Bridging psoriasis and metabolic comorbidities: Toward comprehensive patient management. Priorities from the International Psoriasis Council

Bruce E. Strober, MD, PhD,[a] Alison M. Treichel, MD,[b] Anne M. Bowcock, PhD,[c] Kevin Cooper, MD,[d] Paolo Gisondi, MD,[e] Álvaro González-Cántero, MD, PhD,[f,g] Jo Lambert, MD, PhD,[h] Wilson Liao, MD,[i] Anna López-Ferrer, MD, PhD,[j] Nehal N. Mehta, MD, MSCE,[k] Lone Skov, MD, PhD,[l] Peter C. M. van de Kerkhof, MD, PhD,[m] and Joel M. Gelfand, MD, MSCE[n]

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Advances in genetics, immunology, metabolism, and epidemiology have redefined psoriasis as an inflammatory disease strongly associated with metabolic disease requiring comprehensive management to improve skin and joint outcomes while also addressing risks of obesity, diabetes, cardiovascular disease, and premature mortality. At the 2025 International Psoriasis Council (IPC) Think Tank (for report and references, see https://psoriasiscouncil.org/wp-content/uploads/2025/12/Think-Tank-Puerto-Rico-Congress-Report.pdf), experts reported that psoriasis is associated with greatly elevated risks of metabolic syndrome and major adverse cardiovascular events, with increasing skin disease severity heightening these risks.[1] Notably, obesity increases disease severity and hinders treatment response.[2] Furthermore, Mendelian randomization studies show obesity/visceral adiposity and cardiovascular disease risk contribute to psoriasis pathogenesis.[3] These findings highlight psoriasis as an inflammatory disease featuring contributions from immune cell function and cellular metabolism (Fig 1).[4] Adiposity should be considered a primary target of effective psoriasis therapy in overweight or obese patients.

Abbreviaions used:

IPC: International Psoriasis Council
GLP-1: glucagon-like peptide-1

Type 1 helper T cell, type 17 helper T cell, and innate immune activity are drivers of both psoriasis and cardiometabolic disease.[5] However, biologics show inconsistent cardiometabolic benefits. For example, whereas interleukin 17 inhibitors reduce

From the Department of Dermatology, Yale University School of Medicine, and Central Connecticut Dermatology Research, Cromwell, Connecticut[a]; Department of Dermatology, University of Rochester, Rochester, New York[b]; Department of Dermatology, Icahn School of Medicine at Mount Sinai, New York, New York[c]; Department of Dermatology, University Hospitals Cleveland Medical Center, Case Western Reserve University, Cleveland, Ohio[d]; Section of Dermatology and Venereology, Department of Medicine, University of Verona, Verona, Italy[e]; Department of Dermatology, Ramón y Cajal University Hospital, Madrid, Spain[f]; Department of Dermatology, Faculty of Medicine, Universidad Francisco de Vitoria, Madrid, Spain[g]; Department of Dermatology, Ghent University Hospital, Ghent, Belgium[h]; Department of Dermatology, University of California San Francisco, San Francisco, California[i]; Department of Dermatology, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain[j]; Section of Inflammation and Cardiometabolic Diseases, The George Washington University, Washington, District of Columbia[k]; Department of Dermatology, Herlev and Gentofte Hospital, University of Copenhagen, Copenhagen, Denmark[l]; Department of Dermatology, Radboud University Nijmegen Medical Centre, Nijmegen, Netherlands[m]; and Department of Dermatology, University of Pennsylvania, Philadelphia, Pennsylvania.[n]

