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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Raising the Bar on Obesity Management in Psoriasis and Psoriatic Arthritis: A Collaborative Learning Experience for Dermatology and Rheumatology Healthcare Professionals

Announcer:
Welcome to CME on ReachMD. This activity, titled "Raising the Bar on Obesity Management in Psoriasis and Psoriatic Arthritis: A Collaborative Learning Experience for Dermatology and Rheumatology Healthcare Professionals" is provided by Clinical Care Options, LLC in partnership with Practicing Clinicians Exchange, LLC, National Psoriasis Foundation, Group for Research And Assessment for Psoriasis and Psoriatic Arthritis, and Obesity Medicine Association.

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Dr. Mease:
Here are a few factoids. One of them is that worldwide, there are about 2% of the world, who have the condition psoriasis. In the US, this number is actually 3.2% based on a large NHANES survey conducted by April Armstrong and others.

About 30%, based on most studies, end up having psoriatic arthritis within that psoriasis population. And in both, whether it is psoriasis alone or PsA, the key comorbidities are obesity, metabolic syndrome, which represents the combination of obesity, hypertension, hyperlipidemia, also diabetes and cardiovascular disease.

This is a huge issue for these patients, and one of the reasons for early morbidity and mortality in those that have these diseases. And as the conditions become more severe and untreated, these complications are greater.

This is a graph which gets across the point that once you have psoriasis, your risk for developing psoriatic arthritis increases over time. And this leads to the 30% figure that is most commonly seen within groups of patients with established PsA.

Turning to obesity prevalence. Here's a map of the US that shows in this pinkish reddish color that we are looking at up to 30%, 40% or even higher in some parts. I see Louisiana down there as being very high frequency of obesity. This graph is split into obesity and then severe obesity, which is BMI greater than 30.

There are many reasons for obesity to occur. The ones that we know about and that are part of the psoriatic disease platform are the physiologic and genetic reasons, including:

- Variations in hormone levels;
- Variations in drive for eating;
- Use of medications that may increase weight; and then,
- The underlying disease of psoriatic disease.

This is driven largely by genetic variations in these patients. So even if they really, really, really are trying hard to manage their weight, nonetheless they will be on the obese side because of their genes.

Of course, there are a variety of behavioral factors that drive all of us as humans to be overweight. And that includes diet. And certainly we are guilty of that in American diet, inactivity, emotional factors, lack of sleep, smoking are all contributors.

And then, various environmental and cultural factors that are listed there.

I mentioned that even with people attempting to adjust their activity, increasing physical exercise, decreasing calories, they tend to be overweight. There are other interesting features on the other side, including increased hunger hormone, decreased metabolism and decreased satiety hormones that all are part of the tug of war going on for weight management.

This is a complicated slide, which speaks actually to bidirectional relationship between inflammatory autoimmune diseases like psoriasis and psoriatic arthritis and these various comorbidities that we've been talking about, including, molecular changes that occur starting with, on the right hand side of the slide, with:

- Diabetes and insulin resistance;
- Various factors that lead to increase in visceral adipose tissue or VAT;
- Changes in both inflammatory molecules, but also lipid inflammatory molecules like adiponectin and perivascular fat accumulation;
- Alterations in the gut microbiome, or the skin microbiome, that lead to inflammation and are mediated by fatty acid pathways;
- Dyslipidemia, elevated lipid levels that contribute to inflammation;
- Smoking; and then,
- Reactive oxygen species.

So there is a complex relationship between all of these factors.

And even as patients work hard to control inflammation, control cholesterol, be assessed for and control thrombotic risk and diabetes risk, nonetheless, there remains a certain proportion of these risks that no matter how hard we try to completely ablate them, they remain present.

And so, although it is important to address each of these in our patients, either you as a physician for their autoimmune disease knowing that these are risks for the patient and stepping in to help manage them, or working with the team including primary care physician or primary nurse practitioner that is working with the patient, but also other specialists, including cardiologist and endocrinologist.

This slide also speaks to what we referred to earlier, this bidirectional relationship between inflammation and various physiologic and genetic factors for obesity, diabetes and dyslipidemia, leading to the risk in the first place of having psoriasis. We know that even in childhood, if you have an overweight child, they have a greater risk of psoriasis. And especially as we get into adulthood, that is the case.

And we know also that patients with established psoriasis who are obese have a greater risk of developing psoriatic arthritis. And then with both conditions, there is increased cardiovascular risk.

And these are some of the adipose-related hormones and inflammatory factors that lead to this, including increased leptin, which is a clue to one of your earlier questions.

This is a summary of some of this material. Let's just walk through this.

With inflammation, obesity triggers low-grade chronic inflammation, which can both promote the origin of psoriasis in a person, but also exacerbate existing Psoriasis due to immune dysregulation.

