FACULTÉ DE MÉDECINE PARIS DESCARTES

ASSISTANCE PUBLIQUE HÔPITAUX DE PARIS

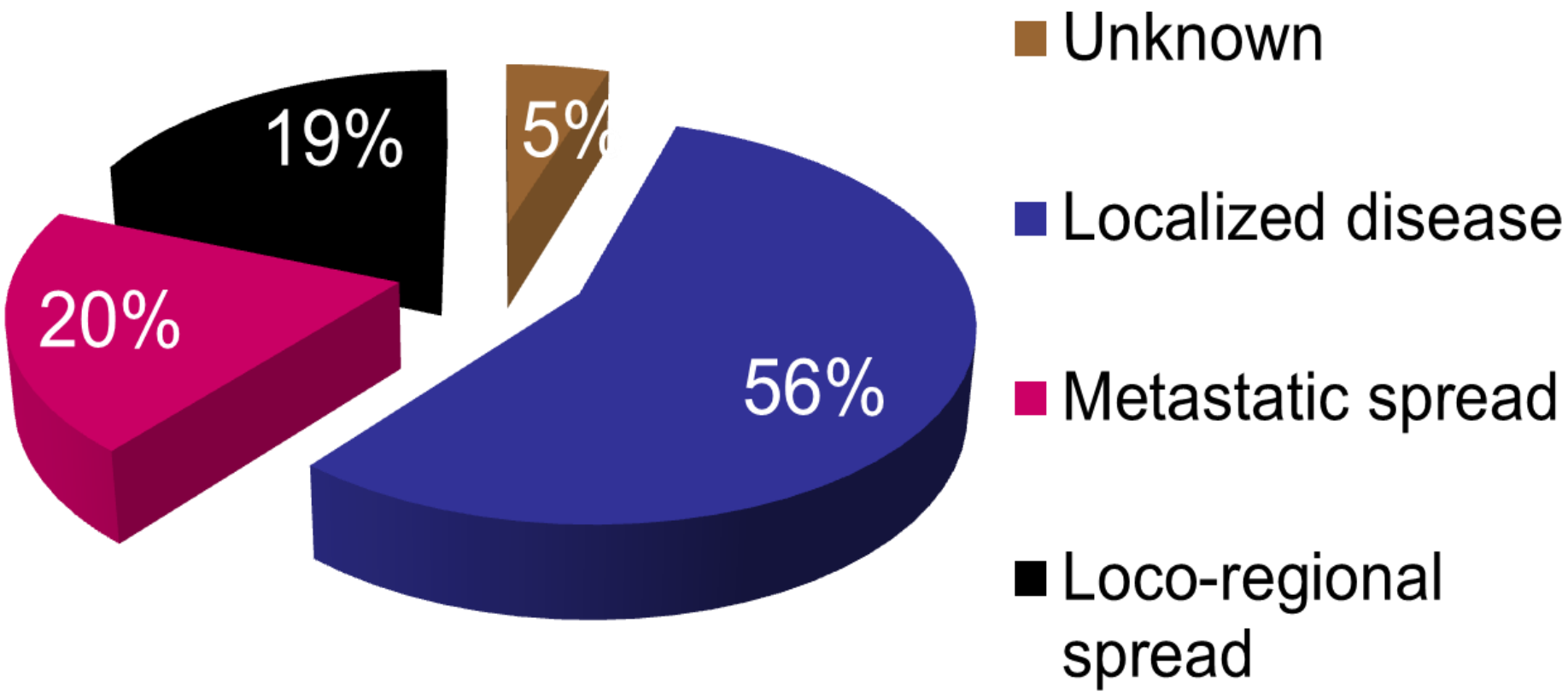
Historique des techniques chirurgicales sur les 10 années passées et mise en perspective des années à venir

