A 71-year-old woman without substantial medical history was referred for 2 months of progressive worsening of vision and pain in her right eye despite corticosteroid treatment following a recent excisional conjunctival biopsy with cryotherapy at an outside institution for suspected squamous cell carcinoma in situ. Pathology was reported to be negative for malignancy. The patient noted postoperative pain that was suspected to be postsurgical inflammatory scleritis and managed by an outside ophthalmologist with a combination of topical prednisolone, oral prednisone, and subtenon triamcinolone acetonide.

On presentation, the patient’s Snellen visual acuity without correction was count fingers in the right eye and 20/50 in the left eye with a baseline of 20/100 in the right eye and 20/60 in the left eye. The anterior segment examination of the right eye revealed conjunctival hyperemia with prominent scleral vessels, greatest inferiorly. Scleral thinning was noted inferotemporally, as well as a temporal crescent of corneal stromal melt (Figure 1). A persistent depot of subtenon triamcinolone acetonide was noted inferotemporally. A retrocorneal white plaque was noted from clock positions 6:00 to 9:30 with 4+ cell and flare per Standardization of Uveitis Nomenclature classification. Posterior synechiae were present and the pupil was peaked inferotemporally. There was no view posteriorly and a B-scan ultrasonography revealed moderate vitreous opacities without retinal detachment, choroidal effusion, or Tenon space edema. The left eye was normal.

WHAT WOULD YOU DO NEXT?

A. Inject intravitreal methotrexate

B. Start topical interferon alpha-2b

C. Perform anterior chamber biopsy of retrocorneal plaque

D. Perform vitreous tap and injection of intravitreal vancomycin, ceftazidime, and voriconazole