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Correspondence to: Bruce E. Strober, MD, PhD, Department of Dermatology, Yale University School of Medicine and Central Connecticut Dermatology Research, 1 Willowbrook Rd, Suite 2, Cromwell, CT 06416. E-mail: brucestrober30@me.com.
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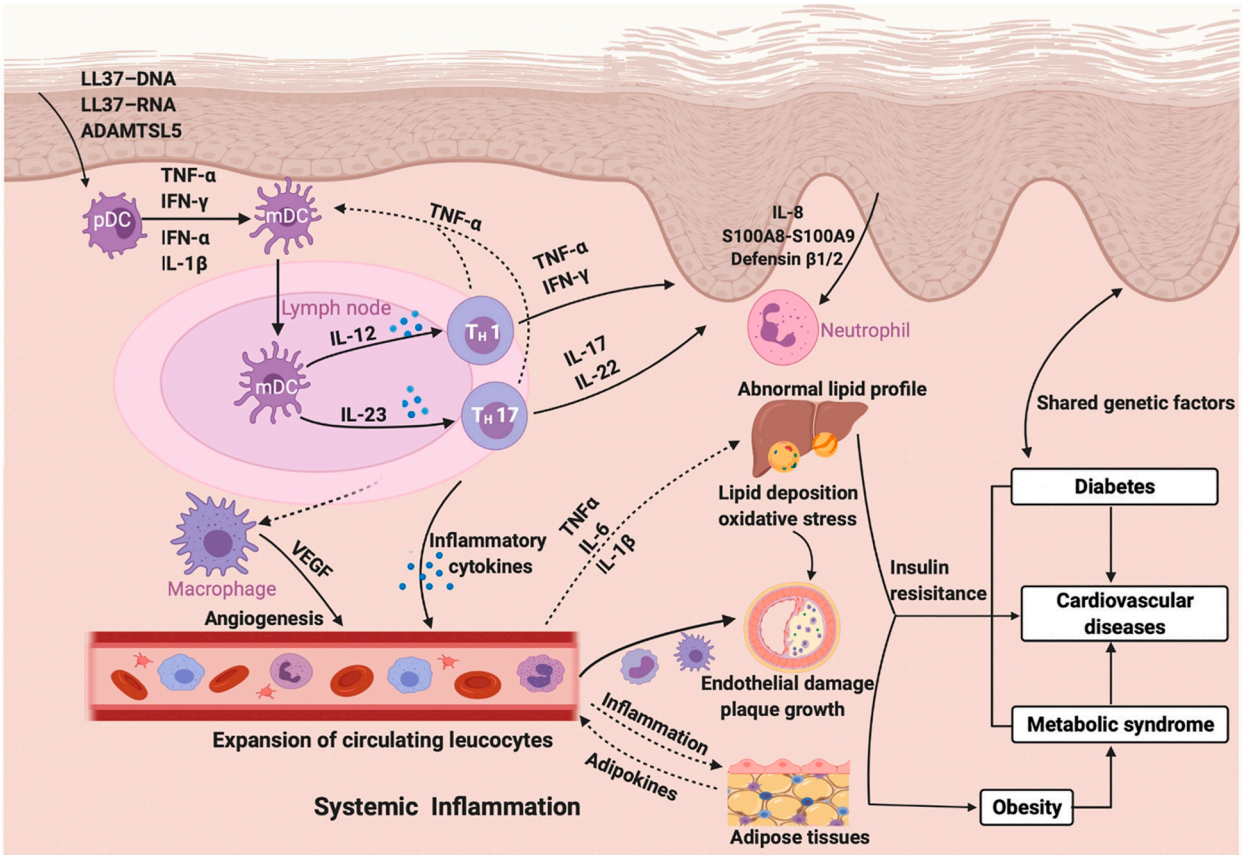

Fig 1. An integrated view of immunometabolism to link metabolic pathways, immune cell biology, and system metabolism.[4] (Reproduced from Cai X, Cui Y, Wang J, et al. Cardiometabolic comorbidities in patients with psoriasis: Focusing on risk, biological therapy, and pathogenesis. Front Pharmacol. 2021;12:774808. https://doi.org/10.3389/fphar.2021.774808. Licensed under Creative Commons Attribution 4.0 (CC BY 4.0).).

skin inflammation and systemic inflammatory markers, with possible modest gains in endothelial function, liver fibrosis, and vascular health, they are metabolically neutral regarding glucose, lipids, and blood pressure. Conversely, glucagon-like peptide-1 (GLP-1) receptor agonists show promising disease-modifying effects via weight loss and direct anti-inflammatory actions on immune cells that may reduce psoriatic arthritis incidence. Genetic studies simulating GLP-1 receptor signaling suggest it protects against psoriatic disease.[3] Initial reports of psoriasis improvement with GLP-1 receptor agonists are promising, but randomized, placebo-controlled monotherapy trials are needed.

