Rising overweight and obesity in Swiss psoriatic arthritis patients, 2007-2022: a nationwide registry-population comparison

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Abstract

Objective

To compare overweight and obesity prevalence in Swiss patients with psoriatic arthritis (PsA) against the general Swiss population from 2007-2022, evaluate temporal trends, and assess socioeconomic correlates (age, sex, education).

Methods

We performed a repeated cross-sectional analysis of adults with PsA in the Swiss Clinical Quality Management in Rheumatic Diseases (SCQM) registry who had BMI recorded in 2007, 2012, 2017, or 2022 (patients could contribute to more than one index year). Age-, sex-, and education-stratified BMI distributions were compared with Swiss Health Survey data using χ^2 goodness-of-fit tests. Within PsA, clinical and socioeconomic variables were compared across BMI categories using Fisher's exact or Kruskal-Wallis tests; pairwise changes over time were assessed with one-sided Wilcoxon rank-sum tests.

Results

Among 1,150 PsA patients in 2022, 37.6% were overweight and 28.2% obese, versus 30.9% and 12.1% in the Swiss population. In cross-sectional comparisons, obesity was associated with more frequent elevated C-reactive protein (55.8% vs. 37.0%), higher patient global assessment (mean [SD] 3.2 [2.4] vs. 2.8 [2.2]) and physician global assessment (2.5 [2.0] vs. 2.1 [1.8]), and lower EQ-5D-3L health state (0.7 [0.2] vs. 0.8 [0.2]). Obesity prevalence rose from 19.4% in 2007 to 28.2% in 2022, a trend driven by men. Obesity prevalence varied across educational strata but did not follow a monotonic social gradient; within each stratum obesity was markedly more common in PsA than in the Swiss general population.

Conclusion

Overweight and obesity affect nearly two-thirds of Swiss PsA patients and have increased since 2007. Cross-sectional associations between obesity, higher inflammatory burden and poorer patient-reported health state, together with the widening gap versus the general population, support integrating structured, multidisciplinary weight-management programmes into PsA treat-to-target care, particularly for men.

Key words

psoriatic arthritis, epidemiology, prevalence, public health, obesity, comorbidity

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Introduction

Obesity is a pivotal comorbidity in psoriatic arthritis (PsA), with a prevalence consistently higher than in the general population (1). Beyond psoriasis (PsO) – where excess weight increases both the risk of PsO and its progression to PsA (2, 3) – adiposity affects the full course of PsA (4). Higher BMI is linked to more active joint and skin inflammation, greater cardiovascular risk, and a 30–50% lower chance of remission on biologics, particularly TNF inhibitors (4-6). Obesity frequently co-exists with the metabolic syndrome, dyslipidaemia, hypertension and insulin resistance, which together drive the elevated cardiometabolic risk observed across the spectrum of psoriatic disease (7, 8). Mechanistically, adipose tissue is not an inert energy reservoir but a metabolically active organ that secretes pro-inflammatory cytokines (TNF-α, IL-6) together with adipokines such as leptin and resistin, while reducing adiponectin – a pattern that amplifies Th17/IL-23 signalling, which is central to PsA pathogenesis, and that may also alter the pharmacokinetics of biologic drugs (6, 8). Recent evidence further emphasises obesity as a modifiable risk factor for the transition from PsO to PsA and as a target for risk-stratified preventive care (3).

Although a higher obesity prevalence in PsA is well described, most studies are cross-sectional and single-centre, with limited insight into temporal trends and socioeconomic determinants. Updated EULAR and GRAPPA recommendations have increasingly called for the integration of obesity and cardiometabolic care into PsA management pathways (9), yet nationwide data describing how obesity evolves relative to the general population – and which patient subgroups are most affected – remain scarce.

Using Swiss registry data, we quantified trends in obesity among PsA patients *versus* the general population from 2007 to 2022 and examined socioeconomic correlates within PsA (sex, age, education). These results may help inform weight management strategies in routine PsA care and support multidisciplinary resource allocation.

