An 81-year-old woman was referred to our service for assessment of 3 darkly pigmented corneal lesions (Figure 1A). Two years ago, she underwent uncomplicated right cataract surgery at a different center. Her postoperative course had been complicated by persistent low-grade anterior uveitis for which she received maintenance loteprednol, 0.5%, eye drops on alternate days. She also used latanoprost eye drops at night in both eyes for primary open-angle glaucoma. Her medical history was only significant for hypertension, which was well controlled with ramipril. She denied any ocular trauma or recent travel outside of the country. Review of systems was unremarkable.

On examination, her visual acuity was 20/80 OD and 20/20 OS. Her intraocular pressures measured 17 mm Hg OD and 15 mm Hg OS. The right sclera and conjunctiva were white with 3 distinct hyperpigmented corneal lesions affecting the corneal endothelium and stroma (Figure 1B). There were 2+ cells in the anterior chamber and 1+ vitritis. Dilated fundus examination showed a normal retinal appearance.

What Would You Do Next?

1. Increase the frequency of topical corticosteroids
2. Refer the patient to an ocular oncologist
3. Obtain aqueous fluid for fungal polymerase chain reaction
4. Obtain a vitreous biopsy for bacterial culture