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Conservative Management of a Giant 27-cm Myoma in Pregnancy: A Case Report and Review of the Literature

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A B S T R A C T

The coexistence of pregnancy and uterine leiomyomas is common, but the presence of a giant myoma (>10 cm) presents profound diagnostic and therapeutic challenges. These cases carry significant risks of maternal and fetal morbidity, including compressive symptoms, preterm labor, and malpresentation. Management strategies are contentious, often balancing the high risks of antenatal myomectomy against the uncertainties of conservative observation. We present the case of a 24-year-old primigravida at 25 weeks of gestation with a giant, partially degenerated uterine leiomyoma measuring 26.9 x 18.7 x 24.7 cm. The patient presented with significant abdominal distension, pain, and imaging findings of moderate right-sided hydroureteronephrosis. The sheer size of the mass displaced the uterus and induced a stable transverse lie of the fetus. Despite the considerable risks and the suggestion of potential malignant degeneration on initial MRI, which was later considered less likely, the patient, after extensive multidisciplinary counseling, opted for conservative management with the goal of reaching fetal viability. The pregnancy was closely monitored with serial ultrasonography and clinical evaluation. In conclusion, this case demonstrates that expectant management, even in the face of a giant, symptomatic uterine myoma causing significant anatomical distortion and organ compression, can be a viable strategy. Through meticulous multidisciplinary surveillance and patient-centered decision-making, a successful neonatal outcome was achieved. This report underscores the importance of individualized care plans and highlights the potential for conservative management to succeed in extraordinary clinical scenarios.

1. Introduction

Uterine leiomyomas, or fibroids, are the most common benign tumors of the female reproductive tract, affecting a significant proportion of women of reproductive age.[1] While their prevalence during pregnancy is estimated to be between 2% and 11%, the clinical course is highly variable and often asymptomatic. However, when these benign tumors reach giant proportions—variably defined but generally accepted as exceeding 10-11 cm in diameter or 800 grams in weight—they transform from incidental findings into formidable clinical challenges that can profoundly impact maternal and fetal well-being.

The physiological milieu of pregnancy, characterized by soaring levels of estrogen, progesterone, and other growth factors, creates a complex and often unpredictable environment for myoma growth.[2] While some myomas remain stable or even shrink, a subset, particularly in the first and second trimesters, can undergo rapid enlargement, outstripping their blood supply and leading to ischemic conditions such as red (carneous) degeneration, a source of intense maternal pain. Beyond pain, giant myomas can exert a significant mass effect, leading to a catalogue of obstetric complications.[3] These include an increased risk of miscarriage, premature labor and delivery, placental abruption, fetal growth restriction, and fetal

malpresentation. Furthermore, their sheer bulk can cause severe maternal compressive symptoms, such as hydronephrosis from ureteral compression, bowel obstruction, and deep vein thrombosis from vascular compression.[4]

The management of giant myomas in pregnancy is one of the most debated topics in modern obstetrics.[5] The default approach is conservative, or expectant, management, involving close surveillance, symptomatic relief, and timely intervention for obstetric indications.[6] However, this path is fraught with uncertainty, requiring constant vigilance for the development of life-threatening complications. The alternative, antenatal myomectomy, is a high-risk surgical intervention that is rarely performed due to the substantial risks of catastrophic hemorrhage, uterine atony, pregnancy loss, and the potential need for hysterectomy.[7] The procedure is typically reserved for a narrow set of indications, such as intractable pain from a torsed pedunculated myoma or severe, worsening compressive symptoms unresponsive to conservative measures.[8]

This case report presents a particularly remarkable clinical scenario: a young, 24-year-old primigravida at 25 weeks of gestation with a giant uterine leiomyoma measuring nearly 27 cm in its largest diameter.[9] This mass was not only symptomatic, causing pain and significant abdominal distension, but also resulted in moderate hydroureteronephrosis and a stable transverse fetal lie.[10] The novelty and aim of this report are threefold: first, to detail the successful application of a patient-centered, conservative management strategy in an extreme case where surgical intervention might have been considered; second, to highlight the critical role of advanced, multimodal imaging (ultrasound and MRI) in diagnosing the myoma, assessing its impact, and guiding clinical decisions; and third, to provide a comprehensive review of the pathophysiology, risks, and management dilemmas associated with such a rare and challenging clinical presentation, thereby offering valuable insights for clinicians navigating similar cases.