Methods

We conducted a retrospective, repeated cross-sectional study comparing BMI distributions in adults with PsA and in the Swiss general population at four calendar years (2007, 2012, 2017, 2022). PsA data came from the Swiss Clinical Quality Management in Rheumatic Diseases (SCQM) registry, in which the treating rheumatologist records standardised assessments and patients complete validated patient-reported outcomes and socioeconomic questionnaires (10). Access was granted after review by the SCQM Scientific Committee and Foundation Board.

Comparator data were aggregated from the Swiss Health Survey, a five-yearly, nationally representative, stratified random sample of residents aged ≥15 years that collects self-reported height and weight (11).

The Cantonal Ethics Committee of Zurich approved the protocol (BASEC 2022-00272). All SCQM participants provided written informed consent at inclusion to the patient registry.

Inclusion criteria were a physician-reported diagnosis of PsA in SCQM and a recorded BMI at an index year (± 1 year). Each index year represents an independent cross-sectional snapshot of registry participants with a visit and BMI measurement in that calendar year. Individuals could contribute to more than one index year, but complete follow-up across all years was not required and individual BMI trajectories were not reconstructed. Across the four index years, 2,494 unique PsA patients contributed to at least one snapshot: 1,515 (60.8%) to a single index year, 646 (25.9%) to two, 261 (10.5%) to three, and 72 (2.9%) to all four. The analytic structure is therefore a series of four independent prevalence snapshots, and inferences refer to cohort-level, not within-person, change. BMI categories followed WHO cut-offs: underweight (<18.5 kg/m^2), normal (18.5–24.9), overweight (25.0–29.9), obese (≥30.0) (12). Extracted variables were age, sex, HLA-B27, modified New York criteria, PsA family history, inflammatory back pain, ever-presence of enthesitis (heel), uveitis, dactylitis, psoriasis, C-reactive protein (CRP),

Table I. Baseline characteristics of PsA patients in 2022 by BMI category.

	Patients, n	All patients n=1150 (100)	Underweight n=13 (1.1)	Normal weight n=381 (33.1)	Overweight n=432 (37.6)	Obese n=324 (28.2)	*p*-value
Age, yrs, mean (SD)	1150	55.2 (12.8)	47.8 (16.9)	54.0 (13.6)	55.8 (12.2)	56.2 (12.1)	0.05
Male sex	1150	48.4	7.7	41.7	54.4	50	<0.01
BMI kg/m², mean (SD)	1150	27.7 (5.3)	17.6 (1.3)	22.7 (1.6)	27.4 (1.4)	34.3 (4.2)	<0.01
Symptom duration (y), mean (SD)	1001	15.6 (10.7)	15.6 (6.6)	14.7 (10.5)	16.3 (10.8)	15.7 (10.8)	0.14
HLA-B27 positive	1133	10	15.4	9.9	10.6	9	0.52
Inflammatory back pain	1027	17	40	18	18.4	13.4	0.06
Enthesitis (heel) ever	751	70.6	87.5	68.2	70.1	73.1	0.52
Uveitis ever	1100	5.7	9.1	6.5	5.8	4.5	0.53
Dactylitis ever	1103	47.8	72.7	47.9	47.1	47.7	0.42
Psoriasis ever	1091	87	81.8	84.3	87.3	89.9	0.16
Positive family history	989	43.6	60	41.7	44.2	44.4	0.64
Elevated CRP	1011	45.3	63.6	37.0	43.7	55.8	<0.01
CRP mg/l, mean (SD)	999	4.5 (7.1)	7.0 (16.6)	3.4 (5.7)	4.4 (7.6)	5.9 (7.0)	<0.01
Smoking ever	759	54.7	50	50.2	54.6	60	0.21
Alcohol consumption ever	699	63.4	50	69.2	64.1	56.9	0.04
EQ-5D-3L, mean (SD)	662	0.8 (0.2)	0.8 (0.1)	0.8 (0.2)	0.8 (0.2)	0.7 (0.2)	<0.01
DLQI, mean (SD)	402	3.3 (4.4)	2.4 (3.3)	3.1 (4.0)	3.2 (4.8)	3.6 (4.5)	0.53
PGA, mean (SD)	1088	2.2 (2.0)	2.5 (2.3)	2.1 (1.8)	2.0 (2.0)	2.5 (2.0)	0.01
PtGA, mean (SD)	1063	2.8 (2.3)	2.9 (2.5)	2.8 (2.2)	2.5 (2.2)	3.2 (2.4)	<0.01

