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# Journey from PCOD to PCOS and PMOS: The Ovarian Odyssey A Systematic Review

Dr. Arijit Mazumdar

Assistant Professor, Department of Physiology P.A. Sangma International Medical College and Hospital (PIMC), University of Science and Technology Meghalaya (USTM), Ri-Bhoi District, Meghalaya, India
Email: mazumdararijit17@gmail.com

## ABSTRACT:

**Background**: The condition first described by Stein and Leventhal in 1935 has carried at least three names in clinical use: the colloquial "polycystic ovarian disease" (PCOD), the internationally codified "polycystic ovary syndrome" (PCOS), and, as of 2026, "polyendocrine metabolic ovarian syndrome" (PMOS). Each transition reflects an evolving scientific understanding of a condition that was never confined to the ovary.

**Objective**: To trace, synthesise, and critically appraise the ninety-year nomenclature journey from PCOD through PCOS to PMOS, integrating diagnostic-criteria evolution, pathophysiology, epidemiology, and the 2026 global consensus renaming process.

**Methods**: A structured literature search of PubMed and Google Scholar (inception to September 2026; terms including PCOS, PCOD, nomenclature, diagnostic criteria, polyendocrine metabolic ovarian syndrome) was combined with in-depth analysis of the 2026 Lancet Health Policy global consensus paper, the primary source documenting the renaming process itself.

**Results**: Diagnostic criteria progressively broadened from the restrictive 1990 NIH definition through the 2003 Rotterdam criteria to the 2006 Androgen Excess Society criteria and the 2023 International Evidence-based Guideline, while accumulating evidence confirmed neuroendocrine, metabolic, reproductive, psychological, and dermatological involvement. A rigorous multistep global consensus process engaging 56 organisations and more than 14,000 survey respondents culminated in February 2026 in the new name PMOS, which drops the misleading reference to ovarian cysts while explicitly capturing polyendocrine and metabolic dysfunction.

**Conclusion**: The journey from PCOD to PCOS to PMOS shows how nomenclature must keep pace with pathophysiological understanding; PMOS offers a scientifically accurate, less stigmatising framework poised to reshape diagnosis, research, and care worldwide.

## 1. INTRODUCTION AND BACKGROUND

### *1.1. A condition older than its accurate description*

In 1935, two Chicago gynaecologists, Irving Stein and Michael Leventhal, described seven women with amenorrhoea, hirsutism, obesity, and bilaterally enlarged ovaries studded with small cysts (Stein & Leventhal, 1935). Wedge resection of the ovarian cortex restored menstruation in all seven, and for the next several decades the condition was simply known by their names: Stein–Leventhal syndrome (Azziz & Adashi, 2016). It took more than five decades, several international consensus conferences, and ultimately a structured global renaming process for the field to settle on a name that actually reflects what is now understood

— a polygenic, multisystem, polyendocrine condition in which the ovary is only one of several affected organs (Stener-Victorin et al., 2024; Joham et al., 2022).

An estimated 170 million women of reproductive age live with this condition worldwide, making it one of the most common endocrine disorders in women, and yet it remains among the most persistently misdiagnosed (Neven et al., 2026). In 2026, a global consensus initiative published as a Health Policy paper in The Lancet formally renamed the syndrome polyendocrine metabolic ovarian syndrome, or PMOS, retiring both the colloquial "polycystic ovarian disease" (PCOD) still in everyday use across South Asia and the internationally codified "polycystic ovary syndrome" (PCOS) that had stood since the 1990s (Teede et al., 2026). This review traces that journey from beginning to end.

### *1.2. Why nomenclature matters in medicine*

A diagnostic label is never just a container for clinical facts. It shapes how a condition is taught, researched, funded, coded in health systems, and lived with by patients. Take the word "polycystic": it implies pathological ovarian cysts, but the actual ultrasonographic finding is arrested antral follicles, not true cysts, and pathological ovarian cysts are not in fact increased in this population (Piltonen et al., 2026). Or take "ovary" itself, which anchors the whole condition to a single reproductive organ and obscures decades of evidence that neuroendocrine and metabolic dysfunction are, if anything, equally central to its biology and its long-term health consequences (Teede et al., 2026). The gap between name and biology is not academic. Up to 70% of affected individuals remain undiagnosed, and delayed diagnosis, fragmented care, and patient dissatisfaction have been documented across health systems again and again (Gibson-Helm et al., 2017; Dokras et al., 2017). It is worth being precise about what is, and is not, being claimed here. Nobody involved in the 2026 renaming process argues that changing a name, by itself, cures a metabolic or endocrine disorder, and this review makes no such claim either. What the evidence does support is narrower but still meaningful: an inaccurate name actively degrades the quality of diagnosis, communication, research classification, and patient experience around a condition that already carries substantial biological and psychosocial burden, and correcting that name removes one identifiable, modifiable obstacle to better care — nothing more, and nothing less.

### *1.3. The PCOD-PCOS distinction: a South Asian clinical peculiarity*

Ask a patient in India whether she has PCOD or PCOS, and she may well tell you these are two different conditions — PCOD framed popularly as the milder, more reversible hormonal imbalance, PCOS as the more serious endocrine disorder carrying greater metabolic and cardiovascular risk (UNICEF India, 2026). This distinction has no basis in the international diagnostic literature. No validated international criteria define PCOD as a separate clinical entity, and the term appears nowhere in the NIH, Rotterdam, Androgen Excess Society, or International Evidence-based Guideline frameworks (Teede et al., 2023). If anything, this regional terminological drift is a small case study in the very problem that motivated the global renaming effort: an imprecise name leaves room for imprecise, inconsistent, and sometimes contradictory understanding to take root in both public and professional discourse.

