PMOS (Formerly PCOS/PCOD): Causes, Symptoms, Diagnosis, Infertility 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: PCOD, PCOS or PMOS—What Is the Correct Name?

When a young woman comes to me with irregular periods, acne, unwanted facial hair or difficulty becoming pregnant, one of the first things she often says is:

“Doctor, my ultrasound says PCOD. Does that mean I have cysts in my ovaries?”

Another patient asks:

“What is the difference between PCOD and PCOS?”

And since 2026, another question has become important:

“What is PMOS? Is it a new disease?”

The answer is very important.

PMOS, PCOS and the commonly used term PCOD are not three different diseases.

For many years the internationally accepted name was:

Polycystic Ovary Syndrome – PCOS

The term:

PCOD – Polycystic Ovarian Disease

has also been widely used, especially in India, but PCOS became the more accepted medical terminology because the condition is a syndrome involving many hormonal, reproductive and metabolic features rather than simply an ovarian "disease."

Then, in **May 2026**, an international initiative changed the name from PCOS to:

Polyendocrine Metabolic Ovarian Syndrome – PMOS

The name change has been endorsed by major organizations including the **American Society for Reproductive Medicine** and **Endocrine Society**. The purpose is to emphasize that this condition is not simply about ovaries or "cysts"; it affects multiple hormonal systems, metabolism, fertility, skin, mental health and long-term health.

During the transition, patients will continue to see all of these terms:

- PCOD
- PCOS
- PMOS

on medical records, websites and laboratory reports.

For clarity throughout this article, I will mainly use:

PMOS (formerly PCOS/PCOD).

Why Was PCOS Renamed PMOS?

The old name created two major misunderstandings.

Misunderstanding 1: "You Must Have Ovarian Cysts"

This is false.

A woman can have PMOS/PCOS without any "cysts" being visible on ultrasound.

In fact, what older descriptions commonly called "polycystic ovaries" are usually:

multiple small immature follicles

rather than true pathological ovarian cysts.

The new name therefore removes an unnecessary focus on "cysts."

Misunderstanding 2: "This Is Only an Ovarian Disease"

PMOS can affect:

- menstruation,

- ovulation,
- androgen hormones,
- insulin sensitivity,
- body weight,
- glucose metabolism,
- cholesterol,
- skin,
- hair,
- fertility,
- pregnancy,
- sleep,
- emotional health.

This broader reality is reflected much better by:

Polyendocrine Metabolic Ovarian Syndrome.

The condition is estimated to affect approximately **1 in 8 women**, or more than 170 million women worldwide.

What Is PMOS/PCOS?

PMOS is a common endocrine-metabolic reproductive syndrome characterized by varying combinations of:

1. Abnormal or irregular ovulation

2. Excess androgen activity

3. A characteristic increased follicle pattern in the ovaries or elevated AMH in appropriate adult diagnostic settings

A woman does not need to have all three.

She may have:

- irregular periods without obesity,
- excess facial hair with normal body weight,
- infertility despite very few cosmetic symptoms,

- high androgen levels but no obvious ovarian changes,
- or ovarian morphology without major visible symptoms.

This is one reason PMOS can look very different from one woman to another.

PMOS Is Not Simply "Cysts on the Ovary"

I consider this one of the most important facts for patients.

When ultrasound shows many small follicles, women often become frightened because they hear the word:

"cyst."

But a follicle is the normal structure in which an egg develops.

In PMOS, several follicles may begin development but may not progress to normal dominant-follicle maturation and regular ovulation.

This can result in:

- irregular periods,
- delayed ovulation,
- absence of ovulation,
- infertility.

The follicles seen on ultrasound are therefore not comparable to every:

- ovarian cyst,
- endometrioma,
- dermoid cyst,
- ovarian tumor.

PMOS should not be treated as though the objective is simply to:

"dissolve ovarian cysts."

The real treatment target is the woman's complete:

- hormonal,
- metabolic,
- reproductive,
- menstrual and fertility profile.

What Happens Normally During Ovulation?

In a normal menstrual cycle:

1. several follicles begin growing;
2. one usually becomes the dominant follicle;
3. the dominant follicle matures;
4. an LH surge triggers ovulation;
5. an egg is released;
6. progesterone rises after ovulation;
7. pregnancy may occur if sperm fertilizes the egg.

In PMOS, follicular development may become disrupted.

A number of small follicles can remain at earlier stages rather than one consistently reaching:

normal ovulation.

This is called:

oligo-ovulation

when ovulation occurs infrequently,

or:

anovulation

when ovulation does not occur.

What Causes PMOS?

There is no single cause.

Current scientific understanding suggests PMOS results from a complex interaction between:

- genetics,
- androgen biology,
- insulin resistance,
- ovarian function,

- hypothalamic-pituitary signaling,
- body composition,
- environmental and lifestyle influences.

The exact balance varies between women.

Therefore it is misleading to tell every patient:

“You developed PCOS only because you gained weight.”

Likewise, it is incorrect to say:

“You developed PCOS only because your hormones became imbalanced.”

The hormonal abnormalities are themselves part of the syndrome.

Genetics and Family History

PMOS has an important genetic component.

Women are more likely to develop it when close family members have:

- PMOS/PCOS,
- menstrual irregularity,
- androgen excess,
- metabolic disease.

However, there is no single:

“PCOS gene.”

Many genes and regulatory mechanisms appear to contribute.

This explains why PMOS can occur in:

- sisters with different symptoms,
- lean women,
- overweight women,
- adolescents,
- women who previously had apparently normal cycles.

Insulin Resistance

One of the most important biological features of PMOS is:

insulin resistance.

Insulin is the hormone that helps the body regulate blood glucose.

When body tissues become less responsive to insulin, the pancreas may produce additional insulin to compensate.

High circulating insulin can interact with ovarian endocrine function and contribute to:

- increased androgen production,
- impaired follicular development,
- irregular ovulation.

Insulin resistance is important in PMOS but can occur even in women who are not overweight.

Current international guidance also cautions that routine insulin assays are not sufficiently accurate or useful to diagnose insulin resistance in ordinary clinical practice.

Hyperandrogenism

Androgens include hormones such as:

testosterone.

Women normally produce androgens too.

PMOS can cause excessive:

- androgen production,
- androgen activity.

This may lead to:

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

It can also contribute to disrupted:

- follicular maturation,

- ovulation.

LH and FSH

The pituitary gland produces:

- LH
- FSH.

These hormones help regulate the ovaries.

Some women with PMOS show altered LH-related reproductive signaling.

However:

an abnormal LH ratio is not required to diagnose PMOS.

A normal ratio does not exclude the syndrome.

This is important because many women are diagnosed or dismissed solely from an LH ratio, which is not an appropriate stand-alone diagnostic test.

Is Stress a Cause?

Stress may affect:

- sleep,
- eating behavior,
- metabolic health,
- menstrual patterns,
- quality of life.

But stress alone should not be presented as the proven fundamental cause of PMOS.

Instead, stress management is one component of:

whole-person care.

Does Being Overweight Cause PMOS?

Higher body weight can:

- worsen insulin resistance,

- increase androgen-related metabolic dysfunction,
- contribute to more irregular ovulation

in susceptible women.

