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OPTIMIZATION OF PREGNANCY MANAGEMENT IN THE CONTEXT OF UNDIFFERENTIATED CONNECTIVE TISSUE DYSPLASIA

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Objective: To analyze available literature regarding the course of UCTD during pregnancy, maternal and fetal outcomes, and therapeutic approaches.

Materials and methods: This study was based on systematic analysis and comparative approaches, focusing on contemporary scientific sources addressing the course of undifferentiated connective tissue dysplasia (UCTD) during pregnancy, maternal and fetal outcomes, and therapeutic–tactical management strategies. The research material included recently published international and national scientific articles, clinical guidelines, meta-analyses, and observational studies. During the literature selection process, data concerning disease activity in pregnant women diagnosed with UCTD, the presence of autoimmune markers, the frequency of obstetric and perinatal complications, as well as the therapeutic approaches applied, were analyzed. The primary criteria for selecting scientific sources were their methodological reliability, clinical relevance, and inclusion of data related to women of reproductive age. The collected data were systematized using descriptive and statistical analysis methods, which made it possible to identify the main clinical risk factors and to determine optimal strategies for pregnancy management in women with undifferentiated connective tissue dysplasia.

Results: The analysis of the reviewed literature demonstrated that the clinical course of undifferentiated connective tissue dysplasia (UCTD) during pregnancy is largely determined by the level of disease activity at the time of conception. In women with UCTD in remission or with minimal disease activity, pregnancy most often proceeded without significant complications, and maternal as well as perinatal outcomes were generally favorable. According to published data, increased disease activity and persistent positivity of autoimmune antibodies were associated with a higher incidence of obstetric complications. The most frequently reported adverse outcomes included fetal growth restriction, gestational hypertension, preeclampsia, placental insufficiency, and preterm birth. In a subset of patients, pregnancy acted as a trigger for disease exacerbation or progression to a defined connective tissue disease. The literature analysis also indicated that individualized pregnancy management, early risk stratification, and multidisciplinary follow-up contributed to improved maternal and fetal outcomes. The use of therapeutic agents with an acceptable safety profile during pregnancy, combined with careful monitoring of disease activity and placental function, was shown to reduce the frequency and severity of obstetric and perinatal complications in women with UCTD.

Conclusion: If UCTD is in remission or at a stage of minimal activity at the time of conception, pregnancy outcomes are generally favorable. However, in women with high disease activity or repeated antibody positivity, the risk of disease exacerbation, progression to a defined connective tissue disease, and obstetric complications (such as fetal growth restriction, preeclampsia, and preterm birth) increases. Therefore, in women with UCTD, it is essential to

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assess maternal and fetal risks before planning pregnancy, optimize disease activity, and select medications with minimal potential harm to the fetus.