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Review Paper

Polycystic Ovary Syndrome: A Decade in Review (2016–2026)— Evolving Understanding and Current Therapeutic Approaches

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ABSTRACT

Polycystic Ovary Syndrome (PCOS) is one of the most common endocrine and metabolic disorders affecting women of reproductive age. It is a heterogeneous condition involving hormonal, reproductive, metabolic, and psychological disturbances. Although the terms Polycystic Ovary Syndrome (PCOS) and Polycystic Ovarian Disease (PCOD) are frequently used interchangeably, PCOS is the internationally recognised clinical term. The condition is commonly associated with hyperandrogenism, ovulatory dysfunction, irregular menstruation, polycystic ovarian morphology, insulin resistance, weight-related metabolic abnormalities, and impaired fertility. This review examines the evolving understanding of PCOS during the decade from 2016 to 2026, focusing on its epidemiology, aetiology, pathophysiology, clinical manifestations, diagnostic approaches, complications, and current therapeutic strategies. It provides an integrated overview of lifestyle modification, pharmacological treatment, fertility management, metabolic risk reduction, psychological support, and complementary approaches. Lifestyle intervention remains an important component of PCOS management, with emphasis on healthy dietary patterns, regular physical activity, weight management, adequate sleep, and behavioural support. Pharmacological treatment is individualised according to clinical requirements and may include combined oral contraceptives, metformin, ovulation-induction agents such as letrozole, and anti-androgen therapy. The review also considers complementary and Ayurvedic approaches, while recognising the need for stronger clinical evidence to establish their effectiveness and safety. In addition, it highlights persistent gaps in PCOS awareness among adolescents and young women, emphasising the importance of structured health education and early recognition. The COVID-19 pandemic further exposed challenges

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in accessing continuous PCOS-related healthcare and demonstrated the potential role of telehealth and multidisciplinary care. Future research should focus on personalised treatment, adolescent-specific diagnostic strategies, metabolic risk reduction, long-term outcomes, and evidence-based evaluation of emerging and complementary therapies.

INTRODUCTION

Polycystic Ovary Syndrome (PCOS), historically associated with the description of Stein and Leventhal in 1935, is a common and heterogeneous endocrine disorder affecting women during the reproductive years [2,3]. The disorder may present during adolescence and continue throughout the reproductive lifespan. Its clinical manifestations vary considerably and may include irregular menstrual cycles, clinical or biochemical hyperandrogenism, infertility, metabolic abnormalities, acne, hirsutism, and psychological symptoms [1–3].

The terminology surrounding PCOS and Polycystic Ovarian Disease (PCOD) has generated considerable confusion among patients, students, and healthcare professionals. In many clinical and public-health settings, PCOD and PCOS are used interchangeably. However, there is no universally accepted evidence-based classification in which PCOD represents a consistently milder or reversible disease and PCOS represents a separate, irreversible disease [1,2]. Consequently, the term PCOS should be used as the primary clinical diagnosis, while PCOD may be acknowledged as a commonly used alternative term.

PCOS is a multifactorial disorder involving genetic susceptibility, altered ovarian and adrenal androgen production, neuroendocrine dysfunction, metabolic abnormalities, and environmental influences [1–3]. Insulin resistance and compensatory hyperinsulinaemia may contribute to increased androgen production and reduced sex-hormone-binding globulin concentrations, thereby increasing circulating free androgens [1–3].

The clinical importance of PCOS extends beyond reproductive dysfunction. Affected women may have increased risks of impaired glucose tolerance, type 2 diabetes, dyslipidaemia, hypertension, sleep disorders, psychological distress, and pregnancy-related complications [1–3]. Therefore, contemporary management focuses not only on menstrual and fertility outcomes but also on long-term metabolic and psychological health [1].

This review summarises developments in the understanding and management of PCOS from 2016 to 2026, including terminology, epidemiology, aetiology, pathophysiology, diagnosis, complications, lifestyle intervention, pharmacotherapy, fertility treatment, complementary approaches, adolescent awareness, and healthcare challenges during the COVID-19 pandemic [1–12].

PCOD VERSUS PCOS: TERMINOLOGICAL AND CLINICAL CONSIDERATIONS

PCOS and PCOD are frequently treated as synonymous terms in popular and some academic literature. However, it is important to avoid describing them as two clearly established diseases with consistently different severity, reversibility, or prognosis [1,2].

PCOS is the internationally recognised clinical syndrome. It is diagnosed using established clinical criteria after exclusion of other disorders that may produce similar manifestations [1]. The syndrome is characterised by combinations of clinical and/or biochemical hyperandrogenism, ovulatory dysfunction, and polycystic ovarian morphology [1].

