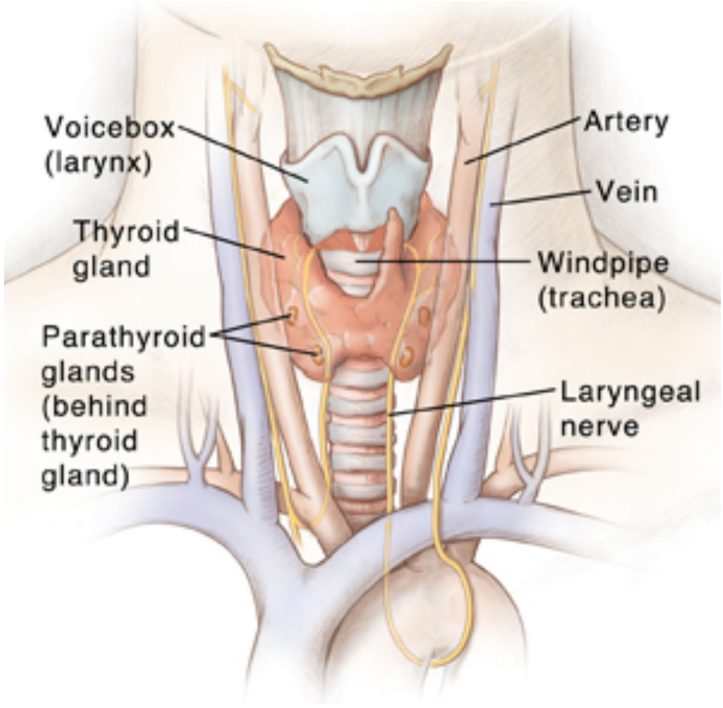
University Hospitals Dorset
NHS Foundation Trust

Thyroidectomy

Endocrine Surgery Patient information

Your surgeon and specialist nurse have explained to you the reason for recommending a thyroidectomy. The purpose of this leaflet is to give you more information about the thyroid gland and having a thyroidectomy, which is a partial or total removal of the thyroid gland.

The thyroid gland



The thyroid gland is found halfway down the front of the neck. The gland consists of two lobes and a connecting bridge of tissue called the isthmus. The thyroid gland produces a hormone called thyroxine. Thyroxine is circulated in your blood to control the speed at which your chemical processes work, known as your metabolism.

Why do I need thyroidectomy?

There are several reasons why thyroidectomy is recommended. It may be recommended if:

- you are experiencing symptoms from an enlarged thyroid
- you have an overactive thyroid due to toxic nodule, thyrotoxicosis, or Graves' disease
- you have a suspicious thyroid nodule
- you have thyroid cancer

Symptoms from enlarged thyroid (goitre)

Benign (non-cancerous) thyroid nodules and swelling are common. Up to 60% of people have harmless thyroid nodules they are unaware of. Most benign goitres are safe to leave alone and do not require surgery. However, sometimes these swellings can cause difficulty breathing, swallowing, or sleeping flat. In these situations, surgery may be recommended to relieve symptoms.

If your thyroid is very large, your surgeon may advise thyroidectomy to prevent you from developing future problems with swallowing or breathing.

Overactive thyroid

You may have a nodule in your thyroid that is producing too much thyroxine, known as toxic nodule, or the whole thyroid gland may be overactive as seen in Graves' disease.

These conditions can be managed and treated in several ways. Tablets to control the overactivity, radioactive iodine, or surgery can all be considered.

Surgery will permanently cure the overactivity, but there are risks from this procedure that we will cover later in this leaflet.

Suspicious thyroid nodule

Most thyroid nodules are benign. Biopsy of a nodule with fine needle aspiration (FNA) does not always give a diagnosis of the nature of a nodule. If there is any uncertainty, your surgeon may recommend removal of half of your thyroid, known as a lobectomy, so that diagnosis can be confirmed.

Thyroid cancer

Thyroid cancer is rare. It accounts for less than 5% of all thyroid nodules. Treatment may mean removal of half or all of the thyroid gland. Removal of the thyroid gland is called a thyroidectomy.

