Cours DES pneumologie socle

Imagerie oncologique

Bilan initial du cancer
Classification TNM

GROUPE HOSPITALIER PARIS SAINT-JOSEPH
Hôpital Paris Saint-Joseph

Dr Caroline Caramella

Bilan d'extension Recommandations

1- TDM avec injection
- Thoracique et abdominale

2- En l'absence de métastase visible et si le patient est considéré curable
- PET-TDM
- Imagerie cérébrale

- 65% des patients sont métastatiques ou localement évolués au diagnostic

CHEST Supplement
DIAGNOSIS AND MANAGEMENT OF LUNG CANCER, 3RD ED: ACCP GUIDELINES

Methods for Staging Non-small Cell Lung Cancer

Diagnosis and Management of Lung Cancer, 3rd ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines

Stratégies thérapeutiques

20% - S5a 50%

Cancer localisé

= quelle que soit la taille de la tumeur, pas ou peu de ganglions thoraciques

- Patient opérable (/fonction)

  = Chirurgie

- Patient non opérable = Radiothérapie

20% - S5a 25%

Cancer localement avancé

= quelle que soit la taille de la tumeur, trop de ganglions

Radio-chimiothérapie

Visée CURATIVE

60% - S5a 4%

Cancer métastatique

Traitement systémique

- chimioT
- immunoT
- Thérapie ciblée

Visée PALLIATIVE

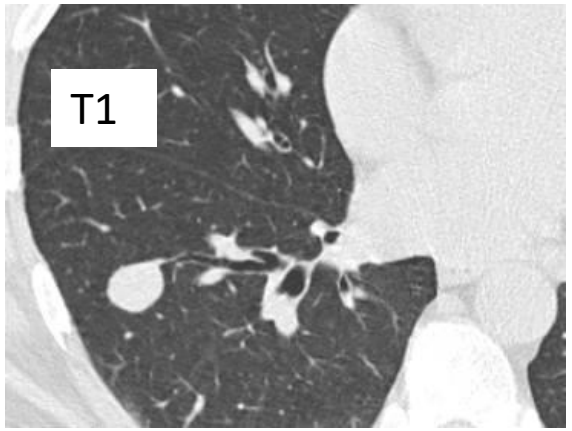
Taille

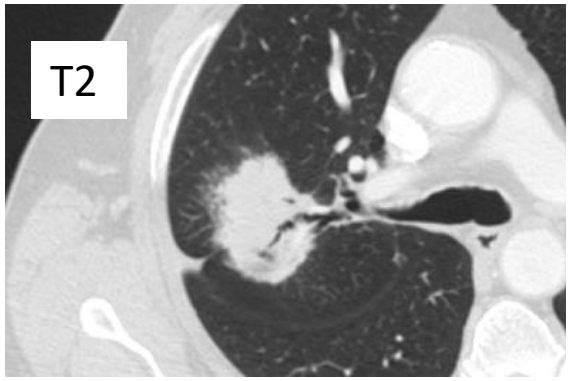
T1: < 3 cm (T1a < 1cm; T1b 1-2 cm; T1c)

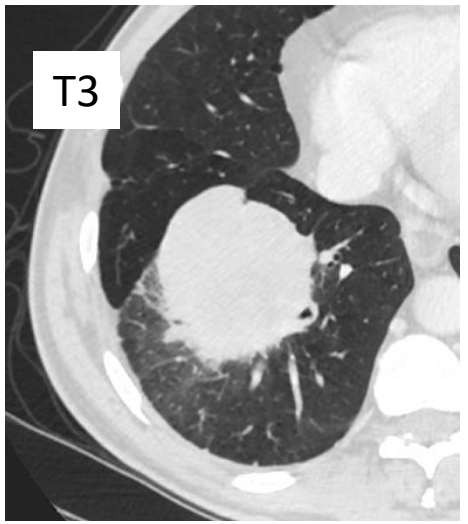
T2: 3 à 5 cm (T2a <4 cm ; T2b)

