PMOS vs. PCOS: Understanding the Difference, Diagnosis, Treatment and the Role of Unani Medicine

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Medical literature reviewed and updated: September 2026

Introduction: "Doctor, Is PMOS Different From PCOS?"

Since the terminology changed in 2026, I have started receiving an important new question from women:

"Doctor, I was diagnosed with PCOS. Now I am reading about PMOS. Have I developed another disease?"

Another patient asks:

"Is PMOS the severe form of PCOS?"

Some women say:

"My previous doctor said PCOD, another said PCOS, and now websites are saying PMOS. Which diagnosis is correct?"

The answer is reassuring:

PMOS and PCOS are not two different diseases.

PMOS is the **new international name** for the condition that was previously called:

Polycystic Ovary Syndrome – PCOS

In May 2026, after a large international consensus process, the condition was renamed:

Polyendocrine Metabolic Ovarian Syndrome – PMOS

The American Society for Reproductive Medicine has formally endorsed this change. The intention was to give the condition a name that better represents its true biological nature: a complex endocrine, metabolic and reproductive syndrome rather than merely a problem of "ovarian cysts."

The international guideline itself was updated in 2026 to use PMOS terminology, but an important point is that:

the diagnostic and treatment recommendations did not suddenly change simply because the name changed.

The 2023 International Evidence-Based Guideline remains the foundation; the terminology was updated to PMOS in May 2026, with the next full guideline revision expected in 2028.

So, if you were previously diagnosed correctly with PCOS:

you do not now have a new disease. Your condition has a new, more accurate name.

PMOS vs. PCOS in One Sentence

The simplest explanation is:

PCOS is the former name; PMOS is the current name for the same syndrome.

PCOS

Polycystic Ovary Syndrome

PMOS

Polyendocrine Metabolic Ovarian Syndrome

The change reflects progress in our understanding of the condition.

What About PCOD?

In India and South Asia, many patients still use:

PCOD – Polycystic Ovarian Disease

This term has been used widely in:

- clinics,
- ultrasound reports,
- websites,
- general conversation.

However:

PCOD is not recognized in current international diagnostic guidelines as a separate milder disease distinct from PCOS/PMOS.

The material supplied for this article described PCOD as a comparatively mild structural ovarian disorder and PCOS as a separate systemic endocrine-metabolic syndrome.

That distinction is common on health websites, but it is **not the current evidence-based international classification**.

Modern professional guidance recognizes:

- PMOS, formerly PCOS,
- and separately **polycystic ovarian morphology – PCO/PCOM** on ultrasound.

It does not establish "PCOD" as an internationally standardized mild counterpart of PMOS.

Therefore, for a professional medical website, I recommend saying:

PMOS (formerly PCOS; often called PCOD in everyday usage)

rather than presenting PCOD and PCOS as two different diseases.

PMOS vs. PCOS vs. PCO: The Important Difference

These three expressions are often confused.

PMOS

The current name of the endocrine-metabolic reproductive syndrome.

PCOS

The former name of the same syndrome.

PCO / PCOM

A description of ovarian morphology seen on ultrasound.

A woman can have:

polycystic ovarian morphology without having PMOS.

This is extremely important.

An ultrasound alone cannot establish the complete syndrome.

Why Was PCOS Renamed PMOS?

For decades, the name “Polycystic Ovary Syndrome” created several misconceptions.

The biggest was:

“PCOS means there are many pathological cysts in the ovaries.”

This is misleading.

The characteristic ultrasound appearance usually represents:

multiple small follicles

rather than the type of cyst we see in:

- an endometrioma,
- dermoid cyst,
- simple ovarian cyst,
- other ovarian masses.

The second problem was that the word “ovary” made the condition sound like an isolated gynecological disorder.

But modern research shows that it can involve:

- ovarian function,
- insulin metabolism,
- androgen hormones,
- menstrual cycles,
- fertility,
- cardiovascular risk factors,
- glucose regulation,
- sleep,
- skin and hair,
- psychological health,
- pregnancy outcomes.

For this reason the new name:

Polyendocrine Metabolic Ovarian Syndrome

better represents the systemic nature of the condition.

Was the Name Change Based on One Doctor's Opinion?

No.

The name change followed a major international consultation.

ASRM reports involvement from:

- 56 patient organizations and professional societies,
- approximately 22,000 survey responses,
- multiple workshops involving healthcare professionals and women with lived experience.

Women affected by the syndrome were an important driving force behind the change.

This is why PMOS should be regarded as:

the emerging internationally preferred terminology

rather than simply a new internet name.

How Common Is PMOS?

Current international PMOS resources estimate that the condition affects approximately:

1 in 8 women

or more than:

170 million women worldwide.

Reported prevalence varies according to:

- age,
- ethnicity,
- population studied,
- diagnostic criteria.

Does PMOS Mean a More Severe Form of PCOS?

No.

This is another misconception.

There is no rule that:

PCOS = mild

and:

PMOS = severe.

They are two names for the same underlying syndrome.

Individual women can certainly experience:

- mild symptoms,
- moderate symptoms,
- very significant reproductive or metabolic problems.

But PMOS is not the “advanced stage” of PCOS.

Has the Biology of the Disease Changed?