There is increased insulin resistance, which is part of the obesity picture. And this in and of itself may contribute to psoriasis by affecting keratinocyte proliferation and inflammation.

Adipokines are the, if you will, inflammatory molecules that are released by adipose tissue cells. And this can, of course, influence, our inflammatory activity and also dampen the response to anti-inflammatory or immunomodulatory medications that we are using.

Microbiome changes, especially in the gut, that are changed or expressed differently when a person is obese will then subsequently affect systemic inflammation and then genetic factors underlying all of this.

These are some of the key cytokines which we all know except for perhaps IL-8, and again speaks to the bidirectional nature of this relationship with TNF, IL-17, IL-6 and IL-23, all being involved and being increased when you have:

A. The autoimmune disease on the one hand; and
B. Obesity on the other.

We all know that when we get a CRP level back from the lab, we have to take into account, is the patient that we are seeing this value in overweight or not. And so sometimes when I see an overweight patient yielding a CRP that is slightly elevated from the lab, I do not know whether that is because they have unchecked inflammation in their skin and joints, or is it because of the obesity?

When it is very, very high, I assume that there is unchecked inflammation in skin and joints that is contributing to it. But it is important to recognize that CRP elevation is part of the obesity picture and increases cardiovascular risk factors, including atherosclerosis.

Steve, we've got another question.

Dr. Feldman:
Yeah. Thanks for going through the relationship between the psoriatic disease and obesity. To put a cap on it, which of the following pathophysiologic changes observed in psoriatic diseases are associated with cardiovascular risk? The increased:

A. Omentin;
B. Leptin;
C. Basal metabolic rate; or
D. Decreased interleukin 6.

Speaker:
The poll is open. Please vote. All right. Thank you so much for your votes. I will close the poll and share our results.

Dr. Feldman:
Super. Next slide.

Dr. Mease:
You all got it. That is great.

Dr. Feldman:
Yes. The increased leptin contributes to insulin resistance, diabetes, dyslipidemia, and metabolic syndrome. All right. next.

We'll talk about the screening and management. Next slide. It is all yours.

Dr. Mease:
Actually, Steve, why do not you take it away?

Dr. Feldman:
Yeah. Let me describe our case. It is a patient with moderate to severe psoriatic disease and obesity. She's 53 years old, moderate to severe psoriasis. She has psoriatic arthritis, prediabetes and obesity. She has got extensive disease, scalp, body, lower extremities. A former smoker who quit ten years ago, 20-pack year history of smoking.

On exam, you see all these lesions on the scalp, torso and legs. She has swelling in the proximal and distal interphalangeal joints along with heal tenderness. Pain is seven out of ten getting better as the day goes by. Blood pressure 140 over 90. Current medications include methotrexate and ibuprofen. That is interesting.

All right. Next slide.

Aside from evaluating her skin and joints, what else might you assess?

A. Nothing else;
B. Height and weight for BMI;
C. Ask the patient what her weight is, whether she's doing exercises; and
D. Evaluate lipids and glucose to assess cardiovascular risk.

You can choose more than one of these, if you like.

Speaker:
Poll is open. Please vote. All right. Thank you for your votes. We will close the poll and share the results.

Dr. Feldman:

Okay. Very good. And then next slide.

After evaluating Martha carefully for her psoriatic diseases, you plan to initiate a biologic. During your assessment, you note that her BMI is like 32. In addition to treating her psoriasis and psoriatic arthritis, what else might you consider for addressing her obesity? Again, you can choose more than one of these.

A. Defer intervention for obesity, given the multiple things you're having to deal with;
B. Refer to an obesity medicine specialist for comprehensive evaluation and management;
C. Provide counseling on lifestyle modification for weight loss without pharmacological intervention and consider referral; and then,
D. Assess suitability for initiation of an anti-obesity medication as part of a comprehensive weight loss management plan.

Speaker:
Poll is open. Please vote. Wonderful. Thank you for your votes. We will close the poll and share results.

Dr. Feldman:
Super. All right. Phil, next slide, and I'll return it to you.

Dr. Mease:
Thank you. Okay. Interesting set of questions. And often difficult, because of the lots of issues that we are going through talking about psoriasis, psoriatic arthritis. We are talking about medicines that are immunomodulatory, their risk.

And so, how much do you get into a single visit? But this is right up there as should if not addressed in the first visit and certainly in the second visit.

This is just the recommendation that comes out of the American Academy of Dermatology and National Psoriasis Foundation about the recommended goals of what you talk to a patient about, including at least acknowledging that CV risk is present in patients that are hypertensive, diabetic, hyperlipidemia and are overweight.

