

Adult Polycystic Ovarian Syndrome Pathway

Primary Care Management

Long Term Management:
Diabetes risk Annual HBA1C Screening
CVD risk QRISK2 if appropriate
Obesity Weight Management & Low GI Diet
Obstructive Sleep Apnoea Epworth Score [Link](#)
Pregnancy Gestational Diabetes Screening
Emotional Wellbeing Negative Body Image, Psychosexual, Eating Disorders
Support Group [Verity-PCOS](#)

Consider Adrenal tumour, Cushing's Syndrome & Late Onset Congenital Adrenal Hyperplasia:
 Signs of virilization (deep voice, reduced breasts size, increased muscle bulk, clitoral hypertrophy)
 Rapidly progressing hirsutism
 Testosterone >5 or 2x upper limit of normal



Refer Endocrinology

Diagnosis: 2/3 criteria
 Infrequent or No Ovulation (Infrequent or No periods)
 Clinical and/or Biochemical Hyperandrogenism
 PCO on USS (>12 follicles 2-9mm size, single or both ovaries and/or increased ovarian volume >10cm³)

Testosterone: normal or raised
SHBG: normal to low (surrogate marker of insulin resistance)
FAI: normal or raised
Prolactin: Mildly raised
 Check LH, FSH, TFTs for other causes of amenorrhoea

Amenorrhoea (<4 periods/yr), abnormal vaginal bleeding or BMI++
 Provera[®] (medroxyprogesterone) 10mgs od 14 days to induce withdrawal bleed **then** USS to assess endometrium



Endometrium normal, aim to prevent endometrial hyperplasia
 Provera[®] (medroxyprogesterone) 10mgs od 14 days every 3 months
 COCP/IUS/Cerazette[®]



Endometrium >10mm or abnormal changes



2ww Referral

Hirsutism



Weight Loss
 2nd Gen COCP eg Microgynon[®]
 Yasmin[®] (drospirenone COCP)
 Dianette[®] (co-cyprindiol COCP)
 Vaniqa[®] (6-8wks for benefit, loss of benefit on cessation) 4 months trial
 Hair removal methods

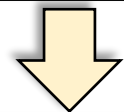


Refer Endocrinology
 If no benefit

Acne



Weight Loss
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[Acne Vulgaris Management](#)



Refer Dermatology
 If no benefit

Fertility



Refer Gynaecology Collaborative

Please consider further guidance at <https://cks.nice.org.uk/polycystic-ovary-syndrome>