Arnaud Méjean

HÔPITAUX UNIVERSITAIRES PARIS OUEST

Hôpital européen Georges-Pompidou

Extend of Disease at Diagnostic

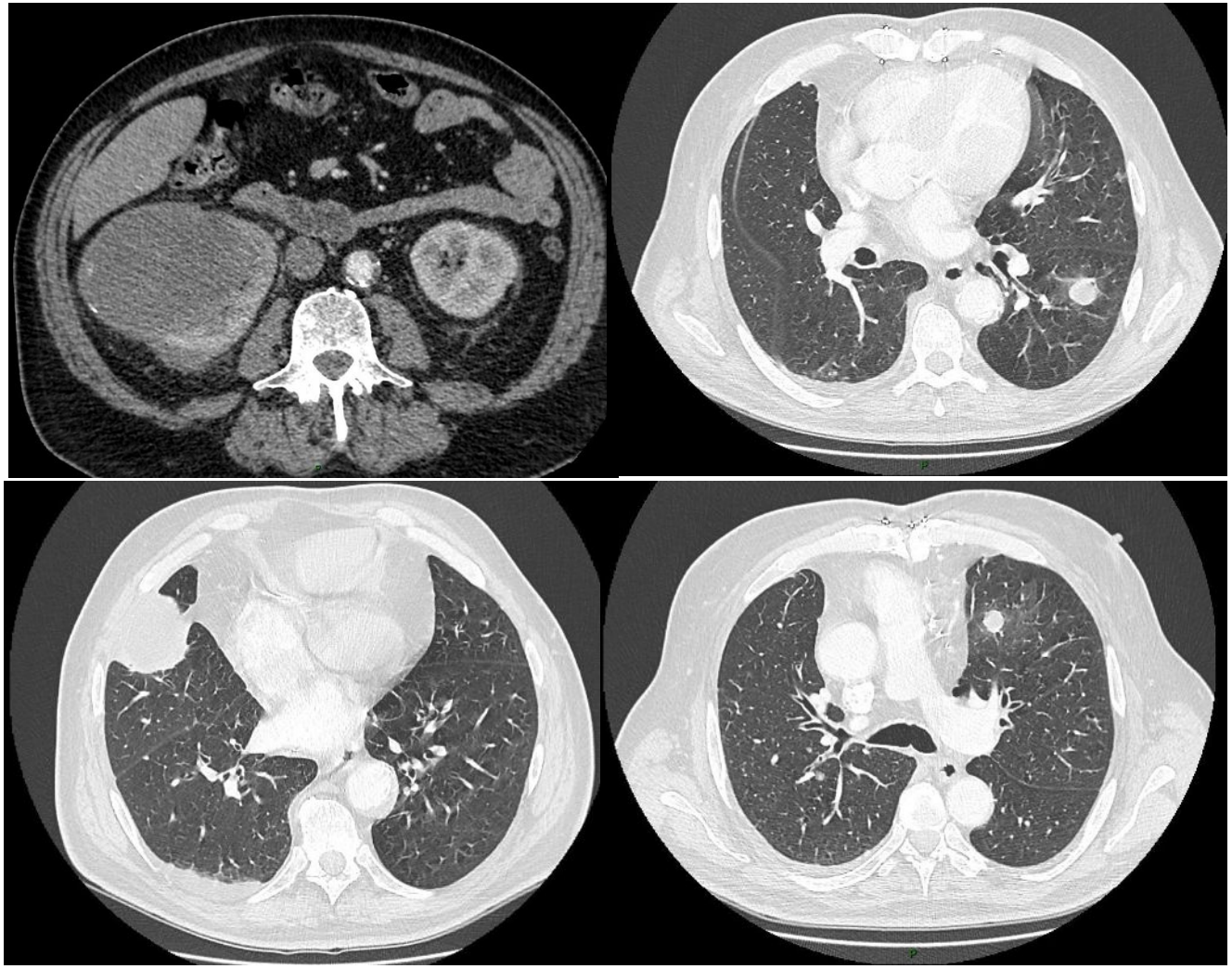


National Cancer Institute. SEER 2008, Cancer of the kidney

3 grandes situations

- Tumeur métastatique
- Tumeur localement avancée
- Tumeur localisée

CCR M+



H, 66 ans

Hématurie

AEG, - 7 Kg

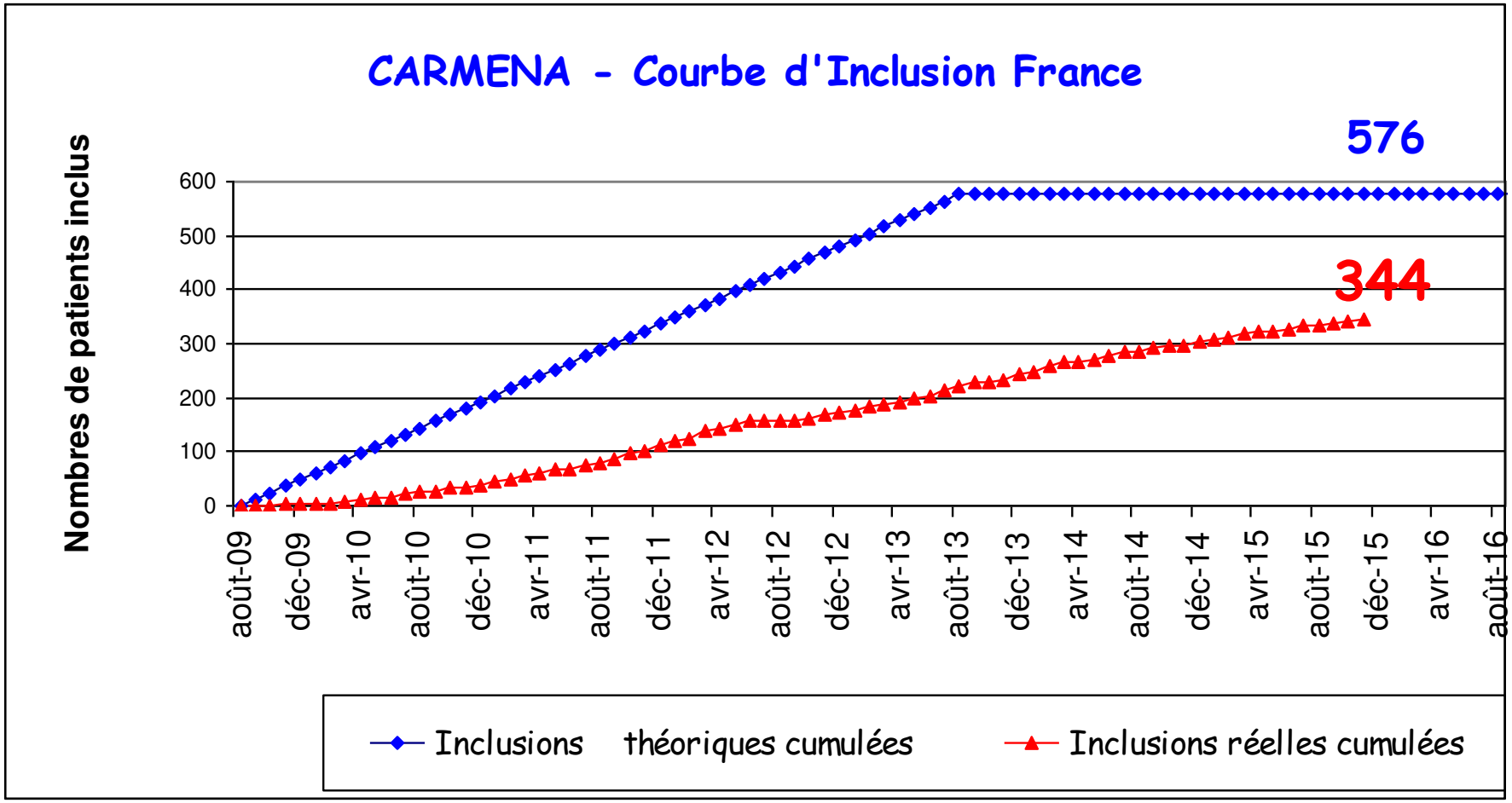
HTA, PTHD

CKD-EPI = 66 ml/min

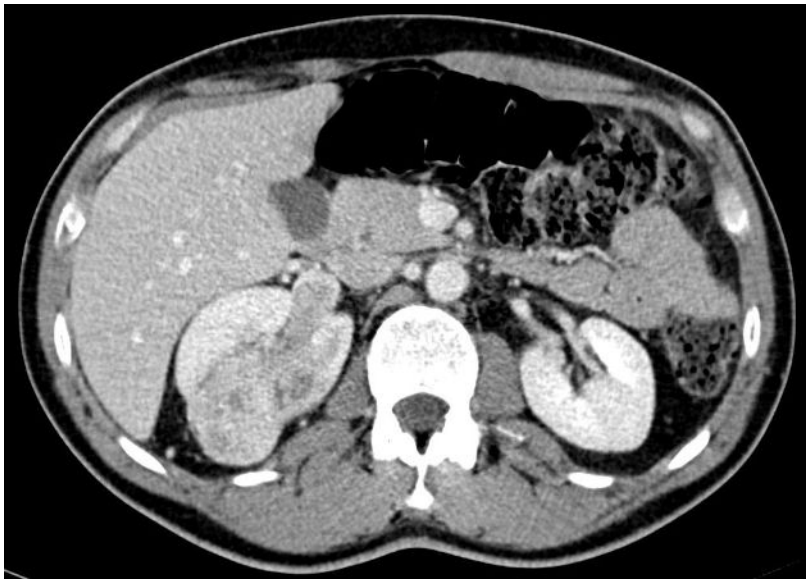
TDM 2010 : tumeur du RD de 5 cm

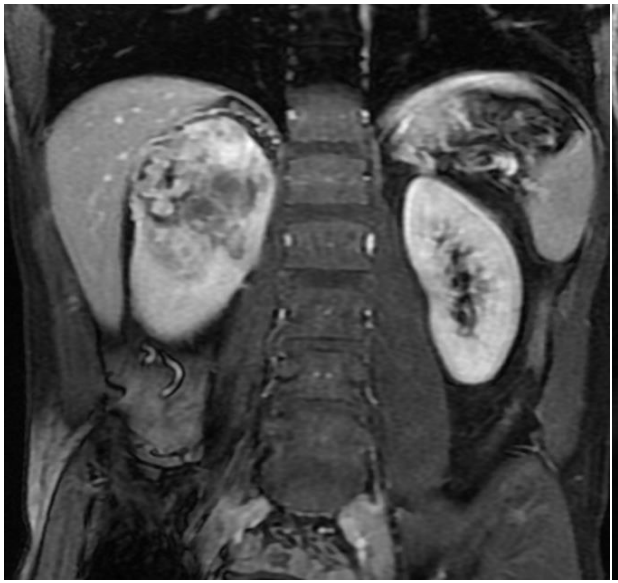
CAT CCR M+ ?

- Protocole CARMEMA
- Opérabilité ? (PS, Oncogériatrie, …)
- Si oui : Néphrectomie cytoréductive
- Si non : Biopsie +++ puis antiangiogéniques


CARMENA - Courbe d'Inclusion France
576
344
Nombres de patients inclus
600
500
400
300
200
100
0
août-09
déc-09
avr-10
août-10
déc-10
avr-11
août-11
déc-11
avr-12
août-12
déc-12
avr-13
août-13
déc-13
avr-14
août-14
déc-14
avr-15
août-15
déc-15
avr-16
août-16
Inclusions théoriques cumulées
Inclusions réelles cumulées

CCR localement avancé





H, 52 ans

Hématurie

TBEG

Otospongiose

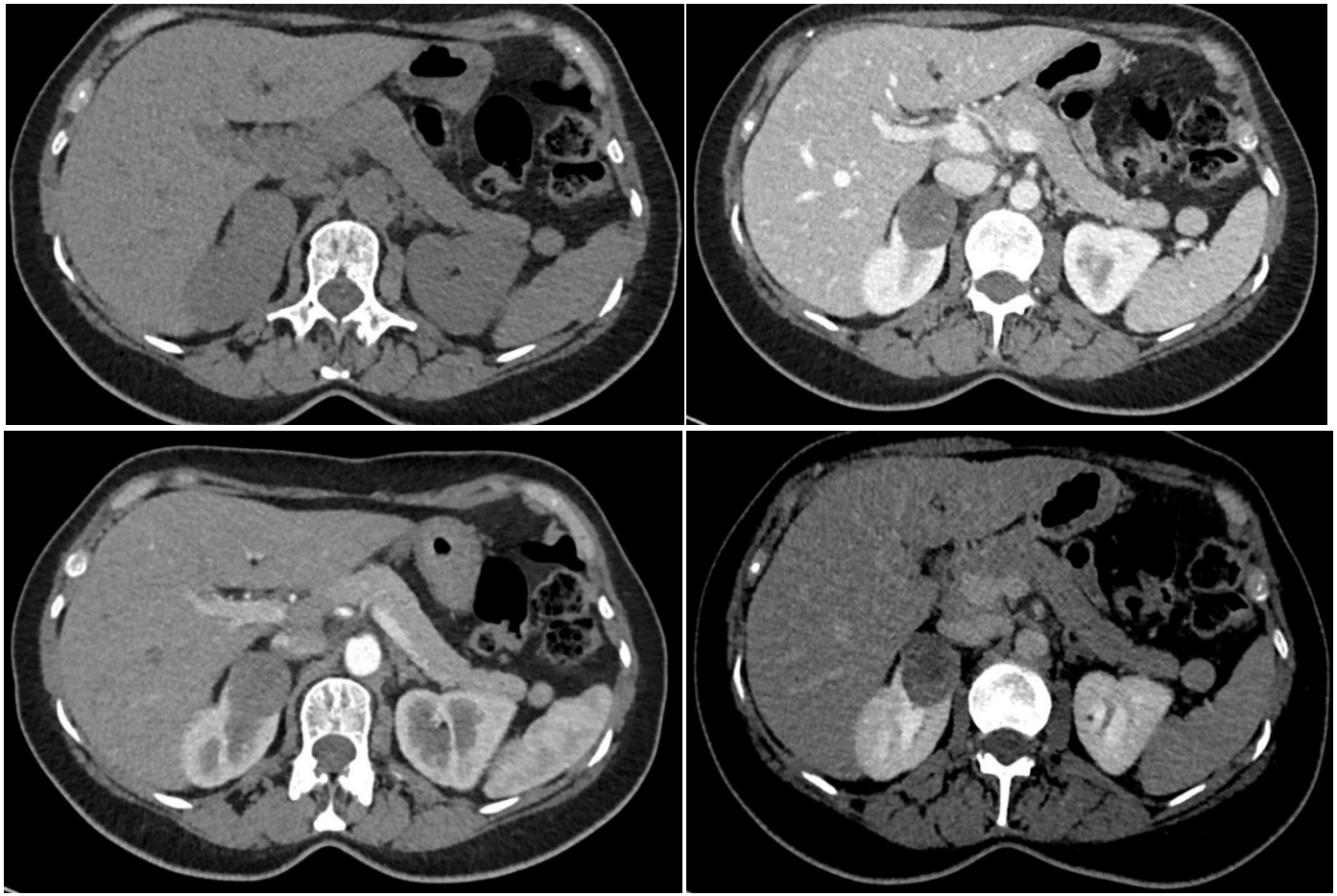
CKD-EPI = 86 ml/min

Doute sur thrombus

CAT RCC localement avancé ?

- Bilan complet ?
- Opérabilité ? (PS, Oncogériatrie, …)
- Antiangiogéniques néo-adjuvant après biopsie ?
- Traitement : Néphrectomie totale avec éxérèse la plus complète possible

Tumeur du rein localisée



F, 42 ans

Découverte fortuite sur écho

ATCD gynéco

CKD-EPI = 112 ml/min

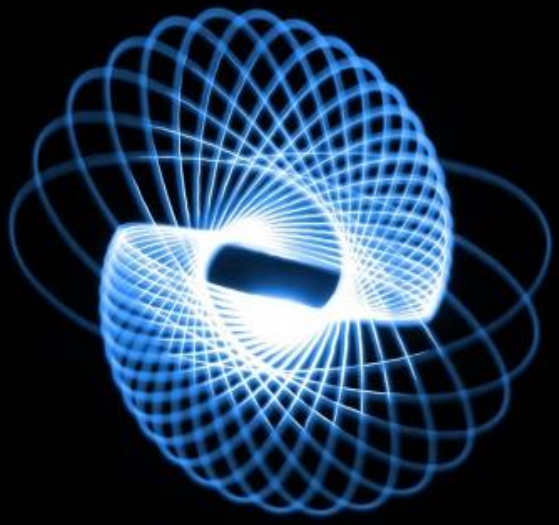
CAT Tumeur localisée ?

- Complément d'imagerie (TDM tho, IRM, écho de contraste) ?
- Biopsie ?
- Traitement ?
- RCP +++

Size, Volume
Location, Peri-tumoral fat
Limits, Hilar fat

Tumor

Kidney



Patient

Creat serum
eGFR
Renal disease

Age
BMI
Comorbidity
Oncogeriatry
Anticoag

MSKCC disease free survival

Open PN < 4 cm, pT1a, all histo

Lee, J Urol, 2000

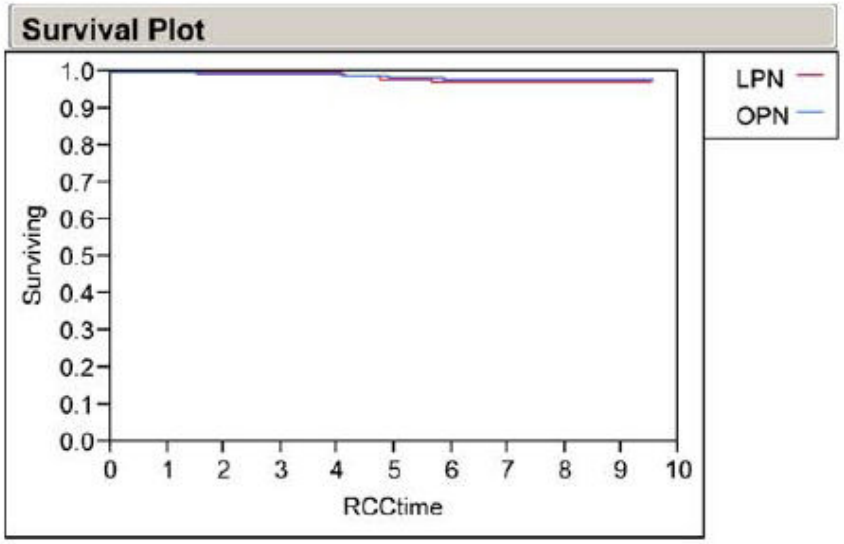
60 mo = 95 % DFS

7-Year Oncological Outcomes After Laparoscopic and Open Partial Nephrectomy

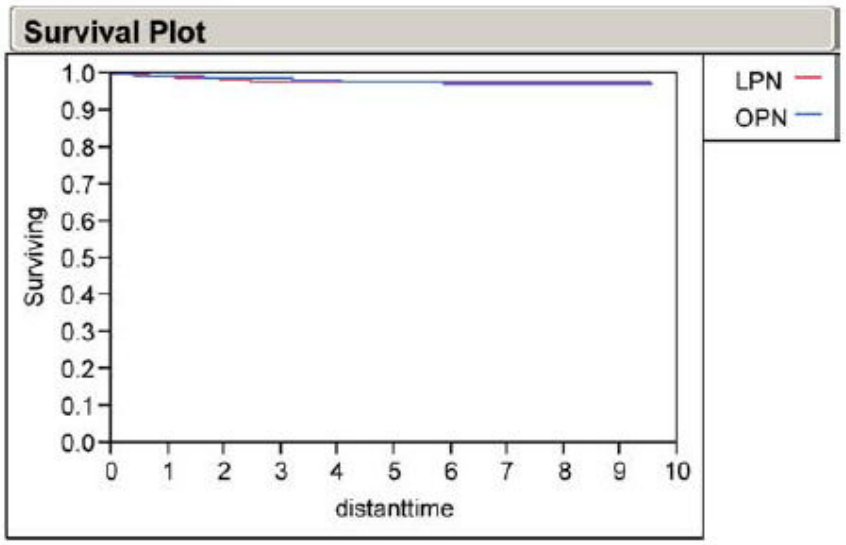
Brian R. Lane*,† and Inderbir S. Gill‡,§

THE JOURNAL OF UROLOGY® Vol. 183, 473-479, February 2010

A



B

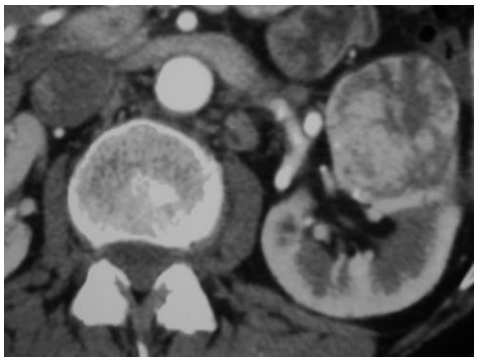


Kaplan-Meier estimates of cancer specific (*A*) and metastasis-free (*B*) survival after LPN and OPN.

