

**Psychiatry · Educational evidence summary**

Anticholinergic burden and extrapyramidal-symptom treatment

This psychiatry article focuses on anticholinergic burden and extrapyramidal-symptom treatment.

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

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The word “EPS” hides several questions

An adjunct may appear on a psychiatric medication list with the reason “for EPS.” That abbreviation does not identify the actual movement syndrome, its severity, or whether it is still present. An anticholinergic review should make those questions visible before treating the adjunct as either automatically necessary or automatically inappropriate.

The purpose of this spotlight is to explain why indication matters. It does not diagnose a movement disorder, provide acute treatment instructions, or recommend a taper. A source classification describes the medicine; the clinical syndrome determines the context in which that evidence is being considered.

Different syndromes do not share one treatment rule

A 2024 evidence review distinguishes drug-induced parkinsonism and dystonia, for which anticholinergics can have a role, from tardive dyskinesia, akathisia, and neuroleptic malignant syndrome, for which they are not recommended as a general treatment. The review also argues against using “EPS” as though it were one condition. [Drug-induced movement-disorder review, 2024](#)

The implication for documentation is specific: record the assessed syndrome and the indication for the adjunct. A medicine prescribed historically for a movement concern does not prove that the same concern is active today. Conversely, a high anticholinergic classification cannot determine that the original clinical indication was invalid.

Reconstruct the adjunct’s history

Identify when the adjunct was started, what it was intended to address, whether benefit was documented, and whether the underlying treatment has since changed. A medication list may preserve the name long after the initiating event is difficult to reconstruct. That is a reconciliation problem requiring clinical review, not an invitation for the evidence tool to invent the missing history.

Distinguish regular use from occasional availability. If a medicine is ordered for use when needed, the relevant exposure is not automatically the maximum possible frequency. Record actual use when



known and keep uncertainty explicit when it is not. A burden comparison should not conceal these differences.

Keep the adjunct and the primary treatment separate

The adjunct may contribute its own source-specific observation. That value should not be reassigned to the antipsychotic or used to claim that the antipsychotic alone explains the regimen's classification. The medicines have related clinical roles but remain separate evidence records.

This separation also improves a discussion of options. A review might need to revisit the adjunct's indication, the movement assessment, or the broader treatment strategy. The directory cannot decide which of those questions should lead to a change. It can show the evidence relevant to each medicine without making a prescribing choice.

Why route and duration deserve attention

A one-time administered product and a chronic oral regimen should not be described as the same exposure simply because the ingredient name is similar. Preserve route, formulation, and actual use. If the source observation is broader or narrower than the current product, show the limitation rather than infer a route-specific category.

Duration is also a clinical field that many ordinal classifications do not model. A category can stay constant while a medicine's use changes from brief to continuing treatment. That is a reason to maintain a timeline, not a reason to multiply the category by the number of treatment days and present the product as a validated index.

Geriatric context adds another layer

The original references include geriatric guidance on alternatives. Such guidance should be applied within its stated older-adult scope and alongside the actual syndrome and treatment context. It should not be generalized into a blanket rule for younger adults or children.

Similarly, a supplemental Beers tag is distinct from a scale observation. Its criterion and qualification need to be read directly. Neither a tag's presence nor its absence adjudicates the movement diagnosis or gives a patient-specific treatment plan.

A practical review conversation

The first useful question is often "What movement problem is this medicine currently treating?" Follow with the documented response, current pattern of use, and whether the treatment history has changed. Only then can the source-specific anticholinergic evidence be weighed alongside the reason the adjunct exists.

If the indication remains uncertain, write that explicitly and identify the clinician who will review it. Do not remove the medicine from the record or mark it as unnecessary merely to produce a cleaner



burden summary. The medication history and the source evidence should remain accurate while the clinical question is resolved.

Limits of this spotlight

The presence of an anticholinergic adjunct does not establish a movement diagnosis, and a burden category does not determine the appropriate treatment. This article supports precise documentation and a syndrome-specific review. It does not replace assessment by the treating team or justify starting, stopping, or changing medication solely from a source value.

References

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Disclosure

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

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