AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Clinical Indicators: Thyroidectomy

Procedure	**CPT**	**Days**[1]
Excision of cyst or adenoma	60200	90
Partial lobectomy	60210	90
Partial lobectomy with contralateral subtotal lobectomy	60212	90
Total lobectomy (hemithyroidectomy)	60220	90
Total lobectomy with contralateral subtotal lobectomy	60225	90
Total thyroidectomy	60240	90
Total or subtotal thyroidectomy with limited neck dissection	60252	90
Total or subtotal thyroidectomy with radical neck dissection	60254	90
Completion total thyroidectomy	60260	90
Substernal thyroidectomy with sternal split	60270	90
Substernal thyroidectomy without sternal split	60271	90

Related Procedures	**CPT**	**Days**[1]
Fine needle aspiration biopsy	88170	XXX
Office flexible laryngoscopy	31575	0
Image-guided needle biopsy	88171	XXX
Aspiration of thyroid cyst	60001	0
Percutaneous core biopsy	60100	0
Modified radical neck dissection	38700	90
Radical neck dissection	38724	90
Mediastinal/paratracheal lymph node dissection	38746	ZZZ

Indications

1. History (one or more required)

a. Thyroid mass

b. Family history of thyroid disease

c. History and/or symptoms of hyper or hypothyroidism

1 RBRVS Global Days

d. History of radiation to the neck
e. History of accidental exposure to radiation
f. History of medullary carcinoma in the family with positive RET oncogene or stimulation test for calcitonin
g. A neck mass with histologic findings of metastatic thyroid tumor

2. Related Symptoms

a. Hoarseness
b. Dyspnea, stridor
c. Dysphagia

3. Physical Examination (required)

a. Complete physical examination of the head and neck with emphasis on inspection and palpation of the thyroid gland and neck.
b. Indirect mirror or fiberoptic flexible laryngoscopy

4. Tests (one or more required)

a. Fine needle aspiration biopsy
b. Thyroid nuclear scan
c. Ultrasonography
d. Ultrasonography-guided fine needle biopsy
e. CT scan of neck and chest
f. MRI of neck and chest

5. Tests (required)

a. Pre-operative tests as required by institutional guidelines
b. Thyroid function tests (T3,T4, TSH)

6. Tests (optional)

a. Serum calcium, phosphorous, albumin
b. Chest radiograph
c. Airway films (for suspected tracheal compression/deviation)
d. Flow-volume studies (for suspected tracheal compression/deviation; retrosternal goiter)
e. For suspected or proven medullary carcinoma:
    - Calcitonin level
    - RET oncogene
    - Stimulation tests for calcitonin
    - Alkaline phosphatase
    - Urine catecholamines

- Imaging studies of the abdomen

Postoperative Observations

a) Immediate respiratory distress - notify surgeon; remove dressing. Surgeon to consider:
- Vocal cord paralysis
- Hematoma
- Tracheomalacia
- Hypocalcemia

b) Bleeding - check for expanding hematoma; notify surgeon
c) Hypocalcemia - symptoms and signs: tetany; circumoral paraesthesia/dysesthesia; carpopedal spasm; Chvostek's sign; mental status changes.

Notify surgeon; obtain blood sample for calcium and albumin levels; prepare IV calcium gluconate or calcium chloride.

Outcome Review

1. One Week

a. Vocal cord function - hoarseness? aspiration? respiratory distress?
b. Calcium level - normal levels?
c. Wound infection?
d. Pathology report - compare with pre-operative diagnosis
e. Need for thyroid hormone replacement/suppression therapy

2. Beyond One Month

a. If thyroid cancer - total body scan done? Ablative radioactive iodine indicated?
b. Thyroid hormone replacement/suppression given?
c. Calcium levels - normal?
d. TSH levels?
e. Vocal cord paralysis?, vocal cord paresis?, hoarseness?, aspirations?
f. Keloid/hypertrophic scar formation?

3. Beyond One Year

a. Vocal cord paralysis?, dysphonia?, hoarseness?, aspirations?, rehabilitative procedure indicated?
b. If cancer - follow-up includes:
- Physical examination
- Chest radiographs
- Periodic thyroid scan
- Thyroglobulin level

- Ultrasonography

c. If benign - follow-up includes:
   - Physical examination - recurrent neck mass?
   - Symptoms or signs of hyper or hypothyroidism - adjust medication
   - Thyroid function tests

Associated ICD-9 Diagnostic Codes (Representative, but not all-inclusive codes)

226	Benign tumor of thyroid
193	Primary malignant tumor of thyroid
198.89	Secondary malignant tumor of thyroid
234.8	*In situ* tumor of thyroid
237.5	Tumor of thyroid - unspecified
240.0	Goiter, specified as simple
240.9	Goiter, unspecified
241	Non-toxic goiter
241.9	Unspecified non-toxic nodular goiter
242.0 to 242.9	Toxic diffuse goiter
242.1	Toxic uninodular goiter
242.2	Toxic multinodular goiter
242.3	Toxic nodular goiter, unspecified
242.4	Thyrotoxicosis from ectopic thyroid nodule
242.8	Throtoxicosis of other specified origin
242.9	Throtoxicosis without mention of goiter or other cause
246.2	Thyroid cyst
245.2	Hashimoto's thyroiditis
245.3	Riedel's thyroiditis
189.98	Cervical metastatic disease
238.8	Cervical tumor - uncertain behavior
197.3	Secondary tracheal tumor

Related ICD-9 Diagnostic Codes (Representative, but not all-inclusive codes)

240.1; 244.9	Hypothyroidism
519.8	Airway obstruction
787.2	Dysphagia
786.1	Stridor
530.89	Esophageal compression

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519.1	Tracheomalacia
275.4	Hypocalcemia
252.1	Hypoparathyroidism
478.3	Vocal cord paralysis

Additional Information

Assistant Surgeon -- Varies
Supply Charges -- N
Prior Approval -- N/A
Anesthesia Code(s) -- 00160

Patient Information

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 usually done 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 although . Bleeding or infection 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. Vocal cord weakness or paralysis may be caused by swelling, stretching, or injury to the recurrent laryngeal nerve which passes very close to the thyroid gland. Temporary hoarseness may result. Again, this is uncommon, ususally temporary complication. Permanent vocal cord paralysis is rare.
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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