

# La transition enfant -adulte



# Questions pivotales de la transition

1. Début de prise en charge/test génétique
2. Surveillance des risques (rares) de l'enfance
  - Tumeurs sexuelles (ovaire, testicules) PJ
  - Medulloblastome et Hépatoblastome (PAF)
3. Aide en endoscopie interventionnelle / suivi
  - Suivi du grêle PJ
  - Suivi endoscopique PAF
4. Aide à la prise de décision (endoscopie interventionnelle et chirurgie)

# Quand faut-t-il débiter la surveillance ? (en se basant sur le test génétique)

## Test génétique :

- PAF : APC 12-14 ans - MUTYH 18-20 ans
- Peutz Jeghers : à partir de 3 ans ou si symptômes

## Rappel : test prédictif encadré par la loi !

- Jamais avant l'âge de début de suivi recommandé
- nécessite une consultation d'oncogénétique

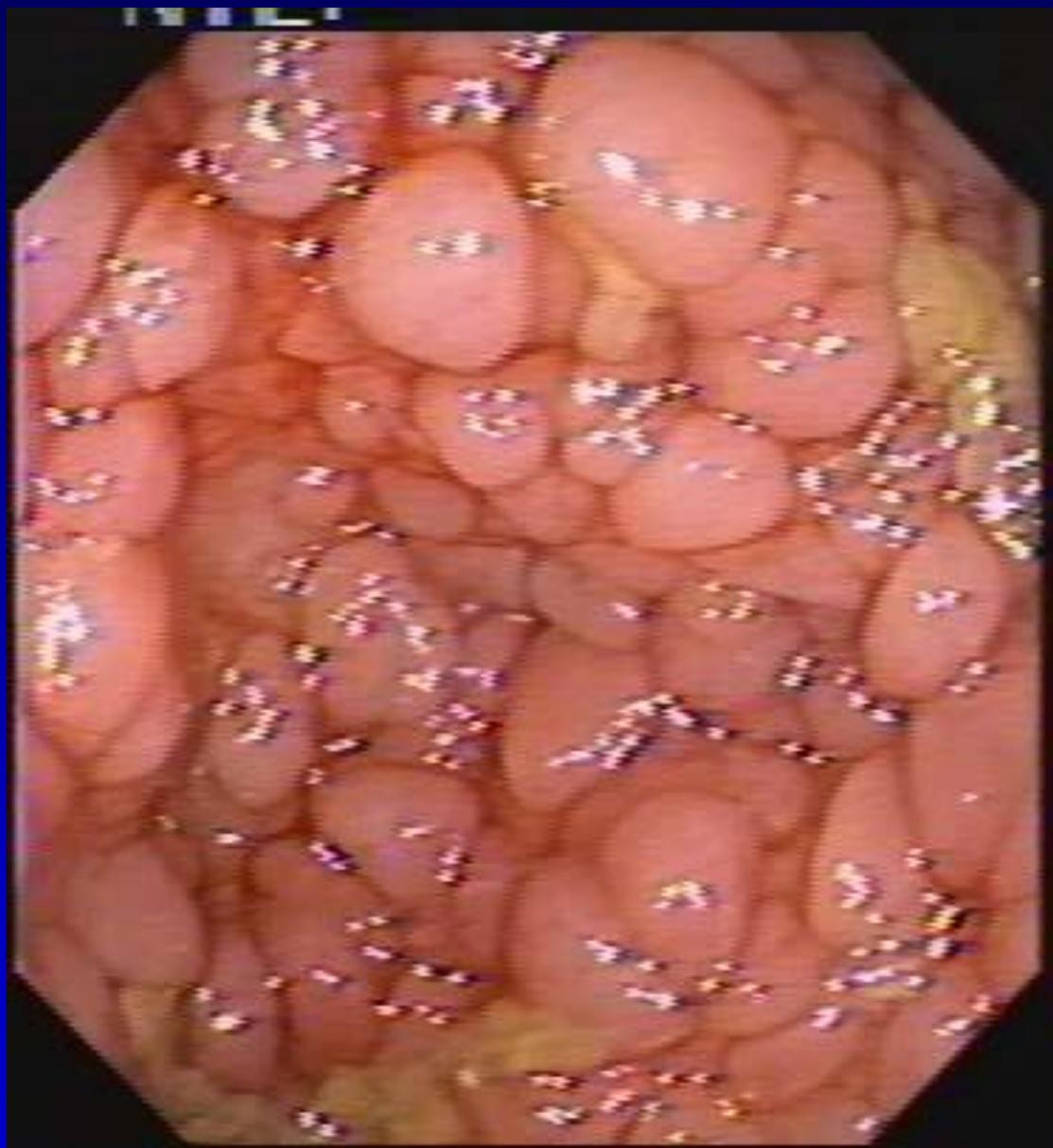
## Quel suivi endoscopique 12-18 ans PAF et coordination avec les pédiatres