The Rotterdam framework traditionally allows diagnosis when two of these three features are present after exclusion of other relevant conditions [1,5]. Contemporary international guidance has further refined the diagnostic approach, particularly in adolescents and in the interpretation of ovarian morphology [1].



The term PCOD is commonly used in India and other South Asian settings to describe conditions involving menstrual irregularity, ovarian morphology, hormonal abnormalities, or

metabolic dysfunction. However, it should not automatically be classified as a distinct, milder, or reversible form of PCOS [1,2].

Table 1. PCOS and PCOD: Terminological Considerations

Feature	PCOS	PCOD
Accepted clinical terminology	Internationally recognised diagnostic term [1]	Commonly used alternative/popular term [2]
Diagnostic definition	Defined by established diagnostic criteria [1,5]	No universally accepted separate diagnostic criteria [1,2]
Main manifestations	Ovulatory dysfunction, hyperandrogenism and/or polycystic ovarian morphology [1]	Often used to describe similar reproductive or ovarian abnormalities [2]
Metabolic abnormalities	May include insulin resistance, dysglycaemia, dyslipidaemia and increased cardiometabolic risk [1–3]	May be described in association with similar metabolic abnormalities
Fertility	Fertility may be reduced because of ovulatory dysfunction, but pregnancy can often be achieved naturally or with treatment [1]	Depends on the underlying reproductive abnormality
Long-term management	Individualised and generally requires ongoing monitoring [1]	Management should be based on the underlying clinical features rather than the label alone

Therefore, rather than describing PCOD and PCOS as separate disorders of different severity, clinicians and researchers should focus on the patient's specific reproductive, metabolic, dermatological, and psychological features [1].

EPIDEMIOLOGY

PCOS is one of the most common endocrine disorders affecting women of reproductive age. Reported prevalence varies according to the population studied and the diagnostic criteria used [1–3]. Differences in study methodology, age, ethnicity, clinical presentation, and diagnostic thresholds contribute to substantial variation between studies [1,3].

The Rotterdam criteria identify a broader group of women than the earlier National Institutes of Health (NIH) criteria because ovarian morphology may contribute to diagnosis [1,5]. Consequently,

prevalence estimates should always be interpreted in relation to the diagnostic criteria and study population [1].

In India, PCOS has received increasing attention as an important reproductive and metabolic health issue. Urbanisation, changes in dietary patterns, sedentary behaviour, increasing obesity, and improved awareness may contribute to the increasing recognition of the disorder [2,3].

Adolescents represent a particularly important population because menstrual irregularity and acne may overlap with normal pubertal development. Overdiagnosis should therefore be avoided, while persistent or significant symptoms should receive appropriate assessment [1].

AETIOLOGY AND RISK FACTORS

The precise aetiology of PCOS remains incompletely understood. Current evidence



supports a multifactorial model involving genetic, endocrine, metabolic, developmental, and environmental influences [1–3].

Major factors associated with PCOS include:

1. Genetic predisposition:

PCOS frequently demonstrates familial clustering. Multiple genes involved in steroidogenesis, insulin signalling, gonadotropin activity, and metabolic regulation have been investigated, although no single gene is responsible for the syndrome [2,3].

2. Insulin resistance:

Insulin resistance is an important pathophysiological feature in many, although not all, women with PCOS. Compensatory hyperinsulinaemia may stimulate ovarian androgen production and reduce hepatic production of sex-hormone-binding globulin [1–3].

3. Obesity and central adiposity:

Higher adiposity, particularly central adiposity, may aggravate metabolic dysfunction and hyperandrogenism. However, PCOS also occurs in women who are not overweight [1,3].

4. Hyperandrogenism:

Excess androgen production is a central feature in many women with PCOS and contributes to hirsutism, acne, androgenic alopecia, and impaired follicular development [1–3].

5. Chronic low-grade inflammation:

Inflammatory and metabolic pathways may contribute to the development and persistence of PCOS, although their exact causal role remains under investigation [2,3].

6. Lifestyle and environmental factors:

Physical inactivity, dietary patterns, sleep disturbance, psychosocial stress, and environmental exposures may influence metabolic

and reproductive health. These factors should be considered as contributors rather than single established causes of PCOS [2,3].

7. Developmental and prenatal influences:

Prenatal androgen exposure and other early-life factors have been investigated as potential contributors to later PCOS susceptibility, although the mechanisms remain under study [3].

PATHOPHYSIOLOGY

PCOS involves interactions between the hypothalamic-pituitary-ovarian axis, ovarian steroidogenesis, insulin signalling, adipose tissue, and metabolic pathways [1–3].

