



Geriatrics • Educational evidence summary

Anticholinergic burden and antipsychotic exposure in later life

This geriatric evidence summary examines anticholinergic burden and antipsychotic exposure in later life.

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The indication changes the clinical question

An antipsychotic prescribed for a longstanding psychiatric illness raises a different review question from one added during an acute episode or used for a behavioral symptom in dementia. The ingredient may be the same, but the treatment goal, expected benefit and consequences of changing therapy can differ substantially.

A source-scale category does not capture that distinction. It identifies one aspect of medication evidence. A responsible review begins by establishing why the medicine is used and then places the anticholinergic findings alongside that clinical purpose.

The source records show a diverse class

The [public clozapine observations](#) are value 3 across all seven represented source versions. Olanzapine has value 3 in BAAS 2019, KABS 2020 supplement and Yamada ABS 2023, with value 2 in the other four public source observations. Quetiapine has value 2 in six public sources and value 3 in Yamada ABS 2023.

These findings should remain separate. They are not a head-to-head outcome trial, and their categories do not establish equivalent therapeutic doses or a universal ordering of overall safety. The differences show why a class-wide value would erase information already present in the sources.

The original labels and versions also matter. If a source does not specify a formulation or route, its category should not be presented as an experimentally established result for every product. A preferred medication name organizes retrieval; it does not create missing product evidence.

Anticholinergic activity is one mechanism among several

Antipsychotics can be relevant to a clinical review for reasons beyond antimuscarinic activity. A low category in one scale cannot rule out every medication-related concern, just as a high category cannot identify the mechanism behind every symptom. Product information and the clinical context remain necessary.



The [radioreceptor study](#) provides laboratory evidence for some psychotropic medicines under specified conditions. That evidence can inform classification but does not measure the person's current exposure or determine the balance between psychiatric benefit and tolerability.

The [AGS criteria](#) address antipsychotic use in several geriatric contexts. Their indication-specific language and exceptions should be preserved rather than condensed into an unqualified instruction. A selected criterion is not a substitute for the treatment history.

Look beyond the primary antipsychotic

Adjunctive medicines and nonpsychiatric treatments can contribute to the exposure question. A medicine added for sleep, anxiety, nausea, bladder symptoms or movement-related concerns may be relevant even if the antipsychotic itself has been unchanged. The review should therefore examine the full reconciled regimen.

Actual use matters, especially for as-needed products. The presence of an order does not establish how frequently it was administered. A symptom timeline should distinguish exposure preceding a change from medication given in response to that change.

The [primary schizophrenia study by Joshi and colleagues](#) examined medication burden and cognition across the regimen using a cross-sectional design. Its design supports an association question, not a conclusion that changing one medication will necessarily improve cognition or preserve psychiatric stability.

Later-life interpretation requires population context

A study of adult outpatients with schizophrenia is not automatically a study of frail nursing-home residents or people with dementia. Baseline cognition, illness course, comorbidity and treatment history can differ. The population should remain attached to any cited result.

The same applies to outcomes. Cognitive test performance, delirium, functional ability and relapse are distinct endpoints. Evidence about one cannot be assumed to establish the effect on all of them. A medication review should identify which outcome is being considered and what evidence addresses it.

Distinguish chronic treatment from a recent addition

For an established treatment, document benefit, previous experience and the concern that now motivates review. For a recent addition, establish the indication, intended duration and follow-up responsibility. A burden category alone cannot determine whether continuation is appropriate.

After hospitalization, reconcile the intended current plan with the pre-admission and inpatient records. The [WHO transition-safety framework](#) supports carrying the rationale and follow-up question across the handoff. An antipsychotic should not be continued or discontinued merely because a medication-list discrepancy went unexplained.

What a focused review can ask

Which symptom or function has changed? Which exposures preceded the change? What treatment benefit is being preserved? Does a specific geriatric criterion or product warning apply? Which uncertainty would be resolved by knowing the route, dose or indication?



These questions help the treating team assess the regimen without treating the largest source value as an automatic instruction. Any medication change requires appropriate clinical supervision and monitoring of both the concern and the original illness.

The evidence boundary

Anticholinergic classification can improve the precision of antipsychotic review, but it cannot replace psychiatric assessment. Preserve source disagreement, distinguish supplemental criteria and keep the treatment's purpose visible. A useful explanation makes the clinical discussion better informed without claiming that a badge has already decided the treatment plan.

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