We present a case of a 31 year old parturient at 34 weeks sent from her primary care provider’s office for complaints of worsening shortness of breath over the past month. Patient had dyspnea with minimal exertion, palpitations, and orthopnea, requiring five pillows to sleep. Patient had attributed her symptoms to pregnancy and had not sought care earlier. Patient was admitted to cardiology for further workup. Echocardiogram showed a small to moderate pericardial effusion and signs of early tamponade. CT chest revealed a 17.3 x 9.6 x 9.8 cm mediastinal mass abutting the aortic arch, encasing the left common carotid and left subclavian arteries with partially encasement of the right brachiocephalic artery, and tracheal deviation. Patient developed severe pre-eclampsia over the next 2 days and required an urgent cesarean section. Preoperative evaluation revealed that the patient was tachypneic, tachycardic, hypertensive and showed clinical signs of venous obstruction of the innominate veins. There was also concern for possible phrenic nerve involvement. Given the clinical implications, a multidisciplinary approach was taken involving obstetrics, anesthesiology, neonatology, cardiology and cardiothoracic surgery. After thorough consideration of risks versus benefits of neuraxial versus general anesthesia, decision was made to proceed with general anesthesia. Cesarean section proceeded uneventfully. Patient was kept spontaneously breathing throughout the procedure and was successfully extubated immediately afterwards.