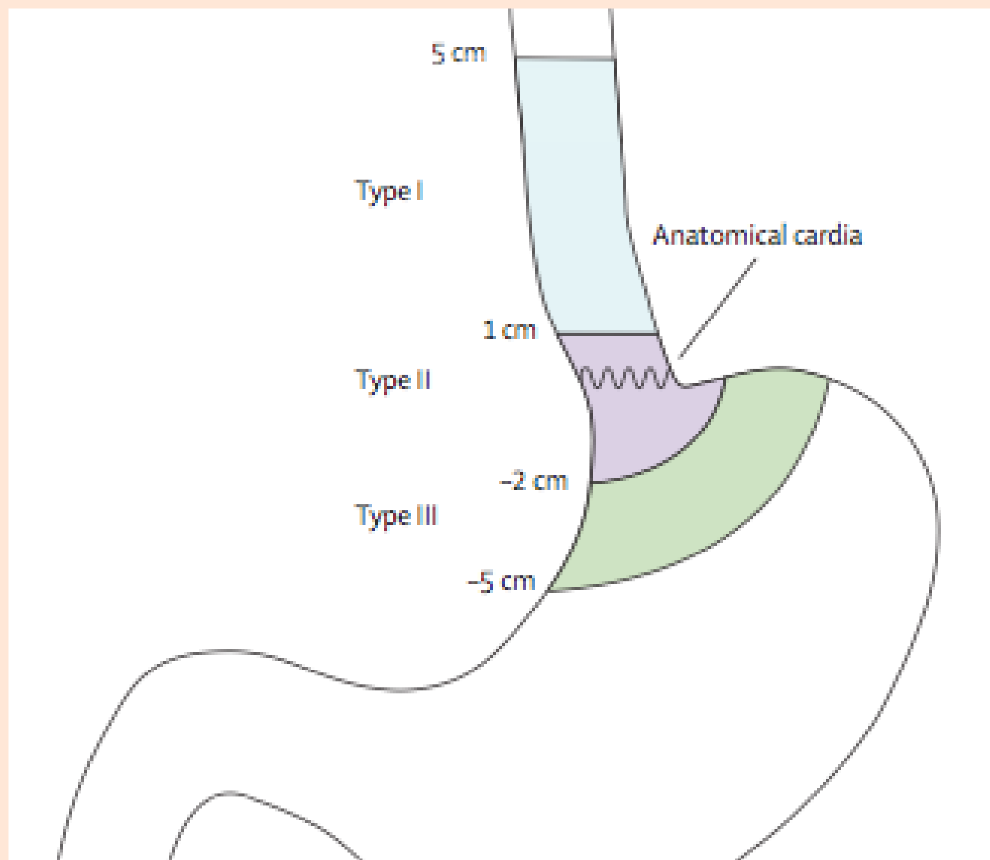
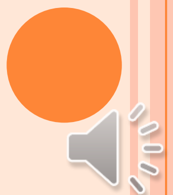
CANCER DE L'ESTOMAC

Pr.H.BOUCENNA

I. INTRODUCTION :

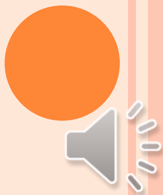
- Classification selon Siewert : Classification endoscopique des tumeurs de la jonction œsogastrique



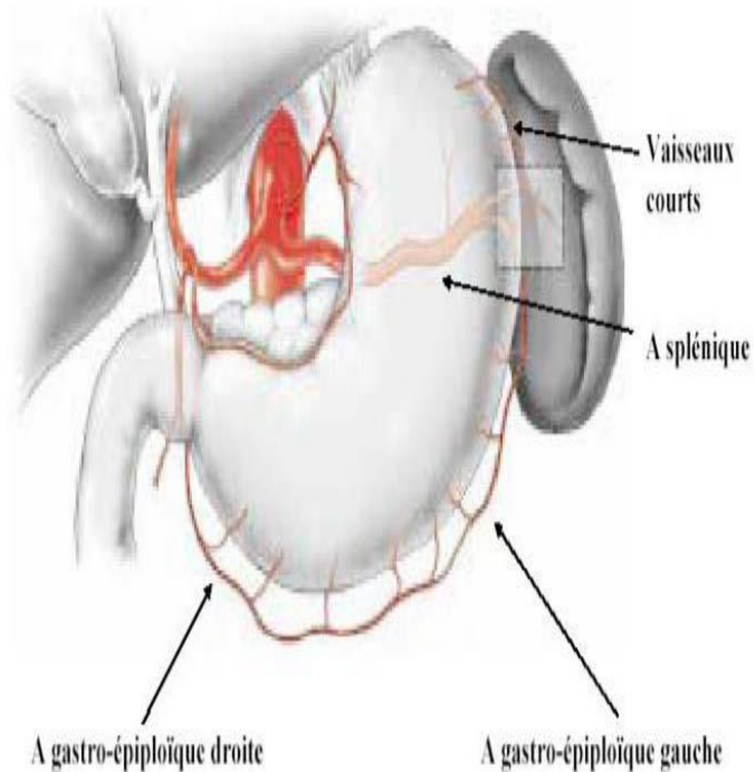


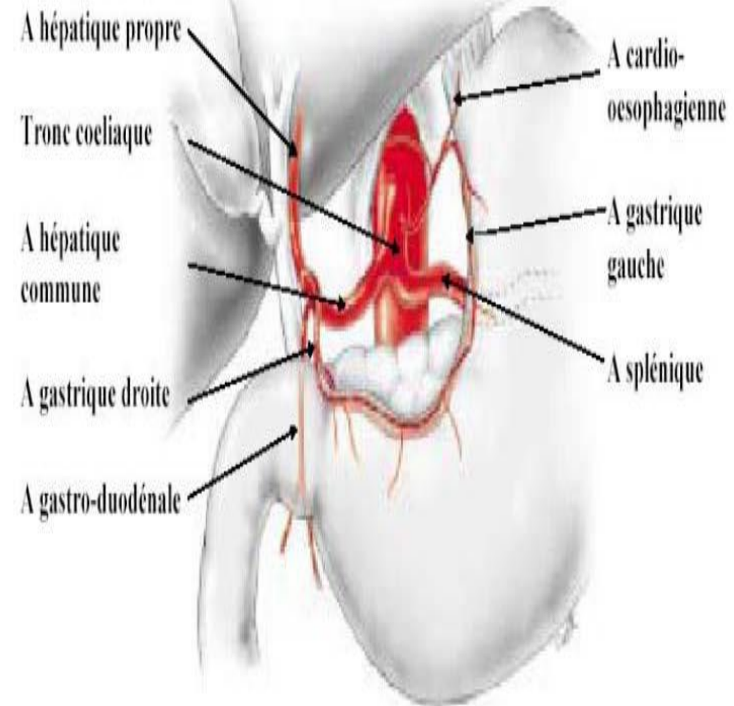
II. RAPPEL ANATOMIQUE:

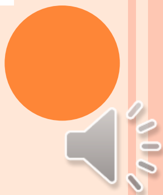
Partie cardiale de l'estomac
Corps de l'estomac
Petite courbure
Incisure angulaire
Canal pylorique
Partie pylorique de l'estomac
Antre pylorique (sinus)
Grande courbure