2. Case Presentation

A 24-year-old G1P0A0 woman of Indonesian ethnicity, with a confirmed gestational age of 25 weeks and 0 days based on a first-trimester ultrasound, presented to the emergency department of Wangaya Regional General Hospital. Her chief complaints were progressively worsening lower abdominal pain over the preceding week and a noticeable abdominal enlargement that seemed disproportionate to her stage of pregnancy for the past three months. The pain was described as a constant, dull ache with intermittent sharp, stabbing episodes, localized primarily to the right lower and mid-abdomen, with a visual analog scale score of 6/10. She also reported nausea and a significant, unintentional weight loss of 12 kg over the last three months, which she had attributed to decreased appetite. She denied any fever, vomiting, changes in bowel habits, or vaginal bleeding. Fetal movements were first perceived one month prior and were reported as regular (Table 1). The patient's past medical and surgical history was unremarkable. She had no known chronic illnesses such as hypertension or diabetes. Her menstrual cycles had always been regular (28-day intervals, 5 days of flow) with no history of menorrhagia or dysmenorrhea. She had no prior use of contraception. This was her first pregnancy, which was conceived spontaneously.

During her first trimester, at approximately 10 weeks of gestation, a routine ultrasound had identified a uterine mass, and she was advised to seek specialist follow-up at a tertiary care center. However, due to personal reasons, she did not pursue this recommendation until the onset of her current symptoms. There was no known family history of uterine fibroids or other gynecological malignancies. On physical examination, the patient was alert and oriented but appeared to be in moderate distress due to pain. Her vital signs were stable: blood pressure 110/70 mmHg, heart rate 88 beats per minute, respiratory rate 18 breaths per minute, and temperature 37.1°C. Her body mass index (BMI) was 21.5 kg/m². Cardiovascular and respiratory examinations were normal.

Table 1. Clinical summary of findings on admission.

A comprehensive overview of the patient's condition upon presentation to the emergency department.

PARAMETER	FINDING / VALUE
Patient Demographics	
Age	24 years
Obstetric History	G1P0A0 (Primigravida)
Gestational Age	25 weeks + 0 days
Clinical Presentation	
Chief Complaints	• Progressively worsening lower abdominal pain (VAS 6/10) • Abdominal enlargement disproportionate to gestational age • Nausea and significant unintentional weight loss (12 kg)
Vital Signs	BP: 110/70 mmHg, HR: 88 bpm, RR: 18/min, Temp: 37.1°C
Abdominal Examination	• Fundal Height: 30 cm (size-date discrepancy) • Palpable Mass: Approx. 20×20 cm, firm, solid, smooth surface • Fetal Heart Rate: 145 bpm (via Doppler)
Laboratory Findings	
Hematology	Hb: 10.4 g/dL (Mild Anemia), Platelets: 424,000/µL (Thrombocytosis)
Renal Function	BUN: 12 mg/dL, Creatinine: 0.8 mg/dL (Normal)
Tumor Marker	CA-125: 18 U/mL (Normal)
Imaging Findings	
Obstetric Ultrasound	• Singleton live fetus, 25w0d, EFW: 760g • Fetal Lie: Stable Transverse • Placenta: Posterior, normal amniotic fluid • Mass: Heterogeneous, solid, 22×14 cm, anterior subserosal
Magnetic Resonance Imaging (MRI)	• Mass Size: 26.9 × 18.7 × 24.7 cm • Characteristics: Leiomyoma with extensive cystic/hemorrhagic degeneration • Uterine Displacement: Superolateral to the left • Compression: Moderate right hydroureteronephrosis

The abdominal examination was striking. The abdomen was markedly distended, with a fundal height of 30 cm, corresponding to approximately 30-31 weeks of gestation, a significant size-date discrepancy. On palpation, a large, firm, and solid mass was identified, occupying the majority of the right and central aspects of the lower and mid-abdomen. The mass measured approximately 20 x 20 cm by palpation, with a smooth surface and well-defined borders. It had limited mobility and appeared to arise from the pelvis. The fetal pole could not be clearly delineated, and the fetal lie was difficult to

assess clinically. The fetal heart rate was auscultated with a handheld Doppler at 145 beats per minute.

Initial laboratory tests revealed mild normocytic, normochromic anemia (Hemoglobin: 10.4 g/dL, Hematocrit: 31%). Her white blood cell count was within the normal range at 8,500/µL, but thrombocytosis was noted (Platelet count: 424,000/µL), potentially indicative of an inflammatory state. Renal function tests (BUN: 12 mg/dL, Creatinine: 0.8 mg/dL) and liver function tests were normal. The tumor marker Cancer Antigen 125 (CA-125) was ordered to help differentiate from a malignant ovarian process, and the result was 18 U/mL (Normal range: <35 U/mL), which was reassuring, although CA-125 can be an unreliable marker during pregnancy.

