A Stepwise Approach to PMOS Diagnosis

Patient with suspected PMOS

Step 1. History suggests oligo-anovulation AND clinical hyperandrogenism

↓ **Yes**

Exclude thyroid disease, hyperprolactinemia, congenital adrenal hyperplasia, and pregnancy

↓ **Yes**

✓ **PMOS Diagnosed**

↓ **No**

Proceed to Step 2

Step 2. Oligo-anovulation WITHOUT obvious clinical hyperandrogenism?

↓ **Yes**

Obtain biochemical testing:

- Total testosterone
- SHBG
- Androstenedione
- ± DHEAS

↓

Biochemical hyperandrogenism?

→ **No** → ***Proceed to Step 3***

↓ **Yes**

Thyroid disease, hyperprolactinemia, congenital adrenal hyperplasia, and pregnancy excluded

→ **Yes** → ✓ **PMOS Diagnosed**

↓ **No**

Step 3. Oligo-anovulation WITHOUT hyperandrogenism (clinical or biochemical)
OR
Hyperandrogenism (clinical or biochemical) WITHOUT oligo-anovulation

↓ **Yes**

>8 years post-menarche? → **No** → If only 1 criteria present reassess 8 years post-menarche

↓ **Yes**

Obtain transvaginal ultrasound* → **Polycystic ovarian morphology present?**

If ultrasound is unavailable or impractical: AMH may be used as an alternative if > 8 years post-menarche

↓ **Yes**

Thyroid disease, hyperprolactinemia, congenital adrenal hyperplasia, and pregnancy excluded

↓ **Yes**

✓ **PMOS Diagnosed**

↓ **No**

PMOS not confirmed; consider alternative diagnosis

Remember: Incidental polycystic ovarian morphology alone is not diagnostic. Clinical history and evidence of ovulatory dysfunction or hyperandrogenism remain essential.