Values are expressed as % unless otherwise indicated.
Underweight: BMI <18.5; normal weight: BMI ≥18.5 to <25; overweight: BMI ≥25 to <30; obese: BMI ≥30.
PsA: psoriatic arthritis; CRP: C-reactive protein; EQ-5D-3L: EuroQol 5 Dimensions, 3-Level (5 dimensions: mobility, self-care, usual activities, pain/discomfort, anxiety/depression; 3 levels: no problems, some problems, extreme problems labelled 1–3); PGA: physician global assessment; PtGA: patient global assessment.

smoking, alcohol, and patient/physician global assessments. Health state was derived from EQ-5D-3L. Education (mandatory/secondary/tertiary) and occupation (blue- *vs*. white-collar; *e.g*. transport/manufacturing/agriculture *vs*. office/homemakers/teachers) were recorded. Because educational attainment is recorded only once in the SCQM cohort — at the SCQM inclusion, via a voluntary socioeconomic questionnaire — we treated education as a time-invariant characteristic and carried the value recorded forward to all subsequent index years, rather than restricting to information collected at the BMI-index visit. This broader ascertainment rule applied to education only and did not affect BMI, which was taken from the BMI-index visit as described above.

We described the sample overall and by BMI group. Categorical variables were compared with Fisher's exact test; continuous variables with Kruskal-Wallis. Analyses used complete cases for the variables of interest; because BMI is not captured for every registry visit, results reflect participants with recorded BMI at each index year. BMI distributions in PsA were compared with those in the general population by age, sex and education using χ^2 goodness-of-fit tests. Temporal changes in mean BMI among PsA patients were evaluated; although BMI was non-normally distributed, means with standard deviations were reported to maintain comparability with the clinical PsA and obesity literature, in which BMI is predominantly expressed as mean (SD); medians with interquartile ranges yielded consistent results and did not change the direction of any temporal comparison. Differences were assessed using one-sided Wilcoxon rank-sum tests. No adjustment for multiple testing was applied. Analyses were performed using R version 4.3 (R Core Team, 2023) (13).

Results

In 2022, 1,150 PsA patients had a recorded BMI (Table I). Obese patients were older (mean [SD] 56.2±12.1 years) and more often male (50.0%) than normal-weight patients (54.0±13.6 years; 41.7% male). Elevated CRP prevalence rose from 37.0% in normal weight to 55.8% in obesity, with higher mean CRP (5.9±7.0 mg/L *vs*. 3.4±5.7 mg/L). EQ-5D-3L scores were lower in obese patients (0.7±0.2 *vs*. 0.8±0.2). Patient global (3.2±2.4 *vs*. 2.8±2.2) and physician global (2.5±2.0 *vs*. 2.1±1.8) scores were higher in obesity.

At each index year, overweight and obesity combined were more common in PsA than in the Swiss population. In 2022, 37.6% of PsA patients were overweight and 28.2% obese, *versus* 30.9% and 12.1% in the general population (Fig. 1A). The relative increase in obesity from 2007 to 2022 was of similar magnitude in PsA and the general population, but the absolute obesity gap widened from 11 percentage points in 2007 to 16 points in 2022.

The proportion of obese PsA patients increased from 19.4% in 2007 to 28.2% in 2022. One-sided Wilcoxon rank-sum tests comparing BMI values of different index years in PsA showed a significant increase between 2007–2012 (p=0.0067) and a further increase between 2012–2022 (p=0.02), whereas the adjacent shifts 2012–2017 and 2017–2022 were not significant overall. In sex-stratified analyses, males showed a significant BMI increase between 2012 and 2022 (p=0.02); females did not show a significant change since 2012.

