A 61-year-old Black man with hypertension and diabetes presented with decreased vision 3 months after uneventful cataract surgery in his left eye. He had undergone laser retinopexy for retinal tears in his right eye and a scleral buckle and vitrectomy for a retinal detachment in his left eye 1 year earlier. Best-corrected visual acuity (BCVA) was 20/40 OD and counting fingers OS. Intraocular pressure (IOP) was 14 mm Hg in the right eye and 44 mm Hg in the left eye. Anterior segment examination of the right eye was unremarkable, while ophthalmoscopic examination showed vascular attenuation and treated retinal breaks. In the left eye, microcystic corneal edema and Descemet membrane folds limited examination, but no residual lenticular fragments or neovascularization of the iris or angle were seen. The patient was discharged taking timolol, dorzolamide, brimonidine, and prednisolone. Twelve days later, the cornea had cleared and IOP in the left eye improved to 32 mm Hg. Gonioscopy revealed 360° of anterior synechiae and complete angle closure, which was documented on ultrasound biomicroscopy (Figure 1). The patient started treatment with 500 mg of acetazolamide daily and referred to the glaucoma service for surgical evaluation.

When the patient returned for his glaucoma evaluation 3 days later, he was noted to have loss of appetite, drowsiness, nausea, and malaise. The patient’s intraocular examination was stable bilaterally. During this visit, the patient developed acute chest pain and respiratory insufficiency requiring immediate transfer to the emergency department. He was found to have a hemoglobin level of 8.5 g/dL (to convert to grams per liter, multiply by 10.0) and a hematocrit level of 22.1% (to convert to a proportion of 1.0, multiply by 0.01).

What Would You Do Next?

1. Obtain blood cultures, perform vitreous tap, and inject antibiotics
2. Perform laser iridotomy
3. Observation
4. Perform hemoglobin electrophoresis