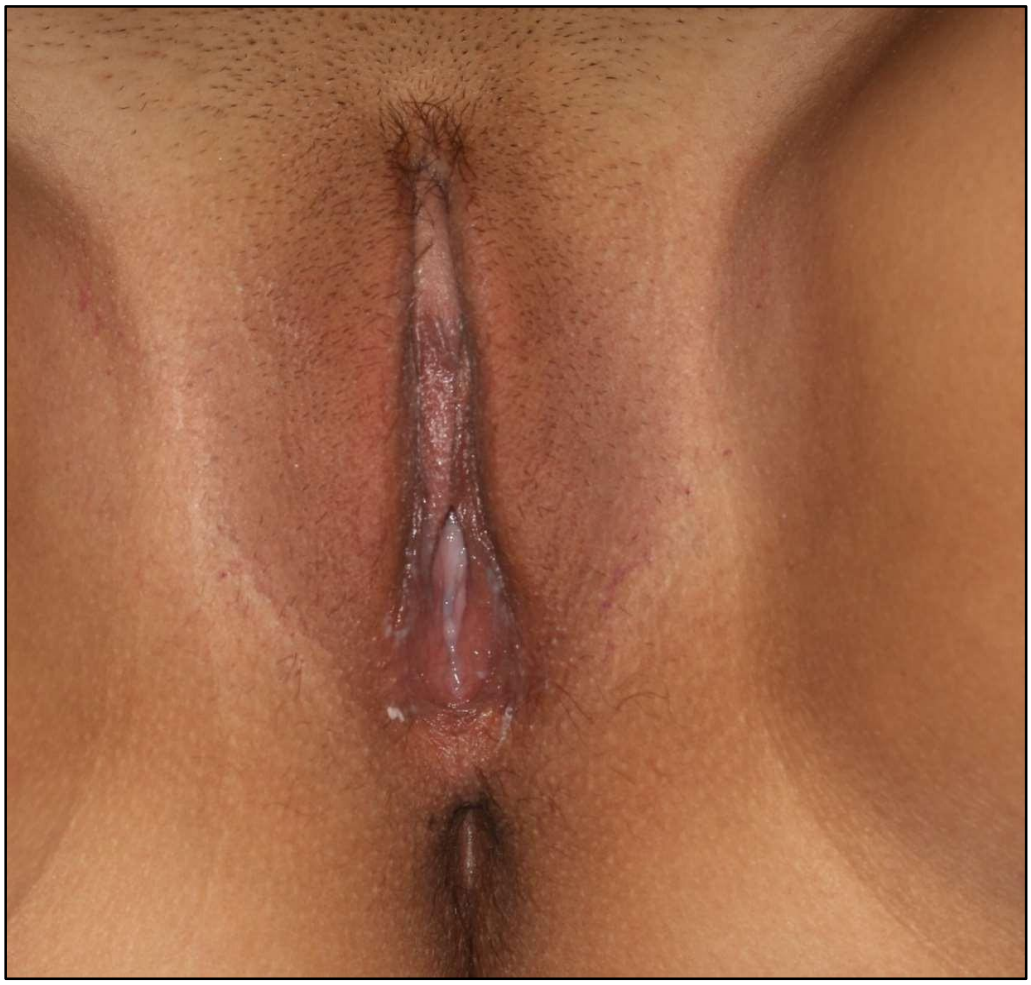
APD 6-a. Close-up of right-hand fingertips



APD 6-b. Close-up of left-hand fingertips

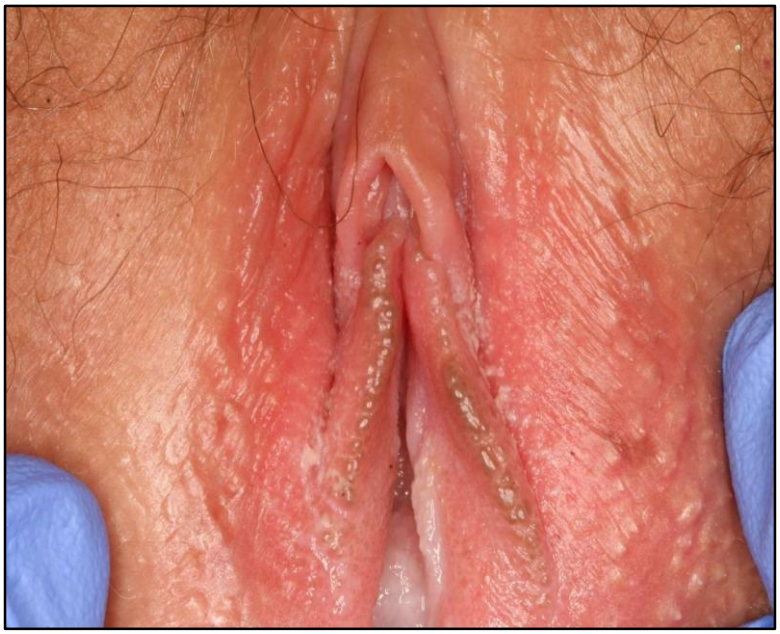
Note: After capturing the photographs shown in procedures 1 through 6, begin the anogenital assessment and photography portion of the examination. After explaining the procedure and ensuring the patient is comfortable and draped appropriately, assist the patient into the lithotomy position.

7. Take an orientation photograph of the genital area ***(APD 7)***. It is important that normal anatomy as well as any injury or visible physical evidence is photodocumented before labial separation and traction begins. Normal anogenital anatomy is standard in photodocumentation and serves as a source of comparison for injury findings and other areas of interest.

