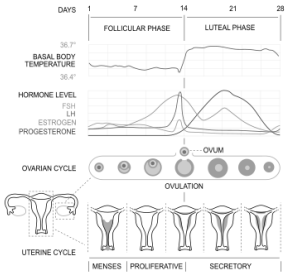
WHIP MEETING 18TH OF MARCH 2017

PCOS

Dr. Tania Widmer

Obstetrician&Gynaecologist

PATHOPHYSIOLOGY



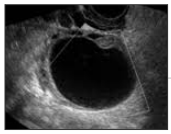
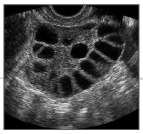
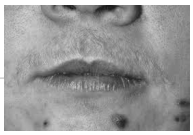
- Normal cycle 21-35 days

DIAGNOSIS

Table 1
Criteria for the Diagnosis of Polycystic Ovary Syndrome
(Other Hormonal or Androgen Excess Conditions Being Previously Excluded)[a]

NIH/NICHD (must meet both criteria)	ESHRE/ASRM (Rotterdam criteria) 2004	Androgen Excess Society 2006
Includes all of the following:	Includes two of the following:	Includes all of the following:
• Clinical and/or biochemical hyperandrogenism	• Clinical and/or biochemical hyperandrogenism	• Clinical and/or biochemical hyperandrogenism
• Menstrual dysfunction	• Oligo-ovulation or anovulation • Polycystic ovaries	• Ovarian dysfunction and/or polycystic ovaries

Abbreviations: ESHRE/ASRM = European Society for Human Reproduction and Embryology/American Society for Reproductive Medicine; NIH/NICH = National Institutes of Health/National Institute of Child Health and Human Disease.
[a]Adapted from *Clin Epidemiol*. 2014;6:1-13.

CLINICAL MANAGEMENT

- Interdisciplinary care
- PCOS in the adolescent
- PCOS and menstrual disturbance
- PCOS and fertility

INTERDISCIPLINARY CARE

- GP
- Dietician
- Psychologist
- Exercise physiologist
- Endocrinologist
- Gynaecologist

Clear care plan
Communication

LONG TERM HEALTH ISSUES

- Assessment for CV risk factors
  - Lipid profile every 2 years
  - GTT every 2 years
  - BP annually if normal BMI, each visit if BMI >25
- Weight management
  - Weight loss if BMI >25
    - 5% of weight loss can improve symptoms
  - Avoiding weight increase if BMI <25
- Emotional wellbeing – screening for
  - Depression (28-64%, versus 7-8%)
  - Anxiety (34-50% vs 18%)
  - Negative body image
  - Disordered eating
  - Psychosexual dysfunction

PCOS IN THE ADOLESCENT

- 1st year after menarche = 85%
- 3rd year after menarche = 59%
- 6th year after menarche = 25%

} of cycles are anovulatory

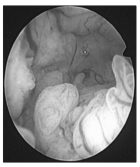
DIAGNOSIS of PCOS:
•Hyperandrogenism should be a feature
•Ultrasound is not reliable
•Transvaginal only if sexually active
•Consider in young woman if periods still irregular 2 years after menstruation commenced

If OCP already commenced to treat abnormal bleeding = need to stop it for 3 months prior to hormonal testing

PCOS AND MENSTRUAL DISTURBANCE

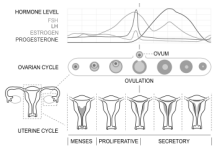
- 70% of women with PCOS have menstrual disturbance
- 50% oligomenorrhoea (cycles longer than 35 days)
- 20% have amenorrhoea
- Some women have irregular, heavy and prolonged bleeding

- BEWARE of Endometrial hyperplasia and cancer!!
- Threshold for sampling endometrium LOW
  - Pipelle
  - Hysteroscopy



MANAGEMENT OF ABNORMAL BLEEDING

- Exclude pregnancy, endometrial hyperplasia or cancer and malignancy of cervix
- Lifestyle
  - Weight loss, exercise
- Hormonal therapy
  - OCP
  - Progesterone for 10 days every 3 months if amenorrhoea
  - Mirena
  - Implanon
  - Progesterone only pill



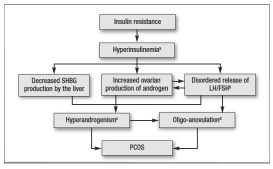
PCOS AND FERTILITY

- Exclude other causes - male factor, tubal factor, endometriosis
- Intensive lifestyle modifications for 3-6 months should be first line (with BMI >30)
- If BMI >35 recommend weight loss - then pharmacological

- Clomiphene Citrate 50mg-150mg for 5 days from D2-D6 of cycle
  - Ovulation rate of 60-85%
  - Twins in 5-7%
  - OHSS 1%
  - Best monitored with Ultrasound from D10

PCOS AND FERTILITY

- Metformin
  - IR in 65-80% of women with PCOS – even in normal BMI
  - Dose 1500-2550mg/day
  - Titrate up slowly
- Aromatase inhibitors (Letrozole)
  - Off label use



RESOURCES

CRE PCOS Centre for Research Excellence in Polycystic Ovary Syndrome

Jean Hailes

Evidence-based guideline for the assessment and management of polycystic ovary syndrome

Developed 2011
Updated August 2015 - Section 7.4 Aromatase inhibitors
Further update scheduled 2016/2017

Polycystic ovary syndrome

Health professional tool
Assessment, investigations & management

PCOS Australian Alliance

Jean Hailes