



Psychiatry · Educational evidence summary

Anticholinergic burden and antidepressants

This psychiatry article focuses on anticholinergic burden and antidepressants.

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The name “antidepressant” does not finish the review

An antidepressant may be prescribed in different clinical contexts, and a medicine’s current purpose cannot reliably be inferred from its class name. An anticholinergic review should therefore begin with the exact ingredient, preparation, actual use, and documented indication. The same source category can appear beside different treatment histories without resolving whether those histories are clinically comparable.

This article focuses on reading that evidence. It does not supply a preferred antidepressant list, new medication ratings, or a substitution plan. The aim is to explain why an ingredient-specific observation, a dose-qualified geriatric criterion, and a treatment decision must remain distinct.

Source classifications and antidepressant families

A class grouping such as tricyclic antidepressant or selective serotonin reuptake inhibitor can help organize a medication list, but it does not authorize a score for an unlisted medicine. Each source observation belongs to the named ingredient or product and version. A class-level description is useful background only when it is clearly labeled as such.

When a source includes a medicine and another does not, first determine whether the second source has no entry, a redistribution limitation, or an unresolved identity. Those situations cannot be turned into zero. When both sources publish values, retain both with their provenance rather than creating an average that appears more precise than either observation.

Doxepin illustrates a qualification that should not disappear

The 2023 AGS Beers Criteria distinguish doxepin above 6 mg per day in the relevant antidepressant criterion. That qualification belongs to a geriatric prescribing criterion; it does not rewrite an ordinal anticholinergic scale row. The actual total daily dose is therefore necessary to interpret the criterion, while the source-native scale evidence remains unchanged. [AGS Beers Criteria, 2023](#)

This is a useful example of two records answering different questions. A reader may see an ingredient-level scale classification and a dose-dependent criterion on the same page. The correct



response is to explain both. Removing the qualifier creates an overly broad statement; lowering a scale value to reflect the qualifier creates an unsupported transformation.

A lower classification is not a complete tolerability profile

An anticholinergic table does not measure every adverse effect, interaction, withdrawal concern, or treatment outcome relevant to antidepressants. A medicine with less evidence of anticholinergic activity in a selected source is not therefore free of clinically important concerns. Likewise, a medicine flagged for review can still have a documented benefit that matters in an individual discussion.

The question should be “How does this evidence contribute to the current treatment assessment?” rather than “Which number proves this is the best drug?” Any comparison needs the purpose of treatment and the outcomes the person hopes to improve. The directory does not infer that a medicine used for one indication is an equivalent alternative for another.

Keep withdrawal and recurrence separate from burden

NICE’s depression guidance advises discussing discontinuation with the prescriber and recognizes that abrupt cessation or missed doses can produce withdrawal symptoms. It also recommends monitoring during dose reduction for both withdrawal and returning depression. Those considerations remain relevant even when an anticholinergic concern is well founded. [NICE NG222](#)

A burden table cannot provide a taper schedule or distinguish withdrawal from recurrence in a specific person. It can support the reason for a clinical conversation. The subsequent plan requires information about the medicine, duration of treatment, previous experience, current symptoms, and available follow-up that an ingredient lookup does not contain.

Reading a comparison in practice

Begin with the two exact medication records and confirm that the source versions are comparable. Note whether each row is a published value, published zero, or absent observation. Then read the accompanying identity and formulation notes. Add any age-, dose-, or condition-qualified criterion as a separate item rather than inserting it into the scale comparison.

Document what the comparison does not contain. It may not model dose, treatment response, other medicines, or the reason a previous option was not continued. A useful written summary can therefore state both a source difference and the information still required before it has prescribing significance.

Limits and the question to take forward

Psychosis-specific cognitive evidence cited in this library does not establish the same magnitude of effect in every person treated for depression or another indication. Nor can a geriatric criterion be generalized to all ages. These are limits of applicability, not reasons to discard the evidence.



The question to take forward is specific: which original source observations and qualified criteria apply to this exact medication, and how do they relate to the current treatment goal and concern? That preserves scientific clarity while leaving treatment decisions with the clinical team and the person receiving care.

References

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4. Mancini V, et al. Anticholinergic Burden and Cognitive Function in Psychosis: A Systematic Review and Meta-Analysis. Am J Psychiatry. 2025;182:349-359. [Source](#)
5. National Institute for Health and Care Excellence. Depression in adults: treatment and management. NG222. Recommendations. [Source](#)

Explore the evidence

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

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