Thyroid Disease is the Topic for Today's General Surgery Review

Patients with thyroid disease are referred to me because of compressive symptoms related to a goiter, a hyper functioning nodule or a dominant nodule in which cancer needs to be excluded. I ask the patient if there is family history suggesting MEA syndrome and if the patient has noted any change in voice or compressive symptoms. A history of therapeutic radiation to the head and neck is very important and dictates that any nodule be removed. A baseline TSH and calcium are ordered.

The physical examination is focused on the thyroid itself as well as the regional lymph nodes. Nothing beats a good physical examination but the ultrasound device comes in a close second. During the last 10 years surgeons have learned to use ultrasound as a second set of eyes; with it we are able to see the thyroid and surrounding lymph nodes in detail. Once we have identified a suspicious nodule we perform a sono directed fine needle aspirate (FNA) in our office. If the FNA is definitive for cancer then the proper surgery can be planned. Surgery is also indicated if the FNA is atypical, suspicious or does not agree with the clinical picture.

Surgery may take the form of a unilateral thyroid lobectomy in which case I await the final path report to guide therapy. In the face of the most common form of thyroid cancer, papillary cancer, a total thyroidectomy is performed. Most recently some have advocated routine central compartment node dissection believing that the removal of occult metastasis results in improved results and survival. The need for this added amount of surgery needs to be carefully weighed against its potential benefit and risk in any given patient since it increases the risk of nerve injury or hypocalcemia. If the tumor is incidental and less than 1 cm, nodal dissection is not necessary. However in all others with papillary cancer I do perform central compartment node dissection. Any lymph nodes that have been proven to be positive that are outside the central compartment are removed during a selective neck dissection which means that the area of the lateral or posterior neck that is involved is cleared of nodal tissue leaving the other structures intact.

Patients undergoing thyroidectomy usually spend one night in observation, calcium is given orally for a week; long term problems with calcium are very rare. Fortunately our technique of direct visualization and protection of the recurrent laryngeal nerve has resulted in a low rate of voice change. In patients in

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whom neck surgery has been previously done and in whom scarring can be expected I may use nerve monitoring intra operatively. Patients with Papillary Thyroid carcinoma require post op I131 treatment which is coordinated in consultation with our endocrine colleagues. Patients are then treated with thyroid suppression and in general do very well. I hope this has been informative. Don't hesitate to call with any questions regarding surgical disease.

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