A 79-year-old man with paraplegia, neurogenic bladder, and chronic urinary tract infection (UTI) presented in August 2022 after 4 months of right eye redness, discharge, pain, and decreased vision. He had already been using topical moxifloxacin, bacitracin-polymyxin ointment, and antibacterial Avenova spray each 4 times daily in his right eye for chronic conjunctivitis.

On examination, his best-corrected visual acuity was 20/200 OD and 20/25 OS with normal intraocular pressures. His right eye had copious mucopurulent discharge, 3+ conjunctival hyperemia, and prominent palpebral papillae (Figure). The corneal epithelium was intact but diffusely hazy with punctate epithelial erosions identified with fluorescein. The anterior chamber was deep and quiet, and there was a limited view to his fundus. His left eye was unremarkable. Gram stain and cultures of the mucopurulent discharge were collected by inferior fornix swab, and the patient was admitted to the hospital. Hourly topical fortified vancomycin (2.5%) and ceftazidime (5%) were started, and intravenous meropenem was given for his chronic UTI. An orbit computed tomography scan showed normal lacrimal system and sinuses. Cultures speciated Staphylococcus aureus resistant to penicillin. The patient’s right eye improved marginally over the 3-day hospital course, and he was discharged with a regimen of fortified vancomycin every 2 hours, saline irrigation, tobramycin/dexamethasone ointment nightly, and oral amoxicillin/clavulanic acid.

Biweekly follow-up examinations remained stable with 20/200 OD and continued 3+ conjunctival hyperemia and mucopurulent discharge with intact corneal epithelium. One month after discharge, he was readmitted for increased pain. Repeat conjunctival cultures demonstrated *P aeruginosa* resistant to all antibiotics except piperacillin/tazobactam, with a minimum inhibitory concentration of 16 μg/mL. This result was reported to the CDC. Intravenous piperacillin-tazobactam and tobramycin were added, and topical trimethoprim/polymyxin 4 times a day, tobramycin and vancomycin every 2 hours, prednisolone 4 times a day, and nightly tobramycin/dexamethasone were continued. After 10 days, a new infiltrate was noted with 10% thinning. Topical and intravenous antibiotics were stopped, and oral doxycycline, 100 mg twice a day, and vitamin C, 2 g per day, topical cyclosporine, 0.05%, and preservative-free lubrication were started to slow corneal thinning. Povidone-iodine flushes (2.5%) were initiated with marginal improvement of the mucopurulent discharge. Three separate conjunctival cultures demonstrated extensively resistant *P aeruginosa*. He was discharged with this regimen with minimal improvement. At his last visit nearly 9 months after onset of the conjunctivitis and 5 months after we initially saw him, the visual acuity in his right eye degraded to light perception with continued severe hyperemia, purulent discharge, and diffusely hazy cornea. He was awaiting evaluation with a corneal specialist at an academic center.