

**Foundations · Educational evidence summary**

What does an anticholinergic score of 1, 2, or 3 mean?

This foundation article explains what does an anticholinergic score of 1, 2, or 3 mean?.

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The number needs a sentence beside it

A small colored badge is easy to recognize and easy to overinterpret. The important question is what the source meant by that category. A useful statement includes the medication, named scale, source version and published value. Without that information, “the score is 2” leaves the reader to guess which instrument was used and what its categories represent.

Does 3 mean three times as much effect as 1?

Not merely because the categories are numbered that way. Ordinal categories express an ordering within a method. They do not necessarily have equal distances, and their numbers are not automatically units of concentration, receptor occupancy or clinical risk. Multiplying or dividing them as if they were physical measurements creates a meaning the source may never have defined.

The distinction also applies to changes. A movement from one category to another is not a quantified percentage reduction in harm. To make a claim about how much risk changes, a study would need an appropriate outcome model and evidence for that use.

Are 1, 2 and 3 defined the same way everywhere?

No common numbering scheme guarantees common definitions. Instruments differ in the evidence they consider and the rules they use to resolve uncertainty. The [KABS development report](#), for example, describes its own classification and consensus process. A category obtained from that method remains a KABS classification, even when another scale uses the same numeral.

This is why UnifiedACB retains source-specific rows. The number and source are a pair. Relabeling a category under a more familiar acronym would make it easier to read superficially while making the evidence less accurate.



What does a score of zero mean?

An explicit zero means the source published a zero for that medication entry. Its meaning is bounded by the source method and scope. It is not a certificate that the medicine cannot cause adverse effects, and it does not address every mechanism by which a medication might affect function.

The [public dataset](#) marks explicit zeros with a distinct evidence state. That makes it possible to distinguish a genuine source finding from a blank cell. The distinction remains necessary even when the zero appears reassuring.

If the medicine is not listed, can I call it zero?

No. An absent row may reflect the source's medication coverage, a route exclusion, an unresolved match or a public-reuse restriction. There is no published numerical finding in that cell to reinterpret. Recording zero would convert a gap into a claim.

A transparent report says that no verified value is available from the specified source version. It can still show values supplied by other sources. Keeping the gap visible is more useful than forcing every cell to contain a number.

Can several low categories be treated as one high category?

Only a particular instrument's own aggregation rules can define a regimen-level calculation. Even then, two medication lists with the same permitted total may differ in ingredients, exposure patterns and clinical purpose. Arithmetic equality does not establish pharmacological or clinical equivalence.

UnifiedACB does not create a synthetic score by averaging ordinal categories across sources. Its comparison is intended to expose the underlying observations. A reader can inspect which medicines contributed to each source's findings without being given an invented conversion between instruments.

Does a high category tell me to stop the medicine?

It identifies a source classification that may deserve discussion. It does not measure treatment benefit, identify an appropriate substitute or describe the consequences of withdrawal. Those questions depend on the medication's indication, actual use and clinical context. The [AGS criteria](#) likewise require their context and qualifications to be read rather than reduced to an isolated badge.

A useful follow-up asks what aspect of the classification matters in the present situation. That may involve route, daily dose, a coexisting condition or another medication. The response should explain the relevant evidence before suggesting that the number alone settles a treatment decision.

How should I quote a result?

Use wording such as "This medication has a published value of X in the named source version." If other sources differ, mention the disagreement separately. If a source has no verified entry, state



that explicitly. This keeps the description reproducible and prevents a classification from being mistaken for a diagnosis or a calibrated estimate of personal harm.

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