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The Effect of Adherence to the Mediterranean Diet on Metabolic Health and Quality of Life in Women of Reproductive Age with Polycystic Ovary Syndrome (PCOS)

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Abstract

Background. Polycystic ovary syndrome (PCOS) is the most common endocrine disorder of women of reproductive age. Beyond irregular ovulation and hyperandrogenism, it carries a heavy metabolic burden — insulin resistance, central obesity, dyslipidaemia, increased risk of type 2 diabetes and fatty liver disease — and measurably lowers quality of life (QoL) through effects on mood, body image and fertility. Lifestyle modification is the first-line treatment in every major guideline, but no single diet has been proven superior.

Aim. To review the evidence on how adherence to the Mediterranean diet (MD) may influence metabolic health and QoL in women of reproductive age with PCOS, to explain the biological mechanisms involved, and to propose a practical framework for measuring adherence and outcomes.

Methods. Narrative review of international guidelines, systematic reviews, randomised trials and observational studies on PCOS, Mediterranean-type dietary patterns, insulin resistance and health-related QoL. Diagrams and tables were prepared by the authors to summarise the material; they are conceptual and are not new patient data.

Findings. The MD is rich in fibre, monounsaturated fat, omega-3 fatty acids and polyphenols and has a low glycaemic load. These features act on the same pathways that drive PCOS: insulin resistance, chronic low-grade inflammation, oxidative stress and excess adiposity. Large trials in the general population show reductions in cardiovascular events and diabetes incidence, and dietary studies in PCOS show improvements in weight, insulin sensitivity and androgen-related markers with healthy, MD-like patterns. High-quality PCOS-specific MD trials remain few and short.

Conclusion. The Mediterranean diet is a safe, sustainable and physiologically well-founded dietary pattern for women with PCOS, and greater adherence is plausibly associated with better metabolic and psychosocial outcomes. It should be delivered together with physical activity, sleep and stress management, and alongside medical therapy where indicated.

Keywords: polycystic ovary syndrome; Mediterranean diet; insulin resistance; metabolic syndrome; quality of life; adherence; lifestyle intervention; women of reproductive age.

1. Introduction

Polycystic ovary syndrome affects roughly 8–13% of women of reproductive age worldwide, and a large share of them remain undiagnosed [1,4]. It was historically viewed as a gynaecological problem of the ovary, but it is now understood as a **systemic endocrine–metabolic condition** in which hormonal, metabolic, psychological and reproductive features interact [1,3]. A woman with PCOS may seek care for acne or unwanted hair, irregular periods, difficulty conceiving, weight gain or low mood — and all of these may share a common root in insulin resistance and androgen excess.

Because insulin resistance sits at the centre of the disease for many women, diet is not a side issue; it is a treatment. The 2023 international evidence-based guideline places healthy lifestyle, including diet, physical activity and behavioural support, at the foundation of PCOS management and states that no specific dietary pattern is clearly superior as long as it is healthy, nutritionally adequate and acceptable to the woman [1]. This opens the question of *which* healthy pattern is easiest to follow for years. The Mediterranean diet, developed from

the traditional eating of countries around the Mediterranean Sea and inscribed by UNESCO as an intangible cultural heritage, is among the best-studied patterns in medicine [10,12–14].

The title of this work asks about **adherence**, not merely about the diet itself. A diet only produces benefits to the degree that it is actually followed. For this reason the review also describes validated tools for measuring adherence and discusses how adherence can be linked to metabolic markers and to QoL scores.

1.1 Aim and objectives

- To describe the clinical and metabolic features of PCOS relevant to nutrition.
- To describe the Mediterranean diet, its components and nutrient profile.
- To explain the mechanisms by which MD adherence can improve metabolic health and quality of life in PCOS.
- To summarise the available evidence and its limitations.
- To provide practical, locally adaptable guidance and a framework for measuring adherence.

2. Polycystic Ovary Syndrome: Definition, Epidemiology and Diagnosis

2.1 Epidemiology

Prevalence estimates range from about 6% to over 13% depending on the diagnostic criteria used and the population studied; broader criteria (Rotterdam) identify more women than the older NIH criteria [4,5]. PCOS usually appears around puberty and persists through the reproductive years, with metabolic risks continuing into and beyond the menopausal transition. Lean women can be affected, but excess weight — especially abdominal fat — worsens every component of the syndrome.

2.2 Diagnosis

In adults the diagnosis relies on the Rotterdam criteria: two of three features, after exclusion of other causes such as thyroid disease, hyperprolactinaemia and non-classic congenital adrenal hyperplasia [1,2]. The 2023 guideline also allows anti-Müllerian hormone (AMH) to be used instead of ovarian ultrasound in adults.

