**Cyclospora cayetanensis** is an intestinal coccidian protozoon that has emerged as a significant human infectious agent worldwide, causing self-limiting gastroenteritis in immunocompetent hosts. Human-to-human spread of the parasite occurs indirectly via the environment through oocysts in contaminated water, food, or soil. The parasite has a cosmopolitan distribution and is endemic in tropical and subtropical areas (3). The parasite is commonly limited to travelers to Latin America, the Indian subcontinent, and Southeast Asia, including China (4); therefore, infection with *Cyclospora cayetanensis* is known as traveler’s diarrhea (5). *Cyclospora cayetanensis* is an important cause of waterborne and food-borne outbreaks due to imported fruits and vegetables from developing countries. The underreporting of infection with this parasite likely occurs because standard examinations for ova and parasites may not include the identification of *Cyclospora* oocysts. This oversight is at least partly due to the lack of awareness of this disease among the public and medical workers (1). The following criteria have been established for the diagnosis of cyclosporiasis (by the CDC in 1997): detection of oocysts in stool, intestinal fluid, or small bowel biopsy specimens by microscopic examination; demonstration of oocyst sporulation; and detection by molecular methods (not a routine parasitology screening tool) (2). *Cyclospora cayetanensis* oocysts are spherical and between 8.0 and 10 μm in diameter, with a 50-nm-thick wall and an outer threadlike coat, which is referred to as a wrinkle by some researchers (see Fig. 1a and b in the photo quiz). Diagnostic tests also include phase-contrast microscopy, modified acid-fast staining with variable staining (from pale to red) (see Fig. 1c and d in the photo quiz), and autofluorescence with UV illumination. Ova and parasite exams typically include only direct and concentrated microscopic exams and trichrome stains without modified acid-fast staining or autofluorescence testing. Multiple stool specimens collected on subsequent days are required because parasites are shed intermittently. Of note, two of our patient’s specimens were positive, and one was negative. The treatment for *Cyclospora* infection is a 7-day course of oral trimethoprim-sulfamethoxazole, which proved to be effective for our patient. Health care providers should evaluate *Cyclospora* infection in patients presenting long-lasting diarrheal illness and order the appropriate tests for this parasite.

### REFERENCES