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Original Article

Evaluating the Quality of Life of Women with Polycystic Ovary Syndrome

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ABSTRACT

Background: Polycystic ovary syndrome is a common endocrine and metabolic disorder among women of reproductive age and may affect physical, psychological, social, and reproductive well-being. Quality-of-life assessment is important because clinical symptoms alone may not fully reflect the lived burden of the condition. Objective: To evaluate quality of life among women with polycystic ovary syndrome and examine its association with clinical, treatment-related, lifestyle, psychological, and social factors. Methods: This cross-sectional observational study included 92 premenopausal women diagnosed with polycystic ovary syndrome attending selected gynecology departments in Lahore, Pakistan. Data were collected using a structured pre-tested questionnaire and analyzed using IBM SPSS Statistics version 27. Frequencies and percentages were calculated for categorical variables, and associations with self-rated quality of life were assessed using chi-square analysis. Results: Most participants rated their quality of life as good (70.7%) or very good (8.7%). Sadness or anxiety was reported by 87.0%, low self-esteem by 82.6%, depression by 75.0%, and lack of family support by 79.3%. Physical activity at least three times weekly was significantly associated with quality of life ($p<0.001$). Treatment status, hormonal contraception use, inositol use, and dietary practice were not significantly associated with quality of life. Selected psychosocial associations require coding verification before final interpretation. Conclusion: Women with polycystic ovary syndrome may report favorable global quality of life despite substantial psychosocial burden. Integrated care should include lifestyle counseling, psychological screening, and social support. Keywords: Polycystic ovary syndrome; quality of life; psychological distress; physical activity; self-esteem; family support.

INTRODUCTION

Polycystic ovary syndrome is one of the most common endocrine and metabolic disorders among women of reproductive age and is characterized by heterogeneous reproductive, dermatological, psychological, and metabolic manifestations. Its clinical presentation commonly includes menstrual irregularity, hirsutism, acne, obesity, infertility concerns, insulin resistance, and emotional distress, all of which may affect daily functioning and perceived health status. The diagnostic approach to PCOS has evolved across the National Institutes of Health criteria, the Androgen Excess Society criteria, and the Rotterdam criteria, with the Rotterdam criteria being widely used in clinical and research settings because they capture the broad phenotypic spectrum of the disorder (1).

Beyond its reproductive consequences, PCOS has a substantial psychosocial burden. Women with PCOS frequently report concerns related to body image, self-esteem, mood disturbance, social functioning, marital or partner relationships, sexual health, and future fertility. These symptoms may not be life-threatening in the immediate sense, but they can produce persistent distress and reduce health-related quality of life. Previous evidence has shown that women with PCOS often experience impaired quality of life due to the combined effects of physical symptoms, psychological distress, and metabolic risk, particularly when symptoms such as hirsutism, weight gain, infertility, and menstrual irregularity remain insufficiently controlled (2).

Quality of life is a multidimensional construct reflecting an individual's perception of physical, psychological, social, and environmental well-being in relation to personal expectations, cultural values, and health status. In chronic endocrine conditions such as PCOS, quality-of-life assessment is clinically important because symptom severity alone may not fully reflect the patient's lived experience. Two women with similar clinical manifestations may differ substantially in emotional adjustment, family support, treatment access, acceptance of appearance, and coping ability. Therefore, patient-reported quality-of-life assessment provides a more comprehensive understanding of the burden of PCOS than clinical diagnosis alone (3).

Several studies have reported that depression, anxiety, body dissatisfaction, low self-esteem, sexual dysfunction, and reduced social participation are common among women with PCOS. Lifestyle-related factors, including dietary practices and physical activity, may also influence symptom perception and overall well-being, although cross-sectional studies cannot establish causal relationships. Similarly, treatment status, hormonal therapy, metabolic management, and psychosocial support may shape how women perceive and manage their condition. These factors highlight the need to evaluate quality of life in relation to clinical symptoms, treatment patterns, lifestyle behaviors, and psychosocial variables rather than describing PCOS only as a reproductive or metabolic disorder (4).

