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Ascariasis with Paralytic Ileus and Acute Gastroenteritis in a 2-Year-Old Child: A Case Report

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Abstract

Ascariasis, caused by Ascaris lumbricoides, is a common soil-transmitted helminth infection among children in developing countries. Severe infestation may cause gastrointestinal complications, including intestinal obstruction and ileus. This case report describes the clinical presentation, diagnostic findings, and management of a pediatric patient with ascariasis complicated by ileus, acute gastroenteritis, dehydration, and electrolyte imbalance.A 2-year-old girl presented with watery diarrhea for three days, vomiting, fever, decreased appetite, and a history of passing worms in her stool. Physical examination revealed a moderately ill appearance, a tympanic abdomen, and decreased bowel peristalsis. Laboratory findings showed eosinophilia, basophilia, hypokalemia at 3.2 mmol/L, and hypochloremia at 93.1 mmol/L. Stool examination revealed watery stool with mucus, 6–11 leukocytes per high-power field, and Ascaris lumbricoides eggs. Abdominal radiography demonstrated dilated small and large bowel loops with a herringbone pattern suggestive of ileus.The patient was diagnosed with ascariasis complicated by ileus, acute gastroenteritis, mild-to-moderate dehydration, and electrolyte imbalance. Management included intravenous rehydration, nasogastric decompression, ondansetron, albendazole 400 mg as a single dose, zinc supplementation, oral rehydration therapy, and empirical ceftriaxone. During hospitalization, gastrointestinal symptoms gradually improved, accompanied by continued passage of worms in the stool.This case emphasizes the importance of prompt diagnosis and comprehensive management of complicated pediatric ascariasis. Hygiene education, environmental sanitation, and regular deworming remain essential to prevent infection and reinfection in endemic areas.

Introduction

Ascariasis is a parasitic disease that remains a public health problem in many developing countries, particularly in tropical and subtropical regions with inadequate environmental sanitation. This disease is caused by infection with the nematode Ascaris lumbricoides, which is transmitted through soil contaminated with worm eggs. Although often considered a mild disease, ascariasis can lead to various serious complications if the number of infecting worms is high or if it is not properly managed. This infection is commonly found in children due to behaviors such as playing in the dirt, the habit of putting hands in the mouth, and low awareness

of personal and environmental hygiene (Corvino et al., 2026; Hawa & Muslam, 2024; Demir & Haşıloğlu, 2023; Andleeb et al., 2025; Kapur, 2023).

Globally, soil-transmitted helminth (STH) infections remain a significant public health burden. Children are the most vulnerable group to infection due to their immature immune systems and high exposure to contaminated environments (Singh et al., 2022; Lloyd & Saglani, 2023; Sun et al., 2023). In addition to causing direct health issues, STH infections also contribute to malnutrition, stunted growth and development, reduced learning ability, and diminished quality of life in children. Therefore, ascariasis is not merely viewed as a common infectious disease but also as a public health issue with long-term impacts on human capital.

Indonesia is among the countries with a still relatively high prevalence of STH infections. Tropical geographical conditions, high humidity, and limited access to adequate sanitation are factors that support the continuation of the parasite's life cycle (Narayani et al., 2024; Wulandari et al., 2025). Various studies in Indonesia indicate that A. lumbricoides infections are still found in various population groups, particularly children living in rural areas or environments with poor hygiene. An epidemiological study in Semarang indicates that STH infections remain a public health issue requiring special attention through sustained prevention and control efforts (Kurscheid et al., 2020; Trasia, 2023; Kusumasari et al., 2025; Adrizain et al., 2024).

Transmission of ascariasis occurs through the ingestion of infective eggs found in food, beverages, or hands contaminated with soil. After ingestion, the eggs hatch in the small intestine, and the resulting larvae migrate via the bloodstream to the lungs before returning to the digestive tract to develop into adult worms. This complex life cycle allows for a variety of clinical manifestations across various organs. Larval migration and the presence of large numbers of adult worms can cause inflammatory reactions and diverse organ dysfunction (Holland, 2021; Ananthakrishnan & Domachowske, 2025; Honcharov et al., 2022).

