International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

PCOS to PMOS: Revisiting a Multisystem Disorder through an Individualised Lens

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Abstract

Polycystic ovary syndrome (PCOS) is one of the most common endocrine disorders affecting women of reproductive age and is increasingly recognised as a complex condition extending beyond reproductive dysfunction. In 2026, an international consensus process proposed the term Polyendocrine Metabolic Ovarian Syndrome (PMOS) to reflect better the endocrine, metabolic, reproductive, and psychosocial dimensions of the disorder. This narrative review explores the evolving PMOS paradigm, with particular emphasis on disease heterogeneity, psychological burden, stress-related neuroendocrine dysregulation, and the role of lifestyle and mind-body interventions in long-term management. The review highlights the bidirectional relationship between psychological distress and metabolic dysfunction, including the potential involvement of hypothalamic-pituitary-adrenal axis dysregulation in disease expression. The implications of the PMOS framework for individualised care are discussed, with particular attention to the relevance of constitutional homoeopathic assessment as a patient-centred approach that considers physical, emotional, and behavioural characteristics. Current evidence from reviews, observational studies, case reports, and a pilot randomised controlled trial suggests growing interest in homoeopathic approaches to PCOS/PMOS. The transition from PCOS to PMOS reflects a broader understanding of the disorder as a heterogeneous multisystem condition and supports the exploration of individualised and integrative approaches to care. Further high-quality research is required to clarify the role of constitutional homoeopathic assessment within PMOS management.

Keywords: Polyendocrine Metabolic Ovarian Syndrome (PMOS); Polycystic Ovary Syndrome (PCOS); Homoeopathy; Individualisation; Integrative Medicine; Lifestyle Medicine.

Introduction

Polycystic ovary syndrome (PCOS) is one of the most common endocrine disorders affecting women of reproductive age, with an estimated global prevalence of approximately 10–13%, depending on the diagnostic criteria used. [2] Traditionally, it has been defined by a combination of hyperandrogenism, ovulatory dysfunction, and polycystic ovarian morphology. However, growing evidence over the past two decades has demonstrated that the disorder extends beyond reproductive dysfunction and encompasses a broad spectrum of endocrine, metabolic, psychological, and dermatological manifestations. Women with the condition frequently experience insulin resistance, obesity, dyslipidaemia, impaired glucose

metabolism, infertility, anxiety, depression, and reduced quality of life. [2, 3] Consequently, the traditional ovary-centred terminology has increasingly been considered insufficient to capture the full clinical complexity of the disorder.

Recognising these concerns, an international multistep consensus process published in The Lancet in 2026 recommended renaming PCOS as Polyendocrine Metabolic Ovarian Syndrome (PMOS). [1] The revised nomenclature acknowledges the multifaceted nature of the condition and reflects its endocrine, metabolic, reproductive, and psychosocial dimensions. Beyond a change in terminology, PMOS represents a conceptual shift in understanding the disorder as a heterogeneous multisystem condition rather than an isolated ovarian disease.

The recognition of PMOS has important implications for clinical practice. This narrative review examines the evolving PMOS paradigm, explores the role of stress and neuroendocrine dysregulation in disease expression, and discusses the relevance of constitutional homoeopathic assessment within an integrative model of care.

PMOS: A Multisystem and Heterogeneous Disorder

The transition from PCOS to PMOS reflects a broader understanding of the disorder as a complex interaction of endocrine, metabolic, reproductive, and psychosocial factors. While menstrual irregularities, anovulation, and hyperandrogenism remain central clinical features, many women also experience metabolic disturbances such as insulin resistance, obesity, dyslipidaemia, and an increased risk of type 2 diabetes mellitus. [1, 2, 3] These manifestations contribute substantially to long-term morbidity and reinforce the need to view PMOS beyond its reproductive implications.

Equally important are the psychological dimensions of the disorder. Women with PMOS frequently report anxiety and depressive symptoms compared with unaffected women. [5] Body-image dissatisfaction, low self-esteem, and impaired quality of life have also been consistently documented. [4, 6] Visible manifestations such as hirsutism, acne, alopecia, and weight gain may negatively influence self-perception and social functioning, while infertility-related concerns often add further emotional burden. Increasing recognition of these psychosocial dimensions has contributed to a more holistic understanding of the condition.

A defining characteristic of PMOS is its marked heterogeneity. Patients sharing the same diagnosis may present with markedly different clinical symptoms. Some women seek medical attention primarily for infertility and menstrual disturbances, whereas others are more affected by metabolic complications, dermatological manifestations, or psychological distress. Such variability suggests that disease labels alone may not adequately capture individual patient experiences.

The heterogeneity of PMOS highlights the importance of management strategies that move beyond disease labels and acknowledge individual differences in symptom expression, psychosocial burden, and therapeutic priorities.

Stress, Psychological Burden, and Neuroendocrine Dysregulation

The recognition of PMOS as a multisystem disorder has drawn increasing attention to the role of psychological health in disease expression and progression. Beyond reproductive and metabolic manifestations, women with PMOS experience significantly higher rates of anxiety and depressive symptoms than unaffected controls. [5] Psychological morbidity and impaired quality of life have also been consistently reported across systematic reviews and position statements. [4, 6]

The psychosocial burden of PMOS is not merely a consequence of the disorder but may actively interact with its biological pathways. Increasing evidence suggests a bidirectional relationship in which disease manifestations contribute to emotional distress, while chronic psychological stress may further aggravate endocrine and metabolic dysfunction. This perspective has encouraged greater interest in the role of neuroendocrine mechanisms linking stress and PMOS. [4,6,7]

One of the principal pathways involved is the hypothalamic–pituitary–adrenal (HPA) axis, which regulates the physiological stress response. Chronic activation of the HPA axis results in sustained secretion of cortisol and other stress-related hormones. Elevated cortisol levels have been associated with insulin resistance, altered glucose metabolism, visceral adiposity, and low-grade inflammation, all of which are recognised contributors to the pathophysiology of PMOS. [7] Persistent stress may therefore amplify metabolic disturbances already present in susceptible individuals.

