Maude Elizabeth Seymour Abbott
“She was an institution”

Born on March 18, 1869 at St Andrews, a small village on the north shore of the Ottawa River.

Higher Education for Women ??

In the minds of many if not most men, women were considered incapable of the increased mental strain which higher education demanded.
Her Early Steps

Class Valedictorian
Winner of the
Lord Stanley Gold Medal

But what about medicine??

Maude set her mind on McGill, and petitioned the Registrar who replied, “I am sorry to inform you that the Faculty of Medicine can hold out no hope of being able to comply with your request.”
Enlightened Opinions

*Dr. F.J. Shepherd*, “Introduction of women amongst medical students would be nothing short of a calamity.”

*Dr. G. E. Fenwick, Professor of Surgery*, “I will resign if women are allowed to take the medical course.

*Dr. F. W. Campbell* argued that, “In the difficult work of surgery, they would not have the nerve. Can you think of a patient in a critical case, waiting while the medical lady fixes her bonnet or adjusts her bustle?”
Maude graduated from Bishop’s in June 1894 with brilliant honors. Vienna was the medical Mecca, so she immediately planned her post graduate work in Europe. One of the greatest medical opportunities in Vienna was pathology with Kolisko and Albrecht, an experience that made possible Maude’s later work.

And she traveled--London, Heidelberg, Zurich--exposing herself to the best minds in contemporary medicine. These years of study and travel were the happiest in her professional life.

But what Maude wanted above everything else was to be on the staff of the McGill Medical Faculty
Osler’s Advice to Maude

“I wonder if you realize what an opportunity you have?
That McGill Museum is a great place.”

And so he gently dropped a seed that dominated all her future work.
Before World War II, congenital malformations of the heart were regarded as *hopeless futilities*, an occupation appropriate for the few women in medicine. Maude Abbott was advised by William Osler to occupy herself with the collection of anatomic specimens at McGill, and Helen Taussig was advised to occupy herself with the hopeless futilities in the Harriet Lane children’s clinic at Hopkins. *Congenital heart disease in adults was an oxymoron.*
The Two Few Women in Medicine

Maude Abbott

Helen Taussig
Maude and Helen
ATLAS
OF
CONGENITAL CARDIAC
DISEASE
MAUDE E. ABBOTT

The Osler Library
McGill

1936
1000 Cases
2006 Re-publication on the occasion of the 100th Anniversary of the International Association of Medical Museums, now called the International Academy of Pathology
Aug 27th 1931

Dr. Munde E. Abbott
McGill University
Montreal, Canada.

Dear Dr. Abbott:

As you requested, I am sending you a reprint of my article "A Persistent Ostium atrioventriculare Communicating with Septal Defects in a Mongolian Idiot." I am also sending the heart reported in this article. This is being done at the request of Dr. Elliott C. Culter, Professor of Surgery, Western Reserve University, Cleveland, Ohio. The patient was his daughter, and he wishes the heart to be added to the collection in your museum.

I want to again thank you for your advice about this case.

Sincerely,

George M. Robson M.D.
MECKEL'S CASE (1827) OF EXTREME COARCTATION.
Marked development of collateral circulation in a
man aged 35, who died from rupture of right auricle.
1. Chick Heart at 50 hours
Orthodiagraph by Hugo Rösler showing cœur-en-sabot in tetralogy of Fallot.
CYANOSIS RETINAE. Eye ground in a cyanotic child aged 3 1/2 yrs.

Painting by Harriet Blackstock
McGill University
Chart 1: Statistics of Congenital Cardiac Disease (1,000 Cases Analyzed)

<table>
<thead>
<tr>
<th>Classification of Defects</th>
<th>Cardiac Findings</th>
<th>Clinical</th>
<th>Cause of Death</th>
<th>Relative Frequency</th>
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<th>Age</th>
<th>Sex</th>
<th>Premonitory Signs</th>
<th>Postmonitory Signs</th>
<th>Other Findings</th>
<th>C. M.</th>
<th>Systolic</th>
<th>Diastolic</th>
<th>Other Findings</th>
<th>Cause of Death</th>
<th>Relative Frequency</th>
</tr>
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(Continued on the next page)
OSLER'S CASES OF BICUSPID AORTIC VALVE.
Showing low raphe and infective endocarditis. From the Montreal General Hospital Reports, 1880. Specimens in McGill Museum.
F.W. - SUMMARY OF CASE

HISTORY:
White male, age 45. Chief complaint, weakness and dyspnea. Past history - known to have had heart disease for 15 years. Six months ago was ill with symptoms of grippe from which he never recovered. Recently noticed purpuric spots over legs.

PHYSICAL EXAMINATION:
There was fever, tachycardia, enlarged spleen, purpura over legs, hydrothorax. Heart: Systolic and diastolic murmurs and systolic thrill over aortic area.

PATHOLOGICAL FINDINGS:
Heart: Weight 460 grams.
1. Two aortic cusps; two normal commissures and one fused commissure. Circumference of ring 6 cm. Length of combined cusp 3.2 cm. (Right and left anterior), posterior cusp 2.8 cm. Both coronary arise from sinus of combined cusp.
2. Anterior cusp is divided by a high, short raphe. Free margin of cusp has uninterrupted swing. Posterior cusp and aortic leaflet of mitral valve are the seat of ulcerative endocarditis. Spleen showed on culture streptococcus viridans. There was an embolic glomerulo-nephritis.

CAUSE OF DEATH:
Subacute bacterial endocarditis.

MICROSCOPICAL EXAMINATION:
Parallel serial sections through raphe. Weigert's elastica stain.
1. Serial section 10. The raphe is seen as an elevation upon the sinus surface of the valve just distal to its attachment. The annulus fibrosus arises deep to the aortic elastic media. The superficial ending of the elastica proceeds further toward the valve than the deep ending at the wedge shaped junction.
2. Serial section 29 - Approximately 2 mm. advanced. The connective tissue of the annulus now lies superficial to the elastic fibers.
3. There has been a reversal of the relationship at the annulus-media junction. Normal commissural relationships.
4. Serial section 54 - Approximately 15 mm. advanced. Normal commissural relationship of the annulus-media junction still maintained. The deep ending of the aortic elastic fibers does not however proceed as far behind the valve as at a normal commissure. No evidence of inflammatory reaction.

DIAGNOSIS:
Probable congenital bicuspid valve. The criteria for microscopic identification may be incorrect for this case.
J.F.—MEDICAL EXAMINER'S CASE SUMMARY

HISTORY:
White male, age 52. Patient brought to hospital and died a few minutes after arrival.

PATHOLOGICAL FINDINGS:
Heart: 770 grams.
Two aortic cusps; two normal commissures. Circumference of ring 7.5 cm. (Left anterior and right anterior), posterior cusp 3.5 cm. Both coronaries arise from sinus of the combined cusp. Small accessory right coronary. Combined cusp, particularly at its free margin, shows extensive calcium deposition. No raphe within cusps. Uninterrupted swing of free edge of valves. Posterior cusp shows area of perforation close to commissure. Moderate amount of calcium at root of posterior cusp and upon aortic leaflet of mitral valve. Aorta immediately above smooth. Abdominal aorta arterio-sclerotic. Kidneys show no embolic glomerular lesions. No other congenital anomalies.

CAUSE OF DEATH:
Congestive heart failure.

DIAGNOSIS:
Congenital bicuspid aortic valve. Aortic stenosis. The gross criteria are sufficiently characteristic. No microscopic study in this case.