And so noting that as an established comorbidity and speaking to the fact that there is a genetic proclivity, I think helps in the process of taking away some of the guilt that patients hesitant to talk about this.

And then either I recognize that many dermatologists do not get involved with managing this. Many rheumatologists do not as well, but some rheumatologists will try to be internist and take this on if the patient doesn't have a good structure of a primary care physician and, say, a cardiologist in the background to help with this.

And then these, on the right hand side, are some of the things that we do in the clinic to address these factors.

It is important not only to detect obesity. I mean, it is pretty obvious. But there it is. And the importance of detecting it and then weighting into management, so that you can improve the biomarkers that are evidence of diabetes, hyperlipidemia and so forth.

This speaks to the relationship between patients who are obese and have an increased visceral adiposity as well as subcutaneous adiposity. There are a variety of issues that are related to increased obesity, including what we've spoken about already:

- Hyperlipidemia;
- Insulin dysregulation;
- Glucose dysregulation;
- Thrombotic potential;
- Inflammatory markers being increased; and
- Impaired endothelial function.

Here are a number of studies. I actually know most of the lead authors on each of these studies. They're near and dear to me.

Di Minno is an interesting character. He's a nutritionist based in Naples, Italy, and works with a rheumatologist there named Lello Scarpa[?], who's kind of an old school rheumatologist, been around forever. And one of the early PsA ologist in Italy.

Di Minno did two different studies that were unique. One was simply observing that the patients in their practice in Naples who were obese were not able to achieve a threshold, that is a goal of therapy and psoriatic arthritis called minimal disease activity, or MDA.

MDA is constituted by seven different items, including:

- Tender and swollen joint count of less than or equal to one;

- Getting to a enthesitis score of less than or equal to one;
- Having a skin score of less than 3% of body surface area with this representing 1% of my body surface area. So the patient's handprint.

And so this was an obvious thing to ask or address. But it was clear that the patients who were obese just weren't getting there despite all their efforts at treatment.

And then the second Di Minno article here is it was an interventional trial in which they put half the patients onto nearly a very, very, very severely calorie restricted diet and found that patients who lost at least 10% of body weight were much more likely to achieve minimal disease activity threshold. So it was one of the cleanest studies that I've seen, which has showed a direct correlation between weight loss and being able to get to a state of low disease activity or remission. Kind of a crime in Naples, Italy, because the food there, if you've ever had eaten there, it is terrific. And so I hate to think about being on a diet there.

The second article is listed here, Lihi Eder. She is a rheumatologist based in University of Toronto. And in this particular study of almost 600 patients that were part of Dafna Gladman's psoriatic arthritis cohort there, she found that patients that were obese were much less likely to achieve the same target of treatment, MDA that I spoke to earlier.

And Alexis Ogdie, who's at the University of Pennsylvania, looked at a registry that I am involved with along with her. And we found that patients with a BMI of greater than 30 were much less likely to achieve a remission or low disease activity.

All of these same take-home messages apply in psoriasis as well. There are studies that show similar impairment of ability to get to low PASI scores or low BSA scores if you're obese. Steve?

Dr. Feldman:
Yeah. So let's look at the post-test on this question. Our 52-year-old patient for follow-up and management of psoriatic arthritis, well-controlled hypertension, mild psoriasis, not on biologic therapy. Based on the American Academy of Dermatology-National Psoriasis Foundation guidelines, which of the following best describes the recommendation for obesity screening?

A. It is recommended because the patient has psoriatic disease;
B. Obesity screening is recommend due to the presence of the psoriatic arthritis and risk factors;
C. Obesity screening is not recommended if there is just mild psoriatic disease; or
D. Obesity screening is recommended due to concerns about weight-related complications.

Speaker:
Our poll is open. All right. Thank you very much. We'll close the poll and share results.

Dr. Feldman:
Very good. Yes. Screening recommended. Next slide.

It has the correct answer on it. Yes. So all patients with psoriatic disease should receive annual screening regardless of severity. More frequent for those with comorbidities.

Okay. So here we have we are getting more into treatment now. We've just spoken about one of the strong rationales for weight loss. This gives sort of starting at the bottom of the pyramid, the straightforward things that are advisable for patients in terms of lifestyle talking about nutrition. And then a lot of what we are going to be talking about in the remaining slides is going to be having to do with pharmacotherapy.

And this is an exploding area with new medications that are coming into the market for treatment of obesity.

And then there are certain surgical procedures that are in cartoon fashion, noted here, including bariatric surgery, which can include, in the especially very high BMI patients, significant weight loss.

So starting again at the bottom of the pyramid, there are lifestyle measures that we can speak to, including increased activity, physical activity. We can talk about healthy diets, not smoking and all to try to maintain normal BMI.

