CLASSIFICATIONS

L'*International Mesothelioma Interest Group* avait proposé une stadification selon les principes de la classification TNM (12), classification admise par l'UICC dans sa 6eme édition.
Cette classification avait été établie à partir d'un nombre limité de cas essentiellement chirurgicaux et reposait essentiellement (pour le T) sur le *staging* chirurgical lors de la thoracotomie ; la valeur pronostique des stades ainsi définis a été confirmée par l'analyse rétrospective de séries de patients ayant subi une thoracotomie à fin d'exérèse pour mésothéliome (13). Cette validation ne concerne néanmoins que la classification pTNM, c'est-à-dire après *staging* chirurgical, mais non la stadification clinique, établie à partir de moyens non invasifs, thoracoscopie incluse. L'appréciation réelle du degré d'extension n'est en effet possible que lors d'une thoracotomie, les moyens de *staging* clinique n'étant pas suffisamment discriminants. Cette classification s'avère donc peu adéquate pour la sélection des patients candidats à une éventuelle chirurgie d'exérèse.
Ces insuffisances ont conduit à envisager une révision de la classification TNM à partir de l'analyse d'une série de 3101 patients. Elle confirme l'absence de différence de pronostic entre les T1 et les T2 de même qu'entre les stades I et II et l'impossibilité de classer correctement les patients avec les moyens de l'évaluation pré-chirurgicale qui sous-estime l'extension dans plus de 70% des cas (14). L'extension de cette série à 3519 cas dont 2460 se sont avérés éligibles pour l'analyse des facteurs pronostiques a permis à l'IASLC de proposer une révision de la classification pour l'intégrer dans la 8ème classification TNM de l'*American Joint Commission on Cancer et de l'Union for International Cancer Control staging system* (15–18). La prédominance de cas chirurgicaux inclus dans cette base de données pour une maladie où la grande majorité des patients sont traités médicalement demeure un problème majeur pour cette classification (cf annexe). La principale modification proposée pour la classification du T est de rassembler les T1a et les T1b dans une même catégorie de tumeurs classées T1 du fait de l'absence de discrimination pronostique de l'atteinte de la plèvre viscérale, impossible à évaluer cliniquement. L'évaluation du volume tumoral à partir de 3 mesures de l'épaississement de la plèvre semble avoir une forte implication pronostique quel que soit le stade mais ne sera pas encore incluse dans la prochaine classification. L'analyse du N a conduit à rassembler les N1 et N2 dans la même catégorie N1 en l'absence de différence pronostique entre ces deux catégories, qu'elles soient évaluées cliniquement ou confirmées histologiquement. Les ganglions controlatéraux à la tumeur antérieurement classés N3 sont reclassés en N2. La valeur pronostique défavorable de la présence de métastases a été confirmée malgré la faible prévalence des formes M1.
Les nouveaux stades proposés issus de cette analyse incluent les stades IA (T1N0), les stades IB (T2-3N0), les stades IIIA (T3N1), les stades IIIB (T1-3N2 ou tout T4) et les stades IV (M1) (18). La 8ème édition de la classification TNM des cancers de l'UICC fait donc référence à cette nouvelle classification depuis le 1/01/2017 (figure 1). L'ancienne classification IMIG/UICC 6ème édition est présentée en annexe.

T - Tumeur	**T1**	Tumeur limitée à la plèvre pariétale ou viscérale ou médiastinale homolatérale.
	T2	Tumeur de la plèvre pariétale ou viscérale homolatérale, avec l'un au moins des caractères suivants : • atteinte du muscle diaphragmatique, • atteinte du parenchyme pulmonaire.
	T3	Tumeur localement avancée mais potentiellement résécable : tumeur de la plèvre pariétale ou viscérale homolatérale, avec l'un au moins des caractères suivants : • atteinte du fascia endothoracique, • extension à la graisse médiastinale, • extension nodulaire isolée, résécable à la paroi thoracique, avec ou sans destruction costale, • atteinte péricardique non trans-murale.
	T4	Tumeur localement avancée non résécable : tumeur de la plèvre pariétale ou viscérale homolatérale, avec l'un au moins des caractères suivants : • atteinte diffuse ou multifocale de la paroi thoracique avec ou sans destruction costale, • atteinte trans-diaphragmatique du péritoine, • extension directe à la plèvre contro-latérale, • extension directe aux organes médiastinaux, au rachis, à la face interne du péricarde, au myocarde.
N - Adénopathies	**Nx**	Envahissement loco-régional inconnu.
	N0	Absence d'atteinte ganglionnaire.
	N1	Atteinte homolatérale des ganglions thoraciques.
	N2	Atteinte des ganglions thoraciques controlatéraux ou des ganglions sus-claviculaires homo ou controlatéraux.
M	**M0**	Pas de métastases à distance
	M1	Présence de métastases à distance

STADES :

Stade IA : T1N0 M0.
Stade IB : T2 N0 M0, T3N0M0.
Stade II : T1N1M0, T2 N1 M0.
Stade IIIA : T3N1M0.
Stade IIIB: Tous TN2, T4N0M0, T4N1M0.
Stade IV : Tous T ou tous N M1.

	N0	N1	N2	M1
T1	**IA**	**II**	**IIIB**	**IV**
T2	**IB**	**II**	**IIIB**	**IV**
T3	**IB**	**IIIA**	**IIIB**	**IV**
T4	**IIIB**	**IIIB**	**IIIB**	**IV**

Figure 1 : **Classification actuellement en vigueur des mésothéliomes pleuraux malins (UICC 8ème édition)**

Recommandations

La classification TNM définie par l'IMIG a été réactualisée dans le cadre de la 8ème révision de la classification des cancers, entrainant une modification de la définition du T et du N ainsi que de la stadification, est désormais à utiliser même si l'évaluation reste délicate pour les patients non-chirurgicaux majoritaires, notamment pour préciser le T.

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