No.

The woman's biology did not change because the terminology changed.

What changed is:

how we describe the condition.

The older name emphasized:

- ovaries,
- cysts.

The newer name emphasizes:

- multiple endocrine systems,
- metabolism,
- ovarian/reproductive function.

The international guideline explicitly states that the recommendations remain unchanged following the 2026 terminology update.

What Actually Happens in PMOS?

PMOS involves a complex interaction between several biological pathways.

Important features may include:

- abnormal follicular development,
- irregular ovulation,
- excess androgen activity,
- insulin resistance,
- metabolic dysfunction,
- genetic susceptibility,
- altered ovarian endocrine signaling.

Not every woman has all of these abnormalities.

This explains why PMOS can look completely different in two patients.

Example: Two Women With the Same PMOS Diagnosis

Patient A

- age 21,
- normal body weight,
- irregular periods,
- facial hair,
- acne,
- normal glucose.

Patient B

- age 32,
- overweight,
- insulin resistance,
- infertility,
- irregular ovulation,
- few cosmetic symptoms.

Both can have PMOS.

This is why individualized treatment matters.

The Main Biological Features of PMOS

1. Ovulatory Dysfunction

The ovaries may not release an egg regularly.

This can lead to:

- delayed periods,
- missed periods,
- infertility.

---

2. Hyperandrogenism

Androgen hormones may be increased or more biologically active.

This may result in:

- facial hair,
- body hair,
- acne,
- scalp hair thinning.

---

3. Polycystic Ovarian Morphology

The ovaries may contain an increased number of small follicles.

But this feature:

is not mandatory in every woman.

---

4. Insulin Resistance and Metabolic Dysfunction

Some women have reduced sensitivity to insulin.

The body compensates by producing more insulin.

This may contribute to:

- increased androgen activity,

- metabolic changes,
- difficulty with regular ovulation.

But insulin resistance can exist in:

- overweight women,
- normal-weight women.

Does Every Woman With PMOS Have Insulin Resistance?

No.

It is common but not universal.

Furthermore, current PMOS guidance does not recommend routine blood insulin measurements as the primary way of diagnosing insulin resistance because commonly available insulin assays are not reliable enough for routine clinical decision-making.

Metabolic assessment should instead consider:

- glucose testing,
- OGTT when appropriate,
- blood pressure,
- lipid profile,
- clinical risk factors.

How Is PMOS Diagnosed?

The diagnosis is not made by ultrasound alone.

For adults, current evidence-based criteria require:

two of three main features

after excluding important alternative diagnoses.

Criterion 1: Ovulatory Dysfunction

This may include:

- irregular menstrual cycles,
- infrequent menstruation,

- absent ovulation.

Criterion 2: Clinical or Biochemical Hyperandrogenism

Clinical signs may include:

- hirsutism,
- acne,
- androgen-related scalp hair thinning.

Biochemical assessment may demonstrate elevated androgen levels.

Criterion 3: Polycystic Ovarian Morphology or Appropriate Adult AMH Evidence

In adults, ultrasound can evaluate ovarian morphology.

An important modern update is that:

AMH can be used as an alternative to ultrasound within the adult diagnostic algorithm in appropriate circumstances.

However:

AMH should not be used alone to diagnose PMOS.

If Irregular Periods and Hyperandrogenism Are Already Present, Is Ultrasound Necessary?

Often:

No.

When an adult clearly meets:

- ovulatory dysfunction,
- hyperandrogenism

criteria, ovarian imaging is not always required simply to confirm the syndrome.

This reinforces why PMOS should not be thought of primarily as a “cyst disease.”

What Does Polycystic Ovarian Morphology Mean?

The current international fertility glossary describes PCOM as ultrasound morphology generally involving:

- increased follicle number,
- and/or increased ovarian volume,

depending on the imaging technique and clinical context.

But:

PCOM by itself does not equal PMOS.

Many otherwise healthy women can have this appearance.

Is PMOS Diagnosed Differently in Teenagers?

Yes.

Adolescent diagnosis requires particular caution.

Teenagers often naturally have:

- irregular cycles,
- acne,
- follicle-rich ovaries

during normal maturation after menarche.

Therefore, current guideline recommendations are more restrictive.

Adolescent PMOS generally requires persistent:

menstrual irregularity plus hyperandrogenism

after excluding alternative causes.

Routine ovarian ultrasound and AMH are not recommended as diagnostic tools during the early post-menarche years.

This helps prevent healthy adolescents from being incorrectly labelled with a lifelong endocrine syndrome.

Conditions That Can Mimic PMOS

Before confirming PMOS, clinicians may need to consider other explanations.

These can include:

- pregnancy,
- thyroid disease,
- hyperprolactinemia,
- non-classic congenital adrenal hyperplasia,
- hypothalamic amenorrhea,
- Cushing syndrome,
- androgen-producing adrenal or ovarian tumors,
- some medication effects.

The exact work-up depends on:

- symptoms,
- severity,
- physical findings.

Red Flag: Rapid Virilization

PMOS usually causes gradual symptoms.

Sudden severe androgen symptoms such as:

- rapidly deepening voice,
- sudden severe hirsutism,
- clitoral enlargement,
- rapidly increasing muscle mass

require further evaluation.

