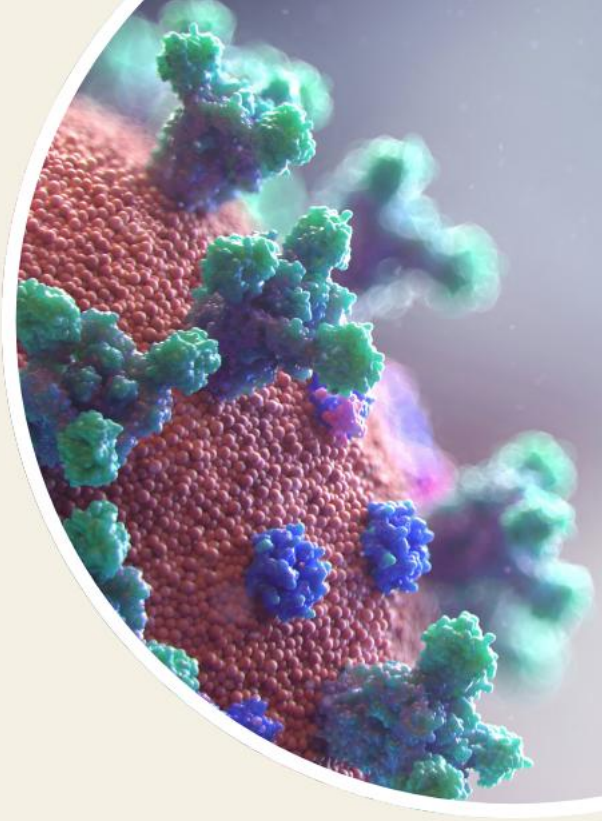
Congrès CANCER IMMUNE

CANCER DE L'IMMUNODÉPRIMÉ

jeudi 19 février 2026 - Paris



Avancées thérapeutiques et scientifiques générées par le collectif K-VIROGREF de 2013 à 2025

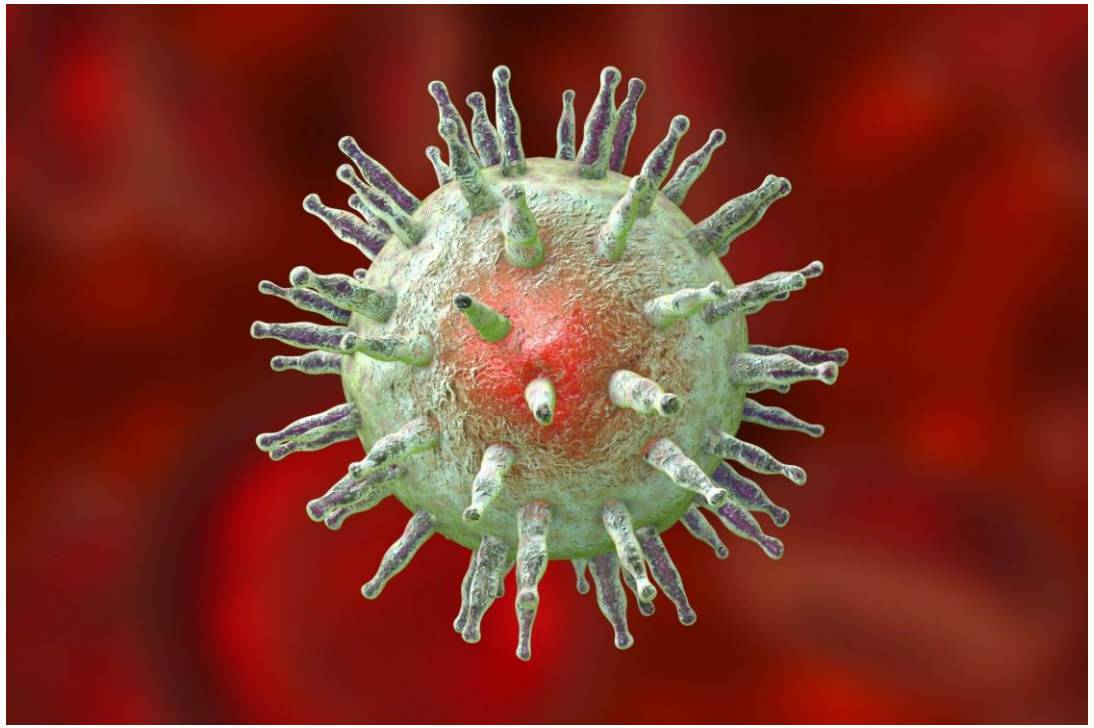
Dr Sylvain Choquet
Paris, France

SORBONNE UNIVERSITÉ
CRÉATEURS DE FUTURS DEPUIS 1257
HÔPITAUX UNIVERSITAIRES PITIÉ SALPÊTRIÈRE CHARLES FOIX

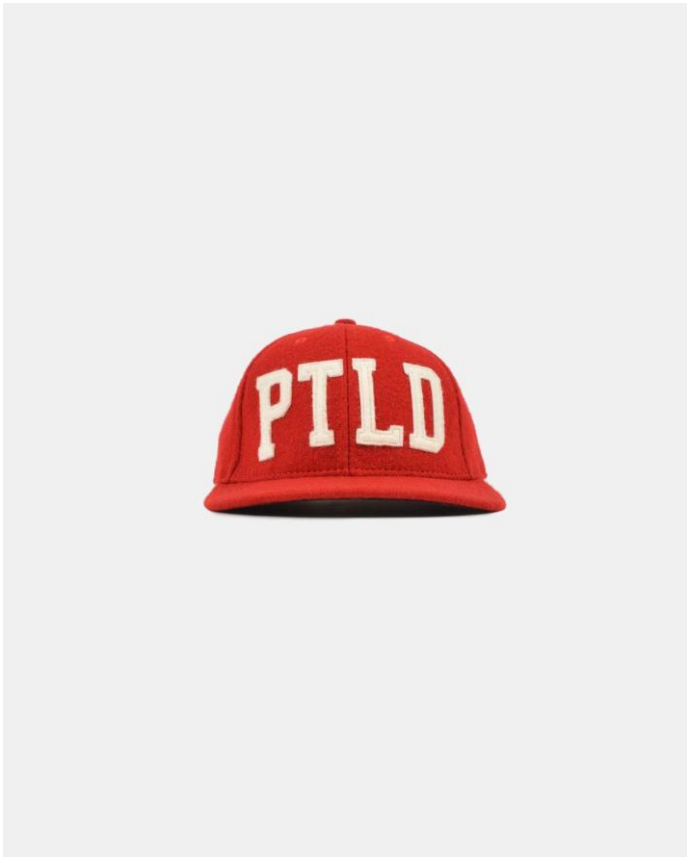
Liens d’intérêt

- AbbVie, AstraZeneca, Atara, BeiGene, Gilead/Kite, Janssen, Novartis, Pierre Fabre and Takeda.

Préhistoire de k-virogref



1964



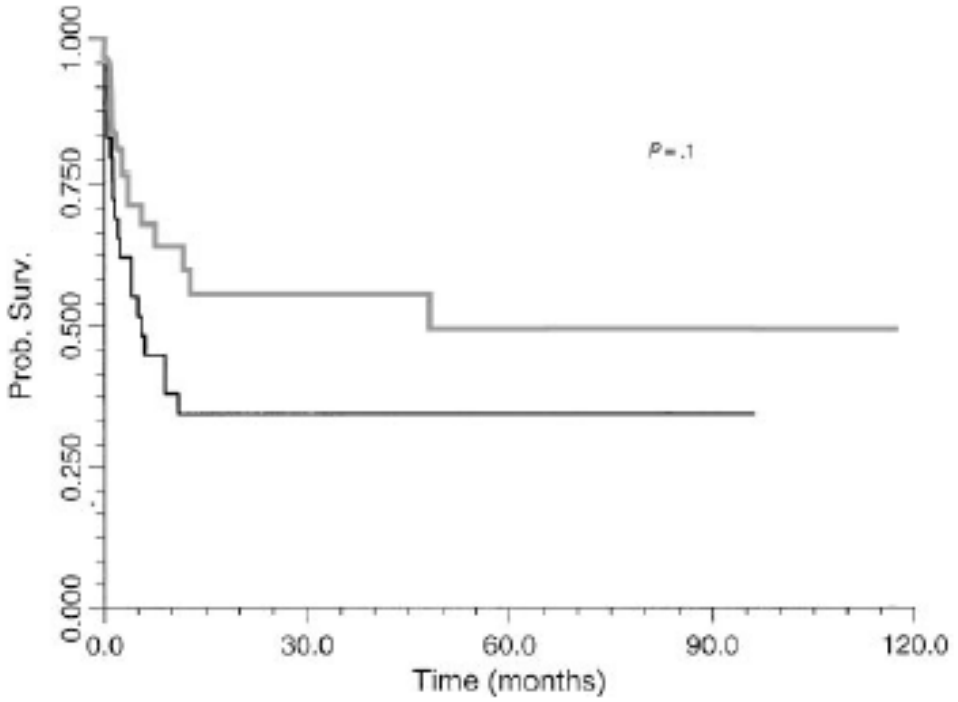
1976

Anti–B-Cell Monoclonal Antibody Treatment of Severe Posttransplant B-Lymphoproliferative Disorder: Prognostic Factors and Long-Term Outcome

By Malika Benkerrou, Jean-Philippe Jais, Véronique Leblond, Anne Durandy, Laurent Sutton, Pierre Bordigoni, Jane Luce Garnier, Jérôme Le Bidois, Françoise Le Deist, Stéphane Blanche, and Alain Fischer

Blood 1998

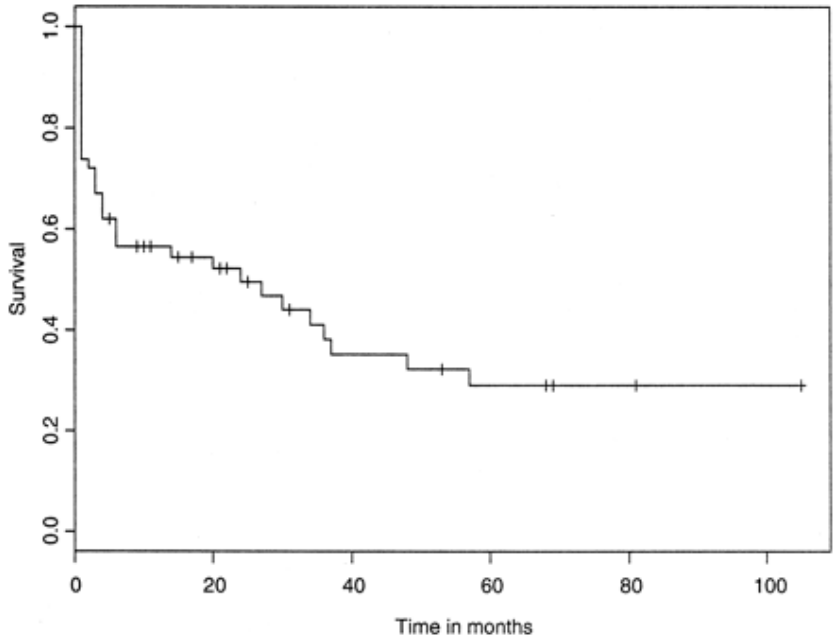
Anti CD21 + anti CD24



Multicenter Study > J Clin Oncol. 2001 Feb 1;19(3):772-8. doi: 10.1200/JCO.2001.19.3.772.

Identification of prognostic factors in 61 patients with posttransplantation lymphoproliferative disorders

V Leblond [1], N Dhedin, M F Mamzer Bruneel, S Choquet, O Hermine, R Porcher, S Nguyen Quoc, F Davi, F Charlotte, R Dorent, B Barrou, J P Vernant, M Raphael, V Levy

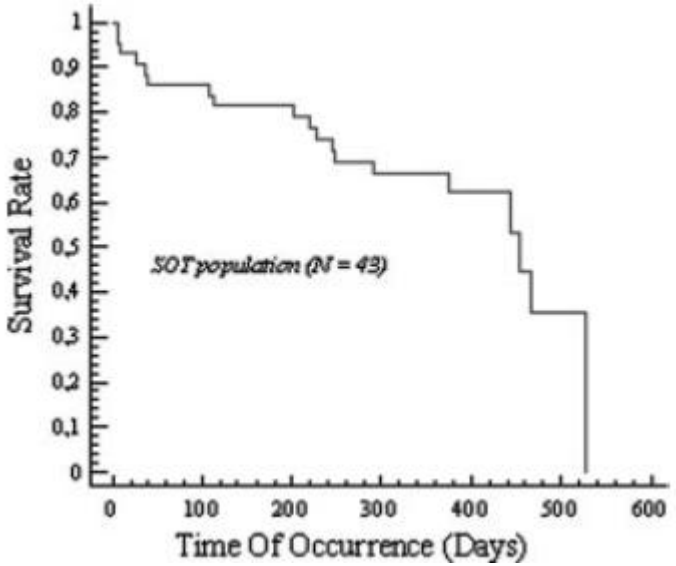


Efficacy and safety of rituximab in B-cell post-transplantation lymphoproliferative disorders: results of a prospective multicenter phase 2 study

Sylvain Choquet, Veronique Leblond, Raoul Herbrecht, Gérard Socié, Anne-Marie Stoppa, Peter Vandenberghe, Alain Fischer, Franck Morschhauser, Gilles Salles, Walter Feremans, Etienne Vilmer, Marie-Noelle Peraldi, Philippe Lang, Yvon Lebranchu, Eric Oksenhendler, Jeanne Luce Garnier, Thierry Lamy, Arnaud Jaccard, Augustin Ferrant, Fritz Offner, Olivier Hermine, Anne Moreau, Samira Fafi-Kremer, Patrice Morand, Lucienne Chatenoud, Nathalie Berriot-Varoqueaux, Loïc Bergougnoux, and Noel Milpied

