Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/advances-in-womens-health/improving-outcomes-for-patients-with-pcos/16171/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Improving Outcomes for Patients with PCOS

Announcer:
You're listening to *Advances in Women's Health* on ReachMD. On this episode, we'll hear from Dr. Dawn Kimberly Hopkins, who's a research associate at the Henry Jackson Foundation in Bethesda, Maryland. Today, she'll be discussing the manifestations, treatment options, and unmet needs of polycystic ovary syndrome, also referred to as PCOS. She also presented a session on this topic at the 26th Annual Nurse Practitioners in Women's Healthcare Conference.

Here's Dr. Hopkins now.

Dr. Hopkins:
If we understand the manifestations, then we can identify the condition better, and that is really my focus of my presentation is to really dig into the pathophysiology so that we can understand and expect certain conditions. But the main ones are really hirsutism, so hyperandrogenism, menstrual dysfunction, so anything from oligomenorrhea to menorrhagia to extended cycle, shortened cycle. Anything that is not a normal regular 21- to 35-day cycle that's dysfunctional. And what we also notice are polycystic ovaries on ultrasound, but we try to look at the clinical presentation first because you can really look at a person and see if they have severe acne, facial hair; if you're doing a physical exam, you can see the body hair; so one, they have that hirsutism. They're usually going to have that central obesity, even if they're thin because we know that the hyper insulin that women have, or hyperinsulinemia, likes to go to the abdominal tissue, that visceral tissue, and grow those fat cells, so you'll see women usually are a little overweight, or if they're thin then they'll have probably a little bit of central obesity. The things that we don't think about are the psychological symptoms—anxiety, depression, paranoia, eating disorders. And one of the biggest frustrations as a provider is providers are confused on how to diagnose it. There were originally three organizations that put out diagnostic criteria, so there was always, "Well, which one do we use?" But now the new guidelines have stated that the recommendation is to use the Rotterdam criteria, and that is any of the three symptoms— the androgens, menstrual cycle dysfunction, or polycystic ovaries—any two of those three and you're diagnosed. So the frustration is that if you are a provider who works with women, you should know those symptoms at least that if you see someone who's a little hairy, a little acne, that should tip you off. Let me look a little further. And we should always assess a reproductive woman's menstrual cycle. That is the indicator of physiological health for females.

The other thing, which goes along with it, is support. A lot of the women are frustrated trying to convince healthcare providers that there's something wrong. We know the history of women coming to try and get care and making them marginalized or just not heard, and so that's really frustrating that these women don't have the support that they need.

And then the third thing that is frustrating is we have known about PCOS since 1935 when it was Stein-Leventhal syndrome. That's like 80 years ago. We have no medication specifically for PCOS. Even though women have different symptoms and signs, we basically use the same therapies, just mix it up, and that is we want to control the menstrual cycle, so we'll go with some type of birth control. Once we test for PCOS, we will see that they may have some impaired glucose tolerance or that they're insulin resistant, so we're going to go with the metformin because we want to help keep the blood sugar regulated and to try to combat that insulin resistance. And then now, more recently, with the new GLP-1 agonists, we're looking into that, but there's not a lot of research right now to support it, but that is a recommendation after trying metformin. It really is birth control, metformin, or we might try a spironolactone if they're over 30 or their blood pressure is an issue because we know with the oral contraception there's that potential with the estrogen, so we may take the birth control off of the plate, keep the metformin, and then go with the spironolactone to help with the androgens because between the metformin and the spironolactone can help regulate the cycles also and keep that facial body hair down.

So the three points that I would like to get across to the audience is the different manifestations, so that they can have a better chance of identifying the condition. And then I also am going to spend a bit of time on the pathophysiology because once you understand what's going on, like I said, you can think about the different comorbidities that probably are going to pop up and that you should probably look for. And then lastly, the treatment options, because I was a part of the international PCOS guideline, management for PCOS, and we worked really hard to try to have evidence-based therapies, and unfortunately, they just validated what we already have and let us know we need more.

Announcer:
That was Dr. Dawn Kimberly Hopkins discussing polycystic ovary syndrome. To access this and other episodes in our series, visit *Advances in Women's Health* on ReachMD dot com, where you can Be Part of the Knowledge. Thanks for listening!