

**Geriatrics • Educational evidence summary**

Anticholinergic burden and falls

This geriatric evidence summary examines anticholinergic burden and falls.

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Start with the fall, not with a total

A useful falls review begins with what happened: the activity, location, time, symptoms and consequences. A medicine taken shortly before getting up at night raises a different exposure question from a stable medication on a list after a daytime trip over an obstacle. The source classification can inform the review, but the event's circumstances give it clinical meaning.

Falls are also heterogeneous outcomes. A single fall, recurrent falls, an injurious fall and difficulty walking are not the same endpoint. Evidence about one should not be presented as an identical estimate for another. The distinction matters when a burden scale is discussed as a possible risk marker.

Evidence basis and what it can support

This is a narrative review of selected primary evidence, including the [LIFE study analysis of anticholinergic burden, mobility and falls](#), the [Health ABC functional analysis](#), and the [2023 AGS falls-related criteria](#). It is not a systematic review or a new calculation of fall risk.

These sources address related but distinct questions. A study examining medication exposure within a cohort can identify associations. A guideline can organize prescribing concerns for a history of falls. Neither establishes the cause of a particular event merely because the person has a classified medication on the list.

Medication effects can converge on the same event

A fall can be influenced by attention, balance, vision, blood pressure, strength or the environment. Different medicines can affect these domains through different mechanisms. Anticholinergic classification captures only part of the medication assessment, and a low category does not exclude other relevant effects.

This is especially important when a study uses a combined anticholinergic and sedative exposure measure. The [Health ABC analysis](#) used the Drug Burden Index. Its functional findings should not be attributed entirely to antimuscarinic activity, because the instrument includes sedative exposure as well.

The clinical review therefore needs to retain the exact medications and their purposes. A total that hides the contributors can make it difficult to distinguish different exposure patterns or identify which aspect of treatment deserves closer examination.



Timing and actual use are essential

An as-needed medicine should be evaluated according to whether and when it was taken. A prescription's presence on the chart does not establish exposure at the time of a fall. Conversely, a nonprescription nighttime product may be missing from the electronic medication list despite being relevant to the event.

Recent changes also matter. The review should distinguish a new medication, a changed schedule, a different formulation and a stable regimen. It should document whether symptoms began before or after those changes. That chronology helps assess plausibility without making the source category carry information it does not contain.

The reason for treatment can be linked to fall risk too. Pain, urinary urgency, sleep problems or another condition may affect mobility and attention independently of the medicine used to treat it. A comparison that ignores the indication may attribute too much of the observed risk to the medication.

Interpret the geriatric criterion accurately

The [AGS history-of-falls-or-fractures criterion](#) provides a context-specific reason to review several medication groups. It is not a list of drugs that cause every fall, and its concerns are not limited to a single mechanism. The relevant criterion should be explained alongside the person's actual context.

A source-scale value remains a separate observation. A Beers concern does not overwrite the value, and a low source rating does not negate the criterion. When multiple medicines are involved, the regimen-level clinical review is broader than examining one profile in isolation.

What UnifiedACB contributes

The [public source observations](#) make it possible to identify which sources classify a medication and whether their values differ. Route and formulation notes help avoid attaching a broad ingredient-level finding to a more specific product without explanation. Explicit zero remains distinct from absent public evidence.

For a falls question, those details should be paired with an account of the actual exposure. Ask can explain the available classifications and why a geriatric criterion may be relevant. It should not calculate a personal fall probability or recommend a medication change solely from a badge.

A review that can be followed over time

Choose a concrete concern to monitor: recurrent events, dizziness around a particular time, difficulty transferring or another documented functional problem. The treating team can then consider whether medication-related factors are plausible alongside other causes and decide how to evaluate them.

If care changes, record what changed and what outcome is being assessed. Improvement after several simultaneous interventions cannot automatically be assigned to the burden score. A lower category total is not the same as fewer falls, and a fall-free short interval may not establish a durable effect.



The review should also preserve treatment benefit. Removing a useful treatment without an appropriate plan can create a different functional problem. That is why the goal is an individualized, monitored clinical decision rather than the lowest possible number.

Evidence limitations

Falls studies differ in ascertainment, follow-up, baseline mobility, living environment and medication measurement. Self-reported events, medical-record events and actively monitored falls may not capture the same outcome. Confounding by illness and prior falls can remain even when measured factors are adjusted for.

The practical interpretation is therefore bounded: medication evidence can identify a plausible contributor and a question worth reviewing. It cannot replace the event history or establish causation on its own. A careful falls assessment keeps both the exposure evidence and the rest of the person's situation in view.

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Explore the evidence

[Ask UnifiedACB](#) about a medication or source, browse the [Medication Library](#), or read the [methodology](#).

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