

TEP FDG / ORL

Indications: cas cliniques

Dr HECTOR Eric

Dr MEURIOT Sabine

Dr VOITOIT Jean Baptiste

Service de médecine nucléaire IMANORD HPVA

Service de médecine nucléaire GIE NEI hôpital de Roubaix

GEI TEP de l'Union Roubaix

Place de la TEP FDG dans la prise en charge des tumeurs ORL

- diagnostic de la tumeur primitive
- bilan d'extension initial

Référentiel régional de RCP ONCO hauts de France cancers des voies aérodigestives supérieures

Indication d'une TEP FDG Bilan initial	Si stade T	Ou si N
Cavité buccale	T3, T4 (>4 cm)	> N2b ou si adp cervicale basse
Oropharynx	T2, T3 ,T4 (>2 cm)	> N2b ou si adp cervicale basse
Hypopharynx	T3, T4 (>4 cm)	> N2b ou si adp cervicale basse
larynx	T3, T4 (envahissement)	> N2b ou si adp cervicale basse
Rhinopharynx	systematique	
Adp sans porte d'entrée	systematique	
Cavité naso sinusienne	option	
Glande salivaire	option	

Place de la TEP FDG dans la prise en charge des tumeurs ORL

- diagnostic de la tumeur primitive
- bilan d'extension initial
- adp cervicale sans primitif retrouvé
- dans le staging
- aide à la détermination des volumes en radiothérapie
- évaluation de la réponse au traitement
- surveillance
- diagnostic de la récurrence

-sensibilité de la TEP

95% pour la détection de la lésion primitive

70 à 90% pour atteinte ganglionnaire

-Détection des atteintes à distance

lésions II

ou lésion primitive synchrone (environ 8%)

-changement thérapeutique dans 10% des cas

-Adp sans primitif : mise en évidence du primitif dans 1 cas sur 4 et changement d'orientation thérapeutique dans 20% des cas

En pratique

- Bilan d'une adénopathie sans porte d'entrée
+++++
- BE des grosses tumeurs localement avancées
- Recherche d'un second cancer synchrone

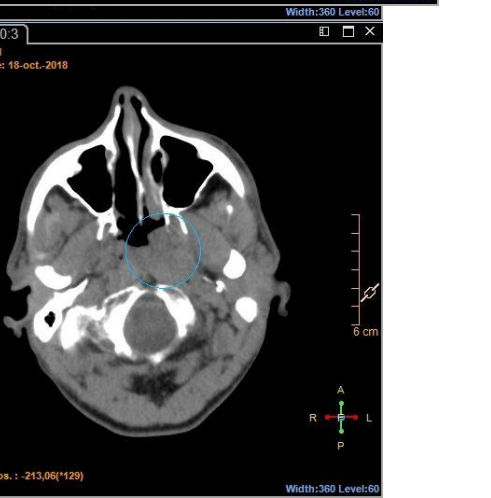
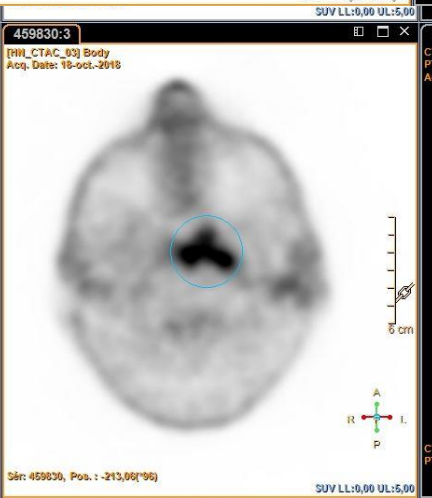
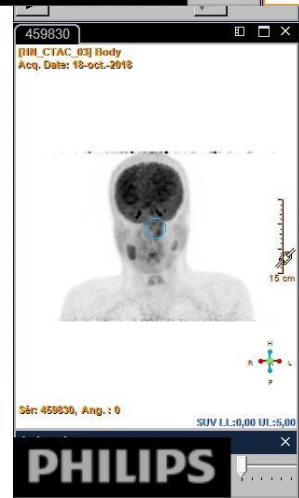
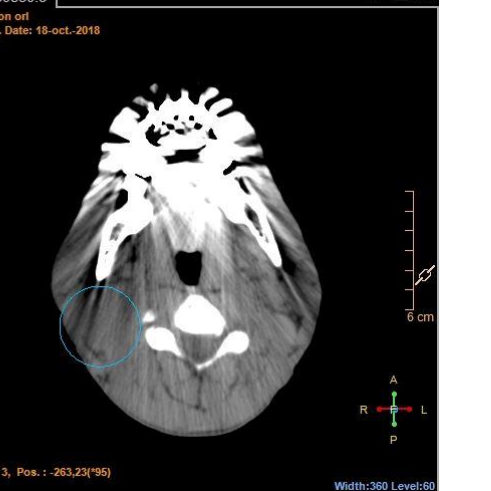
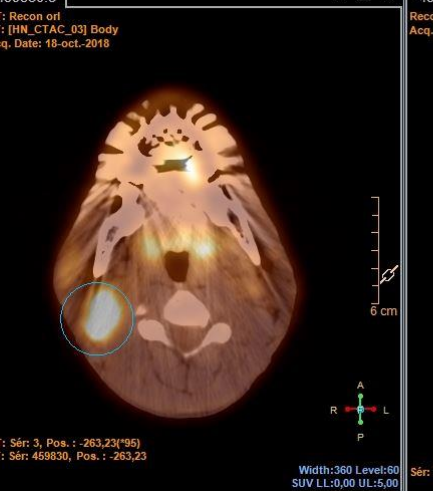
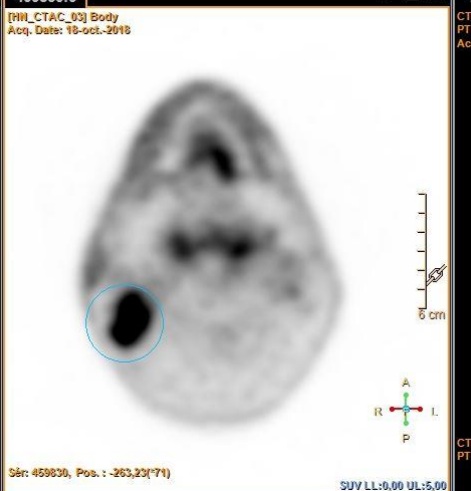
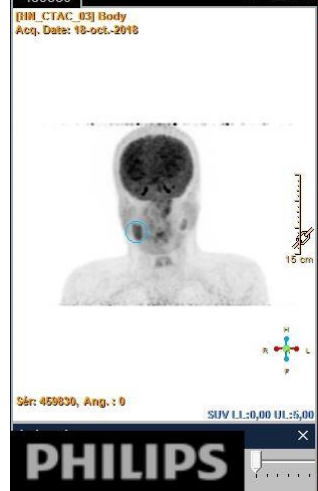
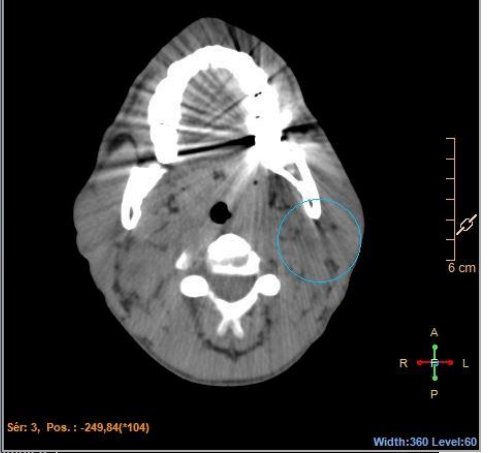
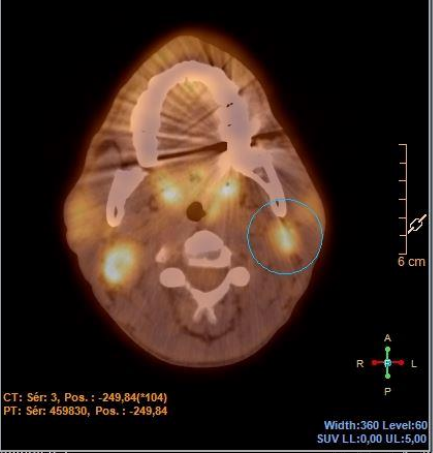
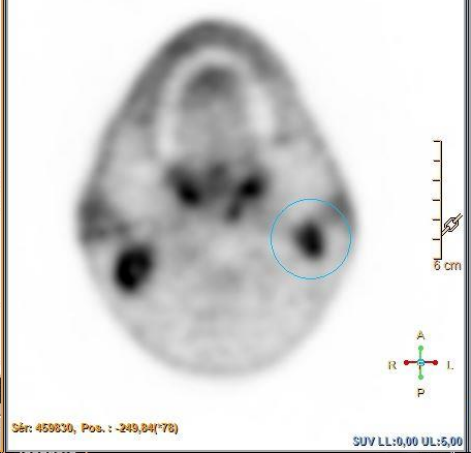
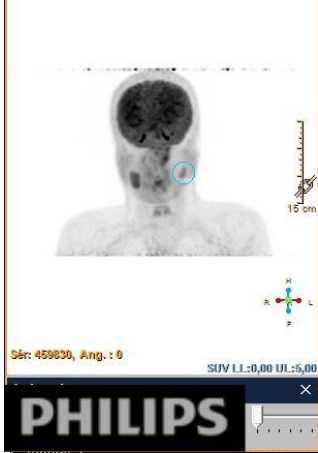
CAS CLINIQUES

BE initial

- Monsieur T M, 36 ans
- Obstruction nasale ancienne
- Apparition adp cervicale droite aout 2018

- carcinome indifférencié du naso pharynx
- T4N2 en IC

- Recherche de localisations à distance
 - Pas d'extension à distance

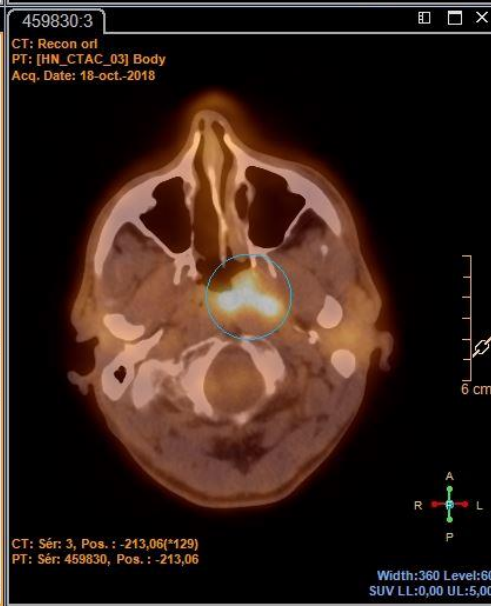
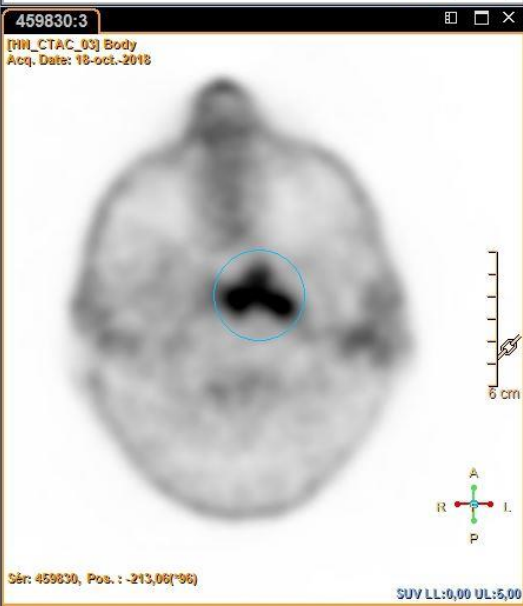
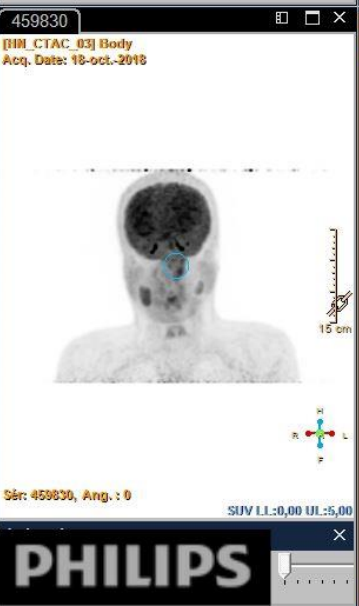
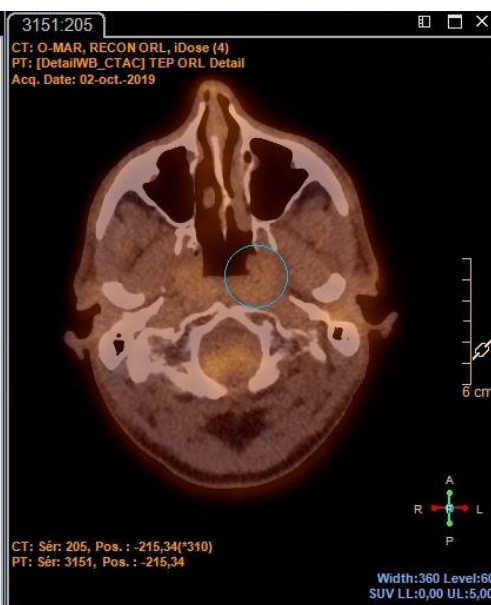
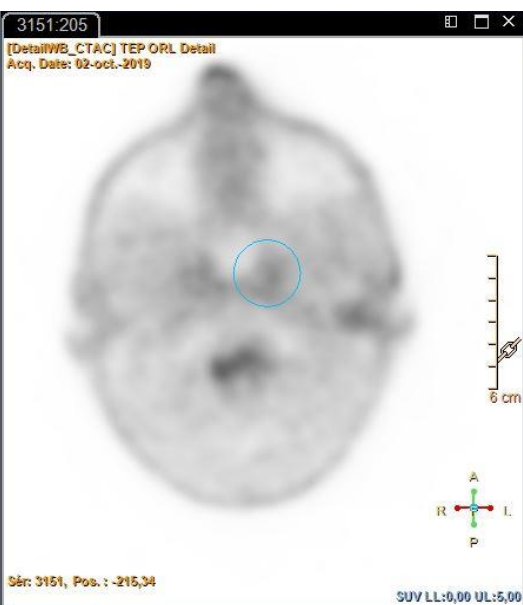
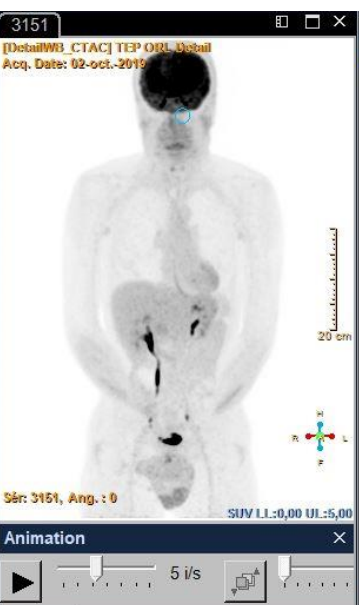


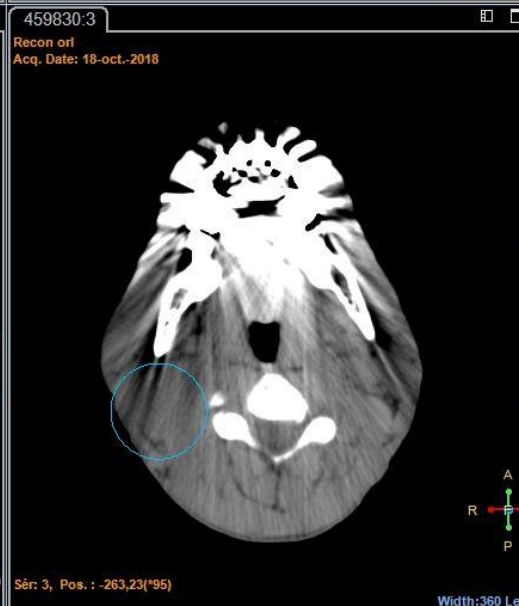
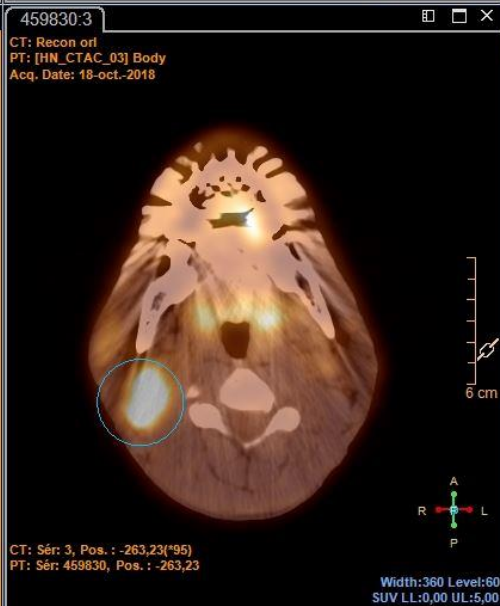
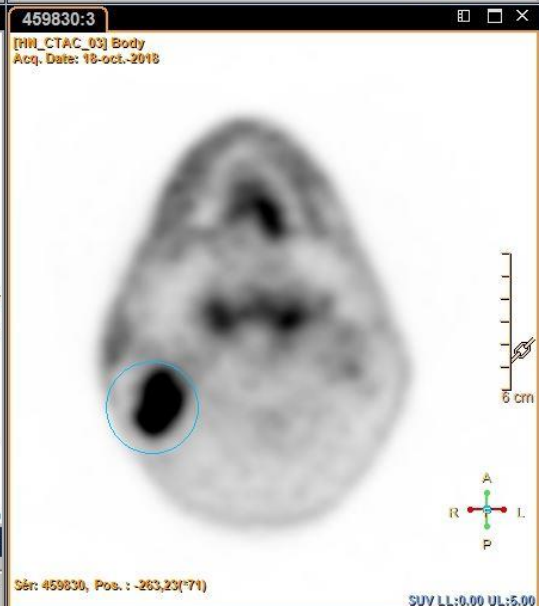
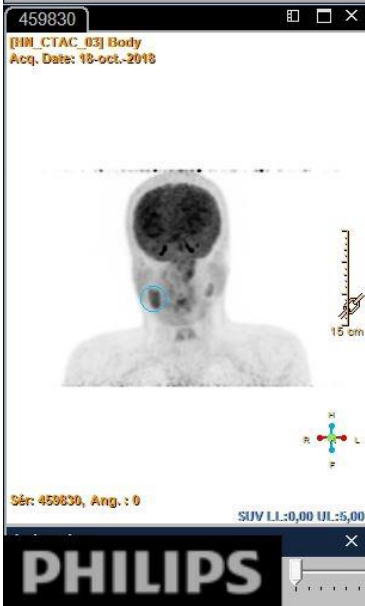
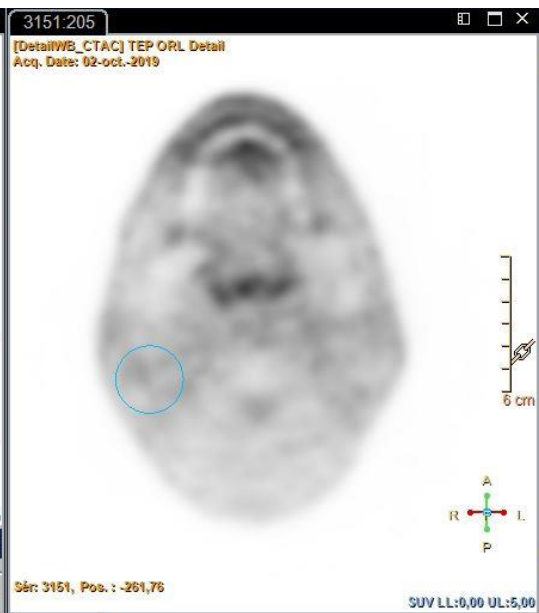
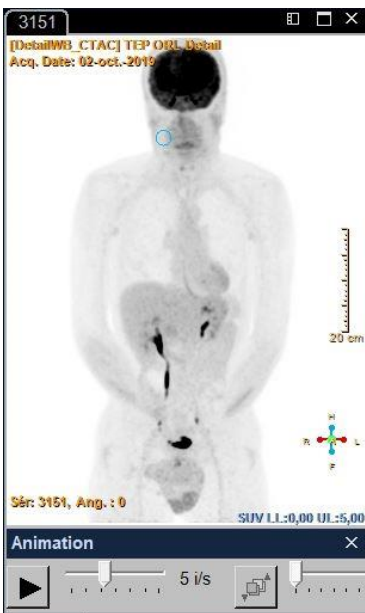
Bilan de fin de traitement