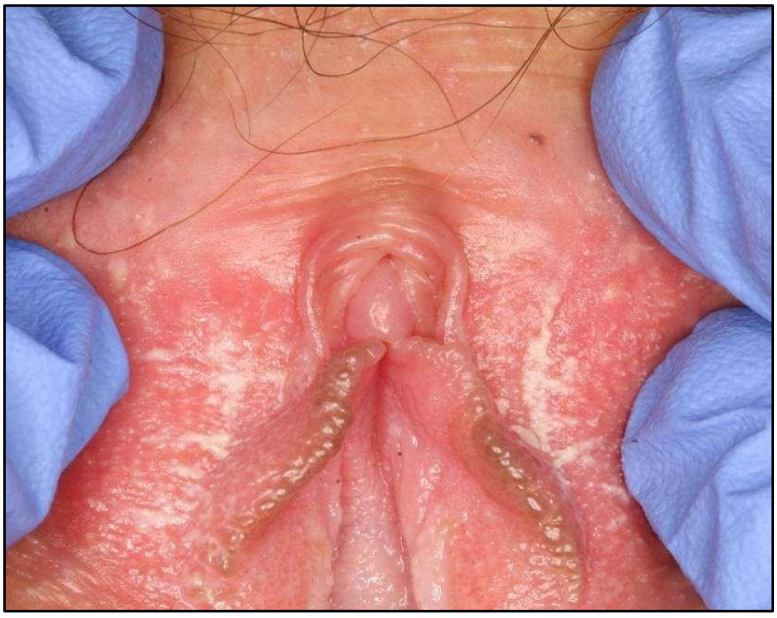


APD 7. Anogenital orientation photo (vulva)

8. Begin at the superior aspect of the vulva and photograph the clitoral hood ***(APD 8)***. Gently retract the hood to allow full visualization of the clitoral glans and photograph all visible areas ***(APD 9)***. Note the presence of any debris or potential physical or biological evidence requiring collection. Ensure a thorough assessment is performed, capturing 2 to 4 high-quality forensic photographs of this anatomical structure.



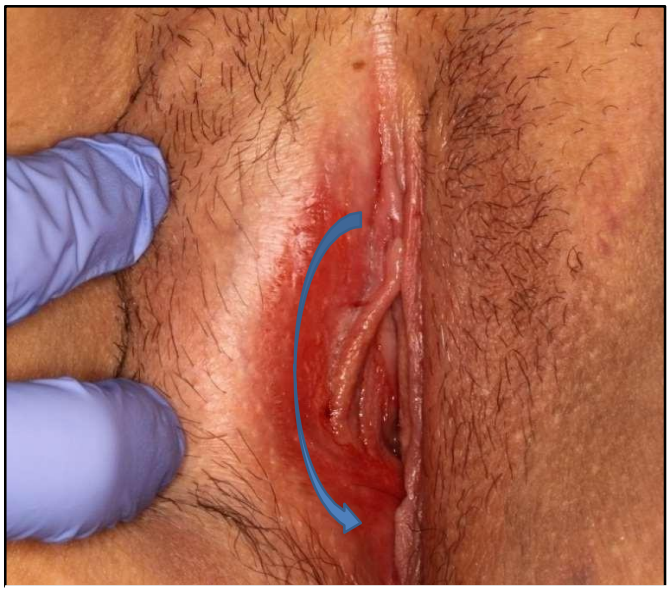
APD 8. Clitoral hood



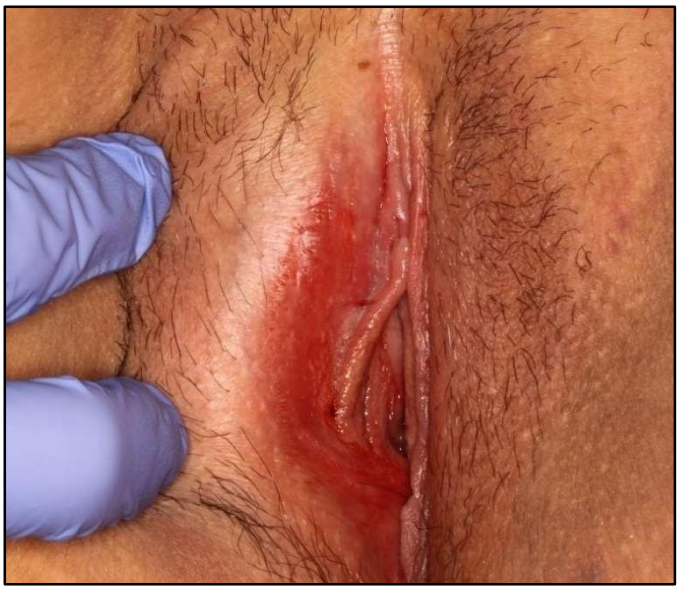
APD 9. Clitoris (after exposure of clitoral hood)

9. Gently separate and open the labia minora on the right and left sides. Also assess and photodocument the interlabial sulcus and folds. Capture at least 2 photographs of each side (right and left). Expose and photodocument one side at a time as this will minimize the amount of stretching and discomfort for the patient.

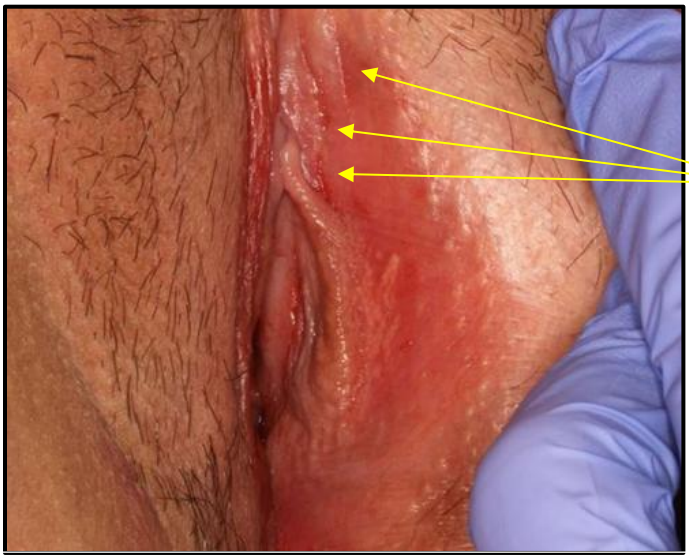
Note: In these photographs you can see that the opening of the right labia minora demonstrates erythema at the interlabial sulcus from 8-11 o'clock. The arrow identifies where to swab in the vestibule. Shown with and without an arrow so detail can be seen (APD 10-a and b). The assessment and photodocumentation was repeated for the left minora (APD 11).



