Lester Dragstedt was born in Anaconda, Montana, the son of Swedish immigrant parents. His entire college and professional education took place at the University of Chicago, where he received a B.S. degree in 1915, a master's degree in physiology in 1916, a Ph.D. in physiology in 1920, and the M.D. degree (from Rush) in 1921. His first academic appointment was as a physiologist at the State University of Iowa. In 1925 Dragstedt was recruited by Dallas B. Phemister to help design the new University Hospital research facilities on the campus of the University of Chicago. Following completion of this responsibility Phemister appointed Dragstedt as Associate Professor of Surgery, stating, "I can teach surgery to a physiologist; I am interested in teaching physiology to surgeons." In 1947 Dragstedt succeeded Phemister as chairman, a post he occupied until his retirement in 1959.

Dragstedt was regarded as a skilled clinician as well as a dexterous and artistic surgeon. But he was particularly recognized for his contributions as physiologist-surgeon in the treatment of diseases of the pancreas, parathyroids, and especially diseases of the stomach. In 1943, he performed a transthoracic vagotomy on a patient with a duodenal ulcer who refused to accept the standard operation, subtotal gastrectomy. A lesser known but classical work of Dragstedt and his coworkers is reproduced here for this series. Dragstedt was the originator of the skin-grafted ileostomy in the treatment of ulcerative colitis. The author describes a complete "take" of the split-thickness graft in four patients, although he observed that the "resulting ileostomy looked somewhat like a penis." One can only surmise about the psychologic disability that would be produced. The stoma could, however, be fitted with an appliance that would minimize the risk of abdominal wall digestion. When reading the article and understanding the experimental studies proposing the possible causative organism of ulcerative colitis, one is impressed by Dragstedt's creative thinking.

Dragstedt's renown as a basic scientist was illustrated by his election to the National Academy of Sciences. Following his Chicago retirement he became again a full-time physiologist with appointments as research professor in both the department of surgery and the department of physiology at the University of Florida College of Medicine. Active until the end, he died at his summer home on Elk Lake, Michigan on July 16, 1975.


CHRONIC ULCERATIVE COLITIS*
A SUMMARY OF EVIDENCE IMPLICATING BACTERIUM NECROPHORUM AS AN ETIOLOGIC AGENT†

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Lester R. Dragstedt
Departments of Surgery, Bacteriology, and Medicine of the University of Chicago during the past eight years. Most of the data presented in previous reports has been confirmed in our further experience and considerably amplified. As a result of this work we are persuaded that Bacterium necrophorum, together with factors, some of which are at present unknown, plays an etiologic role in the disease.

It has long been recognized that the part played by bacterial infection in chronic ulcerative colitis, as in other enteric infections, has been difficult of solution to a large extent because of the extraordinary variety and abundance of the normal intestinal flora. The nature of the bacterial species in the various levels of the normal gastrointestinal tract and their relative abundance has been found to depend among other things on the type of organisms ingested with the food, the presence of foci of infection in the nose and mouth, the acidity of the gastric secretion, the rate of passage of the fecal current, and perhaps of greatest importance on the character of the diet. It is small wonder, then, that cultures taken from the colon discharges or from lesions, seen with the proctoscope, in patients with chronic ulcerative colitis have yielded a wide variety of organisms and little agreement among investigators.

A number of years ago, in a study of the problem of acute intestinal obstruction, one of us together with Moorhead and Burcky made the observation that segments of the intestine isolated from continuity with the alimentary tract but retaining their normal blood supply become sterile after the passage of time. Thus, a segment of jejunum or ileum, isolated as in Figure 1, and washed with sterile water to remove solid material, becomes sterile in a few weeks if dropped back into the peritoneal cavity. Dack has similarly observed that such segments drained to the outside as in the Thiry-Villa fistula also become sterile if undisturbed by the trauma of irrigation or injection. The factors involved in this self-sterilization seem to be chiefly mechanical and consist in the protective action of the intestinal mucus, which entangles the organisms, and peristalsis which steadily propels them along the tube. It occurred to us then that a study of the bacteria in the colon of patients with chronic ulcerative colitis ought to be more significant when the diseased colon is isolated from the fecal stream and the processes of self-sterilization are operative, in which case the organisms that might be found to persist ought to be of greater significance than the birds of passage.

It is not our purpose to discuss the merits of ileostomy in the treatment of chronic ulcerative colitis. It is our conviction that the procedure is definitely beneficial when so performed that irritation and digestion of the abdominal wall does not occur. The method that we have employed will be presented in detail elsewhere and a short description will suffice here (Fig. 2). The abdomen is opened through a short, low right rectus incision. The ileum is transected about four inches from the cecum and the distal end closed. The mesenteric vessels supplying the lower six inches of the proximal end of ileum are divided about an inch from the point where they enter the intestinal wall, in order to preserve the distal arcade and thus prevent necrosis of the portion of ileum that is to be exteriorized. The ileum is then brought out six inches beyond the skin surface and the wound closed loosely, with the mesenteric border sutured at the lower end of the incision so that the exteriorized ileum will arch downward. A small Pezzar catheter is then tied into the lumen of the bowel to drain off the intestinal content. A rectangular segment of skin, four by eight inches in size and six one-thousandths of an inch thick is then cut from the neighboring abdominal wall with a Padgett dermatome and wrapped carefully around the exteriorized portion of