Dogme de la NE

Néphrectomie partielle

Recommandations sur les traitements conservateurs des tumeurs du rein localisées		
Indications	Recommandations	Grade
Élective	La néphrectomie partielle est recommandée pour le traitement de toutes les tumeurs T1 sous réserve de l'obtention de marges saines et d'une morbidité prévisible acceptable.	C



Patard et al, Prog Urol, 2013

Recommendations	GR
Surgery is recommended to achieve cure in localised RCC.	B
PN is recommended in patients with T1a tumours.	A
PN should be favoured over RN in patients with T1b tumour, whenever feasible.	B
Ipsilateral adrenalectomy is not recommended when there is no clinical evidence of invasion of the adrenal gland.	B
LND is not recommended in localised tumour without clinical evidence of LN invasion.	A

Ljunberg et al, EAU, 2015

NE facteur de risque d'IR ?

- 662 pts, 1989 -2005, T unique < 4 cm, rein controlat sain, créat normale
- 390 NP, 272 NE

26 % MDRD préop < 60 ml/'

Huang WC, Lancet, 2006

Chronic kidney disease after nephrectomy in patients with renal cortical tumours: a retrospective cohort study

William C Huang, Andrew S Levey, Angel M Serio, Mark Snyder, Andrew J Vickers, Ganesh V Raj, Peter T Scardino, Paul Russo

Lancet Oncol 2006; 7: 735–40

26% pts (créat nle) sont IR avant chir

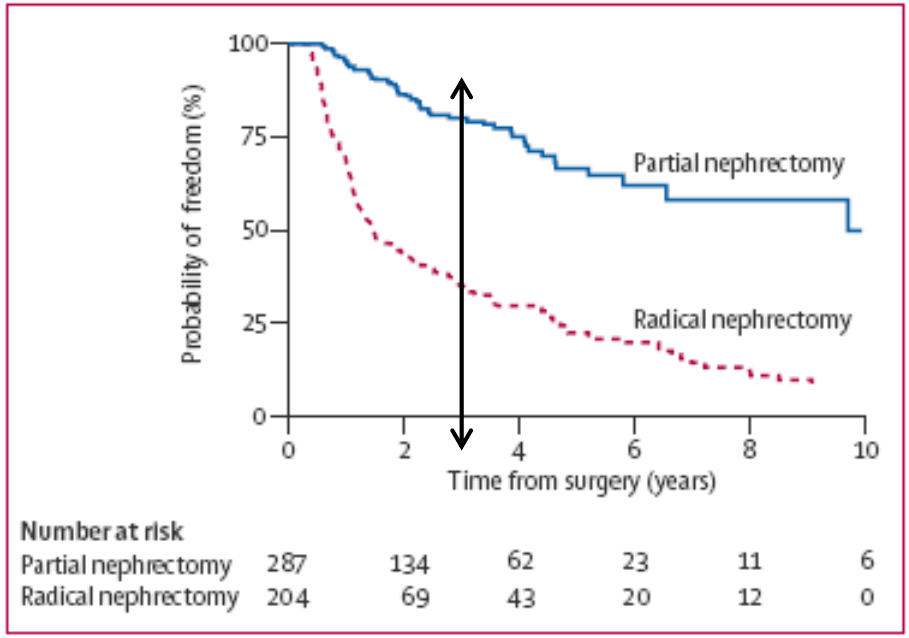


Figure 2: Probability of freedom from new onset of GFR lower than 60 mL/min per 1·72 m², by operation type

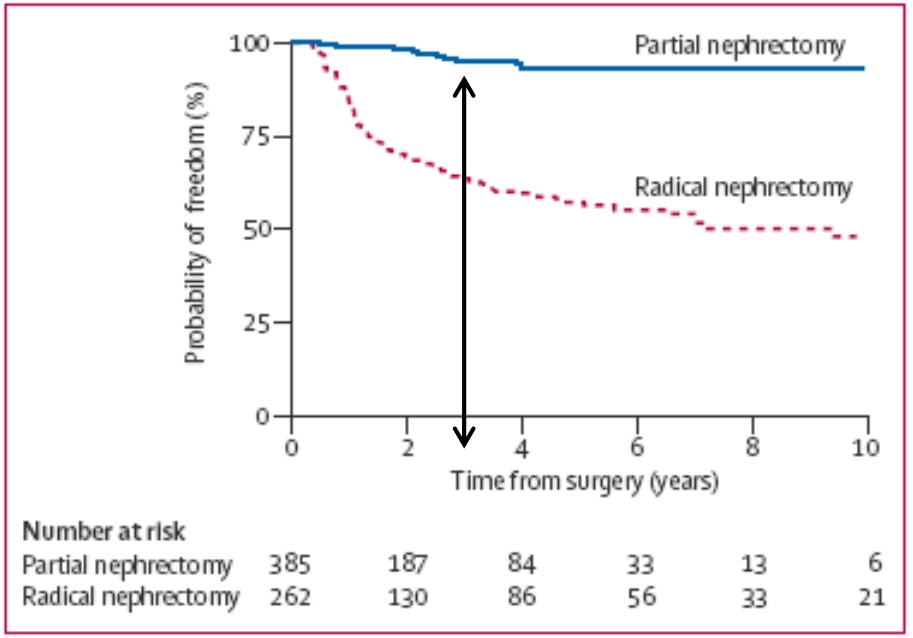


Figure 3: Probability of freedom from new onset of GFR lower than 45 mL/min per 1·72 m², by operation type

A 3 ans

80% après NP
35% après NE

95% après NP
64% après NE

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

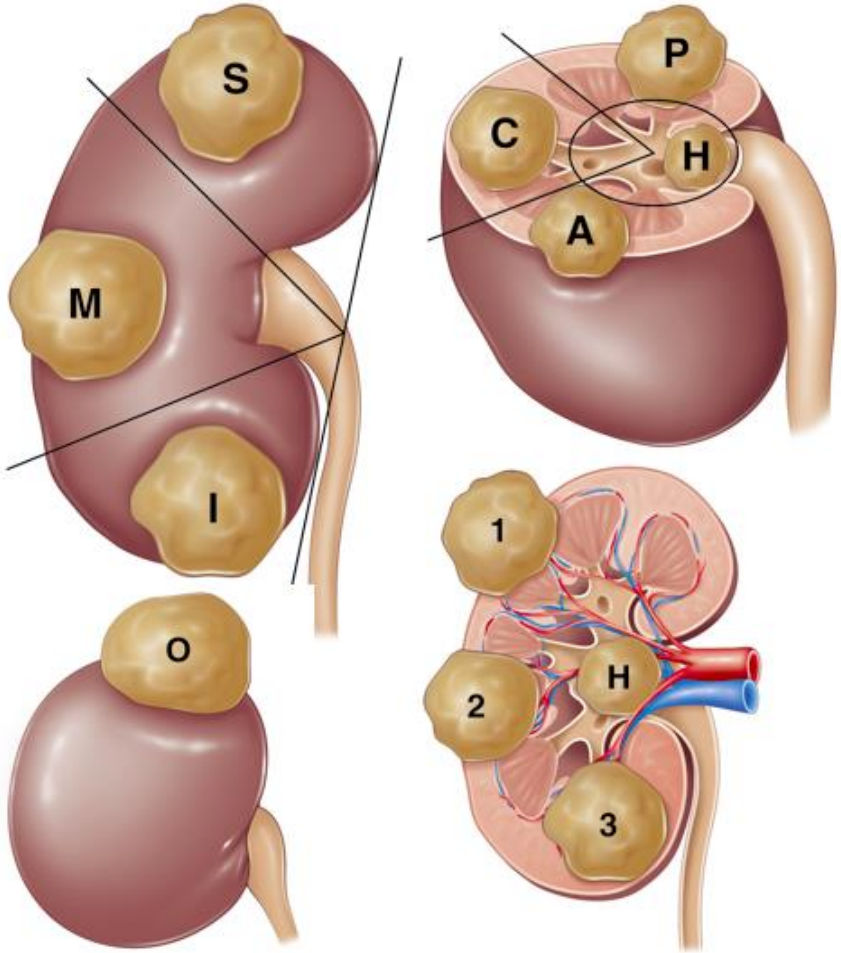
Chronic Kidney Disease and the Risks of Death, Cardiovascular Events, and Hospitalization

Alan S. Go, M.D., Glenn M. Chertow, M.D., M.P.H., Dongjie Fan, M.S.P.H., Charles E. McCulloch, Ph.D., and Chi-yuan Hsu, M.D.

1 120 295 adultes
FU = 2.84 ans

Estimated GFR	Death from Any Cause	Any Cardiovascular Event	Any Hospitalization
	adjusted hazard ratio (95 percent confidence interval)		
≥60 ml/min/1.73 m²†	1.00	1.00	1.00
45–59 ml/min/1.73 m²	1.2 (1.1–1.2)	1.4 (1.4–1.5)	1.1 (1.1–1.1)
30–44 ml/min/1.73 m²	1.8 (1.7–1.9)	2.0 (1.9–2.1)	1.5 (1.5–1.5)
15–29 ml/min/1.73 m²	3.2 (3.1–3.4)	2.8 (2.6–2.9)	2.1 (2.0–2.2)
<15 ml/min/1.73 m²	5.9 (5.4–6.5)	3.4 (3.1–3.8)	3.1 (3.0–3.3)

