One Name, New Understanding: Transitioning from PCOS To the Proposed PMOS - A Global Nomenclature Shift and Its Implications for Diagnosis, Care, And Research in Reproductive-Age Women

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***Abstract*—For nine decades, the term "polycystic ovaries," which was initially described by Stein and Leventhal in 1935, has been based on a single, mostly coincidental ultrasonography result. That name was changed in May 2026. A coalition of 56 professional and patient organizations, led primarily by Monash University, formally retired the term Polycystic Ovary Syndrome (PCOS) in favor of Polyendocrine Metabolic Ovarian Syndrome (PMOS) following a consensus process of over ten years that incorporated the opinions of over 20,000 patients, clinicians, and researchers across six continents.**

This review explains the methodology behind the renaming, traces the scientific and social case that rendered the previous name untenable, and looks at what actually changes and what doesn't for diagnosis, treatment pathways, coding and reimbursement, research prioritization, and patient experience. It also takes into account the significant minority of opposing voices, such as the concerns of established patient advocacy groups, as well as the practical difficulties that are likely to arise during a three-year international transition.

The review concludes by examining how the revised, metabolically anchored disease concept opens up new therapeutic avenues, such as phytopharmacological and nutraceutical approaches, and what needs to be done before the name on the page and the treatment patients receive are truly in line.

***Index Terms*—Insulin Resistance, metabolic syndrome, nomenclature, Polycystic Ovary Syndrome, PCOS, Polyendocrine Metabolic Ovarian Syndrome, PMOS, women's health.**

I. INTRODUCTION

1.1 Background: PCOS as historically defined and diagnosed

Polycystic Ovary Syndrome has, for most of its clinical history, been described first and understood second. Irving Stein and Michael Leventhal's original 1935 case series reported seven women with amenorrhoea, obesity, and enlarged ovaries studded with what appeared, on gross inspection, to be cysts; surgical wedge resection of the ovaries restored ovulation in several of them, and the eponymous Stein-Leventhal syndrome entered the literature as a gynaecological curiosity rather than a systemic disease [1]. That founding observation ovaries that looked cystic on visual or, later, ultrasonographic inspection fixed the disorder's name and its conceptual centre of gravity for the rest of the twentieth century.

Formal diagnostic criteria came considerably later, and diverged rather than converged. The first commonly used definition was that of the National Institutes of Health in 1990 and required persistent anovulation plus clinical or biochemical hyperandrogenism. This was greatly expanded by the 2003 Rotterdam consensus, which added polycystic ovarian morphology on ultrasound as a third criterion and, by requiring only two out of three traits, created four different phenotypes under a single diagnostic umbrella [2].

Later the Androgen Excess and PCOS Society recommended that hyperandrogenism should be a necessary criterion but recognized the metabolic range

of the disease [3]. When the International Evidence-Based Guideline for the Assessment and Management of PCOS was first published in 2018, specialists were already aware that the condition was considerably more than an ovarian disorder: insulin resistance, chronic low-grade inflammation, dyslipidemia and long-term cardiometabolic risk were recognized as core, not incidental, features of the syndrome [4]. But the term provided to patients at the time of diagnosis had not budged one inch since 1935.

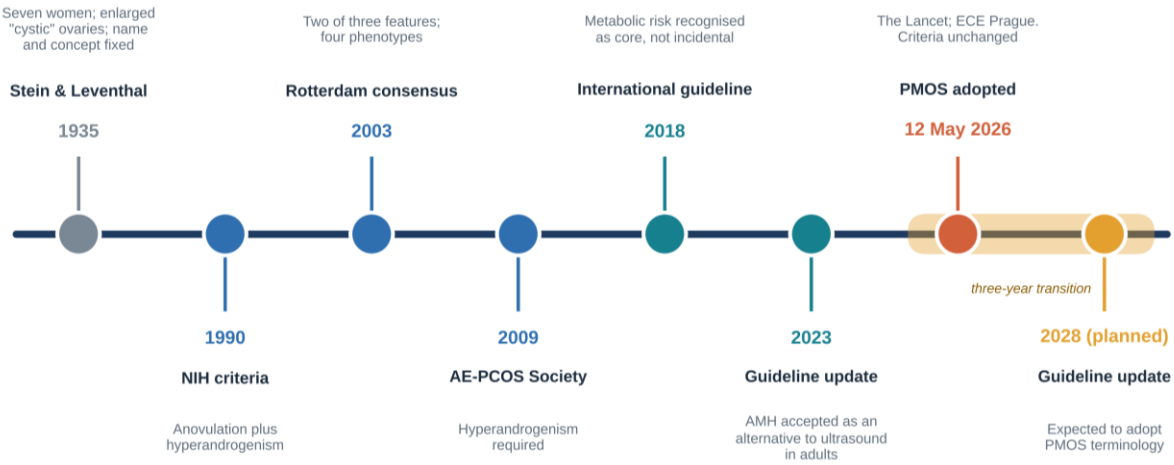


Figure 1. Historical timeline

1.2 Purpose and scope of this review

The aim of this review is more limited and modern than most PCOS material published before 2026. It starts from the premise that the name itself was changed in May 2026, rather than re-arguing the biology of the illness from basic principles. A multistep global consensus process led by researchers at Monash University, in partnership with 56 academic, clinical and patient organizations, has formally replaced “Polycystic Ovary Syndrome” with “Polyendocrine Metabolic Ovarian Syndrome” (PMOS) in a paper published in The Lancet and simultaneously presented at the European Congress of Endocrinology in Prague [5]. This review explores the rationale for this shift, the process of reaching consensus, the intended meaning of the new language, and the implications both immediate and long-term of this renaming for clinical practice, research design, policy-making, and the patient experience. It draws on the primary consensus publication, responses from professional societies, patient advocacy statements and the wider commentary that followed the announcement, and places all of this alongside the pathophysiological evidence that had already been reshaping clinical understanding of the syndrome for at least two decades before the name finally caught up. It is worth noting explicitly that earlier institutional and academic drafts discussing this reform including preliminary internal documents that circulated before the consensus was finalized sometimes referred to the proposed entity as "Polycystic Metabolic-Ovarian Syndrome," preserving the word "polycystic" while appending a metabolic qualifier. The final, ratified name eliminates "polycystic" altogether in favor of "polyendocrine," a distinction that turns out to be substantive rather than cosmetic, as later sections of this review make clear.

