A 63-year-old woman with a history of type 1 diabetes presented with gradually progressive vision loss in the right eye for the past year. Her visual acuity on presentation was 20/80 OD and 20/25 OS. Anterior examination findings of both eyes were normal with clear posterior chamber intraocular lenses. Fundus examination of the right eye showed choroidal folds and a macula-involving retinal detachment with no identifiable retinal break and shifting subretinal fluid (Figure 1A). Fundus examination findings in the left eye were normal. Fluorescein angiography did not identify areas of leakage. B-scan ultrasonography demonstrated broad areas of low reflectivity within the sub-Tenon space and around the optic nerve (Figure 1B). Magnetic resonance imaging (MRI) revealed a contrast-enhancing area of soft- tissue thickening encircling the right optic nerve (Figure 1C). Serologies for syphilis, Lyme disease, rheumatoid factor, and antineutrophilic cytoplasmic antibody–associated vasculitis were negative. Chest radiographic findings were unremarkable.

WHAT WOULD YOU DO NEXT?

A. Begin oral prednisone

B. Observe with interval orbital MRI

C. Perform pars plana vitrectomy for retinal detachment repair

D. Perform biopsy of the optic nerve lesion