Polycystic Ovary Syndrome

Diagnosis and cardiometabolic/endometrial risk screening in polycystic ovary syndrome.

2023 International Guideline
PCOS Assessment & Management Guideline
Teede et al. · Monash University 2023

GRADE — EBR · Evidence-Based | CR · Consensus | PP · Practice Point

1 Diagnosis (Adults)

CR — Diagnose with **2 of 3**: (i) clinical/biochemical hyperandrogenism, (ii) ovulatory dysfunction, or (iii) polycystic ovaries on ultrasound **or** elevated AMH — after excluding thyroid disease, hyperprolactinemia, and non-classic CAH (TSH, prolactin, 17-OHP).

PP — **Adolescents:** require both irregular cycles (per menarche-based thresholds) **and** hyperandrogenism — ultrasound/AMH **not recommended** within 8 years of menarche given overlap with normal physiology; reassess "at-risk" cases over time.

CR — Further evaluate for **hypogonadotropic hypogonadism, Cushing's disease, or androgen-secreting tumor** if amenorrhea or severe clinical features are present — overt virilization is inconsistent with PCOS.

CR — PCOS can be considered an **enduring/lifelong diagnosis**; a postmenopausal diagnosis can rely on a documented history of features earlier in life.

2 Cardiometabolic Screening

DOMAIN	RECOMMENDATION
CV risk	Consider all women with PCOS at increased cardiovascular risk; assess risk factors at diagnosis
Lipids	Full lipid profile at diagnosis regardless of age/BMI; repeat frequency guided by results and risk factors
Blood pressure	Annually, and when planning pregnancy or fertility treatment (high risk of hypertensive pregnancy disorders)
Glycemic status	Assess at diagnosis regardless of age/BMI (OGTT preferred); reassess every 1–3 years based on risk factors
Obstructive sleep apnea	Higher prevalence in PCOS — maintain a low threshold for screening/referral

3 Endometrial Risk

PP — Women with PCOS have markedly **higher risk of endometrial hyperplasia/cancer** — inform patients, but overall absolute risk remains low, so **routine screening is not recommended**; investigate abnormal bleeding or thickened endometrium as in the general population.

4 Emotional Wellbeing

EBR — Be aware of the **high prevalence of moderate-to-severe depressive and anxiety symptoms** in PCOS — screen routinely; if detected, assess severity and manage or refer per standard care.

EBR — Consider **disordered eating and eating disorders** in PCOS regardless of BMI; refer to a qualified professional if suspected.

CR — Seek permission to discuss **psychosexual function** and body-image concerns; consider psychological therapy as first-line for associated depression, anxiety, or disordered eating alongside lifestyle and medical therapy.

5 Lifestyle Management

EBR — **Lifestyle intervention** (exercise alone, or diet + exercise combined) is first-line for the prevention and management of weight/metabolic features and should be encouraged for all women with PCOS. Any diet/activity pattern consistent with general population guidelines confers benefit — no single approach is superior.

CR — Use **behavioral strategies** (goal-setting, self-monitoring) to support lifestyle change; be aware of and actively counter **weight stigma** in clinical encounters.

6 Fertility & Ovulation Induction

EBR — **Letrozole** should be first-line pharmacological therapy for ovulation induction (still off-label in many countries) — preferred over clomiphene citrate for improved live-birth rates.

EBR — **Clomiphene + metformin** can be used rather than clomiphene alone to improve ovulation/pregnancy rates; combined-cycle monitoring should match clomiphene-alone monitoring. Multiple-pregnancy risk is increased with clomiphene (± metformin) — counsel and monitor accordingly.

Remember — This guideline is co-published for management alongside the Endocrine Society's Hirsutism guideline (see PCOS-specific card here for diagnosis, screening, wellbeing, and fertility content).

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