II. THE CASE FOR CHANGE: WHY "PCOS" FELL SHORT

2.1 The false "cyst" framing and clinical effects

Most follicular formations seen on ovarian ultrasonography in this disease are not cysts, therefore the old label is definitional rather than esthetic. These small, immature antral follicles have not matured and ovulated because they were halted early. The term "cysts" implies a separate diseased lesion requiring monitoring or intervention; however, the discovery is a signal of disturbed follicular dynamics with little clinical importance.

Polycystic-appearing ovaries are often found in women without other syndrome symptoms, and a significant percentage of women who fulfill complete diagnostic criteria for the illness do not have them [2,4]. A term based on a trait that is neither necessary

nor sufficient for the diagnostic was always going to be descriptively bad.

2.2 Delayed diagnosis, missing cases, inconsistent ovary-centric care

This mismatch has caused massive diagnostic delay. The consensus authors cited the World Health Organization's estimate that 70% of women with the condition go undiagnosed [6] as proof that the nomenclature and its ovary-centred framing were failing patients at the point of first clinical contact [5]. A patient with irregular periods, acne, weight gain, and exhaustion are more likely to be referred for a pelvic ultrasound than insulin resistance screening since the differential diagnosis list suggests the ovary. Endocrine, dermatological, and primary care physicians have long treated the syndrome's metabolic and dermatological symptoms independently of gynecologists, who treat its reproductive symptoms. The disease name does not indicate a common cause. According to commentary on the 2026 renaming, cardiometabolic risk is under-screened compared to reproductive symptoms, even though cardiometabolic disease causes more long-term mortality for most affected women [5,7].

2.3 Name stigma and psychological effects

Beyond its clinical imprecision, the former name had a psychosocial cost that patient advocacy groups emphasized for years before the rebranding. Being told one has "polycystic ovaries" can lead to misperceptions that one's ovaries are diseased, that fertility is compromised, or that a surgical or invasive gynecological problem is present, none of which are true and none of which address the syndrome's long-term metabolic risks.

Contemporary commentary on the renaming highlighted that the former terminology's emphasis on "cysts" and "ovary" reduced a complicated, lifelong hormonal and metabolic condition to a narrow and terrifying anatomical mistake [7,8]. The consensus process revealed that patients associated the old name with shame, confusion about fertility prospects, and a sense that the condition was being dismissed as a cosmetic or reproductive inconvenience rather than a lifelong cardiometabolic health risk [5].

This stigma had multiple registers. At the individual clinical encounter, women have long reported that the word "cyst" caused unnecessary anxiety about ovarian cancer or surgery, which a clinician had to defuse before discussing management.

A name that emphasizes the ovary also frames the condition almost exclusively as a fertility issue relevant only to women actively trying to conceive, and less relevant or urgent for adolescents, women who have completed their families, or women not currently pursuing pregnancy. That framing conflicts with the epidemiological fact that metabolic risk begins early, often in adolescence, and persists throughout the reproductive lifespan and beyond menopause, regardless of a woman's fertility intentions [4,21]. Also, a name that implicitly limits the condition's relevance to a specific life stage or objective was unsuitable for the ailment it was meant to depict.

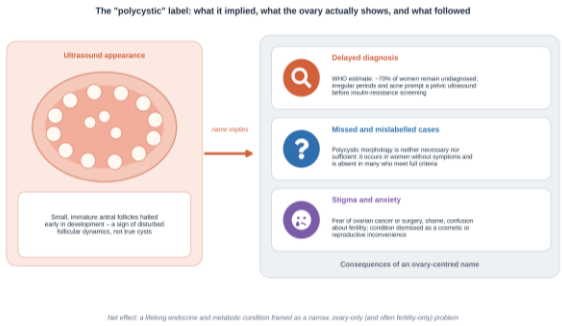


Figure 2. The cyst misnomer and its effects

2.4 Historical ovarian frame persistence despite conflicting evidence

Why a name that was imprecise for decades changed so slowly is worth considering. The institutional inertia around an established diagnostic label guideline committee, insurance systems, drug labels, and clinical trial registries had accumulated around "polycystic ovary syndrome" for over a century, and no earlier renaming proposal succeeded in assembling the breadth of endorsement needed to move that infrastructure in a coordinated manner [5,8].

Even a room of experts convinced that metabolic dysfunction was central to the disease's biology could not agree on whether or how to act on that consensus once the practical difficulty of coordinated global renaming was presented [8]. Section 3.3 discusses how a decade later, a new willingness to regard implementation planning as separate from the name decision broke that impasse.

