

## SURVEILLANCE

Quel que soit le stade, le type histologique et les caractéristiques moléculaires de la maladie, **la surveillance doit être organisée pour permettre la prise en charge sans délai de tout nouveau symptôme, qu'il soit évocateur d'une évolution tumorale ou d'un effet secondaire des traitements instaurés.**

**Le TEP-FDG n'a pas d'indication dans la surveillance des patients.**

### 1 CBNPC opérés

Dans le but d'allonger la survie, l'objectif des consultations et des examens est de diagnostiquer un second cancer ou une rechute accessible à un traitement performant.

**L'arrêt du tabac est impératif pour diminuer le risque de second cancer** (→ référentiel Tabac).

Les comorbidités doivent être prises en charge, au premier rang desquelles la BPCO et les pathologies cardiovasculaires.

**Aucun consensus n'existe concernant les modalités et la fréquence de surveillance, que le patient ait été traité par chirurgie, +/- chimiothérapie et/ou radiothérapie.**

L'essai IFCT 0302 - surveillance a été rapporté à l'ESMO 2017<sup>36</sup>. Il avait pour objectif de comparer deux stratégies de surveillance des patients opérés (stades I à IIIA de la 6<sup>ème</sup> TNM) : une stratégie minimale basée sur la radiographie thoracique, et une stratégie maximale basée sur le scanner thoraco-abdominal injecté. Il faut noter que 82% des patients inclus avaient un CBNPC de stade I ou II. Il apparaît que les deux stratégies ne sont pas différentes en termes de survie. Pendant les deux premières années (période à risque de rechute métastatique et/ou locorégionale), la détection plus précoce des récidives par un scanner thoraco-abdominal semestriel était sans influence sur la survie. Une analyse exploratoire suggère, qu'à partir de la troisième année, le scanner thoracique annuel pourrait être plus performant, notamment pour détecter les seconds cancers. Il est nécessaire de prendre en compte la dimension liée à l'irradiation par scanners répétés, et on préférera un scanner faiblement dosé sans injection, en particulier au-delà de 5 ans. A titre de comparaison, un scanner basse dose annuel correspond à moins de 6 mois d'irradiation naturelle en France ou 50 radiographies thoraciques (127).

En pratique, on peut proposer un schéma de surveillance reposant sur un examen clinique et une imagerie thoracique tous les 6 mois (dont au moins un scanner thoraco-abdominal avec injection annuel) pendant 2 ans puis au moins un scanner thoracique annuel jusqu'à au moins 5 ans, et poursuivre au-delà tous les 1 à 2 ans par un scanner thoracique faiblement dosé et non-injecté. L'arrêt de la surveillance doit se discuter en cas d'altération significative de l'état général et/ou cognitif du patient et/ou survenue de comorbidités sévères.

**OPTION : Un scanner thoracique annuel à partir de la 3<sup>ème</sup> année pourrait être utile pour détecter les seconds cancers broncho-pulmonaires dans les CBNPC de stades I à IIIA opérés.**

### 2 CBNPC traités par radiothérapie stéréotaxique

L'objectif de la surveillance est principalement de détecter les ré-évolutions tumorales susceptibles de faire l'objet d'un traitement curatif, les deuxièmes cancers broncho-pulmonaires primitifs et les effets indésirables à court, moyen et long terme du traitement. La difficulté de la surveillance après radiothérapie stéréotaxique vient des modifications tomodensitométriques induites par l'irradiation.

<sup>36</sup> Westeel V et al. Results Of The Phase III Ifct-0302 Trial Assessing Minimal Versus Ct-Scan-Based Follow-Up For Completely Resected Non-Small Cell Lung Cancer (NSCLC). ESMO 2017, #12730



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