The definition of polycystic ovary syndrome (PCOS) is initially represented as oligo/amenorrhoea, hirsutism, fat and enlarged ovaries with multiple cysts and thickened tunica by Stein and Leventhal in 1935. The first diagnosing of PCOS was utterly supported look on histologic examination of bilateral ovaries with thickened stroma i.e. polycystic ovaries (PCO), in girls presenting with hairiness, anovulation or both.

Within the 1970s the introduction of immunochemical assay techniques as histologic diagnosing, serum biochemical markers characteristic of PCOS, elevated concentrations of luteinizing hormone (LH), androgen (T) and/or androstenedione (A), low or traditional levels of follicle stimulating hormone (FSH), and attenuated hormone binding simple protein (SHBG) became different diagnosing techniques. PCOS could be a common pathology effecting 4–8 percent of ladies of reproductive age as estimated by the NIH/NICHD criteria. Many studies have shown that its prevalence differs according to the applied diagnostic criteria. The Rotterdam criteria showed 2–3 times more prevalence than obtained using the NIH/NICHD criteria. The main pathophysiology of PCOS remains unknown however; the key options embrace hormone resistance, abnormal gonadotrophic hormone dynamics and sex hormone excess.

In distinction to insulin resistance, about 60 to 70% of ladies with PCOS are weighty, and fat is related to insulin resistance. Girls with PCOS have higher insulin resistance as compared that of weighty girls within the general
Insulin response to associate oral glucose challenge was notably higher in patients with PCOS than in weighty management subjects while not polycystic ovary syndrome. Dunaif et al. conjointly found higher insulin resistance of patients with PCOS compared with management subjects was true for each lean and weighty patients with PCOs. PCOS conjointly happens in 50% of ladies with not severe growth of unneeded hair. Skin disease is a smaller amount prevailing in PCOS and not as frequent as hairiness however it may also be a marker of hyperandrogenism. Around 15%–30% of adult girls with PCOS have clinical presentation of acne.

The distinction in prevalence of skin disease and hairiness is also thanks to the distinction in 5 reductase action within the sebaceous gland and also the hair follicle (almost 40% dihydrotestosterone), of ladies with skin issue and acne were diagnosed with PCOS. It’s advocate to raise regarding emission history of ladies presenting with acne a nd evaluated for the opposite signs of hyperandrogenism. There are 40% of ladies with PCOS were suffering from infertility. An ovulatory infertility condition is usually caused by PCOS. In females with PCOS the varieties of primeval follicles are normal however primary and secondary follicles are multiplied in number but, thanks to disorientation in factors affecting normal follicular development, follicular growth restricts as follicles grow to 4–8 millimetre, and ovulation doesn’t begin as dominant follicles doesn’t develop.

Abortion conjointly happens often in PCOS with incidences starting from 42%–73%. The adoption of an authentic approach to characterize the morphology of the polycystic ovary is required for PCOS diagnosis using the Rotterdam and AES criteria. The Rotterdam criteria advocated the presence of ≥12 follicles measuring 2-9 mm in diameter and of volume ≥10 cm3 for polycystic ovarian morphology. This description is sufficient to characterize the polycystic ovary. However, with the passage of time, ultrasound technology have made significant advancements, latest ultrasound technology has better resolution and smaller follicles are easily detectable. These advancement prompted concerns revising the factors to outline polycystic female internal reproductive organ morphology. Allemand et al. conducted a study using 3D TVS to assess the mean follicle number per ovary (FNPO). This study involved more number of follicles in 10 patients with PCOs and 29 normoandrogenic ovulatory in control. PCO is regarded when mean FNPO is more than 20.1, with specificity and sensitivity of 100% and 70% respectively. Ovarian volume assessed by 2D TVS, of more than 13 cm3 is expected as PCO with a specificity and a sensitivity of 100 and 50%, respectively.

**METHODS:**
A literature search was performed with the use of search engines. The following search engines provided the articles for this systematic review, PubMed, Medscape, NCBI, and Google Scholar. For article searching following keywords were used; Polycystic ovaries, obese and non-obese. After performing unbiased searching on databases only those articles were included using keywords polycystic ovaries, obese and non-obese. Only those articles were included in which patients was suffering polycystic ovaries in the population of female. Researches were assessed for quality as well as applicability. Extraction of data was done from full journal articles. Raw data were used for summary statistics if they were not reported.