III. THE GLOBAL CONSENSUS PROCESS BEHIND PMOS

3.1 Multistep consensus methodology overview

The developers of PMOS underline that its exceptionally long and procedurally rigorous development process was meant to succeed where prior, more informal name suggestions had failed [5]. The authors date the initiative to an October 2015 meeting in Sicily, where an initial group of specialists met to explore renaming the syndrome but could not agree on the need for change, let alone a replacement title [8]. Instead of dismissing that disagreement, Professor Helena Teede of Monash University's Center for Health Research and Implementation and collaborators like Professor Terhi Piltonen of the University of Oulu used it to start a longer, iterative stakeholder engagement program [5,9].

That initiative built on two worldwide surveys between 2017 and 2023 before a third, considerably larger survey of approximately 15,000 stakeholders in 2025 [8]. The consensus authors estimate that 22,000 patients, clinicians, researchers, and charity and advocacy organization representatives provided renaming opinions over the eleven-year involvement period [8]. Later rounds of the process used iterative Delphi polls and nominal group workshop procedures to surface and resolve dispute systematically rather than depending on a single vote or expert panel [5]. The effort was funded by an Australian Center of Research Excellence grant and endorsed by 56 leading academic, clinical, and patient organizations, including the Endocrine Society, the International Androgen Excess and PCOS Society, and Verity [5,10].

3.2 Stakeholder engagement size

Commentators have called it the broadest and most rigorous disease-renaming process ever [8]. Clinical, research, patient, and advocate representatives voted on the ultimate name in an organized manner. Only two formal dissidents remained after 87 quickly backed the winning choice and one more by the time the consensus manuscript was submitted [8]. After eleven years and 22,000 contributions, 90 independently nominated stakeholders reached near-unanimity on the term, which the authors argue is part of its legitimacy: this was not a top-down rebranding imposed by a small expert committee, but the end of the largest deliberative exercise on a single disease name.

3.3 New name principles

The consensus authors tested every candidate name against a set of principles: scientific accuracy, patient benefit, ease of communication, avoidance of stigma, cultural appropriateness across the very wide range of languages and health systems in which the term would need to function, and a concrete, pre-planned implementation strategy rather than a name proposed in the abstract [5,1]. Polyendocrine metabolic ovarian syndrome, endocrine metabolic ovulatory syndrome, and ovulatory metabolic endocrine syndrome advanced to the ultimate stage [8]. Polyendocrine metabolic ovarian syndrome (PMOS) was the winner, meeting the accuracy and communicability criteria simultaneously: "polyendocrine" indicates that multiple hormonal systems beyond the ovary are involved, "metabolic" places insulin resistance and cardiometabolic risk at the disease's center rather than treating them as downstream complications, and "ovarian" maintains continuity with the reproductive dimension.

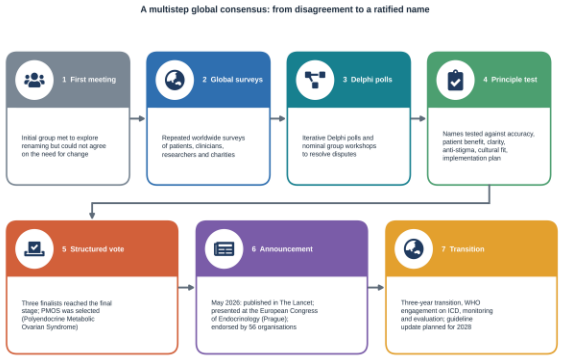


Figure 3. Seven-stage consensus process

IV. DEFINING POLYENDOCRINE METABOLIC OVARIAN SYNDROME (PMOS)

4.1 What the new name captures that "PCOS" did not

Each element of the new three-word name does definitional work that "polycystic ovary syndrome" did not. "Polyendocrine" is the most conceptually significant departure: it explicitly acknowledges that the syndrome arises from disturbed signaling across several interacting endocrine axes the hypothalamic-pituitary-ovarian axis, insulin and pancreatic beta-cell signaling, adrenal androgen production, and, in a

meaningful subset of women, thyroid function rather than from a single-organ abnormality [9]. "Metabolic" foregrounds insulin resistance, dyslipidemia, and elevated long-term risk of type 2 diabetes and cardiovascular disease as core disease features present from an early stage, not as complications that accrue later in women who happen to also be overweight [4,12]. "Ovarian" is retained, deliberately, because disrupted folliculogenesis and ovulatory dysfunction remain a genuine and diagnostically necessary feature of the syndrome; the consensus authors were explicit that the new name was not intended to erase the ovarian component, only to stop it from monopolizing the disease concept [5,9].



Figure 4. Systems represented by PMOS

4.2 Endocrine, metabolic, reproductive, dermatological, and psychological dimensions

The clinical phenotype that PMOS is designed to name has always been broader than reproductive medicine alone, even when the label suggested otherwise. On the endocrine and reproductive side, hyperandrogenism and disrupted hypothalamic-pituitary-ovarian signaling produce oligomenorrhoea or amenorrhoea, chronic anovulation, and reduced fertility, while manifesting cutaneously as hirsutism, acne, and androgenic alopecia [4,13]. On the metabolic side, insulin resistance is present in a large majority of affected women independent of body mass index, driving compensatory hyperinsulinemia that in turn stimulates ovarian theca-cell androgen production and suppresses hepatic synthesis of sex hormone-binding globulin, tightening a reciprocal loop between metabolic and reproductive dysfunction [12,14]. Chronic low-grade inflammation, mediated by elevated tumor necrosis factor-alpha, interleukin-6, and C-reactive protein, alongside oxidative stress and, in a growing evidence base, alterations in gut microbial composition, appear to sustain and amplify both the metabolic and reproductive arms of the disorder [14,15,16]. Psychologically, the condition carries a well-documented burden of anxiety, depression, body-image disturbance, and reduced quality of life that both predates and compounds the disease's physical manifestations, and which the consensus process explicitly cited as part of the case for a name that better reflects the totality of what patient's experience [5,17].

