balance
the menopause support app

Polycystic ovary syndrome (PCOS) and the menopause

Polycystic ovary syndrome (PCOS) is a common condition that affects the way the ovaries work. Around 1 in 10 women are thought to have PCOS, which makes it the most common female hormone condition in the UK[1].

Although PCOS is often associated with people of reproductive age, it doesn't automatically resolve when your periods stop and you reach the menopause. In fact, PCOS is a lifelong condition – and some symptoms of PCOS are similar to those experienced during the perimenopause. This overlap of symptoms can make PCOS harder to diagnose and manage during the perimenopause and menopause.

What are the symptoms of PCOS?

More than half of those who are affected by PCOS don't have any symptoms. Those that do have symptoms are most likely to become aware of them during their late teens and early 20s.

The main features of PCOS are:

- irregular or absent periods
- excess facial hair, male pattern hair loss, and acne – these are usually as a result of raised androgen levels (characteristically 'male' hormones that women also produce), including high testosterone
- polycystic ovaries – a scan may show that your ovaries are enlarged, and may contain fluid-filled sacs (cysts) that surround the eggs

PCOS often runs in families and can be difficult to diagnose because it affects people in different ways. Some may have severe symptoms, while others may have no idea that they're affected as they have few symptoms. PCOS can become even more difficult to diagnose during the perimenopause and menopause, because the main feature of the syndrome (irregular or missing periods) is also a common feature when entering the peri/menopause.

It's important to diagnose PCOS because it can result in difficulties getting pregnant, due to irregular ovulation or failure to ovulate. It can also lead to weight gain and, if left untreated, can increase your risk of developing type 2 diabetes, high blood pressure, raised cholesterol and cardiovascular disease in later life. PCOS makes your body less responsive to the hormone insulin, which can result in high blood sugar levels. In addition, the hormone deficiency caused by the menopause also raises your risk of many of these conditions if hormone replacement is not taken.

PCOS and the menopause

During the perimenopause, levels of the hormones estrogen, testosterone and progesterone begin to fluctuate and then decline and stay low forever. If you have PCOS, you may already have lower levels of estrogen and progesterone (which helps to regulate periods and maintain a pregnancy) so these changes can make your existing symptoms worse.

People with PCOS also tend to have higher levels of testosterone but levels of testosterone reduce during the perimenopause and menopause. Women with PCOS often have symptoms of testosterone

deficiency more than those without PCOS – these include memory problems, brain fog, reduced stamina, fatigue and low libido.

Both PCOS and peri/menopause can cause the following symptoms or changes:

- irregular or missed periods
- fertility problems
- mood swings
- difficulty sleeping
- hair loss (general thinning in menopause, male pattern hair loss in PCOS)
- unwanted hair growth (e.g. facial hair)
- weight gain

It can be more difficult to spot symptoms of the perimenopause and menopause if you have PCOS, especially if you have a history of irregular periods. However, if you're over the age of 40 and notice any new changes in your periods, mood, skin or hair, these are more likely to be associated with the perimenopause than PCOS.

Some studies show that people with PCOS are less likely to experience hot flushes and sweating during the perimenopause and menopause, however they are more likely to report problems with vaginal dryness[2].

On average, people with PCOS tend to reach the menopause an average of two years later than those who are not affected.

Managing PCOS

There's no cure for PCOS, but symptoms can sometimes be managed through lifestyle changes such as eating a healthy diet, taking regular exercise and taking steps to improve your sleep.

Eating a Mediterranean style diet is one of the best ways to help PCOS[3]. This type of diet means eating plenty of vegetables, legumes/pulses/beans, whole grains, extra virgin olive oil, nuts and seeds, fermented dairy foods, fish and seafood, fresh fruit and eating little meat. Eating 30g of milled flax seed each day, perhaps stirred into breakfast, may also help reduce the inflammatory and glycemic effects of PCOS[4].

These types of dietary and lifestyle changes may also improve more general symptoms of the perimenopause and menopause.

Your doctor may also be able to prescribe medication to help with PCOS symptoms such as excessive hair growth, irregular periods and fertility problems.

PCOS and HRT

Most people with PCOS can safely take HRT. As well as managing symptoms of the perimenopause and menopause, HRT can also help reduce your risk of type 2 diabetes and cardiovascular disease, which is particularly beneficial as PCOS increases your risk of developing these conditions.

Replacement estrogen can be given as a skin patch, a spray or a gel that you rub into your skin, or as a tablet that you swallow. If you still have a uterus (womb) you'll also need a progesterone alongside this. The safest type of replacement progesterone is called micronised progesterone, which is branded as Utrogestan in the UK, and comes in the form of a capsule that you swallow and can sometimes be used vaginally. Alternatively, you can have a Mirena coil inserted into your uterus that will last for 5 years.

If you have PCOS, you're likely to be used to having higher levels of testosterone, so you're more likely to

experience symptoms when levels begin to decline sharply during the perimenopause and menopause and stay low thereafter. As a result, you may benefit from taking testosterone as part of your HRT. Although it's not currently licensed for women in the UK, testosterone is prescribed by many menopause experts and some GPs as it has many benefits including:

- increased energy and stamina
- improved muscle mass and strength
- better concentration, clarity of thought and memory
- improved sleep
- increased libido and sexual arousal

Testosterone is usually given as a cream or gel, which you rub into your outer thigh or buttocks, like a moisturiser. It can also sometimes be given as an implant that is inserted under the surface of your skin.

You don't usually need to have a blood test before treatment is started, but your doctor is likely to want to measure the testosterone levels in your blood after a few months, to ensure your levels are within the normal 'female' range.

Sources:

1. https://www.nhs.uk/conditions/polycystic-ovary-syndrome-pcos/
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8189332/
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6836220/
4. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6982376/