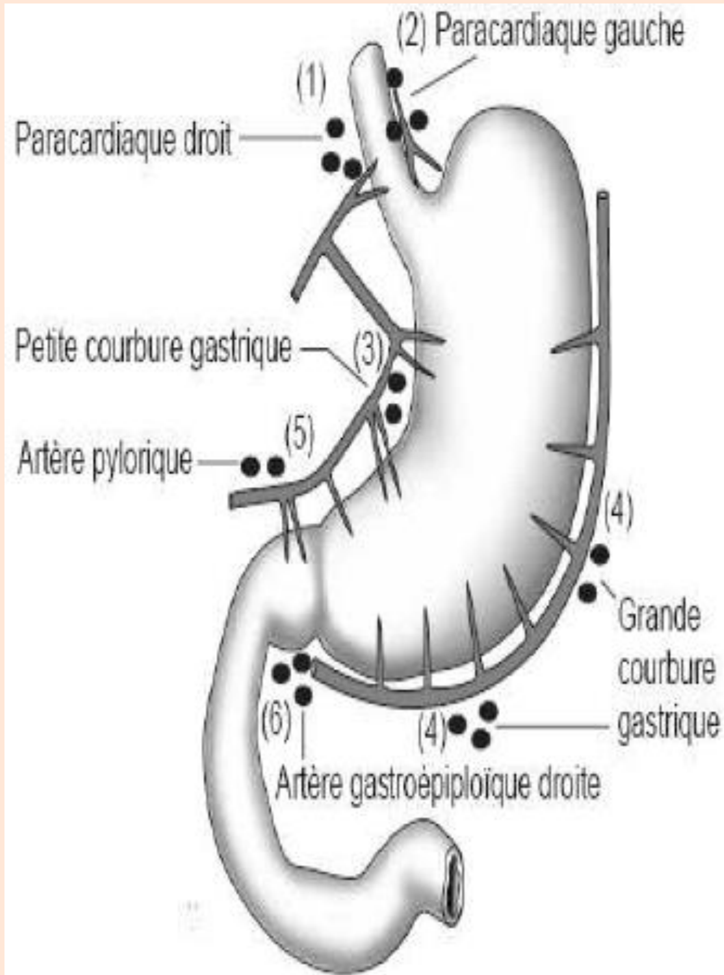
Vascularisation

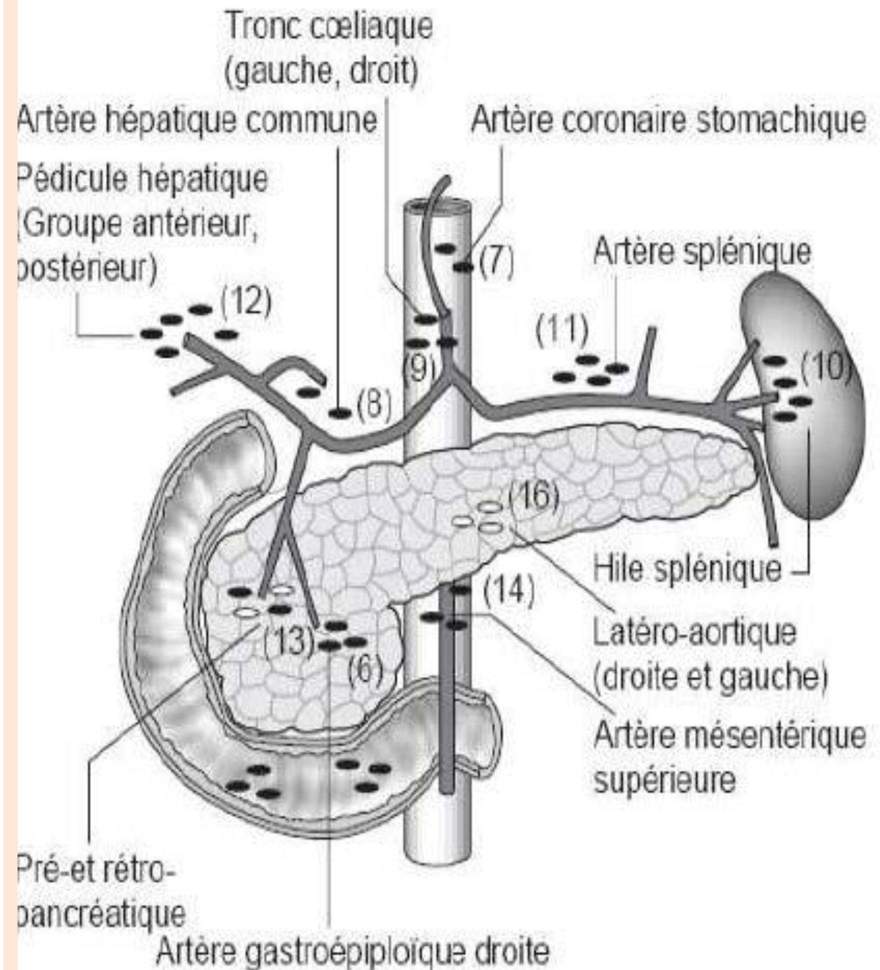




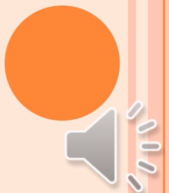


Drainage lymphatique





III. EPIDEMIOLOGIE:



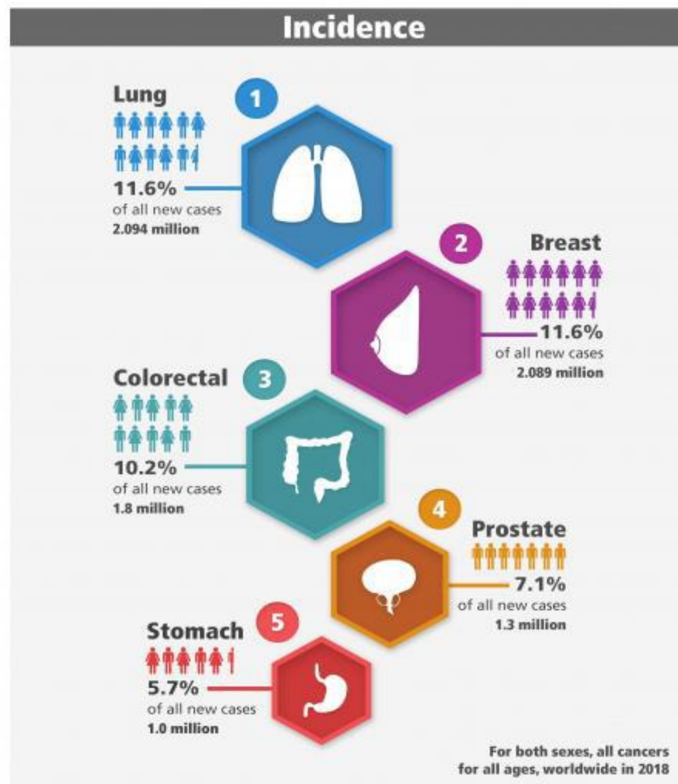
1.INCIDENCE

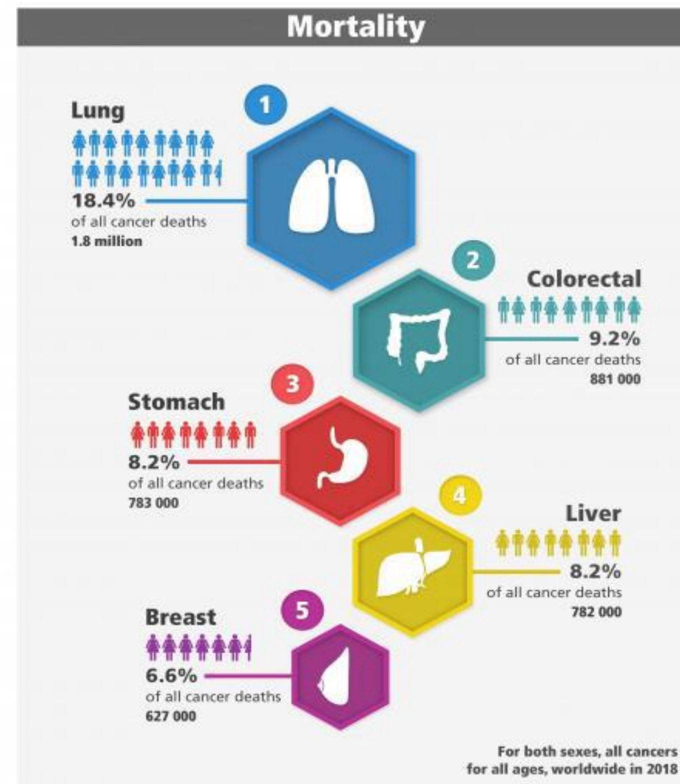
International Agency for Research on Cancer

CANCER TODAY

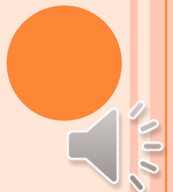
The five most commonly diagnosed cancer types

Percentages of new cancer cases and cancer deaths worldwide in 2018

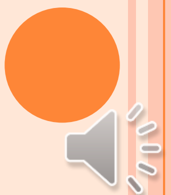




Data source: GLOBOCAN 2018
Available at Global Cancer Observatory (http://gco.iarc.fr/)
© International Agency for Research on Cancer 2018

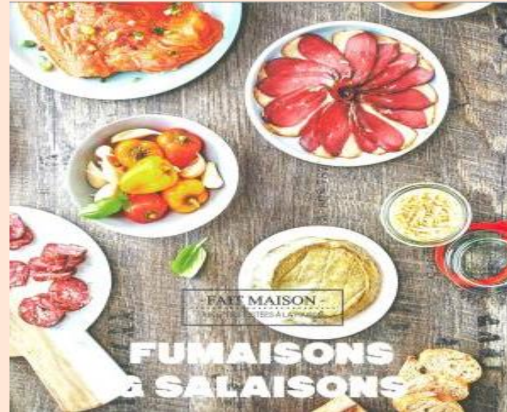


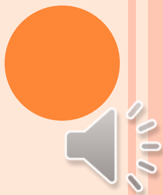
2.AGE ET SEXE



3. FACTEURS CARCINOGENES:

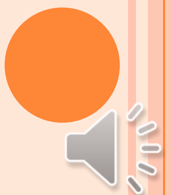
- **Les facteurs environnementaux**





3. FACTEURS CARCINOGENES:

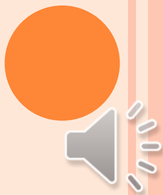
- **Infections à Hélicobacter pylori (HP)**



3. FACTEURS CARCINOGENES

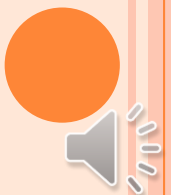
- **Les facteurs génétiques**

Transmission de la mutation
Cas familiaux



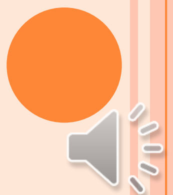
4.Conditions précancéreuses

- **La gastrite chronique atrophique**



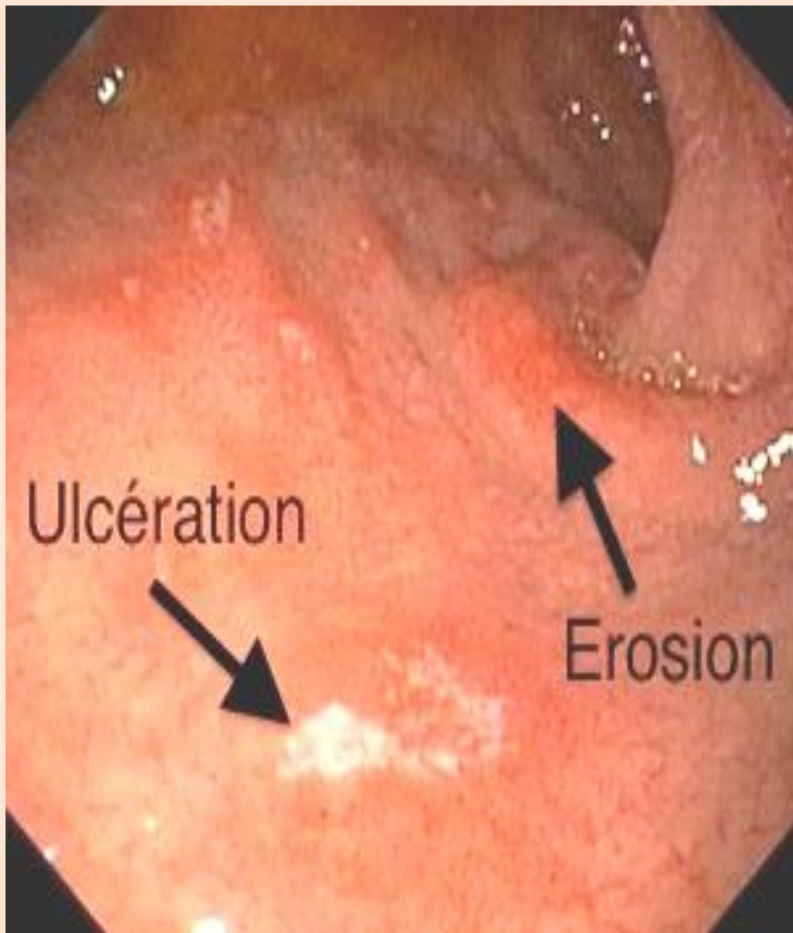
4.Conditions précancéreuses

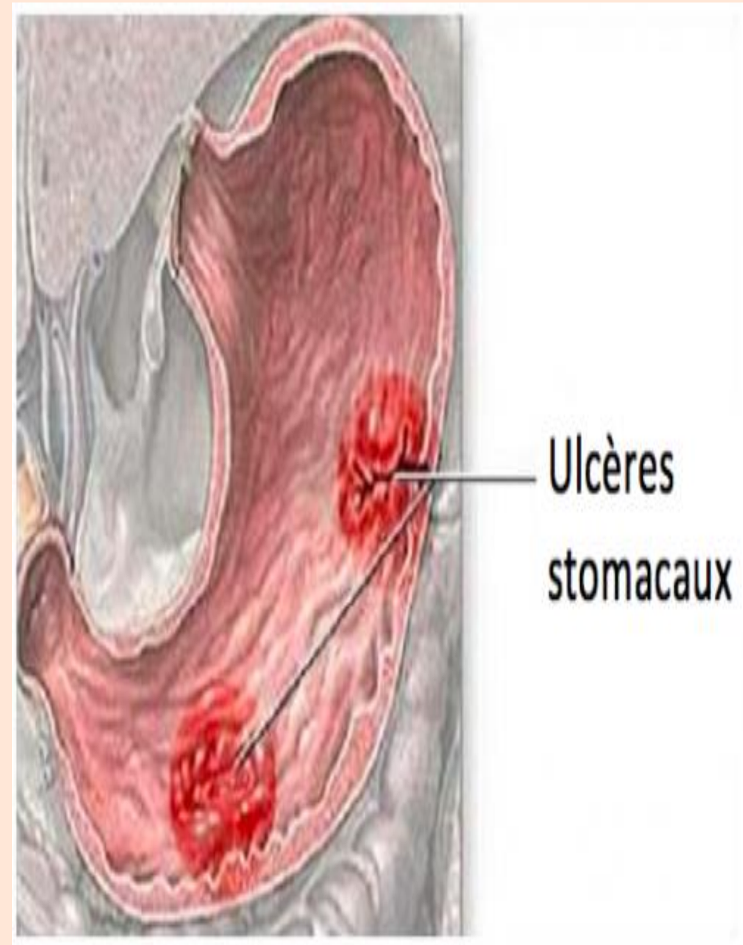
- **La maladie de ménétrier ou gastropathie hypertrophique géante**

