

## 4<sup>th</sup> World Congress on Polycystic Ovarian Syndrome

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## POLYCYSTIC OVARY SYNDROME AND ANOVULATORY INFERTILITY: AN EVOLVING STRATEGY

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he polycystic ovary syndrome (PCOS) accounts for approximately 80% of women with anovulatory infertility. Various factors influencing ovarian function and fertility are adversely affected by an individual being overweight, the degree of hyperandrogenism and having elevated serum concentrations of luteinizing hormone (LH). Interestingly, a Finnish study showed that whilst women with PCOS may take longer to conceive, but their lifetime fertility is not impaired and they may display sustained fertility with advancing age as compared with infertile eumenorrheic women. For those who do present with anovulatory infertility, the principles of therapy are first to optimize health before commencing treatment and then induce regular unifollicular ovulation, whilst minimizing the risks of ovarian hyperstimulation syndrome (OHSS) and multiple pregnancies. Weight loss, in those who are overweight, should improve the endocrine profile, the likelihood of ovulation, a healthy pregnancy and the response to ovulation induction therapy. Anovulation associated with PCOS has long been known to be amenable to surgical treatment, and a long-term cohort study has shown persistence of ovulation and normalization of serum androgens and sex hormone-binding globulin (SHBG) up to 20 years after laparoscopic ovarian electrocautery in over 60% of subjects, particularly if they have a normal BMI. There is interesting new data on improved efficacy using aromatase inhibitors compared with clomiphene citrate (CC). *In vitro* fertilization (IVF) may be required for women with anovulatory PCOS who do not conceive with ovulation induction or if there are other fertility factors such as tubal damage or male factors. The effect of basal serum LH and LH/FSH ratio on outcomes of *in vitro* fertilization-embryo transfer in patients with polycystic ovarian syndrome will be discussed.

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