



## Geriatrics • Educational evidence summary

# Anticholinergic burden and sleep-related medications

This geriatric evidence summary examines anticholinergic burden and sleep-related medications.

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## “For sleep” describes an intention, not one drug class

A nighttime product may contain an antihistamine, an antidepressant or a medicine with a different mechanism. Grouping them only by the reason they are taken can hide important distinctions. An anticholinergic review begins with the actual ingredient and product, then asks which source evidence applies.

The clinical goal also needs definition. Difficulty falling asleep, repeated awakenings and daytime tiredness are different concerns. A medication category does not establish the cause of the sleep problem or measure whether treatment is helping. The review should retain both nighttime benefit and daytime function.

## Nonprescription ingredients deserve an explicit place on the list

Products obtained without a prescription can be omitted when a person is asked only about regular medicines. Combination labels may also make the sedating ingredient less obvious than the brand name. The [medication-reconciliation framework](#) supports identifying the full ingredient list and actual use before interpreting exposure.

Diphenhydramine and doxylamine are useful examples for source reading because both have public observations in UnifiedACB. They should not be treated as identical merely because they can appear in nighttime products. The exact product, route, frequency and reason for use remain necessary.

## What the preserved source observations show

The [public diphenhydramine record](#) contains value 3 in each of its seven represented source versions. That is agreement among published classifications, not seven independent clinical trials of every nighttime use. The source labels and versions should remain attached to the finding.

Doxylamine illustrates a different pattern: the public BAAS 2019, CALS 2022 and KABS 2020 supplement entries are 3, while GABS 2018 is 1. Those are preserved source values. The disagreement should be explained rather than resolved by an average or by choosing the result that best fits an expected class narrative.



The [AGS first-generation-antihistamine criterion](#) supplies geriatric context, but it is a separate evidence layer. Its presence does not change the original classifications or establish the effect of a particular household regimen.

## Doxepin shows why dose cannot be omitted

The [geriatric doxepin criterion](#) identifies doses above 6 mg/day and separately discusses the lower-dose context. Its statement about the safety profile at 6 mg/day or less is specific to that criterion and should not be expanded into a claim that all possible medication risks are absent. A question about doxepin used for sleep therefore needs the relevant exposure detail before the criterion is interpreted. Tablet strength alone may not establish the total amount taken in a day.

The [public doxepin observations](#) remain source-native values from their own scales. The clinical dose qualification does not authorize creating a new low-dose ordinal score within those sources. A careful explanation can preserve the scale table and explain the geriatric qualification alongside it.

This example also shows why an indication is not enough to infer a dose. “Used for sleep” should not automatically be translated into a specific regimen. If the daily dose materially changes the answer, ask for it rather than assuming it.

## Sedation and anticholinergic activity should remain distinguishable

Some sleep-related medication concerns arise through mechanisms other than antimuscarinic activity. A low anticholinergic category does not mean a medicine has no effect on alertness, balance or other functions. The [AGS discussion of sedative-hypnotic groups](#) is broader than its strong-anticholinergic list.

Conversely, a medication classified as anticholinergic should not be described only as a sedative if the relevant concern involves another effect. The review needs the specific product information and clinical question. A single generic “sleep medicine” label is too imprecise to carry all of that meaning.

## Connect timing to the actual concern

Record when the product is taken, how often it is used and whether recent use differs from the usual pattern. A medicine kept for occasional use and the same medicine taken nightly create different exposure histories. The source category does not distinguish them automatically.

Describe the outcome directly: whether sleep improved, whether daytime activities changed, or whether a new symptom appeared. A temporal relationship can support a review question without proving causation. Other health, schedule and environmental changes may contribute to the same complaint.

The [inpatient diphenhydramine study](#) provides a medication-specific clinical signal in a particular setting. It should not be generalized into an exact estimate of next-day impairment for every community user or every product formulation.



## A useful clinical discussion

The treating team can consider the reason for use, the observed benefit, the source classifications and any product-specific concerns. The goal is an appropriate plan for the sleep problem and the person's priorities. The directory does not select a substitute solely because it has a lower category or provide an unsupervised discontinuation schedule.

If care changes, assess both sleep and daytime function. A lower burden measure is not sufficient evidence that the overall problem improved. The meaningful outcome is whether the person's symptoms and daily life are better under the agreed plan, with the relevant treatment risks and benefits considered.

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## Explore the evidence

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

## Disclosure

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