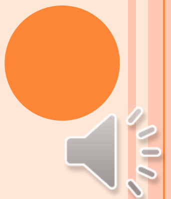


4.Conditions précancéreuses

- **L'ulcère gastrique chronique:**

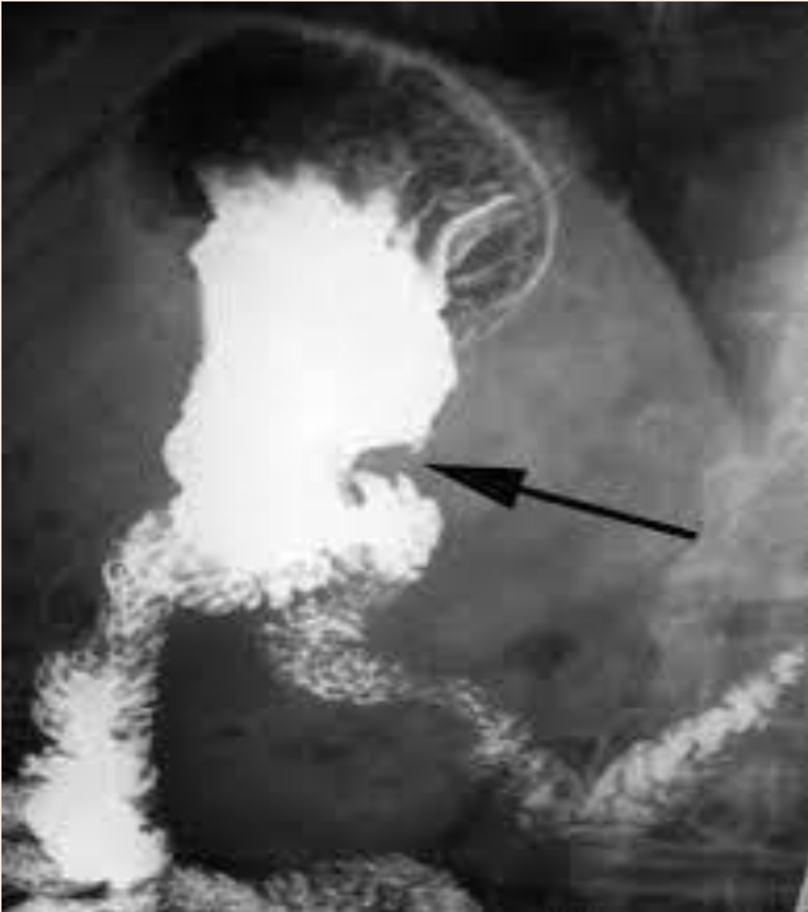


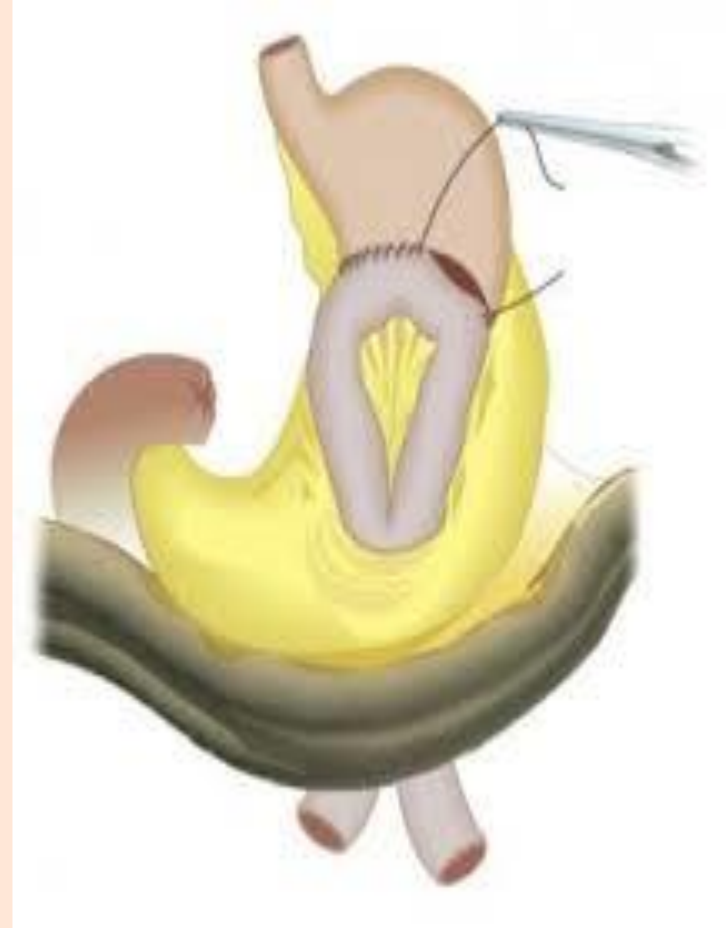


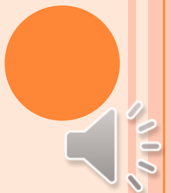


4.Conditions précancéreuses

- **Les gastrectomies partielles pour des pathologies bénignes:**

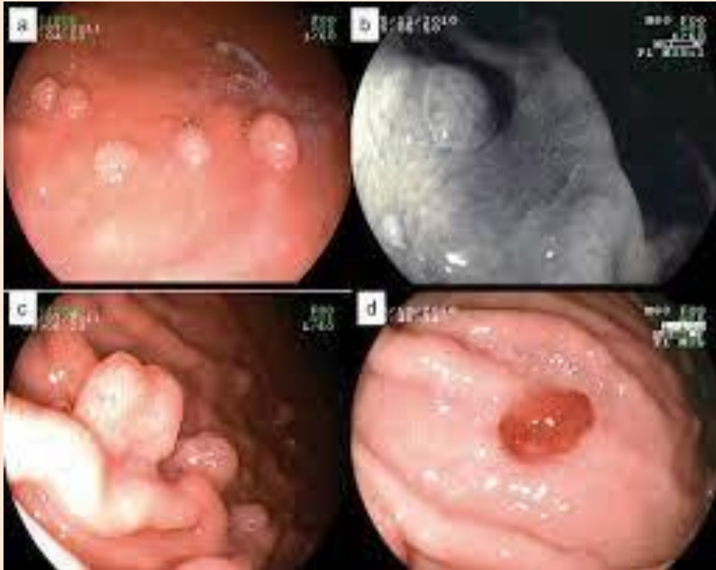


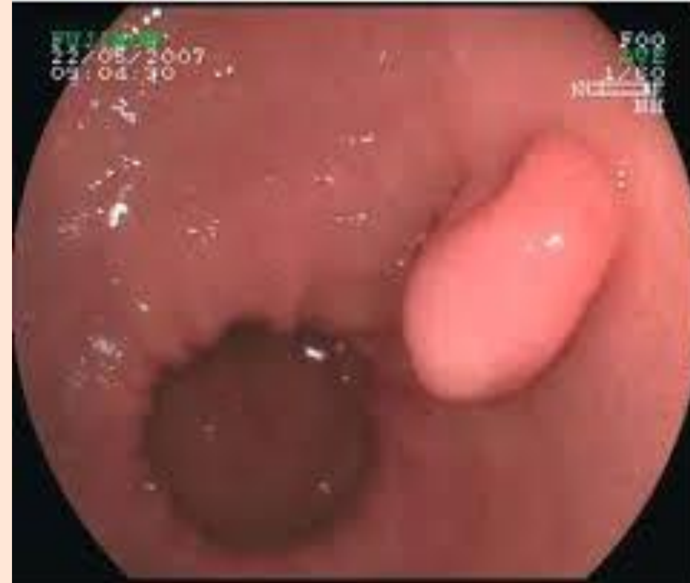


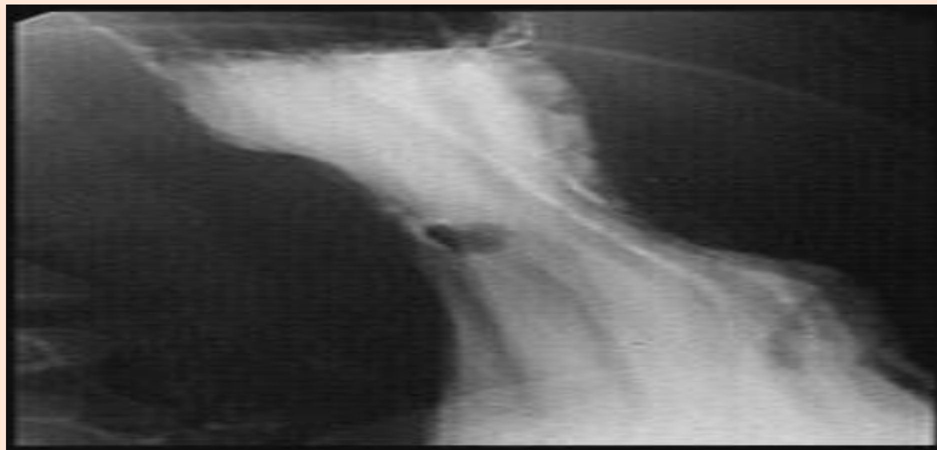


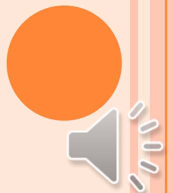
4.Conditions précancéreuses

- Les polypes gastriques:



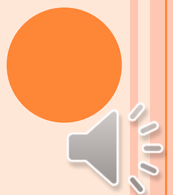




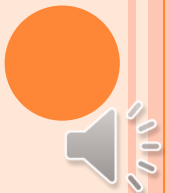


4.Conditions précancéreuses

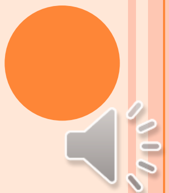
- **Achloryhdries « iatrogènes»:**



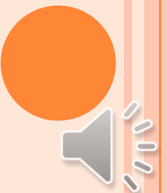
IV. ANATOMO-PATHOLOGIE:



1.ADÉNOCARCINOME:

