Post-Operative Vaginoplasty Guide to the First Year

This is a resource for primary care providers supporting routine and longitudinal care of patients of Women's College Hospital-Transition-Related Surgeries Program who have undergone gender-affirming vaginoplasty procedures. To support continuity of care for patients, your client's surgical team has completed a brief care plan summarized in SECTION 1. Further instructions and recommendations related to ongoing care can be found in **SECTION 2**. In SECTION 3 you can find a FAQ, additional clinical resources, guidelines and contact information for your client's surgical team.

SECTION 1

Patient Surgery Profile

Patient name used:	Patient name on administrative/legal documents:	Patient pronouns:
Surgery date:	Surgeon(s):	Surgical Technique:

Intra-operative/immediate post-operative complications:

Dilator depth after surgery	**purple/blue/green/orange dilator to dot # 1 2 3 4 5**

Dilator Schedule

3 x/day	For 3 months
2 x/day	For 6 months
1 x/day	For 3 months
1-2 x/week	Indefinitely

SECTION 2

Clinical care and follow up

We recommend 5 touch points in the first year following surgery: **2 weeks, 3 months, 6 months, 9 months, one year and annually thereafter**. Visit frequency could increase if there are complications. At every visit complete a review of systems: **After care regimen adherence (ie. Dilation schedule), activities, genitourinary function and symptoms, gastrointestinal function and symptoms, pain, sexual health and mental health.**

Follow up template:

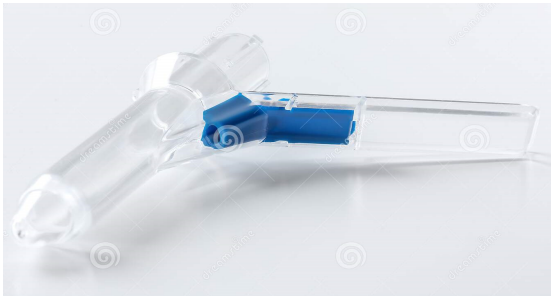
Follow Up Interval	Expected course/Check-in
2 weeks	- Frequent dilations (minimum 3x/day) - Activity is limited and restricted - Expect spray with voiding - Ensure normal bowel function, no gas or stool per vagina - Pain: with dilations, incisions, sharp stabbing pain to clitoris - Will have sloughing skin graft, sutures and discharge per vagina - On exam expect ++ swelling, bleeding, posterior forchette separation - No sex exploration at this time - Poor mental health including worsening anxiety and low mood is common
3 months	- Twice daily dilations - May have lost 1-2cm depth, focus on keeping current depth - Activities: no weight restrictions, return to baseline (swim, sex and exercise) - Voiding should have improved but can still spray - Pain should be minimal, dilation may still be uncomfortable - Sex: encourage active exploration, supportive conversation - Scarring: can do scar care if desired/helpful - Internal exam: canal well epithelialized - If hypergranulation: treat with Silver N2/Topical steroids
6 months	- Twice daily dilations - Should have no activity restrictions - Ensure able to achieve orgasm if desired - Hypergranulation common
9 months	- Once daily dilations
One year	- Dilating once weekly for life (depth>width) - Complete nerve healing (1-1.5 years) - Final aesthetic - Gender dysphoria

After care regimen 	Dilations: - Frequency - depth (# dot) - size dilator - length of time at full depth
	Douche: - We do not routinely recommend douching. - Douching is used to manage any unwanted symptoms such as vaginal discharge and malodour and can be used to manage hypergranulation. - Use a douche bottle with a long tip with a pump function - Solution. We recommend an isotonic (normal saline) or hypertonic (white vinegar/water mix or soapy water) solution
Activities	The first two weeks after surgery are the most challenging and will restrict their ability to return to baseline function.
	At two weeks patients should focus on short, frequent walks avoiding too many stairs and heavy lifting.
	At two months, patients should be slowly returning to baseline function with complete return at three months.
	Everyone heals differently, but significant limitations impeding a return to baseline/work at three months should prompt an assessment as this would be atypical.
Genitourinary	Assess patients ability to void normally. Urinary spray can be normal after surgery. Despite some spray with urination being normal after surgery, there should have been some improvement by about 6 months.
	Urinary spray can be an associated with complications such as urethral meatal obstruction. A visual inspection of the urethral meatus to rule out complications should be done.
	Urethral stenosis is a possible complication and this should also be evaluated (is the urethra visible, open and able to accommodate a 16Fr foley).
Gastrointestinal	Bowel function after surgery can change.
	Assist patients with improved bowel function if necessary.
	Ensure no gas or stool is coming from the vagina.
	Gas or stool in the vagina raises the possibility of a fistula and should be assessed by the surgical centre.
Pain	Pain is common after surgery with most patients having pain at some point in recovery. Pain with dilations in the first three months is common. Acute post-surgical pain is typically addressed with standard analgesics. Ensuring pain is

