A middle-aged patient with history of bilateral penetrating keratoplasty (PKP) performed 20 years earlier for keratoconus presented with pain and blurriness of the right eye for 2 days. The patient reported adherence with the home regimen of prednisolone acetate 1%, 1 drop daily in both eyes for postoperative prophylactic immunosuppression. The patient reported no recent infectious illness or trauma. At a prior clinic visit, both corneal grafts were clear and compact, although both were ectactic. When using scleral contact lens (SCL), their best-corrected visual acuity was previously 20/40 OD.

On current presentation, the uncorrected visual acuity was counting fingers right eye, with no improvement on refraction and inability to tolerate a hard lens. Intraocular pressure was 18 mm Hg in the right eye. The eye had diffuse edema of the ectactic graft with microcystic edema, bullae, and folds in the Descemet membrane (DM)(Figure1). There were no visible keratic precipitates or endothelial rejection lines. The anterior chamber was formed without visible inflammatory cells. Posterior segment examination could not be performed, though B-scan ultrasonography was unrevealing. Because of concern about acute graft rejection, the patient started prednisolone acetate 1% drops every hour (with taper over several weeks) and methylprednisolone, 24 mg (with taper over 6 days). Three weeks later, the patient had no improvement in the edema or vision and reported occasional pain.

WHAT WOULD YOU DO NEXT?

A. Prescribe oral valacycolvir

B. Prescribe the higher-potency topical corticosteroid topical difluprednate

C. Perform anterior segment optical coherence tomography

D. Prescribe a second course of oral corticosteroids