Table 1. Rotterdam criteria (two of three required) [1,2]

Criterion	What is assessed	Typical findings
1. Ovulatory dysfunction	Cycle length and regularity	Cycles >35 days or <8 cycles/year; amenorrhoea
2. Hyperandrogenism (clinical)	Ferriman–Gallwey score, acne, scalp hair loss	Hirsutism, persistent acne, female-pattern alopecia
2. Hyperandrogenism (biochemical)	Total/free testosterone, free androgen index	Raised free testosterone, low SHBG
3. Polycystic ovarian morphology	Transvaginal ultrasound or AMH	≥20 follicles per ovary (2–9 mm) and/or raised ovarian volume; high AMH

2.3 Phenotypes

Combining the three criteria produces four recognised phenotypes. The metabolic risk is generally highest in the phenotypes that combine hyperandrogenism with ovulatory dysfunction (A and B) and lowest in the non-hyperandrogenic phenotype (D) [3,4].

Table 2. PCOS phenotypes [3,4]

Phenotype	Hyperandrogenism	Ovulatory dysfunction	Polycystic ovaries	Metabolic risk
A (classic / full)	Yes	Yes	Yes	Highest
B (classic, non-PCOM)	Yes	Yes	No	High
C (ovulatory)	Yes	No	Yes	Intermediate
D (non-hyperandrogenic)	No	Yes	Yes	Lower

3. Pathophysiology: Why Diet Matters

The exact cause of PCOS is unknown and is probably polygenic, with environmental amplification. The best-supported mechanistic model places **insulin resistance with compensatory hyperinsulinaemia** in a central role [6,7]. High insulin acts on the ovary together with luteinising hormone to increase androgen production by theca cells, and it lowers hepatic production of sex-hormone-binding globulin (SHBG), which raises the fraction of biologically active free testosterone. The result is hyperandrogenism and disturbed follicular development, with anovulation. Adipose tissue — particularly visceral fat — adds free fatty acids and inflammatory cytokines and lowers adiponectin, which makes insulin resistance worse and closes a vicious circle (Figure 1).

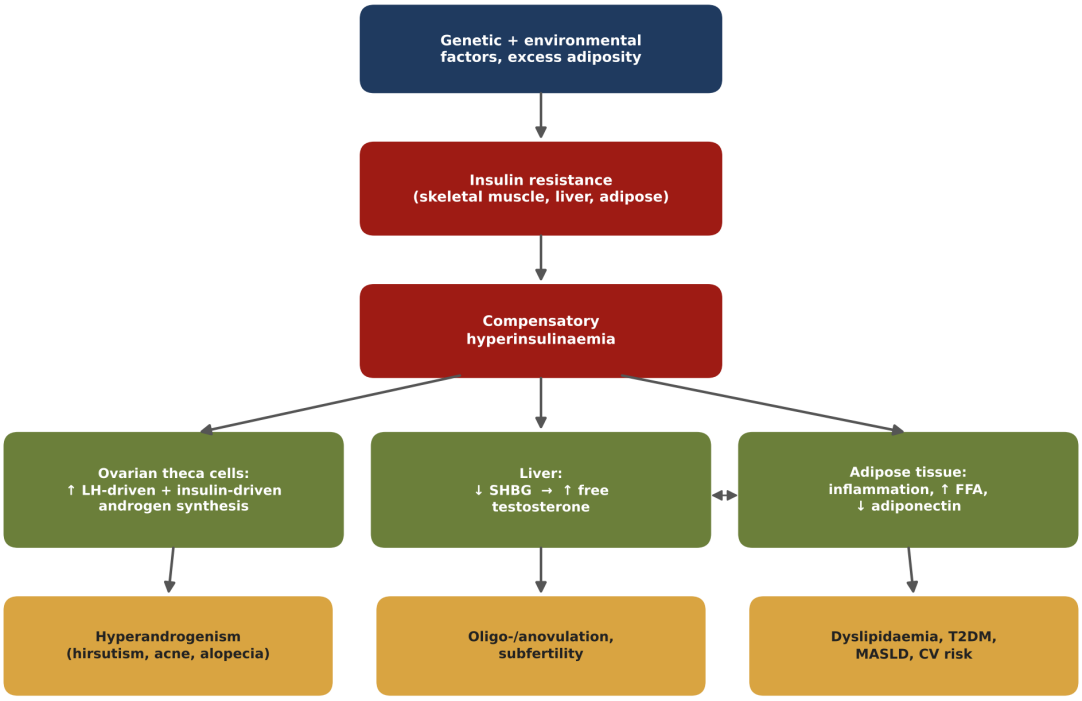


Figure 1. Simplified pathophysiology of PCOS: insulin resistance and hyperinsulinaemia drive ovarian and hepatic effects that produce the clinical and metabolic picture (schematic prepared by the authors, based on [6,7]).