	adequately controlled in the first three months so that frequent dilations occur is crucial.
	It is important to understand the behavior that elicits pain (ie dilation, sex, specific movements/activity) and its location (i.e. clitoral, introital, deep perineal)
	Treatment: Analgesics (NSAIDS, Acetaminophen, Gabapentin), Behavioral modification, Pelvic PT. The role for hormones, steroids and antibiotics is unclear.
	Education is an important part of addressing pain. Ensure ongoing dilations, support with dilation technique and strategies, and provide an anatomic review. Resources: Self PT, Progress tracker, Trans Pelvic Health App, https://www.pelvicpaineducation.com/ppep-videos; http://painguide.com
	Chronic pelvic pain (CPP) is pain that lasts longer then 6 months, is not responsive to the usual therapies (Tylenol, NSAIDS) and associated with disability (impairment of quality of life). A small number of patients will have CPP after vaginoplasty. CPP should trigger early intervention and referral to pain specialists.
Sexual Health	Explore goals prior to surgery: orgasm, penetrative sex with a partner, anatomy of partner, toys, no sexual desires etc.
	Sexual function is multifactorial, influenced by one's body image, genetics, hormones, mental health, physical health, sexual history, current partner etc. It is not just about genitals. Sexual health/activity prior to surgery can inform post surgery experiences and should be discussed.
	Assess pre-existing and new medications such as SSRI's that can impact sexual function including desire and orgasm.
	Sexual function concerns should prompt a physical exam to ensure there are no physical complications. Assess if the clitoris is buried, absent or over exposed. Denervation or necrosis is rare but possible. Also ensure the vaginal canal wide/deep enough for penetration. Orgasm may be more challenging to achieve after surgery for some. The density of the nerve receptors in the glans penis is less than that of the natal clitoris.
	If orgasm and erogenous sensation is a goal, sexual exploration should occur early on. Gentle touch and sensory stimulation should begin in the first 4 weeks, with more active exploration at 8 weeks and full exploration at 12 weeks. Encouraging exploration is important as waiting a

	long time after surgery before any nerve exploration can potentially compromise nerve regeneration potential.
	Fears and anxieties around sex after surgery are very common. Having open and explorative conversations about sex, the importance of foreplay, lube, clitoral stimulation and addressing patients concerns is important to improve function overall.
Psychiatric/Mental Health	Poor mental health is common after this surgery. Despite this surgery being well documented to improve mental health and wellness overall, there is a risk for mental health destabilization in the perioperative period. Pre-surgical mental wellness can have an impact and is important to optimize prior to surgery.
	General anesthesia is an independent risk factor for poor mental health. In addition, pain, restrictive dilation schedules, disruptive routines, and lack of support can have a negative impact on mental health.

Approach to examination



Ensure you are taking a trauma, trans and patient centered approach to exam. Ask if patients would like anyone else in the room and tell them you can stop the exam at any time. Verbalize each step before you take it. You can have the patient hold a mirror so they can participate in the exam.
Have the patient on the exam table with the bottom half of their clothes removed, covered in a sheet/gown. Lift the gown/sheen and complete a visual exam. Start with an initial touch outside of the labia majora and then gently move hands towards labia. Assess the anatomy and position of the clitoris, clitoral hood, vestibule, urethral meatus and vaginal entrance. Look at the skin for scarring, skin changes, and palpating for any masses in the labia majora. An internal exam can be safely performed after 12 weeks, unless clinically indicated to do so earlier. Using a single digit to assess the vaginal canal can be helpful prior to using an instrument, feeling for pelvic floor tightness, internal scarring. Using an anoscope for the exam (instead of a speculum) can help with the ease of the exam.

A guide to how to carry out a physical exam can be found here.

SECTION 3

Frequently Asked Questions

1. When can my patient resume activities like exercise, intimacy and swimming?

These should resume by approximately 12 weeks (some patients heal a little faster/slower). Once the incisions are scars, water submersion is possible. We encourage a gradual re-introduction to exercise. Intimacy is encouraged at 12 weeks with gentle exploration/self stimulation beginning at 8 weeks.