Coloscopie complète tous les 1-2 ans (selon la densité et taille des polypes) + 1 évaluation de la papille par sécurité

- Coordination avec les pédiatres pour i) age de colectomie et ii) évaluation du rectum pour le type de colectomie

- Critères d'alarme : taille > 1 cm, dysplasie de haut grade, polypose confluyente (mutation 1309)

Risque : rares cas de cancer précoce sur polyposes agressives et confluentes

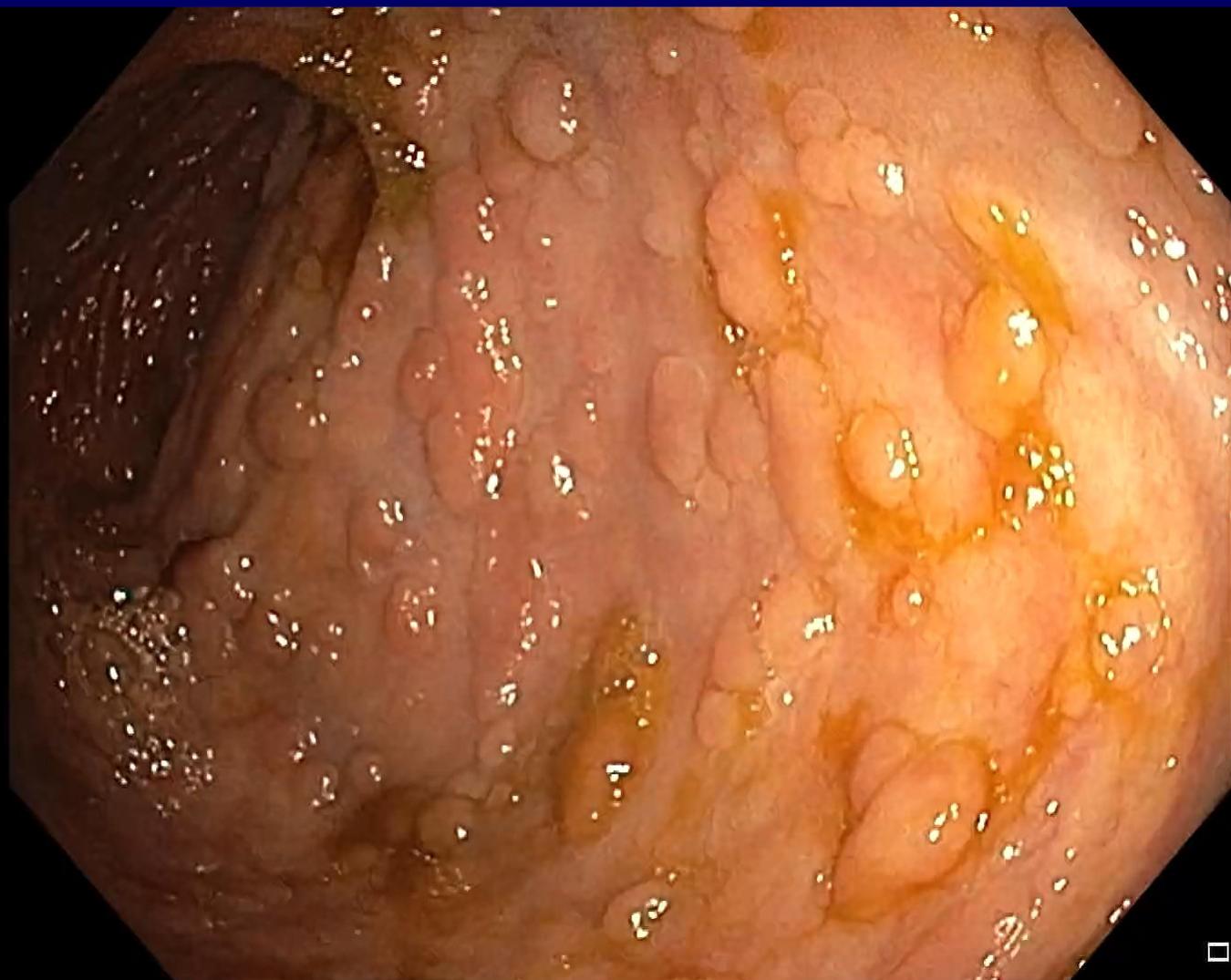


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Nom patient:

