A 55-year-old female with a known right parietooccipital World Health Organization grade IV glioblastoma presented to the eye emergency department for 2 weeks of bilateral floaters followed by eye pain, photophobia, and blurry vision. She had previously undergone partial tumor resection and 1 round of chemotherapy. A direct infusion of her-pes simplex virus type 1(HSV-1), C134 oncolytic virus was injected into her glioblastoma as part of a clinical trial 3 weeks before presentation.

Her presenting visual acuity was 20/400ODand 20/40OS. Corneal edema and 3+ anterior chamber cell were present in both eyes. Vitritis obscured details of the fundi, but peripheral retinal whitening and perivascular hemorrhages were appreciable bilaterally. Optical coherence tomography of the maculae showed intraretinal and subretinal fluid.

The patient was admitted for intravenous acyclovir. A diagnostic anterior chamber tap and bilateral intravitreal foscarnet injections were performed. Serological infectious and autoimmune testing was negative.

One day after admission, a rhegmatogenous retinal detachment developed in the right eye and a pars plana vitrectomy with retinal detachment repair and silicone oil insertion was performed. Intraoperative pure vitreous samples revealed more than 1 million copies/mL of HSV. Subsequent specialized polymerase chain reaction (PCR) of these samples confirmed the presence of HSV-1, C134.

Biweekly intravitreal antiviral injections were administered for 3 weeks (alternating ganciclovir and foscarnet). Prednisone, 60 mg, by mouth was initiated after 2 days of antiviral therapy. The patient was monitored in the intensive care unit for 6 days before discharge and given valacyclovir, 2 g, by mouth three times daily.

Over a 3-month period, she underwent 3 vitrectomies in the right eye and 2 in the left eye, repairing rhegmatogenous retinal detachments with proliferative vitreoretinopathy.