The clinical manifestations of ascariasis vary widely, ranging from asymptomatic cases to severe, life-threatening complications. In mild infections, patients often do not exhibit characteristic symptoms (Weinstock & Leung, 2022; Tunali & Korkmaz, 2023). However, in moderate to severe infections, symptoms may include abdominal pain, nausea, vomiting, diarrhea, loss of appetite, weight loss, and growth disturbances. In some cases, the presence of a large number of worms can cause intestinal obstruction, volvulus, perforation, and even complications in the hepatobiliary and pancreatic tracts (Syahruddin, 2025).

One significant impact of ascariasis in children is the occurrence of nutritional status disorders. Chronic infection can lead to reduced nutrient absorption, increased metabolic demands, and the loss of nutrients due to prolonged inflammatory processes (Roth-Walter et al., 2024; Palmer, 2022; Morales et al., 2023). Consequently, children infected with roundworms face a higher risk of malnutrition, growth retardation, and cognitive developmental disorders. The association between A. lumbricoides infection and undernutrition has been demonstrated through various studies showing an increased risk of nutritional disorders in infected children (Djohan et al., 2023; Fauziah et al., 2022; Loglo et al., 2024; Tapia-Veloz et al., 2025).

In addition to causing nutritional disorders, ascariasis can also lead to serious gastrointestinal complications. The accumulation of adult worms in the intestinal lumen can cause mechanical obstruction or impaired intestinal motility (Bąska & Norbury, 2022). This condition has the potential to progress to ileus, a condition in which normal bowel movement ceases, leading to abdominal distension, vomiting, abdominal pain, and elimination disorders. In young children, this complication can develop rapidly and increase the risk of dehydration and electrolyte imbalance if not treated promptly (Nadeem et al., 2024; Tsegaye et al., 2023; Hassan et al., 2022).

Paralytic ileus is a relatively rare complication but one with serious clinical consequences (Lu & Xu, 2025; Matsui et al., 2022). This condition is characterized by a decrease or cessation of intestinal peristaltic activity without the presence of a clear mechanical obstruction. In severe cases of ascariasis, local inflammation, metabolic disturbances, and the irritative effects of the worms' presence can contribute to the development of ileus. Symptoms include abdominal distension, repeated vomiting, decreased bowel sounds, and the inability to pass stool or gas (Dworsky & Chen, 2026; Williams, 2023).

Complications of ascariasis can be more severe when accompanied by acute gastroenteritis (AGE) (Siviero et al., 2024). Persistent diarrhea and vomiting can lead to significant fluid and electrolyte loss. In children, this condition can progress to dehydration and electrolyte imbalances that affect the function of various organs. Hypokalemia and hypochloremia are electrolyte disturbances commonly found in patients with significant gastrointestinal fluid loss and can worsen existing intestinal motility disorders.

The diagnosis of ascariasis is established through a combination of medical history, physical examination, and supportive tests. A history of worms being expelled via stool or vomit is a crucial clue in establishing the diagnosis. Stool examinations are frequently used to detect worm eggs, although a negative result does not always rule out the possibility of infection, particularly under certain conditions. Radiological examinations, such as plain abdominal X-rays, also play a crucial role in identifying complications such as obstruction or ileus that may result from severe infection (Collins et al., 2023; Gupta et al., 2023).

Management of ascariasis depends on the severity of the disease and associated complications. Anthelmintic therapy, such as albendazole, is the first-line treatment because it effectively kills adult worms and has a good safety profile in children (Farhan et al., 2025; Manavi et al., 2025). In addition to causal therapy, patients with gastrointestinal complications require supportive care, including fluid and electrolyte correction, gastrointestinal decompression, and close monitoring of clinical status. Various studies have shown that the use of albendazole yields a high success rate in the eradication of A. lumbricoides infection (Conterno et al., 2020).

