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Review Article

The Penis in the Picture: The Throckmorton Sign, Genital Visibility, and Communicative Care in Medical Imaging

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Abstract

Medical imaging can render intimate anatomy visible even when that anatomy is incidental to the diagnostic purpose of an examination. This review uses the Throckmorton sign as a starting point for examining the communicative implications of incidental genital visibility in medical imaging. Drawing on scholarship concerning intimate physical examination, sexual-health communication, medical visualization, genital body image, patient experiences of imaging, and the ethics of intimate clinical images, I introduce two new provisional concepts. *Clinical intimacy translation* describes the communicative process through which personally intimate embodiment becomes clinically intelligible, discussable, viewable, and actionable anatomy. *Genital salience* describes the degree to which genital anatomy acquires or retains personal, relational, sexual, gendered, or identity significance within a clinical encounter or representation. Together, these concepts demonstrate why clinical relevance and personal salience should be treated as independent dimensions. I conclude by identifying communicative practices for addressing incidentally visible intimate anatomy, including anticipating visibility when feasible, normalizing without trivializing, maintaining clinical purpose, and remembering the absent patient. Patient-centered imaging requires attention not only to what medical technologies make visible, but also to what happens communicatively after intimate anatomy becomes visible.

Introduction

Pelvic radiography is commonly performed to evaluate suspected fractures and other pathology involving the pelvis and hip. Although the diagnostic focus is typically skeletal, the resulting image may also render other anatomical structures visible, including the penis. One unusual consequence of this incidental visibility is the Throckmorton sign, also known as the John Thomas sign: the observation that the penile shadow on an anteroposterior pelvic radiograph may point toward the side of a hip fracture. Thomas and colleagues reported on this association in a brief letter after noting that the phenomenon had previously circulated largely through medical teaching and what they described as “darkroom banter” [1]. Their brief report brought published attention to an association that had largely circulated as clinical lore.

Thomas and colleagues’ letter was later challenged by Murphy and colleagues who examined 200 pelvic radiographs and assessed penile direction, angle, and length in relation to

hip fracture laterality [2]. They found the John Thomas sign to be an unreliable predictor of fracture side, concluding that its diagnostic performance was worse than chance. One proposed explanation for the sign has itself been positional: a displaced hip fracture may alter lower-limb and pelvic positioning in ways that could affect the apparent direction of penile lie [2]. Murphy and colleagues, however, found no reliable relationship between fracture laterality and penile direction or angulation [2]. Penile lie on a radiograph should therefore not be treated as a stable anatomical indicator independent of patient positioning, bodily asymmetry, and other possible influences. The Throckmorton sign therefore remains more memorable as a radiological curiosity than compelling evidence of pathology.

Yet its curiosity raises a different clinical question. The penis in these images is incidental to the diagnostic purpose of the radiograph, but it is nevertheless visible enough to be noticed, measured, named, discussed, taught, and joked about. Here, incidental refers to anatomy visible in an image despite not being the diagnostic target of the examination; it does not

refer to an incidental radiologic finding. The Throckmorton sign thus illustrates an overlooked communicative feature of medical imaging: technologies designed to visualize clinically relevant anatomy may simultaneously render intimate anatomy visible when that anatomy has little or no relevance to the purpose of the examination.

For imaging professionals accustomed to viewing anatomy clinically, such visibility might be unremarkable. For patients, however, genital anatomy can carry meanings involving privacy, sexuality, masculinity, gender, body image, and interpersonal vulnerability. These meanings need not be present for every patient, nor should clinicians presume embarrassment merely because genital anatomy is visible. Rather, the Throckmorton sign prompts a broader question: What communicative responsibilities arise when clinically incidental anatomy may nevertheless be personally salient anatomy?

This review uses the peculiar case of the penis in the pelvic radiograph to consider genital visibility, patient experience, and communicative care in medical imaging. Its starting proposition is simple: clinical irrelevance does not necessarily mean personal irrelevance.

Discussion

From the intimate body to the clinical body

Clinical encounters routinely require health professionals to see, discuss, and touch parts of the body that patients may otherwise regard as private or intimate. Medicine therefore depends upon communicative practices that allow intimate embodiment to become clinically actionable without automatically becoming sexualized. Giuffre and Williams found that physicians used multiple interactional strategies to desexualize physical examinations, including medical terminology, professional demeanor, conversation, privacy practices, chaperones, and meeting patients while they were still clothed [3]. Some strategies effectively objectified the patient as an anatomical body. Although objectification can carry negative connotations, a limited clinical version can also serve an important interactional purpose: breasts, genitals, and other intimate anatomy must sometimes become examinable body structures rather than sexual objects.