Although international literature has increasingly emphasized the psychosocial and quality-of-life burden of PCOS, local clinical data remain important because cultural expectations, family structures, marital concerns, body-image norms, healthcare access, and social support may influence how women experience the condition. In the Pakistani clinical context, women with PCOS may face unique challenges related to delayed diagnosis, fertility-related stress, limited psychological support, and social stigma attached to reproductive and appearance-related symptoms. Evaluating quality of life in this population may therefore help clinicians identify the domains most affected by PCOS and guide more patient-centered counseling, referral, and management strategies.

This study aimed to evaluate quality of life among women diagnosed with polycystic ovary syndrome attending selected gynecology departments in Lahore, Pakistan, and to examine its association with clinical characteristics, symptom burden, treatment status, lifestyle practices, psychological factors, self-esteem, appearance acceptance, and family support.

MATERIAL AND METHODS

This cross-sectional observational study was conducted among women diagnosed with polycystic ovary syndrome attending the Department of Obstetrics and Gynecology at the University of Lahore Teaching Hospital and Nawaz Sharif Social Security Hospital, Lahore, Pakistan. Data collection was carried out over a four-month study period from 4 June to 10 August 2025 after approval from the Departmental Research Committee and the institutional ethics committee of the University of Lahore. The study was designed to assess self-reported quality of life and its association with clinical, treatment-related, lifestyle, psychological, and social factors among women with PCOS.

The study population comprised premenopausal women with a diagnosis of PCOS who were available during the data collection period and agreed to participate. Participants were approached in the gynecology outpatient or clinical setting, informed about the purpose of the study, and enrolled after obtaining informed consent. Participation was voluntary, and respondents were informed that they could withdraw at any stage without any effect on their clinical care. Confidentiality and anonymity were maintained by recording responses without personally identifying information, and the collected data were used only for research purposes.

The sample size was calculated as 92 participants using a 95% confidence level and a 6% margin of error with population adjustment. A non-probability sampling approach was used to recruit eligible participants during the study period. Data were collected through a structured, pre-tested questionnaire completed by the respondents. Before the main data collection, the questionnaire was piloted on a small sub-sample to assess clarity, comprehensibility, and feasibility of administration. The final questionnaire collected information on sociodemographic characteristics, duration since PCOS diagnosis, perceived symptom severity, treatment status, hormonal contraception use, inositol use, dietary practices, physical activity, reproductive status, perceived impact of PCOS on life domains, sadness or anxiety related to PCOS, perceived lack of control, depression, appearance acceptance, low self-esteem, family support, symptom annoyance, and comorbid conditions accompanying PCOS.

The primary outcome was self-rated quality of life, categorized as very good, good, poor, or very bad. Independent variables included age group, residence, education, socioeconomic status, job status, duration of PCOS diagnosis, perceived severity and annoyance of symptoms, current treatment status, hormonal contraception use, inositol use, dietary care, physical activity at least three times per week, having children, perceived effect of PCOS on life, sadness or anxiety due to PCOS, lack of control over the condition, depression, acceptance of appearance, low self-esteem, family support, and presence of accompanying comorbid conditions. Categorical variables were operationalized according to the response categories used in the questionnaire. Responses with missing values were retained in descriptive reporting using the available denominator for each variable.

Data were entered and analyzed using IBM SPSS Statistics version 27. Descriptive statistics were used to summarize categorical variables as frequencies and percentages. Associations between quality-of-life categories and categorical clinical, lifestyle, treatment-related, psychological, and social variables were assessed using the chi-square test. Where expected cell counts were small, the appropriateness of the chi-square test was reviewed and exact testing was considered for interpretation. A p-value of less than 0.05 was considered statistically significant. All analyses were interpreted cautiously because the cross-sectional design permits assessment of association but does not establish temporal sequence or causality.

Ethical approval was obtained from the relevant ethics committee of the University of Lahore before data collection. Informed consent was obtained from all participants before enrolment. Participants were assured that there were no direct risks or penalties associated with participation or withdrawal. All data were stored securely, accessed only by the research team, and analyzed in aggregate form to protect participant confidentiality.

