

What doctors want patients to know about PMOS

JUL 8, 2026



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AT A GLANCE: Polyendocrine metabolic syndrome (PMOS) is a common hormonal and metabolic condition that can affect people throughout their lives. PMOS may contribute to irregular menstrual periods, excess hair growth, acne, weight-related challenges, and difficulties with fertility and reproduction. Here are the key things you will learn about PMOS from four physicians in this article:

- Polycystic ovary syndrome, or PCOS, has been renamed to polyendocrine metabolic syndrome, or PMOS, to reflect this is a complex, long-term endocrine and metabolic disorder.
- By moving beyond a name centered on ovarian appearance, PMOS highlights the conditions, systemic impact and supports more comprehensive care.
- Symptoms of PMOS can include irregular or missed periods, excess facial and body hair, acne, weight gain and fertility challenges.
- A thorough medical history is key, while testing helps rule out other causes before a PMOS diagnosis is confirmed.

Polycystic ovary syndrome (PCOS)—recently renamed polyendocrine metabolic syndrome (PMOS)—is one of the most common causes of female infertility. It affects up to 15% of women of reproductive age in the U.S. But it is more than just that. PMOS is a lifelong health condition that continues far beyond a woman’s childbearing years, according to the Centers for Disease Control and Prevention.

This complex hormonal disorder that often includes irregular menstrual cycles and excess weight is often misunderstood and misdiagnosed, significantly affecting a woman’s health and well-being. Knowing more about PMOS not only aids in early detection, but also helps

patients make informed decisions about their health.

The AMA's What Doctors Want Patients to Know™ series gives physicians a platform to share what they want patients to understand about today's health care headlines.

For this installment, four physicians took time to discuss what patients need to know about PMOS. They are:

- [Keisha Renee Callins, MD, MPH](#), an ob-gyn who practices in rural Georgia, and an alternate delegate in the AMA House of Delegates for the Medical Association of Georgia.
- [Laura Katz, MD](#), an ob-gyn who is in private practice at Laura A. Katz, MD, PC, in Monroe, Michigan, and a member of Professional Medical Corp.
- Mary LaPlante, MD, an ob-gyn who practices in Cleveland.
- Kelsey J. Sherman, MD, a family physician who practices in Lakewood, Colorado.

[Professional Medical Corp.](#) is part of the [AMA Health System Member Program](#), which provides enterprise solutions to equip leadership, physicians and care teams with resources to help drive the future of medicine.

PCOS is now known as PMOS

Changing the name from polycystic ovary syndrome to polyendocrine metabolic ovarian syndrome “was introduced this year to provide terminology that is broader, clearer, and more accurately reflects the condition's underlying features,” said Dr. Callins. “The updated name is also intended to be more inclusive and less stigmatizing for patients.”

“Importantly, this name change aims to address longstanding gaps in clinical care that have contributed to delays in diagnosis and treatment,” she explained. “Developed through a global collaborative initiative, the new terminology is expected to influence not only clinical practice and patient care, but also future research priorities, healthcare policy and public awareness.”

The transition to PMOS is expected to occur over time as clinicians, researchers and health systems adopt the new terminology.

Changing from PCOS to PMOS broadens clinical focus

“The transition from PCOS to PMOS does not change the underlying diagnosis or management of the condition, but it broadens the clinical focus to better reflect its endocrine, metabolic and reproductive dimensions,” Dr. Callins explained. “By moving beyond a name centered on ovarian appearance, PMOS highlights the condition’s systemic impact and supports more comprehensive care, including attention to long-term risks such as type 2 diabetes and cardiovascular disease.

“The new terminology may also enhance patient self-advocacy by validating the full spectrum of symptoms and health concerns associated with the condition,” she added, noting that “while the name has changed, the principles of informed and shared decision-making remain the same.”

“Because PMOS affects reproductive, metabolic, and endocrine health, management should take a multidisciplinary approach and be tailored across the lifespan—from menses to maternity to menopause—to support optimal health outcome,” Dr. Callins emphasized.

