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MOLLITIES UTERI.*

By CHARLES D. SCUDDER, M. D.

Four years ago a nulliparous patient suffering from marked anteflexion of the uterus presented herself at my clinic in the Demilt Dispensary. She returned shortly after with an evident retroflexion of the organ, and in the course of the next half-year this alternate anteflexion and retroflexion showed itself repeatedly. The infra-vaginal part of the cervix and the body were normal, so I decided that the supra-vaginal cervix, and that portion of uterine tissue immediately above it, were in an atonic or softened condition. Close study, and later on a careful history of cases, showed that this atony was by no means rare. A series of observations was made which may help in clearing up still further the question of uterine pathology, and which will be of unquestionable interest to this society as throwing light on a few questions of prognosis and treatment in patients suffering from certain varieties of uterine affections.

The supra-vaginal cervix, and that portion of the uterus containing the internal os, will be called the middle segment of the uterus as distinguished from the cervix—that part observed by the aid of the speculum—and the body or upper third of the organ. *Mollities* suggests itself as an

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excellent term wherewith to designate the extraordinary softness which sometimes affects the uterus. From the time the case referred to above was treated to the present a large number—about one hundred in all—have been recorded, and fully two hundred more patients have been seen, who collectively furnish sufficient material to present results from a clinical standpoint. The writer takes the liberty of limiting his statements to his own experience, as the literature on this subject is diffuse and unsatisfactory.

Every one is familiar with the mollities of the cervix that appears in pregnancy. If the middle segment of a pregnant uterus is carefully examined, an evident softening will frequently be detected. The examining finger can indent the uterine tissue, and the fundus can be raised and depressed without moving the cervix. This sign of the early weeks of pregnancy is valuable, although it is neither invariable nor infallible. Mollities will also be found—rarely, however—in the body of a gravid uterus. Such uteri are so soft that the transverse diameter is often enlarged, and the antero-posterior diameter so markedly diminished that the fœtus apparently lies with its length directed transversely in a soft sac, which can be molded by the hand, and which may allow—as noted in one case—the utmost perfection in the determination of position when confinement is close at hand. In the case just mentioned, the abdominal walls being thin, the recti muscles being separated, and the child lying in the softened fundus of an anteflexed uterus—the whole mass forming a large hernia and hanging half-way to the knees—it was somewhat difficult to decide whether an extra-uterine pregnancy was not present. Again, mollities affects the whole gravid uterus. The order of frequency in the gravid uterus seems to be mollities of the cervix, of the middle segment, of the body, and of the entire uterus.

This same softness exists as a diseased condition in both nulliparous and multiparous women. The cervix may be very soft, the middle segment may be atonic, the body may be the site of this disease, or mollities may affect the whole uterus. The diagnosis can readily be made. A softened cervix is at once appreciated by the examining finger. A softened middle segment can be detected by raising the body of the uterus with the vaginal finger and depressing it with the abdominal hand. If mollities of the middle segment exists, the body will readily be moved without a change of axis in the cervix, showing that an exceedingly soft tissue lies between the body and the cervix. Mollities of the body is easily diagnosticated, if one has acquired skill in examination, by the readiness with which it can be molded. There is also a characteristic lack of definition in the uterine body which confuses many who are not practiced in conjoined manipulation. When the uterus, as such, is softened, definition is almost entirely lost, and the organ feels like a thick, wet dish-rag.

In point of frequency, I have found mollities of the middle segment to be most common in the nulliparous and in the multiparous non-gravid uterus; next, mollities of the fundus; then mollities of the cervix; and that of the whole uterus most infrequent.

Mollities seems to be due to malnutrition of the body as such, and of the uterus in particular. Bad hygiene in the matters of exercise, ventilation, food, rest, clothing, etc., tends to produce a lack of vigor, which finds local expression in an atonic uterus. This cause may be considered as a predisposing and also, in some cases, as an exciting cause of mollities. Changes in uterine nutrition induced by (*a*) congestions, or inflammations of the uterus, ovaries, or surrounding tissues and organs, and (*b*) by pregnancy, neoplasms, etc., act as potent factors in producing this condi-

tion. So that it may sometimes be secondary to uterine disease, but often a primary cause of uterine disease, when it involves either the body or the middle segment of the uterus. It seems clear to me that mollities of the middle segment, produced by systemic depression, is the starting-point of a large number of uterine and ovarian diseases.

