A 37-year-old woman was referred for evaluation of a retinal detachment in her left eye. She noted a sudden vision loss in her left eye 3 days prior to presentation. Her Snellen visual acuity on presentation was 20/20 OD and 20/200 OS, and intraocular pressure was normal in both eyes. Anterior segment examination revealed shallowing of the anterior chamber in the left eye. Posterior examination results demonstrated a retinal detachment in the posterior pole with shifting fluid and no identifiable retinal break (Figure 1A). No vitreous cell was noted. Findings of imaging testing were notable for thickened choroid with a hyporeflective band on ultrasound biomicroscopy (Figure 1B).

She had a medical history of idiopathic pulmonary arterial hypertension (World Health Organization group 1 pulmonary hypertension) and was currently undergoing evaluation for a bilateral lung transplant. She was currently taking macitentan, an endothelial receptor antagonist; subcutaneous treprostinil, a continuous prostanoid infusion; and riociguat, a guanylate cyclase stimulator. She noted increased dyspnea, exertional hypoxemia, and peripheral edema in the preceding weeks; her diuretic therapy was adjusted and oxygen therapy was added. Chest, abdomen, and pelvis computed tomography demonstrated an ovarian cyst and cardiomegaly. Echocardiography showed findings of severe pulmonary hypertension and severe right ventricular dysfunction.

WHAT WOULD YOU DO NEXT?

A. Perform pars plana vitrectomy for retinal detachment repair

B. Begin high-dose prednisone

C. Work with pulmonary hypertension specialist to optimize pulmonary hypertension management

D. Start eplerenone therapy