RESULTS

A total of 92 premenopausal women diagnosed with polycystic ovary syndrome were included in the analysis. The sociodemographic profile of the participants is presented in Table 1. Most participants were aged 18–23 years (n=49, 53.3%), followed by 24–29 years (n=29, 31.5%). Most participants were unmarried (n=64, 69.6%), students (n=45, 48.9%), and had higher education (n=77, 83.7%). Nearly half of the participants lived in large cities (n=44, 47.8%), and most reported good socioeconomic status (n=60, 65.2%).

Table 1. Sociodemographic Characteristics of Women With PCOS (n=92)

Characteristic	Category	n (%)
Age group, years	18–23	49 (53.3)
	24–29	29 (31.5)
	30–35	5 (5.4)
	>35	9 (9.8)
Marital status	Unmarried	64 (69.6)

Characteristic	Category	n (%)
	Married	28 (30.4)
Job status	Actively working	22 (23.9)
	Studying	45 (48.9)
	Non-active	25 (27.2)
Residence	Large city	44 (47.8)
	Medium-sized city	27 (29.3)
	Small city	18 (19.6)
	Abroad	3 (3.3)
Education	Higher	77 (83.7)
	Secondary	14 (15.2)
	Vocational	1 (1.1)
Socioeconomic status	Good	60 (65.2)
	Very good	18 (19.6)
	Sufficient	12 (13.0)
	Poor	2 (2.2)

The study population was predominantly young, educated, unmarried, and urban. This profile should be considered when interpreting the generalizability of the findings because older, married, rural, and less-educated women were underrepresented in the sample.

Clinical characteristics and treatment-related variables are summarized in Table 2. Nearly half of the participants had been diagnosed with PCOS within the previous 1–3 years (n=45, 48.9%). Symptom severity was most frequently reported as very bothersome (n=28, 30.4%), followed by bothersome (n=22, 23.9%) and moderately bothersome (n=21, 22.8%). Most participants were under the constant care of a gynecologist (n=66, 71.7%). Overall, 63 participants (68.5%) reported receiving treatment for PCOS-related symptoms, while 40 participants (43.5%) reported using hormonal contraception and 34 participants (37.0%) reported taking inositol.

Table 2. Clinical and Treatment-Related Characteristics of Women With PCOS

Variable	Category	n (%)
Duration since PCOS diagnosis	Up to 1 year	14 (15.2)
	1–3 years	45 (48.9)
	4–6 years	19 (20.7)
	Up to 10 years	5 (5.4)
	>10 years	9 (9.8)
Perceived symptom severity	Non-disruptive	9 (9.8)
	Little bothersome	12 (13.0)
	Moderately bothersome	21 (22.8)
	Bothersome	22 (23.9)
	Very bothersome	28 (30.4)
Constant care provider	Gynecologist	66 (71.7)
	Dietitian	11 (12.0)
	Dermatologist	11 (12.0)
	Psychologist	4 (4.3)
Receiving treatment for PCOS symptoms	Yes	63 (68.5)
	No	29 (31.5)
Hormonal contraception use	Yes	40 (43.5)
	No	52 (56.5)
Inositol use	Yes	34 (37.0)
	No	58 (63.0)

Most participants had relatively recent PCOS diagnoses and were receiving some form of clinical care, primarily from gynecologists. Psychological care was reported by only 4.3% of participants despite the high frequency of psychological symptoms reported later in the results.

Lifestyle, reproductive, psychosocial, and quality-of-life variables are presented in Table 3. Most participants rated their quality of life as good (n=65, 70.7%), while 8 participants (8.7%) rated it as very good, 12 (13.0%) as poor, and 7 (7.6%) as very bad. Family life was the most frequently affected life sphere (n=37, 40.2%), followed by social life (n=30, 32.6%). A total of 49 participants (53.3%) reported following some form of diet, and 56 (60.9%) reported physical activity at least three times per week. Sadness or anxiety due to PCOS was reported by 80 participants (87.0%), depression by 69 (75.0%), low self-esteem by 76 (82.6%), and lack of family support by 73 (79.3%).