10/12/2020

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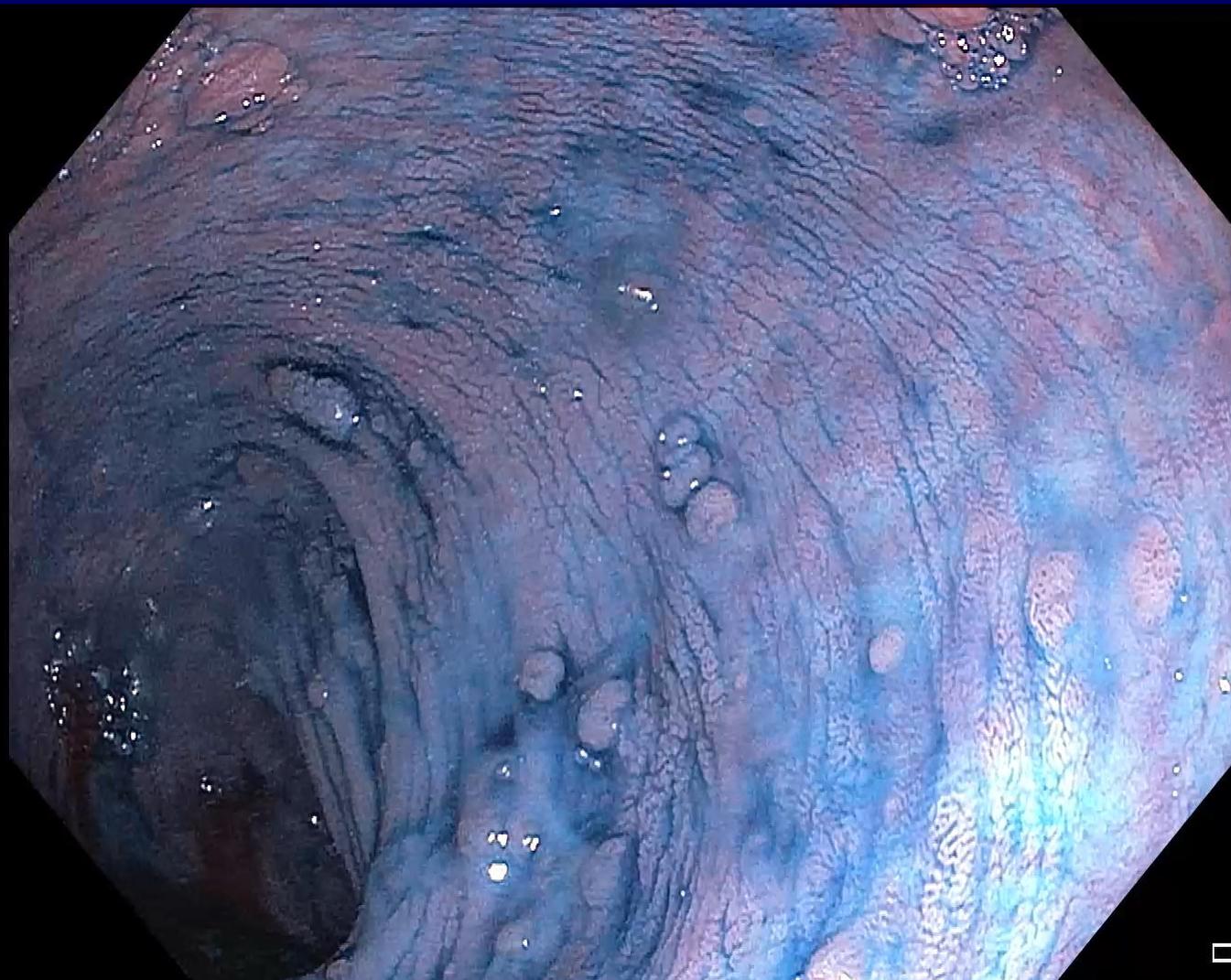


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Commentaire:



# La vision des pédiatres de Lyon (centre Mardi / Sophie Heissiat)

Bonne identification des correspondants

Manque peut être une consultation commune de transition  
(mais atténuée par les contacts familiaux au contraire des mici)

Manque une réunion de calage sur les protocoles de suivi  
et les décisions type colectomie

Tous les patients de pédiatrie n'ont pas eu  
de consultation d'oncogénétique ?

