**Introduction**

Ovarian cysts are the most common abdominal findings during prenatal evaluation (incidence 1/2500).\(^1\) These cysts are frequently unilateral and diagnosed in the 3rd trimester, as an anechoic thin-walled cyst superior and parasagittal to the bladder. Hormonal stimulation has been proposed as having a paramount effect on its pathogenesis. The sudden drop in hormone circulating levels after birth leads to an involution of these masses.

The differential diagnosis of ovarian cysts includes lesions with cystic conformation originating from any abdominal viscera (renal cyst, ureterocele, urinoma, urachal abnormalities, dilated bowel, meconium cyst, enteric duplication cyst, lymphangioma, choledochal cyst, and cystic neuroblastoma).\(^1\)

**Case Report:** Female, 38 yo, 3G (1 eutocic labour, 1 abortion). 1\(^{st}\) and 2\(^{nd}\) trimester US and blood test normal, diagnosed with a fetal pelvic cyst at 30 weeks.

**Fig. 1:** US (30w5d): pelvic cystic image with 35mm diameter

**Fig. 2:** US (34w4d): right pelvic cyst with 60X56X60mm, suggesting a right adnexal cyst

**Fig. 3:** US (37w1d): right pelvic cyst with 65x60mm

**Discussion**

This case report emphasises the importance of the 3rd trimester ecographic evaluation. Simple cysts commonly resolve without medical intervention.\(^1\) Size and ultrasound appearance are the major determinants of perinatal outcome in fetuses with ovarian cysts.\(^2\)

A conservative approach with timely exams to monitor growth and characteristic findings is acceptable.\(^3\) In our case report, considering the cyst characteristics, even with a diameter of 65mm, the authors chose to monitor rather than to intervene. After birth the cyst spontaneously regressed, with no need to intervention and preserving the ovary.