Table 3. Lifestyle, Psychosocial, Reproductive, and Quality-of-Life Characteristics

Variable	Category	n (%)
Self-rated quality of life	Very good	8 (8.7)
	Good	65 (70.7)
	Poor	12 (13.0)
	Very bad	7 (7.6)
Sphere of life affected	Sexual	11 (12.0)
	Family	37 (40.2)
	Social	30 (32.6)
	Professional	14 (15.2)
Following any kind of diet	Yes	49 (53.3)
	No	43 (46.7)
Physical activity ≥3 times/week	Yes	56 (60.9)
	No	36 (39.1)
Having children	Yes	16 (17.4)
	No	76 (82.6)
PCOS affecting overall life	Yes	19 (20.7)
	No	73 (79.3)
Sadness/anxiety due to PCOS	Yes	80 (87.0)
	No	12 (13.0)
Lack of control over PCOS	Yes	64 (69.6)
	No	28 (30.4)
Depression	Yes	69 (75.0)
	No	23 (25.0)
Acceptance of appearance	Yes	76 (82.6)
	No	16 (17.4)
Low self-esteem due to PCOS	Yes	76 (82.6)
	No	16 (17.4)
Family support	Yes	19 (20.7)
	No	73 (79.3)
Symptom annoyance	Little bothersome	65 (70.7)
	Moderately bothersome	8 (8.7)
	Very bothersome	12 (13.0)
	Bothersome	7 (7.6)
Comorbid condition accompanying PCOS	Yes	43/90 (47.8)
	No	47/90 (52.2)
	Missing	2/92 (2.2)

Although most participants rated their overall quality of life as good or very good, high proportions reported sadness or anxiety, depression, low self-esteem, perceived lack of control, and inadequate family support. This pattern suggests that global self-rated quality of life and specific psychosocial burdens may not move in the same direction and should be interpreted as related but distinct patient-reported outcomes. The comorbidity variable had two missing responses, so its denominator was 90 rather than 92.

Associations between self-rated quality of life and clinical characteristics are shown in Table 4. Duration since PCOS diagnosis was not significantly associated with quality of life (p=0.34). Perceived symptom severity was also not significantly associated with quality of life (p=0.52), and comorbid conditions accompanying PCOS were not significantly associated with quality of life (p=0.21). Symptom annoyance showed a statistically significant association with quality of life (p<0.001), although the distribution demonstrated complete separation across categories and therefore requires verification for possible coding overlap or measurement redundancy.

The association between symptom annoyance and quality of life should be interpreted with caution because the cross-tabulation shows a one-to-one distribution between annoyance categories and quality-of-life categories. This pattern may reflect true strong association, but it may also indicate coding duplication, category misalignment, or a questionnaire structure in which symptom annoyance and quality-of-life rating are not independent measures. Verification against the original dataset and questionnaire coding is required before this finding can be interpreted clinically.

Table 4. Association of Quality of Life With Duration of PCOS, Symptom Burden, and Comorbidity

Variable	Category	Good n	Very Good n	Poor n	Very Bad n	Total n	p-value
Duration since PCOS diagnosis	<1 year	18	3	3	0	24	0.34
	1–3 years	24	3	5	4	36	
	4–6 years	13	0	4	2	19	
	7–10 years	6	0	0	1	7	
	≥11 years	4	2	0	0	6	
Symptom annoyance	Little bothersome	65	0	0	0	65	<0.001
	Moderately bothersome	0	8	0	0	8	
	Very bothersome	0	0	12	0	12	
	Bothersome	0	0	0	7	7	
Perceived symptom severity	Bothersome	18	1	3	0	22	0.52
	Moderately bothersome	11	3	4	3	21	
	Very bothersome	18	3	4	3	28	
	Little bothersome	11	0	1	0	12	
	Non-disruptive	7	1	0	1	9	
Comorbid condition accompanying PCOS	Yes	32	3	3	5	43	0.21
	No	31	5	9	2	47	

Associations between quality of life and treatment or lifestyle variables are shown in Table 5. Receiving treatment for PCOS-related symptoms was not significantly associated with quality of life (p=0.13). Hormonal contraception use, inositol use, and dietary practice were also not significantly associated with quality of life. Physical activity at least three times per week showed a statistically significant association with quality of life (p<0.001). Among physically active participants, 52 of 56 participants rated their quality of life as good or very good, compared with 21 of 36 participants who were not physically active.

