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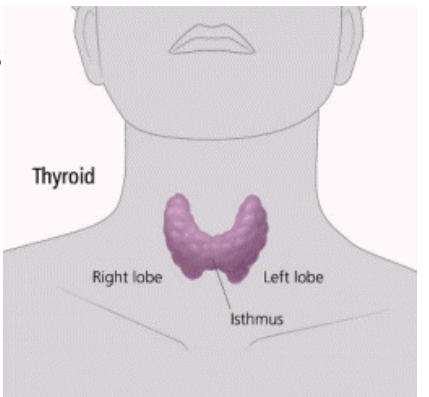
Thyroidectomy For Nodular Disease *(1 of 4)*

Introduction

The operation to remove the thyroid gland is known as a thyroidectomy. Your surgeon will explain to you the reason for recommending surgery as treatment for your thyroid problem. The surgeon will also discuss whether it is planned to remove all your thyroid or only part of it.



The thyroid gland

The thyroid gland produces a chemical substance (a hormone) called thyroxine. This hormone circulates around the body in the blood and controls the speed at which the body's chemical processes work.

The normal thyroid has considerable spare capacity for making thyroxine and so normally as much as half of the gland can be removed without any need for thyroxine replacement in the form of daily tablets after the operation. If, however, the whole thyroid has been removed you will need to take thyroxine for the rest of your life.

Very close to the thyroid glands are four tiny glands called parathyroid glands, each not much bigger than a grain of rice. These produce a hormone which controls the level of calcium in your body. The parathyroid glands are normally left in place when the thyroid gland is operated on but their function may be affected by the operation on the thyroid; there is more information about this later in this leaflet.

Consent

By law we must obtain your written consent to the operation beforehand. Staff will explain all the risks, benefits and alternatives before they ask you to sign a consent form. If you are unsure about any aspect of the treatment proposed, please do not hesitate to speak again with a senior member of staff.

Surgery

The operation is done under a general anaesthetic (i.e you will be asleep for the operation). The surgeon will make a cut in your neck, in a skin crease or following the grain of the skin. It is a symmetrical cut even if the thyroid abnormality is only on one side. Most thyroidectomy wounds heal

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You are entitled to a copy of any letter we write about you. Please ask if you want one when you come to the hospital.

Please complete The Friends & Family Test to tell us about your experience at: www.salisbury.nhs.uk/FriendsFamily or download our App from the Apple App store or Google Play Store.

The evidence used in the preparation of this leaflet is available on request. Please email: patient.information@salisbury.nhs.uk if you would like a reference list.

Name: Anna Aertssen
Role: Consultant
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to produce a very satisfactory scar. In some thyroid operations it is necessary to remove some of the lymph glands from the neck. The absence of these glands does not normally produce any problems; if your surgeon expects to remove lymph glands it will have been discussed with you.

Possible complications

All operations carry risks that include postoperative infections (e.g. in the wound or chest), bleeding in the wound and various problems due to the anaesthesia, but these are very rare. Most thyroid operations are straightforward and associated with few problems as follows:

Scar: The scar may become relatively thick and red for a few months after the operation before fading to a thin white line. Some patients develop a thick exaggerated scar but this is very rare.

Voice change: It is impossible to operate on the neck without producing some change in the voice; fortunately this is not normally detectable. A specific problem related to thyroid surgery is injury to one or both of the recurrent laryngeal nerves. These nerves pass close to the thyroid gland and control movement of the vocal cords. Injury to these nerves causes hoarseness and weakness of the voice. It is quite common for the nerve not to work properly after thyroid surgery due to bruising of the nerve but this recovers over a few days or weeks. The external laryngeal nerve may also be injured and this results in a weakness in the voice although the sound of the voice in unchanged. You might have difficulty in reaching high notes when singing, your voice may tire more easily and the power of your shout reduced. Careful surgery reduces the risk of permanent accidental injury to a very low level but cannot eliminate it. Injury to both nerves is extremely rare but is a serious problem and may require a tracheostomy (a tube placed through the neck into the windpipe).

Low blood calcium level: Patients having surgery to the thyroid gland risk developing a low calcium level if the four tiny parathyroid glands which control the level of calcium in the blood, stop working after the operation. It is normally possible to identify and preserve some if not all of these glands and so avoid a long-term problem. Unfortunately even when the glands have been found and kept they may not work properly. If this happens then you will need to take extra calcium and/or vitamin D permanently. The risk of you needing long-term medication because of a low calcium level is very small indeed (about 1 in 50).

Thyroid function: If all the thyroid gland is removed then you will require lifelong replacement of thyroxine. Fortunately this is a straightforward once-a-day tablet with little need for adjusting the dosage. If most but not all the thyroid gland is removed then in the early weeks after the operation the remaining thyroid may not produce enough thyroxine itself and you may require replacement tablets temporarily until the retained thyroid produces enough hormone. This will be monitored by regular blood tests.