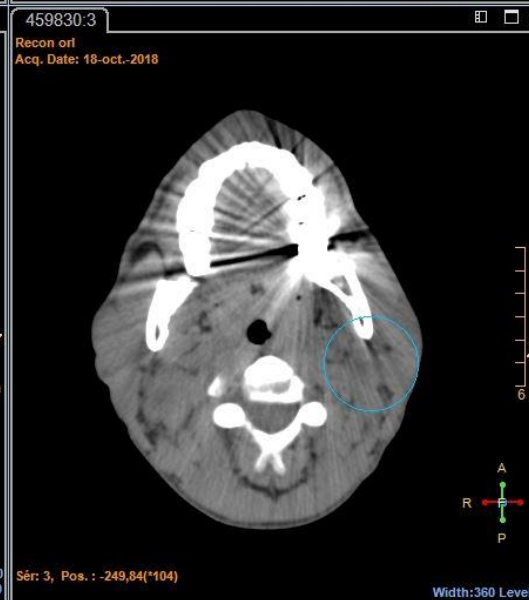
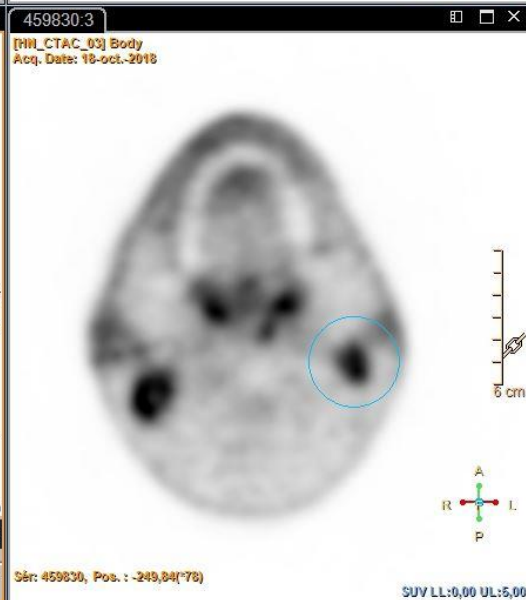
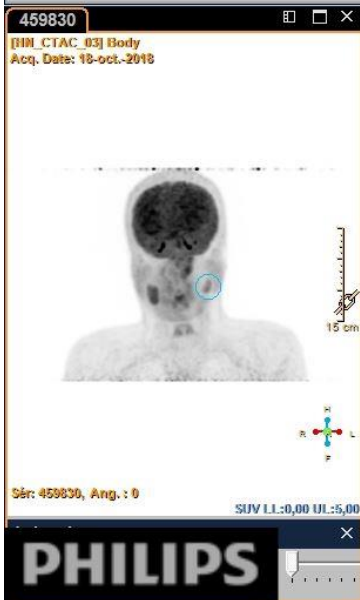
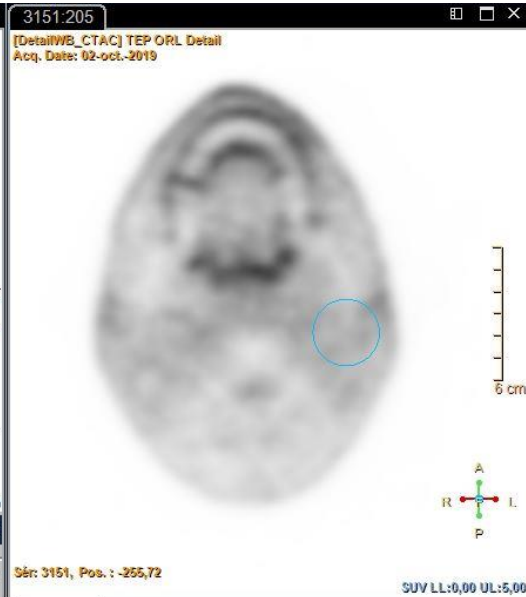
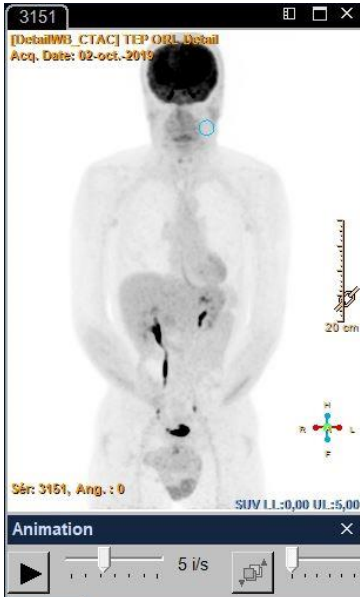
- Monsieur TM
- Bilan après chimiothérapie d'induction TCF
- Puis radiothérapie terminée en avril 2019
- Adp du secteur 2b Droit sur bilan IC en avril 2019

- → tep octobre 2019 négative : surveillance

Bilan fin traitement

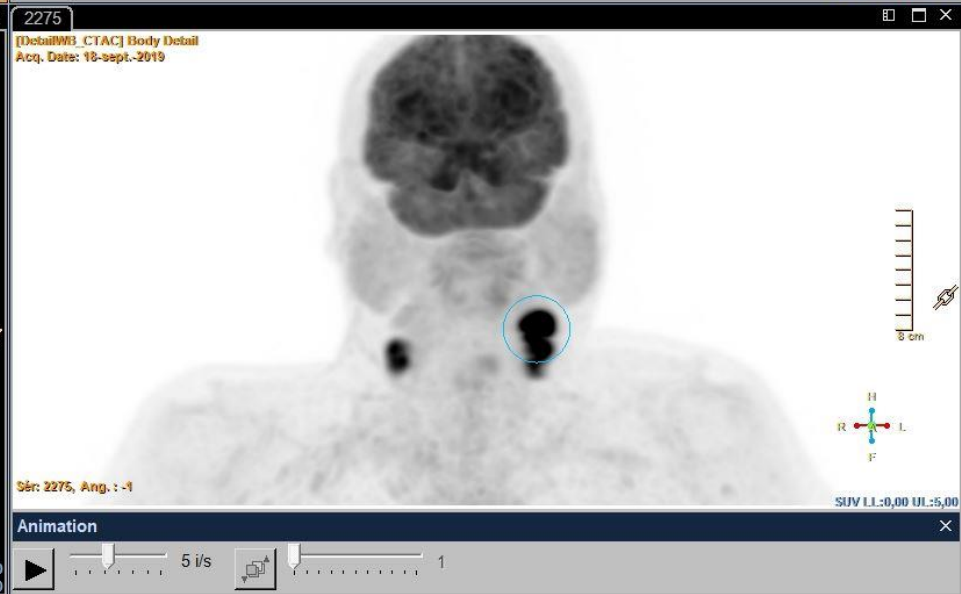
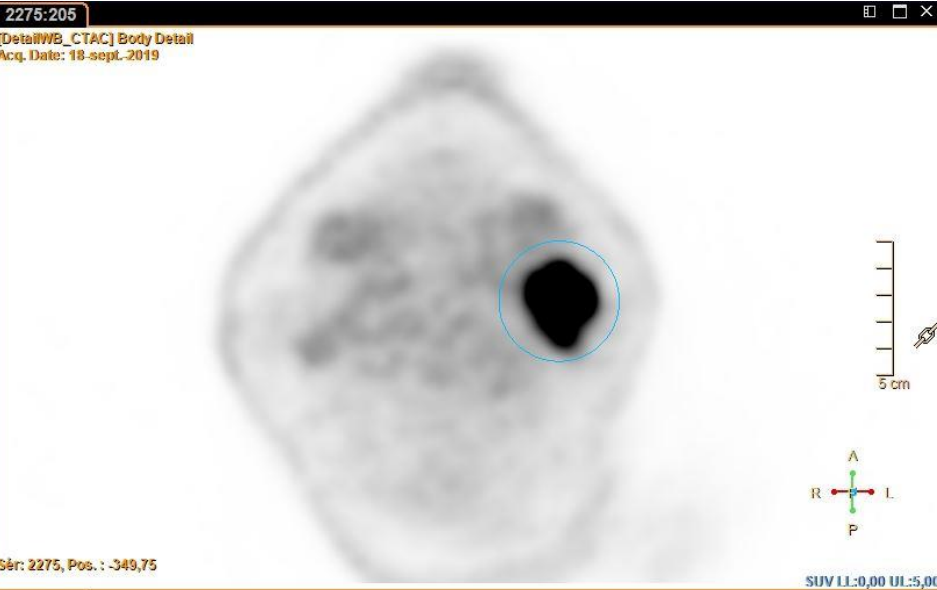


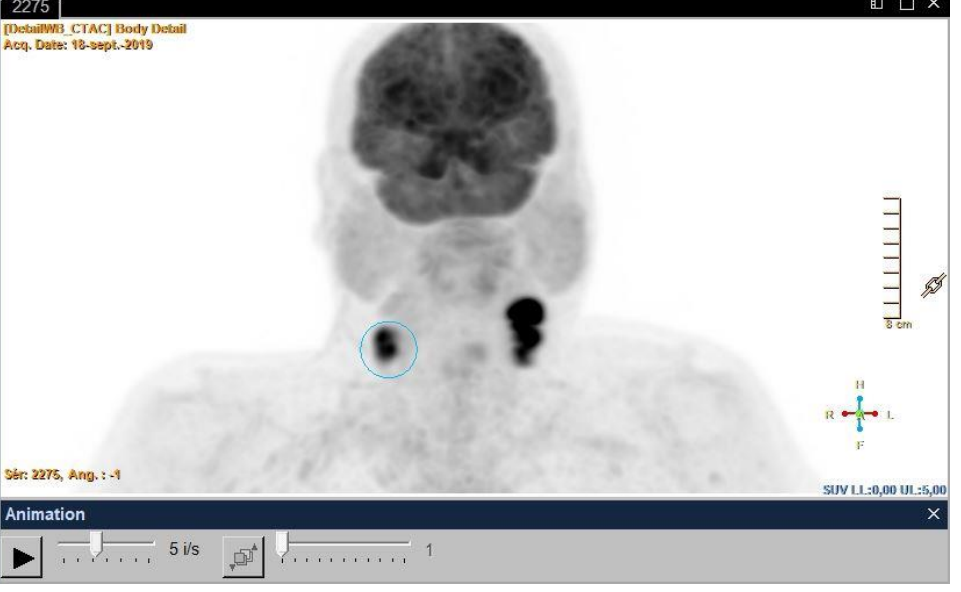
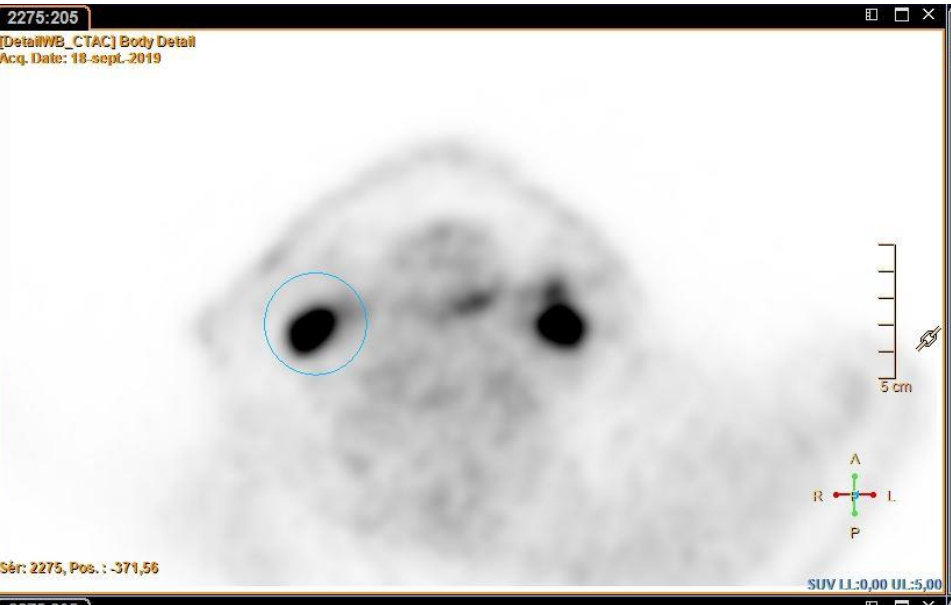




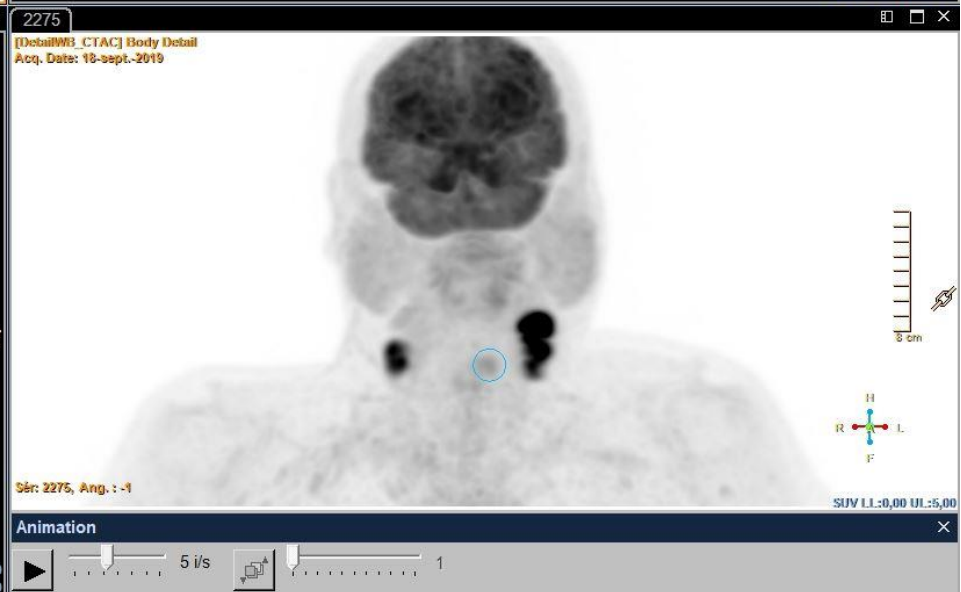
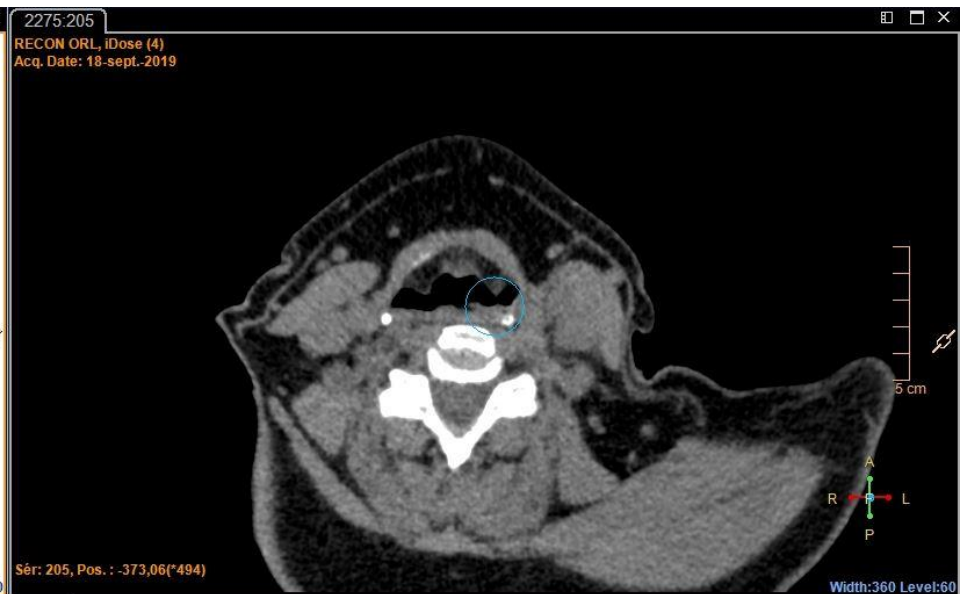
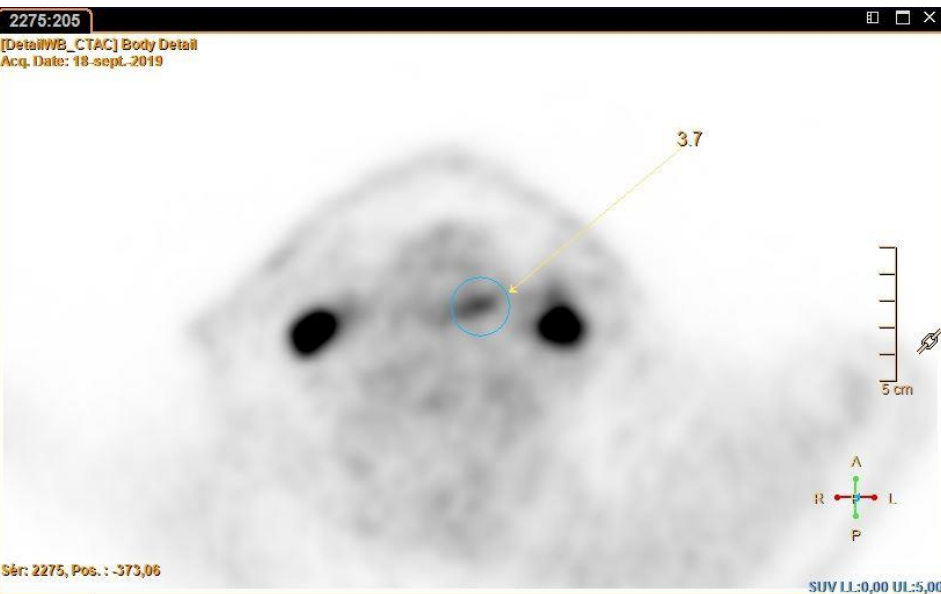
Bilan d'une adp : recherche de primitif

- Monsieur J JM, 64 ans
- Apparition brutale adp latéro cervicale gauche en juillet 2019
- Naso fibro: RAS
- Recherche de primitif
- Scanner : polyadénopathie cervicale bilatérale





PHILIPS

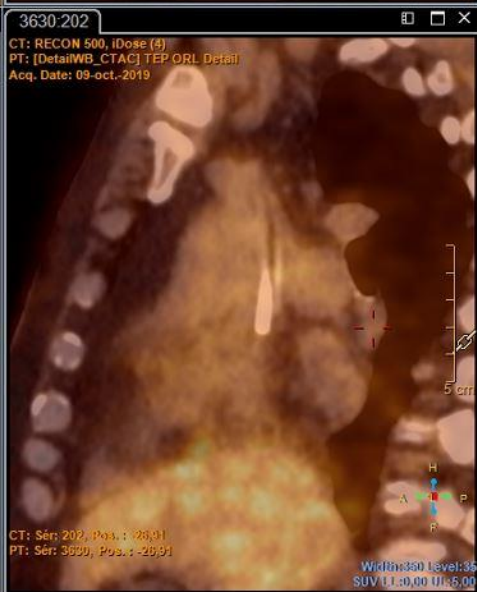
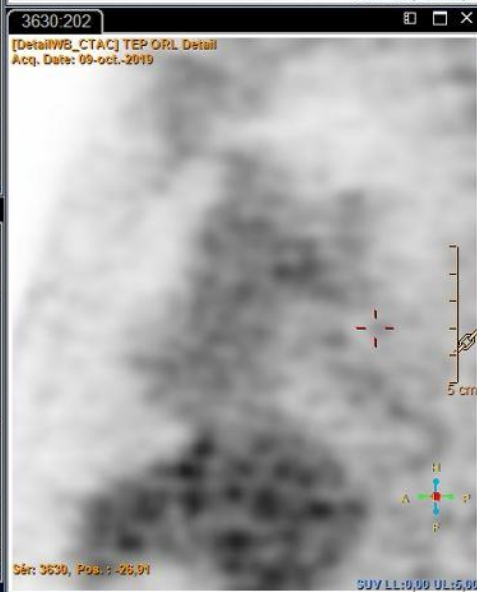
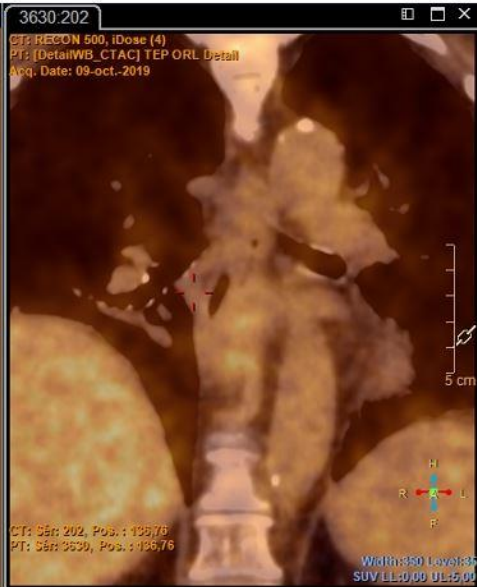
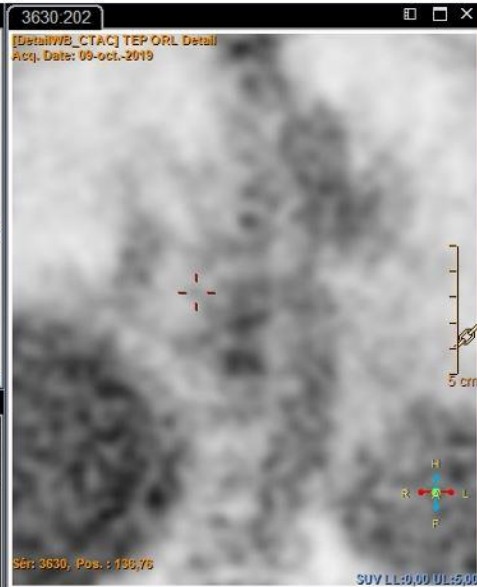
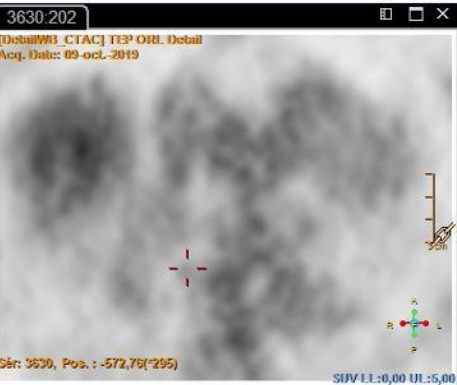