Two practical points follow. First, **anything that lowers insulin resistance** — weight loss, exercise, better carbohydrate quality, less visceral fat — should reduce androgen drive and improve ovulation. Second, because insulin resistance in PCOS can be present even in lean women, dietary quality matters regardless of body weight.

4. Metabolic Health in PCOS

The metabolic profile of PCOS is a cluster of linked abnormalities. Women with PCOS have a several-fold higher risk of impaired glucose tolerance and type 2 diabetes, and they are more likely to develop metabolic syndrome, non-alcoholic fatty liver disease (now termed MASLD), obstructive sleep apnoea and gestational complications [1,3,7]. Table 3 lists the main components and how diet can influence them.

Table 3. Metabolic features of PCOS and potential dietary influence

Metabolic feature	Why it occurs in PCOS	How a Mediterranean-type diet can help
Insulin resistance / hyperinsulinaemia	Intrinsic defect in insulin signalling, amplified by adiposity	Low glycaemic load, high fibre, unsaturated fats improve insulin sensitivity [13,18]
Central obesity	Insulin-driven fat storage, reduced energy expenditure	Satiating, energy-controlled pattern; supports 5–10% weight loss [1,16]
Dyslipidaemia	High triglycerides, low HDL, raised small LDL	Replaces saturated fat with olive oil, nuts, fish; omega-3 lowers triglycerides [12]
Impaired glucose tolerance / T2DM	Progressive beta-cell exhaustion	MD lowered diabetes incidence in high-risk adults [13]
MASLD (fatty liver)	Hepatic insulin resistance, lipogenesis	Lower sugar and refined carbohydrate; healthy fats
Hypertension and CV risk	Endothelial dysfunction, inflammation	MD reduced major CV events in high-risk adults [12]
Chronic low-grade inflammation	Adipokines, oxidative stress	Polyphenols, vitamins C and E, omega-3 reduce inflammatory markers

5. Quality of Life in PCOS

Health-related quality of life is reduced in women with PCOS compared with women without the condition. The reasons are multifactorial: visible signs such as hirsutism and acne affect self-esteem; weight gain affects body image; irregular cycles and infertility cause anxiety; and the prevalence of depression and anxiety symptoms is higher than in the general female population [1,8]. Importantly, the psychological burden is not fully explained by body weight, which means that it needs direct attention in management.

QoL is measured with generic tools such as the SF-36 [9] and with the condition-specific PCOS Questionnaire (PCOSQ), which scores five domains: emotions, body hair, body weight, infertility and menstrual problems [8].

Table 4. PCOSQ domains and links to nutrition [1,8]

Domain	Typical concern	Possible dietary / lifestyle link
Emotions / mood	Low mood, anxiety, mood swings	Omega-3, B-vitamins, stable blood glucose, regular shared meals, physical activity
Body weight	Weight gain, difficulty losing weight	Sustainable, non-restrictive diet; behavioural support
Body hair / acne	Hirsutism, acne, hair loss	Lower insulin and androgens over months; combined with medical therapy
Menstrual problems	Irregular or absent periods	Weight reduction and insulin-sensitising diet can restore cycles
Infertility	Anovulation, anxiety about conception	Pre-conception weight and metabolic optimisation [1]

6. The Mediterranean Diet

6.1 Origin and definition

The pattern was first described in the 1950s–60s by Ancel Keys and colleagues, who observed low rates of coronary heart disease in populations of southern Italy and Greece despite a high fat intake — the fat being mainly olive oil. Today the MD is defined less as a strict recipe and more as a **pattern**: plant-based foods as the foundation, olive oil as the principal fat, fish and poultry in moderation, limited red and processed meat, little added sugar, and meals eaten slowly and socially. Higher adherence has been associated with lower overall mortality, lower cardiovascular disease and lower cancer incidence [10,14].

