Lung abscess is an acute (<6 weeks) or chronic (>6 weeks) microbial infectious disease of the lung that causes necrosis of the pulmonary parenchymal tissues and the formation of cavities. It is often complicated to manage and treat, and is potentially life-threatening. A report from Massachusetts General Hospital indicated that the mortality rate in the period from 1909 to 1923 (before the antibiotic era) was 75% (1). Drainage reduced the mortality rate to 20-35%. Now, in the 21st century, appropriate antimicrobial therapy has further reduced the rate to 1.0-8.7% (3-6).

Lung abscess is mostly caused by the aspiration of oral anaerobic bacteria, including but not limited to Peptostreptococcus species, Bacteroides species, and Fusobacterium species. Antibiotics are usually administered as the initial medical treatment for lung abscess, and the patient’s response is checked. Although around 80% of lung abscess patients are successfully treated with antibiotics covering anaerobes, when conservative therapy fails, invasive therapy with drainage or surgery is required (7-9) (Figure). Approximately 10% of patients undergo surgical resection in the acute and chronic phase (10).

Drainage is a very useful treatment for abscesses anywhere in the body. If possible, drainage should be performed in addition to antimicrobial therapy for lung cases. Either percutaneous or endoscopic approaches can be used for the tube drainage of lung abscesses. Percutaneous transthoracic drainage (PTD) was first described in 1938 (11) and endoscopic drainage (ED) with bronchoscopy was first reported in 1954 (7). The most suitable timing for the initiation of tube drainage and the optimum duration of drainage has not to be determined. When no improvement is achieved at 10 to 14 days after medical treatment, drainage therapy is indicated (12), and should be performed as soon as possible, especially for refractory lung abscesses (13, 14). PTG has been performed more frequently than ED; ED is alternative to PTG that is used to treat cases involving central abscesses distant from the pleura in which there is a risk of puncturing the normal lung tissue (15) (Table). In ED, a guidewire is first inserted into the bronchus leading to the cavity through the working channel of the bronchoscope. Selective bronchography is then performed to identify the location of the guidewire, and a catheter is slipped over the guidewire into the cavity (15, 16). Recently endoscopic ultrasonography with a guide sheath (EBUS-GS) has often been used for the diagnosis of pulmonary peripheral le-
should be performed to accumulate more clinical evidence. The treatment of refractory lung abscesses, and studies investigating the selection of an appropriate antibiotic, which might have the advantages of detecting the causative pathogens and facilitate early infectious source control by allowing the selection of an appropriate antibiotic, which might make the duration of antimicrobial therapy shorter.

There are still unsolved clinical questions in relation to the treatment of refractory lung abscesses, and studies should be performed to accumulate more clinical evidence.

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References