THE GLOBAL PULSE OF HEALTHCARE · MDFORLIVES INSIGHT REPORT

PCOS to PMOS: The Reframe Is Clear. The Care Pathway Is Not.

HCP perspectives on metabolic risk, diagnostic confidence, treatment sequencing, referral pressure, and long-term ownership after the proposed PCOS-to-PMOS reframe.

Real Opinions · Clinical Patterns · Validated by Data

506	6	455	70.2%
HCPs profiled by specialty	countries represented	complete responses	completion rate

WHY THIS REPORT

A name change can redirect attention. It cannot, by itself, redesign the pathway.

The PCOS-to-PMOS reframe gives clinicians a clearer language for a condition long constrained by an ovary-first label. The data suggests that HCPs are ready to read the condition as endocrine-metabolic, not just reproductive. Yet the same responses reveal a practical gap: diagnostic confidence is moving faster than coding, treatment intent is moving faster than access, and referral intent is moving faster than specialist capacity.

Across 506 healthcare professionals profiled by specialty, the dominant pattern is not resistance to PMOS. It is a mismatch between the new clinical framing and the old operational infrastructure. This report follows that mismatch through diagnosis, dermatology triage, pharmacological sequencing, reimbursement barriers, long-term screening, referral pressure, and the question that sits beneath all of it: who owns the patient after reproductive care ends?

> **How to read this report.** The first two administrative questions in the source survey report were ignored, as requested. Hidden country punching and specialty/frequency questions were retained for respondent context. The survey includes 648 total responses, 455 completes, and 193 partials. Question denominators vary by completion and routing. Specialty-routed bases include endocrinology n=42 for Q8, dermatology n=35 for Q9, FP/GP plus O&G n=368 for Q15, and endocrinology n=40 for Q20. Findings reflect HCP perception and reported practice patterns, not formal clinical guidance.

EXECUTIVE SUMMARY

Eight findings that separate metabolic intent from pathway readiness.

INSIGHT 01

The reframe lands as a metabolic risk signal

53.7% say PMOS most strongly signals broader metabolic

INSIGHT 02

The risk being missed is not subtle

When the condition is managed mainly as reproductive, risk. Only **8.2%** see limited clinical change, suggesting the field understands the purpose of the reframe.

72.0% point to insulin resistance or cardiovascular risk as the risk most likely to be missed.

INSIGHT 03

Clinicians have largely moved past morphology

83.2% would diagnose or document at the presented stage. Hyperandrogenism and insulin resistance together carry **71.5%** of diagnostic weight.

INSIGHT 04

The old scan logic still delays patients

Among endocrinology respondents, **76.2%** report frequent or moderate 12+ month delays in referred patients while awaiting a "normal" ultrasound result.

INSIGHT 05

Metabolic-first care is endorsed, but sequencing remains conservative

67.2% say metabolic treatment should begin at diagnosis, yet only **25.5%** place GLP-1 or incretin therapy as an early option.

INSIGHT 06

Access, not belief, is the largest therapy barrier

61.4% cite insurance or prior-authorization restrictions for non-T2DM indications as the top barrier to advanced metabolic therapies.

INSIGHT 07

The post-reproductive patient still lacks a clear owner

Shared care is the leading coordination model at **33.9%**, but **33.0%** say patients fall out of structured care because no clear owner exists.

INSIGHT 08

The field is asking for one practical artefact

48.1% say a shared management protocol would most improve care. Add dashboards and joint clinics, and **86.7%** choose a system-level solution.

01

SECTION 01

The reframe reads as a metabolic risk signal, not a cosmetic relabel

53.7% say the proposed reframe most strongly signals broader metabolic risk

CONTEXT

The first insight question asked what the PCOS-to-PMOS reframe communicates clinically. This matters because a name change only becomes useful if clinicians translate it into a different risk frame.

