

JB Pritzker, Governor

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Summary and Action Items

- Alert providers and local health departments (LHDs) that *Cyclospora* season begins May 1
- Request LHDs conduct enhanced investigation of domestically acquired cases
- Remind health care providers and laboratories about testing requirements to identify *Cyclospora*
- Request laboratories forward clinical materials positive for *Cyclospora* to the IDPH Laboratory

Background

[Cyclosporiasis](#) is an intestinal illness caused by the microscopic parasite *Cyclospora cayetanensis*. Generally, there is a seasonal increase in reported cyclosporiasis infections during the months of May through August. *Cyclospora* outbreaks in the United States, including in Illinois, have been linked to various types of imported fresh produce. *Cyclospora* cases in the United States are also more commonly seen among persons who traveled internationally prior to illness onset.

IDPH and LHD Response

Cyclosporiasis is reportable to local health departments by health care providers and laboratories. Clinically compatible cases with a laboratory test that detects *Cyclospora* organisms or DNA in stool, intestinal fluid/aspirate, or intestinal biopsy specimens are considered confirmed cases. Local health departments should interview all laboratory confirmed and epi-linked probable cases of *Cyclospora*, regardless of when they became ill, with the standard questions for this disease and with the [Cyclosporiasis National Hypothesis Generating Questionnaire \(CNHGQ\)](#), available on the IDPH CD [Cyclosporiasis Web Portal page](#). Completed questionnaires should be sent to the IDPH Communicable Disease Control Section through secure email to DPH.Foodborne@Illinois.gov or faxed to 217-524-0962. The CNHGQ used to interview cases of *Cyclospora* will be incorporated into the *Cyclospora* questionnaire within the new Illinois Disease Surveillance System (IDSS), anticipated for deployment in mid-July 2026. Upon IDSS deployment, LHDs will enter CNHGQ data into IDSS and will no longer need to complete the PDF version of the questionnaire.

IDPH, along with local health departments, will investigate cases through extensive case interviews, identify potential outbreaks, and work with federal partners to identify sources of exposure.

Potential Exposures

People can become infected with *Cyclospora* by consuming food or water contaminated with the parasite. In the United States, foodborne outbreaks of cyclosporiasis have previously been linked to various types of imported fresh produce such as raspberries, basil, cilantro, snow peas, and lettuce.

Symptoms

The average incubation period is seven days but can range from two days to two weeks or more. *Cyclospora* can cause watery diarrhea, weight loss, fatigue, anorexia, nausea, and abdominal cramps. Symptoms can last for a few days to a month or longer. Symptoms may go away and come back again multiple times. Most people who have healthy immune systems will recover without treatment. However, there is an effective antibiotic, and clinicians should consider treatment of confirmed cases based on clinical status.

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Transmission

People can become infected with *Cyclospora* by consuming food or water contaminated with the parasite. Person-to-person transmission generally does not occur.

Diagnosis

Health care providers should consider *Cyclospora* as a potential cause of prolonged diarrheal illness. *Cyclospora* infection is diagnosed by examining stool specimens or with the use of culture-independent diagnostic tests on stool specimens. Clinicians should specifically request stool testing for *Cyclospora*, as testing is not routinely conducted in all laboratories. A single negative test result is not definitive to rule out *Cyclospora* infection. When clinical suspicion is high, multiple stool specimens should be submitted to increase the testing yield.

Laboratories: *Cyclospora cayetanensis* oocysts, which are 8-10 micrometers in diameter, can be detected by modified acid-fast staining of stool. Fluorescence microscopy also can be utilized for detection of oocysts, which are auto fluorescent. This [link](#) provides additional helpful tools to aid in the laboratory diagnosis of *Cyclospora*. Diagnosis using culture-independent diagnostic tests (CIDT), such as the BioFire® FilmArray® Gastrointestinal (GI) Panel (multiplex PCR), has become more common. Laboratories should forward clinical materials positive for *Cyclospora* to the [IDPH Springfield or Chicago Laboratory](#) until September 1, 2026.

