Transcript Details

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Psoriasis and Obesity: Going Pound for Pound on Comprehensive, Patient-Centered Management

Announcer:
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Dr. Ungar:
So we're going to start off with our patient over here, Bill, who have some of the medical history here—66-year-old with moderate to severe plaque psoriasis for the last 10 years, worsening symptoms over the last 6 months, itchy, thick plaques on the back, knees. Previously responded to topical steroids and phototherapy, but now that's plateaued. Also has a history of diabetes that's controlled with metformin, and obesity with a BMI of 33 and the associated symptoms listed below here.

So with that in mind, Bill, I'd like to just kind of kick this off by asking you a question. When did you learn, if you have, about the link between psoriasis and obesity?

Bill:
I learned about the connection when I was asked if I'd be willing to come to this conference and appear on this panel. No one has ever spoken to me about it at all.

Dr. Ungar:
Yeah. So unfortunately, I think that's probably all too common an experience. And you know, as we'll discuss, that link is a very important one, both from, you know, the perspective of treating patients and also for patients to understand as well, to be able to take, you know, kind of better ownership of their health, both in regards to psoriasis and the obesity. So, sorry to hear that, but hopefully now you're learning more about that, along with the rest of us.

So do poll #3 here: Which of the following best describes your understanding of the relationship between psoriasis and obesity? And we'll get the voting started here. So A: Obesity has no clear association with psoriasis severity or onset; B: Psoriasis is a purely cutaneous condition and is not affected by metabolic factors; C: Obesity is a risk factor for the development and increased severity of psoriasis due to its pro-inflammatory state; or D: Weight loss has no impact on treatment response in patients with moderate to severe psoriasis.

Alright, so we're going to jump in here. So you know, psoriasis is a chronic inflammatory skin disease that is quite common, affecting 2% of the global population. Certainly, don't know the causes, but combination environmental and genetic factors play a role. And very importantly, 10—or really up to 30% of patients with psoriasis also have psoriatic arthritis, really highlighting this as a systemic disease. And one doesn't need to have significant skin involvement to have that psoriatic arthritis. So really a systemic disease.

Crucially, it's also associated with obesity, metabolic syndrome, diabetes, hypertension, cardiovascular disease. And the link between this obesity, metabolic syndrome and psoriasis is a very strong one, and the complication risk in this kind of sweep of conditions

increases with psoriasis severity.

This is occurring in a background of an obesity epidemic that's increasing. And I think this really highlights here that most of this map here, which is pink or red, which is at least 30% obesity and 23 states have at least 35% of the population with obesity. Now, over the last decade or so, the overall rates of obesity have not really been increasing at a significant rate, but very importantly, severe obesity has been increasing, going from 7.7% to 9.7%. And it's not a binary condition; the more severe the obesity, the greater all the kind of risk factors and inputs that we're going to be discussing occurs.

Now, when we talk about psoriasis and psoriatic arthritis, obesity is particularly prevalent in patients with psoriatic arthritis, exceeding even that what we see with inflammatory conditions like rheumatoid arthritis as well as skin-limited psoriasis. And you know, again, this is really highlighting that link between the systemic inflammatory state and obesity, manifesting in different ways throughout the body. Patients with psoriasis have increased odds for obesity than those without psoriasis, and the worse the psoriasis, the greater the obesity prevalence.

Now, in the context of psoriasis and obesity, you know, we think about weight management and some of the inputs that are kind of leaning towards weight loss, you know, decreased caloric intake, increased activity. But on the other hand, there are metabolic factors, various hormonal inputs, that play a role in promoting weight gain and obesity. And many of these, as we're going to discuss, are linked to the same underlying pathophysiologic processes that we see in psoriasis itself.

And this, I think, really highlights the interconnectedness of inflammation as it manifests with obesity, bidirectionally, and psoriasis as well. Various metabolic factors play a role in promoting inflammation. The inflammatory state of psoriasis, which I think is kind of more intuitive, plays a role as well. We know there's a role for the GI microbiome and dysbiosis in that regard. Adipose tissue is pro-inflammatory as well. And so we see that from a number of different angles, we're getting promotion of inflammation and the downstream consequences of cardiovascular disease.

And again, you know, all of these diagrams have arrows going in different directions, because it is a complicated issue, and the different factors often feed into each other, promoting a, kind of, vicious cycle in many cases. And so, obesity promotes insulin resistance diabetes. Psoriasis does the same through mechanisms like increased leptin, decreased adiponectin. Psoriatic arthritis has many of the same inflammatory or pro-inflammatory hormones as well. In many cases still today, whether skin psoriasis or probably more so in the case of psoriatic arthritis, TNF inhibitors are used to treat these conditions—that can have a pro weight gain result in many patients as well, further exacerbating many of the issues. And ultimately, these factors combine to promote cardiovascular risk, which is a major issue in patients with psoriasis.

And so why is weight loss beneficial? You know, I think much of this is quite intuitive and well known, but still worth mentioning. So when we decrease weight, many of those risk factors decrease as well, independent of other factors. So decreasing weight typically improves lipid profiles, insulin sensitivity, decreases blood glucose, insulin levels, decreases the overall inflammatory state. And a relatively small amount of weight loss—and you know, we can use that term loosely—often is accompanied by a greater proportion of visceral adipose tissue weight loss, which is the most, kind of, pro-inflammatory component of that. And so even achieving some, you know, marginal weight loss can have, you know, tremendous benefits, and we're going to dig into a lot of that pretty soon as well.