And then a variety of cardiovascular risk prevention meds ranging from baby aspirin to use of statins for hyperlipidemia, and GLP-1 receptor agonists, which we are going to speak a lot more about coming up here and colchicine.

So here is a recommendation from the American Academy of Endocrinology about medical care patients with obesity, starting with their history, physical exam, clinical test including hemoglobin A1C, for example, and lipids. And then really, talking about a review of systems including cardiovascular disease or inflammatory disease, and getting a history of their weight over time and their efforts to control that, if

any.

This is some recommendations that have been put forward by the Endocrine Society having to do with when to think about starting pharmacotherapy. And basically, it is any time that you are facing a situation where the patient has started to try lifestyle and diet approaches, exercise and really not accomplishing much, which is unfortunately, the majority of the cases that I deal with.

And so increasingly as we have start to get more and more medicines that can be highly effective. And as we look to the future and the cost for these medicines starts to come down and be more reachable by people with ordinary incomes, then I think that this will become a bigger part of our daily work as inflammation physicians, as we help patients with their obesity management.

Here's a summary of some of the mechanisms that current medications have. If we start within the upper left, I am going to go right to the GLP-1 receptor agonist. And GLP by the way stands for glucagon-like peptide. So it is glucagon-like peptide 1 receptor agonist, not antagonist but agonist.

And then the newer developed medications have a dual mechanism. And GIP stands for glucose-dependent insulinotropic polypeptide. Say that rapidly, glucose-dependent insulinotropic polypeptide. So it is combined with GLP-1 receptor agonists and there are overlapping mechanisms between these two.

And as I'll show you in a moment, so the slightly older medicines are liraglutide and semaglutide. And the semaglutide is given once a week subcutaneously. Liraglutide is a daily administration, so not very convenient. And then, tirzepatide is an advancement on these. It is this dual mechanism. It is also administered weekly. And as you see, it has greater efficacy in a head to head trial that was published in the *New England Journal* not long ago.

These medicines have impacts on cells all over the body, starting with the brain, where they impact our sense of satiety. So we have an increased sense of satiety with these medicines on board. So we are less driven to want to eat more.

And then there are also impact on the stomach and intestine, as well as pancreas, and their physiologic effects on decreased gastric emptying, for example, from the stomach. And then in the gray box right beneath them are listed a host of additional mechanisms that are being developed, including, again, overlapping mechanisms that have to do with glucagon receptors, and also something called amylin agonist that are showing effectiveness in clinical trials.

I will comment, by the way, that the pipeline includes some oral medications, which may make it easier for some people who are squeamish about doing subcutaneous administration of meds. And then, one of the other things that some of your communities may be experiencing is that compounding pharmacies have the capability of creating some of these molecules quite readily.

And so there is competition going on from the compounding pharmacies as well. So we are anticipating that as more of these drugs become introduced, the prices will come down.

Other medicines that are mentioned on this page are slightly older, for example, phentermine topiramate. These have to do with dopamine and norepinephrine metabolism in the brain as well as GABA receptor, which can lead to modest weight reduction. And then bupropion and naltrexone can have similar mechanisms working on dopamine and norepinephrine.

And then there is something called orlistat. It is an enzyme, which interferes with the function of a lipase. And so you get lipids or large lipids that are not broken down in the intestine to make them more easily absorbed. And they're excreted. And so it makes for bowel movement a change of stool which becomes a little bit greasier, so to speak. But it can be modestly effective. But I must admit that the GLP-1 receptor agonist family is really taking over this space.

And this speaks to the relative efficacy, as we've mentioned before, that starting with lifestyle and going up to bariatric surgery as being the most efficacious in more extreme obesity cases.

This is a little acronyms of the five C's. Think about contraindications and cautions, for example, with the GLP-1 receptor agonist. If a patient has a history of significant pancreatitis, one should have caution. But in general, most people do not have contraindications to these meds. We do need to warn them about adverse effects that can occur during the gradual ramping up of dose, including nausea, vomiting, diarrhea, or on the other hand, constipation.

And then, of course, cost and coverage. And then there can be combinations of these.

Now, I've already spoken to the mechanism of several of these, the next couple of tables that we are going to see. And the point here is just to mention what are the most common adverse effects when you use any of these weight loss medications. And they're typically nausea and then other factors like headache and so on. You can read through these, adverse effects here.

And then contraindications, pregnancy would be one. And then there are some specific ones that have to do with the specific drug.

I've already spoken to the common adverse effects for the GLP-1 receptor agonist family. And again, pregnancy is considered a contraindication.

Each of these medicines, by the way, is approved to treat either diabetes or obesity or both. Interestingly, they have different trade names depending on whether or not you're prescribing them for weight loss or for diabetes. Same medication, but just different name.

