



Geriatrics • Educational evidence summary

Anticholinergic burden and functional decline

This geriatric evidence summary examines anticholinergic burden and functional decline.

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Function is the outcome the person experiences

Difficulty rising from a chair, managing medications, walking to the bathroom or preparing a meal can matter more to daily life than a numerical exposure category. Functional decline describes a change in those abilities. It should be measured and discussed directly rather than inferred from a higher burden score.

Anticholinergic evidence can help identify a medication-related question within that assessment. It does not define function itself. Two people with the same source classifications may have different baseline abilities, treatment benefits, illnesses and environments, so the same number cannot describe their experience of change.

Specify which ability changed

Physical performance tests, self-reported mobility and activities of daily living capture different aspects of function. A study of walking performance cannot automatically establish the same effect on medication management or social participation. Likewise, a cognitive test result is not a complete measure of independence.

A useful clinical description names the task, the prior level of ability and the timing of change. “Needs help transferring since hospitalization” is more informative than “function worse.” It creates an outcome that can be evaluated alongside exposure history and other clinical information.

What the primary evidence actually examined

The [Health ABC longitudinal study](#) examined Drug Burden Index exposure in relation to objective physical function over time. The Drug Burden Index includes anticholinergic and sedative medications. Its findings should therefore retain that combined-exposure definition instead of being presented as proof of one isolated pharmacological mechanism.

The [original DBI development study](#) also illustrates the importance of a specified population and functional measure. A study in community-dwelling older adults does not establish identical effects in every care setting. The method and outcome are part of the evidence, not background details that can be dropped from the explanation.



These studies provide a reason to examine medication exposure when function changes. They do not allow a directory to calculate how many walking steps or independent activities a particular medication is costing an individual.

Why illness and treatment are difficult to separate

The conditions that lead to medication use can themselves affect function. Pain may limit walking, depression may alter activity, and urinary symptoms may disrupt sleep or mobility. A medicine can provide benefit for one domain while raising concern in another. Looking only at a burden category loses that balance.

Acute illness and hospitalization can also change both the medication list and functional ability. If both change during the same period, the medication difference is not automatically the cause of the functional decline. The chronology and competing explanations need to be documented.

This is a general limitation of observational interpretation. An adjusted association can account for measured differences, but it cannot guarantee that every relevant difference between exposed and unexposed people has been removed.

What to add to a medication-focused history

Clarify the actual regimen before and after the change, including occasional products and administration times. Record the indication and perceived benefit of medicines under review. Ask which functional task is affected and whether the difficulty varies with time of day, recent doses or other symptoms.

The aim is to establish a testable clinical question. For example, the treating team may wish to evaluate whether a documented exposure pattern contributes to a particular limitation. That is more useful than assuming that every listed medication contributes equally or that the source with the largest number identifies the cause.

How to read UnifiedACB alongside a function assessment

The [source table](#) identifies published classifications and preserves gaps. It can show disagreement that deserves explanation. It does not measure strength, gait or daily independence, and it does not replace a functional assessment.

Supplemental [geriatric criteria](#) may identify a relevant condition-specific concern. Those criteria should be connected to the actual clinical context and kept separate from the ordinal observations. A criterion can sharpen the review question without becoming a new functional-risk score.

Also distinguish ability from opportunity. A record that a task was not performed does not necessarily establish that the person could not perform it. The setting, available assistance and assessment method should be described so that an apparent functional change is not merely a change in how it was observed.

Judge a change by the intended outcome

If the treating team changes care, assess the functional goal that motivated the review. A reduction in a burden measure is not itself evidence that the person transfers more safely or manages daily tasks more independently. The desired outcome must be observed, and the benefit of the original treatment must also remain part of follow-up.



This approach avoids overpromising. A medication review may uncover a meaningful contributor, an unrelated source of limitation or several interacting factors. The evidence remains useful when it supports a clearer assessment rather than a predetermined explanation.

A practical interpretation

Keep function concrete, exposure specific and causation provisional until the clinical evidence supports a stronger conclusion. Published burden measures can direct attention to medication-related possibilities. The person's abilities, goals and observed course determine whether that attention leads to a meaningful improvement.

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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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