These findings may indicate another androgen-producing disorder rather than ordinary PMOS.

Symptoms of PMOS

The syndrome may affect many areas of health.

Possible features include:

- irregular periods,

- absent periods,
- delayed menstruation,
- difficulty becoming pregnant,
- excessive facial/body hair,
- acne,
- scalp hair thinning,
- weight gain,
- insulin resistance,
- acanthosis nigricans,
- abnormal glucose metabolism,
- psychological distress.

Not every woman experiences every symptom.

PMOS and Infertility

PMOS is one of the most important causes of:

anovulatory infertility.

But this is also one of the areas where treatment can be very successful.

Many women with PMOS have:

- many follicles,
- adequate egg reserve,

but the follicles do not consistently progress to:

normal ovulation.

Restoring or inducing ovulation can therefore significantly improve fertility potential.

Does PMOS Mean a Woman Cannot Become Pregnant Naturally?

No.

Many women with PMOS:

- ovulate intermittently,

- conceive naturally.

Others need relatively simple fertility treatment.

The diagnosis should therefore not be presented as:

permanent infertility.

Before Treating PMOS Infertility, Evaluate the Couple

If pregnancy is the goal, I believe this is essential.

I want to know:

- woman's age,
- duration of infertility,
- whether ovulation occurs,
- whether the fallopian tubes are functional,
- male partner's semen analysis.

A woman may have PMOS and her husband may simultaneously have:

- severe oligozoospermia,
- low sperm motility,
- azoospermia.

Treating only the woman's periods for one year may therefore waste reproductive time.

PMOS and AMH: Another Common Confusion

Women with PMOS often have:

higher AMH

because they have a large number of small developing follicles.

This does not necessarily mean:

better fertility.

Many follicles may be present while ovulation remains irregular.

Likewise:

high AMH alone does not diagnose PMOS.

Metabolic Health in PMOS

The move from PCOS to PMOS makes the metabolic component much clearer.

Important associated concerns include:

- impaired glucose tolerance,
- type 2 diabetes,
- dyslipidemia,
- hypertension,
- sleep apnea.

This means a consultation focused only on:

“When will my periods come?”

can miss important long-term health issues.

Type 2 Diabetes Risk

Women with PMOS have an increased risk of:

- impaired glucose regulation,
- type 2 diabetes.

This risk is not limited to women with obesity.

Appropriate glucose assessment is therefore an important part of care.

Psychological Health

PMOS is associated with increased prevalence of:

- depression,
- anxiety,
- poor body image,
- reduced quality of life.

These are legitimate health concerns.

They should not be dismissed as:

“just stress because the periods are irregular.”

Current PMOS guidance specifically recognizes psychological health as an important part of management.

Sleep Apnea

Women with PMOS have an increased prevalence of:

obstructive sleep apnea.

Symptoms may include:

- loud snoring,
- unrefreshing sleep,
- excessive daytime sleepiness.

Sleep health can therefore form part of comprehensive care.

PMOS and Endometrial Health

When ovulation occurs very infrequently, long periods may pass without normal progesterone exposure.

This can increase the risk of:

- endometrial hyperplasia,
- eventually endometrial cancer.

The absolute cancer risk remains low, but prolonged untreated amenorrhea should not simply be ignored.

Cycle regulation and endometrial protection can therefore be important even when pregnancy is not currently desired.

PMOS and Pregnancy

Women with PMOS can have healthy pregnancies.

However, current evidence recognizes higher average risks of complications including:

- gestational diabetes,
- hypertensive pregnancy disorders,

- pre-eclampsia,
- preterm birth.

This is why metabolic health matters before and during pregnancy—not only while trying to conceive.

Modern Treatment: PMOS vs PCOS

Because PMOS and PCOS are the same condition:

their treatment is the same.

There is no new "PMOS medicine" required simply because the terminology changed.

Treatment continues to depend on:

- symptoms,
- metabolic health,
- menstrual health,
- fertility goals.

Treatment Goal 1: Lifestyle and Metabolic Health

Healthy lifestyle remains a foundation of treatment.

This may involve:

- nutritious diet,
- regular exercise,
- good sleep,
- smoking avoidance,
- weight management where appropriate.

The international guideline emphasizes lifestyle intervention for women across the PMOS spectrum and specifically warns against:

weight stigma.

A woman should not be told:

"Just lose weight and everything will disappear."

Does Every Woman Need to Lose Weight?

No.

Lean PMOS exists.

For women who are above their healthy metabolic weight, reduction may improve:

- insulin sensitivity,
- menstrual regularity,
- ovulation.

But for lean patients, the aim may instead be:

- metabolic fitness,
- nutrition,
- exercise,
- regular sleep.

Treatment Goal 2: Irregular Menstrual Cycles

When pregnancy is not currently desired, possible options may include:

- combined oral contraceptive pills,
- periodic progestogen,
- individualized endocrine treatment.

These can help with:

- menstrual regulation,
- endometrial protection,
- androgen-related symptoms.

They do not permanently remove the underlying PMOS tendency.

Treatment Goal 3: Metabolic Dysfunction

In selected women:

metformin

may be useful, particularly for metabolic features.

