Impact of PMOS on Women's Health, Sexual Function, Fertility and Married Life

Understanding Polyendocrine Metabolic Ovarian Syndrome, Hormonal and Metabolic Changes, Body Image, Mood, Intimacy and the Integrative Unani Approach

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An Important 2026 Update: PCOS Is Now Called PMOS

Before discussing the impact of this condition, I want to begin with an important change that many patients and even some healthcare professionals may not yet know.

On **12 May 2026**, an international global consensus officially renamed **Polycystic Ovary Syndrome (PCOS)** as **Polyendocrine Metabolic Ovarian Syndrome (PMOS)**. The reason is important. The old name created the misleading impression that the disease was mainly about ovarian "cysts," while in reality it can affect reproductive hormones, metabolism, weight regulation, skin and hair, psychological health, fertility and long-term health. The new term is therefore intended to describe the condition more accurately and reduce misunderstanding and stigma. PMOS affects approximately **one in eight women**, or more than 170 million women worldwide.

The international guideline itself was updated in May 2026 to use PMOS terminology, while its clinical recommendations remain based on the comprehensive 2023 international evidence-based guideline until the next major update scheduled for 2028.

Throughout this article, I will therefore use **PMOS**, while occasionally mentioning **PCOS** in brackets so that patients can connect the new name with older reports, prescriptions and online information.

Introduction

When a woman comes to me with PMOS, she rarely comes with only one problem.

She may say:

“Doctor, my periods are irregular.”

She may also say:

“My weight keeps increasing.”

“I have facial hair and acne.”

“I am losing scalp hair.”

“I no longer feel confident in front of my husband.”

“My sexual desire has reduced.”

“I become anxious and irritable.”

Or, perhaps most painfully:

“We have been married for years and I am still unable to conceive.”

These experiences show why PMOS should never be reduced to “cysts in the ovaries.”

The background material prepared for this article correctly emphasizes that PMOS/PCOS can extend far beyond gynaecological symptoms, affecting body image, emotional wellbeing, sexual confidence, fertility and intimate relationships.

The latest international guideline takes exactly this broader approach. It recognizes reproductive, metabolic, cardiovascular, dermatological, sleep-related and psychological consequences and specifically asks clinicians to consider **psychosexual function, body image, anxiety, depression and quality of life**.

As a physician focused on sexual disorders and infertility, I believe this broader understanding is essential.

A woman with PMOS does not need only an ultrasound report.

She needs to be understood as a whole person.

What Is PMOS?

Polyendocrine Metabolic Ovarian Syndrome (PMOS), formerly PCOS, is a heterogeneous endocrine and metabolic condition affecting women across the reproductive lifespan.

In adults, current international criteria generally diagnose PMOS when **two of three major features** are present after excluding other disorders that can cause similar symptoms:

Diagnostic domain	What it means
Ovulatory dysfunction	Irregular, infrequent or absent ovulation/menstrual cycles

Diagnostic domain	What it means
Hyperandrogenism	Clinical signs such as hirsutism or biochemical evidence of excess androgens
Polycystic ovarian morphology	Characteristic ovarian follicle pattern on ultrasound; in appropriate adults AMH can sometimes be used as an alternative to ultrasound

Current international criteria remain based on this framework, with important differences for adolescents to avoid overdiagnosis.

An important point is that a woman does **not** necessarily need visible "cysts" to have PMOS.

What older ultrasound reports called "polycystic ovaries" largely reflects a characteristic pattern of numerous small follicles rather than dangerous ovarian cysts.

This misunderstanding was one of the major reasons for the 2026 name change.

What About the Term PCOD?

In India and South Asia, many patients use the words **PCOD and PCOS** as though they refer to two completely different diseases, with PCOD described as a mild or temporary condition and PCOS as a severe permanent disease.

This distinction is not part of the current international diagnostic guideline.

The internationally recognized terminology is now **PMOS, formerly PCOS**. "PCOD" may continue to appear colloquially or in older records, but current evidence-based classification does not define PCOD as a separate universally recognized milder syndrome.

The supplied background material presents PCOD and PCOS as distinct diseases with very different severity, fertility effects and reversibility. For a professional website article, that distinction should be corrected because it can confuse patients.

The more useful question is not:

"Do I have mild PCOD or severe PCOS?"

It is:

"Which PMOS features do I have, how are they affecting my health, and which require treatment?"

PMOS Is More Than an Ovarian Disorder

The new name—**Polyendocrine Metabolic Ovarian Syndrome**—helps explain the modern understanding of the disease.

PMOS can involve several interacting systems.

The ovaries may have difficulty releasing eggs regularly.

Androgen levels or androgen activity may be increased.

Insulin resistance is an important underlying feature in many patients.

Weight regulation and metabolic risk may be affected.

Skin and hair may change.

Psychological health may be affected.

Sleep disorders may occur.

Fertility can become difficult.

Sexual wellbeing and intimate relationships may also be affected.

This multisystem nature is exactly what the 2026 terminology change was intended to communicate.