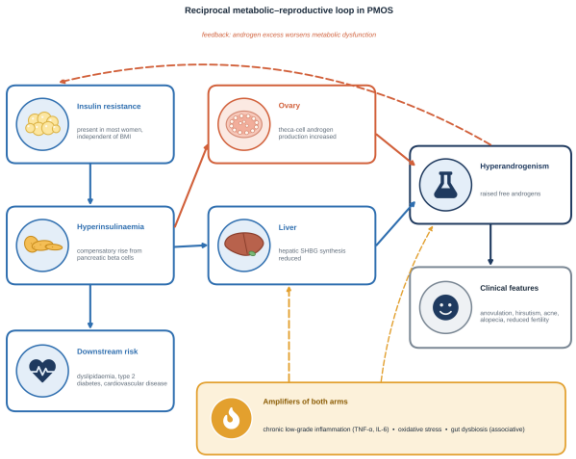


Figure 5. Insulin–androgen feedback loop

4.3 How diagnostic criteria and disease framing are; and are not changing alongside the name

It is a point that essentially every professional communication following the May 2026 announcement has been careful to make: the renaming does not, in itself, alter diagnostic criteria [5,18,19]. The Rotterdam-derived framework requiring two of three features among oligo- or anovulation, clinical or biochemical hyperandrogenism, and polycystic ovarian morphology on ultrasound remains the operative diagnostic standard for women who will now be labelled with PMOS rather than PCOS [2,18]. What has changed is framing rather than criteria: the consensus authors and endorsing societies have signaled those future revisions of the International Evidence-Based Guideline, expected to formally incorporate the new terminology by its next scheduled update in 2028, are likely to consider whether diagnostic and risk-stratification frameworks should evolve further to reflect the disorder's polyendocrine

and metabolic dimensions more explicitly [5,20]. For the time being, however, a woman diagnosed under the old criteria before May 2026 and a woman diagnosed under the same criteria after that date have, clinically speaking, the same diagnosis under two different names [18,19].

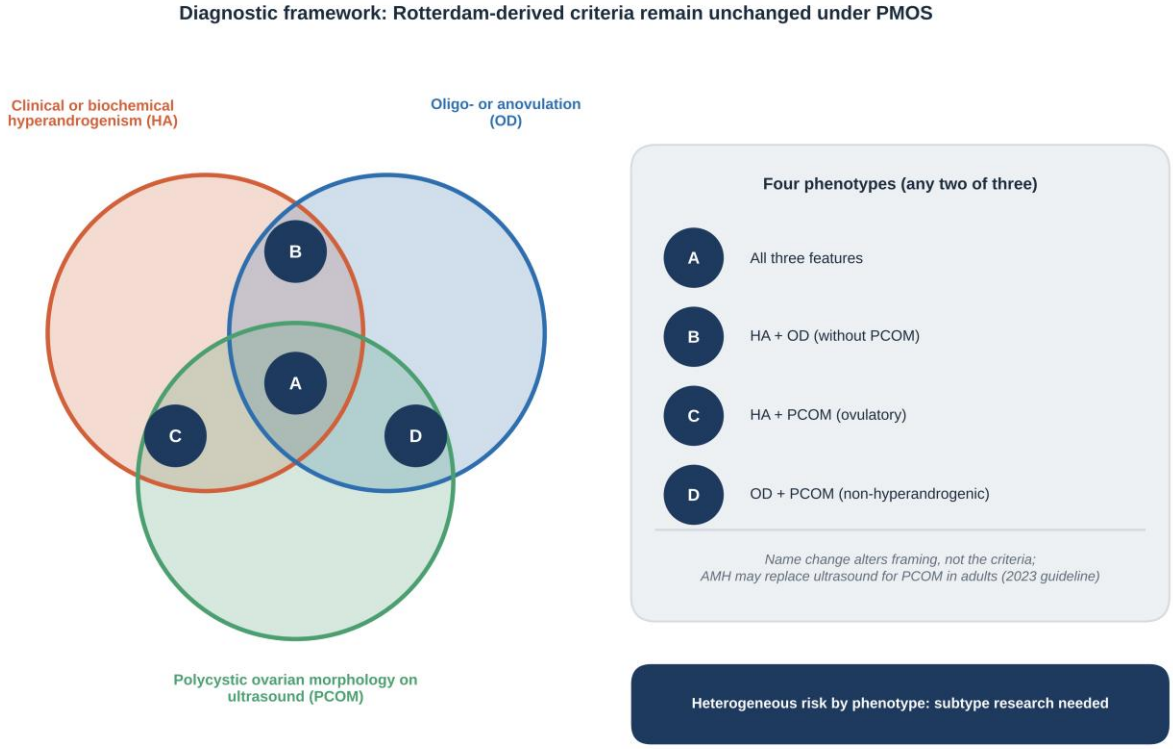


Figure 6. Rotterdam criteria and four phenotypes

V. CLINICAL PRACTICE IMPLICATIONS

5.1 Impact on diagnosis and screening across specialties

The intended effect of the renaming on clinical practice is primarily one of emphasis rather than mechanism. By foregrounding "metabolic" and "polyendocrine" in the disease's very name, the consensus authors and endorsing bodies hope to prompt more consistent metabolic screening fasting glucose or a 75-gram oral glucose tolerance test, lipid profiling, blood pressure measurement, and waist circumference at the point of diagnosis, regardless of which specialty first encounters the patient [4,12]. This matters particularly for dermatologists managing hirsutism or acne and pediatric or adolescent-medicine clinicians managing early menstrual irregularity, both of whom may previously have treated the presenting complaint without triggering metabolic work-up, since nothing in the old disease name signaled that such screening was relevant to their specialty [7,21]. Endocrinologists and gynecologists, who already manage the syndrome's metabolic and reproductive dimensions respectively, are less likely to see an immediate change in their own diagnostic behavior, but may find the renaming useful as a communication tool when referring patients across specialty lines.

