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Huge subserosal fibroid with macrosomic baby in a term pregnancy with successful caesarean in north India: A rare case report

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Abstract
A fibroid is a smooth-muscle benign tumor. The incidence of fibroids in pregnancy is approximately 0.1% to 3.9%. Pregnancy with a large fibroid is associated with a greater risk of abortion, intrauterine growth restriction of the baby, hemorrhage, preterm labor, prolonged premature rupture of the membrane and birth asphyxia. We report a case of a large subserosal fibroid in the pregnancy of a 28-year-old female which proceeded to term (37 weeks + 3 days) without any complications, resulting in the birth of a large baby weighing 4 kg via lower segment caesarean section.

Keywords: Fibroid in pregnancy, subserosal fibroid, macrosomic baby, term cesarean with fibroid, uterine fibroids

Introduction
Uterine fibroids are the most common non-cancerous tumors of the female reproductive system. Their occurrence is in 20%-40% of women [1]. Mother remains undiagnosed because of the initial pregnancy due to the asymptomatic nature and lack of awareness to undergo routine ultrasonography. Fibroid growth during pregnancy is not uniform; the majority of growth happens in the first trimester due to a hyperestrogenic state, with minimal increases seen in the second and third trimesters. Larger fibroids, particularly those over 5 cm in size, are more prone to grow during pregnancy and can lead to negative input/complication in the progression of pregnancy outcomes [2].
The clinical symptomatology of fibroids is seen in one-third of women with huge fibroids consisting of pressure symptoms like increased urine frequency, constipation, lower backache, pelvic pain, increased and abnormal bleeding, infertility, and poor pregnancy outcomes. It is recognized that uterine fibroids, particularly when they are numerous, intramural, or submucosal, are linked to a higher likelihood of early pregnancy loss [3].
There is a lack of literature review in North India on successful pregnancy till term with large fibroid. This report is aimed at presenting a rare and very interesting case of a pregnant woman who was diagnosed with a full-term pregnancy with a large subserosal fibroid measuring 8 cm, posteriorly rotated.

Case presentation
A 28-year-old primigravida housewife with a good socioeconomic background presented to our tertiary care center for an antenatal checkup at 8 weeks of gestation after the confirmation via urine pregnancy test at home. The patient was prescribed folic acid for the 1st trimester and advised to have an NT/NB (nuchal translucency/nasal bone) scan at 12 weeks of gestation. On follow-up of the patient, she was shifted to iron and calcium and the scan report showed gravida, single, cephalic, NB+, NT 2.6mm, placenta-anteriorly upper, expected fetal weight 148 grams with no gross congenital deformity. The clinical examination showed fundal height at the level of the pubic symphysis without outlining any fibroid abdominally.
A further level 2 scan was instructed for the patient, but the patient was lost to follow-up. On 1/1/25 the patient presented to emergency with the onset of labor pain. An emergency ultrasound with color Doppler and NST (non-stress test) was done for fetal well-being, which shows a gravida, single, cephalic, placenta-posteriorly upper, expected fetal weight 3660 grams with multiple fibroids measuring 6.7*3*7.8 cm (subserosal) and two anterior fibroids measuring 2*2 cm (intramural and subserosal).

Pre-Operative Course

The patient was acknowledged with the high-risk condition requiring admission of the mother in the ICU (intensive care unit) and the baby in the NICU (neonatal intensive care unit), post-op if any complications occur. An informed consent for emergency caesarean was taken. The Multidisciplinary team came into action for the procedure for the well-being of the mother as well as the baby.

The blood samples of all routine tests were sent with the arrangement of 2 units of PRBC (packed red blood cells). Preoperative antibiotic coverage was given.

Intraoperative Course

Spinal anesthesia was given. Under all aseptic precautions, the patient's part was cleaned and draped, and a Pfannenstiel incision was given. The uterovesical fold was separated, and a small nick was given on the lower segment, which extended digitally. A healthy male baby weighing 4kg was delivered, who cried immediately at birth and was shifted to the mother's side. All the fibroids were identified, with the largest measuring 7*3.6*8cm on the posterior surface at the level of the fundus, and left untouched. The hemostasis was achieved and the abdomen was closed back in layers.

Postoperative course

The patient was managed conservatively for a further 5 days with intravenous antibiotics, vitals monitoring, and stitch line care with dressing done on Day 2 & Day 4. There was no need for blood transfusion; thus, the patient was discharged on Day 5 with the advice of stitched removal on Day 10.

