

Closing the gap: a 5-step plan for psoriasis and metabolic disease

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Psoriasis is more than a skin condition; it is a systemic inflammatory disease with well-established links to a host of metabolic comorbidities, including obesity, type 2 diabetes, dyslipidemia, and hypertension. Despite this clear association, the integration of metabolic screening and management into routine dermatological practice remains inconsistent, leaving many patients at elevated risk for cardiovascular events and other complications. A recent consensus statement aims to bridge this persistent care gap, proposing a structured, five-step action plan for clinicians. This framework provides a practical roadmap for identifying and addressing metabolic disease in patients with psoriasis, moving beyond skin-deep management to holistic patient care.

KEY TAKEAWAYS

- **The Pivot:** A new five-step action plan provides a structured approach for integrating metabolic disease screening and management into psoriasis care.
- **The Data:** The plan emphasizes regular screening for obesity, dyslipidemia, hypertension, and type 2 diabetes, recognizing the bidirectional relationship between psoriasis and these conditions.
- **The Action:** Clinicians should implement systematic screening protocols and collaborate with primary care and other specialists to optimize long-term outcomes for patients with psoriasis.

Psoriasis, a chronic inflammatory skin condition affecting millions globally, has long been recognized for its visible dermatological manifestations. But the disease's impact extends far beyond the skin. It is now understood as a systemic inflammatory disorder, with a significant burden of associated comorbidities, particularly those within the metabolic syndrome spectrum. Patients with psoriasis face a heightened risk of developing obesity, type 2 diabetes, dyslipidemia, and hypertension, conditions that collectively increase their cardiovascular morbidity and mortality. This bidirectional relationship means that not only does psoriasis predispose individuals to metabolic dysfunction, but metabolic comorbidities can also exacerbate psoriasis severity and compromise treatment efficacy. The challenge for clinicians lies in effectively integrating the management of these systemic risks into routine dermatological practice, which often focuses primarily on skin clearance.

The unmet need for a structured approach to this complex patient population prompted the development of a five-step action plan. This framework is designed to empower dermatologists and other healthcare providers to systematically screen for, monitor, and manage metabolic comorbidities in patients with psoriasis. The goal is to move beyond reactive treatment of individual symptoms and instead foster a proactive, integrated care model that addresses the full scope of

the disease and its systemic implications. The plan emphasizes collaboration across specialties, recognizing that optimal care for these patients requires a multidisciplinary effort.

Understanding the Psoriasis-Metabolic Link

The connection between psoriasis and metabolic disease is rooted in shared inflammatory pathways. Chronic systemic inflammation, a hallmark of moderate-to-severe psoriasis, contributes to insulin resistance, endothelial dysfunction, and dyslipidemia. Adipokines, cytokines, and other inflammatory mediators released from psoriatic lesions and adipose tissue play a central role in perpetuating this cycle. For instance, elevated levels of TNF-alpha, IL-6, and IL-17, key drivers of psoriatic inflammation, are also implicated in the pathogenesis of insulin resistance and atherosclerosis. This intricate bidirectional relationship means that effectively managing one condition often has beneficial effects on the other, underscoring the importance of a holistic approach.

Patients with psoriasis often exhibit higher rates of obesity, with a dose-dependent relationship between body mass index (BMI) and psoriasis severity. Obesity itself is a pro-inflammatory state, further fueling the systemic inflammation seen in psoriasis. This creates a vicious cycle where obesity exacerbates psoriasis, and severe psoriasis makes weight management more challenging. Similarly, the prevalence of type 2 diabetes is significantly higher in patients with psoriasis, particularly those with more extensive skin involvement. The chronic inflammatory milieu contributes to impaired glucose metabolism, while diabetes can, in turn, worsen psoriatic flares and reduce responsiveness to treatment. Dyslipidemia, characterized by elevated triglycerides and low HDL cholesterol, is also common, contributing to the accelerated atherosclerosis observed in this patient group. Hypertension, another component of metabolic syndrome, is frequently seen in psoriasis patients, further increasing their cardiovascular risk profile.

The Five-Step Action Plan for Integrated Care

The proposed action plan outlines a systematic, practical approach for clinicians to address the metabolic burden in psoriasis patients. This framework is designed to be adaptable across various clinical settings, from specialized dermatology clinics to general practice. The first step involves screening and risk stratification. This means routinely assessing all psoriasis patients for metabolic comorbidities at initial presentation and at regular intervals thereafter. Key parameters include BMI, waist circumference, blood pressure, fasting glucose, HbA1c, and a lipid panel. Early identification allows for timely intervention and prevents progression to more severe disease states.

