

National Guideline

Assessment and Management of Polycystic Ovarian Syndrome (PCOS) / Polyendocrine Metabolic Ovarian Syndrome (PMOS)



**Ministry of Health,
Family and Welfare**
Republic of Maldives



**SOCIETY OF OBSTETRICIANS
AND GYNAECOLOGISTS OF MALDIVES**

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1.0 Background

Polycystic Ovary Syndrome (PCOS) / Polyendocrine Metabolic Ovary Syndrome (PMOS) is the most common endocrine disorder affecting women of reproductive age, with an estimated global prevalence of 8–13%, depending on the diagnostic criteria used. Despite its high prevalence, approximately 70% of affected women remain undiagnosed, resulting in delayed diagnosis, inconsistent management, and increased risk of long-term health complications. PCOS/ PMOS represents a significant public health issue because it affects not only reproductive health but also metabolic, cardiovascular, and psychological wellbeing throughout the life course.

In May 2026, an international consensus endorsed by major professional societies, including the Endocrine Society, the European Society of Human Reproduction and Embryology (ESHRE), and the American Society for Reproductive Medicine (ASRM), recommended renaming Polycystic Ovary Syndrome (PCOS) as Polyendocrine Metabolic Ovarian Syndrome (PMOS). The new terminology acknowledges that the condition is a complex multisystem disorder extending beyond ovarian dysfunction. As the term PCOS remains widely recognized in clinical practice and existing literature, both terms (PCOS/PMOS) are used interchangeably throughout this guideline.

PCOS/PMOS is a heterogeneous disorder characterized by varying combinations of:

- Ovulatory dysfunction (oligo-ovulation or anovulation);
- Clinical and/or biochemical hyperandrogenism; and
- Polycystic ovarian morphology on ultrasound or elevated anti-Müllerian hormone (AMH), where appropriate.

The clinical presentation varies considerably between individuals and across the lifespan. Women may present with menstrual irregularities, infertility, hirsutism, acne, obesity, or metabolic abnormalities, while others remain asymptomatic until seeking care for infertility or pregnancy. The heterogeneity of the syndrome often contributes to delayed diagnosis and inconsistent management.

The underlying pathophysiology is complex and multifactorial, involving genetic susceptibility interacting with environmental and lifestyle factors. Key mechanisms include insulin resistance with compensatory hyperinsulinaemia, ovarian and adrenal androgen excess, altered neuroendocrine regulation, chronic low-grade inflammation, and metabolic dysfunction. Excess body weight is not the primary cause of PCOS/PMOS but is an important modifier that may exacerbate both reproductive and metabolic manifestations. Importantly, PCOS/PMOS also occurs in women with normal body weight, highlighting the need for individualized assessment regardless of body mass index.

PCOS/PMOS is associated with significant short- and long-term health consequences. Women are at increased risk of subfertility, pregnancy complications, impaired glucose tolerance, type 2 diabetes mellitus, dyslipidaemia, hypertension, metabolic syndrome, obstructive sleep apnoea,

and cardiovascular risk factors. There is also an increased prevalence of anxiety, depression, eating disorders, reduced quality of life, and body image concerns. These diverse manifestations necessitate a comprehensive, multidisciplinary approach to care that extends beyond symptom management.

Within the Maldives, PCOS/PMOS represents an increasingly important clinical condition encountered in primary care, obstetrics and gynaecology, endocrinology, and fertility services. Rising rates of overweight and obesity, increasing prevalence of diabetes and metabolic disease, changing reproductive patterns, and growing demand for infertility services underscore the need for standardized national guidance. Variations in diagnostic practices, access to investigations, and management approaches across healthcare settings may contribute to inconsistent care and inequities in health outcomes.

This National Guideline has been developed to provide evidence-based recommendations for the diagnosis, assessment, treatment, and long-term management of PCOS/PMOS within the Maldivian healthcare system. It is based primarily on the most recent International Evidence-based Guideline for the Assessment and Management of PCOS/PMOS, while considering local healthcare resources, clinical practice, and service delivery. The guideline promotes standardized, patient-centred, culturally appropriate, and multidisciplinary care, aiming to improve health outcomes, optimize fertility and pregnancy outcomes, reduce long-term complications, and enhance quality of life for women and adolescents with PCOS/PMOS in the Maldives.

2.0 Scope of the guideline

This guideline provides evidence-based recommendations for the diagnosis, assessment, treatment, and long-term management of polyendocrine metabolic ovarian syndrome (PCOS/PMOS) in the Maldives. It has been developed to support consistent, high-quality, and patient-centred care across all levels of the healthcare system while reflecting the best available international evidence and local clinical practice.

The guideline applies to adolescents and adult women with suspected or confirmed PCOS/PMOS, including women planning pregnancy, undergoing fertility treatment, and those requiring ongoing management beyond the reproductive years. It addresses the full spectrum of care, including diagnosis, lifestyle management, treatment of reproductive, metabolic, and psychological manifestations, fertility care, pregnancy, and long-term follow-up.

The recommendations are intended for all healthcare professionals involved in the care of women with PCOS/PMOS, including obstetricians and gynaecologists, reproductive medicine specialists, endocrinologists, primary care and family physicians, nurses, midwives, dietitians, psychologists, exercise professionals, and healthcare trainees

This guideline follows the principles of evidence-based practice, shared decision-making, multidisciplinary collaboration, culturally appropriate care, equity in access to healthcare, and the prevention of long-term complications. Management should be individualized according to each woman's symptoms, reproductive goals, metabolic risk profile, and personal preferences, recognizing PCOS/PMOS as a lifelong condition requiring ongoing review and support.

3.0 Principles of Care Delivery

3.1 Information, Education and Resources

- Ensure information and education are provided in a respectful, empathetic and patient-centred manner, particularly at the time of diagnosis and during major life transitions.
- Provide tailored information, education and resources that are evidence-based, culturally appropriate, inclusive and accessible to all individuals with PCOS/PMOS, and provide guidance to reduce exposure to misinformation.
- Ensure PCOS/PMOS education is incorporated into undergraduate, postgraduate and continuing professional development programmes for healthcare providers.
- Adapt educational resources and clinical approaches to reflect cultural, linguistic, social and individual differences within the population.

3.2 Models of Care

- Establish models of care that ensure equitable access to primary care, with clear pathways for referral to specialist and multidisciplinary services when required.
- Develop integrated care pathways to support timely diagnosis, coordinated long-term follow-up, and appropriate use of virtual care.
- Promote multidisciplinary collaboration and healthcare professional education to improve evidence-based diagnosis, management and lifelong care of women with PCOS/PMOS.

3.3 Cultural, Linguistic and Social Considerations

- Provide culturally appropriate education and support resources for individuals with PCOS/PMOS and their families throughout the lifespan.
- Consider cultural beliefs, social circumstances and individual preferences when developing management plans.
- Promote public awareness of PCOS/PMOS to reduce stigma, misinformation and marginalisation.
- Ensure educational materials are available in appropriate languages and formats according to population needs.

3.4 Supporting Family and Interpersonal Relationships

- Encourage education and awareness initiatives to improve understanding of PCOS/PMOS among families and communities.
- Provide individuals and families with culturally appropriate resources addressing the impact of PCOS/PMOS on relationships, fertility, mental health and wellbeing.
- Consider psychosocial support and counselling for individuals experiencing distress related to family expectations, stigma or interpersonal challenges.

3.5 Patient–Care Provider Partnership

- Healthcare providers should use shared decision-making approaches and support individuals with PCOS/PMOS to actively participate in their healthcare decisions.
- Provide information regarding diagnosis, treatment options, reproductive implications and long-term health risks using clear, evidence-based and empathetic communication.
- Ensure consultations allow adequate time to address individual concerns, priorities and management goals.
- Use structured communication approaches when discussing diagnosis or significant health information.
- Support patient agency by encouraging self-management skills, confidence and active involvement in ongoing care.

3.6 Key Components of an Effective PCOS / PMOS Model of Care

Principle	Key Actions
Patient-centred care and shared decision-making	Individualise management according to symptoms, priorities, preferences, culture and life stage. Establish shared goals, support informed decision-making and encourage active patient participation in care planning.
Accessible information and health education	Provide reliable, understandable and culturally appropriate information resources to support health literacy and self-management.
Integrated and multidisciplinary care	Link primary care with specialist and multidisciplinary services. Encourage collaboration between healthcare professionals to provide comprehensive care, including lifestyle and metabolic health support, reproductive and fertility care, and psychological assessment and support where required.
Lifelong approach to care	Provide ongoing care across adolescence, reproductive years and later life, addressing reproductive, metabolic, psychological and social health needs throughout the lifespan.
Cultural sensitivity and inclusivity	Recognise the influence of social beliefs, stigma, cultural factors and language barriers, and ensure care is respectful, accessible and responsive to individual needs.
Digital health and continuity of care	Use digital health and virtual care approaches where appropriate to improve access, communication and continuity of care.
Healthcare professional education and quality improvement	Ensure ongoing education, training and adherence to evidence-based practice among healthcare professionals involved in PCOS/ PMOS care.

4.0 Diagnosis and Initial Assessment

4.1 Diagnostic Criteria

- Use the modified Rotterdam criteria for diagnosis of PCOS/ PMOS
- Exclude other disorders that may mimic the condition.

Modified Rotterdam criteria

Diagnose PCOS/ PMOS when at least two of the following are present:

1. Ovulatory dysfunction.
 2. Clinical or biochemical hyperandrogenism.
 3. Polycystic ovarian morphology on ultrasound or elevated anti-Müllerian hormone (AMH).
- Do not require ovarian ultrasound or AMH when both ovulatory dysfunction and hyperandrogenism are present.
 - Interpret androgen levels and AMH results using laboratory/assay-specific reference ranges.

4.2 Clinical Assessment

History

Menstrual history

- Age at menarche
- Cycle length or duration
- Cycle regularity
- History of irregular menstrual cycles or amenorrhea
- History of heavy menstrual bleeding or abnormal uterine bleeding.