Blood 2006

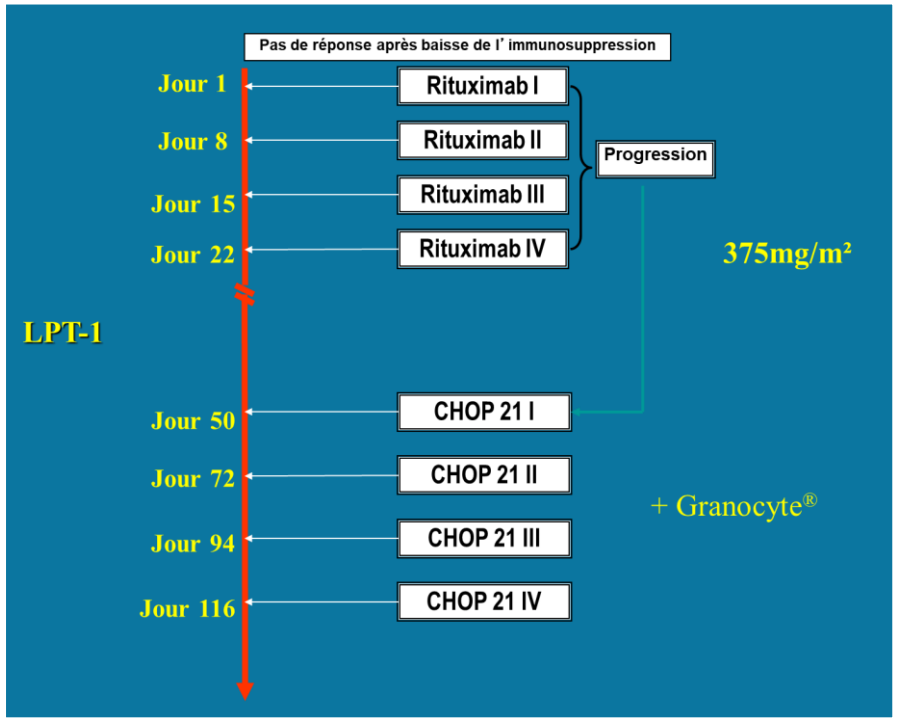
SG

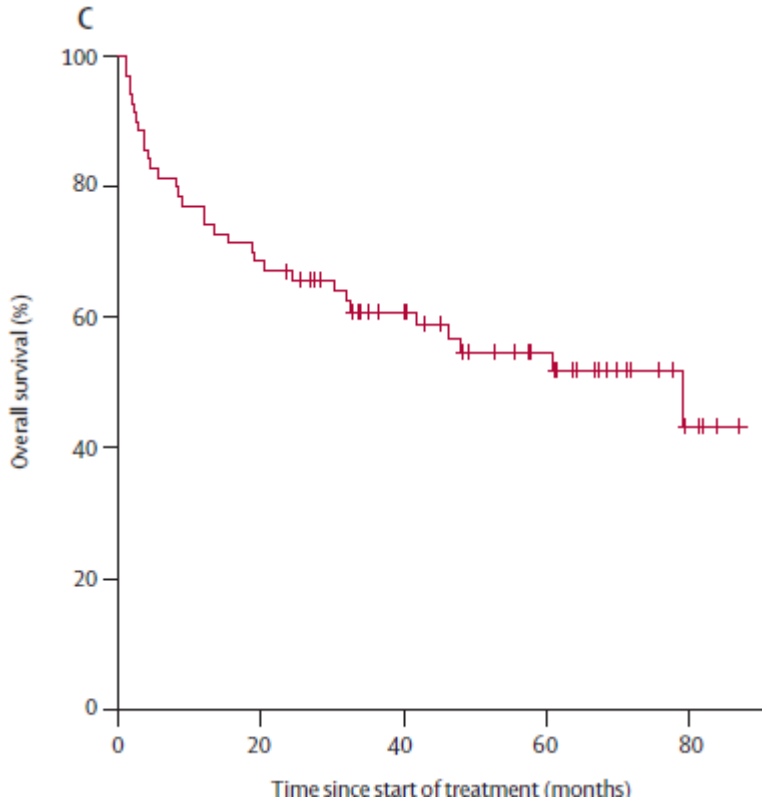


Sequential treatment with rituximab followed by CHOP chemotherapy in adult B-cell post-transplant lymphoproliferative disorder (PTLD): the prospective international multicentre phase 2 PTLD-1 trial

Ralf Trappe, Stephan Oertel, Veronique Leblond, Peter Mollee, Monica Sender, Petra Reinke, Ruth Neuhaus, Hans Lehmkuhl, Heinz August Horst, Gilles Salles, Franck Morschhauser, Arnaud Jaccard, Thierry Lamy, Malte Leithäuser, Heiner Zimmermann, Ioannis Anagnostopoulo Martine Raphael, Hanno Riess, Sylvain Choquet, for the German PTLD Study Group and the European PTLD Network

Lancet Oncol 2012; 13: 196–206





K-VIROGREF

Collaborations

J Clin Oncol. 2013 Apr 1;31(10):1302-9. doi: 10.1200/JCO.2012.43.2344. Epub 2013 Feb 19.

Post-transplantation lymphoproliferative disorder after kidney transplantation: report of a nationwide French registry and the development of a new prognostic score

Sophie Caillard [1], Raphael Porcher, François Provot, Jacques Dantal, Sylvain Choquet, Antoine Durrbach, Emmanuel Morelon, Valérie Moal, Benedicte Janbon, Eric Alamartine, Claire Pouteil Noble, Delphine Morel, Nassim Kamar, Matthias Buchler, Marie France Mamzer, Marie Noelle Peraldi, Christian Hiesse, Edith Renoult, Olivier Toupance, Jean Philippe Rerolle, Sylvie Delmas, Philippe Lang, Yvon Lebranchu, Anne Elisabeth Heng, Jean Michel Rebibou, Christiane Mousson, Denis Glotz, Joseph Rivalan, Antoine Thierry, Isabelle Etienne, Marie Christine Moal, Laetitia Albano, Jean François Subra, Nacera Ouali, Pierre François Westeel, Michel Delahousse, Robert Genin, Bruno Hurault de Ligny, Bruno Moulin

Comment > Transplantation. 2013 Aug 15;96(3):e18-9. doi: 10.1097/TP.0b013e31829b0868.

Early and late posttransplant lymphoproliferative disorder after lung transplantation--34 cases from the European PTLD Network

Heiner Zimmermann, Sylvain Choquet, Daan Dierickx, Martin H Dreyling, John Moore, Angelika Valentin, Jana K Striefler, Hanno Riess, Veronique Leblond, Ralf Ulrich Trappe

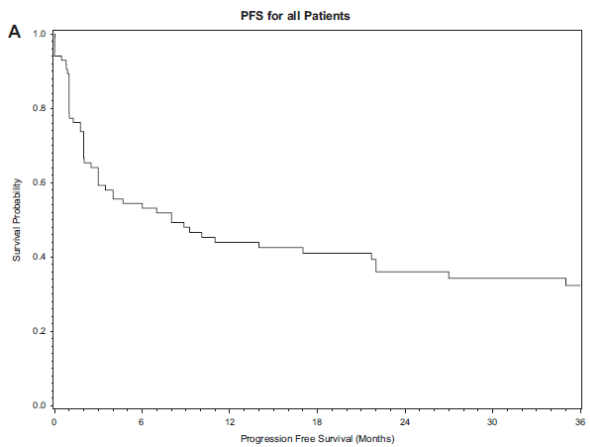
PMID: 23917690 DOI: 10.1097/TP.0b013e31829b0868

American Journal of Transplantation 2013; XX: 1–11
Wiley Periodicals Inc.

doi: 10.1002/ajt.12211

Primary CNS Posttransplant Lymphoproliferative Disease (PTLD): An International Report of 84 Cases in the Modern Era

A. M. Evens[1,*,†], S. Choquet[2,†], A. R. Kroll-Desrosiers[3], D. Jagadeesh[1], S. M. Smith[4], F. Morschhauser[5], V. Leblond[2], R. Roy[6], B. Barton[3], L. I. Gordon[6], M. K. Gandhi[7], D. Dierickx[8], D. Schiff[9], T. M. Habermann[10] and R. Trappe[11]



Etudes cliniques

VOLUME 35 · NUMBER 5 · FEBRUARY 10, 2017

JOURNAL OF CLINICAL ONCOLOGY

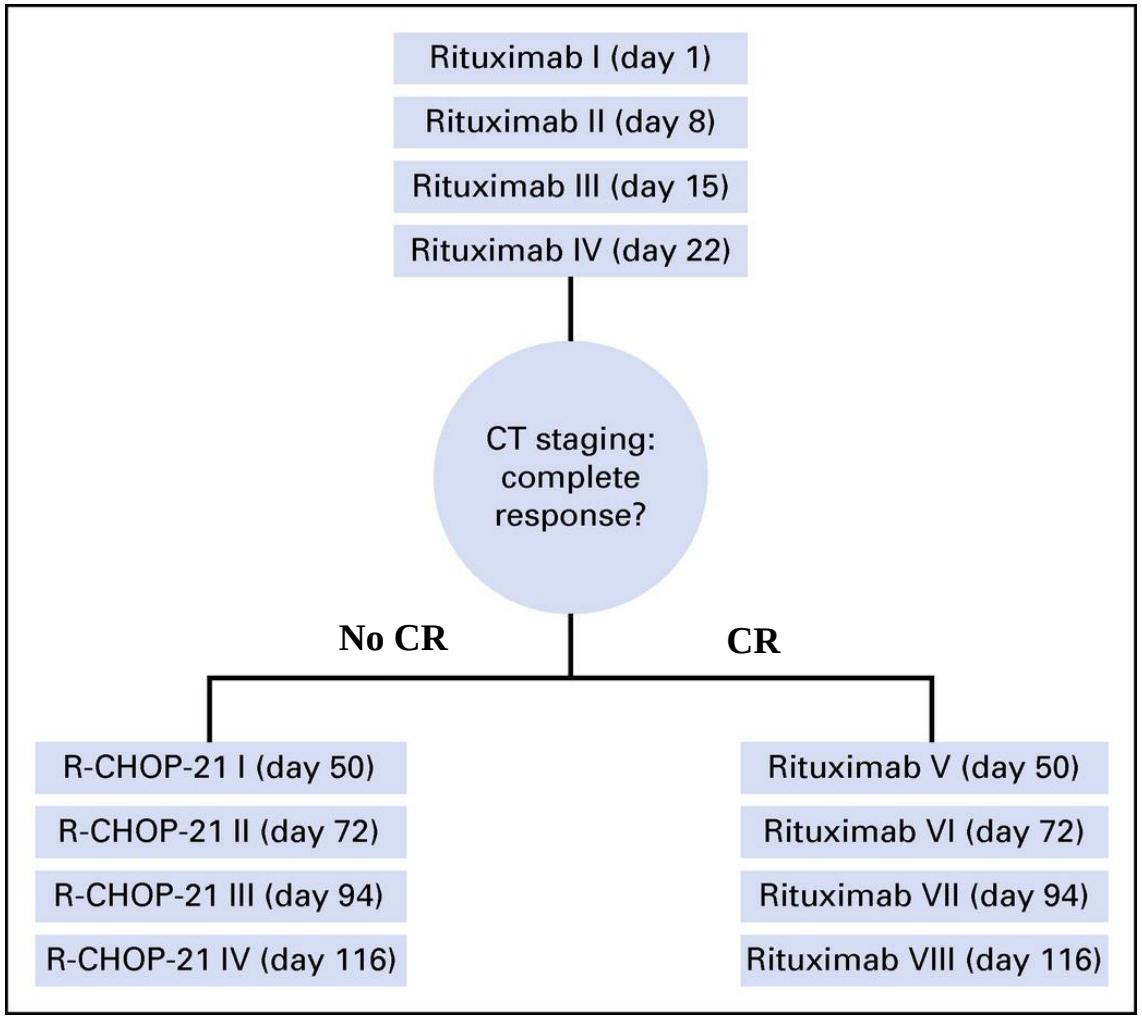
ORIGINAL REPORT

Response to Rituximab Induction Is a Predictive Marker in B-Cell Post-Transplant Lymphoproliferative Disorder and Allows Successful Stratification Into Rituximab or R-CHOP Consolidation in an International, Prospective, Multicenter Phase II Trial

Ralf U. Trappe, Daan Dierickx, Heiner Zimmermann, Franck Morschhauser, Peter Mollee, Jan M. Zaucha, Martin H. Dreyling, Ulrich Dührsen, Petra Reinke, Gregor Verhoef, Marion Subklewe, Andreas Hüttmann, Thomas Tousseyn, Gilles Salles, Volker Kliem, Ingeborg A. Hauser, Corrado Tarella, Eric Van Den Neste, Olivier Gheysens, Ioannis Anagnostopoulos, Veronique Leblond, Hanno Riess, and Sylvain Choquet

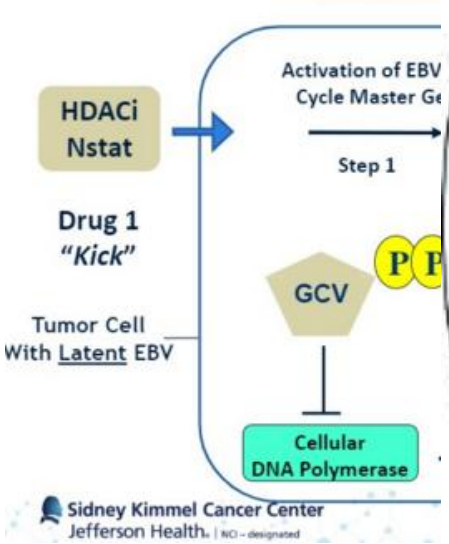
Traitement avant 2025 des LPT CD20+

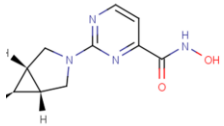
- Réduction du traitement IS
- Traitement séquentiel
- LPT non destructrices : baisse IS



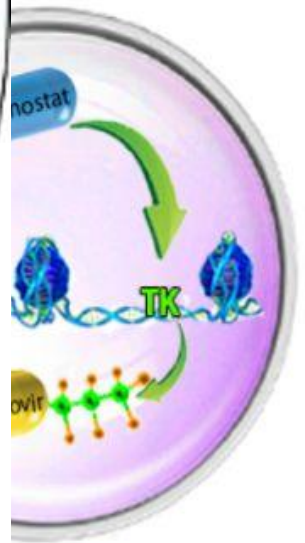
Trappe RU et al. *JCO* 2017

Antivir icaces ?





tinostat
inhibiteur)