Insulin Resistance and PMOS

Insulin resistance is one of the important physiological features associated with PMOS.

Insulin normally helps move glucose from the blood into the body's cells.

When cells become less responsive to insulin, the pancreas may compensate by producing more insulin.

Higher insulin levels can interact with ovarian androgen production and other metabolic pathways.

However, an important clinical qualification is necessary:

not every woman with PMOS has identical insulin resistance, and insulin resistance itself is not currently required as a diagnostic criterion.

The international guideline recognizes insulin resistance as an important pathophysiological feature but states that routinely available clinical insulin-resistance tests are not sufficiently accurate or useful to be recommended as routine diagnostic testing.

So I do not diagnose PMOS simply because someone's fasting insulin appears high.

The whole clinical picture matters.

PMOS and Weight Gain

Many women tell me:

“I am eating less than everyone else, but I still gain weight.”

Weight management can indeed be more challenging for some women with PMOS.

The international guideline recognizes that underlying biological mechanisms may contribute to greater long-term weight gain and can make weight management more difficult. At the same time, it warns clinicians against assuming that women with PMOS simply eat badly or exercise less than other women.

This distinction matters psychologically.

A woman should not be told:

“You have PMOS because you are lazy.”

Nor should she be told:

“Weight loss is impossible because your metabolism is completely broken.”

Neither extreme is accurate.

Healthy lifestyle measures remain effective and important, and they provide benefits even when the weighing scale changes only modestly.

Weight Stigma Can Become Part of the Disease Burden

Many women with PMOS have already been repeatedly told:

“Just lose weight.”

Sometimes this is delivered without any acknowledgement of how difficult the process has been.

The international guideline specifically tells healthcare professionals to recognize **weight stigma and weight bias** and to use respectful, individualized discussions about weight.

That approach is important in sexual medicine as well.

If every consultation leaves a woman feeling ashamed of her body, we should not be surprised when she later struggles to feel sexually confident.

Facial Hair, Acne and Scalp Hair Loss

Hyperandrogenism can cause some of the most visible symptoms of PMOS.

These may include:

facial or body hirsutism, acne and androgen-related scalp hair thinning.

From a laboratory perspective, these may appear to be dermatological symptoms.

From the woman's perspective, however, they may affect her identity every single day.

She may spend substantial time:

shaving, waxing, threading, covering acne or trying to conceal thinning hair.

The supplied background material correctly highlights how unwanted hair, acne and hair loss may become sources of embarrassment and withdrawal from intimacy.

A 2026 mixed-methods study found that women with PMOS/PCOS reported greater body-image distress than normative populations, particularly where higher BMI and hirsutism were present. Poorer body image was also associated with greater depression, anxiety, disordered eating and poorer quality of life.

So treating hirsutism and acne is not merely cosmetic care.

For some patients it is part of psychological and sexual-health treatment.

PMOS and a Woman's Sense of Femininity

Some patients use very emotional language.

They say:

“I don't feel feminine anymore.”

It is important not to dismiss this experience.

But it is equally important not to reinforce it.

Facial hair or elevated androgens do not make a woman “less female.”

These are clinical symptoms of an endocrine condition.

A partner who understands this can make an enormous difference.

A supportive response is:

“This is a medical symptom. It doesn't change how I see you.”

Repeated teasing about weight, hair or acne can do the opposite and may profoundly damage intimacy.

Body Image and Intimacy

Sexual intimacy requires a degree of physical and emotional vulnerability.

A woman who feels ashamed of her body may start thinking during intimacy:

“Can he see my facial hair?”

“Does my abdomen look too large?”

“Is he looking at my acne?”

“Will he find my body unattractive?”

Instead of experiencing touch, she begins monitoring herself.

This cognitive distraction can reduce sexual enjoyment and arousal.

Body-image research in women with PMOS increasingly confirms that weight, hirsutism, acne and hair loss can influence psychological wellbeing, intimate relationships and quality of life.

PMOS and Depression

Mental health is now a core part of PMOS management.

The international guideline recommends that healthcare professionals recognize the high prevalence of moderate-to-severe depressive symptoms and screen adults with PMOS accordingly.

A 2025 umbrella review of systematic reviews found substantial rates of depressive symptoms and depressive disorders among women with PCOS, though exact estimates varied according to the assessment method.

A separate 2025 analysis focusing on low- and middle-income countries found particularly high levels of reported depression and anxiety, while also noting large differences between studies.

The important clinical message is not that every woman with PMOS will develop depression.

It is:

we should actively ask.

PMOS and Anxiety

Anxiety may arise from many sources:

uncertain periods, fear about fertility, concern about weight, unwanted hair, worry about diabetes, repeated pregnancy tests or pressure from relatives.

Current international recommendations therefore call for anxiety screening as part of adult PMOS care.

If significant anxiety or depression is identified, the guideline recommends appropriate assessment and psychological treatment according to established mental-health standards. Evidence-based approaches such as CBT may be useful, especially where body-image distress, low self-esteem or psychosexual problems are present.

