PCOD / PCOS — Now PMOS

Understanding Polyendocrine Metabolic Ovarian Syndrome from Modern Medicine and the Unani System of Medicine

By Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Qualifications:
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

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Introduction

One of the most common questions young women ask me in clinical practice is:

“Doctor, my ultrasound says PCOD. Does this mean I have cysts in my ovaries? Will I be able to become pregnant?”

My first response is usually to remove this fear.

What has traditionally been called **PCOD or PCOS is not simply a disease of ovarian cysts**. It is a complex hormonal, metabolic and reproductive condition that can affect menstrual periods, ovulation, fertility, body weight, insulin function, skin, hair and even emotional well-being.

There has also been an important international change in terminology.

In **May 2026**, a global consensus process officially introduced **Polyendocrine Metabolic Ovarian Syndrome, or PMOS**, as the new name for the condition previously known as **Polycystic Ovary Syndrome (PCOS)**. Major organizations including the American Society for Reproductive Medicine, the Endocrine Society and the European Society of Human Reproduction and Embryology have supported the change. The reason is important: the old term “polycystic” incorrectly suggested that pathological ovarian cysts were the defining feature, while in reality this is a multisystem endocrine and metabolic condition. A transition period is expected during which the terms PCOS and PMOS will both continue to be used.

Because patients in India are still very familiar with the terms **PCOD and PCOS**, I will use PCOD/PCOS and PMOS together in this article so that the subject remains easy to understand.

Worldwide, the condition affects roughly **10–13% of women of reproductive age**, and WHO estimates that as many as 70% of affected women may remain undiagnosed. It is also one of the leading causes of irregular ovulation and infertility.

At **Saira Health Care**, my approach is to explain to patients that this condition is not merely about making periods regular for one or two months. Good treatment should look at the woman's **menstrual health, hormones, metabolism, fertility goals, lifestyle, psychological health and long-term risks**.

This is also one of the reasons I find the individualized philosophy of **Unani medicine** useful when it is applied carefully and integrated with appropriate modern diagnosis.

What Is PCOD, PCOS or PMOS?

PMOS is a chronic hormonal and metabolic condition in which normal communication between the brain, ovaries, insulin system and other endocrine pathways becomes altered.

Three major features are commonly seen:

Irregular or absent ovulation may lead to delayed, unpredictable or missing menstrual periods. Higher androgen activity may cause excessive facial or body hair, acne or scalp-hair thinning. The ovaries may also show a characteristic appearance containing many small immature follicles.

The important word here is **follicles**.

They are not necessarily pathological “cysts.”

This misunderstanding became so significant that it was one of the major reasons international experts supported changing the name from PCOS to PMOS in 2026. The new terminology emphasizes that this is a **polyendocrine, metabolic and ovarian syndrome**, rather than simply an ovarian-cyst disease.

A woman can therefore have PMOS without visible “polycystic ovaries,” and a woman can have polycystic-appearing ovaries on ultrasound without actually having the full syndrome.

That distinction is extremely important.

PCOD and PCOS: Are They Different?

The term **PCOD—Polycystic Ovarian Disease**—has been widely used in India and South Asia, but it has not been the preferred modern diagnostic terminology.

For many years, **PCOS—Polycystic Ovary Syndrome**—was the internationally accepted term.

Now, since May 2026, **PMOS—Polyendocrine Metabolic Ovarian Syndrome**—is being introduced as the updated international terminology.

In practical conversation, when patients say they have PCOD, they are usually referring to the same clinical spectrum historically called PCOS.

It is therefore not useful to frighten patients by suggesting that PCOD is a mild disease while PCOS is a completely different severe disease. Management should be based on the woman's actual symptoms, examination and investigations.

Why Does PMOS Develop?

There is no single cause.

Modern research suggests that PMOS develops because of an interaction between **genetic susceptibility, androgen excess, insulin resistance, ovarian dysfunction, metabolic factors and environmental influences**.

A woman does not develop PMOS simply because she ate the “wrong food,” gained weight or did not exercise enough.

Family history matters. WHO notes that women with a family history of PCOS/PMOS or type 2 diabetes have an increased risk.

At the same time, lifestyle can influence how strongly the condition expresses itself.

For example, a woman may inherit a tendency toward insulin resistance. If metabolic stress increases, insulin levels can rise further. Higher insulin can stimulate ovarian androgen production and interfere with normal follicular development and ovulation.