5.2 Effects on treatment pathways and multidisciplinary care models

Consistent with the renaming's stated intent to leave underlying disease biology and management unchanged, the consensus paper and subsequent professional-society commentary are explicit that fertility treatment protocols, insulin-sensitizing pharmacotherapy, and dermatological management for hirsutism and acne all continue exactly as before [18,19]. What the new name is intended to support, rather than mandate, is a shift toward multidisciplinary care models in which endocrinology, gynecology, dermatology, nutrition, and psychological support are coordinated around a single disease concept rather

than operating as parallel, loosely connected referral pathways [5,17]. Several professional statements accompanying the announcement frame this as the renaming's principal practical ambition: not to change what is done for any individual patient on a given clinic visit, but to change how consistently the full range of appropriate care metabolic, reproductive, dermatological, and psychological is offered as a bundle rather than left to the instincts of whichever specialist happens to see the patient first [17,19].

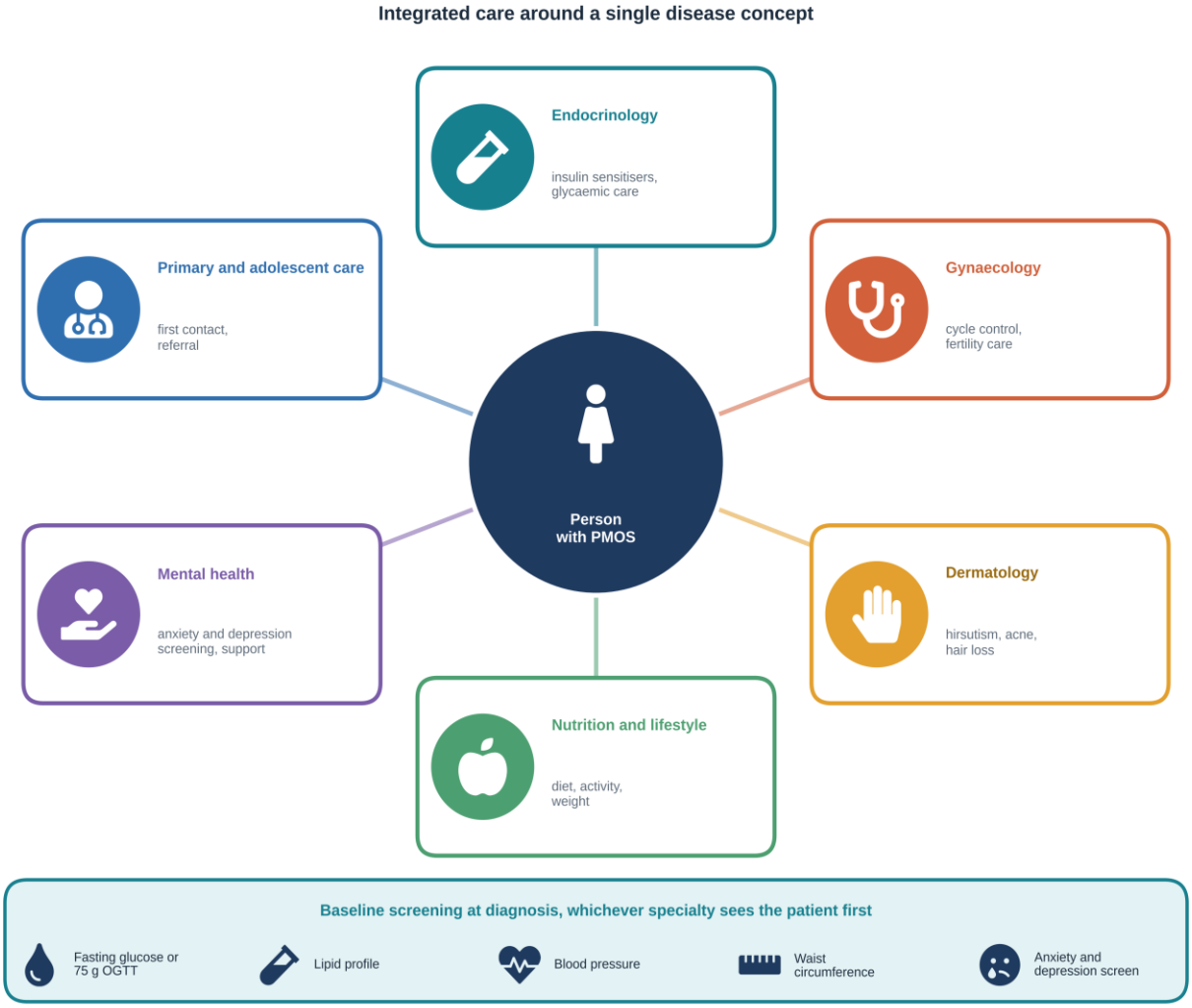


Figure 7. Multidisciplinary care and baseline screening

5.3 Billing, coding, and health-record transition challenges

The most concretely disruptive near-term implication of the renaming lies in administrative infrastructure rather than clinical decision-making. The American Society for Reproductive Medicine, one of the 56 endorsing organizations, moved quickly after the announcement to issue coding guidance through its Coding Committee, addressing practical questions such as how to code ultrasound follicle monitoring or surgical procedures when a patient's chart now reads "PMOS" rather than "PCOS" [19]. This is necessary because the underlying diagnostic codes have not yet changed: ICD-10-CM code E28.2 and the corresponding ICD-11 code 5A80.1, both still labelled "polycystic ovary syndrome," remain the operative billing codes during the transition, with formal engagement between the consensus organizers and the World Health Organization to update the International Classification of Diseases still in progress rather than complete [20,22,23]. In practice, this means clinicians, coders, and electronic health record systems will need