T3: 5 à 7 cm

T4: > 7 cm

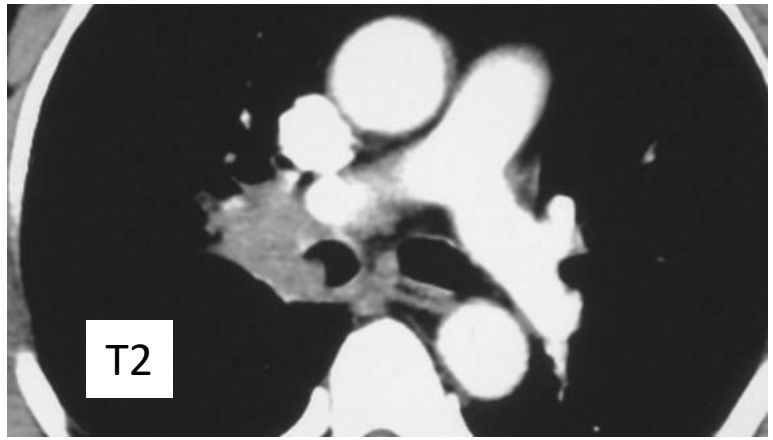




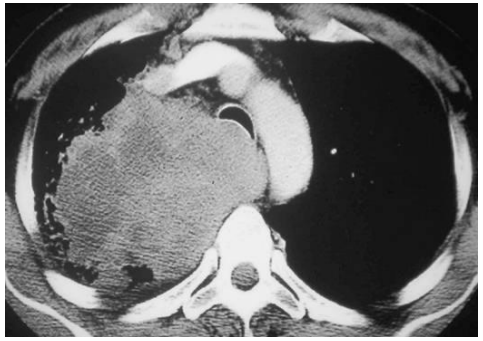


Trachée-Carène

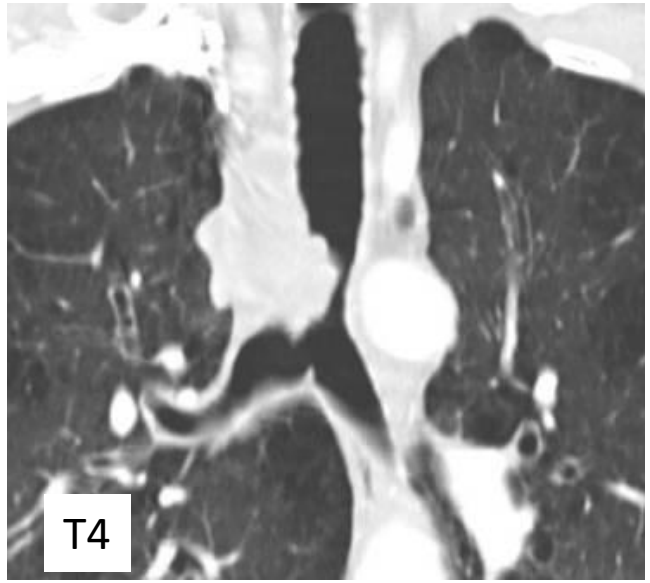
T2: 3 à 5 cm (T2a <4 cm ; T2b)
ou atteinte de la bronche souche



T3: 5 à 7 cm

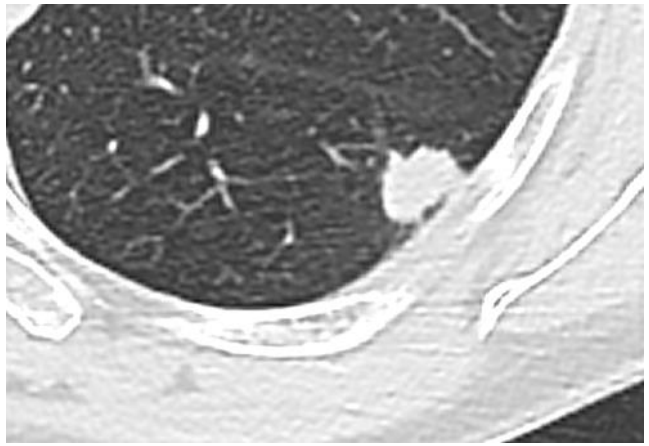


T4: > 7 cm
Envahissement trachée, carène



Plèvre

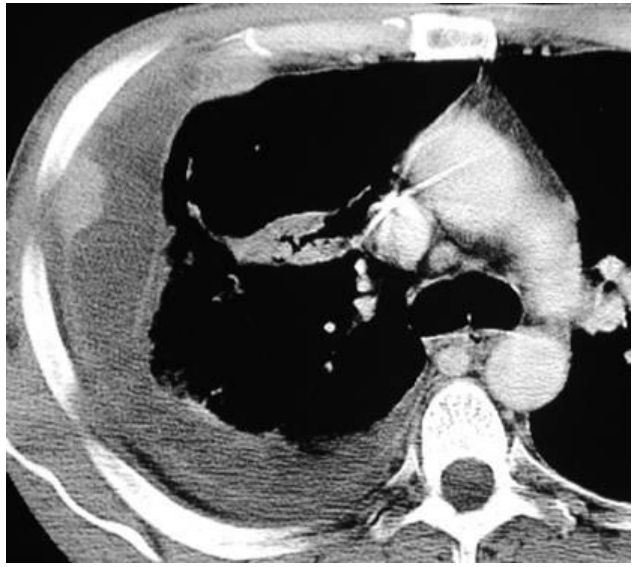
T2: 3 à 5 cm (T2a <4 cm ; T2b)
ou atteinte de la bronche souche
ou invasion de la plèvre viscérale