This can create a cycle involving **insulin resistance, increased androgen activity and abnormal ovulation**.

But not every woman with PMOS has insulin resistance to the same degree, and not every woman with PMOS is overweight.

I frequently remind patients that **“lean PCOS” is real**. A thin woman can have significant hormonal and reproductive symptoms, just as a woman with higher body weight can.

Treatment should therefore never be reduced to telling every patient to “just lose weight.”

The Role of Insulin Resistance

Insulin is a hormone that helps glucose move from the blood into cells for energy.

When the body's tissues become less responsive to insulin, the pancreas may compensate by producing more insulin.

This is known as **insulin resistance**.

Insulin resistance plays an important role in PMOS and can contribute to increased androgen production, metabolic problems and difficulty with ovulation.

However, an important update from current international guidance is that routine fasting-insulin testing is **not recommended as a reliable way to diagnose insulin resistance in everyday PMOS care**, because available insulin assays have limited clinical usefulness.

Instead, women with PMOS should be assessed for abnormal glucose metabolism. The international guideline identifies a **75-g oral glucose tolerance test (OGTT)** as the most accurate available method, regardless of body weight.

This is another example of why treatment should not be based only on one insulin value printed on a laboratory report.

The Role of Androgens

Androgens are often described as “male hormones,” but women naturally produce them too.

The problem arises when androgen production or activity becomes excessive.

Increased androgen activity can contribute to facial hair, body hair, acne, oily skin and thinning of scalp hair.

It can also interfere with normal follicular development and ovulation.

The ovaries are an important source of excess androgen in PMOS, although adrenal hormones can also contribute in some women.

When androgen levels are extremely high or symptoms develop very rapidly—for example, sudden severe facial hair growth or rapid virilization—the physician should not automatically assume PMOS. Other causes, including rare androgen-producing ovarian or adrenal tumors, must be considered. Current international guidance specifically emphasizes investigation of unusually severe or rapidly progressive hyperandrogenism.

Common Symptoms

No two women with PMOS look exactly alike. One woman may mainly have irregular menstruation; another may have infertility; another may have acne and unwanted facial hair while maintaining relatively regular periods.

Common features can include:

- Irregular, delayed, infrequent or absent menstrual periods.
- Difficulty with ovulation and difficulty becoming pregnant.
- Excessive facial or body hair, medically called hirsutism.
- Persistent acne or oily skin.
- Thinning of scalp hair or female-pattern hair loss.
- Weight gain or difficulty managing weight in some women.
- Dark, thickened skin around the neck, underarms or groin, known as acanthosis nigricans.
- Emotional distress, anxiety, depression or poor body image.

WHO and international guidelines emphasize that PMOS affects much more than menstruation. It is associated with reproductive, metabolic, dermatological and psychological manifestations.

Do You Need Ovarian Cysts to Have PMOS?

No.

This is one of the biggest misconceptions about the condition.

A woman can meet diagnostic criteria without polycystic ovarian morphology.

WHO explains that diagnosis is generally based on at least two of three major features after other causes have been excluded: evidence of androgen excess, irregular or absent ovulation, and polycystic ovarian morphology.

Furthermore, the small structures commonly seen on ultrasound are primarily **immature follicles**, not the same thing as pathological ovarian cysts that may require surgery.

This was a major motivation behind the 2026 change from PCOS to PMOS.

How PMOS Is Diagnosed in Adults

Diagnosis should not be made from an ultrasound report alone.

For adults, contemporary criteria generally require at least **two of three features** after alternative causes are excluded:

Ovulatory dysfunction: usually irregular or absent menstrual cycles.

Clinical or biochemical hyperandrogenism: for example hirsutism or appropriately measured elevated androgen levels.

Polycystic ovarian morphology: assessed using appropriate ultrasound criteria, or in suitable adults through serum anti-Müllerian hormone assessment according to the current diagnostic algorithm.

The 2023 International Evidence-Based Guideline introduced **AMH as an alternative method for defining polycystic ovarian morphology in adults**, but it should not simply be added to ultrasound to create more diagnostic criteria. If a woman already has clear irregular cycles together with hyperandrogenism, neither ultrasound nor AMH is necessarily required to establish the diagnosis.

This is an important improvement because it helps reduce over-investigation and overdiagnosis.