Table 5. Association of Quality of Life With Treatment and Lifestyle Variables

Variable	Category	Good n	Very Good n	Poor n	Very Bad n	Total n	p-value
Receiving treatment for PCOS symptoms	Yes	49	5	6	3	63	0.13
	No	16	3	6	4	29	
Hormonal contraception use	Yes	32	1	4	3	40	0.21
	No	33	7	8	4	52	
Inositol use	Yes	28	2	3	1	34	0.28
	No	37	6	9	6	58	
Following any kind of diet	Yes	40	3	3	3	49	0.08
	No	25	5	9	4	43	
Physical activity ≥3 times/week	Yes	49	3	3	1	56	<0.001
	No	16	5	9	6	36	

Physical activity was the only lifestyle or treatment-related variable with a reported statistically significant association with quality of life. However, because the study design was cross-sectional, the finding should be interpreted as an association only. The data do not establish whether physical activity improved quality of life, whether women with better quality of life were more likely to remain physically active, or whether both were influenced by other unmeasured factors.

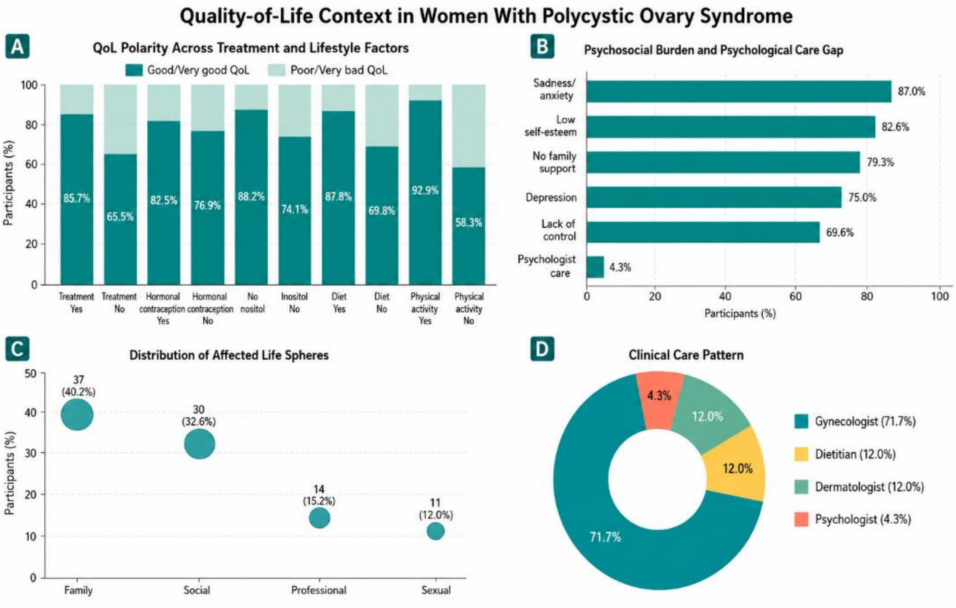
Associations between quality of life and reproductive, psychological, and social variables are presented in Table 6. Having children was not significantly associated with quality of life (p=0.39). Sadness or anxiety due to PCOS and perceived lack of control were also not statistically significant in the reported analysis. The perceived effect of PCOS on overall life, depression, appearance acceptance, low self-esteem, and family support were reported as significantly associated with quality of life (p<0.001). However, several distributions in this table are directionally inconsistent with the narrative interpretation and require coding verification.

The reported association between perceived overall life impact and quality of life is directionally coherent: all participants who reported that PCOS affected their life rated their quality of life as poor or very bad, while those who reported no overall life effect rated their quality of life as good or very good. Appearance acceptance also showed a plausible pattern, with most participants who accepted their appearance reporting good or very good quality of life. However, the distributions for depression, low self-esteem, and family support appear inconsistent with expected clinical direction and with the manuscript narrative.