But:

PMOS also occurs in lean women.

Therefore a thin woman should never be told:

“You cannot have PCOS because your weight is normal.”

And a woman with a higher body weight should not be blamed for developing the condition.

The current international guideline specifically emphasizes minimizing:

weight stigma

in PMOS care.

Lean PMOS / Lean PCOS

Some women with PMOS have:

- normal BMI,
- no obvious obesity,
- regular-looking body composition.

They may still experience:

- irregular ovulation,
- acne,
- hirsutism,
- infertility,
- metabolic abnormalities.

Lifestyle care remains useful, but treatment should not be reduced to:

“lose weight.”

Common Symptoms of PMOS

Symptoms vary widely.

Possible manifestations include:

- irregular periods,
- delayed periods,
- missed periods,
- very infrequent menstruation,
- difficulty becoming pregnant,
- excess facial hair,
- excess body hair,
- acne,
- oily skin,
- scalp hair thinning,
- weight gain,
- difficulty controlling weight,
- darkened skin in body folds,
- metabolic abnormalities,
- mood symptoms.

Not every woman experiences all of these.

Menstrual Symptoms

One of the most common features is:

irregular ovulation and menstruation.

A woman may have:

- periods every 40–60 days,
- only a few periods each year,
- prolonged gaps without menstruation.

Others may have relatively regular bleeding but still experience less consistent ovulation.

Hirsutism

Hirsutism means excessive terminal hair growth in androgen-sensitive areas such as:

- upper lip,
- chin,
- chest,
- abdomen,
- back.

It is one of the most useful clinical indicators of androgen excess.

However, normal hair patterns vary significantly across:

- ethnicity,
- family background.

Clinical assessment should therefore be individualized.

Acne

Androgen excess can increase sebaceous-gland activity and contribute to:

- acne,
- oily skin.

Acne alone does not diagnose PMOS.

Scalp Hair Thinning

Some women develop androgen-related scalp hair loss.

This may resemble:

female-pattern hair loss.

Other causes of hair loss—such as thyroid disease, iron deficiency and nutritional problems—may also need consideration.

Acanthosis Nigricans

Dark, thickened skin may occur around:

- neck,

- underarms,
- groin.

This can be associated with:

insulin resistance.

It should prompt appropriate metabolic assessment rather than simply cosmetic treatment.

PMOS and Infertility

PMOS is one of the major causes of:

anovulatory infertility.

The basic problem is often not that the woman has no eggs.

Instead:

eggs may not be released regularly.

Therefore many women with PMOS have very good fertility potential once:

- ovulation is restored,
- the male partner is evaluated,
- other infertility factors are excluded.

PMOS should not automatically be interpreted as permanent infertility.

Can a Woman With PMOS Become Pregnant Naturally?

Yes.

Many women with PMOS:

- ovulate intermittently,
- conceive naturally.

Others require:

- lifestyle treatment,
- ovulation induction,
- IUI,
- IVF.

The fertility plan depends on:

- age,
- duration of infertility,
- ovulation,
- fallopian tubes,
- sperm quality,
- other female factors.

Pregnancy Should Be Planned as Couple-Based Care

Whenever a patient comes to me for PMOS-related infertility, I do not look at only:

- her ovaries,
- her AMH,
- her weight.

I also want to know:

Has the male partner had a proper semen analysis?

A woman may have PMOS while her partner simultaneously has:

- low sperm count,
- poor motility,
- abnormal morphology,
- azoospermia.

Treating the woman's ovulation for months without evaluating the male partner can waste valuable reproductive time.

How Is PMOS Diagnosed in Adults?

Modern diagnosis has become more precise.

In adults, after excluding important disorders that can mimic PMOS, the current international guideline generally requires:

Two of the following three features:

1. Clinical or biochemical hyperandrogenism

This means signs such as:

- hirsutism

or appropriately measured elevated androgen levels.

2. Ovulatory dysfunction

Such as:

- irregular,
- infrequent or absent menstrual cycles.

3. Polycystic ovarian morphology on ultrasound or elevated AMH used appropriately as an adult diagnostic alternative

AMH can now be used in adult diagnostic pathways as an alternative marker of polycystic ovarian morphology, but:

AMH should not be used alone as a stand-alone PMOS test.

If Periods Are Irregular and Androgens Are High, Is Ultrasound Necessary?

Not always.

If an adult already clearly has:

- ovulatory dysfunction,
- hyperandrogenism,

the diagnosis can generally be made without requiring ultrasound solely to prove “polycystic ovaries.”

This avoids unnecessary imaging and reinforces:

PMOS is not fundamentally an ovarian-cyst diagnosis.

Can AMH Diagnose PMOS?

In adults:

AMH may contribute to diagnosis

as an alternative to ultrasound assessment of polycystic ovarian morphology in the appropriate diagnostic algorithm.

But it should not be interpreted alone.

A high AMH result does not automatically mean:

PMOS.

And AMH is not recommended in adolescents for diagnosis.

PMOS Diagnosis in Adolescents

Adolescent diagnosis requires special caution because normal puberty itself can cause:

- irregular cycles,
- acne,
- physiological ovarian changes.

Current international recommendations require both:

persistent menstrual-cycle irregularity appropriate to the time since menarche

and:

clinical or biochemical hyperandrogenism

after excluding other causes.

Adolescents with only one feature may be considered:

“at risk”

and followed over time rather than being prematurely labelled.

Ultrasound Should Not Be Used to Diagnose Adolescent PMOS Early After Menarche

Current international guidance does not recommend:

- ovarian ultrasound,
- AMH

for diagnosis within approximately:

8 years after menarche

because normal adolescent ovarian physiology can resemble PMOS.

This helps prevent overdiagnosis.

What Conditions Should Be Excluded?

PMOS is a diagnosis that requires exclusion of important mimicking disorders.

Depending on the presentation, clinicians may consider:

- pregnancy,
- thyroid disease,
- hyperprolactinemia,
- non-classic congenital adrenal hyperplasia.

Current international guidance recommends assessment using:

- TSH,
- prolactin,
- 17-hydroxyprogesterone

where appropriate.

More extensive investigation may be needed if there is:

- severe androgen elevation,
- rapid virilization,
- severe amenorrhea,
- suspicion of Cushing syndrome,
- androgen-producing tumor,
- hypogonadotropic hypogonadism.

Rapid Virilization Is Not Typical PMOS

If a woman develops rapidly progressive:

- deepening voice,
- severe sudden hair growth,
- increased muscle mass,
- clitoral enlargement,
- dramatically elevated androgens,

this requires investigation beyond ordinary PMOS.

An androgen-producing:

- ovarian,
- adrenal lesion

may need exclusion.

Tests Commonly Considered in PMOS

Depending on individual symptoms, evaluation may include:

- menstrual and reproductive history,
- pregnancy test,
- total/free testosterone or appropriate androgen assessment,
- TSH,
- prolactin,
- 17-hydroxyprogesterone,
- glucose assessment,
- lipid profile,
- blood pressure,
- ultrasound where indicated,
- AMH in selected adults.

No woman needs every possible hormone test simply because she has PMOS.

Glucose Testing in PMOS

Women with PMOS have an increased risk of:

- impaired glucose tolerance,
- type 2 diabetes.

