

and absence of dedicated hospital wards.¹⁰ Yet, little progress has been made in the past 4 years. Society continues to regard adolescents with deep suspicion. Instead of promoting prevention and engagement, antisocial behaviour orders and prison sentences are readily distributed. Everybody agrees that today's young people are the future for society and each particular nation. Yet young people are often not taken seriously enough to seek and respect their views and opinions. Completely senseless paradoxes exist. Until recently, it was possible in the UK to buy cigarettes at 16 years of age but the notion to lower the age of voting is meeting continued resistance. Parents and teachers dread the years between the ages of 14 and 18 rather than awaiting them with great curiosity about the next generation's new approach to life's challenges.

With growing successes in neonatal care and increased child survival—largely achieved by sustained and expanded vaccination programmes—in both developed countries and, hopefully in the not too distant future also in developing countries, eyes should be firmly focused on the teenage years. Rather than talking about an existing gap in services that needs to be bridged, adolescent health-care services should be perceived as the most important opportunity to treat emerging

problems early and prevent ill-health by educating about and firmly establishing a healthy lifestyle. Only then will the full potential of future generations be met.

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Us and them: worldwide health issues for adolescents

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Why do the health and social needs of young people sometimes command attention, but sometimes remain obscure? The invisibility of certain societal problems is caused partly by a lack of documentation. Examples abound: the stark photographs by Jacob Riis, the Danish reformer who went to the USA in the late 19th century, shocked the conscience of a nation, with images of child factory-workers and extended families languishing in dank tenement buildings.¹ Michael Harrington's *The other America: poverty in the United States* achieved the same for hunger and poverty as public-health priorities of the early 1960s.² In Australia, Burdekin's report highlighted the plight of homeless and socially disadvantaged youth in a way that provoked shock and shame.³ Common to these examples is the slow agenda-building on behalf of groups that have remained invisible because of their stigmatised or diminished status.⁴

This *Lancet* Series shows deep sensitivity to the complex health and social needs of young people, and how those needs evolve in the face of sociocultural change worldwide. The papers in this Series incorporate three fundamental principles: first, rapidly changing social contexts promulgate new and sometimes unexpected health threats; second, health and ill-health are understood best as a result of complex interplay between biological, psychological, and sociological factors; and third, such sociological factors have global reach in their effect on young people.

Contextual change igniting new threats to health is exemplified by the movement of rural populations to towns. The sequelae of concentrated poverty, crowding, and increased exposure to harm signals new health and social threats to populations, and is under way in many developing countries.⁵ Slow sensing and response mechanisms that are intended to alert health

and social systems to emergent (and urgent) needs present a challenge. As shown by this *Lancet Series*, most primary and secondary prevention mechanisms are inadequate for this age-group, and are not based on evidence and best practice.

Health as the interplay of biopsychosocial and cultural factors underscores the multidisciplinary nature of adolescent health. This principle is highlighted by the need for youth-friendly health services and by the effect of puberty on young people's health and behaviour. For young people with chronic illness and disability, the transition through puberty is compounded by the challenge of moving from paediatric to adult health-care systems. Furthermore, the cultural features of health and health services are discussed clearly in a paper by Linda Bearinger and co-workers on global issues in sexual and reproductive health:⁶ urgent health concerns are juxtaposed with cultural taboos and traditions that are challenged by the threat of HIV/AIDS, the growing mobility of young people, and competing cultural values and aspirations, fuelled in good measure by the media.

Emphasis of the global reach of changes that affect young people creates a shorter line between us and them, whether divides are drawn internationally or between and among social groups of young people in a particular country. In the words of Marian Wright Edelman, the advocate and champion for children and youth, the health and social needs of vulnerable and disenfranchised young people serve as an early-warning system of threats that will ultimately engulf larger populations.⁷ This principle, reflected in papers on social and ecological determinants of substance use, mental health, and special populations, is shown also by the growing number of countries where the gap in opportunities between rich and poor people widens.⁸ There are 1.75 billion people aged 10–24 years worldwide, 1.5 billion of whom live in developing countries. In least-developed nations, young people make up more than a third of the population—ie, the poorer the country, the younger its population. In countries with a large number of youthful people who are poor, unemployed, and likely to have few countervailing opportunities, the likelihood of widespread violence and governmental instability is increased.⁹ The 20th century has seen periods of rebellion and revolution that tend to occur when young

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Men and young boys at the Children's Aid Society's office in New York, around 1895

people comprise a disproportionately large portion of the population, and prospects for advancement are regarded as limited and irrevocably bleak. Moreover, when the number of young people, especially males, exceeds available opportunities for education and employment, the result can be socially and politically explosive.¹⁰

Clearly, action is predicated on an understanding of problems, their causes, and appropriate courses for such action. Whether motivation is self-interest or driven by empathy and concern for the needs of young people, we are the generation of practitioners, educators, researchers, and advocates who are witness to social changes from which we cannot remove ourselves. For those with the privilege of wealth, education, and skill, our responsibility is to name what we see, articulate causes, and advocate effective pathways of response. In doing so, we act on insight from ancient times, understanding that solutions to human problems begin with the transformation of something from invisible to visible, by the giving of a name. The famous magician's flourish—*avra kedabra*—probably derives from Aramaic, meaning: "I will create

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as I speak.” Here, by synthesis of our knowledge about trends in adolescent health and identification of ways to make care systems more responsive and grounded in knowledge of what works, we not only name the factors that threaten young people’s health worldwide, but we also contribute to solutions. More than any time in the past, as our world becomes ever more intimate, this urgent endeavour must be shared.

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Steroids to prevent postextubation laryngeal oedema

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Mechanical ventilation via an endotracheal tube has undoubtedly saved the lives of many patients with acute respiratory failure. As these patients recover, respiratory support is gradually reduced until the patient is breathing unaided and the endotracheal tube can be removed. Although extubation is generally uneventful, in some patients mechanical irritation by the endotracheal tube causes substantial laryngeal oedema. In such patients, extubation might precipitate upper-airway obstruction,

which, in severe cases, will require reinsertion of the endotracheal tube. For a patient recovering from critical illness, reintubation is a major setback that, even after correction for disease severity, is associated with a considerable increase in mortality.^{1,2} Any intervention that increases the chances of successful extubation is therefore of great interest. In today’s *Lancet*, Bruno François and colleagues report the findings of a large study of the effect of steroid prophylaxis on the incidence of postextubation laryngeal oedema.³

If laryngeal oedema is suspected before extubation, patients are usually treated with a short course of intravenous steroids. When diagnosed after extubation, intravenous steroids and epinephrine nebulisers are given in an attempt to avoid reintubation. The evidence in support of this approach has been limited, with most of the data coming from studies of infants and children.^{4–6} However, findings from trials in children are not applicable to adults because of differences in upper-airway geometry and the approach to airway management. Only three studies in adults have examined the effect of steroid prophylaxis on the incidence of postextubation laryngeal oedema. In the largest study,⁷ in 700 patients, pretreatment with dexamethasone 1 h before extubation did not reduce the incidence of postextubation laryngeal oedema. In a smaller study,⁸ pretreatment with hydrocortisone 1 h

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