Table 6. Association of Quality of Life with Reproductive, Psychological, and Social Variables

Variable	Category	Good n	Very Good n	Poor n	Very Bad n	Total n	p-value
Having children	Yes	11	3	1	1	16	0.39
	No	54	5	11	6	76	
PCOS affecting overall life	Yes	0	0	12	7	19	<0.001
	No	65	8	0	0	73	
Sadness/anxiety due to PCOS	Yes	56	5	12	7	80	0.06
	No	9	3	0	0	12	
Lack of control over PCOS	Yes	45	5	8	6	64	0.77
	No	20	3	4	1	28	
Depression	Yes	55	7	6	1	69	<0.001
	No	10	1	6	6	23	
Acceptance of appearance	Yes	65	8	3	0	76	<0.001
	No	0	0	9	7	16	
Low self-esteem due to PCOS	Yes	65	8	3	0	76	<0.001
	No	0	0	9	7	16	
Family support	Yes	0	0	12	7	19	<0.001
	No	65	8	0	0	73	

For example, participants reporting depression and low self-esteem were more frequently distributed in the good or very good quality-of-life categories, while all participants reporting family support were distributed in the poor or very bad quality-of-life categories. These patterns suggest possible reversed coding or data-entry error and should be verified before final interpretation.



QoL = quality of life; PCOS = polycystic ovary syndrome.

Figure 1 Quality-of-life context among women with polycystic ovary syndrome. Panel A shows the proportion of participants reporting good/very good versus poor/very bad quality of life across treatment and lifestyle factors. Panel B demonstrates the contrast between high psychosocial burden and low psychological care uptake, with sadness/anxiety reported by 87.0%, low self-esteem by 82.6%, lack of family support by 79.3%, depression by 75.0%, and psychologist care by only 4.3% of participants. Panel C presents the distribution of affected life spheres, with family life most frequently affected at 40.2%, followed by social life at 32.6%. Panel D shows the clinical care pattern, where gynecologist care predominated at 71.7%, while psychologist involvement remained limited. Percentages were derived from reported aggregate counts in the manuscript.

DISCUSSION

This cross-sectional study evaluated quality of life among women diagnosed with polycystic ovary syndrome and explored its association with clinical, treatment-related, lifestyle, psychological, and social factors. Most participants rated their overall quality of life as good or very good; however, a substantial proportion also reported sadness or anxiety, depression, low self-esteem, lack of perceived control, and inadequate family support. This pattern indicates that global self-rated quality of life may remain favorable in some participants despite meaningful psychosocial burden, and therefore quality-of-life assessment in PCOS should not be limited to a single global question. A multidimensional approach is particularly important because PCOS affects reproductive health, physical appearance, emotional well-being, social functioning, and perceived control over health, all of which may influence the patient's lived experience.

The predominance of younger participants in this study is clinically relevant because PCOS commonly presents during adolescence and early reproductive age, when menstrual irregularity, acne, hirsutism, weight concerns, and fertility-related uncertainty may strongly influence body image and self-esteem. Earlier epidemiological and clinical literature has consistently described PCOS as a common endocrine disorder among women of reproductive age, with variable reproductive and metabolic manifestations (5,6). In the present study, nearly half of the participants reported diagnosis within the preceding 1–3 years. This finding should be interpreted as the diagnostic profile of the sampled participants rather than evidence of increasing disease incidence, because the cross-sectional design does not permit temporal trend estimation.

The findings also emphasize the psychosocial dimension of PCOS. High frequencies of sadness or anxiety, depression, low self-esteem, and perceived lack of control were reported, supporting previous evidence that women with PCOS may experience psychological distress in addition to reproductive and metabolic symptoms. Prior studies have reported associations between PCOS and depression, anxiety, impaired body image, sexual dysfunction, and reduced health-related quality of life (7–9). In clinical practice, these symptoms may be under-recognized when consultation focuses primarily on menstrual regulation, fertility concerns, or metabolic management. The low proportion of participants receiving psychological care in this study, despite high self-reported emotional burden, suggests a gap between psychosocial need and service utilization.

Physical activity was significantly associated with better self-rated quality of life in the reported analysis. Participants who reported physical activity at least three times per week more frequently rated their quality of life as good or very good than those who were not physically active. This finding is consistent with previous evidence suggesting that lifestyle behaviors, weight management, and reduction of androgenic or metabolic symptoms may improve perceived well-being among women with PCOS (3,4). However, the present study cannot establish whether physical activity improved quality of life, whether women with better quality of life were more likely to engage in physical activity, or whether both were influenced by unmeasured factors such as symptom severity, body mass index, treatment adherence, social support, or motivation. Therefore, this association should be interpreted cautiously and should not be framed as causal.

