Place de la chirurgie dans le traitement des tumeurs des VADS

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"malade est malade"
Introduction
Introduction
A tendency for increasingly younger patients to develop larynx and hypopharynx carcinomas was observed. Most patients had stage IV disease but no trend for a percentage increase in locally advanced tumors was observed. A significant increasing trend in hypopharyngeal cancer has been seen in males.

Facteurs de risque :

Tabac

Alcool
Introduction

Type

- Cavité buccale: 30%
- Oropharynx: 25%
- Larynx: 25%
- Hypopharynx: 15%
- Rhinopharynx: 5%
Place de chirurgie ?
Traitement chirurgical
Traitement chirurgical

Rhinopharynx
Oropharynx
Cavité buccale
(Pharyngo)larynx
Glandes salivaires
Thyroïde
Trachée
### Traitement chirurgical

**Classification TNM de l’UICC (Genève, 1997)**

<table>
<thead>
<tr>
<th>T (tumeur)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1</td>
<td>T ≤ 2 cm</td>
</tr>
<tr>
<td>T2</td>
<td>2 cm &lt; T ≤ 4 cm</td>
</tr>
<tr>
<td>T3</td>
<td>T &gt; 4 cm</td>
</tr>
<tr>
<td>T4</td>
<td>T envahissant les structures adjacentes (par exemple, corticale osseuse, musculature extrinsèque de la langue, sinus maxillaire, peau).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N (Nodes) adénopathies métastatiques</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>pas d’adénopathie métastatique</td>
</tr>
<tr>
<td>N1</td>
<td>N ≤ 3 cm</td>
</tr>
<tr>
<td></td>
<td>unique, homo-latérale</td>
</tr>
<tr>
<td>N2</td>
<td>N ≤ 6 cm</td>
</tr>
<tr>
<td>N2a</td>
<td>3 cm &lt; unique, homo-latérale ≤ 6 cm</td>
</tr>
<tr>
<td>N2b</td>
<td>multiples homo-latérales ≤ 6 cm</td>
</tr>
<tr>
<td>N2c</td>
<td>bilatérales ou contro-latérales ≤ 6 cm</td>
</tr>
<tr>
<td>N3</td>
<td>N &gt; 6 cm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M (métastase)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MO</td>
<td>Absence de métastase viscérale</td>
</tr>
<tr>
<td>M1</td>
<td>Présence de métastase viscérale</td>
</tr>
</tbody>
</table>
Adénopathies cervico-faciales

Traitement chirurgical
Introduction
Nasopharynx

T1-2N0

Radiothérapie

T1-2 N1-2

Rxchimio

T3-T4N3
Nasopharynx

- Récidive locale : Chirurgie de rattrapage 38%

- Récidive ganglionnaire : évidement ganglionnaire
  Survie à 5 ans : 38% à 67%

Il y a préparé le podium des présidentielles. Il paraît qu'il y aura deux vainqueurs cette année.
Oropharynx

cT1-T2

Radiothérapie

Chirurgie de rattrapage

Chirurgie T+N

Radiothérapie adjuvante
Oropharynx

cT3-4

CT/RT

Chirurgie de rattrapage

Chirurgie

Traitement adjuvant
Traitement

Chirurgie

Radio(chimiothérapie)
Traitement chirurgical
T1 T2 T3 ou T4 ≤ à 4 cm infiltrant les muscles extrinsèques de langue et chirurgie possible ?

Non

Chirurgie impossible

Oui

Chirurgie possible

RTE T et N
+ chimio concomitante
Option : RTE + curie pour les T1T2N1 (petite taille)

Scanner cervico-facial et thoracique à 3 mois

Résidu N ?

Non

Chirurgie N si T contrôlée

Oui

Surveillance
Cavité buccale
Traitement unimodal

Chirurgie conservatrice :

Exérèse par voie endoscopique (laser $\text{CO}_2$) pour les petites tumeurs bien exposables avec mobilité conservée

Chirurgie partielle transcartilagineuse (exemple : cordectomie, frontolatérale, Tücker...) ou subtotale reconstructive (exemple : crico-hyoïdo-épiglotto-pexie ou CHEP, crico-hyoïdo-pexie ou CHP)

Radiothérapie
Résultats
Radiotherapy for T1 and T2 laryngeal cancer: the Dalhousie University experience

PATIENTS AND METHODS:

A total of 373 cases of laryngeal cancer reported in Nova Scotia from 1990 through 2001 were reviewed. All cases were classified by T stage and affected sites (glottic = 233, supraglottic = 136, subglottic = 4). We focused on those patients with T1 and T2 cancers of both the glottis and the supraglottis who received radiotherapy as a primary modality.

RESULTS:

Eighty-eight percent (150 of 170) of T1/T2 glottic cancers were first treated with radiotherapy. Seventy-one percent (80 of 112) and 63.3% (24 of 38) of T1 and T2 glottic cancers, respectively, were controlled by radiation, with an average follow-up of 37 months. Of those T1 glottic cancers unsuccessfully treated by radiotherapy, 14 underwent surgical salvage, with 9 of these patients being free of disease following an average of 57 months. For T2 glottic cancers unsuccessfully treated by radiotherapy, five patients underwent surgical salvage, of whom four (68.4%) were free of disease after an average follow-up of 62 months. Seventy-five percent of T1 (3 of 4) and 70.6% (25 of 35) of T2 supraglottic cancers were successfully controlled by radiotherapy. Salvage surgery was attempted in five patients; however, all patients except one died of disease.
Role of radiotherapy in early glottic carcinoma.