APD 10-a. Arrow identifying the location to swab

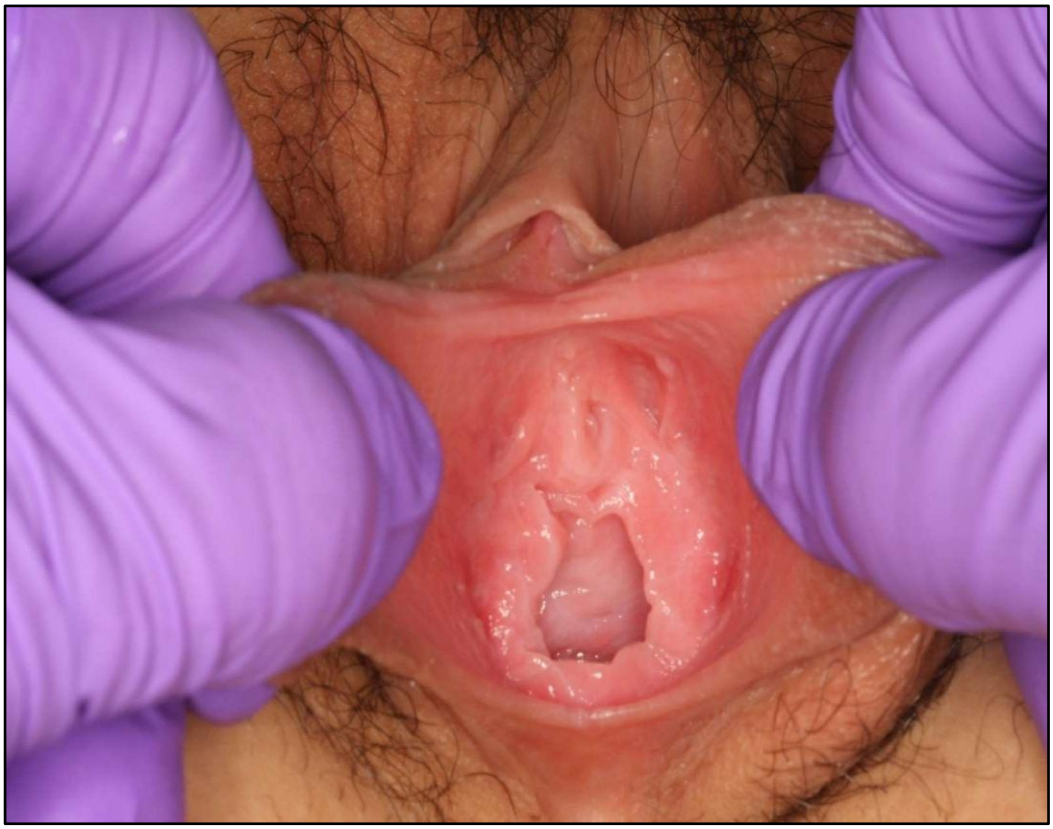


APD 10-b. Erythema noted to right interlabial sulcus



APD 11. Erythema and lacerations noted to left interlabial sulcus

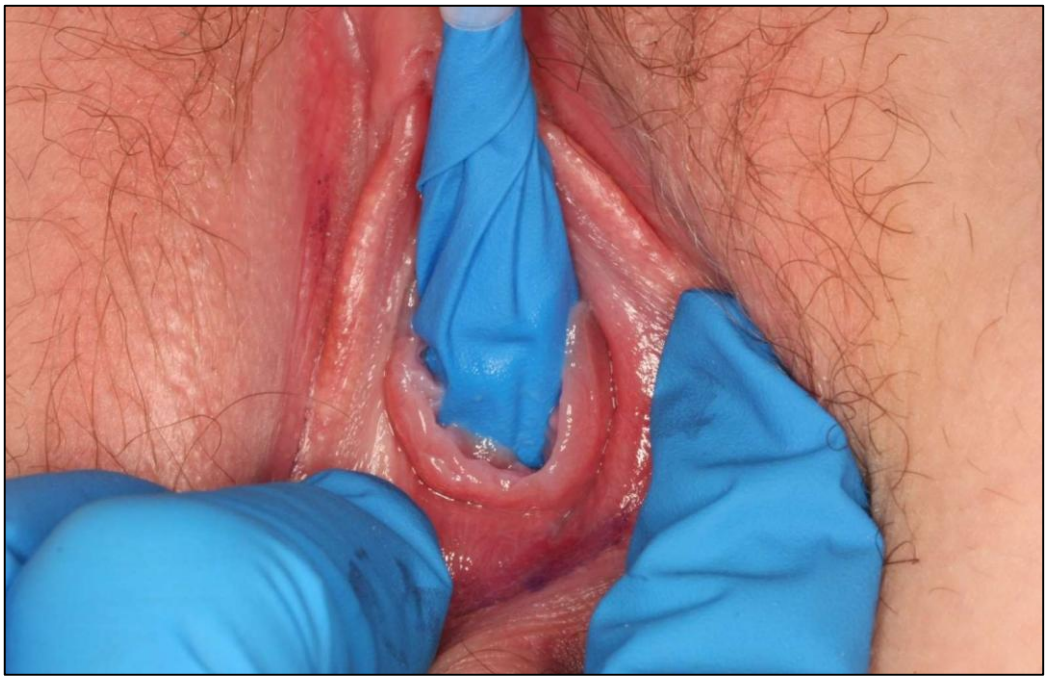
11. Use labial traction to visualize the hymen, urethra and peri urethral area. This is an example of labial traction being used to expose these areas. With labial traction the posterior fourchette is also exposed in this photograph ***(APD 12).***



