

4. Les patients asthmatiques

La réalisation d'une bronchoscopie fait chuter le VEMS d'environ 10 à 26% y compris chez des volontaires sains. Cette chute semble plus importante chez les personnes présentant une hyperactivité bronchique, surtout en cas de réalisation d'un lavage broncho-alvéolaire ou de biopsies (52–54).

Les patients présentant un asthme sévère ont plus fréquemment besoin de corticoïdes oraux et de bronchodilatateurs après le geste. L'administration de bronchodilatateurs avant l'endoscopie ne modifie pas le pourcentage de chute du VEMS mais augmente le VEMS absolu à la fin du geste, le VEMS étant optimisé avant le geste.

Recommandations

- Chez un patient asthmatique, le contrôle de l'asthme doit être optimisé au mieux avant une endoscopie, spécialement en cas de LBA ou biopsies.
- Un traitement bronchodilatateur en nébulisation peut être envisagé avant le geste.

5. Les patients BPCO

La présence d'une bronchopathie chronique obstructive est corrélée à une augmentation du taux de complication lors d'une bronchoscopie lorsque le VEMS/CVF est < 50%, ou le VEMS est < 1 litre et VEMS/CVF < 68% (55). Le risque s'élève alors à 5% (pneumopathie, hypoxie, défaillance respiratoire) au lieu de 0,6% chez les patients à fonction respiratoire normale. La présence d'une hypercapnie et/ou d'une hypoxie augmente également ce risque (+30% de désaturation, +50% de *weezing* et +20% d'arrêt prématuré de la procédure dans étude de Chechani dans laquelle 77% des patients étaient BPCO hypercapniques) (56). Par contre, ce risque ne semble pas être modifié par l'administration de bronchodilatateurs en nébulisation avant le geste mais est majoré par l'administration d'une prémédication (5).

Recommandations

- Avant une bronchoscopie, chez un patient suspect de BPCO, il est recommandé de réaliser une spirométrie et si le TVO est sévère (VEMS < 40% de théorique et/ou SAT < 93%), une gazométrie.
- Chez ces patients BPCO, l'apport d'oxygène et la sédation intraveineuse peuvent induire une hypercapnie. La sédation doit donc être évitée lorsque la PaCO₂ pré-endoscopie est élevée et l'apport en oxygène doit être contrôlé. Le traitement avant le geste doit être optimisé.

6. Standards et performances des techniques diagnostiques de la bronchoscopie souple en cancérologie thoracique

Lorsqu'un cancer bronchique est suspecté chez un patient, un scanner thoracique doit être réalisé et **si la lésion est centrale** et le statut ganglionnaire non déterminant, l'endoscopie doit être réalisée. De nombreuses études ont montrés la sensibilité des biopsies endobronchiques pour le diagnostic (43 à 93% selon les études).

L'association de biopsies à un brossage et aspiration bronchique augmente la rentabilité diagnostique de la bronchoscopie. Dans la méta-analyse faite en 2007 par l'*American College of chest physicians*, 35 études concernant des endoscopies faites sur des lésions centrales ont été regroupées soit 4507 patients. La sensibilité des biopsies était de 74%, des brossages de 59% et des aspirations de 48%. La rentabilité globale de toutes les techniques associées était de 88% (57). Auparavant, une étude Ecossaise faite sur 2238 bronchoscopies retrouvait, en cas de lésion endobronchique visible, une sensibilité diagnostique des biopsies seules de 82%, qui

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