The Leeds Teaching Hospitals NHS Trust

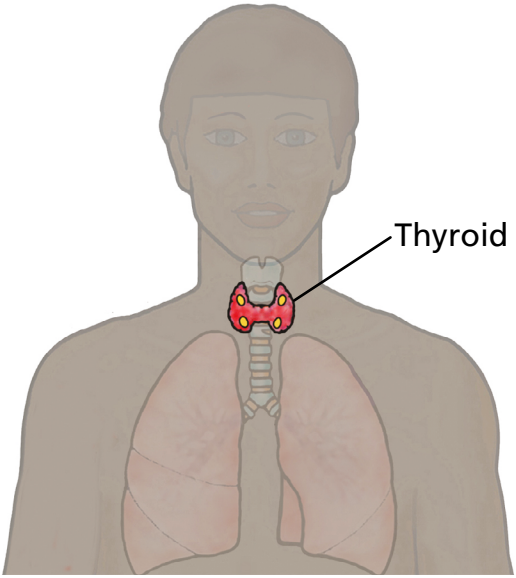
# Thyroid lobectomy

## Information for patients having surgery at Leeds General Infirmary

This leaflet provides information on having a thyroid lobectomy, reasons for this and alternatives to surgery. Along with the risks of surgery and aftercare.

## What and where is the thyroid gland?

The thyroid is a butterfly-shaped gland found in your neck, in front of your windpipe. Its main job is to produce hormones, especially thyroxine.




Thyroxine helps control your metabolic rate. When the thyroid gland produces too much thyroxine, everything works too quickly. This is called an overactive thyroid or hyperthyroidism. An example of this is Graves' disease.

Symptoms of hyperthyroidism include heart palpitations, weight loss, sweating, diarrhoea and hunger. An underactive thyroid gland produces too little thyroxine and this slows the body down resulting in weight gain, tiredness, hair thinning and constipation. The majority of patients undergoing thyroid lobectomy surgery have normal thyroid function.

## What are the reasons for removal of a thyroid lobe?

There are many reasons why your surgeon may recommend removal of a thyroid lobe. The most common reasons are:

- **Suspicious nodules** - nodules within the thyroid are very common but certain features on ultrasound can be suspicious for cancer. Sometimes biopsies can help but often they cannot prove either way whether a nodule is benign (non-cancerous) or malignant (cancer). Surgery is the only way to provide a definitive answer.
- **Cancer** - when biopsies have proven a thyroid nodule is a cancer, surgery is recommended to remove the thyroid gland. If the nodule is small sometimes only the thyroid lobe containing the cancer needs to be removed.
- **Goitre** - an enlargement of the thyroid which can cause swallowing and breathing problems due to pressure in the neck and chest. If only one side of your thyroid is enlarged, your surgeon may recommend a thyroid lobectomy to relieve these pressure symptoms.
- **Toxic nodule** - some thyroid nodules produce too much thyroxine making the patient hyperthyroid. Surgery to remove the lobe containing the nodule will cure this.

## What are the alternatives to surgery?

- **Suspicious nodules** - if patients decline diagnostic surgery for suspicious nodules or are unfit, these nodules can be monitored with repeat ultrasound. If they become more worrying or increase in size then surgical options can be reviewed.

- **Cancer** - surgery provides the only definite chance of cure in thyroid cancer.
- **Goitre** - if a goitre is causing no symptoms and the gland does not look worrying on scans, then it can be monitored in the clinic. If the gland remains unchanged you can be discharged. If you subsequently develop breathing or swallowing symptoms or scans show it is growing down into the chest, then surgery can be reconsidered.
- **Toxic nodule** - you can be treated with anti-thyroid medication eg Carbimazole or Propylthiouracil or undergo radioactive iodine treatment to control the overproduction of thyroxine. Both these methods have risks including recurrent disease and medication side effects. Surgery provides a definite long term cure.

## What is a thyroid lobectomy?

A thyroid lobectomy is a procedure to remove half the thyroid gland from the neck.

## How is surgery performed?

A thyroid lobectomy is performed under a General anaesthetic which means you will be completely asleep for the procedure. The thyroid lobe is removed through a horizontal cut in your neck which will be closed with stitches (normally dissolvable) before you wake up.

Some patients may also require a drain (plastic tube) in their neck. If you are having day case surgery this will be removed before you go home.

## What are the potential risks?

All surgery carries potential risk but these are generally low in thyroid surgery.