Weight plays an important role with how well people do from the skin and joint perspective in psoriasis. So again, you know, these are obviously interconnected, but even from the dermatology perspective, thinking about how we can achieve best results with skin and joints as well, weight plays a role. So a number of studies have established this. Patients with obesity are less likely to achieve minimal disease activity than those without obesity. In multiple studies, people with elevated BMIs, less likely to have significant disease responses. And patients with greater weight or with weight loss were more likely to achieve that minimal disease activity state than those with lower rates of weight loss. So from the perspective of psoriasis, treating obesity is beneficial in terms of outcomes.

And this, from another angle, really highlights again the interconnectedness here. So we know that psoriasis produces pro-inflammatory cytokines, IL-17, TNF, IL-23 which promotes adipose tissue inflammation. But adipose tissue is itself an active inflammatory producer as well, producing cytokines like TNF-alpha, IL-23, IL-17 as well. And so you can see this feedback loop that is really combining to produce a state of systemic inflammation. And as we've discussed already, the inflammatory state, obesity, these are worsening outcomes of the skin. And the worse the skin and joints, the further exacerbation that we are seeing with the obesity aspect as well.

Alright, so with that in mind, we're going to revisit the question—what was the pre-test question? So which of the following pathophysiologic changes observed in psoriasis are associated with cardiovascular risk? And again, everyone take a few moments to get your answers in. So A: Increased omentin; B: Increased leptin; C: Increased basal metabolic rate; or D: Decreased secretion of IL-6. So please answer those questions. Yeah.

Alright, so hopefully everyone had a chance to get those answers in. Okay, trying to advance the slide here. Oh, there we go.

So the answer is B, increased leptin. By virtue of the fact that patients with psoriasis have elevated leptin, which then contributes to insulin resistance, diabetes, dyslipidemia, metabolic syndrome, all major risk factors for cardiovascular disease.

So Bill, I think, hopefully you're learning more about this connection as well. And, you know, our goal, I think, should all be to incorporate these concepts and this understanding into treating patients. Patients should not be siloed off. Here's your skin, here's your metabolic disease, and especially when the links are so carefully or so integrally tied to each other.

I just want to take a moment to highlight here that if you have questions, whether for this segment coming up, get those answers in. We're going to get to a Q&A at the end of the session, but best to get the questions in while they're fresh. And with that, I'm going to pass the mic to Dr. Almandoz.

Dr. Almandoz:
Thank you so much, Dr. Ungar, for the introduction. Good evening, everyone. My name is Jaime Almandoz. I'm an endocrinologist, an obesity medicine specialist. I'm not a dermatologist, and you can tell that I'm the non-dermatologist by my sunburn, right? Shamed into it.

Alright, so my section is going to be evidence-based strategies for obesity screening and management in psoriasis care. Quite a mouthful. So we're going to do a pre-test question.

So Sarah's a 49-year-old woman with moderate psoriasis and obesity who comes to your office for a follow-up visit. You plan to initiate a biologic therapy. Her medical history includes well-controlled type 2 diabetes. Based on the AAD-NPF guidelines, which of the following best describes the recommendations for obesity screening for Sarah? Is it: A: Obesity screening is recommended because the patient has psoriatic disease, regardless of disease severity; B: Obesity screening is recommended due to the presence of psoriasis and cardiovascular risk factors because she's got diabetes; C: Obesity screening is not recommended for patients with mild psoriatic disease; or D: Obesity screening is recommended due to concerns about weight-related complications impacting psoriatic disease management.

Okay. So what we're going to do—you guys have it on the screen? Okay. Alright. Okay, so now—has everyone answered the question? Okay, just checking. I love a technical glitch. The technical glitch is me.

So we're going to start talking again with Bill about kind of what's been going on. So we already heard, Bill, when you were talking with Dr. Ungar, that really this is not something that's been discussed with you at all. And so it sounds like you were advised to do some lifestyle modification, enroll in a gym, right? I mean, that's great, right? So here you walk onto the stage, you got your cane, and they're like, 'Have you thought about doing CrossFit? Have you heard about it?' Right? And then your dermatologist referred you to your primary care doctor, who said, 'This is a lot. Go see your primary care doctor.' What did your primary care doctor tell you to do?

Bill:
She said that maybe I could try intermittent fasting to lose weight.

Dr. Almandoz:
What did you know about intermittent fasting? Isn't that just skipping breakfast?

Bill:
Yeah, I mean, I knew it as a concept, and that was sort of what it meant to me—don't eat, you know, a late-night snack and maybe skip breakfast. That's kind of what it meant to me.

Dr. Almandoz:
It's kind of like the house wine for weight loss in primary care, right? It's kind of, 'Hey, I know you've lived with obesity for 20 years. Have you thought about not eating?' Groundbreaking, right? Can you imagine how ridiculous that sounds to patients? But even in internal medicine, I have residents rotate with me every week, and I go, what do you tell people in your primary care clinic? And they go, 'Oh, well we just tell them to get like a to-go box when they sit down and just put half of it away.' Is that working? Does that even work when the average chain restaurant meal is probably giving that person more than enough food for an entire day, will putting half of that to-go actually make a meaningful difference in their weight? Just a thought.