The second step focuses on lifestyle modifications. This is the cornerstone of metabolic disease management and is particularly critical in psoriasis. Patients should receive counseling on healthy diet, regular physical activity, and weight management. Even modest weight loss can significantly improve both metabolic parameters and psoriasis severity, often enhancing the response to dermatological therapies. Clinicians should provide resources or refer patients to dietitians and exercise specialists. For a comprehensive guide to managing endocrine and diabetes conditions, the Oxford Handbook of Endocrinology and Diabetes (4th ed) offers practical guidance.

The third step involves pharmacological management of comorbidities. When lifestyle interventions alone are insufficient, appropriate pharmacotherapy for obesity, type 2 diabetes, dyslipidemia, and hypertension should be initiated. This requires close collaboration with primary care physicians, endocrinologists, and cardiologists. The choice of medication should consider potential interactions with psoriasis treatments and the overall inflammatory burden. For example, some antihypertensive medications may have a neutral or even beneficial effect on psoriasis, while others might

exacerbate it. Careful consideration of these factors is paramount.

The fourth step emphasizes optimizing psoriasis treatment with metabolic comorbidities in mind. Certain systemic psoriasis therapies may have beneficial effects on metabolic parameters, while others might worsen them. For instance, some biologics, particularly TNF-alpha inhibitors and IL-17/IL-23 inhibitors, have been shown to improve insulin sensitivity and lipid profiles in addition to clearing skin. Conversely, traditional systemic agents like cyclosporine can worsen hypertension and dyslipidemia. The choice of psoriasis therapy should therefore be guided not only by skin severity but also by the patient's metabolic profile, aiming for treatments that offer dual benefits or at least do not exacerbate existing comorbidities.

Finally, the fifth step highlights the importance of multidisciplinary collaboration and patient education. Effective management of psoriasis and its metabolic comorbidities requires a team approach involving dermatologists, primary care physicians, cardiologists, endocrinologists, dietitians, and mental health professionals. Regular communication and shared decision-making are essential. Patients must also be educated about the systemic nature of their disease, the importance of adherence to both dermatological and metabolic treatments, and the benefits of lifestyle changes. Empowering patients with knowledge fosters self-management and improves long-term outcomes.

Challenges and Future Directions

Implementing this comprehensive action plan is not without its challenges. Time constraints in busy clinical practices, a lack of formal training in metabolic disease management among dermatologists, and insufficient inter-specialty communication are significant barriers. Integrating metabolic screening into existing workflows requires systemic changes and dedicated resources. Patient adherence to complex treatment regimens and lifestyle modifications can be difficult to achieve and maintain over time. The psychological burden of living with a chronic skin condition like psoriasis, coupled with the demands of managing multiple comorbidities, can impact motivation and engagement. Still, the benefits of this integrated approach far outweigh the difficulties. By proactively addressing metabolic comorbidities, clinicians can reduce the risk of major adverse cardiovascular events, improve overall quality of life, and potentially enhance the efficacy of psoriasis treatments. Future research should focus on developing validated screening tools tailored for psoriasis patients, exploring novel therapies that target both skin and metabolic inflammation, and evaluating the long-term impact of integrated care models on patient outcomes. The ultimate goal is to establish a standard of care where the systemic nature of psoriasis is fully acknowledged and managed, ensuring that patients receive comprehensive, patient-centered care that extends beyond the visible symptoms.

CLINICAL IMPLICATIONS

The proposed five-step action plan for managing psoriasis and metabolic comorbidities is a necessary step towards holistic patient care. For too long, dermatologists have focused primarily on skin clearance, often overlooking the significant systemic risks that accompany chronic inflammation. This framework demands a shift in clinical practice, requiring dermatologists to expand their scope of assessment and engage more actively in metabolic screening.

The emphasis on multidisciplinary collaboration is particularly salient. Primary care physicians, endocrinologists, and cardiologists must be integrated into the care pathway, not as an afterthought, but as essential partners. This necessitates clear communication channels and shared treatment goals, moving

beyond fragmented care to a truly integrated model. The plan also highlights the need for ongoing patient education, empowering individuals to understand the systemic nature of their disease and actively participate in their own health management.

But the success of this plan hinges on practical implementation. Clinics will need to adapt workflows, and clinicians may require additional training in metabolic screening and counseling. The pharmaceutical industry also has a role to play, developing therapies that offer dual benefits for both psoriasis and metabolic dysfunction, or at least demonstrate metabolic neutrality. Without these systemic changes, even the most well-intentioned guidelines risk remaining aspirational rather than transformative.

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