

doi: 10.13241/j.cnki.pmb.2017.18.014

甲状腺全切除术与半切除术治疗甲状腺癌的临床效果分析*

张晶虹 张立军 计嘉军 许英晨 栗光明[△]

(北京同仁医院普外科 北京 100730)

摘要 目的:比较甲状腺全切除术与半切除术治疗甲状腺癌的临床效果。**方法:**选取我院收治的 90 例甲状腺癌患者,对所有患者行甲状腺全切除术或近全切除术,同时应用 I131 以及甲状腺激素抑制治疗作为辅助治疗,并对所有患者进行随访。**结果:**两组患者的术中出血量、喉返神经显露率比较差异无统计学意义($P>0.05$),观察组的手术切口以及手术时间均明显长于对照组($P<0.01$),甲状旁腺显露率高于对照组($P<0.01$)。两组患者暂时性、永久性喉返神经损伤,暂时性、永久性甲状旁腺功能低下发生率比较差异无统计学意义($P>0.05$)。复发率为 13.33%(6/45),观察组无复发,两组患者术后复发率比较差异具有统计学意义($P<0.05$)。**结论:**甲状腺全切除术治疗甲状腺癌的效果优于半切除术,且能够有效降低术后复发率。

关键词:甲状腺全切除;甲状腺癌;浸润转移

中图分类号:R653;R736.1 **文献标识码:**A **文章编号:**1673-6273(2017)18-3467-03

Analysis of the Effect of Total Resection and Half Resection of Thyroid on the Thyroid Carcinoma*

ZHANG Jing-hong, ZHANG Li-jun, JI Jia-jun, XU Ying-chen, LI Guang-ming[△]

(Department of General Surgery, Beijing Tongren Hospital, Beijing, 100730, China)

ABSTRACT Objective: To Analysis the effect of suppressing thyroid carcinoma metastasis process of using total resection of thyroid contrast and half resection. **Methods:** Selected 90 cases of patients with thyroid cancer in our hospital, for all patients received thyroid resection or subtotal resection, all at the same time using I¹³¹ and thyroid hormone suppression therapy as auxiliary treatment, and follow-up for all patients. **Results:** No statistical difference was found in the bleeding amount, laryngeal recurrent nerve exposure rate between two groups of patients ($P>0.05$), the incision and operation time in observation group were significantly longer than those of the control group ($P<0.01$), the parathyroid gland show rate was higher than that in the control group ($P<0.01$), the temporary and permanent laryngeal recurrent nerve injury, temporary and permanent parathyroid function showed no significant difference between two groups ($P>0.05$). Recurrence was found in 6 cases of the control group, the recurrence rate was 13.33% (6/45), none was found in the observation group, the postoperative recurrence rate was significantly higher in the control group than that of the observation group ($P<0.05$). **Conclusion:** The application of total resection of thyroid gland was better than half resection in the treatment of thyroid carcinoma, which could effectively reduce the postoperative recurrence.

Key words: Total excision of the thyroid gland; Thyroid cancer; Metastasis

Chinese library classification(CLC): R653; R736.1 **Document code:** A

Article ID: 1673-6273(2017)18-3467-03

甲状腺癌为临床上常见的恶性肿瘤疾病,其发病率逐渐升高,治疗时几乎需要对所有的甲状腺癌患者实施甲状腺全切除术。但有学者指出^[1]甲状腺局部切除术后容易复发,也有学者认为甲状腺全切除术后将会出现较多的并发症,所以目前对于手术选择全切或部分切除及其临床疗效尚有争议^[2,3]。因此,本研究对 90 例甲状腺癌患者进行分组比较甲状腺全切除术对比半切除术在抑制甲状腺癌浸润转移的临床效果,现报道如下。