An urgent obstetric ultrasound was performed (Figure 1). It confirmed a single, live intrauterine pregnancy at 25 weeks and 0 days of gestation. Fetal biometry was consistent with dates: Biparietal Diameter (BPD) 6.25 cm (25w3d), Head Circumference (HC) 22.30 cm (24w3d), Abdominal Circumference (AC) 20.42 cm (25w1d), and Femur Length (FL) 4.47 cm (24w6d). The estimated fetal weight was 760 grams. The fetus was in a stable transverse lie, with the head in the maternal left flank and the breech in the right flank. The placenta was located on the posterior uterine wall, away from the cervix, and amniotic fluid volume was normal.

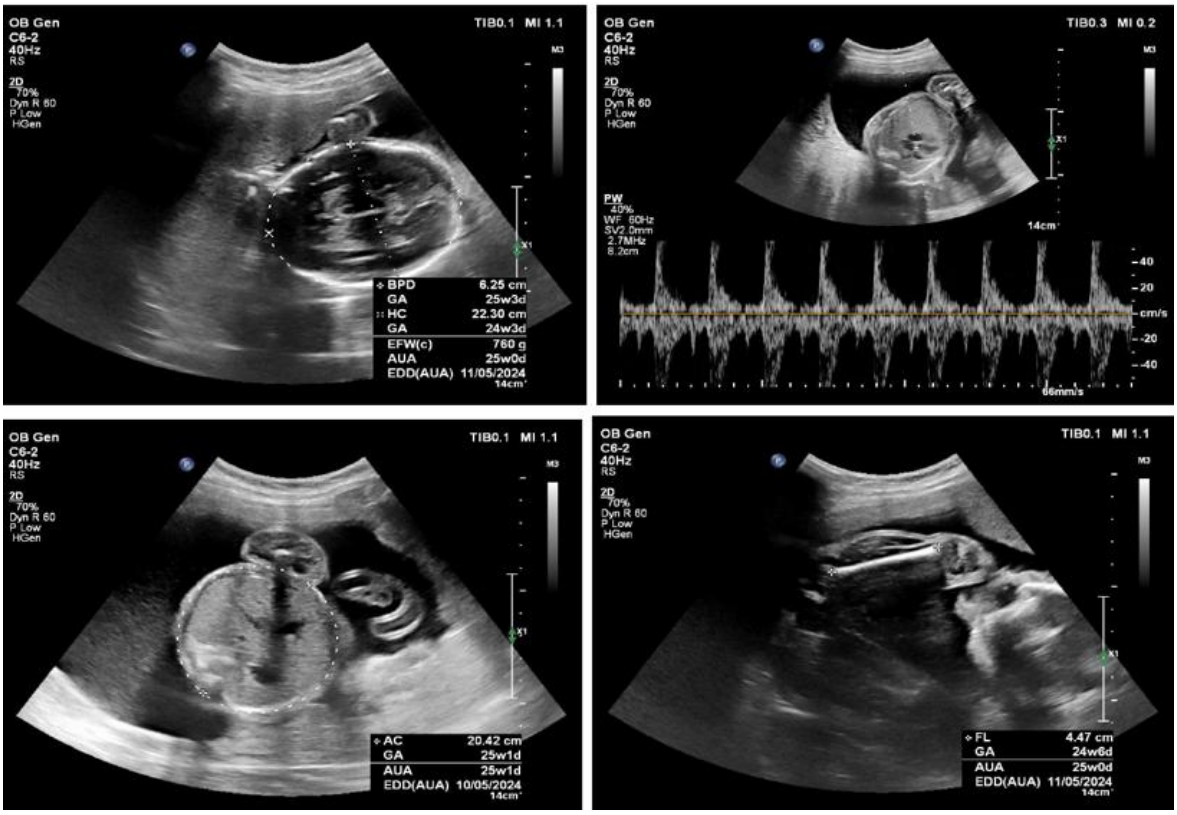

Figure 1. Ultrasound result showed a fetal image.

The ultrasound also visualized a massive, heterogeneous, predominantly solid mass measuring approximately 22 x 14 cm (Figure 2). The mass appeared to originate from the anterior subserosal aspect of the lower uterine segment and extended superiorly, displacing the gravid uterus posteriorly and to the left. Color Doppler imaging revealed peripheral vascularity consistent with a uterine leiomyoma.