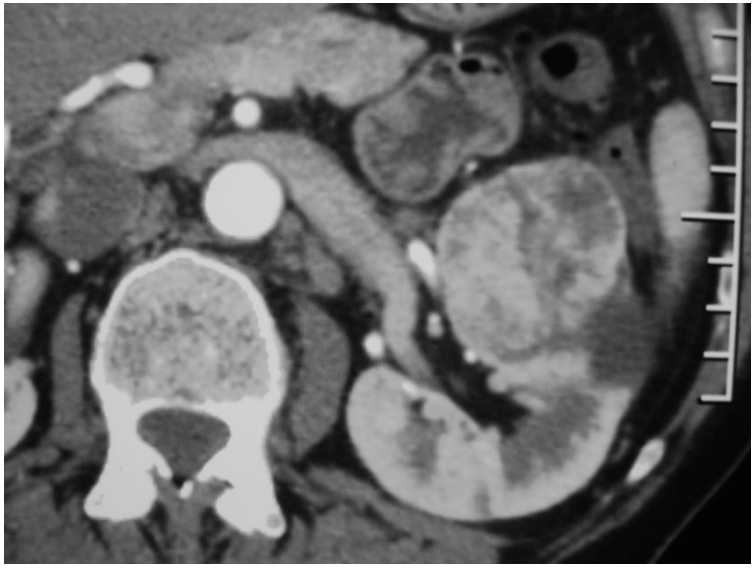
Néphrectomie partielle



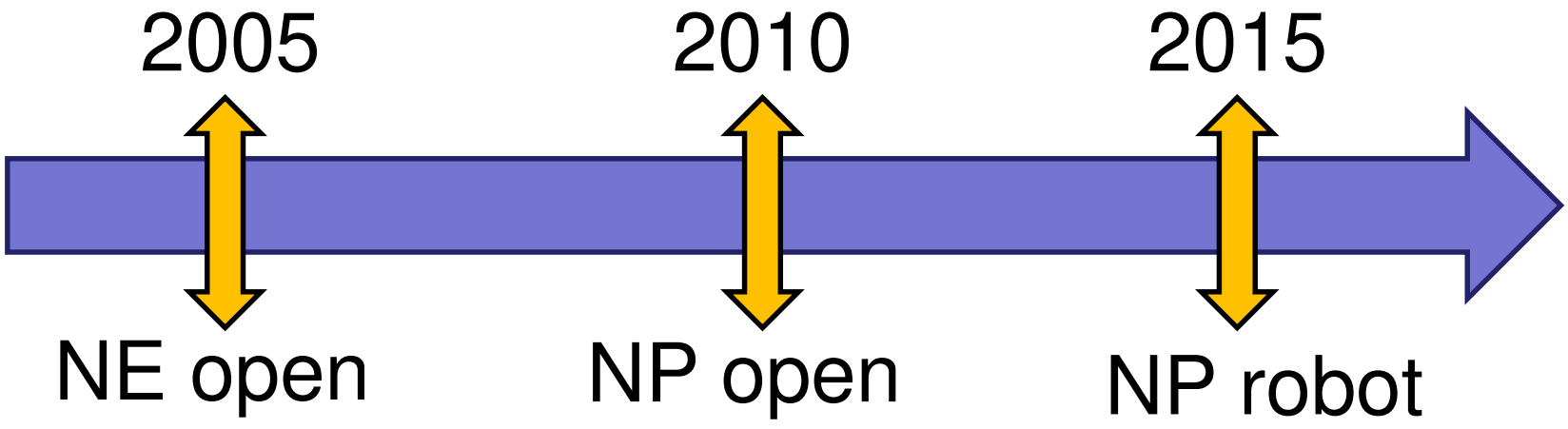
- de 4 à 7 cm
- périphérie au centre
- ouverte au robot

Objectif :

Préservation néphronique

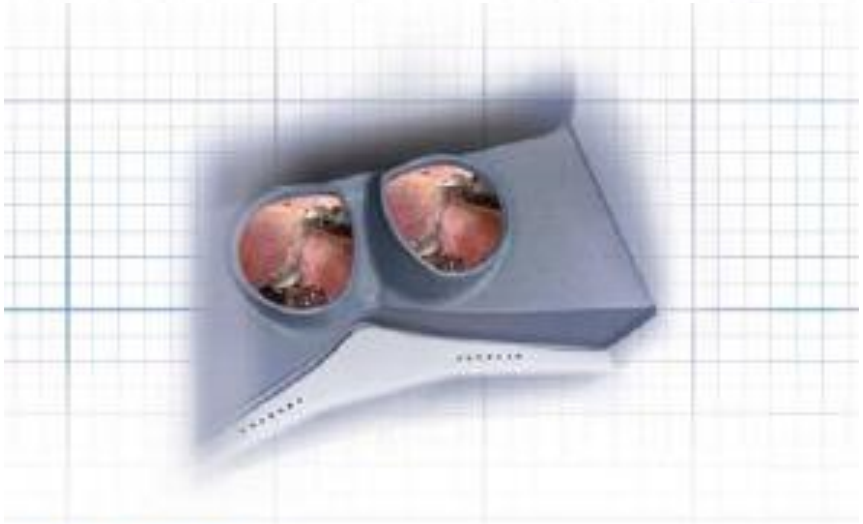


Femme de 60 ans
ATCD : K sein (2000) en rémission
Tabac : 25 PA
HTA
1m60, 52 Kg, ECOG = 0, ASA = 1
Découverte fortuite pour douleurs abdo
Créat : 66 µmol/L, DFG = 90 ml/min



Pertes sg, DMS, antalgiques

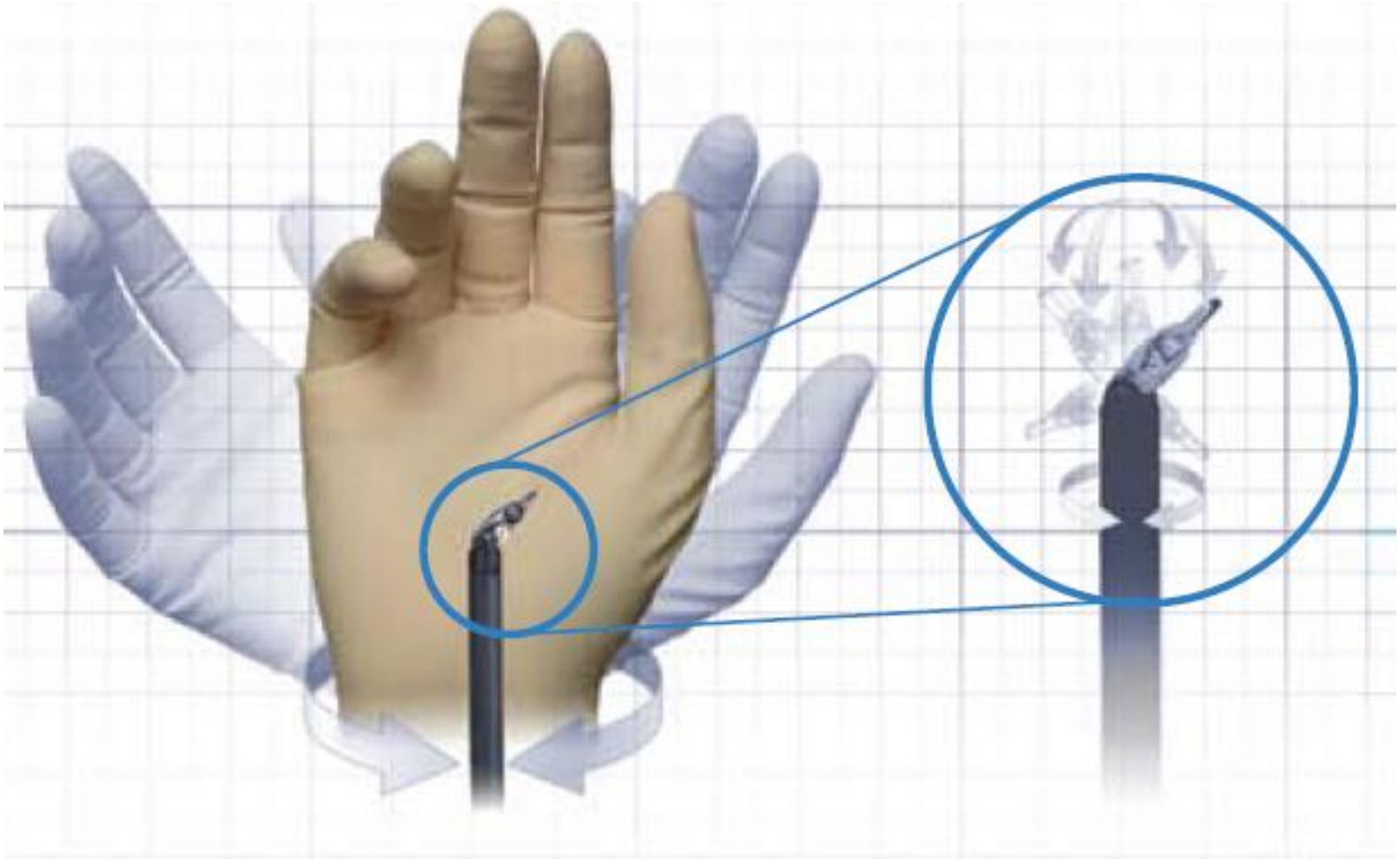
Robotique



3D HD Vision

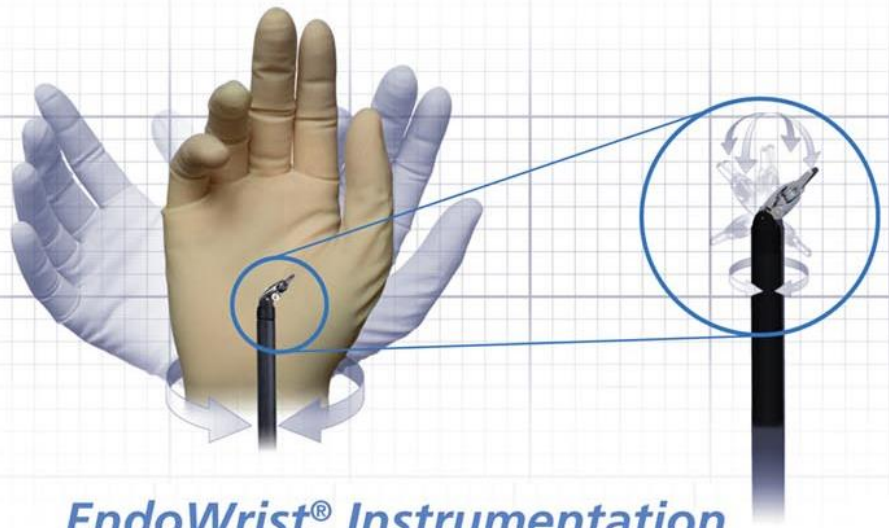
INTUITIVE

« Intuitive Surgery »