So what we actually do, unfortunately, in primary care, is not really provide people with viable tools. So what we're going to do in this section is talk about some additional tools that we can use in order to treat obesity. So for the audience, let's see if I mess this up again: How confident are you in your ability to integrate evidence-based obesity management strategies into patient care? A: Not confident; B: Slightly confident; C: Somewhat confident; D: Fairly confident; or E: Completely confident.

Dr. Almandoz:
Okay, so somewhat confident. I won't call on anyone, don't worry.

Alright, so we're going to get into the meat of the talk. So the American Academy of Dermatology and NPF screening recommendations for comorbidities, or really, cardio metabolic comorbidities, in people with PD disease, are the following. So there should be a cardiovascular—or really, what should be a cardiometabolic risk assessment to screen people for hypertension, hyperglycemia, hyperlipidemia. And it's recommended that there is earlier and more frequent and more aggressive screening, if you will, for patients with more than 10% body surface area affected, or for those who are candidates for either systemic therapy or phototherapy.

And what this looks like in terms of screening is, from a metabolic syndrome perspective, when we think about that as the relationship between excess and dysfunctional adiposity and our cardiovascular health, it's checking blood pressure, looking at body weight, BMI, as a tool that is for screening, waist circumference, blood sugar, A1c, and of course lipid profile as well. From a mental health perspective, there's an emphasis on screening for mood disorders such as anxiety and depression, and of course for extremes, including suicidal ideation.

And then from a lifestyle modification, in addition to things such as healthy, balanced eating, physical activity, look at smoking cessation, limiting alcohol consumption, stress management, et cetera, as part of all of this together. The goal is really early obesity detection, which may sound strange. Well, obesity detection, what does that really mean? But I think when we look at society, that almost 75 or close to 80% of people are now living with a BMI above 25, so what would be considered a higher unhealthy body weight, we're really not doing a good job of even starting a conversation, even documenting this in a chart, for us to really work out the prevalence and the correlation of disease. And so, really screening and detecting obesity early allows us to do timely interventions, including starting lifestyle modification and medical treatments, perhaps before someone develops the severe obesity that Dr. Ungar was talking about. One in 10 adults has a BMI over 40, 1 in 7 women age 40 to 60 has a BMI over 40. Just ruminate on that—40% of adults now, by 2050, it will be 60% of adults and 1 in 3 children. Okay, so sobering fact.

In terms of early weight management, we know, based on kind of what we saw earlier with the relationship between weight reduction and changes in visceral adiposity that we were talking about, there can improvements in blood sugar, blood pressure, lipids, reductions in important, meaningful outcomes to our patients, like diabetes, cardiovascular disease, and even having to use a CPAP, right? There can be better physical function and quality of life, including mobility, better mental health, and overall well-being.

So it sounds like a good package, right? The challenge is, it's really hard to do. This is the obesity treatment pyramid. And I kind of have a little bit of a love-hate relationship when things are displayed in a pyramid like this, because it almost seems to tell you that you need to start at the bottom and work your way up, where I think what this is, at least doing, or how I like to reframe this, is it's reinforcing that lifestyle modification is still foundational for health, regardless of weight. And I think that's important.

When you look at the house wine of, 'Hey, let's eat less and move a little bit more,' on average, people are going to lose 2 to 5% of their body weight, and by 6 months, they'll have gained it all back. We've all seen this in clinical practice. We may have experienced it ourselves or seen it in loved ones. But that's not to say that it's not an important health behavior. So we need to make sure that, regardless, that this is something that we emphasize, especially in the era of new obesity treatments, where people think that we no longer need to incorporate lifestyle, it's still foundational. More aggressive or assertive calorie restrictions—there's very low-calorie diets—can induce greater magnitudes of weight loss, but it's usually transient.

Pharmacotherapy kind of will older generations about 5 to 10% body weight loss. Newer generations, we're talking 15 to 22%. We'll talk about that. Endoscopic or endobariatric procedures, somewhere in the realm of 10 to 20% weight reduction. And then, of course, bariatric surgery, but less than 1% of the eligible population undergoes, but still a great treatment for obesity, about 20 to 40% body weight reduction.

The average person who comes to see me at my clinic at the University in Dallas wants to lose 30 to 40% of their body weight. That is not going to happen alone with trying to eat a more balanced diet and walk more. We need to be aware of what we are asking of our patients, what they want of themselves from a health perspective, and make sure we are offering appropriate therapies that is matched to the magnitude of change that we want and that they want too.

The important thing is, when we look at weight reduction or lifestyle change, there is an anti-inflammatory kind of component to this—not to sound too hokey—with regards to how health behaviors can influence improvements in inflammation and overall well-being.

From a behavioral therapy perspective, we're talking about physical activity, stress and sleep management, smoking cessation, and moderating alcohol intake. From a dietary perspective, a more balanced diet—we could all do better jobs at having a more balanced diet that includes more fruits and vegetables and kind of whole foods. So really, dietary quality is really what we're emphasizing rather than

restrictive patterns of cutting out certain things or vilifying certain products. Minimizing processed food is an example of how we can do this, cutting back on sugar-sweetened beverages. And of course, it says maintain healthy BMI, but I think for 80% of the population, it's how do we get to a healthier BMI and then work on maintaining it.