PMOS in Teenagers Requires Special Care

Adolescence deserves a much more cautious approach.

It is normal for menstrual cycles to be somewhat irregular during the first years after menarche, and acne is also very common during puberty.

For this reason, we should not label a teenager with PMOS simply because an ultrasound shows multiple follicles.

Current international guidance specifically states that ultrasound criteria for polycystic ovarian morphology are **not recommended for diagnosing adolescents** because normal teenage ovaries can have a similar appearance.

If features are suggestive but the full diagnostic criteria are not met, the girl may be considered at increased risk and followed over time rather than being given a permanent diagnosis too early.

This protects young patients from unnecessary fear and stigma.

Other Conditions Must Be Excluded

A proper PMOS diagnosis is a diagnosis of a syndrome, not the result of one test.

Depending upon symptoms, the clinician may need to consider thyroid disorders, elevated prolactin, pregnancy, non-classical congenital adrenal hyperplasia, Cushing syndrome, androgen-secreting tumors and other causes of menstrual irregularity or androgen excess.

This is particularly important if symptoms begin suddenly or become severe very quickly.

In my practice, I explain to patients that an ultrasound report reading **"bilateral polycystic ovaries" does not by itself prove PMOS**.

Clinical history comes first.

PMOS Is More Than a Menstrual Problem

For many years, the condition was treated mainly as a gynecological problem.

Modern evidence has changed that understanding substantially.

In fact, the new term **Polyendocrine Metabolic Ovarian Syndrome** was selected precisely because the condition affects multiple systems rather than only the ovaries.

Women with PMOS have an increased risk of abnormal glucose tolerance and type 2 diabetes regardless of age or BMI. Current guidance recommends assessing glycemic status at diagnosis and repeating it every one to three years according to individual risk.

A lipid profile is also recommended at diagnosis, and blood pressure should generally be assessed annually.

Women with PMOS also have an increased prevalence of obstructive sleep apnea, particularly when snoring, unrefreshing sleep and daytime fatigue are present.

This is why simply prescribing a tablet to induce menstruation every month does not represent complete PMOS care.

PMOS and Mental Health

This is another area that was ignored for too long.

Women with PMOS have a higher prevalence of anxiety and depressive symptoms. Acne, unwanted facial hair, difficulty managing weight, fertility problems and social pressure can also negatively affect confidence and body image.

The international guideline recommends screening adults and adolescents with PMOS for depression and adults for anxiety, with appropriate further assessment and treatment when significant symptoms are detected.

As a doctor, I believe this is particularly important in infertility practice.

A woman who has already spent months worrying about menstruation and pregnancy does not need more blame. She needs clear information, realistic expectations and respectful treatment.

PMOS and Endometrial Health

When menstruation remains absent for long periods because ovulation is not occurring, the lining of the uterus may continue to be exposed to estrogen without regular progesterone-related shedding.

Over time, this can increase the risk of **endometrial hyperplasia**.

Women with PMOS have a higher risk of endometrial hyperplasia and endometrial cancer compared with women without the condition, although the absolute chance of developing cancer remains low and routine cancer screening is not recommended solely because PMOS is present.

Protective strategies include maintaining appropriate menstrual-cycle regulation and, when indicated, progestogen treatment.

A woman whose periods remain absent for many months should therefore not simply wait indefinitely.

PMOS and Fertility

PMOS is one of the most common causes of **anovulatory infertility**, meaning that pregnancy is difficult because an egg is not being released regularly.

But this does **not** mean that a woman with PMOS cannot become pregnant.

I consider this one of the most important things to tell patients.

Many women with PMOS conceive naturally. Others become pregnant after lifestyle and metabolic management, while some require ovulation-induction treatment.

International guidance specifically reassures women that pregnancy can often be achieved naturally or with assistance.

Infertility assessment should still evaluate the couple as a whole. If pregnancy is not occurring, we should not assume the woman's PMOS is the only explanation.

Semen analysis of the male partner, tubal factors, age, ovarian reserve where relevant, duration of infertility and other reproductive conditions must also be considered.

This is particularly relevant to my clinical work in **sexual disorders and infertility**, because successful fertility treatment requires evaluation of both partners rather than focusing on one ultrasound report.

Modern Treatment of PMOS

There is no single medicine that cures every aspect of PMOS.

WHO describes it as a chronic condition for which there is currently no universal cure, but symptoms, fertility and long-term health risks can be managed effectively.