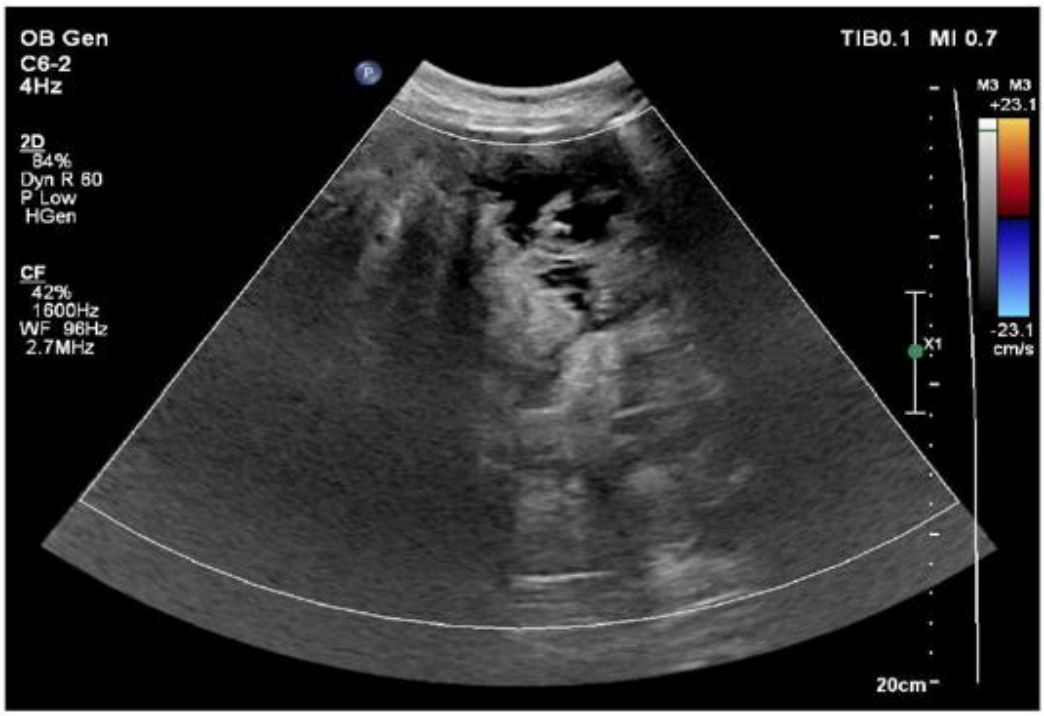

Figure 2. Ultrasound result showed the presence of a solid mass.

To better characterize the mass, delineate its relationship with surrounding structures, and assess for potential malignancy, a non-contrast Magnetic Resonance Imaging (MRI) of the abdomen and pelvis was performed. The MRI provided exquisite anatomical detail (Figure 3), confirming a well-defined, oval-shaped mass measuring 26.9 x 18.7 x 24.7 cm. The mass demonstrated features characteristic of a leiomyoma with extensive cystic and hemorrhagic (red) degeneration. It appeared isointense on T1-weighted images and heterogeneously hypointense on T2-weighted images, with large internal areas of high T2 signal intensity representing cystic change. Crucially, the MRI confirmed that the mass was compressing the right mid-ureter against the pelvic brim, causing moderate proximal dilatation of the ureter and renal pelvis (hydroureteronephrosis). The gravid uterus was displaced superolaterally to the left. The mass received its primary blood supply from hypertrophied branches of the uterine artery. There was no evidence of lymphadenopathy or peritoneal disease. While the initial radiology report mentioned the possibility of malignant degeneration (leiomyosarcoma) due to its size and degenerative changes, the lack of invasive features, normal CA-125, and overall characteristics on MRI made a benign leiomyoma the overwhelmingly likely diagnosis.

The patient was admitted to the high-risk obstetrics unit. The initial diagnosis was G1P0A0 at 25 weeks 0 days gestation with a giant, symptomatic uterine leiomyoma, complicated by moderate right hydroureteronephrosis, mild anemia, and a stable transverse fetal lie. A multidisciplinary team meeting was convened, including maternal-fetal medicine specialists, gynecologic oncologists, urologists, and neonatologists, to discuss the management plan (Table 2). The team reviewed the significant risks associated with continuing the pregnancy, including preterm labor, placental abruption, worsening renal compromise, and potential for emergency surgery. The high-risk nature of an antenatal myomectomy was also thoroughly discussed, emphasizing the risks of uncontrollable hemorrhage and pregnancy loss.