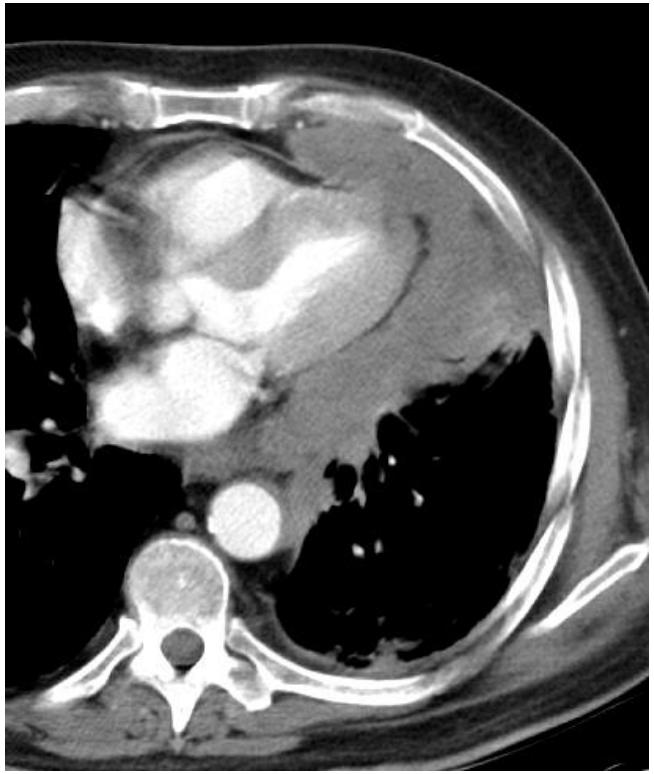


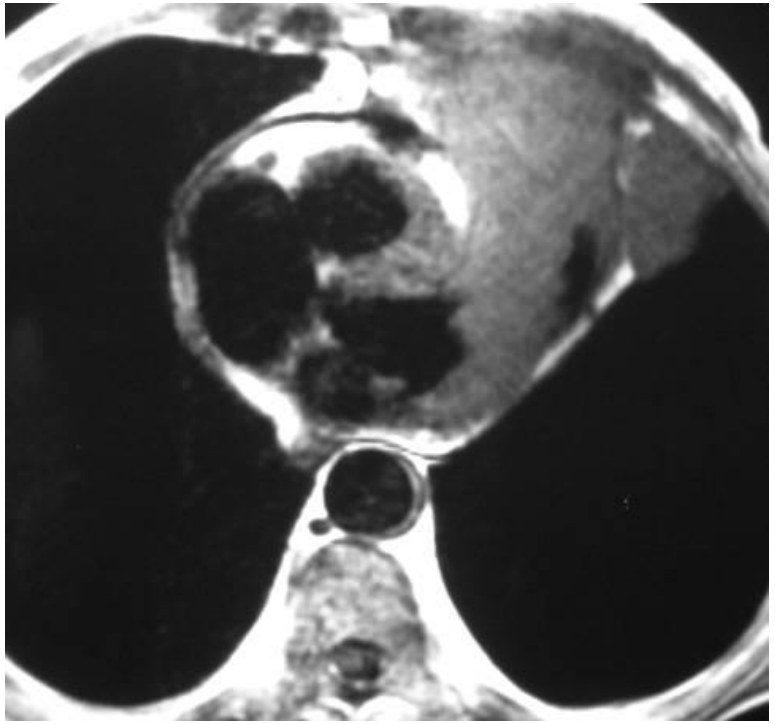
T3: 5 à 7 cm
plèvre pariétale

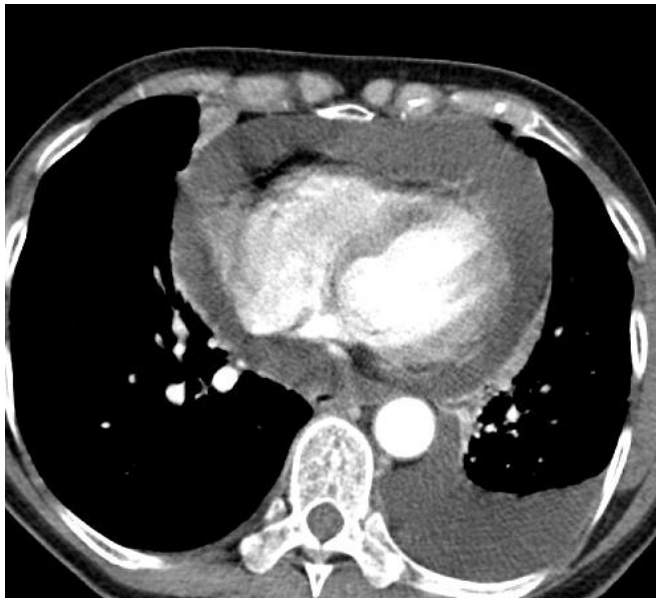
T4: > 7 cm
Envahissement trachée, carène

M1a: épanchement pleural malin/nodules pleuraux









Péricarde:

T3 envahissement
M1a épanchement malin

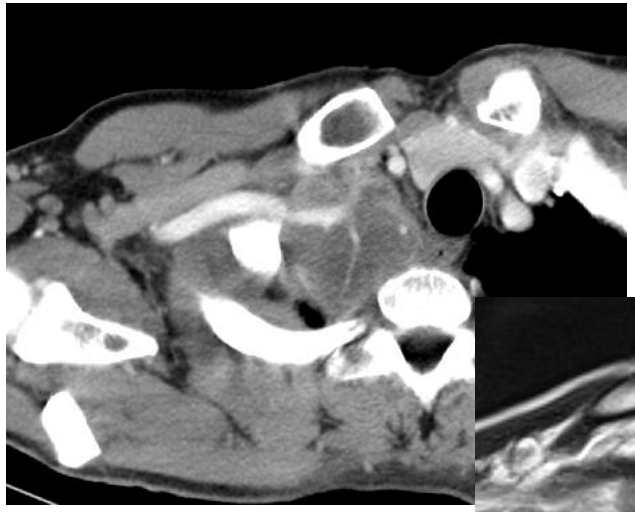
Atélectasie

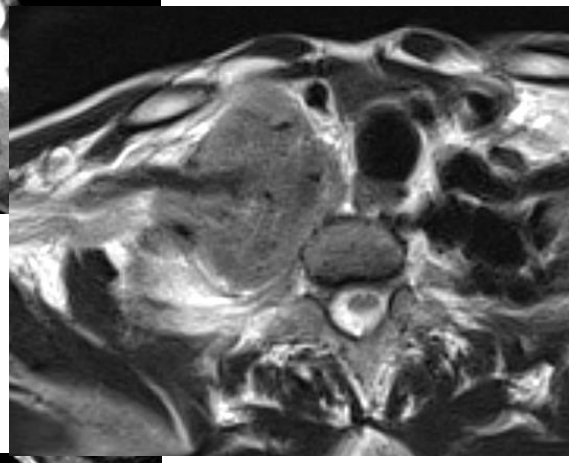
T2: 3 à 5 cm (T2a <4 cm ; T2b)
ou atteinte de la bronche souche
ou invasion de la plèvre viscérale
ou atélectasie locale (< 1 poumon)

T3: 5 à 7 cm

Paroi

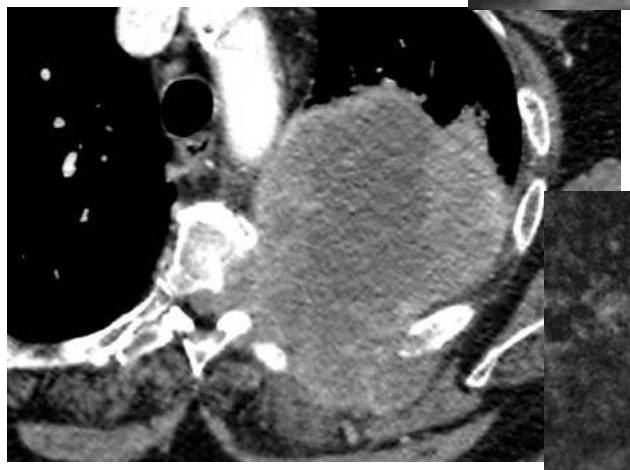
T3: 5 à 7 cm
ou envahissement de la paroi

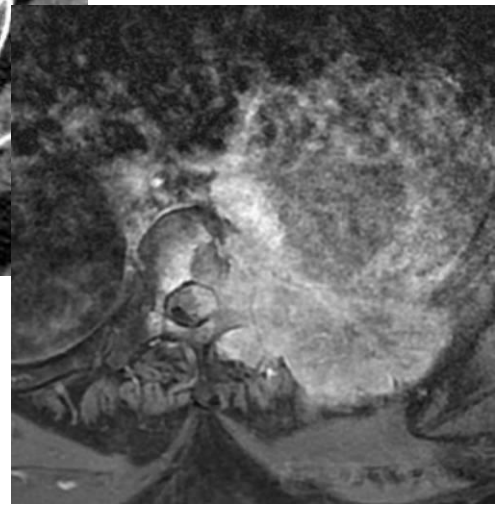




IRM nécessaire

T4: > 7 cm
Envahissement trachée, carène
ou envahissement corps vertébral





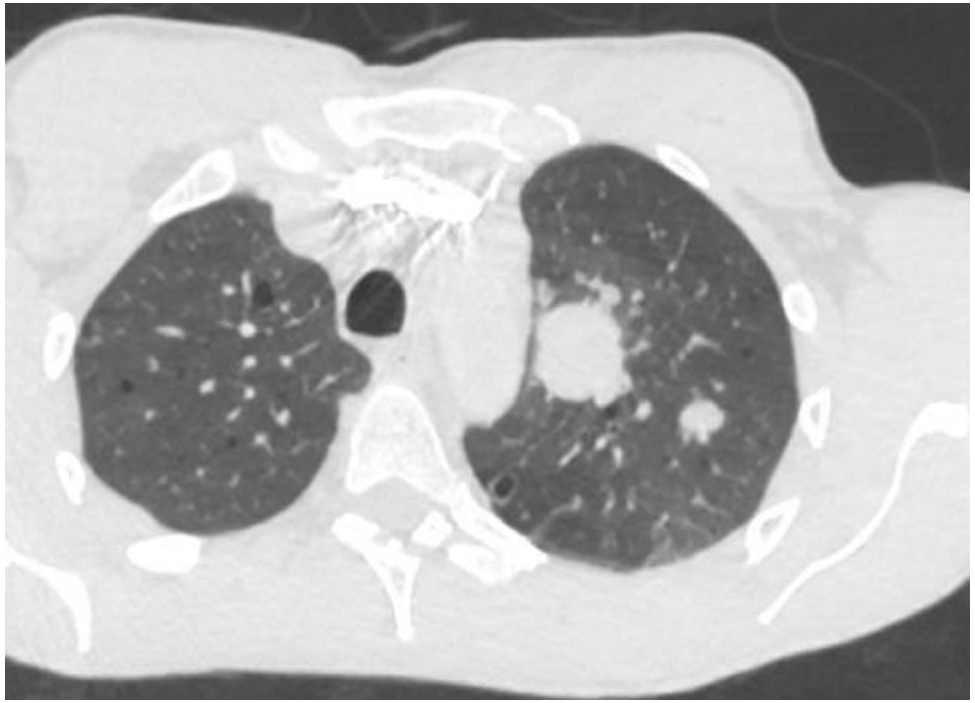
Nodule tumoral supplémentaire

T3: 5 à 7 cm
ou envahissement de la paroi
ou 1 nodule tumoral **dans le même lobe**

