Cyclosporiasis:

What Family Physicians Need to Know

- Symptoms resemble many common gastrointestinal illnesses (e.g., viral gastroenteritis, food poisoning, medication side effect, *C. diff* infection). Any patient with prolonged or relapsing *watery* diarrhea should prompt consideration of Cyclospora, especially during summer produce-associated outbreak season, even if initial testing is negative.
- Fresh produce remains a common source of exposure. Washing produce is a recommended food safety practice, but it cannot be relied upon to eliminate Cyclospora contamination.
- Specifically request Cyclospora laboratory testing on stool specimens because routine stool culture and ova and parasite (O&P) examinations do not reliably detect the parasite. Molecular (PCR-based) diagnostic testing or Cyclospora smear are usually needed for detection.
- Physicians should report cases to their local Health Department.

Consider Cyclospora in Patients with:

- Watery diarrhea lasting longer than >7 days
- Relapsing or intermittent symptoms after initial improvement
- Recent consumption of fresh produce, and/or other family members reporting illness after eating fresh produce (e.g, raspberries, lettuce).
- Negative initial stool studies
- Illness occurring during spring and summer outbreak season

Typical Incubation:

- Approximately 1 week after exposure
- Range: 2 to 14 days
- No reported human-to-human transmission. (Oocysts shed in the stool are not immediately infectious.)

Common Diagnostic Pitfalls:

Key Message: Routine stool culture or O&P testing may miss Cyclospora.

- Not all GI PCR panels detect Cyclospora.

- Physicians may need to specifically request Cyclospora testing, which can be expensive and may not be covered by insurance.
- Multiple stool specimens collected on different days may be needed; false reassurance from a single negative stool test is common.
- Testing is *not* performed on formed stool.

First-line Treatment: TMP-SMX remains the treatment of choice.

- Treat *confirmed* cases of cyclosporiasis with trimethoprim-sulfamethoxazole (TMP-SMX) for immunocompetent adults; consider longer courses (3-4 weeks) or higher frequency dosing (3-4 times daily) for patients with immunocompromising conditions.
- Standard adult dosing: TMP 160 mg/SMX 800 mg, orally twice daily, 7-10 days.
- Though TMP-SMX is considered the treatment of choice for pediatric patients over age 2 months, it is not currently FDA-approved. Dosing is weight-based.
- Treatment shortens course of symptoms, but Cyclospora infections can be self-resolving.

Additional Considerations: Illness may persist for weeks if untreated and symptoms may relapse.

Limited evidence suggests sulfa-allergic patients may use ciprofloxacin (500mg orally twice daily) or nitazoxanide (500mg orally twice daily, 3 days). If other options fail, pyrimethamine and folinic acid (used to treat cystoisosporiasis in sulfa-allergic patients) could be considered.

References

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