

Thyroidectomy

Thyroidectomy is an operation in which one or both lobes of the thyroid gland are removed. The most common indications for thyroidectomy include a large mass in the thyroid gland, difficulties with breathing related to a thyroid mass, difficulties with swallowing, suspected or proven cancer of the thyroid gland and hyperthyroidism (overproduction of the thyroid hormone). Your physician will discuss the need for thyroidectomy based on your history, the results of a physical examination and tests. The most common tests to determine whether a thyroidectomy is necessary include a fine needle aspiration biopsy, thyroid scan, ultrasound, x-rays and/or CT scan, and assessment of thyroid hormone levels.

The procedure is performed under general anesthesia. The extent of surgery (removal of one or both lobes) may sometimes be determined in the course of surgery after microscopic examination of tissue removed during the surgery. After surgery it is very common to have difficulties and/or pain with swallowing. This pain is usually resolves within 24 to 72 hours. Bleeding or infections are also possible short-term complications. Although rare in thyroid surgery, some patients may develop a thick scar or keloid.

Two complications specific to thyroid surgery are hypocalcemia and vocal cord weakness or paralysis. Hypocalcemia, or low blood levels of calcium, may occur after complete removal of both thyroid lobes. This condition is caused by injury to four tiny glands called parathyroid glands, which are located within or very close to the thyroid gland. Hypocalcemia is usually temporary, but sometimes may require calcium supplements if sufficiently pronounced. Permanent hypocalcemia is fortunately rare. Swelling, stretching, or injury to the recurrent laryngeal nerve, which passes very close to the thyroid gland, may cause vocal cord weakness or paralysis. Temporary hoarseness may result. Again, this is an uncommon, usually temporary complication. Permanent vocal cord paralysis is rare. The nerve is monitored intraoperatively using a nerve integrity monitor.

Depending on the final histologic (microscopic examination) diagnosis of the gland removed, continuous follow-up by your endocrinologist and/or surgeon may be indicated

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