WHAT THE DATA SHOWS

Broader metabolic risk is the leading interpretation at **53.7% (n=267)**. More shared care follows at **15.5% (n=77)**, less ovarian focus at **12.5% (n=62)**, better patient clarity at **10.1% (n=50)**, and limited clinical change at **8.2% (n=41)**.

THE INSIGHT

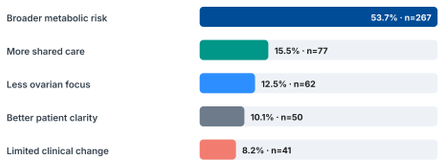
Clinicians are not treating PMOS as a vocabulary update. They are reading it as a risk reorientation. The proposed name is doing its first job: moving attention from cyst morphology toward metabolic and systemic consequences.

WHY IT MATTERS

The communication challenge is no longer to convince clinicians that PCOS/PMOS is metabolic. It is to give them a working pathway that acts on that metabolic frame consistently.

Q3 – What the reframe most strongly signals clinically

Base: n=497



Broader metabolic risk leads at 53.7%, while only 8.2% see limited clinical change.

02

SECTION 02

The risks clinicians fear missing are insulin resistance and cardiovascular disease

72.0% name insulin resistance or cardiovascular risk as the missed risk under reproductive-first care

CONTEXT

The survey asked which risk is most likely to be missed when PCOS/PMOS is managed mainly as a reproductive condition. This question reveals whether the reframe is clinically meaningful or merely semantic.

WHAT THE DATA SHOWS

36.6% (n=182) choose insulin resistance and **35.4% (n=176)** choose cardiovascular risk. Mental health burden follows at **12.5%**, long-term follow-up at **11.9%**, and dermatologic signs at **3.6%**.

THE INSIGHT

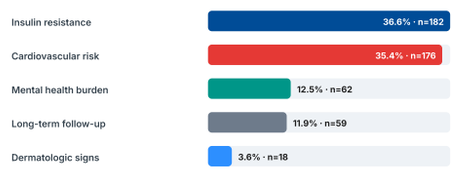
The field is naming a two-part blind spot: glucose-metabolic risk and cardiovascular risk. This is important because it moves PMOS away from symptom management alone and toward preventive surveillance across the life course.

WHY IT MATTERS

Any PMOS pathway that still centers cycle control without metabolic and cardiovascular surveillance will underdeliver on the reframe clinicians already understand.

Q4 – Risks most likely to be missed under reproductive-first management

Base: n=497



Insulin resistance and cardiovascular risk total 72.0% when combined.

03

SECTION 03

Clinicians have mostly let go of the ovary, but the pathway has not fully followed

83.2% would diagnose or document based on clinical and biochemical markers, even without morphology

CONTEXT

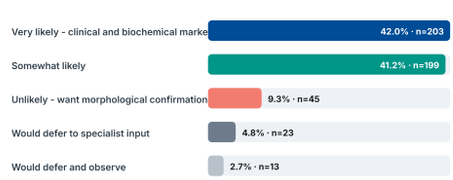
The diagnostic case tested whether clinicians would document PCOS/PMOS at an early stage when clinical and biochemical markers are present but morphology does not confirm the legacy image.

WHAT THE DATA SHOWS

42.0% (n=203) are very likely and **41.2% (n=199)** are somewhat likely to diagnose or document. Only **9.3% (n=45)** are unlikely because they want morphological confirmation. Diagnostic weight is led by hyperandrogenism at **42.9%** and insulin resistance at **28.6%**; ultrasound findings account for **8.1%**.

Q5 – Likelihood to diagnose or document at this stage

Base: n=483



Very likely plus somewhat likely totals 83.2% (n=402).

