A Black woman in her early 70s with a history of coronary artery disease after coronary artery bypass operations, hypertension, and colon polyps presented to oculoplastic surgery with 1 week of progressive right-sided proptosis and headache, described as severe pain radiating to the back of her head. This was associated with right eyelid ptosis and blurry vision. Prior to presentation, an outside ophthalmologist treated her with 1 week of oral prednisone, 20 mg/d, for presumed orbital inflammation with no improvement. She denied additional symptoms. Notably, she described headache and sudden vision loss in the right eye after coronary artery bypass grafting 1 year ago for several days before spontaneous improvement with incomplete resolution. Personal and family histories were negative for malignant neoplasm and autoimmune disease.

Examination revealed right-sided uncorrected Snellen visual acuity of 20/60 associated with restricted supraduction, abduction, and infraduction. Pupils were equal in size without a relative afferent pupillary defect, and intraocular pressures were 10 mm Hg OD and 11 mm Hg OS. Visual fields had temporal restriction to confrontation of the right eye. Vision, motility, and visual fields were normal on the left. Pertinent findings included right- sided proptosis of 2 mm, cranial nerve V1 and V2 hypoesthesia, eyelid ptosis with a margin to reflex distance 1 of 0 mm, optic disc pallor, and vessel attenuation. Outside magnetic resonance imaging (MRI) demonstrated an infiltrative mass involving right greater than left orbital apices, the right optic nerve, and right extraocular muscles. There was enhancement of the cavernous sinuses, right pterygopalatine fossa, right sphenoid wing, and right middle cranial fossa dura (Figure 1).

WHAT WOULD YOU DO NEXT?

A. Restart corticosteroids at a higher dose

B. Refer to the neurosurgery department for cranio-orbito-zygomatic craniotomy

C. Perform urgent orbital exploration and biopsy

D. Order urgent radiotherapy