A 17-year-old male with an unremarkable medical history presented with 2 days of painless blurred vision in the right eye. Three weeks prior, he was admitted with fever, myalgias, hepatosplenomegaly, lymphadenopathy, and truncal rash. Laboratory evaluation revealed leukopenia and thrombocytopenia. Heterophile antibody test results were negative. He recovered with supportive treatment.

On examination, the patient was well appearing. His best-corrected visual acuity in the affected right eye was 20/25 and baseline count fingers in the left, secondary to amblyopia. His intraocular pressures were normal and extraocular movements were full. Examination was notable for 1+ anterior chamber cell in the right eye. Dilated fundus examination of the right eye revealed vitreous cell and a supratemporal branch retinal artery occlusion (BRAO) abutting the fovea. Multiple retinal nerve fiber layer infarcts were observed bilaterally throughout the posterior pole and retinal periphery. Fluorescein angiography demonstrated multifocal areas of retinal arteriolar and capillary nonperfusion, more so in the right eye than the left. Optical coherence tomography (OCT) of the right eye showed loss of inner retinal laminations, presumably due to intracellular swelling of the ganglion cell layer within areas of retinal arteriolar and capillary nonperfusion (Figure 1). Late vascular staining appeared limited to venules at the boundary of perfused and nonperfused retina and scattered areas of capillary nonperfusion. The patient denied intravenous drug use or antecedent trauma.

WHAT WOULD YOU DO NEXT?

A. Obtain outpatient embolic workup

B. Perform intravitreal corticosteroid injection

C. Order serologic infectious and inflammatory workup

D. Check blood pressure