This risk can occur independent of body weight.

The international guideline recommends assessment of glycemic status and recognizes the:

75-g oral glucose tolerance test – OGTT

as the most accurate test for assessing glycemia in PMOS.

Routine insulin-level testing is much less useful for everyday clinical care.

Lipid and Blood-Pressure Assessment

PMOS can be associated with adverse:

- cholesterol,
- triglyceride,
- blood-pressure profiles.

Current guidance therefore recognizes the need to assess cardiovascular and metabolic risk factors during long-term care.

PMOS Is Not Classified as "Mild, Moderate and Severe" by Standard Diagnostic Guidelines

The supplied material describes:

- mild PCOS,
- moderate PCOS,
- severe PCOS.

This is not the standard evidence-based diagnostic classification.

Symptoms can certainly range from:

- mild,
- to clinically significant.

But PMOS is better understood by its specific clinical features and phenotypes than by a universal mild/moderate/severe scale.

Classical Adult PMOS/PCOS Phenotypes

For clinical and research purposes, the Rotterdam-feature combinations are sometimes described as phenotypes.

Phenotype A

- hyperandrogenism,
- ovulatory dysfunction,
- polycystic ovarian morphology.

Phenotype B

- hyperandrogenism,
- ovulatory dysfunction.

Phenotype C

- hyperandrogenism,
- polycystic ovarian morphology,
- relatively preserved ovulation.

Phenotype D

- ovulatory dysfunction,
- polycystic ovarian morphology,
- without overt hyperandrogenism.

These patterns can help explain why two women with the same syndrome may look very different.

They are:

phenotypes—not severity grades.

PMOS and Insulin-Resistant Phenotype

Some women have prominent:

- insulin resistance,
- obesity,
- acanthosis nigricans,
- metabolic abnormalities.

But:

“insulin-resistant PCOS” is not a separate formal disease category.

Insulin resistance is one important component of the syndrome.

Long-Term Complications and Associated Health Risks

PMOS should not be viewed only as:

“a period problem.”

It can affect health across the lifespan.

Type 2 Diabetes

Women with PMOS have increased risk of:

- impaired glucose tolerance,
- type 2 diabetes.

This is one reason metabolic follow-up is important even when the immediate complaint is:

- acne,
- infertility.

Dyslipidemia

Abnormalities may include:

- raised triglycerides,
- LDL abnormalities,
- reduced HDL.

Lifestyle and medical treatment should be based on the actual lipid profile and overall cardiovascular risk.

Blood Pressure and Cardiovascular Health

Women with PMOS have increased prevalence of several cardiovascular risk factors.

Long-term cardiovascular risk assessment therefore forms part of modern PMOS management.

This does not mean every woman with PMOS will develop heart disease.

Obstructive Sleep Apnea

PMOS is associated with increased risk of:

obstructive sleep apnea.

Symptoms may include:

- loud snoring,

- unrefreshing sleep,
- daytime sleepiness.

The international guideline recognizes sleep apnea as an important associated condition.

Depression and Anxiety

Women with PMOS have substantially increased rates of:

- depressive symptoms,
- anxiety.

Current international guidance recommends awareness and screening rather than assuming these problems are simply emotional reactions to cosmetic symptoms.

Eating Disorders and Body-Image Concerns

Some women experience:

- disordered eating,
- body-image distress,
- frustration after repeated weight-focused medical advice.

A respectful treatment plan should address:

- physical health,
- psychological health

without stigma.

Endometrial Hyperplasia and Endometrial Cancer

When menstruation and ovulation are very infrequent, the endometrium may experience prolonged stimulation without regular progesterone exposure.

Women with PMOS have an increased risk of:

- endometrial hyperplasia,
- endometrial cancer.

However:

the absolute risk remains low

and routine endometrial cancer screening is not recommended for every woman with PMOS.

Preventive strategies may include:

- menstrual-cycle regulation,
- weight management where appropriate,
- regular progestogen exposure where medically indicated.

Does PMOS Cause Ovarian Cancer?

The older supplied material states that women with PCOS have an increased risk of:

ovarian cancer.

This should not be presented as an established routine complication of PMOS.

The best-established gynecological cancer association is:

endometrial hyperplasia and endometrial cancer.

PMOS and Pregnancy Risks

Pregnancy is completely achievable for many women with PMOS.

However, once pregnant, these women should be recognized as having a higher-risk pregnancy profile for complications including:

- gestational diabetes,
- hypertensive disorders,
- pre-eclampsia,
- preterm birth.

Current 2026 PMOS pregnancy initiatives specifically emphasize these increased pregnancy risks.

This means good care should continue:

after the pregnancy test becomes positive.

Can PMOS Be Permanently Cured?

This is an important question.

PMOS is usually considered:

a long-term endocrine-metabolic condition.

There is currently no single treatment that permanently removes the underlying syndrome from every woman.

But:

PMOS can often be managed extremely well.

Symptoms may improve dramatically.

Women may achieve:

- regular menstrual cycles,
- better metabolic health,
- improved acne,
- reduced unwanted hair growth,
- normal ovulation,
- successful pregnancy.

Mayo Clinic's current PMOS information similarly notes that no universal cure exists, while treatment can effectively control symptoms and long-term risks.

Modern Treatment of PMOS

There is no one treatment for every woman.

Treatment should first ask:

What does this particular woman need?

Possible goals include:

- regular menstruation,
- fertility,
- control of acne,
- reduction of hirsutism,
- metabolic health,
- weight management,
- diabetes prevention,

- endometrial protection.

Treatment should be matched to those goals.

---

1. Lifestyle Management – Foundation of Treatment

Current international guidance recommends healthy lifestyle behaviors for:

all women with PMOS.

This includes:

- healthy eating,
- physical activity,
- behavioral strategies,
- prevention of excess weight gain where appropriate.

Importantly:

there are health benefits even when weight does not decrease.

Lifestyle treatment should not be reduced to:

“lose weight and come back.”

Is There One Best PCOS Diet?

No.

There is currently no single diet proven superior for every woman with PMOS.

A sustainable pattern should ideally emphasize:

- vegetables,
- fruits,
- pulses,
- adequate protein,
- whole grains where suitable,
- nuts,
- seeds,
- healthy fats,

- reduced ultra-processed food,
- reduced excess sugar.

The best dietary plan is one that:

- meets nutritional needs,
- improves metabolic health,
- can realistically be maintained.

Exercise

Exercise can improve:

- insulin sensitivity,
- cardiovascular fitness,
- psychological health,
- body composition.

This remains beneficial even when the scale does not change substantially.

Weight Management

For women with higher body weight who wish to reduce weight, even modest improvements can benefit:

- metabolic health,
- menstrual regularity,
- ovulation.

However, the treatment goal should be individualized.

Current guidelines specifically warn clinicians against:

weight stigma.

---

2. Combined Oral Contraceptive Pills

For women who:

- are not currently trying to conceive,

- have irregular cycles,
- hyperandrogenic symptoms,

combined oral contraceptive pills are often first-line pharmacological treatment.

They can help with:

- cycle control,
- acne,
- hirsutism.

They also provide endometrial protection in appropriately selected women.