Treatment should therefore be based on what the woman needs.

A patient trying to become pregnant requires a different treatment plan from someone whose main concern is acne or irregular menstruation.

A woman with significant metabolic risk needs a different emphasis from a lean young woman with hirsutism and irregular cycles.

Personalization is essential.

Lifestyle Is the Foundation of Treatment

The strongest international recommendations emphasize healthy lifestyle measures for **all women with PMOS**, regardless of whether they are overweight.

This includes healthy eating, regular physical activity and behavioural strategies that can improve metabolic health, quality of life and body composition.

Importantly, guidelines state that there are benefits from a healthy lifestyle **even without weight loss**.

Another important point is that there is **no single scientifically proven "best PCOS diet."**

The international guideline found insufficient evidence to recommend one specific diet composition over all others. Sustainable healthy eating based on individual preferences and general nutritional principles is preferred over extreme or nutritionally unbalanced diets.

So when patients ask me whether they must completely stop rice, wheat, fruit, milk or another particular food, my answer is that PMOS management should not become a punishment.

Diet should be realistic enough to continue long term.

Weight Management Without Blame

If a patient has higher body weight, reducing excess weight may improve metabolic health and sometimes improve menstrual regularity and ovulation.

But it is equally important to recognize that weight regulation in PMOS can itself be difficult.

International guidelines now explicitly ask clinicians to recognize and avoid **weight stigma**.

I consider this a very positive change in medicine.

A woman should receive proper PMOS treatment whether she is overweight, underweight or at an average weight.

Medicines for Menstrual Irregularity and Androgen Symptoms

For women who are not currently trying to become pregnant, **combined oral contraceptive pills** may be considered for irregular menstrual cycles and symptoms such as hirsutism.

Current international guidance supports COCPs as a major pharmacological option for menstrual irregularity and hyperandrogenism, while emphasizing individualized assessment of risks and contraindications.

This does not mean that every woman with PMOS must take birth-control pills.

The choice depends on age, symptoms, fertility goals, blood pressure, smoking, cardiovascular risk and personal preferences.

The medicine should fit the patient.

Metformin

Metformin is widely used in PMOS, particularly where metabolic problems or insulin resistance-related risk is important.

The current international guideline recommends considering metformin particularly for metabolic outcomes in adults with PMOS and a BMI of 25 kg/m² or above; it may also be considered in some women with lower BMI, although evidence there is more limited.

Metformin can cause gastrointestinal side effects, particularly when treatment begins. Gradual dose adjustment may improve tolerance.

Long-term use can also be associated with lower vitamin B12 levels in some patients, so monitoring may be appropriate where risk factors are present.

Metformin is useful, but it should not be described as a universal “PCOS cure.”

Treatment of Hirsutism and Acne

For excessive facial or body hair, treatment may include menstrual and hormonal management, cosmetic techniques such as laser hair reduction and, in selected women, anti-androgen medicines.

Anti-androgen medicines require particular care because pregnancy must be avoided during treatment due to potential effects on a developing fetus. Current guidance therefore recommends effective contraception when these medicines are used.

Acne may require dermatological treatment in addition to management of the underlying hormonal condition.

Improvement in hirsutism usually takes time because existing hairs do not disappear immediately when hormone levels change.

Treatment When Pregnancy Is Desired

For women with anovulatory infertility due to PMOS and no other infertility factors, **letrozole is currently recommended as the first-line pharmacological treatment for ovulation induction**.

This is an important update because many patients still believe clomiphene must always be the first medicine.

Letrozole has better evidence for improving ovulation, clinical pregnancy and live-birth outcomes in this situation.

Other options can include clomiphene citrate, metformin in selected cases, gonadotropins and eventually assisted reproductive treatment.

IVF is not automatically the first treatment simply because PMOS is present.

It is generally considered when simpler treatment has not succeeded or when additional infertility factors make IVF appropriate.

Pregnancy in Women With PMOS

Once pregnancy occurs, the patient should still receive appropriate follow-up.

Women with PMOS have a higher risk of certain pregnancy complications, including abnormal glucose levels and hypertensive disorders.

Current guidelines recommend attention to blood pressure, metabolic health and preconception factors. An OGTT should be considered when planning pregnancy or seeking fertility treatment, with appropriate repeat testing during pregnancy when indicated.

