# TOXICITE PULMONAIRE DES IMMUNOTHERAPIES

Les traitements anti-cancéreux par immunothérapie (anti-PDL1, anti-PD1 et anti-CTLA4) ont un profil de toxicité très différent de celui des chimiothérapies cytotoxiques.
Les toxicités pulmonaires comprennent les pneumopathies interstitielles diffuses (syndrome de détresse respiratoire aigüe, fibrose pulmonaire, pneumopathie organisée), des granulomatoses sarcoïdose-like et des pleurésies (127,128).

## 1. Evaluation (PID)

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|---|---|
| **Grade 1** | Asymptomatique, diagnostic clinique ou radiologique uniquement, pas de traitement nécessaire |
| **Grade 2** | Symptomatique, traitement nécessaire, gène fonctionnelle |
| **Grade 3** | Symptômes sévères, limitant les activités quotidiennes, oxygénothérapie nécessaire |
| **Grade 4** | Conséquences vitales ; intervention urgente requise. |
| **Grade 5** | Décès |

**Tableau 32 – Classification des PID selon la classification CTCAEV5.0**

## 2. Prise en charge

L'incidence des toxicités pulmonaires n'est pas négligeable : elle est estimée de 3 à 12% en fonction des séries dont 1 à 2% de grade 3 et 4 (127,129,130). Il est par conséquent recommandé de disposer d'une EFR complète avant traitement.
Ces toxicités pulmonaires sont plus fréquentes en cas d'association de traitement (anti-PD1 ou -PDL1 et anti-CTLA 4) (127).
La majorité des toxicités surviennent dans les 3 premiers mois de traitement. Lors de la survenue d'une toxicité pulmonaire, la médiane de durée du traitement était de 2,3 (0,2-27,4) mois dans une cohorte rétrospective de 64 patients (131).
Le tableau clinico-radiologique n'étant pas pathognomonique, il est important d'éliminer d'autres étiologies (notamment infectieuses et cardiologiques) avant d'envisager un traitement spécifique (127) (Figure 9). Dans cette même cohorte, 31 ont eu un lavage broncho-alvéolaire interprétable. La grande majorité avait une alvéolite mixte à prédominance lymphocytaire. Parmi ces 31 patients, 24 avaient un taux de lymphocytes supérieur à 15%, 5 avaient un taux d'éosnophiles supérieur à 5% et 20 avaient un taux de neutrophiles supérieur à 3 %.
Le traitement repose sur une corticothérapie (de préférence précédée par une antibiothérapie d'épreuve) et/ou la suspension ou l'arrêt définitif de l'immunothérapie. La prise en charge d'une toxicité de type pneumopathie interstitielle aigue est illustrée par la figure 10 (127,132).

### Recommandation

**- Il est recommandé de réaliser une EFR complète avant immunothérapie.**

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