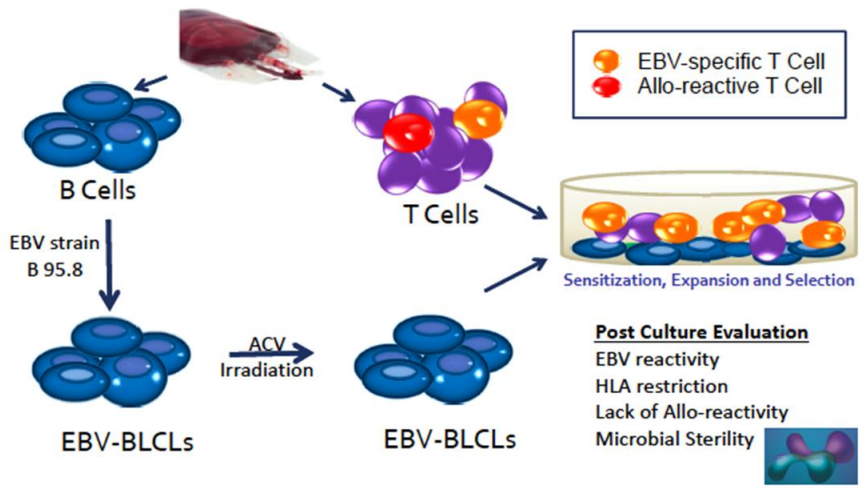


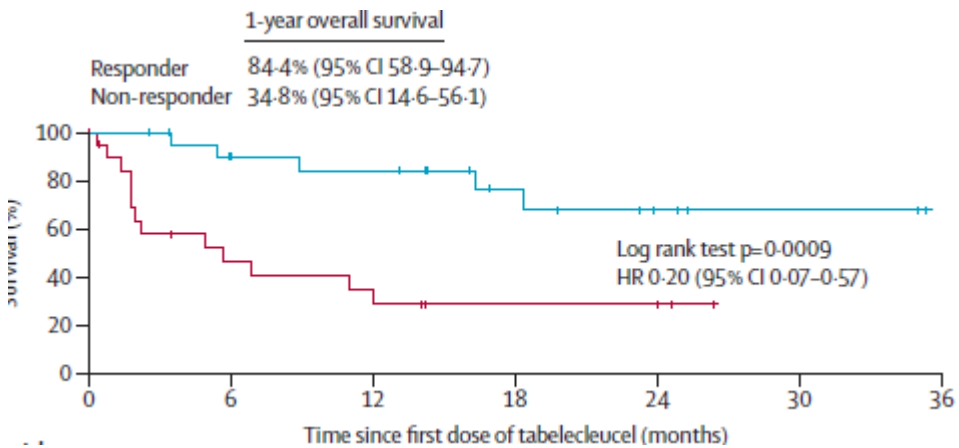
ASH 2019

Tabelecleucel for allogeneic haematopoietic stem-cell or solid organ transplant recipients with Epstein–Barr virus-positive post-transplant lymphoproliferative disease after failure of rituximab or rituximab and chemotherapy (ALLELE): a phase 3, multicentre, open-label trial

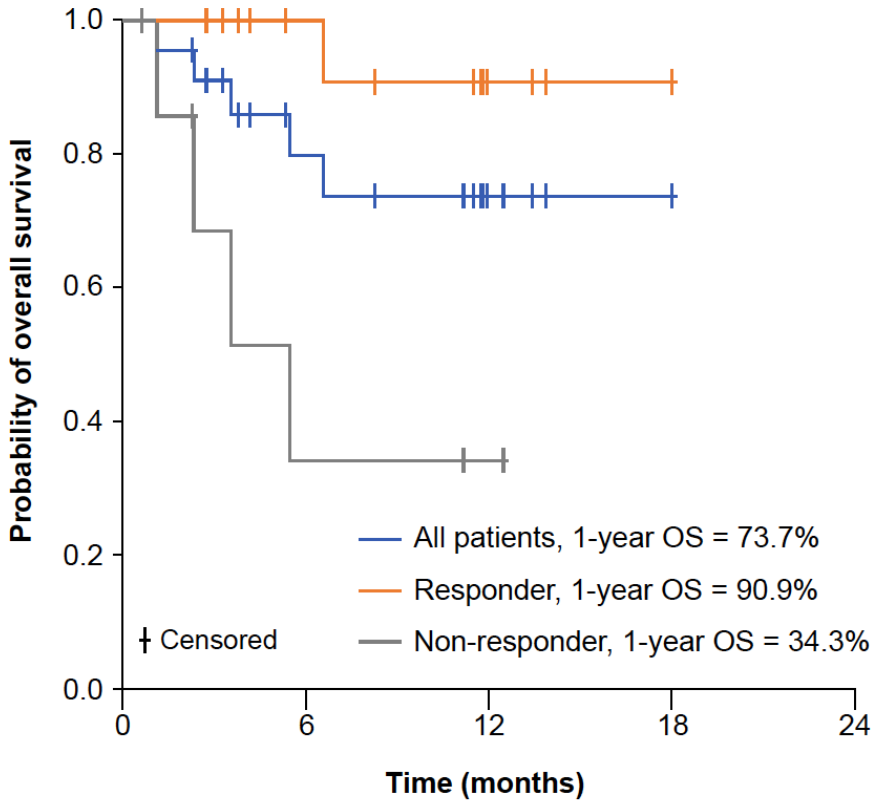
Kris Michael Mahadeo, Robert Baiocchi, Amer Beitinjaneh, Sridhar Chaganti, Sylvain Choquet, Daan Dierickx, Rajani Dinavahi, Xinyuan Duan, Laurence Gamelin, Armin Ghobadi, Norma Guzman-Becerra, Manher Joshi, Aditi Mehta, Willis H Navarro, Sarah Nikiforow, Richard J O'Reilly, Ran Reshef, Fiona Ruiz, Tassja Spindler, Susan Prockop

Lancet Oncol 2024; 25: 376–87





Programme d’accès compationnel

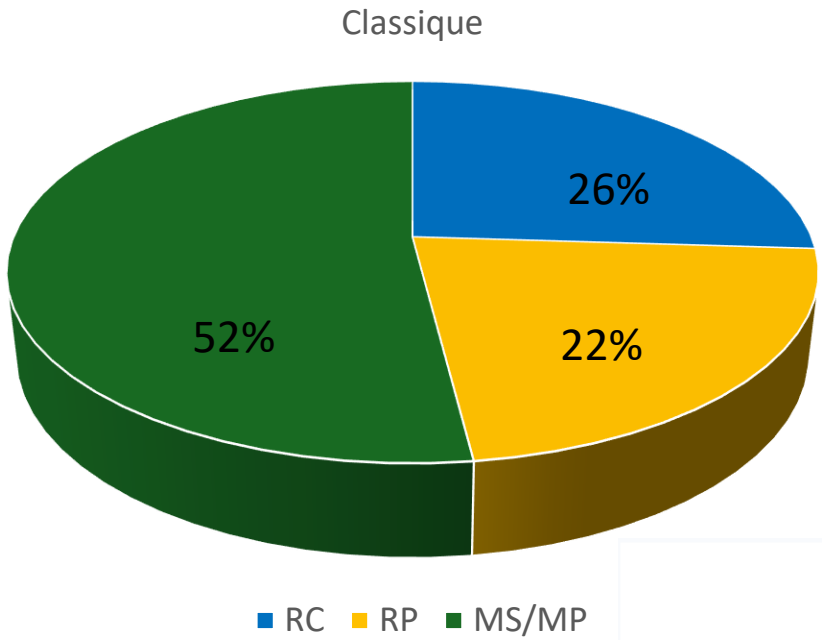


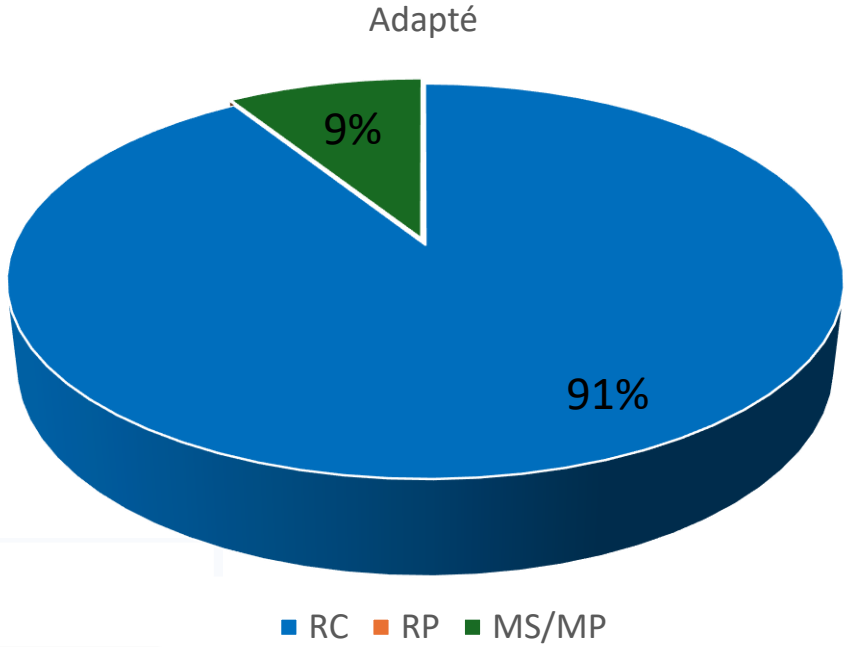
Number at Risk (Event)

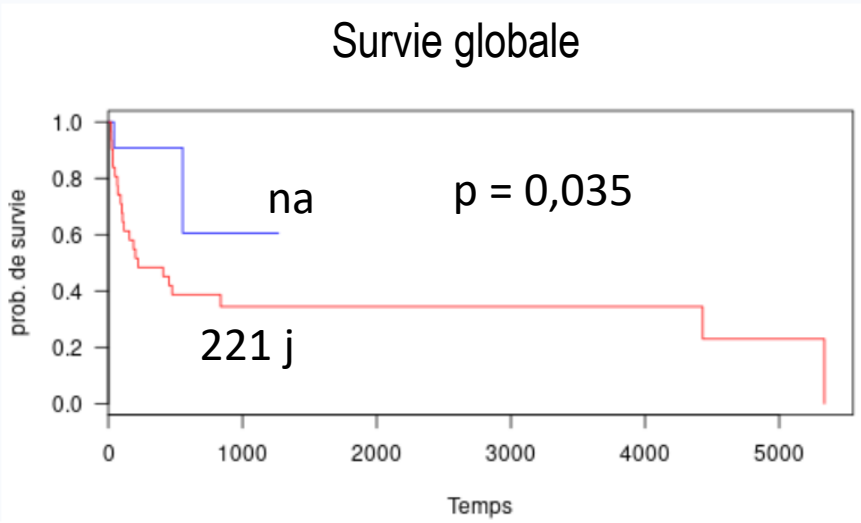
All patients	24 (0)	13 (4)	4 (5)	1 (5)	0 (5)
Responder	16 (0)	11 (0)	3 (1)	1 (1)	0 (1)
Non-responder	8 (0)	2 (4)	1 (4)	0 (4)	