PHILIPS

- Confirmation du caractère métabolique des adp
- Doute sur la partie postérieure de l'hypopharynx gauche
- Examen ORL guidé : lésion superficielle de la partie postérieure de la paroi interne du sinus piriforme gauche.
- Ponction cyto : cellules carcinomateuses
- Panendoscopie
- T1N3bM0
- Chimio induction

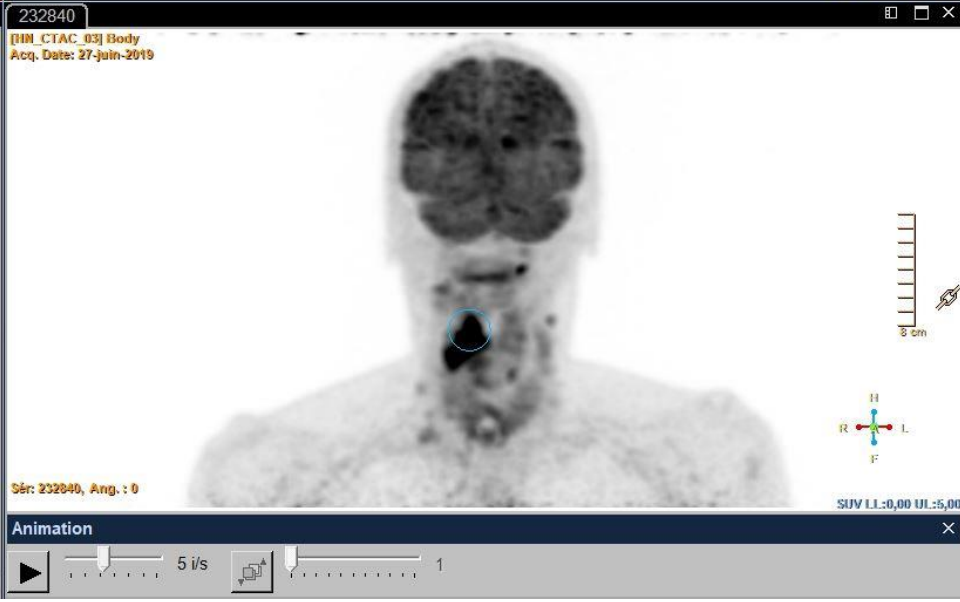
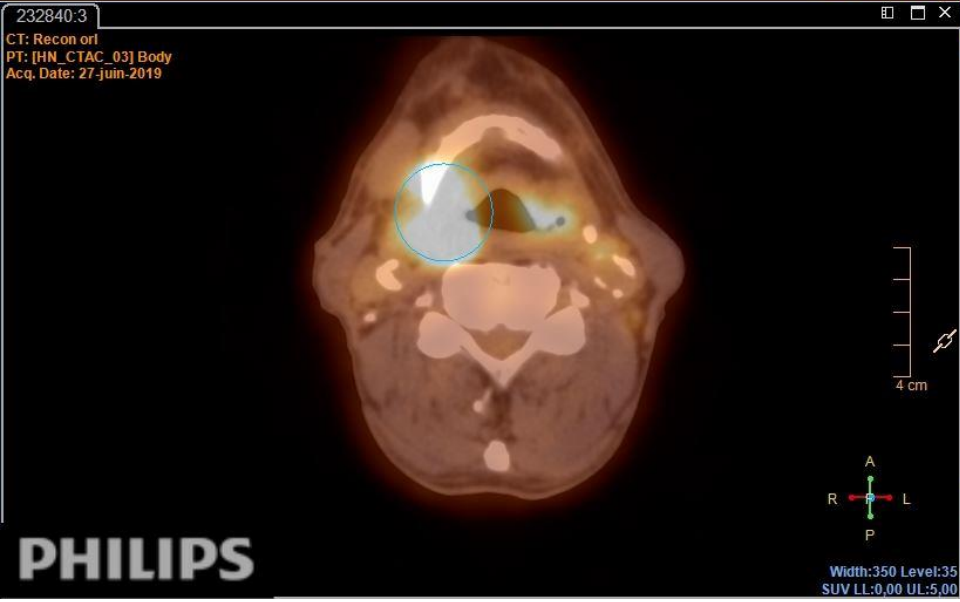
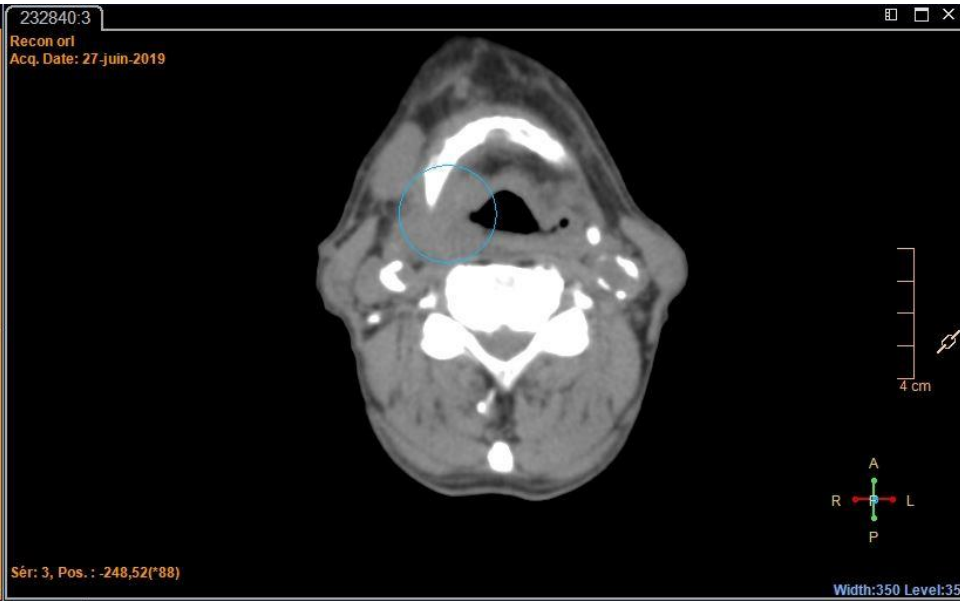
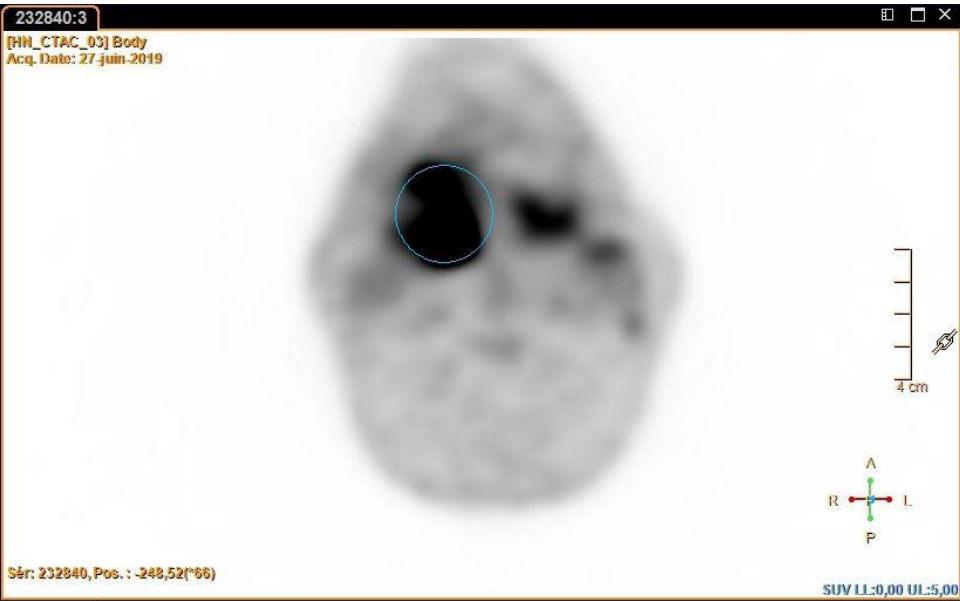
Bilan avant radiothérapie

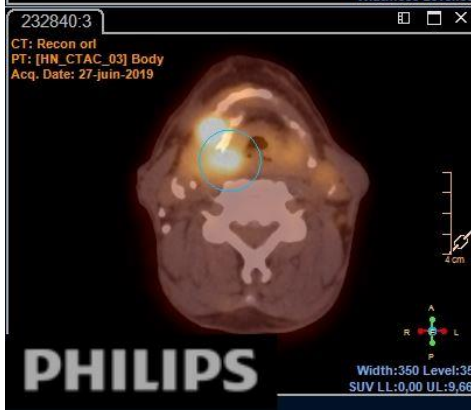
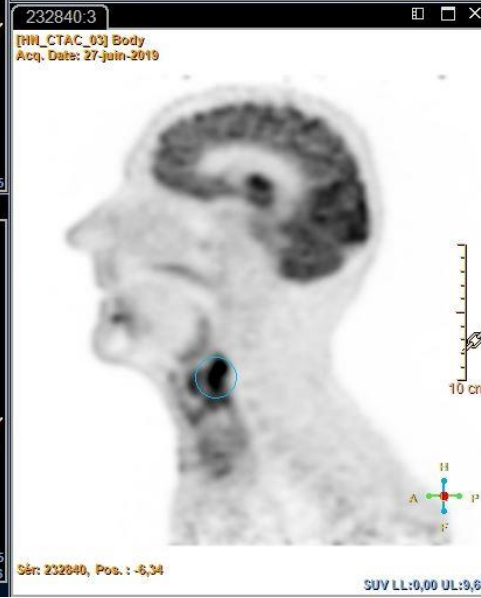
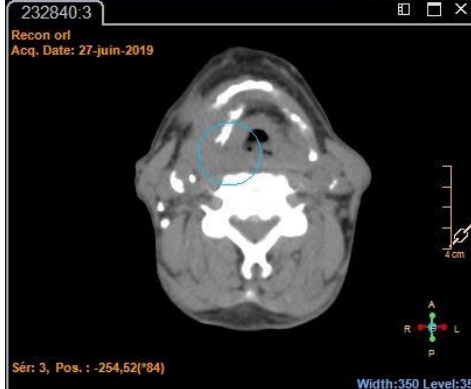
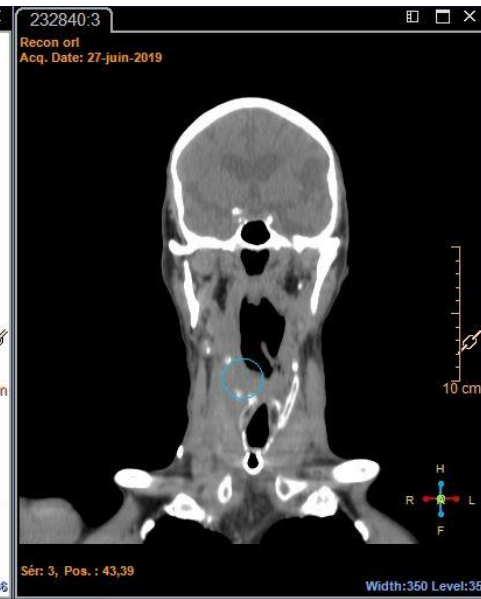
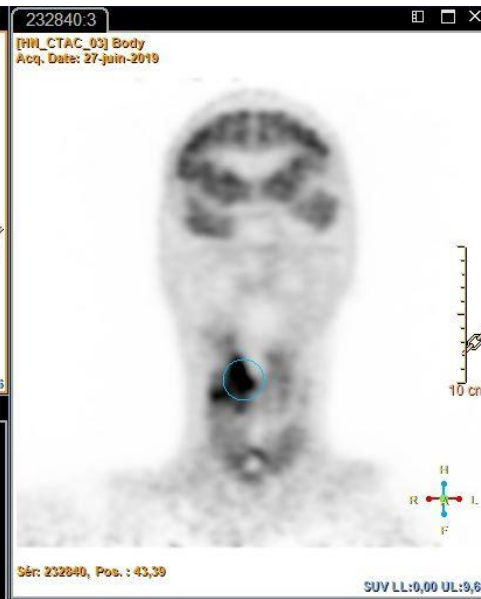
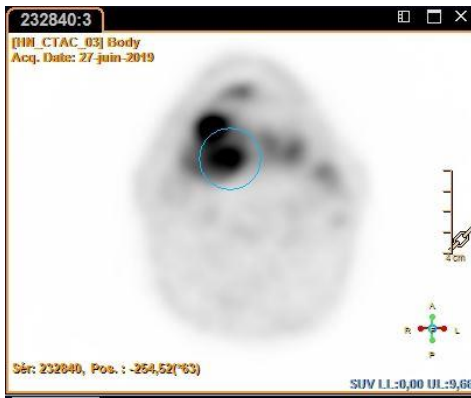
- Madame N MJ, 70 ans
- Bilan d'une dysphagie et dysphonie
- Carcinome épidermoïde étendu du sinus piriforme droit.
- T3N0M0 en IC
- Bonne réponse (IC) après chimio TCF (2 cures)
- Mais : Adp latéro oesophagienne droite (09/19)
- Appréciation du métabolisme afin d'adapter le champs de radiothérapie (ATCD K sein)

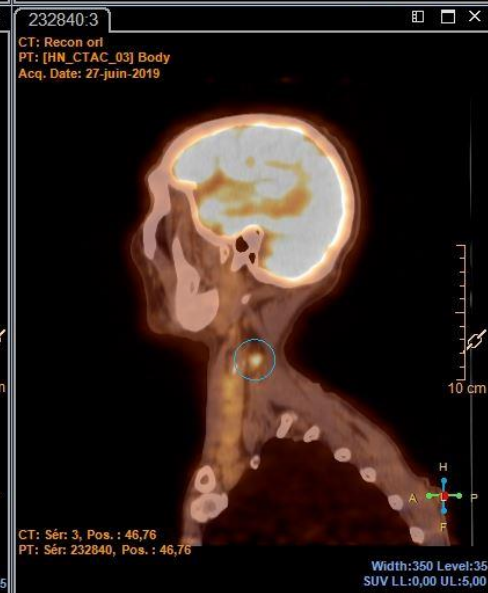
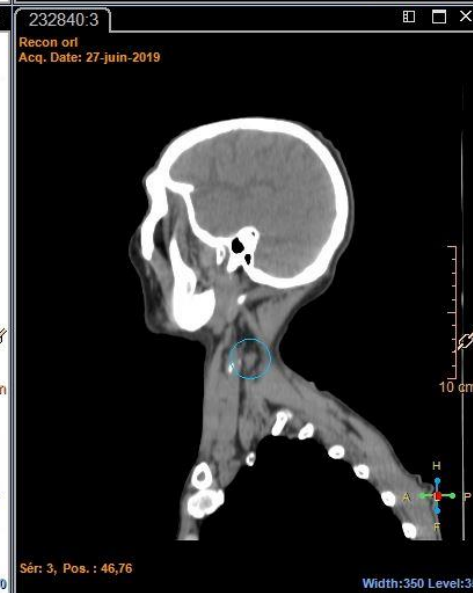
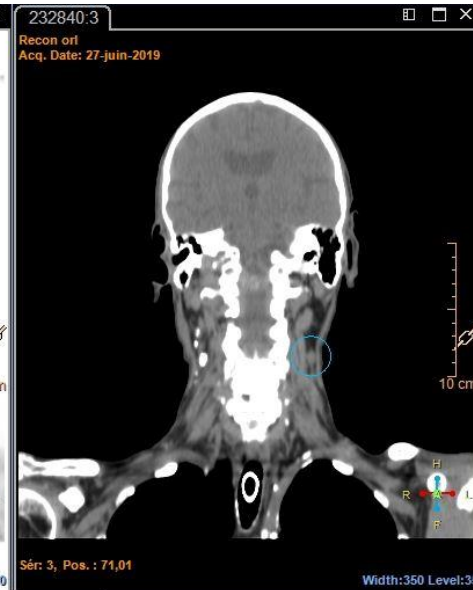
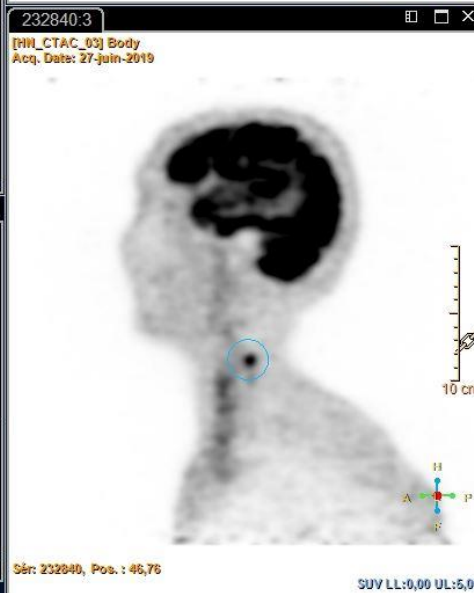
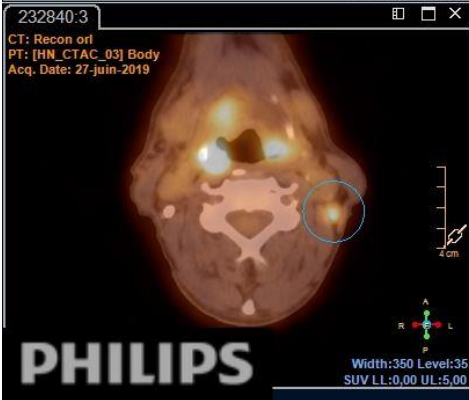
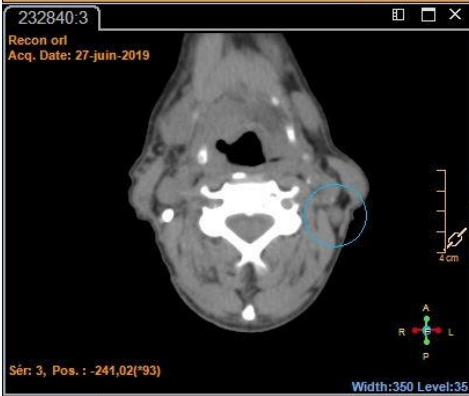
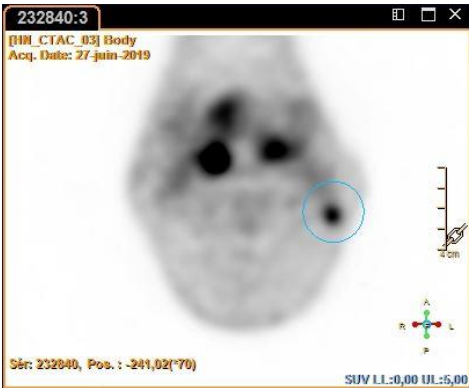


