PCOS GP Tool

Refer to the PCOS care plan and PCOS guideline translation tools, available at the below link.

This PCOS GP Tool is based on the best available evidence and was co-designed with health professionals, and aims to assist in the delivery of evidence-based care.

For more information on PCOS, see the International PCOS evidence-based guideline for the assessment and management of polycystic ovary syndrome available at:

www.monash.edu/medicine/sphpm/mchri/pcos

CRE PCOS
Centre for Research Excellence in Polycystic Ovary Syndrome

MONASH University

asrm
American Society for Reproductive Medicine

eshre
SCIENCE MOVING PEOPLE MOVING SCIENCE

Step 1: Irregular cycles + clinical hyperandrogenism

(exclude other causes)* = diagnosis

Step 2: If no clinical hyperandrogenism

Test for biochemical hyperandrogenism
(exclude other causes)* = diagnosis

Step 3: If ONLY irregular cycles OR hyperandrogenism

Adolescents ultrasound is not indicated = consider at risk of PCOS and reassess later

Adults - request ultrasound for PCOM, if positive
(exclude other causes)* = diagnosis

* Exclusion of other causes requires TSH, Prolactin levels, FSH and if clinical status indicates other causes need to be excluded (e.g. CAH, Cushings, adrenal tumours etc). Hypogonadotrophic hypogonadism, generally due to low body fat or intensive exercise, should also be excluded clinically and with LH and FSH levels.

Rotterdam diagnostic criteria requires two of:

1. Oligo – or anovulation
2. Clinical and/or biochemical hyperandrogenism (calculated bioavailable, calculated free testosterone, SHBG, FAI)
3. Polycystic ovaries on ultrasound* (and exclusion of other aetiologies such as: thyroid disease, hyperproplactinemia, FSH (if pre-mature menopause is suspected) and non-classic congenital adrenal hyperplasia)

* Vaginal ultrasound is not needed if 1 and 2 are present and not recommended for < 20yrs due to the high incidence of PCOM (Polycystic ovary morphology)

Irregular periods

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)

When irregular menstrual cycles are present a diagnosis of PCOS should be considered.

Ethnic variation

Consider ethnic variation in the presentation and manifestations of PCOS, including differences in hirsutism and acanthosis nigricans and in metabolic sequelae including obesity and insulin resistance.

Clinical hyperandrogenism

Hirsuitism / Alopecia / Acne

Goals

Symptom reduction

Hirsutism

* Be aware of the potentially negative psychosocial impact of clinical hyperandrogensim. Unwanted excess hair growth or female pattern hair loss should be considered important in assessment and management, regardless of apparent clinical severity

- Use standardised visual scales such as the modified Ferriman Gallwey score (mFG) with a level ≥ 4 - 6 indicating hirsutism, noting that self-treatment is common and can limit clinical assessment
- The mFG cut-off scores for defining hirsutism are the same across ethnicities – however prevalence and degree of hirsutism severity varies by ethnicity
- Only terminal hairs should be considered in pathological hirsutism, with terminal hairs clinically growing > 5mm in length if untreated, varying in shape and texture and generally being pigmented

Acne No universally accepted visual tool for assessment

Alopecia Use Ludwig visual score

Management

Hirsutism - mGF scale

Note that terminal hair growth has considerable ethnic variability

- Cosmetic options: laser hair removal, depilatory creams, threading, plucking, waxing and electrolysis
- Pharmacological therapy options (6 -12 months to see benefit)
- Combination therapy – if ≥ 6 months of OCP is ineffective, consider adding anti-androgen to OCP (Contraception is vital to prevent pregnancy while on anti-androgen medication)

Reproductive

Irregular Periods

Goals

- Regular menstrual cycles
- Reduction of risk of endometrial cancer (2 – 6 fold increased risk before menopause, however absolute risk low overall)
- Routine ultrasound screening of endometrial thickness in PCOS is not recommended

Management

- Consider commencing the COCP (In young women make a plan 8 years post menarche to fully assess hormone levels Will need to cease COCP for 3 months prior to assessment)
- If cycles < 4 per year - Medroxyprogesterone acetate to induce a withdrawal bleed if pt does not want to commence COCP

Referrals

GP monitor

Fertility

Goals

Family planning Conception if desired Optimise fertility

Management

- Encourage pt to consider conceiving prior to 35 yrs to allow time for fertility interventions, if needed
- Prevention of weight gain, lifestyle changes, weight loss of 5-10% of total body weight, if needed.