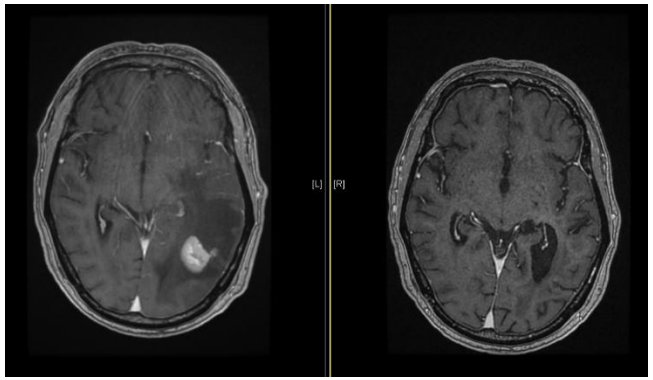
Sources : Choquet S et al. ICML 2023

MTX adapté



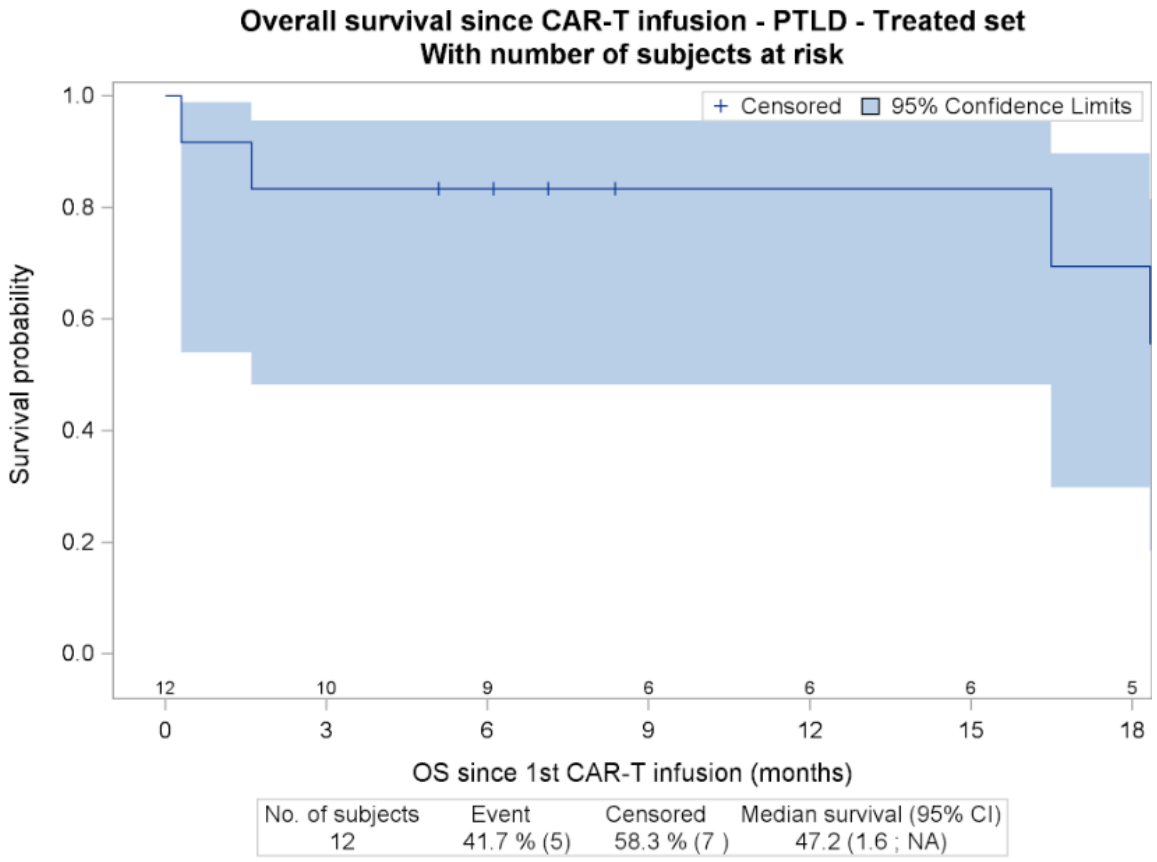


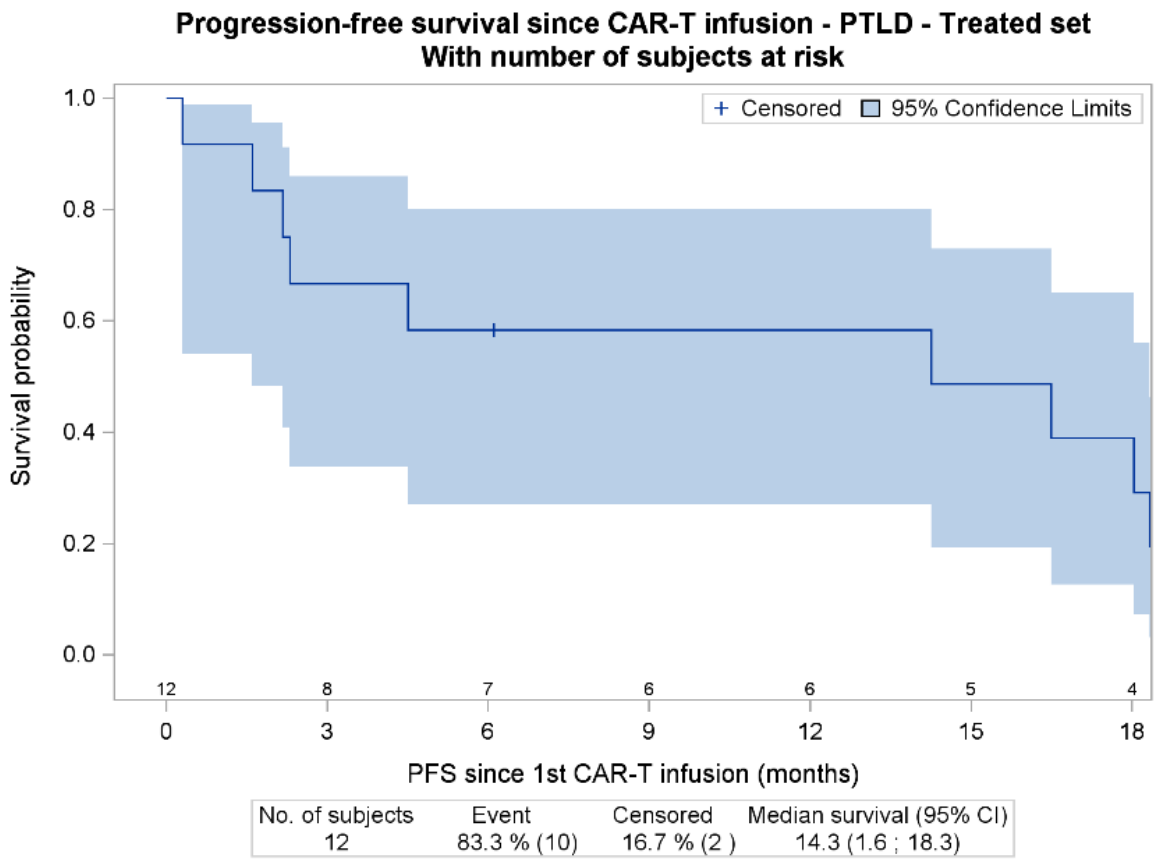




Choquet S et al. *SFH* 2020

Etude Cancerogref/DESCAR-T





Corvilain E

Etudes biologiques

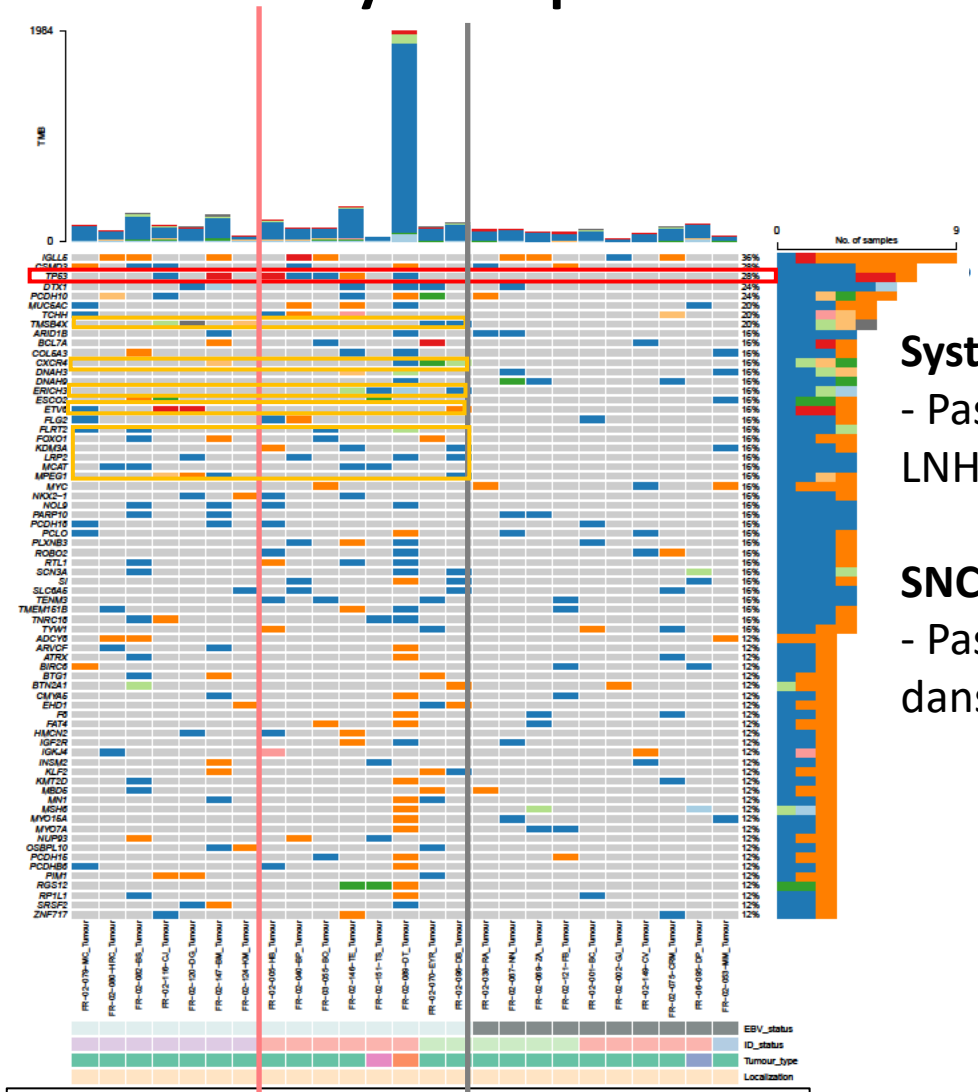
Epstein-Barr virus and immune status imprint the immunogenomics of non-Hodgkin lymphomas occurring in immune-suppressed environments

Marine Baron,[1,2*] Karim Labreche,[3*] Marianne Veyri,[4+] Nathalie Désiré,[3+] Amira Bouzidi,[5] Fatou Seck-Thiam,[3] Frédéric Charlotte,[6] Alice Rousseau,[1] Véronique Morin,[1] Cécilia Nakid-Cordero,[1] Baptiste Abbar,[1] Alberto Picca,[1] Marie Le Cann,[7] Noureddine Balegroune,[2] Nicolas Gauthier,[2] Ioannis Theodorou,[8] Mehdi Touat,[9] Véronique Morel,[2] Franck Bielle,[10] Assia Samri,[1] Agusti Alentorn,[9] Marc Sanson,[9] Damien Roos-Weil,[2] Corinne Haioun,[11] Elsa Poullot,[12] Anne Langlois de Septenville,[13] Frédéric Davi,[13] Amélie Guihot,[1] Pierre-Yves Boelle,[3] Véronique Leblond,[2] Florence Coulet,[14] Jean-Philippe Spano,[4#] Sylvain Choquet,[2#] and Brigitte Autran[1#] on behalf the IDeATIon study group. IDeATIon study group: Baptiste Abbar,[4] Isabelle Brocheriou,[6] Jacques Cadranel,[15] Jérôme Denis,[5] Erell Guillerm,[13] Ahmed Ibdaih,[8] Stéphanie Jouannet,[5] Jean-Marc Lacorte,[5] Anne-Geneviève Marcelin,[14] Alberto Picca,[2] Kahina Belkhir[4] and Cécilia Nakid-Cordero[2]

Haematologica 2024

Paysage mutationnel selon le statut EBV

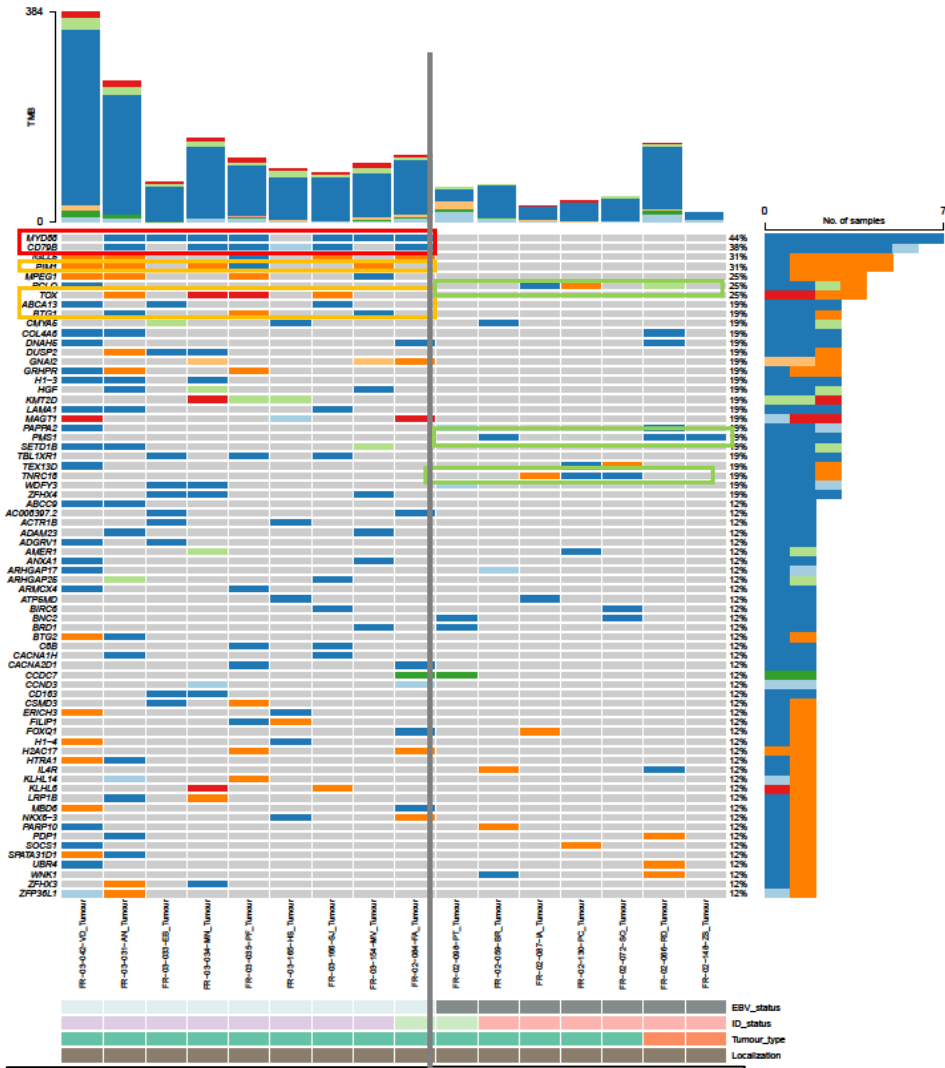
Systémique



Systémique :
- Pas de mutation *TP53* dans LNH EBV+ (p= significatif)

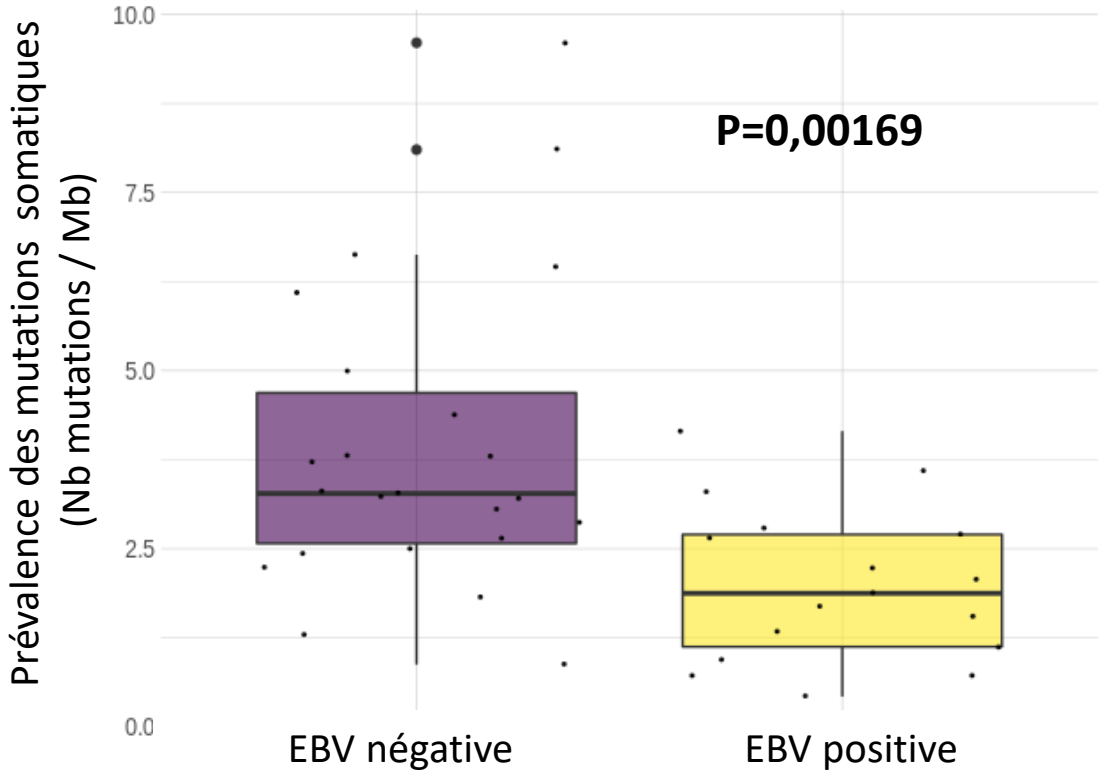
SNC :
- Pas de mutation *MyD88 ni CD79b* dans LNH EBV+ (p= significatif)