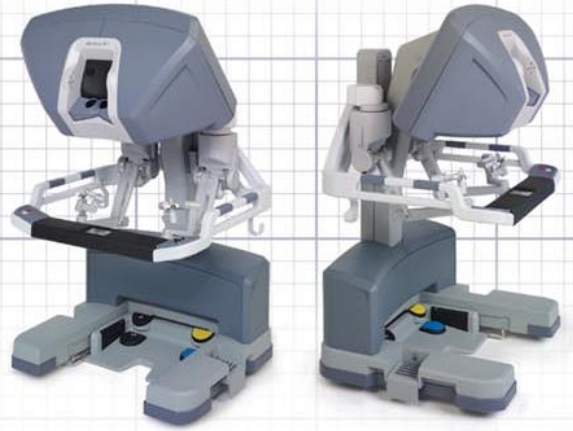


Intuitive® Motion

3D HD Vision



EndoWrist® Instrumentation

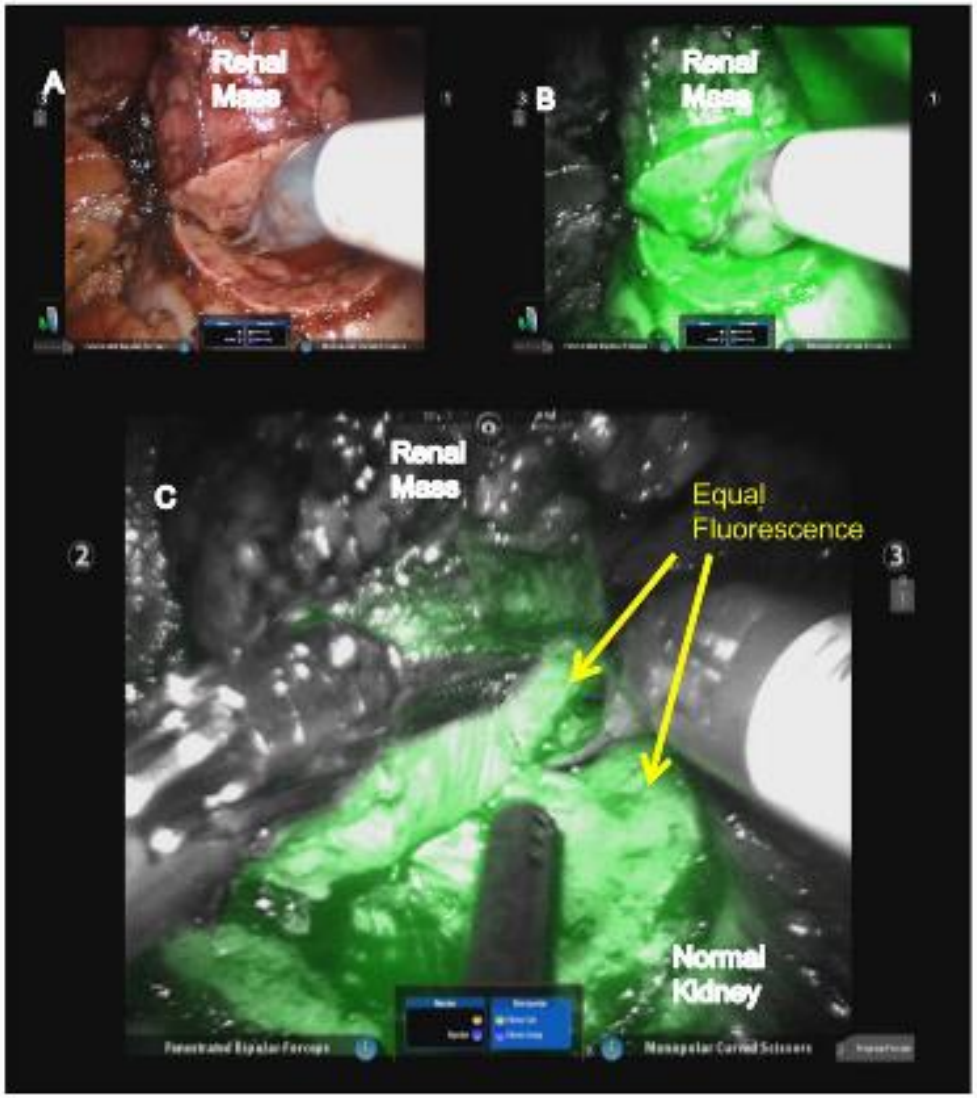


Dual Console Capability

Evolution

- Fluorescence
- Dissection hypervasculaire
- Naviguation 3D
- « Vraie » chirurgie robotique

Fluorescence



De moins en moins invasif

NE open

NE lap

NP open

NP lap

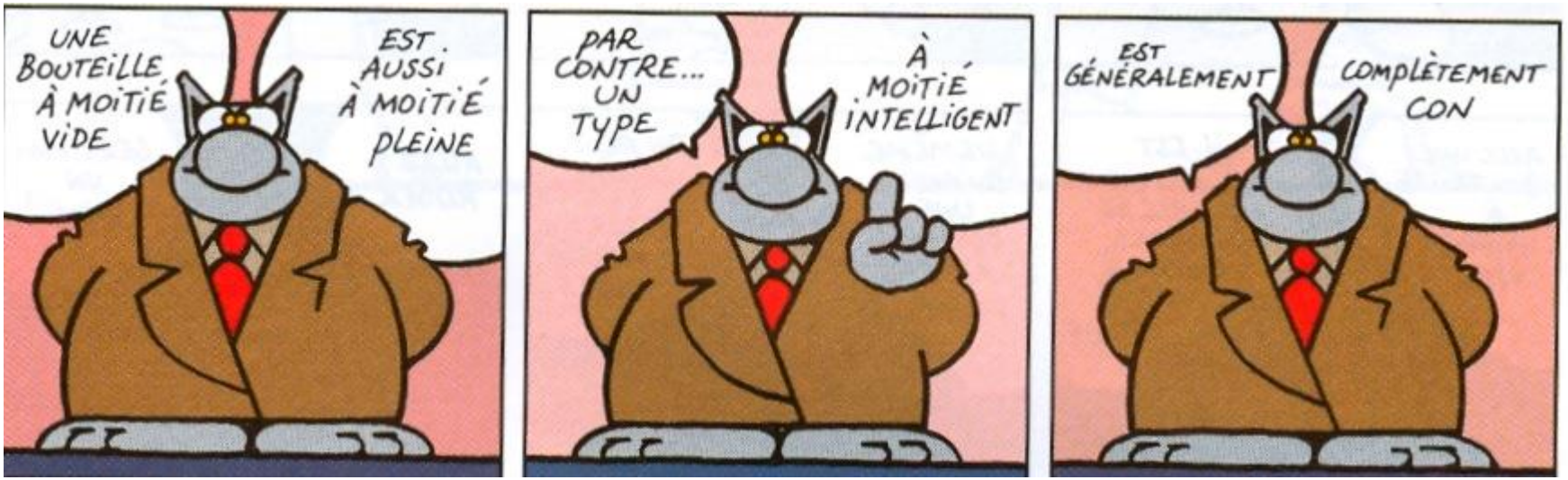
NP rob

RFA

RxTh

SA

A-t'on vraiment progresser en 10 ans ?

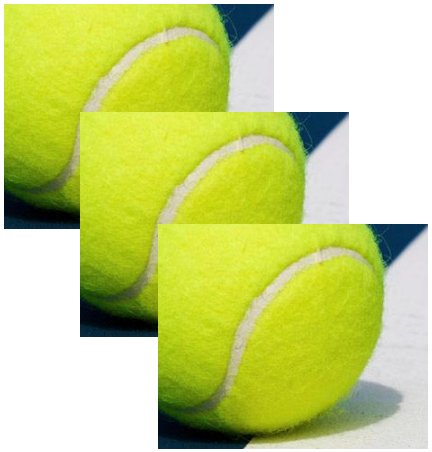


OUI

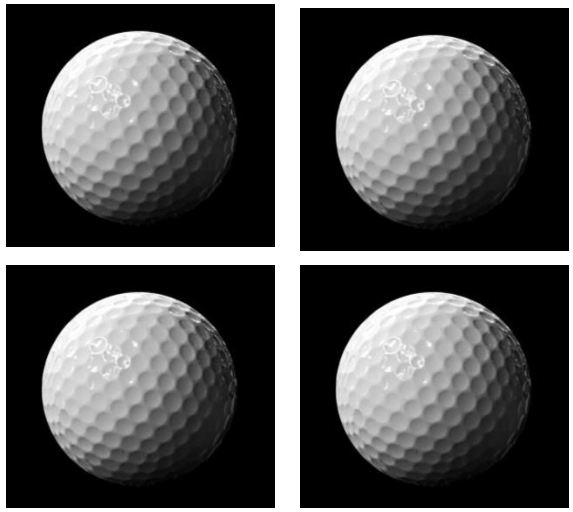
- Plus de NP et ses csq
- Plus de coelio et ses csq
- Plus d'ablatifs et ses csq.

NON

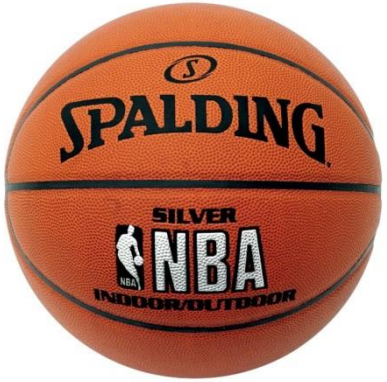
- Pas assez de NP….
- Qui dépister ?
- Qui opérer ?
- Qui ne pas opérer ?
- Néoadjuvant pour qui et comment ?
- Adjuvant pour qui et comment ?
- Métastatique ?

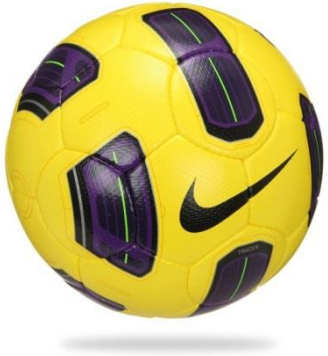



Official League




IRB
RUGBY
WORLD CUP
2015


SPALDING
SILVER
NBA
INDOOR/OUTDOOR




barnett


Kappa
Dove
MEN
+CARE
NATIXIS

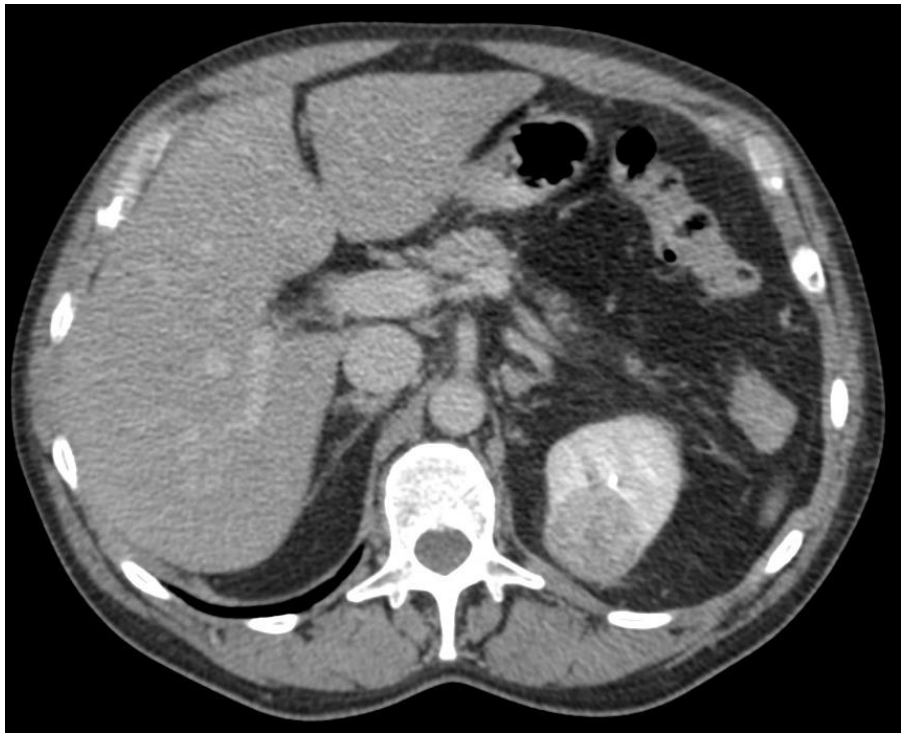

TROPHÉES
Boulisme
2010

Femme 44 ans, TRG 2012, pRCC non type 1 de haut grade marges saines

2012

2015

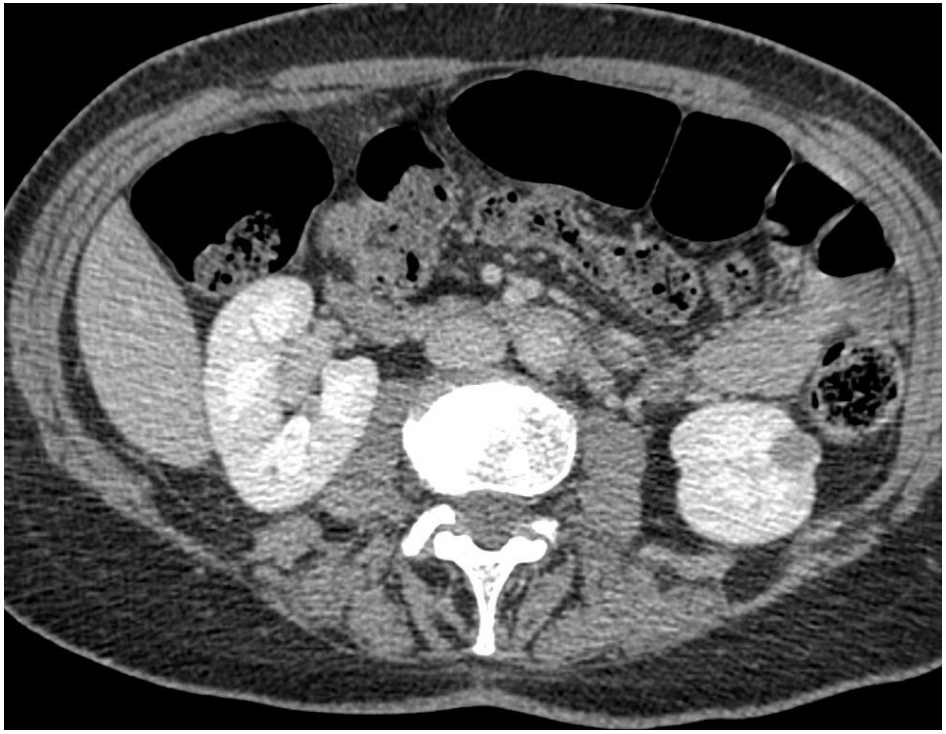
Homme, 65 ans, TRG 2013, cRCC, Fuhrman 2, marges saines

