What should be done for a patient with traumatic optic neuropathy? The best information does not support the use of corticosteroids for traumatic optic neuropathy at any dose, although based on admittedly limited data, anti-inflammatory doses of corticosteroids (e.g. oral prednisone, 60-100 mg range per day or methylprednisolone 1 mg/kg every 6 hours) are likely safe. In the absence of imaging studies suggesting an optic nerve sheath hemorrhage, an uncommon clinical circumstance, surgery should be reserved for conscious patients with delayed visual loss or whose vision does not improve in the first 24-48 hours, particularly if there is a flashed visual evoked potential that is at least 50% of the normal eye or there is a relative afferent pupillary deficit that is less than 2.1 log units. It is worth noting that optic canal fractures may be a marker for how much force impacted the nerve rather than an indication for surgery. In the meantime, there is some evidence that the use of either erythropoietin or an erythropoietin receptor agonist may be beneficial in patients with traumatic optic neuropathy, and this potential treatment deserves a more thorough assessment as does the natural history of traumatic optic neuropathy itself. A multicenter trial of high-dose steroids vs surgery vs observation alone will likely be initiated in the near future in India and hopefully will provide the answers to some of these issues.