**RESULTS:**
As literature reviewed of 30 articles and only 39 were included in this review, it is found that Mean age of all subjects was 24–35 year. Obese 20–29 year and non-obese 19–35 year. Hirsutism was observed mostly in obese patient of PCOs and not observed in non-obese. Incidence of Amenorrhea was higher in non-obese than obese patients. Acne was observed in all patients.

**DISCUSSION:**
As literature reviewed of 30 articles and only 39 were included in this review, it is found that Mean age of all subjects was 24–35 year. Obese 20–29 year and non-obese 19–35 year. Hirsutism was observed mostly in obese.
patient of PCOs and not observed in non-obese. Incidence of Amenorrhea was higher in non-obese than obese patients. Acne was observed in all patients. Several researchers and clinicians used multiple definitions for polycystic ovarian syndrome, which cause unpredictability and uncertainty in inconsisteny around the diagnosis, pathogenesis and management of the disease. Many researches have shown that Rotterdam criteria enhances the likelihood of detecting PCOS. Analytical parameters for grading polycystic ovary be of practical value as it helps in increasing the frequency of diagnosis. This study introduced easy to use analytical parameters for ovarian dysfunction such as cycle length more than 35 days, less than 9 menstrual cycles per year or correlation amenorrhea with hormonal and metabolic parameters of polycystic ovary syndrome. But also this irregularity does not mean ovulatory dysfunction. Using ultrasonography as the conventional diagnostic tool may be perplexing, as polycystic ovarian appearance is a typical finding of ovulation problems and has nothing to do with PCOs. Jonard et al. in his study stated that ovarian volume is a useful diagnostic parameter for diagnosis of PCOS. Although ovarian volume is useful in determining the extent of cycle disruption, sonographic criteria are dependent on the operator’s experience and may result in discrepancies in results. In 1925 to 1935 Stein and Leventhal found a relation between the presence of bilateral polycystic ovaries and signs of oligomenorrhea, amenorrhea, hirsutism, acne and obesity. With numerous researches it is now said that women can have polycystic ovaries in the absence of one or two mentioned features of hirsutism, obesity, menstrual irregularity or anovulation. In fatty women with PCOS the incidence of acne, hirsutism, obesity, menstrual irregularity or anovulation problems and has nothing to do with PCOs. In a study conducted by CB bunker et al 150 women were recruited and 98 of them were scanned for PCOS out of these 98 women 69 women were diagnosed for PCOS. 70% of women with acne have polycystic ovaries on ultrasound but do not have any remarkable relation with the other features of the PCOS. In our study all subjects had acne. Since we concluded that all women with acne should be evaluated for polycystic ovaries.

**CONCLUSION:**

It is concluded that there is a significant effect of obesity on clinical features of patients with PCOS.

**REFERENCES:**

[1] Taylor, A.E. Understanding the Underlying Metabolic Abnormalities of Polycystic Ovary Syndrome and Their Implications. Am.J.Obstet.Gynecol. 1998; 179: S94–S100.

[2] Goldzieher, J.W. & Green, J.A. The Polycystic Ovary: Clinical and Histological Features. J Clin Endocrinol Metab 1962; 22: 325–338.

[3] Conway, G.S., Honour, J.W., & Jacobs, H.S. Heterogeneity of the Polycystic Ovary Syndrome: Clinical, Endocrine and Ultrasound Features in 556 Patients. Clin.Endocrinol. (Oxf.)1989; 30: 458-470.

[4] Azziz R, Woods KS, Reyna R, Key TJ, Knochenhauer ES, Yildiz BO. The Prevalence And Features Of The Polycystic Ovary Syndrome In An Unselected Population. J Clin Endocrinol Metab. 2004;89:2745–2749.

[5] Diamanti-Kandarakis E, Kouli CR, Bergiele AT, Et Al. A Survey Of The Polycystic Ovary Syndrome In The Greek Island Of Lesbos: Hormonal And Metabolic Profile. J Clin Endocrinol Metab.1999;84: 4006–4011.

[6] Knochenhauer ES, Key TJ, Kahsar-Miller M, Waggoner W, Boots LR, Azziz R. Prevalence Of The Polycystic Ovary Syndrome In Unselected Black And White Women Of The Southeastern United States: A Prospective Study. J Clin Endocrinol Metab. 1998;83:3078–3082.

