**PCOS**

**Letter to Primary Care Provider**

\_\_\_\_\_\_\_\_\_ is being discharged from the endocrine clinic.

Rationale for discharge from Endocrine Care:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has PCOS on the basis of:

* Oligomenorrhea
* Hyperandrogenism
* PCO morphology on imaging

**Treatment**

* Endometrial protection:
* OCP
* Cyclical progestin
* Natural cycle
* Other:\_\_\_\_\_\_\_\_\_\_\_\_

* Hyperandrogenism:\_\_\_\_\_\_\_\_\_\_\_\_\_
* She has been counselled on teratogenicity and should not become pregnant while taking this medication

* Metabolic:
* Metformin:
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCOS is a life-long diagnosis with emphasis placed on reducing long term cardiovascular risk. Ongoing surveillance of risk factors can be managed in the primary care setting.

Summary of key results:

**Blood work:**

|  |  |  |
| --- | --- | --- |
| **Date** | **Test** | **Result** |
|  | TSH |  |
|  | Prolactin |  |
|  | 17-OH Progesterone |  |
|  | Progesterone |  |
|  | FSH/LH |  |
|  | Estradiol |  |
|  | Total testosterone |  |
|  | Bioavailable testosterone |  |
|  | DHEAS |  |
|  | A1C or OGTT |  |
|  | ALT |  |
|  | LDL & Tg |  |

**Imaging:**

Pelvic U/S  (mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surveillance:

Please continue to monitor for cardiovascular risk factors, including:

* BP annually
* Dysglycemia
* Assessment every 1-3 years.
* OGTT is the preferred test. If unavailable or difficult to obtain, can be substituted with A1C and fasting glucose.
* Pre-conception: 75g OGTT. If OGTT is not done pre-conception, it should be offered at the first pre-natal visit, especially if additional risk factors for GDM
* If symptoms of OSA, consider ordering a sleep study
* Lipid profile every XX years
* Screening for depression, anxiety, and disordered eating

Criteria for escalation or re-referral:

Please refer back to myself or another endocrinologist if:

1. The patient wishes to discuss alternative pharmacotherapy for endometrial protection or hyperandrogenism
2. The patient is not satisfied with their medical therapy for hirsutism
3. The patient is not satisfied with their medical therapy for acne or alopecia ***(please refer to dermatology in parallel)***
4. The patient wishes to become pregnant within the next 12 months and
5. Is not having a spontaneous natural cycle ***(please refer to an endocrinologist with fertility expertise or directly to fertility clinic)***
6. Their 75g OGTT is abnormal
7. The patient has symptoms of endometrial hypertrophy (such as intermenstrual bleeding, menstrual bleeding longer than 10 days, or natural cycle > 3 months apart***) (suggest a pelvic ultrasound to assess endometrial thickness and referral to endocrinology and gynecology in parallel).***