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Abbreviations	
AMH	Anti-Müllerian hormone
DHEAS	Dehydroepiandrosterone sulfate
FSH	Follicle-stimulating hormone
LH	Luteinizing hormone
PCOM	Polycystic ovary morphology
PCOS	Polycystic ovary syndrome
TSH	Thyroid-stimulating hormone

INDICATIONS FOR TESTING
Clinical signs of hyperandrogenism (eg, hirsutism, acne, female pattern hair loss) and/or ovulatory dysfunction (eg, oligomenorrhea, amenorrhea, infertility)

PERFORM
Formal clinical assessment^a for hyperandrogenism and ovulatory dysfunction^b
AND
Testing to exclude other possible etiologies^c

Clinical findings suggest ovulatory dysfunction^d
No initial evidence of hyperandrogenism

Clinical evidence of both hyperandrogenism and ovulatory dysfunction^d

Clinical findings suggest hyperandrogenism^d
No initial evidence of ovulatory dysfunction

Test for biochemical hyperandrogenism
ORDER
Free testosterone concentration by laboratory calculation^e
AND
Total testosterone concentration by tandem mass spectrometry

PCOS confirmed

Test for ovulatory dysfunction in midluteal phase
ORDER
Serum progesterone measurement

Evidence of biochemical hyperandrogenism

Evidence of ovulatory dysfunction

No

Yes

PCOS confirmed

No

Yes

PCOS confirmed

Assess for PCOM^f
ORDER
Transvaginal ultrasound^g
OR
Serum AMH testing

Evidence of PCOM

Yes

PCOS confirmed

No

Insufficient evidence for PCOS diagnosis
Consider other etiologies

^aRefer to the [modified Ferriman-Gallwey scale](#) to evaluate hirsutism and to the [Ludwig visual scoring system](#) to evaluate hair loss. For clinical criteria in the evaluation of menstrual irregularity, refer to the [International Evidence-Based Guideline for the Assessment and Management of Polycystic Ovary Syndrome](#).

^bOvulatory dysfunction can, but may not always, present with menstrual irregularity. If anovulation is suspected in the presence of regular menstruation, assess midluteal serum progesterone concentrations.

^cRule out thyroid disease (test TSH), hyperprolactinemia (test prolactin), and congenital adrenal hyperplasia (test serum 17-hydroxyprogesterone). Additional lab work to rule out hypogonadotropic hypogonadism (test LH and FSH), ovarian failure (test FSH), Cushing disease, and androgen-secreting tumors should be considered based on patient history and clinical picture.

^dWith no other etiologies identified.

^eIf free testosterone is not elevated, measurement of DHEAS or androstenedione by tandem mass spectrometry may be considered.

^fCurrently, assessment for PCOM is not recommended in individuals <8 yrs postmenarche.

^gRefer to the [International Evidence-Based Guideline for the Assessment and Management of Polycystic Ovary Syndrome](#) for additional guidance on the use of ultrasound to evaluate adults for PCOM.

References
1. Teede HJ, Tay CT, Laven J, et al. [International evidence-based guideline for the assessment and management of polycystic ovary syndrome 2023](#). Monash University, 2023. [Updated: August 2023; Accessed: September 2023]
2. Goodman NF, Cobin RH, Futterweit W, et al. [American Association of Clinical Endocrinologists, American College of Endocrinology, and Androgen Excess and PCOS Society disease state clinical review: guide to the best practices in the evaluation and treatment of polycystic ovary syndrome—part 1](#). *Endocr Pract*. 2015;21(11):1291-1300.