Objective
A cystic hygroma is a multiloculated cystic space lined by endothelial cells. It occurs as a result of lymphatic malformation. Most cystic hygromas involve the lymphatic jugular sacs and present in the posterior neck region. Other common sites are the axillary, mediastinal, inguinal, lung, gastrointestinal tract, spleen, liver, bone and retroperitoneal regions. Approximately 50% of these cystic lesions persist and are present at birth. The soft cystic masses distort the surrounding anatomy, including the airway and as such can pose a significant risk of airway obstruction at birth. They can be associated with chromosomal abnormalities. This report shows our experience with the prenatal diagnosis of such a fetus with a large cystic hygroma.

Methods
This is a case report.

Results
A 35 years old primigravida patient was referred to our department with a diagnosis of a lymphatic malformation in the fetus. The measurements of the mass were 95 x 57 x 67 mm on two dimensional ultrasound taken at 22 week of gestation and in addition there was hydrothorax. The ultrasound examination of the first trimester was normal and no karyotype was done at the local hospital. There was no history of genetic disorders or structural anomalies in the family history. A detailed ultrasonography revealed a polycystic tumor extending from the cheek through the neck to the right side of the chest to the height of the heart with size of 110 x 100 x 80 mm. The chest was symmetrical, but in the right pulmonary area, a cystic structure of 38 x 32 x 25 mm displaced the mediastinum and the heart to the left. The MRI scan confirmed the extent of the tumor. There was retrosternal extension causing displacement of the oesophagus and upper respiratory tract. Fetal echocardiography was normal. Steroids were given at 32 weeks of gestation. An interdisciplinary team specialized in fetal anomalies, including an obstetrician, a neonatologist, a pediatric surgeon, a surgical oncologist, a geneticist, a radiologist and a pediatric cardiologist, was convened in order to determine the optimum date for delivery, as well as further management of the newborn. The team decided to deliver the baby by caesarean section at 34 weeks of gestation. A live baby girl weighing 2400g was born with APGAR scores of 1 -3 – 6 – 7 but died 20 minutes after delivery as a result of circulatory respiratory failure due to upper vena cava compression. In the post-mortem histopathological result a multifocal mixed-type choroidal hemangioma (major lymphoid angiomatosus hemangiomas) was described.

Conclusion
Although the cystic hygroma is a benign congenital tumor of lymphatic origin, it can impose a significant risk of compressing the airway at birth, so the main objective in managing such cases is securing the airway. In our case, despite the good intubation, the newborn could not have been saved due to cardiovascular complications. Prenatal ultrasonography and MRI are shown to be good diagnostic modalities in prenatal period and provide necessary and extremely useful data, which allows to plan the further managements of the neonate, including interventions of anesthesiologists, pediatricians and pediatric surgeons.