What tests are needed before my operation?

Vocal cord check

If you are having this operation, you may be advised to have your vocal cords checked before surgery, particularly if you have had surgery on your neck before. This means an appointment in an ear, nose and throat (ENT) clinic which will be arranged for you.

At the appointment, a small camera is inserted into the nose under local anaesthetic to view the vocal cords and to check they are moving correctly. If a problem is found, a referral to the voice clinic will be made for assessment and treatment as required.

How is surgery performed?

A thyroidectomy is performed under general anaesthetic in theatre.

An incision (cut) is made low down at the front of the neck. If you are having a thyroid lobectomy, just one side of the thyroid will be removed. If you are having a total thyroidectomy, all of the thyroid will be removed.

Sitting just behind the thyroid are four small glands called the parathyroid glands. These glands, which are about the size of a grain of rice, produce a hormone called parathyroid hormone, which controls the level of calcium in your blood. The surgeon will try to locate and preserve these glands. However, they are sometimes removed with the thyroid gland, or their function may be affected by the surgery. This may lead to a condition called hypoparathyroidism, which is a low production of parathyroid hormone, resulting in low calcium levels in your blood. There is more information about this later in this leaflet.

What are the potential risks of thyroidectomy?

To reduce the chance of some of the following complications happening, you can make sure you are as fit as possible before your operation by:

- stopping smoking
- reducing your weight
- reducing your alcohol intake
- keeping active
- doing regular exercise

General surgical risks

Scarring

Most neck incisions heal to produce a very faint scar. The scar may become thickened and red for a few months after the operation, before fading to a thin white line. Some patients developed a thick, exaggerated keloid scar, but this is uncommon and unpredictable. After about two weeks, once the skin has healed, gently massaging the scar from the middle of the neck to the outside of the neck can help to smooth, soften, and flatten the scar.

Pain

There will be some discomfort at the operation site. This can be controlled with painkillers such as paracetamol and ibuprofen. Keep your head and neck moving, you will not cause any damage to the operation site by moving your head.

Bleeding/haematoma

Any operation carries a risk of bleeding either during or after surgery. Very occasionally, a drainage tube may be temporarily placed into the wound at the time of your operation. This tube is usually removed on the ward after 24 hours.

If a collection of blood, known as a haematoma, develops at the site of your operation, then it may be necessary to return to theatre for the wound to be opened and the collection of blood to be removed. This is done to prevent breathing problems from the pressure of the haematoma on your windpipe.

If you are usually prescribed blood thinning medication, the risk of bleeding or haematoma will be higher.

Infection

Any surgery carries a risk of wound infection. Signs of infection include fever, a red wound, discharge from the wound, and increasing pain at the site of surgery. If infection is confirmed, antibiotic treatment may be necessary.

You have a higher risk of wound infection if you are diabetic or if you smoke.

Deep vein thrombosis (DVT)/pulmonary embolism (PE)

Any patient has a general anaesthetic risk of developing blood clots in the legs (DVT) or lungs (PE). To reduce this risk, you will be given elasticated stockings to wear while in hospital. Keeping active before and after your operation can help to reduce this risk.

Stroke, heart attack, death

Anaesthetic and cardiovascular risks such as these are extremely rare, and making sure you are as healthy as possible before your operation, will reduce the risk of complications.

Specific risks and consequences

Voice change and damage to recurrent laryngeal nerves (RLN's)

The RLN's control your vocal cords. They are very close to the thyroid gland. Due to their location, they are at risk of injury from this procedure. Damage to the RLN's can be temporary, the risk of this is 4-6%, or permanent, which has a 1-2% chance of happening. Damage to the RLN's may cause hoarseness and weakness of the voice as well as swallowing difficulties. Temporary damage causes short term changes to the voice. This may last a few days or up to six months.

In the event of permanent damage to the RLN's, voice change may persist. The risk of permanent voice change is approximately 2%. If your surgeon suspects there is permanent paralysis of the vocal cord(s), you may be referred to our team of voice specialists who can offer advice and interventions to help improve the strength of your voice. Improvement in your voice can be expected for up to one year after surgery.