They do not:

permanently cure PMOS.

Bleeding while taking the pill does not necessarily mean underlying spontaneous ovulation has been permanently restored.

---

3. Progestogen for Endometrial Protection

Some women who do not menstruate regularly and are not seeking immediate pregnancy may require intermittent:

progestogen

or another method of cycle/endometrial protection.

This should be individually prescribed.

---

4. Metformin

Metformin is an insulin-sensitizing medication.

Current international guidance uses metformin primarily for:

- metabolic features,
- particularly in women at higher metabolic risk.

It may help some women with:

- insulin resistance,
- glucose abnormalities,
- menstrual regulation.

But metformin is not automatically:

the best fertility medicine for every woman with PMOS.

The 2023 international guideline notes that metformin has greater evidence for metabolic management than inositol.

Metformin and PMOS Infertility

When the primary problem is anovulatory infertility:

letrozole is now preferred over metformin alone.

This is supported both by the international guideline and the WHO 2025 infertility guideline.

---

5. Treatment of Hirsutism and Acne

Options can include:

- combined oral contraceptives,
- cosmetic hair-removal approaches,
- laser treatment,
- selected anti-androgens,
- dermatological therapy.

Anti-Androgen Medicines

Medicines such as spironolactone may be considered in selected women when other therapy is inadequate.

Because anti-androgens can potentially affect a male fetus:

effective contraception is important when these medicines are used.

They should not be self-prescribed.

---

6. Inositol

Inositol supplements have become extremely popular online.

Current guideline evidence suggests possible limited benefits for some women, but evidence remains less robust than many advertisements imply.

Metformin has stronger evidence for several metabolic indications.

Therefore inositol should not be described as:

a proven PCOS cure.

---

7. Anti-Obesity Medicines

Modern weight-management medicines may be considered in selected women according to general obesity treatment guidelines.

This increasingly includes drugs from:

- GLP-1-related treatment classes.

However:

- pregnancy planning matters,
- medication safety must be considered,
- effective contraception may be necessary while using certain drugs.

Women trying to conceive should discuss medication discontinuation and timing with their treating physician.

Treatment of PMOS-Related Infertility

This is particularly relevant to my practice at Saira Health Care.

The first step is:

confirm that anovulation is really the primary fertility problem.

Before repeatedly stimulating ovulation, I also want to know:

- are the fallopian tubes functional?
- is the male partner's semen adequate?
- what is the woman's age?
- how long has infertility been present?

Letrozole – Current First-Line Fertility Treatment

The **WHO 2025 infertility guideline** recommends:

letrozole over clomiphene citrate or metformin

as first-line pharmacological treatment for infertility due to PMOS/PCOS-related ovulatory dysfunction.

WHO also suggests letrozole alone rather than routinely combining it with metformin.

This is one of the most important modern updates for PCOS-related infertility.

What If Letrozole Is Not Available or Cannot Be Used?

WHO notes that where off-label letrozole use is unavailable or not permitted, alternatives can include:

- clomiphene citrate,
- clomiphene with metformin in appropriate patients.

Medication choice should be individualized and monitored.

Why Ovulation-Induction Medicines Need Supervision

These medicines can cause:

- multiple follicular development,
- multiple pregnancy,
- ovarian over-response.

Ultrasound monitoring may be appropriate in many treatment cycles.

Patients should not repeatedly take:

- letrozole,
- clomiphene

without medical supervision.

Second-Line Fertility Treatment

When oral ovulation-induction treatment is unsuccessful, WHO 2025 suggests:

gonadotrophins

over routine laparoscopic ovarian drilling.

This is a conditional recommendation and treatment requires careful monitoring because gonadotrophins may increase risks including:

- multiple pregnancy,
- ovarian hyperstimulation.

Laparoscopic Ovarian Drilling

Ovarian drilling was previously used much more frequently.

It can still have a role in selected patients.

But:

it is not routine first-line treatment in 2026.

Surgery should never be presented as necessary simply because an ultrasound shows "polycystic ovaries."

IVF in PMOS

If appropriate pharmacological fertility treatments fail—or another clear IVF indication exists—IVF can be considered.

WHO 2025 suggests IVF after unsuccessful treatment with:

- oral ovulation induction,
- gonadotrophins

rather than indefinite expectant management.

Ovarian Hyperstimulation Syndrome – OHSS

Women with PMOS can be particularly sensitive to ovarian stimulation and may have increased risk of:

OHSS

during fertility treatment.

Modern IVF protocols allow clinicians to substantially reduce this risk through:

- individualized stimulation,
- appropriate trigger strategies,
- embryo-freezing strategies where needed.

Treatment at experienced fertility centers is therefore important.

PMOS and AMH

Women with PMOS frequently have:

higher AMH

because of an increased number of small follicles.

In adults, AMH can now contribute to PMOS diagnosis as an alternative to ultrasound in an appropriate diagnostic pathway.

But:

AMH alone should not diagnose PMOS.

High AMH also does not mean:

better fertility.

A woman may have many follicles but irregular ovulation.

Preparing for Pregnancy

Before fertility treatment or natural conception, I consider:

- blood pressure,
- glucose status,
- weight/metabolic health,
- smoking,
- folate,
- medications,
- mental health,
- sleep,
- male-factor fertility.

Women with PMOS should enter pregnancy with metabolic risk factors managed as well as possible.

PMOS in the Unani System of Medicine

The Unani system has a long history of treating:

- menstrual irregularity,
- amenorrhea,
- female infertility,
- metabolic and constitutional disorders.

But an academically responsible point must be made:

PMOS/PCOS as defined by modern endocrine criteria is not described as one exact disease entity in classical Unani texts.

Modern PCOS has therefore been correlated by Unani scholars with classical presentations such as:

Ihtibas al-Tamth

for absent or markedly suppressed menstruation,

and:

'Uqr

for infertility.

Published Unani literature also relates some PCOS presentations to classical descriptions involving:

- obesity,
- hirsutism,
- menstrual disturbance.

An Important Correction: The Four Humors in Unani Medicine

The supplied material describes:

"three humors/dhatus."

This is not correct Unani terminology.

Classical Unani medicine describes four:

Akhlat

Dam

Blood

Balgham

Phlegm

Safra

Yellow bile

Sauda

Black bile

“Dhatu” belongs to another traditional medical framework and should not be used as though it were the Unani term for Akhlat.

Traditional Unani Understanding of PMOS-Like Presentations

Some contemporary Unani interpretations associate PCOS-like symptoms particularly with:

- Ghalba-i-Balgham,
- Su'-i-Mizaj Barid,
- Ihtibas al-Tamth,
- ‘Uqr,
- obesity.

Published Unani literature describes a traditional theory in which abnormal Balgham and altered constitutional states may contribute to:

- menstrual suppression,
- weight gain,
- infertility.

However:

this traditional humoral explanation is not scientifically identical to modern insulin resistance, androgen excess or follicular biology.

I believe both frameworks should be described honestly.

Modern Biology and Unani Concepts Should Not Be Artificially Equated

It would be scientifically incorrect to say:

- Balgham = insulin resistance,
- Safra = testosterone,

- ovarian follicles are literally collections of phlegm.

