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Editorial

Transition clinics in women with polycystic ovary syndrome

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Recent guidelines, both Indian and international, appreciate the existence of polycystic ovary syndrome (PCOS) in peri- and post-menopausal women.[1,2] This acknowledgment is a corollary of a recent consensus statement on cardiovascular risk assessment and prevention in women with PCOS.[3] These developments expand, rather than negate, the importance of PCOS, allowing one to view it as a life-long disorder, with dynamic patterns, based upon life-stage and symptomatic needs.

The increasing prevalence of PCOS, combined with improved longevity, in general, suggests that a large number of women with this syndrome are, and will, enter the postmenopausal age group. During the reproductive age group, these patients seek medical advice for menstrual irregularity, infertility, and cutaneous manifestation from a variety of health care providers, including gynecologists, endocrinologists, and dermatologists. Many, but not all, experience various components of the metabolic syndrome,[4] and may or may not consult an endocrinologist as well. There is no formal system, however in which care of these persons is transferred to another set of physicians once they have completed their obstetric career. This is in stark contrast to the attention paid to transition clinics for children with diabetes, who graduate to adult care upon reaching adolescence.[5]

The main aim of long-term management in PCOS is to prevent, identify and manage cardiovascular and metabolic risk factors.[3] This is best done by a team of endocrinologists, who are well-versed with the pathophysiologic and therapeutic implications of PCOS. The counseling and medical skills needed for management of PCOS are similar to those required for treating impaired glucose tolerance and obesity.

We, therefore, suggest the establishment of metabolic transition clinics for women with PCOS. These clinics will include in their ambit, younger women as well as those in their mid-life. These multi-disciplinary clinics, led by an endocrinologist, and should include other relevant specialties such as infertility, dermatology, and psychology. The aim should be to assure seamless transfer of responsibility, from gynecologist or dermatologist, to endocrinologist, while making the person understand that PCOS may be a life-long disorder, with dynamic clinical manifestations that change with age.

While we acknowledge this, we must also accept that medical nutrition therapy (MNT) is an integral part of PCOS management. It is MNT which provides the link between various clinical manifestations of PCOS. Therefore, it makes "good clinical sense" to include medical nutrition specialists in the management team of PCOS. The MNT provider can serve as a stable anchor for the woman with PCOS, providing a sense of stability, continuity, and belonging, as she changes her other healthcare providers, according to needs and circumstances.

We hope that Journal of Medical Nutrition and Nutraceuticals will continue to promote research in the field of PCOS, and highlight the important role of this specialty in PCOS management.

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