PMOS Does Not Automatically Cause "Mood Swings" Through One Hormone

It is tempting to explain every emotional symptom by saying:

"Your hormones are fluctuating, so your mood is unstable."

The relationship is more complicated.

Hormones, body image, infertility stress, sleep, metabolic health, social stigma and personal circumstances can all contribute.

We should therefore avoid reducing a woman to her hormones.

If she has persistent depression, severe anxiety or another mental-health disorder, she deserves proper treatment rather than being told:

"It is only your PCOS hormones."

Sleep and PMOS

Sleep is another area that is often overlooked.

The international guideline recognizes a higher risk of **obstructive sleep apnoea** in women with PMOS and recommends appropriate assessment when symptoms are present.

Symptoms may include:

loud snoring, waking unrefreshed, excessive daytime sleepiness or witnessed pauses in breathing.

Poor sleep may then worsen:

fatigue, mood, metabolic health and sexual interest.

A 2025 systematic review and meta-analysis continues to support the association between PMOS/PCOS, hormonal-metabolic factors and sleep problems.

When a woman tells me:

“I have no energy and no libido,”

I therefore ask about sleep as well as hormones.

Impact of PMOS on Sexual Health

Sexual health is one of the most under-discussed aspects of PMOS.

A woman may be receiving treatment for:

irregular periods, insulin resistance, acne and infertility

while nobody asks:

“How has this condition affected your intimate life?”

The international guideline specifically recommends considering the multiple influences on psychosexual function, including:

higher weight, hirsutism, mood disorders, infertility and PMOS medications.

This is highly relevant to my focused clinical practice in sexual disorders and infertility.

What Does the Latest Research Say About Sexual Dysfunction?

A major 2025 systematic review and meta-analysis involving 40 studies found that women with PMOS/PCOS had, on average, lower scores across several Female Sexual Function Index domains—including desire, arousal, lubrication, orgasm, satisfaction and pain—than women without the condition.

However, there was substantial statistical heterogeneity between the studies, meaning sexual function varies greatly among women and the condition should not be assumed to cause sexual dysfunction in every patient.

Another 2025 systematic review found increased odds of sexual dysfunction overall among women with PMOS, while again highlighting wide variation across studies.

I therefore tell patients:

PMOS can affect sexual wellbeing, but there is no single PMOS sexual pattern.

Reduced Sexual Desire

Some women report that their sexual desire has decreased.

The reason may involve:

depression, anxiety, exhaustion, infertility stress, body-image concerns, relationship tension or fear of an unsatisfying sexual experience.

High androgen levels do not automatically guarantee high libido.

Human sexual desire cannot be predicted from testosterone alone.

This is one area where the supplied source makes an important general observation: psychological health and body image can sometimes outweigh simple assumptions based on androgen levels.

However, I would phrase this less absolutely than saying psychology “always overrides” hormones.

Sexual desire is produced by an interaction between **biology, psychology and relationship context**.

Sexual Arousal

A woman may still love and desire her partner but find that physical arousal develops slowly.

Anxiety can interfere with attention to sexual stimulation.

Body-image monitoring can distract from pleasurable sensations.

Infertility can make intercourse feel goal-oriented rather than intimate.

Some medications may also influence sexual response.

These factors should be assessed individually.

Orgasm and Sexual Satisfaction

Difficulty reaching orgasm may also occur.

But PMOS does not create one direct “orgasm hormone deficiency.”

Orgasm is influenced by:

arousal, stimulation, psychological attention, partner communication, pain, medications and many other factors.

If sexual satisfaction has declined, the correct approach is to understand what has changed rather than simply prescribe a libido tonic.

Does PMOS Cause Painful Intercourse?

This requires an important correction.

Pain during intercourse is **not a defining diagnostic feature of PMOS**.

The international diagnostic criteria concern ovulatory dysfunction, hyperandrogenism and characteristic ovarian morphology/AMH—not dyspareunia.

The supplied material suggests that enlarged “cystic ovaries” and PMOS-related inflammation commonly cause sexual pain. That should not be treated as a universal explanation.

If a woman with PMOS has persistent painful intercourse, I would consider other possible causes such as:

endometriosis, infection, pelvic-floor dysfunction, vaginal dryness, vulvovaginal disorders or another pelvic condition.

The diagnosis of PMOS should not prevent us from identifying a second problem.

PMOS and Married Life

PMOS can enter a marriage in many different ways.

Sometimes the main issue is fertility.

Sometimes it is body image.

Sometimes the partner does not understand why weight loss has been difficult.

Sometimes sexual desire is mismatched.

Sometimes the woman has depression but neither partner recognizes it.

Sometimes relatives repeatedly ask:

“When will you have a baby?”

Over time, the couple may start arguing about the disease instead of working together against it.

This is why partner education can be useful.

A Husband Should Understand the Disease Without Becoming the Doctor

A supportive husband or partner does not need to control every meal, every medicine or every kilogram of weight.

