PCOS Rename to PMOS: Critics Cite Diagnostic, Therapeutic Concerns

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The nomenclature of Polycystic Ovary Syndrome (PCOS) is under scrutiny, with a proposed rebranding to Polycystic Ovarian Metabolic Syndrome (PMOS) aiming to better reflect the condition's systemic metabolic components. However, this proposed change has generated significant debate among clinicians and researchers, primarily concerning its potential impact on diagnostic criteria, patient understanding, and the focus of therapeutic interventions.

KEY TAKEAWAYS

- The Pivot: A proposed renaming of PCOS to PMOS seeks to emphasize the metabolic aspects of the condition.
- The Data: The debate centers on whether the new name accurately captures the full phenotypic spectrum and avoids misdirection in clinical management.
- The Action: Clinicians should remain aware of ongoing discussions regarding PCOS terminology and its potential influence on future diagnostic and treatment guidelines.

Polycystic Ovary Syndrome (PCOS) is a common endocrine disorder affecting women of reproductive age, with a prevalence estimated between 5% and 10% globally, depending on the diagnostic criteria applied. The syndrome is characterized by a constellation of signs and symptoms, including hyperandrogenism (clinical or biochemical), ovulatory dysfunction (oligo- or anovulation), and polycystic ovarian morphology on ultrasound. However, the clinical presentation of PCOS extends beyond these reproductive manifestations, frequently encompassing significant metabolic disturbances such as insulin resistance, dyslipidemia, and an increased risk of type 2 diabetes mellitus and cardiovascular disease. This multifaceted presentation has long prompted discussions regarding the adequacy of the current nomenclature, which some argue overemphasizes the ovarian component while potentially downplaying the systemic metabolic burden.
The term 'Polycystic Ovary Syndrome' was first coined in 1935 by Stein and Leventhal, who described a syndrome of amenorrhea, hirsutism, and enlarged ovaries. Over subsequent decades, understanding of the condition evolved, leading to various diagnostic criteria. The National Institutes of Health (NIH) criteria, established in 1990, required both hyperandrogenism and ovulatory dysfunction. The Rotterdam criteria, introduced in 2003 by the European Society of Human Reproduction and Embryology (ESHRE) and the American Society for Reproductive Medicine (ASRM), broadened the definition by requiring two out of three criteria: hyperandrogenism, ovulatory dysfunction, or polycystic ovarian morphology. This expansion led to the identification of different PCOS phenotypes, some of which do not present with overt hyperandrogenism or polycystic ovaries, further complicating the naming debate. The Androgen Excess and PCOS Society (AE-PCOS Society) criteria, proposed in 2006, emphasized hyperandrogenism as a mandatory

component, reflecting its central role in the pathophysiology.

The current proposal to rename PCOS to Polycystic Ovarian Metabolic Syndrome (PMOS) stems from a desire to more accurately reflect the condition's systemic nature. Proponents of PMOS argue that the 'syndrome' in PCOS is vague and does not adequately convey the significant metabolic health risks associated with the condition. They contend that explicitly including 'Metabolic' in the name would enhance awareness among patients and healthcare providers regarding the long-term implications beyond reproductive health. This could, theoretically, lead to earlier screening for metabolic complications, such as impaired glucose tolerance, dyslipidemia, and hypertension, and a more proactive approach to their management. The argument is that a name change could shift the clinical focus from solely addressing reproductive symptoms (e.g., infertility, hirsutism) to a more holistic management strategy that prioritizes metabolic health, potentially reducing the incidence of type 2 diabetes and cardiovascular events in this patient population.

However, the proposed renaming to PMOS has met with considerable opposition. Critics raise several concerns, primarily focusing on the potential for diagnostic confusion and the misrepresentation of the condition's full spectrum. One major point of contention is that not all individuals diagnosed with PCOS exhibit significant metabolic dysfunction. While insulin resistance is prevalent, its severity varies, and some phenotypes of PCOS are predominantly reproductive, with minimal metabolic derangements. Renaming the condition to PMOS could imply that metabolic dysfunction is a mandatory component for diagnosis, potentially excluding patients who meet current PCOS criteria but do not present with overt metabolic syndrome features. This could lead to a reduction in the diagnosed prevalence of the condition, leaving some patients without an appropriate diagnosis and access to care.

Furthermore, the term 'Polycystic Ovarian' within PMOS still places emphasis on the ovarian morphology, which is itself a point of debate. Polycystic ovarian morphology (PCOM) on ultrasound is present in a significant proportion of healthy women (up to 20-25%) who do not meet other diagnostic criteria for PCOS. Conversely, some women with clear clinical and biochemical signs of PCOS do not exhibit PCOM. The continued inclusion of 'Polycystic Ovarian' in the proposed name may perpetuate the misconception that ovarian cysts are the primary pathological feature, rather than a morphological marker that may or may not be present. This could detract from the understanding of PCOS as a complex endocrine disorder driven by hormonal imbalances, particularly hyperandrogenism, and insulin resistance, rather than a primary ovarian pathology.