The anatomy of the ovary is different

“The word polycystic or PMOS sounds a little scary, so when I describe it to patients, I tell them it looks like there’s popcorn all over the ovary,” Dr. Callins said. “So, as opposed to the ovary looking like an egg that is round and white, it looks like small cysts everywhere.

“And they’re not cysts that are at risk of rupturing or causing a problem. It’s just that the anatomy of the ovary is different and that’s what’s changing the hormonal levels,” she added.

With PMOS, your body doesn’t process insulin

“It really all comes down to understanding the concept of insulin resistance, which can feel like an overwhelming concept when you’re first introduced to it,” Dr. Sherman said. “Insulin is our hormone that we all use to process carbohydrates, sugar and—to a lesser extent—proteins.

“And when you have PMOS, your body doesn’t process insulin as effectively, so you need more of it,” she added. “Then the downstream effects of that are really what creates all of the symptoms that patients experience and makes this a really hard condition to live with for many people.”

Because insulin is too high, “that makes your ovaries overproduce testosterone,” Dr. Sherman said. “So, insulin resistance puts you at higher risk for diabetes, [heart disease](#), stroke, certain types of cancers and autoimmune conditions.”

Additionally, many women may have “that spare tire that appears out of nowhere that won’t go away,” said Dr. Katz. “And then take that a step further. Insulin is a hormone, and it gets bored, so it calls in its pals fat, salt and water. That’s where that bloated feeling happens and never goes away.

“That’s your insulin, fat, salt and water sitting there because there’s nothing to drive it into the muscles where it’s going to be used,” she added. “Now, take that a step further again and we’re going to lead into the ovary part.”

“Insulin is supposed to help us metabolize our sugars, but when there’s extra, it’s not good for it. So, that insulin looks for other stuff to do,” Dr. Katz said, noting “it starts attacking the ovaries and as the insulin floods the ovaries, it starts making all those little cysts instead of just one mature egg and ovulation stops, periods get irregular or absent.”

“If we can lower a person’s insulin levels, we can significantly improve their symptoms,” Dr. Sherman said. “Metformin is the medication that we use and is really effective for a lot of people with PMOS.”

PMOS causes irregular periods

“In [women with PMOS](#), they can have oligomenorrhea—decreased menstrual cycles—or irregular and heavy bleeding,” Dr. LaPlante said. “Once you have your first period, give it two to three years to regulate out.”

For girls who have fewer periods, “they’re going to be more likely to have long-term problems with ovulation and regular cycles,” she said. “The long-term problems are secondary to the fact they are not ovulating.”

“I have women who will go through four months without a cycle, six months without a cycle and then when they do have a cycle,” it can be extraordinarily heavy, Dr. Callins said. “Now not everyone who has irregular periods has PMOS, but cycle irregularity is a big symptom.”

“If you’re having irregular cycles, then follow up with your ob-gyn or your family medicine physician to find out whether or not anything else needs to be tested or ruled out,” she said.

Your ovaries are “just fine”

“I always tell my patients: Your ovaries are just fine,” said Dr. Sherman, emphasizing “there’s nothing wrong with your ovaries. It’s more the environment that they’re in.”

“So, your ovaries are trying to ovulate, they’re trying to do their job and because there’s so much testosterone around, those eggs don’t ever fully ovulate,” she said. “They get stalled and that’s what we see in the ultrasound.”

“People with PMOS actually have more eggs than normal. Their fertile years last longer and it’s because all of those skipped cycles they have a really big egg reserve,” Dr. Sherman said. “So, they actually maintain their fertility for a longer period of time. They’re more likely to be able to get pregnant in their early 40s, but the time to get there can take longer.”

Genetics can play a role in PMOS

“If you look around at a family, for example, who has [type 2 diabetes](#), that could be something coming in the future, but we can catch it before it happens,” said Dr. Katz. “We don’t want to mask anything. We want to prevent something from happening.”

“We don’t want to wait until you have type 2 diabetes and then catch it. We want to step in before it happens,” she said. “This is a precondition that we can identify and subvert the final process of the failure of the pancreas.

