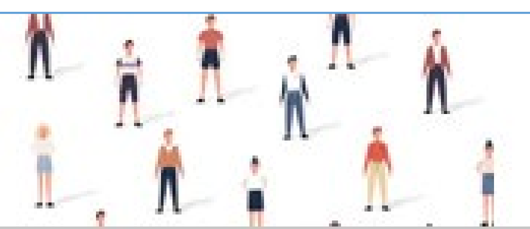
La pré habilitation en oncologie digestive une arme thérapeutique à ne pas méconnaitre pendant la phase du traitement néo adjuvant

Expérience du service de chirurgie générale CHU Mohammed VI Oujda

13 JUIN 2023

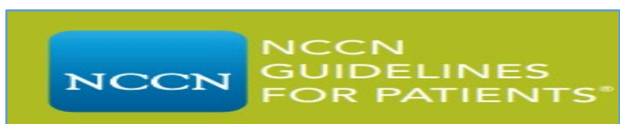
JOURNÉE NATIONALE D'ONCO-RÉHABILITATION



INTRODUCTION

- Cancers digestifs: motif fréquent de consultation/ décès

- Prise en charge multiD, participation active du patient



- Traitement néo adjuvant :Gold standard

Review > Pharmacology. 2021;106(3-4):143-153. doi: 10.1159/000510343. Epub 2020 Sep 23.

Neoadjuvant Chemotherapy in Pancreatic Cancer: An Appraisal of the Current High-Level Evidence

- Longue période d'attente: pré-habilitation

World J Surg
https://doi.org/10.1007/s00268-018-4569-y

CrossMark

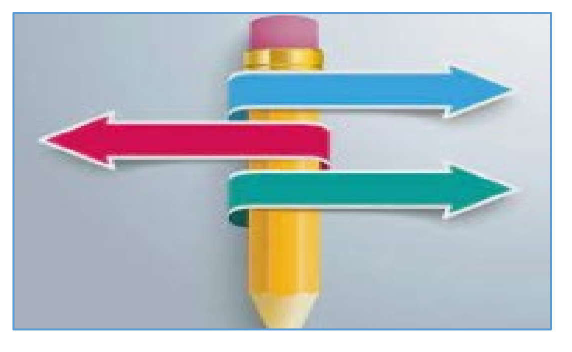
SCIENTIFIC REVIEW

The Impact of Total Body Prehabilitation on Post-Operative Outcomes After Major Abdominal Surgery: A Systematic Review

Alison Luther[1] · Joseph Gabriel[2] · Richard P. Watson[3] · Nader K. Francis[4,5]

- Bon post op = accès au traitement adjuvant= mission complète

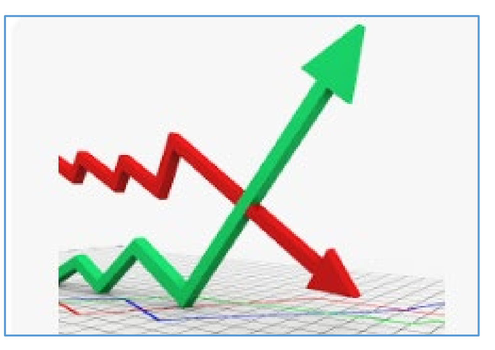
MATÉRIEL ET MÉTHODES



Etude transversale descriptive analytique de 125 cas présentant un cancer digestifs ayant reçu un traitement néo adjuvant

- **G1** (n=60 patients): ayant bénéficié d’une chirurgie de résection carcinologique sans programme de pré habilitation

* **G2** (n=65 patients) : ayant bénéficié d’une chirurgie de résection carcinologique avec programme de pré habilitation



Paramètres non modifiables

- L’âge moyen des patients dans le G1 était de 56 ans versus 54,5 ans dans le G2 **(p=0.07)**

- L’évaluation préopératoire retrouvait un IMC moyen de 26kg/m2 en G1 VS 26.2 kg/m2 G2 **(p=0.067)**

- La durée moyenne de la période du traitement néo adjuvant avait dépassé 3 mois tous cancers confondus

- 10 patients au total étaient jugés inopérables ,**80%** parmi eux dans le groupe G1

