

BONNES PRATIQUES EN ENDOSCOPIE SOUPLE (DIAGNOSTIC)

L'endoscopie bronchique souple est une procédure diagnostique importante qui peut être réalisée en sécurité chez des patients ambulatoires. Dans une grande étude multicentrique prospective de 2009 portant sur plus de 20 986 procédures, le taux de complications sévères était de 1,1% et la mortalité de 0,02 (1). Les principaux événements rapportés sont des troubles du rythme cardiaque, hémorragies minimes ou sévères, bronchospasmes/laryngospasmes, toux, dyspnée, désaturations, défaillance cardio-respiratoire, pneumothorax, œdèmes pulmonaires. Dans des études prospectives plus petites, le taux de complications est plus élevé avec 7% pour Hehn *et al* (4,3% respiratoires, 2,8% de non-respiratoire) et plus de 30% pour Bechara *et al* (dont 8% de sévères) (2,3). Cet examen diagnostique ne semble pas plus à risque chez les personnes âgées de plus de 65 ans, voire de plus de 85 ans (4). De nombreux facteurs peuvent influencer le risque de complications, et inclus ceux inhérents au patient et ceux inhérent à la procédure elle-même (sédation, type de prélèvement réalisé ...). L'utilisation d'une check-list avant la procédure permet d'identifier de possibles risques de complication (annexe 1).

Pour aider les pneumologues dans leur pratique, plusieurs sociétés savantes ont édité des recommandations de bonnes pratiques pour l'endoscopie bronchique souple diagnostique (5-8).

1. L'hypoxie

Il est habituel de constater une baisse significative de la saturation lors d'une endoscopie bronchique, qui peut débuter au moment de l'anesthésie, se majorer au moment du passage des cordes vocales et qui est plus importante en position assise, lors de l'utilisation d'aspiration, lors des prélèvements ou en cas de prémedication avec des benzodiazépines (9-13). L'hypoxie est le plus souvent transitoire et sera significative si elle se prolonge plus d'une minute. Elle est plus fréquente en cas de baisse du peakflow (inférieur à 60% de la théorique) ou du VEMS inférieur à 1 litre et en cas de présence d'une hypoxie avant le geste (13).

Habituellement l'hypoxie est corrigée par l'apport d'oxygène par voie nasale ou pharyngée au débit de 2 à 4 litres par minute (11,14). Il semble que l'utilisation d'oxygénothérapie haut débit pas canule nasale pourrait permettre le geste chez patient hypoxique (sous O₂ au-delà de 6L/min) avec plus de sécurité en cas d'urgence diagnostique sans autre alternative (FIO₂ 100%, 60L/min) (15,16).

Recommandations

- Pendant une endoscopie bronchique le patient doit être surveillé en continu au saturomètre.
- Une supplémentation en oxygène doit être administrée en cas de désaturation de moins de 94% ou sat < 90% de plus de 1 minute pour réduire les risques de complications dus à l'hypoxie.
- Ces complications sont corrélées à la saturation initiale, la fonction respiratoire, les comorbidités, la sédation, et le type de prélèvement.

2. Les risques cardiaques

L'hypoxie survenant lors d'une endoscopie bronchique est classiquement à l'origine d'une augmentation de fréquence cardiaque (environ 40% de la fréquence de base), de la pression sanguine (environ 30% de la base), et de l'index cardiaque. Cependant, les troubles du rythme sévères pendant une endoscopie sont rares et semblent liés à une ischémie myocardique lors d'hypertension (17,18).

Les tachycardies sinusales sont fréquentes pendant l'endoscopie (14). Les arythmies atriales surviennent à n'importe quel moment de la procédure alors que les arythmies ventriculaires sont plus fréquentes au moment du passage de cordes vocales et lors d'hypoxie (19).

L'augmentation de la pression systolique et de la fréquence cardiaque pendant l'endoscopie est associée à une modification ECG dans 15% des cas (segment ST, bloc de branche) et corrélé à l'âge élevé et au nombre de



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