

Reflections on the Hungarian Oxford Cognitive Screen in post-stroke cognitive care

We read with great interest the article ‘The need for post-stroke cognitive screening - the rationale behind the Hungarian adaptation of the Oxford Cognitive Screen (OCS) and its pilot study’ by Takács et al. on the Hungarian adaptation and pilot study of the Oxford Cognitive Screen (OCS) for post-stroke cognitive screening [1]. The study addresses a major and persistent gap in stroke care: cognitive impairment after stroke is common, clinically meaningful, and still underdetected in routine practice. By developing a Hungarian version of a stroke-specific, freely available screening tool, the authors make an important contribution to the field and to future rehabilitation pathways in Hungary.

We commend the authors for the structured translation process, multidisciplinary approach, and feasibility testing in acute stroke patients. The pilot confirms that the Hungarian OCS is understandable, acceptable, and practical to administer in a real-world setting. This is particularly valuable because general cognitive screening tools such as the MMSE and MoCA, although widely used, were not designed for stroke populations and may miss domain-specific deficits or be confounded by language and motor impairments. In contrast, the OCS was developed to capture the heterogeneous, domain-based pattern of post-stroke cognitive impairment and has been shown to be particularly useful for deficits such as neglect, apraxia, and language-related impairment [2–4].

At the same time, we believe the manuscript opens the door to several important next steps. First, the language-specific adaptation of the sentence task and the modified scoring approach are methodologically understandable in Hungarian, but they also highlight the need for formal norming and cut-off derivation in the target populations. Without such data, cross-language comparability and the interpretation of borderline scores remain limited. This is not a limitation of the adaptation itself, but it highlights a key methodological principle: linguistic equivalence does not ensure psychometric equivalence.

Second, we believe the paper would benefit from a stronger implementation perspective. Recent guidance increasingly supports systematic post-stroke cognitive screening according to local feasibility, ideally as part of a structured care pathway rather than as an optional or isolated add-on to care [5,6]. Evidence from acute stroke-unit studies and guideline-aligned reviews supports screening for cognitive impairment before discharge, because early assessment helps identify patients at risk of persistent post-stroke cognitive difficulties and supports downstream rehabilitation planning [7,8]. Similarly, implementation-oriented work has framed acute post-stroke screening as the first step in a broader cognitive care pathway, rather than as a standalone exercise [5]. This is important because screening only has clinical value if abnormal findings trigger a defined next step, such as more detailed assessment, rehabilitation referral, caregiver counseling, or follow-up planning.

This pathway-based approach is especially relevant because barriers to cognitive screening in acute stroke units remain substantial, including limited time, competing clinical priorities, and uncertainty about which tool to use. At the same time, studies of acute stroke practice have argued that cognitive assessment should not be delayed indefinitely, since early recognition of impairment may affect discharge planning, rehabilitation needs, and long-term outcomes [9,10]. European Stroke Organisation and European Academy of Neurology guidelines treat post-stroke cognitive impairment as a core post-stroke syndrome and address its prevention, diagnosis, management, and prognosis, underscoring the need for structured and systematic assessment rather than opportunistic testing [11]. For that reason, the most useful future direction for the Hungarian OCS is not only further psychometric validation, but also testing how it performs when integrated into a realistic stroke-care pathway with clear referral and follow-up steps.

In this respect, the real value of the Hungarian OCS will not lie only in its validity as a test, but in whether it can be integrated into acute stroke workflows, used by non-neuropsychologists, and linked to concrete decisions about referral, rehabilitation, and follow-up.

Third, future validation should move beyond feasibility and address the populations most likely to benefit from a stroke-specific tool. This should include patients with aphasia, neglect, more severe strokes, and diverse lesion patterns—populations in whom stroke-specific tools are most likely to provide added value, to determine whether OCS-based screening predicts functional outcome, rehabilitation needs, or later cognitive decline. If successful, the Hungarian OCS could become more than a translated instrument: it could serve as the foundation for a guideline-concordant screening pathway tailored to post-stroke care in Hungary.

Taken together, the next stage should move from feasibility to implementation: large-scale validation, integration into care pathways, and evaluation of whether OCS-based screening improves clinically meaningful outcomes.

CRediT authorship contribution statement

Polona Rus Prelog: Conceptualization, Writing – original draft, Writing – review & editing. **Matija Zupan:** Writing – review & editing. **Senta Frol:** Conceptualization, Supervision, Validation.

Declaration of competing interest

The authors have no competing interests to declare.

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