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EDITORIAL

Polycystic Ovary Syndrome Beyond Fertility: The Psychosocial and Metabolic Burden we Still Ignore

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INTRODUCTION

Polycystic ovary syndrome (PCOS) is one of the most common endocrine disorders affecting women of reproductive age, yet it continues to be discussed and managed primarily through the narrow lens of fertility[1]. In both academic literature and clinical practice, the dominant focus often remains on ovulation, menstrual irregularity, infertility, and assisted conception. Although these reproductive concerns are important, they represent only one dimension of a far more complex and chronic condition. PCOS is not merely a fertility disorder; it is a lifelong multisystem syndrome with profound psychological, metabolic, endocrine, and social consequences that frequently begin in adolescence and persist long after reproductive concerns have faded[2].

This limited fertility-centered framing has created a serious gap in care[3]. Many women with PCOS present initially not because they are trying to conceive, but because they are struggling with weight gain, acne, hirsutism, scalp hair thinning, menstrual unpredictability, emotional distress, fatigue, poor self-esteem, or difficulty maintaining metabolic health. Yet these symptoms are too often trivialized, cosmetically dismissed, or considered secondary to the "real" problem of infertility. As a result, diagnosis is delayed, emotional suffering is normalized, and long-term cardiometabolic risks are left unaddressed. In many healthcare settings, especially in low- and middle-income countries, PCOS remains significantly underdiagnosed and undertreated, despite its high prevalence and broad clinical burden[4].

The Problem with a Fertility-Only View of PCOS

The way PCOS is traditionally framed has shaped the way it is recognized, investigated, and managed[5]. In many cases, a woman's symptoms are not fully acknowledged until she reports difficulty conceiving. This approach is deeply problematic because it suggests that the condition becomes clinically meaningful only when fertility is threatened. Such thinking ignores the fact that many of the most distressing and disabling features of PCOS have little to do with reproduction itself[6].

When irregular menstruation, acne, excessive hair growth, obesity, or mood changes are seen as minor inconveniences rather than medically significant features of a chronic syndrome, women are denied timely diagnosis and meaningful intervention[7]. This not only delays treatment but also reinforces the perception that female health concerns are worthy of attention only when linked to pregnancy or reproductive potential. In reality, PCOS often begins years before fertility is ever considered and may continue to affect health well beyond the reproductive years[8].

A fertility-only model also creates a fragmented therapeutic strategy[9]. Women may receive short-term hormonal treatment to regulate cycles or improve ovulation while the deeper metabolic and psychosocial burden remains largely ignored. Such management may temporarily address symptoms without changing the long-term trajectory of the disorder. This is not comprehensive care; it is symptom containment[10].

The Hidden Psychosocial Burden of PCOS

One of the most neglected aspects of PCOS is its profound psychosocial impact[11]. For many women, the greatest burden of the condition is not infertility, but the daily emotional and social consequences of living in a body that feels medically and socially misunderstood. Hirsutism, acne, alopecia, obesity, menstrual irregularity, and skin changes may seem clinically routine to healthcare providers, but for patients these features often carry a deep psychological cost[12].

PCOS can significantly distort self-image and self-worth[13]. Excess facial hair, persistent acne, scalp hair thinning, and central weight gain often affect how women perceive their femininity, attractiveness, and confidence. These concerns are not superficial or cosmetic. They can shape interpersonal relationships, social participation, marital prospects, sexual wellbeing, and emotional resilience. In societies where female appearance and reproductive identity are heavily scrutinized, the psychological burden of PCOS can become especially severe[14].

Many women with PCOS live with silent embarrassment and chronic self-consciousness[15]. They may avoid social settings, feel ashamed of their appearance, or internalize the belief that their body is "abnormal" or "unfeminine." Such experiences can gradually erode quality of life, especially when symptoms are persistent, visible, and poorly explained. The emotional toll is often worsened by repeated medical encounters in which their distress is minimized or reduced to advice about weight loss and lifestyle change without empathy or structured support[16].

Mental Health in PCOS Is Not Secondary

The psychiatric dimension of PCOS deserves far greater clinical attention than it currently receives[17]. Women with PCOS consistently demonstrate higher rates of depression, anxiety, low self-esteem, body dissatisfaction, eating disturbances, and impaired quality of life compared with women without the condition. These mental health challenges are not merely reactive responses to infertility. They often emerge early, including during adolescence and young adulthood, suggesting that psychological vulnerability is woven into the lived experience of the syndrome itself[18].

