

**Methods/Research · Educational evidence summary**

Rechecking both sides of the ADS-to-rADS change table

This methods article addresses rechecking both sides of the ADS-to-rADS change table.

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Abstract

A change table can be internally consistent while misrepresenting either the earlier or revised source. This methods article defines a bidirectional audit for comparing ADS and revised ADS records. The evidence basis is the published ADS study, the indexed rADS correction notice, and the current UnifiedACB public source registry. The present review inspects registry scope; it does not claim a newly completed row-by-row re-extraction of the restricted source tables. The proposed approach verifies the “old” side against its frozen source and the “new” side against the specified revised or corrected source, preserving literal labels, values, identities, and locators. Changes are classified as additions, removals, identity revisions, value revisions, or unresolved differences. The verified public boundary is that registry visibility does not authorize redistribution of withheld row-level data. No new medication scores or agreement statistics are reported. The aim is an auditable change record, not a synthetic compromise between versions.

Introduction

Source updates are often summarized as a list of changed values. That format can hide important distinctions. A medicine may have been renamed rather than rescored, a combination split rather than removed, or a correction applied to a different document version than the reviewer assumed. A comparison needs to establish what both sides actually represent.

ADS and revised ADS also belong to a history of measurement development. The original ADS paper examined associations with serum anticholinergic activity. [Carnahan et al., 2006](#) That source history should not be overwritten by later terminology. A revised or corrected version needs its own identifier, source record, and verification scope.

Methods

The completed activity for this article was a read-only inspection of the current public registry and review of the cited publication records. No restricted table was newly extracted, no private row was republished, and no new empirical comparison was performed. The following steps define a proposed full audit for a future authorized source review.



First, freeze both inputs. Record the exact earlier source snapshot and the exact revised source, including whether a correction has been incorporated. Publication year alone may not distinguish an original table from a corrected one. The indexed 2025 correction notice demonstrates the need to identify the corrected version explicitly. [rADS correction notice, 2025](#)

Second, verify the earlier side independently. For every row claimed to have changed, confirm the literal medication label, original value or evidence state, source locator, and relevant route or formulation. Do not accept the “old value” printed in a secondary change table as its own proof. It should reconcile to the actual frozen earlier source.

Third, verify the revised side in the same way. Confirm the new label and observation in the designated revised or corrected source. An absent row should remain absent unless the source explicitly supplies another state. A correction should be applied only to the source version and fields it actually addresses.

Fourth, resolve identity before classifying the difference. Exact spelling changes, synonyms, salts, stereoisomers, combinations, and route-specific products need explicit handling. A merge or split can alter apparent counts without representing a pharmacologic reclassification. Record the mapping decision and its evidence separately from the source values.

Fifth, assign a change type. Useful categories are an added observation, removed observation, unchanged observation under a revised label, explicit value change, scope or qualification change, and unresolved discrepancy. These are audit categories, not new clinical ratings. A row may require more than one documented change type rather than a forced single explanation.

Finally, check completeness in both directions. Every item claimed to be removed should be sought in the revised source under the approved identity rules, and every addition should be checked against the earlier source. Preserve unmatched records and reasons. Counts should be reported with their unit: literal rows, normalized concepts, or public observations are not interchangeable denominators.

Results

The public registry identifies an ADS 2006 supplied-appendix snapshot and a corrected rADS 2025 source version. Their registry records preserve separate source identifiers and public-reuse limitations. Neither contributes row-level observations to the current public dataset inspected for this article. [UnifiedACB public evidence dataset, v3.0 RC12 final](#)

That is a verified publication-scope finding, not a claim that the source tables contain no medicines or that the scales are clinically invalid. It means this public article cannot responsibly report a newly verified list of ADS-to-rADS score changes from the public rows alone. No count of rescored medicines, agreement coefficient, or completed bilateral table audit is asserted here.

Discussion

The main value of bidirectional checking is that it tests two independent claims. A correct revised value does not prove that the earlier value was transcribed correctly, and a correct earlier value does



not prove that the intended correction was applied. An audit that checks only one side can preserve a plausible but false history of change.

Identity decisions deserve equal attention. If two labels are merged without justification, the comparison can create an apparent value change where none exists. If a synonym is left unmatched, it can create a false removal and addition. The source labels should remain available even after a normalized concept is assigned so another reviewer can reconstruct the decision.

Rights and verification are separate from discoverability. A source can be listed in the registry to explain provenance while its row-level redistribution remains withheld. An article should not fill that gap by reproducing a table from an unreviewed copy or borrowing values from another scale. A public boundary is part of the evidence record, not an obstacle to be hidden.

The resulting change table should be useful to both readers and maintainers. Readers need to know what changed and why. Maintainers need the exact input versions, transformations, unresolved issues, and rollback path. A concise summary can accompany the record, but should not replace the audit trail or create a consensus value across historical versions.

Limitations

This article specifies a review method and reports the inspected public registry scope. It is not a completed independent re-extraction of ADS and rADS tables, and it does not adjudicate every medication identity in those sources. The existence of a correction notice alone does not establish which individual values should change in a separate database.

A full audit requires authorized source access, exact locators, and review of all relevant documents and corrections. Even a perfect transcription comparison would demonstrate source fidelity, not improved clinical prediction or superiority of one version for every population. Those are separate validation questions.

Conclusion

Check the earlier and revised records independently, then classify the difference with identity and scope intact. Where public source access is insufficient, report that boundary instead of inventing a change list. A trustworthy version comparison preserves the history of the evidence, including uncertainty and redistribution limits.

References

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Disclosure

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