Advancing from clinical diagnosis to clinical pathology, mollities of the cervix presents nothing of interest; that of the fundus and of the entire uterus exhibits the phenomena of sluggish circulation and complete atony; but when the middle segment is affected, a most interesting chain of phenomena, due to the results produced by this softening, will be seen. A young nulliparous woman presents herself, complaining of general ill-health and of bearing down when exercising. She has paid no attention to the laws of health, either through force of circumstances, ignorance, or carelessness, and complains of loss of appetite, costiveness, headache, fatigue on rising in the morning, general languor, etc., in addition to pelvic distress. An examination shows an atonic middle segment, and nothing else. Simple treatment is proposed and successfully carried out. Later on she may return. Cross-examination shows that proper hygiene has again been neglected. The symptoms complained of previously have returned, with the addition of increased discomfort on exertion and painful menstruation on the first and second day. Conjoined manipulation now shows a well-marked anteflexion, with a softened middle segment. If this is not relieved by proper treatment, the flexion will become very marked. Frequent micturition and troublesome uterine dysmenorrhœa will add themselves to the other symptoms, and later on ovarian dysmenorrhœa will develop. The body of the uterus will be found enlarged and sensitive. Menorrhagia and sometimes metrorrhagia will appear. The ovaries become sensitive and subsequently enlarged.

This represents a natural pathological series of phenomena, which present themselves in different stages to the notice of physicians. The multiparous patient differs only in that she generally starts with a subinvoluted uterus, the heavy body of which flexes itself far more readily than that of the unimpregnated uterus, if mollities of the middle segment is present. But the subjective and objective symptoms are about the same. The flexion seems to be determined by the position of the uterine axis. If this inclines backward, a retroflexion can be inaugurated by any over-exertion. If it inclines forward, an anteflexion is likely to take place. Of course, if the flexions are not restored naturally, or by the aid of the physician, they will in time become fixed, and mollities will give place to a hardening of uterine tissue.

The prognosis of mollities is generally good if no exhausting disease of other vital organs is present and if hygienic regulations can be carefully observed. If a flexion exists with mollities of the middle segment, the conditions are most favorable for its relief, as this softness allows of easy reduction, and treatment can be adopted which will maintain the body of the uterus in its normal position and restore tone to that organ.

Treatment must be constitutional and local. Appropriate food, proper exercise, a correct attitude, free-fitting clothing, lying quiet at least one hour a day, breathing pure air, etc., must be insisted upon in every case. Quinine, aloes, capsicum, and nux vomica have proved to be excellent uterine tonics. The bowels should be carefully regulated with fruit, vegetables, and water. If costiveness is obstinate, the following recipe for bran biscuit will often be efficacious:

Take of bran, one quart; flour, one pint; milk, one pint; molasses, eight tablespoonfuls; baking soda, two tea-

spoonfuls. Mix. Bake as soda biscuit. One or two at each meal.

If these fail, cascara, aloes, etc., must be employed.

Flexions should be restored by digital reposition, the patient lying on her back in anterior displacements, and being placed in Sims's, or preferably the genu-pectoral position, if she suffers from retroflexion. Resting ten minutes three times a day in the genu-pectoral position relieves and assists in the cure of both anteflexions and retroflexions, when atony of the middle segment exists. Reposition with the Sims or Elliot repositor can readily be accomplished, and pessaries suitable to each case, or even cotton tampons, will facilitate a cure.

Allowing for prejudice, clumsiness in adjusting pessaries, and lack of judgment in the selection of proper instruments, a great deal of the opposition to these invaluable aids is due to not recognizing the presence or absence of mollities of the middle segment of the uterus. The writer has seen anteflexions of marked degree, in which this condition was present, relieved entirely by attention to hygiene, without any local treatment. Pessaries used in this class of cases often benefit, without any manual interference. But, if the uterine tissue has become hardened, the continual pressure of an unyielding, sensitive, engorged body upon a rigid instrument will give rise to great discomfort, and sometimes positive injury. In like manner, repositors, used when mollities of the middle segment is present, are valuable; whereas, if the uterus has been so long flexed that the atony has disappeared, the greatest skill is required to effect the desired result, and hence many regard the repositor as a dangerous instrument. Again, digital reposition has often been abandoned and set at naught because the practitioner has failed in reducing a rigid flexion after a few trials. If he recognizes mollities he can predict success by reposition. If it

is absent, he knows that he has a difficult case to deal with, and can make a guarded prognosis and expect long-continued treatment before the case can be cured.

Uterine massage will be found easy and of very great service if mollities is present.

In conclusion, I would urge the members of this society to observe for themselves the several points raised. Careful study will probably confirm what has been said as to the presence of such a condition as mollities; its importance as a pathological factor, especially when the middle segment of the uterus is affected; and the value of recognizing the condition with reference to prognosis and treatment in certain kinds of uterine disease.

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