Preface

These guidelines are intended to cover your post-operative needs in the first year after surgery.

Always use them as your first point of reference if anything causes you concern.

Throughout the document the term “Dr Suporn“ is used. This does not always mean literally “Dr Suporn”, but can always also be taken to mean “any surgeon of the Suporn Clinic”

Timescales

All timescales mentioned in this document are for guidance only. Every patient will have different experiences; some will find things easier than others. Do not compare notes with others to judge what stage you think you should be at; for every patient there is a different set of experiences and a different healing rate.

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Contents

SRS - POST OPERATIVE RECOVERY

General Comments

The most important thing for any post-operative woman is to BE PATIENT. It takes 12 months before a SRS result is final. Please do not expect everything to look perfect, and "work" perfectly within just a few weeks of leaving Chonburi. Also, do not compare recovery rates with other patients – particularly with those who underwent surgery with another surgeon. You are a unique human being who has undergone a unique and invasive procedure. What someone else has experienced has no relevance to your own rate of recovery, and it makes no sense to be jealous of someone who says their recovery has been quicker than you think yours is being. Just deal with your own recovery, not someone else's.

Seeing Your Own Doctor

Please do NOT be tempted to go to see your own doctor if you feel something is wrong – unless it is quite obvious your problem needs urgent attention. In general, your local doctor will not have the experience to deal with a newly post-operative SRS patient, particularly with Dr Suporn's technique, and will possibly do harm where in fact there is nothing to be at all concerned about. Similarly, please try to avoid seeing your doctor or a gynaecologist until you are about 12 month's post-operative. Again, their inexperience with SRS cases will not necessarily be helpful. Tell us first, and we will advise based on our very considerable experience. If we think it is necessary to see a doctor locally, we will tell you – but that is only very rarely necessary.

SCAR TISSUE CONTRACTION

It's really important that you understand what scar tissue contraction is, because it will affect you throughout all your recovery.

Whenever you undergo any surgery, or have any injury that damages skin, bone or other tissue, when it heals it does so by forming a scar. You have already seen scars form on your skin after a cut for example. If you have ever observed the healing process of a superficial scar, you will have noticed that the skin puckers together and commonly forms a small depression, often darker than normal skin, but over time the depression apparently fills with normal skin.

What is actually happening during that process when you see the puckering and depression is the consequence of scar tissue contraction, which is a tightening of the healing tissue.

Scar tissue is typically harder and less pliable or flexible than the normal tissue, but over time the scarring will soften, and will be replaced by normal tissue.

During healing after blood clots, the body helps rebuild the skin tissue with a type of cell called fibroblasts. Fibroblasts break down the clot and start replacing it with proteins – mostly collagen. While this replacement process (healing) is going on, the scar has a different texture than surrounding tissue that it is trying to build. It looks different, doesn't have a normal blood supply, and if superficial - doesn't have sweat glands or hair.

Those visual scars that you have already seen are superficial. But in any surgery, there is also a lot of scarring occurring under the surface that you can't see, where incisions have been made, or some trauma has occurred. That's all just part of the healing process. It's nothing for you to worry about, but is something that will affect you throughout your recovery.

Typically the kind of scarring (superficially and internally) that you will experience will take 12 months to fully soften, and to fully recover. Until the scar tissue has softened, you will be affected by it.

Scar tissue contracture is an extremely powerful force. It happens slowly, but you can't stop it from happening; it's part of the healing process. However, you can help it heal a little more quickly by massaging and stretching, because these stimulate the blood supply locally to the scar and accelerate healing by breaking down built-up collagen.

DILATION AND DEPTH

This document will put a lot of emphasis on dilation. Dilation is essential to overcome the force of Scar Tissue Contraction. If you don't dilate adequately, scar tissue contraction will reduce the vaginal depth, and the vaginal width – which if let to go too long will become permanent losses. We cannot correct permanent loss of vaginal depth, so it is every patient's responsibility to ensure they don't lose depth – by following our guidance and dilating adequately and properly. It is absolutely VITAL therefore that you dilate regularly as we advise, to overcome the significant force of scar tissue contraction.

If you stop dilating, scar tissue contraction will just carry on without you!

So, dilation is the key to retaining depth and gaining vaginal width. It is the one feature of post-operative recovery that is totally within your control. Only you can do it, but if you don't, you will lose depth and/ or width permanently. There is nothing that can be done to recover permanent loss other than by a major operation called a colonvaginoplasty – which is a procedure we don't do.

You will need to dilate your vagina to some extent for the rest of your life, though the amount you do so – and how and why – will be described in the following sections. Please read them very thoroughly.

Dilators

To help you with dilation the Clinic provides 3 different sized dilators:

Small Dilator
(28 mm diameter)

You may use the small dilator if you have difficulty dilating with the medium dilator. You can use it for 5 - 10 minutes before changing to the medium size. But you should not push small dilator too hard because it is sharp at the tip which might cause pain and damage.

Medium Dilator
(31 mm diameter)

There are 2 medium dilators, each made of a different material. The white one (1) is made from resin, and is “unbreakable” and is used for travelling. The clear medium dilator (2) is the main and dilator which you should use every time. You must achieve full depth every time you dilate.

Large Dilator
(34mm diameter)

The 34 mm dilator is the largest we can supply, and is the next step of dilation. You should wait until Dr Suporn tells you to use this, which he will usually tell you about 2 weeks after surgery. Initially he will tell you to use it for just 5-10 minutes, but later you should try to use this dilator at all times instead of any smaller one

Dilation Techniques

There are 2 techniques which we will teach while you are in Chonburi. The first is called Static Dilation and the second is Dynamic Dilation. You will use mainly static dilation immediately post-operative in Chonburi, but will progress to the more advanced dynamic dilation technique when told to do so by Dr Suporn.

Static Dilation

Static Dilation's main purpose is to prevent wound closure. Without some form of dilation immediately after surgery, the neo-vagina would try to heal up, the same as any other wound.

You will be taught how to prepare for dilation and how to insert the dilator. Static Dilation involves no more than inserting a well lubricated dilator to full depth, then holding the dilator in place in the vagina. To help you during that period, we give you a blue band or strap to pull on gently to hold the dilator in place at full depth for a set period of about a half hour.

After you have held the dilator in place at full depth for half an hour, withdraw the dilator and rinse.

This dilation technique is done only until about 2-3 weeks post- operative. Dr Suporn will continue to check your skin graft inside. When he decides it has healed sufficiently, he will instruct you to do Dynamic Dilation but you must not do that until you are told to do so.

Once you have been told to do Dynamic dilation, you should never need to do Static Dilation again. The blue band is only intended to be used during static dilation. It should not be used during dynamic dilation

Dynamic – or Active Dilation

After 2 weeks post-operative, the neo-vagina is no longer a surgical wound *per se*, and the purpose of dilation changes significantly. Scar tissue contraction starts to occur, and in line with that the purpose of dilation must change.

The object of dilation is to oppose the force of scar tissue contraction, and to soften the scar tissue that forms. It is really important that you understand that basic principle.
Scar tissue contraction is a natural bodily function, and is enormously powerful. If you allow it to run its natural course without trying to oppose it, it will have the effect of reducing vaginal depth and width. Static dilation alone does not help soften the scar tissue and – even though it helps to maintain depth to some extent, it does not help with widening the vaginal entrance or introitus at all. This can make progression to larger dilators very uncomfortable and difficult.

After 2 weeks post-operative and when permitted by Dr Suporn – and for every dilation session thereafter – you should dilate with a dynamic or active technique. Dr Suporn will suggest you do Dynamic Dilation 3 times a day, spending 15 minutes each time once you have reached your full depth.

 Do not do dynamic dilation before you are told to do it or you might damage the fragile vaginal lining skin graft.

Once you have been told to do Dynamic dilation, you should never need to do Static Dilation again.

The blue band is only intended to be used during static dilation. It should not be used during dynamic dilation. It should not be used during dynamic dilation

Preparing for Dilation

This section is intended to help you prepare and relax for each dilation session:

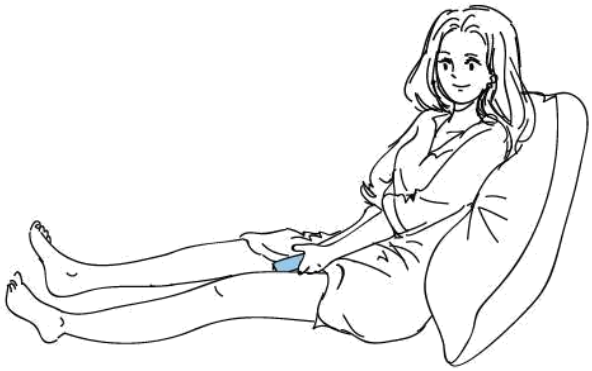
Environment

- Make sure you have enough time to dilate. If you are in a hurry or have something else to do immediately afterwards, your session will become rushed – especially if it doesn't go quite as well as you had hoped

- Prepare your environment to be as comfortable and enjoyable as possible. Turn down the lights to a soothing level, and put some light soothing music on in the background, or a relaxing movie. Watching thriller movies is not always relaxing!

- Make your bed comfortable. Prepare what you will lie on in advance. Have a little check list of what you need immediately to hand and lay them out on the bed next to where you will lie so that when you start dilating, you don't have to go and look for things, or move to do so.

- Your bed should be flat. Use enough pillows to support your back, to raise it between 45 and 70 degrees from the horizontal position (no more). Please see picture below:



- Don't prop yourself too upright, or you will not be able to insert the dilator to the required full depth. If you are finding insertion difficult, lie more horizontally until you find the ideal position for yourself.

- Switch your cell phone off. Dilation is much more important than answering the phone or texting messages; those can wait, but scar tissue contraction won't.

Physical Preparation

- If you have regular bowel movements, try to time your dilation session to start very soon after a bowel movement. That way your intestines will be empty. This will be much more comfortable, and will enable you easily to get quickly to depth. A full or constipated bowel can even prevent you reaching full depth by a significant amount. Moreover, at full depth, the dilator can compress the bowels causing some discomfort and making you feel over-full, as well as possibly inducing some constipation.

- Empty your bladder. If you feel the need to pass urine during a dilation session, you will become increasingly tense and dilation will become more difficult as the urgency to urinate increases.

Mentally Prepare – RELAXATION

We cannot overemphasize the importance of being relaxed. The more relaxed you are, the easier dilation will be. Contrarily, the more tense you are and fearful of dilation, the harder it will be.

While we don't pretend that dilation is fun, do not dread or hate dilation. If those words are in your thoughts, you will not be fully relaxed.