Language participates in this transformation. In their systematic review of sexual-health communication, Kelder and colleagues identified depersonalization as one way clinicians and patients manage delicate topics [4]. Possessive language can shift toward less personal forms—*your vagina*, for example, becomes *the vagina*—while intimate actions can similarly be transformed into clinical phenomena. Such language creates interactional distance between the embodied person and the anatomy or activity under discussion.

Genital care makes the importance of this communicative work especially apparent. Cartron and Zampella recommend explaining the clinical rationale for genital examination, seeking permission, using appropriate anatomical terminology, protecting patient autonomy, and attending to verbal and nonverbal signs of vulnerability [5]. Their discussion of

involuntary erection is particularly instructive: erection during examination need not indicate sexual arousal, and clinicians are advised to normalize the physiological response while avoiding laughter or joking that might heighten embarrassment [5].

I provisionally propose *clinical intimacy translation* to describe the communicative process through which personally intimate embodiment becomes clinically intelligible, discussable, viewable, and actionable anatomy. Such translation is not inherently dehumanizing. Indeed, it may be precisely what permits respectful intimate care. The clinician must sometimes be able to encounter a penis simply as anatomy. Yet translation does not erase the patient's relationship with the translated body. The clinical penis can become *the penis* rather than *your penis*, but the patient's embodied relationship with that anatomy does not necessarily disappear with the grammatical possessive.

Imaging the intimate body

Medical imaging introduces another layer to clinical intimacy translation because the body becomes not only observable but represented. Medical visualization technologies establish particular ways of seeing bodies, mediating what becomes visible and how bodily interiors and structures become clinically intelligible [6]. The resulting image can also persist beyond the immediate encounter. Unlike a clinician's transient observation during physical examination, a medical image can be stored, retrieved, reviewed, shared, taught from, and interpreted when the patient is no longer physically present.

The production of a medical image is itself an interpersonal encounter. In general radiography, patients may be asked to remove or adjust clothing, move into particular positions, remain still, and cooperate with instructions before an exposure is made. Recent qualitative research suggests that consent in general radiography is often treated as implied through such cooperation and positioning, making explanation, information-giving, permission, and responsiveness important components of the encounter [7]. Patient-centered radiography research similarly demonstrates that these seemingly routine actions can carry relational consequences. Patients have described feeling intimidated or even assaulted when instructed to remove clothing or lie down without adequate explanation, whereas clear explanations, questions about comfort, and adaptation to physical limitations can support rapport and compassionate care [8]. The circumstances under which intimate anatomy becomes visible therefore include not only the technical field of view but also how the patient is prepared, positioned, covered, and communicated with while the image is produced.

These considerations become particularly important when positioning may expose or depict genital anatomy. Guidance concerning intimate examination recommends gowns or continued covering when feasible, explanation before intimate areas are exposed, permission before proceeding, and attention to patient preferences regarding chaperones or examiner gender [5]. Gender-affirming imaging guidance likewise emphasizes privacy, chaperones for sensitive examinations, trauma-informed communication, and explanation of

shielding practices when shielding is used or requested [9]. Not every preference can necessarily be accommodated, particularly in urgent or emergency imaging where pain, mobility, positioning requirements, staffing, and clinical urgency may constrain available choices. Even under those conditions, however, concise explanation can help preserve a patient's sense of participation and control. Genital salience may therefore arise not simply from what anatomy appears on an image, but also from how much explanation, privacy, choice, and control accompanied the moment in which that image was created.

Ethical scholarship on medical photography demonstrates why this distinction matters. Lakdawala and colleagues argue that images involving genitalia, breasts, or extensive nudity warrant particular attention because intimate images may carry psychological significance and implications for identity [10]. Their analysis also emphasizes consent, privacy, storage, access, dissemination, and limiting bodily exposure to what is clinically necessary [10]. Although medical photography and diagnostic radiography are not equivalent practices, both illustrate a fundamental feature of technologically mediated clinical visibility: an image of intimate anatomy can exist separately from the embodied person whose anatomy it represents.

Medical imaging therefore does not merely make anatomy visible. It creates a representation of a person's anatomy that can remain visible when the person is no longer present. This distinction is particularly important for incidental anatomy. A patient undergoing pelvic radiography may understand that the pelvis will be imaged without anticipating every anatomical structure that the resulting image will reveal. Once created, moreover, the image can enter professional interactions in which the patient has little or no participation. In the case of the Throckmorton sign, the penis can be noticed, interpreted, measured, discussed, taught from, or joked about while the person whose penis appears in the image is entirely absent.