SNC

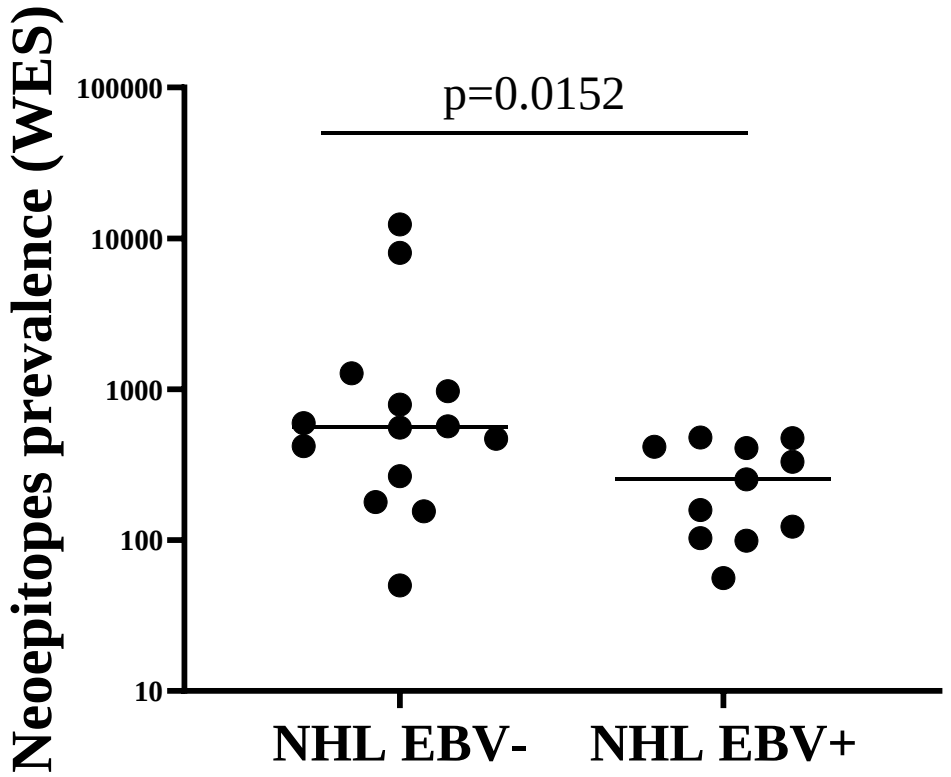


Spécificité mutationnelle : EBV+ vs EBV-

Mutations



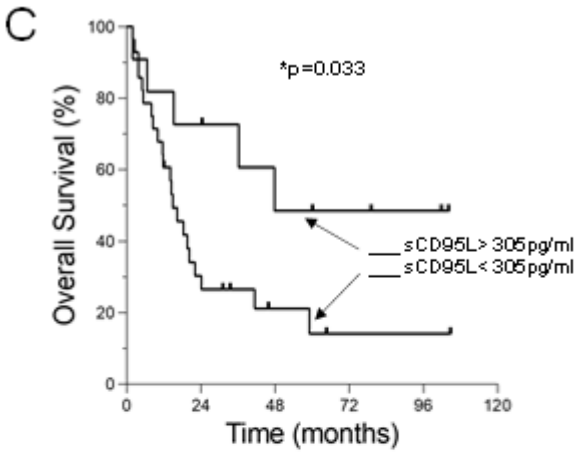
Néo-épitopes

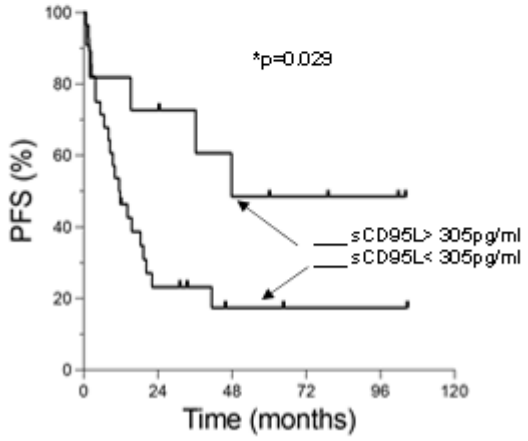


Baron M, ASH 2022

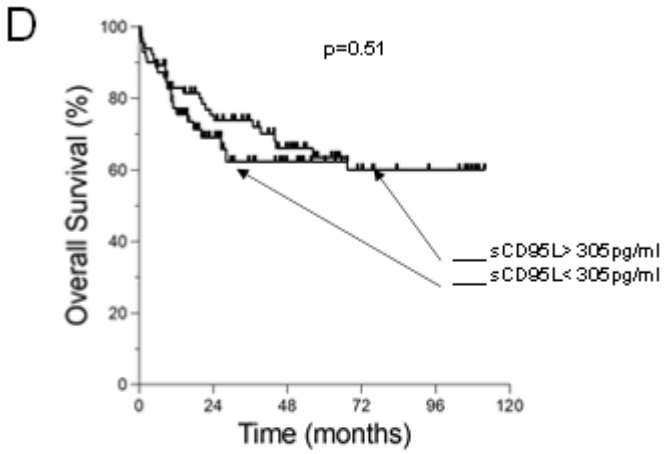
CD95Ls

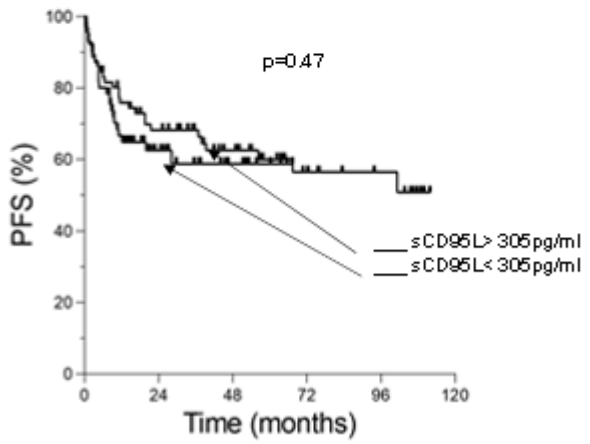
SNC



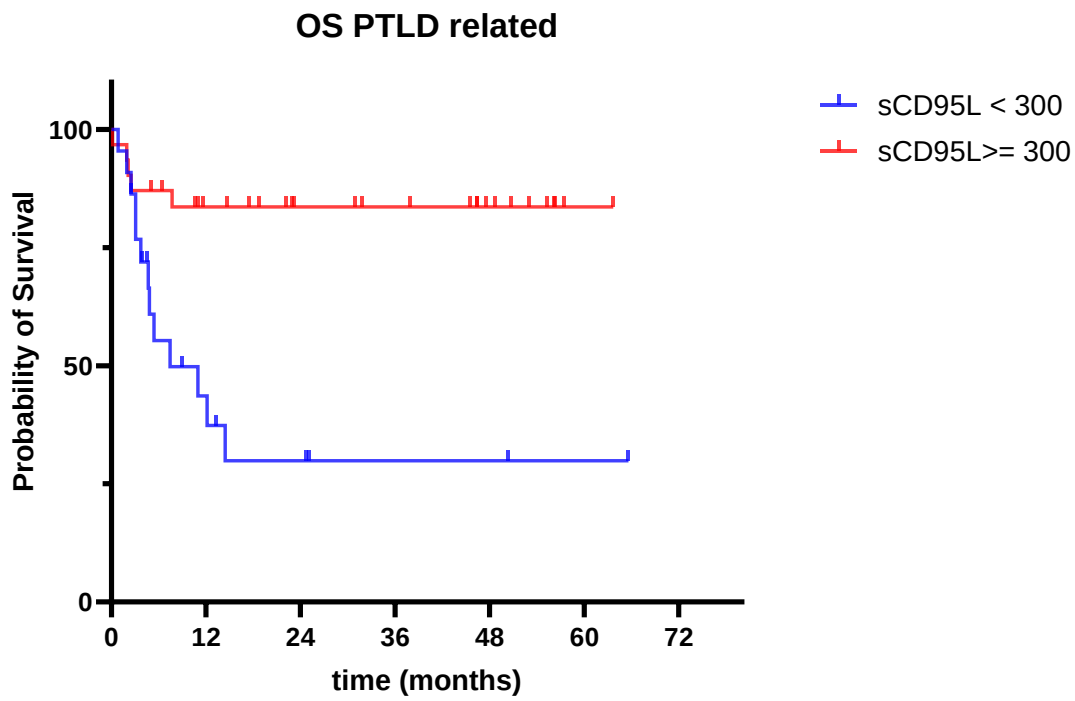


Systémique





SNC

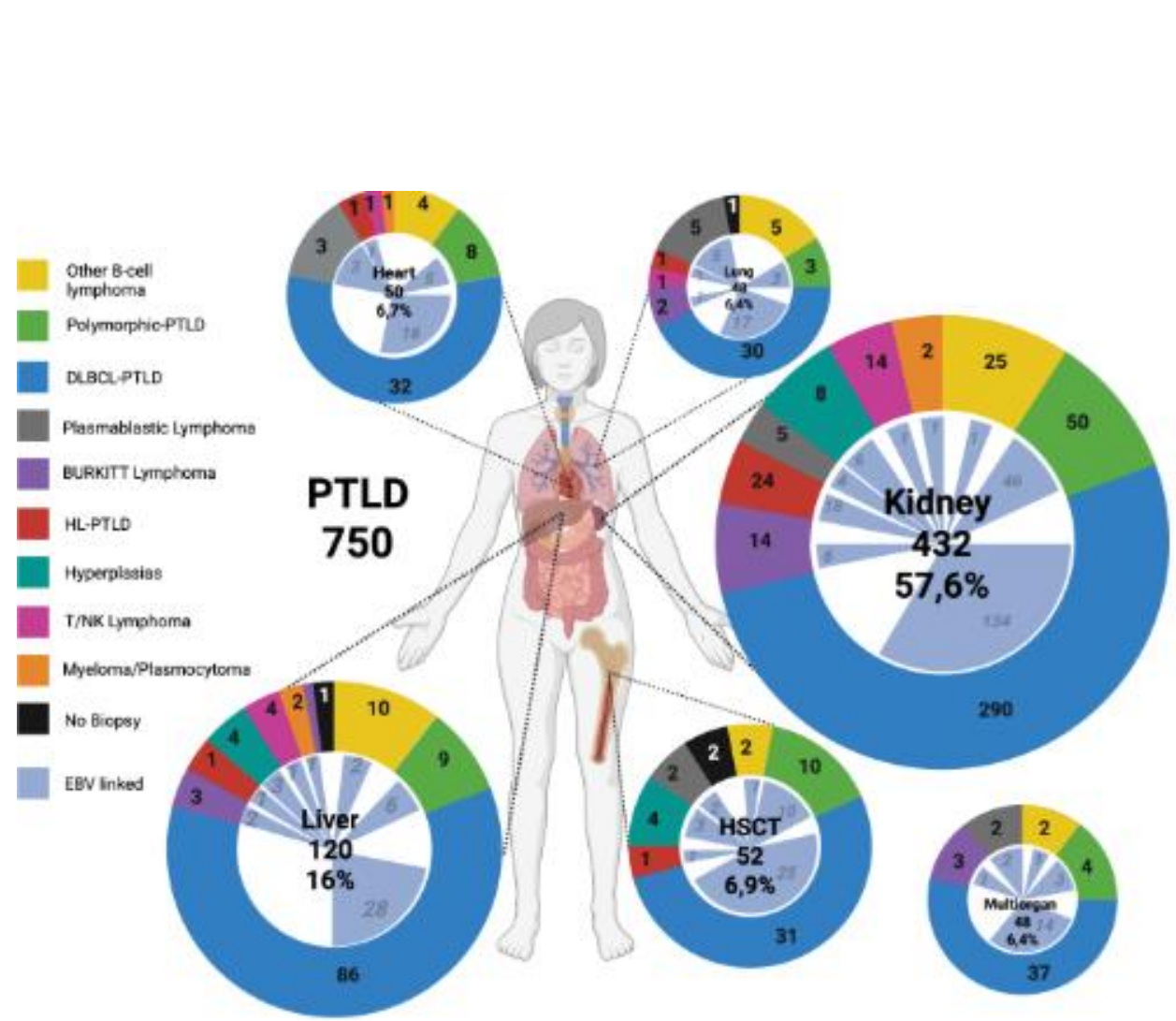


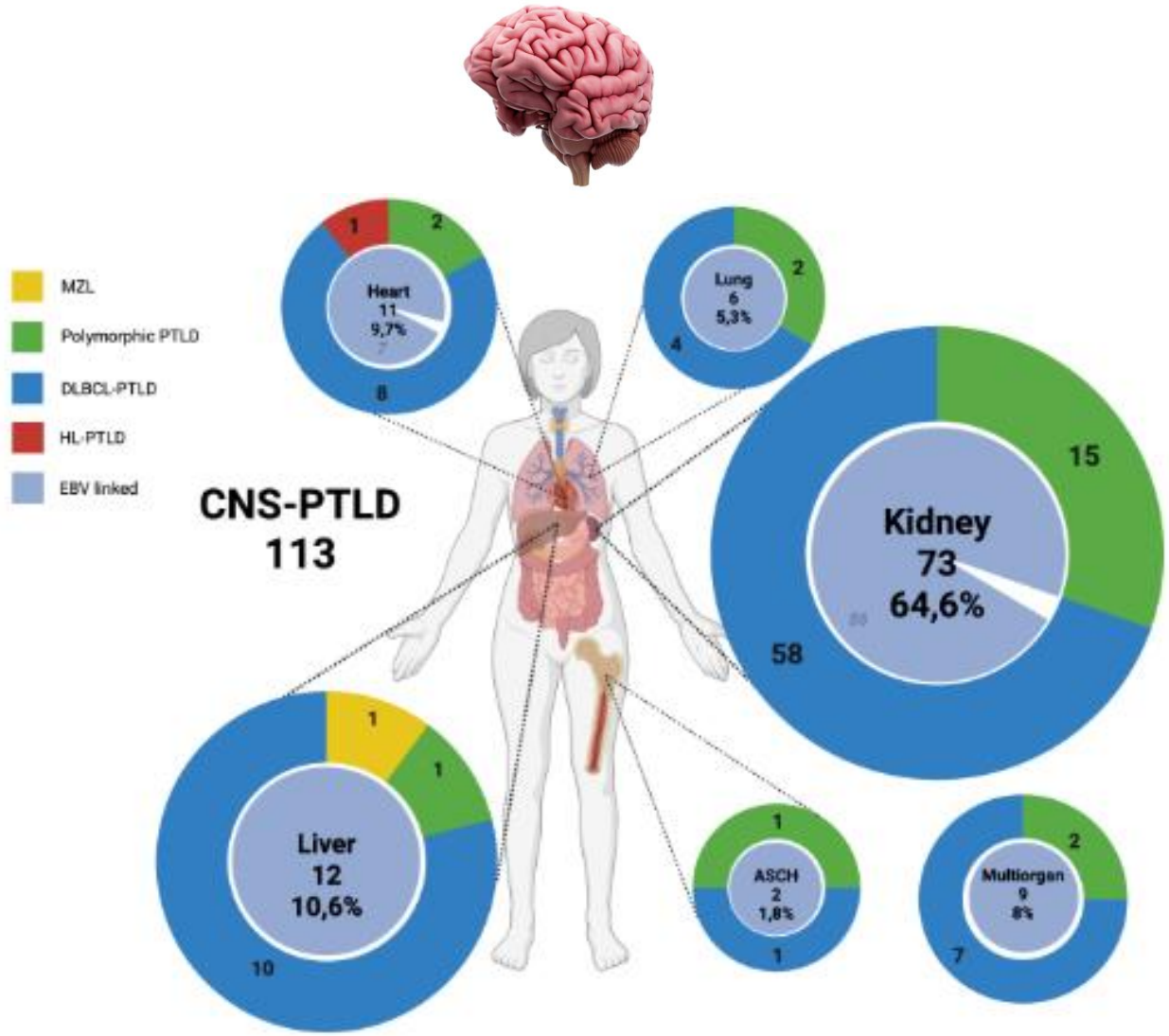
Hazard Ratio (logrank)	A/B
Ratio (and its reciprocal)	4.881
95% CI of ratio	1.850 to 12.88