Irregular menstrual cycles are defined as:

Normal in the first year post menarche as part of the pubertal transition	
> 1 to < 3 years post menarche	< 21 or > 45 days
> 3 years post menarche to perimenopause	< 21 or > 35 days or < 8 cycles per year
> 1 year post menarche	> 90 days for any one cycle
Primary amenorrhea by age 15 or > 3 years post thelarche (breast development)	

*Detailed recommendations for approach to diagnosis and management of PCOS/ PMOS in adolescence, refer to **Chapter 8: Special Considerations in Adolescence**.*

Symptoms of hyperandrogenism

- Hirsutism
- Acne
- Female pattern hair loss

Reproductive history

- Infertility
- Pregnancy complications
- Previous fertility treatments

Weight changes

- Recent weight gain
- Previous weight-loss interventions

Symptoms suggestive of insulin resistance

- Hyperpigmentation of skin folds
- Skin tags
- Central weight gain

Symptoms of obstructive sleep apnoea

- Day time sleepiness and fatigue
- Loud snoring
- Waking unrefreshed from sleep
- Witnessed apnoea

History of cardiovascular disease

- History of hypertension
- History of hyperlipidemia
- History of smoking

Psychological wellbeing

- Symptoms of anxiety and depression
- Eating disorders
- Body image concerns

Current medications

- Hormonal contraception
- Medications affecting androgen levels

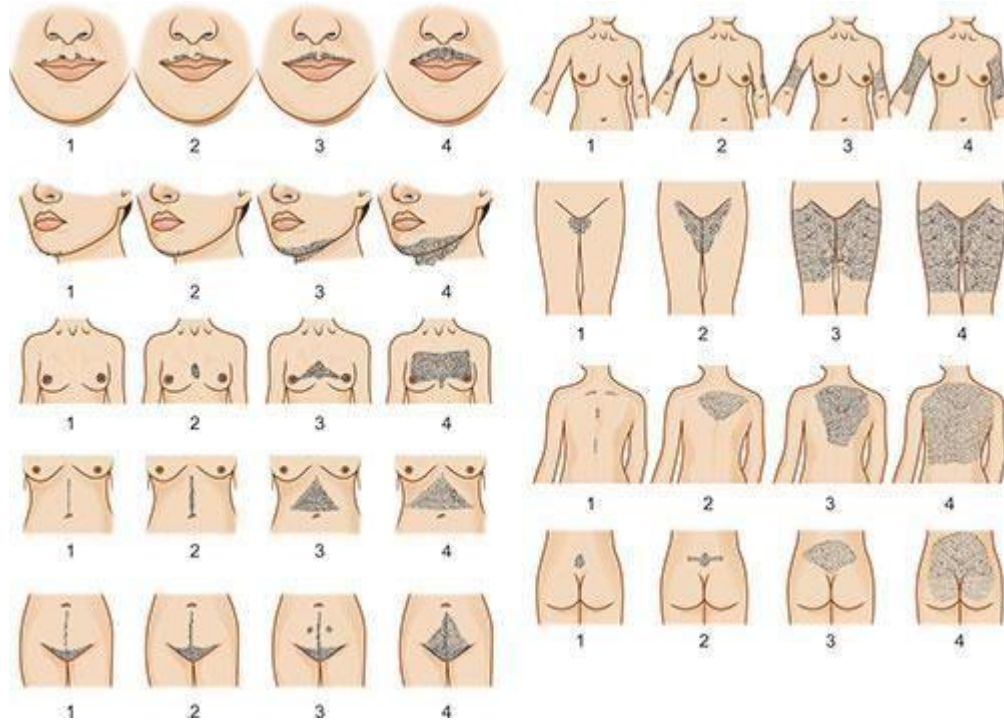
Family history

- PCOS
- Type 2 diabetes mellitus
- Cardiovascular disease
- Dyslipidaemia
- Endometrial cancer

Physical Examination

- Measure:
 - Height, weight and body mass index (BMI)
 - Waist circumference where appropriate
 - Blood pressure at diagnosis.
- Assess
 - Clinical hyperandrogenism - hirsutism, acne and androgenic alopecia
 - Features suggestive of alternative endocrine disorders - virilisation, Cushingoid features and thyroid disease.
 - Signs of insulin resistance - acanthosis nigricans, skin tags

- Consider the presence of hirsutism alone as predictive of biochemical hyperandrogenism and PCOS/ PMOS in adults.
- Use a modified Ferriman Gallwey score (mFG) of 4–6 to detect hirsutism.



Modified Ferriman Gallwey (mFG) scoring system. Growth of terminal hair is assessed on nine different places on the body. If there is no terminal hair present, the score is zero. The mFG score is the total sum of points.

4.3 Laboratory Assessment

Assess for anovulation

- Recognise that ovulatory dysfunction can occur with regular cycles.
- Test for serum progesterone levels if anovulation is suspected.

Assessment of Hyperandrogenism

- Use biochemical testing when clinical hyperandrogenism is absent, unclear, or discordant.
- Use total and free testosterone as the primary biochemical tests to assess hyperandrogenism in women with suspected PCOS/ PMOS.
- Calculate the free androgen index (FAI) when free testosterone measurement is unavailable: $FAI = (Total\ Testosterone / SHBG) \times 100$.
- Consider androstenedione and DHEAS if testosterone levels are not elevated but clinical suspicion remains high.
- Do not routinely repeat androgen measurements during follow-up unless clinically indicated.
- Do not assess biochemical hyperandrogenism while on hormonal contraception where possible, as results may be unreliable. Consider reassessment after withdrawal for at least 3 months with alternative contraception.
- Investigate alternative causes of hyperandrogenism when androgen levels are markedly elevated or there is rapid onset/progression of symptoms, including possible androgen-secreting tumours.

Exclusion of Alternative Diagnoses

- Measure thyroid stimulating hormone (TSH) to exclude thyroid dysfunction.
- Measure serum prolactin to exclude hyperprolactinaemia.
- Measure 17-hydroxyprogesterone to exclude non-classical congenital adrenal hyperplasia.
- Consider additional endocrine investigations when clinical features suggest Cushing syndrome, androgen-secreting tumours, primary ovarian insufficiency or hypothalamic amenorrhoea.

4.4 Ultrasound Assessment

- Use transvaginal ultrasound for assessment of ovarian morphology when appropriate and acceptable to the woman.
- Use transabdominal ultrasound when transvaginal ultrasound is not appropriate.
- Do not diagnose PCOS/ PMOS based on ultrasound findings in adolescents.
- Ensure ultrasound reports include any additional pelvic pathology, including endometrial assessment for thickness and pattern.
- Interpret polycystic ovarian morphology (PCOM) using the following criteria:

Ultrasound Parameter	Diagnostic Threshold	When to Use	Comments
Follicle Number Per Ovary (FNPO)	≥20 follicles in at least one ovary	Preferred criterion in adults using high-resolution transvaginal ultrasound	Most accurate and recommended marker for diagnosing PCOM.
Follicle Number Per Section (FNPS)	≥10 follicles in at least one ovary	Use with older ultrasound technology is used, where image quality is insufficient to allow for an accurate assessment of follicle counts, or with transabdominal ultrasound.	Alternative criterion when whole-ovary follicle count cannot be accurately assessed.
Ovarian Volume (OV)	≥10 mL in at least one ovary		Ovarian enlargement alone is sufficient to define PCOM when follicle counts are unreliable.
• To obtain FNPO or FNPS, count the follicles measuring 2–9 mm in diameter. • Assess for other ovarian features and/or pathology including ovarian cysts, corpus lutea, dominant follicles (≥10 mm) (which should not be included in ovarian volume calculations) • When a dominant follicle is noted on one ovary, rely on the contralateral ovary FNPO for diagnosis of PCOM.			

4.5 Anti-Müllerian Hormone (AMH)

- Do not use both ultrasound and AMH routinely for diagnosis of PCO morphology.
- Use AMH only within the diagnostic algorithm and not as a standalone diagnostic test.
- Do not use AMH to diagnose PCOM in adolescents.
- Interpret AMH results in correlation with factors that may influence Serum AMH levels in the general population, including:

Factor	Effect on AMH Level
Age	Generally peaks between 20–25 years of age.
Body mass index (BMI)	Lower in women with higher BMI.
Hormonal contraception and ovarian surgery	Suppressed by current or recent COCP use or previous ovarian surgery.
Menstrual cycle day	May vary across the menstrual cycle.

4.6 Assessment for Long Term Health Risks Associated with PCOS / PMOS

- Assess women with PCOS/ PMOS for associated long-term health risks at the time of diagnosis.
- Assess the following at diagnosis:
 - Glycaemic status.
 - Cardiovascular risk factors (blood pressure, BMI, waist circumference where appropriate, lipid profile, smoking status and family history).
 - Weight and obesity (BMI and waist circumference where appropriate).
 - Psychological health (anxiety, depression, body image concerns and disordered eating where indicated).
 - Obstructive sleep apnoea (symptoms including loud snoring, witnessed apnoea, excessive daytime sleepiness and unrefreshing sleep).

- Refer women with identified or suspected abnormalities to appropriate specialist services for further assessment and management.
- *Detailed recommendations for ongoing risk assessment, surveillance and long-term management are provided in **Chapter 9: Long-Term Health Risks and Lifelong Follow-up**.*

5.0 Lifestyle Management

Lifestyle intervention comprises healthy eating, regular physical activity and behavioural support and should be considered first-line management for all women with PCOS/ PMOS

5.1 Lifestyle Interventions

- Consider lifestyle intervention (exercise alone or combined healthy diet, physical activity and behavioural strategies) for all women with PCOS/ PMOS to improve:
 - Metabolic health
 - Central adiposity
 - Lipid profile
 - Overall health and wellbeing
- Offer healthy lifestyle advice to all women with PCOS/ PMOS regardless of BMI to:
 - Maintain a healthy weight
 - Prevent excess weight gain
 - Achieve modest weight loss where appropriate
 - Improve body composition and quality of life
- Ensure lifestyle management remains a core component of PCOS/ PMOS management throughout the lifespan.
- Promote sustainable healthy behaviours that can be adopted throughout life.
- Develop individualized lifestyle goals jointly with the woman, taking into account her preferences, priorities, culture and readiness for change.
- Inform women that clinically important health benefits may occur even without significant weight loss.
- For women with higher body weight:
 - Focus on preventing further weight gain throughout life.
 - Prescribe an individualized energy deficit based on age, body weight and physical activity where weight loss is desired.
 - Monitor improvements in waist circumference, waist-to-hip ratio and metabolic health in addition to body weight.
 - Provide ongoing review and long-term support.

- For women with normal BMI, adolescents and women during key life stages (preconception, pregnancy and menopause):
 - Focus on healthy sustainable lifestyle behaviours
 - Encourage prevention of excess weight gain.
- Do not use fasting insulin levels or insulin resistance assays routinely for clinical management.

5.2 Behavioural Strategies

- Advise behavioural interventions to improve adherence to lifestyle changes and facilitate long-term maintenance of healthy behaviours.
- Consider incorporating behavioural strategies alongside dietary and exercise interventions, including:
 - Goal setting
 - Self-monitoring
 - Problem solving
 - Relapse prevention
 - Positive reinforcement
 - Assertiveness training
- Use SMART goals that are:
 - Specific
 - Measurable
 - Achievable
 - Relevant
 - Time-bound
- Consider behavioural or cognitive behavioural interventions to improve:
 - Lifestyle adherence
 - Engagement
 - Retention
 - Weight management
 - Emotional wellbeing

5.3 Dietary Management

- Inform women that no single dietary composition has demonstrated superiority over another for improving:
 - Weight
 - Metabolic outcomes
 - Hormonal profiles
 - Reproductive outcomes
 - Psychological wellbeing
- Recommend a balanced dietary pattern consistent with National Food Based Dietary Guidelines, tailored to individual preferences and cultural practices.
- Ensure dietary advice is individualised, practical and sustainable.
- Encourage sustainable eating patterns emphasizing:
 - Vegetables and fruits
 - Whole grains
 - Legumes and pulses
 - Lean protein
 - Healthy fats
 - High-fibre, low glycaemic index carbohydrates
- Avoid unnecessarily restrictive or nutritionally unbalanced diets.
- Assess barriers to dietary change, including:
 - Psychological factors
 - Socioeconomic limitations
 - Cultural influences
 - Family environment
 - Personal motivation
- Refer women requiring additional nutritional support to a registered dietitian or appropriately trained nutrition professional where available.