### *1.4. Objectives of this review*

This systematic review sets out to do five things: trace the historical and terminological evolution from Stein–Leventhal syndrome through PCOD and PCOS to PMOS; synthesise the parallel evolution of diagnostic criteria that accompanied, and often outpaced, the nomenclature; summarise the multisystem pathophysiology that ultimately justified the 2026 renaming; describe the global consensus process that produced PMOS in enough detail that readers can judge its rigour for themselves; and critically weigh the clinical, educational, and public-health implications of this transition for the healthcare fraternity worldwide. Throughout, the review tries to hold two things in mind at once, which is harder than it sounds: taking the new nomenclature seriously as a genuine scientific improvement, while also treating it with the same critical scrutiny any reviewer would apply to a newly published guideline, rather than accepting it uncritically simply because it is recent and well publicised.

### *1.5. Precedent: renaming is not new to medicine*

PMOS is not the first condition to be renamed on grounds of accuracy and stigma, and it is worth placing it alongside its predecessors. "Mongolism," a term rooted in a now-discredited racial taxonomy, was gradually replaced by "Down syndrome" following the 1959 discovery that trisomy 21 was its genetic basis, with the World Health Organization formally discouraging the older term by the mid-1960s. "Manic-depressive illness" became "bipolar disorder" with the 1980 publication of DSM-III, a change intended to de-emphasise the older term's association with unpredictability and social unreliability. In the United States, Rosa's Law replaced "mental retardation" with "intellectual disability" in federal statute in 2010, following years of

advocacy from patients and families who found the older term dehumanising. Leprosy, similarly, has been increasingly referred to in clinical and public-health contexts as "Hansen's disease," a shift driven almost entirely by the profound historical stigma attached to the older name rather than by any change in the underlying microbiology. Each of these precedents shares a common thread with the PCOS-to-PMOS transition: the recognition that a name coined under one state of scientific knowledge, or one social attitude, can actively harm patients once that knowledge or attitude has moved on. What sets the PMOS renaming apart, however, is the scale and rigour of the consensus process behind it — none of the precedents above were produced through anything resembling the multistep, patient-co-designed global methodology described in Section 8.

## 2. METHODS

### *2.1. Search strategy and information sources*

A structured literature search was conducted across PubMed/MEDLINE and Google Scholar from inception to September 2026, using combinations of the terms "polycystic ovary syndrome," "polycystic ovarian disease," "PCOD," "PCOS," "polyendocrine metabolic ovarian syndrome," "PMOS," "nomenclature," "diagnostic criteria," "Rotterdam criteria," and "name change." Reference lists of retrieved articles were hand-searched for further relevant sources. One paper deserves particular mention: the 2026 Lancet Health Policy paper by Teede and colleagues, published on behalf of the Global Name Change Consortium, is at the time of writing the only published account of the structured multistep global consensus process that produced PMOS. It was analysed in depth and forms the evidentiary backbone of Sections 6 through 8 of this review (Teede et al., 2026).

### *2.2. Eligibility criteria*

Peer-reviewed original research, systematic reviews, meta-analyses, consensus statements, and international guideline documents published in English were eligible for inclusion. Historical primary-source articles establishing the original 1935 description and each subsequent named diagnostic criteria set (1990, 2003, 2006, 2018, and 2023) were prioritised for the nomenclature-and-criteria narrative. Non-peer-reviewed patient-education material was used sparingly, and only to illustrate real-world terminological usage — for instance, how the PCOD/PCOS distinction is commonly explained to patients — never as evidence for a clinical or biological claim.

### *2.3. Data synthesis approach*

The evidence base here is unusually heterogeneous, spanning historical case reports, consensus methodology papers, epidemiological meta-analyses, and a single definitive account of the 2026 renaming. For that reason, this review takes a systematic-narrative hybrid approach rather than attempting a quantitative meta-analysis. Findings are woven together thematically across the nomenclature timeline, the evolution of diagnostic criteria, the pathophysiology, and the consensus renaming process itself, with figures and tables built to consolidate information that is otherwise scattered across more than forty primary sources.

## 3. FROM STEIN–LEVENTHAL TO PCOD: THE EARLY HISTORY

### *3.1. The 1935 description and its therapeutic legacy*

Stein and Leventhal's original report, titled simply "Amenorrhea associated with bilateral polycystic ovaries," described a triad of polycystic ovaries, hirsutism, and oligo- or amenorrhoea across a genuine case series rather than a handful of isolated case reports. That methodological choice mattered: combined with the authors' prolific subsequent output and the inclusion of a proposed surgical therapy, bilateral ovarian wedge resection, it gave the syndrome the traction to become a lasting fixture of clinical practice (Stein & Leventhal, 1935; Azziz & Adashi, 2016; Dastur Adi & Tank, 2010). For several decades afterwards, the condition was understood almost entirely as a gynaecological disorder rooted in ovarian pathology — a framing whose consequences long outlasted wedge resection itself, which fell out of surgical favour relatively quickly.

### *3.2. Emergence of the term "polycystic ovarian disease" (PCOD)*

As the eponymous label gave way to descriptive terminology through the mid-twentieth century, "polycystic ovarian disease" entered common clinical usage, particularly across South Asia, where it is still heard in clinics today. The term carried forward exactly the same ovary-centred logic as the 1935 description, framing the condition as a structural abnormality of the ovary — a "disease" of that one organ — rather than a systemic endocrine disorder. Unlike PCOS, PCOD was never formally codified

by any international consensus body: no defined diagnostic criteria, no biochemical thresholds, no phenotypic classification. Its continued use, and the popular but clinically unsubstantiated belief that it represents a milder condition distinct from PCOS, says more about the durability of an outdated conceptual model than about any real clinical distinction (UNICEF India, 2026; Norman et al., 2023).

### *3.3. From disease to syndrome: an important conceptual shift*

Relabelling the condition as a syndrome rather than a disease, formalised through the 1990 NIH conference discussed in Section 4, was a genuine conceptual advance. A syndrome, by definition, is a constellation of signs and symptoms that can arise from a heterogeneous set of underlying mechanisms — an epistemic humility that the word "disease" simply does not carry. So the shift from PCOD to PCOS was not cosmetic rebranding; it tracked real movement in scientific understanding. But "polycystic ovary" stayed embedded in both terms, carrying the ovary-centred misconception forward for another three decades before it was finally corrected.