Educational attainment was available

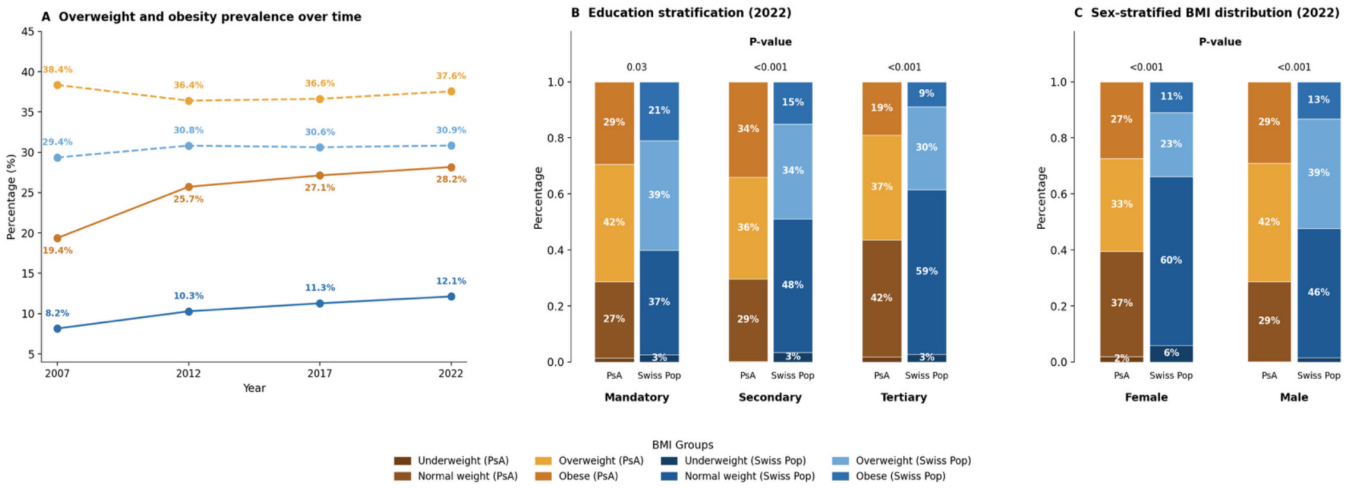

Fig. 1 A: Prevalence of overweight (BMI 25–29.9 kg/m²; dashed lines) and obesity (BMI ≥30 kg/m²; solid lines) among PsA patients (orange) and the general Swiss population (blue) across four index years.
B: BMI category distribution in 2022 by educational attainment (mandatory, secondary, tertiary), comparing PsA (orange shades) with the Swiss general population (blue shades), with χ^2 goodness-of-fit tests.
C: Sex-stratified BMI category distribution in 2022 in PsA *vs*. the general Swiss population, with χ^2 goodness-of-fit tests.

Table II. Socioeconomic differences between BMI categories in 2022.

	Patients, n	All patients	Underweight	Normal weight	Overweight	Obese	*p*-value
Education	879						**<0.001**
Mandatory		15.5	25.0	12.8	17.3	15.9	
Secondary		52.9	12.5	47.2	51.2	62.9	
Tertiary		31.6	62.5	40.0	31.5	21.1	
Job type	594						**0.13**
Blue-collar worker		28.4	0	28.1	24.8	34.3	
White-collar worker		71.5	100	71.9	75.2	65.7	

Values are expressed as % unless otherwise indicated. *p*-values are from Fisher's exact tests assessing the overall association between each socioeconomic variable and BMI category. PsA: psoriatic arthritis.

for 879 of 1,150 patients (76%) in 2022 (Table II; Fig. 1B). Obesity prevalence varied across educational strata but did not follow a monotonic social gradient: 29% (40/136) for mandatory schooling, 34% (158/465) for secondary, and 19% (53/278) for tertiary. Within each stratum, obesity was markedly more common in PsA than in the Swiss general population (21%, 15% and 9%, for mandatory, secondary and tertiary schooling, respectively). Occupational data in 2022 (n=594) showed no statistically significant association: blue-collar 34% (57/168) *vs*. white-collar 26% (110/425).

Sex-stratified stacked bars (Fig. 1C) showed overweight and obesity combined in 71% of males (235/557 overweight; 162/557 obese) *versus* 61% of females (197/593 overweight; 162/593 obese). Underweight prevalence was higher in women (2%) than men (<1%).

