Obesity Is Associated With Residual Disease Activity and Lower Quality of Life in Patients Who Achieve Clinical Response to Psoriatic Arthritis Treatment: Post Hoc Analysis From the SPIRIT Studies

Scan the QR code for a list of all Lilly content presented at the congress.

Other company and product names are trademarks of their respective owners.

Joseph F. Merola[1], William Tillett[2], Uta Kiltz[3], Elizabeth L. Perkins[4], Allyson Perry[5], Marcus Ngantcha[5], Blessing Ibe[5], Russel Burge[5], Andris Kronbergs[5], Norman Madsen[6]

[1]UT Southwestern Medical Center, Dallas, USA, [2]University of Bath, Bath, UK, [3]Rheumazentrum Ruhrgebiet, Herne, Germany; Ruhr University Bochum, Bochum, Germany, [4]Rheumatology Care Center, Hoover, USA, [5]Eli Lilly and Company, Indianapolis, USA, [6]University of Rochester, Rochester, USA

Sponsored by Eli Lilly and Company

OBJECTIVE

- To investigate effects of obesity on HRQoL and disease activity among patients with PsA who achieved ACR50 or DAPSA LDA

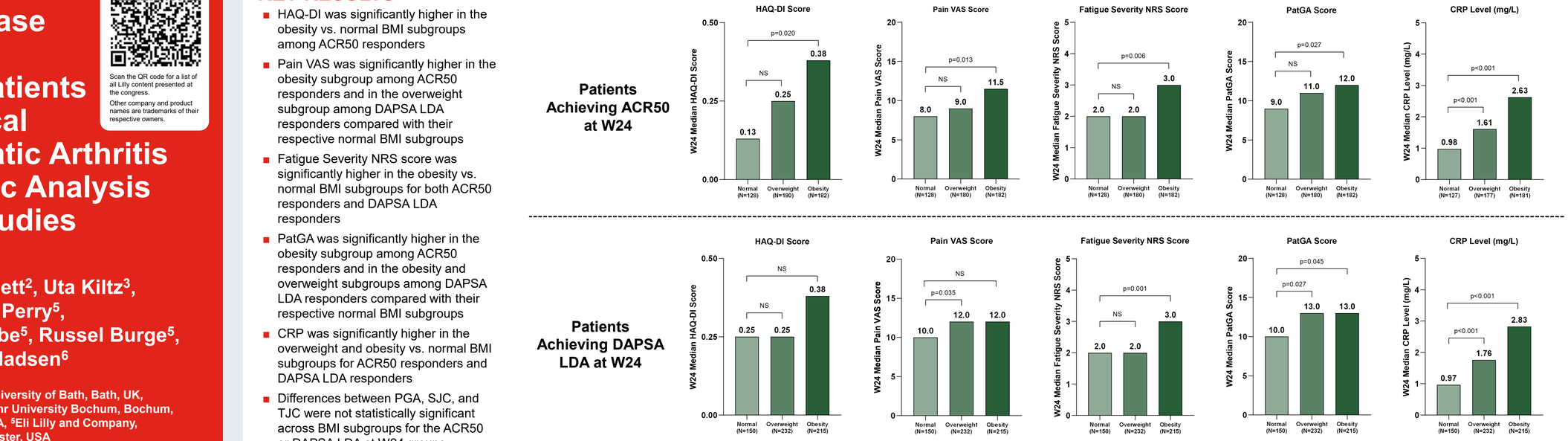
CONCLUSIONS

- In patients with PsA who achieved stringent treatment targets, obesity is associated with some indicators of negative impact on PsA disease activity (ie, pain, PatGA, CRP) and HRQoL (ie, fatigue, functional disability)
- While with current advanced therapies, patients with PsA and obesity can achieve effective improvement and lower disease activity, their functional ability, HRQoL and other health outcomes may be further improved by also treating their comorbid obesity

Fall Clinical Dermatology Conference (Fall CDC)
Las Vegas, USA; 23-26 October 2025

KEY RESULTS

- HAQ-DI was significantly higher in the obesity vs. normal BMI subgroups among ACR50 responders
- Pain VAS was significantly higher in the obesity subgroup among ACR50 responders and in the overweight subgroup among DAPSA LDA responders compared with their respective normal BMI subgroups
- Fatigue Severity NRS score was significantly higher in the obesity vs. normal BMI subgroups for both ACR50 responders and DAPSA LDA responders
- PatGA was significantly higher in the obesity subgroup among ACR50 responders and in the obesity and overweight subgroups among DAPSA LDA responders compared with their respective normal BMI subgroups
- CRP was significantly higher in the overweight and obesity vs. normal BMI subgroups for ACR50 responders and DAPSA LDA responders
- Differences between PGA, SJC, and TJC were not statistically significant across BMI subgroups for the ACR50 or DAPSA LDA at W24 groups



Note: Data shown are based on observed data at W24 by BMI subgroup.

