



Clinical update alert: Cyclospora

S: Cyclospora has received recent media attention due to reported outbreaks nationwide, **resulting in an increase in patients presenting to urgent care specifically requesting testing or antibiotic treatment for Cyclospora infection.**

B: *Cyclospora cayetanensis* is a microscopic intestinal parasite that causes cyclosporiasis, a diarrheal illness acquired through ingestion of contaminated food or water. Outbreaks in the United States are most associated with imported fresh produce. Symptoms typically include prolonged watery diarrhea, abdominal cramping, nausea, loss of appetite, fatigue, bloating, and weight loss. Illness may last for several weeks if untreated and can be more severe in immunocompromised individuals.

Current outbreak summary: As of July 9, 2026, CDC has confirmed 843 domestically acquired cases in 31 states. However, there are approximately 3000 cases reported across 32 states including 2600 cases in Michigan. State reported cases exceed CDC case count because CDC confirmation may lag state reporting by several weeks.

Diagnostic testing:

Molecular testing is the preferred test.

Routine stool studies and ova and parasite (O&P) examinations may miss the diagnosis. Multiple laboratory manuals and major commercial reference labs specifically state that "routine O&P testing does not detect Cyclospora)

Diagnostic testing options include specialized cyclospora smear that requires special dyes or molecular testing. Molecular testing is typically part of a panel, though some commercial lab testing sites is offering cyclospora testing by itself. Molecular testing is expensive with out of pocket costs as much as \$200-700.

A: **Recent media coverage may increase patient demand for Cyclospora testing even when clinical suspicion is low.** The likelihood of Cyclospora infection is highest in patients with:

- Prolonged watery diarrhea, typically lasting more than 7–10 days
- Relapsing or persistent symptoms
- Relevant exposure history, such as consumption of potentially contaminated fresh produce or known outbreak exposure
- Immunocompromising conditions or chronic immunosuppressive medication use
- Travel to areas where Cyclospora is more common



Testing is generally of low yield in patients with brief, self-limited diarrheal illness lasting only a few days and no epidemiologic risk factors.

R: Clinicians should evaluate patients requesting Cyclospora testing based on symptom duration, severity, immune status, and exposure history rather than media reports alone. Consider a GI pathogen PCR panel that includes Cyclospora in patients with persistent diarrhea (generally >7–10 days), significant risk factors, or immunocompromising conditions.

Routine gastrointestinal pathogen panel testing is not recommended for all patients with acute diarrhea. Indiscriminate testing increases healthcare costs, may identify organisms that are not responsible for the patient's symptoms, and can result in the detection of colonization or asymptomatic carriage that does not require treatment. Diagnostic testing should be guided by clinical suspicion and the likelihood that results will alter management.

Patient education should emphasize that not every episode of diarrhea warrants Cyclospora testing and that most short-duration diarrheal illnesses are caused by other pathogens and resolve with supportive care alone.

Testing recommendations

Do NOT routinely test for Cyclospora when

1) Acute, short-duration diarrhea (<7-10 days)

- A. Most episodes of acute diarrhea are caused by viral pathogens and resolve spontaneously
- B. Cyclospora infection typically causes prolonged, relapsing watery diarrhea, often lasting weeks if untreated
- C. Testing patients with < 7 days of symptoms has a very low diagnostic yield

2) Symptoms are improving or have resolved

- A. If diarrhea is resolving without treatment, testing is unlikely to change management
- B. Positive results may represent detection of an organism that is no longer clinically relevant

3) No current diarrhea

- A. No diarrhea = No testing
- B. Formed stool will cause rejection of testing

4) Testing is requested solely because of news coverage or outbreak reports

- A. Routine testing of low-risk patients increases healthcare costs without improving outcomes

5) An alternative diagnosis is more likely

- A. Medication related? I.e GLP
- B. IBS



Consider testing:

- 1) Persistent diarrhea without improvement > 7=10 days
- 2) Immunocompromised state
- 3) Travel to endemic regions
- 4) Consumption of potentially contaminated fresh produce
- 5) Known epidemiologic exposure during a recognized outbreak

When ordering a GI pathogen PCR panel for suspected Cyclospora infection, document:

- 1) Duration of diarrhea
- 2) Severity of symptoms
- 3) Relevant exposure history
- 4) Immunocompromising conditions, if present
- 5) How test results are expected to influence management

Treatment:

The recommended 1st line treatment for cyclospora infection is Bactrim DS 1 pill twice a day for 7-10 days. While cyclosporiasis may eventually resolve without treatment in some patients, routine treatment of confirmed infection is recommended due to the tendency for prolonged or recurrent watery diarrhea. The primary benefit of treatment is symptom resolution rather than prevention of invasive disease or serious complications. Patients with mild, improving symptoms may be managed supportively while awaiting test results, but confirmed cases should generally receive TMP-SMX unless contraindicated.

Key Point: Cyclospora testing should be driven by clinical suspicion and epidemiologic risk factors—not by media attention alone. Appropriate test utilization improves diagnostic stewardship, reduces unnecessary healthcare spending, and minimizes the detection of clinically insignificant findings.



Self-assessment Quiz:

Question 1:

A 37-year old woman presents to urgent care requesting testing for Cyclospora after reading about it on WRAL. She asks specifically for a testing. Which of the following historical features would provide the strongest justification for testing for cyclospora?

- A. 2 day history of watery diarrhea after eating at a restaurant, with symptoms improving
- B. 4 days of diarrhea after a camping trip, with one episode of vomiting and no other symptoms
- C. 7 days of watery diarrhea without fever or blood, but symptoms are gradually improving
- D. 12 days of watery diarrhea associated with bloating, fatigue, and intermittent abdominal cramping
- E. 3 days of bloody diarrhea, fever to 102F, and severe abdominal pain

Question 2:

Which single feature would most increase the likelihood of Cyclospora infection in a patient with diarrhea?

- A. Fever > 102F
- B. Bloody stools
- C. Diarrhea lasting 10-14 days
- D. Multiple sick contacts with similar symptoms
- E. Vomiting as the predominant symptom

Question 3:

A 34-year-old woman presents to urgent care with 12 days of intermittent watery diarrhea. At the onset of symptoms, she had 5–6 loose stools per day associated with mild abdominal cramping. She denies fever, hematochezia, severe abdominal pain, or vomiting. Over the last 3 days, her symptoms have improved, and she is now having 1–2 loose stools daily. She is tolerating oral fluids and has no signs of dehydration.

A gastrointestinal pathogen PCR panel obtained 2 days earlier returns positive for Cyclosporiasis. She is otherwise healthy and takes no medications.

Which of the following is the MOST appropriate management?

- A. Reassure the patient that Cyclospora is self-limited and no treatment is indicated because symptoms are improving.
- B. Prescribe loperamide alone because antimicrobial therapy does not shorten the duration of illness.
- C. Initiate trimethoprim-sulfamethoxazole therapy because treatment is recommended for confirmed Cyclospora infection, even when symptoms are mild or improving.
- D. Repeat the gastrointestinal PCR panel in 7 days and only treat if Cyclospora remains detectable.
- E. Prescribe azithromycin because it is the preferred treatment for mild Cyclospora infection.