



1.3 Quel suivi après traitement endoscopique des CIS et carcinomes micro-invasifs ?

Le taux de récurrence sur la zone traitée est compris entre 0 et 28% selon les études (147–149,151–154), sous la forme d'un nouveau CIS ou d'un carcinome invasif. Il est donc conseillé d'effectuer une surveillance par endoscopie bronchique souple 3 mois après le geste, puis tous les 6 mois pendant 5 ans en raison de ce risque de récurrence ou du risque d'apparition d'autres lésions (phénomène de cancérisation de champ). Dans cette indication, il est conseillé d'utiliser l'auto-fluorescence ou le NBI. Les auteurs de ce document préconisent également un scanner thoracique annuel pendant cette période.

2. Obstruction des voies aériennes proximales

Une bronchoscopie souple préalable reste indispensable, même rapide chez un patient très dyspnéique, afin d'évaluer précisément les caractéristiques de l'obstruction (localisation, bourgeon endoluminal ou compression extrinsèque...) mais aussi dans le but d'éliminer une paralysie bilatérale des cordes vocales responsable au moins en partie de la symptomatologie et nécessitant une prise en charge ORL de première intention (cordectomie). Un scanner thoracique, avec reconstructions 3D si possible, permet d'évaluer la viabilité de l'arbre bronchique et du parenchyme pulmonaire d'aval et d'aider au choix de la prothèse (156).

2.1 Par une tumeur maligne endoluminale bourgeonnante

- Pourquoi traiter ?

Il est recommandé de traiter une obstruction proximale par une tumeur bourgeonnante afin de diminuer la dyspnée, de lever une atélectasie, de diminuer le risque d'hémoptysie et d'infection sous-sténotique (157). La désobstruction bronchique avant tout traitement anti-cancéreux permet d'améliorer l'état respiratoire et général du patient et donc sa tolérance aux traitements. La survie est améliorée si la désobstruction est réalisée précocement (158). L'adjonction d'un traitement complémentaire paraît également améliorer la survie (158,159).

La désobstruction bronchique ramène le pronostic de la maladie à celui d'un stade équivalent sans obstruction centrale. Trois études récentes confirment l'amélioration de la dyspnée, de la capacité à l'exercice, du VEMS, de la CV forcée, et de la qualité de vie après une bronchoscopie interventionnelle pour obstruction maligne (160–162). Dans SPOC, on note une amélioration de la qualité de vie dans les 2 bras (stent/pas de stent) avec un effet prolongé dans le bras stent (163).

Dans une étude récente, les facteurs associés à une amélioration de la dyspnée et de la qualité de vie chez les patients présentant un cancer avec obstruction des voies aériennes centrales étaient, entre autres : les patients naïf de traitement, un délai court entre le diagnostic oncologique et la désobstruction, une meilleure fonction respiratoire et le fait de recevoir une chimiothérapie après la désobstruction (164).

En cas de détresse respiratoire aiguë, ces effets sont suffisamment bénéfiques et immédiats pour justifier un transfert en réanimation et l'intubation du patient dans l'attente du geste endoscopique (165,166), après évaluation du rapport bénéfice risque.

- Quand traiter/Qui traiter ?

Les critères objectifs que les auteurs de ce document retiennent pour poser l'indication d'une désobstruction bronchique sont (128,129,132,135) :

- CBNPC proximal accessible au bronchoscope rigide : trachée, carène, bronches souches, tronc intermédiaire
- Obstruction > 50% ou très symptomatique
- Voies aériennes et poumon fonctionnels et sains au-delà de l'obstruction
- PS ≤ 2 en dehors de l'altération de l'état général directement liée à l'obstruction

Le carcinome bronchique à petites cellules n'est pas une bonne indication de désobstruction en raison de l'efficacité rapide attendue de la chimiothérapie ± radiothérapie, sauf en cas d'échappement à ces traitements (132).