2. When can/should a patient experiment for orgasm? How can this be done?

Patients should start clitoral exploration early on – often with gentle touch and sensory stimulation for the first 4 weeks, with more active exploration at 8 weeks and full exploration at 12 weeks. Use of a vibrator over the lower mons/clitoral hood is encouraged. Direct clitoral stimulation may be too sensitive for some patients. Stimulating the "G" spot internally with external exploration can also be helpful in achieving climax.

3. How do I best examine the neo-vagina?

We use a lit anoscope, an instrument more similar to a dilator. This can increase the comfort of a pelvic exam. Using the term 'scope' or 'instrument' may be more gender affirming. Regular or pediatric speculums can also be used.

4. Why does the skin look separated? What should I do?

The skin around the posterior forchette can separate in the first few weeks after surgery. Typically this will heal by 12 weeks. Keeping the area dry and clean with a saline rinse is typically adequate wound care. Staying with a smaller size dilator until this heals can be appropriate management. Dilation must continue despite the wound separation and support is often required.

5. If my patient needs ongoing support I can't provide, where do I turn?

This should be something discussed with the patient prior to surgery. If the patient is not able to easily return to the surgical center, are there local experts (urology, gynecology or plastic surgery typically) who can provide complication management?

6. My patient continues to have pain post operatively, how do I know if this is normal at this stage?

Pain after surgery is typical. Usually the first two weeks post op, patients may require regular use of analgesics. By one month, patients may still continue to have discomfort with dilation. By three months the pain should be minimal and more "discomfort." Both

dilating and sitting for a long while can still be “uncomfortable” at three months but should be mostly improved by 6 months.

7. My patient is struggling to dilate, what can I do?

Supporting the patient with dilation in the office can help identify some problem areas and facilitate support. Pelvic physio can also be a very helpful therapy post vaginoplasty. Some Pelvic PT’s have specific training in working with clients post vaginoplasty.

8. My patient is bleeding with dilations, what can I do?

Bleeding with dilations is typical after surgery. After 8 weeks, bleeding from the vagina should prompt an internal exam. Assess for graft healing/loss, granulation or hypergranulation tissue. Hypergranulation should be treated at this point.

9. My patient’s urination is going everywhere, is that normal?

Urinary spray is very common after surgery. Typically this does improve with time. A physical exam can identify if there are any issues external to the urethra meatus that require attention. Ensure you assess for urethral meatal obstruction or stenosis on assessment.

10. My patient is bothered by intravaginal hair, what are my options?

If permanent hair removal was not completed prior to surgery, some hair growth in the vaginal canal is common. Currently in Ontario, there is no permanent way of removing this hair once it is in the vault. We recommend manually removing the hair with alligator forceps or long forceps. Hair left inside the vault typically does not cause any physical issues but in some cases it can interfere with the integrity of the skin of the vaginal canal and cause skin breakdown and contribute to hypergranulation.

To consult with clinicians at Women’s College Hospital- Transition Related Surgery Program contact:
414-323-6148
transitionrelatedsurgery@wchospital.ca

Further clinical resources

Vaginoplasty Guidebook: a patient education and support resource provided to patients undergoing vaginoplasty at Women's College Hospital- TRS program.

RHO Surgical Summary Sheets: documents providing an overview of gender-affirming surgical procedures, complications, expected outcomes and pre/post operative care needs.

Guidelines for Gender-Affirming Primary Care- Quick Reference: resource for primary care providers related to respectful and affirming care, hormone care and management.

Sexual Health Screening: a guide containing screening recommendations that are based on anatomy and is inclusive of gender-affirming surgeries and hormone therapy.

Transgender People and STIs (UCSF): a guide on providing gender-affirming care related to STIs

Gender-Affirming Patient Care in a Hospital Setting: a quick resource providing safety and confidentiality tips to help make clinical and hospital settings safer for transgender and gender-diverse patients.

Transition-Related Surgery Post Surgical Care: A Practical Guide for Healthcare Providers and Researchers: an evidence review and guide for primary care providers and researchers regarding post-operative needs of transgender and gender-diverse patients.

UCSF Vaginoplasty Procedures, Complications and Aftercare: a guide on vaginoplasty including techniques and procedures involved, complications and post-operative care and management.

Vaginoplasty: Summary for Primary Care Providers: a summery document meant to support discussion of vaginoplasty surgery between providers and patients.