

# Perceptions of Living with and Managing Both Psoriatic Disease and Overweight/Obesity: A Qualitative Interview Study



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## OBJECTIVE

- The objective of this study was to qualitatively summarize the experiences of adults with PsD and overweight/obesity who are receiving concomitant treatment for both conditions.

## CONCLUSIONS

- Individuals with PsD and overweight/obesity reported physical health and quality of life improvement after incretin hormone therapy. Early and proactive provider engagement around PsD and weight management options may enhance health outcomes.

### Disclosures

BM and AC are employees of Eli Lilly and Company. UD, YW, AH, MM, ES, and NK are employees of Analysis Group, a company that received funding for this research from Eli Lilly and Company. CB has received funding as a speaker/consultant for Novartis, Lilly, Pfizer, Johnson & Johnson, AbbVie, Sanofi, Sobi, BMS, UCB. TBJ has received research funding from Amgen, Castle, CorEvitas, Novartis, Pfizer, and Regeneron; served as an advisor for AbbVie, Arcutis, Aslan, Boehringer-Ingelheim, Bristol Myers Squibb, Dermavant, Galderma, Incyte, Janssen, Leo, Lilly, Pfizer, Novartis, Sanofi, Sun, Takeda, and UCB; and speaker for AbbVie, Amgen, Arcutis, BMS, Dermavant, Galderma, Janssen, Lilly, Leo, Ortho, Sanofi, and UCB. HSP has received funding as a consultant for Lilly.

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## SYNOPSIS

- Psoriasis vulgaris (PsO) and psoriatic arthritis (PsA) (together, psoriatic disease, PsD) are chronic inflammatory conditions that significantly impair quality of life (QoL). Obesity is common in PsD, and the two conditions can exacerbate one another. Recent expert consensus state that weight control is a vital component of improving health outcomes for patients with PsD.
- This study examined real-world experiences of adults in the U.S. receiving advanced therapies for PsD and, more recently, incretin hormones for overweight/obesity. Twenty participants completed in-depth, semi-structured interviews on the impact of PsD and overweight/obesity on QoL, changes after initiating incretin hormone therapy, and interactions with healthcare providers (HCPs).

### Objective

- The objective of this study was to qualitatively summarize the experiences of adults with PsD and overweight/obesity who are receiving concomitant treatment for both conditions.

## FOUR KEY THEMES EMERGED

- Impact of living with PsD and overweight/obesity before weight-loss medications was largely negative.
- Weight-loss medications contributed to meaningful improvements in QoL, including physical and mental health.
- Individuals wanted more interaction and information from providers of weight-loss medications and PsD.
- Individuals perceived a relationship between weight and health, but not always between weight and PsD.

## METHODS

**Data source:** Adults with PsD and overweight/obesity were invited to participate in the study. Participants were recruited primarily through a market research patient panel, with additional outreach from the National Psoriasis Foundation.

Potential participants received a unique invitation link to complete a screener. Eligible participants were asked to review an informed consent form, and those who provided consent completed a short survey capturing basic demographic and clinical information. Upon completion of the short survey, participants were invited to schedule a one-on-one web-based interview. Interviews lasted approximately 60-minutes and followed a semi-structured format, during which participants responded to open-ended questions about their experiences with PsD and overweight/obesity. All interviews were completed between March and June 2025.

### Eligibility criteria

- Adults (≥18 years) with self-reported PsD (PsO and/or PsA)
- On current biologic or advanced PsD therapy for ≥ 12 months (TNF, IL-17, IL-12/23, IL-23, JAK, T-cell, and PDE-4 inhibitors)
- Initiated incretin hormone therapy ≥3 months after PsD treatment and on current therapy for 6-12 months (semaglutide or tirzepatide)
- Overweight (BMI 25-29.9 kg/m<sup>2</sup>) or obesity (BMI ≥30 kg/m<sup>2</sup>) at incretin hormone initiation, calculated based on self-reported height and weight
- Living in the US and able to read/speak English or Spanish
- Participants were excluded if they were: (1) pregnant (2) receiving biologic or advanced PsO/PsA therapies as part of a clinical trial, (3) receiving incretin hormones as part of a clinical trial, (4) receiving active cancer treatment, or (5) diagnosed with end-stage renal disease requiring dialysis

### Data analysis

- Demographics and clinical characteristics were described using means and standard deviations for continuous variables, and counts and percentages for categorical variables
- Interview transcripts were coded for emergent concepts using NVivo v12.0, conceptual responses were summarized as the number of times a concept was discussed and the percentage this response was raised by unique participants
- Thematic analysis was conducted to assess patterns across responses

Figure 1. Commonly reported quality of life limitations BEFORE starting incretin hormone therapy