T4: > 7 cm
Envahissement trachée, carène
ou envahissement corps vertébral
ou 1 nodule tumoral **dans un autre lobe** du même poumon

M1a: nodule distinct dans le poumon **controlatéral**

Attention

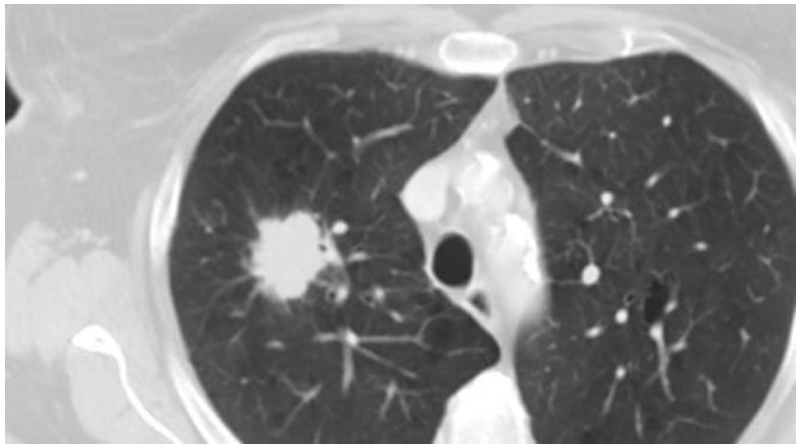


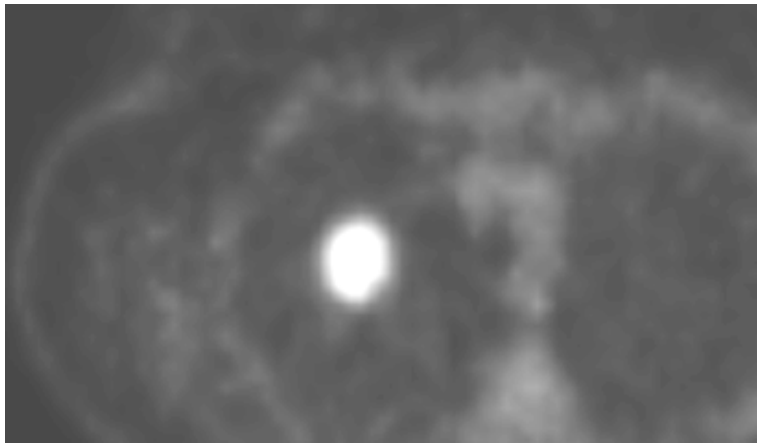
T3 ?