It can improve:

- insulin sensitivity,
- glucose-related outcomes,
- menstrual function in some women.

However:

metformin is not the best fertility medicine for every PMOS patient.

Treatment Goal 4: Hirsutism and Acne

Depending on pregnancy goals, options may include:

- hormonal treatment,
- cosmetic hair removal,
- laser treatment,
- dermatological therapy,
- selected anti-androgens.

Anti-androgens must be used carefully because pregnancy exposure can be unsafe.

Fertility Treatment: Letrozole Is the Current First-Line Drug

For a woman with:

- PMOS,
- anovulatory infertility,
- no other major infertility factor,

the current WHO infertility guideline suggests:

letrozole

over:

- clomiphene citrate,
- metformin

as first-line pharmacological ovulation induction.

WHO also suggests letrozole alone rather than routinely adding metformin.

This is a major evidence-based point for any modern PMOS infertility article.

What If First-Line Treatment Fails?

Treatment may progress to:

- other pharmacological approaches,
- gonadotropin stimulation,
- IVF when indicated.

WHO recommends considering IVF after unsuccessful appropriate pharmacological treatment rather than continuing ineffective therapy indefinitely.

Does Every PMOS Patient Need IVF?

No.

Many women conceive:

- naturally,
- after ovulation induction.

IVF is generally considered when:

- simpler treatment fails,
- age makes delay undesirable,
- tubal disease exists,
- major male-factor infertility is present,
- another IVF indication exists.

PMOS vs. PCOS in the Unani System of Medicine

This is another important question.

Because:

PMOS and PCOS are the same modern syndrome,

there is no separate:

- “Unani treatment for PCOS,”

- “different Unani treatment for PMOS”

simply because of the new name.

The underlying patient remains the same.

What changes is that the newer terminology actually fits well with one useful aspect of Unani medicine:

the whole-person approach.

PMOS involves much more than the ovary, and Unani medicine traditionally evaluates:

- constitution,
- diet,
- metabolism,
- menstrual health,
- sleep,
- physical activity,
- general wellbeing.

Is There an Exact Classical Unani Name for PMOS?

No exact one-to-one classical diagnosis corresponds perfectly to the modern syndrome.

The source material provided for this article discusses PMOS-like disease through traditional concepts including:

- Su'-i-Mizaj Barid Balghami,
- Balgham,
- Ihtibas-e-Tams,
- ‘Uqr.

These can be useful for explaining the traditional Unani framework.

However:

they should not be presented as direct biochemical equivalents of modern insulin resistance, testosterone excess or ovarian follicular physiology.

Modern PMOS is defined through contemporary reproductive endocrinology.

Traditional Unani concepts are a separate historical physiological framework.

The Four Humors in Unani Medicine

Classical Unani theory recognizes four:

Akhlat

Dam

Blood

Balgham

Phlegm

Safra

Yellow bile

Sauda

Black bile

Official Ministry of AYUSH descriptions confirm that the Unani system is based on this four-humor framework.

This is different from the term:

Dhatu

used in another traditional medicine framework.

For a professional Unani article, terminology should therefore remain accurate.

Mizaj

Unani medicine also evaluates:

Mizaj – temperament.

For me, the useful clinical principle here is:

individualization.

Two women with PMOS should not automatically receive identical treatment simply because they share one diagnostic label.

Their:

- body composition,
- menstrual pattern,

- metabolism,
- age,
- fertility goals,
- associated diseases

may be completely different.

Ghalba-i-Balgham and Barid Mizaj

Contemporary Unani literature often interprets PCOS-like presentations through:

- Ghalba-i-Balgham,
- Su'-i-Mizaj Barid,
- menstrual retention or irregularity,
- obesity where present.

These should be described as:

traditional Unani concepts

rather than saying that Balgham is scientifically identical to:

- insulin,
- cholesterol,
- ovarian cyst material.

This distinction protects the scientific credibility of integrative care.

Four Major Unani Treatment Modalities

CCRUM and the Ministry of AYUSH recognize four major therapeutic approaches:

Ilaj-bil-Tadbir

Regimenal therapy

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgical treatment

For PMOS, the first three can be particularly relevant as supportive components.

Ilaj-bil-Ghiza – Dietotherapy

Diet is particularly relevant because PMOS can involve:

- insulin resistance,
- excess body weight,
- metabolic dysfunction.

A practical diet may focus on:

- vegetables,
- pulses,
- adequate protein,
- whole grains where appropriate,
- fruit,
- nuts,
- seeds,
- healthy fats.

It is usually sensible to reduce:

- excess refined sugar,
- sugar-sweetened drinks,
- frequent ultra-processed food,
- excessive calorie intake where relevant.

But I would not tell every PMOS patient:

“You must never eat cucumber, yogurt or rice because they produce phlegm.”

Modern evidence does not support such universal restrictions.

Diet should be:

individualized, balanced and sustainable.

Ilaj-bit-Tadbir – Regimenal Therapy

This traditional category may include attention to:

- physical activity,
- sleep,
- stress,
- daily routine,
- weight management.

These aspects overlap meaningfully with modern PMOS lifestyle recommendations.

