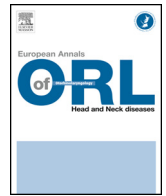




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Original article

Outpatient hemithyroidectomy: A retrospective feasibility analysis

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ABSTRACT

Background: Outpatient surgery is a major public health policy issue. It is controversial for total thyroidectomy, which raises the question of hemithyroidectomy. The present study assessed our experience in outpatient hemithyroidectomy.

Objectives: To evaluate the rates of postoperative hematoma and unscheduled hospital admission.

Material and methods: A multicenter retrospective analysis was conducted in two hospital centers between January 2009 and December 2013. Exclusion criteria for outpatient hemithyroidectomy comprised: ASA score >2, anticoagulant therapy, risk of completion procedure, and associated procedure requiring >12 hours' surveillance. Data were collated for age, gender, weight, postoperative complications, and unscheduled hospital admission.

Results: During the study period, 294 hemithyroidectomies were performed, 130 of which on an outpatient basis (44%). There were no medical contraindications to outpatient surgery in 64% of patients operated on under conventional admission. In the outpatient group, mean age was 44 years. Eight completion thyroidectomies were performed in the outpatient group, and only two patients required admission for surveillance, with no revision surgeries. All patients were satisfied or very satisfied with outpatient management.

Conclusion: In our experience, outpatient hemithyroidectomy was safe and reliable.

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1. Introduction

In France, the rate of outpatient surgery has been constantly increasing for several years, encouraged by the health authorities. Most endocrine surgeons, however, remain very cautious with regard to performing thyroidectomy on an outpatient basis. Only 18% of French endocrine surgeons [1] have performed outpatient thyroidectomy, and outpatient surgery constitutes only a small part (1–20%) of their practice in most cases. The main concern is compressive cervical hematoma, although it is a rare complication (1%) [2]. A review of the literature discloses no consensus. Most reported series did not differentiate between results for 12 h and 24 h admission, failed to provide sufficiently precise data, or did not distinguish between total and partial outpatient thyroidectomy, according to Kraft et al. [3]. Hemithyroidectomy is a well-codified procedure, with a complications rate that is usually low. Given the spread of outpatient surgery, the question of the feasibility of outpatient hemithyroidectomy arises.

2. Materials and methods

A multicenter retrospective study included all hemithyroidectomies performed on an outpatient basis or with conventional admission, between January 2009 and December 2013.

Two hospital centers participated: center A, a non-teaching regional hospital with a high volume of endocrine surgery, and center B, a general hospital with a low volume of endocrine surgery. Both structures included an independent day-care facility, but the operating rooms were not dedicated to day surgery. Outpatient procedures were performed before 1 pm; the two outpatient departments were open from 7 am to 7 pm.

Patients were managed by 1 of 3 experienced endocrine surgeons.

All hemithyroidectomies were performed under general anesthesia via anterior cervicotomy. Hemostasis was ensured by irrigated thermofusion or bipolar forceps. Wires were used near the recurrent nerve, which was systematically located using a NIM nerve monitor. Frozen section biopsy was systematic.

The indication for outpatient surgery was made in preoperative consultation by the surgeon, who also explained the advantages and disadvantages to the patient.

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All patients were followed up by telephone by an outpatient surgery nurse on D+1. A surgical check-up was systematically scheduled for D+30.

Demographic analysis was performed. Indications were classified as:

- single >2 cm nodule
- toxic nodule
- multinodular goiter predominating unilaterally
- suspect nodule <2 cm.

Any associated procedures were listed: neck dissection and type (central and/or lateral), parathyroidectomy and side, other non-endocrine surgery.

Indications for secondary completion thyroidectomy were analyzed.

Operating and postoperative surveillance times were noted. Discharge was systematically authorized by both anesthetist and surgeon.

Reasons for cross-over to classical admissions were sought: nausea and vomiting, short surveillance, pain, and hematoma with or without surgical revision. Other causes were also detailed.

Any unscheduled consultations or admission were listed.

At D+1, outpatients were questioned by phone about nausea and vomiting, pain intensity and satisfaction.

Statistical analysis used SPSS 20.0 software. Continuous variables were expressed as mean and range, and discrete variables as percentage. Qualitative variables were compared on chi² test, and quantitative variables on Student t test. The significance threshold was set at $P < 0.05$.

3. Results

130 of the 294 hemithyroidectomies performed between January 1, 2009 and December 31, 2013 (44%) were initially scheduled as day surgery (Table 1).

