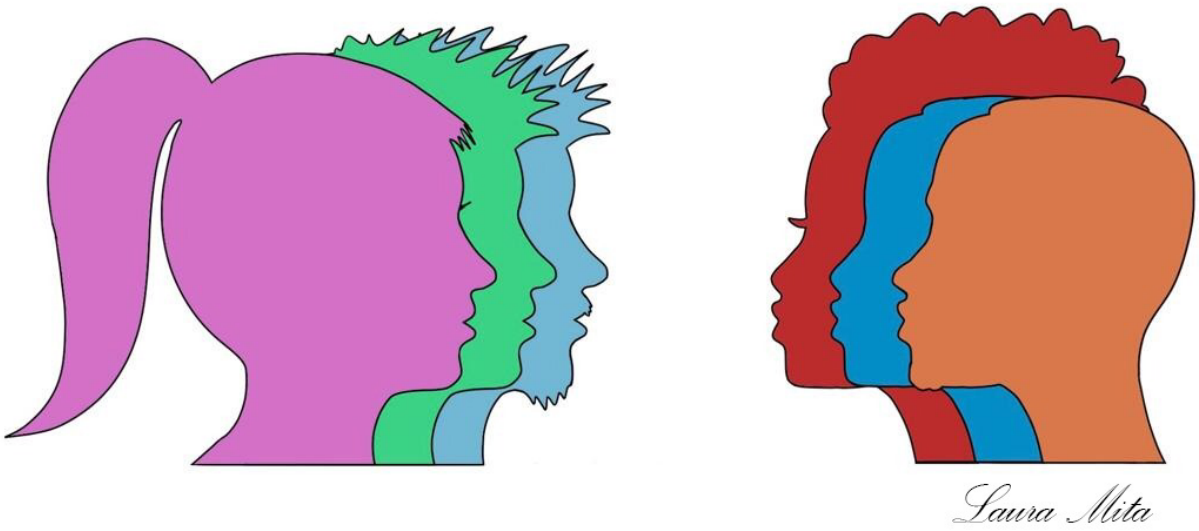
INTESTINAL VAGINOPLASTY



SURGERY

In intestinal Vaginoplasty, an intestinal segment will be used to create a Vagina.

Bowel segment vaginoplasty can be performed in transgender women for different reasons:
Insufficient penoscrotal skin or when penile or penoscrotal inversion technique has failed.

The advantage of intestinal transportation especially in revision cases, is the provision of a reliable length of **vascularized tissue with an epithelial surface.** Different intestinal segments may be used, the commonest are sigmoid colon, caecum or ileum.

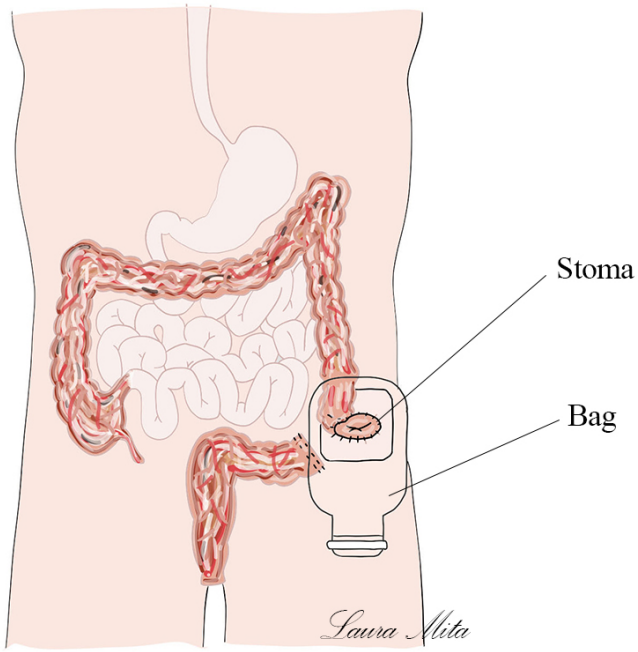
Possible Complications

The operation may be performed “open” (via an incision on the abdominal wall) or laparoscopically (keyhole surgery through small incisions)
With an open surgical approach, the possible risks include:
Wound infection
Wound dehiscence following a failure of the wound to close properly. This can cause abdominal muscles to weakness, allowing tissue and organs to form a **hernia.**

Rectal Perforation

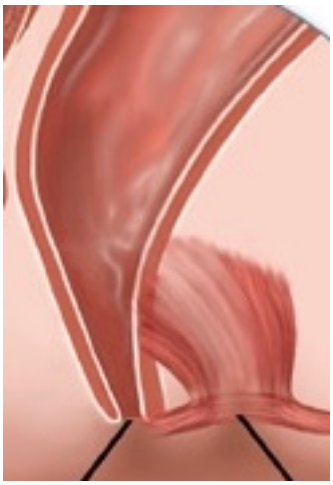
In revision surgery the neovaginal cavity has to be re-dissected. Dissection can be demanding, and the **risk of intraoperative rectal injury is higher**. In this case a colostomy might be needed if the intra operative repair is thought not to be watertight, with the risk that it will leak into the vagina (fistula).