P value	0.0007

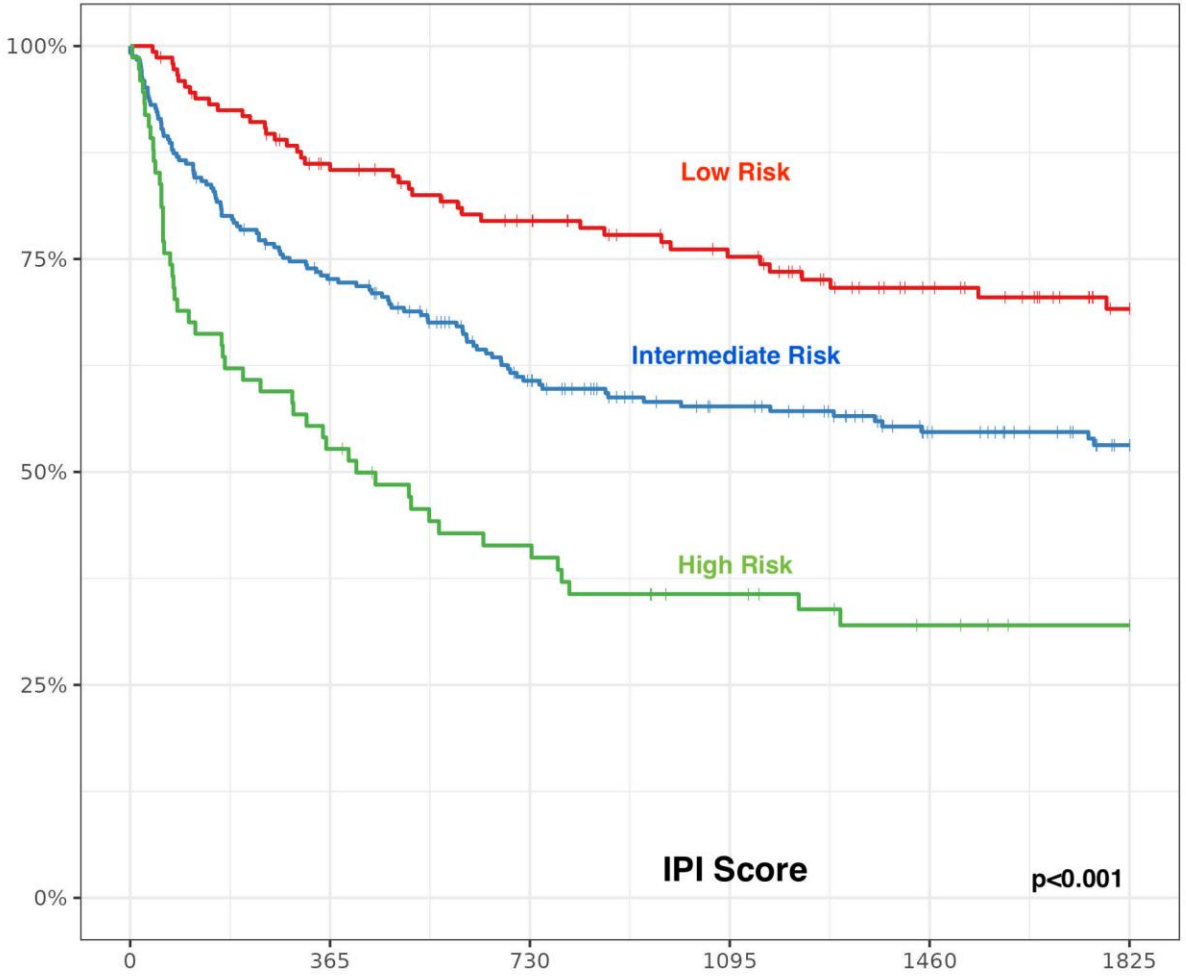
Registre

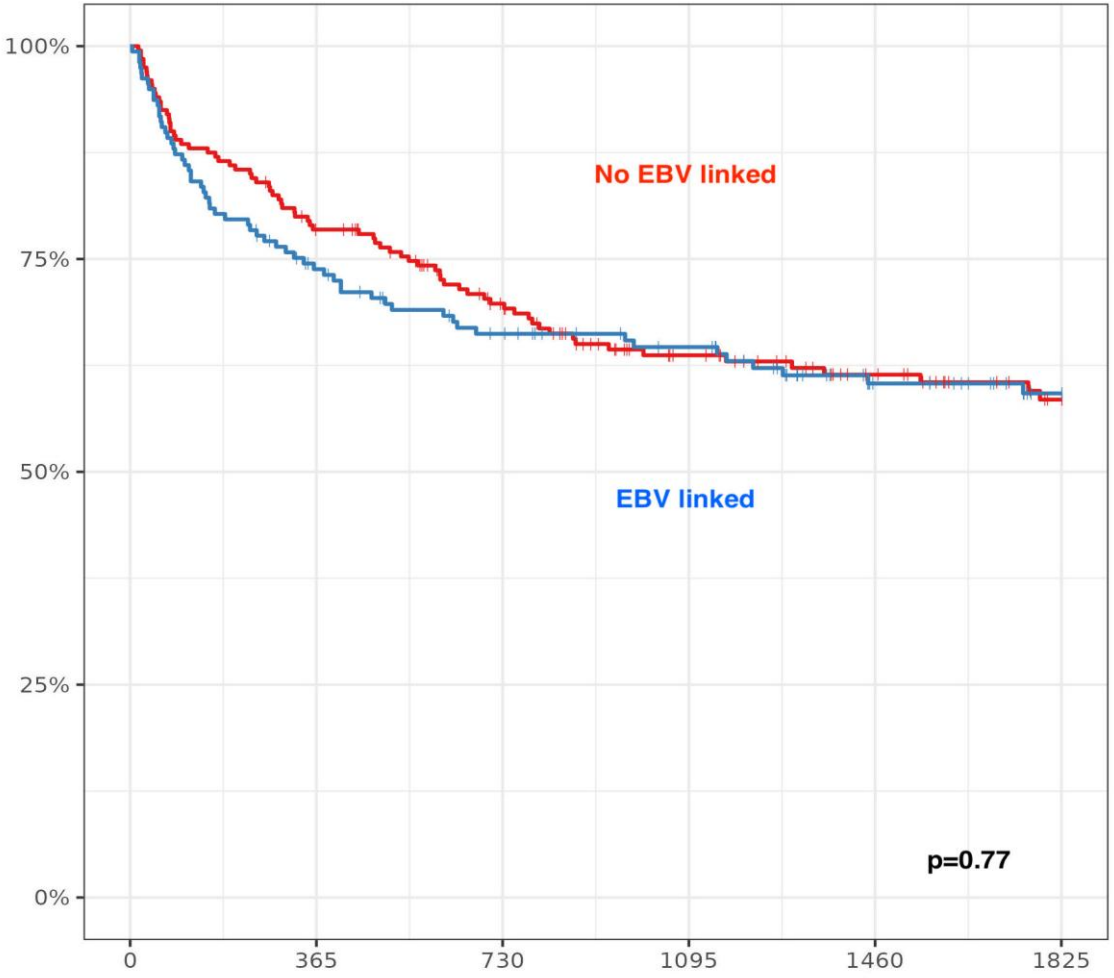
Répartition des anatomopathologies



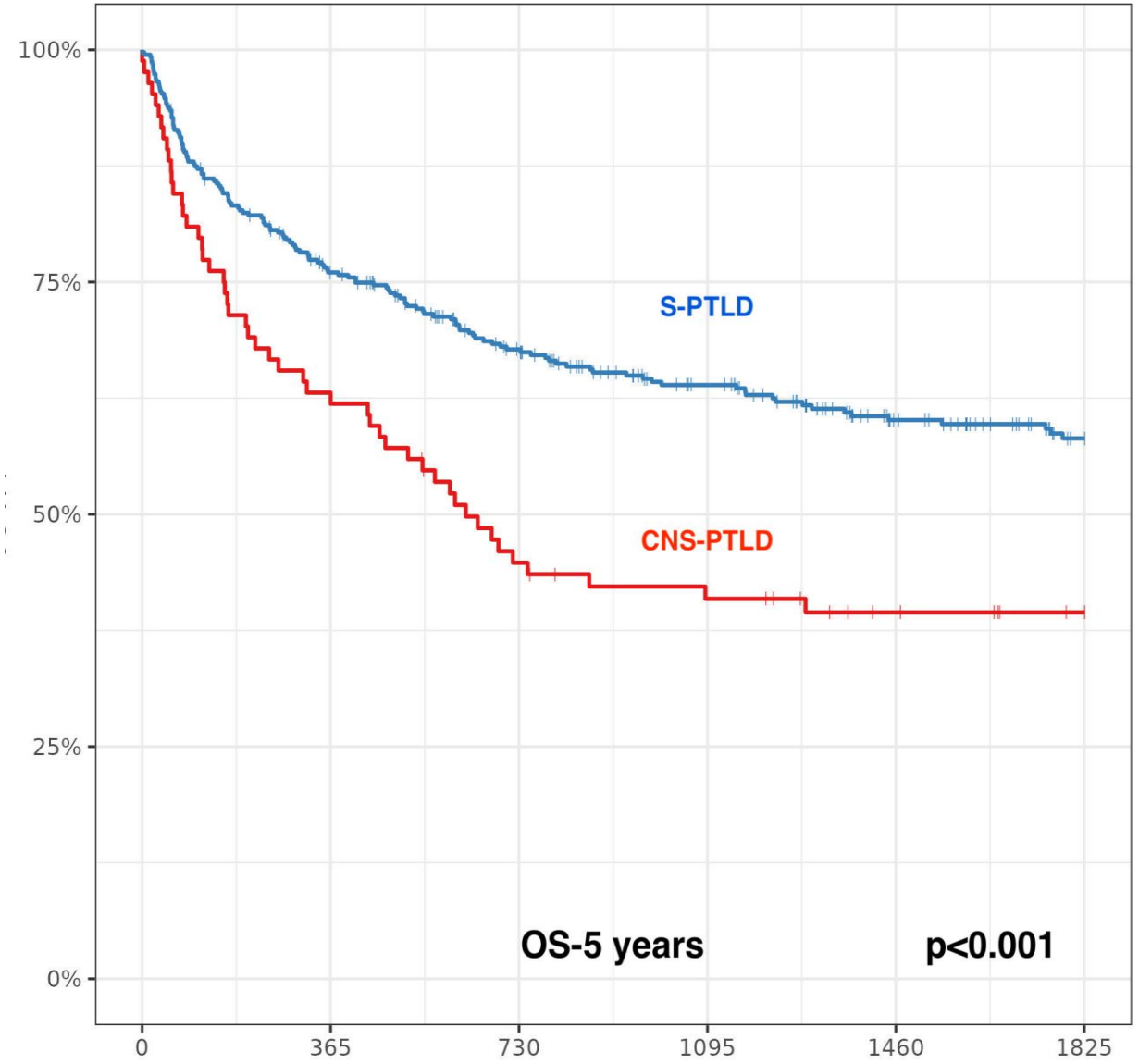


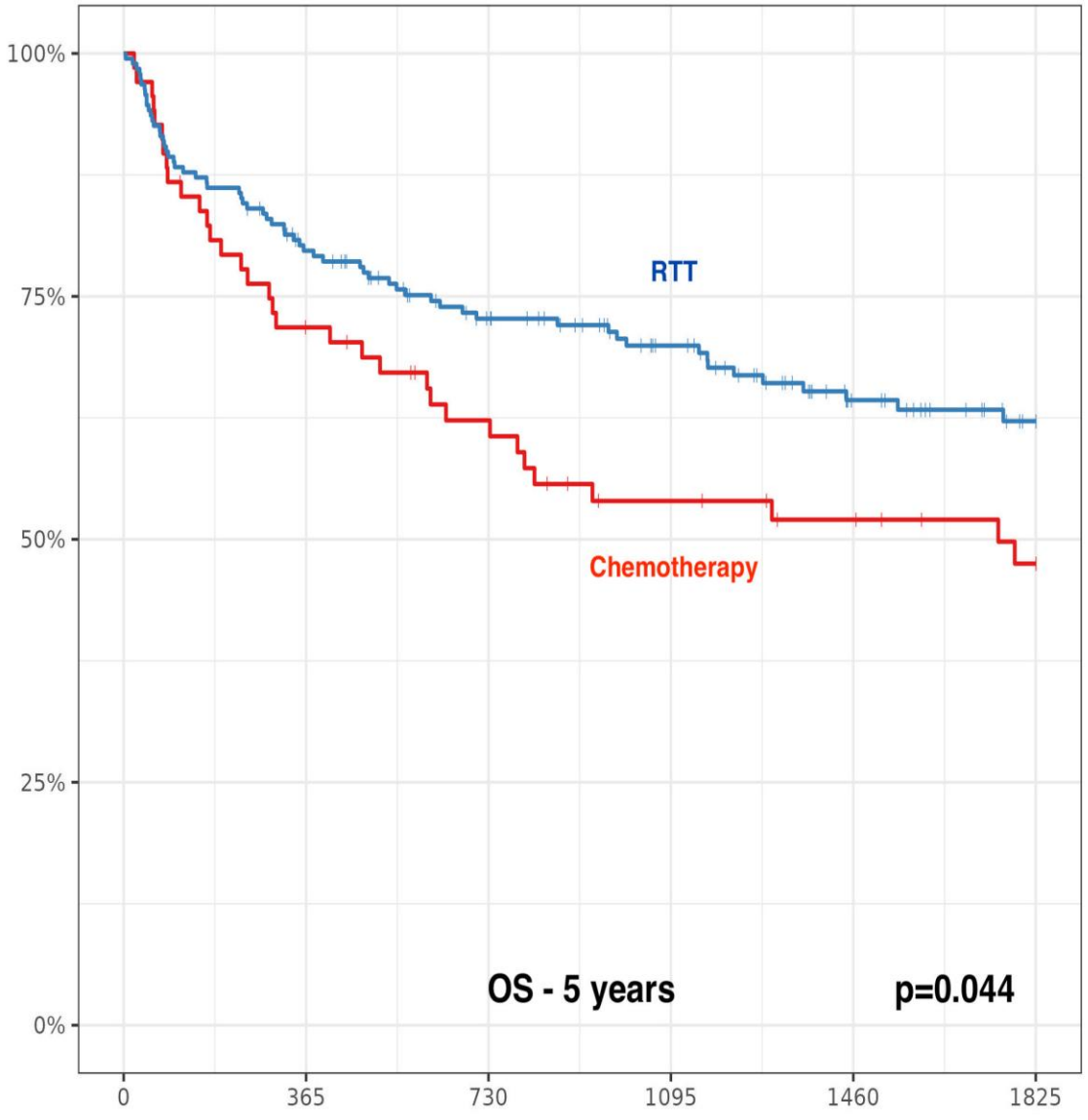
Registre K-virogref : facteurs pronostiques