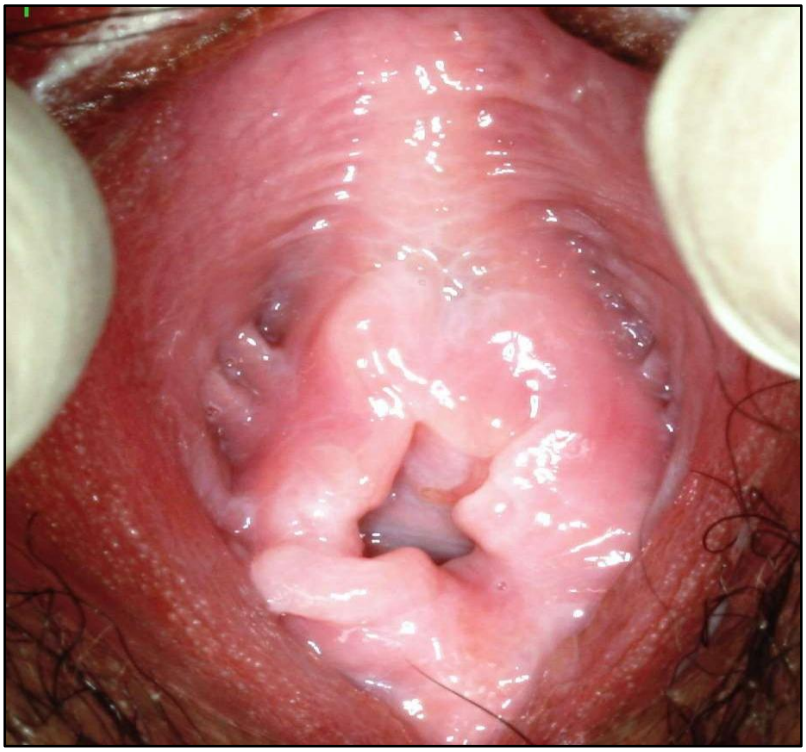
APD 12. Labial traction exposing hymen, urethra, and periurethral area

12. Adjunct tools may be used to facilitate hymenal visualization, such as an obstetric swab or a Foley catheter. An obstetric swab covered with the finger of a blue, powder-free, non-latex glove may be gently placed posterior to the hymen ***(APD 13)*** to enhance visualization. Inspect for the presence of debris or potential evidence requiring collection. Carefully assess the hymen for shape, hymenal remnants, non-acute notches or mounds, acute transections, or other findings indicative of injury or anatomical variation. Take 2-4 photographs of the hymen, urethra, and peri-urethral area. Continue using labial traction and expose the peri-urethral bands ***(APD 14)***. Take 1-2 photographs and note any variations, debris, injury, or other areas of interest.

    - An obstetric swab should only be used on an estrogenized hymen and not on pre-pubescent children. Use with caution on the post-menopausal patient and gently test first for any discomfort before proceeding.
    - Children have a flatter surface in this area than the adult estrogenized female

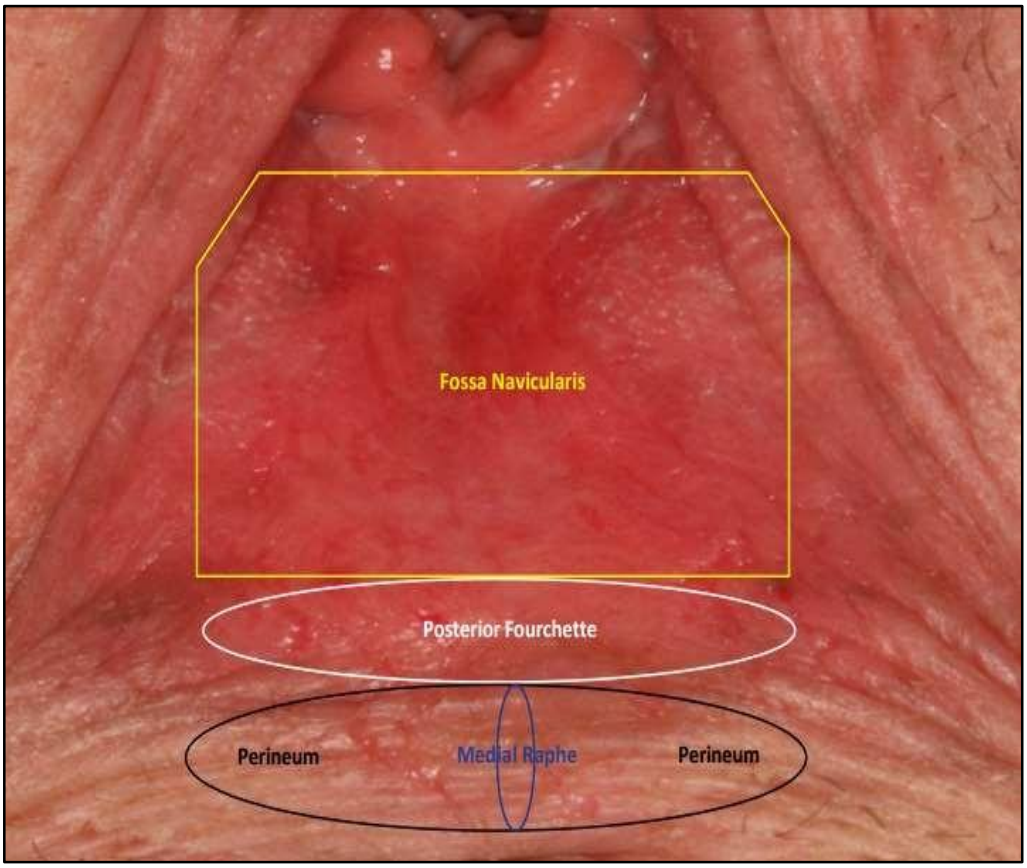


APD 13. An obstetric swab covered with the finger of a non-latex powder free glove