Q7 – Finding carrying the most diagnostic weight

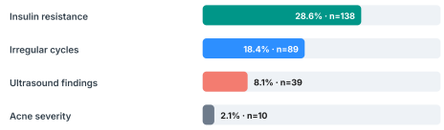
Base: n=483

THE INSIGHT

Clinical judgment has largely moved beyond ultrasound dependence. But among hesitant clinicians, the leading reason is still that structural ovarian change should be present before systemic metabolic intervention. This shows a residual legacy criterion, not a lack of awareness.

WHY IT MATTERS

PMOS implementation needs diagnostic documentation support, EHR pathways, and referral templates that allow biochemical and clinical markers to carry enough weight without forcing an imaging gate.



Hyperandrogenism and insulin resistance together account for 71.5%.

04

SECTION 04

The delay is visible at the endocrinology door and the early signal is visible at the dermatology door

76.2% of endocrinology respondents report frequent or moderate 12+ month scan-related diagnostic delay

CONTEXT

Two specialty-routed questions reveal where the legacy pathway delays patients and where earlier detection may enter the system. Endocrinology sees delayed referrals; dermatology sees skin signs that may be the first visible prompt.

WHAT THE DATA SHOWS

Among endocrinology-routed respondents, **31.0%** frequently and **45.2%** moderately treat referred patients whose diagnosis was delayed by more than 12 months while awaiting a "normal" ultrasound. Among dermatology-routed respondents, only **11.4%** treat the skin alone, while **88.6%** order metabolic workup, refer, or treat and investigate concurrently.

THE INSIGHT

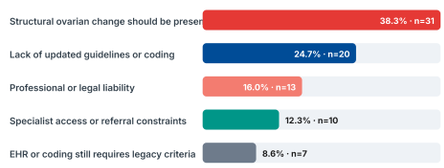
The old pathway creates delay upstream, while dermatology may already be functioning as an early metabolic gateway. Skin symptoms are not just cosmetic signals. In this data, they are potential entry points into earlier endocrine-metabolic recognition.

WHY IT MATTERS

A PMOS care pathway should not only educate endocrinologists and O&G. It should give dermatology a simple metabolic workup prompt and a clear referral route, while reducing imaging-dependent delays before specialist review.

Q6 – Primary driver of hesitation

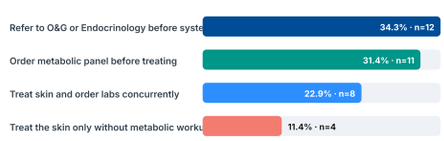
Base: n=81 hesitant respondents



The top hesitation is continued dependence on structural ovarian change, not only lack of updated guidance.

Q9 – Dermatology next step when skin signs suggest PCOS/PMOS

Base: n=35 dermatology-routed respondents



88.6% investigate or refer rather than treating skin alone.

05

SECTION 05

Metabolic-first care is endorsed, but pharmacological sequencing remains cautious

67.2% say metabolic-focused treatment should be introduced at diagnosis

CONTEXT

The treatment questions asked how clinicians move from risk recognition to initial pharmacological choice, what endpoint drives that choice, and where GLP-1 or incretin-based therapies sit.

WHAT THE DATA SHOWS

Combination from day one is the largest first-line approach at **34.9%**, followed by insulin-sensitiser monotherapy at **25.3%**, OCP monotherapy at **20.9%**, lifestyle modification alone at **11.3%**, and incretin/weight-management therapy as initial therapy at **7.7%**. The main endpoint is beta-cell preservation and metabolic progression mitigation at **42.6%**. Metabolic treatment at diagnosis is supported by **67.2%**.

THE INSIGHT

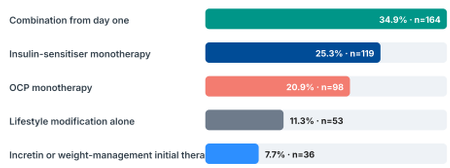
Clinicians have accepted the logic of early metabolic care, but treatment intensity is still stepped. GLP-1 and incretin therapies are not rejected; they are mostly deferred, with **33.6%** placing them after metformin and only **25.5%** placing them as an early option.