Preconception care should also address smoking, alcohol, folate, nutrition, exercise, sleep and mental health.

Understanding PMOS from the Unani Perspective

The modern syndrome we now call PMOS was not described under this exact name in classical Unani texts.

It would therefore be historically incorrect to claim that Ibn Sina or other classical physicians described “PCOS” exactly as we diagnose it today.

However, classical Unani literature discusses several overlapping clinical patterns, particularly **Iḥtibās al-Ṭamth**, meaning absent or suppressed menstruation, together with obesity, excessive hair growth, infertility and disturbances of reproductive function.

A 2025 review of classical Unani literature explored the historical relationship between **Iḥtibās al-Ṭamth, hirsutism and modern PCOS**, showing that Unani physicians recognized links between menstrual disturbance and abnormal hair growth long before contemporary endocrine explanations became available.

Within the Unani system, health is traditionally understood through principles including **Mizaj (temperament), Akhlat (humours), Quwa (faculties), A'za (organs), diet, lifestyle and the body's natural regulatory capacity**.

The four principal humours are **Dam (blood), Balgham (phlegm), Safra (yellow bile) and Sauda (black bile)**.

Many contemporary Unani descriptions of the PCOS/PMOS clinical pattern give particular importance to **Ghalba-e-Balgham**, or predominance of phlegmatic characteristics, especially when menstrual delay and metabolic symptoms coexist.

These concepts belong to the traditional Unani framework and should not be presented as biologically identical to insulin resistance, androgen excess or modern endocrine physiology.

Both systems use different explanatory models.

A Correction About “Nadi Pariksha”

The term **Nadi Pariksha** is associated primarily with Ayurvedic terminology.

In Unani medicine, traditional pulse assessment is referred to as **Nabz**.

For a professionally written Unani article, I would therefore describe diagnosis as involving history, clinical examination, assessment of Mizaj and **Nabz**, rather than using “Nadi Pariksha.”

This distinction is important when presenting traditional medicine accurately.

Why the Unani Approach Can Be Useful in PMOS

One of the aspects I value in Unani medicine is its emphasis on **the patient's complete constitution rather than one isolated laboratory value**.

A woman with irregular periods, constipation, poor sleep, sedentary lifestyle, central weight gain, stress and infertility should not be treated as though the only abnormality is an ovary seen on ultrasound.

Unani medicine places significant emphasis on correcting diet, activity, sleep, mental state and other essential factors of life in addition to pharmacotherapy.

Interestingly, this holistic focus has considerable practical overlap with the latest international PMOS guideline, which also places lifestyle management, psychological well-being, metabolic health and individualized treatment at the centre of care.

The theoretical explanation is different, but the practical lesson is similar:

The whole patient matters.

Ilaj-bil-Ghiza — Dietotherapy

In Unani medicine, **Ilaj-bil-Ghiza** means treatment through dietary modification.

For a woman with PMOS, I consider diet according to her Mizaj, body composition, glucose metabolism, digestive condition, activity level and other medical problems.

The purpose is not to impose an extreme “PCOS diet.”

Rather, the aim is to create an eating pattern that improves metabolic health and can realistically be maintained over time.

Modern guidelines similarly conclude that no single diet composition is superior for all women with PMOS and encourage sustainable healthy eating tailored to the individual.

This is an area where individualized Unani dietotherapy and contemporary nutritional principles can work together sensibly.

Ilaj-bil-Tadbir — Regimental and Lifestyle Management

Ilaj-bil-Tadbir involves appropriate regulation of lifestyle and selected traditional regimens according to the patient's condition.

In practical contemporary PMOS care, I pay particular attention to regular physical activity, sleep, stress, bowel habits, daily routine and maintenance of healthy metabolic function.

These are not minor additions to treatment.

Lifestyle intervention is one of the strongest recommendations in current international PMOS management.

For women who are physically inactive, gradually increasing daily movement can improve metabolic health even before major changes occur on the weighing scale.

Ilaj-bil-Dawa — Unani Pharmacotherapy

Unani medicine contains a large pharmacopoeia of single and compound medicines traditionally selected according to symptoms, temperament and underlying imbalance.

Certain formulations have been explored scientifically for PMOS/PCOS.

Some research preparations have included herbs such as **Hulba (fenugreek), Dalchini (cinnamon), Badiyan, Aneesun, flaxseed and other traditional medicines**.