to manage a period expected to last at least until the 2028 ICD update in which the diagnosis documented in the clinical note may read "PMOS" while the code submitted for reimbursement still reads "polycystic ovary syndrome," a mismatch that professional coding bodies are actively working to bridge through interim guidance rather than a clean simultaneous cutover [19,20].

5.4 Screening tools and risk-stratification practice likely to follow the renaming

Although the Rotterdam-derived diagnostic criteria remain formally unchanged (Section 4.3), several professional communications following the announcement have pointed to specific screening practices that clinicians are being encouraged to apply more consistently under the new framing, even ahead of any formal guideline revision. These include earlier and more routine use of a 75-gram oral glucose tolerance test in women with additional cardiometabolic risk factors, since fasting glucose and glycated hemoglobin alone are recognized to under-detect impaired glucose tolerance in this population; baseline and periodic lipid profiling regardless of body mass index, given that metabolic abnormalities are well documented even in lean phenotypes of the condition; and structured psychological screening for anxiety and depression as a routine component of the diagnostic visit rather than an optional add-on raised only if the patient volunteers such symptoms [4,12,17]. None of this represents a change to the diagnostic criteria themselves, but it reflects the kind of practice-level shift the renaming is explicitly designed to encourage: treating metabolic and psychological assessment as default components of the diagnostic encounter, on the same footing as pelvic ultrasound and androgen testing, rather than as supplementary investigations ordered only when a clinician happens to think of them.

VI. IMPLICATIONS FOR RESEARCH AND POLICY

6.1 Reframing research priorities toward metabolic and systemic outcomes

One of the more consequential long-term effects the consensus authors hope for is a shift in how research questions about the condition are framed and funded. A disease named around ovarian morphology tends, unsurprisingly, to attract research funding and trial design centered on reproductive endpoints ovulation induction, live birth rates, and ovarian response to treatment even though cardiometabolic disease accounts for a larger share of long-term morbidity in affected women [4,12]. By formally repositioning the condition as fundamentally polyendocrine and metabolic, the renaming is intended to make it correspondingly more natural for funders, journal editors, and trial designers to prioritize cardiometabolic endpoints, insulin sensitivity, and long-term cardiovascular outcomes alongside rather than subordinate to reproductive endpoints [5,9].

6.2 Effects on funding, clinical trial design, and drug or nutraceutical development framing

For pharmaceutical and nutraceutical developers, the renaming carries a practical signal about how future products aimed at this population are likely to be positioned and evaluated. Commentary written for the health-industry and market-strategy audience following the announcement has characterized 2026 to 2028 as a critical window in which organizations developing therapeutics, diagnostics, or care programmes for the condition should reassess whether their existing positioning often built, historically, around fertility or reproductive framing remains aligned with a diagnostic concept now explicitly centred on metabolic dysfunction [24]. This creates a plausible opening for interventions aimed primarily at insulin sensitization, inflammation, and oxidative stress to be evaluated and marketed as addressing the condition's core pathophysiology rather than as adjuncts to fertility treatment, a point taken up further in Section 9 of this review.

6.3 Alignment with international disease classification systems

Formal alignment with international classification infrastructure is under way but not complete. The consensus paper explicitly commits its authors to continued engagement with the World Health Organization to progress integration of the new terminology into the International Classification of Diseases, alongside a managed three-year transition period that includes monitoring, evaluation, and openness to further terminological refinement as evidence on disease subtypes accumulates [5,20]. The nearest fixed milestone is 2028, when the International

Evidence-Based Guideline already adopted for use across 195 countries is scheduled for its next full update and is expected to formally adopt PMOS as the guideline's primary terminology [5,20,22]. Until that point, the WHO's own coding infrastructure, and by extension most national insurance and health-record systems built on it, will continue to operate on "polycystic ovary syndrome" as the coded diagnosis, even where clinical documentation has already moved to the new name [22,23].

VII. THE PATIENT PERSPECTIVE

7.1 Lived-experience drivers behind the renaming effort

Patient testimony was not a peripheral input into the consensus process but one of its central evidentiary pillars, gathered systematically across all three international surveys conducted between 2017 and 2025 [5,8]. The recurring themes in that testimony diagnostic delay, dismissive or fragmented care, confusion about fertility implications, and the psychological weight of a name perceived as trivializing a serious, lifelong condition map closely onto the clinical case for change outlined in Section 2, and the consensus authors describe the process as having been driven "with, and for," people affected by the condition rather than imposed on them by clinicians and researchers alone [5,7].

