# Hirsutism

Diagnosis, general approach, pharmacologic treatment, and hair removal for premenopausal women with hirsutism.

**2018 Endocrine Society**
Hirsutism Clinical Practice Guideline
Martin et al. · JCEM 2018;103:1233-1257

GRADE — 1 · Strong For | 2 · Suggest For | 2- · Suggest Against | 3 · Strong Against

## 1 Diagnosis

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| 2 | Test androgens (early AM **total + free testosterone**, reliable specialty assay) in all women with an **abnormal hirsutism score** — or with normal testosterone if hair growth is moderate/severe, or mild with other hyperandrogenic clinical clues (menstrual disturbance, progression despite therapy). |
| 2 | Screen hyperandrogenemic women for **NCCAH** (21-hydroxylase deficiency) via early-AM 17-hydroxyprogesterone; screen regardless of testosterone level if **high-risk ethnicity or family history**. |
| 2- | **Against** androgen testing in eumenorrheic women with unwanted local hair growth but a **normal** hirsutism score. |

## 2 General Approach

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| 2 | **Pharmacological therapy first** for patient-important hirsutism despite cosmetic measures; add direct hair removal for additional cosmetic benefit. Either approach is reasonable for **mild hirsutism without an endocrine disorder**. |
| 1 | **Lifestyle changes** for hirsute women with obesity, including those with PCOS. |

## 3 Pharmacologic Treatment

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| 2 | **Oral contraceptives** as initial therapy for most women not seeking fertility — no single OC is preferred. If higher **VTE risk** (obese, age >39), use the lowest effective ethinyl estradiol dose (~20 mcg) with a low-risk progestin. |
| 2 | **Add an antiandrogen** if hirsutism persists after 6 months of OC monotherapy; no antiandrogen is preferred over another, but **avoid flutamide** (hepatotoxicity). Allow ≥6 months before adjusting any pharmacologic regimen. |
| 2- | **Against antiandrogen monotherapy** as initial therapy (teratogenic) unless adequate contraception is used — reasonable as initial therapy if not sexually active, sterilized, or on LARC. |
| 2 | Consider **combination OC + antiandrogen** for severe, distressing hirsutism or prior OC-monotherapy failure — not recommended as standard first-line. |
| 2- | **Against** insulin-lowering drugs, topical antiandrogens, and GnRH agonists for hirsutism — GnRH agonists only for severe hyperandrogenemia (e.g., ovarian hyperthecosis) unresponsive to OC/antiandrogens. |

## 4 Direct Hair Removal

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| 2 | **Photoepilation** for auburn/brown/black hair; **electrolysis** for white/blonde hair. In women of color, use a long-wavelength, long-pulse laser (Nd:YAG or diode) with skin cooling — warn Mediterranean/Middle Eastern patients of **paradoxical hypertrichosis** risk and prefer topical therapy or electrolysis for them. |
| 2 | Add **topical eflornithine** for a faster response to photoepilation; use concurrent **pharmacologic therapy** in known hyperandrogenemia choosing hair removal, to minimize regrowth. |

**Remember —** Pharmacologic therapy and hair removal are complementary, not competing — most patients benefit from both. Give any pharmacologic regimen at least 6 months before judging its effect.

Martin KA, Anderson RR, Chang RJ, et al. Evaluation and Treatment of Hirsutism in Premenopausal Women: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2018;103(4):1233-1257.