Modern endocrinology describes PMOS through:

- insulin signaling,
- androgen production,
- follicular development,
- hypothalamic-pituitary-ovarian function,
- genetics.

Unani medicine describes the patient using its own traditional:

- Mizaj,
- Akhlat,
- Asbab,
- functional concepts.

They can be used in an integrative clinical model without pretending they are identical.

Why I Consider Unani Medicine Useful in PMOS

PMOS is a condition where several areas strongly overlap with the traditional whole-person approach.

These include:

- diet,
- weight,
- physical activity,
- menstrual health,
- digestion,
- sleep,
- stress,
- fertility.

For appropriately selected patients, Unani treatment can therefore provide:

supportive, individualized long-term management

alongside necessary modern investigations and fertility treatment.

Mizaj-Based Individualization

Two women with PMOS may look completely different.

Patient A

- 22 years old,
- thin,
- irregular periods,
- severe acne.

Patient B

- 31 years old,
- obesity,
- insulin resistance,
- infertility.

Patient C

- 29 years old,
- normal weight,
- facial hair,
- regular periods,
- high testosterone.

Patient D

- 34 years old,
- PMOS,
- infertility,
- male partner with severe oligozoospermia.

Giving every patient:

the same PCOD package

is not good individualized medicine.

Unani medicine's emphasis on:

Mizaj

can support a more personalized framework.

Ilaj-bil-Ghiza – Dietotherapy

Dietotherapy is one of the most useful components of integrative PMOS management.

The goal may include:

- improving metabolic health,
- healthy weight,
- better nutrition,
- supporting menstrual function.

Diet should be adapted to:

- body composition,
- glucose status,
- cultural preferences,
- practical affordability.

I generally encourage:

- vegetables,
- pulses,
- fruit,
- nuts,
- seeds,
- adequate protein,
- less refined sugar,
- fewer heavily processed foods.

There is no scientifically proven:

single “PCOS diet.”

Ilaj-bit-Tadbir – Regimenal Therapy

This can include individualized attention to:

- physical activity,
- sleep,
- stress,
- weight management,
- routine,
- overall health.

These principles have meaningful overlap with current guideline-based lifestyle management.

Ilaj-bid-Dawa – Unani Pharmacotherapy

Traditional medicines may be chosen according to:

- menstrual pattern,
- Mizaj,
- metabolic health,
- associated reproductive symptoms.

Medicines traditionally described with properties such as:

- Mudirr-i-Hayd,
- Munzij,
- Muhallil,
- Muqawwi

appear in Unani gynecological practice.

But traditional terminology should not be translated into claims such as:

“scientifically proven to normalize all PCOS hormones”

unless appropriate trials support that statement.

Darchini – Cinnamon: One of the Better-Studied Traditional Agents

Darchini has been studied clinically in women with PCOS.

A randomized single-blind study conducted at the **National Institute of Unani Medicine** enrolled 40 women and compared:

- Darchini/cinnamon,
- metformin

for 60 days.

Menstrual-cycle improvement occurred in both groups; the study reported approximately **51.9% improvement in menstrual pattern in the cinnamon group versus 61.3% in the metformin group**. Insulin-resistance measures did not significantly improve, and post-ovulatory progesterone did not show a significant between-group advantage.

This study is useful because it provides genuine clinical research rather than only traditional claims.

But it was:

- small,
- short,
- not a fertility/live-birth trial.

Therefore:

Darchini cannot be claimed to cure PMOS or replace guideline-supported therapy.

Other Cinnamon Research

Other randomized studies have also reported potential improvements in:

- menstrual cyclicity,
- selected metabolic measures

with cinnamon supplementation in women with PCOS.

The overall evidence is interesting but still not strong enough to make cinnamon:

the standard first-line therapy for PMOS.

Nigella Sativa – Kalonji

A 2024 randomized clinical trial in adolescents with PCOS evaluated:

Nigella sativa

against medroxyprogesterone over 16 weeks and assessed:

- ovarian volume,
- androgen-related hormones,
- hirsutism,
- metabolic and anthropometric outcomes.

This type of research is encouraging for traditional-medicine investigation.

But again:

- it is not evidence of a universal cure,
- it does not replace the international PMOS diagnostic and treatment pathway.

Recent Unani Case Literature

A 2024 report from a researcher affiliated with the National Institute of Unani Medicine described one patient treated with a formulation containing:

- Nankhwah,
- Badiyan,
- Waj Turki

for three menstrual cycles.

The report described improved:

- menstrual regularity,
- flow,
- ovarian volume.

This is useful as:

a case report

but it is not equivalent to a randomized controlled trial or evidence of pregnancy/live-birth benefit.

The Evidence Gap in Unani PMOS Treatment

I consider it important to tell patients and researchers clearly:

We need more high-quality studies measuring:

- ovulation,
- androgen levels,
- glucose metabolism,
- menstrual regularity,
- pregnancy,
- live birth,
- long-term metabolic outcomes.

Traditional use provides:

a rationale for research.

It does not automatically provide:

proof of efficacy.

Dr. Qasmi's Nuskha No. 149 – Cystocure and PMOS/PCOD

Saira Health Care's current pharmacy page lists:

Dr. Qasmi's Nuskha No. 149 – Cystocure

among formulations used for cyst-related problems, including PCOD. The listed ingredients include traditional herbal ingredients such as:

- Kachnar Guggul,
- Halela Siyah,
- Amla,
- Balela,
- Zanjabeel,
- Darchini,
- Filfil Siyah,
- Filfil Daraz

and others.

Saira Health Care's female-infertility pharmacy section also currently includes Nuskha No. 149 among its available Dr. Qasmi formulations.

How I Would Position Nuskha No. 149 Responsibly

In an individualized Saira Health Care programme, Nuskha No. 149 may be considered as:

a traditional supportive formulation

for selected women when clinically appropriate.

However, because PMOS is not literally a disease of pathological ovarian cysts:

the aim should not be described simply as "destroying ovarian cysts."

The small follicles seen in PMOS are part of abnormal follicular development rather than ordinary pathological cysts that need to be dissolved.

I have not identified a high-quality product-specific randomized trial showing that Nuskha No. 149 reliably:

- restores ovulation,
- normalizes testosterone,
- corrects insulin resistance,
- produces pregnancy,
- increases live birth

in women with guideline-diagnosed PMOS.

Therefore:

I would not present Nuskha No. 149 as a scientifically proven stand-alone cure for PMOS.

Its role is better described as one possible component of:

Dr. Qasmi's individualized integrative treatment programme.

Why This Makes the Saira Health Care Approach Stronger

A professional fertility centre gains credibility by distinguishing:

Traditional experience

from:

modern scientific evidence.

A patient can still receive:

- Unani dietotherapy,

- regimenal care,
- individualized traditional medicines

without being told that one tablet replaces:

- glucose screening,
- letrozole,
- ovulation monitoring,
- fertility assessment.

Dr. Nizamuddin Qasmi's Individualized PMOS Treatment Approach

When a woman comes to me at Saira Health Care with PMOS/PCOS, I prefer a structured evaluation.

Step 1: Confirm the Diagnosis

I first establish whether she actually has PMOS.

