



Psychiatry · Educational evidence summary

What anticholinergic burden scores cannot tell us about an individual psychiatric patient

This psychiatry article focuses on what anticholinergic burden scores cannot tell us about an individual psychiatric patient.

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A number can be clear while the clinical answer remains uncertain

An anticholinergic category may be easy to display, yet the question a person wants answered may be much broader: whether a medicine is causing a problem, whether treatment should change, or what will happen in the future. These questions explain why a precise source value can coexist with an uncertain individual conclusion.

Can the score tell me whether I will develop cognitive impairment?

An ingredient or regimen classification is not an individualized prediction unless a separate model has been developed and validated for that purpose. It does not automatically include the person's baseline cognition, history, exposure timing, or other relevant factors. A population association cannot be read as a personal probability.

UnifiedACB therefore reports the original evidence rather than generating a synthetic cognitive-risk percentage. A source value can support a review question without forecasting an individual outcome.

Can it tell me which medicine caused a symptom?

No. The presence of a classified medicine identifies a potential contributor to consider, not the cause of the symptom. Clinical timing, actual use, the condition being treated, other medicines, and competing explanations all matter. The current list may also have been shaped by the symptom itself.

The appropriate wording is that the evidence may be relevant to a concern and warrants interpretation in context. Saying the score proves causation would go beyond what the lookup and much of the underlying observational literature establish.



Can it tell me how much cognition would improve after a change?

The psychosis meta-analysis reports group findings and identifies a need for randomized evidence to quantify benefit more reliably. It does not provide a formula for predicting one person's cognitive gain. [Mancini et al., 2025](#)

A clinical change may involve several consequences at once, including effects on the condition the medicine treats. Follow-up must therefore assess actual outcomes rather than assume that a lower total represents a fixed amount of improvement.

Does the highest-rated medicine have to be changed first?

A category does not encode the medicine's benefit, the available alternatives, the person's previous treatment experience, or the consequence of a change. Those considerations may alter which question is most important to address. A source table cannot prioritize a treatment decision solely by sorting values.

A review can begin by clarifying an uncertain adjunct or correcting the medication list even when that does not change the largest contributor. The purpose is better clinical understanding, not a contest to obtain the smallest number.

Is a lower classification proof that an alternative is safer overall?

No. Anticholinergic evidence covers one aspect of a medicine. It does not compare all adverse effects, interactions, effectiveness, or treatment-specific concerns. A proposed alternative must be appropriate for the same clinical purpose before a burden comparison can meaningfully contribute.

The absence of a medication from one scale provides even less basis for reassurance. Missing remains missing, and a published zero stays tied to the source and measurement that produced it.

Can two people with the same score be treated as equivalent?

They may have different medicines, doses, formulations, durations, coverage gaps, diagnoses, and treatment histories. The same category can therefore summarize different underlying records. Those differences should remain available for interpretation.

For research, this is a reason to describe contributors and context. For clinical care, it is a reason to examine the actual regimen rather than assume that a total captures everything relevant about the person.

Can a Beers tag settle the question?

A supplemental geriatric criterion has its own population and possible dose, route, indication, or condition qualifications. It is not a universal safety score. Its presence can prompt a specific review question; its absence from a selected overlay does not establish appropriateness. [AGS Beers Criteria, 2023](#)



The criterion should be reported separately from the source-native scale observations. Neither should be allowed to overwrite the other or masquerade as an individual prescribing decision.

What can the score help me do?

It can identify source-classified contributors, reveal disagreements, show missing observations, and direct attention to the original evidence. Combined with an accurate medication history, it can support a focused conversation about a defined concern and the information needed to assess it.

That is a useful role even without a personal prediction. The strongest answer may be a precise statement of what the source reports and what the clinical team still needs to determine.

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](#)
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4. American Geriatrics Society. American Geriatrics Society 2023 updated AGS Beers Criteria for potentially inappropriate medication use in older adults. *J Am Geriatr Soc*. 2023;71(7):2052-2081. [Source](#)

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