2 adénocarcinomes
Profil moléculaire distinct
lobectomie curage
2 x pT1N0

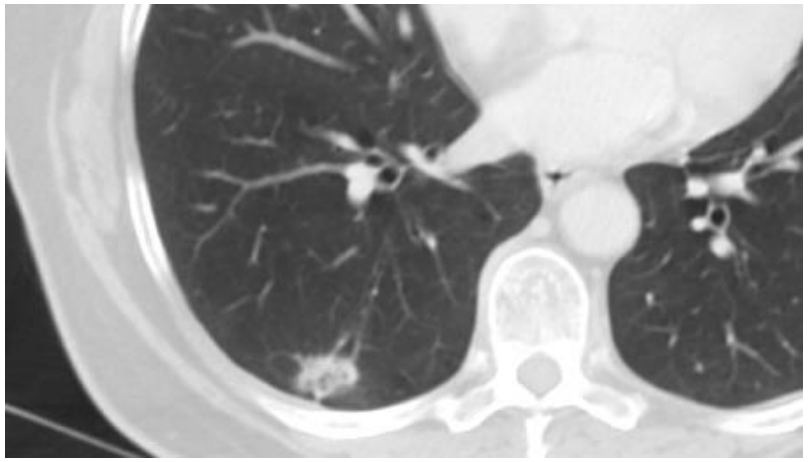
1-10% de 2ème cancer primitif synchrone

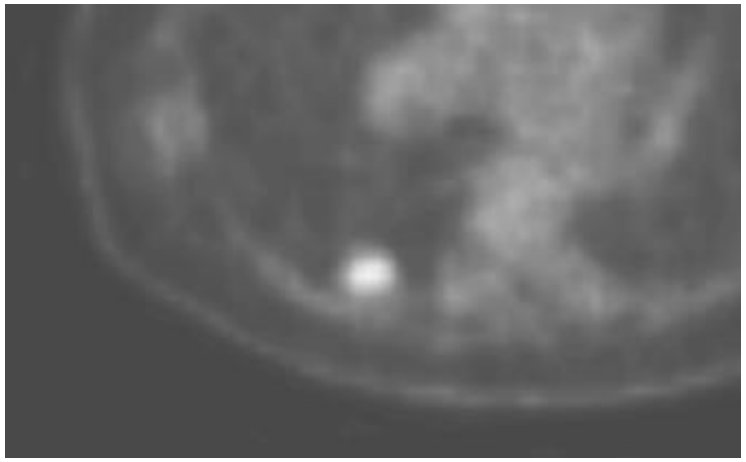
Aziz . Eur J Cardiothorac Surg 2002





T4?
CPC





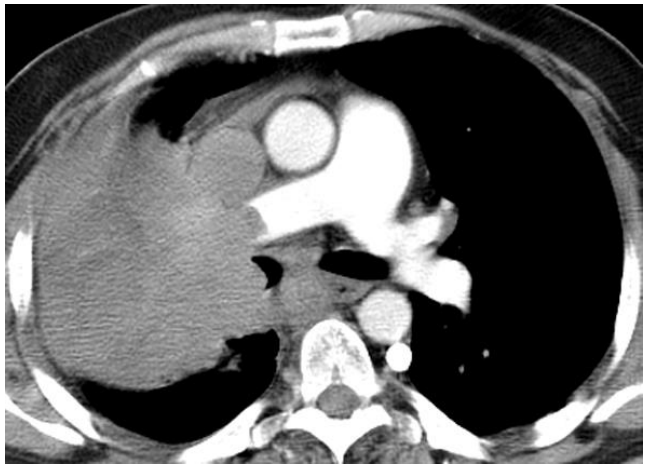
adénocarcinome

Autres T4

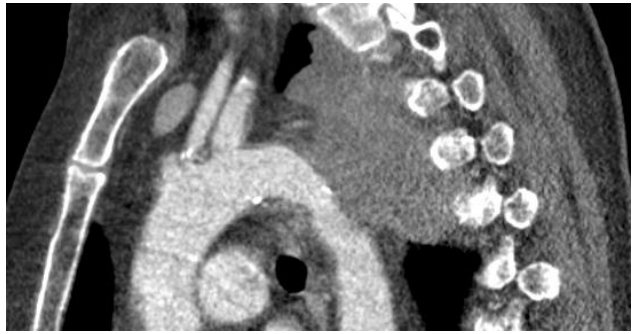
Oesophage

Myocarde

Autres T4



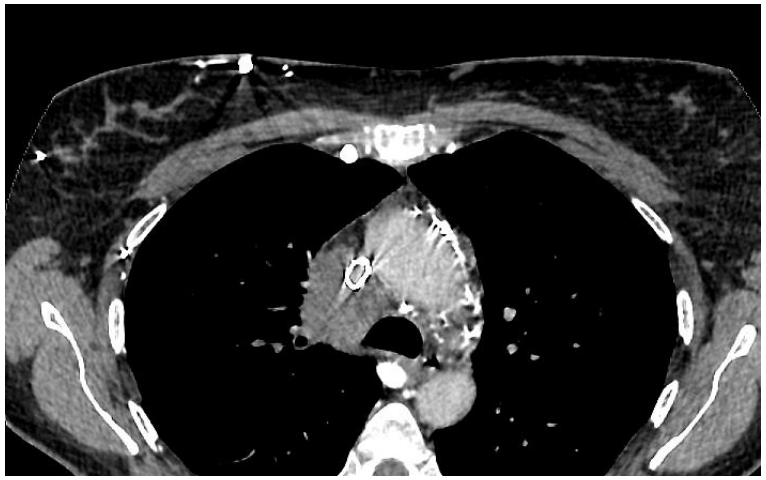
Aorte



Artères/veines pulmonaires

Contre-indication bevacizumab (Avastin ®)