Background

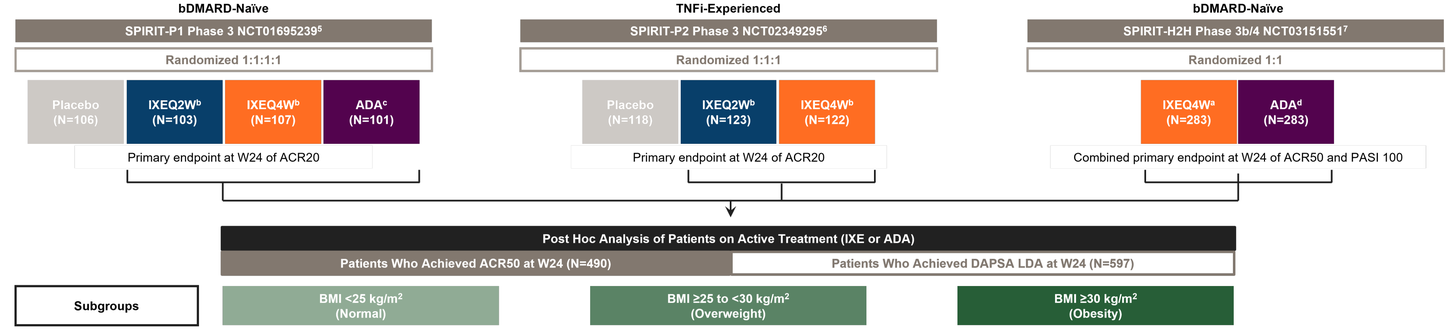
- Approximately 27-40% of patients with PsA live with obesity,[1] which is associated with poorer clinical outcomes and reduced treatment response compared with patients with normal BMI[2-4]
- Among clinical responders to PsA treatment, the impact of BMI on outcomes has not been assessed

Methods

Assessments and Statistical Analyses

- Using observed data, the following measures at W24 were reported across BMI subgroups
  - HRQoL outcomes: HAQ-DI and Fatigue Severity NRS
  - Measures of disease activity: Pain VAS, PatGA, PGA, CRP, SJC, and TJC
- The non-parametric Mann-Whitney U test was used to statistically compare differences between the obesity vs. the normal BMI groups and overweight vs. normal BMI groups (p-value <0.05 indicates statistical significance); no multiplicity testing adjustment was performed, and the analysis was not adjusted for baseline assessments of QoL or disease activity

Post Hoc, Unadjusted, Treatment-Agnostic Analysis of SPIRIT-P1, -P2, and -H2H[a]



[a]Heterogeneity of source trials may impact the model of pooled findings; [b]160-mg starting dose at W0 and 80-mg ixekizumab thereafter; [c]40-mg Q2W; [d]Patients who met the criteria for moderate-to-severe PsO received an 80-mg starting dose, followed by 40 mg Q2W starting at W1. Patients without moderate-to-severe PsO received a 40-mg starting dose, followed by 40 mg Q2W starting at W2.

References

1. Siebert S, et al. *Joint Bone Spine*. 2025;92:105904.
2. di Minno MN, et al. *Arthritis Care Res (Hoboken)*. 2013;65:141-147.
3. Eder L, et al. *Ann Rheum Dis*. 2015;74:813-817.
4. Vallejo-Yagüe E, et al. *BMJ Open*. 2022;12:e061474.
5. Mease PJ, et al. *Ann Rheum Dis*. 2017;76:79-87.
6. Nash P, et al. *Lancet*. 2017;389:2317-2327.
7. Mease PJ, et al. *Ann Rheum Dis*. 2020;79:123-131.

Abbreviations: *ACR20=American College of Rheumatology 20% response rate; ACR50=American College of Rheumatology 50% response rate; ADA=adalimumab; bDMARD=biologic disease-modifying anti-rheumatic drug; BMI=body mass index; CRP=C-reactive protein; DAPSA=Disease Activity in Psoriatic Arthritis; HAQ-DI=Health Assessment Questionnaire-Disability Index; HRQoL=health-related quality of life; IXE=ixekizumab; LDA=low disease activity; NRS=Numeric Rating Scale; NS=nonsignificant; PASI=100% improvement in Psoriasis Area and Severity Index; PatGA=Patient's Global Assessment; PGA=Physician's Global Assessment; PsA=psoriatic arthritis; PsO=psoriasis; Q2W=every 2 weeks; Q4W=every 4 weeks; SJC=swollen joint count, 66 joints; TJC=tender joint count, 68 joints; TNFi=tumor necrosis factor inhibitor; VAS=visual analog scale; W=Week*

Disclosures: J. F. Merola is a consultant and/or investigator for: AbbVie, Amgen, Biogen, Bristol Myers Squibb, Dermavant, Eli Lilly and Company, Janssen, LEO Pharma, Novartis, Pfizer, Regeneron, Sanofi, Sun Pharma, and UCB Pharma; **W. Tillett** has received grants, speaker fees, or honoraria from: AbbVie, Amgen, Celgene, Eli Lilly and Company, Janssen, Merck Sharp & Dohme, Novartis, Pfizer, and UCB Pharma; **U. Kiltz** has received grant and/or research support and consultancy fees from: AbbVie, Amgen, BIOCAD, Biogen, Chugai Pharmaceutical, Eli Lilly and Company, Grünenthal, Janssen, Merck Sharp & Dohme, Novartis, Pfizer, Roche, and UCB Pharma; and has received research grants from: AbbVie, Bristol Myers Squibb, Celgene, Eli Lilly and Company, GSK, Janssen, Novartis, Pfizer, and UCB Pharma; **E. L. Perkins** is a consultant for: AbbVie, Bristol Myers Squibb, Eli Lilly and Company, Johnson & Johnson, Novartis, and UCB Pharma; **A. Perry**, **M. Ngantcha**, **B. Ibe**, **A. Kronbergs**, and **R. Burge** are current employees and shareholders of: Eli Lilly and Company; **N. Madsen** has received grants/research support from Bristol Myers Squibb, Eli Lilly and Company, Johnson & Johnson, and MoonLake Immunotherapeutics; and has been a paid consultant for Eli Lilly and Company.

Medical writing assistance was provided by Annabel Campbell, PhD, and Thai Cao, MS, of Envision Catalyst, an Envision Medical Communications agency, a part of Envision Pharma Group, and was funded by Eli Lilly and Company