5.4 Physical Activity

Regular physical activity improves insulin sensitivity, cardiometabolic health and overall wellbeing in women with PCOS/ PMOS. No specific exercise modality has been shown to be superior.

- Inform women that no particular type or intensity of exercise has demonstrated superiority over another for improving metabolic or reproductive outcomes.

- Adults should aim for:
 - 150–300 minutes/week of moderate-intensity aerobic activity, **OR**
 - 75–150 minutes/week of vigorous-intensity aerobic activity, **OR**
 - An equivalent combination of both
- AND**
 - Muscle strengthening activities on at least 2 non-consecutive days/week
- For greater weight loss or prevention of weight regain:
 - ≥250 minutes/week of moderate-intensity activity or
 - ≥150 minutes/week of vigorous-intensity activity
- Adolescents should perform:
 - At least 60 minutes/day of moderate-to-vigorous physical activity
 - Muscle- and bone-strengthening activities on at least 3 days/week
- Advise reducing sedentary behaviour and replacing prolonged sitting with physical activity whenever possible.
- Encourage incorporation of physical activity into daily life, including:
 - Walking
 - Cycling
 - Household activities
 - Occupational activity
 - Recreational sport
 - Structured exercise
- Assess barriers to exercise including:
 - Body image concerns
 - Fear of injury
 - Mental health issues
 - Environmental and safety concerns
 - Socioeconomic or cultural factors
- Consider referral to an exercise physiologist or appropriately trained healthcare professional where available.
- Consider use of wearable activity trackers or smartphone applications to support self-monitoring and improve adherence.

5.5 Weight Management

Women with PCOS/ PMOS have a substantially higher lifetime risk of overweight and obesity than women without PCOS/ PMOS. Weight gain is influenced by complex biological, behavioural and environmental factors, although the exact mechanisms remain incompletely understood.

- Recognize that women with PCOS/ PMOS are at increased risk of progressive weight gain over time.
- Inform women that current evidence does not consistently demonstrate major physiological or behavioural differences explaining weight gain compared with women without PCOS/ PMOS.
- Emphasize prevention of excess weight gain as a lifelong priority.
- Develop realistic, individualized weight management goals recognizing that:
 - Weight regulation is often more challenging in PCOS/ PMOS.
 - Long-term healthy behaviours are more important than rapid weight loss.
 - Improvement in metabolic health remains the primary treatment goal.

5.6 Weight Stigma

Weight stigma negatively affects psychological wellbeing, healthcare engagement and healthy lifestyle behaviours. Women with PCOS/ PMOS frequently report experiencing weight bias within healthcare settings and from family members.

- Recognize that weight stigma is common in women with PCOS/ PMOS and has significant adverse psychological and health consequences.
- Be aware of personal and professional weight bias and its impact on clinical care.
- Adopt weight-inclusive, respectful and person-centred communication. When discussing weight:
 - Ask permission before discussing or measuring weight.
 - Explain how weight measurements influence clinical management.
 - Use respectful language such as "higher weight" where appropriate.
 - Offer blind weighing if preferred.
 - Ensure appropriately sized equipment and examination facilities are available.

- Offer individualized care according to the woman's preferences and goals; it may include either:
 - Weight-centred management focused on intentional weight loss, or
 - Weight-inclusive care emphasizing healthy lifestyle behaviours without focusing primarily on weight loss.
- Provide equitable assessment and management regardless of body size.
- Promote awareness of weight stigma among healthcare professionals, health services and family members.

6.0 Management of Menstrual, Endocrine and Metabolic Features

Management of PCOS/ PMOS should be individualised according to the woman's presenting symptoms, reproductive goals, metabolic risk profile, preferences, and access to treatment.

Lifestyle intervention remains the foundation of management and should be recommended for all women with PCOS/ PMOS, alongside pharmacological or other interventions where indicated.

6.1 Menstrual Dysfunction

6.1.1 Menstrual irregularity

- Offer a combined oral contraceptive (COC) as first-line pharmacological treatment for menstrual irregularity in women who are not seeking pregnancy.
- Use the lowest effective dose of ethinylestradiol (generally 20–30 micrograms) to minimise adverse effects while achieving symptom control.
- Consider continuous or cyclic progestogen-only therapy to provide regular endometrial protection for women who cannot use, decline or have contraindications to oestrogen-containing contraception.
- Consider metformin in women with menstrual irregularity, particularly where metabolic features, impaired glucose tolerance or obesity are present.
- Do not use metformin as first-line treatment solely for menstrual regulation when a COC is appropriate and acceptable.
- Consider inositol supplementation in women with PCOS/ PMOS after discussion of limited evidence of clinical benefit, uncertain optimal formulation and dose, and potential variability in product quality.

6.2 Hyperandrogenism

6.2.1 Hirsutism

- Offer a combined oral contraceptive as first-line pharmacological treatment for hirsutism in women not seeking pregnancy.

- Offer mechanical hair removal or laser/light-based therapies as adjunctive or alternative treatments according to availability, cost and patient preference.
- Inform women that laser/light-based therapies offer longer-term reduction of unwanted body hair, but may require multiple treatment sessions and effectiveness depends on factors such as skin type and hair colour.
- Consider cost and availability when offering / selecting hair removal therapies.
- Ensure treatment is performed by appropriately trained providers to minimise risks of burns, pigment changes and scarring.
- Explain that improvement in hirsutism usually requires at least 6 months of therapy with COC and/or cosmetic hair removal therapy, because of the hair growth cycle.
- Consider anti-androgen therapy if there is inadequate response after at least 6 months of COC therapy or when COCs are contraindicated.
- Ensure effective contraception is used when prescribing anti-androgens due to the risk of fetal harm, particularly undervirilisation of a male fetus.
- Consider metformin for women with PCOS/ PMOS and hirsutism when metabolic indications are present, including central adiposity or insulin resistance.
- Consider inositol supplementation after counselling regarding limited evidence for improvement in hirsutism.

6.2.2 Acne

- Offer a combined oral contraceptive for management of acne associated with PCOS/ PMOS when contraception is acceptable.
- Consider referral to dermatology for severe, refractory or scarring acne.

6.2.3 Female pattern hair loss

- Consider a combined oral contraceptive as first-line treatment.
- Consider anti-androgen therapy where symptoms persist despite adequate treatment and once effective contraception is ensured.
- Consider referral to dermatology for persistent, severe or atypical hair loss.

6.3 Metabolic Health

- Offer metformin in combination with the COCP in high metabolic risk groups including:
 - BMI > 25 kg/m²
 - Diabetes mellitus
 - Impaired glucose tolerance
 - High-risk ethnic groups.
- Consider metformin in women with PCOS/ PMOS with a BMI < 25 kg/m², when metabolic benefit is likely.
- Consider inositol supplementation in women with PCOS/ PMOS who prefer complementary therapies, recognising:
 - Potential modest improvement in some metabolic parameters.
 - Limited evidence of clinical benefit compared with metformin.

6.4 Weight Management

- Set realistic, individualised and achievable goals based on the woman's circumstances, preferences and health priorities.
- Explain that even modest weight reduction may improve:
 - Ovulation
 - Menstrual regularity
 - Insulin sensitivity and
 - Cardiometabolic health.
- Do not use weight alone as the primary measure of treatment success.
- Monitor multiple outcomes, including:
 - Waist circumference.
 - Body mass index.
 - Blood pressure.
 - Glycaemic markers.
 - Lipid profile.
 - Menstrual function.
 - Quality of life.
- Consider anti-obesity medications for women with PCOS/ PMOS and overweight or obesity, particularly when lifestyle intervention alone has been insufficient.
- Consider bariatric/ metabolic surgery for women with PCOS/ PMOS after multidisciplinary assessment.

6.5 SUMMARY TABLES - PHARMACOLOGICAL THERAPIES

6.5.1 Combined Oral Contraceptives (COCPs)

Role	First-line pharmacological treatment for menstrual irregularity and hyperandrogenic symptoms in women not seeking pregnancy.
Choice of preparation	Use the lowest effective dose of ethinylestradiol (generally 20–30 micrograms) to minimise adverse effects while achieving symptom control. Consider preparations containing norethisterone, levonorgestrel, norgestimate or desogestrel due to lower VTE risk. Reserve cyproterone acetate-containing preparations for moderate-to-severe hirsutism or acne when alternatives are inadequate. No single COCP is superior for all women with PCOS/ PMOS.
Before prescribing	Assess age, BMI, smoking status, blood pressure, migraine history, VTE risk, cardiovascular disease, thrombophilia, postpartum status and other relevant comorbidities. Assess postpartum VTE risk in accordance with local protocols.
Contraindications	Migraine with aura, previous DVT/PE, thrombogenic mutations, severe liver disease, breast cancer, stroke, ischaemic and complicated valvular heart disease and other contraindications.
Common adverse effects	Nausea, breast tenderness, headache, mood changes, breakthrough bleeding, bloating.
Serious adverse effects	VTE, stroke, myocardial infarction, hypertension.
Counselling	Discuss benefits, expected bleeding patterns, common adverse effects and warning symptoms (e.g. chest pain, sudden shortness of breath, unilateral leg swelling or pain, severe sudden headache, or other neurological symptoms) requiring urgent review.

6.5.2 Progestogen-only Therapy

Role	Provides endometrial protection in women with PCOS/ PMOS and prolonged anovulation. Use for irregular or absent menstrual cycles, when COCPs are contraindicated or unacceptable.
Choice of progestogen	Options include continuous or cyclical progestogen therapy. Choice depends on individual factors, formulation, tolerability and eligibility. Formulations for endometrial protection include: oral formulations, injectable progestogens, subdermal implants, and intrauterine systems.
Before prescribing	Assess individual eligibility, contraindications and patient preferences.
Common adverse effects	Irregular bleeding, breast tenderness, mood changes and headaches.
Counselling	Explain that progestogen therapy provides endometrial protection but does not improve hirsutism, acne or other features of hyperandrogenism. Discuss expected bleeding patterns and potential adverse effects.

6.5.3 Anti-Androgens

Role	Second-line treatment for persistent hirsutism, if there is inadequate response after at least 6 months of COC therapy or when COCs are contraindicated.
Choice of anti-androgens	Spirolactone: - Consider as the preferred anti-androgen due to its relatively favourable safety profile. - Common doses range from 25–100 mg/day. - Monitor for adverse effects, including menstrual irregularity, hypotension and electrolyte abnormalities, where clinically indicated. Cyproterone acetate: - Consider in selected women - Doses ≥10 mg/day should not be routinely used due to an increased risk of thromboembolism and meningioma with prolonged exposure. Finasteride: - Consider in selected cases - Use cautiously because of its teratogenic potential and possible risk of liver toxicity. Flutamide and bicalutamide: - Generally not recommended due to the risk of hepatotoxicity and the limited evidence supporting their use in PCOS/ PMOS.
Before prescribing	Ensure effective contraception; do not prescribe if pregnancy is a possibility.
Monitoring	Potassium levels (with spironolactone) and liver functions where appropriate.
Adverse effects	Menstrual irregularity, hyperkalaemia, liver toxicity, feminisation or undervirilisation of a male fetus if pregnancy occurs, and meningioma risk with prolonged high-dose cyproterone acetate.
Counselling	Limited evidence supporting anti-androgen therapy in PCOS/ PMOS; adverse effects and the need for contraception.