APD 14. Hymen and peri-urethral bands

13. Photograph the posterior fourchette, fossa navicularis, and perineum**.** Typically, 2-4 pictures are needed to capture photodocumentation of these structures, as well as any debris, acute injury, and other areas of interest ***(APD 15).***



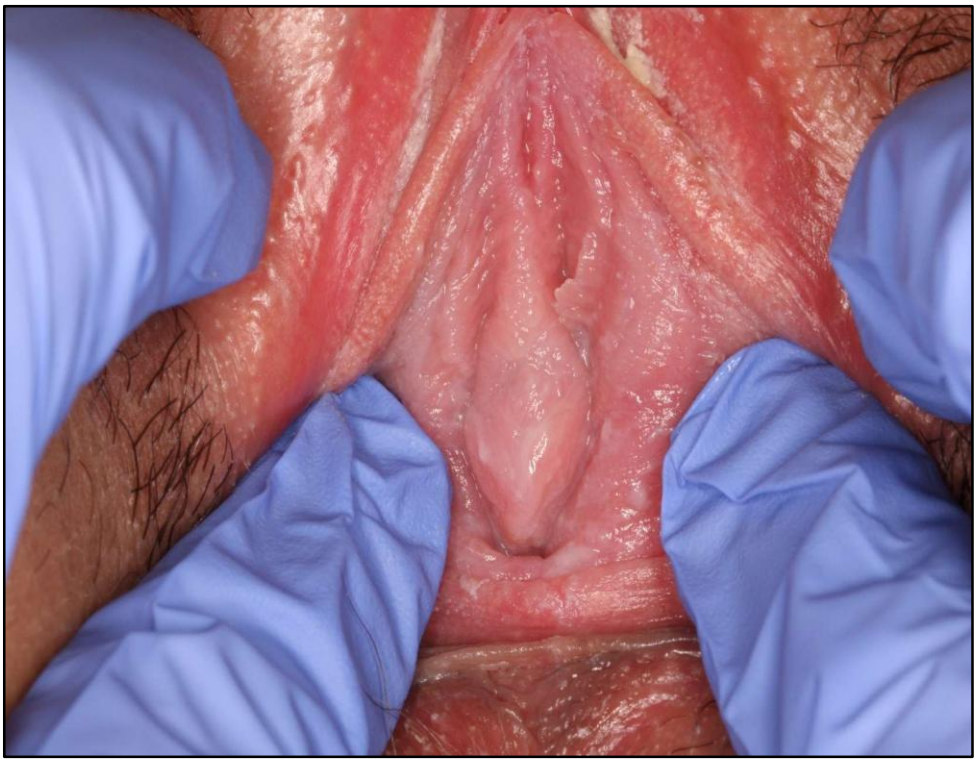
APD 15. Multiple tears to posterior fourchette, extending up to the fossa navicularis and down to the perineum with erythema from 4-8 o'clock

14. If using Toluidine Blue (TB) dye, follow the steps outlined below in the TB Dye Procedure box.
Note: See SDFI Toluidine Blue (TB) Dye Procedure supplement for more information.

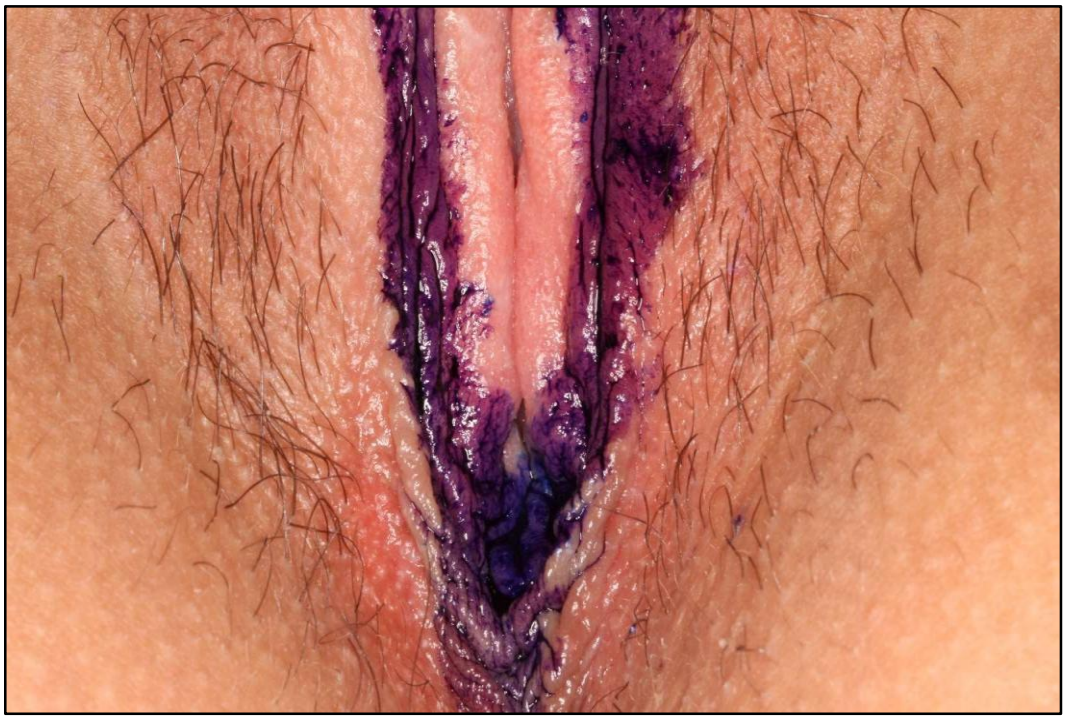
- Apply the TB dye to the non-mucous membrane tissue of the genital area.
- Take pictures, swab for evidence, and then apply the dye.
- Photograph again while waiting for dye to dry (30-60 seconds) and then gently clean the excess dye off and photograph the area again.
- The following three photographs show the injury ***(APD 16-a),*** dye application ***(APD 16-b),*** and injury highlighted by the TB dye after removal of excessive dye ***(APD 16-c)***.
- Dye is applied before speculum insertion in adolescent and adult females.

