**Introduction:**
Whenever a sudden drop in intrapleural effusion occurs after a major pulmonary resection, a bronchopleural fistula is suspected. It often presents with a productive cough due to oral expulsion of pleural fluid as the fistula allows direct communication between the thoracic space and bronchi. An empyema usually follows due to contamination of bacterial flora from the bronchus into the usually aseptic pleural space. Still, sometimes a sudden drop in the pleural fluid occurs in a clinically stable patient, with a usually benign evolution.

**Discussion:**
This rare entity was first described in 2011 by Merritt et al., in a subset of patients who presented inconsistently with a sudden drop in the pleural fluid level following pneumonectomy and coined the term benign emptying of the post-pneumonectomy space (BEP). These same authors presented the largest series of confirmed BEPS, with seven cases, with to the best of our knowledge, no more than 20 cases described. Several mechanisms were proposed to explain this entity. Kanakis et al. theorised the existence of a transient bronchopleural fistula that closes spontaneously. This causes the negative pleural pressure to equalise that of the atmosphere, the hydrostatic balance to be reversed and fluid to be absorbed through the parietal pleura. Another possible explanation is a defect in the diaphragm, either congenital, a porous diaphragmatic syndrome, or created at the time of the surgery, being more likely when an extrapleural pneumonectomy is performed.

Similarly, a less-than-watertight chest wall closure, would allow the fluid to enter the soft tissues of the chest wall. Finally, Gervész-Zapata et al. described a case of a drop in air-fluid level likely due to severe dehydration.

Given the case of a septic patient with a sudden drop in the intrapleural effusion level, and even in the setting of a contralateral pneumonia, the hypothesis of a bronchopleural fistula could not be ruled out. Still, upon review, the patient was stable, ventilating well and had had no oral expulsion of liquid. Bronchoscopy and CT scan showed no fistula, and the surgical team had not seen or caused any diaphragmatic lesion. The question that should be asked is at what point is a wall and watch approach valid? The authors believe that even though BEPS is a diagnosis of exclusion, this point is just before a surgical reexploration.