Official Unani sources also emphasize the:

Asbab-e-Sitta Zarooriya

or six essential determinants of health, including:

- air/environment,
- food and drink,
- physical activity and rest,
- psychological activity and rest,
- sleep and wakefulness,
- retention and elimination.

Exercise Is Particularly Valuable

Physical activity can help:

- insulin sensitivity,
- cardiovascular fitness,
- psychological health,
- weight management where appropriate.

This does not mean every woman needs:

extreme daily exercise.

Exercise should be appropriate to:

- age,
- medical condition,
- fitness,
- pregnancy goals.

What About Hijama?

Hijama or cupping is a recognized form of regimenal therapy within Unani practice.

However, I would not describe Hijama as:

the "gold standard" treatment of PMOS

or claim that it has been proven to:

- dissolve ovarian follicles,
- normalize LH and testosterone,
- restore fertility

without stronger high-quality clinical evidence.

If used:

it should be considered supportive regimenal care

and should not replace:

- metabolic screening,
- evidence-based ovulation induction,
- fertility evaluation.

What About Fasd or Venesection?

Traditional Unani literature includes venesection in selected historical indications.

It is not part of current evidence-based standard PMOS management.

It should not be routinely performed simply because a woman has:

- irregular periods,

- PCOS/PMOS.

Any invasive procedure requires:

- appropriate indication,
- trained supervision,
- careful safety assessment.

Ilaj-bid-Dawa – Unani Pharmacotherapy

Traditional medicines may be individualized according to:

- menstrual pattern,
- constitution,
- metabolic health,
- associated infertility,
- general health.

But herbal medicines should not be described as universally:

“balancing all hormones”

unless clinical evidence demonstrates that effect.

Darchini – Cinnamon

Among traditional interventions, Darchini has some direct clinical research in PCOS.

A randomized controlled study involving women meeting Rotterdam criteria compared:

- cinnamon,
- metformin

over 60 days.

The study reported improvement in menstrual patterns in both groups:

- approximately 51.9% in the cinnamon group,
- approximately 61.3% in the metformin group.

However:

- insulin resistance did not significantly improve,

- progesterone evidence of ovulation did not show a meaningful superiority.

This means:

Darchini may have a supportive role, particularly in menstrual health, but the study does not prove that cinnamon cures PMOS or infertility.

Dr. Qasmi's Nuskha No. 149 – Cystocure

Saira Health Care Pharmacy currently lists:

Dr. Qasmi's Nuskha No. 149 – Cystocure

for several cyst-related and PCOD-related concerns.

At Saira Health Care, such a formulation may be selected as part of an:

individualized traditional treatment programme

when appropriate.

However, one important 2026 correction is necessary:

PMOS is not fundamentally a disease of pathological ovarian cysts.

Therefore, the therapeutic objective should not be described as:

“destroying or dissolving all PCOS cysts.”

The small ovarian follicles characteristic of PMOS are part of follicular physiology and altered maturation.

I have not identified high-quality product-specific randomized evidence demonstrating that Nuskha No. 149 reliably:

- restores ovulation,
- normalizes insulin resistance,
- normalizes androgens,
- cures PMOS,
- improves live-birth rates.

Therefore I position it as:

supportive individualized traditional care, not a proven replacement for evidence-based PMOS treatment.

Natural Does Not Mean Risk-Free

Traditional medicines can:

- interact with medicines,
- affect glucose,
- affect the liver,
- stimulate menstruation,
- potentially be unsuitable during pregnancy.

This matters particularly in infertility treatment because a woman may become pregnant before realizing it.

Any formulation traditionally classified as:

Mudirr-i-Hayd

or emmenagogue should be reviewed immediately if pregnancy is:

- possible,
- suspected,
- confirmed.

Dr. Nizamuddin Qasmi's Special Approach to PMOS/PCOS at Saira Health Care

At Saira Health Care, my approach is not:

"Ultrasound shows cysts, so give cyst medicine."

I prefer the following structured plan.

Step 1: Confirm Whether the Patient Actually Has PMOS

I review:

- menstrual cycles,
- hyperandrogenism,
- ultrasound where appropriate,
- AMH where appropriate,

- alternative diagnoses.

A normal young woman should not receive a lifelong PMOS label because of one ultrasound.

Step 2: Understand the Patient's Main Goal

Is the priority:

- menstrual regularity?
- acne?
- facial hair?
- metabolic health?
- infertility?
- pregnancy?

Treatment changes depending on the objective.

Step 3: Assess Metabolic Health

Depending on the individual:

- glucose,
- OGTT,
- lipid profile,
- blood pressure

may be needed.

Step 4: Consider Thyroid, Prolactin and Other Endocrine Conditions

PMOS should not become a convenient label that prevents us from finding:

- another endocrine disease.

Step 5: Assess Lifestyle and Mizaj

I review:

- food,

- physical activity,
- sleep,
- body composition,
- stress,
- traditional constitutional findings.

This allows individualized Unani care rather than a generic package.

Step 6: Use Ilaj-bil-Ghiza

Diet is adjusted according to:

- metabolic needs,
- weight,
- glucose status,
- fertility goals.

The aim is sustainable reproductive and metabolic health.