That can become another form of pressure.

Support means:

understanding the condition, listening, attending an important appointment when invited, supporting healthy lifestyle changes and avoiding shame-based comments.

It also means remembering that the woman is more than her diagnosis.

The relationship should not become:

husband = supervisor

and

wife = patient.

It should remain a partnership.

Communication About Body Changes

If facial hair, acne or weight change has damaged confidence, the subject should be discussed carefully.

Statements such as:

“You have put on too much weight.”

or

“Why don't you remove that hair?”

can deepen existing shame.

A more helpful conversation is:

“I know these symptoms are difficult for you. How can I support you?”

Body-image research increasingly shows that these concerns are clinically significant and associated with mental-health burden and quality of life.

PMOS and Infertility

PMOS is one of the major causes of **anovulatory infertility** because some women do not release an egg regularly.

But this does **not** mean that a woman diagnosed with PMOS is infertile.

Many women with PMOS conceive naturally.

Others need relatively simple ovulation treatment.

Some need more advanced fertility care.

The important thing is not to turn a PMOS diagnosis into a prediction that pregnancy will never occur.

First-Line Fertility Treatment Has Changed

For women with PMOS-related anovulatory infertility and no other major infertility factor, current international guidance recommends **letrozole as the preferred first-line pharmacological treatment for ovulation induction**.

Clomiphene, metformin, gonadotropins and other approaches have roles depending on circumstances, while IVF is generally considered later when simpler treatments fail or when another indication for IVF exists.

This is important because patients sometimes spend years trying supplements while effective fertility treatment is available.

Infertility Can Affect Sexual Intimacy

Once pregnancy becomes difficult, intercourse can become tightly linked to ovulation.

The couple may stop having sex because they want each other and begin having sex because:

“Today is the fertile day.”

That can increase performance anxiety in the husband and reduce spontaneous desire in the wife.

Sex becomes a fertility procedure.

When I manage PMOS-related infertility, I therefore consider:

reproductive treatment and sexual-health preservation together.

Pregnancy is important, but so is protecting the relationship during treatment.

PMOS and Long-Term Metabolic Health

PMOS is not only a fertility condition.

Current international guidance recommends assessing and managing metabolic and cardiovascular risk because women with PMOS have higher rates of glucose intolerance, type 2 diabetes and other cardiometabolic risk factors.

This does not mean every woman with PMOS will develop diabetes or cardiovascular disease.

It means prevention matters.

Blood pressure, glucose status and lipid profile may need assessment according to clinical guidance.

PMOS and Endometrial Health

Long-standing very infrequent periods can allow the lining of the uterus—the endometrium—to remain exposed to prolonged estrogenic stimulation without regular progesterone-related shedding.

Women with PMOS have a higher relative risk of endometrial hyperplasia and endometrial cancer.

However, the **absolute risk remains low**, so routine cancer screening is not recommended simply because someone has PMOS. Preventive strategies include managing prolonged amenorrhoea, appropriate cycle regulation and addressing additional risk factors.

A woman who goes for prolonged periods without menstruation should therefore discuss this with her clinician rather than assume missing periods are harmless.

Lifestyle Treatment Is a Core Part of PMOS Care

Lifestyle intervention remains one of the central recommendations for PMOS.

Current international guidance strongly recommends healthy eating and physical activity for overall health, metabolic risk, quality of life and weight management. Importantly, there are measurable health benefits **even without major weight loss**.

This is something I emphasize strongly.

Lifestyle treatment should not be presented merely as:

“Lose weight so that your periods become normal.”

It is about improving long-term health.

There Is No Single "Best PMOS Diet"

This is an area where internet advice frequently becomes extreme.

Some patients are told:

"You must eat keto."

Others:

"You must completely eliminate carbohydrates."

Others:

"Only a low-GI diet can cure PMOS."

The international guideline specifically states that current evidence does **not show one dietary composition to be superior to all others** for weight, metabolic, hormonal, reproductive or psychological outcomes in PMOS.

The preferred diet is therefore:

nutritionally balanced, sustainable, culturally acceptable and individualized.

This directly qualifies the supplied source's stronger claims that certain dietary patterns, particularly ketogenic or specific high-protein approaches, are inherently superior.

Physical Activity

Regular physical activity supports:

metabolic health, cardiovascular fitness, mental health, body composition and sleep.

The PMOS guideline generally aligns activity recommendations with standard adult health guidance, including aerobic activity together with muscle-strengthening exercise.

The best exercise is not necessarily the most intense programme.

It is the one a woman can continue safely over time.

Walking, cycling, swimming, resistance exercise, yoga or combinations can all contribute.

Yoga and Stress Management

Yoga may be a useful supportive strategy for fitness, stress management and body awareness.

A 2025 randomized trial from AIIMS investigated yoga in women with PCOS and reported improvements in several biological measures related to oxidative stress and mitochondrial function.

Such findings are interesting.