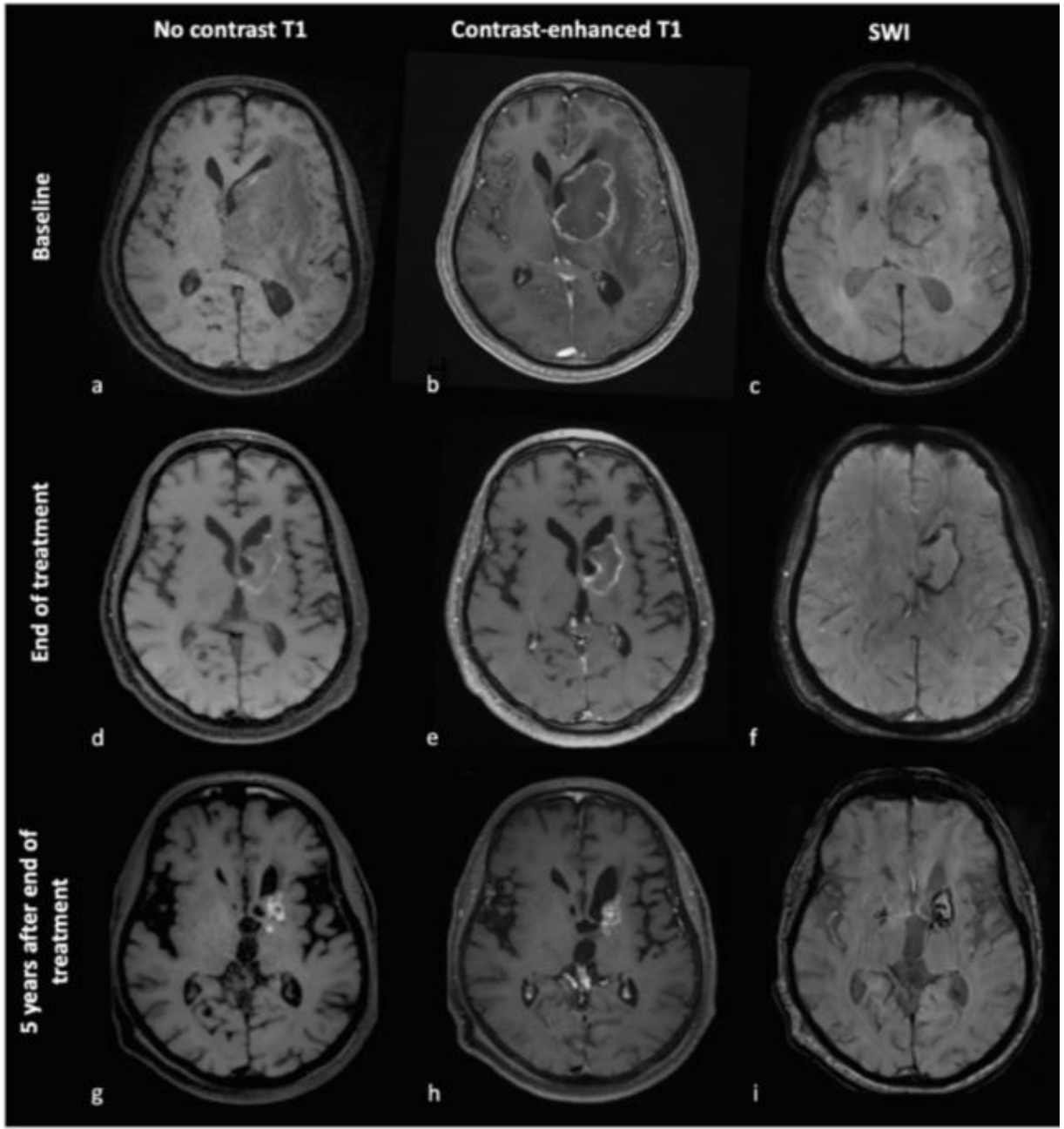


Registre K-virogref : facteurs pronostiques





Interprétation des réponses IRM des LPT SNC



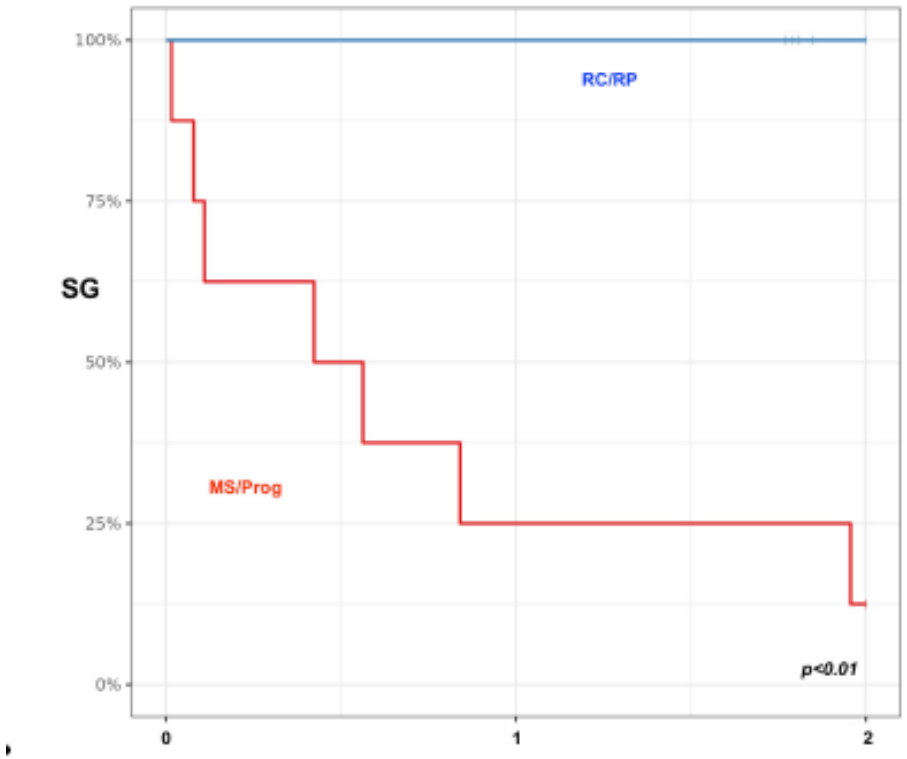
Shulz N et al. *J Neurooncol* 2024

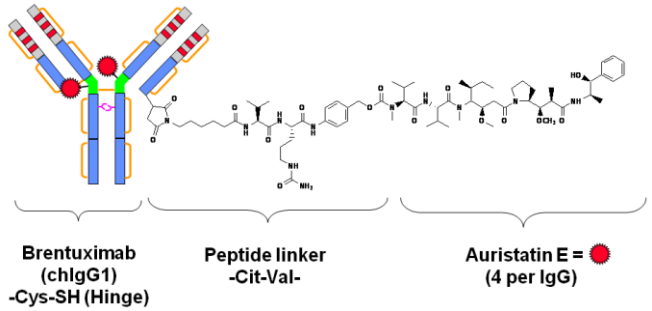
Facteurs prédictifs de la réponse au rituximab +/- chimio

	Univariate Analysis		Multivariate Analysis	
	P	Odd Ratio	*P*	Odd Ratio
Clinical data				
Age	0.954			
Sex	0.535			
PS ECOG ≥2	0.123			
B symptoms	0.036*	2.95 (1.06–8.21)	0.08	2.60 (0.89–7.56)
Lymphoma characteristics				
Histology	0.508			
EBER	0.539			
Stage	0.976			
Extranodal organs involved ≥2	0.088	2.58 (0.85–7.78)		
Biological results				
LDH > N	0.834			
B2m	0.693			
Albumin	0.142			
Prognostic scores				
IPI ≥3	0.278			
NCCN-IPI ≥4	0.271			
Transplantation related data				
Time between transplantation and PTLD	0.298			
Age at transplantation	0.287			
Multiple transplantation	0.197			
Graft involvement	0.670			
Reduction of immunosuppression	1.000			
PET measurements				
TMTV	0.031*	1.00 (1.00–1.00)		
TMTV > 135 ml	0.009*	4.13 (1.39–12.27)	0.022*	3.71 (1.21–11.36)
TTLG	0.070	1.00 (1.00–1.00)		

Morland D et al. *Hemasphere* 2023

Brentuximab-Vedotin : vraie vie





N = 15
1/3 en 1° ligne
47% RC
SG : 2 ans

Tichadou A et al. *SFH* 2025

Enseignement


CORRESPONDANCES EN Onco-Hématologie
DOSSIER
Hémopathies malignes chez les sujets immunodéprimés
Coordonné par Sylvain Choquet
• Épidémiologie et prise en charge des lymphomes associés au VIH – J.M. Michot, O. Lambotte
• Quels déficits immunitaires héréditaires faut-il rechercher lors du diagnostic de lymphome chez un adulte jeune ? – F. Touzot
• Lymphoprolifératons après transplantation S. Choquet
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PRIMER

Post-transplant lymphoproliferative disorders

Vikas R. Dharnidharka[1], Angela C. Webster[2], Olivia M. Martinez[3], Jutta K. Preiksaitis[4], Veronique Leblond[5] and Sylvain Choquet[5]

Abstract | Post-transplant lymphoproliferative disorders (PTLDs) are a group of conditions that involve uncontrolled proliferation of lymphoid cells as a consequence of extrinsic immunosuppression after organ or haematopoietic stem cell transplant. PTLDs show some similarities to classic lymphomas in the non-immunosuppressed general population. The oncogenic Epstein–Barr virus (EBV) is a key pathogenic driver in many early-onset cases, through multiple mechanisms. The incidence of PTLD varies with the type of transplant; a clear distinction should therefore be made between the conditions after solid organ transplant and after haematopoietic stem cell transplant. Recipient EBV seronegativity and the intensity of immunosuppression are among key risk factors. Symptoms and signs depend on the localization of the lymphoid masses. Diagnosis requires histopathology, although imaging techniques can provide additional supportive evidence. Pre-emptive intervention based on monitoring EBV levels in blood has emerged as the preferred strategy for PTLD prevention. Treatment of established disease includes reduction of immunosuppression and/or administration of rituximab (a B cell-specific antibody against CD20), chemotherapy and EBV-specific cytotoxic T cells. Despite these strategies, the mortality and morbidity remains considerable. Patient outcome is influenced by the severity of presentation, treatment-related complications and risk of allograft loss. New innovative treatment options hold promise for changing the outlook in the future.

PRIMEVIEW

POST-TRANSPLANT LYMPHOPROLIFERATIVE DISORDERS

nature REVIEWS DISEASE PRIMERS

For the Primer, visit doi:10.1038/nrdp.2015.88

Post-transplant lymphoproliferative disorders (PTLDs) are a group of lymphoma-like conditions characterized by an uncontrolled proliferation of lymphoid cells as a consequence of therapeutic immunosuppression following a transplant. PTLDs can develop after a solid organ transplant (SOT-PTLD) or haematopoietic stem cell transplant (HSCT-PTLD); these two transplant settings differ with regard to disease course, prevalence and management.

EPIDEMIOLOGY

The incidence of PTLD depends on the type of transplant. SOT-PTLDs occur in ~10% of SOT recipients; patients who receive intestinal and multi-organ transplants have the highest risk, followed by lung, heart, liver and kidney transplants. Recipients of a HSCT have the lowest risk, with HSCT-PTLD occurring in <2% of patients. Most HSCT-PTLDs are of donor origin, whereas most SOT-PTLDs arise from recipient-derived cells. PTLDs commonly arise in the lymph nodes, gastrointestinal tract, liver, central nervous system and lungs. Incidence of PTLDs, especially early-onset PTLD, is considerably higher in children than adults, whereas the risk of developing late-onset PTLD rises from 60 years of age. The Epstein–Barr virus (EBV) is a key pathogenic driver of many early-onset PTLDs, but other viruses (including cytomegalovirus, hepatitis C virus and herpes virus 8) might also have a role.

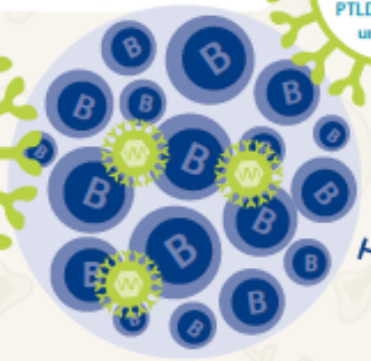
EBV-seronegative patients who receive an EBV-positive transplant have a greater than 12-fold increased risk of developing PTLD compared with recipients who are EBV-positive before transplantation

MECHANISMS

PTLDs show some similarities with classic lymphomas in the general population, but only occur in immunosuppressed individuals following transplantation

EBV drives lymphoma development in 50–80% of PTLDs, especially in early-onset disease

The aetiological trigger for EBV-negative PTLDs remains unknown



An impaired immune response, especially the T cell response, can lead to the reactivation of latent EBV or a hampered response to a new infection, leading to hyperproliferation of infected B cells

PREVENTION

EBV viral load in the blood of patients with early-onset PTLD is higher than in transplant recipients who do not develop PTLD, and detectable EBV precedes the development of clinical symptoms. This finding has led to the 'pre-emptive' prevention strategy, which combines viral load measurement with interventions that might lower the risk of developing PTLD, such as reduction of the level of immunosuppression. However, standardization of the viral load measurement and monitoring over time (including at baseline) is required.

DIAGNOSIS

The timing of SOT-PTLD diagnosis follows a bimodal distribution, with a peak in the first 2 years (early onset) and a second peak between 5 and 10 years (late onset) after transplantation. Most HSCT-PTLDs occur weeks to months after transplantation. Symptoms depend on the location of the lymphoid mass. The gold standard for PTLD diagnosis is histopathological examination of biopsy specimens and imaging (FDG-PET/CT). The WHO classification — developed in 2008 — is mainly based on histological features.

PTLD is a heterogeneous condition. Lymphomas arise mainly from B lymphocytes, but originate from T cells or natural killer cells in a minority of patients, can be monomorphic or polymorphic, and monoclonal or polyclonal.

MANAGEMENT

First-line treatment for SOT-PTLDs involves reduction of immunosuppression, which will lead to a complete regression of the PTLD in ~10% of patients within weeks, but increases the risk of graft rejection and graft-verus-host disease. If the response is incomplete, patients can be treated with rituximab (a B cell-specific antibody against CD20), followed, if necessary, by chemotherapy or a combination of chemotherapy and rituximab. In HSCT-PTLD, *ex vivo*-generated cytotoxic T cells or pre-emptive rituximab are additional options. Antiviral therapy, radiotherapy, surgery and adoptive immunotherapy can also be used in specific cases.