In normal reproductive physiology, hypothalamic gonadotropin-releasing hormone stimulates pituitary secretion of luteinising hormone (LH) and follicle-stimulating hormone (FSH). These hormones regulate follicular development, oestrogen production, and ovulation [3].

In PCOS, altered gonadotropin secretion and increased ovarian androgen production may interfere with normal follicular development. Increased androgen production by ovarian theca cells can impair selection of a dominant follicle and contribute to ovulatory dysfunction [2,3].

Insulin resistance may further amplify androgen excess. Increased insulin concentrations can stimulate ovarian androgen synthesis and decrease hepatic production of sex-hormone-binding globulin, resulting in increased circulating free androgen levels [1–3].

The interaction between hyperandrogenism, insulin resistance, adiposity, and altered follicular development can create a self-reinforcing cycle of reproductive and metabolic dysfunction [1–3].

Importantly, the pathophysiology of PCOS is heterogeneous. Not every woman with PCOS has the same degree of insulin resistance, obesity, androgen excess, or ovarian morphology [1]. This heterogeneity supports an individualised approach to diagnosis and management.



CLINICAL MANIFESTATIONS

Clinical presentation varies considerably between individuals [1–3].

Common reproductive manifestations

- 1 Oligomenorrhoea [1–3].
- 2 Amenorrhoea [1–3].
- 3 Irregular or unpredictable menstrual cycles [1–3].
- 4 Ovulatory dysfunction [1].
- 5 Difficulty conceiving [1–3].

Hyperandrogenic manifestations

- Hirsutism [1–3].
- Acne [1–3].
- Female-pattern hair loss or androgenic alopecia [1,3].
- Biochemical elevation of androgen concentrations [1].

Metabolic manifestations

- Increased central adiposity [1–3].
- Insulin resistance [1–3].
- Impaired glucose tolerance [1].
- Dyslipidaemia [1–3].
- Increased risk of type 2 diabetes [1–3].

Psychological manifestations

- Anxiety [1,4].
- Depression [1,4].
- Body-image concerns [4].
- Reduced quality of life [1,4].

Acanthosis nigricans may occur in association with insulin resistance, particularly in individuals with metabolic risk factors [3].

DIAGNOSTIC CRITERIA

There is no single laboratory test that independently establishes the diagnosis of PCOS. Diagnosis requires clinical assessment,

appropriate biochemical evaluation, and exclusion of alternative causes [1,3,5].

1. NIH Criteria, 1990

The original NIH framework emphasised:

- Clinical and/or biochemical hyperandrogenism.
- Chronic oligo-ovulation or anovulation.
- Exclusion of other causes [5].

2. Rotterdam Criteria, 2003

The Rotterdam criteria broadened diagnosis by requiring any two of the following three features after appropriate exclusion of other disorders:

- Oligo- or anovulation.
- Clinical and/or biochemical hyperandrogenism.
- Polycystic ovarian morphology [5].

3. Androgen Excess and PCOS Society Criteria, 2006

This framework emphasised hyperandrogenism together with ovarian dysfunction and/or polycystic ovarian morphology after exclusion of other causes [5].

Contemporary international guidance has further refined the approach to diagnosis, particularly for adolescents [1]. In adults, anti-Müllerian hormone may be used as an alternative to ultrasound for defining polycystic ovarian morphology under appropriate circumstances, but it should not be used as a single diagnostic test [1].

Ultrasound thresholds should be interpreted according to the ultrasound technology and contemporary guideline recommendations rather than applying older follicle-count thresholds universally [1].

The LH:FSH ratio is **not a diagnostic criterion for PCOS** and should not be used alone to establish the diagnosis [1,3].



Conditions that should be considered or excluded include thyroid dysfunction, hyperprolactinaemia, non-classic congenital adrenal hyperplasia, Cushing syndrome where clinically suspected, androgen-secreting tumours, and other causes of menstrual dysfunction [1,3].

COMPLICATIONS

Reproductive complications

Ovulatory dysfunction is a major cause of subfertility and infertility associated with PCOS [1–3]. However, PCOS does not mean that pregnancy is impossible. Many women achieve pregnancy either spontaneously or with appropriate fertility treatment [1].

Pregnancy in women with PCOS may be associated with increased risks of gestational diabetes and hypertensive disorders, particularly in the presence of additional metabolic risk factors [1].

Metabolic complications

PCOS is associated with increased risk of insulin resistance, impaired glucose tolerance, type 2 diabetes, dyslipidaemia, hypertension, and cardiometabolic risk [1–3].