RESULTATS

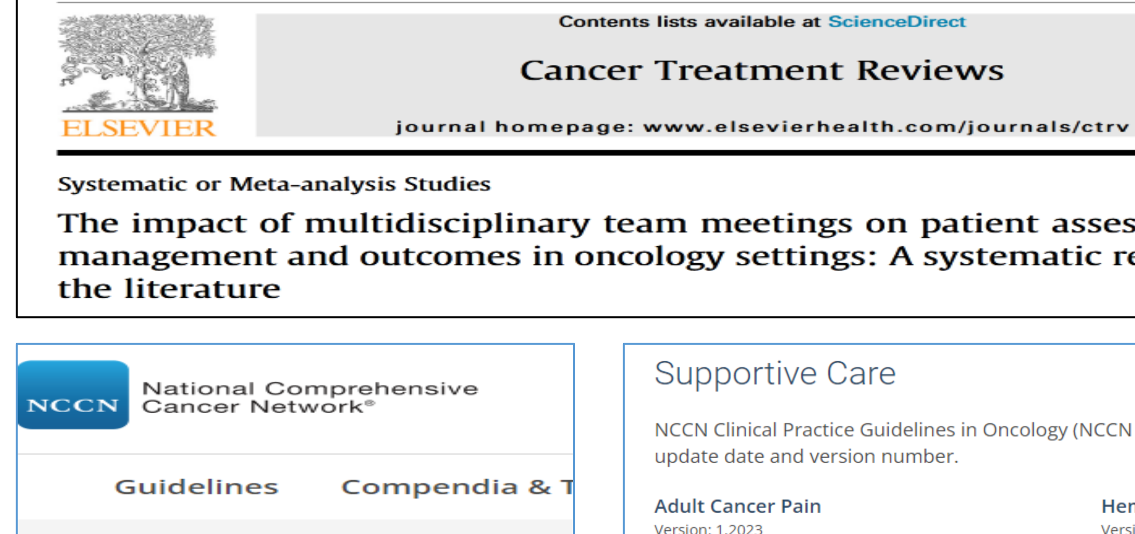
Paramètres modifiables

- Les complications pulmonaires (15% G2 vs 70% G1) **(p=0.003)**
- Décompensation de tares: **G2** 6% Vs 23 % **G1**
- 7 décès/**G1** dans les 3 mois du post opératoire Vs un seul cas **G2**
- L'accès au traitement adjuvant était rapide dans le groupe G2 en moyenne de **4** semaines Vs **7** semaines dans le G1
- Seulement 70% des patients **G1** ont reçu toutes les doses adjuvantes

DISCUSSION

Le contrôle optimal d’un cancer:

- RCP



- Adapter les choix au patient

- Soins de support: obligation

Pré-habilitation : protocoles généraux

Table 1. Overview of risk factor prehabilitation strategies. Screening tools can be employed by multiple clinicians at the earliest opportunity in the preoperative pathway. Further assessment may need to be conducted by specialist healthcare professionals such as a dietician or nutritionist. Prehabilitation interventions should follow similar key principles aiming to achieve meaningful risk factor modification in the available time before surgery.

Risk factor	Screening (all patients)	Assessment (at risk patients)	Intervention principles	Prehabilitation goals
Physical activity	Assess against chief medical officer recommendations for healthy adults: 150 minutes moderate intensity exercise per week or 75 minutes vigorous intensity exercise per week plus muscle strengthening exercise on 2 or more days per week. Patients failing to meet one or both criteria should be offered exercise prehabilitation.	Objective assessment of physical fitness eg cardiopulmonary exercise test 6 minute walk test incremental shuttle walk test.	Combined aerobic and resistance training programme. Prescribed based on objective fitness assessment. Monitored and modified to account for improvements in fitness.	Improve aerobic capacity Develop lean muscle mass
Inspiratory muscle training	ARISCAT score. Consider IMT in 'intermediate-' and 'high-' risk patients.	n/a	Structured IMT programme.	Develop muscles of respiration and reduce risk of perioperative pulmonary complications.
Smoking	Establish smoking status. All smokers should be offered cessation support.	Support access to cessation services for assessment. Fagerström score used to titrate nicotine therapy.	Gold-standard cessation programme (combines counselling and nicotine replacement therapy).	Preoperative cessation.

Clinical Medicin

Prehabilitation

Alcohol	Establish weekly intake in units. Patients with a 'hazardous' intake (>14 units per week) should undergo further assessment.	AUDIT/AUDIT-C questionnaires in those with higher intakes.	Patients with features of dependence will require input from specialist alcohol services. Those with 'hazardous' intakes may respond to the 'brief alcohol intervention'.	Modify non-ha
Nutrition	MUST (Can be adapted for preoperative setting).[39]	Dietician/nutritionist assessment.	Identify macro- and micronutrient deficiencies (ensure total protein intake 1.5–2.0 g/kg daily). 'Food first' approach to correction. Consider protein supplementation following exercise training sessions.	Correct malnut Suppor
Psychological factors	HADS	Assessment for poorly controlled depression and anxiety and low self-efficacy to engage with prehabilitation.	Build self-efficacy through other risk factor interventions. Education programmes. Specialist input for psychological intervention.	Improv anxiety Develop for preh surgery

