A 46-year-old woman was referred for a second opinion regarding hydroxychloroquine retinal toxicity. Her medical history included systemic lupus erythematosus (SLE), diabetes type 1, nonalcoholic steatohepatosis, mild congenital hearing loss, and anemia. SLE was man- aged with azathioprine and belimumab, and she had been taking hydroxychloroquine, 400 mg, daily for 5 years before the medication was recently stopped due to concern for retinal toxicity. Review of systems was notable for imbalance, cognitive decline, major depression, and recent onset of suspected seizures.

Snellen visual acuity was 20/30 OD and 20/20 OS and intraocular pressures were nor- mal. Results of slitlamp examination of the anterior segment were unremarkable, with clear corneas, quiet anterior chambers, and clear lenses bilaterally. Fundus examination revealed bilateral discrete perifoveal circular areas of atrophy. The optic discs and fundus were otherwise unremarkable. Fundus autofluorescence and optical coherence tomography (OCT) revealed perifoveal hypoautofluorescence corresponding with complete retinal pigment epithelium and outer retinal atrophy on OCT (Figure and insert). Automated 10-2 visual field testing revealed dense paracentral ring scotomata bilaterally.

WHAT WOULD YOU DO NEXT?

A. Confirm hydroxychloroquine retinal toxicity and recommend observation when not receiving therapy

B. Recommend AREDS 2 supplementation

C. Intravitreal injection of a complement inhibitor

D. Genetic evaluation