A man in his early 50s was admitted to the hospital after acute hypoxemic respiratory failure and cardiac arrest following aspiration, requiring 3 minutes of cardiopulmonary resuscitation. The patient was intubated on the scene and remained intubated due to lactic acidosis and elevated liver function test results. After these abnormalities normalized 3 days later, he was extubated and breathing comfortably on room air with normal vital signs, mild right-sided weakness, and no other known complications. One day after extubation, he noticed blurry vision peripherally and difficulty focusing at near. Ophthalmology was consulted. On evaluation, he had near visual acuity (VA) of 20/25 OU, no afferent pupillary defect, and full but slow confrontational visual fields (VF) on bedside examination. Anterior segment and dilated fundus examination results were normal. Results from computed tomography (CT) head scan without contrast and magnetic resonance imaging (MRI) brain scan with and without contrast were unremarkable. Two days later, the patient noted worsening vision and was found to have a VA of 20/40 in each eye with homonymous right- inferior quadrantanopia. A code stroke was called with repeat CT scan/CT angiography and MRI brain both with and without contrast that remained unremarkable, as did repeat se- rum electrolytes and metabolic panels (Figure 1). The following day, the patient noted further vision loss and was found to have bilateral light perception vision. There was no pupillary defect, blink to threat, optokinetic reflex response, or intraocular pathology explaining the substantial vision loss including fundus abnormalities. Repeat CT scan/CT angiography demonstrated no abnormalities.

WHAT WOULD YOU DO NEXT?

A. Repeat brain MRI

B. Obtain an electroretinogram

C. Consult psychiatry

D. Observation