This is important because mental health symptoms in PCOS are frequently under-recognized[19]. Women may present with fatigue, poor motivation, sleep problems, emotional eating, social withdrawal, or irritability, but these features are rarely explored in a structured way during endocrine or gynecological consultations. Instead, psychological symptoms may be seen as peripheral or unrelated, even though they may strongly influence treatment adherence, daily functioning, and overall wellbeing[20].

There is also a dangerous tendency to assume that once fertility is restored or menstruation improves, the broader burden of PCOS has been adequately addressed[1]. This assumption is clinically unsound. A woman may ovulate regularly and still suffer from severe body image distress, chronic anxiety, insulin resistance, social shame, and poor metabolic health. If mental health is not assessed and supported as a routine part of PCOS care, then management remains incomplete[2].

Body Image, Stigma, and the Social Experience of PCOS

Body image concerns are especially central to the lived burden of PCOS[3]. Unlike some chronic diseases that remain largely invisible, many manifestations of PCOS are externally noticeable. Weight gain, facial hair, acne, and scalp hair loss may expose women to comments, judgment, stigma, and unsolicited advice from family members, peers, and even healthcare professionals. These experiences can be deeply humiliating and emotionally exhausting[4].

Weight stigma is particularly harmful in PCOS care[5]. Many women report being blamed for their symptoms or being given simplistic advice such as "just lose weight," without acknowledgement of the endocrine, metabolic, and psychological complexity of the condition. While weight management can be clinically relevant in some patients, a purely weight-focused approach often becomes reductionist and counterproductive. It risks framing the patient as personally responsible for a disorder that is biologically multifactorial and often difficult to manage[6].

This stigma may discourage women from seeking follow-up care, especially if previous clinical encounters were dismissive or judgmental[7]. Over time, patients may disengage from the healthcare system altogether, not because their symptoms have improved, but because they no longer expect to be understood. This is a serious failure of patient-centered care[8].

The Metabolic Burden We Continue to Underestimate

While the psychosocial burden of PCOS is substantial, the metabolic burden is equally serious and still not adequately appreciated in routine practice[9]. Too many women are told that PCOS is "just a hormonal issue," when in fact it is strongly associated with insulin resistance, abdominal obesity, impaired glucose metabolism, dyslipidemia, hypertension, and an increased long-term risk of type 2 diabetes and cardiovascular disease[10].

PCOS often serves as an early clinical signal of broader metabolic dysfunction[11]. A young woman presenting with irregular periods and hirsutism may already have significant insulin resistance, chronic low-grade inflammation, altered lipid handling, and central adiposity. If clinical management

focuses only on cycle control or cosmetic symptoms, the deeper cardiometabolic risk remains largely invisible until more serious disease emerges later in life[12].

This is particularly concerning because the metabolic consequences of PCOS may begin silently and progress gradually over years[13]. Many women are not routinely screened for glucose intolerance, dyslipidemia, fatty liver disease, blood pressure abnormalities, or other metabolic complications unless they are visibly obese or actively trying to conceive. Such selective screening misses the reality that metabolic risk in PCOS is not confined to one phenotype. Even women who are not overtly obese may carry meaningful insulin resistance or cardiometabolic vulnerability[14].

PCOS as a Lifelong Endocrine-Metabolic Disorder

A major conceptual mistake in PCOS care is treating it as a temporary reproductive issue of young adulthood rather than a chronic disorder with life-course implications[15]. PCOS does not disappear simply because a woman is no longer planning pregnancy. The hormonal, metabolic, and psychological effects of the syndrome may evolve over time, but they often remain clinically relevant throughout adulthood and into later life[16].

Women with PCOS may continue to face increased risks of metabolic syndrome, type 2 diabetes, cardiovascular dysfunction, non-alcoholic fatty liver disease, obstructive sleep apnea, and persistent mental health challenges[17]. This means that PCOS should be approached not as an isolated gynecological diagnosis but as a chronic endocrine-metabolic condition requiring longitudinal follow-up and interdisciplinary management[18].