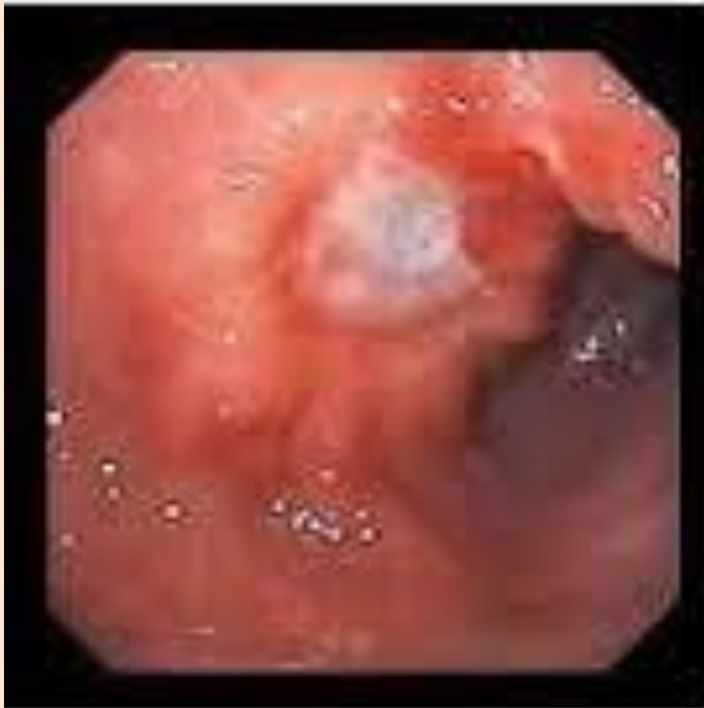


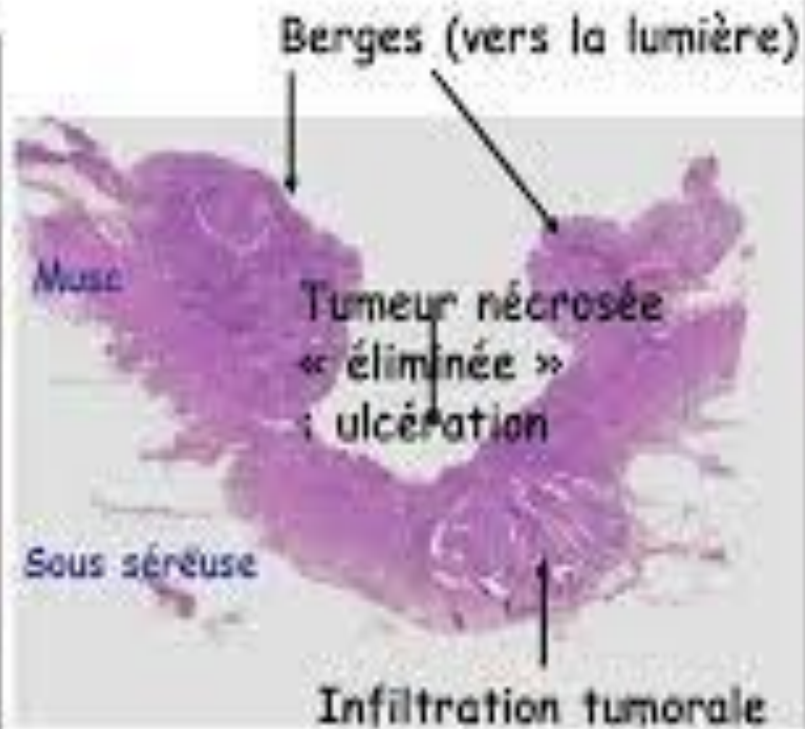
ASPECTS MACROSCOPIQUES



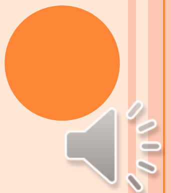
Aspects macroscopiques

Cancer ulcéré de l'estomac

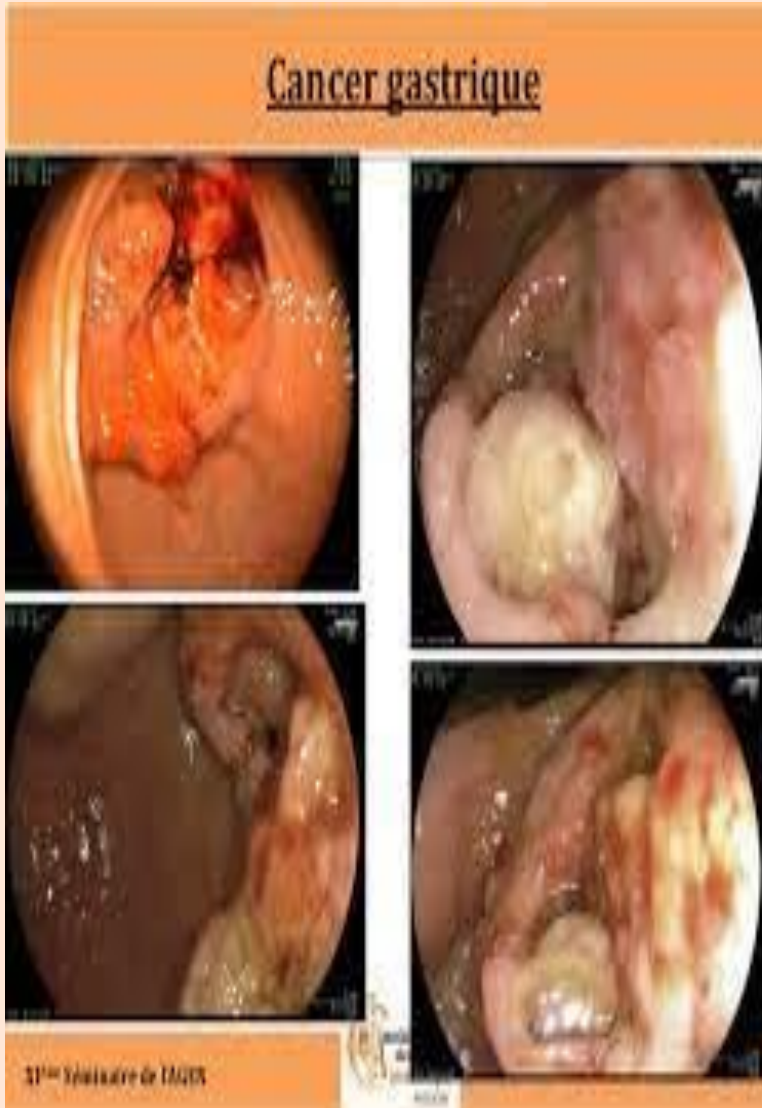


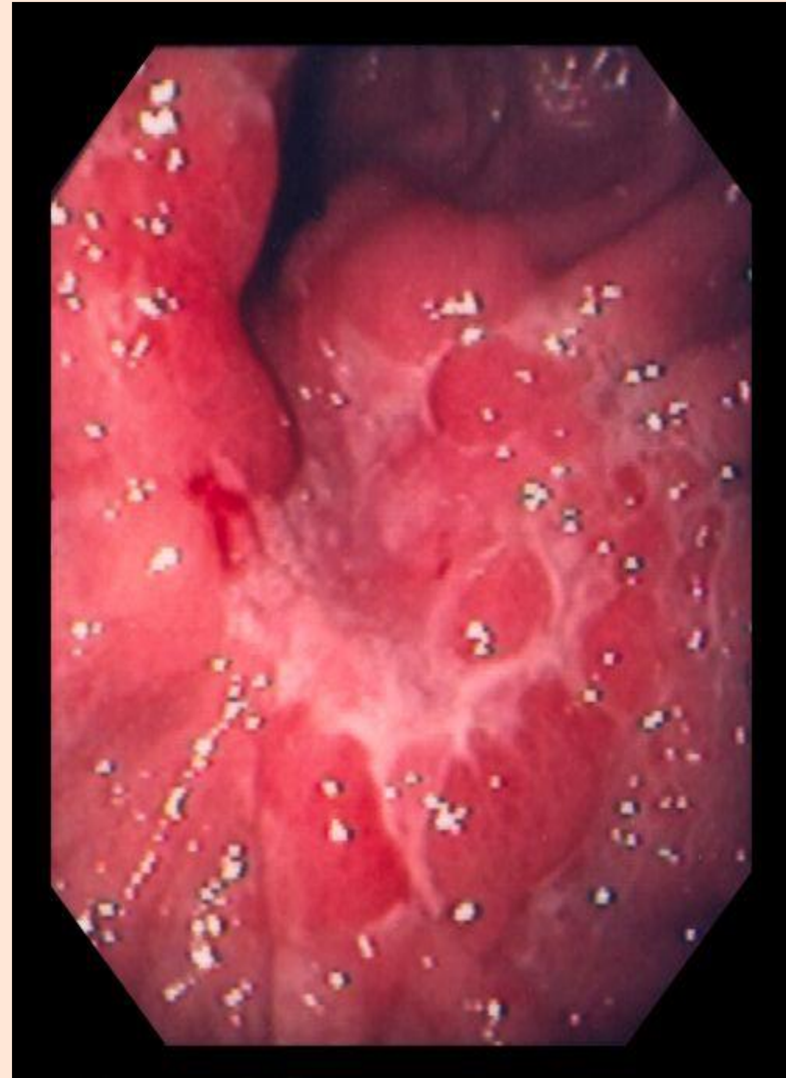


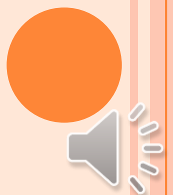
Adénocarcinome gastrique, tumeur ulcérée, infiltrante



Aspects macroscopiques

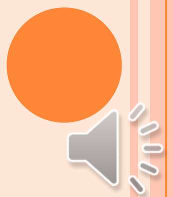




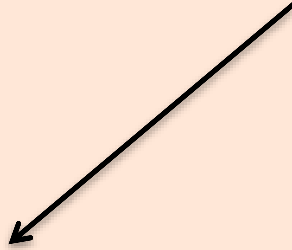


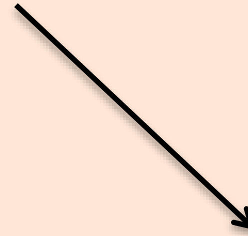
LOCALISATION

Œsophage abdominal
cardia
FUNDUS
20%
CORPS
Duodénum
pylore
ANTRE
60%
20%



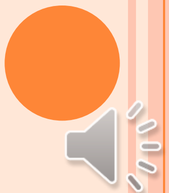
MICROSCOPIE



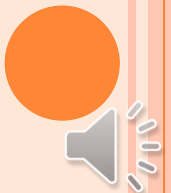


Types histologiques

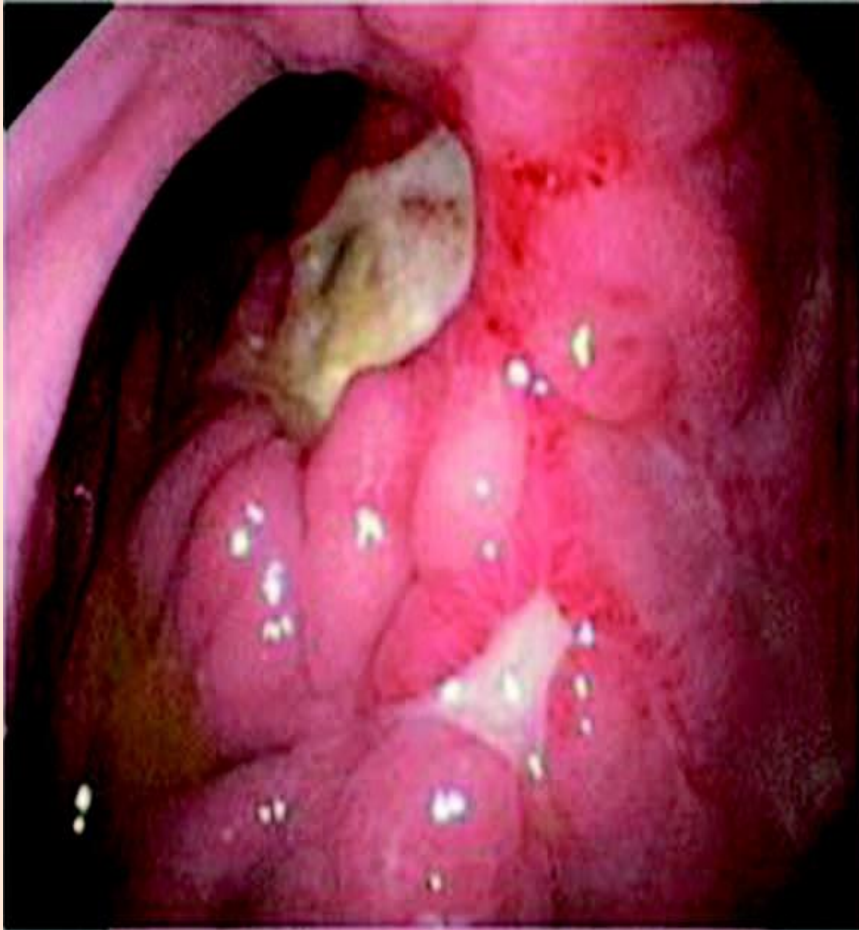
Degré de différenciation

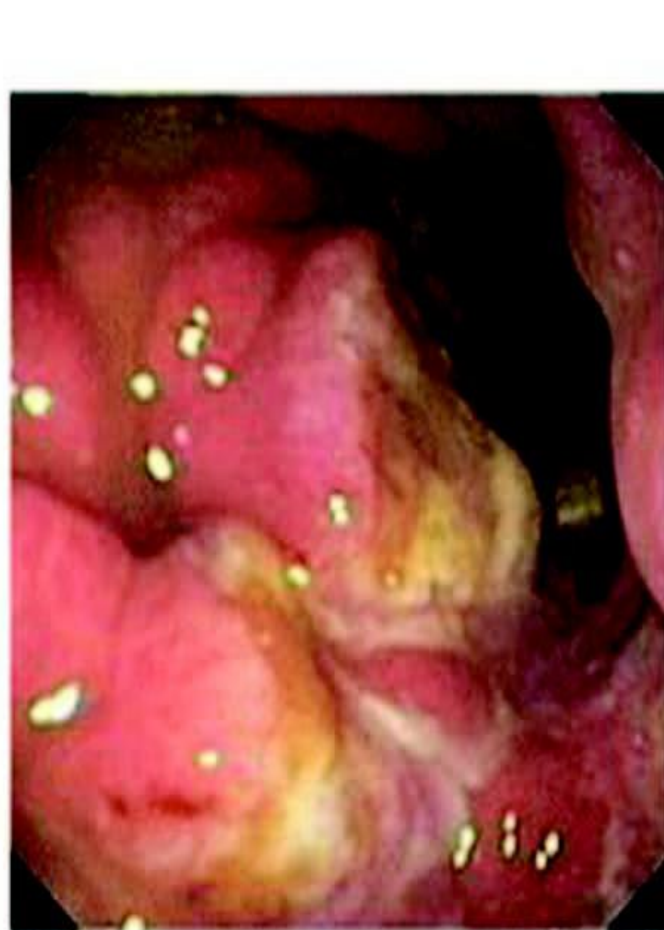


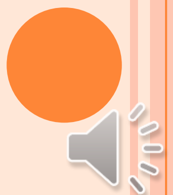
Autres types histologiques



Autres types histologiques

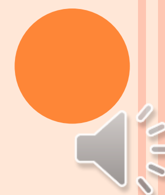






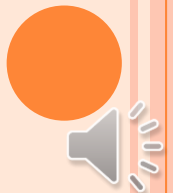
Extension :

