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Chest roentgenogram in this patient was consistent with a lung abscess. Sputum Gram stain showed numerous white blood cells and many pleomorphic-shape bacteria, both Gram-negative and Gram-positive cocci and bacilli. Therefore, this patient had an anaerobic lung abscess.

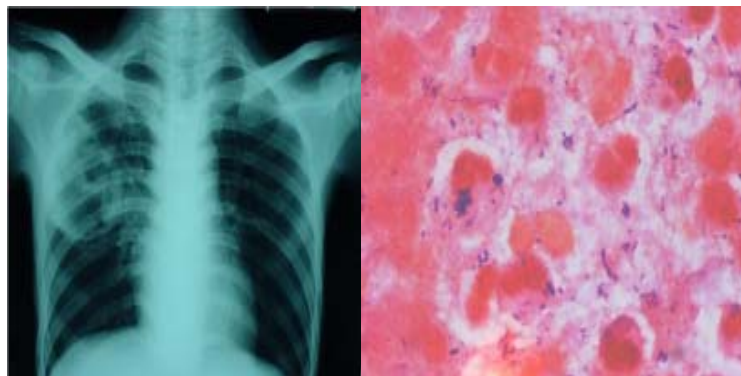
Approximately 80 percent of lung abscesses are primary; most occur as a complication of aspiration pneumonia and are polymicrobial infections due to anaerobic bacteria normally present in the patient's mouth. The most frequently isolated anaerobes are *Peptostreptococcus* spp., *Fusobacterium nucleatum*, and *Prevotella* spp.. In addition, anaerobic lung abscesses in some patients contain multiple anaerobe species as well as microaerophilic streptococci and viridans streptococci.

Penicillin is considered the drug of first choice of treatment. But in recent decades, many anaerobic mouth flora, including *Fusobacteria*, *Prevotella* spp., and non-*fragilis Bacteroides*, have been shown to produce penicillinase. Clindamycin has been shown superiority over penicillin in the treatment of anaerobic lung abscess. Metronidazole monotherapy, has been shown in clinical studies to be inferior to clindamycin.

Other alternative agents include a penicillin plus a β -lactamase inhibitor, carbapenems, and quinolones with good anaerobic activity (moxifloxacin). The optimal treatment duration is not clear. Patients often are treated for 6 to 8 weeks or more, and treatment is discontinued when clinical findings resolve and chest roentgenogram is clear or has only small stable residual lesion.

References

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**Figure 1.****Figure 2.**