In addition, there are additional risk mitigation strategies, such as aspirin, statins, incretin-based therapies, and others for specific populations that are also indicated. When we look at the use of obesity medications, also called anti-obesity medications, or obesity management medications, these are things which can be added to lifestyle modification to help people to achieve a greater magnitude of weight reduction and also to maintain that.

We've talked about how lifestyle modification is foundational, regardless of weight status and where we want to be, but considering the addition of obesity medications for those who have challenges with initiating or maintaining lifestyle changes, or for those who experience weight recurrence, or if they have weight-related complications or comorbidities, that we know these medications could help, and that includes type 2 diabetes, steatotic liver disease, obstructive sleep apnea, and many other things for which there are secondary indications for these therapies.

We're fortunate to live in a time where there are many obesity medications. Stick your hand up if you've prescribed a medication for weight loss in the last year. So quite a few people. Stick your hand up if you prescribed a medication for weight loss 5 years ago. Not really, right? And that's kind of a few things. One, we really didn't have good stuff five years ago, right? We pretty much had amphetamines. But what we're also seeing is a lot of demand for this, not just from a health perspective, but also from our patients. Hands up if a patient has come in to you asking for an obesity medication within the last couple of years. Exactly.

So what we're seeing is an uptake, but also a demand for people who want to use effective therapies. We have the oldies—some are not goodies—things such as orlistat, a pancreatic lipase inhibitor, which really stops you from absorbing about 1/3 of your dietary fat. So it gets really messy with our standard Western diets.

When we think of biodegradable devices, those are really the hydrogels that kind of occupy space in our stomach. Those really aren't being produced right now. Phentermine is the number one prescribed obesity medication in the country because many people are familiar with it. It's a sympathomimetic that can be used by itself or in combination with topiramate, which adds in some carbonic anhydrase action and GABAergic properties that decrease cravings and also change flavor profile by impacting our taste buds. Bupropion/naltrexone, really kind of focuses in on kind of pleasure and reward centers that can really help with hedonic drive for consumption.

And now we have kind of the newer generations, the incretin-based therapies, liraglutide being the first one, GLP-1 mono agonist, followed by semaglutide, another GLP-1 mono agonist, given weekly, and then tirzepatide, a dual GIP/GLP-1 receptor agonist, in addition to a host of off-label medications and pipeline medications that many of you will have seen in the news in the last 6 months.

There are medications that don't work, and then there are medications that have side effects. That's what I tell the trainees all the time, right? And so what we need to do is make sure that we match the treatment, not just in terms of effectiveness and efficacy, but also in terms of what are potential risks. So if I have a post-bariatric patient, I'm not going to give them orlistat, for example, because their risk for malnutrition is going to go up exponentially. If I have somebody who has anxiety and insomnia, I'm less likely to give them a stimulant, such as phentermine, or, for example, something like bupropion, which is more of a stimulating antidepressant medication.

So what we need to do is kind of look through—and these will be available as part of the enduring materials—and think, for my patient, if they can't get access to a GLP-1 agent, what else could I do to help decrease their body weight in a way that is right for them and safe for them? It almost feels like we're in a GLP-1 or bust environment these days, but there are effective treatments that can be used to help people to achieve a healthier weight.

With regards to medications that are kind of what we call second generation incretin obesity medications, we're really focusing on semaglutide and tirzepatide. Daily liraglutide is an option, average about 8 to 9% body weight reduction versus semaglutide, which is about 15, and tirzepatide which is about 22%. These work centrally in the brain to tell the brain that we've already eaten and tells the stomach to empty more slowly so we're satisfied with less food for longer.

We're fortunate to have the first direct head-to-head comparison. These are results from the SURMOUNT-5 trial, which looked at semaglutide 2.4 mg weekly compared with tirzepatide for weight reduction at 72 weeks, and what we see here is 15.4 versus 21.6% weight reduction. So people lost more than 45%, greater weight reduction with tirzepatide relative to semaglutide, and greater likelihood of achieving 20 and 25% weight reduction, which is a target for many of patients coming in requesting weight loss.

So what we have are effective agents that work, as long as you take them, as long as you can get them. That's another conversation for another day.

In addition, there's a lot in the pipeline as well. There's no end to the combination of different incretin-based hormones, mono agonists, dual agonists, and tri agonists that are coming in the pipeline. And I think we're coming to a place where we can create more of a precision approach to obesity care, where we're not just relying on something that has the greatest magnitude of weight loss, hoping that, for example, everything else is going to follow along with the weight reduction. By leveraging the action of different proteins and hormones, we can hopefully influence different metabolic pathways and also different inflammatory pathways along the way as well, in a way that is individualized to the patient.

Beyond that, when we look at the results, so these are from three of the STEP studies looking at weekly semaglutide, in addition to the weight reduction—and I apologize for these being both small and crowded—what we can see is the weight reduction through 68 weeks. So that's after the dose titration, and then followed for 52 weeks on treatment. We can also see reductions in CRP as a marker of inflammation. So reductions in CRP of somewhere between 40 and up to 60% at 68 weeks with treatment.

And we see this in a variety of different incretin-based therapy studies, where in addition to the weight reduction, and sometimes independent to large changes in body weight, we see reductions in inflammation that are likely benefiting not just overall health and well-being, but inflammatory and autoimmune conditions as well.

