

Treatment of paresis of the laryngeal nerve after thyroid surgery
methods of bioresonance therapy and acupuncture

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In operations on the thyroid gland, the experience of the surgeon is of great importance, the correctly selected and well-implemented technique and technique of the operation, the provision of complete anesthesia, taking into account what kind of anesthesia optimal for this operation. numbering And yet, even a very large experience, in many thousands of complications. operations, does not completely rid the In the surgical clinic of the VNI experimental endocrinology and chemistry of hormones during 629 operations performed from 1962 to 1966 for diffuse toxic goiter, in 26 patients (4.1%) such complications as damage to the recurrent laryngeal nerve, hypoparathyroidism, bleeding, asphyxia, thyrotoxic crisis were stated. Colcock and King (1962) from the Lehi clinic noted 16.5% of complications in the last 1246 operations. Approximately the same percentage of tetany and recurrent laryngeal nerve damage at Mayo Clinic. In surgical facilities with less experience, they should naturally occur more frequently. Therefore, one can only envy V.M. Udod (1969), who writes that in 1268 operations on the thyroid gland "no complications were observed during or after the operation," or M.I.Mishenin (1970), never in 10 years who did not notice damage to the laryngeal nerves during operations for goiter. The frequency of complications and their nature are associated primarily with the severity of the operation. Relapsing goiters are especially notorious in this respect. With recurrent goiter, the number of complications increases 10 times or more.

Complications in the surgical treatment of thyroid gland (thyroid) diseases are divided into 3 groups:

1. Specific complications - damage to the laryngeal nerves, hypoparathyroidism, bleeding during and after surgery, thyrotoxic crisis.

2. Local complications associated with surgical intervention on neck - injury to the trachea, esophagus, great vessels, pneumothorax, injury to the cervical plexus, air embolism.

3. Complications observed with any surgical intervention - postoperative pneumonia, thromboembolism, exacerbation chronic pathology, wound suppuration and others.

Deserve the greatest interest complications, being specific for thyroid surgery.

The most common among them is damage to the laryngeal nerves, which, according to the literature, occurs in 2-7% of cases and is manifested by impaired phonation, breathing and swallowing.

Injury to the external (motor) branch of the superior laryngeal nerve causes only mild, rapidly passing hoarseness. When the internal (sensitive) portion is damaged, the epiglottis is anesthetized, which is clinically manifested by "choking" while eating, especially liquid food. This symptom, as a rule, also disappears in the immediate postoperative period. It is in connection with the meager and transitory

With clinical symptoms, trauma to the branches of the superior laryngeal nerve is quite rare, and the focus is on the lesion of the recurrent laryngeal nerve.

It is believed that the main mechanism of recurrent nerve injury is its relationship with the inferior thyroid artery. Variants of this the relationship is very variable: the nerve can be behind the artery, in front of it, spirally embrace or intersect with it. In addition, pronounced violations of topographic and anatomical ratios in connection with the adhesive process or cicatricial deformity, especially with recurrent and multinodular goiter. In rare cases, cases of the inclusion of a nerve in the thyroid tissue have been described. A similar position is real with a large, rapidly growing goiter, when the nerve is between the nodes growing back and inward. In such cases, even the most advanced surgical technique cannot guarantee its safety. The greatest threat arises when the lower poles of the thyroid lobes are highlighted. In 30% of cases, the nerve passes in front of the inferior thyroid artery, which, when the lateral lobe is pulled, will inevitably lead to its tension.

Clinical manifestations of lesions of the recurrent laryngeal nerve depend on the location of the vocal folds: with unilateral paresis, the fold can be maximally reduced (adduction paresis) and then only slight changes in the voice will be observed; or maximally abducted (abductive paresis), which is manifested by a pronounced violation of phonation. With bilateral lesions of nerves with an adduction position of the folds, the likelihood of asphyxia is high.

However, more often in clinical practice, unilateral nerve damage occurs, in which unilateral paralysis or paresis of the vocal cord from the corresponding side develops, accompanied by aphonia, hoarseness. In some cases, these symptoms may be associated with compression of the nerve formed in the postoperative period by hematoma in the area of operation.

Treatment of postoperative unstable paresis of the vocal cords consists in draining the wound when fluid accumulates in it, using antibiotics, proserin, special exercises for the voice and galvanizing the muscles of the neck and larynx. Most often, such paresis disappear within 1–5 months after the operation. Persistent paralysis is difficult to treat. Sometimes other methods are added to the treatment regimen, for example, acupuncture.

The prognosis of postoperative bilateral laryngeal paralysis directly depends on its cause.

If both recurrent laryngeal nerves have been damaged (crossed), the mobility of the vocal folds is irreversibly lost. If the integrity of the nerves (nerve) is preserved (traumatic paresis), it makes sense to work with a phonopedist. As a rule, the mobility of at least one vocal fold is restored.

Purpose of work: analysis of the therapeutic capabilities of the APC "IMEDISFALL" in patients with postoperative paresis of the laryngeal nerve after surgery for nodular goiter.

Materials and methods

There were treated 50 patients aged 18 to 60 years (all women) with a diagnosis of postoperative paresis of the laryngeal nerve, conventionally divided into 2 groups of 25 people. Group I received conventional drug treatment using various options for BRT (multiresonance therapy) and acupuncture, group II received conventional drug treatment. Multiresonance therapy (MRI) included basic endogenous bioresonance therapy (BRT), resonance frequency therapy (RFT) using an inductor.

In 11 cases in patients after surgery, the laryngologist ascertained paresis of the vocal cord, of which one patient was bilateral, although the operation was on one side. Voice change after surgery was found in 34 out of 50 patients, and laryngoscopic paresis after surgery was found in 15 patients. Occasionally in our practice, there were cases when phonation or respiration during the operation changed for a short time, and then complete restoration of voice and respiration occurred. These episodes should be associated with novocaine blockade of the recurrent nerve and reflex contraction of the opposite ligament (in case of respiratory failure).

In 15 patients out of 50 the next day after the operation, "choking" was found. Food, especially liquid food, got into the larynx - "in the wrong throat," as the patients figuratively said. This condition was interpreted as a lesion of the sensory fibers of the superior laryngeal nerve. If the patient is asked to swallow water when the head is tilted to the side opposite to that on which the nerve is supposed to be damaged, swallowing occurs normally, since on this side the sensitivity of the epiglottis is not disturbed, and it covers the larynx at the time the contents of the pharynx pass. If the patient tilts his head to the side where the nerve is suspected,

"Choking" is especially noticeable and painful.

To assess the results of treatment, we used clinical and laboratory research methods.

generally accepted

results

In the course of treatment, a more rapid decrease in clinical symptoms was noted in group I. The disappearance or a significant decrease in complaints was observed in 18 (72%) patients of the main group and 8 (32%) patients in the comparison group. In the main group, the severity of symptoms decreased by 3-4 days after therapy, and in the comparison group by 5-6 days. In addition, in the group of patients where MRI was used in the treatment, there were no adverse reactions from the therapy that were typical for conventional therapy of the acute period.

Conclusion: MRI in combination with acupuncture is an effective and well-tolerated therapy, which makes it possible to recommend it for use in this category of patients.

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