Swallowing difficulty: Usually swallowing is improved following thyroid surgery, especially for large goitres or those that have extended into the chest, but occasionally some mild difficulty may develop or be persistent.

We wish to emphasise that these potential side effects and complications are exceedingly

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rare, but we believe it is best to tell you about them rather than have you develop a complication without having been forewarned. If you are unclear about the topics in this sheet or if you are unclear about any other details of your operation please ask one of the surgical team.

What are the benefits of the operation?

Removing the thyroid gland will improve your difficulties with breathing and swallowing and the appearance of your neck.

Are there any alternatives?

Surgery is not essential unless you have symptoms that are bothering you or there is a suspicion of cancer. Your surgeon will have discussed this with you. You can decide not to have the swelling treated.

What happens on the day of surgery?

If your admission is at 8.00am, you must not eat anything for 6 hours before this time. You may have non-milky drinks (squash, water etc) until 6.30am.

If you are coming into hospital at 12.30pm you may have a light breakfast (cereal and toast, for example) at 8.00am and non-milky drinks until 11am. For your own safety it is very important that you do not have anything to eat or drink after the times stated. If you do your operation will have to be delayed or even postponed to another day.

What happens after the operation?

You will be cared for in the High Care or Step Down ward in the Surgical Unit. Please note that these areas care for men and women on the same ward, however the nurses take great care to maintain your privacy and dignity.

At the end of the operation the surgeon may consider it appropriate to leave a small "drain" tube in the neck. This will normally be removed on the first or second day after surgery.

Will it hurt?

For the first few days after your operation you should expect some discomfort in your neck and when swallowing. You will be given painkillers in hospital and will be given some to take home and you may want to take these regularly at first.

When will I be able to go home?

You will normally be allowed home 2 to 4 days after your operation. You will need to leave the ward by 10am on the day that you are allowed home. If you are unable to travel this early in the day you will be transferred to the Discharge Lounge. This offers comfortable seating, hot and cold drinks and meals if needed until you are collected. Parking for this area is free in a 'pick up point'.

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When can I go back to work?

You should be able to return to work and normal activities after about 2 weeks. However this may vary depending the type of work you do. It is normal to feel tired for the first few weeks. You can drive as soon as you are able to perform an emergency stop without pain, but check with your insurance company, as policies vary.

Follow up

You will be given an appointment to be seen in the Out Patient Department about 2 weeks after your operation. At this time the surgeon will discuss the results with you and any further treatment and follow up you may need.

Is there anything I should look out for when I go home?

If you have any concerns about your wound because it is red, hot, swollen or painful you should seek advice from your GP or practice nurse.

Further information

British Thyroid Foundation ☎01423 709707 or 01423 709448

PO Box 97, Clifford Wetherby, West Yorkshire LS23 6XD

www.btf-thyroid.org

The British Association of Endocrine and Thyroid Surgeons

Their website **www.baets.org.uk** has a link to a number of recommended sites.

NHS Choices

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What is Clinical Audit?

Clinical audit is a quality improvement cycle that involves the measurement of the effectiveness of healthcare against agreed / proven high quality standards and brings practice in line with these standards, so as to improve the quality of healthcare and health outcomes. It is an important process to enable healthcare providers to monitor the quality of care they provide against explicit high standards and modify this where necessary. It is therefore a constant, dynamic process that ensures high quality standards of care through a transparent responsibility and accountability for these standards. Essentially it asks the questions what should we be doing, are we doing it right and how can we improve?

Clinical audit can be used to assess three aspects of patient care (structure, process and outcome). Structure is what a service needs to provide a safe service e.g. the availability of on-call consultants to deal with post-operative problems; process is what we do to deliver this service e.g. whether suspected thyroid cancer patients are seen promptly in outpatient clinics; and outcome is a measure used to determine the quality of this process, such as the number of patients taken back to theatre following thyroid surgery for post-operative bleeding.

What is the United Kingdom Registry of Endocrine and Thyroid Surgery (UKRETS)?

Formerly known as the British Association of Endocrine and Thyroid Surgeons (BAETS) Audit, UKRETS is the Thyroid and Endocrine Surgery Audit for the United Kingdom which was set up in 2004 and run by the British Association of Endocrine and Thyroid Surgeons (BAETS). It was established with the aim of improving the quality of services and outcomes for patients undergoing endocrine surgical operations. BAETS collects information on the outcomes from thyroid, parathyroid, adrenal and endocrine pancreatic surgery. Currently there are > 100,000 entries in the UKRETS database.

The data from UKRETS is analysed and published anonymously in a national report, now in its 5th edition in 2017. This report sets out the extent of endocrine surgery undertaken by BAETS members in the UK as well as detailed information on investigations, pathology, operative details and surgical outcomes. This provides valuable information on the quality and safety of surgical outcomes, trends in the management of surgical endocrine disease and provides a national standard, against which BAETS members can compare to their own practice. This helps drive up standards and improve outcomes for patients undergoing endocrine surgical operations.

