

Expanding the Scope beyond Pregnancy-Related Emergencies

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Introduction

For decades, critical care in obstetrics has largely been synonymous with the management of pregnancy-related complications such as preeclampsia, eclampsia, obstetric hemorrhage, sepsis, and obstructed labor. While these remain leading causes of maternal morbidity and mortality worldwide, women's health in the intensive care landscape extends far beyond the boundaries of pregnancy and childbirth. As life expectancy increases, lifestyle patterns shift, and chronic diseases become more prevalent, women face an expanding spectrum of acute and chronic health challenges requiring specialized critical care. Cardiovascular disease, oncological emergencies, autoimmune conditions, sepsis unrelated to pregnancy, trauma, and metabolic disorders are increasingly being recognized as major determinants of women's critical illness trajectories. Expanding the scope of critical care for women acknowledges their unique biological, social, and cultural determinants of health, while also addressing gaps in diagnosis, treatment, and outcomes. This paradigm shift emphasizes that women's health in critical care must be redefined to encompass a holistic, lifespan-based approach [1].

Description

The traditional prioritization of pregnancy-related emergencies in women's critical care has been driven by their historical contribution to maternal mortality. In low- and middle-income countries, postpartum hemorrhage, hypertensive disorders of pregnancy, and puerperal sepsis remain significant challenges, compounded by limited access to antenatal care, skilled birth attendants, and Intensive Care Units (ICUs). However, while efforts to improve maternal survival in the perinatal period must continue, there is growing recognition that many women admitted to ICUs present with conditions unrelated to pregnancy. Cardiovascular disease, for instance, has become the leading cause of death among women globally, yet it remains underdiagnosed and undertreated in critical care settings due to gender disparities in research and clinical practice. Acute myocardial infarction, stroke, and heart failure present differently in women, often with atypical symptoms, contributing to diagnostic delays and worse outcomes [2].

Oncological emergencies represent another area requiring greater attention. Women with breast, cervical, or ovarian cancers frequently require critical interventions for complications such as tumor lysis syndrome, sepsis secondary to immunosuppression, or airway obstruction due to mediastinal masses. Advances in oncology have improved survival rates, but they have also increased the likelihood that women will encounter acute critical illnesses during treatment. Similarly, autoimmune disorders such as Systemic Lupus Erythematosus (SLE) and rheumatoid arthritis, which disproportionately affect women, often flare during reproductive years and may precipitate life-threatening complications such as lupus nephritis, pulmonary hemorrhage, or catastrophic antiphospholipid syndrome. These conditions demand specialized expertise and multidisciplinary collaboration in the ICU, underscoring the need for a broader definition of women's critical care [3].

Infectious diseases, while historically associated with puerperal sepsis in obstetrics, increasingly extend beyond pregnancy-related contexts. The COVID-19 pandemic illuminated the vulnerabilities of women to respiratory failure, thromboembolic complications, and long-term sequelae that required ICU-level care. Tuberculosis, HIV, and malaria continue to disproportionately affect women in certain regions, and their complications often necessitate prolonged critical care interventions. Furthermore, urinary tract infections, pelvic inflammatory disease, and other gynecological infections can progress to systemic sepsis when untreated, further challenging the traditional obstetric-centric view of women's ICU needs. By expanding the scope, clinicians acknowledge the full burden of infectious and systemic diseases affecting women throughout their lifespan [4].

Metabolic and endocrine emergencies also demand increasing attention in the critical care of women. Diabetic ketoacidosis, thyroid storm, adrenal crises complications are more prevalent due to rising rates of metabolic syndrome among women globally. Polycystic ovarian syndrome (PCOS), though primarily viewed as a reproductive disorder, is closely linked with metabolic and cardiovascular risk factors, increasing the likelihood of critical illness later in life. Postmenopausal women face heightened risks of osteoporosis-related fractures, often complicated by trauma and prolonged ICU stays [5].

Conclusion

The evolution of women's critical care must move beyond its historical focus on pregnancy-related emergencies to embrace a comprehensive, lifespan-based perspective. While obstetric emergencies will always remain a cornerstone of maternal health, women's critical illness is increasingly shaped by cardiovascular disease, cancer, autoimmune conditions, infections, trauma, metabolic disorders. Addressing these challenges requires gender-sensitive diagnostic frameworks, biomarker-driven protocols, equitable access to interventions, and multidisciplinary collaboration across specialties. Expanding the scope also demands that healthcare systems confront structural inequities, enhance research representation, and invest in ICU infrastructure, especially in resource-limited settings. Preventive strategies that extend beyond reproductive health into chronic disease management will further reduce the burden of critical illness among women. Ultimately, broadening the definition of women's critical care affirms the principle that women's health is not confined to pregnancy and childbirth, but encompasses the entire continuum of life, deserving of comprehensive, equitable, and specialized attention within critical care medicine.

Acknowledgement

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Conflict of Interest

None.

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