WHY IT MATTERS

The field needs clearer treatment-sequencing confidence for non-diabetic PMOS patients, especially where metabolic markers are already abnormal but diabetes is not yet present.

Q10 – First-line pharmacological approach

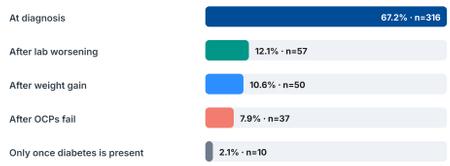
Base: n=470



Combination from day one is the largest single first-line approach at 34.9%.

Q13 – When metabolic-focused treatment should be introduced

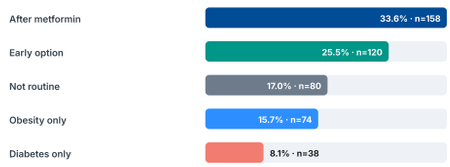
Base: n=470



67.2% support metabolic-focused treatment at diagnosis.

Q14 – Where GLP-1 or incretin therapies currently sit

Base: n=470



Only 25.5% place GLP-1/incretin therapies as an early option.

06

SECTION 06

The biggest therapy barrier is not knowledge. It is access policy.

61.4% cite insurance or prior-authorization restrictions for non-T2DM indications

CONTEXT

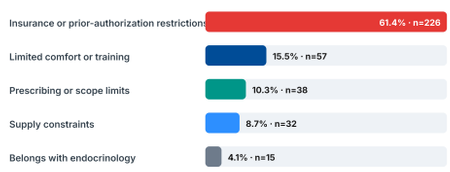
For advanced metabolic therapies, the survey asked FP/GP and O&G respondents what prevents prescribing in non-diabetic PCOS/PMOS patients.

WHAT THE DATA SHOWS

The leading barrier is insurance/prior-authorization restrictions at **61.4% (n=226)**. Limited comfort or training is much lower at **15.5%**, followed by prescribing or scope limits at **10.3%**, supply constraints at **8.7%**, and belief that metabolic management belongs with endocrinology at **4.1%**.

Q15 – Primary barrier to advanced metabolic therapies

Base: n=368



Insurance and prior-authorization restrictions dominate at 61.4%.

THE INSIGHT

This is not primarily an education gap. It is an access architecture gap. The reframe encourages clinicians to think metabolically, but the reimbursement framework still appears to require a narrower metabolic endpoint before advanced therapy becomes practical.

WHY IT MATTERS

PMOS may not translate into earlier metabolic treatment unless payer logic, prior-authorization pathways, and coding frameworks recognize high-risk non-diabetic patients.

07

SECTION 07

Post-reproductive care has a screening instinct, but ownership remains fragile

66.1% support automatic annual metabolic and cardiovascular screening based on PCOS/PMOS status

CONTEXT

The post-reproductive case tested who should coordinate ongoing care, what triggers screening, which long-term risk should be prioritized, and why patients fall out of structured care.

WHAT THE DATA SHOWS

Shared care is the leading coordination response at **33.9%**, followed by FP/GP at **29.3%**, endocrinology at **22.4%**, and O&G at **11.7%**. Automatic annual screening is supported by **66.1%**. Cardiovascular risk is the top long-term priority at **49.6%**. Yet the leading reason patients fall out of care is no clear care owner at **33.0%**.

THE INSIGHT

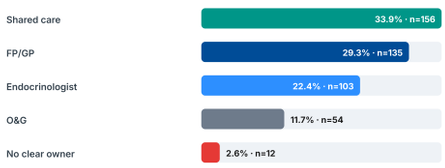
Clinicians know these patients need annual metabolic-cardiovascular surveillance, but the handoff remains weak. Shared care can either mean coordinated responsibility or distributed ambiguity. The data suggests the latter risk is real.

