

# 08 - Other atypical eating disorders

## Other atypical eating disorders

Drug treatment of other psychiatric conditions CHAPTER 9 reboxetine, lamotrigine, liraglutide, methylphenidate, zonisamide and sodium oxybate in BN/BED or both.<sup>15</sup> Bupropion is not recommended due to a high risk of seizures in BN.<sup>15</sup> Acamprosate<sup>37</sup> also has limited evidence in BED. Systematic reviews<sup>35,38</sup> confirm the modest efficacy of SSRIs and also suggest benefit for lisdexamfetamine (based on one high-quality RCT<sup>39</sup>). Lisdexamfetamine is approved for BED in the USA.<sup>40</sup> Some limited evidence supports the use of a slow-release combination of phentermine and topiramate, however this combination was refused marketing authorisation owing to serious adverse effects.<sup>15</sup> The noradrenaline/dopamine reuptake inhibitor dasotraline may also be effective<sup>41</sup> but its development appears to have ceased in 2020. Comorbid depression Depression is a frequent comorbidity in BN and BED. Citalopram has been shown to be more effective than fluoxetine for depressive symptoms in BN patients.<sup>42</sup> As weight gain is a frequent side effect of mirtazapine, this antidepressant should be avoided or used with caution for the treatment of comorbid depression in BED.<sup>33</sup> Other atypical eating disorders There have been very few useful studies of the use of medicines to treat atypical eating disorders other than AN, BN and BED.<sup>6,43</sup> Evidence for avoidant restrictive food intake disorder based on case reports/series and chart reviews suggests some benefit for mirtazapine, SSRIs (fluoxetine, sertraline), olanzapine and cyproheptadine.<sup>15</sup> In the absence of evidence to guide the management of other atypical eating disorders (also known as 'eating disorders not otherwise specified'), it is recommended that the clinician considers following the guidance of the eating disorder that most closely resembles the individual patient's eating disorder (Box 9.1).<sup>6</sup> Box 9.1 Summary of UK NICE guidance on eating disorders<sup>6</sup>

Anorexia nervosa ■ ■ Psychological interventions are the treatments of choice and should be accompanied by psychoeducation and monitoring of the patient's weight, mental and physical health and any risk factors ■ ■ Do not offer medication as the sole treatment for anorexia nervosa

Bulimia nervosa ■ ■ An evidence-based self-help programme or cognitive behaviour therapy for bulimia nervosa should be the first choice of treatment followed by other psychological therapies ■ ■ A trial of fluoxetine may be offered in combination with other treatments. Do not offer medication as the sole treatment for bulimia nervosa

Binge eating disorder ■ ■ An evidence-based self-help programme or cognitive behavioural therapy for binge eating disorder should be the first choice of treatment followed by cognitive behavioural therapy ■ ■ A trial of a selective

serotonin reuptake inhibitor can be considered in combination with other treatments. Do not offer medication as the sole treatment for binge eating disorder ■ ■Lisdexamfetamine is also an option

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