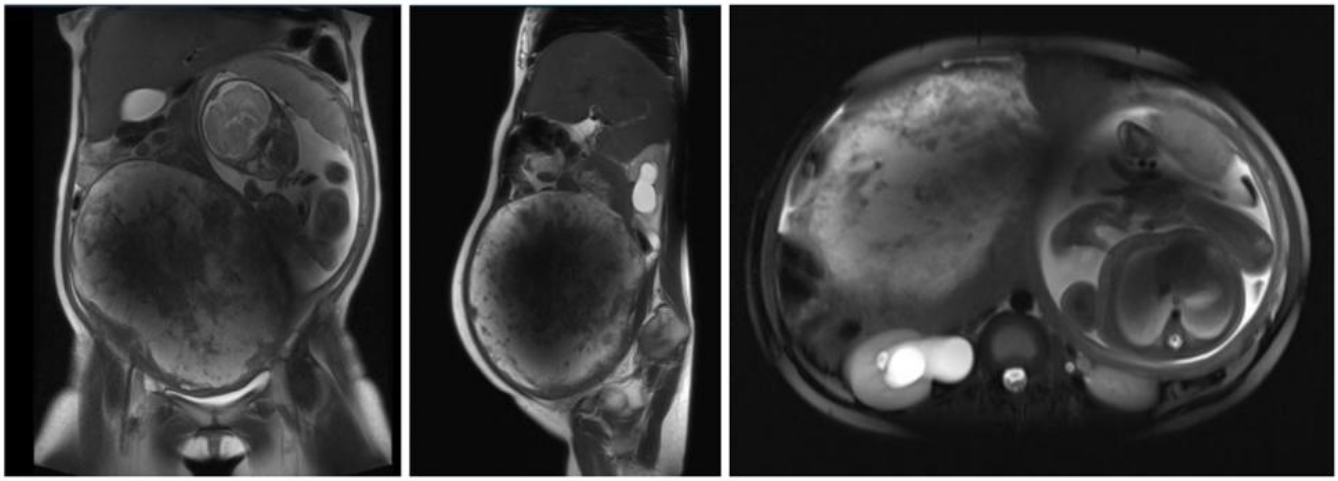

Figure 3. MRI result.

Following extensive counseling where the severity of her condition and the uncertain prognosis were candidly discussed, the patient and her family expressed a strong and unwavering desire to continue the pregnancy, explicitly wishing to avoid any surgical intervention that might jeopardize the fetus. In alignment with this patient-centered decision, a comprehensive conservative management plan was formulated with her full consent. This multifaceted strategy prioritized intensive maternal and fetal surveillance, which included daily fetal kick counts, twice-weekly non-stress tests, and serial ultrasounds every two to three weeks to meticulously monitor fetal growth, amniotic fluid volume, and myoma size. Concurrently, maternal symptomatic control was addressed with regular acetaminophen for pain management, deliberately avoiding opioids to prevent fetal sedation. Proactively anticipating the significant risk of preterm delivery, a course of intramuscular dexamethasone was administered as antenatal corticosteroids to promote fetal lung maturity. Furthermore, the patient's mild anemia was corrected with oral ferrous sulfate. Finally, addressing the compressive uropathy, the plan incorporated vigilant renal monitoring of function and symptoms, with the urology team deferring ureteral stenting unless clinically warranted to avoid the immediate risks associated with the procedure.

The patient remained hospitalized for one week for initial stabilization and monitoring, after which she was discharged with a plan for frequent outpatient follow-up. Her pain gradually subsided to a manageable level. Serial ultrasounds showed appropriate interval fetal growth, and the myoma size remained relatively stable throughout the remainder of the pregnancy. The right hydronephrosis did not progress. The fetal lie remained transverse due to the persistent mass effect of the myoma, making a vaginal delivery impossible.

At 36 weeks and 4 days of gestation, the patient presented with regular uterine contractions. Given the fetal maturity, the stable transverse lie, and the obstruction of the birth canal by the giant myoma, the decision was made to proceed with a planned Cesarean delivery. A classical (vertical) uterine incision was performed to safely access the uterine cavity, avoiding the large anterior myoma. A healthy male infant was delivered with Apgar scores of 8 and 9 at 1 and 5 minutes, respectively, and a birth weight of 2,850 grams.