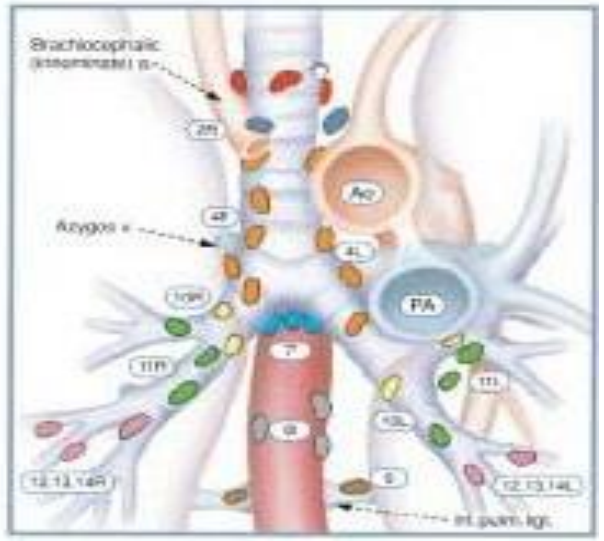
VCS

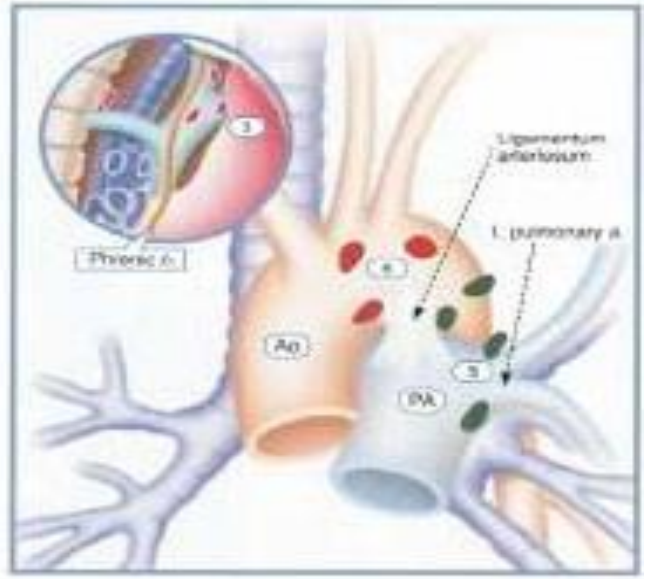


La stadification N

- TDM insuffisante = TEP scanner FDG
- Critère de taille en petit axe
  - > 10 mm en général
  - > 13 mm dans la loge de Barety et en sous carénaire
  - > 6 mm en hilaire
- Sensibilité CT 69%, TEP 79%
- Spécificité CT 77%, TEP 91%

Ikezoe J JCAT 1990
Dwamena Radiology 1999



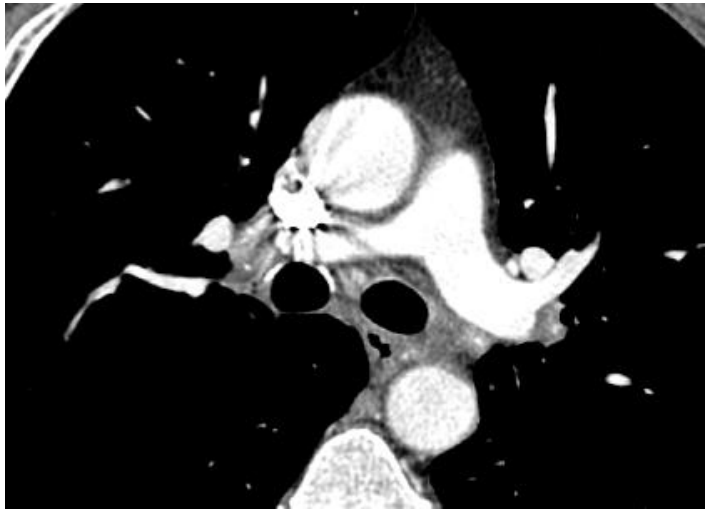


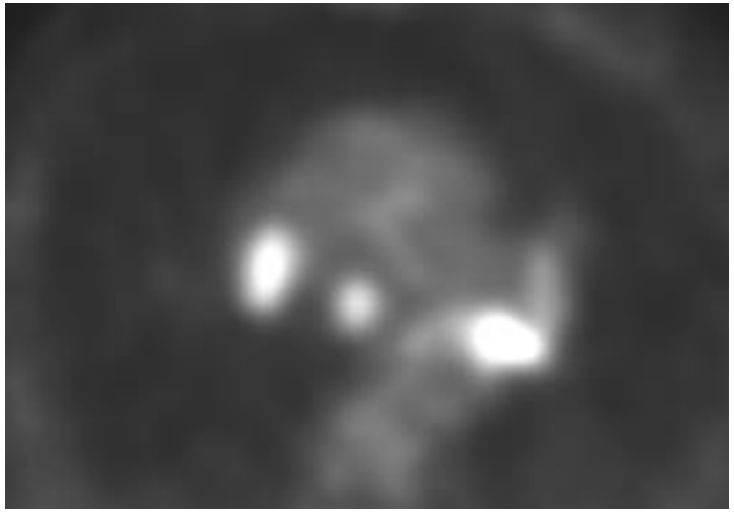
N1: adp intrapulmonaire, péribronchiques ou hilaire homolatérales

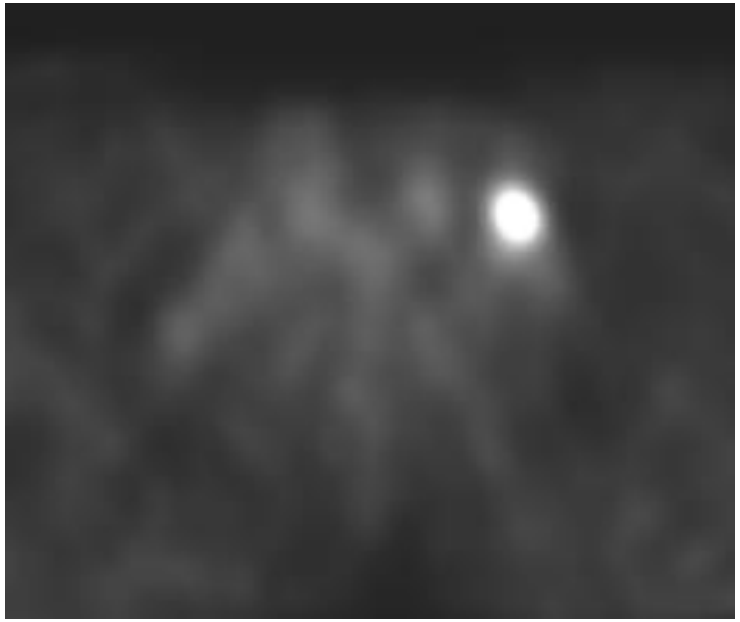
N2: adp médiastinale homolatérale ou **sous carénaire**