However, I do not recommend that patients copy herbal combinations from research papers or social media and begin treatment themselves.

The dose, preparation, quality, associated illnesses, pregnancy status and other medicines all matter.

Safed Musli, for example, is used traditionally in several reproductive and vitality-related preparations, but current evidence specifically establishing it as a treatment for PMOS is far less developed than many promotional claims suggest.

Traditional use and proven clinical effectiveness are not the same thing.

What Does Research Say About Unani Medicine in PMOS?

This is an area where the evidence is **promising but still developing**.

A 2021 randomized multicentre trial involving 73 women evaluated two forms of a coded Unani polyherbal formulation containing cinnamon, licorice, flaxseed and *Vitex agnus-castus* against metformin over 12 weeks. The researchers reported improvements in several hormonal measures and menstrual-flow outcomes in the herbal groups.

That study is interesting because it was randomized, but it remains one relatively small trial. Its conclusions need independent replication before the formulation can be considered equivalent or superior to established treatment for the broader PMOS population.

A separate **2024 open-label study involving 30 women** evaluated an Unani formulation containing Aneesun, Hulba, Suddab, Majeeth and Lobia Surkh. The investigators reported improvement in menstrual cyclicity and selected metabolic or ultrasound measures. Because

the study was small and open-label, it should be regarded as preliminary rather than definitive evidence.

More recently, a **2026 prospective pre–post clinical study of 30 women** evaluated a Unani formulation containing Nankhawah, Badiyan and Wajturki. Researchers reported improvements in menstrual-cycle duration, ovarian-volume measurements, hirsutism scores, acanthosis nigricans and quality-of-life measures.

Again, this is encouraging, particularly because it demonstrates that Unani PMOS research continues to develop in India. But the study did not provide the strength of evidence of a large, multicentre, blinded randomized controlled trial.

A contemporary 2026 review of lifestyle and adjunctive therapies similarly concluded that traditional systems including Unani medicine are promising supportive approaches, while emphasizing the need for better-quality standardized clinical trials.

This is the balanced position I believe should be communicated to patients.

Can Unani Medicine "Remove Ovarian Cysts"?

I do not like explaining PMOS treatment in those terms because it reinforces the same misconception that led to the international name change.

The follicles seen in PMOS are not necessarily pathological cysts that need to "melt" or be surgically removed.

The real clinical objectives are to improve menstrual and ovulatory function, reduce excessive androgen symptoms, improve metabolic health, protect the uterine lining and address fertility when pregnancy is desired.

If follow-up ultrasound measurements improve during treatment, that can be encouraging, but the patient should not be treated only to make an ultrasound picture look different.

We treat the woman, not the scan.

My Clinical Approach to PMOS at Saira Health Care

When a woman consults me at **Saira Health Care**, I do not begin treatment simply because an ultrasound report says PCOD.

First, I confirm whether the patient actually fits the clinical picture.

I assess her menstrual history, age at menarche, degree of cycle irregularity, acne, hirsutism, scalp-hair loss, weight pattern, signs of insulin resistance, family history, thyroid history, medications and fertility goals.

If pregnancy is desired, I consider ovulation and evaluate the couple's fertility rather than concentrating exclusively on the woman's ovaries.

Where appropriate, modern investigations can include androgen assessment, thyroid and prolactin testing, glucose evaluation, lipid profile, blood pressure and pelvic ultrasound.

For PMOS itself, current guidance recommends evaluating metabolic risks even in women who are not overweight.

Alongside this, as a Unani physician, I assess **Mizaj, dietary habits, digestive function, sleep, daily routine, physical activity and the broader constitutional pattern**.

The treatment plan is then individualized.

What Makes My Treatment Approach Different?

The principle I follow is that **there should not be one fixed prescription for every woman with PCOD/PMOS**.

Imagine four women.

One is 19 years old with acne and menstrual irregularity but no fertility concern.

Another is 29 years old and trying to conceive.

A third has obesity, prediabetes and irregular menstruation.

A fourth is lean, has severe hirsutism and suddenly worsening androgen levels.

Calling all four patients “PCOD cases” and prescribing the same medicine would ignore major differences.

My aim at Saira Health Care is therefore to combine the **individualized temperament- and lifestyle-based strengths of Unani medicine with appropriate hormonal, metabolic and fertility evaluation**.