- Locorégionale
- Extension lymphatique
- Extension métastatique

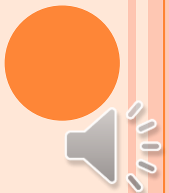


Classification TNM des cancers de l'estomac : UICC 2017 (8ème Edition)

Tumeur primitive (T)	**Tx :** renseignements insuffisants pour classer la tumeur **T0 :** pas de tumeur primitive **Tis Carcinome in situ :** Tumeur intra-épithéliale sans invasion de la lamina propria, dysplasie de haut grade **T1 :** Tumeur limitée à la muqueuse ou à la sous-muqueuse (cancer superficiel) T1a : Tumeur envahissant la lamina propria ou la musculaire muqueuse T1b : Tumeur envahissant la sous muqueuse **T2 :** Tumeur étendue à la musculeuse **T3 :** Tumeur envahissant la sous-séreuse, le tissu conjonctif sans envahissement des structures adjacentes ou du péritoine viscéral **T4 :** Tumeur envahissant la séreuse ou les organes adjacents T4a : Tumeur envahissant la séreuse (péritoine viscéral) T4b : Tumeur envahissant un organe ou une structure de voisinage (rate, côlon, foie...) L'envahissement de l'œsophage ou du duodénum n'est pas considéré comme l'envahissement d'un organe adjacent
Adénopathies régionales (N)	**Nx :** renseignements insuffisants pour classer les ganglions lymphatiques régionaux **N0 :** pas de signe d'atteinte des ganglions lymphatiques régionaux **N1 :** envahissement de 1 à 2 ganglions lymphatiques régionaux **N2 :** envahissement de 3 à 6 ganglions lymphatiques régionaux **N3 :** envahissement de 7 ou plus ganglions lymphatiques régionaux N3a : envahissement de 7 à 15 ganglions lymphatiques régionaux N3b : envahissement de 16 ou plus ganglions lymphatiques régionaux
Métastases à distance (M)	**Mx :** renseignements insuffisants pour classer la (les) métastase(s) à distance **M0 :** pas de métastase à distance **M1 :** présence de métastase(s) à distance (dont ganglions sus-claviculaires, rétro-pancréatique, mésentérique, para-aortique)

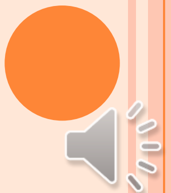


V.ETUDE CLINIQUE



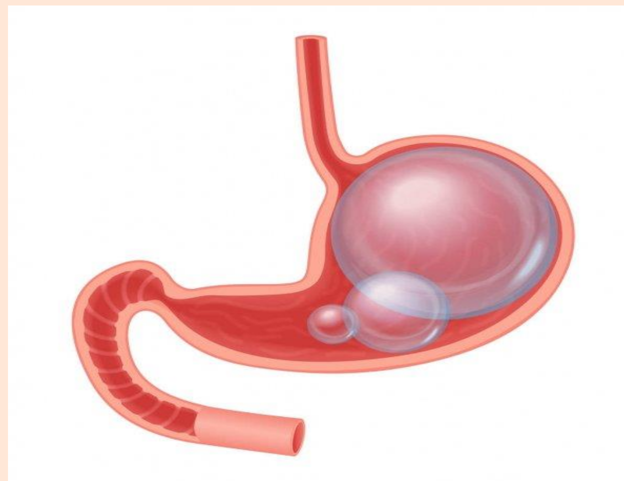
1.Signes révélateurs

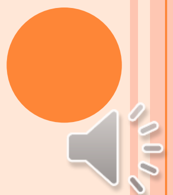
- **Douleur épigastrique :**



1.Signes révélateurs

- **Syndrome dyspeptique**



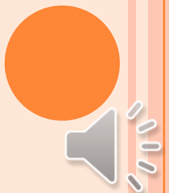


1.Signes révélateurs

Vomissements

Amaigrissement

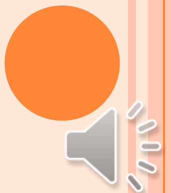
Hémorragies digestives :



1.Signes révélateurs

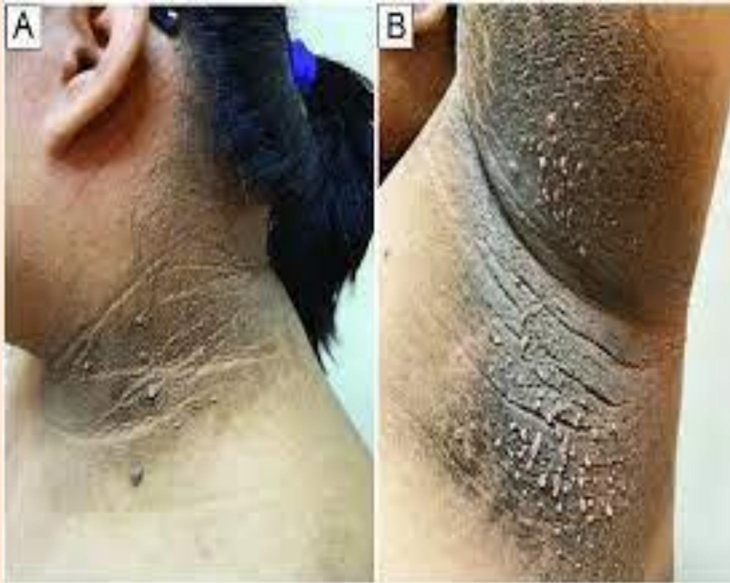
Dysphagie

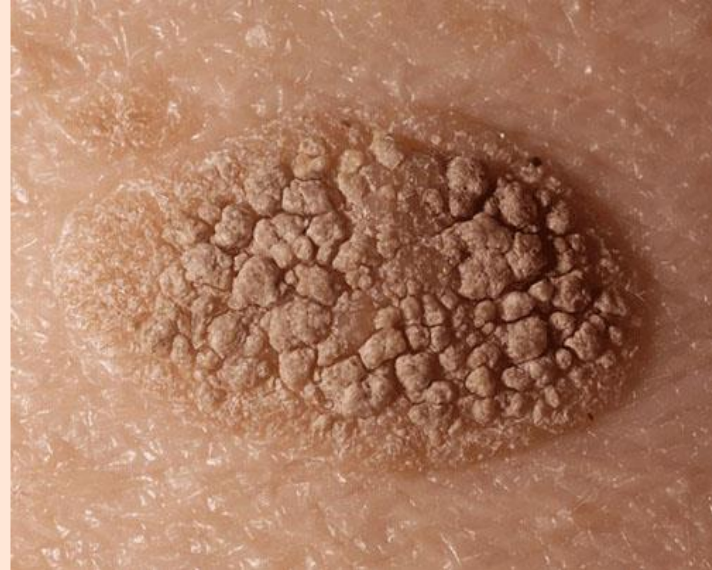
Troubles du transit

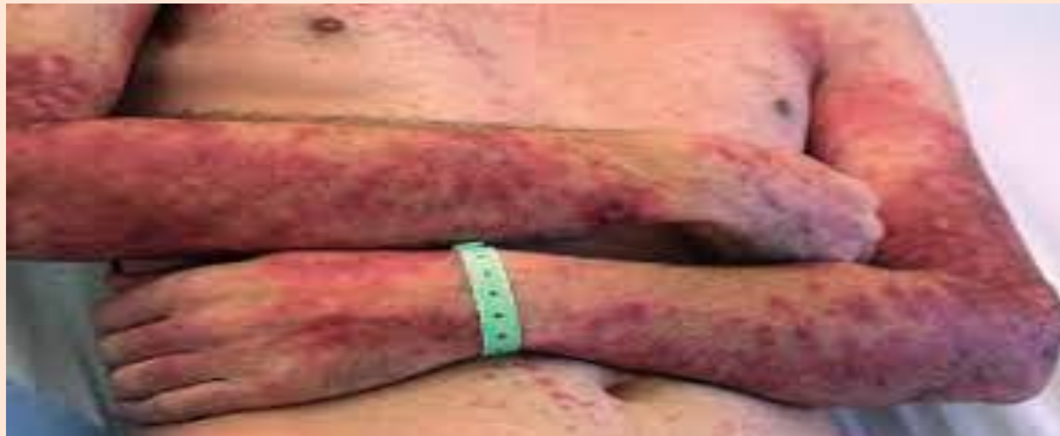


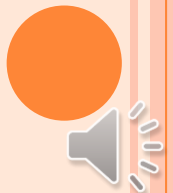
1.Signes révélateurs

- **Syndromes para-néoplasiques**

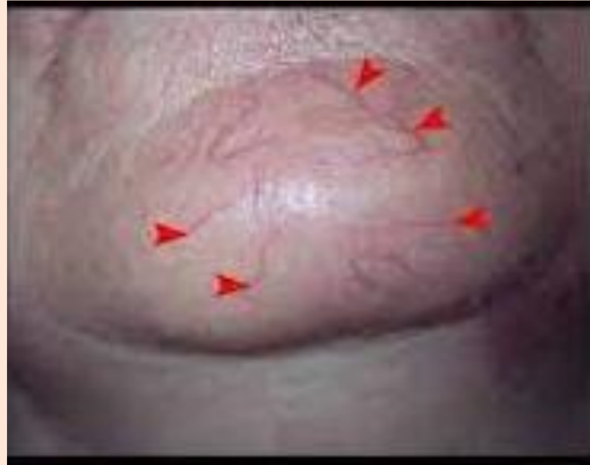


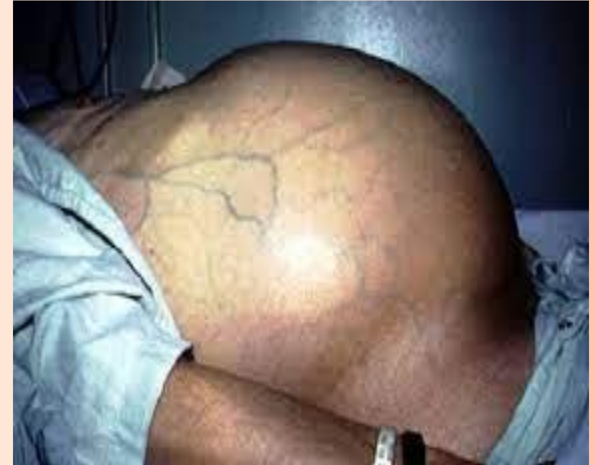


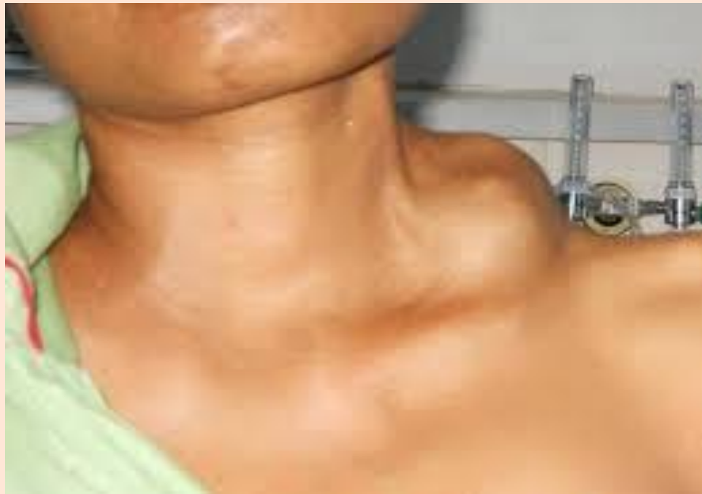


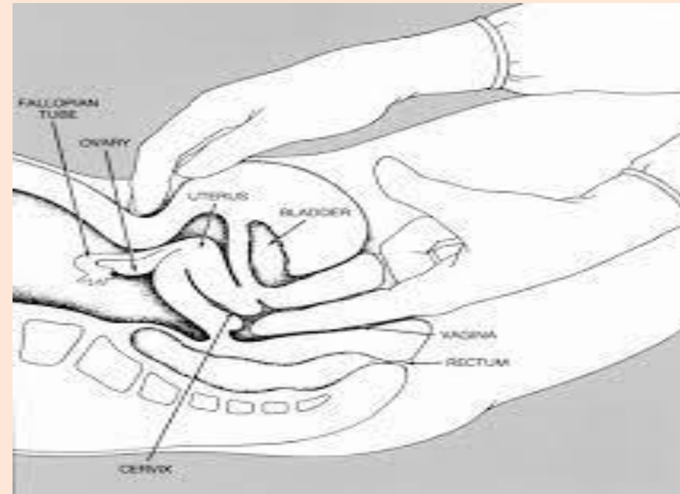


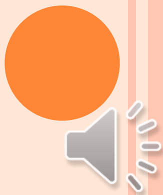
2.Examen physique





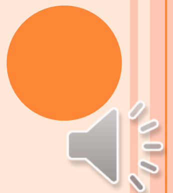




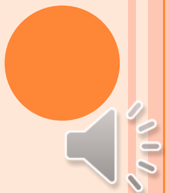


2.EXAMEN COMPLEMENTAIRES

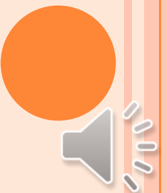
- **l’endoscopie œso-gastro-duodénale avec biopsie**