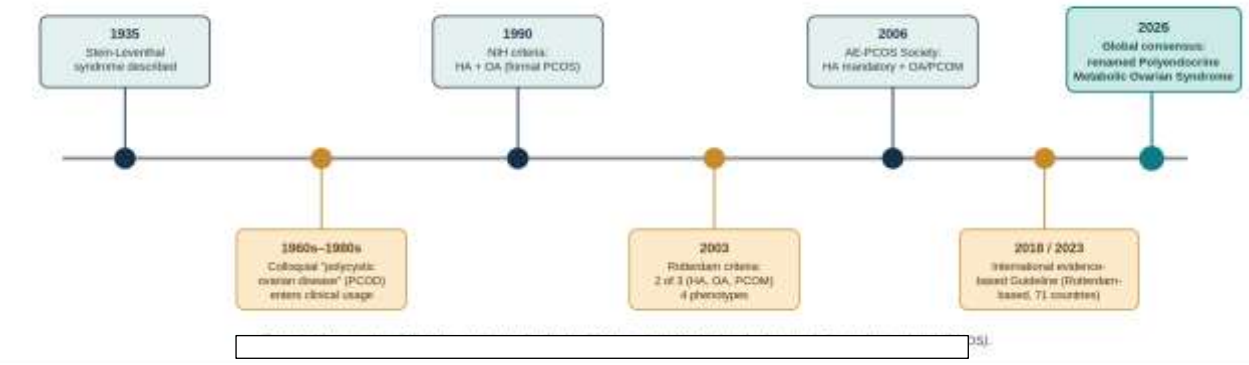


**Figure 1.** Ninety-year evolution of nomenclature for the condition now designated polyendocrine metabolic ovarian syndrome (PMOS).

## 4. FROM PCOD TO PCOS: EVOLUTION OF DIAGNOSTIC CRITERIA

### *4.1. The 1990 NIH criteria*

In April 1990, the US National Institutes of Health convened the first international conference dedicated to the condition. The consensus criteria that emerged were based on expert questionnaire responses rather than primary clinical research data: chronic oligo-anovulation and clinical or biochemical hyperandrogenism, with related endocrinopathies excluded (Zawadzki & Dunaif, 1992). Ovarian morphology on ultrasound was deliberately left out, reflecting genuine uncertainty at the time about how specific that appearance really was. Narrow as they now look, the NIH criteria were the first real attempt to formalise the syndrome using measurable clinical and biochemical parameters rather than an eponymous case description.

### *4.2. The 2003 Rotterdam criteria: broadening the phenotype*

A joint European Society of Human Reproduction and Embryology/American Society for Reproductive Medicine (ESHRE/ASRM) consensus workshop held in Rotterdam in 2003 threw the diagnostic net much wider, requiring only two of three features — oligo-anovulation, clinical or biochemical hyperandrogenism, or polycystic ovarian morphology on ultrasound — once related disorders had been excluded (Rotterdam ESHRE/ASRM-Sponsored PCOS Consensus Workshop Group, 2004). This produced four distinct phenotypes, two of which had no place under the 1990 NIH definition: ovulatory women with hyperandrogenism and polycystic ovaries, and anovulatory women with polycystic ovaries but no hyperandrogenism (Lizneva et al., 2016). Diagnosed prevalence roughly tripled overnight, and while the Rotterdam criteria, in modified form, remain the most widely endorsed framework internationally, their expansiveness drew immediate and lasting criticism over whether all four phenotypes genuinely represent one coherent biological entity (Azziz, 2006).

### *4.3. The 2006 Androgen Excess and PCOS Society criteria*

In 2006 the Androgen Excess Society, later renamed the Androgen Excess and PCOS (AE-PCOS) Society, proposed a middle path: hyperandrogenism as a mandatory feature, present alongside either ovulatory dysfunction or polycystic ovarian

morphology, with related disorders excluded (Azziz et al., 2006). This sat between the stricter NIH 1990 criteria and the broader Rotterdam 2003 criteria in how inclusive it was, and it deliberately excluded the non-hyperandrogenic Rotterdam phenotype — oligo-anovulation plus polycystic ovarian morphology without hyperandrogenism — on the grounds that hyperandrogenism was the syndrome's defining biological feature, not an optional one.

### *4.4. The 2018 and 2023 International Evidence-based Guidelines*

By the 2010s, three competing criteria sets had generated exactly the kind of confusion one would expect. An international collaboration spanning more than thirty professional societies across seventy-one countries responded by co-developing the first International Evidence-based Guideline for the assessment and management of PCOS in 2018, updated in 2023 (Teede et al., 2023; Mousa et al., 2026). This guideline formally endorsed the Rotterdam criteria as the diagnostic framework of choice for adults, with two important refinements: adolescents require both oligo-anovulation and hyperandrogenism, since isolated polycystic ovarian morphology is common and often physiological at that age, and elevated anti-Müllerian hormone (AMH) was formally accepted as an alternative to ultrasound for assessing polycystic ovarian morphology in adults (Peña et al., 2025; van der Ham et al., 2024). By the 2023 update, the guideline was already in use across 195 countries — giving the 2026 renaming initiative a stable international diagnostic foundation to build on (Teede et al., 2026).

It is worth pausing on why this diagnostic consolidation had to happen before nomenclature reform could succeed. Renaming a poorly defined entity risks simply attaching a new label to old confusion. By 2023, however, the field had a single, internationally validated diagnostic framework in active use across the large majority of the world's health systems, phenotypes that were reasonably well characterised, and a growing evidence base linking each phenotype to distinct patterns of metabolic and reproductive risk. That stability is precisely what let the 2026 consensus process focus its energy on getting the name right, rather than having to simultaneously relitigate what the condition actually was.