Lie down on the bed….and relax. Do not start dilating yet. Prepare your vagina by applying lots of lubricant to the vaginal entrance with your fingers – and to a depth of about an inch.

Gently massage the opening with your fingers, making sure you stretch the vaginal introitus and fully lubricate it. Be very sure to apply a lot of lubricant around the vaginal opening and into the vaginal canal. Apply this gently with your fingers rather than the dilator. Of course the dilator should also be copiously lubricated as well. Five minutes preparation will help ease the entry of the dilator considerably.

Massage your vaginal muscle gently to help relaxation. You should do this by inserting your finger into the vaginal canal and press down onto the posterior wall until you feel the vaginal opening is softer, and the muscle more relaxed

Once you have done that – relax fully. Lie comfortably on the bed, arms at your side and relax every muscle in your body. Your legs should be relaxed and flat to the bed, and reasonably straight and close together. Do not bring your knees up too high as one would in child-birth otherwise this will tense the abdominal muscles and make insertion more difficult. Similarly, spread your legs a little bit, Keep the legs flat on the bed, close together - and relax all the tension in them.

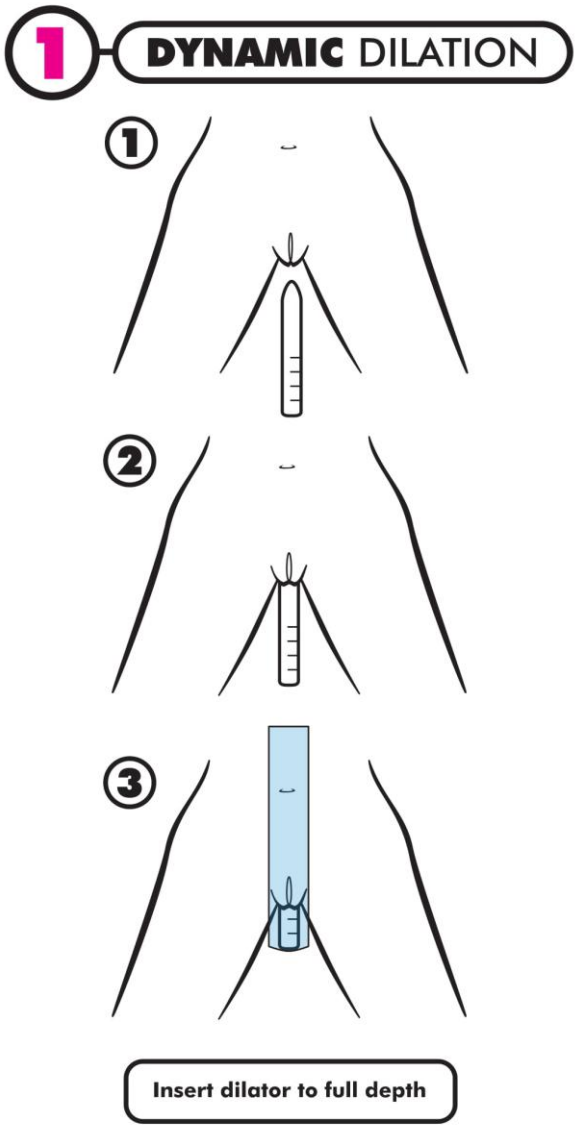
Think of tension easing out of each muscle from the tips of your fingers and toes – and move those thoughts inwardly to the main parts of your body. It takes a couple of minutes, by which time you should try to make yourself feel as heavy as possible – that is a relaxed state. Think of beautiful things – the sunshine glistening off a tranquil lake, or the gentle splash of water from a small waterfall with fish at the bottom. Think tranquility.

Inserting the Dilator

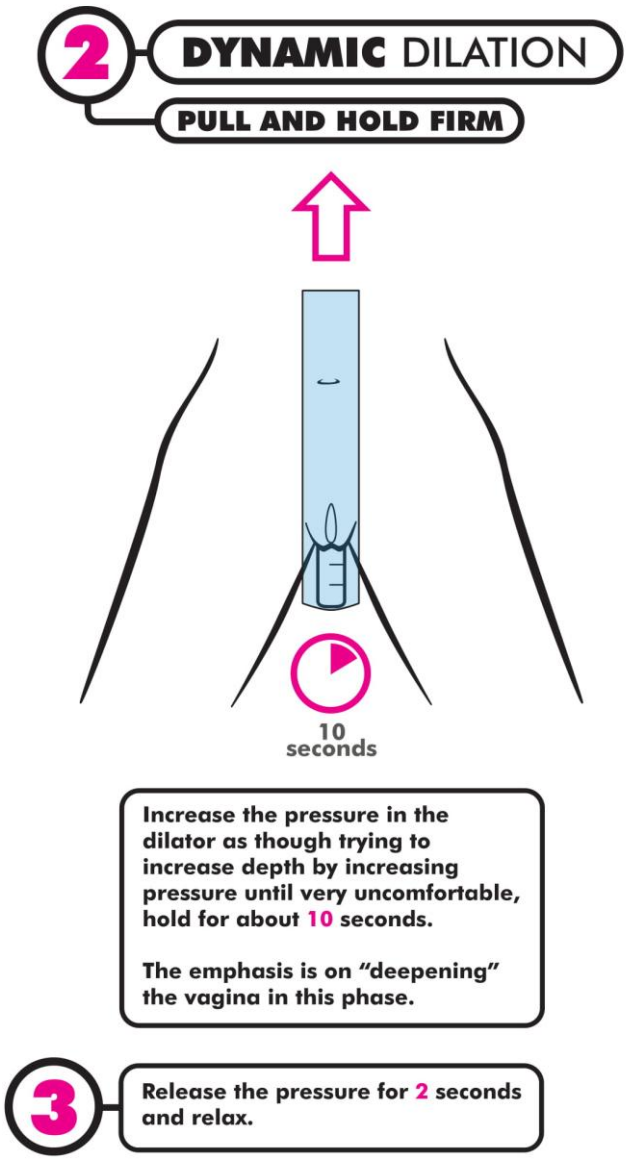
Stay relaxed and still for a full minute or so. In the first 2 months after surgery, add a condom onto the dilator for cleanliness.

1. Liberally apply lubricant over the entire shaft of the dilator, and ease it into the vagina by very gently "stirring" to keep working it inwards while maintaining a gentle pressure on the end to ensure the dilator keeps moving. By gently stirring when pushing, you will more easily "ease" the dilator into place. As well as expelling any air compressed by the dilator at the end of the vagina. Trapped air can slow things down a lot, and be very uncomfortable.

   Keep the dilator moving until you reach full depth. If you feel things tighten up, or become uncomfortable just – relax. Don't stop moving the dilator, and don't take pressure off the end! If you stop and try to start again, you will find it more difficult to start again than if you keep going. To repeat - gently stirring while you insert the dilator will help you reach depth the most quickly. If insertion is still difficult - remove the dilator, re-lubricate it - and start again.

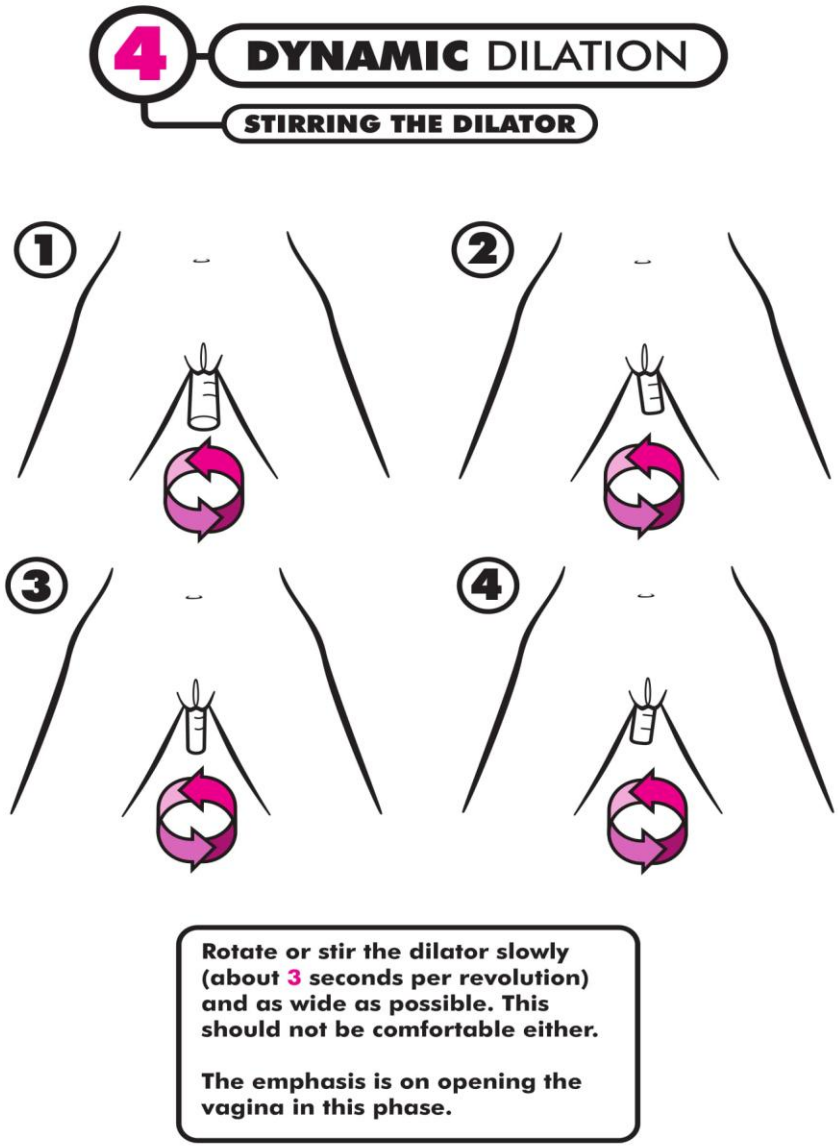


2. Once you have reached full depth – increase the pressure on the tip of the dilator by pressing hard with your fingers to try to increase the depth. Hold the increased pressure for about 10-15 seconds using as much pressure as you can tolerate. Only use your fingers for this, not the blue band.



