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Editorial

BEYOND ACUTE RESPIRATORY DISTRESS SYNDROME: CLINICAL CONSENSUS IN AN UNEQUAL WORLD

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The article by Estenssoro et al.[1] on the New Global Definition of Acute Respiratory Distress Syndrome (ARDS) offers an opportunity to reflect on an issue that concerns not only critical care medicine but much of global medicine as well: the development of international definitions and guidelines in contexts that do not proportionally include settings with limited resources. This results in recommendations that fail to adequately consider social, economic, and infrastructural disparities when establishing clinical criteria or standards[2,3].

The 1994 AECC definition allowed unification of diagnostic criteria for ARDS but showed limitations in accuracy. The large ARDS Network trials, which adopted it as reference, transformed clinical practice and revealed the heterogeneity of enrolled patients[4-8]. This process culminated in the Berlin Definition (2012), which sought greater reproducibility and severity stratification, providing a stronger framework for research and care[9]. However, this entire development took place almost exclusively in high-income countries. As a result, physiopathologically sound diagnostic frameworks were established that are not always applicable where arterial blood gases, mechanical ventilators, or computed tomography are unavailable. In such scenarios, the risk is twofold: failure to diagnose due to lack of means, or diagnosing late when therapeutic options have been drastically reduced[10,11].

The New Global Definition of ARDS, published in 2024, represents an important advance[12]. It introduces diagnostic categories that include non-intubated patients, accepts the use of the SpO_2/FiO_2 ratio when PaO_2 is not available, and recognizes lung ultrasound as a valid alternative to radiography or computed tomography. These modifications are not concessions but *context-adapted science*: they aim to expand diagnostic equity and enable earlier interventions where technological limitations are a daily barrier.

However, even this global effort reveals underlying tensions. The panel that developed the definition included only one representative from low- and middle-income countries (LMICs). Membership was determined through a *cascade recruitment* process –panelists recommending other panelists– and decisions were made during in-person meetings, a format that may foster conformity bias and limit diversity of perspectives. In other words, the resulting definition shows greater inclusiveness than the process that produced it.

The recent experience of a more diverse international panel that employed the Delphi method to discuss the definition and subphenotypic classification of ARDS[11] demonstrates that it is possible to combine representativeness, methodological rigor, and transparency[12]. The Delphi approach, through successive rounds of anonymous consultation, reduces peer pressure, equalizes participants' voices, and promotes the inclusion of experts who might otherwise be excluded for geographic, linguistic, or infrastructural reasons.

In a recent article, we have addressed this inequity, which extends even to the evaluation of scientific output from peripheral countries[13]. ARDS is a paradigmatic example: the lack of realistic adaptations in its definitions may obscure how the syndrome presents and evolves across large regions of the world, hindering the contribution of such data to global evidence building.

The lesson extends beyond ARDS. It reminds us that most international guidelines and consensus statements –from resuscitation to sepsis management– are developed in technologically advanced environments and extrapolated to regions with limited resources without appropriate adaptation. This not only hampers implementation but also perpetuates the invisibility of local knowledge, which could enrich and, in some cases, substantially modify the recommendations.

If we aspire for terms such as “global” and “universal” to have real meaning in medicine, the processes by which definitions and guidelines are built must include, from the outset, the substantive participation of experts from the settings most affected by disease. It is not about validating their reality *a posteriori*, but about integrating it into the very DNA of the consensus.

The article by Estenssoro et al.[1] opens a door: it explicitly recognizes the need for flexible definitions adapted to diverse health realities and underscores the importance of accessible diagnostic tools. The challenge now is for the next global consensus not only to *speak* of equity but to *practice* it in its methodology. Because in an unequal world, defining is an act of power –and doing so inclusively is, above all, an act of justice.

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