It's important, when we look at obesity care, not to think that this is a set-it-and-forget-it type condition, or we just write a prescription and hope that it's going to work; this is an integration of a variety of different team members to optimize nutrition, physical activity, mental health, and overall well-being to make sure that we are focusing in on the patient in the center. This is patient-centered care, not just a number on a scale or how much skin is inflamed.

In addition, there are a variety of different resources that you can access. It'll be part of the enduring materials that I would encourage you to explore.

And so with that, we're going to get to the post-test question. So we're back to Sarah, and so the 49-year-old lady who has moderate psoriasis and obesity and who's here for follow-up visit. So the question is, which of the following best describes the recommendations for obesity screening? Is it A: Obesity screening is recommended because a patient has psoriatic disease, regardless of disease severity; B: Obesity screening is recommended due to the presence of psoriasis and cardiovascular risk factors; C: Obesity screening is not recommended for patients with mild psoriatic disease; or D: Obesity screening is recommended due to concerns about weight-related complications impacting psoriatic disease management.

And so the answer is A. And the rationale being, according to the joint statement, that all patients with psoriatic disease should receive an annual screening for obesity, regardless of severity. Patients with more active disease, or those with comorbidities, such as hypertension, dyslipidemia, or metabolic syndrome, should be screened more frequently.

And so with that, so Bill, you know, kind of with the wrap-up there, you can see that there are a lot of different things that we have beyond lifestyle and dietary modification that can help not just also facilitate that weight reduction that your doctor wants and that you want as well, but also can help to decrease inflammation and hopefully get to the root cause of some of the challenging health issues you have. What do you think about that?

Bill:
I think that'd be great.

Dr. Almandoz:
Alright, so if you do have any questions or I skipped over things that you want clarity on, please do put them into the iPad and we'll address them at the end. Thank you so much.

Dr. Butler:
Alright, we'll go to the final part of this wonderful session. We're going to talk about patient-centered approaches. Before I go into that, I want to welcome everyone to Tucson. This is my home, so I feel very comfortable with the cacti over there. So thank you to whoever put that up there. Raj, I'm looking at you. Thank you. I feel very comfortable. But welcome, everybody. Sorry, it's a little hot.

Let's start with a pre-test. So we have a 45-year-old woman with mild psoriasis and a BMI of 37 who visits your office for frequent flares. She has tried various nutrition and activity strategies with short-term benefit but prefers to avoid surgery. Which healthcare professional statement best reflects shared decision-making—a concept we're going to go over a bunch in this next 10 minutes—shared decision-making when discussing medication options for obesity?

So let's move forward on this. We're going to do another pre-test here. Just pummel you guys with tests before we get into shared decision-making. So how confident are you in your ability to initiate conversations with patients about their weight? Great, great DJ.

Alright, so I'm going to turn to Bill here for this next section. Another part of the richness of this conversation is to be able to ask Bill these questions. So of course,

Bill, I don't mean to speak for you, but there's some frustration I've heard and losing confidence in the standard treatment approach, and is interested in systemic treatments but concerned about the idea of shots and side effects. So I think, tell me, tell the audience a little about where that conflict comes in for you, between wanting different outcomes but the risks of the medications you perceive.

Bill:
Right. Well, I'm a multiple myeloma survivor, and so I've been through a lot of treatments—chemotherapies, shots in my belly, you know, a lot of side effects from medications. And so, while I recognize that my weight is a problem, you know, I'm reluctant to start a new medication or to, you know, undergo, you know, some other kinds of treatments that may make those side effects come back, make them worse, that sort of thing.

Dr. Butler:
I think that's a perfect answer and captures probably what a lot of us see in clinic rooms, which is a really earnest conflict for a patient who's had prior experiences or fears that have driven something about the medication that's a very true part of the medication.

So let's dive into how we approach that. One more poll here, I promise: Which best reflects how you typically start discussions on obesity, if you typically do that?

Alright, we'll move it forward here. I think that probably reflects exactly where most of us are linking.

So initiating these discussions about obesity, you know, in dermatology practice, as Jaime was mentioning, is probably not something that we were doing 5 to 10 years ago, but it's starting to pervade now, and it's really important that we get some comfort with it. And, you know, I say this to my residents every day, I said it to them today, is before you learn to run, you've got to learn to walk. And I think sometimes it really helps for us as specialists to just take a step back and really capture what we want to be doing in a room with a patient, which is truly sharing the decision. And I think sometimes we get a little myopic as specialists, because we're trained to do really specialized things. But at the end of the day, we all want to be there coaching, supporting, and helping somebody through a specific decision.

So here's some of those strategies specifically when it comes to obesity. So of course, using respectful person-first language, of course educating on obesity and the benefits of weight loss. I think our understanding of that question or those facts has grown exponentially within the last several years, and so I think we can add a ton more richness to that conversation than we did just years ago.

Of course, considering the available referrals and other options, that's another piece to this that I don't think we do as specialists a lot. I think we're sort of ping-ponging between primary care and us, and then we ping-pong back. But we can also be the ones that initiate those discussions with dietitians and surgeons who may also be looking for these same outcomes.

Of course, discussion of treatment options regarding risks and benefits. Like Bill was mentioning, this is not a straightforward discussion here; this is something that's going to be deeply personal, and so digging into that risk-benefit discussion. Educating on the physical activity and nutrition element of this that we all know very well. We see it every day on our screens and our feeds, but coming from a healthcare professional, there's evidence that there's a lot of value when it comes from one of us.

