

Letters

COMMENT & RESPONSE

Issues Regarding GLP-1 RA Use in Eating Disorders

To the Editor We read the article¹ by Peiper et al on glucagon-like peptide-1 receptor agonist (GLP-1 RA) use and misuse among people with eating disorders (EDs). Although GLP-1 RAs certainly have potential for harm in patients with ED, 2 methodological points deserve further discussion. First, the authors compare a 32.1% lifetime GLP-1 RA use in their ED sample to 15% in the general population, and they imply excess use related to ED psychopathology. However, this comparison does not account for the higher prevalence of obesity and type 2 diabetes (T2D) among people with EDs.² In the study,¹ 37.1% of participants had a body mass index level greater than or equal to 30 (calculated as weight in kilograms divided by height in meters squared), and 10.8% had diabetes or metabolic syndrome. Bulimia nervosa and binge-eating disorder (BED) are accompanied by obesity in 30% of patients. BED is associated with a 3- to 6-fold higher rate of obesity.^{2,3} BED and bulimia nervosa also increase the risk of T2D by 3.69 and 3.45, respectively.³ Given that GLP-1 RAs are US Food and Drug Administration-approved for obesity and T2D, higher use in patients with more of these comorbidities may reflect appropriate prescribing rather than use to maintain ED. Critically, the authors do not specify how ED diagnoses were determined, whether diagnoses were current, or whether EDs were predominantly restrictive vs binge type. These distinctions significantly influence risk-benefit analyses.

Second, the nonprobability sampling approach introduces bias. Participants were recruited through ED-specific networks and asked about GLP-1 RA consumption. This design likely attracted individuals with medication experience. Nonprobability online surveys in psychiatry can produce prevalence estimates up to 8 times higher than probability-based surveys. Demographic calibration fails to sufficiently correct for psychological factors influencing participation.⁴ The survey's orientation around GLP-1 RA misuse also introduces bias. The survey did not allow participants prescribed GLP-1 RAs off-label for EDs to be counted as users, nor did it assess whether GLP-1 RA use positively or negatively impacted ED behaviors

and/or symptoms. Misuse was defined broadly to include using less than prescribed or medication sharing. Both would be contrary to ED-motivated misuse. Finally, the study lacks a general population estimate of GLP-1 RA misuse, rendering the reported 10.1% misuse rate difficult to interpret.

The conclusion that GLP-1 RA pharmacovigilance is urgently needed among people with EDs would be strengthened by defining how much use exceeds what medical comorbidity alone would predict. Future studies should include matched comparator groups controlling for body mass index and diabetes, use probability-based sampling, examine impact on ED, and establish a clear misuse definition.⁵

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