A 73-year-old man presented to the oculoplastics clinic with a 5-day history of a rapidly growing right eyebrow lesion. The lesion was not causing substantial discomfort, and the patient denied additional symptoms, including vision changes. The patient had no history of malignancy or other dermatologic problems. On examination, he had a large erythematous nodule with raised borders under the right brow with central ulceration that was draining clear material (Figure 1A). The rest of the ophthalmic examination was normal. Based on the rapid presentation and clinical appearance, the lesion was hypothesized to be a brow abscess. The patient was prescribed clindamycin 4 times a day for 10 days and erythromycin ointment twice a day for 10 days, instructed to start warm compresses to promote abscess drainage and healing, and told to follow up in 1 week. Erythromycin, commonly used in skin infections, was used topically for coverage of gram-positive and some gram-negative organisms. Clindamycin was prescribed orally due to the concern for skin abscess and to cover Staphylococcus and Streptococcus species.

After 1 week, the lesion continued to enlarge (Figure 1B). The ulcerated central depression displayed minimal drainage without expressible material. The patient’s ophthalmic examination continued to be otherwise normal. Although trimethoprim/sulfamethoxazole and clindamycin cover various Staphylococcus subtypes, the patient was prescribed trimethoprim/sulfamethoxazole for 14 days given no response to the clindamycin trial and to increase the gram-negative coverage. At the patient’s next visit 1 week later, 2 weeks after presentation, the lesion remained refractory to treatment and appeared unchanged.

WHAT WOULD YOU DO NEXT?

A. Observe with no additional testing or intervention

B. Biopsy of the lesion

C. Corticosteroid injection

D. Trial another antibiotic (such as doxycycline) for atypical mycobacteria and anti-inflammatory properties