

**Geriatrics · Educational evidence summary**

Anticholinergic burden in dementia care

This geriatric evidence summary examines anticholinergic burden in dementia care.

UnifiedACB · Published October 3, 2026 · Updated October 4, 2026

[Read the current article](#)

<https://unifiedacb.com/articles/028-anticholinergic-burden-in-dementia-care/>

Start with a goal the person and care partner recognize

In dementia care, medication review should connect to a meaningful goal: comfort, alertness, continence, sleep, participation or the ability to complete a familiar activity. A burden score does not tell the team which goal matters most or whether a medicine is helping achieve it.

The first question is therefore why each relevant medicine is being used and what benefit has been observed. This creates a basis for discussing exposure concerns without losing the reason treatment was started. A classification can identify a possible tradeoff, but it cannot perform that balance on its own.

Distinguish the baseline from a new change

Document the person's usual cognition, behavior and function before interpreting a change. A sudden alteration in attention, alertness or behavior is a different clinical question from a gradual change over time. It should not be assumed to represent dementia progression merely because dementia is already diagnosed.

Medication timing can be one part of the assessment. Recent starts, more frequent as-needed use, formulation changes and transitions of care may help establish the sequence. The [AGS dementia and delirium contexts](#) support careful review of relevant medicines, while the clinical assessment determines what is happening in the individual situation.

Use care-partner observations precisely

A care partner may notice changes that a medication list cannot capture: the person is harder to engage during meals, needs more help with transfers or behaves differently at a particular time. These observations become more useful when the timing and specific activity are recorded.

Avoid turning an observation into a causal conclusion prematurely. "More sleepy after the regimen changed" identifies a sequence worth investigating. It does not establish which change caused the symptom, especially when illness and several treatments changed together.



The person's own experience and preferences should remain part of the discussion whenever possible. An exposure measure cannot substitute for their priorities or the burdens of treatment and monitoring.

Read each evidence layer for its own purpose

The [UnifiedACB source table](#) describes published medication classifications. It can reveal differences among sources and distinguish an explicit zero from an absent entry. It does not assess dementia stage, behavioral symptoms or treatment response.

The [geriatric criteria](#) add contextual prescribing concerns. These may depend on the syndrome, indication or other qualification. A selected overlay entry should not be read as a command to stop therapy, and absence from the overlay does not establish appropriateness.

Product information can add more specific detail. For example, the [oxybutynin extended-release label](#) contains a precaution concerning preexisting dementia treated with cholinesterase inhibitors. That is a product-specific clinical issue. It should be explained as such rather than converted into an additional ordinal burden point.

Keep the whole regimen in view

A medicine for sleep, allergy, bladder symptoms or nausea may be prescribed outside the team managing dementia. Nonprescription products may not appear in the clinical record. Medication reconciliation is therefore necessary before interpreting cumulative exposure.

The actual use of as-needed treatment also matters. An order that is rarely used and the same order administered regularly are different exposure histories. The directory cannot infer the administration pattern from the presence of the medicine on a list.

Define what follow-up would show

If the treating team considers changing care, agree on the outcome to observe and the benefit that must be preserved. A useful plan can name the target symptom, a functional measure meaningful to the person and the time at which the team will reassess.

The [randomized trial of burden reduction in frail older adults](#) reminds readers that lowering an exposure measure and demonstrating cognitive improvement are separate outcomes. A numerical reduction should not be reported as a clinical success unless the relevant outcome was actually assessed.

Several simultaneous changes may also make attribution uncertain. That uncertainty belongs in the follow-up note. The review can still improve care even when it does not identify one medication as the sole explanation for every change.

Questions that make the discussion useful

- What symptom or function is this medicine intended to improve?



- What has changed from the person's usual baseline, and when?
- Which source finding or product-specific precaution is relevant?
- What would count as improvement, and what treatment benefit needs monitoring?

The purpose of anticholinergic review in dementia care is a clearer, person-centered clinical question. Source evidence is valuable when it helps the team understand exposure and uncertainty while retaining the person's comfort, function and treatment goals.

References

1. American Geriatrics Society 2023 Updated AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. *J Am Geriatr Soc.* 2023;71:2052-2081. [Source](#)
2. Vennard O, Stewart C, Tolia M, Soiza RL, Myint PK. Anticholinergic Medication Burden Scales: A Systematic Review. *J Am Geriatr Soc.* 2026;74(6):1771-1784. [Source](#)
3. American Geriatrics Society Beers Criteria Alternatives Panel. Alternative Treatments to Selected Medications in the 2023 AGS Beers Criteria. *J Am Geriatr Soc.* 2025;73:2657-2677. [Source](#)
4. Fox C, et al. Effect of medications with anti-cholinergic properties on cognitive function, delirium, physical function and mortality: a systematic review. *Age Ageing.* 2014;43:604-615. [Source](#)
5. Ruxton K, Woodman RJ, Mangoni AA. Drugs with anticholinergic effects and cognitive impairment, falls and all-cause mortality in older adults: a systematic review and meta-analysis. *Br J Clin Pharmacol.* 2015;80(2):209-220. doi:10.1111/bcp.12617. [Source](#)
6. Egberts A, et al. Anticholinergic Drug Burden and Delirium: A Systematic Review. *J Am Med Dir Assoc.* 2021;22:65-73.e4. [Source](#)
7. UnifiedACB. Preserved public source-observation dataset, v3.0 RC12 final; inspected for this editorial revision. [Source](#)
8. DailyMed. Oxybutynin chloride extended-release tablets. Official prescribing information; set ID 7d2332b4-9e48-4bb2-a2c3-75e16e1d455b. [Source](#)
9. Kersten H, et al. Cognitive effects of reducing anticholinergic drug burden in a frail elderly population: a randomized controlled trial. *J Gerontol A Biol Sci Med Sci.* 2013;68:271-278. doi:10.1093/gerona/gls176. [Source](#)

Explore the evidence

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

Disclosure

Funding: None. Conflict of interest: None declared for the UnifiedACB educational project.

Educational evidence summary. This content does not provide patient-specific medical advice and does not replace clinical judgment, medication reconciliation, or prescribing guidance.