Polycystic Ovary Syndrome (PCOS) Management: Menstrual Disorder and Fertility Treatment

Partnering to Navigate Polycystic Ovary Syndrome PCOS

Start by assessing the patient's reproductive goals and values

One Key Question: "Would you like to become pregnant in the next year?"

OR

PATH:
Parenting/Pregnancy Attitudes: "Do you think you might like to have (more) children at some point?"
Timing: "When do you think that might be?"
How Important?: "How important is it to you to prevent pregnancy (until then)?

Lifestyle Considerations for All Patients		
Healthy Diet	**Physical Activity**	**Weight Loss:**
• Mediterranean-style, anti-inflammatory diet • Tailor guidance to individual's personal and cultural food preferences • Recommend Medical Nutrition Therapy, if available	• 150 minutes per week moderate intensity OR • 75 minutes per week vigorous activity • Include muscle strengthening • Higher intensity or duration for weight loss	5-10% of body weight for patients who are overweight or obese
Use SMART (Specific, Measurable, Achievable, Realistic and Timely) goal setting and self-monitoring.		

Menstrual Disorder Treatment for People NOT trying to Conceive			
Contraception		Cyclic Progesterone	Metabolic Methods
Combined Hormones	**Progesterone Only**		

• Includes combined oral contraception pills (COCs), patch and ring
• Also treats hyperandrogenism
• May lead to more predictable bleeding patterns
	• Includes progesterone-only pills, injections (like Depo Provera), hormonal IUDs and implants
	• Less predictable bleeding patterns
	• Depo-Provera may cause weight gain and delayed return of ovulation
		• Minimal change of other hormonal parameters
		• No delay in starting ovulation induction if pregnancy intentions change
		• Does not prevent pregnancy - counsel on effective birth control methods
		• Use every 1-3 months (minimum of 4 times per year)
		• Can use a 10-day course of:
		  ◦ Medroxyprogesterone 10mg daily OR
		  ◦ Micronized progesterone 200mg daily (bioidentical)
			• Weight Loss, Nutrition, and Physical Activity
			• Metformin may be combined with hormonal methods, especially for people who have prediabetes or are obese

Flip for patients who are trying to conceive

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Menstrual Disorder Treatment for People Trying to Conceive			
Cyclic Progesterone	**Ovulation Induction**	**Metabolic Methods**	**Surgical**

• May be used to induce withdrawal bleed prior to ovulation induction, but not necessary.
• Can use a 10-day course of:
  ◦ Medroxyprogesterone 10mg daily OR
  ◦ Micronized progesterone 200mg daily (bioidentical)
	• Letrozole: 1st Line for PCOS
	  ◦ Start with 2.5mg daily for 5 days starting on day 3 of the cycle (day 1 is first day of menstrual bleeding)
	  ▪ May increase by 2.5mg up to 7.5mg
	  ◦ Alternative dosing: 10mgx1 on day 3
	• Clomiphene citrate
	  ◦ Start dose of 50mg on day 3 and continue for 5 days
	  ◦ May increase to 100mg
	• Evaluate ovulation with day 21 progesterone (>3ng/mL) or basal body temperature increase 12-16 days before next menstrual cycle begins. LH surge or cervical mucous peaks are alternatives
	• If no, or delayed, ovulation, add metformin (if not already taking) and/or switch agents
		• Weight loss prior to conception has been shown to improve live birth rate
		  ◦ A course of weight loss medication prior to trying to conceive should be recommended for overweight/obese patients
		• Metformin
		  ◦ Target dose: 1500mg/day
		  ◦ Strongly recommend if body mass index greater than or equal to 25
		  ◦ May be combined with letrozole or clomiphene citrate
			Ovarian surgical drilling - rarely done

When to refer to Reproductive Endocrinology and Infertility (REI)*:	
• No ovulation despite treatment • Under 35 years of age: no conception despite ovulation for 12 months • Over 35 years of age: no conception despite ovulation for 6 months	*If REI referral is not feasible for patient, consider evaluation for male factor and/or tubal factor infertility.