The power of naming disease correctly: PCOS is now PMOS

A young woman presents with irregular periods, insulin resistance, hirsutism, and difficulty losing weight. She is told she might have polycystic ovary syndrome (PCOS). She leaves the clinic and, like many patients today, turns to the Internet for answers. She searches "ovarian cysts" and quickly becomes more anxious—reading about cyst rupture, surgery, and ovarian cancer. Eventually reassured that the cysts themselves are not dangerous, she accepts a prescription for oral contraceptives and moves on with her life. The irregular cycles improve, but the underlying metabolic dysfunction remains. Years later, she develops prediabetes and continues to struggle with her mental health and body image.

The diagnosis was correct. The name was not.

PCOS has now been renamed polyendocrine metabolic ovarian syndrome (PMOS). The change, introduced in *The Lancet* (May 2026) and spearheaded by Professor Helena Teede of Monash University in conjunction with international societies and patient groups, reflects a contemporary understanding of this highly prevalent condition.[1]

The addition of "polyendocrine" and "metabolic" to the name signifies a paradigm shift that recognizes that PCOS has always been more than a disease of the ovaries. The new name is a clearer, more accurate description of the condition and incorporates the perspectives of clinicians and patients.[2]

PMOS affects 1 in 8 people with ovaries, making it the most common endocrinopathy in women of reproductive age. The emphasis on ovarian cysts likely came from its origin in 1935 as Stein-Leventhal Syndrome, after a series of women with amenorrhea and polycystic ovaries who were diagnosed and treated via laparotomy.[3] Although ultrasound findings of polycystic ovarian morphology became central to diagnosis in later decades, they do not represent the full pathophysiology of the condition.

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The 2003 Rotterdam Criteria, which form the basis of the current diagnostic guideline, define PCOS/PMOS by two of three features:

- Oligo- or anovulation (cycles of less than 21 days or more than 35 days).
- Clinical or biochemical signs of hyperandrogenism.
- Polycystic ovaries (originally more than 12 follicles/ovary; updated in 2018 to more than 20 follicles/ovary due to improved ultrasound resolution).

Exclusion of other causes (e.g., Cushing syndrome, androgen-secreting neoplasms, congenital adrenal hyperplasia) is necessary.[3]

The most recent international evidence-based guideline for the assessment and management of PCOS[4] continues to endorse the Rotterdam Criteria but does *not* require ultrasound evidence of polycystic ovarian morphology to establish the diagnosis. Elevated anti-Müllerian hormone (AMH) may be used in adults as an alternative to transvaginal ultrasound when assessing ovarian morphology. This is a welcome addition to the diagnostic framework, because AMH can be measured at any point in the menstrual cycle (~$80 in BC; private pay) and is more accessible than specialized ultrasound. In adolescents (10–19 years of age), the diagnosis is made based on irregular cycles and hyperandrogenism.[1]

The diagnostic algorithms developed through the international guideline process are freely available online and provide practical guidance on diagnosis, emotional well-being, lifestyle, pharmacological treatment for nonfertility indications, infertility, and PCOS and diabetes.[5] Patient resources, including the AskPMOS app, are also available and can facilitate education and self-management.[6]

The new name—PMOS—better captures the full complexity of a condition involving insulin dysregulation, androgen excess, ovarian dysfunction, and neuroendocrine pathways. Its manifestations extend far beyond reproduction and include features that are:

- Metabolic (e.g., obesity, type 2 diabetes, cardiovascular disease, hypertension).
- Reproductive (e.g., infertility, endometrial cancer, pregnancy complications).
- Psychological (e.g., anxiety, depression, reduced quality of life).
- Dermatological (e.g., alopecia, acne, hirsutism).[1]

One of the problems with the term PCOS is that it directs attention to a feature that is neither universal nor pathological. Although more than 20 small follicles—often referred to as "ovarian cysts"—may be seen on ultrasound in women with PMOS, these are a manifestation of disrupted ovulation, not the principal cause of the disorder. The updated nomenclature reminds us to focus on the patient rather than a single imaging finding and to prioritize prevention and management of the condition's broader health consequences.

Medicine has a long history of misleading names. Heartburn does not involve the heart, ringworm is not caused by a worm, adults can get juvenile diabetes, German measles is not measles, and endometriosis

Continued on page 190

Access to specialists in BC: When you don't know what you don't know

As I doom scroll through my news feed, I begin to wonder who *isn't* on diversion. Is it pediatrics in the North, internal medicine/ICU on the Island, and obstetrics in the Interior? Or is it pediatrics in the Interior, internal medicine/ICU in Vancouver Coastal, and obstetrics in Fraser? "All of the above" got me through medical school, so that's probably the right answer.

I check the call schedule. Neurology: blank. Respirology: blank. Hematology: blank. Good thing I'm just a physician; I would hate to be a patient right now.

Over the last few years, we have seen a growing number of specialist service interruptions and closures across BC. It is often our rural communities that are first or disproportionately impacted. We saw rural ER and maternity diversions years before this became a common urban issue. Hospitals, health authorities, and call groups struggle to piece together services. Strategies have included incentives to attract locums, virtual care, and task shifting onto other specialists and primary care. When these fail, we take our sick, vulnerable patients and put them in an ambulance through a mountain pass or use expensive flight resources to transport them far from home. Diversions are bad for our patients, our health expenditures, and our carbon footprint.

To address the evolving specialist crisis, we must understand the magnitude of the problem. A Doctors of BC and Consultant Specialists of BC joint survey in 2024 estimated that 1.2 million BC residents are waiting for an outpatient specialist consultation.[1] This estimate was generated using self-reported data from approximately 900 specialists. As of 1 May 2026, there were 142 unfilled psychiatry postings on Health Match BC.[2] While a health services researcher may question using these rudimentary measures to determine access to specialists, they would be hard-pressed to find good sources of data.