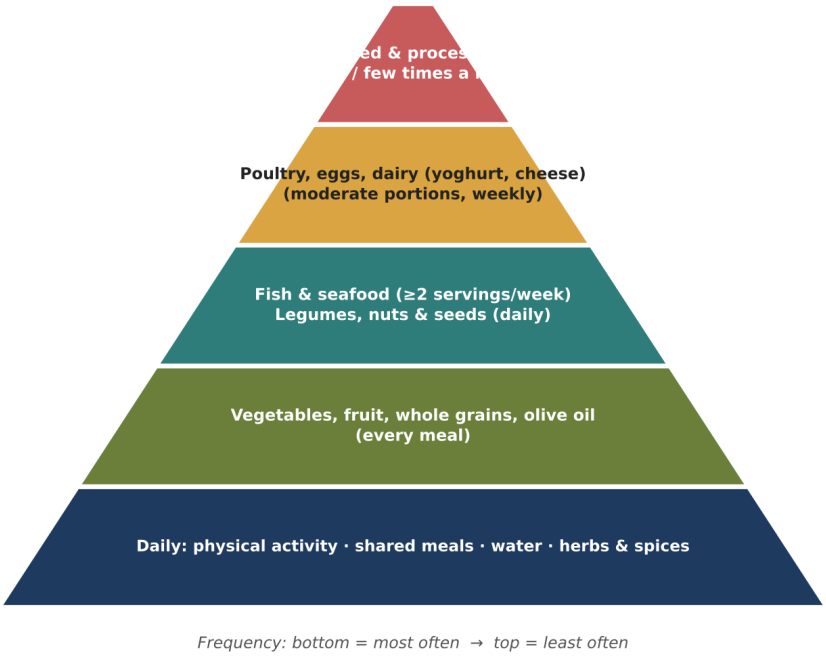


Figure 2. The Mediterranean diet pyramid (adapted by the authors). Foods at the base are eaten most often; those at the top least often.

6.2 Food groups and recommended frequency

Table 5. Components of the Mediterranean diet

Food group	Recommendation	Key nutrients / compounds	Relevance in PCOS
Vegetables	≥2 servings per day; 1 at every main meal	Fibre, vitamin C, carotenoids, polyphenols	Low energy density, anti-inflammatory
Fruit	2–3 servings per day (whole, not juice)	Fibre, vitamins, flavonoids	Sweetness without a rapid glucose spike if eaten whole
Whole grains	Daily; wholemeal bread, bulgur, oats, brown rice	Fibre, B-vitamins, magnesium	Lower glycaemic response, better insulin sensitivity
Legumes	≥3 servings per week (ideally more)	Plant protein, fibre, iron, folate	Slow-release carbohydrate, satiety
Olive oil (extra virgin)	Main culinary fat; 2–4 tbsp per day	Oleic acid (MUFA), hydroxytyrosol, oleocanthal	Anti-inflammatory; replaces saturated fat
Nuts and seeds	A handful (30 g) per day	MUFA, PUFA, vitamin E, magnesium	Improved lipids and insulin sensitivity
Fish and seafood	≥2 servings per week, including oily fish	Omega-3 (EPA, DHA), iodine, vitamin D	Lower triglycerides, mood support
Poultry, eggs	Moderate; 2 servings per week each	High-quality protein	Protein without saturated load of red meat
Dairy	Moderate; yoghurt, cheese	Calcium, protein, probiotics (fermented)	Choose unsweetened, low-sugar types
Red / processed meat	<2 servings per week; processed rarely	Saturated fat, haem iron, additives	Reduces inflammatory and insulin-resistance load
Sweets, sugary drinks	Occasional only	Free sugars	Major driver of hyperinsulinaemia
Herbs and spices	Use daily instead of salt	Polyphenols	Flavour without added salt

6.3 Nutrient profile

The MD is relatively high in total fat (often 35–40% of energy), but the fat is predominantly monounsaturated and polyunsaturated. Carbohydrate comes mainly from vegetables, legumes, fruit and whole grains, so fibre intake is high and glycaemic load is low. Protein is moderate and mostly from plant sources, fish and poultry. Figure 3 compares the approximate macronutrient distribution of three patterns; it is illustrative, since exact values vary between studies and countries.