Such a reframing has important implications for clinical care[19]. It demands earlier identification, more structured long-term monitoring, and greater integration between gynecology, endocrinology, psychiatry, nutrition, dermatology, and primary care. Without this broader perspective, healthcare systems will continue to treat the visible symptoms of PCOS while missing its deeper biological and psychosocial consequences[20].

Why This Matters Even More in Developing Countries

The burden of PCOS is especially under-recognized in developing countries, where women's hormonal and mental health concerns are often normalized, stigmatized, or medically neglected[1]. In many low-resource settings, women may live for years with symptoms of PCOS without receiving a formal diagnosis. Irregular periods may be dismissed as routine, unwanted hair growth may be hidden rather than discussed, and emotional distress may be interpreted as a personal weakness rather than a health issue requiring support[2].

Cultural expectations can intensify this burden[3]. In societies where womanhood is strongly tied to appearance, menstruation, marriage, and fertility, women with PCOS may face layered forms of social pressure. They may be criticized for weight gain, judged for skin or hair changes, blamed for delayed conception, or discouraged from discussing menstrual and emotional problems openly. Such pressures can make PCOS not only a medical condition, but also a socially isolating one[4].

Healthcare systems in these contexts may also lack integrated pathways for diagnosis and follow-up[5]. Women may consult multiple specialists for separate symptoms without anyone addressing the syndrome as a whole. A patient may visit a gynecologist for irregular cycles, a dermatologist for acne, a physician for weight gain, and still never receive comprehensive counselling about insulin resistance, mental health, long-term risk, or lifestyle support. This fragmentation contributes directly to poor outcomes[6].

What Clinical Practice Must Do Differently

The management of PCOS must move beyond reproductive endpoints and toward whole-person care[7]. That begins with how clinicians think about the condition. Every consultation for suspected or confirmed PCOS should include attention not only to menstrual and fertility history, but also to emotional wellbeing, body image, metabolic risk, sleep, diet, physical activity, and long-term health concerns[8].

Routine screening should extend beyond ovulatory dysfunction to include blood pressure, waist circumference, fasting glucose or HbA1c, lipid profile, and a careful assessment of mental health symptoms[9]. Clinicians should ask directly about anxiety, depression, eating behaviors, fatigue, social distress, and self-esteem rather than assuming these issues are outside the scope of endocrine or gynecological care[10].

Equally important is the tone of care[11]. Women with PCOS need informed, respectful, non-stigmatizing conversations. They need clinicians who explain the syndrome clearly, validate the legitimacy of both visible and invisible symptoms, and avoid reducing management to simplistic instructions about body weight. Lifestyle support is important, but it must be realistic, individualized, and delivered with empathy rather than blame[12].

The Need for Better Medical Education and Public Awareness

Part of the problem lies in how PCOS is taught[13]. In many medical training settings, PCOS is still presented mainly as a reproductive endocrinology topic rather than as a multisystem chronic disease. This educational framing

influences how future clinicians recognize symptoms, prioritize risks, and communicate with patients[14].

If trainees are taught to think of PCOS primarily as a cause of infertility, they are less likely to identify its psychiatric burden, metabolic significance, or impact on long-term health[15]. Medical education should therefore expand its teaching of PCOS to include mental health, body image, insulin resistance, cardiometabolic risk, patient-centered communication, and the social determinants that shape delayed diagnosis and poor follow-up[16].

Public awareness must also improve[17]. Women should not need to wait until infertility becomes a concern before learning that irregular cycles, hirsutism, unexplained weight gain, acne, or persistent fatigue may represent a significant endocrine disorder. Early awareness can improve help-seeking behavior, reduce stigma, and support earlier intervention[18].

CONCLUSION

PCOS has been underestimated for far too long because medicine has allowed fertility to dominate the conversation. This narrow framing has obscured the much larger reality: PCOS is a chronic, multisystem disorder that affects emotional wellbeing, body image, metabolic health, cardiovascular risk, and overall quality of life across the lifespan. Its burden is not confined to the ovaries, nor should its management be confined to reproductive goals.

The women living with PCOS do not experience it as a single fertility problem. They experience it as a daily negotiation with their hormones, appearance, weight, mental health, energy, identity, and future health risks. If clinical practice continues to ignore these dimensions, then it is not merely under-treating a syndrome—it is failing to see the full person behind the diagnosis.

The time has come to stop asking only whether women with PCOS can conceive. The more urgent question is whether healthcare systems are finally prepared to care for them completely.

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