During the Cesarean section, the giant subserosal myoma was visualized, confirming the MRI findings. It was located in the anterior lower uterine segment, was highly vascular, and distorted the uterine anatomy significantly. A Cesarean myomectomy was deemed too high-risk due to the potential for massive

hemorrhage and was not performed. The uterine incision was closed, and hemostasis was secured. The estimated blood loss was 800 mL. The postoperative course was uneventful. Both mother and infant were discharged in good condition on the fourth postoperative day. The patient was counseled on the need for future myomectomy prior to subsequent pregnancies.

Table 2. Therapeutic intervention and management.

A detailed summary of the multidisciplinary management plan and patient outcomes.

COMPONENT OF CARE	ACTION / INTERVENTION	RATIONALE / OUTCOME
Initial Diagnosis & Counseling		
Admission Diagnosis	G1P0A0 @ 25w0d with giant symptomatic uterine leiomyoma, moderate right hydronephrosis, mild anemia, and stable transverse fetal lie.	To establish a comprehensive understanding of the complex clinical picture for targeted management.
Multidisciplinary Team	Consultation with Maternal-Fetal Medicine, Gynecologic Oncology, Urology, and Neonatology.	To formulate a holistic management plan by weighing risks/benefits from all relevant specialties.
Patient Counseling	Extensive discussion of risks (preterm labor, renal compromise, surgery) and benefits of conservative vs. surgical (antenatal myomectomy) approaches.	To ensure informed consent and shared decision-making. The patient expressed a strong desire to continue the pregnancy conservatively.
Conservative Management Plan		
Maternal/Fetal Surveillance	• Daily fetal kick counts • Twice-weekly Non-Stress Tests (NSTs) • Serial ultrasounds every 2-3 weeks	For early detection of fetal distress, assessment of fetal growth, and monitoring of myoma size and amniotic fluid volume.
Symptomatic Control	Regular acetaminophen for abdominal pain.	To manage pain effectively while avoiding opioids and NSAIDs, which carry fetal risks. Pain gradually subsided.
Fetal Lung Maturity	Course of intramuscular dexamethasone (6 mg q12h x 2 doses).	To accelerate fetal lung development in anticipation of a high-risk preterm delivery.
Anemia Correction	Oral ferrous sulfate supplementation.	To treat mild anemia and improve maternal physiological reserve.
Renal Monitoring	Monitoring of renal function and symptoms. Ureteral stenting was deferred.	To manage hydronephrosis conservatively while avoiding procedural risks. Outcome: Hydronephrosis remained stable and did not progress.
Follow-up & Delivery Outcome		
Pregnancy Progression	Continued outpatient follow-up after 1 week of hospitalization. Myoma size remained stable.	Successful continuation of pregnancy with appropriate fetal growth.
Delivery Indication	Onset of regular uterine contractions at 36 weeks + 4 days.	Term labor in the context of an obstructed birth canal and stable transverse lie mandated delivery.
Mode of Delivery	Planned Cesarean section via a classical (vertical) uterine incision.	To safely deliver the infant by avoiding the giant anterior myoma, which blocked the lower uterine segment.
Intraoperative Management	Cesarean myomectomy was not performed.	Deemed too high-risk for massive hemorrhage due to the myoma's size and vascularity.
Neonatal Outcome	Healthy male infant, 2,850g. Apgar scores: 8 (1 min) and 9 (5 min).	Excellent neonatal outcome, validating the conservative management strategy.

3. Discussion

This case of a young primigravida with a giant, symptomatic 27-cm leiomyoma managed successfully with a conservative approach provides a platform to explore the intricate challenges this condition poses. The discussion will delve into the pathophysiology of myoma growth in pregnancy, the spectrum of maternal and fetal risks, the nuances of diagnostic imaging, and the critical analysis of management strategies.[11] The behavior of uterine leiomyomas during pregnancy is a subject of ongoing research and debate. These benign monoclonal tumors, arising from the smooth muscle cells of the myometrium, are exquisitely sensitive to the hormonal storm of gestation. Estrogen and progesterone, the primary architects of the uterine environment, are known to be potent promoters of myoma growth.[12] They exert their effects by binding to their respective receptors, which are found in higher concentrations in leiomyoma tissue compared to normal myometrium, stimulating cellular proliferation and inhibiting apoptosis.

