

and anemia is often observed with anaerobic lung abscesses. A subset of patients with putrid lung abscesses may report discolored phlegm and foul-tasting or foul-smelling sputum. Patients with lung abscesses due to non-anaerobic organisms, such as *S. aureus*, may present with a more fulminant course characterized by high fevers and rapid progression.

Findings on physical examination may include fevers, poor dentition, and/or gingival disease as well as amphoric and/or cavernous breath sounds on lung auscultation. Additional findings may include digital clubbing and the absence of a gag reflex.

■ DIFFERENTIAL DIAGNOSIS

The differential diagnosis of lung abscesses is broad and includes other noninfectious processes that result in cavitary lung lesions, including lung infarction, malignancy, sequestration, cryptogenic organizing pneumonia, sarcoidosis, vasculitides and autoimmune diseases (e.g., granulomatosis with polyangiitis), lung cysts or bullae containing fluid, and septic emboli (e.g., from tricuspid valve endocarditis). Other less common entities can include pulmonary manifestations of diseases that usually present at locations other than the chest (e.g., inflammatory bowel disease, pyoderma gangrenosum).

■ DIAGNOSIS

Lung abscesses are documented by chest imaging. Although a chest radiograph usually detects a thick-walled cavity with an air-fluid level, CT permits better definition and may provide earlier evidence of cavitation. CT may also yield additional information regarding a possible underlying cause of lung abscess, such as malignancy, and may help distinguish a peripheral lung abscess from a pleural infection. This distinction has important implications for treatment because a pleural space infection, such as an empyema, may require urgent drainage.

As described earlier (see “Pathology and Microbiology,” above), more invasive diagnostics (such as transtracheal aspiration) were traditionally undertaken for primary lung abscesses, whereas