Discussion

In this nationwide registry study, overweight and obesity affected nearly two-thirds of Swiss PsA patients, and the prevalence gap *versus* the general population widened over 15 years. The 2022 obesity prevalence (28%) far exceeded the Swiss population (12%), consistent with North American and Scandinavian reports (14), and cross-sectionally aligned with higher inflammatory burden reflected in CRP and in patient- and physician-reported global assessments (7).

The findings mirror recent SCQM data in axial spondyloarthritis (axSpA), where obesity was also more common than in the general population, associated with higher disease activity, and concentrated among socially disadvantaged groups with lower education and manual jobs (15). Together, these data indicate that excess weight is a common, modifiable comorbidity across spondyloarthropathies and should be addressed proactively in rheumatology care.

Our study adds two points. First, obesity prevalence increased substantially in PsA between 2007 and 2022; the proportional increase was broadly comparable to the general population, but levels remained consistently higher in PsA. Second, sex-stratified trends suggest that men primarily drive the continued rise since 2012, whereas women's BMI has plateaued. This contrasts with axSpA, where rising BMI was more pronounced in females (15). The divergence warrants further study; hypotheses include sex-specific hormonal effects on metabolism, differences in physical activity or diet, or variations in treatment exposure.

A number of methodological points merit explicit discussion. First, our design is repeated cross-sectional, not

longitudinal. Each index year is an independent snapshot; individuals could contribute to more than one snapshot, but individual weight trajectories were not tracked. Temporal trends therefore describe cohort-level prevalence and cannot disentangle whether rising obesity reflects new patients entering the registry with higher BMI, existing patients gaining weight, or both. In addition, the observed associations between obesity and higher CRP, global assessments or lower EQ-5D-3L are based on cross-sectional data and should be interpreted as descriptive; confounding cannot be excluded as relevant variables were not adjusted for. Obesity may promote systemic inflammation, but pain, fatigue and reduced physical activity related to active PsA may equally predispose to weight gain, and common factors such as socioeconomic status, diet and treatment exposure may drive both.

Second, BMI in SCQM is clinician-measured at the rheumatology visit, whereas BMI in the Swiss Health Survey is derived from self-report. Validation studies consistently demonstrate that self-report underestimates weight and overestimates height, yielding BMIs that are on average 0.3–0.6 kg/m^2 lower than measured values and obesity prevalence that is typically 4–7 percentage points lower than the true prevalence (16); under-reporting is more pronounced in women and in the highest BMI ranges. A proportion of the obesity gap, therefore, likely reflects this measurement bias rather than a true PsA/population difference. Nevertheless, Swedish and Canadian registry studies that compared measured PsA with measured population data have reported a persistent excess of obesity in PsA of similar direction, albeit smaller in magnitude (14), suggesting that methodological bias explains only a fraction of the gap.

Third, educational attainment was recorded for 879 of 1,150 patients (76%) in 2022. This high completeness reflects the carry-forward approach: because educational attainment is a stable patient-level characteristic, the value captured at SCQM inclusion was propagated to every subsequent index year, rather than being treated as missing. Approximately one quarter of patients still lack this variable, and residual selection bias cannot be excluded. Obesity prevalence differed significantly across strata but did not follow a monotonic social gradient: it was highest in the secondary group (34%, 158/465), intermediate in mandatory schooling (29%, 40/136) and lowest in tertiary education (19%, 53/278). Within each stratum obesity was markedly more common in PsA than in the Swiss general population, indicating that the PsA-population obesity gap persists across the full educational spectrum. The non-monotonic pattern argues against a simple education-obesity gradient in PsA and should be re-examined in larger datasets with complete socioeconomic capture and with attention to age, sex and occupation as potential effect modifiers.