Prevention

Avoiding food or water that may have been contaminated with feces is the best way to prevent cyclosporiasis. Consumers and retailers should always follow safe fruit and vegetable handling recommendations.

Contact

Health care providers and laboratories should contact their [local health department](#) with questions or to report cases. Local health departments should contact the IDPH CD Section at 217-782-2016 or DPH.Foodborne@Illinois.gov with any questions.

Additional Resources

[IDPH Cyclospora Overview and Prevention Fact Sheet](#)

[IDPH Cyclospora Web Portal](#)

[IDPH Cyclospora page](#)

[CDC Cyclosporiasis page](#)

[CDC Case Definition](#)

Target Audience

Local Health Departments, Infectious Disease Physicians, Hospital Emergency Departments, Infection Control Preventionists, Health Care Providers, and Laboratories

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Domestically Acquired Cyclosporiasis Cases in Multiple U.S. States, 2026

JULY 14, 2026

AT A GLANCE

- Distributed via the CDC Health Alert Network
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- CDCHAN-00531



Summary

The Centers for Disease Control and Prevention (CDC) is notifying clinicians, public health practitioners, and laboratorians of cases of domestically acquired cyclosporiasis in multiple U.S. states. Since May 1, 2026, CDC has received reports of 1,645 confirmed domestic cases of cyclosporiasis and is aware of more than 5,100 cases that require further analysis to confirm the illness as domestically acquired cyclosporiasis. This is substantially higher than the 249 cases reported nationally by this same time last year. Of the 1,645 case-patients with available information, 141 (9%) were hospitalized, and none have died. CDC, the [U.S. Food and Drug Administration \(FDA\)](#), and state and local health departments are working together to investigate multistate outbreaks of *Cyclospora* infections and to identify the sources of illness. Because cyclosporiasis is often underdiagnosed and underreported, the true number of illnesses is likely higher than what has been reported to CDC. This Health Advisory provides background information about cyclosporiasis, current U.S. surveillance data, and recommendations for clinicians, laboratorians, and public health departments to support recognition, diagnosis, and reporting.

Background

[Cyclosporiasis](#) is a gastrointestinal illness caused by the microscopic parasite *Cyclospora*. People can become infected by consuming food or water contaminated with the parasite. This illness is not usually spread directly from person to person. Case counts typically rise during spring and summer months, and CDC considers May 1–August 31 the annual cyclosporiasis season. Previous outbreaks have been linked to consuming contaminated fresh produce.

[Symptoms](#) of cyclosporiasis typically begin about 1 week after exposure. Onset of symptoms can occur 2–14 days after being exposed. The most common symptoms include watery diarrhea, which can be frequent, along with loss of appetite, weight loss, bloating, nausea, and fatigue. Less common symptoms include low-grade fever and vomiting. Without treatment, symptoms can follow a remitting-relapsing course that can last from a few days to a month or longer. Illness can be severe, but is not usually life-threatening. Complications can include malabsorption, cholecystitis, and reactive arthritis. Laboratory detection of *Cyclospora* in stool can be challenging even in symptomatic patients, and standard ova and parasite exams might not detect it reliably. Clinicians should specifically request diagnostic testing for *Cyclospora* when it is clinically suspected.

Since May 1, 1,645 lab-confirmed cases were reported to CDC in people who acquired cyclosporiasis in the United States. Cases were reported by 34 states. Case-patients developed illness after eating food in the United States and did not report any travel during the previous 14 days. Case-patients ranged in age from 2–95 years, with a median age of 44 years, and 56% were female. Of 1,645 case-patients with information available, 141 (9%) were hospitalized. No deaths have been reported. This is substantially higher than the 249 cases reported nationally from May 1–July 16, 2025.

CDC is working closely with FDA and state health authorities to investigate multiple clusters of cyclosporiasis. CDC has posted an [investigation notice](#) about an outbreak with more than 400 cases in at least four U.S. states that appear to be epidemiologically linked, suggesting that there could be a common source of these infections.