COLOSTOMY



Introital Stenosis

Where the bowel segment joints the skin in the perineum, **this join may narrow** requiring further surgery in some 5-10% of patients.
When too much neovaginal tissue is left in place, dilation can become difficult with subsequent risks of stenosis. All patients will need to dilate the new vagina at interval to keep it open and this requirement is lifelong.
Dilation of the introitus is required, however, **deep vaginal dilation in not necessary.**



Anastomotic leakage

The join between the ends of the bowel where it has been divided to allow the chosen segment of bowel to be used for the vagina **may break down**. This may happen in up to 1% of cases, and if it does occur, peritonitis ensues, with the need for an emergency operation. At this operation, it may be necessary to bring the ends of the bowel out onto the surface of the abdomen into a bag (ileostomy or colostomy). **Stricture formation can occur where the join of the bowel becomes narrow with the healing.**

Neovagina inflammatory bowel disease

The lining of the bowel is designed to be in contact with intestinal content. When it is taken out of circuit for a long time, some patients develop **inflammation of the lining**. This defunction enteritis is usually asymptomatic initially, but may become apparent after many years, with bleeding and pain. This may necessitate using special douches to try to stop the inflammation, but in the worst case the vagina may need to be removed.

Other possible complications:

- Risks of neovaginal malignancies
- Abdominal wall infection
- Intraoperative blood loss necessitating transfusion
- Post-operative bleeding
- Post-operative Ileus.
  Ileus is the medical term for effective paralysis of a segment of the gut after an operation. It is much more common after open surgery than laparoscopy and may delay being able to eat and drink normally.

- DVT
- Neovaginal prolapse
- Urinary tract infection
- Excessive amount of mucus secretion
- Malodorous Discharge
- Postcoital bleeding

Annual vaginal examination is recommended

A guide to your stay in hospital

You will be admitted at 16:30 the day before your surgery.

On the day of the operation, you will receive an enema to clean the large bowel.

You will have the first of your daily injections for prevention of Deep Vein Thrombosis (DVT).

Surgery Day: Unless the Consultants have visited the previous day, your Consultants will arrive to see you and sign your consent forms with you. The Anaesthetist will also see you. You will be given anti-thrombosis stockings to wear, which will remain on throughout your stay. One of the nurses will take you down to the operating theatre for your operation.

After your time in recovery, when the nurses think it's safe you will be transferred back to the ward. You must remain on the bed until the pressure dressing is removed.

Day One: The Consultant comes to see you the dressings will be taken down, the 'drip' and morphine pump will be removed, and the large, bulky dressing will be changed by nursing staff to a smaller dressing if all is well. If you have had a laparoscopic operation, you will usually be encouraged to start to eat and drink. After open surgery, this may be delayed by a couple of days

If all is well, you can start to mobilise on day one

Day Two – five: Nursing staff will check your wounds and a Consultant will visit daily. You are responsible for changing your

sanitary pads and disposing of them in bins with yellow bags. During this time, you may also continue to mobilise.

Day Five: The Consultant or specialist nurse will remove your pack and instruct you in dilation. Your catheter will also be removed either with your pack or later on that day.

After your first dilation, you will be able to shower. Please ensure you wash your dilators in just warm water and dry. Dilation should be done three times a day. If you need supervision with the second dilation, please ask the nursing staff for support. Now the catheter is out, you will begin to urinate on your own.

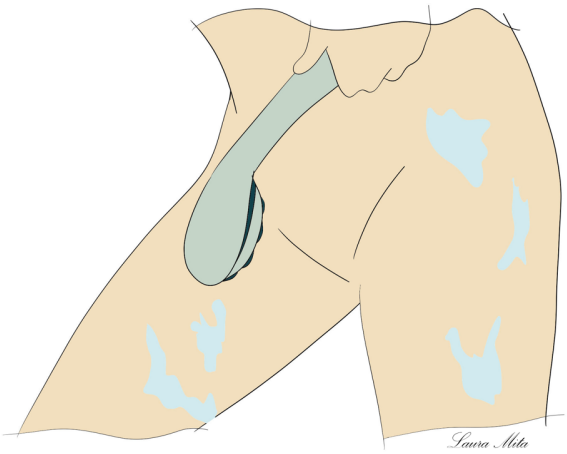
Having a urine catheter inserted for any reason increases your risk of developing urine infection. The symptoms are very easy to identify. You will experience a stinging sensation when passing urine and your frequency will increase. The colour and odour of the urine may change it may have a cloudier and dark colour and it may have a very strong smell

