systemic associations, including febrile illnesses, oral contraceptive use, and systemic shock.[2] Notably, this patient denied any of these predisposing factors. Hyperviscosity from leukoblasts in patients with acute leukemia have been linked to AMN[5]; however, this patient responded well to gilteritinib and had no myeloblasts in her peripheral blood prior to presentation.

In mice, retinal expression of Flt3 is upregulated in ischemic conditions.[6] In addition, mice lacking Flt3 show markedly reduced angiogenesis.[6] As such, we speculate that gilteritinib, a highly selective FLT3 inhibitor, may impair the retina's normal response to a transitory ischemic state. If the outer capillary plexus is involved, outer retinal damage can result in an AMN phenotype, as in this patient. Her symptoms resolved after stopping gilteritinib. However, the improvement could also be the natural evolution of AMN over time. While it was impossible to sustain this patient's gilteritinib regimen in the setting of a clinical trial, it might be prudent to continue providing this life-saving therapy to some patients with AML, with close monitoring via optical coherence tomography.

The spectrum of cancer therapy–associated retinopathies continues to increase as new immune and targeted therapies are developed. This case highlights the importance of maintaining a high index of suspicion for these entities in patients with cancer who are receiving novel treatment regimens.

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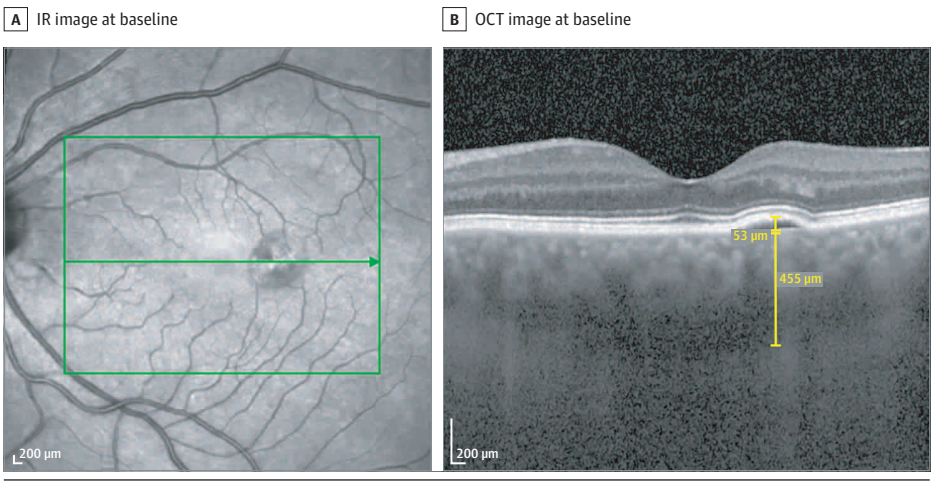
Relapsing Pigment Epithelial Detachment in Central Serous Chorioretinopathy After Dilated Eye Examination

We found great interest in the case reported by Watson and Yellachich[1] that described a pigment epithelial detachment (PED) due to central serous retinopathy that relapsed during 2 separate clinical occasions 1 hour after receiving topical phenylephrine, 2.5%. A single case of such an unusual finding that has, to our knowledge, never been previously reported requires confirmation through additional patient findings, and so we would also like to report a case of a PED that fluctuated in size in response to topical phenylephrine drops.

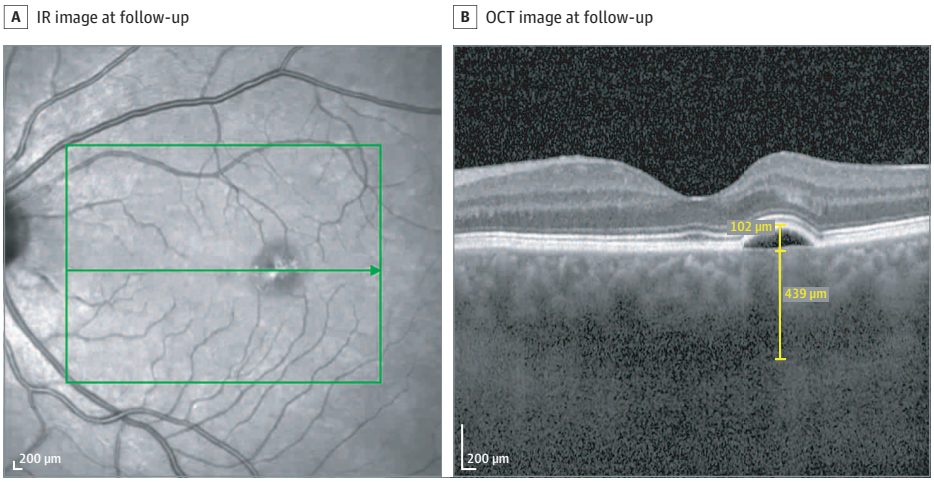
A 52-year-old white woman with a diagnosis of central serous retinopathy in the left eye for the last 10 years presented to our institution. She was treatment naive and had a PED that has intermittently fluctuated in size and presence over the years. On presentation, in the left emmetropic eye, optical coherence tomography imaging (Spectralis; Heidelberg Engineering) showed a thick choroid (455 µm) and a juxtafoveal PED, with a height of 53 µm and no associated subretinal fluid