If a patient needs modern ovulation induction, a gynecological procedure, endocrinological care or assisted reproduction, that should not be unnecessarily delayed.

If the main problems can be improved through lifestyle, metabolic management and appropriate Unani care, we focus strongly on those areas.

Integration should mean using each approach where it is most appropriate—not making one system compete with another.

PMOS and Sexual Health

PMOS can also affect sexual well-being indirectly.

Women may experience reduced confidence because of acne, unwanted facial hair, weight-related concerns or infertility.

Irregular menstruation and anxiety surrounding pregnancy can create stress between partners.

Some women experience reduced sexual desire, while others may have concerns about body image or intimacy.

International guidelines specifically recognize the psychological and psychosexual effects that can accompany PMOS.

Because my clinical work at Saira Health Care has a focused practice in **sexual disorders and infertility**, I consider these concerns part of the patient's overall reproductive health rather than treating them as unrelated problems.

The Contribution of Saira Health Care

At **Saira Health Care**, one of our continuing aims in the field of sexual disorders and infertility is to bring conditions such as PMOS into a more scientific and respectful conversation.

Women often arrive after trying multiple diets, supplements, menstrual tablets or fertility remedies without a clear diagnosis.

Some have been told that they have “many cysts” and will never become pregnant.

Others have been blamed entirely for their body weight.

These messages can create unnecessary fear.

Our approach emphasizes patient education, confidential consultation, appropriate investigation, individualized Unani management, lifestyle and dietary guidance, metabolic assessment, fertility evaluation where required and appropriate referral or modern treatment when clinically indicated.

For me, this is a meaningful contribution because long-term PMOS care depends not only on medicine but also on helping a woman understand her own condition.

About Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi, Founder and Chief Physician of Saira Health Care**, with a focused clinical practice in **sexual disorders and infertility**.

My professional training includes:

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

My work in sexual and reproductive medicine has reinforced one lesson repeatedly: fertility disorders cannot be treated properly without looking at the patient as a whole.

PMOS is an excellent example.

It involves reproductive hormones, metabolic health, menstrual function, fertility, emotional health and lifestyle simultaneously.

This is why an individualized and multidisciplinary approach is so valuable.

Can PMOS Be Completely Cured?

This is another question I receive frequently.

PMOS is better understood as a **chronic predisposition that can be effectively managed**, rather than something that disappears permanently after a three-month course of medicine.

WHO states that there is currently no universal cure, although lifestyle changes, medicines and fertility treatment can substantially improve symptoms and reproductive outcomes.

A woman may have very regular periods and normal ovulation for years after appropriate treatment and lifestyle modification.

That represents excellent control.

But symptoms may return if hormonal or metabolic circumstances change.

For this reason, I prefer to speak about **long-term management and restoration of healthy function rather than guaranteed permanent cure**.

Does Every Woman With PMOS Need to Lose Weight?

No.

Healthy lifestyle is recommended for everyone, but weight loss is not a requirement for every woman.

Women who are not overweight should focus on maintaining healthy habits and preventing excessive weight gain.

Women with higher weight may obtain clinical benefits from appropriate weight management, but this should be discussed respectfully and without stigma.

Does Every Woman Need Metformin?

No.

Metformin is particularly useful for selected metabolic indications, but it is not automatically necessary for every patient.

Treatment should be based on metabolic risk, symptoms and individual circumstances.

Does Every Woman Need an Ultrasound?

No.

In adults with both clear ovulatory dysfunction and hyperandrogenism, ultrasound is not necessarily required for diagnosis. AMH may also be used as an alternative to ultrasound for defining ovarian morphology in appropriate adults.

Ultrasound is specifically not recommended as the basis for diagnosing adolescents.

Can a Woman With PMOS Become Pregnant Naturally?

Yes.

Many women with PMOS conceive naturally, especially when ovulation occurs intermittently.

When anovulation is preventing pregnancy, effective fertility treatments are available.

Current evidence recommends letrozole as first-line pharmacological ovulation induction for women with anovulatory PMOS infertility without other infertility factors.

Is IVF Necessary for PMOS?

Not usually as the first treatment.

IVF may become appropriate when simpler ovulation-induction approaches have failed, when additional infertility factors are present or when the clinical circumstances justify assisted reproduction.

Every infertile couple should be evaluated individually.

Can Unani Medicine Help?