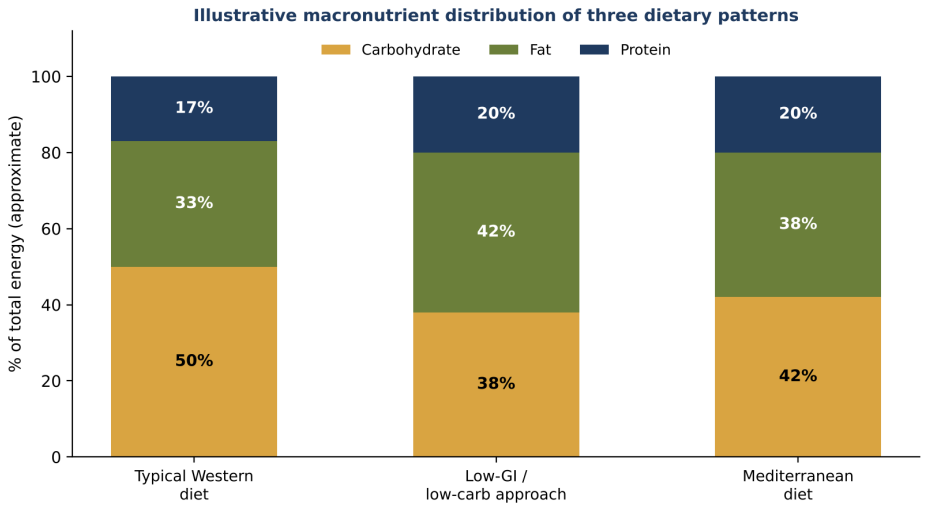


Figure 3. Illustrative macronutrient distribution (approximate % of total energy). The quality of each macronutrient differs more than the percentages suggest.

6.4 Putting it on the plate

For daily practice a plate model is easier to remember than percentages: half of the plate vegetables and fruit, a quarter whole grains, a quarter protein (fish, legumes, poultry, eggs), with olive oil as the cooking and dressing fat.

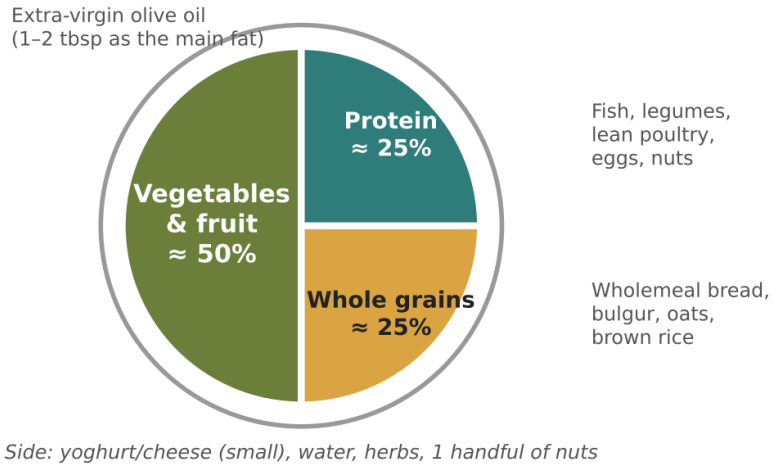


Figure 4. Mediterranean plate model for a main meal.

7. Mechanisms Linking Mediterranean Diet Adherence to PCOS Outcomes

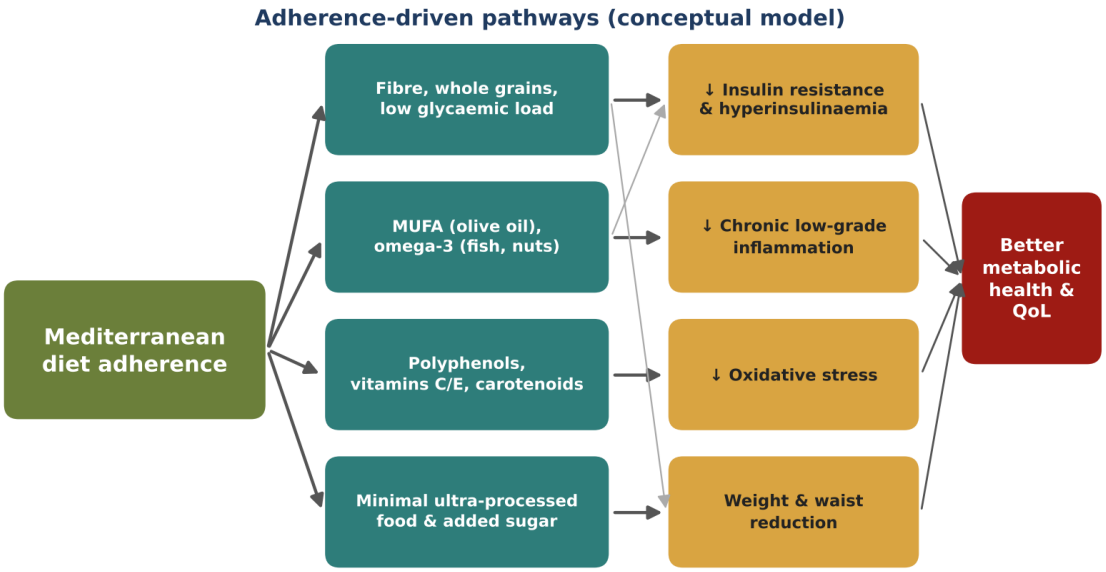


Figure 5. Conceptual model: components of the Mediterranean diet act on insulin resistance, inflammation, oxidative stress and adiposity, which together improve metabolic health and QoL.