Psychological complications

Anxiety, depression, body-image concerns, and reduced quality of life are important aspects of PCOS care [1,4]. Psychological assessment should therefore be incorporated into comprehensive management [1].

Endometrial complications

Persistent ovulatory dysfunction may result in prolonged exposure of the endometrium to oestrogen without adequate progesterone opposition. This increases the risk of endometrial

hyperplasia and may increase the risk of endometrial cancer [1,2].

MANAGEMENT

Management should be individualised according to the patient's symptoms, reproductive goals, metabolic risk, psychological wellbeing, age, preferences, and contraindications [1].

LIFESTYLE MANAGEMENT

Lifestyle intervention is a core component of PCOS management and is recommended for all women with PCOS [1].

Important components include:

- Healthy and sustainable dietary habits [1].
- Regular physical activity [1].
- Reduction of prolonged sedentary behaviour [1].
- Adequate sleep [1].
- Psychological and behavioural support where required [1].
- Prevention of excessive weight gain [1].
- Individualised weight management when appropriate [1].

There is no single diet that has been demonstrated to be universally superior for PCOS. Dietary interventions should therefore be sustainable, nutritionally balanced, culturally appropriate, and adapted to individual preferences [1].

Physical activity should be tailored to the individual's age, fitness, preferences, and health status [1]. For adults, general population recommendations include approximately 150–300 minutes of moderate-intensity aerobic activity per week or an equivalent amount of vigorous activity, together with muscle-strengthening activity [1].

Importantly, health benefits may occur even in the absence of weight loss. Therefore, PCOS management should not focus exclusively on body weight [1].



PHARMACOLOGICAL MANAGEMENT

Pharmacological therapy should be selected according to the patient's principal treatment objective [1].

1. Combined Oral Contraceptive Pills

Combined oral contraceptive pills may be used in reproductive-age women with PCOS for menstrual cycle regulation and management of hyperandrogenic symptoms [1].

The choice of formulation should consider individual contraindications, cardiovascular risk factors, adverse effects, and patient preference [1].

2. Metformin

Metformin has an important role in selected women with PCOS, particularly when metabolic abnormalities are present [1].

Potential benefits include improvement in insulin sensitivity, glycaemic parameters, lipid profiles, and some aspects of menstrual function [1].

Metformin should not be regarded as a universal treatment for every manifestation of PCOS [1].

3. Letrozole

Letrozole is an aromatase inhibitor and is currently recommended as the preferred first-line pharmacological treatment for ovulation induction in women with PCOS and anovulatory infertility when there are no other infertility factors [1].

Pregnancy must be excluded before ovulation induction, and treatment should be medically supervised [1].

4. Clomiphene Citrate

Clomiphene citrate remains an option for ovulation induction, particularly where letrozole is unavailable, contraindicated, or not permitted according to local regulatory practice [1].

5. Anti-androgen Therapy

Anti-androgens such as spironolactone may be considered for persistent hirsutism when first-line measures do not provide adequate improvement or cannot be used [1].

Effective contraception is important when anti-androgens are prescribed because of potential fetal anti-androgenic effects during pregnancy [1].

6. Inositol

Inositol preparations may be considered according to individual preferences and clinical circumstances. Evidence suggests possible metabolic benefits, but clinical benefits for ovulation, hirsutism, and weight are more limited than sometimes portrayed [1].

7. Anti-obesity Pharmacotherapy

In selected adults with higher weight, medications such as GLP-1 receptor agonists or orlistat may be considered according to general obesity-management principles and individual clinical circumstances [1].

COMPLEMENTARY AND AYURVEDIC APPROACHES

Complementary and Ayurvedic approaches are widely used in South Asian communities. Various herbal preparations and traditional interventions have been investigated for their possible effects on menstrual function, insulin sensitivity, body weight, inflammation, and hyperandrogenism [6–8].

Investigated interventions include cinnamon, fenugreek, fennel, ashwagandha, liquorice, ginseng, and other traditional herbal preparations [6,8].

However, evidence for these interventions remains variable. Findings from laboratory experiments, animal studies, small clinical trials, and individual



case reports should not be interpreted as equivalent to evidence from large randomised controlled trials [6–8].

An Ayurvedic case report has described improvement in menstrual and ultrasound parameters following traditional treatment in an individual with PCOS [7]. Such evidence may support further investigation but cannot establish treatment efficacy or generalisability [7].

Therefore, complementary therapies should be discussed with qualified healthcare professionals, particularly because herbal products may have pharmacological effects, drug interactions, variable quality, or potential adverse effects [6–8].

IMPACT OF THE COVID-19 PANDEMIC ON PCOS CARE

The COVID-19 pandemic disrupted healthcare services worldwide, including the management of chronic reproductive and metabolic disorders [4,9].