I do not diagnose PMOS simply because:

an ultrasound says “polycystic ovaries.”

Some women have polycystic ovarian morphology without the clinical syndrome.

Step 2: Understand the Main Complaint

What does the patient actually want treatment for?

- irregular periods?
- acne?
- facial hair?
- weight concerns?
- infertility?
- metabolic health?

The treatment changes according to the goal.

Step 3: Review Menstrual Cycles

I ask:

- How many days apart?
- How many periods per year?
- How long has the pattern been present?

Step 4: Assess Androgen Symptoms

I look for:

- hirsutism,
- acne,
- scalp hair loss.

Where appropriate, androgen testing may be considered.

Step 5: Exclude Mimicking Disorders

Depending on the case, this may involve:

- pregnancy testing,
- TSH,
- prolactin,
- 17-hydroxyprogesterone,
- further endocrine evaluation.

Step 6: Assess Metabolic Health

I consider:

- glucose status,
- OGTT where appropriate,
- blood pressure,
- lipid profile,
- body composition,

- family history of diabetes.

Step 7: Ask About Sleep and Psychological Health

I ask about:

- snoring,
- daytime sleepiness,
- anxiety,
- depression,
- body-image concerns.

PMOS is much more than an ovary problem.

Step 8: If Pregnancy Is Desired, Evaluate the Couple

I consider:

- female age,
- duration of infertility,
- ovulation,
- tubes,
- male semen analysis.

Step 9: Begin Lifestyle and Unani Support

This can include:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- individualized traditional medicines,
- appropriate physical activity,
- sleep optimization.

Step 10: Use Modern Medication When It Has a Clear Indication

For example:

When periods/hyperandrogenism are the priority

combined oral contraceptive treatment may be appropriate.

When metabolic dysfunction is prominent

metformin may be useful in appropriately selected patients.

When infertility from anovulation is the priority

letrozole is the current preferred first-line pharmacological fertility therapy.

Step 11: Monitor Outcomes Objectively

I do not judge treatment success only by:

“The ultrasound shows fewer follicles.”

I assess relevant outcomes such as:

- menstrual frequency,
- ovulation,
- androgen symptoms,
- glucose,
- weight/metabolic health,
- pregnancy.

Step 12: Escalate Fertility Treatment at the Correct Time

If oral treatment fails, appropriate next steps may include:

- gonadotrophins,
- selected reproductive procedures,
- IVF.

Unani treatment should not become a reason to delay treatment indefinitely.

Treatment Duration

PMOS does not have one universal:

- one-month,
- three-month,
- six-month

cure.

Treatment is often long-term because metabolic and endocrine tendencies can persist.

Some outcomes, such as menstrual-cycle improvement, may be seen over months.

Fertility treatment timelines should depend strongly on:

- age,
- ovarian reserve,
- male fertility,
- duration of infertility.

PMOS Success Stories: What Should Count as Success?

The phrase:

“success story”

needs careful definition.

For one woman, success may mean:

- periods became regular.

For another:

- spontaneous ovulation returned.

For another:

- facial hair growth became manageable.

For another:

- glucose status improved.

For another:

- letrozole produced ovulation.

For another:

- pregnancy occurred.

All are meaningful outcomes.

How Saira Health Care Should Document PMOS Success Stories

For a scientifically credible case, ideally record:

1. age,
2. presenting symptoms,
3. diagnostic criteria,
4. menstrual pattern,
5. androgen findings where available,
6. ultrasound/AMH where appropriate,
7. glucose/metabolic status,
8. fertility duration,
9. semen status of partner when infertility is present,
10. treatment given,
11. objective follow-up,
12. pregnancy/live birth if applicable,
13. patient consent.

This is much stronger than saying:

“PCOD cured 100%.”

Saira Health Care's Contribution to PMOS, Sexual Health and Infertility

Saira Health Care currently lists:

- PCOD/PCOS,
- irregular menses,
- female infertility,
- decreased AMH

among the reproductive-health conditions managed within its clinical practice and pharmacy categories.

The value of an infertility-focused clinic is particularly important because PMOS may overlap with:

- ovulation problems,
- female infertility,
- male infertility,
- sexual-health problems.

A couple may need several problems addressed at the same time.

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 public profile describes my focused and specialized clinical work in:

- sexual disorders,
- male infertility,
- female infertility,

and specifically lists:

- PCOD/PCOS,
- irregular menstruation,
- decreased AMH

among the conditions addressed in the practice.

Saira Health Care's current professional publications also use the additional training credentials:

- Certificate in Urology – London, UK,
- Masters in Male Infertility – MasterHealthPro,
- Integrated Sexual and Reproductive Health – ISRH, UNFPA.

Why Male-Infertility Training Is Relevant in PMOS

A woman with PMOS-related ovulatory dysfunction may be perfectly capable of becoming pregnant after restoring ovulation.

But if her husband simultaneously has:

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

ovulation induction alone may not solve the couple's infertility.

This is why infertility treatment should consider:

both partners from the beginning.

Common Myths About PMOS/PCOS/PCOD

Myth 1: PCOD, PCOS and PMOS are three separate diseases.

Fact: PMOS is the new 2026 name for the condition previously known as PCOS; PCOD is an older commonly used term.

Myth 2: PMOS always causes ovarian cysts.

Fact: Ovarian cysts are not required for diagnosis. The ultrasound appearance usually represents multiple small follicles.

Myth 3: If ultrasound is normal, PMOS is impossible.

Fact: Adults may meet diagnostic criteria through hyperandrogenism plus ovulatory dysfunction without requiring ultrasound.

Myth 4: Every woman with polycystic ovaries has PMOS.

Fact: Ovarian morphology alone is insufficient for diagnosis.

Myth 5: Only overweight women develop PMOS.

Fact: Lean women can also have the syndrome.

Myth 6: PMOS is caused only by obesity.

Fact: Genetics, insulin biology, androgen physiology and other factors interact.

Myth 7: Insulin resistance occurs only in overweight patients.

Fact: It can occur in lean PMOS as well.

Myth 8: An LH ratio diagnoses PMOS.

Fact: It is not a required stand-alone diagnostic criterion.

Myth 9: AMH alone diagnoses PMOS.

Fact: AMH may contribute to adult diagnosis but should not be used by itself.

Myth 10: AMH or ultrasound should diagnose adolescent PMOS.

Fact: Neither is recommended during the early post-menarche years because normal adolescent physiology overlaps with PMOS features.

Myth 11: PMOS means permanent infertility.

Fact: Many women conceive naturally or with relatively simple ovulation treatment.

Myth 12: Metformin is the best fertility treatment for every PMOS patient.

Fact: Current WHO guidance prefers letrozole over metformin or clomiphene as first-line pharmacological ovulation induction.

Myth 13: Letrozole is required for every woman with PMOS.

Fact: It is mainly a fertility treatment for women with ovulatory dysfunction who are trying to conceive.

Myth 14: Every woman with PMOS needs ovarian drilling.

Fact: It is not routine first-line treatment; current WHO guidance favors gonadotrophins after unsuccessful oral treatment.

Myth 15: PMOS automatically causes ovarian cancer.

Fact: The established gynecological concern is increased endometrial hyperplasia/endometrial cancer risk; absolute risk remains low.