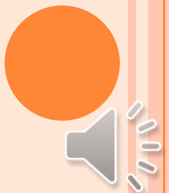
VI.FORMES CLINIQUE



1.Formes compliquées

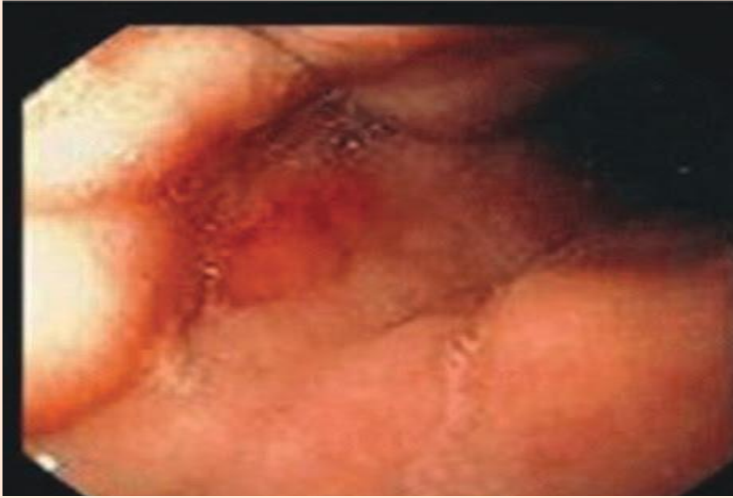


2.Formes topographiques

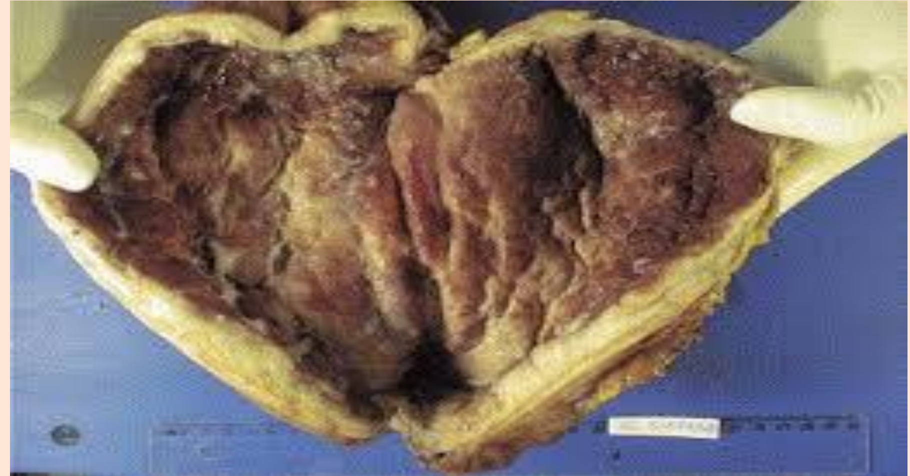


3.Formes anatomocliniques

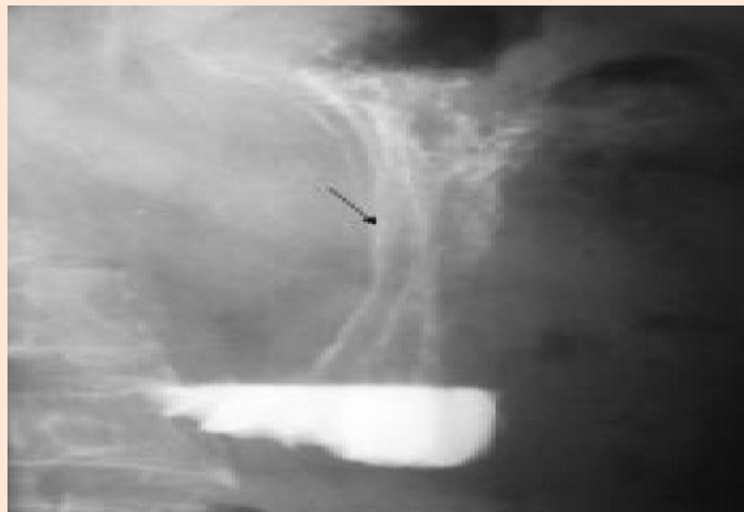
- La linite plastique (5%)

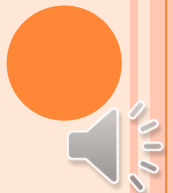


Aspect endoscopique d'une linite



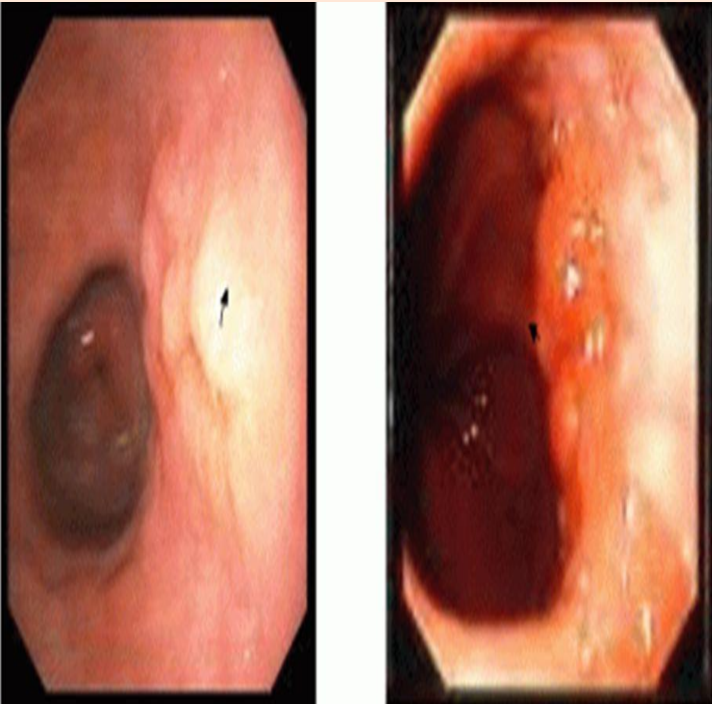
Aspect macroscopique d'une linite gastrique