3. Then relax the pressure on the dilator for a couple of seconds.

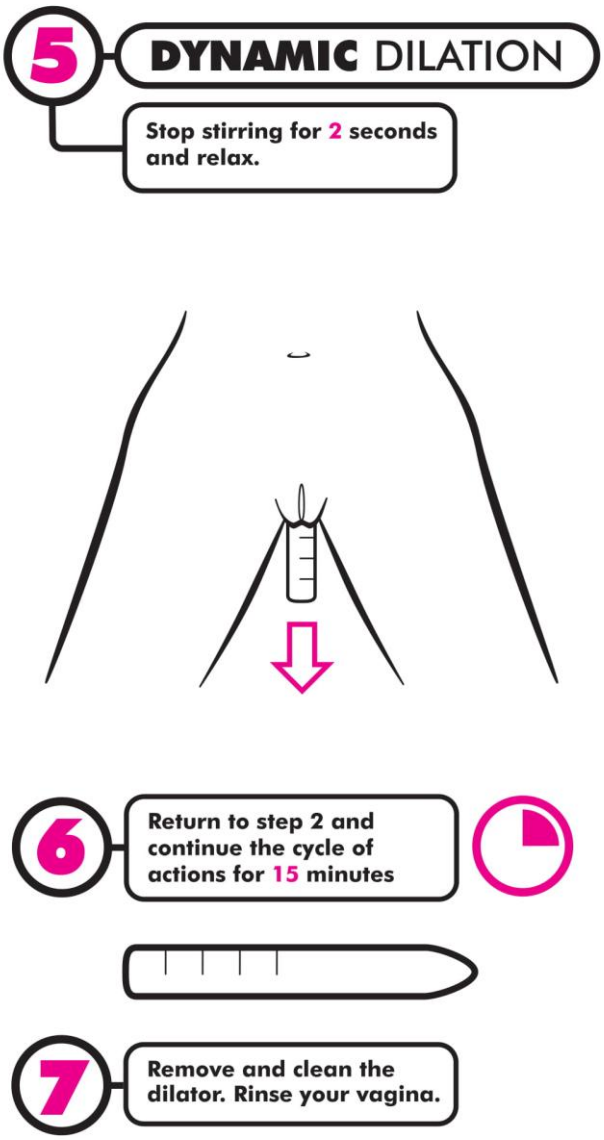
4. Once you have relaxed the pressure, move the dilator in a slow, wide stirring motion to try to open out the vaginal introitus as much as possible. You should be rotating the dilator in a circular motion (pivoted about its tip so that it sweeps a conical shape). Remember - this is a STIRRING motion and NOT a TWISTING motion of the dilator. You will be able to feel the dilator move widely around the rim of the vaginal opening – much the same as in any stirring action. But in the first 3 months, make sure you stir with gentle movement only – which should last about 3-5 seconds per full circle.



5. Stop stirring, and again increase the pressure to attempt to increase the vaginal depth.

6. Repeat from stage (3) – (5) as many times as necessary to complete 15 minutes at full depth.

7. Withdraw the dilator, and clean up.



That technique is called “Dynamic” dilation – and is dramatically more effective in increasing vaginal width than the static method. It will also help maintain vaginal depth far better. It should be the cornerstone of all future dilation sessions after the first month post-operative.

Dynamic dilation is an extremely effective technique, but it is not at all comfortable. Do not expect it to be! It is your task to make it as effective as possible and to work really hard at it. The harder you work (the more dynamic) the more effective will be the long-term result.

Although you can control the degree of discomfort, the less comfortable you are without it becoming "excruciating" – the more effective the dilation session will be. The hard work (and discomfort) will have the effect of softening and widening the vaginal opening.

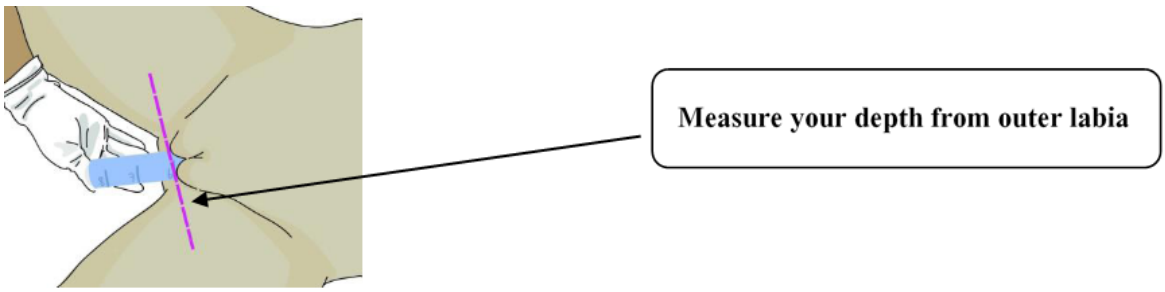
Some More Notes on Dilation

What is Full Depth – Where Do We Measure From?

The yardstick measure of all dilation is with the medium-size dilator given to you by the Clinic, and is the one which should be used to determine your regular full depth.

Do not become obsessed by depth measurement, or attempt to measure accurately to a millimeter. There will be minor variations from day to day in any event – and even having a full bowel can make a difference of a half inch (12 mm) or so.

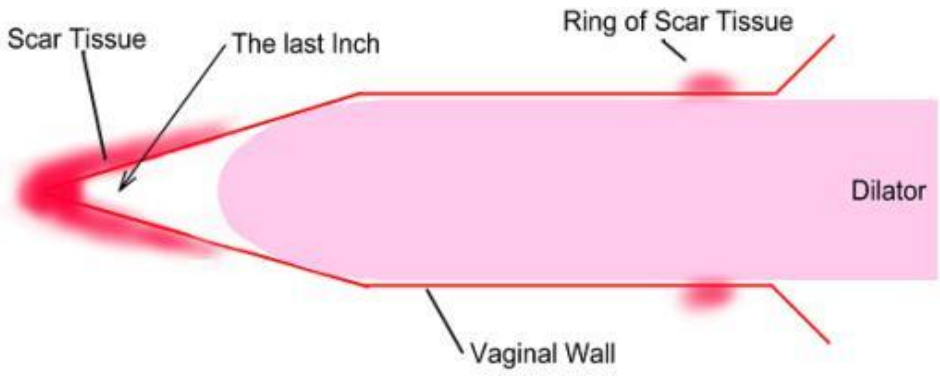
All you need to do is consistently measure using the same reference point on your body each day, and make a comparative check rather than a definitive one. A common place to measure from is the outermost part of the labia as pictured below:



The Last Inch

Some clients think that the last inch of dilation is a barrier. It's not, but pushing the dilator "the last inch" is difficult for every patient, because of simple geometry. This diagram will explain why, and what you can do about it:

In simplistic terms, the end of the vagina comes to a point, where the incision to produce the vagina, terminates. Although that statement is not 100% accurate in surgical terms, for the purposes of this explanation, it is accurate enough. It is at that point where most scar tissue exists, because that is where the body finds it easiest to start healing what it considers to be a "wound".



As you can see, because of the shape of the dilator, as it gets towards the end of the dilator, it meets the vaginal wall before it gets to the end of the vagina.

You can now see that to dilate "The Last Inch", the scar tissue has to be stretched over the rounded end of the dilator. The stretching hurts, so don't be surprised. It would hurt even if there was no scar tissue. Never forget -the principle of dilation is to oppose the force of scar tissue contraction - and this diagram should help explain a bit more what that means. For most people it hurts a lot, and they confuse that sensation with it being an impenetrable barrier. It isn't. It just needs relaxation, and some hard work to overcome.

The diagram also helps to explain why the first part of inserting the dilator can also be difficult. There is a "ring" of scar tissue near the vaginal opening where the perineum was turned inwards to form the vaginal introitus. That tissue forms a very hard and resistant scar, which has to be stretched over the dilator. It hurts to do that, but the more lubricant you put on this area before you start, the better. The "stirring" part of the dynamic dilation technique is aimed at stretching that particular scar tissue, so the stirring needs to be done as widely as possible.

Dilator Size

The larger the dilator, the earlier it reaches the vaginal wall at the end, and the narrower the dilator, the further in it can be inserted before touching the vaginal wall. That is why it is harder to dilate to full depth with the large dilator, than the medium and the small dilator is the easiest.

If you find the last inch to be really difficult, move down a size with the dilator you are using. There is no harm at all with that. You will find it much easier to get to depth, and much more quickly. That will make you much more relaxed, which in turn will make dilation a lot easier. This is a positive spiral! It's a "win - win" situation.

Never be afraid to downsize if you need to. Downsizing makes retention of depth much easier, and in real terms does not affect width much at all, providing you dynamically dilate correctly using the "stirring" motion to stretch the vaginal opening. It is very difficult to recover lost depth and - if left too long - can become impossible. However, it is much easier to increase vaginal width at any time.

Withdrawing the dilator

Withdrawing the dilator is also not always as easy as some imagine, because of very simple physics. As you withdraw the dilator, the ring of scar tissue wipes off the lubricant, just like a car windshield wiper. That means that the surface of the dilator that goes over the ring, is drier. That makes friction higher, which takes more force to move it - which in turn hurts more.
Withdrawing the dilator also creates a vacuum at the far end of the vagina, which makes withdrawal a bit more difficult.

The solution is simply to relax and “stir” gently as you withdraw, which reduces tension in the muscles surrounding the scar tissue and releases and trapped air.

Quality Dilation

Every dilation session you do must achieve an objective with a clear purpose in mind. It must be a “Quality Session”. A session where full depth is achieved, and then pressure is taken off while lying in bed for a further hour or more (static dilation), is NOT a Quality Session. With time, doing that alone will inevitably allow scar contraction to occur, and depth will slowly but inexorably be eroded.

A **Quality Session** is defined as one where full depth is achieved, and hard pressure and work (“dynamic dilating”) is applied to attempt to increase that depth and vaginal width for a period of 10-15 minutes.

The purpose is to reach depth as quickly as possible and stretch the contracting scar tissues to compete against the shrinkage.

 If you don't achieve depth, it is not a "quality" session, and the time spent has mostly been wasted.

The dilation time clock starts ticking once full depth has been reached – which will vary for every patient. Again – don't compare notes with other patients; it is simply not a useful thing to do. You are you – and she is she.

How Much, How Often?

In the first 2 months after leaving Chonburi (months 2 and 3 post-operative) , aim to have 3 "Quality Sessions" a day – but no fewer than 2.

If time is of the essence, "Quality" sessions can be reduced to 5-10 minutes each, but it is important to do this more often each day.

First Month Post-Operative (in Chonburi)

During the first month, while you are in Chonburi, you'll probably find dilation to be easy in relative terms. Firstly, it is easy from the psychological point of view, because the experience is new and relatively exciting in some respects, and there are no external pressures to prevent dilation. You'll have plenty of time free for dilation, and it is therefore relatively easy to create a schedule that does not interfere with any other part of your life. Most clients are still weary from their surgery during that period, and the period in bed necessary for dilation is a welcome rest for most.