Myth 16: One Unani medicine can permanently cure every PMOS patient.

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

Myth 17: Classical Unani medicine describes modern PCOS exactly.

Fact: Classical descriptions such as Ihtibas al-Tamth and ‘Uqr overlap with some presentations but are not identical to the modern endocrine syndrome.

Myth 18: Darchini has been scientifically proven to cure PMOS.

Fact: Small clinical trials suggest possible menstrual and metabolic benefits, but they do not demonstrate universal cure or live-birth benefit.

Myth 19: Nuskha No. 149 scientifically dissolves all PMOS follicles.

Fact: PMOS follicles are not ordinary pathological cysts, and high-quality product-specific randomized evidence demonstrating this effect has not been identified.

SAIRA HEALTH CARE
An ISO Certified Clinic
SEXUAL DISORDERS & INFERTILITY CENTER

Frequently Asked Questions

What is PMOS?

PMOS stands for:

Polyendocrine Metabolic Ovarian Syndrome

and is the new name for PCOS.

When was PCOS renamed PMOS?

The new name was announced internationally in:

May 2026.

Why was the name changed?

To better reflect that the condition affects:

- multiple hormones,
- metabolism,
- reproductive health,

rather than merely producing ovarian “cysts.”

Is PCOD the same as PMOS?

PCOD is an older commonly used term.

The current international term is:

PMOS.

How common is PMOS?

Current international resources estimate that it affects approximately:

1 in 8 women.

Do I need ovarian cysts to have PMOS?

No.

Can PMOS occur with a normal ultrasound?

Yes.

Can PMOS occur in thin women?

Yes.

What are the main symptoms?

Common features include:

- irregular periods,
- hirsutism,
- acne,
- scalp hair thinning,
- ovulation problems,
- infertility,
- metabolic abnormalities.

How is PMOS diagnosed in an adult?

Generally by two of:

- hyperandrogenism,
- ovulatory dysfunction,
- polycystic ovarian morphology or appropriate adult AMH evidence,

after excluding alternative disorders.

Can AMH be used to diagnose PMOS?

In adults, it can contribute as an alternative to ultrasound within the complete diagnostic algorithm.

It should not be used alone.

Can AMH diagnose PMOS in teenagers?

No.

Current guidelines do not recommend AMH for adolescent diagnosis.

What is the best medicine for PMOS?

There is no one best medicine for everyone.

Treatment depends on whether the priority is:

- periods,
- acne/hair growth,
- metabolism,
- fertility.

What is the best fertility medicine for PMOS?

For infertility caused by anovulation from PMOS, current WHO guidance suggests:

letrozole first line over clomiphene or metformin.

Can metformin help?

Yes, especially for selected metabolic problems.

It may also assist menstrual regulation in some patients.

Is metformin necessary for every woman?

No.

Can I become pregnant naturally?

Yes.

Many women with PMOS conceive naturally.

When is IVF needed?

IVF may be considered after unsuccessful ovulation-induction treatment or when another IVF indication exists.

Can PMOS return after treatment?

Symptoms can recur because the underlying endocrine-metabolic tendency can persist.

Long-term health management is important.

Can weight loss cure PMOS?

Weight management can significantly improve symptoms in some women, but it does not constitute a guaranteed permanent cure.

Can a normal-weight woman still benefit from exercise?

Yes.

Lifestyle benefits occur even without weight loss.

Is PMOS related to diabetes?

PMOS increases risk of:

- impaired glucose tolerance,
- type 2 diabetes.

Which glucose test is most accurate?

The:

75-g OGTT

is considered the most accurate assessment of glycemic status in PMOS.

Does PMOS increase endometrial cancer risk?

Yes, relative risk is increased, especially with long-standing untreated anovulation.

But absolute risk remains low and routine cancer screening is not required for every patient.

Does PMOS cause depression or anxiety?

Rates of both are increased, and psychological health should be addressed as part of care.

Can Unani medicine help PMOS?

Unani medicine may offer valuable supportive care through:

- individualized diet,
- lifestyle,
- menstrual-health treatment,
- weight/metabolic support,
- selected traditional medicines.

It should complement modern diagnosis and necessary fertility treatment.

What is PMOS called in Unani medicine?

There is no exact classical equivalent.

Modern Unani authors commonly correlate aspects of the condition with:

- **Ihtibas al-Tamth**
- **'Uqr**
- traditional Balghami/Su'-i-Mizaj concepts.

Is Darchini useful?

Small randomized clinical studies suggest possible benefit for menstrual regularity and selected metabolic outcomes.

Evidence is not sufficient to describe it as a universal cure.

What is the role of Nuskha No. 149?

Saira Health Care currently lists **Dr. Qasmi's Nuskha No. 149 – Cystocure** among formulations used in its PCOD/female reproductive-health programme.

In a professional integrative treatment plan, it should be considered:

individualized supportive traditional therapy

rather than a scientifically proven stand-alone PMOS cure.

Latest Scientific Update: 2025–2026

1. PCOS Is Now PMOS

The most visible recent change occurred in May 2026 when the condition was renamed:

Polyendocrine Metabolic Ovarian Syndrome.

The name was chosen following broad international professional and patient participation and is intended to reduce the misleading focus on ovarian cysts.

---

2. PMOS Is Now Estimated to Affect Around 1 in 8 Women

Current international PMOS resources refer to more than:

170 million women worldwide.

---

3. Adult Diagnostic Criteria Now Include AMH as an Alternative to Ultrasound

In adults, elevated AMH can be used appropriately as an alternative marker to ovarian ultrasound within the complete diagnostic criteria.

It is:

- not a stand-alone test,
- not recommended for adolescent diagnosis.

---

4. Fertility Treatment Has Become More Evidence-Based

WHO's first global infertility guideline was published on:

28 November 2025.

For PMOS-related anovulatory infertility, it recommends:

letrozole over clomiphene citrate or metformin as first-line pharmacological treatment.

---

5. Gonadotrophins Are Preferred Over Routine Ovarian Drilling After Failed Oral Therapy

WHO suggests gonadotrophins rather than laparoscopic ovarian drilling after unsuccessful oral pharmacological therapy.

---

6. IVF Has a Defined Role After Failed Pharmacological Treatment

WHO suggests moving to IVF rather than indefinite expectant management when appropriate pharmacological therapy remains unsuccessful.

---

7. PMOS Pregnancy Care Is Receiving Greater Attention

Current 2026 research programs emphasize that women with PMOS need appropriate recognition in pregnancy because of increased risks including:

- gestational diabetes,
- pre-eclampsia,
- preterm birth.

My Final Message to Women With PMOS

If someone has told you:

“You have PCOD because your ultrasound shows cysts,”

please understand that the condition is much broader.

If someone has told you:

“You cannot become pregnant because you have PCOS,”

do not lose hope.

And if someone promises:

“One medicine will permanently cure your PCOD and dissolve every ovarian cyst,”

ask for a proper diagnosis first.

The important questions are:

Are my periods irregular?

Am I ovulating?

Do I have clinical or biochemical androgen excess?

Do I actually meet PMOS diagnostic criteria?

Do I even need an ultrasound?

Do I need AMH testing?