| Framework (year) | Core diagnostic requirement | Approximate prevalence generated | Key limitation |
|---|---|---|---|
| NIH (1990) | Oligo-anovulation AND hyperandrogenism; exclusion of related disorders | 5–10% | Excludes polycystic ovarian morphology; may under-diagnose |
| Rotterdam / ESHRE-ASRM (2003) | 2 of 3: oligo-anovulation, hyperandrogenism, polycystic ovarian morphology | 6–21% | Generates 4 phenotypes; broadest and most debated definition |
| AE-PCOS Society (2006) | Hyperandrogenism mandatory PLUS oligo-anovulation or polycystic ovarian morphology | 10–15% | Excludes the non-hyperandrogenic Rotterdam phenotype |
| International Evidence-based Guideline (2018 / 2023) | Rotterdam-based for adults; both criteria required in adolescents; AMH accepted as ultrasound alternative | ≈10–13% (adult, global pooled) | Global adoption still incomplete; terminology ("PCOS") remained unaddressed until 2026 |

**Table 1.** Evolution of diagnostic criteria for the condition now designated PMOS.

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## 5. EPIDEMIOLOGY AND GLOBAL BURDEN

### *5.1. Global prevalence*

Contemporary systematic reviews and meta-analyses put the global figure at more than 170 million reproductive-age women, making this one of the most prevalent endocrine disorders in women anywhere (Neven et al., 2026). Prevalence estimates swing quite a bit depending on which diagnostic criteria are applied, which region is studied, and how the study itself was designed — anywhere from roughly 4% to 21% across pooled international data (Lizneva et al., 2016). India offers a tidy illustration of the same pattern: pooled meta-analytic prevalence sits around 11% overall, close to 10% when Rotterdam or AE-PCOS criteria are used, and under 6% when the stricter NIH criteria are applied instead (Bhide et al., 2023). The takeaway is simple — how you define the condition largely determines how common it looks.

Regional variation goes beyond diagnostic-criteria choice alone. Adolescent and young-adult cohorts in South India have reported prevalence figures at the higher end of the global range, alongside strikingly low baseline awareness of symptoms and management options among the very population most affected — a combination that, in practice, compounds diagnostic delay well beyond what criteria selection alone would predict (Jabeen et al., 2022). East Asian cohorts, by contrast, have tended to show somewhat lower rates of the classic hyperandrogenic phenotype and correspondingly different clinical presentations, a pattern that has fed directly into ongoing debate about whether phenotypic expression itself varies meaningfully by ethnicity or whether it simply reflects differences in how criteria are applied and interpreted across health systems. Urban-rural disparities add a further layer: adolescent girls in urban Indian settings have shown higher documented PCOS burden than their rural counterparts, plausibly reflecting differences in diet, activity levels, and obesity prevalence, though better access to diagnostic ultrasound and biochemical testing in urban centres may also simply be detecting more of what already exists (Balaji et al., 2015).

### *5.2. Diagnostic delay and underdiagnosis*

Despite how common the condition is, up to 70% of affected individuals worldwide go undiagnosed, and multiple surveys have found real dissatisfaction among patients with the information and care they receive at diagnosis (Gibson-Helm et al., 2017; March et al., 2010; Teede et al., 2025). This is not purely a patient-side problem: gaps in physician knowledge of diagnostic criteria and management have been documented even among specialists, which suggests diagnostic delay owes as much to systemic and educational shortfalls as to any reluctance on the part of patients to seek care (Dokras et al., 2017).

### *5.3. Economic and health-system burden*

In the United States alone, the pregnancy-related and long-term health consequences of the condition are estimated to impose a substantial annual economic burden on the healthcare system, driven by the costs of infertility management, type 2 diabetes, cardiovascular disease, and endometrial cancer risk (Riestenberg et al., 2022). Because the condition falls disproportionately on women during their most reproductively and economically active years, its costs ripple out well beyond direct healthcare spending into lost productivity and long-term disability — which only strengthens the case for a nomenclature and management framework that actually reflects its multisystem reach.

## 6. PATHOPHYSIOLOGY: WHY "OVARY" ALONE WAS NEVER ENOUGH

### *6.1. Neuroendocrine abnormalities*

At the centre of the pathophysiology sits increased gonadotropin-releasing hormone (GnRH) pulsatility, which drives elevated luteinising hormone (LH) secretion relative to follicle-stimulating hormone. That LH excess stimulates theca-cell androgen production, feeding the hyperandrogenism now recognised as the syndrome's defining endocrine and diagnostic feature. Elevated ovarian, and often adrenal, androgens are what drive the hirsutism, acne, alopecia, and metabolic disturbance seen at the bedside (Azziz et al., 2016; Bizuneh et al., 2025a; Hiam et al., 2019). Importantly, this is not a fixed, unidirectional cascade. Hyperinsulinaemia, discussed in the next subsection, feeds back onto the hypothalamic-pituitary axis to further increase LH pulsatility, and elevated androgens themselves can blunt the normal negative-feedback sensitivity of the hypothalamus to progesterone — so the neuroendocrine, metabolic, and ovarian axes of the condition are locked in a genuinely circular relationship rather than a simple upstream-to-downstream chain. This circularity is itself part of why a name centred on any single organ was always going to fall short.

### *6.2. Metabolic dysfunction*

Insulin resistance and compensatory hyperinsulinaemia affect roughly 85% of affected individuals, including a majority of lean women, and this resistance amplifies androgen secretion while disrupting ovarian steroidogenesis in turn — a genuinely bidirectional relationship between the metabolic and endocrine sides of the condition, not a one-way street (Cassar et al., 2016; Stepto et al., 2013). Central adiposity is increased, and mendelian randomisation studies have implicated it as causal rather than merely correlated, worsening symptom severity as it accumulates; low-grade inflammation, adipokine dysregulation, and sympathetic nervous system dysfunction entrench the metabolic disturbance still further (Dobbie et al., 2023; Shorakae et al., 2018). Downstream, cardiometabolic complications follow: impaired glucose tolerance, gestational diabetes, metabolic dysfunction-associated steatotic liver disease, type 2 diabetes, dyslipidaemia, hypertension, and vascular dysfunction are all more common, and recent data from predominantly premenopausal cohorts show elevated odds ratios for composite cardiovascular disease (1.68), myocardial infarction (2.50), and stroke (1.71) compared with unaffected women (Tay et al., 2024; Joham & Teede, 2022).