And this gives you, in bar graph form, the average and range of the degree of weight loss that can be expected. And it has been shown in clinical trials with these medicines.

Now, there are a whole bunch of studies. In my teaching deck, I've got a couple of slides that enumerate the various animal and human studies that show that when you use drugs like GLP-1 receptor agonist or the dual combination ones with GIP, there is a change in inflammatory markers in the body.

Here we are getting across the point that CRP diminishes. And this is taking patients who are overweight being treated, do not have an underlying inflammatory disease, but they are changing their CRP from one level to another. So we know that across the board high-sensitivity CRP, which is a risk factor for cardiovascular complications, is reduced.

There are also many studies which we are not getting into in depth here, but which show the reduction in TNF, reduction in IL-6, reduction in IL-1, reduction in IL-17 in both animals and humans that occurs with use of these medications.

Taking advantage of this concept of reduced inflammation and the benefits of weight loss in managing chronic autoimmune inflammatory diseases, here's an example of first a psoriasis trial. And the next slide will show you a psoriatic arthritis trial that is now underway by Lilly to compare using their IL-17A inhibitor, ixekizumab, which is approved for psoriasis and psoriatic arthritis treatment, as well as axial SpA treatment to compare monotherapy with that medication with combining ixekizumab and their drug, tirzepatide, which is a GLP-1 receptor agonist, and GIP combined.

These, on the left-hand side, are reflected the baseline characteristics of the patients coming into this study. Notice that the primary endpoint is at week 36. This is different than our usual week 12 or week 16 primary endpoint, and this has to do with the fact that it is important for the patient to tolerate these medicines to ramp up the dose slowly, gradually.

And so when you're getting used to using these medicines, you start with the lowest dose. And then on a weekly basis or every other week basis, gradually increase the dosage in order to try to avoid pushing the patient into too severe reaction with nausea from the get go.

The primary outcome of this comparative head-to-head trial is going to be achievement of PASI 100, complete clearance of skin, and at least a 10% weight reduction. Secondary outcomes will be slightly lower thresholds, achieving a PASI 75 response and a 5% weight reduction, for example, or achieving either PASI 100 alone or achieving 10% weight reduction alone.

I am not a betting person, but I am betting that the combination is going to win out in this particular trial.

And then the psoriatic arthritis trial that is now enrolling has a very similar schema and similar primary endpoint. And the primary outcome is going to be achieving at least an American College of Rheumatology, 50% response in their psoriatic arthritis characteristics, as well as at least a 10% weight reduction.

This is what's coming. These are the array of medicines that some of which have already been approved, but some which are in clinical trials, which I referred to earlier. And you're seeing more and more combinations where there are two different mechanisms that are in encompassed in a single treatment going forward, like take retatrutide. This is another Lilly medication which is a GIP/GLP-1 dual receptor agonist that is different than tirzepatide. And it is affecting and includes glucagon receptor as well.

And then there is this Amgen agent and so on and so forth. So there are a number of these that are coming along.

This slide was inserted, in case you want to go do some further reading. And actually, I do not know whether or not these slides are being made available to you after the program. Maybe our moderator can.

Speaker:
Yes, they will be. Yes.

Dr. Mease:
Perfect. Okay. So this particular slide provides a link to websites where you can learn more and harvest review articles to try to increase your knowledge base here. And if you're getting in, and if you're in your clinic and it sounds like you all might be doing this already, we didn't have open mic at the beginning. But if you're a rheumatology and endocrinology group, then my guess is that you've got specialists within your group that are working with obesity. And so you probably are cross referring within your group and know all this

stuff already that we've been talking about. But just in just in case, here are some references. Steve?

Dr. Feldman:
Yeah. So let's follow up on our patient with moderate to severe psoriatic disease. So Martha returns three months later after starting a biologic. And good news. She reports intermittent morning stiffness in her fingers and toes. The heel tenderness is improved. Still bothersome, shared difficulties adhering to her diet plan and exercise regimen. I do not know if you all know this, but patients aren't always fully adherent with our recommendations.

The swelling in the proximal and distal joints has improved, improved range of motion. That is great. Updated medications. She's on infliximab, ibuprofen and lisinopril. And her weight, she's lost two pounds. BMI is still roughly 32. Blood pressure may be a touch better. Lipids are within normal limits and A1C is 5.5%.

Dr. Mease:
So she's made a little bit of progress, but a long way to go. And weight is going to be certainly part of this.

So now we are getting into a section of the talk, and I'll try to hurry us along, because I know you've got to get into your workday. Having to do with the conversation with the patient and sensitivity around that and difficulty of it. So, Steve?

After receiving recommendations from an obesity medicine specialist, what would your next steps be?