6.5.4 Metformin

Role	Primarily improves metabolic outcomes; modest benefits for menstrual regularity and ovulation. Consider in women with higher BMI, impaired glucose tolerance or metabolic risk.
Dosing considerations	Starting dose: Low dose (250–500 mg) once daily. Titration: Increase by 500 mg every 1–2 weeks as tolerated. Maintenance dose: 1500–2000 mg/day. Maximum dose: Adults: 2500 mg/day; Adolescents: 2000 mg/day.
Administration	Take with food and consider extended-release formulation if gastrointestinal intolerance occurs.
Use caution in	Severe renal impairment, severe hepatic disease, conditions associated with hypoxia or lactic acidosis risk.
Monitoring	Glycaemic status, blood pressure, lipid profile, weight, waist circumference. Consider monitoring of Vitamin B12 levels when high risk of deficiency (e.g. long-term metformin use, diabetes mellitus, previous bariatric/ metabolic surgery, pernicious anaemia, vegan diet).
Common adverse effects	Nausea, diarrhoea, bloating, abdominal discomfort, reduced appetite.
Counselling	Adverse effects are generally dose dependent, more common during initiation and often self-limiting.

6.5.5 Inositol

Role	Complementary therapy with uncertain clinical benefit.
Choice of formulation	Available in various formulations, including myo-inositol and d-chiro-inositol. No specific formulation, dose or combination can currently be recommended.
Potential benefits	May improve some metabolic parameters.
Limited evidence	Ovulation, hirsutism, weight management and pregnancy outcomes remain uncertain.
Counselling	Advise women to disclose use of supplements. Explain variability in product quality and regulation.

6.5.6 Anti-obesity Medications

Role	Consider as an adjunct to lifestyle intervention for selected adults with obesity and PCOS/ PMOS.
Before prescribing	Discuss expected weight reduction, potential metabolic benefits, adverse effects, cost, accessibility, duration of therapy, limited long-term safety data and the likelihood of weight regain after discontinuation. Ensure effective contraception when pregnancy is possible.
Choice of medication	GLP-1 receptor agonists (liraglutide, semaglutide): May improve weight reduction, insulin sensitivity and cardiometabolic outcomes. Should be used alongside, and not as a replacement for, lifestyle intervention. Orlistat: Reduces dietary fat absorption and may provide modest weight reduction. Requires dietary counselling and monitoring for gastrointestinal adverse effects.
Contraindications and precautions	Use GLP-1 receptor agonists cautiously in women with relevant contraindications, including previous pancreatitis or certain endocrine tumour syndromes. Not recommended for adolescents with PCOS/ PMOS-related obesity.
Monitoring	Monitor weight, metabolic parameters and treatment tolerance. For prolonged orlistat use, consider monitoring of fat-soluble vitamins.
Common adverse effects	GLP-1 receptor agonists: Nausea, vomiting, diarrhoea, constipation and abdominal discomfort. Orlistat: Flatulence, oily stools, faecal urgency and diarrhoea.
Counselling	Reinforce the importance of ongoing lifestyle intervention. Counsel regarding potential weight regain after discontinuation and the need for effective contraception.

6.6 SUMMARY TABLES: MECHANICAL AND SURGICAL TREATMENT STRATEGIES

6.6.1 Mechanical Hair Removal and Laser / Light-Based Therapy

Method	Remarks
Shaving	Simple, inexpensive; requires frequent repetition; may cause skin irritation or folliculitis, pigmentation changes, ingrown hairs
Plucking/ threading/ waxing	Useful for small areas; requires less frequent repetition than shaving; may cause skin irritation or folliculitis, ingrown hairs
Depilatory creams	May irritate sensitive skin; patch testing recommended
Electrolysis	Permanent hair reduction; painful, requires multiple sessions and skilled providers, and is expensive
Laser hair removal	Effective for long-term reduction, particularly in women with dark hair; multiple sessions required; may result in burns, temporary irritation, pigmentary changes, rare scarring
Intense pulsed light (IPL) therapy	May reduce hair growth; effectiveness varies by skin and hair type; may result in burns, temporary irritation, pigmentary changes, rare scarring

6.6.2 Bariatric / Metabolic Surgery

Role	Consider bariatric/metabolic surgery for selected women with PCOS/PMOS and obesity after multidisciplinary assessment. May contribute to improvements in weight, insulin resistance, hypertension, prevention and management of type 2 diabetes mellitus, hyperandrogenic symptoms, menstrual regularity, ovulation and fertility outcomes.
Surgery methods	Sleeve gastrectomy, gastric bypass and other approved procedures
Before prescribing	Ensure effective contraception (ideally initiated before surgery).
Pregnancy considerations	Advise delaying pregnancy until after the recommended postoperative period and until weight stabilisation, usually approximately 12 months following surgery. Counsel women that pregnancy soon after bariatric/metabolic surgery may increase the risk of nutritional deficiencies, fetal growth restriction, preterm birth, small-for-gestational-age neonates and prolonged neonatal hospitalisation.
Postoperative care and monitoring	Ensure women planning pregnancy after bariatric/metabolic surgery receive appropriate nutritional assessment, monitoring and supplementation before conception.
Counselling	Counsel regarding likelihood of rapid return of fertility after surgery and need to delay pregnancy after surgery. Reinforce the need for ongoing multidisciplinary follow-up, adherence to nutritional supplementation and preconception optimisation before attempting pregnancy.

7.0 Assessment and Management of Psychological Features in Women with PCOS/ PMOS

7.1 Quality of Life

- Recognise that PCOS/ PMOS can significantly impair health-related quality of life across physical, emotional, social, reproductive, and metabolic domains.
- Ask women about the impact of PCOS/ PMOS symptoms (including menstrual irregularities, infertility, hirsutism, acne, obesity, and metabolic complications) on their daily functioning, emotional wellbeing, relationships, work, education, and overall quality of life.

7.2 Screening for Depression and Anxiety

- Screen all adolescents and adults with PCOS/ PMOS for symptoms of depression and anxiety at diagnosis.
- Standardise use of mental health screening tools for depression, anxiety as well as self-harm assessment (e.g. PHQ-9, GAD-7, C-SSRS).
- Consider repeat screening during follow-up based on:
 - new or worsening symptoms;
 - significant life events;
 - infertility evaluation or treatment;
 - pregnancy and the postpartum period;
 - major changes in physical symptoms or weight;
 - clinician judgement.
- Assess for:
 - depressive symptoms;
 - anxiety symptoms;
 - psychosocial stressors and risk factors;
 - risk of self-harm or suicidal ideation.
- Refer women with moderate to severe symptoms, positive screening results, or suspected psychiatric disorders for comprehensive mental health assessment and appropriate treatment.

7.3 Body Image and Self-esteem

- Discuss with women concerns related to:
 - weight;
 - hirsutism;

- acne;
- alopecia;
- fertility;
- perceived femininity and self-confidence.
- Address potentially modifiable physical symptoms alongside psychological support.
- Consider referral for psychological intervention when body image distress and low self-esteem significantly affect wellbeing or daily functioning.

7.4 Eating Disorders and Disordered Eating

- Consider eating disorders and disordered eating in all women with PCOS/ PMOS regardless of BMI.
- Identify via history diagnosable eating disorders (including anorexia nervosa, bulimia nervosa, binge-eating disorder, night-eating syndrome) and other specified or unspecified disorders of eating that are clinically significant.
- Maintain a high index of suspicion, particularly before initiating weight management interventions.
- Assess for behaviours suggestive of:
 - binge eating;
 - restrictive eating;
 - purging behaviours;
 - excessive exercise;
 - unhealthy weight-control practices.
- Refer women with suspected eating disorders to appropriately trained mental health or eating disorder services for diagnostic assessment and management.
- Avoid recommending restrictive dietary interventions in women with suspected or confirmed eating disorders without specialist input.

7.5 Psychosexual Health

- Obtain permission before initiating discussions about sexual health and address the topic in a sensitive, non-judgmental manner.
- Consider the contribution of the following to psychosexual difficulty:

- obesity;
 - hirsutism;
 - acne;
 - infertility;
 - depression and anxiety;
 - medications;
 - relationship factors;
- Refer women experiencing significant psychosexual distress for appropriate psychological, sexual health, or specialist care.

7.6 Psychological Interventions

- Consider cognitive behavioural therapy (CBT) as a first-line psychological intervention where appropriate, in women who have depression, anxiety, eating disorders, or significant psychological distress.
- Consider psychological therapies for women experiencing:
 - body image distress;
 - low self-esteem;
 - psychosexual concerns;
 - adjustment difficulties.
- Offer psychological interventions according to patient preference, symptom severity, local service availability, and existing mental health guidelines.
- Consider telehealth-delivered psychological therapy where face-to-face services are unavailable.

7.7 Pharmacological Management

- Consider psychological therapy as first-line treatment for mild to moderate depression and anxiety where appropriate.
- Consider medications for persistent moderate to severe mental illness, recurrent psychiatric disorders, or where psychological therapy alone is insufficient.
- Refer to specialist services for moderate to severe symptoms for assessment and initiation of antidepressant or anxiolytic medications when clinically indicated.
- Avoid medications associated with significant weight gain where suitable alternatives are available.

7.8 Integrated Care

- Recognise that effective management of PCOS/ PMOS symptoms, including weight, hirsutism, acne, menstrual irregularities, infertility, and metabolic complications, may improve psychological wellbeing.
- Coordinate care between primary care providers, gynaecologists, endocrinologists, dietitians, psychologists, psychiatrists, fertility specialists, and other relevant healthcare professionals when indicated.
- Ensure women have access to education, peer support, and reliable information regarding the psychological effects of PCOS/ PMOS.
- Reassess psychological wellbeing regularly as part of ongoing long-term follow-up.

8.0 Fertility and Reproductive Health

8.1 General Principles

- Reassure women with PCOS/ PMOS that pregnancy can often be achieved naturally or with appropriate fertility treatment.
- Commence prenatal vitamin supplementation before or at the start of ovulation induction, in accordance with routine preconception care.
- Exclude pregnancy before initiating ovulation induction therapy.
- Discuss the expected benefits, potential adverse effects and available evidence before commencing treatment.
- Monitor women receiving ovulation induction therapy for adverse effects and treatment response.

8.2 Preconception Assessment

8.2.1 Lifestyle optimisation

- Counsel women regarding the adverse effect of excess weight on fertility, miscarriage and live birth rates.
- Aim to optimise weight before conception or commencement of fertility treatment, with a target BMI of at least $<35\text{kg/m}^2$.
- Encourage weight reduction to a BMI $<30\text{ kg/m}^2$ before conception where feasible, particularly in women with sufficient time available (e.g. age <37 years and normal ovarian reserve).
- Recommend a weight loss of 5–10% in women with overweight or obesity, where appropriate, to improve ovulation and fertility.
- Advise adherence to the general lifestyle management recommendations for dietary and physical activity guidance to optimise weight, metabolic health and fertility outcomes.
- Encourage smoking cessation and avoidance of alcohol and recreational drugs.

8.2.2 Medical assessment

- Assess:
 - Blood pressure
 - Body mass index
 - Glycaemic status (using a 75 g OGTT)
 - Lipid profile when indicated
- Optimise management of:
 - Diabetes
 - Hypertension
 - Dyslipidaemia
 - Thyroid disease
 - Mental health disorders
- Review all medications before conception and discontinue contraindicated drugs.

