INFORMED CONSENT FOR THYROID SURGERY

Patient Name:

Patient ID : **Date:**

Nationality : **Passsport No:**

Address:

- **MY PROCEDURE**

I hereby give my consent for Dr. to perform.

The intervention (decribed below) has been detailed and recommended to me and is planned to take place at hospital.

- **MY BENEFITS**

Some potential benefits of this procedure may include:
- To get rid of tyroid cancer or cancer-suspicious nodules, by doing unilateral or bilateral thyroidectomy.
- To get rid of hyperthyroidism or thyrotoxicosis (toxic guatr) that can lead to serious health problems as long as it remains.
- To get rid of anti-thyroid drugs with significant side effects due to hyperthyroidism.
- To get rid of a thyroid disease that can cause discomfort by putting pressure on the respiratory tract.

- **MY RISKS**

I understand that there are potential risks, complications and side effects associated with any surgical procedure. The problems that may arise if I do not accept or delay the surgical procedure recommended for me are described in detail above. Although it is not possible to list all the risks, the possible surgical risks and complications and the side effects of the surgery that will be applied have been detailed and informed in all its aspects.

For cancer, Bilaterally total thyroidectomy (removing of whole thyroid tissue from the neck) is usually performed. This procedure is done to remove all visible thyroid tissue. But technically, this is often not possible. In other words, 1-2 mm of healthy thyroid tissue can be left behind after thyroidectomy. These remaining small tissues can grow up to a few millimeters over the years. Although this is not

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common, it does not cause a major medical problem and does not mean a tumor recurrence. On the other hand, there is no guarantee of zero recurrence rate after any cancer surgery.

In some types of tumors, when small and unilateral, right or left lobectomy (one-sided thyroid removal) may be a sufficient and appropriate procedure.

A more comprehensive lymphatic area surgery may be required if cancer-related cervical lymph node metastasis is detected during surgery. Each surgical area has its own risk and possibility of complications.

Most patients may have a temporary change in voice in the first few days after surgery. But the real vocal cord paralysis occurs in 10% of patients. The majority of the paralysis recover within a few months. In total, 2-3% of patients develop permanent laryngeal nerve palsy. This rate is higher in thyroid cancer patients, in giant goitre surgery, and in more extensive cancer surgery.

Many patients with laryngeal nerve palcy benefit from speech therapies and corrective surgery. If you are an acoustic artist or a vocal artist, talk to your surgeon in advance.

Laryngeal nerve monitoring during thyroid surgery is used in almost all patients to reduce the likelihood of nerve injury. This procedure significantly prevents two-sided nerve palsy. When a one-sided nerve palsy develops during this procedure, the surgery is stopped. The surgical operation of the other side is performed when laryngeal nerve functions fully returned. Because tracheotomy (inserting a tube into the respiratory tract) may require after bilateral nerve palsy.

Calcium deficiency: The small tissues located behind of the thyroid gland, called the parathyroid glands, can be damaged, resulting in signs such as drowsiness in the fingers, contractions in the hands and feet. This is usually a temporary problem. But long-term calcium support may be required. This condition is rare, but can be permanent and may require lifelong medication. If you have lower calcium levels after surgery, you may have symptoms such as drowsiness in your fingers, contractions in your hands and feet. In this case, you will be given calcium-containing medicines either through the vein or through the mouth. In 15% of patients after tyroid surgery, 25% after parathyroid surgery, calcium is required for several days or weeks. They can even temporarily administer calcium-containing medications to prevent blood calcium levels from falling during discharge. Only 12% of patients have to take calcium for more than 6 months.

Hypothyroidism: If all of your wole thyroid gland is removed, you'll have to take your hormone pils for the rest of your life. This should not be perceived as a complication. If it's partially removed, it'll be clear in the next few weeks whether you're taking the medicine or not.

Scars in the neck and loss of sensitivity around the wound are common, but often disappear or recede within a few months. Bleeding and infection are very rare.

As with every surgery, some complications may be related to general anesthesia. During the surgery, the patient will be anesthetized, and a tube will be inserted into the respiratory tube to get my breath from there. The removal of the tube after this process may be delayed or not possible. In this case, the patient is treated in intensive care. Again, anesthesia-related complications can lead to a risk of death less than 1/1000 ratio. Detailed information on complications associated with anesthesia will be obtained from the anesthesiology team, and the responsibility for these matters lies with the anaesthetics team.

During and after surgery, clot (thrombus) from deep venous system can result in pulmonary embolism. To prevent this, the necessary medication will be initiated before the surgery and continued after the operation. Additional measures, such as early mobilization of the patient after the surgery, will also be taken. However, a method that will eliminate this risk 100% is not yet known in medicine. This is a very serious condition and there is a risk of death.

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I accept the above-mentioned surgical procedures and I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures.
I will not resort to legal proceedings because of the surgical complications of my above-mentioned illness and acceptable complications inherent in my treatment.

Use your own handwriting to write "I understand what I read".

……

Signature:_____ Date: _____ Time: _____

Patient is unable to consent because _____. I therefore consent for the patient.

Authorized Consenter's Signature: _____ Date: _____ Time: _____

Witness
Name: _____

Witness Signature: _____ Date: _____ Time: _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician

Name:
_____

Physician Signature: _____ Date: _____ Time: _____

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