During pregnancy, serum estrogen and progesterone levels increase dramatically. However, the growth pattern of myomas is not linear. The most significant growth, if it occurs, is typically observed during the first trimester. Previous study demonstrated that a substantial proportion of myomas exhibit rapid growth in the first few weeks of pregnancy, potentially influenced by the surge of human chorionic gonadotropin (hCG), which has been shown to have a stimulatory effect on myoma cells.[13] As pregnancy progresses into the second and third trimesters, myoma growth tends to slow or stabilize. This paradoxical effect may be due to several factors, including downregulation of hormone receptors, relative ischemia as the myoma outgrows its blood supply, or the influence of other local growth factors. In our case, the patient reported abdominal enlargement over three months, suggesting significant growth during the late first and early second trimesters, consistent with these findings.[14]

A critical complication of rapid myoma growth is degeneration, which occurs in approximately 5-10% of cases during pregnancy. Red (carneous) degeneration is the most common type seen in gestation.[15] It is an ischemic infarction that occurs when the tumor's vascular supply is compromised. This leads to venous thrombosis within the periphery of the myoma, causing hemorrhagic infarction and necrosis of the central tissue. Clinically, this manifests as acute, severe abdominal pain, fever, nausea, and leukocytosis, creating a diagnostic dilemma as it can mimic other acute abdominal conditions like appendicitis or placental abruption. The MRI findings in our patient, showing extensive cystic and degenerative changes, are highly suggestive that she was experiencing symptoms from this process. The thrombocytosis observed in her initial bloodwork may also have been part of the systemic inflammatory response to this tissue necrosis.[16]

The presence of a giant myoma dramatically amplifies the risks inherent to pregnancy. These risks can be broadly categorized into maternal and fetal complications, primarily driven by the mass effect of the tumor.[17] As vividly demonstrated in our case, pain from degeneration or mechanical pressure is the most common complication. The sheer size of the myoma led to a significant size-date discrepancy and abdominal distension. More critically, the compression of the right ureter resulted in hydronephrosis. Untreated, progressive ureteral obstruction can lead to pyelonephritis, loss of renal function, and even sepsis. The decision to manage her hydronephrosis expectantly was based on stable renal function and the high risks of ureteral stent placement in pregnancy, which include infection, stent migration, and the need for replacement. Giant myomas are a significant risk factor for preterm labor. They can increase uterine irritability through stretching of the myometrial fibers and the local release of prostaglandins from degenerating tissue. The risk is proportional to the size of the myoma.[18]

Figure 4. Pathophysiology of myoma growth and degeneration in pregnancy flowchart.

Myomas, particularly those located near the placental implantation site (retroplacental), can interfere with decidual blood flow. This can increase the risk of placental abruption, a life-threatening obstetric emergency. They also increase the risk of placenta previa by distorting the uterine cavity and limiting available implantation sites in the upper uterine segment. Myomas located in the lower uterine segment, as in this case, can cause labor dystocia by obstructing the birth canal, necessitating a Cesarean

delivery. They are also associated with an increased risk of postpartum hemorrhage. The stretched myometrium in the presence of a large myoma may not contract effectively after delivery, leading to uterine atony. The presence of a giant myoma often necessitates a classical (vertical) uterine incision during Cesarean section to avoid incising the myoma itself, which would lead to torrential hemorrhage. A classical incision carries implications for future pregnancies, as it increases the risk of uterine rupture, mandating elective Cesarean delivery in all subsequent pregnancies.

Fetal malpresentation was a key feature of our case. The giant anterior myoma occupied the entire lower uterine segment and pelvic inlet, forcing the fetus into a stable transverse lie. This made vaginal delivery impossible and mandated a Cesarean section. Other malpresentations, such as breech or oblique lie, are also common. While not observed in our patient, FGR is a potential risk. Large myomas may compete with the uteroplacental unit for blood supply, potentially compromising nutrient and oxygen delivery to the fetus. In rare cases, very large myomas can exert direct pressure on the developing fetus, leading to positional deformities such as torticollis, dolichocephaly (flattening of the head), and limb abnormalities. This is more common with intramural or submucosal myomas that impinge upon the uterine cavity.