I believe **Unani medicine can be particularly useful as an individualized supportive approach** for many women with PMOS because it gives importance to diet, daily routine, sleep, physical activity, temperament, menstrual health and appropriately selected pharmacotherapy.

Small clinical studies of Unani formulations have reported promising improvements in menstrual and other PMOS-related measures.

However, the evidence base is still smaller than that available for established modern PMOS treatments.

Therefore, I do not advise replacing necessary diabetes treatment, ovulation induction, hormonal management or fertility treatment solely because a product is described as “natural.”

The best treatment is the treatment that matches the patient's actual clinical needs.

When Should You Consult a Doctor?

A woman should seek evaluation when periods repeatedly remain absent or very irregular, when there is significant facial hair or persistent acne, when scalp hair is thinning, when unexplained weight or metabolic changes occur, or when pregnancy is not occurring despite regular attempts.

Medical assessment is especially important when androgen symptoms develop rapidly, menstrual bleeding is unusually heavy or prolonged, there are symptoms of diabetes, or the woman is planning pregnancy.

Teenagers with irregular periods should also be evaluated carefully rather than being diagnosed from ultrasound alone.

A Personal Message From Dr. Nizamuddin Qasmi

Whenever a woman comes to me worried about PCOD, I try to correct one thought first:

Do not think of yourself as a patient whose ovaries are filled with dangerous cysts.

That picture is misleading.

What we now call **PMOS** is a complex hormonal and metabolic condition. The ovaries are involved, but they are only one part of the story.

Your menstrual cycle matters.

Your metabolism matters.

Your sleep and emotional health matter.

Your skin and hair symptoms matter.

And if you are trying to become pregnant, your fertility goals matter.

I also want women to understand that having PMOS does not mean that they have caused their own condition through poor lifestyle, and it certainly does not mean that pregnancy is impossible.

Treatment should begin by understanding your individual pattern.

In my practice at Saira Health Care, I use the holistic strengths of the Unani system—particularly individualized assessment, Ilaj-bil-Ghiza, lifestyle regulation and appropriate medicines—while also taking advantage of modern hormonal, metabolic and fertility investigations when required.

I believe this is a responsible way to practise reproductive medicine today.

We should neither reject traditional knowledge simply because it is traditional, nor reject modern evidence when it can protect the patient's health.

The objective is the same: better menstrual health, better metabolic health, improved fertility where required and a healthier quality of life.

Conclusion

PCOD, historically called **PCOS and now internationally renamed Polyendocrine Metabolic Ovarian Syndrome (PMOS)**, is one of the most common endocrine and metabolic conditions affecting women.

The 2026 name change is more than a change in terminology. It reflects a major improvement in our understanding: this condition is **not simply about ovarian cysts**.

PMOS may affect menstruation, androgen levels, metabolism, fertility, emotional health, sleep and long-term cardiovascular and diabetes risk.

Diagnosis should be based on appropriate clinical criteria rather than ultrasound alone. Treatment should be individualized according to symptoms and fertility goals. Healthy lifestyle is fundamental, while medicines such as combined hormonal contraceptives, metformin or fertility medicines have specific evidence-based roles. For anovulatory

infertility without other factors, letrozole is currently the preferred first-line ovulation-induction medicine.

From the Unani perspective, overlapping patterns have traditionally been understood through concepts such as **Iḥtibās al-Ṭamth, Mizaj, Akhlat and particularly Balghami patterns**, with treatment centred on dietotherapy, lifestyle regulation and individualized pharmacotherapy.

Modern studies of Unani formulations are producing encouraging findings, including clinical studies published in 2021, 2024 and 2026, but larger and more rigorous trials are still needed before universal treatment claims can be made.

At **Saira Health Care**, my approach is therefore not to give every woman the same "PCOD medicine." My focus is to understand the hormonal, metabolic, menstrual and reproductive factors affecting that individual patient and to use an appropriate combination of **Unani principles, lifestyle management, clinical investigation and fertility care**.

Dr. Nizamuddin Qasmi
Founder & Chief Physician
Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Medical Disclaimer: This article is intended for patient education and general health awareness. PMOS/PCOS can have reproductive, hormonal and metabolic consequences, and treatment should be individualized by a qualified healthcare professional. Herbal, hormonal, fertility and metabolic medicines should not be started solely on the basis of online information, particularly during pregnancy or when other medical conditions are present.