Figure 1. Baseline Imaging Prior to Receiving Topical Phenylephrine, 2.5%



A, Infrared (IR) image at baseline prior to receiving medication. B, Optical coherence tomography (OCT) at baseline prior to receiving medication demonstrated a thick choroid and a juxtafoveal pigment epithelial detachment without subretinal fluid.

Figure 2. Follow-up Imaging After Receiving Topical Phenylephrine, 2.5%



A, Infrared (IR) image at follow-up after receiving medication. B, Optical coherence tomography (OCT) at follow-up after receiving medication demonstrated an enlarged juxtafoveal pigment epithelial detachment without subretinal fluid.

(**Figure 1**). The right eye had a thick choroid with no outer retinal irregularities. One hour after receiving 1 drop of topical phenylephrine, 2.5%, optical coherence tomography was repeated with the follow-up method, and the PED was noted to have increased in size to a height of 102 µm, with no subretinal fluid noted (**Figure 2**). Although the fluctuations in both cases may be unrelated to the phenylephrine, the timing suggests a relationship. Additionally, the change that is noted in such a short time is well beyond our experience in evaluating PEDs. The exact mechanism by which phenylephrine is producing this effect is uncertain, but we can hypothesize that phenylephrine can possibly be affecting choroidal blood flow or retinal pigment epithelium function.

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Documenting Course of 2 Cases of Conjunctivitis in Mobile Hospitals During the Coronavirus Disease 2019 Pandemic

Owing to the pandemic of coronavirus disease 2019 (COVID-19), caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), medical resources, including respirators and intensive care beds, are increasingly in shortage. In this context, a number of large indoor stadiums and exhibition centers were transformed into mobile hospitals for treatment of patients with mild COVID-19. These may have played a key role in controlling the outbreak.[1] However, within these relatively crowded units for patients, even with strict disinfection and infection control management, it still may be difficult to control the risk of some manifestations of infectious diseases, such as conjunctivitis.

Report of Cases | We document the course of 2 cases of confirmed COVID-19 with conjunctivitis in a mobile hospital. One (**Figure 1**) is a 29-year-old male patient, who noted conjunctival congestion of the right eye before admission to the mobile hospital. Health care workers did not notice the patient's ocular symptoms and the potential transmission risk by conjunctivitis. After the patient entered the mobile hospital, an ophthalmologist noted and reported the conjunctivitis. Conjunctival swab of both eyes was performed and SARS-CoV-2 was detected in the sample. Digital polymerase chain reaction was used for the detection of virus, and the copy number was 89.3 copies/mL (>50 copies/mL is considered as positive for the detection). While unproven as a treatment, antiviral ganciclovir eyedrops were given; the patient was isolated from other patients to potentially prevent nosocomial infection (Figure 1). Further investigation is warranted to elucidate the potential antiviral efficacy of ganciclovir against COVID-19.

In a second case (**Figure 2**), a 51-year-old woman presented with ocular symptoms 10 days after admission to the mobile hospital. She had conjunctival congestion, epiphora, and watery secretions in the right eye, and similar findings were noted in the left eye 2 days later. Severe acute respiratory syndrome coronavirus 2 detection was detected in the tears. Digital polymerase chain reaction was used for the detection of virus, and the copy number was 116.1 copies/mL (the threshold for determining a positive test was >50 copies/mL). Chest computed tomography demonstrated lung infection compared with her previous computed tomography results. The patient showed symptoms of hypoxemia and was transferred to a tertiary hospital for further intensive treatment (Figure 2), and