8.2.3 Nutritional supplementation

- Offer folic acid before conception according to national recommendations.
- Advise higher-dose folic acid of 5 mg once daily for women with BMI ≥ 30 kg/m².
- Assess and treat vitamin D deficiency when indicated.
- Correct iron deficiency before pregnancy whenever detected and correction is possible.

8.2.4 Pregnancy counselling

- Inform women that PCOS/ PMOS is associated with an increased risk of:
 - Miscarriage
 - Gestational diabetes
 - Hypertensive disorders of pregnancy
 - Preterm birth
 - Caesarean birth
 - Large-for-gestational-age infants
- Explain that optimisation of health before conception reduces maternal and neonatal complications.
- Encourage early antenatal booking and continued pregnancy surveillance.

8.3 Fertility Assessment

- Offer initiation of fertility assessment without delay on presentation for women with oligo-and anovulatory menstrual cycles or a diagnosis of PCOS/ PMOS.
- Evaluate both partners.
- Exclude other causes of infertility, including:
 - Tubal disease
 - Endometriosis
 - Uterine abnormalities
 - Male factor infertility
- Assess ovarian reserve only when clinically indicated.
- Consider tubal patency testing before ovulation induction in selected women, especially those with clinical history of factors associated with tubal infertility

8.4 Ovulation Induction

8.4.1 Letrozole

- Offer letrozole as first-line pharmacological treatment for ovulation induction in infertile anovulatory women with PCOS/ PMOS who have no other infertility factors.
- Exclude pregnancy before commencing treatment.
- Inform women that letrozole is associated with higher ovulation, clinical pregnancy and live birth rates than clomiphene citrate.
- Counsel women regarding the small risk of multiple pregnancy.
- **Recommended regimen:**
 - Commence **2.5 mg orally once daily for 5 days**, starting on **day 2–5 of the menstrual cycle**.
 - Increase the dose in subsequent cycles to **5 mg daily**, then **7.5 mg daily** If ovulation does not occur.
 - Maximum dose: **7.5 mg daily**.
 - Limit treatment to **up to six ovulatory cycles**.
- Consider ultrasound monitoring during treatment, particularly during dose escalation or when there is concern regarding multifollicular development.

8.4.2 Clomiphene Citrate

- Consider clomiphene citrate when letrozole is unavailable contraindicated or unsuccessful.
- Consider metformin as an adjunct in women with obesity, insulin resistance or clomiphene resistance.
- Counsel women regarding the increased risk of multiple pregnancy with clomiphene citrate.
- **Recommended regimen:**
 - Commence **50 mg orally once daily for 5 days**, beginning on **day 2–5 of the menstrual cycle**.
 - Increase by **50 mg per cycle** if ovulation does not occur after 2 cycles.
 - Maximum dose: **150 mg daily**
 - Limit treatment to **up to six ovulatory cycles**.
- Consider ultrasound monitoring during treatment, particularly during dose escalation or when there is concern regarding multifollicular development.
- Document clomiphene resistance when ovulation is not achieved despite treatment with the maximum recommended dose of clomiphene citrate.
- Document clomiphene failure when pregnancy is not achieved despite successful ovulation following clomiphene citrate treatment.

8.4.3 Metformin

- Consider metformin in women with:
 - Obesity (BMI ≥ 30 kg/m²).
 - Insulin resistance.
 - Clomiphene resistance.
- Inform women that metformin alone is less effective than letrozole or clomiphene citrate.
- Counsel women regarding gastrointestinal adverse effects.
- **Recommended regimen:**
 - Commence **500 mg once daily with food**.
 - Increase gradually by **500 mg every 1–2 weeks** according to tolerance.
 - Usual maintenance dose: **1,500–2,000 mg daily** in divided doses.
 - Maximum dose: **2,500 mg daily**.

8.4.4 Combination therapy

- Consider clomiphene citrate combined with metformin to improve ovulation and pregnancy rates in selected women.

8.5 Gonadotrophins

- Offer gonadotrophins as second-line therapy after failure of oral ovulation induction.
- Use a low-dose step-up protocol to minimise risk of multiple pregnancy.
- Perform serial transvaginal ultrasound monitoring.
 - Initially after the first 4 to 5 days of starting treatment.
 - Subsequently, at intervals of 1 to 3 days according to response.
- Recommended regimen:
 - Start at **37.5 to 75 IU FSH daily**.
 - Increase the dose in small **increments of 25 to 37.5 IU** after **7–14 days** if there is an inadequate ovarian response (if no follicle >10 mm has developed).
 - Aim for **single follicle development**.
- Cancel the cycle if > 2 follicles measuring ≥ 16 mm develop.
- Advise avoidance of unprotected intercourse if the cycle is cancelled because of excessive follicular response.

8.5.1 Trigger for Ovulation

- Administer human chorionic gonadotrophin (hCG) 5,000 IU when at least one dominant follicle measures ≥ 18 mm.
- Do not administer hCG if two or more follicles >16 mm are present because of the increased risk of multiple pregnancy.

8.6 Laparoscopic Ovarian Surgery

- Consider laparoscopic ovarian diathermy / laparoscopic ovarian drilling as second-line treatment for women with anovulatory infertility resistant to pharmacological ovulation induction therapy.
- Do not offer laparoscopic ovarian surgery as first-line therapy.

- Discuss:
 - Benefits.
 - Operative risks.
 - Possible reduction in ovarian reserve.
- Recommended technique:**
 - Use monopolar or bipolar diathermy.
 - Apply **4 diathermy points** per ovary, **at 40 watts** for **4 seconds** at each diathermy point, to reduce the amount of damage to the surface of the ovary and risk of peri-ovarian adhesions.
 - Instil **500–1,000 mL of an isotonic solution** into the pouch of Douglas at the end of the procedure to cool the ovaries and reduce postoperative adhesions.

8.7 Assisted Reproductive Technology

8.7.1 In vitro fertilisation (IVF)

- Offer IVF when first- and second-line ovulation induction treatments fail or where another indication for IVF exists.
- Counsel women regarding the increased risk of ovarian hyperstimulation syndrome (OHSS).
- Recommend elective single embryo transfer where appropriate, to minimise the risk of multiple pregnancies.

8.7.2 GnRH antagonist protocol

- Use a GnRH antagonist protocol to reduce the risk of OHSS in women with PCOS/ PMOS undergoing IVF.
- Consider GnRH agonist trigger with a freeze-all strategy in women at high risk of OHSS.

8.7.3 Trigger type

- Use GnRH agonist trigger for final oocyte maturation, and freeze all suitable embryos:
 - In an IVF/ICSI cycle with a GnRH antagonist protocol.
 - Where a fresh embryo transfer is not intended.
 - Where there is an increased risk of ovarian hyperstimulation syndrome.

- Inform patients that GnRH agonist trigger has lower pregnancy rates compared to hCG trigger, especially in fresh embryo transfers, however hCG triggers are associated with higher risk of OHSS.

8.7.4 Controlled ovarian stimulation

- Use either urinary or recombinant FSH.
- Do not routinely add exogenous recombinant LH in combination with FSH.
- Select the gonadotrophin preparation (e.g. hMG, urinary FSH, recombinant FSH, with or without LH supplementation) based on availability, cost, and patient or clinician preference, as fertility outcomes are comparable.

8.7.5 Adjunct metformin

- Consider metformin in women with PCOS / PMOS undergoing IVF, especially with a long GnRH agonist protocol to reduce the risk of OHSS and miscarriage.

8.7.6 In vitro maturation (IVM)

- Consider IVM in women at very high risk of OHSS, as it limits or omits ovarian stimulation prior to oocyte retrieval.
- Consider IVM only in facilities and clinical units with sufficient expertise.
- Counsel women that live birth rates are lower than conventional IVF.

8.8 Complementary and Adjunctive Therapies

8.8.1 Inositol

- Do not routinely recommend inositol for infertility treatment in PCOS/ PMOS.
- Inform women that current evidence regarding efficacy and safety is limited.
- Discuss the variability in commercially available preparations.

8.8.2 Anti-obesity Medications

- Do not use anti-obesity medications solely to improve fertility outside research settings.
- Counsel women regarding the limited evidence for reproductive outcomes.
- Ensure effective contraception while using GLP-1 receptor agonists.
- Discontinue treatment before attempting conception in accordance with product recommendations.

9.0 Pregnancy in Women with PCOS/ PMOS

9.1 Prepregnancy counselling and optimisation

- Recognise women with PCOS/ PMOS as being at increased risk of adverse pregnancy outcomes.
- Inform women with PCOS/ PMOS that, while most pregnancies result in healthy maternal and neonatal outcomes, they have an increased risk of specific obstetric and neonatal complications.
- Provide preconception counselling for women with PCOS/ PMOS; include discussion of:
 - BMI optimisation
 - Glycaemic screening
 - Increased risk of miscarriage
 - Increased risk of gestational diabetes mellitus
 - Increased risk of hypertensive disorders
 - Increased risk of preterm birth
- Optimise maternal health before and during pregnancy through appropriate weight management, glycaemic assessment, blood pressure monitoring, and management of comorbidities.
- Ensure multidisciplinary care where appropriate, particularly for women with obesity, diabetes, hypertension, or other significant medical disorders.

9.2 Pregnancy Risks

- Counsel women with PCOS/ PMOS regarding their increased risk of:
 - Miscarriage.
 - Gestational diabetes mellitus (GDM).
 - Gestational hypertension.
 - Pre-eclampsia.
 - Preterm birth.
 - Caesarean birth.
 - Low birth weight and fetal growth restriction.
 - Neonatal intensive care unit (NICU) admission.
- Inform women that obesity with or without PCOS/ PMOS further increases adverse pregnancy outcomes.

9.3 Antenatal Assessment and Monitoring

9.3.1 At Booking

- Document a diagnosis of PCOS/ PMOS at the first antenatal visit on the antenatal record.
- Assess BMI and blood pressure.
- Assess for additional metabolic risk factors, including previous gestational diabetes, family history of diabetes, and obesity.
- Consider early assessment of glucose metabolism in women at high risk of hyperglycaemia in pregnancy.
- Counsel regarding healthy gestational weight gain, nutrition and physical activity.
- Consider early referral of women with PCOS/ PMOS who have obesity, previous gestational diabetes, chronic hypertension or multiple metabolic risk factors to specialist obstetric services.
- In geographically remote settings, prioritise early risk assessment and timely referral to regional or tertiary centres for women with additional pregnancy risk factors.

9.3.2 During Pregnancy

- Offer screening for gestational diabetes in accordance with national guidance, with consideration of earlier testing in women at high risk or with multiple risk factors for hyperglycemia in pregnancy.
- Monitor blood pressure throughout pregnancy with increased vigilance for hypertensive disorders.
- Monitor fetal growth according to routine obstetric indications.
- Provide standard obstetric surveillance while individualising care according to maternal risk factors.

9.4 Metformin During Pregnancy

- Do not routinely continue or commence metformin during pregnancy solely to prevent pregnancy complications in women with PCOS/ PMOS.
- Consider continuing or initiating metformin on an individual basis after shared decision-making where there is a potential clinical benefit.