Physically, dilation is also easy during the first month. At that time the scar tissue contraction has not started, and there is a high degree of numbness surrounding the surgery site taking away a lot of the associated feelings or pain.

We expect you to treat the first month as a "learning period" during which they should find out as much as possible about how to dilate. We expect you to do dilation 3 times for 20 minutes each "session"

Between 7 days to 14 days – Dilate twice a day with static dilation with the medium dilator only, for 30 minutes.

After 14 days (But not before given permission to do so) - Dynamic dilation 3 times a day. You should spend 10-15 minutes at full depth with the medium dilator, followed by 5-10 minutes with large dilator (- a total of 20 minutes at full depth)

Months 2 and 3 Post-Operative (The “Difficult Period”)

Months 2 and 3 represent the most challenging period for virtually every client and you’ll need to do a bit more dilation.

Mentally, or emotionally they now are usually back at home, adjusting to a number of changes in their life, into which they now have to fit an invasive dilation regimen. The novelty and excitement of "the Chonburi Experience" is fading; life is starting to get back to "real life" when every-day things have to be attended to, but with fewer hours left in which to do them. Most have to go back to work. There is now no-one immediately on hand with whom to share experiences or problems, and no nursing staff to deal with any problems or concerns they might have. Thus, any small problems can quickly assume large proportions, and if not properly managed and foreseen, can even become overwhelming for some individuals.

During this period scar tissue starts forming, hardening, and contracting. Nerves start re-attaching, and the numbness gradually recedes to be replaced by some higher level of pain or discomfort than was experienced in Chonburi. It is easy to believe that the pain represents a problem with the surgery, or the healing process, but it does not - it is only to be expected and to be dealt with.

It is absolutely vital during this period to maintain a rigorous dilation regimen and not to shirk in any way. This is the period when vaginal depth is either retained, or irretrievably lost. Diligent dilation opposes the contraction, and helps the scar tissue to form in an expanded (deep) condition. Without diligent dilation and maintenance of depth, there is every likelihood that the vaginal lining will contract and permanently form with less depth - which cannot be recovered by dilation alone.

If you aren’t experiencing any particular difficulties with dilation during the "difficult period" (about 70 - 80% of all cases), then 2 or 3 “Quality Sessions” per day is adequate, but the ideal is 3 or 4 sessions, if you have enough time. Remember - TOTAL TIME SPENT DILATING IS LESS IMPORTANT THAN TIME SPENT AT DEPTH. If you don’t achieve the required depth, the time spent dilating is largely irrelevant and wasted. Once depth has been achieved and maintained, you should work hard doing dynamic dilation for 15 minutes. Only Quality Sessions are acceptable.

Naturally the discomfort might seem to oppose the need to dilate rigorously but never consider dilation to be "too difficult". This feeling must be overcome and the speed with which the "difficult period" passes is influenced by 3 factors:

- One’s Self (YOU!)
- Creation of Scar Tissue, and
- Reattachment of Nerves.

YOU are almost certainly the most crucial during this phase, and mental preparation is vital. If you believe dilation will hurt, it will. Once that belief exists, you’ll invariably be tense, which in turn makes dilation more difficult. "Failure" during a dilation period will

make you feel even more anxious about dilation, and a "vicious circle" gets created. Most important is that you prepare mentally for each session, which should not be rushed. Pain killers can be taken symptomatically, but their automatic or habitual use is not recommended.

 The second and third months post-operative are the "Difficult Period" for most clients, and will present the greatest challenge

Months 4 – 6

During months 4 to 6, dilation will become start to much easier as the scar tissue heals with a wide vaginal cavity, and the nerves "settle down" to normal sensation. The exact time taken will vary from person-to-person, and a few might even take longer than 6 months before everything has settled fully. But rest assured - it will. Most clients will still require 2-3 Quality Sessions per day to maintain depth during this time.

After 6 months

After 6 months, you may try reducing your dilation regimen to just one or two Quality Session per day. Some may choose to reduce this a little, but they should be sure to check the depth at each session and if necessary, return to higher frequency if they feel that depth is not being maintained.

The rule to apply here is "Dilate as little as possible, Without Losing Depth". The last 3 words are the most important. If you find you are losing depth, or the vaginal opening is tightening up, increase the number of Quality Sessions each day to recover any loss.

After 12 months

Typically after 12 months, all healing has subjectively finished, you can start reducing dilation to 2 - 3 times a week at most to check the depth. Again, if you lose depth with reduced dilation, increase the frequency again to get it back.

Quick Summary

First month -> Dynamic Dilation 3 times a day with M and L

2 - 3 months -> Dynamic Dilation 2 - 3 times (or more)a day with M and L

4 - 6 months -> Dynamic Dilation 2 - 3 times a day with M and L

6 - 12 months -> Dynamic Dilation 1 - 2 times a day with M and L **

After 1 year -> Dynamic Dilation 2 - 3 times a week**

** You may reduce dilation Without Losing Depth

Pain Killers

Try to avoid using pain killers automatically before each dilation session. This indicates you are mentally preparing for it to be painful. Don't, if at all possible. Mentally prepare for dilation to be onerous – but not worse. RELAX instead! If you really have to take a pain killer – take as little as possible.

Difficult Dilation or Loss of Depth

Not everyone finds dilation easy and – if you don't - don't worry either. You are not alone – but you are a unique individual. What you call pain might be excruciating to someone else – and what someone else calls excruciating might be only mildly uncomfortable to you. Pain thresholds vary – and cannot be measured.

After leaving Thailand and once away from the immediate care of the Clinic some clients find difficulty with dilation. Small problems assume the proportions of big problems, and they stop dilating in the belief that the problem and pain will go away on its own accord. That is a huge mistake, and taking a day off to recover will only make things more difficult later.

When you face difficult dilation problems, it is important that instead of reducing the amount of dilation you do - you should increase the amount of dilation you do. It is very easy to stop dilating in the belief that the problem will go away, but in fact the opposite is true.

Under difficult circumstances you must dilate - more often than usual if necessary - and should do so 3 or 4 times a day - though each session can be shorter. We advise the following:

- NEVER be afraid to reduce the size of the dilator in order to make dilation easier. The important thing to do is get to your regular depth. Width can be increased later by diligent dynamic dilation.

- Try to get as much depth as possible. Obviously, more is better. You only need to keep the dilator at depth for about 10-15 minutes, maintaining pressure and dynamically dilating.

- Remove the smaller dilator, and try with the next size, again only dynamically dilating for 5-10 minutes.

- Do not worry about bleeding. Some may occur, but it is almost certain not to be serious. The main thing to do is to relax to remove as much tension, doubt and worries as possible from your mind and body. There might be some pain - and for that use pain killers symptomatically until you are better mentally prepared and your dilation sessions become easier - which they will.

- Paradoxically, if you can't achieve depth during any particular session, you should try again as soon as possible very shortly afterwards. The natural healing process during this period is such you can't afford to wait 12 hours before trying again - it is simply too long a period to wait. The rule therefore, if time is at a premium, is "LITTLE and OFTEN".

Loss of Depth

The second and third months are the critical period – the Difficult Period. If you have any indication of losing depth – increase the daily number of Quality Sessions until depth is restored.

At risk of being repetitious, the important feature is to concentrate on achieving DEPTH – and trying to increase it. However, it is equally important that over time you should try to "build up" during each dilation period to the full width dilator, and if possible each dilation session ideally would be concluded by a few minutes Quality Dilation at full depth with the large dilator. Lost depth cannot be regained. While "narrowness" can sometimes be increased later, it is quite a long process to do so.

Dilating During the Journey Home

Trying to plan a dilation session on the journey home is not necessary and is completely impractical so don't do it. Just concentrate on getting home safely and as relaxed as possible.

The First Dilation Session after Getting Home

During the journey home, you will become very tense due to the stress of the journey, and the high altitude flight will bloat your abdomen. You will almost certainly experience increased swelling on the entire surgery site. That's entirely normal, and it will settle down within a week. It is very common on the first few sessions home to have difficult dilation sessions, and even believe you have lost 2 or 3 inches depth because of the difficulty. Don't worry at all. You have not lost any depth – you just are not relaxed enough. Simply follow the guidelines on difficult dilation above, and dilate using a narrower dilator than you regularly uses. Do that for a week or so, and then re-introduce a larger size dilator as mentioned above.

Progression to Larger Dilators

Progression to the larger dilator is something you can do as suits your own circumstances best.

The easiest way to progress to a larger dilator is to start with the dilator that you normally use (medium size), and undergo 10-15 minutes Quality Dilation session with it. Withdraw the normal dilator, and insert the next larger dilator for a further 10-15 minutes Quality Dilation session. Do not expect at first to reach the same depth with the larger dilator as you normally do with your usual dilator, but work hard to try to do so. Some clients may never achieve the same depth with a larger dilator as they do with the previous smaller size, so do not worry too much if this is your own experience. With time, the next size dilator will become your "normal" dilator, from which you can try to repeat the cycle of vaginal expansion.

If you have some difficulty with moving up to the next size – it is simply an indicator that you are not yet ready to do so. It is not a race. Just wait another week or so during which you should work hard at increasing width – than try again.

3 Golden Rules of Dilation

- Relax!
- Think "QUALITY DILATION"
- Time spent not at depth is of little benefit

DOUCHING THE VAGINA

The vaginal lining is essentially a skin graft. Human bodies shed skin continuously – and in the first year post-operatively your vagina will shed skin at quite a high rate.

The inside of your vagina will start to secrete alkaline secretions, and it is warm (38C or 98F) There is some possibility of small amounts of blood in your vagina due to minor ruptures in the first couple of months.

"Yellow Discharge" and Vaginal Odour

During the first few months after surgery you might experience a yellow discharge from the vagina. It is a common early post-operative event for all post-SRS women. Others may experience a similar, more viscous, discharge close to the clitoris. These discharges are not unusual, and they are formed by a slurry of shed skin tissues, which are usually not washed out fully after previous dilation.

They are usually not indicative of any infection, and will not therefore respond to antibiotics or similar medication. Occasionally, if there has been a little blood (as described previously) the blood, skin and natural fluids "ferment" and form a yellowish fluid, which can be disconcerting, and may cause some patients to be anxious. It is nothing to worry about, and not unusual. The corrective action is to rinse gently but very thoroughly with warm water, and to use a diluted vaginal soap to cleanse the area gently. These fluids can collect in the clitoral hood, and when combined with natural secretions can form an unpleasant odour. With time, the formation of these fluids will subside, but for some patients they can be expected occasionally during the healing process, which may continue for several months post-operatively.