### *6.3. Ovarian and reproductive dysfunction*

Neuroendocrine abnormalities disrupt ovarian steroidogenesis and impair follicular maturation, and hyperinsulinaemia-driven dysregulation of granulosa and theca cell function makes this worse still. The end result is disrupted folliculogenesis and the accumulation of small antral follicles that gives the condition its classic ultrasonographic appearance, while elevated AMH, itself a consequence of that disordered folliculogenesis, is now built into the adult diagnostic criteria (van der Ham et al., 2024; Pea et al., 2024). Clinically, all of this shows up as ovulatory dysfunction, menstrual irregularity, infertility, and a raised risk of pregnancy complications and adverse birth outcomes (Bahri Khomami et al., 2024a; Bahri Khomami et al., 2024b).

### *6.4. Psychological and dermatological dimensions*

Depression, anxiety, disordered eating, and reduced quality of life all occur more often in this population, compounding the burden of visible dermatological signs — hirsutism, acne, androgenic alopecia — that are themselves direct consequences of hyperandrogenism (Stener-Victorin et al., 2024). These features matter enormously to patients and account for much of the distress reported around diagnosis, but the global consensus process concluded that they are largely secondary to the core endocrine disturbance rather than independent diagnostic pillars in their own right, which is why they were not written into the new name (Teede et al., 2026).

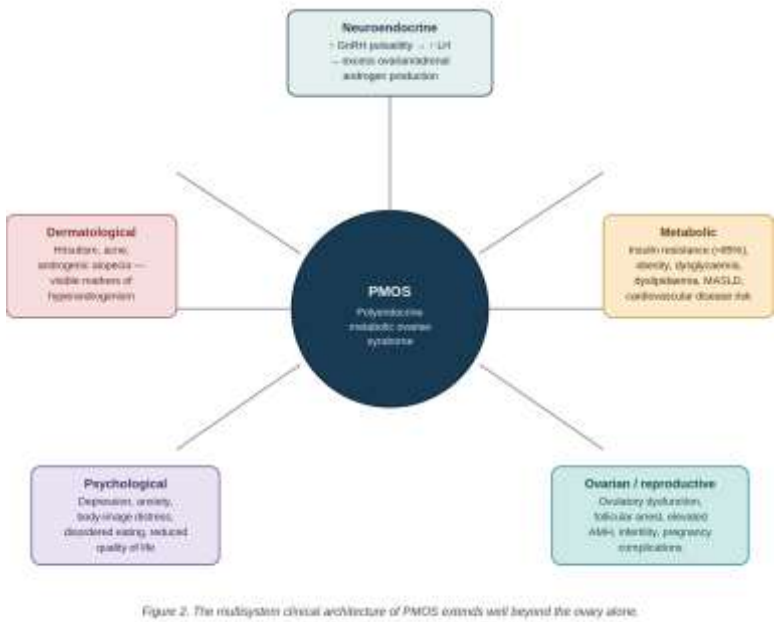


**Figure 2.** The multisystem clinical architecture of PMOS extends well beyond the ovary alone.

## 7. THE PROBLEM WITH THE NAME "POLYCYSTIC OVARY SYNDROME"

### *7.1. The cyst misnomer*

Probably the single most fundamental inaccuracy in the name PCOS, inherited directly from PCOD before it, is the implication of pathological ovarian cysts. What actually shows up on ultrasound is arrested antral follicular development: immature follicles that failed to progress to ovulation, not true pathological cysts, and pathological ovarian cysts are not actually increased in this population (Piltonen et al., 2026). Even patient-facing educational material has had to work around this, routinely clarifying that "despite the name, not everyone with PCOS has cysts" — a small but telling sign of how much confusion the name itself has generated across nine decades, among patients, clinicians, policymakers, and the public alike.

### *7.2. Diagnostic delay and patient dissatisfaction*

A narrow, ovary-centred name delays diagnosis and gets in the way of clear communication between patients and health professionals, and it has been directly linked to patient dissatisfaction with the information and care provided at diagnosis (Gibson-Helm et al., 2017; Dokras et al., 2017). A longitudinal international survey run specifically to inform the renaming process found that the overwhelming majority of both patients and health professionals recognised these problems and wanted a change (Teede et al., 2025).

### *7.3. Stigma and the reproductive framing*

There is also a stigma cost. The reproductive focus built into the name can reinforce shame in sociocultural contexts where fertility carries high social value, and many people with the condition report distress tied directly to the name itself, quite apart from their actual symptoms (Norman et al., 2023; Teede et al., 2025). This dimension turned out to be one of the most consistently prioritised principles across the global consensus surveys described in Section 8, and patients rated stigma avoidance even more highly than health professionals did.

### *7.4. Previous, unsuccessful attempts at renaming*

None of this is a new observation. Leaders in reproductive medicine — among them Ricardo Azziz, Andrea Dunaif, Bart Fauser, Robert Norman, and Helena Teede — had been pushing for a name change for well over a decade, and the 2012 US National Institutes of Health Office of Disease Prevention Evidence-based Methodology Workshop explicitly recommended one (Norman et al., 2023; Teede et al., 2026). Yet every previous attempt stalled, held back by a lack of inclusive global leadership, no coordinated international consensus process, poor alignment among patient advocacy groups, no agreement on an alternative name, and no comprehensive implementation strategy to actually carry a new name into practice (Teede et al., 2025; Teede et al., 2026). These were exactly the barriers the 2026 initiative was built to overcome.

## 8. THE GLOBAL CONSENSUS PROCESS: BIRTH OF PMOS

### *8.1. Governance and funding*

The Australian National Health and Medical Research Council funded the Centre for Research Excellence in Women's Health in Reproductive Life to lead the initiative, working alongside the Androgen Excess and PCOS Society and Verity, a UK-based patient charity whose reinvigoration of the renaming cause in 2023 is really what got the whole process moving again (Teede et al., 2026). An international steering group was set up with representatives from the lead agencies, and patient groups and professional societies from the International PCOS Guideline Network were brought in, with deliberate outreach to broader disciplines and world regions beyond the usual circle.