7.1 Improved insulin sensitivity

The low glycaemic load and high fibre content blunt post-meal glucose and insulin peaks. Monounsaturated fatty acids improve membrane function and insulin signalling, while reduced saturated fat and refined sugar lessen ectopic fat deposition in liver and muscle. In women with PCOS, dietary interventions of different types have been shown to improve markers of insulin resistance, with healthy, lower-glycaemic patterns performing well [15,18]. Lower circulating insulin should in turn reduce ovarian androgen synthesis and raise SHBG.

7.2 Anti-inflammatory and antioxidant effects

Women with PCOS show higher levels of inflammatory markers and oxidative stress than weight-matched controls. Olive oil polyphenols, vegetable and fruit antioxidants and marine omega-3 fatty acids reduce inflammatory signalling. Because inflammation worsens insulin resistance and may disturb ovarian function, this pathway reinforces the metabolic benefits.

7.3 Weight and body composition

A moderate weight loss of 5–10% produces clinically meaningful improvements in cycle regularity, androgen levels and insulin resistance [1,16]. The MD is not a low-calorie diet by design, but its high fibre, protein and water content promotes satiety, and it can be combined with an energy deficit when weight loss is the goal. The attraction for long-term adherence is that it does not forbid whole food groups.

7.4 Gut microbiota

Fibre-rich, plant-predominant diets increase the diversity of gut bacteria and short-chain fatty acid production. Altered microbiota have been reported in PCOS, and this is an active area of research, although causal evidence in humans is still limited.

7.5 Mood and quality of life

Several routes are plausible: omega-3 fatty acids and B-vitamins support neurotransmitter function; stable blood glucose avoids energy swings; weight and skin improvements help body image; and the social, unhurried eating culture of the Mediterranean tradition may reduce stress and emotional eating. Evidence for direct QoL gains from MD in PCOS is still emerging and mainly comes from small studies, so this remains a hypothesis supported by general-population data.

8. Measuring Adherence

Adherence is typically assessed with short questionnaires. The most widely used is the **14-item Mediterranean Diet Adherence Screener (MEDAS)** from the PREDIMED trial, which gives one point for each criterion met (score 0–14) [11]. The longer Mediterranean Diet Score of Trichopoulou et al. (0–9) is based on food-group intake relative to the population median [10].

Table 6. Items of the MEDAS 14-point screener [11]

#	MEDAS item	Criterion for 1 point
1	Olive oil as the main culinary fat	Yes
2	Olive oil per day	≥4 tablespoons
3	Vegetables per day	≥2 servings (≥1 raw or as salad)
4	Fruit per day	≥3 pieces (including natural juice)
5	Red / processed meat per day	<1 serving
6	Butter, margarine or cream per day	<1 serving
7	Sugar-sweetened drinks per day	<1 serving
8	Wine per week	≥7 glasses*
9	Legumes per week	≥3 servings
10	Fish / seafood per week	≥3 servings
11	Commercial sweets / pastries per week	<3 servings
12	Nuts per week	≥3 servings
13	Prefers chicken / turkey to red meat	Yes
14	Sofrito (tomato–onion–garlic–olive oil sauce) per week	≥2 servings

**Alcohol is not recommended as part of a health plan, and in studies of younger women or women planning pregnancy this item is usually removed or scored as met by non-drinkers; a modified 13-item score is then used.*

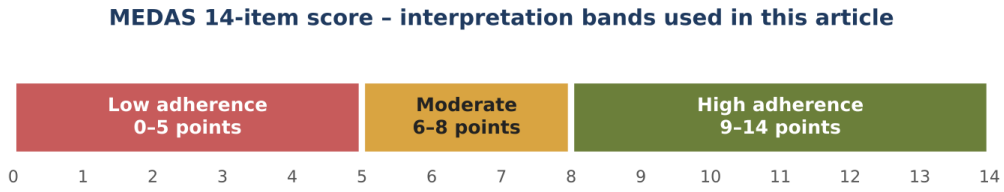


Figure 6. Interpretation bands for the MEDAS score (commonly used cut-offs: ≥9 = high adherence).

9. Summary of the Evidence

The evidence base can be arranged in three layers: (1) high-quality general-population trials that establish the benefits of the MD; (2) guideline-level and systematic-review evidence on diet in PCOS; and (3) PCOS-specific studies of MD adherence, which are mostly observational or small intervention studies.

