What's in a Name? Why PCOS is Becoming PMOS

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IN MAY 2026, polycystic ovary syndrome (PCOS) was renamed polyendocrine metabolic ovarian syndrome (PMOS) following a global consensus led by Monash University, Melbourne, Australia; the Androgen Excess & PCOS (AE-PCOS) Society; and Verity PCOS UK, Surrey, UK. At the European Society of Human Reproduction and Embryology (ESHRE) Congress 2026, a session titled 'Renaming PCOS: governance, consensus process, outcomes and global implementation' explored the whys, hows, and impacts of this change for patients worldwide. The session was chaired by Alessandra Alteri, Saint Camillus International University of Health Sciences, Rome, Italy; and Katerina Bambang, The Delphi Clinic, Liverpool, UK, and featured three speakers from the PCOS Name Change Committee.

WHY THE NAME MATTERS

Anju Joham, Monash University, explained that PMOS is a condition characterised by endocrine changes, including insulin resistance, which is present in 75–95% of affected women; gonadotropin-releasing hormone pulsatility changes, leading to luteinising hormone and follicle-stimulating hormone imbalance; elevated anti-Müllerian hormone (AMH), which causes follicular arrest; adipokine dysregulation; and insulin-like growth factor signalling issues.[1] The name PCOS implies that the pathology lies with the ovaries. However, Joham explained, this terminology could cause harm, as research has shown that the features of the condition are much broader. Piltonen et al.[2] studied the ovarian features of the condition, and their findings showed that the condition is associated with polycystic ovary morphology, with increased ovarian volume and increased follicles, which are deceivingly referred to as cysts. However, the study showed that there was no difference in benign or pathological cysts between the two groups, suggesting that there is no increased risk of cysts in patients with PMOS.[2]

Further research has shown a clustering of metabolic features in patients with PMOS, with an increased risk of diabetes, dyslipidaemia, insulin resistance, and hypertension.[1] Additionally, data have shown an increased risk of cardiovascular events, including major adverse cardiovascular events, myocardial infarction, angina, and need for revascularisation, unrelated to obesity.[3] A subsequent study of Nordic women with PMOS confirmed that in women with a BMI lower than 25 kg/m^2, cardiovascular risk was increased.[4]

An international evidence-based guideline, published in 2023, which looked at the assessment and management of the condition, supports the endocrine and metabolic origins of the condition, with a range of features manifesting across the lifespan.[5] In adolescence, the most prominent symptoms are an increasing BMI and psychological burden, while reproductive years are marked by subfertility, pregnancy complications, and more significant metabolic features. Post-menopause, the condition does not disappear, and metabolic features start to predominate. The guidelines also feature updated diagnostic criteria for

PMOS, with the main change being the addition of AMH, which can be used in lieu of polycystic ovary morphology on ultrasound. For adults, two of the following are now required for diagnosis: oligo- or anovulation; clinical and/or biochemical hyperandrogenism; and polycystic ovaries or elevated AMH levels. In adolescents, both oligo-or anovulation and clinical and/or biochemical hyperandrogenism need to be present. Since ovarian changes are expected as part of normal pubertal development, it is recommended not to use polycystic ovary morphology for diagnosis, or to include AMH levels, as these do not peak until early 20s.

Joham concluded that the term PCOS is a misnomer, focusing on a single organ while ignoring the wide range of endocrine, metabolic, psychological, and dermatological effects of the condition. This mislabelling not only impacts health outcomes but also policy, funding, research, education, and care.

> **PMOS was chosen as an accurate, symptom-based term that frames this condition as multidisciplinary**

THE ROAD TO CONSENSUS

In 2012, Joham explained, a workshop was held to change the name, but due to the lack of global leadership, patient alignment, agreement on an alternative name, and implementation strategies, the process stalled. The new initiative addressed these barriers, starting with a survey of nearly 8,000 patients and HCPs, confirming that the name was inaccurate and needed to be changed. This was followed by a significant consultation process, which looked at knowledge gaps, and a workshop at the AE-PCOS Society Annual Meeting in 2023, which endorsed the name change. Finally, they conducted another survey with 22,000 participants, showing overwhelming support for a name change. Throughout this process, 56 organisations were involved across six continents, covering a range of disciplines, including gynaecology, endocrinology, dermatology, metabolic health, psychology, and nutrition.

The next step was to decide on a new name that would reflect the span of the condition, eliminate the misleading term 'cysts', reduce reproductive stigma, and recognise the range of metabolic, psychological, and cardiometabolic features, while facilitating implementation. PMOS was chosen as an accurate, symptom-based term that frames this condition as multidisciplinary, allowing for more holistic, patient-centred care.[6]

FROM CONSENSUS TO CLINICAL PRACTICE

Terhi Piltonen, Oulu University Hospital, Finland, explained that this change now needs to be carried out at all levels, including policy, research, education, and care. To ensure this, they have created a 3-year, eight-step implementation strategy, with an embedded evaluation strategy to monitor global uptake. This starts with the public dissemination through publications; the creation of resources on a global scale; content shared through media and social media; updating health information systems; notifying researchers, funders, journals, and databases; international classification through an updated International Classification of Diseases (ICD) code; education, from global conferences to universities; and revising international guidelines.