Referrals

Refer fertility specialist if unable to conceive after lifestyle changes at 12/12 if < 35 years or at 6/12 if > 35 years

Psychological

Emotional Wellbeing

Goals

Assess, monitor and manage depression, anxiety, body image and low self esteem

Management

Assessment of anxiety and or depressive symptoms involves assessment of risk factors, symptoms and severity. Symptoms can be screened using the following stepped approach:

Step 1: Initial questions could include:

Over the last 2 weeks, how often have you been bothered by the following problems:

- feeling down, depressed, or hopeless?
- little interest or pleasure in doing things?
- feeling nervous, anxious or on edge?
- not being able to stop or control worrying?

Step 2: If any of the responses are positive, further screening should involve:

Assessment of risk factors and symptoms using age, culturally and regionally appropriate tools, such as the Patient Health Questionnaire (PHQ) or the Generalised Anxiety Disorder Scale (GAD7), and/or refer to an appropriate professional if positive to any of the screening questions.

Referrals

Consider referral to a psychologist, counselor

Metabolic features

Cardiovascular Risk Factors

Lipids

Goals

Reduce cardiovascular risk factors

Management

Lipid profile: baseline, if BMI > 25

Referrals

GP to monitor

Cardiovascular Risk Factors

BP

Goals

Target < 85/130

Management

Baseline - every 12 months

Referrals

GP to monitor

Diabetes Risk

Goals

Awareness of high prevalence of gestational diabetes, IGT and type 2 diabetes in PCOS at a young age with risk independent of, yet exacerbated by obesity

Screening

Glycaemic status should be assessed in ALL women with PCOS at baseline, then every one to three years based on presence of other diabetes risk factors

An oral glucose tolerance test (OGTT), fasting plasma glucose or HbA1c can be used but in high risk women with PCOS (BMI >25 or in Asians > 23kg/m2, history of IGT or gestational diabetes, family history of DM2, or high risk ethnicity) an OGTT is recommended.

An OGTT is recommended pre-pregnancy and pre-fertility treatment, and at 25-28 weeks gestation given high risks of hyperglycaemia and high risks in pregnancy.

Lifestyle

Refer to Algorithm 3 and provide pt with PCOS Lifestyle and PCOS infographic.

Lifestyle interventions are as effective in women with PCOS as in women without PCOS.

Diet

Goals

Maintain healthy diet

Management

Key messages

- No one diet is more effective in weight reduction
- Healthy, balanced diet
- Reduce overall caloric intake if an unhealthy weight

Referrals

Consider referral to dietitian

Physical Activity

Goals

Target exercise – See PCOS lifestyle infographic for age specific information.

Management

Exercise routine established

Referrals

GP to monitor

Consider referral to exercise physiologist, trainer

Weight

Goals

Prevention of excess weight gain

Target 5-10% weight loss

Management

Weigh and monitor women regularly, vital to:

- Targeting prevention
- Key message: 5-10% weight loss will greatly assist in symptom control
- Encourage simple behaviour change – prioritisation of healthy lifestyle, family support, lifestyle and exercise planning, setting of small achievable goals
- If unhealthy weight pt unable to lose weight 6/12 with lifestyle changes consider metformin (titrate dose, starting 500mgs up to 2g)

Referrals

Consider referral via team care arrangement if appropriate:

- Dietitian for tailored dietary advice, education and behavioural change
- Exercise physiologist for tailored exercise program, motivation and support
- Group support, diet and exercise programme

Other

Obstructive Sleep Apnea

Goals

Use Berlin questionnaire
sleepapnea.org/assets/files/pdf/berlin-questionnaire.pdf

Management

Screening should only be considered for OSA in PCOS to identify and alleviate related symptoms, such as snoring, waking unrefreshed from sleep, daytime sleepiness, and the potential for fatigue to contribute to mood disorders. Screening should not be considered with the intention of improving cardiometabolic risk, with inadequate evidence for metabolic benefits of OSA treatment in PCOS and in general populations

Referrals

Consider referral to sleep clinic

Additional GP Tools

GP tools available at:

www.monash.edu/medicine/sphpm/mchri/pcos

Algorithms

Algorithm 1	Screening, diagnostic assessment, risk assessment and life-stage
Algorithm 2	Prevalence, screening, diagnostic assessment and treatment of emotional wellbeing
Algorithm 3	Lifestyle
Algorithm 4	Pharmacological treatment for non-fertility indications
Algorithm 5	Assessment and treatment of infertility

Patient infographics

- What is PCOS and do I have it?
- Lifestyle and PCOS
- Emotional wellbeing and PCOS
- Fertility and PCOS
- PCOS treatment

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