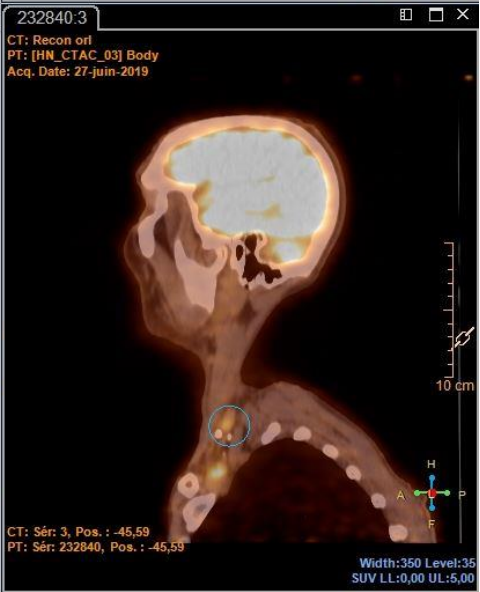
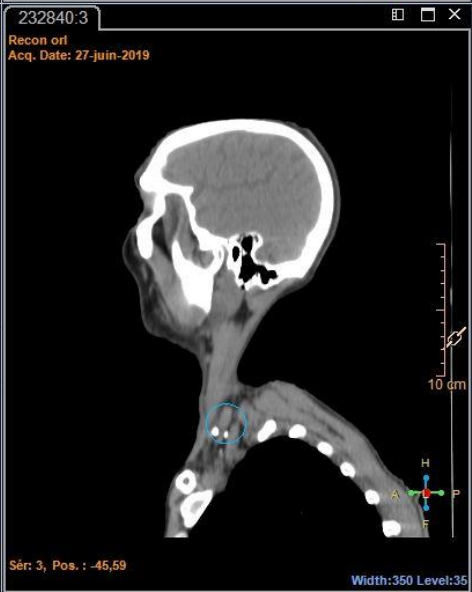
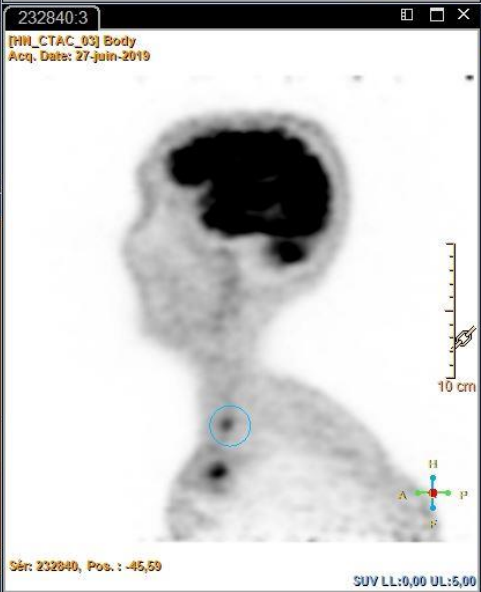
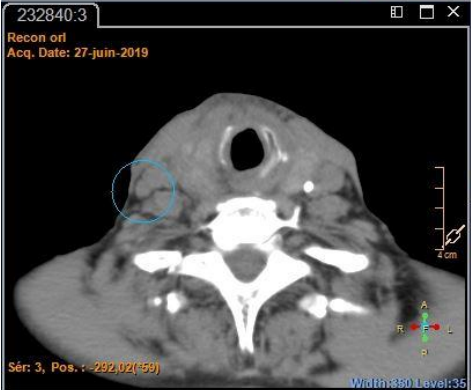
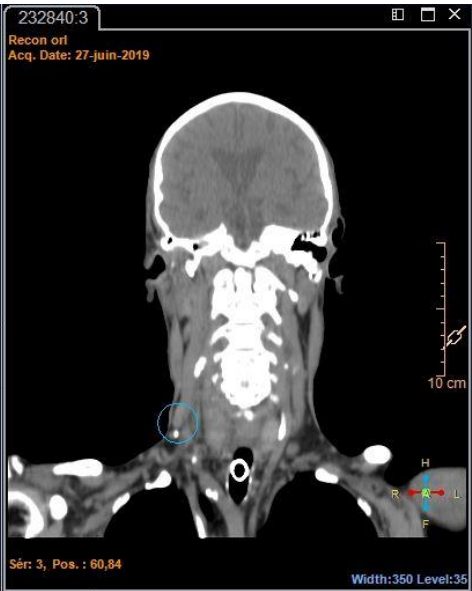
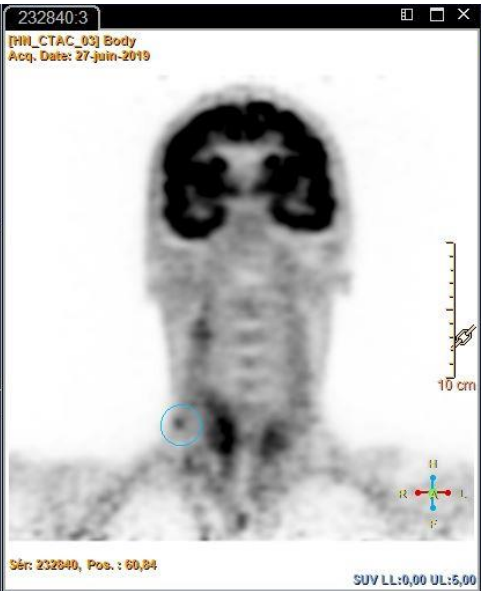
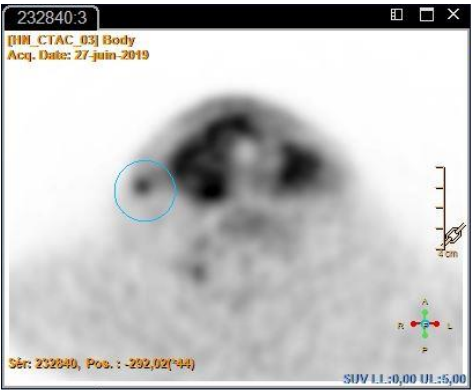
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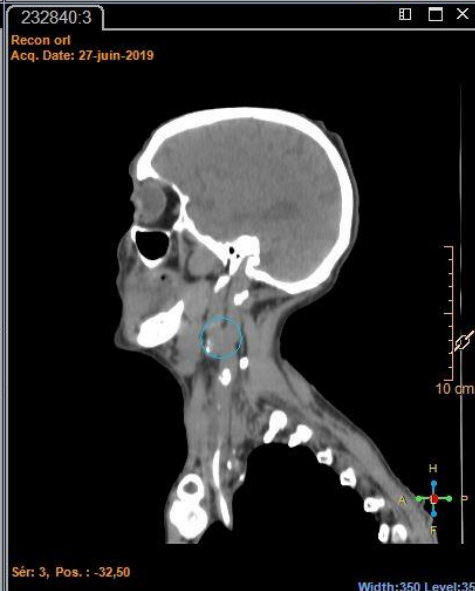
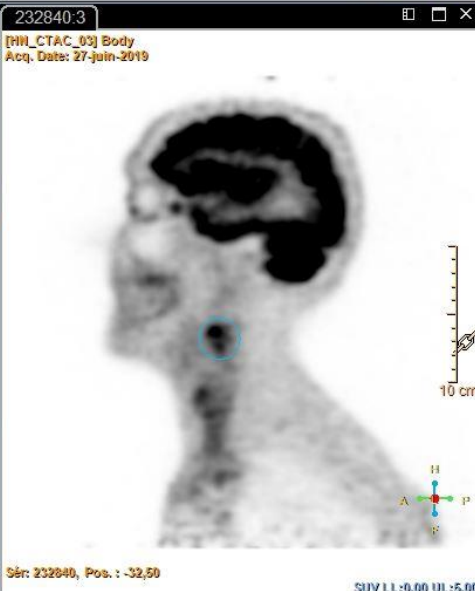
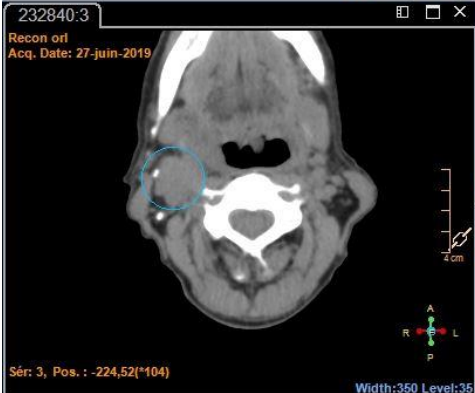
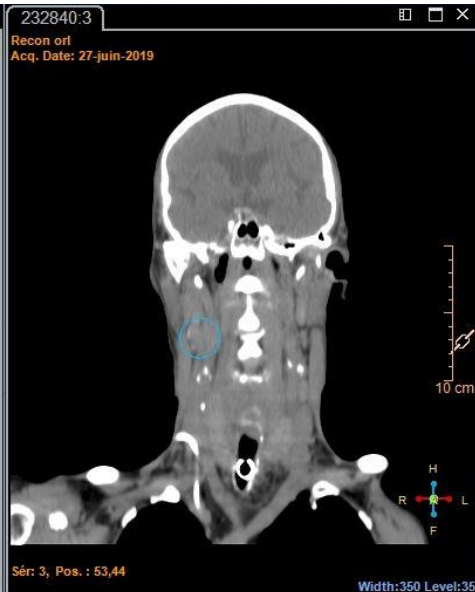
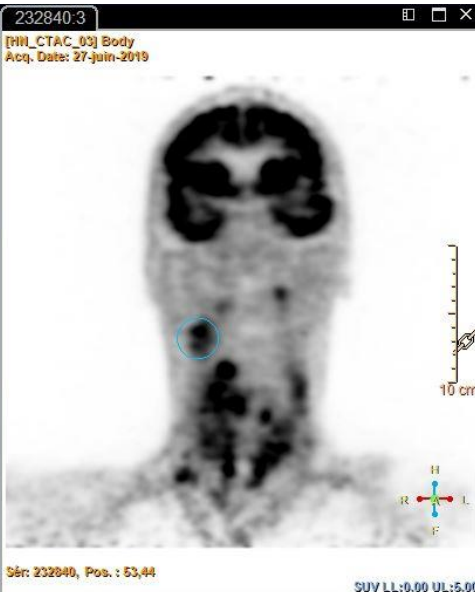
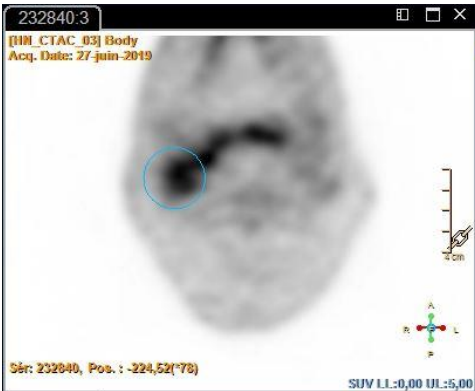
- Monsieur B S, 63 ans
- juillet 2019, dysphonie et dysphagie
- Carcinome épidermoïde évolué du sinus piriforme droit étendu à la margelle laryngée (trachéotomie)
- Ganglions équivoques à G en IC

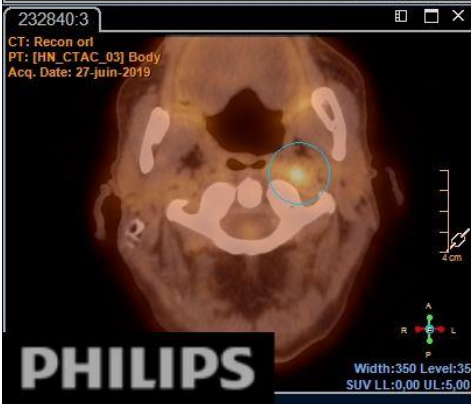
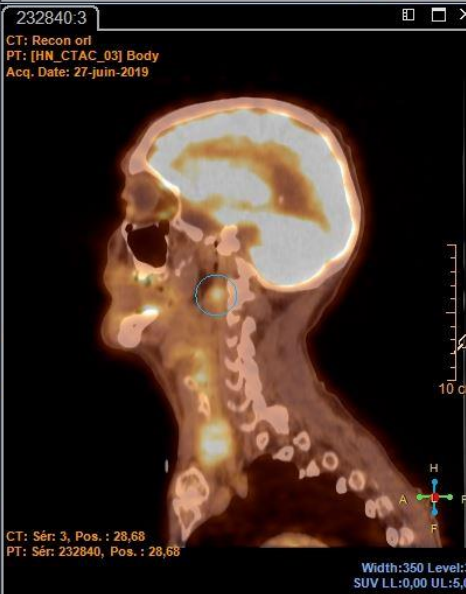
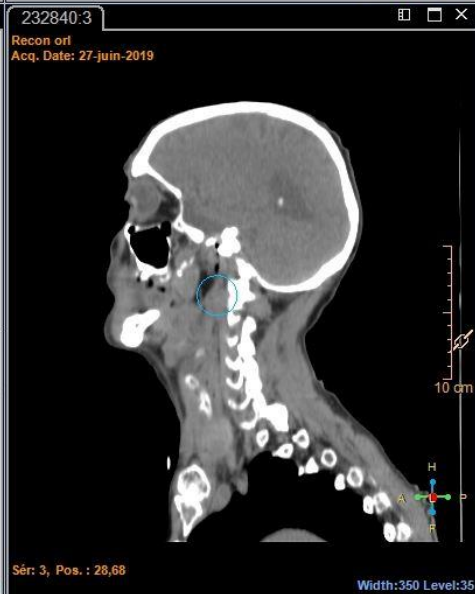
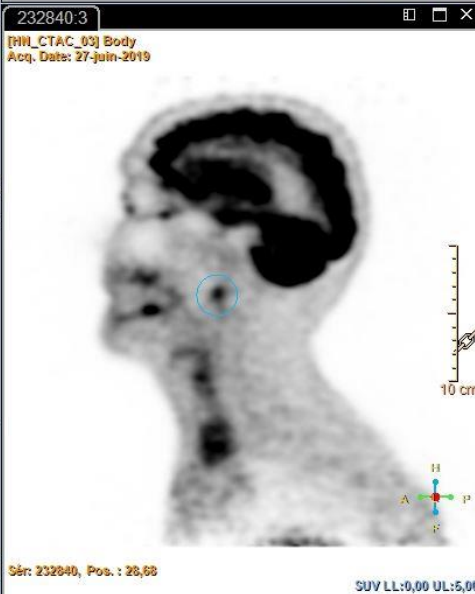
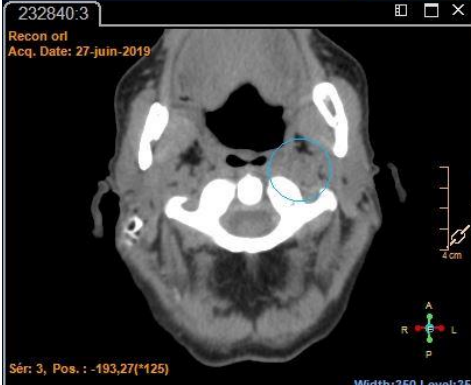
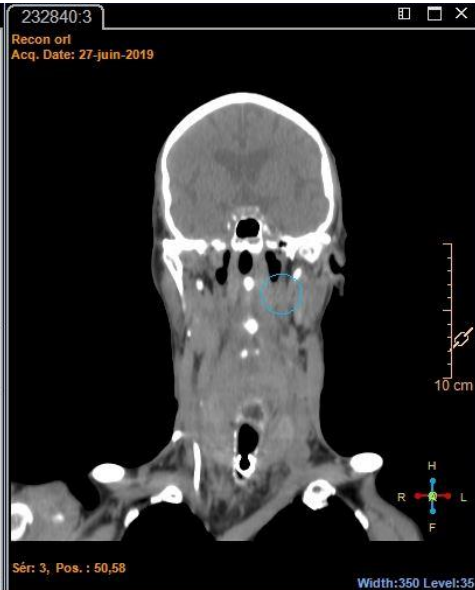
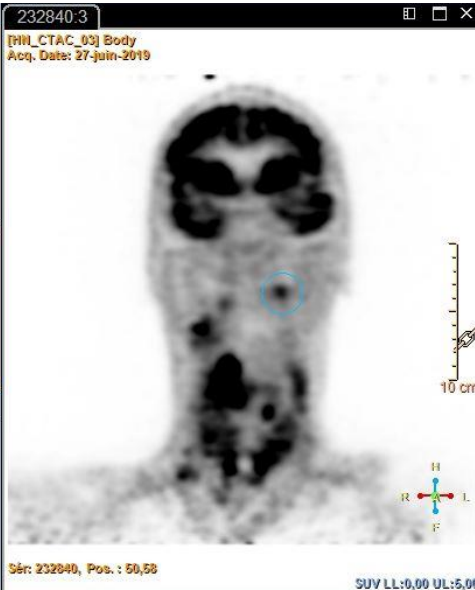
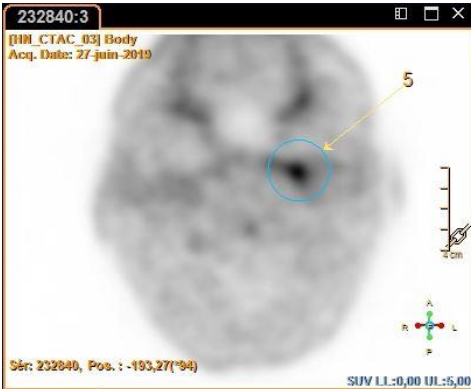


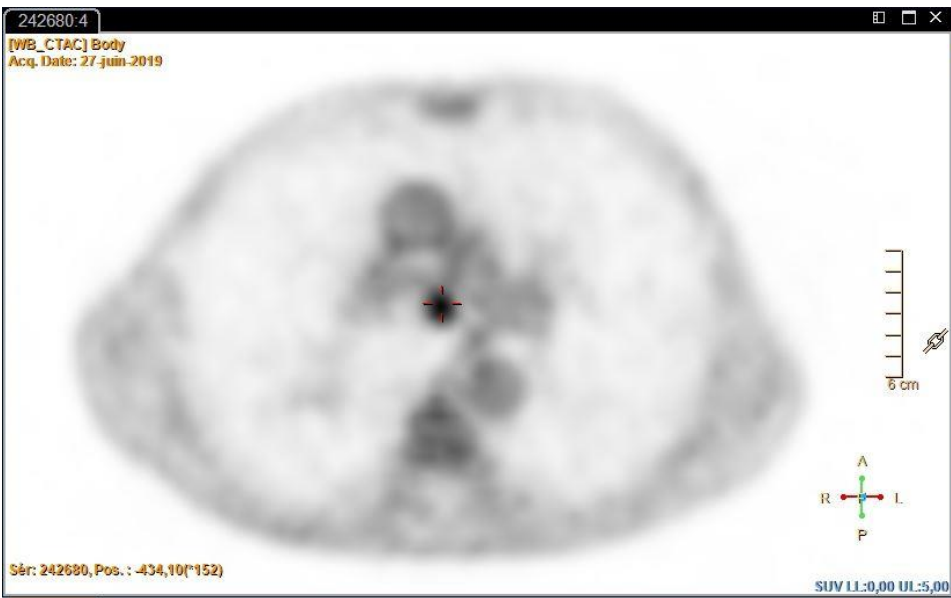


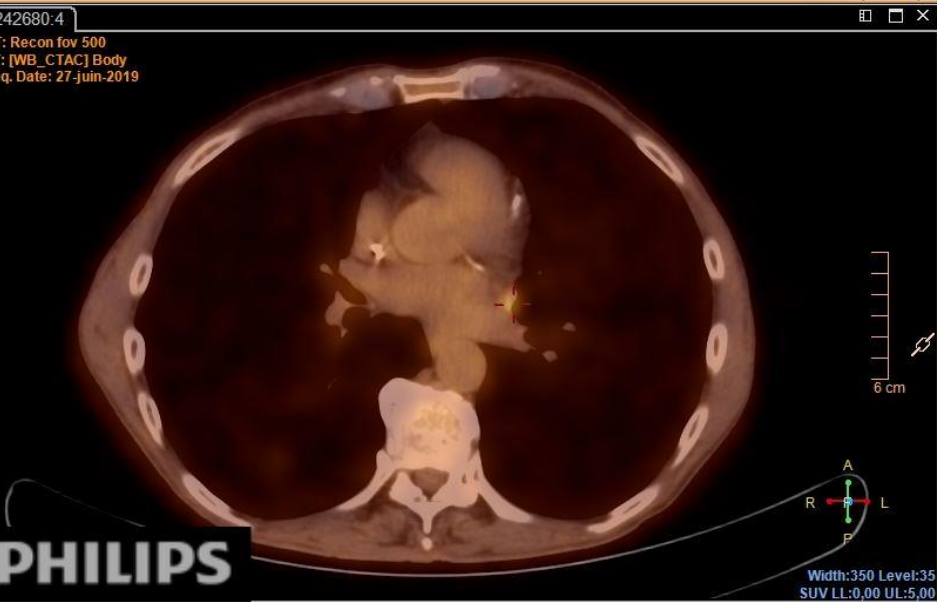
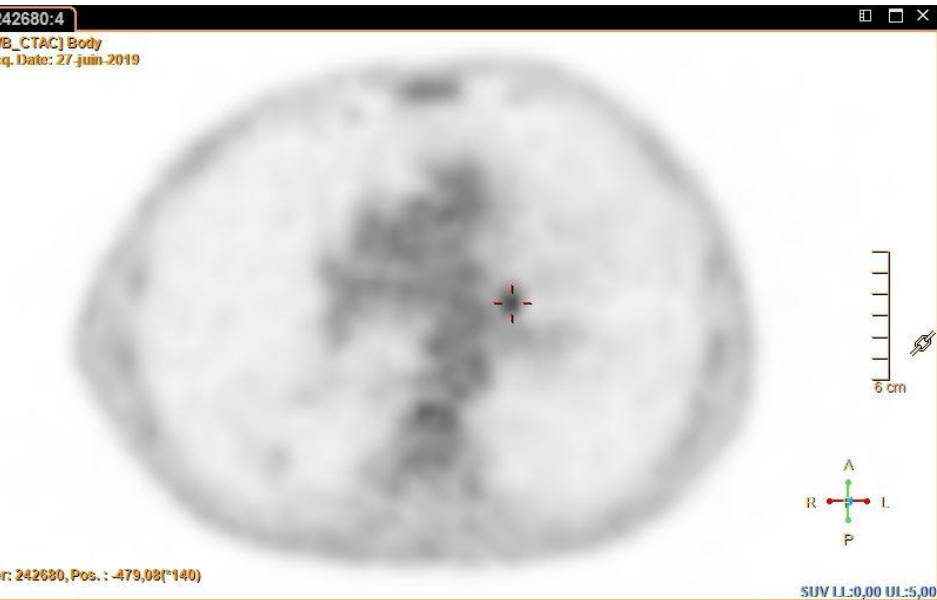