- Counsel women that:
 - metformin has not consistently been shown to reduce the risk of gestational diabetes, hypertensive disorders, miscarriage or other major pregnancy complications;
 - evidence suggests metformin may reduce the risk of preterm birth and modestly prolong gestation;
 - long-term effects on offspring remain uncertain and continue to be investigated.

9.5 Intrapartum and Neonatal Care

- Plan intrapartum care according to standard obstetric indications.
- Inform neonatal services when maternal risk factors indicate an increased likelihood of neonatal complications or NICU admission.
- Ensure appropriate referral and transfer planning for women receiving care in regional facilities who require higher-level obstetric or neonatal services.

9.6 Postpartum Care

- Offer postpartum glucose testing to women who develop gestational diabetes in accordance with national guidance.
- Assess cardiovascular and metabolic risk following pregnancy, particularly in women who experienced gestational diabetes or hypertensive disorders.
- Counsel women regarding healthy lifestyle measures to reduce future cardiometabolic risk.
- Ensure ongoing long-term follow-up for metabolic health as part of routine PCOS/ PMOS management.

10.0 Special Considerations in Adolescence

PCOS/ PMOS diagnosis and management in adolescents require careful consideration because features of normal pubertal development may overlap with PCOS/ PMOS. Management should focus on symptom control, prevention of long-term metabolic complications and psychological wellbeing.

10.1 Diagnosis in Adolescents

- Use adolescent-specific criteria when diagnosing PCOS/ PMOS, recognising that irregular menstrual cycles and acne may be physiological features of puberty.
- Discuss with patients and guardians the diagnostic challenges at this life stage, and the optimal timing of assessment and diagnosis in adolescents with irregular cycles.

Criterion	Recommendation
Diagnosis of PCOS/ PMOS	Diagnose PCOS/ PMOS only when both of the following are present after exclusion of other disorders: • Persistent menstrual irregularity according to years since menarche • Clinical and/or biochemical hyperandrogenism.
Adolescents "at increased risk" of PCOS/ PMOS	• Consider adolescents at increased risk if: ◦ Only one diagnostic feature is present (either persistent menstrual irregularity or clinical/biochemical hyperandrogenism). ◦ Features are present before being commenced on any hormonal therapy (if commenced before diagnosis of PCOS/ PMOS) ◦ Persisting or progressive features/ symptoms with age ◦ Significant weight gain in adolescence • Manage symptoms and provide ongoing follow-up.
Pelvic ultrasound	Do not use pelvic ultrasound or polycystic ovarian morphology for diagnosis in adolescents. Pelvic ultrasound should not be used for diagnosis until 8 years after menarche .
Anti-Müllerian hormone (AMH)	Do not use AMH for the diagnosis of PCOS/ PMOS in adolescents.
Reassessment of adolescents "at increased risk"	Reassess adolescents at increased risk at or before full reproductive maturity (8 years post-menarche) , or earlier if symptoms progress or new clinical features develop.

10.2 Management in Adolescents

- Provide education and reassurance regarding PCOS/ PMOS, its symptoms, long-term health implications and available treatment options.
- Offer lifestyle intervention to all adolescents with PCOS/ PMOS, focusing on:
 - Healthy eating patterns.
 - Regular physical activity.
 - Prevention of excess weight gain.
 - Positive body image.
- Avoid weight-focused approaches that may negatively affect psychological wellbeing.
- Consider COCPs for adolescents with persistent menstrual irregularity or bothersome hyperandrogenic symptoms, following assessment of eligibility and preferences.
- Consider metformin in adolescents with PCOS/ PMOS who have metabolic risk factors, including:
 - Higher BMI.
 - Impaired glucose tolerance.
 - Increased diabetes risk.
- Consider psychological screening and support, particularly for:
 - Anxiety or depression.
 - Body image concerns.
 - Disordered eating.
 - Reduced quality of life.
- Provide age-appropriate counselling regarding contraception, fertility and future reproductive health.

10.3 Transition of Care

- Ensure adolescents with PCOS/ PMOS receive coordinated transition to adult healthcare services when appropriate.
- Encourage self-management skills, including understanding of symptoms, lifestyle measures, medications and long-term follow-up needs.

11.0 Long-Term Health Risks and Lifelong Follow-up

11.1 Glycaemic Assessment and Risk of Diabetes mellitus

- Offer assessment of glycaemic status to all women at diagnosis of PCOS/ PMOS.
- Use a 75-g oral glucose tolerance test (OGTT) as the preferred method for assessing glycaemic status.
- Consider fasting plasma glucose or HbA1c only when an OGTT cannot be performed.
- Repeat glycaemic assessment every 1–3 years according to individual risk factors, including:
 - Higher BMI or central adiposity.
 - Increasing age.
 - Previous gestational diabetes.
 - Family history of type 2 diabetes mellitus.
 - Other metabolic risk factors.
- Offer a 75-g OGTT to:
 - Women with PMOS/PCOS and BMI ≥ 25 kg/m².
 - Women with BMI < 25 kg/m² who have additional diabetes risk factors, including:
 - Age > 40 years.
 - Previous gestational diabetes.
 - Family history of type 2 diabetes mellitus.
- Offer an OGTT before conception or fertility treatment if it has not been performed within the previous year.
- Monitor women with impaired fasting glucose or impaired glucose tolerance regularly for progression to diabetes.
- Consider metformin in women with impaired glucose tolerance who have not achieved improvement despite appropriate lifestyle intervention.

11.2 Cardiovascular Risk Assessment

- Assess cardiovascular risk factors at diagnosis and periodically thereafter, including:
 - Blood pressure.
 - Body weight and BMI.
 - Waist circumference where appropriate.
 - Lipid profile.
- Glycaemic status.
- Assess smoking status.
- Assess family history of premature cardiovascular disease.
- Optimise management of hypertension, dyslipidaemia and diabetes according to national cardiovascular risk management guidelines.
- Refer women with pre-existing cardiovascular or metabolic conditions for appropriate specialist optimisation when required.

11.3 Psychological, Psychosocial and Psychosexual Health

- Assess psychological wellbeing at diagnosis and during ongoing care.
- Screen for symptoms of anxiety and depression using validated screening tools where available.
- Assess body image concerns and psychological distress associated with:
 - Hirsutism.
 - Acne.
 - Obesity.
 - Infertility or reproductive challenges.
- Consider assessment for disordered eating behaviours when clinically indicated, regardless of body weight.
- Consider assessment of psychosexual wellbeing, including concerns related to body image, sexual function and self-esteem.
- Provide information regarding available mental health support services.
- Refer women with moderate or severe psychological symptoms or diagnosed psychological disorders for appropriate counselling and management by qualified mental health professionals.

11.4 Obstructive Sleep Apnoea

- Assess for symptoms of obstructive sleep apnoea at diagnosis and during follow-up, particularly in women with obesity and metabolic dysfunction.
- Assess symptoms including:
 - Loud snoring.
 - Witnessed apnoea.
 - Excessive daytime sleepiness or fatigue.
 - Waking unrefreshed from sleep.
- Screen women at increased risk using validated questionnaires where available (e.g., the Berlin Questionnaire).
- Consider referral for diagnostic sleep assessment in women with suggestive symptoms.
- Refer women with confirmed or suspected obstructive sleep apnoea for appropriate specialist management.

11.5 Endometrial Hyperplasia and Endometrial Cancer

- Inform women that PCOS/ PMOS is associated with an increased risk of endometrial hyperplasia and endometrial cancer, although the absolute risk remains low.
- Do not perform routine endometrial cancer screening in asymptomatic women.
- Treat oligo- or amenorrhoea with cyclical progestogen therapy to induce a withdrawal bleed at least every 3–4 months if spontaneous menstruation does not occur.
- Consider transvaginal ultrasound in women with:
 - Persistent amenorrhoea without withdrawal bleeding.
 - Abnormal uterine bleeding.
- Perform endometrial biopsy and/or hysteroscopy when indicated, particularly when increased endometrial thickness is identified or when additional risk factors are present, including:
 - Long-standing untreated amenorrhoea.
 - Abnormal uterine bleeding or heavy menstrual bleeding.
 - Obesity.
 - Type 2 diabetes mellitus.
- Counsel women regarding preventive strategies, including:
 - Weight management.
 - Menstrual cycle regulation.
 - Appropriate progestogen therapy.

11.6 Menopause and Post-Reproductive Life Stage

- Consider PCOS/ PMOS as a lifelong condition, with clinical and metabolic features that may persist beyond the reproductive years.
- Recognise that clinical and biochemical hyperandrogenism may persist after menopause in women with PCOS/ PMOS, although androgen levels generally decline with age.
- Consider a diagnosis of PCOS/ PMOS in postmenopausal women only when there is:
 - A documented diagnosis before menopause; or
 - A well-established history during reproductive years (approximately 20–40 years of age) of:
 - Oligo-ovulation or amenorrhoea.
 - Clinical and/or biochemical hyperandrogenism, with or without polycystic ovarian morphology.
- Do not diagnose PCOS/ PMOS solely on the basis of postmenopausal ovarian morphology or androgen levels in women without a compatible reproductive history.
- Investigate postmenopausal women with new-onset, severe or rapidly progressive hyperandrogenism, particularly worsening hirsutism or virilisation, to exclude:
 - Androgen-secreting ovarian or adrenal tumours.
 - Ovarian hyperthecosis.
 - Other causes of androgen excess.

11.7 Lifelong Follow-up and Continuity of Care

- Provide regular follow-up according to individual risk factors, age, symptoms and treatment goals.
- Monitor metabolic, reproductive, psychological and quality-of-life outcomes throughout life.
- Ensure continuity of care across reproductive, metabolic and menopausal life stages.
- Use a multidisciplinary approach involving appropriate healthcare professionals according to individual needs.
- Support shared decision-making and provide culturally appropriate information to enable women to participate actively in lifelong PCOS/ PMOS management.

11.8 SUMMARY TABLE - LIFELONG FOLLOW UP OF WOMEN WITH PCOS / PMOS

Time Point	Assessment	Recommended Action
At diagnosis:	Weight, height, BMI, waist circumference, Blood pressure, hirsutism, acne, alopecia	Establish baseline and document
	Menstrual history and ovulatory status, pregnancy intentions and contraception needs	Establish baseline
	Mental health (anxiety, depression, body image, eating disorders)	Establish baseline
	Sleep assessment (particularly if overweight/obese)	
	Family history (diabetes, CVD, endometrial cancer)	Establish baseline
	Glycaemic assessment (OGTT or HbA1c and FBS) Lipid profile, thyroid profile where indicated Nutritional assessments including serum iron, ferritin, calcium and magnesium, where appropriate.	Establish baseline
Every Visit:	Weight/BMI and waist circumference Blood pressure	Measure and reinforce lifestyle interventions
	Menstrual regularity	Assess endometrium
	Pregnancy planning/contraception	Discuss management as appropriate
	Lifestyle (diet, exercise, smoking, sleep)	Review and reinforce
	Medication adherence and adverse effects	Review
Annually / Every 1-5 years	Mental health screening: with validated tools for anxiety, depression and quality of life. Address psychosexual health, body image issues and eating disorders	Assess and Reinforce lifestyle interventions. Refer for assessment psychological therapy or treatment

Cardiovascular risk review: BP, smoking, obesity, diabetes risk and physical activity, Lipid profile	Assess more frequently if abnormal
Hyperandrogenic symptoms	Review and reinforce
Sleep symptoms/ OSA : Screen for obstructive sleep apnoea with validated tools (e.g. Berlin questionnaire). Confirm with sleep study	Review and reinforce
Glycaemic status: Repeat OGTT, HbA1c/FBS according to risk profile	Review and reinforce
Liver function/NAFLD assessment	Metabolic risk factors
Endometrial assessment: routine ultrasound screening is not recommended	Evaluation and management of abnormal uterine bleeding
Fertility assessment	When pregnancy is desired

Appendix

Appendix 1: PHQ-9 and GAD-7 Screening Tools

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

*Over the **last 2 weeks**, how often have you been bothered by any of the following problems?
Please circle your answers.*

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very Difficult Extremely Difficult

*Over the **last 2 weeks**, how often have you been bothered by any of the following problems?
Please circle your answers.*

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very Difficult Extremely Difficult

UHS Rev 4/2020

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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Appendix 2: C-SSRS Screening Tool

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version – Since Last Visit

SUICIDE IDEATION DEFINITIONS AND PROMPTS		Since Last Visit	
Ask questions that are bold and underlined		YES	NO
Ask Questions 1 and 2			
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>			
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. <u>Have you actually had any thoughts of killing yourself?</u>			
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6			
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it." <u>Have you been thinking about how you might do this?</u>			
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them." <u>Have you had these thoughts and had some intention of acting on them?</u>			
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?</u>			
6) Suicide Behavior <u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.			

