# BILAN PRE-THERAPEUTIQUE

Une imagerie cérébrale doit être systématiquement réalisée lors du bilan inaugural des cancers bronchiques.
Il est recommandé d'effectuer une IRM cérébrale plutôt qu'un scanner dans le bilan pré thérapeutique car la sensibilité de l'IRM est supérieure à celle du scanner cérébral notamment pour les lésions de moins de 5mm (8,9). Une étude de 2008 sur 481 CBPC montre un taux de MC qui passe de 10% avec une TDM à 24% avec l'IRM (10).
Une TDM cérébrale peut suffire en cas de métastases multiples en situation multi métastatique, si le délai d'obtention du scanner est plus rapide.
Un examen neurologique est nécessaire pour juger du retentissement de l'atteinte cérébrale ainsi qu'un bilan d'extension de la maladie (Scanner thoraco-abdomino-pelvien et éventuellement TEP scan ➔ Réf. CBNPC).

**Recommandation**

**Une IRM pré thérapeutique est recommandée en cas de métastase cérébrale unique ou de métastases cérébrales multiples pour lesquelles un traitement par chirurgie ou radiothérapie stéréotaxique est envisagé.**

**<u>OPTION :</u> une TDM cérébrale (avec injection) peut suffire en cas de métastases multiples en situation multi métastatique, si le délai d'obtention du scanner est plus rapide.**

# MOYENS THERAPEUTIQUES

## 1. Exérèse chirurgicale

Malgré des progrès majeurs dans les traitements systémiques et les techniques de radiothérapie, la résection neurochirurgicale demeure un outil primordial dans le traitement des métastases cérébrales (MC). Ceci est particulièrement vrai pour les métastases cérébrales uniques, accessibles, et à distance des zones fonctionnelles. Des guidelines actualisées en 2019 ont été rédigées par l'association américaine des neurochirurgiens (11).
Ainsi, toute lésion opérable dans des conditions de sécurité fonctionnelle satisfaisante avec, idéalement, une exérèse complète envisageable peut relever d'une exérèse chirurgicale. L'opérabilité est déterminée par le neurochirurgien. La chirurgie sera particulièrement indiquée :

- Lorsqu'un diagnostic histologique est nécessaire, ce qui est plus fréquemment le cas dans les situations de métastases métachrones.
- Pour les métastases de grande taille pour lesquelles un traitement combiné par chirurgie + radiothérapie stéréotaxique (RTS) est probablement préférable à une RTS seule lorsqu'il est possible.
- Pour les lésions de la fosse cérébrale postérieure, à fortiori en cas de lésion symptomatique avec hypertension intracrânienne.
- Le caractère kystique de la lésion serait un argument pour la neurochirurgie, en fonction du contexte.
- <u>Une recherche d'anomalie moléculaire ciblable et une recherche du statut PDL1 doit être réalisée sur la pièce opératoire.</u>

*N.B : Trois études* princeps *mais anciennes (datant des années 90) ont randomisé chirurgie + IET versus IET seule. Les deux premières (12,13) ont conclu à une augmentation de la survie globale de 2 à 6 mois et à une diminution des récidives avec la chirurgie. La troisième (14) était négative mais les patients n'avaient pas d'IRM préopératoire et étaient en moins bon état général (KPS sup à 50%).*

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