In large microcystic CCAM that develop hydrops, fetal therapeutic options are limited. Thoracoamniotic shunts can not be placed since the lung mass is solid, and there are no large cysts to be drained. Preliminary studies using open fetal surgery with resection of the lesion between 22 to 32 weeks of gestation, reported a survival rate of 50% [16]. Likewise, percutaneous laser ablation of the microcystic lesions have been proposed [17, 18], but further studies are necessary to consider these techniques as a therapeutic option. In addition to fetal surgery, non-invasive treatments have been published. Small-case series have reported a potential negative effect of prenatal steroid management on the growth of microcystic CCAM with a substantial positive effect in hydrops ution and survival [19-21]. They reported a CCAM volume decrement in

necessary to consider these techniques as a therapeutic option. In addition to fetal surgery, non-invasive treatments have been published. Small-case series have reported a potential negative effect of prenatal steroid management on the growth of microcystic CCAM with a substantial positive effect in hydrops resolution and survival [19-21]. They reported a CCAM volume decrement in >70%, resolution of hydrops above 80% and on average 30 days later, and survival rate >90% in cases managed with maternal betamethasone (12mg intramuscularly, 2 doses, 24-hours apart). Preliminary evidence has suggested the use of fetal bronchoscopy for prenatal gement of bronchial atresia[11, 22].