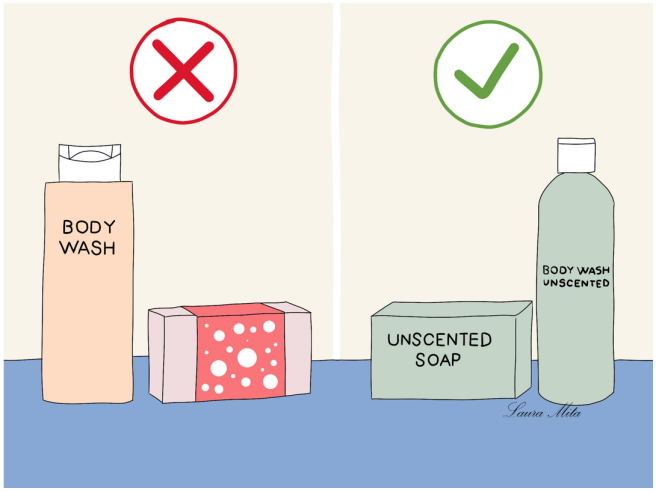
If you experience one of these symptoms while you are at hospital, please let us know. If you are back at home and you feel unwell, please contact your GP or the nearest A&E service as you might need antibiotics.

Day six to nine: Depending on return of bowel function and oral intake, you will be discharged from hospital and you will be provided with recovery advice

Wound Care

All stitches/sutures are dissolvable. You can bathe or shower as many times as you wish. **Do not use scented perfumed soaps or bath oils for 4-6 week**





Dilation

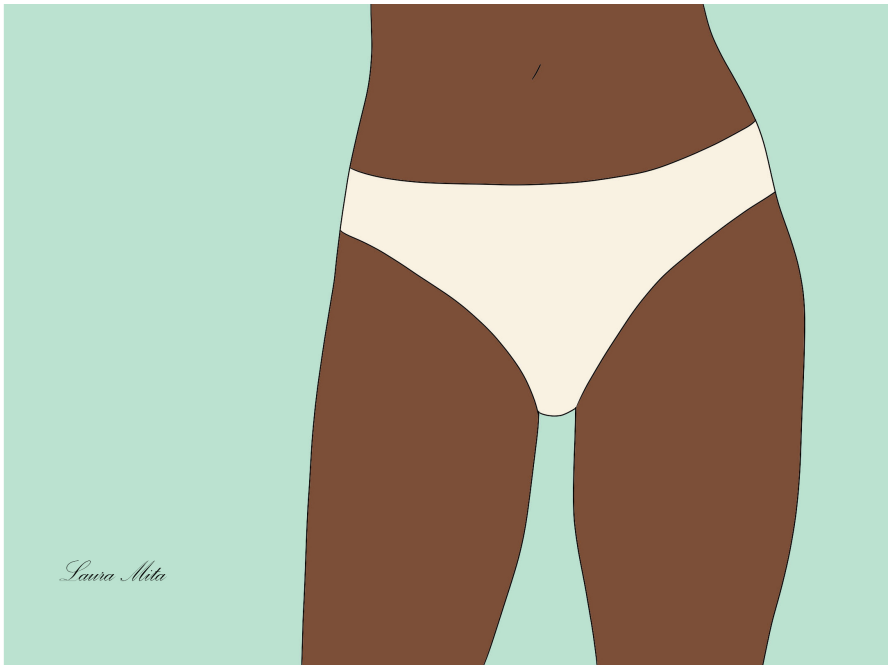
Dilate three times a day
Never rotate or twist the dilator but use straightforward push and pull movements. If you struggle to find the opening use your finger to help guide you.

The purpose of dilating is to maintain open the joints between the bowel segment and the perineum.
Dilation of the introitus is required, however, **deep vaginal dilation in not necessary.**

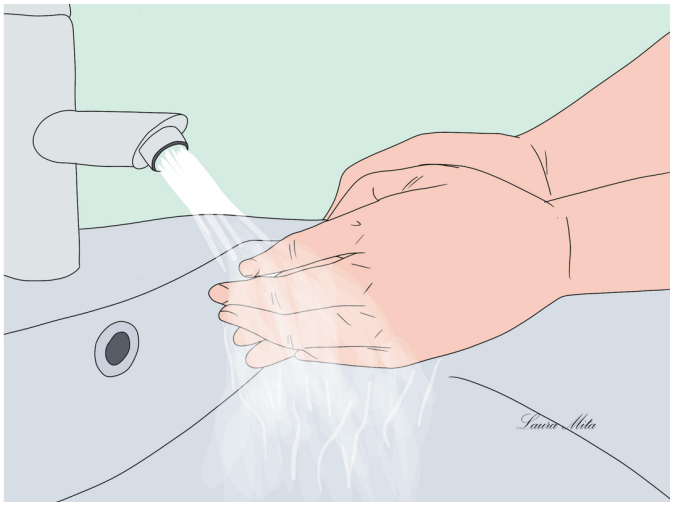
Vaginal Douching is recommended if there is any discharge