7.2 Support from patient advocacy groups versus reservations

Support for the renaming among surveyed patients was strong but not unanimous, with figures cited in industry commentary suggesting approximately 86% patient support and 71% clinician support for a name change in principle during the consensus surveys [24]. Institutional patient advocacy, however, was more divided than these topline figures suggest. Several major organizations — including the Endocrine Society, the International Androgen Excess and PCOS Society, and the UK charity Verity formally endorsed the new name as one of the 56 signatory organizations [5,10]. The National Polycystic Ovary Syndrome Association, by contrast, publicly declined to endorse the change, acknowledging that the underlying effort had been undertaken in good faith and "in the spirit of what is right and what is best for the people who live with it," while stopping short of adopting the new terminology itself [25]. Among the small number of formal dissenters within the consensus vote itself, Sasha Ottey, executive director of PCOS Challenge described in contemporaneous reporting as America's leading PCOS patient association and Angela Grassi, a registered dietitian and head of the PCOS Nutrition Center, both raised the concern that the new name changed a great deal without resolving everything it might have: in particular, that retaining "ovarian" in the name leaves no room for the condition's possible expression in men, a line of research that was itself one of the motivations behind reconsidering the old name in the first place [8].

7.3 Risks to patient support networks and continuity of care

A further concern raised repeatedly in post-announcement commentary, distinct from disagreement over the specific chosen term, is the practical cost of abandoning a name around which patient communities, support networks, and decades of awareness-raising infrastructure have been built [7,25]. Online communities, non-profit organizations, research registries, and patient-facing educational material have accumulated for years under the PCOS name; a change in terminology risks fragmenting search, referral, and peer-support pathways during the transition, particularly for patients newly seeking information who may not immediately recognize PMOS as the same condition discussed in years of existing patient literature [7]. Reassuringly, most patient-facing guidance issued since the announcement has explicitly addressed this by presenting both names side by side "PMOS (formerly PCOS)" during the transition period, and by stressing consistently that no patient's existing diagnosis, treatment plan, or fertility care changes as a direct result of the renaming [18,19,25].

VIII. CHALLENGES AND OPEN QUESTIONS

8.1 Global and regional adoption challenges

The consensus authors included a three-year transition time in the implementation approach because they expected unequal global uptake [5,20]. The consensus-driven health systems and countries Australia, the UK, and parts of the US are likely to adopt faster than others. Clinical commentaries in India suggest that major national medical bodies may

take two to four years after the initial announcement to formally incorporate PMOS into clinical guidelines and undergraduate medical curricula, a lag considered normal for international guideline changes but one that will leave clinicians in some regions using the old terminology for much longer than the headline three-year t. The consensus authors' specific requirements for multilingual translation and cultural adaption of the new word complicate uniform global deployment [5,11].

8.2 Terms may outpace care advances.

A more fundamental question, raised explicitly at professional conferences after the announcement, is whether a name change of this scale risks becoming symbolic without matching investment in screening infrastructure, referral pathways, and reimbursement structures. At a 2026 conference session reported by Medscape, David Ehrmann, professor emeritus of medicine and former director of the Center for Polycystic Ovary Syndrome at the University of Chicago, publicly questioned the scientific process and the practical value of the new term, and audience members voiced similar reservations [26]. Any large nomenclature reform carries the risk that updating what a disease is called is easier and faster than updating how health systems screen for, refer, and reimburse care for it. The coding and billing infrastructure needed to make PMOS operationally useful in daily clinical administration was still being developed, as Section 5.3 shows.

8.3 "PCOS" in legacy literature, patient records, and awareness

Despite explicit policy timelines, "PCOS" will remain in medical and patient terminology for a long time. The previous word underpins decades of research, patient charts, insurance records, medication histories, and public awareness campaigns, none of which are being renamed [18,19]. In the months after the announcement, patient-facing guidance has consistently advised that both names will likely be used interchangeably for years, that PCOS will continue to appear on medical records, laboratory reports, and prescriptions, and that researchers and clinicians searching historical literature will need to continue using "PCOS" as a search term indefinitely, regardless of how quickly PMOS becomes the preferred term. The persistence of legacy language is not a defect in the implementation strategy, but an inherent structural element of changing the name of a condition with tens of thousands of publications and hundreds of millions of medical data.

8.4 Scientific questions the name change does not answer

Despite its lengthy deliberation, the renaming leaves numerous important scientific questions unanswered. The consensus authors acknowledge that the four Rotterdam-derived phenotypes captured under the single PMOS label are more heterogeneous in presentation and long-term risk than a single name can fully convey and call for continued research into subtype-specific risk stratification as evidence accumulates [5,20].

Two of the consensus process's dissenting voices addressed the topic of whether and how an analogous metabolic-endocrine condition may manifest in men, which remains a live and partially answered research question [8]. Gut microbiota dysbiosis is increasingly implicated in the condition's pathophysiology, although the evidence is associative rather than causal, and molecular clarity sufficient to justify microbiota-targeted treatments is yet years away [15,16]. These unresolved concerns are not criticisms of the renaming; rather, they show that a well-executed name change should be seen as clearing conceptual ground for future inquiry, not as a scientific advance.

IX. FUTURE DIRECTIONS

9.1 Priorities for the transition period

The consensus authors own implementation strategy identifies education, phased guideline revision, and continued monitoring as the central priorities for the three-year transition window, with the 2028 International Guideline update serving as the fixed point around which most institutional adoption is likely to cluster [5,20]. For individual institutions and clinicians, the most immediately actionable priorities are relatively modest: updating patient-facing educational material to introduce the new term alongside the old rather than in place of it, ensuring coding staff are aware of interim billing guidance such as that issued by the American Society for Reproductive Medicine, and using the renaming as a prompt to audit whether metabolic screening is being

consistently offered to patients regardless of which specialty first makes the diagnosis [17,19,21].