But yoga should be described as a **supportive lifestyle intervention**, not as a substitute for treatment of severe hyperandrogenism, diabetes or infertility when these require medical management.

Metformin

Metformin has an important role in PMOS, particularly where metabolic features are present.

The international guideline recommends considering metformin primarily for metabolic outcomes such as insulin resistance-related metabolic risk and glucose and lipid parameters, with individualized use according to BMI and the clinical situation.

It can also help menstrual-cycle regulation in selected patients.

However, metformin is not a universal treatment for:

facial hair, infertility, acne and every other PMOS symptom simultaneously.

Treatment needs to match the patient's priorities.

Combined Oral Contraceptive Pills

For women who are not currently trying to conceive, combined oral contraceptive pills are commonly used for:

irregular menstrual cycles and hyperandrogenic symptoms such as hirsutism.

The international guideline considers combined oral contraception first-line pharmacological treatment for these symptoms in appropriate patients.

Choice depends on:

medical history, contraindications, cardiovascular risk and individual preferences.

This treatment should not be prescribed merely because someone has PMOS; it should address a specific clinical goal.

Anti-Androgen Treatment and Hair Reduction

Selected patients with significant hirsutism may need additional treatment.

Laser hair-reduction procedures can be useful for some women, and anti-androgen medicines may be considered when appropriate and when pregnancy is reliably prevented because several anti-androgens can harm a developing male fetus.

Again, treating hirsutism can have benefits extending beyond appearance by improving body confidence and psychological wellbeing.

GLP-1 Medicines and Weight Management

Current PMOS guidance allows anti-obesity medications such as **liraglutide or semaglutide** to be considered in adults with higher weight according to general obesity-management guidelines, in addition to lifestyle treatment.

Women who could become pregnant require effective contraception while using GLP-1 receptor agonists because pregnancy safety data are inadequate.

Recent clinical research continues to investigate semaglutide in women with PMOS, including its effects on weight, metabolic parameters and reproductive outcomes.

These medicines should not be thought of as casual “PCOS weight-loss injections.”

They require individual medical evaluation.

What About Myo-Inositol?

Myo-inositol is widely marketed for PMOS.

Current international guidance is more cautious than much advertising.

For general PMOS management, inositol may be discussed according to patient preferences, but clinical benefits are considered limited and evidence regarding specific types, combinations and doses remains uncertain.

For PMOS-related infertility specifically, the guideline regards inositol as **experimental**, because evidence for ovulation, pregnancy and live-birth outcomes is too uncertain for it to be recommended as established fertility therapy.

Therefore, I would not describe inositol as:

“a proven natural replacement for metformin or letrozole.”

Psychological Treatment

When depression, anxiety, disordered eating, body-image distress or psychosexual problems are present, psychological treatment should become part of the management plan.

The international guideline specifically recommends evidence-based psychological therapy, including CBT where appropriate, for relevant psychological and psychosexual concerns.

Psychological treatment is not an admission that PMOS is “all in the mind.”

It means that a physical endocrine condition is producing genuine psychological consequences that also deserve treatment.

Protecting Sexual Intimacy

When PMOS has affected sexual confidence, couples may benefit from deliberately removing performance pressure.

For example, affectionate physical closeness does not always need to end in intercourse.

Partners can reconnect through:

conversation, comfortable touch and time together without making every intimate moment another test of libido, erection, penetration or fertility.

If significant sexual dysfunction exists, structured psychosexual counselling can be considered.

The aim is to help the couple experience intimacy as a relationship again rather than only as a medical requirement.

The Unani Perspective on PMOS

As a physician trained in Unani medicine, I consider one of the greatest strengths of the system to be its **individualized and whole-person approach**.

Traditional Unani medicine evaluates health through concepts such as **Mizaj**, or temperament, and **Akhlat**, the classical humours:

Dam – blood, Balgham – phlegm, Safra – yellow bile and Sauda – black bile.

It also places great emphasis on the relationship between physical health, psychological wellbeing and lifestyle. Official Ministry of Ayush documentation continues to describe this psychosomatic and individualized foundation of Unani medicine.

These concepts are traditional medical constructs.

They should **not** be presented as direct equivalents of modern biochemical variables such as insulin, testosterone, AMH or glucose.

Asbab-e-Sitta Zarooriya and PMOS

The Unani framework of **Asbab-e-Sitta Zarooriya**, or the Six Essential Factors, includes:

air and environment, food and drink, movement and rest, psychological activity and repose, sleep and wakefulness, and retention and elimination.

The Ministry of Ayush describes these factors as central to health promotion within Unani medicine.

For a patient with PMOS, this framework can be especially useful because the modern management plan also requires attention to:

diet, exercise, sleep, weight, mental health and daily routine.

This is one area where Unani preventive principles and contemporary PMOS medicine can complement each other naturally.

Ilaj bil Ghiza – Dietotherapy

Dietotherapy has an important place in Unani practice.

For a woman with PMOS, I use the concept of dietotherapy to support an individualized eating pattern based on:

body composition, metabolic health, glucose status, dietary habits, nutritional deficiencies and reproductive goals.

