Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

We conclude that rights-based approaches merit deeper consideration to advance control for air pollution worldwide at a time when air quality is notably deteriorating in many parts of the world. They provide a universal rationale and approach for action, even in the face of widely varying legal and regulatory schemes.

Jonathan M Samet, Sofia Gruskin, for the Forum of International Respiratory Societies working group collaboration

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Middle East respiratory syndrome in the shadow of Ebola

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Ebola virus disease was first discovered in 1976 in Zaire[1] as a new lethal zoonotic disease affecting human beings. For 38 years, Ebola was restricted to localised outbreaks in a few remote regions of central Africa where it was brought under control rapidly, without attracting global attention.[2] The first cases of the ongoing Ebola epidemic—which is the largest outbreak so far—occurred in December, 2013, in Guinea, west Africa.[3] Complacency and inaction by national governments and international organisations, even after calls for support from non-governmental organisations such as Medécins sans Frontières, combined with poor health-care systems and infrastructures, led to a rapid increase in the number of cases of the disease, which spread rapidly into neighbouring Liberia, Sierra Leone, and Nigeria. It was only on Aug 8, 2014, that Ebola virus disease was declared a Public Health Emergency of International Concern by WHO.[4] As of Jan 7, 2015, 20 747 clinically compatible cases of Ebola virus disease have been reported from nine countries: Guinea (2775), Liberia (8157), Sierra Leone (9780), Mali (8), Nigeria (20), Senegal (1), Spain (1), the USA (4), and the UK (1), with at least 8235 deaths (39·7% mortality rate).[5]

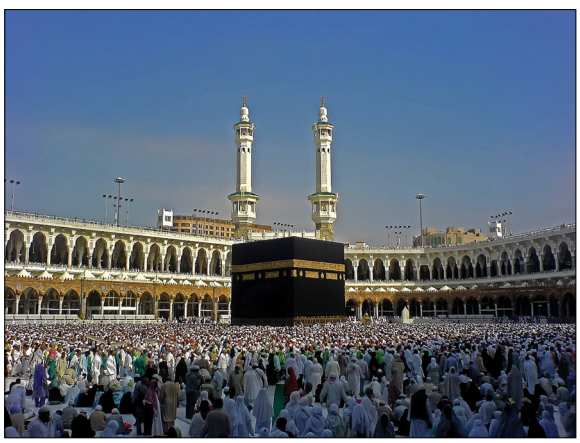
The current Ebola outbreak in west Africa is a grim reminder that novel zoonotic viruses that cause lethal human diseases remain a persistent threat to global health security. Without any obvious explanation, viruses can cross species to infect human beings. If they become easily transmissible among people, they can have a devastating effect regionally a long time after they were first discovered. Therefore, alertness and vigilance, within both health systems and global public health bodies, is needed. The intense political and media attention on Ebola for the past 5 months has overshadowed attention on other threats of ongoing global infectious diseases.

As with Ebola virus, the Middle East respiratory syndrome coronavirus (MERS-CoV) is a newly recognised viral zoonosis of human beings with a high mortality rate. MERS-CoV was first isolated from a patient who died from a severe respiratory illness in June, 2012, in Jeddah, Saudi Arabia.[6] As of Jan 5, 2015, 944 laboratory-confirmed cases of MERS have been recorded, with a

37% mortality rate.[7] Although most cases of MERS have occurred in Saudi Arabia and the United Arab Emirates, cases have also been reported from Europe, the USA, north Africa, and Asia in people with a history of travel to the Middle East. Since the virus was first identified in September 2012, seven MERS-related meetings of the WHO Emergency Committee have been convened.[8] The small number of cases and low risk of human-to-human transmission have not yet warranted the declaration of MERS-CoV as a Public Health Emergency of International Concern.[9] Large increases in the numbers of MERS cases in Saudi Arabia in April–May, 2013, in Al-Hasa province,[10] and in Jeddah hospitals in April–May, 2014,[11] were related to nosocomial outbreaks, poor hospital infection control measures, and improved screening. By contrast with Ebola virus disease, only a small amount of human-to-human transmission has been reported.[9-11] Reassuringly, no cases of MERS occurred during the Hajj pilgrimage in October, 2014, but a recent increased number of cases has been reported in Taif province, Saudi Arabia.[12]

MERS-CoV evoked worldwide consternation and became a focus of the media spotlight, which continued for 2 years until it was overshadowed by the Ebola outbreak. Worryingly, 26 months since the first case of MERS-CoV was reported, many basic questions remain unanswered and it remains a serious threat to global health security.[13] Little is known about its transmission characteristics. Although phylogenetic analysis of MERS-CoV isolates from human beings show that camels and bats are reservoirs for the virus, the exact mode of transmission to human beings is not yet known. Like all coronaviruses, MERS-CoV is prone to mutation and recombination and could acquire the ability to become more easily transmissible among human beings. If this occurred, it would increase the likelihood of a pandemic, which could potentially be exacerbated by the presence of millions of pilgrims from all continents, including Africa, who visit Saudi Arabia each year.[14] As is the case with Ebola virus disease, no specific drug treatment or vaccine exists for MERS-CoV, and infection prevention and control measures are crucial to prevent spread of the disease.

The persistence of MERS-CoV and Ebola virus disease draw attention to a global failure by public health systems to adequately assess and respond to such outbreaks, because of an absence of proper risk assessment and communication, transparency, and serious intent to define and control the outbreaks. In light of the shortcomings



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in existing public health surveillance capacity and infrastructures, a revised long-term strategy that addresses global governance of public health is needed. Recent statements from the G20 Summit in Brisbane, Australia, and from the World Bank Group suggest that world leaders are learning the lesson of the consequences of failure to invest in prevention, detection, and initiation of rapid aggressive early responses. Experiences from Ebola virus disease and MERS-CoV outbreaks show that all governments and WHO urgently need to implement a well-financed and well-managed response system in a sustainable way, well before the next infectious disease crisis emerges. In addition to the existing appropriate global priority focus on the Ebola virus disease, we need to ensure that MERS-CoV is not forgotten. Proactive surveillance, research into the epidemiology and pathogenesis, and development of new drugs and vaccines for all emerging and re-emerging infectious diseases that potentially threaten global health security[15] should be maintained. There is no room for complacency.

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We declare no competing interests.

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Retraction and republication—*Effect of early versus late or no tracheostomy on mortality of critically ill patients receiving mechanical ventilation: a systematic review and meta-analysis*

See **Comment** page 95 and **Articles** page 150

On June 27, 2014, *The Lancet Respiratory Medicine* published online a systematic review and meta-analysis of early versus late tracheostomy.[1] Following publication, our attention was drawn to some possible data discrepancies affecting the findings for intensive-care-unit mortality and we issued an expression of concern highlighting the details on Oct 14, 2014.[2] The editors have discussed the corrections that are necessary in the paper, and the findings of a panel that we convened, and decided that because of the extent of the changes necessary, the previous version of the Article should be retracted and a corrected version republished after re-review. The corrected version of this paper can therefore be found in this issue and the changes made are highlighted in both versions of the paper in an appendix of the Article.

The Editors of The Lancet Respiratory Medicine
The Lancet Respiratory Medicine, London EC2Y 5AS, UK

1 Siempos II, Ntaidou TK, Filippidis FT, Choi AMK. Effect of early versus late or no tracheostomy on mortality of critically ill patients receiving mechanical ventilation: a systematic review and meta-analysis. *Lancet Respir Med* 2014; published online June 27. http://dx.doi.org/10.1016/S2213-2600(14)70125-0.

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