9.2 Opportunities the new framing creates for metabolic-health-focused interventions

The more scientifically interesting long-term consequence of the renaming may lie in the therapeutic strategies it makes newly natural to pursue and evaluate. A disease concept explicitly organized around insulin resistance, chronic low-grade inflammation, oxidative stress, and adipose tissue dysfunction creates a more coherent rationale for interventions that act on those pathways directly, rather than treating them as secondary to reproductive management [12,14,16]. This is where plant-derived phytoconstituents and nutraceutical formulations, an area of research that has grown substantially over the past decade even while the disease name lagged behind the underlying science, may find a clearer conceptual home under the PMOS framework.

Several classes of phytoconstituents illustrate the point. Berberine, an isoquinoline alkaloid, has been studied for its capacity to improve insulin sensitivity and glucose utilization through mechanisms including activation of AMP-activated protein kinase, with associated reductions in circulating androgen levels reported in preclinical and early clinical work [27,28]. Curcumin, the principal polyphenolic constituent of turmeric, is among the most extensively studied natural anti-inflammatory and antioxidant compounds, acting substantially through modulation of nuclear factor-kappa B signaling, and has been investigated for its potential to improve insulin sensitivity and reduce the chronic inflammatory burden characteristic of the syndrome's metabolic phenotype [16,27]. Quercetin and related flavonoids such as apigenin, kaempferol, and naringenin share a broadly overlapping pharmacological profile antioxidant, anti-inflammatory, and, in various preclinical models, capable of modulating steroidogenic enzyme activity relevant to androgen production though the clinical evidence base for most individual flavonoids in this specific condition remains at an early, largely preclinical stage [27,29]. Resveratrol, a stilbenoid polyphenol with sirtuin-modulating and antioxidant properties, and diosgenin, a steroidal saponin with glucose-regulating and anti-inflammatory activity, round out a broader category of compounds under active investigation for potential roles in supporting insulin sensitivity and ovarian follicular health [27,29].

None of this evidence is currently sufficient to support phytoconstituent-based products as primary therapy in place of established pharmacological management, and the review authors emphasize that further well-designed clinical trials rather than preclinical mechanism studies alone are needed before firm recommendations can be made [27,29]. What the PMOS framework arguably changes are the conceptual plausibility of that research programme: evaluating a botanical insulin-sensitizer or antioxidant compound makes considerably more intuitive sense as a strategy against a disease explicitly defined as metabolic and polyendocrine than it did against a disease whose very name pointed toward the ovary.

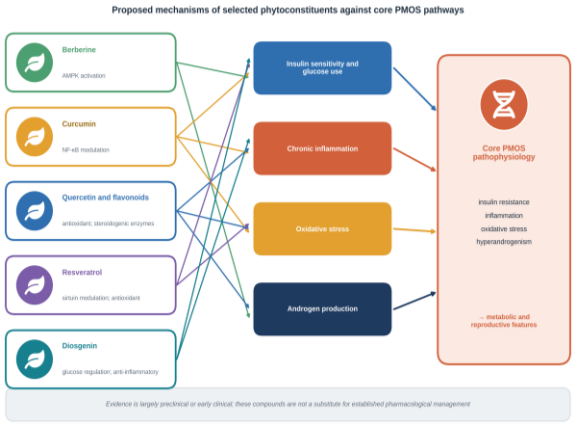


Figure 8. Phytoconstituents and PMOS pathways

9.3 Guideline updates and research realignment

Looking beyond the immediate transition period, the clearest markers of whether the renaming has achieved its intended effect will be visible in the 2028 International Guideline revision and in the shape of research funding calls issued in the intervening years. A guideline revision that meaningfully expands metabolic screening recommendations and multidisciplinary care pathways rather than simply substituting one name for another throughout the existing document would represent the renaming succeeding on its own stated terms. Equally, funding bodies and journals that begin actively soliciting and prioritizing cardiometabolic and mechanistic research alongside reproductive endpoints would suggest the reframing is achieving genuine traction in the research ecosystem, rather than remaining confined to nomenclature alone.

X. CONCLUSION

The transition from PCOS to PMOS is, on its surface, a change of three words for one. Beneath that surface, it represents the culmination of an eleven-year, 22,000-person deliberative process explicitly designed to correct a definitional error that had shaped diagnostic behavior, research funding, and patient experience for nine decades: the conflation of a common, largely benign ultrasound finding with the identity of a complex, lifelong, multisystem endocrine and metabolic disorder [1,5,8]. The new name does not, by itself, change a single diagnostic criterion, treatment algorithm, or reimbursement code that infrastructure is still catching up, and by the consensus authors' own three-year timeline, will continue catching up for some time yet [18,19,20]. What it does change, if the renaming achieves what its authors intend, is the starting assumption that a clinician, a researcher, a policymaker, or a newly diagnosed patient brings to the condition: not a reproductive curiosity defined by an incidental ovarian finding, but a systemic hormonal and metabolic disorder in which reproductive dysfunction is one visible manifestation among several, no more or less important than the cardiometabolic risk that accrues silently across the same patient's lifetime.

Whether this reframing translates into measurably earlier diagnosis, more consistent metabolic screening, and better-coordinated multidisciplinary care rather than remaining, as some clinicians have already cautioned, a largely symbolic relabeling is an empirical question that only the coming years of implementation, guideline revision, and outcomes research can answer [26]. For clinicians, the immediate task is straightforward: treat the new name as an invitation to audit whether metabolic and psychological care are being offered as consistently as reproductive care, regardless of which specialty first sees the patient. For researchers and funders, it is an invitation to weight cardiometabolic and mechanistic endpoints as heavily as reproductive ones in future trial design. And for the pharmaceutical, nutraceutical, and phytopharmaceutical development community, it is an invitation to evaluate insulin-sensitizing, anti-inflammatory, and antioxidant interventions on their own mechanistic merits against a disease concept that, for the first time in its history, actually says what it means.

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