

All Under One Roof

Complex fetal conditions require timely evaluation, multidisciplinary collaboration and coordinated care planning.

 Multidisciplinary expertise across fetal intervention, maternal-fetal medicine, neonatology, pediatric surgery and other pediatric specialties

 Comprehensive fetal imaging, diagnostic evaluation, counseling and intervention within one coordinated program

 Dedicated genetic counseling, nursing, sonography and social work support throughout the patient journey

 Direct physician-to-physician collaboration with responsive communications to referring providers

 24/7 referral access for urgent consultation, case discussion and coordinated patient transfer when needed

Dedicated Referral Access for Providers

Our team is available around the clock to support referrals, urgent consultation and provider-to-provider communications for complex fetal cases.

24/7 Dedicated Physician Line:
844-543-3825

24/7 Text Line:
443-447-9599

Save Our 24/7 Physician Access Line
Scan to add our dedicated contacts directly to your mobile device.



Patient Scheduling Line: 410-502-6561

Fax: 410-367-2912

hopkinsmedicine.org/fetal-therapy

600 N. Wolfe St., Suite 228, Baltimore, MD 21287



Treating Disease Before Birth

Comprehensive fetal therapy and multidisciplinary care for complex pregnancies.

GIVING EVERY CHILD THE BEST POSSIBLE START



The Johns Hopkins Center for Fetal Therapy provides coordinated evaluation, advanced fetal intervention and multidisciplinary care for pregnancies affected by complex fetal conditions.

Our team partners closely with referring providers to support timely consultation, collaborative decision-making and seamless continuity of care.



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Multidisciplinary Expertise

The Johns Hopkins Center for Fetal Therapy brings together specialists to provide individualized planning and care for both mother and baby — all within one integrated program, ***all under one roof*** at The Johns Hopkins Hospital.

Specialists in fetal diagnosis, fetal intervention and high-risk maternal care:

Ahmet A. Baschat, M.B.B.Ch.B.A.O., *Director*
Michelle Kush, M.D.
Mara Rosner, M.D.
Katelyn Ann Uribe, M.D.

Multidisciplinary Partners

- Neonatology
- Pediatric Surgery
- Pediatric cardiology
- Pediatric Neurology/Neurosurgery
- Pediatric Nephrology/Urology
- Pediatric ENT-Surgery

In-House Specialist Support

- Specialized fetal therapy nursing team
- Expert sonographer team
- Genetic counselor
- Dedicated social work support
- Longitudinal patient coordination and family support

FETAL THERAPY	KEY INDICATIONS / REFERRAL CRITERIA		GESTATIONAL AGE
Fetoscopic tracheal occlusion	• Severe left CDH – observed-to-expected lung/head ratio <30%	• Severe right CDH – observed-to-expected lung/head ratio <45%	FETO at 27–29 weeks; balloon removal by 35 weeks
Fetal Blood Sampling, Fetal Transfusions and Partial Exchange	• For suspected fetal anemia with elevated MCA PSV • Fetal hydrops	• Stage II-IV twin anemia polycythemia sequence (TAPS)	16–35 weeks
Fetoscopic Laser Surgery	• For stage I–IV twin-twin transfusion syndrome (TTTS)	• Stage II–IV twin anemia polycythemia sequence (TAPS)	16–28 weeks
Fetal Myelomeningocele (MMC) Closure (Fetoscopic or Open)	• Isolated MMC T-1 to S-1	• Hindbrain herniation	22–26 weeks
Fetal Aortic Ballon Valvoplasty	• Critical aortic stenosis with preserved left ventricular function		22–30 weeks
Fetal Shunting Procedure	• Lower urinary tract obstruction with preserved renal function and progressive oligohydramnios	• Fetal hydrothorax • Severe fetal cystic lung malformations	22–32 weeks
Serial Amnioinfusion	• Anhydramnios due to early gestational fetal renal disease or renal agenesis		22–32 weeks
Vein of Galen (VOG) Embolization	• Fetal VOG at high risk for fetal or neonatal decompensation	• No brain parenchymal damage	26–34 weeks
Fetoscopic or Other Ultrasound-Guided Surgeries	1. Amniotic bands 2. Twin reversed arterial perfusion (TRAP)	3. Placental tumors 4. Fetal tumors	Varies by indication
Vasa Previa Fetoscopic Laser Occlusion	• Type II or III vasa previa with 80% primary placental mass		28–32 weeks
Open Fetal Surgery	• Fetal sacrococcygeal teratoma with fetal hydrops	• Giant CPAM with fetal hydrops unresponsive to conventional therapy • Fetal tumors	28–32 weeks
Ex-utero Intrapartum Treatment	• Fetal airway obstruction		35–38 weeks
Transplacental Medical Treatments	• Antiarrhythmic treatment of fetal cardiac arrhythmias • Sirolimus therapy for fetal tumors • Trikafta for fetal cystic fibrosis	• Intravenous immunoglobulin (IVIG) therapy for 1. Severe hemolytic disease (HDFN) 2. Alloimmune thrombocytopenia (fNAIT) 3. Gestational autoimmune fetal liver disease (GALD) • Nipocalimab for severe fetal hemolytic anemia (AZALEA Trial) • Risdiplam for fetal spinal muscular atrophy type 1	

General Exclusion Criteria

- Additional fetal anomalies or genetic abnormalities identified by invasive testing
- Fetal findings that are incompatible with long-term survival or quality of life
- Active infection, fetal demise risk, or nonamenable etiologies
- Maternal risks and significant preexisting conditions
- Increased and unmanageable preterm delivery risk
- Specific exclusion criteria for treatments offered under protocol