In addition to metabolic effects, neuroendocrine dysregulation may influence reproductive function. Stress-related hormonal alterations can affect hypothalamic signalling and disrupt the delicate balance of reproductive hormones, potentially contributing to menstrual irregularities and ovulatory dysfunction. Emerging evidence also suggests interactions between the HPA axis and the hypothalamic-pituitary-ovarian (HPO) axis, further highlighting the complex relationship between psychological and reproductive health. [7]

Recognition of the stress-PMOS relationship also provides a rationale for interventions aimed at improving emotional well-being and reducing neuroendocrine burden. Lifestyle modification, stress-management strategies, and mind-body interventions have therefore gained increasing attention as complementary components of PMOS care. Such approaches seek not only to improve psychological health but also to influence metabolic and reproductive outcomes through interconnected biological pathways. [2, 7]

Lifestyle Medicine and Mind–Body Interventions

The expanding understanding of PMOS as a multifactorial disorder has reinforced the importance of comprehensive management strategies that extend beyond symptom control. Contemporary approaches increasingly recognise that metabolic, reproductive, and psychological dimensions of the condition are closely interconnected and may be influenced by modifiable lifestyle factors. Consequently, lifestyle medicine is now regarded as a fundamental component of PMOS management across all phenotypes. [2]

Dietary modification, regular physical activity, weight optimisation, and adequate sleep have consistently been associated with improvements in metabolic and reproductive outcomes. Even modest lifestyle changes may positively influence insulin sensitivity, ovulatory function, menstrual regularity, and overall well-being. Importantly, the benefits of lifestyle interventions are not restricted to women with obesity, as metabolic dysfunction may also be present in lean individuals with PMOS. [2,3]

Sleep and stress management have emerged as increasingly important yet often overlooked aspects of care. [2, 7] Disturbed sleep patterns, chronic stress, and sedentary lifestyles may contribute to neuroendocrine dysregulation and further aggravate metabolic abnormalities.

Mind-body interventions such as yoga and mindfulness-based practices have shown potential benefits in improving selected hormonal, metabolic, and psychological outcomes in women with PMOS/PCOS. [8]

Importantly, lifestyle and mind-body interventions should not be viewed merely as adjunctive measures but as integral components of long-term disease management. Their value lies in addressing multiple

dimensions of PMOS simultaneously, including metabolic health, reproductive function, emotional well-being, and overall quality of life.

Although lifestyle interventions constitute a cornerstone of PMOS management, patients differ considerably in their clinical presentation, psychosocial concerns, and therapeutic priorities. Consequently, effective long-term management often requires an individualised approach that extends beyond general lifestyle recommendations.

Individualisation in PMOS: Relevance of Constitutional Homoeopathic Assessment

The broad clinical spectrum of PMOS presents important challenges for long-term management. Despite sharing a common diagnosis, women with PMOS may differ considerably in their clinical presentation, metabolic profile, psychological burden, lifestyle factors, and treatment priorities. While some individuals primarily seek care for menstrual irregularities and infertility, others may be more affected by insulin resistance, obesity, dermatological manifestations, anxiety, depression, or reduced quality of life. Such variability presents a challenge to uniform management strategies and highlights the importance of individualised assessment. [1]

Within homoeopathy, individualisation has long been regarded as a fundamental principle of clinical practice. Constitutional assessment extends beyond disease-specific symptoms and seeks to understand characteristic physical, mental, emotional, and behavioural patterns. Such an approach appears particularly relevant in PMOS, where considerable variation exists in symptom expression and disease experience. [9, 10]

Several authors have discussed the potential relevance of individualised homoeopathic approaches in the management of PCOS and related endocrine disorders. Recent review articles have highlighted the conceptual alignment between constitutional homoeopathy and the heterogeneous nature of PCOS/PMOS. [9, 10]

The World Health Organisation has also acknowledged the growing role of traditional, complementary, and integrative medicine within people-centred healthcare systems. [11]

The available clinical literature includes case reports and case series describing favourable outcomes following individualised homoeopathic treatment in selected patients. [14, 15] In addition, a prospective observational study reported improvements in clinical outcomes among women receiving homoeopathic care. [13]

Evidence from a pilot randomised placebo-controlled trial has also encouraged further investigation into the role of homoeopathy in PCOS management. [12] However, interpretation of these findings requires caution because small sample sizes, methodological heterogeneity, and variations in outcome assessment limit most studies. [9, 12, 13]

Conclusion

The shift from PCOS to PMOS acknowledges the multidimensional nature of the disorder and highlights the limitations of a one-size-fits-all approach to management. Given the considerable heterogeneity in clinical presentation and patient experience, individualised care remains central to effective long-term management. Constitutional homoeopathic assessment may offer a relevant perspective within an integrative care framework. However, robust clinical research is required to further clarify its role in PMOS management.

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