And then, of course, providing patient-centered care, and I'll just harp on that because I think it's so important. And if you guys have not been around lately, there's something called AI that's coming, just spoiler alert. And the value of us as coaches and support is going to be so critical because the availability of information is about to explode. Someone's going to type in, 'What are the five best treatments for weight loss,' where before they may have had to find *JAMA Derm* or something beyond *JAMA* or *New England Journal* to find these facts. And now they'll find it like that. So they need someone to shepherd them through that. So this is really developing a skillset that's stealing us in this coming era.

So let's start this discussion, this discussion that we may not do all the time. And there's three specific areas here that I think we should tag. And I'm not going to go over each one of these examples, you can read through them, but I think these three topics are ones that if you come away with these three aspects of the discussion, I think that's a healthy start in that walking process of building this muscle of having this conversation.

So number one is ask patients for permission to discuss their weight. I talk about this with my residents a lot. We need equity to be having these really significant conversations with patients. So this isn't something where you walk in the room. I know every dermatology provider here is very busy. You have 10 minutes with a patient. You're not going to walk into a room and immediately say, 'Oh, there's a weight issue here, so I'm going to offer treatment.' This is something that requires equity, and this is part of that building of

equity with the patient that perhaps you may cash in on in that visit or cash in on at a later visit when you follow up.

So number two is asking patients about their weight-specific history. Trying to understand them builds empathetic rapport that I don't think our normal questioning of just looking at the skin and making a diagnosis necessarily gives a runway for this specific discussion. So I think if you can start to ask, 'What has your weight journey been like?' you're starting to dive into that, and you receive a runway to be able to see, is this something they want to talk about? Is this something that they've explored before?

And then the last one is assessing the patient's history and the weight-related comorbidities. Again, as healthcare providers, we all know about these, but I think in dermatology, we tend to shy away from them. But we need to be part of this house of medicine where we use the muscle that we know, both from a patient-centered communication side and what we know about these conditions. And I think the psoriasis gurus of the world have really done a nice job educating us on that.

And I'm going to build on Jaime's talk, because I do think that there is an element here that often is missed in the weight loss conversation, which is that this is a chronic condition, and Jaime hit on it several times, which is, this is not a—I forget the phrase you use, I was trying to keep it in my brain—but you don't just shut this off. This isn't something where you just take a medication and then it goes away. This is a chronic disease. And I personally think that us in dermatology, we're pretty darn good at chronic diseases. We really understand how to control these chronic diseases, and that's really what we see in weight management. Yes, you may see initial improvements, but it's going to take continued effort. And I don't mean effort in the sense of just doing CrossFit. I mean it's going to take continued effort in multiple different avenues, and this is where we have agency. This is where we can educate. This is where we can guide. This is where we can be nimble and help somebody in that chronic disease struggle here.

So if you look at these new hot-shot treatments, I think some of them have been criticized for the lack of their durability. If you come off the treatments, as you see here, you start to see return of weight. And I think the sort of lay discussion of that as well, they don't really work because everything just comes back. But I challenge us again to think of weight as something that we have to hit in multiple different avenues.

And I think this is a new era in dermatology and in medicine in general, where we're not just thinking of diseases along one line. As much as it's nice to block one cytokine or have one treatment for acne, it's not that anymore. It's about continuous coaching, personal reliability, and communication with this equity strategy of getting to know somebody.

So we're talking about these clinical strategies to prevent weight regain and comorbidity recurrence. And that's where our role as healthcare professionals is to make sure that we maintain that coaching relationship, where they may have some successes, and you're not shaking their hand and saying, 'Good luck, get out the door. Hope for the best.' We have to know what this pattern looks like and be able to manage when we see them back in 3 months, and you may see some changes in weight, or you may not even see some changes in weight, but you should ask about them because now you are part of this journey for them, and you are coaching, supporting along this chronic disease journey.

So as we again take a step back as supra-specialists, we are capable of not only being the specialist that we want to be, seeing the skin, identifying morphology, knowing these really complex treatments or procedures, but also taking that patient-centered approach. And specifically with obesity management, we're able to personalize our care plans. That goes for both dermatologic conditions and for weight management. That also means that we can be collaborative. My wife is a geriatrician, and she's like, 'You guys don't collaborate with anybody.' And I challenge that a bit. She usually challenges me with many things, but this is the thing where I think we can grow. I think we can work specifically in the idea of weight management. I think we can grow in our collaborative approach, not only with the primary care. We have a license with these patients that I think many other specialties don't necessarily have. Of course, I've talked about this. I love using the word coach, but this continuous support and follow-up is huge. That's how you build the equity, that's how you're able to guide treatment approach.

And then, of course, we are powerful as educators. It's not just skin check and leave or biologic and out, there are other elements to this that we can help promote. And we heard about all the different ways that we can influence this obesity management discussion, as long as we're relying on that patient-centered discussion and shared decision-making.

So as we take a step back and look at this through the obesity and psoriasis lens, these are the five points that I want you to go away with: so engaging patients and their caregivers with respectful and personal person-centered language, discussing history, potential comorbidities, treatment options and lifestyle choices to facilitate comprehensive care and enhance their quality of life, build a trusting relationship—that equity that I talked about—educate, educate, educate about the chronicity of this and the possibilities, and the ability to recover even if there have been steps back. And then the last one is always consider those patient goals and preferences.

