

Psoriasis and Obesity

Obesity Impacts the Body's Homeostasis



Pathological increase of adipose tissue and dysfunction induces qualitative and quantitative changes in signal production¹

These changes induce low-grade systemic inflammation¹⁻³, insulin resistance^{1,4}, endothelial dysfunction⁴, synthesis of pro-clotting factors⁴, and other metabolic disorders¹; ultimately leading to the impairment of multiple organs and their functions¹

Up to **38%** of patients with PsO have comorbid obesity^{a,b,5,6}

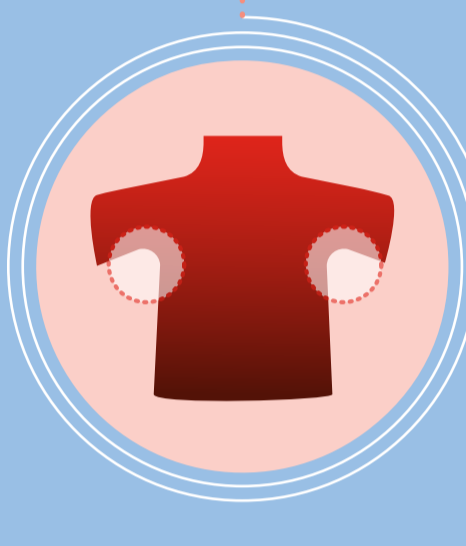


Patients With PsO and Comorbid Obesity Are More Likely to Have Involvement of Challenging Body Areas



Palms and Soles^{c,d,7}

3.5x



Inverse PsO (intertriginous areas)^{a,c,8}

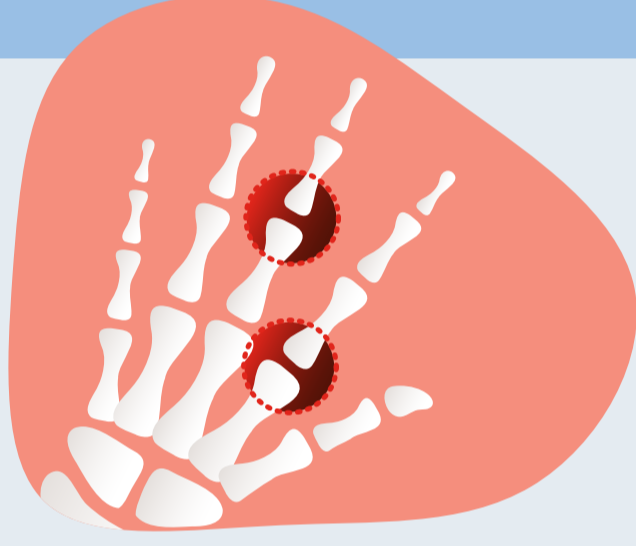
2.2x



Nails^{a,c,9}

1.8x

Higher prevalence in patients with comorbid obesity



1.5x to 3x^e
higher risk of PsA in patients with PsO and comorbid obesity^{f,10}

Treatment Considerations

Patients with PsO and comorbid obesity^a may have a **lower response to some biologics** for PsO, compared to those without comorbid obesity¹¹

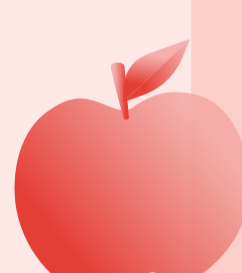
Weight loss is associated with a numerical **reduction in PASI score**¹²

AAD/NPF Recommendations for Dermatologists¹³



Inform patients regarding the **association** between metabolic syndrome components and PsO

Advise patients to practice a healthy lifestyle (appropriate diet, regular exercise, smoking cessation, and mental wellness)



Ensure that the patient is engaged with their PCP for appropriate screening

Communicate with the patient's PCP to have them evaluated and appropriately treated for obesity/comorbidities (including referral to the appropriate HCP specialist to confirm diagnosis and treatment)



Explore the other infographics in the **Comorbidities in Psoriasis** series

^aObesity defined as BMI ≥30 kg/m². ^bThe National Health and Nutrition Examination Survey (NHANES) is a nationally representative survey of the US civilian, non-institutionalized population conducted by the CDC National Center for Health Statistics (NCHS). The cross-sectional survey includes an in-home interview to obtain sociodemographic characteristics and medical history, and a physical examination and laboratory measures, including BMI, taken at a mobile examination center. Patients self-reported being diagnosed with PsO.^{5,6} ^cStudies involved a small number of patients and not all studies consistently reported the same prevalence. ^dObesity defined as BMI ≥25 kg/m². ^eBased on data from a study in US women. ^fObesity definition ranged from BMI ≥30 kg/m² to ≥35 kg/m². AAD=American Academy of Dermatology; BMI=Body Mass Index; CDC=Centers for Disease Control and Prevention; HCP=Healthcare Professional; NPF=National Psoriasis Foundation; PCP=Primary Care Provider; PsA=Psoriatic Arthritis; PsO=Psoriasis. 1. Favaretto F, et al. *Rev Endocr Metab Disord*. 2022;23(1):71-85. 2. Guo Z, et al. *JID Innov*. 2022;2(1):100064. 3. Porta S, et al. *Front Immunol*. 2021;11:590749. 4. Russolillo A, et al. *Rheumatology (Oxford)*. 2013;52(1):62-67. 5. CDC NHANES questionnaires, datasets, and related documentation. <https://wwwn.cdc.gov/nchs/nhanes/Default.aspx> (Accessed January 30, 2024). 6. Data on file. Lilly USA LLC. DOF-IX-US-0341. 7. Rathod A, et al. *Indian Dermatol Online J*. 2022;13(5):606-610. 8. Herron MD, et al. *Arch Dermatol*. 2005;141(12):1527-1534. 9. Czarnecka A, et al. *Medicina (Kaunas)*. 2023;59(11):2006. 10. Scher JU, Ogdie A, et al. *Nat Rev Rheumatol*. 2019;15(3):153-166. 11. Pirro F, et al. *Clin Drug Investig*. 2021;41:917-925. 12. Jensen P, et al. *JAMA Dermatol*. 2013;149(7):795-801. 13. Elmets CA, et al. *J Am Acad Dermatol*. 2019;80(4):1073-1113.