

PRACTICE GAPS

Gaining Insights Into the Relationship of Obesity, Weight Loss, and Psoriasis

Dermatologists now recognize that patients with psoriasis have an associated increased risk for and prevalence of hypertension, diabetes, dyslipidemia, obesity, and vascular disease. However, changes in management of patients with psoriasis have lagged behind advances in knowledge. Specifically, the complex relationship between psoriasis and obesity has become a focus of study. Patients with a higher body mass index (BMI) have an increased risk for new-onset psoriasis, and the higher the BMI (obesity), the higher the Psoriasis Area Severity Index at disease onset.¹ In some patients, obesity follows the onset of psoriasis,² possibly because of the particular inflammatory cytokine milieu. In this issue, Jensen et al³ identify the benefits of a low-energy diet in patients with psoriasis, with a trend toward reduced disease severity and significant improvement in quality of life. These findings may help us embrace a more comprehensive approach to patients with psoriasis.

One explanation for the clinical findings reported by Jensen et al³ is that reduction in obesity and its related cytokines may improve skin disease. The significant lifestyle changes required for intensive weight-loss therapy

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may also play some role in this improvement. Patients did not alter their antipsoriatic treatments during this study, and the relative dosage or strength and efficacy of therapies may be enhanced as patients lose weight and achieve higher effective dosing. A weight-based treatment effect has been seen in clinical trials of some biological agents, with differences in treatment response based on patients' weights.⁴ Herein lie the greatest challenges to practitioners: how can we better educate our colleagues and ourselves so that ultimately patients change their lifestyles and lose weight to improve their psoriasis and their quality of life and reduce their risk of associated comorbid conditions?

Changes in practice begin with understanding the reported relationship between psoriasis and weight.³ Although many factors may be at play, patients who lost weight seemed to show improvement in their condition and quality of life. Dermatologists might consider weight loss and dietary changes beyond the scope of their practice, but these findings help us provide patients with scientific evidence to encourage change. Education and patient support are the requisite first steps and may be even

more helpful coming directly from dermatologists. Although intensive weight-loss and dietary programs may be beyond their scope of practice, weighing patients at visits and calculating their BMI is not. Tracking changes in such measurements should also become easier with electronic medical records.

Dermatologists should advocate for patients and develop readily available referral sources for nutritionists and other specialists (eg, endocrinologists), as needed. Patient education materials provided by advocacy groups, including the American Academy of Dermatology and the National Psoriasis Foundation, should highlight potential benefits of lifestyle modifications. It is also critically important to understand the therapeutic implications of weight loss and appropriately manage potentially dangerous systemic medications, such as cyclosporine, methotrexate, or acitretin, which may achieve higher plasma levels and increased potential toxicity with weight loss.

For all the advances in research and specialization in medicine, the key may simply be better communication: dermatologists reaching out to and working more closely with colleagues to help patients improve their quality and quantity of life.

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