While the majority of laboratory and vital sign assessments represent standard primary care evaluations, dermatologists, rather than acting as primary care providers, are well-positioned to screen for increased metabolic risk in psoriasis patients by leveraging the frequent dermatology visits these patients already attend. Screening protocols, focusing on body mass index, glucose, triglycerides, low-density lipoprotein cholesterol, hemoglobin A1c, and blood pressure, should be used to identify patients with increased risk of cardiometabolic disease. Subsequent coordination with other specialties would increase preventative benefit. These patients would undergo obesity management via low-calorie or anti-inflammatory diets, exercise, pharmacologic weight-loss therapies (prescribed by the dermatologist or another provider), and possibly bariatric surgery, with dermatologists serving in a screening, educational, and coordinating capacity, or actually prescribing weight-loss therapies, resulting in improved treatment-independent disease severity and potentially enhanced efficacy for psoriasis medications.

During IPC's Think Tank, a multi-step priority-setting exercise employed 1 to 5 point rankings (77 responses), yielding 12 initial priorities; these were refined via a second weighted survey (81 responses), resulting in a final list of 5 prioritized action items, shown in Table I (see https://psoriasiscouncil.org/

Table I. Top 5 priorities identified at the IPC Think Tank regarding screening and treatment related to psoriasis and metabolic health

Top 5 priorities	Weighted average*
1. Develop practical screening algorithms for metabolic and cardiovascular comorbidities in psoriasis to guide routine practice, enhance early identification and interventions for cardiometabolic risks, and strengthen dermatologists' roles in coordinating appropriate and timely specialty referrals for patients.	2.08
2. Advocate for international guidelines to explicitly emphasize the necessity of comorbidities screening in psoriasis, addressing frequent denials of coverage and payment by private and governmental payers.	2.64
3. Conduct properly powered, randomized, placebo-controlled clinical trials evaluating GLP-1 agonists as monotherapy versus placebo in patients with mild to moderate psoriasis, assessing efficacy on disease severity, mechanisms of action, weight loss, and cardiometabolic outcomes, while identifying patient subgroups most likely to benefit.	2.81
4. Develop guidance and educational programs for dermatologists on responsibly endorsing, communicating, and integrating GLP-1 agonists with multitargeted therapies (eg, statins, antihypertensives) for managing obesity and metabolic comorbidities in psoriasis patients, without overstating the evidence.	2.97
5. Assess efficacy and synergistic impacts of GLP-1 agonists on psoriasis and cardiometabolic outcomes, utilizing data mining to identify biologic-treated or comorbid subgroups most likely to benefit.	3

*Lower weighted averages indicate higher priority.

rapid-communication-metabolic-methodology/ for the full methodology). These priorities serve as a practical roadmap to raise the standard of care by bridging dermatology and metabolic medicine. They emphasize improved screening algorithms, guideline advocacy for payer coverage, additional clinical trials of GLP-1 agonists, educational programs for dermatologists, and data-mining to identify optimal subgroups. They promote multidisciplinary collaboration, early identification of cardiometabolic risks, and targeted research, particularly beneficial for younger patients who often lack regular primary care follow-up.

Declaration of generative AI and AI-assisted technologies in the writing process

Not used.

