

**Foundations · Educational evidence summary**

ACB vs ADS vs ARS vs KABS vs other scales

This foundation article explains aCB vs ADS vs ARS vs KABS vs other scales.

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

[Read the current article](#)

<https://unifiedacb.com/articles/004-acb-vs-ads-vs-ars-vs-kabs-vs-other-scales/>

The useful comparison is broader than the abbreviation

ACB, ADS, ARS and KABS are often placed beside one another because each helps organize anticholinergic medication evidence. That shared purpose can make their numbers appear interchangeable. A better comparison begins with what each approach was designed to capture, how its list was assembled and what evidence supports its use.

The question is not simply which acronym should win. A method can be useful for describing one medication set or outcome while leaving other questions unresolved. The appropriate choice for a research analysis also depends on coverage, available exposure data and the population under study. A website that displays several sources should make these differences easier to inspect.

ACB: preserve the document behind the label

The name Anticholinergic Cognitive Burden signals an emphasis on cognitive effects, but the abbreviation alone does not identify a particular list or revision. A reader needs the actual source document and its category definitions. It is not valid to attach “ACB” to a value obtained from a different scale merely because both use small integers.

UnifiedACB’s [source registry](#) includes an ACB 2012 record with its own publication link and reuse status. That source-registry presence should not be confused with public redistribution of its medication rows. A provenance record can explain why a source is known to the project while its source-native table is not reproduced publicly.

ADS: a medication scale examined against an assay

The [ADS publication by Carnahan and colleagues](#) investigated association with serum anticholinergic activity. The measurement target matters: correspondence with an assay is not the same question as an intervention preventing delirium or improving cognition. A source can contribute useful validation evidence without establishing every possible clinical use of the instrument.



For comparisons, the important practical point is to identify the ADS version and the document used to obtain each medication classification. A supplied appendix, original article and later revision are separate provenance objects. They should not be blended into one undocumented “ADS” list.

ARS: keep the published risk classification identifiable

The original ARS publication is explicitly concerned with anticholinergic adverse effects in older persons. That focus provides a reason to examine its development and outcome assessment separately from a laboratory activity study. It does not make the scale a complete patient-specific model of all medication harm.

UnifiedACB retains an [ARS source record](#) separately from the other scale families. When a source is represented by metadata without public medication observations, readers should consult its linked publication for the source-native list. A blank public comparison cell must not be presented as a newly inferred ARS zero.

KABS: local applicability and explicit source versions

The [KABS development study](#) considered medications available in Korea and combined existing classifications with literature assessment and expert consensus. It demonstrates why geography can affect coverage without implying that a missing medication is biologically inactive. The source’s exclusions and decisions belong to its interpretation.

The publicly represented KABS observations in UnifiedACB are identified as a 2020 validation-supplement version. That distinction matters even though the scale’s development publication appeared earlier. The directory also preserves document-level anomalies, including entries where a main-text table and medication-list supplement do not provide the same information. A scale-family name is too coarse to describe those differences faithfully.

Other public scales are additional sources, not replacements

The current [public observation file](#) contains rows from BAAS 2019, CALS 2022 primary Table 4, GABS 2018, JARS 2025, KABS 2020 validation supplement, SWE-ABS 2023 and Yamada ABS 2023. These source-version labels tell the reader where a visible finding came from. Their presence does not authorize renaming one source’s value as another source’s score.

The directory’s list of source metadata is larger than the set of sources with public observation rows. This is a publication and provenance distinction. It should be reported directly rather than hidden by filling missing columns with values imported from other scales. Preserving the boundary also helps maintain the rights and reuse conditions attached to the original material.

Where dose-aware tools and Beers criteria fit

The [Drug Burden Index](#) is relevant to the wider discussion because it incorporates defined dose information and includes sedative exposure. It should be described by its own calculation and



outcome evidence. A DBI result is not a differently formatted ordinal ACB score, and combining the two without a justified model would create a new instrument.

The [AGS Beers Criteria](#) contribute another type of evidence: potentially inappropriate medication use in particular older-adult settings and conditions. They can identify a clinical context worth reviewing even when a source-scale category is low or unavailable. That complementary role does not supply a missing anticholinergic rating.

A comparison checklist that preserves meaning

- Identify the instrument and exact publication, table or supplement.
- Describe whether its purpose is classification, exposure estimation or an outcome-related assessment.
- Check which medications and formulations were eligible for inclusion.
- Keep published zero separate from no verified public entry.
- State which population and endpoint support any claim of validation.
- Keep numerical results separate unless a published method explicitly defines their combination.

Choosing an interpretation rather than a winner

A fair comparison can reveal that one source covers a medication another does not, or that two sources assign different categories to the same verified concept. It cannot establish a universally superior scale by counting entries or choosing the highest value. For clinical reading, the result should be a clearer account of the evidence. For research, it should be a prespecified, reproducible choice of instrument with a transparent missing-data rule.

References

1. 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](#)
2. Chew ML, et al. Anticholinergic activity of 107 medications commonly used by older adults. *J Am Geriatr Soc.* 2008;56:1333-1341. [Source](#)
3. Carnahan RM, et al. The Anticholinergic Drug Scale as a measure of drug-related anticholinergic burden: associations with serum anticholinergic activity. *J Clin Pharmacol.* 2006;46:1481-1486. [Source](#)
4. Rudolph JL, et al. The anticholinergic risk scale and anticholinergic adverse effects in older persons. *Arch Intern Med.* 2008;168:508-513. [Source](#)
5. Boustani M, et al. Impact of anticholinergics on the aging brain: a review and practical application. *Aging Health.* 2008;4:311-320. [Source](#)
6. Lisibach A, Benelli V, Ceppi MG, et al. Quality of anticholinergic burden scales and their impact on clinical outcomes: a systematic review. *Eur J Clin Pharmacol.* 2021;77(2):147-162. [Source](#)
7. UnifiedACB. Preserved public source-observation dataset, v3.0 RC12 final; inspected for this editorial revision. [Source](#)



8. Jun K, Hwang S, Ah YM, Suh Y, Lee JY. Development of an Anticholinergic Burden Scale specific for Korean older adults. *Geriatr Gerontol Int*. 2019;19:628–634. doi:10.1111/ggi.13680. [Source](#)
9. Hilmer SN, et al. A drug burden index to define the functional burden of medications in older people. *Arch Intern Med*. 2007;167:781–787. [Source](#)
10. American Geriatrics Society. 2023 updated AGS Beers Criteria for potentially inappropriate medication use in older adults. *J Am Geriatr Soc*. 2023;71:2052–2081. doi:10.1111/jgs.18372. [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.