The TB Dye Procedure:

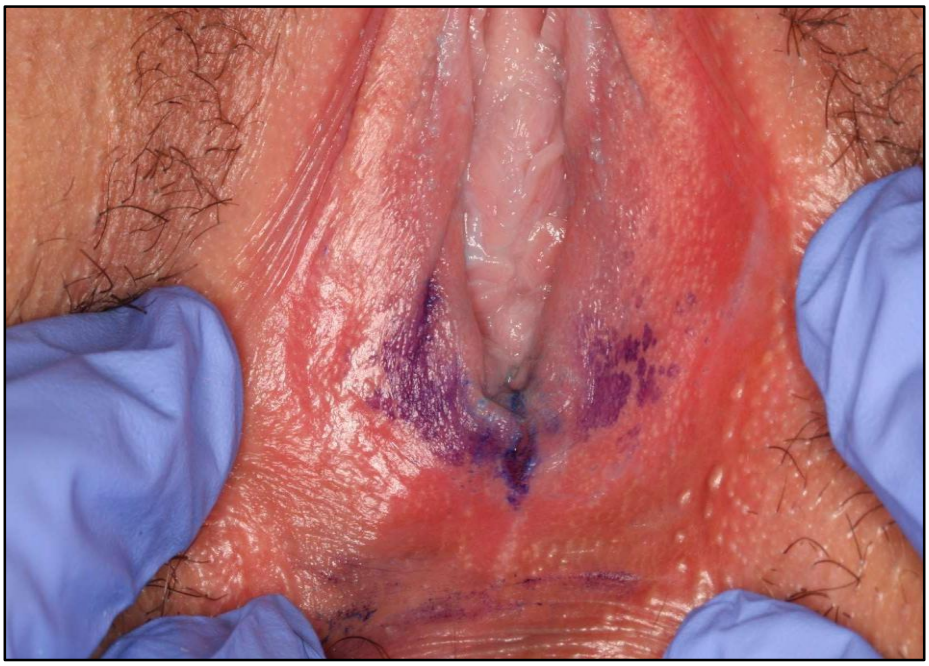
1. Look.
2. Photograph.
3. Swab for kit.
4. Clean.
5. Photograph.
6. TB dye application.
7. Photograph
8. TB dye removal.
9. Photograph; interpretation of results.
10. Vaginal speculum insertion, if needed.
11. Photograph.



APD 16-a. Photograph before the TB dye has been applied



APD 16-b. Photograph after the TB dye application (before removing excess)

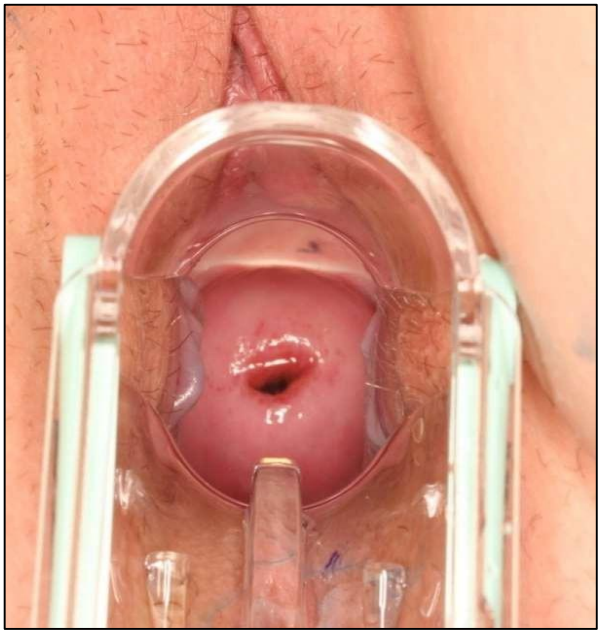


APD 16-c. Photograph after removal of excess TB dye, highlighting abrasions and laceration

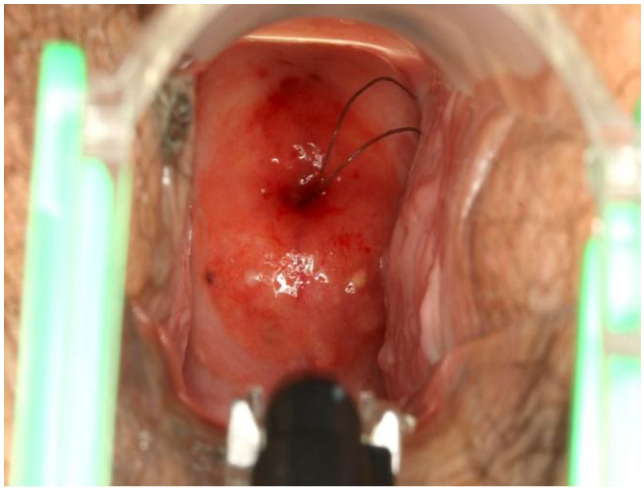
15. Once the external genital structures are thoroughly assessed and photodocumented, the examiner should proceed to the assessment and evaluation of the vagina and cervix by placing a speculum in adolescent and adult females (Tanner stage 3 or greater). The cervix is visualized at the distal end of the vagina. With the speculum in place, observe the vaginal walls and take 1-2 photographs of the right and left sides. Take several photographs of the cervix ***(APD 17-a and b)***. Additional photographs are needed if the examiner identifies injury, debris, anatomical variants, or other areas of interest. If the camera will not focus on the cervix, you likely need to step back and are too close. If using a colposcope, adjust the magnification and focus.