- Apply lubricant to the small dilator and massage the vaginal opening.
- Get the small dilator with your non dominant hand.
- Slide your finger into your vagina and once there, placed the small dilator just under the finger at the entrance and as your finger is removed the dilator should slowly be moved for at least 4 inches (10cm). It is important to get the dilator past the pelvic muscle, but once beyond there it is not necessary to pass it any further.
- Lower the angle to make it parallel with the bed. The tip will naturally follow the lumen of the vagina and should not need a lot of force to insert. To avoid injury, do not apply any excess pressure. Move the dilator and hold it.
- Repeat this again with the big dilator and leave for twenty minutes. Never twist or rotate the dilator but use straightforward push and pull movements.
- First eight weeks following surgery dilation is normally needed three times a day. At this point it is usually the time to gradually reduce the frequency of dilation. Usually this is down to once per week at around a year, but there is significant variation between patients.

Wear comfortable, cotton underwear that's loose enough to prevent the fabric from rubbing against your genitals.



Change your pads every 2 to 4 hours.
Wash hands before and after any contact with the genital area.



When wiping your bottom, make sure you wipe gently from front to back. This will help prevent bacteria in your anus infecting the cut and surrounding tissue.

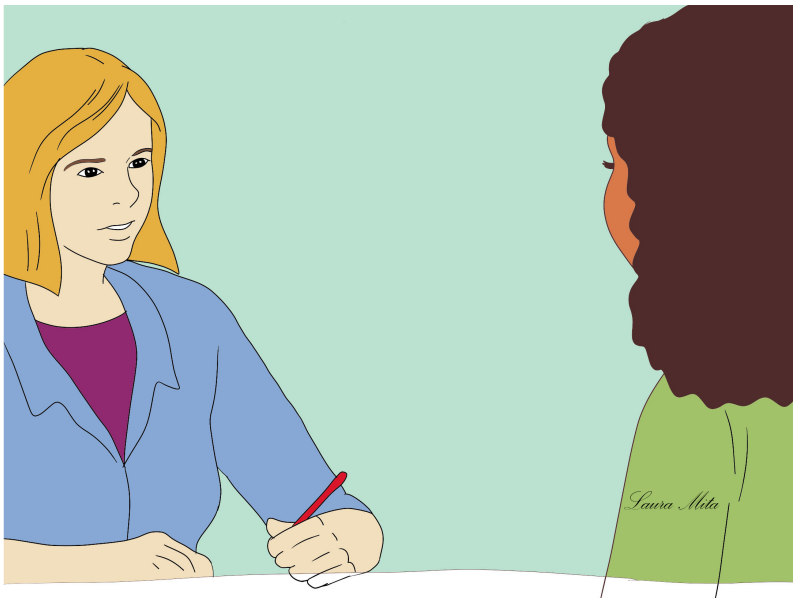
Hormones after surgery

You can start taking your hormones as soon as you get home providing you are mobile at the same dose taken before surgery.
After 8 weeks you should check your hormone level by your GP.

Signs of wound infection

Severe pain. Chills and fever of over 38.5°C for more than 24 hours.

Increased Pain, Swelling, Redness or Warmth Around the wound, yellowish or greenish pus or fluid with a foul odour. Your GP may prescribe you some antibiotics if the swab comes back positive



Massaging your scars

In order to stimulate blood circulation and improve the flexibility of the tissue surrounding the surgical site, it is important to begin massaging your scars once they have closed. Massage in the direction of the scar with Bio oil or E45 Cream.

We recommend doing light activity after three weeks and resume regular daily activity during the third month.
You need medical advice if you develop some of the following symptoms:
Abdominal cramping.
Fever
Appetite loss.
Feeling of fullness.
Constipation.
Inability to pass gas.
Stomach swelling.
Nausea.
Vomiting, especially vomiting stool-like contents.

Email for concerns: gendernurse@parkside-hospital.co.uk

I have read the above points and discussed the operation of intestinal vaginoplasty with the Specialist Nurse.

Nurse Signature:

_____

Date: ___/___/_____

Patient Signature:

_____

Date: ___/___/_____