### *8.2. Delphi surveys and nominal group workshops*

Building on 7,708 responses already gathered from two earlier surveys and workshops in 2017 and 2023, two new global Delphi-method surveys added a further 14,360 responses from 10,411 patients and 3,949 health professionals. Survey A (April–October 2025) went out in English, Chinese, German, Persian, and Malaysian across multiple online platforms, and it established the guiding naming principles and ranked candidate approaches. Workshop A (November 2025) then brought together 90 attendees from multiple world regions into structured breakout groups — each co-chaired by a patient and a health professional, and each including representation from three to five world regions and at least three disciplines — to test candidate terminology iteratively and vote on it. Survey B (January 2026) and Workshop B (February 2026) worked through the remaining sticking points, particularly around the reproductive term, before final consensus was reached (Teede et al., 2026).

### *8.3. Guiding principles*

Six principles, established through the Delphi surveys and endorsed at Workshop A, steered the whole process: support for clinical care, research, and better health outcomes; scientific and medical accuracy; clarity and communication; avoidance of stigma; cultural and linguistic appropriateness; and feasibility of implementation. Interestingly, patients rated stigma avoidance highest while health professionals rated accuracy highest — a genuine tension the consensus process had to work through rather than paper over (Teede et al., 2026).

| Principle or approach | Overall support | Patient support | Health professional support |
|---|---|---|---|
| Scientific accuracy | 67% | 60% | 86% |
| Ease of communication | 68% | 62% | 85% |
| Avoidance of stigma | 71% | 66% | 85% |
| Cultural appropriateness | 60% | 53% | 80% |
| Approach: new, accurate symptom-based name | 78% (approx. mean) | 86% | 70% |
| Approach: adopt a generic name (e.g., "diabetes" model) | ≈50% | 45% | 54% |
| Approach: retain PCOS acronym, new full terms | ≈30% | 20% | 39% |

**Table 2.** Naming principles and approaches: survey-reported support (Survey A, April–October 2025).

### *8.4. From candidate terms to the final name*

Endocrine and metabolic terms had strong, consistent backing across both surveys and workshops. The reproductive term was another matter. It aligned well with the condition's genetics and clinical features, but its potential to cause stigma in some cultural contexts kept coming up as a concern. "Ovulatory" was preferred over "reproductive" in Workshop A on the grounds that it felt less stigmatising, though participants worried it was too narrow — it doesn't capture the full range of reproductive features and stops making sense after menopause. Survey B's top-ranked name was "polyendocrine metabolic ovulatory syndrome," but Workshop B revised this to "polyendocrine metabolic ovarian syndrome" once "ovarian" — which covers endocrine, follicular, and ovulatory disturbance all at once — edged out both "ovary" and "ovulatory", with 62–67% support among both patients and professionals. One earlier front-runner, "endocrine metabolic ovulatory syndrome," was dropped entirely after its acronym, EMOS, turned out to overlap with an unrelated youth subculture carrying distress and self-harm connotations — a small detail, but a good illustration of just how much granular, real-world diligence went into this process (Teede et al., 2026).

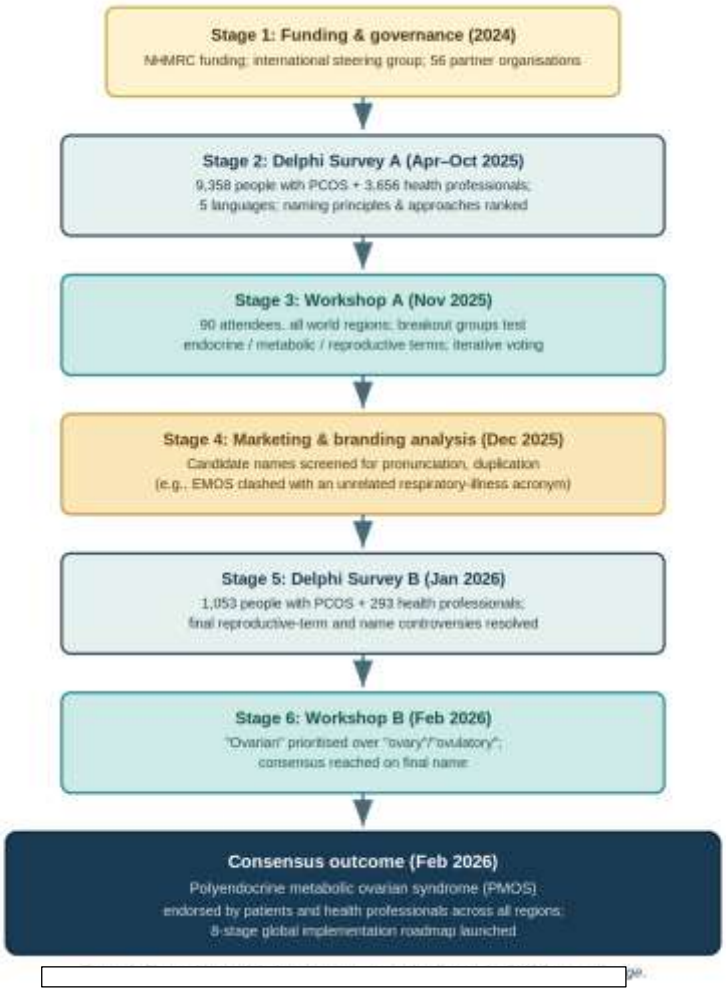


**Figure 3.** The multistep global consensus process leading to the PMOS name change.

### *8.5. Outcome and scale of engagement*

By February 2026, every workshop participant but two had endorsed the final name, polyendocrine metabolic ovarian syndrome — and those two also opposed a name change in principle, citing evolving genetic science and general unease about rebranding and marketing. Taken as a whole, the process engaged 56 organisations, drew more than 14,000 survey responses, and brought together roughly 90 workshop representatives from multiple continents, making it by a wide margin the most rigorous and inclusive renaming effort ever undertaken for a common medical condition (Teede et al., 2026).

