Marci L. Bowers, MD
Gynecologic Surgery
134 W. Main St. #11
Trinidad, CO 81082
(877) 439-2244 fax: (877) 439-9922

GRS Discharge Instructions

Dilation Procedure. We ask that you ***dilate*** initially 3 times per day for 10-15 minutes at a time, utilizing the dilators provided by the hospital. Start with the largest dilator that does not provide significant discomfort. Dilation is normally fairly uncomfortable although tolerable and it does get better. Fear not. You should, within the next week or two, be able to 'graduate' upwards in dilator diameter. In all but the rarest of cases, your vagina has been fitted to the widest of dilators. You should increase to the next size dilator within10 days of surgery, the next size after 7 days and so on. Depth is important to regain when initially dilating each time (usually with a narrowish stint) and you may wish to place a permanent mark on the dilator of choice to see that you reach this each time. Depth can be measurably increased (with persistence) but also can be sacrificed (with neglect). There may also be blood and/or suture material which you'll notice upon removing the dilator, especially during the first couple of weeks. Use plenty of lubrication always. You should also use a quarter-sized dollop of Metrogel ointment once you have regained depth. If your dilator meets resistance, back it out, add more lube, and try it again. Sometimes a *slight* twisting motion may facilitate getting past these tender points. You may even choose to use a bit of your pain medication prior to dilating. But…DILATION IS ESSENTIAL.

Dilation frequency is 3 times daily for 15 minutes at a time. You should be as religious as possible with this initially. After 3 months, you can go down to twice daily and down to once daily after 6months,. Thereafter, you may experiment with a less frequent dilation schedule, especially if you are having receptive intercourse. Although our patients seem to maintain depth very well, 'use it or lose it' remains the time-honored mantra.

Intercourse is possible after about 6 weeks postoperatively. Be liberal with lubrication and do take it slowly…the tissue is sensitive and will take months to evolve during the healing process. Regular receptive intercourse eventually may take the place of dilations but…common sense becomes the rule here. Stay well-hydrated by drinking at least 8 glasses of water per day. ***Bladder infections*** are far more common in women because of the shorter urethral length so always void before and after intercourse or sexual activity.

Discharge. There will be some blood-tinged discharge on your pads for at least a few weeks…this may even have a frankly reddish color. This goes away as healing advances. ***Odor*** will change from a somewhat unpleasant 'healing odor' to a more natural 'feminine odor' as your vagina populates itself with native bacteria. This takes months but will be a welcome change. Your vagina is lined with squamous epithelium, the same lining that covers the vagina in natal women. As a result, you will forever more have some ***vaginal discharge***. Normally, this is a whitish-yellowish color. Excessive vaginal discharge, especially in the first few weeks after surgery can be of some concern in indicating an overabundance of bacteria or an imbalance in the bacteria and may require antibiotic treatment. The purpose of the ***Metrogel*** ointment used during dilation is to keep anaerobic bacteria from overpopulating the vagina while your natural bacterial composition takes place during this time. It is an antibiotic ointment and can be used if an unpleasant smell develops in the future although we ask you to have your primary doctor prescribe this. D***ouching*** (usually with a cap of white vinegar in warm water) is encouraged by some surgeons although I discourage this after, say, the first 6 months, as it depletes the vagina of bacteria that maintain normal vaginal health and well-being. For the short-term, douching can be helpful as an inexpensive alternative to the Metrogel, 2 or 3 times weekly. Your smell will be your best clue as to how things are down there. I also recommend daily 10-15 minute ***warm baths*** beginning one week after your release. Add a handful of Epson salts also as this can be helpful in drawing blood flow to the areas of healing and help maintain cleanliness. ***Yeast infections*** too are not uncommon and can be treated with over-the-counter medications of your choice (Monistat, etc.). ***STD's*** (sexually transmitted diseases) are possible despite the absence of natal vaginal and cervical lining. This includes HIV and its associated precautions.