Accurate diagnosis and characterization of large pelvic masses in pregnancy are paramount. Both ultrasound and MRI play crucial, complementary roles. Ultrasonography is the first-line imaging modality. It is safe, widely available, and cost-effective. In this case, ultrasound was essential for confirming fetal viability, assessing fetal biometry, and providing the initial identification and measurement of the mass. Doppler studies helped to confirm its uterine origin by demonstrating feeding vessels from the uterine artery. However, ultrasound has limitations, especially with giant masses. The posterior aspects of the tumor can be difficult to visualize (acoustic shadowing), and its precise relationship with adjacent organs, such as the ureters, can be unclear. Magnetic Resonance Imaging (MRI) has emerged as the gold standard for complex pelvic pathology in pregnancy when ultrasound is inconclusive. It is considered safe in the second and third trimesters and does not use ionizing radiation. Its superior soft-tissue contrast provides unparalleled anatomical detail. In our case, MRI was invaluable for precise characterization, delineating anatomical relationship and excluding malignancy.[19] MRI accurately measured the myoma in three dimensions (26.9 x 18.7 x 24.7 cm) and detailed its internal architecture, confirming extensive degeneration. It also definitively showed the compression of the right ureter and the displacement of the uterus, which were critical for understanding the patient's symptoms and for surgical planning. While leiomyosarcoma is rare (<0.5% of presumed fibroids), it is a key differential diagnosis for a large, rapidly growing, or degenerating uterine mass. MRI features suggestive of sarcoma include irregular margins, heterogeneous signal intensity, and restricted diffusion. While our patient's MRI had some of these features (size, degeneration), the overall morphology was more consistent with a benign process, a conclusion supported by the normal CA-125 level and the lack of progression.

The management of a giant symptomatic myoma in pregnancy is a tightrope walk, balancing maternal safety against fetal survival and the patient's autonomy. Conservative (expectant) management is the cornerstone of treatment and was the path chosen for our patient. It involves a "watchful waiting" approach with several key components; pain management, close surveillance and timely intervention. Pain is managed with analgesics like acetaminophen. Non-steroidal anti-inflammatory drugs (NSAIDs) are generally avoided after 32 weeks due to the risk of premature closure of the fetal ductus arteriosus. Regular clinical and sonographic monitoring is essential to track myoma size, fetal growth, and the development of complications like worsening hydronephrosis.[20] The goal of timely intervention is to carry the pregnancy to a gestational age where fetal viability is high, ideally to term.

Delivery is typically indicated for standard obstetric reasons (labor, pre-eclampsia) or for worsening maternal or fetal compromise directly related to the myoma.

The success of conservative management in this extreme case underscores its potential. The patient's unwavering commitment to the pregnancy was a crucial factor, highlighting the importance of shared decision-making. Surgical removal of a myoma during pregnancy is a rare and perilous undertaking. The gravid uterus is a highly vascular organ, and the myoma itself has a rich blood supply. Attempting to enucleate a myoma, especially one of this size, carries a very high risk of uncontrollable hemorrhage, which could necessitate a hysterectomy and result in the loss of the pregnancy and future fertility. However, there are select, albeit controversial, indications where antenatal myomectomy may be judiciously considered. These clinical scenarios are typically reserved for cases where conservative management fails or is untenable. The first is the torsion of a pedunculated subserosal myoma, which can precipitate an acute surgical abdomen, making surgical removal the only viable option to resolve the emergent condition. A second indication arises from intractable pain, specifically severe and unremitting pain secondary to myoma degeneration that proves refractory to maximal medical therapy. Finally, intervention may be warranted in the face of severe and progressive compressive symptoms that threaten maternal well-being, such as worsening renal failure resulting from bilateral ureteral obstruction, where continued observation would lead to irreversible organ damage. Most successful reported cases of antenatal myomectomy involve smaller, pedunculated, or easily accessible subserosal myomas, often performed in the early second trimester. Performing this surgery on a 27-cm intramural/subserosal myoma at 25 weeks would have been an extremely high-risk endeavor. The decision by the multidisciplinary team to pursue a conservative path was therefore judicious and appropriate.

4. Conclusion

This case of a giant 27-cm uterine leiomyoma in a young primigravida presented a formidable constellation of clinical challenges, including severe compressive symptoms, fetal malpresentation, and the diagnostic uncertainty of a massive pelvic tumor. The successful outcome, culminating in the delivery of a healthy term infant, was achieved through a carefully orchestrated conservative management plan. This plan was built on a foundation of advanced multimodal imaging, proactive multidisciplinary collaboration, and, most importantly, a patient-centered approach that respected the patient's autonomy and her profound desire to continue the pregnancy. This report adds to the limited body of literature on the management of such extreme cases, providing compelling evidence that even in the face of daunting complications, expectant management can be a safe and effective strategy, offering a chance for a "view" of a healthy newborn despite the "challenge" of the elephant in the womb.

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