GCA can occur in people of colour: Authors' reply

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We thank Hughes *et al.* [REF] for their response. We value their intention of minimising harm related to missed alternative diagnoses and glucocorticoid-related adverse events, although this applies to all races. We respectfully disagree with their statement that race should be incorporated in clinical assessment, as the impact of missed GCA diagnosis may be devastating. Our supplementary evidence table described multiple supportive cohort studies. Since our publication, re-analysis[1] of the Gruener et al[2] study (which showed that GCA may occur at similar rates in white and black patients) has demonstrated that clinical presentation is also similar in these groups. Specifically there were no significant differences in biopsy classification (active vs healed arteritis) and visual/ophthalmic findings between white and black patients[1].

Our goal was to highlight the danger of race-based assumptions in clinical algorithms and teaching, which may exacerbate health inequalities. There are multiple recent examples of this from other medical specialties[3]. It is concerning that once established, race-based assumptions can be institutionalized. One such example includes the GCA probability score (GCAPS)[4], where an ethnicity adjustment (minus 3 points for non-white patients) was subsequently implemented[5]. Penalising non-white patients in this manner could lead to missed/delayed diagnoses. The focus should be to improve diagnostic services for all patients, including access to fast-track investigative pathways and diagnostic tests (e.g. imaging and pathology). Prioritization for fast-track pathways should be based on the usual clinical features (biologically-relevant variables) of GCA, as opposed to race and ethnicity.

It is imperative that rheumatologists join the current call to adopt race-agnostic approaches to halt the propagation of healthcare inequity. As clinicians we aim to be data-driven and practice evidence-based medicine, but critical thinking is imperative to interpret data, including appraising the biased context in which data is generated. We need to interrogate unchallenged dogma in GCA and argue that race should not be incorporated *de facto* in clinical reasoning.

References.

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