## 9. SCIENTIFIC RATIONALE FOR EACH COMPONENT OF THE NEW NAME

### *9.1. "Polyendocrine"*

"Polyendocrine" captures something the old name never could: that the condition arises from multiple interacting endocrine abnormalities — neuroendocrine (GnRH/LH), ovarian and adrenal androgen excess, and insulin/adipokine signalling — rather than from an isolated ovarian problem. Large-scale genomic meta-analyses now confirm polygenic origins spanning neuroendocrine, metabolic, and reproductive pathways, a depth of biological evidence that simply didn't exist when PCOS was first named (Zhao et al., 2025; Hiam et al., 2019). It is also, frankly, a more honest term than "endocrine" alone would have been: the singular form implies a single gland or axis gone wrong, whereas the genetic and physiological data point squarely at several interacting systems, none of which can be singled out as the sole root cause. That nuance would have been lost with a simpler, single-system label, and its preservation in the final name is arguably one of the more scientifically ambitious choices the consensus process made.

### *9.2. "Metabolic"*

Insulin resistance affects the large majority of affected individuals; central adiposity has causal evidence behind it from mendelian randomisation studies; cardiometabolic complications are both common and consequential for long-term health. Given all that, it's no surprise the survey and workshop data came down firmly in favour of including "metabolic" in the new name — among the highest-supported terms tested, at 76% overall support and 79% ranked first at Workshop A (Teede et al., 2026; Dobbie et al., 2023).

### *9.3. "Ovarian"*

Keeping "ovarian", rather than dropping ovarian reference altogether or opting for the narrower "ovary" or "ovulatory", reflects both science and pragmatism. Ovarian dysfunction — disrupted steroidogenesis, impaired folliculogenesis, and the ovulatory and menstrual disturbance that follows — remains a defining, diagnostically central feature. And the term supports an evolutionary rather than revolutionary rebrand, keeping enough continuity with the familiar PCOS acronym to ease the practical transition for patients, clinicians, and health information systems everywhere (Teede et al., 2026).

## 10. CLINICAL AND PUBLIC HEALTH IMPLICATIONS

### *10.1. Diagnosis and awareness*

An accurate, multisystem-reflective name should prompt clinicians outside gynaecology — in primary care, endocrinology, cardiology, dermatology, psychiatry — to think of this diagnosis in patients presenting with metabolic or psychological features, not just reproductive complaints. Over time, that alone could help close some of the diagnostic-delay gap documented in Section 5.2.

### *10.2. Research and funding alignment*

The old misnomer complicated epidemiological classification, research comparability, and health-system coding for decades; a more accurate name should improve scientific coherence and help direct research funding more sensibly, particularly toward the metabolic and cardiovascular dimensions that have historically taken a back seat to the condition's reproductive manifestations (Teede et al., 2026).

### *10.3. Policy and classification systems*

Part of the implementation strategy involves formal engagement with the World Health Organization to fold the new terminology into international disease classification systems, including the International Classification of Diseases (ICD), alongside updates to electronic health records and the Systematized Nomenclature of Medicine—Clinical Terms (SNOMED CT) (Teede et al., 2026). These structural changes matter enormously — without them, the name change risks staying confined to the academic literature rather than reaching everyday research classification and health-system data.

### *10.4. Patient experience and stigma reduction*

Because people with the condition were involved at every stage of the consensus process — governance, survey co-design, workshop participation, dissemination — the resulting name carries a kind of patient-endorsed legitimacy that earlier, expert-only proposals never had. Given that stigma avoidance was patients' single highest-rated principle, dropping the misleading "cyst" framing is likely to meaningfully ease the psychological burden of diagnosis, quite apart from anything that changes in clinical management.

### *10.5. Global health equity considerations*

A note of caution belongs here too. The consensus process itself acknowledged lower participation from low- and middle-income countries and from Asia, Africa, and South America (see Section 12), and the practical burden of implementation will not fall evenly across health systems. Wealthier health systems, with established electronic health records and well-resourced professional societies, are likely to adopt PMOS terminology far faster than systems still working to achieve consistent PCOS diagnosis and management in the first place. For a country such as India, where PCOD terminology remains deeply embedded in both patient and clinician vocabulary, the practical rollout of PMOS will depend less on the elegance of the global consensus process and more on ordinary, unglamorous work: updating undergraduate and postgraduate curricula, retraining primary-care physicians who may never see the original Lancet publication, and producing patient materials in regional languages that avoid

simply transliterating an English acronym. Without deliberate investment in this translation work, PMOS risks becoming a term used correctly in tertiary academic centres while PCOD and PCOS persist, unchallenged, everywhere else — precisely the fragmented, inconsistent outcome the renaming process was designed to avoid.

## 11. IMPLEMENTATION STRATEGY AND GLOBAL ROADMAP

The implementation strategy was co-designed using the Consolidated Framework for Implementation Research and the Expert Recommendations for Implementing Change project, and it unfolds across eight coordinated stages running from academic dissemination through to formal integration into the International Guideline, due for its next update in 2028 (Teede et al., 2026). A managed three-year global transition period, with monitoring and evaluation built in from the start, underpins the whole roadmap.

| Stage | Focus | Key activities |
|---|---|---|
| 1 | Publication and academic dissemination | Health Policy publication, commentaries, clinical reviews, textbook updates |
| 2 | Resource development | Multilingual patient and clinician resources across diverse delivery platforms |
| 3 | Global communication and engagement | Society toolkits, multimedia dissemination, coordinated worldwide events |
| 4 | Health-system integration | Electronic health record and SNOMED CT updates; engagement with EMR vendors |
| 5 | Policy and research alignment | Engagement with funders, journal editors, regulators, and industry |
| 6 | International classification | Formal engagement with WHO for ICD integration |
| 7 | Transition and refinement | 3-year managed transition; monitoring; refinement as subtypes are clarified |
| 8 | Guideline integration | Incorporation into the International Guideline (195 countries), updated 2028 |

**Table 3.** Eight-stage global implementation roadmap for PMOS.

The consensus process flagged some real practical considerations along the way: careful, culturally sensitive language translation matters enormously, especially in settings where infertility and reproductive implications get tangled up with a woman's perceived social worth, and sustained coordination across health systems, research infrastructure, and public communication is what will keep this from suffering the same fragmentary uptake that undid earlier renaming attempts (Teede et al., 2026).