1 资料与方法

1.1 一般资料

选取 2013 年 1 月-2016 年 1 月北京同仁医院普外科收治的 90 例甲状腺癌患者,其中男 46 例,女 44 例,年龄 20-74 岁,平均 (55.6 ± 3.2) 岁,所有患者在原则上优先应用甲状腺全切除术治疗,若无部分切除手术指征则改为近全切除术。所有患者均经 CT 检查确诊,根据不同的治疗方式将其分为观察组及对照组,每组 45 例,其中观察组中男 26 例,女 19 例,年龄 45-67 岁,平均 (47.4 ± 10.8) 岁,应用甲状腺全切除术治疗,对照组中男 24 例,女 21 例,年龄 (44.8 ± 9.2) 岁,应用甲状腺次全切除术治疗,两组患者在年龄、性别等一般资料比较无明显差异,具有可比性($P>0.05$)。

* 基金项目:首都卫生发展科研基金专项(2016-2-2053);首都医科大学基础临床合作研究基金(2016-2-2053);

北京市医管局临床医学发展专项(扬帆计划)临床技术创新项目(xm201302)

作者简介:张晶虹,研究方向:普外科,电话:13501122244, E-mail: zhangjingklk@163.com

[△] 通讯作者:栗光明,研究方向:普外科, E-mail: hukaiws@163.com

(收稿日期:2016-12-03 接受日期:2016-12-30)

1.2 手术方法

观察组行甲状腺全切除术,体位为仰卧位,麻醉后,在胸骨上方2横指处作横行切口,长度约7-8 cm,分离皮瓣,将颈白线切开,剥离甲状腺,仔细分离紧贴于腺体的被膜组织,并将其放入旁边的纤维脂肪组织中,切断甲状腺静脉及其下静脉并予以结扎,分离气管前间隙并分离^[4],切除肿块一侧甲状腺组织,标本术中冰冻处理,若病理为良性肿瘤,则放置引流管并结束手术,若病理为恶性,则需要将对侧的甲状腺叶同时切除,同时需行中央淋巴结清扫,淋巴结肿大患者则需行扩大淋巴结清扫术。对照组行甲状腺次全切除术,术中无需显露上位甲状旁腺,双侧甲状腺上级需保留<25%^[5],下位甲状旁腺的显露同上。

1.3 辅助治疗方法

术后所有患者均不摄入碘,并对有淋巴结转移者进行I¹³¹

核素治疗,治疗时间为1月,随后服用甲状腺素抑制剂,嘱患者定期随访复查甲状腺素水平,根据复查结果调整药物剂量,术后常规服用优甲乐治疗直至TSH指标低于0.1 uIU/mL。

1.4 统计学分析

采用SPSS 21.0对数据进行统计学分析,计量资料采用(均数±标准差)表示,例数和百分比为计数资料,采用 χ^2 检验,计数资料采用t检验,以P<0.05为差异具有统计学意义。

2 结果

2.1 两组患者的手术情况比较

两组患者的术中出血量、喉返神经显露率比较差异无统计学意义,观察组的手术切口以及手术时间均明显长于对照组(P<0.01),甲状旁腺显露率显著高于对照组(P<0.01),见表1。

表1 两组患者的手术情况比较

Table 1 Comparison of the surgical situation between two groups

Groups	n	Operative incision(cm)	Intraoperative blood loss (ml)	Operative time (min)	Laryngeal recurrent nerve show rate(%)	Parathyroid gland (%)
Observation group	45	6.4± 0.8	32.5± 11.3	82.3± 19.6	44(97.78)	43(95.56)
Control group	45	5.2± 0.5	34.8± 13.2	68.3± 11.2	40(88.89)	37(82.22)
P value		<0.05	>0.05	<0.05	>0.05	<0.05

2.2 两组患者术后并发症发生情况比较

两组患者在暂时性、永久性喉返神经损伤,暂时性、永久性

甲状旁腺功能低下的发生率比较差异均无统计学意义(P>0.05),见表2。

表2 两组患者术后并发症的发生情况比较

Table 2 Comparison of the incidence of postoperative complications between two groups

Groups	n	Temporary laryngeal recurrent nerve injury	Permanent laryngeal recurrent nerve injury	Temporary low parathyroid function	Permanent parathyroid low function
Observation group	45	1	0	4	1
Control group	45	0	0	3	0
P value		>0.05	>0.05	>0.05	>0.05

