PCOS

Diagnosis, comorbidity screening & lifelong care

CLINICAL PATHWAY

Rotterdam criteria: 2 of 3 in adults. AMH can now replace ultrasound for polycystic morphology. Lifestyle change restoring just 5–10% weight loss is first-line therapy for every phenotype — pharmacotherapy is then directed at the dominant symptom.

ROTTERDAM CRITERIA — 2 OF 3

- Anovulation: cycles >35 or <21 days, or <8 cycles/year
- Hyperandrogenism: clinical (hirsutism, acne, alopecia) or biochemical (raised testosterone, low SHBG)
- Polycystic ovarian morphology: ≥12 follicles or volume >10mL on ultrasound, or AMH >35 pmol/L in adults
- Exclude mimics first: TSH, prolactin, 17-OH progesterone, DHEAS

KEY COMORBIDITIES — SCREEN AT DX

- Metabolic: insulin resistance, ~4× T2DM risk, gestational diabetes, NAFLD — OGTT pre-pregnancy or if BMI >25
- Cardiovascular: higher rates of hypertension, dyslipidaemia and metabolic syndrome — calculate CVD risk
- Mental health: depression and anxiety at 2–3× population prevalence — screen at diagnosis and annually
- Endometrial: unopposed oestrogen from anovulation raises hyperplasia risk if fewer than 4 bleeds a year

BASELINE WORKUP AT DIAGNOSIS

Order together to avoid repeat visits: androgens (early-morning total testosterone, SHBG), exclusion bloods (TSH, prolactin, 17-OH progesterone, β-hCG if cycle disturbance), and metabolic screening (HbA1c or OGTT, fasting lipids, LFTs).

SYMPTOM-DRIVEN MANAGEMENT

- Hirsutism/acne: combined pill first-line; add spironolactone if insufficient at 6 months
- Cycle control: combined pill or cyclic progestogen — aim for a minimum of 4 bleeds a year for endometrial protection
- Insulin resistance: metformin, titrated up — PBS-subsidised for T2DM, used off-label for PCOS metabolic features
- Fertility: letrozole is commonly first-line (not clomiphene); refer if ovulation isn't restored after 3 cycles
- Mental health: psychology/CBT; screen with PHQ-9/GAD-7 annually

ONGOING SCREENING SCHEDULE

Annually: HbA1c or OGTT (sooner pre-pregnancy or if BMI >25 or family history), BP and lipids (statin if 5-year CVD risk >10%), and a mental health check. At every visit: BMI and waist circumference, with a lifestyle goal of 5–10% weight loss.

PATIENT RESOURCES

Jean Hailes for Women's Health (jeanhailes.org.au) and the AskPCOS app support patient self-management alongside your review.

■ SAFETY

- Don't diagnose PCOS in adolescents on imaging or AMH alone — they need both other Rotterdam criteria
- Maintain a minimum of 4 bleeds a year on any cycle-control regimen to protect the endometrium
- Letrozole, not clomiphene, is commonly first-line for ovulation induction

■ RED FLAGS / REFER

- Rapid virilisation (sudden voice deepening, clitoromegaly) → exclude an androgen-secreting tumour
- Anovulation despite 3 cycles of letrozole → fertility specialist
- Diagnostic uncertainty in a patient under 18 → paediatric endocrine
- Post-menopausal/intermenstrual bleeding, or endometrial thickness >7mm on ultrasound