If you have any reason to believe that such a discharge may be an infection rather than a discharge as described, this will usually be accompanied by signs that the discharge is emanating from an open wound rather than from within the vagina itself, and may be accompanied by localised inflammation and higher skin temperature, and possible general feeling of fever. In those circumstances, please advise the Clinic immediately and describing as many of your symptoms and circumstances as possible so that Dr Suporn can recommend an appropriate course of action, or recommend seeing your own doctor if it is causing concern and discomfort.

Typically, this "yellow discharge" will diminish and disappear within 3 months of the operation, though in some cases it can linger longer, in diminishing amounts.

While the yellow discharge is prevalent in the first 2 or 3 months particularly it is important to clean the vagina regularly and thoroughly as necessary to remove all traces of lubricant or the blend of warmth, alkalinity, skin (enzyme) and lubricant may form a perfect environment for fermentation. This fermentation can occur very quickly (an hour), and may manifest itself in a thick yellow discharge – that is easily misidentified as being pus – or an

infection. It is almost certainly not – but if left it can create an environment for infection – and can quickly smell very offensively.

First Month Post-Operative

While you are in Chonburi you will be given a syringe, and will be shown by our staff how to use that to gently clean out the vaginal cavity of accumulated debris and discharge. You should continue to use this technique until about 6 weeks post-operative.

Second and Third Month Post-Operative

The syringe the Clinic supplies is inadequate after about 6 – 8 weeks for fully cleansing the vagina. It cannot penetrate deep within the vagina so instead we would like you to clean out the vagina by douching. Please obtain a proper vaginal douche bottle intended specifically for the purpose. This has a long spout on it, and a spray nozzle specifically designed to cleanse the vagina to the full depth of the vaginal cavity. These are stocked by most pharmacies at low cost.

If you are unable to obtain a vaginal douche, a rectal enema bottle is equally effective, and will certainly be available at almost any pharmacy. There are many types on the market, but choose the kind that has a "squeezy" bulb to hold the warm water to enable you to control the flow of water, rather than one that relies on gravity. Do NOT choose anything that hooks up directly to your taps or faucets; those can apply dangerously high pressure.

Here's a couple of examples of what to look for:

Douching is most important in the first 2-3 months post op to rinse the vagina of all traces of lubricant which can otherwise harbour germs and allow bacteria to develop. During this period you should douche inside your vagina after each dilation session by irrigating twice with 50cc of clean warm water only, and for a third time with a solution of 50cc water and 5cc Betadine.

After 3 months

You should douche on an "as required" basis by using water mixed with a few drops of shower soap, followed by rinsing with clean water only to clear away any residual soap. You might find it convenient while showering to insert shower soap into the vagina with your fingers at this stage, rather than using a douche bottle.

Smearing

It is not uncommon to experience some light yellow smearing on your panties for many months after surgery. This is normal and typically hormonal. It does not need any special treatment other than washing as described, if it also causes an offensive odor.

Vaginal Odor

Long-term vaginal odor can occur, and it can be difficult to track down its exact cause.

Obviously it is important first to be sure that there is no infection internally. However, that rarely occurs.

Secondly, if you have any small wounds internally such as granulation or a tear in the vaginal wall, those might bleed occasionally. The blood will be subject to bacterial attack, and if not washed away regularly, could smell foul.

Most commonly vaginal odor is hormonal, and can be affected by *any* medications that you take (not just HRT) – or your diet. Very well-known culprits are:

> ***Progesterone based HRT***. Typically progesterone based HRT can cause a very offensive vaginal odor. If it does, you should discuss stopping taking it with your prescribing doctor.
>
> ***Anti-Androgens (such as Androcur)***. You shouldn't need to take an anti-androgen after surgery anyway, but rarely a doctor will prescribe a limited amount to deal with certain conditions. Its continued use can cause offensive vaginal odor
>
> ***High Dosages of Estrogen HRT*** Very high levels of estrogen based HRT can also cause vaginal odor. Check with your prescribing doctor if your levels might be high.

Most important to remember though, is that your vaginal lining is normal skin – unlike the structure of a genetic vagina. The skin used to line your vaginal wall has sweat glands, and will also shed skin flakes continuously. Those skin flakes can ferment, and can cause a light yellow stain Usually that is unimportant.

But if you are athletic, live in a hot climate wear tight clothing or are prone to perspiring, you might get a build-up of vaginal odor which can be treated when or if it occurs exactly the same as any other BO (Body Odor) – just by washing internally with soap and water.

Thick “Cheesy” Substance near Clitoris and under Labial Folds

Occasionally you might experience a thick cream-like substance that smells “cheesy” and accumulates around the clitoris, under and within the labial folds. This substance is most probably smegma, and just needs to be washed away with the tip of a cotton-bud soaked in clean warm water.

SENSITIVITY, ORGASM and VAGINAL LUBRICATION

Vaginal Lubrication

The vagina will - to some extent - be self-lubricating, but the degree to which this occurs will vary from individual to individual. Dr Suporn's technique differs from both penile inversion and colon vaginoplasty procedures in that he uses the scrotal sac for the vaginal lining. The scrotal sac is very oestrogen absorbent; to a certain extent the oestrogen you take through HRT is collected and secreted through the vaginal lining. In addition, some natural secretion will also occur initially from the prostate gland. Finally, during SRS Dr Suporn always retains the Cowper's gland or bulbourethral gland. In non-genetic females this gland is responsible for the thin, colourless lubricating fluid that is secreted during sexual arousal ("precum"), which also adds to the natural lubrication. While the total lubrication can be very significant, we would not make any claim that the self-lubrication is to the same degree as it is for a natal female. However, it is physiologically more likely to occur using Dr Suporn's technique, than it is with penile inversion.

Sensation and Orgasm

If you are sensate pre-op, then there is every reason to believe you will be sensate (and probably more so) post-operatively. However, - as with the pre-operative condition - there is no guarantee that any patient will be orgasmic, though almost every patient is.

Vaginal Sensation

Like natal females, there are no sexual nerves within the vagina itself, and sensation (as with natal females) is derived from the clitoris. Additionally you will experience sexual sensation from the secondary sensate tissue or "Chonburi Organ" which is contiguous with the clitoris, and positioned under the upper inner faces of the labia minora.

No sexually sensate tissue is placed in the vaginal cavity, nor can it be.

Orgasm

There is a fundamental difference between being sensate, and being orgasmic. In general terms - if you are sensate pre-operatively, you can reasonably expect to have innervate and sensate clitoris result post-operatively. The likelihood of permanent loss of sensation is exceptionally low; the nerve bundles from the glans penis tissue are retained intact to form the clitoris and secondary sensate area. For many clients, early post-operative feelings are often hyper-sensitivity rather than lack of sensitivity. This is sometimes interpreted as pain. In both cases, the nerves settle down to normal sensation within months of the operation, but it is not unheard-of that this could take 2 years for the brain to be in full synchronism with the body's sexual sensations.

While sexual sensation is virtually guaranteed, the same cannot be said about orgasmic capability. The ability to orgasm is influenced by a wide variety of factors - not all of which are physical. Most men who are incapable of orgasm are not insensate. Not all genetic women ever experience orgasm - and research shows that the proportion who do not could be as high as 45%. The entire mechanism of orgasm is different between a male and a female.

You don’t need to be reminded that in a post-operative woman one of the major contributory factors to the sensation of orgasm - the testes - have been physically removed. Orchiectomy does not in itself necessarily prevent orgasm - but it can degrade orgasmic capability for some considerable time and for some can result in some difficulty with achieving orgasm. That is an unpredictable, uncontrollable and inescapable effect of orchiectomy.

SRS introduces many changes to the body besides the physical result of the operation itself. Most particularly, the endocrine system goes through a severe change, and for some it can take many months before it stabilises. Those hormone imbalances will inevitably affect one's sexual appetite and capabilities. There is nothing that can be done to directly affect that during the operation; it is an unpredictable outcome of the operation, and the results and effects - I am afraid - "come with the territory". In most cases they will return to some sort of "normality", but when - and to what extent - cannot be foreseen.

SRS often brings a host of other non-physical changes with it. These can result in stress, anxiety or even severe depression. All of these affect the ability to orgasm - and in fact are almost certainly the major contributory factors. Worrying about such an inability only increases the anxiety, and hence the profoundness of the inability - the infamous vicious circle.

In almost every case where orgasmic capability has deteriorated, the cause is *unlikely to be physical*. Most inabilities are caused by stress, concern and other related disturbances. Peer pressure and comparisons with apparently unaffected patients increases that anxiety. Hearing that patients of another surgeon are orgasmic (and secretly imagining therefore that one wished one had chosen another surgeon, for example) add to the pressure, the anxiety and the inability. Our patients enjoy as high a percentage of sensate and orgasmic success (if not higher) as any other surgeon. There is plenty of evidence to prove that.

If you experience difficulty with orgasm, I am afraid we cannot offer an easy answer - because there isn't one. The simplest advice is to try to learn not to worry about it so much, and to de-rate its importance in your life for a while. Then one day - once the pressure is off - things might just happen again.

We have to assume that things will stabilise eventually; we just don't know when. The best advice we can offer therefore is to relax, wait - and just let it happen. If orgasm doesn't happen, there is no point in worrying about it. Faking orgasm is no solution, because it is a manifestation of your own mental pressure saying "I ought to be able to do this - so I will....but I know I haven't....". The "failure" under such circumstances adds to the mental

pressure. I deliberately put "failure" in inverted commas because it should not be seen as a failure. Just see it as "one of those things" and - for a woman - not at all uncommon.

This is useful reading. Even if it doesn't say what you want it to say, it will probably say what you need to know:
http://www.netdoctor.co.uk/sex_relationships/facts/orgasmtrouble.htm

AESTHETIC APPEARANCE

There is not a great deal one can say about aesthetic appearance. It is not within your control, but you can reasonably be confident that you will have a result as good as – if not better than – any of the examples on our web site at http://www.supornclinic.com

In the first few weeks post-operative, you will undergo a large number of physical changes. Swelling will reduce, scars will start to diminish. Asymmetries will come and go. Some changes might surprise you, and be beyond your comprehension. It is really important that you do not try to make an objective assessment about the result of your SRS operation until you are 3 months post-operative. If you try to do so earlier, you will be worrying unnecessarily, and making a judgement of an outcome far too soon.

