The more concerning lesion is what we refer to as an indeterminate choroidal lesion (ICL), sometimes called atypical or suspicious choroidal nevus. These are not definitively UM, but may exhibit one or more clinical features that historically are associated with an active UM. The presence of these features may represent risk factors for future growth and progression to malignant UM.

We specifically ask patients if they are having any visual symptoms that may suggest fluid exudation or lesion growth (eg, photopsias, visual field changes) and if they are, then we aggressively seek out any prior fundus photos to compare previous documentation of the lesion, including evidence of change or growth of the lesion.

Key clinical examination features to note include pigmentation pattern (predominantly melanotic, amelanotic, or mixed pigmentation), an estimate of the size and distance to the fovea and optic nerve (in millimeters or disc diameters), the presence of subretinal fluid (SRF) (eg, overlying or adjacent to the lesion), lipofuscin accumulation, characterized by orange pigment, presence of drusen, or associated RPE alterations near the lesion, indicative of previous SRF (also referred to as high water mark) (Figure 20-2). All lesions are photographed and optical coherence tomography (OCT) images of the lesion are obtained. A standard 10 MHz B-scan ultrasound probe is used to

Figure 20-1. Choroidal nevus with overlying drusen, estimated to have a low risk for growth or malignant transformation.

Figure 20-2. ICL with moderate risk of growth and progression into a UM. Specifically, this demonstrates pigmented nevus with a more posterior location and subretinal fluid.