Case Report

Pre-operative use of Lugol’s iodine in a case with toxic adenomatous goiter

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Received: 06 March 2021
Accepted: 06 April 2021

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ABSTRACT

Euthyroid state is considered a requisite before planning a thyroid surgery. Before such a surgery, pharmacotherapy can be used for managing a hyperthyroid state. It warrants a long-term treatment with pharmacotherapy agents like imidazole class (carbimazole, methimazole) or propylthiouracil. In cases with large goiters, with pressure symptoms like dyspnoea, dysphagia, dysphonia; a surgeon would prefer a pharmacotherapy with a quicker action than the established agents. Lugol’s iodine was used pre-operatively before the advent of newer agents. In rural areas, where patients present with large goiters, hyperthyroid states due to lack of awareness and availability of the modern pharmacotherapy, Lugol’s iodine can be a rescue pre-operative therapy to make such a patient euthyroid and to decrease the vascularity of the goiter, which facilitates a safer thyroid surgery.

Keywords: Thyroid surgery, Euthyroid, Lugol’s iodine

INTRODUCTION

A patient with goiter and a hyperthyroid state can be treated with pharmacotherapy, surgical management or radioiodine.¹ A goiter in hyperthyroid state often has increased vascularity.² Intra-operative and immediate postoperative bleeding and a thyrotoxic storm are the most dreaded complications of thyroid surgery. A reduction in bleeding also facilitates a clean dissection and better visualization of important structures like recurrent laryngeal nerves as well as the parathyroid glands. In the early 20th century, it was postulated and later proven that preoperative use of inorganic iodine leads to decreased morbidity and mortality.³ The histology of adenomatous goiter varies from solid to gelatinous or colloid-rich type. The etiology includes iodine deficiency, dietary goitrogens or inherent dyshormonogenesis.⁴ The use of inorganic iodine in pharmacological doses inhibits iodine transport in the thyroid and iodide organification (Wolff-Chaikoff effect) and rapidly inhibits thyroid hormone synthesis and release and thereby negating the thyrotoxicosis. However, after a few weeks, the effect weans off and the thyrotoxicosis recurs. Therefore, short-term use of inorganic iodide is useful in preparing patients with hyperthyroidism for thyroid surgery. Usually, it is given in dosage of three to five drops thrice daily for 10 days.⁵

The use of inorganic iodine as a pre-operative preparation before thyroid surgery was first postulated by Plummer in 1923.⁶ Lugol’s iodine is a solution of elemental iodine, potassium iodide and distilled water. It was previously used as a disinfectant, starch detector, histological preparation and Schiller’s test. Its use in thyroid surgery started in the 1920s.
CASE REPORT

A 45 year old male presented to the outpatient department with a large thyroid swelling for 8 years. The swelling was localized on the left of the midline initially and gradually progressed in size to involve both lobes and isthmus over 8 years to the current size (18×10×5 cm). He also complained of hoarseness of voice and difficulty in breathing for the last 6 years. There was no medication history for the same. On examination, the surface of the swelling was bosselated, had a firm consistency and the lower border of the swelling was palpable just above the jugular notch. The patient had mild tachycardia, fine tremors and hoarseness of voice. There was mild engorgement of the neck veins.

The ultrasonography of the swelling demonstrated multiple ill-defined nodular lesions of heterogenous echotexture involving the whole thyroid gland along with a few cystic areas and calcifications. There was hypervascularity throughout the gland. The trachea was compressed and distorted along with lateral displacement of the common carotid artery and internal jugular vein bilaterally. The cytology report on FNAC showed scattered clusters of follicular epithelial cells with cyst macrophages and suggested a nodular goiter as the diagnosis. A CT scan of the neck confirmed these findings with a demonstration of a retrosternal extension of the left lobe. Both X-ray soft tissue neck and indirect laryngoscopy suggested a slight tracheal shift towards the left. The patient presented with a hyperthyroid state with a thyroid panel showing serum T3 as 2.21 ng/mL, serum T4 as 10.74 µg/dL and TSH as 0.02 mIU/L. A repeated thyroid profile after one month showed a persistent hyperthyroid state with T4 as 15.43 µg/dL, free T4 as 3.7943 µg/dL and TSH as 0.046 mIU/L.

The patient was posted for a total thyroidectomy and necessary preoperative preparation was started. The patient was started on 5% Lugol’s iodine 10 drops (60 mg) thrice daily along with tablet methimazole 10 mg, tablet propranolol 20 mg and tablet hydrocortisone 10 mg thrice daily. The Lugol’s iodine was administered for 7 days and the thyroid profile was repeated, which showed euthyroid state, serum T3 as 1.49 ng/mL, serum T4 as 10.73 µg/dL and serum TSH as 0.2 mIU/L. After attaining fitness from an anesthetist and endocrinologist, the patient underwent a total thyroidectomy. The procedure went uneventful. The specimen retrieved was subjected to histopathological examination, which reported it to be an adenomatous goiter. The patient recovered well, with no postoperative complications, but the hoarseness of voice persisted congruent with the preoperative state. The patient was started on antibiotics, calcium supplements and discharged with hormone replacement.