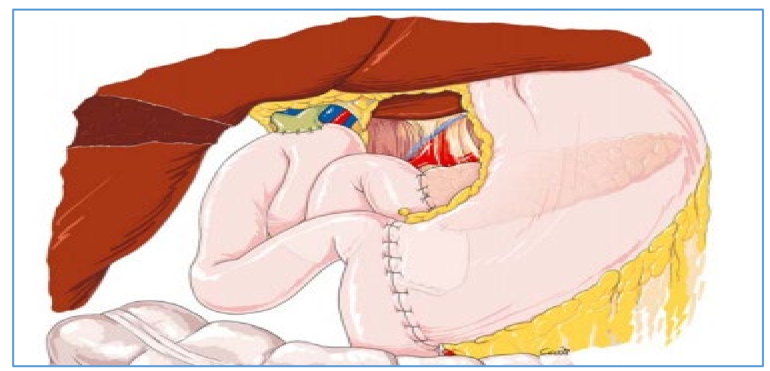
Particularité des cancers digestifs

- 20% à 80%:chance curative/opérabilité

J Hepatobiliary Pancreat Sci. 2022 Sep;29(9):1004-1013. doi: 10.1002/jhbp.1159. Epub 2022 May 22

Prognosis of pancreatic head cancer with different patterns of lymph node metastasis

- Une à Trois anastomoses digestives
- Morbi-mortalité non négligeable



Evidence for enhanced recovery in pancreatic cancer surger

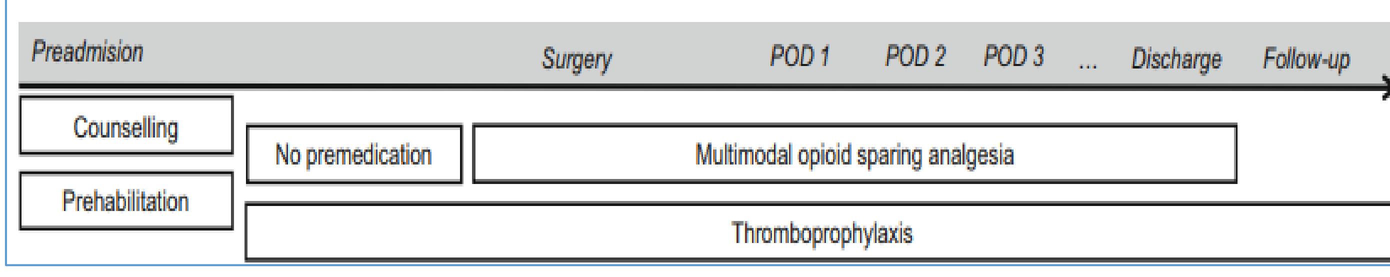
Didier Roulin [1] · Nicolas Demartines [1]

Received: 19 June 2020 / Accepted: 24 June 2020

- Récupération améliorée/Préhabilitation

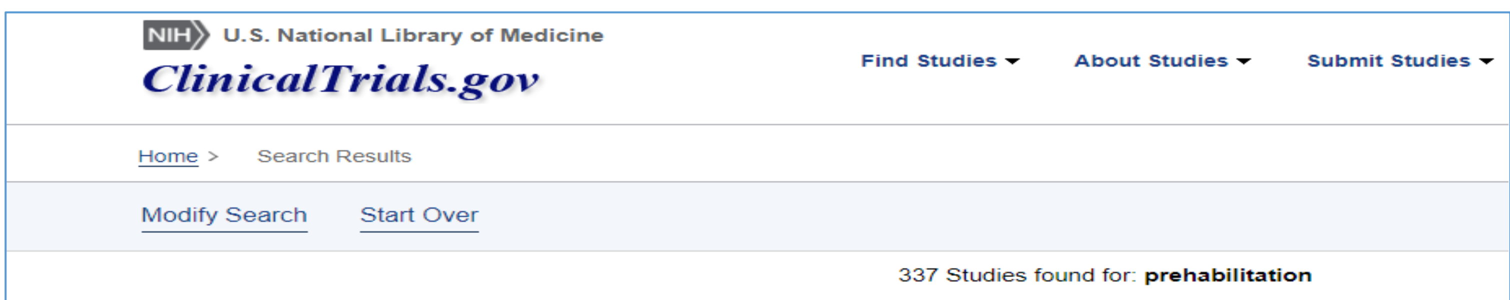
Pré habilitation

- 1/3 des étapes de la prise en charge
- Dizaine des étapes
- Critères communes/ critéres spécifiques