For a useful evaluation to be done, please take some reference pictures of your vulva at one, 2 and 3 months post-operative. The differences will be immense. This will help you realize why earlier evaluation would have been misleading. A further picture taken at 6 months post-operative will show further significant change - but it will not be until 12 months that the final result has emerged.

Because the vulva's appearance will be undergoing constant change, you should not try to make any objective assessment about its appearance until 9 months post-operative at the earliest.

SOME WORDS ON COMPLICATIONS

What if Something Goes Wrong?

Dr Suporn's SRS surgery is a wonderful achievement. However - he cannot produce miracles, and the results might not always meet expectations. Because of the widely - discussed exposure his surgery attracts, patient expectations are unusually high, and it is easy at times to imagine from what one reads that "nothing can go wrong" or "everything will be perfect". Things can go wrong; no operation result is perfect - and it is unwise to imagine otherwise - even though it is exceptionally unusual for anything to go seriously wrong with his operations.

However, if you feel anything is at all wrong, please make sure you contact the Clinic first by writing to admin@supornclinic.com. Please do not write to any other address, and do not direct enquiries to members of the Thai Clinic nursing staff whom you might have befriended. They are not in a position every time to answer your question fully and in a timely manner.

Post-operatively Dr Suporn's patients experience very few complications and those that arise are generally very minor in nature. One of the very reasons we expect patients to stay with us for an extended period post-operatively is so that we can administer close care, and tend to any difficulty that may arise. Very few do. This also ensures our patients are fit and well when they leave us. By comparison, Because of the length of stay under close care and supervision, the incidence of post-operative infection is virtually nil, and any cases are cleared up before they leave us.

In around 3500(as of 2019) primary SRS cases, Dr Suporn has only had two reported cases of enterovaginal fistula as a direct result of the operation. None of Dr Suporn's surgeries has resulted in a mortality.

Vaginal prolapse is not possible with Dr Suporn's technique. Only 2 or 3 patients in the past 15 years have needed to us for major and urgent repairs to an SRS. Patients do return to us for cosmetic improvements, and as much the reason for this is that - unlike other surgeons we offer the opportunity for free cosmetic improvement.

Granulation

Granulation is not uncommon, nor any cause for concern. This happens in a high proportion of all plastic surgery cases, and vaginoplasty and labiaplasty are not exceptions.

Vaginal or External Bleeding

Few patients bleed while they are in Chonburi – and if they do are always confident that Dr Suporn is close at hand to help. However – bleeding to some extent if far more common when you have left Chonburi – so it is easy to imagine something has suddenly gone wrong. The likelihood is that nothing has gone wrong.

It is extremely common to bleed from the vagina - or more commonly around the urethra. It's very common when having a bowel movement, up to about 6 (occasionally 9) months post-operative. It can occur almost at any time after surgery even after a long period when it has not occurred before. It can even happen occasionally when urinating. The basic cause is "straining" which stresses the surgery site - more so while passing solids. Just try to make sure that all bowel movements are easy, and require little effort. Drinking lots of water and eating a fibrous diet to help maintain regularity can both help.

It's usually not a serious matter at all - in fact we would not even classify it as a complication. Assuming that it is coming from somewhere within the surgical site, it almost certainly won't develop into anything serious, but of course you should please monitor its occurrence, and if it starts to occur more frequently, or become difficult to stop, please let us know. We would typically expect the frequency with which it occurs to diminish, and it will recover spontaneously without the need for any treatment.

Stopping Bleeding

Stay Calm!

The first and most import thing to do is not to panic! Bleeding is only very rarely serious, and can almost always be dealt with very easily. Just keep calm and try to identify the source. Also note that any blood that drops into water will appear to be a huge amount of blood, because just a few drops of blood colours water very deeply. Also remember that the sight of your own blood also seems to be a lot more than you imagine it is! If you don't stay calm, your blood pressure will rise making it more difficult to stop the bleeding

Identify Source

It's easy to misidentify the source of any bleeding, especially if it occurs while urinating or passing solids. Just a few drops from near the clitoris can quickly gather near the vaginal entrance, making you believe you have vaginal or even rectal bleeding instead of clitoral bleeding.

If you are unsure of the source, take a glass of clean warm water with you, and sit on the toilet. Then pour the water over the entire vulva, and observe. The water will wash all the blood away. If bleeding has already stopped, you don't need to do anything. But if there is

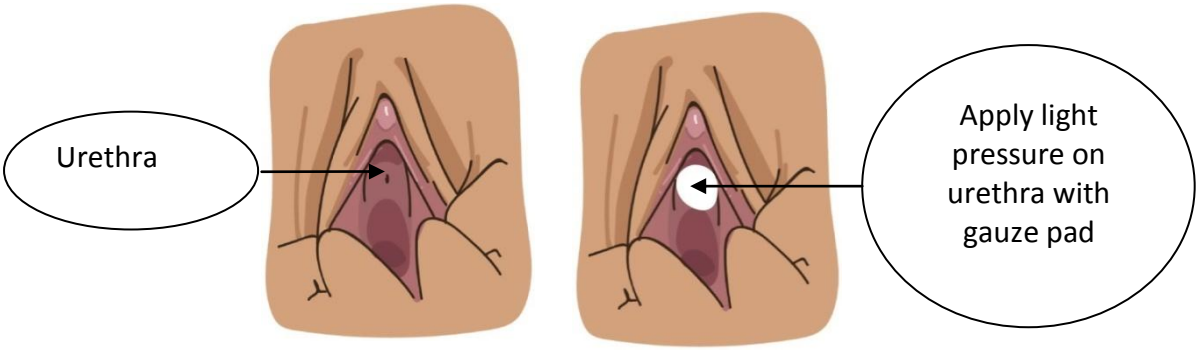
still some light bleeding, as you pour the water over the area, you can quite easily see where the bleeding is coming from.

There are 4 main areas of bleeding: (1) the urethral area, (2 & 3) outside and inside the vagina, and (4) close to the clitoris. Within the first 3 or 4 months post-operative you might experience bleeding in any of these areas.

If you experience active bleeding, you shouldn't walk, move or panic which may cause more bleeding.

Bleeding around urethra:

1. Bleeding from within the urethra itself is quite unusual, but bleeding from the external surrounding tissue is very common. 95% of bleeding comes from around the urethra because it was erectile tissue. If bleeding occurs, using a cotton ball, gauze or even your fingers press around your urethra for a few minutes until the bleeding stops.



2. Extravaginal bleeding: In the event of bleeding from around the vaginal entrance, but not in the vaginal cavity, apply a cold pack on top of the vagina to stop external bleeding

3. ***Intravaginal bleeding***: In the event of bleeding from inside the vagina, and if there is seemingly a lot of blood, you can use the medium dilator inserted inside as though doing static dilation. Keep the dilator inside for 10-15 minutes. This will apply pressure to the wound, and help the bleeding to stop.

- ***Bleeding near the clitoris*** can occur in the early days post-operative, especially if one experiences sexual excitement, and blood engorgement. Treatment is as for bleeding near the urethra.

Note.

In case of active bleeding which you cannot stop, go to your local Emergency Room at hospital and seek help. Please be aware that this would be an extremely unusual thing to have to do.

Note: Just be aware that if the blood is coming from the rectum (which should be identifiable if the stools are covered with blood, or contain clots of blood) then a possibly more serious situation exists that might *not be at all related to the operation*, and should be investigated by your own doctor.

If the above guidance is not enough for you, please tell us about it by checking out this section

Blood Smears

Occasionally after dilation during the first few months (and possible even longer) post-operatively, you may also see a smear of blood on the dilator. In the first few months you may also see a small amount of blood smearing on panty-liners. Unless the blood is bright red, and has all the appearance of flowing blood, there is nothing unusual about this, and there is no need at all for concern. It is solely caused by very minor superficial rupture caused by the dilation, and it has no long lasting effect at all.

Darkened Urine

You may experience darkened urine in the first month after surgery. This can be caused by some minor bleeding within the urethra, and is generally nothing to be concerned about because it will clear spontaneously with time. It can also be caused by simple dehydration. In the first few months of healing, the body requires considerably more water than usual to help with the healing process. It is essential therefore to drink copious quantities of fresh water each day to help the healing process, and to help the kidneys filter out and flush away unwanted poisons.

Urinary Tract Infection

Very occasionally, some clients might develop a Urinary Tract Infection (UTI). The incidence of UTI is similar in a post-operative woman as it is for a genetic female. UTI is less common in genetic males, hence its incidence might give the individual patient some cause for concern because it is something not previously experienced. It is not “post-SRS’ problem, but simply a “woman’s problem” and can be treated by your local doctor in exactly the same way as she would treat any of her other female patients.

Urinary tract infections can cause pain and other feelings of discomfort, often while urinating. The urine also may look different from usual.

You may know by the way your urine looks and smells. With a urinary tract infection, especially in the lower urinary tract (the bladder or urethra), urine in the toilet bowl may look cloudy (whitish instead of clear pale yellow) and less easy to see through, or reddish with traces of blood in it.

UTI Symptoms:

Typical symptoms of UTI are:

- **Burning**

  The usual way for a urinary tract infection to announce itself is with a strong burning sensation (dysuria) during urination.

- **Frequency**

  Typically, people who have a urinary tract infection find that they want to urinate more often than usual, but only a small amount of urine comes out each time.

- **Urgency**

  Besides wanting to urinate often, people may feel each time the strong need to urinate immediately. That need is called "urgency."

- **Pain and muscle spasms**

  Some women who have urinary tract infections do not feel a burning sensation when they urinate. Instead, they feel pain and muscle spasms in the genital region either while they are urinating or immediately afterward.

- **Pressure over the pubic bone**

  Almost every woman who has a urinary tract infection feels pressure or discomfort in the up-and-down centre (midline) of the abdomen just above the pubic bone. Pain or pressure in that place is called suprapubic pain or pressure.

- **Back pain**

  Back pain during a urinary tract infection is an important clue to tell the health care professional. That combination of symptoms can mean a kidney infection (pyelonephritis).

- **Chills and fever**

  People who have a simple infection of the lower urinary tract usually do not have chills and fever. Having chills and fever suggests a more serious infection, such as a kidney infection (pyelonephritis) or bacteremia, in which bacteria from an infection have entered the bloodstream and are circulating through the body with the blood.

  Many other conditions can make urine look cloudy or bloody, too, though.