Treatment-related variables, including receiving treatment for PCOS symptoms, hormonal contraception use, inositol use, and dietary practice, were not significantly associated with quality of life in the reported analysis. This may reflect heterogeneity in treatment duration, treatment indication, adherence, symptom profile, patient expectations, or treatment response. It is also possible that treatment status alone is too broad to capture meaningful clinical improvement, because different participants may have received different therapies for different symptoms. Future studies should record treatment type, duration, adherence, clinical response, body mass index, metabolic status, menstrual regularity, hirsutism score, acne severity, fertility concerns, and validated quality-of-life domain scores to better explain treatment-related differences.

The study also found that family and social spheres were frequently affected. Family life was the most commonly reported affected domain, followed by social life, professional life, and sexual life. This finding is important in settings where family expectations, marital prospects, fertility-related concerns, and appearance-related symptoms may influence how women perceive and disclose PCOS. Previous research has shown that hirsutism, infertility concerns, body dissatisfaction, and perceived femininity may substantially affect health-related quality of life in women with PCOS (10,11). Therefore, clinical counseling should include discussion of emotional well-being, body image, social functioning, and family support rather than focusing only on biomedical management.

Some reported association patterns require cautious interpretation because several cross-tabulations appear directionally inconsistent with expected clinical patterns and with the manuscript narrative. In particular, the reported distributions for depression, low self-esteem, and family support may reflect possible reversed coding, category misclassification, or data-entry error. For example, the tabled results suggested that participants reporting depression or low self-esteem were frequently distributed in favorable quality-of-life categories, while participants reporting family support were distributed in unfavorable quality-of-life categories. These findings should be verified against the original coded dataset before being interpreted clinically. Until coding is confirmed, the manuscript should report these associations descriptively and avoid definitive statements that depression, low self-esteem, or lack of support independently lowered quality of life in this sample.

This study has several limitations. First, the cross-sectional design restricts causal inference and prevents assessment of temporal relationships between lifestyle, treatment, psychological factors, and quality of life. Second, the use of non-probability sampling and recruitment from selected hospital settings may limit generalizability to all women with PCOS in the wider community. Third, the study population was predominantly young, urban, educated, and unmarried, which may underrepresent older, rural, married, less-educated, or socioeconomically disadvantaged women. Fourth, the manuscript does not clearly report the diagnostic criteria used to confirm PCOS or the name and scoring method of the quality-of-life questionnaire. Fifth, several variables were self-reported, including depression, anxiety, self-esteem, and family support, without evidence of validated psychological screening tools. Finally, selected statistical associations require coding verification before final interpretation.

Despite these limitations, the study highlights an important clinical issue: women with PCOS may report acceptable overall quality of life while simultaneously experiencing substantial psychological and social burden. This supports the need for integrated PCOS care that includes gynecological management, lifestyle counseling, psychological screening, body-image support, and family-centered education where appropriate. Future research should use validated PCOS-specific quality-of-life instruments, standardized diagnostic criteria, larger multicenter samples, and multivariable analysis to identify independent predictors of impaired quality of life among women with PCOS.

CONCLUSION

Most women with polycystic ovary syndrome in this study rated their overall quality of life as good or very good, but high proportions reported sadness or anxiety, depression, low self-esteem, perceived lack of control, and limited family support, indicating that global quality-of-life ratings may not fully capture the psychosocial burden of PCOS. Physical activity was significantly associated with more favorable quality-of-life ratings, while treatment status, hormonal contraception use, inositol use, and dietary practice were not significantly associated with quality of life in the reported analysis. Because the study was cross-sectional, these findings should be interpreted as associations rather than causal effects. Selected psychosocial associations, particularly those involving depression, low self-esteem, and family support, require verification against the original coded dataset before definitive interpretation. Overall, the findings support the need for patient-centered PCOS care that integrates gynecological treatment with lifestyle counseling, psychological screening, and social support.

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