So we're going to go back to those polls that we were pummeling you with in the beginning. So how confident are you in your ability to

integrate shared decision-making for obesity management strategies into patient care? Alright, it's growing. I love it now. Let's do the debrief.

So you know, Bill, I think your personal conflict of having a lot of side effects with your other medications, or the concern of reliving those is very real, and this is where that discussion comes in. So having a trusted healthcare provider who can guide you through that, not sugarcoat it, in an earnest, honest way, is what I thin the next era is for dermatology, and I hope you see it that way as well.

Bill:
I do.

Dr. Butler:
Awesome. So please submit those questions and answers. This is when we'll end up doing it. I think we do have a couple posttests. Let me make sure that I didn't fly through them. Yes.

So we have our 45-year-old with mild psoriasis, BMI 37. She prefers to avoid surgery, as I mentioned. Which healthcare provider statement best reflects shared decision-making when discussing medication options for obesity? Give you a couple seconds to answer.

And the answer is—and this was a tough one. It is A, the response reflects shared decision-making by inviting the patient to explore treatment options in a collaborative, respectful way. It centers the patient's goals, acknowledges the medications are one possible tool, and emphasizes finding a personalized fit rather than prescribing a one-size-fits-all. Now. I think this is hard. I don't think the other ones necessarily don't do those things, but I think of the choices, this was probably the best one.

And then one more posttest here, I believe. Going forward, how confident are you in your ability to initiate conversations with patients about their weight? Alright, very confident. I love it.

And do you plan to make clinical changes or changes to your clinical practice based on what you learned from today's program? There is a right answer to this one.

We'll go into the Q&A right after this, guys. So thanks for bearing with us.

Just kidding. One more. There you go. Perfect, awesome. I'm told there's one more here, after the takeaways. Perfect.

So this is just to sum up all the rich discussion today. So we're taking away the pathophysiology of obesity, which Benji was able to go over in an expert way, even modest weight loss, and this is a fact that I love to bring into clinic that I learned from developing these slides, even modest weight loss is beneficial in improving health outcomes. Anti-obesity medications are effective tools that help patients achieve significant weight loss. And then, of course, the multidisciplinary approaches that address these underlying mechanisms of obesity and psoriasis are so critical to our ability to treat and meet these patients where they are.

So please take a minute to text in one key change.

Dr. Ungar:
We can probably start answering questions in parallel.

Dr. Butler:
Yeah. And I think they're up there. And I think there were several from Jaime's talk, so I'd love for Jaime to get to talk.

Dr. Almandoz:
Yes. So I think what we can do is kind of do a combined one. I like this first one. What they're basically asking is, do you prescribe obesity medications for patients with psoriatic disease? Or do you refer them out to an obesity specialist or an endocrinologist?

Dr. Ungar:
Yeah, I mean, well, I think that the conversation that Dan just had really illustrated there's no one-size-fits-all. It really depends on the patient, depends on the circumstance. Often, I will try to pair with obesity specialists and so on, but, I think, at the very least, initiating the conversation, bringing that as part of their skincare—you know, the care for their skin, although that's really their overall health. I think it's important so that we're not siloing off, 'Okay, I treat your skin. They're treating your obesity,' and there's no relation between the two.

Dr. Butler:
I'm very similar, but a little more blunt. I definitely prescribe them, but I first ask, what is your goal from a weight standpoint? And then once I know that, if they say anything that's even more complex, than, you know, 'I'm looking for a singular medication.' I say, Look, there's people who know this much better than I do.

The other element to this is access. So, you know, I've struggled through trying to find different access portals. So that's been a struggle

for, at least me in dermatology and some other people I've spoken with, but I'm certainly doing it more and more for several of our obesity comorbid skin conditions.

Dr. Almandoz:
Yeah, I think that's a great point. And to your wife's point, I think we all need to collaborate more. I think there are challenges where it's not just about a dermatologist, an endocrinologist, obesity specialist collaborating on the patient. It's about how we're incorporating registered dietitians, other resources in our community to make sure this happens. As much as I would love for every sub-specialist to be able to prescribe an obesity medication, these impact a lot of different things. And so you may have a patient who has type 2 diabetes on other medications, or on three blood pressure medications, are you going to see them back with the frequency to adjust all those medications too? So we need to work out a patient-centered approach where we can collaborate together to make sure that we're not just focusing on the weight, but we're adjusting things and working together in a way that works for the patient. So I think that's a great question.

I'll take this one quickly. If someone has undergone bariatric surgery and lost weight but then gained it back, would you treat them with a GLP-1 receptor agonist? And if so, what are they most at risk for? And is there special nutrition counseling? So kind of with that, back to Dan's point, you know, we don't cure obesity—surgery is not curative, medicines aren't curative. And we've published several papers from our group regarding post-bariatric weight recurrence and using medications to treat it. They are just as effective in people after bariatric surgery. But beyond that, many people who live with severe obesity will have other cardiometabolic and other issues that these medications will benefit, be that recurrent steatotic liver disease, recurrent hyperglycemia, or cardiovascular risk. So don't just think about this as I'm treating the weight that's coming back. It's how am I going to keep their diabetes in remission? If we can use that term for diabetes, how are we going to control their other risk factors to improve their long-term risk and quality of life?