In the unlikely event that both RLN's are damaged, both vocal cords may be paralysed. This can result in complete blockage of the airway requiring a tracheostomy, which is a tube placed through the front of the neck directly into the windpipe, to bypass the blockage. If the nerve damage is temporary, the tracheostomy will be temporary. However, if the damage is permanent, the tracheostomy may be permanent.

Low calcium levels

Removal of the parathyroid gland(s), or damage affecting the function of the glands, is sometimes unavoidable. In either of these situations, the effect may be that your calcium level falls to below the normal range. Early symptoms of low blood calcium include a tingling sensation around the mouth and/or your fingertips. You must inform a member of staff if you develop these symptoms, so that an urgent blood test can be taken.

If calcium is confirmed to be low, you will be prescribed calcium and vitamin D supplements. Usually, these tablets are needed for just a few weeks, until the parathyroid function returns, but a small number of patients will need life long calcium and vitamin D. In this situation, you will be referred for ongoing monitoring with the endocrinology team.

Thyroxine replacement

If you have had a total thyroidectomy, you will need lifelong thyroxine replacement. Levothyroxine will be prescribed for you before you leave hospital. A blood test will be arranged six weeks after your operation to check the level of thyroxine in your blood. The dose of levothyroxine may need to be adjusted based on these results.

If you have had a thyroid lobectomy, you may require thyroxine supplementation. A blood test will be arranged six weeks after your operation to check the function of the remaining thyroid lobe. If this blood test shows that your thyroid hormone levels are low, you will be prescribed thyroxine tablets.

Informed consent

Once a date for your operation is agreed, you will need to attend the hospital for a consent appointment. This will be with the surgeon or one of the specialist surgical endocrine nurses. They will make sure you understand the reason for the recommendation for surgery and have read and understood this leaflet. They will then go through the operation in detail with you to ensure you understand the benefits and risks. You will then be asked to sign a consent form.

What happens on the day of surgery?

You will be admitted to hospital on the day of surgery. Before surgery you will be contacted by the hospital to confirm your instructions, including time of arrival to hospital, where you need to go, and when you must stop eating and drinking. Unless otherwise directed, you should continue to take any regular medication.

Before your operation you will meet your surgeon. This is an opportunity for you to ask any outstanding questions you have.

You will also be seen by the anaesthetist who will discuss the anaesthetic with you. If you have any more questions, it is important you ask them then.

When it is time for your operation, a nurse will collect you and walk with you to the theatre area. You will enter the anaesthetic room and be asked to sit or lie on the trolley. The anaesthetist and theatre staff will then prepare you for giving the anaesthetic. This will include inserting a cannula, which is a small plastic tube, into a vein in your hand or arm. Monitoring of your pulse and blood pressure will begin and you may be asked to put on an oxygen mask. Once everything has been prepared, the anaesthetist will inject the anaesthetic drugs into the cannula. When you are asleep, a breathing tube will be passed into your airway so your breathing can be controlled. At this point you will be taken to the operating theatre.

How long does the operation take?

Your operation can take as little as half an hour but may be up to an hour and a half. The length of time it takes depends on how easily the abnormal gland(s) are found and removed.

Where will I wake up after the operation?

After the operation you will be taken to the recovery area in theatres to be closely monitored while you wake up. Here, specially trained nurses will carry out regular checks on your breathing, heart rate, and blood pressure, as well as your wound. When they are happy you are well enough, you will be moved to the overnight ward to continue your recovery. You can expect to be discharged home the following day.

What can I do after my operation and how will I feel?

Pins and needles

If you have had all of your thyroid removed, very occasionally you may experience symptoms of low calcium such as pins and needles in your lips and/or fingertips. Please ensure that you let a member of staff know so a blood test can be done to check your calcium levels.

If you develop these symptoms after leaving hospital, you should contact the surgical endocrine specialist nurse or attend the Emergency Department (ED) for an urgent blood test.

