Polyendocrine Metabolic Ovarian Syndrome

GP Update, 2026

Polyendocrine Metabolic Ovarian Syndrome (PMOS), formerly known as PCOS, is the same condition with a more accurate name. The change shifts the focus away from “ovarian cysts” and towards the broader endocrine, metabolic, reproductive and psychological features that need to be managed across the patient’s lifetime.

Key changes at a glance

The name has changed, not the diagnosis.
The diagnostic criteria remain guideline-based during the transition. The important change is a more holistic approach to assessment and ongoing care.

Think beyond the ovaries.
PMOS encompasses endocrine dysfunction, insulin resistance and cardiometabolic risk, reproductive dysfunction, skin and hair symptoms, psychological wellbeing and sleep.

Avoid over-testing.
In an adult with irregular cycles and hyperandrogenism, ultrasound or AMH is not required simply to establish the diagnosis. Repeated ultrasounds do not monitor or predict PMOS progression.

Cardiometabolic risk is central.
Screen for cardiovascular risk, dysglycaemia and sleep apnoea, regardless of whether the patient is overweight.

Key takeaways for GPs

1. Confirm the diagnosis accurately

Adults ≥20 years: diagnosis requires 2 of 3 criteria, after excluding other disorders:

- Oligo-anovulation
- Hyperandrogenism
- Polycystic ovarian morphology or AMH

Adolescents 10–19 years: both oligo-anovulation and hyperandrogenism are required, with caution around the timing of menarche and risk of overdiagnosis.

Exclude mimics such as thyroid dysfunction and hyperprolactinaemia, and investigate severe, rapidly progressive or virilising features.

2. Screen for the whole syndrome

At diagnosis and during ongoing review, consider:

Assess	Practical approach
Lipids	Fasting lipid profile at diagnosis and annually
Blood pressure	BP every visit or maximally annually
Glycaemia	Fasting glucose at diagnosis and annually
Sleep	Ask about snoring, unrefreshing sleep, fatigue and daytime sleepiness; consider Epworth Sleepiness Scale
Mental health	Depression, anxiety, body image, eating concerns and quality of life
Reproductive health	Cycle pattern, fertility intentions and preconception planning
Skin/hair	Acne, hirsutism and alopecia
Endometrium	Prevent prolonged amenorrhoea; routine screening is not recommended

3. Match treatment to the patient's priorities

- **Lifestyle**: focus on sustainable healthy eating, physical activity, prevention of weight gain and behaviour change rather than prescribing a particular "PMOS diet". No specific diet has been shown to be superior.
- **Irregular cycles/hyperandrogenism**: COCP is a key treatment, with low-dose preparations generally preferred. Drospirenone-only therapy may be useful where oestrogen is contraindicated or not tolerated.
- **Metabolic features**: metformin is primarily used for metabolic management. Monitor gastrointestinal effects and B12 absorption.
- **Hirsutism**: anti-androgens such as spironolactone require effective contraception; laser/light therapies may also help selected patients.
- **Fertility**: letrozole is first-line pharmacological ovulation induction, with referral to fertility or gynaecology services where appropriate.

Practice tip

Do not let the ultrasound report drive the consultation.

If a patient presents with an ultrasound report describing "polycystic ovaries", ask what their understanding is before explaining it.

Reassure them that PMOS is not a condition of pathological ovarian cysts and that the ultrasound appearance reflects follicular development. Repeated ultrasounds are generally unnecessary once the diagnosis is clear and may increase anxiety without providing useful prognostic information.

Then broaden the consultation:

Cycles > metabolic risk > mood > sleep > skin/hair > fertility goals > long-term prevention

> **PMOS is a lifelong condition, even when symptoms improve.** Regular cycles, weight management or improved metabolic markers do not mean the underlying risk has disappeared. Continue annual review of cardiometabolic risk and adapt management as the patient moves through different life stages.
>
> **The goal is not simply to treat irregular periods. It is structured, long-term care of the whole patient.**