Step 7: Use Ilaj-bit-Tadbir Appropriately

This may include:

- exercise,
- sleep optimization,
- stress reduction,
- other supervised regimenal measures.

Step 8: Add Individualized Unani Pharmacotherapy

Selected traditional formulations may be used according to:

- symptoms,
- menstrual pattern,
- overall reproductive condition.

They should be monitored rather than used indefinitely without objective assessment.

Step 9: If Pregnancy Is Desired, Evaluate the Male Partner

This is especially important because my clinical practice is focused on both:

Sexual Disorders & Infertility.

Saira Health Care's public physician profile specifically lists:

- PMOS/PCOS,
- irregular menses,
- decreased AMH,
- male infertility problems

within the clinic's fertility work.

Step 10: Determine Whether Ovulation Is the Actual Fertility Barrier

If ovulation is irregular:

ovulation induction may be appropriate.

Step 11: Use Evidence-Based Fertility Medication When Indicated

For anovulatory infertility due to PMOS:

letrozole is currently the preferred first-line pharmacological option.

Unani supportive treatment can be integrated appropriately, but it should not prevent access to effective fertility medicine.

Step 12: Monitor Ovulation and Treatment Response

Success should be measured by clinically useful outcomes such as:

- more predictable cycles,
- ovulation,
- improved metabolic status,
- pregnancy

rather than merely:

“the ultrasound cyst count decreased.”

Step 13: Escalate Treatment When Necessary

If appropriate treatment fails:

- gonadotropins,
- IVF

may need discussion.

Why Saira Health Care's Infertility Focus Matters

PMOS infertility is rarely just:

“an ovarian problem.”

A couple may simultaneously have:

- PMOS,
- low AMH,
- tubal disease,
- male low sperm motility,
- sexual dysfunction.

The Saira Health Care model emphasizes patient-centered individualized care and combines traditional knowledge with modern diagnostic understanding.

This approach is useful because infertility should be managed as:

a couple's reproductive problem

rather than placing the full burden on the woman.

About Dr. Nizamuddin Qasmi

I am:

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

My professional education and additional training include:

- **BUMS – Hamdard University, Delhi**
- **MD**
- **CGO**
- **Certificate in Infertility – MGBIMS, Delhi**
- **Certificate in Urology – London, UK**
- **Masters in Male Infertility – MasterHealthPro (HealthPro)**
- **Integrated Sexual and Reproductive Health – ISRH, UNFPA**

Saira Health Care's published professional material confirms this byline and identifies my clinical work as focused on:

sexual disorders and infertility.

PMOS vs. PCOS: Quick Comparison

Question	PCOS	PMOS
Full form	Polycystic Ovary Syndrome	Polyendocrine Metabolic Ovarian Syndrome
Is it a different disease?	No	No
Status	Former internationally accepted name	Current 2026 name
Main biological condition	Endocrine-metabolic reproductive syndrome	Same syndrome
Does it require ovarian cysts?	No	No
Diagnostic criteria	Established international criteria	Same criteria
Treatment	Lifestyle, hormonal/metabolic therapy, fertility treatment when indicated	Same treatment

Why change the name?	Old name overemphasized ovaries and “cysts”	Better reflects endocrine, metabolic and reproductive effects
Unani treatment	Individualized supportive care	Same individualized approach

---

PMOS vs. PCOD: Quick Comparison

Question	PCOD	PMOS
International standard diagnosis?	Not currently standardized as a distinct disease	Yes, current international terminology
Often used in India?	Yes	Increasingly
Should PCOD be considered a separate mild disease?	Not according to current international guidance	—
What should patients do with an old PCOD diagnosis?	Reassess using accepted PMOS diagnostic criteria	—

Common Myths

Myth 1: PMOS is a new disease discovered in 2026.

Fact: It is the new name for PCOS.

Myth 2: PMOS is worse than PCOS.

Fact: They are the same syndrome.

Myth 3: PCOD is a mild disease and PCOS is severe.

Fact: Current international diagnostic guidance does not recognize this as a formal disease distinction.

Myth 4: PCOS becomes PMOS when insulin resistance develops.

Fact: PMOS is simply the new name for the entire syndrome.

Myth 5: PMOS requires ovarian cysts.

Fact: No. Ovarian morphology is only one possible diagnostic component.

Myth 6: A normal ultrasound rules out PMOS.

Fact: No. Hyperandrogenism plus ovulatory dysfunction may establish the adult diagnosis after exclusion of other causes.

Myth 7: Polycystic ovarian morphology automatically means PMOS.

Fact: No. Morphology alone is not sufficient.

Myth 8: High AMH proves PMOS.

Fact: AMH may contribute to adult diagnosis but cannot be used alone.

Myth 9: Teenagers should be diagnosed from ultrasound.

Fact: Current guidance deliberately avoids ultrasound/AMH diagnosis during early post-menarche years.

Myth 10: Every PMOS woman is overweight.

Fact: Lean PMOS is well recognized.

Myth 11: Every woman has insulin resistance.

Fact: No.

Myth 12: Metformin is the first fertility medicine for everyone.

Fact: Letrozole is currently preferred first line for appropriate anovulatory PMOS infertility.

Myth 13: PMOS always causes infertility.

Fact: Many women conceive naturally.