Table 7. Key evidence on the Mediterranean diet and on diet in PCOS

Source (design)	Population	Main finding	Implication for PCOS
PREDIMED, Estruch 2018 (RCT) [12]	High-CV-risk adults, MD + olive oil or nuts vs control	About 30% fewer major cardiovascular events	Supports cardiometabolic protection, a key risk in PCOS
Salas-Salvadó 2014 (RCT) [13]	Older adults at high risk, no diabetes at baseline	MD with olive oil lowered diabetes incidence by about half vs control	Relevant to the high diabetes risk in PCOS
Sofi 2008 (meta-analysis) [14]	Cohort studies, general population	2-point increase in adherence linked to ~9% lower overall mortality	Dose-response relationship with adherence
Moran 2013 (systematic review) [15]	Dietary composition in PCOS	No clear superiority of one macronutrient pattern; weight loss improves outcomes	Choose a healthy, acceptable and sustainable pattern
Lim 2019 (Cochrane review) [16]	Lifestyle interventions in PCOS	Lifestyle changes may improve weight, androgen and insulin outcomes; certainty low	Lifestyle first, need for better trials
Shang 2020 (meta-analysis) [18]	Diet interventions in PCOS	Dietary change improved insulin-resistance markers; no single diet clearly best	MD-like healthy patterns are reasonable
Barrea 2019 (observational) [17]	Women with PCOS vs controls	Adherence was lower in PCOS; higher adherence linked to more favourable body composition and metabolic profile	Direct PCOS-specific association
Teede 2023 (guideline) [1]	International evidence-based guideline	Healthy lifestyle for all; 5–10% weight loss in overweight; ≥150 min/week moderate activity	Frames the MD as one acceptable healthy pattern

What the evidence does and does not show

- The MD has strong evidence for cardiometabolic benefit in the general population, and these are the main risks in PCOS.
- Guidelines do not name the MD as the only correct diet for PCOS; they endorse any healthy pattern the woman can keep up.
- PCOS-specific randomised trials of the MD, with QoL as an outcome and follow-up longer than 6 months, are still needed.
- Observed benefits depend on adherence, which declines over time without support.

10. Practical Application

10.1 Principles for counselling

- Set small, specific goals (for example, one more portion of vegetables per day, or olive or cold-pressed oil instead of butter).
- Replace rather than remove: refined bread → wholemeal; sweets → fruit and nuts; fatty red meat → fish, legumes or poultry.
- Reduce ultra-processed foods and sugary drinks, which are the largest dietary drivers of hyperinsulinaemia.
- Combine with ≥150 minutes of moderate activity per week and two muscle-strengthening sessions [1].
- Review adherence with MEDAS at baseline and every 3 months, together with weight, waist circumference and, when available, fasting glucose/insulin and lipids.

10.2 Sample seven-day menu

Table 8. Example one-week Mediterranean-style menu (adapt to energy needs and preferences)

Day	Breakfast	Lunch	Dinner
Mon	Oat porridge, walnuts, apple, cinnamon	Lentil soup, wholemeal bread, tomato-cucumber salad with olive oil	Baked fish, steamed vegetables, bulgur
Tue	Plain yoghurt, berries, seeds	Chickpea and vegetable stew, green salad	Grilled chicken, roasted aubergine and peppers
Wed	Wholemeal toast, boiled egg, tomato	Bean salad with onion, parsley, lemon and olive oil	Vegetable omelette, large salad, 1 slice wholemeal bread
Thu	Oats, dried apricot (2–3), almonds	Whole-grain pasta with tomato–garlic sauce, rocket	Sardines or tuna salad, boiled potatoes
Fri	Cottage cheese, cucumber, wholemeal bread	Brown rice with vegetables and chickpeas	Baked trout, cabbage-carrot salad
Sat	Vegetable scramble, olives	Grilled vegetables with feta, whole-grain bread	Chicken and vegetable soup, lentil side
Sun	Fruit salad with yoghurt and nuts	Family meal: stuffed peppers, salad, fruit	Light: hummus, vegetables, wholemeal flatbread

10.3 Local adaptation

In Central Asia, olive oil can be costly and fresh fish less available, but the Mediterranean *principles* can be applied with local foods: legumes (lentils, beans, chickpeas), walnuts and other nuts, seasonal vegetables and herbs, apricots and other fruit, fermented dairy without added sugar, wholegrain bread and bulgur, and cold-water or tinned fish. Where olive oil is too expensive, unrefined cold-pressed vegetable oils in moderate amounts are a reasonable compromise, while reducing deep-fried dishes, fatty meat preparations, white bread, sweets and sweetened tea. The pattern matters more than the exact ingredients.

10.4 Place of diet within the whole treatment

Diet does not replace medical therapy. Depending on the woman's goals, clinicians may add combined oral contraceptives for cycle control and hyperandrogenism, metformin for metabolic features, anti-androgens, or ovulation induction for fertility; evidence for inositol supplements is mixed [1]. Sleep, stress management and psychological support are also part of the care pathway, particularly because of the higher burden of depression and anxiety. Any dietary programme in adolescents or in women with a history of disordered eating should be supervised by a clinician to avoid harm.