    Once photographs are taken and evidence swabs are collected (and/or Sexually Transmitted Infections (STI) swabs if applicable), the examiner will clean the cervix and take 1-2 additional photographs before removal of the speculum. The examiner should include a description of the appearance of the cervix and cervical os in their written documentation. Anatomical variants, such as the visualization of ectropion, as well as findings that may indicate erosion or infection, should also be included.

    Note: Always follow trauma informed care approaches. A speculum exam may not be tolerated by every patient. Prior to beginning the speculum exam, the patient should be instructed to alert the examiner if they experience any pain or discomfort. Stop the speculum exam if requested by the patient.

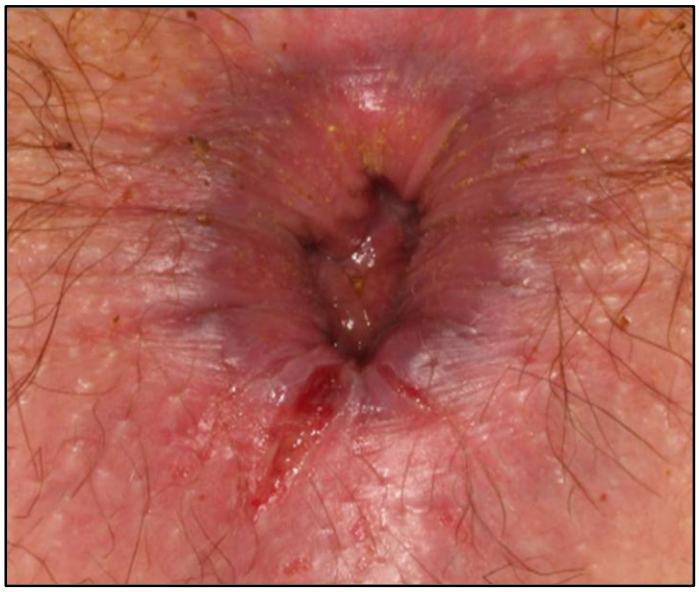


APD 17-a. Speculum in place with cervix visualized

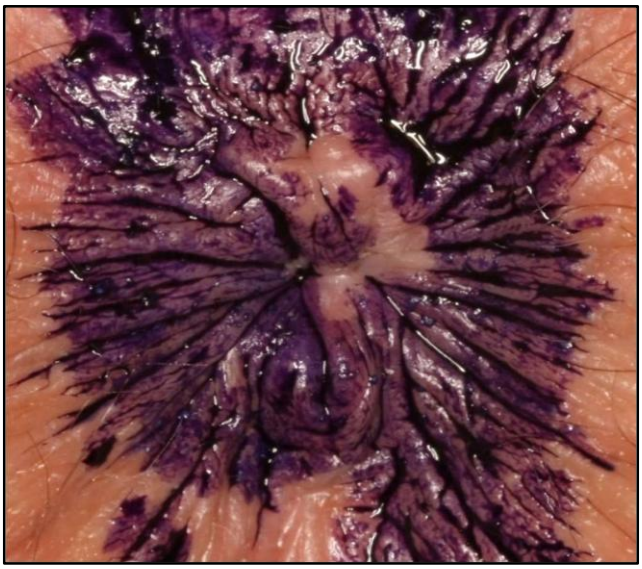


APD 17-b. Cervix with ectropion surrounding the cervical os. Two IUD strings and Nabothian cysts visible

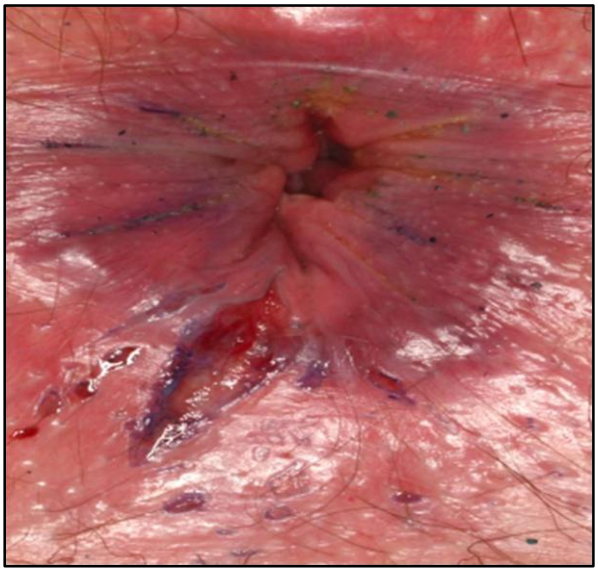
16. Place the patient in a supine cannon ball position with arms under the knees and inspect the anus and perianal folds. After the anus dilates, take 2-3 photographs, including any anatomical variants, injury, or other areas of interest ***(APD 18-a through c)***. If there is a history of attempted or completed anal penetration, collect evidence swabs, clean, and photograph again. Repeat the TB dye procedure of this structure with photographs.



