Objective
Presentation of intrauterine diagnosis and clinical course of type III, fetal congenital cystic adenomatoid malformation.

Methods
Case report.

Results
Fetal congenital cystic adenomatoid malformation is defined as hamartomatous overgrowth of terminal bronchioles. Although rare, they encompass the most common malformation of the lungs. Their mass effect can cause cardiac axis deviation, mediastinal shift leading to hydrops fetalis, and esophageal compression resulting in polyhydramnios. About 40% of cases resolve antenatally, about 50% remain unchanged and 10% continue to enlarge. Here, we present a case with solid (microcystic) congenital cystic adenomatoid malformation presenting with ascites, which was managed successfully in our institution. 22 year-old patient (gravida 1 para 0) applied to our department for routine follow up at 16 weeks of gestation. On sonogram; hyperechogenic mass arising from right lung, and filling almost entire thorax resulting in mediastinal shift to left was detected (Figure 1). Because of the pulmonary vascular supply, cystic adenomatoid malformation was diagnosed. At 21 weeks of gestation fetal ascites was detected. Anatomical survey did not reveal any accompanying fetal abnormality. The patient was counselled about the situation and termination of the pregnancy was offered. The family opted to continue the pregnancy. During follow up, at the gestational age of 25 weeks, the ascites disappeared and cardiac axis and left lung was normal. The mass was only on the right hemitorax with normal appearing lung tissue on the right upper hemitorax. The patient was followed till term and the mass persisted at the lower right hemitorax. At 40 weeks of gestation, cesarean section was performed because of arrest of labor. A female fetus of 3520 gr with fifth minute Apgar score of 10 was delivered. The newborn was admitted to neonatal care unit because of tachypnea and retractions. Right middle and lower lobectomy was performed on the day of admission. The newborn was accepted to neonatal intensive care unit and went on very well without any prematurity complications.

Conclusion
Congenital cystic adenomatoid malformations represent as hyperechoic lesions (with cystic or solid appearance). Unilateral cases usually have good prognosis and mediastinal shift and resultant hydrops are assumed to have poor prognosis. Detailed sonogram should be performed in these cases to reveal any accompanying fetal anomaly. Because of those complications and the possible need for surgery in the postnatal period, antenatal and postnatal care of these cases should be undertaken in referral centers.