The objective is not to prescribe a stereotyped “PCOS diet.”

A woman with diabetes requires different priorities from a lean woman with PMOS and normal glucose metabolism.

A patient with obesity should not automatically be given calorie-dense sweet traditional preparations simply because they are regarded as strengthening.

Unani dietotherapy is most useful when it is adapted to modern metabolic knowledge.

Ilaj bit Tadbir – Regimenal and Lifestyle Management

Ilaj bit Tadbir may support:

appropriate exercise, healthy routine, stress management and restoration of sleep.

These areas are highly relevant to PMOS.

A woman who sleeps poorly, experiences severe stress and remains physically inactive may benefit considerably from improvement in these areas—even if no herbal medicine is prescribed.

This lifestyle emphasis is consistent with both Unani health principles and the international PMOS guideline.

Psychological Wellbeing in Unani Care

The traditional Unani focus on psychological balance is especially valuable in women with:

body-image distress, fertility anxiety, depression or sexual concerns.

In a modern integrative clinic, this should translate into:

respectful counselling, stress management and referral for evidence-based psychological treatment when necessary.

Unani care should not tell a depressed woman merely:

“Your temperament is disturbed.”

If she has depression, she deserves appropriate mental-health care.

Ilaj bid Dawa – Unani Pharmacotherapy

Unani pharmacotherapy may have an adjunctive role when selected by an appropriately qualified practitioner after considering the patient's:

symptoms, metabolic health, menstrual pattern, fertility goals and other medicines.

However, direct modern evidence for specific Unani medicines in PMOS remains developing.

The latest CCRUM annual report for 2024–25 describes an **ongoing preclinical PMOS/PCOS research programme** evaluating Unani formulations in a letrozole-induced animal model. It reported experimental findings with Majoon Dabidul Ward and ongoing evaluation of other formulations.

CCRUM's National Research Institute of Unani Medicine for Skin Disorders has also listed an open-label active-controlled clinical study evaluating a Unani formulation for PMOS/PCOS.

This is encouraging because it shows that the field is being studied.

But an ongoing study or animal experiment is **not proof of a clinical cure**.

Can Unani Medicine Cure PMOS Permanently?

I would not make that promise.

PMOS is a heterogeneous long-term endocrine and metabolic condition.

Symptoms may improve greatly.

Menstrual cycles can become more regular.

Metabolic health can improve.

Some women who initially struggle with conception can later achieve pregnancy.

But no responsible physician should guarantee that one Unani formulation—or one modern medicine—will permanently remove the syndrome from every patient.

The goal is **effective long-term management and prevention of complications**, not an unrealistic promise.

Herbs and Natural Medicines

Several herbal products have been researched in PMOS/PCOS, including fenugreek and various traditional formulations.

For example, a 2024 randomized trial comparing fenugreek with metformin found improvements in both groups, but metformin was more effective for several metabolic measures and menstrual irregularity. The authors concluded that fenugreek could not substitute for metformin, though it may have potential as an adjunct in selected circumstances.

This is the kind of balanced interpretation I support.

“Natural” should not mean:

“better than modern medicine.”

Nor should “modern” mean:

“traditional medicine has nothing useful to offer.”

The best approach is evidence-informed integration.

Hijama and PMOS

Hijama, or wet cupping, is part of traditional Unani regimenal therapy.

Some historical and small contemporary studies have explored cupping in PMOS/PCOS and metabolic conditions.

However, current evidence is **not strong enough to claim that Hijama restores ovulation, eliminates insulin resistance, normalizes hormones or cures PMOS**.

It may be considered as an adjunctive traditional regimen in selected patients where appropriately practiced, but it should not replace:

metabolic evaluation, cycle protection, fertility treatment or treatment of significant depression or anxiety.

This is an important qualification to stronger claims sometimes made in traditional-health literature.

My Approach at Saira Health Care

At **Saira Health Care**, when a woman with PMOS consults me, I do not start treatment based only on an ultrasound.

I first want to understand:

her menstrual pattern, androgen-related symptoms, metabolic health, weight history, sleep, emotional wellbeing, sexual health and reproductive goals.

A woman seeking pregnancy requires a different treatment plan from a woman whose main problems are acne and irregular menstruation.

A woman with severe depression requires attention to mental health.

A woman with sexual pain requires separate investigation rather than assuming PMOS is responsible.

A woman with facial hair and body-image distress may need dermatological and psychological support as much as reproductive treatment.

That is what individualized care means.

The Saira Health Care PMOS Assessment Philosophy

My preferred approach can be summarized as:

confirm the diagnosis → identify the patient's main symptoms and priorities → assess metabolic and long-term risks → protect menstrual and endometrial health → address psychological and sexual wellbeing → evaluate fertility when desired → introduce sustainable lifestyle management → use appropriate medical and/or Unani treatment → review outcomes over time.

This is not a one-size-fits-all treatment.

It is a patient-centred plan.