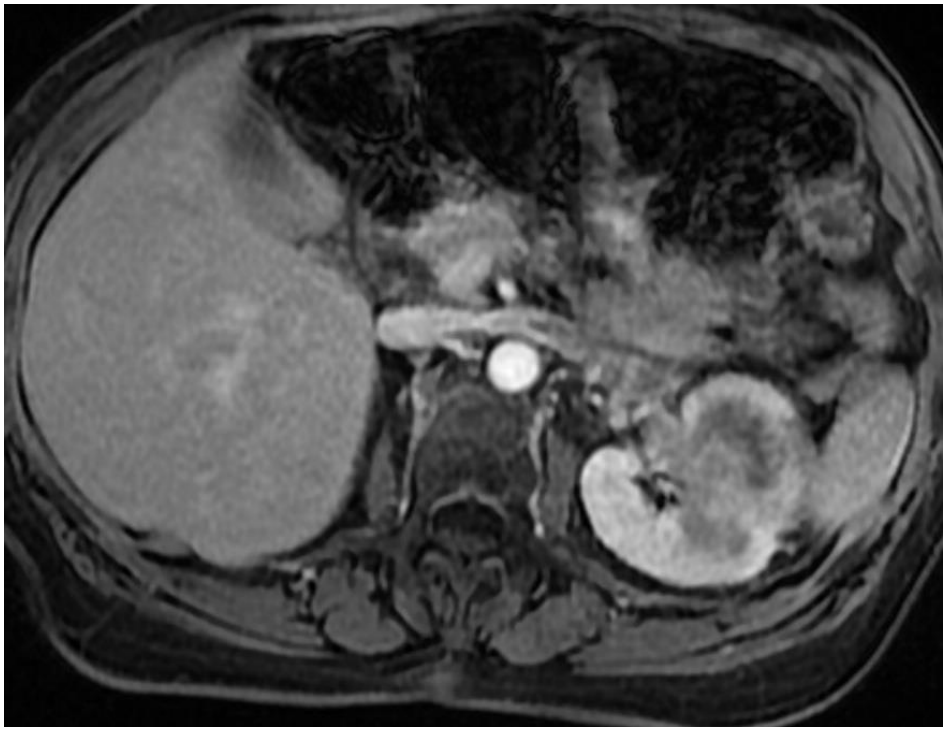


2013

2015

Femme, 74 ans, VHL, cRCC, Fuhrman 2
RFA 2012,





2012

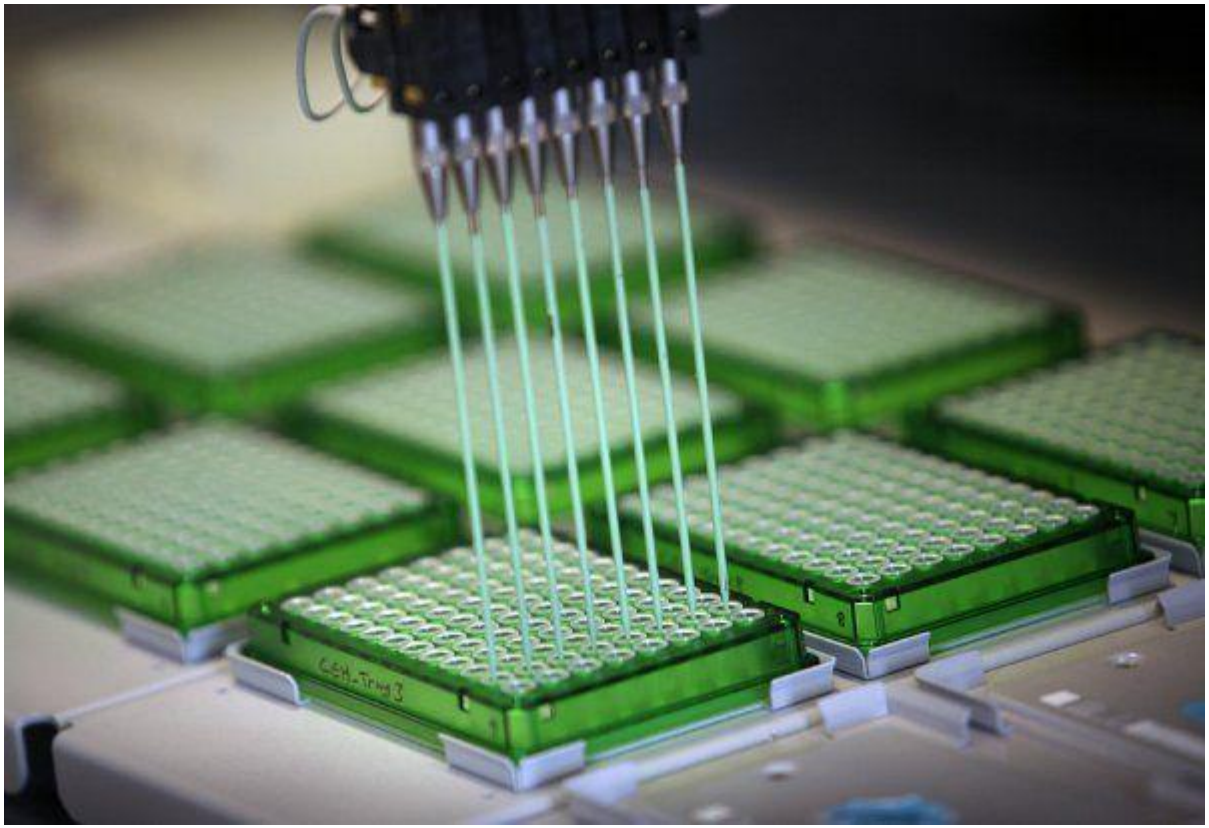
2015

Nous n'avons aucune stratégie élaborée

Nous restons sur un modèle binaire : opérer ou ne pas opérer

Quel Futur ?

