

**Psychiatry · Educational evidence summary**

Anticholinergic burden and cognitive testing

This psychiatry article focuses on anticholinergic burden and cognitive testing.

UnifiedACB · Published October 3, 2026 · Updated October 4, 2026

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Make the test interpretable before explaining the result

A cognitive test records performance under particular conditions. To interpret it alongside medication exposure, the assessor needs more than a drug list copied from the chart. The relevant questions include what was actually taken, when it was taken relative to testing, whether treatment recently changed, and whether the assessment conditions were comparable to earlier testing.

This guide explains how to document those details. It does not provide a washout schedule, advise withholding medication before testing, or supply an adjustment formula. Altering prescribed treatment for a test requires a clinical plan; a burden category alone cannot justify it.

Define the cognitive outcome

“Cognition” can refer to a global composite or a particular ability such as learning, attention, or processing speed. Record the actual instrument and domain. A change in one score does not establish a change in every aspect of cognition, and a test result is not the same outcome as daily functioning.

The schizophrenia literature reviewed by Georgiou and colleagues includes different cognitive measures and study designs. That diversity is part of why the findings should be interpreted with the assessment method attached. [Georgiou et al., 2021](#) The directory can describe medicine evidence; it cannot infer which domain a person’s complaint belongs to.

Record exposure at the relevant time

Prescribed treatment and actual administration may differ. For scheduled medicines, establish the current regimen. For occasional medicines, document whether they were used within the period relevant to the assessment. If the history cannot be verified, record that uncertainty rather than selecting a presumed typical pattern.

Include recent changes, route, and preparation. An old prescription retained in the record should not be silently treated as current exposure. Likewise, a familiar ingredient name is insufficient if the



formulation or use pattern changed between assessments. The purpose is to make the testing context reproducible, not to create a pharmacokinetic model from incomplete information.

Preserve the distinction between a scale and a concentration

A source classification is not a measured concentration at the time of testing. Unless a method explicitly includes dose and timing, those clinical details do not become part of its numeric category. Multiplying a category by dose or dividing it by time since administration would create a new, unvalidated measure.

Document the source version used and the contributor rows that were available. If a medicine is absent from a source, leave it missing. If different sources disagree, the record should show that disagreement rather than presenting an average as the exposure estimate.

Check comparability before calling a change meaningful

When comparing assessments, distinguish changes in the instrument, language, instructions, setting, and opportunity to practice from changes in the person's performance. Also record clinically relevant differences in illness state or sleep that the assessor considers important. These are questions about interpretation, not reasons to dismiss a result that is inconvenient.

The same discipline applies to the exposure side. If a lower burden description resulted from correcting a duplicate medicine or choosing a different scale version, it should not be described as a pharmacologic intervention. If treatment changed, record what changed and when, rather than attributing every later test difference to the category.

A useful testing note

An illustrative note might state: "The current medication list and reported occasional use were recorded on the assessment date. The selected scale does not model administration timing. One medicine has no public observation in that source. Results are interpreted with the present testing conditions and are not numerically corrected for anticholinergic burden."

This is a documentation example, not a finding from a patient or study. Its value is that another reviewer can identify the measurement limits. It also makes clear that uncertainty in the exposure record has not been converted into an assumed absence of effect.

If medication is a research covariate

Specify the exposure definition before inspecting the test results. Retain the scale version, treatment window, approach to occasional use, and missing-data rules. A researcher should not select whichever scale gives the strongest association after seeing the outcome and then present that choice as prespecified.

Analyses should distinguish descriptive association from causal claims and report the amount of exposure information actually available. A result in participants with complete medication histories



may not generalize to those excluded because their histories were incomplete. Those decisions belong in the methods and limitations.

What cannot be inferred

No published category gives a valid number of points to add back to a cognitive score. A high classification does not prove impaired performance, and a low or missing classification does not invalidate a reported difficulty. The defensible approach is to record the context, interpret the test on its own terms, and use medication evidence to guide a properly scoped clinical or research question.

References

1. 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](#)
2. Vennard O, Stewart C, Tolia M, Soiza RL, Myint PK. Anticholinergic Medication Burden Scales: A Systematic Review. *J Am Geriatr Soc*. 2026;74(6):1771-1784. [Source](#)
3. Georgiou R, et al. Anticholinergic Burden and Cognitive Performance in Patients With Schizophrenia: A Systematic Literature Review. *Front Psychiatry*. 2021;12:779607. [Source](#)

Explore the evidence

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

Disclosure

Funding: None. Conflict of interest: None declared for the UnifiedACB educational project.

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