Pain

After this operation, most patients only need simple painkillers such as paracetamol and ibuprofen to control any discomfort.

Nausea and vomiting

You may feel sick for up to 24 hours after the anaesthetic. Medication can be given to control this.

Eating and drinking

You may have some intravenous fluids, known as a drip, attached to the cannula in your arm when you wake up. This will stay in place to keep you well hydrated until you are able to tolerate fluids. You will be able to eat and drink once you are awake enough.

Going to the toilet

Occasionally, anaesthetics can cause the bladder to temporarily stop working properly, which causes urinary retention (holding wee in your bladder). You may need a catheter (small tube) placed into your bladder to drain the urine. The catheter is usually removed after 24 hours, with the bladder function returning to normal.

Walking

You may feel unsteady on your feet when you first try and get up after the operation. You should ask a nurse on the ward to help you until you feel safe to walk independently. You will be encouraged to get up and move around as soon as you can, as this helps your recovery and reduces the likelihood of some of the possible complications.

Washing and dressing

You can wash and shower as normal after the operation. Just gently pat the wound area dry after showering. Do not lie in a bath as you should not soak your wounds until they are well healed, and this may take up to two weeks. You can dress as normal after the operation.

When can I go home?

You will stay in hospital overnight for observation and it is very likely that you will go home the following day.

How do I care for my wound when I go home?

Depending on the surgeon who performed your operation, there may be different advice for stitch removal. You will be advised by the hospital team whether you have stitches that need to be removed and when.

You should avoid soaking your wound and swimming is not advised for at least two weeks after surgery.

If you are concerned about any swelling or redness of the wound after leaving hospital, you can call the surgical endocrine specialist nurse or your GP surgery for advice.

Once your wound is fully healed, which is after about two weeks, it is recommended that you massage the scar with a simple moisturiser each day, which will help to soften and smooth out the scar.

When can I drive?

After an anaesthetic you should not drive for 48 hours. You should only return to driving when you are pain free and are able to turn your head comfortably. Your insurance company may have specific limitations.

When can I go back to work/normal activity?

This will depend on the type of work you do and how you are recovering. Most patients are well enough to return to work after two weeks.

When will I be seen in clinic after my operation?

You will be sent an appointment to see the surgeon and/or endocrinologist two to six weeks after your operation.

You will be asked to have a blood test before this appointment so we can assess your thyroid function tests and in some cases calcium and parathyroid levels as well.

Who can I contact if I have further questions?

If you have further questions, please contact:

Royal Bournemouth:
Tanya Longshaw, advanced nurse practitioner
Tel: **0300 019 4674** Email: **Tanya.Longshaw1@nhs.net**

Poole:
Carly Ringrose, advanced nurse practitioner
Tel: **0300 019 2990** Email: **Carly.Ringrose@nhs.net**

Other resources and sources of support

BAETS (British Association of Endocrine and Thyroid Surgeons)
Website: **www.baets.org.uk**

Parathyroid UK (The national voice for people living with parathyroid conditions)
Website: **www.parathyroiduk.org** Helpline tel: **01342 316315**

You and your hormones (an education resource from the Society for Endocrinology)
www.yourhormones.info/patients

BAETS
BRITISH ASSOCIATION OF
ENDOCRINE & THYROID SURGEONS

UK registry of endocrine and thyroid surgery (UKRETS)

Patient information leaflet

The UK registry of endocrine and thyroid surgery aims to collect information on the results of surgery for every UK patient undergoing thyroid, parathyroid, adrenal, or pancreatic endocrine surgery operations.

If you are having a thyroid, parathyroid, or adrenal (endocrine) operation in England, Wales, Scotland or Northern Ireland, the surgeon performing the surgery may collect information on this for the purposes of clinical audit.

Clinical audit is a process by which the surgical team reviews treatments and outcomes with the aim of finding ways to improve care.

This leaflet describes what patient information is kept in the UK registry of endocrine and thyroid surgery (UKRETS), and how this data is used to promote good practice and maintain standards.

What is UKRETS?

