Staff Advisory: Cyclosporiasis — What You Need to Know

July 13, 2026

Your patients and family members may ask you for advice regarding the increased incidence of cyclosporiasis. The following is a summary of the current epidemiology, diagnostics, and treatment options. For further detail, see Mathison and Pritt, 2021 https://doi.org/10.3390/microorganisms9091863
and the CDC cyclosporiasis page at:
www.cdc.gov/cyclosporiasis/php/surveillance/index.html

Background

Cyclosporiasis is an intestinal illness caused by the parasite *Cyclospora cayetanensis*, transmitted through ingestion of contaminated fresh produce or water. Humans are the only known host. The organism cannot be transmitted directly person-to-person because oocysts require 1–2 weeks outside the host to become infectious (sporulation).

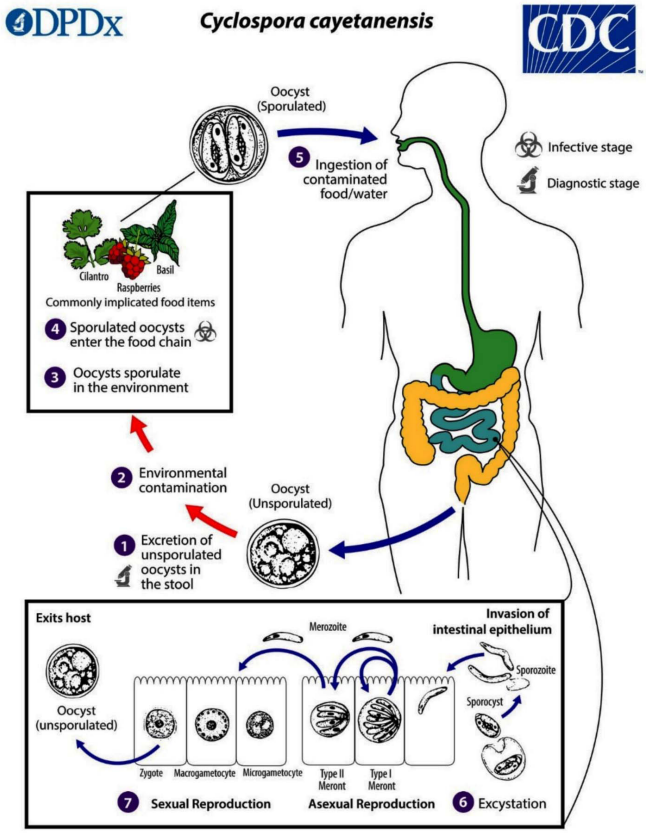

Figure 1. Life cycle of *Cyclospora cayetanensis*. Unsporulated, non-infective oocysts are passed in the feces (**1**). In the environment (**2**), sporulation occurs after days or weeks at temperatures between 22 °C to 32 °C, resulting in the division of the sporont into two sporocysts, each containing two elongated sporozoites (**3**). The sporulated oocysts can contaminate fresh produce and water (**4**) images, which are then ingested (**5**). The oocysts excyst in the gastrointestinal tract, freeing the sporozoites, which invade the epithelial cells of the small intestine (**6**). Inside the cells, they undergo asexual multiplication into Type I and Type II meronts. Merozoites from Type I meronts perpetuate the asexual cycle, while merozoites from Type II meronts undergo sexual development into macrogametocytes and microgametocytes upon invasion of another host cell. Fertilization occurs, and the zygote develops to an oocyst, which is released from the host cell and shed in the stool (**7**). Figure courtesy of the CDC-DPDx.

Increasing Public Health Concern
Reported cases of cyclosporiasis in the United States have increased significantly over the past decade:
- 2018–2019: Cases surged, with 55% of all FoodNet cases during 2015–2019 occurring in 2019 alone (758 cases); the number of reported outbreaks rose from 8 (2015–2017 combined) to 40 in 2019.
- 2020–2022: Incidence remained significantly elevated above prior reference periods.
- 2022–2023: Cases spiked significantly, stabilizing at roughly 3,000 nationally.

2024–2025: National tracking became fragmented. In 2025, the CDC officially made the tracking of Cyclospora optional for state health departments under its foodborne surveillance network, which broke the continuity of national year-end totals.

2026: While the CDC currently reports 843 confirmed domestic cases as of early July, an additional 1,500 suspected cases are pending analysis. Meanwhile, individual state dashboards show massive regional outbreaks (e.g., Michigan alone reported 1,562 cases by mid-July, pushing the actual national estimate well over 2,900.