WHY IT MATTERS

The PMOS pathway must define a named coordinator and a specific handoff trigger after reproductive care ends. Otherwise, cardiovascular risk may be recognized in theory but missed in continuity.

Q16 – Who should coordinate ongoing PCOS/PMOS follow-up

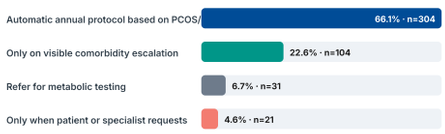
Base: n=460



Shared care leads, but no single owner commands a majority.

Q17 – Trigger for comprehensive metabolic and cardiovascular screening

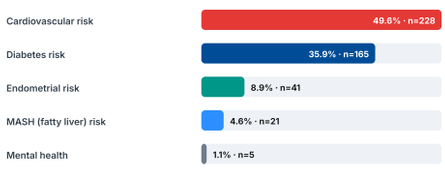
Base: n=460



66.1% support automatic annual protocol-based screening.

Q18 – Long-term risk to actively prioritize

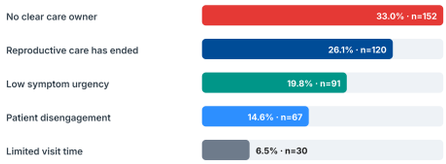
Base: n=460



Cardiovascular risk leads at 49.6%, ahead of diabetes risk at 35.9%.

Q19 – Most likely reason patients fall out of structured care

Base: n=460



No clear care owner is the leading reason at 33.0%.

08

SECTION 08

Referral intent is rising faster than specialist capacity

72.5% of endocrinology respondents say expanded pre-T2DM referral is not fully sustainable as-is

CONTEXT

The survey tested whether the reframe changes early referral behavior and whether endocrinology clinics could absorb pre-T2DM PMOS referrals.

WHAT THE DATA SHOWS

62.0% become more likely to refer early-stage non-diabetic patients, either to a multidisciplinary team (**35.8%**) or endocrinology (**26.2%**). Among endocrinology-routed respondents, **45.0%** say volume is manageable only with a dedicated mid-level metabolic clinic, **27.5%** say it is unsustainable without delaying diabetic/thyroid care, and **27.5%** say it is fully sustainable as-is.

THE INSIGHT

A successful reframe may increase referral pressure before capacity expands. The data does not support a simple "send to endocrinology" model. It points toward distributed care, triage criteria, and dedicated metabolic capacity.

WHY IT MATTERS

Implementation should route patients by risk and complexity, not by label alone. Otherwise, PMOS may reduce diagnostic delay while creating a new referral bottleneck.

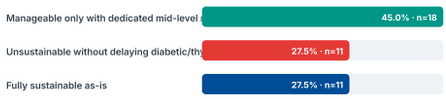
Q21 – How the reframe changes referral likelihood

Base: n=455

62.0% become more likely to refer to endocrinology or a multidisciplinary team.

Q20 – Endocrinology capacity if all pre-T2DM PMOS patients are referred

Base: n=40 endocrinology-routed respondents



72.5% say the volume is not fully sustainable as-is.

09

SECTION 09

The field is asking for a shared protocol, not another awareness message

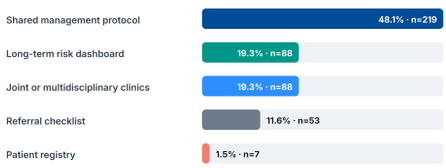
48.1% say a shared management protocol would most improve cross-specialty PCOS/PMOS care

CONTEXT

The final improvement question asked which system artefact would most improve cross-specialty care. This question reveals what clinicians think the pathway needs next.

Q22 – What would most improve cross-specialty care

Base: n=455



WHAT THE DATA SHOWS

A shared management protocol leads at **48.1% (n=219)**. Long-term risk dashboard and joint/multidisciplinary clinics are tied at **19.3%** each. Referral checklist follows at **11.6%**, while patient registry is **1.5%**.