PMOS and Sexual Disorders: A Special Focus

Because my focused clinical work includes **sexual disorders and infertility**, I consider sexual health an important part of PMOS care.

If a woman reports:

reduced desire, poor arousal, difficulty reaching orgasm, embarrassment about her body or avoidance of intimacy,

I do not automatically prescribe an aphrodisiac.

I ask what is driving the problem.

Is she depressed?

Does she dislike her body because of hirsutism?

Is infertility making sex stressful?

Is intercourse painful for an unrelated reason?

Does her partner misunderstand her condition?

Has medication changed her sexual response?

Current research and guideline recommendations support precisely this multifactorial approach.

PMOS and Infertility: A Special Focus

Similarly, I do not tell every woman with PMOS:

“You will need IVF.”

First we determine whether she is ovulating and whether any other infertility factor exists.

The male partner must also be assessed where infertility is present.

If the primary problem is PMOS-related anovulation, current evidence-based ovulation treatment can be used.

Unani lifestyle and supportive care may be integrated where appropriate without delaying effective fertility treatment.

This is especially important with increasing age, where unnecessary delays can matter.

Why the Male Partner Still Needs Evaluation

A woman with PMOS can become the obvious focus of infertility treatment simply because she already has a diagnosis.

That can be a mistake.

A husband may simultaneously have:

low sperm count, reduced motility, varicocele or another male fertility problem.

The couple should therefore be evaluated as a couple.

PMOS should not become an excuse to assume:

“The infertility must be the woman's fault.”

Helping Couples Protect Their Marriage

I often tell husbands:

Do not turn every conversation into a discussion about weight, menstruation or pregnancy.

And I tell women:

Do not assume your partner understands what PMOS feels like unless you explain it.

A useful conversation might be:

“When I avoid intimacy, it is not always because I do not want you. Sometimes I feel uncomfortable with my body or worried about infertility.”

The partner can respond:

“Tell me what would help you feel safer and more supported.”

This simple shift can reduce misunderstanding.

Non-Sexual Intimacy Is Important

If libido temporarily decreases or sexual activity has become stressful, a couple should not allow all physical affection to disappear.

Affectionate conversation, holding hands, hugging, shared meals, walks and mutually welcomed touch can protect the relationship while the underlying problem is addressed.

Sexual health is part of intimacy.

It is not the only form of intimacy.

What Partners Should Avoid

The most damaging approaches usually involve:

constant criticism of weight, joking about facial hair, repeatedly demanding pregnancy updates, pressuring the woman for sex, comparing her body with other women or implying that infertility makes her less feminine.

These behaviours do not treat PMOS.

They magnify its psychological effects.

PMOS Does Not Define a Woman

This is one of the most important messages I want patients to remember.

PMOS is a medical condition.

It is not a definition of:

your femininity, your attractiveness, your value as a wife or your ability to become a mother.

A hormone report cannot measure your worth.

Frequently Asked Questions

Is PMOS the same condition that used to be called PCOS?

Yes. **Polyendocrine Metabolic Ovarian Syndrome (PMOS)** became the new internationally agreed name for PCOS in May 2026. The change reflects the fact that the condition is much broader than ovarian “cysts.”

Why was the name PCOS changed?

The word “polycystic” was misleading because the condition does not require pathological ovarian cysts and involves endocrine, metabolic, psychological and reproductive systems. The new name was selected after a large international consensus process involving patients and multidisciplinary professionals.

Is PCOD different from PMOS?

Current international guidance does not define “PCOD” as a separate universally recognized mild disease. PMOS is the new name for PCOS and is the preferred evidence-based terminology.

Does every woman with PMOS have ovarian cysts?

No.

PMOS can be diagnosed without characteristic ovarian morphology when other diagnostic criteria are fulfilled. The ovarian appearance also reflects multiple follicles rather than dangerous “cysts” in the ordinary sense.

Does every woman with PMOS have insulin resistance?

No.

Insulin resistance is an important feature of the syndrome but varies among individuals and is not currently required for diagnosis.

Can thin women have PMOS?

Yes.

PMOS is not restricted to women with overweight or obesity.

A woman can have PMOS at any body size.

Weight and metabolic management must therefore be individualized.

Is weight loss the only treatment?

No.

Healthy lifestyle is important, but treatment may also address menstrual irregularity, metabolic health, hirsutism, acne, psychological symptoms and infertility depending on the individual.

Which diet is best for PMOS?

There is no single diet proven superior for every patient.

Current international guidance recommends sustainable healthy eating tailored to the woman's needs and preferences rather than promoting one restrictive diet for everyone.

Can PMOS cause depression or anxiety?

Women with PMOS have higher rates of depression and anxiety symptoms than comparison populations, and the international guideline recommends screening adults for these problems.

Can PMOS reduce sexual desire?

It can contribute indirectly or directly through multiple pathways, including body-image concerns, depression, anxiety, infertility, higher weight and treatment-related factors.

Recent systematic reviews report lower average sexual-function scores among women with PMOS, although there is wide individual variation.