The majority of U.S. cases are now domestically acquired (only ~21% report recent international travel) and are linked to consumption of imported fresh produce — particularly leafy greens, herbs (cilantro, basil), and berries — during the peak season of May through August. CDC genotyping data suggest the U.S. burden is driven by frequent, repeated introductions of contaminated produce from endemic regions rather than a persistent domestic source.

Clinical Presentation
- Incubation period: approximately 7 days
- Symptoms: Watery diarrhea (often profuse), loss of appetite, weight loss, cramping, bloating, nausea, fatigue, and low-grade fever
- Illness may be prolonged (weeks) or relapsing if untreated
- Immunocompromised patients (HIV/AIDS, transplant recipients) may experience more severe and protracted illness

Diagnosis
- *Cyclospora* testing must be **explicitly requested** — it is not included in routine ova and parasite examinations but it is included in the GI panel by PCR in the Baptist system. Therefore **order "GI panel by PCR."** Cyclosporiasis is a nationally notifiable disease. All positive tests are automatically reported to the State of Florida thereby meeting our reporting requirement.

Treatment
- **Adults (immunocompetent):** Trimethoprim-sulfamethoxazole (TMP-SMX) one double-strength tablet (160 mg TMP / 800 mg SMX) twice daily for 7 days.
- **Adults (immunocompromised):** One double-strength tablet four times daily for 10 days, followed by secondary prophylaxis (one DS tablet three times weekly) to prevent relapse.

- **Pediatric patients ≥2 months to 18 years:** 8 – 10 mg/kg TMP and 40 – 50 mg/kg SMX per day, orally, in 2 divided doses for 7 – 10 days (CDC). An oral suspension is available.
- **Contraindications:** TMP-SMX is contraindicated in infants less than 2 months of age, patients with sulfonamide hypersensitivity, megaloblastic anemia due to folate deficiency, and severe hepatic or renal impairment. **Caution**: the use of dofetilide (brand name Tikosyn) is an absolute contraindication to the use of trimethoprim. Also, TMP-SMX is associated with multiple significant drug interactions. Check before prescribing.
- **Sulfa-intolerant patients:** Ciprofloxacin 500 mg twice daily for 7 days is an alternative in adults, though it is less effective. No highly effective alternative has been established for sulfa-intolerant children.

Food Preparation Advice for Patients

A critical point to convey to patients is that *Cyclospora* oocysts are **resistant to standard chlorine-based washing and sanitizing** at concentrations used in the food industry and in household products. Washing fresh produce under running water reduces but does not eliminate the risk. Therefore, the following specific food preparation strategies should be recommended:

For all patients during peak season (May–August):

1. Wash all fresh produce thoroughly under clean running water before consumption. While this does not guarantee removal of all oocysts, it reduces the parasite load.
2. Cook vegetables whenever possible. *Cyclospora* oocysts, like other protozoan parasites, are sensitive to standard pasteurization temperatures and are killed by heating to ≥70°C (158°F). Vegetable soups, stews, stir-fries, roasted vegetables, and broiled or steamed vegetables are all safe options.
3. Blanch fresh vegetables and fruits briefly in boiling water (30–60 seconds) before consumption if they are to be eaten in a lightly cooked or semi-raw state (e.g., in salads or as garnishes). This brief exposure to boiling water (100°C / 212°F) is sufficient to kill protozoan oocysts while preserving much of the texture and nutritional value of the produce.
4. Be especially cautious with high-risk produce items that have been repeatedly linked to outbreaks: cilantro, basil, mixed salad greens, mesclun, iceberg lettuce, snap peas, and raspberries.

Additional precautions for immunocompromised patients:

Immunocompromised individuals, including those with HIV/AIDS (especially CD4 <200 cells/mm^3), organ transplant recipients, patients on immunosuppressive therapy, and those undergoing chemotherapy — should take extra precautions:
- Avoid eating raw or uncooked fresh produce during peak cyclosporiasis season (May–August), particularly leafy greens, fresh herbs, and imported berries.

- Prefer cooked vegetables and fruits during this period: vegetable soups, cooked and broiled vegetables, steamed greens, and cooked fruit compotes are safe and nutritious alternatives.
- If raw produce is desired, **blanch items in boiling water** before consumption.
- Peel fruits that can be peeled (e.g., bananas, oranges, melons) and consume only the interior.

These recommendations are consistent with existing guidelines for immunocompromised patients, which broadly advise avoiding raw produce in settings where parasitic contamination is a concern.

Thank you for your attention to this evolving public health issue.

Allan Feingold, MD, FRCP(C), FCCP
Medical Director
Occupational and Environmental Medicine
South Miami Hospital

Yvonne Johnson, MD
Chief Medical Officer at South Miami Hospital