Polycystic ovary syndrome and mental health: a call to action

Polycystic ovary syndrome (PCOS) is the most common endocrinopathy in adult women (1). It can't be cured, but thanks to many years of fruitful research and intensive investigation, multiple modalities to help manage the condition throughout a woman's lifetime have emerged. Those of us who have been in practice for more than a decade or two have likely had the experience of managing mothers and daughters with the condition. Many of us have supported our PCOS patients through an adolescence complicated by acne and hair growth, an early adulthood complicated by infertility and irregular menses, and late reproductive age complicated by the new emergence of regular menstrual cyclicity, the latter a source of complete puzzlement (not to mention inconvenience) for our patient! Most of us have learned by now to carefully screen our patients with PCOS and initiate preventive therapy to avoid long-term and life-threatening complications of the disorder such as type 2 diabetes, heart disease, and endometrial cancer.

While we have made laudable advances in the treatment of so many aspects of this condition, it is remarkable that so little research has addressed the quality of life and psychosocial issues that frequently accompany a diagnosis of PCOS. Perhaps we have been too busy arguing about the diagnostic criteria (2). Whatever the reason, in this issue we have a globally authored position statement from the Androgen Excess-Polycystic Ovary Syndrome Society calling attention to this critical unmet need for women with PCOS (3).

Is it any wonder that a disorder that makes a woman prone to obesity and hirsutism, striking at her sense of attractiveness, and saddles her with infertility, striking at the heart of her identity as a woman, wreaks emotional havoc? PCOS is known to be related to a significantly lower self-reported quality of life (4), and this finding has largely been attributed to the comorbidities of the disorder such as hirsutism and obesity. While this is acknowledged, the authors make the case that several of the behavioral issues that afflict women with PCOS at a higher rate than the general population, such as depression and anxiety, are not simply explainable by the comorbidities of PCOS itself. Eating disorders also appear to be more prevalent in women with PCOS.

What is also clear from the statement is that we need more evidence-based treatments to offer our patients with PCOS. Standard treatments for PCOS such as metformin and oral contraceptives may have a positive impact on depression, but neither lifestyle, oral contraceptives, or metformin appeared to improve anxiety. Treatment of hirsutism appears to be of benefit. However, overall evidence is scarce. We are sorely in need of more information.

Fortunately, there is a relatively simple way to begin the process of addressing the behavioral challenges for women with PCOS. We can follow the path we have followed successfully for the 'medical' aspects of the disease. As reproductive endocrinologists, we are likely to interact with these women at many time points throughout their lives and in many settings. We will be their most frequent medical point of contact. We need to screen effectively and systematically. We need to learn how to mitigate some of the more troubling symptoms, and we need to help amass the evidence base for the therapies we propose by supporting the appropriate clinical trials.

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