Hormone therapy is usually continued while you are hospitalized but should be dropped, typically by 50%. I like Estradiol 2 mg daily or the Climara patch (0.10 mg weekly) or injectable Estradiol (because injectables and patches do not go through the liver and raise triglyceride levels). In my experience, estradiol levels and lipid profiles are the only ***blood tests*** that need to be followed by your general practitioner once you have completed surgery. I do feel ***mammography*** is wise on a schedule similar to that of natal women. More study is clearly indicated in this area

although I have strong feelings about the role that diet has in breast cancer causation so am likely to advocate for the health benefits of vegetarianism (if you have not already heard from me on this one!) ***Pap smears*** are, in my opinion, unnecessary. You will hear some say that this is your 'rite of passage' and is vital but…your vagina is made from penile/scrotal skin, tissue that largely lacks the kind of vulnerability as that which exists for the cervix in natal women. We rarely do them in natal women who have undergone hysterectomy so…enough said. The ***prostate*** atrophies so completely on estrogen that routine exams are, in my opinion, unnecessary following GRS. I would suggest a ***baseline PSA*** (Prostate Specific Antigen) one year after surgery…if normal, I would drop any residual concern you or your primary care doctor might have regarding the prostate.

Activity is encouraged as your strength allows but should be on a daily basis. We do not suggest lifting more than 10 pounds for 4 weeks after surgery. Heavy exercise (running, swimming, etc.) should probably wait about 6 weeks before resumption.

Diet is unrestricted although an emphasis on fluids, fruits, and vegetables is suggested. If you experience severe constipation, you should let us know. Bananas or Mangoes are suggested daily. Milk of Magnesia or mineral oil are suggested in the meantime taken usually at bedtime. Constipation can remain a problem as long as you are on pain medication.

Final Appearance of your results depend upon many factors but, especially, time. You will normally feel that the appearance is at its worst about ***one week*** after returning home. If not, great! Within ***4 weeks***, most stitches have dissolved, the swelling has gone down by 75% and any bruising should have vanished. About ***3 months*** out things start looking really good although the healing and swelling continue to improve even up to one year out. If, however, things do not look to your satisfaction by 3 months***, we want to know!***. Although very few patients have ever had to return for follow-up of any kind, this always remains an option and you are welcome to schedule with us at any time. Touch-up work can require a second operation (so-called ***labiaplasty***) but can be handled at times with a simple office revision which is done normally at minimal cost. This is where an e-photo to us can be of help. Future patients are also appreciative of the star-quality photos too so don't forget to send us good news.

Complications following release are unlikely although could include fever (>101 degrees), redness of the skin, severe pain along any incision line, or excessive bleeding. A firm, tender swelling in one or both labia can be a sign of a ***hematoma***….this is an organized collection of blood and clot beneath the skin that will normally resolve with time and heat, so long as it is no larger than, say, a golf ball. Slight ***separation of the skin*** along an incision site (especially as the stitches dissolve) is also a possible mild complication that requires lots of patience, a bit of Neosporin along the edges and a possible visit to your local doc. Re-sewing of the area is almost never a practical option. Do continue to dilate although you may wish to use smaller diameter dilators that put less strain on the separated tissue. Your body will heal itself with scar tissue that will fade and rarely be a long-term problem. Occasionally, a patient will develop ***granulation tissue*** at this separation. Granulation tissue is a tender, sometimes oozy reddish tissue that can bleed if touched. Granulation tissue is best treated by your local doc with either excision (best option) or with silver nitrate application.

If you are still having problems, please let us know so that we might help you. Depending upon urgency of the problem, you may call us or send us an e-mail. If you do need to see a physician after you've returned home, please have he or she phone us if there are uncertainties about caring for you. An ***emergency*** is rare but should prompt our immediate attention. **Try our office first, then Robin at (xxx) xxx-xxxx, then Dr. Julie Nicole (xxx) xxx-xxxx or Dr. Bowers at (xxx) xxx-xxxx if unable to reach Robin**. We normally wish to retain our privacy but want you to feel free to reach us if necessary.

Above all, please ***keep in touch*** with us…especially if you move or have news to share with us. We are committed to your happiness and would like to hear that you have done well in your new body. We periodically ask that former patients participate in questionnaires regarding your surgical experience so may ask that of you as well so…keep your information current!

Good Luck!
Marci L. Bowers, MD
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