APD 18-a. Photograph of the anus and anal canal



APD 18-b. Photograph of the anus after TB dye application



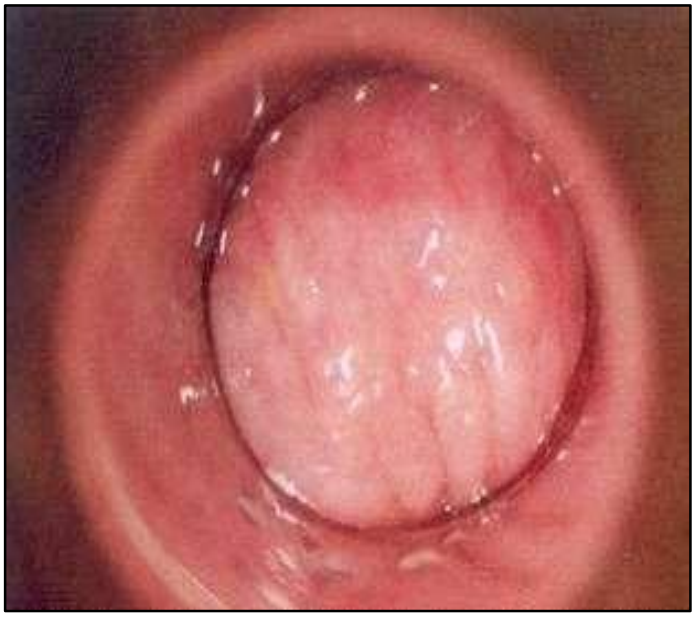
APD 18-c. Photograph of the anus after removal of excess TB dye, highlighting multiple lacerations

17. Follow local organizational policy and procedure for anoscope insertion.

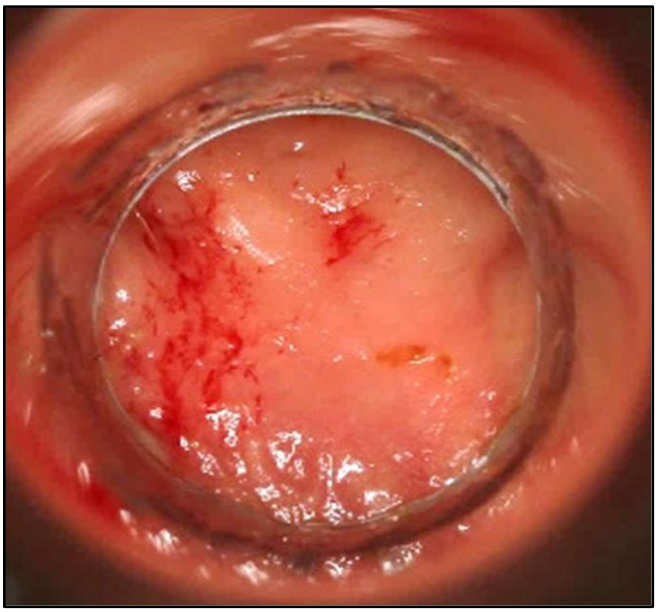
- Once an anoscope is placed into the rectum, take 3-4 pictures ***(APD 19-a and b)***. Collect evidence swabs and clean, then follow with 1-2 additional photographs. Remove the anoscope 1/3 of the way out and take 1-2 photographs. Remove the anoscope slightly further and take 1-2 photographs of the dentate line (also known as the pectinate line), ensuring that the anal and rectal canals have been thoroughly assessed and evaluated. The anoscope can now be removed.

- This will complete the series of pictures for the intraoral and anogenital examination of the patient who has been sexually assaulted.

  Note: In this guideline, no pictures of male genitalia were presented. The examination of male genitalia is external. External photodocumentation and assessment techniques apply. The anal evaluation would be the same as described above.



APD 19-a. Rectum with anoscope in place

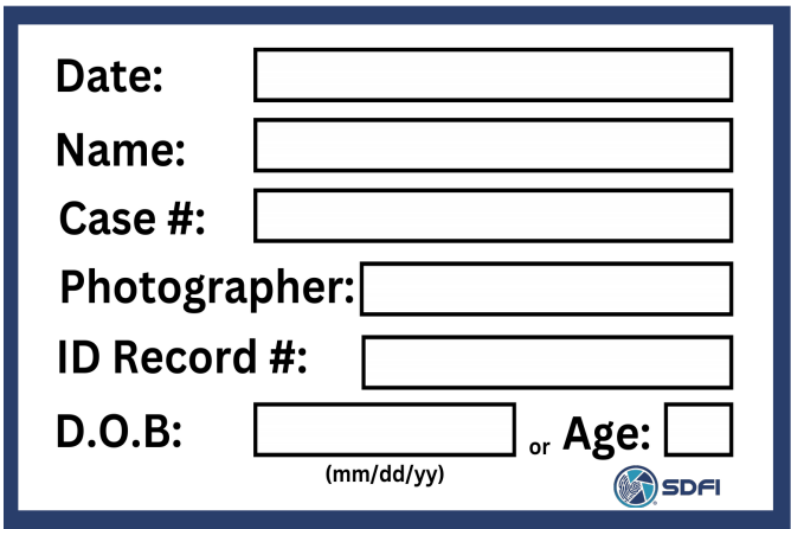


APD 19-b. Injury to rectum noted with anoscope in place

18. The last picture that the examiner will take for the exam will be that of the bookend card or patient's ID wristband. ***(APD 20)***.

19. Consider a follow up exam to reevaluate injury healing. Schedule accordingly if applicable.

Note: This will mark the conclusion of the photodocumentation component of the examination. Remember to check photos in real-time and retake any photos that are blurry, dark, or otherwise not a clear and accurate representation of what is seen in person. Best practice for photodocumentation of a comprehensive anogenital assessment includes 20-40 anogenital photographs.



APD 20. SDFI Bookend Card Sample.

References

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