11. Challenges, Limitations and Research Gaps

Table 9. Barriers and research gaps

Barrier / gap	Explanation	Suggested response
Cost and availability	Olive oil, fish and nuts may be expensive	Use local substitutes; legumes and seasonal produce are inexpensive
Declining adherence over time	Motivation and supervision fall after 3–6 months	Regular follow-up, group sessions, self-monitoring
Cultural food habits	Traditional dishes may be high in fat and refined carbohydrate	Modify preparation methods rather than abandoning the cuisine
Small, short PCOS trials	Few RCTs of MD with QoL outcomes	Larger trials with 12+ months follow-up
Heterogeneity of PCOS	Four phenotypes, differing BMI and insulin status	Stratified analysis by phenotype and BMI
Measurement of adherence	Self-report questionnaires have bias	Combine MEDAS with biomarkers (e.g. plasma carotenoids, lipids)
Confounding by lifestyle	Exercise, sleep and medication change together with diet	Control for co-interventions in study design

12. Suggested Framework for Evaluating Adherence

For students or clinicians who wish to evaluate this question in practice, Figure 7 outlines a simple prospective design. Women aged 18–45 with PCOS by Rotterdam criteria are enrolled, baseline adherence and outcomes are measured, a Mediterranean-style plan with counselling is delivered, and outcomes are repeated after 12–24 weeks. Participants are then compared by adherence level (for example MEDAS ≥9 versus lower). Primary outcomes can be HOMA-IR or waist circumference; secondary outcomes include lipids, cycle regularity, free androgen index and PCOSQ scores. Ethical approval, informed consent and

appropriate sample-size calculation are required for any real study.

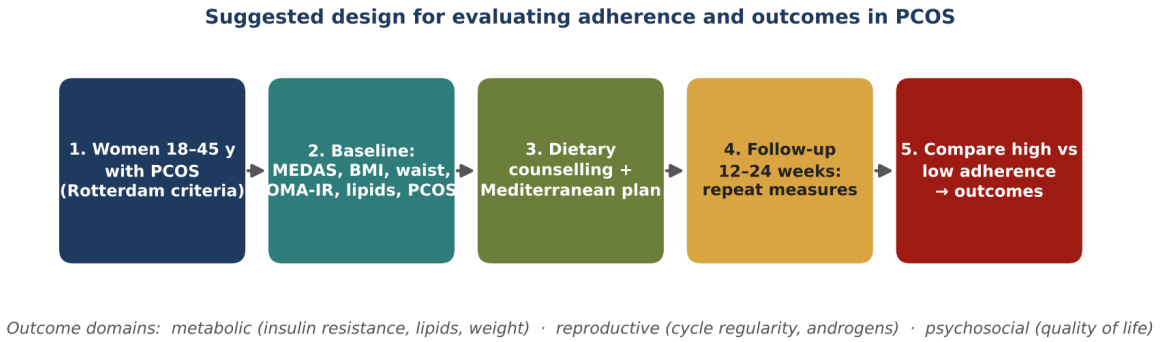


Figure 7. Proposed design for assessing the relationship between Mediterranean diet adherence, metabolic outcomes and QoL.

13. Conclusion

PCOS is a lifelong metabolic–reproductive condition in which insulin resistance, inflammation and excess adiposity interact with psychological burden. The Mediterranean diet addresses these mechanisms through low glycaemic load, high-quality fats, abundant fibre and antioxidants, and a culturally rich, flexible eating style that many people can sustain. Although PCOS-specific trials are still limited, the combination of guideline support for healthy dietary patterns, strong general-population evidence for the MD, and clear biological plausibility makes it a rational first-choice dietary approach. Success depends on **adherence**, which should be measured, supported and re-assessed, and on integrating diet with physical activity, psychological care and medical treatment when needed.

Key take-home points

- PCOS is a systemic metabolic condition; insulin resistance is a central target of diet.
- No single diet is proven best, but the Mediterranean pattern is healthy, sustainable and evidence-based in related conditions.
- Vegetables, legumes, whole grains, nuts, fish and olive oil form the core; sweets, sugary drinks and processed meat are minimised.
- Measure adherence (MEDAS) and track weight, waist, glucose/insulin, lipids and QoL.
- Aim for 5–10% weight loss in overweight women and ≥150 minutes of activity per week.
- Diet complements, and does not replace, medical care.

Disclaimer: This article is an educational literature review prepared for study purposes. It is not individual medical advice. Women with PCOS should consult their physician or dietitian before making major dietary changes.

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