Referral Support Service

Gynaecology

GY10
Polycystic Ovarian Syndrome

Definition

- PCOS is a common endocrine disorder, with a prevalence of 6-7% of population. It is characterized by ovulatory failure and hyperandrogenism; causing oligomenorrhoea, hirsuitism, acne and subfertility. (USS features of polycystic ovaries can be found in upto 20% of women, but the syndrome is only diagnosed with clinical features)
- Longer term sequelae include; Type 2 DM, cardio-metabolic syndrome, obesity and sleep apnoea.

Investigations

- History: establish clinical features, such as acne, hirsuitism, irregular periods, subfertility
- Examination: BMI, hirsuitism, presence of acne.
- Investigations:
    - baseline USS
    - Bloods: TFTs, Prolactin, FSH/LH (D1-5), Free Androgen Index
        - A raised free testosterone is more clinically significant than the traditional FSH/LH ratio for diagnostic purposes.

Exclude Red Flag Symptoms

- Endometrial Hyperplasia and carcinoma risk is elevated in this cohort, particularly when associated with < 4 periods a year (in the absence of hormonal therapy). Sudden changes in bleeding pattern over age 40 should be regarded as higher risk, consider early referral.
- Androgen-Secreting Tumours: a female with a total testosterone level >5nmol/L should be referred for further investigations.

Management

- Subfertility: Please refer to the subfertility guideline, which supports early referral for patients with oligomenorrhoea, with a BMI under 35, for consideration of clomiphene therapy or ovarian driling.
- Oligomenorrhoea: general advice for any woman with PCOS is to ensure 4 withdrawal bleeds a year to prevent endometrial hyperplasia. This may be using any hormonal form of contraceptive.
- The Mirena offers excellent endometrial protection and contraception.
- If contraception is not required, then quarterly courses of progesterone e.g. Norethisterone 5mg tds for 10d to induce menses is recommended.
- The RCOG patient info sheet is a fantastic resource to guide patients.
- Symptoms of hyperandrogenism:
    - Weight loss- particularly if BMI >25 can improve sx

  - COCP- all will help reduce androgen levels, but Dianette, which contains cyproterone acetate, may yield quicker improvement, then consider conversion to a standard COCP after a year. Yasmin, is a second line COCP licensed for acne management.
  - Topical agents containing eflornithine; Vaniqa
  - Unlicensed therapies include: spironolactone and anti-androgens, but specialist advice should be sought to support the use of these agents.
- Longterm Risks: All patients should be given lifestyle advice on PCOS, about importance of healthy eating and exercise, but they should also be counselled about the 10-20% risk of T2DM and need for annual screening after age 40, with HbA1c levels.

Referral Information

Diagnosis

Two out of three of the following criteria should be met

1. USS findings of polycystic ovaries (12+ peripheral "string of pearls" cycts)
2. Oligo – or Anovulation
3. Biochemical or clinical features of hyperandrogenism

Essential information for Referral

- History should state if advice sought on diagnostic uncertainty, symptom management or subfertility input
- Hormone profile
- USS result
- Current contraception and parity
- Smear history
- Treatments options *please indicate which tried, effective or contraindications exist*
  - Mirena
  - COCP
- Relevant past medical/surgical history
- Current regular medication
- BMI – (Under 35 for surgery) and smoking status

Patient information leaflets/ PDAs

RCOG PILS
PatientUK

References

RCOG Long term Consequences of PCOS- please click here