Polyendocrine Metabolic Ovarian Syndrome

GP Update, 2026

Frequently Asked Questions, with Dr Simone Gonzo

How often should a patient with PMOS have a withdrawal bleed if they are amenorrhoeic?
Patients should have no longer than 3 months between periods, to reduce the risk of endometrial hyperplasia. For patients using the COCP, a bleed approximately every three months can provide predictable cycle control while helping protect the endometrium.

Should progesterone be used to regulate cycles in a patient taking the COCP?
The key consideration is avoiding prolonged amenorrhoea. Aim for a bleed at least every three months to provide endometrial protection, rather than routinely adding progesterone without considering the patient's existing hormonal regimen.

Should all patients with PMOS be prescribed metformin?
Not necessarily, but patients may benefit from metformin even without established insulin resistance, particularly where there is a strong family history of diabetes. Metformin for PMOS is not a PBS-listed indication and may require a private prescription. Gastrointestinal tolerance should also be considered.

Is inositol useful for insulin resistance in PMOS?
Inositol can be used, but metformin combined with lifestyle and dietary measures was considered the more useful approach.

Are GLP-1 medications appropriate for patients with PMOS who are overweight or obese?
They may be useful when appropriately prescribed and when treatment can be sustained. Significant weight loss can provide substantial benefit, while metabolic benefits may still be relevant even when weight loss is limited. Cost and PBS access are practical considerations.

Which COCP is preferred when pregnancy is not currently planned?
A low-dose COCP that the patient tolerates well is generally appropriate. A drospirenone-containing preparation may be particularly useful when acne or hirsutism is also present.

Does the COCP affect future fertility?
The COCP is reversible, and fertility generally returns after stopping it, assuming there are no other fertility issues. It can therefore be a useful choice when pregnancy is not currently desired.

What is the first-line treatment for ovulation induction in PMOS?
Letrozole is first-line for pharmacological ovulation induction when appropriate. Preconception care should also include optimisation of cardiometabolic risk and attention to folate, blood pressure, medications, sleep and mood.

What should be checked before a patient with PMOS attempts pregnancy?
Consider an oral glucose tolerance test and lipid assessment, alongside optimisation of cardiometabolic risk. Review folate supplementation, blood pressure, medications, sleep and mood as part of preconception care.

If PMOS symptoms improve, can the condition go away?
No. PMOS should be viewed as a long-term metabolic condition. Even when cycles become regular and other symptoms improve, patients may remain at increased metabolic and cardiovascular risk. Annual review of cardiovascular and metabolic risk is therefore important.