Myth 14: Every ovarian follicle needs to be dissolved.

Fact: The small follicles seen in PMOS are not ordinary pathological cysts.

Myth 15: One herbal formula can permanently cure every case.

Fact: PMOS is heterogeneous and requires individualized long-term management.

Frequently Asked Questions

Is PMOS the same as PCOS?

Yes.

PMOS is the new name for PCOS.

When was the name changed?

The international name change was announced in:

May 2026.

What does PMOS stand for?

Polyendocrine Metabolic Ovarian Syndrome.

Why was PCOS renamed?

Because the old name misleadingly focused on:

- ovarian cysts,
- ovaries alone.

The new name better reflects the condition's:

- endocrine,
- metabolic,
- ovarian/reproductive

nature.

Did diagnostic criteria change in 2026?

The terminology changed, but the underlying guideline recommendations remain unchanged from the current evidence-based framework.

Does my old PCOS diagnosis remain valid?

If it was correctly made:

Yes.

You now have the same condition under the PMOS name.

What if my report says PCOD?

PCOD remains widely used informally, particularly in India.

The diagnosis should ideally be reviewed against current PMOS criteria rather than assuming PCOD is a different mild disorder.

Do I need cysts?

No.

Can I have PMOS with a normal ultrasound?

Yes.

Can AMH diagnose PMOS?

It can contribute in adults as part of an accepted diagnostic algorithm but should not be used alone.

Can a teenager be diagnosed from AMH?

No.

Can a thin woman have PMOS?

Yes.

Is PMOS curable permanently?

It can usually be managed very effectively, but there is currently no universal one-time treatment that permanently removes the syndrome in every woman.

Can PMOS infertility be treated?

Yes.

Many women respond well to:

- lifestyle optimization,
- ovulation induction.

What is the first-line fertility medicine?

For anovulatory infertility due to PMOS:

letrozole

is currently preferred by WHO over clomiphene or metformin in appropriate patients.

Can Unani medicine help?

Unani medicine can provide useful individualized supportive care involving:

- dietotherapy,
- lifestyle/regimenal care,
- menstrual-health support,
- metabolic support,
- selected traditional medicines.

It should complement accurate diagnosis and necessary fertility treatment.

Is PMOS treated differently from PCOS in Unani medicine?

No.

Because they are the same biological condition.

What is the traditional Unani interpretation?

Contemporary Unani literature often interprets overlapping presentations through concepts such as:

- Su'-i-Mizaj,
- Balghami states,
- Ihtibas-e-Tams,
- ‘Uqr.

These are traditional concepts, not direct equivalents of insulin resistance or androgen excess.

Can Hijama cure PMOS?

There is insufficient high-quality evidence to describe Hijama as a proven stand-alone cure.

Does cinnamon help?

A small randomized study suggests possible improvement in menstrual pattern, but it did not prove universal endocrine or fertility normalization.

Does Dr. Qasmi use Nuskha No. 149?

Nuskha No. 149 – Cystocure is currently listed in Saira Health Care's PCOD/female reproductive-health programme.

Its use should be individualized and should not be interpreted as proof that PMOS is simply an ovarian-cyst disease.

Latest 2026 Scientific Position

The most important recent developments are:

PMOS has replaced PCOS as the preferred name.

The change reflects the systemic endocrine and metabolic nature of the syndrome.

The existing international guideline recommendations remain in force.

Adult diagnosis continues to focus on ovulatory dysfunction, androgen excess and ovarian morphology/appropriately used AMH.

Lifestyle and psychological wellbeing remain central to management.

For PMOS-related anovulatory infertility, letrozole is the current preferred first-line pharmacological option.

IVF is appropriate when indicated after unsuccessful pharmacological treatment rather than allowing ineffective treatment to continue indefinitely.

My Message to Patients

If your previous report says:

PCOS

and your new doctor says:

PMOS

please do not think that your disease has suddenly become worse.

If another report says:

PCOD

do not assume that you have a completely separate disease.

Instead ask:

Do I genuinely meet PMOS diagnostic criteria?

Are my periods irregular because I am not ovulating?

Do I have androgen excess?

Do I actually need ultrasound?

Is AMH relevant in my case?

Have thyroid and prolactin problems been considered?

What is my glucose status?

Do I have metabolic risk factors?

Am I trying to become pregnant?

Has my husband's semen been checked?

Are my tubes open?

Can diet and individualized Unani treatment support my reproductive health?

Do I need letrozole?

Should I consider more advanced fertility treatment rather than waiting?

These questions are far more useful than simply asking:

"Is PCOD better than PCOS?"

Conclusion

The most important message is simple:

PMOS and PCOS are the same condition.

PMOS—**Polyendocrine Metabolic Ovarian Syndrome**—became the new internationally endorsed name in May 2026 for what was previously called:

Polycystic Ovary Syndrome – PCOS.

The name was changed because the old term:

- overemphasized ovarian cysts,
- underrepresented metabolic and endocrine disease,
- contributed to misunderstanding.

PCOD remains a widely used term in India, but current international guidance does not recognize it as a formally separate mild disease that must be distinguished from PCOS/PMOS.