Genital salience

Recognizing the persistence of intimate images does not mean assuming that patients are necessarily embarrassed by them. Genital visibility and genital significance are not equivalent. I use *genital salience* as a provisional term to describe the degree to which genital anatomy acquires or retains personal, relational, sexual, gendered, or identity significance within a clinical encounter or representation.

Salience is therefore contextual rather than intrinsic. One patient may regard incidental genital visibility as entirely unremarkable. Another may experience concerns about privacy or appearance. Another may understand the penis in relation to masculinity, sexuality, or sexual adequacy. Another may experience gender dysphoria or trauma-related discomfort. Salience may also be relational: anatomy that creates little concern when viewed by a clinician may become acutely significant when an intimate partner, parent, child, trainee, or other person is present. Finally, salience can be emergent rather than anticipated. A patient may enter an imaging

encounter with no concern about genital visibility and become self-conscious only after unexpectedly encountering their own genital anatomy on the resulting image.

Research concerning penile body image illustrates why objective anatomy and subjective meaning should not be conflated. Schifano and colleagues note longstanding cultural associations between the penis and masculinity, fertility, and strength and describe how subjective perceptions of penile size can diverge from objective dimensions, sometimes involving shame and insecurity [11]. Related qualitative research indicates that privacy, embarrassment, and masculinity can shape men's experiences of seeking sexual-health care [12]. These findings do not establish that men will experience incidental penile visibility negatively. Rather, they demonstrate that genital anatomy may carry meanings extending well beyond its immediate biomedical significance.

Importantly, genital salience is not reducible to cisgender men's concerns about penile size. Research with transgender and gender-diverse patients demonstrates more broadly that medical imaging can intersect with dignity, privacy, identity, communication, and emotional comfort. Grimstad and colleagues found unexpected emotional discomfort across multiple imaging modalities among transgender and gender-diverse patients and identified patient experience as involving factors such as privacy, respect, procedural explanation, and participation [13]. Recommendations for gender-affirming radiologic care similarly emphasize explaining why information about intimate anatomy is clinically necessary, respecting patients' terminology, protecting privacy, and providing control where feasible [9]. These experiences should not be treated as proxies for those of cisgender male patients. Rather, they demonstrate the larger point that the meaning of anatomy cannot be inferred simply from the anatomy visible in an image.

Clinical relevance and personal salience are thus independent dimensions. Genital anatomy can be both clinically relevant and personally salient, as when genital pathology is itself being investigated. It can be clinically relevant but of little personal salience to a particular patient. Incidental anatomy may likewise be personally unremarkable. The communicatively interesting situation arises when anatomy is clinically incidental yet personally salient. The Throckmorton sign provides an unusually vivid example of this possibility.

In making these arguments, it is important to note that no study identified for this review directly examines how patients experience incidental genital visibility in diagnostic radiography. The present argument therefore draws together adjacent literatures to propose clinical intimacy translation and genital salience as provisional concepts for empirical investigation rather than as evidence that such visibility necessarily produces harm. When discomfort does occur, the framework suggests several possible communicative mechanisms, including unexpected re-personalization of clinically objectified anatomy, violated expectations about what would become visible, and perceived loss of control over who may view, discuss, or retain the resulting image. These

proposed mechanisms remain hypotheses requiring direct empirical examination.

The throckmorton problem: From clinical observation to communicative care

Return, then, to the penis in the pelvic radiograph. What begins as incidental anatomy becomes visible, noticed, directional, named, measured, taught, and historically joked about [1,2]. Clinical intimacy translation has effectively moved from *my penis* to *the penis* to *the radiographic image*. Yet professional attention can partially reverse that translation: the clinically incidental penis again becomes a particular person's penis—one with a direction, appearance, or other characteristics—while that person may not even be present.

This is what makes the history of the Throckmorton sign's "darkroom banter" analytically useful [1]. Humor itself is not inherently incompatible with compassionate medicine, nor does every patient experience penile humor as offensive. Indeed, research in radiological breast cancer screening suggests that appropriately deployed humor can strengthen patients' perceptions of empathy and the patient-radiologist relationship [14]. The communicative issue is one of perspective. Contemporary guidance concerning genital examination cautions clinicians against laughing or joking about an involuntary erection because a physiological event may nevertheless be experienced by the patient as vulnerable or embarrassing [5]. Similarly, professional humor that appears harmless among clinicians may concern anatomy that remains intimate to the patient whose body produced the image.