“That’s a good thing. We’re not masking anything. We’re just preventing something from happening,” Dr. Katz added, noting that “just because your family members have type 2 diabetes doesn’t mean you have to have it too. If you take steps to prevent type 2 diabetes from developing, you can potentially prevent PMOS too.”

A thorough medical history is key

For diagnosing PMOS, “first of all, I take a good thorough history. I look at everything about the patient. I look at what other medications they are on, what is going on in their family history,” Dr. Katz said. “I look at their physical appearance, such as acne, empty hair follicles, and take a full menstrual history—whether they are skipping periods or not having them at all.”

“Then I follow that up with a head-to-toe physical exam because often there could be skin changes associated with PMOS and insulin resistance,” she said, adding that “insulin even collects in the skin and it makes that dark brown, velvety kind of skin that shows someone has insulin resistance, which can contribute to PMOS.”

Testing means ruling out other causes

“A big part of testing for PMOS and the lab work is to rule out other causes,” said Dr. Sherman. “We want to make sure you don’t have a testosterone secreting tumor, for example, which can occur on people’s adrenal glands.”

“There’s a certain condition called congenital adrenal hyperplasia that we rule out as well with a lab,” she said. “We also want to make sure your thyroid, blood sugars, cholesterol,

liver and kidney labs all look OK.”

“That’s putting together this whole picture of your thyroid and prolactin. Those are two reasons that your periods can become irregular,” Dr. Sherman explained. “I also test people for their insulin because I want to know if you’re making more insulin than you should.”

“So, we really put together all these labs and we rule out other causes. And once many things have been ruled out, then it leaves PMOS as the remaining diagnosis,” she said.

You can still get pregnant with PMOS

“What I hear very commonly is: ‘They told me I would never get pregnant,’” Dr. Callins said, noting that “a lot of my young patients are not interested in [contraception](#) because they don’t think that they can get pregnant. It impacts their reproductive decision-making because that’s the first thing they hear and it’s really unfortunate.”

“The fertility rate is different—about 85% for the general population and about 50% for the PMOS population with frequent unprotected sex for a year,” Dr. LaPlante said. There are patients “with PMOS who have made the decision to just not do any intervention, not take birth control and they’re the ones who will go years and years and think they can’t get pregnant and use that as the reason not to have birth control.

“And they’ll be the ones who end up pregnant and surprised because they’ve had irregular periods,” she added. “Sometimes they go for lengths of time without periods, so if they miss their period for a while, they may not notice, or they don’t think twice about it and then they suddenly have something happen and they end up pregnant and they find out late and then they haven’t seen gotten prenatal care.”

But “if we can get a person to ovulate more regularly, then their chance of getting pregnant goes up dramatically,” said Dr. Sherman, noting that “people with PMOS actually have more eggs than normal, so their fertile years last longer and it’s because all of those skipped cycles that they have a really big egg reserve.

“So, they actually maintain their fertility for a longer period of time and they’re more likely to be able to get pregnant in their early 40s. But the time to get there can take longer,” she added.

“I’ve got plenty of patients who have lost weight and got pregnant and had multiple babies,” Dr. Callins said. “And that’s why getting away from the perception of PMOS as a disease is very important. It really is just a condition that can be managed based on symptoms.”

Facial hair is fairly common

When looking at symptoms of PMOS, “facial hair is a pretty common thing,” Dr. Callins said. “However, if a patient mentioned that to me, the first thing I’m going to ask them is if anyone else in their family has facial hair because sometimes it’s hereditary and it’s not PMOS.”

“So, it can be just that the women in the family have a mustache and so you have one too,” she said. “That is why the family history is important.”

“If facial hair is an issue and testosterone levels are an issue, then sometimes we use birth control or other medications for that too,” Dr. Callins said. “But also, some of that is aesthetic too. So, I’m having conversations with my patients about investing in laser treatment or waxing to help manage the aesthetic part of what may happen sometimes with that hormonal imbalance.”

