Correspondence on 'EULAR recommendations for the management of systemic lupus erythematosus: 2023 update' by Fanouriakis *et al*

We read with great interest the new EULAR guidelines[1] for the management of systemic lupus erythematosus (SLE), and we appreciate the care taken in synthesising the newest research to advance best practices in lupus care. Nonetheless, we were concerned by the inclusion of a recommendation to consider patient race and ethnicity when selecting among immunosuppressant options. The authors state, 'When choosing therapy, immutable characteristics, such as race and ethnicity…should be taken into account. For example, black patients with LN may be more responsive to mycophenolate than CYC.'

This interpretation is problematic in several respects. Foremost, race is a social construct rather than a biologic reality.[2] Rather than being an immutable characteristic of an individual, conceptions of race and ethnicity are continually created and recreated by societies, and racial and ethnic categories are influenced by the beliefs and prejudices of socially and politically dominant groups. Disparities in treatment response and outcomes in SLE may be related to harms of marginalisation of and discrimination against certain racial and ethnic groups, but these effects are consequences of racism,[3] not results of race itself, and therefore do not justify use of different medications. Race-based medicine has been increasingly recognised as harmful and scientifically unfounded, without basis in genetics or ancestry.[4 5] As rheumatologists, we have a responsibility to ensure that guidelines in our field do not perpetuate inaccurate beliefs about biological differences between races by endorsing race-based approaches to care.

Further, the strength of the evidence cited in support of racial differences is weak. While a post-hoc analysis of the ALMS (Aspreva Lupus Management Study)[6] trial comparing cyclophosphamide to mycophenolate for lupus nephritis induction did show numerically different response rates to mycophenolate versus cyclophosphamide among Black patients (54% vs 40%), this difference was not statistically significant. Importantly, among the small number of Black patients receiving cyclophosphamide (n=20), only half completed a full 24-week course, compared with 71% of those of other racial groups who received cyclophosphamide. Furthermore, the authors themselves state that the trial was not powered to detect an effect based on race or ethnicity, which limits the generalisability of their findings to the larger population of patients with lupus nephritis. We therefore propose that the lesson to be taken from this research is not that Black patients require different treatment, but that the myriad social consequences of race may drive differential outcomes through differences in medication access and exposure, even within a trial setting. It is important to recognise that investigation of race with the assumption that it functions as a biological factor rather than a social determinant may lead researchers to overlook more plausibly causative differences, such as treatment duration and access to care.

We therefore call on the EULAR recommendation authors to remove the statement endorsing differential treatment based on race and ethnicity—and to revise the characterisation of race and ethnicity as immutable characteristics. Guidelines such as these are a critical tool to advance the standard of SLE care and teach physicians, including those in training, about the newest approaches to lupus care. We have an important opportunity to promote equitable treatment for all patients with lupus, across all care settings by removing recommendations for race-based decisions.

Submitted on behalf of the Childhood Arthritis and Rheumatology Research Alliance Health Equity Research Workgroup, SLE Committee, Lupus Nephritis Workgroup, and Diversity, Equity and Inclusion Advisory Committee.

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