Conflicts of interest

Strober has served as a consultant (honoraria) for AbbVie, Alumis, Almirall, Amgen, Arcutis, Boehringer Ingelheim, Bristol-Myers Squibb, Capital One, CorEvitas, Immunovant, Johnson & Johnson, LEO Pharma, Eli Lilly, Maruho, Oruka, Meiji Seika Pharma, Protagonist, Takeda, Novartis, Pfizer, UCB Pharma, Regeneron, and Sanofi-Genzyme. He holds stock options in Mindera Health and selectION. He has served as a speaker for AbbVie, Arcutis, Eli Lilly, Incyte, Janssen, Regeneron, and Sanofi-Genzyme. He is the Scientific Co-Director of the CorEvitas Psoriasis Registry (consulting fee) and has served as an investigator for the CorEvitas Psoriasis Registry, Incyte, and Oruka. Treichel and Bowcock have no relevant conflicts of interest. Cooper serves as a consultant for Therakos, PALA Pharmaceuticals, and Treg Therapeutics and has received research support from the LEO Foundation, Castle Biosciences, and Amgen. Gisondi has received honoraria as a consultant and/or speaker for AbbVie, Almirall, Bristol-Myers Squibb, Eli Lilly, LEO Pharma, Janssen, Novartis, Pfizer, Takeda, and UCB. Gonzalez-Cantero has served as a consultant for AbbVie, Janssen, Novartis, Eli Lilly, Almirall, Bristol-Myers Squibb, Amgen, Boehringer Ingelheim, UCB, Celgene, and LEO Pharma and has received grants and other payments. Lambert has received recent grant support from AbbVie, Almirall, Amgen, Bristol-Myers Squibb, Johnson & Johnson, Novartis, and UCB and has served as an advisor and/or speaker for AbbVie, argenx, Almirall, Bristol-Myers Squibb, MS Pharma Inc, Celltrion, Johnson & Johnson, Novartis, and UCB. All fees were paid to an institutional scientific account and not for personal benefit. Liao has received research grants from Amgen, Gilead, Janssen, LEO, Regeneron, and Takeda and has served as a consultant for AbbVie. López-Ferrer has served as an advisor and/or speaker for AbbVie, Almirall, Amgen, Bristol-Myers Squibb, Boehringer Ingelheim, Eli Lilly, Galenicum Derma, Johnson & Johnson, LEO Pharma, L'Oréal, Novartis, Oruka, and UCB. Nestor has served as a consultant and/or investigator for AbbVie, Amgen, Bristol Myers Squibb, Janssen, Eli Lilly, Novartis, Pfizer, Sun Pharma, Tourmaline Bio, and Abcentra and has received honoraria from Medscape, WebMD, and Elsevier for academic content development. Skov has received research funding from Almirall, UCB, Sanofi, Bristol-Myers Squibb, Janssen, and LEO and has received honoraria as a

consultant and/or speaker for AbbVie, Eli Lilly, Novartis, Pfizer, LEO Pharma, Bristol-Myers Squibb, Janssen, UCB, Almirall, Galderma, Takeda, Stada, and Sanofi. van de Kerkhof has received fees for consultancy services or lectureships from Almirall, Eli Lilly, Novartis, Janssen Pharmaceutical, Bristol-Myers Squibb, UCB, Boehringer Ingelheim, Centrion, and Sandoz. Gelfand has served as a consultant for AbbVie, Artax (DSMB), Bristol-Myers Squibb, Boehringer Ingelheim, Celldex (DSMB), FIDE, GSK, Inmagene (DSMB), Eli Lilly, LEO, MoonLake (DSMB), Janssen Biologics, Novartis, UCB (DSMB), NeuroDerm (DSMB), Oruka, Teva (DSMB), and Veolia North America and has received honoraria. He has received research grants (to the Trustees of the University of Pennsylvania) from Amgen, Bristol-Myers Squibb, Eli Lilly, and Pfizer Inc. He has also received payment for continuing medical education work related to psoriasis that was indirectly supported by pharmaceutical sponsors. Gelfand serves as Deputy Editor of the *Journal of Investigative Dermatology* and receives honoraria from the Society for Investigative Dermatology. He is also the Chief Medical Editor for Healio Dermatology, for which he receives honoraria, and is a member of the Board of Directors of the International Psoriasis Council and the Medical Dermatology Society, for which he receives no honoraria.

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