Mechanisms linking obesity to PsA are biologically plausible and increasingly well characterised. Adipose tissue secretes pro-inflammatory cytokines (TNF-α, IL-6) and adipokines such as leptin and resistin, while adiponectin declines (6, 8); this adipokine imbalance amplifies Th17/IL-23 axis signalling – central to PsA pathogenesis – and may additionally reduce biologic drug exposure via altered volume of distribution and clearance. The net effect is a self-reinforcing loop in which pain and fatigue reduce physical activity, weight increases, adipose-driven inflammation worsens and joint damage accumulates; this model is supported by the association of obesity with reduced probability of remission on biologics and by evidence that weight loss increases the likelihood of minimal disease activity (4, 5). Recent work has also highlighted obesity as one of the most important modifiable risk factors for the transition from cutaneous psoriasis to PsA (3), further positioning weight management as a candidate preventive intervention along the entire psoriatic disease continuum.

Clinical implications are substantial and align with contemporary EULAR and GRAPPA recommendations that integrate comorbidity management, including obesity, into PsA care (9). First, because obesity attenuates the response to TNF inhibitors and is associated with shorter drug survival (6), BMI should be considered when selecting and sequencing biologics; IL-17 and IL-23 inhibitors, for which evidence of BMI-independent efficacy is accumulating, may be preferable in patients with marked obesity, although head-to-head trial evidence in obese PsA patients remains limited. Second, obesity defines a subgroup at greater risk of 'difficult-to-treat' PsA and should prompt earlier multidisciplinary engagement involving dietetics, physiotherapy and behavioural support. Third, structured weight-management pathways should be embedded within treat-to-target strategies, with measurement of BMI at each visit and explicit goals (for example, a 5–10% reduction in body weight in patients with obesity). Fourth, men appear to carry a disproportionate burden in our cohort and may warrant tailored outreach. Fifth, the increasing availability of effective pharmacological weight-loss therapies (*e.g.* GLP-1 receptor agonists) is likely to transform obesity care in the coming years and deserves dedicated prospective evaluation in rheumatology populations.

Strengths include a large, nationwide sample, standardised clinical data capture and a 15-year observation window. Limitations merit careful consideration. First, as discussed above, BMI sources differ between SCQM (clinician-measured) and the Swiss Health Survey (self-reported), likely inflating part of the observed gap. Second, the repeated cross-sectional design describes prevalence trends but not causal pathways or individual BMI trajectories; changes could reflect inclusion or attrition patterns, and BMI was not recorded for every registry participant at each index year. Third, although educational attainment was available for 76% of the 2022 cohort, the observed pattern was non-monotonic and should be confirmed in datasets with complete socioeconomic capture. Fourth, the current analysis did not adjust for treatment exposure (in particular corticosteroids and specific biologics), cardiometabolic comorbidities (diabetes, hypertension, dyslipidaemia), or lifestyle factors (diet, physical activity, smoking dose);

these can influence BMI, disease activity and CRP, and therefore represent unmeasured confounders of the BMI-outcome associations. A fully adjusted individual-level multivariable analysis would be valuable but was beyond the scope of this descriptive prevalence study. Finally, BMI alone imperfectly captures adiposity; imaging of visceral fat or waist-to-hip ratio would complement these findings.

Conclusion

Obesity in Swiss PsA patients is rising and now more than doubles that of the general population. Cross-sectionally, excess weight is associated with a higher inflammatory burden and poorer patient-reported health status. Differences in obesity prevalence across educational strata were observed but did not follow a simple social gradient, and further study in larger datasets is warranted. Our findings support embedding structured, multidisciplinary weight-management and preventive strategies into PsA treat-to-target care, with particular attention to men, and motivate longitudinal and interventional research to clarify mechanisms and test targeted programmes.

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A list of current partners that support SCQM is available on:
https://www.scqm.ch/en/partners/

Partners from previous years can be found in the respective annual reports on: https://www.scqm.ch/en/about-scqm/annual-reports/

SCQM supporting partners had no role in the study design or in the analysis and interpretation of the data, the writing of the manuscript or the decision to submit the manuscript for publication.

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Competing interests

J.-T. Maul has served as advisor and/or received speaking fees and/or participated in clinical trials sponsored by Abbvie, Almirall, Amgen, BMS, Celgene, Eli Lilly, Incyte, Janssen-Cilag, LEO Pharma, MSD, Novartis, Pfizer, Pierre Fabre, Roche, Sanofi, Takeda, and UCB.

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The other authors have declared no competing interests.

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