Figure 1 (a and b): Thyroid swelling.

Table 1: Timeline of events.

<table>
<thead>
<tr>
<th>Event</th>
<th>Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st thyroid profile: hyperthyroid state</td>
<td>2</td>
</tr>
<tr>
<td>Admission</td>
<td>0</td>
</tr>
<tr>
<td>Lugol’s iodine administration</td>
<td>1</td>
</tr>
<tr>
<td>2nd thyroid profile: euthyroid state</td>
<td>10</td>
</tr>
<tr>
<td>Total thyroidectomy</td>
<td>12</td>
</tr>
<tr>
<td>Discharge</td>
<td>21</td>
</tr>
</tbody>
</table>
DISCUSSION

As already discussed, a euthyroid state is of paramount importance during thyroid surgery. A hyperthyroid state can be managed with pharmacotherapy with carbimazole or propylthiouracil, which warrants a long-term treatment. In cases, as seen here, when patients present from rural areas, where awareness, as well as availability of modern pharmacotherapy is scarce, they usually have advanced disease and pressure symptoms. In such patients, preoperative preparation with Lugol’s iodine which potentially can acquire euthyroid state promptly and decreases the vascularity in the lesion is a breakthrough. The use of Lugol’s iodine for this purpose started in the early 1920s but took a backseat with the advent of modern pharmacotherapy and its widespread availability.

According to American thyroid association, a patient must be brought to a euthyroid state using methimazole and inorganic iodide. They also state that in cases where a patient cannot be euthyroid preoperatively, e.g. allergy to antithyroid drugs or emergency thyroidectomy, inorganic iodide and beta-blockers must be administered. This aims at rendering a patient euthyroid as well as decreasing the vascularity by decreasing angiogenic stimuli (lowering CD34 expression) and thereby decreasing the blood loss and improving visibility for the preservation of vital structure during the surgery. It also decreases the possibility of intra or postoperative thyroid storm by inhibiting the release of the hormones as well as inhibiting the organification of iodide moieties.

Calissendorff et al in a study in twenty seven patients in 2017 administered Lugol’s iodine preoperatively for different factors like agranulocytosis, hepatotoxicity and other side effects of antithyroid drugs. They demonstrated a significant decrease in the levels of free T3 and free T4, but no change in the TSH levels. Minor complications like rash, nausea and vomiting were noted in 15% of the patients. There also was a significant improvement in tachycardia.

Yilmaz et al in their study conducted in 2016 enrolled 40 patients who were stratified into three groups, receiving preoperative treatment with Lugol’s iodine (group 1), no preoperative treatment with Lugol’s iodine (group 2) and healthy euthyroid adults (group 3). Doppler study was used to measure blood flow through the vasculature and thyroid profiling along with thyroid volume and the resistance index of main thyroid arteries were measured. They found out that Lugol’s iodine was the only significant independent factor that decreased the blood loss during thyroidectomy by 7.40-fold.

Hope and Kelly et al in their review article have stated that there are scant literature and evidence regarding the use of Lugol’s iodine for preoperative preparation for thyroidectomies. After an extensive study of the literature regarding the same, they have concluded that large prospective randomized control studies need to be undertaken to establish whether Lugol’s iodine is efficacious enough to be used as a routine preoperative preparation tool before thyroid surgeries.

As in the case discussed here, the patient hailed from a rural area and despite having compressive symptoms due to the huge thyroid swelling, medical or surgical facilities were not sought for 8 years. The patient was clinically hyperthyroid (tachycardia, tremors) at presentation and had dysphonia, dyspnoea. The radiological investigations suggested significant displacement of neck structures (common carotid arteries, internal jugular veins and trachea) and increased vascularity of the swelling. This was a chronic, symptomatic and toxic swelling with increased risk of intraoperative complications and excess blood loss and thyrotoxic storm. Preoperative preparation with Lugol’s iodine was done as mentioned above. The thyroidectomy done was uneventful with minimal blood loss, adequate visualization and preservation of important structures bilaterally and a controlled thyroid profile. This
underlines that prompt action by Lugol’s iodine rendered the patient clinically and biochemically euthyroid within 8 days and it is also likely that it also played a role in decreasing the vascularity of the thyroid gland. A decrease in the heart rate may also have played a part in reducing the rate of blood flow in the vasculature and thereby distension.

CONCLUSION

This case underlined the importance of Lugol’s iodine as a routine preoperative preparation tool for thyroid surgeries. Management of hyperthyroid state and hypervascularity with Lugol’s iodine was also emphasized.

We also wanted to propagate the notion that a larger, prospective, randomized study is warranted to establish whether Lugol’s iodine was efficacious enough to be used as a routine preoperative preparation tool before thyroid surgeries.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES


Cite this article as: Kulkarni S, Murchite S, Parab S, Tiwari V, Rajagopal A. Pre-operative use of Lugol’s iodine in a case with toxic adenomatous goiter. Int Surg J 2021;8:1630-3.