PMOS can affect mental health

“How information is communicated is very critical,” said Dr. Callins. “I meet young patients in their 20s who were told they had PMOS when they were in their teens and they have been walking around with a fog because they feel like they have this thing and it can impact their mental health, especially if they’re concerned about future fertility.”

For example, “depression is at four times the average risk. Anxiety’s five times and suicide’s actually seven times the average risk,” said Dr. Sherman. “So, when we talk about PMOS being full body, it’s not just the trouble getting pregnant, it’s really how this

affects people in their day-to-day life.”

“Seek the medical help and support that you need to work through the physical or emotional challenges that you may encounter while managing your PMOS symptoms,” said Dr. Callins. “The more you know about how PMOS can affect your body—such as your changes in your skin or cycle or weight—puts you in a mindset that is dedicated to conquering your challenges.”

PMOS is a chronic condition

With PMOS, “it’s not really a cure situation. It’s something genetically that you’re predisposed to,” said Dr. Katz, sharing that she has polyendocrine metabolic ovarian syndrome and has “had a couple kids because we know how to address this condition and help.”

“But PMOS is a chronic condition, and you can’t think of it as being cured because it is a genetic predisposition. We can properly manage it though,” she said.

There are physical appearance changes

“The basic things with mental health and PMOS would be body appearance because there may be a woman who’s got that pear shape and has got the abdomen that won’t go away and the increase in body hair on the face and other places,” said Dr. Katz. “So, physical appearance concerns or insecurity with that.

“As far as PMOS in and of itself causing mental disturbance, not really, but it’s more of the outward appearance changes or the difficulty in getting pregnant,” she added, noting “that’s what affects a person’s mental health and then you do need support for that.”

That is where your physician can help “to educate you properly and tell you what is going on with your body and guide you through being the captain of your own team to help fix it,” Dr. Katz said.

Metformin can help

“Metformin often gets a bad reputation because it can cause diarrhea. That’s often because it is prescribed instantly, three times a day without patients understanding that if you eat a lot of sugar, it’s going to hurt you,” Dr. Katz said, noting “it’s important for patients to know that up front.”

“That is why I often do the nonextended release version and then slowly build up to two or three times a day over a six-week period to give them a chance to get used to it,” she said. “You’re much more likely to be successful that way. Or you start with the extended release, which tends to be more gut friendly at the beginning. But patients have to change their eating.”

Additionally, “we can—much more safely even—put patients on metformin and that is considered a fertility option, which is much safer, and they can stay on it when they’re pregnant,” Dr. Katz said, “because you’re managing the PMOS so your ovaries can work better.”

Weight-loss medications can help

“While nutrition and exercise are always critical parts of a healthy lifestyle overall and part of weight loss, sometimes a person needs more support than that,” Dr. Sherman said. “And we know that as you try to lose weight, your hunger goes up, your metabolism goes down and your body really fights and sabotages you to get you back to your starting weight.

“It can feel like this losing battle because we’re saying you have to eat smaller and smaller and smaller portions while your hunger and cravings go up the whole time,” she added. “There are certain older medications that are appetite suppressants that can work really well and are safe for people who have PMOS.”

There are also “medications out that are the GLP-1 agonists with names like Ozempic, Wegovy or Mounjaro,” Dr. Sherman said. “And those are all really powerful because they target that hormonal pathway, that insulin pathway that we know is already abnormal when you have PMOS.

“These can be really powerful agents because it allows people to lose weight without feeling miserable in the process,” she said. “Their hunger stays quiet, their cravings stay quiet and then they can follow these different nutrition plans without feeling like they’re sacrificing their happiness.”

But it is important to note that these medications are not approved for the treatment of polycystic ovary syndrome. They are approved for treatment of either type 2 diabetes or obesity. Also, they are not recommended for women who are attempting pregnancy and should be discontinued when a woman becomes pregnant.

“One of the issues with [medications used for weight loss](#) is that they should not be used without a plan for behavior modification,” Dr. Callins said. “Losing weight involves using as many available tools as possible to not only lose weight but to maintain that weight loss.”