BACKGROUND:

Early glottic carcinoma has a high local control prospect with radiotherapy. This review evaluates a single center's experience.

RESULTS:

This review of 522 patients includes 24 with Tis, 356 with T1, and 142 with T2. Ultimate local control rates were as follows: Tis 87.5%, T1 94.7%, and T2 84.5%.

CONCLUSION:

Definitive radiotherapy for early glottic carcinoma provides high local control rates, with the option of surgical salvage to achieve ultimate local control.
Radiotherapy versus surgery for early T1-T2 glottic carcinoma

To compare surgery and radiotherapy as treatments for early T1-T2 glottic cancer in terms of local and regional control, complications, cost, and voice outcome.

RESULTS: The recurrence rate following primary treatment was 37.5% for group 1 and 22% for group 2. Group 1 patients presented with 25% of local complications (vocal fold scars) and no systemic complications. Patients in group 2 presented with local and systemic complications: 35% for local and 27% for systemic.

CONCLUSION:

Surgery and radiotherapy are both very effective in terms of local and regional control for early glottic carcinoma. However, surgery tends to be more cost-effective, with less complications and possibly a better voice outcome.

Traitement multimodal

Radiochimiothérapie concomitante

Chirurgie radicale :

Laryngectomie totale

Laryngectomie totale plus ou moins étendue selon l'extension tumorale aux structures anatomiques adjacentes avec possibilité de mise en place d'un implant phonatoire immédiatement ou dans un deuxième temps.
Résultats
T4a laryngeal cancer survival: retrospective institutional analysis and systematic review.

METHODS:

- Records of 108 laryngeal cancer patients treated by total laryngectomy were reviewed. pT4a cases treated by primary total laryngectomy between 1998 and 2010 were included. Overall and disease-free survival at 2 and 5 years were reported.

RESULTS:

- At 2 years, overall and disease-free survival were 81.3% and 78%, respectively. The 5-year overall and disease-free survival rates were 60%.

CONCLUSIONS:

- Primary total laryngectomy provides a high survival rate for pT4a laryngeal cancer.

Laryngoscope. 2014 Jul;124(7):1618-23
Traitement unimodal

Radiothérapie

Chirurgie conservatrice :

éxérèse par voie endoscopique (laser C0₂) pour les petites tumeurs bien exposables avec mobilité conservée

chirurgie partielle par voie externe (exemple : Alonso, Paul André).
Chirurgie

Pour les 2 localisations et sauf cas particulier, la chirurgie conservatrice n’est indiquée :

- qu’en l’absence d’atteinte cartilagineuse
- qu’en l’absence de trouble de la mobilité laryngée
- quand les suites fonctionnelles (respiration, déglutition) postopératoires semblent acceptables.
Chirurgie radicale :

pharyngo-laryngectomie totale circulaire avec ou sans thyroïdectomie totale et reconstruction pharyngée par lambeau libre ou musculo-cutané.
Predictive factors for pharyngocutaneous fistulization after (pharyngo) laryngectomy.

Postoperative complications, especially pharyngocutaneous fistulization (PCF), are more frequent after total laryngectomy (TL) performed for salvage after (chemo)radiotherapy than after primary TL. The aim of this study was to identify the incidence of PCF, predictive factors for PCF, and the relationship of PCF to survival.

RESULTS:

The overall incidence of PCF was 26.3% (57 of 217 cases). The incidence of PCF after primary TL was 17.1% (12 of 70), that after salvage TL was 25.5% (25 of 98).

CONCLUSIONS:

Incidence of PCF after TL is significantly higher in patients with hypopharynx cancer, previous chemoradiotherapy, a low albumin level, more-extended pharyngeal resection, or pharynx reconstruction. The occurrence of PCF does not influence the rate of survival.

Les autres cancers ORL

Traitement chirurgical
## Glandes salivaires

<table>
<thead>
<tr>
<th>Site tumoral</th>
<th>T1 -2, bas grade</th>
<th>T1-T2 haut grade</th>
<th>T3</th>
<th>T4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parotide</td>
<td>Parotidectomie</td>
<td>Parotidectomie+ curage ganglionnaire (N+) + RX</td>
<td>Parotidectomie+ curage ganglionnaire+ RX</td>
<td>Parotidectomie+ curage ganglionnaire+ RX</td>
</tr>
<tr>
<td>sousmaxillaire</td>
<td>Exérèse</td>
<td>Exérèse radicale+ RX</td>
<td>Exérèse radicale+curage ganglionnaire + Rx</td>
<td>Exérèse chirurgicale+ curage ganglionnaire+Rx</td>
</tr>
</tbody>
</table>
Cancers thyroïdiens
Cancers thyroïdiens

<table>
<thead>
<tr>
<th>Type</th>
<th>Survie 5 ans</th>
<th>Survie 10 ans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stade I</td>
<td>Stade II</td>
</tr>
<tr>
<td>Papillaire</td>
<td>100 %</td>
<td>100 %</td>
</tr>
<tr>
<td>Folliculaire</td>
<td>100 %</td>
<td>60 %</td>
</tr>
<tr>
<td>Médullaire</td>
<td>100 %</td>
<td>98 %</td>
</tr>
<tr>
<td>Anaplastique</td>
<td></td>
<td></td>
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Cancers thyroïdiens
Conclusions

We ALL have a bit of the ‘Big Picture!’