We need high-quality data on specialist distribution and wait times, intraprovincial referral patterns, and deferred care due to access limitations. Estimating specialist wait times at the provincial level is a daunting task, as there is minimal interconnectivity between EMR systems, and there are numerous parallel referral paths, both within and across health authorities. This can lead to duplicate and unnecessary referrals and inefficient care. Pathways is an excellent resource containing specialist wait-time information, but these data are self-reported. EMR systems can be leveraged to report on wait times for individual specialists, likely by triage priority, but the process will be different depending on whether you use Med Access, Accuro, or one of the 15 or so other systems used in BC.[3] Creating a standardized method to extract wait-time data across all EMR systems can be done, but if the responsibility to generate these reports is left in the hands of individual physicians, it will never happen.

We need a collaborative, data-driven approach to addressing gaps in specialist care.

The *Medical Services Plan Information Resource Manual: Fee-for-Service Payment Statistics* reports on physician numbers.[4] For example, in 2024–2025, there were 103 fee-for-service otolaryngologists practising in BC. Of these, 45 were in Vancouver Coastal Health, and two were in Northern Health. This speaks to the supply, but what about demand? Does Northern Health have 4% of the otolaryngology needs of Vancouver Coastal Health? The Canadian Institute for Health Information (CIHI) reports data on specialist counts by province.[5] CIHI data are readily available and allow for comparisons to be made between provinces and territories, but the data often lag by years and do not include standards for what should be considered an acceptable distribution. We need benchmarks for acceptable access, and these will vary by specialty, subspecialty, subsubspecialty, and reason for referral.

We have some building blocks to understand the gaps in specialist access, but we need a better process to extract and analyze these data, and we need definitions of acceptable access. This shouldn't be based exclusively on comparators with other regions and must reflect the access that is needed to support the health of our population. This necessitates a collaborative effort from physicians, the Ministry of Health, health authorities, allied health professionals, and patients. We have a shared responsibility to improve access to specialist care in BC.

We need a collaborative, data-driven approach to addressing gaps in specialist care. Once we fully understand the magnitude of the specialist access crisis in BC, we can stop using Band-Aids for bullet holes and develop a comprehensive provincial strategy to enhance access to specialist care. ■

—Denise Jaworsky, MD, PhD, FRCPC

References

1. Doctors of BC, Consultant Specialists of BC. 2024 specialist waitlist survey results. Accessed 1 May 2026. www.doctorsofbc.ca/sites/default/files/documents/2024-specialist-waitlist-survey-results.pdf.

References continued on page 190

Specialists in BC *Continued from page 189*

2. Health Match BC. Find a job. Accessed 1 May 2026. https://applicants.healthmatchbc.org/JobsBoard/HMBC/Default.aspx.
3. Doctors of BC. Provincial EMR strategy member survey 2022: Summary of results. 2022. Accessed 1 May 2026. www.doctorsofbc.ca/sites/default/files/provincial_emr_strategy_member_survey_2022.pdf.
4. BC Ministry of Health, Health Sector Information, Analysis, and Reporting Division. Medical Services Plan information resource manual: Fee-for-service payment statistics 2024/2025. October 2025. Accessed 1 May 2026. www.llbc.leg.bc.ca/public/PubDocs/bcdocs/340499/340499_msp_information_resource_manual_2024_2025.pdf.
5. Canadian Institute for Health Information. Supply, distribution and migration of physicians in Canada, 2024 – data tables. In: Physicians. Accessed 1 May 2026. www.cihi.ca/en/physicians.

PMOS *Continued from page 188*

is not simply misplaced endometrial tissue. While these examples may seem amusing or harmless, terminology influences how patients understand their conditions.

A new name alone will not improve care and outcomes, but it will shift the conversation from ovarian cysts to a better appreciation of the multiple systems involved. PMOS is more than a new name; it is an opportunity to align our language with our science and ultimately improve the patient care we provide. ■

—Caitlin Dunne, MD, FRCSC

References

1. Teede HJ, Khomami MB, Morman R, et al. Polyendocrine metabolic ovarian syndrome, the new name for polycystic ovary syndrome: A multistep global consensus process. Lancet 2026. In press. https://doi.org/10.1016/S0140-6736(26)00717-8.
2. Monash Centre for Health Research and Implementation. PCOS has a new name and is now known as PMOS – polyendocrine metabolic ovarian syndrome. Simple patient messages. Accessed 3 June 2026. www.mchri.org.au/wp-content/uploads/2026/05/Simple-patient-message-website.pdf.
3. Dunne C. Diagnosis and treatment of polycystic ovary syndrome (PCOS) using virtual health. This Changed My Practice (TCMP) by UBC CPD. 30 November 2022. Accessed 3 June 2026. https://thischangedmypractice.com/diagnosis-and-treatment-pcos-using-virtual-health/.
4. Teede HJ, Tay CT, Laven J, et al. Recommendations from the 2023 international evidence-based guideline for the assessment and management of polycystic ovary syndrome. Hum Reprod 2023;38:1655-1679. https://doi.org/10.1093/humrep/dead156.
5. Monash Centre for Health Research and Implementation. PCOS practice tools for health practitioners. Accessed 3 June 2026. www.mchri.org.au/guidelines-resources/health-professionals/pcos-practice-tools/.
6. Monash Centre for Health Research and Implementation. AskPCOS app. Accessed 3 June 2026. https://mchri.org.au/guidelines-resources/community/askpcos-app/.

Additional resources for women with PMOS from the Monash Centre for Health Research and Implementation: www.mchri.org.au/guidelines-resources/community/pmos-resources-2/.