Several principles of communicative care follow, with different responsibilities becoming especially relevant at different points in the imaging process. First, clinicians should *anticipate intimate visibility* when feasible. For radiographers, who often have the most direct contact with patients during preparation and image acquisition, this may involve explaining positioning, clothing adjustment, or other aspects of the procedure that could make intimate anatomy visible. Patients need not receive an inventory of every structure an image might capture, but clear communication before positioning or exposure can reduce surprise and preserve a sense of participation in the encounter [7,8].

Second, clinicians can *normalize without trivializing*. Genital anatomy is ordinary human anatomy, and treating it clinically can reduce shame or unnecessary sexualization. Radiographers can enact this principle through professional language, attention to privacy, and responsiveness to discomfort during the examination itself. Radiologists and other clinicians who later discuss the image can similarly avoid treating incidental genital visibility as remarkable merely because it is noticeable. Normalization, however, should not require dismissing a patient's concerns about privacy, appearance, or who may view the image.

Third, clinicians should *maintain clinical purpose*. This responsibility becomes particularly important for radiologists and other professionals interpreting, reviewing, or discussing images after acquisition. Attention to incidental anatomy may

occasionally be medically or educationally justified, but clinical visibility alone does not make every observation, comparison, joke, or use equally necessary. Lakdawala and colleagues' discussion of intimate medical photography is instructive here because it distinguishes legitimate clinical purposes from circumstances in which the patient's body risks becoming spectacle [13]. Educators using clinical images likewise should consider whether attention to intimate anatomy serves a genuine teaching purpose or merely redirects attention toward anatomy that happens to be visible. The relevant ethical question is not whether intimate anatomy may be seen, but what purposes authorize continued attention to it.

Finally, clinicians should *remember the absent patient*. This principle is especially important for radiologists, educators, trainees, and other clinicians who may encounter an image after the patient has left the imaging room. Radiologic images can create interactional distance precisely because the represented body remains available when its owner is elsewhere. One useful communicative heuristic is therefore simple: Would this way of discussing the anatomy remain professionally appropriate if the patient were present? Existing patient-centered radiology guidance already emphasizes explanation, trust, confidentiality, dignity, participation, and attention to what matters to patients [15]. Extending those principles to incidentally visible intimate anatomy requires no special "penis protocol." It requires recognizing that clinical visibility and personal significance can coexist.

These provisional concepts also suggest a research agenda for examining intimate visibility in medical imaging directly. Patient interviews following pelvic radiography could explore whether genital visibility is noticed, when it becomes salient, what meanings patients attach to that visibility, and whether those meanings change depending on who is present or who may later access the image. Survey and experimental research could distinguish anticipated from experienced concerns about embarrassment, privacy, image access, or loss of control and test whether anticipatory communication about intimate visibility changes patient responses. Research with radiographers and radiologists could likewise examine how professionals understand incidental genital visibility, what communicative practices they use to manage it, and how decisions about positioning, viewing, discussing, storing, or teaching from images are made. Finally, observational or discourse-based research could examine how intimate anatomy is discussed when patients are present and absent. Together, such studies could test when clinical intimacy translation becomes consequential, identify conditions that increase or decrease genital salience, and determine whether particular communicative practices improve patient experience.

Conclusion

The Throckmorton sign is unlikely to transform diagnostic imaging. Its limited clinical utility instead makes it valuable for revealing a less obvious feature of medical images: anatomy can be incidental to diagnosis without being incidental to the person whose body is represented. Medical imaging necessarily transforms embodied people into clinically interpretable

representations, allowing clinicians to identify, evaluate, and communicate about anatomy and pathology. Yet intimate anatomy does not automatically shed its personal, relational, sexual, gendered, or identity meanings merely because it appears within a clinical image.

The concepts of *clinical intimacy translation* and *genital salience* provide complementary ways of understanding this tension. Clinical intimacy translation describes the communicative work through which intimate embodiment becomes clinically manageable anatomy. Genital salience recognizes that patients may retain meanings that clinical practice appropriately brackets in order to provide care. Neither concept requires clinicians to presume that patients will experience genital visibility as embarrassing or distressing. Instead, they encourage attention to the possibility that clinical visibility may have different significance for the person being imaged.

The penis may be incidental to the image. It is not necessarily incidental to the person whose penis it is. The Throckmorton sign therefore points toward something more consequential than the side of a hip fracture: the need to consider not only what medical images allow clinicians to see, but how communicative care should govern what happens after intimate anatomy becomes visible.

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