Traitement personnalisé

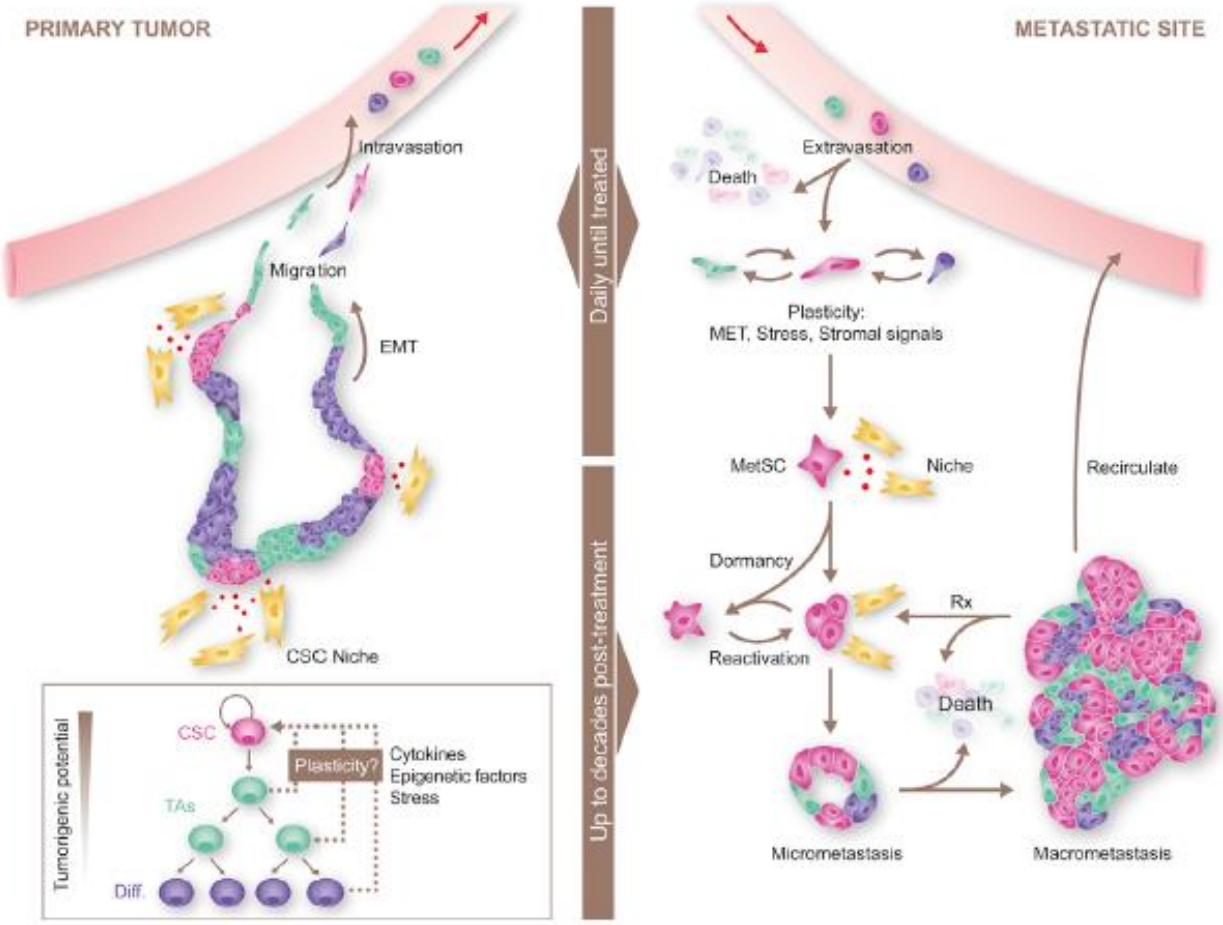


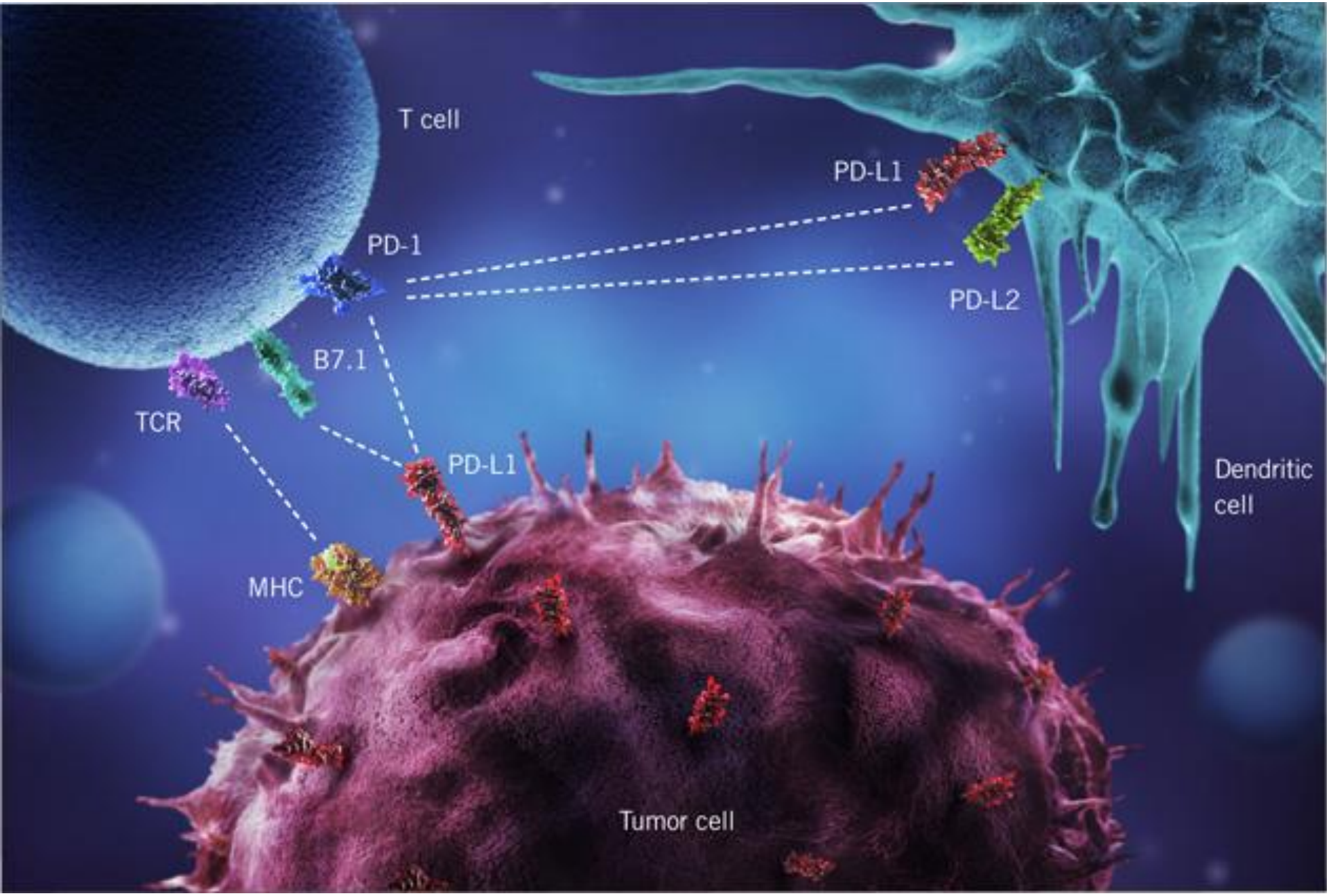
Metastatic Stem Cells: Sources, Niches, and Vital Pathways

Cell Stem Cell
Review

Thordur Oskarsson,[1,2,3] Eduard Batlle,[4,5] and Joan Massagué[6,7,*]

Cell Stem Cell *14*, March 6, 2014



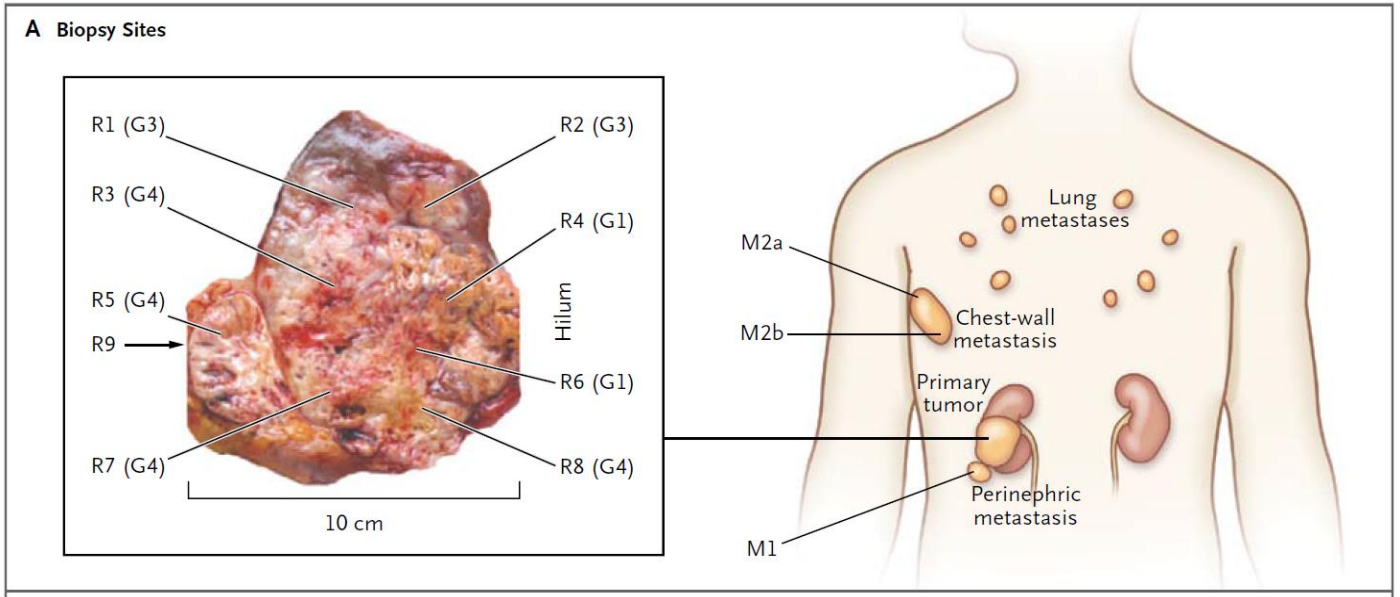

T cell
PD-L1
PD-1
PD-L2
B7.1
TCR
PD-L1
Dendritic cell
MHC
Tumor cell

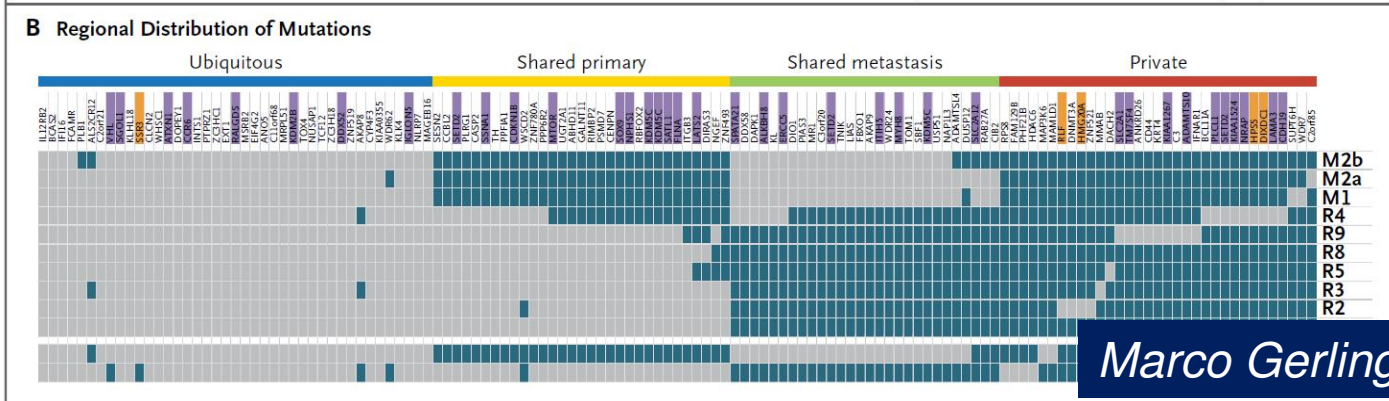
Définir des séquences de traitement

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MARCH 8, 2012 VOL. 366 NO. 10

Intratumor Heterogeneity and Branched Evolution Revealed by Multiregion Sequencing





Marco Gerlinger et al

MOLECULAR ORIGINS OF CANCER

Molecular Basis of Metastasis

N ENGL J MED 359;26
DECEMBER 25, 2008

Anne C. Chiang, M.D., Ph.D., and Joan Massagué, Ph.D.

Tumor initiation: unlimited growth potential, survival, genomic instability

Genes: *KRAS, BRAF, EGFR, HER2, P13K* (suppressors: *APC, p53, PTEN, BRCA1, VHL1*)

Metastasis initiation: invasion, marrow mobilization, angiogenesis, epithelial-to-mesenchymal transition

Genes: *RHoC, LOX, VEGF, CSF-1, ID1, TWIST1, MET, FGFR, MMP-9, NEDD9*

Metastasis progression: vascular remodeling, immune evasion, extravasation

Genes: *EREG, COX-2, MMP-1, CCL5, ANGPTL4*

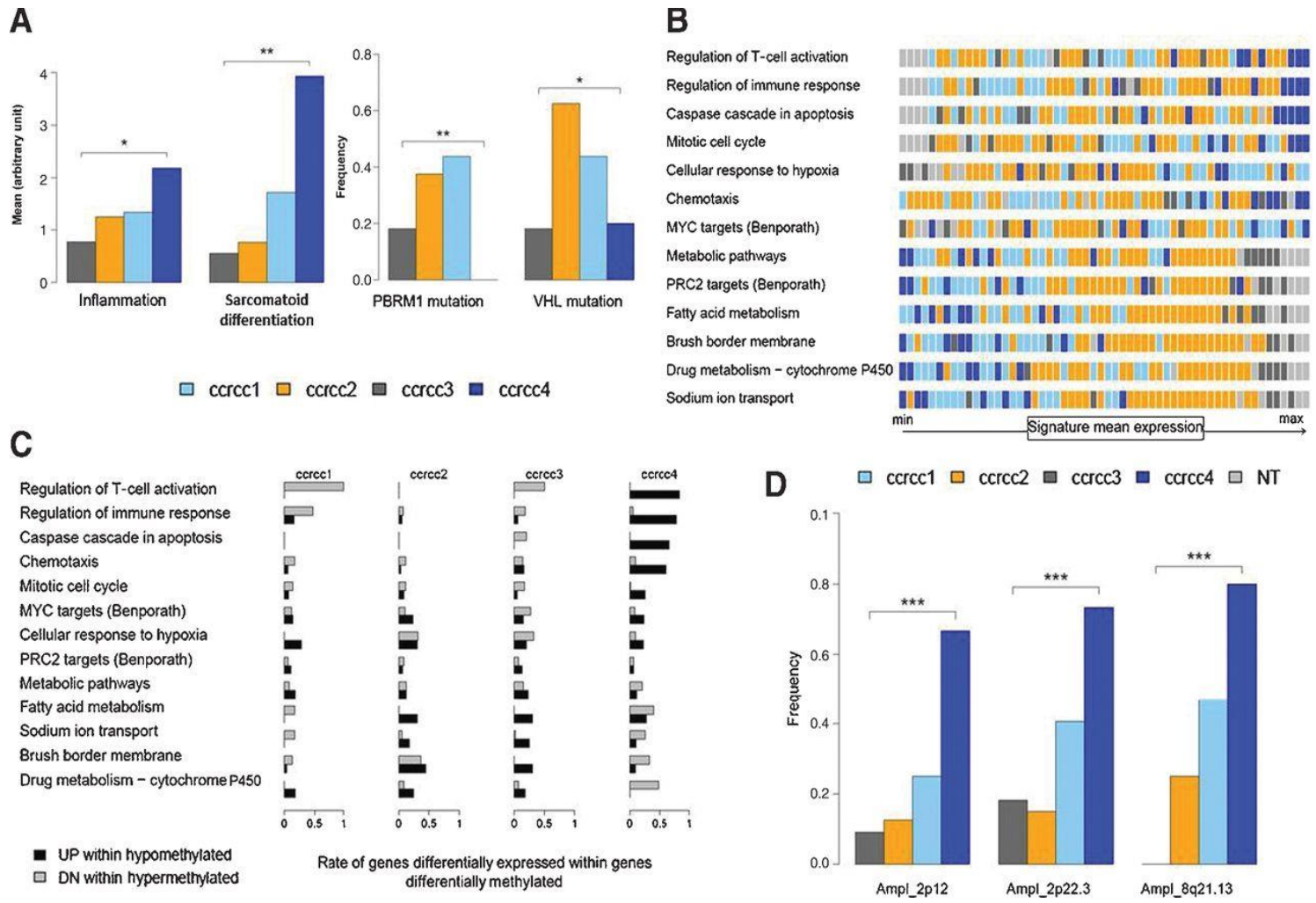
Metastasis virulence: organ-specific functions