Move more and sit less

“Not everybody has time to do an exercise regimen. So, what I recommend for exercise is if you can get some cardio in, that’s good,” Dr. LaPlante said. “And if you can’t, then look at your day and find out how you can put increased activity in your day.

“Whether it’s getting up and walking between tasks, using the stairs more often, doing five jumping jacks in the morning or jump roping, whatever people can build into their day that gets them moving then burn the calories is important,” she added.

“Additional benefits from more movement can include improvement in mood and sleep. Having an accountability partner can make a difference as well,” Dr. Callins said. “Get creative—join a dance class, learn a new sport, try yoga, and then challenge yourself to train for a 5K race.”

Dr. Katz agrees that movement exercise is important but aim for activities “out of your normal activity because the active exercise is not just a cliché. It will chemically force the insulin to go into the muscle where it can be used.”

Maintain a healthy diet

“First of all, stop skipping meals. You have to somehow force yourself to get in three meals,” Dr. Katz said, noting those meals should have “both protein and carbs.”

“What I’ll do for patients is I’ll concoct various smoothie recipes that could serve as a meal because even just skipping one meal could put five pounds on you by the next day because your pancreas thinks you’re starving and it holds onto everything,” she said.

“Diet plays a really big role. I advocate for balanced-plate eating, where I want people to be able to visually look at their plate and make sure they’re getting what they need without feeling they need to count and weigh their food,” Dr. Sherman said. “Visually, you want one-half of your plate to be full of non-starchy vegetables.”

“Then a quarter of your plate is a lean protein, and a quarter of your plate is a complex carbohydrate, especially if we can do whole foods like a sweet potato or lentils or beans,” she said. “But I also advocate for balance.”

“[Balanced plate eating](#) not only means the actual food groups on your plate are balanced, but also there is room for sugary foods and more processed foods sometimes,” Dr. Sherman said. “But about 80% of the time you want to be eating your veggies and lean proteins and 20% of the time allowing yourself to have a little more flexibility with your diet without guilt.”

“Set yourself up for success by planning ahead. It seems much easier to make unhealthy food choices out of convenience,” Dr. Callins said. “There are many health benefits to be gained by moving to a plant-based lifestyle and believe it or not, this does not mean that you must become vegan or vegetarian. Making the transition is probably not as challenging as you may think and could be an opportunity to help keep our planet healthy as well.”

Additionally, “there’s a wonderful book I love called *The Insulin-Resistance Diet* that is right on track from the beginning and is short and describes everything you need to know about choosing the right foods,” Dr. Katz said. “It has a grocery list that says buy this, don’t buy this. And when you’re going out to eat, it has restaurant suggestions too.”

Don’t overlook sleep’s importance

“Sleep is important too because there is some information that women who have PCOS don't sleep as well,” Dr. LaPlante said. “And then we know that sleep—especially if you have [sleep apnea](#) that's untreated—will cause some subtle changes in certain hormones and then increase your rate for obesity, heart disease and PMOS.”

“There's data out there that shows that if you have sleep apnea and you treat it with your CPAP and you're wearing your CPAP consistently, it will actually make it easier to control your diabetes, easier to control your sugar, easier to lose weight,” she said. “That also then backs up to [good sleep hygiene](#), regular sleep wake cycles, getting adequate sleep. Those will affect everything in a positive way.”

Discuss PMOS with your physician

“Once you're two or three years past your first period, then you should start having a conversation with your physician,” Dr. LaPlante said. “At that point in time, they can look at all your factors—your history, your weight, your activity level—and decide whether or not any testing is needed at that time or whether or not your initial plan's going to be to monitor and whether or not there's other factors.”

“If you decide to not go on birth control, take any medications or other management options at that point in time, make sure it's a yearly ongoing conversation with your physician,” she said.

“Understanding PMOS is really about understanding why your body works the way it does and allows you to have an honest conversation with your physician or medical provider about how to achieve your personal goals throughout the different phases of your life,” Dr. Callins said.

“Don't be afraid to ask questions. It is your right and your body,” said Dr. Katz. “The care of women should not follow a cookie cutter philosophy. Every woman deserves individualized, personalized care to fit her own needs.”