is generally somewhat plumper and less lanceolate than the other types of pneumococci. Its capsule is larger, as shown by the His stain, and is usually stained pink with the counterstain of the Gram stain. The colonies on solid media are more moist, mucoid and larger than those of the other types. The peritoneal exudate in the mouse is usually quite mucoid, and can be drawn out into strings with the platinum wire. It occasionally happens, however, that strains of pneumococci Type III are encountered which do not show well-developed mucoid characteristics, and Type II strains are found which show mucoid characteristics well developed. Therefore, the serological method of differentiation is the most reliable. It should be remembered that *Streptococcus mucosus* (which possesses a capsule) is not bile-soluble.

The type of infecting pneumococci should always be verified from a culture of the heart’s blood of the mouse or by the Avery method.

*(To be continued.)*

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**CONGENITAL CYSTIC KIDNEYS AND LIVER, GASTRIC ULCER, GASTRO-ENTEROSTOMY: LATER, GASTRIC CARCINOMA; PERFORATION.**

**By T. Gillman Moorhead, M.D., F.R.C.P.I.**

In April, 1918, I received a letter from a patient asking for an appointment. He told me that he was a miller by trade, was 45 years of age, and had been quite well until twelve months ago, when he began to suffer from dyspepsia, with severe pains in the chest, and from vomiting. He had at first got complete relief from the consumption of bisurated magnesia, but of late this had failed to alleviate his sufferings. On arrival, I saw a tall man, extremely emaciated; and on examining the abdomen, I was fortunate enough to see at once large
peristaltic waves originating obviously in the stomach. The diagnosis of pyloric obstruction was therefore easily made, and was confirmed by the discovery of an easily palpable, mobile lump in the epigastrium. Further examination, however, rather complicated matters, as, in addition, a large swelling was felt on the left side of the abdomen, in the kidney region, and extending downwards from that region. As far as I could determine, this swelling was composed of an upper part, which felt like a somewhat enlarged kidney, and a lower part, also feeling rather like a kidney, and separable from the upper portion by a distinct groove. The mass was slightly moveable on deep respiration. As the urine was absolutely normal, much doubt existed in my mind, and in that of Mr. Johnston, who later saw the case with me, as to the nature of this tumour, and at first we greatly feared that it might be a malignant retroperitoneal mass, in which case operation, even to relieve the stomach symptoms, seemed hardly justifiable, inasmuch as the patient was extremely weak and thin. However, a test meal administered a couple of days after the patient was first seen by me showed the presence of abundant hydrochloric acid, and in consequence I decided to recommend operation. The abdomen was opened, a pyloric stricture was found, presumably non-malignant, and a gastro-enterostomy was performed. The patient was so ill that Mr. Johnston thought it inadvisable to do anything more than what was absolutely necessary, and in consequence he closed the abdomen without investigating the left-sided swelling. Rapid improvement followed: within a fortnight the patient insisted on returning home, and in October he wrote to inform me that he had gained nearly two stone in weight, and had long since been back at his work.

I heard nothing further till November 5th, 1919, i.e., about 18 months after the operation.

He then again came to see me, and told me that he had remained perfectly well till five weeks previously, when he again began to suffer from severe pain after his