

**Pediatrics · Educational evidence summary**

Anticholinergic burden in pediatric psychiatry

This pediatric review addresses anticholinergic burden in pediatric psychiatry.

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An adjunct needs a documented clinical question

In pediatric psychiatry, an anticholinergic medicine may appear beside an antipsychotic or another treatment. Its presence raises several distinct questions: why it was prescribed, whether the target problem was documented, how it is actually used, and what outcomes need monitoring. A source category does not answer these questions or determine whether the regimen is appropriate for a child.

This article is a narrative review of a pediatric prescribing study and the evidence boundaries relevant to interpretation. It reports no new patient analysis. It also does not transfer adult psychosis findings or geriatric prescribing criteria into a pediatric treatment rule.

What the Hong and Bishop study measured

Hong and Bishop retrospectively reviewed antipsychotic initiation in children and adolescents aged 5–18 years. Among 152 included patients, anticholinergic use during the first 30 days was recorded in 21%, while extrapyramidal symptoms were documented in 8%. The difference describes prescribing and chart documentation in that setting; it does not prove that every use without a recorded symptom was inappropriate. [Hong and Bishop, 2010](#)

That last distinction is essential. A medical record can omit an assessment or contain treatment intended to prevent a problem. A retrospective utilization study cannot recover every undocumented clinical decision. The result supports asking for the indication and reviewing practice; it does not justify declaring a particular child's adjunct unnecessary.

Prescribing, symptoms, and outcomes are different data

A prescription record establishes that a medicine was ordered or supplied under the study's definition. It may not establish actual administration. A documented symptom is an observation in the record, which may differ from the symptom's true frequency. A cognitive outcome or functional outcome requires its own measurement.

A study can therefore be informative about utilization without validating a cognitive-risk threshold. The reader should retain the study design and endpoint when discussing the finding. Recasting a prescribing pattern as proof of cognitive harm would change the question after the fact.



Identify the movement syndrome when relevant

The abbreviation “EPS” includes different clinical problems and is not a sufficient treatment indication by itself. The adult movement-disorder review cited elsewhere in this library distinguishes syndromes with different responses to anticholinergic treatment; that principle supports precise diagnosis, but it is not a pediatric dosing or management protocol. [Drug-induced movement-disorder review, 2024](#)

For a child’s review, record the syndrome assessed by the treating clinician, the reason for the adjunct, and its observed benefit. If that information is missing, state the gap and identify who will review it. The directory should not diagnose the movement problem from the name of the medicine prescribed.

Read the complete regimen and treatment purpose

Separate the primary psychiatric treatment, symptom-directed adjuncts, and medicines for other conditions. Record actual occasional use rather than count every available product as daily exposure. A change in a burden description may result from an adjunct or a corrected list without a change in the primary psychiatric treatment.

The intended benefit should remain visible. An evidence summary that lists only potential exposure concerns can make the regimen appear purposeless. Conversely, a beneficial treatment history does not erase a source-supported concern. The clinical team needs both pieces of information to make an informed assessment.

What the scale can contribute

UnifiedACB can show which original sources classify a medicine, preserve disagreements, and identify missing observations. Those are source-data functions. The tool should not rescale an adult ordinal category by a child’s weight or infer a pediatric threshold from a familiar adult cutoff.

Route and formulation also remain part of the record. An ingredient-level observation is not proof that the child’s exact preparation has been independently studied. If a source does not provide a route-specific entry, report the limitation rather than silently transferring evidence across products.

Include development and setting in outcome assessment

If the concern concerns learning, attention, or participation, identify the actual outcome and who observes it. Parent reports, teacher reports, and formal cognitive testing can provide different information. A disagreement between settings may be clinically useful rather than an error that must be averaged away.

The timeline should also distinguish changes in treatment from changes in the child’s environment or illness. A later improvement cannot automatically be assigned to a lower burden category when several things changed. A careful account of events is necessary for interpretation, even though it cannot eliminate all uncertainty.

An audit of current prescribing could improve on a list of co-prescriptions by recording why the adjunct was started, whether the relevant symptom was documented, and whether that indication is still active. These would be future audit variables, not information that can be retrospectively assumed from the Hong and Bishop study. The audit should also preserve uncertainty when an old



note does not explain the decision. An undocumented reason is a documentation gap; it is not proof that no reason existed.

Outcome assessment should follow the treatment question. Relief of a specific movement symptom, ability to continue an effective antipsychotic, cognitive performance, and daily functioning are different outcomes. A useful review can consider their tradeoffs without presuming that an improvement in one guarantees improvement in all. The medication evidence map helps identify source-classified exposure, while the clinical record supplies the indication and observed response needed to interpret the adjunct's role.

Evidence gaps and limitations

The prescribing study is historical and setting-specific. It does not provide a current national utilization estimate, establish individual appropriateness, or quantify long-term cognitive effects. The broader pediatric literature also does not validate a universal burden threshold across psychiatric diagnoses and developmental stages.

Clinical interpretation

The useful question is whether every current medicine has a clear purpose, accurate use history, and appropriate follow-up. Source evidence can make a contributor visible, while the treating team evaluates the indication, benefit, concern, and alternatives. No medication should be started, stopped, or changed solely because of the burden category described here.

References

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Explore the evidence

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

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