Based on the above, ascariasis remains a relevant disease with the potential to cause serious complications in children, particularly in areas with poor sanitation. Cases of ascariasis accompanied by paralytic ileus, acute gastroenteritis, and electrolyte disturbances in a two-year-old child are relatively rarely reported but hold high educational value for healthcare professionals. Therefore, this case report was prepared to describe the clinical manifestations, diagnostic process, and comprehensive management of a pediatric patient with severe ascariasis complicated by paralytic ileus and acute gastroenteritis, thereby serving as a learning resource to enhance early detection and appropriate management.

Methods

This study used a descriptive case-report design to present the clinical manifestations, diagnostic process, management, and short-term outcome of a two-year-old girl with ascariasis complicated by paralytic ileus, acute gastroenteritis, dehydration, and electrolyte imbalance. Data were retrospectively obtained from hospital medical records covering examinations and treatment conducted from April 23 to May 1, 2026.

The reviewed data included demographic characteristics, birth and developmental history, immunization status, presenting symptoms, frequency of diarrhea and vomiting, history of worm passage, oral intake, urinary output, and previous treatment. Physical examination data included general condition, vital signs, hydration status, anthropometric measurements based on WHO growth standards, and abdominal findings.

Diagnostic evaluation comprised a complete blood count, macroscopic and microscopic stool examination, serum electrolyte analysis, and plain abdominal radiography. The diagnosis was

established by integrating the clinical history, physical examination, detection of *Ascaris lumbricoides* eggs, electrolyte abnormalities, and radiological evidence of ileus.

Management included intravenous rehydration, nasogastric decompression, oral rehydration solution, zinc, ondansetron, antipyretic and antimicrobial therapy, and single-dose albendazole. Clinical progress was monitored through changes in gastrointestinal symptoms, abdominal distension, appetite, fluid intake, worm expulsion, urinary output, vital signs, and general condition. Data were analyzed descriptively and presented chronologically. Patient confidentiality was maintained by excluding personally identifiable information.

Result and Discussion

The reported case involves a 2-year-old girl admitted to the hospital with the primary complaint of loose stools (diarrhea) that began three days prior to admission. The diarrhea occurred up to eight times per day and was accompanied by vomiting four times per day as well as fever. The patient's parents also reported a decreased appetite and that the child appeared fussy and lethargic. Nevertheless, the patient was still able to consume fluids orally, and no urinary dysfunction was observed. Key findings included the passage of worms in the stool and a history of prior medical care for similar symptoms approximately one week before admission.

Based on the results of the medical history, physical examination, laboratory tests, and radiological examinations, the patient was diagnosed with ascariasis complicated by paralytic ileus, acute gastroenteritis (AGE), mild-to-moderate dehydration, and electrolyte imbalances in the form of hypokalemia and hypochloremia. During the course of treatment, the patient received supportive and causal therapy, including intravenous rehydration, gastrointestinal decompression using a nasogastric tube (NGT), administration of antiemetics, antibiotics, zinc supplementation, oral rehydration solution, and anthelmintic therapy with albendazole. Patient characteristics, results of ancillary tests, and clinical course during treatment.

The patient is An. N, a 2-year-old girl admitted to the hospital on April 30, 2026. She is the first and only child in the family, with no history of miscarriage in the mother. The patient's father is 21 years old with a high school education, while the mother is 21 years old, a homemaker with a high school education. Based on the medical history, the patient presented with the primary complaint of loose stools (diarrhea) that began three days prior to hospital admission. Diarrhea occurred approximately eight times per day and was accompanied by fever and vomiting four times per day. The patient's parents also reported that the child appeared fussy, lethargic, and had a decreased appetite, although she was still able to drink well. Urination remained within normal limits. Significant history included the passage of worms in the stool and a history of hospitalization one week prior with similar complaints. No history of seizures, allergies, or contact with tuberculosis patients was found; however, there was a history of contact with smokers and incomplete immunization status.

