

Increase in Cyclosporiasis Cases in Tennessee and Multiple U.S. States, 2026

Summary

The Tennessee Department of Health (TDH) and Centers for Disease Control and Prevention (CDC) are investigating substantial increases in domestically acquired cyclosporiasis cases. TDH has received reports of 44 confirmed cases of cyclosporiasis among Tennesseans, compared to 8 cases in TN the same time last year; we expect 2026 cases to continue to increase. Nationally, CDC is reporting 1,645 confirmed cases and is aware of over 5,000 cases that require further analysis. Of the Tennessee case-patients with available information, ages range from 11-86 years, with a median age of 52 years, and 66% were female. Three patients were hospitalized, and none have died. TDH, CDC, the U.S. Food and Drug Administration (FDA), and other state and local health departments are working together to investigate multistate outbreaks of *Cyclospora* infections and to identify the sources of illness.

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 unlikely to 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, such as lettuce, tomato, onion, fresh herbs (e.g. cilantro), and berries.

Symptoms

Symptoms of cyclosporiasis typically begin about 1 week after exposure; however 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.

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.
- Advise patients with suspected or confirmed cyclosporiasis that if their test results are positive for *Cyclospora* they will be contacted by public health professionals to be interviewed about their symptoms and food/water exposures. In the meantime, encourage them to start working on a food and activity record for the two weeks before illness onset.
- 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. **Note:** TDH's Division of Laboratory Services (DLS) cannot provide testing outside of ongoing outbreak investigations. Clinicians can order testing through commercial laboratories such as LabCorp, Quest, AEL, Pathgroup, and ARUP if they cannot do testing through their clinic.
- 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. No highly effective alternatives have been identified yet for persons who are allergic to (or are intolerant of) TMP-SMX. It is not recommended to begin treatment without a confirmed diagnosis.
- Advise patients to stay well hydrated, especially if diarrhea is frequent or severe.
- Contact staff at TDH for support at 615-741-7247.

Recommendations for Disinfecting *Cyclospora* in Healthcare Settings

- Person-to-person transmission of *Cyclospora* is unlikely, given the typical lifecycle of the parasite.
- *Cyclospora* is unlikely to be killed or inactivated by routine chemical disinfection and no EPA-registered disinfectant has been proven effective. When patients are incontinent or diapered, the risk of contaminating healthcare surfaces may increase. Facilities should first clean surfaces with a detergent to remove visible soil and scrub the surfaces. After cleaning, apply an EPA-registered hospital disinfectant. Immediately afterward, healthcare personnel (HCP) should remove gloves and perform hand hygiene.
- HCP should always use Standard Precautions, including wearing gloves when direct contact with feces is possible. Use a gown, facemask, and eye protection, or face shield if splashing might occur. Perform hand hygiene before and after every patient contact. If hands are visibly soiled, wash with soap and water, scrubbing vigorously for 15–20 seconds; if not visibly soiled, an alcohol-based hand sanitizer may be used. For patients with gastroenteritis who are diapered or incontinent, HCP should use Contact Precautions when providing direct care.

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 TDH per [disease reporting requirements](#).
- Forward confirmed specimens to the TDH Division of Laboratory (DLS) for genotyping. Submit requests through the [Laboratory Web Portal](#), selecting Parasitology as the test section and *Cyclospora* as the test. For DLS submission questions, please contact Dorothy Baynham at Dorothy.Baynham@tn.gov or 615-262-6393.

For more information:

- [CDC Health Alert published July 14, 2026](#)
- [National cyclospora surveillance](#)
- [Clinical care of cyclosporiasis](#)