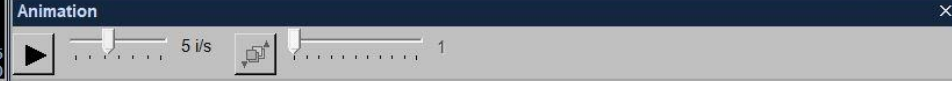
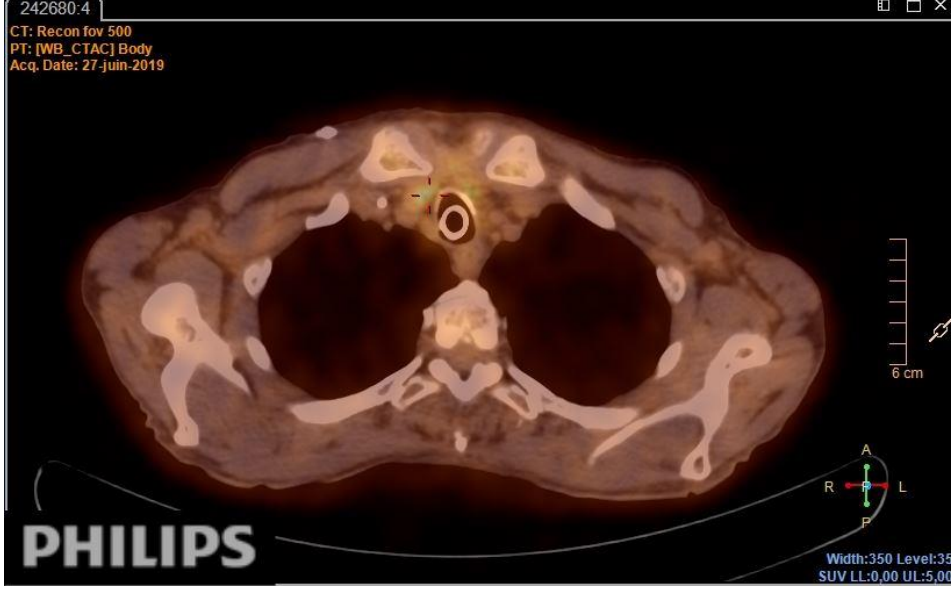
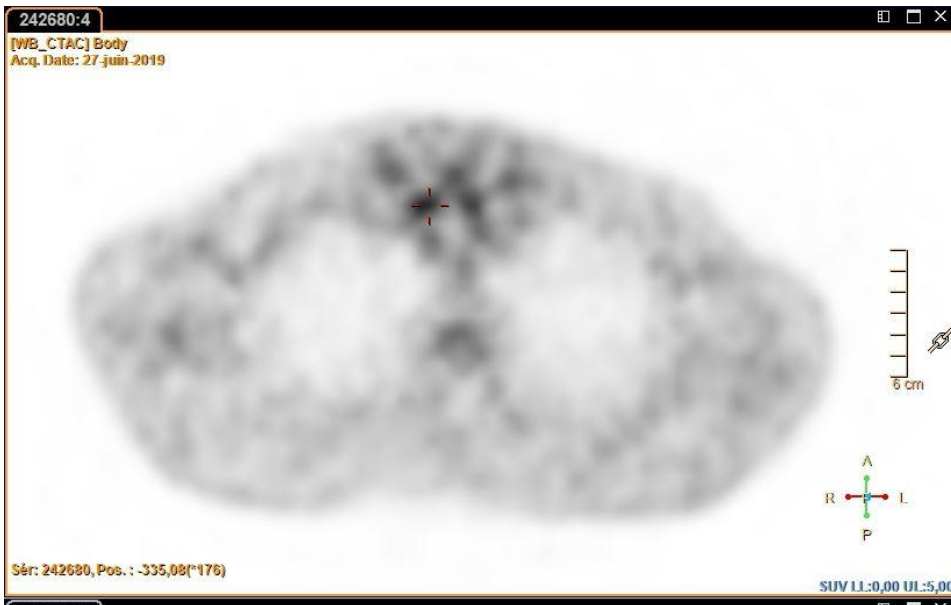


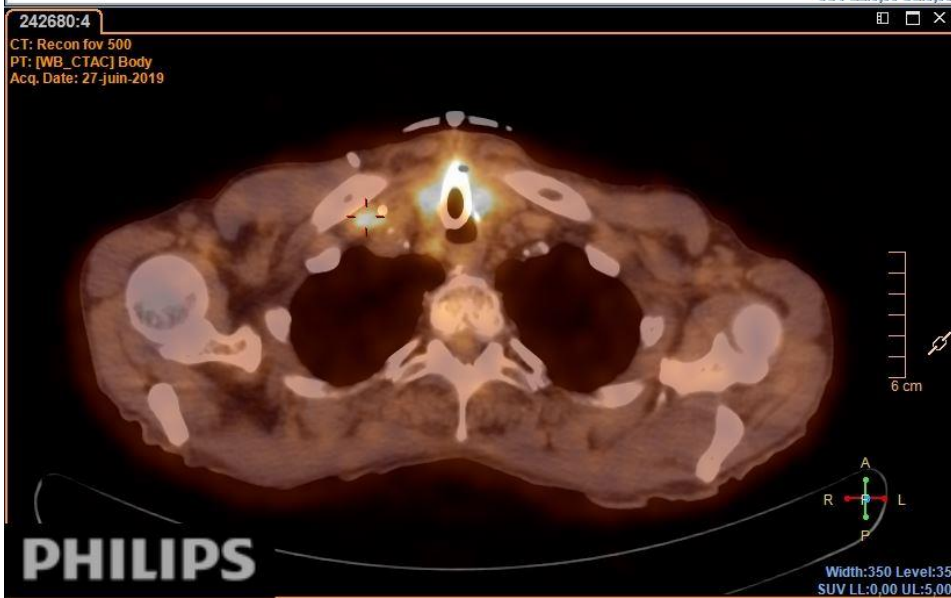
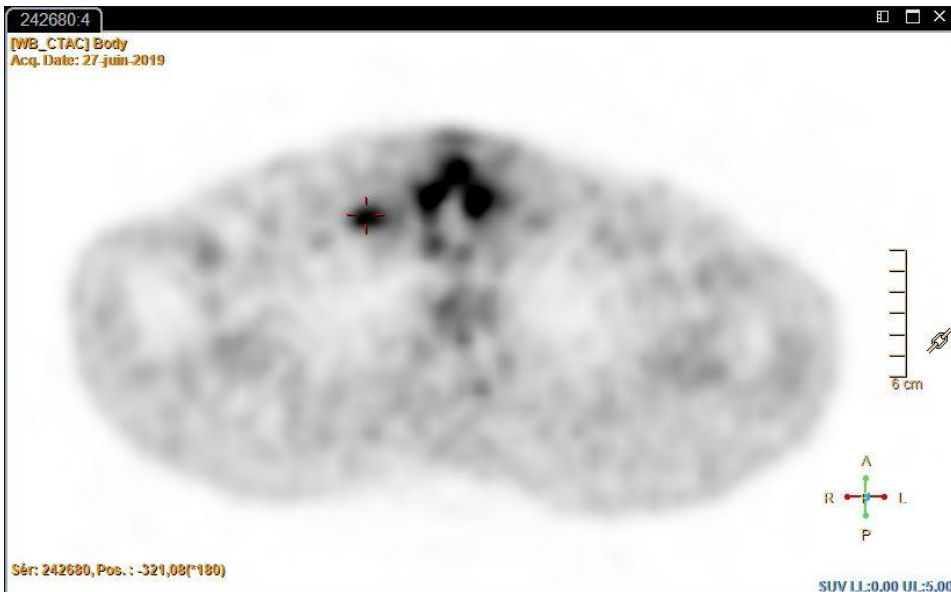












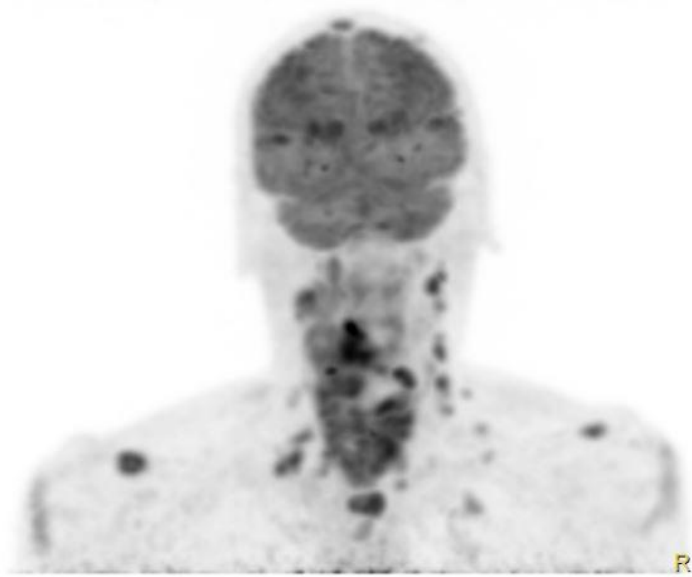
- Monsieur BS
- Extension ganglionnaire, latéro cervicale, sus claviculaire, médiastinale.
- Chimiothérapie induction: TCF
- Réponse partielle après 2 cures

- Augmentation taille surrénale gauche en IC
- Progression locale après chimiothérapie d'induction

- TEP de contrôle

5436

[DetailWB_CTAC] TEP ORL Detail
Acq. Date: 07-nov.-2019



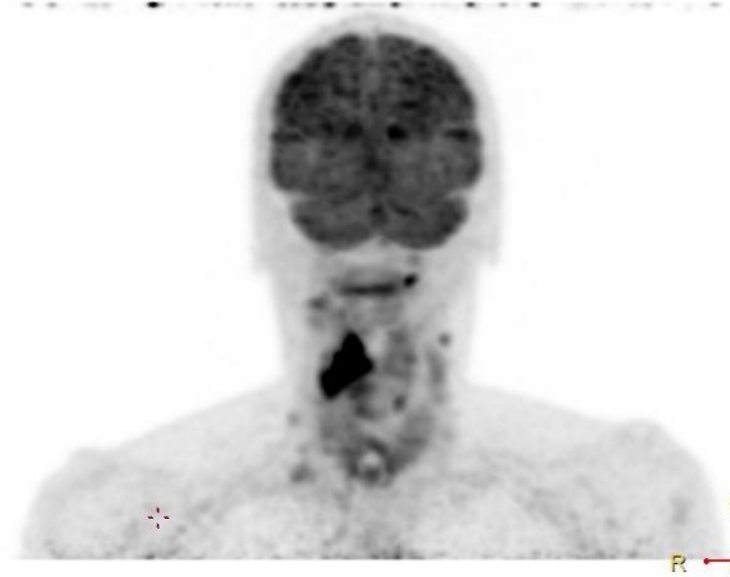
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SUV LL:0,00 UL:5,00

Animation 5 i/s 1

232840

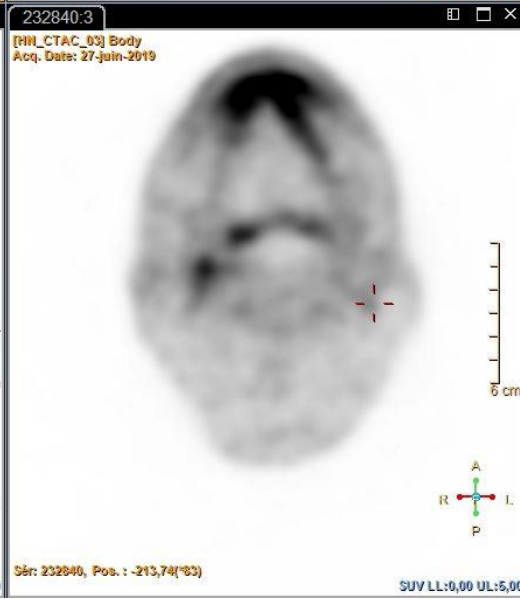
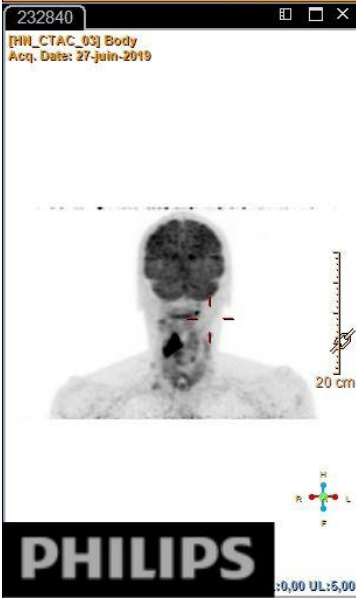
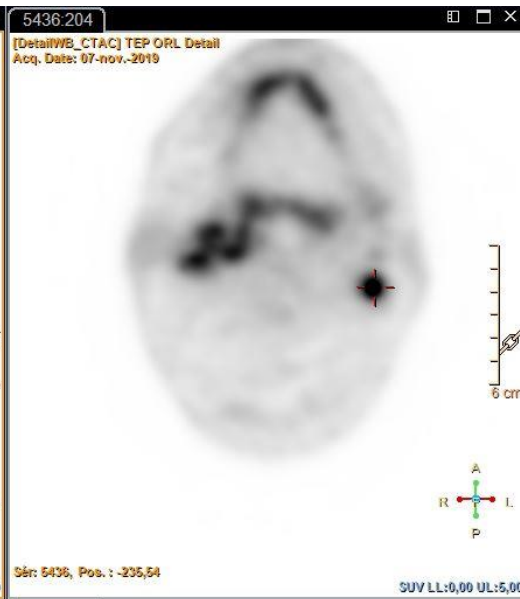
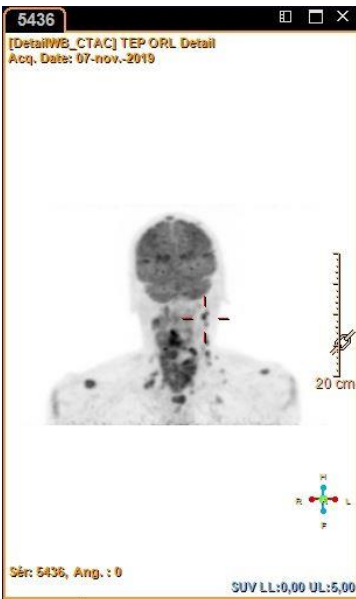
[HN_CTAC_03] Body
Acq. Date: 27-juin-2019



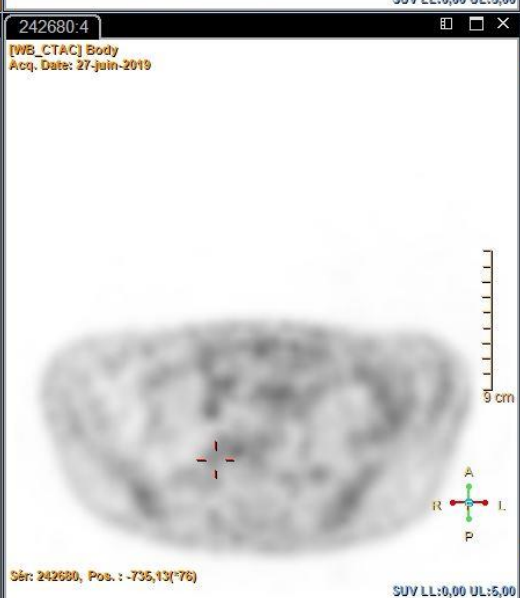
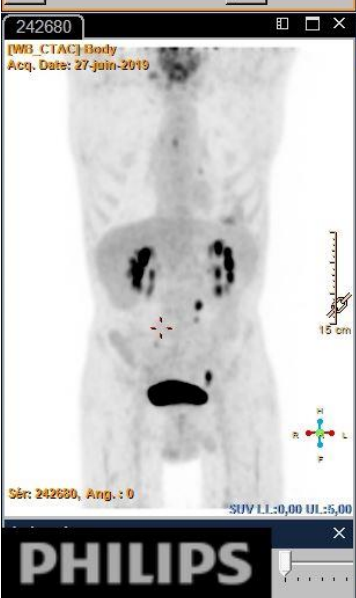
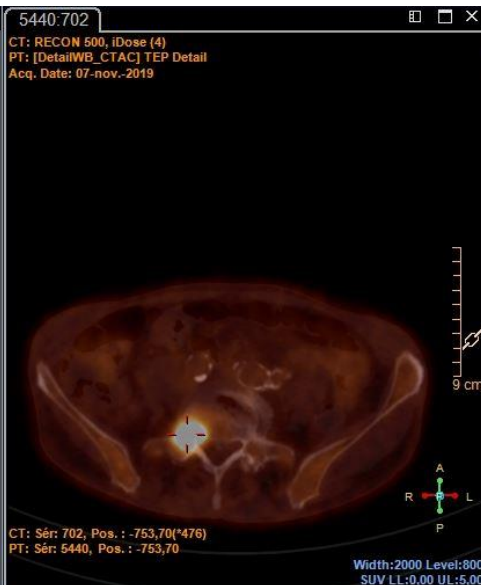
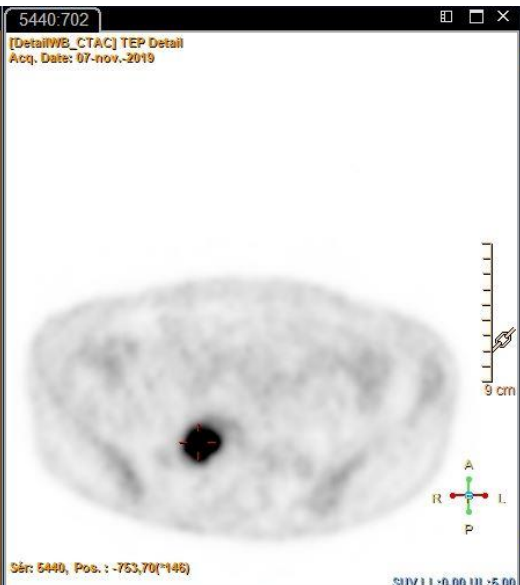
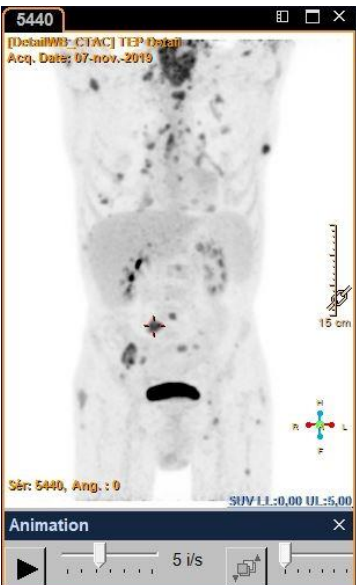
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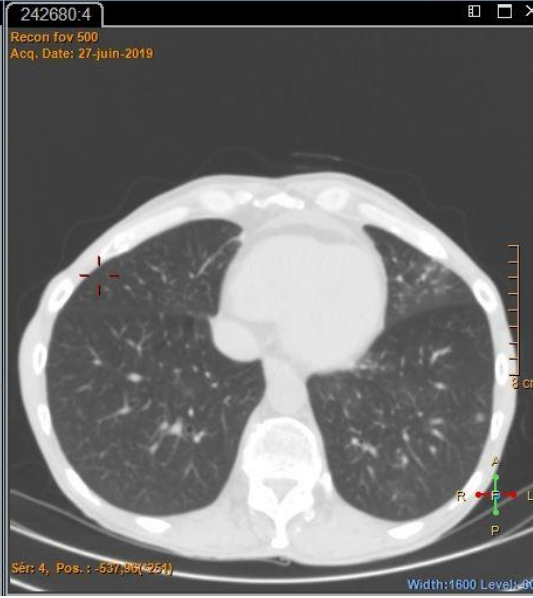
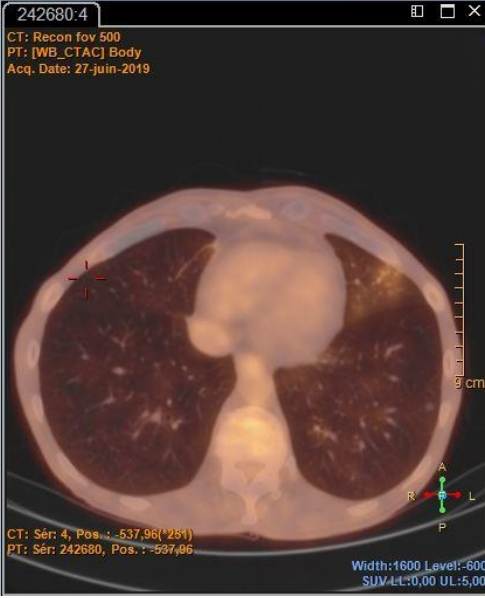
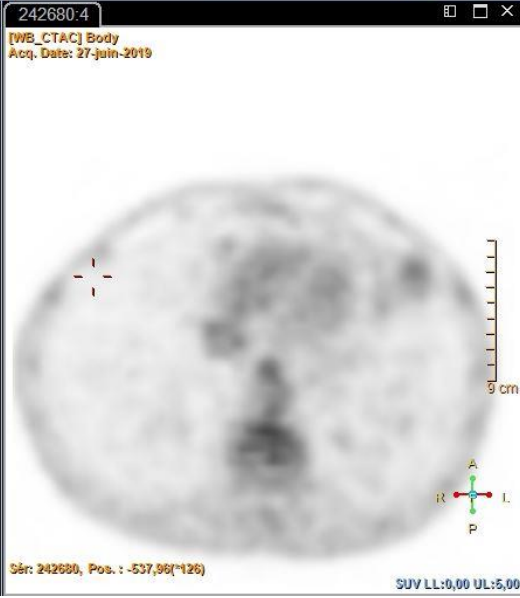
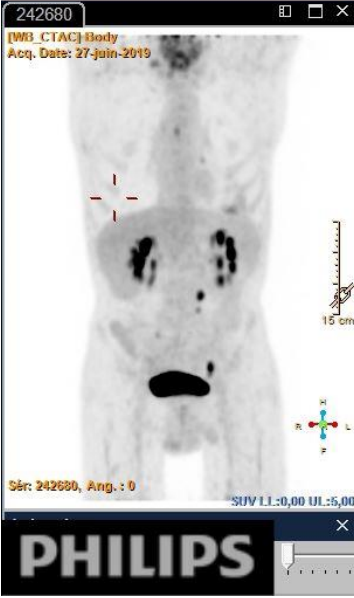
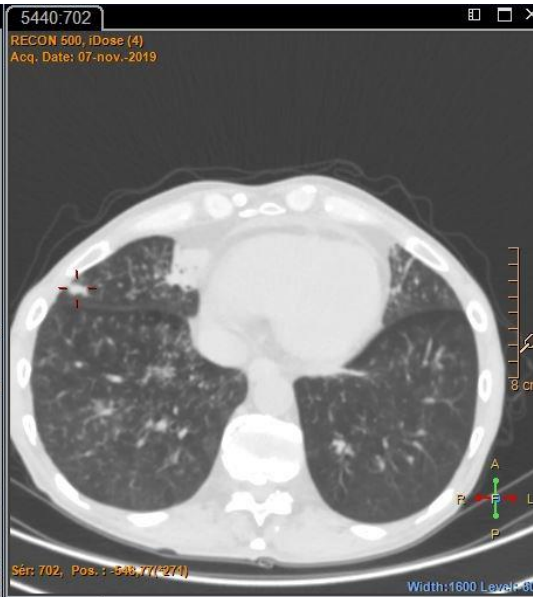
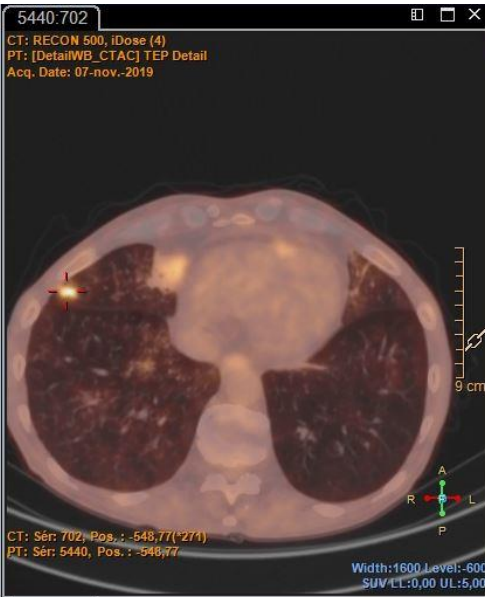
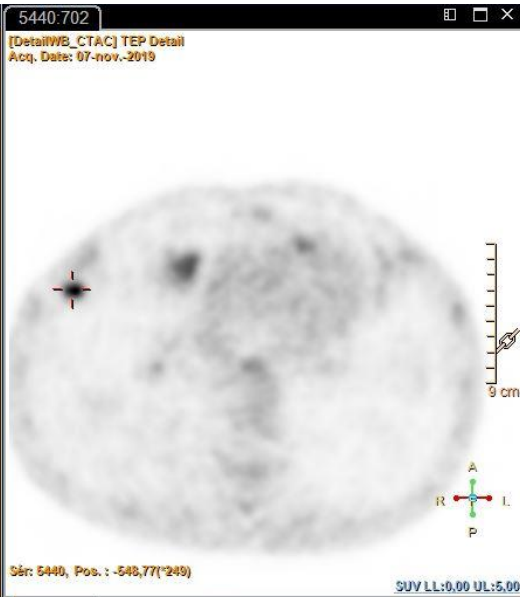
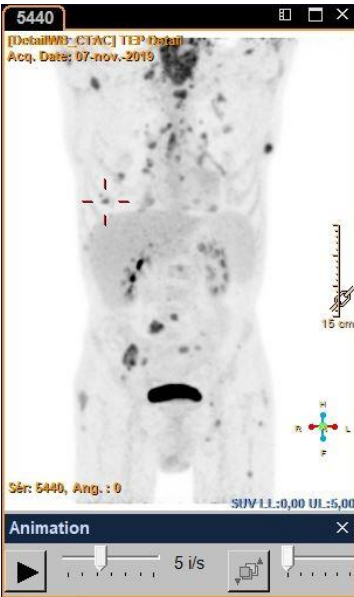
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Animation 5 i/s 1