Have thyroid, prolactin and other causes been considered?

What is my glucose status?

Do I need an OGTT?

How are my cholesterol and blood pressure?

Am I trying to become pregnant?

Are my fallopian tubes open?

Has my husband had a semen analysis?

Would lifestyle and individualized Unani treatment help my overall reproductive health?

Do I need letrozole?

When should we consider gonadotrophins?

When would IVF be more appropriate than waiting?

These questions lead to much better treatment than simply treating:

"cysts."

Conclusion

Polyendocrine Metabolic Ovarian Syndrome:

PMOS

is the current 2026 name for the condition formerly known as:

PCOS

and widely referred to as:

PCOD.

It is a complex endocrine-metabolic reproductive syndrome—not simply a disease of ovarian cysts.

PMOS may involve:

- irregular ovulation,
- excess androgen activity,

- altered follicular development,
- insulin resistance,
- metabolic risk,
- dermatological symptoms,
- infertility,
- psychological health.

Current adult diagnosis generally requires two of:

1. **clinical/biochemical hyperandrogenism**
2. **ovulatory dysfunction**
3. **polycystic ovarian morphology or appropriately used elevated AMH**

after excluding important alternative diagnoses.

In adolescents, diagnosis is more restrictive and requires:

- persistent menstrual irregularity,
- hyperandrogenism,

while ultrasound and AMH should not be used during the early years after menarche.

Treatment should be individualized.

Lifestyle management remains fundamental for:

all women with PMOS

and provides health benefits even in the absence of weight loss.

For non-fertility symptoms, options may include:

- cycle regulation,
- combined oral contraceptives,
- metformin for selected metabolic indications,
- dermatological and anti-androgen treatment.

For infertility due to anovulation:

letrozole is currently the preferred first-line pharmacological treatment.

If oral therapy fails:

- gonadotrophins may be considered,

- IVF has an established later role.

The **Unani system of medicine** provides a valuable individualized framework through:

- Mizaj assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- supervised Ilaj-bid-Dawa,
- menstrual-health support,
- metabolic and nutritional care.

Modern Unani literature correlates some PMOS presentations with classical concepts such as:

- **Ihtibas al-Tamth**
- **'Uqr**
- traditional Balghami and Su'-i-Mizaj states.

Clinical research on traditional interventions is growing.

A small randomized NIUM study found menstrual-pattern improvement with Darchini, although metabolic and ovulatory outcomes were limited and the study does not establish a universal cure.

At **Saira Health Care**, PMOS/PCOD/PCOS is managed within an individualized sexual-health and infertility practice.

Current Saira Health Care resources list:

- PCOD/PCOS,
- irregular menses,
- decreased AMH,
- female infertility

among the clinic's reproductive-health areas.

Dr. Qasmi's Nuskha No. 149 is currently listed within Saira Health Care's PCOD/female reproductive-health programme, but it should be represented as part of an individualized traditional treatment approach—not as a scientifically proven universal PMOS cure.

My approach as **Dr. Nizamuddin Qasmi** can therefore be summarized as:

Confirm that the woman actually has PMOS.

Do not diagnose it from ultrasound alone.

Do not treat normal ovarian follicles as pathological "cysts."

Evaluate menstrual cycles and androgen symptoms.

Exclude thyroid, prolactin and other endocrine conditions.

Assess metabolic health.

Address sleep and psychological wellbeing.

Use healthy lifestyle measures for every patient.

Use individualized Unani dietotherapy, regimenal therapy and pharmacotherapy where appropriate.

Use metformin when there is a clear metabolic indication.

Use guideline-supported hormonal treatment when required.

For anovulatory infertility, use letrozole appropriately as current first-line pharmacological treatment.

Evaluate the male partner and fallopian tubes before wasting fertility time.

Escalate to gonadotrophins or IVF when necessary.

And never promise that one herb, tablet or "cyst medicine" will permanently cure every woman with PMOS.

For every woman who asks:

"Doctor, can my PCOS be treated, and can I become pregnant?"

my answer is:

Yes. PMOS can usually be managed very effectively, and many women with the condition can conceive naturally or with appropriate fertility treatment. The key is not simply to remove 'cysts'; it is to understand your ovulation, hormones, metabolic health, fertility goals and complete reproductive profile, then choose an individualized treatment combining appropriate modern care with responsible Unani support.

Selected Medical References

1. **International Evidence-Based Guideline for the Assessment and Management of Polyendocrine Metabolic Ovarian Syndrome (PMOS), formerly PCOS.** Monash Centre for Health Research and Implementation; current 2026 terminology and international guidance.

2. **American Society for Reproductive Medicine.** PCOS Is Now PMOS: Understanding the Name Change. May 2026.
3. **Endocrine Society.** Polyendocrine Metabolic Ovarian Syndrome: New Name to Improve Diagnosis and Care. May 2026.
4. **International Evidence-Based Guideline for PCOS/PMOS.** 2023 recommendations, now incorporated into PMOS resources.
5. **World Health Organization.** *Guideline for the Prevention, Diagnosis and Treatment of Infertility.* 2025.
6. **WHO 2025 – Treatment of PCOS-Related Ovulatory Infertility.** Letrozole, gonadotrophins and IVF recommendations.
7. Khan AA, Begum W. **Efficacy of Darchini in the Management of Polycystic Ovarian Syndrome: A Randomized Clinical Study.** *Journal of Herbal Medicine.*
8. Naaz A. **Effect of Unani Formulation in PCOS: A Case Report.** 2024.
9. **Current Saira Health Care Physician Profile and PMOS/PCOS Services.**

Medical Disclaimer

This article is intended for:

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

It is not a substitute for:

- individual consultation,
- gynecological examination,
- pregnancy testing,
- endocrine evaluation,
- glucose testing,
- ultrasound,
- fertility investigation,
- semen analysis,
- reproductive endocrinology consultation.

A diagnosis of PMOS/PCOS should not be made solely because:

- an ultrasound shows multiple follicles,
- AMH is elevated,
- periods are irregular,
- acne is present.

Do not independently start:

- letrozole,
- clomiphene,
- metformin,
- oral contraceptive pills,
- spironolactone or other anti-androgens,
- gonadotrophins,
- progesterone,
- weight-loss medicines,
- Unani medicines,
- Ayurvedic medicines,
- herbal supplements

without appropriate medical supervision.

Dr. Qasmi's Nuskha No. 149 or other traditional formulations should not be interpreted as guaranteed cures for PMOS.

Women with:

- prolonged amenorrhea,
- severe rapidly developing androgen symptoms,
- very high testosterone,
- infertility,
- diabetes,
- significant metabolic disease,
- suspected endometrial abnormality,

- pregnancy plans

should receive appropriate clinical evaluation.

Women seeking pregnancy should also have the male partner evaluated when relevant.

Where:

- letrozole,
- gonadotrophins,
- IUI,
- IVF

are medically indicated, traditional treatment should not unnecessarily delay evidence-based fertility care.

No modern, Unani, herbal, hormonal or fertility treatment can ethically guarantee:

- permanent PMOS cure,
- ovulation,
- pregnancy,
- live birth.

Saira Health Care
www.sairahealthcare.com

Medical literature reviewed and updated: September 2026