The source material supplied for this article contains the commonly repeated online distinction between “mild structural PCOD” and “systemic PCOS” , but for Saira Health Care's professional disease section, I recommend correcting that distinction rather than reproducing it as established medical fact.

PMOS can involve:

- irregular ovulation,
- androgen excess,
- metabolic dysfunction,
- insulin resistance,
- altered ovarian follicular development,
- infertility,
- dermatological symptoms,
- psychological effects,
- increased long-term metabolic risk.

The modern treatment approach remains individualized.

It may include:

- healthy lifestyle,
- cycle regulation,
- metabolic treatment,
- acne/hirsutism treatment,
- ovulation induction,
- fertility treatment.

For infertility caused by PMOS-related anovulation:

letrozole is the current preferred first-line pharmacological treatment.

The **Unani system of medicine** can offer meaningful supportive care through:

- Mizaj-based individualization,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,

- Ilaj-bid-Dawa,
- nutritional management,
- physical activity,
- menstrual-health support,
- metabolic-health support.

Official AYUSH and CCRUM sources recognize these major Unani therapeutic modalities and the traditional four-humor framework.

At **Saira Health Care**, I prefer an integrative approach:

Confirm the diagnosis rather than relying only on ultrasound.

Use PMOS as the current terminology while recognizing PCOS/PCOD terms patients already know.

Evaluate menstrual and androgen symptoms.

Assess metabolic health.

Evaluate both partners when infertility is present.

Use individualized Unani diet, lifestyle and pharmacotherapy where appropriate.

Use modern endocrine treatment when indicated.

Use letrozole appropriately for anovulatory infertility.

Escalate to further fertility treatment when necessary.

Do not treat normal small ovarian follicles as tumors that simply need to be destroyed.

And do not promise a permanent cure from one herbal or hormonal medicine.

For every woman who asks:

“Doctor, what is the real difference between PCOS and PMOS?”

my answer is:

There is no difference in the disease itself. PMOS is the newer and more accurate name for PCOS. The woman, her symptoms, her fertility potential and the evidence-based treatment remain the same. What has improved is our terminology: instead of viewing the condition merely as ‘cysts in the ovaries,’ we now recognize it as a broader endocrine, metabolic and reproductive syndrome that requires individualized whole-person care.

Selected Medical References

1. **American Society for Reproductive Medicine.** *PCOS Is Now PMOS: Understanding the Name Change.* May 27, 2026.
2. **Monash University / International PMOS Guideline Program.** *Polyendocrine Metabolic Ovarian Syndrome: New Name to Improve Diagnosis and Care.* May 2026.
3. **International Evidence-Based Guideline for the Assessment and Management of PMOS, formerly PCOS.** Current terminology update 2026.
4. **World Health Organization.** *Guideline for the Prevention, Diagnosis and Treatment of Infertility.* 2025.
5. **WHO.** Treatment of infertility due to ovulatory dysfunction associated with PCOS/PMOS.
6. **Central Council for Research in Unani Medicine / Ministry of AYUSH.** Official Unani therapeutic approaches.
7. Khan AA, Begum W. **Efficacy of Darchini in the Management of Polycystic Ovarian Syndrome: A Randomized Clinical Study.** *Journal of Herbal Medicine.*

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Professional Education & Training

- **BUMS – Hamdard University, Delhi**
- **MD**
- **CGO**
- **Certificate in Infertility – MGBIMS, Delhi**
- **Certificate in Urology – London, UK**
- **Masters in Male Infertility – MasterHealthPro (HealthPro)**
- **Integrated Sexual and Reproductive Health – ISRH, UNFPA**

Saira Health Care's published professional profile identifies Dr. Nizamuddin Qasmi's focused practice in **Sexual Disorders & Infertility** and specifically includes PCOD/PCOS, irregular menstruation, decreased AMH and other male and female fertility problems among the conditions addressed.

Medical Disclaimer

This article is intended for:

- patient education,
- reproductive-health awareness,
- general medical information.

It does not replace:

- gynecological consultation,
- endocrine evaluation,
- pregnancy testing,
- ultrasound,
- fertility assessment,
- metabolic testing,
- semen analysis,
- reproductive endocrinology consultation.

Do not diagnose PMOS solely because:

- ultrasound shows multiple follicles,
- AMH is elevated,
- acne is present,
- menstruation is irregular.

Do not independently take:

- letrozole,
- clomiphene,
- metformin,
- hormonal contraceptives,
- progesterone,
- anti-androgen medicines,
- gonadotrophins,

- Unani medicines,
- herbal medicines,
- supplements

without appropriate professional guidance.

Traditional Unani treatment may provide useful individualized support, but it should not delay evidence-based fertility care when:

- infertility has persisted,
- female age is increasing,
- tubal disease exists,
- significant male-factor infertility exists,
- ovulation-induction treatment has failed.

Dr. Qasmi's Nuskha No. 149 or any other traditional formulation should not be interpreted as a guaranteed permanent cure for PMOS.

No modern, Unani, hormonal, herbal or assisted-reproductive treatment can ethically guarantee:

- permanent normalization of PMOS,
- ovulation,
- conception,
- live birth.

Saira Health Care
www.sairahealthcare.com

Medical literature reviewed and updated: September 2026