N3: adp médiastinale controlatérale ou **sus claviculaire**

Autres adp= M1







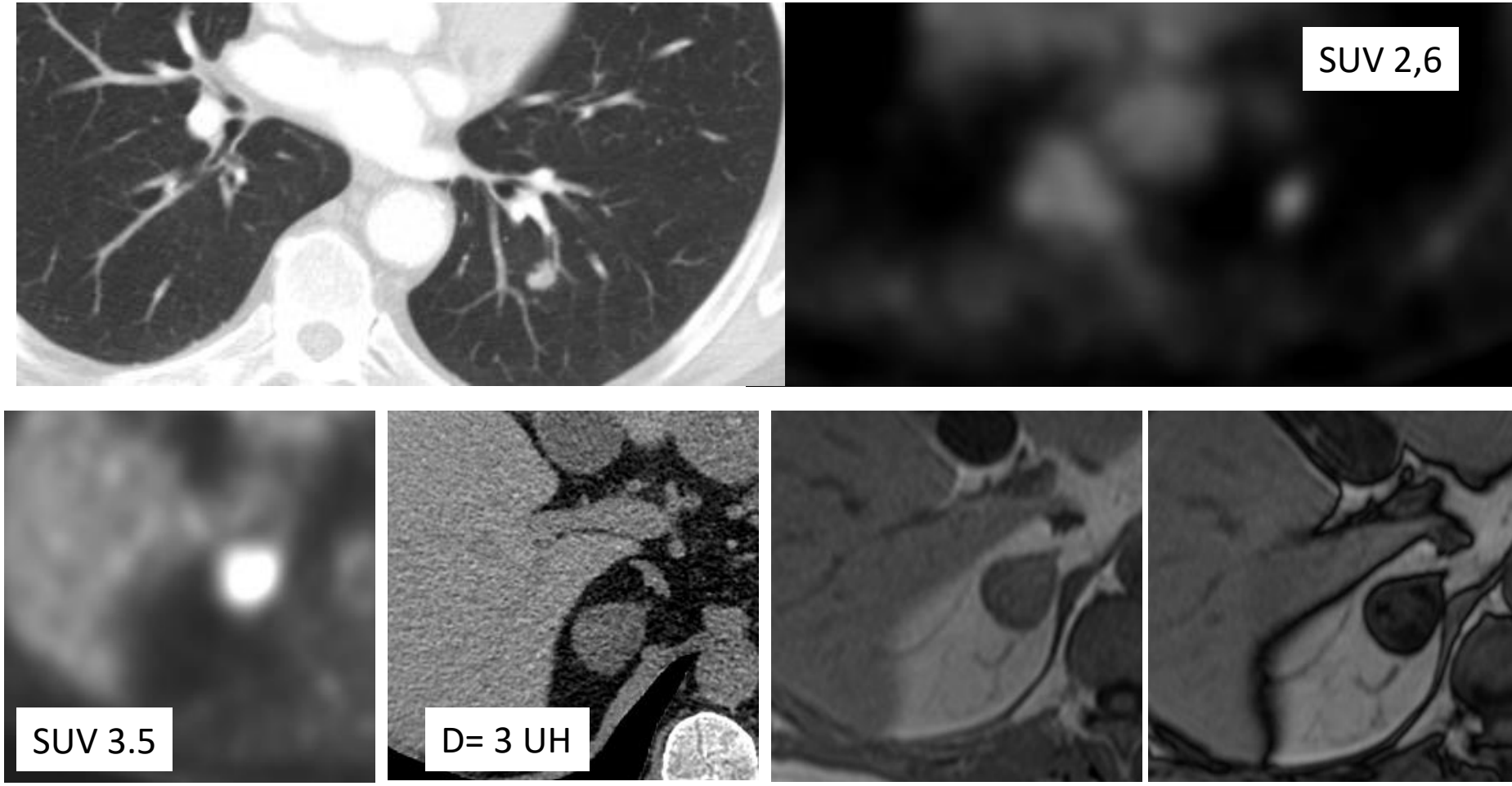
M1

- M1a: métastase(s) **thoracique(s):** nodule(s) pulmonaire(s), plèvre, péricarde
- M1b : 1 seule métastase **extra thoracique**
- M1c: > 1 métastase extra thoracique

Attention aux faux + du PET

- **Surrénale : Adénome jusqu'à SUV 5.4**

Boland Radiology. 2011
Perri Am J Roentgenol. 2011



Conclusion: A quoi sert la TNM ?

Classification basée sur le pronostic

Ne jamais considérer un patient comme non curable a priori

Le patient est-il curable?

- Stadification T
- Stadification N

Le patient est-il ***vraiment*** métastatique?

- Oligo-métastatique?

Pour rappel

- 65% des cancers bronchiques sont découverts à un stade localement avancé ou métastatique
- Alors que le dépistage permettrait de les diagnostiquer à un stade curable