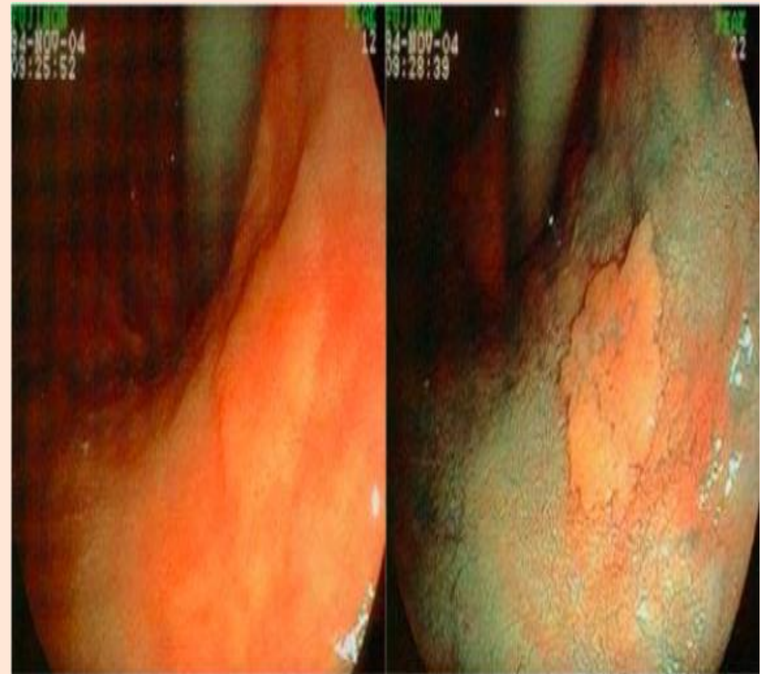


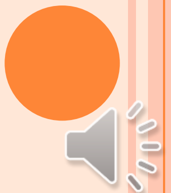


3.Formes anatomocliniques

- **Cancer superficiel (15%) :**

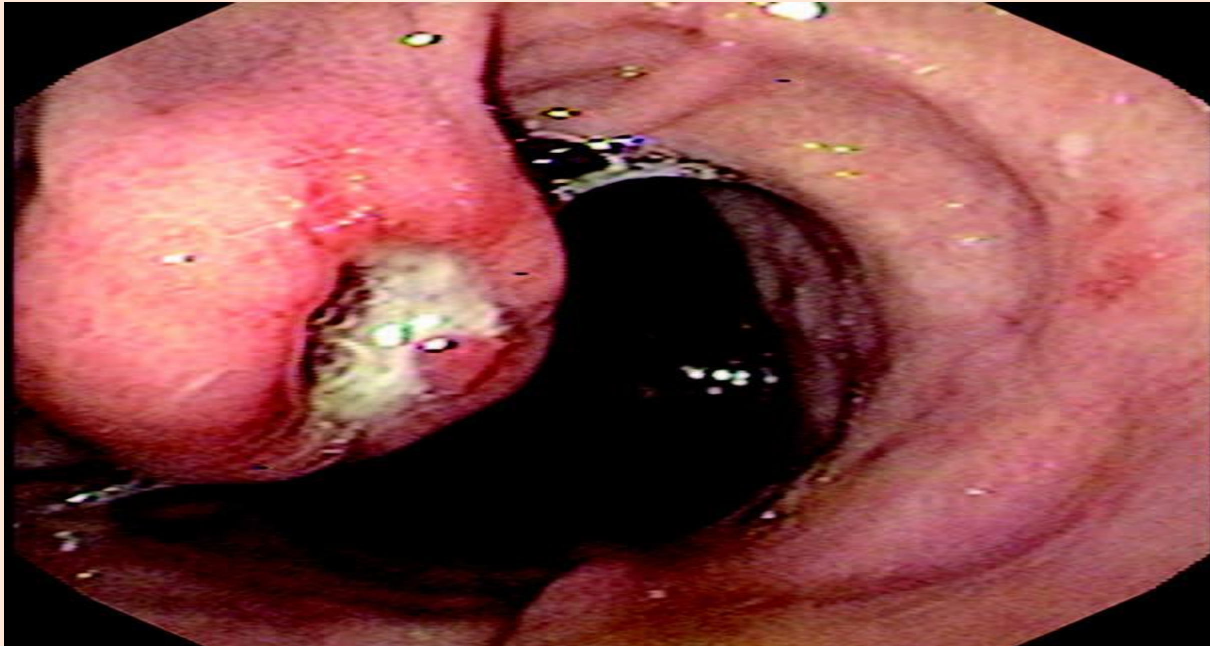




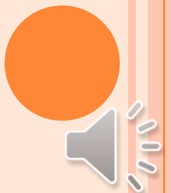


4.FORMES HISTOLOGIQUES

- **Tumeurs stromales gastro-intestinales**



Aspect endoscopique d’une tumeur stromale



4.FORMES HISTOLOGIQUES

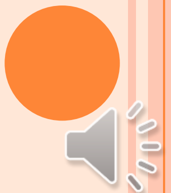
- **Lymphomes :**

Lymphomes gastriques à petites cellules du MALT: aspects endoscopiques

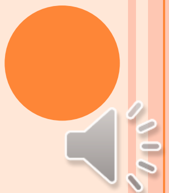
Aspect pseudogastritique

Aspect ulcéré

Aspect de gros plis ulcérés

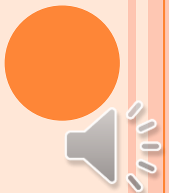


VII. Bilan pré-thérapeutique



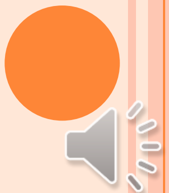
1. Bilan d'extension

Clinique



1. Bilan d'extension

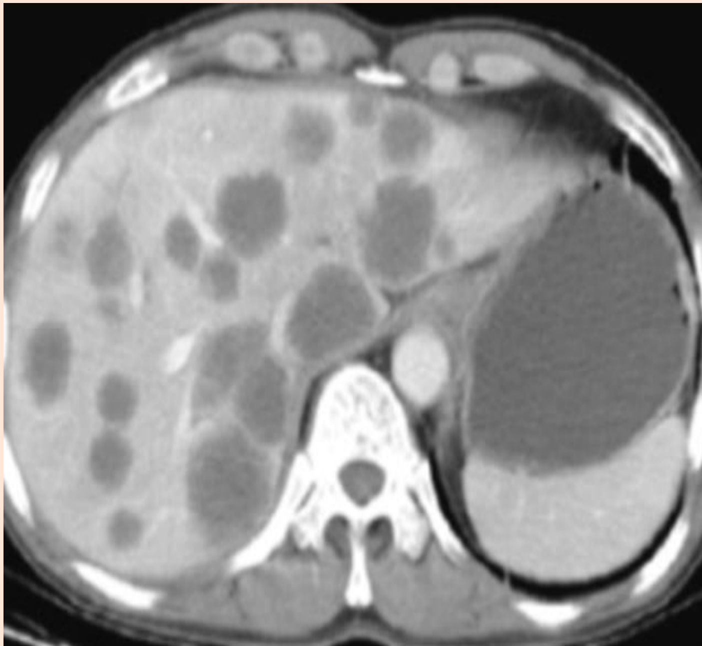
Para clinique

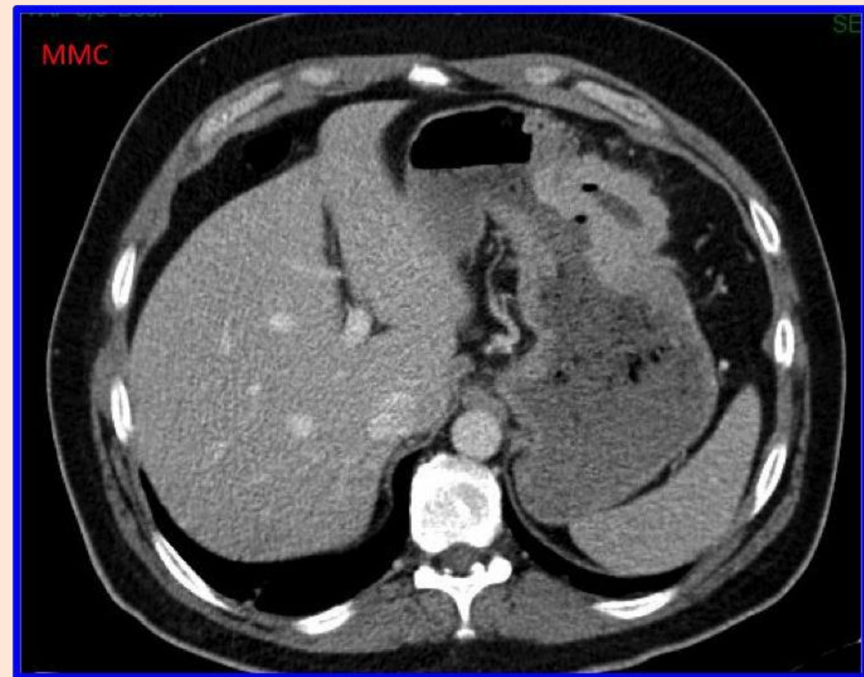


1. Bilan d'extension

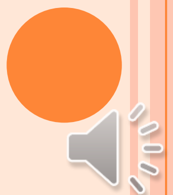
Para clinique

Scanner thoraco-abdomino-pelvien





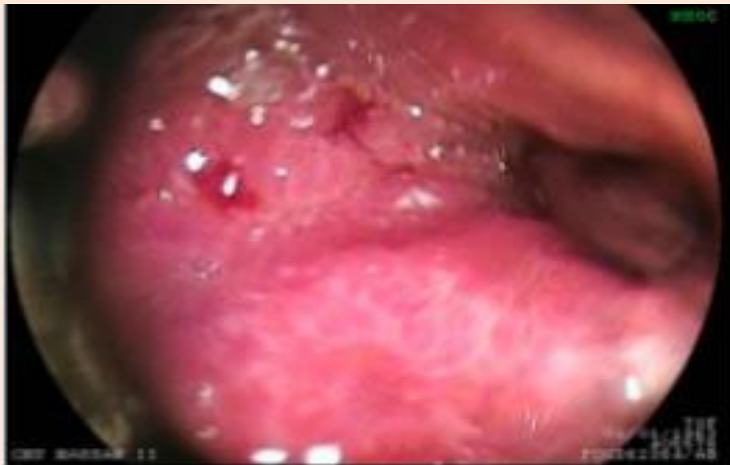
Une tumeur T3, avec infiltration grossière du tissu adipeux péri gastrique de l'antre

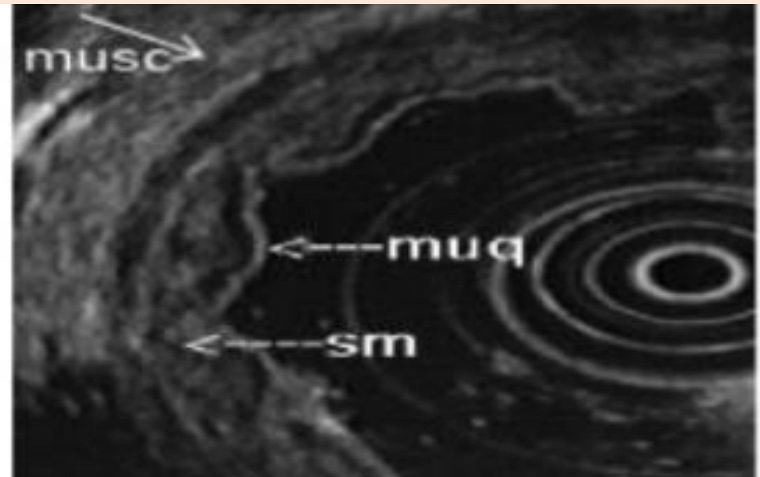


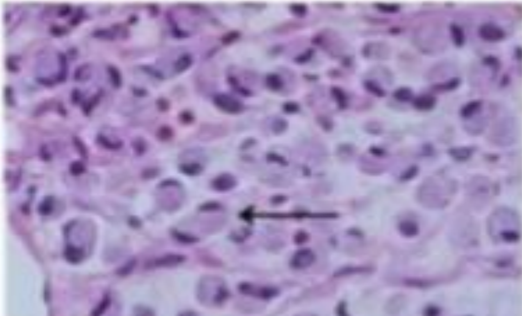
1. Bilan d'extension

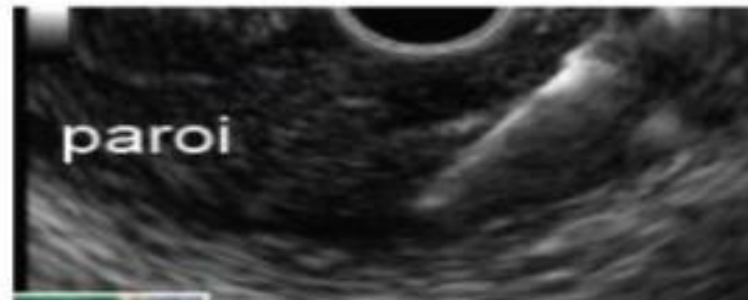
Para clinique

Echoendoscopie

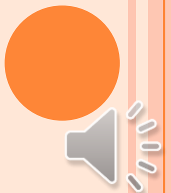








Linite

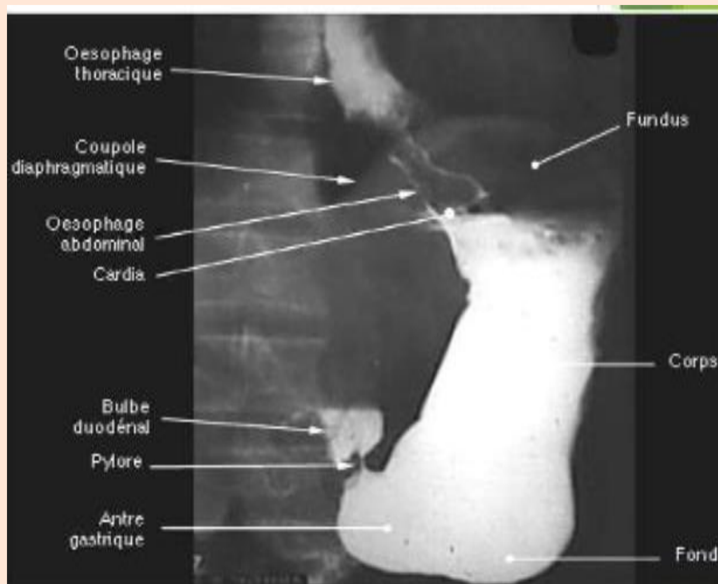


1. BILAN D'EXTENSION

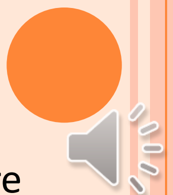
Para clinique

Autres examens: ne sont pas systématiques

- Les marqueurs tumoraux
- Transit œso-gastro-duodénal (TOGD)

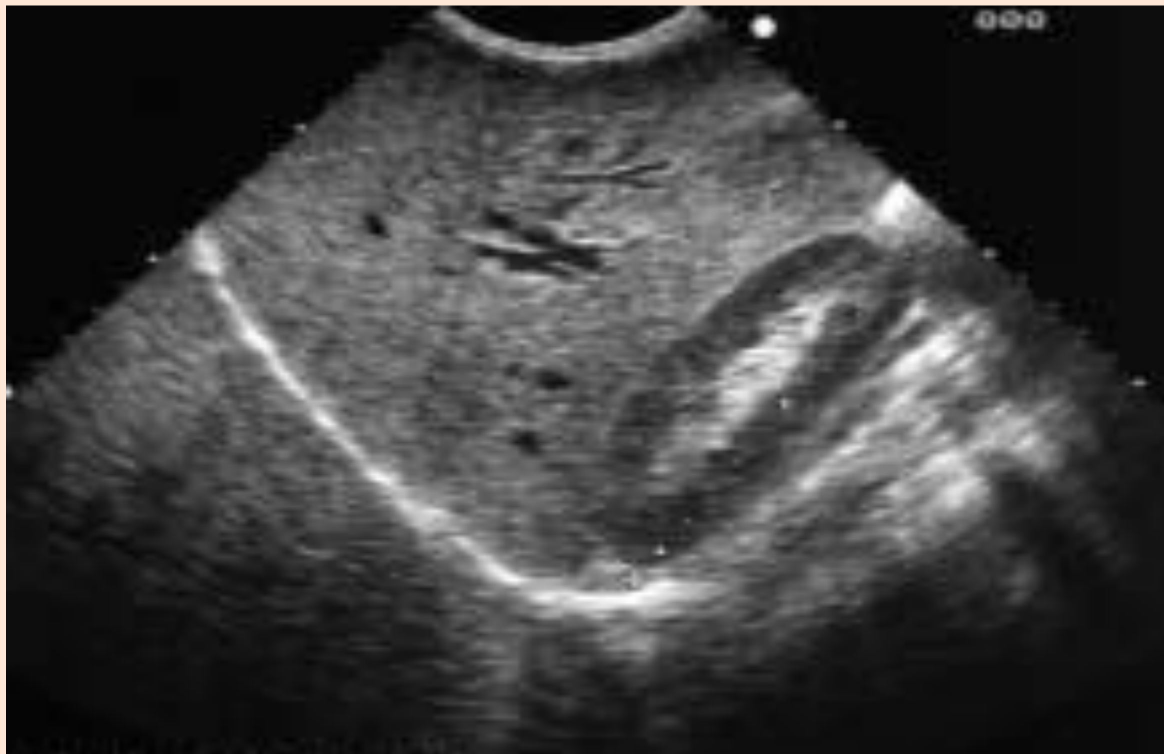


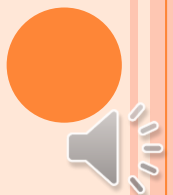
tumeur de la petite courbure atteignant l'antre