# Règles médico légales anesthésie / bloc adulte

Endoscopie au bloc adulte :  
15 ans, 25 kg, ASA 1 ou 2

# Règles hospitalisations des mineurs

Chambre seule / accompagnement des parents  
/ hôpital de jour

## Ce qui aide la transition

Lyon : conseil génétique fait par l'équipe adulte  
(mais sans doute différent ailleurs :  
oncogénéticiens dissociés ? )

Suivi des parent pas le centre adulte (confiance)

Transmission images simplifiée  
(logiciel identique, serveur? )

Site d'endoscopie commun (Lyon antérieur)

## Recommandations de réalisation des examens de surveillance selon le PPS établi pour chaque patient dans le cadre d'un syndrome de Peutz-Jeghers

### Surveillance testiculaire dès la naissance :

- Examen clinique annuel des testicules et échographie si anomalie

### Surveillance digestive à partir de 4 ans :

- **Suivi du grêle :**
  - Consultation annuelle et échographie abdominopelvienne **jusqu'à 8 ans**. Capsule si doute à l'échographie.
  - Capsule systématique **tous les 2 ans à partir de 8 ans**
    - Traitement des polypes  $\geq 2\text{cm}$  de **4 ans à 15 ans**
    - Traitement des polypes  $\geq 1\text{cm}$  de **à partir de 15 ans**
- **Coloscopie complète et Endoscopie œsogastroduodénale** réalisée dans les conditions techniques jugées optimales par l'endoscopiste (score de Boston  $\geq 7$ ).
  - 1<sup>er</sup> examen à **10 ans** :
    - **Si polypes**, coloscopie **tous les 3 ans**
    - **Si normale**, reprendre le suivi à **partir de 18 ans tous les 2 ans**

## Ce qui complique la transition

Homogénéisation des évaluations  
(nécessite la transmission d'images, RCP communes)

Méthodes de préparation  
(sonde gastrique chez l'enfant...)

Flou sur l'âge de début chez les adultes

# Spécificités polypose adénomateuse

Suivi des pathologies rares de l'enfant

- Hépatoblastome
- Thyroïde

A quel âge démarrer le suivi endoscopique ?  
Théorie 13 ans, en pratique ?

Bilan duodénal jeune ? Pas dans les recos...

H pylori : éradiquer tôt ? Ou plus tard ?

# Spécificités peutz jeghers

Tumeurs rares de l'enfant  
Leydigomes, Ovaires granulosa

Suivi du grêle : échographie, capsule à 8 ans  
ou avant ?

Entéroscopie chez l'enfant

Début suivi 12 ans gastro -colo ok en général

# Spécificités polypose juvénile

Pas de suivi extra digestif

Début suivi 12 ans ok pour tous

Pas de risque gastrique jeune

Rendu Osler (bilan spécifique jeune, dépistage pulmonaire et cérébral)



# Transition – polyposes digestives

Pr Emmanuel MAS

CRCM MARDI Toulouse

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# Expérience toulousaine

- **Pas réellement de transition**
- **MAIS :**
  - Cohérence gastropédiatres – gastroentérologues – chirurgiens digestifs
  - RCP GENEPEY
  - Information/connaissance de leur maladie (enfants/parents)
- **Pathologies différentes des MICI**