- Low Risk
- Moderate Risk
- High Risk

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Appendix 3: Berlin Questionnaire

Berlin questionnaire

Name _____

Address _____

SLEEP EVALUATION

1 Complete the following:

height _____ age _____

weight _____ male/female _____

CATEGORY 1

2 Do you snore?

- ☐ yes
☐ no
☐ don't know

If you snore:

3 Your snoring is?

- ☐ slightly louder than breathing
☐ as loud as talking
☐ louder than talking
☐ very loud. Can be heard in adjacent rooms.

4 How often do you snore?

- ☐ nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ never or nearly never

5 Has your snoring ever bothered other people?

- ☐ yes
☐ no

6 Has anyone noticed that you quit breathing during your sleep?

- ☐ nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ never or nearly never

CATEGORY 2

7 How often do you feel tired or fatigued after your sleep?

- ☐ nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ never or nearly never

8 During your wake time, do you feel tired, fatigued or not wake up to par?

- ☐ nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ never or nearly never

9 Have you ever nodded off or fallen asleep while driving a vehicle?

- ☐ yes
☐ no

If yes, how often does it occur?

- ☐ nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ never or nearly never

CATEGORY 3

10 Do you have high blood pressure?

- ☐ yes
☐ no
☐ don't know

BMI = _____

Scoring Questions: Any answer within box outline is a positive response.

Scoring Categories: Category 1 is positive with 2 or more positive responses to questions 2-6 ☐

Category 2 is positive with 2 or more positive responses to questions 7-9 ☐

Category 3 is positive with 1 or more positive responses and/or a BMI > 30 ☐

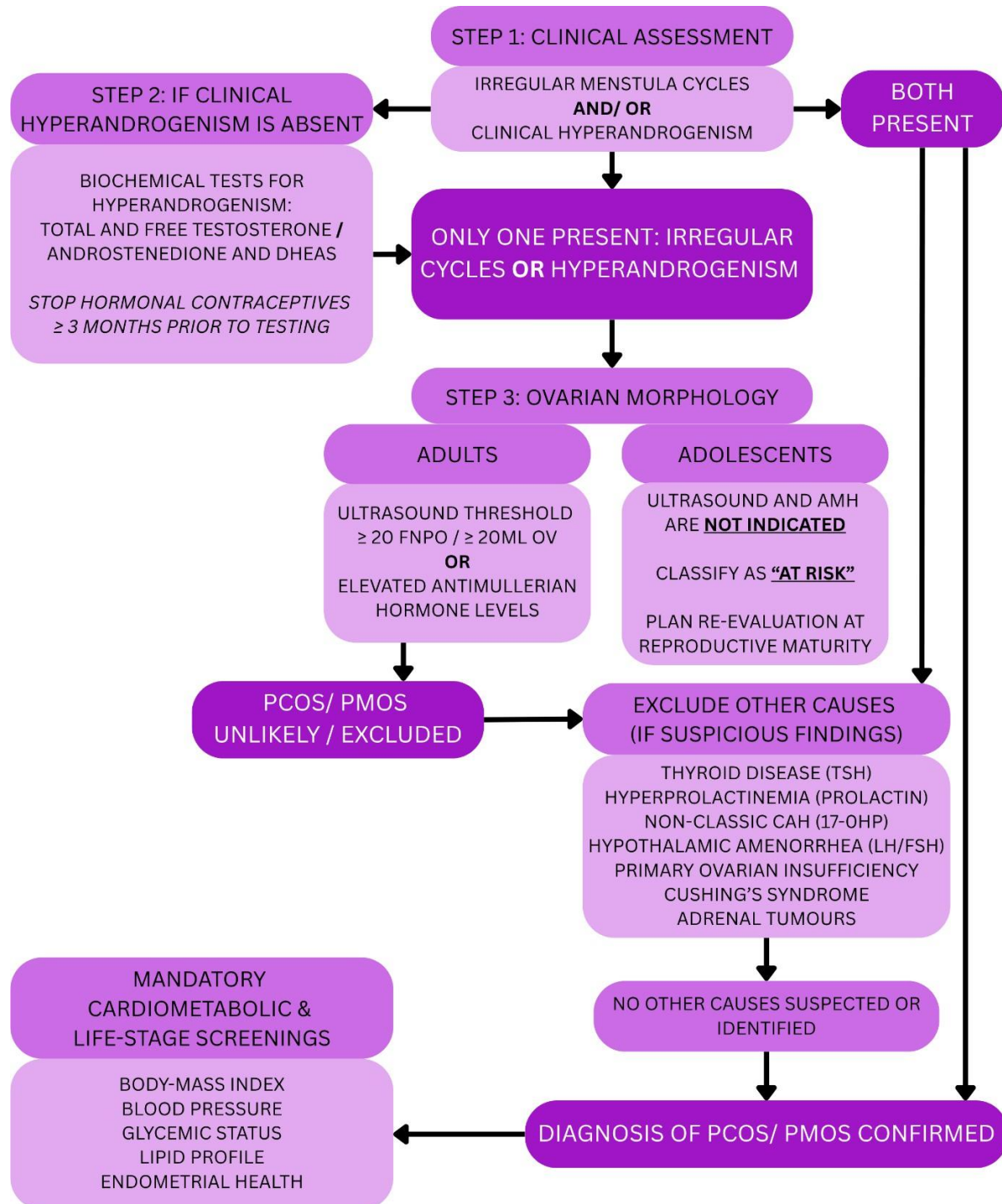
Final Results: 2 or more positive categories indicates a high likelihood of sleep disordered breathing.

