The Advantage of Total Thyroidectomy to Avoid Reoperation for Incidental Thyroid Cancer in Multinodular Goiter

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Hypothesis: To investigate the impact of total thyroidectomy on the rate of completion thyroidectomy for incidentally found thyroid cancer in euthyroid multinodular goiter.

Design: A randomized, prospective clinical trial.

Setting: A tertiary referral center.

Patients: Patients with euthyroid multinodular goiter without any preoperative suspicion of malignancy, history of familial thyroid cancer, or previous exposure to radiation were randomized (according to a random table) to total or near-total thyroidectomy leaving no remnant tissue or less than 1 g (group 1; n = 109) or bilateral subtotal thyroidectomy leaving 5 g or more of remnant tissue (group 2; n = 109). Patients with preoperative or perioperative suspicion of malignancy were excluded.

Main Outcome Measures: We compared the complication rates and the incidence of thyroid cancer requiring radioactive iodine ablation and completion thyroidectomy between groups.

Results: There were no permanent complications. The rates of temporary unilateral vocal cord dysfunction and hypoparathyroidism showed no significant difference between groups 1 and 2 (0.9% vs 0.9% and 1.8% vs 0.9%, respectively; P > .05). Papillary cancer was found in 10 group 1 patients (9.2%) and 8 group 2 patients (7.3%) (P = .80). Of the 9 patients requiring radioactive iodine ablation, reoperation was avoided in 5 group 1 patients; the remaining 4 group 2 patients underwent completion thyroidectomy (P = .007).

Conclusion: We recommend total or near-total thyroidectomy in multinodular goiter to eliminate the necessity for early completion thyroidectomy in case of a final diagnosis of thyroid cancer.

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Total thyroidectomy is the procedure of choice in patients with thyroid cancer, Basedow or Graves disease, and toxic multinodular goiter. In recent years, total thyroidectomy has emerged as a surgical option to treat patients with multinodular goiter, especially in endemic iodine-deficient regions. Multinodular hyperplasia frequently involves the whole gland in endemic regions, and there is no normal tissue to leave behind. The rate of recurrence is high after subtotal resections for multinodular goiter in long-term follow-up, despite postoperative thyroid hormone supplementation. A considerable number of patients undergoing primary treatment with subtotal resection need reoperation for recurrence, which has a higher rate of complication compared with the primary procedures. The incidence of thyroid cancer varies from 7.5% to 13% in multinodular goiter. The presence of multiple nodules decreases the diagnostic value of fine-needle aspiration biopsy, and thyroid cancer is frequently an incidental postoperative histological finding in multinodular goiter. In such patients treated with subtotal thyroidectomy, completion thyroidectomy might be necessary.

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The aim of this study was to investigate whether total or near-total thyroidectomy decreased the rate of completion thyroidectomy for incidentally diagnosed thyroid cancer in multinodular goiter in an endemic iodine-deficiency region.

METHODS

From September 1, 2001, to December 31, 2002, we undertook a prospective study to compare the rates of completion thyroidectomy for...
The mean ± SD age was found to be significantly higher in group 1 (50.3 ± 12.5 years) compared with group 2 (45.7 ± 12.1 years) (P = .02). The male-female ratio was 15:94 and 17:92 in groups 1 and 2, respectively (P = .70). A coexistent dominant nodule was found in 39 patients (17.9%), including 20 in group 1 and 19 in group 2.

**PREOPERATIVE FINDINGS**

Total and near-total thyroidectomy was performed in 19 (17.4%) and 90 (82.6%) patients, respectively, in group 1. Bilateral subtotal thyroidectomy was performed in all 109 patients in group 2. The total amount of remnant tissue was estimated to be 5 g in 77 patients (70.6%), 6 g in 26 (23.9%), and 7 g in 6 (5.5%).

**PERIOPERATIVE FINDINGS**

Permanent hypoparathyroidism and vocal cord paralysis were not encountered in either group of patients. The rate of temporary unilateral vocal cord dysfunction was the same (0.9%) in both groups. Although not statistically significant, the incidence of temporary hypoparathyroidism was slightly higher in group 1 than in group 2 (1.8% vs 0.9%).

The mean ± SD value of the TSH value at the first postoperative month was significantly higher in group 1 compared with group 2 (45.3 ± 17.3 vs 11.5 ± 6.5 mIU/L) (P < .001). Papillary cancer was detected in 18 patients (8.2%), of whom 13 (72%) had papillary microcarcinoma (<1 cm). Of 39 patients with a coexistent dominant nodule, papillary cancer was found in only 1. This patient had a papillary microcarcinoma not originating from the dominant nodule and without local invasion or multicentricity. The incidence of papillary cancer was 9.2% (10/109) in group 1 and 7.3% (8/109) in group 2 (P = .80) (Table). Of 18 patients with papillary cancer, 9 (50%) had microcarcinoma with no local invasion or multicentricity. These patients were scheduled for follow-up only. The remaining 9 patients were found to have the histological criteria for RAI ablation (Table). Of these 9 patients, 5 were in group 1 and 4 in group 2. Five patients in group 1 received RAI ablative therapy directly. The TSH values of the 4 patients in group 2 were below 30 mIU/L, and these patients underwent completion thyroidectomy before ablative therapy. Thus, of 9 patients requiring RAI ablation, reoperation was avoided in 5 group 1 patients; however, 4 patients in group 2 underwent follow-up. Patients with noninvasive microcarcinoma who did not receive RAI ablation received suppressive doses of thyroid hormone after thyroidectomy. The follow-up schedule of these patients was similar to that of patients undergoing operation for benign goiter (neck examination and determination of serum TSH values every 6 months for the initial 2 years and then annually). Linear correlation, paired t test, and Fisher exact test were used for statistical analysis, and P < .05 was accepted as significant. The ethics committee of our institution approved the study, and informed consent was obtained from all patients participating in the trial.