PHILIPS

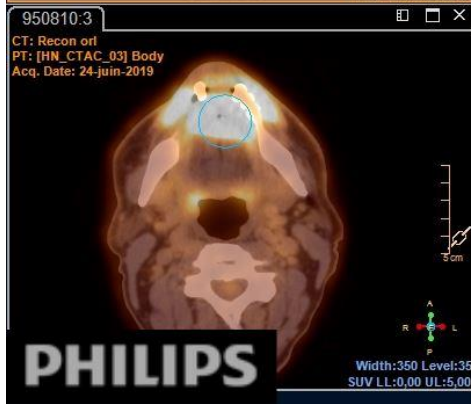
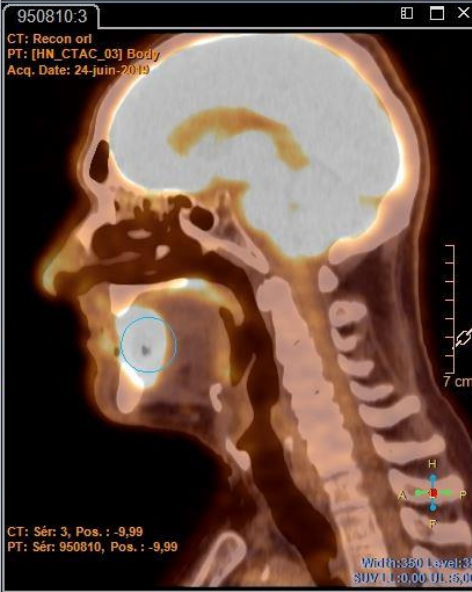
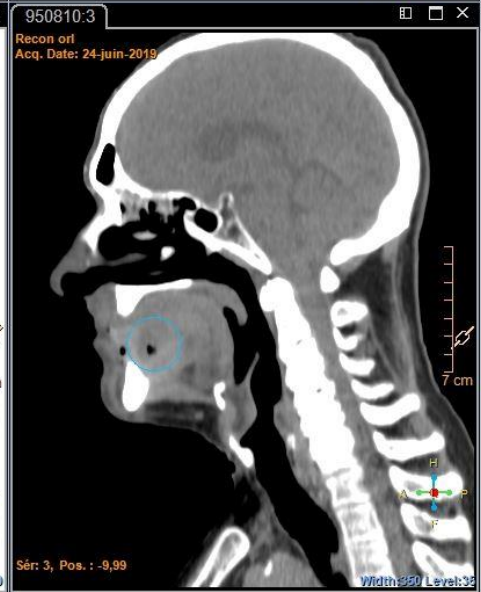
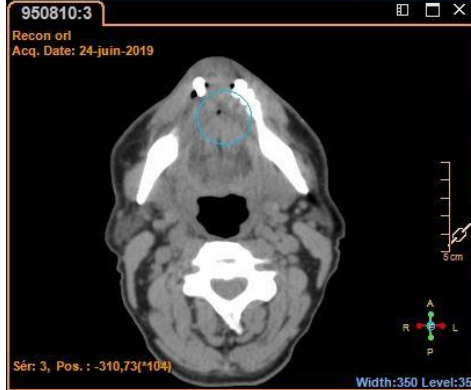
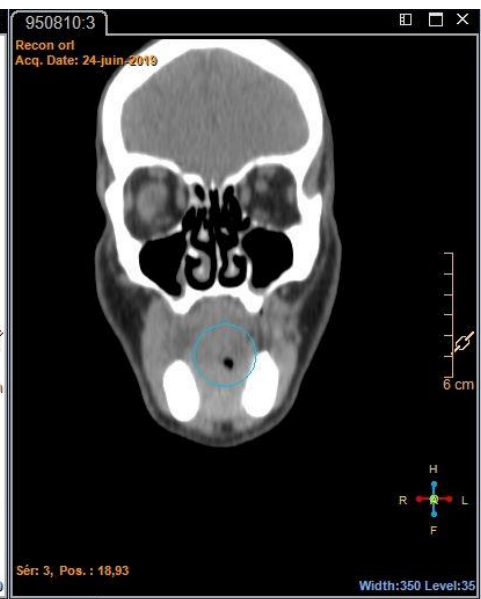
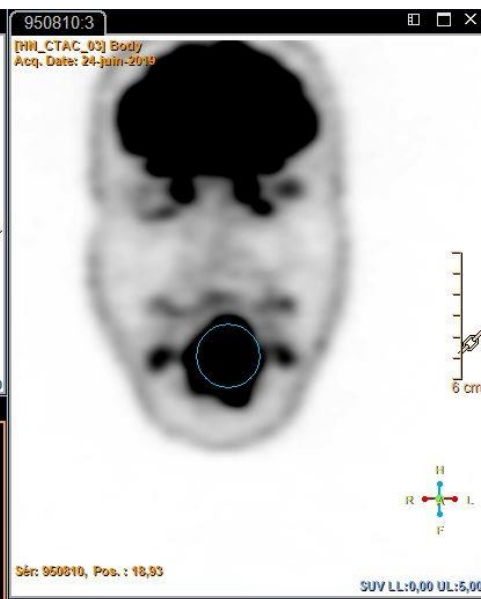
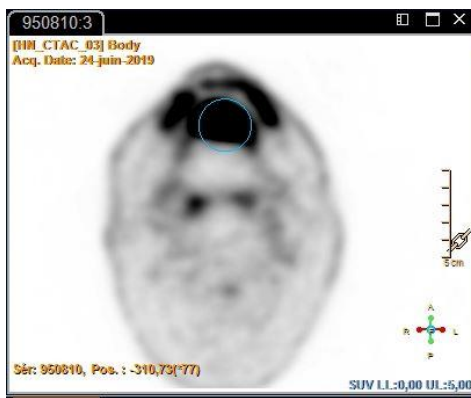


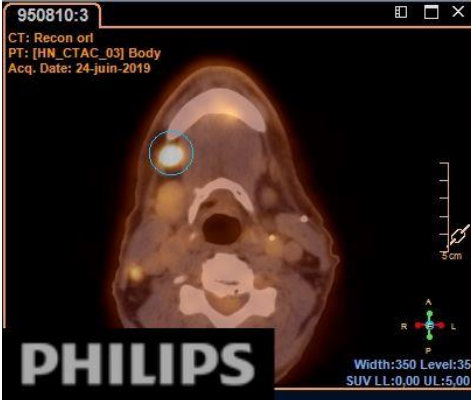
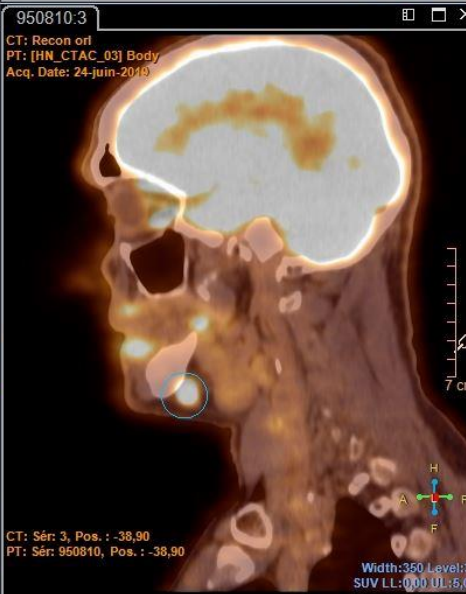
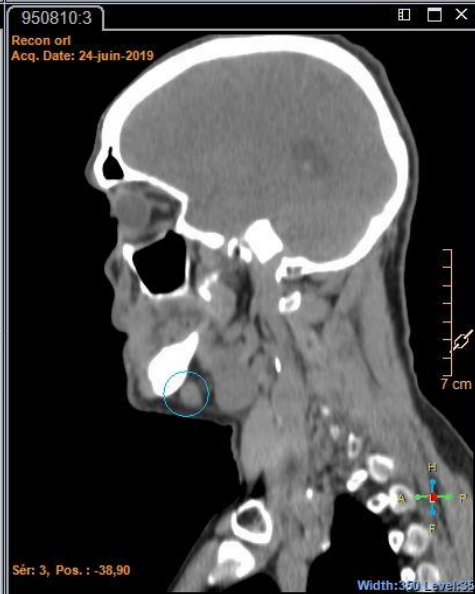
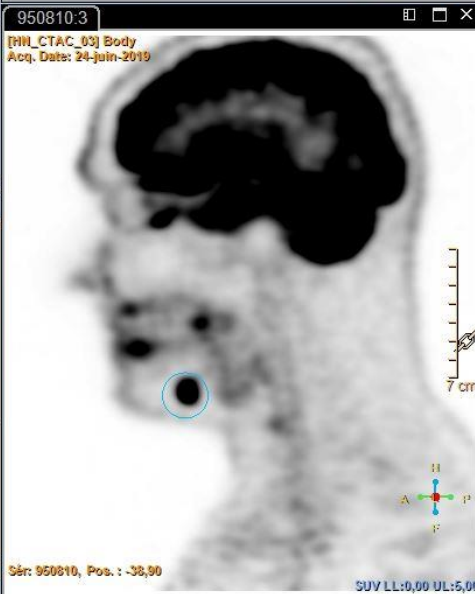
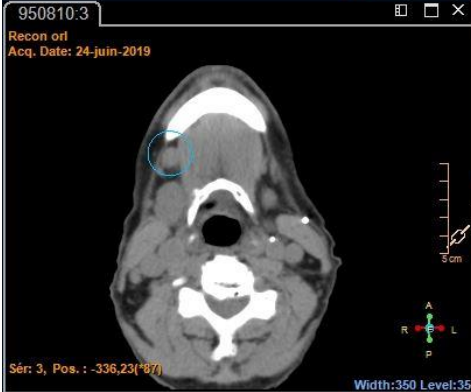
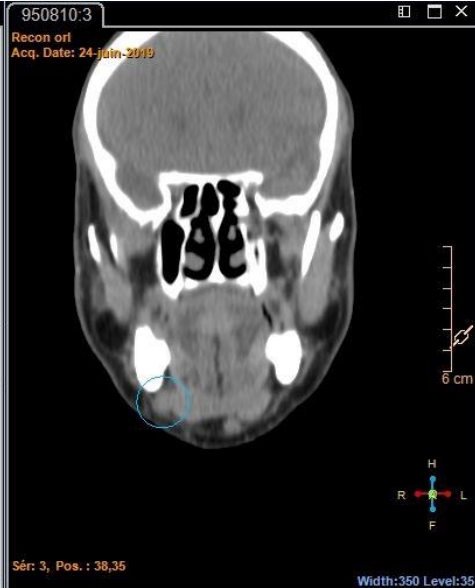
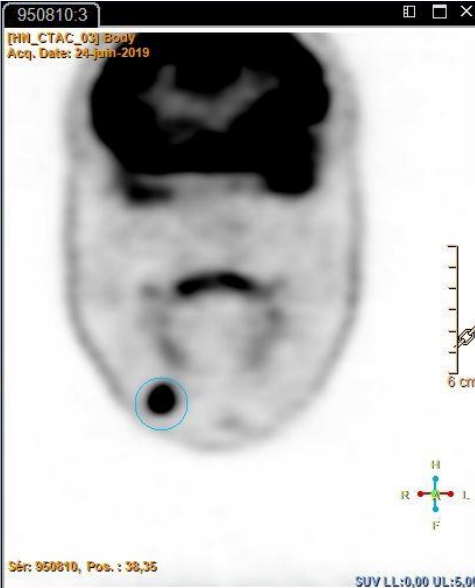
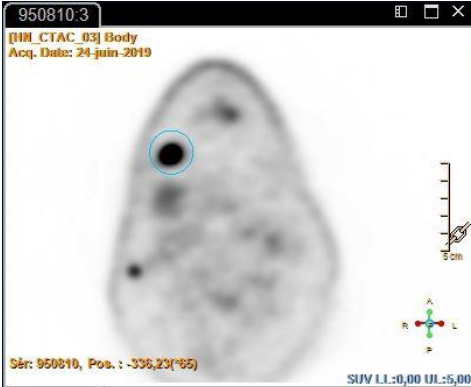


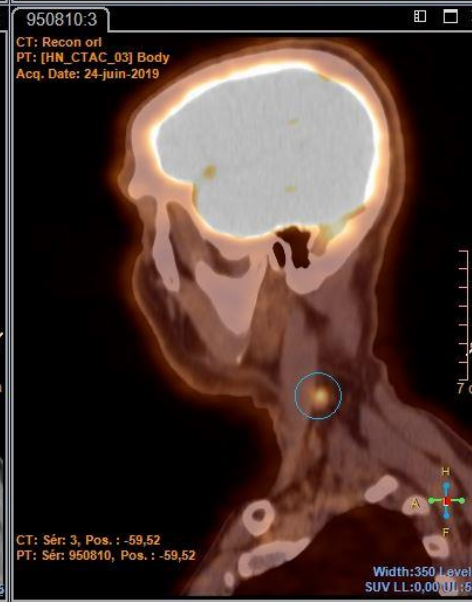
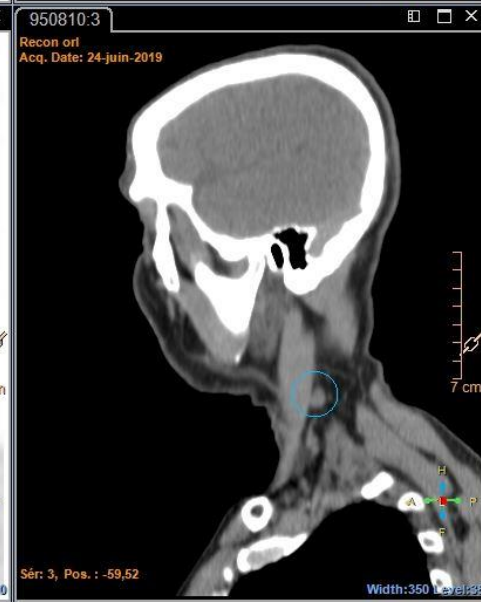
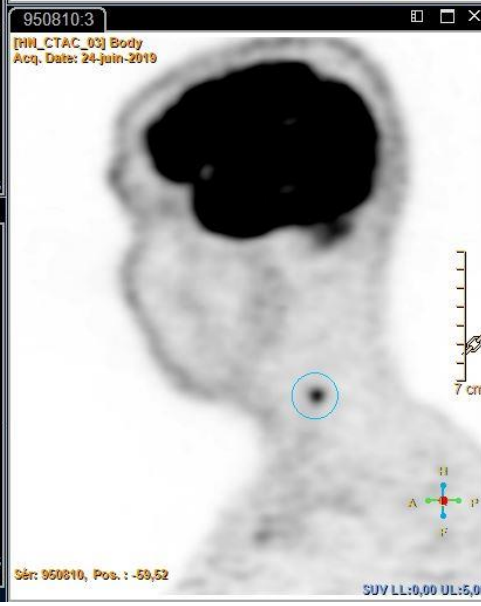
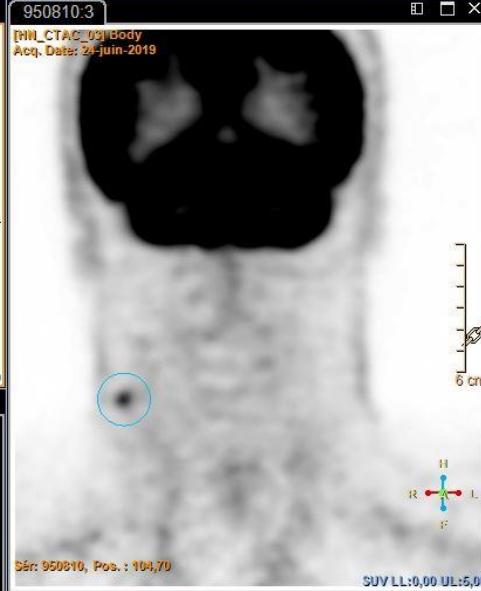
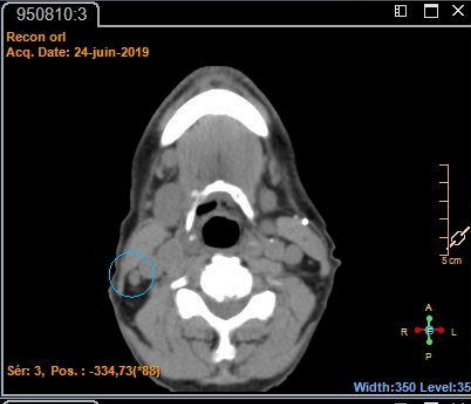
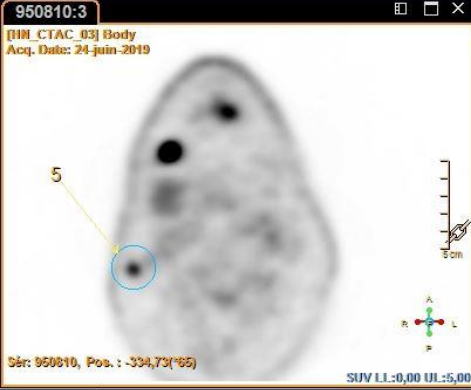
- Évolution métastatique
 - Pulmonaire
 - Osseuse
 - Surrénalienne
 - Ganglionnaire
- 2ième ligne : immunothérapie nivolumab

