A47-year-old man presented to our clinic with a sudden decrease in vision in the right eye. One month prior, he had presented to the emergency department with binocular diplopia, bilateral cranial nerve 6 palsies, and an undifferentiated pontine mass on brain magnetic resonance imaging. Broad serologic workup results were negative, except for a positive syphilis total antibody with a nonreactive rapid plasma reagin test. Lumbar puncture with flow cytometry and cerebrospinal fluid venereal disease research laboratory test (CSF VDRL) result was also negative. The patient reported a history of syphilis treated with intramuscular penicillin 9 years prior. He was treated with systemic corticosteroids and discharged home on a steroid taper.

On our examination, his visual acuity was count fingers in the right eye and 20/20 in the left. He had a right afferent pupillary defect and intraocular pressures were 12 in the right eye and 11 in the left. Anterior segment examination was normal. Posterior examination of the right eye revealed 3+ vitreous cell, 2+ vitreous haze, and a large optic nerve head mass with optic disc hyperemia, scattered dot hemorrhages, and a subtle placoid lesion in the posterior pole (Figure 1A). Optical coherence tomography of the optic nerve demonstrated a large spherical mass protruding out of the optic nerve head (Figure 1B) and granular disruption of the ellipsoid zone in adjacent peripapillary retina.

WHAT WOULD YOU DO NEXT?

A. Perform diagnostic anterior chamber and/or vitreous tap and inject vancomycin and ceftazidime

B. Perform pars plana vitrectomy for diagnostic vitreous biopsy

C. Reinitiate systemic prednisone therapy

D. Obtain additional treponemal test and, if positive, begin intravenous penicillin