The birth history indicates that the patient was born in a hospital with the assistance of a doctor, had a birth weight of 2.0 kg, and received early breastfeeding initiation (EBI). The patient's growth and development were assessed as age-appropriate, marked by the ability to observe hands, grasp objects, and roll over independently at 4 months of age, utter a single syllable and point to a single picture at 7 months of age, and the eruption of the first tooth at 12 months of age. Upon admission to the hospital, the patient's general condition appeared moderately ill with a clear level of consciousness (GCS 15). Vital sign measurements showed blood pressure of 95/51 mmHg, a pulse rate of 126 beats per minute, a respiratory rate of 22 breaths per minute, a body temperature of 36.8°C, and oxygen saturation of 99% on room air. Anthropometric measurements showed a weight of 10 kg, height of 85 cm, head circumference of 45 cm, abdominal circumference of 54 cm, chest circumference of 53 cm, and upper arm circumference of 14 cm. Based on the WHO growth charts, the patient's nutritional status is

classified as good, with weight-for-age at the -2 SD limit, height-for-age in the normal category, and weight-for-height also within the normal range.

Figure 1. Weight-for-Age (WFA) Growth Curve for Girls Aged 0–5 Years According to WHO Standards

Figure 2. Length/Height-for-Age (LFA or HFA) Growth Curve for Girls Aged 0–5 Years According to WHO Standards

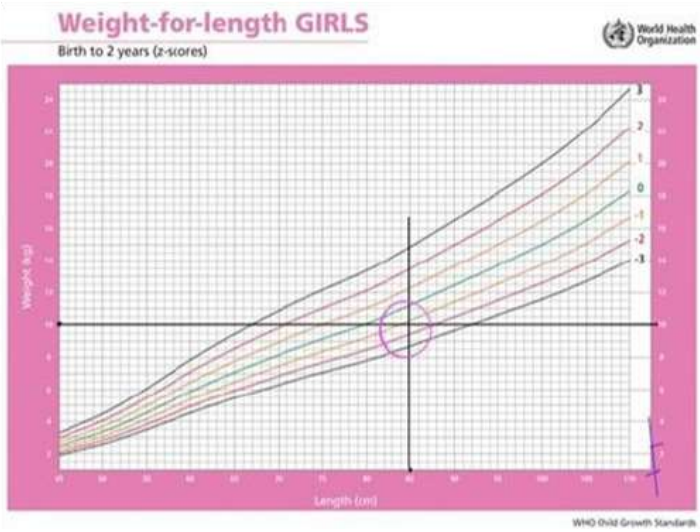

Figure 3. Weight-for-Length (WFL) Curves for Girls Aged 0–2 Years According to WHO Standards

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On physical examination, the head and neck were within normal limits. Eye examination showed no anemia of the conjunctiva and no icterus of the sclera. No stomatitis or dry lips were found in the oral cavity, while the tongue appeared clean with no coating. Examination of the pharynx and tonsils showed no signs of hyperemia, with tonsil size T1-T1. No nasal flaring or enlarged lymph nodes in the neck were found. Thoracic examination showed a normochest chest shape and symmetry between the left and right sides. Lung examination revealed symmetrical chest wall movement without retraction, equal tactile fremitus on both sides, sonorous percussion in both lung fields, and auscultation showed normal vesicular breath sounds without rales or wheezing.

Cardiac examination revealed no visible ictus cordis and no palpable thrill. Percussion indicated normal cardiac borders, while auscultation revealed regular S1 and S2 heart sounds without murmurs. On abdominal examination, the abdominal wall appeared flat and moved with respiration. Auscultation revealed bowel sounds were still audible but with decreased peristalsis. Abdominal percussion produced tympanic sounds, while palpation revealed no tenderness, and the liver and spleen ( ) were not palpable. Lymph node examination showed no lymphadenopathy. Additionally, examination of the extremities revealed warm extremities with a capillary refill time (CRT) of less than two seconds, indicating that peripheral perfusion remains good.

Laboratory Tests

Routine hematology tests were performed on April 23, 2026, to assess the patient's general condition and detect any signs of infection or accompanying hematological disorders. The results showed a white blood cell count of 13.0 × 10^3/µL with a predominance of neutrophils (66.4%), indicating an inflammatory response or infection. Additionally, elevated levels of monocytes (8.7%) and basophils (3.7%) were found, exceeding reference values. The platelet count was also elevated to 417 × 10^3/µL (mild thrombocytosis). Regarding erythrocyte parameters, the MCV was 73.9 fL and the MCH was 23.5 pg, both below the reference range, suggesting a trend toward microcytic hypochromic erythrocytes. Meanwhile, hemoglobin levels, hematocrit, and red blood cell count remained within normal limits.