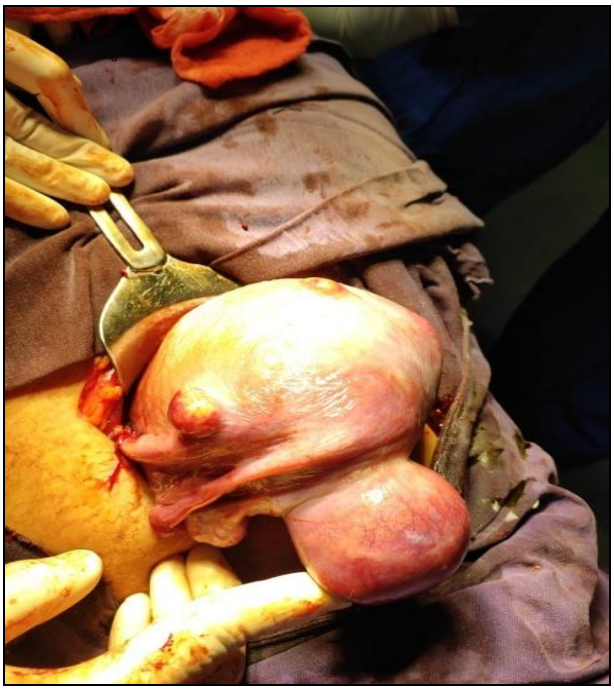

Fig 1: Ultrasound Image Showing Subserosal Fibroid

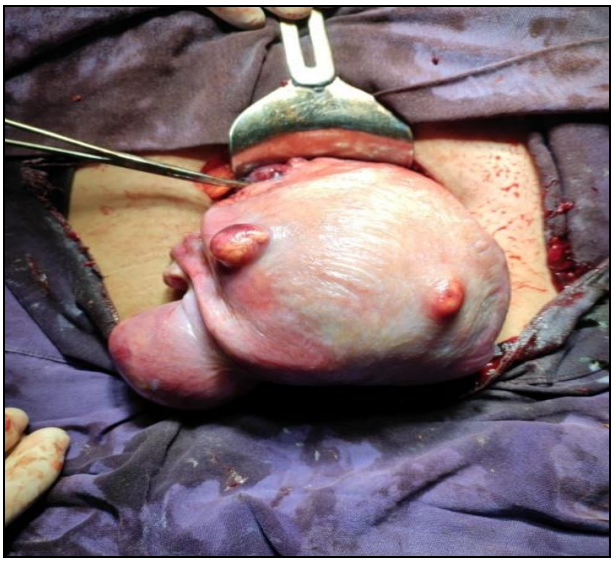

Fig 2: Intraoperative View of the Uterus with Fibroid

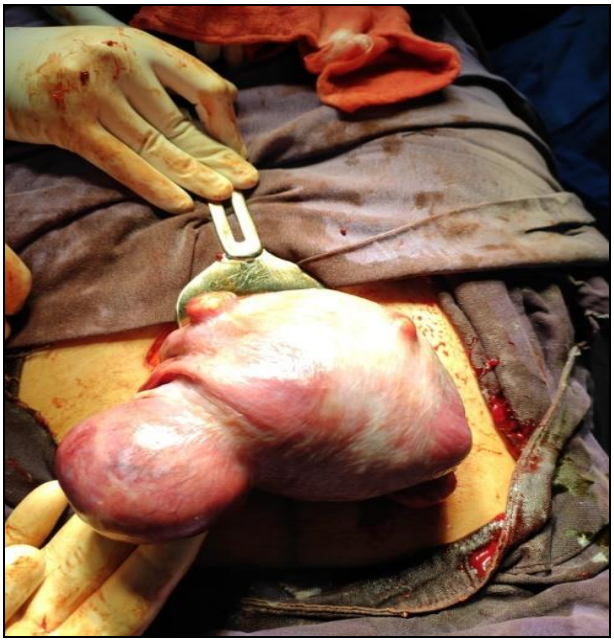

Fig 3: Delivered Macrosomic Baby Post Caesarean

Discussion

This case of ours was very high-risk and challenging due to incidental ultrasonography finding of a huge fibroid and big baby. Understanding the risks, the patient underwent an emergency cesarean.

The risks of fibroids are increasing due to late conception and rising maternal ages. The important parameters of a fibroid are its size and location, which decide the mortality risk in pregnancy of both mother and baby [4]. Many patients are unaware and fail to follow up for antenatal care, thereby missing the important scans and delaying the crucial lead time to get these benign tumors and other high-risk features. Also, diagnosing uterine fibroids during pregnancy presents significant challenges due to the limitations of ultrasound in distinguishing fibroid tissue from the natural thickening of the myometrium. As the pregnancy progresses, changes in uterine anatomy and the presence of the fetus and placenta complicate detection and evaluation. This can lead to difficult and often painful examinations for patients [5].

Large fibroids are problematic since they take up the vascularization that was required by the uterus and fetus to develop. Thus, it leads to fetal malformations, heart failure, limb defects, and torticollis [6]. During labor, there can be labor dystocia, interference with myometrial contractility, increased PPH risk, fetal distress, and intrauterine death [7].

Pain is the most common symptom in fibroids because of degeneration [red degeneration] or torsion [8]. This can be managed conservatively. Patients are likely to go into preterm labor, unlike our patient who delivered at term. In comparison to the findings by Petroulakis *et al*. (2024), who described the complexities of managing a huge fibroid during pregnancy, our case was not diagnosed with a fibroid on initial ultrasonography findings. It was identified on the scan when the patient presented in the emergency department in our tertiary care hospital with labor pains. Also, it was located posteriorly and of subserosal type. Their case was delivered preterm with complications of hemorrhage in contrast to ours, which we delivered at term without intra- and postpartum hemorrhage. A baby boy was born weighing 4 kg, whereas in their case, a baby girl weighing low birth weight was born (2.02 kg).

The expertise of a multidisciplinary team during such high-risk cases ensures an optimistic approach and reliable outcome, as it did in our case. Likewise, a decision not to perform myomectomy during cesarean was accurate, as it might lead to huge blood loss resulting in inevitable hysterectomy or the patient's death [9]. We individualized the treatment that was beneficial to our patient.

Conclusion

Fibroids developing during the pregnancy may be asymptomatic and non-harmful, but in case of huge fibroids, essential supervision by the clinician and awareness of the need to follow up must be inculcated to the patient. Depending on the typical features of fibroids, the approach to delivering the baby varies. In our case, the decision of an emergency cesarean, in view of high-risk antepartum hemorrhage, incoordination of the uterine inertia, and shoulder dystocia, finally led to the safety of the mother as well as the well-being of the baby without any known complications.

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