1. Bilan d'extension

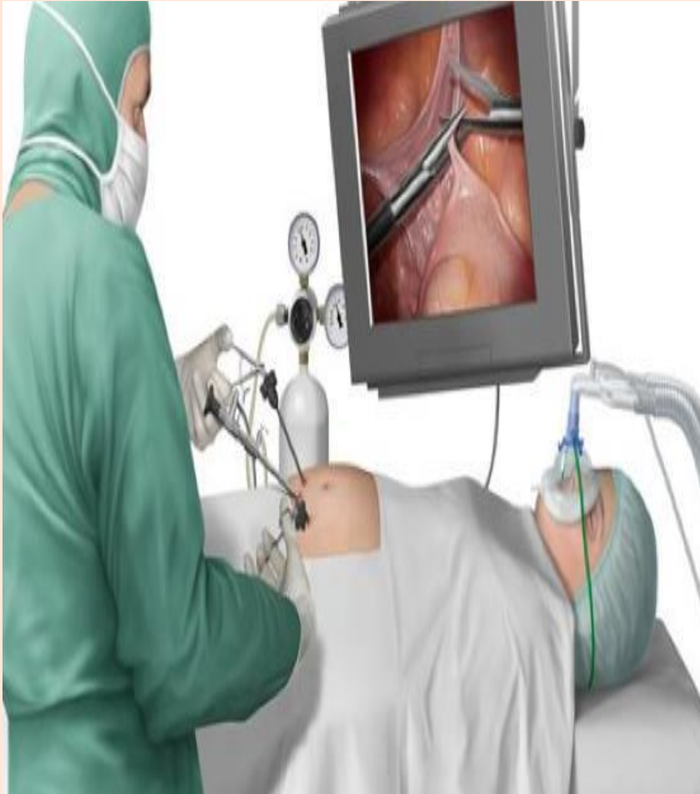
Echographie abdominale

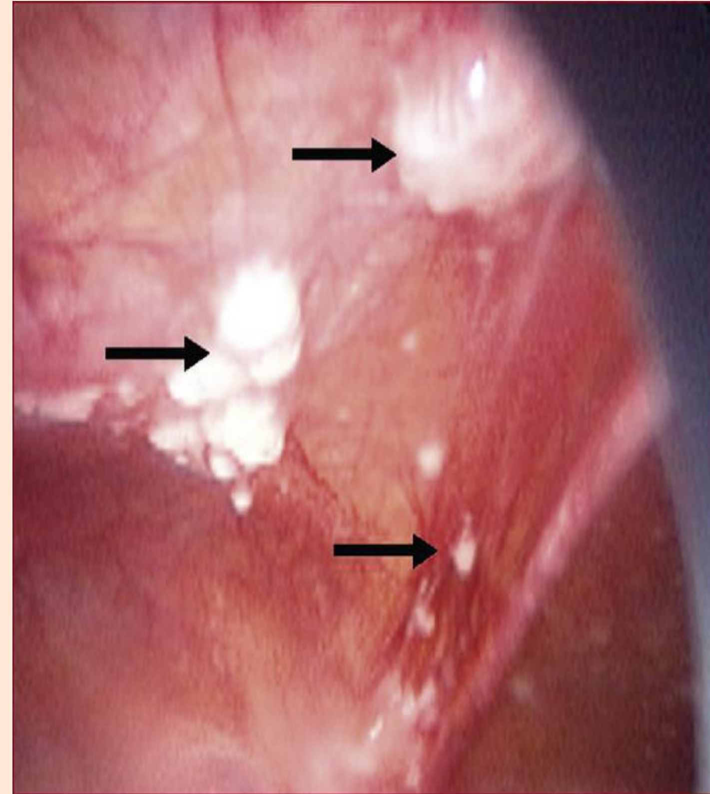




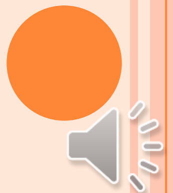
1. Bilan d'extension

Cœlioscopie exploratrice





Carcinose péritonéale

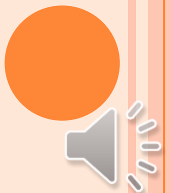


2. Bilan d'opérabilité

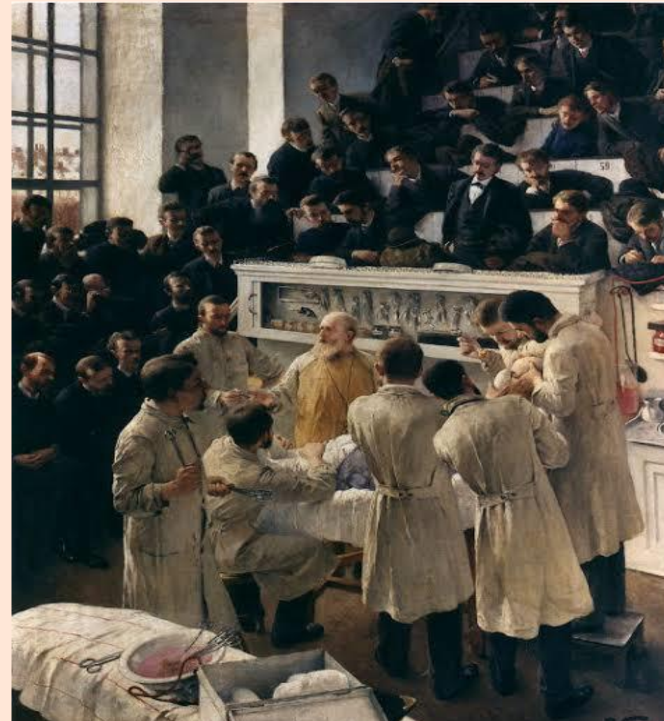
Recherche des comorbidités

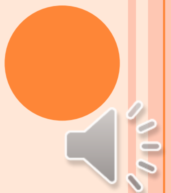
Consultation d'oncogénétique

Evaluation gériatrique

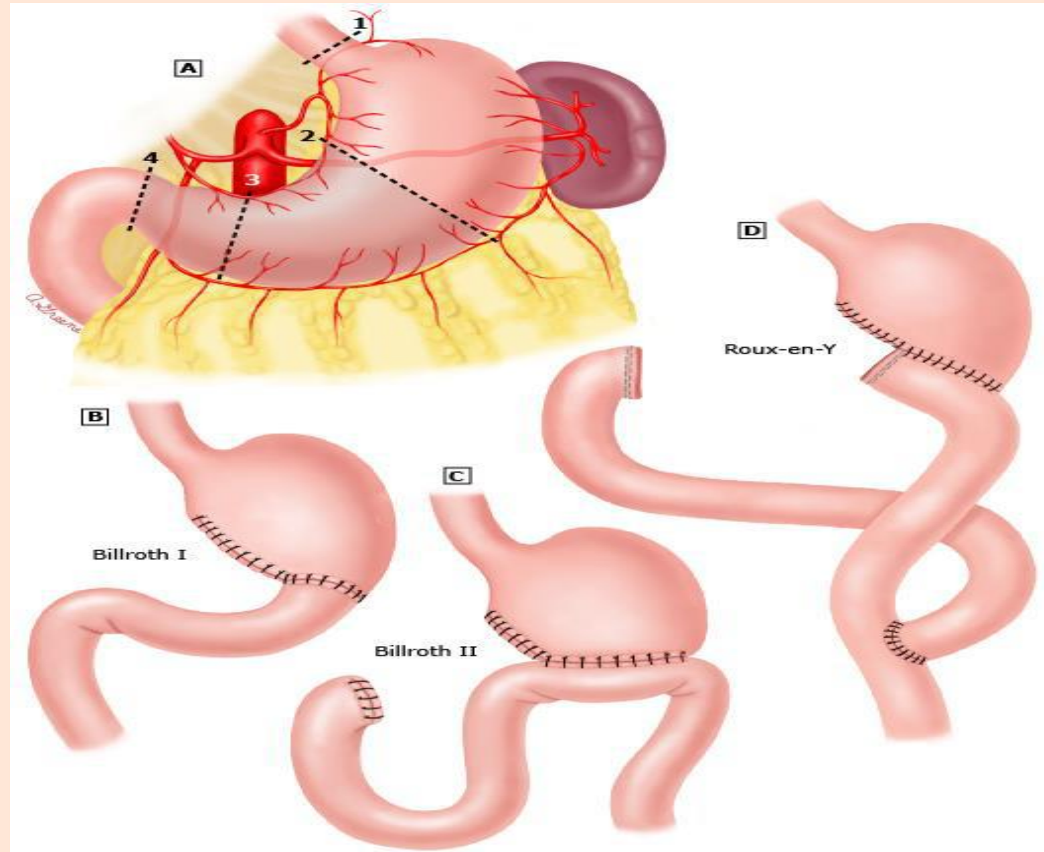


VIII. STRATEGIE THERAPEUTIQUE

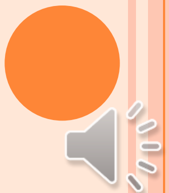




1. Gastrectomies / montages



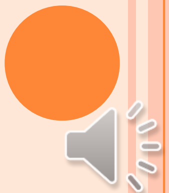
Différents types d'anastomose en cas de Gastrectomie 4/5



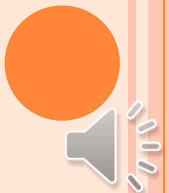
1. Gastrectomies / montages

(a) (b)

Différents types de montage après gastrectomie totale



2.Chirurgie palliative



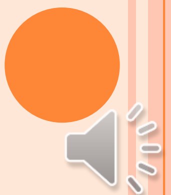
3. **Associations thérapeutiques**

Chimiothérapie péri-opératoire (3 cures avant et 3 cures après chirurgie R0) est devenue une référence.

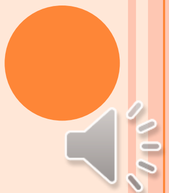
Radio-chimiothérapie proposée en adjuvant (après l'intervention) aux patients opérés sans chimiothérapie préopératoire avec des critères de mauvis pronostic.

Chimiothérapie néo adjuvante (de 1ère intention) dans les formes localement avancées (tumeur non résécable, patients métastatiques).

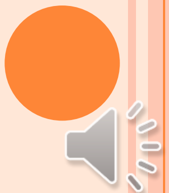
Chimiothérapie hyperthermique intra péritonéale (CHIP) dans les tumeurs T3 et T4 pour prévenir la carcinose.



3.Traitement instrumental (Mucosectomie endoscopique)



IX. PRONOSTIC

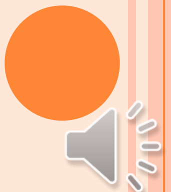


1.FACTEURS DE BON PRONOSTIC

-Chirurgie curatrice sans résidu tumoral (résection R0) et limites d’exérèse saines.

-Age < 70 ans.

- Lésion T1 ou T2, pas de métastase, ni de ganglions envahis



1.FACTEURS DE MAUVAIS PRONOSTIC

-Chirurgie avec résidu tumoral (R1 ou R2) ou limites d'exérèse envahies.

-Age > 70 ans.

-Tumeur diffuse et linite gastrique.

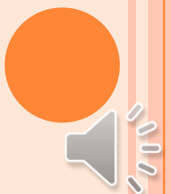
-Présence de cellules indépendantes en bagues à chaton.

-Tumeur de plus de 4 cm.

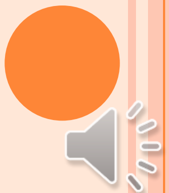
-T3-T4,

- présence de métastase, ganglions envahis.

- Tumeur peu différenciée.



x. CONCLUSION



Merci pour votre attention