UKRETS is a clinical audit or registry that endocrine and thyroid surgeons use to monitor their practice. It was set up by the British Association of Endocrine and Thyroid Surgeons (BAETS) and is approved by the Healthcare Quality Improvement Partnership (HQIP), an independent organisation led by Academy of Medical Royal Colleges, The Royal College of Nursing, and National Voices.

BAETS stipulate that all surgeons performing thyroid surgery contribute data on all their relevant operations to UKRETS. BAETS strongly recommends that all other relevant endocrine operations are also recorded.

Surgeons enter data directly onto the database through a secure web-based connection. UKRETS analyse this data to provide information on their standard of clinical care and patient outcomes. This allows surgeons and their hospitals to know where they are doing well, as well as highlight areas they can improve.

UKRETS is part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by HQIP for England.

What information is collected on me?

UKRETS collects information about the endocrine operation you have while in hospital. In addition, your gender, date of birth, and date of operation are recorded to allow individual surgeons to know they are accessing the correct patient record when entering data from your follow up postoperative appointments - your NHS number may be collected also in the future.

Only information related to your surgery is collected, such as the severity of your condition, the type of investigations and treatment you receive, your surgical treatment and wider clinical outcomes of your operation.

UKRETS do not need you to have any extra appointments, or clinical tests. The registry does not collect information on any care that does not relate to your thyroid or endocrine surgery.

Opting out from the UKRETS

If you do not wish your personal data - date of birth, gender, and date of operation - to be entered on the database, please inform your surgeon. Your decision will be respected, and your choice will be recorded in the front of your medical notes.

If you have changed your mind and wish to have your details removed from the registry, please contact either by:

Email:
secretary@baets.org.uk

Tel:
0207 3044771

In writing:
UK Registry of Endocrine and Thyroid Surgery,

at: BAETS,
ASGBI Office,
Royal College of Surgeons of England,
35-43 Lincoln's Inn Fields,
London WC2A 3PE

How will your information be used?

UKRETS only publishes information describing the care received by groups of similar patients. It does not publish information on individual patients, and your personal details will never be made public.

The information collected by UKRETS is used:

- To produce information on the quality of care received by patients having thyroid and endocrine surgery in the United Kingdom.
- UKRETS produces reports that describe whether care is meeting national standards. The reports are available to the public, endocrine and thyroid surgeons, hospital management, and NHS England.

- To enable sharing of good practice amongst all NHS organizations.
- To provide patients with information about endocrine services at different hospitals, such as the number of operations done each year, and the rates of complications after surgery.
- To help commissioners and policy makers with decisions about how endocrine surgery should be organized within the NHS.

Further information on how BAETS processes your data in UKRETS is available on the BAETS website at the following address:
www.baets.org.uk/wp-content/uploads/UKRETS-fair-processing-statement-v2.pdf

How your information is be kept safe?

The registry has strict data security measures to keep the information held on you confidential.

We follow rules about how the data is stored in a secure environment and that it is only made available to appropriate staff. The registry conforms to the confidentiality rules established by the Data Protection Act 1998, the NHS Act 2006, and the Health and Social Care Act 2008.

Your personal data will never be shared with anyone outside BAETS or Dendrite, the company that hosts the database.

It is important that the UKRETS has information from all patients to give an accurate picture of thyroid and endocrine surgery in the UK.

Further information on the measures taken to ensure your data is stored safely in UKRETS are available on the BAETS website at the following address:
www.baets.org.uk/wp-content/uploads/UKRETS-privacy-notice-v2.pdf

Further information

If you would like more information about UKRETS, please ask your endocrine or thyroid surgeon.

You are entitled to access your data in UKRETS to see what information is stored on you. To request this please complete a BAETS subject access request form, which you can find at the following address: **http://baes.e-dendrite.com/sar.html**

To read this leaflet in a different language,
please visit our website: **www.uhd.nhs.uk/visit/patient-information-leaflets**
and use the language and accessibility function available along the top of the site.

To ask for this leaflet in larger print, please contact the patient experience team on **0300 019 8499**
or email **uhd.patientexperienceteam@nhs.net**.

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