Recommendations for Clinicians

- Consider cyclosporiasis in patients presenting with prolonged or relapsing watery diarrhea, particularly during the May–August cyclosporiasis season, even without a history of international travel.
- Ask patients with suspected or confirmed cyclosporiasis about their recent food and travel history to assist local investigations.
- Specifically request *Cyclospora* laboratory testing on stool specimens because routine ova and parasite (O&P) examinations might not reliably detect the parasite. Consider molecular (PCR-based) diagnostic testing where available, because it can improve detection.
- Treat confirmed cases of cyclosporiasis with 7-10 days of trimethoprim-sulfamethoxazole (TMP-SMX) for immunocompetent adults and children over age 2 months; consider longer courses for patients with immunocompromising conditions. Consult current [CDC clinical guidance for recommended dosing](#).
- Advise patients to stay well hydrated, especially if diarrhea is frequent or severe.
- Contact the Council for State and Territorial Epidemiologists (CSTE) [clinician line](#)  after hours for on call support if needed.

Recommendations for Disinfecting *Cyclospora* in Healthcare Settings

- Given the typical lifecycle of *Cyclospora*, person-to-person transmission is unlikely, even within healthcare settings. If an affected patient is continent of stool, the level of environmental contamination is probably small.
- *Cyclospora* is unlikely to be killed or inactivated by routine chemical disinfection. No EPA-registered disinfectant products have been demonstrated to be effective against *Cyclospora*. When affected patients are incontinent or diapered, the risk of contamination of healthcare surfaces might be higher. Facilities should clean surfaces initially with a detergent to remove any visible soil and scrub the surfaces thoroughly. After this cleaning, an EPA-registered hospital disinfectant should be used. Immediately after cleaning, healthcare personnel (HCP) should remove gloves used during cleaning and [clean their hands](#).
- HCP should always use [Standard Precautions](#), including wearing gloves when there might be direct contact with feces. A gown, facemask, and eye protection, or face shield should be used if splashing might occur. Hand hygiene should be performed before and after every patient contact. If hands are visibly soiled, HCP should wash them with soap and water, scrubbing vigorously for 15-20 seconds. If hands are not visibly soiled, alcohol-based hand sanitizer may be used. For patients with gastroenteritis who are diapered or incontinent of stool, HCP should use [Contact Precautions](#) when providing direct patient care in healthcare settings.

Recommendations for Laboratorians

- Check that stool testing protocols include specific diagnostic methods for *Cyclospora* detection (e.g., modified acid-fast staining or PCR), rather than relying solely on routine ova and parasite (O&P) exams.
- Promptly report confirmed *Cyclospora* results to the ordering clinician and to the state, tribal, local, or territorial health department per jurisdictional reporting requirements.

Recommendations for Health Departments

- Communicate with local clinicians and laboratories about this increase in cases and the importance of specific *Cyclospora* diagnostic testing.
- Promptly report confirmed cyclosporiasis cases to CDC to support national surveillance; cyclosporiasis is nationally notifiable in 47 states, the District of Columbia, and New York City.
- Interview patients with confirmed cases about recent food and travel exposures to help identify potential common sources.
- Coordinate with CDC and FDA on multistate cluster and traceback investigations as requested.

Recommendations for the Public

- Visit a clinician if you have prolonged or watery diarrhea, especially if it lasts more than a few days.
- Reduce your risk by thoroughly washing fresh produce under clean running water before eating and by following [safe food handling](#) practices. Be aware that chemically disinfecting or sanitizing produce might not fully eliminate *Cyclospora*. It is important to thoroughly wash produce even if it is labeled as pre-washed.

For More Information

- [Cyclosporiasis | CDC](#)

- [Surveillance of Cyclosporiasis | CDC](#)
- [Clinical Care of Cyclosporiasis | CDC](#)
- [Preventing Cyclosporiasis | CDC](#)
- [CSTE On call line](#) 

The Centers for Disease Control and Prevention (CDC) protects people’s health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national and international organizations.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES 

HAN message types

- **Health Alert:** Conveys the highest level of importance about a public health incident.
- **Health Advisory:** Provides important information about a public health incident.
- **Health Update:** Provides updated information about a public health incident.

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This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations.

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SOURCES

CONTENT SOURCE:

[Office of Emergency Risk Communication \(OERC\)](#)