Designed by Laura Marshall

Article number: 15088; doi:10.1038/nrdp.2015.88; published online 28 Jan 2016

Recommandations

K-VIROGREF

1EME RÉUNION NATIONALE RECOMMANDATIONS

ANCERS RARES POST-TRANSPLANTATION

19 JUIN
2018

CENTRE D'ÉCOLOGIE CELLULAIRE

HôPITAL PITIÉ – SALPÊTRIÈRE

Metro ligne 6, station : chevaleret

WWW.K-VIROGREF.ORG

Nouvelles propositions de recommandations

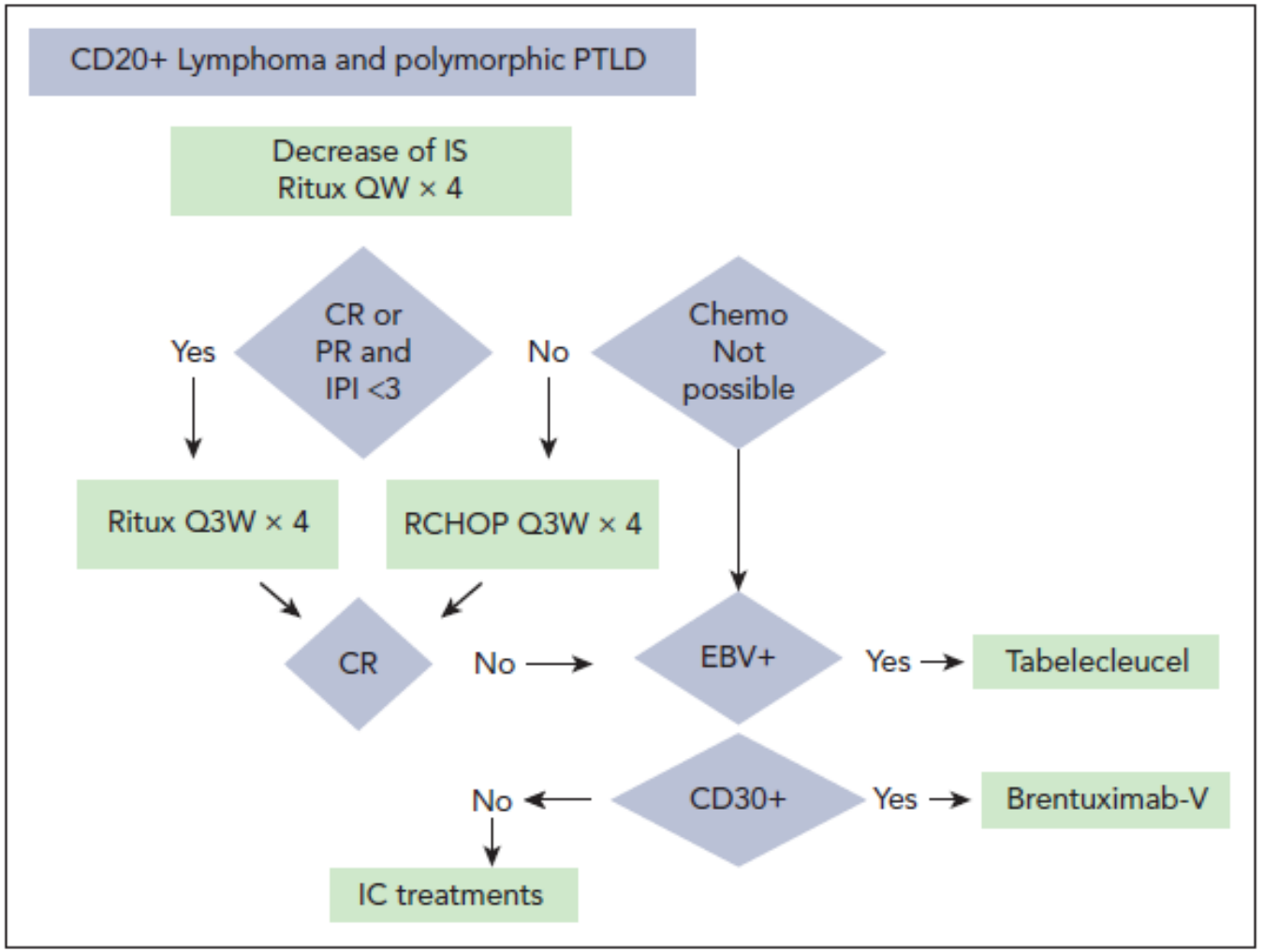
LYMPHOID NEOPLASIA

Comment on Chaganti et al, page 392

Treatment of PTLD: a slow and difficult path

Sylvain Choquet | Pitié-Salpêtrière Hospital, Assistance Publique–Hôpitaux de Paris, and Sorbonne Université

In this issue of *Blood*,[1] Chaganti et al present the results of a phase 2 study (TIDaL) combining ibrutinib with risk-stratified therapy as first-line treatment of CD20⁺ posttransplant lymphoproliferations (PTLDs). The goal of the study was to increase the complete remission (CR) rate after initial therapy to at least 40% using a 7-week cycle of continuous once-daily oral ibrutinib, 560 mg, with 4 doses of weekly rituximab (IR).



Blood 2024

Recommandations 2026

- ✓ Revue de la littérature
- ✓ Recommandations publiées
- ✓ Commentaire et propositions des experts
- ✓ Recommandations

Levels of evidence	
I	Evidence from at least one large randomized, controlled trial of good methodological quality (low potential for bias) or meta-analyses of well-conducted randomized trials without heterogeneity
II	Small randomized trials or large randomized trials with a suspicion of bias (lower methodological quality) or meta-analyses of such trials or of trials with demonstrated heterogeneity
III	Prospective cohort studies
IV	Retrospective cohort studies or case–control studies
V	Studies without control group, case reports, and experts' opinions
Grades of recommendation	
A	Strong evidence for efficacy with a substantial clinical benefit, strongly recommended
B	Strong or moderate evidence for efficacy but with a limited clinical benefit, generally recommended
C	Insufficient evidence for efficacy or benefit does not outweigh the risk or the disadvantages (adverse events, costs, etc.), optional
D	Moderate evidence against efficacy or for adverse outcome, generally not recommended
E	Strong evidence against efficacy or for adverse outcome, never recommended

Recommendations

- **EBV viral load measurement should be performed on whole blood** (III, A).
- **Viral load monitoring for a given patient should be conducted in the same laboratory using the same technique** (III, B).
- **EBV viral load may be expressed either in copies/mL or in IU/mL** (III, B).
- **When viral load comparisons between different laboratories are required, results should preferably be expressed in IU/mL** (III, B).
- **EBV viral load monitoring is necessary in patients at high risk for PTLD** (e.g., EBV D+R–, high-risk post-HSCT according to Storek 2023, and intestinal transplant recipients) (III, A).
- **In high-risk patients, EBV viral load monitoring should be performed weekly during the first 3–4 months, every two weeks until month 6, and then monthly until the end of the first post-transplant year** (V, B).
- **In patients at moderate or low risk, if EBV viral load monitoring is performed, it should be carried out monthly until month 6 and then every three months until the end of the first post-transplant year** (V, C).
- **In children under one year of age, monitoring should follow the same schedule as for moderate- or low-risk patients** (V, C).
- **No consensus exists regarding the threshold for initiating preemptive therapy; however, a level ≥100,000 copies/mL for SOT recipients or an**

Dermatologie

Management of Kaposi sarcoma after solid organ transplantation: A European retrospective study

Julie Delyon, MD, PhD,[a] Clementine Rabate, MD,[b] Sylvie Euvrard, MD,[c] Catherine A. Harwood, MD, PhD,[d] Charlotte Proby, FRCP,[e] A. Tülin Güleç, MD,[f] Deniz Seçkin, MD,[f] Veronique Del Marmol, MD, PhD,[g] Jan Nico Bouwes-Bavinck, MD, PhD,[h] Carla Ferrándiz-Pulido, MD, PhD,[i] Maria Andrea Ocampo, MD,[c] Stephane Barete, MD, PhD,[j] Christophe Legendre, MD, PhD,[b] Camille Francès, MD, PhD,[k] Raphael Porcher, MD, PhD,[l] and Celeste Lebbe, MD, PhD,[a] the Skin Care in Organ Transplant Patients Europe (SCOPE) group

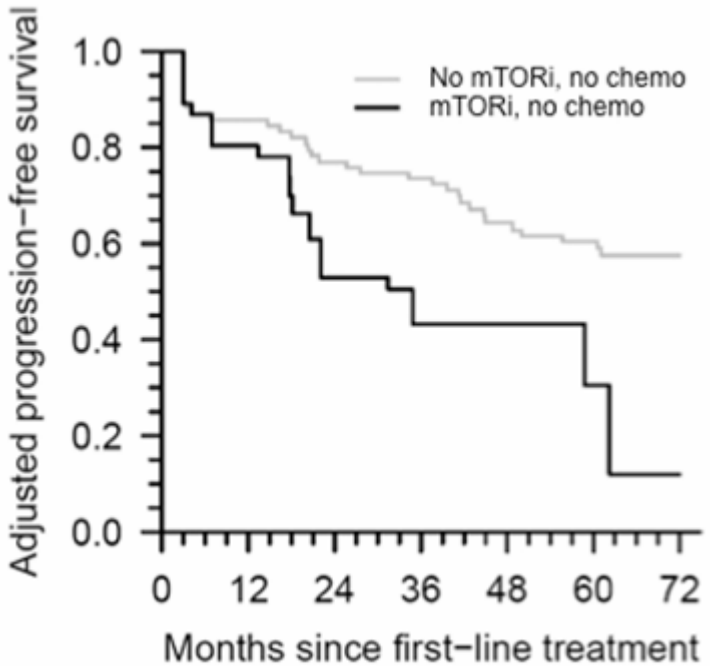
Paris and Lyon, France; London and Dundee, United Kingdom; Ankara, Turkey; Brussels, Belgium; Leiden, The Netherlands; and Barcelona, Spain

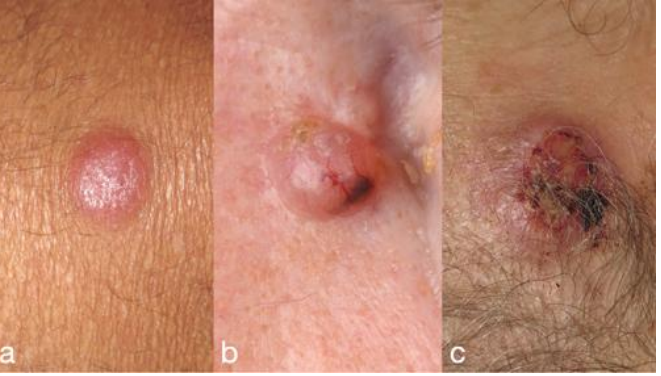
J Am Acad Dermatol
Volume 81, Number 2

2019

CAPSULE SUMMARY

- The therapeutic armamentarium against post-transplant Kaposi sarcoma is based on 3 axes: reduction of immunosuppression, conversion to mammalian target of rapamycin inhibitors, and use of chemotherapy.
- Therapeutic management of post-transplant Kaposi sarcoma is mostly based on reduction of immunosuppression and conversion to mammalian target of rapamycin inhibitor, inducing response in more than 80% of patients.





European Dermatology Forum

Guideline on the diagnosis and treatment of Merkel Cell Carcinoma

Developed by the Guideline Subcommittee of the
European Dermatology Forum

Subcommittee Members:

Prof. Dr. Celeste Lebbe, Paris (France)
Prof. Dr. Jean-Jacques Grob, Marseille (France)
Dr. Veronique del Marmol, Brussels (Belgium)
Prof. Dr. Ketty Peris, Rome (Italy)
Prof. Dr. Mark Middleton, Oxford (United Kingdom)
Dr. Alessandro Testori, Milano (Italy)
Prof. Dr. Claus Garbe, Tübingen (Germany)
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Prof. Dr. Philippe Saiag, Vienna (Austria)
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Prof. Dr. Alexander Stratigos, Athens (Greece)

2018

European Journal of Cancer 171 (2022) 203–231

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Available online at www.sciencedirect.com

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journal homepage: www.ejcancer.com

Review

Diagnosis and treatment of Merkel cell carcinoma: European consensus-based interdisciplinary guideline – Update 2022

Marie-Léa Gauci [a], Cynthia Aristei [b], Jurgen C. Becker [c], Astrid Blom [d], Veronique Bataille [e], Brigitte Dreno [f], Veronique Del Marmol [g], Ana M. Forsea [h], Maria C. Fargnoli [i], Jean-Jacques Grob [j], Fabio Gomes [k], Axel Hauschild [l], Christoph Hoeller [m], Catherine Harwood [n], Nicole Kelleners-Smeets [o], Roland Kaufmann [p], Aimilios Lallas [q], Josep Malvehy [r], David Moreno-Ramirez [s], Ketty Peris [t,u], Giovanni Pellacani [v], Philippe Saiag [d], Alexander J. Stratigos [w], Ricardo Vieira [x], Iris Zalaudek [y], Alexander C.J. van Akkooi [z], Paul Lorigan [aa], Claus Garbe [ab], Céleste Lebbé [a,*] On behalf of the European Dermatology Forum (EDF), the European Association of Dermato-Oncology (EADO) and the European Organization for Research and Treatment of Cancer (EORTC)

Journées k-virogref

Journée k-virogref 2023

Journée k-virogref 2024

Journée k-virogref 2025


20 mai 2026
sylvain.choquet@aphp.fr

10h30

Introduction

par le Dr Sylvain Choquet (Paris), le Dr Baptiste Abbar (Paris) et le Dr Fontanet Bijou (Bordeaux)

10h40

Transplantation Nouvelle Aquitaine

Rein (Bordeaux, Limoges, Poitiers) · Foie · Coeur · Poumon · Cellules souches hématopoïétiques · Pédiatrie

12h30

Déjeuner

13h30

Etat d'avancement et bilan d'activité CANCEROGREF

par Nourredine Balegroune (Paris)

13h45

Réunion CAM

(Classification Advancement Meeting) Chicago, mars 2026

par le Dr Sylvain Choquet (Paris)

14h00

Inhibiteurs de carrefour immunologique (anti PD1/antiCTLA4) et transplantation

par le Dr Baptiste Abbar (Paris)

14h15

PHRC Carcinome hépatocellulaire sur transplantation hépatique

par le Dr Filomena Conti (Paris)

14h30

Registre k-virogref/CANCEROGREF : analyse sur plus de 750 LPT

par le Dr Antoine Tchandou (Marseille)

14h45

Utilisation du Brentuximab-Vedotin dans les LPT

par le Dr Fontanet Bijou (Bordeaux)

15h00

Dermatologie et transplantation d'organe

par les dermatologues Bordelais

15h30

Pause

15h45

Mise à jour des recommandations dans les PTLD

par le Dr Sylvain Choquet (Paris)

16h00

Cancers pulmonaires chez les patients transplantés

16h15

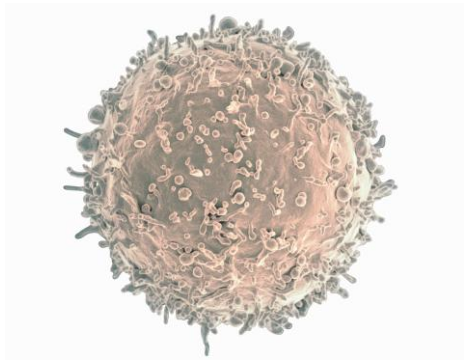
Utilisation des anticorps engageurs de lymphocytes T (bi-spécifiques)

par le Dr Marine Baron (Paris)

17h15

Discussion et conclusion

Remerciements



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