A 64-year-old woman presented with diminution of vision, progressive redness, and dull aching pain in the right eye for 8 months. There was no history of trauma. Her medical history was unremarkable.

an examination, her best-corrected visual acuity measured 20/60 OD and 20/25 OS. The anterior segment showed dilated corkscrew conjunctival vessels (Figure 1), a shallow anterior chamber in the right eye, and nuclear cataract in both eyes. Pupillary reaction and color vision were normal in both eyes. Intraocular pressure was 16 mm Hg by Goldman applanation tonometry in both eyes. Gonioscopy revealed an occludable angle in the right eye without evidence of blood in the Schlemm canal. Both eyes’ extraocular movements were full and free in all directions of gaze. Dilated fundus examination showed a clear vitreous cavity in the right eye, 360° serous choroidal detachment partly obscuring the optic disc nasally (Figure 1), and the fundus in the left eye was unremarkable.

What Would You Do Next?

1. Ultrasound biomicroscopy
2. Uveitis workup and steroids
3. Thyroid profile
4. Magnetic resonance imaging with magnetic resonance angiography or digital subtraction angiography