### 1. General risks

- **Bleeding** - there is a small risk of bleeding with any surgery. The chance of large blood loss requiring a blood transfusion after thyroidectomy is very low. Occasionally people bleed in their neck after surgery causing swelling (haematoma). Although this is rare patients may need to go back to theatre urgently to stop the bleeding.
- **Infection** - any surgery carries a risk of wound infection or chest infection but these are both uncommon after thyroid surgery.
- **Deep Vein Thrombosis (DVT)/Pulmonary embolism (PE)** - patients having a general anaesthetic are at risk of developing blood clots in their legs (DVT) or lungs (PE). To reduce this risk you will be given special stockings to wear whilst in hospital and are advised to keep active.
- **Scarring** - most scars in the neck heal well and are barely visible after a few months. However, some people are prone to developing thickened and bumpy scarring called keloid. If you have had problems with keloid scarring in the past it is important to let your surgeon know before surgery.

### 2. Specific risks

- **Voice change** - the nerves that control your vocal cords (and so your ability to speak) travel behind your thyroid gland and have to be carefully separated from the thyroid during thyroid surgery.

  There is a risk that these nerves may become damaged during surgery which could affect your voice. The chance of permanent damage to your voice is very low (less than 1 in 100 patients). However, some patients may notice a temporary change to their voice that lasts a few weeks or months due to bruising or stretching of the nerve. Some patient notice subtle voice changes even without evidence of nerve damage. If this may be a problem because of your occupation or hobbies, please let your surgeon know.

- **Swallowing problems** - following thyroid surgery some patients may experience difficulty in swallowing. This is normally temporary and improves with time.

- **Further surgery** - if cancer is found within the thyroid lobe once it is examined under a microscope you may require further surgery to remove the remainder of your thyroid gland if it is felt it will reduce your chance of recurrence. This is not advised for all cancers. Your surgeon will normally inform you about whether this is required when you are reviewed in clinic 2 weeks following surgery.

## What happens on the day of surgery?

Patients having thyroid lobectomy surgery are normally admitted on the day of surgery.

Normally several days before surgery you will be contacted by the hospital to confirm your instructions for the day of

admission including time of arrival to hospital, where you need to go and when you have to stop eating and drinking.

On the day of the surgery you will be seen by the surgeon who will explain the surgery again. If you haven't signed a consent form before, you will be asked to complete it on the day. You will also be seen by the anaesthetist who will discuss the anaesthetic with you. If you have any further questions at this time it is important you ask them now.

Your operation will take between 1-2 hours to be performed. After the procedure you will wake up in the recovery area, also known as PACU (Post Anaesthetic Care Unit). Here, specially trained nurses will monitor your recovery from surgery with 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 ward area.

You will normally be able to eat and drink once you are awake enough, unless the surgeon has given specific instructions. Family and friends are able to visit the evening of surgery.

## What happens after surgery?

Following surgery, you will either remain on the ward overnight for on going monitoring, or, if you have been informed by your surgeon that your operation will be as a day case procedure you will be allowed home after 6 hours observation. In this situation you will be reviewed on the ward round by the surgical team before discharge.

If you were taking any medications for an overactive thyroid, e.g. carbimazole or propylthiouracil, prior to surgery these will stopped before you are discharged home.

## When will I go home?

Some patients will have been told that we anticipate them going home the same day. Others will be staying overnight and going home the next day. Your surgeon will advise and confirm.

## Wound care after discharge

Usually the wound has dissolvable stitch under the skin. Keep the wound dry for a couple of days, then shower as usual and pat dry. You should avoid soaking the wound and swimming is not advised for a least 2 weeks after surgery.

You may notice the end of the stitches, like fine hairs sticking out from either end of your wound. These can be trimmed by yourself or the GP or left until review in clinic by your surgeon

**If you are concern about any swelling or redness to the wound after discharge from hospital you may call Ward L23 on telephone number: 0113 392 7423 day or night for advice. Alternatively, you can see your GP.**

## When will I be seen in clinic?

The majority of patients will be seen in clinic 2 weeks after discharge from hospital. Sometimes the appointment date will be given to you prior to leaving the ward but it is more likely you will receive this through the post.

**Please contact Ward L23 on telephone number 0113 392 7423 if you have not been offered an appointment within 3 weeks of your operation. This may not be the ward you stayed on for your operation, but it is staffed by experienced Head & Neck nurses and is always open.**

## When can I go back to work/normal activity?

Most patients are well enough to return to work 3-4 weeks after surgery. During this time it is important to take things gently. **It is advisable not to drive for a few days after surgery and to review your car insurance policy for specific limitations.**

## Further information

Thyroid surgery is a common operation performed regularly with relatively few risks.

Please consider how the benefits and potential risks of surgery might affect you as an individual including your occupation and/or hobbies. We are always happy to discuss this with you in detail.

***Further information can be found on the following websites:***

**http://www.baets.org.uk**

**http://www.btf-thyroid.org**

**http://www.amend.org.uk**

## Notes

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