Table 1. Laboratory Tests (04/23/2026) - Routine Blood

Routine Blood Test	Result	Reference Range
WBC	13.0	5.0–19.0
Neutrophils	66.4%	20.0–45.0
Lymphocytes	19.5%	46.0–76.0
Monocytes	8.7%	0.0–5.0
Eosinophils	1.7%	0.0–5.0
Basophils	3.7%	0.0–1.5
RBC	5.32	3.90–5.30
HGB	12.5 g/dL	9.5–14.1
HCT	39.3%	30.0–40.0
MCV	73.9 fL	70.0–84.0
MCH	23.5 pg	28.0–32.0
MCHC	31.8 g/dL	31.0–35.0
RDW-CV	12.7%	11.6–14.0
RDW-SD	37.5 fL	39.0–46.0
PLT	417	150–400
PCT	0.2%	0.16–0.33
MPV	5.7 fL	8.0–15.0
PDW	17.6%	15.0–17.0

Laboratory Tests - Stool Analysis (April 24, 2026)

Table 2. Laboratory Test Results: Stool Analysis

Test	Result	Unit	Reference Range
Fecal Analysis			
Macroscopic			
Color	Yellow		Yellow
Consistency	Thin		Soft
Mucus	Positive		Negative
Blood	Negative		Negative
Microscopic			
White blood cells	6–11		Negative
Red blood cells	1–3		Negative
Worm eggs	Ascaris L +		Not Found

Color: Yellow

Consistency: Watery

Mucus: Positive

Blood: Negative

White blood cells: 6–11

Red blood cells: 1–3

Worm eggs: None found

Laboratory Tests - Electrolytes (04/29/2026)

Sodium: 135.5 mmol/L (136–145)

Potassium: 3.2 mmol/L (3.5–5.1)

Chloride: 93.1 mmol/L (94–110)

Radiology Examination (04/28/2026)

Results: Intestinal gas is distributed to the distal colon; dilation of the small bowel *loops* and colon with a *herringbone* pattern is observed. Both the psoas lines and the preperitoneal fat lines are intact. The bones are intact.

Impression: Signs of ileus

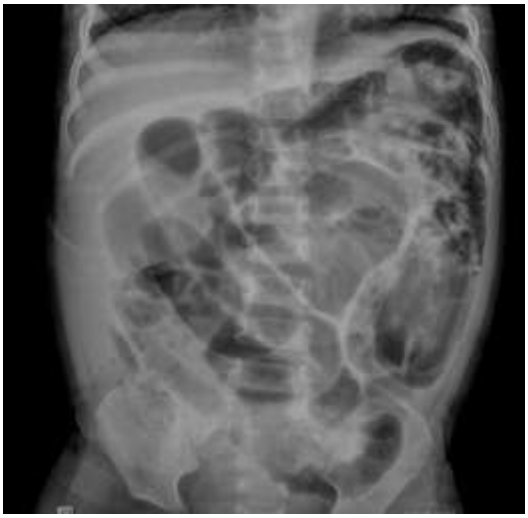

Figure 4. Radiological Examination

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***Assessment* (Diagnosis)**

Ascariasis with complications of paralytic ileus

Acute gastroenteritis (AGE)

Mild to moderate dehydration

Electrolyte imbalance (hypokalemia, hypochloremia)

Instructions / Management

IVFD at 16 drops per minute

NGT decompression

Ondansetron 1 mg IV

Albendazole ½ tablet (400 mg *single dose*)