Another critical concern is the potential impact on patient identity and advocacy. Many patients with PCOS have formed communities and advocacy groups around the existing name. A change in nomenclature could disrupt these established networks, potentially causing confusion and a sense of disenfranchisement. Patients may feel that their condition is being redefined in a way that does not fully capture their lived experience, particularly if their primary concerns are reproductive or dermatological rather than metabolic. The psychological impact of a name change, and the potential for patients to feel their condition is being minimized or misunderstood, cannot be overlooked.

From a therapeutic perspective, critics argue that the renaming to PMOS might inadvertently narrow the focus of treatment. If the name emphasizes metabolic aspects, there is a risk that clinicians might prioritize metabolic interventions (e.g., metformin, lifestyle modifications for weight management) over treatments for hyperandrogenism (e.g., oral contraceptives, anti-androgens) or ovulatory dysfunction (e.g., clomiphene citrate, letrozole). While metabolic management is undeniably crucial, a comprehensive approach to PCOS requires addressing all facets of the syndrome based on individual patient presentation and priorities. A name that overemphasizes one aspect could lead to an

imbalanced treatment strategy, potentially neglecting other significant symptoms that impact a patient's quality of life. The process of renaming a well-established medical condition is complex and requires broad consensus from international medical societies, patient advocacy groups, and regulatory bodies. Any change must be supported by robust evidence demonstrating that the new name offers clearer diagnostic utility, improves patient outcomes, and enhances understanding without introducing new ambiguities. The current debate highlights the challenges in finding a single name that accurately encapsulates the diverse clinical phenotypes and pathophysiological mechanisms of a complex syndrome like PCOS. While the intent behind PMOS to highlight metabolic risk is valid, the potential for unintended consequences on diagnosis, patient care, and research focus necessitates careful consideration and further deliberation among stakeholders.

The discussion around PCOS nomenclature underscores a broader challenge in medicine: how to name conditions that present with heterogeneous symptoms and involve multiple organ systems. The desire for a name that is both precise and comprehensive often conflicts with the need for simplicity and clinical utility. For PCOS, the ongoing dialogue reflects a growing understanding of its systemic nature, moving beyond a purely gynecological perspective. However, the proposed PMOS name, while addressing some limitations, introduces new ones, particularly regarding diagnostic inclusivity and the potential for an overly narrow focus on metabolic features. The path forward likely involves continued research into the underlying mechanisms of PCOS, which may eventually lead to a more nuanced classification system that better guides diagnosis and personalized treatment strategies, rather than a single, potentially reductive, name change.

CLINICAL IMPLICATIONS

The proposed renaming of Polycystic Ovary Syndrome to Polycystic Ovarian Metabolic Syndrome is a classic example of medical nomenclature attempting to catch up with evolving pathophysiological understanding, yet potentially tripping over its own feet. For clinicians, the immediate implication is one of vigilance. While the intent to highlight metabolic risk is commendable, the risk of diagnostic drift is substantial. If PMOS implies a mandatory metabolic component, we risk excluding patients who meet current Rotterdam or AE-PCOS criteria but present primarily with reproductive or androgenic symptoms, thereby denying them appropriate diagnosis and management. This could lead to a fragmented approach to care, where patients are either over-diagnosed with metabolic syndrome or under-diagnosed with the broader endocrine disorder.

From a patient perspective, the confusion a name change could generate is not trivial. Patients with PCOS have built communities and understanding around the existing name. A shift to PMOS, particularly if not universally adopted or clearly explained, could lead to a sense of their condition being redefined or misunderstood. It also risks shifting the focus away from the distressing symptoms of hyperandrogenism or infertility that often drive patients to seek medical attention, potentially leading to a perception that their primary concerns are being sidelined in favor of metabolic parameters they may not yet exhibit. This could impact adherence to treatment plans if patients feel their immediate needs are not being addressed.

For the pharmaceutical industry and guideline bodies, this debate signals a need for caution. Any renaming would necessitate a re-evaluation of diagnostic codes, clinical trial inclusion criteria, and treatment guidelines. The current landscape of PCOS management, which includes metformin, oral contraceptives, anti-androgens, and ovulation induction agents, is well-established. A name change that overemphasizes the metabolic aspect might inadvertently steer research and development towards metabolic interventions, potentially neglecting

> the ongoing need for improved therapies for reproductive and androgenic symptoms. The ESHRE/ASRM and AE-PCOS Society guidelines, which have painstakingly evolved over decades, would require significant revision, a process that is both resource-intensive and prone to further debate. Until a consensus emerges, clinicians should continue to manage PCOS based on current, established criteria, ensuring a holistic approach that addresses all aspects of the patient's presentation.

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