## 12. STRENGTHS AND LIMITATIONS OF THE GLOBAL CONSENSUS PROCESS

What stands out most about the 2026 renaming initiative is the sheer scale of genuine partnership between patients and health professionals, present at every stage from governance and co-design through to recruitment, interpretation, and implementation, using transparent consensus methods aligned with established frameworks like the James Lind Alliance process (Teede et al., 2026). That is a sharp contrast with earlier, expert-driven renaming proposals, which never had comparable inclusivity or a coordinated plan for actually putting a new name into practice.

That said, the process's own authors are upfront about its limitations. Representation across world regions and disciplines was uneven, with lower participation from low- and middle-income countries and from Asia, Africa, and South America. The purposive, non-probability sampling approach and voluntary participation could have introduced selection bias, and the response rate for the widely disseminated Survey A simply could not be determined. On the encouraging side, subgroup analysis by region did not turn up major differences in final term or name preferences, which suggests the consensus held up reasonably well across cultures despite the sampling caveats (Teede et al., 2026). As with any nomenclature change this large, the real test will be uptake over the coming years, not the elegance of the consensus process itself.

## 13. IMPLICATIONS FOR CLINICAL PRACTICE AND MEDICAL EDUCATION

### *13.1. For practising clinicians*

Clinicians across specialties should expect a multi-year transition period during which PCOS and PMOS terminology will coexist in patient records, referral letters, and the published literature. Proactively explaining the name change to patients, especially the removal of the misleading cyst reference, is a low-cost, high-value conversation that may directly ease diagnosis-related distress.

This transition period also creates a practical documentation challenge that is easy to overlook. Patients diagnosed years ago under NIH, Rotterdam, or AE-PCOS criteria, and recorded in their charts as having PCOS, will not automatically have their phenotype re-classified under PMOS terminology, and clinicians should not assume that a change in name implies any change in an individual patient's actual diagnostic status or management plan. In practice, the safest approach during the transition years is to record both terms together in clinical notes and referral correspondence — for instance, "PMOS (previously PCOS)" — until health information systems and coding infrastructure have caught up with the new nomenclature, echoing the terminology bridge that Stage 4 of the implementation roadmap (Table 3) is explicitly designed to build.

### *13.2. For medical curricula*

Medical education — physiology, endocrinology, obstetrics and gynaecology curricula in particular — should teach PMOS from the outset as a polyendocrine metabolic disorder, rather than teaching PCOS as a gynaecological condition and only later appending metabolic complications as an afterthought. Reordering the conceptual framework this way could itself sharpen diagnostic suspicion among trainees who encounter the condition's metabolic or dermatological presentations before its reproductive ones.

### *13.3. For South Asian and Indian clinical practice specifically*

Given the colloquial use of "PCOD" discussed in Section 3.2, the shift to PMOS gives South Asian health systems a genuine opportunity: retire an unvalidated regional term and adopt an internationally accurate one in the same move, rather than ending up with a confusing three-way inconsistency between PCOD, PCOS, and now PMOS in everyday clinical conversation (Bhide et al., 2023; Jabeen et al., 2022).

## 14. FUTURE DIRECTIONS AND RESEARCH PRIORITIES

A few research priorities stand out, both from this review and from the consensus process itself: tracking the real-world impact of the name change on diagnostic timeliness and patient-reported stigma over time; refining PMOS subtypes as genomic and metabolomic phenotyping matures; building validated, culturally adapted diagnostic and communication tools for the many languages and health systems where implementation has to happen; and checking, honestly, whether nomenclature-driven gains in research funding and classification actually translate into better cardiovascular and metabolic outcomes for women living with the condition. The eight-stage implementation roadmap already builds in a three-year evaluation window, which hands the healthcare research community a rare, live natural experiment in medical nomenclature reform (Teede et al., 2026).

There is also a quieter, more specific research question worth flagging for South Asian settings in particular: does replacing PCOD with PMOS in patient-facing communication measurably change how women interpret their diagnosis, their perceived fertility risk, and their willingness to seek follow-up care? Given how entrenched the PCOD/PCOS distinction already is in everyday clinical conversation across the region, this is not a question that can simply be assumed to have the same answer as it would in a health system where PCOD was never in use to begin with. A prospective, comparative study following newly diagnosed patients through the transition period — some told they have PMOS, others still told they have PCOD or PCOS, depending on where they happen to seek care — could offer genuinely new evidence on whether nomenclature reform changes behaviour and not just terminology.

## 15. CONCLUSION

The journey from PCOD to PCOS to PMOS is, at bottom, a story about medical language slowly catching up with medical science. What began in 1935 as a gynaecological curiosity, then carried a colloquial "disease" label still tied to the ovary, then a codified "syndrome" label still anchored to that same organ, has finally been renamed to reflect ninety years of accumulated evidence: a polygenic, polyendocrine, metabolic, and ovarian condition affecting more than 170 million women worldwide. The rigorous, patient-inclusive, multistep global consensus process behind polyendocrine metabolic ovarian syndrome offers a genuine model for how nomenclature change can work in medicine — not by top-down expert declaration, but through structured, transparent, and truly global engagement. For the healthcare fraternity, the job now is to make sure this new accuracy actually earns its keep: earlier diagnosis, better-targeted research, and measurably better outcomes for every woman living with PMOS. Ninety-one years separate Stein and Leventhal's original seven case reports from the 2026 consensus that finally corrected the name their observations gave rise to. That is a long time for a misnomer to persist in active clinical use, and it is a fair question to ask why it took so long. Part of the answer, as this review has tried to show, is that accurate naming had to wait for accurate science — the polygenic, multisystem picture of PMOS simply was not available to clinicians in 1935, or even in 1990. But part of the answer is also structural: earlier renaming attempts failed not for lack of scientific justification but for lack of process, coordination, and patient voice. The 2026 initiative succeeded, in the end, not because the case for change was new, but because the method for making that change finally matched the scale of the problem it was trying to solve.

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