Does high testosterone mean a woman with PMOS should have a high sex drive?

No.

Sexual desire cannot be predicted by one hormone.

Mental health, body image, relationship context, health, medications and sexual experiences also influence desire.

Does PMOS cause painful intercourse?

Painful intercourse is not a defining PMOS symptom.

Persistent sexual pain should be evaluated for other conditions such as endometriosis, pelvic-floor dysfunction, infection or vaginal disorders rather than automatically blamed on PMOS.

Does PMOS mean I cannot become pregnant?

No.

PMOS can make conception more difficult when ovulation is irregular, but many women conceive naturally or with appropriate fertility treatment.

What is the first-line fertility medicine for PMOS?

For appropriate women with anovulatory infertility and no other infertility factor, **letrozole is the preferred first-line pharmacological ovulation-induction treatment** under current international guidance.

Is metformin useful?

Metformin is particularly useful for selected metabolic features and can help cycle regulation in some patients. Its role should be individualized rather than treating it as a universal PMOS medicine.

Is myo-inositol proven to treat PMOS infertility?

No.

Current guideline evidence considers inositol experimental for PMOS-related infertility because effects on ovulation, pregnancy and live-birth outcomes remain uncertain.

Can Unani medicine help PMOS?

Unani medicine can make a useful **integrative contribution**, particularly through individualized dietotherapy, physical activity, sleep regulation, stress management, psychological wellbeing and carefully supervised pharmacotherapy.

CCRUM is actively researching Unani formulations for PCOS/PMOS, including ongoing preclinical and clinical projects.

However, current evidence does not justify claiming that any single Unani medicine permanently cures PMOS.

When Should a Woman Seek Medical Attention?

A woman with suspected or diagnosed PMOS should seek professional assessment particularly when menstrual periods are very infrequent or absent for prolonged periods, abnormal uterine bleeding develops, hirsutism or androgenic symptoms progress rapidly, significant depression or anxiety occurs, symptoms of diabetes develop, pregnancy is desired but conception is delayed, or sleep-apnoea symptoms are present.

Persistent pelvic pain or painful intercourse should also be evaluated rather than automatically attributed to PMOS.

Any thoughts of self-harm or suicide require urgent mental-health support.

A Message From Dr. Nizamuddin Qasmi

When a woman tells me:

“Doctor, PMOS has changed my entire life,”

I understand why she feels that way.

It may have changed her menstrual cycle.

It may have changed her skin or hair.

It may have made weight management difficult.

It may have affected how she sees herself in the mirror.

It may have reduced her sexual confidence.

And if pregnancy has not occurred, it may have placed enormous pressure on her marriage.

But I want every patient to understand something very clearly:

PMOS can be managed.

The diagnosis should not become your identity.

I do not believe in treating only an ultrasound report.

I want to know what PMOS is doing to **you**.

If irregular menstruation is your main concern, we address that.

If metabolic health is the concern, we address it.

If hirsutism has affected your confidence, we address it.

If depression or anxiety is present, it deserves proper care.

If sexual desire has decreased, we investigate why.

If infertility is the problem, we evaluate both partners and select treatment according to the actual fertility factor.

As a physician trained in Unani medicine, I believe its holistic principles can contribute meaningfully here.

Mizaj, Ilaj bil Ghiza, Ilaj bit Tadbir, sleep, physical activity and psychological balance remind us that the patient is more than one hormone or one ovary.

But responsible Unani medicine also means respecting contemporary evidence.

I do not tell a woman that one herb will permanently cure PMOS.

I do not tell her that every problem is caused by “hormonal imbalance” without investigation.

I do not delay effective fertility therapy when reproductive time is important.

And I do not treat anxiety, sexual dysfunction or marital distress as unimportant side issues.

At **Saira Health Care**, my goal is to combine careful assessment, sexual and reproductive-health expertise, appropriate modern investigation and responsibly integrated Unani principles to develop an **individualized plan for the whole patient**.

The objective is not merely to produce regular periods.

The objective is to improve:

metabolic health, reproductive health, sexual wellbeing, emotional confidence, fertility where desired and overall quality of life.

About the Author

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BUMS – Hamdard University, Delhi
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At **Saira Health Care**, the clinical focus includes individualized assessment of sexual disorders, male and female reproductive-health concerns and infertility, with responsible integration of Unani principles and contemporary evidence-based medical evaluation.

Medical Disclaimer

This article is intended for **patient education and general health information**. It does not replace an individual medical consultation, examination, laboratory assessment, fertility evaluation or personalized treatment plan.

PMOS is a heterogeneous condition. Treatment depends on age, symptoms, metabolic health, menstrual pattern, pregnancy goals and other medical factors.

Prescription medicines such as oral contraceptives, metformin, anti-androgens, GLP-1 receptor agonists and fertility medicines require appropriate professional assessment.

Unani and herbal medicines should also be used under qualified professional supervision because products may vary in quality and may interact with prescription medicines.