Zinc Syrup 1x1

Paracetamol 70 mg IV

Ceftriaxone 1 g every 24 hours IV

Oral rehydration solution 1x1

Follow-up

Table 3. Follow-Up Examinations

Date	Subjective	Objective	Assessment	Planning
04/30/2026	Abdominal pain is present; the abdomen appears distended and there is a mass in umbilical region. No fever. The child appears lethargic. Appetite is decreased, but the child is willing to drink. Two bowel movements worms twice. Urination is normal.	General condition: Moderate pain, GCS 15. BP: 98/60 mmHg, HR: 81 bpm, Res: 23 bpm, Temp: 37.3°C, SpO_2: 100% on room air.	GEA + dehydration mild to moderate	• IVFD RL 28 drops per minute• Ciprofloxacin 0.2 mg every 12 hours IV• Ranitidine amp/12 hours• Ondansetron 4 mg every 8 hours• Ketorolac amp/12 hours• Molagit 1 tablet for each loose bowel movement• Zinc 1 tablet• N-Acetylcysteine 200 mg 3 times daily• Albendazole 400 mg single dose
05/01/2026	No abdominal pain, abdomen appears bloated. No fever. The child appears lethargic. Appetite is good; the child is willing to drink. Worms were passed twice.	General Condition: Moderate pain, GCS 15. BP: 84/50 mmHg, HR: 91 bpm, Res: 23 bpm, Temp: 36.2°C, SpO_2:	GEA + mild-to-moderate mild-to-moderate	• IVFD at 16 bpm• Ondansetron 1 mg IV• Zinc syrup 1x1• Paracetamol 70 mg IV• Ceftriaxone 1 g every 24 hours IV• Oral rehydration solution 1x1

	Urination is normal.	100% on room air.		

Based on the results of the medical history, physical examination, laboratory tests, and radiological examinations, the patient was diagnosed with ascariasis complicated by paralytic ileus, acute gastroenteritis (AGE), mild-to-moderate dehydration, and electrolyte imbalances in the form of hypokalemia and hypochloremia. The patient then received comprehensive therapy, which included intravenous rehydration using Asering solution, gastrointestinal decompression via nasogastric tube (NGT) placement, administration of antiemetics, antibiotics, zinc supplementation, oral rehydration solution, and a single-dose course of albendazole. During the course of treatment, the patient was also monitored periodically to assess clinical progress and response to the administered therapy.

Monitoring results showed a gradual improvement in clinical condition. Complaints of abdominal pain decreased, appetite improved, and vital signs remained stable. The patient continued to pass worms in the stool during the observation period, indicating a response to the antihelminthic therapy. Overall, the patient's clinical progress demonstrated a good response to the provided management; therefore, the patient's prognosis is considered favorable, though continued education regarding personal hygiene, environmental sanitation, and adherence to a regular deworming program remains necessary to prevent reinfection.

This case demonstrates that pediatric ascariasis may produce overlapping functional ileus, acute gastroenteritis, dehydration, and electrolyte disturbances rather than complete mechanical obstruction. The presence of decreased bowel sounds, diffuse bowel dilatation, continued stool passage, absence of peritoneal signs, and improvement without surgery support a predominantly functional or partial obstructive process. Heavy Ascaris lumbricoides infestation can impair intestinal transit through worm aggregation, localized inflammation, and neuroimmune-mediated dysmotility (G/Kidan et al., 2024; Siviero et al., 2024).

Recent pediatric reports describe more severe presentations requiring laparotomy, enterotomy, ileostomy, or bowel resection. Turyasiima et al. (2021), Elmi et al. (2022), Sulmiati et al. (2023), Ali et al. (2023), Supangat et al. (2025), and Barrera Sánchez et al. (2025) reported complete obstruction, worm bolus formation, appendicitis, bowel ischemia, or failure of conservative management. In contrast, the present patient remained hemodynamically stable, had no guarding or rebound tenderness, and improved following decompression, rehydration, and anthelmintic therapy. These differences indicate that surgery should be reserved for complete obstruction, peritonitis, ischemia, perforation, or clinical deterioration. Nevertheless, close monitoring remains essential because ileal perforation and necrosis can develop rapidly, particularly in young children (Molla et al., 2023).