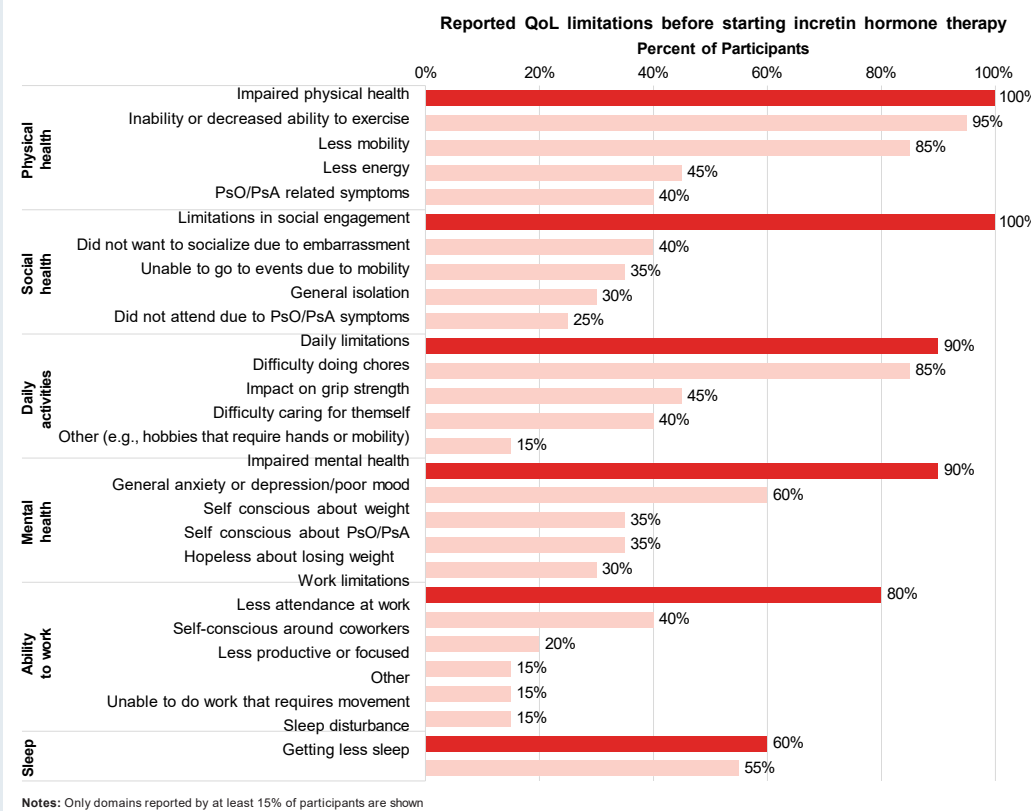
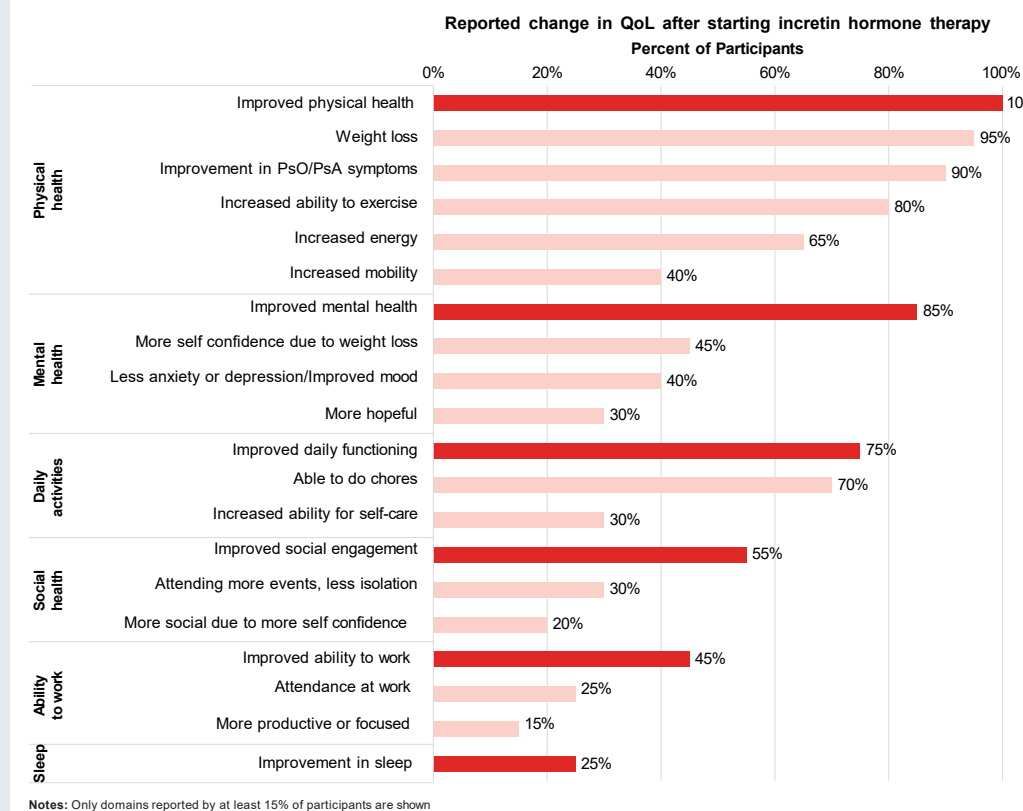