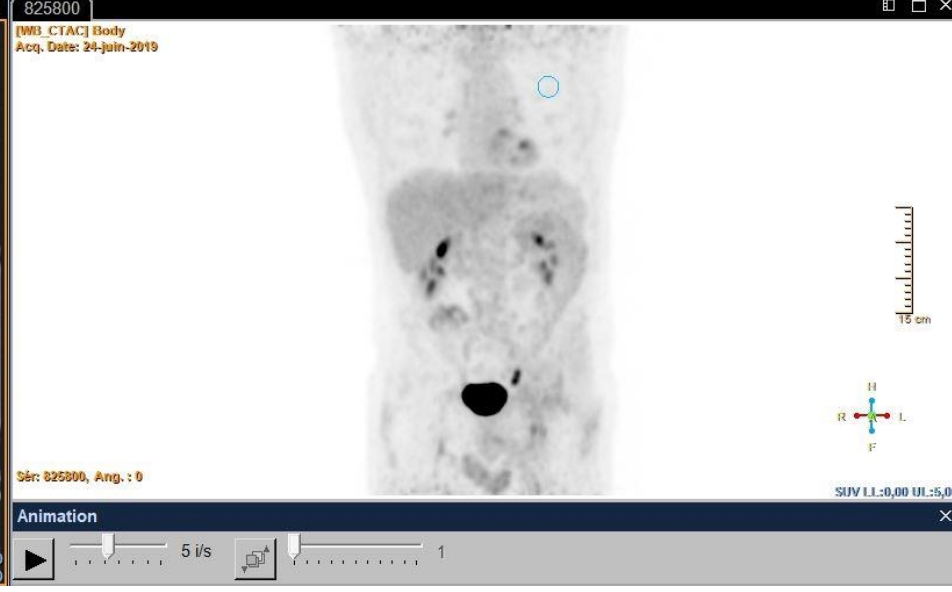
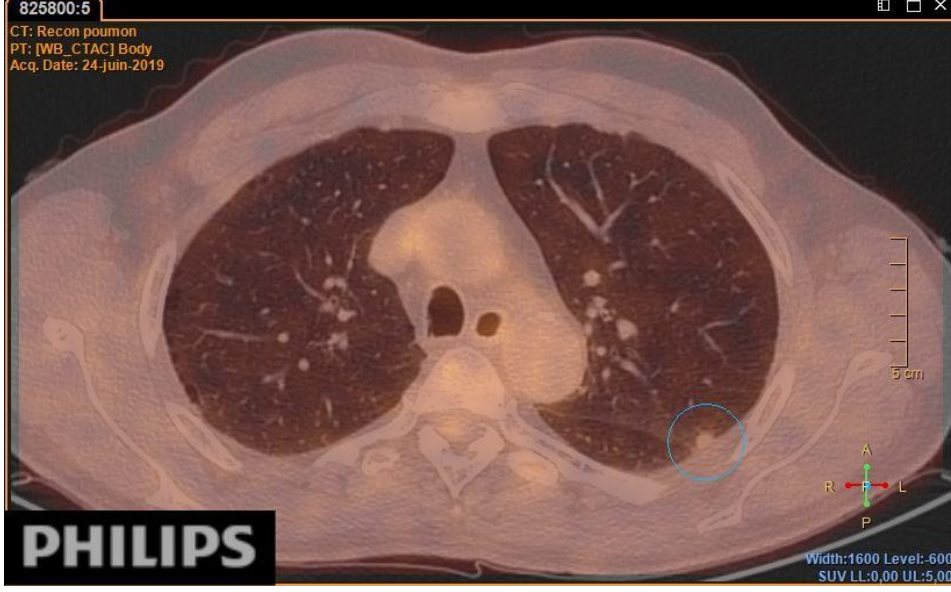
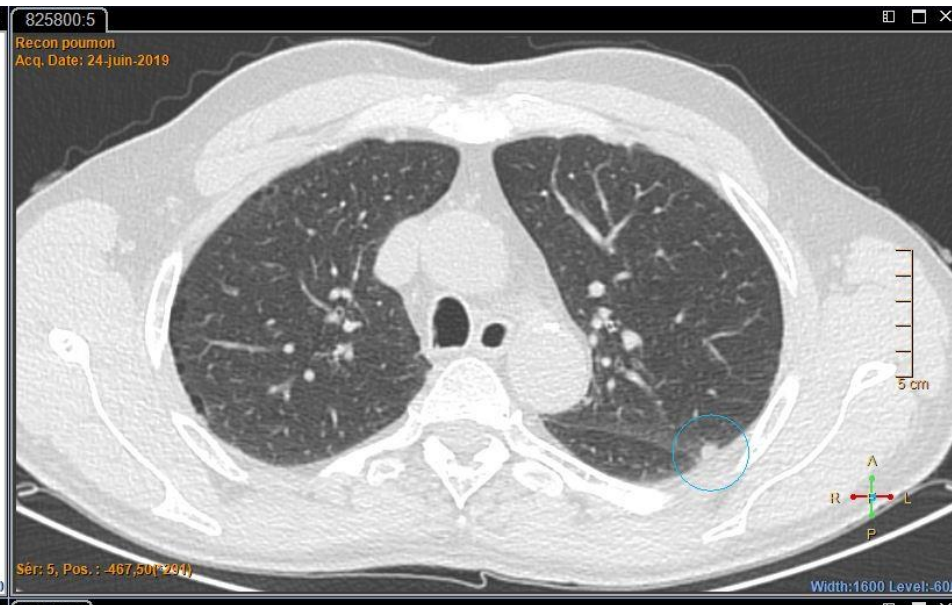
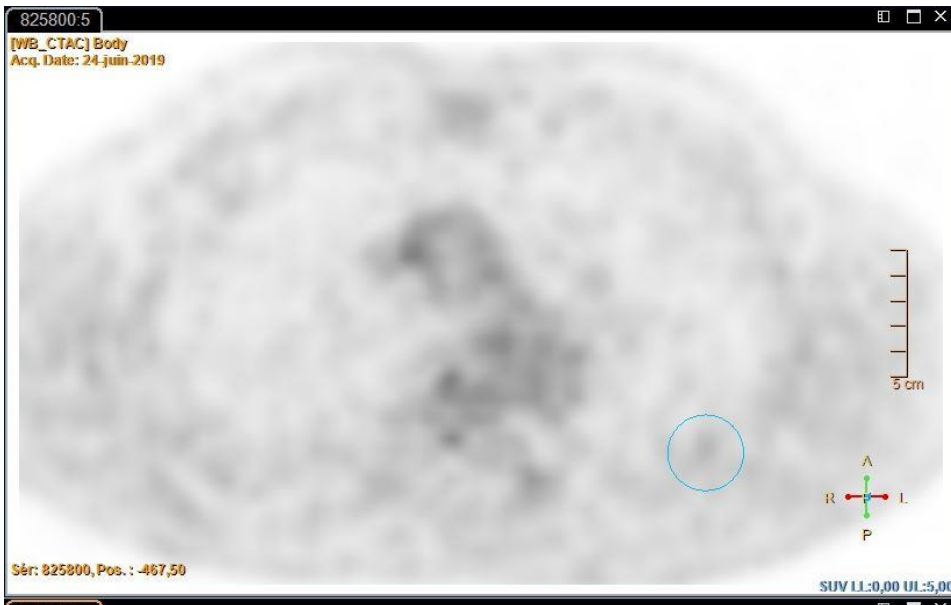
BE initial

- Monsieur DV M, 59 ans
- Lésion du plancher antérieur de bouche
- Nodule pulmonaire en IC: localisation II ou primitif ?







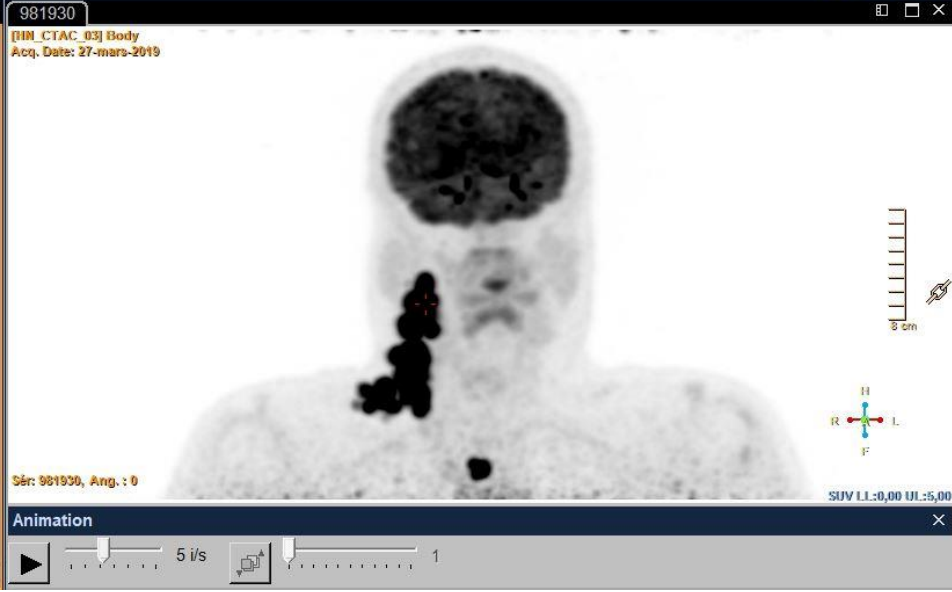
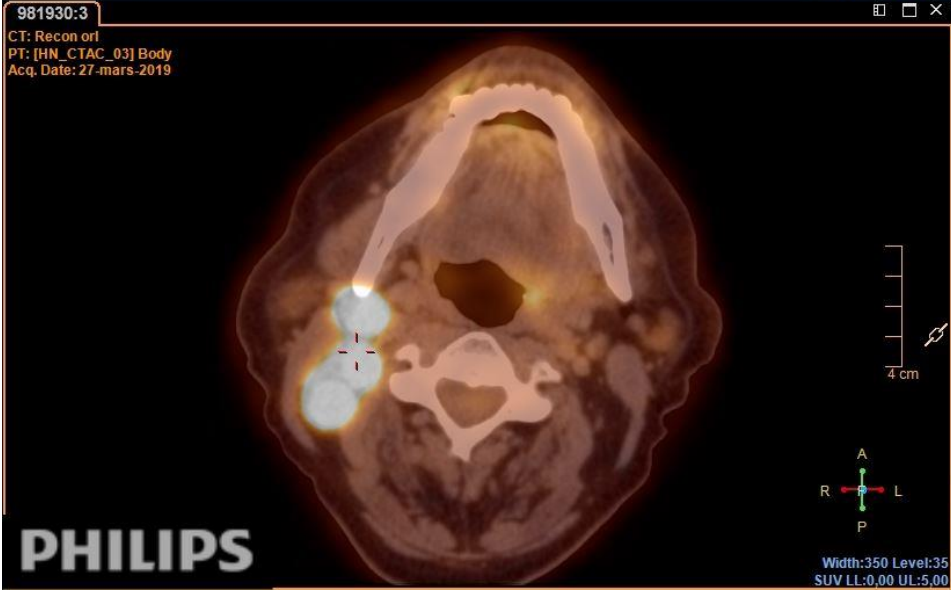
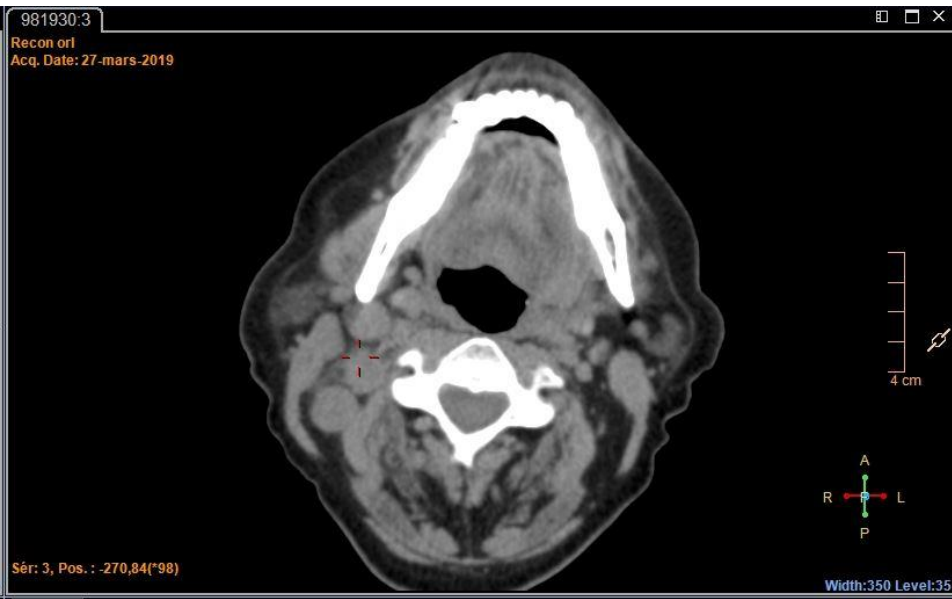
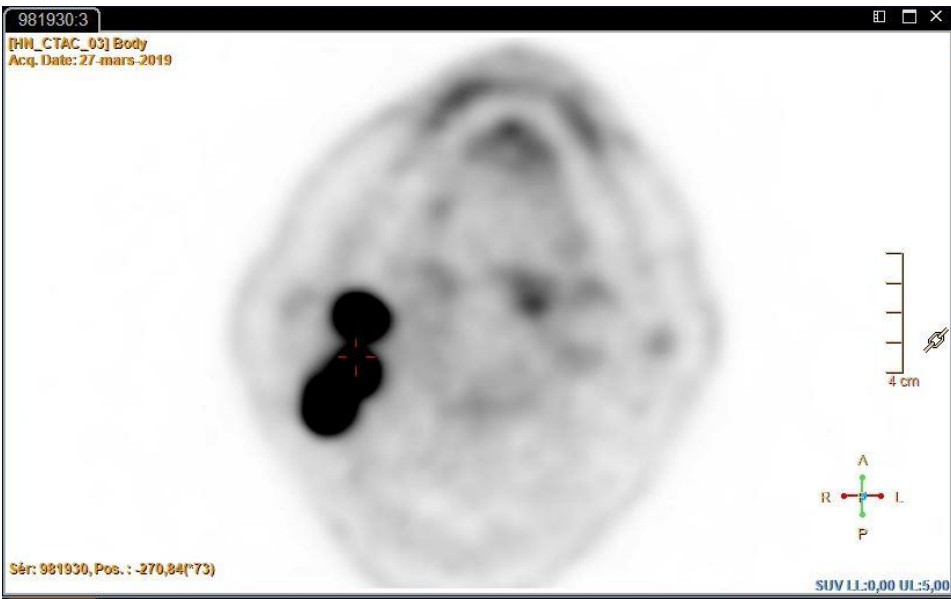


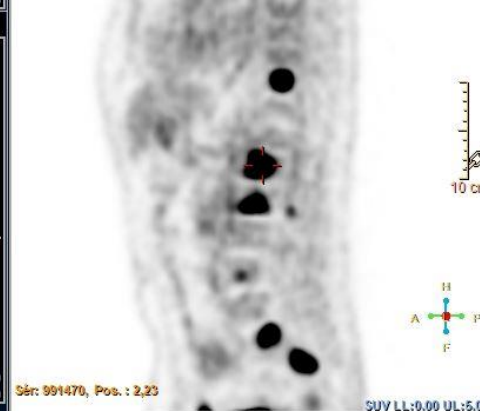
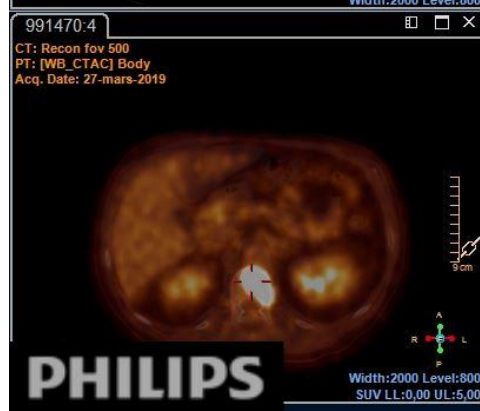
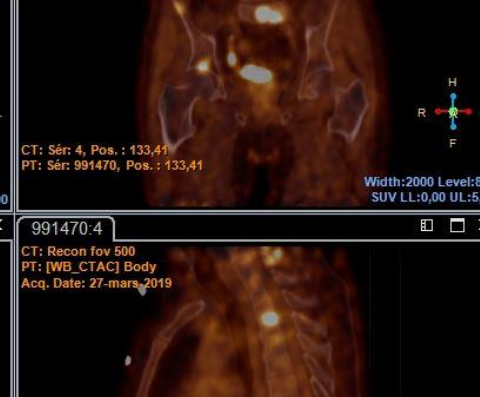
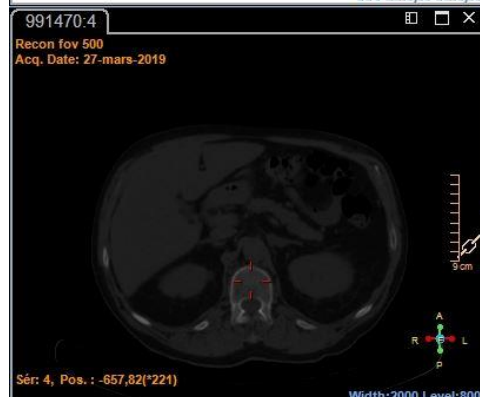
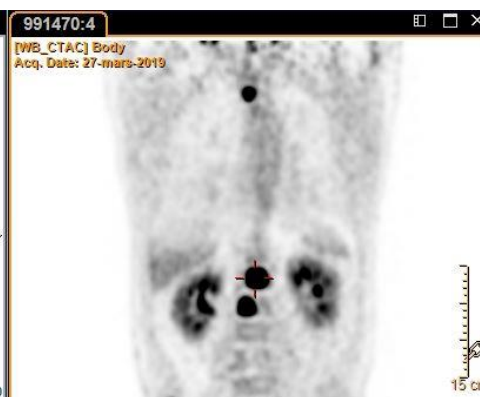
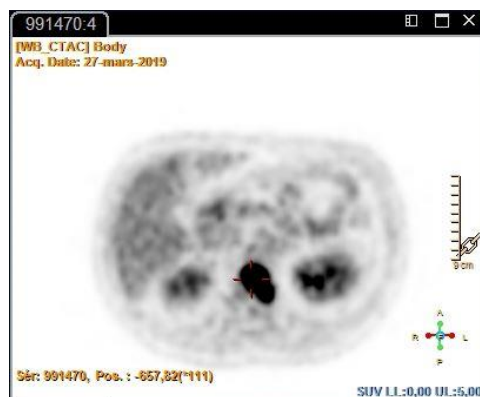
- Chirurgie: pelviglossectomie + curage 2 + lambeau nasogenien
- Carcinome épidermoïde
- Emboles vasculaires
- Recoupes limites
- Adp + en rupture capsulaire
- → radio chimioconcomitante

- surveillance

Recherche de primitif

- Monsieur M C, 62 ans,
- Tuméfaction cervicale depuis novembre 2018,
- Polyadénopathies cervicales droites, sans porte d'entrée

