

cently, percutaneous excision under computed tomographic guidance (via trochar or arthroscope) or ablation (radiofrequency or laser photo-coagulation) has given comparable results with lower morbidity.⁵ Medical management has been advocated by some.⁶

Fig. 4 demonstrates radiofrequency ablation of the lesion seen in Fig. 3. The tip of the radiofrequency electrode is centred on the nidus (arrow), which is ablated by the heat generated. Although complete de-

struction or excision of the nidus is essential for cure, the reactive sclerotic bone does not require treatment and may resolve with time.

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Category 11, Item 2

This patient's chest x-ray shows an empyema that has reached the chronic or organized phase. This phase is characterized by the development of a restrictive fibrous pleural peel that limits chest expansion. Any fluid remaining in the chest is viscous and usually cannot be drained through a tube thoracostomy.

Effective treatment of an organized or chronic empyema requires removal or drainage of the infected material and ideally resection of the restricting peel. Open or thoracoscopic decortication is advised. Decortication consists of debriding the peel surrounding the lung and draining or removing any infected liquid present in the pleural space. Decortication can be accompanied by moderate hemorrhage and should not be attempted in a septic or poor-risk patient. Poor-risk patients should undergo drainage of the infected pleural space and removal of the source of sepsis without attempting to free the restricted lung. Successful drainage of an organized empyema usually requires lysis of multiple loculations, debridement of necrotic tissue, and prolonged tube drainage. Because the lung is usually adherent to the chest wall except where the abscesses are located, rib resection with or without marsupialization usually allows enough space for access to break up multiple loculations, perform limited debridement, and to serve as a portal for drainage as this cavity slowly heals.

Because chronic empyema is characterized by multiple loculated areas, viscous fluid, and thick restrictive pleural peel, tube thoracostomy alone is not effective to drain the infection and does nothing for the restrictive peel on the lung.

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