



Figure 5-1. Algorithm for the diagnosis and management of the clinically isolated syndrome.

Atypical optic neuritis (ie, infectious, other inflammatory, infiltrative) may require different treatments than idiopathic or demyelinating optic neuritis. Some atypical features for you to consider at presentation include retinal exudates, retinal hemorrhages, severe optic disc edema, no light perception vision, and the absence of pain. When these atypical features are present, in addition to a MRI brain/orbits, I would recommend further diagnostic considerations, including antinuclear antibody test (ANA), fluorescent treponemal antibody absorption (FTA-ABS), angiotensin-converting enzyme (ACE) level, Lyme titer, chest x-ray, and lumbar puncture to look for other causes of optic neuropathy (Figure 5-1). Optical coherence tomography (OCT) and electrophysiological (electroretinogram [ERG], visual evoked response [VER]) studies may be helpful in select cases where the distinction of a retinal condition from an optic nerve process is difficult. The results of these tests might alter your treatment decisions.

In regard to your questions, let me deal first with, “What is the treatment for optic neuritis and how and when should treatment be given?” The ONTT, the largest and most comprehensive study of the optic neuritis patient population to date, has provided important data about the clinical presentation and course of acute demyelinating optic neuritis. This trial, which followed an initial cohort of 457 patients, had the primary