[7] Michelmore KF, Balen AH, Dunger DB, Vessey MP. Polycystic Ovaries And Associated Clinical And Biochemical Features In Young Women. Clin Endocrinol(Oxf). 1999;51:779–786.

[8] Asuncion M, Calvo RM, San Millan JL, Sancho J, Avila S, Escobarmorreale HF. A Prospective Study Of The Prevalence Of The Polycystic Ovary Syndrome In Unselected Caucasian Women From Spain. J Clin Endocrinol Metab. 2000;85:2434–2438.

[9] March WA, Moore VM, Willson KJ, Phillips DI, Norman RJ, Davies MJ. The Prevalence Of Polycystic Ovary Syndrome In A Community Sample Assessed Under Contrasting Diagnostic Criteria. Hum Reprod. 2010;25(2): 544–551.

[10] Mehrabian F, Khani B, Kelishadi R, Ghanbari E. The Prevalence Of Polycystic Ovary Syndrome In Iranian Women Based On Different Diagnostic Criteria. Endokrynol Pol. 2011;62(3):238–242.

[11] Tehrani FR, Simbar M, Tohidi M, Hoseinpanah F, Azizi F, The Prevalence Of Polycystic Ovary Syndrome In A
Community Sample Of Iranian Population: Iranian PCOS Prevalence Study. Reprod Biol Endocrinol. 2011;9:39.

[12] Yildiz BO, Bozdag G, Yapici Z, Esinler I, Yarali H. Prevalence, Phenotype And Cardiometabolic Risk Of Polycystic Ovary Syndrome Under Different Diagnostic Criteria. Hum Reprod. 2012;27(10):3067–3073.

Chang RJ, Nakamura RM, Judd HL, Kaplan SA. Insulin Resistance In Nonobese Patients With Polycystic Ovarian Disease. J Clin Endocrinol Metab 1983;57:356-9.

Dunaif A, Segal KR, Futterweitz W, Drobrjansky A. Profound Peripheral Insulin Resistance, Independent Of Obesity, In Polycystic Ovary Syndrome. Diabetes 1989;38:1165-74.

[14] Alila Medical Media/Shutterstock

Souter I, Sanchez L, Perez M, Bartolucci A, Azziz R. The Prevalence Of Androgen Excess Among Patients With Minimal Unwanted Hair Growth. Am J Obstet Gynecol. 2004;191:1914–1920.

[15] Otten MW, Otten MW, Otten MW.

Azziz R, Sanchez L, Knochenhauer ES, Et Al. Androgen Excess In Women: Experience With Over 1000 Consecutive Patients. J Clin Endocrinol Metab. 2004;89(2):453–462.

[16] Souter I, Sanchez L, Perez M, Bartolucci A, Azziz R. The Prevalence Of Androgen Excess Among Patients With Minimal Unwanted Hair Growth. Am J Obstet Gynecol. 2004;191:1914–1920.

[17] Azziz R, Sanchez L, Knochenhauer ES, Et Al. Androgen Excess In Women: Experience With Over 1000 Consecutive Patients. J Clin Endocrinol Metab. 2004;89(2):453–462.

Fauzer B, Tarlatzis B, Rebar R, Et Al. Consensus On Women's Health Aspects Of Polycystic Ovary Syndrome (PCOS): The Amsterdam ESHRE/ASRM-Sponsored 3rd PCOS Consensus Workshop Group. FertilSteril. 2012;97(1):28–38. E25.

[18] Ferriman D, Gallwey J. Clinical Assessment Of Body Hair Growth In Women. J Clin Endocrinol Metab. 1961;21:1440–1447.

[19] Unluhizarci K, Kaltsas G, Kelestimur F. Non Polycystic Ovary Syndrome-Related Endocrine Disorders Associated With Hirsutism. Eur J Clin Invest. 2012;42(1):86–94.

[20] Adams J, Polson D, Franks S. Prevalence Of Polycystic Ovaries In Women With Anovulation And Idiopathic Hirsutism. Br Med J (Clin Res Ed). 1986;293(6543):355–359.

[21] Wijeyaratne CN, Balen AH, Barth JH, Belchetz PE. Clinical Manifestations And Insulin Resistance (IR) In Polycystic Ovary Syndrome (PCOS) Among South Asians And Caucasians: Is There A Difference? Clin Endocrinol (Oxf). 2002;57:343–350.

