

## **2. Stades I et II cliniques inopérables du fait d'une exploration fonctionnelle respiratoire médiocre ou médicalement inopérables**

Si l'état général du patient le permet, une radiothérapie à visée curative est recommandée sous la forme d'une radiothérapie en conditions stéréotaxiques pour les stades T1N0 ou T2aN0, voire certains T2bN0 (tumeur jusque 5 cm). Le taux de contrôle local est lié à la taille du volume cible et est supérieurs à 85% à 3 ans dans la majorité des séries et le taux de toxicité tardive, y compris la toxicité pulmonaire, est acceptable, inférieur à 10 % (76).

En cas d'impossibilité d'obtenir un diagnostic histo-cytologique, une radiothérapie stéréotaxique doit être discutée en RCP devant une lésion suspecte au scanner, évolutive (>2mm sur deux TDM à 3 mois d'intervalle) et hyper métabolique au TEP-FDG, après élimination d'une cause infectieuse respiratoire (➔ Référentiel nodules). Il n'y a aucune contre-indication formelle sur le plan de l'état respiratoire.

Une dose totale équivalente biologique d'au moins 100 Gy permet d'obtenir de meilleurs résultats en terme de contrôle local (77). Les schémas validés sont ceux en 3 à 5 fractions (45-54Gy/3F, 48Gy/4F à 50Gy/5F)<sup>9</sup> pour les tumeurs périphériques. Le schéma doit être plus fractionné pour les tumeurs centrales (<2cm / trachée, carène, bronches souches, cœur, gros vaisseaux, canal médulaire, plexus et oesophage), en 5 à 8 fractions (50Gy/5F à 60Gy/8F)<sup>8</sup> voir 10 ou 15 fractions pour les tumeurs ultra-centrales. Il est préférable que les tumeurs ultra-centrales soient traitées en centre expert.

Pour les stades IIB, l'indication de chimiothérapie (après un diagnostic cyto- ou histologique) associée à la radiothérapie sera discutée en RCP.

La gestion des mouvements respiratoires est importante : scanner 4D, respiration contrôlée, *gating* respiratoire, *tracking*, CBCT, CBCT 4D si disponible.

### **Recommendations**

Dans les stades I et II inopérables, si l'état général du patient le permet, une radiothérapie à visée curative est recommandée sous la forme d'une radiothérapie en conditions stéréotaxiques pour les tumeurs N0.

Une radiothérapie stéréotaxique à visée curative est recommandée, dans les stades I voire certains IIA ( $T \leq 5\text{cm}$ ) inopérable.

En l'absence de preuve cyto- ou histologique, une radiothérapie sans preuve, à visée curative, des stades cl à clIIA est envisageable en cas de contre indication au bilan diagnostic invasif sous réserve d'une évolution d'au moins 2mm entre deux scanners à 3 mois d'intervalle et d'une hyperfixation en TEP.

**OPTION : Ablation thermique ou autres techniques de radiologie-interventionnelle pour les tumeurs de moins de 3 cm**

## **3. Stades pIB à pIIIA réséqués avec mutation EGFR**

L'essai ADAURA, publié en 2020, a testé un traitement par osimertinib pendant 3 ans (contre placebo), après chirurgie et chimiothérapie adjuvante (autorisée mais non obligatoire<sup>10</sup>, décision prise en RCP) dans les CBNPC non-épidermoïdes de stades IB, II et IIIA réséqués (selon la TNM7). Ceci correspond donc aux stades IB à IIIA (plus les actuels T4N2 soit certains IIIB) dans la classification TNM8. Le délai d'initiation de l'osimertinib était de 10 semaines après la chirurgie en l'absence de chimiothérapie adjuvante, 26 semaines alternativement. Les patients

<sup>9</sup> Fractionnements fréquemment utilisés, donnés à titre indicatifs.

<sup>10</sup> Dans cet essai 32% des patients de chaque bras étaient de stade IB, 31% dans le bras osimertinib étaient de stade N2 (30% dans le bras placebo) ; et 40% dans chaque bras n'ont pas reçus de chimiothérapie adjuvante.

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