Une étude rétrospective récente identifie un groupe de patients bénéficiant d'une meilleure survie après bronchoscopie interventionnelle (désobstruction +/- pose stent) : les carcinomes épidermoïdes recevant un traitement spécifique (médiane = 13 mois, $p < 0,0001$). Les groupes de patients atteints d'adénocarcinome, de cancers à grandes cellules et pour lesquels la classification ASA (*American Society of Anesthesiology*) est à 4 ont le plus mauvais pronostic (0,8 et 2,7 mois respectivement, $p < 0,0001$). De manière générale, les facteurs de mauvais pronostic étaient : un score ASA élevé, l'histologie adénocarcinome, une maladie métastatique et l'absence de traitement spécifique (167).

- Quels moyens thérapeutiques ?

En bronchoscopie rigide sous anesthésie générale, plus rapide et plus sûre (possibilité d'hémostase et d'aspiration « haut débit ») que l'endoscopie souple : résection mécanique seule ou associée au laser Nd/YAG ou à la thermocoagulation. Dans cette indication, la thermocoagulation paraît aussi sûre et efficace que le laser pour un coût inférieur (168).

La cryothérapie et la photothérapie dynamique sont également efficaces mais ne sont pas adaptées à la désobstruction bronchique en raison de leur action retardée. Elles peuvent cependant être utilisées en l'absence d'obstruction critique (6,157,169).

Après désobstruction et récupération d'un diamètre $> 50\%$ de la normale, l'intérêt de la pose d'une prothèse endobronchique afin de diminuer le risque de récurrence est discuté. Des éléments de réponse sont attendus avec les conclusions de l'essai prospectif randomisé SPOC (promoteur CHU St-Etienne). Les premiers résultats montrent une diminution de 29% du risque de ré-obstruction ou de décès ($HR=0,71$) dans le bras « endoprothèse ». Cet impact est statistiquement significatif dans le sous-groupe de patients ayant déjà reçu une ligne de traitement. Dans l'essai prospectif randomisé SPOC (promu par le Pr Vergnon), la désobstruction améliore tous les paramètres de qualité de vie et ce résultat est prolongé jusqu'à un an par la pose de prothèses. En termes de risque de ré-obstruction, la pose de prothèse après désobstruction a un intérêt si le patient n'est pas en première ligne de chimiothérapie. Si par contre une première ligne est appliquée (doublets avec sels de platine) l'efficacité de ce traitement fait que le bénéfice de l'effet barrière de la prothèse n'existe plus statistiquement (163).

La radiothérapie permet de lever une atélectasie dans 54% des cas (170). Si une radiothérapie externe est envisagée, il faut privilégier, dans la mesure du possible, la pose d'une prothèse en silicone.

La curiethérapie endobronchique par endoscopie souple ne doit pas être utilisée en situation d'urgence car son action est retardée. Elle est efficace seule (171–174) mais ses résultats sont meilleurs si elle est combinée à une radiothérapie thoracique externe (139) ou à une désobstruction par bronchoscopie rigide. Cependant une revue récente de 14 essais cliniques randomisés ne permet pas de conclure à un intérêt de la curiethérapie endobronchique dans le contrôle des symptômes ou en terme de survie en comparaison d'une radiothérapie externe ou d'une désobstruction par laser (175). L'utilisation en routine de la curiethérapie endobronchique dans la prise en charge initiale d'une obstruction maligne n'est donc pas recommandée (176).

2.2 Par une compression tumorale extrinsèque

La pose d'une prothèse endobronchique est indiquée si le calibre trachéal ou bronchique est réduit de 50% ou plus (141,177). Elle permet de diminuer la dyspnée (178) et d'améliorer les valeurs spirométriques (179). Mise en place quand le Performance Status est < 4 , elle pourrait améliorer significativement la survie (180). Dans cette indication, seules les prothèses en silicone ou les prothèses métalliques couvertes sont

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Endoscopie

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