The percentage of hemithyroidectomies performed on an outpatient basis was generally stable over the preceding 5 years (Fig. 1).

Table 2 shows demographic data for the whole sample and per group.

Table 3 shows the main indications.

Table 1
Number of hemithyroidectomies included per center.

	Center A	Center B
Outpatient	95 (46%)	35 (40%)
Conventional	111 (54%)	53 (60%)
Total	206	88

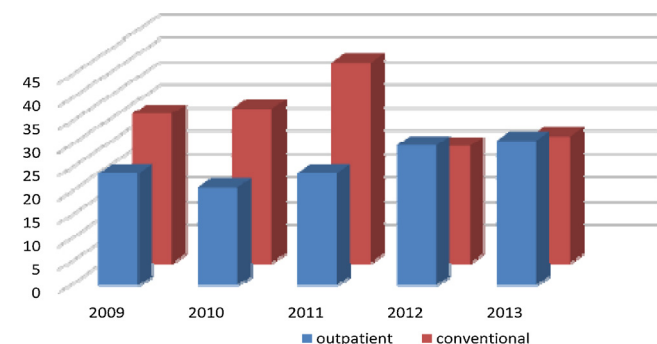


Fig. 1. Annual distribution of outpatient and conventional admission in the two centers.

Table 2
Patient characteristics.

	Whole series	Outpatient	Conventional	P
Mean age (years)	47.6	44	50.5	<0.001
Gender F/M	238/56	103/27	135/29	<0.01
ASA I-II	276 (94%)	130 (100%)	146 (89%)	
ASA III-IV	18 (6%)	0	18 (11%)	

Table 3
Distribution of surgical indications.

	Whole series	Outpatient	Conventional	P
Nodule >2 cm	189 (65%)	86 (66%)	103 (62%)	n.s
Multinodular goiter	33 (11%)	11 (9%)	22 (13%)	n.s
Toxic nodule	42 (14%)	21 (16%)	21 (13%)	n.s
Suspect nodule	30 (10%)	21 (9%)	18 (11%)	n.s

n.s: non-significant.

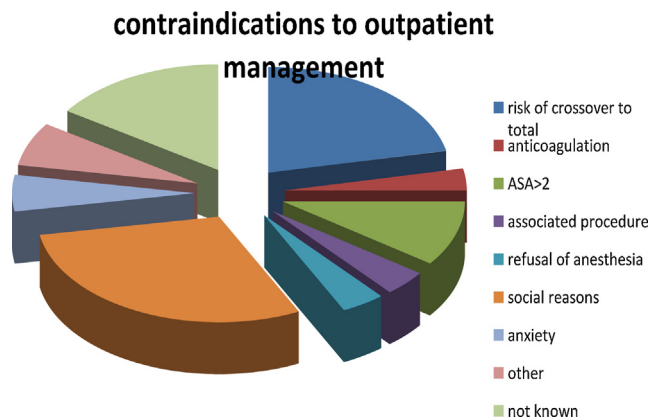


Fig. 2. Distribution of contraindications to outpatient surgery.

Outpatient management was not implemented in 164 cases, for the following reasons (Fig. 2):

- in 39 cases, for high risk of having to complete thyroidectomy during the same step: 16 cases of suspect nodule, with reassuring frozen section biopsy, and 23 of contralateral nodules on preoperative ultrasonography; all 39 of these patients finally underwent only hemithyroidectomy;
- in 6 cases, for risk of hemorrhage: 4 patients under AVK and 2 under Plavix (clopidogrel); Kardegic (aspirin lysine) was not considered a contraindication;
- in 18 cases, for ASA score >2;
- in 7 cases, for associated surgery requiring >12 h surveillance: 1 extended neck dissection, 5 contralateral parathyroidectomies, and 1 associated breast procedure;
- in 53 cases, for social reasons: 32 for ≥ 1 hour's distance between home and hospital, 8 patients living alone, and 13 with other social issues (language, socioeconomically disadvantaged, compliance problems, etc.);
- in 10 cases, patient's refusal (due to anxiety);
- in 12 cases, for miscellaneous reasons: outpatient department closure during school holidays, resected gland volume considered too great for outpatient treatment, or thyroiditis;
- in 28 cases, no reason for not implementing outpatient surgery could be found in the records.

Secondary completion thyroidectomy was performed in 13 cases:

- in 7 cases, for carcinoma discovered on definitive histology;
- in 6 cases, for recurrence of multinodular goiter.

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