THE INSIGHT

Clinicians are not asking first for more awareness. They are asking for shared operating rules. The reframe has created conceptual alignment, but pathway execution still needs a common protocol that tells every specialty what to do next.

WHY IT MATTERS

The most useful next artefact is a cross-specialty protocol that connects diagnosis without morphology, metabolic screening, first-line sequencing, referral thresholds, and a named long-term owner.

A shared management protocol is the top answer at 48.1%.

Derived signal map

Combined values calculated from exact survey responses.

53.7%
RISK SIGNAL
Clinicians most often interpret PMOS as broader metabolic risk.

83.2%
DIAGNOSIS SHIFT
Very or somewhat likely to diagnose/document without morphology.

67.2%
METABOLIC TIMING
Say metabolic-focused treatment should begin at diagnosis.

72.5%
CAPACITY GAP
Endocrinology volume is not fully sustainable as-is.

SPECIALTY LENSES

What this means at the clinic door

The same data carries different operational implications depending on where the clinician sits in the pathway.

FP/GP and Primary Care

62.1% of profiled HCPs · n=314

Primary care is the largest respondent base and one of the likely long-term anchors for annual screening. The opportunity is to make metabolic and cardiovascular screening automatic rather than dependent on visible deterioration.

Highest-leverage move: use PCOS/PMOS status itself as a trigger for annual metabolic-cardiovascular review.

Obstetrics and Gynaecology

15.8% of profiled HCPs · n=80

O&G remains central to diagnosis and early management, but the reframe demands a stronger metabolic handoff once reproductive management is no longer the main care anchor.

Highest-leverage move: define the transition point from reproductive care to metabolic and cardiovascular follow-up.

Endocrinology

8.7% of profiled HCPs · n=44

Endocrinology sees the cost of diagnostic delay and the risk of referral congestion. Only 27.5% of routed respondents say expanded referral volume is fully sustainable as-is.

Highest-leverage move: define escalation criteria and support mid-level metabolic clinics or shared-care protocols.

Dermatology

7.3% of profiled HCPs · n=37

Dermatology may be an early gateway when acne, hirsutism, or hair loss coincide with cycle irregularity. The survey shows 88.6% investigate or refer rather than treating skin alone.

Highest-leverage move: formalize a metabolic workup prompt when skin signs suggest possible PCOS/PMOS.

FROM INSIGHT TO IMPACT

The pathway needs four practical upgrades.

The data does not show a field confused by the PMOS reframe. It shows a field that understands the metabolic meaning, but still works inside old infrastructure. A shared protocol can convert the reframe from a label into a care pathway.

1. **Document without morphology when markers are sufficient**
   Reduce dependency on ovarian morphology when clinical

2. **Build metabolic screening into routine follow-up**
   Make annual lipids, HbA1c, liver markers, and cardiovascular risk review protocol-based, not event-triggered.

and biochemical evidence already supports diagnosis.

3 **Clarify treatment sequencing and access**

Bridge the gap between early metabolic intent and payer-gated advanced therapy options.

4 **Name the care owner and referral thresholds**

Define who coordinates long-term care, when referral is appropriate, and what endocrinology should absorb.

This is the in-depth report.

It reflects how verified healthcare professionals interpret the PCOS-to-PMOS transition in practice: not as a naming exercise, but as a test of whether systems can catch up to metabolic reality.

Real Opinions to Insights · Validated by Data

REFERENCES AND SOURCE NOTES

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The Global Pulse of Healthcare

Real Opinions to Insights. Validated by Data. This report synthesizes responses from healthcare professionals across the United States, United Kingdom, Canada, Italy, France, and Germany, gathered through the MDForLives clinician community.

Methodology note: Findings reflect HCP perception and reported behavior in response to a PCOS-to-PMOS insight survey. The first two administrative questions in the source survey report were ignored. Percentages and counts are reported exactly from the source file; denominators vary by question and routing.

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