Item	Recommendation
1. Counseling	Dedicated multimedia preoperative counseling.
2. Prehabilitation	Prehabilitation program 3–6 weeks before surgery.
3. Biliary drainage	Avoidance of preoperative drainage, only if bilirubin > 250 μmol/l, c
4. Smoking and alcohol cessation	Smoking and high alcohol consumption cessation at least 4 weeks b
5. Nutrition	Preoperative nutritional intervention if severe weight loss. Nutritiona based on BMI and weight loss.
6. Immunonutrition	Not recommended.
7. Fasting and carbohydrates	Preoperative fasting: 6 h for solids and 2 h for liquids. Carbohydrate
8. Pre-anesthetic medication	No anxiolytics. Acetaminophen and single dose gabapentinoid.
9. Thromboprophylaxis	Concomitant chemical and mechanical thromboprophylaxis.
10. Antibioprophylaxis and skin preparation	Single dose iv antibiotic less than 60 min before skin incision. Intra if preoperative biliary stenting. Therapeutic postoperative antibiot Use of alcohol-based preparations and wound protectors.
11. Epidural analgesia	Thoracic epidural for open PD.
12. Postoperative analgesia	Multimodal opioid sparing analgesia.
13. Wound catheter	Preperitoneal wound catheter as alternative to epidural for open PD.
14. PONV prophylaxis	PONV prophylaxis adapted to risk factors.
15. Hypothermia	Active warming to maintain temperature above 36 °C.
16. Postoperative glycemic control	Glucose levels should be maintained as close to normal as possible
17. Nasogastric tube	No postoperative nasogastric tube.
18. Fluid balance	Avoidance of fluid overload.
19. Perianastomotic drain	Early drain removal at 72 h in low-risk patients.
20. Somatostatin analogs	No systematic use of somatostatin.
21. Urinary catheter	Early urinary catheter removal.
22. Delayed gastric emptying (DGE)	No acknowledged prophylactic strategy. Early diagnosis of intraabd Artificial nutrition in case of prolonged DGE.
23. Stimulation of bowel movement	Use of chewing gum, alvimopan, or mosapride.
24. Diet	Normal diet after surgery according to tolerance.
25. Mobilization	Early and active mobilization.
26. Minimal invasive surgery	Laparoscopic PD only in highly experienced high-volume center. N for robotic-assisted PD.
27. Audit	Regular and continuous audit.

Pré habilitation



- Domaine actif de recherche

Réanimation/chirurgie

SCIENTIFIC REVIEW

Prehabilitation Before Major Abdominal Surgery: A Systemati Review and Meta-analysis

Michael J. Hughes[1] · Rosie J. Hackney[1] · Peter J. Lamb[1] · Stephen J. Wigmore[1] · D. A. Christopher Deans[1] · Richard J. E. Skipworth[1]

Review > J Clin Anesth. 2023 Jun;86:111053. doi: 10.1016/j.jclinane.2023.111053. Epub 2023 Feb 1.

Efficacy of supervised exercise prehabilitation programs to improve major abdominal surgery outcomes: A systematic review and meta-anal

Pablo Duro-Ocana [1], Fabio Zambolin [2], Arwel W Jones [3], Angella Bryan [4], John Moore , Tanviha Quraishi-Akhtar [6], Jamie Mcphee [7], Hans Degens [8], Liam Bagley [9]

- Que des chiffres positifs

Meta-Analysis > Ann Am Thorac Soc. 2021 Apr;18(4):678-688. doi: 10.1513/AnnalsATS.202002-183OC.

Preoperative Exercise Training to Prevent Postoperative Pulmonary Complications in Adults Undergoing Major Surgery. A Systematic Review and Meta-analysis with Trial Sequential Analysis

Benjamin Assouline [1], Evelien Cools [1], Raoul Schorer [1], Bengt Kayser [2], Nadia Elia [1 3],

- Impact économique positif

Financial Impact of Anastomotic Leakage in Colorectal Surgery

Davide La Regina [1], Matteo Di Giuseppe [1], Massimo Lucchelli [2], Andrea Saporito [3], Luigi Boni [4], Christopher Efthymiou [5], Stefano Cafarotti [1], Michele Marengo [1], Francesco Mongelli [6]

Conclusion

- RCP= consultation MPR

- Préparation physique :place primordiale

- Pré-habilitation=Augmente l'opérabilité=Plus de patients aptes au traitement adjuvant