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MERYCISM OR RUMINATION IN MAN.

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I WAS much interested in reading the article by Dr. Brockbank under the above title in the *BRITISH MEDICAL JOURNAL* of February 23rd, as when in England I had a case in many respects similar to that related by a "professional gentleman" in Dr. Brockbank's paper. The patient in my case also was a young professional man of about 28 years of age, and rumination had first occurred some ten years ago when he was studying at college. As in a majority of the cases cited by Dr. Brockbank, the rumination occurred most frequently after dinner, and it was mostly meat that was regurgitated, though other substances—such as bits of vegetable, etc.—also came up. It was only very rarely that fluids were regurgitated. The process would start a short time after the completion of the meal, usually within a quarter of an hour, and a mouthful or two would come up at a time without any voluntary effort on his part, and quite unaccompanied by any acid eructations or pyrosis. The patient seldom brought up more than eight or ten mouthfuls altogether, and never went so far as to rechew a whole meal. At first he used to spit out the mouthfuls as they were regurgitated, but by-and-by, as there was no disagreeable taste accompanying them, he got into the habit of chewing them over again and reswallowing them, finally reaching the stage of quite enjoying the process of rumination, more especially if the food regurgitated were anything he particularly liked.

When I saw him this curious idiosyncrasy had been in existence for some ten years. The habit did not seem to worry him at all, and, as a matter of fact, I only came to know about it accidentally. In his case there was no family history of such a habit; his father and mother both had good digestions, and, of several brothers and sisters, none were affected. At the time I set it down to a somewhat anomalous form of atonic dyspepsia, although at a loss to account for the rumination of food without any other unpleasant symptoms. The regurgitation in this case, however, was not constant, and the patient himself said it varied largely with his general health, being much worse and more frequent when he was

working hard at college and feeling "run down" than during the vacation, when he was taking plenty of exercise and feeling in "good form." Unlike a number of Dr. Brockbank's cases, he at no time suffered from constipation. On the other hand, he had occasional bad attacks of flatulence, accompanied by pain; these, however, were very infrequent, though, generally speaking, he appeared to have a "weak" digestion. His stomach was particularly intolerant of fat, and, as in a number of Dr. Brockbank's cases, bits of bacon used to come up, a mouthful at a time, after breakfast. He also illustrated in a marked degree what one might almost call a "selective" action of the stomach in regurgitating certain articles of food and not others (see Dr. Brockbank's paper, p. 425). In the case of my patient the regurgitation was certain to occur after eating fat, even if swallowed unconsciously—for example, if he had partaken of a stew or curry in which small pieces of fat were mixed up with meat, etc., whether anything else were regurgitated or not, these bits of fat were certain to be returned shortly after the meal was concluded. Even when his general health was at its best and he was not bringing up his food as a rule, if he inadvertently swallowed a bit of fat it was absolutely certain to be regurgitated. The fat he did not rechew but always spat out, as he did not like it. In the case of the food he did rechew—meat, etc., but principally meat—he had no more trouble with it after he had reswallowed it.

It is a very curious thing that when he was ruminating little the food returned would usually be of an indigestible nature—for example, bits of gristle, skin, etc., as if his stomach were pointing out that these bits needed more mastication than the rest, if that organ were not to be overtaxed. In the case under notice smoking had no effect in preventing the rumination.

Another point of interest is that the actual rechewing and reswallowing of food was distinctly secondary to the regurgitation and might be spoken of as an "acquired" habit, as the patient had been regurgitating and spitting out his food for some time before he began to rechew and reswallow it.

Except for this peculiarity of merycismus the patient was in good health—in fact, of very active habits, going in for gymnastics, golf, cycling, swimming, etc.—and, although not fat, had not lost weight during the ten years he had been ruminating.

I should be inclined to class this case in subdivision (6) of the varieties of merycism as classified by Lemoine and Linossier and quoted in Dr. Brockbank's paper.

In conclusion, I may state that I had this patient for a long time under observation, and was enabled to verify personally all the facts stated.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL.

TWO CASES OF DIAPHRAGMATIC HERNIA.

SUCH anomalies are uncommon. During the four years that I have been in charge of the public mortuary at Hong Kong, only these two cases have been found.

CASE I.—The child was stillborn. The defect in the diaphragm was on the right side. Through this, part of the stomach, the greater part of the small intestines, the omentum, and a fold of the large gut had passed. The heart was displaced to the left. The left lung was fully developed, the right being only about one-third of its normal size, and lying posteriorly. The serous membranes of the peritoneal and right pleural cavity were continuous through the cleft in the diaphragm. The other organs were normal.

CASE II.—The child was stillborn. The defect in the diaphragm was on the left side. Through this the entire stomach, the majority of the folds of the small intestine, a large loop of the large intestine, the omentum, and the spleen had passed into the left pleural cavity. The other organs were normal.

According to Arnheim, about 400 cases had been reported up to 1896. The condition is also found in animals. They are not true hernias, in that there is no sac. Most authorities are agreed that the left side of the diaphragm is the seat of predilection for such a condition. In my own cases, however, one existed on the right, the other on the left side of the diaphragm.

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