Shaving does not affect the rate or duration of the anagen phase or diameter of hair. However, it yields a blunt tip rather than the tapered tip of uncut hair, which gives the illusion of thicker hair. Chemical depilatory agents are also commonly used to dissolve the hair. Most depilatories contain sulfur and have an unpleasant odor. In addition, irritant dermatitis can occur. Epilation methods, such as plucking or waxing, are relatively safe and inexpensive, but cause some discomfort. These methods do not cause an increase in hair diameter. Scarring, folliculitis, and hyperpigmentation (particularly in women of color) may occur. Although not a method of hair removal, bleaching with products containing hydrogen peroxide and sulfates is a method for masking the presence of undesired hair, particularly facial hair. Side effects include irritation, pruritus, and possible skin discoloration.

In addition to cosmetic and/or pharmacologic therapy, lifestyle changes for obese women with PCOS may improve their hirsutism. In a meta-analysis of four studies that included 132 subjects, lifestyle changes (diet, exercise, behavioral, or combination therapy) resulted in weight loss, a decrease in serum testosterone and fasting insulin concentrations, and a small improvement in Ferriman–Gallwey scores when compared with minimal or no treatment—mean difference, −1.19 [95% confidence interval (CI) (−2.35 to −0.03)] (49). However, lifestyle changes should not be considered a primary therapy for hirsutism, as their impact is not clinically significant, particularly when compared with OCs (50). Our approach is consistent with the Endocrine Society clinical guidelines on the diagnosis and treatment of PCOS (40).

3.0 Pharmacological Treatments

Initial therapies

3.1. For the majority of women with hirsutism who are not seeking fertility, we suggest OCs as initial therapy for treating patient-important hirsutism. (2 |⊕⊕OO)

3.2. For most women with hirsutism, we suggest against antiandrogen monotherapy as initial therapy (because of the teratogenic potential of these medications) unless these women use adequate contraception (2 |⊕OOO). However, for women who are not sexually active, have undergone permanent sterilization, or who are using long-acting reversible contraception, we suggest using either OCs or antiandrogens as initial therapy (2 |⊕OOO). The choice between these options depends on patient preferences regarding efficacy, side effects, and cost.

3.3. For most women, we do not suggest one OC over another as initial therapy, as all OCs appear to be equally effective for hirsutism, and the risk of side effects is low. (2 |⊕⊕OO)

3.4. For women with hirsutism at higher risk for VTE (*e.g.*, those who are obese or over age 39 years), we suggest initial therapy with an OC containing the lowest effective dose of ethinyl estradiol (EE) (usually 20 mcg) and a low-risk progestin (Table 2). (2 |⊕OOO)

3.5. If patient-important hirsutism remains despite 6 months of monotherapy with an OC, we suggest adding an antiandrogen. (2 |⊕⊕OO)

3.6. We do not suggest one antiandrogen over another (2 |⊕⊕OO). However, we recommend against the use of flutamide because of its potential hepatotoxicity. (1 |⊕⊕OO)

3.7. For all pharmacologic therapies for hirsutism, we suggest a trial of at least 6 months before making changes in dose, switching to a new medication, or adding medication. (2 |⊕OOO)

3.8. In patients with severe hirsutism causing emotional distress and/or in those women who have used OCs in the past and have not experienced

Table 2. OCs and Associated VTE Risks

Progestin Generation	Progestin Relative Androgenicity	Progestin Relative VTE Risk[a,b]	Progestin Absolute VTE Risk[b,c]	Progestin/Dose	EE Dose (mcg)
1	Medium	2.6	7	Norethindrone 0.5–1.0 mg	20, 35
2	High	2.4	6	Levonorgestrel 0.15 mg	20, 30
2–3	Low	2.5	6	Norgestimate 0.25 mg	35
3	Low	3.6	11	Gestodene 0.075 mg	20, 30
3	Low	4.3	14	Desogestrel 0.15 mg	20, 30
4	Antiandrogen	4.1	13	DSP 3 mg	20, 30
—	Antiandrogen	4.3	14	CPA 2 mg[d]	35

[a] Relative risk compared with no OC use.

[b] Vinogradova *et al.* (73); Stegeman *et al.* (57).

[c] Extra cases VTE per 10,000 women treated with OCs per year.

[d] OCs containing CPA are not available in the United States.

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