

**Geriatrics • Educational evidence summary**

Anticholinergic burden and mobility

This geriatric evidence summary examines anticholinergic burden and mobility.

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Mobility is more than whether a fall occurred

A person may have no recent fall yet struggle to rise from a chair, walk to the bathroom or move confidently through a familiar space. Mobility describes these abilities and their limitations. A falls history is relevant, but it does not replace a direct description of movement and daily function.

Anticholinergic medication evidence can identify an exposure worth reviewing within that assessment. It does not measure gait speed, balance, endurance or transfer ability. A source category should therefore be connected to a specific mobility question rather than treated as a functional diagnosis.

Identify the task and the setting

Ask which movement has become difficult and under what circumstances. Getting out of bed at night, walking outdoors and transferring from a low chair are different tasks. The environment, available support and the person's usual ability can influence the observed limitation.

Timing can also help define the clinical question. Does the difficulty fluctuate during the day? Did it begin after hospitalization or another change in health? Was a medication added or used more often before the change? These details create a more informative exposure history than a list of categories alone.

The point is not to infer a mechanism from a pattern without assessment. It is to give the treating team a concrete observation that can be examined alongside the medication evidence and other causes.

What the primary studies measured

The [LIFE study analysis](#) examined anticholinergic burden in relation to mobility and falls. Its inclusion of both outcomes is a reminder that they are distinct measures. A finding about one should not be relabeled as a result for every aspect of physical function.

The [Health ABC longitudinal analysis](#) studied Drug Burden Index exposure and objective physical function. Because the DBI includes sedative as well as anticholinergic exposure, its findings should retain that definition. It would be inaccurate to attribute the entire association to muscarinic blockade without additional evidence.



These studies support attention to medication exposure when evaluating mobility. They do not provide a formula that converts a source-scale category into a predicted change in walking ability for an individual using the directory.

Several pathways can produce the same difficulty

Mobility can be affected by pain, weakness, illness, vision, attention, balance and the physical environment. Medicines can be relevant through several mechanisms, and the conditions they treat can also affect movement. A burden classification captures only one part of that network of possibilities.

For example, a treatment may improve the symptom that limits activity while also raising a tolerability concern. Removing its benefit from the discussion would make the assessment incomplete. The clinical question is the overall effect on the person's function, not simply whether the medication contributes a category.

Observational studies must contend with the same problem at a group level. People receiving more treatment may have more illness or lower baseline function. Adjustment for measured factors helps, but it does not make every association causal or identify the responsible ingredient.

Use the source table to clarify exposure

The [UnifiedACB medication observations](#) identify the source versions and original labels behind each category. They can reveal missing coverage or disagreement. Those findings help explain why an exposure is being considered, while leaving the mobility assessment itself separate.

Preserve route and formulation details. A historical ingredient-level classification may not describe a precise current product. Also clarify actual use, especially for occasional medicines taken before particular activities or at night. An order that was never administered should not be treated as an established exposure at the time of a mobility problem.

Add geriatric context without replacing the assessment

The [AGS falls-related criteria](#) can identify relevant prescribing concerns in older adults with that history. The criterion is not a measurement of current gait or a diagnosis of the reason mobility has changed. Its qualification and clinical context should remain attached to the explanation.

A low source category does not exclude other medication effects, and absence from a selected overlay does not establish that the regimen is appropriate. The clinical review needs the full medication and functional picture.

Follow the movement outcome directly

If the treating team modifies care, assess the task that motivated the review. Is the person transferring more easily, walking the intended distance or participating more comfortably? A lower burden result does not answer those questions. They require observation and follow-up.

Document other changes made at the same time, such as rehabilitation, treatment of an illness or environmental adjustments. If mobility improves after several interventions, attribution to one medication decision may remain uncertain. That limitation should be acknowledged while the functional improvement itself is recorded accurately.



A useful interpretation of mobility evidence

The strongest practical use of anticholinergic evidence is to make an exposure question specific enough to investigate. Name the movement task, establish the timeline and retain the source classification as one piece of the assessment. The person's actual mobility and treatment goals determine whether the review leads to a meaningful benefit.

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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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