



Geriatrics · Educational evidence summary

Anticholinergic burden after hospitalization

This geriatric evidence summary examines anticholinergic burden after hospitalization.

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Three lists can describe three different situations

After hospitalization, the home medication list, inpatient administration record and discharge instructions may describe different exposures. A burden comparison is meaningful only after those differences are understood. Otherwise, a number can change because an old entry was carried forward or a temporary order remained visible, even when actual use is different.

The [AHRO MATCH toolkit](#) treats medication reconciliation as a structured process at transitions. Applied to anticholinergic evidence, the same principle comes before scoring: establish the intended current regimen, then interpret its source classifications. The directory cannot decide which conflicting list is authoritative for an individual's care.

Reconstruct the pre-admission regimen

Identify what the person was actually taking before the illness, including nonprescription and occasional products. Record the ingredient, formulation, route, schedule and reason for use. Distinguish a medication that was on a historical list from one that was still being taken.

This baseline is important when the clinical question is whether exposure changed during the admission. Without it, the review cannot separate a new inpatient medicine from an existing treatment that was simply documented more clearly in hospital.

The baseline also includes function and symptoms. A new concern after discharge should be compared with the person's usual state and the course of the illness, rather than attributed to a medication list merely because the list changed.

Identify what was actually administered

An inpatient order and an administered dose are different records. As-needed medicines may have been ordered but never used, or used more often than a brief list suggests. Administration information helps establish which exposures occurred before a symptom or functional change.

The [inpatient diphenhydramine study](#) illustrates why hospital medication exposure can be clinically relevant. Its findings should not be converted into a claim that every inpatient order caused a later problem. The specific medicine, actual use and timing still matter.



Also distinguish a temporary indication from an ongoing one. A medicine used during an acute episode may require an explicit post-discharge decision. A source-scale category cannot determine whether that indication persists.

Read the discharge plan as a set of decisions

For each difference, clarify whether the medicine was started, stopped, resumed, substituted or changed in dose or formulation. The reason for the change is part of the handoff. If the instructions are unclear, the responsible clinical team should resolve them rather than asking the patient to infer the plan from a score.

The [WHO transition-safety report](#) emphasizes the importance of medication information across care boundaries. For this focused review, a useful handoff identifies both the intended regimen and the questions that remain open. Simply forwarding several unreconciled lists leaves the exposure uncertain.

Interpret source evidence only after the list is clear

The [UnifiedACB medication table](#) can then show which source observations apply to the identified ingredients. Preserve route and formulation distinctions, particularly when the hospital substituted a product or changed the route. A missing public value should remain missing rather than being counted as zero.

A supplemental [geriatric criterion](#) may help identify a particular post-hospital review question, but it does not tell the team which discharge decision was intended. Clinical criteria and reconciliation solve different problems and should remain separately documented.

If comparing an earlier and later burden result, use the same source version and make the included medication sets explicit. Otherwise, an apparent change may reflect method or coverage differences rather than a change in exposure.

Connect follow-up to a concrete concern

The concern may be alertness, bowel function, urinary symptoms, mobility or the benefit of a newly added treatment. Name the outcome and document when it changed. A post-hospital symptom can reflect recovery, ongoing illness, environmental changes or medication effects; the review should not assume one explanation in advance.

If the treating team changes care, assess the relevant outcome and any loss of treatment benefit. A lower score is not evidence that the person is recovering better. Likewise, a stable score does not establish that nothing clinically important changed.

Before the handoff is complete

- There is one reconciled current list with product and administration details.
- Relevant differences from the pre-admission regimen have an explanation.
- Temporary medicines have an explicit review plan where needed.
- The person and receiving team know whom to contact about discrepancies.
- Follow-up addresses symptoms and treatment goals rather than a number alone.



After hospitalization, the most valuable anticholinergic review often begins by making the medication history accurate. Source evidence can then support a focused clinical question instead of amplifying confusion between lists.

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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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