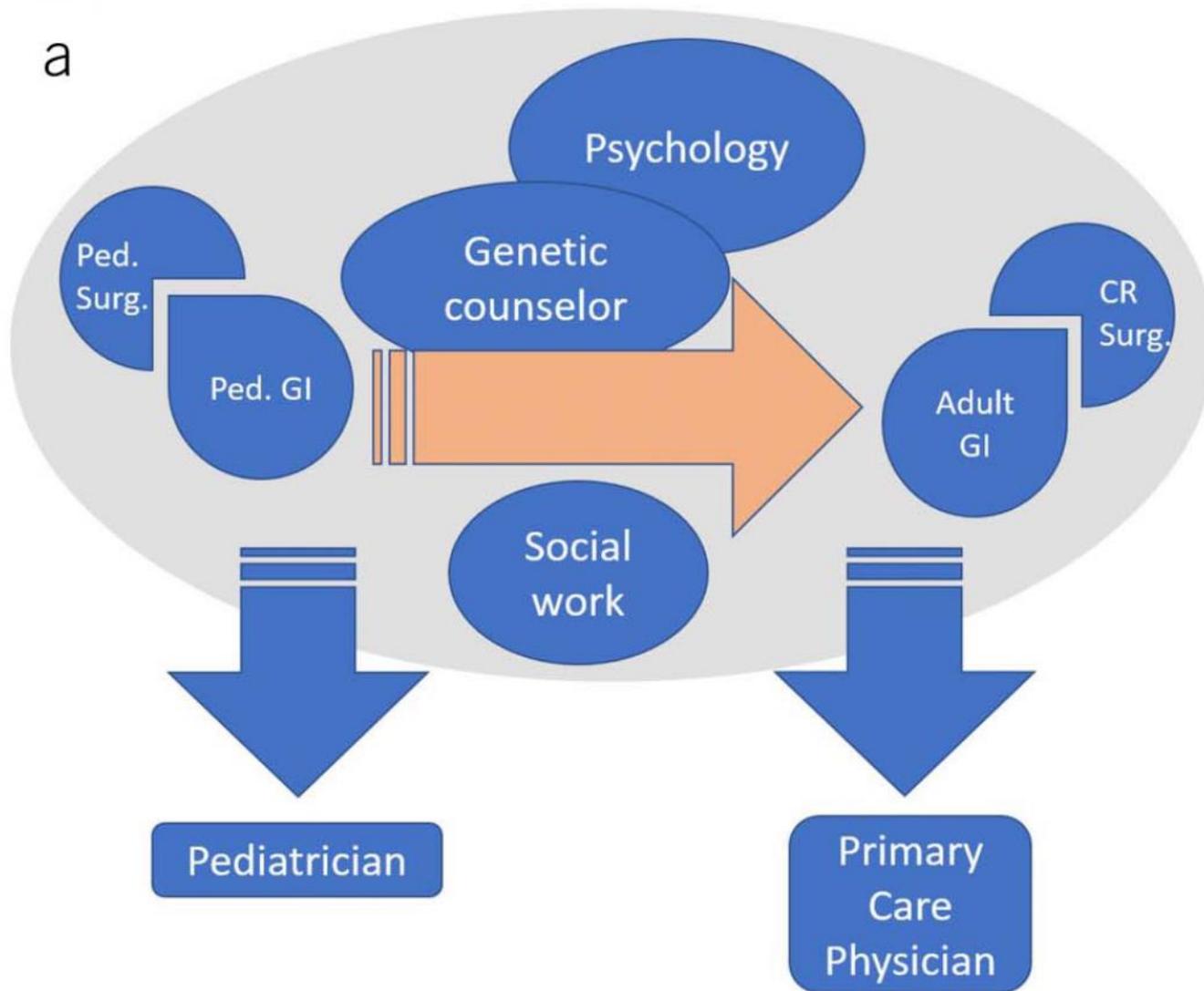


# **ACG Clinical Report and Recommendations on Transition of Care in Children and Adolescents With Hereditary Polyposis Syndromes**

Thomas M. Attard, et al. Am J Gastroenterol 2021;116:638–646.

<https://doi.org/10.14309/ajg.00000000000001140>

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We recommend consultation, during early adolescence, by social workers involving, as needed, financial counselors, and financial assistance programs.





# Points d'amélioration

- **Psychologues**
- **Assistantes sociales**
- **Enseignants**

# ACG Clinical Report and Recommendations on Transition of Care in Children and Adolescents With Hereditary Polyposis Syndromes

Equipe multidisciplinaire et registre idéalement

Impliquer tôt les enfants dans leur prise en charge médicale

Pas de transition au moment des évènements majeurs (colectomie)

Décision du moment de la colectomie : point majeur

Transition plus précoce si la lourdeur de la prise en charge le justifie

Importance d'un psychologue lors des différentes transitions

Conseil financier et accompagnement

Evoquer les questions de transmission, de fertilité

# Points majeurs

Communication entre médecins

Transfert d'images

Protocoles clairs (PPS)

Possibilité d'endoscopie en commun sur l'un des sites

Quels moyens ? Psychologue ?