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What does UKRETS measure?

UKRETS collects data on the number of endocrine surgical operations, including indications for surgery, results of pre-operative biopsies and scans, extent of surgical operations, intraoperative surgical adjuncts used, pathology details, post-operative complications, length of stay, re-admission rates, mortality, and long-term outcomes such as hypocalcaemia and voice change following neck surgery. Data on outcomes, such as hypocalcaemia following thyroidectomy, are also displayed in funnel plots in the Annual Reports, with confidence intervals to indicate surgeons whose results are outliers from the national average.

Who manages UKRETS?

UKRETS was set up by Dendrite Clinical Systems Ltd (data processor) for the British Association of Thyroid and Endocrine Surgeons (data controller) in 2004. BAETS members from throughout the United Kingdom submit data on patients undergoing thyroid, parathyroid, adrenal and pancreatic endocrine surgical operations to UKRETS. All data collected is subject to strict rules of confidentiality and data protection, and securely stored by Dendrite Clinical Systems Ltd so that patients do not need to worry about it getting into the wrong hands.

How is UKRETS data processed?

The consultant providing your care will securely input information from your operation into UKRETS via password protected access to the BAETS national audit. This is securely transferred to and stored by Dendrite Clinical Systems Ltd. Dendrite therefore act as guardians for your data. Your date of birth, gender, date of operation and discharge from hospital are currently the only patient-identifiable information recorded in UKRETS. Every three to four years Dendrite analyse this data in the national report. This data is published in a completely anonymous format, so there is no way of anyone identifying your information from this.

Consultant Outcome Publication

Every year Dendrite submits information on the outcomes from its thyroid surgical operations from a 4-year time period from UKRETS to the Healthcare Quality Improvement Programme (HQIP) which publishes these in NHS Choices. This is part of the Consultant Outcome Publication (COP) and is freely available to the public and healthcare providers. Outcomes in this report are searchable by surgeon, hospital or postcode. Currently information published in this surgeon-specific outcome report includes number of operations, data completeness, re-operation for bleeding, re-admission rate, mortality, and length of stay. It provides a useful resource for members of the public when choosing a surgeon or hospital in which to undergo a thyroid operation as you will be able look at their results for thyroid operations to help you make decisions about your care. You will also be able to see in the surgeon-specific outcome report how much thyroid surgery each consultant or hospital performs and their clinical outcomes compared to the national

average. Where results differ significantly from the national average, there may well be good reason, and you can discuss this with your GP and/or surgeon. Click on the NHS Choices website for more details.

Who will benefit from UKRETS data?

Surgical consultants can use UKRETS and COP data to compare their own practice to their colleagues and national standards, and take steps to improve their practice if necessary. The data from UKRETS also helps is assessing consultants' performance during the appraisal and revalidation process. Hospital managers can use this information to identify areas needing improvement and ensure that standards are being maintained in trusts around the UK. Data from UKRETS may be used, with permission from the BAETS executive, for research projects to improve our knowledge of endocrine and thyroid surgery. Publication of research findings in peer-reviewed journals is then disseminated to a worldwide audience. This all has the effect of driving up standards in endocrine surgery for the benefit of patients and the general public who can also access the information the Consultant Outcome Publication when choosing where to have their surgery.

How reliable is the UKRETS data?

UKRETS is a large national audit and data entry is done by busy clinicians. It is therefore subject to human error and the time-constraints that clinical practice entails. Missing data rates for some items are higher than others, particularly late follow-up data, due to the greater time and effort required to update these measures. Data is also self-reported and so isn't subject to external evaluation. Linking data in UKRETS with information in other NHS databases is anticipated in the future to determine whether the data provided by each hospital is complete and accurate. Although UKRETS is a compulsory national audit, comparison of the number of cases submitted to UKRETS with hospital episode statistics (HES) has shown that just over half of all thyroid and parathyroid operations are currently submitted to UKRETS, and so it remains an objective of the British Association of Endocrine and Thyroid Surgeons to increase the overall proportion of endocrine surgical cases performed in the UK entered into UKRETS.

How we keep your information safe?

Data protection and privacy is an important part of UKRETS so no patient-identifiable information can be identified in the results. All data is collected and stored according to strict rules of confidentiality as laid down by the Data Protection Act 1998. UKRETS data is securely stored by Dendrite Clinical Systems Ltd.

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Can I opt out of UKRETS?

Yes. When your consultant goes through the details of your operation with you in the clinic he/she will discuss data collection in UKRETS and provide you with a patient information sheet outlining what this involves. You'll be given the option to allow your information to be recorded in UKRETS or not. If you decide to opt out of data collection, this wish will be respected and the decision recorded in your case notes.

Contact Details

www.baets.org.uk

British Association of Endocrine and Thyroid Surgeons,

Association of Surgeons of Great Britain and Ireland,

35-43 Lincoln's Inn Fields,

London,

WC2A 3PE

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