2.3 两组患者术后随访情况的比较

所有患者在围手术期以及住院期间均无死亡,术后所有患者均获得随访,随访时间为6-12月,观察组随访期间无出现复发病例,对照组中6例出现复发,复发率为13.33%(6/45),两组患者术后复发率比较差异具有统计学意义(P<0.05)。

3 讨论

甲状腺癌为多中心发病率最高的内分泌恶性肿瘤性疾病,目前甲状腺全切除术以及近全切除术为治疗甲状腺癌的主要方式,全切除或近全切除的优势为能够最大程度清除原发灶^[6-8],虽然具有一定的致残性,但术后辅助激素治疗能够改善症状,严密的操作能够有效避免并发症的发生率^[9],在进入喉部前与甲状腺相互靠近时,只需要对颈中腹侧被膜就能够较好地避开甲状旁腺以及喉返神经以免误伤。进行甲状腺全切除术后,甲状腺将失去正常的分泌功能^[10-12],患者需要进行定期复诊并进行必要的调节二降低药物的使用剂量,从而使得患者体内的甲状腺素保持于正常的水平,术后通过恢复饮食就能够进行甲

状腺素片等替代治疗,并根据患者的基础代谢水平来调整相关药物的用量^[13],同时需要注意机体所需甲状腺素受到多种因素的影响,如环境、情绪等,若患者出现疲惫、心率减慢以及食欲变差等情况时需要及时复诊并调节药物的用量^[14,15],相关研究结果显示甲状腺替代药物的用量与患者的年龄有关,年龄越大则需要越少的药物剂量,所以年轻患者所需的甲状腺素相对量较大^[16-18]。

本次研究结果显示甲状腺全切除术治疗的患者手术切口以及手术时间均明显长于半切除术治疗的患者,但其甲状旁腺的显露率明显更优,复发率显著降低,且未增加术后并发症的发生,表明甲状腺全切除术在降低术后复发率上的明显优势。此外,两种术式治疗的患者术中出血量、喉返神经显露等方面比较无明显差异,且两组患者术后喉返神经损伤、甲状旁腺损伤等比较亦无明显差异,说明了2种手术方式在安全性以及疗效方面相当,但是全切除术组的复发率明显低于近全切除组,说明全切除手术方式的远期临床疗效明显优于近全切除术。

既往国外有学者指出双侧甲状腺多发结节患者行全切除

术后的复发率与参与甲状腺组织的体积为正相关关系,复发患者再次进行手术时出现永久性喉返神经损伤以及甲状旁腺损伤的概率均明显高于首次手术^[19],其可能与二次手术时甲状腺原组织已被破坏、组织粘连严重以及喉返神经和甲状旁腺显露困难有关。本次研究结果显示在甲状旁腺显露方面,全切除术组的显露率达标,但是仍有部分患者未得到显露,其可能是由于下位甲状旁腺位置变异导致的^[20]。从理论上来说,全切除手术更容易造成喉返神经以及甲状旁腺损伤,但在显微镜下进行精细操作大大降低了喉返神经及甲状旁腺损伤的概率。

综上所述,应用甲状腺全切除术治疗甲状腺癌的治疗的效果良好,能够有效降低术后复发率。

参考文献(References)