A. Defer intervention for obesity, given the multiple concerns;
B. Refer to a specialist;
C. Provide counseling on lifestyle modification for weight loss without pharmacological intervention; or
D. Suitability for initiation of anti-obesity medications as part of that comprehensive weight management plan.

Do a single choice for this one.

All right. We'll move into those patient-centered approaches and discussion strategies with patients.

Dr. Mease:
Here's several mom and apple pie phrases that speak to this whole issue of how you talk to patients, and focusing in on where they are in all of this. This is difficult I have to acknowledge.

So one of the things that I am learning as I am talking to folks that are specialists in this area is trying to avoid use of words like overweight or obesity and so on, or words fat. We do not want to use this kind of language. So we want to talk about weight management, perhaps, but not necessarily implying that the patient is overly obese.

We need to think of it as a disease unto itself with goals of treatment and maintenance of achievements, of those goals. And we know that with the medicines that we've been speaking about, the GLP-1 receptor agonist, that they can be highly effective. But once they're stopped, they lose effectiveness and the patients may tend to regain their weight.

It takes a village. And that is a commonly used phrase here, where all kinds of folks might be involved in helping the patient with weight, including the specialists that are mentioned here, but also primary care physicians, the nursing staff, psychologists, support groups and so on.

This again speaks to it takes a village with the importance of multidisciplinary care, communication between the various healthcare providers, and greater access to therapies. So, for example, a single rheumatologist sitting in their private office or a single dermatologist may not have the bandwidth or the capability of getting into all of this. And so using the team.

Here are some simple recommendations, including having larger chairs in the office, getting appropriately sized blood pressure cuffs, properly sized gowns, measuring tape, and then getting BMI, both height and weight. And there is a comment at the bottom here about scale should be in a private area. And many patients are embarrassed and do not want to know their weight. So again, this speaks to the sensitivity of the conversation.

Dr. Feldman:
All right. Your clinic wants to implement changes to de-stigmatize diagnosis and care of these patients. Which of the following would you implement to achieve this goal?

A. Posters that emphasize weight loss as a primary goal;
B. Standard handout on dietary restrictions;
C. Limiting discussions about weight to specialized appointments; or

D. Providing larger gowns and furniture to accommodate patients of all of all sizes.

Speaker:
The poll is open. Please vote. All right. Thank you for your votes. We'll close the poll and share results.

Dr. Feldman:
Very good. next slide, Phil?

Yeah. Larger gowns and furniture to accommodate patients, appropriate sized blood pressure cuffs and all that. Thank you.

Dr. Mease:
Here are some comments about the conversation.

Asking permission to discuss weight. And here's some sample ways of doing that:

- Can we discuss your weight as part of your overall health?
- Are you comfortable discussing your weight with me?
- Can we touch on the topic of weight?

Weight specific history.

- Can you share any factors that you think might have influenced your weight?
- Can you recall any events or circumstances that coincided with changes in your weight?
- What strategies have you used to manage your weight?
- Have you noticed any patterns in your weight change over time? And so on and so forth.

And then of course, the management of the other diseases that they're seeing you for or that are comorbidities. This is just saying:

- Put yourself in the head of the patient you're with;
- Be empathic;
- Try to have a shared conversation about this;
- Get into their head. Get into their space; and
- Do not push things too far, and save it for a different visit if it feels like there is a caution or there is not enough time and so on.

These are just some studies that have shown us that that patients actually are willing to get into these conversations and want to have a role in them and want to know, ultimately, your honest opinion about the fact that they need to lose weight.

These are all again just key points about being empathic in your conversations. So again, all of these slides are saying the same thing, creating a space where the patient feels comfortable about having this conversation with you and working toward health goals that are shared with the patient and taking your time to listen and hear their concerns.

You may need to have a psychologist involved with you that you can work with. And recognize that there may be a real stigma around these conversations.

Setting goals. So do not try to do a crash, weight loss program, but anticipate that it is going to take time and effort. And for example, if you're using pharmacotherapy that it is going to take time to gradually ramp up the dosing of the medicine to avoid adverse effects. And then just see the patient on a periodic basis.

We have, in our clinic, a person who deals with prior authorizations. So we have a full time person just that is all they do. They're getting approvals for the various immunomodulatory medicines that that we use. But they're now beginning the process of looking into access for the weight loss drugs.

And then knowing resources for the patients that do not have adequate insurance or coverage to refer to.

Dr. Feldman:
All right. So Martha calls the office a month later, unable to start a GLP-1 receptor agonist due to cost with her insurer decides to try the over-the-counter orlistat, the lipase inhibitor instead. She's lost a few pounds but struggled with the GI side effects, feel she needs to stop. Her psoriatic symptoms have continued to improve. She's recently started walking 30 minutes a day three times a week.

What would be our next step?