**RESULTS**

**The Histological Feature of Papillary Cancer in Groups 1 and 2**

<table>
<thead>
<tr>
<th>Tumor Size, cm</th>
<th>No. of Foci</th>
<th>Thyroid Capsule Invasion</th>
<th>Extrathyroidal Invasion</th>
<th>Indication for Reoperation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient 1</td>
<td>0.6</td>
<td>3</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Patient 2</td>
<td>1.1</td>
<td>2</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Patient 3</td>
<td>0.8</td>
<td>4</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Patient 4</td>
<td>0.4</td>
<td>3</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Patient 5</td>
<td>1.1</td>
<td>1</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Patient 6</td>
<td>0.3</td>
<td>1</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Patient 7</td>
<td>0.3</td>
<td>1</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Patient 8</td>
<td>0.3</td>
<td>1</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Patient 9</td>
<td>0.2</td>
<td>2</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Patient 10</td>
<td>0.2</td>
<td>1</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient 1</td>
<td>1.1</td>
<td>1</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Patient 2</td>
<td>0.5</td>
<td>3</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Patient 3</td>
<td>2.5</td>
<td>1</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Patient 4</td>
<td>1.5</td>
<td>Multiple</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Patient 5</td>
<td>0.6</td>
<td>2</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Patient 6</td>
<td>0.6</td>
<td>2</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Patient 7</td>
<td>0.5</td>
<td>1</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Patient 8</td>
<td>0.3</td>
<td>1</td>
<td>−</td>
<td>−</td>
</tr>
</tbody>
</table>

Abbreviations: Minus sign, negative finding; plus sign, positive finding.
completion thyroidectomy (P = .007). There were no complications after completion thyroidectomy in those 4 patients.

**COMMENT**

In the present study, the incidence of incidental thyroid cancer was found to be 8.2% in patients undergoing operation for multinodular euthyroid goiter without any preoperative or perioperative suspicion of malignancy. We documented that performance of total or near-total thyroidectomy instead of subtotal resection as the primary procedure significantly reduced the rate of completion thyroidectomy for incidentally found thyroid cancer in multinodular goiter. Total or near-total thyroidectomy was associated with a slightly higher risk for temporary hypoparathyroidism, but this was not statistically significant.

The goal of surgical treatment in thyroid disease should be to eliminate the disease with low complication rates and to minimize the necessity for reoperative procedures. Reoperations are undertaken for postoperative histological evidence of thyroid cancer or recurrent goiter during further follow-up and are associated with higher complication rates compared with primary procedures.1,6-20,24,25

Multinodular goiter is the most common indication for thyroidectomy in endemic iodine-deficient regions. Preoperative evaluation for thyroid cancer by means of fine-needle aspiration biopsy is difficult in multinodular goiter owing to the presence of multiple nodules, and thyroid cancer is frequently an unexpected postoperative finding. The risk for malignancy was thought to be lower in multinodular goiter compared with solitary cold nodules. Recent studies, however, documented that this was not the case. The incidence of thyroid showed no significant difference in solitary cold nodules and in cold nodules of multinodular goiter, and patients with thyroid cancer frequently presented with multinodular goiter.21-27

Reoperation should be performed in patients with incidentally found thyroid cancer if the histological criteria mandate RAI ablation and there is a large volume of thyroid remnant. In the present study, of 9 patients scheduled for RAI ablation, tumor size was smaller than 1.5 cm in 7. Although these patients were considered to be at low risk according to MACIS (Metastasis, Age, Curative resection, Invasion, Size) classification, histological examination revealed multifocality, thyroid capsule invasion, or extrathyroidal spread. Low-risk patients have a favorable prognosis, but multifocality, thyroid capsule invasion, and extrathyroidal invasion were shown to adversely affect the prognosis.28-31 Baudin et al31 analyzed the data of 281 patients with thyroid microcarcinoma (<1 cm) and documented that patients with more than 1 tumor focus had a significantly higher rate of recurrence compared with those with unifocal tumors, and multifocality significantly influenced the prevalence of RAI treatment. The RAI ablation was found to be an important factor in prolonging the disease-free interval and survival in patients with well-differentiated thyroid cancer, even low-risk patients.32 In Turkey, a considerable number of patients undergoing operation for thyroid cancer adher to the postoperative fol-

**CONCLUSIONS**

The incidence of thyroid cancer in multinodular goiter without any previous suspicion of malignancy was found to be 8.2%. Subtotal thyroidectomy resulted in a significantly higher rate of completion thyroidectomy for incidentally diagnosed thyroid cancer compared with total or near-total thyroidectomy. No permanent
complications occurred, and the extent of surgical resection had no significant effect on the rate of temporary complications. We recommend total or near-total thyroidectomy in multinodular goiter to eliminate the need for completion thyroidectomy in case of a false diagnosis of thyroid cancer.

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REFERENCES