  Note: *If your urine looks cloudy and smells bad, you quite possibly have an infection and should consult your doctor who will prescribe a suitable course of antibiotics.*

Treatment of UTI

Initial "First Aid" treatment of suspected UTI is to drink a lot of water to help the urine stream flush out the poisons. If the symptoms do not respond quickly – see your own doctor without delay. Your doctor will prescribe antibiotics. Untreated UTI can become a serious problem, so don't ignore the symptoms

Urination

All Dr Suporn's post-SRS women are able to urinate normally (providing, of course, that they were able to do so pre-operatively). We are not aware of any cases of permanent or even short-term incontinence, and there is no reason to imagine such a problem would occur unless the patient had another problem prior to the operation. Only once has a client left our care with a urethral catheter still inserted, and that patient had it removed about 2 weeks after leaving us and recovered fully.

Spraying in unwanted directions during urination is not uncommon (in fact, it is a typical female complaint) albeit a nuisance. But please wait until at least 6 month post-operatively before evaluating, because swelling and healing rates can affect this quite considerably

Granulation

Granulation tissue is simply an area of tissue where healing tissue lies underneath a very thin layer of skin. It is quite easily identifiable as an area of bright red tissue, very shiny in appearance because of the thin skin and might give the impression of being a sore area. It is not always as sensitive as one might imagine.

Granulation tissue is not an unusual condition following plastic surgery. Virtually all cases of granulation heal spontaneously and *without treatment* over a period of no longer than 6 months – which Dr Suporn usually recommends you allow to occur.

If you have any doubts or concerns about any granulation you might have, please contact our admin and send photos. Do NOT see your own doctor for treatment. Just tell us please and we will let you know what (if anything) needs to be done.

Necrosis

Necrosis is an emotive word because it means "dead tissue" and it is easy therefore to imagine something has gone seriously wrong – or is "falling off". Almost certainly Dr Suporn will have identified any necrosis before you left Chonburi, and you can be assured it is really nothing to worry about. There are 2 main kinds. One is skin necrosis – and this can be seen as greyish or white coloured skin hanging off – usually outside areas of sutures. Just ignore these; they will come away of their own accord but you can apply Silverderm to limit the amount, and to soften the newly-forming tissue beneath.

The second is area necrosis – where an apparently larger area appears white-ish or grey. Again, this is superficial, and the underlying tissue will be healthy. All that will happen in this case is that the white-ish coloured region will slowly return to natural pink coloured tissue over a period of a few weeks. Again, topical application of Silverderm, is appropriate.

MEDICINES and CARE PRODUCTS

Hibiscrub

Use of Hibiscrub to cleanse the wound can be stopped 2 -3 weeks post operatively, depending how well your healing occurs.

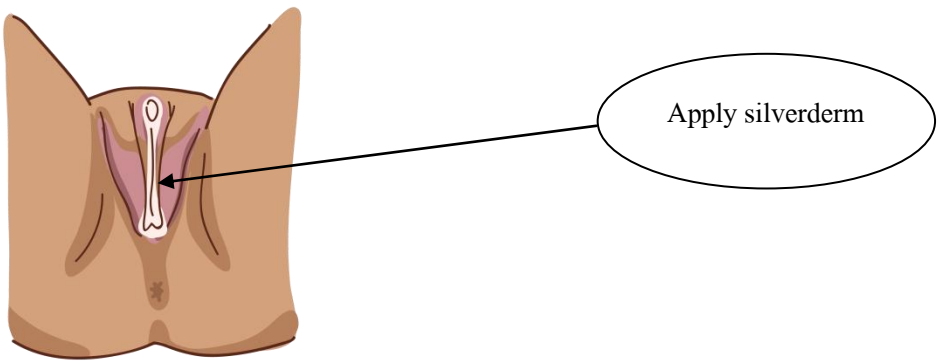
Do NOT use Hibiscrub unnecessarily, or any later than 6 weeks post-operative. It is a powerful antiseptic, and prolonged unnecessary use can irritate or burn the sensitive skin.

Betadine

You should apply Betadine on the external wound for only 2-3 weeks, but should continue to add to the final douche rinse for 2 months. After 2 months, it is no longer necessary to use Betadine to cleanse after douching. You might find it more comfortable and more relaxing to take a warm saline bath of clean water, and gently rinse after dilating.

Silverderm

You will be given Silverderm as an antiseptic cream to help wound recovery. It is a prescription-only medication. Once the supply we have given you runs out, you do not need to continue to apply any other cream or ointment externally. You have to apply 2 months after surgery, but no longer. If you still have a lot left after 2 months post-operative, just stop using it anyway. If you run out of it sooner than 2 months post-operative or you feel the need at all to soothe the skin, you may use any antiseptic cream obtainable at any pharmacy without prescription.



Condoms

The use of condoms to cover the dilator is recommended in the early stages of dilation when in Chonburi to minimize the risk of infection to the healing neo-vagina and surrounding vulva. After 2 months post-operatively, you may stop covering the stents with a condom as a pre-dilation preparation, and apply lubricant direct to the stent. However, it is essential that the dilator be thoroughly cleaned after each use.

Sutures or Stitches

You will see 2 main kinds of sutures used on your vulva. The thick green or black stitches (which look horrible) are rapid acting soluble sutures, which will shed occasionally up to about 2 months post-op – usually sooner. Doubtless you have already shed a large number without knowing; that is perfectly normal.

There are also a number of sutures that look like nylon. These are also soluble, but they are slower acting, and may remain in place for some while. Normally they will be gone before 4 months post-operatively, but occasionally might take longer to dissolve. They can be a little irritating (Dr Suporn puts them in particularly sensitive areas) and the ends can be a little uncomfortable. If the ends become too irritating, the ends can be snipped carefully by a professional to make them less likely to scratch. However, if you do this, please try to keep the suture itself intact. We assure you that they will all eventually dissolve, and they should not be removed by your GP.

For information, every suture Dr Suporn uses in SRS is soluble and none should be taken out deliberately.

Lubricant

There is no need to use Q-C or KY gel if you prefer to try something else. Neither is the best lubricant on the market, and can tend to dry up sooner than ideal. Feel free to experiment with what you find best. There are a number of proprietary lubricants on the market in drug stores and pharmacies. KY make a liquid lubricant, and there are products such as Sensilube easily available. Some may prefer to use an emollient cream based product to introduce some moisturizing effect which can be beneficial to the vaginal lining, but whatever you use make sure it is ultimately water-based so that it can easily be washed out. A number of products are also available as sex-lubricants.

Water–based lubricants should be used in the first 3 months post-operative, to enable all slurry and debris to be rinsed away easily when douching.

Once you are 3 months post-operative, you may consider starting to use a natural oil-based lubricant such as organic coconut oil, almond oil or organic jojoba oil. There is considerable benefit in using an oil. Unlike a water-based lubricant, it penetrates into the skin, softening the scar tissue more quickly, and helping with skin elasticity. Typically, oils are also more slippery than water-based lubricants, making insertion of the dilator easier, and more comfortable. Just be aware, some clients have experienced a malodorous vagina when using coconut oil. If you do, try almond or jojoba oil instead.

Antiandrogens

In most cases, post-operatively there is no need to continue anti-androgens post-operatively. However, in some cases (about 5-10%) patients find that unwanted male characteristics can return immediately post-operative. This is more common for those patients who took anti-androgens for only relatively short period of time pre-operatively. It occurs because immediately post-operative the adrenal system detects an abnormal loss (of testosterone), and immediately "goes into overdrive" to compensate for the loss of testosterone. It thus produces as much as it can by any means - which of course introduces unwanted effects.

BACK TO NORMAL LIFE

Bathing

For the first month post-operatively in Chonburi you should not take a bath. It is perfectly safe to do so in the second month once you have got home, and a tablespoonful of salt will help the healing process. After the second month it is perfectly safe to bath regularly, and to include perfumed bubble bath or similar additives. However, don't soak in the bath for a long time while you still have sutures present. Long exposure to warm water can soften the skin and make any residual sutures easier to tear out.

Returning To Work and Other Activities

We offer the following general advice regarding post-operative recovery. Naturally every patient will heal at a different rate, and individual circumstances will differ. However, please treat this is a reasonable guide for planning your post-operative activities and expectations:

In general, patients are well enough to return home unaided 3 weeks after surgery. One or two request wheelchair assistance for the return flights, but this is usually a matter of convenience rather than necessity.

Returning to Work

We do not advise returning to work until one week after returning home at the absolute earliest. This gives you time to adjust after a tiring journey, and to adjust into the new daily routine of dilation.

Patients may return to work 6 weeks to 2 months post-operatively providing their jobs are relatively sedentary. This will depend on their rate of recovery progress while under our care.

Patients who have jobs that involve mostly standing all day, but are relatively low in manual labour should reduce their working hours or duties during the second month post-operatively so that they are not on their feet for more than 4 hours per day. During the 3rd month post-operatively, these patients may gradually increase the amount of work they do, and return to full employment without limitation 3 months post-operatively.

No patient should engage in any heavy lifting activities until they are 3 months post-operative. Patients whose duties normally involve manual labour, or heavy lifting should seek duties from their employer that are less physically demanding, and for a shorter period of time during the working day.

Sports

You may swim gently in a clean swimming pool after 2 months or sea after 3 months. (Leave it much long longer before swimming in the sea or river.)

You can start gentle aquaerobics after about 3 month post-operative, but should not over-stretch the upper leg at all in the early stages.

You may undertake gentle sports after 3 months, but should avoid contact sports or any exercise that would jar the body for 6 months post-operatively. SRS is not a hugely invasive operation, but it is important not to put too much strain on the groin area in the first few months.

"Exploring" and Masturbation

Try to avoid sexual arousal in the first 3 months after surgery. You have a lot of erectile tissue which will engorge when sexually excited. Coupled with localized swelling that can persist for quite a long time after surgery, along with scar tissue contraction, "erections" or engorgement can be quite painful. This is "normal" but best avoided.

Gentle exploration can normally be done quite safely 3 months post-operatively. However, be very careful for the first 3 months not to open widely the labia minora, or stretch the clitoris hood and frenulum. The tissues are very fragile in the first few months, and tears can result which can only be corrected by being repaired by Dr Suporn.

Do not be frightened or intimidated by your new acquisition. It is yours. Take time to find out which parts are pleasant to touch and which – in the early days at least – those which are less so. Treat it with care – of course – but take ownership of your vulva and learn to treat it as an integral part of your body – not as the site of an operation.