A. I recommend she continue the orlistat because she's seen some benefit;
B. Recommend she stop it and pay out of pocket for a GLP-1, which is most likely to be effective;
C. Recommend she stop the orlistat and continue with lifestyle only;
D. Refer to an obesity medicine specialist for comprehensive evaluation; and then, finally,
E. Use shared decision-making to discuss other options for anti-obesity pharmacotherapy that may be within her budget.

Speaker:
Poll is open. Please vote. Thank you for your votes. We'll close the poll and share results.

Dr. Mease:
Okay. So what have we learned? We've learned about a lot, I think, about obesity and other comorbidities of psoriasis and psoriatic arthritis, including hyperlipidemia, diabetes, cardiovascular disease in general, and the complex interrelationship between the inflammation that is induced by obesity, as well as the inflammation induced by psoriasis and psoriatic arthritis, and the importance of down regulation of all contributors to inflammation in order to have longer life and better quality of life.

We should not try to have dramatic changes, necessarily, but be accepting of modest weight changes and work with the patient, as they try to gain more and more control over their weight.

Anti-obesity medicines are effective, and increasingly potentially available as competition brings down cost in the long run. And we see long-term socioeconomic results for our communities as a whole.

And then working with the village of specialists and various healthcare practitioners, including nursing staff, that can help us with this.

Steve, any comments about your own work in this arena?

Dr. Feldman:
We'll have time I think in the question and answer stuff. I've just got a couple post test questions I want to go through.

Going forward, how confident are you in your ability to initiate conversations with patients about their weight? Not confident to very confident. Where do you fit now?

Also you should know I think there is a chat function and you can put questions or comments into the chat for us to discuss at the end.

Speaker:
All right. Our poll is open. And yes, you may submit questions in Q&A at any time throughout the event, so please feel free to do that. All right. Thank you for your votes. We will close the poll and share results.

Dr. Feldman:
Excellent. More confident. Very good. That is excellent. All right. Next slide.

Dr. Mease:
That is interesting. Good.

Dr. Feldman:
Going forward, how comfortable are you with medical management of obesity in patients with psoriatic disease? Again, somewhere between very uncomfortable and very comfortable.

Speaker:
The poll is now open. All right. Thank you for your votes. We will close the poll and share results.

Dr. Feldman:
Okay. I can't remember how we started. I think we've moved up.

Speaker:
Definitely moved up.

Dr. Feldman:
We got one last poll question for you. Do you plan to make any changes in your clinical practice based on what we learned today? I know I did. I made a whole list of things that I learned from you, Phil. I want to take back to my team later today.

100%. Yes. Excellent. Alright. We can open it up for questions and answers, little discussion time now.

Dr. Mease:

I am going to stop sharing, Steve, so that we can.

Dr. Feldman:
Okay. That works.

Speaker:
Alright. At this time, we are open for any questions that you may have for Dr. Mease and Feldman. A reminder to please submit using the Q&A function in Zoom. And as we give you time to submit the question, I would like to draw your attention to the chat panel, where you will find the links that you can follow at the conclusion of the talk. You will need to log in to or create a CCO account.

The first link is to the downloadable slide deck from today's presentation. And the second is a link to the program evaluation to complete and claim credit for attending the presentation. You do have 30 days from today to claim credit. After 30 days, credit for today's program will expire.

So with that, I am looking through. I do not yet see. Let's see.

Dr. Feldman:
I got questions for Phil. Phil, I do not want to put back up the final slide with the QR codes for those who want to use that for the online evaluation, because I'd love to get their feedback on the program today.

Dr. Mease:
Sorry.

Dr. Feldman:
No problem. So I am very interested in the behavioral aspects of psoriatic disease and the relationship between obesity and psoriasis. We talked heavily about the shared cytokines, shared genetics. But I just wonder if having joint pain prevents exercise. And I know in the world of psoriasis, there is concern that people's embarrassment with how they look would stop them from going to the why and stop them from exercising.

One of my partners is a hair specialist, and she finds that even how people do their hair and the impact of exercise on their hair, especially in African American women and Black women, prevents them from exercising. And so I wonder if there is behavioral issues here at play as well?

Dr. Mease:
Well, of course. I mean, the first one you commented on about joint pain, that is a paramount issue. And recall that our patient had heel pain. So that was either due to Achilles or plantar fascia enthesopathy. Even if her joints and skin had been well controlled, which often they are, enthesitis can be a real pesky issue that, especially in the heel, which can prevent people from doing exercise regularly or even going walking around the lake with their dog.

So we constantly are talking about that with our patients. And I didn't know that about hair. That is striking.

Dr. Feldman:
Yeah.

Dr. Mease:
So what happens with hair?

Dr. Feldman:
Yeah. I mean, I think people do their hair and I guess sweat and things can affect the hair. And they just won't exercise.