Women with PCOS reported challenges including delayed or cancelled medical appointments, reduced access to multidisciplinary services, changes in physical activity, changes in dietary behaviour, weight changes, increased stress, and difficulties accessing routine investigations and treatment [4].

A Canadian survey of women with PCOS reported substantial changes in health behaviours and healthcare experiences during the pandemic [4]. These findings highlight the vulnerability of patients with chronic conditions when healthcare systems experience major disruption [4,9].

Telehealth became increasingly important during the pandemic and may continue to complement face-to-face PCOS care. However, telehealth cannot completely replace physical examination, laboratory testing, imaging, or certain aspects of multidisciplinary management [4].

AWARENESS AND KNOWLEDGE AMONG ADOLESCENTS AND YOUNG WOMEN

Awareness of PCOS among adolescents and young women remains an important public-health concern [10,11].

Studies conducted among school and college students have identified gaps in knowledge regarding menstrual abnormalities, hyperandrogenic symptoms, risk factors, lifestyle modification, diagnosis, long-term complications, prevention, and management [10,11].

Educational programmes have demonstrated improvements in knowledge scores among adolescent participants [11]. These findings support the implementation of age-appropriate reproductive-health education in schools, colleges, and community settings [10,11].

However, awareness programmes should avoid encouraging self-diagnosis. Menstrual irregularity and acne may occur normally during adolescence, and diagnosis of PCOS in adolescents requires age-appropriate clinical assessment [1].

Early recognition should therefore be combined with appropriate referral to qualified healthcare professionals [1,10,11].

EMERGING THERAPEUTIC DIRECTIONS

Research between 2016 and 2026 has expanded understanding of the biological heterogeneity of PCOS [1,12].

Emerging areas of research include phenotype-based and data-driven classification, metabolic subtyping, gut microbiome research, novel insulin-sensitising approaches, GLP-1 receptor agonists and weight-management therapies, nutraceutical interventions, inositol formulations, molecular and genetic biomarkers, and personalised treatment strategies [1,12].

Although these areas are promising, many remain investigational. Emerging therapies should not be described as established clinical treatments until



adequate clinical evidence demonstrates their safety and effectiveness [1,12].

FUTURE PERSPECTIVES

Future PCOS research should focus on several priorities. Improved diagnostic strategies are required, particularly for adolescents, in whom normal pubertal development may overlap with PCOS features [1].

Greater emphasis should be placed on identifying individual metabolic and reproductive risk profiles rather than treating PCOS as a uniform disorder [1,12].

Long-term studies are needed to clarify cardiovascular, metabolic, psychological, and reproductive outcomes [1]. High-quality clinical trials are also required to determine the efficacy and safety of complementary and Ayurvedic interventions [6–8].

Multidisciplinary care involving physicians, gynaecologists, endocrinologists, pharmacists, dietitians, psychologists, and other healthcare professionals may improve long-term management and quality of life [1].

CONCLUSION

Polycystic Ovary Syndrome is a common and heterogeneous endocrine-metabolic disorder with reproductive, metabolic, dermatological, and psychological manifestations [1–3]. Although PCOS and PCOD are frequently used interchangeably, PCOS is the internationally recognised clinical term, and there is insufficient evidence to define PCOD universally as a separate, milder, or reversible disease [1,2].

Contemporary management should be individualised and should address the patient's presenting symptoms, reproductive goals, metabolic health, psychological wellbeing, and personal preferences [1]. Lifestyle intervention remains a central component of care, while

pharmacological treatment should be selected according to the primary clinical objective [1]. Combined oral contraceptive pills may be used for menstrual irregularity and hyperandrogenic symptoms, metformin is particularly useful for selected metabolic indications, and letrozole is the preferred first-line pharmacological treatment for ovulation induction in women with PCOS-related anovulatory infertility when no other infertility factors are present [1].

PCOS-related psychological health and quality of life should receive equal consideration alongside reproductive and metabolic outcomes [1,4]. The COVID-19 pandemic highlighted the need for resilient healthcare systems and accessible multidisciplinary services [4,9]. Complementary and Ayurvedic approaches remain areas of interest, but current evidence is insufficient to consider most such interventions established treatments [6–8].

Improved awareness, appropriate adolescent assessment, prevention and management of metabolic risk, evidence-based pharmacotherapy, psychological support, and personalised long-term care remain essential for improving outcomes in women with PCOS [1,10,11]. Continued research should prioritise precision medicine, validated biomarkers, long-term outcomes, and robust evaluation of emerging and complementary therapies [1,12].

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