REFERRAL COPY

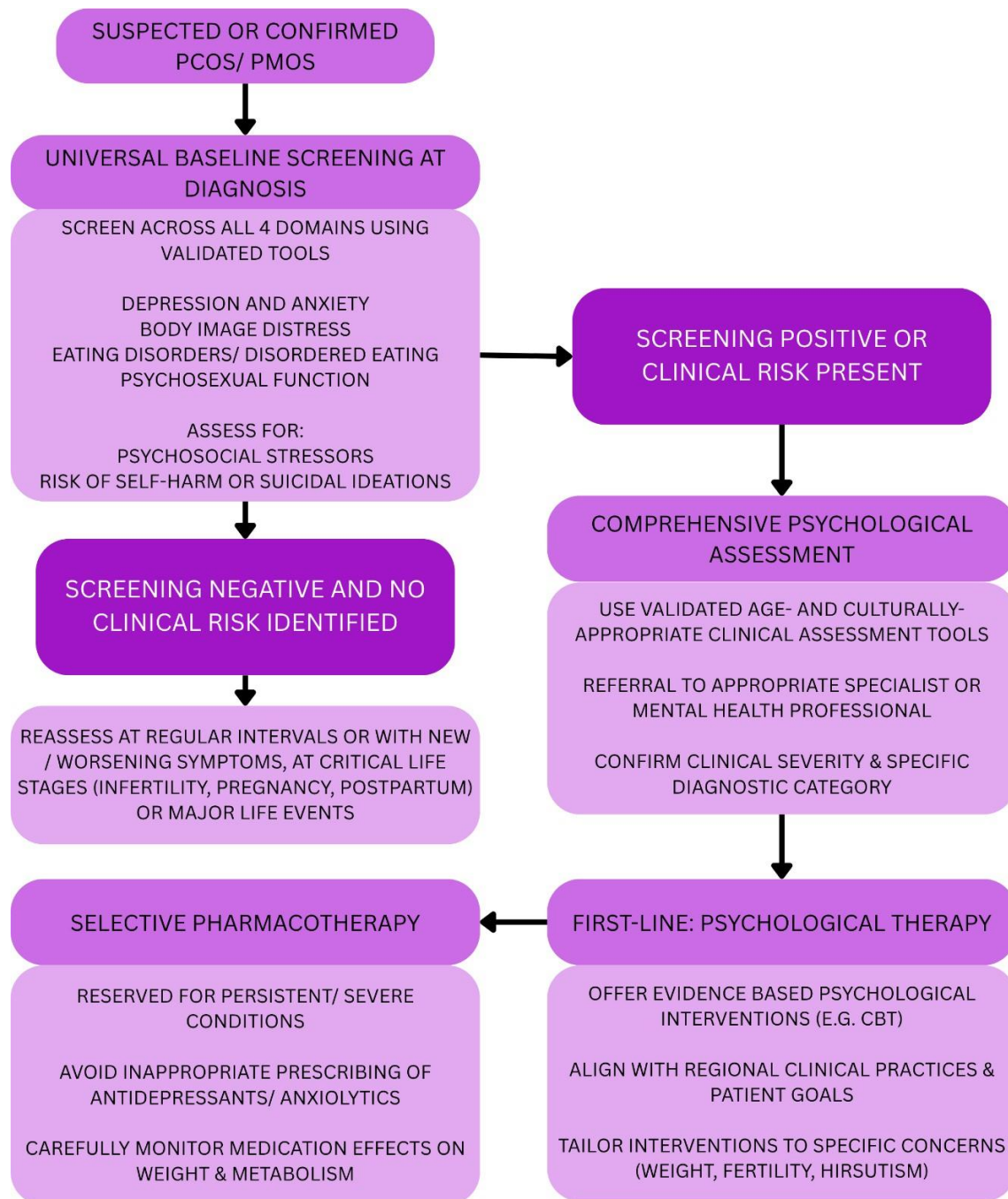
EDWARD

Algorithms

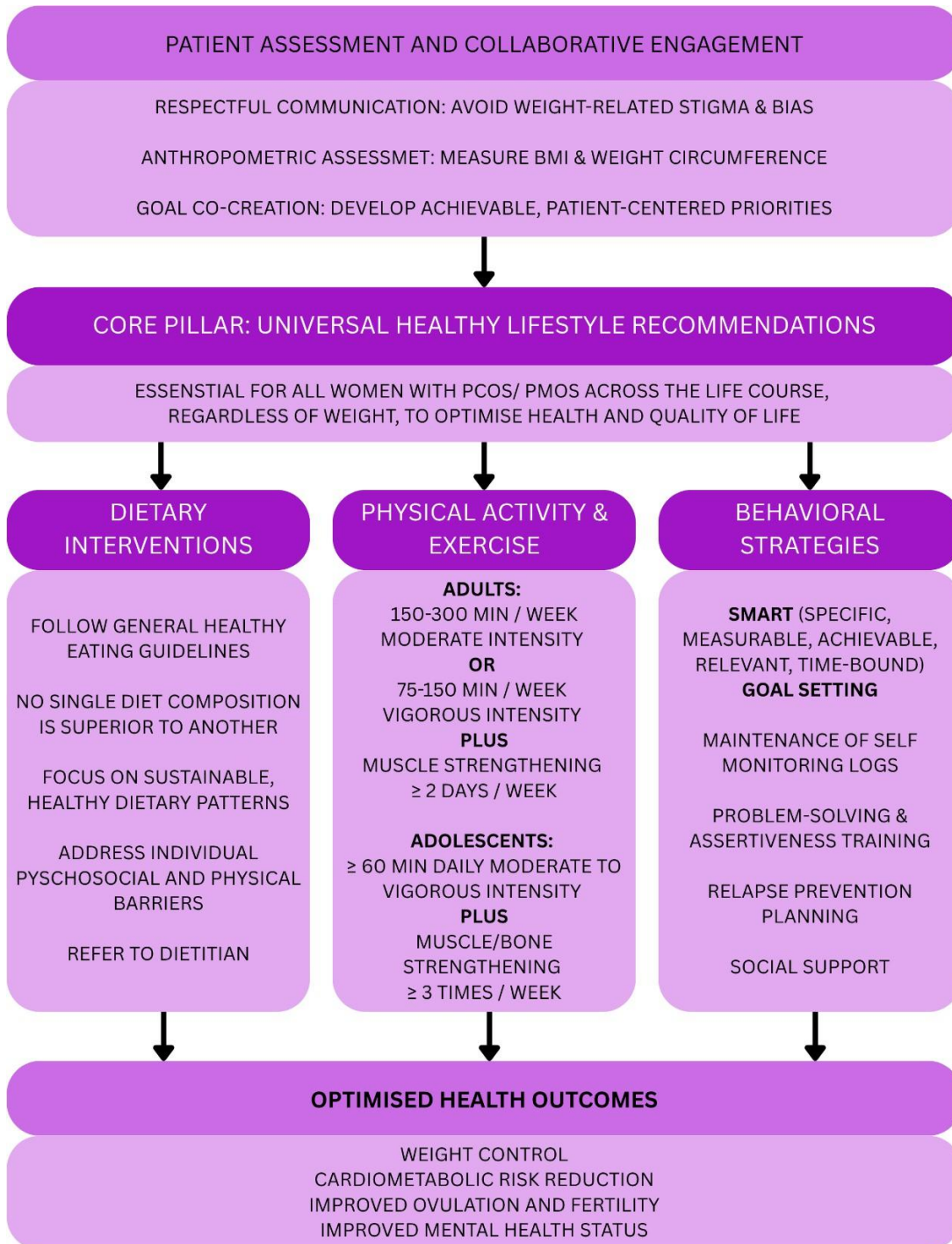
Algorithm 1: Screening, Diagnosis and Risk Assessment



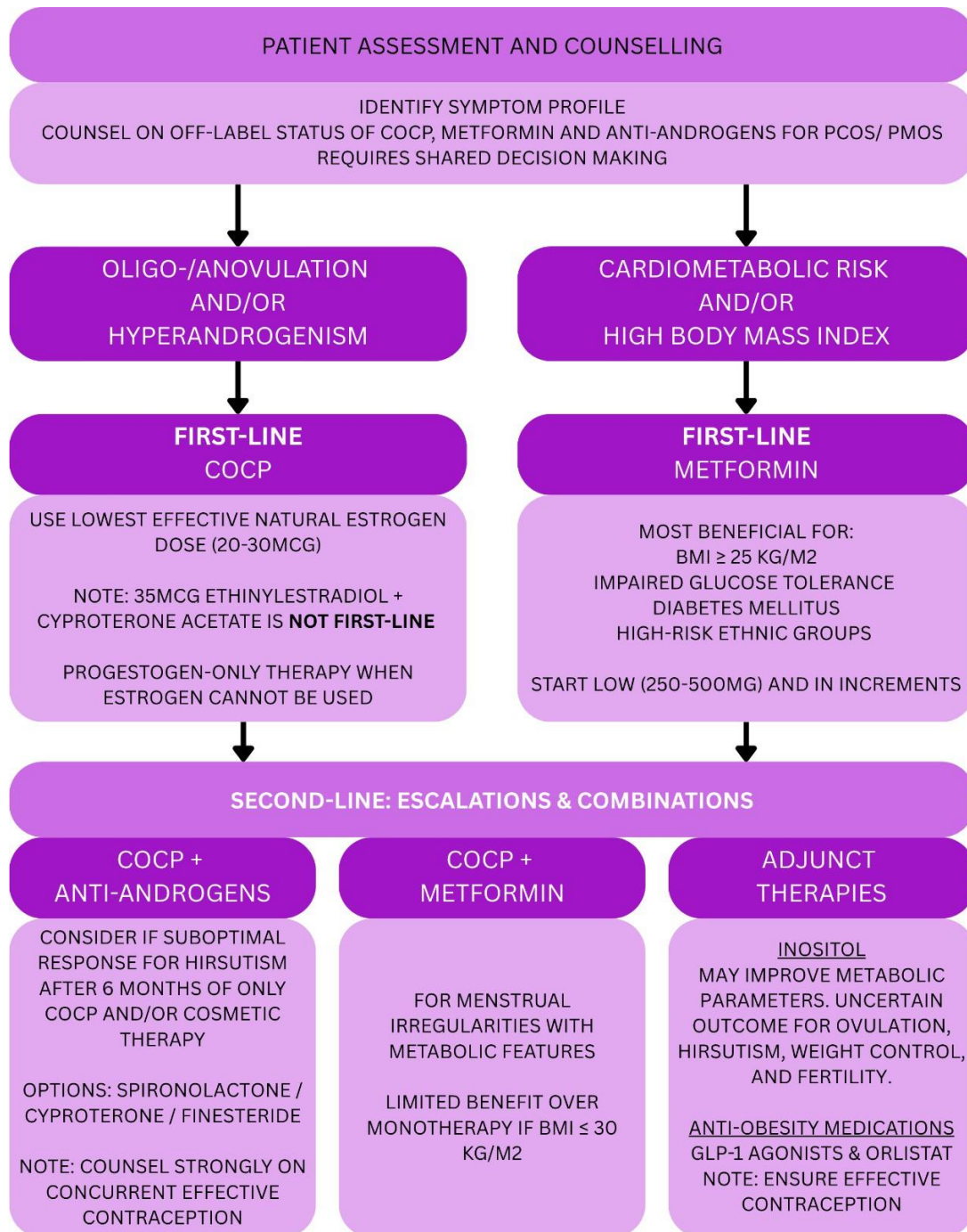
Algorithm 2: Emotional Well-Being & Psychological Care



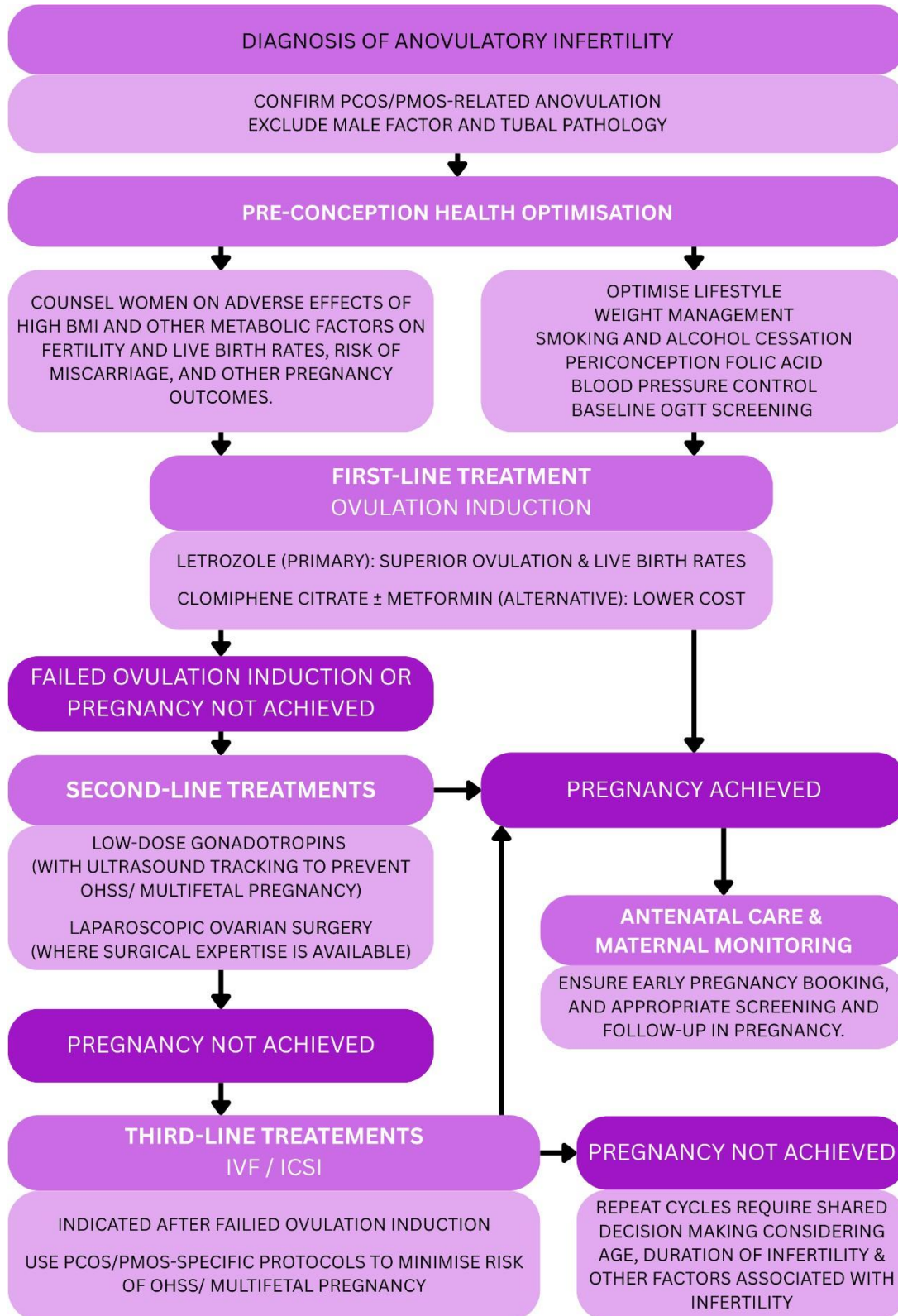
Algorithm 3: Lifestyle & Weight Optimisation



Algorithm 4: Pharmacological Management (Non-Fertility)



Algorithm 5: Management of Anovulatory Infertility



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