Useful Telephone Numbers

North Hampshire ENT Partnership
Hampshire Clinic - 01256 377733

The Hampshire Clinic
Switchboard - 01256 357111
Lyde Ward - 01256 377773
Enbourne Ward - 01256 377772

Frimley Park Hospital
(for out of hours emergencies)
Switchboard - 01276 604604

Basingstoke & North Hampshire Hospital
Switchboard - 01256 473202
DTC - 01256 313332

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NORTH HAMPSHIRE ENT
ENT | HEAD & NECK SURGERY

Information for Patients on

Thyroid Surgery

Information
Booklet T006

The North Hampshire ENT Partnership consultants are

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Appointed to North Hampshire Hospital in 1998. Special interest in head and neck surgery and facial plastic surgery.

Introduction

The Thyroid gland is a small dumb-bell shaped gland that sits low down in the neck just in front of the windpipe. It is just in front of the windpipe. Its main function is to produce the hormone thyroxine, which controls your body's metabolism. Too much thyroxine and your metabolism is overactive and too little thyroxine and your metabolism slows down and you would feel slow and lethargic.

Attached to the thyroid gland are 4 little parathyroid glands, which control the calcium level in the blood. Also, running just behind the thyroid gland are 2 nerves called the recurrent laryngeal nerves. These control the movement of the vocal cords within the voice box on each side.

Problems With the Thyroid Gland That Require Surgery

1. Sometimes the thyroid gland can become markedly enlarged. This is called a goitre. If the gland gets very large, not only can it look very unattractive with an obvious swelling in the neck, it can also squeeze on the windpipe and the gullet causing problems with breathing and swallowing. This sometimes requires an operation to remove the thyroid gland.

2. The gland may become overactive and produce too much thyroxine. If this happens, it causes serious problems with the body's metabolism. Normally, people who have this problem will have been looked after by their own doctor and then an Endocrinologist. The most common form of management for this problem is with radiation treatment. However, in some people the radiation treatment is not appropriate and an operation to remove the thyroid gland is a better option.

3. A solitary nodule in the thyroid gland. In some people, a solitary nodule develops within the thyroid gland. Despite all our investigations, usually a needle test and an ultrasound scan, a definite diagnosis is not possible. Sometimes the investigations suggest that the nodule may be something a little more serious. In these situations the only way to confirm exactly what the nodule is, is to remove it for analysis by the Pathologist. (This is done by looking at the specimen under a microscope).

   In this situation only a portion of the thyroid gland is removed; an operation called a thyroid lobectomy.

Sources of additional information

The North Hampshire ENT Partnership
www.ent-hampshire.com

British Association of Otorhinolaryngologists
www.entuk.org

Risks

As with all operations there is a risk of bleeding or infection, although these are uncommon in this operation.

The main specific risk, if the operation is a thyroid lobectomy, is damage to the recurrent laryngeal nerve. Damage to this nerve is very uncommon, but occasionally even if the operation appears to go extremely smoothly, there can be some bruising of the nerve. This may be recognised as a slight huskiness of the voice, which may last a few days or even a few weeks after the surgery until complete recovery occurs.

In a total thyroidectomy (when the whole gland is removed) there is the same risk to the recurrent laryngeal nerve on the other side. In addition however, there is a risk of damage to the parathyroid glands. Normally these glands are identified during the procedure and preserved, but even if this is done the glands can sometimes be bruised after the surgery, which leads them to become under-active for a period of time. If this occurs, the calcium level in the blood will drop and this can lead to problems with pins and needles in the fingers and toes and around the lips. Occasionally, it can lead to some muscular twitching.

If the calcium level does drop, then calcium supplements may be required for a period of time until the parathyroid glands recover. Very occasionally, even if preserved the parathyroid glands can stop working and calcium replacement may be required for life. Of course, anyone having a total thyroidectomy will require thyroxine replacement, which will continue for life.

If any problems arise after you have gone home, please contact the ENT ward, or the Consultant's Secretary.

About the Operation

You will attend the hospital about 1-2 weeks before the operation for a pre-operative assessment. You should not have suffered from a common cold for at least 2 weeks before the operation. If you have had a cold, please ring the Consultant's Secretary.

Please advise us if you take the oral contraceptive pill, as this may need to be stopped temporarily.

You will be admitted to hospital on the morning of the surgery.

Operations to remove part or all of the thyroid gland are nearly always performed under a general anaesthetic (fast asleep). An incision is made in the front of the neck, often in a skin crease if one is present. This incision will leave a scar.

In the operation of thyroid lobectomy, the blood supply to the affected lobe of the thyroid gland is identified and divided. The blood vessels are then tied to prevent any bleeding. Next, the parathyroid gland and the recurrent laryngeal nerve on that side are found and preserved. The lobe of the thyroid gland is then removed.

In the operation of total thyroidectomy, the same procedure is repeated on both sides to remove the thyroid gland completely.

Typically the operation of thyroid lobectomy takes about 45 minutes and the operation of total thyroidectomy 90 – 120 minutes.

At the end of the operation a small plastic drain is left in one side for a thyroid lobectomy and both sides if a total thyroidectomy has been performed. This is to prevent the collection of any blood in the operation site. The incision is then closed (often with special staples). The next day, the plastic drain will be removed. If the operation has been a thyroid lobectomy, discharge home later that day is the usual course.

In the operation of total thyroidectomy, although the drains are usually removed the following day, it is very important to check the calcium level and so the hospital stay is normally 2 to 3 days after the operation.

What to Expect Afterwards

After leaving the hospital, the main problem is normally related to the length of operation and anaesthetic.

People often feel tired and worn out for a few days afterwards until things get back to normal.

Often the front of the neck will feel a little bruised and swollen for some time afterwards. Often the voice will be a little husky for a few days afterwards. This may be related to some bruising of the recurrent laryngeal nerves, but is more often related to having a tube in the throat for the anaesthetic.

The stitches or skin staples that have been used to close the incision should be removed about 1 week after the surgery. This can normally be arranged with your doctor’s surgery.

A follow-up outpatient appointment will be made for 4 weeks after the surgery.

Finally, we would recommend you allow at least 2 weeks for convalescence before getting back to normal activities. A medical certificate can be supplied if needed.