Genes: *CXCR4, RANKL, CTGF, interleukin-11, endothelin-1*

Prin

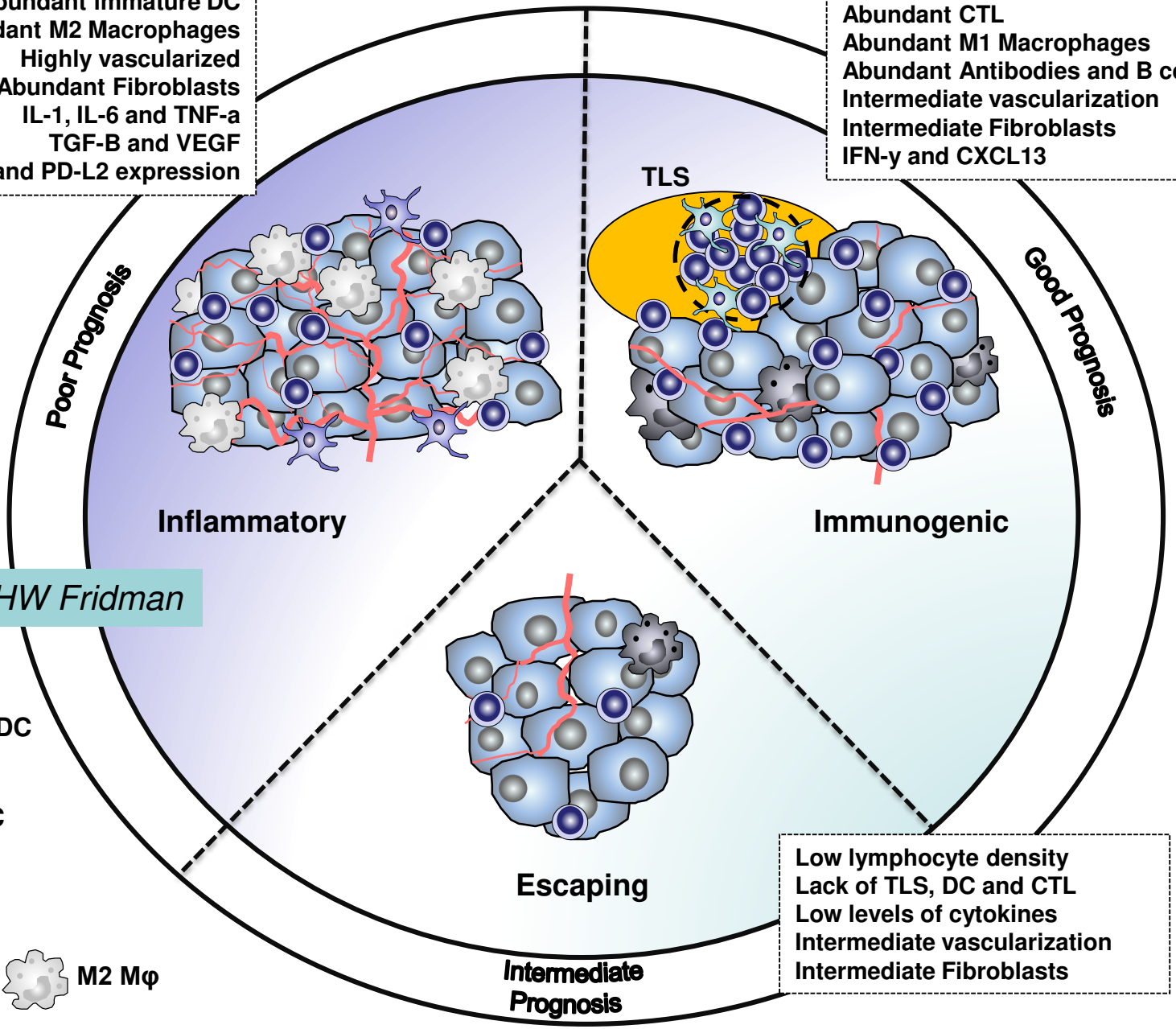
Metastasis

Characteristics of the four molecular subgroups of ccRCC

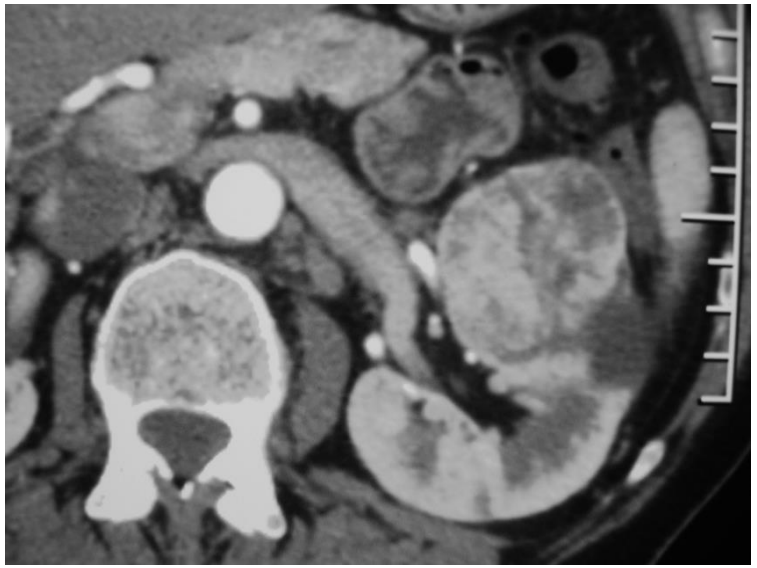


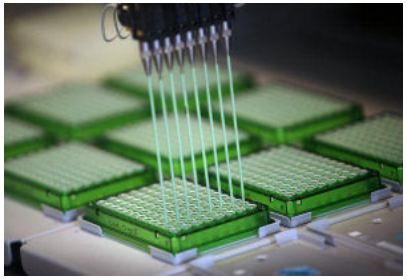
B Beuselink et al, Clin Cancer Res, 21,1329-1339, 2015

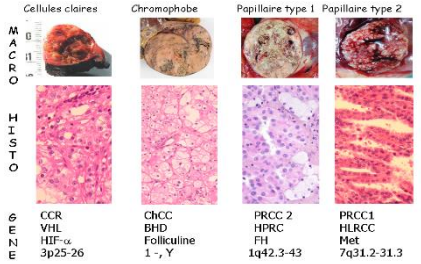
THE IMMUNE WHEEL

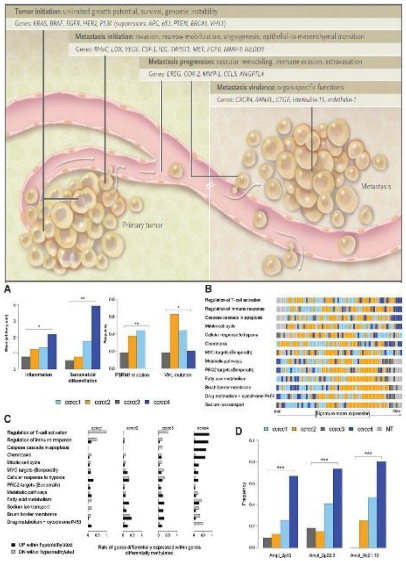


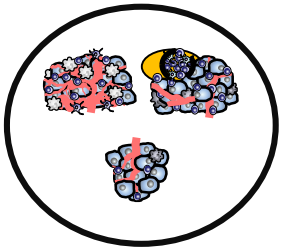
L'Avenir….



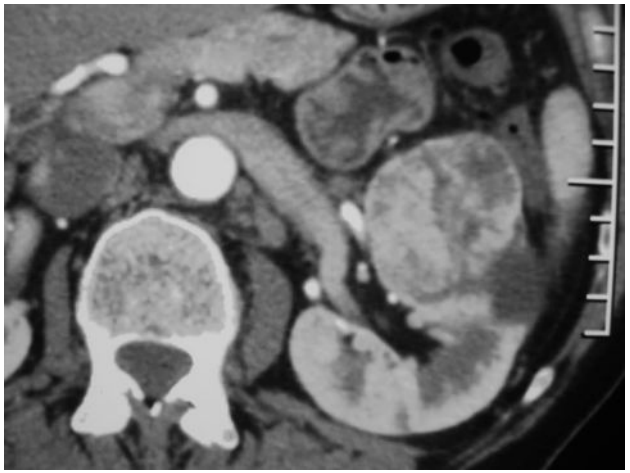


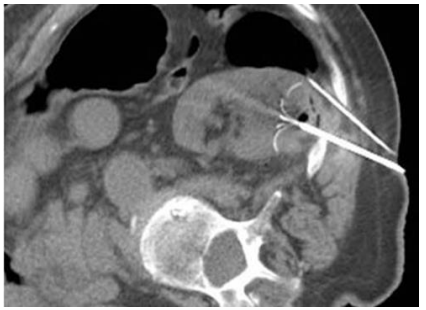






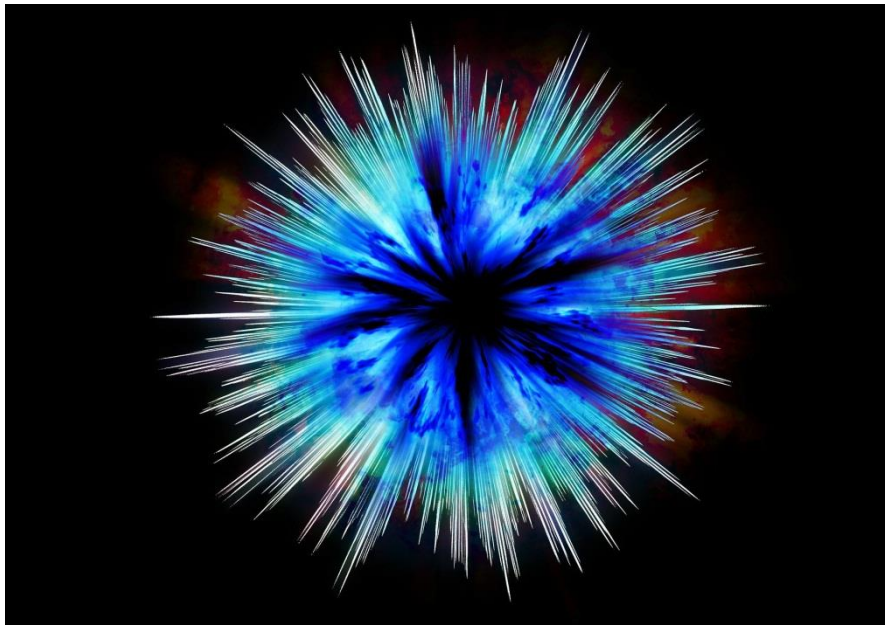
IDENTITE TUMORALE





Conclusion

- Oui cette décennie a apporté son lot de progrès
- Mais le vrai « big bang » est encore à venir….



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