Most of these are already underway, with 25 publications so far across a range of journals, millions of people reached across social media, and the National Institute for Health and Care Excellence (NICE) Guidelines having already adopted the new term.

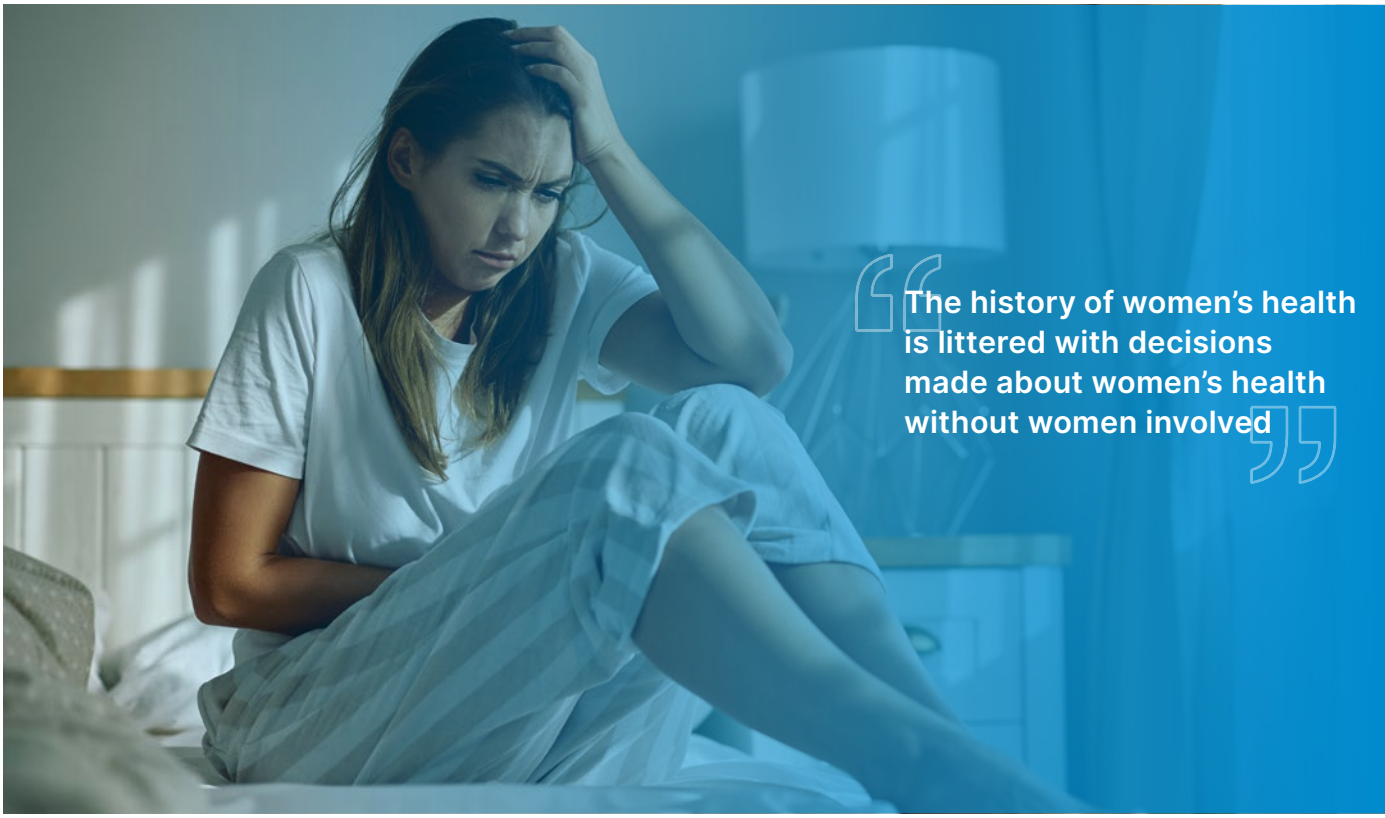
THE PATIENT VOICE

Rachel Morman, Patient Advocate and Chair of Verity PCOS UK, the UK's leading patient charity for PMOS, emphasised that more than 14,000 women with PMOS, from all over the world, contributed to this consensus and were integral to the process by co-designing surveys, co-chairing workshops alongside HCPs, shaping governance, and bringing real-world multicultural perspectives. "The history of women's health is littered with decisions made about women's health without women involved, and this was very much different, and it should set the bar for future condition name changes to come," said Morman. The name change was able to happen because patients, clinicians, and researchers who wanted better, and cared deeply, refused to give up. While they did not create evidence, they created an environment where the evidence could no longer be ignored, and this was the foundation of the name change.

In the end, 86% of patients and 76% of HCPs supported the change, and 97% of workshop participants agreed on the final name, showing a democratic, globally informed decision. Morman concluded by sharing the story of Victoria, who was diagnosed with PMOS in her 40s thanks to the name change, and who has already experienced an improvement in quality of life since starting treatment, showing the impact that this is already having on patient care.

CONCLUSION

PMOS affects 170 million people of reproductive age worldwide, and it is estimated that more than 70% of women with PMOS are undiagnosed. The transition from PCOS to PMOS is not just a change in terminology but reflects a broader change in how the condition is understood and validates patient experiences. While the change will not, on its own, change care, it lays the foundation for more accurate diagnosis and better care worldwide.



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