Sexual Intercourse

Patients may try gentle sexual intercourse no sooner than 3 months after surgery (after the Difficult Period). It is likely that full penetration might be difficult and painful at first, and penetration (like dilation) might take some time to be achieved. It may help considerably to try intercourse after dilating, when the vagina is fully open. If intercourse causes any pain or difficulty, do not continue. Common sense will indicate what is comfortable. Providing they have dilated diligently; most patients are able to enjoy intercourse 6 months post-operatively.

Post-Op Depression

Post-operative depression can result after any major operation under general anaesthesia. The operation takes a lot of energy out of the body, and in the first few weeks it requires as

much energy as it can get to concentrate on the healing process. This monopolising of your precious energy resources can leave you tired, run down and emotionally exhausted. If you are aware of the possibility of such a thing in advance, you can make some mental preparation how to defeat it. The best advice here is to keep mentally and physically active, and to keep your mind clear of concerns of any kind about the operation itself.

There is, however, another basis for patients to suffer from post-operative depression after SRS. Undergoing SRS is a huge step in any non-natal female's life. It usually marks the end of transition, and planning for it mentally and physically can become an all-consuming task. Many patients devote endless hours of their lives planning, thinking, discussing, debating and researching the whole subject and its associated activities. This is something that can devour one's life for years before the operation

TELLING US ABOUT YOUR CONCERNS

Please remember that Dr Suporn gave you a clean bill of health before leaving Chonburi, and it is extraordinarily unlikely that anything he observed then will have changed soon after arriving home. However, because this is the time most of you feel a bit braver about exploring, it tends to coincide with you finding something you were not aware was there, or might not quite like the look of. Please refer to these notes to see if the topic is covered and – whatever you do – DO NOT PANIC. The likelihood of anything being seriously wrong is extraordinarily low, and can best be solved in a calm and level-headed way.

Most of you will not need to contact us, but a few will. Statements limited to "I have lots of pain – what shall I do?" are not at all helpful, and will only lead to a delay in diagnosing the possible cause. The following checklists should help you when getting in touch so that we have as much information as possible.

Sending Photographs

If you feel anything is wrong, when you contact us at admin@supornclinic.com, please make sure that any descriptions you give are as complete as possible, and send photographs if at all possible to show the area of concern.

When taking photographs of your vulva, please ensure that the pictures are in focus and show the detail necessary to clearly show the area(s) of concern. This can usually best be done with an assistant. However, it is not always easy to find someone willing to help you with this. If you cannot get anyone to take pictures of your vulva, I suggest the following:

- Lie in a comfortable position with the digital camera conveniently to hand. Position a mirror (plain mirror - NOT magnifying) between your legs such that you can clearly see a reflection of your vulva showing the specific areas of concern. Use your fingers to reveal the areas as appropriate. Then simply take a picture of the reflection (be careful about flash). Take as many pictures as necessary but 4 should be more than enough. Photographs should be high quality and sent in .jpg format. Before sending the pictures, please use your image editing software to reduce each image file size to about 150 Kbytes maximum.

Please check the pictures before you send them. If you cannot clearly see the problem, nor can Dr Suporn. In that event, please take some new ones.

Bleeding

Before telling us about bleeding, please be as explicit and detailed as possible. Can you please describe as precisely as possible the bleeding you experience?

Please try to locate exactly what its source is, and advise. If at all possible, please take a picture showing where you think was the exact source.

- When does it bleed? Is it:
  - After dilation
  - After exercise or similar stress
  - When urinating or bowel movement o While you are asleep
  - At any time for no apparently noticeable reason
- How frequently does the bleeding occur?
- How much blood is normally present? Please remember - a very small amount of blood can be a lot
- How soon does it stop bleeding? Is it easy to stop bleeding?
- What colour is it? Is it bright red - or diluted with other fluids?

Pain

If you experience unusual pain, please fully describe the pain you are experiencing:

Please try to locate exactly where the pain is and advise. If it is across a wide area or region, please tell us what that area is. Please supply a photograph if it could help to identify the location.

- Is the pain:
  - A sharp pain
  - A dull ache
  - A throbbing pain
  - Like “pins and needles”
  - A different sensation
- Is the pain constantly present, or does it only occur at certain times? If only at certain times - please describe what you are doing that brings on the pain. Is it:
  - After or during dilation
  - After exercise or similar stress
  - When urinating or bowel movement
  - Associated with any bleeding

- Symptomatic of something else

- Try to assess the level of pain:

  - Does it stop you from doing other things, and make you want to wait until it subsides?
  - How tolerable or intolerable do you find it? Use the following table to try to quantify it:

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild pain			Moderate Pain			Severe Pain			
	Nagging, Annoying, but has little effect on ADLs**			Interferes significantly with ADLs			Disabling. Unable to perform some ADLs			

****ADLs (Activities of Daily Living):** The things we normally do in daily living including any daily activity we perform for self-care (such as feeding ourselves, bathing, dressing, grooming), work, homemaking, and leisure

- How long does the pain generally last? Does any specific action help to ease the pain?

- Do you feel the need to take pain killers to help ease the pain?

Other Symptoms

Apart from describing any pain or bleeding, please tell us if you have any other symptoms such as:

- New appearance of localised swelling
- Localised high skin temperature
- Redness or soreness
- General feeling of being run down
- High body temperature
- Sweating or faintness
- Loss of Energy
- Discharge from wounds

The more precise detail you can give about your symptoms, the easier it will be for Dr Suporn to identify the possible cause, and to make a suitable recommendation for a course of action.

Summary

In summary – you have chosen the best surgeon in the world to undergo your SRS with. However, that does not mean that an ultimate result can be guaranteed without some hard work on your behalf, and nor can you expect it always to be achieved without a few minor difficulties. There is always rapid help at hand if you ever feel worried or unsure.

…… but there's more! ……

COSMETIC IMPROVEMENT

Occasionally the final result you achieve is less than perfect, and you might wish to have it improved. These imperfections are not the consequence of a "failed operation" and are just caused because your body did not heal as expected. The way in which a body heals is not predictable, so things can go a bit awry occasionally. Only about 15% of our clients return to have these blemishes with, so please do not automatically start thing that you will need to return for a "revision" because the chances are that you won't need to.

To deal with these imperfections we offer an option to return for Cosmetic Improvement.

Eligibility

Our surgeons will not undertake any cosmetic improvement of SRS until at least 12 months after the operation, by which time the scar tissue has healed, and become elastic. We will also not accept any requests for CI sooner than 9 months post-operative .

Requesting Cosmetic Improvement

No sooner than 9 months post-operative, if you wish to undergo a cosmetic improvement procedure, please send a description of which features you are unhappy with and wish to have altered, along with some clear pictures(1) that show the areas of your concern. When we do cosmetic improvement, we like to do a complete review of every feature that might benefit from improvement. Please send us at least 2 pictures that show every feature of the vulva, specifically:

- One photo showing the overall genitalia, with the labia closed and hands away from it

- A second photo with the labia minora held evenly open, exposing the vulval vestibule to show the clitoris, urethra and surrounding tissue, and the vaginal opening.

Note:

(1) "Clear" means well-focused - not large. We try to examine all photographs on a typical medium resolution PC screen of around 1900 x 1200 pixels. There is nothing to be gained by sending photographs with a file size larger than this resolution. However please do not send tiny photos, because when we expand those to the size of a PC screen, they become pixelated and detail is lost.

(2) Always hold the camera lens at least 2 feet (60cm) from the skin – even if you want to show some specific detail. Most cameras are not capable of focusing properly when close to the skin. If we need to see detail, we can zoom in digitally.

Please check the pictures you send and make sure that you can clearly see the features that you wish us to see when the pictures are displayed full-size on a PC screen. If you can't see clearly what you want us to see, then we won't be out to see it ourselves. We'll then just ask you to send better pictures, which absorbs more of your and our time.

Length of Stay after Cosmetic Improvement Surgery

From the pictures you send, our surgeons can then assess the extent to which he can help, and determine an approximate revision procedure and operation time. We can then subsequently agree a mutually acceptable date for the operation.

Typically, we expect patients to stay about 14 days after any revision procedure before travelling home, to minimize the risk of any delicate work being damaged.

Price of SRS Cosmetic Improvement Surgery

Eligibility for free Cosmetic Improvement surgery is described on our web site at http://www.supornclinic.com/html/support/commitment.html

If you remain eligible for free procedures, we will absorb the surgical costs of any CI operation, including post-operative medication and care. If you are no longer eligible for free cosmetic improvement at the time you wish to undergo it, there will be a nominal charge – currently (2019) 40, 000 Baht for operations done in the Clinic, and 150, 000 Baht if General Anesthesia and hospitalization are necessary.

In all cases you are responsible for all travel costs to and from the Clinic, and for accommodation in Thailand

FREQUENTLY ASKED QUESTIONS (FAQs)

1. **Where should I measure my depth?**
   It doesn't matter too much where you measure from, as long as you are consistent so that any changes from week to week can be noted.

2. **How long should I use condoms?**
   2 months after surgery.

3. **How often do I have to do dynamic dilation?**
   3 times a day.

4. **When can I use only the large size dilator?**
   Approximately 2 weeks after checking your vagina cavity from the doctor.

5. **How long do I need to clean inside by water mixed with Betadine?**
   2 months after surgery. And after that you can clean inside by water mixed with soap.

6. **When can I do a cosmetic improvement?**
   After 1 year.

7. **What should I do when I have bleeding?**
   First stay calm and use gauze to press at the bleeding area. Check out the section on bleeding here (Please check PDF in USB).

8. **What should I do when I have active bleeding?**
   If you have continually active bleeding that you cannot stop using the advice here (Please check PDF in USB), you should go to the hospital.

9. **What should I do when I have UTI?**
   The first aid is to drink plenty of water, but if symptoms persist, please see your own doctor for treatment. Do not leave it unchecked. UTI can be dangerous if left untreated

10. **What should I do when I have a granulation?**
    Just leave it. A granulation can be spontaneously healed by itself.

11. **How long do I have discharge?**
    Approximately 3 months.

12. **How long do I have to use Silverderm and Betadine?**
    For 2 months after surgery.

13. **When can I take a bath?**
    1 month after surgery.

14. **When can I masturbate?**
    3 months after surgery.

15. **When can I have sexual intercourse?**
    3 months after surgery. Please note that you should dilate before and be gentle.

16. **When can I have anal sex?**
    3 months after surgery.

17. **When can I swim?**
    In the swimming pool 2 months; in the sea 3 months.

18. **When can I do electrolysis in surgery area?**
    No sooner than 6 months after surgery

19. **When can I apply scar cream on my scar?**
    After 6 – 12 months.

20. **When can I tattoo my vulva?**
    1 year after surgery.