SPEAKER: So this has been a really powerful care model. And we find that the patients-- it's incredibly common that we find patients telling us that this is the first time anyone has really explained things to them. It's the first time they've been with physicians who really understand what's going on for them. And for us to be able to approach it with multiple providers that are linked, I think, is just very satisfying in this world in which fragmented care is so common.

So what do we do in terms of this comprehensive plan? So the first thing we do is talk to them about the criteria that are used to make the diagnosis. And we talk to them about whether we think they meet those criteria or not. Now, if they don't meet the criteria, we're still going to address any issues they have or any problems they have. But we want to be careful about establishing whether they fall into this category or not. If they do, we also want to talk to them about look, this is not a life-threatening disease. This is something that's manageable. It's common. It's also very heterogeneous.

So at the end of the day, we want to figure out very specifically what is going on with this patient. Just because you have PCOS doesn't tell you that much. You need to know what aspects of PCOS are really bothering the patient and then take it from there. And we talk a lot about how so many of these aspects can be managed, or at least greatly improved, with lifestyle management measures.

We break down the care plan really into sort of four to five different categories. So we talk about menstrual control, control of hyperandrogenism, fertility, long-term health. And then also overlaying all of this is potential psychology aspects, with depression and anxiety being very common.

So let's break it down. Let's talk a little bit about menstrual cycle control. So our concern here is that with PCOS, women aren't ovulating very frequently. And that can lead to unopposed estrogen and risk of hyperplasia, which is overgrowth of the lining. It could potentially lead to endometrial cancer. So we want to educate patients on the fact that this is something that we need to prevent. And we talk to them about the different ways of preventing it, including cyclic progestins, oral contraceptives, or using a progestin IUD.

When we talk about hyperandrogenism, next, we need to really drill down on specifically what are the features that are bothering this patient. We have done a very in-depth skin exam with our dermatologist, and she develops the plan on this end. And so we want to think about acne, androgenic alopecia, and hirsutism. Certainly one of the first-line treatments is oral contraceptives. These have been shown to be very effective as your first-line, because they increase sex hormone binding globulin, and then that, downstream, sort of soaks up the extra androgen and inhibits LH.

But in many cases, the oral contraceptives aren't really enough. Patients have often already tried them. So then we're going to talk about additional measures. So for acne, there's many topical treatments, depending on the features that the dermatologist is seeing that we will use, or potentially oral retinoids-- so Accutane and things like that. For alopecia, really the first-line and the one drug that's been FDA-approved is Rogaine. And so we give instructions on the use of that. And then for excessive hair growth, spironolactone is an anti-androgen that, when combined with oral contraceptives, has been shown to be pretty effective. And so that's often our next step. We also are able to educate the patients about the options for laser or other types of mechanical removal methods that often are really useful-- unfortunately, are very often not covered by insurance, despite the fact that this can be a very disfiguring problem.

All right, and then fertility-- so a lot of times, the patients are seeing us not specifically to get pregnant at that moment. Our multidisciplinary clinic is really aimed at patients not yet trying to get pregnant, because if they're trying to get pregnant, they'll just come and see one of us in our regular clinic for fertility planning. But we do want to educate patients about fertility. It's not unusual.

In fact, just yesterday, we had a patient who came from pretty far away, a very rural area. And it was a young girl who had been told she was not going to be able to get pregnant. And we want to really educate women that that's not the case, that this is a very treatable disorder, but that word is out there. So we certainly try to re-educate.

So the first thing we talk about is that the treatment of infertility due to anovulation in PCOS is very straightforward in the vast majority of cases. In the majority of cases, it can be accomplished with oral medications. It doesn't require IVF or a lot of expensive treatments. So patients need to know that. They need to know that this is one of the easiest treatable things that we deal with from a fertility standpoint.

They also need to remember that PCOS isn't birth control. So these women don't obviously very regularly, but they do ovulate. And so they can't necessarily go without birth control just because they have PCOS. So that's another teaching point.

We also review the strategies. So we might say, look, it sounds like you might be ready to conceive in the next year. Let's think about-- let's talk to you specifically about some of the things we can do. So for women who are overweight with the PCOS, we will tell them that weight loss and lifestyle change are really first-line. For some women with PCOS, weight loss can improve ovulations on their own. And so some women with PCOS conceive on their own when they undertake these.

But more importantly in my mind is just that it puts that patient in the most optimal state for getting pregnant. We think that the pregnancy itself will be healthier if they're able to do everything they can to optimize lifestyle strategies.

We also talk about the medications that we could use. So the oral medications that are first-line now are Clomid or letrozole. Metformin has been used, is used in certain cases. But it's not first-line on the basis of large randomized controlled trials, which have shown Clomid and letrozole to be more effective. And then for some women, gonadotropins are required. So these are the injectable medications like injectable FSH, so more like a standard fertility medication.

And then long-term health and lifestyle modification-- so we want to educate our patients as well about the liabilities from a metabolic standpoint of having PCOS. I will try to frame this for patients as the fact that in America, all of us are really at risk of diabetes in a way because of our lifestyle and because of dietary aspects, but that with PCOS, you may have a slightly increased risk. And it's something to be aware of and to manage.