And, of course, integrating nutrition, because having obesity is a risk factor for malnutrition. Having bariatric surgery is a risk factor for malnutrition. Fortunately, most patients after bariatric surgery are not getting guideline-based screening for post-bariatric deficiencies and are not taking recommended micronutrient supplements. So we need to make sure that we don't compound risk for malnutrition by just prescribing medications blindly in this population.

Dr. Butler:
Absolutely. There's one that says—and I would love for everyone to answer this, just because I love hearing everyone's thoughts on this—but how do you incorporate shared decision-making specifically in your practice with therapeutic goals? Do you have any tips or tricks, or pearls that you use that you're willing to share?

Dr. Ungar:
I mean, I'm happy to start. You know, I think the answer to that, you know, really gets compounded when we think about multiple aspects about health. You know, if it's just the skin, that's a different story. But when you have someone with obesity or risk for obesity as well, that's part of it. You know, coming from the dermatology side of things, thinking about that as a starting point, to me, you know, we talk about the different options, and I really kind of present it—I think of it as a menu of options for patients, and discuss the benefits, downsides, the different characteristics of the treatments, anywhere from topicals to systemics, phototherapy, kind of the whole range, and try to understand what seems to make sense to them the most.

I think that one of the most powerful factors in treatment success is patients buying into the decision and feeling like they have ownership. And I think this is, you know, really is true of really every aspect, but when patients understand or feel like they are part of the decision, they're going to be more likely to follow up, adhere to treatment, and get the best outcomes.

Dr. Almandoz:
Patients are the subject matter experts in their lives and their goals. And I think kind of the way I talk through with patients is, you know, we help patients in a lot of different ways. What's our destination together? Because there are a lot of different ways that we can get there. There are a lot of different modes of transport. And that could be—if we're talking about obesity—lifestyle, medication, surgery, but each mode of transport has its own cost, takes longer, or may not be accessible right now. And so making sure that we work out how we're going to measure success, both on and off the scale, what are quality-of-life things that we can use for engagement tools, because what we're doing is practicing chronic disease management. We all do that; dermatologists, endocrinologists, all of us. And so the question is, how do we engage our patients in this? Because this is not just something that we're going to cure, write a script, and we're done. So it's so important, like you just said, Benji, that we need to kind of work out how we're going to engage them in part of this journey, so that we don't just expect things to happen.

Dr. Butler:
Yeah. I mean, I love that. And I'll just pick on from both of you, the idea of the menu, I think, is a great one to say, hey, here's the menu.

Let's choose together. Then also what Jaime said about the journey, which is, hey, we're in this journey together for a destination. Let's figure out how to get there.

And then just from the provider standpoint, I do want to acknowledge that shared decision-making is very different for a lot of patients. I mean, how many times have you settled into that shared decision-making conversation, and you tee up, you do your best empathetic communication, and the patient's like, 'You're the doctor, tell me what to do"? And so I've had that happen many times. And then I use exactly what Benji said, where I mirror it right back and say, Look, your agency in this is what will help this succeed. So I need you to buy in. So I could prescribe something because I'm the doctor, but I need you to buy in too. So tell me how you feel about this. So I think that mirroring effect is really important, as well. But I couldn't agree more with you guys.

Dr. Ungar:
I'll just do one more very quick one. Yeah, so there's one. Some patients taking anti-obesity medication, does this affect your treatment selection for psoriatic disease? And if so, what considerations are you making when selecting a permanent medication for the patient's psoriatic disease? You know, so I think that this is kind of just a comment. I think, you know, one of the things that's a little too bad is that many of the treatments have shifted from weight-based treatments in psoriasis. We have to go back, you know, several generations now to have some of that. And when particularly if someone is more obese, we know that their disease can be more resistant. And you know, if they're on an anti-obesity medication, I think that's a good start. That's kind of encouraging that we're going to get better responses. But we really have to talk about effective treatments.

Now, the reality is, we fortunately, several effective treatments. You know, many of the menu still exists, so it's not that it necessarily greatly impact things, but I think it still needs to be thought about in the context of what else they're on, what else they're taking. I don't typically prescribe TNF inhibitors at this point to treat psoriasis. If someone has obesity, that would be a knock against that. If there was a circumstance where I'd be thinking about that, especially in psoriatic arthritis where it's often used, that might be something that I actually shift away from.

Dr. Almandoz:
Bill, as we start to wrap up, are there things that you'd like people to take away from a patient perspective? What are your takeaways?

Bill:
The last discussion really, you know, struck me. I suppose that there are those people who say, 'Dr. Butler, you're the doctor, you tell me what to do,' but what I want is to be included. My multiple myeloma care has been so wonderful, because from the first moment, my doctor made it clear to me that I was a part of this, that he wasn't just treating me, but I was a part of the whole procedure.

And you know, the other thing about weight loss and these various things is be willing to have the conversation. You know, I told these guys before, I know I'm overweight, I get dressed, I look in the mirror, I know I'm overweight. You not telling me that, or not talking about it, doesn't change the fact. So I really, you know, would appreciate it as a patient, whether everybody agrees with this, I don't know, but I certainly would appreciate it if you were willing to have the conversation, because my health depends on it.

Dr. Butler:
Well said, Bill, thank you. You're such a value to have here, and you're the real star of this, so thank you.

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