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.

Les modifications tomodensitométriques consécutives à la radiothérapie stéréotaxique pulmonaire, en particulier dans les 6 à 12 premiers mois, consistent en des aspects de consolidation et de verre dépoli. Au-delà de 6 à 12 mois, l'aspect tomodensitométrique peut être celui d'une fibrose post-radique classique (condensation(s), perte volumique, bronchectasies) de volume supérieur au volume de la tumeur irradiée, d'une fibrose cicatricielle, d'une fibrose pseudo-tumorale (condensation(s) bien circonscrite(s) limitée(s) à la zone d'irradiation à forte dose), d'une fibrose sous-pleurale, d'un bronchogramme aérique. Les images qui doivent faire suspecter une récidive locale sont :

- l'infiltration des structures adjacentes,
- des marges bombantes,
- la croissance persistante,
- la croissance prenant l'aspect d'une masse,
- la croissance sphérique,
- la croissance crânio-caudale,
- la perte du bronchogramme aérique.

En cas de forte suspicion de récidive locale, un TEP-Scan peut être proposé en gardant en mémoire que les lésions post-radiques peuvent être hypermétaboliques.
Un suivi clinique et par scanner thoracique (dont thoraco-abdominal avec injection au moins une fois par an) peut être proposé. Le bénéfice du scanner thoracique n'a jamais été démontré. Le premier suivi peut être proposé à 3 mois, puis à 6, 12, 18, et 24 mois puis chaque année jusqu'à 5 ans (128).
La problématique au-delà de 5 ans étant la même qu'après chirurgie d'un CBNPC, la poursuite du suivi clinique et tomodensitométrique, de préférence à l'aide d'un scanner thoracique faible dose sans injection de produit de contraste, tous les un à deux ans, peut être proposée avec l'objectif de détecter les seconds cancers broncho-pulmonaires. Les modalités d'arrêt du suivi sont identiques aux CBNPC opérés.

3 Carcinomes bronchiques de stades III traités par chimio-radiothérapie +/- immunothérapie adjuvante

La réalisation d'un premier scanner, rapidement après la fin de la chimio-radiothérapie est recommandée, pour pouvoir débuter le traitement par durvalumab dans les 42 jours. Son objectif est de poser l'indication d'un traitement par durvalumab chez les patients éligibles et après s'être assuré de l'absence de progression tumorale et/ou de toxicité pulmonaire du traitement par chimio-radiothérapie.
Par la suite, dans la mesure où le traitement a été délivré avec une intention curatrice, les objectifs sont 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. Les modifications tomodensitométriques induites par l'irradiation rendent difficile le diagnostic différentiel avec la récidive locale.
Bien que son bénéfice n'ait jamais été démontré, un suivi clinique et par scanner peut être proposé. Le premier suivi peut être proposé à 3 mois, puis à 6, 9 (en cas de traitement par durvalumab), 12, 18, 24 mois (dont au moins un scanner thoraco-abdominal avec injection annuel), puis annuellement jusqu'à 5 ans. Une imagerie encéphalique peut être envisagée chez ces malades à haut-risque à 6 mois, 12 mois et 24 mois.
La problématique au-delà de 5 ans étant la même qu'après chirurgie d'un CBNPC, la poursuite du suivi clinique et tomodensitométrique, de préférence à l'aide d'un scanner thoracique faible dose sans injection de produit de contraste, tous les un à deux ans, peut être proposée avec l'objectif de détecter les seconds cancers broncho-pulmonaires. Les modalités d'arrêt du suivi sont identiques aux CBNPC opérés.

En cas de forte suspicion de récidive, un TEP-FDG peut être proposé en gardant en mémoire que les lésions post-radiques peuvent être hyper-métaboliques.

4 Carcinomes bronchiques de stades IV

La surveillance des patients recevant un traitement systémique a pour objectif d'évaluer la réponse selon les critères RECIST, et de détecter les éventuels effets secondaires pulmonaires dans un objectif de *monitoring* thérapeutique.

Aucune donnée de la littérature ne permet de proposer un rythme de surveillance avec un niveau de preuve suffisant. Le télé-suivi des symptômes est une approche prometteuse et en cours de développement (129).

De manière arbitraire, en se basant sur les pratiques courantes, une réévaluation clinique avant chaque renouvellement de traitement s'impose et une imagerie thoraco-abdominale avec injection (et éventuellement cérébrale), ainsi que de l'ensemble des sites métastatiques initiaux peut être proposée selon un rythme trimestriel. Lorsque le même traitement, en particulier une immunothérapie ou un ITK sont poursuivis au-delà de 2 ans, l'évaluation tumorale peut être élargie à un rythme semestriel.

En cas d'immunothérapie, le 1er bilan doit être réalisé plus précocement (8 ou 9 semaines selon la molécule utilisée).

Dans le cas particulier des patients recevant une thérapie ciblée pour une altération oncogénique ou une immunothérapie prolongée, compte-tenu du risque élevé de progression encéphalique ou leptoméningée, une imagerie encéphalique (IRM cérébrale de préférence) peut être considérée dans le cadre du bilan d'évaluation, même en l'absence d'atteinte cérébro-méningée au bilan initial.

5 Suivi des patients par des outils connectés

Chez les patients éligibles et volontaires, la surveillance des symptômes des patients, par voie éléctronique, à l'aide de dispositif validé peut être utilisée lorsque l'AMM de ces dispositifs les rendra disponibles (129).

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