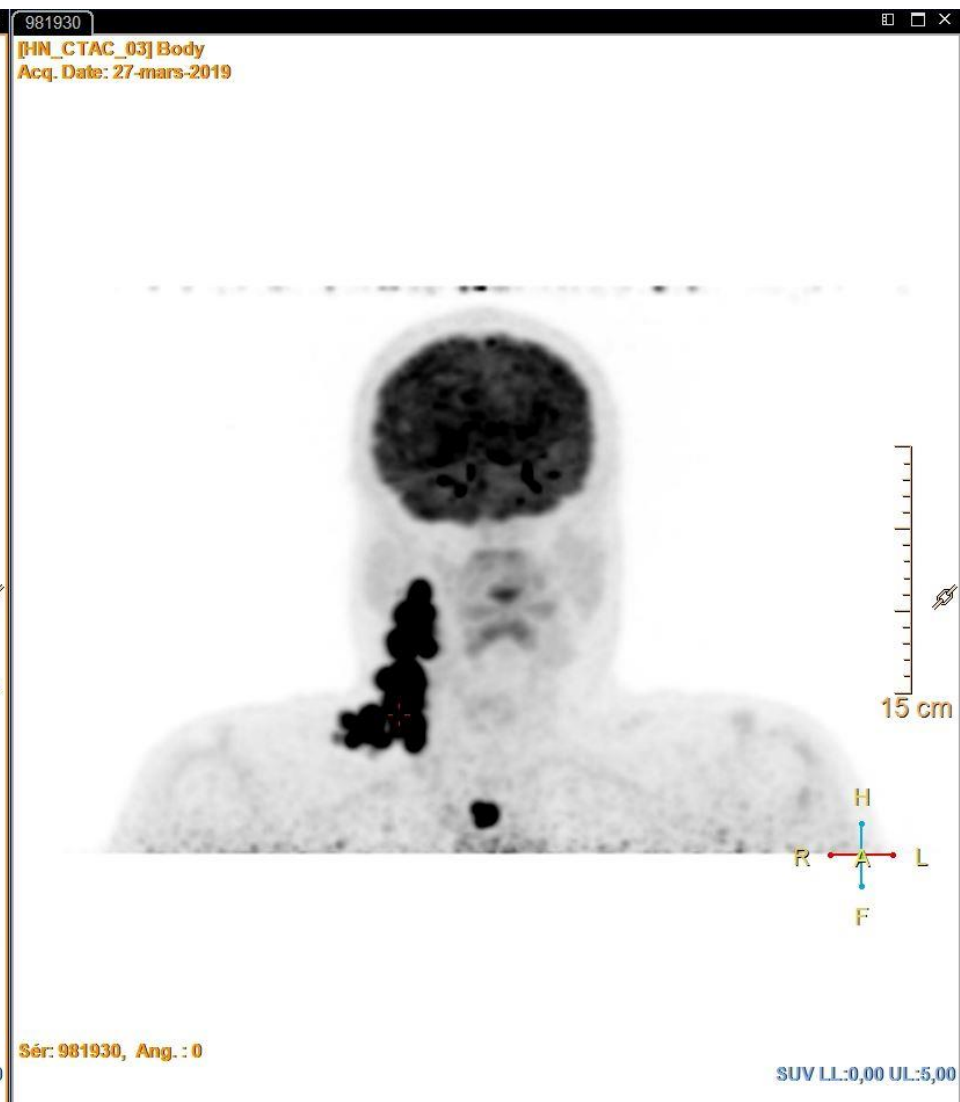
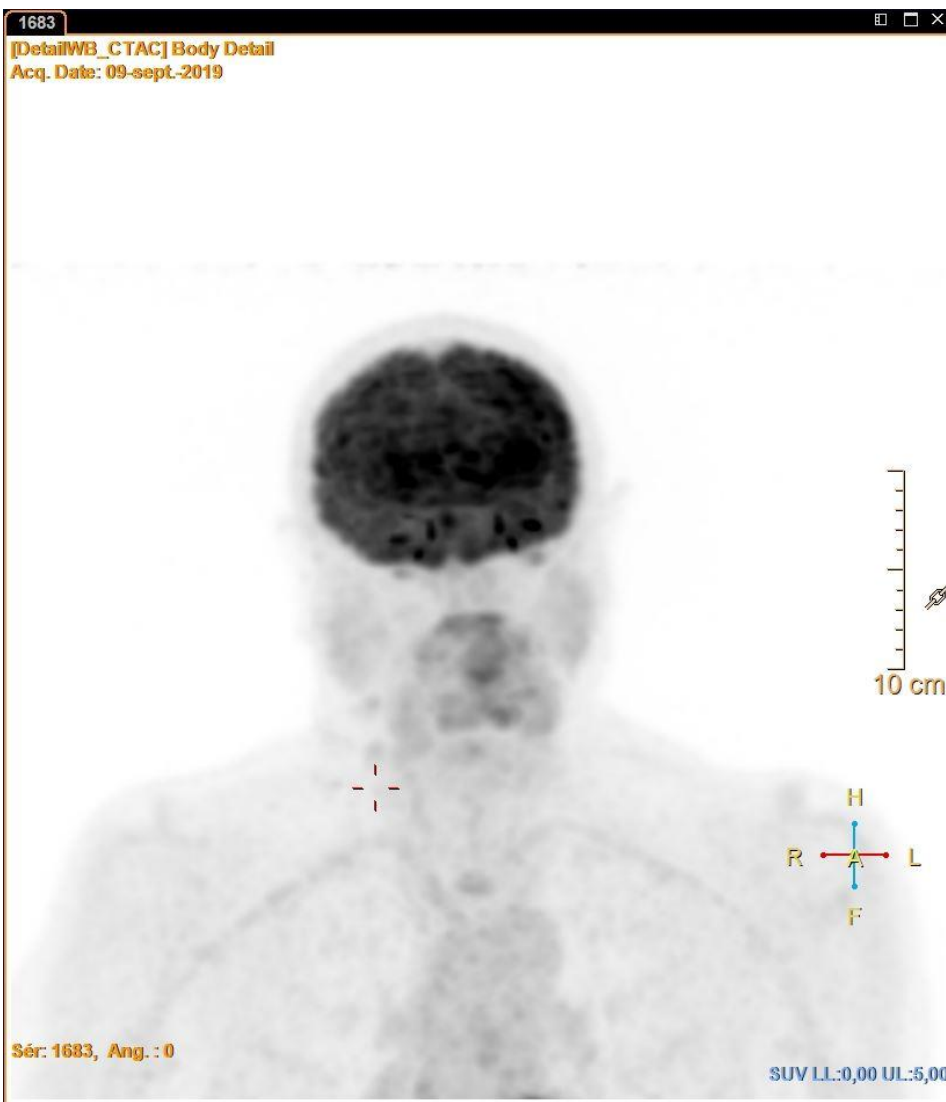




- Pas d'anomalie VADS
- Lésions ggl cervicales + lésions osseuses
- → lymphome ?????
- Bilan hémato : dysglobulinémie monoclonale IgM Kappa

- Biopsie : carcinome épidermoïde sans primitif retrouvé
- Lésions osseuses atypiques, mais pas d'autre primitif connu
- → chimio induction TCF : bonne réponse

Contrôle post traitement



PHILIPS

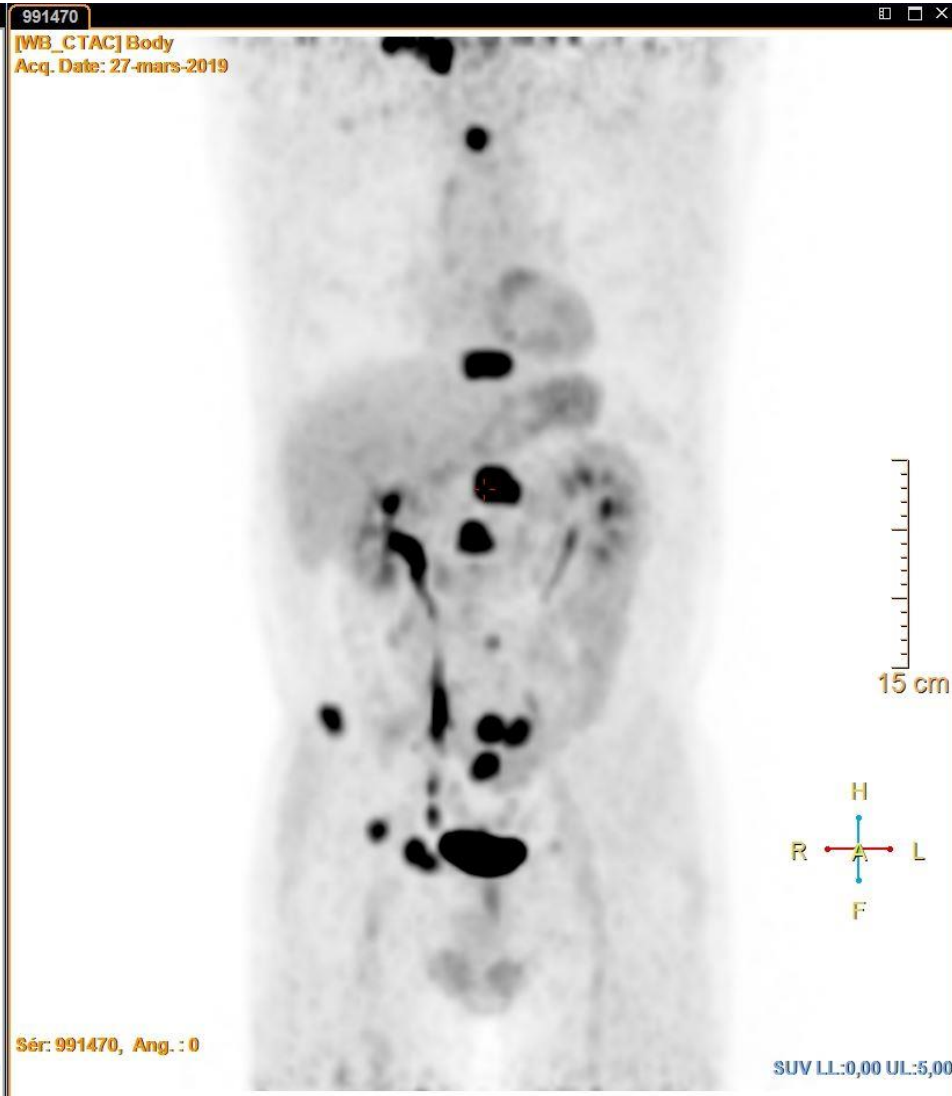
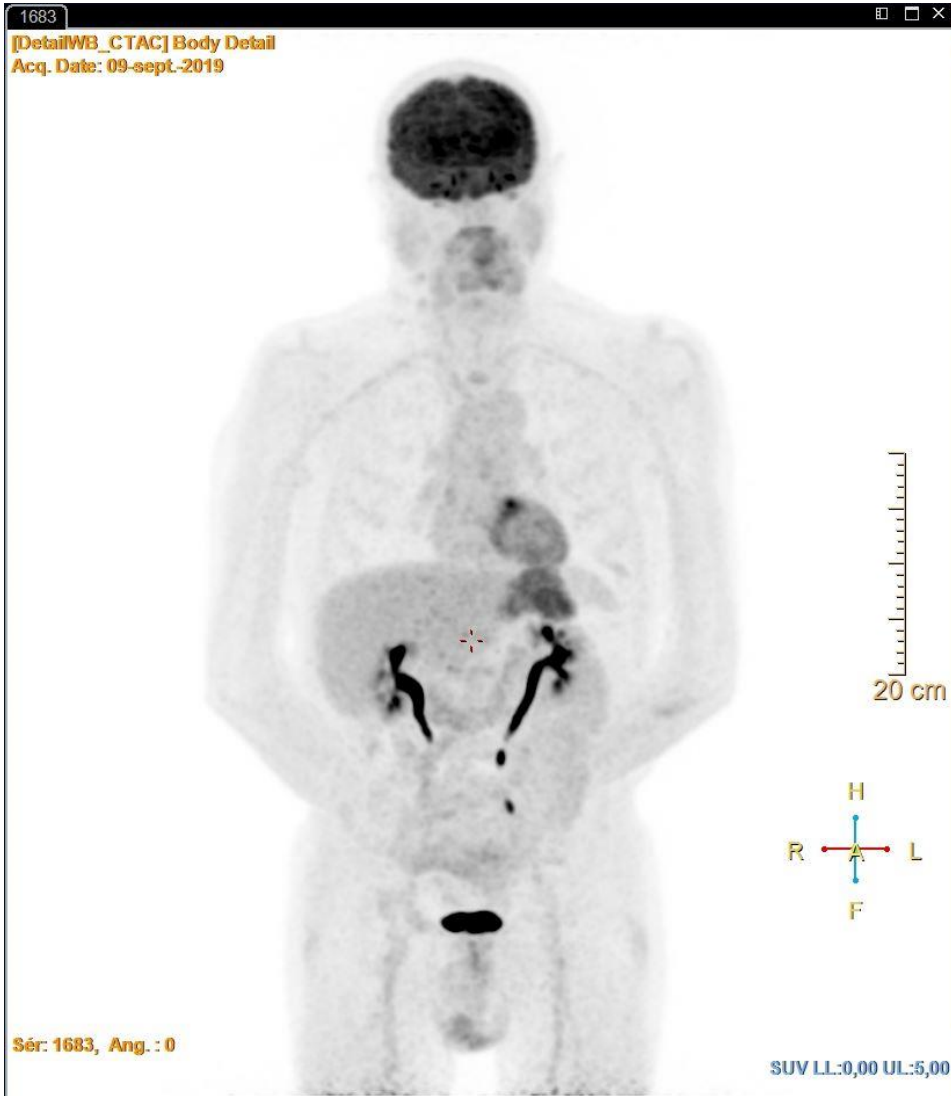
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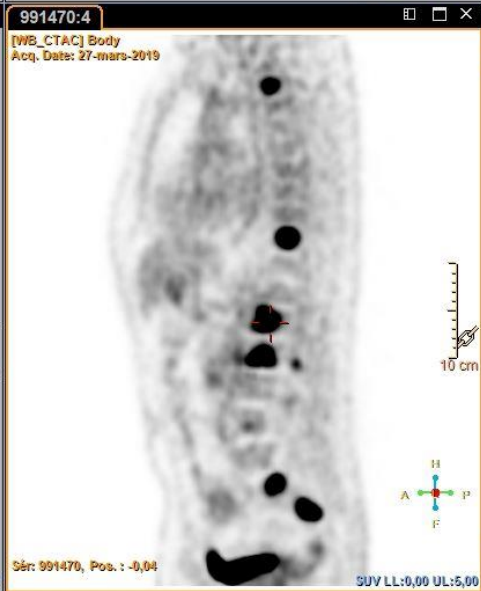
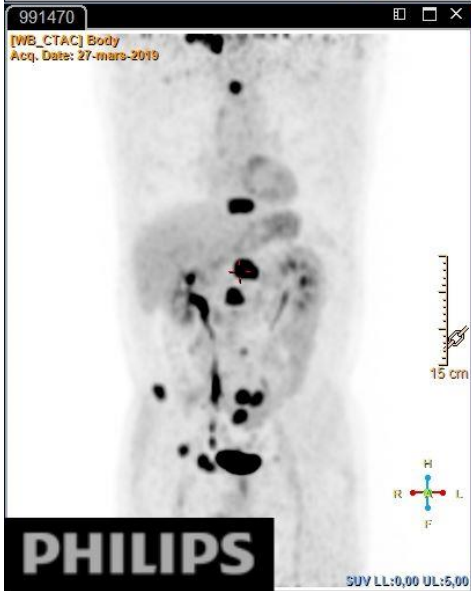
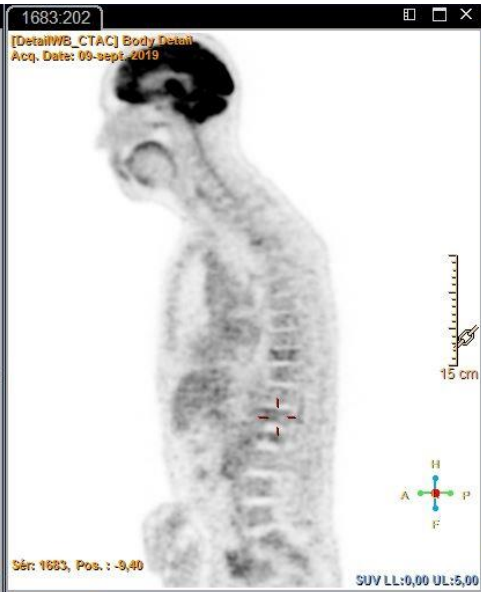
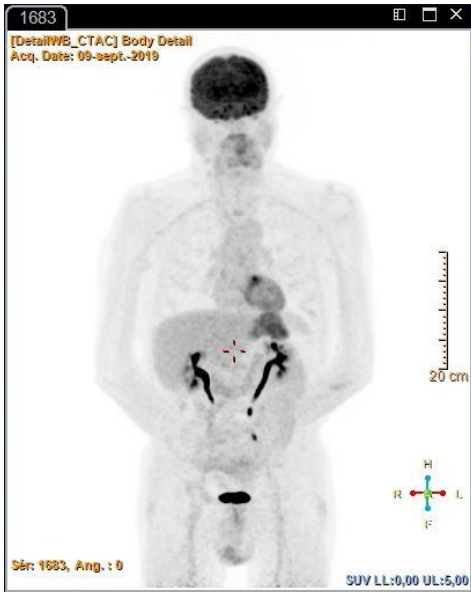


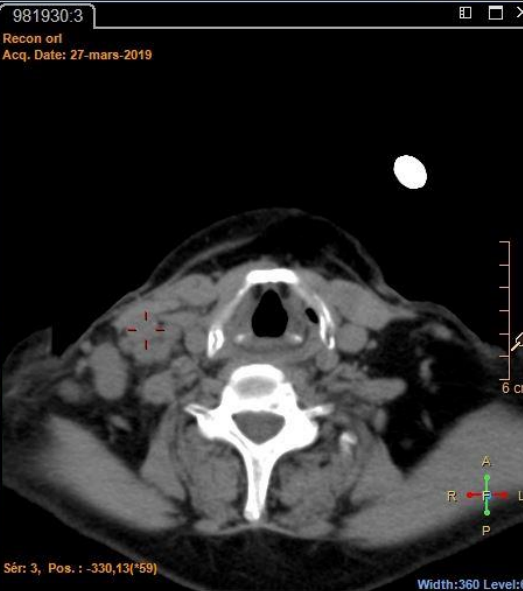
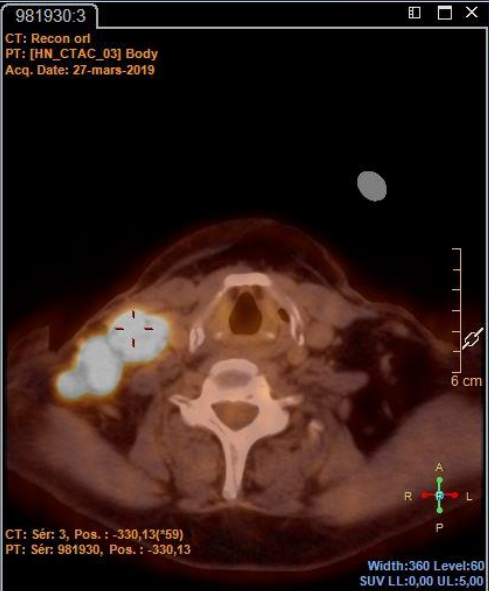
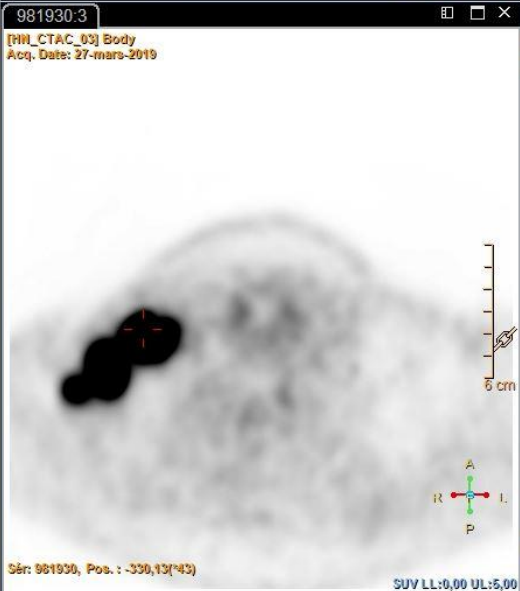
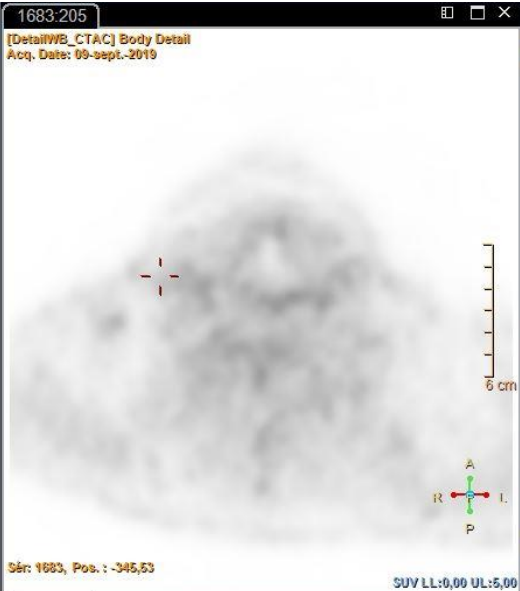
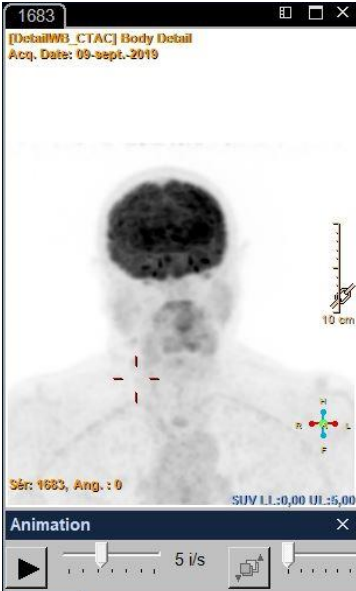
5 i/s



1







- Poursuite du TTT par
 - Radiothérapie + sels de platine