[22] Eden J. The Polycystic Ovary Syndrome Presenting As Resistant Acne Successfully Treated With Cyproterone Acetate. Med J Aust. 1991;155(10):677–680.

[23] Teede H, Deeks A, Moran L. Polycystic Ovary Syndrome: A Complex Condition With Psychological, Reproductive And Metabolic Manifestations That Impacts On Health Across The Lifespan. BMC Med. 2010;8:41.

[24] Brussard M, Ainemelk Y, Baillargeon JP. Basic Infertility Including Polycystic Ovary Syndrome. Med Clin North Am. 2008;92:1163–1192.

[25] Glueck C, Phillips H, Cameron D, Sieve-Smith L, Wang P. Continuing Metformin Throughout Pregnancy In Women With Polycystic Ovary Syndrome Appears To Safely Reduce First-Trimester Spontaneous Abortion: A Pilot Study. FertilSteril. 2001;75(1):46–52.

[26] Jakubowicz DJ, Luorno MJ, Jakubowicz S, Roberts K, Nestler JE. Effects Of Metformin On Early Pregnancy Loss In The Polycystic Ovary Syndrome. J Clin Endocrinol Metab. 2002;87(2):524–529.

[27] Rotterdam ESHRE/ASRM-Sponsored PCOS Consensus Workshop Group. Revised 2003 Consensus On Diagnostic Criteria And Longterm Health Risks Related To Polycystic Ovary Syndrome. FertilSteril. 2004;81:19–25.

[28] Lujan ME, Jarrett BY, Brooks ED, Et Al. Updated Ultrasound Criteria For Polycystic Ovary Syndrome: Reliable Thresholds For Elevated Follicle Population And Ovarian Volume. Hum Reprod. 2013;28(5):1361–1368.

[29] Dewailly D, Gronier H, Poncelet D, Et Al. Diagnosis Of Polycystic Ovary Syndrome (PCOS): Revisiting The Threshold Values Of Follicle Count On Ultrasound And Of The Serum AMH Level For The Definition Of Polycystic Ovaries. Hum Reprod. 2011;28(11):3123–3129.

[30] Allemand MC, Tummon IS, Phy JL, Foong SC, Dumescia DA, Session DR. Diagnosis Of Polycystic Ovaries By Three-Dimensional Transvaginal Ultrasound. FertilSteril. 2006;85(1):214–219.

[31] Ajossa S, Guerriero S, Paoletti AM, et al. Uterine perfusion and hormonal pattern in patients with polycystic ovary syndrome. J Assist Reprod Genet 2001;18:436.

[32] Cussons AJ, Stuckey BG, Walsh JP, Burke V, Norman RJ. Polycystic ovarian syndrome: marked differences between endocrinologists and gynaecologists in diagnosis and management. Clin Endocrinol(Oxf)2005;62(March (3)):289–95. 35. Polson DW, Adams J, Wadsworth J, Franks S.

[33] Polycystic ovaries—a common finding in normal...
[36] Rasool et al., Polycystic ovaries & obesity women. Lancet 1988;1(April(8590)):870–2. Jonard S, Robert Y, Dewailly D. Revisiting the ovarian volume as a diagnostic criterion for polycystic ovaries. Hum Reprod 2005;20(October(10)):2893–8.

[37] Stein IF, Leventhal ML (1935): Amenorrhea associated with bilateral polycystic ovaries. Am J Obstet Gynecol, 29:181-91.

[38] Siddiqui, I.A., Tamimi, W., Tamim, H. et al. A study on clinical and sonographic features in obese and nonobese patients with polycystic ovary syndrome. Arch Gynecol Obstet 281, 467–471 (2010). https://doi.org/10.1007/s00404-009-1124-y

[39] Goldzieher JW, Zereg GS (1985): Polycystic ovarian disease in clinical reproductive endocrinology. Sherman RP, 406.

[40] Gambineri A, Pelusi C, Vicennati V, Pagotto U (2002): Obesity and polycystic ovary syndrome. Int J Obes Relat Metab Disord, 26:883-96.

[41] Cosar E, Koken G, Sahin FK, Arioz DT & Yilmazer M. Insulin sensitivity does not differentiate by hirsutism in non-obese women with polycystic ovary syndrome. Endocrine Journal 2008 55 465–468.