A 77-year-old male with history of hypertension and asthma presented with 3 months of progressive decline in vision in the left eye. He had no known ocular history. At presentation, best-corrected visual acuity was 20/100 OD and 20/50 OS. Intraocular pressures were normal bilaterally and pupils were equally reactive. Examination of the right eye was unremarkable except for moderate cataract. The left-eye slitlamp examination was remarkable for a shallow but quiet anterior chamber and moderate cataract. Dilated fundus examination of the left eye revealed shallow peripheral serous choroidal detachments, bullous inferior macula-involving retinal detachment with shifting fluid, and diffuse hyperpigmented lesions involving the macula and superior fundus that corresponded to areas of nodular retinal pigment epithelium thickening on optical coherence tomography (Figure 1). These hyperpigmented lesions were associated with hyperautofluorescence and blockage on fluorescein and indocyanine green angiography. No retinal breaks were seen on scleral depressed examination. Ultrasound biomicroscopy demonstrated 360° ciliochoroidal effusion. Axial length was 24.30 mm OD and 24.32 mm OS. The patient denied a history of known refractive error.

Results of inflammatory laboratory tests were negative for antineutrophil cytoplasmic antibodies, rheumatoid factor, and Treponema pallidum antibodies. Chest radiography and magnetic resonance imaging of the brain and orbits with and without contrast showed no extraocular disease. Treatment with 60-mg prednisone was initiated for 1 week but did not result in any changes in examination findings. The patient had a negative systemic review of systems.

WHAT WOULD YOU DO NEXT?

A. Scleral buckle with cryotherapy

B. Pars plana vitrectomy

C. Intravitreal steroid trial

D. Scleral windows surgery