PMOS Survey for Clinicians — iGEM Lund
The "" Marks mandatory questions.*

About the Survey
This survey is run by iGEM Lund 2026, a student research project at Lund University, to better understand clinical perspectives and treatment practices for PMOS (formerly PCOS). At the end of the survey, we may also invite you to take part in an optional follow-up conversation about your clinical experience with PMOS. This is entirely optional and separate from the survey itself.
This survey takes approximately 10–15 minutes to complete (17 questions).

Eligibility check

- ☐ I confirm that I currently treat or have treated patients with PMOS/PCOS in a clinical capacity (**mandatory**).*

Your data and privacy
Participation is voluntary, your answers will be kept confidential, and you can withdraw at any time without giving a reason.
Read our full privacy notice here *[Expandable privacy notice]*

- ☐ I have read the privacy notice and give my consent to the processing of my personal data as described above (**mandatory**).*
- ☐ Optional: I agree that anonymized quotes from my open-text answers may be shared publicly on our project website (**optional**).

Section 1 – Background
1. What is your clinical role?*

- ☐ General practitioner / family physician
- ☐ Gynaecologist
- ☐ Endocrinologist
- ☐ Reproductive medicine specialist
- ☐ Dietitian or nutritionist with PMOS specialization
- ☐ Other (please specify) _____

2. Approximately how many PMOS patients do you see per month?*

- ☐ Fewer than 5
- ☐ 5–15
- ☐ 16–30
- ☐ More than 30

3. How many years have you been treating patients with PMOS?*

- ☐ Less than 2 years
- ☐ 2–5 years
- ☐ 6–10 years
- ☐ More than 10 years

Section 2 – Current treatment practices

4. Which treatments do you most commonly prescribe or recommend for PMOS? Select all that apply.*

- ☐ Combined oral contraceptive pill
- ☐ Progestogen-only treatment
- ☐ Spironolactone or other anti-androgens
- ☐ Metformin
- ☐ Clomiphene or other ovulation induction agents
- ☐ Inositol supplementation
- ☐ Lifestyle modification (diet, exercise)
- ☐ Other (please specify) _____

5. In your practice, would you say your primary treatment goal is typically to address the underlying cause of PMOS or to manage symptoms?*

- ☐ Primarily addressing underlying cause (e.g. insulin resistance, LH/FSH dysregulation)
- ☐ Primarily managing symptoms (e.g. acne, hirsutism, cycle irregularity)
- ☐ Both equally, depending on the patient
- ☐ It varies
- ☐ Other (please specify) _____

6. When prescribing treatment, do you typically distinguish between PMOS subtypes?*
e.g. hyperandrogenic PMOS (HA-PMOS), Overweight-obesity phenotype (OB-PMOS), High level of sex hormone-binding globulin (SHBG-PMOS), Elevated luteinizing hormone and antimüllerian hormone, AMH (LH-PMOS)

- ☐ Yes, routinely
- ☐ Sometimes, when clearly identifiable
- ☐ Rarely, not always practical
- ☐ No, treat based on presenting symptoms

7. What are your biggest frustrations with current PMOS treatment options? Select all that apply.*

- ☐ Side effects of hormonal treatments (e.g. mood changes, weight gain, reduced libido)
- ☐ Patient non-compliance or reluctance
- ☐ Treatments manage symptoms but do not address the root cause
- ☐ Limited options for patients who cannot or will not use hormonal therapy
- ☐ Insufficient evidence base for many commonly used treatments
- ☐ Difficulty distinguishing subtypes clinically
- ☐ Patient dissatisfaction with outcomes
- ☐ Other (please specify) _____

8. How often do patients report dissatisfaction with or discontinue hormonal treatments?*

- ☐ Never
- ☐ Rarely
- ☐ Moderate frequency
- ☐ Frequently
- ☐ Almost always

Section 3 – Attitudes toward a novel approach

Current PMOS/PCOS treatment options, hormonal contraceptives, anti-androgens such as spironolactone, metformin, don't work for or aren't tolerated by all patients.

Hyperandrogenism, elevated androgen levels, is a feature of three of the four recognized PCOS/PMOS phenotypes. Recent research links androgen levels to the gut: once excreted there, androgens can be reactivated by gut bacteria and recirculated back into the bloodstream.

The remaining questions are about a **hypothetical product** that does **not exist yet**: a daily oral probiotic tablet containing a genetically engineered, living bacterium, without synthetic hormones. The bacterium would only express its active **enzyme**, a 5β-reductase, under gut-like conditions and when androgen levels are above a certain threshold, so it stays inactive elsewhere in the body and only acts when needed.

Once active, the enzyme **lowers androgen activity in the gut,** reducing how much active androgens get recirculated back into the bloodstream, with the aim of lowering androgen levels systemically and reducing hyperandrogenism symptoms specifically.

9. What is your initial clinical reaction to this treatment concept?*

- ☐ Promising
- ☐ Interesting but uncertain, need data
- ☐ Skeptical
- ☐ Not relevant to my practice
- ☐ Other (please specify) _____

10. How would you view this product in the context of your current treatment options?*

- ☐ First-line alternative to hormonal treatment
- ☐ Adjunct to existing hormonal treatment
- ☐ Last resort
- ☐ Would not consider prescribing
- ☐ Other (please specify) _____

11. What would be your primary safety or clinical concerns? Select all that apply.*

- ☐ Long-term safety of a live engineered bacterial strain
- ☐ Risk of horizontal gene transfer or unintended ecological effects
- ☐ Unpredictable colonisation or persistence in the gut
- ☐ Insufficient reduction in systemic androgen levels
- ☐ Patient acceptance of a genetically engineered organism
- ☐ Regulatory and approval pathway uncertainty
- ☐ Lack of clinical trial data
- ☐ No significant concerns at this stage
- ☐ Other (please specify) _____

This approach reduces androgen symptoms rather than addressing root hormonal dysregulation. How significant a concern is this to you clinically?*

- ☐ Not a concern
- ☐ Minor concern
- ☐ Moderate concern
- ☐ Serious concern
- ☐ Major concern

13. In your experience, how open are your patients to non-hormonal or microbiome-based treatments?*

- ☐ Very open
- ☐ Somewhat open
- ☐ Neutral/mixed
- ☐ Somewhat reluctant
- ☐ Largely reluctant

14. If safety and efficacy were demonstrated in clinical trials, how likely would you be to consider prescribing this product?*

1 = very unlikely, 5 = very likely

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5

15. If this treatment were significantly more expensive than existing hormonal treatments and not covered by insurance or public healthcare, how would that affect your willingness to recommend it?*

- ☐ Would still recommend regardless of cost
- ☐ Only for patients who could afford it comfortably
- ☐ Hesitant if it creates financial burden
- ☐ Major barrier
- ☐ Unsure/depends on system

Section 4 – Open response (optional)

Please avoid including specific patient names, colleague names, or clinic names in your written answers below.

16. What evidence or data would you most need to see before considering this product clinically viable? Your answer__

17. Is there anything else you would like to share about unmet needs in PMOS treatment, or about this product concept? Your answer__

Thank you for completing this survey. As agreed at the start, your anonymized responses will be used for this research project.

Interested in sharing more? We are looking for clinicians to participate in a 15–30 minute online interview to share their experiences treating patients with PMOS. Learning about the challenges of treating this condition are vital for our project's success. If you are interested, you can contact us at information@igemlund.org.

Any questions? Contact us at: information@igemlund.org