Dr. Mease:
Okay.

Dr. Feldman:
Yeah. I am no joint expert, but I would imagine you could tell people go to the swimming pool.

Dr. Mease:
Yes.

Dr. Feldman:
So they have skin lesions, maybe they can't do that either. So like a double whammy.

Dr. Mease:

Yeah, you're right on both points. And when I bring up swimming up here in Seattle, it doesn't go over that well because it is cold. And so I say where do you find a pool that is heated enough for you to be comfortable in it? And there are a couple of pools in the area that have enough heat, but otherwise they're not swimming in Puget Sound, that is for sure.

Dr. Feldman:
The finding that the patients who lose weight are more likely to achieve their good disease outcome. I've seen that. Again, I wonder how much of that is the biology and how much of that is you're selecting for patients who are more adherent to treatment?

I mean, I think a lot about adherence. It is what I study. That the people who are adherent enough to lose weight, which is a really difficult problem, are probably going to adhere to their treatment regimen better. They put their topicals on more, you know, take their injection treatment. I know this is hard to believe, but a lot of times patients aren't fully adherent.

Anyway, do you think it is the biology, or do you think we are just looking at adherent patients when we see these improvements?

Dr. Mease:
Well, I think it is probably both. You bring up a good point that I would have not thought about adherence as much prior to your question. And then I do know that that is one of your areas of contribution is writing about adherence and studying it. But there is a lot of biology there. And I think that is getting increasingly documented in all of the down regulation of various inflammatory cytokines that occur with obesity management.

And we are going to see a lot of that, that science coming out of these studies that are combining drugs like tirzepatide with ixekizumab and so on.

Dr. Feldman:
A lot of this relates to insulin resistance and the obesity. In dermatology, one of the signs we see in patients who have severe insulin resistance is acanthosis nigricans. And I was just wondering if rheumatologists are on the lookout for that the darkening, the velvety change people will get around their necks, maybe in their underarms. Also overlying the joints, I think, is another common place to see the skin thickening in insulin resistance.

Dr. Mease:
Got it on my radar. That is interesting, Steve. So I've learned more than one thing today as well. Okay.

Dr. Feldman:
You may notice that. Okay. Now, you mentioned that for the GLP-1 receptor agonist, they can have both diarrhea or constipation. Now, how can a drug do both of those?

Dr. Mease:
Well, I've seen data that suggests both can happen. And so that I just accept that.

Dr. Feldman:
I wonder. I mean, you do so many studies and you've got to report every adverse event. And if somebody has constipation, you report it. If they have diarrhea, they report it. I wonder if it's all due to drug or if it's just events that happen to people and they just ascribe it to drugs?

Dr. Mease:
Good point. I think diarrhea is the more common issue.

Dr. Feldman:
All right. I had just one last question. I do not know. We have a couple in the chat. Let's go to the ones.

Speaker:
Yeah. Do you see a couple here.

Dr. Feldman:
Yeah. Rheumatologists going to be able to get prior auth for these drugs? That is a great question.

Dr. Mease:
It is coming, is the answer. I've been doing a little presentations in different parts of the country in last month or so, and I am hearing more and more of rheumatology clinics where this is happening. So where they're successfully able to get some of these through. There is also, by the way, Lilly is helping out by easing access to tirzepatide in people that get prescribed ixekizumab. The hooker is that you've got to prescribe ixekizumab in order to get that chip.

But I think that it's going to start to become easier for rheumatologists to get prior auth and probably dermatology offices, I am assuming.

Dr. Feldman:
Yeah. I mean, I am a dermatologist, I do not manage joints. I do not feel like an obesity specialist. But with the ability to get patients low-cost tirzepatide if they're on ixekizumab, if I see an obese patient with really bad psoriasis, I am thinking about ixekizumab maybe more than I would have otherwise.

There is a comment here. Seems like it's a talk for, is that OA and DD[?]? I am not sure what that refers to because, again, I am a dermatologist. You mentioned that the primary outcome in the ixekizumab, tirzepatide size were 36 weeks. And I just wondered if it takes 36 weeks to see the weight loss change and that is why they wanted to push out the time?

Dr. Mease:
No. Well, it's a gradually increasing phenomenon. So if you look at the curve, you'll start seeing it earlier than 36 weeks. But you're not necessarily getting up to the optimal dose until you've been on it for a while. It takes several months to get on an optimal dose. So then you've got to run with that optimal dose for a period of time before the appropriate primary endpoint.

Dr. Feldman:
There is a great question, practical question. Is there a specific process involved? I assume that is for getting the tirzepatide with the ixekizumab. And my sales rep for those drugs handed me a handout that had a step by step information on how to do that. That was very helpful to me.

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