- [1] Zheng XC, Wang SY, Liu S, et al. Senile thyroid carcinoma recurrence risk factors[J]. Chinese journal of gerontology, 2016, 4(2): 367-368
- [2] YanLQ, Li FX, Zhang S, et al. Analysis of resection of thyroid carcinoma of thyroid parathyroid hormone level changes and the influence factors analysis [J]. Chinese general practice, 2015, 18(29): 3579-3581
- [3] Liu Zhi-ting, Lin Ai-hua. Dietary Factors and Thyroid Cancer Risk: A Meta-Analysis of Observational Studies[J]. Nutrition and Cancer: An International Journal, 2014, 5/8(5/8): 214-216
- [4] Cai DC. Different surgical methods using in patients with thyroid carcinoma postoperative parathyroid function and the influence of hypocalcemia[J]. Journal of Chinese basic medicine, 2016, 23 (18) : 2814-2817
- [5] Zheng XQ, Dong L, Gao M, et al. The thyroid malignant tumor treatment research progress [J]. Chinese journal of general surgery, 2016, 31(2): 175-176
- [6] Chen WP, Xie Y. Laryngeal recurrent nerve injury in thyroid cancer radical factor analysis [J]. Journal of the Chinese general practice magazine (electronic version), 2016, 10(2): 159-161
- [7] Zhou H, Xu H, Zhang J, et al. Combination of dexamethasone and tropisetron before thyroidectomy to alleviate postoperative nausea, vomiting, and pain: Randomized controlled trial[J]. World Journal of Surgery, 2012, 6(6): 211-212
- [8] Sywak MS, Palazzo FF, Yeh M, et al. Parathyroid hormone assay predicts hypocalcaemia after total thyroidectomy [J]. ANZ journal of surgery, 2007, 8(8): 346-347
- [9] Tian W. Pay attention to the prevention of complications in total resection of thyroid[J]. Chinese surg, 2015, does (3): 161-163
- [10] Zhou Q, Yang SS, Peng CX, et al. Colour to exceed and D2-40 immunohistochemical detection of value to the diagnosis of thyroid carcinoma [J]. Journal of general practice in China, 2014, 17(11): 1253-1256
- [11] Liu D. The effects of levothyroxine using in bone mineral density patients with thyroid cancer surgery [J]. Chinese journal of primary medicine and pharmacy, 2015, 22(17): 2577-2579
- [12] Miccoli P, Materazzi G, Berti P. Minimally invasive thyroidectomy in the treatment of well differentiated thyroid cancers: indications and limits[J]. Current opinion in otolaryngology & head and neck surgery 2010, 2(2): 197-198
- [13] Li BH. Rise in tonga subtraction joint levothyroxine sodium tablets on postoperative hypothyroidism thyroid cancer research [J]. The influence of the forefront of medicine, 2015, 5(7): 353-353354
- [14] Chiang FY, Lee KW, Chen HC, et al. Standardization of intraoperative neuromonitoring of recurrent laryngeal nerve in thyroid operation[J]. World Journal of Surgery: Official Journal of the Societe Internationale de Chirurgie, Collegium Internationale Chirurgiae Digestivae, and of the International Association of Endocrine Surgeons, 2010, 2(2): 44-45
- [15] Li XY, Wang ZM, Huang Y, et al. Surgical treatment of thyroid cancer, with 487 cases report [J]. Chinese journal of general surgery, 2010, 12 (5): 459-462
- [16] Feroci F, Rettori M, Borrelli A, et al. Dexamethasone prophylaxis before thyroidectomy to reduce postoperative nausea, pain, and vocal dysfunction: a randomized clinical controlled trial[J]. Head and neck: Journal for the sciences and specialities of the head and neck, 2011, 6 (6):51-53
- [17] Shen H, Wei BJ, Xie H, et al. Primary parathyroid function with thyroid cancer cases [J]. Chinese journal of otolaryngology head and neck surgery, 2016, 11(4): 273-276
- [18] Schietroma M, Cecilia EM, Carlei F, et al. Dexamethasone for the prevention of recurrent laryngeal nerve palsy and other complications after thyroid surgery: A randomized double-blind placebo-controlled trial [J]. JAMA otolaryngology- head & neck surgery, 2013, 5 (5): 99-100
- [19] Chia-Che Chen, Fahad Javaid Siddiqui, Ta-Liang Chen, et al. Dexamethasone for prevention of postoperative nausea and vomiting in patients undergoing thyroidectomy: meta-analysis of randomized controlled trials [J]. World Journal of Surgery: Official Journal of the Societe Internationale de Chirurgie, Collegium Internationale Chirurgiae Digestivae, and of the International Association of Endocrine Surgeons, 2012, 1(1): 733-734
- [20] Grodski S, Farrell S. Early postoperative PTH levels as a predictor of hypocalcaemia and facilitating safe early discharge after total thyroidectomy[J]. Asian journal of surgery, 2007, 3(3): 113-114