The diagnosis was strengthened by the history of worm passage, detection of Ascaris eggs, and radiographic evidence of ileus. Stool microscopy confirms infection but may be negative in immature, single-sex, or intermittently egg-producing infections. Imaging therefore remains important when complications are suspected. Plain radiography identifies bowel dilatation, whereas ultrasonography can directly visualize worms and assess obstruction, intussusception, bowel viability, and hepatobiliary migration (Elmi et al., 2022; Siviero et al., 2024). Ultrasonography could therefore be considered when clinical and radiographic findings do not clearly distinguish paralytic from mechanical obstruction.

Acute gastroenteritis probably aggravated the intestinal dysfunction through repeated fluid and electrolyte loss. Diarrhea and vomiting can produce hypokalemia and hypochloremia, while potassium depletion further reduces gastrointestinal smooth-muscle activity. Yang et al. (2023) found that hypokalemia was associated with delayed intestinal recovery, supporting a bidirectional relationship between electrolyte depletion and dysmotility. Therefore, fluid and potassium correction in this patient represented an essential component of ileus management,

not merely supportive care. Pediatric gastroenteritis evidence also supports oral rehydration whenever tolerated and intravenous fluids when vomiting, dehydration, or impaired intestinal function limits enteral therapy (Leung & Hon, 2021; Poonai et al., 2021).

Ondansetron was appropriate because reducing vomiting can improve oral rehydration success and limit further electrolyte losses. Bonvanie et al. (2021) demonstrated that a single ondansetron dose significantly reduced persistent vomiting in young children, while Poonai et al. (2021) reported lower rates of intravenous rehydration and hospitalization when ondansetron was followed by oral rehydration. However, antiemetic therapy should not delay reassessment when abdominal distension, bilious vomiting, tenderness, or bowel dysfunction persists.

The use of albendazole was supported by the subsequent expulsion of worms and clinical improvement. Conservative management with nasogastric decompression, fluid correction, and delayed or carefully monitored anthelmintic administration is appropriate in stable patients without peritonitis. Conversely, recent operative cases show that anthelmintics alone are insufficient when a fixed worm bolus, ischemia, or complete obstruction is present (Ali et al., 2023; Supangat et al., 2025). Antibiotic therapy should be evaluated separately because fecal leukocytes and mucus do not independently confirm bacterial gastroenteritis. Diaz et al. (2024) emphasized that antibiotics should be reserved for suspected invasive bacterial infection, dysentery, sepsis, or confirmed bacterial pathogens.

Although the patient's current nutritional status was generally preserved, ascariasis may have cumulative nutritional consequences if reinfection occurs. Fauziah et al. (2022) found a significant association between intestinal parasitic infection and childhood stunting, while Stracke et al. (2021) demonstrated that soil-transmitted helminths may alter the intestinal microbiome. Follow-up should therefore include growth monitoring, nutritional assessment, and evaluation of possible iron deficiency. Long-term prevention requires more than anthelmintic treatment. Regular deworming, safe disposal of feces, handwashing, clean food and water, and improved sanitation are required because absence of recent deworming and unsafe fecal disposal substantially increase infection risk (Kasiita et al., 2025).

Conclusion

Ascariasis in children remains a health issue that can lead to various serious complications if not properly managed. In this case, a 2-year-old girl was diagnosed with ascariasis complicated by paralytic ileus, acute gastroenteritis, mild-to-moderate dehydration, and electrolyte imbalances including hypokalemia and hypochloremia. The diagnosis was established based on medical history, physical examination, laboratory tests, and radiological findings indicating ileus. Management, which included rehydration, correction of electrolyte imbalances, gastrointestinal decompression, supportive care, and anthelmintic therapy, resulted in a good clinical response, demonstrating that prompt and comprehensive management plays a crucial role in preventing the patient's condition from worsening.

Based on the findings of this case, healthcare workers need to increase their vigilance regarding the possibility of ascariasis complications in children, especially in patients with a history of worms passing through the stool and severe gastrointestinal complaints. In addition, prevention efforts need to be continuously improved through education on clean and healthy living behaviors, such as washing hands with soap, maintaining food and beverage hygiene, and improving environmental sanitation. A program for the periodic administration of deworming medication to children also needs to be implemented consistently to break the chain of transmission, reduce the incidence of ascariasis, and prevent complications that can interfere with children's growth and development.

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