Figure 2. Commonly reported quality of life improvements AFTER starting incretin hormone therapy



## Results

### Demographic and clinical characteristics [Table 1]

- A total of 20 participants were recruited (19 from market research panels and 1 from the National Psoriasis Foundation). The mean age was 50.3 years; 75% were White, and 60% were female
- Among the 20 participants, 9 had both PsO and PsA, 6 had PsO only, and 5 had PsA only. The median disease duration was 11.0 years for PsO and 3.0 years for PsA
- The median duration of current PsD treatment was 18.0 months, with most participants using ixekizumab or secukinumab (35% each) at the time of the study
- The mean BMI prior to starting incretin hormone therapy was 39.0 kg/m<sup>2</sup>, with 95% classified with obesity and 5% with overweight
- The median duration of current incretin hormone therapy was 7.5 months, with most participants using semaglutide (70%) at the time of the study

### Experience living with and managing PsD and overweight/obesity prior to incretin hormone therapy initiation

- When asked to describe their experiences living with PsD, 60% of participants characterized it as “not good”, while 20% said it “depends on the day”. Joint pain (50%) and skin symptoms (35%) were cited as the most distressing symptoms
- Participants reported trying different treatments for PsD symptom management, including prescription medications (100%) and topical creams (15%)
- Most participants described living with overweight/obesity as “not good” (85%) and reported trying various weight management methods prior to initiating incretin hormone therapy, such as diet (75%), exercise (30%), and over-the-counter medications (15%), often noting difficulty in finding effective strategies
- Participants primarily initiated incretin hormone therapy to lose weight (90%), with 20% seeking improvement in PsD symptoms
- Prior to initiating incretin hormone therapy, participants reported impaired QoL across physical health (100%), social engagement (100%), daily functioning (90%), mental health (90%), work (80%), and sleep (60%) [Figure 1]

### QoL after incretin hormone therapy initiation [Figure 2]

- Following incretin hormone initiation, all participants (100%) reported physical health improvements, including weight loss (95%), PsD symptom improvement (90%), and increased ability to exercise (80%)
- Most participants reported improvements in mental health (85%) and daily functioning (75%), including greater self-confidence related to weight loss (45%), ability to do chores (70%), and self-care (30%)
- About half reported improvements in social engagement (55%) and ability to work (45%)

### Interactions with HCPs about weight management

- Most participants (60%) initiated the conversations about weight-loss medications with their HCP
- Only 40% recalled providers discussing the potential connection between PsD and weight
- Many (80%) wished these discussions had occurred earlier, with 25% specifically wishing they had taken place at the time of PsO/PsA diagnosis
- Additionally, 30% expressed a desire for more information from providers about weight-loss treatment options

Table 1. Demographic and clinical characteristics

Demographic Characteristic	Total (N = 20)
Age (years) (Mean ± SD)	50.3 ± 12.4
Female, n (%)	12 (60.0%)
Race/ethnicity, n (%) <sup>1</sup>	
White	15 (75.0%)
Hispanic or Latino	5 (25.0%)
Black or African American	1 (5.0%)
Employment status, n (%) <sup>1</sup>	
Working, full-time	13 (65.0%)
Working, part-time	4 (20.0%)
Retired	3 (15.0%)
Self-employed	1 (5.0%)
Other	1 (5.0%)
Clinical characteristics	
Diagnosis of PsD, n (%)	
Both PsO and PsA	9 (45.0%)
PsO only	6 (30.0%)
PsA only	5 (25.0%)
Time since PsO diagnosis (years)	
Mean ± SD	10.7 ± 6.7
Median [IQR]	11.0 [4.0, 15.0]
Time since PsA diagnosis (years)	
Mean ± SD	6.9 ± 8.2
Median [IQR]	3.0 [2.0, 8.0]
Current PsD medication, n (%)	
ixekizumab	7 (35.0%)
secukinumab	7 (35.0%)
bimekizumab	2 (10.0%)
brodalumab	1 (5.0%)
adalimumab or biosimilar	1 (5.0%)
risankizumab	1 (5.0%)
guselkumab	1 (5.0%)
Time on current PsD medication (months)	
Mean ± SD	25.9 ± 16.3
Median [IQR]	18.0 [14.0, 36.0]
BMI before taking incretin hormone therapy (kg/m <sup>2</sup> ) (Mean ± SD)	39.0 ± 6.4
Overweight/obesity status, n (%)	
Overweight	1 (5.0%)
Obesity	19 (95.0%)
Current incretin hormone therapy, n (%)	
semaglutide	14 (70.0%)
tirzepatide	6 (30.0%)
Time on current incretin hormone therapy (months)	
Mean ± SD	8.6 ± 2.4
Median [IQR]	7.5 [6.0, 11.0]

Abbreviations: BMI, Body Mass Index; IQR, Interquartile Range; PsA, Psoriatic Arthritis; PsD, Psoriatic disease; PsO, Psoriasis; SD, Standard Deviation.  
Note: 1. Multiple responses were allowed, so counts and percentages may not sum to the total N or 100%.