A case report of a pulmonary abscess

Case presentation
A 34-year-old male, with history of lung ALK positive adenocarcinoma (subsequent to lobectomy and treated with adjuvant chemotherapy and radiotherapy), that posteriorly developed distal esophagus adenocarcinoma (immunohistochemically different from the lung), affecting the cardia. Was surgically proposed to eso-gastrectomy and eso-gastrostomy. Due to the partial dehiscence of the anastomosis, it was proposed an endoluminal prosthesis. One month after, during the removal of the prosthesis, that wasn’t possible, a second one was placed (stent in stent). Three weeks later, in the attempt of removing the inner prosthesis, it was found an esophageal orifice, probably of iatrogenic cause. A chest-computerized axial tomography revealed (images 1, 2, 3, 4 and 5) multiple esophageal fistulas and one that was inducing a pulmonary abscess of 16 cm. He was started on empiric antibiotherapy with metronidazole, clindamycin and fluconazole. A new esophageal prosthesis was placed and percutaneous drainage was performed, and its microbiological study revealed: *klebsiella pneumoniae* carbapenemase (KPC), with CIM for meropenem of 16 and a *Candida cruzei*. The antibiogram showed: CIM Meropenem: 16 mg/L; CIM Ertapenem: 16 mg/L; CIM Colystin: 1 mg/L and CIM Tigecycline: 0.38 mg/L. Accordingly, to the antibiogram, was started on tigecycline, colistine and amphotericin B. However, there wasn’t any improvement, and the patient died on 45th day of his admission.

Discussion
The emergency of multiresistant microorganisms it’s a challenge for treatment, control and prevention. When these infections involve abscesses, adequate drainage and an appropriate long term antibiotic therapy has shown an improvement in the outcome. However, there is some debate concerning the appropriate dosage and the most favorable pharmacokinetic/pharmacodynamic profiles in this cases. Unfortunately the optimal treatment is unknown. The use of aminoglycosides, polymyxin combinations and tigecycline appeared to have higher success rates. Obviously, in this case, due to its clinical past history and immunosuppression, even the best approach wasn’t enough.

References

Diagnóstico: Pulmonary abscess due to KPC-3
*Klebsiella pneumoniae*

Tatiana Fonseca¹, Maria Ana Canelas¹

¹Department of Internal Medicine, Centro Hospitalar Vila Nova de Gaia Esponho, Vila Nova de Gaia, Portugal

Correspondencia: tatifonseca_84@hotmail.com

Cómo citar este artículo: Fonseca T, Canelas MA
Pulmonary abscess due to KPC-3 Klebsiella pneumoniae. Galicia Clin 2017; 78 (1): XX-XX

Recibido: 08/07/2016; Aceptado: 18/07/2016